

# MATRIX HOME CARE

# MEDICAL SOCIAL WORK ASSESSMENT

Name of Responsible Person:		Relationship:	Phone:	PT/CL Name:		Date:
Person to Contact in Emergency:		Relationship:	Phone:	Address:		
Prior Medical Social Work Service		Referral Source/Date				
Frequency/Duration of Visit						
Rehabilitation Potential		Physician			Phone	
	Diagnosis	Date of Onset	AGENCY/SNF:		Dates of Stay:	
Primary						
Secondary			AGENCY/SNF:		Dates of Stay:	
SPECIFIC INFORMATION DESIRED						
_____						
_____						

**I. PERSONAL, PSYCHOSOCIAL AND FAMILY FUNCTIONING AND FINANCIAL INFORMATION:**

<b>A. HOUSEHOLD MEMBERS</b> (names and relationships)	<b>SIGNIFICANT OTHERS</b> (names and relationships)	<b>COMMENTS</b>
_____	_____	_____

**B. BEHAVIOR INDICATORS/PSYCHOSOCIAL FUNCTIONING:**

Key PT = patient  
PCP = Primary Care Person

	GOOD PT PCP	FAIR PT PCP	POOR PT PCP	COMMENTS
Functional Ability				
Memory				
Comprehension				
Judgment/Decision Making				
Communication Ability				
Knowledge of Health Problems				
Motivation to Resolve Needs				
Compliance with Treatment				
Ability to Accept Help				

**C. Significant psycho/social/emotional factors/needs for counseling:** \_\_\_\_\_

\_\_\_\_\_

Refer to: Case Manager: \_\_\_\_\_ Psych Nurse: \_\_\_\_\_ MHMR: \_\_\_\_\_ Other: \_\_\_\_\_

<p><i>Client/Designee: I certify that the Matrix Home Care Employee listed on this time slip worked the times indicated and the work was performed in a satisfactory manner. I agree to the times regarding this time slip.</i></p> <p>Employee Signature: _____</p> <p>Patient/Client Signature: _____</p>	PT/CL NAME: _____
	ADDRESS: _____
	CITY, STATE, ZIP: _____
	VISIT DATE: _____
	TIME IN: _____ TIME OUT: _____

# MATRIX HOME CARE

## MEDICAL SOCIAL WORK ASSESSMENT

Patient/Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

### II. ASSESSMENT SUMMARY:

III. LONG-TERM CARE PLANNING: \_\_\_\_\_ Access community resource utilization on ongoing basis  
 \_\_\_\_\_ Provide information, referral consultation & collateral contacts as needed  
 \_\_\_\_\_ Counsel/teach re: appropriate community resource utilization  
 \_\_\_\_\_ Instruct pt/family to call Care Team if assistance needed after discharge

IV. **Problem Areas/Reasons:**  
 Identify factors which are impeding patient's ability to achieve maximal health potential/ compliance with treatment plan.

**HOUSING:** Adequate YES NO  
 Due to: Crowding  
 Sanitation  
 Structural deficiency  
 Neighborhood  
 Dysfunctional utilities  
 Other: \_\_\_\_\_

**EQUIPMENT/SUPPLIES/INFORMATION:**  
 Adequate YES NO  
 Due to: Knowledge deficit  
 Income deficit  
 Other: \_\_\_\_\_

**INCOME:**  
 Adequate: YES NO  
 Due to: No income resource  
 Disproportionate living or medical expenses  
 Poor financial planning/ decision making

Other: \_\_\_\_\_

**SAFETY:**  
 Adequate YES NO  
 Due to: Lack of supervision  
 Abuse/neglect  
 Poor Judgement  
 Environment  
 Alcohol/substance abuse  
 Prone to falls or medical emergencies  
 Other: \_\_\_\_\_

**TRANSPORTATION:**  
 Adequate YES NO  
 Due to: Unable to drive  
 Unable to ride in car  
 Driver not available  
 Can't afford  
 Inaccessibility

Other: \_\_\_\_\_

**PERSONAL CARE/HOUSEKEEPING:**  
 Adequate YES NO  
 Due to: Lives alone  
 Elderly/ill PCP  
 Extreme dependency of pt.  
 Employed PCP  
 Refuses to accept help  
 Cannot afford to hire

Other: \_\_\_\_\_

**FOOD/MEALS:**  
 Adequate YES NO  
 Due to: Pt/PCP unable to prepare meals  
 Inadequate income  
 Inability to shop for groceries  
 Other: \_\_\_\_\_

**OTHER:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### CARE PLAN

PROBLEM NUMBER	PROBLEM	GOALS	PLAN INTERVENTION	DATE RESOLVED

DISCHARGE PLANS	PLAN OF CARE REVIEW (Date & Initial)
	1. _____ 3. _____ 5. _____
	2. _____ 4. _____ 6. _____

Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_