Social Services

Initial Assessment

**Social Services Initial Assessment**

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| --- | --- |
| **Name:** | **Preferred Name:** |
| **Admission Date:** | **Admitted From** ❑Home ❑Acute Care ❑SNF ❑ALF ❑Other: |
| **Prior Living Arrangement:** | **Admission Diagnosis:** |
| **Religious Affiliation :** | **Marital or Personal Preference Status**  ❑Married ❑Widow/Widower ❑Life Partner ❑LGBTQ ❑Other: |

**Decision Making Responsibility** (*Check all that apply)*

❑Legal guardian ❑Other legal oversight ❑ Durable power of attorney (healthcare)

❑Durable power of attorney (financial) ❑Family member responsible ❑Resident responsible for self

Who is involved in decision making?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Advance Directives:** (*Check all that apply)*

❑Healthcare Directive ❑Living Will ❑Durable Power of Attorney for Health Care

❑Limited Treatment Plan ❑Feeding Restrictions ❑Medication Restrictions ❑Other:

**Code Status:** ❑CPR ❑No CPR ❑DNI ❑Other **Copies of legal documents in chart:** ❑Yes ❑No

❑ POLST/MOLST (Circle)

Other/Comments:

Funeral arrangements/Mortuary preference:

**Placement Status/Discharge Plan** *(Check all that apply)*

**Discharge Goals:** ❑Discharge to home with services ❑Discharge to home without services

❑Resident expresses preference to return to the community

❑Resident has a support person who is positive towards discharge

❑Transfer to another facility ❑Transfer to an assisted living

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

**Projected Stay (discharge projected):**

❑Within 30 days ❑Within 31-90 days ❑D/C status uncertain ❑Long-term stay at this facility

**Cognitive Status:** Upon initial interview of the resident**,** *(Check all that apply)*

❑No memory impairment ❑Short-term memory impairment ❑Long term memory deficit

❑Diagnosis of dementia ❑Unable to communicate ❑Unable to make daily decisions

**Communication Patterns** *(Check all that apply)*

❑No difficulties ❑HOH ❑Deaf ❑Gestures/sounds ❑Sign language ❑Written notes only

❑Speech impediment ❑Language interpreter/Language(s) spoken: \_\_\_\_\_\_\_\_\_\_\_ ❑Communication board ❑Unable to communicate ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Situations**

**Expectations of resident regarding their stay:** ❑Improve or maintain physical health

❑Improve or maintain mental health ❑Comfort/pain management/end of life care

❑Improve or maintain social situation

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**Current life stressors/grief issues**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Hobbies or Interests**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Community Interests and Integration** (List current and past community involvement, social clubs, organizations, engagement and access as well as level of involvement)

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**Describe Substance Use**

❑Cigarettes/Cigars (Packs per day \_\_\_\_\_\_\_\_\_\_) ❑Alcohol Use (Number of drinks per day \_\_\_\_\_\_\_\_\_\_)

❑History of use of illegal substances (Y/N) ❑Current Use of illegal substances: Describe:

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**Social History (Education, family, routines, work history, sleep patterns, personal preferences, etc.)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mood and Behavior Patterns: (Complete during observation period)**

**Dementia**

Diagnosis of Alzheimer’s Disease (or related disorders) or Dementia: ❑Yes ❑No

Describe any mood or behaviors and plan of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental and Psychological Disorders**

History of Mental Health or Mental Disorder Diagnosis: ❑Yes ❑No

If Yes – Describe Treatment:

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**History of Trauma and/or Post Trauma Stress Disorder:** ❑Yes ❑No

If Yes – Describe Treatment:

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**Completion of PASARR Level II:** ❑Yes ❑No

If Yes – Describe Resident Recommendations:

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| **Patient Health Questionnaire – 9 (PHQ-9©) – Over the past two weeks how often have you been bothered by any of the following problems?** (As referenced in the CMS RAI MDS 3.0 Manual) | | | | |
| **Questions** | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| **Little interest or pleasure in doing things** | **0** | **1** | **2** | **3** |
| **Feeling down, depressed, or hopeless** | **0** | **1** | **2** | **3** |
| **Trouble falling or staying asleep, or sleeping too much** | **0** | **1** | **2** | **3** |
| **Feeling tired or having little energy** | **0** | **1** | **2** | **3** |
| **Poor appetite or overeating** | **0** | **1** | **2** | **3** |
| **Feeling bad about yourself – or that you are a failure or have let yourself or your family down** | **0** | **1** | **2** | **3** |
| **Trouble concentrating on things, such as reading the newspaper or watching television** | **0** | **1** | **2** | **3** |
| **Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual** | **0** | **1** | **2** | **3** |
| **Thoughts that you would be better off dead or of hurting yourself in some way** | **0** | **1** | **2** | **3** |
| **For office coding** | **0+** | **\_\_\_\_\_\_+** | **\_\_\_\_\_\_+** | **\_\_\_\_\_\_+** |
|  | **Total Score \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

**Interventions:** (Check all that apply)

❑Evaluation by a licensed mental health specialist ❑Group therapy

❑Resident specific deliberate changes in environment to address mood/behavior patterns

❑Re-orientation (cueing) ❑Cue for socialization/activities ❑Offer support ❑None of the above

Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe what interventions have worked in the past:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Resident’s response to interventions:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Information gathered from:**  ❑Resident ❑Resident Representative ❑Family/Friend ❑Guardian ❑Medical Record ❑Staff ❑Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature/Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**