SOCIAL SERVICE EVALUATION

PHYSICAL/FUNCTIONAL STATUS

Provide a brief overview of the resident's level of adjustment to current physical/functional status regarding ADLs, mobility, equipment for mobility, assistive devices, podiatric care, dental needs, nutrition issues/weight loss and pain management.

Is resident currently physically or chemically restrained? ❍ No ❍ Yes, type & reason:

_____

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location:_____

SENSORY CONCERNS (VISION/HEARING/COMMUNICATION)

Are there sensory limitations that affect the resident's functioning level? Is adaptive equipment needed?

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location:_____

FAMILY RELATIONSHIPS/SUPPORT SYSTEMS

Identify significant others (including spouse, children, extended family and friends). Provide a brief overview including frequency of visits, level of support and correspondence, involvement in care planning, etc. Note any changes in family constellation (i.e., divorce, death, move, birth).

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location:_____

PSYCHOSOCIAL WELL-BEING/SOCIALIZATION

Address relationships with staff, roommate, other residents, friends, volunteers and visitors. Describe resident's attitude about admission to facility. Note family's attitude and feelings about resident's admission, preadmission living situation and reason for admission/continued stay.

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location:_____

COGNITIVE/MENTAL STATUS

Provide a brief overview of resident's orientation, short and long-term memory, decision-making ability, ability to adjust and cope with stress. Address related diagnoses, resident attitudes/feelings about disabilities and continued stay.

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

Continued on next page

SOCIAL SERVICE EVALUATION

MOOD STATE/BEHAVIOR PROBLEMS/PSYCHOSOCIAL ADJUSTMENT

Provide a brief overview of resident's current status and related psychiatric diagnosis(es). Describe personality and behavior patterns before admission and identified areas of concern.

Current psychiatric-related diagnosis(es)? ❍ No ❍ Yes

Is PASRR Level II screen indicated? ❍ No ❍ Yes

Is resident currently taking any psychoactive drug(s)? ❍ No ❍ Yes

List current psychoactive medications:

History of alcoholism? ❍ No ❍ Yes

History of drug abuse/dependency? ❍ No ❍ Yes

History of trauma – PTSD, etc.? ❍ No ❍ Yes

Triggers or stressors? ❍ No ❍ Yes

Does resident feel safe here? ❍ No ❍ Yes

If yes to any of the above, describe:

Language, cultural or ethnic factors present? ❍ No ❍ Yes

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location: _____

PERSONAL NEEDS/PAY STATUS

Who assists in meeting resident's personal needs? Financial and legal matters? Are there advance directives: DPOA, CPR/DNR, living will? Has a legal guardian been appointed? If so, identify by name.

Payment Status: ❑ Medicaid ❑ Medicare ❑ Private Pay ❑ VA ❑ Other: _____

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location: _____

REFERRALS AND OUTSIDE RESOURCES

Provide a brief overview of contact with referrals and outside resources (i.e., talking books, absentee ballots, transportation services, counseling services, spirtual needs, end-of-life concerns, discharge plans). Identify resident and family goals.

Are referrals indicated? ❍ No ❍ Yes, _____

Additional information available? ❍ No ❍ Yes, location: _____

Signature/Title of Person Completing This Evaluation: _____ Date: _____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed