**Section 1: Bedside Patient Screening by Admitting Provider**

|  |  |  |
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| **1a** | Do you live alone? |  *yes no***❑ ❑**  |
| **1b** | Are you the primary caregiver for somebody else?* Yes, for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No
 |  |
| **1c** | When feeling well, do you feel safe in your own home?If **no**, consider initiating Social Work referral for further assessment  |  *yes no***❑ ❑**  |
| **2a** | Can this patient be alone at home during the acute hospitalization? Check each of the following:* Does not have delirium
* Able to access a telephone and dial desired # (e.g. 911, HaH number) independently
* Able to ambulate independently within apartment (with or without assistive devices)
* Has not fallen in the last 6 months: If had a fall, # ❑ 1 ❑ 2+
* Able to access food and feed self independently
* Able to toilet independently (incontinence ok)
 |  |
| **2b** | **If any of the checkboxes above were left blank**, what is the plan for 24/7 care during the HaH admission?* Formal caregiver (e.g. HHA, RN, LPN)
	+ Days/Hours:
	+ Agency Name (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Agency Tel (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Informal caregiver(s) e.g. family members or friends
	+ Relationship/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Days/Hours:
	+ Relationship/Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Days/Hours:
 | *Select all that apply* |
| **3a** | If supplemental oxygen is needed: Do you or anyone in your home smoke? | *yes no*  |
| **3b** | If supplemental oxygen is needed and the patient or other resident smoke: are they willing to abstain from smoking in the house? | *yes no*  |
| **3c** | If supplemental oxygen is needed: can your home fit the equipment? It is the size of a large suitcase. | *yes no*  |
| **4** | Do you have any pressure ulcers (#)? **❑** *1*  **❑** *2* **❑** *3*  **❑** *4*  **❑** *5+*If yes, please describe, if able to assess:  | *yes no*  |
| **5** | Emergency Contact Information:* Name:
* Phone:
* Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Proxy Information:* Name: \_\_\_
* Phone: \_\_
* Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signed HCP form or has form at home: Form given to pt/family to read/sign at home: *yes no yes no*     |
| **6** | Code status:  Full Code  DNR/DNI Preferences:  Do Not Hospitalize  |
| **7** | Do you have a preferred pharmacy?Name: Location: \_\_\_ |
| *Provider Signature: Date:\_\_\_\_\_\_\_\_\_\_\_\_* |