**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:\_\_\_\_\_\_\_\_\_\_\_\_* | | |