Social Services Initial Assessment

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Social Services Initial Assessment

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?_____
_____

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

Resident Name:_____**MR#**_____**Room#**_____

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

_____
_____

Current life stressors/grief issues:_____
_____
_____
_____

Hobbies or Interests:_____
_____
_____
_____

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

_____
_____
_____
_____

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:

_____
_____

Resident Name:_____MR#_____Room#

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:

_____
_____
_____
_____

Resident Name:_____ **MR#**_____ **Room#**_____

History of Trauma and/or Post Trauma Stress Disorder: ❑Yes ❑No
If Yes – Describe Treatment:

_____
_____
_____
_____

Completion of PASARR Level II: ❑Yes ❑No
If Yes – Describe Resident Recommendations:

_____
_____
_____
_____

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 _____			

Resident Name:_____MR#_____Room#

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:_____
_____
_____
_____

Resident's response to interventions:_____
_____
_____
_____

Information gathered from: ❑Resident ❑Resident Representative ❑Family/Friend ❑Guardian
❑Medical Record ❑Staff ❑Other: _____

Signature/Title:_____ Date:_____

Resident Name:_____MR#_____Room#