

CARE MANAGEMENT – INITIAL VISIT

Date: _____

Name: _____ DOB: ____/____/____

Please answer the following questions:

My highest level of education completed: _____

The best time to call me: _____

Phone number: _____

I am concerned about these health problems:

Circle how important these health concerns are to you: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

1 = not sure at all 5 = somewhat sure 10 = very sure

I would like to make these changes:

Circle how ready you feel to make these changes: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

1 = not sure at all 5 = somewhat sure 10 = very sure

My doctor is concerned about:

Biopsychosocial Assessment

Demographics:

- Age
- Education
- Employment
- Fixed income/insurance
- Family

Physical Health:

- Rx, OTC
- Physicians, frequency of visits
- How they describe health
- Eating habits
- Bowel/bladder function
- Ambulation/get up and go

ADL's:

- Self care/taking meds
- Using phone
- Shopping/cooking/housework
- Driving
- Handle money/pay bills

Mental Health:

- Personality
- Intelligence – problem solving skills
- Memory/Cognition

Emotional Health:

- Depression
- Anxiety
- Excessive worries

Sexual Health:

- Issues

Social:

- How spend time during day
- Hobbies/pets
- Read/tv/internet

Spirituality:

- Particular religion
- Philosophy that is comforting

Environment/Safety of Home:

- Comfort/Safety issues
- Plumbing/heat/electric
- Falls over past year

Risks:

- Evidence of abuse, neglect/self-neglect
- Mental incapacity

Advance Directives:

- 5 Wishes
- Living Will
- Health Care POA

Initial Care Management Visit Patient _____ Date: _____

Goals	Action Plan	Potential Roadblocks/Resources

Care Manager: _____ Follow-up: _____

By signing below, I understand my care management plan and its importance towards managing my health.

Patient Signature: _____ Date: _____

Subsequent Care Management Visit Patient _____ Date: _____

Goals	Action Plan	Potential Roadblocks/Resources

Care Manager: _____ Follow-up: _____

By signing below, I understand my care management plan and its importance towards managing my health.

Patient Signature: _____ Date: _____