EI ASSESSMENT FORM

Alternate Contact Information

Alternate Contacts? ( ) Yes ( ) No

If yes….

EI Alternate Contact Information:

Spouse Name: _____

Parent/ Guardian Name: _____

Primary Language: _____

Third Party Insurance: _____

EI's Alternate Address: _____

EI's Alternate Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact's Alternative Phone Number: _____

Official PCP Alternate Information

Official PCP's Alternate Phone Number: _____

Official PCP's Alternate Fax Number: _____

Alternate PCP? ( ) Yes ( ) No

If yes….

Alternate PCP Name: _____

Alternate PCP NPI: _____

Alternate PCP's Phone Number: _____

Alternate PCP's Fax Number: _____

Referral Information

Referral Source:

( ) Medicaid Agency ( ) Community Based Organization/ Agency

( ) Emergency Department ( ) Hospice/Palliative Care Program

( ) Hospital/In-Patient ( ) Home Health

( ) Mental Health Provider ( ) EI/Caregiver

( ) Pharmacist ( ) Pharmacy

( ) PCP ( ) School/School Nurse

( ) Specialist(s) ( ) Other _____

Referral Reason:

( ) Asthma ( ) BMI over 25 ( ) Cancer ( ) Cardiovascular Disease ( ) COPD

( ) Diabetes ( ) Heart Disease ( ) Hepatitis C ( ) HIV ( ) Mental Health Disorder

( ) Sickle Cell Anemia ( ) Substance Use Disorder ( ) Transplant

( ) Neurological Disorders ( ) Other Medical Conditions

( ) Receiving inadequate care for medical conditions, including medical, mental health, and substance use disorders

( ) Receiving contraindicated medications and/or in need of medication reconciliation

( ) Uses the Emergency Department with conditions that could be treated in primary care settings

( ) Recent hospitalizations(s)

( ) Needs Care Management for medical or behavioral conditions that can be positively affected/better controlled

( ) Additional Clinical or social information supports unstable conditions

( ) Other: _____

Referral Reason Comments:

Height/Weight Details

Height: ____ ft, ____in

Weight: _____ lbs

Current Situation

EI's General Perception of Health: ( ) Excellent ( ) Very Good ( ) Good ( ) Fair
( ) Poor

Medical Conditions:

Durable Medical Equipment? ( ) Yes ( ) No
If yes, please list:

Tobacco Use: ( )Smoker ( ) Non-Smoker ( ) Exposure to Smoke ( ) Previous Smoker
If previous smoker, date of quitting: _____

Allergies

EI has allergies? ( ) Yes ( ) No
If yes, please list:

Social Needs

EI has social needs issues? ( ) Yes ( ) No
If yes…

Social Needs: ( ) Community Agency Coordination ( ) Education Barriers
( ) Environmental ( ) Family Issues ( ) Financial ( ) Food Stamps
( ) Home Safety Risk ( ) Housing ( ) Inability to Care for Oneself
( ) Lack of Resources ( ) Literacy ( ) Support System is Inadequate
( ) Transportation ( ) Other: _____

Social Issue Living Situation:

Recent Exams

Date of last PCP visit: _____

Date of last health checkup: _____

Date of last dental exam: _____

Date of last eye exam: _____

Functional Assessment

Cognitive Impairment? ( ) Yes ( ) No
If yes, please describe:

Cognitive Impairment Severity: ( ) Mild ( ) Moderate ( )Severe

EI is alert? ( ) Yes ( ) No

EI Oriented to Time? ( ) Yes ( ) No

EI is Oriented to Place? ( ) Yes ( ) No

EI has Motor Impairment? ( ) Yes ( ) No
If yes, please describe:

Motor Impairment Severity: ( ) Mild ( ) Moderate ( ) Severe

EI has other Functional Impairment? ( ) Yes ( ) No
If yes, please describe:

Other Functional Impairment Severity: ( ) Mild ( ) Moderate ( ) Severe

Guardian/Caregiver Assessment

Has Caregiver? ( ) Yes ( ) No

If yes….

Caregiver Alert? ( ) Yes ( ) No

Caregiver Oriented to Time? ( ) Yes ( ) No

Caregiver Oriented to Person? ( ) Yes ( ) No

Caregiver Oriented to Place? ( ) Yes ( ) No

Caregiver has Motor Impairment? ( ) Yes ( ) No

If yes, please Specify:

Motor Impairment Severity: ( ) Mild ( ) Moderate ( ) Severe

Caregiver has Intellectual Disabilities? ( ) Yes ( ) No

If yes, please describe:

Caregiver Has Other Functional Impairment? ( ) Yes ( ) No

If yes, please describe:

Other Functional Impairment Severity: ( ) Mild ( ) Moderate ( ) Severe

Sensory Deficits

Needs Assistance with Phone: ( ) Yes ( ) No

Touch Deficits: ( ) Yes ( ) No

Visual Deficits: ( ) Yes ( ) No

Hearing Deficits: ( )Yes ( ) No

Speech Deficits: ( ) Yes ( ) No

ADL/IADL

ADL

Enter/Exit Home: ( ) Need Met ( ) Need Support ( ) Self Perform

Ambulate: ( ) Need Met ( ) Need Support ( ) Self Perform

Bathing: ( ) Need Met ( ) Need Support ( ) Self Perform

Bed Mobility: ( ) Need Met ( ) Need Support ( ) Self Perform

Dressing: ( ) Need Met ( ) Need Support ( ) Self Perform

Personal Hygiene: ( ) Need Met ( ) Need Support ( ) Self Perform

Toilet Use: ( ) Need Met ( ) Need Support ( ) Self Perform

Transfer: ( ) Need Met ( ) Need Support ( ) Self Perform

ADL

Home Maintenance: ( ) Need Met ( ) Need Support ( ) Self Perform

House Work: ( ) Need Met ( ) Need Support ( ) Self Perform

Laundry: ( ) Need Met ( ) Need Support ( ) Self Perform

Meal Preparation: ( ) Need Met ( ) Need Support ( ) Self Perform

Medical Management: ( ) Need Met ( ) Need Support ( ) Self Perform

Money Management: ( ) Need Met ( ) Need Support ( ) Self Perform

Phone Use: ( ) Need Met ( ) Need Support ( ) Self Perform

Shopping Errands: ( ) Need Met ( ) Need Support ( ) Self Perform

Transportation: ( ) Need Met ( ) Need Support ( ) Self Perform

Standing Specialist(s)/Therapist(s) Referrals

Standing Specialist(s)/Therapist(s)? ( ) Yes ( ) No

If yes…

Specialty: _____

Name: _____

Needs Referral: _____

Made Referral: _____

Last Visit Date: _____

Comments:

Specialty: _____

Name: _____

Needs Referral: _____

Made Referral: _____

Last Visit Date: _____

Comments:

Closing Questions

Are you currently under hospice care? ( ) Yes ( ) No

Are you currently receiving home health services? ( ) Yes ( ) No

Are you currently receiving other care coordination or case management services?
( ) Yes ( ) No If yes, please specify:

Would you like any information about end of life issues? ( ) Yes ( ) No

Cultural preferences identified? ( ) Yes ( ) No
If yes, please specify:

Identified barriers to care plan? ( ) Yes ( ) No
If yes, please specify:

Care plan reviewed with EI/guardian? ( ) Yes ( ) No

EI/guardian agreeable to plan of care? ( ) Yes ( ) No

Safety concerns/needs identified:

Management Status: ( ) Medium ( ) High

Location where information was gathered: _____

Date when form information was gathered: _____

Completing by:
Name:_____ Title: _____ Date: _____