CASE MANAGEMENT DISCHARGE PLANNING ASSESSMENT

1. MEDICAL TREATMENT FACILITY	2. DATE

3. PATIENT INFORMATION

3a. NAME	3b. FMP / SPONSOR SSN	3c. AGE	3d. DATE OF BIRTH

3e. BRANCH OF SERVICE	3f. STATUS
☐ USA ☐ USAF ☐ USN ☐ USMC ☐ USCG ☐ OTHER ________	☐ ACTIVE ☐ ACTIVE RESERVE ☐ DEPENDENT ☐ RETIRED

3g. RANK	3h. DUTY STATION

3i. HOME OF RECORD

3j. MARITAL STATUS	3k. NUMBER OF DEPENDENTS
☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED	

3l. ADSM DISPOSITION	3m. ORDERS	3n. POA
☐ CONLV ☐ LIMDU ☐ PEB ☐ MEB	☐ YES ☐ NO	☐ YES ☐ NO

4. CONTACT INFORMATION

4a. NAME	4b. RELATIONSHIP

4c. HOME TELEPHONE NO.	4d. WORK TELEPHONE NO.	4e. CELLULAR TELEPHONE NO.

5. PCM

5a. NAME	5b. TELEPHONE NO.

6. ATTENDING MD

6a. NAME	6b. TELEPHONE NO.

7. ADMITTING DX

7a. NAME	7b. TELEPHONE NO.

8. DISCHARGE PLAN *(Include POC and Telephone Number)*

☐ 8a. HOME	POC NAME	TELEPHONE NO.
☐ 8b. SNF	POC NAME	TELEPHONE NO.
☐ 8c. INPATIENT REHAB	POC NAME	TELEPHONE NO.
☐ 8d. HOSPICE	POC NAME	TELEPHONE NO.
☐ 8e. HOME HEALTH AGENCY	POC NAME	TELEPHONE NO.
☐ 8f. DME	POC NAME	TELEPHONE NO.
☐ 8g. SUPPLIES	POC NAME	TELEPHONE NO.
☐ 8h. MEDICATIONS	POC NAME	TELEPHONE NO.
☐ 8i. CD OF FILMS SENT / GIVEN TO	POC NAME	TELEPHONE NO.

9. LIVING SITUATION

- [ ] On Base
  - [ ] Barracks
  - [ ] Private Room / Bath
  - [ ] Shared Room / Bath
  - [ ] House / Apartment
  - [ ] Single Story
  - [ ] Multiple Story
- [ ] Off Base
  - [ ] House / Apartment
  - [ ] Single Story
  - [ ] Multiple Story
- [ ] Congregated Living (SNF, ECF, Retirement Home, Assisted Living, etc.)
- [ ] Other ______________

10. VOCATION

- [ ] Education
- [ ] Impact of health on work status
- [ ] Occupation
- [ ] Vocation Rehab

VA Contact ______________

11. SUPPORT SYSTEM

- [ ] None
- [ ] Spouse / Family
- [ ] Friends
- [ ] Church / Temple
- [ ] Other ______________

12. INSURANCE COVERAGE / FINANCIAL INFORMATION

- [ ] TRICARE Prime
- [ ] TRICARE Standard
- [ ] TRICARE for Life
- [ ] TSGLI
- [ ] SGLI
- [ ] Other Insurance ______________

Financial Assessment Needed ______________

13. REPEAT ADMISSION

- [ ] Not Applicable
- [ ] Same DX ______________
  - [ ] 7 Day
  - [ ] 14 Day
  - [ ] 21 Day
  - [ ] 28 Day
- [ ] Different DX ______________

14. VERBAL SKILLS

- [ ] Adequate
- [ ] Non-Verbal
- [ ] English
- [ ] Interpreter Needed

Primary Language ______________

15. TRANSPORTATION

- [ ] Drives Self
- [ ] Family / Friend
- [ ] Public Transportation
- [ ] Community Transportation
- [ ] Ambulance

MEDEVAC Date ______________ MEDEVAC Time ______________

16. CONSCIOUSNESS

- [ ] Alert
- [ ] Oriented
- [ ] Disoriented
- [ ] Disoriented at times
- [ ] Comatose
- [ ] Agitated
- [ ] Lethargic
- [ ] Previous LOC

17. PHYSICAL STATUS

- [ ] Independent Ambulation
- [ ] Bed Bound
- [ ] W / C
- [ ] Ambulate w/device type: ______________
- [ ] Continent
- [ ] Incontinent
  - [ ] Bladder
  - [ ] Bowel
- [ ] Catheter
- [ ] Ostomy

18. IMPAIRMENTS

- [ ] Hearing
- [ ] Sight
- [ ] Speech
- [ ] Cognitive
- [ ] TBI
- [ ] PTSD
- [ ] Hospital Bed
- [ ] W / C
- [ ] Prosthesis
- [ ] Feeding Tube
- [ ] Respiratory
- [ ] Other: ______________

19. BASELINE LEVEL OF FUNCTIONING *(Source of Information)*

PT ______________

Caregiver ______________

Medical Record ______________

20. NOTES

21. CASE MANAGER

21a. NAME (Printed)	21b. E-MAIL ADDRESS	21c. TELEPHONE NO.

21d. SIGNATURE	21e. DATE