

**General Assessment**

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| Member Name: | **UCare** Number: |
| Click here to enter text. | Click here to enter text. |
| **DOB:** | **UCare Product:** | Date Completed: |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Referral Source**: Click here to enter text. |

**Health History**

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| 1. **How many hospitalizations have you had in the last 12 months?**
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| **Number:** **Please describe (list date, dx and any other applicable information)**: Click here to enter text. |
| **1.1 Four Pillars. Complete this section if a member was identified due to a recent admission and subsequently has discharged home (or to usual care setting) within last 30 days. If no recent admission with discharge home, proceed to question #2.** |
| **Do you have a follow-up appointment scheduled? (CM Note – if due to a Mental Health hospitalization, follow-up appointment should be within 7 days.)****Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Can you verbalize the warning signs/symptoms to watch for & how to respond?****Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Do you have a Personal Health Care Record?****Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **CM: Was medication reconciliation completed? (Document current meds in medication section of assessment.)****Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **CM: Any homecare/DME or resource needs (etc.) from most recent admit?****Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| 1. **How many ER Visits have you had in last 12 months?**
 |
| **Number** **Please describe**: Click here to enter text. |
|  Do you have any of the following health conditions?  |
| **Neurological**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Cardiac**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Respiratory**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **GI**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Endocrine**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Orthopedic**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Renal**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Autoimmune**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Other:** [ ]  Yes [ ]  No If yes, what? Click here to enter text. |

**Mental Health and Substance Use**

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| 1. **Do you have any of the following health conditions?**
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| **Mental Health dx or concerns:**  [ ]  Yes [ ]  No  If yes, what? Click here to enter text. | **Substance Use/Abuse dx or concerns**:  [ ]  Yes [ ]  No or NA If yes, what? Click here to enter text. |

**Medications *(Prescribed and Over-the-counter)***

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| 1. **Please list all medications and supplements you are taking. Include name, dose and frequency taken.**
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| **How do you organize your medications?** *(i.e. med box, dispenser, etc.)* Click here to enter text.**Do you ever miss doses of your medications?** [ ]  Yes [ ]  No [ ]  Chose not to answer **If yes, please tell me what your challenges are:** Click here to enter text. |

**Preventative Care**

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| 1. **Have you had any of the following tests or exams within the last 12 months?**
 | **If No, would you like****CM to assist scheduling?** |
| **Annual Physical or wellness exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Dental Exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Vision Exam (note if member has diabetes, will need dilated eye exam)?**Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Mammogram (recommended ages 50-74)?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Prostate Exam or PSA (USPSTF) test (recommended ages 55-69)?**Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Colorectal screening (recommended ages 45-75) If no, would you be willing to do an in-home test?** Choose an item.**?** **Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Flu Shot?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Pneumonia Shot (recommended ages 65+)?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **For members with diabetes only.****Have you had any of the following tests within the last 12 months?** | **If No, would you like** **CM to assist scheduling?** |
| **A1C test?** Choose an item.**Kidney function test (urine albumin/creatinine ratio)?** Choose an item.**Dilated eye exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ] **Yes** [ ]  **No** [ ] **Yes** [ ]  **No** [ ]  |

**Activities of Daily Living and Home Safety**

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| 1. **Do you need assistance with any of the following (check all that apply). If yes, please describe needs.**
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| [ ]  **Ambulating/transferring** [ ]  **Grooming** [ ]  **Dressing** [ ]  **Bathing** [ ]  **Toileting** [ ]  **Incontinence issues** [ ]  **Meal Preparation** [ ]  **Eating** **Comments:** Click here to enter text. |
| **Have you had any falls in the last 12 months? [CM – ask about trip hazards in the home]**[ ]  Yes [ ]  No [ ]  Chose not to answer* **If yes, describe**: Click here to enter text.
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**Social Determinant of Health Needs**

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| 1. **Do you have any of the following needs? *(Check all that apply)***
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| [ ]  utility resources (heat/electricity/water) [ ]  food resources [ ]  transportation resources [ ]  prescription medication resources   [ ]  safety needs [ ]  other resource needs[ ]  denies resource needs**Additional Comments**: Click here to enter text.  |

**Advanced Directives**

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| 1. **Do you have any of the following in place? *(Check all that apply)***
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| [ ]  Advance Directives [ ]  Living Will [ ]  Durable Power of Attorney for Health Care [ ]  Durable Power of Attorney for Financial**If none of the above were listed, was a discussion about Advance Directives completed?**   [ ]  Yes [ ]  No* **If no, why not?** Click here to enter text.

**Additional Comments**: Click here to enter text.  |

**Member appropriate for CM?** [ ]  Yes [ ]  No Click here to enter text.

**Member consents to CM?** [ ]  Yes [ ]  No Click here to enter text.

**Case Manager Signature & Credentials:** Click here to enter text.

**Date:** Click here to enter a date.