

Enrollees with Special Health Care Needs (ESHCN)

Interdisciplinary Team Assessment



Name:		Date:
Member ID:		DOB:
Parents:	M:	F:
Other family members:		
Language:		
PCP:		
Medical Home:		
Medical / Clinical		
<input type="checkbox"/> History & Physical in chart, dated:		
Diagnoses:		
Nursing Issues:		
<input type="checkbox"/> Activity Intolerance <input type="checkbox"/> Impaired Adjustment <input type="checkbox"/> Caregiver Role Strain <input type="checkbox"/> Coping Ability <input type="checkbox"/> Spiritual Distress <input type="checkbox"/> Ineffective Health Maintenance	<input type="checkbox"/> Self-care Needs <input type="checkbox"/> Altered Nutrition <input type="checkbox"/> Risk for Injury <input type="checkbox"/> Educational Challenges <input type="checkbox"/> Impaired Physical Mobility <input type="checkbox"/> Grieving, anticipatory / dysfunctional	<input type="checkbox"/> Adhering to Treatment Plan <input type="checkbox"/> Acute/Chronic Pain <input type="checkbox"/> Environmental Concerns <input type="checkbox"/> Social Interaction Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Ineffective Management of Therapeutic Regime: Families/Individuals
Functional Issues:		
<u>ADL(S)</u> <input type="checkbox"/> Independent <input type="checkbox"/> Assistance w/ Bath <input type="checkbox"/> Assistance w/Cooking <input type="checkbox"/> Assistance w/Dressing <input type="checkbox"/> Assistance w/Eating	<u>Ambulation</u> <input type="checkbox"/> Independent <input type="checkbox"/> Uses Aids	<u>Mobility Aids</u> <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Gurney <input type="checkbox"/> Motorized Scooter <input type="checkbox"/> Service Animal <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair
Is the member participating in: <input type="checkbox"/> ST <input type="checkbox"/> OT <input type="checkbox"/> PT		
Comments: _____		
<u>Home Health Services</u>		
<input type="checkbox"/> RN <input type="checkbox"/> PT <input type="checkbox"/> HHA/BA <input type="checkbox"/> MSW <input type="checkbox"/> OT <input type="checkbox"/> ST		
Name of Home Health Agency:		
Social Work Issues:		
<u>Advocacy:</u>		<u>Education & Information Provision:</u>

- Family / Care Conference needed
- Advance Directives needed

- Educating Consumers Re: Disease (i.e.; participation in CHF or DM classes)
- Pt/Fam Education Re: _____

Bereavement:

- Grief/Loss Counseling & Support Groups
- New Terminal Diagnosis, or Diagnosis with less than 1 year expected life

Health Policy:

- Provide General, Non-Partisan Information on Health Policy Issues (i.e.; changes in Medicare regulations)

Case Management/Discharge Planning:

- Decreased ADL Function or Increased Falls
- Increased # of Clinic Visits
- Pre-surgery Discharge Planning
- Advanced Care Planning
- Resides Alone, Isolated, Few Supports – needs Alternative Living Situation

Health Promotion:

- Adherence Promotion (Motivational Interviewing & Counseling)

Community Development:

- Partner with CHC Administration in promoting Community Involvement

Liaison/Linking:

- Prescription Drug Assistance Program
- Assist Consumer to Connect w/Referral

Counseling:

- Coping with Illness
- Adjustment to New Diagnosis
- Parenting Issues
- Caregiver Burnout/Distress
- Support Group Provision
- Pt/Fam Education re: use of services and appointments

Psychosocial Assessment:

- Mini-Mental Status Exam
- Functionality/Environmental Assessment
- Complete Psychosocial Assessment
- Mental Health Assessment (Depression, Personality Disorder, Anxiety)

Referral:

- Referral to Specific Agency with Inter-Agency Coordination

Crisis Intervention:

- Domestic Violence
- Child or Vulnerable Adult Abuse
- Homelessness
- Lack of Food
- Immediate Placement Needs
- Other Acute Events: _____

Resource Provision:

- Provide a List/Array of Services
- Transportation
- Financial Concerns/lacks Medical Coverage

Critical Incident Stress Debriefing:

- Trauma Intervention (pt/fam/staff)

Service Development:

- Population Problem-Solving & Working with Community Agencies to Develop Services

Service Coordination:

- Care Coordination Across Multiple Settings

Dental Care:

Currently receiving dental care?
If not, is dental care needed?

- Yes No
Yes No

Dentist's Name	Address	Phone and Fax	Date of Last App't

Vision Care:

Currently receiving vision care? Yes No
 If not, is vision care needed? Yes No

Provider's Name	Address	Phone and Fax	Date of Last App't

Nutrition Care:

Is there a need for dietary supplements? Yes No
 Any dietary considerations? Yes No
 If yes, what are they? _____

Weight changes? Yes No
 Describe: _____

How is client's appetite?

Developmental (for children only)

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT completed, including: Health and developmental history, Nutritional assessments, Developmental assessment, Physical examination, Dental screening, Vision screening, Hearing screening, Laboratory tests, Immunizations, Health education, Diagnosis and Treatment

- At birth 2 - 4 days By 1 month 2 months 4 months 6 months 9 months 1 year 15 months 18 months Once every year, ages 2 – 20 (age: _____)
 Pre-adolescent Assessment (age 11-12)

Developmental Screening Results:

TEST	RESULTS
<input type="checkbox"/> PDQ-R	
<input type="checkbox"/> ASQ	
<input type="checkbox"/> Denver II	
<input type="checkbox"/> ELM	
<input type="checkbox"/> CAT/CLAM	
<input type="checkbox"/> PARS (adol)	
<input type="checkbox"/> Other	

Immunizations:

- HepB DTaP Hib IPV MMR Varicella PCV Influenza HepA

Plan for Transition to Adult Services (if appropriate):

Mental Health

Mental Status: Alert & oriented X 3 Other: _____

Does client have a psychiatric history/diagnosis? Yes No

Diagnosis: _____

Has client ever been hospitalized for a psychiatric condition? Yes No

Date	Where	Reason	Duration

Is client currently on medication for a psychiatric condition? Yes No

Prescribed Medication	Purpose	Dates on Medication

Is client being monitored for medication adherence? Yes No

Does client report adherence to the medication regimen? Yes No

Barriers to adherence: _____

Is client currently getting mental health treatment? Yes No

If yes, please identify:

Clinician	Program	Address	Phone and Fax

Substance / Alcohol Use

CAGE:

Have you ever thought you ought to **CUT DOWN** your drinking/using? Yes No

Has anyone ever **ANNOYED** you by criticizing your drinking/using? Yes No

Have you ever felt **GUILTY** about your drinking/using? Yes No

Have you ever had to have an **EYE-OPENER** - a drink/drug first thing in the morning? Yes No

Is there a history of patient drug use/alcohol abuse? Yes No

Is there a history of family drug use/alcohol abuse? Yes No

Has client ever sought treatment for alcohol/drug use? Yes No

If yes, location and type of treatment:

Housing / Living Situation

Current Living Situation

- Living with both parents Living with one parent: _____
 Living with other relatives: _____

Current Housing Situation

- Parents Own Home Rent an Apartment Single Room Occupancy
 Scattered Site Housing Group Home Shelter
 With Family/Friends Other: _____

Are utilities working? Yes No

Major appliance working? Yes No

Is there an accessible telephone? Yes No

Are there safety concerns? Yes No

Identify any/all concerns: _____

Home Assistance Programs Currently Receiving

- CHORE Housekeeper (cooking/cleaning) COPES
 Meals on Wheels Family Member Private Care Provider

Child Care Programs being used: _____

Support System

Indicate those not listed above as living with client who client identifies as supports:

Name	Relationship	Phone

Is religion/spirituality considered a support for client? Yes No

Religious Affiliation: _____

What are client's interests and hobbies? _____

Transportation

- Has own transportation Has access to funds for transportation
 Needs vouchers/tokens Needs specially arranged transportation
 Other: _____

Are there any other transportation issues?

Legal Needs

Advance Care Directives: Yes No
 DPOA for Healthcare: Yes No
 Guardian: Yes No
 Comments: _____

Self-efficacy

Has family explored health care financing for young adults? Yes No
 Checked eligibility for SSI the month the teen turns 18? Yes No
 Guardianship procedures needed before the teen turns 18? Yes No
 If developmental disabilities, notify DDD for adult services at age 21? Yes No
 Vocational Rehabilitation notified for teens in last school year? Yes No

Employment / Income needs

Income

Social Security (Retirement)
 S.S.I.
 S.S.D.I.
 TANF
 Disability (Employment)
 Pension
 Food Stamps

Employment Status

Leave of Absences
 Retired
 Disabled
 Working (Full Time)
 Working (Part Time)
 Student (Full Time)
 Student (Part Time)

Other employment/income needs: _____

School (for children only)

Which school does client attend? _____
 Individualized Education Plan in place at school and Medical providers provided input? Yes No
 Transition plan (school) in place for teens on IEPs? Yes No
 Other comments: _____

Signatures

Patient (reqd if age 14 or over, if able)	Parent (one reqd if under age 14)	Parent (one reqd if under age 14)
PCP – MD/PA/ARNP	RN/LPN	MSW/BSW/Soc Svc
Specialist	Specialist	Other Medical
School Representative	CSHCN RN/FRC	DDD/Other Govt Agency Representative
Other	Other	Other