

## Health Needs Assessment Form

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male or Female

Patient SS# \_\_\_\_\_ LHA Member ID # \_\_\_\_\_

Advance Directives: Yes  No

Family members assisting with care:

Name \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Immunizations: Pneumonia Yes  No  Date: \_\_\_\_\_ Influenza Yes  No  Date: \_\_\_\_\_

Risk Factors:

Smoking: Yes  No  Addressed by PCP  Diet: Yes  No  Addressed by PCP

Alcohol: Yes  No  Addressed by PCP  Other: Yes  No  Addressed by PCP

Date of Most Recent PCP Visit: \_\_\_\_\_ Date of Next Scheduled Appointment: \_\_\_\_\_

Height \_\_\_\_\_ Date: \_\_\_\_\_ Weight: \_\_\_\_\_ Date: \_\_\_\_\_

Vitals B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Date: \_\_\_\_\_

Acute Conditions/Diagnoses \_\_\_\_\_ Date of Occurrence \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Chronic Conditions/Diagnoses/Disabilities \_\_\_\_\_ Date of Onset \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Significant Medical History/Recent Hospital Admissions**

**Date of Occurrence**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Current Prescription Medication	Dose	Frequency	Brand or Generic
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- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Current Specialty Care Referrals:**

Specialist Name	Phone#	Specialty Type	Reason for Referral
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- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Current Ancillary Services (HHC, DME, medical supplies, PT, Hearing Aide)**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

<u>Special Needs</u>	<u>Functional Level of ADLs</u>	Self	Partial Assist	Full Assist
	▪ Bathing/Showering -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Bowel and bladder management -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Dressing-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Eating-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Feeding-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Functional mobility-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Personal care items ----- (hearing aids, glasses, prosthetics, adaptive equipment, etc. )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Personal hygiene and grooming -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Sleep/Rest-----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Toilet Hygiene -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	▪ Sexual activity: (circle one) Yes or No			

**Recommend for Case Management ?** (circle one) Yes or No

If yes, why?

PCP Name: \_\_\_\_\_

PCP Signature: \_\_\_\_\_ Date: \_\_\_\_\_