CHRISTIANA CARE HEALTH SERVICES

Date: _____

Instruction:
To be completed by Care Coordinator or Care Coordinator Assistant.

ONCOLOGY DISCHARGE PLANNING ASSESSMENT TOOL

DISCHARGE PLANNING INITIAL ASSESSMENT: Admitting Diagnosis: _____

LIVING ARRANGEMENTS:

☐ **House:** ☐ 1 Story ☐ 2 Story ☐ Split Level/Bi-Level # of Steps to Enter: ___ ☐ Homeless ☐ Mobile Home

☐ **Apartment:** Floor#: _____ # of Steps to Enter: _____ Elevator: ☐ Yes ☐ No

☐ **Other Care Facility:** Name of facility: _____

Bathrooms – First Floor: ☐ Full ☐ Partial **Second Floor:** ☐ Full ☐ Partial

CAREGIVER AFTER DISCHARGE: ☐Yes ☐ No

Name: _____ Relationship: _____ Phone(H): _____ (W):_____

Name: _____ Relationship: _____ Phone(H): _____ (W):_____

Mental status: ☐ Oriented ☐ Confused ☐ Unable to answer questions

Prior functional status: _____

Vascular access devise: ☐ Yes ☐ No Type: _____ Agency: _____

Independent with activities of daily living: ☐ Yes ☐ No If no, describe: _____

independent with mobility: ☐ Yes ☐ No If no, describe: _____

☐ with necessary devices: _____

FINANCIAL CONCERNS: ☐ No ☐ Yes If yes, describe: _____

TRANSPORTATION ISSUES: ☐ No ☐ Yes If yes, describe: _____

PRESCRIPTION PLAN: ☐ Yes ☐ No Referred to: _____

PREVIOUS HOME HEALTH CARE/HOME MEDICAL EQUIPMENT: ☐ No ☐ Yes

If yes, describe service , equipment & vendors: _____

PATIENT/FAMILY CONCERNS: ☐ No ☐ Yes If yes, describe: _____

ASSESSMENT – ANTICIPATED DISCHARGE PLAN: ☐ No post acute care needs identified at this time

☐ Home Health Care Services: ☐ Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Respiratory Therapy ☐ Intravenous Antibiotic ☐ Total Parental Nutrition (TPN) ☐ Other: _____

Choice Menu Receipt Signed: ☐ Yes Agency: _____

□ **DURABLE MEDICAL EQUIPMENT:**

☐ Home O_2 ☐ Infusion Therapy/antibiotics ☐ Nebulizer treatments ☐ Walker ☐ Ventilator

☐ Wheelchair ☐ Continuous Positive Airway Pressure (CPAP)/BiPaP ☐ Cane ☐ Commode ☐ Hospital Bed

☐ Tube Feed Supplies: _____

☐ Other: _____

Plan communicated to Patient/ Family Initial: _____ Date: _____

REVISED ANTICIPATED DISCHARGE PLAN:

PLACEMENT:

Type of Facility: □ Nursing Home □ Assisted Living □ Hospice □ Other: _____

Comments: _____

Plan communicated to Patient/Family:

Signature: _____ Print Name: _____ Date: _____