MiCMRC Pediatric Comprehensive Assessment V3

Patient Name:

DOB:

MRN:

Mother Name:

Mother Phone:

Father Name:

Father Phone:

Guardian Name, if applicable:

Guardian phone:

Alternative phone of Parent/Guardian:

Patient resides with:

Siblings, if any:

Date of visit:

Primary Care Physician (PCP) contact information:

Care Manager Name and Licensure:

Physician Specialists:

Other providers involved in care and phone:

Type of visit: ◯ Phone ◯ Face-to-face

Visit duration in minutes: ◯ 5-10 ◯ 11-20 ◯ 21-30 ◯ 31-60 ◯ >60

Source/Contact: ☐ Patient ☐ Mother ☐ Father ☐ Guardian ☐ Other:

Comments:

Consent for care management: ◯ Yes ◯ Verbal consent ◯ Declined

Authorized representative statement required:
- ☐ Yes
- ☐ No

Height: _____ Weight: _____

Head circumference: _____ BMI: _____ Other: _____

Active Diagnoses:

Accidents/Date:

Surgeries/Surgeon:

Hospitalization/ED Summary:
- ☐ Multiple hospitalizations in the past year
- ☐ Multiple ED admissions in the past year

Other/Comments:

Patient/Caregiver/ Guardian self-reported problems and concerns:

Allergies:

Additional Care Team(s)

Currently using Home Health Agency (HHA):
- ◯ Yes
- ◯ Not used at this time

HHA Agency Name, Contact, Phone Number:

Frequency:

If Previous HHA Used: Agency Name, Contact, Phone Number:

Home Health Agencies:

- ☐ Not indicated at this time
- ☐ Nursing
- ☐ Social Worker
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Home schooling/tutoring
- ☐ Other:

Indicate if any of the above therapies were used in the past:

Currently using DME agency:

- ◯ Yes
- ◯ Not used at this time

DME Equipment used , Agency Name, Contact, Phone Number:

Other Outpatient Therapies:

- ☐ Not indicated at this time
- ☐ Behavioral health
- ☐ Radiation therapy
- ☐ Cardiac evaluation
- ☐ Pulmonary Assessment
- ☐ Anticoagulation
- ☐ Diabetes management/education
- ☐ Infusion services
- ☐ Dialysis
- ☐ Transfusion services
- ☐ Central line/port placement
- ☐ Rehabilitation
- ☐ Other:

Outpatient Therapy Agency Name, Contact, Phone number:

Comments:

Medication Reconciliation

Pharmacy Name, Location, Phone:

Barriers to Adherence:

- ☐ No identified barriers
- ☐ Financial issues
- ☐ Unable to obtain medications
- ☐ No refills
- ☐ Complexity of medications
- ☐ Does not understand purpose of medication
- ☐ Side effects
- ☐ Unable to swallow pills
- ☐ Ineffective per patient
- ☐ Too many medications
- ☐ Unable to open bottles
- ☐ Other:

Side Effects:

- ☐ No reported side effects
- ☐ Side effects reported, specified below
- ☐ Potential Interactions

Comments:

Adherence Aids:

- ☐ Pill box
- ☐ Calendar/schedule supplied by nurse
- ☐ Other:

If pill box used, it is filled by:

Medications Reconciled:

- ☐ Yes
- ☐ No
- ☐ Medication changes, specified below

Comments:

Reviewed with whom:

Medication Reconciliation Comments:

Immunizations

Immunizations reviewed according to MCIR: ☐ Yes ☐ No

Comments:

Subjective

Patient/Caregiver Concerns:

Income:	☐ Patient	☐ Caregiver
Food	☐ Patient	☐ Caregiver
Medication	☐ Patient	☐ Caregiver
Utilities	☐ Patient	☐ Caregiver
Housing	☐ Patient	☐ Caregiver
Legal	☐ Patient	☐ Caregiver
Immigration	☐ Patient	☐ Caregiver
Other, please specify below:	☐ Patient	☐ Caregiver

Other may include: Healthcare, Childcare, Education, or Clothing & Household supplies:

Mobility Status, Activities of Daily Living and Physical Rehabilitation

Patient/Other reports:

Age appropriate activities:	◯ Yes	◯ No
Deficits for age present:	◯ Yes	◯ No
Toilet trained:	◯ Yes	◯ No
Enuresis:	◯ Yes	◯ No

Comments:

Level of assistance with Activities of Daily Living:

- ☐ Independent
- ☐ Requires total care
- ☐ Fully continent

Assistance required with: ☐ Bathing ☐ Toileting ☐ Dressing
☐ Medications ☐ Feeding
☐ Other:

General hygiene: ◯ No problem ◯ Poor

Regular exercise: ◯ Yes ◯ No

Physical limitations: ◯ Yes ◯ No

Describe Functional Status:

Comments:

Activities:
☐ Participates in sports
☐ Hobbies
☐ Plays video games
☐ Interests
☐ Watches TV
☐ Other:

Describe type of activities and hours spent per day:

Cognitive and Schooling
Name of school, type of schooling, teacher, contact information:

Known or diagnosed cognitive deficits and reported by whom:

REVIEW OF SYSTEMS

Patient/Other reports:

Vision: ☐ No problem ☐ 20/20 corrected ☐ Uses readers

Cataracts: ☐ R ☐ L

Blind ☐ R ☐ L

Other:

Comments:

Hearing: ☐ No problem ☐ Hard of hearing ☐ Reads lips ☐ Uses sign language

Wears hearing aids ☐ R ☐ L

Deaf ☐ R ☐ L

Other:

Comments:

Oral/Dental: ☐ Good dentition ☐ Gingivitis ☐ Canker sores ☐ Tongue lesions ☐ Difficulty swallowing ☐ Dentures/Partials ☐ Mucositis ☐ Orthodontic appliance

Missing teeth: ☐ Upper R ☐ Upper L ☐ Lower R ☐ Lower L

Date of last dental check up:

Other:

Comments:

Cardiovascular: ☐ No problem ☐ Edema ☐ Fatigue ☐ Pallor ☐ Hx DVT ☐ Chest pain / angina

Characterize chest pain / angina:

Other:

Comments:

Pulmonary: ☐ No problem ☐ Wheezing ☐ Cough ☐ Short of breath ☐ Hx thoracentesis ☐ Hx pleurodesis ☐ Exercise induced asthma

Pleural effusion/dullness: ☐ R ☐ L

O2 in use: ☐ Yes ☐ No

If O2 in use, liters per minute:

Other:

Comments:

Sleep Hygiene:
- ☐ No problem
- ☐ Sleep apnea
- ☐ Uses CPAP
- ☐ Excessive snoring

Other:

Comments:

Chills: ◯ Yes ◯ No

Sweats: ◯ Yes ◯ No

Fever: ◯ Yes ◯ No

Thermometer to take temperature at home: ◯ Yes ◯ No

Comments:

Neurological:
- ☐ No problem
- ☐ Numbness / tingling
- ☐ Foot drop

Other:

Comments:

Musculoskeletal:
- ☐ No problem
- ☐ Arthralgia
- ☐ Myalgia
- ☐ Weakness
- ☐ Abnormal coordination

Other:

Comments:

GI:
- ☐ No problem
- ☐ Stomatitis
- ☐ Colostomy
- ☐ Ileostomy
- ☐ Dumping syndrome
- ☐ Hx Paracentesis
- ☐ Irritable bowel
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ GERD
- ☐ Hx ulcers
- ☐ Hiatal hernia
- ☐ Whipple procedure
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea

If diarrhea or vomiting, number of episodes in 24 hours:

Other:

Comments:

GU:

- ☐ No problem
- ☐ Chronic UTI
- ☐ Frequency
- ☐ Burning
- ☐ Incontinence
- ☐ Hx urethral stent
- ☐ Ureterostomy
- ☐ Other:

Comments:

Gynecological:

- ☐ No problem
- ☐ Cystitis
- ☐ Hx STD
- ☐ Pregnant
- ☐ Other:

If pregnant, gestational age:

Last pelvic exam/pap smear date:

Comments:

Skin:

- ☐ No problem
- ☐ Stump
- ☐ Stoma
- ☐ Dermatitis
- ☐ Bruising
- ☐ Jaundice
- ☐ Wounds
- ☐ Alopecia

Location/description if any wounds:

If alopecia, type:

- ☐ Pre-existing
- ☐ Chemo/Radiation

Other:

Comments:

Any additional Review of Systems Comments:

PAIN

- ☐ Denies pain
- ☐ Chronic
- ☐ Acute

Frequency:

Intensity/Pain Scale (1-10)

Character:

Duration:

Treatment of pain: ☐ Pharmaceutical ☐ Non-Pharmaceutical

Comments:

NUTRITIONAL STATUS

☐ Stable weight
☐ Recent weight loss greater than 5% in one month
☐ Decreased appetite/intake decline last 3 months
☐ Picky eater
☐ Average daily liquid intake is adequate
☐ Concerns about daily liquid intake

Nutrition-related preferences: ☐ Supplements ☐ Vegan ☐ Vegetarian ☐ Kosher ☐ Other:

Recommended diet:

Tube feedings: ☐ No problem ☐ Problems ☐ NA

Number of feedings/meals per day:

Comments:

COMMUNICATION STATUS

Physical or cognitive barriers affect patient's ability to communicate: ○ Yes ○ No

Comments:

Preferred language for health care:

Preferred language for printed materials:

Interpreter needed: ☐ Yes ☐ No

Other identified barriers to communication:

Health literacy assessment of patient/ caregiver:

Comments:

SOCIAL SUPPORT AND SPIRITUALITY

What is the patient's/ caregiver's mode of transportation? (Check all that apply.)

- ☐ Walk
- ☐ Public bus
- ☐ Friends
- ☐ ADA transport
- ☐ Drives self
- ☐ Family
- ☐ Taxi (self-pay)
- ☐ Insurance funded transport
- ☐ Other:

Does the patient/caregiver have reliable transportation to/from the doctor's office?

- ◯ Yes
- ◯ No

What is the patient's spiritual or religious affiliation?

What is the level of involvement of family and friends on a regular basis with the patient/caregiver, including phone calls, emails, etc.?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less frequently than monthly

How does the patient cope with life events and daily stress? (Check all that apply.)

- ☐ Keeps it to him/herself
- ☐ Talks to friends
- ☐ Talks to a professional
- ☐ Internet resources
- ☐ Talks to family
- ☐ Prays
- ☐ Support group
- ☐ Plays with friends
- ☐ Other:

Is the patient involved in community activities, groups, social events, or volunteering?

- ◯ Yes
- ◯ No

If yes, describe:

What has the patient previously done for enjoyment or recreation?

Is (s)he able to engage in these activities now?

- ◯ Yes
- ◯ No

Does the patient/caregiver report having adequate support? ◯ Yes ◯ No

If no, what support is desired?

Are there any specific cultural or spiritual practices/ restrictions the health care team should know about when providing care? ◯ Yes ◯ No

If yes, describe:

SEXUALITY

Is the patient sexually active? ◯ Yes ◯ No

Is the patient using birth control? ◯ Yes ◯ No

If yes, indicate method used:

ABUSE/DOMESTIC VIOLENCE

Referred to care team social worker: ◯ Yes ◯ No

Concerns about child abuse: ◯ Yes ◯ No

Comments:

MENTAL HEALTH STATUS

Has the patient participated in counseling? ☐ Yes, in the past ☐ Currently in counseling ☐ No

If yes, or currently in counseling how does patient describe their experience?

Does the patient report any history of substance use to help them calm down, feel better, reduce stress, or just have fun?

◯ Yes ◯ No

If yes, complete:

☐ Alcohol ☐ Cocaine ☐ Crystal meth
☐ Marijuana
☐ Other: _____

Has the patient ever received drug or alcohol treatment?

◯ Yes ◯ No

If yes, describe:

_____

How often does the patient have a drink containing alcohol?

☐ Never
☐ Monthly or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

Has a relative, friend, doctor, or another health worker been concerned about the patient's drinking and suggested that they cut down?

☐ No, never drinks
☐ Yes, but not in the last year
☐ Yes, within the last year

Smoking Status

☐ Non-smoker
☐ Second-hand exposure
☐ Interested in smoking cessation
☐ Smoker
☐ e-cigarettes
☐ chewing tobacco

If patient smokes, how many packs per day for how many years?

_____

Depression Screening
Over the last 2 weeks, how often has the patient been bothered by any of the following problems?

	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

Patient Total Score: _____

Are there signs / symptoms present for caregiver distress/ anxiety problems?

- ☐ Yes
- ☐ No
- ☐ Referred to care team social worker
- ☐ Reviewed with social worker
- ☐ Other: _____

Comments:

Recent family stress: ◯ Yes ◯ No

Comments:

ADVANCE CARE PLANNING

Does the patient have any of the following?

Advance Directive (living will, durable power of attorney for health care, health care proxy ◯ Yes ◯ No

Do not resuscitate order ◯ Yes ◯ No

Do not resuscitate order in community ◯ Yes ◯ No

Court appointed guardian ◯ Yes ◯ No

Durable power of attorney for financial ◯ Yes ◯ No

If the patient DOES NOT have an advance directive, does the patient or a support person want information? ☐ No, not interested ☐ No, already has information ☐ Yes

Comments:

If yes to the above, are the documents in the patient's medical record? ◯ Yes ◯ No

If yes, describe:

PLAN OF CARE

Palliative Care: ◯ Yes ◯ No

Comments:

CARE MANAGEMENT ASSESSMENT

Barriers Identified:

Interventions to Address Barriers:

SELF-MANAGEMENT ACTION PLAN

Asthma ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Cardiac Conditions ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Obesity ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Diabetes ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

ADD/ADHD ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Autism ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Cancer ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Medication Therapy ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Developmental Disabilities ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Depression ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Genetic-Related Conditions ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Pain Control ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Other, please specify:

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Preventive Care

Date of most recent health screening:

- ☐ Weight Assessment and Nutrition/Physical Activity Counseling
- ☐ Childhood Immunization Status
- ☐ Lead Screening

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Coordination of Services:

Referred to: ☐ DME ☐ HHA ☐ PCP ☐ ED

Advance Care Planning:

Summary:

Re-evaluation of Plan of Care and Progress Toward Goals Achievement:

Follow-up planned and time frame:

Name of individuals in attendance/relationship:

Level of understanding:

Readiness for change:

Care Manager Signature and Date:	
Physician Signature and Date:	
If this box is checked, please see Care Manager addendum to Comprehensive Assessment.	☐