MiCMRC Pediatric Transitions of Care Note V7

Name:

DOB:

MRN:

Patient phone:

Alternate contact Name/Phone/ Relationship:

Name of person spoke with if other than patient and relationship to patient:

Primary Care Physician (PCP) contact information:

Care Manager Name and Licensure:

Type of visit: ◯ Phone ◯ Face-to-face

Duration of visit in minutes: ◯ 5-10 ◯ 11-20 ◯ 21-30 ◯ 31-60 ◯ >60

Date of Admission:

Date of Discharge:

Today's Date:

Discharged from:
◯ Hospital ◯ SNF
◯ LTAC ◯ Inpatient Rehab
◯ Community Mental Health ◯ Other:

Discharge Diagnosis:

Summary of Admission:

Patient/Caregiver self-reported problems/ concerns:

ASSESSMENT

Patient Medical Status:

Active Diagnoses:

Surgical History:

Does the patient have the support of a caregiver: ◯ Yes ◯ No

If yes, name of caregiver:

Describe level of support the caregiver provides:

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

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

Confidence of patient and/or caregiver to carry out care at home:

Comments:

Marital status:

- ◯ Married
- ◯ Single
- ◯ Divorced
- ◯ Separated
- ◯ Significant Other

Does patient live alone? ◯ Yes ◯ No

If no, who does patient live with:

Does patient/caregiver have concerns about access to food? ◯ Yes ◯ No

If yes, describe:

Are there stairs in the home? ◯ Yes ◯ No

Is the home dwelling safe? ◯ Yes ◯ No

If not safe, indicate concerns: ☐ Heat ☐ Water ☐ Electrical ☐ Other:

Comments:

Psychosocial Issues:

Functional Status:

Cognitive and Mental Health Status:

Social/Community Support:

Fall Risk Assessment:

MEDICATIONS

Medication Reconciliation conducted with patient or caregiver: ◯ Yes ◯ No

New medications prescribed upon discharge: ◯ Yes ◯ No

Comments:

Medication changed or discontinued upon discharge: ◯ Yes ◯ No

Comments:

Describe how patient takes medication:

- ☐ As prescribed
- ☐ Taking medication not indicated on discharge summary or medical record
- ☐ Discrepancy not explained by the current care plan
- ☐ Discrepancy not explained by the patient's clinical status
- ☐ Discrepancy not explained by formulary substitution

Comments:

Barriers identified related to medications:

- ☐ No identified barriers
- ☐ Financial
- ☐ Unable to obtain medications
- ☐ No refills
- ☐ Complexity of medications
- ☐ Does not understand purpose of medication
- ☐ Side effects (if any, describe below)
- ☐ Ineffective per patient/parent/guardian
- ☐ Too many medications
- ☐ Unable to open bottles
- ☐ Patient/parent/guardian forgets
- ☐ Refuses to take
- ☐ Other

Comments related to barriers:

Adherence Aids:

- ☐ Pill box
- ☐ Positive Behavior Reinforcement Plan
- ☐ Other

If adherence aid used, who manages:

Advised to bring medications to follow up appointment: ◯ Yes ◯ No

HOME CARE SERVICES

DME Ordered: ◯ Yes ◯ No

If ordered, describe:

Needed equipment in home is present: ◯ Yes ◯ No ◯ NA

Comments:

Home Health ordered at discharge: ◯ Yes ◯ No

If Yes:
- ☐ Home Health Nurse
- ☐ Social Work
- ☐ OT
- ☐ PT
- ☐ Respiratory Therapy
- ☐ Pharmacist
- ☐ Other

Did Home Care Services contact patient: ◯ Yes ◯ No

If No, was Home Care Services contacted? Describe follow up:

PATIENT/PARENT/CAREGIVER EDUCATION

Recalls how and when to recognize worsening symptoms: ◯ Yes ◯ No

Reviewed action steps if symptoms worsen or other change in status:
- ☐ Practice phone number provided
- ☐ Practice daytime and after hours number provided
- ☐ Ask to speak with Care Manager
- ☐ Patient/parent/caregiver knows when and whom to call for help

Comments:

Patient's level of understanding:

Readiness for change:

Patient agrees with plan: ◯ Yes ◯ No

TRANSITION OF CARE SELF-MANAGEMENT PRIORITIZED GOALS

Short term goal and Target date:

Long term goal and Target date:

IDENTIFIED NEEDS MANAGED DURING TRANSITION CALL

Describe identified needs:

- ☐ No needs identified
- ☐ Acute care visit facilitated
- ☐ Urgent care evaluation facilitated
- ☐ Re-education on disease process/condition
- ☐ Re-education on plan of care
- ☐ Home care services ordered, but patient has not been contacted
- ☐ Transportation
- ☐ Unable to contact patient, called 3 times
- ☐ Other:

Comments:

Identified needs require physician follow up: ◯ Yes ◯ No

Follow up planned, specify with whom, and time frame:

Care Manager Signature and Date: