MiCMRC 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
	Widowed	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 Ineffective per patient Too many medications Unable to open bottles Other:		
Comments related to barriers:			
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 EDUCATION

Recalls how and when to recognize worsening symptoms:	Yes No
Reviewed with patient 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 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:	