Form 8

CLOSING SUMMARY <health>

(chart numbers)

Print or type
Mark all applicable responses

(worker)

Client Name

Birth Date

Sex
( ) M
( ) F

_____ _____ _____
(month) (day) (Year)

Date Admitted _____ _____ ____

Date S. S. Opening _____ _____ ____

Date S. S. Closing _____ _____ ____

Primary Diagnosis (medical)

Secondary Diagnoses (medical)

_____

_____

_____

Physician

Service Area(s)

_____

_____

_____

_____

_____

_____

Health Status at Discharge
( ) No impairment
( ) Temporary impairment
( ) Permanent impairment – good prognosis
( ) Permanent Impairment – poor prognosis
( ) Deceased

Continue
( ) None
( ) Medication / Prosthesis
( ) Home health
( ) Other home supports
( ) ECF / nursing home
( ) Hospice
( ) Rehabilitation
( ) Other _____
(specify)

Referred by _____

Number of interviews / consultations
( ) 1 ( ) 2-5 ( ) 6-9 ( ) 10+

Primary Problem / Need
(Social Service)

Status at Closing
( ) Resolved/ improved ( ) No Change ( ) Deteriorated (N/A)*

Secondary Problems / Needs
(Social Service)

_____ ( ) + ( ) 0 ( ) - ( ) N / A
_____ ( ) + ( ) 0 ( ) - ( ) N / A
_____ ( ) + ( ) 0 ( ) - ( ) N / A

+ Not addressed

Services

( ) Information / referral
( ) Transportation
( ) Continuity of care
( ) Assessment
( ) Advocacy
( ) Individual counseling
( ) Group work
( ) Couple, family counseling
( ) Education
( ) Other _____
(specify)