The Knolls
Adult Day Medical Program
SOCIAL WORK ASSESSMENT

DATE:_____ **For: *Initial Assessment:___ Readmission Assessment:___***

Name:_____Date of Birth: _____Age: _____

Applicant Accompanied by: _____

Referral Source: _____

Reason for Application: _____

Birth Place:_____ Education:_____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single

Religion:_____Do you need assistance with religious linkage?

Advanced Directives: Education provided [ ] Advance Directives reviewed [ ]
DNR [ ] HCP [ ] POA [ ] LW [ ] Other:_____
Participant lacks mental capacity to complete Advanced Directives [ ]
Participant has no family supports [ ]

Primary Occupation: _____

Retirement Precipitant: ☐ Yes ☐ No

COGNITIVE/PSYCHIATRIC FUNCTION

Orientation X's: _____ Confused: ☐ Yes ☐ No

Thought Process: ☐ Clear ☐ Unclear

Thought Disorder: ☐ Yes ☐ No ☐ Slight

Memory Retention: Short Term: E G F P
Long Term: E G F P

Appearance: _____

Presenting Affect: _____

Is Applicant Engageable? _____

History of Social Skills: _____

Medical Diagnosis w/ Related Cognitive Impairment: _____
_____

History of Past Psychiatric Dysfunction: _____
_____

Psychiatric Diagnosis: _____

Anxiety: _____

Depression: _____

Family Supports/ Contacts:

1. Name:_____ Relationship:_____
   Phone No. H: _____ C: _____

2. Name:_____ Relationship:_____
   Phone No. H: _____ C: _____

CAREGIVERS:

Support Received from family member or friend: ☐ Yes ☐ No

Name of Caregiver(s): _____

Caregiver(s) needs: _____

Residential/ Group Home Staff: ☐ Yes ☐ No Name of Residence:_____

Home Attendant Agency: ☐ Yes ☐ No Hours of Home Attendant: _____

Name of Agency:_____ Agency Telephone No.: _____

APPLICANT'S SUMMARY:

Applicant's Strengths: _____
_____

Applicant's Disabilities: _____
_____

Will this participant have difficulty tolerating the choice of transportation if they utilize the Program's contracted service? ☐ Yes ☐ No
If yes, why? _____

Disposition after initial assessment: Appropriate for MESADC? ☐ Yes ☐ No

If not appropriate, alternative plan: _____
_____

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PROBLEMS, NEEDS, CONCERNS

Problems	*Goals*	*Social Work Intervention*

SW Signature: _____

Date: _____

P:AssmPkt.SWAssmt