Cover Page

Patient Name: _____

Date of Birth: ___ /___ /_____

Gender: ○ Male ○ Female

Admission ID#: CHR - _____

Phone#: _____

Visit Date: ___ /___ /_____

Visit Type: _____

RN Name: _____

RN CODE #: CHR - _____

EISEP/OFA/DSS Determination of Service

1. Determining appropriateness of in-home service under EISEP/OFA/DSS:

a.

	Present (refer)	Not Present
Changes to physical ability/mobility status requiring caregiver assistance to ambulate from the last 3 months	○	○
Need for rehabilitation/receiving rehabilitation services of PT/OT/SP	○	○
Need help with catheter care or ostomy care?	○	○
Any new wound care/decubiti	○	○
Worsening chronic condition and the patient is no longer able to manage by themselves (e.g., Alzheimer's disease or other Dementia)	○	○
Need for medical equipment monitoring	○	○
Need assistance with monitoring vital signs	○	○
Need or presence of administration of medication (including IVs and injections)	○	○

b. How many ER visits/hospitalizations? in the last 3 months (Increased falls, injuries; >2 per quarter-refer):

c. How many falls occurred in the last 3 months (Increased falls, injuries; >2 per quarter-refer)?

d. Patient/family comments _____

e. Additional information _____

_____

f. Nurse signature X_____

g. Patient Signature:

X_____ **OR** ☐ Patient is unable to sign. Authorized agent signing on the patient's behalf:

Reason that patient is unable to sign:

_____

Authorized agent signature:

X_____

Print name:

_____

Relationship to patient:

_____