Care Transition Care Plan

A Special Needs Member has been admitted to an inpatient facility for treatment. Please complete the following information to assist in the Care Transition Process. The completed form should be faxed to the Case/Utilization Management Department at the facility and then ***placed on the patient's medical chart/electronic medical record.***

Member Information:

Member Name: **Date of Birth:** **ID#:**

Medical Information:

Current medical/social issues (i.e. current medical problem, living arrangements, caregiver issues, financial concerns, etc): _____

_____

Significant past medical/behavioral health history: _____

Medications (including OTC/herbals):_____

_____

Allergies (include prescription/foods/etc): ☐ NKA ☐ Yes _____

Special Dietary Needs: ☐ No ☐ Yes _____

Durable Medical Equipment: ☐ Oxygen ☐ Other: _____

Advance Directive: ☐ Yes ☐ No ☐ Unknown **Cognitive Status:** ☐ Normal ☐ Impaired

Functional Status: ☐ Independent ☐ Needs Assist **Assistive Devices:** _____

Pain Screening / Pain Management Plan (within past year): ☐ No ☐ Yes _____

Preferences:

Language Barrier: ☐ No ☐ Yes _____ **Cultural Preference:** ☐ No ☐ Yes _____

Caregiver/Health Care Partner: ☐ No ☐ Unknown ☐ Yes _____

Contact/Service Information:

Is member receiving Home Health Care: ☐ No ☐ Yes **Agency Name:** _____

Personal Care Home resident: ☐ No ☐ Yes **Name:**_____

Physician Specialist: _____

Durable Medical Equipment: _____ **Other:** _____

Emergency Contact: _____ **Relationship:** _____

MD Signature:_____ **Date:**_____