



Next Site of Care Questionnaire

Patient Name _____ Date _____

INDEPENDENCE			
Ambulatory Status <input type="radio"/> No assistance needed <input type="radio"/> Assistive device needed <input type="radio"/> Caregiver needed	Activities of Daily Living <input type="radio"/> No assistance needed <input type="radio"/> Assistance needed for one or more ADLs <input type="radio"/> Dependent on caregiver for one or more ADLs	Cognitive Status <input type="radio"/> Oriented <input type="radio"/> Forgetful <input type="radio"/> Disoriented	Caregiver Availability <input type="radio"/> 24 hours a day (or no caregiver needed) <input type="radio"/> Less than 24 hours a day <input type="radio"/> No capable caregiver available

THERAPIES				
Therapy Needs (Select all that apply):				
<input type="checkbox"/> Ambulatory Status	<input type="checkbox"/> Activities of Daily Living	<input type="checkbox"/> Cognitive Status	<input type="checkbox"/> Caregiver Availability	

TRANSITION OF CARE NEEDS				
Ostomy <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Tube Feeding <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Tracheostomy <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Catheter <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Injectable Meds <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New
Existing <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Clinical Nursing Oversight <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Teaching and Training Activities <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Wound Care <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New	Oxygen or Other Respiratory Support <input type="radio"/> Not needed <input type="radio"/> Existing <input type="radio"/> New

PROPOSAL		
Proposal: _____	Staff Member Name: _____	
Proposal discussed with Interdisciplinary Team? Yes No	Agrees with CARL Proposal? Agrees Disagrees	
Reason 1: Who _____ Why _____	Reason 2: Who _____ Why _____	
Reason 3: Who _____ Why _____		
Options for Who:		
<input type="checkbox"/> Family prefers other	<input type="checkbox"/> Case Management prefers other	<input type="checkbox"/> Patient too well for recommendation
<input type="checkbox"/> Patient prefers other	<input type="checkbox"/> Physical Therapy prefers other	<input type="checkbox"/> Not enough caregiver support
<input type="checkbox"/> MD/Provider prefers other	<input type="checkbox"/> Patient too ill for recommendation	<input type="checkbox"/> Other
Options for Why:		
<input type="checkbox"/> Patient too ill for recommendation	<input type="checkbox"/> Patient discharged to hospice/palliative care	<input type="checkbox"/> Post-Acute community services not available to meet the patient's discharge needs
<input type="checkbox"/> Patient too well for recommendation	<input type="checkbox"/> Patient discharged/transferred to another hospital for inpatient care	<input type="checkbox"/> Other
<input type="checkbox"/> Not enough caregiver support		
Additional Comments: _____		