Patient Name: **Patient ID:**

Date: **Episode Start Date:**

Content of Comprehensive Assessment

Requirement	Y/N	Comments
Admit timely		
Pt. strengths, goals and care preferences		
Continuing need for home care		
Review of all medications (Identify potential adverse reactions, ineffective drug therapy, side effects, significant drug reactions, duplication and noncompliance with meds.		
Patients primary caregiver and other available support		
Willingness to provide care		
Availability and schedules		
Patients representative if any		
All pertinent diagnoses		
Mental, psychosocial and cognitive status		
Types of services, supplies and equipment required		
Frequency and duration of visits to be made		
Prognosis		
Rehab potential		
Functional limitations		
Activities permitted		
Nutritional requirements		
All Medications and Treatments		
Safety Measures		
Risk for Emergency dept visits and rehospitalizations		
Measures to mitigate risk of above		
Patient and caregiver education		
Pt. Specific interventions and education		
Measurable outcomes and goals mutually identified by the patient and agency		
Advance directives		
Copy of POC left in home		
Written instructions visit schedule		
Written instructions Med list		
Written instructions all treatment inc. therapy		
Written instructions 411 for clinical director		