

Needs Interpreter  YES Language \_\_\_\_\_ Advanced Directives placed in chart  YES  
 Male  Female Age \_\_\_\_\_ Marital Status  Single  Divorced  Widow  Married \_\_\_\_\_ years  
 Funeral Home & Planning Needs \_\_\_\_\_

**ADVANCED DIRECTIVES**

living will  POA-HC  patient/family will provide  patient/family provided copy  none

**Check Factors**

Complex Medical  Medical Family  Prior Negative Experience  Suicide  No DNR  No Caregiver Plan  
 Describe \_\_\_\_\_

**Patient's Mental Status**

Oriented  
 Disoriented  Person  Place  Time  Purpose  Intermittent Confusion  Forgetful  Agitated

**Patient's Occupation & Quality of Life Interests** \_\_\_\_\_

**CURRENT FAMILY COMPOSITION**

NAME (Use * to indicate the communication point person)	Indicate the Relationship Legal Surrogate / POAHC	DOB	Telephone (Home) (Work)

Are children in the family  NO  YES Age, Gender, Needs \_\_\_\_\_

ADJUSTMENT TO ILLNESS/PAIN	Check if applies	COMMENTS (INDICATE HOW COPING)
Financial stress		
Acceptance and Understanding of Chronicity/Prognosis		
Does not readily discuss illness		
Angry, rejection of terminal status		
Denial of terminal status		
Marked depression		
Marked anxiety/fear		
Bargaining to live for event/goal		
Recent Dx/prognosis		
Difficulties with body image		
Unresponsive; cannot evaluate		
Suicidal ideation		

NEED FOR A FAMILY MEETING  NO  YES \_\_\_\_\_

ABUSE/NEGLECT/SAFETY ISSUES  Alcohol/drug abuse  Mental Health Hx  Neglect  NA

Signature \_\_\_\_\_

Date/Time \_\_\_\_\_



Mount Carmel, Columbus, Ohio

**Psychosocial Spiritual Aftercare  
Assessment**

NAME

DOB

MR #

FAN #

