Society for Transplant Social Workers Psychosocial Assessment Tool
for Potential Organ Transplant Recipients

IDENTIFYING INFORMATION

Name_____ DOB_____/_____/_____

Medical Record #_____ Assessment Date_____/_____/_____ Location_____

Type of transplant_____ Address_____

Gender_____ Race_____ _____

Primary language_____ Other languages/fluency_____

Religion/Spirituality_____ People present at assessment_____

Do you have any religious, ethnic or personal objections to accepting blood products, surgery and/or transplant?

Citizenship

Where were you born? If outside of US:

What year did you move to the US?

What is your current citizenship status?

Date of Approval: Date of Expiration:

Do you have any outstanding citizenship concerns?

FAMILY BACKGROUND & SUPPORTIVE RELATIONSHIPS

Parental information (biological, adoptive, foster, other)

Sibling information (biological, adoptive, foster, other)

Children (biological, adoptive, foster, other)
-Number of pregnancies (UNOS question)
-Names, age, health status, relationship, address

Marital/Relationship Status: Married / Significant Other / Separated / Divorced / Widowed / Single / Other:

What affects has your illness had on your relationships?

Household composition:

How would you describe your family life & role in it?

Are there any current or history of significant life changes or traumatic events?

Support/Caregiver Plans

** Include specific information on who will learn medications, care needs, hands-on help, and transportation for appointments, etc. * (See Addendum Reference Tool for Caregiver Commitment example)*

Who will be your Primary Caregiver?

Contact #:

Health status & availability:

Who will be your Secondary Caregiver(s)?

Contact #:

Health status & availability:

Other Important Supportive Relationships:

1. If several caregivers are involved, will they be able to cooperate with each other?
2. How comfortable are you asking for and/or receiving help?
3. Have you been or are you currently a caregiver for someone else (i.e. children, spouse, parents)?
   * If you're not there, who will help them?
4. Are there any ongoing family disagreements or life issues that may be impacted by the transplant?
5. Does anyone in your household or caregiving team use tobacco, or abuse alcohol or illicit substances?

Advance Directives

Do you have an Advance Directive? Yes / No (provide forms and/or education if needed)

Do you have a DPOA for Healthcare or Finances? Yes / No A Living Will ? Yes/No Who is the Proxy?

EDUCATION/EMPLOYMENT/FINANCIAL SITUATION

What is the highest level of education you completed? ☐Grade: ____Grade ☐ HS graduate ☐Associates ☐Bachelors ☐Masters ☐PhD ☐ Other:

What type of work do you do?

Do you have concerns about your job because of your illness/pending transplant?

How long have you been employed?

Are you still working?

If still working, is it full time or part time?

If part time, is it due to: ☐ Demands of Work ☐ Disability ☐ Insurance Conflict

☐ Inability to find full time work ☐ Patient Choice ☐ Unknown ☐ N/A

If no longer working, your status is: ☐ Disability ☐ Retirement (start date) ___/___/_____ ☐other:

Date of last employment: ___/___/_____

How do you plan to cover your expenses while off work?

What are your thoughts about returning to work after transplant?

Time expected to be off work following transplant:

Disability

☐SSDI (filed/approved/pending)

☐SSI (filed/approved/pending)

☐Long-term disability (available, started, pending)

☐Short-term disability (available, how long before it starts)

☐VA Disability (start/stop date/pending)

Financial Status

Do you have any current financial concerns?

Is current income adequate to meet monthly needs and current medications? Yes / No

How do you manage when you do not have enough money during the month?

Will your caregiver being off work have an effect on your income?

Amount of money needed due to time off work of patient and/or caregiver:

Have you ever filed for bankruptcy? ☐No ☐Yes If Yes, When?

Patient plan to pay for housing & transportation post-transplant:

Amount of money anticipated for this purpose:

Would you be interested in fundraising information? (Provide information as requested)

INSURANCE/RESOURCES

Primary Insurance: _____

Secondary Insurance: _____

Tertiary / Rx Coverage:_____

Who currently pays your insurance premium(s)? Cost per month?

What is your yearly insurance deductible?

Who will pay for your insurance premium after transplant?

Is your insurance through a high-risk pool, individual policy or COBRA?

Are you aware of a coordination of benefits with your insurance and Medicare (if applicable)?

Medicare Savings Program (QMB, SLMB, QI): _____

Low Income Subsidy for Medicare Part D: Yes No

Medicare Part D Plan (if applicable): _____

Medication coverage

Has your citizenship status affected your ability to obtain medications?

What are your medication costs for generic, brand preferred, and non-preferred brand medications?

Indicate medication costs after transplant:

How will you pay for these medications after transplant?

VA Benefits

Have you served in the military? ☐Yes ☐No

If yes: Branch: _____ Years of Service:_____ Honorable Discharge _____

Were you involved in active combat? Do you use a VA Clinic? Yes / No

Do you know what/if any benefits are available to you?

UNDERSTANDING OF MEDICAL SITUATION

What is your primary diagnosis?

When did you become aware of your diagnosis?

What do you understand about the cause your disease?

What do you know about your disease process?

Do you have any other health issues?

If yes, how do they impact you?

If applicable - Dialysis Center, Schedule and Start Date (if applicable):

Treatment Compliance/Adherence

How do you manage your medications now? (please check all that apply)

☐ Memory ☐ List ☐ Pillbox ☐ Caregiver ☐Other:

Do you have any difficulties in getting or taking your medications? Yes / No If yes: please mark all applicable reasons

- ☐ Don't have the resources (money, transportation) to get the medications
- ☐ Don't like taking medications
- ☐ Can't read the instructions easily
- ☐ Hard for me to understand
- ☐ The timing of all the medications is confusing for me
- ☐ My blood pressure drops when I take all my meds
- ☐ I don't like taking my medications in public
- ☐ I forget the medications I have to take when I am not home
- ☐ I don't have enough help to get or take my medications
- ☐ Other/Comments:

Have you ever changed the way you take a medication without talking to the doctor?

Do you have a PCP or other medical provider you see regularly in the community?

What has your relationship been like with your medical providers?

Knowledge & Understanding of transplant process

Do you know anyone else that has had a transplant?

What has their experience been like?

Tell me a little about what you understand about transplant.

What do you know about the risks of transplant?

What is your biggest concern?

What do you think your support system's main concern is about you getting a transplant?

Were the psychosocial risks of transplant reviewed: Yes ☐ No ☐

Willingness/Desire for Treatment (Transplant)

Do you want to proceed with a transplant?

What are your expectations for transplant?

How did you start thinking of transplant as a treatment choice?

If previously denied listing, why were you denied? Please describe that experience and how it is different now.

If previously transplanted, what was that experience like and what is different now?

FUNCTIONING ABILITY/PERSONAL CARE

Home Environment

Living Situation: ☐ Private Home ☐ Apartment ☐ Trailer ☐ Assisted Living ☐ Nursing Home ☐ Other:

Indicate number of steps and if bed / bath is on the same level:

Assistive devices in the home – grab bars, shower chair, lift chair, ramp, elevator, etc

Function Ability

What physical changes/declines/improvements have you seen in the last 6 months?

Please describe your greatest physical limitation(s)

Ambulation:

☐ Unassisted

☐ Assisted (with walker, cane, companion, etc.)

☐ Non-ambulatory (uses wheelchair/scooter exclusively)

Vision:

☐ No vision impairment

☐ Mild/Moderate Impairment – uses visual aides (glasses/contacts, magnifying glass, lg print)

☐ Significantly Impaired – i.e. legally blind

Hearing:

☐ No hearing impairment

☐ Mild/Moderate Impairment – uses hearing aides, speak slowly/loudly

☐ Significantly impaired – i.e. reads lips, requires sign language interpreter

Transportation:

☐ I am completely independent and drive myself

☐ I can drive but am not due to medical issues/current limitations

☐ My family or friends drive me to appointments, errands, etc.

☐ I take public transportation or have public assistance transportation

Sleep:

☐ No problems with sleep

☐ Some difficulty sleeping – uses sleep aide

☐ Sleep Apnea – uses CPAP

Hygiene:

☐ Able to bathe self, groom

☐ Carries out hygiene routine on a regular basis (i.e. clean and well-groomed?)

☐ Requires assistance

Exercise:

☐ Participates routinely in an exercise regimen

☐ Participates occasionally in an exercise regimen

☐ Participates in Pulmonary/Cardiac Rehab program or PT/OT

☐ Does not exercise

Household tasks – are you independent with:

☐ Cooking

☐ Yardwork

☐ Cleaning/laundry

☐ Shopping (grocery and personal)

Sexual Function/Activity - has your medical situation impacted your sexual functioning?

☐ No Changes or issues

☐ Receiving medical management

☐ Functioning affected by medical situation

Hobbies/Interests

What are your hobbies/interests (pastimes and stress-relievers)?

Do you have any activities that you're unable to do now, that you hope to return to after transplant?

Cognitive Functioning/Health Literacy:

How do you best learn new information? (i.e. reading, verbal, visual, personal research, family explanation, medical explanation, hands-on demonstration, etc)

Do you have any history of developmental delays/learning differences/special education/OT/PT/Speech?

Do you have any current or past problems with a medical issue (i.e. CVA, TBI, encephalopathy) that has impacted your cognitive function?

What is the family's perception of patient's cognitive functioning/dysfunction?
*(Administer ADLQ , if appropriate – * See Addendum Reference Tool)*

Have you noticed any problems with or changes in:

☐ Your attention span/concentration level for conversations, TV/reading, etc.?

☐ Episodes of disorientation/getting lost driving or at a store?

☐ Problems with safety risks/concerns (i.e. leaving the stove on or a candle burning, forgetting to lock the front door, not preparing food appropriately, etc.)?

☐ Your ability to manage your medical regimen?

(Screening with Mini Mental Status Exam or Montreal Cognitive Assessment, if appropriate.
**(See Addendum Reference Tool)*

MENTAL HEALTH

Indicate Mental Status: (Check all that apply)

Indicate status: ☐ Alert ☐ Lethargic ☐ Inconsistent ☐ Sedated/other:

Orientation: ☐ Person ☐ Place ☐ Time ☐ Situation

Indicate Appearance : (Check all that apply)

☐ Malnourished ☐ Obese ☐ Poor Hygiene ☐ Body Image Concerns

☐ Appears stated age ☐ Well groomed ☐ Other:

Indicate Affect: (Check all that apply)

☐ Within normal limits ☐ Easily engaged in conversation ☐ Cooperative ☐ Flat

☐ Angry ☐ Anxious ☐ Blunted ☐ Dysphoric ☐ Euphoric ☐ Other:

Indicate Cognitive Function:

Attentive: ☐ Yes ☐ No Comment:

Memory Problems: ☐ Yes ☐ No Comment:

*If yes, is it related to current medical condition: ☐ Yes ☐ No

Thought Processes:

Organized? ☐ Yes ☐ No:

Do you have a history of : (please check all that apply)

☐ Depression ☐ Anxiety ☐ Panic attacks

☐ Bipolar disorder ☐ Schizophrenia ☐ OCD

☐ Anorexia ☐ Bulimia ☐ ADHD

☐ PTSD ☐ BPD ☐ Other:

Has anyone ever physically, emotionally, or sexually abused you?

Have you ever attempted suicide or thought about harming yourself or others? ☐ Yes ☐ No

*If Yes, please described:

Have you ever been hospitalized in a psychiatric hospital? ☐ Yes ☐ No

*If yes, date: _____ Diagnosis: _____ Symptoms: _____

Do you currently or have you ever seen a therapist/counselor/psychiatrist? ☐ Yes ☐ No

*If yes, indicate Name/Contact Information:

Have you used medications for mental health issues, sleep and/or pain now or in the past? ☐Yes ☐No

*If yes, please indicated names/dosages/prescribing provider information:

Generalized Anxiety Disorder Questionnaire GAD-2

Over the last 2 weeks how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge.

☐ 0 Not at all
☐ 1 Several days
☐ 2 More than half the days
☐ 3 Nearly every day

2. Not being able to stop or control worrying.

☐ 0 Not at all
☐ 1 Several days
☐ 2 More than half the days
☐ 3 Nearly every day

GAD-2 Total score Add responses to both questions ____+ ____ =____

**If the score is ≥ 3, refer for further evaluation (or follow with the other 5 items of the GAD-7 to grade symptom severity) *(See Addendum Reference Tool)*

Patient Health Questionnaire (PHQ 2) – Depression Scale

During the past month, have you often been bothered by:

1. Feeling down, depressed or hopeless?

☐ 0 Not at all
☐ 1 Several days
☐ 2 More than half the days
☐ 3 Nearly every day

2. Little interest or pleasure in doing things?

☐ 0 Not at all
☐ 1 Several days
☐ 2 More than half the days
☐ 3 Nearly every day

PHQ-2 Total score: Add responses to both questions ____+ ____ = ____

Score range is from 3 to 6. A score ≥3 is considered a positive response for depression.

If a positive response is obtained, other symptoms such as fatigue, restlessness, guilt, poor concentration, suicidal ideation, and change in sleep or appetite should be elicited to confirm possible depression and need for referral.

*Patients who screen positive should be further evaluated with the PHQ-9 to determine if they meet criteria for a depressive disorder. *(See Addendum Reference Tool)*

If any problems were identified above: How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

COPING

Brief Coping Scale

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

1. I've been concentrating my efforts on doing something about the situation I'm in. ☐ 1 ☐ 2 ☐ 3 ☐ 4
2. I've been saying to myself "this isn't real." ☐ 1 ☐ 2 ☐ 3 ☐ 4
3. I've been taking action to try to make the situation better. ☐ 1 ☐ 2 ☐ 3 ☐ 4
4. I've been refusing to believe that it has happened. ☐ 1 ☐ 2 ☐ 3 ☐ 4
5. I've been trying to come up with a strategy about what to do. ☐ 1 ☐ 2 ☐ 3 ☐ 4
6. I've been accepting the reality of the fact that it has happened. ☐ 1 ☐ 2 ☐ 3 ☐ 4
7. I've been trying to find comfort in my religion or spiritual beliefs. ☐ 1 ☐ 2 ☐ 3 ☐ 4
8. I've been learning to live with it. ☐ 1 ☐ 2 ☐ 3 ☐ 4
9. I've been thinking hard about what steps to take. ☐ 1 ☐ 2 ☐ 3 ☐ 4
10. I've been praying or meditating. ☐ 1 ☐ 2 ☐ 3 ☐ 4

Scales are computed as follows:

Active coping, items 1 and 3 ***Planning, items 5 and 9*** ***Religion, items 7 and 10***
Denial, items 2 and 4 ***Acceptance, items 6 and 8***

Active, Planning, Acceptance, and Religion coping styles are considered adaptive while Denial as a coping style is considered maladaptive. The higher the score, the more likely the coping style used by the patient.

What are the other stressors in your life?

What helps you cope when you are feeling stressed?

SUBSTANCE ABUSE

Tobacco

Have you ever smoked/chewed tobacco? If so, what age did you start and when was the last time you used tobacco?

How often do you smoke/chew? How much do you smoke/chew?

Alcohol

Do you drink alcohol ☐Yes ☐No

CAGE QUESTIONS:

Have you ever felt you needed to **C**ut down on your drinking? ☐ Yes ☐ No

Have people **A**nnoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt **G**uilty about drinking? ☐ Yes ☐ No

Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

- *Two positive responses (or clinical judgment) indicates further screening (*See Addendum Reference Tool)*

At what age did you begin drinking? When was the last time you consumed any alcohol at all?

On average, how many times per week (or month) do you drink? _____ x / ☐ Week ☐ Month
How many drinks on average per occasion? _____ /occasion
Is it ever more than this? ☐ No ☐ Yes:_____
Was there ever a time period in your history when your drinking was heavier?

When you were first diagnosed with your [presenting problem], were you told to stop drinking alcohol? ☐ Yes ☐ No If yes, were you able to stop at that time? ☐ Yes ☐ No If so, how? If not, why not?

Illicit Substances

Have you ever used any illicit drugs (marijuana, heroin, ecstasy, ketamine, speed, mushrooms, LSD, cocaine, injectables, uppers/downers)?

Any history of prescription drug abuse (using more than what was prescribed, using other people's prescriptions)?

If so, what age did you start? What substance(s) did you use?

How often did you use? How much?

When was the last time you used (what & amount)?

Substance Abuse & Treatment History

What is your family history with alcohol and drug use?

What (if any) consequences has your use (tob/alc/drug) had on your life (i.e., interpersonal, family, work, health, financial, legal, etc)?

Did you find you needed to increase the amount of the substance you used over time to achieve the same level of intoxication or effect, or experienced a lesser effect with continued use of the same amount?

If you've stopped using (tobacco/drugs/alcohol), when/why did you stop? Did you go through signs of withdrawal when you stopped? Did you experience cravings after stopping, or do you still experience cravings?

Did you go through a program to help you stop? Are you still in treatment? Name of program/type/length of treatment (Inpatient, Intensive Outpatient, Outpatient, AA, medication, self-help or 12 Step, etc):

Did you return to (tobacco/drinking/drug abuse) after this attempt at stopping?

** See Addendum Reference Tool for further evaluation of abuse or dependence using DSM IV criteria*

LEGAL ISSUES

Are you currently or have you ever been on probation or parole?

Do you have or have you ever had any warrants out for your arrest?

Have you had any substance related legal problems?

Do you have any current child support concerns?

Do you have a valid driver's license?

IMPRESSION:

Low Risk – 1; Moderate Risk – 2; High Risk – 3; Absolute contraindication - 4

Social Support	☐ 1	☐ 2	☐ 3	☐ 4
Identified Strengths / Risks:				
Financial/Insurance	☐ 1	☐ 2	☐ 3	☐ 4
Identified Strengths / Risks:				
Compliance	☐ 1	☐ 2	☐ 3	☐ 4
Identified Strengths / Risks:				
Functional Status	☐ 1	☐ 2	☐ 3	☐ 4
Identified Strengths / Risks:				
Cognitive Functioning	☐ 1	☐ 2	☐ 3	☐ 4
Identified Strengths / Risks:				
Mental Health	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

Coping Skills	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

Substance Use	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

Legal Issues	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

Understanding of transplant process	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

Motivation for transplant	☐ 1	☐ 2	☐ 3	☐ 4

Identified Strengths / Risks:

** See Addendum Reference Tool for Psychosocial Risk Profile Scoring Tool*

PLAN:

What intervention, follow up or consults are needed?

RECOMMENDATION:

Psychosocial Risk Profile (related to patient's ability to adhere to a transplant regimen and be successful)

Absolute psychosocial barriers to transplant were identified:

High, transplant outcomes will likely be impacted by the following psychosocial barriers:

Moderate, transplant may be impacted by the following psychosocial concerns:

Low, no psychosocial issues were identified that may impact transplant outcome: