Patient Self-Hospitalization Risk Assessment

Are You at Risk for Going to the Hospital?

Name: _____ **Date:** _____

My Top Health Wish or Goal: _____

Check all Boxes that are True for you:	
❑ I needed home health care after leaving the hospital.	❑ I have very poor health.
❑ I have been in the hospital or emergency room in the past year.	❑ I need help taking my pills.
❑ I have heart problems/weak heart.	❑ I need help using my inhalers.
❑ I have diabetes.	❑ I have three health problems. They are: _____ _____ _____
❑ I feel short of breath often.	❑ I fell down in the last year.
Check all that apply: I need some help every day to: ❑ dress ❑ take a bath ❑cook	❑ I live alone.
❑ I often feel down, hopeless, or depressed.	I have a: ❑ skin sore; ❑ skin ulcer; ❑ pressure sore on my body, legs, or feet. ❑ *I may need help to heal the sore or wound*
❑ I sometimes get mixed up or confused.	
My total number of checked boxes above is _____. **(5)** *or more checked boxes could mean a higher chance of having hospital trips.*	

I'm interested in knowing more about services from: ❑ **Physical Therapy** ❑ **Occupational Therapy** ❑ **Speech Therapy**	**I'm interested in knowing more about services from:** ❑ **Social Worker**	**I'm interested in knowing more about services from:** ❑ **Hospice care**	**I'm interested in knowing more about services from:** ❑ **Nursing**

Patient Signature: _____**Date:** _____

Home Health Signature: _____**Date:** _____

❑ **I know how to call for help and have a "Call Me First" home poster.**

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy.
Publication number: 10SOW-WV-HH-BK-102912. App. 10/12 Revised and adapted from Girling Health Care