Care Management Chart Review Tool

DEMOGRAPHIC

Name: _____ DOB: _____Gender: _____Insurance: _____
PCP Name: _____ Phone Number:_____
Care Manager: _____Phone Number:_____

Health team/community supports:	Role (Mental Health provider, health coach, SASH, etc):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIMARY DX: _____
OTHER KEY DIAGNOSES (include Active and Historical): _____
_____
_____

MEDICAL NEIGHBORHOOD

Two or more admissions to the hospital in the past 6 month?	YES	NO
Three or more Emergency room visits in the past 6 months?	YES	NO
Has not been to PCP in past year?	YES	NO
No documented Goals of Care conversation or Advanced Directive on file?	YES	NO

COMMENTS:

MEDICAL STATUS/HEALTH TRAJECTORY

Uses 5 or more medications?	YES	NO
Greater than 3 chronic health conditions?	YES	NO
Requires assistance with ADLs (Activities of Daily Living)?	YES	NO

COMMENTS:

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SOCIAL SUPPORT

Communication Barriers (language, sensory deficits)?	YES	NO
Cognitive barriers?	YES	NO
Does not have stable housing?	YES	NO
Limited social support?	YES	NO
Is not currently employed?	YES	NO
Financial barriers (including underinsured, unable to afford meds)?	YES	NO
Transportation issues?	YES	NO
Literacy issues (difficulty with reading/writing)?	YES	NO
Issues with bereavement (losses/grieving)?	YES	NO

COMMENTS:

SELF MANAGEMENT/MENTAL HEALTH

Non-adherence to previous treatments?	YES	NO
Hospital admission(s) in the past year for mental health-related reason?	YES	NO
Current Behavioral Health diagnosis/substance abuse?	YES	NO

COMMENTS:

OTHER IMPORTANT INFORMATION

Other underlying issues not noted above?	YES	NO

If yes, please comment: