

Every Woman's Life

CASE MANAGEMENT NEEDS ASSESSMENT AND CARE PLAN

| | |
|---|---|
| Client Name: | Social Security No: |
| Day Phone: | Alternate Contact Person: Phone No: |
| Case Manager Name: | Form Completion Date: |
| Provider Name: | |
| Abnormal Breast Result (date and result): | Abnormal Cervical Result (date and result): |

| NEEDS ASSESSMENT * | |
|--|---|
| I feel that I will <u>not</u> have the support of my family and/or friends if I need it. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| I may have problems getting to follow-up appointments if they are recommended for me. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If follow-up tests/services are recommended for me, I may need help in understanding them. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are there other issues that would prevent you from receiving follow-up care? | <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ _____ _____ |

***A "YES" answer in any category requires a care plan.**

| CARE PLAN | | | | |
|--------------------------|--|------|------------------|---------|
| | Problem | Plan | Client Contacts* | Outcome |
| <input type="checkbox"/> | Inadequate social support | | | |
| <input type="checkbox"/> | Lacks access to services | | | |
| <input type="checkbox"/> | Lacks understanding of services needed | | | |
| <input type="checkbox"/> | Other issues | | | |

* Record date and type of contact (1-telephone, 2-office visit, 3-home visit, 4-mail, 5-certified mail, 6-email, 7-text message)

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