DISCHARGE RISK ASSESSMENT - *to be completed at 2 days prior to discharge*

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

CHECK ALL THAT APPLY

- ☐ Lives at home with limited or no community support
- ☐ Requires assistance with medication management
- ☐ Polypharmacy (more than 7 medications)
- ☐ History of mental illness
- ☐ Issues with health literacy
- ☐ Requires assistance with ADLs/IADLs
- ☐ Cognitive impairment
- ☐ **End stage conditions**
- ☐ Diagnosis of CHF/COPD/DM/HIV-AIDS
- ☐ Incontinent
- ☐ Acute/chronic wound or pressure ulcer
- ☐ History of falls
- ☐ Decreased adherence to treatment plan
- ☐ Repeat hospitalization / ED visits
- ☐ Requires assistance with managing O2 and/or nebulizer

Total # checked _____

Score ≥ 5

The patient is **HIGH RISK** for re-hospitalization. **Refer to Home care service, SNF, or Hospice.**

OR

Score 2-4

The patient is **MODERATE RISK** for re-hospitalization. **Refer to Home care service prior to D/C.**

Score < 2

The patient is **LOW RISK** for re-hospitalization. **Discharge home.**

NOTIFY AGENCIES UPON COMPLETION:

HOME HEALTH AGENCY NAME / NOTIFIED

_____

☐ Called DATE/TIME_____
☐ FAX'd DATE/TIME_____

SKILLED NURSING FACILITY NAME / NOTIFIED:

_____

☐ Called DATE/TIME_____
☐ FAX'd DATE/TIME_____

HOSPICE NAME / NOTIFIED:

_____

☐ Called DATE/TIME_____
☐ FAX'd DATE/TIME_____

PCP NAME / NOTIFIED:

_____

☐ Called DATE/TIME_____
☐ FAX'd DATE/TIME_____

COMPLETE BY_____

DATE/TIME_____

Patient Sticker

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