**Assessment Interview / Notes /Care Plan Development** Date:

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client ID:

Client Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Age:

**Question and Task Bank:**

Situation (Dx, current treatment, recommended treatment)

Prognosis

Wishlist (what does your client hope you can do?)

Expectations (what does your client expect that is possible to accomplish?)

Insurance challenges / constraints

Timeline (if applicable – any deadlines, wait times, etc)

Additional: (imaging, drugs and supplements, medical records retrieval, appointments, transportation, communication with family, prescription reviews, check-ins, home safety checks, others)

Providers and Contact Info:

Pharmacy (plus location and phone)

Insurance Details (Primary, Secondary):

Other Specifics:

*Use additional pages for more notes and information.*

**Possible Add-On Services:**

Prescription Review

Home Safety Review

Collection / Development of Advance Directives

Insurance Review (finding better plans)

Records Binder / Organization (include out of pocket cost for binder and dividers)

Medical Bill Review / Organization

|  |  |
| --- | --- |
| **Service Required** | **Estimated Time Required** |
|  |  |
| Medical Records – Collection time |  |
| Phone calls |  |
| Appointment time |  |
| Care Coordination / Finding Providers |  |
| Transportation |  |
| Follow up, reporting, recording, misc needs |  |
| Prescription Review |  |
| Medical Bill Organization |  |
|  |  |
| **TOTAL Time Estimated** |  |

*(none of these hours include out-of-pocket expenses)*

Hourly rate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Math: (time x rate)

Total for this project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(transfer this to the estimate)*