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)*