# ONCOLOGY DISCHARGE PLANNING ASSESSMENT TOOL

**Date:** _______________

**Instruction:**
To be completed by Care Coordinator or Care Coordinator Assistant.

## DISCHARGE PLANNING INITIAL ASSESSMENT:

**Admitting Diagnosis:** __________________________________________

## LIVING ARRANGEMENTS:

- [ ] House: 1 Story
- [ ] 2 Story
- [ ] Split Level/Bi-Level
- [ ] # of Steps to Enter: ___
- [ ] Homeless
- [ ] Mobile Home

- [ ] Apartment: Floor#: __________
- [ ] # of Steps to Enter: __________
- [ ] Elevator: [ ] Yes [ ] No

- [ ] Other Care Facility: Name of facility: ____________________________________________________________________

## Bathrooms

- [ ] First Floor: Full
- [ ] Partial
- [ ] Second Floor: Full
- [ ] Partial

## CAREGIVER AFTER DISCHARGE:

- [ ] Yes [ ] No

**Name:** _________________________  **Relationship:** ______________  **Phone (H):** ______________  **(W):** ______________

**Name:** _________________________  **Relationship:** ______________  **Phone (H):** ______________  **(W):** ______________

-- Mental status: [ ] Oriented [ ] Confused [ ] Unable to answer questions

-- Prior functional status: __________________________________________________________________________________

-- Vascular access devise: [ ] Yes [ ] No  **Type:** ___________________________  **Agency:** ______________

-- Independent with activities of daily living: [ ] Yes [ ] No  **If no, describe:** _________________________________________________________________________

-- Independent with mobility: [ ] Yes [ ] No  **If no, describe:** _________________________________________________________________________

-- with necessary devices: ________________________________________________________________________________

## FINANCIAL CONCERNS:

- [ ] No [ ] Yes  **If yes, describe:** _________________________________________________________________________

## TRANSPORTATION ISSUES:

- [ ] No [ ] Yes  **If yes, describe:** _________________________________________________________________________

## PRESCRIPTION PLAN:

- [ ] Yes [ ] No  **Referred to:** __________________________________________________________

## PREVIOUS HOME HEALTH CARE/HOME MEDICAL EQUIPMENT:

- [ ] No [ ] Yes

**If yes, describe service, equipment & vendors:** _________________________________________________________________________

## PATIENT/FAMILY CONCERNS:

- [ ] No [ ] Yes  **If yes, describe:** _________________________________________________________________________

## ASSESSMENT – ANTICIPATED DISCHARGE PLAN:

- [ ] No post acute care needs identified at this time

- [ ] Home Health Care Services:  [ ] Nursing  [ ] Physical Therapy  [ ] Occupational Therapy  [ ] Speech Therapy  
  [ ] Respiratory Therapy  [ ] Intravenous Antibiotic  [ ] Total Parental Nutrition (TPN)  [ ] Other: ______________

**Choice Menu Receipt Signed:** [ ] Yes  **Agency:** ________________________________________________________________

## DURABLE MEDICAL EQUIPMENT:

- [ ] Home O₂  [ ] Infusion Therapy/antibiotics  [ ] Nebulizer treatments  [ ] Walker  [ ] Ventilator  
  [ ] Wheelchair  [ ] Continuous Positive Airway Pressure (CPAP)/BiPaP  [ ] Cane  [ ] Commode  [ ] Hospital Bed

- [ ] Tube Feed Supplies: ________________________________________________________________________________

- [ ] Other: ___________________________________________________________________________________________

**Plan communicated to Patient/Family:** Initial: __________  Date: __________

## REVISED ANTICIPATED DISCHARGE PLAN:

## PLACEMENT:

**Type of Facility:**  [ ] Nursing Home  [ ] Assisted Living  [ ] Hospice  [ ] Other: __________________________

**Comments:** ______________________________________________________________________________________

**Plan communicated to Patient/Family:**
**Signature:** _________________________  **Print Name:** _________________________  **Date:** __________