SafeMed Inpatient Enrollment Form

CONTACT INFORMATION

Address:

____

____

____

Mailing Address:

____

____

____

Phone Number: _______________________ **Alternate Phone**:________________________

Alternative Contact #1:

____

Relationship: _________________________ **Phone Number**: _______________________

Alternative Contact #2:

____

Relationship: _________________________ **Phone Number**: _______________________

INSURANCE INFORMATION

Medical Insurance Type:

☐	☐	☐
Medicare Only	Medicaid Only	Medicare/Medicaid

Prescription Coverage:____

Insurance Provider: ____

Health Insurance Member ID#: ____

Pharmacy #1: ____

Pharmacy #2: ____

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SafeMed PROGRAM

INFORMAL CAREGIVER INFORMATION

Carer/Care Representative:____ No Carer Available

By 'carer' we mean someone **you rely on to help with daily life,** but is not paid to do so – meaning a family member, friend or relative. By designating a carer, you authorize this individual to be part of your care team and assist with implementing your care plan upon leaving the hospital, assist organizing follow up services as needed, and support ongoing communication of needs and concerns to your care team.

Carer understands role on care team and accepts designation. YES NO

**Add carer contact information if not already entered under alternative contact information.*

DEMOGRAPHIC INFORMATION

Gender:

□ Male
□ Female
□ Unknown

Height: ________________
Weight: ________________

Race:

□ American Indian/Alaskan Native
□ Asian
□ Black/African American
□ Native Hawaiian/Pacific Islander
□ White/Caucasian
□ Multi-Racial
□ Unknown

Ethnicity:

□ Hispanic/Latino
□ Not Hispanic/Latino

Marital Status:

□ Single/Never Married
□ Married
□ Separated
□ Divorced
□ Widowed
□ Civil Union/Domestic Partnership
□ Cohabitating with Partner
□ Other: ________________________
□ Prefer Not to Say

Where are you living right now?

□ Own house/Apartment
□ With friend/relative
□ SRO/boarding home
□ Institutional setting, *specify*____________
□ Other: ________________

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SafeMed PROGRAM

Does the patient have lack of social support at home or in the community? *Yes is =<3 Yes No

On a scale of 1 to 5, how often does a family member(s) or friend support you with your healthcare needs?*

☐	☐	☐	☐	☐	☐
1 (No one supports me)	2	3 (Sometimes I get support)	4	5 (I get a lot of support)	Unable to Respond

Does the patient have limited mobility*? Yes No
*Yes if A through D

Which of the following statements fits you best in terms of health? (select best fit)*
- ☐ A) Must stay in bed all or most of the time.
- ☐ B) Need the help of another person in getting around inside or outside the house.
- ☐ C) Need the help of some special aid, like a cane or wheelchair, to get around inside or outside the house.
- ☐ D) Do not need the help of another person or special aid, but have trouble getting around freely.
- ☐ E) Not limited in any ways.

Does the patient report difficulty using current durable medical equipment at home?
(Check all that apply) Yes No

- ☐ Apnea Monitor
- ☐ Bath bench/shower chair
- ☐ Bedside commode
- ☐ Blood pressure equipment
- ☐ Cane
- ☐ CPAP/biPAP
- ☐ Feeding pump
- ☐ Glucometer
- ☐ Grab bars
- ☐ Hospital bed
- ☐ Nebulizer
- ☐ Oxygen
- ☐ Peak flow
- ☐ Scales
- ☐ Trach supplies
- ☐ Walker
- ☐ Wheelchair
- ☐ None
- ☐ Other:

Does the patient have limited access* to healthy food choices? Yes No
* Yes, if =>3

Do you have trouble affording food on a regular basis?

☐	☐	☐	☐
Yes (2)	No (0)	Not Sure (1)	Prefer Not to Say (1)

Where do you buy/get most of your food?

☐	☐	☐	☐
Grocery store (0)	Convenience Store (2)	Restaurant (1)	Food Pantry/Other unpaid food source (1)

Who is responsible for food provision in current household?

☐	☐	☐	☐
Myself (1)	Spouse (1)	Other family member (2)	Other (2)

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Does the patient have reliable transportation? Yes No
* Yes if patient has transportation source and can get to medical appointments.

How do you get around? (Check All That Apply)

□ I drive a car.
□ My friends or family drive me.
□ I take public transportation.
□ I walk, ride a bike, or ride a scooter.
□ I cannot get around easily.
□ Other: ________________________

How do you get to your medical appointments? (Check All That Apply)

□ I drive a car.
□ My friends or family drive me.
□ I take public transportation.
□ I walk, ride a bike, or ride a scooter.
□ I cannot get to my medical appointments.
□ Other: ________________________

OUTPATIENT CASE MANAGER: YES NO

Name:
____

Address:
____
____
____

Phone Number: ________________________

Date Last Seen: ________________________

HOME HEALTH: (at current discharge): YES NO

Name:
____

Address:
____
____
____

Phone Number: ________________________

Date Last Seen: ________________________

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