

(Agency Name)

## **At Risk Registry Evaluation Form**

The At Risk Evaluation Form should be completed for each patient upon admission. The completed and signed form should be placed in the patient's medical record and home folder. If the patient is assessed as "At Risk", information should be entered into the At Risk Registry upon admission and updated every 7 days. Only patients meeting these guidelines should be entered in the Registry.

### **Mississippi At-Risk Home Health/Hospice Patient Criteria:**

- a. Home Health/Hospice patients who live alone, without a caregiver and unable to evacuate themselves, or
- b. Home Health/hospice patients with a caregiver physically or mentally incapable of carrying through on an evacuation order, or
- c. Home Health/Hospice patients/caregivers without the financial means to carry through on an evacuation order, or
- d. Home Health/Hospice patients/caregivers simply refusing to evacuate

**Patient Name** \_\_\_\_\_ **Patient weight** \_\_\_\_\_

Date of Birth: yyyy-mm-dd \_\_\_\_\_ **Sex** \_\_\_\_\_ **Resides in** \_\_\_\_\_ **county** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Mobile** \_\_\_\_\_ **Diagnosis** \_\_\_\_\_

**Cross Street** \_\_\_\_\_ **House** \_\_\_\_ **Mobile Unit** \_\_\_\_ **Apartment** \_\_\_\_

**Complex/ Mobile Home Park Name** \_\_\_\_\_ **Apartment/Lot** \_\_\_\_\_

**Primary Caregiver** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Next of Kin** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Address** \_\_\_\_\_

**Primary Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**DME** \_\_\_\_\_

**DME Supplier** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Supplies** \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ **Phone** \_\_\_\_\_

### **Check all that apply to your patient**

O2 Dependent \_\_\_\_ Ventilator \_\_\_\_ Infusion Therapy \_\_\_\_ Tube Feeding \_\_\_\_ Pets in Home? \_\_\_\_  
Ambulatory \_\_\_\_ Needs assistance \_\_\_\_ Bedbound \_\_\_\_ Wheelchair \_\_\_\_ Walker \_\_\_\_

I grant permission to medical providers, transportation providers, and other care providers as necessary, to provide care and disclose any information necessary to respond to my needs.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(or family member)