Ingham County MEDICAL CARE FACILITY

Outpatient Rehabilitation Services Social Services Screening and Referral

Patient Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

Questions	Yes	No
1. Do you need help to finish school?		
2. Are you currently employed?		
3. Are you able to do your job with your current injury/illness?		
4. Do you need help getting job training?		
5. Do you need assistance related to employment?		
6. Do you need assistance with daily self-care? (e.g. bathing, toileting, etc.)		
7. Do you need help getting clothes and other necessities?		
8. Do you need help with childcare?		
9. Do you need help getting groceries?		
10. Do you need help preparing food?		
11. Do you need help with transportation?		
12. Do you need help with financial concerns?		
13. Do you feel safe in your current living environment?		
14. Is anyone causing you harm or making you feel uncomfortable?		
15. Do you have other concerns/needs that we have not asked you about?		
Comments:		

☐ Patient mentioned he/she would like to be contacted by a social worker.

PT Signature _____ __N/A

OT Signature _____ __N/A

SLP Signature _____ __N/A

A copy of this form is maintained prior to sending to the MSW and kept in the patient's medical record.

For Medical Social Worker to complete.

☐ No referral necessary.

☐ Social service assessment is indicated. Patient contacted and initial assessment appointment scheduled for _____.

☐ Social service assessment is indicated. Patient contacted and declined referral.

Signature: _____ Date: _____