SOCIAL SERVICES TRIGGER SHEET

Patient: ______________________________ **Date:** __________________________

Cell Phone: ___________________________

SOCIAL SERVICES COUNSELING TRIGGERS:

No.	Description	Yes	No
1.	Are you currently living in a nursing home type facility that is already responsible for providing social worker type services? (If yes, skip to the signatures of this form. If no, please continue with questions 2-11)		
2.	Are you currently under the care of a qualified social worker, psychologist, psychiatrist, or vocational rehabilitation counselor?		
3.	Do you have a spouse, partner, caregiver or family member at home to assist with your care if needed?		
4.	Do you have unresolved feelings regarding your current physical problems (For example: worry, anger, depression, fear, etc.)		
5.	Have you experienced recent notable weight loss **OR** gain?		
6.	Do you have difficulty preparing meals?		
7.	Are you **UNABLE** to bathe, feed or adequately conduct household activities?		
8.	Do you feel you are under any situations that are causing you distress?		
9.	Are your transportation needs met?		
10.	Have you ever been under the care of a nursing home or home health agency?		
11.	Do you request to speak with a social worker and/or vocational adjustment services professional? **(Please note that under certain circumstances, we are legally required to refer your case or provide information to a social worker, another healthcare provider, or the appropriate governmental authority. Your decision not to request to speak to a social worker or vocational adjustment services professional does not relieve us of these obligations, if applicable.)**		

Patient Signature: __________________________________ **Date:** __________

**********************FOR OFFICE USE ONLY**********************

Trigger Sheet Referred To Social Worker: **Yes** **No**

Therapist Signature: __________________________________ **Date:** __________

Social Worker Note (If Referred to Social Worker): ______________________________________

____

____

____

____

Social Worker Signature: ______________________________ **Date:** ___________

© 2013 Farmington Sports and Rehabilitation Center. All rights reserved.