# Patient Care Transition Self Assessment Tool

*Please answer the following questions for yourself or loved one considering new services:*

1. *Have you been to the Emergency Room or put in the hospital several times in the last 6 months?* ☐ Yes ☐ No
2. *Do you feel your current treatments are doing you more harm than good?* ☐ Yes ☐ No
3. *Are you able to maintain an acceptable comfort level for yourself?* ☐ Yes ☐ No
4. *Have you been making more frequent calls to your Physician or Nurse Practitioner?* ☐ Yes ☐ No
5. *Are you spending the majority of your time in a bed or chair?* ☐ Yes ☐ No
6. *Have you started taking medication for pain or discomfort?* ☐ Yes ☐ No
7. *Have you fallen 2 times or more in the last 6 months?* ☐ Yes ☐ No
8. *Have you started feeling weaker?* ☐ Yes ☐ No
9. *Do you have to have help from others to:*
   a. *Bathe* ☐ Yes ☐ No
   b. *Dress* ☐ Yes ☐ No
   c. *Eat* ☐ Yes ☐ No
   d. *Get out of Bed* ☐ Yes ☐ No
   e. *Walk* ☐ Yes ☐ No
10. *Have you lost weight? Are your clothes looser?* ☐ Yes ☐ No
11. *Do you have Shortness of Breath even at rest in a chair or bed?* ☐ Yes ☐ No
12. *Have you been told that you have a life limiting/incurable condition?* ☐ Yes ☐ No
13. *Has your quality of life declined in the last 6 months?* ☐ Yes ☐ No

*(Three or more YES answers may indicate that a change in level of care may be appropriate.)*