

SOCIAL SERVICES/VOCATIONAL ADJUSTMENT SERVICES NOTICE OF AVAILABILITY

Dear Patient:

Federal regulations require our clinic to evaluate the social work needs of our patients. Please take a few minutes to complete the following:

SEVEN SOCIAL QUESTIONS

1. Do you have a spouse, partner equivalent, or family member at home to assist with your care, if required? No Yes
2. Are your needs being met in regard to obtaining and administering medications, changing dressings and making necessary brace adjustments, etc? No Yes
3. Do you have a normal appetite? No Yes
4. Do you sleep comfortably for 6-8 hours each night? No Yes
5. Do you have any barriers to mobility that are unresolved? (For example: difficulty with stairs, bathing, transportation, etc.) No Yes
6. Do you have unresolved feelings regarding your current physical problems? (For example: anger, worry, depression, fear, etc.) No Yes
7. Considering your current physical abilities, do you feel that your expectations of physical therapy will be met? No Yes

In accordance with regulatory guidelines, our clinic will consider your individual need for and interest in social work/vocational adjustment intervention and provide *referrals* to local area service providers as appropriate in areas such as the following:

- ◇ Individual or family counseling
- ◇ Anxiety and stress management
- ◇ Vocational rehabilitation training
- ◇ Social integration and/or community re-entry
- ◇ Other information and referrals regarding Social Security Worker's Compensation, community resources, etc.
- ◇ Depression, anger, boredom or frustration issues
- ◇ Adjustment to physical disability or institution
- ◇ Financial assessment and management
- ◇ Discharge planning

Our evaluation, counseling and referral services are provided by a qualified professional licensed by the State.

No I do not request to talk with a social and/or vocational adjustment services professional.

Yes I do request to talk with a social and/or vocational adjustment services professional.

Notice Received and Acknowledged:

Patient Signature

Date

Comments: _____

Physical or Occupational Therapist

Signature

Date