STANFORD HOSPITAL & CLINICS
Coordinated Care

Self-Assessment

NAME (Please Print): _____

What is the best way to contact you? (Provide all that apply)

Telephone: _____ Email: _____

1. What is your health insurance plan as a Stanford employee or dependent? Circle one:

Blue Shield EPO	**Blue Shield PPO**	**Blue Shield High-Deductible PPO**	**UMR EPO**	**UMR PPO**	**Other/Unsure**

2. How close to retirement are you? _____

GENERAL HEALTH INFORMATION

3. In general, how would you rate your current health? Circle one:

Excellent	**Very Good**	**Good**	**Fair**	**Poor**

4. How many specialists do you see? _____

5. What conditions/diagnoses do you have? _____

_____

_____

_____

6. Please list the medications you are taking: *(If you do not take medications, skip to Question 7)*

Name of Drug	**Dosage/Strength**	**How many times a day do you take this?**

6A. During the past <u>WEEK</u>, how often did you forget to take, or decide not to take, one or more of these medications? Circle one:

None	**Sometimes**	**Often**	**Always**

7. If you needed immediate help for a health problem, how many friends or relatives do you feel close to, such that you could call on them for help? Circle one:

3 or more	**2**	**1**	**None**

8. Think about your current medical conditions. How confident are you that you can manage these medical conditions day-to-day? Circle one:

I don't have any health problems	**Very confident**	**Somewhat confident**	**Not very confident**

9. During the past 6 months, how many times did you go to the Emergency Room? Circle one:

None	**One or more**

9A. Do you think it is likely that you will need to go to the Emergency Room again in the next 6 months? Circle one:

Not likely	**Somewhat likely**	**Very likely**

10. During the past 6 months, how many times did you stay in the hospital overnight as a patient? Circle one:

None	**One or more**

10A. Do you think it is likely you will need to be hospitalized again in the next 6 months? Circle one:

Not likely	**Somewhat likely**	**Very likely**

11. If you are eligible for Stanford Coordinated Care, may we contact your primary care clinician to introduce him or her to this program and your participation? Circle one:

Yes (please see question 11A)	**Not at this time, please**

11A. If yes, please provide the name of your primary care clinician's name and affiliation:

Name: _____

***Note**: If eligible for SCC services, at your first intake appointment you will be asked to sign an enrollment agreement.*

**In order for Stanford Coordinated Care (SCC) to quickly assess whether you will be a good fit, we would like your consent to release your claims history from your chosen medical plan. This information is necessary for SCC to confirm that you are in need of our services. Your signature authorizes SCC to obtain any claims history necessary to determine appropriate enrollment in SCC.*

Signature: _____ **Date:** _____

Please send your responses to SCC by one of the following methods:
Mail to: Stanford Coordinated Care at **211 Quarry Road, Suite 102, Palo Alto, CA 94304**
Call to speak with a member of the SCC team: (650) 724-1800
Fax to: (650) 736-2550