

# SOCIAL WORK/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. **Are your short and long term goals consistent with your abilities?** 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 Workman'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** have a need for these services.

Yes  I **do** have a need for these services.

Notice Received and Acknowledged:

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Therapist Signature**

\_\_\_\_\_  
**Date**

