OLIVE VIEW-UCLA MEDICAL CENTER
CLINICAL SOCIAL WORK
POLICY & PROCEDURE

NUMBER: 1321
VERSION: 1

SUBJECT/TITLE: ASSESSMENT

POLICY: A clinical social work assessment will be conducted and documented for each patient referred to SW. Patients referred to clinical social work and who consent to engage in the process will be evaluated, assessed and will received an initial bio-psycho social assessment. The initial assessment is completed and documented within 72 hours of receiving the referral. Recurring patients will be briefly reassessed for changes since the last visit. Changes will require a full psychosocial assessment before interventions can be planned.

PURPOSE: To provide a clinical bio-psycho-social assessment for all patients where it is clinically indicated. (i.e., homelessness, suicidal/homicidal ideation, domestic /elder abuse, drug/alcohol abuse, grave disability, patients on an involuntary hold, etc.).

DEPARTMENTS: All Departments.

DEFINITIONS: Psychosocial evaluation, clinical social work assessment.

PROCEDURE: The initial assessment interview and content will vary depending on the purpose for the referral and the patient's situation.

General models include aspects of the following steps:

1. FORMAT ELEMENTS
Recording Title, Date, Worker Signature, Patient ID, Language of the Interview, Referral Information, Patient Demographics, Patient Diagnosis, and Reason for the Health Care Visit.

2. ASSESSMENT ELEMENTS
Patient/Family Understanding of their Illness and Educational needs, Mental Status Exam, Support System Members and Strengths, History of Abuse if any, Problem Formulation if any.

3. INTERVENTION ELEMENTS
Interventions, Assessment Summary/ Plan, Evaluation, Follow Up and

Reassessment Plan.

4. DOCUMENTATION

The primary documentation vehicle of the department is electronic. The electronic format makes available all of the elements listed above. The social worker may choose which portions of the format are appropriate for each encounter. All portions of the electronic format also allow for narrative.
All relevant information and patient contacts will be entered in the progress notes of the patient's medical record. Entries should be made as soon as possible after the worker/patient contact occurs (same day). If the documentation is hand written it must include the date, time, name of the department and workers signature and his/her title.

References: VC Policy 400	
Approved by: Stephanie Johnson (Assistant Hospital Administrator)	Date: 07/25/2011
Review Date: **07/25/2014**, 3/5/01 JS, 3/1/02 JS, 5/2/03 JS, 3/18/04 JS, 7/18/04 JS, 5/1105 JS, 10/1/06 JS, 11/10/07 JS	Revision Date:
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