HD Reach Needs Assessment for Care Management

Information about me:	Preferred method of contacting me (please check all that apply)
Name:	
Mailing address:	
City, State Zip:	
County:	
Home phone:	☐
Work phone:	☐
Mobile phone:	☐
Email:	
Date of Birth:	
CAG repeat length (if applicable):	

Please describe yourself:

☐Person with HD
☐Caregiver
☐At-Risk individual
☐Family Member
☐Other, please describe: ___________________________

We really CARE about the security of your private health information. HD Reach will not release any information about you without your signed written consent, consistent with practices followed by healthcare institutions

If you are a caregiver, please provide the following information about the person with HD for whom you are providing care:	Preferred method of contacting me (please check all that apply)
Name:	
Mail address:	
Cite, State Zip:	
County:	
Home phone:	☐
Work phone:	☐
Mobile phone:	☐
Email:	
Date of Birth:	
CAG repeat length (if known):	

Emergency Contact information:

We use this information in the event of an emergency only. You may change this contact information at any time.

Name:
Relationship:
Daytime phone:
Evening Phone
Mobile phone:
Email:
My emergency contact is also my health care power of attorney. ☐Yes ☐No

Communication networks may be complicated in HD families. What is the best time to privately communicate with you? Who in your family is part of the solution, and therefor someone you would like to be involved? How do you communicate with the person with HD in your family? We care about these details!

Health Care Information

Health Insurance Information:

Please have your insurance card available for your visit with the HD Reach Social worker. We will not bill or otherwise contact your insurance carrier for any reason. We collect this information in order to assist you in obtaining referrals, help you understand your benefits or otherwise coordinate your care. Providing this information is optional!

Who are your current health care providers? *We will NOT contact any provider without your written consent.*
PRIMARY CARE PHYSICIAN:
NAME:
ADDRESS:
PHONE:
FAX:
PSYCHIATRIST:
NAME:
ADDRESS:
PHONE:
FAX:
MENTAL HEALTH PROVIDER OR THERAPIST:
NAME:
ADDRESS:
PHONE:
FAX:
HUNTINGTON'S DISEASE PHYSICIAN:
NAME:
PRACTICE:
ADDRESS:
PHONE:
FAX:
SPECIALTY:

What problems are you currently experiencing? Please let us know which of the following difficulties are problems that you need our active help in solving now.

At-risk issues
☐ Counseling about testing
☐ Genetic testing resources
Comments:

Mental health issues
☐ Aggression
☐ Anxiety
☐ Apathy (inactive, passive, lack of goal directed behavior, but not depressed)
☐ Depression
☐ Insomnia
☐ Irritability (Episode of rage in response to no apparent trigger)
☐ Perseveration (Persistent, continuous, repetitive behavior or speech)
☐ Resistance to Care (Refusing to go to the Dr. or take medications)
☐ Suicidal thoughts or actions
Comments:
Physical health issues
☐ Chorea/falls (Jerky involuntary movements)
☐ Swallowing and nutritional problems
☐ Communication issues
Comments:
Social issues
☐ Disability, interactions with law enforcement or parole officers
☐ Employment
☐ Family conflict/communication problems
☐ Financial planning
☐ Paying for health care
☐ Paying for shelter and housing
☐ Paying for food and/or nutritional supplements
☐ Transportation/driving
Comments:
Long term care placement issues
☐ Determining when its time to consider long term care
☐ Determining what is the right facility for my loved one
☐ Finding in home services
☐ Finding a long term care facility
☐ Paying for long term care
Comments:
How urgent are your needs?
☐ Routine
☐ Urgent: things will become an emergency within a week if problems are not handled soon
☐ Critical
☐ Emergency: I need help today – **CALL 911 or your local mobile crisis team**, then call your physician, and then call HD Reach for further assistance at 919-803-8128 from 9-4:30PM weekdays.