Rehospitalization Clinical Record Review Tool
(for use when a patient is rehospitalized after SOC)

Care Behaviors	*Clinical Record Number:*	*Clinical Record Number:*	*Clinical Record Number:*	*Clinical Record Number:*	*Clinical Record Number:*	Total (# checked)
1. Initial patient referral was from a hospital.						
2. The reason the patient was rehospitalized is clearly stated ("other" and "unknown" are not acceptable).						
3. Who initiated the process leading to patient's rehospitalization (specify: agency, family, physician, or other healthcare service provider)?						
4. The patient/family notified the agency when re-hospitalization occurred.						
5. Rehospitalization was due to patient's primary diagnosis.						
6. Rehospitalization was due to medication adverse effect.						
7. How many days between SOC/ROC and rehospitalization (include SOC date)?						
8. Did the patient see their primary physician prior to rehospitalization?						
9. Did the patient have any urgent/ER visits prior to rehospitalization?						
10. Was there any indication that this patient was at risk for hospitalization at the SOC/ROC assessment?						
11. If yes, was the agency's high-risk care plan followed that addressed the patient's risk for hospitalization?						
12. Is there evidence that patient's high risk was communicated to other disciplines involved in patient's care?						

Aspects of Care Delivery Needing Modification:

1. _____
2. _____

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