CLEVELAND CLINIC
BLOOD & MARROW TRANSPLANT PROGRAM

Name:_____ Age:_____ CCF#:_____ Date:_____

Marital Status: ***Single*** ***Committed Relationship*** ***Married*** ***Separated*** ***Divorced*** ***Widowed***

Length of Marriage/Committed Relationship:_____ Name of Significant Other:_____
Previous marriages_____

Household members:_____

Please indicate if your parents are living or deceased. ***Mother***_____ ***Father***_____

Please indicate number of siblings. ***Sister(s)***_____ ***Brother(s)***_____

If you have children, please list them below:

NAME	**AGE**	**M/F**	**CITY/STATE**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who are other supportive persons in your life (extended family, friends, work colleagues): _____
_____

Who will be your primary caregiver(s) throughout the transplant process:_____
_____

PHYSICAL LIVING ENVIRONMENT: Steps to enter:__, One level___, Two level__ , First floor bath?____

EDUCATION & EMPLOYMENT

Please circle your highest level of education:

Less than 12th grade ***High School/GED*** ***Some College*** ***College Degree*** ***Post Graduate Degree*** ***Vocational Training***

Do you have any military service? _____ ***If so, are you registered with the VA for health benefits?*** _____

Please circle your current employment status:

Not Employed ***Retired*** ***Disabled*** ***Part-time*** ***Full-time*** ***Stay at Home Parent*** ***Student***

What type of work do/did you do?_____

FINANCIAL

Please indicate if you have access to the following benefits either from your employer or private policy (please circle):

Short-term Disability ***Long-term Disability*** ***Family Medical Leave (FMLA)***

Have you applied for any of these benefits? _____

Have you applied for social security disability? _____

Is your primary caregiver employed? ***Yes*** ***No*** If yes, please let us know if they need Family Medical Leave paperwork completed: _____

What financial concerns for do you have? _____

What is your health insurance coverage? _____

What is your prescription drug coverage? _____

INTERESTS & HOBBIES

What do you enjoy doing in your leisure time? _____

What do you have planned to pass time while in the hospital? _____

COPING

What are some things you do to cope with the stress of your illness and treatment? _____

_____

What concerns do you have about how your children/family members are coping with your illness?

_____

Is spirituality a source of support for you? ***Yes*** ***No*** If Yes, do you affiliate with a specific religion or denomination?_____

Have you ever attended a support group? ***Yes*** ***No***
If yes, please tell us about your experience_____

MENTAL HEALTH

Current and past mental health needs can impact your wellbeing throughout the transplant process. We ask about mental health needs prior to transplant to ensure that we are supporting our patients.

Have you ever or are you currently being treated for any mental health needs? ***Yes*** ***No*** If yes, please indicate (ex. anxiety, depression, or other mental health condition):_____

If you are currently taking medication for a mental health need (anxiety or depression), please list:
Medication(s)_____ **How long have you been taking this**?_____

If you have taken medication in the past for a mental health need, please list:
Medication(s)_____ **How long did you take this?** _____

Are you currently, or have you ever received counseling services? _____

Have you ever experienced/witnessed any trauma, violence or abuse? ***Yes*** ***No*** If yes, please explain further if you are comfortable doing so:

_____

SUBSTANCE USE

The next questions relate to your experience with tobacco, alcohol, marijuana and other drugs. We ask about substance use to identify resources that may be available to help our patients.

Substances	**Past/Current Use**	**Frequency of Use**	**Amount used / Per day / Per week**
Tobacco ***Yes No***	_____	_____	_____
Caffeine ***Yes No***	_____	_____	_____
Alcohol ***Yes No***	_____	_____	_____
Marijuana ***Yes No***	_____	_____	_____
Other Drugs ***Yes No***	_____	_____	_____

Any legal concerns:_____

COMPLEMENTARY THERAPIES

Are you utilizing any complementary therapies at this time (herbs, supplements, relaxation techniques, etc.)? ***Yes*** ***No*** If yes, please describe:_____

ADVANCE DIRECTIVES

Do you have a living will? ***Yes*** ***No***

Do you have a durable health care power of attorney? ***Yes*** ***No***

If yes, please bring a copy to be scanned into your electronic medical record.

RESOURCES

Please list any social service or cancer support agencies assisting you:_____

Are you receiving assistance from the Leukemia and Lymphoma Society? ***Yes*** ***No***
If yes, please indicate the type of assistance:_____,

Are you receiving financial assistance from any program/organization? ***Yes*** ***No***
If yes, please indicate:_____

If you live 60 minutes or more from the Cleveland Clinic and would like information about lodging accommodations you may call our Lodging Coordinator at 216-444-5461.

Discounted parking options are available. Please see any valet desk for purchase.

Please list any other information you would like us to know about you or any questions you may have.

_____

_____

THANK YOU!
BMT Social Work Team

Please bring the completed form to your social work appointment.