

**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.