A HANDBOOK ON STATISTICAL REPORTING
IN THE FIELD OF
MEDICAL SOCIAL SERVICE

PREPARED BY A JOINT COMMITTEE OF THE
American Association of Hospital Social Workers
AND THE
Advisory Committee on Social Statistics in Child Welfare and
Related Fields of the United States Children's Bureau

JUNE 1933
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LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
CHILDREN'S BUREAU,
Washington, April 18, 1933.

MADAM: I have the honor to transmit herewith the second handbook on policies and procedures in a special type of social-statistics report, prepared in connection with the Bureau's project for the registration of current social statistics in child welfare and related fields. The first handbook, which was published in June 1932, dealt with records and statistics in the field of public-health nursing. It was prepared by a joint committee representing the National Organization for Public Health Nursing and the Bureau's advisory committee on social statistics.

The handbook on statistical reporting in the field of medical social service here presented, has been prepared by a joint committee representing the American Association of Hospital Social Workers and the Bureau's advisory committee on social statistics. This committee was organized in the fall of 1928. Agnes H. Schroeder, who served as chairman; Edith Baker; and Fanny L. Mendelsohn (until her resignation in July 1932) represented the American Association of Hospital Social Workers. Raymond Clapp, Ralph G. Hurlin, Harry L. Lurie, and A. W. McMillen represented the committee of the Association of Community Chests and Councils and the Local Community Research Committee of the University of Chicago, which at the time of the joint committee's organization was in charge of the social-statistics project.

When the project was transferred to the Children's Bureau on July 1, 1930, the former representatives of the social-statistics committee were appointed to represent the Bureau's advisory committee on social statistics. Katharine F. Lenroot and Kathryn D. Goodwin of the Bureau staff were appointed as Bureau representatives, and Miss Goodwin succeeded Mr. McMillen as committee secretary. In July 1932 Emma A. Winslow, the Bureau's newly appointed director of social statistics, replaced Miss Lenroot as one of the Bureau's representatives.

As is described by Miss Schroeder in the foreword, the committee has considered in detail the points to be covered in statistical recording in the field of medical social service and has conducted certain cooperative experiments upon which to base its specific recommendations as to items for statistical reports and desirable methods of compilations. The plan for reports here advocated is the result of long-continued study by persons closely associated with reporting problems in the field of medical social service. It has been adopted by

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LETTER OF TRANSMITTAL

the Children's Bureau for use for monthly reports during 1933 in the metropolitan areas cooperating in the Bureau's social-registration project.

Although there is still much to be done in perfecting the statistical recording of medical social work, it is believed that the handbook transmitted herewith will contribute greatly to that end.

Respectfully submitted.

Hon. Frances Perkins,
Secretary of Labor.

Grace Abbott, Chief.
FOREWORD

The aim of the joint committee of the American Association of Hospital Social Workers and the committee on the registration of social statistics has been to formulate a method of statistical recording in the field of medical social work that will enable those who use it to express numerically the volume of medical social work done. Any method of statistical recording must be adapted to the processes it is intended to measure, and must change as they change.

The difficulties which have faced the joint committee have been due in large measure to the fact that medical social work, as one of the special applications of the social case work method, is still emerging, with certain functions defined and others in the process of clarification. In the selection of essential services to be counted, the committee has relied on authoritative source material, such as the Functions of Hospital Social Service and the statement of Minimum Standards to be met by Hospital Social Service Departments (see appendix A). However, as medical social workers are engaged also in other activities than those as yet defined, the committee has attempted through experimentation to formulate a tentative list of the additional activities of medical social workers. It is evident, therefore, that the project of evolving a method of statistical recording in medical social work should be a continuous one and that, as practice becomes more clearly defined, statistical recording should keep pace with developments.

In spite of the difficulties it is apparent that the effort to begin is not untimely. Social workers have long used statistical reports as a service-accounting device, and community funds and welfare federations have gathered service statistics from an increasing number of agencies and cities in the last decade. As these figures are being used for the purposes of interagency and intercity comparisons of the amount of service rendered and its cost, it is imperative that earnest effort be made to develop a method of statistical recording which takes cognizance of qualitative factors and accepted standards of work, although it may not attempt to measure them.

The following objectives of statistical recording in the field of medical social work are suggested:

1. To keep account of the volume of service rendered to patients by medical social service throughout the country.
2. To show change in volume of service from time to time; i.e., month to month and year to year.
3. To obtain facts of value in making comparisons, such as comparisons of the work of different social-service departments and of medical social work with other social-work activities.
4. To yield facts of value in making decisions within the social-service department, and by the hospital administration.
5. To furnish a means of interpreting the work to those who support it.

The plan here described attempts to achieve these objectives. The figures obtained give an unduplicated count of patients served through social examination, social treatment, and other recorded services, and show the relationship between the number of patients receiving such services. In order to compare the activity of individual staff members, more information than is in these monthly statistical reports will be needed. Comparison of the reports of individual workers will be significant, but the reports for the department as a unit cannot give a complete picture of the activity of an individual worker. When the comparison of the reports of individual workers reveals a need for the evaluation of a worker's activities, a job analysis and the study of recorded work are indicated.

In formulating the plan for statistical recording the committee has consulted with certain standing committees of the American Association of Hospital Social Workers. Members of the committee on functions, the committee on minimum standards, and the records committee have been especially helpful. The chairman of the committee on functions has attended meetings of the committee on statistics and has presented to her committee certain questions for its consideration. The studies on which the committee on functions is working at present will undoubtedly throw further light on the determination of the units of count.

The committee on minimum standards has furnished valuable advice as to the emphasis to be placed on certain standards in defining the field of medical social work in relation to statistical reporting. This committee is working out a method for applying its recommendations on minimum standards to be met by hospital social service departments, which will be of definite service in selecting departments to use the statistical forms suggested in this handbook.

The records committee has been interested in statistical recording since 1922, as is shown by the annual report of that year. A statistical reporting project in cooperation with the Russell Sage Foundation has been conducted since 1927 by the records committee of the North Atlantic district of the association. The committee on statistics has relied on the recommendations of the records committee of the association for the record outline conforming to the minimum standards form, which has been used in the definition of medical social case recording. Contact with the experience gained in the collection and publication of monthly reports by the North Atlantic district of the association has been maintained through the membership on the statistics committee of Mrs. Fanny L. Mendelsohn, chairman of the records committee of the North Atlantic district, and Ralph G. Hurlin, of the Russell Sage Foundation.

The work of the committee on statistical recording has included the determination of units of count, their definition, and the construction of statistical-record forms. The problem is akin to problems of case work in other fields, such as family case work or child welfare, but is complicated by the fact that medical social work is carried on under the auspices of a medical institution. The extent and form of medical social work is determined to a degree by the requirements of medical and hospital programs. The requirements of medical practice and hospital procedure result in certain emphases in case work, and in

1 A Medical Social Case Record Form; see appendix B.
FOREWORD

participation of the social-service department in activities not originally anticipated; for example, in the admission of patients to the hospital or clinic, and in medical follow-up work.

One of the most helpful factors in the development of the plan has been the cooperative assistance of certain social-service departments in the use of the experimental schedules. The committee is greatly indebted to these departments for their assistance, which resulted in the clarification of some difficult problems and important modifications of the plan for statistical recording outlined in earlier reports of the committee.

During the summer and early fall of 1931 the tentative plan described in the first report issued by the committee (July 1931) was tried by 28 social-service departments in 7 cities throughout the country, in which 1 or more workers were selected to compile their statistics according to the recommended plan. The time period was in most cases a month, though in a few instances it was shorter. The results of the experiments, including questions and comments, were sent to the committee for consideration at its meeting on November 6 and 7. As a result of some of the questions raised and because the committee felt that the experimental period had been too brief, it was decided to continue the experiment through another year.

The trial of the plan indicated that the major items on the schedule seemed to be appropriate. However, no information was provided on the number of individual patients served and the committee felt that further effort should be made to develop a plan for recording such information by social-service departments. A difficult point to determine was the unit of count for services to patients not taken under social treatment. The committee agreed that the most desirable unit would be the number of patients served, but such a count presented certain difficulties in record keeping. Some departments, however, felt that such a measure was of great importance to them, and the committee accordingly prepared a revision of the statistical plan to provide for the count of individual patients served in place of the count in terms of interviews recommended in the first report of the committee. In the revised report issued in January 1932 the new plan was designated as plan B and presented as an alternative to the original plan, which was designated as plan A.

During 1932, 10 of the departments that had already experimented with the form and 4 others agreed to use the tentative plan for a longer period. The periods covered were as follows: Entire year or remainder of year, beginning in February, 9 departments; remainder

1 The following departments participated in the trial of the plan during the summer and early fall of 1931:
   Boston: Boston Dispensary, Children’s Hospital, Massachusetts General Hospital, and Peter Bent Brigham Hospital; Chicago: Chicago Lying-in Hospital, Children’s Memorial Hospital, Cook County Hospital, Jewish Tuberculosis Service, Mandel Clinic of Michael Reese Hospital, Psychiatric Service of Michael Reese Hospital, Presbyterian Hospital, University of Chicago Clinic, and Women’s and Children’s Hospital.
   Cleveland: University Hospitals, Charity Hospital, City Hospital, Mount Sinai Hospital, St. John’s Hospital, and St. Luke’s Hospital.
   Nashville: Vanderbilt University Hospital.
   New York: Mount Sinai Hospital, Grasslands Hospital, and Presbyterian Hospital.
   St. Louis: Jewish Hospital, St. Luke’s Hospital, St. Mary’s Hospital, and Washington University Clinics.
   San Diego: American Red Cross (United States Naval Hospital).

2 Departments that participated during 1932:
   Plan A: Grasslands Hospital, Valhalla, N. Y.; Children’s Memorial Hospital, Chicago, Ill.; Vanderbilt University Hospital, Nashville, Tenn.; Boston Dispensary, Boston, Mass.; and Jewish Hospital, St. Louis, Mo.

   Plan B: Johns Hopkins Hospital, Baltimore, Md.; Massachusetts General Hospital, Boston, Mass.; Mount Sinai Hospital, Cleveland, Ohio; Michael Reese Hospital, Chicago, Ill.; Mayo Clinic, Rochester, Minn.; Graduate Hospital of the University of Pennsylvania, Philadelphia, Pa.; University Hospitals, Cleveland, Ohio; American Red Cross (Walter Reed Hospital), Washington, D.C.; Washington University Clinics, St. Louis, Mo.; and Barnes Free Skin and Cancer Hospital, St. Louis, Mo.

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of year, beginning in May, 1 department; four months, beginning in March, 4 departments. Copies of the monthly reports were sent to the committee, and in the course of using the plan valuable suggestions and criticisms were offered. Whenever possible, members of the committee met with local groups, and on several occasions special questions were submitted to the participants.

On July 9, 1932, the committee met in Cleveland to study the reports and the other material that had been sent in. On the basis of the figures yielded by the schedule and the reactions of those who were using both plans, the committee decided to adopt plan B for general use in 1933. Certain changes and corrections were made in the schedule and in the handbook, mainly for the purpose of clarification and to secure accuracy and consistency with accepted practice. It was agreed to recommend that the count of patients receiving other than full case-work service be made only in hospitals having satisfactory methods for making this count. In the earlier reports of the committee, a method of making such counts from index cards was described. Following further experimentation, a simpler method for obtaining this information was devised and is included in this report.

The experiments revealed lack of uniformity in reporting "steering" or "cooperative" work, and in recognition of the value of reporting separately this type of service, it was decided to refer this question to the social-service departments cooperating in the experiment and to certain members of the American Association of Hospital Social Workers. The replies to the questionnaire on steering service indicated that there is wide variation in practice. As with other questions that need further study in the field of medical social work, the committee suggests that, for the present, the conclusions reached from the study of the replies be used as a basis for statistical recording. These findings have been incorporated in the schedule for the monthly report described in this handbook.

As the functions of medical social work become more clearly defined, and as the possibilities of qualitative statistical measurement of medical social case work are clarified, it is expected that further developments will be made in the methods of statistical recording. It is hoped that through actual use of the forms included in this handbook, suggestions will be obtained that will be of value in pointing the way.

Agnes H. Schroeder, Chairman.
Chapter I.—DEFINITION OF THE FIELD OF MEDICAL SOCIAL SERVICE

A clear definition of the field of medical social service must precede any collection of statistics that seeks to extend beyond the activities of a single department. Thus, if the council of social agencies or a local committee of the American Association of Hospital Social Workers wishes to obtain a picture of the total service rendered by hospital social service in a given city, it should be possible for either of them by applying this definition, to determine which departments should be included and which should be excluded. Moreover, a total figure for one city obtained in this way could then safely be compared with the total figure for another city, if the latter has also scrupulously followed the definition of the field in compiling its data.

The purpose here is to indicate the attributes by which hospital social service may be identified, rather than to set a standard toward which departments should aim. The fact that a department does not fall within the field as defined below does not imply that such a department is doing poor work. But it means that, for the purposes of statistical comparisons, the department in question lacked some of the elements common to all the other services and should neither be compared with them nor added to them to obtain a homogeneous total for the city.

The committee on functions of the American Association of Hospital Social Workers presents in its published report a discussion of the social factors in the lives of patients that, because of their effect upon medical problems, may be considered the concern of hospitals and especially of hospital social service departments. It states:

Social factors which appear in hospital practice fall into three main categories:

1. Social conditions which bear directly on the health of the patient, either inducing susceptibility to ill health or helping or hindering the securing and completing of medical care.

2. Social distress caused to others by the illness of patients; such as loss of income, neglect of children, and so forth.

3. Social problems not having direct cause-and-effect relation to the health condition, but collateral to it. Such problems would exist independently of the sickness.

These factors exist in many possible combinations. The functions committee points out that the social factors falling into class 1 are the proper and special concern of the physician, and therefore of the hospital, and that much of the social work done under hospital auspices will fall into this class. The meeting of social needs caused by sickness (class 2) is in greater measure the responsibility of the community outside the hospital. The social problems of the third

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1 The Functions of Hospital Social Service, p. 59.
class seen to fall outside the aim of the hospital, although even these problems may be important in relation to the whole view of the patient's medical problem. The committee states:

For this collateral problem the hospital must, when necessary, try to find resources outside of medical auspices, whether within the immediate patient-group or in one of the community's agencies. The hospital must indeed at times seek such resources beyond its own walls in all three types of social complication. And in all three types there will be cases in which the whole treatment, medical and social, will fall within the purpose of the hospital and may best be accomplished under its auspices.²

With this classification of the problems that may be considered the primary concern of social-service departments of medical institutions in mind, the committee at its meeting November 8, 1929, adopted the following definition of the field of medical social service upon which to base its plan for statistical reporting:

*The field of medical social service includes departments doing medical social examination and treatment in distinctly medical institutions or centers, and meeting the minimum standards adopted by the American Association of Hospital Social Workers.*

It will be observed that, in this definition only such departments are included as are engaged in medical social examination and treatment. The admitting department of a hospital, if administratively distinct from the social-service department, does not fall within the field, but departments of medical social service that handle admissions as one of their functions are included in the field, provided they meet the minimum standards set forth below.

At its meeting on April 26, 1930, the committee formulated and adopted the following definitions for medical social examination and for medical social treatment:

*A medical social examination is a study of the personality and environment of the patient in order to discover the social and psychological factors influencing the physical or mental health of the patient, social problems coexistent with the health condition, and to reveal both the causes of the problems and the elements on which treatment may be built, when indicated. It is differentiated from the interview or inquiry that is primarily for the purpose of ascertaining the economic and medical eligibility of patients for clinic or hospital admission.*

*Medical social treatment is the attempt to carry into effect a plan whose purpose is the adjustment of the social problems of the patients as revealed by the medical and social examinations. Responsibility may be carried solely by the medical social workers or in cooperation with others.*

It is assumed that the various steps taken in social examination and treatment will be recorded in summary form or in chronological order as described in the medical social case record outline. (See appendix B.)

The definition of the field stresses the fact that work in this field is conducted "in distinctly medical institutions or centers." Thus the case-work departments of maternity homes, which are primarily domiciliary institutions, are not included in the definition of the field of medical social service, though it is understood that many hospital social service departments which do belong in the field will render case treatment to unmarried mothers. Likewise, societies for the handicapped may often use techniques and pursue objectives similar to those of medical social workers, but, since they do not function in and as a part of a medical institution or center, they do not belong within the field of medical social service.

² Ibid., pp. 59-60.
DEFINITION OF THE FIELD

A word must be said relative to psychiatric social work in medical institutions or centers. It is not intended to include the entire field of psychiatric social service in the field of medical social service. It is recognized, however, that many medical social service departments include psychiatric social work as one of the functions of the department. Such services should be considered as included in the field of medical social work. The term "medical" as used throughout this report includes "psychiatric" wherever such combination prevails.

Departments doing medical social examination and treatment in distinctly medical institutions or centers may still not fall within the definition, because they must also meet at least these minimum standards of the American Association of Hospital Social Workers:  

Medical social case work must be the major activity of the department.

The department must keep case records  

that:

a. Identify the case accurately.

b. State clearly the reasons why medical social study and treatment were or were not undertaken.

c. Describe the problems presented, those dealt with, and the social treatment given.

d. State, when the case is closed, the reasons for closing and the status of the case at that time.

The head of the department must be eligible for active membership in the American Association of Hospital Social Workers.

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1 For full statement of minimum standards of the association see appendix A.
2 See medical social case record form, appendix B.
3 See membership requirements of American Association of Hospital Social Workers, appendix C.
Chapter II.—UNITS OF COUNT FOR STATISTICAL REPORTS

The most difficult task in preparing a statistical system for departments of medical social service is to decide upon and to define the units in terms of which the volume of service may be measured. A study of the units that have been used from time to time yielded a large number of class names, such as "intensive service," "slight service," "short service," "steering case," and "contacts." It is unlikely that these terms, as they have been used, have been given verbal definition sufficiently exact to be statistically acceptable. This situation is not peculiar to hospital social service, but exists also in other fields of social work.

Since in this field social-service intake is usually limited to hospital and clinic intake, it is important to know how many patients admitted to the hospital or clinic come to the attention of the social-service department, and, of this number, how many receive social case work, and how many receive other forms of social service. The basic measurements of the volume of medical social case work may be assumed to be: (1) The number of patients who are given a social examination, and (2) the number who are given social treatment. In addition to social examination and treatment other services are performed by medical social workers that have a bearing upon the care of patients. Various measures have been suggested for this type of service, but because considerable importance is attached to the relation of the number of patients served by the medical institution to the number receiving service from the social-service department, the committee recommends a measure in terms of the number of patients served.

The intake of the social-service department, as stated above, is usually limited to the intake of the hospital or clinic. The total case load of the department, however, may include some cases of persons not actually patients. For example, an individual who has been discharged from medical care may require the continuation of specific case-work processes begun while he was a patient. A person requiring continued medical social care, such as a cardiac, syphilitic, or diabetic, may not have kept his clinic appointments, although not discharged by the physician. In occasional instances patients merely under observation may be included.

The items suggested for monthly reports and adopted by the Children's Bureau for use in its social registration project are shown on pages 5 and 6.

The form for monthly reports is divided into six sections: Section A, patients given full recorded social examination; section B, patients under social treatment; section C, patients receiving other recorded social service; section D, admitting service; section E, relief; and section F, staff. Sections A and B will provide the most significant material for comparisons and evaluation of departments, since they provide the measure of the volume of case-work service. Sections C and D will make it possible to measure the varied services rendered by the
### MEDICAL SOCIAL SERVICE

**Agency:**

**Street:**

**City:**

**Month:**

**(Name of person filling out report)**

**(Report should coincide with calendar month)**

#### A. PATIENTS GIVEN FULL RECORDED SOCIAL EXAMINATION.

1. Examinations initiated during month

2. Examinations terminated; not taken under social treatment

#### B. PATIENTS UNDER SOCIAL TREATMENT.

3. Carried over from preceding month (Item 7 last month)

4. Intake: Total
   - a. New
   - b. Old (Last under social treatment prior to January 1)
   - c. Recurrent (Last under social treatment during this calendar year)

5. Total patients under social treatment during month
   - a. Active
     - (1) Cooperative-service cases included in item 5a
   - b. Inactive

6. Discharged from social treatment during month

7. Carried forward to following month

#### C. PATIENTS RECEIVING OTHER RECORDED SOCIAL SERVICES.

8. Patients served for the first time this year

9. Total receiving service during month
   - a. Receiving interpretative service
   - b. Receiving administrative service
   - c. Receiving discharge service
   - d. Receiving medical follow-up service

10. Cooperative-service cases included in item 9

#### D. ADMITTING SERVICE.

11. Patients interviewed for admission to hospital

12. Patients interviewed for admission to out-patient service

13. Applicants refused admission

#### E. RELIEF. (From social-service funds)

<table>
<thead>
<tr>
<th>Number of Patients</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>14. To patients reported in section B</td>
<td>$...</td>
</tr>
<tr>
<td>15. To patients not reported in section B</td>
<td>x x x</td>
</tr>
<tr>
<td>16. Total</td>
<td>x x x</td>
</tr>
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</table>

[OVER]

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<table>
<thead>
<tr>
<th>F. STAFF.</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Paid staff: Total on last day of month (Report part-time workers fractionally).</td>
<td></td>
</tr>
<tr>
<td>a. Administrative workers</td>
<td></td>
</tr>
<tr>
<td>b. Supervisors and case workers</td>
<td></td>
</tr>
<tr>
<td>c. Clerical and all other</td>
<td></td>
</tr>
<tr>
<td>18. Number of social workers in training.</td>
<td></td>
</tr>
<tr>
<td>a. Hours of service during month</td>
<td></td>
</tr>
<tr>
<td>19. Number of volunteer workers</td>
<td></td>
</tr>
<tr>
<td>a. Hours of service during month</td>
<td></td>
</tr>
</tbody>
</table>

Please read carefully the instructions for filling out this form.
social-service department to patients of the hospital or clinic. These are the services which have been measured heretofore in terms of "slight service." It is not to be assumed that these services are unimportant, nor that they lack qualities of social case work. They are not, however, the major function of the medical social-service department. (See appendix A.) Sections E and F will provide valuable material for comparisons in regard to policy and case load. Although these classifications are apparently simple, further explanation is necessary if they are to be interpreted uniformly.

Section A.—PATIENTS GIVEN FULL RECORDED SOCIAL EXAMINATION

Item 1. Examinations initiated during month.
Item 2. Examinations terminated; not taken under social treatment.

As defined by the committee, a medical social examination is a study of the personality and environment of the patient in order to discover the social and psychological factors influencing the physical or mental health of the patient and the social distress created by the illness of the patient or social problems coexistent with the health condition, and to reveal both the causes of the problems and the elements on which treatment may be built. It is differentiated from the interview or inquiry, which is primarily for the purpose of ascertaining the economic and medical eligibility of patients for clinic or hospital admission.

The records committee of the American Association of Hospital Social Workers has prepared an outline for the recording of this type of examination. (See appendix B.) The kind and amount of social history recorded will vary somewhat according to the needs of the individual patient and his social situation, as is stated in the introductory section of the outline. Only those examinations which are recorded in a manner that will meet the essential requirements of this outline should be counted under section A.

Each individual patient should be counted separately. Thus if the social needs of Mr. and Mrs. John Brown are scrutinized, two units are recorded in section A provided that both Mr. and Mrs. Brown are patients of the institution in which the department functions. But if Mr. Brown is a patient and Mrs. Brown is not a patient of the institution, only one unit is recorded in section A, even though the social needs of both husband and wife are considered. If, however, Mrs. Brown becomes a patient at a later date, she may be counted as receiving a social examination in the month in which she is accepted for social treatment.

In item 1, section A, should be counted the fully recorded social examinations undertaken during the month; thus a patient whose social examination was undertaken in January and carried over into February would be counted in January only.

The number of patients given a social examination and the number taken under treatment will not necessarily coincide, because not all the patients examined will be accepted for treatment. Also, some patients taken under social treatment will be recurrent cases and will not require a reexamination. In order to obtain an unduplicated count of patients given full recorded examinations during the year, patients should be counted only once in this section during a calendar year. Therefore, when a patient who has formerly received social treatment from the department is given a social examination to determine whether
he needs further social treatment, he should not be counted in section A if an examination has been counted within the calendar year. If he is again taken under treatment, he should be counted in the appropriate subdivisions of section B; if not, the service should be counted in section C, item 9.

When a patient who was discharged from social care previous to the calendar year is again given a social examination, he may be counted under section A. If the decision is against giving the patient further social treatment, service should not be counted in section B, even though the decision may be recorded in the old case record. The service, if recorded, would be counted in the most appropriate item of section C if it occurs in a month subsequent to termination of the examination process. (See p. 14.)

In item 2 should be entered the number of social examinations terminated during the month in which it was decided not to accept the patient for social treatment. Services for these patients after the closing of the examination may be reported in section C.

**Section B.—PATIENTS UNDER SOCIAL TREATMENT**

Item 3. Carried over from preceding month (item 7 last month).

Item 4. Intake: Total.

(a) New.

(b) Old (last under social treatment prior to January 1).

(c) Recurrent (last under social treatment during this calendar year).

Item 5. Total patients under social treatment during month.

(a) Active.

(1) Cooperative-service cases (included in 5a).

(b) Inactive.

Item 6. Discharged from social treatment during month.

Item 7. Carried forward to following month.

The number of patients under social treatment is reported in section B. Those patients who are accepted for social treatment during the month will be reported in item 4 and its subdivisions in the month accepted.

Medical social treatment, as defined by the committee, is the attempt to carry into effect a plan whose purpose is the adjustment of the social problems of the patients as revealed by the medical and social examinations. Responsibility may be carried solely by the medical social worker or in cooperation with others. It is assumed that the various steps taken in medical social treatment will be recorded in summary form or in chronological order as described in the outline for medical social case records. (See appendix B.)

The great variation in the present practice in cooperative service, often termed steering service, has made definition of this type of service difficult. So many social-service departments have expressed the wish to keep a separate count of such services for purposes of interpretation that the joint committee has formulated the following tentative definition:

_Cooperative service_ is rendered when the workers from a case-work agency assume responsibility for supplying the social history, for arranging to have the patient come to the clinic for examinations and treatment, and for attending conferences when indicated; and when the medical social workers assume responsibility for interpreting the social information to the doctor, interpreting the medical condition and recommendations to the patient and the other agency, assisting the latter in carrying out the treatment measures, and reporting to the agency any changes in the physical condition of the patient.
The type of responsibility assumed by the medical social-service department for this kind of service varies greatly in different communities. Some social-service departments maintain a continuing responsibility for service to the patient as well as for the interpretation to the agencies of information concerning the patient, and in these departments patients thus served should be reported in section B. This type of service in other departments conforms more nearly to the definition of interpretative service (p. 13). In these departments patients so served should be reported in section C, item 9a.

In item 3 in section B is recorded the number of patients under social treatment at the opening of the month's work. In item 4 should be reported the total intake of patients taken under social treatment during the month. Many of these will be patients who are also counted in section A as having received social examination during the month. Some may be former patients well known to the department, not counted in section A for this month, who are again taken under social treatment.

Item 4 is subdivided to show the number of patients who are new, old, and recurrent. New patients are those never previously accepted for social treatment by the department. Old patients are those who have previously been under social treatment by the department, but who are now taken under treatment again for the first time since the opening of the present calendar year, January 1. Recurrent patients have also previously been under social treatment by the department but have already been counted once this year. This distinction between old and recurrent patients is important, because from it an unduplicated total of the number of different patients under social treatment during the year may be computed. This is done by adding items 4a and 4b for each of the 12 months of the year to item 3 for January.

Patients transferred from one worker to another within the same department should not be included in the total intake for the department, but should be listed as received by transfer in the individual reports of the workers, as described on page 27.

The total number of patients under social treatment (item 5) is the sum of items 3 and 4. Departments will find this figure useful in watching the trend in the total number of patients under care from month to month. The subdivision of this item to show the number active and inactive gives a further valuable means of evaluating the work of the department.

Patients under active social treatment are those with whom, or in behalf of whom, the social worker has had during the month some contact related to the attempt to carry out the treatment plan. Contacts may be interpreted as interviews, conferences, telephone and telegraph communications, or letters. It is a general rule that when there are several patients in a family, all under social care, activity during the month in behalf of one patient will be counted for each patient in the family group.

Because of the importance of knowing the number of patients under active social treatment who were cooperative-service cases as defined above, provision has been made for their separate recording.

Patients under inactive social treatment are those for whom the social worker anticipates the need for further case-work service but
with whom or in behalf of whom no contact has been made during the current month. This may be due to either the nature of the treatment plan at the time or the conditions in the social-service department, such as absence of workers or pressure of work.

In item 6 is recorded the number of patients whose social treatment is discontinued during the month. Patients discharged from medical social treatment by transfer to another agency should be counted in this item, and in the month of transfer the case is counted as active. A case transferred to another agency is understood to be one in which all responsibility for continuing the case work is relinquished. A case referred is one in which another agency has been asked to cooperate, but in which both agencies continue service. Such a case would therefore continue to be counted under medical social treatment.

Patients whose social treatment is terminated, even though the patient may still be receiving medical care from the institution in which the department functions, should be counted in item 6. Patients should not be counted in item 6 simply because they are discharged from further medical care unless they are also discharged from further social treatment by the medical social-service department. If several members of a family are patients and under social treatment, one member may be discharged although the others remain under social treatment. For example, a tonsillectomy may be arranged for a child whose mother has heart disease. The child may be discharged from social treatment after the medical care has been completed, although the mother remains under social treatment.

The total number of patients whose social treatment is terminated during the month, if subtracted from item 5, should give the number still under social treatment at the close of the month’s work. It is desirable that an actual check be made of the patients still under treatment at the close of the month to determine whether their number corresponds with the figure obtained by subtracting item 6 from item 5.

Patients transferred from one worker to another in the same department should not be included in the total number discharged but should be listed as transferred to other workers in the reports of individual workers, as later described (p. 27).

The foregoing instructions relate to the recorded case work activities of departments of medical social service. These case-work activities, by common consent of the committees on functions and on minimum standards of the American Association of Hospital Social Workers, constitute the function of social-service departments.

Section C.—PATIENTS RECEIVING OTHER RECORDED SOCIAL SERVICES

Item 8. Patients served for the first time this year.
Item 9. Total receiving service during month.
(a) Receiving interpretative service.
(b) Receiving administrative service.
(c) Receiving discharge service.
(d) Receiving medical follow-up service.
Item 10. Cooperative-service cases included in item 9.

In addition to their primary function of social case work, medical social-service departments accept responsibility for serving patients in other ways. Many of these services require for their performance
case-work techniques and subject matter. Some of the services rendered by social workers are so slight that no record is made of them. Others, however, have a permanent value for future contacts with the patient and are recorded either in the records of the social-service department or in the patient's medical history. In carrying out these services, unless they were preceded by a social examination without acceptance for treatment, medical social workers do not make intensive social examinations and may not record the services in the accepted case-work method. Examples of these services are: Determining the advisability of furnishing appliances; assisting the physician in his diagnosis and aiding him in adapting treatment to the individual patient; interpreting to the patient his medical condition or the medical institution; securing continued attendance of a patient until medical treatment has been completed; and ascertaining that the patient has adequate facilities for care after discharge from the hospital. All these activities may serve as a "screening" process by which social problems may be discovered. The social worker may then undertake to serve the patient through medical social case work, but for many of the hospital's patients the less complete service only is rendered.

The committee agreed that items should not be included in the monthly report which serve no purpose except accounting for the time of the workers and decided that it is desirable to include in a monthly report a count of only those services that are recorded in such a way as to be useful in future contacts with the patient. Thus if a patient is interviewed at the institution with respect to some confusion concerning his appointments, but no other service is rendered, and no entry regarding the interview is made in either hospital or social-service department records, such a service would be regarded as an "unrecorded" service and would not be included in the monthly report.

Since services of sufficient importance for recording are, in general, undertaken for a specific purpose, it is assumed that at least a partial social inquiry is conducted to discover the relevant social factors. Such inquiries are less complete than the medical social examination in purpose, scope, and method of recording. The facts pertinent to the situation are recorded in the medical charts or in social records, according to the policy of the particular social-service department. The content of such recorded material includes identifying data, personal history, financial data, and reports of social agencies. Any combination of these, or all of them, would be included in accordance with the need of the particular patient under care.

In other words, a "recorded" service is something more than a tally on a day sheet, or notes on a statistical card or in the worker's notebook. It involves the entering of information that can subsequently be identified if the same patient comes again to the department. The committee does not wish to imply, however, that it uses the term "recording" in any formal or stereotyped sense. The essential attributes of "recording" are:

1. That the information can be identified in case of future contacts with the patient.
2. That the information is of such a character that it has potential utility in the medical care of the patient or in any future social case work that may be undertaken.
The determination of the exact nature and the naming of the services that do not represent a complete case-work service is the responsibility of the professional group. The association's committee on functions is now working on a study that will undoubtedly throw light on the nature of these services. When this study is completed, more authoritative units of count may be devised. In view of the facts that social-service departments have been cooperating in the registration of social statistics and that it is very likely that the current studies of the committee on functions will not be ready in the near future, the joint committee on statistical recording has adopted a tentative classification of the services which, although not to be classified as medical social case work, are to be counted as social services.

It will be observed that while noncase-work services are distributed according to functions, this is not done for case-work services. The committee does not imply that analysis of the services involved in case-work processes is of less importance. It considers, however, that such analyses require individual record study and could best be made through periodic reviews rather than in current monthly summaries.

The problem of classifying services was attacked through a special study carried on in three representative departments during 1930. This study ignored the recorded case-work activities and sought to obtain a picture of only the recorded services other than case work. From this study four general classifications were developed: (1) Admission, (2) interpretation, (3) discharge, and (4) follow-up. Subsequent study indicated that in addition to these classifications a fifth, which has been called administration, should be added, and that admission service could best be regarded as an independent unit, since practice in regard to its performance by social workers varies widely. It is recognized, of course, that at present social-service departments vary in their responsibilities for performing these services. Some departments perform all of them, some only certain of them, and others none.

The description and classification of these other services proved to be a difficult task, and the committee does not assert that its conclusions are final but recommends the use of the suggested classifications until a more satisfactory means of measuring these services can be devised.

Services may be in the form of interviews either with the patient himself, or in behalf of the patient with a relative, with the patient's "group", with professional persons or other interested individuals, inside or outside the institution, but not with members of the staff of the social-service department. They may be in the form of completed telephone calls or of letters, excluding form letters. Interviews may be in the ward, in the clinic, or elsewhere. They may be accompanied by some concrete action, such as directing the patient to another social or health agency or making arrangements with an employer for the return of the patient for further medical treatment, but such concrete action does not necessarily mean that the patient should be counted in section B. A certain action might in varying circumstances fall into a different category. The arranging of con-

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UNITS OF COUNT FOR STATISTICAL REPORTS

Valescent care might be a discharge service in one instance; in another, it might be definitely interpretative service. To be counted, however, these services must be of sufficient importance to be recorded either in the records of the social-service department or in the patient's medical history. Units of service are to be counted only if they are performed by professional social workers.

It is recognized that the services are not mutually exclusive because a service classified under one heading sometimes combines elements of the others. But it seemed to the committee that the most satisfactory plan was to establish the following general classifications, rather than to attempt to list a large number of specific services.

Interpretative service includes interviews or letters that seek to explain the medical institution or the social-service department to the patient, the patient's group, or social workers and interested individuals outside the hospital; or that endeavor to provide the professional personnel of the medical institution or the hospital authorities with a more adequate understanding of the patient. Such services when rendered in behalf of former patients may be included. It is granted that interpretation will usually be a part of every service, but it is the intention to include in this heading only services in which interpretation is the primary purpose.

Administrative service includes fee determinations subsequent to the admission of patients, advisory service to an admitting department, and recommendations as to whether appliances (such as glasses and braces) or drugs are to be given free or on partial payment by the medical institution or by the social-service department, when the patient is apparently unable to pay for them. Interpretation will undoubtedly be a part of these services; but if the purpose of the interview is administrative, the service should be so classified. In making recommendations, important considerations are the probable effect on the patient of giving such relief, whether the patient is likely to use it effectively, and the resources of the patient and the community.

Discharge service includes interviews for the purpose of finding out for the hospital authorities whether a patient who is about to be discharged has adequate facilities for care after his discharge, and any service performed by the social worker that has a bearing upon the patient's discharge from the hospital or clinic, including arrangements for valescent care, transfer to other institutions, or arrangements in connection with deaths.

Medical follow-up service is that rendered with respect to broken appointments, for the purpose of persuading the patient to return for further medical examination or treatment, and in making investigations to determine the end results of treatment procedures or to discover whether the patient's adjustment has been and is continuing to be satisfactory. Studies of medical follow-up work and of clinic management in the past have shown that effective interpretation at the patient's first visit and other important visits to the clinic reduce very materially the amount of follow-up work necessary. Medical follow-up service is often given to a patient formerly under social treatment and formerly included in section B. A closed case should not be reopened, however, for the sole purpose of recording a follow-up interview. If a case has been closed, the entry with regard to the
follow-up service would customarily be recorded in the old case record, but the count for the monthly report should be under section C only.

Patients should not be counted in section C if they have been included in sections A or B of the same month's report. Occasionally a patient whose social examination or treatment is the responsibility of one worker may receive from another worker a service that would fall within the definitions of this section. Although each worker would report the service on her daily report, as is described later, the patient should be counted only by the worker to whom the case is assigned for social examination and treatment. This procedure will prevent the inclusion of the patient in both sections of the report and duplication in the month's report for the department.

Patients who have received case-work service which has been terminated prior to the current month may be counted here if they receive subsequent service without again being taken under treatment. Patients who are counted in section C may later be counted in sections A or B; but if either social examination or treatment is begun within the same month as the other form of service, the patient should not be counted in section C.

As described later, the fact that a patient is counted in section D, as receiving admission service, will not affect the counts in other sections of the report.

Item 8 in section C provides for the entry of information on the number of patients who received during the month a recorded service other than a social examination or treatment, and who have not been counted previously since the beginning of the calendar year in section A or B. This count is an essential step toward obtaining an unduplicated annual count of patients served by the social-service department.

Item 9 records the number of different patients who received recorded services other than case work during the month, including those counted in item 8 as being served for the first time this year. Subdivisions of item 9 provide for the entry of information on the number of different patients receiving each of the four types of recorded service previously defined (interpretative, administrative, discharge, and medical follow-up). The sum of these subdivisions will not equal the total in item 9, since some patients will receive more than one of these types of service during the month.

In item 10 should be reported the number of patients who received recorded services, other than case work, from the medical social service department in cooperation with the services of another social agency. These cases will also have been included in item 9.

Section D.—ADMITTING SERVICE

Item 11. Patients interviewed for admission to hospital.
Item 12. Patients interviewed for admission to out-patient service.
Item 13. Applicants refused admission.

Admitting service includes the determination of medical and economic eligibility, through the consideration of the patient's medical need and the cost of the necessary medical treatment in relation to his resources and obligations.

Some institutions employ medical social workers as admitting officers, and these workers are administratively independent of the institution's department of medical social service. In such cases the patients interviewed by the admitting officers should not be included
in the monthly reports. In other institutions, the department of social service, in addition to carrying the responsibility for case work, may also handle the admissions in certain services, or have medical social workers assigned as admitting officers. Under such conditions the patients served should be counted in this section. If the admitting service is performed by clerks, even if they are administratively included in the social-service department, the service should not be entered, since this report deals only with services rendered by professional social workers.

When the social-service department is not responsible for admissions but may in certain instances act in an advisory capacity to an administratively separate admitting department, those services should be counted as "administrative" services in section C, rather than as admitting service in this section. Similarly, when a patient has not been admitted to the hospital by the social-service department but is interviewed by a social worker subsequent to admission in regard to rate determination or rate adjustment, this service, if recorded, should be counted in section C.

The section on admitting service is independent of other sections of the report, in that all patients interviewed in relation to eligibility for admission to the hospital and clinic are to be counted, regardless of whether they may also be counted as receiving other types of service; however, a patient should be counted only once in connection with each admission to the in-patient service of the hospital and only once during the year in regard to eligibility for clinic service, regardless of the number of contacts involved in these services.

Departments that carry responsibility for admissions may be able to secure the data for these items in the report from the admission records of the institution.

Section E.—RELIEF

Item 14. Patients reported in section B.
Item 15. Patients not reported in section B.
Item 16. Total.

Section E of the monthly report relates to relief. Departments that give relief either occasionally or as a regular practice should bear in mind certain definitions which must be observed if the relief reports are to be comparable from one institution to another. Relief includes not only special medical relief, such as orthopedic appliances or special dietary allowances, but also material relief, such as cash grants, loans, taxi fares, and aid in kind to patients of the hospital or clinic, when such relief is given from funds controlled by the medical social service department, either as a part of the budget allocated to it by the medical institution or as a grant from other sources. Supplies provided out of hospital stock, either with or without endorsement of the social-service department, should not be included as relief. Similarly, free or part-pay hospital care, even though granted upon advice of the social-service department, should not be included as relief. Communication expenses (car fare, telegrams, etc.) in behalf of patients and similar expenditures necessitated by the processes of social investigation and case-work treatment may be considered administrative expense, and it is recommended that they should not be regarded as relief.
Ordinarily relief will be in cash or in goods. Occasionally relief may be for service as, for example, when a woman is employed by the department to keep house for several children during the period of their mother’s hospitalization. In some institutions it is necessary to house patients temporarily in outside lodging houses or to provide meals, and such meals and lodgings provided patients and paid for by the social-service department should be regarded as relief.

The general rule to follow is to include as relief only funds that pass through the bookkeeping system of the department and are entered in the relief account. It is recommended that funds entrusted to the department for the care of a particular patient should not be entered in the relief account but should be kept in a special account. Money paid in advance by the department upon a definite guarantee of repayment should not be entered as relief.

The widely different accounting practices in regard to donations of used or second-hand goods makes it seem unwise to include such items in relief at the present time. New goods, however, are equivalent to cash; and if the department includes such donations in its books as cash receipts, the amount given may be included in the relief report in terms of the money value of their purchase price.

It will be noted that although the schedule asks for the amount of relief given to patients who are not under social treatment, it does not ask for the number of these patients. Some departments may wish to keep this information, but it was omitted in the plan for reports because in some instances the number to whom small amounts, such as lunches or car fares, were given was so great as to make recording a burden.

Section F.—STAFF

Item 17. Paid staff: Total on last day of month. (Report part-time workers fractionally.)
   (a) Administrative workers.
   (b) Supervisors and case workers.
   (c) Clerical and all other.

Item 18. Number of social workers in training.
   (a) Hours of service during month.

Item 19. Number of volunteer workers.
   (a) Hours of service during month.

The staff of the department should be reported in this section. It is desirable to report the paid staff as of the last day of the month. In large staffs several changes in personnel may occur during the month and an average figure for the month would therefore be burdensome to compute. It is simpler to report the staff as of the last day of the month, and occasional inaccuracies (such as would be caused by a worker’s leaving 3 days before the end of the month and being replaced 2 days after the opening of the new month) will usually cancel one another during the year. Workers absent on sick leave or vacation should be included even though they may not be on duty on the last day of the month. If vacation substitutes are employed, they should be counted as additional workers.

All employees of the social-service department, social workers in training, and volunteers giving regular service should be reported in this section. Psychiatric social workers attached to the department should be included and also social workers assigned to admitting service or other special work.
In item 17 (Paid staff) part-time workers and workers spending only a portion of their time in the work reported in previous sections should be counted fractionally, in units not less than one-fourth time. Workers whose duties might fall within more than one of the subdivisions of this item should be counted under the classification of major importance. For example, the head social worker should be reported as a case supervisor unless she has case supervisors under her direction, in which case the head worker should be counted as an administrative worker.

Students receiving social-work experience are to be counted in item 18 regardless of whether they receive a salary or maintenance from the organization. Volunteers, other than students, performing service for the social-service department should be included in item 19. Part-time students and volunteers are not to be counted fractionally, but the total number of individuals with whom the department has had a definite arrangement for service during the month should be reported, with the number of hours of service given.
Chapter III.—FORMS FOR STATISTICAL RECORDING

This chapter describes the forms recommended for use in recording data for the compilation of monthly statistics in accordance with the plan outlined in the preceding chapter. Three forms are presented: a daily tally sheet, a social-treatment card, and a statistical card.

DAILY TALLY SHEET

A suggested form for a daily tally sheet is shown on page 19. The items and their most useful arrangement will vary according to the special needs of each department and the availability of the desired statistical information from other sources. For example, departments carrying full responsibility for admissions may prefer to obtain figures for the monthly report from the hospital or clinic records, and omit columns 13 to 15 on the daily tally sheet. If the tally sheet is used for the individual recording of a large number of admissions, it is more convenient usually to have the columns for entry placed next to the patient's name and number rather than at the extreme right of the tally sheet as on the suggested form. In some departments all relief grants are reported on a special form, and entry on the daily tally sheet would be an unnecessary duplication.

The volume of work handled by each worker will determine whether a new tally sheet must be used each day. If a sheet is used for more than one day, each new date should be entered on a separate line. If a worker is absent on a given date, or has no services of the specified type to record, she should record the date and insert the remark "No entries this date."
# DAILY TALLY SHEET

Medical Social Service Department of  
(Medical institution)  

Date:  
(Month, day, year)  

Report of  
(Social worker's name)  

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Number</th>
<th>Cooperative-service case</th>
<th>Recorded services to patients not under social examination or treatment</th>
<th>Full recorded social examination</th>
<th>Social treatment</th>
<th>Admitting service</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)     (5)     (6)     (7)    (8)     (9)    (10)     (11)    (12)    (13)    (14)    (15)</td>
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As is described in the following chapter, the information entered on the tally sheet forms the basis for the counts for section A (patients given full recorded examination) of the monthly statistical report. When a full recorded social examination is initiated or terminated, the name of the patient is entered in column 1 of the tally sheet and the identifying number (social service, hospital, or clinic), in column 2. If the examination is initiated, a check mark (✓) is placed in column 9. If the examination is terminated without the patient’s being taken under social treatment, a check mark is placed in column 10. If the examination results in the patient’s being taken under social treatment, the check mark is placed in column 11.

According to the plan for statistical recording here recommended, a social-treatment card is made out routinely for all patients listed in columns 1 and 2, shown by a check in column 11 to have been taken under social treatment. The social-treatment cards, rather than the entries on the tally sheet, are used in making the counts for section B (patients under social treatment) of the monthly statistical report. The routine entry on the tally sheets of information on patients discharged from social treatment has value in providing a check on the completeness of the recording of this information on the social-treatment cards. Space is provided in column 12 on the tally sheet for such entry.

If the case is being handled in cooperation with another case-work agency, a check mark should be placed in column 3 as a means of insuring complete recording of this information on social-treatment cards for use in counting the number of cooperative-service cases for the monthly report.

The counts on patients receiving certain recorded social services for the first time this year and during the current month (section C of the monthly report) are made from information transferred to statistical cards from the tally sheets, or directly from the tally sheets following coding from information on the statistical cards to eliminate duplication in the count of patients receiving the same type of service more than once. It is essential, therefore, to enter on the tally sheet each day the name and number of each patient receiving interpretative, administrative, discharge, or medical follow-up service. If it is a cooperative-service case, this should be designated by check mark in column 3. Check marks are made in columns 4 to 7 to show all forms of services rendered to the patient during the day, whether or not such services have been reported at some previous time.

Entries in the columns on admitting service (13 to 15), for section D of the monthly report, may be check marks in relation to the entry of the names and numbers of individual patients in columns 1 and 2. Departments that prefer to obtain all counts on admitting service from other hospital or clinic records may enter the total number for the day in the appropriate columns on the daily tally sheet, or omit all entries on the tally sheet with reference to admitting service, as described above.

Information on the amount of relief to patients under social treatment (item 14 in section E of the monthly report) is received from data entered by the case worker directly on the social-treatment cards. Information on the amount of relief provided to other patients (item 15 in section E) should be entered separately for each case in column 8 of the tally sheet. Certain departments, especially those...
in which relief is given infrequently, may prefer to enter all information on relief on the tally sheet instead of partly on social-treatment cards and partly on the tally sheet, and separate at the end of the month the amount provided to patients under and not under social treatment. As suggested above, departments with special systems for relief reports may wish to omit all entries on relief from the tally sheet or social-treatment card, and obtain from other records the information desired for the monthly statistical report.

SOCIAL-TREATMENT CARD

The use of a social-treatment card for recording certain information concerning patients under social treatment provides a body of pertinent social data which can be tabulated from time to time for the administrative guidance of the department or to determine the correlation of various social factors in cases requiring social treatment. The card presented here (see p. 22) contains only such items as are needed in the compilation of data for the monthly statistical reports and for special studies of age, sex, color, marital status, and occupation. The card can be expanded as desired to provide additional detail for research use.
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>S. M. W.</th>
<th>Des.</th>
<th>Div.</th>
<th>Sep.</th>
<th>U. M.</th>
<th>Occupation</th>
<th>Social-Treatment No.</th>
<th>Social-Treatment Status During Month</th>
<th>RELIEF</th>
</tr>
</thead>
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<td></td>
<td>192</td>
<td>January</td>
<td>February</td>
</tr>
</tbody>
</table>

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A separate card should be prepared for each patient accepted for social treatment. If several members of a family are under care in the social-service department, their cards may be clipped together if the department so desires. It should be borne in mind, in this connection, that only the members of a family who are patients of the hospital or clinic should be included in the counts of patients under social treatment. (See p. 4.)

The top of the social-treatment card provides space for the entry of the name of the patient, the number of the case in the department of medical social service, and the number assigned to the patient by the medical institution. If the case is being handled cooperatively with another case-work agency, this should be indicated by a check mark in the designated space. Some departments may prefer to enter the name of the agency sharing responsibility for the patient’s care.

Space is provided below the name of the patient for entries on age, sex, color, marital status, and occupation. In most cities, the two symbols W and C will be sufficient for the entry after “Color”, referring respectively to “White” and “Colored.” If only these two symbols are used, it is desirable to enter C for any person not of unmixed Caucasian blood, as is done by the Bureau of the Census. Some cities may wish to use additional symbols, such as M for Mexican, or Y for the yellow races of the Orient.

The symbols relating to marital status refer to the following conditions: S, single; M, married; W, widowed; Des., deserted; Div., divorced; Sep., separated; UM, unmarried mother. The symbol on the social-treatment card that is applicable in a given case should be indicated by a check mark placed in the space at its right.

The entry on occupation need not necessarily refer to the job most recently held, since in periods of unemployment people may accept unaccustomed types of labor. It should mean the type of work at which the individual habitually gains his living when he can find employment in his own line.

The main section of the card provides columns for entries on the status of the case each month, and the amount of relief provided. In the month in which a case is accepted for social treatment, the date of acceptance should be entered in the “Active” column on the designated line for the month, and a symbol added to indicate whether the patient is “new”, “old” (last under social treatment prior to Jan. 1), or “recurrent” (last under social treatment during this calendar year). Each year in January new cards should be made out for all patients “carried over” from the preceding year, and the status designated on the card as an old case under care on January 1.

When a patient is discharged from social treatment, the date of discharge should be entered on the social-treatment card, with a symbol added to indicated discharge. If death occurs while the patient is in the hospital, the date of death should be entered as the date of discharge. Transfer of a case to another worker in the department should be indicated by the entry of the date of transfer and the appropriate symbol. The following symbols are suggested for use in the entries in this column: N, new; O, old; R, recurrent; Dis., discharged; T, transferred.

If a case worker grants relief to a patient under social treatment, the amount of each grant during the month should be entered separately in the relief column on the social-treatment card. As previously
discussed, the daily tally sheet or a special plan for relief reports may be preferred in certain departments for recording all data on relief, and the recording of such information on the social-treatment card omitted.

**STATISTICAL CARD**

Elimination of duplication in counts of services to the same individual is made possible through the use of a statistical card (see p. 25) for the entry of information on the first service of a specified type rendered to an individual during a calendar month. Certain departments may wish to combine with the plan suggested for statistical cards the items suggested for entry on the social-treatment cards, and use one form and one file for all cases served. Other departments may find it more convenient to limit the use of statistical cards to cases for which social-treatment cards are not prepared; for example, those receiving interpretative, administrative, discharge, or medical follow-up service, and those given social examination but not taken under social treatment.

The plan here described provides for the use of the social-treatment cards by the individual social workers in preparing the counts on patients under social treatment for section B of the monthly report. Experience indicates, however, that it is advisable to have statistical cards prepared routinely for all cases taken under social examination and treatment, and any change in status should be entered on the statistical card as well as on the social-treatment card. This procedure makes possible the more rapid identification of cases previously served and simplifies the elimination of duplication in counts of individuals receiving administrative, interpretative, or other special service following discharge from social treatment.
<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Service No.:</th>
<th>Hospital No.:</th>
</tr>
</thead>
</table>

**STATISTICAL CARD**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Service No.:</th>
<th>Hospital No.:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Consultant</th>
<th>Service</th>
<th>Social evaluation</th>
<th>Medical/Health</th>
<th>Discharge</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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The recommended plan provides, therefore, for the preparation of statistical cards for all patients served during the year, and for the entry on these cards of information on any of the four forms of recorded service during the month and also any change in status with reference to social examination or treatment. As service to a patient may or may not be rendered at different times in cooperation with another case-working agency, space is provided also for the monthly checking of status as a cooperative-service case in relation to the preparation of monthly counts on the number of such cases receiving service.

The type of service rendered or any change in status, as indicated on the worker’s tally sheet, should be checked in the appropriate column of the card. Since the cards are intended to yield a count of the number of different patients who receive each type of service, and not the number of times the various services are rendered, the card need be checked only once during a month for any one type of service, although the tally sheets will record all contacts. For example, if a patient receives an interpretative service on the 1st day of the month, and again on the 10th, only one check should be entered on the card. If he also receives a discharge service, however, another check should be entered in that column.

At the beginning of each calendar year a statistical card should be made out for each patient under social examination or treatment, and the status designated in the appropriate column. New cards should be made out for all other patients served the first time their names appear on the daily tally sheet after the beginning of the calendar year, whether or not they have been served during the preceding year.
Chapter IV.—METHOD OF MAKING SERVICE COUNTS

This chapter describes in detail the procedure recommended in making service counts for statistical reports from the entries on the daily tally sheets, social-treatment cards, and statistical cards.

COUNTS OF PATIENTS GIVEN FULL RECORDED SOCIAL EXAMINATION

The method recommended for determining the number of social examinations given during the month for section A of the monthly report is the use of entries on the daily tally sheet. The total number of check marks in column 9 of the tally sheets is the figure to record in item 1 of the monthly report showing the number of examinations initiated. The total number of check marks in column 10 is the figure to be recorded in item 2, showing the number of examinations terminated with the patient not taken under social treatment.

Since these processes will be undertaken only once, no duplication should occur in the entries on the tally sheets.

COUNTS OF PATIENTS UNDER SOCIAL TREATMENT

Figures for section B of the monthly report are derived from the entries on the social-treatment cards. The person who compiles the monthly report should check through the daily tally sheets to see that a social-treatment card has been filled out for every patient opposite whose name a check has been placed in column 11 of the daily tally.

Some supervisors prefer to compile the items regarding total intakes and discharges from the central records of the department, and ask each worker to furnish at the end of each month a list of cases which have received no attention from any worker during the month, in order that these cases may be reviewed, as well as to obtain the count of active and inactive cases. Any duplications that occur in such lists are easily eliminated if the case numbers are given. Other departments make an arbitrary rule that transferred cases shall be counted only by the worker to whom they are assigned on the last day of the month. This method provides an unduplicated count of cases but does not enable workers to balance their own case counts. Much difficulty is avoided when the program of the department makes it possible to transfer cases only on the first or last day of the month.

As many departments prefer to have the report compiled from the separate reports submitted by each worker, the method for doing so will be described. Since the report for the department as a whole should not contain duplications, certain additional items will need to be kept by individual workers if this method is followed.

The chief source of duplication in count is the practice of transferring patients from one worker to another, and also from one unit of the social-service department to another. In order to avoid counting such patients twice when the workers' reports are totaled,
the schedules used by individual workers should include supplementary items that will enable each worker to preserve an arithmetical balance in regard to her own case load but will eliminate duplication in the total for the department. Such a schedule would include the following items for use in preparing the counts for section B of the monthly report:

Report of _____________________________

(Worker's name)

B. PATIENTS UNDER SOCIAL TREATMENT:

3. Carried over from preceding month.
4. Intake: Total of 4a, 4b, 4c.
   a. New.
   b. Old.
   c. Recurrent.
4x. Received by transfer from other workers (not included in item 4).
5. Total patients under social treatment (sum of items 3, 4, and 4x).
   a. Active.
      (1) Cooperative service.
      b. Inactive.
6. Discharge from social treatment during month.
6x. Transferred to other workers (not included in item 6).
7. Carried forward to following month (should equal item 5 minus total of items 6 and 6x).

To compile the departmental report from the individual workers' reports, all items except 4x and 6x may be added to produce corresponding totals for the department without duplication. Items 4x and 6x should cancel each other for the department as a whole. Item 5 of the workers' report includes cases received by transfer; this duplication can be eliminated from the departmental total by subtracting the total reported by all workers for item 4x.

One method of compiling the monthly report from the social-treatment cards is suggested here, although it is recognized that there are other equally effective methods which individuals may prefer to follow. The method is the same whether the compilation is made from a central index or by individual workers. If it is made by workers, each worker will find it convenient to keep a file box on her desk containing the cards relating to the cases she has under social treatment. This file box may be divided into four parts. The front section should contain cards for patients carried over on the first of the month, the second section cards for patients taken under treatment during the month, the third section cards for patients received by transfer from other workers in the department, and the last section cards for patients discharged from treatment during the month. As cases are closed, the social-treatment card may be removed from the front section of the box and placed in the back section.

When a card is first inserted in the box, a symbol should be entered to indicate whether the case is new, old, recurrent, or received by transfer from another worker. Early in January a new card should be made out for each case carried over from the preceding year, and its status indicated. For each case taken under care during the year (except recurrent cases) a social-treatment card is made out. Cards for recurrent cases need only be removed from the closed file, marked as recurrent in the active column for the month, and inserted in the second section in the case worker's file box.
METHOD OF MAKING SERVICE COUNTS

At the end of each month the cards in the separate sections of the box should be counted and the resulting figures entered in the schedule used by the individual worker in preparing section B of the monthly report. The number of patients carried over from the preceding month (item 3) will be the same as item 7 in the report for the preceding month and may be obtained from that source rather than by counting the cards.

Item 4 (Intake) is equal to the number of cards in the second section of the box unless some of the patients who were admitted to social care during the month have also been discharged by the social-service department during the same period. If this is the case, the number of such patients may be obtained by inspection of the cards in the second section of the box to obtain the number of cards in the second section of the box to obtain the figure for item 4. This total intake should be classified into three groups, new, old, and recurrent, on the basis of the status on the most recent date of acceptance for social treatment, and the number in each group should be entered opposite items 4a, 4b, and 4c, respectively.

Item 4x (Number of patients received by transfer from other workers) is equal to the number of cards in the third section of the box.

Item 5 (Total number of patients under social treatment during month) is the sum of items 3, 4, and 4x. In recording the number of active cases, each worker should count only cases for which she is responsible at the end of the month and cases that she has closed during the month, not counting as active those transferred to other workers. Although this may not give full credit to the individual worker in a given month, because she may have worked on cases transferred before the month ended, during the course of the year the transfers will approximately balance each other. To obtain items 5a and 5b, the number of cases active and inactive during the month, each case worker at the end of the month must go through all the cards in the box, and opposite the proper month insert a check in the column headed "active," if the case received attention during the month. The number of active cases handled in cooperation with another case-work agency should be counted and entered in item 5a (1).

Item 7 (Number of cases carried forward to the following month) is equal to item 5 minus the sum of items 6 and 6x. This should be verified by an actual count of the cards in the first three sections. These cards should then be filed together in the first section of the box and the cards of dismissed patients should be removed from the box and placed in a central file. The same process is repeated from month to month.

COUNTS OF PATIENTS RECEIVING OTHER RECORDED SERVICES

Figures for section C of the monthly report may be secured from the entries on statistical cards or from the entries on tally sheets following coding to eliminate duplications in counts of service to the same individual. If the count is made from cards, they should be filed in two sections, with the cards showing a service other than social examination or treatment kept in one section in preparation for the counts for items 8 to 10 at the end of the month.

In large departments it has been found that identification from the central file of statistical cards is seriously impeded by the division of the file into two sections and the necessity of refiling the cards each
month after the count has been made. For this reason the system of coding the entries on the tally sheets in order to make the monthly count from the sheets is recommended.

If the statistical file includes cards for patients receiving examination and treatment, all items for the monthly report may be obtained from the cards or coded tally sheets, although the plan described here assumes that items for section B will be obtained from reports of the individual social workers and that the clerk will be responsible only for the counts in sections A, C, and D.

If the coding plan is to be used, the clerk will check the tally sheets against the cards daily, or as frequently as practicable, and will make cards for new cases and enter information on the cards for cases already under care in accordance with the entries on the tally sheets as previously described. After making the entry on the statistical card the clerk will make a code mark for each check made by the social worker in columns 3 to 7 of the tally sheet, as the basis of counts for the monthly report.

The following symbols for coding are suggested as being simple and distinctive:

A'cross (x) indicates that the service as checked by the social worker in columns 4 to 7 on the tally sheet was to a patient who has not been counted previously during the year as receiving any type of service, including examination or treatment. The number of check marks thus coded on the tally sheets will be the entry for item 8 on the monthly report.

One circle (O) indicates that the service as checked in any of the four columns was to a patient who has not been coded previously during the month as receiving any service, although he has been counted in a previous month of the year as indicated by entries on the statistical card. Entries in column 3 of the tally sheet showing a cooperative-service case should be coded in this way the first time the patient's name appears during the month with designation as a cooperative-service case.

A double circle (OO) indicates that the patient has already been counted during the month as receiving one of the four services, but has also been given an additional type of service for which he is to be counted for the subdivisions of item 9, but not for item 9 itself, which should be an unduplicated count of patients. Second services in the same classification will be disregarded in the patient count, and will not be coded.

At the end of the month the items relating to patients receiving other recorded social services of the monthly report are obtained as follows:

Item 8 (Patients served for the first time this year) is obtained by counting the number of crosses (x) appearing in columns 4, 5, 6, and 7 of the tally sheet.

Item 9 (Total receiving service during month) equals the number of crosses (x) and single circles (O) appearing in the four columns.

Items 9a (Number of patients receiving interpretative service during month) is obtained by counting the number of coded items in column 4, including crosses (x), single circles (O), and double circles (OO). Items 9b, 9c, and 9d are obtained similarly by counting the coded items in columns 5, 6, and 7, respectively.

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METHOD OF MAKING SERVICE COUNTS

Item 10 (Cooperative-service cases included in item 9) is obtained by counting the number of circles in column 3 of the tally sheet. A section of a tally sheet as coded and counted would appear thus:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Cooperative service</th>
<th>Interpretative service</th>
<th>Administrative service</th>
<th>Discharge service</th>
<th>Follow-up service</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Jones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>David Roberts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Jones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane Anderson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Jones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Jones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Brown</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total of code entries</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
<td>(7)</td>
</tr>
</tbody>
</table>

The counts for items in section C of the report would then be:

8. Patients served for first time this year (3 X's)........ 3
9. Total receiving service during month (3 X's, 2 O's)....... 5
   (a) Receiving administrative service (column 4, 1 X, 1 O).... 2
   (b) Receiving interpretative service (column 5, 2 X's)...... 2
   (c) Receiving discharge service (column 6, 1 O, 1 O)......... 2
   (d) Receiving follow-up service (column 7, 2 O O's)......... 2
10. Cooperative-service cases included in item 9 (column 3, 2 O's). 2

COUNTS OF ADMITTING SERVICE

The count of admitting service is in terms of patients served. This count may be made through the use of the tally sheet, and if desired, a column for admitting service may be provided on the statistical card. Only one process in connection with each admission or decision in regard to eligibility is counted, regardless of the number of contacts. Departments that carry full responsibility for admissions may prefer to obtain the items for the schedule from the admission records of the hospital or clinic. There will be some duplication of patients counted in this section during the year as admitted to in-patient service, but for clinic or out-patient service a patient should be counted only once during the calendar year.

The number of patients served in connection with admission cannot be added to the monthly or annual totals of patients receiving other services, but is an item of additional interest for comparison with the total number of patients admitted to the hospital and clinic.

UNDUPLICATED COUNT OF PATIENTS SERVED DURING YEAR

The unduplicated count of all other patients served during the year may be obtained by adding the following items:

A-2 (sum of 12 months).
B-3 (as of January 1).
4-a (sum of 12 months).

4-b (sum of 12 months).
C-8 (sum of 12 months).

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RELIEF TOTALS

If relief for patients under social treatment is kept by individual social workers and recorded on the social-treatment card, in order to obtain the figures for section E of the monthly report it is necessary to use both the social-treatment cards and the tally sheet. Item 15 is obtained from the tally sheets, but item 14 (relief to patients under social treatment and the number of such patients) is obtained from the social-treatment cards.

Let us assume that Mrs. Brown is given $5 in relief on June 5 and $10 in relief on June 23. The social-treatment card would then contain the entries 6-5—$5, 6-23—$10, in the column headed “relief” opposite the month of June. At the end of June all social-treatment cards would be examined and those with a relief entry opposite June would be counted. The number of cards having such an entry would be the correct figure for the first entry for item 14. The amounts on the social-treatment cards thus segregated must then be totaled and the result entered in the second entry for item 14.

The entry for item 15 will be obtained from the daily tally sheets. The monthly report asks only for the amount of relief given under these circumstances and not for the number of patients to whom it was given. Therefore it is immaterial whether the patient receives relief once or more than once during the month. The entry for item 15 is simply the sum of the amounts entered in column 8 of the daily tally sheet. Item 16 is the sum of items in the second column for items 14 and 15. Some departments may pay small amounts, such as lunches or taxi fares for patients who have received no other recorded service; in such cases the amount may be entered in the relief column of the tally sheet and on the schedule, even if the case is not checked otherwise. If the number of such instances is so large as to make recording of relief on the tally sheet a burden, the amounts may be compiled from order blanks or other financial records and entered on the schedule instead of being recorded on the tally sheet.
Appendix A.—A STATEMENT OF MINIMUM STANDARDS TO BE MET BY HOSPITAL SOCIAL-SERVICE DEPARTMENTS

INTRODUCTION

Many social elements are inherent in the practice of medicine, and the physician needs to know his patient in a personal way, the environment in which he lives and works, his capacity to understand and participate in a plan of treatment, his obligations and resources. Nevertheless, many physicians are seeing patients in hospitals or clinics where the highly organized machinery necessary to the institution tends both to rob the patient of his individuality and, by isolating him from his natural environment, to prevent the physician from understanding him as fully as is desirable. At the same time medical practice is requiring the patient to participate in the plan for his treatment—regular attendance at clinic, changes in hygiene and diet, or convalescent care. Medical social service has, therefore, been developed in the hospital as a twofold service to the physician and to the patient.

The basis of medical social service is the medical need of the patient—a need which may be aggravated by social conditions and which may require social as well as medical treatment. This service contributes to the physician’s understanding of the patient and his problem by bringing to his attention significant data regarding the patient’s personality and environment. It may enable the patient to understand and carry through a plan of treatment which is satisfactory to the physician and which may necessitate adjustments in his work or home.

When a hospital decides to organize a “Hospital Social Service Department” and utilizes this name it should recognize and meet certain obligations, as herein stated.

FUNCTIONS

The primary purpose of a hospital social service department is to further the medical care of the patient by a method of medical social case study and treatment. The major activity of the department, therefore, should be medical social case work. The method is that of social case work correlated with medical treatment; it requires the assembling and analyzing of data, the outlining and carrying through of an integrated medical social plan.

Through its work with individual patients the social aspects of many of the hospital’s functions have become apparent. Two such functions are the admission of patients and the regular attendance of patients at clinic. The admission of patients involves the determining of fees, which should be based on a consideration of the patient’s medical requirements, his personal and family obligations and resources. The attendance of patients at a clinic depends on each patient understanding what is expected of him and sometimes necessitates social adjustment in order to accomplish this. The social-service department may participate in these hospital functions as a part of its service to individual patients, namely, to further the medical care of the patient on an individual basis.

ORGANIZATION

It is important to the hospital that its medical and social work be closely integrated in function and organization. The social-service department, therefore, should function as an integral part of the institution.

There should be one director, or executive head of the department, who will be responsible to the executive officer of the institution and through him to the board of management.

The impetus to establish the department and the funds with which to finance it may in some instances come from outside the hospital organization. When this is done, the head of the social-service department should, nevertheless, be responsible to the administration of the hospital in all matters pertaining to hospital organization and policy.

1 Adopted May 1928 by the American Association of Hospital Social Workers, Chicago, Ill.
The head of the social-service department should be a member of conferences called by the director of the hospital, or by the chief of any department, to discuss or to formulate policies pertaining to the social care of patients and to the community relationships of the hospital.

**FACILITIES**

Medical social case work requires personal conferences with various individuals in matters which are often of a confidential character. This makes it necessary that the department should have office facilities which afford as great privacy as possible and at the same time are readily accessible to patients and physicians.

**RECORDS**

The department should keep records of its medical social case work which should be readily available for use in the medical treatment of the patient. The privacy of the social case record should at all times be safeguarded.

The record should identify the case accurately, state clearly the reasons medical social study and treatment were or were not undertaken, the problems presented, those dealt with, and the social treatment given. It should include a statement at the time the case is closed which will give the reasons for closing and the status of the case at that time.

**PERSONNEL**

The head of the social-service department should be eligible for active membership in the American Association of Hospital Social Workers.
Appendix B.—A MEDICAL SOCIAL CASE RECORD FORM

This first medical social record form, which is offered by the records committee of the American Association of Hospital Social Workers as meeting the present minimum standards of the association, is intended for use as a separate social record which will be filed in the social-service department and not as a part of a unit medical record. The proposed form consists of a folder in which is kept a face sheet with pages of history which will be of the same size as the face sheet. A list of items which identify the patient and may be arranged as desired for the face sheet is recommended, together with an outline for use in classifying the medical and social history. The selection of material for the record is important; the medical information should be such as to give a clear understanding of the patient's present and possible future physical and mental condition and its social implications. Although the kind and amount of social history which is secured and recorded will be determined by the needs of the individual patient, the committee believes that there are certain data which may be considered basic in the solution of any problem. This basic material may be arranged under the five subheadings of "Social data" in the history outline. Additional social history which comes out in the social study and the chronological narrative of treatment or summary statements of progress should be written on numbered pages and kept in the folder.

Flexibility in the use of this form, the size, arrangement of topics, and so on, is urged. The committee does not wish to have this or any form standardized and hopes from time to time to improve this one and to develop others for case recording.

SUGGESTED ITEMS FOR FACE SHEET

1. Items referring to patient
   
   Name.—Write surname first and other names in full.
   Address.—Write street and number as well as city and State. If patient later moves, new address with the date should be added.
   Previous address.—Write street and number as well as city and State, with approximate dates.
   Date of birth.—State month, day, and year.
   Maiden name: Pt., Wf., Mq.—If patient is a married woman, give her maiden name; if patient is a married man, give maiden name of his wife; if patient is unmarried, give maiden name of mother.
   Birthplace.—Write name of city or town and the State, if born in the United States of America; write name of city or town and country, if outside the United States of America.
   Citizen.—Write "Yes", "No", or "First papers."  
   S. M. W. D. Sep.—Indicate, by drawing a circle around the abbreviation applicable, whether patient is single, married, widowed, divorced, or legally separated. If deserted, this notation may be added.
   Arrival in U.S.A.—State month and year.
   Arrival in city.—State month and year.
   Race.—State whether White, Negro, Mongolian, American Indian, or Oceanic.
   Religion.—State whether Roman Catholic or Greek Catholic, or Jewish; if Protestant, state the denomination.
   Date record opened.—Write month, day, and year.
   Medical record number.—Enter patient's medical record number if necessary for reference.

2. Items referring to relative and household
   
   Names of relatives and household.—Under this heading all members of the family should be listed, with the name of spouse first, or, if unmarried, list first the names of father and mother and note whether living or dead. Then enter

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1 Formulated by Ruth E. Lewis for the records committee of the American Association of Hospital Social Workers and adopted in June 1930 by the association at its annual meeting.
the names of children or siblings in chronological order beginning with the oldest. Patient may also be included in his place in the family group. The other relatives, then members of household, such as roomers may be listed here also. 

Kin.—State here the relationship to patient.

Date of birth.—Enter year and, if known, month and day.

Birthplace.—Write name of city or town as well as State in U.S.A. Write name of city or town and country, if outside the U.S.A.

Civil status.—Designate by using abbreviations “S” (single); “M” (married); “W” (widowed); “D” (divorced); or “Sep.” (separated).

Address.—State as exactly as possible if different from that of patient; otherwise write “Same.”

Medical record number.—Enter the record number if necessary in locating or identifying medical records.

3. General items

Social service number.—Enter here the serial record number if one is used for filing.

Report of social-service exchange.—Enter the date of registration and list the names of agencies previously registered with the exchange, the date of their registration and their record numbers, if available. Add names of agencies, dates, and record numbers of subsequent registrations. If there is no record at the exchange, write “No record.”

Name of social worker.—Write name of worker who opens record and add subsequent ones if there is a change.

MEDICAL SOCIAL HISTORY OUTLINE

1. Reason for social study

State why patient came to attention of social-service department. If case was referred, give name of referring person with his title or position.

2. Medical situation

Under this heading should be included such previous medical data as is significant to the medical social workers, the present diagnosis, recommendations for treatment, and the prognosis. The recommendations for treatment may include the place in which treatment is to be given, length of time, type, diet, medicines, and so on. The prognosis should be interpreted as including the expected outcome both with and without treatment and the extent to which it may be modified by the social conditions.

The source of this information (for instance, the name of the physician and his position) and the date on which it was secured should be clearly stated.

3. Social data

a. Family background or history.—Here may be given information in regard to parents, siblings, or spouse, and, in certain instances, of other relatives in such detail as is essential to an understanding of the patient and present situation. Their cultural background, health, education, religion, employment, earnings, recreation, attitudes toward each other, and so on, may be described. In the case of a child, and in many others, there will probably be the need of subdividing as more detailed information will be required.

b. Personal history.—Information under this heading should cover as many of the following points as are pertinent: The patient’s education, work history (as previous and present industry, occupation, work hazards, and so on), marital history, interests, recreation, religion, patient’s attitude toward medical social situation, and so on.

c. Financial data.—Give a complete statement of the budget, including income from wages and other sources, and also details of the expenses and debts.

d. Housing and home conditions.—Description of the neighborhood and the house itself, including the number of rooms, sleeping accommodations, routine of living, and so on, should be given.

e. Reports from social agencies.—These reports should contain the dates on which the social agency opened and closed its case, its reasons for accepting responsibility, its social findings, action taken, and the situation at the time of closing.

The kind and amount of social information should be determined by the medical and social problems of the individual patient, but each of the aspects of the situation as outlined in a to e should be considered and described. Material should be concisely presented. In all instances the source of information, the date, and the name of the worker should be stated.
4. Medical social problems
   The medical social problems should be stated. The headings "Findings", "Medical social diagnosis", and "Medical social classification" may be used for appropriate content.

5. Medical social plan
   State the plan of procedure for solving the above problems.

6. Medical social treatment
   In summary form or in chronological order with the exact dates should be given the steps taken to solve the problems. Changes in the medical or social situation necessitating changes in the social plan and treatment should be noted under the date the information was obtained.

7. Disposition and evaluation
   The situation should be stated and the definite reason given for the closing at this time. If certain problems have not been solved or no attempts made to do so, reason should be made clear. If possible, estimate what changes that have taken place seem to have resulted from treatment.
Appendix C.—MEMBERSHIP REQUIREMENTS OF THE AMERICAN ASSOCIATION OF HOSPITAL SOCIAL WORKERS

EXTRACTS FROM THE CONSTITUTION OF THE ASSOCIATION

Article II—PURPOSE

The purpose of the association shall be to serve as an organ of intercommunication among hospital social workers, to maintain and improve standards of social work in hospitals, dispensaries, special clinics, or other distinctly medical or psychiatric institutions, and to stimulate its intensive and extensive development.

Article III—MEMBERS

Individuals and institutions in the United States of America and the Dominion of Canada shall be eligible for membership in this association, according to classification hereinafter stated in the bylaws.

EXTRACTS FROM THE BYLAWS OF THE ASSOCIATION

Article II—MEMBERSHIP

Section 1. Membership shall be of the following classes: active, junior, associate, contributing, sustaining, corporate, and honorary.

Sec. 2. Any person may be admitted to active membership in the association who:

(a) Has graduated from a school of social work approved by the executive committee as hereinafter specified:

   (1) Has taken a full course in medical or psychiatric social work and has had 1 year's experience in the practice of the same.

   (2) Has taken a full course in any other type of social work and has had 18 months' experience in the practice of medical or psychiatric social work.

(b) Has had a bachelor's degree or its equivalent (to be determined by the executive committee), at least 2 years of supervised case-work experience in a recognized social agency (this being understood to include a medical social agency meeting the requirements of minimum standards of the American Association of Hospital Social Workers), and has had in addition 18 months' experience in the practice of medical or psychiatric social work.

(c) Has had at least 2 years of supervised case-work experience in a recognized social agency (this being understood to include a medical social agency meeting the requirements of minimum standards of the American Association of Hospital Social Workers) and has had in addition 3 years' experience in the practice of medical or psychiatric social work.

(d) Is considered by the executive committee to be a person of exceptional ability who lacks sufficient formal educational experience, but who has had 5 years or more of experience in social work of which not less than 3 years have been spent in the practice of medical or psychiatric social work.

(e) Has graduated from an accredited high school or its equivalent, and has graduated from an accredited school of nursing, and has had, in addition, 18 months' experience in the practice of medical or psychiatric social work.

Sec. 3. Any person may be admitted to junior membership who has entered the field of medical or psychiatric social work but who has not fulfilled the requirements for active membership. Junior members must be transferred to active membership upon fulfilling the requirements for active membership. Members who have not fulfilled the requirements for active membership within 6 years shall be transferred to associate membership or dropped. Junior members...
APPENDIXES

may have all the privileges of active membership except the right to vote or hold office.

Sec. 4. A person may be admitted to associate membership who is ineligible for active or junior membership and who is interested in or concerned with social work or its development in hospitals, dispensaries, special clinics, or other distinctly medical or psychiatric institutions. Junior members who have not fulfilled the requirements for active membership may become associate members as specified in section 3. Associate members may have all the privileges of active membership except the right to vote or hold office.

Sec. 5. Institutions or organizations engaged in social work or its development in hospitals, dispensaries, special clinics, or other distinctly medical or psychiatric institutions are eligible for corporate membership.

Sec. 6. Candidates for membership shall make application on blanks approved by the executive committee. Each application shall be indorsed by two active members of the association.

Sec. 7. Approval by the chairman of the district and the chairman of the district committee on membership, the payment of dues, and registration with the association shall constitute election to membership for candidates within the districts.

Approval by the executive committee of the association, the payment of dues, and registration with the association shall constitute election to membership for candidates outside of organized districts.

Sec. 8. The name of the candidate for membership whose application has been disapproved may not be presented again within 1 year.

Sec. 9. Active members in good standing once admitted may retain active membership in the association by the payment of annual dues. If dues are not paid by April 30 of the current year, members shall be dropped, due notice having been given.

Sec. 10. Active and junior members who have been dropped for nonpayment of dues may only be reinstated by paying the amount of dues in arrears and the current annual dues and by meeting the current qualifications for membership.

Sec. 11. Active, junior, and associate members upon payment of required dues may be listed as contributing members, retaining the same voting privileges as are conferred by the original type of membership.

Sec. 12. Active, junior, associate, and corporate members upon payment of required dues may be listed as sustaining members, retaining the same voting privileges as are conferred by the original type of membership.

Sec. 13. Honorary membership may be conferred upon any individual who has rendered distinguished service to hospital social work on recommendation of the executive committee by unanimous vote of the association at an annual meeting.