

McLaren Print System Order

Order No: 43031 Reprint Previous Order No: 25181
 Order Date: 2019-02-22
 User: Kathy Nedorw
 Phone: (810) 985-8144

Ship Location: Dr. Patel
 1205 Richardson
 Port Huron, MI 48060

Forms

Quantity: 100
 Paragon Dept No: 7418
 Dept Name: Internal Med
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-352
 Item Description: Needs Assessment
 Revision Date: 10/2018
 Print: 1 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Misc Info: ss;black

McLaren MEDICAL GROUP **Needs Assessment**

Patient Name (First, Last) _____ Date of Birth _____

Date of Assessment: _____

Patient: Please fill out the information below to better assist us with your care.

Our goal is to educate our patients in order to provide the best possible care. Would you consider yourself ready to learn? Yes No

| | |
|---|--|
| Learning Preference | Cultural Considerations |
| Check all that apply: | Do you have any religious or cultural practices that we should be aware of? |
| <input type="checkbox"/> Demonstration | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please describe: _____ |
| <input type="checkbox"/> Video | Communication Needs |
| <input type="checkbox"/> Read Instructions | Do you have impaired vision or are blind? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Picture Instructions | Can you read? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> No preference | Can you write? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Language Preference

English Other, please list _____

Do you need an interpreter? Yes No

Are you deaf? Yes No Do you use sign language? Yes No NA

Safety

Do you keep fire arms in the home? Yes No

If you answered Yes, do you take safety precautions with firearms in the home? Yes No NA

Abuse

Violence and/or sexual abuse is a problem for many people, which is why we routinely screen all patients for violence or abuse in their lives. Are you experiencing violence and/or sexual abuse? Yes No

Fall Risk

Have you fallen in the last year? Yes No

Do you experience forgetfulness or confusion? Yes No

Do you use a walker or cane? Yes No

Depression Screening

Over the past 2 weeks, have you experienced any of the following:

Little interest or pleasure in doing things? Yes No

Feeling down, depressed or hopeless? Yes No

Advanced Directive

Do you have an Advanced Directive, which is written instructions for your family and health care provider in the event that you cannot make a decision about your care? Yes No

Would you like information on Advanced Directives? Yes No NA

Clinical Staff: If Yes checked for Advanced Directive, was information given? Yes No

Information Given by _____ Relationship to Patient (if not self) _____ Date _____

Clinical Staff only
 Reviewed by: _____
 Provider's Signature (Required) _____ Date & Time (Required) _____

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