

## McLaren Print System Order

Order No: 51445 Reprint Previous Order No: 25181  
 Order Date: 2020-01-03  
 User: Deb Oldenburg  
 Phone: 989-667-6358

Ship Location: McLaren Bay Health Pavilion Deb Oldenburg  
 3175 W Professional Dr  
 Bay City, mi 48706

### Forms

Quantity: 100  
 Paragon Dept No: 69500  
 Dept Name: Bay Breast Surgery  
 Company Number: 810

Order Total Price: 3.60

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: 2 Hole Top  
 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 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: \_\_\_\_\_ Date & Time (Required) \_\_\_\_\_

Provider's Signature (Required) \_\_\_\_\_ Date & Time (Required) \_\_\_\_\_

MM-352 Rev. 10-2018