

McLaren Print System Order

Order No: 54319 Reprint Previous Order No: 25181
Order Date: 2020-05-19
User: Kimberly Gunsell
Phone: 989-316-4272

Ship Location: McLaren Bay Family Medicine
3720 Katalin Ct Suite 201
Bay City, MI 48706

Forms

Quantity: 500
Paragon Dept No: 69000
Dept Name:
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

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 Check all that apply: <input type="checkbox"/> Demonstration <input type="checkbox"/> Video <input type="checkbox"/> Read Instructions <input type="checkbox"/> Picture Instructions <input type="checkbox"/> No preference	Cultural Considerations Do you have any religious or cultural practices that we should be aware of? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe: _____
Communication Needs Do you have impaired vision or are blind? <input type="checkbox"/> Yes <input type="checkbox"/> No Can you read? <input type="checkbox"/> Yes <input type="checkbox"/> No Can you write? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Other, please list _____ Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you deaf? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use sign language? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Safety Do you keep fire arms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered Yes, do you take safety precautions with firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Fall Risk Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you experience forgetfulness or confusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use a walker or cane? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical Staff: If Yes checked for any Fall Risk question, was Fall Prevention Education given? <input type="checkbox"/> Yes <input type="checkbox"/> No NA, give reason: _____
Depression Screening Over the past 2 weeks, have you experienced any of the following: Little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No Feeling down, depressed or hopeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	Clinical Staff: If Yes checked for either Depression Screening question, the Provider will complete a PHQ-9 screening.
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Would you like information on Advanced Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Clinical Staff: If Yes checked for Advanced Directive, was information given? <input type="checkbox"/> Yes <input type="checkbox"/> 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. 01-2018