

## McLaren Print System Order

Order No: 62587 Reprint Previous Order No: 25181  
 Order Date: 2021-05-25  
 User: Debra Osmer  
 Phone: 5179133825

Ship Location: mclaren mmp southside medical center  
 5525 s. mlk blvd  
 Lansing , Mi 48911

### Forms

Quantity: 500  
 Paragon Dept No: 68325  
 Dept Name: mclaren mmp southside  
 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:  Do you have any religious or cultural practices that we should be aware of?  
 Demonstration  Yes  No  If Yes, please describe: \_\_\_\_\_  
 Video **Communication Needs**  
 Read Instructions Do you have impaired vision or are blind?  Yes  No  
 Picture Instructions Can you read?  Yes  No  
 No preference Can you write?  Yes  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 **Clinical Staff: If yes checked for any Fall Risk question, was Fall Prevention Education given?**  
 Yes  No  NA, give reason: \_\_\_\_\_  
 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: **Clinical Staff: If yes checked for either Depression Screening question, the Provider will complete a PHQ-9 screening.**  
 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) \_\_\_\_\_

MM-352 Rev. 10-2018