

McLaren Print System Order

Order No: 62773 Reprint Previous Order No: 25181
 Order Date: 2021-06-02
 User: Jodi LaPlant
 Phone: 989-667-3410

Ship Location: WEST SIDE MED MALL ATTN: JODI LAPLANT SUITE 12
 4175 N EUCLID AVE SUITE 12
 BAY CITY, MI 48706

Forms

Quantity: 100
 Paragon Dept No: 69580
 Dept Name: BAY NEUROSCIENCES
 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 Check all that apply:	Cultural Considerations 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 <small>If Yes, please describe: _____</small>
<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

<p>Fall Risk</p> <p>Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you experience forgetfulness or confusion? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you use a walker or cane? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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: _____</p>
<p>Depression Screening</p> <p>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</p>	<p>Clinical Staff: If yes checked for either Depression Screening question, the Provider will complete a PHQ-9 screening.</p>

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