McLaren Business Products

McLaren Print System Order

Order No: 89767
Order Date: 2024-11-11
Order Request Date:
User: Angie Claerhout
Phone: 9896672802

Ship Location: Bay Spine Surgery
4175 N Euclid Ave Suite 9
Bay City, Michigan 48706
Brochures
Quantity: 100
Paragon Dept No: 56087
Dept Name: McLaren Bay Spine Surgery
Company Number:

Order Total Price: 3.35

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
Poster:
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	Cultural Considerations
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?
Do you experience forgetfulness or confusion? ☐ Yes ☐ No	☐ Yes ☐ No
Do you use a walker or cane? ☐ Yes ☐ No	☐ NA, give reason _____
Depression Screening	Clinical Staff: If Yes checked for either Depression Screening question, the Provider will complete a PHQ-9 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) _____

Spec Info: WestSide Medical Mall -Attn: Angie Claerhout -Suite #9