

McLaren Print System Order

Order No: 52831 Reprint Previous Order No: 25181
 Order Date: 2020-02-25
 User: Theda Simmonds
 Phone: 989-393-2857

Ship Location: McLaren Occupational and Convenient Care - Bay City
 4 Columbus Ave
 Bay City, MI. 48708,

Forms

Quantity: 1000
 Paragon Dept No: 69100
 Dept Name: Occupational Convenient Care
 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

<p>Learning Preference</p> <p>Check all that apply:</p> <p><input type="checkbox"/> Demonstration</p> <p><input type="checkbox"/> Video</p> <p><input type="checkbox"/> Read Instructions</p> <p><input type="checkbox"/> Picture Instructions</p> <p><input type="checkbox"/> No preference</p>	<p>Cultural Considerations</p> <p>Do you have any religious or cultural practices that we should be aware of?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe: _____</p> <p>Communication Needs</p> <p>Do you have impaired vision or are blind? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can you read? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can you write? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Language Preference</p> <p><input type="checkbox"/> English <input type="checkbox"/> Other, please list _____</p> <p>Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p>	
<p>Safety</p> <p>Do you keep fire arms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p>	
<p>Abuse</p> <p>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</p>	
<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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>NA, give reason: _____</p>
<p>Depression Screening</p> <p>Over the past 2 weeks, have you experienced any of the following:</p> <p>Little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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>
<p>Advanced Directive</p> <p>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</p> <p>Would you like information on Advanced Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>Clinical Staff: If Yes checked for Advanced Directive, was information given? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

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