

McLaren Print System Order

Order No: 55862 Reprint Previous Order No: 25181
 Order Date: 2020-08-03
 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

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?
 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) _____

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