PATIENT SAFETY SCREEN

At MedStar Franklin Square Medical Center, WE CARE ABOUT YOUR SAFETY! We consider YOU an essential member of our healthcare team. Please help us by providing information about any safety issues you may have while under our care.

Patient Name: _____ Date of Birth: _____
Today's Date: _____
Name of person completing form: _____ Relationship: _____

1) <u>Communication:</u> Which phone number(s) do you prefer us to call? (Please check all that apply)
Home phone #:_____ Ok to leave voicemail? □ Yes □ No
Work phone #:_____ Ok to leave voicemail? □ Yes □ No
Cell phone #: _____ Ok to leave voicemail? □ Yes □ No

Do you have trouble hearing or understanding information over the phone? □ Yes □ No

Who would you prefer us to leave a message with? □ **DO NOT LEAVE A MESSAGE WITH ANYONE**
Name: _____ Relationship: _____ Phone #:_____

When we mail information, may we use:
□ Envelope with office return address □ Plain envelope □ **DO NOT MAIL**
Mailing address:
_____
Street address City State Zip code

Would you like us to discuss your healthcare needs with a caregiver, family member, or significant other?
□ Yes □ No If yes: Name:_____ Phone #:_____
May we discuss the following (check ALL items that apply):
□ Appointments □ Billing Issues □ Medications □ All healthcare information

For each section below, ***<u>check ALL items that apply</u>*** to you. You may provide an additional explanation in the line below each section.

<u>2) Learning Needs/Sensory:</u>
□ Highest grade completed in school: _____
□ I prefer to learn in what language: _____ (please specify)

	Yes	No		Yes	No
I like to receive handouts			I have difficulty reading		
I like to listen to information			I have difficulty writing		
I like to watch videos to learn about healthcare			I need transportation to the doctor's office		
			I have hearing problems/use a hearing aid		
			I have vision problems/use glasses/contacts		
			I have trouble sensing heat, cold, touch		

Additional Information:_____

3) Nutrition:

	Yes	No		Yes	No
I'm a healthy eater			Overweight		
I would like more information about nutrition			Underweight		
High fiber diet			Diabetic diet		
Low cholesterol diet			Gluten-free diet		
Low salt diet			Vegetarian		
Low fat diet			Receive nutrition through a tube or an IV		
Low sugar diet			Problems tasting food		

Additional information:_____

4) Spiritual/Cultural:

	Yes	No
My spiritual needs affect my healthcare		
My cultural backgrounds or beliefs affect my healthcare		

Additional Information:_____

5) Environmental/Functional/Falls:

	Yes	No		Yes	No	
Live with others			Live alone			
Able to care for myself independently			Need help with daily activities			
I participate in regular exercise			Unable to exercise			
			Use a walker			*
			Use a cane			*
			Use a wheelchair			*
			History of falling in the past two years			*
			Unsteady on my feet			*
			Medications make me dizzy			*
			I believe I might be at risk for falling			*

Additional Information:_____

Office Use Only:
* May indicate risk for fall

Fall prevention brochure provided_____
Patient referred to Primary Care Physician to discuss fall risk_____

6) Substance Use:

I use:	Yes	No		Yes	No
Caffiene (Daily)			Beer		
Cigarettes			Wine		
Cigars			Liquor		
Chewing tobacco			Marijuana		
			Other illicit drug use		

7) Safety/Emotional Health:

	Yes	No		Yes	No
I feel happy			I feel hopeless		
I am able to do the things I love			I feel down or depressed		
I have support from friends and family			I sometimes feel like harming myself or others		
I feel safe			I feel threatened and afraid		
I see a counselor for mental health concerns			I am sometimes forced to do things I don't want to do		
I take medications for mental health concerns			I feel neglected/my needs are not being met		

Additional Information:_____

9) Immunizations:

	Yes	No		Yes	No
Up to date on all immunizations			Have not had a flu shot this year		
			Have not had a pneumovax shot		
			Have not had a tetanus shot in the past 5 years		
			I'm unsure if I'm up to date on immunizations		

Office Use Only:
Patient referred to Primary Care Physician to discuss immunizations_____

10) Advance Directives:

	Yes	No
I have an advance directive/living will		
I would like more information about advance directives		
I have selected someone to make health decisions for me if I'm not able		
If so, who? Name_____ Phone:_____		

Office Use Only:
Patient was given information about Advance Directives_____
Advance Directive information is on file in the medical record_____

Reviewed by:_____ Date:_____
Reviewed/updated: _____ _____ _____
Initials/Date/Time *Initials/Date/Time* *Initials/Date/Time*