

Name: _____

Medical Number: _____

Who to Call: _____

Educator: _____

ASSESSMENT

Barriers to education: None

- | | | |
|---|--|---|
| <input type="checkbox"/> Language | <input type="checkbox"/> Age | <input type="checkbox"/> Motor or sensory impairment (describe):
_____ |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Religion | |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Emotional state | <input type="checkbox"/> Other (describe):
_____ |
| <input type="checkbox"/> Unable to read | <input type="checkbox"/> Denial | |

How does the patient learn best:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Hands on |
| <input type="checkbox"/> Demonstration | <input type="checkbox"/> Video |

Outside services required:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical Therapy | |

TEACHING TOPIC	INITIATED	PATIENT VERBALIZED	PATIENT DEMONSTRATES	COMMENTS

Patient Signature: _____ Date: _____

Educator Signature: _____ Date: _____

Notes