



DT0002



OUTPATIENT DATA BASE

ADDRESSOGRAPH OR PRINT PATIENT NAME AND ACCOUNT NUMBER

Instructions: Please answer the following questions as completely as possible. This information will help us plan and provide your care. Thank you.

| | | |
|----------------------|----------------|-------------------|
| YOUR NAME: _____ | YOUR AGE _____ | YOUR HEIGHT _____ |
| email address: _____ | | |

What are your primary health concerns? _____

Emergency contact _____ Relationship _____ Phone # (____) ____ - _____

PHYSICIANS

Primary _____ Phone _____

Cardiologist _____ Phone _____

Pulmonologist _____ Phone _____

Other _____ Phone _____

I DO NOT TAKE ANY MEDICINES I HAVE MEDICINES WITH ME

NON-PRESCRIPTION MEDICINE

| NAME OF MEDICINE | DOSE (STRENGTH) | HOW OFTEN TAKEN | DOCTOR PRESCRIBING | |
|------------------|-----------------|-----------------|--------------------|--|
| | | | | <input type="checkbox"/> NONE |
| | | | | <input type="checkbox"/> Aspirin containing products |
| | | | | <input type="checkbox"/> Herbal remedies/supplements |
| | | | | <input type="checkbox"/> List: _____ |
| | | | | <input type="checkbox"/> Nutritional drink supplements |
| | | | | <input type="checkbox"/> Vitamin supplements |
| | | | | <input type="checkbox"/> Sleeping pills <input type="checkbox"/> Laxatives |
| | | | | <input type="checkbox"/> Eyedrops <input type="checkbox"/> Antacids |
| | | | | <input type="checkbox"/> Diarrhea meds <input type="checkbox"/> Diet meds |
| | | | | <input type="checkbox"/> Allergy meds |
| | | | | <input type="checkbox"/> Other (list) _____ |
| | | | | _____ |

Do you have any allergies to medications or foods? Y N; If you answered **yes**, please list allergies and your reaction(s):

What medications do you take for pain relief? (list): _____

How would you rate the effectiveness of your pain meds? (circle one) Not Satisfied: 0 1 2 3 4 5 Very Satisfied

TOBACCO USE: Do you smoke: Y No; Did you ever smoke? Y No; **If yes**, for how long? _____

Cigarettes per day _____ When did you quit? _____

ALCOHOL USE: Y N; How often?: _____ CAFFEINE USE: (coffee, tea, cola) Y N

Recreational drugs? Y N; If yes, what type & how often: _____



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MEDICAL HISTORY

***Please indicate all that apply using the following key: S=self M=Mother F=Father O=Other (i.e. sibling, grandparents)**

***CARDIOVASCULAR SYSTEM (use key above)**

- None High Blood Pressure _____ Low Blood Pressure _____
 Chest pain/angina _____ Feet swelling _____ Leg pain when walking _____
 Irregular or fast heartbeat _____ Heart valve problems _____ Heart murmur _____
 Congestive Heart Failure _____ Bypass Surgery _____ Heart Attack _____
 High cholesterol _____

***ENDOCRINE (use key above)**

- None Thyroid _____ Other _____
 Diabetes Type I ____ II ____ Diabetes MD: _____
 In the past have you met with any of the following:
 Diabetic Educator Dietitian M.D. Support Group
 Do you check your blood sugar at home? Yes No Do you have a target sugar range? Yes _____ No
 What is a low blood sugar for you? _____ What are your symptoms? _____
 What is a high blood sugar for you? _____ What are your symptoms? _____
 How do you treat a low blood sugar? _____ High blood sugar? _____
 Do you have a daily foot care routine? Yes No
 Have you had a recent hemoglobin A1C test? Yes - Results _____ % No

NUTRITION

- Are you currently on a special diet? Yes No; If yes, which type of diet is it? (see next line)
 Medically Prescribed Self Prescribed; Type: _____
 Have you met with or are currently working with a dietitian? Yes No
 Would you be interested in meeting with the rehab dietitian? Yes No
 Have you had unplanned weight loss/gain of more than 10 lbs. in the last 6 months? Yes No

EXERCISE

- Do you have a regular exercise routine? Yes No; If yes, ____ days per week _____ minutes per day

GOALS FOR HEALTHY LIFESTYLE CHANGES (Please circle all that apply)

- | | | |
|--------------------------------|----------------------|-------------------|
| Cardiovascular Fitness | Muscle Strengthening | Weight Loss/Gain |
| Improve Sense of Well Being | Muscle Endurance | Improve Stamina |
| Disease Prevention/Maintenance | Weight Management | Stress Management |

Please list any other health and fitness goals below. There may be something more specific to you and your lifestyle (i.e. improve your stamina for playing golf, walk unassisted, return to work, etc.) you may want to add:

STAFF USE ONLY Risk factor list:



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MEDICAL HISTORY (Continued)

TESTS/STUDIES

Please include most recent tests/studies (ex: stress test, echocardiography, arterial/venous doppler, etc.)

| TYPE OF TEST | WHEN | RESULTS |
|--------------|------|---------|
| | | |
| | | |
| | | |
| | | |
| | | |

SURGERY &/OR INVASIVE PROCEDURES

Please include all surgeries and procedures (angioplasty/catheterization, pacemaker implant, etc.)

| PROCEDURE/SURGERY | WHEN | RESULTS/COMPLICATIONS |
|-------------------|------|-----------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Please circle all that apply to you now or in the past:

| Lungs/Breathing | Blood/Coagulation | Musculoskeletal | |
|--|--|---|---|
| Shortness of breath Persistent cough or cold Pneumonia Emphysema Asthma or wheezing Bronchitis | Bruise or bleed easily AIDS/HIV Transfusions (blood/plasma) Low blood count (anemia) Sickle cell disease Hepatitis: A B C | Arthritis Back/neck problems Unusual muscle weakness Muscle/Joint pain Activity restrictions: _____ _____ | |
| Nervous System | Skin | Gastrointestinal | Renal and Urinary |
| Confusion or memory loss Headaches Mental health problems Dizziness Fainting or blackouts Seizures or convulsions Stroke(s) Alzheimer's | Rash Ulcers Cellulitis Sensitivity to tape | Constipation Heartburn/Reflux Diarrhea Ulcers Hemorrhoids Rectal bleeding Gall bladder problems Liver problems Pancreatitis | Trouble urinating Kidney stones Kidney disease Urinary tract infection Bladder infection Renal dialysis Type: _____ Last done: _____ |



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| SOCIAL SUPPORT/ FINANCIAL NEEDS | SPIRITUAL/CULTURAL/ LEARNING NEEDS | INFECTION CONTROL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|---|-------------------------------------|--|-----------------------------------|---|---|---------------------------------------|---|---|---|--|---|---|---|--|---|---|---|---|---|---|---|--|---|---|---|------------------------------------|---|---|---|--|---|---|---|--|
| <p>Please check all that apply:</p> <p><input type="checkbox"/> Have financial needs or concerns that limit your access to health care? Please list: _____</p> <p><input type="checkbox"/> Do not feel safe from physical and/or mental abuse in the environment you live in?</p> <p><input type="checkbox"/> Have concerns about coping with the stress in my life</p> <p><input type="checkbox"/> The anxiety I feel related to my diagnosis limits me from resuming my normal activities.</p> <p><input type="checkbox"/> Problems with communication, intimacy, and/or sexual relations negatively impacted my relationship with significant support people since my diagnosis.</p> <p><input type="checkbox"/> Would like to see a Social Worker.</p> <p>Current work status: <input type="checkbox"/> Active <input type="checkbox"/> Medical Leave <input type="checkbox"/> Retired</p> <p>Occupation: _____</p> <p>Avocational/Vocational work/energy requirements: _____ _____ _____</p> | <p>Are there any spiritual, traditional, or cultural practices that you need to be a part of your care? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____</p> <p>Is there any way we can assist with your religious and/or spiritual practices? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____ _____</p> <p>Would you like a chaplain to visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How best do you learn? (Check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> TV/Video tapes</td> <td><input type="checkbox"/> Repetition</td> </tr> <tr> <td><input type="checkbox"/> Demonstration</td> <td><input type="checkbox"/> Pictures</td> </tr> <tr> <td><input type="checkbox"/> Verbal explanation</td> <td><input type="checkbox"/> Reading - <input type="checkbox"/> Large Print</td> </tr> </table> <p>Other: _____</p> <p>Educational Topics: circle 1st 2nd 3rd Priority</p> <table border="0"> <tr> <td><input type="checkbox"/> Heart Safety</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Cardiac Medications</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Risk factors of heart disease</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Benefits of Exercise</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Weight Management</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Nutrition</td> <td>1</td> <td>2</td> <td>3</td> </tr> <tr> <td><input type="checkbox"/> Stress Management</td> <td>1</td> <td>2</td> <td>3</td> </tr> </table> <p>I would like to see: <input type="checkbox"/> Interpreter <input type="checkbox"/> Patient Services Representative</p> <p>Other: _____</p> | <input type="checkbox"/> TV/Video tapes | <input type="checkbox"/> Repetition | <input type="checkbox"/> Demonstration | <input type="checkbox"/> Pictures | <input type="checkbox"/> Verbal explanation | <input type="checkbox"/> Reading - <input type="checkbox"/> Large Print | <input type="checkbox"/> Heart Safety | 1 | 2 | 3 | <input type="checkbox"/> Cardiac Medications | 1 | 2 | 3 | <input type="checkbox"/> Risk factors of heart disease | 1 | 2 | 3 | <input type="checkbox"/> Benefits of Exercise | 1 | 2 | 3 | <input type="checkbox"/> Weight Management | 1 | 2 | 3 | <input type="checkbox"/> Nutrition | 1 | 2 | 3 | <input type="checkbox"/> Stress Management | 1 | 2 | 3 | <p>Have you had a cough for more than 2 weeks with any of the following?</p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Bloodstained sputum <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Night sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Lethargy</p> <p>Does someone in your family or who you live with have TB now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever been placed on isolation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when? _____ Reason: _____ _____ _____</p> <p>For patients 12 years or younger: Are your immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| <input type="checkbox"/> TV/Video tapes | <input type="checkbox"/> Repetition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Demonstration | <input type="checkbox"/> Pictures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Verbal explanation | <input type="checkbox"/> Reading - <input type="checkbox"/> Large Print | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart Safety | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Cardiac Medications | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Risk factors of heart disease | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Benefits of Exercise | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Weight Management | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Nutrition | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Stress Management | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>How many times in the last year have you visited the:</p> <p>Hospital: _____ ER: _____ Doctor: _____</p> <p>Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list the people that provide you support in your life: _____ _____</p> <p>Do you feel this is adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please list any religious/cultural barriers that may affect your care: _____ _____</p> <p>Do you have any of the following feelings about your disease? Angry Afraid Depressed Helpless Accepting</p> <p>Other: _____</p> | <p align="center">NUTRITION</p> <p>Would you like to meet with the dietitian? <input type="checkbox"/> Yes <input type="checkbox"/> NO</p> <p>Have you had any of the following? (Check all that apply)</p> <p>Current difficulty swallowing or chewing Unplanned weight loss of more than 10 lbs in last 6 months Are you currently on a special diet?</p> <p>Type of Diet: What percent of the time do you follow a low fat diet? ____ <20% ____ 20-39% ____ 40-59% ____ 60-79 ____ >80%</p> <p>Completed by: _____ Date: _____</p> <p>Relationship to patient: _____</p> <p>Unable to complete due to: _____</p> <p>Updated by: _____ Date: _____</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



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Multidisciplinary Referral

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*****FOR STAFF USE ONLY*****

Instructions: Notify the appropriate department and document below.

SOCIAL SERVICES

1. Financial needs
2. Difficulty adjusting to illness
3. Pt./Family request
4. Other: _____

NUTRITION SERVICE

1. Unplanned weight loss/gain
2. Patient request
3. Appears malnourished/cachectic
4. Other: _____

PATIENT SERVICES (X4000)

1. Sign language interpreter
2. Haring impaired equipment
3. Patient/Family request
4. Hotel, transportation assistance
5. Other: _____

EDUCATION SERVICES

Heart Failure Program Nurse (X3961)

1. H/O frequent adm. For CHF
(readmit w/n 90 days)
2. New onset CHF (NYHA class
II, III, IV)
3. Patient/RN/MD request
4. Other: _____

PASTORAL CARE (X3258)

1. Spiritual distress/despair
2. Patient/Family request
3. Special religious practice
4. Other: _____

PHYSICAL/OCCUPATIONAL

THERAPY (X6281) (COMPUTER ENTRY)

1. New onset dependent or impaired
mobility (bed mobility, transfers, fait)
2. New onset dependent or
3. Equipment use/safety

INTERNATIONAL PATIENT

SERVICES (X3350)

1. Language barrier
2. Cultural practices
3. Patient/Family request
4. Other: _____

DIABETES EDUCATOR (X54457)

(requires MD order) (COMPUTER ENTRY)

1. Newly diagnosed Type 1
2. Hospitalized for hyper/hypoglycemia
3. New to glucose monitoring/insulin
4. High risk OB/gestational
5. Other: _____

INFECTION CONTROL (#3174)

1. Exhibits s/s of TB
2. Recent exposure to TB
3. Family history of TB
4. Hx MRSA/VRE
(within 1 year)
5. Pt's demographic sheet
flagged for MDRO
6. Other: _____

PALLIATIVE CARE

CONSULTATION (X2628)

1. Uncontrolled end-of life symptoms
(pain/SOB/NV)
2. Code III status
3. Family needs education on s/s of
approaching death and/or needs
for assistance with comfort measures
4. Other: _____

PATIENT INFORMATION REVIEWED AND REFERRAL NEEDS ASSESSED BY:

**NOTE: If pain problem identified and not under satisfactory control
complete "Pain Inventory" form.**

**COMFORT
GOAL _____**

_____ RN Date/Time _____ Unit _____ No referral needs identified at this time.

(See Evaluation of Outcomes on for ongoing follow-up assessments and referrals)

| DEPARTMENT NOTIFIED | WHY # | DATE/TIME | COMPUTER ENTRY | SIGNATURE | DISCIPLINE SIGNATURE | DATE/TIME |
|---------------------|-------|-----------|----------------|-----------|----------------------|-----------|
| | | | | | | |
| | | | | | | |
| | | | | | | |