Patient Learning Needs Assessment

- *Would you prefer to use a translator when discussing your healthcare? Please list your preferred language______________________________*

- *I learn better by:*
  a. *Doing* ***b.*** *Hearing* ***c.*** *Reading* ***d.*** *Writing*

- *I have the following condition(s) that may affect my learning:*
  a. *Vision Problems* ***b.*** *Hearing Problems* ***c.*** *Reading Difficulty* ***d.*** *other*

  Please Explain:____

- *Is there someone that you would like to include in any discussions regarding your Healthcare:* ***YES*** ***NO*** *If* ***"Yes"*** *please specify the name of the person(s) and your relation to that person(s).*

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- *If necessary, do you have someone that will be able to assist you in taking care of yourself?* ***YES*** ***NO***

- *Do you have any spiritual needs or cultural beliefs that may impact the type of medical treatment you receive?* ***YES*** ***NO*** *If* ***"YES"*** *please specify*

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- *Do you have any other questions, concerns, or special needs that your Healthcare Provider needs to know about?* ___________________________

  Patient signature: ____

  Reviewed by: ___________________________ *Date:* _________________