



St. Anthony's Medical Center has designed this screening in order to better identify the potential needs of the whole person. If you answer yes to any question, our staff will assist you to obtain information from the appropriate department. You may choose no or may make a notation that you have chosen not to answer. Please sign your name, so that we know you have been given this opportunity.

NUTRITIONAL SCREENING:

Height _____ Current Weight _____

- 1. Have you had unintentional weight loss of more than 5 pounds in 1 month? Yes No
- 2. Have you had unintentional weight loss of more than 15 pounds in 6 months? Yes No
- 3. Does your current medical condition require a special diet? Yes No

Comments: _____

Referral unnecessary Referral made to outpatient Registered Dietician call 525-1266

PASTORAL CARE SCREENING:

- 1. Would you be interested in meeting with our Chaplain/Support Coordinator? Yes No
- 2. Are you currently dealing with grief/loss? Yes No

Comments: _____

Referral unnecessary Referral made to Support Coordinator call 525-4183

SOCIAL SERVICE SCREENING:

- 1. Would you be interested in meeting with a counselor? Yes No
- 2. Are you currently in a relationship with someone who is making you feel afraid, hurting you, forcing sexual contact, trying to control your life or making you feel unsafe? Yes No
- 3. Would you like information/help planning to make your end of life desires known? (Health Care Directives) Yes No
- 4. Would you be interested in a consultation regarding the use of drugs or alcohol? . . . Yes No
- 5. Would you be interested in a consultation regarding quitting smoking? Yes No
- 6. Is anyone at home dependent on you? Yes No
- 7. Do you have help at home? Yes No
- 8. Is the father of the baby involved? Yes No

Support Person: _____

Comments: _____

Referral unnecessary Referral made to Social Service call 525-4640
 Social Service Pages Information given on safe havens



**SCREENING FOR PERINATAL
AMBULATORY SERVICES**

PAIN SCREENING:

1. Do you have or have you had any pain in the last month? Yes No Intensity (0-10 scale) _____
2. Affects: Sleep Activity Appetite Other: _____

Onset	Location	Description/Duration (Time)	Intensity (0-10)	Worst Pain	Past Interventions	Goals/Acceptable Level (0-10)

Description:
 A = Sharp
 B = Dull
 C = Aching
 D = Tight
 E = Pressure
 F = Consistent
 G = Intermittent

Intensity:
 No Pain - 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - Worst Pain

Interventions:
 A = Medication
 B = Positioning
 C = Emotional Support
 D = Distraction Technique
 E = Other

Comments: _____

COMMUNICATION/EDUCATION SCREENING:

1. Is English your primary language? Yes No If "No" list primary: _____
 Language Interpreter? Yes No
 Deaf Interpreter? Yes No Will need interpreter for consents, medical detail
2. Do you have special needs? None Personal Cultural Religious Beliefs
 Explain: _____
3. Do you have emotional needs? Yes No
 Explain: _____
4. Learning Barriers: Education Cognitive Emotional Sight Hearing Speech
 Cultural Values Language Lack of Motivation None
 Other: _____
5. Learning Preference: Verbal Written Family Member Visual
 Other: _____

Comments: _____

Patient Signature: _____ Date: _____ Time: _____

Registrar Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____



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 AMBULATORY SERVICES**