Patient Communication/Learner Assessment

In order that we may better serve you, please answer the following questions.

1. When learning new information about your health, do you have any difficulty because of the following?
   - [ ] I cannot hear well
   - [ ] I do not speak English well
   - [ ] I cannot see well
   - [ ] I cannot read English well
   - [ ] I have trouble remembering things
   - [ ] No difficulties
   - [ ] Other, please specify: ____________________________

2. If there is someone needed to help you (e.g. act as an interpreter), please name that person: ____________________________
   If you need an interpreter, please specify the language needed: ____________________________

3. How do you prefer to learn?
   - [ ] Written instructions
   - [ ] Oral instructions
   - [ ] Demonstrations

4. Do you have religious or cultural beliefs you want us to consider when we are planning your care?
   - [ ] Yes
   - [ ] No

5. Can we leave messages regarding your health?
   - At your home: [ ] Yes  [ ] No  Telephone #: ____________________________
   - At work: [ ] Yes  [ ] No  Telephone #: ____________________________
   - On a cell phone: [ ] Yes  [ ] No  Telephone #: ____________________________

6. Do you prefer to communicate through electronic mail (e-mail)?
   - [ ] Yes  [ ] No
   - If yes, please print your e-mail address: ____________________________

7. Please list the individuals that you would like to have access to your health information:
   - At any time you may revoke the right you have given the individuals listed below.
   - First and Last Name
   - Relationship
   - Please circle all that applies to each individual
     1. Test results (MRI, x-ray, labs, etc.)
     2. Sensitive information: (HIV and AIDS results, sexually transmitted disease results, behavioral/mental health notes)
     3. Viewing of medical record
     4. Billing
     5. All

In accordance with the Health Information Privacy Act passed on April 14, 2003, you must sign below to have the practices listed above take place.

Patient Signature ____________________________ Date ____________________________