

**DEPARTMENT OF SURGERY
GEORGETOWN UNIVERSITY
HOSPITAL PATIENT / FAMILY
TEACHING RECORD**

PRINT OR USE PATIENT LABEL

Patient Name _____
Last First

MR # _____

DOB _____

PATIENT, PLEASE FILL IN ALL EXCEPT SHADED AREA.

The purpose of this Learning Needs Assessment is to promote one's participation in his or her own health care and to ensure that information regarding evaluation and treatment is presented to him or her in the most effective and appropriate manner possible.

LEARNING NEEDS ASSESSMENT:

Date: _____ Patient Family / Significant Other Patient is unable to participate

What is the easiest way to learn? Reading Listening Demonstration

Difficulty with reading / writing? Yes No

Physical factors affecting education: No Vision Hearing Language Cognitive Other _____

Emotional issues related to learning? (i.e., anxiety, anger, grief) No Yes: _____

Religious and/or cultural preferences to learning? No Yes: _____

Comments: _____

HEALTH PROMOTION / EDUCATION TOPICS:

TOPIC	DATE	EDUCATION
Test and Lab Results reviewed with patient.		<input type="checkbox"/> Brochure / hand-out given. Title: _____ <input type="checkbox"/> Other form of education (list below): _____ <input type="checkbox"/> Patient / family demonstrated understanding
Surgical options / procedures for treatment described.		<input type="checkbox"/> Brochure / hand-out given. Title: _____ <input type="checkbox"/> Other form of education (list below): _____ <input type="checkbox"/> Patient / family demonstrated understanding
Instruction for post-surgical care reviewed.		<input type="checkbox"/> Brochure / hand-out given. Title: _____ <input type="checkbox"/> Other form of education (list below): _____ <input type="checkbox"/> Patient / family demonstrated understanding
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