(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

PATIENT LEARNING ASSESSMENT

OTSG APPROVED *(Date)*

PART I - PATIENT'S/GUARDIAN'S SELF-ASSESSMENT

1. Learning barriers

a. Do any of the following interfere with your ability to learn? Chronic illness or pain. ☐ Yes ☐ No Vision or hearing impairment. ☐ Yes ☐ No Reading or speaking problems. ☐ Yes ☐ No Trouble understanding or remembering. ☐ Yes ☐ No

b. Do you have difficulty reading English?☐ Yes ☐ No c. What is your first language? _____

2. Self care

a. Do you have any problems taking care of yourself? ☐ Yes ☐ No If so, please describe: _____

b. Do you have any questions concerning the current diet and/or medication(s) you are taking? ☐ Yes ☐ No If so, what?

_____

3. Your preference of teaching methods (*Please select as many methods as you prefer.*)

[ ] Provider explaining to me [ ] Showing me a video [ ] Giving me materials to read

4. Social barriers

a. Do you have, or have you ever had, religious beliefs that may impact your health care? ☐ Yes ☐ No If so, what: _____

_____

b. Do you have any cultural beliefs surrounding health care? ☐ Yes ☐ No If so, what: _____

PART II - PROVIDER'S/NURSING STAFF COMMENTS

5. Comments on "Yes" responses to the patient's/guardian's self assessment in part I (*If additional space is needed, use back of form.*)

PART III - PERIODIC VERIFICATION OF 'NO CHANGE' IN THE INFORMATION ENTERED ABOVE IN PART I

Date	Patient's/Guardian's signature	Date	Patient's/Guardian's signature	Date	Patient's/Guardian's signature

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL

☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION

☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT