PATIENT HEALTH RISK ASSESSMENT FORM

FUNCTIONAL STATUS SCREENING

Bathes on own: ☐ Y ☐ N

Toilets on own: ☐ Y ☐ N

Transfers on own: ☐ Y ☐ N

Dresses on own: ☐ Y ☐ N

Eats on own: ☐ Y ☐ N

Mark if you need assistance with:

Laundry: ☐ Y ☐ N

Shopping: ☐ Y ☐ N

Transportation: ☐ Y ☐ N

Handling Finances: ☐ Y ☐ N

Using The Telephone: ☐ Y ☐ N

Meal Preparation: ☐ Y ☐ N

Managing Medications: ☐ Y ☐ N

Housework and Basic Home Maintenance: ☐ Y ☐ N

PATIENT SELF ASSESSMENT

Compared to 1 year ago – I feel my physical health is

- ☐ better
- ☐ worse
- ☐ same

Compared to 1 year ago – I feel my mental health is

- ☐ better
- ☐ worse
- ☐ same

Tobacco Use

In the last 30 days have you used tobacco?

Smoked:

- ☐ Yes
- ☐ No

Smokeless tobacco product

- ☐ Yes
- ☐ No

If yes to either, are you interested in quitting?

- ☐ Yes
- ☐ No

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?

☐ days

On days when you drank alcohol, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks on one occasion?

- ☐ Never
- ☐ Once during the week
- ☐ 2-3 times during the week
- ☐ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

- ☐ Yes
- ☐ No

Depression Screening

PHQ -2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

0=Not at all, 1=several days, 2=more than half the days, 3=nearly everyday.

_____ *1.* Little interest or pleasure in doing things

_____ 2. Feeling down, depressed or hopeless

URINARY INCONTINENCE

Do you have trouble holding your bowels or bladder?

- ☐ Yes
- ☐ No

FALL RISK AND SAFETY SCREENING

Have you had any falls in the past year: ☐ Y ☐ N

*If yes, how many _____

_____

- ☐ Balance
- ☐ Gait
- ☐ Vision
- ☐ Hearing
- ☐ Cognition
- ☐ Continence Balance
- ☐ NO impairment detected

PAIN SCREENING

Do you have pain?

- ☐ Yes
- ☐ No

If yes, what is the current intensity of pain (0-10) 0=no pain, 10=worst pain _____

Pain assessment as clinically appropriate (onset, location, duration, characteristics, aggravating factors, relieving factors, etc) _____

EXERCISE / PHYSICAL ACTIVITY

How often are you exercising _____ minutes _____ times a week

ADVANCE CARE PLANNING

We will be discussing this with you at your visit. However, if you have an up to date advanced care planning, please bring it with you to your visit.

List of Specialists, DME and home health

SPECIALIST

Cardiology - Specialist Name

Ophthalmology / Optometrist - Specialist Name

Dermatology - Specialist Name

Urology - Specialist Name

Orthopedic - Specialist Name

Neurology - Specialist Name

Endocrinology - Specialist Name

Pulmonology - Specialist Name

Sleep Medicine - Specialist Name

Vascular Surgeon - Specialist Name

Gastroenterology (GI) - Specialist Name

Gynecologist - Specialist Name

Allergy / Immunology - Specialist Name

Hematology / Oncology - Specialist Name

Specialty Specialist Name

Specialty Specialist Name

Specialty Specialist Name

Specialty Specialist Name

Specialty Specialist Name

Specialty Specialist Name

Durable Medical Equipment / DME (CPAP, Oxygen, etc)

Company Name Services provided (CPAP, Oxygen, wheelchair, etc)

Company Name Services provided (CPAP, Oxygen, wheelchair, etc)

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HOME HEALTH

Company Name

Utah Advance Health Care Directive

*(Pursuant to Utah Code Section 75-2a-117, effective 2009)**

Part I:	***Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.***
Part II:	***Allows you to record your wishes about health care in writing.***
Part III:	***Tells you how to revoke or change this directive.***
Part IV:	***Makes your directive legal.***

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____ Cell Phone: (_____) _____

Birth Date: _____

Part I: My Agent (*Health Care Power of Attorney)*

A. No Agent

If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.

☐ **I do not want to choose an agent.**

B. My Agent

Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____

C. My Alternate Agent

This person will serve as your agent if your agent, named above, is unable or unwilling to serve.

Alternate Agent's Name: _____

Street Address: _____

City, State, Zip Code: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Work Phone: (_____) _____

Part I: My Agent (*continued)*

D. Agent's Authority

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

E. Other Authority

My agent has the powers below only if I initial the "***yes***" option that precedes the statement. I authorize my agent to:

____YES ____ NO Get copies of my medical records at any time, even when I can speak for myself.

____YES ____ NO Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.

F. Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent as follows:

_____

_____

_____

G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

____YES ____ NO I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.

H. Consent to Participate in Medical Research

____YES ____ NO I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Organ Donation

____YES ____ NO If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

Part II: My Health Care Wishes (*Living Will*)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

***Choose only one** of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.*

Option 1	
_____ Initial	**I choose to let my agent decide.** I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances.
Additional comments:	

Option 2	
_____ Initial	**I choose to prolong life.** Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards.
Additional comments:	

Option 3		
_____ Initial	**I choose not to receive care for the purpose of prolonging life,** including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life.	
If you choose this option, you must also choose either (a) or (b), below		
_____ Initial	(a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care.	
_____ Initial	(b) My health care provider should withhold or withdraw life-sustaining care if ***at least one*** of the initialed conditions is met:	
If you selected (a), above, do not choose any options under (b).		I have a progressive illness that will cause death
		I am close to death and am unlikely to recover
		I cannot communicate and it is unlikely that my condition will improve
		I do not recognize my friends or family and it is unlikely that my condition will improve
		I am in a persistent vegetative state
Additional comments:		

Option 4	
_____ Initial	I do not wish to express preferences about health care wishes in this directive.
Additional comments	

Part II: My Health Care Wishes (*continued*)

Additional instructions about your health care wishes:

_____

_____

_____

If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

- Writing "void" across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
- Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
- Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
- Signing a new directive. ***(If you sign more than one Advance Health Care Directive, the most recent one applies.)***

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

_____ _____

Date Signature

_____

City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:

1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

_____ _____

Signature of Witness Printed Name of Witness

_____ _____ _____ _____

Street Address City State Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

_____

_____

Name: _____