UCLA Ambulatory Care
PATIENT EDUCATION ASSESSMENT

In order to help us in meeting your education needs, please take the time to answer the questions below:

Person completing the form:  □ Patient  □ Family  □ Significant Other  □ Healthcare Professional

1. Is English your main language?  □ Yes  □ No
   Do you have another language in which it is easier for you to communicate?  □ Yes  □ No
   Preferred language: ____________________________________________________________

2. Do you have any problems with your vision or hearing that might affect how we teach you?  □ Yes  □ No
   If "Yes," please explain: ______________________________________________________

3. How would you prefer to receive information regarding your care? (Check all that apply.)
   □ Written  □ Verbal  □ Demonstrate
   □ Other ________________________________________________________________

4. Do you have any beliefs or practices that might affect how we teach you?  □ Yes  □ No
   If "Yes," please explain: (Such as: religious, cultural, or spiritual)

5. Are you ready to receive health instruction?  □ Yes  □ No
   If "No," please explain: ______________________________________________________

Patients: Please Stop Here

To be completed by a healthcare professional when a patient's condition changes.

1. Have the patient's educational needs changed since the last assessment?  □ Yes  □ No
   Date ____________________________  Signature / Title ____________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________
   □ Yes  □ No  Date__________________________

* = Requires Note

Comments: __________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
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