

Name: DOB: MRN:
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Documentation of Patient/Family Education

Which language do you prefer to speak? English Spanish Other _____ Are you able to read? Yes No

Which language do you prefer to read? English Spanish Other _____

How many years of school have you completed? _____ Where? _____ Did you graduate? _____

How do you learn best? Individual teaching Class/group Demonstration Reading Video Other _____

Do you have any problems that make it hard for you to learn, such as hearing loss, poor eyesight, physical limitations or difficulty reading?
Please describe: _____

General Topic(s)	Date	Educator(s)	Attendee(s)	Discussed/Demonstrated...	Disposition (Follow-up, Referral, Education Complete)	Initials of Educator & Primary Attendee (or person-in-interest)

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Advance Directives	AD	Foot Care	FC	Patient	PT
Attention Deficit Hyperactivity Disorder	ADHD	General Health	GEN	Parent/Guardian	P/G
Anticoagulation	AC	Hypertension	HTN	Caregiver	CG
Asthma	AS	Medication (non-anticoagulation)	MED	Other Family	OF
Depression	DEP	Nutrition (including lipids, salt, etc)	NU	Other	OT (and specify)
Diabetes Mellitus	DM	Pain Management	PM		
Equipment (e.g., home glucose monitor)	EQ	Pregnancy	PRG		
Exercise	EX	Self-Management Goals	SM		
Family Planning	FP	Tobacco Cessation	TOB		

Action	Code
Standard Education Packet given	SEP (+ Topic from Table 1 above)
Videotape shown	VID (+ Topic from Table 1 above)
Special Education	NSE (non-standardized education)
Observation of Patient	OBS (+ what was observed)