Barnabas Health
Ambulatory Care Center

RWJBarnabas HEALTH

Saint Barnabas
Medical Center

RWJBarnabas HEALTH

SUMMARY LIST

Outpatient Rehabilitation Services

Initial Visit Date: _____

Referring MD: _____ **Primary MD:** _____

Patient Problem (chief complaints): _____

Height: _____ **Weight:** _____ **N/A:** _____

Allergies/Adverse Allergic Drug Reactions (Note symptoms exhibited): _____

_____ ☐ **No Allergies**

Please check all significant medical diagnoses and conditions: ☐ **No significant medical history**

Diagnosis/Condition	Date	Diagnosis/Condition	Date
☐ Cancer **Type:**		☐ Multiple Sclerosis	
☐ Diabetes		☐ Seizures	
☐ High Blood Pressure		☐ Infectious disease (TB / Hepatitis / MRSA)	
☐ Heart Disease		☐ Skin conditions	
☐ Angina/Chest Pain		☐ Polio / post polio	
☐ Deep Vein Thrombosis		☐ Urinary incontinence	
☐ Pacemaker		☐ Depression	
☐ Stroke		☐ Sleep disorder	
☐ Circulation Problems		☐ HIV positive	
☐ Arthritis		☐ Are you / could you be pregnant	Yes / No
☐ Osteoporosis / Ostopenia		☐ Other	
☐ Lung problems		☐ Other	
☐ Asthma		☐ Other	

Please list all significant surgical/invasive procedures:

	Date

Current medications should include prescribed and over the counter medications, herbal medications and supplements

☐ **No medications at this time** _____ / _____ / _____

MEDICATION/VITAMINS/SUPPLEMENTS	DOSE	FREQUENCY	ROUTE

In the past 3 months have you experienced:

☐ Nausea / vomiting	☐ Dizziness
☐ Fever / chills / sweats	☐ Change in your balance
☐ Unexplained weight change	☐ Headaches
☐ Numbness or tingling	☐ Pain at night
☐ Change in appetite	☐ None
☐ Change in bowel / bladder function	

EDUCATION

Language(s) spoken: [ ] English [ ] Spanish [ ] Russian [ ] Other (specify):

_____

Barriers to Learning: [ ] Blind [ ] Deaf [ ] Cognitively Impaired [ ] Language [ ] Emotional/Anxiety
[ ] Other (specify): _____
[ ] Literacy [ ] None

Patient best learns: [ ] Written material [ ] Verbal Explanation [ ] Demonstration
[ ] Visual Aids (handouts, videos, DVD, CD, etc.) [ ] All of the above

Are you a smoker? [ ] Yes [ ] No

DO NOT WRITE BELOW THIS LINE OFFICE USE ONLY

Date	Education Topic	Method of Education	Whom Taught	Outcome of Education	Signature/ Status of Person Providing Education
	If patient is a smoker: Provided education about the specific effects of smoking and ones health along with the "Tobacco Dependence Treatment Program" brochure. Tobacco Dependency Treatment Program (973) 926-7978 Quit Line 866-NJ-STOP Quit net www.nj.quitnet.com	☐ Verbal ☐ Pamphlet	☐ Patient ☐ Spouse ☐ Significant Other ☐ Other	☐ Verbalized understanding ☐ Refused education	

Sign/symptoms of abuse	Nutritional needs	Physical barriers	Patient safety discussed
Yes No	Yes No	Yes No	Yes No
If yes specify:	If yes specify:	If yes specify:	
Action Taken: ☐ Education ☐ Referral ☐ Other	Action Taken: ☐ Education ☐ Referral ☐ Other	Action Taken: ☐ Education ☐ Referral ☐ Other	☐ Verbalized understanding ☐ Other

COMMENTS:

_____

_____

*** Therapist to update additional information as received from patient