O'SULLIVAN RADIOLOGY

Preventative Measures

DOB:_____ **Date:**_____

Name:_____ **Film #**_____

Height: ____ft ____in **Weight:**_____

Please answer the following:

1. Have you ever been diagnosed with hypertension? **YES / NO**
2. Do you have an advanced care plan/a person who can make clinical decisions for you? **YES / NO**
   - If yes, who? _____
3. Please indicate your smoking status: (X)

Never smoked _____ Current daily smoker _____
Former smoker _____ Heavy tobacco smoker _____

If you are a smoker, how many pack(s) per day:

<0.5 Packs, 0.5 Packs, 1 Pack, 2 Packs, 3 Packs, >3 Packs

Please list:

Medication Allergies: Medications:

For Technologist Use:

PHQ-9 Score:_____ Social Needs (+/-):_____

BP: _____

Patient Name:_____ DOB:_____ Film #:_____

Social Needs Screening Tool

Housing

1. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as a part of a household?

   YES OR NO

2. Think about the place you live. Do you have problems with any of the following? (circle all that apply)

   -BUG INFESTATION -INADEQUATE HEAT
   -LEAD PAINT OR PIPES -MOLD
   -OVEN OR STOVE NOT WORKING
   -NO OR NOT WORKING SMOKE DETECTORS
   -WATER LEAKS -NONE OF THE ABOVE

Food

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

   -OFTEN TRUE -SOMETIMES TRUE
   -NEVER TRUE

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

   -OFTEN TRUE -SOMETIMES TRUE
   -NEVER TRUE

Transportation

5. Do you put off or neglect going to the doctor because of distance or transportation?

   YES OR NO

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

   YES OR NO

Child Care

7. Do problems getting child care make it difficult for you to work or study?

   YES OR NO

Employment

8. Do you have a job?

   YES OR NO OR RETIRED

Education

9. Do you have a high school degree?

   YES OR NO

Finances

10. How often does this describe you? I don't have enough money to pay my bills:

    -NEVER -RARELY -SOMETIMES
    -OFTEN -ALWAYS

Personal Safety

11. How often does anyone, including family, physically hurt you?

    -NEVER(1) -RARELY(2) -SOMETIMES(3)
    - FAIRLY OFTEN(4) -FREQUENTLY(5)

12. How often does anyone, including family, insult or talk down to you?

    -NEVER(1) -RARELY(2) -SOMETIMES(3)
    - FAIRLY OFTEN(4) -FREQUENTLY(5)

13. How often does anyone, including family, threaten you with harm?

    -NEVER(1) -RARELY(2) -SOMETIMES(3)
    - FAIRLY OFTEN(4) -FREQUENTLY(5)

14. How often does anyone, including family, scream or curse at you?

    -NEVER(1) -RARELY(2) -SOMETIMES(3)
    - FAIRLY OFTEN(4) -FREQUENTLY(5)

15. Would you like help with any of these needs?

    YES OR NO

SCORING INSTRUCTIONS: For questions 1 through 10: Underlined answers indicate a positive response for a social need for that category.
For questions 11 through 15: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.
Sum of questions 11–14: _____ Greater than 10 equals positive screen for personal safety.

Categories with a positive response:_____

Patient Name:_____ DOB:_____ Film #:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Have you have ever been diagnosed with/or suffered from a mental illness? Yes or No

If so please circle:

Anxiety (any form) Depression (any form) Panic Disorders Phobias