



**Quality of Life Assessment:** Please help us understand how we can best serve your needs by completing the following quality of life assessment. Rate your level of satisfaction in these five areas by circling the appropriate number on the following scale.

1=Very Dissatisfied    2=Not Satisfied    3=Neutral    4= Satisfied    5=Very Satisfied

						<b>Comments</b>
<b>Physical</b>	1	2	3	4	5	_____
<b>Mental:</b>	1	2	3	4	5	_____
<b>Social:</b>	1	2	3	4	5	_____
<b>Emotional:</b>	1	2	3	4	5	_____
<b>Spiritual:</b>	1	2	3	4	5	_____

**How do you learn best?**     Discussion     Hands-On     Audio/Visual     Reading

**Have you been hospitalized in the last 6 months?**     Yes     No

**Have you fallen in the last 3 months?**     Yes     No

**Do you feel safe at home?**     Yes     No

**Do you have any special mobility needs?**     Yes     No

**If yes, please describe:**

**Would you like to be contacted by our PrestigePLUS nurse for a complimentary Wellness Consultation?**     Yes     No

**Do you have the following Advance Directives?**

Living Will     Yes     No

Medical Durable Power of Attorney     Yes     No

5 Wishes     Yes     No

CPR Directive     Yes     No

**Would you like to be contacted by our Advance Directives Resource Specialist?**

Yes     No

**Additional Comments:**

**Consent for Services:** *By signing below, I hereby give my consent for physical assessment, screening procedures, other services, and/or blood tests through PrestigePLUS. I hereby authorize release of information from such procedures to my physician as requested.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For Office Use Only:**

**Reminder Calls: Please initial/date**

**Advance Directives** \_\_\_\_\_ **Get to Know You/Us** \_\_\_\_\_