Decision aid request form (DHMC)

Patient : ____-__________________

MRN: ______________________________ Provider: ______________________________

Date: ___________________ VCR tape ☐ DVD ☐

Prev	☐ **PSA**	Cardiac	☐ **Treatment choices for CAD**
	☐ **Colon Cancer Screening**		☐ **Living with CHD**
	☐ **Advanced Directives**		☐ **CHF**
	☐ **Healthcare that's right for you**		☐ **Managing A-fib**
Ortho	☐ **Knee osteoarthritis**	Misc	☐ **Depression**
	☐ **Hip osteoarthritis**		☐ **Weight loss surgery**
	☐ **Herniated disc**		
	☐ **Spinal stenosis**	Uro/Gyn	☐ **BPH**
	☐ **Chronic low back pain**		☐ **Managing menopause**
	☐ **Acute low back pain**		☐ **Abnml Uterine Bleeding**
			☐ **Uterine fibroids**
☐ **Other**			

Provider's intention for patient after viewing decision aid:

- ☐ Wait to hear from patient
- ☐ Reappointment in GIM to discuss
- ☐ Referral to specialist

Send original with patient; carbon to Decision Support Project (email: gimsupport)