

**Decision aid request form (DHMC)**

**Patient :** \_\_\_\_\_ -

**MRN:** \_\_\_\_\_

**Provider:**

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

**VCR tape**

**DVD**

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

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)