

## **Ambulatory Care Center**

182-19 Horace Harding Expressway

Fresh Meadows, NY 11373 Tel: 718-670-2902/2903 Tel: 718-670-2671/2672

Fax: 718-357-1176

## Welcome to the New York Hospital Queens Ambulatory Center

This outpatient center provides comprehensive primary care services and sub-specialty services. Nutrition, social work, and phlebotomy services are also available.

Office hours: Mondays-Fridays: 8:30-5 pm (by appointment) Same-day and walk-ins appointments available based on medical need.

Please arrive at the office 30 minutes before your appointment time to complete any paperwork. Please bring:

Medical insurance card (if available)
Photo identification
List of medications/medication bottles
Prior medical records: previous lab/test results (if available)
Immunization/vaccination record (if available)

Please complete these forms and bring them with you to your initial or next appointment. For questions, please call the number above.

If your insurance company requires you to choose a primary care physician, please ensure that you have changed your primary care physician to one of our internal medicine physicians before your visit:

Ebenezer Odoom, MD Liana Leung, MD, MPH Wei-fun Sung, MD Renuka Shetty Das, MD

The office also provides the following additional services:

Allergy Podiatry
Endocrinology Pulmonary
Geriatric medicine Rheumatology

Gastroenterology/Hepatobiliary Nutrition and Social Work

Nephrology/Hypertension Urology

Thank you for coming to our office. We look forward to serving you.

## NYHQ AMBULATORY CARE

□ NEW (Complete all section)

	<b>UPDATE</b>	(Complete	Section I)
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Today's Date:										
		PATIEN	NT INFOR	MATION (	SECTIO	N I)				
Patient's last name:			First name:		Marital status:					
						Single	Mar 🔲 🛚	Div Sep	Wid 🗌	
Street address:			City:			State:	Zip:		Apt#:	
Birth date:	Sex:			Home phone no.:			Alterna	Alternate phone no.:		
	□F	□ M					(			
Social Security no.:		Religion	Native Language				Country Born			
		Father's First Name	Name Preferred land			i language:	Race:  American Indian/Alask Native Asian Black or African Ameri			
		Insurance #:			Ethhnicity:  Hispanic or Latino Not Hispanic or Latin		□ Native Hawaiian or oth Pacific Islander □ White □ Two or More Races			
E-mail address:		Employer:								
		SPOUS	E INFORM	MATION (S	ECTION	II)				
Spouse's last name:			Firs	st:						
Street address:	t address:		City:	City: St		State:	Zip:	Zip: Apt#:		
Birth date:	Sex:			Home phone no.:			Alternate phone no.:			
	□F	□ M ( )						( )		
		NE	XT OF KI	N (SECTIO	N III)					
Last name:				First:						
Street address:			City:	City:		State:	Zip:		Apt#:	
Birth date:	Sex:			Home phone no.:			Relationship to Patient		tient	
	□F	М		( )						
		EMERG	ENCY CO	NTACT (SE	CTION	IV)				
Last name:				First:						
Street address:			City:			State:	Zip:		Apt#:	
Birth date:	Sex:	□ м	Home phone		no.:		Relationship to Patient			
Patient Signature:						Date:				

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Tork Hospital Queens						
DATA SOURCE						
Patient Interpreter, Name Other						
• Patient's preferred language: Speaks						
Patient's preferred language: Reads □ English □ Other     Does Patient have language needs that need to be addressed? □ Yes □ No						
• Does Patient have language needs that need to be addressed? ☐ Yes ☐ No • If yes: interpretation method: ☐ Language line ☐ Staff interpreter ☐ Video service ☐ Sign language interpreter						
☐ Refused Hospital Interpreter Service ☐ Other						
• Does patient have cultural or religious issues that need to be addressed?   Yes No						
Explain how any Barriers noted above impact on the patient or family's ability to learn Patient Plan of Care:						
PSYCHOSOCIAL SCREEN						
1. Highest Level of Education:						
2. Residing at:  Home Rehab.  Nursing home Group Home Adult Home Other: Patient live alone Patient lives with:						
3. Family/friend support? ☐ Spouse ☐ Friend ☐ Family ☐ Alone						
4. Marital Status: Single Married Divorced Widowed Children: Yes or No How many?  5. Working Status? Yes or No Divorced Divorced Housewife Disabled Retired						
6. Feelings of Depression: No Yes						
7. Has anyone ever hurt you in your home?: ` \( \text{No} \) \( \text{Ves, explain:} \)						
FUNCTIONAL ASSESSMENT Allergies:  No Yes. describe:						
Adverse Drug Reaction: No Yes, describe:						
Level of Consciousness: Awake Alert Oriented to Person Place Time Lethargic  Denture: None Upper Lower With Patient Bridge Caps Loose Teeth						
Vision: Normal Glasses Contacts Prosthesis Glasses Blind						
Hearing: Normal Impaired Deaf Hearing Aid						
Speech: Normal Impaired Unable to Speak Other Implants: Ortho Pacemaker Other						
Ambulation: 🗆 Independent 🗆 Needs Assistance 🗆 Cannot Climb Stairs 🗆 Wheelchair 🗀 Home Bound						
☐ Bed Bound ☐ Uses Cane ☐ Walker  History of Falls within the last (1) year: ☐ Yes ☐ No ☐ Frequency						
Spiritual: Does the patient have any cultural or religious needs that need to be addressed?						
Needs assistance for normal activities:						
ADYANCE DIRECTIVE None Health Care Proxy Living Will MOLST (Medical Orders for Life Sustaining Treatment)						
Copy of Advance Directive in the Chart?  Yes No Copy of in the Chart? Yes No						
If none, was the patient given information on advance directives?    Yes    No						
LEARNING NEEDS ASSESSMENT     Person being taught:   Patient   Family   Significant Other:						
Abilities/Barrier: None Physical Visual Language Hearing Emotional Cognitive						
Cultural Motivational Religious Financial Concerns Age-Related Issues						
Explain how the barriers noted above impact patient's plan of care:  Learners learn best by:  Verbal						
Understands Verbal Instructions:   Yes No						
Reads Written Instructions:						
• Has patient ever smoked?:  Yes No When did patient last smoke?						
• Has patient ever smoked?: ☐ Yes ☐ No When did patient last smoke? • Quit within the last year? ☐ Yes ☐ No How much does patient smoke each day?						
If patient has quit within the past year or still smokes, patient provided with information on smoking cessation:						
SUBSTANCE ABUSE:  Do you drink alcohol?  Yes No Frequency: Recreational Drugs? Yes No Frequency:						
Signature Name: Date: Time: am/pm Title: (Physician/NP/PA/RN/LPN) MRCA#142210						

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