

**Parish Nursing Services
Client Interaction Form**

Client Name: _____

DOB: _____ Age/ Age Range _____ Date: _____

Gender M F Marital Status _____ Time: _____

Address : _____

Phone: _____

Ethnic Heritage¹(circle): C A H OA NA ME FE MC U O

Congregational Status (circle): Parishioner Non-Parishioner

Referral Source² (circle): S P NP PS MD HCP M O PN FAM

Contact Person: _____ Phone: _____

Advanced Directives: Y N Living Will Y N Durable Power of Attorney for Health Care Y N

Primary Health Care Professional: _____

Address: _____ Phone: _____

Pertinent Medical History:(circle) DM HTN Cardio Vascular Pulmonary

Cancer Glaucoma Urinary Other: _____

Pertinent Medication History: _____

Comments/ Additional Information: _____

Has BP screening form Parish Nurse X _____

Congregation _____

¹ C=Caucasian; A=African American/Black; H=Hispanic; OA=Oriental/Asian; NA=Native American; ME=Middle Eastern; FE=Far Eastern; MC=Multi-Cultural; U=Unknown; O=Other

² S=Self; P=Parishioner; NP=Non-Parishioner; PS=Pastoral Staff; MD=Physician; HCP=Other Health Care Professional; M=Media; O=Other; PN=Parish Nurse; FAM=Family