# PCMH Orientation Checklist Date:

**TC 09**

**Patient Details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **DOB:** |  | **MRN:** |  |

*MA/Nursing: Use checklist during every New Patient visit and attach to medical record*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Task** | **Complete** | **No** | **Follow-up Action** |
| **1** | Personal physician selected? | [ ]  | [ ]  |  |
| **2** | Consent for records transfer obtained? | [ ]  | [ ]  |  |
| **3** | Intake forms filled? | [ ]  | [ ]  |  |
| **4** | Does patient have insurance? | [ ]  | [ ]  |  |
| **5** | If not, insurance resources provided? | [ ]  | [ ]  |  |
| **6** | Special accommodations? | [ ]  | [ ]  |  |
| **7** | PCMH Responsibilities explained? | [ ]  | [ ]  |  |
| **8** | Patient Responsibilities explained? | [ ]  | [ ]  |  |
| **9** | Access and after-hours explained? | [ ]  | [ ]  |  |
| **10** | Contact information provided? | [ ]  | [ ]  |  |

*MA additional notes:*

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MA Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Provider notes:*

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| --- |
|  |

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_