Spiritual Care Patient Encounter

For Spiritual Care Team Member to complete

Patient Name: _____ **DOB**: _____ **Date**: _____

Type of Contact: ☐**Phone** ☐**In-Person** ☐**Other** _____ **Ph.#** _____

Preferred Language: ☐**English** ☐**Spanish** ☐**Other:** _____

Primary Care Provider: _____

Type of Encounter: ☐Formal ☐Informal

In Response to: ☐Social Services Referral ☐Spiritual Care Screening/ Assessment

☐Prayer Request ☐Provider/ Staff Request ☐Follow-up From Previous Encounter

☐Other: _____

Description of Encounter/ Observations: _____

_____

_____

_____

_____

_____

_____☐Continued on back

Recommendations: _____

_____

_____

Follow Up by Clinical/Social Work/Resource Staff Needed? ☐Yes ☐No

Does Medical Provider Need to be Contacted (and why)? ☐Yes ☐No

_____

Is an Additional Spiritual Care Appointment Needed? ☐Yes ☐No

Name Person Completing Form: _____

Signature: _____