

**1. Patient Identification**

Patient Name: *Last* \_\_\_\_\_

*First* \_\_\_\_\_

*M.I.* \_\_\_\_\_

HIS ID (CNDS): \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Inactive Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Med-IT ID: \_\_\_\_\_

Enrollment Status:  Active  Has Insurance  Moved  
 Age Ineligible  Income Ineligible  Lost To Follow-up  
 Deceased  Request to Drop

BCCCP Referral Status:  Actively enrolled in BCCCP  Not Enrolled in BCCCP - WISEWOMAN Referral Only

**2. Patient Enrollment/Annual Screening**

**3. Primary Language Spoken at Home**

Screening Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Visit Type:

Follow-up—LSP/HC Complete

English  Spanish  Arabic  Chinese  French  Italian  Japanese  
 Korean  Polish  Russian  Tagalog  Vietnamese  Creole  Portuguese  
 Hmong  Other Language

Race (select all that apply):  White  Black or African American  Native Hawaiian or Pacific Islander  American Indian or Alaska Native  Unknown

Zip Code \_\_\_\_\_

Ethnicity  Hispanic/Latino  Non-Hispanic/Latino  Unknown

Years of education:  <9<sup>th</sup> grade  Some high school  High school grad. or equiv.  Some college or higher  Don't know

WW Patient Navigation Paid By:  BCCCP  WISEWOMAN  Indian Health Services/Tribal Funds  Other Funds  N/A (did not receive navigated services)

**Clinical Measurement Results**

Clinical Measurement Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Blood Pressure 1<sup>st</sup> Reading \_\_\_\_ / \_\_\_\_

Blood Pressure 2<sup>nd</sup> Reading \_\_\_\_ / \_\_\_\_

Height (inches) \_\_\_\_\_

Weight (pounds) \_\_\_\_\_

Waist Circumference (inches) \_\_\_\_\_

**Risk Reduction Counseling**

Risk Reduction Counseling Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**4. Medical History**

**5. Medication Status**

- a. Do you have **high cholesterol**?  
 Yes  No  Don't know/not sure
- b. Do you have hypertension (**high blood pressure**)?  
 Yes  No  Don't know/not sure
- c. Do you have **Diabetes** (either Type 1 or Type 2)?  
 Yes  No  Don't know/not sure
- d. Have you had any of the following:
  - I. **Stroke/transient ischemic attack (TIA)**  
 Yes  No  Don't know/not sure
  - II. **Heart Attack**  
 Yes  No  Don't know/not sure
  - III. **Coronary Heart Disease**  
 Yes  No  Don't know/not sure
  - IV. **Heart Failure**  
 Yes  No  Don't know/not sure
  - V. **Vascular Disease (peripheral arterial disease)**  
 Yes  No  Don't know/not sure
  - VI. **Congenital Heart Disease and Defects**  
 Yes  No  Don't know/not sure
  - VII. **Gestational hypertension**  
 Yes  No  Don't know/not sure
  - VIII. **Gestational diabetes**  
 Yes  No  Don't know/not sure
  - IX. **Pre-eclampsia/eclampsia**  
 Yes  No  Don't know/not sure

- a. Do you take medication to lower your blood pressure?  
 Yes  No  N/A  Don't know/not sure
- b. Do you take a statin medication to lower your cholesterol?  
 Yes  No  N/A  Don't know/not sure
- c. Do you take other (non-statin) medication to lower your cholesterol?  
 Yes  No  N/A  Don't know/not sure
- d. Do you take medication to lower your blood sugar (for diabetes)?  
 Yes  No  N/A  Don't know/not sure
- e. Are you taking aspirin daily to help prevent a heart attack or stroke?  
 Yes  No  Don't know/not sure
- f. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? \_\_\_\_\_ (number of days)  
 None  N/A
- g. During the past 7 days, on how many days did you take prescribed medication (including diuretics) to lower your blood pressure? \_\_\_\_\_ (number of days)  
 None  N/A
- h. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)? \_\_\_\_\_ (number of days)  
 None  N/A

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*First* \_\_\_\_\_

*M.I.* \_\_\_\_\_

**6. Blood Pressure, Self-Measurement**

- a. Do you measure your blood pressure?
  - Yes
  - No-Was never told to measure blood pressure
  - No-Doesn't know how to measure blood pressure
  - No-Doesn't have equipment
  - Don't know/hot sure
  - Not Applicable
- b. How often do you measure your blood pressure?
  - Multiple times per day
  - Daily
  - A Few times per week
  - Weekly
  - Monthly
  - Don't know/hot sure
  - Not Applicable
- c. Do you regularly share blood pressure readings with a health care provider for feedback?
  - Yes
  - No
  - Don't know/hot sure
  - Not Applicable

**7. Nutrition Assessment**

- a. How many cups of fruits and vegetables do you eat in an average day \_\_\_\_\_ (in cups)
- b. Do you eat fish at least two times a week?
  - Yes  No
- c. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains?
  - Less than half  About half  More than half
- d. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly?
  - Yes  No
- e. Are you currently watching or reducing your sodium or salt intake?
  - Yes  No
- f. In the past 7 days, how often do you have a drink containing alcohol? \_\_\_\_\_ (Number of Days)  None
- g. How many alcoholic drinks, on average, do you consume during a day you drink? \_\_\_\_\_ (Number of Drinks)  None

**8. Physical Activity Assessment**

- a. How many minutes of physical activity (exercise) do you get in a week? \_\_\_\_\_ (in minutes)  None

**9. Smoking status**

- a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
  - Current  Quit (1-12 months ago)  Quit(>12 months ago)  Never Smoked

**10. Quality of Life Assessment**

- a. Over the past 2 weeks, how often have you been bothered by any of the following problems?
  - I. Little interest or pleasure in doing things?  Not at all  Several Days  More than half  Nearly Every Day
  - II. Feeling down, depressed, or hopeless?  Not at all  Several Days  More than half  Nearly Every Day

**Tobacco Cessation Resource Referral**

**Referral Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Type of Cessation Resource**

- Quit Line
- Community-based tobacco program
- Other tobacco cessation resources

**Status of Cessation Resource**

- Yes - Completed Tobacco Cessation Program
- No - Partially completed Tobacco Cessation Program
- No - Discontinued from tobacco cessation activity when reached
- No - Could not reach to conduct tobacco cessation activity
- Client Refused Referral

**Workup Status**

What is the status of the work-up?

- Medically necessary
- Not medically needed
- Medically necessary follow-up appointment declined
- Client refused workup

**Date of Follow-up** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Referral Reason**  Blood Pressure

**Comments**

Comments:

<b>NC WISEWOMAN Follow-Up Screening (DHHS 4051C)</b>		<b>Agency:</b>	
<b>Patient Identification</b>		<b>Patient Name:</b> <i>Last</i> <i>First</i> <i>M.I.</i>	
<b>Social Determinants of Health (SDOH) Assessment</b>			
<b>1. Computer use</b>		<b>2. Internet Access</b>	
a. During the last 12 months, did you use any of the following? i. Desktop/Laptop ii. Smartphone iii. Tablet/Other portable wireless Computer  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		a. During the last 12 months, did you or any member of this household have access to the internet? <input type="checkbox"/> Yes, by paying a cell phone company or internet service provider <input type="checkbox"/> Yes, without paying a cell phone company or internet service provider <input type="checkbox"/> No access to internet in this house, apartment, or mobile home <input type="checkbox"/> Don't Know	
<b>3. Food Insecurities</b>		<b>4. Transportation Barriers</b>	
a. During the last 12 months, were there any times when you were worried that you would run out of food because of a lack of money or other resources? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		a. During the last 12 months, have you missed a doctor's appointment because of transportation problems?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	
<b>5. Childcare</b>		<b>6. Childcare Barriers</b>	
a. If you are currently using childcare services, please identify the type of services you use. (If not using childcare services, please select 'Not applicable') <input type="checkbox"/> Infant (birth to 11 months) <input type="checkbox"/> After School Care (K-9 <sup>th</sup> grade) <input type="checkbox"/> Toddler (11 to 36 months) <input type="checkbox"/> Not applicable <input type="checkbox"/> Preschool (3 to 5 years) <input type="checkbox"/> Don't Know		a. During the last 12 months, have you had any of these childcare services, please identify the type of services you use. (If not using childcare, please select 'Not applicable'. Select all that apply) <input type="checkbox"/> Cost <input type="checkbox"/> Hours of Operation <input type="checkbox"/> Availability <input type="checkbox"/> Other <input type="checkbox"/> Location <input type="checkbox"/> Not applicable <input type="checkbox"/> Transportation <input type="checkbox"/> Don't Know	
<b>7. Housing</b>			
a. What is your housing situation today? <input type="checkbox"/> I have housing <input type="checkbox"/> I have housing, but I am worried about losing my housing <input type="checkbox"/> I do not have housing <input type="checkbox"/> Don't Know			
<b>8. Intimate Partner Violence</b>			
a. During the last 12 months, how often did your partner physically hurt you? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Fairly Often <input type="checkbox"/> Frequently <input type="checkbox"/> No partner			
b. During the last 12 months, how often did your partner insult or talk down to you? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Fairly Often <input type="checkbox"/> Frequently <input type="checkbox"/> No partner			
<b>9. Medication Adherence</b>			
a. During the last 12 months, did you ever forget to take your medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Want to Answer <input type="checkbox"/> No Medication Taken b. During the last 12 months, were you careless at times, about taking your medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Want to Answer <input type="checkbox"/> No Medication Taken c. During the last 12 months, when you felt better, did you sometimes stop taking your medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Want to Answer <input type="checkbox"/> No Medication Taken d. During the last 12 months, sometimes if you felt worse when you took your medicine, did you stop taking it? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Want to Answer <input type="checkbox"/> No Medication Taken			

NC WISEWOMAN Follow-Up Screening (DHHS 4051D)		Agency:
Patient Identification	Patient Name: Last First M.I.	
Social Determinants Needs Referrals		
1. Computer Use		
Is there a referral need for Computer use? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Computer Use Referred to: _____	
Computer Use Support Utilization Date: __/__/__	Status of Computer Use Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
2. Internet Access		
Is there a referral need for Internet Access? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Internet Access Referred to: _____	
Internet Access Support Utilization Date: __/__/__	Status of Internet Access Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
3. Food Insecurity		
Is there a referral need for Food Insecurity? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Food Insecurity Referred to: _____	
Food Insecurity Support Utilization Date: __/__/__	Status of Food Insecurity Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
4. Transportation		
Is there a referral need for Transportation? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Transportation Referred to: _____	
Transportation Support Utilization Date: __/__/__	Status of Transportation Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
5. Childcare		
Is there a referral need for Childcare? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Childcare Referred to: _____	
Childcare Support Utilization Date: __/__/__	Status of Childcare Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
6. Housing		
Is there a referral need for Housing? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Housing Referred to: _____	
Housing Support Utilization Date: __/__/__	Status of Housing Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
7. Intimate Partner Violence		
Is there a referral need for Intimate Partner Violence? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral Date: __/__/__	Agency/Resource for Intimate Partner Violence Referred to: _____	
Intimate Partner Violence Support Utilization Date: __/__/__	Status of Intimate Partner Violence Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	

<b>NC WISEWOMAN Follow-Up Screening (DHHS 4051E)</b>		<b>Agency:</b>	
<b>Patient Identification</b>	<b>Patient Name:</b> <i>Last</i>	<i>First</i>	<i>M.I.</i>
<b>Social Determinants Needs Referrals</b>			
<b>8. Medication Adherence</b>			
Is there a referral need for Medication Adherence? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Referral Date:</b> ___/___/___		Agency/Resource for Medication Adherence Referred to: _____	
<b>Medication Adherence Support Utilization Date:</b> ___/___/___		Status of Medication Adherence Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
<b>9. Mental Health</b>			
Is there a referral need for Mental Health? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Referral Date:</b> ___/___/___		Agency/Resource for Mental Health Referred to: _____	
<b>Mental Health Support Utilization Date:</b> ___/___/___		Status of Mental Health Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
<b>10. Language Translation</b>			
Is there a referral need for Language Translation? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Referral Date:</b> ___/___/___		Agency/Resource for Language Translation Referred to: _____	
<b>Language Translation Support Utilization Date:</b> ___/___/___		Status of Language Translation Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
<b>11. Substance Abuse</b>			
Is there a referral need for Substance Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Referral Date:</b> ___/___/___		Agency/Resource for Substance Abuse Referred to: _____	
<b>Substance Abuse Support Utilization Date:</b> ___/___/___		Status of Substance Abuse Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	