NC WISEWOMAN Screening (DHHS 4049A)

Agency:

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

Screening Date ___/___/_____

Visit Type: □ Baseline □ Reassessment □ Follow-up assessment

3. Primary Language Spoken at Home

□ 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 □ Asian □ Native Hawaiian or Pacific Islander □ American Indian or Alaska Native □ Unknown

Zip Code _____

Ethnicity □ Hispanic/Latino □ Non-Hispanic/Latino □ Unknown

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

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 1st Reading _____/_____

Blood Pressure 2nd Reading _____/_____

Height (inches) _____

Weight (pounds) _____

Waist Circumference (inches) _____

Blood Draw Date _/_____/_____

Fasting Status: □ Fasting (at least 9 hrs.) □ Non-fasting

Total Cholesterol	HDL	LDL	Triglycerides	A1C	Glucose (fasting)
_____	_____	_____	_____	_____	_____

Risk Reduction Counseling

Risk Reduction Counseling Date ___/___/_____

4. Medical History

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

5. Medication Status

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

NC WISEWOMAN Screening DHHS (4049B)	**Agency:**
1. Patient Identification	**HIS ID (CNDS):**

Patient Name: *Last* *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/not 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/not sure
- □ Not Applicable

c. Do you regularly share blood pressure readings with a health care provider for feedback?
- □ Yes
- □ No
- □ Don't know/not 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 smoker □ 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	Status of Cessation Resource	
□ Quit Line □ Community-based tobacco program □ Other tobacco cessation resources	□ 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:

NC WISEWOMAN Screening (DHHS 4049C)	Agency:
Patient Identification	**Patient Name:** *Last* *First* *M.I.*

Social Determinants of Health (SDOH) Assessment

1. Computer use

a. During the last 12 months, did you use any of the following?
- i. Desktop/Laptop
- ii. Smartphone
- iii. Tablet/Other portable wireless Computer

□ Yes □ No □ Don't Know

2. Internet Access

a. During the last 12 months, did you or any member of this household have access to the internet?
- □ Yes, by paying a cell phone company or internet service provider
- □ Yes, without paying a cell phone company or internet service provider
- □ No access to internet in this house, apartment, or mobile home
- □ Don't Know

3. Food Insecurities

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 resources?

□ Yes □ No □ Don't Know

4. Transportation Barriers

a. During the last 12 months, have you missed a doctor's appointment because of transportation problems?

□ Yes □ No □ Don't Know

5. Childcare

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')

□ Infant (birth to 11 months)
□ Toddler (11 to 36 months)
□ Preschool (3 to 5 years)
□ After School Care (K-9th grade)
□ Not applicable
□ Don't Know

6. Childcare Barriers

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)

□ Cost
□ Availability
□ Location
□ Transportation
□ Hours of Operation
□ Other
□ Not applicable
□ Don't Know

7. Housing

a. What is your housing situation today?

□ I have housing □ I have housing, but I am worried about losing my housing □ I do not have housing □ Don't Know

8. Intimate Partner Violence

a. During the last 12 months, how often did your partner physically hurt you?

□ Never □ Rarely □ Sometimes □ Fairly Often
□ Frequently □ No partner

b. During the last 12 months, how often did your partner insult or talk down to you?

□ Never □ Rarely □ Sometimes □ Fairly Often
□ Frequently □ No partner

9. Medication Adherence

a. During the last 12 months, did you ever forget to take your medicine?
□ Yes □ No □ Don't Want to Answer □ No Medication Taken

b. During the last 12 months, were you careless at times, about taking your medicine?
□ Yes □ No □ Don't Want to Answer □ No Medication Taken

c. During the last 12 months, when you felt better, did you sometimes stop taking your medicine?
□ Yes □ No □ Don't Want to Answer □ No Medication Taken

d. During the last 12 months, sometimes if you felt worse when you took your medicine, did you stop taking it?
□ Yes □ No □ Don't Want to Answer □ No Medication Taken

NC WISEWOMAN Screening (DHHS 4049D)	Agency:
Patient Identification	**Patient Name:** *Last* *First* *M.I.*

Social Determinants Needs Referrals

1. Computer Use

Is there a referral need for Computer use? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Computer Use Referred to: _____
Computer Use Support Utilization Date: ___/___/____	Status of Computer Use Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

2. Internet Access

Is there a referral need for Internet Access? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Internet Access Referred to: _____
Internet Access Support Utilization Date: ___/___/____	Status of Internet Access Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

3. Food Insecurity

Is there a referral need for Food Insecurity? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Food Insecurity Referred to: _____
Food Insecurity Support Utilization Date: ___/___/____	Status of Food Insecurity Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

4. Transportation

Is there a referral need for Transportation? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Transportation Referred to: _____
Transportation Support Utilization Date: ___/___/____	Status of Transportation Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

5. Childcare

Is there a referral need for Childcare? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Childcare Referred to: _____
Childcare Support Utilization Date: ___/___/____	Status of Childcare Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

6. Housing

Is there a referral need for Housing? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Housing Referred to: _____
Housing Support Utilization Date: ___/___/____	Status of Housing Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

7. Intimate Partner Violence

Is there a referral need for Intimate Partner Violence? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Intimate Partner Violence Referred to: _____
Intimate Partner Violence Support Utilization Date: ___/___/____	Status of Intimate Partner Violence Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service

NC WISEWOMAN Screening (DHHS 4049E)		Agency:
Patient Identification	**Patient Name:** *Last*	*First* *M.I.*

Social Determinants Needs Referrals

8. Medication Adherence	
Is there a referral need for Medication Adherence? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Medication Adherence Referred to: _____
Medication Adherence Support Utilization Date: ___/___/____	Status of Medication Adherence Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service
9. Mental Health	
Is there a referral need for Mental Health? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Mental Health Referred to: _____
Mental Health Support Utilization Date: ___/___/____	Status of Mental Health Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service
10. Language Translation	
Is there a referral need for Language Translation? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Language Translation Referred to: _____
Language Translation Support Utilization Date: ___/___/____	Status of Language Translation Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service
11. Substance Abuse	
Is there a referral need for Substance Abuse? □ Yes □ No **Referral Date:** ___/___/____	Agency/Resource for Substance Abuse Referred to: _____
Substance Abuse Support Utilization Date: ___/___/____	Status of Substance Abuse Referral: □ In Progress □ Closed □ Refused □ Already Receiving Service