

1. Patient Identification	Patient Name: Last _____ First _____ M.I. _____
----------------------------------	--

HIS ID (CNDS): _____	Date of Birth: ____ / ____ / ____	Inactive Date: ____ / ____ / ____
----------------------	-----------------------------------	-----------------------------------

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: <input type="checkbox"/> New Enrollee <input type="checkbox"/> Rescreening (11-18 months)	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Creole <input type="checkbox"/> Portuguese <input type="checkbox"/> Hmong <input type="checkbox"/> Other Language <input type="checkbox"/> Don't want to answer
--------------------------------------	--	--

Race 1: White Black or African American Native Hawaiian or other Pacific Islander American Indian or Alaska Native Unknown
Race 2: White Black or African American Native Hawaiian or other Pacific Islander American Indian or Alaska Native Unknown NA

Zip Code _____	Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown
----------------	--

Years of education: <9th grade Some high school High school grad. or equiv. Some college or higher Don't know Don't want to answer

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

Clinical Measurement Results (For 1st BP, 2nd BP, Weight, Total Cholesterol, HDL, LDL, Glucose, 777=Unable to Obtain, 888=Client Refused
 For Height, Waist: 77=Unable to Obtain, 88=Client Refused for A1C & Triglycerides: 7777=Unable to Obtain, 8888=Client Refused)

Clinical Measurement Date ____ / ____ / ____	Blood Pressure 1 st Reading ____ / ____	Blood Pressure 2 nd Reading ____ / ____
--	--	--

Height (inches) _____	Weight (pounds) _____	Waist Circumference (inches) _____
-----------------------	-----------------------	------------------------------------

Blood Draw Date ____ / ____ / ____	Fasting Status <input type="checkbox"/> Fasting (at least 9 hours) <input type="checkbox"/> Non-fasting
------------------------------------	---

Total Cholesterol _____	HDL _____	LDL (fasting) _____	Triglycerides (fasting) _____	A1C (for diabetics and non-fasting) _____	Glucose (fasting) _____
----------------------------	--------------	------------------------	----------------------------------	--	----------------------------

Risk Reduction Counseling	Risk Reduction Counseling Date ____ / ____ / ____
----------------------------------	---

4. Medical History (DKNS=don't know/not sure, DWTA=don't want to answer)	5. Medication Status (NA/55=Not Applicable, 0=None, DKNS/77=don't know/not sure, DWTA/88=don't want to answer)
---	---

a. Do you have high cholesterol?
 Yes No DKNS DWTA

b. Do you have hypertension (high blood pressure)?
 Yes No DKNS DWTA

c. Do you have Diabetes (either Type 1 or Type 2)?
 Yes No DKNS DWTA

d. Have you been diagnosed as having:

I. Stroke/transient ischemic attack (TIA)
 Yes No DKNS DWTA

II. Heart Attack
 Yes No DKNS DWTA

III. Coronary Heart Disease
 Yes No DKNS DWTA

IV. Heart Failure
 Yes No DKNS DWTA

V. Vascular Disease (peripheral arterial disease)
 Yes No DKNS DWTA

VI. Congenital Heart Disease and Defects
 Yes No DKNS DWTA

a. Do you take a statin medication to lower your cholesterol?
 Yes No NA DKNS DWTA

b. Do you take other (non-statin) medication to lower your cholesterol?
 Yes No NA DKNS DWTA

c. Do you take medication to lower your blood pressure?
 Yes No NA DKNS DWTA

d. Do you take medication to lower your blood sugar (for diabetes)?
 Yes No NA DKNS DWTA

e. Are you taking aspirin daily to help prevent a heart attack or stroke?
 Yes No NA DKNS DWTA

f. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? _____ (number of days)

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)

h. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)? _____ (number of days)

1. Patient Identification	HIS ID (CNDS): _____
----------------------------------	-----------------------------

Patient Name: Last _____	First _____	M.I. _____
---------------------------------	--------------------	-------------------

6. Blood Pressure, Self-Measurement (at Home or using other calibrated sources)	7. Nutrition Assessment (00=None, 88=Don't want to answer, DWTA=don't want to answer)
---	---

- | | |
|---|--|
| <p>a. Do you measure your blood pressure?
 <input type="checkbox"/> Yes
 <input type="checkbox"/> No-Was never told to measure blood pressure
 <input type="checkbox"/> No-Doesn't know how to measure blood pressure
 <input type="checkbox"/> No-Doesn't have equipment
 <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA <input type="checkbox"/> Not Applicable</p> <p>b. How often do you measure your blood pressure?
 <input type="checkbox"/> Multiple times per day <input type="checkbox"/> Daily <input type="checkbox"/> A Few times per week
 <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA <input type="checkbox"/> Not Applicable</p> <p>c. Do you regularly share blood pressure readings with a health care provider for feedback?
 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DKNS <input type="checkbox"/> DWTA <input type="checkbox"/> Not Applicable</p> | <p>a. How many cups of fruits and vegetables do you eat in an average day _____ (in cups)</p> <p>b. How many vegetables do you eat in an average day? _____ (in cups)</p> <p>c. Do you eat fish at least two times a week?
 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>d. Thinking about all the servings of grain products you eat in a typical day; how many are whole grains?
 <input type="checkbox"/> Less than half <input type="checkbox"/> About half <input type="checkbox"/> More than half <input type="checkbox"/> DWTA</p> <p>e. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly?
 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>f. Are you currently watching or reducing your sodium or salt intake?
 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DWTA</p> <p>g. In the past 7 days, how often do you have a drink containing alcohol?
 _____ (Number of Days) <input type="checkbox"/> DWTA</p> <p>h. How many alcoholic drinks, on average, do you consume during a day you drink? _____ (Number of Drinks) <input type="checkbox"/> DWTA</p> |
|---|--|

8. Physical Activity Assessment (000=None, 888=Don't want to answer)

- | |
|---|
| a. How much moderate physical activity do you get in a week? _____ (in minutes) |
| b. How much vigorous physical activity do you get in a week? _____ (in minutes) |

9. Smoking status (66=less than one, 88=don't want to answer, 00=none)

- | |
|--|
| a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)
<input type="checkbox"/> Current <input type="checkbox"/> Quit (1-12 months ago) <input type="checkbox"/> Quit (>12 months ago) <input type="checkbox"/> Never Smoked <input type="checkbox"/> DWTA |
|--|

10. Quality of Life Assessment (77=Don't know/Not Sure, 88=Don't want to answer)

- | |
|--|
| 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? <input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly Every Day <input type="checkbox"/> DWTA
II. Feeling down, depressed, or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Several Days <input type="checkbox"/> More than half <input type="checkbox"/> Nearly Every Day <input type="checkbox"/> DWTA |
|--|

Tobacco Cessation Resource Referral	Referral Date ____/____/____
--	-------------------------------------

Type of Cessation Resource	Status of Cessation Resource	
<input type="checkbox"/> Quit Line <input type="checkbox"/> Community-based tobacco program <input type="checkbox"/> Other tobacco cessation resources	<input type="checkbox"/> Yes - Completed Tobacco Cessation Program <input type="checkbox"/> No - Partially completed Tobacco Cessation Program <input type="checkbox"/> No - Discontinued from tobacco cessation activity when reached	<input type="checkbox"/> No - Could not reach to conduct tobacco cessation activity <input type="checkbox"/> Client Refused Referral

Workup Status	Diagnostic Exam Date ____/____/____	Referral Reason <input type="checkbox"/> Blood Pressure
----------------------	--	--

- | |
|---|
| What is the status of the work-up?
<input type="checkbox"/> 1. Medically necessary <input type="checkbox"/> 2. Not medically needed <input type="checkbox"/> 3. Medically necessary follow-up appointment declined <input type="checkbox"/> 4. Client refused workup |
|---|

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		2. Internet Access	
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 <input type="checkbox"/> Don't want to answer		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 <input type="checkbox"/> Don't want to answer	
3. Food Insecurities		4. Transportation Barriers	
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 <input type="checkbox"/> Don't want to answer		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 <input type="checkbox"/> Don't want to answer	
5. Child Care		6. Child Care Barriers	
a. If you are currently using child care services, please identify the type of services you use. (If not using child care services, please select 'Not applicable') <input type="checkbox"/> Infant (birth to 11 months) <input type="checkbox"/> After School Care (K-9 th 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 <input type="checkbox"/> Don't want to answer		a. During the last 12 months, have you had any of these child care related problems (If not using child care, 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	
7. Housing			
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 <input type="checkbox"/> Don't want to answer			
8. Intimate Partner Violence			
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"/> Don't want to answer <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"/> Don't want to answer <input type="checkbox"/> No partner			
9. Medication Adherence			
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 Know <input type="checkbox"/> Don't want to answer			
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 Know <input type="checkbox"/> Don't want to answer			
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 Know <input type="checkbox"/> Don't want to answer			
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 Know <input type="checkbox"/> Don't want to answer			

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 <input type="checkbox"/> No <input type="checkbox"/> 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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. Child Care			
Is there a referral need for Child Care? Yes <input type="checkbox"/> No <input type="checkbox"/> Referral Date: __/__/__		Agency/Resource for Child Care Referred to: _____	
Child Care Support Utilization Date: __/__/__		Status of Child Care 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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? Yes <input type="checkbox"/> No <input type="checkbox"/> 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	

NC WISEWOMAN Screening (DHHS 4049E)		Agency:	
Patient Identification	Patient Name: <i>Last</i>	<i>First</i>	<i>M.I.</i>
Social Determinants Needs Referrals			
8. Medication Adherence			
Is there a referral need for Medication Adherence? Yes <input type="checkbox"/> No		Agency/Resource for Medication Adherence Referred to:	
Referral Date: ___/___/___		_____	
Medication Adherence Support Utilization Date: ___/___/___		Status of Medication Adherence Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
9. Mental Health			
Is there a referral need for Mental Health? Yes <input type="checkbox"/> No		Agency/Resource for Mental Health Referred to:	
Referral Date: ___/___/___		_____	
Mental Health Support Utilization Date: ___/___/___		Status of Mental Health Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
10. Language Translation			
Is there a referral need for Language Translation? Yes <input type="checkbox"/> No		Agency/Resource for Language Translation Referred to:	
Referral Date: ___/___/___		_____	
Language Translation Support Utilization Date: ___/___/___		Status of Language Translation Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	
11. Substance Abuse			
Is there a referral need for Substance Abuse? Yes <input type="checkbox"/> No		Agency/Resource for Substance Abuse Referred to:	
Referral Date: ___/___/___		_____	
Substance Abuse Support Utilization Date: ___/___/___		Status of Substance Abuse Referral: <input type="checkbox"/> In Progress <input type="checkbox"/> Closed <input type="checkbox"/> Refused <input type="checkbox"/> Already Receiving Service	