**AL WISEWOMAN Health Coaching/LSP/Reassessment Contact Form**

Date: ___________________________ ABCCEDP Provider: ________________________________________________________________

Client Name: ___________________________________________________________ DOB: _______________ Cell Phone: (________) ____________

*First Middle Initial Last*

Address: ________________________________________________________________________________________________________________________

Email: __________________________________________________________________ Telephone: (________) _________________________________

Referred to Health Coaching for: **(circle all that apply)** **Hypertension** **Diabetes** **Hyperlipidemia** **Weight** **Smoking Cessation**

Does patient wish to participate in Health Coaching? Yes ☐ No ☐ Not at this time☐

If no and if applicable, was patient provided with community resource materials? Yes ☐ No ☐

________________________________________________________________________________________________________________________

Was a referral made on patient's behalf? Yes ☐ No ☐ Where? _______________________________________________________________

**HC SESSION 1:** ________________________ Face to Face (required for 1st) ____________minutes

**Date** **Type** **Duration**

Topics/Goals Completed: _______________________________________________________________________________________________

Is patient on hypertension medications? Yes ☐ No ☐ How does patient purchase medications? ______________________________________

Does patient need a referral to compassionate care program for hypertension medications? Yes ☐ No ☐ (document referral)

Adherence Plan: _______________________________________________________________________________________________________

Does patient have access to home BP monitoring? Yes ☐ No ☐

Were community BP monitoring resources discussed or provided? Yes ☐ No ☐

Does patient plan to monitor BP? Yes ☐ No ☐

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? _______________________________________________________________________

**Nutritional Counseling appointment made? Yes** ☐ **No** ☐ **Date of Appointment:** ____________________________________________

What incentive items did the patient receive: Pill Box Yes☐ No ☐ Stretch Band Yes☐ No ☐ Blood Pressure Monitor Yes☐ No ☐

**HC SESSION 2:** ______________________ __________________________ _______________minutes

**Date** **Type** **Duration**

Person completing session: ____________________________________________________________________________________________

Topics /Goals Completed: ______________________________________________________________________________________________

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? _______________________________________________________________________________

Community Referrals made for: Utility Bills ☐ Housing ☐ Medication Assistance ☐ Food ☐ Clothing ☐ Transportation ☐ Domestic Violence ☐

Mental Health ☐ Suicide ☐ Chemical Dependency ☐ Employment ☐ Parenting/Grandparenting ☐ Household items ☐ Other:_____________

**HC SESSION 3:** ______________________ _________________________ ______________minutes

**Date** **Type** **Duration**

Topics/Goals Completed: _______________________________________________________________________________________________

Is patient a smoker? Yes ☐ No ☐ Was a smoking cessation referral made? Yes ☐ No ☐ (document referral)

Why not? _______________________________________________________________________________

Why not? _______________________________________________________________________________

Community Referrals made for: Utility Bills ☐ Housing ☐ Medication Assistance ☐ Food ☐ Clothing ☐ Transportation ☐ Domestic Violence ☐

Mental Health ☐ Suicide ☐ Chemical Dependency ☐ Employment ☐ Parenting/Grandparenting ☐ Household items ☐ Other:_____________

**Health Coaching Completion Date:________________**

**Patient: ____________________________ Tracking #: ______________________________**

**<u>Hypertension Medication Follow up</u>: Must be completed on all patients beginning hypertension medications**

Was follow up completed within 10 working days following an addition/change in hypertension medication? Yes ☐ No ☐ Date: ____________

Is patient's medication plan working? ______________________________________________________________________________

Changes to plan: ______________________________________________________________________________________

**Was patient referred to USDA lifestyle Program? Yes ☐ No ☐**

**Additional Health Coaching Activities Including: phone contact, support groups, follow up etc.**

| Date | Activity |
|---|---|
| | |
| | |
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| | |

**Community Referrals**

| Date | Agency | Follow up (required) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Date: _______________ Weight: ____________ Blood Pressure: ____________ Taken By: _______________

Date: _______________ Weight: ____________ Blood Pressure: ____________ Taken By: _______________

Date: _______________ Weight: ____________ Blood Pressure: ____________ Taken By: _______________

Date: _______________ Weight: ____________ Blood Pressure: ____________ Taken By: _______________

Date: _______________ Weight: ____________ Blood Pressure: ____________ Taken By: _______________

**<u>7 Month Follow-up Assessment:</u>** Date: ____________________ Type: ______________________ Duration: _______

Health issues reviewed: BP ____ Meds ____ Smoking ____ Diet ____ Physical Activity _____ Quality of life issues ______

Health Plan: ________________________________________________________________________________________

__________________________________________________________________________________________________

**WISEWOMAN Rescreening date:** __________/__________/__________ **(12 to 18mos)**

Annual Reminder Call completed on: _______________________________________________________________________

**(Revised: 06/24/2015)**