Partners in Health Community Access Program Data Sheet

Directions
Shade circles like this:
Do not shade like this:

Today's Date m m / d d / 2 0 y y

Please complete using blue or black ink.

Facility:

First Name: **Last Name:** **M. I.**

Social Security Number **Date of Birth:** **Gender:** ○ Male ○ Female

Diagnosis? (Mark all that apply) ○ Diabetes ○ Asthma ○ Hypertension ○ Depression ○ None of these

Preventive

Colonoscopy/Sigmoidoscopy :	○ Yes ○ No	Date:	m m
Blood in stool :	○ Yes ○ No	Date:	m m
Mammogram :	○ Yes ○ No	Date:	m m
PAP :	○ Yes ○ No	Date:	m m
For Future Use:	○ Yes ○ No	Date:	m m
Pneumonia Shot :	○ Yes ○ No	Date:	m m
Flu Shot :	○ Yes ○ No	Date:	m m

Diabetes

Documented Self Management :	○ Yes ○ No	Date:	m m
First Hemoglobin A1c:	Value : .	Date:	m m
Second Hemoglobin A1c:	Value : .	Date:	m m
Aspirin Use :	○ Yes ○ No ○ NA	Date:	m m
Urine test for protein:	○ Normal ○ Abnormal ○ NA	Date:	m m

Hypertension

Documented Self Management :	○ Yes ○ No	Date:	m m
First Blood Pressure:	Systolic :	Diastolic :	Date: m m
Second Blood Pressure:	Systolic :	Diastolic :	Date: m m

Asthma

Documented Self Management :	○ Yes ○ No	Date:	m m
Severity Assessment :	○ Mild Intermittent ○ Mild Persistent ○ Moderate Persistent ○ Severe Persistent	Date:	m m
Anti-inflammatory Meds :	○ Yes ○ No ○ NA	Date:	m m
Peak Flow:	○ Yes ○ No ○ NA	Date:	m m

Depression

Documented Self Management :	○ Yes ○ No	Date:	m m
Evaluation :	○ Yes ○ No	Date:	m m

Care Management Action : ○ Phone ○ Note or Letter ○ Appointment Date: m m

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