Reset Form

Statement of Consent to Participate
In the Hawaii WISEWOMAN: Well-Integrated Screening and Evaluation for WOMen Across the Nation Program

Program Description

The purpose of the Hawaii WISEWOMAN program is to assist women with managing their risk for cardiovascular disease ("CVD") by promoting the management of hypertension ("HTN") and high cholesterol through risk reduction services and referrals to healthy behavior support services ("HBSS"), social services, and support needs for low-income, uninsured, and underinsured women aged 35-64 who enrolled in the Breast and Cervical Cancer Control Program ("BCCCP").

As a participant in the WISEWOMAN program, you will receive screening tests to identify your CVD risk factors and help in reducing or managing those risk. These screening tests include: 1) height and weight measurements, 2) blood pressure measurements, 3) lab work, and 4) a smoking assessment. Participants will also be asked questions regarding their health history and medication use, health behaviors, and social determinants of health. Participants will meet with their health care provider to discuss clinical and health risk assessment results. Program participants will be referred to community-based resources that reflect the identified social need(s) of the participant.

Consent to Release Health Information

I, _____, have read the above and understand the services available to me under the WISEWOMAN program.

I, _____, authorize my health care provider _____, to release my health information and complete medical record, which may include information related to my health exams, diagnostic tests, CVD screening and risk reduction services, and/or treatment, to the Hawaii State Department of Health (HSDOH), Hawaii WISEWOMAN Program for the purpose of providing qualified health care services under the federally funded WISEWOMAN program. These services include, but are not limited to, paying for screening and/or diagnostic tests, developing and implementing a plan of care relating to screening and diagnostic results, risk-reduction counseling, healthy behavior support services, and evaluating the effectiveness of the program regarding the services and care I received.

I authorize the HSDOH to release my data without any identifiable information to Carahsoft Technology Corp., a HSDOH contracted agent, and the Centers for Disease Control and Prevention ("CDC") for the purpose of program data collection, reporting, and evaluation requirements.

I understand that my health information disclosed to those identified above is kept confidential, and my consent may be rescinded at any time upon written or verbal request or upon my discharge from the Hawaii WISEWOMAN Program.

By signing below, I certify I have read and understand the above information and give consent to authorize the above services for myself. I understand that I may withdraw from the WISEWOMAN program and withdraw consent to release health information at any time. Unless otherwise revoke, this authorization will expire 18 months from the date signed.

Signature	Date	Witness Signature	Date

OFFICE USE ONLY		
State/Tribal Code:	**ANSI Geographic Code:**	**NPI:**
Time Period of Screening:	**Type of Screening:**	**Funding Source:**

Hawaii WISEWOMAN Data Collection Form: Baseline/Risk Reduction

Demographics

**Not required if Hamakua Intake forms are also submitted*

Date:	**First Name:**	**Last Name:**	**DOB:**
Address:		**State:**	**Zip Code:**

Select your highest level of education*: ☐ Below 9th grade ☐ Some high school ☐ High school graduate or equivalent ☐ Some college ☐ Don't know/ not sure ☐ Don't want to answer

Race*: ☐ White ☐ Black/AA ☐ Asian ☐ Native Hawaiian / Pacific Islander ☐ American Indian/ Alaska Native ☐ Unknown	**Other Race*:**	**Hispanic/ Latino*:** ☐ Yes ☐ No

Primary Language*: ☐ English ☐ Spanish ☐ Hawaiian ☐ Japanese ☐ Korean ☐Tagalog ☐ Vietnamese ☐ Don't want to answer	**Other Language*:**

Health History

1. Do you have any of the following conditions (select all that apply):

		Yes	No	Don't Know / Not Sure
a)	Hypertension	☐	☐	☐
b)	High Cholesterol	☐	☐	☐
c)	Diabetes (Type 1 or Type 2)	☐	☐	☐

2. Have you had any of the following? (Select all that apply):

		Yes	No	Don't Know / Not Sure
a)	Stroke/Transient Ischemic attack (TIA)	☐	☐	☐
b)	Heart Attack	☐	☐	☐
c)	Coronary Heart Disease	☐	☐	☐
d)	Heart Failure	☐	☐	☐
e)	Vascular Disease	☐	☐	☐
f)	Congenital Heart Disease & Defects	☐	☐	☐
g)	Gestational Hypertension	☐	☐	☐
h)	Gestational Diabetes	☐	☐	☐
i)	Pre-eclampsia/ eclampsia	☐	☐	☐

3. Was medication prescribed to lower any of the following (select all that apply):

	Yes	No	Don't Know / Not Sure
a) Blood Pressure	☐	☐	☐
b) Cholesterol (Statin)	☐	☐	☐
c) Cholesterol (other prescribed medication)	☐	☐	☐
d) Blood Sugar	☐	☐	☐

4. Are you taking aspirin daily to prevent a heart attack or stroke? ☐ Yes ☐ No

5. During the past 7 days, how many days did you take prescribed medication for the following conditions:

	Number of Days	None	Don't Know / Not Sure
a) High Blood Pressure:		☐	☐
b) High Cholesterol:		☐	☐
c) High Blood Sugar:		☐	☐

Health Behaviors

1. Do you measure your blood pressure at home or use other calibrated sources?	☐ Yes ☐ No ☐ No, don't know how to measure my blood pressure	☐ No, don't have equipment ☐ Don't know/ Not sure
2. How often do you measure your blood pressure at home or use other calibrated sources?	☐ Multiple times per day ☐ Daily ☐ A few times per week ☐ Weekly	☐ Monthly ☐ Don't know ☐ Not applicable
3. Do you regularly share blood pressure readings with a health care provider for feedback?	☐ Yes ☐ No ☐ Don't know ☐ Not Applicable	
4. How many cups of fruits and vegetables do you eat in an average day?	_____# of Cups ☐ None ☐ Don't want to answer	
5. Do you eat fish at least two times a week?	☐ Yes ☐ No	
6. Thinking about all the servings of grain products you eat in a day; How many are whole grain (ex. wheat, brown rice, oats, barley, etc.)?	☐ Less than half ☐ About half ☐ More than half ☐ Don't want to answer	
7. Do you drink less than 36 ounces of beverages with added sugars (450 calories) weekly?	☐ Yes ☐ No ☐ Don't want to answer	
8. Are you currently watching or reducing your sodium or salt intake?	☐ Yes ☐ No ☐ Don't want to answer	
9. In the past 7 days, how often do you have a drink containing alcohol?	_____ # of Day(s) ☐ None ☐ Don't want to answer	
10. How many alcoholic drinks, on average, do you consume during a day you drink?	_____# of drinks ☐None ☐ Don't want to answer	
11. How many minutes of physical activity (exercise) do you get in a week?	_____# of minutes ☐ None ☐ Don't want to answer	

12. Do you smoke or use any form of tobacco, such as cigarettes, pipes, cigars, or E-cigs?	☐ Current smoker ☐ Quit (1-12 months) ☐ Quit (more than 12 months)	☐ Never smoked ☐ Don't want to answer

13. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half	Nearly everyday	Don't want to answer
a. Little interest or pleasure in doing things	☐	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐	☐

As an effort to reduce barriers and increase access to care, services, and resources please answer the following questions. Your responses will allow us to refer you to the appropriate services and/or programs. All responses provided on this assessment will be kept confidential with your care team.

Social Determinants of Health Assessment

1. Do you use any of the following types of computers? (Select all that apply)
☐ Desktop / Laptop ☐ Smartphone ☐ Tablet / other portable wireless computer
☐ Don't want to answer

2. Do 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 internet access ☐ Don't know ☐ Don't want to answer

3. If you are currently using childcare services, please identify the type of services you use. <u>If not, select Not Applicable</u>.
☐ Infant (birth to 11mos) ☐ Toddler (11 to 36mos) ☐ Preschool (3 to 5 yrs)
☐ Don't know ☐ Not applicable

4. Have you had any of these child-care related problems during the past year? (Select all that apply)
☐ Cost ☐ Availability ☐ Location ☐ Transportation ☐ Hours of operation
☐ Other ☐ Don't know

5. The following will ask about how safe you feel:
How often does your partner physically hurt, insult, or talk down to you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently ☐ Don't want to answer

6. This item is related to medication-taking adherence:
Do you ever miss or stop taking (name of health condition) medication as prescribed, including forgetting doses or stopping when you feel better or worse?
☐ Yes ☐ No ☐ Don't want to answer

**Food, transportation, and housing MDE answered through PRAPARE questions 4, 5, 1/2 respectively.*

HI WISEWOMAN Patient Clinical Data Form

Hawaii WISEWOMAN Patient Clinical Data Form	
Patient ID:	**Provider/Clinic:**
Name:	**DOB:**

Clinical Values			
Height: _____in.	Weight: _____lbs.	Waist: _____in.	Fasting: ☐ Yes ☐ No

Blood Pressure		
1st BP Reading:	_____ / _____	mm HG
2nd BP Reading:	_____ / _____	mm HG
Average BP Reading:	0_____ / 0_____	mm HG

Blood Pressure Alert
***Alert BP: Systolic >180 mm HG OR Diastolic > 120 mm HG Require immediate medical evaluation**

Is a medical follow-up for BP reading necessary?

☐ **Medically necessary** **Date of follow-up appt:**
☐ Not medically necessary
☐ Medically necessary follow-up appointment declined

Cholesterol	
Total Cholesterol:	_____mg/dl
HDL Cholesterol:	_____mg/dl
LDL Cholesterol:	_____mg/dl
Triglyceride:	_____mg/dl

Glucose	
Blood Glucose (fasting only)	_____mg/dl
A1C	_____%

Risk Reduction Counseling Session	
Start Date:	**Completion Date:**
HBSS Referral Date:	

Adjusted Medication Plan			
Was patient prescribed a new medication for hypertension today?	☐ Yes	☐ No	☐ N/A
Was patient prescribed a new medication for cholesterol today?	☐ Yes	☐ No	☐ N/A
Was patient prescribed a new medication for diabetes today?	☐ Yes	☐ No	☐ N/A

WISEWOMAN Initial Health Coaching / Risk Reduction Form

Patient ID:	**Provider/Clinic:**
Name:	**DOB:**

Clinical / Lab Results

Average BP Reading: 0_____ / 0_____mm HG

Total Cholesterol: _____mg/dl

Blood Glucose (fasting only): _____mg/dl

A1C: _____%

1. **Does participant wish to participate in HBSS (Health Coaching, YMCA BPSM, DPP)?**

☐ Yes **If yes, which HBSS will the participant be enrolled in? (Select all that apply)**

☐ **Health Coaching** Date enrolled:

☐ **YMCA-BPSM** Date enrolled:

**To qualify for YMCA-BPSM, participants must: 1.) Have been diagnosed with high blood pressure (HBP) and/or on antihypertensive medication, 2.) Not experienced a recent (within the last 12 months) cardiac event, 3.) Not have atrial fibrillation or other arrhythmias, 4.) Not have or are at risk for lymphedema.*

☐ **DPP** Date enrolled:

**To qualify for DPP, participants must be at risk for type 2 diabetes and ready to make a lifestyle change.*

☐ No If participant does not wish to participate in HBSS, were they referred to community resources? ☐ Yes ☐ No

2. **Refused referral to Tobacco Cessation?**

☐ Yes

☐ No If no, what type of tobacco cessation referral? Date:

3. **What type of community resource referrals were made?** **Follow up on LSP tracking form

☐ Housing ☐ Financial ☐ Employment

☐ Food ☐ Crisis/Emergency ☐ Transportation

☐ Mental Health ☐ Childcare ☐ Partner violence

☐ Other:

4. **Participant's Health Goals:**

☐ Blood Pressure Control ☐ Nutrition ☐ Physical Activity

☐ Healthy Weight ☐ Stress Management ☐ Tobacco Use

☐ Medication Adherence

Participant's plan is to:

Additional notes:

Participant to answer the following question:

On a scale of 0-10, how confident are you that you can be successful in achieving the plan discussed today? _____
(0 = not confident at all, 10 = really confident)

Participant signature: _____ Date: _____

WISEWOMAN Provider Signature: _____ Date: _____

Hawaii WISEWOMAN Lifestyle Support Tracking Form	
Patient ID:	**Provider/Clinic:**
Name:	**DOB:**
Referral Program:	☐ Health Coaching (HC) ☐ YMCA-Blood Pressure Self-Monitoring (YMCA-BPSM)[1] ☐ Diabetes Prevention Program (DPP)[2]

To be completed by Health Coach, Healthy Heart Ambassador, or DPP Lifestyle Coach.

Health Coaching			
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Were minimum number of sessions (3) completed?		☐ Yes ☐ No	
Health Coach Signature:			

HHA-BPSM			
Blood Pressure Readings			
BP Reading:	Date:	BP Reading:	Date:
BP Reading:	Date:	BP Reading:	Date:
BP Reading:	Date:	BP Reading:	Date:
BP Reading:	Date:	BP Reading:	Date:
BP Reading:	Date:	BP Reading:	Date:
Did participant measure their BP at home at least two (2) times per month?		☐ Yes ☐ No	
HHA Office Hours			
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Did participant attend at least two (2) personalized consultations per month with a trained HHA?		☐ Yes ☐ No	
Nutrition Seminar			
Webinar #:	Date:	Webinar #:	Date:
Webinar #:	Date:	Webinar #:	Date:
Did participant attend four (4) of the monthly nutrition webinars?		☐ Yes ☐ No	
Health Coach/HHA Signature:			

[1] To qualify for YMCA-BPSM, participants must: 1.) Have been diagnosed with high blood pressure (HBP) and/or on antihypertensive medication, 2.) Not experienced a recent (within the last 12 months) cardiac event, 3.) Not have atrial fibrillation or other arrhythmias, 4.) Not have or are at risk for lymphedema.

[2] To qualify for DPP, participants must be at risk for type 2 diabetes and ready to make a lifestyle change.

Diabetes Prevention Program			
Core Sessions			
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Did participant complete at least 9 core sessions?		☐ Yes ☐ No	
Maintenance/Post-Core Sessions			
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Session #:	Date:	Session #:	Date:
Did participant complete at least 3 maintenance/post-core sessions?		☐ Yes ☐ No	
Health Coach/Lifestyle Coach Signature:			

Community Resource Referral Utilization				
Type of Referral	**Outcome**			**Date**
Housing	☐ Scheduled	☐ Utilized	☐ Not utilized	
Food	☐ Scheduled	☐ Utilized	☐ Not utilized	
Mental Health	☐ Scheduled	☐ Utilized	☐ Not utilized	
Financial	☐ Scheduled	☐ Utilized	☐ Not utilized	
Crisis/Emergency	☐ Scheduled	☐ Utilized	☐ Not utilized	
Childcare	☐ Scheduled	☐ Utilized	☐ Not utilized	
Employment	☐ Scheduled	☐ Utilized	☐ Not utilized	
Transportation	☐ Scheduled	☐ Utilized	☐ Not utilized	
Partner Violence	☐ Scheduled	☐ Utilized	☐ Not utilized	
Other: _____	☐ Scheduled	☐ Utilized	☐ Not utilized	