WV WISEWOMAN
Risk Assessment & Care Plan

Provider Name:		Date:	
Last Name:	First Name:	M.I.	Date of Birth:

☐ Integrated/Initial Visit ☐ Follow-Up Visit ☐ Reassessment Visit

CVD Risk Factor (check all that apply)

☐ High Blood Pressure ☐ Elevated Cholesterol ☐ Diabetes ☐ Tobacco Use

☐ Obesity ☐ Other: _____

(HBSS Health Coaching is a required component for all participants)

HBSS Referral	Date	Length of Program	Anticipated Completion Date	Actual Completion Date
☐ Health Coaching				
☐ Self-Monitoring Blood Pressure				
☐ Weight Watchers				
☐ Walk with Ease				
☐ Dining with Diabetes				
☐ Take off Pounds Sensibly (TOPS)				
☐ In-House Approved HBSS Name of HBSS _____				

☐ Tobacco Cessation Referral Date: _____
☐ Quitline ☐ Community-Based Tobacco Program ☐ Internet-Based Tobacco Program
☐ Other Tobacco Cessation Resources

Tobacco Cessation Activity Completed Date: _____
☐ Completed tobacco cessation activity
☐ Partially completed tobacco cessation activity when reached
☐ Discontinued from tobacco cessation activity when reached
☐ Could not reach to conduct tobacco cessation activity

Contact Type	Patient Navigation
☐ Face to Face ☐ Phone ☐ myCareHalo App Messaging ☐ Mail ☐ Spoke with Participant ☐ Did Not Speak with Participant	Notes: _____ _____ _____ ☐ Lost to Follow-up (Provide dates and method of contact attempts): Method: _____ Dates: _____

Care Coordinator Tracking

Is this a Barrier?		Date of Referral	Referral Declined	Date of Service Utilization
01 Computer Use	☐ Yes ☐ No		☐ Yes	
02 Internet Access	☐ Yes ☐ No		☐ Yes	
03 Food Insecurity	☐ Yes ☐ No		☐ Yes	
04 Transportation	☐ Yes ☐ No		☐ Yes	
05 Childcare	☐ Yes ☐ No		☐ Yes	
06 Housing	☐ Yes ☐ No		☐ Yes	
07 Intimate Partner Violence	☐ Yes ☐ No		☐ Yes	
08 Medication Adherence	☐ Yes ☐ No		☐ Yes	
09 Mental Health	☐ Yes ☐ No		☐ Yes	
10 Language Translation	☐ Yes ☐ No		☐ Yes	
11 Substance Use	☐ Yes ☐ No		☐ Yes	