



WEST VIRGINIA WISEWOMAN Diagnostic Evaluation Form



Provider Name		Provider Phone Number	
Last Name	First Name	SSN#	Date of Birth / /

Diagnostic evaluation should happen within 7 days for all alert screenings for those with newly diagnosed, uncontrolled hypertension, and/or diabetes. Diagnostic evaluation should happen before HSMM.

Reason(s) for Referral	
<input type="checkbox"/> Blood Pressure: ____ / ____ mm Hg	Systolic Blood Pressure (SBP) >180 mm Hg or Diastolic Blood Pressure (DBP) >120 mm Hg
<input type="checkbox"/> A1C: _____ %	A1C <3.5 or >9.0
Date Referred / /	Date of Scheduled Diagnostic Visit / /
Participant Status (check one): <input type="checkbox"/> Refused (<i>participant had alert screening value, but refused work-up</i>) <input type="checkbox"/> Follow-up (<i>participant intends to see an alternate provider within 7 days</i>)	Referred to: <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <input type="checkbox"/> In-house evaluation (complete Diagnostic Provider information)

COMPLETED BY DIAGNOSTIC PROVIDER:

Submit to WV WISEWOMAN and Referring Provider, include a copy of evaluation notes to referring provider.

Participant Status (check one): <input type="checkbox"/> Work-up complete (<i>attended Diagnostic Evaluation</i>) <input type="checkbox"/> Lost to follow-up (<i>participant did not attend her scheduled work-up</i>)						
After being prescribed medication, on what date(s) did the participant have her blood pressure re-measured either by a healthcare provider, or with another community resource?						
Date: / /	1 st Blood Pressure	/	2 nd Blood Pressure	/	Average Blood Pressure	/
Date: / /	1 st Blood Pressure	/	2 nd Blood Pressure	/	Average Blood Pressure	/
Date: / /	1 st Blood Pressure	/	2 nd Blood Pressure	/	Average Blood Pressure	/
Provider Name:			Evaluation Date: / /		Length of Visit (mins):	

Clinician Signature: _____ **Date:** _____