WEST VIRGINIA WISE WOMAN

West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH | Office of Maternal, Child and Family Health

WV WISEWOMAN
Risk Assessment and Care Plan

WISEWOMAN Screening Facility: ____________________

Initial WW Visit: ________ / ________ / ________

Follow-Up Integrated Visit/Reassessment: ________ / ________ / ________

Annual Rescreening/Completion: ________ / ________ / ________

Social Security #: ____________________ DOB: ________ / ________ / ________

Client Name: (Last, First, MI) ____________________

CVD Risk Factor (check all that apply)

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

☐ Obesity ☐ Other: ____________________

HBSS referral	Date	Length of program	Anticipated completion date
☐ Self-Monitoring BP ☐ Tobacco Cessation referral ☐ Quitline ☐ Community-based Tobacco program ☐ Internet-based tobacco program ☐ Other tobacco cessation resources	________ ________	________ ________	____________________ ____________________

Patient Navigation/Care Coordination Tracking

Barriers	Resolved?	Resources/Referrals Provided
01. Computer Use	☐ Yes ☐ No	**Social Services and Support:**
02. Internet Access	☐ Yes ☐ No	☐ Transportation Assistance/Referral
03. Food Insecurity	☐ Yes ☐ No	☐ Translator/Language Services
04. Transportation	☐ Yes ☐ No	☐ Schedule Appointment
05. Childcare	☐ Yes ☐ No	☐ Provided Education
06. Housing	☐ Yes ☐ No	☐ Financial Assistance Referral
07. Intimate Partner Violence	☐ Yes ☐ No	☐ Social Work Referral
08. Medication Adherence	☐ Yes ☐ No	☐ Community Resources Referral
09. Mental Health	☐ Yes ☐ No	☐ Flexible Appointment Time
10. Language Translation	☐ Yes ☐ No	☐ Child/Elder Care Resource Referral
11. Substance Use	☐ Yes ☐ No	☐ Referral to County WVDHS Office
12. Fear of Test	☐ Yes ☐ No	☐ Referral to Mental Health Services
13. Gender of Provider	☐ Yes ☐ No	☐ Other: ____________________
14. Scheduling Appointments	☐ Yes ☐ No	
15. Literacy/Health Literacy	☐ Yes ☐ No	**HBSS referrals:**
16. Disability (Physical/Intellectual/Learning Disorder)	☐ Yes ☐ No	☐ Health Coaching
	☐ Yes ☐ No	☐ Self-monitoring blood pressure
17. Insurance Issues	☐ Yes ☐ No	☐ Tobacco Cessation referral
18. Family/Social Support Issues	☐ Yes ☐ No	☐ Quit Line
19. Financial Issues	☐ Yes ☐ No	☐ Community-based tobacco program
20. Issues with Work	☐ Yes ☐ No	☐ Internet-based tobacco program
21. Lack of Motivation/Commitment	☐ Yes ☐ No	☐ Other tobacco cessation resources
	☐ Yes ☐ No	

Barriers	Resolved?
22. Unrealistic Goal Setting	☐ Yes ☐ No
☐ Other _____	☐ Yes ☐ No

Contact Type	Result
☐ Face to Face ☐ Phone ☐ MyCareHalo App Messaging ☐ Mail	☐ Spoke with Client ☐ Did Not Speak with Client Date Patient Utilized social service: _____ ☐ Tobacco Cessation Activity Completed: ☐ 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

Patient Navigation

☐ Date HBSS Completed _____

Notes: _____

_____

_____

_____

☐ Lost to Follow-up

*Please feel free to provide additional outcome comments in the notes section.