OMB No. 0990-
Exp. Date XX/XX/20XX

SERVICE DELIVERY FORM
TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of the home visit. Pharmacist will send the completed form to the program coordinator.

Patient Name: _____

Pharmacist Name: _____

Visit Date: _____
The following service(s) have been provided to me today (please check appropriate diagnosis):

- Baseline Screening
  - Blood Pressure
  - Diabetes
- Baseline Knowledge Survey
  - Blood Pressure
  - Diabetes
- Disease State/Monitoring Education
  - Blood Pressure
  - Diabetes
- Medication Management Education
  - Blood Pressure
  - Diabetes
- Other: _____
  _____
  _____
  _____
  _____
  _____

Patient Signature: _____ Date: _____

Pharmacist Signature: _____ Date: _____

suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer