

**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:

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

Patient Signature: _____ Date: _____

Pharmacist Signature: _____ Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990- . The time required to complete this information collection is estimated to average (hours)(minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or 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