

ELIGIBILITY SCREENING FORM: HYPERTENSION AND DIABETES

(Completed by Program Staff at Time of Recruitment)

**Patient Centered Care Collaboration to Improve Minority Health Initiative
[Houston Hub]**

Conducted by Texas Southern University College of Pharmacy and Health Sciences

Step I. - Recruitment Location (please indicate by checking below)

- Telephone
- Lyerly
- Bellerive
- Historic Oaks of APV

Date: _____

Step II. - Eligibility Section (please ask the patient the following questions to determine eligibility)

1. Do you have: high blood pressure? diabetes?	Y Y	N N
2. Are you taking at least one medication for: high blood pressure? diabetes?	Y Y	N N
3. Are you age 55 or older?	Y	N
4. What is your race/ethnicity? <input type="checkbox"/> African-American <input type="checkbox"/> Asian-American <input type="checkbox"/> Hispanic/Latino		
5. Are you a resident of (mention facility name checked in Step I)? 5a. If no, please indicate facility name: _____	Y	N
6. Do you have regular access to a telephone? For telephone follow-up	Y	N

Step III. - Determine patient eligibility. (Patient eligible, only if Yes to all questions above)

- **If answered “No” to any of the questions above, the patient is not eligible:**
 - o Use the following text to end the encounter with the patient:
“Thank you for your time. You are not eligible to participate in the study at this time.”
- **If answered “Yes” to all questions above, please continue to Step IV below**

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 15 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

Step IV. - Patient Demographics:

Sex: Male Female

Patient Name (Last, First):

Phone number 1: _____ Phone Number 2:

Address:

Date of Birth (MM/DD/YYYY): _____

Race/Ethnicity: _____

Please mark preferred spoken language:
 English Spanish Vietnamese Cantonese
Mandarin

Please mark preferred written language:
 English Spanish Vietnamese Cantonese
Mandarin

- What is the highest level of education that you have completed?
- Middle school or lower
 - High School
 - Associate Degree
 - Technical School Certification
 - Four-year College Degree
 - Graduate School

For telephone follow-up
When is a good time to come for a home visit (Circle all that apply)?

Monday	AM	PM	Saturday	AM	PM
Tuesday	AM	PM	Sunday	AM	PM
Wednesday		AM			PM
Thursday	AM	PM			
Friday		AM			PM

Date: _____
 Client ID #: _____

Step V. -PCCC Items:

We would like to know how you heard about this health program. Please check all answers that apply.

1. How did you learn about this health program?

a. Through personal contact with a:

Friend, neighbor, or relative

Health care professional

Social service professional

Other _____

b. Through written materials I read:

Brochure

Direct mail

Other _____

c. Through social media/electronic materials I read:

Email

Telephone text message

Facebook posting

Other _____

The statements below describe attitudes and beliefs you may have about why you signed up for the health program and about your health condition(s): diabetes, hypertension, or being overweight. Please rate how much you agree or disagree with each one by placing a check mark in the appropriate box.

1 = I strongly disagree
 2 = I somewhat disagree
 3 = I'm neutral
 4 = I somewhat agree
 5 = I strongly agree

	1	2	3	4	5
2. Why did you sign up for the program?					
a) I need help managing my health condition					
b) I need information on my health condition					
c) The classes will be taught by a trained professional (community health worker, health educator, pharmacist)					
d) The class will be taught in my language					
e) The materials will be written in my language					
f) Someone will call me to follow-up on what I learn and remind me of what I should do to manage my health					
g) It is easy to get to the program location					
h) It will not take a lot of my time					
i) It does not cost me anything					

Step VI. - Baseline Data Collection

1. Past Medical History

a. *What conditions have you been diagnosed with in the past?*

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

b. *Have you had the following conditions within the **past 6 months?***

- Stroke
- Heart attack
- Chest pain
- Vision problems
- Kidney disease
- Peripheral vascular disease
- Unusual weight loss
- Cuts/bruises that are slow to heal
- Tingling numbness in the hands/feet
- Recurring skin, gum, or bladder infections
- Hospital admission due to high blood pressure/diabetes
- Emergency room visits due to high blood pressure/diabetes
- Physicians office visits due to high blood pressure/diabetes
- Adverse events caused by high blood pressure/diabetes medications

2. Social History:

- Smoking (_____ packs per day for _____ years)
- Alcohol (what kind? _____ how often? _____)
- Illicit drug use (such as: _____)

3. Do you have any history of an allergic drug reaction?

Drug Name: _____ Type of reaction:

4. Do you have a primary care physician? Yes No

***Note: If no primary care physician, please refer to Harris County Hospital District.**

5. If yes, to question #4, who is your primary care physician?

PCP Name: _____ Phone: _____

Fax : _____

Address:

6. Is your doctor from Harris County Hospital District? Yes No

7. Are you okay with us contacting your physician to let him/her know you are participating in this program and inform them about any irregular findings? Yes No

8. Are these needed?

Self Monitoring Questions (please refer to appropriate section below):

9. Behavior - pre/post changes

Hypertension:

10. Do you have a blood pressure machine at home? Yes No

11. How often do you monitor your blood pressure?

- More than one time per day
- Daily
- Weekly
- Monthly
- Never

12. If “Never” to question #11, what is the reason for not monitoring your blood pressure at home? (Check all that apply)

- Unable to purchase a machine
- Health related disability (e.g. arthritis, poor vision)
- Not sure how to use the machine
- Lack of help
- Time
- Not important
- Don't know

13. On average, how often do you see your health care professional for your blood pressure?

- Every Week
- Every Month
- Quarterly
- Every year
- Never
- Don't know

Diabetes:

14. Do you have a glucose meter at home? Yes No

15. How often do you monitor your blood sugar?

- More than one time per day
- Daily
- Weekly
- Monthly
- Never

16. If “Never” to question #15, what is the reason for not monitoring your blood sugar at home? (Check all that apply)

- Unable to purchase a machine
- Health related disability (e.g. arthritis, poor vision)
- Not sure how to use the machine
- Lack of help
- Time
- Not important
- Don’t know

17. On average, how often do you see your health care professional for your diabetes?

- Every Week
- Every Month
- Quarterly
- Every year
- Never
- Don’t know

18. Are you currently participating in any exercise program? Yes No

19. Are you currently participating in any diet program? Yes No