Form Approved

OMB No. 0955-XXXX

Exp. Date TBD

**Access, Exchange, and Use of Social Determinants of Health Data in Clinical Notes (SDOH)**

**Patients and Care Partners Prescreening Questionnaire (English)**

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 0955-XXXX. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete 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.

**PRESCREENING QUESTIONNAIRE-Patients and Care Partners (English)**

What is your name?

What is your email address?

What is your phone number?

What is your zip code?

What is your date of birth? (terminate if younger than age 18)

What is your race? (can pick more than 1)

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or other Pacific Islander

Other: \_\_\_\_\_\_\_\_\_

Prefer not to answer

Are you of Hispanic, Latino, or Spanish ethnicity?

Yes

No

Prefer not to answer

What sex were you assigned at birth, on your original birth certificate?

Female

Male

How do you describe yourself?

Female

Male

Transgender

Do not identify as female, male or transgender

Prefer not to answer

What is your sexual orientation?

Heterosexual or straight

Gay or lesbian

Bisexual

Prefer not to answer

Do you speak a language other than English at home?

Yes

No

[If yes] Do you speak Spanish at home?

Yes

No

Which of the following best describes the location where you live?

Urban

Suburban

Rural

Are you deaf or do you have serious difficulty hearing?

Yes

No

Are you blind or do you have serious difficulty seeing even when wearing glasses?

Yes

No

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

Yes

No

Do you have serious difficulty walking or climbing stairs?

Yes

No

Do you have difficulty dressing or bathing?

Yes

No

Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping?

Yes

No

Do you have two or more chronic health care conditions?

Yes

No

Are you a caregiver of a child below the age of 18?

Yes

No

What was your total household income last year?

1. $0 – $24,999
2. $25,000-$49,999
3. $50,000-$74,999
4. $75,000-$99,999
5. $100,000-124,999
6. $125,000 or more
7. Prefer not to answer

Prescreening Questionnaire-Clinicians/Healthcare Professionals

What is your name?

What is your email address?

What is your phone number?

What is your zip code?

What is your race? (can pick more than 1)

White

Black or African American

American Indian or Alaska Native

Asian

Native Hawaiian or other Pacific Islander

Other: \_\_\_\_\_\_\_\_\_

Prefer not to answer

Are you of Hispanic, Latino, or Spanish ethnicity?

Yes

No

Prefer not to answer

How do you describe yourself?

Female

Male

Transgender

Do not identify as female, male or transgender

Prefer not to answer

Are you a physician?

Yes

No

(if yes) In what specialty are you licensed to practice? (can choose more than 1)

Internal medicine/Primary care (adult)

Pediatrics

Emergency medicine

Surgery

Psychiatry

Other: \_\_\_\_\_\_\_\_\_\_\_\_

(if no)

Are you a: (can choose more than 1)

Registered nurse

Physician assistant

Advanced practice registered nurse

Licensed social worker

Emergency management technician

Psychologist

Physical therapist

Occupational therapist

Registered dietician nutritionist

Other: \_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following roles within your organization? (can choose more than 1)

Care or case manager

Discharge planner

Community resource specialist

Which of the following best describes the setting where you provide care? (can choose more than 1)

Academic/Teaching hospital (or affiliated outpatient practice)

Private or Public Community-based hospital (or affiliated outpatient practice)

Public, Safety Net Hospital (or affiliated outpatient practice)

Private practice no hospital affiliation

Federally qualified health center

Community-based social services organization

Community-based behavioral health organization

Emergency services organization

Which of the following best describes the location where you work?

Urban

Suburban

Rural

What is the size of your organization?

Solo practice or 2 clinician practice

Small group practice (10 or fewer clinicians)

Multispecialty practice with more than 10 clinicians

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_