Form Approved

OMB No. 0955-XXXX

Exp. Date TBD

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

**Clinicians and Healthcare Professionals Prescreening Questionnaire**

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-Clinicians and 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_