2018 Farmworker Outreach Health Assessment - Adult (18 and up)

Version 4/7/2017

Demographic and Internal Use

First _____ Last _____

DOB mm / dd / yyyy □ Estimate Gender ID M / F / TM / TF / O / U

Sex at Birth M / F Phone _____

OK to text appointment info? Yes / No *Se me han explicado las normas de privacidad.* _____
(Explain privacy policy and ask patient to initial).

¿Ud. tiene donde vivir? Yes / No

St. Address _____ City _____

State ____ Zip _____ County _____ Date moved to address mm / dd / yyyy

Type Migrant / Seasonal / Other □ For migrant: H2A?

Race White / Black / American Indian / Asian / Unknown / Other / Refuse Hispanic Yes / No

Preferred Language Span / Eng / Other If other, preferred lang _____

English interpreter needed? Yes / No US veteran? Yes / No

HH Income

Amount ($) _____ Frequency week / biweek / bimo/ monthly / yr

Months _____ Yrly Income _____ Family Size _____

Internal

Date mm / dd / yyyy

ORW _____

FHASES ID # _____

Site _____

Cohort _____

Camp Phone _____

Service location _____

Employer _____

Employer phone _____

Emergency Contact #

First name _____

Last name _____

Relationship _____

Phone _____

	ASSESSMENT			Provided	Follow Up	Declined
911	Explain 911		Health ed	□	□	
	Explain clinic services		Health ed	□	□	
Ins.	Insurance None / Medicaid / Medicare / Health Choice / Private		Health ed	□	□	
			Referral	□	□	□
Vitals	BP systolic _____ *(optional)* BP systolic _____		Health ed	□	□	
	BP diastolic _____ *(optional)* BP diastolic _____		Referral	□	□	□
	If ≥120/80, offer health ed. If ≥140/90, offer referral.					
	Optional Weight _____ Height _____		Health ed	□	□	
	BMI _____		Referral	□	□	□
	If ≥26 offer health ed.					
	Optional		Health Ed	□	□	
	Blood Glucose _____		Referral	□	□	□
	If ≥200, offer referral.					
General Health	¿Usted ha sido diagnosticado con alguna condición médica? *Have you been diagnosed with any medical conditions? If yes, list.*	Yes / No				
	¿Tiene algún problema o preocupación sobre su salud? *Do you have any health problems or concerns? If yes, list concerns.*	Yes / No				
	IF YES to either of the previous two questions, ¿Usted quiere ayuda o más información sobre este problema? *Do you want more assistance or information for this health problem?*	Yes	Health Ed	□	□	
			Referral	□	□	□
		No	Diabetes, pregnancy, HTN, HIV, TB or abnormal cancer screen, consider MCN			
	¿Está tomando (o debería estar tomando) medicinas, vitaminas, hierbas, o tratamientos naturales? *Are you or should you be taking any medicines, vitamins, herbs, or natural treatments? If yes, list.*	Yes	Health Ed	□	□	
		No	Referral	□	□	
Dental	¿Usted usa un cepillo de dientes e hilo dental todos los días? *Do you brush and floss your teeth daily? (Does patient have good dental hygiene?)*	Yes	Health Ed	□	□	
			Referral	□	□	
		No	Dental Supplies	□	□	
			If no, provide health ed			
Occupational	¿Cómo se protege de pesticidas? *How do you protect yourself from pesticides? (Can patient name 2 methods of pesticide safety?)*	Yes	Health Ed	□	□	
		No	If no, provide health ed			
	¿Se ha enfermado por contacto con pesticidas en esta temporada? *Have you gotten sick because of contact with pesticides this season?*	Yes	Referral	□	□	□
			AIR protocol	□	□	□
		No	If yes, provide referral and complete Air Protocol			
	¿Cómo se protege del sol ó del calor? *How do you protect yourself from the heat? (Can patient name 2 ways to prevent heat illness?)*	Yes	Health Ed	□	□	
		No	If no, provide health ed			
	¿Se preocupa por condiciones en su trabajo? *Are you worried about conditions at your work place?*	Yes	Referral	□	□	□
		No	If yes, refer to reporting options.			
Car Safety	¿Cúales son las consequencias de tomar alcohol y manejar? *What are the consequences of drinking and driving? (Is patient able to list at least 2 risks related to drinking & driving?)*	Yes	Health Ed	□	□	
		No	If no, provide health ed			
	¿Cuando va en un carro, usa usted el cinturon de seguridad si lo hay? *When riding in a car do you wear a seat belt, if available?*	Yes	Health Ed	□	□	
		No	If no, provide health ed			

	ASSESSMENT			Provided	Follow Up	Declined
Alcohol/Tobacco/Drugs	¿Usted fuma o usa productos de tabaco? *Do you smoke or use tobacco products?*	Yes / No	Health Ed Referral NC Quitline If yes, provide health ed	□ □ □	□ □ □	
	IF YES: □ every day □ sometimes □ smoker, current status unknown IF NO: □ former smoker □ never □ Unknown if ever smoked					
	¿Usted toma bebidas alcohólicas, incluyendo cervezas? *Do you drink alcoholic beverages, including beer?*	Yes / No	Health Ed	□	□	
	¿Ha experimentado alguna vez con drogas? *Have you ever experimented with drugs?*	Yes / No	Health Ed	□	□	
	If YES to either, ask the next 4 questions. (Include drugs only if patient reported experiment'g with drugs in the previous question). 1. ¿Ha sentido alguna vez que debería reducir su uso de alcohol y/o drogas? *Have you ever felt that you ought to cut down on your drinking or drug use?*	Yes / No	Referral If yes to any of the 4 questions, provide referral.	□	□	□
	2. ¿Se ha sentido alguna vez molesto por las críticas de la gente acerca de su uso de alcohol y/o drogas? *Have people annoyed you by criticizing your drinking or drug*	Yes / No				
	3. ¿Alguna vez se ha sentido culpable o mal debido a su uso de alcohol y/o drogas? *Have you ever felt bad or guilty about your drinking or drug use?*	Yes / No				
	4. ¿Alguna vez ha necesitado alcohol y/o drogas temprano en la mañana para calmar sus nervios o ayudarlo con la resaca? *Have you ever had a drink or used drugs first thing in the morning to steady your*	Yes / No				
Sexual/Repro Health	¿Quiere hacerse el exámen de VIH o de otras enfermedades transmitidas sexualmente? *Are you interested in being tested for HIV or other sexually transmitted diseases?*	Yes / No	Health Ed Referral Oraquick Clear View	□ □ □ □	□ □ □ □	 □ □ □
	¿Quiere anticonceptivos/condones? *Would you like contraception/condoms?*	Yes / No	Health Ed Referral Condoms If yes, provide condoms; Referral if applicable	□ □ □	□ □ □	
	¿Quiere más información sobre planificación familiar? *Would you like more information on family planning methods?*	Yes / No	Health Ed Referral	□ □	□ □	
	¿Ud. se considera? (Marque uno). *Do you consider yourself?* □ Heterosexual (ni gay, ni lesbiana) □ Lesbiana, gay u homosexual □ Bisexual □ Algo distinto □ No sé □ Me niego a contestar					
Women	**FOR WOMEN ONLY** ¿Piensa que es posible que esté usted embarazada? *Do you think you may be pregnant?*	Yes / No	Referral Pregnancy test If yes, offer referral and if migrant, consider MCN	□ □	□ □	□ □
	Ages 18-50 : ¿Toma ácido fólico? *Do you take folic acid?*	Yes / No	Health Ed Folic Acid If no, provide folic acid and health ed	□ □	□ □	 □
	Ages 21-64 : ¿Cuándo y dónde fue su último exámen de papanicolau? *When and where was your last pap?* (*Was last pap within last three years AND does pt. know clinic location?)* LOCATION: DATE : mm / dd / yyyy	Yes / No	Health Ed Referral for pap If yes, complete medical records release. If no, offer referral	□ □	□ □	 □
50 +	**FOR AGES >50 ONLY** ¿Le han hecho una prueba para cáncer del colon? *Have you had recent screening for colon cancer? (Either a colonoscopy in past 5 years or stool occult blood testing in the past year)*	Yes / No	Health ed Referral Stool Card If no or unknown, provide stool guaiac or FIT test/referral	□ □ □	□ □ □	 □ □
BH	Durante las últimas 2 semanas, ¿se ha sentido varias veces con poco interés o deseo de hacer cosas? *During the last 2 weeks have you often had little interest or pleasure in doing things?*	Yes / No	Health Ed Referral RHS-15	□ □ □	□ □ □	 □ □
	Durante las últimas 2 semanas, ¿se ha sentido desanimado, deprimido o sin esperanzas? *During the last 2 weeks have you been feeling down, depressed or hopeless?*	Yes / No	If yes to either question, offer full depression screen (RHS-15) For positive RHS-15, offer referral			
CM	¿Alguien en donde trabaja o vive le hizo sentir amenazado(a) o en peligro, a usted o a otra persona? *Does anyone where you work or live ever make you or anyone you know feel scared or unsafe?*	Yes / No	Referral If yes, provide referral.	□	□	□
	¿Tiene alguna otra inquietud o preocupación? *Do you have any other problems or needs? (como comida, ropa, vivienda)*	Yes / No	Referral	□	□	□

Health Ed

911	Colon Cancer screen	Family Planning	Immunizations	Pesticides	Sun Exposure
ACA/ insurance	Condom	First Aid	Insect/Snake bite	Poisonous Plants	Tuberculosis*
Athletes foot	Dental	Folic Acid	Living Condition	Pre/Post HIV Counseling	Vision/Eye Care
Back Pain	Diabetes*	General Health	Medication Use	Prenatal*	Vitamins
Cancer*	Domestic Violence	GTS	Nutrition	Seatbelt	Water Safety
Cholesterol	DWI	Heat Illness	Obesity Counseling	Skin/Wound Care	Other _____
Clinic services	Emotional Health	HIV/AIDS/STIs*	Pap	Smoking	
Cold Stress	Exercise	Hypertension	Personal Hygiene	Substance Abuse	

* Consider MCN