2020 Farmworker Outreach Health Assessment - Adol (12-17) | ORW: | Date:

Privacy

My signature indicates that I understand that my privacy will be protected within this farmworker health network except in the following circumstancs: if harm is suspected of a minor, elderly, or disabled person.

Signature: _____

Demographics

Name (first, last): _____ Birth date: _____ □ Est.

Preferred language: **Span/ Engl/ Other:** _____ Do you need an interpreter? **Yes/ No**

Worker typer: **Migrant (□ H2A?)/ Seasonal/ Other** Unaccompanied minor? **Yes/ No**

How do you consider yourself? **Man/ Woman/ Transgender man/ Transgender woman/ Other/ Decline to answer**

(If migrant) Estimated departure date: _____

What sex were you assigned at birth? **Male/ Female** Housing: **Own/ Rent/ Grower-provided/ Homeless**

Address: _____ City: _____

State: _____ Zip code: _____ County: _____

Health insurance: **None / Medicaid / Medicare / Health Choice / Private** Family income ($ amount): _____

Amount is per: week **/ 2 weeks/ month / year** # months worked ____ # familyl members: _____

Hispanic or Latino? **Yes/ No/ Decline** Race: **White/ Black/ American Indian/ Asian/ Decline**

How do you consider yourself? **Heterosexual (not gay nor lesbian)/ Lesbian, gay, or homosexual/ Bisexual/ Something different/ I don't know/ Decline to answer**

COVID-19

Do you currently have fever, cough, sore throat, unusual fatigue, headache, chills, diarrhea, loss of taste or smell, or shortness of breath? □ Yes □ No _____

If yes, see "NCFHP Interim COVID-19 Guidance: Screening Call with Sick Worker"

Health ed: ☐ Provided ☐ Follow up

Vitals

Blood pressure: _____ Health ed: ☐ **Provided** ☐ **Follow up**

If >120/80, offer health ed. If >140/90, offer referral. Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

General health

Is there something that worries you about your health? **No/ Yes:**_____

(If yes) How can I help you with this problem? _____

Have you ever been diagnosed with a medical condition? **No/ Yes:**_____

Are you taking (or should you be taking) medicines? **No/ Yes:**_____

Have you had a physical exam in the last two years in which you received vaccines? *If no, provide referral to primary care or health department.* **No/ Yes**

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Diabetes, pregnancy, HTN, HIV, TB or abnormal cancer screen, consider MCN

Occupational

Do you work in the fields? **No/ Yes**

(If yes) Would you like more information on how to protect yourself at work? (such as pesticides, heat stress, or something else) **No/ Yes:** _____

(If yes) Do you worry about conditions at work? (like unfair pay, pesticides exposure, or other illegal practices) **No/ Yes:** _____

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Health ed on _____

☐ **Provided** ☐ **Follow up**

BH

In the last 2 weeks, have you often felt little interest or desire to do things? **No/ Yes**

In the last 2 weeks, have you felt sad, depressed, or hopeless? **No/ Yes**

If yes to either question, offer full depression screen (RHS-15)

For positive RHS-15, offer referral

RHS-15 □ **Provided** □ **Follow up**

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Substance use

Do you drink alcohol, including beer? **No/ Yes** *If yes, complete 4 CAGE questions below.*

In the past year have you used an illegal drug or prescription medication for non-medical reasons? *(ex: the experience or feeling the drug causes)* **No/ Yes** *If yes, complete 4 CAGE questions below.*

CAGE-AID

Have you ever felt that you should reduce your drug or alcohol use? **No/ Yes**
Have you ever felt bothered by criticism by other people about your drug or alcohol use? **No/ Yes**
Have you ever felt guilty or bad due to your drug or alcohol use? **No/ Yes**
Have you ever felt that you needed drugs or alcohol in the morning to calm your nerves or to help with a hangover? **No/ Yes**
If yes to any of the 4 questions, provide referral.

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

CM

Does someone where you work or live threaten you or make you feel in danger? **No/ Yes**
Do you have any other worries or concerns? **No/ Yes:** _____

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Communication

How can we communicate with you? *Ask patient to initial next to each below if OK.*

Cell number: _____ Teléfono fijo: _____

_____ OK to leave a message. _____ OK to leave a message.
_____ OK to leave a voicemail. _____ OK to leave a voicemail.
_____ OK to send a text (SMS) even though complete privacy is not guaranteed.
_____ OK to send a message through WhatsApp even though it may not be completely private.

Email address: _____
_____ OK to send a message.

How do you prefer that we communicate with you? *Mark preference.*

Addtl. Health Ed

Would you like more information on the following topics? *Circle those desired and check off if provided.*

□ Dental health □ Family planning □ Nutrition □ Drug or alcohol abuse
□ Diabetes □ Hypertension □ STIs/ HIV □ Other(s)_____
□ Emotional health □ Green Tobacco Sickness □ Smoking

Notes