



Patient: _____ DOB: _____ Date: _____

MED-IT ID:

HBSS HEALTH COACH SUMMARY

Does Patient want to participate in HBSS? Yes No

If no, was a Community Resource Book provided? Yes No

Health Coaching Completion Dates

First HC Session: Date _____ Type: Face-to-Face Phone Email Internet Other

Second HC Session: Date _____ Type: Face-to-Face Phone Email Internet Other

Third HC Session: Date _____ Type: Face-to-Face Phone Email Internet Other

Referral to Nutritional Counseling? Yes No

Health Coaching Notes: Description, Referrals, Follow-ups, Tools (Include referrals, community and in-house, and food assistance)

Session 1:

Session 2:

Session 3:

Session 4: