AL WISEWOMAN Clinical Initial HBSS Contact Form

Date:_____ **ABCCEDP Provider:**_____

First Name: _____ **Last Name** _____ **DOB** _____ **Phone:** _(____)_____

Address _____**City:** _____ **State:**_____**Zip Code:**_____

Does Patient want to participate in HBSS? **Yes** **No**

If No, was community resources provided? **Yes** **No**

Hypertension Medication Plan

On Hypertension Meds? Yes , If Yes, how does patient purchase meds _____

No **Not Applicable**

Adherence Plan:

Community Resource Referrals Made

Alabama Quit Line	**Yes**	**No**
Mental Health Assistance	**Yes**	**No**
Medication Assistance	**Yes**	**No**
Primary Care Physician Referral	**Yes**	**No**
Substance Abuse	**Yes**	**No**

Other: _____

Program Tools Provided

Pill Box	**Yes**	**No**
Stretch Band	**Yes**	**No**
My Plate	**Yes**	**No**
Sports Bottle	**Yes**	**No**
Fitness Tracker	**Yes**	**No**
Seasonal Sustenance	**Yes**	**No**

Nutritional Counseling Referral

Nutritional Counseling **Appointment Date:** _____

No Referral Made Yet **Not Applicable**

Home BP Monitor Overview

Was Home Blood Pressure Monitor Date Issued Today? Yes, Date: _____ **No**

If Yes, please complete the SMBP section in the AL WISEWOMAN Clinical HBSS Contact Form

HBSS Completion Date:

Follow-Up After HBSS Completion Date:

If Follow-up After HBSS was completed, please complete Follow-Up After HBSS Clinical Measurements Form