Prime Contractor Information

Washington State WISEWOMAN **Risk Reduction** Form

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **DOB:** |  | | | **Date:** |  |
| **Labs reviewed with patient?\*** Yes ☐ No ☐ **Sent in Writing?** Yes ☐ No ☐ | | | | | | | |
| **Date patient informed of lab results (if not avail same day)? / /** | | | | | | | |
| **Participant decided as priority area:** | | | | | | | |
| Nutrition | | | | | Yes ☐ No ☐ | | |
| Physical activity | | | | | Yes ☐ No ☐ | | |
| Smoking cessation | | | | | Yes ☐ No ☐ | | |
| Medication adherence for hypertension | | | | | Yes ☐ No ☐ | | |
| Reviewed risk factors for CVD, stroke, chronic disease with patient | | | | | Yes ☐ No ☐ | | |
| Addressed smoking status | | | | | Yes ☐ No ☐ | | |
| Discussed role of diet and physical activity with patient | | | | | Yes ☐ No ☐ | | |
| If referred for smoking cessation, what type of resources was patient referred to (check resource below). If not applicable, leave blank.  ☐ Quit Line  ☐ Community‐based tobacco program  ☐ Other tobacco cessation resource (e.g. 2Morrow App), User ID  **Referral Date:** | | | | | | | |
| Outcome of tobacco cessation referral, if applicable: ☐ Completed ☐ Partially completed ☐ Discontinued | | | | | | | |
| Does client wish to participate in a lifestyle intervention program?  **Referral Date:** | | | | Yes ☐ No ☐ | | | |
| **Referral Program or Site:** (Only check if referral program is known, otherwise leave blank)  Blood pressure Self-Monitoring  Health Coaching  BP Self-Monitoring w/ Clinical Support  Big 4 Health Coaching  Diabetes Prevention Program  Lose to Win YMCA  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

**FAX to:**