Client Identification

Program # ___ ___ ___

ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Enrollment Date ___ ___ / ___ ___ / ___ ___ ___ ___
(mm / dd / yyyy)

Last Name _____

First Name _____

Middle Initial _____

Patient Navigation Contacts

Patient Navigation Contact #1: Date ___ ___ / ___ ___ / ___ ___ ___ ___
(mm / dd / yyyy)

Patient Navigation Contact #2: Date ___ ___ / ___ ___ / ___ ___ ___ ___
(mm / dd / yyyy)

Status of Navigation

- ⬭ Refused after Contact #1
- ⬭ Lost to Follow-up

→ Comments:

Barriers Assessment

Which barriers would keep you from healthcare screenings? ***(check all that apply)***

- ⬭ 1. Don't have a provider *****
- ⬭ 2. Travel to the appointment
- ⬭ 3. Remembering the appointment date
- ⬭ 4. Paying for the service *****
- ⬭ 5. Understanding the provider's directions
- ⬭ 6. Fear
- ⬭ 7. Need an interpreter
- ⬭ 8. Need a referral to specialist *****
- ⬭ 9. No insurance *****
- ⬭ 10. Work hours
- ⬭ 11. Need child or family member care
- ⬭ 12. Disability (physical or mental)
- ⬭ 13. Pain/discomfort (real or perceived)
- ⬭ 14. Beliefs/cultural practices
- ⬭ 15. Lack of emotional support
- ⬭ 16. Other _____
- ⬭ 17. None at this time

***** *No Action Plan required*