Client Identification

Program # ___ ___ ___ Last Name _____ First Name _____ MI _____
Please PRINT *Please PRINT*

ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ **Screening** Visit Date generating contact: ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
(*Enter Visit Date from **Screening form***)

Healthy Behavior Support Services (HBSS)

21. Blood Pressure Self Monitoring by YMCA (BPSM YMCA)
    a. Referred ◯ 1. Yes ◯ 2. No 3. Referral Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    b. Participated ◯ 1. Yes ◯ 2. No 3. First Date of Participation ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    c. Completed ◯ 1. Yes ◯ 2. No 3. Completion Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

22. Diabetes Prevention Program (DPP)
    a. Referred ◯ 1. Yes ◯ 2. No 3. Referral Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    b. Participated ◯ 1. Yes ◯ 2. No 3. First Date of Participation ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    c. Completed ◯ 1. Yes ◯ 2. No 3. Completion Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

23. Medication Therapy Management (MTM)
    a. Referred ◯ 1. Yes ◯ 2. No 3. Referral Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    b. Participated ◯ 1. Yes ◯ 2. No 3. First Date of Participation ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    c. Completed ◯ 1. Yes ◯ 2. No 3. Completion Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

24. Self Monitoring Blood Pressure by Iowa WW (SMBP WW)
    a. Referred ◯ 1. Yes ◯ 2. No 3. Referral Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    b. Participated ◯ 1. Yes ◯ 2. No 3. First Date of Participation ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    c. Completed ◯ 1. Yes ◯ 2. No 3. Completion Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

25. Walk With Ease (WWE)
    a. Referred ◯ 1. Yes ◯ 2. No 3. Referral Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    b. Participated ◯ 1. Yes ◯ 2. No 3. First Date of Participation ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
    c. Completed ◯ 1. Yes ◯ 2. No 3. Completion Date ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

26. **Post assessment** scheduled date: ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*