ZUFALL HEALTH

PATIENT NAVIGATION INTAKE FORM

Complete this form with the patient at the time of initial contact

__ New Patient __ Established Patient

Name: _____ D.O.B. _____
Address: _____
Telephone: _____ Cell: _____ Can message be left? Yes __ No __
Emergency Contact Person: _____ Relation: _____
Emergency Contact Number: _____

Does the patient have health insurance?

__ Yes __ No

If yes: __ Private/Commercial __ Medicare __ Medicaid

__ Other: _____

How was patient referred to the Patient Navigation Program?

__ Psychiatrist Name: _____ Phone: _____
__ Counselor Name: _____ Phone: _____
__ Other Name: _____ Phone: _____

Current/Past Medical History:

1) _____ Yr. Dx: _____
2) _____ Yr. Dx: _____
3) _____ Yr. Dx: _____
4) _____ Yr. Dx: _____

Current Medical Doctor _____ Phone: _____
Prior Medical Doctor _____ Phone: _____

Current/Past Medication:

1) _____
2) _____
3) _____
4) _____

POTENTIAL PROBLEMS/BARRIERS TO CARE

Health Insurance/Financial Concerns

- Inadequate or lack of insurance coverage
- Pre certification problems
- Difficulty paying bills
- Need for financial assistance from Medicare/Medicaid
- Need for prescription assistance
- Need for medical equipment/supplies (w/c, dressings)
- Citizenship problems
- Other: _____

Transportation To and From Treatment

- Public transportation needed
- Private transportation needed
- Other: _____

Physical Needs

- Child/elder care
- Housing/housing problems
- Food, clothing, other physical needs _____
- Prostheses, wigs, etc
- Vocational support (job skills, employment skills)
- Extended care needs (home care, hospice, long term care)
- Other: _____

Communication/Cultural Needs

- Primary language other than English
- Inability to read or write
- Poor health literacy
- Cultural barriers (i.e. effect on lifestyle choices)
- Other: _____

DISEASE MANAGEMENT

Treatment Compliance Issues (missed appointments, etc)

- Mental health services needed
- Poor understanding of treatment plan
- Needs to talk with a provider (physician, nurse, therapist, etc.)
- Wants more information about: _____
- Other: _____

Support Services for Referrals

__ Social Worker
__ Nutritionists
__ Financial Counselors
__ Clergy
__ Support of family member
__ Support Groups

Plan of Care and Follow-up:

1. _____
2. _____
3. _____
4. _____
5. _____

Additional Comments/Notes:

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