**SECTION B**

**Be Well Care Management Program Assessment Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Vital Signs –** **All members** | **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**BP:** \_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Height:** \_\_\_\_\_\_\_\_\_\_\_ **BMI:** \_\_\_­­\_\_\_ |
| **Hypertension** | Complete the Vital Signs section above. |
| **Diabetes****and /or****Dyslipidemia****(High Cholesterol**) | **HA1C:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Lipid Panel:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Chol: \_\_\_\_\_\_\_\_ TGL: \_\_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_ HDL: \_\_\_\_\_\_\_\_ **Eye Exam**: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal: [ ] YES [ ] NO Diabetic Retinopathy Finding: [ ] Mild [ ] Moderate [ ] Severe**Foot Exam**: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetic Altered Sensation Finding: [ ] Mild [ ] Moderate [ ] Severe |
| **Asthma** | [ ] Completely Controlled [ ] Somewhat Controlled [ ] Not Controlled at all[ ]  Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent |
| **COPD** | [ ] Completely Controlled [ ] Somewhat Controlled [ ] Not Controlled at all[ ]  Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent |

Name of Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please present this form in person at the Shaw Family Health Center, **OR** Mail to Shaw Family Health Center, 2659 Abutment Road, Dalton, GA 30721, **OR** Fax to: 706-913-1269, **OR** email to SFHC@Premisehealth.com