**SECTION B**

**Be Well Care Management Program Assessment Form**

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

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

|  |  |
| --- | --- |
| **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