Sage*Plus* Screening Form

CLINICAL ASSESSMENT: Lab Visit Date ___ /___ /_____

TYPE OF SCREENING:

◯ INITIAL/BASELINE SCREENING ◯ FOLLOW-UP SCREENING (3-11 mos. after initial screening) ◯ RESCREENING (12-18 mos. after initial screening)

OFFICE VISIT DATE (same as BP date)	**PATIENT MRN**	**SAGE ORG ID #**	**SAGE ENCOUNTER #**

FIRST NAME	**LAST NAME**	**DATE OF BIRTH** (mm/dd/yyyy)

HIGHEST LEVEL OF EDUCATION ◯ Less than 9th Grade ◯ Some High School ◯ High School Grad or Equivalent ◯ Some College or Higher ◯ Don't know/Not Sure

LABS

HEIGHT _____ft. _____in.	**WEIGHT** _____lbs.	**WAIST** _____in.
BLOOD PRESSURE _____ /_____	**TOTAL CHOLESTEROL:** _____mg/dL **HDL:** _____ mg/dL **LDL:**_____ mg/dL **TRIGLYCERIDES:**_____ mg/dL	
FASTING: ◯ Yes ◯ No	**A1C** _____%	**GLUCOSE** (fasting)_____ mg/dL

ALERT VALUE*

☐ **Alert Blood Pressure*** (*CDC Alert Value for BP is higher than 180 systolic or* 120 *diastolic*) *Follow-up appointment must be completed within 7 days	☐ Work up complete. Appt. completed on: _____ /_____ / _____ (mm/dd/yyyy)	☐ Work up refused	☐ Work up not complete, lost to follow up

HYPERTENSION

1. **Do you have hypertension (high blood pressure?)** ◯ Yes ◯ No ◯ Don't know
2. Was **medication prescribed** to lower your blood pressure prior to this appointment? ◯ Yes ◯ No ◯ Don't know
   a. If **YES**, how many days was prescribed medication taken in the past 7 days? _____
3. If known, what date was your blood pressure remeasured either by a health care provider, or with another community resource? ___ /___ /_____ (mm/dd/yyyy)
4. Do you measure your blood pressure at home or use another blood pressure machine in the community? ◯ Yes ◯ No ◯ Don't know
   a. If **NO,** why? ◯ Never told to measure ◯ Don't know how ◯ No equipment to measure
   b. If **YES**, how often do you measure your blood pressure at home or with another blood pressure machine in the community? ◯ Multiple times per day ◯ Daily ◯ A few times per week ◯ Weekly ◯ Monthly ◯ Not sure
   c. If **YES,** do you regularly share your blood pressure readings with a health care provider for feedback? ◯ Yes ◯ No ◯ Don't know
5. Have you ever been diagnosed by a health care provider as having the following:
   a. Gestational hypertension: ◯ Yes ◯ No ◯ Don't know
   b. Pre-eclampsia/eclampsia: ◯ Yes ◯ No ◯ Don't know

CHOLESTEROL

6. **Do you have high cholesterol?** ◯ Yes ◯ No ◯ Don't know
7. Was a **statin medication** prescribed to lower your cholesterol prior to this appointment?
   ◯ Yes ◯ No ◯ Don't know
   a. If **YES**, how many days was prescribed statin medication taken in the past 7 days? _____ days
8. Was **another medication** other than statin prescribed to lower cholesterol prior to this appointment?
   ◯ Yes ◯ No ◯ Don't know
   a. If **YES**, how many days was prescribed medication taken in the past 7 days? _____ days

DIABETES

9. **Do you have diabetes (type 1 or type 2)?** ◯ Yes ◯ No ◯ Don't know
10. **Was medication prescribed** to lower blood sugar prior to this appointment?
    ◯ Yes ◯ No ◯ Don't know
    a. If **YES**, how many days was prescribed medication taken in the past 7 days? _____ days
11. **Have you ever been diagnosed by a health care provider as having gestational diabetes**?
    ◯ Yes ◯ No ◯ Don't know

HEART & STROKE

12. Are you taking **aspirin** daily to help prevent a heart attack or stroke? ◯ Yes ◯ No ◯ Don't know
13. Have you been diagnosed by a health care provider as having any of the following?
    Stroke/transient ischemic attack (TIA): ◯ Yes ◯ No ◯ Don't know/ Not sure
    Heart Attack: ◯ Yes ◯ No ◯ Don't know/ Not sure
    Coronary Heart Disease: ◯ Yes ◯ No ◯ Don't know/ Not sure
    Heart Failure: ◯ Yes ◯ No ◯ Don't know/ Not sure
    Congenital Heart Disease: ◯ Yes ◯ No ◯ Don't know/ Not sure
    Vascular Disease (peripheral arterial disease): ◯ Yes ◯ No ◯ Don't know/ Not sure

HEALTHY BEHAVIORS

14. How many cups of **fruits and vegetables** do you eat in an average day? _____ cups
15. Do you eat **fish** at least two times a week? ◯ Yes ◯ No
16. Thinking about all the servings of grain products you eat in a typical day, how many are **whole grains?** (e.g., oatmeal, bread, rice) ◯ Less than half ◯ Half ◯ More than half
17. Do you drink less than 36 ounces (three 12 oz. cans of soda is equal to 36 oz.) of **sugar sweetened beverages** a week? ◯ Yes ◯ No
18. How many minutes of **physical activity** (exercise) do you get in a week? _____ minutes
19. Are you currently watching or reducing your **sodium or salt intake**? ◯ Yes ◯ No

20. Over the past 2 weeks, how often have you experienced any of the following **feelings**?

a. Little interest or pleasure in doing things:

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

b. Feeling down, depressed, or hopeless:

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

SDoH referral: _____ Date: ___/___/____ (mm/dd/yyyy)
(N/A = refused or not needed)

21. The following questions are about **alcohol** consumption:

a. In the past 7 days, how many days did you have a drink containing **alcohol**? _____ days

b. How many **alcoholic drinks, on average, do you consume during a day** you drink? _____ drinks

SDoH referral: _____ Date: ___/___/____ (mm/dd/yyyy)
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22. **Do you smoke** (e.g., cigarettes, pipes, cigars) or use commercial tobacco or nicotine in any form?

◯ Current smoker ◯ Quit (1-12 months ago) ◯ Quit (more than 12 months ago) ◯ Never smoker

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SOCIAL DETERMINANTS OF HEALTH ASSESSMENT AND REFERRALS

SOCIAL DETERMINANTS OF HEALTH

23. Do you use any of the following types of **computers:** Desktop/Laptop, Smartphone, and/or Tablet/Other portable wireless computer? ◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

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24. Do you or any member of your household have access to the **internet**?

◯ Yes—with a cell phone or internet provider ◯ Yes—without paying company/internet service provider

◯ No access to internet in house/apt/mobile home ◯ Don't know ◯ Prefer not to answer

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25. During the **last 12 MONTHS,** was there a time when you were worried you would run out of **food** because of a lack of money or other resources? ◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

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26. Have you ever missed a doctor's appointment because of **transportation** problems?

◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

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(N/A = refused or not needed)

27. Do you **use or need child care** services? ◯ Yes ◯ No ◯ Don't know

a. If **YES,** what type? (Select all that apply)

☐ Infant (Birth to 11 months) ☐ Toddler (11 to 36 months) ☐ Preschool (3 to 5 yrs.)
☐ After school care (K-9th grade) ☐ Don't know ☐ Prefer not to answer

b. If **YES**, have you had any of these child care related problems during the past year? (Select all that apply)

☐ Cost ☐ Availability ☐ Location ☐ Transportation ☐ Hours of operation ☐ Other ☐ Don't know

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28. What is your **housing** situation today?

◯ I have housing ◯ I have housing, but I am worried about losing my housing
◯ I do not have housing ◯ Don't know ◯ Prefer not to answer

SDoH referral:_____ Date: ___/___/_____ (mm/dd/yyyy)
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29. The following will ask you about **how safe you feel.**

a. How often does your **partner physically hurt you**?

◯ Never ◯ Rarely ◯ Sometimes ◯ Fairly often ◯ Frequently ◯ Prefer not to answer ◯ No partner

b. How often does your **partner insult or talk down** to you?

◯ Never ◯ Rarely ◯ Sometimes ◯ Fairly often ◯ Frequently ◯ Prefer not to answer ◯ No partner

SDoH referral:_____ Date: ___/___/_____ (mm/dd/yyyy)
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30. Do you take any **prescribed medications**? ◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

a. Do you ever **forget** to take your prescribed medicine? ◯ Yes ◯ No ◯ Prefer not to answer

b. Are you **careless** at times about taking your medicine? ◯ Yes ◯ No ◯ Prefer not to answer

c. When you feel better, do you sometimes **stop** taking your medicine? ◯ Yes ◯ No ◯ Prefer not to answer

d. Sometimes if you feel worse when you take your medicine, do you **stop** taking it?

◯ Yes ◯ No ◯ Prefer not to answer

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HBSS

31. **Referral to Health Behavior Support Services** (Pick one):

◯ **Health coaching -** provided by MDH
◯ **Walk with Ease -** provided by MDH
◯ **Zumba -** in person North Minneapolis
◯ Patient is **undecided** (MDH will reach out to discuss program)

Ask your clinic about availability:
◯ **Health coaching -** provided by clinic
◯ **Medication Therapy Management -** provided by clinic
◯ **Nutrition Education -** provided by clinic

Date risk reduction counseling completed: _____ /_____ /_____ (mm/dd/yyyy)

Staff name (please print):_____

Please complete and fax to the Sage Screening Program: 1-877-495-7545