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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01218 (06/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control SectionPage 1 of 2 |
| wisewoman client ENROLLMENT And Consent  |
| Last Name | First Name  | Middle Initial | Date of Birth |
|       |       |   |       |
| Street Address | City  | State | ZIP Code |
|       |       |    |       |
| Day Phone Number | Alternative Phone Number |
|       |       |
| 1. Race: First Race

[ ]  1 White [ ]  2 Black or African American [ ]  3 Asian[ ]  4 Native Hawaiian or Other Pacific Islander [ ]  5 American Indian or Alaska Native [ ]  6 Other:       |
| 1. Race: Second Race

[ ]  1White [ ]  2 Black or African American [ ]  3 Asian[ ]  4 Native Hawaiian or Other Pacific Islander [ ]  5 American Indian or Alaska Native [ ]  7 Unknown |
| 1. Education: Highest grade completed

[ ]  1 Less than 9th grade [ ]  2 Some high school [ ]  3 High school graduate or equivalent[ ]  4 Some college or higher [ ]  7 Don’t know/Not sure |
| 1. What is the primary language spoken in the home?

[ ]  English [ ]  Spanish [ ]  Arabic [ ]  Chinese [ ]  French [ ]  Italian [ ]  Japanese[ ]  Korean [ ]  Polish [ ]  Russian [ ]  Tagalog [ ]  Vietnamese [ ]  Hmong [ ]  Other |

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| The purpose of the Wisconsin WISEWOMAN Program is to help identify risk for cardiovascular disease, stroke, and diabetes and help reduce risk through assistance with making behavior changes with nutrition, physical activity, and blood pressure control. All information collected will be kept confidential and used for program enrollment, bidirectional referrals, program administration, and case management.**I understand that as a Wisconsin WISEWOMAN Program client:**1. I will be asked questions about my health history and family health history to find out if I am at risk for cardiovascular disease.
2. I will be asked questions about my social services and support needs, which are key to helping me improve my health.
3. I will be asked questions related to what I eat and my level of physical activity to determine my risk for cardiovascular disease.
4. It is my responsibility to see a medical provider if it is required. Even if it is not required, I understand it is a good idea to get approval from my medical provider before beginning regular, planned physical activity.
5. I am willing to make changes in my lifestyle to improve my health by participating in healthy behavior support programs. These programs will be **at no or very low cost** to you.
6. Once I select a healthy behavior support activity, I agree to give permission to my WISEWOMAN Provider Organization to obtain information about my attendance at meetings and any changes in my health (weight, eating habits, and blood pressure readings).
7. I will have a screening visit to check the following: height, weight, waist measurement, blood pressure, cholesterol level, blood glucose level, and check on my mental wellbeing. This screening visit will be performed with my annual exam for the Wisconsin Well Woman Program. For each year that I return for my annual Wisconsin WISEWOMAN Program exam, I may have follow-up Wisconsin WISEWOMAN Program screenings.
8. I will have blood collected to check the cholesterol and blood sugar levels in my body. There will be **no cost** for these tests.
9. If my blood pressure, cholesterol, and/or blood sugar results are not normal, I may be referred to a participating medical provider for a diagnostic office visit. I understand that the Wisconsin WISEWOMAN Program will pay for this diagnostic office visit.
10. If my blood pressure is not in control, I will be provided additional support services to help me in taking my medication(s), understanding my blood pressure numbers, reducing the amount of salt I eat, and other ways to control my blood pressure.
11. I may be referred to social and support resources which are key to helping me improve my health.
12. I understand that the Wisconsin WISEWOMAN Program does not pay for medical treatment services.
13. I understand that the Wisconsin WISEWOMAN Program cannot pay for any medications the medical provider might prescribe for me, but I will be offered assistance to help find free or reduced-cost medications.
14. It is my responsibility to keep all appointments. I give permission for my WISEWOMAN provider to contact me by: [ ]  phone, [ ]  text, [ ]  email for any follow-up services. Check all that apply.
15. I understand that if I have any questions, I can call the Wisconsin WISEWOMAN Program Provider.

I understand the information in this consent and agree to participate in the Wisconsin WISEWOMAN Program. |
| **SIGNATURE** – Client | Date Signed | Client ID Number |
|  |       |       |
| **SIGNATURE** – Provider | Date Signed | Print Name of Provider |
|  |       |       |