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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01222 (06/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control Section |
| wisewoman DIAGNOSTIC AND HYPERTENSION MANAGEMENT REFERRAL |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** |

| 1. Provider Agency Name | 2. Performing Provider Name (NP, PA, or MD) | 3. Date of Contact |
| --- | --- | --- |
|       |       |       |
| 4. Client Name (Last, First MI) | 5. Date of Birth | 6. Client ID Number |
|       |       |       |
| **SECTION 2 – REASON(S) FOR REFERRAL** |
| 1. Indicate the reason(s) for the client’s referral. Check all that apply.
 |
| [ ]  Alert Blood Pressure[ ]  Stage 1 or Stage 2 Blood Pressure[ ]  Hypertension Management | [ ]  Further Assess for Diabetes, Hypertension, or High Cholesterol Diagnosis[ ]  Other |
| 1. Describe clinical assessment findings. Include results of further tests completed at this visit.
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|       |
| 1. What date(s) did the client have her blood pressure remeasured either by a healthcare provider, or another community resource? List blood pressures.
 |
| BP 1:      /      | BP 2:      /      | BP Average:      /      |
| 1. Does client have a confirmed medical diagnosis? Check all that apply.

[ ]  High Blood Pressure [ ]  Diabetes [ ]  High Cholesterol |
| SECTION 3 – RECOMMENDATIONS |
| 1. Indicate what recommendations were given to the client. Check all that apply.
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| Medications Prescribed at This Visit (list):      | [ ]  Client already on medication; no changes made[ ]  Therapeutic lifestyle changes (diet, physical activity, weight reduction, stress management, tobacco use)[ ]  No treatment prescribed[ ]  Other treatment, specify:      [ ]  Date of next appointment:      [ ]  Social Services and Support Needs Referral:       |
| 1. Does the client need assistance to obtain prescribed medications? [ ]  Yes [ ]  No

**If yes**, was the client linked to medication assistance? [ ]  Yes [ ]  No |
| 1. Does the client need ongoing monitoring or management of a medical condition? [ ]  Yes [ ]  No

**If yes**, was the client linked to a health care provider for continuing care? [ ]  Yes [ ]  NoName of Provider:      Provider Location:      Other Follow-up Comments:       |
| SECTION 4 – WORKUP STATUS |
| 1. Using the codes **1-4,** enter a workup status number for each screening result:

**1** – Workup complete **2** – Follow-up workup by alternate provider**3** – Client refused workup **4** – Workup not completed; client lost to follow-up |
| Blood Pressure | Blood Glucose | High Cholesterol  |
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