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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01222 (06/2024) | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic 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 |
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| 4. Client Name (Last, First MI) | | | | | | 5. Date of Birth | 6. Client ID Number | |
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| **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. | | | | | | | | |
| 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  No  Name 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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