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| **DEPARTMENT OF HEALTH SERVICES**Division of Public HealthF-01225 (09/2024) | **STATE OF WISCONSIN**Bureau of Community Health PromotionChronic Disease Prevention and Cancer Control Section |
| wisewoman Healthy Behavior Encounter  |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** |
| 1. Provider Agency Name | 2. Performing Provider Name |
|       |       |
| 3. Client MED-IT Number | 4. Date of Contact | 5. Date of the IOV |
|       |       |       |
| 6. Client Name (Last, First MI) | 7. Date of Birth |
|       |       |
| 8. Preferred Contact Option(s) (select all that apply) |
| [ ]  Phone | Main Phone Number:       | Alternate Phone Number:       |
| [ ]  Text | Cell Phone Number:       |
| [ ]  Email | Email Address:       |
| Best Time to Contact |
|       |
| **SECTION 2 – INITIAL HEALTHY BEHAVIOR SUPPORT ENCOUNTER Date:**       |
| 9. Client Selected a HBSS: [ ]  Yes – (Name)       [ ]  No – 30 Day Call Back |
| 10. Client Priority Area (select all that apply) |
| [ ]  Healthy Eating[ ]  Physical Activity[ ]  Blood Pressure Control [ ]  Quit Smoking[ ]  Weight Loss |
| 11. Indicate SMART Goal:       |
| 12. Community Referrals (select all that apply) | 13. Social Services and Support Referrals (select all that apply) |
| [ ]  Healthy Eating[ ]  Physical Activity[ ]  Blood Pressure Control[ ]  Quit Smoking[ ]  Weight Loss[ ]  Other(s) – Specify:       | [ ]  Food Security[ ]  Housing[ ]  Transportation[ ]  Childcare[ ]  Home Safety[ ]  Medication Assistance[ ]  Other(s) – Specify:       |
| SECTION 3 – SUBSEQUENT HEALTH COACHING ENCOUNTERS  |
| *Complete if client had general coaching.* **Date:**       |
| 14. Did the client achieve the stated goal(s)? |
| [ ]  Yes – Client Achieved Goal (select all that apply)[ ]  Eating Healthier[ ]  Increased Physical Activity[ ]  Lower/Controlled Blood Pressure[ ]  Stopped Smoking[ ]  Lost Weight | [ ]  No – Barriers/Challenges (select all that apply)[ ]  Time[ ]  Motivation [ ]  Competing Priorities |
| 15. Did the client make progress on the stated goal(s)? |
| [ ]  Yes – Made Progress on Stated Goal(s) (select all that apply)[ ]  Eating Healthier[ ]  Increased Physical Activity[ ]  Lower/Controlled Blood Pressure[ ]  Stopped Smoking[ ]  Lost Weight | [ ]  No – Barriers/Challenges (select all that apply)[ ] Time[ ]  Motivation [ ]  Competing Priorities |
| 16. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes (*education tools provided and next session date/time*)      |
| SECTION 4 – BLOOD PRESSURE SELF-MONITORING HEALTH COACHING |
| *Complete if client had Blood Pressure Self-Monitoring coaching.* **Date:**       |
| 17. Agreed Provider/Client BP Goal:      /      | Calculated Average SMBP Reading:      /      |
| 18. Did the client achieve blood pressure goal? |
| [ ]  Yes (select all that apply)[ ]  Able to Get Medications[ ]  Taking BP Medications Correctly[ ]  Lowered Sodium[ ]  Doing BPSM[ ]  Readings Shared with Provider[ ]  Lost Weight[ ]  Increased Physical Activity[ ]  Stopped Smoking | [ ]  No – Barriers/Challenges (select all that apply)[ ]  Time[ ]  Motivation [ ]  Competing Priorities |
| 19. Did the client make progress on blood pressure goal? |
| [ ]  Yes (select all that apply)[ ]  Able to Get Medications[ ]  Taking BP Medications Correctly[ ]  Lowered Sodium[ ]  Doing BPSM[ ]  Readings Shared with Provider[ ]  Lost Weight[ ]  Increased Physical Activity[ ]  Stopped Smoking | [ ]  No – Barriers/Challenges (select all that apply)[ ] Time[ ]  Motivation [ ]  Competing Priorities |
| 20. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes (*education tools provided and next session date/time*)      |
| SECTION 5 – WALK WITH EASE HEALTH COACHING |
| *Complete if client had Walk with Ease health coaching.* Date:       |
| Target Walking Time Goal:       |
| 21. Did client achieve target walking time goal? |
| [ ] Yes – Number of Minutes:       | [ ]  No – Barriers (select all that apply)[ ]  Time[ ]  Motivation[ ]  Competing Priorities |
| 22. Did client make progress on target walking time goal? |
| [ ] Yes – Number of Minutes:       | [ ]  No – Barriers (select all that apply)[ ]  Time[ ]  Motivation[ ]  Competing Priorities |
| 23. Were additional Social Services & Support Referrals offered? [ ]  Yes – Specify:       [ ]  No |
| Summary of Session Notes *(education tools provided and next session date/time)*      |
| **Note:** Unsuccessful attempt(s) should be recorded in the Med-IT Recall screen. Examples include, no answer, wrong number, number disconnected, and unable to talk. |