



Care Coordination Services

The Priority Care Center offers Care Coordination services to individuals needing extra support in meeting their health related goals. Services include:

- Designated team to assist you in meeting your goals
 - RN Care Manager
 - Transitionalist Nurse Practitioner
 - Mental Health provider
 - Diabetes Educator
 - Wellness Coach
 - Medical Assistant
- In depth intake process with the RN Care Manager to establish rapport, gather understanding of your health history, and begin setting patient centered goals
- One on one coaching appointments at the Priority Care Center or in your home
- Accompaniment – we can accompany you to your doctor's visits
- Working with your doctor to coordinate care you may need
- Identifying opportunities for additional services the you may need, such as home health care, caregiver support, or community services
- Visiting you in the hospital if you have an in-patient stay
 - Assisting in the discharge planning to ensure you have everything necessary to go home after a hospital admission
- Follow up after any Emergency Room visit
- Health related education
- Answering general health care questions
- Assisting with Shared Decision Making
- Advance Directives and End of Life planning
- Arranging same day appointments with PCP as needed
- Access to a Mental Health provider, Wellness Coach, Personal Trainer or Diabetes Health Educator if appropriate

Once enrolled, we require meeting with you in person. You will be assigned a Nurse Care Manager and you will have a chance to share any goals, concerns, or health issues. Your care team will then contact you, at a minimum of once a month, to check in.

2316 Harrison Ave. Eureka, CA 95501

707.442.0478



Please complete and return this form in the supplied envelope

Participation Agreement

Thank you for choosing to be a part of the care coordination program at The Priority Care Center. Once enrolled,

- You will be assigned a Nurse Care Coordinator who will meet with you for the initial visit in person. At that meeting you will have a chance to share any goals, concerns, or health issues
- Your care team will then contact you a minimum of monthly to check in
- You will be able to access your Care team at the Priority Care Center directly anytime Monday-Friday from 8:30 am – 5:00 pm and after hours and on weekends.

The Priority Care Center team will follow all HIPAA rules of Confidentiality, meaning your personal and medical information will only be shared with the Priority Care Center team and the Doctors and health care providers who are directly involved in your care. If there is a need to share your information with someone else, we would require prior written consent from you, however we are required to report to emergency personnel if you are at risk of harming yourself or others. As part of delivering you the most complete level of care, The Priority Care Center team will have access to past and current medical information from both your Doctor and Insurance Claims. Anonymous data will be used for program evaluation.

You have the right to discontinue your enrollment with care coordination program at The Priority Care Center at any time. Your Care Coordinator also has the right to end your enrollment in with Priority Care for any reason.

Thank you for agreeing to participate in this very exciting service.

Patient Name (Print) _____
Date of Birth

Address

Phone # _____
email address

Best Time to Call _____
Name of Doctor

Patient Signature or Parent/legal guardian signature (if patient is younger than 18) _____
Date



Section 1—Demographic Information

Primary Care Physician:		How were you referred:	
Name (Last, First, M.I.):			A.K.A.:
Date of Birth: / /	Age:	Gender: Male Female Transgender Other	
Mailing Address:			
City:	State:	Zip Code:	
Home Phone: ()	Work Phone: ()	Cell Phone: ()	
E-mail Address:		Do we have permission to contact you via e-mail? Yes No	
Primary Spoken Language: English Spanish Portuguese Other:	To which racial or ethnic group(s) do you <i>most</i> identify: African-American (non-Hispanic) Asian/Pacific Islanders Caucasian (non-Hispanic) Latino or Hispanic Native American or Aleut Other:		
Marital Status: Single Partnered Married Separated Divorced Widowed		Full name of spouse or significant other:	
Employer Name:	Employer Address:	Occupation:	
Employment Status (choose all that apply): Full-time Part-time Self-employed Not employed Retired Active Military	Driver's License Number:		

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:	
Address:		
Home Phone: ()	Work Phone: ()	Cell Phone: ()

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:
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Group Number:	Group Name:
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Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
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Address:	Subscriber's SSN:
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Secondary Insurance:	Subscriber ID Number:
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Group Number:	Group Name:
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Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
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Address:	Subscriber's SSN:
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Other Insurance:	Subscriber ID Number:
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Complete the following questions if the subscriber is someone other than yourself, the patient.

Group Number:	Group Name:
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Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
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Address:	Subscriber's SSN:
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Section 4—Consents

I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

I give consent to for The Priority Care Center to obtain my prescription history.

Signature _____ Date _____/_____/_____



The Priority Care Center

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Name _____ DOB _____

Name: _____ DOB: _____ Gender: M F

Primary Care Provider: _____

Preferred Pharmacy: _____ Location: _____

CURRENT MEDICATIONS/SUPPLEMENTS (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

Name of Medication	Strength of Medication	Dosing Instructions
<i>Example: Tylenol</i>	<i>Example: 500 mg</i>	<i>Example: 1 pill three times a day</i>

Past Medical History (Check all that apply)

<input type="checkbox"/> Acid Reflux/GERD	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> ADHD	<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema/Bronchitis/COPD	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Glaucoma/Cataracts	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer		

Allergies

<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Medication Allergies	<input type="checkbox"/> Environmental/ Seasonal Allergies	<input type="checkbox"/> Latex Allergy
List Allergies		Reaction	



Name _____ DOB _____

Past Surgical History

<u>Date of Surgery</u>	<u>Type of Surgery</u>

Family Medical History

<u>Members</u>	<u>Status</u> (Alive/Deceased)	<u>Diabetes</u>	<u>High blood pressure</u>	<u>Heart Disease</u>	<u>Mental Illness</u>	<u>Cancer (Type)</u>	<u>High cholesterol</u>	<u>Unknown</u>
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings Children								

Social History

Tobacco Use: Current use: Yes No

Past Use: Yes No When did you quit? _____

Type: Cigarettes Cigars Chew E-cigarette

Recreational Drug Use: Yes No

Type: Marijuana Cocaine Heroin Methamphetamine Other _____

Alcohol Use: Daily 4-5 times per week 1-3 times per week less than one time per week none

Type: Beer Wine Liquor

Marital Status: Married Separated Divorced Domestic Partnership Single Widow/Widower

Living Situation: Own Rent Homeless Other _____

Children: Yes No if yes, do they live with you Yes No

Support Network: Spouse/Significant other Family Friends Counselor Other _____

Diet/Exercise: Are you on a special diet? Yes No if yes, what type _____

Do you Exercise? Yes No If yes, how often Daily 3-5 days per week

1-2 days per week less than once per week

What type _____



Name _____ DOB _____

Do you have an Advance Directive in place?

Living Will Durable Power of Attorney Advanced Directive POLST None

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients			
Last Tetanus Booster	<input type="checkbox"/> Within past 10 years	<input type="checkbox"/> More than 10 years ago	<input type="checkbox"/> Unknown
Last Eye Exam (Dilated or Retinal)	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Hearing Exam	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Dental Exam	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Foot Exam	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last colonoscopy/ sigmoidoscopy/Or stool test	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last DEXA Bone Scan	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Pneumonia Vaccine	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Flu shot this season?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Women Only			
Last Pap Smear	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown
Last Mammogram	Date: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Unknown

Concerns

Please indicate any concerns regarding your health in the space provided

NAME: _____

Date: _____

PHQ-9	<i>Over the last 2 weeks how often have you been bothered by any of the following problems?</i>	<i>not at all</i>	<i>several days</i>	<i>more than half the days</i>	<i>nearly every day</i>
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<i>PHQ-9 total score =</i>					

Would you like someone from our office to contact you before your appointment regarding any of the above?

___ Yes ___ No

Are you currently undergoing any treatment for depression?

Medications: _____

Counselor: _____

Other: _____

Client Name: _____ DOB: _____ Date obtained: _____

(PROMIS) Patient Reported Outcomes Measurement Information System is a system of highly reliable, precise measures of patient-reported health status for physical, mental, and social well-being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

Global Health Assessment

Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).

Questions	Excellent (5)	Very Good (4)	Good (3)	Fair (2)	Poor (1)
Global 01: In General, would you say your health is					
Global 02: In general, would you say your quality of life is					
Global 03: In general, how would you rate your physical health?					
Global 04: In general, how would you rate your mental health, including your mood and your ability to think?					
Global 05: In general, how would you rate your satisfaction with your social activities and relationships?					
Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.					
	Completely	Mostly	Moderately	A little	Not at all
Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					
	Never	Rarely	Sometimes	Often	Always
Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					
	None	Mild	Moderate	Severe	Very Severe
Global 08: How would you rate your fatigue on Average?					
Global 07: How would you rate your pain on average?	<input type="checkbox"/> 0	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 2 3	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 4 5 6	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 7 8 9	<input type="checkbox"/> 10
To be completed by staff: Total Score (G03, 06, 07, 08)					_____
Total Score (G02, 04, 05, 10)					_____