Clear form Print

PUBLIC HEALTH DIVISION
HIV Community Services Program

Oregon Health Authority

Care Coordination Triage

Client name: _____ Date: / /

If you received this in the mail, please complete the following questions and return in the enclosed envelope. This will help us address the needs you have at this time.	The Care Coordinator will follow-up on any "Yes" or "Unsure" checked boxes in this column
1. Have you had any problems or delays in getting medication?	☐ No ☐ Yes
2. In the last six months, did you miss any of your last scheduled medical appointments?	☐ No ☐ Yes
3. Do you have any concerns about your housing?	☐ No ☐ Yes
4. Have you been unable to pay for your rent, utilities, transportation or food?	☐ No ☐ Yes
Within the past 12 months: 5. Were you worried whether your food would run out before you got money to buy more? ☐ Often ☐ Sometimes ☐ Never 6. The food you bought just didn't last and you didn't have money to get more? ☐ Often ☐ Sometimes ☐ Never	# 5 or # 6 answered "Often" or "Sometimes"? ☐ No ☐ Yes
7. Are you receiving SNAP benefits? ☐ No ☐ Yes	If "No", qualifies for SNAP? ☐ No ☐ Yes ☐ Unsure
8. Are you uninsured?	☐ No ☐ Yes
9. Do you have unpaid medical bills within the last 12 months that are not in collection?	☐ No ☐ Yes
10. If you use/chew tobacco or smoke cigarettes, would you like to quit?	☐ No ☐ Yes ☐ N/A
11. Would you like assistance in going back to work or volunteering?	☐ No ☐ Yes
During the past two weeks: 12. Have you had little interest or pleasure in doing things? ☐ No ☐ Yes 13. Have you felt down, depressed or hopeless? ☐ No ☐ Yes 14. If yes to #12 or #13 above, are you regularly seeing a mental health professional? ☐ No ☐ Yes ☐ N/A	
15. If you are not regularly seeing a mental health professional, do you want a referral or help connecting with your mental health professional?	☐ No ☐ Yes ☐ N/A
16. If you are regularly seeing a mental health professional, have you missed any mental health appointments in the last month?	☐ No ☐ Yes ☐ N/A
17. In the past year: **Male/male-identified** – How many times in the past year have you had 5 or more alcohol drinks in a day? **Female/female-identified** – How many times in the past year have you had 4 or more alcohol drinks in a day?	☐ None ☐ 1 or more

18. In the past year, have you used a recreational drug other than marijuana or used a prescription medication for non-medical reasons? ☐ No ☐ Yes 19. If yes to #18 above, are you regularly seeing a substance abuse professional? ☐ No ☐ Yes ☐ N/A	
20. If you are not regularly seeing a substance abuse professional, do you want a referral or help connecting with your substance abuse professional?	☐ No ☐ Yes ☐ N/A
21. If you are regularly seeing a substance abuse professional, have you missed any substance abuse treatment appointments in the last month?	☐ No ☐ Yes ☐ N/A
22. Have you had unprotected sex in the past 6 months?	☐ No ☐ Yes
23. Have you shared needles in the past 6 months?	☐ No ☐ Yes
24. Would you like to be notified about health education classes when they become available in your area?	☐ No ☐ Yes—we will contact you if class is available
25. Would you like to speak to the care coordinator for any other reason?	☐ No ☐ Yes

Comments:

List all of the ways you can be reached for follow-up on "yes" responses above *(include new contact information)*:

☐ Phone: ☐ Mail:

☐ Email:

If you are unable to be contacted by the sources listed above and/or if you do not wish to receive mail, when will you check in with your Care Coordinator regarding the "yes" responses?

Office use only: If "yes" has been answered please refer to CC, indicate below the steps taken:

☐ Referred to CC by phone, date:	_____	Initials: _____
☐ Referred to CC by e-mail, date:	_____	Initials: _____
☐ Referred to CC in person, date:	_____	Initials: _____
☐ CC confirms contact with client, date:	_____	Initials: _____

Client name _____