Client Identification

Program # __ __ __

ID # __ __ __ __ __ __ __ __ __

Enrollment Date _____/_____/_____
(mm / dd / yyyy)

Last Name _____

First Name _____

Middle Initial _____

Patient Navigation Contacts

Patient Navigation Contact #1: Date _____/_____/_____
(mm / dd / yyyy)

Patient Navigation Contact #2: Date _____/_____/_____
(mm / dd / yyyy)

Status of Navigation

○ Refused after Contact #1

○ Lost to Follow-up

Comments:

Barriers Assessment

Which barriers would keep you from healthcare screenings? *(check all that apply)*

○ 1. Don't have a provider *

○ 2. Travel to the appointment

○ 3. Remembering the appointment date

○ 4. Paying for the service *

○ 5. Understanding the provider's directions

○ 6. Fear

○ 7. Need an interpreter

○ 8. Need a referral to specialist *

○ 9. No insurance *

○ 10. Work hours

○ 11. Need child or family member care

○ 12. Disability (physical or mental)

○ 13. Pain/discomfort (real or perceived)

○ 14. Beliefs/cultural practices

○ 15. Lack of emotional support

○ 16. Other _____

○ 17. None at this time

* No Action Plan required

Program Staff Initials: _____