Health Screening Form
Project Homeless Connect Omaha (March 29, 2019)

Guest's First Name: _____ **Last Name**: _____ **Age**: _____ **DOB**: _____ **Intake #**: _____

GUEST CONSENT FOR HEALTH SCREENING SERVICES

By signing below, I consent to be examined by the health care providers of the Project Homeless Connect Omaha Event. I further consent to the optical exam, immunizations, and additional screenings. I know that I will receive screening examinations only, a basic picture of my overall health. Based on the results of my examinations today, I may need to seek further health care. I agree to seek further care if the health care providers tell me I need to do so. This information will be shared for follow-up appointment purposes only. Creighton University will gather the information used on this form and will treat it as confidential. No information identifying me will be shared by Creighton University with any State or Federal Government agencies.

Guest's Signature:

Vitals Screening

BP:	HR:	HT:	WT:	Diabetic: Y ☐ N ☐ Previous A1c #: _____ Date: _____ Unknown ☐ Today's blood sugar/A1c: _____ Referral/Education provided: Y ☐ N ☐

Gender you identify with: Male ☐ Female ☐ Other ☐: _____ Veteran: Y ☐ N ☐
Insurance: (Medicare, Medicaid: UnitedHealthcare/WellCare/Nebraska Total Care) Y ☐: _____ N ☐
Have you visited an emergency department in the past two years: 4 visits or more ☐ less than 4 visits ☐
Have you used EMS/ambulance services in the past two years: 4 visits or more ☐ less than 4 visits ☐

Medication Recall Screening

Allergies: Y ☐: _____ N ☐ Type of reaction(s): _____

No medications ☐ If meds are prescribed, but not taken, explain: Transportation ☐ Cost ☐ Need Refill ☐ Other ☐: _____

Medication Name	Dose	Unit	How and when is it taken?	Purpose	Currently taking as prescribed? (Y/N)

Medication Recall Notes:

Musculoskeletal/Neuromuscular Screening

WDL ☐ **WDLX** ☐ (see form)

Podiatrist Screening

WDL ☐ **WDLX** ☐

Recommendations: _____

Immunizations

Influenza: ☐ _____ Other: ☐ _____ Other: ☐ _____ Recommendations: _____

Vision Screening

Reading Glasses
Screened: Y ☐ N ☐ Reading glasses given: Y ☐ N ☐

Prescription Glasses
Screened: Y ☐ N ☐ Voucher given: Y ☐ N ☐

Additional Screenings/Services

Sexual Practices Counseling: ☐	STI testing completed: ☐ Referral: ☐	Hep C testing completed: ☐ Referral: ☐

NE AIDS Project Counseling: ☐ Testing completed: ☐ _____

Lice screening completed: Y ☐ N ☐ Lice treatment provided: Y ☐ N ☐ Haircut (Xenon Academy): ☐

Chief Complaint/Current Health Concern: _____

Medical & Mental Health Screening

Quick review of systems: **WDL** ☐ **WDLX** ☐

Focused Screening

O – WDL; ✓ = WDLX			Notes & Impressions
HEAD/ EYES			
ENT			
NECK			
RESP			
CARDIO/ VASC		☐Smoking ☐ Over 50 years old ☐ Diabetes (check front of form) Refer to ☐ PHCO Radiologist	
CHEST/ BREAST			
SKIN/ ENDO			
NEURO			
OTHER			

Is anyone hurting you: Y ☐ N ☐ Are you being held against your will? Y ☐ N ☐
Referral made: ☐

Currently receiving behavioral or mental health services? Y ☐ N ☐
If yes, describe: _____

Was the Multi-Assessment Tool completed? N ☐ Y ☐ Score:

Patient Health Questionnaire (PHQ-2) completed: Y ☐ N ☐ Score:

Medical Recommendations

MD/NP Student Recommendations: _____
_____

Medical appointment follow-up ☐ Smoking cessation ☐ STI test ☐ X-ray ☐ Medication ☐ Diabetes Edu ☐
No follow-up needed ☐
MD/NP Student Signature: _____
Faculty/Resident Recommendations (additional): _____
Licensed Provider Signature: _____ Date: 3/29/2019

Behavioral Health Summary & Recommendations

WDL ☐ **WDLX** ☐

Recommendations: _____
Referral made to:
Charles Drew Health Center ☐ Community Alliance ☐ Douglas County ☐ Magis Psychiatry Clinic ☐ OneWorld ☐
Other ☐: _____

Radiologist Recommendations (Abdominal Aortic Aneurysm Screening and Ankle-Brachial Index [ABI] Test)

ABI: ☐ Normal ☐ Suggested Peripheral Disease ☐ Critical Ischemia Follow-up: _____

Aneurysm Screening: ☐ NA ☐ Large Symptomatic referral to Emergency Department
☐ Large Asymptomatic >5.5 *follow up with:* _____
Appointment Date: _____ ***Time:*** _____
☐ Small < 5 Referral to follow up with CDHC or PCP
Faculty/Resident Recommendations: _____
Licensed Provider Signature: _____ Date: 3/29/2019

Guest Medical Appointment Plan

Charles Drew Health Center Homeless Clinic appointment made ☐ Magis Acute Care Clinic appointment made ☐
Veteran: Guest referred to Pod A in the Social Services area to make appointment ☐
All Care Health Center: Guest referred to Pod B in Social Services area to make appointment ☐
Guest will schedule own appointment ☐ Other: ☐ _____