Walking Miracles Family Foundation: Patient Navigation Intake Form

Basic Information:

Name: _____ _____Date of Birth:~~DB~~:

_____

Address: _____

_____

West Virginia (WV)~~V~~ County:

_____

Diagnosis: ___Please list you/your child's first diagnosis, all relapses and all subsequent cancers _____

Currently receiving treatment? Yes No (circle one)

Date of diagnosis for each bout with cancer (initial, relapse, and/or subsequent malignancies)

Date of last treatment for each diagnosis

Date of last clinic visit

~~or in survivorship: _____~~

Treating Facility for each diagnosis~~g Facility:~~

_____ _____

Treating Physician for each diagnosis~~:~~ _____

If in survivorship, do you follow with a survivorship clinic Yes No (circle ~~:~~ one)~~—~~ _____

Survivorship clinic

~~and~~ physician/provider ~~name~~:_____

Insurance Provider: _____

Parents' Names: __If under 18, or if parents are responsible for treatment: _____

Parents' Occupation If under 18

Your occupation if over 18~~:~~

_____

Siblings and ~~any~~ other h~~H~~ousehold m~~M~~embers:

_____

_____

How were you/your child ~~as this patient~~ referred to our navigation services? Please answer all that apply

By your/your child's current physician

name~~Physician Name:~~ ____(if any)_____

Current hospital name~~Hospital Name:~~ _(if any)_____

By your/your child's current n~~N~~urse

Name and department (if any)~~:~~ _____

Social worker Name (if any)~~:~~ —_____

Self-referral: _____ Other- Please explain: _____

POTENTIAL PROBLEMS/BARRIERS TO CARE

This list is used to ~~help us to~~ identify your/your child's ~~-~~concerns. ~~at the initial visit and at each follow-up visit.~~ It will help develop a plan of action, including referrals to appropriate services or facilities~~departments. to assist you.~~

Please mark all that apply~~Please check the circle by any concerns you may have and answer any questions asked.~~

Health Insurance/Financial Concerns

◯ Inadequate or lack of insurance coverage

◯ Pre certification problems

◯ Difficulty paying bills

◯ Need for financial assistance from Medicaid/Medicare

◯ Confusing financial paperwork

◯Need for prescription assistance

◯Need for medical equipment or supplies (wheelchairs, dressings)

◯Citizenship problems/undocumented status

◯Loss of employment

◯Difficulty getting time off/FMLA concerns

◯Other: _____

Do you/your child currently receive any assistance such as food stamps, HUD, etc? Yes No (circle one)_____

If not ~~have you tried for this assistance~~, are you interested in applying? Yes No (circle one)~~—~~ _____

Transportation To and From Treatment :

Please mark all that apply

◯Public transportation ~~needed~~

◯Private transportation ~~needed~~

How far do you drive to get to your/your child's ~~-~~treating facility:

_____

How often do you have to travel to your/your child's ~~-~~treating facility:

_____

On your way to the ~~your~~ treating facility do you pay tolls? __Yes No (circle one)_____

If so, how much do you pay: _____

◯Other: _____

Physical/Educational Needs Please mark all that apply

◯Child/elder care

◯Housing/housing problems

◯Food, clothing, other physical needs

◯Prostheses, wigs, etc.

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◯ Vocational support (job skills, employment skills)

◯ Extended care needs: home care, hospice, long-term care

◯ School concerns

Patient's ~~-~~grade and school:

_____

Any issues in school: _____

_____

Does your child ~~they~~ have an IEP or 504 plan? If yes, ~~and if so~~ please upload or mail a copy~~what does it include:~~ _____

_____

Have

~~Did~~ you/your child ~~patient~~ had ~~ve~~ cognitive testing ~~prior to treatment~~ Yes No (circle one). ~~-~~If yes, please upload or mail a copy of the results~~and if so what were the results:~~ _____

_____

If not, are you interested in testing~~.~~? Yes No (circle one). If yes, have you discussed with your/your child's

physician~~–~~? _____

Are you concerned about re-entry into school: _____

◯ Other: _____

Communication/Cultural Needs

◯ Primary language other than English? If yes, what is your/your child's native language?~~-~~

◯ Inability to read/write

◯ Poor health literacy (problems understanding information)

◯ Cultural barriers (i.e., effect on lifestyle choices)

◯ Other: _____

Disease and Psychosocial Management

◯ Request ~~Needs~~ help with obtaining a second opinion (if desired by you ~~patient~~) . If yes, have you/your child discussed this with the treating physician?

◯ Request Mental health services ~~needed~~

Are you/your child ~~Is patient~~ in counseling? Yes No (please circle one). If yes, what is the concern?~~g and if so why:~~ _____

_____

_____

Are parents, siblings or other household members in counseling: Yes. No (please circle one). If yes, what are the concerns? _____

_____

If not, are you/ ~~or~~ your family interested in counseling: Yes. No. (please circle one). If yes, what are you/your child's concerns? _____

~~( ) Does not understand treatment plan, lab results and/or procedures~~

~~( ) Unsure of treatment options~~

~~( ) Inadequate access to lab/tests/imaging results~~

~~( ) Needs to talk to provider (physician, nurse, therapist, etc.)~~

~~( ) Wants more information about:~~ _____

~~( ) Other~~ _____

Our Travel Assistance/Tablet Program

Have you received the ~~your~~ travel card: Yes. No (circle one) _____

If so, what did you use it for based on percentages to equal 100%

Travel _____%

Food _____%

Lodging _____%

Have you received your tablet? Yes or no (please circle one) Apple or Android: _____

Have you received tablet training: Yes or no (please circle one) _____

If you have not received your tablet do you prefer Apple or Android: _____

Information Required:

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The following items are requested by FAX, email, regular mail, or by upload into the tablet provided by Walking Miracles Family Foundation

Copy of HIPAA consent

Protocol calendar or "roadmap" and summary of the treatment plan (this is sometimes called "Schema") for each diagnosis (that is, for the first occurrence of cancer and all relapses or subsequent cancers).

****Please be aware that this information will be required to develop a treatment summary and to schedule an appointment for education.

IEP if applicable

Results of cognitive testing if applicable