Member First Name: Last Name:

Relationship to Member: Self Parent Guardian Friend Lawyer Provider Other

Does this person have permission to answer questions for the member? Yes No

How are you submitting this form: Website Nursewise Provider Mail Fax Health Plan Staff

If we would need to return a call to you, what is the best time and telephone number to reach you?

Morning Afternoon Evening Telephone number: — —

Primary Language if other than English:

1. Do you know who your Primary Care Doctor (PCP) is? Yes No

PCP's Name:

PCP's Phone Number: — —

When did you last see your PCP? Less than 3 months ago More than 3 months ago Never

Do you have an appointment scheduled with your Primary Care Doctor (PCP)? Yes No

If Yes, when? (mmddyyyy):

2. If you are taking any medications do you have any questions about how to take them the way your doctor prescribed?

Yes No

3. Do you have transportation to your doctor appointments? Yes No

4. Are you aware of what an Urgent Care Center is? Yes No

5. Do you know where the Urgent Care Centers in your area are? Yes No

6. Have you been to the Emergency Room (ER) more than once in the last six months? Yes No

7. Are you currently pregnant? Yes No IF YES, PLEASE COMPLETE A PREGNANCY FORM. THE FORM IS ON OUR WEBSITE AND INCLUDED IN YOUR MEMBER WELCOME PACKET.

8. Do you currently have any of the following conditions? (check all that apply)

- Anxiety
- Alcohol or Substance Abuse
- Asthma
- Autism
- Mental Illness: Schizophrenia, Bipolar Disorder, Post Traumatic Stress Disorder, Major Depression, Substance Abuse
- Cancer
- Chronic Pain
- Congestive Heart Failure
- Developmental Disorder
- Diabetes
- Elevated Blood Lead Level
- Hepatitis C
- HIV/AIDS
- Organ Failure such as End Stage Renal Disease or Liver Failure
- Sickle Cell
- Tobacco Use
- COPD
- Transplant (On waiting list, scheduled, or received within the last 12 months)
- Other Medical Condition(s) Please specify.

9. Do you have any special needs (such as hearing, vision or mobility problems)? Yes No

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