MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SHOW ME HEALTHY WOMEN (SMHW)
CLIENT / PATIENT NAVIGATION

P.O. Box 570
Jefferson City, MO 65102-0570
(573) 522-2845

ENROLLMENT SITE / SATELLITE (NAME AND ADDRESS)	NAVIGATOR NAME / DATE

A. PERSONAL DATA

NAME (LAST, FIRST, MIDDLE INITIAL)	PARTICIPANT ID	ID TYPE (CHOOSE ONE)
		Choose an item.

DATE OF BIRTH (MM/DD/YYYY)	CLIENT REFUSES NAVIGATION SERVICES	CLIENT (CHOOSE ONE)
	☐ Yes ☐ No	☐ Moved away ☐ Deceased ☐ Unable to locate ☐ Lost to follow-up

B. CLIENT ASSESSMENT

ASSESSMENT CONTACT TYPE (CHOOSE ONE)	DATE OF CONTACT (MM/DD/YYYY)	CONTACT METHODS (CHOOSE ONE)	LENGTH OF VISIT (CHOOSE ONE)	DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)
Choose an item.		Choose an item.	Choose an item.	
Choose an item.		Choose an item.	Choose an item.	
Choose an item.		Choose an item.	Choose an item.	
Choose an item.		Choose an item.	Choose an item.	

TYPE OF NAVIGATION COMPLETED (CHOOSE ONE)	SERVICES NEEDED (CHOOSE ONE)
Choose an item.	Choose an item.

BARRIERS

SYSTEM BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Healthcare provider is >50 miles
- ☐ No healthcare provider
- ☐ Transportation schedule is inconvenient
- ☐ Housing issue / homeless
- ☐ No phone / invalid phone number
- ☐ Unable to schedule an appointment
- ☐ Lacks capacity to enroll in a health insurance plan
- ☐ Provider unable to bill insurance
- ☐ Unable to take off work
- ☐ Other _____

FINANCIAL BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Has dependents / is a caregiver
- ☐ No health Insurance plan
- ☐ Insurance has high deductible
- ☐ Underinsured
- ☐ Lack of / cannot afford transportation
- ☐ Other _____

PSYCHOSOCIAL BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Cultural / faith-based concerns
- ☐ Education required on lifestyle changes
- ☐ Education required on screening / diagnostics
- ☐ Fear / denial
- ☐ Education level
- ☐ Education required on refusing services / care / treatment
- ☐ Education required on self-care vs. medical care
- ☐ Has concerns about health
- ☐ Education required on cancer
- ☐ Other _____

COMMUNICATION BARRIERS (CHOOSE ALL THAT APPLY)

- ☐ Confused / overwhelmed
- ☐ Needs interpreter
- ☐ Other _____
- ☐ Cultural concerns
- ☐ Unable to read
- ☐ Does not understand (health literacy)

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ACTION PLAN

COUNSELING / COMMUNICATION / EDUCATION (CHOOSE ALL THAT APPLY)

- ☐ Advocated on client's behalf (specify) _____
- ☐ Counseled regarding (specify) _____
- ☐ Discussed client concerns
- ☐ Discussed diagnostic plan options
- ☐ Discussed options of available services
- ☐ Discussed treatment plan options
- ☐ Educated client on available resources
- ☐ Educated client with "teach-back" method on (specify) _____
- ☐ Notified Regional Program Coordinator (RPC) for assistance
- ☐ Provided interpreter services (specify language) _____
- ☐ Provided culturally appropriate brochure / information
- ☐ Provided educational level appropriate brochure / information
- ☐ Provided literacy level appropriate brochure / information
- ☐ Other _____

REFERRALS / APPOINTMENTS (CHOOSE ALL THAT APPLY)

- ☐ Referred to SMHW Provider (specify) _____
- ☐ Referred to breast and/or cervical care provider (specify) _____
- ☐ Referred to other health care services (specify) _____
- ☐ Referred to Breast and Cervical Cancer Treatment (BCCT) Program
- ☐ Referred to transportation resources
- ☐ Scheduled appointment for screening services
- ☐ Scheduled appointment for diagnostic services
- ☐ Scheduled appointment for transportation services
- ☐ Referred to legal services
- ☐ Referred to local agency for assistance (specify) _____
- ☐ Other _____

SERVICES ENROLLMENT (CHOOSE ALL THAT APPLY)

- ☐ Enrolled for Navigation Only Services
- ☐ Enrolled in SMHW Program
- ☐ Facilitated enrollment in BCCT Program
- ☐ Facilitated enrollment in health insurance plan
- ☐ Facilitated enrollment in Medicare / Medicaid
- ☐ Other _____

C. CLIENT MANAGEMENT

DATE NEXT NAVIGATION VISIT OR CALL PLANNED (MM/DD/YYYY)

CLIENT NOTIFIED OF ABNORMAL RESULTS (CHOOSE ONE)	CLIENT TRACKING METHOD (CHOOSE ONE)
Choose an item.	Choose an item.
DATE NAVIGATION / MANAGEMENT TERMINATED (MM/DD/YYYY)	REASON FOR TERMINATION (CHOOSE ONE)
	Choose an item.

D. COMMENTS

BARRIERS / ACTION PLAN / MANAGEMENT / NAVIGATION NOTES

E. FINAL OUTCOMES

FINAL OUTCOMES (CHOOSE ALL THAT APPLY)

- ☐ Diagnostic work-up planned
- ☐ Diagnostic work-up completed
- ☐ Enrolled in BCCT Program
- ☐ Enrolled in a health insurance plan
- ☐ Enrolled in Medicare / Medicaid
- ☐ Improved client adherence
- ☐ Improved client satisfaction
- ☐ Improved timeliness of care
- ☐ Provided case management
- ☐ Received a treatment plan
- ☐ Reduced care fragmentation
- ☐ Screening completed – breast
- ☐ Screening completed – cervical
- ☐ Treatment initiated – cancer
- ☐ Treatment completed – released by MD
- ☐ Other _____

DATE NAVIGATION COMPLETED (MM/DD/YYYY)	

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