



Universal Screening Form

Date: ___ / ___ /20__

Staff: _____

Participating Partners: (Please check your site)

<input type="checkbox"/> Jesse Tree	<input type="checkbox"/> UTMB CCP	<input type="checkbox"/> UTMB ER	<input type="checkbox"/> UTMB FM	<input type="checkbox"/> GCHD	<input type="checkbox"/> 4 C's Island
<input type="checkbox"/> 4 C's Mainland	<input type="checkbox"/> SVH	<input type="checkbox"/> GCSS	<input type="checkbox"/> ADA	<input type="checkbox"/> Other (specify in next box)	

Demographics: (Please fill in as much as possible)

First Name:		Address:		County: (check one)	Telephones: ###-###-####
MI:		Apt#:		Galveston <input type="checkbox"/>	Home:
Last Name:		City:		Brazoria <input type="checkbox"/>	Cell:
DOB:		State:		Harris <input type="checkbox"/>	Work:
ID:		Zip			Alt:

What is your PRIMARY reason(s) for today's visit? (Check all that apply)

<input type="checkbox"/> Hospitality / Breakfast	<input type="checkbox"/> Food	<input type="checkbox"/> Non Medical Assistance	<input type="checkbox"/> Medical Assistance	<input type="checkbox"/> Information	<input type="checkbox"/> Shelter
<input type="checkbox"/> Prescription	<input type="checkbox"/> Social Services	<input type="checkbox"/> Ministerial Assistance	<input type="checkbox"/> Education / Class	<input type="checkbox"/> Follow up	<input type="checkbox"/> Other (specify) _____

What is your PRIMARY means of transportation?

<input type="checkbox"/> Walking	<input type="checkbox"/> Bike	<input type="checkbox"/> Bus	<input type="checkbox"/> Drive a car	<input type="checkbox"/> Get car rides	<input type="checkbox"/> Other (specify) _____
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Have you ever been told that you have? (Check all that apply)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Disability	<input type="checkbox"/> TB
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Other Cancer	<input type="checkbox"/> Substance Abuse / Addiction	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Lead Poison
<input type="checkbox"/> COPD	<input type="checkbox"/> Co-Dependency	<input type="checkbox"/> STD (Sexually Transmitted Disease)	<input type="checkbox"/> Smoking Tobacco Use	<input type="checkbox"/> No Health Problems	<input type="checkbox"/> Other (Specify below) _____

Have you or a member of your family ever been enrolled in any of the following? (Check all that apply)

<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> CHIP	<input type="checkbox"/> QMB	<input type="checkbox"/> HMO
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> AFDC	<input type="checkbox"/> Galveston Co. Indigent Program	<input type="checkbox"/> Insurance	<input type="checkbox"/> None of these



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Client: _____

When you are ill or injured, where do you seek help?

<input type="checkbox"/> 4C's Island	<input type="checkbox"/> 4C's Mainland	<input type="checkbox"/> UTMB Clinics	<input type="checkbox"/> St. Vincent's House	<input type="checkbox"/> Point of Light
<input type="checkbox"/> Luke Society	<input type="checkbox"/> ER-UTMB	<input type="checkbox"/> ER-Mainland Hospital	<input type="checkbox"/> UTMB Brazoria	<input type="checkbox"/> VA
<input type="checkbox"/> Mainland Medical Center Clinic	<input type="checkbox"/> None	<input type="checkbox"/> Other (specify below): _____		

Eligibility (check all that apply):

<input type="checkbox"/> I have a Jesse Tree Adherence Plan.	<input type="checkbox"/> I or a family member is currently using prescription medication.
<input type="checkbox"/> My household income is less than \$40,000 a year.	<input type="checkbox"/> I filed an income tax claim last year.
<input type="checkbox"/> I or a family Member is unemployed.	<input type="checkbox"/> I am a registered voter.
<input type="checkbox"/> I am homeless or doubled up with friends or family.	<input type="checkbox"/> I am raising a grandchild.
<input type="checkbox"/> I own my property.	<input type="checkbox"/> I rent.
<input type="checkbox"/> I am a DHAP client.	<input type="checkbox"/> I am a HRPR client.

The following questions will help to make referrals in keeping with your personal beliefs. To what major religion group do you belong?

<input type="checkbox"/> Christian	<input type="checkbox"/> Jewish	<input type="checkbox"/> Protestant	<input type="checkbox"/> Roman Catholic	<input type="checkbox"/> Unitarian	<input type="checkbox"/> Non-Denominational Christian
<input type="checkbox"/> Mormon	<input type="checkbox"/> Buddhist	<input type="checkbox"/> Islamic	<input type="checkbox"/> Hindu	<input type="checkbox"/> None	<input type="checkbox"/> Other (Specify below) _____

The following question will help to determine if information on health-disparity issues might be of importance to you or your family. Please describe your race. (Check all that apply):

<input type="checkbox"/> Black, Non-Hispanic	<input type="checkbox"/> White, Non-Hispanic	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian	<input type="checkbox"/> Mideastern/Arabian
<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Native American	<input type="checkbox"/> Indian Sub-Continent	<input type="checkbox"/> Other (specify below) _____	