Patient Navigation Form

*Patient Navigators use this tool to document their work assisting each patient through the continuum of care. Keep in patient chart and update after each patient encounter. This form is a paper version of the **Check Hep B REDCap** database.*

Enrollment Information

*Check Hep B enrollment date: / /	*Check Hep B patient ID: *Unique number provided for this program*	Agency patient ID:
Patient last name:	Patient first name:	Date of birth: / /

Address: (# street, apt #, borough)	Zip code:	Phone 1:	Phone 2:	Permission to text: ☐Yes ☐No

Hispanic / Latino / Latina Ethnicity:
Do you identify as Hispanic, Latino, or Latina? Please select one.

- ☐ Yes, Hispanic, Latino, or Latina
- ☐ No, not Hispanic, Latino, or Latina
- ☐ Unknown
- ☐ Declined to answer

Race:
Which of the following races do you identify as? You may select all that apply.

- ☐ Asian, including South Asian
- ☐ Black, including African American or Afro-Caribbean
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ I do not identify as any of these races
- ☐ Unknown
- ☐ Declined to answer

Ethnicity or Cultural Group:
Which specific ethnic or cultural groups do you identify as, if any? You may select all that apply.

- ☐ Arab
- ☐ Chinese
- ☐ Dominican
- ☐ Guyanese
- ☐ Haitian
- ☐ Indian
- ☐ Italian
- ☐ Jamaican
- ☐ Jewish
- ☐ Mexican
- ☐ Puerto Rican
- ☐ Russian
- ☐ Another group or groups. Please specify: _____
- ☐ I do not identify as any specific ethnic or cultural group
- ☐ Unknown
- ☐ Declined to answer

Gender Identity:
How do you currently identify your gender? Please select the one that best describes you:

- ☐ Woman or girl
- ☐ Man or boy
- ☐ Transgender woman or Transgender girl
- ☐ Transgender man or Transgender boy
- ☐ Non-binary or genderqueer person
- ☐ A gender identity not listed here. Please specify: _____
- ☐ Unknown
- ☐ Declined to answer

Sex Assigned at Birth:
What sex were you assigned at birth? Please select one:

- ☐ Female
- ☐ Male
- ☐ A sex assignment not listed here. Please specify: _____
- ☐ Unknown
- ☐ Declined to answer

Sexual Orientation:
Which of the following best describes your sexual orientation? Please select the one that best describes you:

- ☐ Gay or lesbian
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Queer
- ☐ Questioning or not sure
- ☐ A sexual orientation not listed here. Please specify: _____
- ☐ Unknown
- ☐ Declined to answer

Country of birth:	English: ☐Speak ☐Read ☐Write ☐None	Preferred language:	Interpretation needed: ☐ Yes ☐ No

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Assessment: Self-Reported Hep B History	*Obtain the following information from the patient or patient chart.*	
Year of HBV diagnosis:	**Ever treated for HBV?** ☐ Yes ☐ No ☐ Unknown	**If YES, currently taking HBV meds?** ☐ Yes ☐ No
		☐ **Health Promotion "Hep B Basics" complete**

Patient Navigator Assessment *Determine patient needs and develop a "Care Plan"*		**Referrals Made**
How many children? _____ **Pregnant:** ☐ No ☐ Yes		**Pediatric care:** ☐ Yes ☐ No/not needed **Prenatal care:** ☐ Yes ☐ No/not needed
Any household, family or partners in need of notification? ☐ Yes ☐ No ☐ Declined **If YES:** how many contacts:		**HBV test/vaccine for contacts:** ☐ Yes ☐ No/not needed
Any mental health issues? ☐ Yes ☐ No ☐ Unknown		**Mental health services** ☐ Yes ☐ No/not needed
Any alcohol use in the past year? ☐ Yes ☐ No ☐ Declined to answer		**Alcohol treatment** ☐ Yes ☐ No/not needed
Injection drug use in the past year? ☐ Yes ☐ No ☐ Declined to answer **Intranasal drug use in the past year?** ☐ Yes ☐ No ☐ Declined to answer **Injection drug use ever?** ☐ Yes ☐ No ☐ Declined to answer **On methadone maintenance:** ☐ Yes ☐ No **On buprenorphine:** ☐ Yes ☐ No		**Naloxone provided date**: _____ **Substance use or harm reduction services** ☐ Yes ☐ No/not needed
Insurance: ☐ Medicaid ☐ Medicare ☐ NYS Essential Plan ☐ Health Exchange Plan (Metal plans) ☐ Private Insurance ☐ None ☐ Declined to answer **Temp insurance for pregnant women?** ☐ Yes ☐ No	**Name of insurance plan:**	**Insurance enrollment** ☐ Yes ☐ No/not needed ☐ Free or low-cost care
In the past year, have you had trouble paying for food, housing, medications, heating, or other basic need? ☐ Yes ☐ No		**Social services** *(such as: housing, financial, food, legal, transportation)* ☐ Yes ☐ No/not needed
Housing: ☐ Stable housing ☐ Unstable housing ☐ Homeless		
Has consistent transportation for appointments: ☐ Yes ☐ No		
Social support? ☐ None ☐ Family ☐ Friends ☐ Support group ☐ Program		**Hep B support group** ☐ Yes ☐ No/not needed
		☐ **Health Promotion "Getting Ready for Hep B Care" complete** ☐ **Care Plan developed and reviewed with patient**

Hepatitis B Medical Care	*Obtain the following information from the medical provider or patient chart.*
Provider name:	**Hospital/clinic**:
***First HBV medical visit date after enrollment:** / / *Use enrollment date if patient had medical visit before enrollment*	***Most recent HBV medical visit date:** *[Update in REDCap]*
Medical evaluation completion date:	**Co-morbidities:** ☐ None ☐ HIV ☐ Hep C ☐ Psych ☐ Other, specify:
	Stage of Liver Disease: ☐ No Cirrhosis ☐ Cirrhosis ☐ Not evaluated
Most recent liver cancer screening date: *[Update in REDCap]*	**Outcome:** ☐ Liver cancer ☐ No liver cancer

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Hepatitis B Treatment	
***Treatment candidate:** ☐ Yes ☐ No ☐ Information not available	**Rationale for treatment:** ☐ Cirrhosis ☐ Liver cancer ☐ Abnormal labs ☐ Other:
***Treatment start date:**	**If treatment delay, reason why:** ☐ Did not attend appointments ☐ Other:_____ ☐ Could not afford treatment ☐ Patient declined treatment, explain:
Adherence Support: ☐ 3 day after treatment start check-in completed	**Adherence check-in frequency during treatment**: ☐ Weekly ☐ Bi-Weekly ☐ Other:
***Treatment outcome:**	HBV DNA (viral) suppression ☐ Yes ☐ No ☐ Information not available Normalization of ALT ☐ Yes ☐ No ☐ Information not available
Treatment discontinuation date:	**If treatment discontinued, reason why:** ☐ Side effects/adverse event ☐ No viral response ☐ Patient stopped on own ☐ Insurance coverage/cost ☐ Other, explain:
☐ **Health Promotion "Getting Ready for Treatment" complete** ☐ **Treatment Planning Form reviewed with patient**	

Use the following criteria to determine if the patient should be discharged from the program.

Patient: ☐ Attended first routine HBV monitoring visit independently ☐ Is adherent to medications (if applicable)
☐ **Health Promotion "Staying Health with Hep B" complete**

Discharge if client completed the program or ended participation. This is used to determine if client is still active in program.

Discharge	***Discharge date:**
Reason: ☐ Completed program ☐ Deceased ☐ Declined program ☐ Incarcerated ☐ Lost to follow up ☐ Moved ☐ Program ended ☐ Referred to another program ☐ Spontaneously cleared HBV ☐ Other, explain:	
Case Tracking	***Most Recent Encounter Date:** *[Update in REDCap]*
	***Total # encounters with Patient Navigator:**