

Behavioral Health Medical Screening Form

People who are prescribed atypical antipsychotics are at increased risk of developing metabolic syndrome. Many individuals with schizophrenia, bipolar disorder and psychotic disorder are prescribed atypical antipsychotics to treat the serious symptoms of these disorders. Depression is also linked to higher risk of diabetes and cardiovascular disease. It's critical that these individuals have their weight, blood sugar, blood pressure and cholesterol routinely monitored by their doctor, along with education on healthy lifestyle choices.

Integrated health care management services are available with AmeriHealth Caritas Louisiana. You may contact a care manager at **1-888-643-0005**.

Provider Instructions:

Fax the completed form to Rapid Response at **1-855-345-2048** to follow up on any services and/or appointments to assist the member.

Behavioral health provider name:	Completing staff member name:	Date completed:
Member name:	Medicaid ID number:	Date of birth:
Primary care provider (PCP) name:		

1. Living situation	
Where do you currently live?	
<input type="checkbox"/> House/apartment <input type="checkbox"/> Assisted living	<input type="checkbox"/> Shelter <input type="checkbox"/> Homeless
Where do you currently live?	
<input type="checkbox"/> Alone <input type="checkbox"/> Roommate <input type="checkbox"/> Partner/spouse	<input type="checkbox"/> Adult family <input type="checkbox"/> Minor children <input type="checkbox"/> Supervised



2. Hospital/office visit history

In the past 12 months how many times have you:	Never	1 – 2	3 – 5	6 or more
Visited a doctor's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gone to the emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stayed overnight in a hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Cholesterol checked

Date of last test:
 If unknown, recommendation is to follow up with PCP.

4. Glucose levels checked

Date of last test:
 If unknown, recommendation is to follow up with PCP.

5. Vitals

Date taken:

Temp:	Pulse:	BP:	Height:	Weight:	BMI:	Waist:
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6. Social activity

How often do you do the following?	Never	Rarely	Sometimes	Frequently
Receive invitations to go out and do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk to someone about personal/family problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



7. Physical activity

How often do you do the following?	Never	Rarely	Sometimes	Frequently
Go to the gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk or run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Preventive test history

When was the last time you had:	Never	Less than 1 year	1 – 2 years	3 – 4 years	5+ years	Don't know
Colon cancer screen	<input type="checkbox"/>					
Flu vaccine	<input type="checkbox"/>					
Pneumonia vaccine	<input type="checkbox"/>					
Tetanus vaccine	<input type="checkbox"/>					
Dental exam	<input type="checkbox"/>					
Pap test	<input type="checkbox"/>					
Mammogram	<input type="checkbox"/>					

9. Chronic condition history

Do you have any of the following conditions:	Never	In the past	Currently diagnosed	Currently taking medication	Under medical care
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



9. Chronic condition history

High blood pressure	<input type="checkbox"/>				
Stroke	<input type="checkbox"/>				
HIV	<input type="checkbox"/>				
Hepatitis	<input type="checkbox"/>				
Considering your age, how would you rate your overall health?	Poor	Not good	Average	Good	Excellent
	<input type="checkbox"/>				

10. Wellness education
Please check the topics you would like additional information on

Topic	Yes	No	Uncertain
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Healthy cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical activity/exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recovery activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peer support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocation/prevocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:			