

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 individuals with any of these behavioral health conditions have their weight, blood sugar, blood pressure, and cholesterol routinely monitored by their doctor, and also receive 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 the Rapid Response and Outreach Team 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: | Date of birth: |
| Primary care provider 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 |
| Who do you live with? <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: |

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. Preventative test history

| When was the last time you've 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 | Currently 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"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Considering your age, how would you rate your overall health: Poor Not good Average Good Excellent

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

| Topics | 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®/equivalency exam | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vocation/prevocation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specify: | | | |