Patient Navigation Intake Form

Patient Contact/Visit			
	Patient's ID		
		ID: Medical Record #	
		ID: Code number	
		ID: Other	
	Patient's Personal Information		
		FName	
		Lname	
		Address	
		City	
		State	
		Zip	
		Phone-Home	
		Phone-Work	
		Phone-cell	
		Email	
		Other (pop-up space to specify)	
	Ask patient how they prefer to be contacted		
		In-person	
		Phone	
		Home	
		Work	
		Cell	
		Email	
		Postal Mail	
		Other (pop-up space to specify)	
	Emergency Contact 1		
		FName	
		Lname	
		Address	
		City	
		State	
		Zip	
		Phone-Home	
		Phone-Work	
		Phone-cell	
		Email	

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		Other (pop-up space to specify)	
	Emergeny's Contact 2		
		FName	
		Lname	
		Address	
		City	
		State	
		Zip	
		Phone-Home	
		Phone-Work	
		Phone-cell	
		Email	
		Other (pop-up space to specify)	
	Who lives with you (check all that apply)?		
		Partner	
		Spouse	
		Children	
		Parents	
		Others	
		Do Not Want to Answer	
DEMOGRAPHICS			
	What is your gender?		
		Female	
		Male	
		Transgender	
		Do Not Want to Answer	
	What is your sexual orientation?		
		Heterosexual	
		Gay	
		Lesbian	
		Bisexual	
		Transsexual	
		Queer	
		Other	
		Do Not Want to Answer	

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	What is your date of birth?		
	What is your race (check all that apply)		
		American Indian / Alaska Native (AIAN)	
		Pacific Islander	
		Asian	
		African-American	
		Non-Hispanic white (Caucasian)	
		Other (please specify)	
		Don’t know	
		Don't want to answer	
	Are you Hispanic, Latino, Chicano?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	
	What is your preferred religion or spirituality? (check all		
		Abrahamic	
		Atheist	
		Baha'i	
		Buddhism	
		Christianity	
		Confucianism	
		Druidry	
		Hinduism	
		Islam	
		Judaism	
		Native American / Indigenous religions	
		Satanism	
		Scientology	
		Shinto	
		Taoism	
		Voodoo	
		Wicca	
		Non-organized faith or spirituality	
		Other (pop-up space to specify)	
		Don't want to answer	

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	How much schooling have you completed?		
		None	
		Grade school / elementary	
		Middle / Junior high	
		High school graduate / GED	
		Technical or apprentice training	
		Some College (no degree)	
		College AA, AS degree	
		College BA, BS degree	
		Masters Degree	
		Doctorate or more	
		Do Not Want to Answer	
	How were you referred to the program?		
		Healthcare provider	
		Cancer support group	
		Family or friend referred	
		Self-referred	
		Another cancer survivor referred	
		Homeless Program	
		Prison / incarcerated cancer program	
		Other	
	Where do you get most of your medical care?		
		Space to write in	
	Do you have a regular medical provider?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	

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	What is your “Primary” health insurance?		
		I do not currently have health insurance	
		Medicaid	
		Medicare	
		Private (through work, spouse, individual)	
		Self-insured	
		Tri-Care	
		AI/AN exemption from ACA	
		has insurance but doesn't know what it is	
		I do not know or not sure	
		do not want to answer this question	
	What is the best way for you to learn and understand		
		Visual (pictures, photos)	
		Audio (spoken, sounds, voice, music)	
		Written words	
	What language(s) do you speak?		
		Space to write in language (Have write in and that	
	What language do you prefer to use?		
		Write in language	
	Can you read English?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	
	Do you use hearing aids?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	
	Do you wear glasses?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	

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	Do you work either at home or outside your home for		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	
	Do you have dependent children?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	
	Do you have dependent elders?		
		Yes	
		No	
		I do not know or not sure	
		I do not want to answer this question	