Health District
OF NORTHERN LARIMER COUNTY

Cholesterol Screening Intake Form

Last Name _____ **First** _____ **M.I.** _____

Address _____ **City** _____ **State** ____ **Zip** _____

Phone (_____)_____ **Date of Birth** _____ **Age** _____ ○ **Female** ○ **Male**

Race or ethnicity ○ African American/Black ○ Hispanic or Latino
○ White Non-Hispanic ○ Asian or Pacific Islander ○ American Indian, Eskimo or Aleut

Personal Health History (If unsure about conditions listed below, please ask the nurse.)

1. Has a doctor or nurse ever told you that you had any of the conditions listed below?

If so, ☑ check all boxes that apply to you.

- ☐ High Cholesterol
- ☐ Low HDL
- ☐ High Blood Pressure
- ☐ Post Menopausal
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Carotid Artery Disease
- ☐ Peripheral Artery Disease
- ☐ Abdominal Aortic Aneurysm
- ☐ Previous Stroke or Mini-Stroke
- ☐ Chronic Kidney Disease

2. Circle any of the above listed conditions that you currently take medications for.

3. Do you take daily aspirin? ○ Yes ○ No

4. Do you currently smoke or chew tobacco? ○ Yes ○ No ○ Former

Family Health History

☑ Check conditions your parents, brothers or sisters have had:

- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Disease (in men age 55 or younger **or** in women age 65 or younger)
- ☐ High Blood Pressure
- ☐ Stroke

Approximately how long ago did you have the following tests? (Mark one option for each test.)

	Never	0-3 mo	3-12 mo	1-2 yrs	2-5 yrs	5+ yrs	Were the results in the normal range?		
Cholesterol	○	○	○	○	○	○	○ Yes	○ No	○ Don't know
Blood Pressure	○	○	○	○	○	○	○ Yes	○ No	○ Don't know
Blood Sugar	○	○	○	○	○	○	○ Yes	○ No	○ Don't know

Consent for Treatment and Eligibility Statement

I give my consent to Health District of Northern Larimer County staff to perform a blood pressure reading and fingerstick procedure to obtain lipid profile and blood glucose levels for ○ *me* ○ *my child* ○ *person in my guardianship*.
The Health District may offer a discounted fee for legal residents of the Health District of Northern Larimer County.

Client/Guardian Signature _____ **Date** _____

Email Address

Office use only: ☐ Sliding Fee: I II III IV V VI ☐ No charge ☐ Full pay ☐ RDNO Regular doctor ○ Yes ○ No
☐ Scheduled appointment ☐ Walk-in Email ○ Yes ○ No Text message ○ Yes ○ No Risk class ○ A ○ B ○ C
☐ Kendall Reagan Nutrition Center Referral KRNC client survey ☐ phone ☐ email ☐ mail ☐ none ☐ Quit Tobacco Referral

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Name of Client or Client Representative (Please Print) _____ Date of Birth _____

I hereby acknowledge that I received the Health District of Northern Larimer County's Notice of Privacy Practices.

Signature of Client or Client Representative _____ Date (Signature valid for lifetime) _____

(For use when acknowledgement cannot be obtained from the client.)

The client presented to the Health District of Northern Larimer County on _____ (Date) and was provided with a copy of the Health District's Notice of Privacy Practices. A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Client refused to sign.
- ☐ Client was unable to sign or initial because _____
- ☐ The client had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (describe below):

_____

_____

Signature of Employee _____ Date _____

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each client has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specify how those "Good Faith Efforts" should be documented.]