IS YOUR PATIENT STRUGGLING WITH ASTHMA, DIABETES OR HYPERTENSION MANAGEMENT?

City Health Works (CHW) provides clinically-supervised and trained health coaches to support patients with poorly controlled asthma, blood pressure or diabetes through motivational coaching, self-management education, social support and referrals. CHW will keep you informed on your patient's progress with regular updates and alerts for urgent medical issues.

MAKE A REFERRAL TO CHW TODAY!

1: Check ELIGIBILITY & EXCLUSION CRITERIA

2: Complete the REFERRAL FORM

3: If patient is present at time of referral, complete CONSENT FORM

4: Return this packet to CITY HEALTH WORKS BIN or fax securely to David Strefling, Health Coach Supervisor, at 646-684-4679.

Eligibility Criteria

- **Uncontrolled Asthma**
- **Uncontrolled BP ≥ 140/90**
- **Uncontrolled DM HbA1C ≥8**
- **Harlem or Upper West Side Zip Codes:** 10024, 10025, 10026, 10027, 10029, 10030, 10031, 10032, 10033, 10034, 10035, 10037 and 10039

Exclusion Criteria

- **Cognitive Issues**: Advanced dementia, complicated or severe mental illness.
- **Medical Issues:** Gestational diabetes, cancer treatment or end-stage disease.
- **Substance Abuse Issues:** Active alcohol or substance abuse.

REFERRAL FORM (FOR PROVIDER TO COMPLETE)

I. PATIENT DATA

NAME: _____

M.R.N: _____

Language Spoken: ❑ English ❑ Spanish ❑ Other: _____

Health Coaching Required for Uncontrolled (check all that apply): ❑ Asthma ❑ DM ❑ HTN

II. PROVIDER BRIEF ASSESSMENT

Priority Areas for Health Coaching (check all that apply): ❑ Healthy Eating ❑ Being Active

❑ Taking Meds ❑ Losing Weight ❑ Quit Smoking ❑ Other:_____

Known Self-Management Barriers (check all that apply): ❑ Food Insecurity ❑ Housing

❑ Medication Problems ❑ Insurance ❑ Literacy ❑ Employment ❑ Legal ❑ Transportation

❑ Mental/Emotional Health ❑ Vision/Hearing/Physical Disabilities ❑ Other:_____

III. MEDICAL CLEARANCE

While working with City Health Works, your patient may elect to increase their level of physical activity towards a recommended goal of 150 minutes per week (30 minutes/5 days per week). Please indicate the level of activity your patient can safely participate in below. My patient, listed above, is:

_____ Not cleared to exercise at this time

_____ Cleared to exercise with no restrictions

_____ Cleared to exercise with the following restrictions and/or recommendations:

_____

_____

Referring Provider Signature: _____ Date: _____

Referring Provider Name (Printed): _____

QUESTIONS? Contact: David Strefling, Health Coach Supervisor,
917-903-3690 (cell); 646-684-4679 (fax), dstrefling@cityhealthworks.com

CONSENT FORM – English (For patient to complete)

AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Federal and state regulations give you certain rights related to your health information. City Health Works must get your authorization (permission) to use or give out any health information that might identify you. If you choose to enroll in the City Health Works Program, City Health Works will get personal information about you, including from Mount Sinai Hospital. This may include information that might identify you, including information about your health, such as: Past and present medical records; Results from diagnostic and medical procedures including but not limited to X-rays, physical examinations and medical history; Billing records. Information obtained or created by City Health Works may also be given to Mount Sinai Hospital and your Care Team there, including information about your visits with City Health Works staff.

This Authorization does not have an expiration date. If you do not withdraw this Authorization in writing, it will remain in effect indefinitely. By signing this consent form, you are giving permission to Mount Sinai Hospital Hospital and its staff to give City Health Works your health information and you are giving City Health Works permission to give Mount Sinai Hospital any health information it obtains or creates during your enrollment in the City Health Works Program. You do not have to sign this consent form. If you choose not to sign this consent form, you will not be able to participate in the City Health Works Program. Your decision not to sign this consent form will not have any effect on your medical care and you will not lose any benefits or legal rights to which you are entitled. You have the right to review and copy your health information. You may withdraw or take away your permission to use and disclosure of your health information at any time. You do this by sending written notice to City Health Works at the address listed at the end of this informed consent form. If you withdraw your permission, you will not be able to continue being in the City Health Works Program, but you will not have any penalty or loss of access to treatment or other benefits to which you are entitled. When you withdraw your permission, no new health information which might identify you will be shared after that date.

NOTICE CONCERNING HIV-RELATED INFORMATION: The recipients of HIV-related information are prohibited from re-disclosing any HIV-related information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use your HIV-related information without authorization. If you experience discrimination because of the release or disclosure of HIV-related information, you may contact the New York State Division of Human Rights at 212-480-2493 or the New York City Commission on Human Rights at 212-306-7450. These agencies are responsible for protecting your rights.

WAIVER OF LIABILITY: By signing this consent form, you irrevocably and unconditionally release, waive, and forever discharge all known and unknown claims, promises, causes of action, or similar rights of any type that you may have against City Health Works and/or any other persons acting by, through, under or in concert with City Health Works arising out of or in connection with the collection and disclosure of your personal information authorized by this consent form.

VOLUNTARY PARTICIPATION / WITHDRAWAL: Your participation in the City Health Works Program is voluntary. You may decide not to participate or you may discontinue your participation at any time without penalty or loss of benefits or medical care to which you are otherwise entitled.

DOCUMENTATION OF CONSENT: I have received a copy of this consent form. I know that City Health Works and Mount Sinai Hospital will keep a copy of this consent form.

_____

Signature of Participant

_____ _____

Participant's Name (Please Print) **Participant's Date of Birth**

_____ _____

Participant's Address **Participant's Phone Number**

The participant has read the consent, has demonstrated that he/she understands the consent and has received a copy of the consent form. I observed the process of consent. The prospective participant read this form, was given a chance to ask questions, and appeared to accept the answers.

_____ _____

City Health Works **Date**

127 West 127th Street, Room 207, NY, NY 10027

CONSENT FORM - Español (El paciente debe completar)

AUTORIZACIÓN PARA USAR/ COMPARTIR INFORMACIÓN PERSONAL DE SALUD

Las reglamentaciones federales y estatales le otorgan ciertos derechos relacionados con su información personal de salud. City Health Works requiere su autorización (permiso) para usar o compartir cualquier información que pueda revelar su identidad.

Si usted decide inscribirse al programa de City Health Works, City Health Works tendrá acceso a su información, incluso la que usted proveyó al Mount Sinai Hospital. La misma puede incluir información que revele su identidad, incluso información con respecto a su salud, como: Registros médicos pasados y presents; Resultados de procedimientos y diagnósticos médicos, incluyendo pero no limitado a rayos-X, exámenes físicos e historia clínica; Registros de factura

La información obtenida o creada por City Health Works también podrá ser dada al Mount Sinai Hospital y a su equipo de atención médica, incluso información de sus interacciones con el personal de City Health Works.

Esta Autorización no tiene fecha de vencimiento. Si usted no se retracta, esta Autorización por escrito seguirá vigente indefinidamente.

Al firmar esta Autorización, usted le autoriza al Mount Sinai Hospital y a sus empleados a compartir su información de salud personal con City Health Works, y usted le autoriza a City Health Works a compartir cualquier información de salud que obtenga o crea durante su inscripción en el programa de City Health Works. Usted no está obligado a firmar esta Autorización. Si usted decide no firmar esta Autorización, no podrá participar en el programa de City Health Works. Su decisión de negarse a firmar esta Autorización no tendrá ningún efecto en su atención médica y no perderá ningún beneficio o derecho legal que le corresponda.

Usted tiene el derecho de revisar y de copiar su información de salud personal. Usted puede retractar o retirar el permiso de usar y compartir información de su salud personal en cualquier momento. Esto se hace al enviar una notificación por escrito a City Health Works a la dirección que se encuentra al final de este documento. Si retira su permiso, no podrá continuar en el programa de City Health Works pero no será penalizado y no perderá acceso a atención médica o a beneficios que le correspondan. Desde el día que usted retracte su permiso, ninguna información de salud personal que lo pueda identificar será compartida.

AVISO SOBRE INFORMACION RELACIÓNADA CON EL VIH: Los recipientes de información relacionada con el VIH están prohibidos de revelar esta información sin su autorización, a menos que sean autorizados según la ley federal o estatal. Usted también tiene el derecho de solicitar una lista de personas que pueden recibir o utilizar su información VIH sin autorización. Si sufre discriminación a causa de la revelación de información VIH, usted puede contactar la división de Derechos Humanos del estado de Nueva York al número 212-480-2493, o la comisión de Derechos Humanos de la ciudad de Nueva York al número 212-306-7450. Estas agencias son responsables para proteger sus derechos.

EXONERACIÓN DE RESPONSABILIDAD: Al firmar este formulario de consentimiento, usted irrevocable e incondicionalmente, renuncia para siempre y se libera de todos los reclamos conocidos y desconocidos, promesas, causas de acción, o derechos similares de cualquier tipo que pueda tener con City Health Works o cualquier otra persona actuando por, o en colaboración con City Health Works que surja o en relación con la recopilación y divulgación de su información personal autorizada por este formulario de consentimiento.

PARTICIPACIÓN/RETIRADA VOLUNTARIA: Su participación en el programa de City Health Works es voluntaria. Usted puede decidir no participar o se puede retirar del programa en cualquier momento sin sanción o pérdida de beneficios de cuidados y atención médica a los cuales usted tiene derecho.

DOCUMENTACIÓN DEL CONSENTIMIENTO: Yo he recibido una copia de este formulario de consentimiento. Entiendo que City Health Works y Mount Sinai Hospital mantendrán una copia de este formulario de consentimiento.

_____ _____

Firma del Participante **Nombre del Participante (Letra de molde, por favor)**

_____ _____

Numero del Telefono **Dirección de envio**

_____

Fecha de Nacimiento

El participante ha leído el consentimiento, ha demostrado que entiende el consentimiento, y ha recibido una copia de este formulario de consentimiento. Yo observé este proceso de consentimiento. El prospecto participante leyó este formulario, tuvo la oportunidad de hacer preguntas, y le pareció aceptar las respuestas.

_____ _____

City Health Works **Fecha**

127 West 127th Street, Room 207, NY, NY 10027