	2022 Farmworker Outreach Health Assessment - Adol (12-17)	ORW:	Date:
Optional	**FHASES ID:** _____ **Cohort:**_____ **Employer:** _____		

Privacy*

My signature indicates that I understand that my privacy will be protected within this farmworker health network except in the following circumstancs: if harm is suspected of a minor, elderly, or disabled person.

Signature: _____

Demographics*

Name (first, last): _____ **Birth date**: _____ □ Est.

Preferred language: Span/ Engl/ Other: _____

Worker type: Migrant ((□ H2A? □ H2B?)/ Seasonal/ Other

(*If migrant*) **Estimated departure date**: _____

Unaccompanied minor? Y/N

What sex were you assigned at birth? Male/ Female

Do you need an interpreter? Yes/ No

Hispanic or Latino? Yes/ No/ Decline

Race: □ White □ Black □ American Indian □ Asian □ Decline to answer

What is your current gender identity? Man/ Woman/ Transgender man/ Transgender woman/ Other/ Decline to answer

Do you consider yourself to be: □ Heterosexual (not gay nor lesbian) □ Lesbian, gay, or homosexual □ Bisexual □ Something different □ Unsure □ Decline to answer?

Housing: Own/ Rent/ Grower-provided/ Homeless

Address: _____ **City**: _____ **US veteran?** Sí/ No

State: _____ **Zip code**: _____ **County**: _____

Health insurance: None / Medicaid / Medicare / Health Choice / Private **Family income** ($ amount): _____

Amount is per: week / 2 weeks/ month / year **# months worked** ____ **# family members**: _____

COVID-19*

In the last 2 weeks have you had fever, cough, sore throat, unusual fatigue, headache, chills, diarrhea, loss of taste or smell, or shortness of breath? □ Yes □ No _____

Do you live with someone or have you been around someone who has been diagnosed with COVID-19 in the last 2 weeks? □ Yes □ No _____

Have you received the COVID-19 vaccine? □ Yes □ No

1st dose date:_____ clinic: _____ manufacturer: _____
2nd dose date:_____ clinic: _____ manufacturer: _____
Booster date:_____ clinic: _____ manufacturer: _____

Do you have your vaccine card? □ Yes □ No *(If not, help replace)*

Health ed: ☐ Provided ☐ Follow up
Vaccine : ☐ Provided ☐ Referral ☐ Follow up ☐ Declined
Testing : ☐ Provided ☐ Referral ☐ Follow up ☐ Declined

Vitals

Blood pressure: _____

If >120/80, offer health ed. If >140/90, offer referral.

Health ed: ☐ Provided ☐ Follow up

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

General health

Is there something that worries you about your health? No/ Yes:_____

(If yes) **How can I help you with this problem?** _____

Have you ever been diagnosed with a medical condition? No/ Yes:_____

Are you taking (or should you be taking) medicines? No/ Yes:_____

Referral: ☐ Provided ☐ Follow up ☐ Declined
Diabetes, pregnancy, HTN, HIV, TB or abnormal cancer screen, consider MCN*

Occupational* *Schedule a diabetes departure visit, if needed:* _____

Occupational

Do you work in the fields? No/ Yes

(If yes) **Do you worry about conditions at work?** (like unfair pay, pesticides exposure, or other illegal practices) **No/ Yes:** _____

(If yes) **Would you like more information on how to protect yourself at work?** (such as pesticides, heat stress, or something else) **No/ Yes:** _____

Referral: ☐ Provided ☐ Follow up ☐ Declined

Health ed: □ Provided □ Follow up
Health ed topic: _____

MH

In the last 2 weeks, have you often felt little interest or desire to do things? *(PHQ-2)* **No/ Yes**

In the last 2 weeks, have you felt sad, depressed, or hopeless? *(PHQ-2)* **No/ Yes**

If yes to either question, offer a referral or full depression screen (PHQ-9: Modificado for Teens)
For positive PHQ-9, offer referral

Referral: ☐ Provided ☐ Follow up ☐ Declined

PHQ-9: ☐ Provided ☐ Follow up

Substance use

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? ____

2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles) or "**synthetic marijuana**" (like "K2," "Spice")? ____

3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? ____

4. Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs? Yes/No

If the patient answered…
"1" or more for Q. 1, 2, or 3 ---> Ask all questions in CRAFFT Part B and provide health ed.
---> Refer if "yes" to 2 or more in Part B

CRAFFT Part B: ☐ Provided ☐ Follow up ☐ Declined
Health ed: ☐ Provided ☐ Follow up ☐ Declined
Referral: ☐ Provided ☐ Follow up ☐ Declined

CM

Does someone where you work or live threaten you or make you feel in danger? No/ Yes

Do you have any other worries or concerns? No/ Yes: _____

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Communication*

How can we communicate with you?
Ask patient to initial next to each below if OK.

Cell number: _____
_____ OK to leave a message with another person.
_____ OK to leave a voicemail.
_____ OK to send a text (SMS) even though complete privacy is not guaranteed.
Email address: _____
_____ OK to send a message.

Emergency contact (optional)
Full name: _____
Phone number: _____
Relationship: _____

How do you prefer that we communicate with you? *Circle preference.*

Addtl. Health Ed

Would you like more information on the following topics? *Circle those desired and check off if provided.*

□ COVID-19	□ Emergency preparedness	□ Internet access	□ Telehealth services
□ Dental health	□ Emotional health	□ Nutrition	□ Other(s)_____
□ Diabetes	□ Green Tobacco Sickness	□ STIs/ HIV	
□ Drug or alcohol abuse	□ Hypertension	□ Smoking	

Notes