Cooper
Collaborative Care

Thank you for your interest in Cooper Collaborative Care. The application materials consist of the following:

1. Screening questionnaire for enrollment
2. URICA – Short form for physical health behavior state
3. Authorization to Release Information

Patients should complete and return all three application forms to Cooper Collaborative by scanning and sending to kursh-maxwell@cooperhealth.edu or faxing to 856-536-1634, Attention: Max Kursh.

Referring physicians should either route a note in EPIC to Dr. Robertson or send a staff message indicating that you had the conversation about the CCC practice with the patient and are making the referral. Physicians should also indicate the reason for the referral (i.e. the diagnoses that the referring physician believe qualify the patient for the CCC practice).

If the patient is considered a good fit for the practice, they will be invited for a Meet and Greet, and then establish care with Dr. Robertson if both parties agree that Cooper Collaborative Care is an appropriate practice.

If you have any questions about the application process, please contact the Cooper Collaborative Care office at 856-874-0139.

[redacted]

Name: _____ Today's Date: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

COOPER COLLABORATIVE CARE

SCREENING QUESTIONNAIRE FOR ENROLLMENT

Please answer the following questions by checking the box that best corresponds to your answer or by writing a response. You should answer each question honestly and to the best of your knowledge.

1. How would you rate your current health?

Poor	Fair	Good	Very Good	Excellent
○	○	○	○	○

2. How do you believe a doctor would rate your current health?

Poor	Fair	Good	Very Good	Excellent
○	○	○	○	○

3. How many prescribed medications do you take on a regular basis?
(i.e. – medications prescribed by a doctor only, do not include over the counter medications or vitamin supplements)

None	1-3	4-6	6+
○	○	○	○

4. Do you have a primary care provider? (i.e. - a regular doctor)

○ – Yes

○ – No

If yes, how would you rate the relationship with your primary care provider?

Poor	Fair	Good	Very Good	Excellent
○	○	○	○	○

5. Not including your primary care provider, how many other medical/health providers do you see at least once a year? (e.g. - cardiologist, physical therapist, counselor, etc...)

None	1-3	4-6	6+
○	○	○	○

6. In the past 6 months have you been admitted to a hospital?

O – Yes

O – No

If yes, how many times, and what were the reasons you were admitted?

7. In the past 6 months, have you gone to the Emergency Department?

O – Yes

O – No

If yes, how many times and what were the reasons for your visit(s)?

8. In the past 3 months, do you think you accomplished less than you would have liked because of a limitation with your physical health?

O – Yes

O – No

9. In the past 3 months, do you think you accomplished less than you would have liked because of a limitation with your emotional health?

O – Yes

O – No

10. In the past 3 months, have you had difficulty keeping your appointments or getting your medications because of financial concerns?

O – Yes

O – No

11. I feel supported by my doctors and other health care providers.

Always	Usually	Sometimes	Never
○	○	○	○

12. I feel there is good communication between my care providers and that everyone is "*on the same page*."

Always	Usually	Sometimes	Never
○	○	○	○

13. I feel that my care providers listen to me and understand my concerns so that my goals are their goals.

Always	Usually	Sometimes	Never
○	○	○	○

14. I feel that I am able to contact my care providers whenever I need, any time or day or night.

Always	Usually	Sometimes	Never
○	○	○	○

15. I feel able to manage my own health. (I know where I need to go, what I need to do, and when I need to call for assistance)

Always	Usually	Sometimes	Never
○	○	○	○

16. I feel supported by my friends and family when it comes to my health.

Always	Usually	Sometimes	Never
○	○	○	○

17. I feel that I am up to date with all preventative medical services. (mammogram, colonoscopy, vaccinations, etc...)

Always	Usually	Sometimes	Never
○	○	○	○

18. Are you currently diagnosed or being treated for any of the following medical conditions?

Check all that apply

(If you check yes to any medical condition below, please also indicate whether it is controlled, uncontrolled or if you are unsure)

(√)	Medical Condition	Controlled	Uncontrolled	Not Sure
☐	None	O	O	O
☐	Anxiety	O	O	O
☐	Arthritis	O	O	O
☐	Asthma	O	O	O
☐	Back Pain	O	O	O
☐	Blood Disorder	O	O	O
☐	Blood Pressure	O	O	O
☐	Cancer	O	O	O
☐	Chronic Pain	O	O	O
☐	Depression	O	O	O
☐	Diabetes	O	O	O
☐	Digestive Disorder	O	O	O
☐	Heart Failure	O	O	O
☐	Infectious Disease	O	O	O
☐	Kidney Disease	O	O	O
☐	Obesity	O	O	O
☐	Organ Transplant	O	O	O
☐	Pregnancy	O	O	O
☐	Psychiatric Condition	O	O	O
☐	Reflux	O	O	O
☐	Tobacco Use	O	O	O

19. If you checked yes to any medical condition above, is there anything about this condition that you do not understand? (What it is, why you have it, how you treat it, etc...)

O – Yes

O – No

If yes, Please explain.

20. We would appreciate any comments or additional information that you would like to share with us.

University of Rhode Island Change Assessment (URICA)

Short Form for Physical Health Behavior State

Please indicate the extent to which you agree or disagree with each statement. Make your choice in terms of how you feel RIGHT NOW, not what you have felt in the past or would like to feel. Remember that statements refer to the physical health problem(s) that bother you or the care management program we are offering you.

Circle the number that best describes how much you agree or disagree with each of these statements about your physical health.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. It doesn't make much sense for me to consider changing my lifestyle for my health.	1	2	3	4	5
2. I've been thinking that I might want to change something about my lifestyle for my health.	1	2	3	4	5
3. At times, my lifestyle causes health problems and I'm determined to change.	1	2	3	4	5
4. It is frustrating, but I feel like I do not have control over my lifestyle even though I thought I did.	1	2	3	4	5
5. Trying to change my lifestyle for my health is pretty much a waste of time for me.	1	2	3	4	5
6. I guess I have faults, but there's nothing that I really need to change about my lifestyle or health.	1	2	3	4	5
7. I thought once I had resolved my physical health problems I would be free of them, but sometimes I still find myself struggling with them.	1	2	3	4	5
8. I may have a problem with my lifestyle and health and think I should work on it.	1	2	3	4	5
9. I am really working hard to change my lifestyle for my health.	1	2	3	4	5
10. I hope that someone will give me good advice for me about my lifestyle and health issues.	1	2	3	4	5
11. Anyone can talk about changing their lifestyle, but I am actually going to do something about it.	1	2	3	4	5
12. After all I have done to try and change my lifestyle and health, every now and then, I still struggle with it.	1	2	3	4	5

The Cooper Health System

AUTHORIZATION FOR USE OR DISCLOSURE OF PHI

I, _____, hereby authorize The Cooper Health System to use the health information about me (*Print Name*) that is specified below, and to disclose such health information to

_____

(Identification of recipient, address, telephone number)

for the following purposes:

_____.

If the above purpose(s) includes the use or disclosure of your health information for The Cooper Health System's marketing purposes, or another entity's marketing, The Cooper Health System **will/will not** be paid, either directly or indirectly, for using or disclosing your health information for such marketing purpose(s).

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO THIS AUTHORIZATION

Date(s) of Service

_____

[ ]	Admission Record	[ ]	Operative Reports	[ ]	AIDS or HIV-related information
[ ]	Discharge Summary	[ ]	X-Rays	[ ]	Emergency Department Record
[ ]	Laboratory Results	[ ]	Pathology Report(s)	[ ]	History and Physical Consultation(s)
[ ]	Psychiatric Records	[ ]	Drug abuse and/or alcoholism treatment records		
[ ]	Consultations	[ ]	Photographs, Video or other recordings or images		
[ ]	Other (specify) _____				

This authorization will expire on _____ or when the following event happens: _____.
(*Date*)

This authorization will automatically expire one year from the date it is given. An authorization for disclosure of psychiatric records will automatically expire 60 days from the date it is given.

I understand that I may revoke this authorization at any time, even if it has not expired, by giving a written notice to the Director of Health Information Management. I understand that my revocation will become effective on the day it is received by The Cooper Health System. I also understand that The Cooper Health System may, under certain circumstances, have a continued right to use or disclose my health information if The Cooper Health System has already used or disclosed the information on the basis of this authorization.

I understand that if I am giving this authorization as a condition of receiving insurance coverage, The Cooper Health System may have access to health information about me if there is a question about a claim I made under the insurance policy. I understand that a full description of other rights that I may have in regard to a revocation of this authorization can be found in The Cooper Health System's Notice of Privacy Practices.

Notice to the Individual Giving This Authorization

Your failure to give this authorization may result in the withholding of treatment or services from you, if the treatment is research-related or if the services were to be provided only for the purpose of creating health information about you.

This Authorization shall operate as a complete release of liability of The Cooper Health System, its trustees, officers, agents and employees for the release of information as specified above.

Once The Cooper Health System discloses information on the basis of this authorization, we have no control over the recipient's use of the information. The person to whom we disclose your information may disclose it to someone else, and The Cooper Health System will no longer be able to protect the information.

_____ _____

Patient Signature *Date* *Authorized Representative* *Date*

_____ _____

Print Name *Print Name* *Relationship to Patient*

Address: _____ *Patient's Date of Birth:* _____