CHAMPION HEALTH PLAN

Dear Member,

Thank you for participating in the **Health Risk Assessment (HRA) for ESRD**. Your answers will enable your case manager to customize your care plan. We assure confidentiality and urge you to be as precise as possible.

YOUR FULL NAME:		**CELL PHONE #:**	( )
DATE OF BIRTH:		**GENDER:** __Male __Female __Other_____	
PREFERRED LANGUAGE:	__English __Spanish __Vietnamese Other:		
RACE OR ETHNICITY:	__White __Black/African American __Asian __Hispanic __Pacific Islander __ American Indian/Alaska Native __Pacific Islander/Hawaiian __Other __I choose not to answer		
ESRD DIAGNOSIS?	__Yes __No	**TYPE OF DIALYSIS:**	__Hemodialysis __Peritoneal __Other
DIALYSIS CENTER NAME:		**PHONE:**	( )
ADDRESS			
DIALYSIS TREATMENTS	3 per week? __Yes __No		
ACCESS - Challenges in accessing treatment - transportation or any other?			__Yes __No
ESRD DIET - Difficulties in maintaining the recommended ESRD Diet?			__Yes __No
HOSPITAL - Have you been admitted to hospital in the past year?	__Yes __No	How many times? ___	
ER - Have you gone to the Emergency Room in the past year?	__Yes __No	How many times? ___	

WHAT OTHER HEALTH CONDITIONS DO YOU HAVE

__Anxiety __Asthma __Bi-Polar __Cancer __COPD/Emphysema
__Dementia __Depression __Diabetes __Hearing problem __Heart problem
__Heart failure __High blood pressure __Stroke __Vision problem
__Other:_____
_____

EMOTIONS: IN THE PAST YEAR HAVE YOU EXPERIENCED OR ARE YOU NOW EXPERIENCING ANY OF THE FOLLOWING? CHECK ALL THAT APPLY:

__Recent unintentional weight Loss
__Decline in grip strength
__Have fallen in the past year
__Regular feelings of exhaustion or fatigue
__Trouble walking or climbing stairs
__Slower walking speed or reduced physician activity.

WHICH OF THE FOLLOWING APPLY TO YOU? CHECK ALL THAT APPLY.

__Physical Activity ___times per week
__Use Alcohol ___times per week
__Smoke or use Tobacco ___times per week
__Use a seat belt in cars __Yes __No

WHICH OF THE FOLLOWING EMOTIONS YOU HAVE EXPERIENCED IN THE PAST TWO (2) WEEKS? CHECK ALL THAT APPLY.

__Feelings of sadness or hopelessness
__Feelings of significant stress
__Feelings of significant anger or rage
__Feelings of loneliness or social isolation

SUPPORT: LIST ANY SUPPORT OR RESOURCES HELPING WITH YOUR ESRD CARE OR WELLNESS NEEDS. CHECK ALL THAT APPLY.

__Family __Caregiver __Living facility assistance __Community resources

ADLS – ACTIVITIES OF DAILY LIVING	**CAN DO THIS MYSELF**	**NEED A LITTLE HELP**	**NEED SIGNIFICANT HELP**
Bathing			
Dressing			
Eating			
Toileting			
Walking			
Transferring (from bed to chair etc.)			
Is there someone to help you with the above when needed?			__Yes __No
IADLS – INSTRUMENTAL ACTIVITIES OF DAILY LIVING	**CAN DO THIS MYSELF**	**NEED A LITTLE HELP**	**NEED SIGNIFICANT HELP**
Shopping			
Food preparation			
Using the telephone			
Housekeeping			
Laundry			
Taking medications			
Handling my finances			
Do you sometimes run out of money to pay for food/rent/bills/medicine?			__Yes __No
Is there someone to help you with the above when needed?			__Yes __No
MEDICATION & DIETARY GUIDANCE:			
How many different prescription medications do you take? __1-3 __4-6 __7-10 __more than 10			
Do you have challenges understanding or adhering to medications prescribed?			__Yes __No
Do you have difficulty in picking up medications?			__Yes __No
TRANSPORTATION: IN THE PAST YEAR HAS LACK OF TRANSPORTATION CAUSED YOU TO MISS ANY OF THE FOLLOWING?			
Missed medical appointments?			__Yes __No
Missed non-medical appointments?			__Yes __No
I choose not to answer			__Yes __No
VACCINATIONS / IMMUNIZATIONS: INDICATE WHICH YOU HAVE HAD IN THE PAST 12 MONTHS OR WANT TO HAVE.			
FLU SHOT: __Yes __No __ Not yet but want it.		**PNEUMONIA SHOT:** __Yes __No __ Not yet but want it.	
COVID VACCINE in past 12 months: __Yes __No __ Not yet but want it.			
GOALS & PREFERENCES:			
What are your personal primary objectives for ESRD care and general health?			
Specify any treatment preferences, care coordination wishes, or end-of-life decisions:			
Share any other vital information about your health or care necessities:			

Please use extra pages if more space is needed.

Mail to: **Champion Health Plan, PO Box 15337, Long Beach, CA 90815-9995**

Additional information: