Form 1	**Date Completed** *dtcomplete*
	M M D D Y Y Y Y

Assessment: 1 □ recruitment

Site ID *siteID*	**Practice Name** *siteName*	**EpicCare Practice Name**
01	9-South	Gen Med HBC Oakland
02	Turtle Creek	Gen Med Turtle Creek
03	FM – Squirrel Hill	Upp Fam Med Sq Hill
04	Suburban East Medical Center	Suburban East Office
05	Shadyside Family Health Center	Fhc Faculty
06	Partners in Health - Delmont	Partners (sub-practice)
06	Partners in Health – Level Green	Partners (sub-practice)
06	Partners in Health - Murraysville	Partners (sub-practice)
07	Squirrel Hill Family Practice	Squirrel Hill Fam Pract
08	Lawrenceville FHC	Smfhc Lv Office
09	New Kensington FHC	Smfhc New Kensington
10	Craig Medical – Squirrel Hill	Cma (sub-practice)
10	Craig Medical – Squirrel Hill Passavant	Cma (sub-practice)
11	Garfield/Bloomfield Family Health Center	Smfhc B/G
12	Renaissance Family Practice – Penn Hills	RFP (sub-practice)
12	Renaissance Family Practice - Aspinwall	RFP (sub-practice)
12	Renaissance Family Practice - Gibsonia	RFP (sub-practice)
12	Renaissance Family Practice - RIDC	RFP (sub-practice)
12	Renaissance Family Practice - Glenshaw	RFP (sub-practice)
12	Renaissance Family Practice - Millvale	RFP (sub-practice)
12	Renaissance Family Practice - Morningside	RFP (sub-practice)
13	Shea Medical Center	Shea Medical
14	Latterman	Latterman Fhc Pcp
15	Health Care Associates - Harmer	Health Cntr Harmar
16	Health Care Associates - Monroeville	Health Cntr Mnrvl
17	Health Care Associates - Oakland	Health Cntr Oakland

Demographics

1. Date of referral: *dtReferral*

M	M	D	D	Y	Y	Y	Y

4. Gender: *gender*

Male ☐-1 Female ☐-2

5. Date of birth: *dtBirth*

Form 1	**Date Completed** *dtcomplete* M M D D Y Y Y Y

Assessment: 1 □ recruitment

M	M	D	D	Y	Y	Y	Y

6. Email Address: *email*

_____

7. Home Phone: *home_phone*

			-				-				

8. Work Phone: *work_phone*

			-				-				

9. Cell Phone: *cell_phone*

			-				-				

***Must have at least one phone number for 7, 8 or 9**

10. Referring PCP *physicianRefer*
Last Name: _____*last_name* **First Name:** _____*first_name*

Reached Patient *reached_patient*

0-☐ No 1-☐ Yes (Verify above information)

IF NO, Reason: *reason_not_reached*

☐ Out of window
☐ Never reached
☐ Wrong contact information
☐ Other If other, specify _____ *reason_other*

STOP SCREENING