Guam Hypertension Prevention and Control Project

PARTICIPANT PACKET

2022

(Revised August 2022)

Introduction: Guam Hypertension Prevention and Control Project

The 2019 Behavioral Risk Factor Surveillance System (BRFSS) revealed that the age-adjusted prevalence rate of adult Guamanians who have high blood pressure is 30.3%. This is an increase from 2015 (29.5%) and 2017 (29.1%). The hypertension prevalence rate for 2019 was similar for men (32.6%) and women (28%) with 1/3 of the adult population suffering from hypertension. It is not surprising that heart disease, cancer, stroke, diabetes, and various other non-communicable diseases (NCDs) for which hypertension is a significant risk factor has comprised more than 60% of all deaths on the island of Guam for many years. In addition, individuals with hypertension are at greater risk for getting severely ill from COVID-19.

The Guam Department of Public Health and Social Services is continuing the Hypertension Intervention Initiative 2022 under the Guam Hypertension Prevention and Control Project with aims to further improve systems and services in order for adults on Guam with hypertension to truly control their blood pressure numbers.

We would like to THANK YOU for opting to join this project. We want to assure you that participation is completely voluntary.

As a participant in the project, we will be offering you access to particular health, wellness and education programs and services to inform you of how to control and manage your high blood pressure. We will also have a patient navigator who will communicate with you to see how you are doing in the project.

Our goal is that by joining this project, you will be much better equipped to navigate your journey in improving your high blood pressure numbers and overall health.

We wish you all the best, and we thank you again for joining the project!

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Program Registration Form

The purpose of this Registration Form is to get information on program participants and their high blood pressure. Individual information obtained will be kept confidential. Aggregate data will be used for research, reporting purposes and to evaluate the program.

PERSONAL INFORMATION

1. Name: (Last) _____ (First) _____ (M.I.) _____

2. Mailing Address: _____

3. Home Address: _____

4. Home Phone: _____ 5. Daytime contact number: _____

6. Health Insurance: (Check One)
   [ ] Calvo's [ ] Staywell [ ] Medicare [ ] Medicaid/MIP [ ] HML [ ] Military
   [ ] TakeCare [ ] Moylan's [ ] Others (Specify) _____ [ ] None

7. Doctor/ Health Provider: _____ 8. Last date seen by doctor: _____

9. Age: _____ 10. Date of Birth: _____/ _____/ _____
   (Month/Day/Year)

11. Gender: [ ] Male [ ] Female 12. Highest year of education: _____
    (Check One)

13. Ethnic Group: (Check One)

[ ] Chamorro [ ] Black [ ] Chinese [ ] Marshallese [ ] Chuukese
[ ] White [ ] Japanese [ ] Palauan [ ] Yapese [ ] Kosraean
[ ] Filipino [ ] Korean [ ] Pohnpeian [ ] Others (specify): _____
[ ] Multiple (specify): _____

MEDICAL HISTORY

14. Has a **physician ever said** you had any of the following health problems? **(Mark all that applies to you)**
    [ ] Coronary Heart Disease [ ] Heart Attack [ ] Angina Pectoris
    [ ] Coronary Angioplasty [ ] Transient Ischemic Attack [ ] Abdominal Aortic Aneurysm
    [ ] Blockage of arteries to the legs or Carotid Artery [ ] Coronary Bypass Surgery
    [ ] Hypertension (Diagnosed) [ ] Stroke [ ] COVID-19 [ ] None

15. Which of the following pertains to you? **(Mark all that applies to you)**
    [ ] Stroke [ ] High Blood Pressure [ ] Hypertension (Diagnosed) [ ] High Blood Sugar
    [ ] Diabetes [ ] Tobacco User [ ] Uses Electronic Cigarettes (Vape) [ ] COVID-19 Positive
    [ ] High Blood Cholesterol [ ] Heart attack in 1st Degree relative [ ] Date Positive: _____
    [ ] Female 55 years or older [ ] Male 45 years or older

16. When did you receive your last reading for BLOOD PRESSURE: **(Please specify the month and year OR # of months since the last time it was checked)**: _____

17. Are you currently under your doctor's (or health care provider's) care? [ ] Yes [ ] No

PLEASE RETURN THIS COMPLETED FORM TO YOUR NURSE.

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GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

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ARTHUR U. SAN AGUSTIN, MHR
DIRECTOR

LAURENT SF DUENAS, MPH, BSN
DEPUTY DIRECTOR

TERRY G. AGUON
DEPUTY DIRECTOR

Consent for Health Services

I, the undersigned, understand that I will be fully informed of the need, risks, and advantages of each medical procedure and treatment, and do hereby give my free and full consent to the Department of Public Health and Social Services (DPHSS) to perform such necessary examinations and treatment deemed advisable in connections with my diagnosis and the maintenance of good health. I also understand that I have the right to refuse such care, unless required by law.

I understand that it is my responsibility to supply accurate and complete medical history information to those involved with my care, and to inform those involved with my care if I do not understand any instructions given or cannot follow them.

This consent, unless sooner revoked in writing, shall expire upon my discharge by appropriate authorities of DPHSS.

Name of Patient	Date
Signature of Patient (Parent/Legal Guardian,if minor)	Date
Witness	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Department of Public Health and Social Services (DPHSS) Notice of Privacy Practices.

- It tells me how DPHSS will use my health information for the purposes of treatment, payment for any treatment, and health care operations.
- It explains in more detail how DPHSS may use and share my health information for other purposes other than treatment, payment, and health care payment.
- It tells me how DPHSS will use and share my health information as required/permitted by law.
- It explains my individual rights in regards to my health information.
- If I am a DPHSS consumer receiving health services, I consent to DPHSS using and disclosing my treatment and medical records maintained by DPHSS for the purpose detailed in the Notice of Privacy Practices.

Name of Patient	Date
Signature of Patient (Parent/Legal Guardian,if minor)	Date
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Department of Public Health and Social Services
Guam Hypertension Prevention and Control Program

Protected Health Information Disclosure

In general, the HIPAA Privacy rule gives individuals the right to request a restriction on use and disclosure of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI to be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner regarding my appointments, results, referrals, or other medical information (please check all that apply);

- ☐ Home Telephone: _____
- ☐ Work Telephone: _____
- ☐ Okay to leave detailed message
- ☐ Okay to leave message with call back numbers only
- ☐ Okay to mail at home address
- ☐ Okay to mail at my work address
- ☐ Okay to authorize DPHSS staff to identify themselves to when calling to leave message on, any answering device or with other person answering the phone at the following numbers; _____ or _____

Please add any special instructions regarding Continuity of Care, Billing Issues and Medical Record Release (i.e. specific family member or representative): _____

_____

_____ _____

Patient's Printed Name Date

_____

Patient's Signature