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Part 1: Self Written Narrative

Category	Description	Needed?	Question	Ranking
1	Name	Yes / No	How would you like us to refer to you?	
			What would you like us to call you?	
			We have your name in our system recorded as _____, is this how you would like for us to refer to you? (yes/no); what would you like us to call you?	
Alternative(s)				
2	Pronouns	Yes / No	What pronouns would you like us to use?	
			What are your pronouns	
Alternative(s)				
3	Family/Important People	Yes / No	Tell us a bit about your family:	
			Who is/are the most important person/people in your life?	
			Can you tell us a bit about the most important people in your life?	
Alternative(s)				
4	Comfortable Openers	Yes / No	What is your favorite food and who cooks it best?	
			What are some things that make you happy?	
			Is there anything that makes your day a bit better?	
Alternative(s)				

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5	**Most Important**	**Yes / No**	What is most important to you?	
			What do you enjoy doing the most?	
			What do you value most?	
Alternative(s)				
6	**Activities/Hobbies**	**Yes / No**	What are some of your favorite activities?	
			Do you have any pets?	
			What are some of your favorite things to discuss?	
			What are some things that you really enjoy?	
			What do you enjoy doing the most?	
			Name three things that you like to do:	
Alternative(s)				
7	**My Life/Who am I?**	**Yes / No**	Can you tell us a bit about your week?	
			What is your job at the moment, can you tell us why you enjoy it?	
			What does your week generally look like?	
			What was your favorite job?	
			How important is your work to you?	
			What would you like other people to know about you?	
			What would you feel is important that we know about you?	
			What do you think is important for your health care team to know about you?	
			What do you like to do when you are stressed?	
Alternative(s)				
8	**Adjectives**	**Yes / No**	What are three words that you think describe you best?	
Alternative(s)				

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9	**Overall/General**	**Yes / No**	If you were being interviewed by a TV station and they asked you to provide a few sentences about who you are, what would you write?	
			If you were able to write a few sentences to tell your health care team about yourself, what would you want them to know? (What would be important to tell them about?)	
			If you could write a few sentences to introduce yourself to your health care providers, what would you like them to know about you?	
			Describe yourself to me as if I don't know you, what would you want me to know?	
			Describe yourself to me as you would like me to know you. (Maybe a really good intro line)	
Alternative(s)				

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Part 2: Health Goals

Category	Description	Needed?	Question	Ranking
1	Health	Yes / No	Why is your health important to you?	
			What is most important to you about your health?	
			What do you feel is important that we know about your health and well-being?	
			What do you consider healthy?	
			What does health mean to you?	
Alternative(s)				
2	Personal Goal Preference(s)	Yes / No	What would you like your healthcare team to focus on?	
			Is there anything that you would like your healthcare team to know more about?	
Alternative(s)				
3	Goals (Short Term)	Yes / No	Are you planning on seeing a health care provider anytime soon?	
			Would you like some assistance with scheduling your next visit?	
			At your next visit, what are some things you would like your doctor to focus on? (running list)	
			Is there anything that happened since your last visit that you think is important for your doctor to know about?	
Alternative(s)				
4	Goals (Long Term)	Yes / No	What are you looking to improve in relation to your health?	
			What are your goals in relation to your health?	
			Where do you want to see yourself in the short term (next 6 months to a year)?	
			Where do you want to see yourself in the long term (next xx years)?	
			What do you believe to be your optimal health? What is your goal?	
			What are the goals you have to reach in terms of your health, body, weight, etc.?	
Alternative(s)				

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Part 3: Care Preferences

Category	Description	Needed?	Question	Ranking
1	**Partnership**	**Yes / No**	How involved would you like to be in determining and managing your care/treatment?	
			How do you envision the relationship between health care providers and yourself?	
			How active would you like to be in your treatment/planning?	
			What are some things that you find to be important in the relationship between a patient and their health care provider?	
	Alternative(s)			
2	**Reflection – Patient/Provider**	**Yes / No**	When you work with health care providers, what do you think is most important to them? Is this what is most important to you?	
			How do you think your health care team would describe you? Is this who you are? How do you want them to see you?	
	Alternative(s)			
3	**Communication**	**Yes / No**	How would you like your health care team to communicate with you about your care?	
			How important is communication to you? How would you like us to communicate with you?	
			How would you like your health care provider to discuss information related to your health?	
			How detailed would you like your provider to be?	
			Language: Would you like us to communicate with a translator during your visit? Would you like the instructions that are provided to you to be in your native language and/or English?	
			What language do you prefer to read in?	
			Would a translator improve your understanding of the information?	
			How detailed would you like me to be when answering questions with a translator?	
			What is most important to you about communication with your health care provider? Or how a health care provider communicates with you?	
			How do you like to receive information? (verbal, written, videos?)	
			How do you like to communicate?	

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			How do we effectively communicate with you?	
Alternative(s)				
4	**Treatment/Care Issues**	**Yes / No**	Are there any things that bother you that you would like us to know about? (taking pills, needles, etc.)	
Alternative(s)				
5	**Care Improvement**	**Yes / No**	What are some things we can do as your health care team to make you feel more comfortable?	
			What are some things that have bothered you in previous interactions with health care providers? How can we do better?	
			What are some positive things you remember health care providers doing?	
			What are things that really stick out?	
Alternative(s)				
6	**Advanced Directive and Decision Making**	**Yes / No**	Have you completed an advanced directive?	
			Is there a person who you would like to make decisions for you? Is there a person who can decide for you?	
			We see that you have an emergency contact listed, is the person you feel safe for us to communicate with about your medical information?	
			Who should we contact if there is something going on with you?	
Alternative(s)				

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Part 4: Variation Questions

Category	Description	Needed?	Question	Ranking
1	General	Yes / No	Is there anything in your past/environment/community/etc. that you think is really important for us to know about? Anything that may impact your health or the care decisions we make?	
			IS there anything in your life that is impacting your health (physical, emotional, spiritual, mental)?	
			Is there anything that is stopping you or getting in the way of you improving your health?	
			Is there anything that is stopping you from getting healthier?	
			What are things outside of the hospital that impact your health?	
			Are there any barriers to your health that you would want your doctor to know about?	
	Alternative(s)			
2	Community	Yes / No	What are some things in your community you need or think are missing, making it more difficult to be healthy?	
			Is there anything outside of the hospital/healthcare setting that is impacting your health?	
			What are some things that would benefit your health if they were available in your environment/community?	
			Is there anything in your community that is missing that could improve your health?	
			Is there anything in your community or the area you live in (good or bad), that you think we should know about?	
			Does the community/environment you live in impact your health? This could be good or bad.	
			What are things that are impacting your health?	
			What are some things you need in your community/environment to be healthier?	
	Alternative(s)			
3	Health Care Access	Yes / No	Is it easy for you to go see your doctor?	
			What are some things that are making it more difficult to see your doctor?	
			What is stopping you from accessing care when you need it?	
			Is there anything that is stopping you from accessing care when you need it?	
			Is there anything we could do to make accessing our services easier?	
			Is there anything that is hindering you from obtaining better health?	
			Is there anything that is getting in your way of receiving your care here or in our system?	
			What is stopping you from getting great healthcare?	

Alternative(s)				
4	**Needs**	**Yes / No**	Is there anything that you need or want, that you think we could support you in getting/obtaining?	
Alternative(s)				

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Part 5: Social Determinants

Social Determinants	Question	Ranking
Family and Community Support	If for any reason you need help with day to day activities such as bathing, preparing meals, shopping, managing finances, etc. do you get the help you need? (don't need any help, I get all the help I need, I could you more help, I need a lot more help)	
	How often do you feel isolated or lonely from those around you?	
Alternative(s)		
Health Care	How difficult is it for you to see your doctor?	
	Are you having any difficulty getting your medications or going to other specialists?	
Alternative(s)		
Housing Stability	In the last 12 months, was there a time when you were not able to pay the mortgage or rent?	
	In the last 12 months, how many places have you lived?	
	In the last 12 months, was there a time wen you did not have a steady place to sleep or slept in a shelter (including now)?	
	What is your living situation today? (steady place; but I am worried; I do not have a steady place to sleep	
	Think about the place you live: do you have problems with any of the following? Pests, mold, lead paint or pipes, lack of heat, oven or stove not working, smoke detectors missing, water leaks, none of the above.	
Alternative(s)		
Education and Work	Do you speak a language other than English at home?	
	Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent?	
	Do you have a high school degree?	
	Do you have difficulty reading hospital materials – like the after-visit summary we provide after your visits?	
	What is your current work situation	
	How many different jobs have you had in the last year?	
	Do you want help finding or keeping work or a job?	

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Alternative(s)		
Food Security	Within the past 12 months, have you worried that your food would run out before you got the money to buy more?	
	Within the past 12 months, has the food you bought not been enough and you didn't have enough money to buy more?	
Alternative(s)		
Financial Resources	How hard is it for you to pay for the very basics like food, housing, medical care, and heating?	
Alternative(s)		
Safety and Environment	Are you ever worried that you might not be safe?	
	Are there any weapons kept in or around your home?	
	How often does anyone, including family and friends physically hurt you?	
	How often does anyone, including family and friends, insult or talk down to you?	
	How often does anyone, including family and friends threaten you with harm?	
	How often does anyone, including family and friends, scream or curse at you?	
Alternative(s)		
Transportation Needs	In the past 12 months, has lack of transportation kept you from any medical appointment or from getting medications?'	
	In the past 12 months has lack of transportation kept you from meetings, work, or from getting things you need for daily living?	
Alternative(s)		

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Disabilities		
	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)	
	Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)	
Alternative(s)		
Stress	Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?	
Alternative(s)		
Mental Wellbeing	Over the past 2 weeks, how often have you been bothered by any of the following problems?	
	Little interest or pleasure in doing things?	
	Feeling down, depressed, or hopeless?	
Alternative(s)		
Substance Use	How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.	
	How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?	
	How many times in the past year have you used prescription drugs for non-medical reasons?	
	How many times in the past year have you used any recreational drugs?	
Alternative(s)		
Other Topics/Questions		

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Part 6: The Concept of Successful Health Care Navigation

Question	Scale / Answer	Needed?
On a scale of 1 to 5, with 1 being very uncomfortable and 5 being very comfortable, HOW COMFORTABLE DO YOU FEEL WITH:		
Making major medical decisions.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Being seen alone for your doctor's visits.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Creating a medical summary/personal health record and maintaining this independently.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Using the MyChart Online system to communicate with your health care team.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Reading and understanding your after-visit summaries.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Reading and understanding your prescriptions	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Knowing when and how to take your medications	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Getting your prescriptions at your local pharmacy.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Contacting your health care team and asking for a refill before you run out of medication.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Getting and maintaining your health care insurance	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
***Do you have health care insurance?	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Obtaining government benefits/support (social services, housing, food stamps, etc.)	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
The concept of consent, confidentiality, and your rights as a patient.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No

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Question	Scale / Answer	Needed?
On a scale of 1 to 5, with 1 being very uncomfortable and 5 being very comfortable, HOW COMFORTABLE DO YOU FEEL WITH:		
Scheduling or canceling appointments with your primary care provider.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
*** Do you currently have a primary care provider?	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Scheduling or cancelling appointments with other doctors involved in your care	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Obtaining your medical records in case they are needed.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Informing people about your medical conditions, medications, and any other important information in case you have moved or are receiving care in a new location.	1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯	Yes / No
Question	**Scale / Answer**	**Needed?**
Please answer the following questions according to the options provided below:		
Do you have someone to contact for non-urgent medical needs?	Yes / No	Yes / No
Do you know where to go to seek emergency care?	Yes / No	Yes / No
***Where would you go to seek emergency care? (please write the name of the location in the space provided to the right)		Yes / No
Do you know what medical conditions/diseases you are currently living with?	Yes / No	Yes / No
*** If comfortable, please write those here: (please write the medical conditions you are currently living with in the space provided to the right)		Yes / No
Do you know any of the complications these medical conditions/diseases can cause?	Yes / No	Yes / No
*** If so, please write those complications here: (please write the name of the medical condition and a brief description of the complications) For example: High Blood Pressure, it can damage the heart over time if it is not lowered.		Yes / No
Question	**Scale / Answer**	**Needed?**

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Please answer the following questions according to the options provided below		
Do you have access to online resources to learn more about your medical conditions?	Yes / No	Yes / No
Would you like us to provide you with some more resources?	Yes / No	Yes / No
What are the names of the medications you are taking? (please write the # of pills you are supposed to take and the time of day that you take it) For example: Water Pill, 2 pills/morning and night	1. 2. 3.	Yes / No
What are each of your medications for? (please write the name of the medication and what it is for) For example: Furosemide – this is a pill to get rid of some of the extra water in my body.	1. 2. 3.	Yes / No
Are you having any difficulty with getting a part-time or full-time job?	Yes / No	Yes / No
Do you have someone who you can speak with about questions or concerns related to school or work?	Yes / No	Yes / No
*** Would you like us to find someone to speak with you about this?	Yes / No	Yes / No
Do you have someone to speak with about college, job training, or vocational programs?	Yes / No	Yes / No
*** Would you like us to find someone to speak with you about this?	Yes / No	Yes / No