



Client Contact Form

Pathfinders, Project #2

CHA Name: _____

NOTE: Complete every time you talk to a woman or talk to someone on her behalf.

Contact Information	Client's Name: _____		Phone# _____		ID#: _____			
	Attempts to Contact by Phone (Date, Time, Call Result) Example #1: 1/2/00, 8:00pm, Message left Example #2: 1/2/00, 8:00pm, No Answer NOTE: Home visit if "no contact" after a minimum of 5 call attempts.							
	1) _____			6) _____				
	2) _____			7) _____				
	3) _____			8) _____				
	4) _____			9) _____				
	5) _____			10) _____				
	Reason for Contact							
	<input type="checkbox"/> Administer pre-survey		<input type="checkbox"/> Remind her of appointment		<input type="checkbox"/> Administer survey		<input type="checkbox"/> Check if she kept appointment	
	<input type="checkbox"/> Provide consultation/referral information		<input type="checkbox"/> Other(specify): _____					
Contact Details								
Contact Date: _____			Contact Time: _____					
Contact To / From (circle one): _____								
Contact Type: <input type="checkbox"/> Phone or <input type="checkbox"/> In Person (specify location): _____								
Total Time with Client*:		Travel Time*:		Expenses:				
Hours	Minutes	<input type="checkbox"/> Travel Only No Contact	Hours	Minutes	Mileage	Parking		

Contact Outcome	Appointment Information	
	Appointment date: _____ Time: _____ Clinic: _____	
	Appointment kept?: <input type="checkbox"/> Yes <input type="checkbox"/> No, why? _____	
	<input type="checkbox"/> Cancelled <input type="checkbox"/> Rescheduled appt, date/time _____	
	Date to give reminder call**: _____ Date to check if appointment was kept**: _____	
	Consultation	
	<input type="checkbox"/> A. Consumer skills (blue/green/pink/yellow)	
	<input type="checkbox"/> D. Appointment Magnet	
	<input type="checkbox"/> Abnormal Pap Education	
	<input type="checkbox"/> Other (specify): _____	
Referrals		
<input type="checkbox"/> B. Transportation <input type="checkbox"/> AC Transit Voucher		
<input type="checkbox"/> C. Child care		
<input type="checkbox"/> I. Mental Health		
<input type="checkbox"/> J. Alcohol abuse		
<input type="checkbox"/> K. Substance abuse		
<input type="checkbox"/> L. Domestic violence		
<input type="checkbox"/> M. Sexual abuse		
<input type="checkbox"/> V. HIV/AIDS		
<input type="checkbox"/> Other (specify): _____		
Outreach Plan		

* See Reverse
**Enter Dates in calendar book

Contact Notes & Comments

*** Prolonged Contact or Travel Times**

Please explain any unusually long contact times due to interruptions, delays, long waits or other reasons.

General Comments