Client ID: _____

Women's Health Outcome Summary

Admission ID: _____

Client's name *(first, middle, last)* _____ Maiden name _____

Client alias _____ Alias Client ID _____

Birth date ____/____/____ Social Security # _____

Street address _____ Apt# _____ County _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Message phone _____ Message place _____ Message contact _____

Emergency contact _____ Phone _____ Relationship _____

Discharge date: _____/_____/_____

Primary Payment Source: *(enter option from payment source table below)* _____

Payment source:
(check all that apply)

☐ county funds	☐ Medipass	☐ SSI	☐ other
☐ eligible/not receiving Title XIX	☐ OB indigent	☐ Title V	specify _____
☐ HawkI	☐ presumptive eligibility	☐ uninsured	
☐ Medicare	☐ private insurance	☐ unknown	
☐ Medicaid/Title XIX	☐ self-pay/sliding scale	☐ non-billable	

Does client have a primary medical care provider? (medical home) ☐ yes ☐ no ☐ unknown

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

	Name	Date
Outcome form completed by:		
Data entered by:		
Quality assurance inspection:		