

DREAM Atlanta CHW Intervention– ENCOUNTER REPORT

PARTICIPANT UID: _____

CHW NAME: _____

CLINIC SITE: _____

ENCOUNTER DATE: ____ / ____ / ____
MM DD YYYY

ENCOUNTER TIME: ____ : ____ ____
HH MM AM/PM

ENCOUNTER TYPE: ☐ In-Person ☐ By Phone

Check any boxes if relevant and describe what occurred or what was discussed.

- ☐ Participant requested health information ☐ Participant requested a referral or service
- ☐ Participant reported or was measured to have very high or low blood sugar / very high blood pressure
- ☐ Participant reported an illness, a new diagnosis, a medical procedure, or hospitalization ☐ Other

Describe: _____

Describe the actions taken or recommendations provided by the CHW. _____

Describe the outcome. _____

FOLLOW-UP

Describe any necessary follow-up or any follow-up that was provided. _____
