FARMACY

Patient Eligibility Screening Tool

For FARMacy program staff use only:

Participant Name:_____ Participant MRN #:_____

Date (MM/DD/YY): _____/_____/_____ WVU Extension ID #_____

County where FARMacy is held: _____ Name of Clinic/Site_____

1. Have you participated in a FARMacy program before? Yes ☐ No ☐

2. Please list the patient's chronic disease diagnoses (check all that apply):

Asthma ..... ☐
COPD ..... ☐
Heart disease ..... ☐
High blood pressure ..... ☐
Lipid metabolism disorder ..... ☐
Obesity ..... ☐
Prediabetes ..... ☐
Type 2 diabetes ..... ☐
Other (list):_____ ☐

Next I am going to read/have you read two statements. Please tell me if they were often true, never true or sometimes true.

3. "There were times during the past 12 months when we worried our food would run out before we had money to buy more."

Often true ..... ☐
Sometimes true ..... ☐
Never true ..... ☐

4. "There were times during the past 12 months, when the food we bought just didn't last and we didn't have money to get more."

Often true ..... ☐
Sometimes true ..... ☐
Never true ..... ☐

5. Being part of the FARMacy program means you are eligible to come to the FARMacy every week for 15 weeks. We also ask that you participate in 6 nutrition education/cooking sessions, complete at least 4 surveys and have measurements taken such as body weight, A1c, blood pressure and lipids via a finger stick or blood draw.

   Are you willing to commit to these parts of the program? Yes ☐ No ☐

6. What challenges do you face in participating in all sessions of the FARMacy program and nutrition education program? (check all that apply).

   Transportation ..... ☐
   Work schedule ..... ☐
   Child or dependent care ..... ☐
   Scheduled vacation ..... ☐
   Other (list)_____ . ☐