

FARMACY X

Patient Eligibility Screening Tool

For FARMacy program staff use only:

Participant MRN #: _____ WVU Extension ID #: _____

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

Name: _____

Date: __/__/____

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) _____