



WISEWOMAN Medical Care Case Management Form

Date _____

Agency Name		MBCIS ID	
Last Name	First Name	Middle Initial	Birth Date

Reason for Medical Care Case Management: Alert Blood Pressure Alert Glucose
 Alert Total Cholesterol

Client Status: Attended Diagnostic Exam on _____.
 Missed Diagnostic Exam (**Document attempts at follow-up below.**)
 Unable to contact client
 Client refused to follow through with referral

What type of treatment was prescribed? (Check all applicable boxes and describe treatment in the space provided.)

Medication _____

Therapeutic lifestyle changes _____

Other treatment _____

- Client already on medication – No medication changes
- No treatment prescribed by provider

Attempts at follow-up:

Case Manager Signature _____ **Date** _____

This form must be completed and mailed within 10 business days AFTER the Diagnostic Exam to:

Michigan Department of Community Health
ATTN: WISEWOMAN Program
P.O. Box 30195
Lansing, MI 48909