Illinois Breast and Cervical Cancer Program
Clinical Navigation Barrier Assessment

Name: _____ **Cornerstone #:** _____ **Birth Date:** _____

Complete for ALL clients that are Clinical Navigated-Insured:
Assessment Date: _____/_____/_____

1. Do you have communication difficulties? ☐ Deaf ☐ Blind ☐ Other Handicap ☐ None
2. Do you speak English? ☐Yes ☐ No If no, primary language: _____
3. Do you read/write English: ☐Yes ☐ No
4. Barriers to keeping appointments:
   ☐Transportation ☐ Child/family care ☐ Work schedule ☐ Understanding medical needs ☐ None
   ☐ Lack of money ☐ Lack of interpreter ☐ Travel Distance ☐ Making appointments ☐Other: _____
5. What concerns do you have?
   ☐ Discomfort/pain ☐ Embarrassment ☐ Fear of cancer ☐ Overwhelmed by information ☐ Other: _____
   ☐ None

Comments:_____
_____
_____

See Case Notes ☐ In chart ☐ In Cornerstone

Complete for clients with abnormal screening results:
Assessment Date:_____

6. Do you have someone you can talk to? ☐Yes ☐ No
7. If needed, do you have someone to help around the house? ☐Yes ☐ No
8. If you have several appointments for testing or treatment, will you need transportation assistance? ☐Yes ☐ No
9. Would you like to belong to or participate in a support group? ☐Yes ☐ No
10. What concerns do you have?
    ☐Discomfort/pain in procedure ☐ Overwhelmed by information ☐ Relationship with family/friends
    ☐ Loss of employment ☐ Body image (alteration in body) ☐ Feelings or anger, sadness
    ☐ Fear of cancer ☐ None ☐ Other: _____

Comments:_____
_____
_____

See Case Notes ☐ In chart ☐ In Cornerstone

Client education and support:

☐ Assistance with scheduling appointments: _____ Date: _____
☐ Transportation arrangement: _____ Date: _____
☐ Child care/adult day care arrangements: _____ Date: _____
☐ Arrangements made for interpreter: _____ Date: _____
☐ Referred to fiscal department or hospital foundation at: _____ Date: _____
☐ Referred to Social Services for counseling/support: _____ Date: _____
☐ Referred to treatment services (please list the agency/organization referred to)_____ Date:_____

Referral or contact information provided for

☐ Reach to Recovery ☐ Cancer Information Services (CIS) ☐ American Cancer Society (ACS)
☐ Cancer Care/ Avon Cares ☐ Patient Advocate Foundation ☐ Gilda's Club
☐ Lynn Sage ☐ Migrant Clinicians Network ☐ Other_____

Comments: _____
_____
_____

***There must be a minimum of two contacts with client.**

Nurse Clinical Patient Navigator Signature: _____ **Date:** _____