

Health Liaison Notes Sheet

Your Name: Health Liaison _____

Date: _____

Disclaimer: Health Liaisons do not diagnose or provide medical treatment. You do not need to ask sensitive questions.

Overview

<i>Health Liaison Contact Name:</i>	_____
<i>Relation:</i>	_____
<i>Reason for Selection:</i>	
<i>Age:</i>	_____
<i>Gender:</i>	_____
<i>Health Goal:</i>	Their health goal while working with you as their health liaison:
<i>Family History:</i>	
<i>Medications/vitamin supplements:</i>	
<i>Allergies:</i>	

Independence

Activities of Daily Living (ADLs)

examples: bathing, dressing, toileting, feeding, getting in and out of bed or chair, etc.

Are they independent in their ADLs?

☐ yes ☐ no

Additional Notes:

Instrumental Activities of Daily Living (IADLs)

examples: Managing finances, Shopping for groceries, Preparing meals, Doing laundry, Housekeeping, Taking medications, using transportation, etc.

Are they independent in their IADLs?

☐ yes ☐ no

Additional Notes:

Social History

Home:

(Do they live alone, with others, in an apartment, etc.)

Employment:

(Are they retired or working, what do/did they do?)

Hobbies/Interests:

Include any additional notes as you feel necessary

Physical

(Most recent lab work report. If they don't know, that's ok, encourage them to look into it!)

- **Blood Pressure:** _____ mmHg
- **Blood Sugar (HbA1c):** _____ %
- **Total Cholesterol:** _____ mg/dL
- **BMI:** _____ kg/m² _____ range per WHO*

To find BMI, ask for:

- Weight: _____
- Height: _____

Lifestyle

- **Alcohol:** How many alcoholic drinks per week?
 - **Smoking:** How frequently do they smoke per week?
 - **Aerobic Activities:** Do they get at least 150 minutes of moderate physical activity (ex. walking) or 75 minutes of high intensity physical activity per week?
 - **Sleep:** Any sleep disturbances/disorders? How many hours of routine sleep per night?
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Nutrition

Do they fulfill these dietary habits?

- ☐ 4.5 servings of fruit (~2 cups) and vegetables (~2.5 cups) per day
- ☐ 2 servings (~5.5 oz) of lean protein per day
- ☐ 3 or more servings of whole grains (3-6 oz) per day
- ☐ Less than 1,500 mg (~2/3 tsp) of sodium per day
- ☐ Less than 6 tsp (women) to 9 tsp (men) of added sugar per day (sugar sweet beverages like soda, dessert, etc.)

Source: American Heart Association

Has there been anything bothering them? This could include physical discomfort, stress, or other factors.

Finish!

Reflection

Review

Put together what you think are key findings, strengths, and areas for growth or concern. Use this reflection to discuss:

Plan

Think about changes in knowledge on health topics or changes in behaviors to be healthier. Create plans together to help achieve their goals with education, follow-ups, resources, or changes to their lifestyle based on the review:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Next meeting date: _____