Prevention Matters

Los Angeles County Department of Health Services
Office of Women's Health
1-800-793-8090
www.ladhs.org/owh

Community Partner Questionnaire

Organization_____

1. **What types of services do you provide for women?**
   a) Clinical Services ( ) Yes ( ) No
   b) Health Education & Training ( ) Yes ( ) No
   c) Referral & Information ( ) Yes ( ) No
   d) Mental Health/Counseling Services ( ) Yes ( ) No
   e) Advocacy ( ) Yes ( ) No
   f) Policy ( ) Yes ( ) No

   Other:_____

   Estimated # of women seen per year: _____

2. **Does your agency provide services in languages other than English?** ( ) Yes ( ) No

   Additional languages: _____

3. **Do you have health educators on your staff?** ( ) Yes ( ) No

4. **Do you utilize Promotoras de Salud?** ( ) Yes ( ) No

5. **Does your agency use volunteers?** ( ) Yes ( ) No
   If yes, as educators?____ as outreach workers? ____

WAYS WE CAN PARTNER:

1. **In what specific ways can the Office of Women's Health assist your agency in providing education and services for women?**
   1. Providing Multi-lingual Educational Materials ( ) Yes ( ) No
   2. Educational Presentations for Patients ( ) Yes ( ) No
   3. Educational Presentations for Staff ( ) Yes ( ) No
   4. Writing an article for your newsletter ( ) Yes ( ) No
   5. Providing Clinical Referrals ( ) Yes ( ) No
   6. Bringing the mobile clinic to your site ( ) Yes ( ) No
   7. Promoting your activities on the OWH website ( ) Yes ( ) No
   8. Other, Please List:_____
      _____

2. **Do you provide health education classes? ( ) Yes ( ) No If yes, on what topics?**

_____

_____

Organization_____

WAYS WE CAN PARTNER (con't):

3. Will you distribute educational materials? ( ) Yes ( ) No

If yes, which topics?
heart disease ___ diabetes ___ breast cancer ___ cervical cancer ___ ovarian cancer___
lung cancer___ colorectal cancer ___ osteoporosis___ menopause___ arthritis___
depression/anxiety___ stress management ___ weight & fitness ___ nutrition ___
domestic violence ____ other_____

What language(s)? _____

4. Which of the above do you produce that you can provide to the OWH?

_____

_____

What language(s)? _____

5. Do you provide translation/proofreading services? ( ) Yes ( ) No

What language(s)? _____

6. The OWH is planning a series of community dialogues for which medical experts will provide important women's health information and create a "dialogue" with providers and members of the community regarding their health concerns. **Would your agency like to coordinate a community dialogue with the OWH?** ( ) Yes ( ) No

Preferred language for the dialogue: _____

Preferred topic(s) _____

7. Does your agency have facilities available for presentations? ( ) Yes ( ) No

Facility Capacity_____ TV ___ VCR___ LCD Projector___ Slide Projector___

8. The OWH is developing a Speaker's Bureau to coordinate speakers for community dialogues as well as community requests for speakers.
Can you provide speakers on health topics? ( ) Yes ( ) No

If yes, what topics? _____

What language(s)?: _____

9. Can you publicize or promote OWH community events? ( ) Yes ( ) No

10. The OWH is developing the *Prevention Matters* campaign with an emphasis on heart health and will be asking community agencies for their feedback on the campaign message and materials.
Would you like to be included in a heart health focus group? ( ) Yes ( ) No

11. Do you promote heart health? ( ) Yes ( ) No
If yes, please indicate how: ___clinical services ___ education ___advocacy

12. Who is your target population(s)? _____

Organization_____

IF YOU PROVIDE CLINICAL SERVICES:

1) **Hours of service** _____

2) **What preventive services does your agency provide for women?**
   Comprehensive screenings (blood pressure, cholesterol, diabetes) ____
   Pap test___ Clinical Breast Exam____ Mammograms: On site___ referred___
   Other_____

   Services are performed in: office____ clinic___ hospital____

3) **Is the Pap test offered to your patients as part of their routine physical examination?**
   ( ) Yes ( ) No

4) **Are you a Provider for:**
   Family PACT ( ) Yes ( ) No
   Breast and Cervical Cancer Treatment Program (BCCTP) ( ) Yes ( ) No
   Cancer Detection Program: Every Woman Counts? ( ) Yes ( ) No
   a) Breast services only? ( ) Yes ( ) No
   b) Breast & cervical cancer services? ( ) Yes ( ) No

5) **Do you provide services to patients with:** health insurance? ___ Medi-Cal?___ Medicare?___
   For no charge?___ on a sliding scale basis?___ on a fee-for-service basis? _____

6) **Do you have a female physician/nurse practitioner available?** ( ) Yes ( ) No

7) **Do you provide medical services in Spanish?** ( ) Yes ( ) No

8) **Do you provide medical services in other languages?** ( ) Yes ( ) No

   If yes, what languages:_____

9) **Is your agency interested in receiving clients from the OWH?** ( ) Yes ( ) No
   If yes, please indicate for what services:
   Pap testing and follow-up ____
   Clinical Breast Exams, Mammograms, and follow-up ____
   Preventive Services, i.e. screening for cholesterol, blood pressure, diabetes, etc. ____
   General Medical Referrals ____
   Specialty Referrals ____ Please list specialties: _____
   Other: _____

10) **If the client provides a medical release form, will you provide result data on screenings of clients referred by the OWH?** ( ) Yes ( ) No

   If no, why not? _____

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CONFIRMATION OF COMMUNITY PARTNERSHIP

_____**Yes**, please confirm our participation as a Community Partner in the *Prevention Matters* campaign.

_____We are not interested at this time.

Name of Organization_____

Executive Director _____

Contact Person_____

Mailing Address_____

City_____Zip Code_____

Direct Phone (_____)_____Fax (____)_____

Email Address_____

Website _____

Signed By:

Name_____

Title_____ Date_____

If you have any questions, please contact Esther McDowell, Outreach Manager at 626.569.3823

PLEASE FAX THIS FORM WITH THE COMPLETED QUESTIONNAIRE TO

FAX: 626. 288.9335

If you know someone who may be interested in becoming a community partner, please pass this on.