

HEALTH COORDINATOR MONTHLY REPORT FORM

Name of Site: _____

Month _____ **Year** _____ **Ward** _____

Date of Activity _____ **No. of Hours** _____ **No. of Attendees** _____

A. Health Information Disseminated:

Topic: _____ **How Many:** _____

Topic: _____ **How Many:** _____

Topic: _____ **How Many:** _____

B. Health Screenings Provided:

1. _____ **How Many:** _____

2. _____ **How Many:** _____

3. _____ **How Many:** _____

C. Discussion Topic, Presenters, if any:

Name _____ Title: _____ Topic _____ Organization _____

Name _____ Title: _____ Topic _____ Organization _____

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D. Referrals

Referral Made	Organization Referred to	Multidisciplinary Team Partner		Reason for Referral	Status of Referral
		Yes	No		

Describe how the activity/event increased access to and/or awareness of community prevention health services that help manage chronic diseases especially diabetes, cardiovascular disease, stroke, and/or hypertension.

Successes _____

Challenges _____

Please indicate any technical assistance needs _____

Next Activity Planned: _____ **Date** _____

Signature of Authorized Representative **Date**

Contact Number _____