Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#10. ENCOUNTER/BILLING FORMS

Adolescent encounter (*MON 8*)
Baseline information form (*BAL 11*)
Bill coding form (*TER 2*)
Bill coding form (*TER 2R*)
Bill coding form (*COT 8*)
Client encounter report (*HIP 7*)
Client visit data collection (*TRA 4*)
Encounter form (*HPH 11*)
Encounter form (*WAI 2*)
Encounter form (*WAI 3*)
Encounter record (*COT 1*)
Encounter record (*BAL 3*)
Encounter record (*BAL 3R*)
Financial assessment/sliding fee assignment (*CAM 2*)
Immunization encounter report (*HIP 6*)
Intake/encounter form (*SEA 1*)
Medical team encounter record (*BAL 28*)
Mental health/substance abuse encounter form (*POR 7*)
Mental health team encounter record (*BAL 46*)
Outreach encounter record (*BAL 29*)
Pediatric encounter form (*HIP 2*)
Pediatric encounter form (*MON 13*)
Social work daily encounter form (*COT 5*)
Telephone record (*MON 5*)

MON 8

MONTEFIORE

N.Y. CHILDREN'S HEALTH PROJECT
DIVISION OF COMMUNITY PEDIATRICS

ADOLESCENT ENCOUNTER

NAME: LAST FIRST

MR NUMBER |__|__|__|-|__|__|-|__|__|__|-|__|__|__| ACCT. #

Social Security No. |__|__|__|-|__|__|-|__|__|__|__| DATE

PARENT'S NAME: (LAST) (FIRST)	MOTHER'S DOB	MOTHER'S SOCIAL SECURITY #

DATE OF BIRTH	SEX OF PT. MALE FEMALE	PLACE OF SERVICE/RES. |__|__|	Med\C NUMBER	

ADDRESS: (STREET) (CITY) (ZIP) ___DOMICILE ___HOMELESS	PHONE NUMBER	RACE ___ ___

CURRENT HOUSING STATUS ?	___HOMELESS: ___SHELTER ___COVENANT ___FRIENDS ___STREET ___SQUAT ___FAMILY	___DOMICILED: ___OWN APT/ROOM ___FAMILY

Have you seen another provider since your last visit? (Including E.R. and hospital) _____ No _____ Yes When: _____
Where? _____

CHIEF COMPLAINT	
HISTORY OF PRESENT ILLNESS	

MENSTRUAL HX	LMP		DURATION	
CONTRACEPTION HX	PRESENTLY USING:			LAST TIME USED:

SUBSTANCE ABUSE HX	TYPE	QUANTITY\FREQ:	LAST USE?
TOBACCO			
ETOH			
DRUGS			

VITAL SIGNS	WT:	HT	PULSE	RESPIRATORY	BP

CHECK IF NORMAL		DESCRIBE ABNORMALITY	CHECK IF NORMAL		DESCRIBE ABNORMALITY
Appearance			Lymph Node		
Head			Abdomen		
Eyes			Pelvic		
Ears			Genitalia		
Nose			Rectum		
Throat			Neuro		
Mouth			DTR		
Neck			Tone		
Lungs			Muscles		
Breast			Bones/Joint		
Heart			Spine		
Pulses			Skin		
			Nails/Hair		

ADOLESCENT ENCOUNTER

CODE	DIAGNOSIS/PROBLEM	CHR	RES	AC
626.0	Amenorrhea / Oligomenhea			
285.9	Anemia			
789.0	Abdominal Pain			
493.9	Asthma			
706.1	Acne			
691.8	Atopic Dermatitis			
490	Bronchitis			
785.2	Cardiac Murmur			
372.3	Conjunctivitis			
786.2	Cough			
564.0	Constipation			
V06	Delayed Immunization			
PDI	Provider DelayedImmunzation			
311	Depression			
521.0	Dental Caries			
558.9	Diarrhea			
625.3	Dymenorrhea			
984.9	Elevated Lead			
783.4	FTT/Underweight			
V25.09	Family Planning			
009.0	Gastroentritis			
784.0	Headache			
HR	Health Risk:			
401.9	Hypertension			
550.9	Iguinal Hernia			
112.3	Moniliasis			
075	Monoucleosis / Infectous Mono.			
278.0	Obesity			

NAME : LAST FIRST

MR # 900-|___|___|-|___|___| - |___|___|

CODE	DIAGNOSIS/PROBLEM	CHR	RES	AC
382.9	Otitis Media-Effus-Acute			
381.3	Otitis Media-Effus-Chronic			
462	Pharyngitis/Tonsilitis			
486	Pneumonia			
422	Pregnancy (suspected)			
V22.2	Pregnancy			
782.1	Rash (Non-specific)			
447.9	Rhinitis			
133	Scabies			
315.2	School / Learning (Problem)			
S S	Special Studies			
099.8	Sexually Transmitted Disease:			
	Chlamydia			
	G.C.			
	Syphilis			
305.9	Substance Abuse			
112.0	Thrush			
110.9	Tinea Infestation			
959.9	Trauma			
011.9	Tuberculosis			
	T B Exposed			
465.9	Upper Respetory Infection			
599	Urinary Tract Infection			
616.10	Vaginitis			
052.9	Varicella			
783.2	Weight Loss			
V20.2	Health Maintenece\Well Child			
	Other:			

Visit Type | WELLCHILD/PREVEN | ACUTE VISIT | FOLLOW-UP | NURSE VISIT | INITIAL VISIT | OTHER

IMMUNIZATIONS

	DPT		MMR		Hep B						
	Td		IPV		TETRAMUNE						
	TOPV		IPPD		IPV						
	IPV		HIB								
	OTHER :										

LAB

	HgB		cap lead		G.C.						
					Chlamydia						
	CBC		Venous Lead		Hep Screen						
					PAP						
	Throat culture		urine cult		VDRL						
					Chemistry						
			Urinalysis								
	Hcg :										

MISCELLANEOUS

	Counseling		Vision screen								
	P E Form		Hearing screen								
	W I C Certif.		Tympanometry								
	Letter		Wound Care								
	Med		Suture Removal								
	E.R. F/U		Other:								

ASSESSMENT / PLAN :

REFERRAL	TO	REASON	APPT. DATE

Signed: ✗

BAL 11

Date _____ HCH # _____

☐ New ☐ Update

HEALTH CARE FOR THE HOMELESS, INC.
BASELINE INFORMATION

So that we can help you get care, please answer these questions as best you can

Last Name_____ **First Name**_____ **MI**_____ **Jr. Sr. III** *(Circle)*

Alias (AKA)_____ **Date of birth**_____ **Social Security #** _____--_____--_____

Sex *(Check one)* ☐ Male ☐ Female

Race *(Check one)* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Education *(Check off on the ONE that best describes the highest level completed)*

☐ None ☐ Grade school ☐ Some high school ☐ High school grad / GED
☐ Vocational / Tech School ☐ Some college ☐ College grad

Father's full name (First Name, MI, Last Name) _____

Mother's maiden name (First Name, MI, Last Name) _____

Where were you born? City _____ State (If U.S.) _____

Country (If outside U.S.) _____

What is your marital status? *(Check one)* ☐ Single ☐ Married ☐ Separated/Divorced/Widowed ☐ Unknown

How many children do you have? _____ How many under 18 years old? _____ How many stay with you? _____

Do you have any relatives or friends in Baltimore? *(Check one)* ☐ Yes ☐ No ☐ Unknown

Are you currently living ... *(Check one)* ☐ By yourself ☐ With a partner ☐ With family **# of family members** ____

Where did you spend last night? *(Check one)* ☐ Shelter ☐ Street ☐ Hospital ☐ Jail/Prison ☐ Friend
☐ Relatives ☐ Detox ☐ Other ☐ Unknown

Current address _____ ☐ None
Address City State Zip

Phone number _____

Mailing address _____ ☐ None
Address City State Zip ☐ Same as above

How long have you been in Baltimore? *(Check one)* ☐ Less than 1 month ☐ 1-5 months ☐ 6-12 months
☐ 1-5 years ☐ More than 5 years ☐ Unknown

See reverse side →

PATIENT NAME | BIRTHDATE

ADDRESS

CITY, STATE, ZIP

Terry Reilly Health Services
BOISE CLINIC
848 La Cassia • Boise, Idaho 83705
(208) 344-3512 IRS 82-0300537

TER 2
28549

DATE OF SERVICE | CLINICIAN | APPT. TIME

NEW PATIENT ☐ | INSURANCE AND NUMBER | PROVIDER(S) KEY | CONS. KEY

☐ Patient To Wait **IN HOUSE LABORATORY**

KEY	SERVICE	FEE
☐ C0015	Sample Processing	
☐ C4001	CBC	
☐ C4007	Differential	
☐ C0004/C0014	Hematocrit	
☐ C3005	Sed Rate	
☐ C0533	Prothrombin Time	
☐ C3010	Glucose-One Touch	
☐ C3000	Glucose	
☐ C3001/C3100	Glucose 1 hr/3 hr	
☐ C3003	Bilirubin-neonatal	
☐ C3002	Cholesterol	
☐ C0300	Potassium	
☐ C5001	EIA Preg Test	
☐ C4002/C4004	UA Dipstick / OB	
☐ C4003/C9003	UA Micro / OB	
☐ C3006/C9006	Urine Culture / OB	
☐ C3007	Throat Culture	
☐ C3009	Strep Screen	
☐ C3011	Mono Test	
☐ C3008/C3018	GC Culture / OB	
☐ C3012	Chlamydia	
☐ C3015	Wet Prep	
☐ C3004/C0014	Stool-Occult Bld 1 / 3	
☐ C4012	PKU Collection	
☐ C6001/C6002	TB PPD	
☐ _____	_____	

OUTSIDE LABORATORY

☐ S6246	Glycohemoglobin	
☐ S1100	PAC 1	
☐ S1000	PAC 2	
☐ S8223	PAC 10- Prenatal	
☐ S1108	PAC 20	
☐ _____	PAC ___	
☐ S896	Pap Smear /	
☐ C810	Collection	
☐ S1773/C6006	HIV / State	
☐ S616	Serology-RPR	
☐ S700	Herpes Culture	
☐ _____	Culture ___	
☐ C9015	Culture Handling	
☐ _____	_____	
☐ _____	_____	

SPECIAL PROCEDURES

☐ 11100	Biopsy, Skin	
☐ _____	Cast _____	
☐	Plaster	
☐	Synthetic	
☐ 69210	Ear Irrig.	
☐ 93000	EKG	
☐ _____	Excision _____	
☐	_____	
☐ _____	I&D _____	
☐ 17340	Liq. Nitrogen	
☐ 59025	Non-Stress Test	
☐ 9910M/11975	Norplant Kit/Implant	
☐ 11976	Norplant Removal	
☐	Suturing	
☐	Loc/Lg/Comp	
☐ _____		

SUPPLIES

☐ 1112/1113	Surg. Tray Sm/Lg	
☐ 99070	_____	

MEDICATIONS: (PH) ☐ SPANISH LABEL

	CODE	FEE	CODE	FEE

OFFICE VISITS

CPT/KEY		FEE
☐ 99201	New Prob Foc	
☐ 99202	Exp Hist	
☐ 99203	Det Hist	
☐ 99204	Comp Hist	
☐ 99205	Comp Hist-High	
☐ 99211	Est. Min Visit	
☐ 99212	Prob Foc	
☐ 99213	Exp Hist	
☐ 99214	Det Hist	
☐ 99215	Comp Hist	

PHYSICAL EXAMS

☐ 99381	Infant, New	
☐ 99391	Infant, Est	
☐ 9938__	School, New	
☐ 9939__	School, Est	
☐ 102	Ins, ICC, New	
☐ 103	Ins, ICC, Est	
☐ 0900__	EPSDT	

OB CARE

☐ 59400	OB Package	
☐ 100	PN Workup	
☐ 101	Ltd Visit	

SURCHARGES

☐ 99050	After Hours	
☐ 99052	Night	
☐ 99054	Sun/Holiday	

SPECIAL SERVICES

☐ HE	Health Ed	
☐ ___	Nutr.	
☐ ___	_____	
☐ ___	_____	

PSYCHIATRY/MENTAL HEALTH

☐ ___	_____	
☐ ___	_____	
☐ ___	_____	

VACCINES

☐ 90701	Imm-DTP	
☐ 90702	Imm-DT (Ped)	
☐ 90718	Imm-Td (Adult)	
☐ 90707	IMM-MMR	
☐ 90712	Oral Polio	
☐ 90724	Imm-Influ	
☐ 90732	Imm-Pneum	
☐ 90737	HIB	
☐ 90782	Therapeutic	
☐ 90788	Inj-Antib	
☐ INJ	_____	

ULTRASOUND

☐ 76805	Fetal, Complete	
☐ _____		

X-RAY

		FEE
☐ _____		
☐ _____		

NURSING ORDERS:

DIAGNOSIS: (CIRCLE)

Abdominal Pain	HEPatitis
Abscess/Cellulitis	HERnia, Hiatal
Acne	HERnia, Inguinal
ANemia, Iron def	HIVes
ANGina pectoris	HYPertension
ANXiety	HYperthyroidism
ARTerioscierosis	HYPOthyroidism
ARTHritis, Osteo	Immunization
ARTHritis, Rheumatoid	IMPetigo
ASThma	INFluenza
Back pain, unspec	Laceration_____
BRONchitis	Lipoma Benign
BRONChialitis	Menopausal Symptoms
CERVicitis	Menstr. Disorders
Chest Pain	Mononucleosis
CHLAMYdia	Neuralgia
CHOLelithiasis	Obesity
COLitis	OSTeroporosis
CONcussion, unspec	Otitis, Externa
CONJunctivitis, unspec	Otitis, Media
COPD	Otitis, Serous
CRoup	Parkinsonism
Cyst, Ganglion	Pelvic Inf Dis
Cust, Sebaceous	PHaryngitis
Cystocele W/o prolapse	Physical Exam
Depression	PNeumonia
DERMatitis	Post Partum Check
Diabetes Mellitus	PregnanCy
Diarrhea, unspec	Rash
Emphysema	SCABies
EPistaxis	SEIZure disorder
Family Planning	Sinusitis, Unspec
Fatigue	Sprain, Ankle
Fibrocystic Breast	Sprain, Neck
Gastritis & Duodenitis	Strain, Back
GASTroenteritis	SYNcope
GONorrhea	Tendonitis
Gout	THRUsh
Hay Fever	TONsillitis
Head Injury	Ulcer Peptic
Headache, Migraine	Upper Resp Inf
Headache	URethritis
Heart Dis., Arrhythmia	Urinary Tract Inf
Heart Dis., ARteno	Vaginitis, gardenerella
Heart Dis., C.F.	Vaginitis, Monilial
Heart Dis., Ischemia	Vaginitis, Trichomon.
Heart Dis., M.I.	Varicose Veins
Heart Dis., Rheumatic	Warts, Viral
HEmorrhoids	Well Child Care
	Wound, Puncture

OTHER DX:

☐ **Family Planning Enc.**

TODAY'S CHARGES	TOTAL ADJUSTED CHARGES	AMOUNT COLLECTED

RTC | CL | REASON?

YOUR NEXT APPOINTMENT

Time ____ : ____ AM PM Date ____ / ____ / ____

Clinician _____

CLINIC 1

ATTN: MEDICARE PATIENT
DO NOT USE this bill for claiming Medicare benefits
A claim will be submitted on your behalf

TER 2R

PATIENT NAME	BIRTHDATE	Terry Reilly Health Services BOISE CLINIC 848 La Cassia • Boise, Idaho 83705 (208) 344-3512 IRS 82-0300537	NO.
ADDRESS			
CITY, STATE, ZIP		DATE OF SERVICE / CLINICIAN / APPT. TIME	
NEW PATIENT ☐	INS & NUMBER	PROVIDER KEYS	CONS KEY

✓	Code	Description	Fee
		NEW PT, EVAL/MGMT	
	99201	Prob Focused	
	99202	Expanded Prob Foc	
	99203	Detailed	
	99204	Comprerv/Mod Complex	
	99205	ComprenHigh Complex	
	99058	Ofc Emergency Basis	
	Above	Outside OB package	
	101	Routine, OB Pkg	
	101	3 wk Postpartum	
	101	6 wk Postpartum	
	99354	Prolonged 1st 31-60 min after E/M	
	99355	ea addt'l 30 min	
	99401/02	Counseling 15 min/30 min	

✓	Code	Description	Fee
		EST PT, EVAL/MGMT	
	99211	Min/Supervised Nrsg	
	99212	Prob Focused	
	99213	Expanded Prob Foc	
	99214	Detailed/Mod Complex	
	99215	Compren/Hig Complex	
		PREVENTIVE CARE	
		(Must have wellness DX)	
	NEW	EST	
	99381	< 1 yr 99391 —	
	99382	1-4 yrs 99392 —	
	99383	5-11 yrs 99393 —	
	99384	12-17 yrs 99394 —	
	99385	18-39 yrs 99395 —	
	99386	40-64 yrs 99396 —	
	99387	> 65 yrs 99397 —	

✓	Code	Description	Fee
		MENTAL HEALTH	
	90862	Pharmacologic Mgmt -PSY	
	90801	Psy Diagnostic Interview	
	M0601	Testing - — qtr hr units (SW)	
	90841	Therapy, Ind - —Qtr hr units	
	90842	<90 min — 90843 < 30 min —	
	90844	< 60 min	
		X-RAY/ULTRASOUND	
	71020	Chest - 2 views	
	76815	Fetal Ultrasound, LTD	

✓	Code	Description	Fee
		IMMUNIZATIONS	
	90702	DT	
	90701	DTP	
	90700	DTaP	
	90737	HIB	
	90744	HEP B < 11 yrs	
	90745	HEP B 11-19 yrs	
	90746	HEP B 20+ yrs	
	90724	Influenza	
	90707	MMR	
	90712	Oral Polio	
	90732	Pneumonia	
	90703	Tetanus	
	90720	Tetramune (DTP & HIB)	

✓	Code	Description	Fee
		PROCEDURES	
	(Code E/M when hx, ex & dec is > than usual for proc- + 25 mod to E/M)		
	* Add Tray Code		
	92552	Audiometry	
	11730*	Avulsion, Nail plate, Single	
	11731*	Second — 11732 — ea addt'l	
	11100 *	Biopsy,skin, single	
	11101 *	Biopsy,skin >1 Ea added —	
	29—	Cast Loc ———	
		Supplies - Plaster — Syn —	
	69210	Cerumen removal (Ear Irrigation)	
	57452 *	Colposcopy–57454 w/biopsy —	
	17000 *	Destruction, 1 face lesion	
	17001 *	2nd/3rd EA	
	17002 *	each & over 3 — #	
	17100 *	Destruction, non-facial, 1 lesion	
	17101 *	2nd 17102 > 2, ea addt'l —	
	17110	Destruction, warts 1-15	
	93000	EKG	
	58100 *	Endometrial Aspiration	
	——— *	Excision, lesion Size: cm —	
		Benign 114— Malig 116—	
		Loc:	
	11200 *	Excision, skin tags	
	11201 *	Addt'l, EA	
	10060 *	I & D of abscess, Simple/Single	
	10061 *	I & D of abscess, Comp or Mult	
	59025	Non-stress Test	
	11975 *	Norplant Insert	
	A4260	Kit	
	11976 *	Norplant Removal	
	94760	Oximetry, Pulse Single	
	94761	Multiple	
	45330 *	Sigmoid, flex —45331w/biopsy –	
	94010	Spirometry — Bronch 94060 —	
	12——*	Suturing Size ——— cm	
		Sub ———	
		Deeper than sub - layered —	
	55250	Vasectomy	

✓	Code	Description	Fee
		INHOUSE LABORATORY	
	—Patient to Wait —Fasting —Non-Fasting —hrs pp		
	C0015	Blood Collection	
	C4001	CBC	
	C4007	Differential	
	C0004/14	Hematocrit Coulter/ Spun—	
	C3005	Sed Rate	
	C0533	Prothrombin Time	
	C3010	Glucose-Fingerstick	
	C3000	Glucose	
	C3001	Glucose 1 hr —C3100 3 hrs—	
	C0101	Amylase	
	C3003	Bilirubin-Neonatal	
	C0147	Creatinine	
	C0300	Potassium	
	C5001	HCG-Urine	
	C4002	UA Dipstick	
	C4004	UA Dipstick (OB)	
	C4003	UA Microscopic	
	C3006	Urine Culture	
	C3007	Strep Culture (Throat)	
	C3009	Strep Screen	
	C3008	GC Culture	
	C3012	Chlamydia	
	C3015	Wet Prep	
	C3034/04	Stool Occult Blood x 3/ x 1	
	C4012	PKU Collection	
	C6001	TB PPD	
		SUPPLIES	
		Dressing, burn Sm –Med – Lg –	
		Dressing, reg Sm – Med – Lg–	
		Eye Tray	
		Surgical Tray, Sm — Lg —	

✓	Code	Description	Fee
		OUTSIDE LAB	
	S———	Hemoglobin-A1C	
	S1100	PAC 1	
	S1000	PAC 2	
	S8223	PAC 10-Prenatal	
	S1108	PAC 20	
	S4448	PAC 38	
	S———	PAC —	
	S1773	HIV to LC	
	C6006	HIV to State	
	S616	Serology - RPR	
	S———	Culture ———	
	C9015	Culture Handling	
	S———	24 Urine for———	
	S896	Pap Smear AND	
	& C810	Collection	
		INJECTABLES(Code Drugs)	
	90782	INJ	
	90788	INJ-Antibiotic	
	95115	INJ-Allergy-Single 95117— (2+)	
	J1055	Depo Provera-150mg	
	J3420	Vitamin B-12-1000MCG (Medicare Waiver?)	
	J———		
		PHARMACY	

NURSING ORDERS	YOUR NEXT APPOINTMENT TIME: DATE: RE:	TODAY'S CHGS	LESS SF & RED	= NET CHGS	TOTAL COLL

CIRCLE AND LIST IN PRIMARY DIAGNOSIS ORDER

1 _____ 2 _____ 3. _____ 4. _____

CARDIOVASCULAR

ABNORMAL HT SOUND	785.3
ANGINA	413.9
AROTHIC VALVE DISORDERS	424.1
ASHD	414.00
ASVD	440._
ATRIAL FIBRILLATION	427.31
BRADYCARDIA	427.81
BRUIT	785.9
CAD	414.90
CARDIOMEGALY	429.3
CHESTPAIN, PRECORDIAL	786.51
CHESTPAIN, TIGHTNESS	786.59
CHESTPAIN, WALL/RESP	786.52
CHF	428.0
CVA	436
EDEMA	276.6
ELEVATED BP	796.2
HYPERTENSION, BENIGN	401.1
HYPERTENSION, MAL	401.0
HYPERTENSION, UNSPEC	401.9
HYPOTENSION, ORTHOST	458.0
LEFT HEART FAILURE	428.1
LOWER EXTER.	
THROMBOPHLEBITIS SUPER	451.0
MI	410.90
MITRAL VALVE DISORDERS	424.0
MURMUR	785.2
MVD	424.0
OLD MYOCARDIAL INFRACTION	412
PALPITATIONS	785.1
PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA	427.0
PERIPHERAL VAS DIS	440.29
PRIMARY PULMONARY HYPERTENSION	416.0
RHYTHM DISORDER	427.9
TACHYCARDIA	785.0
TIA	435.9
VENOUS STASIS	459.81

GASTROENTEBOLOGY

AB/PELVIC MASS/SWELL	789.30
RUQ 789.31 LUQ	789.32
RLQ 789.33 LLQ	789.34
ABD TENDERNESS	789.60
RUQ 789.61 LUQ	789.62
RLQ 789.63 LLQ	789.64
ABDOMINAL RIGIDITY	789.40
RUQ 789.41 LUQ	789.42
RLQ 789.43 LLQ	789.44
ABDOMINAL PAIN UNSPEC	789.00
RUQ 789.01 LUQ	789.02
RLQ 789.03 LLQ	789.04
CHOLECYSTITIS	575.0
CHOLEDOCHOLITHIASIS W/	574.4_
COLITIS, LGE INT	555.1
CONSTIPATION	564.0
DIARRHEA, INFECT	009.2
DIARRHEA	558.9
DIVERTICULITIS	562.11
DYSPEPSIA	536.8
ESOPHAGEAL REFLUX	530.81
ESOPHAGITIS	530.19
GASTRITIS, ACUTE	535.00
GASTROENTERITIS, ACUTE	558.9
HEMORRHOIDS, INTERNAL	455.0
HEMORRHOIDS, EXTERNAL	455.3
HERNIA, HIATAL	553.3
HERNIA, UMBILICAL	553.1
HERNIA, INGUINAL	550.9_
IRRITABLE BOWEL SYN	564.1
NAUSEA W/VOMITING	787.01
NAUSEA ALONE	787.02
VOMITING ALONE	787.03
PUD	533.90
RECTAL BLEEDING	569.3

GENITOURINARY/FEMALE

ABNORMAL PAP	795.0
AMENORRHEA	626.0
BREAST DISCHARGE	611.79
BREAST MASS	611.72
BREAST PAIN	611.71
CERVICITIS	616.0
CHLAMYDIA	079.98
CONDYLOMA	078.10
CYSTOCELE/RECTOCELE	618.0
CYSTITIS, ACUTE	595.0
DUB	626.8
DYSMENORRHEA	625.3
ENDOCERVICAL POLYP	622.7
FIBROIDS	218.9
FIBROCYSTIC BREAST	610.1
GONORRHEA	098.0
HEMATURIA	599.7
HORMONE REPLACE PM	V07.4
IRREGULAR MENSES	626.4
INCONTINENCE	788.30
MENOPAUSAL SYN	627.2
MENORRHAGIA	626.2
OVARIAN CYST	620.2
PAP AND PELVIC	V72.3
PELVIC PAIN	625.9
PID, ACUTE	614.3
PID, CHRONIC	614.4
PMS	625.4
URETHRITIS	597.80
UTI	599.0
VAGINITIS, NONSPECIFIC	616.10
ATROPHIC	627.3
BACTERIAL	616.10
MONILIAL	112.1
VAGINAL BLEEDING	623.8

MUSCULOSKELETAL

ARTHRALGIA	719.40
ARTHRITIS, LOCALIZED	715.10
GENERALIZED	715.90
RHEUMATOID	714.0
BURSITIS, (WHERE)	
_____	727.3
CARPAL TUNNEL SYN	354.0
CONTUSION (WHERE) _____	
COSTOCHONDRITIS	733.99
DEGENERATIVE DISC	722.6
DISLOCATION CR FX (WHERE)	
_____	
GANGLION CYST	727.43
INGROWN TOENAIL	703.0
JOINT PAIN MULTI SITES	719.49
LUMBAGO	724.2
MUSCLE SPASM	728.85
OSTEOPOROSIS	733.00
TENDONITIS _____	
SCIATICA	724.3
SPRAIN/STRAIN, ANKLE	845.0
CERVICAL	847.0
KNEE/LEG	844.9_
LUMBAR	847.2
WRIST	842.00
PAIN _____	
SWELLING _____	

PEDIATRICS & IMMUNIZATIONS

ADD NOT HYPERACT	314.00
W/HYPERACTIVITY	314.01
COLIC	789.0
CROUP	464.4
DEVELOPMENTAL DELAYS	783.4
DIAPER RASH	691.0
ENURESIS	788.30
FAILURE TO THRIVE	783.4
FEEDING PROBLEMS	779.3
HYPERBILIRUBINEMIA	782.4
THRUSH	112.0
TONGUE TIED	750.0
WELL CHILD CHECK	V20.2
OTHER: _____	

IMMUNIZATIONS

HEM INF TYPE B (HIB)	V03.81
STREP PNEUM	V03.82
OTHERSPEC BACT VAC	V03.89
INFLUENZA VIRUS	V04.8
VIRAL HEPATITIS	V05.3
DPT VIRUS	V06.1
MMR	V06.4
TD TETANUS-DIPHTHERIA	V06.5
VARICELLA	V05.4
OTHER V COMBINATIONS	V06.8
DTAP	

PREGNANCY

NORMAL FIRST PREG	V22.0
NORMAL OTHER PREG	V22.1
HIGH RISK _____	V23._
DESCRIBE:	
POST PARTUM EXAM	V24.2
ANEMIA, PREG	648.20
BLIGHTED OVUM	631
DECEASED FETAL MOV	656.9_
DIABETES - PREG	648.8_
ECTOPIC PREGNANCY	633.9
FALSE LABOR	644.10
FETAL DEMISE	656.40
FETAL DISTRESS	656.30
FETAL ABN SIZE	653.50
GESTATIONAL DM	648.83
HYPEREMESIS GRAV	643.00
LARGE FOR DATES	766.1
MISSED ABORTION	632
PREG. COMP BY UTI	646.63
PREG. COMB BY VD	647.23
SPONTANEOUS ABORTION	634.90
THREATENED ABORTION	640.00
OTHER: _____	

CONTRACEPTIVE DIAGNOSIS

CONTRACEPTION, IUD	V25.42
(/REINSERTION, REMOVAL)	
CONTRACEPTIVE ADVISE	V25.09
CONT IUD INSERT	V25.1
CONTRACEPTION FU BCP	V25.41
CONTRACEPTIVE MANAGEMENT	V25
CONTRA, INITIAL BCP	V25.01
FAMILY PLANNING	V25.09
NORPLANT INSERT	V25.5
NORPLANT REMOVAL	V25.8

RESPIRATORY AND ENT

ABNORMAL CHEST SOUND	786.7
ACUTE MIXILLARY	461.0
ACUTE NASOPHARYNGITIS	460
ALLERGIC RHINITIS	477.9
ASTHMA	493.90
BRONCHIOLITIS	466.1
BRONCHITIS, ACUTE	466.0
BRONCHITIS, CHRONIC	491.9
BRONCHOSPASM	519.1
CERUMEN IMPACTION	380.4
CONJUNCT/ALLERGIC	372.14
CONJUNCTIVITIS/ACUTE	372.00
COPD	496
COPD W/EMPHYSEMA	492.8
COUGH	786.2
CROUP	464.4
EUSTACHIAN DISORDER	381.9
HEARING LOSS	389.00
HYPERTROPHY OF TONSILS AND ADENOIDS	474.1
INFLUENZA	487.1
OTITIS MEDIA	381.00
OTITIS MEDIA, CHRONIC	382.9
OTITIS MEDIA, EXTERNA	380.10
OTITIS MEDIA, SEROUS	381.01
PHARYNGITIS, ACUTE	462
PLEURISY	511.0
PNEUMONIA	486
PNEUMONIA, VIRAL	480.9
SINUSITIS, ACUTE	461.9
SINUSITIS, CHRONIC	473.9
STREP THROAT	034.0
TONSILLITIS, ACUTE	463
TUBERCULOUS	011.9
URI, ACUTE	465.9
WHEEZING	786.09

SKIN

ACNE	706.1
ACTINIC KERATOSIS	702.0
SENILE KERATOSIS	702.8
BURN, WHERE_____	
1ST/2ND/3RD	
CELLULITIS_____	
DERMATITIS	
ATOPIC	691.8
CONTACT	692.9
FUNGAL	111.9
NONSPECIFIC	692.9
DERMATOPHYTOSIS	110.9
ECZEMA	692.9
FELON	681.01
FUNGUS INFECTION	117.9
HIVES	708.9
IMPETIGO	684
INSECT BITES, NON-INFE	919.4
KELOID	701.4
LIPOMA	214.1
NEVUS	216.9
SEBACEOUS CYST	706.2
SEBORRHEIC KERATOSIS	702.19
SCABIES	133.0
TINEA	110.9
TINEA CORPORA	110.5
TINEA URGUIUM	110.1
URTICARIA	708.9
WARTS	078.10
WARTS, PLANTARIS	078.19
LACERATION_____	
_____ CM	
PUNCTURE WOUND _____	

MISCELLANEOUS

ABNORMAL COAG STUDY	790.92
ABNORMAL _____	
ALCOHOL ABUSE	305.00
ALCOHOLISM	V11.3
ANEMIA	285.9
ANXIETY	300.00
ATHERO. OF THE EXTREMITI	440.20
DEHYDRATION	276.5
DEMENTIA, SENILE	290.3
DENTAL CARIES	521.0
DEPRESSION	311
DIABETES CONTROL NID	250.00
UNCONTROLLED NID	250.02
DM - CONTROLLED ID	250.01
DM - UNCONTROL ID	250.03
DRUG DEPENDENCY	304.90
EDEMA	782.3
EPISTAXIS	784.7
FATIGUE	780.7
FEVER	780.6
GINGIVITIS	523.0
HEADACHES	784.0
MIGRAINE, COMMON	346.10
HEPATITIS B	070.30
HEPATITIS, INFECTIOUS	070.1
HERPES, ZOSTER	053.9
HIV	042
HIV + NO SYMPTOMS	V08
HYPERLIPIDEMIA	272.4
HYPOTHYROIDISM	244.9
INFECTION RESISTANT TO PENICILLINS	V09.0
INSOMNIA	780.52
LYMPHADENOPATHY	785.6
MALNOURISHED	263.9
MORBID OBESITY	278.01

MISCELLANEOUS

OBESITY	278.0
ORAL APHTHAE	528.2
PALPITATIONS	785.1
PERIDONTAL ABSCESS	523.3
PURE HYPERCHOLESTEROLEMIA	272.0
RASH	782.1
STOMATITIS	528.0
TOBACCO USE	305.1
TOBACCO USE, HX OF	V15.82
TREMOR	781.0
VARICOSE VEINS OF LOWER EXT.	454
VERTIGO	780.4
WEIGHT GAIN	783.1
WEIGHT LOSS	783.2

PREVENTIVE

WELL CHILD CHECK	V20.2
HEALTH EXAM, ADULT	V70.0
PATIENT REQUEST STUDY	V70.9
OTHER: _____	
OTHER: _____	

MALES

BPH	600
EXPOSURE TO HIV	v01.7
HEMATURIA	599.7
HYDROCELE	603.9
IMPOTENCE	302.72
INCONTINENCE	788.30
PROSTATITIS	601.9
URETHRITIS	597.80

COT 8

CHARTER OAK TERRACE/RICE HEALTH CENTER
81 Overlook Terrace Hartford, CT
(203) 236-0857

CHART # _____
☐ WI ☐ Appt. Time _____
☐ New ☐ Change

Name: _____

Address: _____ DOB: _____ M ( ) F

City: _____ Zip: _____ ☐ B ☐ W ☐ H ☐ O

Insurance Name & Number _____ ☐ SP

Provider: Date:

Procedures		
Int. Evaluation		90801
Ind. Psych./Therapy		90841(2190Y)
Parent Interview		90847(2240Y)
Fam. Therapy		90847(2910Y)
Group Therapy		90853(2200Y)
Psychiatric Consult		90801A
Ind. Therapy MD		90841(2190Y)
Psychological Eval.		E90830
Intellectual Eval.		2800Y
Scholastic Ach. Test		2810Y
Personality Diag./Eval.		90830(2820Y)
Organic Brain Eval.		90830(2830Y)
Apt./Int./Educ. Eval.		90830(2840Y)
Outside Agent Consult		
Name		
School Consult/PPT		2860Y
Nonbillable Proc.		
Case Management		

Multiaxial System

Axis I	Clinical Syndromes V Codes	Diagnosis
Axis II	Dev. Dis. Personality Dis.	
Axis III	Physical Dis. & Conditions	
Axis IV	Severity of Psycosoc. Stressors	
Axis V	Global Assessment of Functioning	

OTHER COMMENTS:

Prescriptions:

Next Appt. _____

Type of Service _____

Cancelled _____ No Show _____ Unit of Service _____

(1 Unit = To 1.0 Hours; More Than .5 Hours, Next Higher Unit)

DSM-III-R Diagnoses			Eating Disorders			Schizophrenia			Impulse Control Dis.		
Dis. of Child/Inf./Adol.			Anorexia Nervosa		307.10						
Dev. Disorders			Bulimia Nervosa		307.51						
Mental Retardation			Pica		307.52	**Delusional Paranoid Dis.**			**Adjustment Disorders**		
Mld. Ment. Retard		317.00	Rumination Dis./Infancy		307.53				w/anxious mood		309.24
Mod. Ment. Retard.		318.00	Eating Disorder NOS		307.50	**Mood Disorders**			w/depressed mood		309.00
Sev. Ment. Retard.		318.10	**Tic Disorders**			**Bipolar Disorders**			w/disturbance of conduct		309.30
Prof. Ment. Retard		318.20	Tourette Disorder		307.23	Mixed		296.6X	w/mix. dis. of emo. & cond		309.40
Unspec. Ment. Retard		319.00	Chronic Motor/Vocal Tic		307.22	Manic		296.4X	w/mixed emotional feat.		309.28
Pervasive Dev. Dis.			Transient Tic Dis.		307.21	Depressed		296.5X	w/physical complaints		309.82
Autistic Dis.		299.00	Tic Dis. NOS		307.20	Cyclothymia		301.13	w/withdrawal		309.83
Pervasive Dev.		299.80	**Elimination Dis.**			Bipolar Dis. NOS		296.70	w/work (academic) inhibition		309.23
Specific Dev. Dis.			Func. Encopresis		307.70	**Depress. Disorders**			Adjustment Dis NOS		309.90
Academic Skills Dis.			Func. Enuresis		307.60	Single Episode		296.2X			
			Speech Dis. NOS			Recurrent		296.3X	**Psych. Fac. Aff. Phy. Cond.**		
			Cluttering/Stuttering		307.00	Dysthymia		300.40			
Language/Speech Dis.			**Other Disorders**			Depressive Dis. NOS		311.00			
			Elective Mutism		313.23	**Anxiety Disorders**					
			Identity Disorder		313.82	Obsess. Compulsive OB		300.30			
Motor Skills Disorders			Reactive Attach. Dis.		313.89	Post-Traumatic Stress		309.89	**Personality Disorders**		
			Stereotypy/Habit Dis.		307.30	General Anx. Disorders		300.02	Paranoid		301.00
			Undiff. Attn. Def. Dis.		314.00	Anxiety Disorder		300.00	Schizoid		301.20
Spec. Dev. Dis. NOS		315.90	**Organic Mental Disorder**			Panic Disorder		301.21	Schizotypal		301.22
Other Dev. Disorders						Social Phobia		300.23	Antisocial		301.70
Dev. Dis. NOS		315.90				**Somatoform Disorders**			Borderline		301.83
Disruptive Beh. Dis.			**Psychoactive Subst. Dis.**			**Dissociative Disorders**			Histranic		301.50
A.D.H.D.		314.01	Alcohol Dependence		303.90	Multiple Personality		300.14	Narcissistic		301.81
Conduct Disorders			Alcohol Abuse		305.00	Depersonalization Dis.		300.60	Avoidant		301.82
Group Type		312.20	Cannabis Dependence		304.30	Dissociative Dis. NOS		300.15	Dependent		301.60
Solitary Aggressive Type		312.00	Cannabis Abuse		305.20	**Psychotic Disorders**			Obsess. Comp.		301.40
Undiff. Type		312.90	Cocaine Dependence		304.20	Brief Reactive Psychoses		298.80	Passive Aggres.		301.84
Opposit. Def. Dis.		313.81	Cocaine Abuse		305.60	Psychotic Dis. NOS		298.90	Personality Dis. NOS		301.90
Anxiety Dis. Child/Adol.						**Sleep Disorders**					
Sep. Anxiety Dis.		309.21									
Aviod. Dis. Ch.Adol.		313.21									
Overanxious Dis.		313.00									

HIP 7

Homeless Initiative Program
1835 N. Meridian Street
Indianapolis, IN 46202
(317) 931-3055

CLIENT ENCOUNTER REPORT

HN Account # (if known) ___ ___ ___ ___ ___
Release Signed: _____(check here if Yes)

People's Health Center
2340 E. 10th Street
Indianapolis, IN 46201

Seen at HIP before? ____Yes ____No ____Don't Know

DATE SEEN: _____/_____/_____

SITE: aib ap cc d gn grp hc hf hh hip hl ihn jcs lh lld mto **phc/hip client** phn pw sa st wm **home visit** OTHER: _____

Last Name: **First Name:** **M.I.** (optnl) Mother's name _____

_____ _____ _____ **DOB:** _____/_____/19 _____ **AGE:** _____

SSN: _____ - _____ - _____ **RACE:** B W H Nat.American Asian/Pacific Islander Other _____ **SEX:** F M

Veteran?: N Y (___/___ to ___/___) **Other veteran adult in family?** N Y **If Yes to either,** # of children (<18) in family? ____

FAMILY STATUS: S(unattached adult) A:**M**, 0 Children **A**: Not M, Children (Ages _ _ _ _ _ _) A: **M**+C (Ages_ _ _ _ _ _)
Child YP (15-19 Head of Household) Youth/Runaway Unknown

EDUCATION: 0-11 12 13-15 16+

NEED TO VERIFY INFO BELOW AT EVERY ENCOUNTER
HOUSING: SHltr ST TRan DO-u : _____
OT: _____ UNknown

MEDICAL RESOURCES : MAid # _____
Mcare# _____
PrvInsCo: _____ # _____
VAMed: _____
Other: _____ NONE

FINANCIAL RESOURCES: Empl/Pen AFDC SSD SSI
Unempl.Ins. WIC WorkComp FDS Oth.VA.Ben None
Other: _____

CONTACT INFO:
Site/Addr: _____ Rm# _____
Site CaseWrkr _____
Phone Number _____

INFO BELOW NEEDED AT 1st HIP ENCOUNTER OF YEAR
HOUSING: SHl ST TRan DO-u: _____
DV Sit PsychFacil SubAbuse.trmt.fac HosP Jail/Prison
Living w/Friend/Family RentlHsing UNknown
Other: _____

REFERRAL FROM: SELf STOutrch Shl/HsingStff ADProgrm
Hosp/CLinic MentlHlthOutpt.clnc OtherSocServ.staff
PSychHosp POLice PHAwaitList CHUrch UNKnown
OTHer: _____

DISABILITIES REPORTED WHEN ENTERING HIP PROGRAM:
severe Mental Illness chronic Substance Abuse: (alcohol or drug)
BOth mental ilness and substance abuse AIDS/Related Illness
None Reported Other: _____

EMERGENCY CONTACT: Relationship: _____
Name: _____
Address: _____
Phone: _____

NOTES: _____

TREATMENT/INTERVENTION: _____

Time (minutes) 99401 **15** 99402 **30** 99403 **45** 99404 **60**
Axis 1: _____ Axis 2: _____
_____ _____

ICD-9 # **Mark Primary Code with a √ or X in the ( )**

( ) V60.0 Housing	( ) V60.2 Poverty	( ) V40.9 M.H./Behv.	( ) 305.00 Alcohol c.p.	( ) 305.90 Drugs c.p.	( ) V65.40 Counsel	( ) V67.9 Follow-up	( ) Other-describe #_____ _____

Next Appt: ___/___/___ _____a.m./p.m.
HIP Case Manager Encounter Report: 2/97

Signature, Initials, Title: _____ **Provider #** _____

ROUTING: **White:** Billing **Canary:** Medical Record **Pink:** Client File with Case Manager

7021777 CH-2280 (MAR 97)

TRA 4 Clinic: _____

Client Visit Data Collection Service Site: _____

CLIENT IDENTIFICATION

ID: ☐☐☐-☐☐☐ DATE OF BIRTH: __/__/__ SEX: M F DATE OF SERVICE: __/__/__

First (3 ltrs) Last (3 ltrs)

DEMOGRAPHICS

[ ] Check here if this information has been submitted to the SFCCC for this Client this year, and skip to Clinical Services.

RACE/ETHNICITY (Check One)	FAMILY STATUS (Check One)	HOUSING STATUS (Check One)
[ ] AFRICAN AMERICAN/BLACK		
[ ] ASIAN/PACIFIC ISLANDER	[ ] UNATTACHED TO GROUP OR FAMILY	[ ] SHELTER
[ ] HISPANIC /LATINO	[ ] LIVING IN A FAMILY UNIT	[ ] TRANSITIONAL
[ ] NATIVE AMERICAN/ALASKAN	[ ] HEAD OF HOUSEHOLD	[ ] DOUBLING UP
[ ] CAUCASIAN	[ ] OTHER _____	[ ] STREET or VEHICLE or MAKESHIFT
[ ] OTHER _____	[ ] UNKNOWN	[ ] OTHER _____
[ ] UNKNOWN		[ ] UNKNOWN

FINANCIAL RESOURCES (Check all that apply)		MEDICAL RESOURCES: (Check all that apply)
[ ] AFDC	[ ] UNEMPLOYMENT INSURANCE	[ ] MEDI-CAL/MEDICAID
[ ] SSI	[ ] WAGES/PENSION	[ ] MEDICARE
[ ] WIC	[ ] NONE	[ ] PRIVATE INSURANCE
[ ] FOOD STAMPS	[ ] OTHER _____	[ ] SELF PAY
[ ] OTHER VA BENEFITS	[ ] UNKNOWN	[ ] VA MEDICAL
[ ] GENERAL ASSISTANCE		[ ] NONE
		[ ] OTHER _____
		[ ] UNKNOWN

CLINICAL SERVICES

DIAGNOSIS AND CONDITIONS (Check all that apply)

DIAGNOSIS:	ICD-9-CM Codes
INFECTIOUS DISEASES	
TUBERCULOSIS	
[ ] PPD SCREENING	
[ ] PRIOR TB INFECTION	
[ ] NEW TB INFECTION	
[ ] ACTIVE TB DISEASE	001 - 0018
HIV	
[ ] HIV INFECTION	
[ ] AIDS	
[ ] STDs	090 - 099
[ ] HEPATITIS b	070.2/3
[ ] INCOMPLETE IMMUNIZATIONS	V04,V06
[ ] OTHER REPORT. COMMUNICABLE DISEASE	
RESPIRATORY / CIRCULATORY	
[ ] HYPERTENSION	401 - 405
[ ] PERIPHERAL VASCULAR DISEASE -	443
[ ] PNEUMONIA	480 - 486
[ ] INFLUENZA	487
[ ] CHRONIC RESPIRATORY CONDITION	491 - 493
ENDOCRINE / NUTRITIONAL / DIGESTIVE	
[ ] DIABETES MELLITUS	250
[ ] NUTRITIONAL DISORDERS	260 - 261
[ ] ANEMIA	280 - 281
[ ] DENTAL / ORAL DISEASE	520 - 523
[ ] GI DISORDERS	530 - 535, 571
MENTAL ILLNESS / DISORDERS	
[ ] SEVERE MENTAL ILLNESS	295 - 297
[ ] DEVELOPMENTAL DELAYS	315
[ ] MENTAL RETARDATION	317 - 319

DIAGNOSIS:	ICD-9-CM Codes
SOCIAL CONDITIONS	
[ ] ALCOHOL DEPENDENCE	303
[ ] DRUG DEPENDENCE	304
[ ] TRAUMA	E960 - 969
[ ] CHILD/ADULT ABUSE	995.5 - 995.81
SELF LIMITED AND OTHER CONDITIONS	
[ ] SKIN DISEASES	680 - 709
[ ] EXPOSURE / COLD / HEAT	991 - 992
[ ] PREGNANCY	V22 - 23
[ ] ACUTE INFECTIONS	
[ ] ILL DEFINED CONDITIONS	780 - 796
OTHER	
[ ] _____	
[ ] _____	
[ ] _____	

TYPE OF SERVICE (Check all that apply)

[ ] MEDICAL
- [ ] MD [ ] MID-LEVEL [ ] NURSE

[ ] DENTAL
- [ ] DENTIST [ ] HYGIENIST

[ ] MENTAL HEALTH/PSYCHIATRY
[ ] CASE MANAGEMENT
[ ] SUBSTANCE ABUSE COUNSELING
[ ] OUTREACH
[ ] EDUCATION
[ ] OTHER HEALTH/CLINICAL

FORWARD 1 COPY OF THIS FORM, ALONG WITH A MONTHLY INVOICE TO:
SAN FRANCISCO COMMUNITY CLINIC CONSORTIUM 1748 MARKET STREET, SUITE 205 SAN FRANCISCO, CA 94102 (415) 252-7291

form 610 rev. 08/20/92

HPH 11

HOMELESS PERSONS HEALTH PROJECT ENCOUNTER

County of Santa Cruz Health Services Agency

CLIENT NAME_____ **OTHER NAME**_____ **CHART #**_____
Last First MI

SEX [ ] M [ ] F **DOB**____/____/____ **SS#**____/____/____

MARTIAL STATUS [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

MAILING ADDRESS_____ **MSG#** [ ]____-____
Street / PO Box City State / Zip

RESIDENCE_____ **PHONE**[ ]____-____
Street / PO Box City State / Zip

ETHNICITY
American Indian, Asian, Black, Caucasian, Hispanic, Filipino, Portuguese, Other

PREFERRED LANGUAGE
English, Spanish, Portuguese, Tagalog, Sign Language, Other

IMMIGRATION STATUS (N/A)_____ **COUNTY OF RESIDENCE** (Unknown)_____ **DATE ARRIVED**____/____/____

EMERGENCY CONTACT NAME_____ **RELATIONSHIP**_____

ADDRESS_____ **TELEPHONE #** [ ]____-____
Street/PO Box City State / Zip

❖ **Change** ☐ **No Change** ☐ ❖

==========

DATE OF ENCOUNTER____/____/____ **MCARE / MCAL / MCRUZ / HPHP** coverage through: _____

PROVIDER_____ **TYPE X** (Specialty) **SITE H** (Homeless Project)

VISIT CLASS

182 Dental Hygiene	**181-XBVM6** ICC Medical	**181-XBVE5** ICC Psychosocial	**>>> DX code** _____
185 Eligible / Recert	**187-XBVV7** Sub Abuse Gen.	**187-XBVC8** Sub Abuse Tx Related	_____
186 Public Health Visit	**188-XBVP3** MH Assessment	**188-XBVX4** MH Counseling	_____

==========

IHPB2 SERVICE TYPE **F** Field **O** Office **I** In Behalf **T** Telephone **H** Home **C** Conference

IHPZ5 HOMELESS SERVICE DELIVERY LOCATION

N	New Life Community Services	**6**	Downtown Watsonville	**U**	Familia Center
D	Dominican Hospital	**7**	Pajaro Rescue Mission	**3**	Davenport
5	Downtown Santa Cruz	**T**	St. Patricks Loaves & Fishes	**X**	San Andreas Camp
R	River St. Shelter	**S**	Salud Para La Gente	**Y**	Murphys Camp
K	St. Francis Soup Kitchen	**E**	Watsonville Community Hospital	**A**	River Levy / Santa Cruz
Q	ISSP / Santa Cruz	**2**	Watsonville Health Center	**8**	Temp Residence / Motel
G	SCAP / Drop-In Center	**0**	La Flor del Valle Table	**O**	Other Service Site
1	Santa Cruz G M C	**I**	ISSP / Watsonville	**H**	HPHP Office
C	Homeless Community Resource Ctr	**Z**	River Levy / Watsonville	**BB**	Janus
P	Pajaro Shelter	**AA**	NeedleExchange	**CC**	Treatment Centers
				V	San Lorenzo Valley

ARVX7 CURRENT LIVING SITUATION

0	Unknown	**3**	Transitional/Temporary	**4**	Homeless Shelter
2	Over Crowded / Doubling Up	**7**	No Shelter / Street / Outdoors / Vehicle	**5**	Substandard Shelter / Ag Labor
8	Other				

XAXM5 CLIENT STATUS **ADULTS:** (> 18 yrs) w/o Children: w/Children: **CHILDREN:** (< 18 yrs) On Own:

B	Single	**E**	Single	**C**	w/Families	**G**	Single
D	Coupled	**F**	Coupled			**I**	Coupled
						J	Parenting

ARPZ1 MIGRANT / SEASONAL / NO **ASDB8 TRANSLATION** (Services Needed / Provided ?) Yes ☐ No ☐

XAXV6 USER RESOURCES Medical Care Resources:

2	MediCare	**7**	HPHP
5	MediCal	**8**	None
6	MediCruz	**13**	VA Medical
3	Private Insurance		

Last Name:_____ First Name:_____ Client #:_____

☐ Case Management?

Member of a family? ☐

Encounter Type:

4. Advocacy, services, referrals
5. Monitoring, follow-up (Contact with client; no services provided)
6. Notes (No contact with client)

Encounter Area:

1. WHC
2. Sand Island
3. Ala Moana
4. YWCA
5. Waikiki
6. Nimitz
7. Other Honolulu
8. Mokuleia
9. Swanzy
10. Waimanalo
11. Haleiwa
12. Ewa
13. Kualoa
14. Hauula
15. Waimea
16. Kahaluu
17. Waipahu
18. Airport
19. Kapiolani
20. Other Oahu

Medical Services Provided:

1. Health Assessment
2. Acute Episodic Care
   Skin, GI, GI, URI, burn, other
3. Family planning, education or counseling
4. HIV education or counseling
5. Nutrition education or counseling
6. Vital signs
7. Immunization check
8. Immunization
9. Lab work, tests
10. Chronic Disease Management
    a. diabetes
    b. hypertension
    c. asthma
    d. other
11. Other

Date: _____ Time:_____ Staff Member/Title:_____

Referrals made:

1. WHC doctor
2. WHC nurse
3. Public health nurse
4. Other medical
5. Mental health
6. CRSP Team
7. STD/AIDS Education
8. Substance abuse services
9. Dental
10. Vision
11. Family planning/education
12. Employment
13. Employment training
14. Child & Family Assistance
15. Food
16. Clothing
17. Transitional housing
18. Temporary shelter
19. Social Security
20 Veterans' Assistance
21. Welfare
22. Legal assistance
23. Education
24. Bilingual Access Line
25. Immunization check
26. Other(specify in notes)

Nurse-Assessed Health Needs:

1. Food
2. Clothing
3. Medical care
4. Shelter
5. Immunization
   a. 0-2
   b. 3-5
   c. 6+
6. Prenatal care
   a. 1st trimester
   b. 2nd trimester
   c. 3rd trimester
7. Dental care
8. Mental health services
9. Detox
10. Family Planning
    a. method
    b. education/counseling
11. STD/AIDS education
12. Nutrition education/counseling
13. Other
14. None indicated

Encounter:

Posted ☐

WAI 3

Last name:_____ **First/A.K.A.:**_____ **Client #:**_____ Case mgt? ☐

Member of a family? ☐

Encounter Location:

1. WHC
2. Sand Island
3. Ala Moana
4. YWCA
5. Waikiki
6. Nimitz
7. Other Honolulu_____
8. Mokuleia
9. Swanzy
10. Waimanalo
11. Haleiwa
12. Ewa
13. Kualoa
14. Hauula
15. Waimea
16. Kahaluu
17. Waipahu
18. Airport
19. Kapiolani Park
20. Other_____

Encounter Type:

4. Advocacy/Services/Referrals
5. Monitoring/Followup (contact with client; no services provided)
6. Notes (no face-to-face contact; advocacy/research done for client or info added to client file.)

Non-medical services/goods provided:

1. Lifestyle/hygiene counseling
2. Advocacy and help with other agencies
3. Mailing address
4. Food
5. Clothes
6. Bus passes
7. I.D. assistance
8. Telephone use
9. Family counseling
10. Mental health counseling
11. Substance abuse counseling
12. Other (specify in notes)

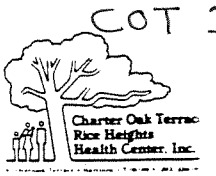
Referrals made:

1. WHC doctor
2. WHC nurse
3. Public Health Nurse
4. AMM doctors or other medical
5. Mental health
6. CRSP team
7. STD/AIDS education/testing
8. Substance abuse services
9. Dental
10. Vision
11. Family Planning education
12. Employment
13. Employment training
14. Family counseling
15. Food
16. Clothing
17. Transitional housing
18. Temporary shelter
19. Social Security
20. Veterans' assistance
21. DHS (Welfare)
22. Legal
23. Education
24. Bilingual Access Lin
25. Immunization check
26. Other (specify in notes)

Date (yy/mm/dd):_____ Staff member (name and title):_____

COT 1

CHARTER OAK TERRACE/RICE HEALTH CENTER
81 Overlook Terrace Hartford, CT
(203) 236-0857



# of encounters _____

☐ Medical _____

☐ Dental _____

☐ Mental Health _____

☐ Social Service _____

PRINT CLEARLY

☐ NEW
☐ FIRST YEARLY VISIT

Name _____

Shelter: _____ DOB: _____ M ( ) F ( )

City: _____ Zip: _____ ☐ B ☐ W ☐ H ☐ O

Insurance _____

Provider _____ Date: _____

☐ Bill ☐ Do Not Bill Homeless

INFECTIOUS DISEASE	**ACCIDENTS**	**OB/GYN**	**OTHER**
TB	Abrasion	Breast Disorder	Group
Prior	Bruise/Contusion	Exposure to STD	Life Skills
New	Burn	Family Planning	Home/Hosp. Visits
Active	Foreign Body	Menstrual Disorder	Prescriptions
HIV Infection	Fracture	Pelvic Pain	Appt. Reminder
AIDS	Laceration	Other	Tokens
STD's	Sprain/Strain	**MS–CONNECT TISSUE**	Housing
Type:	Suture Removal	Pain	Employment
Hepatitis B	Wound Open	Joint Pain	Social Service
Incomplete Immunizations	**BEHAVIOR/MENTAL**	Low Back Pain	**HEALTH MAINTENANCE**
OTHER REPORTABLE DISEASES	Anxiety	Cramping	Counselling
Chicken Pox	Depression	Other	Dietary Counselling
Measles	Emotional Disorder	**NERVOUS SYSTEM**	Health Advice
Mumps	Other	Dizziness	AIDS Prevention
Rubella	**CARDIOVASCULAR**	Seizure	Substance Abuse Counseling
Pertussis	BP	Headache	
Tetanus	Chest Pain	Other	
RESPIRATORY/CIRCULATORY	Edema	**RESPIRATORY**	
HTN	Other	Allergy Symptoms	
Peripheral Vasc Disease	**GASTROINTESTINAL**	Cough	
Pneumonia	Abdominal Pain	Sore Throat	
Influenza	Blood Sugar	Laryngitis	
CHRONIC RESPIRATORY CONDITION	Constipation	Nasal Congestion	**REFERRALS–AGENCIES**
Chronic Bronchitis	Diarrhea	Sinusitis	Medical
Emphysema	Hemorrhoids	Other	Dental
Asthma	Jaundice	**SKIN & SO**	Eye
ENDOCRINE/NUTRITIONAL/DIGESTIVE	Malnutrition	Acne	Substance Abuse
Diabetes Mellitus	Thrush	Boil/Abscess	Mental Health
Nutritional Disorders	Vomiting/Nausea	Rash	HIV
Anemia	Other	Insect bites	Housing
Dental/Oral Disease	**EAR & EYE**	Scabies	Employment
GI DISORDERS	Conjunctivitis	Warts	Social Service
Ulcers	Poor Vision	Other	
Gastritis	Hearing	**UNDEFINED**	Appt. Date
Chronic Liver Disease	Ear Pain	Fever	
MENTAL ILLNESS/DISORDERS	Other	General Symptoms	
Severe Mental Illness	**RENAL/GU**	Other	
Developmental Delays	Voiding		
Mental Retardation	Backpain		
SOCIAL CONDITIONS	Other		
ETOH Dependence			
Drug Dependence			
Trauma			
Child/Adult Abuse			
SELF LIMITED/OTHER CONDITIONS			
Skin Diseases			
Exposure/Cold/Heat			
Pregnancy			
Teen Age Pregnancy			
Acute Infections			

Notes:

Age: _____

Provider: _____

BAL 3

HEALTH CARE FOR THE HOMELESS, INC.
ENCOUNTER RECORD

TODAY'S DATE ___/___/___

Name: _____ (Last) _____ (First) _____ (MI)

PROVIDER NAME: _____

HCH ID# |_|_|_|_|_|_|_|

Provider Code |_|_|_|

APPOINTMENT/WALK-IN: _____
(CIRCLE ONE OF THE ABOVE) TIME

Baseline Update (Complete only if information is different from what is already in the Baseline Record):

SEX (circle one): Male.....1 Female.....2

RACE: (circle one): White.....1 Black.....2 Hispanic.....3 Asian.....4 American Indian.....5 Other.....6

EDUCATION (Circle the ONE that best describes the highest level completed):
None.....1 Grade School.....2 Some high school.....3 High school grad/GED.....4
Vocational/tech. school.....5 Some college.....6 College grad.....7 Under school age.....8

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

MARITAL STATUS: Single.....1 Married.....2 Separated/Divorced/Widowed.....3 SSI/SSDI Benefits...No __ Yes __ Pending __

I. SITE (CIRCLE ONE)

1. HCH
2. OTHER |_|_|_|

II. CLASSIFICATION (CIRCLE ONE)

1. MEDICAL
2. MENTAL HEALTH
3. SOCIAL SERVICES
4. OUTREACH
5. STREETREACH

III. SPECIAL RISK DATA (CIRCLE ALL THAT APPLY)

NO	YES	No Assess.	
0	1	99	1. HIV
0	1	99	2. SEXUALLY AT RISK
0	1	99	3. INJECTION DRUG ABUSE
0	1	99	4. NON-INJECTION DRUG ABUSE
0	1	99	5. ALCOHOL ABUSE

_____
Provider Signature

IV. BILLING (CIRCLE ONE)

1. BILLABLE
2. NON-BILLABLE

V. CASE MANAGEMENT (CIRCLE ONE)

1. DEU
2. TARGETED CASE MGMT.
3. CASE MANAGEMENT

VI. MEDICAL ASSISTANCE STATUS (MUST CIRCLE AT LEAST ONE)

1. DALP/GPA/NO FMA
2. FMA |_|_|_|_|_|_|_|_|_|_|_|_|_|_| (New)
3. PHARMACY ASSISTANCE |_|_|_|_|_|_|_|_|_|_|_|_|_|_| (New)
4. NONE
5. UNKNOWN

VII. INTERVENTION (CIRCLE ALL THAT APPLY - UP TO 12)

INJECTION
1. DT
2. HEPTOVAX
3. INFLUENZA VACCINE
4. PPD
5. PNEUMOVAX
6. PROLIXIN/HALDOL
7. OTHER

LAB WORK
8. BLOOD DRAW (JHH)
9. BLOOD DRAW (MERCY)
11. EKG
19. BLOOD GLUCOSE
20. MICROSCOPIC SLIDES
21. URINE TEST

OTHER
12. WOUND CARE
13. PRESCRIPTION
14. OTC MEDICATION
15. COUNSELING
16. HEALTH EDUCATION
17. RELATIONSHIP BUILDING
22. B.P. TESTING
23. EAR IRRIGATION
24. HIV PRE-TEST COUNSELING
25. HIV POST-TEST COUNSELING
26. ASSESSMENT
18. OTHER |_|_|_|

VIII. REFERRAL (CIRCLE ONE)

INTERNAL HCH REFERRAL TO:
1. MEDICAL
2. MENTAL HEALTH
3. SOCIAL SERVICES
4. ADDICTIONS
5. OUTREACH

EXTERNAL REFERRAL TO:
1. |_|_|_|
2. |_|_|_|
3. |_|_|_|

IX. SOCIAL SERVICES (CIRCLE UP TO 8 CODES)

HOUSING ASSISTANCE
1. EMERGENCY SHELTER
2. HOUSING AUTHORITY
48. SPECIAL PROGRAMS
49. RENTAL ROOMS
50. EVICTION PREVENTION
51. UTILITIES

SUBSTANCE ABUSE REFERRALS
5. DETOX
6. TRANSITIONAL/REHAB
7. OUTPATIENT TREATMENT

BENEFITS/APPLICATIONS ASSISTANCE
8. GPA/DALP
9. MEDICAL ASSISTANCE
10. SOCIAL SECURITY BENEFITS
12. PHARMACY ASSISTANCE
13. MEAP
14. FOOD STAMPS

ASSISTANCE, OTHER
19. ACCOMPANY CLIENT
20. ADVOCACY
21. CLOTHING
24. EMPLOYMENT/JOB PROGRAM
26. EYEGLASSES
27. FINANCIAL ASSISTANCE
28. FOOD
29. HOUSEHOLD GOODS
30. IDENTIFICATION
32. LEGAL
34. MAIL
35. MEDICAL RECORDS
36. PERSONAL ITEMS
52. IMMIGRATION
53. REPRESENTATIVE PAYEES
54. RELOCATION
55. LAUNDRY
56. Rx/COPAY
57. MEDICAL EQUIPMENT
44. TRANSPORTATION
46. VOCATIONAL REHAB
47. OTHER |_|_|_|

X. **MEDICAL PROBLEM/DIAGNOSIS** (CIRCLE CODE[S] - UP TO 8)

TRAUMA

1. BRUISE/CONTUSION
2. ABRASION/LACERATION
3. FRACTURE
4. HEAD INJURY
5. WEATHER EXPOSURE - HEAT
6. WEATHER EXPOSURE - COLD
7. INFLICTED BY ANOTHER (RAPE, ASSAULT)
8. CHILD ABUSE
9. ADULT ABUSE

BLOOD DISEASES

10. ANEMIA
11. COAGULATION DEFECTS
12. LEAD POISONING
13. OTHER DISEASES OF BLOOD & BLOOD-FORMING ORGANS

CARDIOVASCULAR

14. CAD
15. CHF
16. HYPERTENSION
17. PERIPHERAL VASC. DIS.
18. BP SCREENING
19. OTHER SYMPTOMS INVOLVING C-V SYSTEM

DERMATOLOGIC

20. CONTACT DERMATITIS
21. FUNGAL SKIN INFECTION
22. BURN
23. CELLULITIS
24. IMPETIGO
25. OTHER SYMPTOMS INVOLVING SKIN & INTEGUMENTARY TISSUES
114. ECZEMA
62. SCABIES/LICE

ENDOCRINE/METABOLIC

26. DIABETES MELLITUS
27. GOUT
28. THYROID DISORDER
29. OBESITY
30. OTHER SYMPTOMS - NUTRI./METAB./DEVELOP. (INCL. ABN. WT. LOSS/GAIN)
115. CHOLESTEROLEMIA

GASTROINTESTINAL

31. ABDOMINAL PAIN, UNSPEC.
32. GASTRITIS/REFLUX
33. PEPTIC ULCER
34. DIARRHEA/GASTROENTENTIS
35. HEPATITIS B
36. CHRONIC LIVER DISEASE/CIRRHOSIS
37. PANCREATITIS
38. HEMORRHOIDS
39. OTHER SYMPTOMS INVOLVING DIGESTIVE SYSTEM
116. CONSTIPATION
117. HEPATITIS C

GYNECOLOGICAL/OBSTETRICAL

40. AMENORRHEA
41. CONTRACEPTION
42. BREAST MASS
43. VAGINITIS
44. VAGINAL BLEEDING
45. PREGNANCY
46. ROUTINE GYN EXAM
48. OTHER UNSPEC. SYMPTOMS - FEMALE GENITAL ORGANS

GENITOURINARY

49. CYSTITIS
50. URETHRITIS
51. BPH
52. EPIDYDIMITIS
53. INGUINAL HERNIA
54. RENAL FAILURE
55. OTHER SYMPTOMS INVOLVING URINARY SYSTEM

INFECTIOUS DISEASES

56. AIDS
57. HIV+, SYMPTOMATIC
58. HIV+, ASYMPTOMATIC
59. HIV TESTING
122. CHICKENPOX
61. OTHER STD
123. MUMPS
124. MEASLES
125. RUBEOLA
64. OTHER UNSPEC. INFECTIONS, PARASITIC DISEASES

MUSCULOSKELETAL

65. BACK PAIN
66. ARTHRITIS
67. TENDONITIS/BURSITIS
68 MUSCLE STRAIN/LIGAMENT TEAR
69. CURVATURE OF SPINE
70. OSTEOPOROSIS
71. OTHER SYMPTOMS INVOLVING MUSCULOSKELETAL SYSTEMS

MISCELLANEOUS

72. HEALTH CHECK-UP
73. FOLLOW-UP EXAM
74. FOOT PROBLEM
75. MH PROBLEM
76. ALLERGY, UNSPEC.
77. DRUG REACTION
78. DELAYED/LACK OF IMMUNIZ.
79. DEVELOPMENTAL DELAY
81. MALIGNANCY
82. NON-SPECIFIC COMPLAINTS
82. NON-SPECIFIC COMPLAINTS (INCL. ABN. LAB TESTS)
118. FATIGUE
119. SLEEP DISORDER
126. ATTENTION DEFICIT HYPERACTIVITY DISORDER
127. ADJUSTMENT DISORDER W/MIXED DISTURBANCE OF EMOTIONS & CONDUCT
128. DEV. ARRITHMATIC DISORDER
129. DEVELOPMENTAL EXPRESSIVE WRITING DISORDER
130. DEV. READING DISORDER
131. DEVELOPMENTAL EXPRESSIVE LANGUAGE DISORDER
132. SPEC. DEV. DISORDER NOS.

NEUROLOGIC

83. HEADACHE
84. SEIZURES
85. CVA
86. OTHER SYMPTOMS INVOLVING NERVOUS SYSTEM
120. PERIPHERAL NEUROPATHY

TUBERCULOSIS

87. Hx OF + PPD
88. PPD RDG., NORMAL
89. PPD RDG., ABNORMAL
90. NEWLY + PPD
91. TUBERCULOSIS (ACTIVE DISEASE)

EENT

92. DENTAL PROBLEM
93. PHARYNGITIS
94. THRUSH
95. INFLAMMATION OF EYELIDS
96. CONJUNCTIVITIS
97. FOREIGN BODY (EYE)
98. SINUSITIS
99. ALLERGIC RHINITIS
100. IMPACTED CERUMEN
101. OTITIS - MEDIA
102. OTITIS - EXTERNA
103. HEARING LOSS
104. OTHER NON-SPECIFIC SYMPTOMS INVOLVING THE HEAD & NECK
121. IMPAIRED VISION

SUBSTANCE ABUSE

105. ALCOHOL ABUSE
106. DRUG ABUSE
107. TOBACCO ABUSE

RESPIRATORY

108. URI
109. ASTHMA
110. BRONCHITIS, ACUTE
111. COPD
112. PNEUMONIA
113. OTHER SYMPTOMS INVOLVING RESPIRATORY SYSTEM

IX. **MENTAL HEALTH**

TYPE OF VISIT (CIRCLE ONE)

7. INTAKE/ASSESSMENT
1. DIAGNOSTIC INTERVIEW
2. CHEMO MANAGEMENT
3. IND. THERAPY (30)
5. CONJOINT/FAMILY
6. GROUP THERAPY

DIAGNOSIS (CIRCLE UP TO 8)

1. SCHIZOPHRENIA, PARANOID/295.3____
2. SCHIZOPHRENIA, OTHER/295.____
3. PARANOID DISORDER/297.10____
4. BIPOLAR, MANIC/296.4____
5. BIPOLAR, DEPRESSED/296.____
6. MAJOR DEPRESSION/296.____ ____
7. OTHER/____ ____ ____.____ ____
8. ANXIETY DISORDER/300.____ ____
9. ADJUSTMENT DISORDER/309.____ ____
10. PERSONALITY DISORDER/301.____ ____
11. MENTAL RETARDATION/31____.____ ____
12. ALCOHOL DEPENDENCE/303.9____
13. ALCOHOL ABUSE/305.0____
14. DRUG DEPENDENCE/304.____ ____
15. DRUG ABUSE/305.____ ____
16. OTHER SUBSTANCE ABUSE DISORDERS
    #1 ____ ____ ____.____ ____
    #2 ____ ____ ____.____ ____
17. DISSOCIATIVE IDENTITY DISORDER/300.14
18. DEPERSONALIZATION DISORDER/300.60
19. ATYPICAL DISSOCIATIVE DISORDER/300.15

(4TH AND 5TH DIGIT CODES ARE ONLY NECESSARY UPON INITIAL DIAGNOSIS OR IF A MARKED CHANGE OCCURS.)

BAL 3R

rev.7/1//97

HEALTH CARE FOR THE HOMELESS, INC. ENCOUNTER RECORD

TODAYS' DATE __/__/__

NAME:_____ |_|_|_|_|_|_|_|_|_|
(LAST) (FIRST) (MI) HCH ID#

APPOINTMENT WITH _____ at_____
OR WALK-IN TRIAGE CAT #_____

I. SITE ***(MUST CIRCLE ONE)***
1. HCH 2. OTHER |_|_|_|

II. CLASSIFICATION ***(MUST CIRCLE ONE)*** 1. MEDICAL 2. MENTAL HEALTH 3. SOCIAL SERVICES 4. ADDICTIONS

III. WHERE DID THE CLIENT SPEND LAST NIGHT? ***(MUST CIRCLE ONE)*** 1. SHELTER 2. TRANSITIONAL SHELTER 3. DOUBLING-UP 4. STREET 5. OTHER 6. UNKNOWN 7. HOUSED

IV. INSURANCE STATUS (***MUST CIRCLE AT LEAST ONE)*** IF THERE IS A CHANGE IN BENEFIT STATUS, **CIRCLE** THE NEW NUMBER.

1. PCMI HCH___ OTHER ____ MEDICAID |_|_|_|_|_|_|_|_|_|_| 2. MANAGED CARE AT HCH __/__ OTHER PROVIDER __/__ *NOTE TELEPHONE #* _____

3. MEDICAID NON-MANAGED CARE 4. PHARMACY ASSISTANCE |_|_|_|_|_|_|_|_|_|_| 5.MEDICARE |_|_|_|_|_|_|_|_|_|_| 6. NONE 7. PENDING 8. UNKNOWN

***V. BASELINE UPDATE** (Complete only if different than what is currently in Baseline Record)

SEX *(Circle One):* MALE.....1 FEMALE.....2
RACE *(Circle One):* WHITE.....1 BLACK.....2 HISPANIC.....3 ASIAN.....4 AMERICAN INDIAN.....5 OTHER.....6
EDUCATION *(Circle the ONE that best describes the highest level completed):*
NONE...1 GRADE SCHOOL..2 SOME HIGH SCHOOL .3 HIGH SCHOOL GRAD/GED...4 VOCATIONAL/TECH SCHOOL....5 SOME COLLEGE.....6 COLLEGE GRADUATE...7

SOCIAL SECURITY #:_____ **DATE OF BIRTH:**__/__/__
MARITAL STATUS: SINGLE.....1 MARRIED.....2 SEPARATED/DIVORCED/WIDOWED.....3 SSI/SSDI Benefits.....No____Yes____Pending_____

*** VI. HCH TRACKING (CHECK ANY THAT APPLY. CIRCLE IF IT IS NEW):**
CSAT __ DIAMOND __ RYAN WHITE I __ RYAN WHITE III __ ADDICTION SVC. ____
Signature of Staff Completing Items I Through VI.

VII. SPECIAL RISK DATA (Follow instructions for this section)

NO	YES	NO ASSESS	
0	1	99	1 HIV TEST RESULT IN LAST 6 MONTHS
0	1	99	2. SEXUALLY AT RISK
0	1	99	3. INJECTION DRUG USE
0	1	99	4. NON-INJECTIONS DRUG USE
0	1	99	5. ALCOHOL USE
0	1	99	6. TOBACCO USE

VIII. ASSESSMENT TOOLS ADMINISTERED |_|_|_|_|_| (MUST HAVE CODE) |_|_|_|_|_| (MUST HAVE CODE)

READINESS FOR CHANGE : __Not assessed "Now in SA Treatment Program?" __No. __Yes(Action) If yes, STOP. If no, continue to next question.
"Seriously considering entering treatment in 6 months?" __ No (Precontemplation) __ Yes. If yes, continue to next question; if no, STOP.
"Plan to enter treatment in the next month?"__No (Contemplation) __Yes(Ready for action) IF YES, REFER TO ADDICTIONS TEAM FOR ASSESSMENT!

IX. HAS CLIENT BEEN SEEN IN AN EMERGENCY ROOM SINCE LAST HCH VISIT? (CIRCLE ONE) NO YES IF YES, WHAT DATE? __/__/__ Not assessed

X. HAS CLIENT BEEN ADMITTED TO A HOSPITAL SINCE LAST HCH VISIT? (CIRCLE ONE) NO YES IF YES, WHAT WAS DATE OF DISCHARGE? __/__/__ Not assessed

XI. REPORTABLE INTERVENTIONS: **CPT CODES**
1. Td 2. Heptavax 3. Influenza vaccine

4. ppd placement 5.Eligibility Assistance 6. Relationship building |_|_|_|_|_| |_|_|_|_|_| |_|_|_|_|_| |_|_|_|_|_| |_|_|_|_|_|

7. Crisis intervention case work 8. On-going Case Work 9. Case Management

10. Health Education 11. Individual counseling 12. Group counseling |_|_|_|_| (MUST HAVE CODE)

Signature & Title of Provider completing encounter _____ **Provider code** |_|_|_|_|

13. Prescriptions (how many?____|_____) 14. Other ____|_____|_____ 15. Transportation __/__ tokens to go _____ 16. Care Plan last updated on __/__ (month/year)

Was a reimburseable service provided? (circle one) no yes (If yes, you must complete reverse side) **authorization from other Provider** |_|_|_|_|_|_|_|_|_|_| (call telephone# above)

BAL 3R

***Diagnoses included in today's encounter and Progress Note (may circle up to 8)**

PRIMARY_____ SECONDARY_____

TRAUMA

1. BRUISE/CONTUSION
2. ABRASION/LACERATION
3. FRACTURE
4. HEAD INJURY
5. WEATHER EXPOSURE-HEAT
6. WEATHER EXPOSURE-COLD
7. INFLICTED BY ANOTHER (RAPE, ASSAULT)
8. CHILD ABUSE
9. ADULT ABUSE

GASTROINTESTINAL

31. ABDOMINAL/PAIN,
32. GASTRITIS/REFLUX
33. PEPTIC ULCER GI BLEED
34. DIARRHEA/ GASTROENTENTIS
116. CONSTIPATION
35. HEPATITIS B
117. HEPATITIS C
36. CHRONIC LIVER DISEASE/ CIRRHOSIS
37. PANCREATITIS
38. HEMORRHOIDS
39. OTHER SYMP OF DIGESTIVESYSTEM

MUSCULOSKELETAL

65. BACK PAIN
66. ARTHRITIS
67. TENDINITIS/BURSITIS
68. MUSCLESTRAIN/ LIGAMENT TEAR
70. OSTEOPOROSIS
71. OTHER SX OF MS SYSTEM

ENDOCRINE/METABOLIC

26. DIABETES MELLITUS
27. GOUT
28. THYROID DISORDER
29. OBESITY
115. CHOLESTEROLEMIA

138. DEHYDRATION
143 ELECTROLYTE IMBALANCE
30. OTHER Sx- NUTRI./ METAB./DEVELOP.(INCL. ABN. WT. LOSS/GAIN)

EENT

92. DENTAL PROBLEM
93. PHARYNGITIS
94. THRUSH
121. IMPAIRED VISION
95. INFLAMMATION OF EYELIDS
96. CONJUNCTIVITIS
97. FOREIGN BODY (EYE)
144 GLAUCOMA
98. SINUSITIS
99. ALLERGIC RHINITIS
100. IMPACTED CERUMEN
101. OTITIS - MEDIA
102. OTITIS - EXTERNA
103. HEARING LOSS
104. OTHER NON-SPECIFIC SX. OF HEAD & NECK

BLOOD DISEASES

10. ANEMIA
11. COAGULATION DEFECTS
12. LEAD POISONING
13. OTHER DISEASES OF BLOOD & BLOOD-FORMING ORGANS

GYNECOLOGICAL/OBSTETRICAL

134. PAPSMEAR
46. ROUTINE EXAM
40. AMENORRHEA
45. PREGNANCY
41. CONTRACEPTION
42. ABNORMAL BREAST FINDINGS -FEMALE
135. ABNORMAL MAMMOGRAM
43. VAGINITIS
44. VAGINAL BLEEDING
48. OTHER UNSPEC. SYMPTOMS -FEMALE GENITAL ORGANS
136. ABNORMAL CERVICAL FINDINGS

MISCELLANEOUS

72. HEALTH CHECK-UP-WELL
74. FOOT PROBLEM
75. MH PROBLEM NOS
76. ALLERGY, UNSPEC.
81. MALIGNANCY
82. NON-SPECIFIC COMPLAINTS
83. ABN. LAB TESTS
118. FATIGUE
145 SYNCOPE
139 .DEVELOPMENTAL DISABILITY

HIV/AIDS AND RELATED TESTING

56. AIDS
57. HIV+, SYMPTOMATIC
58. HIV+, ASYMPTOMATIC
59. HIV TESTING (PRE)
140 HIV TESTING (POST)

DATE HIV FIRST DIAGNOSED (NOT NECESSARILY AT THIS CLINIC_

____/____
(mo./yr)

Last CD4 count _____
(must be completed for dx 56, 57, 58)

MENTAL HEALTH

1. SCHIZOPHRENIA, PARANOID/295.3_____
2. SCHIZOPHRENIA, OTHER/295_____
3. PARANOID DISORDER/297.10_____
4. BIPOLAR, MANIC/296.4_____
5. BIPOLAR, DEPRESSION/296._____
6. MAJOR DEPRESSION/296._____ _____
7. OTHER/_____ _____ _____ _____ _____
8. ANXIETY DISORDER/300_____ _____
9. ADJUSTMENT DISORDER/309_____ _____
10. PERSONALITY DISORDER/301_____ _____
11. MENTAL RETARDATION/31_____ _____ _____
20 DEMENTIA290.xx
21 BORDERLINE INTELLECTUAL FUNCTIONING V62.89

CARDIOVASCULAR

14. CAD
15 .CHF
133. MYOCARDIAL INFARCT
16. HYPERTENSION
17. PERIPHERAL VASC. DIS.
18. BP SCREENING
141 CARDIAC ARRYTHMIA
19. OTHER SX. INVOLVING C-V SYSTEM

GENITOURINARY

49. CYSTITIS/UTI
51. BPH
52. EPIDIDYMITIS
53. INGUINAL HERNIA
54. RENAL FAILURE
55. OTHER SYMPTOMS INVOLVING URINARY SYSTEM

NEUROLOGIC

83. HEADACHE
84. SEIZURES
85. CVA
120. PERIPHERAL NEUROPATHY
86. OTHER SX OF NERVOUS SYSTEM

TUBERCULOSIS

87. H_x OF +PPD
88. PPD RDG. TODAY, NORMAL
89. PPD RDG TODAY, ABNORMAL
90. NEWLY +PPD, prophy. indicated
91. TUBERCULOSIS (ACTIVE DISEASE)

SUBSTANCE ABUSE

12. ALCOHOL DEPENDENCE/303.9_____
13. ALCOHOL ABUSE/305.0_____
14. DRUG DEPENDENCE/304._____ _____
15. DRUG ABUSE/305_____ _____
16. OTHER SUBSTANCE ABUSE DISORDERS
    #1_____ _____ _____ _____ _____
    #2_____ _____ _____ _____ _____

DERMATOLOGIC

20. CONTACT DERMATITIS
21. FUNGAL SKIN INFECTION
22. BURN
23. CELLULITIS
24. IMPETIGO
114. ECZEMA
62. SCABIES/LICE
25. OTHER SX. INVOLVING SKIN & INTEGUMENTARY TISSUES

INFECTIOUS DISEASES

122. CHICKENPOX
137. SYPHILIS
142 GONORRHEA
50 URETHRITIS/NGU
61. OTHER STD
64. OTHER UNSPEC. INFECTIONS, PARASITIC DISEASES

RESPIRATORY

108. URI
109. ASTHMA
110. BRONCHITIS, ACUTE
111. COPD
112. PNEUMONIA
113. OTHER SX OF RESP SYS

PROGRESS NOTE (OUTREACH USE ONLY. Record contact info in margin)

CAM 2

Camillus Health Concern, Inc.
Financial Assessment/Sliding fee Assignment

Date: _____ Medical Record #_____

Patient's or Patient's/Guardian's Self Reporting of Income

Name:_____
Last Name First Name DOB

Individual/Family Income (Gross): $_____ ☐ weekly ☐ monthly ☐ annually

Family Size (including yourself): _____

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____

Source of Income:

☐ Employment ☐ Unemployed ☐ VA Benefits ☐ Social Security Retirement Disability

☐ Supplemental Security Retirement Income ☐ Supplemental Security Retirement Disability

☐ Wages ☐ Other ☐ If unemployed, date last employed: _____

Patient's or Patient's/Guardian's Consent

I have read this assessment (or had it read to me) in a language that I understand.

I authorize investigation of all statements contained in this assessment. I understand that misrepresentation or omission of facts is cause for my assessment to be assigned to Full Pay category.

I understand that if there are patient fees for services received at Camillus Health Concern, Inc., they are my responsibility.

_____ _____
Patient or Parent/Guardian Signature Date

_____ _____
Staff Signature (Witness) Date

HIP 6

Homeless Initiative Program
1835 N. Meridian Street
Indianapolis, IN 46202
(317) 931-3055

CLIENT ENCOUNTER REPORT

HN Account # (if known) ___ ___ ___ ___ ___
Release Signed: _____(check here if Yes)

People's Health Center
2340 E. 10th Street
Indianapolis, IN 46201

Seen at HIP before? ____Yes ____No ____Don't Know

DATE SEEN: _____/ _____/_____

SITE: aib ap cc d gn hc hf hh hip hl ihn jcs lh lld mto phc/hip client pw sa st wm home visit OTHER: _____

Last Name: **First Name:** **M.I.** (optnl)Mother's name _____

Address: **Phone:** **DOB:** _____/_____/_____ **Age:** _____

SSN: _____ - _____ - _____ **RACE:** B W H N/A A/P Other _____ **SEX:** F M

Veteran?: N Y (___/___ to ___/___) **Other veteran adult in family?** N Y If Yes to either, # of children (<18) in family? ____

FAMILY STATUS: **S**(unattached adult) A:**M**, 0 Children **A**: Not M, Children (Ages __ __ __ __ __ __) A: **M**+C (Ages__ __ __ __ __ __)
Child **YP** (15-19 Head of Household) **Y**outh/Runaway **U**nknown

INFORMATION ABOUT PARENT: Age: _____ Educational Level: _____ Marital Status: _____ # of Children:_____ (__ __ __ __ __ __) Income: _____

NEED TO VERIFY INFO BELOW AT EVERY ENCOUNTER

HOUSING: **SH**ltr **ST** **TR**an **DO**-u_____
OT:_____ **UN**known

MEDICAL RESOURCES
MAid # _____
Mcare# _____
PrvInsCo:_____ #_____
VAMed:_____
Other: _____ NONE

FINANCIAL RESOURCES: **E**mpl/Pen **A**FDC **SSD** **SSI**
Unempl.Ins. **W**IC WorkComp **F**DS **O**th.VA.Ben **N**one
Other:_____

EMERGENCY CONTACT:
Name:_____
Phone:_____

INFO BELOW NEEDED AT 1st HIP ENCOUNTER OF YEAR

HOUSING: **SH**l **ST** **TR**an **DO**-u:_____
DV Sit **P**sychFacil **SubA**buse.trmt.fac **HosP** **Jail/P**rison
Living w/**F**riend/**F**amily **RentlH**sing **UN**known
OTher:_____

REFERRAL FROM: **SEL**f **STO**utrch **Shl/HsingStf**f **ADP**rogrm
Hosp/CLlinic **MentlHlthOu**tpt.clnc **OtherSocS**erv.staff
PSychHosp **POL**ice **PHA**waitList **CHU**rch **UNK**nown
OTHer:_____

DISABILITIES REPORTED WHEN ENTERING HIP PROGRAM:
severe **M**ental **I**llness chronic **S**ubstance **A**buse: (alcohol or drug)
BOth mental ilness and substance abuse **A**IDS/**R**elated Illness
None **R**eported **O**ther: _____

Relationship:_____
Address: _____

IMMUNIZATIONS:

	PCN Code		PCN Code		PCN Code
___ DPT # 1 2 3 4 5	90711	___ DT (Peds)	90702	___ OPV # 1 2 3 4 5	90712
___ Hib # 1 2 3 4	90737	___ MMR # 1 2	90707	___ Varicella	09716
___ DTaP	90700	___ Hep B # 1 2 3	90744 (0-11 yr)	___ IPV 1 2	90713
___ DTaP/Hib 1 2 3 4	90721	___ Hep B # 1 2 3	90745 (11-19 yr)	___ TB skin Test (PPD)	86580
___ Influenza	90724	___ dT (adults)	90718	___ Other	

CONTRAINDICATIONS	Y/N	If Y, Date	CONTRAINDICATIONS	Y/N	If Y, Date	PATIENT EDUCATION	Done	Note
Illness/Fever last 2 days		/ /	Allergies		/ /	Side Effects / Treatment		
Blood transfusion last 3 months		/ /	History, Seizures/Convulsions		/ /	Pregnancy w/Rubella vaccine		
Immunoglobulin/Hep. Shot 3 mth		/ /	Immunocompromised contacts		/ /	Handwashing w/ OPV		
Any shots past 2 months		/ /	Past reactions: _____		/ /	Consent Forms signed		
Medications being taken		/ /	_____		/ /	Prenatal Ed. re: immunizations		

Referral to: ☐ HIP Case Manager ☐ Health Clinic _____ ☐ Food stamps ☐ WIC ☐ Trustee ☐ Hospital_____
☐ Legal ☐ TANF ☐ Other Referral: _____

NOTES: _____

ICD-9 # **Mark Primary Code with a √ or X in the ( )**

( ) V60.0 Housing	( ) V60.2 Poverty	( ) V65.40 Counsel	( ) V67.9 Follow-up	( ) Other- # ____ Desscribe _____

Next Appt: ___/___/___ ___a.m./p.m. Site: _____ **Signature, Initials, Title:** _____

HIP Immunization Encounter Report: 5/97

ROUTING: **White:** Billing **Blue:** Medical Record

SEA 1

HEALTH CARE FOR THE HOMELESS

INTAKE/ENCOUNTER FORM

Client New to Provider ❒ No ❒ Yes

(Birthdate)

Client ID | | | | | | | | | | | (MO DAY YEAR)

Client Name, Last

First _____ MI _____

Clinic Field (optional)

COMPLETE IF PATIENT IS NEW TO HCH OR WITH A CHANGE

Gender: ❒ M ❒ F

Veteran: ❒ Y ❒ N

❒ Served in Vietnam

❒ Interpreter Used

❒ Interpreter Needed

EDUCATION

❒ Grade School
❒ Some High School
❒ HS Grad/GED
❒ Voc/Tech
❒ Some College
❒ College Graduate

SOCIAL UNIT

❒ Single Adult
❒ Minor Living Alone
❒ Family
_____ Adults
_____ Children

RACE

❒ White
❒ Black
❒ Asian/Pacific Islander
❒ Hispanic
❒ Amer. Ind./AK Native
Tribe _____
❒ Multi-Racial
❒ Other _____

BENEFIT STATUS (R - RECEIVING, A = APPLIED, U = UNK)

_____ Medicare
_____ Medicaid
_____ Managed Care
_____ Plan
_____ Exempt
_____ VA
_____ SSI
_____ Private Insurance
_____ Food Stamps
_____ Social Security
_____ WIC
_____ GAU
_____ AFDC/GAS
_____ ADATSA
_____ Other _____
_____ None

COMPLETE BELOW FOR EACH VISIT

VISIT DATE	STATUS	SERVICE TYPE
	❒ Street ❒ Friends/Relatives	❒ Direct
SITE OF SERVICE	❒ Shelter ❒ Treatment Facility	❒ Administrative
	❒ Hospital ❒ Transitional Housing	❒ Collateral Contact
LEAD HEALTH CLINIC	❒ Jail ❒ Other _____	❒ Died
	❒ At Risk	

HEALTH PROBLEMS*

___ Alcohol Dependence
___ Anemia
___ Cardiovascular
___ COPD
___ Diabetes
___ Dental
___ Developmental Disorder
___ Domestic Abuse
___ Drug Dependence
___ GI Disorder
___ Hypertension
___ Mental Disorder
___ Nutritional Disorder
___ Situational/Interpersonal
___ PVD
___ Skin Disorder
___ STD
___ Trauma
___ Tuberculosis
  ___ Previous
  ___ Infected
  ___ Active
___ Other

PREGNANT

___ Yes
___ No
___ DK

PRENATAL CARE

___ Yes
___ No

IMMUNIZATIONS

___ Up-to-Date
___ Scheduled/Referred
___ Completed This Visit
___ Refused

SERVICES PROVIDED

___ Assessment/Screening
___ Counseling/Teaching
___ Crisis Intervention
___ Nursing Care
___ Primary Medical Care
___ Social Services/Support
___ Dental
___ Respite
___ Well Child Exam
___ HIV Prevention Counseling
___ HIV Prevention Packet
___ Spiritual Counseling

*If HIV+ or AIDS/ARC, fill out an HIV Log form

Provider Signature _____ ❒ MD ❒ NP/PA ❒ RN ❒ MH ❒ SW/CM ❒ CDC ❒ DENTAL

Provider Code (Optional) _____

BAL 28

Social Security Number:_____ Time in to Triage_____

Date Of Birth_____ Time in to Provider_____

Health Care For The Homeless, Inc

Medical Team Encounter Record

Today's Date ____/____/____

Name:_____ |___|___|___|___|___|___|___|___|___|___|
(Last) (First) HCH ID#

☐ Appt With _____ At_____
☐ Walk -In Triage Cat#_____
☐ On Call Referral

I. Site (Must Circle One) 1. HCH 2. Other |___|___|___|

II. **Insurance/Benefit Status (Circle Only One)** PA # / MA# _____
2. Medicaid ___HCH ____Other MCO Code _____
1. MPC (PCMI) ____HCH _____Other Provider_____
4. Pharmacy Assistance
7. Pending PA Date Applied _____
5. Medicare
3. VA Benefits
6. None
8. Unknown
9. Other |___|___|___|

III. **Where Did The Client Spend Last Night (Must Circle One)**
1. Shelter
2. Transitional Shelter
3. Doubling-Up
4. Street
5. Other
6. Hospital
7. Unknown
8. Housed
9. Jail/Prison

IV. **HCH Tracking (Check Any That Apply, Circle If It Is New):** ☐ Ryan White ☐ Addiction Outpatient Program ☐ Viola ☐ N/A

_____ Staff Completing above Items

_____ Staff Completing above Items

Contact Info_____ C/O _____ (If Applicable)_____
Street City State Zip Telephone #

V. Special Risk Data (In The Last 6 Months)

No	Yes	NoAssess	
0	1	99	2. Heterosexual Risk
0	1	99	7. Men Having Sex With Men
0	1	99	3. Injection Drug Use
0	1	99	4. Non-Injections Drug Use
0	1	99	5. Alcohol Use
0	1	99	6. Tobacco Use

Last Tested for HIV?

☐ Tested ☐ >6 months ☐ <6 months
☐ Never Tested
☐ No Assess
Result: POS ☐ NEG ☐ UNK ☐

VI. Assessments

1. HPE date last done____/____/____ ☐ Not done
2. IAF date last done ____/____/____ ☐ Not done

☐ **Chart Not Available**

VII. Emergency Room Visit Since Last HCH Visit ? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location
VIII. Hospital Admit Since Last HCH Visit? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location

IX. CPT Codes (Circle All That Apply)

99201	Office Or Outpatient Visit, New Patient (10 Minutes Face To Face)
99202	Office Or Outpatient Visit, New Patient (20 Minutes Face To Face)
99203	Office Or Outpatient Visit, New Patient (30 Minutes Face To Face)
99204	Office Or Outpatient Visit, New Patient (45 Minutes Face To Face)
99205	Office Or Outpatient Visit, New Patient (60 Minutes Face To Face)
99211	Office Or Outpatient Visit, Established Patient, MD Not Required
99212	Office Or Outpatient Visit, Established Patient (10 Minutes)
99213	Office Or Outpatient Visit, Established Patient (15 Minutes)
99214	Office Or Outpatient Visit, Established Patient (25 Minutes)
99215	Office Or Outpatient Visit, Established Patient (40 Minutes)
99401	Preventive Medicine Counsel/Risk Reduction (15 minutes)
99402	Preventive Medicine Counsel/Risk Reduction (30 minutes)
99403	Preventive Medicine Counsel/Risk Reduction (45 minutes)
99411	Preventive Medicine Counseling In Group Setting (30 Minutes)
99455	Work Related or Medical Disability Exam (402)
81000	Urinalysis, By Dip Stick Or Tablet Reagent
82270	Blood, Occult; Feces Screening, 1-3 Simultaneous Determination
82948	Glucose Finger Stick
86580	Skin Test; Tuberculosis, Intradermal
87070	Throat Culture
87110	Chlamydia Culture
87210	Wet Prep
90703	Tetanus Toxoid
90659	Influenza Virus Vaccine
90732	Pneumococcal Vaccine, Polyvalent
90471	Vaccine Administration
90636	Hep A & B Vaccine
90780	IV Infusion
90782	SC/IM Injection
90788	IM Injection-Antibiotic
93000	EKG
94010	Spirometry/Peak Flow
94664	Nebulizer Treatment
94760	Pulse Oximetry
97602	Wound Care Mgmt
90746	Hepatitis B Vaccine
90632	Hepatitis A Vaccine
11200	Removal of Skin Tags
12001	Suturing Simple Repair
65205	Removal of foreign body, eye
30901	Control Nasal Hemorrhage
69210	Ear Irrigation For Cerumen Removal
10060	I & D Abscess
86703	HIV Testing
99195	Blood Draw

X. Reportable Interventions

5. Eligibility Assistance
6. Relationship Building
10. Health Education
12. Group Counseling |___|___|___|
16. Food
13. Prescriptions#_____
15. Transportation
14. Other |___|___|___| |___|___|___|

#Tokens_____ #Cab Voucher(s)_____

Client Signature_____

_____ |___|___|___|___| 1st Provider
Signature & Title Of Provider Completing Encounter

_____ |___|___|___|___| 2nd Provider
Signature & Title Of Provider Completing Encounter

Was A Reimbursable Service Provided? (Circle One) No Yes
(If Yes You Must Complete The Reverse Side)

*Diagnoses includes in TODAY's Encounter and progress note (circle up to 6) Primary_____ Secondary_____ Tertiary_____

Blood Diseases		
225	285.29	Anemia-Chronic
10	285.9	Anemia-Unspecified
11	286.9	Coagulation Defects
226	280.9	Iron Deficiency Anemia
227	281.9	Macrocytic/Nutritional
13	_____	Other_____
228	282.60	Sickle Cell Anemia
200	282.62	Sickle Cell Crisis
Cardiovascular		
229	413.9	Angina
230	796.2	BP Elevation W/O Dx Of HTN
18	401	BP Screening
14	414.01	CAD
141	427.9	Cardiac Arrhythmia
178	786.50	Chest Pain, Unspec
15	428.0	CHF
231	782.3	Edema Lower Extremity
16	401.1	Hypertension
232	458.0	Hypotension Orthostatic
133	410.0	Myocardial Infarct
19	_____	Other_____
17	443.9	Peripheral Vasc. Disorder
Dermatologic		
22	949.0	Burn
23	682.9	Cellulitis/Abcess Unspec
20	692.9	Contact Dermatitis
114	691.8	Eczema
233	707.15	Foot Ulcer
187	054.9	Herpes Simplex
188	053.9	Herpes Zoster
24	684	Impetigo
234	707.10	Leg Ulcer
235	110.1	Onychomycosis
25	_____	Other_____
198	782.1	Rash
62	133.0	Scabies/Lice Infestation
236	454.0	Stasis Ulcer
21	110.9	Tinea
Eent		
99	477.0	Allergic Rhinitis
96	372.30	Conjunctivitis
179	918.1	Corneal Abrasion
268	522.5	Dental Abscess
269	521.0	Dental Caries
97	930.9	Foreign Body (Eye)
144	365.9	Glaucoma
103	389.9	Hearing Loss
100	380.4	Impacted Cerumen
121	368.9	Impaired Vision
95	373	Inflammation Of Eyelids
192	464.0	Laryngitis
104	_____	Other_____
102	380.10	Otitis-Externa
101	382.9	Otitis-Media
93	462	Pharyngitis
98	461.9	Sinusitis
201	373.11	Sty
270	525.0	Tooth Pain
Endocrine/Metabolic		
115	272.0	Cholesterolemia
138	276.5	Dehydration
237	250.01	Diabetes Mellitus-IDDM
238	250.00	Diabetes Mellitus-NIDDM
26	250.0	Diabetes Mellitus-NOS
143	276.9	Electrolyte Imbalance
239	240.9	Goiter
27	274	Gout
28	242.90	Hyperthyroidism Disorder
240	251.2	Hypoglycemia
190	244.90	Hypothyroidism Disorder
29	278.00	Obesity
30	_____	Other_____
Gastrointestinal		
31	789.00	Abdominal Pain Unspec.
36	571.5	Cirrhosis
116	564.0	Constipation
180	787.91	Diarrhea
32	535.00	Gastritis
34	558.90	Gastroententis
183	530.11	GERD
184	578.90	GI Bleed
241	041.86	Helicobacter Pylori
38	455.3	Hemorrhoids
186	070.1	Hepatitis A
35	070.30	Hepatitis B
117	070.51	Hepatitis C
195	787.01	Nausea/Vomiting
39	_____	Other_____
37	577.0	Pancreatitis
33	533.90	Peptic Ulcer
242	569.3	Rectal Bleeding
Genitourinary		
51	600.0	BPH
49	595.0	Cystitis/UTI
246	790.93	Elevated PSA
52	604.90	Epidydimitis/Orchitis
182	607.84	Erectile Dysfunction
185	599.7	Hematuria
53	550.90	Inguinal Hernia
55	_____	Other_____
199	592.0	Renal Calculus
247	584.9	Renal Failure-Acute
54	585	Renal Failure-Chronic
248	788.30	Urinary Incontinence
249	599.0	UTI
HIV		
56	042	AIDS
58	V08	HIV + Asymptomatic
57	042	HIV+ Symptomatic
59	795.71	Lab Test HIV+
Infectious Diseases		
122	052.9	Chickenpox
250	099.53	Chlamydia
142	098.0	Gonorrhea
189	054.10	Herpes, Genital
251	099.4	NGU
252	112.0	Oropharangeal Candidiasis
64	_____	Other_____
61	099.9	Other STD
137	097.9	Syphilis
203	131.01	Trichomoniasis
50	597.80	Urethritis
Miscellaneous		
77	995.2	Adverse Drug Reaction
76	995.3	Allergy, Unspecified
257	727.1	Bunion
258	700	Callus/Corn
139	314.9	Developmental Delay
181	V58.3	Dressing Change/Suture Removal
118	780.7	Fatigue
259	780.6	Fever
73	V67.51	Follow Up Exam
260	729.5	Foot Pain
74	V49	Foot Problem
72	V70	Health Checkup
191	V72.6	Lab Test Visit
82	799.9	Non Specific Complaints
205	_____	Other_____
261	780.90	Pain Generalized
197	998.59	Post Op Infections
202	998.83	Surgical Complications
206	079.99	Viral Syndrome
262	958.3	Wound Infection
Musculoskeletal		
66	716.90	Arthritis
65	724.5	Back Pain
254	733.6	Costochondritis
69	737	Curvature Of Spine
255	715.00	DJD
256	724.2	Lower Back Pain
68	848.9	Muscle Strain/Ligament Tear
70	733.0	Osteoporosis
71	_____	Other_____
67	727	Tendonitis/Bursitis
Neurologic		
263	780.09	Altered Mental Status
177	354.0	Carpal Tunnel Syndrome
85	438.9	CVA
264	780.4	Dizziness
83	784.0	Headache
194	346.00	Migraine
86	_____	Other_____
120	356.9	Peripheral Neuropathy
265	294.10	Presenile Dementia
84	780.31	Seizures
266	780.2	Syncope
267	435.9	TIA
Ob/Gyn		
135	611.9	Abnormal Breast Findings
136	795.0	Abnormal Cervical Findings
40	626.0	Amenorrhea
42	611.72	Breast Mass
41	V25.01	Contraception
243	626.8	DUB
193	627.2	Menopause
48	_____	Other_____
134	V76.2	Pap Smear
244	625.9	Pelvic Pain
196	614.9	PID
45	V22.2	Pregnancy
46	V72.3	Routine Gyn. Exam
245	219.9	Uterine Fibroid
44	626.2	Vaginal Bleeding
43	616.10	Vaginitis
Opportunistic Infections		
152	180.9	Cervical Cancer
151	622.1	Cervical Dysplasia
253	294.10	HIV/Dementia
150	176.9	Kaposi's Sarcoma
148	031.0	MAC/MAI
149	112.0	Oral Thrush
204	_____	Other_____
146	136.3	PCP
147	130.9	Toxoplasmosis
Respiratory		
109	493.90	Asthma
271	493.9	Asthma Acute Excerbation
110	466.0	Bronchitis Acute
111	496	COPD
272	491.20	COPD Exacerbated
273	493.90	Cough
112	482.9	Pneumonia
108	465.9	URI
Trauma		
2	919.0	Abrasion
9	995.81	Adult Abuse
1	924.9	Bruise/Contusion
3	829.0	Fracture
4	854.00	Head Injury
222	879.8	Laceration/Wound
207	_____	Other_____
7	E96.0	Trauma Inflicted By Another
6	991.6	Weather Exposure-Cold
5	992.9	Weather Exposure-Heat
223	891.0	Wound-Lower Limb
224	884.0	Wound-Upper Limb
Tuberculosis		
87	010.0	Hx Of +Ppd
90	795.5	Newly +Ppd
89	795.5	Ppd Rdg Abnormal
88	V74.1	Ppd Rdg Normal
91	010.0	Tuberculosis (Active Disease)
Mental Health		
162	309___	Adjustment Disorder
161	300.00	Anxiety Disorder
158	296.50	Bipolar, Depressed
157	296.40	Bipolar, Manic
166	V62.89	Borderline-Intellectual Functioning
159	296.20	Major Depression
156	297.1	Paranoid Disorder
163	301.9	Personality Disorder
175	309.81	Posttraumatic Stress Disorder
173	298.90	Psychotic Disorder Nos
172	295.70	Schizo-Affective Disorder
155	295.9	Schizophrenia, Other
154	295.3	Schizophrenia, Paranoid
Substance Abuse		
168	305.00	Alcohol Abuse
167	303.90	Alcohol Dependence
170	305.90	Drug Abuse
169	304.90	Drug Dependence
274	292.00	Drug Withdrawal
275	291.81	Alcohol Withdrawal

POR 7

Homeless Mental Health and Substance Abuse Encounter Form

Staff Name: Date: ☐ HMH ☐ HSA ☐ HPC ☐ HY ☐ PSC

First Name	Last Name	DOB	Svc	Site	M'caid ☐ M'care ☐	Updates

Substance Abuse	**ICD9**	***Mental Health***		Schizophrenic disorders	☐ 295	Unemployment	☐ V62.0
Alcohol intox	☐ 303.0	Anxiety disorders	☐ 300	Schizo affective	☐ 295.7	***Procedures***	
Alcohol depend	☐ 303.9	Attn deficit disorders	☐ 314	***Psycho/Social Issues***		Alcohol Screening	☐ V79.1
Alcoholism continuous	☐ 303.91	Bipolar	☐ 296.5	Bereavment,	☐ V62.82	Followup Psythrpy	☐ V67.3
Alcoholism in remiss	☐ 303.93	Depression (NOS)	☐ 311	Econ/Housing	☐ V60.8	Health	☐ V65.4
Alcohol Abuse	☐ 305.0	Dissociative Disorder	☐ 300.15	Family Circumstances	☐ V61	Mental Screening	☐ V79.9
Cannabis depend	☐ 304.3	Eating Disorders	☐ 307.5	Homelessness	☐ V60.0	Notes/Other ICD9	
Cocaine depend	☐ 304.2	Paranoid states	☐ 297	Housing, Inadequate	☐ V60.1		
Drug depndc, multiple	☐ 304.8	Personality Disorder	☐ 301	Legal Circumstances	☐ V62.5		
Drug depndc, unspec	☐ 304.9	Psychosis, other	☐ 298	Psychosocial, other	☐ V62		
Opoid depend	☐ 304.0	PTSD	☐ 309.81	Resources, inadequate	☐ V60.2		

First Name	Last Name	DOB	Svc	Site	M'caid ☐ M'care ☐	Updates

Substance Abuse	**ICD9**	***Mental Health***		Schizophrenic disorders	☐ 295	Unemployment	☐ V62.0
Alcohol intox	☐ 303.0	Anxiety disorders	☐ 300	Schizo affective	☐ 295.7	***Procedures***	
Alcohol depend	☐ 303.9	Attn deficit disorders	☐ 314	***Psycho/Social Issues***		Alcohol Screening	☐ V79.1
Alcoholism continuous	☐ 303.91	Bipolar	☐ 296.5	Bereavment,	☐ V62.82	Followup Psythrpy	☐ V67.3
Alcoholism in remiss	☐ 303.93	Depression (NOS)	☐ 311	Econ/Housing	☐ V60.8	Health	☐ V65.4
Alcohol Abuse	☐ 305.0	Dissociative Disorder	☐ 300.15	Family Circumstances	☐ V61	Mental Screening	☐ V79.9
Cannabis depend	☐ 304.3	Eating Disorders	☐ 307.5	Homelessness	☐ V60.0	Notes/Other ICD9	
Cocaine depend	☐ 304.2	Paranoid states	☐ 297	Housing, Inadequate	☐ V60.1		
Drug depndc, multiple	☐ 304.8	Personality Disorder	☐ 301	Legal Circumstances	☐ V62.5		
Drug depndc, unspec	☐ 304.9	Psychosis, other	☐ 298	Psychosocial, other	☐ V62		
Opoid depend	☐ 304.0	PTSD	☐ 309.81	Resources, inadequate	☐ V60.2		

First Name	Last Name	DOB	Svc	Site	M'caid ☐ M'care ☐	Updates

Substance Abuse	**ICD9**	***Mental Health***		Schizophrenic disorders	☐ 295	Unemployment	☐ V62.0
Alcohol intox	☐ 303.0	Anxiety disorders	☐ 300	Schizo affective	☐ 295.7	***Procedures***	
Alcohol depend	☐ 303.9	Attn deficit disorders	☐ 314	***Psycho/Social Issues***		Alcohol Screening	☐ V79.1
Alcoholism continuous	☐ 303.91	Bipolar	☐ 296.5	Bereavment,	☐ V62.82	Followup Psythrpy	☐ V67.3
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First Name	Last Name	DOB	Svc	Site	M'caid ☐ M'care ☐	Updates

Substance Abuse	**ICD9**	***Mental Health***		Schizophrenic disorders	☐ 295	Unemployment	☐ V62.0
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Drug depndc, unspec	☐ 304.9	Psychosis, other	☐ 298	Psychosocial, other	☐ V62		
Opoid depend	☐ 304.0	PTSD	☐ 309.81	Resources, inadequate	☐ V60.2		

Homeless Encounter Code Descriptions

Service

CL	Clinical Services
CM	Case Management
CX	Counsel
GT	Group Therapy
GX	Group
HE	Health Education
N	Nursing
SS	Support Services

Site

C	Community
CH	City Hall
CRC	Community Resource Center
HP	Housing Projects
HOS	Hospital
HV	Home Visit
J	Jail
O	Other
OS	Outside
OX	Oxford Street
SAA	Substance Abuse Agency
Y	YMCA or YWCA
YSC	Youth Services Clinic

Please use NON-BLACK ink pen when completing this form.

Social Security Number:_____

Date Of Birth_____

BAL 46

Time in to Triage_____

Time in to Provider_____

Health Care For The Homeless, Inc

Mental Health Team Encounter Record

Today's Date ____/____/____

Name_____ |___|___|___|___|___|___|
(Last) (First) HCH ID#

☐ Appt With _____ At_____
☐ Walk -In Triage Cat#_____
☐ On Call Referral

I. Site (Must Circle One) 1. HCH 2. Other |___|___|___|

II. Insurance/Benefit Status (Circle Only One) PA # / MA# _____

2. Medicaid ___HCH ____Other MCO Code _____
1. MPC (PCMI) ____HCH _____Other Provider_____
4. Pharmacy Assistance
7. Pending PA Date Applied _____
5. Medicare
3. VA Benefits
6. None
8. Unknown
9. Other |___|___|___|

III. Where Did The Client Spend Last Night (Must Circle One)

1. Shelter
2. Transitional Shelter
3. Doubling-Up
4. Street
5. Other
6. Hospital
7. Unknown
8. Housed
9. Jail/Prison

IV. HCH Tracking (Check Any That Apply, Circle If It Is New): ☐ Ryan White ☐ Addiction Outpatient Program ☐Viola ☐N/A

_____ Staff Completing above Items

_____ Staff Completing above Items

Contact Info_____ C/O _____ (If Applicable)_____
Street City State Zip Telephone #

V. Special Risk Data (In The Last 6 Months)

No	Yes	NoAssess	
0	1	99	2. Heterosexual Risk
0	1	99	7. Men Having Sex With Men
0	1	99	3. Injection Drug Use
0	1	99	4. Non-Injections Drug Use
0	1	99	5. Alcohol Use
0	1	99	6. Tobacco Use

Last Tested for HIV?

☐Tested ☐>6 months ☐<6 months
☐Never Tested
☐No Assess
Result: POS ☐ NEG☐ UNK ☐

VI. Assessments

1. IPSE date last done____/____/____ ☐ Not done
2. IAF date last done ____/____/____ ☐ Not done
3. PSYC date last done ____/____/____ ☐ Not done

☐ **Chart Not Available**

VII. Emergency Room Visit Since Last HCH Visit ? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location

VIII. Hospital Admit Since Last HCH Visit? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location

IX. CPT Codes (Circle All That Apply)

90801	Psychiatric Diagnostic Interview Examination Including History, Mental Status Or Disposition
90804	Adult Individual Therapy (20-30 Min)
90805	Adult Individual Therapy With Rx (20-30 Min)
90806	Adult Individual Therapy (45-60 Min)
90807	Adult Individual Therapy With Rx (45-50 Min)
90808	Adult Individual Therapy (75-80 Min)
90809	Adult Individual Therapy With Rx (75-80 Min)
90841	Individual Medical Psychotherapy By A Provider Time Unspecified
90853	Group Therapy Per Patient 45-60 (Max 14 Patients)
90862	Pharmacologic Management

X. Reportable Interventions (Circle All That Apply)

5. Eligibility Assistance
6. Relationship Building
7. Crisis intervention
10. Health Education
11. Individual Counseling
12. Group Counseling |___|___|___|
13. Prescriptions #_____
16. Food
14. Other |___|___|___| |___|___|___|
15. Transportation |___|___|___| |___|___|___|

#Tokens_____ **#Cab Voucher(s)**_____

Client Signature_____

_____ |___|___|___|___|
Signature & Title Of Provider Completing Encounter 1st Provider

_____ |___|___|___|___|
Signature & Title Of Provider Completing Encounter 2nd Provider

Was A Reimbursable Service Provided? (Circle One) No Yes
(If Yes You Must Complete The Reverse Side)

BAL 24

Social Security Number:_____ Date Of Birth_____

Health Care For The Homeless, Inc

Community Health Outreach Encounter Record

Today's Date ___/___/___

Name:_____ |_|_|_|_|_|_| ☐ Appt With _____ At_____
(Last) (First) HCH ID#

I. Site (Must Circle One) 1. HCH 2. Other |_|_|_|

II. Insurance/Benefit Status (Circle Only One) PA # / MA# _____
2. Medicaid ___HCH ____Other MCO Code _____
1. MPC (PCMI) ____HCH _____Other Provider_____
4. Pharmacy Assistance
7. Pending PA Date Applied _____
5. Medicare
3. VA Benefits
6. None
8. Unknown
9. Other |_|_|_|_|

III. Where Did The Client Spend Last Night (Must Circle One)
1. Shelter
2. Transitional Shelter
3. Doubling-Up
4. Street
5. Other
6. Hospital
7. Unknown
8. Housed
9. Jail/Prison

IV. HCH Tracking (Check Any That Apply, Circle If It Is New): ☐ Ryan White ☐ Addiction Outpatient Program ☐Other ☐N/A

_____
Signature Of Staff Completing Items

Contact Info_____ C/O _____ (If Applicable)_____
Street City State Zip Telephone #

V. Special Risk Data (In The Last 6 Months)

No	Yes	NoAssess	
0	1	99	2. Heterosexual Risk
0	1	99	7. Men Having Sex With Men
0	1	99	3. Injection Drug Use
0	1	99	4. Non-Injections Drug Use
0	1	99	5. Alcohol Use
0	1	99	6. Tobacco Use
0	1	99	8 Commercial Sex Worker

Last Tested for HIV?

☐Tested ☐>6 months ☐<6 months
☐Never Tested
☐No Assess
Result: POS ☐ NEG☐ UNK ☐

VI. Assessments

1. ASI ___/___/___ date completed
2. SAMIS ___/___/___ date completed
☐ **Chart Not Available**

Readiness For Change: ___Not Applicable "Now In SA Treatment Program?" ___No ___Yes (Action) If Yes, Stop. If No, Continue To Next Question. __Not Assessed.
"Seriously Considering Entering Treatment In 6 Months?" ___No (Precontemplation) ___Yes. If Yes, Continue To Next Questions; If No, Stop.
"Plan To Enter Treatment In The Next Month?" ___No (Contemplation) __Yes (Ready For Action) If Yes, Refer To Addictions Team For Assessment

VII. Emergency Room Visit Since Last HCH Visit ? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location
VIII. Hospital Admit Since Last HCH Visit? ☐No ☐Yes ☐Not Assessed If Yes, why? ☐Clinic Closed ☐Services CutOff ☐Sent by HCH ☐Other ☐Location

IX. CPT Codes (Circle All That Apply)

86703 HIV Testing

99401 Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (15 Minutes)

99402 Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (30 Minutes)

99403 Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (45 Minutes)

99404 Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention (60 Minutes)

99412 Preventive Medicine Counseling And/Or Risk Factor Reduction Intervention Provided To Individual In Group Setting (60 Minutes)

X. Reportable Interventions (Circle All That Apply)

5. Eligibility Assistance
6. Relationship Building
7. Crisis intervention
9. Case Management
10. Health Education
11. Individual Counseling
12. Group Counseling
16. Food
14. Other |_|_|_| |_|_|_| |_|_|_| |_|_|_|

15. Transportation **#Tokens**_____ **#Cab Voucher(s)**_____

Client Signature_____

_____ |_|_|_|_| 1st Provider
Signature & Title Of Provider Completing Encounter

_____ |_|_|_|_| 2nd Provider
Signature & Title Of Provider Completing Encounter

Progress Notes:

Is Client eligible for PA YES ☐ NO ☐ **Has Pharmacy Assistance application been completed?** YES ☐ NO ☐

Does Client have regular Health Care Provider YES NO (circle only one)

Baseline Info (Please Complete On First Encounter Or If Information Changes)

Sex: (Check One): ☐Male ☐Female

Race: (Check One): ☐White ☐Black ☐Hispanic ☐Asian ☐American Indian ☐Other

Education (Check One That Best Describes The Highest Level Completed):

☐None ☐Grade School ☐Some High School ☐HS Grad/GED

☐Vocational/Tech School ☐Some College ☐College Grad

Social Security #:_____ **Date Of Birth:**_____

Marital Status: ☐Single ☐Married ☐Separated/ Divorced/ Widowed

SSI/SSDI Benefits: ☐Yes ☐No ☐Pending

Veterans Benefits ☐Yes ☐No

HIP 2

Dear Parent: Please help us help your child by answering the questions below. **Date: ____/____/____**

Child's name: _____ Nickname we should use: _____ Date of Birth: ___/___/___ Age: _____

Your concern about the child's health: _____

Specific symptoms. For those that are present write in # of Days on line

____ Ear pain (tugging at ears, crying at night, telling you ear hurts)
____ Right side ____ Left side ____ Both sides
_____ Sneezing
_____ Runny nose __ clear __yellow __green __grey/brown
_____ Sore throat
_____ Cough ___dry ___phlegm color of phlegm: _____
_____ Fever ____(maximum degrees for how long: _____)
_____ Rash - Describe and say where _____
_____
_____ Pain ____ Stomach ____Other : Where_____
_____ Vomiting (throwing up) _____ times in 24 hours

Other things you have noticed that will help us understand:

Has your child changed his or her	Increased	Decreased	Same
____Appetite	____	____	____
____Liquid intake	____	____	____
____Activity level	____	____	____
____Sleep	____	____	____
____Urination	____	____	____
____ times in 24 hrs.			
____BMs	____	____	____
____ times in 24 hrs.			

What medicines have you given to your child in the last three (3) days:

____ Tylenol or generic non-aspirin pain reliever
____ Children's Advil or other ibuprofen
____ Something to help his or her stomach :
Which kind _____
____ Cold medicine : Which kind _____
____ Cough medicine : Which kind _____
____ Something to help his or her bowel movements
Which kind: _____

Thank you. You will get a reply from the nurse after she examines your child.

THE NURSE WILL COMPLETE THIS PART WHEN SHE EXAMINES YOUR CHILD: Date: ____/____/____

Weight_____ Temperature: ____ RR: _____ HR:____ Hycration_____

AF	Nose	Chest
Eyes	Throat	Abdomen
Ears	Cervical Nodes	Lab tests

URI OM Pharyngitis Sinusitis Conjunctivitis Allergic Rhinitis OEx Bronchitis

Other: _____

THIS PART GOES BACK TO THE PARENT: Child's Name: _____

YOUR CHILD HAS: _____

I've prescribed: _____

to be given as follows: _____ times per _____

Special Instructions: _____

_____

Schedule recheck appt. _____. Return to clinic on _____ if not better. RETURN TO CLINIC SOONER if worse.

HOMELESS INITIATIVE PROGRAM, Luise's Love Child Care Center

Date: _____ Provider: _____ (317) 931-3055 to reach nurse

MON 13

MONTEFIORE

New York Children's Health Project
Division of Community Pediatrics

Name: *Last* *First*

MR #: 900-___ ___-___ ___-___ ___

ACCOUNT NUMBER

PEDIATRIC ENCOUNTER

SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ ___

DATE

PARENT'S NAME: *Last* *First*

MOTHER'S D.O.B.

MOTHER'S SOCIAL SECURITY NUMBER ___ ___ ___-___ ___-___ ___ ___ ___

DATE OF BIRTH

AGE ___ ___ Years ___ ___ Months

SEX OF PATIENT ☐ MALE ☐ FEMALE

RACE ___ ___

MED/C NUMBER

SEQ.#

PATIENT'S ADDRESS: *Street* *City* *State* *Zip*

PHONE NUMBER (___ ___ ___) ___ ___ ___-___ ___ ___ ___

IM NUMBER ___ ___

NYCHP NUMBER ___ ___ ___-___ ___-___ ___

PLACE OF SERVICE ___ ___

HOME HOTEL / SHELTER ___ ___

ROOM NUMBER

Have You Seen Another Provider Since Last Visit? ☐ No ☐ Yes Specify: _____

CHIEF COMPLAINT

HISTORIAN

HISTORY OF PRESENT ILLNESS

CURRENT MEDICATIONS

ALLERGIES

GROWTH & DEVELOPMENT / BEHAVIOR

NUTRITION

TYPE OF FORMULA _____ AMOUNT _____ PARENTAL FEEDING CONCERNS: _____

HEIGHT	WEIGHT	HC	PULSE	RESPIRATORY RATE
___ ___.___ ___ (CM)	___ ___.___ (KG.)	___ ___.___ (CM)		
(% tile)	(% tile)	(% tile)	TEMP.	B.P.

CHECK IF NORMAL	DESCRIBE ABNORMALITY	CHECK IF NORMAL	DESCRIBE ABNORMALITY
☐ Appearance		☐ Lymph Node	
☐ Head		☐ Abdomen	
☐ Eyes		☐ Genitalia	
☐ Ears		☐ Rectum	
☐ Nose		☐ Neuro	
☐ Throat		☐ DTR	
☐ Mouth		☐ Tone	
☐ Neck		☐ Muscles	
☐ Lungs		☐ Bones / Joint	
☐ Breast		☐ Spine	
☐ Heart		☐ Skin	
☐ Pulses		☐ Nails / Hair	

S & S INC. 72418 (5/95)

MONTEFIORE

New York Children's Health Project
Division of Community Pediatrics

PEDIATRIC ENCOUNTER

Name: *Last* *First*

MR #: 900-___ ___-___ ___-___ ___

CODE	DIAGNOSIS / PROBLEM	CHR	RES	AC
285.9	Anemia			
493.9	Asthma			
691.8	Atropic Dermatitis			
490	Bronchitis			
466.1	Bronchiolitis			
785.2	Cardiac Murmur			
372.3	Conjunctivitis			
786.2	Cough			
V06	Delayed Immunization			
PDI	Provider Delayed Immunization			
521.0	Dental Caries			
	Developmental Delay			
558.9	Diarrhea			
984.9	Elevated Lead			
783.4	FTT / Underweight / Short Stature			
009.0	Gastroenteritis			

CODE	DIAGNOSIS / PROBLEM	CHR	RES	AC
691.0	Candida (Diaper Rash)			
382.9	Otitis Media-Effus – Acute			
381.3	Otitis Media-Effus – Chronic			
462	Pharyngitis / Tonsillitis			
RAD	Reactive Airway Disease			
486	Pneumonia			
782.1	Rash (Non-specific)			
473.9	Sinusitis			
112.0	Thrush			
110.9	Tinea Infestation			
959.9	Trauma			
465.9	U.R.I.			
052.9	Varicella			
HR	Health Risk:			
V20.2	Health Care Maintenance / Well Child			
	Other:			

VISIT TYPE ☐ Well Child / Preventive ☐ Acute Visit ☐ Follow-Up ☐ Nurse Visit ☐ Initial Visit ☐ Other:

IMMUNIZATIONS			
	DPT		HIB
	dT		Hep B
	TOPV		Tetramune
	MMR		Vacc. Info
	Other:		
	Other:		

LAB			
	HgB		C Lead
	CBC		V Lead
	U Screen		W Cult
	T.C.		PPD
	Other:		
	Other:		

MISCELLANEOUS			
	Counseling		Vision Screen
	PE Forms / Letter		Tympanometry
	WIC Certif.		Hearing Screen
	Meds. Dispensed		Nebulizer
	Prescription Issued		Wound Care
	E.R. F/U		Medical Equipment

ASSESSMENT / PLAN:

REFERRAL	To:	Reason:	Appt. Date:

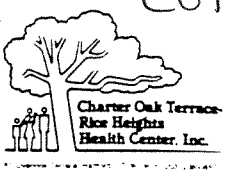
SIGNED: X

S & S, INC. (4/96)

COT 5

HHCP

SOCIAL WORK DAILY ENCOUNTER SHEET



New ☐ Return ☐ First Yearly Visit ☐ Date _____ Encounter # _____

Name: _____ D.O.B. _____ Age_____ Sex_____

Last Address: _____ Social Security # _____

Ethnicity: W ☐ B ☐ H ☐ O ☐ Medical Insurance: _____

Educational Background: E ☐ H.S. ☐ College ☐ Grade Level: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐

Procedure

☐ Referral

☐ Direct Service

☐ Offsite Visit

Appointment Date _____

☐ Medical ☐ Social Services

☐ Dental ☐ Mental Health

Nature of Service

☐ Housing/Shelter	☐ GA	☐ Pregnancy
☐ Substance Abuse	☐ T19	☐ Groups
☐ Mental Health	☐ S.S.	☐ Prescription
☐ Employment	☐ S.S.I.	☐ Interpretation
☐ Domestic Violence	☐ AFDC	☐ Client Advocacy
☐ Education	☐ Financial	☐ Crisis Intervention
☐ Job Training	☐ Furniture/Clothing	☐ Home
☐ Transportation	☐ Legal	☐ Hospital
☐ Child Abuse/Neglect	☐ Aids Prevention/Education	☐ Doctor
☐ Food Stamps	☐ Soup Kitchen/Pantry	☐ Lawyer
☐ Other	☐ _____	☐ _____

NOTES: _____

_____

_____

_____

_____

Chart # _____ **Provider:** _____

MON 5

Telephone Record

Date:_____ Time:_____

Provider/Nurse on call:_____
Primary Care Provider:_____

Patient Name:_____ Age:_____
Site/Address_____
Room/Apt._____
Phone:_____

Chief Complaint:

Tentative Diagnosis:

Plan:

Comments:

Provider/Nurse Signature:_____

Reviewed by:_____
Medical Director

Pink copy: Provider call book/Nurse log book **Yellow copy**: Site provider **White copy**: Dr Sherman/Dr. Shapiro; Medical Records