INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#14. STAFF LOGS

Blood glucose monitoring system – Daily quality control record (*BAL 30*)
Daily encounter report (*BIR 9*)
Encounter form (*POR 8*)
Laboratory processing log (*BAL 38*)
Medication inventory tracking sheet (*BAL 42*)
Social service log (*THU 4*)
TB screening/referrals – Quality improvement program (*NOR 14*)
Walk-in client list (*BAL 43*)

BAL 30

HEALTH CARE FOR THE HOMELESS

ONE TOUCH BLOOD GLUCOSE MONITORING SYSTEM
Daily Quality Control Record

ONE TOUCH Meter

HIGH RANGE = 240-391
LOW RANGE = 41-65

Serial #: ______________________

Check Strip Range = Range on the monitor

Solution Expiration Date (High): __________ Solution Lot: __________

Solution Expiration Date (Low): __________ Solution Lot: __________

ONE TOUCH Test Strip

Lot #: __________ Expiration Date: __________

Code #: __________

LifeScan Customer Service: 1-800-227-8862

MONTH: ______________________

If Center Is Not Open - Write CLOSED

1ST WEEK	DATE	TIME	OPERATOR INITIALS	CONTOL SOLUTION READING HIGH	CONTROL SOLUTION READING LOW	CHECK STRIP	METER CLEANED (*)	COMMENTS
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
2ND WEEK								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
3RD WEEK								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
4TH WEEK								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
5TH WEEK								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								

* Calibrate Qday with ✓ strip.

* Clean Qwk and PRN using a cotton ball with (warm) soap and water. After cleaning, use solution to check for proper functioning of machine then calibrate with ✓ strip

Operator Signature: ______________________ Initials: __________

Operator Signature: ______________________ Initials: __________

Operator Signature: ______________________ Initials __________

BIR 9

Birmingham Health Care
712 - 25th Street North
Birmingham, AL 35203
(205) 323-5311

DAILY ENCOUNTER REPORT

SITE NUMBER: ____________ PROVIDER #____________ DATE: ____________

PROVIDER SIGNATURE:

NAME	ACCOUNT NUMBER	PROCEDURE CODE	UNITS	DIAGNOSIS CODE	CHART NUMBER

POR 8

Homeless/Portland Street Clinic Encounter Form

Staff Name: Date: ☐ HPC ☐ HY ☐ PSC

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

UDS Codes		Diabetes, other	☐ 250.8	TB, Active	☐ 011	Venereal Screen	☐ V74.5	Open Wound	☐ 879.8
AIDS, unspecified	☐ 042.9	Drug Depend	☐ 304	**Procedure Codes**		**Other Codes**		Pregnancy, NL	☐ V22.2
HIV, asymptomatic	☐ V08	Drug Withdrwl	☐ 292.9	Health Advice/Csl	☐ V65.4	Backache	☐ 724.5	Rash, Skin	☐ 782.1
HIV, symptomatic	☐ 042	Eczema/Dermatitis	☐ 692	HIV Test Cnsl	☐ H65.4	Bronchitis, Acute	☐ 466	Scabies	☐ 133.0
Alcohol, Depend	☐ 303.9	Epistaxis	☐ 784.7	Immunization	☐ V06.9	Cystitis/UTI	☐ 595	Seizure disord	☐ 780.3
Alcohol Intox	☐ 303.0	Heart Dis, Unsp	☐ 429.9	Lab Work	☐ V72.6	Depression	☐ 311	Sinusitis	☐ 461.9
Alcohol remiss	☐ 303.93	Hypertension	☐ 401	Mammogram Refer.	☐ R76.1	Gastroenteritis	☐ 558.9	Sore Throat	☐ 462
BP, elevated	☐ 401.9	Hypothermia	☐ 991.6	Pap Smear	☐ V76.2	GE Reflux	☐ 530.1	Toothache	☐ 525.9
Cardia dysrhythm	☐ 427	Nutrition Problem	☐ 269.9	Physical Exam	☐ V20.2	Menopausal Symp	☐ 627.2	Tooth Abscess	☐ 522.5
Contrcept Mngmt	☐ V25	Otitis Media	☐ 381	Preg Test	☐ V72.4	Hypothryroidism	☐ 244.9	URI	☐ 465.9
COPD	☐ 496.0	Pain, Head/Neck	☐ 784	Repeat Rx	☐ V68.1	Leg Injury, any part	☐ 959.7	Vision Imprmnt	☐ 379.09
Dvlp Delays	☐ 783.4	Pap test, abnormal	☐ 795.0	Sight Problem	☐ V41.0	Lice Infestation	☐ 132.9	Other ICD9	______
Diabetes melitis	☐ 250	Sunburn	☐ 692.71	TB Screen (PPD)	☐ V74.1	Mental Disorder	☐ V11.9	Other ICD9	______

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BAL 38

HEALTH CARE FOR THE HOMELESS
LABORATORY PROCESSING LOG

DATE SPECIMEN COLLECTED	CLIENT NAME (LAST, FIRST)	HCH NUMBER	PROVIDER ORDERING TEST	DATE SPECIMEN SENT TO LAB	TEST ORDERED (CBC, UA, etc.) [Use one line for each test ordered]	LAB RECEIVING SPECIMEN [circle one]	DATE TEST RESULTS RECEIVED FROM LAB
						Mercy BCHD Lab Corp State of MD Other: ______	
						Mercy BCHD Lab Corp State of MD Other: ______	
						Mercy BCHD Lab Corp State of MD Other: ______	
						Mercy BCHD Lab Corp State of MD Other: ______	
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						Mercy BCHD Lab Corp State of MD Other: ______	
						Mercy BCHD Lab Corp State of MD Other: ______	

BAL 42

HEALTH CARE FOR THE HOMELESS

MEDICATION INVENTORY TRACKING SHEET

BRAND NAME:		GENERIC NAME:
LOT#	EXPIRATION DATE	MANUFACTURER
DATE RECEIVED	QUANTITY RECEIVED	RECEIVED BY

PLEASE DOCUMENT ALL MEDICATIONS DISPENSED BELOW - PLEASE WRITE LEGIBLY

DATE	CLIENT NAME	HCH#	QUANTITY	PROVIDER

THU 4

THUNDERMIST HEALTH ASSOCIATES
SOCIAL SERVICE LOG

Staff__________________ Week Ending Date__________________________

Date	Service code	Location code	Session (I/G/F)	Time (min)	Comments	Names

Service Codes:
1. Referral
2. Intake
3. Case Management
4. Home-based service
5. Education session
6. Counseling session
7. Medical test HIV, UCG
8. Assessment
9. Follow up
10. Advocacy

Location:
1. Client's home
2. THA
3. Community site
4. Outside agency
5. Phone

Comments:
1. Homeless HCH
2. Case Management
3. Minority Outreach
4. Prenatal
5. Pediatrics
6. Mentor
7. Adult Medicine

Eleanor M. Gray, R.N., Director
Cooperative HCH Network
Northeast Valley Health Corporation
1172 North Maclay Avenue
San Fernando, CA 91340
(818) 838-1388 ext. 118
emgray-nevhc-hch@rocketmail.com

QUALITY IMPROVEMENT PROGRAM

Health Care for the Homeless -4th Quarter Audit

TUBERCULOSIS SCREENING / REFERRALS

Date Reviewed: ________________ **Reviewer(s):** ________________________________ **Title:** ________________________________

Site Name: ____

INDICATORS / CHART NUMBER **PLEASE INDICATE (YES, NO, OR N/A)**																															YES TOTAL	TARGET %	COMPLIANCE
1. TB risk factors assessed and recorded in medical record? (including age, HIV status, DM, immunosuppression, prolonged shelter residence, symptomatic, drug use, recent exposure, recent converter).																																**80%**	
2. Symptom screening done and documented within the past 6 months? (Assess for fever, cough for more than 1 week, weight loss, night sweats).																																**80%**	
3. Last PPD date and result documented?																																**80%**	
4. Hard copy of results in chart?																																**80%**	
5. If PPD not done in past 12 months (and no contraindication for test), was a repeat ordered?																																**80%**	
6. Are results recorded in chart?																																**80%**	
7. If a chest x-ray was ordered, are results documented in the chart?																																**80%**	
REFERRALS: 8. If the chest X-ray was positive was the case reported to the health department and was the client referred for treatment?																																**80%**	
9. If recent PPD conversion (<2 years) was a referral made?																																**80%**	

Additional Comments:

Recommendations:

Actions:

NGR 14

BAL 43

WALK-IN CLIENT LIST

COMPONENT________________ DATE______________

NAME	HCH#	REASON	TRIAGE NO.	SEEN BY (PROVIDER)	DISPOSITION IF NOT SEEN
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					

TOTAL WALK-IN'S SEEN TODAY ____________

TOTAL WALK-IN'S NOT ABLE TO SEE __________