Venice Family Clinic

PATIENT NAME: _____

CHART NUMBER: _____ DOB: _____

TODAY'S DATE: _____

HOMELESS CLINIC PROGRESS NOTE

ADVERSE DRUG REACTION: _____

LMP _____

BLOOD PRESSURE _____ PULSE _____ TEMP _____ WEIGHT _____ BMI _____ BLD SUGAR _____ Hgb _____

UA: glu _____ bili _____ Ket _____ sp.g _____ bld _____ ph _____ pro _____ uro _____ nit _____ leuk _____ other _____

CHIEF COMPLAINT: _____ C.A. _____

SMOKER: ☐ YES ☐ NO ☐ 1-800 NO BUTTS CARD ☐ CESSATION DISCUSSED

Living Situation _____
How long homeless? _____
Family _____
Income _____
Meals _____ Need help? ☐ Yes ☐ No
Transport _____ Need help? ☐ Yes ☐ No
Alcohol ☐ Past ☐ Current ☐ Never
Amount _____ Last used _____
Drug use ☐ Past ☐ Current ☐ Never
Type _____ Last used _____
☐ IVDU ☐ Past ☐ Current ☐ Never
☐ Risk reduction discussed
Tetanus _____
PPD (q yr) _____ TB symptoms _____
Psychiatric hx _____
Last PAP _____ Mammo _____
PAP offered today ☐ Yes ☐ No ☐ Declined
Sexual activity M W ___ # partners in past ___ mos/yrs
Condom use ☐ Always ☐ Sometimes ☐ Never
Family Planning _____
Last HIV Test _____
HIV Test Offered ☐ Yes ☐ No ☐ Declined
☐ HIV/STD prevention discussed
Domestic Violence ☐ Past ☐ Present ☐ None

☐ Substance Abuse Resources ☐ Declined ☐ Needle Exchange ☐ Dental Referral ☐ Tokens/Taxi
☐ Mental Health Resources ☐ Declined ☐ Food Resources ☐ Social Service/Shelter ☐ Condoms ☐ Hygiene Kit

☐ Influenza ☐ Pneumovax ☐ Tdap ☐ PPD ☐ Declined Vaccinations ☐ ____ Out of stock ☐ Clothing/Shower

Health Ed. Topic discussed with patient & understood _____ Labs discussed with patient & understood _____

MEDICATION	STRENGTH	NUMBER	INSTRUCTIONS	REFILLS

PROVIDER SIGNATURE(S) _____ / _____ M.D.

PRINT NAME: _____

Attending Note: (care provided under the continuity clinic exception rule, billing at Level 1,2,or 3; all residents and any interns with greater than 6 mos. experience)
I reviewed and discussed the case of this patient with the resident, including the findings in history, physical examination and the diagnosis and treatment plan at the time of today's visit. I provided personal direction in the services rendered at this visit and I agree with the findings, diagnoses, and plans as documented in the resident's note.
Signature: (write clearly) _____

CASE MANAGEMENT CHEKLIST:

☐ Medical Plan Reviewed ☐ Case Manager Name _____ Agency _____

MEDICAL		PSYCHO-SOCIAL				TRANSPORTATION
Appt.	Ref.	Appt.	Ref.	Appt.	Ref.	
☐	☐ INTERNAL	☐	☐ DENTAL	☐	☐ Shelter ☐ Hygiene Kit	☐ Tokens
☐	☐ EXTERNAL	☐	☐ Substance Abuse	☐	☐ Food ☐ Condoms	☐ Taxi
☐	☐ Lab/X-Ray	☐	☐ Mental Health	☐	☐ Benefits	☐ Maps and or Directions
☐	☐ Family Planning	☐	☐ Other			
☐	☐ Prenatal					

NOTES: _____

_____

Next appt. date _____ Time _____ Clinic _____

How to contact patient: _____

_____ Clinic Coordinator