

MCDPHS HCH OUTREACH – CLINIC ONLY

- | | |
|--|---|
| <input type="checkbox"/> Dr. O'Sullivan | <input type="checkbox"/> MCHP _____ |
| <input type="checkbox"/> Dr. Ellert | <input type="checkbox"/> APIPA _____ |
| <input type="checkbox"/> Janne Croll P.A.C | <input type="checkbox"/> Grant _____ |
| <input type="checkbox"/> Keith Williamson, P.A.C. | <input type="checkbox"/> Mercy Care _____ |
| <input type="checkbox"/> Eureka King | <input type="checkbox"/> Care First _____ |
| <input type="checkbox"/> Cathy Hollis | <input type="checkbox"/> Health Choice _____ |
| <input type="checkbox"/> Linda Looker | <input type="checkbox"/> PHP _____ |
| <input type="checkbox"/> Tresa Floyd | |
| <input type="checkbox"/> Isabel May | Marital Status: Single Married |
| <input type="checkbox"/> Tex Uvalle | Circle One: Male Female |
| <input type="checkbox"/> Allan Gange | Limited English: Y N |
| <input type="checkbox"/> Jeff Jirak | Ethnicity: W B H NA O |

LAST NAME: _____
 FIRST NAME: _____
 DOB: _____
 SOC. SEC. # _____

DATE HOMELESS _____

Substance Abuse History: Y N
 SAC Offered: Y N / Referred: Y N
 Mental Health Issues: Y N

SITE: _____

DOS: _____

Housing Status		SMI		Referred To	
001	Shelter	X1856	YES	AHC	AHCCCS
002	Transitional	X1857	NO	DEN	Dental
003	Doubling Up	Case Management		ADV	Advocates for the Disabled
004	Unknown	W2052	Triage Screening (1/4 Hour)	SHE	Shelter
005	Street	W2030	Case Management 1/4	VLO	Value Options
006	Other	Levels - Outreach		DES	DES – Food Stamps
007	Migrant	X1953	Level 1 - Approached	SOC	Social Security
008	Seasonal	X1954	Level 2 - Engagement	SAT	Substance Abuse Treatment
Income/Poverty Level		X1955	Level 3 - Referral	TRN	Transitional Housing
IP001	< 100%	Immunizations		PER	Permanent Housing
IP002	100% (\$650 per month)	90658	Influenza (Adult)	MDL	Medical
IP003	101-150% (\$850 per month)	Treatments		PSY	Psychiatric
IP004	151-200% (\$1300 per month)	94664	SVN - Initial	**Providers**	
IP005	Over 200	94665	SVN - Subsequent	Levels Of Service	
IP006	Unknown			Level	1 2 3 4 5
Diagnostic Code		Diagnostic Code		Diagnostic Code	
789.0	Abdominal Pain	525.9	Dental Disorder, Unsp	684	Impetigo
919.0	Abrasion	311	Depression	719.40	Joint Pain
303.90	Alcoholism	110.9	Dermatophytosis-Unsp	729.0	Limb Pain
300.00	Anxiety Disorder	250.00	Diabetes NIDDM	724.2	Low Back Pain
493.90	Asthma	250.01	Diabetes IDDM	V68.1	Medication Refill
917.2	Blister, Foot	304.90	Drug Addiction	382.9	Otitis Media
466.0	Bronchitis, Acute	536.8	Dyspepsia	132.9	Pediculosis
682.9	Cellulites / Abscess	388.9	Ear Disorder	462	Pharyngitis, Acute
786.52	Chest Wall Pain	692.9	Eczema	V22.2	Pregnancy
372.00	Conjunctivis, Acute	782.9	Edema	569.3	Rectal Bleeding
564.0	Constipation	780.79	Fatigue	110.3	Tinea Cruris
V25.41	Contraceptive, Oral	829.0	Fracture	110.4	Tinea Pedis
V25.09	Contraceptive, Other	784.0	Headache	465.9	URI
780.39	Convulsive Disorder	070.51	Hepatitis C	599.0	UTI
496	COPD	401.9	Hypertension	879.8	Wound, Open / Laceration

Social Service

In person _____ Phone _____ Collateral Contact _____
 15 Minutes: _____ 30 Minutes: _____ 45 Minutes: _____ 60 Minutes: _____ ()Minutes _____

Social Service: _____

Case Manager's Signature: _____

I have been given a copy and had the opportunity to, or have had explained to me, the information in the "Vaccine Information Pamphlet(s)" or the "Important information Statement(s)" for Influenza Vaccine.
 I agree to the health care provider placing the **FLU Shot**, releasing the Flu Shot results to other health care providers for continuity of care.

I give my consent for routine medical care to be provided by the Health Care for the Homeless Program

Signature Of Recipient/Parent/Guardian or Adult _____ Date _____

S: _____ *Allergies:* _____

O: VS _____ P _____ R _____ BP _____ O2SAT _____

Gen'l	Normal	Abnormal
HEENT	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	_____
Chest	<input type="checkbox"/>	_____
Abd	<input type="checkbox"/>	_____
Ext	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____

A: _____

- Plan:**
- Hydrocortisone Cream 1% 1oz Apply BID PRN
 - A&D Ointment Apply to AA P.R.N
 - Antacid Tabs Chew 2 up to TID P.R.N
 - Antibiotic Ointment Apply to AA B.I.D P.R.N
 - Antifungal Ointment/Cream Apply as directed
 - Acetaminophen Tabs 2 tabs 4 hrs P.R.N
 - Cough Syrup DM 2tsp 4 hrs P.R.N
 - Lice Shampoo 1 bottle externally as dir.
 - MultiVitamins take 1 daily
 - Sudafed 30mg TID ÷
 - Amoxil 500mg Cap ____ Take 1 capsule T.I.D. until gone
 - Cephalexin 500mg ____ Take 1 capsule Q.I.D.
 - Cyclobenzaprine 10mg ____ Take 1 tablet T.I.D. P.R.N
 - Cipro 500mg ____ Take 1 tablet B.I.D. until gone
 - Colace 100mg ____ Take 1 capsule B.I.D. PRN
 - Dilantin 100mg ____ Take __ capsule daily
 - Benadryl 25mg ____ Take 1 tablet q6h P.R.N.
 - Ibuprofen 600mg _1_ T.I.D with Food
 - Ibuprofen 800mg _1_ T.I.D with Food
 - Imodium 2mg ____ Take 2 tabs now and 1 after each loose stool
 - Lisinopril 10mg ____ Take __tablets__times daily
 - Septra DS ____ Take 1 tablet B.I.D until gone
 - Zantac 150mg ____ Take 1 tablet B.I.D
 - Prednisone 10mg ____ Take 4 tablets daily until gone
 - Zithromax 250mg ____ Take 2 tabs now and 1 daily for the next 4 days
 - Naprosyn 500mg ____ Take 1 tablet B.I.D with food

Medical Provider: _____ Date: _____