

Camillus Health Concern, Inc.
PSYCHOSOCIAL REPORT

I. Date _____ CHC Number _____

Client Name _____
Last First SSN

II. Name Children(s)	Age	Sex	Birth Dates
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____
d. _____	_____	_____	_____

III. Family/Friends/Agency Contacts
(name, relationship, address, telephone number)

a. _____

b. _____

c. _____

IV. Presenting Concern(s) _____

V. Living Situation _____

VI. Income and Expenses _____

VII. Family History _____

VIII. Homelessness History _____

IX. Employment History _____

Client Name _____
Last First SSN

XV. Problems

Community or Camillus House Referrals

a. _____

a. _____

b. _____

b. _____

c. _____

c. _____

d. _____

d. _____

XVI. Follow-up Plan _____

Signature: _____

Print Last Name: _____

Title: _____

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

Camillus Health Concern, Inc
Registration Form

CHC Medical Record # _____

1. Last name: _____ Middle initial: _____

2. First name: _____ Phone number: _____

3. Address: _____ Zip Code: _____

4. Emergency contact: _____ Phone number: _____

5. Relationship to emergency contact: _____

6. Social Security: _____ - _____ - _____

7. Country of birth: _____

8. Date of birth: _____ / _____ / _____ Female Male

9. Marital status: _____

10. Nationality: (Please choose one)

Asian Black (Non-Hispanic) Hispanic (All Races) White

Indian/Alaskan Native Pacific Islander Unknown Other _____

11. Preferred Language _____

12. Are you employed: Yes No If yes weekly income \$ _____

13. How many people are supported by this income (including yourself) _____

14. What type of insurance do you have? (Please choose one)

Medicaid Medicare Medipass Physicians Healthcare Plan Not apply

15. Mother's first name: _____

16. Mother's birth last name: _____

17. Father's first name: _____

18. Father's last name: _____

19. Living Situation (Please choose one)

- | | |
|---|---|
| <input type="checkbox"/> Street | <input type="checkbox"/> Hotel/Motel |
| <input type="checkbox"/> Car | <input type="checkbox"/> Substance Abuse/Treatment Center |
| <input type="checkbox"/> Shelter | <input type="checkbox"/> Apt/House (<i>less than 12 months</i>) |
| <input type="checkbox"/> Transitional Housing | <input type="checkbox"/> Apt/House (<i>more than 12 months</i>) |

Staff Initials: _____

CAMILLUS HEALTH CONCERN, INC.

Please complete so that we have the most updated information on you.

Name: _____

Address: _____

Telephone Number: Home _____ Work _____

Check one of the following:

Do you have Medicaid or Medicare? _____ Yes _____ No

Do you get a check every month? _____ Yes _____ No

Thank You

Por favor complete, para que nosotros tengamos la mas reciente informacion de usted.

Nombre : _____

Direccion: _____

Numero de Telefono: -Casa _____ Trabajo _____

Marque uno de los Siguiete:

Usted tiene Medicaid o Medicare? _____ Yes _____ No

Usted recibe un cheque cada Mes? _____ Yes _____ No

GRACIAS . . .

**CAMILLUS HEALTH CONCERN, INC
PATIENT GRIEVANCES**

POLICY NUMBER: MP-07

REVISION DATE: 03/26/02

I. POLICY

Camillus Health Concern, Inc (CHC) is committed to provide quality care to all its consumers. As we strive for "Excellence in Care", we recognize that at times there may be occasions when consumers find themselves involved in circumstances or conditions believed to be unjust, and thus that they have grounds for a grievance. Therefore, it is the policy of CHC to acknowledge consumer rights and provide an impartial and confidential forum for the resolution of any grievance that may be brought to the attention of staff at CHC.

II. Grievance Committee Membership

- A. The Grievance Committee (hereinafter "Committee") will be a Standing Committee consisting of three (3) persons, who will meet on an ad hoc basis. That is, the Committee will meet, if and when a grievance is filed.
- B. Representing a cross section of disciplines and backgrounds, the membership of the Committee will be comprised of:
- One (1) Brother representative from the Brothers of the Good Shepherd, who is staffed at Camillus
 - One (1) CHC Management staff representative
 - One (1) CHC Patient Services staff representative
 - If necessary, the consumer's health care provider and/or case manager will be invited to attend the Grievance Committee meeting.
- C. Membership length will be approximately one (1) year and will be staggered to allow for continuity within the Committee. The Committee Chair, who will be elected by the Committee, will provide oversight to ensure that there is continuity and that the Committee is fully staffed. As needed, the Chair will make recommendations for new members to the Executive Director.

III. PROCEDURES

- A. Every effort will be made to amicably resolve a complaint before it becomes a formal grievance; however, if the consumer declines to speak with a CHC staff member in order to resolve the complaint, he or she has the right to file a formal grievance.
- B. A consumer who verbalizes his or her dissatisfaction with, for example, a service, procedure, employee, or physical appearance of the facility, will be encouraged to resolve the issue by dialogue with the appropriate staff member (the immediate supervisor of the area or discipline covering the grievance). The consumer will do this by verbalizing in private to that supervisor his or her dissatisfaction.
- C. If the complaint is against the immediate supervisor of the area or discipline, then the supervisor will consult with his or her supervisor as to who should address the complaint.
- D. Immediately upon being informed of the dissatisfaction, the supervisor will inform the consumer of the method he or she will use to attempt to resolve the issue. If the supervisor cannot immediately resolve the issue to the satisfaction of the party involved, he or she will follow-up with the consumer within 24 hours, with additional steps in order to resolve the issue.
- E. In the event that the issue cannot be resolved, the consumer may file a formal grievance with the supervisor who has been assisting him or her. As needed, the supervisor will assist the consumer in completing the form and ensure that the form has been completed accurately. See attachment 1 for the Camillus Health Concern, Inc. Grievance Form.
- F. The supervisor will provide a copy of the Grievance Form to the consumer, and the original is then forwarded to the Chair of the Committee.
- G. The Chair then sends a copy of the Grievance Form to the Camillus House Chief Executive Officer and CHC's Executive Director so that they may become aware of possible safety, legal, or other issues. However, the grievance continues to be processed by the Chair of the Committee.

- H. Within five (5) working days, the consumer will be notified, in writing, of the receipt of the grievance and the scheduled date for review by the Committee.
- I. Prior to the meeting, the Chair will forward a copy of the Grievance Form to all Committee members.
- J. Also, prior to the meeting, the Chair may use his or her discretion to initiate a preliminary investigation of the grievance. For example, in order to facilitate the Committee's first meeting, the Chair may decide to conduct some interviews prior to the meeting.
- K. The Chair will maintain all grievance materials and documents, for example, the Grievance Policy and Procedures and meeting minutes, in the Camillus Health Concern Grievance Documents binder.

III. Grievance Review Process

- A. The Committee will make a good faith effort to convene within two (2) weeks of when a grievance is filed and schedule additional meetings, at least every two (2) weeks, until recommendations for the resolution of the grievance are finalized.
- B. The Committee will determine if additional persons need to be interviewed as part of its impartial investigation.
- C. Additional interviews and/or investigation by Committee Members must be written and submitted to the entire Committee for its review at a scheduled meeting.
- D. The Committee's recommendations for action, including timelines, will be prepared and presented by the Chair of the Committee to the Executive Director, who will then either approve the recommendations as presented, or modify them, and then, finally, approve the recommendations. See Attachment 2, Camillus Health Concern, Inc. Grievance Committee Recommendations for Action.
- E. After the Executive Director approves the recommendations, the consumer will be so notified in writing within ten (10) working days.

- F. If the grievance is not resolved at the Committee level, the Committee Chair will confer with an Ad Hoc Committee of the Board of Directors, chosen by the Chairperson of the Board. The Ad Hoc Committee of the Board will review the grievance and recommend to the Board to uphold or to refute the resolution.
- G. The consumer will thereafter be so advised of the final resolution of the grievance.

V. Quality Improvement

- A. The Chair of the Committee will submit summaries of grievances to CHC's Quality Improvement Committee (QIC) for trending and monitoring of the grievances.
- B. The QIC will ensure that all Committee recommendations are implemented, and kept confidential.

DATE: _____

CHC WOMEN'S HEALTH CLINIC

CHC# _____

NAME: _____ AGE: _____ DOB: _____ ALLERGIES: _____

FDLMP _____ X _____ Days

MENOPAUSE/AGE _____ ERT: NO ___ RES: ___ yrs.

G _____ PARA: F _____ P _____ A _____ L _____ SEXUALLY ACTIVE NO YES

Birth Control: None OCP Diaphragm IUD Condoms Other _____

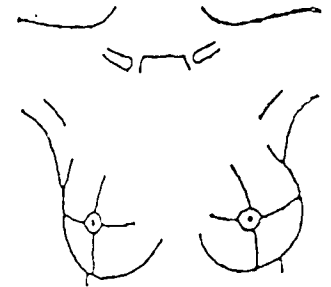
Last PAP: _____ Last MAMMOG _____

F.H. BREAST CA: NO YES: MOTHER SIB AUNT MSBE: NO YES

PMH/STD: MEDS: ETOH: NO / YES
TOB: NO / YES
IVDU: NO / YES
HOMELESS: NO / YES

BS: BP _____ HR _____ R _____ T _____ HT _____ WT _____

BREAST:



PELVIC: EXT. Vaginal Cervix

BIMANUAL: CMT: NEG / POS Adnexa: Uterus:

KOH Wet Mount GM Stain UCG - +

ASSESSMENT / PLAN:

CAMILLUS HEALTH CONCERN

HEALTH MAINTENANCE ASSESSMENT - 1 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer Infant Metabolic Screen: _____

Diet (24 hours): Breast Milk _____ Formula _____ WIC yes no
 Stools: _____ Urine: _____ Sleep: _____ Sleep arrangements: _____

Growth & Development: _____ Raises head slightly _____ Responds to sound _____
 _____ Has tight grasp _____ Fixes on face _____
 _____ Follows objects to midline _____ May smile _____

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Anticipatory Guidance

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)	
1. Appearance: 2. Alertness: 3. Skin/Nodes: 4. Head: 5. Eyes: 6. Ears: 7. Nose: 8. Mouth/Throat: 9. Teeth/Gums: 10. Heart: 11. Chest/Lungs: 12. Abdomen: 13. Genital/Anus: 14. Musculoskeletal: a. Extremities: b. Spine: 15. Neurological: 16. Other: 17. Other:			Nutrition _____ Vitamins, flouride 0.25 mg q.d. _____ Delay solids _____ Feeding/ Spitting up Health _____ Hiccups/ Sneezing/ URI _____ Irregular respirations _____ Rashes Safety _____ Fire retardant clothing _____ Car seats _____ Smoke detector _____ Crib safety/ falls Psychosocial _____ Pacifier/ crying/ colic _____ Hold, cuddle _____ Talk to baby _____ Vision/ colors _____ Attention to other children

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 2 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer Infant Metabolic Screen: _____

Diet (24 hours): Breast Milk Formula WIC yes no
 Stools Urine: Sleep: Sleep Arrangements: _____

Growth & Development _____ Holds head in middle _____ Coos, laughs, locates sound
 _____ Lifts head and chest _____ Social smile
 _____ Follows objects 180°

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:			Anticipatory Guidance																																																													
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Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer Infant Metabolic Screen: _____

Diet (24 hours): _____ Breast Milk _____ Formula _____
 Stools _____ Urine: _____ Sleep: _____ Sleep arrangements: _____

Growth & Development _____ Smiles spontaneously _____ Head steady _____
 _____ Begins reaching _____ Rolls front and back _____
 _____ Hands together _____ Laughs out loud _____
 _____ Moves arms to grasp _____

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

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16. Other:																																																												

Assessment/Plan:

Provider: _____

**CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 MONTH VISIT**

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): Breast Milk _____ Formula _____
 Stools: Urine: _____ Sleep: _____ Sleep arrangements: _____

Growth & Development

_____ Reaches & transfers	_____ Lifts cup, holds bottle
_____ Rolls back to front	_____ Weight bearing
_____ Sits with support	_____ No head lag
_____ Turns to sound	_____ Babbles/Laughs
_____ Reacts to strangers	

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:			Anticipatory Guidance			
Unclothed Physical Exam:			Nutrition	_____ Cereals, fruits, veg.		
1. Appearance:	Normal (✓)	Abnormal (0)	Health	_____ Use of spoon and cup		
2. Alertness:				_____ Teething		
3. Skin/Nodes:				_____ No bottles in bed		
4. Head:				_____ Head injury		
5. Eyes:				_____ URI		
6. Ears:				_____ Thumbsucking		
7. Nose:				Safety	_____ Protect from hot liquids, dangling cords, tablecloth	
8. Mouth/Throat:					_____ Water & Bathtub safety	
9. Teeth/Gums:					_____ Car seat	
10. Heart:				Psychosocial	_____ Poisoning/ Ipecac	
11. Chest/Lungs:					_____ Soft shoes	
12. Abdomen:					_____ Use gates on stairs	
13. Genital/Anus:					_____ Stimulate speech	
14. Musculoskeletal:					_____ Separation anxiety	
a. Extremities:						
b. Spine:						
15. Neurological:						
16. Other:						
17. Other:						

Assessment/Plan: _____ Screen: Hgb _____

Provider: _____

**CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 9 MONTH VISIT**

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): Breast Milk _____ Formula _____ Solids _____
 Stools _____ Urine: _____ Sleep: _____ Sleep arrangements: _____

Growth & Development

_____ Creeps, Crawls, cruises	_____ Understands no & bye bye
_____ Pulls to stand	_____ Retrieves hidden toy
_____ Uses pincher grasp	_____ Starts to explore
_____ Finger feeds	_____ "Dada/Mama" nonspecifically
_____ Sits well	

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

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16. Other:																																																																	
17. Other:																																																																	
Nutrition Health Safety	<input type="checkbox"/> Pica <input type="checkbox"/> Dental care <input type="checkbox"/> Water safety <input type="checkbox"/> Babyproofing the house <input type="checkbox"/> Poison/ burns <input type="checkbox"/> Aspiration <input type="checkbox"/> Toddler car seat if wt. 20 lbs. <input type="checkbox"/> Use of "no"																																																																
Psychosocial	<input type="checkbox"/> Discipline consistency <input type="checkbox"/> Masturbation <input type="checkbox"/> Breath holding spells <input type="checkbox"/> Social games <input type="checkbox"/> Night wakening <input type="checkbox"/> Favorite toy or possession <input type="checkbox"/> stairs <input type="checkbox"/> Stimulate speech																																																																

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 12 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): Breast Milk _____ Formula _____ Solids _____
 Stools: Urine: _____ Sleep: _____ Sleep arrangements: _____

Growth & Development

_____ Walks with support/alone	_____ Makes 1-3 words or meaningful sound
_____ Throws object	_____ Gives hug
_____ Uses mature pincer grasp	_____ Dada/Mama specifically

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:			Anticipatory Guidance	
Unclothed Physical Exam:			Nutrition	_____ Table foods
	Normal (✓)	Abnormal (0)		_____ Drop in appetite
Appearance:				_____ Off bottle
2. Alertness:			Health	_____ Regular milk
3. Skin/Nodes:				_____ Tylenol
4. Head:				_____ Respiratory infections
5. Eyes:			Safety	_____ Hot liquids
6. Ears:				_____ Use of "no"
7. Nose:				_____ Kitchen, stair, water & car safety
8. Mouth/Throat:				_____ Fences, gates, latches
9. Teeth/Gums:				_____ Poisoning, Ipecac
10. Heart:			Psychosocial	_____ Bedtime stories/books
11. Chest/Lungs:				_____ Delay toilet training
12. Abdomen:				_____ Discipline
13. Genital/Anus:				_____ Favorite toy possession
14. Musculoskeletal:				_____ Stimulate speech
a. Extremities:				
b. Spine:				
15. Neurological:				
16. Other:				
Other:				

Assessment/Plan: _____ Screen: Hgb _____
 Lead _____
 Sickle cell _____

Provider: _____

**CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 15 MONTH VISIT**

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours):	_____ Bread, cereal, rice, pasta	_____ Stools per day
	_____ Fruits, vegetables	_____ Voids per day
	_____ Milk, yogurt, cheese	_____ Hrs. of sleep per night
	_____ Meat, poultry, fish, beans	_____ Naps per day

Growth & Development	_____ Builds tower of 2 blocks	_____ Walks well
	_____ Uses 3 to 6 words	_____ Feeds self with fingers
	_____ Understands simple commands	_____ Points to 1 or 2 body parts
	_____ Creeps upstairs	

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- | | |
|--------------|--|
| Nutrition | _____ Utensil use |
| | _____ Diet, snacks |
| | _____ Wean off bottle |
| | _____ Drop of appetite |
| Health | _____ Dental care |
| | _____ Respiratory infections |
| | _____ Hot liquids |
| Safety | _____ Kitchen, stair, water & car safety |
| | _____ Fences, gates, latches |
| | _____ Poisoning, Ipecac |
| Psychosocial | _____ Bedtime stories/books |
| | _____ Delay toilet training |
| | _____ Discipline |
| | _____ Favorite toy or possession |
| | _____ Stimulate speech |
| | _____ Temper tantrums |

Assessment/Plan:

Provider: _____

CAMILLUS HEALTH CONCERN

HEALTH MAINTENANCE ASSESSMENT - 24 MONTH VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): _____ Bread, cereal, rice, pasta _____ Fruits, vegetables _____ Milk, yogurt, cheese _____ Meat, poultry, fish, beans	_____ Stools per day _____ Voids per day _____ Toilet training _____ Naps per day _____ Hrs. of sleep per night
--	---

Growth & Development _____ Runs well _____ Helps to undress _____ Imitates adults _____ Dumps from container _____ Open doors/climbs	_____ 20 words _____ Handles spoon well _____ Stacks 5 to 6 blocks _____ Walks up & down stairs _____ Kicks ball/Throws
---	---

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:	Anticipatory Guidance																																																												
Unclothed Physical Exam: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 25%;">Normal (✓)</th> <th style="width: 25%;">Abnormal (0)</th> </tr> </thead> <tbody> <tr><td>1. Appearance:</td><td></td><td></td></tr> <tr><td>2. Alertness:</td><td></td><td></td></tr> <tr><td>3. Skin/Nodes:</td><td></td><td></td></tr> <tr><td>4. Head:</td><td></td><td></td></tr> <tr><td>5. Eyes:</td><td></td><td></td></tr> <tr><td>6. Ears:</td><td></td><td></td></tr> <tr><td>7. Nose:</td><td></td><td></td></tr> <tr><td>8. Mouth/Throat:</td><td></td><td></td></tr> <tr><td>9. Teeth/Gums:</td><td></td><td></td></tr> <tr><td>10. Heart:</td><td></td><td></td></tr> <tr><td>11. Chest/Lungs:</td><td></td><td></td></tr> <tr><td>12. Abdomen:</td><td></td><td></td></tr> <tr><td>13. Genital/Anus:</td><td></td><td></td></tr> <tr><td>14. Musculoskeletal:</td><td></td><td></td></tr> <tr><td> a. Extremities:</td><td></td><td></td></tr> <tr><td> b. Spine:</td><td></td><td></td></tr> <tr><td>15. Neurological:</td><td></td><td></td></tr> <tr><td>16. Other:</td><td></td><td></td></tr> <tr><td>17. Other:</td><td></td><td></td></tr> </tbody> </table>		Normal (✓)	Abnormal (0)	1. Appearance:			2. Alertness:			3. Skin/Nodes:			4. Head:			5. Eyes:			6. Ears:			7. Nose:			8. Mouth/Throat:			9. Teeth/Gums:			10. Heart:			11. Chest/Lungs:			12. Abdomen:			13. Genital/Anus:			14. Musculoskeletal:			a. Extremities:			b. Spine:			15. Neurological:			16. Other:			17. Other:			Nutrition _____ Pica/Lead _____ Diet, snacks _____ Avoid control struggles/eating Health _____ Dental care _____ Day napping varies Safety _____ Crib to bed _____ Car seat _____ Matches/ Burns/ _____ Falls/ Water safety _____ Fences, gates, latches _____ Play equipment Psychosocial _____ Bedtime stories/ books _____ Night fears _____ Temper tantrums _____ Discipline _____ Unable to share _____ Toilet training/ _____ Bedwetting _____ Genital explor.
	Normal (✓)	Abnormal (0)																																																											
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17. Other:																																																													

Assessment/Plan: _____ Screens: CBC _____
 Lead _____

Provider: _____

**CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 30 MONTH VISIT**

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours):	_____ Bread, cereal, rice, pasta	_____ Stools per day
	_____ Fruits, vegetables	_____ Voids per day
	_____ Milk, yogurt, cheese	_____ Toilet training
	_____ Meat, poultry, fish, beans	_____ Naps per day
		_____ Hrs. of sleep per night

Growth & Development	_____ Puts on clothing	_____ Uses plurals
	_____ Washes & dries hands	_____ Gives 1st & last name
	_____ Separates from Mom easily	_____ Stacks 8 blocks
	_____ Plays tag	_____ Jumps in place
	_____ Copies O	_____ Balance on 1 foot/1sec.

Vital signs: HT: _____ WT: _____ HC: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- Nutrition
 - _____ Diet
 - _____ Healthy snacks
 - _____ Avoid control struggles/eating
- Health
 - _____ Dental care
 - _____ Day napping varies
- Safety
 - _____ Crib to bed
 - _____ Car seat
 - _____ Matches/ Burns/ Falls/ Water safety
 - _____ Fences, gates, latches
 - _____ Medication safety
 - _____ Gun safety
- Psychosocial
 - _____ Bedtime stories/ books
 - _____ Temper tantrums
 - _____ Discipline
 - _____ Unable to share
 - _____ Toilet training/ Bedwetting
 - _____ Genital explor.

Assessment/Plan:

Provider: _____

**CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 3 YEAR VISIT**

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): _____ Bread, cereal, rice, pasta _____ Fruits, vegetables _____ Milk, yogurt, cheese _____ Meat, poultry, fish, beans	_____ Stools per day _____ Voids per day _____ Toilet training _____ Naps per day _____ Hrs. of sleep per night
--	---

Growth & Development _____ Buttons up _____ Dresses with supervision _____ Separates from Mom easily _____ Plays tag _____ Copies O	_____ Uses plurals/past tenses _____ Gives 1st & last name _____ Stacks 8 blocks _____ Broad jumps _____ Group play
--	---

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

Nutrition	_____ Diet _____ Healthy snacks
Health	_____ Avoid control struggles/eating _____ Dental care
Safety	_____ Day napping varies _____ Street safety _____ Car seat _____ Matches/ Burns/ _____ Falls/ Water safety _____ Fences, gates, _____ latches _____ Medication safety _____ Gun safety
Psychosocial	_____ Bedtime stories/ _____ books _____ Temper tantrums _____ Discipline _____ Pretend play _____ Group play/sharing _____ Toilet training/ _____ Bedwetting _____ Genital explor.

Assessment/Plan:

Screen: Dental referral _____

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 4 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): <input type="checkbox"/> Bread, cereal, rice, pasta <input type="checkbox"/> Fruits, vegetables <input type="checkbox"/> Milk, yogurt, cheese <input type="checkbox"/> Meat, poultry, fish, beans	<input type="checkbox"/> Stools per day <input type="checkbox"/> Voids per day <input type="checkbox"/> Toilet training <input type="checkbox"/> Naps per day <input type="checkbox"/> Hrs. of sleep per night
--	--

Growth & Development <input type="checkbox"/> Buttons up <input type="checkbox"/> Dresses self <input type="checkbox"/> Copies + <input type="checkbox"/> Copies <input type="checkbox"/> <input type="checkbox"/> Balances 5 seconds	<input type="checkbox"/> Draws 3 part man <input type="checkbox"/> Names 3 to 4 colors <input type="checkbox"/> Counts to 5 <input type="checkbox"/> Hops on 1 foot <input type="checkbox"/> Catches bounced ball
--	---

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
4. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- Nutrition
 - Small portions
 - Healthy snacks
 - Avoid control struggles/eating
- Health
 - Dental care
- Safety
 - Day napping varies
 - Street safety
 - Fire safety
 - Matches/ Burns/ Falls/ Water safety
 - Toxic substances
 - Bicycle safety
 - Medication safety
 - Gun safety
- Psychosocial
 - Bedtime stories/ books
 - Discipline
 - Pretend play
 - Group play/sharing
 - Toilet training/ Bedwetting
 - Sexual curiosity

Assessment/Plan:

Screen: Dental referral _____
 CBC _____
 Lead _____
 UA _____
 Vision _____
 Audiometry _____

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 5 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): _____ Bread, cereal, rice, pasta _____ Fruits, vegetables _____ Milk, yogurt, cheese _____ Meat, poultry, fish, beans	_____ Stools per day _____ Voids per day _____ Hrs. of sleep per night
--	--

Growth & Development _____ Skips, walks on tiptoe _____ Dresses self _____ Ties shoes _____ 10 word sentences _____ Balances 10 seconds	_____ Draws 6 part man _____ Prints first name _____ Copies ▲ _____ Backward heel/toe walk _____ Catches bounced ball
--	---

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- | | |
|--------------|--|
| Nutrition | _____ Small portions |
| | _____ Healthy snacks |
| Health | _____ Dental care |
| Safety | _____ Street safety |
| | _____ Fire safety |
| | _____ Matches/ Burns/
Falls/ Water safety |
| | _____ Toxic substances |
| | _____ Bicycle safety |
| | _____ Medication safety |
| | _____ Gun safety |
| Psychosocial | _____ Bedtime stories/
books |
| | _____ Discipline |
| | _____ Dressing up play |
| | _____ Gender Identification |
| | _____ Understands
right and wrong |

Assessment/Plan:

Screen: Dental referral _____

Provider: _____

CAMILLUS HEALTH CONCERN
HEALTH MAINTENANCE ASSESSMENT - 6 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): _____ Bread, cereal, rice, pasta _____ Fruits, vegetables _____ Milk, yogurt, cheese _____ Meat, poultry, fish, beans	_____ Stools per day _____ Voids per day _____ Hrs. of sleep per night
--	--

Growth & Development _____ Bounces ball 6 times _____ Ties shoelaces _____ Counts to 10 _____ Prints name and numbers _____ Grade in school	_____ Draws 6 part man with clothes _____ Knows right from left _____ Backward heel/toe walk
--	--

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- | | |
|--------------|--|
| Nutrition | _____ Avoid junk food |
| | _____ Healthy snacks |
| | _____ Maintain appropriate wt. |
| Health | _____ Dental care |
| | _____ Regular exercise |
| Safety | _____ Street safety |
| | _____ Fire safety |
| | _____ Matches/ Burns/
Falls/ Water safety |
| | _____ Learn to swim |
| | _____ Bicycle safety |
| | _____ Limit TV viewing |
| | _____ Gun safety |
| Psychosocial | _____ Bedtime stories/
books |
| | _____ Discipline |
| | _____ Relationship with peers |
| | _____ Communication with
Parents/Praise |
| | _____ Rules/Chores |

Assessment/Plan:

Screen: Dental referral _____
 Cholesterol/Trig _____
 if + family hx _____

Provider: _____

CAMILLUS HEALTH CONCERN

HEALTH MAINTENANCE ASSESSMENT - 7-12 YEAR VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours):
 _____ Bread, cereal, rice, pasta
 _____ Fruits, vegetables
 _____ Milk, yogurt, cheese
 _____ Meat, poultry, fish, beans

Development: Grade in school _____ Performance in school _____
 Career plan _____ Problems with peers/siblings _____
 Favorite Activity _____

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:

Unclothed Physical Exam:

	Normal (✓)	Abnormal (0)
1. Appearance:		
2. Alertness:		
3. Skin/Nodes:		
4. Head:		
5. Eyes:		
6. Ears:		
7. Nose:		
8. Mouth/Throat:		
9. Teeth/Gums:		
10. Heart:		
11. Chest/Lungs:		
12. Abdomen:		
13. Genital/Anus:		
a. Tanner stage:		
14. Musculoskeletal:		
a. Extremities:		
b. Spine:		
15. Neurological:		
16. Other:		
17. Other:		

Anticipatory Guidance

- Nutrition
 - _____ Avoid junk food
 - _____ Healthy snacks
- Health
 - _____ Maintain appropriate wt.
 - _____ Dental care
 - _____ Regular exercise
- Safety
 - _____ Street safety
 - _____ Fire safety
 - _____ Matches/ Burns/ Falls/ Water safety
 - _____ Learn to swim
 - _____ Bicycle safety
 - _____ Limit TV viewing
 - _____ Gun safety
- Psychosocial
 - _____ Books/Library card
 - _____ Communication with parents
 - _____ Alcohol/Drugs/ Smoking
 - _____ Sexual development
 - _____ Pubertal teaching

Assessment/Plan:

Screen: Dental referral _____
 Cholesterol/Trig _____
 if + family hx _____
 CBC & UA _____
 Vision _____
 Audiometry _____
 PPD _____

Provider: _____

HEALTH MAINTENANCE ASSESSMENT - ADOLESCENT VISIT

Date: _____ Date of Birth: _____ Age: _____ Client Number: _____
 Last Name: _____ First Name: _____ Gender: _____
 Medications: _____ Allergies: _____
 Social Hx: _____
 Immunizations: current defer

Diet (24 hours): _____ Bread, cereal, rice, pasta
 _____ Fruits, vegetables
 _____ Milk, yogurt, cheese
 _____ Meat, poultry, fish, beans

Development: Grade in school _____ Performance in school _____
 Career plan _____ Problems with peers/siblings _____
 Favorite Activity _____
 Drugs _____ Sexual activity _____
 Menstrual Hx _____

Vital signs: HT: _____ WT: _____ BP: _____ T: _____ P: _____ R: _____

Subjective:			Anticipatory Guidance	
Unclothed Physical Exam: 1. Appearance: 2. Alertness: 3. Skin/Nodes: 4. Head: 5. Eyes: 6. Ears: 7. Nose: 8. Mouth/Throat: 9. Teeth/Gums: 10. Heart: 11. Chest/Lungs: 12. Abdomen: 13. Genital/Anus: a. Tanner stages: b. Pelvic/penis: 14. Musculoskeletal: a. Extremities: b. Spine: 15. Neurological: 16. Other: 17. Other:	Normal (✓)	Abnormal (0)		
			Nutrition Health Safety Psychosocial	_____ Avoid junk food _____ Healthy snacks _____ Maintain appropriate wt. _____ Dental care _____ Regular exercise _____ Breast / Testes self exam _____ Contraceptive counseling _____ Alcohol/Drugs/smoking _____ STDs/AIDS _____ Gun safety _____ Plans for future _____ Communication with parents

Assessment/Plan: _____ Screen: Dental referral _____
 _____ Cholesterol/Trig _____
 _____ if + family hx _____
 _____ CBC & UA _____
 _____ Vision _____
 _____ Audiometry _____
 _____ PPD _____

Provider: _____

**CAMILLUS HEALTH CONCERN, INC.
COMPREHENSIVE PEDIATRIC HISTORY**

Last Name _____ First Name _____ Client # _____

Allergies: _____

1. Date _____	2. Name of Parent/Guardian _____	3. Care if Parent (s) _____ Work/Away Hours/Day _____ Days/Week _____	Relative/Neighbor _____ Daycare _____ Hours/Day _____ Days/Week _____
---------------	----------------------------------	--	---

4. Family History - Indicate relationship		
Diabetes _____	Emotional illness _____	Birth defects _____
Lung disease/TB _____	Kidney/urinary disease _____	cancer _____
Mental retardation _____	Allergies/asthma _____	seizures _____
Heart disease/Stroke _____	Blood dyscrasias _____	hypertension _____
	Substance abuse _____	other _____

5. Mother's Prenatal History			
Conditions:			
Hypertension _____	Rh _____	Alcohol amt. _____	OTC _____
Diabetes _____	X-ray _____	Tobacco amt. _____	
S.T.D. (specify) _____	HbsAg _____	Prescription _____	Street drugs _____
Rubella _____	Other _____		
Prenatal Care/Trimester begun: _____			

6. Weeks gestation _____	Birth Weight _____	APGAR _____	Length _____	Head Circ. _____	Where delivered _____
--------------------------	--------------------	-------------	--------------	------------------	-----------------------

7. Delivery History			
SVD _____	Prolonged labor _____	Breech _____	PROM _____
Cesarean _____	Precipitous delivery _____	Forceps _____	Other _____

8. Neonatal Problems and Conditions	9. Infectious Disease/Date of Onset
Deformities _____	Rubella _____
Injuries _____	Oxygen _____
Respiratory _____	Irritability _____
Cardiac _____	Feeding _____
Jaundice _____	Incubator days _____
Other (specify) _____	Tremors/seizure _____
	HIV _____
	Measles _____
	Hepatitis B _____
	Pertussis _____
	S.T.D. (specify) _____
	Mumps _____
	Chicken Pox _____
	Other _____

10. Serious Illness, Accident, Hospitalization (s), Frequent Episodes of Minor Illness	
Date: _____	Outcome: _____
Date: _____	Outcome: _____
Date: _____	Outcome: _____

Signature/Title of Interviewer _____

CAMILLUS HEALTH CONCERN DENTAL RECORD

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. ARE YOU UNDER THE CARE OF A PHYSICIAN?
(ESTA USTED BAJO EL TRATAMIENTO DE ALGÚN MEDICO)
REASON (RAZÓN): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. ARE YOU TAKING ANY MEDICINE OR DRUGS?
(ESTA TOMANDO ALGÚN MEDICAMENTO O DROGA)
LIST (NÓMBRELOS): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?
(HA ESTADO USTED HOSPITALIZADO EN LOS PASADOS 5 AÑOS)
WHY? (POR QUE?): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. ARE YOU ALLERGIC TO ANYTHING (DRUGS, FOODS)?
(ES USTED ALÉRGICO A ALGO (MEDICINAS, COMIDAS)
LIST (NÓMBRELOS): _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. HAVE YOU EVER HAVE ANY OF THE FOLLOWING?
(HA TENIDO USTED ALGUNO DE LOS SIGUIENTES) | | |
| HEART TROUBLE (PROBLEMAS DEL CORAZÓN) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| RHEUMATIC FEVER (FIEBRE REUMÁTICA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| HIGH BLOOD PRESSURE (PRESIÓN ALTA O BAJA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| LIVER DECEASE (HEPATITIS) (PROBLEMA DEL HÍGADO) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| EPILEPSY (SEIZURES) (EPILEPSIA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| CANCER _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| TUBERCULOSIS _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ANEMIA _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| BLOOD DISEASE (PROBLEMAS DE SANGRE) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| ASTHMA (ASMA) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| A.I.D.S.-C.I.D.A. (S.I.D.A) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. DO YOU SMOKE? PACKS PER DAY _____
(USTED FUMA? PAQUETES POR DÍA) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. ARE YOU PREGNANT? _____
(ESTA USTED EMBARAZADA?) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. IS THERE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE KNOW ABOUT, OR IS THERE ANY ACTIVITY YOUR DOCTOR SAYS YOU CAN NOT DO?
(SI HAY ALGUNA ENFERMEDAD, CONDICIONA O PROBLEMA NO MENCIONADO ARRIBA QUE USTED PIENSE DEBAMOS SABER, O ALGUNA ACTIVIDAD QUE SU DOCTOR NO LE PERMITE HACER?)
IF SO, EXPLAIN (SI ES ASÍ EXPLIQUE) _____ | | |

DENTAL HISTORY (HISTORIA DENTAL)

1. REASON FOR VISIT? (RAZÓN DE SU VISITA) _____
2. LAST DENTAL VISIT? (ULTIMA VISITA) _____ LAST COMPLETE EXAM (FECHA, EXAMEN COMPLETO) _____
3. DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR MOST DENTAL TREATMENT? YES _____ NO _____
(PREFIERE USTED ANESTESIA LOCAL (NOVOCAÍNA) PARA LA MAYORÍA DE SU TRATAMIENTO DENTAL)
4. HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____
(HA TENIDO USTED PREVIAMENTE ALGÚN PROBLEMA SERIO RELACIONADO CON EL TRATAMIENTO DENTAL)
5. DOES DENTAL TREATMENT MAKE YOU NERVOUS? NO _____ SLIGHTLY _____ MODERATELY _____ EXTREMELY _____
(EL TRATAMIENTO DENTAL LO PONE NERVIOSO?) (NO) (UN POCO) (BASTANTE) (EXTREMADAMENTE)
6. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUN DISEASE, PYORRHEA, TRENCH MOUTH) (HA SIDO TRATADO POR ENFERMEDAD PERIODONTAL (ENFERMEDAD DE ENCÍAS, PIORREA, GINGIVITIS ULCERATIVA) _____
IF YES WHEN (SI ES ASÍ CUANDO) _____

NAME

DATE

ALERT

BIRTHDAY

CHC #

SEX

Signature (Firma) _____

Date (Fecha) _____

Date of Service	Date of Birth	Med Rec #	Age	Encounter Number
Last Name		First Name	Gender	

Vital Signs: Ht _____ Wt _____ Temp _____ Bp _____
HR _____ RR _____ HC _____ Immunizations : Current _____ Defer _____

Allergies: Chief Complaint (walk ins only): _____ _____	<i>Medication List Update</i>
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PROVIDERS SIGNATURE

CAMILLUS HEALTH CONCERN INC.
Adult Progress Note / Episodic Visit

Date of Service	Date of Birth	Medical Record	Age	Encounter Number ██████████
Last Name		First Name	Gender	

Vital Signs: BP _____ HR _____ RR _____ WT _____ Temp _____

<p>Allergies:</p> <p>Living Situation:</p> <p>F/U Appt _____ Walk In: Chief Complaint _____</p> <p>_____</p> <p>_____</p> <p>acco : never _____ yes _____ : _____ ppd x _____ ; DC'd _____</p> <p>Alcohol : no _____ significant past use _____ yes _____ : amount _____</p> <p>Drugs: never _____ significant past use _____ active use _____</p> <p>IVDU _____ Nasal cocaine _____ crack cocaine _____ marij. _____ other _____</p>	<p><i>Medication List - Update</i></p>
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 PROVIDERS SIGNATURE

**Camillus Health Concern, Inc.
Preventative Care Data Form**

Name _____ DOB _____ SEX: M F CHC#: _____

JM#: _____

HIV TESTING:	DATE								
	Result (Pos./Neg.)								
	Location								
	Documentation (Y<N)								

RPR:	DATE								
	Result (titer, NR)								
	Treatment	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	
	Treatment Date Completed								

PPD:	DATE							
	Result (mm, NR)							
	Control POS., NR)							

DIABETES FUNDOSCOPIC/ PODIATRY:	APPT DATE							FAMILY HISTORY
	Seen (Y, N)							
	Podiatry (DateSeen)							

WOMEN'S HEALTH:	CBE DATE						
	Mammogram Date						
	Pap Smear Date						

DIGITAL RECTAL EXAM:	DATE						
	Prostate (Neg. Abn.)						
	PSA						
	F.O.B. (Pos. / Neg.)						
	Sigmoid/ B. E. Date						

IMMUNIZATIONS	Influenza						
	Pneumococcal						
	Td						

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RESPONSIBILITIES

- **You have the responsibility to be considerate and courteous to other clients and Camillus staff.**
- **You have the responsibility and the right to participate in decisions related to your care.**
- **You are responsible to be open and honest with us about instructions you receive concerning your health. Let us know immediately if you do not understand them, or if you feel you cannot follow them.**
- **You are responsible to bring with you information about past illnesses, hospitalizations, medications, and other matters related to your health and/or social history.**
- **You are responsible to be on time for scheduled appointments, or to contact us if you cannot make the appointment.**
- **You are responsible to know and follow the Camillus Code of Conduct (see posting in waiting room).**

CAMILLUS HEALTH CONCERN, INC.

CONSUMER RIGHTS

- **You have the right to receive the best care indicated for your problem** regardless of your gender, race, color, religion, national origin, age, economic status, disability, sexual orientation, or lifestyle.
- **You have the right to be treated respectfully by others** and to be addressed by your proper name without undue familiarity.
- **You have the right to confidentiality of all records and communications.** However, there are limitations to maintaining confidentiality; for example, under the law we are mandated to report the abuse of children, elderly, and disabled. If you have any questions, please ask us.
- **You have the right to review your medical record**, to request amendments, and to request copies of the your medical record.
- **You have the right to know all services available** at Camillus Health Concern, Inc. (CHC)
- **You have the right to know that when the clinic is closed** you can contact your health care provider by calling (305) 577-4840.
- **You have the right to know that all CHC health care providers** are licensed professionals and experienced in the provision of health care.
- **You have the right to seek and receive easily understood information necessary** for you to make informed decisions about your health, social, or psychological situation, including an explanation of all procedures and treatments, and including information about your health care plan, if applicable.
- **You have the right and responsibility to participate in decisions** related to your care.
- **You have the right to appropriate emergency services** by contacting 911, or going directly to the nearest emergency room, or, if necessary, by referral from a CHC health care provider.
- **You have the right to refuse care** by any health care provider and to request a different health care provider if one is available.
- **You have the right to refuse treatment to the extent** permitted by law and be informed of the consequences of that action.
- **You have the right to know when students** are to perform specific examinations or treatment that pertain to your care.
- **You have the right to refuse participation in any research** study or project.

GRIEVANCES

- If you feel you are not being treated fairly or properly, you have the right to formally address your complaint or problem by filing a grievance; however, we encourage you to first speak with a supervisor so that the problem can be immediately resolved.
- We have a grievance process, which allows for you to discuss your concerns with Camillus Management.
- To register a grievance:
You may request a grievance form at the Reception Desk.

Or

You may write a letter to:
Director of Operations
Camillus Health Concern, Inc.
336 N.W. 5th Street
Miami, FL 33128