

NORTH DAKOTA CLINIC VISIT RECORD

COMPLETE AT FIRST VISIT, UPDATE FOR CHANGES AND AT ANNUAL EXAM

CLINIC NO. _____

CLIENT NUMBER _____ DATE OF BIRTH _____ GENDER: F M CONTACT STATUS _____

YEARS OF EDUCATION _____ ANNUAL INCOME _____

HOUSEHOLD SIZE _____ ZIP _____

TOBACCO USER Y N

COMPLETE AT FIRST VISIT ONLY

RACE (check all that apply)

<input type="checkbox"/> 1. White	<input type="checkbox"/> 4. Asian
<input type="checkbox"/> 2. Black or African American	<input type="checkbox"/> 5. Pacific Is. / Hawaiian
<input type="checkbox"/> 3. Am. Ind./Alaskan	<input type="checkbox"/> 6. Unknown / Unreported

LIMITED ENGLISH PROFICIENCY: Y N

HISPANIC Y N Unknown/Not Reported

COMPLETE AT EACH VISIT

4. VISIT DATE _____ - 20____

5. PRIMARY SOURCE OF PAYMENT (check one)

<input type="checkbox"/> 1. No Fee	<input type="checkbox"/> 4. Title XIX
<input type="checkbox"/> 2. Partial Fee	<input type="checkbox"/> 5. Private Insurance
<input type="checkbox"/> 3. Full Fee	

6. CLIENT INSURANCE STATUS (check one)

<input type="checkbox"/> 1. Public Health Insurance
<input type="checkbox"/> 2. Private Health Insurance Covering all or some Family Planning
<input type="checkbox"/> 3. Private Health Insurance Covering no Family Planning
<input type="checkbox"/> 4. Private Health Insurance unknown for Family Planning
<input type="checkbox"/> 5. Uninsured
<input type="checkbox"/> 6. Unknown

7. PURPOSE OF VISIT (check one)

<input type="checkbox"/> 1. Initial Comprehensive	<input type="checkbox"/> 6. Method Check/Depo
<input type="checkbox"/> 2. Annual Comprehensive	<input type="checkbox"/> 7. Education/Counseling Only
<input type="checkbox"/> 3. Medical Visit	<input type="checkbox"/> 8. Pregnancy Test Only
<input type="checkbox"/> 4. Problem Re-Visit	<input type="checkbox"/> 9. Supply Visit
<input type="checkbox"/> 5. STD/Infection Check	

8. CONTRACEPTIVE METHOD (Complete before and after blocks)

01. Steril Male	08. Condom (female)	14. Sponge
02. Steril Female	09. Spermicide	15. Withdrawal
03. Orals	10. Diaphragm	16. Abstinence
04. IUD	11. 3 - Month Injection	17. EC
05. FAM	12. Hormonal Patch	18. Cervical Cap
06. Hormonal Implant	13. Vaginal Ring	19. None
07. Condom (male)		20. Other

Initial Visit After Visit

9. IF NONE AT THE END OF THIS VISIT GIVE REASON

<input type="checkbox"/> 1. Pregnant	<input type="checkbox"/> 4. Infertility
<input type="checkbox"/> 2. Seeking Pregnancy	<input type="checkbox"/> 5. Other Medical Reason
<input type="checkbox"/> 3. Other Reason	<input type="checkbox"/> 6. Relying on Partner Method

10. PROVIDERS OF MEDICAL/COUNSELING SERVICES

<input type="checkbox"/> 1. Physician _____	<input type="checkbox"/> 5. Health Educator/Nutritionist
<input type="checkbox"/> 2. Midlevel Clinician _____	<input type="checkbox"/> 6. Lab Tech
<input type="checkbox"/> 3. RN	<input type="checkbox"/> 7. Medical Assistant
<input type="checkbox"/> 4. LPN	

VISIT CODES _____

NEXT EXAM DATE _____

11. MEDICAL SERVICES PROVIDED

<input type="checkbox"/> 01. BV Tx	<input type="checkbox"/> 11. Diaphragm Fit/Chk	<input type="checkbox"/> 21. IUD Check
<input type="checkbox"/> 02. Blood Pressure	<input type="checkbox"/> 12. EC	<input type="checkbox"/> 22. Medical Hx
<input type="checkbox"/> 03. Candida Tx	<input type="checkbox"/> 13. Gonorrhea Tx	<input type="checkbox"/> 23. Molluscum Tx
<input type="checkbox"/> 04. CBE	<input type="checkbox"/> 14. Height/Weight	<input type="checkbox"/> 24. Pelvic exam
<input type="checkbox"/> 05. Cerv. Cap Fit/Chk	<input type="checkbox"/> 15. HPV Tx	<input type="checkbox"/> 25. Phys Assess
<input type="checkbox"/> 06. Chlamydia Tx	<input type="checkbox"/> 16. HPV Vaccine	<input type="checkbox"/> 26. Rx Change
<input type="checkbox"/> 07. Colposcopy	<input type="checkbox"/> 17. Implant Insert	<input type="checkbox"/> 27. Testicular exam
<input type="checkbox"/> 08. Contracep. Refill	<input type="checkbox"/> 18. Implant Removal	<input type="checkbox"/> 28. Trich Tx
<input type="checkbox"/> 09. Cryotherapy	<input type="checkbox"/> 19. IUD Insertion	
<input type="checkbox"/> 10. 3-Month Injection	<input type="checkbox"/> 20. IUD Removal	

12. LAB SERVICES PROVIDED

<input type="checkbox"/> 30. Blood Glucose	<input type="checkbox"/> 38. HIV Test	<input type="checkbox"/> 46. Repeat Pap
<input type="checkbox"/> 31. CBC	<input type="checkbox"/> 39. HPV Typing	<input type="checkbox"/> 47. RPR/VDRL
<input type="checkbox"/> 32. Chlamydia Test	<input type="checkbox"/> 40. Lipid Profile	<input type="checkbox"/> 48. Stool Occult
<input type="checkbox"/> 33. Gonorrhea Test	<input type="checkbox"/> 41. Metabolic Panel	<input type="checkbox"/> 49. Trichomoniasis
<input type="checkbox"/> 34. Hemoglobin	<input type="checkbox"/> 42. Pap Smear	<input type="checkbox"/> 50. TSH/T4
<input type="checkbox"/> 35. Hepatitis B	<input type="checkbox"/> 43. Ph Test	<input type="checkbox"/> 51. Urinalysis
<input type="checkbox"/> 36. Hepatitis C	<input type="checkbox"/> 44. Neg. Preg Test	<input type="checkbox"/> 52. Wet Mount
<input type="checkbox"/> 37. Herpes Test	<input type="checkbox"/> 45. Pos. Preg Test	

13. CHLAMYDIA

Reason for Visit

<input type="checkbox"/> 1. Symptomatic	<input type="checkbox"/> 6. Patient Request
<input type="checkbox"/> 3. Exposed to STD in Past 60 days	<input type="checkbox"/> 7. Client Meets Screening
<input type="checkbox"/> 4. IUD Insertion	<input type="checkbox"/> 8. Rescreen Prev Pos > 3 Mon.
<input type="checkbox"/> 5. Preg Test Only Visit	

Clinical Signs

<input type="checkbox"/> 1. Cervical Friability	<input type="checkbox"/> 3. PID	<input type="checkbox"/> 5. None
<input type="checkbox"/> 2. Mucopus	<input type="checkbox"/> 4. Urethritis	

Risk History

<input type="checkbox"/> 1. > 1 partner in past 60 days	<input type="checkbox"/> 3. + Chlamydia in past year
<input type="checkbox"/> 2. New partner in past 60 days	<input type="checkbox"/> 4. No Risk History

Treated Presumptively 1. Yes 2. No

Test Type 03. DFA 17.1 TMP/GP/Aptima Combo

Specimen Source

<input type="checkbox"/> 0. Other	<input type="checkbox"/> 3. Vaginal	<input type="checkbox"/> 5. Pharyngeal
<input type="checkbox"/> 1. Cervical	<input type="checkbox"/> 4. Urine	<input type="checkbox"/> 6. Rectal
<input type="checkbox"/> 2. Urethral		

14. COUNSELING SERVICES PROVIDED

<input type="checkbox"/> 61. ABC	<input type="checkbox"/> 71. Immunizations	<input type="checkbox"/> 79. Pregnancy
<input type="checkbox"/> 62. Blood Pressure	<input type="checkbox"/> 72. Infertility	<input type="checkbox"/> 80. Rape Crisis/Abuse
<input type="checkbox"/> 63. Colorectal Scrn.	<input type="checkbox"/> 73. Male Exam	<input type="checkbox"/> 81. Req. Adol Counsel
<input type="checkbox"/> 64. Contraception	<input type="checkbox"/> 74. Mental Health	<input type="checkbox"/> 82. SBE/Breast Health
<input type="checkbox"/> 65. Domestic Viol.	<input type="checkbox"/> 88. PHQ-2	<input type="checkbox"/> 83. Sterilization
<input type="checkbox"/> 66. Exercise	<input type="checkbox"/> 89. PHQ-9	<input type="checkbox"/> 84. Substance Abuse
<input type="checkbox"/> 67. FAM	<input type="checkbox"/> 75. Nutrition	<input type="checkbox"/> 85. STD Follow-Up
<input type="checkbox"/> 68. Female Exam	<input type="checkbox"/> 76. Obesity	<input type="checkbox"/> 86. Tobacco Cessation
<input type="checkbox"/> 69. Genetic Counsel	<input type="checkbox"/> 77. Pap Follow-Up	<input type="checkbox"/> 87. TSE
<input type="checkbox"/> 70. HIV	<input type="checkbox"/> 78. Preconception	

15. REFERRED ELSEWHERE (check all applicable)

<input type="checkbox"/> 01. Abnormal Pap	<input type="checkbox"/> 08. Nutritional Services
<input type="checkbox"/> 02. Breast Concerns	<input type="checkbox"/> 09. OPOP
<input type="checkbox"/> 03. Domestic Violence	<input type="checkbox"/> 10. Other - Medical
<input type="checkbox"/> 04. FAM	<input type="checkbox"/> 11. Positive Pregnancy
<input type="checkbox"/> 05. HIV Services/Screening	<input type="checkbox"/> 12. Rape Crisis/Abuse
<input type="checkbox"/> 06. Infertility	<input type="checkbox"/> 13. Social Services
<input type="checkbox"/> 07. Mental Health	<input type="checkbox"/> 14. Sterilization
<input type="checkbox"/> 19. Nat Lifeline (fax)	<input type="checkbox"/> 15. Substance Abuse
<input type="checkbox"/> 20. Priv. Counselor	<input type="checkbox"/> 16. Tobacco Cessation
<input type="checkbox"/> 21. Human Svcs. Center	<input type="checkbox"/> 17. WIC
<input type="checkbox"/> 22. Taken to Hospital	<input type="checkbox"/> 18. Women's Way
<input type="checkbox"/> 23. Physician Counseled	
<input type="checkbox"/> 24. None Warranted (PHQ-2 or 9)	
<input type="checkbox"/> 25. Client Declined	