# 2018 SEATTLE/KING COUNTY CLINIC
# PATIENT MEDICAL RECORD

**PATIENT LABEL REQUIRED PLACE PATIENT LABEL IN THIS BOX**

**PATIENT INTAKE** **Station:** **Intake Provider:** **HT:** **WT:**

**BP (<180/100 - Dental):** **Pulse:** **Temp:** **Gluc/if Diabetic (<200 Dental Extract):**

**POS (+) SCREEN** **TB:** ☐ N ☐ Y **Measles:** ☐ N ☐ Y **Scabies:** ☐ N ☐ Y **Other:** ☐ N ☐ Y

## HEALTH HISTORY

☐ **NONE**
☐ **Recent hospitalization**
**Cardio / Circulatory**
☐ Angina
☐ Arrhythmia
☐ Bleeding disorder
☐ Heart attack Yr:____
☐ Heart disease
☐ Hyper / Hypotension
**Dental**
☐ Adverse dental RXN
☐ Bisphosphonate / ever used
☐ Dental anxiety
☐ Oral cancer
**Digestive / Excretory**
☐ Asplenia
☐ Liver disease
**Endocrine**
☐ Diabetes
**Muscular / Skeletal**
☐ Joint replacement

**Nervous System**
☐ Seizures
☐ Stroke
**Reproductive**
☐ Breastfeeding (currently)
☐ Pregnant
**Respiratory**
☐ Asthma
**Other**
☐ Radiation therapy: Head / Neck
**Psychosocial**
☐ Alcohol use
☐ Anxiety
☐ Behavioral disorders/concerns
☐ Emotional concerns
☐ E-Cigarette/Vapor use
☐ Marijuana use
☐ Tobacco use
☐ Intravenous drug use
☐ Opioid use
☐ Other substance/drug use
☐ Overdosed on drugs

**Infectious Disease**
☐ Active infectious disease
Type: _____
SX: ☐ Respiratory illness
☐ Gastro illness
☐ Fever last 24 hours
☐ Hepatitis A B C
☐ HIV
☐ MRSA
☐ STI: _____
**Vaccinations**
☐ Hep A / Hep B
**Vision**
☐ Cataracts
☐ Conjunctivitis: current / recurrent
☐ Glaucoma
☐ Vision loss

**Recommendations:**
☐ FOCUS (Behavioral Health App)
☐ Opioid Risk Assessment
☐ NTHK Issued

**ALLERGIES**
☐ None
☐ Aspirin
☐ Other:
☐ Clindamycin ☐ Codeine/Narcotics ☐ Erythromycin
☐ Latex ☐ Penicillin/Antibiotics ☐ Sulfa

**CURRENT RX**
☐ None
☐ Antibiotics
☐ Other:
☐ Antidepressants ☐ Antihistamine ☐ Bisphosphonate
☐ Blood thinners ☐ Hormones ☐ Hydroxychloroquine
☐ Insulin ☐ Metformin ☐ Methotrexate
☐ Statins ☐ Steroids ☐ Tamoxifen

***Routing does not guarantee service. The recommendations are only for the current day of service.***

| ROUTED | | COMPLETED MEDICAL SERVICES | Pg | QTY of svcs | Provider or Tech (Print) | Suite # |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Acupuncture | 6 | 1 | | |
| ☐ | ☐ | Behavioral Health Consult | 7 | 1 | | |
| ☐ | ☐ | Chiropractic | 7 | 1 | | |
| ☐ | ☐ | Dermatology ☐Consult ☐ Skin Cancer Screen ☐ Cryo | 8 | | | 18 |
| ☐ | ☐ | EKG | 12 | 1 | | Roving |
| ☐ | ☐ | Foot Care ☐ General ☐ Podiatry | 8 | | | 21 |
| ☐ | ☐ | Hepatitis C (Rapid) Testing | 9 | 1 | | 56 |
| ☐ | ☐ | HIV (Rapid) Testing | 9 | 1 | | 55 |
| ☐ | ☐ | Immunizations ☐ Flu ☐ Hepatitis A/B ☐Tdap | 2 | | | P. Intake |
| ☐ | ☐ | Lab: *See order form* | 14 | | | 50 |
| ☐ | ☐ | Mammogram | 13 | 1 | | 2 |
| ☐ | ☐ | Nutrition Consultation | 10 | 1 | | 6 |
| ☐ | ☐ | Occupational Therapy | 10 | 1 | | MC |
| ☐ | ☐ | Physical Exam: ☐ General ☐ Naturopathic ☐Wmn's Hlth ☐ Pediatric | 5 | 1 | | |
| ☐ | ☐ | Physical Therapy | 11 | 1 | | MC |
| ☐ | ☐ | RX Dispensed | 6 | | | 19 |
| ☐ | ☐ | RX Written | 6 | | | |
| ☐ | ☐ | Ultrasound: *See order form* | 12 | | | |
| ☐ | ☐ | Wound Care | 11 | 1 | | 25 |
| ☐ | ☐ | X-Ray: *See order form* | 13 | | | |
| ☐ | ☐ | **RETURN WITH RESULTS** | ***Patient return to suite # _____ with results, after the following are complete:*** ☐ Lab ☐ Rapid Testing ☐ Ultrasound ☐ X-Ray ***Provider Name (Print):*** | | | |

| **IMMUNIZATIONS** **SCREENING & CONSENT -** *Please answer the questions listed below for the person receiving the vaccine(s).* | Yes | No |
|---|---|---|
| 1. Is the person sick today? | | |
| 2. Do you have allergies to medications, food, a vaccine component, or latex? | | |
| 3. Have you ever had a serious reaction after receiving a vaccination? | | |
| 4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? | | |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? | | |
| 6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or radiation treatments? | | |
| 7. Have you had a seizure or a brain or other nervous system problem? | | |
| 8. During the past year, have you received a transfusion of blood or blood products, or been given immune globulin or an antiviral drug? | | |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? | | |
| 10. Have you received any vaccinations in the past 4 weeks? | | |

Interpretation used? □ In person □ InDemand Interpreting

| **Vaccinator Name/Title (print):** | **Vaccinator Signature:** |
|---|---|

**HEPATITIS A/B VACCINE (For persons 18 years of age and older)**

**HEPATITIS A/B SHOT** I have been given a copy and have read or have had explained to me the information in the Hepatitis A and Hepatitis B Vaccine Information Statements (VIS), both published on 7/20/2016. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the Hepatitis A/B vaccine and request that the Hepatitis A/B vaccine be given to me or to the person named below for whom I am authorized to make this request.

| **TwinRix** | **Lot number:** |
|---|---|
| 0.5mL dose given IM Site **(circle one):** RA LA RT LT | **Date vaccine and VIS given:** |

**INACTIVATED INFLUENZA VACCINE (IIV) ADMINISTRATION RECORD (For persons 18 years of age and older)**

**INFLUENZA SHOT** I have been given a copy and have read or have had explained to me the information in the Inactivated Influenza ("flu shot") Vaccine Information Statement (VIS), published on 8/7/15. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the influenza vaccine be given to me or to the person named below for whom I am authorized to make this request.

| **Circle one:** Fluarix QIV PF (GSK) or Fluzone HD (sanofi pasteur) *age 65+* | **Lot number:** |
|---|---|
| 0.5mL dose given IM Site **(circle one):** RA LA RT LT | **Date vaccine and VIS given:** |

**TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS (Tdap) ADMINISTRATION RECORD (For persons 18 years of age and older)**

**Tdap SHOT** I have been given a copy and have read or have had explained to me the information in the Tdap Vaccine Information Statement (VIS), published on 2/24/15. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the Tdap vaccine and request that the Tdap vaccine be given to me or to the person named below for whom I am authorized to make this request.

| **Sanofi Pasteur: Tdap (Adacel)** | **Lot number:** |
|---|---|
| 0.5mL dose given IM Site **(circle one):** RA LA RT LT | **Date vaccine and VIS given:** |

| **Patient Name (print):** | **Date of Birth:** |
|---|---|

X _____ Date:_____

***Signature of person receiving vaccine (or person authorized to make request--PARENT OR GUARDIAN)***

**PROVIDERS:** Track services on page 1 of the Patient Medical Record.
Check box(es) to for completed service(s), indicate quantity, print your name.

# 2018 SEATTLE/KING COUNTY CLINIC MEDICAL TRIAGE

*Staple pg 1 & 2 of Patient Medical Record on top of this packet*

**Patient Name (as printed on the label):** _____ **Patient ID (as printed on the label) P**_____

**Station Number:** _____ **Triage Provider:** _____

**Primary Medical Concern:** _____

_____

_____

_____

**MEDICAL HISTORY**

| Condition | Year / Currently a Concern / Family History |
|---|---|
| | |
| | |
| | |
| | |
| | |

**SOCIAL HISTORY** Diet: _____

Exercise: _____

Living Situation: _____

Social Supports/Dependents:

**SUBSTANCE USAGE**

Intravenous Drugs: ☐ NO ☐ YES USAGE:

Non-intravenous & Prescription Drugs: ☐ NO ☐ YES USAGE:

**DRUG USAGE SCREENING (CAGE AID):**

Have you ever felt that you ought to cut down on drug use? ☐ NO ☐ YES

Have you ever felt bad or guilty about your drug use? ☐ NO ☐ YES

Have people annoyed you by criticizing your drug use? ☐ NO ☐ YES

Reference the **Medical Triage Summary** on page 4 for scoring details.

| **ALCOHOL USAGE SCREENING (AuditC-2)** | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| 2. How many standard drinks containing alcohol do you have on a typical day? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| 3. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **Subtotal** | | | | | |
| Reference the **Medical Triage Summary** on page 4 for scoring details. **Total** | | | | | |

**BEHAVIORAL HEALTH SCREENING (PHQ-4)** Ask the patient the following questions, circle the number corresponding to the response.

| Over the last two weeks, how often have you been bothered by any of the following problems? | Not at All | Several Days | More Than Half | Nearly Every Day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge. | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying. | 0 | 1 | 2 | 3 |
| 3. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| 4. Feeling down, depressed, or hopeless. | 0 | 1 | 2 | 3 |
| **Subtotal** | | | | |
| Reference the **Medical Triage Summary** on page 4 for scoring details. **Total** | | | | |

**MEDICAL TRIAGE SUMMARY**

| Available Services | Screening | Recommendations | Provider Notes |
|---|---|---|---|
| Acupuncture | • Pain: headaches, neck, shoulder, back<br>• Stress and/or anxiety<br>• Insomnia, asthma, or digestive issues worsened by stress | ☐ Provider Recmd | |
| Behavioral Health | • Patient should be referred to BH with any indication of self-harm<br>• A "yes" response to any of the CAGE-AID questions<br>• High AuditC-2 Score of 4 or more for men or 3 or more for women<br>• PHQ-4 Total score ≥3 for first 2 questions suggests anxiety. Total score ≥3 for last 2 questions suggests depression.<br>• BH patient can be referred to FOCUS App, track on page 1.<br>• Patient with history of drug use, can be referred to the Opioid Risk Assessment at Patient Intake, track on page 1. | ☐ Provider Recmd | |
| Chiropractic | • Musculoskeletal pain or injury: back and/or neck<br>• History of headaches | ☐ Provider Recmd | |
| Dermatology | • Interest in skin cancer screen<br>• History of skin cancer, large or irregular shaped moles<br>• Other skin conditions or concerns | ☐ Provider Recmd | |
| Foot Care | • Complains of foot pain/injury<br>• Screen feet of diabetic patients | ☐ Provider Recmd | |
| Hepatitis C (Rapid) | • Adults born from 1945 through 1965 should be tested once<br>• Intravenous drug use | ☐ Provider Recmd | |
| HIV (Rapid) | • Inquire if desired by patients 13 – 64 years of age<br>• Intravenous drug use<br>• African Born | ☐ Provider Recmd | |
| Mammogram | • Women yearly, Age ≥ 40<br>• Women with pain, palpable mass, nipple discharge | ☐ Provider Recmd | |
| Nutrition | • High blood pressure or high cholesterol<br>• Diabetes<br>• Interest in weight management | ☐ Provider Recmd | |
| Physical Exam (All Ages) | • Interest in exam, lab &/or imaging services<br>• If interest in alternative medicine, direct towards naturopathic. | ☐ Provider Recmd | |
| Occupational Therapy | • Difficulty using hands for daily activities<br>• Pain, injury or stiffness: elbow, wrist or hand | ☐ Provider Recmd | |
| Physical Exam/ Wmn's Health (GYN) | • Interest in exam, labs (Pap, pregnancy test, etc.) &/or imaging services<br>• Gyn or urinary concerns; family planning; women's issues counseling | ☐ Provider Recmd | |
| Physical Therapy | • MSK pain or injury: back, neck, knee pain, or ankle sprains, etc.<br>• History of balance issues and/or falls<br>• Chronic conditions (ex. diabetes), if patient wants to start exercise | ☐ Provider Recmd | |
| Wound Care | • Complains of skin lesion, wound, or abscess<br>• Sutures needing examination or removal | ☐ Provider Recmd | |

Ask the patient if they would like to receive the following services. Then ask the patient to prioritize up to 5 service areas (1 highest priority/5 lowest priority). Advise patient that services are subject to availability; this does not guarantee service.

| Service | Interest? | Priority | Service | Interest? | Priority |
|---|---|---|---|---|---|
| Acupuncture | ☐ | | Physical Exam: General or Pediatric | ☐ | |
| Behavioral Health Consultation | ☐ | | Physical Exam: Naturopathic | ☐ | |
| Chiropractic | ☐ | | Physical Exam: Women's Health/Gyn | ☐ | |
| Dermatology | ☐ | | Physical Therapy | ☐ | |
| Foot Care | ☐ | | Rapid Hepatitis C Testing | ☐ | |
| Mammogram (Women/40+) | ☐ | | Rapid HIV Testing | ☐ | |
| Nutrition Counseling | ☐ | | Wound Care | ☐ | |
| Occupational Therapy | ☐ | | | | |

| **PHYSICAL EXAM** | **SUITE NUMBER:** |
|---|---|

**SERVICE TYPE:** ☐ General ☐ Naturopathic
☐ General w/ Women's Health ☐ Pediatric

**VITAL SIGNS: BP _____ /_____ HR _____ RR_____ Temp _____ LMP ____ /____ /____ GLUC _____**

**HISTORY OF PRESENT ISSUE(s):**

**EXAMINATION:**

**DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.
*Indicate on page 1 if the patient needs to return to your suite with results for further consultation.*

In Suite Services: ☐ Dermatologist Consult ☐ EKG (page 12) ☐ Wound Care

Out of Suite Services: ☐ Lab (page 14) ☐ Mammogram (page 13) ☐ Rapid Hepatitis C Testing (page 9)
☐ Rapid HIV (page 9) ☐ Ultrasound (page 12) ☐ X-Ray (page 13)

Women's Health Self Service: ☐ Wet Mount collected in suite, microscope and supplies located in Suite 19/20 for evaluation.

**ASSESSMENT:**

**PLAN:**

| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **RX DISPENSED ONSITE** (page 6)<br>☐ **RX TO BE FILLED OFFSITE** (page 6) |
|---|---|

**PROVIDER NAME (Print):** **DATE:**

**PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1.

| PHARMACY | | |
|---|---|---|
| **PRESCRIPTION DISPENSED ONSITE** | | |
| **Available RX, Quantity and Dosage**<br>**Select from list available in the exam room** | **Provider Name (Printed)** | **Pharmacist Int.** |
| | | |
| | | |
| **Patient consented to counseling: □YES □NO** | **Patient Signature:** | |
| **PHARMACIST NAME (Print):** | | **DATE:** |
| **PRESCRIPTION WRITTEN TO BE FILLED OFF SITE** | | |
| **Pharmacists to transcribe RX Written, Quantity & Dosage** | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Prescriptions written to be filled off site were reviewed and confirmed by Seattle/King County Clinic Pharmacist. | | |
| **PHARMACIST NAME (Print):** | | **DATE:** |

| ACUPUNCTURE | SUITE NUMBER: |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ Lab (page 14) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **RX DISPENSED ONSITE** (above)<br>☐ **RX TO BE FILLED OFFSITE** (above) |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

| BEHAVIORAL HEALTH CONSULTATION | SUITE NUMBER: |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ Lab (page 14) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **RX DISPENSED ONSITE** (page 6)<br>☐ **RX TO BE FILLED OFFSITE** (page 6) |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

| CHIROPRACTIC | SUITE NUMBER: |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ X-Ray - for diagnosing injury only (page 13) | |
| **ASSESSMENT/PLAN:**<br>***Patients requiring additional treatment on the same day, must have their Patient Medical Record. Patients are not authorized to return on subsequent days for additional treatment. If they exited and turned in their Patient Medical Record, they are not to be treated.*** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **RX DISPENSED ONSITE** (page 6)<br>☐ **RX TO BE FILLED OFFSITE** (page 6) |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

**DERMATOLOGY** | **SUITE NUMBER: 18**

**SERVICE TYPE(S) Check all that apply:** ☐ Consult ☐ Skin Cancer Screen ☐ Cryo

**HISTORY OF PRESENT ISSUE(s):**

**EXAMINATION:**

**DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.
Out of Suite Services: ☐ Mammogram (page 13) ☐ Ultrasound (page 12) ☐ X-Ray (page 13)
☐ Skin Scraping 1.) Collect sample in suite, microscope and supplies located in Suite 19/20 for initial provider evaluation.
2.) All skin scraping samples are required to be sent for confirmation testing by lab.
Complete order form on page 14. Use "other" box to order testing: KOH Fungal Prep (Skin)

**ASSESSMENT/PLAN:**

**REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**
Give form to patient, direct them to follow up before exiting the Clinic.

☐ **RX DISPENSED ONSITE** (page 6)
☐ **RX TO BE FILLED OFFSITE** (page 6)

**PROVIDER NAME (Print):** **DATE:**

**PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1.

**FOOT CARE** | **SUITE NUMBER: 21**

**SERVICE TYPE(S) Check all that apply:** ☐ General ☐ Podiatry

**HISTORY OF PRESENT ISSUE(s):**

**EXAMINATION:**

**DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.
*Indicate on page 1 if the patient needs to return to your suite with results for further consultation.*
In Suite Services: ☐ Dermatologist Consult
Out of Suite Services: ☐ Lab (page 14) ☐ Ultrasound (page 12) ☐ X-Ray (page 13)

**ASSESSMENT/PLAN:**

**REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**
Give form to patient, direct them to follow up before exiting the Clinic.

☐ **RX DISPENSED ONSITE** (page 6)
☐ **RX TO BE FILLED OFFSITE** (page 6)

**PROVIDER NAME (Print):** **DATE:**

**PODIATRIST NAME (Print):** **DATE:**

**PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1.

| HEPATITIS C (RAPID) TESTING | | | SUITE NUMBER: 56 |
|---|---|---|---|
| **RESULTS:** | **Positive** | **Negative** | **Requests Results Remain Anonymous** |
| **Rapid Hepatitis** | | | |

**ASSESSMENT/PLAN:**

**DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.
Out of Suite Services: ☐ Lab (page 14) Use "other" box to order confirmation testing.

**REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**
Give form to patient, direct them to follow up before exiting the Clinic.

**PROVIDER NAME (Print):** **DATE:**

**PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1.

| HIV (RAPID) TESTING | | | SUITE NUMBER: 55 |
|---|---|---|---|
| **RESULTS:** | **Positive** | **Negative** | **Requests Results Remain Anonymous** |
| **Rapid HIV-1/2 Antibody** | | | |

**ASSESSMENT/PLAN:**

**DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.
Out of Suite Services: ☐ Lab (page 14) Use "other" box to order confirmation testing.

**REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**
Give form to patient, direct them to follow up before exiting the Clinic.

**PROVIDER NAME (Print):** **DATE:**

**PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1.

| NUTRITION CONSULTATION | SUITE NUMBER: 6 |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ Lab (page 14) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **NUTRITIONAL SUPPLEMENTS RECOMMENDED** |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

| OCCUPATIONAL THERAPY | SUITE NUMBER: MC |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ Ultrasound (page 12) ☐ X-Ray (page 13) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **Written exercises provided** |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

| PHYSICAL THERAPY | SUITE NUMBER: MC |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>Out of Suite Services: ☐ Ultrasound (page 12) ☐ X-Ray (page 13) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **Written exercises provided** |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

| WOUND CARE | SUITE NUMBER: 25 |
|---|---|
| **HISTORY OF PRESENT ISSUE(s):** | |
| **EXAMINATION:** | |
| **DIAGNOSTIC SERVICES AVAILABLE:** Provider completes corresponding order form.<br>*Indicate on page 1 if the patient needs to return to your suite with results for further consultation.*<br>In Suite Services: ☐ Dermatologist Consult<br>Out of Suite Services: ☐ Lab (page 14) ☐ Ultrasound (page 12) ☐ X-Ray (page 13) | |
| **ASSESSMENT/PLAN:** | |
| **REFERRAL FOR:** ☐ **Onsite Resources** ☐ **Offsite Services/Follow-up Care**<br>Give form to patient, direct them to follow up before exiting the Clinic. | ☐ **RX DISPENSED ONSITE** (page 6)<br>☐ **RX TO BE FILLED OFFSITE** (page 6) |
| **PROVIDER NAME (Print):** | **DATE:** |
| **PROVIDERS:** Track service on page 1 of Patient Medical Record. Check box(es) for completed service(s), indicate quantity, print your name and suite number. If additional service(s) are ordered, check box(es) in routed column and have patient escorted to service. Prioritize diagnostic services. If patient is to return to you with diagnostic results, fill out ***Return for Results*** section on page 1. | |

**EKG (REQUEST ROVING)** 1) Referring provider completes order form below. 2) Call for EKG Unit. 3) Tech performs in suite EKG and completes EKG section on page 1 of Patient Medical Record. 4) Provider reads EKG and consults cheat sheet &/or Medical or Primary Care Director as needed.

**PREVIOUS EKG ABNORMALITIES:**

**REASON FOR EXAM:**

**EKG RESULTS:**

**REVIEWING PROVIDER NAME (Print):** **DATE:**

**ULTRASOUND** 1) Referring provider completes order form below. Complete Return for Results section on page 1, instruct patient to return to your suite following Ultrasound 2) Patient is sent to Ultrasound. 3) Tech performs Ultrasound and completes Ultrasound section on page 1 of Patient Medical Record. List total number of scanned areas completed. 4) Radiologist reviews Ultrasound, then completes and signs Ultrasound Report below. 4) Patient is instructed to return to referring provider's suite for follow on discussion.

- ☐ abdomen
- ☐ aorta
- ☐ breast: ___ r ___l ___b
- ☐ extremity nonvascular (r/l)
- ☐ gallbladder/pancreas
- ☐ kidneys
- ☐ liver
- ☐ neck
- ☐ transvaginal pelvis
- ☐ testicular
- ☐ thyroid
- ☐ other:_____

**REASON FOR EXAM:**

**ULTRASOUND REPORT:**

**RADIOLOGIST NAME (Print):** **DATE:**

**X-RAY** 1) Referring provider completes order form below. Complete Return for Results section on page 1, instruct patient to return to your suite following X-Ray. 2) Patient is sent to X-Ray. 3) Tech performs X-Rays and completes X-Ray section on page 1 of Patient Medical Record. List total number of X-Rays completed. 4) Radiologist reviews X-Ray, then completes and signs X-Ray Report below. 5) Patient is instructed to return to referring provider's suite for follow on discussion.

| **CRANIAL** | | **THORAX** | | **ABDOMEN** | |
|---|---|---|---|---|---|
| ☐ | mandible | ☐ | chest 2-view | ☐ | abdomen/kub |
| ☐ | sinuses | **LOWER EXTREMITIES** | | ☐ | abdomen 2-view |
| ☐ | waters view | ☐ | ankle 2-view (r/l) | ☐ | abdomen series |
| **UPPER EXTREMITIES** | | ☐ | femur 2-view (r/l) | **SPINE** | |
| ☐ | ac joint series w/o weights (r/l) | ☐ | foot 2-view (r/l) | ☐ | c-spine 2-view |
| ☐ | ac joint series w/ weights (r/l) | ☐ | hips, bilateral | ☐ | c-spine 4-view |
| ☐ | ac joint series: zanca (r/l) | ☐ | hip (r/l) | ☐ | c-spine complete, 2-view, w/ obliques |
| ☐ | elbow 2-view (r/l) | ☐ | knee complete (r/l) | ☐ | t-spine 2-view |
| ☐ | finger(s) 2-view (r/l) | ☐ | knee sunrise (r/l) | ☐ | t-spine 4-view |
| ☐ | forearm 2-view (r/l) | ☐ | os calcis (heel) (r/l) | ☐ | l-spine 2-view |
| ☐ | hand 2-view (r/l) | ☐ | pelvis, ap | ☐ | l-spine 4-view |
| ☐ | humerus 2-view (r/l) | ☐ | tibia/fibula 2-view (r/l) | ☐ | l-spine complete, 2-view, w/ obliques |
| ☐ | shoulder 2-view (r/l) | ☐ | Other: | | |
| ☐ | wrist 2-view (r/l) | | | | |
| ☐ | specialty: ballcatchers' (r/l) | | | | |

**REASON FOR EXAM:**

**X-RAY REPORT:**

**TECH NAME (Print) :**

**RADIOLOGIST NAME (Print):** **Date:**

**MAMMOGRAPHY (PATIENT ESCORTED TO SEATTLE CANCER CARE ALLIANCE MAMMOVAN)** 1) Referring provider completes reason for exam below. 2) Send patient for Mammogram. 3) Results will be discussed with patient by a SCCA Breast Navigator. 4) SCCA provider checks box and signs on page 1 of Patient Medical Record to indicate service is complete.

**REASON FOR EXAM:** ☐ Routine Screening ☐ Symptomatic, describe:

**MAMMOGRAM REPORT (TO BE COMPLETED BY SCCA):**

☐ Normal, repeat annual screening in 12 months
☐ Additional film review, SCCA will contact with final results
☐ Need diagnostic mammogram, referral to SCCA
☐ Need ultrasound, referral to SCCA
☐ Other:

**SCCA RADIOLOGIST NAME (Print):** **Date:**

| PATIENT LABEL REQUIRED<br>PLACE PATIENT<br>LABEL IN THIS BOX | **LAB TESTS** 1) Referring provider completes order form below. Verify that their suite number is on the bottom of page 1 in the Return for Results section and instruct patient to return to suite if Point of Care (POC) tests are ordered. 2) Patient sent to lab for test(s) or with specimen collected. 3) Tech collects samples, completes Lab section on page 1 of Patient Medical Record. List total number of Labs performed. 4) Tech completes POC results section below. 4) Patient is instructed to return to referring provider's suite for POC follow on discussion. 5) All other lab results will be mailed to patient 2-3 weeks after the clinic. |
|---|---|

| | | | |
|---|---|---|---|
| **Date of Collection:** | | **Time of Collection:** | |
| **Collected by:** | | **Physician of Record:** | **Dr. Rick Arnold** |

**POINT-OF-CARE LAB RESULTS:**

| **URINALYSIS** | | | | Other Notes: |
|---|---|---|---|---|
| Color | | Blood | | |
| Appearance | | pH | | |
| Glucose | | Protein | | |
| Ketones | | Nitrites | | |
| Specific Gravity | | Leukocyte Esterase | | |

**RAPID TRICHOMONAS** ☐ DETECTED ☐ NOT DETECTED

**RAPID STREP** ☐ POS ☐ NEG

**PREGNANCY** ☐ POS ☐ NEG

**TECH NAME (Print):** **DATE:**

**LAB ORDER FORM**

| ROUTED | COMPLETE | TEST NAME | SPECIMEN | CODE |
|---|---|---|---|---|
| ☐ | ☐ | **Urine Chemstrip (Point-of-Care)** | Urine | |
| ☐ | ☐ | **Rapid Trichomonas (Point-of-Care)** | Dry Swab | |
| ☐ | ☐ | **Pregnancy Test (Point-of-Care)** | Urine | |
| ☐ | ☐ | **Rapid Strep (Point-of-Care)** | Swab | |
| ☐ | ☐ | Basic Metabolic Panel | SST | 2102 |
| ☐ | ☐ | Hepatic Panel | SST | 2105 |
| ☐ | ☐ | Complete Blood Count | EDTA | 5656 |
| ☐ | ☐ | Urinalysis, complete (Reflex to Culture) | Urine | 1040 |
| ☐ | ☐ | Hemoglobin A1c | EDTA | 3204 |
| ☐ | ☐ | Thyroid Stimulating Panel | SST | 3235 |
| ☐ | ☐ | Culture, wound (aerobic) - *collect in exam room* | eSwab | 7075 |
| ☐ | ☐ | Culture, wound (anaerobic) - *collect in exam room* | eSwab | 7012 |
| ☐ | ☐ | GC/Chlamydia Probe - *collect in exam room* | Aptima Tube | 7078 |
| ☐ | ☐ | PAP Smear - *collect in exam room/complete Cytology Form* | Thin Prep Vial | 8159 |
| ☐ | ☐ | Fecal Occult Blood | FIT Kit | 2294 |
| ☐ | ☐ | Other: | | |

**REFERRING PROVIDER NAME (Print):** **DATE:**

**DIRECTOR AUTHORIZATION**

☐ RFC: ☐ EMG REF: