

IPCOM AVATAR GUIDE

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INTRODUCTION

The purpose of this project is to develop a unique nurse-managed interprofessional (IP) collaborative practice model called **Interprofessional Primary Care Outreach for Persons with Mental Illness (IPCOM)**. Currently, the School of Nursing (SON), University of California, San Francisco (UCSF) has a community-based nursing partnership with the Progress Foundation providing care to a medically underserved, predominately homeless client population in community-based mental health residential treatment facilities.

Progress Foundation is a non-profit organization providing community-based residential treatment and supported housing programs as alternatives to institutional treatment for individuals with psychiatric disabilities. Progress Foundation provides a continuum of residential treatment programs (RTFs) situated in homes operated cooperatively by staff and clients. All programs are staffed 24 hours a day, 7 days a week by professional and non-licensed counselors. There are 3 Acute Diversion Units (ADUs), 10-12-bed crisis residential programs that serve as alternatives to hospitalization, with a typical length of stay of two weeks. Transitional programs offer the next level of care in the continuum. Clients stay between three months and one year. Several of the transitional programs have an identified specialty population focus: LGBT, Latino, African American, seniors and mentally ill mothers housed with their children.

Initially the community-based nursing partnership with the Progress Foundation provided services focused on routine health screening and physical examinations to determine medical stability for residential placement. Currently services have expanded to include urgent care and chronic disease management in the context of mental illness; health promotion and education targeted to the risk profile of people with mental illness; and education for non-licensed Progress Foundation staff on medical conditions and health promotion in aggregate living. PCOM NPs and students make referrals for ongoing primary care although there are multiple constraints (time, lack of care management resources and lack of information technology) that complicate these referrals.

An electronic health record (EHR) called Avatar is used by staff counselors and psychiatrists although paper charts are also maintained for each client. PCOM NPs record the following services they provide in Avatar documents: Admission, Health and Review of Systems, Physical Exam, Diagnosis, Vital Signs, Primary Care Notes and Discharge. The Primary Care Notes also include documentation of any follow-up appointments that are scheduled with a primary care. A paper appointment reminder is given to clients and Progress staff include appointment information in the discharge summary whenever possible.

This Avatar Guide will walk you through the Avatar Sign-In process, how to complete the Avatar Admission form, the identified Avatar clinical forms used for the project, the Avatar Discharge form, how to print "Abstracts" of Avatar forms and the paper IPCOM Appointment form that will be provided to the client. In addition, there are examples of Avatar reports and how to access the Avatar report function.

HOW TO SIGN ON TO AVATAR:

You must be set up as a user in order to access Avatar. The first level of access requires you to enter a number each time you sign-in to Avatar by pressing a button on the token that is provided to you. Super-tokens provide more Avatar access than a regular token. Please ask/know which type of token you have been given.

You must first sign on to DPH WebConnect and have your token or supertoken available.

If you have a supertoken, click the DPH WebConnect icon on the desktop, or the link created in favorites or manually go to: https://webconnect.sfdph.org/dana-na/auth/url_23welcome.cgi

If you only have a token (not a supertoken), you are likely on a different port. Use the link above but replace the “23” in the link with the number of your port (e.g. 19)

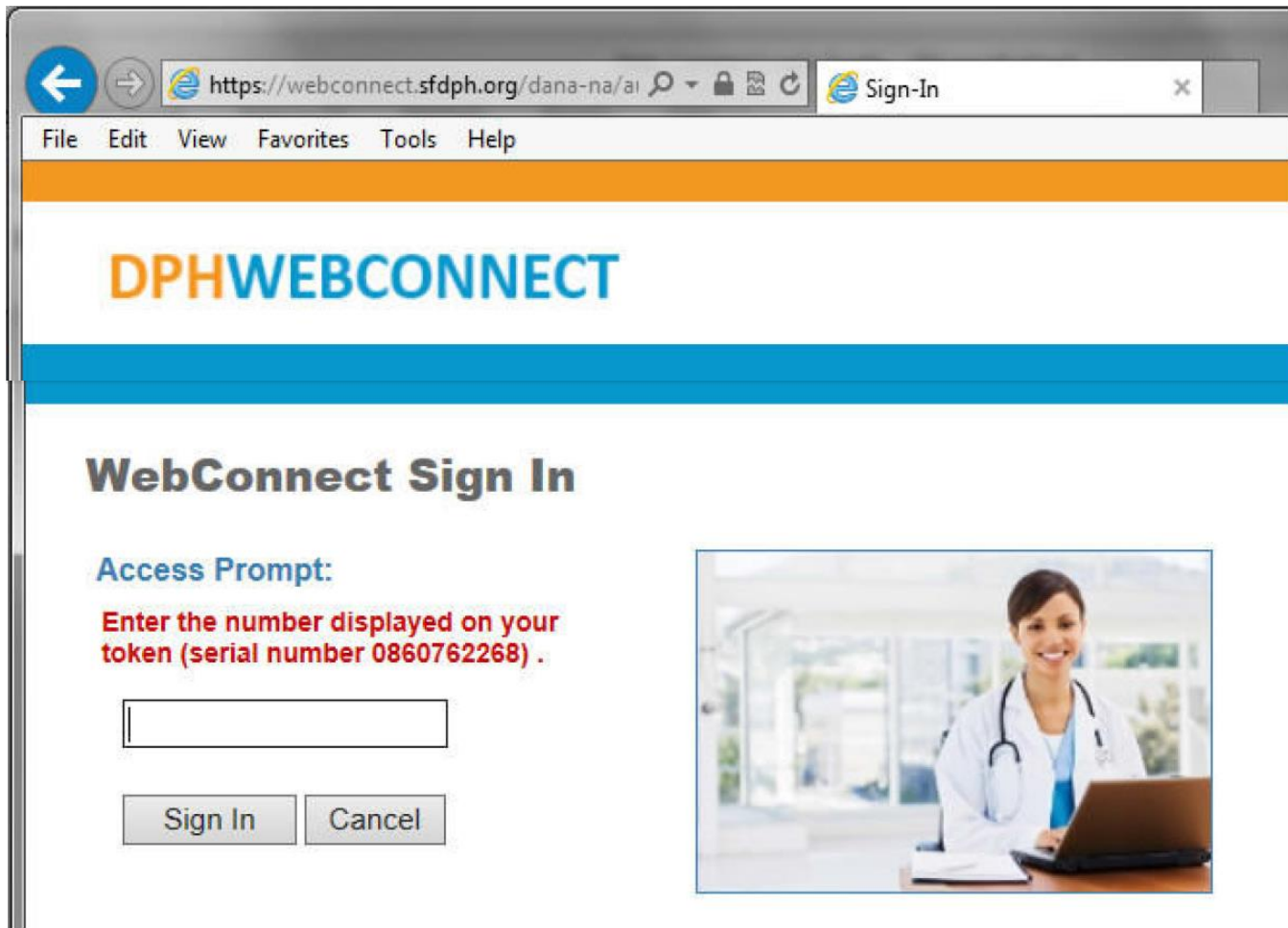
You should see the following screen:



The screenshot shows a web browser window with the address bar containing the URL https://webconnect.sfdph.org/dana-na/auth/url_23welcome.cgi. The browser's menu bar includes File, Edit, View, Favorites, Tools, and Help. The page content features a blue header with the text "DPHWEBCONNECT". Below this is a section titled "WebConnect Sign In" which contains two input fields labeled "username" and "password", and two buttons labeled "Sign In" and "Help". To the right of the sign-in fields is a photograph of a female doctor in a white lab coat with a stethoscope, sitting at a desk with a laptop. At the bottom of the page, there is a line of text: "You will be given your user name and password".

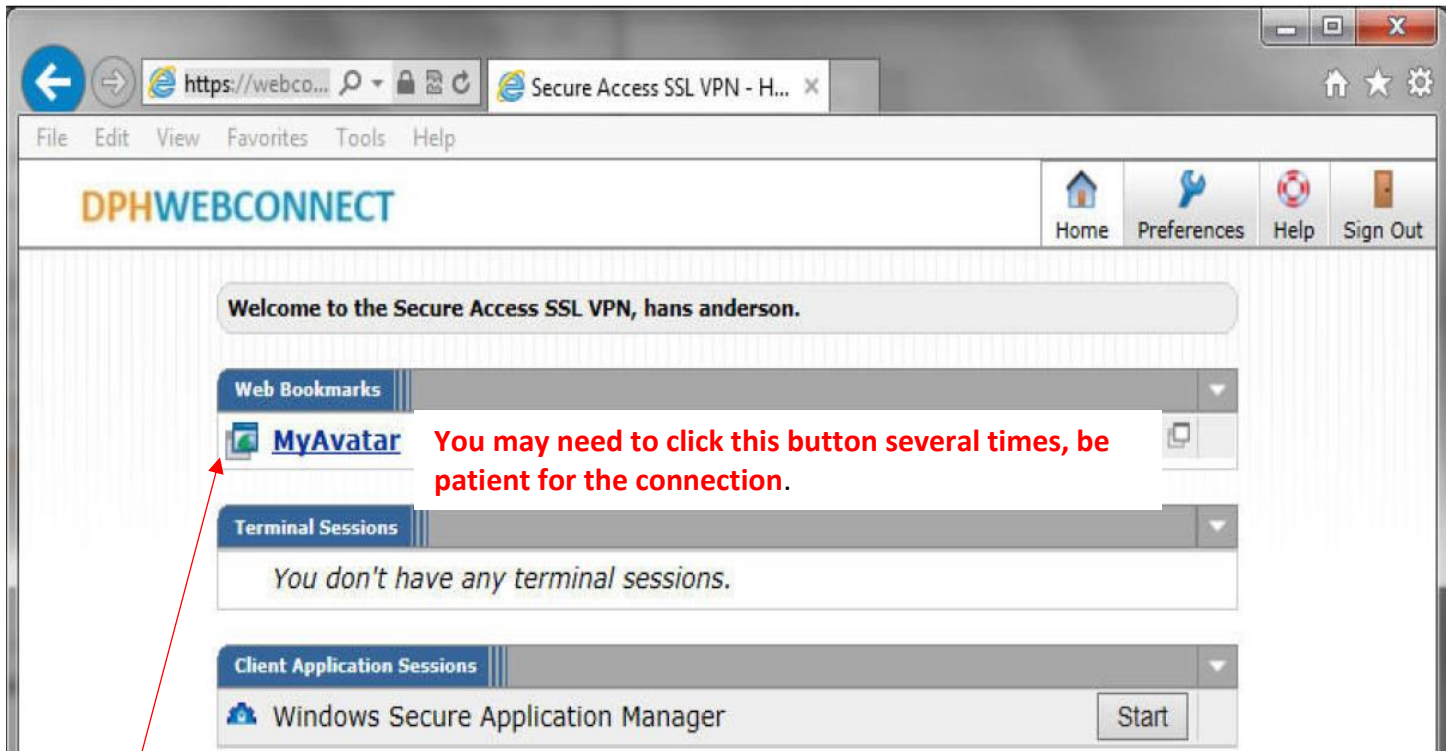
Enter in your user name, and password. Your user name should be in the form “Firstname Lastname”, and is different from your Avatar user name. Your password can be, but is not necessarily the same as your Avatar password. Click “Sign In” when you are finished.

You should now see this screen:



Press the button on your token, making sure to hold it down until all of the numbers appear. Enter the numbers displayed on your token, then press “Sign In”. If you are asked for permission to make changes to your computer, click yes.

You should see the following screen



Click "MyAvatar" to launch Avatar. When you see the following screen, you have successfully logged in to WebConnect, and are now logging in to Avatar



Use all Caps but NOT Caps Lock!

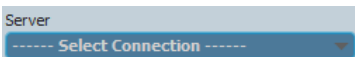
Server: Select AVCALPMLIVE

System Code: Enter SFMH

Username: Enter initial of first name and last name

Password: is case sensitive and will need to be updated every 6 months; gets deactivated if there is no use for 90 days

If you forget your password, forgot your token, or get a message, "INVALID USER NAME OR PASSWORD", contact the HELP DESK- 1-(415)-255-3788



Always select AVACALPMLIVE from the drop down.

SIGN IN ISSUES

Please be sure to pick a working location at the site that maximizes the wi-fi connection

1. “ATTENTION: Invalid username or password. Please re-enter your user information”.



The screenshot shows the DPHWebConnect sign-in page. At the top, it says "DPHWEBCONNECT" in blue. Below that is a blue header bar. The main heading is "WebConnect Sign In". There are two input fields: "username" and "password". Below the fields are "Sign In" and "Help" buttons. At the bottom, there is a red error message: "ATTENTION: Invalid username or password. Please re-enter your user information."

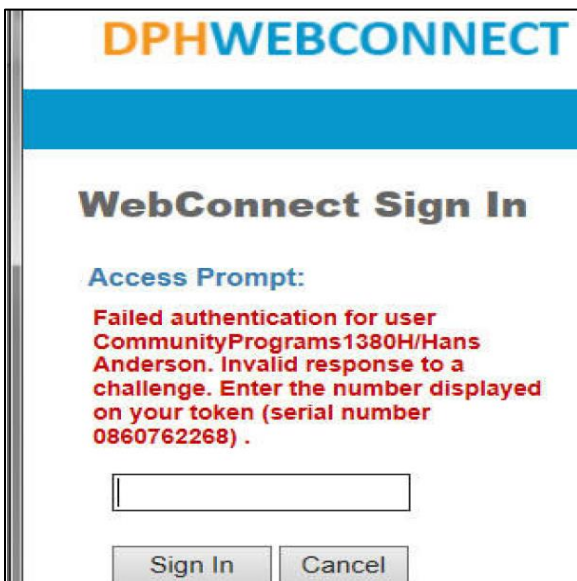
If you see this error, you have either entered an incorrect user name or password.

Make sure that your username is in the format “Firstname Lastname”.

Password Requirements: Mix of upper/lower case letters, contain at least one number, NO special characters, cannot be the same as the last 6 passwords you may have used (make is unique).

If you can’t get past this screen, call the Avatar Help Desk, 1-(415)-255-3788, as you may need a password reset

2. “Failed authentication for user (...) Enter the number displayed on your token (serial number XXXXXXXX) You will see this error message when entering your token numbers



The screenshot shows the DPHWebConnect sign-in page. At the top, it says "DPHWEBCONNECT" in blue. Below that is a blue header bar. The main heading is "WebConnect Sign In". Below the heading is the text "Access Prompt:". The error message is: "Failed authentication for user CommunityPrograms1380H/Hans Anderson. Invalid response to a challenge. Enter the number displayed on your token (serial number 0860762268) .". There is an input field for the token number. Below the field are "Sign In" and "Cancel" buttons.

If you are seeing this screen, your user name and password are correct. This error message occurs when you have entered your token numbers incorrectly, or your token is out of synch with the authentication server. Call the Help Desk 1-(415)-255 3788 for instructions on re-synching your token.

If you do not see the MyAvatar launch screen after entering your token numbers, but see a blank screen or a “Buy this domain” message, this is often because WebConnect was not installed correctly on your machine.

In many cases this can be solved by reinstalling WebConnect by right clicking on the installer and selecting “Run As Administrator”. **It is not enough to be logged in as an administrator, you must select “Run As Administrator”**

Refer to these guides:

<https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/WebConnectTechnicalGuide2014.pdf>

<https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/WebConnectEndUserGuide.pdf>

* Be aware, Avatar automatically locks you out after 30 minutes to 1 hour of no use- you may receive a warning that time has elapsed since last use; you can cancel the warning and remain active or if you need, just log back in.

Windows locks you out after 10 minutes of no use and you will need to re-enter your windows password.

Let's look at the **Home View**, the **Client's Chart View**, **How to Navigate** and review the **Format/Entry Types** used in Avatar. There are 7 Avatar documents that will be used for this project (Admission, Health Review of Systems, Physical, Diagnosis, Vitals Entry, MD Progress Notes and Discharge). There may be times when all are not necessary for a particular client. The most important form is the Admission form which opens the client for service in your program. Some forms require entry or selection of **your** program: **UCSF Primary Care Outreach**.

HOME VIEW

When you first open Avatar, you are in the **Home View**. The Home View tab appears green when active, you can click on Home to return to the Home View at any time, even when forms are open.

The screenshot shows the Avatar Home View interface. At the top, there is a navigation bar with a 'Home' tab highlighted in green. To the right of the navigation bar is a 'Menu Bar' containing 'Preferences', 'Lock', 'Sign Out', 'Switch', and 'Help'. Below the navigation bar, the interface is divided into several sections:

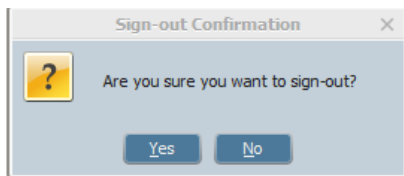
- Client Section:** Includes 'My Clients' (labeled 'B Client Widget'), 'Recent Clients', and a 'Search Clients' field with an 'advanced' option and a 'Close Open Clients' button.
- Forms & Data Section:** Includes 'My Forms' (labeled 'C Forms Widget') with a list of form types such as 'Adult/Older Adult Init Assess SHORT Rpt', 'Adult/Older Adult Closing Summary Rpt', 'ADULT/OLDER ADULT REASSESSMENT RPT', 'Adult/Older Adult TPOC/Reassessment Rpt', 'Adult/Older Adult Closing Summary', 'ANSA Outcomes Rating Report', 'Crisis Evaluation Report', 'Forms', 'Health Monitoring (Adult)', 'Initial Risk Assessment (A/OA)', 'Progress Notes Without Pagebreaks', 'Progress Notes Viewer', and 'Psychiatric Evaluation Form Rpt'. Below this is a 'Recent Forms' section and a 'Search Forms' field. At the bottom of this section is a 'Browse Forms' list with 'Avatar PM', 'Avatar CWS', and 'Avatar MSO'.
- My To Do's Section:** Labeled 'D My To Do's', it shows a table with columns for 'Client', 'Action', 'Form', 'Sent', 'Comments', and 'Note-to-Self'. The table is currently empty.
- Other Sections:** 'Recent Psychiatric Inpatient Admissions' (showing 'No recent admissions'), 'Message Center', and 'MH ADULT TPOC Due'.

Red arrows and labels are used to highlight key features: 'A Menu Bar' points to the top right navigation area; 'B Client Widget' points to the 'My Clients' section; 'C Forms Widget' points to the 'My Forms' section; and 'D My To Do's' points to the 'My To Do's' section.

- A. The **Menu Bar** is displayed at the top of the Home View window and always displays regardless of the Avatar forms that are open. The Menu Bar contains functions you need while you are working in Avatar.

LOCK- if you click LOCK, client information is protected and cannot be viewed if you leave your computer for a short time. Locking the application restricts unauthorized access. You will be required to enter your Avatar password to unlock when you return; however the screen will be at the exact state it was before it was locked.

SIGN-OUT- You should sign out of the Avatar application when you are finished so the system can shut down properly. Sign Out closes the Avatar application. A pop up message appears, asking if “Are you sure you want to sign out”? Click “Yes”.



If you try to sign out and encounter a pop up “Warning, You have open forms” be sure to submit any documents you were working on or your work will be lost! Go back to the Chart View, look at the Menu Bar for any CLIENT or FORMS that may be open. Close and/or SUBMIT the form or close the client’s chart! Then try to sign out again.

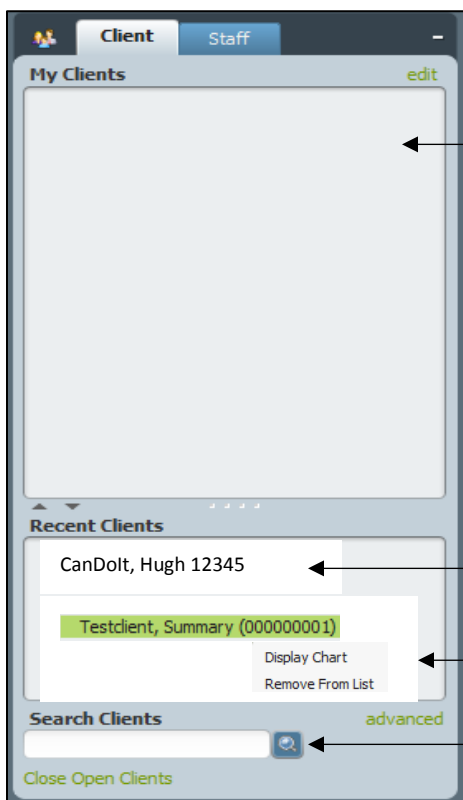


These arrows indicate that you can expand the size of a widget if you hover with your cursor until you see the double arrows and then drag up or down or sideways with your mouse.

Widgets are containers that display information that was in an Avatar form. In the Client widget clients you are working on during the session are displayed. The Forms & Data widget includes the forms used most frequently. You will see how to customize this widget for the forms used for the IPCOM project on page 12.

B. Client Widget: At the bottom of the Client Widget is **“Search Clients”**. Use this field to look for the client you are working with. This is a **smart search field** which means as you start typing in search information, a list of clients that match what you typed are displayed. You can narrow down your search by searching by **name, alias, social security number, Avatar ID or date of birth**. You must double click to select the client; his/her name appears in the Recent Client section. For a client with a common name, like Smith, narrowing the search is important. Sometimes your selection will not be among the first 25 names displayed and you will need to click on, “Show additional names”.

If your search does not display the name of the client and you’ve tried narrowing down, it may be possible the client has not yet been opened or admitted to the IPCOM program. You must always first admit the client into your program!



← This upper portion does not apply for this project as this area contains clients assigned to a user’s caseload.

← You can open the chart of any client listed in Recent Clients by double clicking on the name. OR

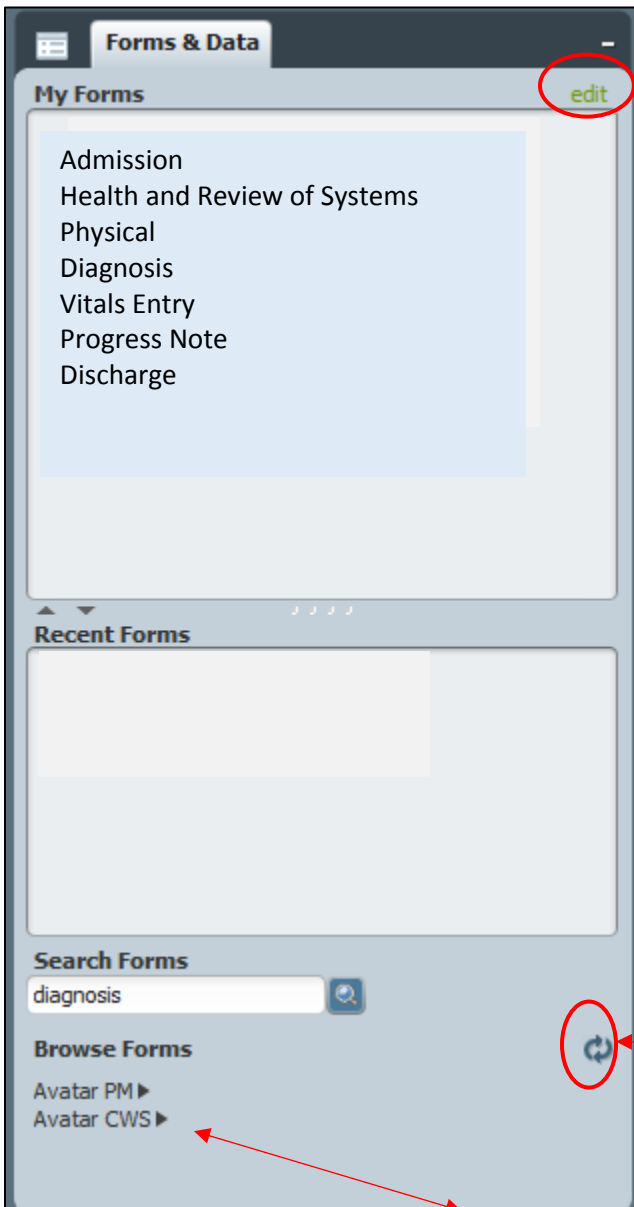
← You can right click on the name and then select Display Chart from the pop up.

← If you click on the magnifier, a larger search window will open

In order to open a form, a client must be selected. It is best to open forms from the client’s chart which will be shown later on page 14 .

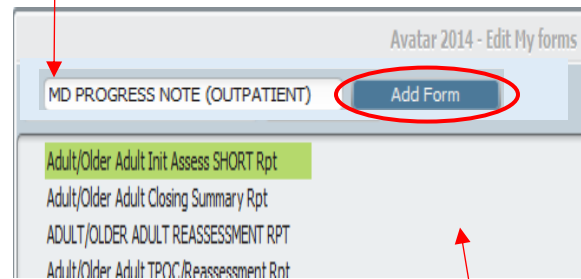
C. CREATING “FAVORITES” FOR YOUR FORMS & DATA widget

In order to create a set of the forms you use most frequently, or “favorites” you click on **edit** to open the window to add forms. You will find it is easier to simply select from the widget, you will not need to search every time you work on a form in Avatar. **It takes less time and is more efficient to access forms from the Chart View and clicking on the PLUS icon.** The **PLUS** icon will display the forms you have set up in the Forms and Data widget.

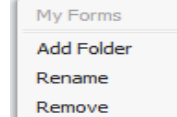


To ADD forms to the forms widget, click the EDIT button

Insert a few letters of the form you want to add, when you see it, double click until it displays in the add form box. Then click **ADD FORM**



You can right click to add folder



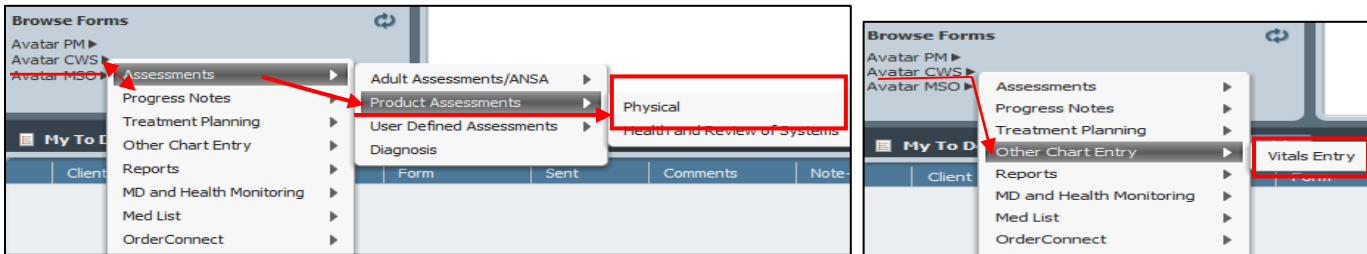
Be sure to click **SAVE** at the bottom and the form will be added to your Forms & Data widget

This is the refresh icon. It will refresh and bring forward any form you may have added in the session.

You can also browse through the Avatar CWS Menu. CWS means Clinical Work Station and is where the clinical forms are located. Click on CWS to view options, then slide your cursor horizontally and sometimes vertically to find the form.

See next page

You can also browse through the Avatar CWS Menu. CWS means Clinical Work Station and is where the clinical forms are located. Click on CWS to view options, then slide your cursor horizontally and sometimes vertically to find the form.



D. My To Do's: Home View also contains a widget with My To Do's. The My To Do list helps you keep track of, view and manage "Draft" documents that need to be submitted as FINAL. The first tab display **all** items (2), the next tab shows new items, within 24 hours.



Click any document in the Form column and it will bring you right to the form and open it. The functionality of this widget can be reviewed at a later date if it becomes necessary for students requiring co-signatures to route their documents to a supervisor. The My To Do list is able to track this.

CHART VIEW

The **CHART VIEW** displays client information and all finalized and scanned documents, and reports. There are 2 widgets: one displays Client Episodes and the other Progress Notes. **Chart View is considered the client's legal chart so it is best to access forms and complete documentation from Chart View.**

You can click on HOME to return to the HOME VIEW, The Client Name displays as green highlighted and active.

Home summary T Preferences Lock Sign Out Switch Help MFRIEDMA

TESTCLIENT, SUMMARY (000000001)
F, 34, 07/01/1980
Ht: 5' 5.1", Wt: 110 lbs, BMI: 18.2 Allergies (5)

Chart Overview

Adult Clinical
Initial Risk Assessment (A/OA)
Adult/Older Adult Assessment (Short)
Adult/Older Adult Assessment (Long)
Diagnosis
Adult/Older Adult Treatment Plan of t
Adult/Older Adult Closing Summary
Crisis Evaluation

Adult Medical
Psychiatric Evaluation Form
Psychiatric Plan of Care
ANSA Outcomes Rating
Health Monitoring (Adult)

Administrative
Admission (Outpatient)
CSI Admission
Episode Guarantor Information
Admission Referral Information
Contact Information
Forms
Update Client Data
Discharge (Outpatient)
MH Vocational Program Referrals / En

Client Views
MHS 140

CLIENT EPISODES

Episode #	Program	Admission Date	Discharge Date
3	Fee for Service MFCC (38AP)	2015-02-28	
1	ACCESS Screening	2010-07-01	

Once you have admitted the client to your program, it will be listed in this episode widget.

Progress Notes

Previous 30 days
Selection: All Notes

Adult Residential (SA) - 03/01/2015 by Pablo M. Munoz

Individual Progress Notes
Progress Note For: New Service

Note Type: Adult Residential (SA)

Notes Field:
Test by Pablo

Date Of Service: 03/01/2015

Service Charge Code: ASSESSMENT/EVALUATION (80001)

Service Program: Fee for Service MFCC (38AP) (38AP)

These are forms that have been submitted. You can open to view or print an "abstract"

This widget shows the date, note type and author of progress notes across all programs. It is set to display the previous 30 days of notes. You can change the number to show more or less. Remember to click refresh to view a note you have just entered.

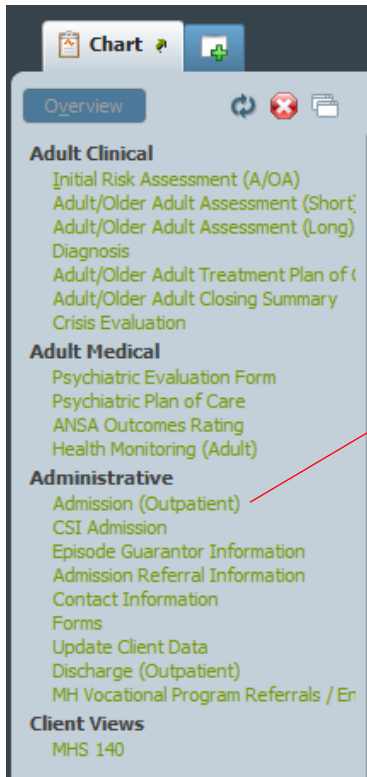
Click here for the e-Links page(for DPH staff only)/Chart view

Home summary T Preferences Lock Sign Out Switch Help MFRIEDMA

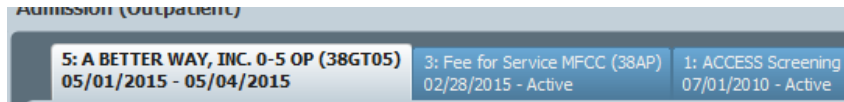
TESTCLIENT, SUMMARY (000000001)
F, 34, 07/01/1980
Ht: 5' 5.1", Wt: 110 lbs, BMI: 18.2 Allergies (5)

In Chart View, the Client Information Bar displays demographics just below the Menu

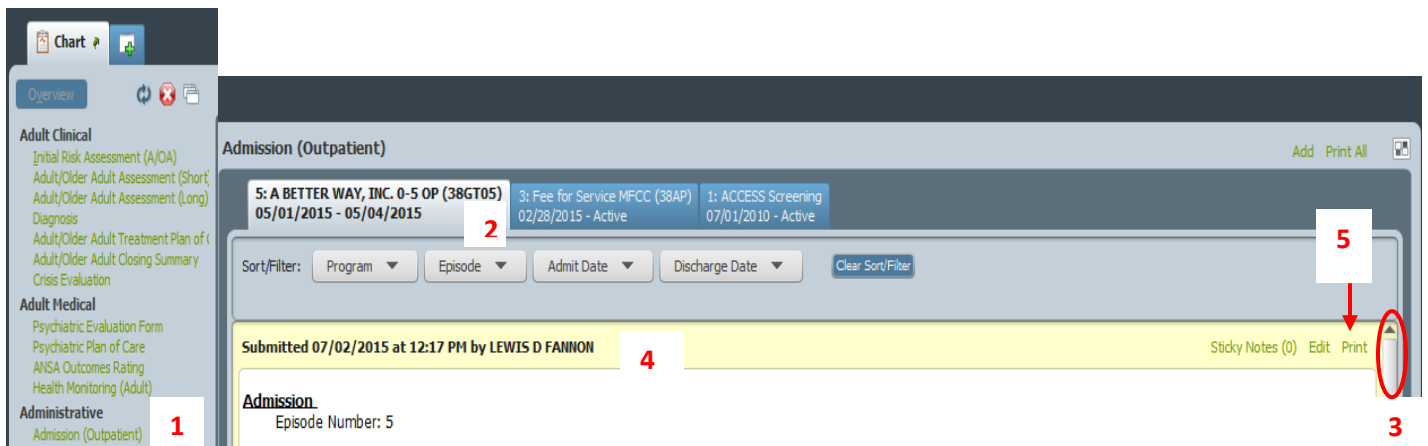
Menu Bar → Allergies display if you hover next to the Allergies icon →



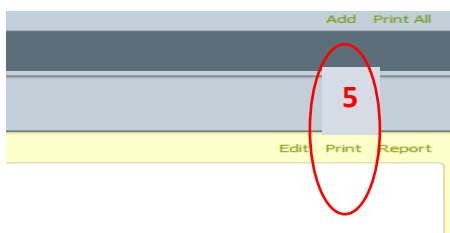
If you open a document from the left hand side, you can view an “abstract” of what has been entered. There may be numerous programs identified for you to scroll through to find the document you want to view. Once you make your selection, there will be an option to print.



Example: The Admission (Outpatient) form was selected. This header shows the different episodes the client is/has been open in. Click on each episode to display information. Sometimes there may be no information. Sometimes in the case of the diagnosis there may be multiple entries to view within an episode.



Once you have selected the form from the left (1) and episode you want to view (2) , you can scroll (3) to view the entries. Each entry is separated by the date submitted and author (4). All the way to the right is an option to print (5)



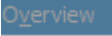
Please Note:
The document you print will be an “abstract” and not a formal legal document. A report that includes the San Francisco County identifiers may be necessary for a legal version print-out of the form.

Other Important icons in Chart View:



This shows you are in Chart View; the green plus icon is described in more detail below.



If you view or open any form or report from the left side of the chart, you can return to the view that displays when Chart View opened. It is called the Overview, just click on OVERVIEW .



This is the **REFRESH** icon which allows any new information to become available if it was added while Avatar is in use. It refreshes the screen to display any recently submitted data.



This **RED X, (X)** closes the client's open chart.

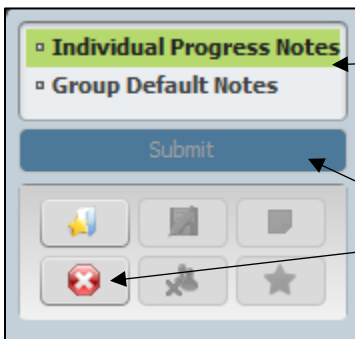


This is an **"UNDOCK"** icon. It allows you work on or view a document in a separate window. If you undock, look for the icon with the arrow pointing downward to re-dock into the view or widget.



This is the **GREEN PLUS** icon. Click on it and a smaller version of the Forms & Data widget from Home View displays for you to select the form you want to open. **This is the "BEST WAY" to open a document for the client**, double click on the client's name to open up Chart View, go to the Green Plus icon, then select the form you want to complete.

Control Panel



The **Control Panel** shows SECTIONS of a form, you can click on the section and go right to that section.

The **Control Panel** is also how you submit the form. **SUBMIT** will SAVE/Submit data.

X allows you to close a form without submitting it.



Do NOT use this!



ZOOM: Located at the bottom of any open form, you can click and hold and move the zoom slider to increase the size of the form by percentage or by clicking the plus or minus buttons

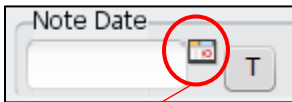
RED/REQUIRED: You must complete any field that displays as red/required in order to submit!



This shows **Chart View** with the **Health and Review of Systems** and **Diagnosis** documents open.



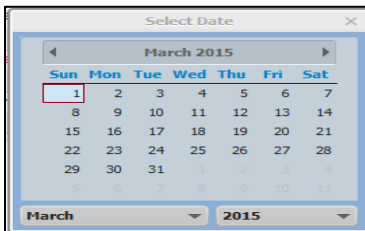
On the side of any Text Box is the **Text Editor icon** (pad & pen). The TEXT Editor expands the view of the entire note and allows you to make changes to the note. You must save any changes to the text before you close out of the TEXT Editor window.



You can click on T for today's date.



If you click on this icon, a "Date Picker" calendar will display to select a date. Once a date is selected it will default into the field.



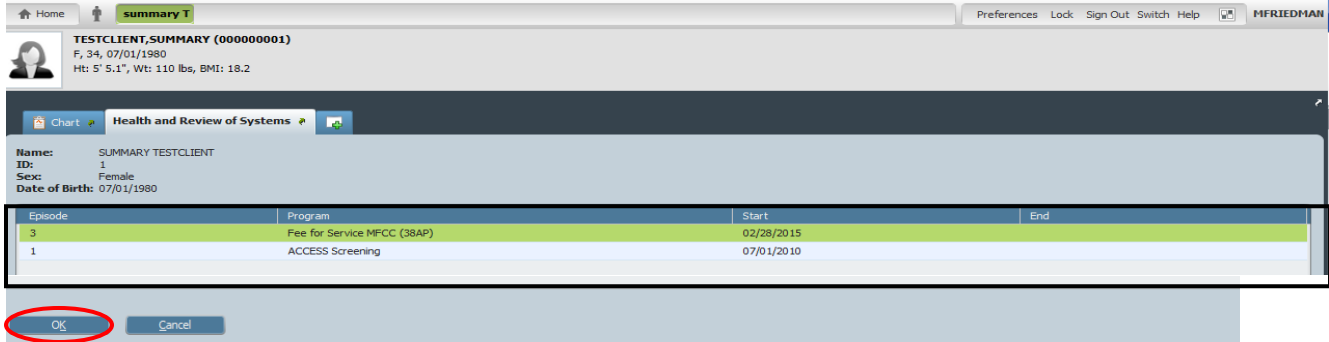
Light Bulb: This is a "help" or prompt for what should be entered in a field. You can hover to see what is contained in the light bulb or click on the light bulb to reveal.

Pre-Display: There are 2 types of Pre-Display screens that may display when you select a form.

- An **EPISODE Pre-Display** requires you to select the episode you are working in. **Remember, when you admit the client into your program it means they are open in your program's episode and that is what you should select when the episode pre-display appears.**

Episode Pre-Display example-

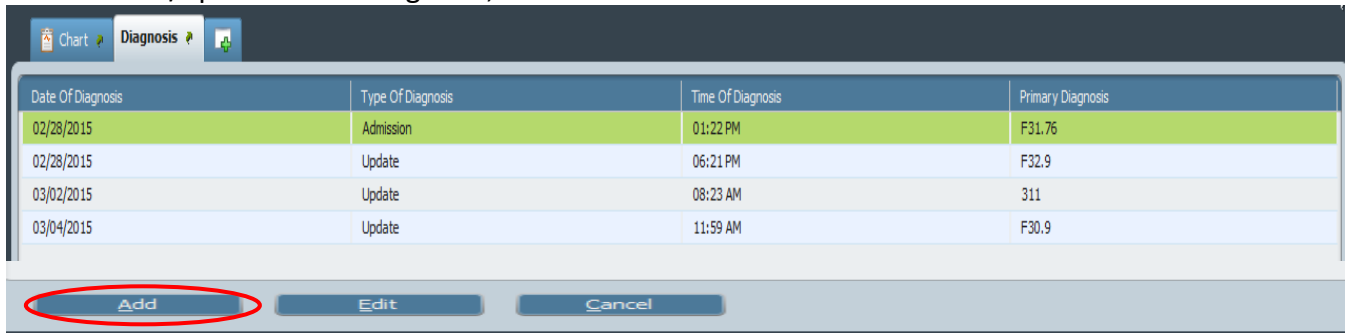
Click to select and highlight the episode you are working in and for which the form will be submitted in.



- A **DOCUMENT Pre-Display** shows other forms submitted within the episode you are working in. You must make a selection, EDIT a form that you left in DRAFT to finalize it, or ADD to OPEN a NEW FORM. **You cannot EDIT a FINAL form but can view it as read only.**

Form Pre-Display example-

Below are the dates and types of the diagnosis forms that have been submitted. Select EDIT to VIEW or to enter a new /update to the diagnosis, select ADD.



Multiple Entry Table: The Diagnosis form has an example of a multiple entry table.

Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10
---------	-------------	--------	-----------------	----------------	----------	------------	------------	--------

New Row Delete Row

For this form you are able to click inside each box and select an option that displays in a pop out box.

Click on **New Row** to activate the entry fields.

Double click on the field **Ranking**, a pop up will display for you to select from.

Double click on the field **Description**, a pop up will display for you to add text.

Double click on the field **Status**, a pop up will display for you to select from.

Double click on the field **Estimated Onset**, a pop up with a calendar will display for you to select the date.

Double click on the field **Classification**, a pop up will display for you to select from.

Double click on the field **Resolved**, a pop up with a calendar will display for you to select the date.

Double click on the field **Bill Order**, a pop up will display for you to add text or number.

Double click on the field **ICD-9 Code**, a pop up will display for you to enter the code.

Double click on the field **ICD-10 Code**, a pop up will display for you to enter the code.

To add another diagnosis, select “New Row” and repeat. This is shown in more detail on pages 28-33.

NOW, Let’s look at the forms you’ll be using for this project:

1. Admission (Outpatient)
2. Health and Review of Systems
3. Physical
4. Vitals Entry
5. Diagnosis
6. MD Progress Notes
7. Discharge (Outpatient)

1. Admission (Outpatient)

You must enter all clients you provide a service for into an IPCOM episode. You must admit the client to your program using the Avatar Admission (Outpatient) form.

Highlight Client → Forms & Data Search → Admission (Outpatient). Double click to open the form.

The screenshot shows the Avatar 2014 software interface. The 'Forms & Data' section is active, displaying a search for 'adm'. The search results are shown in a table with two columns: 'Name' and 'Menu Path'. The 'Admission (Outpatient)' entry is highlighted in blue, and its menu path is 'Avatar PM / Client Management / Episode Management'. A red circle highlights the 'Admission (Outpatient)' entry in the search results. Another red circle highlights the client name 'Testclientavatar, Summaryone (999047242)' in the 'Recent Clients' section. The interface also shows 'My Clients', 'My Forms', 'Recent Forms', 'Search Clients', and 'Recent Psychiatric Inpatient Admissions' sections.

Name	Menu Path
MH Admission Outpatient Bundle	Avatar PM / Client Management / Episode Management
MH Admission Residential Bed Mgmt Bundle	Avatar PM / Client Management / Episode Management
MH Admission Inpatient SFGH Bundle	Avatar PM / Client Management / Episode Management
IMD/RCF Admission Bundle	Avatar PM / Client Management / Episode Management
Admission	Avatar PM / Client Management / Episode Management
Admission (Outpatient)	Avatar PM / Client Management / Episode Management
Admission (Outpatient)	Avatar PM / Client Management / Client Information
CSI Admission	Avatar PM / Client Management / Client Information
CalOMS Admission	Avatar PM / Client Management / Client Information
CalOMS Administrative Discharge	Avatar PM / Client Management / Client Information
Program Admission Form	Avatar CWS / Assessments / User Defined Assessments

Pre- Display Screen: Shows if the client is open in an episode; the program field displays the name. If the discharge date is filled in, you can view the admission information for that episode of care but you cannot edit admission information in an episode that is closed. If there is no discharge date, the client remains open in that program.

You can select to edit admission information in the displayed program's episode if there is no discharge date or ADD and open a new episode for your program.

Select ADD

Avatar 2014

Home summary T Preferences Lock Sign Out Switch Help MFRIEDMAN

TESTCLIENT,SUMMARY (000000001)
F, 34, 07/01/1980
Ht: 5' 5.1", Wt: 110 lbs, BMI: 18.2

Admission (Outpatient)

Episode	Admit Date	Discharge Date	Program
5	05/15/2015		A BETTER WAY, INC. 0-5 OP (38GT05)
4	05/15/2015	05/15/2015	UCSF Primary Care Outreach (IPCOM)
3	02/28/2015		Fee for Service MFCC (38AP)
1	07/01/2010		ACCESS Screening

Add Edit Cancel

Once the admission form opens and you begin to enter information, this pop up screen may appear several times, just click ok. This is a validation screen as clients are usually not open to multiple episodes (programs) at the same time.

Confirm

? Client is Active In Other Episodes.

Ep# 1 Admit : 07/01/2010 - 10:32 AM (ACCESS Screening)

Ep# 3 Admit : 02/28/2015 - 12:42 PM (Fee for Service MFCC (38AP))

Ep# 5 Admit : 05/15/2015 - 02:04 PM (A BETTER WAY, INC. 0-5 OP (38GT05))

OK Cancel

Admission (Outpatient) Form

Some red/required fields may display with Name, Sex and Date of Birth that has defaulted in:

Pre-admit/Admission Date

Pre-Admit/Admission Date: Date you are admitting, click T

Pre-admit/Admission Time

Current
H
M
AM/PM

Pre-Admit/Admission Time: Click Current

Program

Program: Select your Program IPCOM from the drop down list

- A BETTER WAY, INC. 0-5 OP (38GT05)
- A Better Way-SF Outpatient (38GTOP)
- A Better Way-SF Thera Visitati (38GT01)
- A Woman's Place (38BKOP)
- A Woman's Place Drop-In Center (38IQBH)
- AARS Offender Treatment Program
- AARS Project Adapt (38JBOP)
- AARS Project Adapt MH (38IZ3)

Type Of Admission

Source Of Admission

Type of Admission: select the appropriate type from the drop down

First Admission: First admission to your program

Pre-Admission: Not applicable for your program

Re-Admission: Client has been at your program before, is currently closed at your program, you are opening

Admitting/Primary Clinician

Admitting Primary Practitioner: Enter a few letters of your last name; double click so that your name fills the box

Client's Living Arrangements

Client's Living Arrangement: Defaults information from what is most current in Avatar. Be sure to check with the client that information displayed is active. If it is not use the drop down to select the current appropriate current living arrangement.

The other fields in this Admission section are optional

Here is the admission section of the form once I filled it in (notice how many sections there are to complete)

The screenshot shows the Avatar 2014 software interface for an admission form. The client is identified as TESTCLIENT, SUMMARY (00000001), a 34-year-old female born on 07/01/1980. The admission is for episode 6, occurring on 05/17/2015 at 04:10 PM. The program is UCSF Primary Care Outreach, and the type of admission is Re-Admission. The admitting primary clinician is MICHELE FRIEDMAN (004807). The client's living arrangement is Homeless- Abandoned Bldg. The form also includes sections for Disposition, Presenting Problems, and various Disability checkboxes (Disabilities-1, 2, 3).


Next, click on the Demographics section....

Demographics section:

Many of the fields in this section are optional; go down to the red/required **"Smoker"** field.

The screenshot shows a patient record for 'TESTCLIENT, SUMMARY (000000001)'. The 'Demographics' section is active, showing fields for Client Last Name (TESTCLIENT), Client First Name (SUMMARY), and Client's Middle Initial. There are also fields for address (Street, Zipcode, City, County, State), contact information (Home, Work, Cell Phone), and various demographic details like Primary Language (Spanish), Client Race (Asian Indian), Ethnic Origin (Puerto Rican), Religion (Other), Place Of Birth (Arkansas), Country Of Origin (Bangladesh), Maiden Name (Colosio), Marital Status (Not Married), Education (19 Grade), and Employment Status (Unemployed, actively seeking ...). A dropdown menu for 'Smoker' is open, showing options like 'Current Every Day Smoker', 'Current Some Day Smoker', 'Former Smoker', 'Heavy Tobacco Smoker', 'Light Tobacco Smoker', 'Never Smoked', 'Smoker', and 'Unknown If Ever Smoked'. A red 'Smo!' label is placed over the dropdown menu, and a blue box highlights the dropdown options. A red arrow points from the text 'Select the current Smoker status' to the dropdown menu.

Select the current **Smoker** status


Select from the drop down list below 

Not Connected

Other if not listed above
Other if not listed

Primary Care Practitioner
Werler

Practitioner Phone Number

Select from the drop down list below 

Chinatown Public Health Center

Chinatown Public Health Center

Chinese Hospital-CCHCA Providers

Chinese Hospital-Excelsior Clinic


Chinese Hospital-Sunset Clinic

Cole Street Youth Clinic

CPMC (California Pacific Medical Center)

Curry @ Central City Older Adult MH

Curry Senior Center



Not Connected: use this choice to indicate the client does not have a primary care provider.

Unknown: Use this choice if there is a primary care provider/clinic but the name is unknown to the client.

Other: Use this choice if the client's clinic is not listed in the drop down list. Enter the name of the clinic (if known) in the "Other Primary Care Provider" text box below.

Private Practice: Use this choice to describe a primary care practitioner in the individual private practice or small group practice.

Select the appropriate **connected** primary care location or select Not Connected, Unknown, Other, or Private Practice as described above per the light bulb.

At the bottom of the demographics page is another red/required field: **Smoking Status Assessment Date**

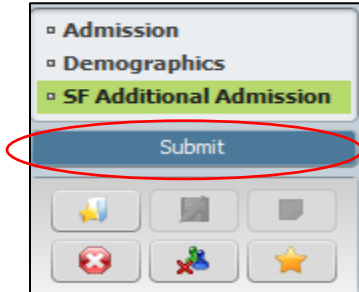
Smoking Status Assessment Date

05/17/2015

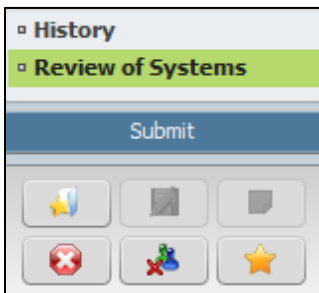
Enter the date you assessed the client's smoking status. This should be T for today as this question is a required field for any new episode/program the client is admitted to.

SF Additional Admission Section: These fields in this section are optional

Always remember to Submit and then document in the MD progress note that the client has been admitted into the IPCOM program!

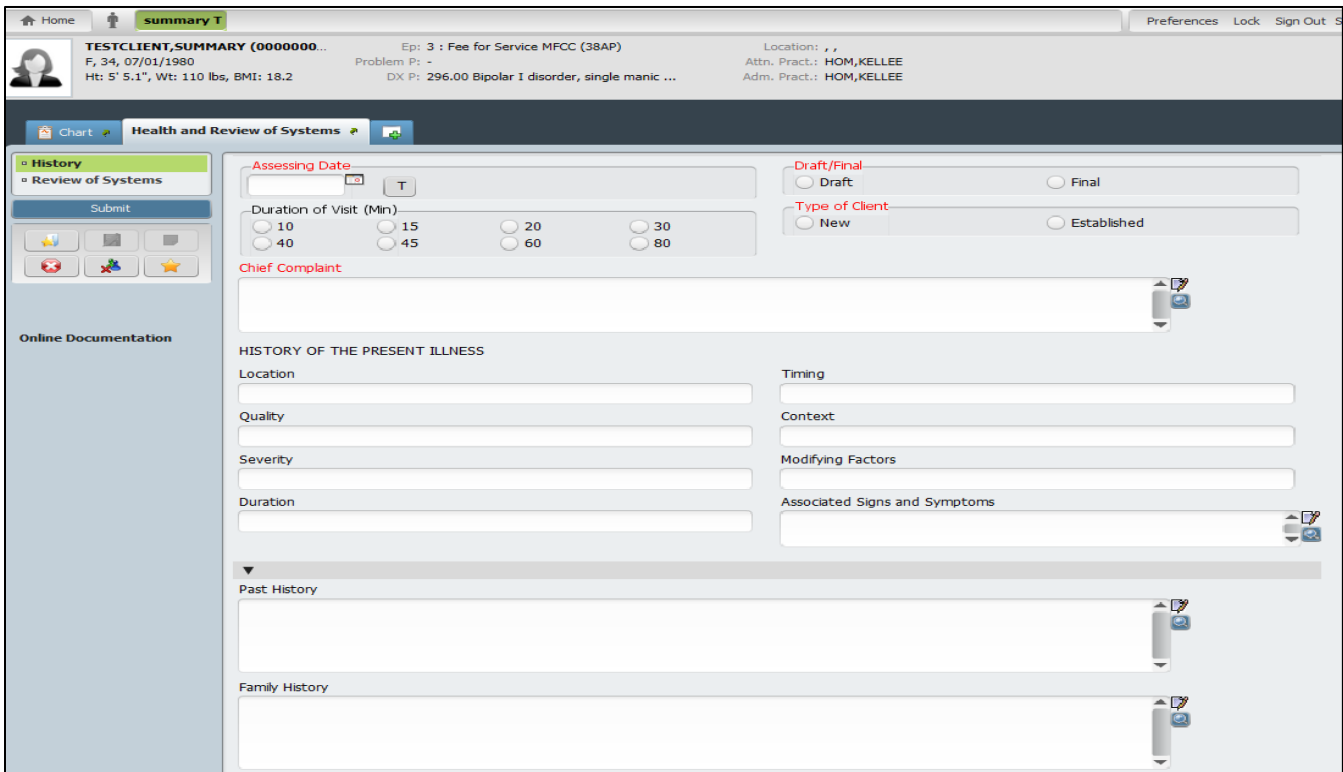


2. Health and Review of Systems



This shows the sections required to complete this document. You can skip ahead to another section.

You must document in the MD Progress Note (Outpatient) that you have finalized the Health and Review of Systems. The Progress Note must be completed within 24 hours of the service and is the bill for the service you provided.



Social History

▼

Comments

▼

Include In Syndromic Reporting

Yes No

Answer "No"

▼

Diagnosis 1

Do Not enter diagnosis

▼

Constitutional

Denies Problem Fatigue Weight Loss
 Weight Gain Fever/Chills Trouble Sleeping

Constitutional - Details, Pertinent Negatives

▼

Eyes

Denies Problem Corrective Lenses Pain Redness
 Watering Blurred Vision Double Vision Flashing Lights

Eyes - Details, Pertinent Negatives

▼

Ear, Nose and Throat

Denies Problem Difficulty Swallowing Sore Throat Hoarseness Dentures/Partials
 Nosebleeds Nasal Discharge Earaches Tinnitus Vertigo

Ear, Nose and Throat - Details, Pertinent Negatives

▼

Cardiovascular

Denies Problem Palpitations Chest Pain
 Murmur Orthopnea Shortness of Breath
 Paroxysmal Nocturnal Dyspnea

Cardiovascular - Details, Pertinent Negatives

Respiratory			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Labored	<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Apnea
<input type="checkbox"/> Snoring	<input type="checkbox"/> Shallow	<input type="checkbox"/> Cough	<input type="checkbox"/> Sputum
<input type="checkbox"/> Hemoptysis	<input type="checkbox"/> Inspiration Pain	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing
Respiratory - Details, Pertinent Negatives			
<input type="text"/>			
Gastrointestinal			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Black or Bloody Stools	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Decreased Appetite		
Gastrointestinal - Details, Pertinent Negatives			
<input type="text"/>			
Genitourinary			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Frequency	<input type="checkbox"/> Hematuria
<input type="checkbox"/> Hesitancy	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Amenorrhea	<input type="checkbox"/> Dysmenorrhea
<input type="checkbox"/> Discharge	<input type="checkbox"/> Impotence	<input type="checkbox"/> Testicular Pain	<input type="checkbox"/> Testicular Swelling
Genitourinary - Details, Pertinent Negatives			
<input type="text"/>			
Musculoskeletal			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Joint Swelling	
<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Muscle Pain	<input type="checkbox"/> Muscle Stiffness	
<input type="checkbox"/> Muscle Atrophy	<input type="checkbox"/> Deformity	<input type="checkbox"/> Fractures	
Musculoskeletal - Details, Pertinent Negatives			
<input type="text"/>			
Skin			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Rashes	<input type="checkbox"/> Itching	<input type="checkbox"/> Lumps
<input type="checkbox"/> Dryness	<input type="checkbox"/> Color Change	<input type="checkbox"/> Change in Hair or Nails	<input type="checkbox"/> Poor Healing
Skin - Details, Pertinent Negatives			
<input type="text"/>			
Neurological			
<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Weakness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tremors	<input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches
			<input type="checkbox"/> Unsteady Gait
			<input type="checkbox"/> Memory Changes
Neurological - Details, Pertinent Negatives			
<input type="text"/>			

Psychiatric

<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Disturbing Thoughts
<input type="checkbox"/> Mania	<input type="checkbox"/> Panic	<input type="checkbox"/> Phobic Fears	<input type="checkbox"/> Stress

Psychiatric - Details, Pertinent Negatives

Hematologic

<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Transfusion History

Hematologic - Details, Pertinent Negatives

Endocrine

<input type="checkbox"/> Denies Problem	<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Polyuria
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> Excessive Sweating

Endocrine - Details, Pertinent Negatives

Allergic Reaction to Food and/or Environment

Notes


3. Physical

Gen'l Multisystem Exam

- EENT (If performed)
- Respiratory (If performed)
- Chest and Cardiovascular...
- GI (If performed)
- Genitourinary (If performed)
- Musculoskeletal (If perfor...
- Neurologic (If performed)
- Psychiatric (If performed)

Summary and Plan

Submit



This shows the sections required to complete this document. You can skip ahead to another section.

You must document in the MD Progress Note (Outpatient) that you have finalized the Physical. The Progress Note must be completed within 24 hours of the service and is the bill for the service you provided.

Assessing Date: T Y

Draft/Final: Draft Final

General Appearance

Eyes - Conjunctivae and Lids	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Conjunctivae, Lids - Details, Pertinent Negatives	<input type="text"/>
Pupils and Irises	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Pupils and Irises - Details, Pertinent Negative	<input type="text"/>
Ophthalmoscopic Exam	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Ophthalmoscopic Exam - Details, Pertinent Negatives	<input type="text"/>
Ears and Nose - External Inspection	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Ears / Nose - Details, Pertinent Negatives	<input type="text"/>
Ears - External Canals and Tympanic Membranes	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Ears - Details, Pertinent Negatives	<input type="text"/>
Hearing	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Hearing - Details, Pertinent Negatives	<input type="text"/>

Respiratory (If performed)

Nose - Mucosa, Septum, Turbinates	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Nose - Details, Pertinent Negatives	<input type="text"/>
Mouth - Lips, Teeth, Gums	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Mouth - Details, Pertinent Negatives	<input type="text"/>
Oropharynx	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Oropharynx - Details, Pertinent Negatives	<input type="text"/>
Neck	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Neck - Details, Pertinent Negatives	<input type="text"/>
Thyroid	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Thyroid - Details, Pertinent Negatives	<input type="text"/>
Respiratory Effort	<input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Respiratory Effort - Details, Pertinent Negatives	<input type="text"/>

Chest - Percussion <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Chest Percussion - Details, Pertinent Negatives <input type="text"/>
Chest - Palpation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Chest Palpation - Details, Pertinent Negatives <input type="text"/>
Lungs - Auscultation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Lungs - Details, Pertinent Negatives <input type="text"/>
▼ Chest and Cardiovascular (If performed)	
Heart - Palpation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Heart Palpation - Details, Pertinent Negatives <input type="text"/>
Heart - Auscultation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Heart Auscultation - Details, Pertinent Negatives <input type="text"/>
Examination of <input type="checkbox"/> Carotids <input type="checkbox"/> Abd. Aorta <input type="checkbox"/> Femoral Art. <input type="checkbox"/> Pedals	Examination of Arteries - Results <input type="text"/>
Extremities for Edema/Varicosities <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Extremities - Details, Pertinent Negatives <input type="text"/>
Breasts - Inspection <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Breasts Inspection - Details, Pertinent Negatives <input type="text"/>
Breasts and Axillae - Palpation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Breasts Palpation - Details, Pertinent Negatives <input type="text"/>
▼ GI (If performed)	
Abdomen <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Abdomen - Details, Pertinent Negatives <input type="text"/>
Liver and Spleen <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Liver and Spleen - Details, Pertinent Negatives <input type="text"/>
Hernia <input type="radio"/> Absent <input type="radio"/> Present	Hernia - Comments <input type="text"/>
Anus, Perineum and Rectum <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Anus, Perineum, Rectum - Details, Pertinent Negatives <input type="text"/>
Stool for Occult Blood <input type="radio"/> Done <input type="radio"/> Not Indicated	

▼ Genitourinary (If performed)	
Male - Scrotal Contents <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Scrotal Contents - Details, Pertinent Negatives <input type="text"/>
Penis <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Penis - Details, Pertinent Negatives <input type="text"/>
Digital Prostate Exam <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Prostate - Details, Pertinent Negatives <input type="text"/>
Female - External Genitalia <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	External Genitalia - Details, Pertinent Negatives <input type="text"/>
Uterus <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Uterus - Details, Pertinent Negatives <input type="text"/>
Adnexa / Parametria <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Adnexa - Details, Pertinent Negatives <input type="text"/>
Lymph Nodes - Two or More Areas <input type="checkbox"/> Neck <input type="checkbox"/> Axillae <input type="checkbox"/> Groin <input type="checkbox"/> Other	Lymph Nodes - Results <input type="text"/>
▼ Musculoskeletal (If performed)	
Gait and Station <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Gait and Station - Details, Pertinent Negatives <input type="text"/>
Digits and Nails <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Digits and Nails - Details, Pertinent Negatives <input type="text"/>
Joints, Bones and Muscles - at Least One Area <input type="checkbox"/> Head and Neck <input type="checkbox"/> Spine, Ribs, Pelvis <input type="checkbox"/> Rt Upper Extremity <input type="checkbox"/> Lt Upper Extremity <input type="checkbox"/> Rt Lower Extremity <input type="checkbox"/> Lt Lower Extremity	Joints, Bones, Muscles - Results <input type="text"/>
Skin - Inspection <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Inspection - Details, Pertinent Negatives <input type="text"/>
Palpation <input type="radio"/> Unremarkable <input type="radio"/> Remarkable	Palpation - Details, Pertinent Negatives <input type="text"/>

▼ **Neurologic (If performed)**

Cranial Nerves
 Unremarkable Remarkable

Cranial Nerves - Details, Pertinent Negatives

Deep Tendon Reflexes
 Unremarkable Remarkable

Deep Tendon Reflexes - Details, Pertinent Negatives

Sensation
 Unremarkable Remarkable

Sensation - Details, Pertinent Negatives

▼ **Psychiatric (If performed)**

Judgement and Insight
 Unremarkable Remarkable

Judgement and Insight - Details, Pertinent Negatives

Brief Mental Status
 Unremarkable Remarkable

Mental Status - Details, Pertinent Negatives

Medical Assessment

Plan

Medical Decision Making

Number of Diagnoses
 Minimal Limited Multiple Extensive

Amount &/or Complexity of Data to be Reviewed
 None/Minimal Limited
 Moderate Extensive

Risk of Significant Complications, Morbidity &/or Mortality
 Minimal Low Moderate High

4. Vitals Entry

This shows the sections required to complete for this document. You can skip ahead to another section.

You must document in the MD Progress Note (Outpatient) that you have finalized the Vitals Entry. The Progress Note must be completed within 24 hours of the service and is the bill for the service you provided.

Add/Edit/Delete Vital Sign

Add Edit Delete **Date** **Time**

Refused Vitals
 Yes No

Blood Pressure Systolic / Diastolic (mmHg) **Position**
 Sitting Lying Standing

Heart Rate (bpm)

Respiration Rate (bpm)

Temperature (F) (C)

Blood Glucose (mg/dL)

Oxygen Saturation (%)

Height (ft in) (in) (cm) **Hint: Enter 5.2 for 5 feet/2 inches**

Weight (lbs) (kgs) **Hint: BMI is calculated once height/weight are entered**

BMI


Pain
 0 - No Pain 1 2 3 4 5 6 7 8 9 10 - Worst Pain

Comments

See next page for the Vitals Graphs and Reports Section

Vitals Reports and Graph

Vital Sign For Graph Drop down options

Vital Sign(s) for Report 

All
 Blood Glucose
 Blood Pressure

Start Date: [] [T] [Y] [] []
Start Time: [] [Current] [H] [] [M] [] [AM/PM] [] []
End Date: [] [T] [Y] [] []
End Time: [] [Current] [H] [] [M] [] [AM/PM] [] []

- Blood Glucose
- Blood Pressure (All Positions)
- Blood Pressure (Lying)
- Blood Pressure (Sitting)
- Blood Pressure (Standing)
- Ht/Wt/BMI
- O2 Saturation
- Pain Scale
- Pulse**
- Respiration
- Temperature



Vital Sign(s) for Report is limited to 9 selections from the selection box. This limitation is necessary for the crystal report to correctly display the results.

5. Diagnosis

This shows the sections required to complete this document. You can skip ahead to another section.

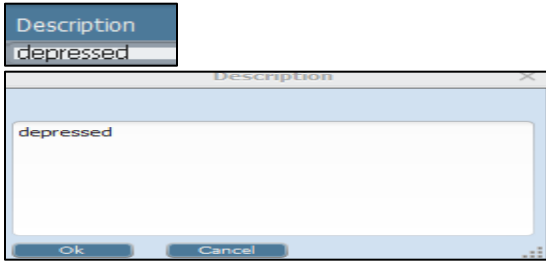
You must document in the MD Progress Note (Outpatient) that you have finalized the Diagnosis. The Progress Note must be completed within 24 hours of the service and is the bill for the service you provided.

Click on **New Row** to activate the entry fields.

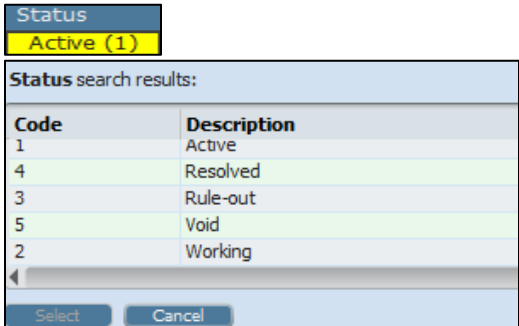
Double click on the field **Ranking**, a pop up will display for you to select from.

Code	Description
1	Primary
2	Secondary
3	Tertiary

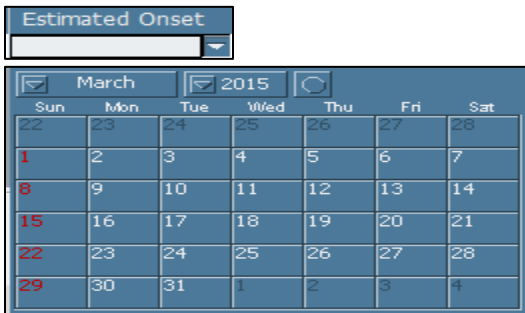
Double click on the field **Description**, a pop up will display for you to add text.



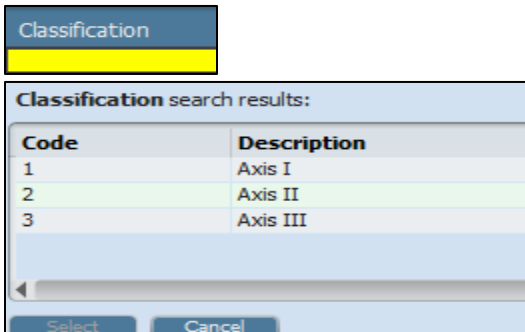
Double click on the field **Status**, a pop up will display for you to select from.



Double click on the field **Estimated Onset**, a pop up with a calendar will display for you to select the date.



Double click on the field **Classification**, a pop up will display for you to select from.



Double click on the field **Resolved**, a pop up with a calendar will display for you to select the date.

The image shows a form field labeled "Resolved" with a dropdown arrow. Below it is a calendar pop-up for March 2015. The calendar has a header with "March" and "2015". The days of the week are listed as Sun, Mon, Tue, Wed, Thu, Fri, Sat. The dates are arranged in a grid. The date 1 is highlighted in red.

Sun	Mon	Tue	Wed	Thu	Fri	Sat
22	23	24	25	26	27	28
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

Double click on the field **Bill Order**, a pop up will display for you to add text or number.

The image shows a form field labeled "Bill Order" with the number "1" entered. Below it is a pop-up window titled "Bill Order" with a text input field containing "1" and "Ok" and "Cancel" buttons.

Double click on the field **ICD-9 Code**, a pop up will display for you to enter the code.

The image shows a form field labeled "ICD-9 Code". Below it is a pop-up window titled "ICD-9 Code" with an empty text input field and "Ok" and "Cancel" buttons.


Double click on the field **ICD-10 Code**, a pop up will display for you to enter the code.

The image shows a form field labeled "ICD-10 Code". Below it is a pop-up window titled "ICD-10 Code" with an empty text input field and "Ok" and "Cancel" buttons.

To add another diagnosis, select “New Row” and repeat.

Show Active Only

Yes No




Selecting “Yes” will remove from the “Diagnoses” grid only, any entry where the “Status” is not “Active” or “Working”. Selecting “No” will add back those entries. If there are any rows that are not active and are missing a required field, those rows will not be removed.

Any newly added row with the “Status” set to a value other than “Active” or “Working” will remain visible unless “Yes” is selected again for “Show Active Only”

Diagnosis Search

311

Diagnosis	ICD-9	ICD-10	DSM-IV
Depressive disorder	311	F32.9	Depressive disorder NOS
Depressive disorder, not elsewhere classified	311	F32.9	Depressive disorder NOS
Adolescent depression	311	F32.9	Depressive disorder NOS
Blues	311	F32.9	
Chronic depression	311	F32.9	Depressive disorder NOS
Clinical depression	311	F32.9	Depressive disorder NOS
Controlled depression	311	F32.9	
Dejected	311	F32.9	
Depressed	311	F32.9	Depressive disorder NOS
Depressed affect	311	F32.9	Depressive disorder NOS
Depressed mood	311	F32.9	

<= Previous 25 1 through 25 of 53 Next 25 =>

Diagnosis Search

311

Code Crossmapping

Code Crossmapping

ICD-9	ICD-10	DSM-IV	SNOMED
311	F32.9	311	35489007
DSM-5: Unspecified depressive disorder			

ACTIVE: Current Diagnosis (Diagnoses)

WORKING: Most appropriate diagnosis during the assessment period. To be used if Active is not yet established.

RULE-OUT: Other diagnoses being considered during the assessment period. PLEASE NOTE: You must have a n active or working diagnosis documented prior to adding a rule out diagnosis.


RESOLVED: This is for diagnoses that no longer exist for the patient, and no intervention is required. For example, a broken leg which has been healed, or full resolution of major depression.

VOID: Consider using for diagnoses which have been considered in rule out, working or active and determined not to apply-DO NOT confuse this with resolved.

Axis III

Axis II

Axis I

General Medical Condition Summary Code (CSI) 



Please check one or more of the appropriate boxes that apply to client Axis III diagnosis.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Hyperlipidemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Arterial Sclerotic Disease	<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Infertility
<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraines
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Blind / Visually Impaired	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Cancer	<input type="checkbox"/> No General Medical Condition
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Other
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Deaf / Hearing Impaired	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Digestive Disorders (Reflux, Irritable Bowel Syndrome)	<input type="checkbox"/> Sexually Transmitted Disease (STD)
<input type="checkbox"/> Ear Infections	
<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Unknown / Not Reported General Medical Condition

Axis IV: Primary Support Group <input type="radio"/> Yes <input type="radio"/> No	Axis IV: Economic <input type="radio"/> Yes <input type="radio"/> No
Axis IV: Social Environment <input type="radio"/> Yes <input type="radio"/> No	Axis IV: Health Care Services <input type="radio"/> Yes <input type="radio"/> No
Axis IV: Educational <input type="radio"/> Yes <input type="radio"/> No	Axis IV: Legal System/Crime <input type="radio"/> Yes <input type="radio"/> No
Axis IV: Occupational <input type="radio"/> Yes <input type="radio"/> No	Axis IV: Other Problems <input type="radio"/> Yes <input type="radio"/> No
Axis IV: Housing <input type="radio"/> Yes <input type="radio"/> No	
Diagnosis - Axis V Current GAF Rating GAF - Highest Level Last 12 Months GAF - Lowest Level Last 12 Months	Diagnostic Classification Infancy And Early Childhood (DC03) Children Global Assessment Scale (CGAS)

6. MD Progress Notes

This shows the sections required to complete this document. You can skip ahead to another section.

You must document in the MD Progress Note (Outpatient) that you have finalized any of the required documents. The Progress Note must be completed within 24 hours of the service and is the bill of the service you provided.

You will select MD Progress Note (Outpatient)

Home Summary T Preferences Lock Sign O

TESTCLIENT,SUMMARY (0000000... Ep: 3 : Fee for Service MFCC (38AP) Location: , ,
F, 34, 07/01/1980 Problem P: - Attn. Pract.: HOM,KELLEEE
Ht: 5' 5.1", Wt: 110 lbs, BMI: 18.2 DX P: 296.00 Bipolar I disorder, single manic ... Adm. Pract.: HOM,KELLEEE

Chart MD PROGRESS NOTE (OUTPATIENT)

Progress Note (Outpati...
Face to Face / Doc and ...
Submit

Progress Note For
 Existing Service
 Existing Appointment
 Independent Note
 New Service

Date Of Service
 03/11/2015 Today Yesterday

UCSF Primary Care Outreach

Service Program Fee for Service MFCC (38AP) Location Office

Service Charge Code

Note Type

User To Send Co-Sign To Do Item To

Note Addresses Which Existing Service/Appointment

Notes Field

See Special Instructions for Notes field entry on page 45

The Provider submitting this progress note certifies that the services provided are supported by appropriate documentation and comply with applicable Federal, State, and City and County of San Francisco regulations.

Location Options: Default is to Office.

- Crisis
- Custodial Care Facility
- Emergency Room - Hospital
- Federally Qualified Health Center
- Field

- Jail (Adult/Youth)
- Job Site
- Mass Immunization Center
- Military Treatment Facility
- Mobile Unit
- Non-Residential Substance Abuse Treatment Facility
- Nursing Facility
- Office

- Outpatient Hospital
- Pharmacy
- Phone
- Psychiatric Facility - Partial Hospitalization
- Psychiatric Residential Treatment Center
- Public Health Clinic
- Residential Care - Adult
- Residential Care - Children

Note Type

▼

- CYF Weekly Day Treatment
- FMP Child Family Monthly Team Meeting
- Group
- Medical - Antipsychotic Polypharmacy
- Medical - Reassessment
- Medical
- MH Adult
- MH CYF

Practitioner

FRIEDMAN, MICHELE (004807) 🔍

Co-Practitioner

🔍

Evidence-Based Practices / Service Strategies (CSI)

- Age-Specific Service Strategy
- Assertive Community Treatment
- Delivered in Partnership with Health Care
- Delivered in Partnership with Law Enforcement
- Delivered in Partnership with Social Services

Draft/Final

Draft Final

PLEASE ENTER YOUR TIME ON TAB 2 ONLY. THE SYSTEM WILL CALCULATE TOTAL TIME FOR YOU!



If Interactive Complexity is present during the service, select "Interactive Complexity" to have the system also render the "Interactive Complexity" service code associated to the "Service Code".

If psychotherapy is present during the service, select "Psychotherapy Add-On" to have the system also render the "Add-On Service Code" associated to the "Service Code".

Note: "Interactive complexity" is only available for service codes that are defined as "Evaluation Management", "Psychotherapy/or "Group Therapy" from the service code set up. "Psychotherapy Add-On" is only available for service codes that are defined as "Evaluation Management" from the service code set up.

TAB 2: Enter Your Time

Face to Face and Documentation/Travel Time

Practitioner Face to Face Time (minutes) For services that take place over the Phone, this reflects direct billable time. Service duration is in

Practitioner Doc and Travel Time (minutes) Duration in minutes

Co-Practitioner Face to Face Time (minutes)

Co-Practitioner Doc and Travel Time (minutes)

If service was conducted in the client's preferred language other than English, indicate which language:

Language Other

- Chinese
- Russian
- Spanish
- Tagalog
- Vietnamese
- _Other**

Special Instructions for Notes Field entry:

You can write your narrative directly into the Notes field or you can copy and paste in your note from a word document. You can copy and paste in your note if you want to use a template created in word.

Most importantly you can copy in any primary care appointment you may have made for the client. Progress notes can be viewed by most Avatar users. Entering follow-up appointments in the Notes Field of the MD Progress Notes provides continuity for other clinicians to be aware of, prompt and follow-up with the client.

Notes Field

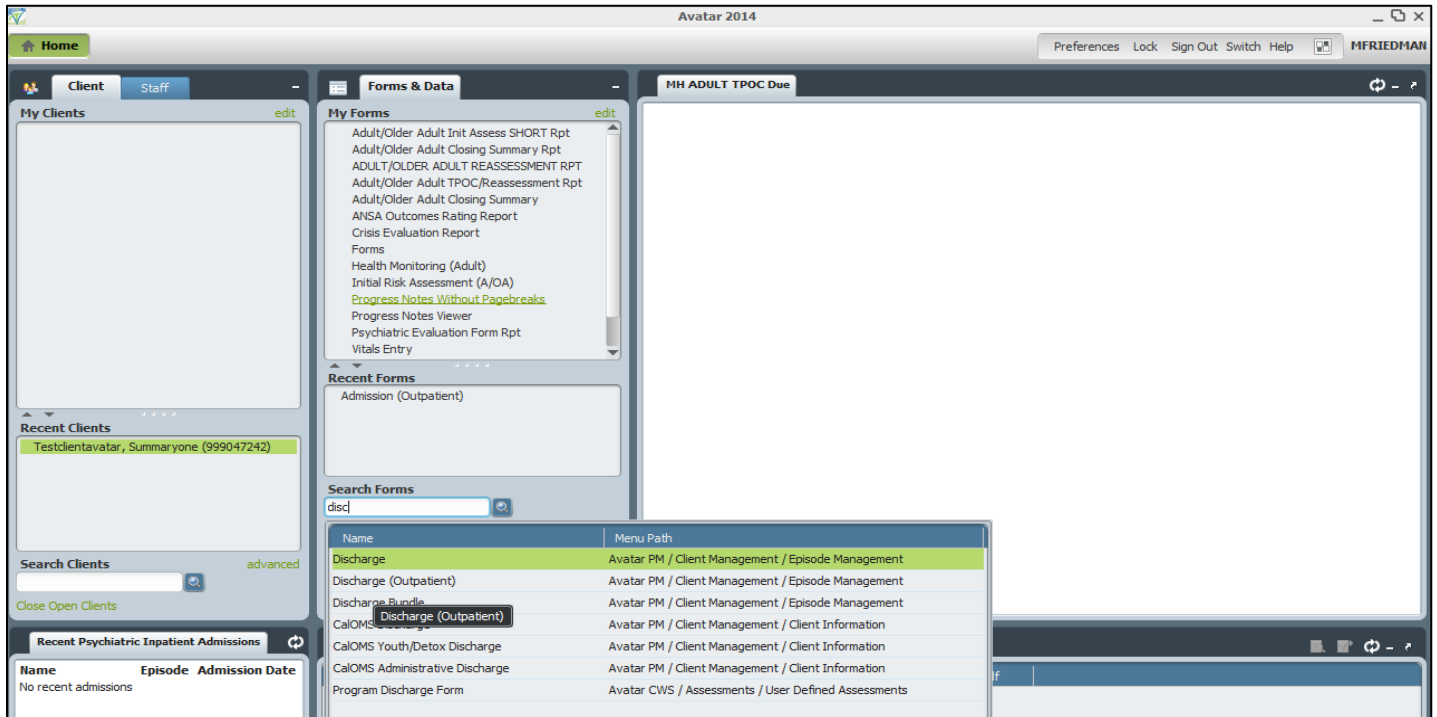
Physical Assessment completed. Client cooperative throughout. Currently with no PCP in SF; requires F/u for elevated blood pressure/ongoing monitoring
Referrals or specific appointments for health services

Where/with Whom	Address/phone	Date/time (if applicable)
SOM Clinic/Dr. Killjoy	123 Your Street (123) 456-7899	7/15/15 10:00a

7. Discharge (Outpatient)

You must discharge all clients you provide a service for and who have been discharged from the Progress program, have gone AWOL or who no longer require IPCOM service. You must discharge the client from your program using the Avatar Discharge (Outpatient) form

Highlight Client Name → Forms & Data Search → Select Discharge (Outpatient); Double click to open the form.



Discharge section of the Discharge (Outpatient) form

Episode Number

The **episode #** you are closing defaults in when the Discharge form opens.

Date Of Discharge T Y

Date of Discharge: Select the date of the actual discharge, click T

Discharge Time H M AM/PM

Discharge Time: Click current

Discharge Day Of Week

Length Of Stay

Discharge Day of Week and **Length of Stay** are optional fields

Home summaryone T Preferences Lock Sign Out Switch Help MFRIEDMAN

TESTCLIENTAVATAR,SUMMARYO... Ep: 1 : CBHS Pharmacy (38CXRX) Location: 1380 Howard st, San Francisco, CA Allergies (0)
F, 46, 01/01/1969 Problem P: - Attn. Pract.: No Entry
DX P: 799.9B Diagnosis or condition deferred o... Adm. Pract.: HOM,KELLEE

Chart Discharge (Outpatient)

Discharge
Demographics

Submit

Episode Number 1

Date Of Discharge

Discharge Time

Discharge Day Of Week

Length Of Stay

Type Of Discharge

Discharge Practitioner

Discharge Remarks/Comments

Hospital Discharge Instructions

Discharge Client Living Arrangement

Online Documentation

Type Of Discharge

Type of Discharge: Select the appropriate reason/type of discharge

- Age Ineligible
- Cannot Locate
- Client Died
- Client Discharged/Program Unilateral Decision
- Client Dissatisfied
- Client Incarcerated
- Client moved out of service area
- Client Withdrew: AWOL, AMA, No Improvement
- Client Withdrew: AWOL,AMA, Treatment Partially Completed
- Consumer Choice/Schedule
- Consumer Choice/Unspecified
- Did Not Need Service
- Discharge/Administrative Reasons
- Discharged by HSA
- Ineligible for Services
- Mutual Agreement/Goals Reached
- Mutual Agreement/Treatment Goals Not Reached
- Mutual Agreement/Treatment Goals Partially Reached
- No follow through
- None
- Other
- Program Transfer
- Referred to CBHS Clinic
- Referred to non CBHS Services
- Request Rescinded
- Treatment Completed
- Unknown

Discharge Practitioner

Discharge Practitioner: Enter a few letters of your last name, double click to select so that your name is in the box.

Demographics section of the Discharge (Outpatient) form

Most of the fields in the Demographic section are optional. This is the top portion-

The screenshot shows the 'Demographics' section of a 'Discharge (Outpatient)' form. The form is populated with the following information:

- Client Last Name:** TESTCLIENTAVATA T
- Client First Name:** SUMARIZATION
- Client's Middle Initial:** (empty)
- Suffix:** (radio buttons for Sr, Jr, III, IV, V, VI)
- Prefix:** (dropdown menu)
- Client's Address - Street:** 1380 Howard st
- Client's Address - Street 2:** (empty)
- Client's Address - Zipcode:** 94103
- Client's Address - City:** San Francisco
- Client's Address - County:** San Francisco
- Client's Address - State:** CALIFORNIA
- Client's Home Phone:** (empty)
- Client's Work Phone:** (empty)
- Client's Cell Phone:** (empty)
- Client's Email Address:** (empty)
- Communication Preference:** (radio buttons for Email, Work Phone, Regular Mail, Cell Phone, Home Phone; Cell Phone is selected)
- Primary Language:** (dropdown menu)
- Client Race:** (dropdown menu)
- Ethnic Origin:** (dropdown menu)
- Religion:** (dropdown menu)
- Place Of Birth:** (empty)
- Country Of Origin:** (dropdown menu)
- Maiden Name:** (empty)
- Client Declined To Provide Information On The Following:** (checkboxes for Ethnic Origin, Race, Language)
- Mother's Maiden Name:** (empty)
- Protection Indicator:** (radio buttons for Yes, No)
- Protection Indicator Effective Date:** (empty)

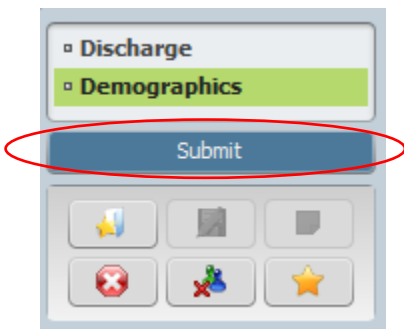
The next page displays the red/required field **"Smoking Status Assessment date"** which you must answer again now that the client is being discharged.

Bottom portion of the Demographics section

The screenshot shows the bottom portion of the Demographics section in the IPCOM system. The form includes the following fields and options:

- Prefix:** A dropdown menu.
- Client's Address - Street:** Text input field containing "1380 Howard st".
- Client's Address - Street 2:** Text input field.
- Client's Address - Zipcode:** Text input field containing "94103".
- Client's Address - City:** Text input field containing "San Francisco".
- Client's Address - County:** Dropdown menu containing "San Francisco".
- Client's Address - State:** Dropdown menu containing "CALIFORNIA".
- Communication Preference:** Radio buttons for Email, Work Phone, Regular Mail, Cell Phone (selected), and Home Phone.
- Primary Language:** Dropdown menu.
- Client Race:** Dropdown menu.
- Ethnic Origin:** Dropdown menu.
- Religion:** Dropdown menu.
- Place Of Birth:** Text input field.
- Country Of Origin:** Dropdown menu.
- Maiden Name:** Text input field.
- Client Declined To Provide Information On The Following:** Checkboxes for Ethnic Origin, Race, and Language.
- Mother's Maiden Name:** Text input field.
- Protection Indicator:** Radio buttons for Yes and No.
- Protection Indicator Effective Date:** Date input field.
- Name Qualifier:** Radio buttons for Keep Private and Unspecified.
- Smoking Status Assessment Date:** Date input field containing "01/01/2015", which is circled in red.

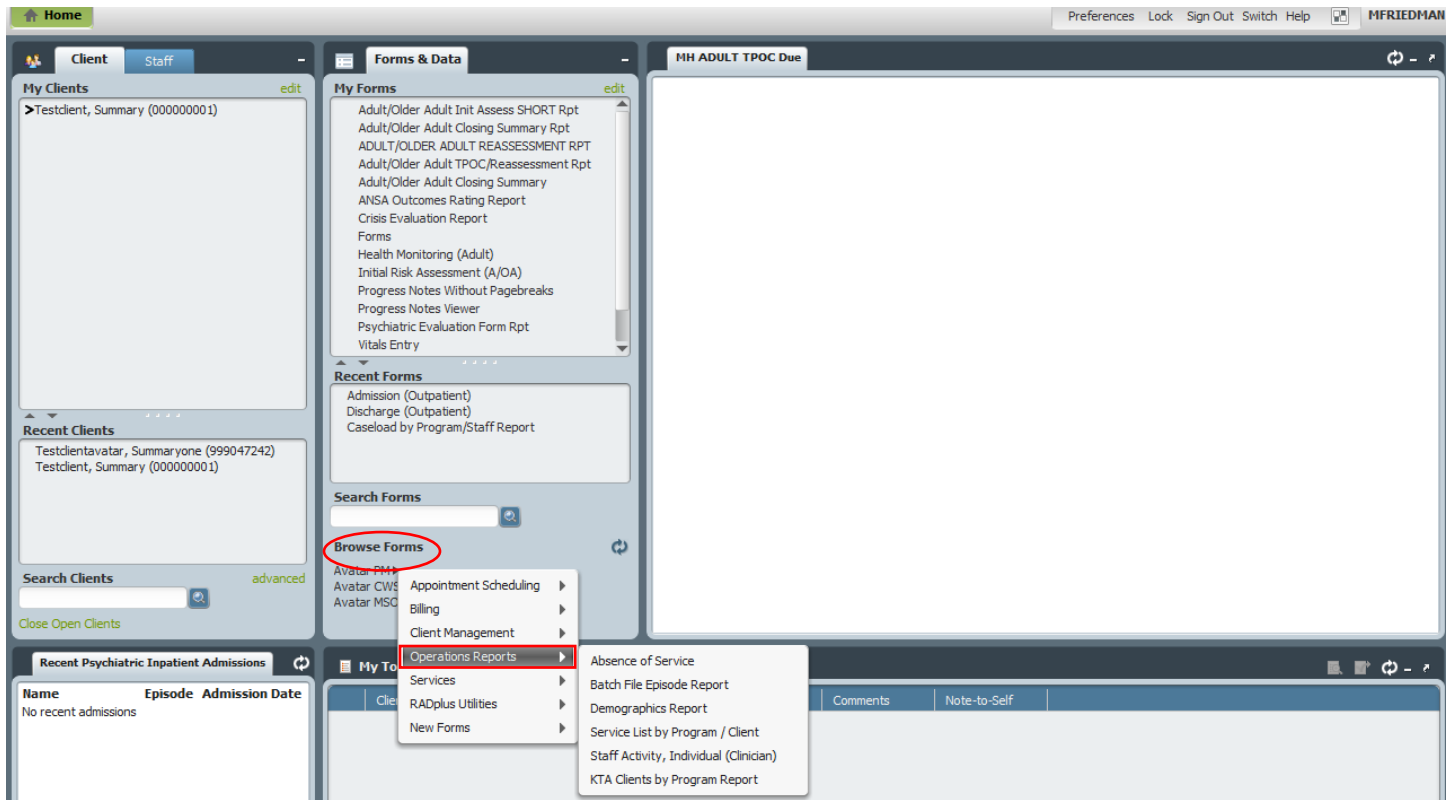
Always remember to Submit and then document in a progress note!



Reports: You can search for a report in the search field or under Avatar CWS (Clinical Work Station) or Avatar PM (Practice Management).

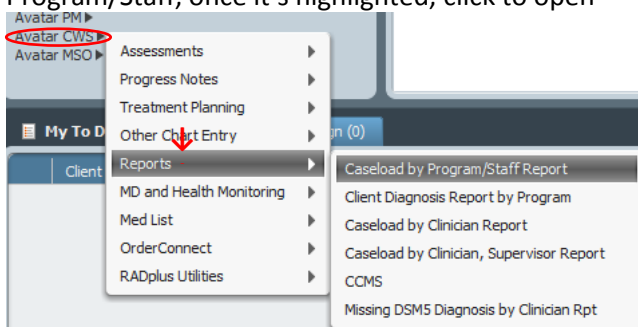
The screenshot shows a web-based clinical application interface. At the top right, there is a user profile for 'MFRIEDMAN' with options for 'Preferences', 'Lock', 'Sign Out', 'Switch', and 'Help'. The main interface is divided into several panels:

- Client Panel:** Contains 'My Clients' (with one client listed: 'Testclient, Summary (000000001)'), 'Recent Clients' (with two clients listed), and a 'Search Clients' field with an 'advanced' search option.
- Forms & Data Panel:** Contains 'My Forms' (a list of various report types like 'Adult/Older Adult Init Assess SHORT Rpt'), 'Recent Forms' (listing 'Admission (Outpatient)' and 'Discharge (Outpatient)'), a 'Search Forms' field, and 'Browse Forms' (listing 'Avatar PM', 'Avatar CWS', and 'Avatar MSO').
- Reports Panel:** A dropdown menu is open under 'Avatar CWS', showing a list of reports: 'Assessments', 'Progress Notes', 'Treatment Planning', 'Other Chart Entry', 'Reports', 'MD and Health Monitoring', 'Med List', 'OrderConnect', and 'RADplus Utilities'. The 'Reports' item is circled in red. A secondary dropdown menu is open from 'Reports', listing: 'Caseload by Program/Staff Report', 'Client Diagnosis Report by Program', 'Caseload by Clinician Report', 'Caseload by Clinician, Supervisor Report', 'CCMS', and 'Missing DSM5 Diagnosis by Clinician Rpt'. The 'Caseload by Program/Staff Report' item is also circled in red.
- Recent Psychiatric Inpatient Admissions Panel:** A table with columns 'Name', 'Episode', and 'Admission Date', showing 'No recent admissions'.
- My To Do Panel:** A task list with a 'Client' column and a 'Reports' column.

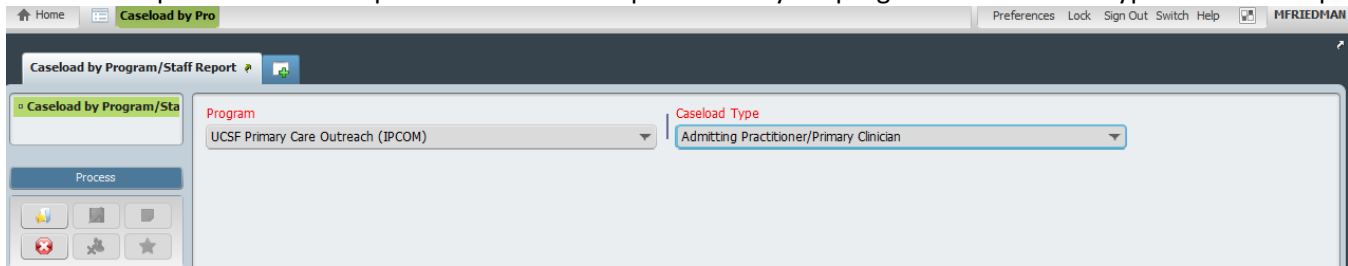


Select the report you want from the Avatar PM or Avatar CWS Menu- just slide you cursor across and then click. There is one report applicable to IPCOM through the Avatar CWS Menu...**Caseload Report by Program/Staff-**

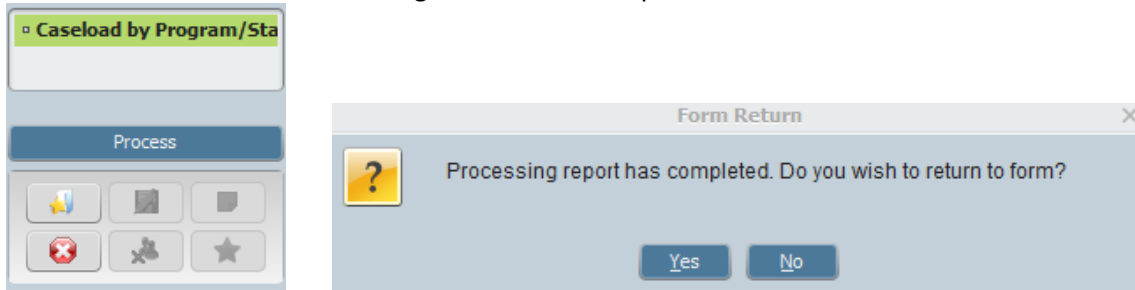
Under the **Avatar CWS Menu**, I brought the cursor down to reports and then slid it over to Caseload Report by Program/Staff, once it's highlighted, click to open



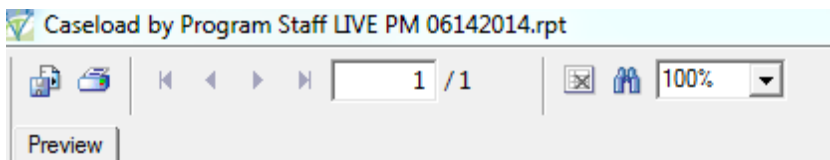
This is the report screen to set parameters for the report. Select your program and caseload type from the drop down



The Control Panel looks the same for *submitting* documents, however, in place of submit, select **Process** for reports. There may be a pop up, Do you wish to return to form? It's Ok to enter Yes or No. Be Patient! It make take a few minutes for the information to be gathered for the report.




At the top of every report is the **Report Name** and under the name, you can **save the report to a disc, print**, the **arrows pointing left** will bring you back a page or to the beginning page, the **arrows pointing right** will bring you forward a page or to the last page of the report. **Information in the white box** shows the **current page number** and the **number after the slash** outside of the box **shows the total number of pages** in the report, the **binoculars** allow you to **search** and the **number per cent in the white box** displays the **magnification** which you can increase or decrease.



Caseload Report

This report shows the open cases for the program by client and either admitting practitioner or attending practitioner.

This is a very important report for IPCOM because it can show the **date when the episode was opened** (date of admission (outpatient) to IPCOM and of the **date of the last service**. This would be a prompt to discharge or close the client from the IPCOM episode. The report displays all the practitioners for the IPCOM program by alphabetical order of last name and the clients that have been admitted to that practitioner. There is a page brake between practitioner caseloads.



San Francisco Department of Public Health
Community Behavioral Health Services

Caseload by Program/Staff Report
Admitting Practitioner/Primary Clinician
UCSF Primary Care Outreach (IPCOM)

Confidential Patient Information

Client Name	Client ID	Age	Race	Epi#	Admitting Practitioner	Attending Practitioner	Episode Opening	Last Service Date	Active/Inactive?
FRIEDMAN, MICHELE (004807)									
TESTCLIENT, SUMMARY	1	34	Asian Indian	6	FRIEDMAN, MICHELE	No Entry	5/17/2015		NO SERVICES
Total caseload for Admitting Practitioner/Primary Clinician FRIEDMAN, MICHELE (004807) :						1			
Total caseload for program UCSF Primary Care Outreach (IPCOM) :						1			

Notes

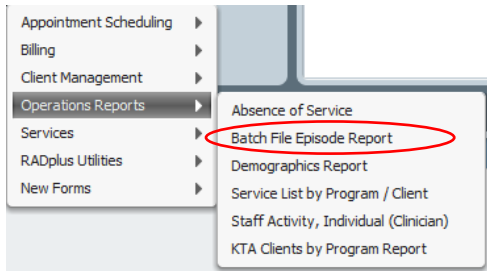
1. Report includes clients with open episodes as of the date end-user runs report. This is the "Avatar Data as of MM/DD/YYYY" date at bottom left of every page.
2. Report may be requested for "Admitting Practitioner/Primary Clinician" or "Attending Practitioner/Physician". Header displays the type end-user selected.
3. "Inactive" displays in red in "Active/Inactive?" column for clients whose last date of service is more than 90 days prior to the "Avatar Data as of" date. Please follow CBHS guidelines for when to discharge a client/close an episode.
4. "No Services" displays in red in "Active/Inactive?" column for clients who do not have any service recorded in Avatar. Review to determine if episode should be closed.
5. Report is sorted by staff person, alphabetically by last name. There is a page break before next staff person. Within the staff list, clients are sorted alphabetically by last name.

Avatar Data as of 5/17/2015
Caseload by Program/Staff Report
Page 1 of 1

CAUTION: Federal and State confidentiality laws apply to protected health information contained in this report. It is the recipient's responsibility to lawfully secure and destroy it.

Avatar PM Reports

Under the **Avatar PM Menu**, I brought the cursor down to Operational Reports and then slid it over to Batch File Episode Report once it's highlighted, click to open



Batch File Episode Report

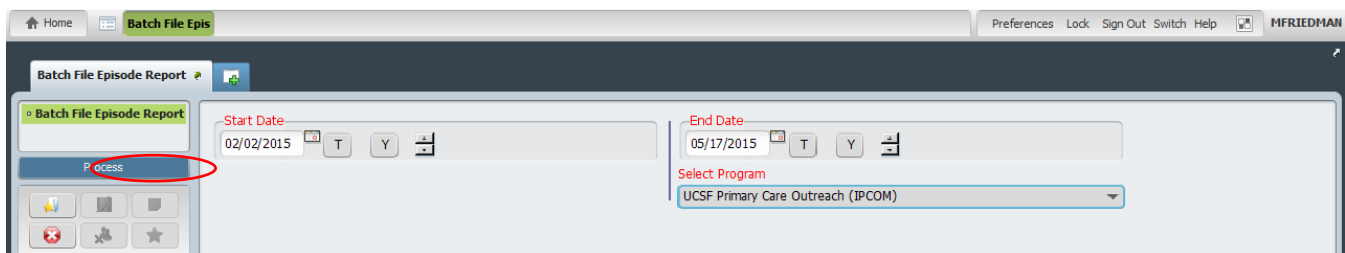
PM → Operational Reports → Batch Field Episode

This report batches any client episodes for a selected program.


Select the date range, enter the Start Date= I put from 2/2/15

As of current date, select the End Date data to be displayed through = I put T for today

Select the Program: UCSF IPCOM → click Process



This report shows by client ID and name if there has been an IPCOM episode, it displays the episode number and the admission and discharge status within a certain date range. Unlike a MHS 140 it does not show episode openings/discharges at all programs the client has received services



City and County of San Francisco, Department of Public Health
Community Behavioral Health Services

Batch File Episode Report

Clients and episodes
From 02/02/2015 To 05/17/2015

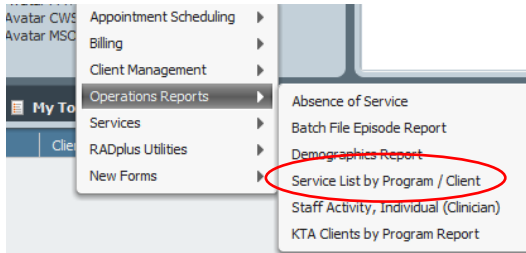
Confidential Patient Information

Program : UCSF Primary Care Outreach (IPCOM)


Client ID	Name	Episode #
1	TESTCLIENT,SUMMARY	Episode 4 Admit Date : 05/15/2015 Discharge Date : 05/15/2015
1	TESTCLIENT,SUMMARY	Episode 6 Admit Date : 05/17/2015 Discharge Date : None

Total # clients: 1 Total # episodes: 2

Services List Report



PM → Operational Reports → Service List by Program/Client
Select Date Range and Program → click Process



San Francisco Department of Public Health
Community Behavioral Health Services

Services by Program/Client

Services Provided between 2/2/2015 and 5/17/2015

UCSF Primary Care Outreach (IPCOM)

(MHS537)

Confidential Patient Information

Client Name (ID #)	Epi #	Practitioner Name (ID #)	Service Date	Service Code	Time (Min)	Cost of Service	Co-Staff ID	Co-Staff Time (Min)	# in Group
[REDACTED]	1	FANNON, LEWIS D	4/2/2015	99204	40				
	Client Total:			1 Service	40				
[REDACTED]		FANNON, LEWIS D	4/30/2015	99203	60				
	Client Total:			1 Service	60				
[REDACTED]		DREIER, FRANCINE	4/7/2015	99212	15				
	Client Total:			1 Service	15				
[REDACTED]		FANNON, LEWIS D	5/12/2015	99203	60				
	Client Total:			1 Service	60				
[REDACTED]	7	BURGEL, BARBARA	5/12/2015	99212	25				
	Client Total:			1 Service	25				
[REDACTED]		FANNON, LEWIS D	3/24/2015	99204	20				
	Client Total:			1 Service	20				
[REDACTED]	1	FANNON, LEWIS D	3/24/2015	99204	60				
	Client Total:			1 Service	60				
[REDACTED]	9	FANNON, LEWIS D	5/14/2015	99204	80				
	Client Total:			1 Service	80				
[REDACTED]		DREIER, FRANCINE	4/7/2015	99212	15				
	Client Total:			1 Service	15				
[REDACTED]		FANNON, LEWIS D	3/26/2015	99203	45				
	Client Total:			1 Service	45				
[REDACTED]		BURGEL, BARBARA	4/14/2015	99203	60				
	Client Total:			1 Service	60				
[REDACTED]		BURGEL, BARBARA	4/14/2015	99202	30				
	Client Total:			1 Service	30				
[REDACTED]		FANNON, LEWIS D	4/30/2015	99203	60				
	Client Total:			1 Service	60				

Avatar Data as of 5/17/2015

Services by Program/Client v1.08

Page 1 of 2

CAUTION: Federal and State confidentiality laws apply to protected health information contained in this report. It is the recipient's responsibility to lawfully secure and destroy it.

See page 2 of this report on the next page →

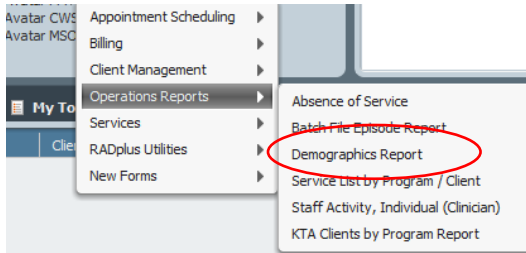
Page 2 Services List Report

Client Name (ID #)	Epi #	Practitioner Name (ID #)	Service Date	Service Code	Time (Min)	Cost of Service	Co-Staff ID	Co-Staff Time (Min)	# in Group
[REDACTED]		FANNON, LEWIS D	4/23/2015	99203	40	[REDACTED]			
		Client Total:		1 Service	40				
		BORDEN, SHERRI A	3/30/2015	99204	60				
		Client Total:		1 Service	60				
		DREIER, FRANCINE	4/7/2015	99213	15				
		Client Total:		1 Service	15				
[REDACTED]		BURGEL, BARBARA	4/7/2015	99212	45				
		Client Total:		1 Service	45				
		FANNON, LEWIS D	5/5/2015	99203	60				
		Client Total:		1 Service	60				
Program Total:	18 Clients		18 Services	790 Min				0 Min	

Notes

1. Includes only clients with services in the date range for this program.
2. Includes only direct services (i.e., services linked to a client.)
3. When requesting this report, enter the "Service" program, not the "Episode" program. If you choose an "Episode" program, the report will be blank.
4. The Cost of Service reflects the charge for the service using the San Francisco Board of Supervisors rate.
5. A group service is listed for each client in the group, with the total time recorded for each client. Thus, if group services are included in this report the Total Program Minutes are inflated.
6. For group services, the Cost of Service is accurately calculated for each client and program total using the formula:
(staff time + co-staff time) x rate per minute / # in group
7. The "Services by Program / Client" report is based on **client** time and units of service. The "Staff Activity Report" is based on **practitioner** time and units of service. Thus, program totals for number of services and minutes frequently do not agree between the two reports. Primary causes for discrepancies are the inclusion of group services and services with more than one practitioner.

Demographics Report



PM → Operational Reports → Demographics Report
 Select Date Range and Program → click Process

City and County of San Francisco, Department of Public Health, Community Health Care (PSP#505)
 Community Behavioral Health Services

Demographics Report
 For Clients Receiving Services at UCSF Primary Care Outreach (IPCOM)
 between 2/2/2015 and 5/17/2015

Age Group	# of Clients	% of Total
2. Adult (19-59)	17	94.4%
3. Senior (60 and over)	1	5.6%
Total	18	

Sex	# of Clients	% of Total
Female	9	50.0%
Male	9	50.0%
Total	18	

Race	# of Clients	% of Total
African Descent - Ot	1	5.6%
Black or African Des	3	16.7%
Chinese	1	5.6%
Native American or A	1	5.6%
No Entry	1	5.6%
Other Hispanic	1	5.6%
White or Caucasian	10	55.6%
Total	18	

Marital Status	# of Clients	% of Total
Divorced	2	11.1%
Not Married	16	88.9%
Total	18	

Primary Language	# of Clients	% of Total
Cantonese	1	5.6%
English	15	83.3%
No Entry	1	5.6%
Spanish	1	5.6%
Total	18	

Education	# of Clients	% of Total
7 Grade	1	5.6%
11 Grade	2	11.1%
12 Grade	9	50.0%
13 Grade	1	5.6%
14 Grade	3	16.7%
16 Grade	1	5.6%
Unknown	1	5.6%
Total	18	

Notes

PRIMARY CARE COORDINATION FORM

Program _____

Date _____

This form has information about taking care of your health, after you leave this program. It includes any recommendations that the Nurse Practitioner made for taking care of your healthy. It also has information about any referrals for health care and any specific appointments that were made for you

If you happen to lose this information, your mental health provider should be able to find it in your clinical record
However, if you have a new problem or a serious illness, go directly to a clinic or emergency room.

Taking care of your health

Referrals or specific appointments for health services		
Where/with Whom	Address/phone	Date/time (if applicable)