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:

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.
Interprofessional Primary Care Outreach for Persons with Mental Illness

Always select AVACALPMLIVE from the drop down.

Click Here
Be patient, it may take a minute or two for the Sign-in pop up to display!

Use all Caps but NOT Caps Lock!

**Server:** Select AVACALPMLIVE  
**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
**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”**.

   ![WebConnect Sign In](image)

   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”**.

   ![WebConnect Sign In](image)

   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:


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.
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!

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 displays 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.

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

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.
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:

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

- **Overview** icon: 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**.

- **Refresh** icon: 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.

- **Close** icon: This **RED X** (X) closes the client’s open chart.

- **Undock** icon: 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.

- **Green Plus** icon: 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.

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Description</th>
<th>Status</th>
<th>Estimated Onset</th>
<th>Classification</th>
<th>Resolved</th>
<th>Bill Order</th>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
</tr>
</thead>
</table>

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.
**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

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.
Admission (Outpatient) Form

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

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

**Pre-Admit/Admission Time:** Click Current

**Program:** Select your Program IPCOM from the drop down list
Interprofessional Primary Care Outreach for Persons with Mental Illness

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

**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)
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.

Select the current **Smoker** status...
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**

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
- [x] No

**Answer “No”**

---

**Diagnosis 1**

**Do Not enter diagnosis**

---

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Constitutional - Details, Pertinent Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denies Problem</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>Fever/Chills</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Eyes - Details, Pertinent Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denies Problem</td>
<td>Corrective Lenses</td>
</tr>
<tr>
<td>Watering</td>
<td>Blurred Vision</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Ear, Nose and Throat</th>
<th>Ear, Nose and Throat - Details, Pertinent Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denies Problem</td>
<td>Difficulty Swallowing</td>
</tr>
<tr>
<td>Nosebleeds</td>
<td>Nasal Discharge</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Cardiovascular - Details, Pertinent Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denies Problem</td>
<td>Palpitations</td>
</tr>
<tr>
<td>Murmur</td>
<td>Orthopnea</td>
</tr>
</tbody>
</table>
### Interprofessional Primary Care Outreach for Persons with Mental Illness

#### Respiratory
- Denies Problem
- Snoring
- Hemoptysis
- Inspiration Pain
- Labored
- Shallow
- Cough
- Shortness of Breath
- Apnea
- Sputum
- Wheezing

#### Gastrointestinal
- Denies Problem
- Diarrhea
- Jaundice
- Heartburn
- Constipation
- Decreased Appetite
- Nausea
- Black or Bloody Stools
- Abdominal Pain

#### Genitourinary
- Denies Problem
- Hesitancy
- Discharge
- Dysuria
- Incontinence
- Impotence
- Frequency
- Amenorrhea
- Testicular Pain
- Hematuria
- Dysmenorrhea
- Testicular Swelling

#### Musculoskeletal
- Denies Problem
- Restricted Movement
- Muscle Atrophy
- Deformity
- Joint Pain
- Muscle Pain
- Joint Swelling
- Muscle Stiffness
- Fractures

#### Skin
- Denies Problem
- Dryness
- Rashes
- Color Change
- Itching
- Change in Hair or Nails
- Lumps
- Poor Healing

#### Neurological
- Denies Problem
- Dizziness
- Tremors
- Seizures
- Numbness
- Tingling
- Weakness
- Unsteady Gait
- Memory Changes
- Headaches

#### Details, Pertinent Negatives

### Additional Information
- [Interprofessional Primary Care Outreach for Persons with Mental Illness](#)
### Psychiatric

- Denies Problem
- Mania
- Nervousness
- Panic
- Depressed Mood
- Phobic Fears
- Disturbing Thoughts
- Stress

#### Psychiatric - Details, Pertinent Negatives

---

### Hematologic

- Denies Problem
- Anemia
- Easy Bleeding
- Blood Clots
- Easy bruising
- Transfusion History

#### Hematologic - Details, Pertinent Negatives

---

### Endocrine

- Denies Problem
- Heat Intolerance
- Cold Intolerance
- Polydipsia
- Polyuria
- Excessive Sweating

#### Endocrine - Details, Pertinent Negatives

---

**Allergic Reaction to Food and/or Environment**

---

**Notes**

---
3. Physical

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.

<table>
<thead>
<tr>
<th>Section</th>
<th>Details</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes - Conjunctivae and Lids</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Pupils and Irisa</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Ophthalmoscopic Exam</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Ears and Nose - External Inspection</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Ears - External Canals and Tympanic Membranes</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Hearing</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Respiratory (If performed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose - Mucosa, Septum, Turbinates</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Mouth - Lips, Teeth, Gums</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Oropharynx</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Neck</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
<tr>
<td>Respiratory Effort</td>
<td>Unremarkable</td>
<td>Remarkable</td>
</tr>
</tbody>
</table>
### Chest and Cardiovascular (If performed)

- **Heart - Palpation**
  - Unremarkable
  - Remarkable

- **Heart - Auscultation**
  - Unremarkable
  - Remarkable

- **Examination of**
  - Carotids
  - Abdominal Aorta
  - Femoral Arteries
  - Pedals

- **Extremities for Edema/Varkosities**
  - Unremarkable
  - Remarkable

- **Breasts - Inspection**
  - Unremarkable
  - Remarkable

- **Breasts and Axilas - Palpation**
  - Unremarkable
  - Remarkable

### GI (If performed)

- **Abdomen**
  - Unremarkable
  - Remarkable

- **Liver and Spleen**
  - Unremarkable
  - Remarkable

- **Hernia**
  - Absent
  - Present

- **Anus, Perineum and Rectum**
  - Unremarkable
  - Remarkable

- **Stool for Occult Blood**
  - Done
  - Not Indicated
## Genitourinary (If performed)

- **Male - Scrotal Contents**
  - Unremarkable
  - Remarkable
  - Scrotal Contents - Details, Pertinent Negatives

- **Penis**
  - Unremarkable
  - Remarkable
  - Penis - Details, Pertinent Negatives

- **Digital Prostate Exam**
  - Unremarkable
  - Remarkable
  - Prostate - Details, Pertinent Negatives

- **Female - External Genitalia**
  - Unremarkable
  - Remarkable
  - External Genitalia - Details, Pertinent Negatives

- **Uterus**
  - Unremarkable
  - Remarkable
  - Uterus - Details, Pertinent Negatives

- **Adnexa / Parametria**
  - Unremarkable
  - Remarkable
  - Adnexa - Details, Pertinent Negatives

**Lymph Nodes - Two or More Areas**
- Neck
- Axilla
- Groin
- Other

- Lymph Nodes - Results

## Musculoskeletal (If performed)

- **Gait and Station**
  - Unremarkable
  - Remarkable
  - Gait and Station - Details, Pertinent Negatives

- **Digits and Nails**
  - Unremarkable
  - Remarkable
  - Digits and Nails - Details, Pertinent Negatives

- **Joints, Bones and Muscles - at Least One Area**
  - Head and Neck
  - Spine, Ribs, Pelvis
  - Rt Upper Extremity
  - Lt Upper Extremity
  - Rt Lower Extremity
  - Lt Lower Extremity
  - Joints, Bones, Muscles - Results

- **Skin - Inspection**
  - Unremarkable
  - Remarkable
  - Inspection - Details, Pertinent Negatives

- **Palpation**
  - Unremarkable
  - Remarkable
  - Palpation - Details, Pertinent Negatives
### Neurologic (If performed)

<table>
<thead>
<tr>
<th>CRANIAL NERVES</th>
<th>REMARKABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td></td>
</tr>
<tr>
<td>Remarkable</td>
<td></td>
</tr>
</tbody>
</table>

**Cranial Nerves - Details, Pertinent Negatives**

<table>
<thead>
<tr>
<th>DEEP TENDON REFLEXES</th>
<th>REMARKABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td></td>
</tr>
<tr>
<td>Remarkable</td>
<td></td>
</tr>
</tbody>
</table>

**Deep Tendon Reflexes - Details, Pertinent Negatives**

<table>
<thead>
<tr>
<th>SENSATION</th>
<th>REMARKABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td></td>
</tr>
<tr>
<td>Remarkable</td>
<td></td>
</tr>
</tbody>
</table>

**Sensation - Details, Pertinent Negatives**

---

### Psychiatric (If performed)

<table>
<thead>
<tr>
<th>JUDGEMENT AND INSIGHT</th>
<th>REMARKABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td></td>
</tr>
<tr>
<td>Remarkable</td>
<td></td>
</tr>
</tbody>
</table>

**Judgement and Insight - Details, Pertinent Negatives**

<table>
<thead>
<tr>
<th>BRIEF MENTAL STATUS</th>
<th>REMARKABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td></td>
</tr>
<tr>
<td>Remarkable</td>
<td></td>
</tr>
</tbody>
</table>

**Mental Status - Details, Pertinent Negatives**

---

**Medical Assessment**

---

**Plan**

---

**Medical Decision Making**

<table>
<thead>
<tr>
<th>NUMBER OF DIAGNOSES</th>
<th>Amount &amp;/or Complexity of Data to be Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>None/Minimal</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RISK OF SIGNIFICANT COMPLICATIONS, MORTALITY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Low</td>
</tr>
</tbody>
</table>
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.

See next page for the Vitals Graphs and Reports Section
Interprofessional Primary Care Outreach for Persons with Mental Illness

Vitals Reports and Graph

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.
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.

![Calendar](image)

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

![Bill Order](image)

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

![ICD-9 Code](image)

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

![ICD-10 Code](image)
To add another diagnosis, select “New Row” and repeat.

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”
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 an 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.
Interprofessional Primary Care Outreach for Persons with Mental Illness

General Medical Condition Summary Code (CSI)

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

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

Axis IV: Primary Support Group
- Yes
- No

Axis IV: Social Environment
- Yes
- No

Axis IV: Educational
- Yes
- No

Axis IV: Occupational
- Yes
- No

Axis IV: Housing
- Yes
- No

Axis IV: Economic
- Yes
- No

Axis IV: Health Care Services
- Yes
- No

Axis IV: Legal System/Crime
- Yes
- No

Axis IV: Other Problems
- Yes
- 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)

See Special Instructions for Notes field entry on page 45
Location Options: Default is to Office.

Location Options:
- Crisis
- Custodial Care Facility
- Emergency Room - Hospital
- Federally Qualified Health Center
- Field
- Jail (adult/youth)
- Job Site
- Mass Immunization Center
- Mobile Unit
- Military Treatment Facility
- 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

**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**

For services that take place over the Phone, this reflects direct billable time. Service duration is in Duration in minutes.

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

- 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 example](image)
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

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

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

Discharge Time: Click current

Discharge Day of Week and Length of Stay are optional fields
Type of Discharge: Select the appropriate reason/type of discharge

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 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

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).
Select the report you want from the Avatar PM or Avatar CWS Menu—just slide your 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.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>Client ID</th>
<th>Age</th>
<th>Race</th>
<th>Episode Opening</th>
<th>Last Service Date</th>
<th>Active/Inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRIEDMAN, MICHELE</td>
<td>004807</td>
<td>34</td>
<td>Asian Indian</td>
<td>6/17/2015</td>
<td>NO SERVICES</td>
<td></td>
</tr>
</tbody>
</table>

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 and user name. This is the "Avatar Date 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 and user selected.
3. "Inactive" displays in "Active/Inactive" column for clients whose last date of service is more than 90 days prior to the "Avatar Date as of" date. Please follow CMS guidelines for when to discharge a client from an episode.
4. "No Services" displays 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.

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
Services List Report

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

<table>
<thead>
<tr>
<th>Client Name (ID #)</th>
<th>Service Date</th>
<th>Service Code</th>
<th>Time (Min)</th>
<th>Cost of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>FANNON LEWIS D</td>
<td>4/2/2015</td>
<td>99204</td>
<td>40</td>
<td>1 Service</td>
</tr>
<tr>
<td>DREIER FRANCINE</td>
<td>4/7/2015</td>
<td>99212</td>
<td>15</td>
<td>1 Service</td>
</tr>
<tr>
<td>BURGEL BARBARA</td>
<td>5/12/2015</td>
<td>99204</td>
<td>30</td>
<td>1 Service</td>
</tr>
<tr>
<td>FANNON LEWIS D</td>
<td>3/24/2015</td>
<td>99204</td>
<td>20</td>
<td>1 Service</td>
</tr>
<tr>
<td>DREIER FRANCINE</td>
<td>4/14/2015</td>
<td>99203</td>
<td>40</td>
<td>1 Service</td>
</tr>
</tbody>
</table>

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 →
## Services List Report

<table>
<thead>
<tr>
<th>Client Name (ID #)</th>
<th>Practitioner Name (ID #)</th>
<th>Service Date</th>
<th>Service Code</th>
<th>Time (Min)</th>
<th>Cost of Service</th>
<th>Co-Staff ID</th>
<th>Co-Staff Time (Min)</th>
<th># in Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>FANNON, LEWIS D</td>
<td></td>
<td>4/23/2015</td>
<td>99203</td>
<td>40</td>
<td>1 Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3/30/2015</td>
<td>99204</td>
<td>60</td>
<td>1 Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/7/2015</td>
<td>99213</td>
<td>15</td>
<td>1 Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/7/2015</td>
<td>99212</td>
<td>45</td>
<td>1 Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5/5/2015</td>
<td>99203</td>
<td>60</td>
<td>1 Service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Program Total:     | 18 Clients                | 18 Services  | 790 Min     | 0 Min       |

Notes:
1. Includes only clients with services in the data range for the 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 the 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:
   \[
   \text{Cost of Service} = \text{staff time} \times \text{rate per minute} \times \text{# in group}
   \]
7. The "Services by Program/Client" report is based on staff 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.

Avatar Data as of 5/17/2015

CAUTION: Federal and State confidentiality laws apply to protected health information contained in this report. It is the recipient's responsibility to妥善保存和销毁报告。
Demographics Report

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

### Demographics Report

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Adult (19-59)</td>
<td>13</td>
<td>72.2%</td>
</tr>
<tr>
<td>3. Senior (60 and over)</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>9</td>
<td>50.0%</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>50.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Descent - Ot</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Black or African Des</td>
<td>3</td>
<td>16.7%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Native American or A</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>No Entry</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Other Hispanic</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>10</td>
<td>55.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Status</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
<td>2</td>
<td>11.1%</td>
</tr>
<tr>
<td>Not Married</td>
<td>16</td>
<td>88.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Language</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cantonese</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>English</td>
<td>15</td>
<td>83.3%</td>
</tr>
<tr>
<td>No Entry</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td>Spanish</td>
<td>1</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th># of Clients</th>
<th>% of Total</th>
</tr>
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<tbody>
<tr>
<td>7 Grade</td>
<td>1</td>
<td>5.6%</td>
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<tr>
<td>11 Grade</td>
<td>2</td>
<td>11.1%</td>
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<tr>
<td>12 Grade</td>
<td>9</td>
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<tr>
<td>13 Grade</td>
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<tr>
<td>14 Grade</td>
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<tr>
<td>16 Grade</td>
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<tr>
<td>Unknown</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
<td><strong>100.0%</strong></td>
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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 health. 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

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### Referrals or specific appointments for health services

<table>
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<tr>
<th>Where/with Whom</th>
<th>Address/phone</th>
<th>Date/time (if applicable)</th>
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