



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Community Health Representative System (BCH)

CHR PCC Forms

User Manual Supplement

Version 1.0
July 2007

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

PREFACE

This document is a supplement to the Services Guide for Community Health Representatives (CHRs). It provides the documentation forms used by the CHRs and other individuals who need to document CHR services and activities performed.

TABLE OF CONTENTS

This section contains printable copies of the following forms:

IHS-535: CHR Comprehensive PCC Encounter Record

IHS-535 1: CHR Abbreviated PCC Encounter Record

IHS-962: CHR PCC Group Encounter Record

**COMMUNITY HEALTH REPRESENTATIVE
COMPREHENSIVE PCC ENCOUNTER RECORD**

RESIDENCE	PROGRAM CODE	PROVIDER CODE 3 5 3	DATE OF SERVICE
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SUBJECTIVE INFORMATION <i>(Include Patient's complaint)</i>	Temp.					
	Pulse					
	Resp.					
	BP					
	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">WT</td> <td style="width:50%;"><input type="checkbox"/> GM</td> </tr> <tr> <td></td> <td><input type="checkbox"/> KG</td> </tr> <tr> <td></td> <td><input type="checkbox"/> LB-OZ.</td> </tr> </table>	WT	<input type="checkbox"/> GM		<input type="checkbox"/> KG	
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OBJECTIVE DATA	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">HT</td> <td style="width:50%;"><input type="checkbox"/> CM</td> </tr> <tr> <td></td> <td><input type="checkbox"/> IN</td> </tr> </table>	HT	<input type="checkbox"/> CM		<input type="checkbox"/> IN
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HEAD	<input type="checkbox"/> CM				
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	Body Mass Index				
	Waist Circumference				
	Vision-Uncorrected				
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HR#	Sex	Purpose of Referral by CHR
Name	Tribe	Insurer
SS#	Community of Residence	CHR Signature
Birthdate	Facility	

HEALTH PROBLEM CODES

Communicable Diseases

ME Measles
 MU Mumps
 CP Chicken Pox
 TB Tuberculosis
 HE Hepatitis
 SX Sexually Transmitted
 HI HIV / AIDS
 GE Gastroenteritis / Diarrhea
 ST Strep Throat
 IM Impetigo
 RA Rabies
 SC Scabies
 HL Head Lice
 OC Other Communicable
 OI Other Infections

Chronic Diseases

CA Cancer
 DM Diabetes Mellitus
 AR Arthritis
 OB Obesity
 HY Hypertension
 SK Stroke
 HT Heart
 LU Lupus
 LD Liver Disease
 CH Congestive Heart Failure
 TH Thyroid
 BD Blood Disorder
 RF Renal Failure
 OX Other Chronic

Digestive

GA Gallbladder
 DE Dental (All)
 IB Irritable Bowel
 GD GERD
 UL Ulcers
 PC Pancreatitis
 OD Other Digestive

Ear

IN Infections
 HP Hearing Problems
 HA Hearing Aids
 OE Other Ear

Behavioral Health

SU Suicide
 NI Nicotine
 AL Alcohol
 SA Substance Abuse
 DP Depression
 SS Stress
 LA Lifestyle Adaptation
 OM Other Mental Health

Suspected Abuse / Neglect

CS Child A / N Suspected
 DV Domestic Abuse Suspected
 EL Elder A / N Suspected
 SL Sexual Abuse Suspected

Health Promotion / Disease Prevention

NU Nutrition
 BF Breast Feeding
 IZ Immunizations
 SH School Health
 IC Injury Control
 SY SIDS
 FI Fitness
 CD Community Development
 OH Other HP / DP

III-Defined Conditions

SN Skin Conditions
 FA Fainting
 HD Headaches
 SF Surgery Follow-up
 FE Fever, unknown origin
 PA Pain, unknown origin
 PS Poisoning
 MB Mobility
 AC Accidental Injury
 AD Activities of Daily Living

Screening

HB A1c
 LP Lipids

Maternal and Child Health

FP Family Planning
 PR Prenatal Care
 PO Postnatal Care
 WC Well Child Care
 WH Women's Health
 FF FAE / FAS

Nervous System

SD Seizure Disorder
 PQ Para / Quadriplegic
 DT Dementia
 SE Senility
 PK Parkinson's Disease
 ON Other Nervous System

Respiratory

CO Cold
 FL Flu
 AS Asthma
 AG Allergy
 CG Cough
 PN Pneumonia
 CR COPD
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 OR Other Respiratory

Urinary Tract

DI Dialysis
 GU Genito Urinary Disease

Vision

ED Eye Disease
 EC Eye Care / Glasses

Other

LT Leave Time
 AM Administrative / Management
 SO Socio-Economic Assistance
 TR Traditional Healing

SERVICE CODES

HE Health Education
 CF Case Find / Screen
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 MP Monitor Patient
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COMMUNITY HEALTH REPRESENTATIVE
ABBREVIATED PCC ENCOUNTER RECORD

CHR Provider Code 3 5 3	Program Code	Date of Service
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ASSESSMENT - PCC PURPOSE OF VISIT

Health Problem Code <i>(see back)</i>	Service Code <i>(see back)</i>	Service Minutes	Narrative

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Patient's Chart Name <i>(Last, First, Middle Initial)</i> :		Patient Identifier:		
Measurements / Tests <i>(this information will pass to the chart)</i> :				
BP: _____ / _____	Weight: _____ lbs.	Height: _____ in.	Temp: _____	Pulse: _____
Respirations: _____	Blood Sugar: _____	Waist Circumference: _____	Hemoglobin A1c: _____	Body Mass Index: _____
CHR Signature: _____		Patient's Signature: _____		

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CONTACT INFORMATION

If you have any questions or comments regarding this distribution, please contact the ITSC Service Center by:

Phone: (505) 248-4371 or
(888) 830-7280

Fax: (505) 248-4297

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov