RESOURCE AND PATIENT MANAGEMENT SYSTEM

Patient Care Component

(PCC)

PCC Forms User Manual

March 2014

Office of Information Technology
Division of Information Resource Management
Albuquerque, New Mexico

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Preface

The Resource and Patient Management System (RPMS) of the Indian Health Service (IHS) is an integrated group of automated data systems designed to operate computers located in any IHS, Tribal, or Urban (I/T/U) health facility (i.e., hospital or full-time clinic). The system also links health facilities to each other and to administrative units such as Area Offices.

The primary objective is to integrate patient care and cost data in a single automated system that collects and stores a core set of health and management data.

The Patient Care Component (PCC) provides for the collection, integration, and storage, on local RPMS computers, of a broad range of health data resulting from inpatient, outpatient, and field visits at I/T/U, contract, and community sites. It is designed to support health care delivery, planning, management, and research.

For health professionals, PCC is a tool that assists in providing the type of care that addresses all of a patient's known health problems and preventive health needs:

- Planners use information such as the numbers of various types of visits and the reasons for these visits.
- Managers use aggregate information such as numbers of patients who have insurance and the types of insurance.
- Researchers use the information for a variety of locally designed projects.

PCC data types include:

- Date, type, and location of visit
- Providers of service
- Measurements
- Diagnoses and procedures
- Examinations
- Health factors
- Patient education
- Health problems and treatment plans
- Personal and family history
- Surgical history
- Reproductive factors
- Laboratory test results

- A variety of other health-related information

1.0 Introduction

A variety of forms are used for entering data into PCC. PCC forms are used by I/T/U health facilities and other providers of health care in the hospital, clinic, and field settings. The following services are documented using PCC forms:

- Ambulatory visits in the clinic
- Ambulatory visits in the home or community
- Nursing home visits
- Telephone calls to patients
- Day surgery
- Observation
- Historical Events (patient not present)
- Chart review (patient not present)

Telephone conversations with patients and chart reviews are to be entered into PCC only when pertinent new information is ascertained about the patient that should appear on PCC Health Summary such as Problem List updates or procedures the patient has had. PCC is not an activity reporting system intended to reflect all activities of I/T/U staff.

Most PCC forms are multi-part, carbonless forms. Basic recording instructions related to PCC are the same for all PCC forms. This manual describes the recording instructions for all PCC forms:

- Section 2.0 provides detailed instructions for use of the Ambulatory Encounter Record. All health care providers and Health Information Management staff should read this section because the contents apply to all forms associated with PCC.
- Section 3.0 provides specific instructions for use of other PCC-related forms.
- Appendix A: contains samples of all PCC forms.

2.0 Ambulatory Encounter Record

The most commonly used form is the Ambulatory Encounter Record, which is used to document a wide variety of services in a number of different settings by many types of providers. It is routinely used in the clinic setting and by field health providers to make a record of patient contacts in the home and community. It is also used to record patient-specific services not delivered face-to-face, such as telephone conversations with patients and chart reviews.

This is a three-part carbonless form used for:

- Filing in the patient's medical record
- Capturing data for entry into PCC
- Documenting referrals to other health care providers
- Recording patient instructions and appointments.

See Figure 2-1 for an example of the Ambulatory Encounter Record.

2.1 General Instructions

1. Write legibly using a ball-point pen with the form on a hard surface. The form is pressure-sensitive consisting of an original page and two copies. You must press hard to produce readable copies. Legibility is the single most important factor in determining how fast and how accurately PCC data entry staff can process the forms.

2. Use only the abbreviations that are agreed upon at your facility. Avoid using terms or symbols that might be confusing to the data entry staff.

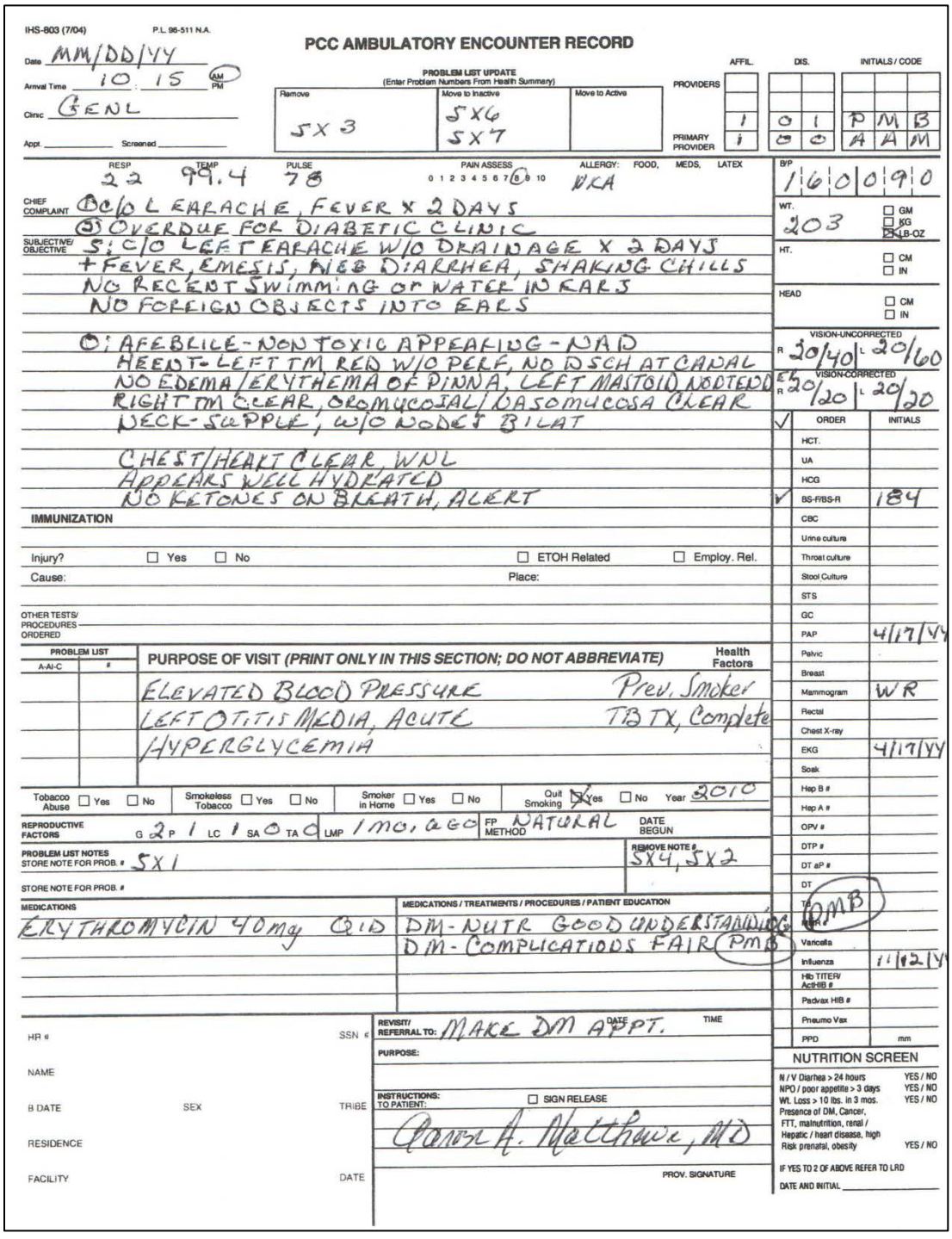
3. A properly completed form requires the following minimum set of information:

    - Date and location of the encounter
    - Identification of the primary provider
    - Purpose of Visit or diagnosis
    - Patient identification (such as name and facility health record number)
    - Signature of the primary care provider

4. If additional space is needed for any item on the Ambulatory Encounter Record, providers may use a second Ambulatory Encounter Record, placing #2 on the top of the form or a progress sheet may be inserted.

5. Copies of completed forms are distributed as follows:

   - White Copy (Original): becomes the outpatient progress note in the facility health record.



IHS-803 (7/04) P.L. 86-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date MM/DD/YY
Arrival Time 10:15 AM PM
Clinic GENL
Appt. ____ Screened ____

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)
Remove: 5X3 | Move to Inactive: 5X6, 5X7 | Move to Active:

AFFIL. / DIS. / INITIALS / CODE
PROVIDERS: 1 | 01 | PMB
PRIMARY PROVIDER: 1 | 01 | AAM

RESP 22 TEMP 99.4 PULSE 78 PAIN ASSESS 0 1 2 3 4 5 6 7 8 9 10 ALLERGY: FOOD, MEDS, LATEX NKA

B/P 160/90

CHIEF COMPLAINT Bc/o EARACHE, FEVER X 2 DAYS
@ OVERDUE FOR DIABETIC CLINIC

SUBJECTIVE/OBJECTIVE S: C/O LEFT EARACHE W/O DRAINAGE X 2 DAYS
+FEVER, EMESIS, NEG DIARRHEA, SHAKING CHILLS
NO RECENT SWIMMING OR WATER IN EARS
NO FOREIGN OBJECTS INTO EARS

O: AFEBRILE-NON TOXIC APPEARING-NAD
HEENT-LEFT TM RED W/O PERF, NO DISCH AT CANAL
NO EDEMA/ERYTHEMA OF PINNA, LEFT MASTOID NONTENDER
RIGHT TM CLEAR, OROMUCOSAL/NASOMUCOSA CLEAR
NECK-SUPPLE, W/O NODES BILAT

CHEST/HEART CLEAR WNL
APPEARS WELL HYDRATED
NO KETONES ON BREATH, ALERT

WT. 203 ☐ GM ☐ KG ☒ LB-OZ
HT. ☐ CM ☐ IN
HEAD ☐ CM ☐ IN
VISION-UNCORRECTED R 20/40 L 20/60
VISION-CORRECTED R 20/20 L 20/20

IMMUNIZATION

Injury? ☐ Yes ☐ No ☐ ETOH Related ☐ Employ. Rel.
Cause: Place:

OTHER TESTS/PROCEDURES ORDERED

✓	ORDER	INITIALS
	HCT.	
	UA	
	HCG	
✓	BS-F/BS-R	184
	CBC	
	Urine culture	
	Throat culture	
	Stool Culture	
	STS	
	GC	
	PAP	4/17/YY
	Pelvic	
	Breast	
	Mammogram	WR
	Rectal	
	Chest X-ray	
	EKG	4/17/YY
	Soak	
	Hep B #	
	Hep A #	
	OPV #	
	DTP #	
	DT aP #	
	DT	
	TD	PMB
	PPD	
	Varicella	
	Influenza	11/12/YY
	Hib TITER/ ActHIB #	
	Pedvax HIB #	
	Pneumo Vax	
	PPD	mm

PROBLEM LIST A-Al-C # | PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE) | Health Factors

1 ELEVATED BLOOD PRESSURE — Prev. Smoker
2 LEFT OTITIS MEDIA, ACUTE — TB TX, Complete
3 HYPERGLYCEMIA

Tobacco Abuse ☐ Yes ☐ No | Smokeless Tobacco ☐ Yes ☐ No | Smoker in Home ☐ Yes ☐ No | Quit Smoking ☒ Yes ☐ No Year 2010

REPRODUCTIVE FACTORS G 2 P 1 LC 1 SA 0 TA 0 LMP 1 MO, AGO | FP METHOD NATURAL | DATE BEGUN

PROBLEM LIST NOTES STORE NOTE FOR PROB. # 5X1 | REMOVE NOTE # 5X4, 5X2

STORE NOTE FOR PROB. #

MEDICATIONS: ERYTHROMYCIN 40mg QID

MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION:
DM-NUTR GOOD UNDERSTANDING
DM-COMPLICATIONS FAIR (PMB)

HR # SSN #
NAME
B DATE SEX TRIBE
RESIDENCE
FACILITY DATE

REVISIT/REFERRAL TO: MAKE DM APPT. DATE TIME
PURPOSE:
INSTRUCTIONS: TO PATIENT: ☐ SIGN RELEASE
Aaron A. Matthews, MD
PROV. SIGNATURE

NUTRITION SCREEN

N / V Diarhea > 24 hours	YES / NO
NPO / poor appetite > 3 days	YES / NO
Wt. Loss > 10 lbs. in 3 mos.	YES / NO
Presence of DM, Cancer, FTT, malnutrition, renal / Hepatic / heart disease, high Risk prenatal, obesity	YES / NO

IF YES TO 2 OF ABOVE REFER TO LRD
DATE AND INITIAL

Figure 2-1: Completed **PCC Ambulatory Encounter Record**

- Pink Copy: sent to PCC data entry.
- Yellow Copies: serve as referral to other providers of service; as a patient appointment slip and instruction form; and as documentation that a patient has sought medical care and should be excused from work, school, etc. (note the printing on the back of the last yellow copy).

2.2 Specific Instructions

This section provides instruction for the PCC Ambulatory Encounter Record (Figure 2-1), item by item.in the order that providers complete the form.

2.2.1 Patient and Visit Identification

When this form is used for an outpatient clinic visit, this section, (Figure 2-2) located in the bottom left corner of the form, is usually completed by health information personnel by imprinting the patient's plastic identification card, which is kept in the health record.

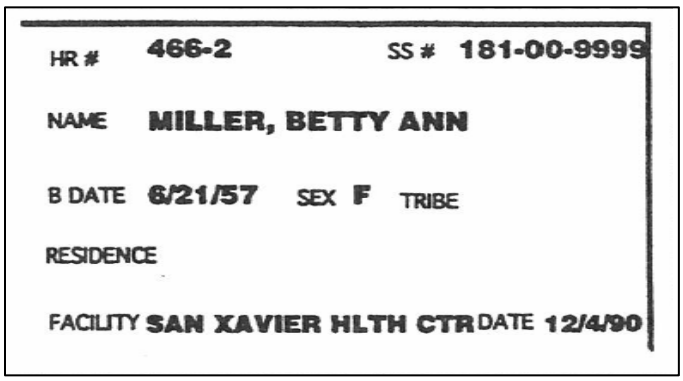


Figure 2-2: Patient and Visit Identification

For after-hours visits and field contacts, providers are responsible for completing identification that includes the patient's name, birthdate, health record number, and sex. Other required items are the date and facility. The patient's community of residence, Social Security Number, and tribal affiliation fields are optional. The health information staff or Service Provider records the location of the patient encounter on the line labeled **Facility**. This will often be the name of an IHS or tribal hospital or clinic, or an urban clinic, but is also used to record Home, Nursing Home, School, Office, and other community-based sites where patient contacts occur.

- **Special Cases**:
  - **Telephone Call**. When this form is used to record a telephone call to a patient that resulted in pertinent new information to be entered into PCC, the facility is identified as the location where the provider works (e.g., Demo Hospital) and a large **T** is recorded in this section of the form as shown in Figure 2-3.

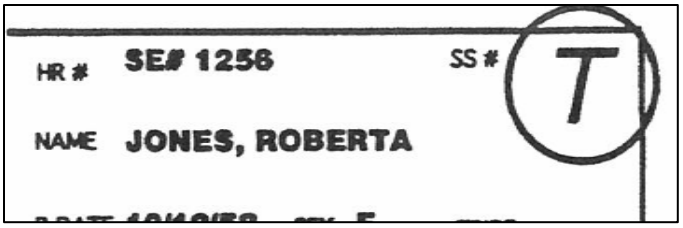


Figure 2-3: Patient and Visit Identification with Telephone Call annotation

- **Chart Review**. If the form is for a chart review, record the location where the chart review was performed as the facility and write a large **R** in this section.
- **Not Found**. If the form is for recording a home visit in which the patient is not found, identify the Facility as **Home** and record the term **Not Found** along with the Purpose of Visit in the Purpose of Visit section of the form.
- **DNKA**. When a patient does not keep an appointment, no form is processed in PCC. If the RPMS Scheduling module is used, the patient may be recorded as a No Show.
- **Did Not Answer**. If a patient signs up in clinic, has a chart pulled and a PCC form initiated, but is not still present when called for service, this does constitute a clinic visit by IHS definition and should be entered into PCC.

2.2.2 Administrative Data

Use the fields in the upper left corner of the form (Figure 2-4) to indicate the type of clinic or clinic code and the patient's arrival time. If the patient's residence differs from the one that appears on the Health Summary, enter the new community and the date moved here. However, the new community is generally updated when the patient goes through the interview/update process in patient registration upon each visit.

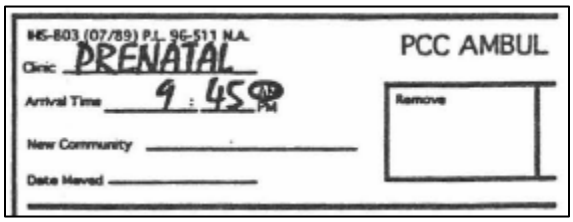


Figure 2-4: Administrative Data area

Special Case: **PHN Time**. Public Health Nurses (PHN) and their aides should record the time of the visit and the time spent for patient contacts on all PCC forms (Figure 2-5). In addition, record travel time if appropriate. This should be done whether the PHN staff person is the primary or secondary provider of care. Enter the activity time as **AT - 20** to record a time of 20 minutes. Enter travel time (round trip) as **TT - 60** to record a time of 60 minutes.

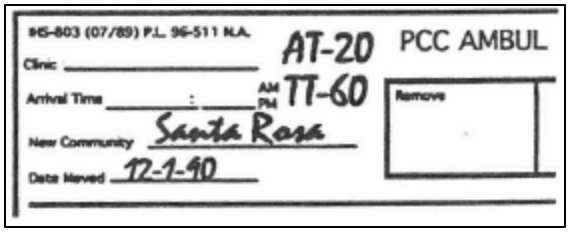


Figure 2-5: PHN Time

There should be only one activity time recorded per form to represent the total time for all participating PHN staff persons on a given visit. Travel time can be lumped on a single form by the PHN and therefore, will not appear on every PCC form.

2.2.3 Respiration, Temperature, and Pulse

These vitals (Figure 2-6) are usually recorded by the clinic nursing staff prior to the patient's contact with the primary provider. Use standard formats and conventions for recording this data. These items are entered and stored in PCC.

Figure 2-6: Temperature, Pulse, and Respirations entries

2.2.4 Blood Pressure, Measurements, and Visual Acuity

Record blood pressure in the standard manner; leading zeros are not required. Record weight in grams, kilograms, or pounds and ounces. Record height in centimeters, inches, or inches and decimal fractions of an inch. Record head circumference in centimeters or inches and decimal fractions of an inch. For weight, height, and head circumference, check the appropriate box to indicate the type of measurement unit used. Enter results of Snellen visual acuity tests in the appropriate sections for uncorrected and corrected vision.

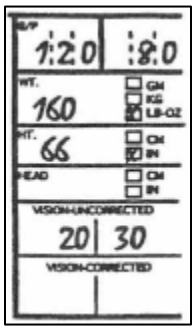


Figure 2-7: Blood Pressure, Measurements, and Visual Acuity entries

2.2.5 Provider Code

Each person providing a health service to the patient should record his or her provider code in the upper right comer of the form (Figure 2-8), with the primary provider using the indicated (bottom) line. The primary provider is the individual who will ultimately sign the form.

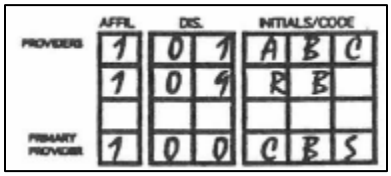


Figure 2-8: Provider Code entries

Provider codes consist of an affiliation code (Appendix B:), a discipline code (Appendix C:), and a code for the given individual, usually his or her initials. The providers at each facility should work with the Site Manager to develop the individual provider identifications to be used.

2.2.6 Chief Complaint/Subjective/Objective

Providers use this section (Figure 2-9) to record the narrative history, physical examination, progress notes, and the subjective and objective observations of the provider. If more space is needed to record information, insert a second encounter form, or write notes on a suitable continuation sheet and add it to the health record.

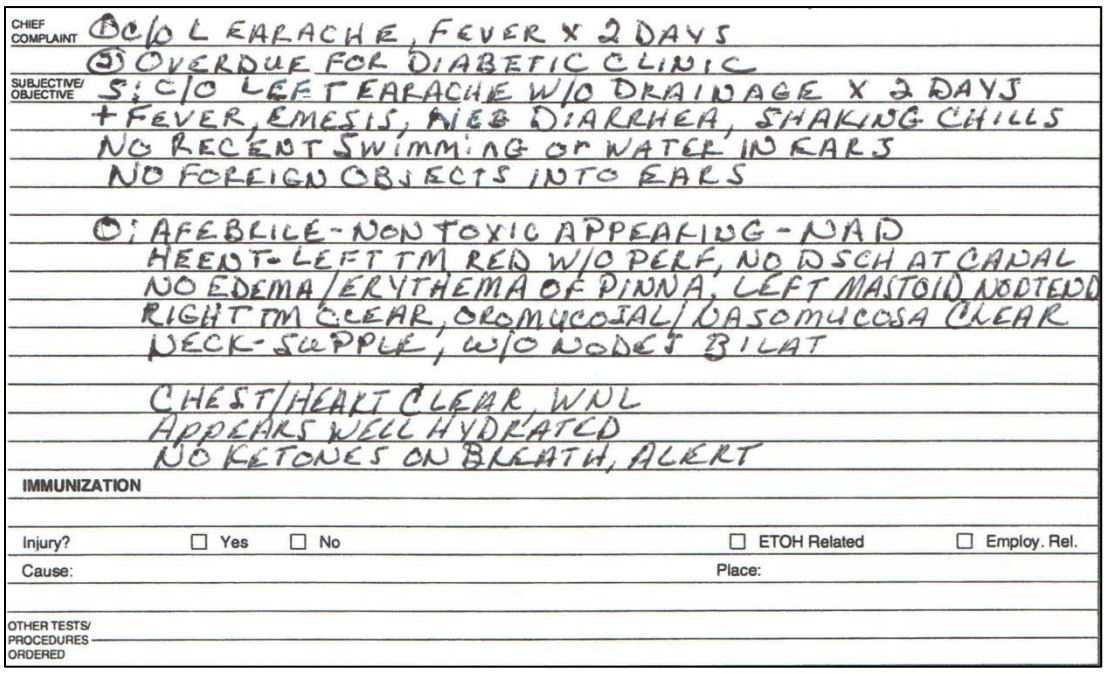


Figure 2-9: Chief Complaint entries

PCC data entry staff will review this section of the form for entry of relevant data, such as immunization history, examinations performed, or lab tests ordered.

2.2.7 Orders

Commonly ordered laboratory tests, examinations, skin tests, and immunizations may be ordered by checking the appropriate box at the right of the form (Figure 2-10). This list was developed on the basis of ordering frequency and PCC Health Maintenance Reminder standards. Tests may be ordered during visit planning (i.e., preparation for a scheduled clinic), triage, or the actual examination. Only those items that have subsequently been initialed will be picked up by data entry. Since the encounter form does not go to the laboratory, the person who actually fills out the laboratory slips should initial the appropriate tests. When the RPMS laboratory component is operating at a facility, the results of the laboratory tests will be passed automatically from that system to the appropriate patient file in the PCC.

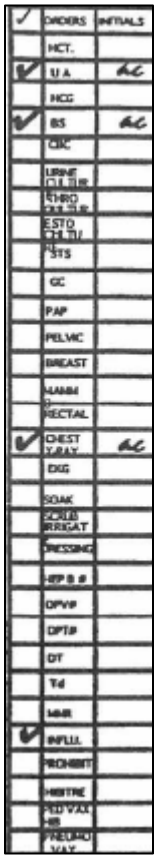


Figure 2-10: Orders

Other laboratory tests, X-rays, or procedures ordered as part of this visit should be requested in the section labeled **Other Tests/Procedures Ordered** located at the bottom of the **Chief Complaint** section (Figure 2-8). Examples might include the ordering of a creatinine, BUN, or X-ray of the lower left leg.

The most frequently ordered immunizations appear in the lower portion of the orders list (Figure 2-10). Series number or booster is no longer required. Immunizations that are ordered but which are not on the list should be entered in the area designated **Medications/Treatments/Procedures/Patient Education** (Figure 2-11).

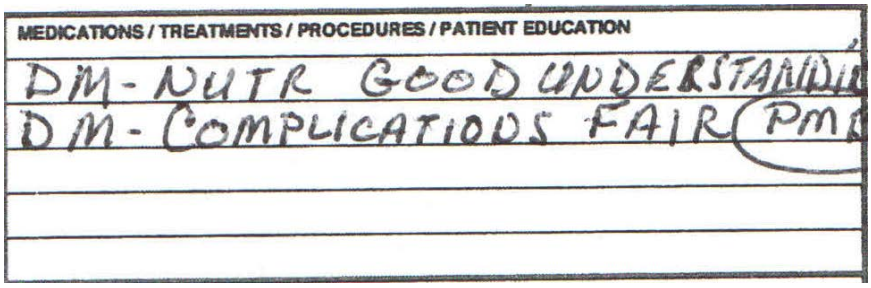


Figure 2-11: **Medications/Treatments/Procedures/Patient Education** section

Likewise, historical immunizations should be recorded, with date (minimum of MM/YY) and facility (if known), in that section.

Special Case: HIB. Until the PCC form is changed to reflect the different types of Hemophilus Influenzae vaccines used (Prohibit, Hibtiter, and Pedraxhib), those immunizations should be recorded in the **Medications/Treatments/Procedures/Patient Education** section. This also applies to any new immunizations.

Skin tests will not be entered into PCC until read. Skin test readings are recorded in millimeters, including negative readings (OOmm).

2.2.8 Purpose of Visit

This is the most important section of PCC Ambulatory Encounter Record. The diagnoses, assessments, and problems entered here will be printed verbatim in the Outpatient and Field Encounters Section of the patient's Health Summary. Every Encounter Form submitted for data entry must have at least one Purpose of Visit (Figure 2-12), but may contain more. This section of the form is also used to create and update a patient's Problem List, which is discussed in the next section of this manual. **Legibility in this section of the form is critical**. Accordingly, providers are required to print in this section. Speed and accuracy of PCC data entry are totally dependent on legibility of data recorded in the Purpose of Visit section.

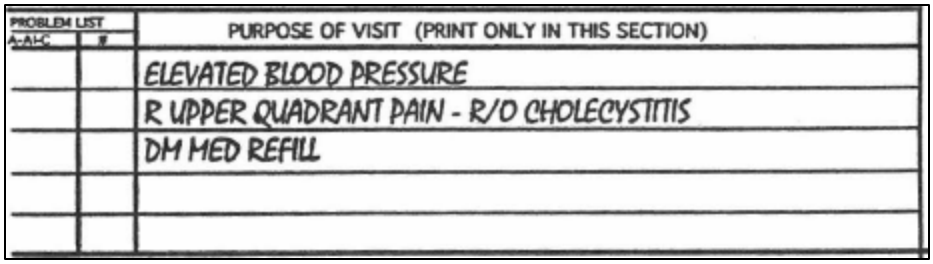


Figure 2-12: Purpose of Visit

Purposes of Visit must be entered in narrative form. They can be medical diagnoses, nursing assessments, symptoms, or socio-economic problems. Purpose of visit recording should be limited to conditions being dealt with during this particular visit; it is inappropriate to list all known conditions or symptoms in this section. When there are multiple Purposes of Visit, each one should be recorded on a separate line.

Coding of the Purposes of Visit to the International Classification of Diseases (ICD) occurs when the data entry staff enters that narrative into PCC. The assignment of ICD codes to the provider narrative allows computer searches to be made for selected diagnoses. The ICD codes are also used for a variety of statistical purposes.

- Special Cases:
  - **Rule Out**. A **Rule Out** diagnosis is acceptable as a Purpose of Visit only when accompanied by additional descriptive narrative (e.g., Right upper quadrant pain, rule out cholecystitis). In this case, the Purpose of Visit is coded to the symptom, but the **Rule Out** phrase is retained in the narrative. A **Rule Out** narrative by itself (e.g., rule out appendicitis) is not acceptable as a Purpose of Visit and is never acceptable as a Problem List entry. This same rule applies for **Suspect**, **Probable,** and **Questionable**' diagnoses. This rule is an ICD Coding Guideline for ambulatory services.
  - **Med Refill**. When the Purpose of Visit is for a medication refill, the provider must always record the condition for which the medication is being used (e.g., Hypertension, Med Refill}. In this way, the ICD code can reflect the actual condition, and the code can be used in queries and quality assurance studies.
  - **Telephone Call/Chart Review**. If telephone contacts or chart reviews result in pertinent information that needs to be added to the patient's computerized record, enter a meaningful Purpose of Visit (e.g., Cholecystitis reported by consultant) in this section, and enter a large **T** (as in Figure 2-3) to indicate telephone contact or **R** for chart review in the patient identification section.

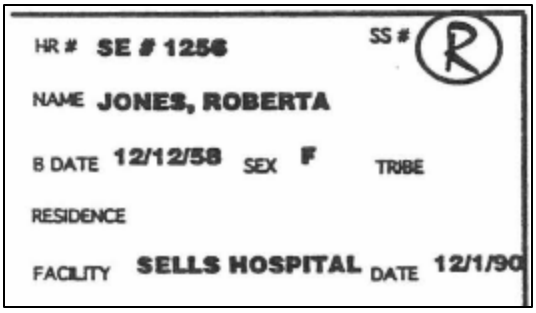
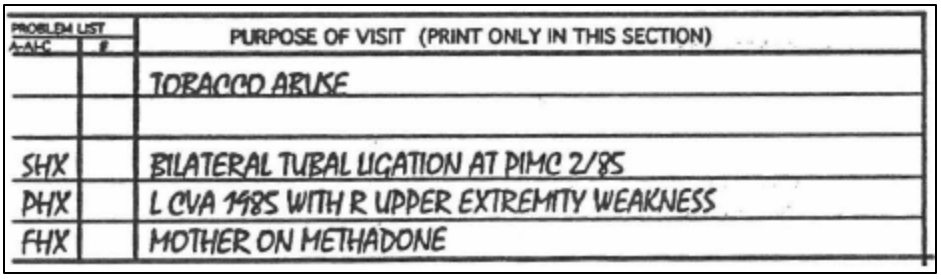

HR # SE # 1256 SS # R
NAME JONES, ROBERTA
B DATE 12/12/58 SEX F TRIBE
RESIDENCE
FACILITY SELLS HOSPITAL DATE 12/1/90

Figure 2-13: Patient and Visit Identification with Chart Review annotation

- **Flow Sheets**. Clinical flow sheets for prenatal, well child, diabetic, and other types of care may be in use at your facility. Their use may be continued in conjunction with PCC. If a flow sheet is in use for a particular visit, record minimal data on the PCC form (e.g., providers, measurements. immunizations) along with a Purpose of Visit such as **Prenatal Care - See Flow Sheet**. This will minimize duplicate recording; but remember, data from the flow sheet will not be entered into the computer.
- **Surgical History**. Record a past surgical procedure, performed at this facility or another facility in the Purpose of Visit section (Figure 2-14) of the form. Preface a surgical history with the letters **SHX**, so that the data entry staff can distinguish it. Include the procedure, date performed (MM/YY or at least a year is required), and the facility (if known) where it was performed. Past procedures, recorded in this way, appear on the Adult Regular Health Summary in the History of Surgery Section.
- **Personal History**. Record a past medical, nursing, dental, social, or psychiatric condition in the Purpose of Visit section for entry in PCC. Preface personal histories with the letters **PHX** for data entry purposes. The personal history narrative should include the date of the condition. Personal history data is not displayed on the Adult Regular Health Summary, but can be added to any PCC Health Summary by the Site Manager.
- **Family History**. Record a past medical, nursing, dental, social, or psychiatric condition pertaining to a family member in the Purpose of Visit section for entry in PCC. Preface family history entries with the letters **FHX** for data entry purposes. The family history narrative should include the date of the condition. Family history data is not displayed on the Adult Regular Health Summary (Figure 2-15), but can be added to any PCC Health Summary by the Site Manager.



PROBLEM LIST A-AFC	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION)
		TOBACCO ABUSE
SHX		BILATERAL TUBAL LIGATION AT PIMC 2/85
PHX		L CVA 1985 WITH R UPPER EXTREMITY WEAKNESS
FHX		MOTHER ON METHADONE

Figure 2-14: Purpose of Visit, Surgical, Personal, and Family History entries

```
*********CONFIDENTIAL PATIENT INFORMATION - JAN 27,2012 10:29 AM**********
   *************PATIENT,DEMO1 (ADULT REGULAR SUMMARY) pg. 1************

---------------------------DEMOGRAPHIC DATA-------------------------------
PATIENT,DEMO1 DOB: Feb 03, 1940 FEMALE  A+
NAVAJO
TUCSON (7711 E. 77IH ST.,TUCSON,ARIZONA,87666) SSN: 000-00-9999
ELIGIBILITY: DIRECT
HEALTH RECORD NUMBERS: 088888 DEMO HOSPITAL/CLINIC
                       054666 DEMO HEALTH CENTER
PRIMARY PROVIDER: (none identified)

-------------------------------ALLERGIES----------------------------------
                 *****PENICILLIN ALLERGY, ANAPHYLAXIS*****
                      *****SULFA ALLERGY, 1977*****

-------------------------INSURANCE INFORMATION----------------------------
INSURANCE                  NUMBER      SUFF COV EL DATE  SIG DATE  END DATE
MEDICAID                   123456789   0    1I  10/14/87
BLUE CROSS/BLUE SHIELD     000-00-5555          01/18/85

-----------------MEASUREMENT PANELS (max 5 visits or 2 years)-------------
            HT    WT    BP      VU     VC
12/10/87    66    200   160/92
10/27/87          186   140/90  40/50  20/20
09/17/87          175   120/80

 --------------------------REPRODUCTIVE HISTORY---------------------------
G3P3LC3SA0TA0 (obtained 12/10187) LMP 11/23/87 (obtained 12/10/87)
CONTRACEPTIVE METHOD: NATURAL TECHNIQUES (obtained 12/10/87)

------------------------------ACTIVE PROBLEMS-----------------------------
SX1      07/06.87DIABETES MELLITUS
SX1SX1     DIABINESE 250 MG
SX1.1    08/30/87NEUROPATHY
SX2      09/17/87PENICILLIN ALLERGY,ANAPHYLAXIS
SX5      10/27/87DYSFUNCTIONAL UTERINE BLEEDING
SX8      01/23/88HYPERTENSION
SX9      01/23/88OBESITY

----------------------------INACTIVE PROBLEMS-----------------------------
SX6      12/10/87     PYELONEPHRITIS
SX7      12/10/87     HX LEFT HIP FRACTURE

--------------------------HISTORY OF SURGERY-----------------------------
07/18/84 (05/16/84) APPENDECTOMY AT PIMC
10/27/87 (0l/02/85) OPEN REDUCION/FIXATION L HIP AT AHSC
```

```
-------------------------MEDICATIONS (max 1 year)-------------------------
12110/87 DIABINESE       250 MG TIT DAILY EXP 3/88 100
12110/87 ERYTHROMYCIN    250 MG TIT QID   EXP 1/88  40

----------------INPATIENT STAYS (max 5 visits or 2 years)-----------------
09/08/87 - 09/15/87 DEMO HOSP     ACUTE PYELONEPHRITIS
                                  PNEUMONIA

-----------OUTPATIENT/FIELD VISITS (max 10 visits or 2 years)-------------
01/23/88     DEMO HEALTH CENTER      DIABETES
12/10/87     DEMO HOSPITAL           ELEVATED BLOOD PRESSURE
                                     LEFT OTITIS MEDIA
10/27/87     DEMO HEALTH CENTER      DYSFUNCTIONAL UTERINE BLEEDING
                                     SULFA ALLERGY, 1977
09/17/87     DEMO HEALTH CENTER      PENICILLIN ALLERGY, ANAPHYLAXIS
                                     VIRAL INFECTION
09/08/87     DEMO HOSPITAL           PYELONEPHRITIS
08/23/87     DEMO HOSPITAL           DIABETES

   ------MOST RECENT PATIENT EDUCATION (max 5 visits or 2 years)--------
12/10/87     DEMO HOSPITAL       DM-DISEASE PROCESS - FAIR UNDERSTANDING
08/23/87     DEMO HEALTH CENTER  DM-DIET - GOOD UNDERSTANDING

         --------MOST RECENT LABORATORY DATA (max 2 years)---------
BLOOD SUGAR        12/10/87  450
STREP CUL          09/17/87    N
HEMATOCRIT         10/27/87   45

 ------------------------------IMMUNIZATIONS-----------------------------
TD-ADULT      12/10/87     DEMO HOSPITAL
PNEUMOVAX     09/17/87     DEMO HEALTH CENTER

---------------------------------SKIN TESTS-------------------------------
PPD       08/01/87 unrep  DEMO HEALTH CENTER
COCCI     04/25/87 0mm    DEMO HEALTH CENTER

*****END * CONFIDENTIAL PATIENT INFORMATION - JAN 27,1988 10:29 AM*****
```

Figure 2-15: Health Summary

2.2.9 Problem List

The Purpose of Visit section (Figure 2-16) is also used to add new active and inactive problems to the Health Summary Problem List and to change the narratives of previously identified problems. Additions and changes to the Problem List should be made only with the Health Summary (Figure 2-15) in hand.

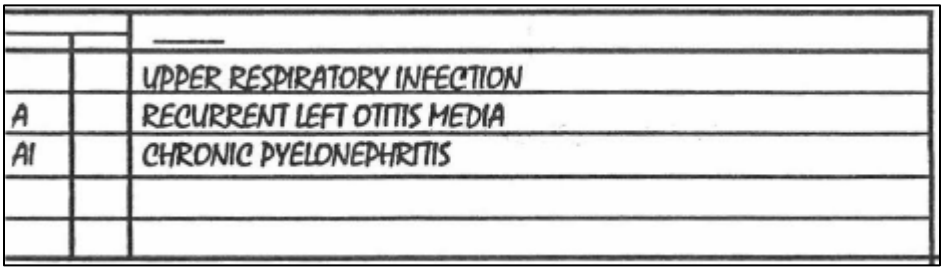


Figure 2-16: Purpose of Visit and Problem List Update

- **Adding Active Problems**. Active problems are differentiated from inactive problems by their direct clinical significance. Active problems are those that are currently affecting the patient's health or, if presently quiescent, are at high risk for recurrence. When a diagnosis is determined to be an active problem and is to be added to the Problem List, write **A** in the far left column headed **A-AI-C**; then write in the narrative for the new problem (which may also be the Purpose of Visit). Numbers for problems are assigned by the computer and consist of an abbreviation for the facility where the problem was identified and a sequential number assigned by the computer.
- **Adding Inactive Problems**. The **AI** designation is used for adding a problem to the inactive Problem List. Inactive problems are defined as problems that have been resolved but may recur in the future. These recurring problems may place the patient at increased risk (e.g., asbestos exposure) or may have left residual physical findings.

  It is not necessary or appropriate to add all Purposes of Visit to the patient's Problem List. All Purposes of Visit will be displayed in the Outpatient Section of the Health Summary, but only selected ones should be added to the Problem List. Appendix D: describes the appropriate contents of a Problem List.

  In order to convey to PCC data entry staff which entries are Purposes of Visit only, which are problems only, and which are both, adhere to the following recording conventions:

  – Narratives recorded with no **A or AI** in the left column are Purposes of Visit only. In Figure 2-17, **Viral Gastroenteritis** is a Purpose of Visit only.
  – Narratives entered in the bottom of the section with an **A or AI** are Problem List additions, but not purposes of this visit. In the example, **Small Stature** and **Atrial Septal Defect** are Problem List additions only.
  – Narratives entered in the top part of the section which do contain an **A or AI** are both Purposes of Visit and Problem List additions. In the example **Chronic Serous Otitis Media** is both a Purpose of Visit and Problem List addition. To make your intentions clear to the data entry staff, draw a line above those narratives that are only for Problem List additions. When known, record an ONSET date for the problem condition next to the problem narrative.

PROBLEM LIST A-AI-C	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION)
		VIRAL GASTROENTERITIS
A		CHRONIC L SEROUS OTITIS MEDIA
A		SMALL STATURE
AI		ATRIAL SEPTAL DEFECT

Figure 2-17: Purpose of Visit/Problem List Update

- **Changing the Status of Existing Problems**. To change the status of existing problems, use the boxes at the top of the page (Figure 2-18) in conjunction with the patient's current Health Summary. A problem may be removed or its status changed to active or inactive by entering the problem number (from the Health Summary) in the appropriate box. A removed problem is actually deleted from the system and not available for future retrieval purposes.

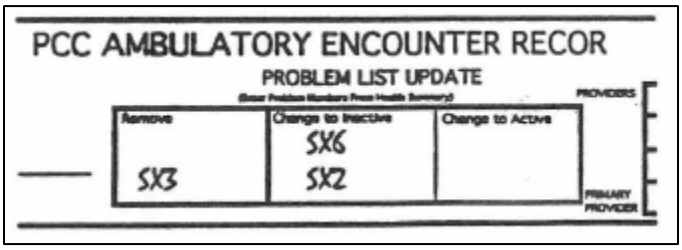
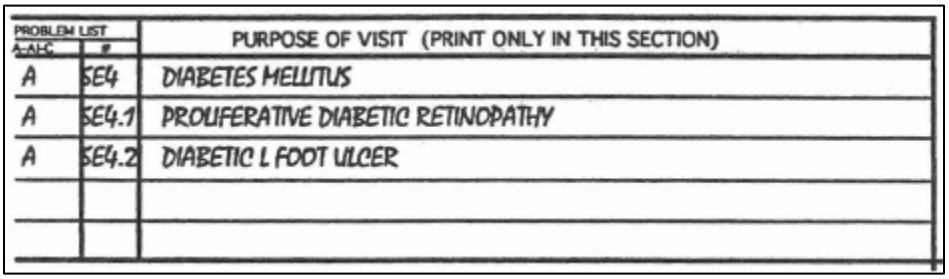


Figure 2-18: Problem List Update

- **Grouping Related Problems on the Problem List**. Providers often wish to group related problems together on the Problem List such as diabetes and its complications or heart-related conditions. This can be done by the provider specifying the problem number when adding a problem (in the absence of such specification, the computer will automatically assign the next sequential number when problems are added.) In Figure 2-19, diabetes, diabetic retinopathy, and a diabetic ulcer of the left foot are all being added to the Problem List.

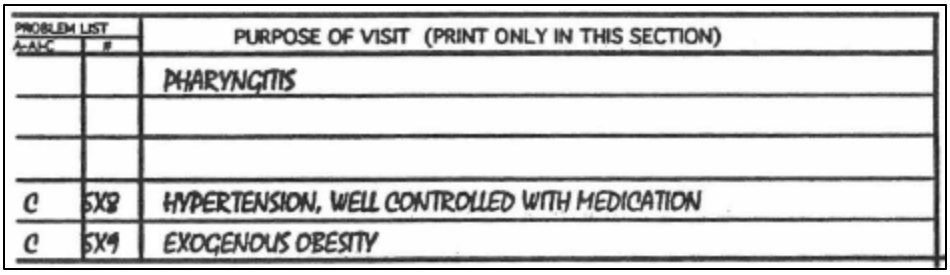


PROBLEM LIST A-ACTIVE I-INACTIVE	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION)
A	SE4	DIABETES MELLITUS
A	SE4.1	PROLIFERATIVE DIABETIC RETINOPATHY
A	SE4.2	DIABETIC L FOOT ULCER

Figure 2-19: Problem List Purpose of Visit

By reviewing the Health Summary, the provider can see that the highest numbered problem currently on the Problem List is, for example, SE3. So the provider can assign number SE4 to Diabetes Mellitus, SE4.1 to Proliferative Diabetic Retinopathy, and SE4.2 to Diabetic L Foot Ulcer. These are the problem numbers that will then appear on the Health Summary. If additional diabetic conditions are added to the Problem List at subsequent visits, the provider merely specifies SE4.3, SE4.4, and so on.

- **Changing Problem Narratives**. If the provider wishes to change the narrative for a problem that is already on the Problem List, the **C** designation is used. Then the problem number, as it appears on the Health Summary, is indicated in the # column, followed by the new narrative (Figure 2-20).



PROBLEM LIST A-A/C	#	PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION)
		PHARYNGITIS
C	SX8	HYPERTENSION, WELL CONTROLLED WITH MEDICATION
C	SX9	EXOGENOUS OBESITY

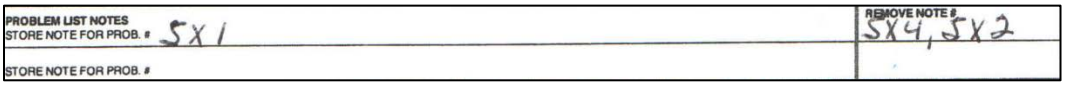
Figure 2-20: Problem List Narrative Changes

Providers should periodically review the quality and clarity of the Problem List entries as they appear on the Health Summary and change the ones that are out of date or inaccurate.

2.2.10 Treatment Plan

Continuing care plans or commentary notes should be recorded in this area. These notes or plans can be linked to problems on the Health Summary or to a diagnosis or Purpose of Visit that is being added to the Problem List. In the sample Health Summary (Figure 2-21), diabetes is problem number SXl, indicating that it was the first problem added to the Problem List at San Xavier Clinic. The accompanying treatment note is numbered SXlSXl, which indicates that this is the first treatment note for problem number SXl. A treatment note number is a combination of the appropriate problem number followed by a note number which is assigned sequentially by the computer.

- **Adding Treatment Notes**. Using the Health Summary, determine the PCC problem number to which the note should be linked. In the Treatment Plan section of the form, next to the label **Store Note For Prob #**, enter the problem number from the Health Summary followed by the treatment note narrative.



PROBLEM LIST NOTES STORE NOTE FOR PROB. # SX1	REMOVE NOTE # SX4, SX2
STORE NOTE FOR PROB. #	

Figure 2-21: Treatment Note for existing Problem

- **Adding Notes for New Problems**. If a note is to be linked to a new problem being added at this visit, choose a dummy variable (such as X.Y, or Z) and enter this variable as the problem number. Use the same variable for the problem note that is to be linked to this new problem. The problem number on the Health Summary will be assigned by the computer, but data entry will know that this problem and note are to be linked. In Figure 2-22, **Iron Deficiency Anemia** is being added as a problem, and **Iron Supplement Daily** is being linked to it as a treatment note by using a temporary problem number of **X**.

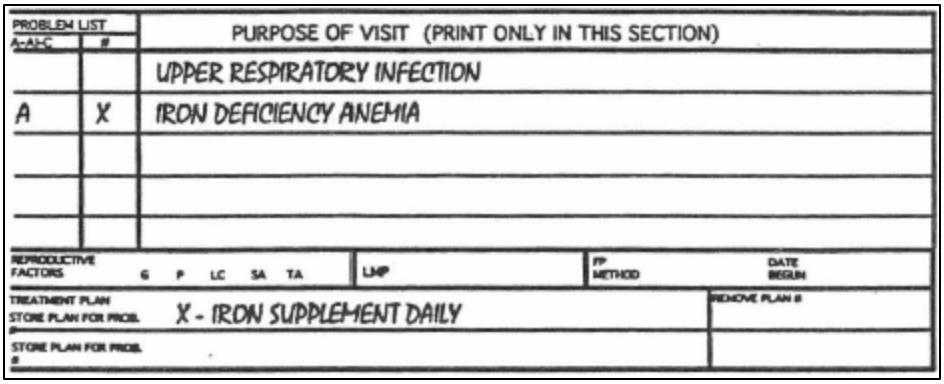


Figure 2-22: Problem List Note for New Problem

- **Deleting Notes**. A problem plan or note may be removed from the Health Summary by entering its note number in the box on the right side the form.

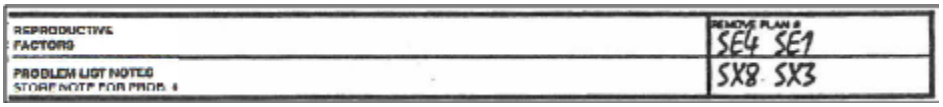


Figure 2-23: Deleting a Note

- **Modifying Notes**. If a note is to be modified, use the **Deleting Notes** procedure for deleting the note that is no longer current. Write a new note and link it to the problem using the Health Summary problem number. This note will be given a number by the computer that differs from the number of the note deleted, but the new note will be linked to the proper health problem.

  Notes are linked internally in PCC to their corresponding problem. When changing the status of an existing problem, the problem and all corresponding notes are changed in the system. For example, when removing a problem, all notes associated with that problem are removed from the system.

2.2.11 Reproductive Factors

The line between the Purpose of Visit and the treatment plan (Figure 2-24) is for recording female reproductive factors that form a part of the patient's health history. Reproductive Factors include Reproductive History, Last Menstrual Period (LMP), Family Planning (FP) Method, and Date Begun for that method. When recorded by providers, this information is displayed on the Health Summary. The Health Summary display includes dates that the information was obtained in order to permit providers to evaluate its timeliness. These factors should be recorded on the form when they represent changes to the data displayed on the Health Summary or when it is important to indicate that these factors were reviewed on the current visit.

The Reproductive History consists of Gravidity (G), Parity (P), Living Children (LC). Spontaneous Abortions (SA), and Therapeutic Abortions (TA). These items are recorded, entered into the system, and displayed on the Health Summary as a single

data field (e.g., **G5P4LC4SAOTA1**). As such, providers should take care to always record all five pieces of data because a partial entry (e.g., **G6P5**) will overlay a more complete earlier entry in the system.

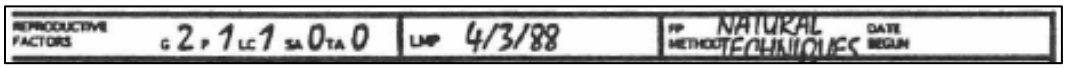


Figure 2-24: Reproductive Factors

Family Planning Methods consist of the following:

- Abstinence
- Barrier/Cervical Cap
- Barrier/Condoms (Female)
- Barrier/Condoms (Male)
- Barrier/Diaphragm
- Barrier/Lea's Shield
- Barrier/Spermicidal Film
- Barrier/Spermicides
- Barrier/Sponge
- Emergency Contraception
- Hormonal/Depo Provera
- Hormonal/Implant
- Hormonal/Oral Combined
- Hormonal/Oral Progestin Only
- Hormonal/Patch
- Hormonal/Vaginal Ring
- IUD - Copper
- IUD - Hormonal
- NA Menopause
- NA Post Hysterectomy
- NA Pregnant
- None
- Other
- Periodic Abstinence Method

- Sterilization (Female)
- Sterilization (Male)

In addition, Estimated Date of Delivery (EDD) can now be entered into PCC. It should be recorded in the Purpose of Visit section of the form next to a pregnancy related diagnosis. The method of determining the EDD should also be recorded. This information will appear on the Health Summary in the Reproductive Factors display. An example of an EDD entry in the Purpose of Visit section is **Pregnancy - EDD 05-12-91 by Sonogram**.

2.2.12 Medications, Treatment, Procedures, and Patient Education

The side-by-side sections in the lower part of the encounter form labeled **Medications** and **Medications/Treatments/Procedures/Patient Education** (Figure 2-25), should be used for those treatments, procedures, etc., that are considered part of the treatment as opposed to being part of the assessment.

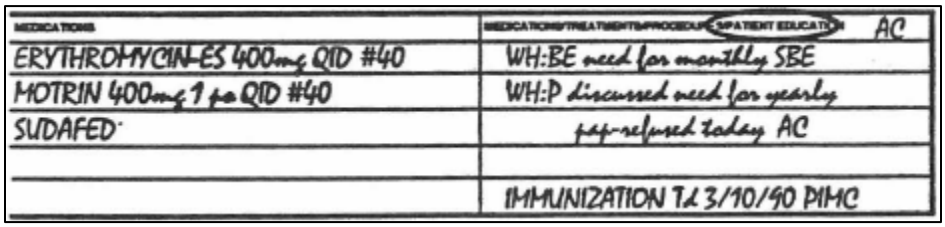


Figure 2-25: Medications, Treatment, Procedures, and Patient Education

Medications and treatments to be provided during the visit should be entered in this section. The provider records the medications ordered here for the use of the pharmacist. However, prescriptions will be coded automatically and added to PCC from the Pharmacy System if it is operating at the facility. Other entries should be made as appropriate to request subsequent services from nursing, social service, and laboratory.

If operative procedures are requested, they will be assigned appropriate procedure codes by the data entry staff and will appear on the Health Summary in the component labeled **History of Surgery**.

Because many IHS patients receive numerous prescriptions at a clinic visit, the left section labeled **Medications** is reserved for medicines, while the right hand section is for recording additional medicines plus other treatments. If additional room is needed for prescriptions, insert a blank progress sheet or another encounter form and note **Continuation from page 1.**

PCC has the capability of capturing additional information recorded in this section such as nursing treatments, procedures, patient education, and health factor data. However. each Service Unit must develop its own lists and codes and arrange with its

local PCC Data Entry Manager to have these items entered into the system. If entered into PCC, they are displayed as separate components on the Health Summary.

If the Health Summary does not contain a complete immunization and skin test history for the patient, previous immunizations should be reported in this section with the dates, and locations of encounter where administered. These will be entered by the data entry personnel and will appear on subsequent Health Summaries.

2.2.13 Injury 1st Visit

To assist the IHS Injury Control Program, it is important to designate the cause and location of injuries sustained by patients and whether these injuries are alcohol-related. For example, if in the Purpose of Visit section a fracture of the right arm is recorded, note in the cause of injury that the patient fell from a bicycle (or whatever the external cause of the injury was), and record the place where the injury occurred such as home, school, highway, workplace, etc. In the far right side of this section (Figure 2-26), check **ETOH Related** or **Employment Related** as appropriate.

Record cause and place only on the first visit for an injury.

Figure 2-26: Injury 1st Visit

Causes and places of injury include, but are not limited to, the following terms:

- Causes of Injury:
  - Motor Vehicle Accident
  - Water Transport
  - Air Transport
  - Accidental Poisoning
  - Fires and Flames
  - Environmental Factors
  - Stings and Venoms
  - Animal Related, Including Bites
  - Drowning and Submersion
  - Cutting and Piercing Objects
  - Firearm Accidents
  - Machinery
  - Suicide Attempt
  - Injury Purposely Inflicted by Others

  - Battered Child
- Places of Injury:
  - Home – Inside
  - Home – Outside
  - Farm, Ranch
  - School
  - Industrial Site
  - Recreation and Sport Site
  - Highway and Street
  - Public Building (Including Barroom)
  - Resident Institution (Including Hospital)
  - Hunting or Fishing (As a Livelihood)

2.2.14 Revisit or Referral To, and Instructions to Patient

Use the section in the lower right comer of the form (Figure 2-27) to indicate future clinic appointments and to provide specific instructions to other providers as well as to the patient. The yellow copies of the form may be given to the patient, if appropriate, or to other health care providers as a referral note. This data is not entered in PCC.

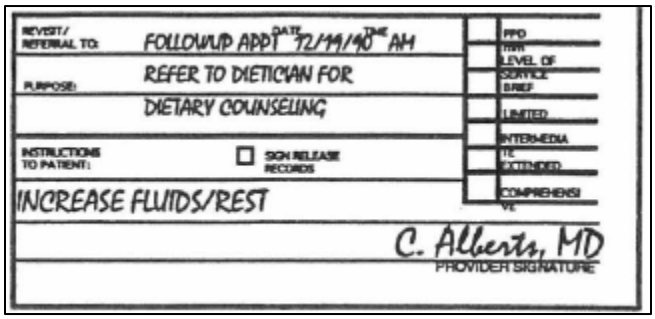


Figure 2-27: Revisit or Referral

2.2.15 Provider Signature

This form is the legal record of services provided and, as such, must be signed by the primary provider of care.

2.2.16 Excuse from School or Work

The bottom part of the yellow copies are perforated and may be torn off and given to the patient as an appointment slip, or as an excuse from school or work, which is printed on the back of the form (Figure 2-28).

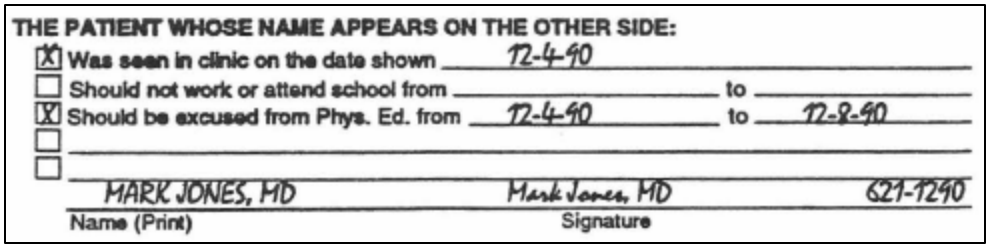

THE PATIENT WHOSE NAME APPEARS ON THE OTHER SIDE:
☒ Was seen in clinic on the date shown 12-4-90
☐ Should not work or attend school from _____ to _____
☒ Should be excused from Phys. Ed. from 12-4-90 to 12-8-90
☐ _____
☐ _____
MARK JONES, MD — Mark Jones, MD — 621-1290
Name (Print) — Signature

Figure 2-28: Excuse from School or Work

3.0 Other Encounter Forms

This section describes the use of, and provides instructions for, other encounter forms used for entry of data into PCC. All of the forms that are titled as PCC forms follow the same reporting instructions and conventions as those described in Section 2.0 of this manual pertaining to PCC Ambulatory Encounter Record. All providers should be well-versed in those instructions before utilizing these other PCC Forms. For the non-PCC forms described in this section, the data entry staff will be entering basic PCC data and not necessarily all data contained on the form.

3.1 PCC Brief Visit Record

The Brief Visit Record (Figure 3-1) may be used in place of the Ambulatory Encounter Record for visits that require limited documentation such as a follow-up wound care examination. In these cases, fully document the initial visit using the Ambulatory Encounter Record. Following the initial visit, the provider shall notify health information personnel to initiate a Brief Visit Record for subsequent visits for the follow- up care for the given diagnosis.

For those items that appear on both the Brief Visit Record and the Ambulatory Encounter Record, follow the instructions for PCC Ambulatory Encounter Record. Record the visit date, provider signature, and provider code for ***each*** visit reported on this form.

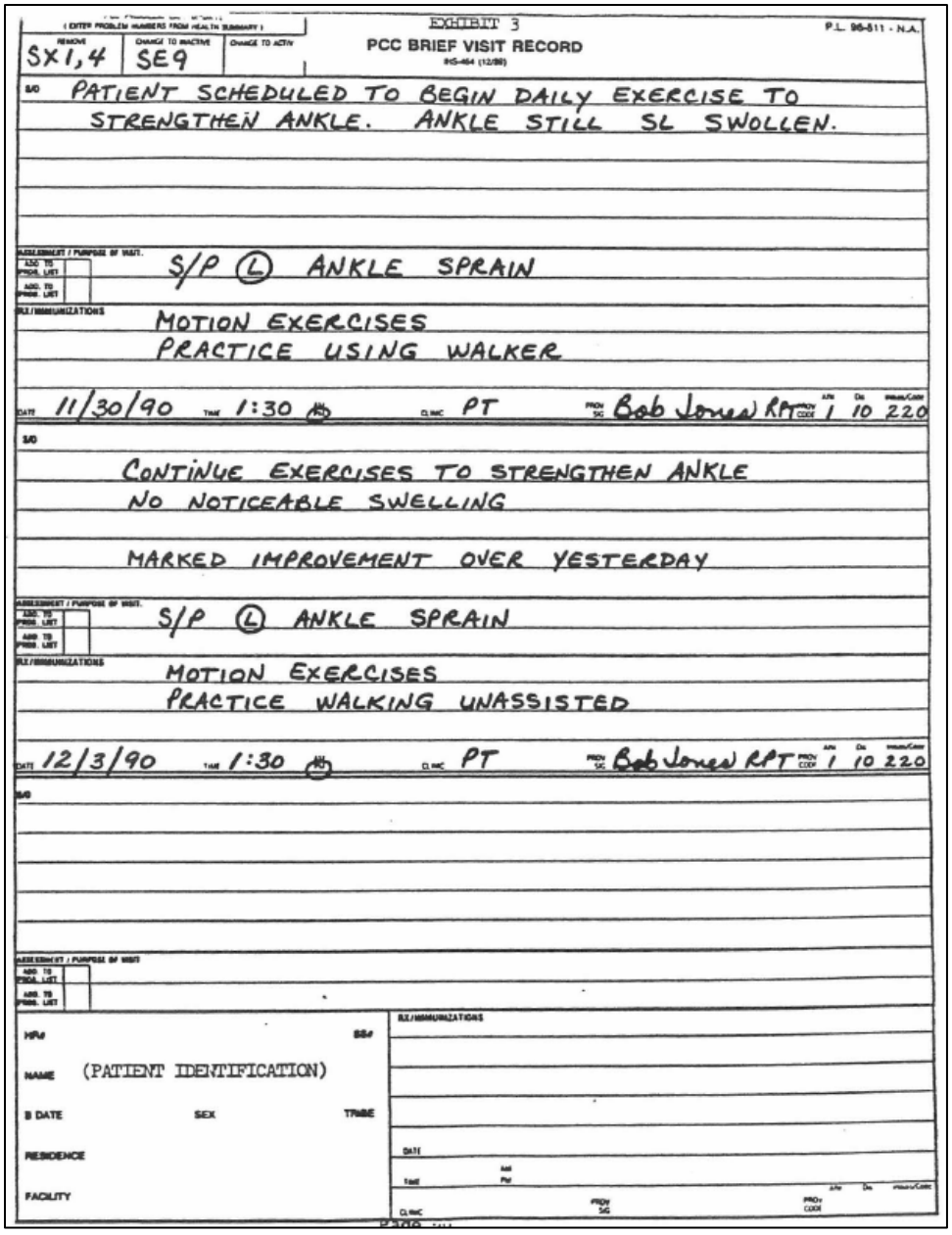


EXHIBIT 3

PCC BRIEF VISIT RECORD

P.L. 96-511 - N.A.

(ENTER PROBLEM NUMBERS FROM HEALTH SUMMARY) | REMOVE: SX1,4 | CHANGE TO INACTIVE: SE9 | CHANGE TO ACTIV:

S/O PATIENT SCHEDULED TO BEGIN DAILY EXERCISE TO STRENGTHEN ANKLE. ANKLE STILL SL SWOLLEN.

ASSESSMENT / PURPOSE OF VISIT: S/P (L) ANKLE SPRAIN

ADD TO PROB. LIST

ADD TO PROB. LIST

RX/IMMUNIZATIONS: MOTION EXERCISES
PRACTICE USING WALKER

DATE 11/30/90 TIME 1:30 (H) CLINIC PT PROV SIG Bob Jones RPT PROV CODE 1 10 220

S/O CONTINUE EXERCISES TO STRENGTHEN ANKLE
NO NOTICEABLE SWELLING

MARKED IMPROVEMENT OVER YESTERDAY

ASSESSMENT / PURPOSE OF VISIT: S/P (L) ANKLE SPRAIN

ADD TO PROB. LIST

ADD TO PROB. LIST

RX/IMMUNIZATIONS: MOTION EXERCISES
PRACTICE WALKING UNASSISTED

DATE 12/3/90 TIME 1:30 (H) CLINIC PT PROV SIG Bob Jones RPT PROV CODE 1 10 220

S/O

ASSESSMENT / PURPOSE OF VISIT

ADD TO PROB. LIST

ADD TO PROB. LIST

HRN BSN

NAME (PATIENT IDENTIFICATION)

B DATE SEX TRIBE

RESIDENCE

FACILITY

RX/IMMUNIZATIONS

DATE

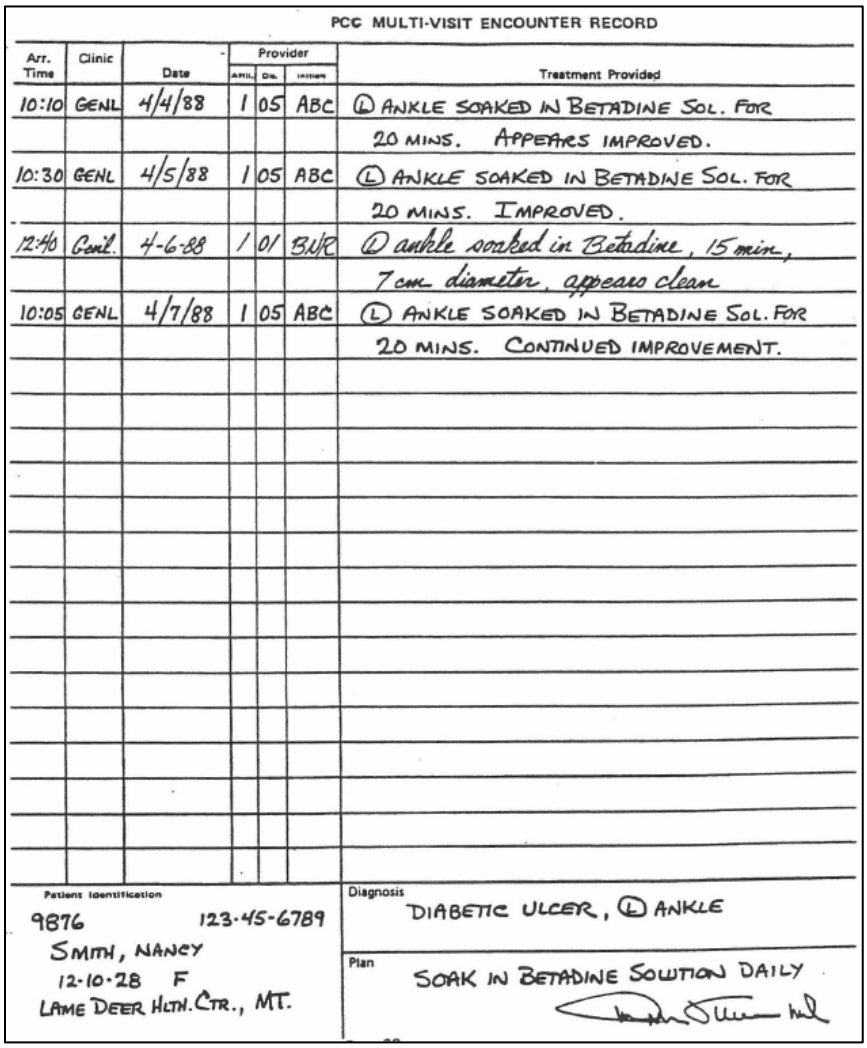
TIME AM PM

CLINIC PROV SIG PROV CODE

Figure 3-1: PCC Brief Visit Record

3.2 PCC Multi-Visit Record

The Multi-Visit Encounter Record is used for patients being treated with high frequency (two or three visits per week) for a specific health problem. Examples of such visits include physical therapy, allergy shots, foot soaks, and dressing changes.



PCC MULTI-VISIT ENCOUNTER RECORD

Apt. Time	Clinic	Date	Provider			Treatment Provided
			APPT.	DIA.	INITIALS	
10:10	GENL	4/4/88	1	05	ABC	(L) ANKLE SOAKED IN BETADINE SOL. FOR 20 MINS. APPEARS IMPROVED.
10:30	GENL	4/5/88	1	05	ABC	(L) ANKLE SOAKED IN BETADINE SOL. FOR 20 MINS. IMPROVED.
12:40	Genl.	4-6-88	1	01	BJR	(L) ankle soaked in Betadine, 15 min., 7 cm diameter, appears clean
10:05	GENL	4/7/88	1	05	ABC	(L) ANKLE SOAKED IN BETADINE SOL. FOR 20 MINS. CONTINUED IMPROVEMENT.

Patient Identification
9876 123-45-6789
SMITH, NANCY
12-10-28 F
LAME DEER HLTH. CTR., MT.

Diagnosis: DIABETIC ULCER, (L) ANKLE

Plan: SOAK IN BETADINE SOLUTION DAILY

Figure 3-2: PCC Multi-Visit Record

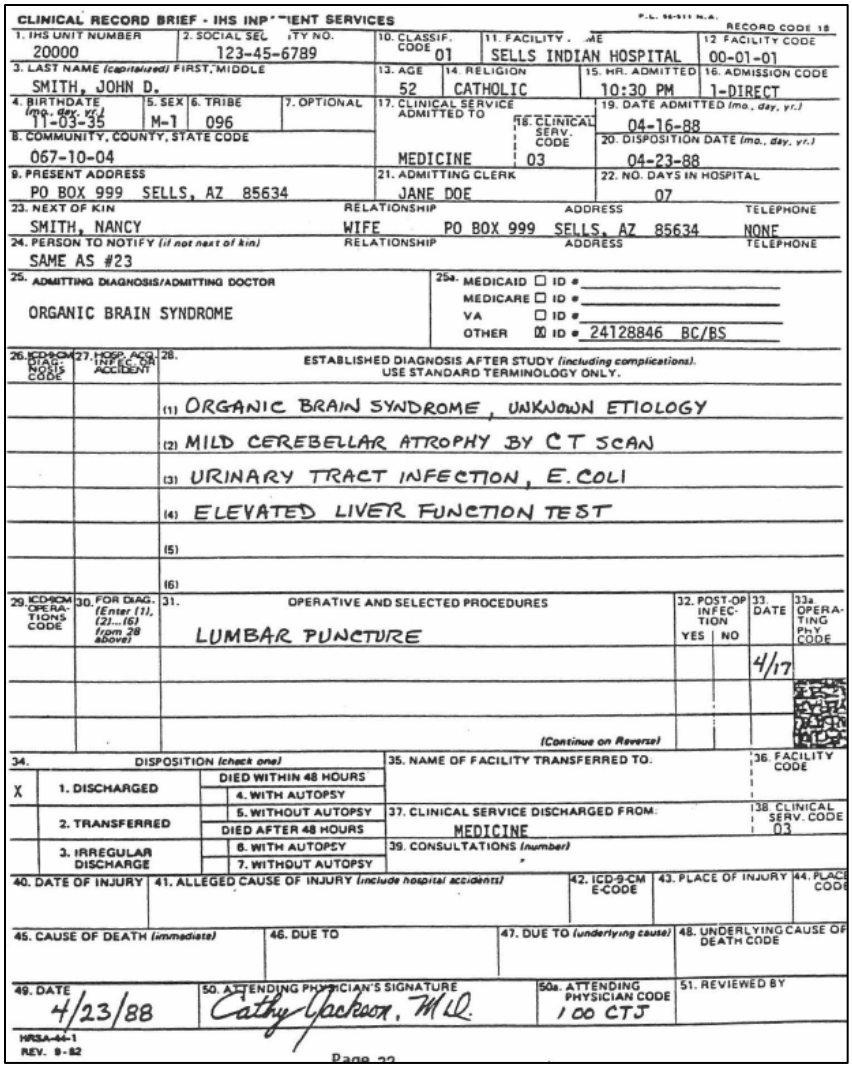
In such cases, fully document the initial visit for the problem on a standard Encounter Record. Following the initial visit, the provider shall notify health information personnel to initiate a Multi-Visit Encounter Record for subsequent visits. All visits recorded on this form will be individually entered into PCC. Specific instructions for the Multi-Visit Encounter Record are as follows:

- **Patient Identification**. This information is either stamped on the form using the patient's plastic ID card or recorded manually. The required information consists of patient ID number, name, sex, birthdate, and facility name.

- **Diagnosis and Plan**. Record these items the first time the form is used. During subsequent visits, there are no additions or changes to the diagnosis or plan. Such additions or changes require a new initial PCC Ambulatory Encounter Record.
- **Arrival Time and Clinic Code**. Record these items in the appropriate column each time the patient is treated.
- **Date, Provider Code, and Treatment Provided**. Record these items for each visit. The **Treatment Provided** area may be used for progress notes and to document the specific service provided. The provider's signature should be recorded in the treatment section for each visit.

3.3 Clinical Record Brief - IHS Inpatient Services

Complete Clinical Record Brief (Figure 3-3) for each hospital discharge according to the instructions contained in the IHS Standard Code Book. The form is printed when the patient is admitted to a hospital via the Admission/Discharge/Transfer (ADT) module and discharge data, such as discharge diagnosis or procedures, are entered into the ADT module when the patient is discharged, transferred, or expires.



CLINICAL RECORD BRIEF - IHS INPATIENT SERVICES

RECORD CODE 18

1. IHS UNIT NUMBER	2. SOCIAL SECURITY NO.	10. CLASSIF. CODE	11. FACILITY NAME	12 FACILITY CODE
20000	123-45-6789	01	SELLS INDIAN HOSPITAL	00-01-01

3. LAST NAME (capitalized) FIRST, MIDDLE	13. AGE	14. RELIGION	15. HR. ADMITTED	16. ADMISSION CODE
SMITH, JOHN D.	52	CATHOLIC	10:30 PM	1-DIRECT

4. BIRTHDATE (mo., day, yr.)	5. SEX	6. TRIBE	7. OPTIONAL	17. CLINICAL SERVICE ADMITTED TO	18. CLINICAL SERV. CODE	19. DATE ADMITTED (mo., day, yr.)
11-03-35	M-1	096		MEDICINE	03	04-16-88

8. COMMUNITY, COUNTY, STATE CODE	20. DISPOSITION DATE (mo., day, yr.)
067-10-04	04-23-88

9. PRESENT ADDRESS	21. ADMITTING CLERK	22. NO. DAYS IN HOSPITAL
PO BOX 999 SELLS, AZ 85634	JANE DOE	07

23. NEXT OF KIN	RELATIONSHIP	ADDRESS	TELEPHONE
SMITH, NANCY	WIFE	PO BOX 999 SELLS, AZ 85634	NONE

24. PERSON TO NOTIFY (if not next of kin)	RELATIONSHIP	ADDRESS	TELEPHONE
SAME AS #23			

25. ADMITTING DIAGNOSIS/ADMITTING DOCTOR: ORGANIC BRAIN SYNDROME

25a. MEDICAID ☐ ID # _____
MEDICARE ☐ ID # _____
VA ☐ ID # _____
OTHER ☒ ID # 24128846 BC/BS

26. ICD-9-CM DIAGNOSIS CODE	27. HOSP. ACQ. INFEC. OR ACCIDENT	28. ESTABLISHED DIAGNOSIS AFTER STUDY (including complications). USE STANDARD TERMINOLOGY ONLY.
		(1) ORGANIC BRAIN SYNDROME, UNKNOWN ETIOLOGY
		(2) MILD CEREBELLAR ATROPHY BY CT SCAN
		(3) URINARY TRACT INFECTION, E. COLI
		(4) ELEVATED LIVER FUNCTION TEST
		(5)
		(6)

29. ICD-9-CM OPERATIONS CODE	30. FOR DIAG. (Enter (1), (2)...(6) from 28 above)	31. OPERATIVE AND SELECTED PROCEDURES	32. POST-OP INFECTION YES	32. POST-OP INFECTION NO	33. DATE	33a OPERATING PhY CODE
		LUMBAR PUNCTURE			4/17	
		(Continue on Reverse)				

34. DISPOSITION (check one)

X	1. DISCHARGED	DIED WITHIN 48 HOURS	4. WITH AUTOPSY
			5. WITHOUT AUTOPSY
	2. TRANSFERRED	DIED AFTER 48 HOURS	6. WITH AUTOPSY
	3. IRREGULAR DISCHARGE		7. WITHOUT AUTOPSY

35. NAME OF FACILITY TRANSFERRED TO:

36. FACILITY CODE

37. CLINICAL SERVICE DISCHARGED FROM: MEDICINE

38. CLINICAL SERV. CODE 03

39. CONSULTATIONS (number)

40. DATE OF INJURY	41. ALLEGED CAUSE OF INJURY (include hospital accidents)	42. ICD-9-CM E-CODE	43. PLACE OF INJURY	44. PLACE CODE

45. CAUSE OF DEATH (immediate)	46. DUE TO	47. DUE TO (underlying cause)	48. UNDERLYING CAUSE OF DEATH CODE

49. DATE	50. ATTENDING PHYSICIAN'S SIGNATURE	50a. ATTENDING PHYSICIAN CODE	51. REVIEWED BY
4/23/88	Cathy Jackson, MD	100 CTJ	

HRSA-44-1
REV. 9-82

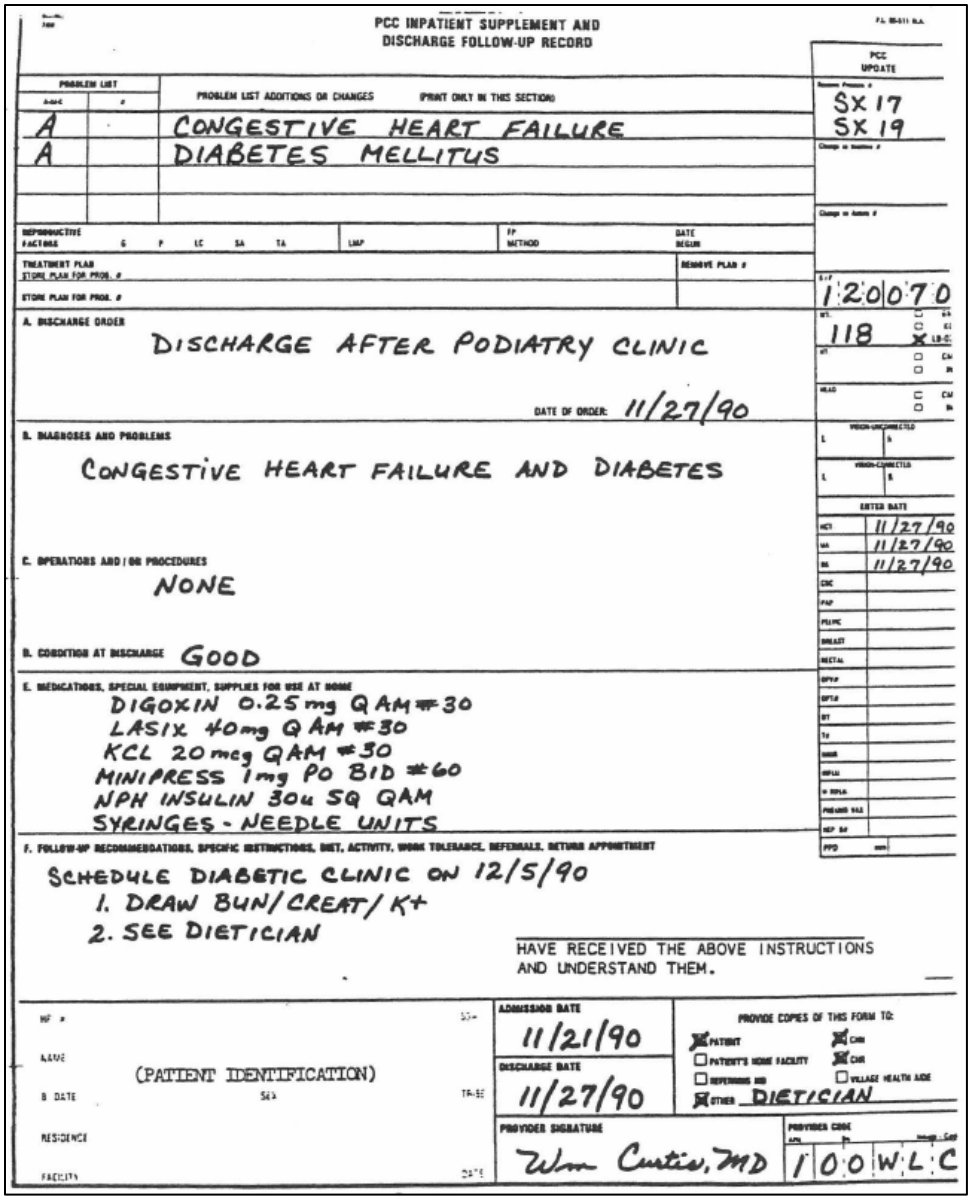
Page 22

Figure 3-3: Clinical Record Brief - IHS Inpatient Services

3.4 PCC Inpatient Supplement and Discharge Follow-Up Record

Use the Inpatient Supplement and Discharge Follow-Up Record to enter information into PCC that is not included on the Clinical Record Brief such as immunizations, discharge medications, treatment plans, and Problem List modifications. Use this form as any of the following:

- A referral form to other providers of service
- A patient appointment and instruction form
- As a patient excuse from work, school, etc.



PCC INPATIENT SUPPLEMENT AND
DISCHARGE FOLLOW-UP RECORD

PCC UPDATE

PROBLEM LIST

PROBLEM LIST ADDITIONS OR CHANGES (PRINT ONLY IN THIS SECTION)

A CONGESTIVE HEART FAILURE
A DIABETES MELLITUS

SX 17
SX 19

REPRODUCTIVE FACTORS G P LC SA TA | LMP | FP METHOD | DATE BEGUN

TREATMENT PLAN
STORE PLAN FOR PROB. #
REMOVE PLAN #
STORE PLAN FOR PROB. #

120070

A. DISCHARGE ORDER
DISCHARGE AFTER PODIATRY CLINIC

DATE OF ORDER: 11/27/90

WT. 118 LBS

B. DIAGNOSES AND PROBLEMS
CONGESTIVE HEART FAILURE AND DIABETES

C. OPERATIONS AND / OR PROCEDURES
NONE

D. CONDITION AT DISCHARGE GOOD

E. MEDICATIONS, SPECIAL EQUIPMENT, SUPPLIES FOR USE AT HOME
DIGOXIN 0.25 mg QAM #30
LASIX 40mg QAM #30
KCL 20 meq QAM #30
MINIPRESS 1mg PO BID #60
NPH INSULIN 30u SQ QAM
SYRINGES - NEEDLE UNITS

ENTER DATE
HCT 11/27/90
HB 11/27/90
PLT 11/27/90

F. FOLLOW-UP RECOMMENDATIONS, SPECIFIC INSTRUCTIONS, DIET, ACTIVITY, WORK TOLERANCE, REFERRALS, RETURN APPOINTMENT
SCHEDULE DIABETIC CLINIC ON 12/5/90
1. DRAW BUN/CREAT/K+
2. SEE DIETICIAN

HAVE RECEIVED THE ABOVE INSTRUCTIONS AND UNDERSTAND THEM.

(PATIENT IDENTIFICATION)

ADMISSION DATE 11/21/90
DISCHARGE DATE 11/27/90

PROVIDE COPIES OF THIS FORM TO:
X PATIENT X CHN
PATIENT'S HOME FACILITY X CHR
REFERRING MD VILLAGE HEALTH AIDE
X OTHER DIETICIAN

PROVIDER SIGNATURE Wm Curtis, MD
PROVIDER CODE 100WLC

Figure 3-4: PCC Inpatient Supplement and Discharge Follow-Up Record

The Inpatient Supplement Record is not required for every discharge. Its use should be highly encouraged to assure prompt updating of the Problem List and other entries on the Health Summary. It is completed as needs dictate according to the previously-outlined uses, or for any other Service Unit-defined needs. When used, there are no required data items. For those data items recorded, the instructions for the Inpatient Supplement Record are identical to those for the Ambulatory Encounter Record.

Inasmuch as providers enter immunizations, discharge medications, treatment plans, and Problem List modifications via the EHR, sites may not be using this form.

3.5 PCC Group Preventive Services Record

Use the Group Preventive Services record (Appendix A:) for entering into PCC various surveillance procedures usually performed in group settings (e.g., school, senior program, etc.).

IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 96-511 N.A.

DATE: MM/DD/YY

LOCATION	PROVIDER CODE Affil.	Dis.	Initials/Code	PROVIDER CODE Affil.	Dis.	Initials/Code	SERVICES PROVIDED
SCHOOL	1	13	JKD	1	05	MFJ	DPT AND PPD READINGS For DEMO HEADSTART

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE	
	TT-30 AT			1M	ST
SMITH, JOE	S	M	123-45-6789	DPT	00
JONES, ROBERT	S	M	123-41-9876		00
BROWN, MARY	S	F	FBC-12-3456	DPT	00
WHITE, JOHN	S	M	723		10
MARTIN, EDWARD	S	M	444-11-2200		00
BUTLER, ELLEN	S	F	17912	DPT	04
POTTER, SUSAN	S	F	222-15-1111		00
DOLAN, RICHARD	S	M	FDE-14-2678		00
KRAUSS, WILLIAM	S	M	987-65-4311		00

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE: Jane Doe, CHN

Figure 3-5: Completed Group Preventive Services Record

If skin test, height, weight, or blood pressure are done in a group setting, the provider may record the service provided below the SERVICES PROVIDED field as illustrated in Figure 3-5.

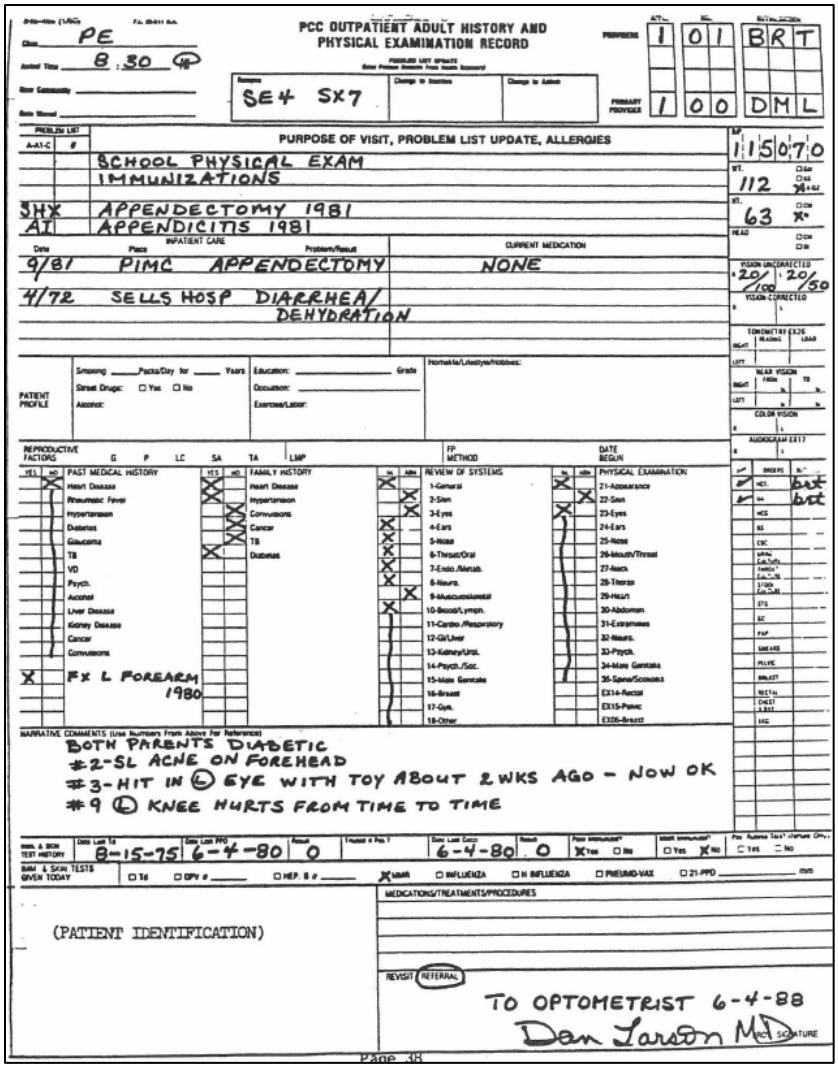
Field health personnel typically initiate this form. When completed, forward the pink copy to the local PCC data entry staff. The service provider should retain the white copy (original) for filing or for use in documenting the services performed in individual records as appropriate. An individual computer generated encounter form may be printed for each visit upon data entry into the Patient Care Component. Specific instructions for this form are as follows:

- **Date, Location Code/Name, and Provider Code**. Self-explanatory.
- **Services Provided**. This section is for the recording of a specific description of services provided (i.e., **Preschool Exams and OPV for Santa Rosa School**).
- **Name, Sex, and ID Number**. Enter the patient's name, sex (M or F), and health record number.
- **Activity Time (AT) and Travel Time (TT** – optional) is required when the Community Health Nurse is the primary or secondary Service Provider. This may be recorded in the Name section. AT is recorded for each individual and TT is recorded only once on the form.
- **Immunizations**. Enter the immunization code (from the lower left corner of the form) and series number (1, 2, 3, 4, 5, 6; do not use B for booster). Recording the series is not necessary.
- **Skin Tests**. Enter skin test results in millimeters of induration when the test is read. No recording is necessary for tests when given.
- **Laboratory Test Results**. Enter hematocrit and/or hemoglobin results in 3-digit numeric values (e.g., 14.7).
- **Examinations**. Make a check mark when hearing or vision screening tests are done.
- **Provider Signature**. Self-explanatory.

3.6 PCC Adult History and Physical Examination Record

Use the Adult History and Physical Examination Record to record a history and physical exam while capturing selected data for entry into PCC. The form contains one blank continuation form; you may add as many more as necessary.

Only the basic PCC data items that are usually entered on the standard Ambulatory Encounter Record will be entered into PCC from this form. Instructions for recording data on this form are identical to those for the Ambulatory Encounter Record.


PCC OUTPATIENT ADULT HISTORY AND PHYSICAL EXAMINATION RECORD

PE

8:30

SE4 SX7

PURPOSE OF VISIT, PROBLEM LIST UPDATE, ALLERGIES

SCHOOL PHYSICAL EXAM
IMMUNIZATIONS

SHX APPENDECTOMY 1981
AI APPENDICITIS 1981

Date	Place	Problem/Result	CURRENT MEDICATION
9/81	PIMC	APPENDECTOMY	NONE
4/72	SELLS HOSP	DIARRHEA/ DEHYDRATION	

PAST MEDICAL HISTORY: Fx L Forearm 1980

FAMILY HISTORY: Tb

NARRATIVE COMMENTS
BOTH PARENTS DIABETIC
#2-SL ACNE ON FOREHEAD
#3-HIT IN (L) EYE WITH TOY ABOUT 2 WKS AGO - NOW OK
#9 (L) KNEE HURTS FROM TIME TO TIME

8-15-75 | 6-4-80 | 0 | 6-4-80 | 0

(PATIENT IDENTIFICATION)

MEDICATIONS/TREATMENTS/PROCEDURES

REVISIT (REFERRAL)

TO OPTOMETRIST 6-4-88

Dan Larson MD

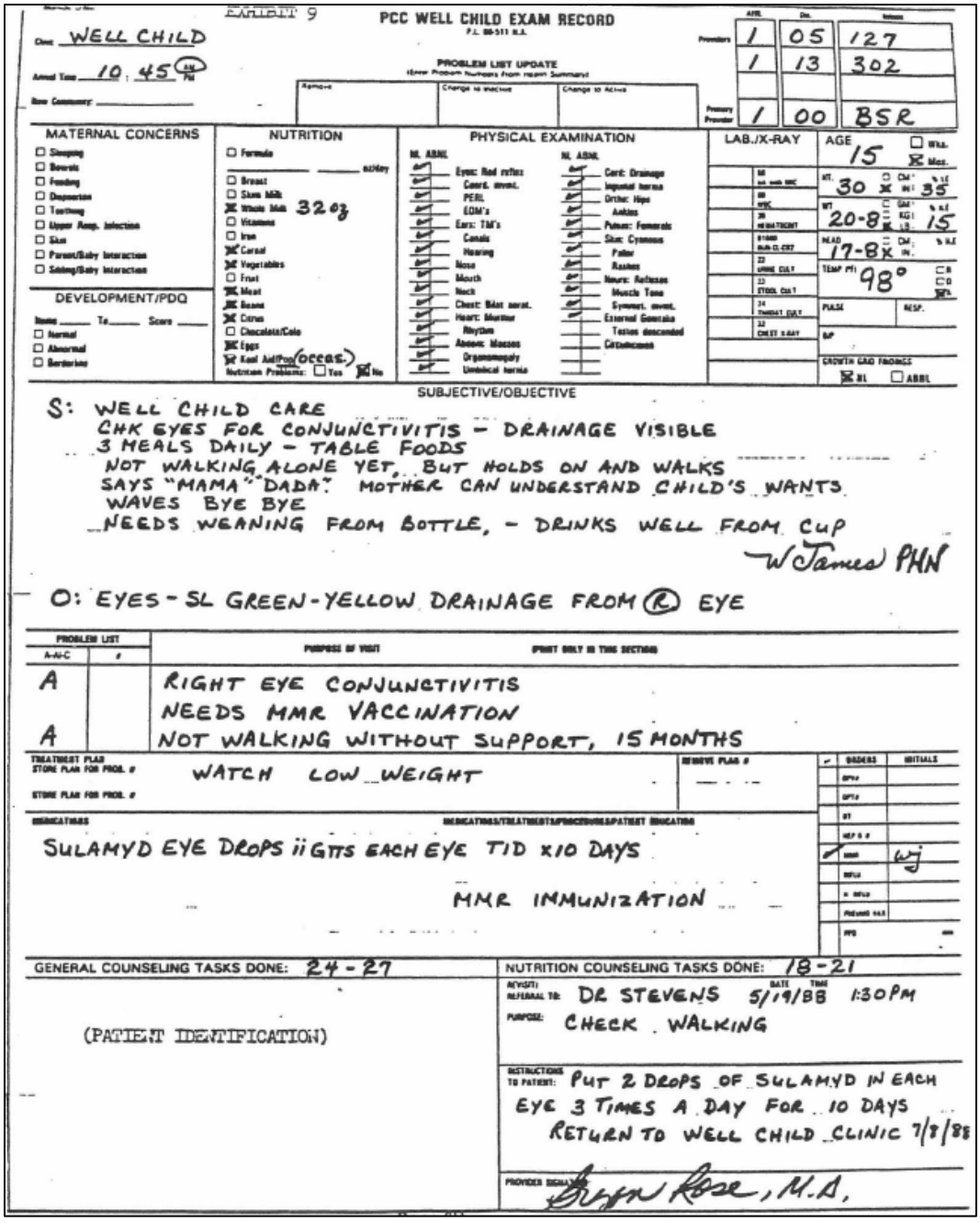
Page 3R

Figure 3-6: PCC Adult History and Physical Examination Record

3.7 PCC Well Child Exam Record

The Well Child Exam Record is designed to assist providers in carrying out a well-child exam while capturing selected data for entry into PCC.

Only the basic PCC data items usually entered on the standard Ambulatory Encounter Record will be entered into PCC from this form. Instructions for recording data on this form are identical to those for the Ambulatory Encounter Record (see Section 2.0).



PATIENT 9

PCC WELL CHILD EXAM RECORD

Client: WELL CHILD
Arrival Time: 10:45 AM
New Community:

PROBLEM LIST UPDATE

Remove	Change to Inactive	Change to Active

Providers			
	1	05	127
	1	13	302
Primary Provider	1	00	BSR

MATERNAL CONCERNS
☐ Sleeping
☐ Bowels
☐ Feeding
☐ Dispersion
☐ Teething
☐ Upper Resp. Infection
☐ Skin
☐ Parent/Baby Interaction
☐ Sibling/Baby Interaction

DEVELOPMENT/PDQ
Name ____ Te____ Score ____
☐ Normal
☐ Abnormal
☐ Borderline

NUTRITION
☐ Formula ____ oz/day
☐ Breast
☐ Skim Milk
☒ Whole Milk 32oz
☐ Vitamins
☐ Iron
☒ Cereal
☒ Vegetables
☐ Fruit
☒ Meat
☒ Beans
☒ Citrus
☐ Chocolate/Cola
☒ Eggs
☒ Food Additives (occas.)
Nutrition Problems: ☐ Yes ☒ No

PHYSICAL EXAMINATION

N	ABN		N	ABN	
		Eyes: Red reflex			Cord: Drainage
		Coord. movmt.			Inguinal hernia
		PERL			Orthop: Hips
		EOM's			Ankles
		Ears: TM's			Pulses: Femorals
		Canals			Skin: Cyanosis
		Hearing			Pallor
		Nose			Rashes
		Mouth			Neuro: Reflexes
		Neck			Muscle Tone
		Chest: Bilat movmt.			Symmetr. movmt.
		Heart: Murmur			External Genitalia
		Rhythm			Testes descended
		Abdom: Masses			Circumcision
		Organomegaly			
		Umbilical hernia			

LAB./X-RAY

AGE 15 ☐ Wks. ☒ Mos.
HT. 30 CM IN 35
WT 20-8 GMS KGS LBS 15
HEAD 17-8 CM IN
TEMP (F) 98° ☐ R ☐ O ☐ AX
PULSE RESP.
BP
GROWTH CHD PROFILE ☒ NL ☐ ABNL

SUBJECTIVE/OBJECTIVE

S: WELL CHILD CARE
CHK EYES FOR CONJUNCTIVITIS - DRAINAGE VISIBLE
3 MEALS DAILY - TABLE FOODS
NOT WALKING ALONE YET, BUT HOLDS ON AND WALKS
SAYS "MAMA" "DADA" MOTHER CAN UNDERSTAND CHILD'S WANTS
WAVES BYE BYE
NEEDS WEANING FROM BOTTLE, - DRINKS WELL FROM CUP
W James PHN

O: EYES - SL GREEN-YELLOW DRAINAGE FROM (R) EYE

PROBLEM LIST A-A-C	#	PURPOSE OF VISIT (FIRST ONLY IN THIS SECTION)
A		RIGHT EYE CONJUNCTIVITIS
A		NEEDS MMR VACCINATION
A		NOT WALKING WITHOUT SUPPORT, 15 MONTHS

TREATMENT PLAN
STORE PLAN FOR PROB. #: WATCH LOW WEIGHT
STORE PLAN FOR PROB. #:
RESERVE PLAN #:

MEDICATIONS
MEDICATIONS/TREATMENTS/PROCEDURES/PATIENT EDUCATION
SULAMYD EYE DROPS ii GTTS EACH EYE TID x10 DAYS
MMR IMMUNIZATION

✓	DATE/HRS	INITIALS
	DPT#	
	DPT#	
	DT	
	HEP B #	
✓	MMR	WJ
	IPV#	
	H. INFLU	
	PNEUMO VAX	
	PPD	mm

GENERAL COUNSELING TASKS DONE: 24-27

(PATIENT IDENTIFICATION)

NUTRITION COUNSELING TASKS DONE: 18-21

(N)VISIT) REFERRAL TO: DR STEVENS DATE 5/19/88 TIME 1:30PM
PURPOSE: CHECK WALKING

INSTRUCTIONS TO PATIENT: PUT 2 DROPS OF SULAMYD IN EACH EYE 3 TIMES A DAY FOR 10 DAYS
RETURN TO WELL CHILD CLINIC 7/7/88

PROVIDER SIGNATURE: Bryan Rose, M.D.

Figure 3-7: **PCC Well Child Exam Record**

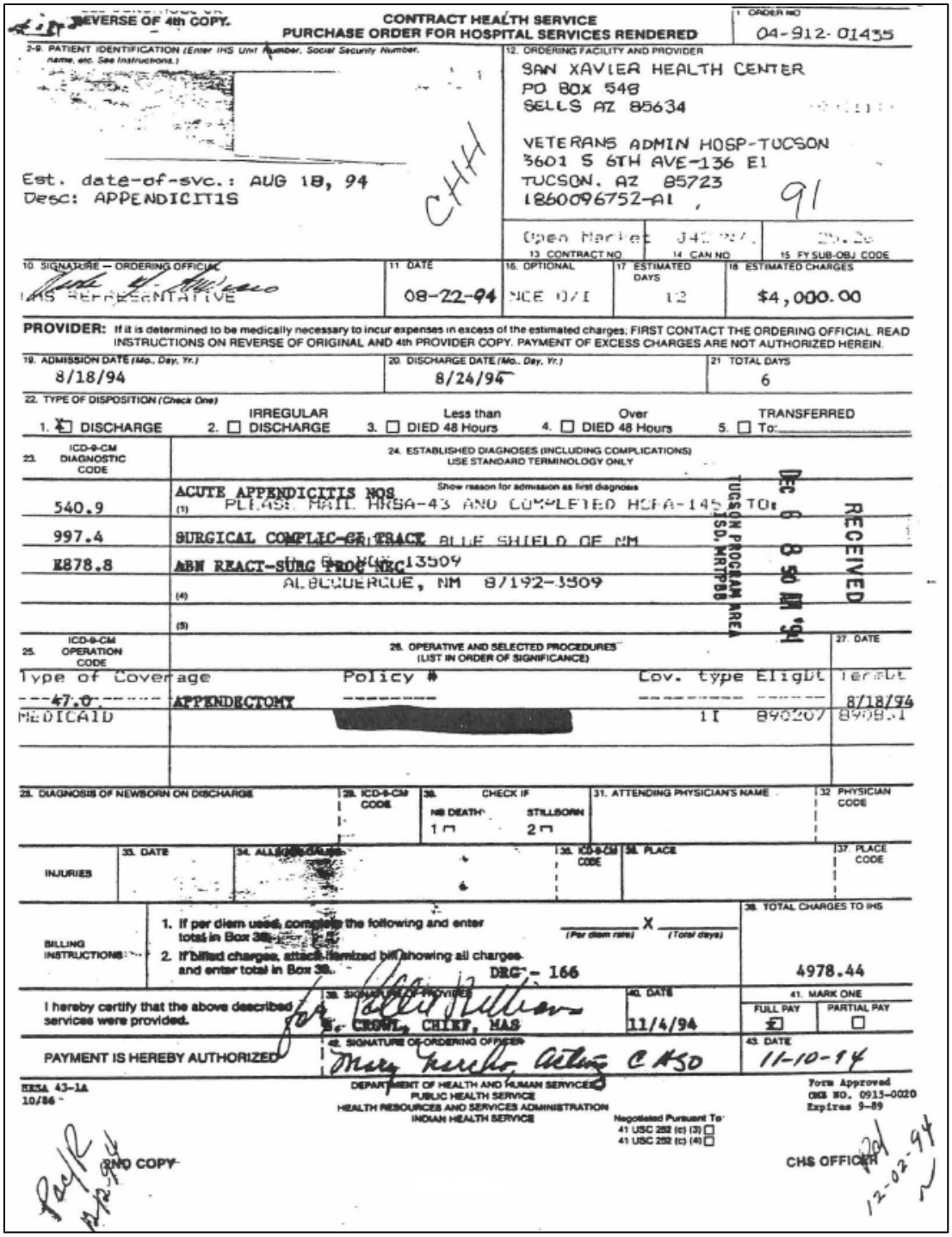
3.8 Contract Health Service Forms

The Contract Health Service (CHS) forms are created via the CHS module and sent to the contract provider/vendor. When the service is completed, the documents are returned either to a fiscal intermediary or directly to the facility where the CHS document is processed for payment. Once the payment is processed in the CHS module, the medical data and payment will cross-over into the PCC database if the

PCC Link is turned-on in the PCC Master Control File. However, if this process is not in place, then CHS forms may be manually entered via PCC data entry.

PCC data for contract health service hospitalizations and visits are entered from CHS billing documents that are completed by IHS CHS administrative staff and contract providers (vendors). The HRSA 43-lA and HRSA 64-1A forms are generated by the IHS CHS administrative staff and sent to the contract providers. The contract providers will either complete these forms or generate the Uniform Bill, UB-82, HCFA-1450 form, or the HCFA-1500 form and attach it to the appropriate HRSA forms.

The Contract Health Service Purchase Order for Hospital Services Rendered, HRSA 43-lA, is used when hospital services are provided at a contract care facility (Figure 3-8). Hospital information is entered from this form or from the UB-82 HCFA-1450 (Figure 3-9).



REVERSE OF 4th COPY.

CONTRACT HEALTH SERVICE
PURCHASE ORDER FOR HOSPITAL SERVICES RENDERED

1. ORDER NO: 04-912-01435

2-9. PATIENT IDENTIFICATION (Enter IHS Unit Number, Social Security Number, name, etc. See Instructions.)

Est. date-of-svc.: AUG 18, 94
Desc: APPENDICITIS

CHH

12. ORDERING FACILITY AND PROVIDER
SAN XAVIER HEALTH CENTER
PO BOX 548
SELLS AZ 85634

VETERANS ADMIN HOSP-TUCSON
3601 S 6TH AVE-136 E1
TUCSON, AZ 85723
1860096752-A1

91

13. CONTRACT NO: Open Market
14. CAN NO: J4[illegible]
15. FY SUB-OBJ CODE: 20.20

10. SIGNATURE — ORDERING OFFICIAL / IHS REPRESENTATIVE
11. DATE: 08-22-94
16. OPTIONAL: NCE 0/I
17. ESTIMATED DAYS: 12
18. ESTIMATED CHARGES: $4,000.00

PROVIDER: If it is determined to be medically necessary to incur expenses in excess of the estimated charges, FIRST CONTACT THE ORDERING OFFICIAL. READ INSTRUCTIONS ON REVERSE OF ORIGINAL AND 4th PROVIDER COPY. PAYMENT OF EXCESS CHARGES ARE NOT AUTHORIZED HEREIN.

19. ADMISSION DATE (Mo., Day, Yr.): 8/18/94
20. DISCHARGE DATE (Mo., Day, Yr.): 8/24/94
21. TOTAL DAYS: 6

22. TYPE OF DISPOSITION (Check One)
1. [X] DISCHARGE 2. [ ] IRREGULAR DISCHARGE 3. [ ] Less than DIED 48 Hours 4. [ ] Over DIED 48 Hours 5. [ ] TRANSFERRED To:

23. ICD-9-CM DIAGNOSTIC CODE	24. ESTABLISHED DIAGNOSES (INCLUDING COMPLICATIONS) USE STANDARD TERMINOLOGY ONLY. Show reason for admission as first diagnosis
540.9	(1) ACUTE APPENDICITIS NOS PLEASE MAIL HRSA-43 AND COMPLETED HCFA-1450 TO:
997.4	SURGICAL COMPLIC-GE TRACT BLUE SHIELD OF NM
E878.8	ABN REACT-SURG PROC NEC PO BOX 13509
	(4) ALBUQUERQUE, NM 87192-3509
	(5)

TUCSON PROGRAM AREA
DEC 6 8 50 AM '94
RECEIVED

25. ICD-9-CM OPERATION CODE	26. OPERATIVE AND SELECTED PROCEDURES (LIST IN ORDER OF SIGNIFICANCE)	27. DATE
Type of Coverage	Policy #	Cov. type Eligbl Termbt
47.0	APPENDECTOMY	8/18/94
MEDICAID	[redacted]	11 890207 8908.1

28. DIAGNOSIS OF NEWBORN ON DISCHARGE	29. ICD-9-CM CODE	30. CHECK IF NB DEATH 1 ☐ STILLBORN 2 ☐	31. ATTENDING PHYSICIAN'S NAME	32. PHYSICIAN CODE

INJURIES	33. DATE	34. [illegible]	35. ICD-9-CM CODE	36. PLACE	37. PLACE CODE

BILLING INSTRUCTIONS:
1. If per diem used, complete the following and enter total in Box 38. ____ (Per diem rate) X ____ (Total days)
2. If billed charges, attach itemized bill showing all charges and enter total in Box 38. DRG - 166

38. TOTAL CHARGES TO IHS: 4978.44

I hereby certify that the above described services were provided.
39. SIGNATURE OF PROVIDER: for [illegible] C. CROWL, CHIEF, MAS
40. DATE: 11/4/94
41. MARK ONE: FULL PAY ☑ PARTIAL PAY ☐

PAYMENT IS HEREBY AUTHORIZED
42. SIGNATURE OF ORDERING OFFICER: Mary Lucero Acting CASO
43. DATE: 11-10-94

HRSA 43-1A
10/86

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
HEALTH RESOURCES AND SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

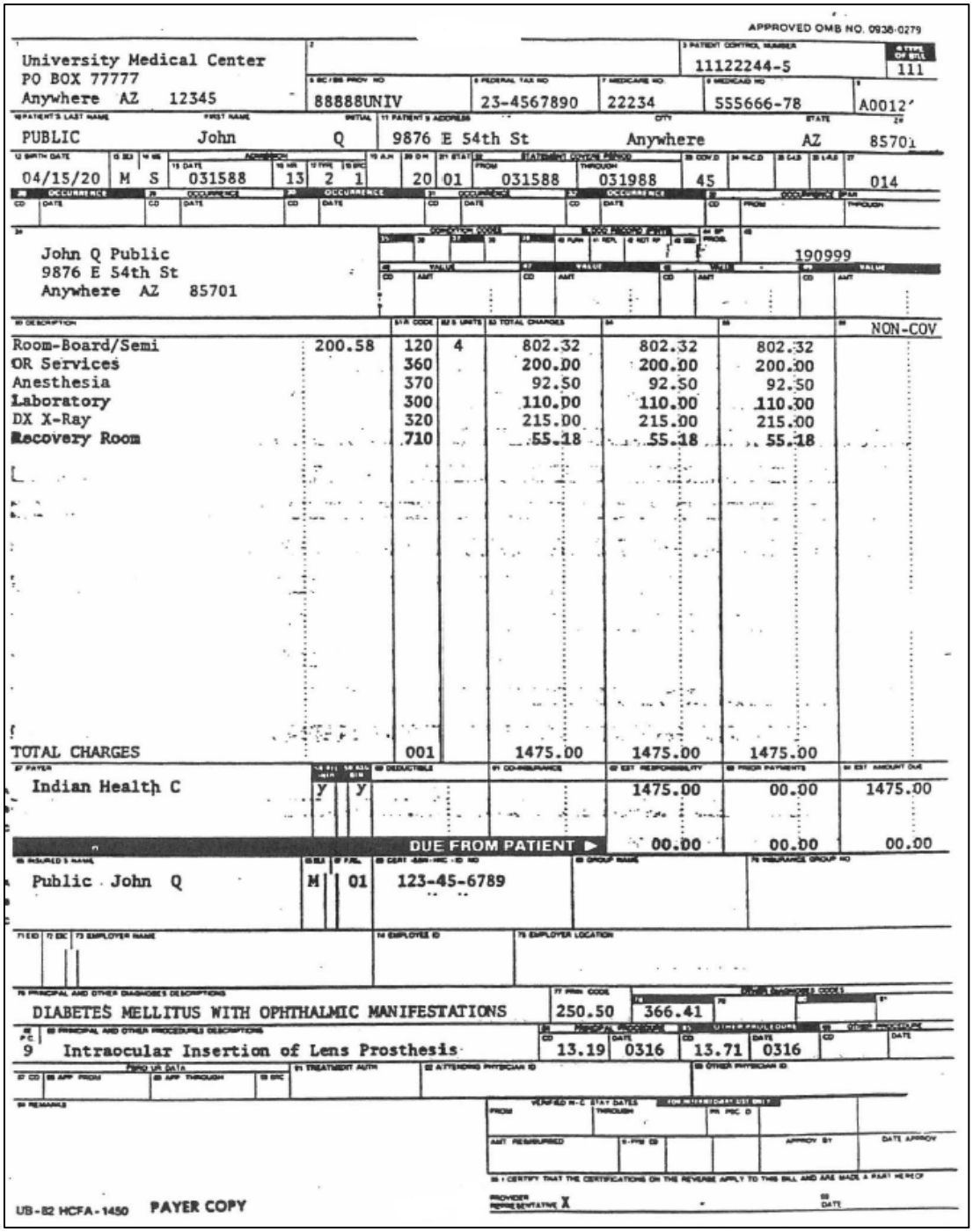
Negotiated Pursuant To:
41 USC 252 (c) (3) ☐
41 USC 252 (c) (4) ☐

Form Approved
OMB NO. 0915-0020
Expires 9-89

2ND COPY

CHS OFFICER 12-02-94

Figure 3-8: Contract Health Service Purchase Order for Hospital Services Rendered, HRSA 43-IA



APPROVED OMB NO. 0938-0279

University Medical Center
PO BOX 77777
Anywhere AZ 12345

11122244-5 | TYPE OF BILL 111

88888UNIV | 23-4567890 | 22234 | 555666-78 | A0012

PUBLIC John Q | 9876 E 54th St | Anywhere | AZ | 85701

04/15/20 | M | S | ADMISSION 031588 | 13 | 2 | 1 | 20 | 01 | STATEMENT COVERS PERIOD FROM 031588 THROUGH 031988 | 45 | 014

John Q Public
9876 E 54th St
Anywhere AZ 85701

190999

DESCRIPTION		REV CODE	UNITS	TOTAL CHARGES			NON-COV
Room-Board/Semi	200.58	120	4	802.32	802.32	802.32	
OR Services		360		200.00	200.00	200.00	
Anesthesia		370		92.50	92.50	92.50	
Laboratory		300		110.00	110.00	110.00	
DX X-Ray		320		215.00	215.00	215.00	
Recovery Room		710		55.18	55.18	55.18	
TOTAL CHARGES		001		1475.00	1475.00	1475.00	

PAYER			DEDUCTIBLE	CO-INSURANCE	EST RESPONSIBILITY	PRIOR PAYMENTS	EST AMOUNT DUE
Indian Health C	Y	Y			1475.00	00.00	1475.00
DUE FROM PATIENT ▶					00.00	00.00	00.00

Public John Q | M | 01 | 123-45-6789

DIABETES MELLITUS WITH OPHTHALMIC MANIFESTATIONS | 250.50 | 366.41

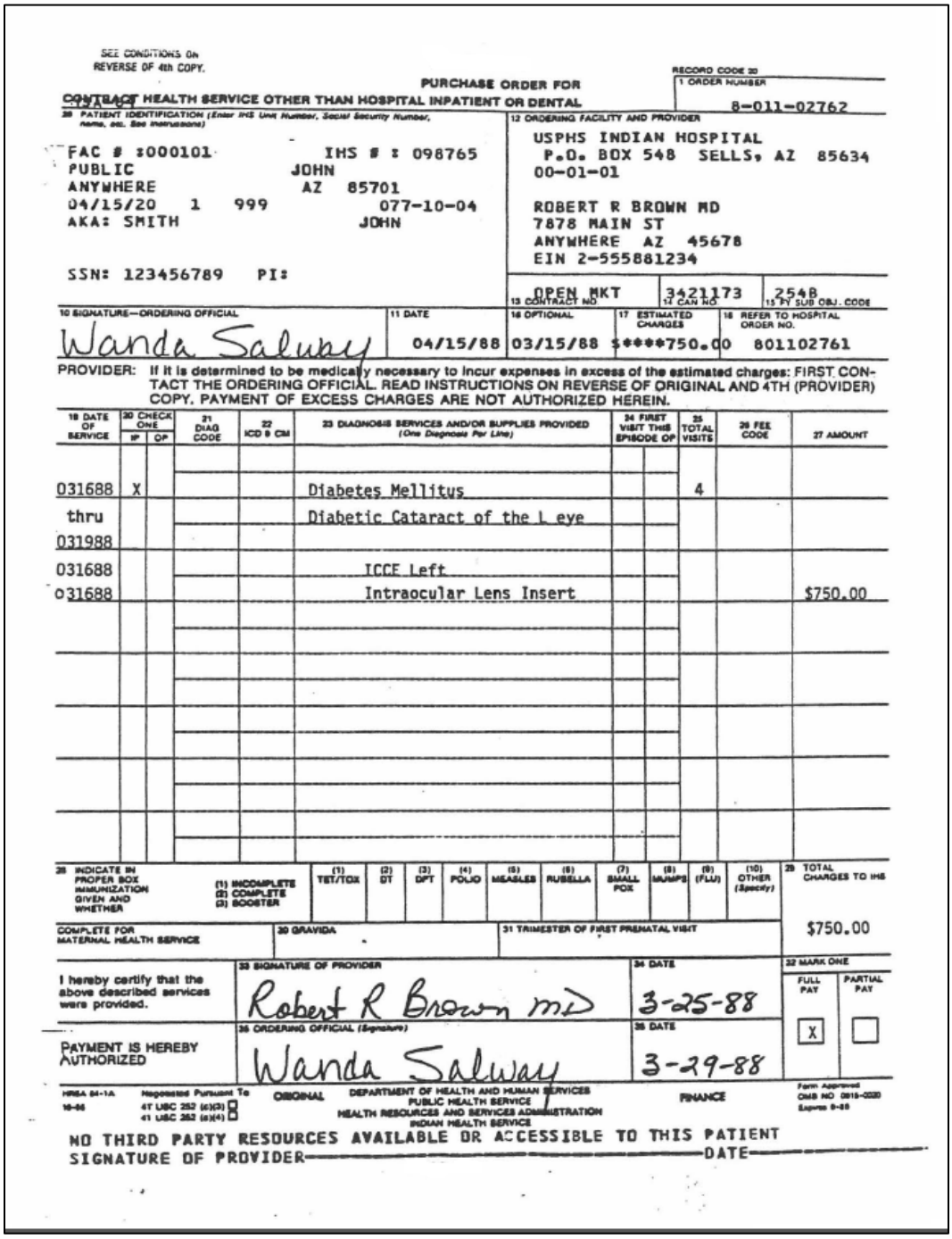
9 Intraocular Insertion of Lens Prosthesis | 13.19 | 0316 | 13.71 | 0316

UB-82 HCFA-1450 PAYER COPY

Figure 3-9: Uniform Bill, UB-82 HCFA-1450

Use the Purchase Order for Contract Health Service Other Than Hospital Inpatient or Dental, HRSA 64- lA, when physician's services are provided for either in-hospital visits (during a patient's hospitalization as in Figure 3-10) or office visits (Figure 3-11). Form HRSA 64-1A may also be used for other services, e.g., transportation (ambulance), pharmacy, laboratory/radiology, supplies. Information can also be

entered from the Health Insurance Claim Form HCFA-1500, for in-hospital visits (Figure 3-12) or office visits (Figure 3-13).



SEE CONDITIONS ON REVERSE OF 4th COPY.

PURCHASE ORDER FOR CONTRACT HEALTH SERVICE OTHER THAN HOSPITAL INPATIENT OR DENTAL

RECORD CODE 20 — 1 ORDER NUMBER: 8-011-02762

29 PATIENT IDENTIFICATION (Enter IHS Unit Number, Social Security Number, name, etc. See instructions)

FAC # :000101 IHS # : 098765
PUBLIC JOHN
ANYWHERE AZ 85701
04/15/20 1 999 077-10-04
AKA: SMITH JOHN

SSN: 123456789 PI:

12 ORDERING FACILITY AND PROVIDER

USPHS INDIAN HOSPITAL
P.O. BOX 548 SELLS, AZ 85634
00-01-01

ROBERT R BROWN MD
7878 MAIN ST
ANYWHERE AZ 45678
EIN 2-555881234

13 CONTRACT NO: OPEN MKT | 14 CAN NO: 3421173 | 15 PY SUB OBJ. CODE: 2548

10 SIGNATURE—ORDERING OFFICIAL	11 DATE	16 OPTIONAL	17 ESTIMATED CHARGES	18 REFER TO HOSPITAL ORDER NO.
Wanda Salway	04/15/88	03/15/88	$****750.00	801102761

PROVIDER: If it is determined to be medically necessary to incur expenses in excess of the estimated charges: FIRST CONTACT THE ORDERING OFFICIAL. READ INSTRUCTIONS ON REVERSE OF ORIGINAL AND 4TH (PROVIDER) COPY. PAYMENT OF EXCESS CHARGES ARE NOT AUTHORIZED HEREIN.

19 DATE OF SERVICE	20 CHECK ONE IP	20 CHECK ONE OP	21 DIAG CODE	22 ICD 9 CM	23 DIAGNOSIS SERVICES AND/OR SUPPLIES PROVIDED (One Diagnosis Per Line)	24 FIRST VISIT THIS EPISODE OF	25 TOTAL VISITS	26 FEE CODE	27 AMOUNT
031688	X				Diabetes Mellitus		4		
thru					Diabetic Cataract of the L eye				
031988									
031688					ICCE Left				
031688					Intraocular Lens Insert				$750.00

28 INDICATE IN PROPER BOX IMMUNIZATION GIVEN AND WHETHER (1) INCOMPLETE (2) COMPLETE (3) BOOSTER

(1) TET/TOX	(2) DT	(3) DPT	(4) POLIO	(5) MEASLES	(6) RUBELLA	(7) SMALL POX	(8) MUMPS	(9) (FLU)	(10) OTHER (Specify)

29 TOTAL CHARGES TO IHS: $750.00

COMPLETE FOR MATERNAL HEALTH SERVICE | 30 GRAVIDA | 31 TRIMESTER OF FIRST PRENATAL VISIT

I hereby certify that the above described services were provided.

33 SIGNATURE OF PROVIDER: Robert R Brown MD — 34 DATE: 3-25-88

PAYMENT IS HEREBY AUTHORIZED

35 ORDERING OFFICIAL (Signature): Wanda Salway — 36 DATE: 3-29-88

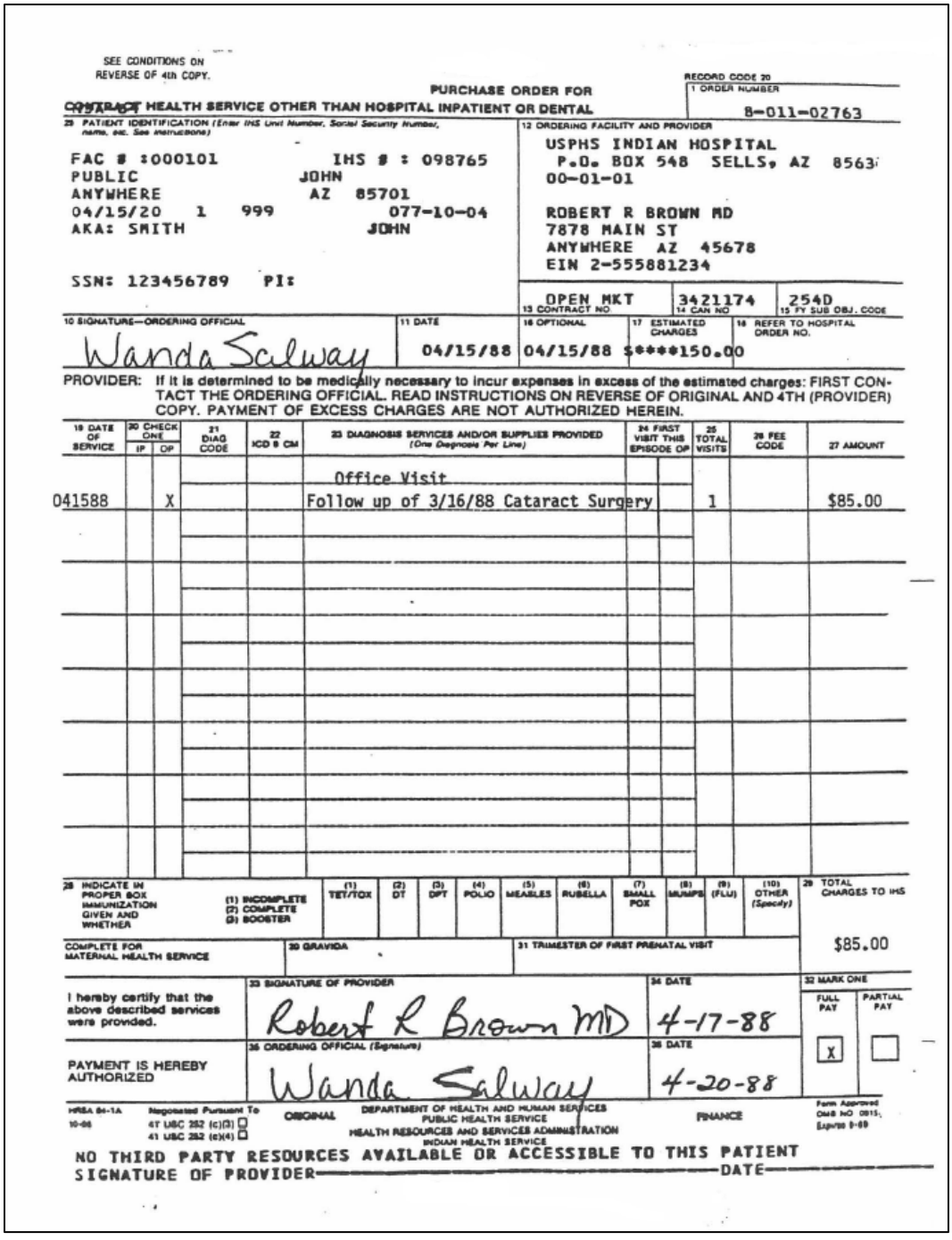
32 MARK ONE: FULL PAY [X] PARTIAL PAY [ ]

HRSA 64-1A 10-86 — Negotiated Pursuant To 41 USC 252 (c)(3) 41 USC 252 (c)(4) — ORIGINAL — DEPARTMENT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE, HEALTH RESOURCES AND SERVICES ADMINISTRATION, INDIAN HEALTH SERVICE — FINANCE — Form Approved OMB NO 0915-0020 Expires 9-88

NO THIRD PARTY RESOURCES AVAILABLE OR ACCESSIBLE TO THIS PATIENT

SIGNATURE OF PROVIDER——————DATE——————

Figure 3-10: Purchase Order for Contract Health Service Other Than Hospital Inpatient or Dental, HRSA 64-IA; In-Hospital Visit



SEE CONDITIONS ON REVERSE OF 4th COPY.

PURCHASE ORDER FOR CONTRACT HEALTH SERVICE OTHER THAN HOSPITAL INPATIENT OR DENTAL

RECORD CODE 20 | 1 ORDER NUMBER: 8-011-02763

29 PATIENT IDENTIFICATION (Enter IHS Unit Number, Social Security Number, name, etc. See instructions)

FAC # :000101 IHS # : 098765
PUBLIC JOHN
ANYWHERE AZ 85701
04/15/20 1 999 077-10-04
AKA: SMITH JOHN

SSN: 123456789 PI:

12 ORDERING FACILITY AND PROVIDER

USPHS INDIAN HOSPITAL
P.O. BOX 548 SELLS, AZ 8563
00-01-01

ROBERT R BROWN MD
7878 MAIN ST
ANYWHERE AZ 45678
EIN 2-555881234

13 CONTRACT NO: OPEN MKT | 14 CAN NO: 3421174 | 15 FY SUB OBJ. CODE: 254D

10 SIGNATURE—ORDERING OFFICIAL: Wanda Salway | 11 DATE: 04/15/88 | 16 OPTIONAL: 04/15/88 | 17 ESTIMATED CHARGES: $****150.00 | 18 REFER TO HOSPITAL ORDER NO.

PROVIDER: If it is determined to be medically necessary to incur expenses in excess of the estimated charges: FIRST CONTACT THE ORDERING OFFICIAL. READ INSTRUCTIONS ON REVERSE OF ORIGINAL AND 4TH (PROVIDER) COPY. PAYMENT OF EXCESS CHARGES ARE NOT AUTHORIZED HEREIN.

19 DATE OF SERVICE	20 CHECK ONE IP	20 CHECK ONE OP	21 DIAG CODE	22 ICD 9 CM	23 DIAGNOSIS SERVICES AND/OR SUPPLIES PROVIDED (One Diagnosis Per Line)	24 FIRST VISIT THIS EPISODE OF		25 TOTAL VISITS	26 FEE CODE	27 AMOUNT
					Office Visit					
041588		X			Follow up of 3/16/88 Cataract Surgery			1		$85.00

28 INDICATE IN PROPER BOX IMMUNIZATION GIVEN AND WHETHER (1) INCOMPLETE (2) COMPLETE (3) BOOSTER

(1) TET/TOX	(2) DT	(3) DPT	(4) POLIO	(5) MEASLES	(6) RUBELLA	(7) SMALL POX	(8) MUMPS	(9) FLU	(10) OTHER (Specify)

29 TOTAL CHARGES TO IHS: $85.00

COMPLETE FOR MATERNAL HEALTH SERVICE | 30 GRAVIDA | 31 TRIMESTER OF FIRST PRENATAL VISIT

I hereby certify that the above described services were provided.

33 SIGNATURE OF PROVIDER: Robert R Brown MD | 34 DATE: 4-17-88

32 MARK ONE: FULL PAY [X] | PARTIAL PAY [ ]

PAYMENT IS HEREBY AUTHORIZED

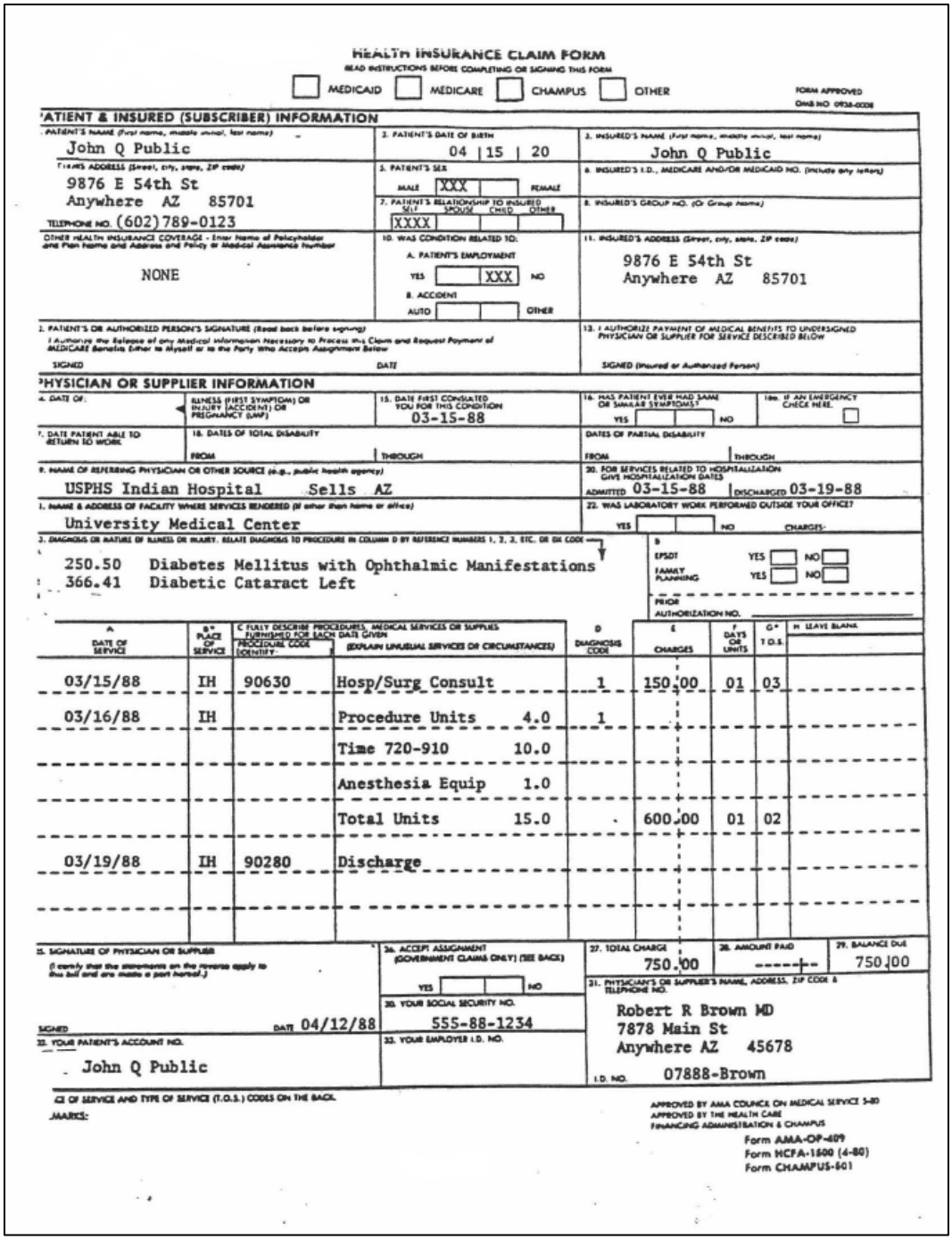
35 ORDERING OFFICIAL (Signature): Wanda Salway | 36 DATE: 4-20-88

HRSA 64-1A 10-86 | Negotiated Pursuant To 42 USC 252 (c)(3) ☐ 42 USC 252 (c)(4) ☐ | ORIGINAL | DEPARTMENT OF HEALTH AND HUMAN SERVICES PUBLIC HEALTH SERVICE HEALTH RESOURCES AND SERVICES ADMINISTRATION INDIAN HEALTH SERVICE | FINANCE | Form Approved OMB NO 0915; Expires 9-89

NO THIRD PARTY RESOURCES AVAILABLE OR ACCESSIBLE TO THIS PATIENT

SIGNATURE OF PROVIDER——————————DATE——————

Figure 3-11: Purchase Order for Contract Health Service Other Than Hospital Inpatient or Dental, HRSA 64- lA - Office Visits



HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

☐ MEDICAID ☐ MEDICARE ☐ CHAMPUS ☐ OTHER

FORM APPROVED OMB NO. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name): John Q Public	2. PATIENT'S DATE OF BIRTH: 04 | 15 | 20	3. INSURED'S NAME (First name, middle initial, last name): John Q Public
4. PATIENT'S ADDRESS (Street, city, state, ZIP code): 9876 E 54th St Anywhere AZ 85701 TELEPHONE NO. (602) 789-0123	5. PATIENT'S SEX: MALE XXX FEMALE ☐	6. INSURED'S I.D., MEDICARE AND/OR MEDICAID NO. (Include any letters):
	7. PATIENT'S RELATIONSHIP TO INSURED: SELF XXXX SPOUSE ☐ CHILD ☐ OTHER ☐	8. INSURED'S GROUP NO. (Or Group Name):
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number: NONE	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT: YES ☐ NO XXX; B. ACCIDENT: AUTO ☐ OTHER ☐	11. INSURED'S ADDRESS (Street, city, state, ZIP code): 9876 E 54th St Anywhere AZ 85701
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing): I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below. SIGNED: DATE:		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (Insured or Authorized Person):

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION: 03-15-88	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐	16a. IF AN EMERGENCY CHECK HERE: ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY: FROM THROUGH	DATES OF PARTIAL DISABILITY: FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency): USPHS Indian Hospital Sells AZ		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED 03-15-88 DISCHARGED 03-19-88	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office): University Medical Center		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE:

250.50 Diabetes Mellitus with Ophthalmic Manifestations
366.41 Diabetic Cataract Left

24 EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐ PRIOR AUTHORIZATION NO.

A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* T.O.S.	H LEAVE BLANK
03/15/88	IH	90630	Hosp/Surg Consult	1	150.00	01	03	
03/16/88	IH		Procedure Units 4.0	1				
			Time 720-910 10.0					
			Anesthesia Equip 1.0					
			Total Units 15.0		600.00	01	02	
03/19/88	IH	90280	Discharge					

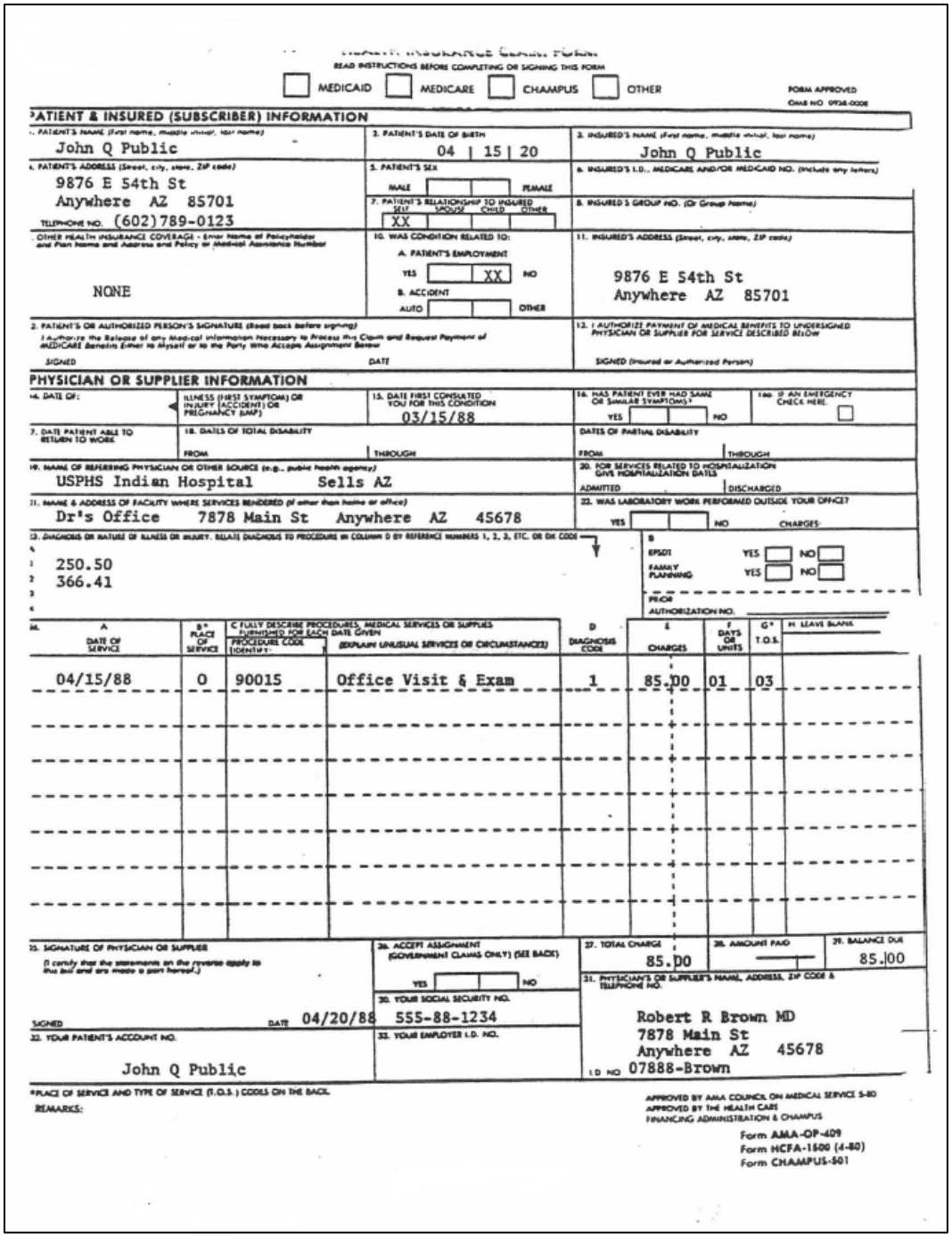
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.) SIGNED DATE 04/12/88	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐	27. TOTAL CHARGE 750.00	28. AMOUNT PAID -----	29. BALANCE DUE 750.00
	30. YOUR SOCIAL SECURITY NO. 555-88-1234	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.: Robert R Brown MD 7878 Main St Anywhere AZ 45678		
32. YOUR PATIENT'S ACCOUNT NO. John Q Public	33. YOUR EMPLOYER I.D. NO.	I.D. NO. 07888-Brown		

32 OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK.

MARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS
Form AMA-OP-409
Form HCFA-1500 (4-80)
Form CHAMPUS-501

Figure 3-12: Health Insurance Claim Form HCFA-1500; In-Hospital Visits



READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

☐ MEDICAID ☐ MEDICARE ☐ CHAMPUS ☐ OTHER

FORM APPROVED OMB NO 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
John Q Public	04 | 15 | 20	John Q Public
4. PATIENT'S ADDRESS (Street, city, state, ZIP code) 9876 E 54th St Anywhere AZ 85701 TELEPHONE NO. (602)789-0123	5. PATIENT'S SEX MALE ☐ FEMALE ☐ 7. PATIENT'S RELATIONSHIP TO INSURED SELF XX SPOUSE ☐ CHILD ☐ OTHER ☐	6. INSURED'S I.D., MEDICARE AND/OR MEDICAID NO. (Include any letters) 8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number NONE	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES ☐ XX NO B. ACCIDENT AUTO ☐ ☐ OTHER ☐	11. INSURED'S ADDRESS (Street, city, state, ZIP code) 9876 E 54th St Anywhere AZ 85701
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I Authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?	16a. IF AN EMERGENCY CHECK HERE ☐
	03/15/88	YES ☐ NO ☐	
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency) USPHS Indian Hospital Sells AZ		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office) Dr's Office 7878 Main St Anywhere AZ 45678		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE

1 250.50
2 366.41
3
4

B EPSDT YES ☐ NO ☐ FAMILY PLANNING YES ☐ NO ☐ PRIOR AUTHORIZATION NO.

M. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE CODE (IDENTIFY)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* T.O.S.	H LEAVE BLANK
04/15/88	0	90015 Office Visit & Exam	1	85.00	01	03	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES ☐ NO ☐	27. TOTAL CHARGE 85.00	28. AMOUNT PAID	29. BALANCE DUE 85.00
SIGNED DATE 04/20/88	30. YOUR SOCIAL SECURITY NO. 555-88-1234	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. Robert R Brown MD 7878 Main St Anywhere AZ 45678 I.D NO 07888-Brown		
32. YOUR PATIENT'S ACCOUNT NO. John Q Public	33. YOUR EMPLOYER I.D. NO.			

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK.

REMARKS:

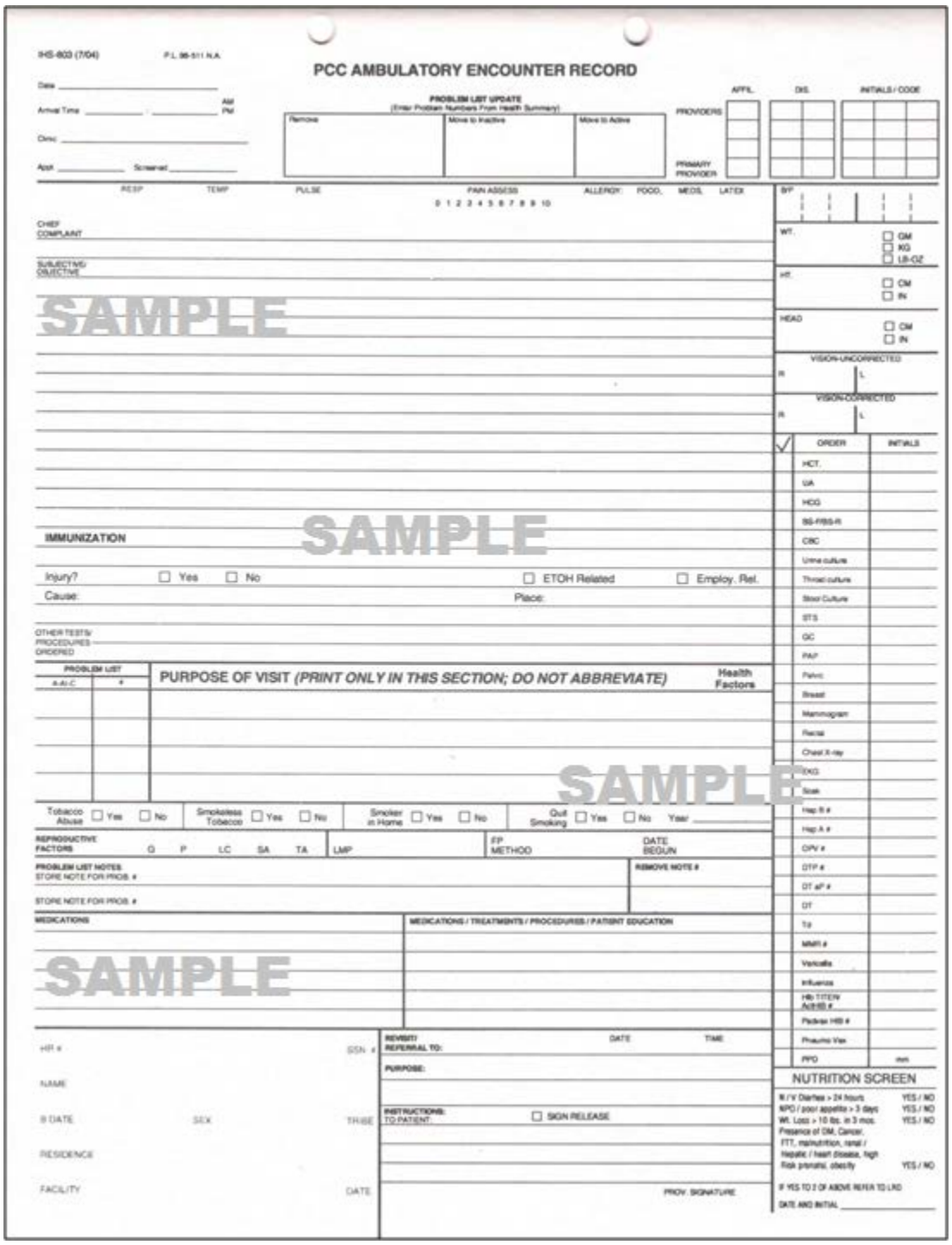
APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form AMA-OP-409
Form HCFA-1500 (4-80)
Form CHAMPUS-501

Figure 3-13: Health Insurance Claim Form HCFA-1500; Office Visits

Appendix A: Sample PCC Forms

A.1 PCC Ambulatory Encounter Record



IHS-603 (7/04) P.L. 86-511 N.A.

PCC AMBULATORY ENCOUNTER RECORD

Date

Arrival Time AM/PM

Clinic

Appt Screened

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)
Remove | Move to Inactive | Move to Active

AFFIL. DIS. INITIALS / CODE
PROVIDERS
PRIMARY PROVIDER

RESP TEMP PULSE PAIN ASSESS 0 1 2 3 4 5 6 7 8 9 10 ALLERGY: FOOD, MEDS, LATEX

BP

CHIEF COMPLAINT

SUBJECTIVE/ OBJECTIVE

WT. ☐ GM ☐ KG ☐ LB-OZ

HT. ☐ CM ☐ IN

HEAD ☐ CM ☐ IN

VISION-UNCORRECTED R L

VISION-CORRECTED R L

SAMPLE

IMMUNIZATION

SAMPLE

Injury? ☐ Yes ☐ No ☐ ETOH Related ☐ Employ. Rel.

Cause: Place:

OTHER TESTS/ PROCEDURES ORDERED

PROBLEM LIST A-to-C # | PURPOSE OF VISIT *(PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)* | Health Factors

SAMPLE

Tobacco Abuse ☐ Yes ☐ No | Smokeless Tobacco ☐ Yes ☐ No | Smoker in Home ☐ Yes ☐ No | Quit Smoking ☐ Yes ☐ No Year

REPRODUCTIVE FACTORS G P LC SA TA | LMP | FP METHOD | DATE BEGUN

PROBLEM LIST NOTES
STORE NOTE FOR PROB. #
STORE NOTE FOR PROB. #
REMOVE NOTE #

MEDICATIONS | MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION

SAMPLE

HRN # SSN #

NAME

D DATE SEX TRIBE

RESIDENCE

FACILITY DATE

REVISIT/ REFERRAL TO: DATE TIME

PURPOSE:

INSTRUCTIONS TO PATIENT ☐ SIGN RELEASE

PROV. SIGNATURE

✓	ORDER	INITIALS
	HCT	
	UA	
	HCG	
	RS-FBS-R	
	CBC	
	Urine culture	
	Throat culture	
	Stool Culture	
	STS	
	GC	
	PAP	
	Pelvic	
	Breast	
	Mammogram	
	Rectal	
	Chest X-ray	
	EKG	
	Scan	
	Hep B #	
	Hep A #	
	OPV #	
	DTP #	
	DT aP #	
	DT	
	Td	
	MMR #	
	Varicella	
	Influenza	
	Hib TITER/ Act-HIB #	
	Pediatric HIB #	
	Pneumo Vax	
	PPD	mm

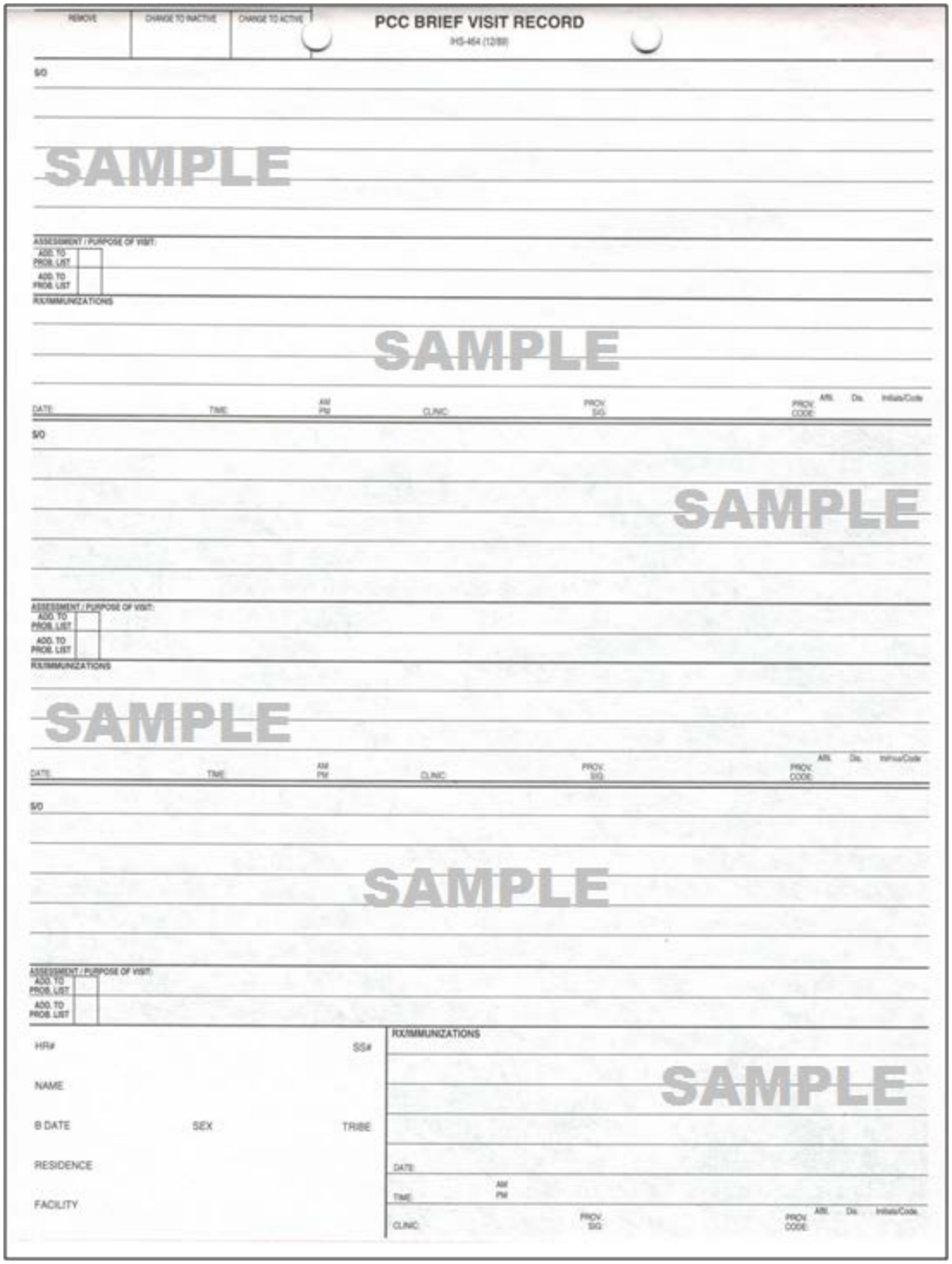
NUTRITION SCREEN

W / V Diarrhea > 24 hours	YES / NO
NPO / poor appetite > 3 days	YES / NO
Wt. Loss > 10 lbs. in 3 mos.	YES / NO
Presence of DM, Cancer, FTT, malnutrition, renal / hepatic / heart disease, high Risk prenatal, obesity	YES / NO

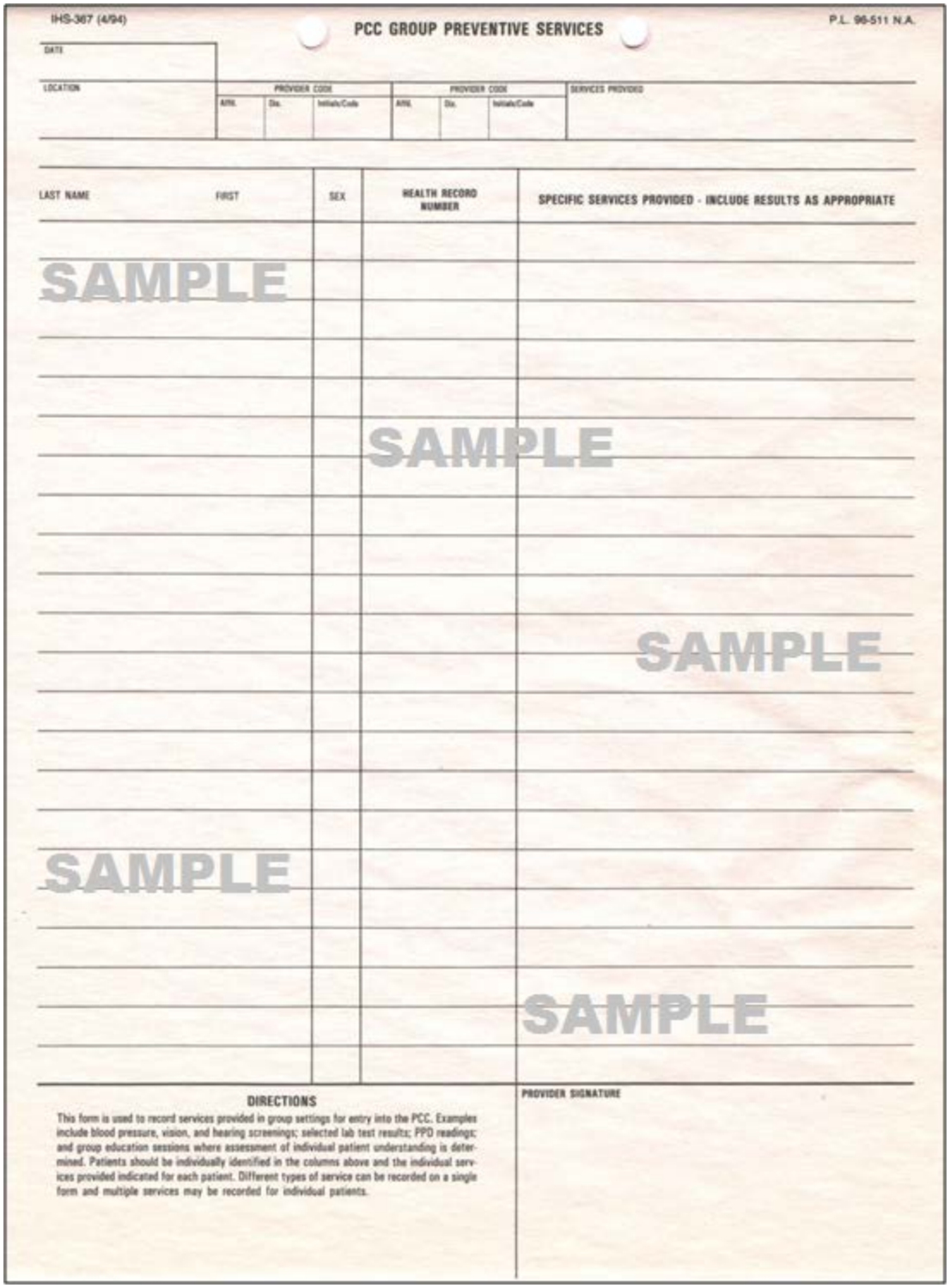
IF YES TO 2 OR ABOVE REFER TO LND

DATE AND INITIAL

A.2 PCC Brief Visit Record



A.3 PCC Group Preventive Services



IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 86-511 N.A.

DATE

LOCATION

PROVIDER CODE: ARN | Div. | Initials/Code

PROVIDER CODE: ARN | Div. | Initials/Code

SERVICES PROVIDED

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE

SAMPLE

SAMPLE

SAMPLE

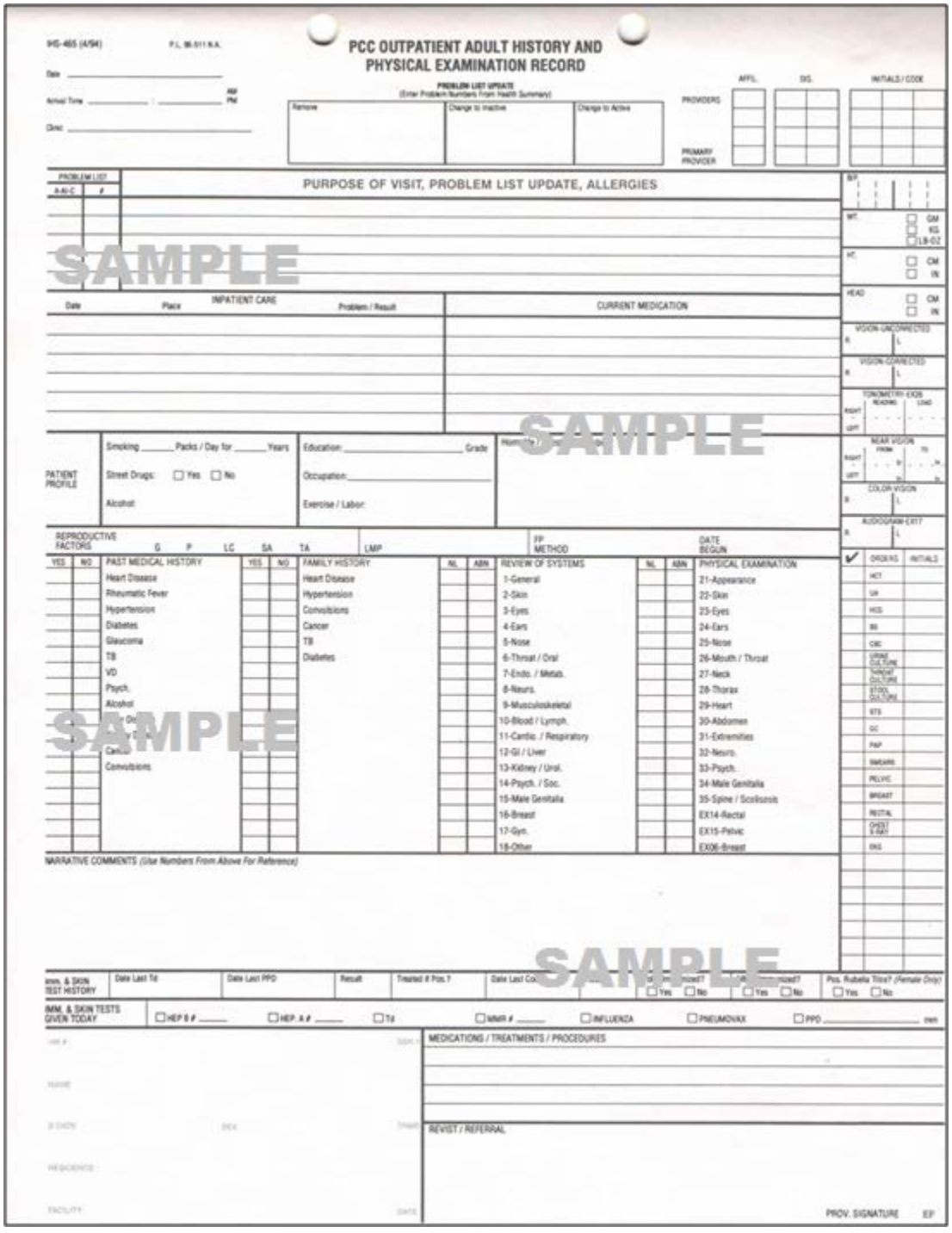
SAMPLE

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE

A.4 PCC Outpatient Adult History and Physical Examination Record



HS-465 (4/94) P.L. 86-511 N.A.

PCC OUTPATIENT ADULT HISTORY AND PHYSICAL EXAMINATION RECORD

Date

Arrival Time : AM PM

Clinic

PROBLEM LIST UPDATE (Enter Problem Numbers From Health Summary)

Remove	Change to Inactive	Change to Active

PROVIDERS / PRIMARY PROVIDER — AFFIL. | DIS. | INITIALS / CODE

PROBLEM LIST — A-to-C | #

PURPOSE OF VISIT, PROBLEM LIST UPDATE, ALLERGIES

SAMPLE

INPATIENT CARE — Date | Place | Problem / Result

CURRENT MEDICATION

SAMPLE

PATIENT PROFILE

Smoking _____ Packs / Day for _____ Years

Street Drugs: ☐ Yes ☐ No

Alcohol:

Education: _____ Grade

Occupation: _____

Exercise / Labor:

SAMPLE

REPRODUCTIVE FACTORS — G P LC SA TA — LMP — FP METHOD — DATE BEGUN

YES	NO	PAST MEDICAL HISTORY
		Heart Disease
		Rheumatic Fever
		Hypertension
		Diabetes
		Glaucoma
		TB
		VD
		Psych.
		Alcohol
		Dr[illegible]
		[illegible]
		Cancer
		Convulsions

YES	NO	FAMILY HISTORY
		Heart Disease
		Hypertension
		Convulsions
		Cancer
		TB
		Diabetes

SAMPLE

NL	ABN	REVIEW OF SYSTEMS
		1-General
		2-Skin
		3-Eyes
		4-Ears
		5-Nose
		6-Throat / Oral
		7-Endo. / Metab.
		8-Neuro.
		9-Musculoskeletal
		10-Blood / Lymph.
		11-Cardio. / Respiratory
		12-GI / Liver
		13-Kidney / Urol.
		14-Psych. / Soc.
		15-Male Genitalia
		16-Breast
		17-Gyn.
		18-Other

NL	ABN	PHYSICAL EXAMINATION
		21-Appearance
		22-Skin
		23-Eyes
		24-Ears
		25-Nose
		26-Mouth / Throat
		27-Neck
		28-Thorax
		29-Heart
		30-Abdomen
		31-Extremities
		32-Neuro.
		33-Psych.
		34-Male Genitalia
		35-Spine / Scoliosis
		EX14-Rectal
		EX15-Pelvic
		EX06-Breast

NARRATIVE COMMENTS *(Use Numbers From Above For Reference)*

SAMPLE

✔	ORDERS	INITIALS
	HCT	
	UA	
	HGB	
	BS	
	CBC	
	URINE CULTURE	
	THROAT CULTURE	
	STOOL CULTURE	
	RTS	
	GC	
	PAP	
	SMEARS	
	PELVIC	
	BREAST	
	RECTAL	
	CHEST X-RAY	
	EKG	

BP

WT. ☐ GM ☐ KG ☐ LB-OZ

HT. ☐ CM ☐ IN

HEAD ☐ CM ☐ IN

VISION-UNCORRECTED R L

VISION-CORRECTED R L

TONOMETRY-EXOS READING LOAD RIGHT LEFT

NEAR VISION FROM TO RIGHT LEFT

COLOR VISION R L

AUDIOGRAM-EXT7 R L

IMM. & SKIN TEST HISTORY — Date Last Td | Date Last PPD | Result | Treated If Pos.? | Date Last Co[illegible] | [illegible] Immunized? ☐ Yes ☐ No | [illegible] Immunized? ☐ Yes ☐ No | Pos. Rubella Titre? *(Female Only)* ☐ Yes ☐ No

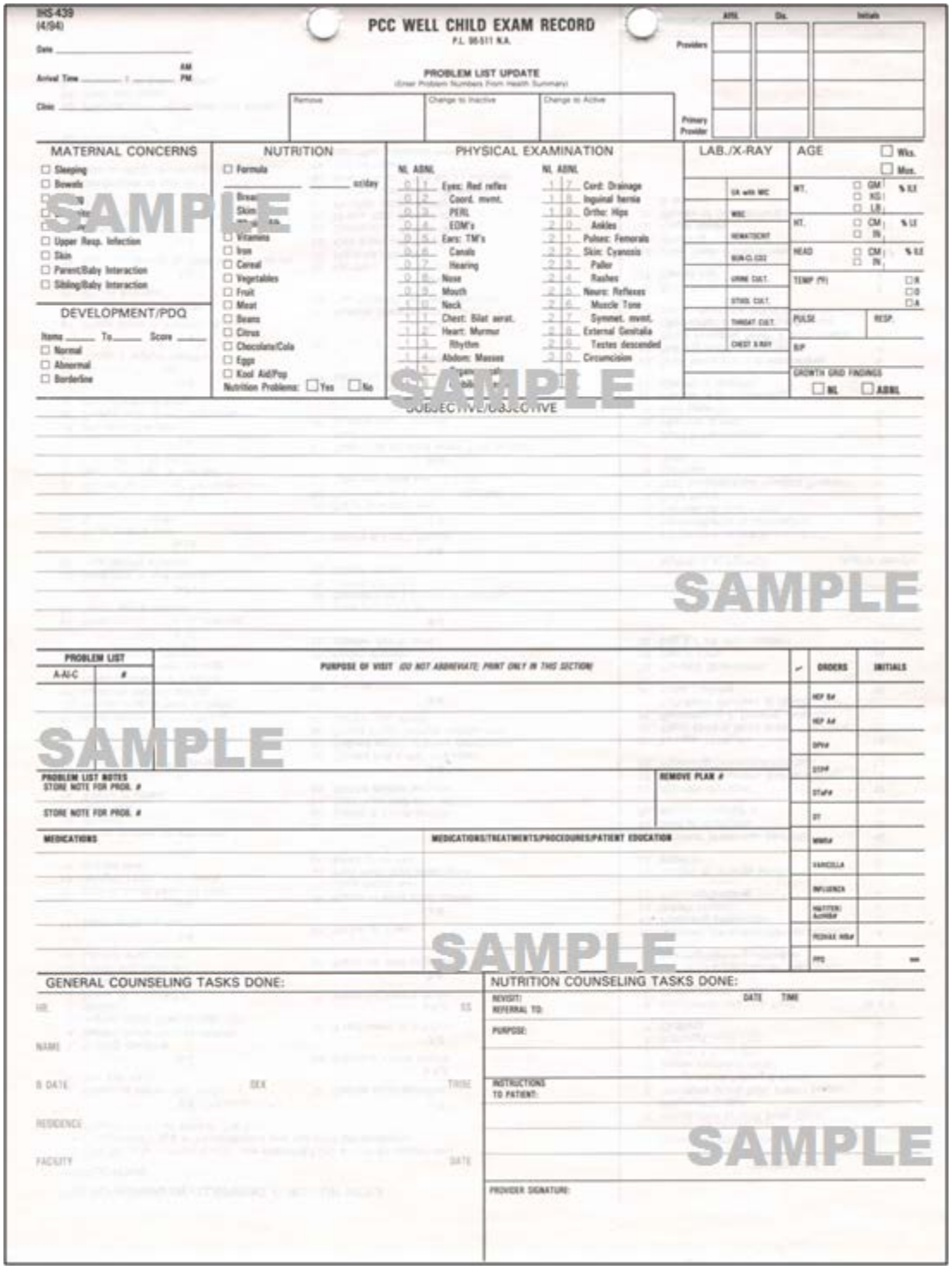
IMM. & SKIN TESTS GIVEN TODAY — ☐ HEP B # _____ ☐ HEP. A # _____ ☐ Td ☐ MMR # _____ ☐ INFLUENZA ☐ PNEUMOVAX ☐ PPD _____ mm

MEDICATIONS / TREATMENTS / PROCEDURES

REVISIT / REFERRAL

PROV. SIGNATURE EF

A.5 PCC Well Child Exam Record



IHS 439
(4/94)

PCC WELL CHILD EXAM RECORD
P.L. 86-511 N.A.

Date
Arrival Time : AM PM
Clinic

PROBLEM LIST UPDATE
(Enter Problem Numbers From Health Summary)
Remove | Change to Inactive | Change to Active

Providers | ARNL | Dia. | Initials
Primary Provider

MATERNAL CONCERNS
☐ Sleeping
☐ Bowels
☐ Upper Resp. Infection
☐ Skin
☐ Parent/Baby Interaction
☐ Sibling/Baby Interaction

DEVELOPMENT/PDQ
Items ____ To ____ Score ____
☐ Normal
☐ Abnormal
☐ Borderline

NUTRITION
☐ Formula
____ ____ oz/day
Breast
Skin
☐ Vitamins
☐ Iron
☐ Cereal
☐ Vegetables
☐ Fruit
☐ Meat
☐ Beans
☐ Citrus
☐ Chocolate/Cola
☐ Eggs
☐ Kool Aid/Pop
Nutrition Problems: ☐ Yes ☐ No

PHYSICAL EXAMINATION

	NL	ABNL		NL	ABNL
01	☐	☐	Eyes: Red reflex	☐	☐ Cord: Drainage
02	☐	☐	Coord. mvmt.	☐	☐ Inguinal hernia
03	☐	☐	PERL	☐	☐ Ortho: Hips
04	☐	☐	EOM's	☐	☐ Ankles
05	☐	☐	Ears: TM's	☐	☐ Pulses: Femorals
06	☐	☐	Canals	☐	☐ Skin: Cyanosis
07	☐	☐	Hearing	☐	☐ Pallor
08	☐	☐	Nose	☐	☐ Rashes
09	☐	☐	Mouth	☐	☐ Neuro: Reflexes
10	☐	☐	Neck	☐	☐ Muscle Tone
11	☐	☐	Chest: Bilat aerat.	☐	☐ Symmet. mvmt.
12	☐	☐	Heart: Murmur	☐	☐ External Genitalia
13	☐	☐	Rhythm	☐	☐ Testes descended
14	☐	☐	Abdom: Masses	☐	☐ Circumcision
15	☐	☐			

LAB./X-RAY
UA with MIC
WBC
HEMATOCRIT
BUN-CL-CO2
URINE CULT.
STOOL CULT.
THROAT CULT.
CHEST X-RAY

AGE ☐ Wks. ☐ Mos.
WT. ☐ GM ☐ KG ☐ LB %ILE
HT. ☐ CM ☐ IN %ILE
HEAD ☐ CM ☐ IN %ILE
TEMP (°F) ☐ R ☐ O ☐ A
PULSE
RESP.
B/P
GROWTH AND FINDINGS ☐ NL ☐ ABNL

SUBJECTIVE/OBJECTIVE

PROBLEM LIST
A-Al-C | #

PURPOSE OF VISIT (DO NOT ABBREVIATE; PRINT ONLY IN THIS SECTION)

PROBLEM LIST NOTES
STORE NOTE FOR PROB. #
STORE NOTE FOR PROB. #

REMOVE PLAN #

MEDICATIONS

MEDICATIONS/TREATMENTS/PROCEDURES/PATIENT EDUCATION

✓ | ORDERS | INITIALS
HEP B#
HEP A#
DPT#
DTP#
DTaP#
DT
MMR#
VARICELLA
INFLUENZA
HAEMOPHILUS influenzae
PNEUMO #/Gp
PPD mm

GENERAL COUNSELING TASKS DONE:
HR SS
NAME
B DATE SEX TRIBE
RESIDENCE
FACILITY DATE

NUTRITION COUNSELING TASKS DONE:
REVISIT: DATE TIME
REFERRAL TO:
PURPOSE:
INSTRUCTIONS TO PATIENT:
PROVIDER SIGNATURE:

SAMPLE

Appendix B: Affiliation Codes

Affiliation	Code
IHS	1
Contract	2
Tribal (non-638 Program)	3
State	4
Municipal	5
Volunteer	6
National Health Service Corps	7
638 Program	8
Other	9

Appendix C: Provider Class List

Title	Code
Administration	57
Alcoholism Counselor	48
Anesthesiologist	82
Audiologist	28
Audiometric Technician	43
Cardiologist	70
CHR	53
Coding/Data Entry	88
Dental Assistant	60
Dental Hygienist	46
Dental Lab	61
Dentist	52
Dermatologist	86
Dietetic Technician	99
Dietician	29
Disease Control Program	55
EMT/Paramedic	38
Environmental Health	02
Eye Care Specialist	36
Family Planning Counselor	37
Family Practice Physician	80
Food Service Supervisor	98
Health Aide	03
Health Educator	04
Health Records	56
Inhalation Therapist	26
Internal Medicine	71
Laboratory Technician	23
Licensed Medical Social Worker	62
Licensed Practical Nurse	OS
Medical Social Worker	06
Medical Student	20
Mental Health	19

Title	Code
Nephrologist	64
Neurologist	85
Nurse Assistant	22
Nurse Midwife	17
Nurse Practitioner	21
Nursing Student	27
Nutrition Technician	97
Nutritionist	07
OB/GYN	72
Ophthalmologist	79
Optometric Assistant	31
Optometrist	08
Orthopedist	73
Osteopathic Medicine	45
Other	15
Otolaryngologist	74
Outreach Worker	35
Papago Nutrition Program	51
Pathologist	83
Pediatric Nurse Practitioner	16
Pediatrician	75
Pharmacist	09
Pharmacy Practitioner	30
PHN/Aides	13
Physical Therapist	10
Physician	00
Physician Assistant	11
Podiatrist	33
Psychiatrist	81
Psychologist	12
Radiologist	76
Registered Nurse	01
School Nurse	14
Speech Therapist	39
Speech/Language Pathologist	42
Surgeon	77

Title	Code
Urologist	78
Ward Nurse/CRN&A	47
X-ray Technician	59

Appendix D: IHS Standard Clinic Codes

Code	Clinic	WL Flag	Primary Care Flag	Definition
01	General	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides acute, chronic, and preventive medical care to all age groups on an appointment or walk-in basis.
02	Cardiology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides major diagnostic, medical treatment pertaining to the heart.
03	Chest And TB	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides major diagnostic, medical treatment pertaining to the chest and/or tuberculosis.
04	Crippled Children	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that serves children with musculoskeletal disabilities.
05	Dermatology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of skin conditions.
06	Diabetic	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services to persons with diabetes.
07	ENT	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of the ear, nose, and throat.
08	Family Planning	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides family planning services and counseling.
09	Grouped Services	N	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services to groups.
10	Gynecology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing care to women by a GYN specialist.
11	Home Care	N	N	Feb 18, 2005 Approved by Medical Records. Health care services provided to patients in their home.
12	Immunization	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment and administration of immunizations.
13	Internal Medicine	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services to patients with internal medicine conditions, diseases, and disorders.

Code	Clinic	WL Flag	Primary Care Flag	Definition
14	Mental Health (Psychiatry)	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides care to patients with mental conditions, diseases, and disorders.
15	Obesity	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment, therapy and support for weight management.
16	Obstetrics	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides care to women during Pregnancy.
17	Ophthalmology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of conditions of the eye by an ophthalmologist.
18	Optometry	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of conditions in of the eye by an optometrist.
19	Orthopedic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of musculoskeletal conditions by an orthopedist.
20	Pediatric	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of conditions in children.
21	Rehabilitation	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services to improve function following disease, illness, or injury.
22	School	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic held off-site at a school that provides medical, education or counseling services to school age children or teens. (K through 12th Grade).
23	Surgical	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides operative diagnosis and treatment by a surgeon.
24	Well Child	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services to well children.
25	Other	Y	N	Feb 18, 2005 Approved by Medical Records. Any specialty organized clinic not otherwise identified (Do not use for after-hours clinics, see clinic code 89).

Code	Clinic	WL Flag	Primary Care Flag	Definition
26	High Risk	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides care and treatment to high risk pregnant women.
27	General Preventive	N	N	An organized clinic providing medical diagnosis and treatment in all age groups with emphasis on prevention of illness.
28	Family Practice	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic providing family medical services through family practice-trained providers.
29	Plastic Surgery	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment, minor surgical intervention, and surgical follow-up of the abnormalities of skin.
30	Emergency Medicine	Y	N	Feb 18, 2005 Approved by Medical Records. A service provided to outpatients who require immediate care to sustain life or prevent critical consequences.
31	Hypertensive	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides care and treatment for hypertensive disorders, conditions and diseases.
32	Postpartum	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services and treatment for the follow-up care of women after childbirth.
33	Respiratory Care	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment and management of restrictive and obstructive lung diseases, offering supervised use of inhaled medications as a therapeutic intervention.
34	Physical Therapy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and treatment for conditions that impair mobility of extremities and ambulation.
35	Audiology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and treatment for hearing loss and hearing impairment disorders/diseases.
36	W. I. C.	N	N	Feb 18, 2005 Approved by Medical Records. Women/Infants/Children. An organized clinic providing assessment, treatment and education of nutrition in women, infants, and children.
37	Neurology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and management of the nervous system diseases, conditions, and disorders provided by a neurologist.

Code	Clinic	WL Flag	Primary Care Flag	Definition
38	Rheumatology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and management of connective tissue or autoimmune diseases provided by a rheumatologist.
39	Pharmacy	Y	N	Feb 18, 2005 Approved by Medical Records. The service of filling and dispensing medications for medical refills or outside prescription orders.
40	Infant Stimulation	N	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and treatment to infants who suffer from development and/or diseases of the nervous system.
41	Indirect	N	N	Feb 18, 2005 Medical Records will request to inactivate. To be INACTIVATED.
42	Mail	N	N	Feb 18, 2005 Medical Records will request to inactivate. To be INACTIVATED. Use 53 FOLLOW-UP LETTER.
43	Alcohol And Substance	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment, counseling, treatment planning, and treatment follow-up for patients with alcohol and/or chemical abuse/dependency.
44	Day Surgery	Y	N	Feb 18, 2005 Approved by Medical Records. Also known as Ambulatory Surgery, Short-Stay Surgery, One-Day Surgery. A day surgery clinic for the performance of surgical procedures on patients who are classified as outpatients and typically are released from the surgery unit on the day of surgery. An organized clinic that performs minimally invasive procedures on patients through an outpatient setting.
45	PHN Clinic Visit	Y	N	Feb 18, 2005 Approved by Medical Records. A patient encounter with the PHN only.
46	NIH Clinic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides pre-screening for patients volunteering for various research studies. For use only by Phoenix Indian Medical Center (P.I.M.C.).
47	Fetal Alcohol Syndrome	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and treatment planning for children suffering from fetal alcohol effects/syndrome.
48	Medical Social Services	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment and treatment support to patients and families designed to enhance physical, social and psychological well being.

Code	Clinic	WL Flag	Primary Care Flag	Definition
49	Nephrology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment and treatment for diseases, disorders and conditions of the kidney provided by a nephrologist.
50	Chronic Disease	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment and treatment for chronic disorders, diseases and conditions.
51	Telephone Call	N	N	Feb 18, 2005 Approved by Medical Records. Contacts with individuals over the telephone for a medically significant intervention.
52	Chart Rev/Rec Mod	N	N	Feb 18, 2005 Approved by Medical Records. Review of the medical record, resulting in documentation of a medically significant condition; absent a direct patient visit.
53	Follow-Up Letter	N	N	Feb 18, 2005 Approved by Medical Records. Clinic code used when a provider sends correspondence to a patient to reschedule an appointment, provide test results, or request the patient to schedule a follow up visit.
54	Radio Call	N	N	Feb 18, 2005 Approved by Medical Records. Contacts with individuals over a radio call.
55	Cast Room	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing application/change/checking/removal of cast.
56	Dental	N	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing assessment, diagnosis, preventive services and treatment for diseases, injuries and malformations of the teeth and supportive structures.
57	EPSDT	Y	N	Feb 18, 2005 Approved by Medical Records. EARLY PERIODIC SCREENING AND DEVELOPMENTAL TESTING. An organized clinic providing well child and anticipatory care to children to ensure normal growth and development.
58	Cancer Screening	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing screening and early detection of cancer.
59	STD	Y	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic that provides for the diagnoses, assessment, and treatment of patients with sexually transmitted diseases.
60	Education Classes	N	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic that provides education classes to individuals and groups on health related issues by collaboration of providers and educators.

Code	Clinic	WL Flag	Primary Care Flag	Definition
61	Devel. Assessment	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing specialized assessment of physical growth, cognitive function, and motor skills as they relate to normal or disordered development in children.
62	Cancer Chemotherapy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic providing chemotherapeutic medication administration and monitoring for treatment of cancer.
63	Radiology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic where medical imaging is performed. (Through x-ray or other modality.)
64	Retinopathy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services for nonflammatory degenerative disease of the retina.
65	Podiatry	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and/or treatment of diseases, injuries and defects of the foot.
66	Ultrasound	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that uses ultrasonic waves to assist in the diagnoses and/or treatment of conditions.
67	Dietary	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides medical care and management specifically related to diet/nutrition.
68	Employee Health UN	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides health care services for employment related screening/conditions.
69	Endocrinology	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of diseases and disorders of the ductless glands.
70	Women's Health Screening	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides health screening, diagnosis, and treatment of conditions specific to women.
71	Computed Tomography	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which uses a technique for producing cross-sectional images of the body in which x-rays are passed through the body at different angles and analyzed by a computer; also called CT scanning or CAT scanning.

Code	Clinic	WL Flag	Primary Care Flag	Definition
72	Mammography	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides x-ray diagnostic examinations of the breast.
73	Genetics	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides assessment, treatment and counseling for disorders caused by a defect in genes, which carry hereditary information.
74	Speech Pathology	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnoses and treatment of the nature and cause of changes in speech function and/or communicating verbally.
75	Urology	Y	Y	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides diagnosis and treatment of conditions/diseases of the genitourinary tract, provided by a urologist.
76	Laboratory Services	Y	N	Feb 18, 2005 Approved by Medical Records. Pathology and clinical laboratory services.
77	Case Management Services	N	N	Feb 18, 2005 Approved by Medical Records. Assuring that the most appropriate type of care and level of care is provided in the most cost effective manner.
78	Over the counter (OTC) Medications	Y	N	Feb 18, 2005 Approved by Medical Records. An encounter that occurs for patients who receive OTC medications.
79	Triage	Y	N	Feb 18, 2005 Approved by Medical Records. A nurse visit only to determine priority of need and proper place of treatment. Usually, the patient is given an appointment to return at another date & time. If the patient is referred from triage to a specific clinic then the appropriate clinic code will be assigned.
80	Urgent Care	Y	N	Feb 18, 2005 Approved by Medical Records. A clinic or freestanding multi-specialty doctors office that provides extended hours for the care of walk-ins and non-emergency and non-life threatening care.
81	Men's Health Screening	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides health screening, diagnosis, and treatment of conditions specific to men.
82	Day Treatment Prog	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides major diagnostic, medical, psychiatric psycho-social and pre-vocational treatment modalities in a defined day treatment program setting.

Code	Clinic	WL Flag	Primary Care Flag	Definition
83	Labor And Delivery	Y	N	Feb 18, 2005 Approved by Medical Records. When a pregnant patient presents directly to the OB Inpatient Unit for outpatient services, i.e., fetal monitoring, non-stress test, contraction stress tests, biophysical profiles, amniotic fluid assessment, and ultrasound.
84	Pain Management	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic 'primarily for the purpose of' pain management.
85	Teen Clinic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides medical and counseling services to adolescents, age range from 11-19.
86	Traditional Medicine	Y	N	Feb 18, 2005 Approved by Medical Records. A setting where the traditional medicine practitioners provides their respective services.
87	Observation	Y	N	Feb 18, 2005 Approved by Medical Records. Services furnished by a hospital on the hospitals premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatients condition or to determine the need for a possible admission as an inpatient.
88	Sports Medicine	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides services concerned with physiology, pathology, and psychology as they apply to persons who participate in sports, including prevention of injuries.
89	Evening	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic held after normal working hours.
90	Telemedicine	Y	N	Feb 18, 2005 Approved by Medical Records. The provision of consultant services by off-site physicians to health care professionals on the scene, as by means of closed-circuit television.
91	Teleradiology	Y	N	Feb 18, 2005 Approved by Medical Records. The provision of radiology services, diagnoses, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient.
92	Dialysis	Y	N	Feb 18, 2005 Approved by Medical Records. The treatment of patients by an I/T/U provider at the dialysis site/room/annex.

Code	Clinic	WL Flag	Primary Care Flag	Definition
93	Occupational Therapy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides treatment to improve physical skills lost as a result of an illness or accident. Evaluation of self-care, work, play, leisure time, and task performance skills; planning and implementation of programs and activities for well and disabled clients of all ages.
94	Tobacco Cessation Clinic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides counseling and assistance in discontinuing the use of tobacco products.
95	Dialysis Laboratory Services	Y	N	Feb 18, 2005 Approved by Medical Records. Dialysis ordered pathology and clinical laboratory services.
96	Pediatric Outpatient Use Of Inpatient Treatment Room	Y	N	Feb 18, 2005 Approved by Medical Records. Outpatient pediatrics services used in the inpatient treatment room. (sounds like a LOCATION rather than an organized clinic).
97	Surgical Outpatient Use Of Inpatient Treatment Room	Y	N	Feb 18, 2005 Approved by Medical Records. Outpatient surgical services used in the inpatient treatment room. (sounds like a LOCATION rather than an organized clinic).
98	Diabetes Education-Group	Y	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic session for group diabetes education using curriculum guidelines and standard education process.
99	Third Party Dental	N	N	Feb 18, 2005 Medical Records will request to inactivate. TO BE INACTIVATED.
A1	Diabetes Education-Individual	Y	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic session for individual diabetes education using curriculum guidelines and standard education process.
A2	Diabetic Retinopathy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides for identification of diabetic retinopathy or annual diabetic retinopathy exam via validated telemedicine.
A3	Ambulance	Y	N	Feb 18, 2005 Approved by Medical Records. Healthcare services provided to patients by ambulance providers who meet state licensure requirements.

Code	Clinic	WL Flag	Primary Care Flag	Definition
A4	Perinatogist	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides specialty care of the fetus and complicated pregnancies. This involves the diagnosis and management of abnormal pregnancies, particularly the diagnosis and management of fetal abnormalities.
A5	Complementary Medicine	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic which provides ancillary care to patients referred from their primary care provider to a complementary medicine provider such as an acupuncturist.
A6	Chiropractic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that provides adjustment and manipulation of the articulations and adjacent tissues of the human body, particularly of the spinal column. Chiropractic is a drug-free, non-surgical science and, as such, does not include pharmaceuticals or incisive surgery.
A7	Ryan White Early Intervention	Y	N	Feb 18, 2005 Approved by Medical Records. Participation in a grant from HRSA for early intervention HIV treatment.
A8	Wellness	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that focuses on promotion or maintenance of good health by maintaining good nutrition, exercise, stress-control, and good personal and familial social relationships.
A9	Ph Preparedness (Bioterrorism)	N	N	Feb 18, 2005 Approved by Medical Records. To be used by providers when the visit is an investigation as a possible/real bioterrorism incident. The services to b provided may include: investigation of incident/counseling/referrals.
B1	Maternity Case Management Support Services	Y	N	Feb 18, 2005 Approved by Medical Records. This is a combination of support services for pregnant women on Medicaid. The services are to assist the client to gain access to needed medical, social, educational and other services.
B2	Radiation Exposure Screening	Y	N	Feb 18, 2005 Approved by Medical Records. Radiation exposure screening and education, including medical, occupational and environmental health histories, physical examinations, laboratory blood work, pulmonary function tests, and radiologic testing, as well as any other indicated medical testing. Educational counseling about the health effects of radiation exposure.

Code	Clinic	WL Flag	Primary Care Flag	Definition
B3	Sands (Stop Atherosclerosis In Native Diabetic Study)	Y	N	Feb 18, 2005 Approved by Medical Records. STOP ATHEROSCLEROSIS IN NATIVE DIAB STUDY. An organized clinic to cover the participation of patients in a new randomized, clinical trial research study that will try to prevent cardiovascular disease among patients 40 years and older and with Type II diabetes mellitus.
B4	Wisewoman	Y	N	Feb 18, 2005 Approved by Medical Records. Includes screening for cardiovascular disease including blood pressure, fasting lipid panel for cholesterol, fasting glucose, weight, height, waist circumference, lifestyle and health history questionnaire. (Used by Alaska).
B5	Nurse Clinic	Y	N	Aug 26, 2005 Approved by Medical Records. An organized clinic staffed by licensed nursing staff (RNs & LPNs) who provide treatment and procedures that do not require a licensed independent provider evaluation on that day.
B7	Diabetic Foot Clinic	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that treats patients with DM foot care and education in the rehabilitation department.
B8	Gastroenterology-Hepatology	Y	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic with focus on the prevention, diagnosis, and treatment of diseases of the digestive tract and diseases of the liver.
B9	Oncology-Hematology	Y	N	Feb 18, 2005 Approved by Medical Records. A prescheduled organized clinic that provides assessment, diagnosis, and treatment pertaining to oncology and hematological disorders.
C1	Neurosurgery	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that deals with the use of surgery to treat disorders and diseases of the peripheral nervous system and the brain.
C2	Pulmonology	Y	N	Feb 18, 2005 Approved by Medical Records. A clinic classified as an internal medicine subspecialty with the focus on the diagnosis and treatment of asbestosis, asthma, bronchitis, chronic cough, COPD (chronic obstructive pulmonary disease), emphysema, hemopytsis, lung cancer, sarcoidosis, solitary pulmonary nodule, obstructive sleep apnea and other sleep disorders.

Code	Clinic	WL Flag	Primary Care Flag	Definition
C3	Colposcopy	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that involves the evaluation of women with abnormal pap smears by examining the uterine cavity with a magnification instrument called a colposcope. The purpose of colposcopy is to prevent the progression of dysplasia to cervical cancer for women at higher risk after pap screening.
C4	Behavioral Health	Y	N	Feb 18, 2005 Approved by Medical Records. An organized clinic that focuses on behavioral health services such as mental health, alcohol and substance abuse, and social services to children, adolescents, adults and their families. Services include assessment, group or individual therapy and where needed, medication management.
C5	Wound Care	Y	N	Aug 26, 2005 Approved by Medical Records. An organized clinic that provides treatment of various types of wounds such as diabetic wounds, burns, minor lacerations, small surgical dehiscence, abrasions, and chronic non-healing wounds. Wounds are cleansed, debrided, dressed with appropriate healing materials, and patient instructed on care of the wound.
C6	Health Aide Clinic	Y	Y	Aug 26, 2005 Approved by Medical Records. An organized clinic that provides care by formally trained, non-licensed health care providers, who provide medical services in rural areas under the supervision of a licensed medical practitioner (physician or mid-level provider). Patients may be seen at home or in the clinic. (ALASKA).
C7	Elder Care	Y	N	An organized clinic that provides comprehensive medical and psycho-social assessment services in an interdisciplinary manner to patients age 65 and older. The team consists of a physician, clinic nurse, public health nurse, medical social worker, dietician, sanitarian, community health representative, behavioral health representative, and others as requested.
C8	Home Based Care	Y	N	An organized clinic that provides coordinated care for high-risk patients, infants to elderly, in need of home-based procedures/services. The care is primarily provided in the home, although some follow up of these patients occurs in the facility. The care is coordinated with Social Services and other disciplines with supervision by a primary care provider.

Code	Clinic	WL Flag	Primary Care Flag	Definition
C9	Telebehavioral Health	Y	N	The provision of behavioral health services via videoconferencing and/or other recognized forms of telemedicine (e.g., store-and-forward software). Services include assessment, individual/couples/family/group therapy, medical management, clinical case consultation, and case management. Conventional telephone consultation alone does not constitute telebehavioral health.
D1	Anticoagulation Therapy	Y	N	An organized clinic that provides cognitive, interpretive, consultative, strategic, educative and definitive services to high risk patients with circulatory compromise where optimal anticoagulation using medicinal products is necessary to prevent life threatening morbidity or mortality. The pharmacist specialist provider works nearly independently with occasional oversight from a medically licensed provider.
D2	Medication Therapy Management	Y	Y	An organized clinic or service that provides patient assessment and intervention by a pharmacist to optimize medication or other treatment related outcomes.
D3	Homeless	N	N	Healthcare services provided to patients in (a) a homeless shelter (public or private facility that provides temporary living accommodations), (b) transitional housing, (c) on the streets, or (d) temporarily living with friends or relatives.
D4	Anesthesiology	Y	N	An organized clinic that provides assessment of surgical patients who require anesthesia, analgesia and/or amnesia pertinent to surgical or other procedures.
D5	Pharmacy Primary Care Clinic	Y	Y	An organized pharmacist driven clinic that provides cognitive, interpretive, strategic, educative and definitive services to patients with acute, chronic and preventive medical conditions. The pharmacist specialist provider works nearly independently with occasional minimal oversight from the medical licensed provider.
D6	Transportation	N	N	A non-emergency medical transport service provided to patients for health service appointments and related activities at various locations, such as, but not limited to, hospitals, physician offices, diagnostic testing appointments, dialysis, etc.
XX	Default Code For Nulls/Blanks	Y	N	
z1	Test			

Appendix E: Problem List Definitions and Conventions

E.1 Major Functions

- Table of Contents for the medical record
- Information Bulletin Board for communication among providers
- Synopsis of medically significant events

E.2 Active Problems

- Include important medical. social, and psychiatric problems
- Have clinical significance and currently affect the patient (e.g., Diabetes)
- May be presently quiescent but are still at high risk to recur (e.g., Congestive Heart Failure)
- May be temporarily active (e.g., pregnancy, burns)

E.3 Inactive Problems

- Have a tendency to recur
- Place the patient at risk
- Include resolved conditions
- Include positive skin test. OB. or birth information

E.4 Surgery

Although surgical conditions that place a:patient at risk are usually included on a manual Problem List. they should not be added to PCC Problem List because they are displayed on the Health Summary in the "History of Surgery" section.

E.5 Problems that are always considered Active

- Abuse
- Alcohol Related Injuries
- Allergies
- Amputations

- Blindness
- Deafness
- Diabetes
- Epilepsy
- Hypertension
- Paralysis
- Recurrent Otitis Media
- Rheumatoid Arthritis
- Suicide Attempt
- Violence Related Injuries

E.6 Where to Look for Active Problems

- Last five encounters or past six months
- Inactive Problem List
- Hospital discharge reports
- Consultant reports

Appendix F: Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

F.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

F.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

F.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS polices and procedures prior to interconnection to or transferring data from RPMS.

F.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

F.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

F.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

F.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

F.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

F.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

F.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

F.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

F.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

F.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

F.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

F.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

F.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Acronym List

ADT	Admission/Discharge/Transfer
CHS	Contract Health Service
EDD	Estimated Date of Delivery
FP	Family Planning
HCFA	Health Care Financing Administration
HRSA	Health Resources and Services Administration
I/T/U	IHS, Tribal, or Urban
ICD	International Classification of Diseases
IHS	Indian Health Service
LMP	Last Menstrual Period
OTC	Over the Counter
PCC	Patient Care Component
PHN	Public Health Nurse
RPMS	Resource and Patient Management System
UB	Uniform Bill

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

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

Fax: (505) 248-4363

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

Email: support@ihs.gov