

Date of Clinic Visit: _____ Type of Visit: New Established Consultation

Nursing Assessment: No Chart Available With Translator ALLERGIES:

Any OTC, Herbal, Patches, Inhalers, Eye Drops, Supplements? Y N Level of Injury _____
If yes, list: _____ Complete Incomplete

Use Tobacco? Y N if yes, Willing to Quit? Y N if yes, Info Given? Y N

Reason(s) for Visit: _____

Vital Signs per Criteria:

Nursing Signature: _____

Chief Complaint:	Social Hx: no yes
	ETOH: [] []
	Tobacco: [] []
	IVDA: [] []

ROS: Pain Assessment Location: _____ Duration/Onset: _____ Intensity (1-10 scale): _____ What makes it better: _____ What makes it worse: _____ Tolerable: yes no N Y N Y N Y N Y N Y	Family Hx:
	HTN: [] []
	DM: [] []
	MI: [] []

Cardiovascular Allergies: [] [] []
Dyspnea Orthopnea Pain Edema Fatigue
If yes, list: _____

Respiratory
Cough SOB Trach Sputum Wheezing

Gastro-Intestinal Tract Medications:
Melena Diarrhea Constipation Bowel program
Hemorrhoids Hematemesis Swallowing Nausea/Vomit.

Genito-Urinary Tract
Dysuria Hematuria Incontinence IC Q 4 or Q6 hr
Reflex voider Foul Odor

Musculo-Skeletal/Skin
Spasms Swelling Ulcer Trauma
Rash Itching Pain Contraction

Objective: MSE- Alert Oriented x

Lungs- CTAB Other:

Heart- Regular Rate Rhythm Other:

Abdomen- Soft NT ND NABS Other:

Extremities- No Edema No skin breakdown Other:

Impression/Diagnosis: _____

Date: _____

[] Restrictions:

[] Disability Note Dictated:

Date: _____

Spinal Cord Injury Primary Care
Clinic: PVR

RLAMC#

Name

Plan/ Instructions:

Medication Changes: Y N If yes :

Physician Orders	Order Items	Today	Before Next Visit	Reason: Required for diagnostics and consults	Affinity Order #	Licensed Signature
	<input type="checkbox"/> CBC with differential					
	<input type="checkbox"/> Comp Metabolic Panel					
	<input type="checkbox"/> U/A					
	<input type="checkbox"/> Urine Culture					
	<input type="checkbox"/> Wound Culture					
	<input type="checkbox"/> EKG					
	<input type="checkbox"/> Other: _____					
	<input type="checkbox"/> X-Ray: _____					
	<input type="checkbox"/> X-Ray: _____					
	<input type="checkbox"/> Other: _____					
	<input type="checkbox"/> Pulmonary Function Tests					
	<input type="checkbox"/> Consult:					
	<input type="checkbox"/> Consult:					
	<input type="checkbox"/> Other: _____					

Patient Education and Post-Visit Counseling	<input type="checkbox"/> Patient verbalized understanding of the following issues:	
	<input type="checkbox"/> Any medication changes	<input type="checkbox"/> Take medications as directed
	<input type="checkbox"/> Diagnostic Tests	<input type="checkbox"/> Keep appointments/Call reschedule if missed
	<input type="checkbox"/> How and when to contact clinic/provider	<input type="checkbox"/> Medication list given
	<input type="checkbox"/> Other: _____	
Licensed nursing staff signature: _____		

Follow Up Appointment	<input type="checkbox"/> Return to Clinic in _____ <input type="checkbox"/> Weeks or <input type="checkbox"/> Months regarding:		
	Clerk Initial: _____	Next Appointment Date: _____	Time: _____

Resident Signature: _____ Provider #: _____

Attending Signature: _____ Provider #: _____

Attending Co-Signature required for student and resident providers

Spinal Cord Injury Primary Care Clinic: PVR

RLAMC#
Name