

Chronic Disease Clinic Follow-Up

Inmate Name: _____	
Number: _____	Institution: _____

List chronic diseases:

1) _____	3) _____	5) _____
2) _____	4) _____	6) _____

Attach pharmacy profile or list current medications: _____

Subjective:

Asthma: # attacks in last month? _____ # short acting beta agonist canisters in last month? _____ # times awakening with asthma symptoms per week? _____	Seizure disorder: # seizures since last visit? _____ Diabetes mellitus: # of hypoglycemic reactions since last visit? _____ Weight loss/gain ↓ ↑ _____ #lbs
CV/hypertension (Y/N): Chest pain? _____ SOB? _____ Palpitations? _____ Ankle edema? _____	
HIV/HCV (Y/N): Nausea/vomiting? _____ Abdominal pain/swelling? _____ Diarrhea? _____ Rashes/lesions? _____	

For all diseases, since last visit, describe new symptoms: _____

Patient adherence (Y/N): with medications? _____ with diet? _____ with exercise? _____

Vital signs: Temp _____ BP _____ Pulse _____ Resp _____ Wt _____ PEFr _____ INR _____

Labs: Hgb A1C _____ HIV VL _____ CD4 _____ Total Chol _____ LDL _____ HDL _____ Trig _____

Range of fingerstick glucose/BP monitoring: _____

PE:

HEENT/neck: _____	Extremities: _____
Heart: _____	Neurological: _____
Lungs: _____	GU/rectal: _____
Abdomen: _____	Other: _____

Assessment:

	Degree of Control				Clinical Status			
	G	F	P	NA	I	S	W	NA
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Plan:

Medication changes: _____

Diagnostics: _____

Labs: _____

Monitoring: BP: _____ X day/week/month Glucose: _____ X day/week/month Peak flow: _____ Other: _____

Education provided: Nutrition Exercise Smoking Test results Medication management Other: _____

Referral (list type): Specialist: _____ Chronic care program: _____

days to next visit? 90 60 30 Other: _____ Discharged from CCC: [name] _____

Advance Level Provider Signature: _____	Date: _____
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