# OREGON CLINIC VISIT RECORD

A. LAST NAME_____ B. FIRST NAME_____ C. M.I._____

D. SOC. SEC. NO. ___-___-____ E. CCare NO. _____

Items A-E only required for CCare Clients

1. SERVICE SITE NUMBER

2. CLIENT NUMBER

3. DATE OF VISIT MO. DAY YR. 2 0

4. DATE OF BIRTH MO. DAY YR.

5. SEX ☐ 1 - Female ☐ 2 - Male

6. ETHNICITY ☐ 6 - Hispanic or Latino ☐ 9 - Not Hispanic or Latino

6a. RACE (Mark All That Apply)
☐ 1 - White ☐ 2 - Black/Afr. Amer. ☐ 3 - American Indian ☐ 4 - Alaska Native ☐ 5 - Asian ☐ 6 - Other ☐ 7 - Unknown/Not Reported ☐ 8 - Native Hawaiian/Pac. Isl.

7. ADDITIONAL DEMOGRAPHIC (Check if Applicable)
☐ 5 - Limited English Proficiency

7a. CLIENT'S PREVIOUS TEST DATES - Females Only
1 - Chlamydia (age ≤ 24) ☐ 1 Never ☐ 2 Unk 3 Date MO. YR.
2 - Pap (age ≥ 21) ☐ 1 Never ☐ 2 Unk 3 Date MO. YR.

8. ZIP CODE

9. ASSIGNED SOURCE OF PAYMENT (Check one)
☐ 01 - No Charge ☐ 02 - Title XIX (OHP) ☐ 08 - CCare* ☐ 03 - WA Take Charge ☐ 04 - Private Insurance ☐ 05 - Full Fee ☐ 06 - Partial Fee ☐ 07 - Other ☐ 10 - Non-CCare Visit/ CCare Supply* ☐ 11 - OVP
*Complete top section and 17 for CCare

9A. DIAGNOSIS CODE (Complete if billing CCare) Z30. ___

9B. WILL INSURANCE BE BILLED FOR THIS VISIT?
(Complete if Question 9 is 8 or 10). ☐ 1- No ☐ 2- Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

18. CLIENT INSURANCE STATUS (check one)
(Principal Health Insurance covering primary care)
☐ 1 - Public Health Insurance ☐ 2 - Private Health Insurance ☐ 3 - Uninsured ☐ 4 - Unknown

10. INCOME AND HOUSEHOLD SIZE
a. Monthly Income? AMOUNT
b. Household Size? NUMBER

11. HEALTH INS. ENROLLMENT ASSISTANCE
☐ 1 - Onsite ☐ 2 - Referral

12. PURPOSE OF VISIT (Check One)
☐ 1 - First Annual Visit ☐ 2 - Return Annual Visit ☐ 3 - Other Medical ☐ 4 - Counseling Only ☐ 5 - Pregnancy Test Visit ☐ 6 - Supply Only-Mailed (CCare Only) ☐ 9 - Supply Only Visit (CCare Only) ☐ 8 - Vasectomy Referral (w/OVP SOP)

13A. **MEDICAL SERVICES** (Check all Applicable)

**Exam & Lab Services**
☐ 02 - Blood Pressure ☐ 03 - Height/Weight ☐ 04 - Thyroid Exam ☐ 05 - Heart/Lung Auscultation ☐ 06 - Breast Exam ☐ 07 - Abdominal Exam ☐ 08 - Extremities ☐ 09 - Bimanual/Speculum Pelvic Exam ☐ 23 - Hgb / Hct ☐ 24 - Urine Dip Strip/Urinalysis ☐ 25 - Pap Test Conventional ☐ 26 - Pap Test Liquid-Based ☐ 27 - Colposcopy ☐ 34 - Immunization ☐ 42 - Male Genitalia Exam ☐ 49 - Colo-Rectal Cancer Screening ☐ 36 - Other Lab or Exam ☐ 37 - No Lab or Exam

**Contraceptive Related Services**
☐ 17 - Diaphragm / Cap Fit ☐ 19 - IUD/IUS Insert ☐ 20 - Sterilization Procedure ☐ 38 - Hormone Implant In ☐ 39 - Hormone Implant Out ☐ 40 - Hormonal Injection ☐ 48 - EC-Immediate Need ☐ 46 - EC-Future Need ☐ 22 - IUD/IUS Removal ☐ 18 - Vasectomy Referral Fee

**Pregnancy Related Services**
☐ 21 - Post Pregnancy Exam ☐ 31 - Serum Pregnancy Test ☐ 32 - Negative Pregnancy Test ☐ 33 - Positive Pregnancy Test ☐ 35 - Infertility Screening

13A. **CONT. MEDICAL SERVICES** (Check all Applicable)

**STD Related Services**
☐ 11 - Vaginitis/Urethritis/Eval/Dx ☐ 12 - Vaginitis/Urethritis/Eval/Rx ☐ 29 - Chlamydia Test ☐ 13 - Chlamydia Treatment ☐ 14 - Chlamydia Presumptive Rx ☐ 15 - Wart Treatment ☐ 16 - Herpes Test ☐ 28 - Gonorrhea Test ☐ 30 - Wet Mount ☐ 43 - HIV Test ☐ 47 - Syphilis Test ☐ 50 - HPV Test

14A. ASSESSMENT/EDUCATION/COUNSELING (Check all Applicable)
☐ 01 - Contraceptive ☐ 02 - Fertility Aware Mthd ☐ 03 - Sterilization ☐ 04 - Infertility ☐ 08 - Preconception ☐ 13 - Abstinence ☐ 07 - Pregnancy Options ☐ 09 - STD/HIV Prevention ☐ 16 - Abnormal Pap ☐ 19 - BSE ☐ 15 - Behavioral Health ☐ 17 - Encourage Parental/ Family Involvement ☐ 18 - Relationship Safety ☐ 12 - Phys. Act./ Nutrition ☐ 05 - Tobacco ☐ 06 - Substance Abuse

19. PREGNANCY INTENTION SCREENING
☐ 1 - Yes, Near Future ☐ 2 - No, Maybe Later ☐ 3 - Unsure ☐ 4 - Never

13B.14B. PROVIDER OF MEDICAL SERVICES/COUNSELING/EDUCATION SERVICES (Mark all that Apply)
☐ 1 - Physicians
☐ 2 - Physician Assistants, Nurse Practitioners, Certified Nurse Midwives
☐ 3 - RNs, LPNs
☐ 4 - Other service providers, health educators, social workers, clinic aides and lab technicians.

15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

**HIGHLY EFFECTIVE**
14 - Male Sterilization
01 - Female Sterilization
11 - Hormone Implant
15 - IUS
03 - IUD
22 – LAM

**MODERATELY EFFECTIVE**
16 - Hormonal Injection
02 - Oral Contraceptives
17 - Hormonal Patch
18 - Vaginal Ring
04 - Diaphragm

**LESS EFFECTIVE**
06 - Male Condom
19 - Female Condom
21 - Contraceptive Sponge
20 - Withdrawal
08 - NFP/FAM
07 - Spermicide

**OTHER**
09 - Other Method
13 - Abstinence
10 - None

BEFORE VISIT ☐☐ AFTER VISIT ☐☐

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.
Pregnant: ☐ 1 - Planned ☐ 3 - Seeking Pregnancy ☐ 8 - Unplanned ☐ 7 - Other

16. REFERRAL INFORMATION (Check all Applicable)
☐ 02 - High Risk Pregnancy ☐ 15 - Adoption ☐ 03 - Abortion ☐ 01 - Prenatal ☐ 16 - Breast Evaluation ☐ 12 - Mammography or U.S. ☐ 05 - Sterilization ☐ 06 - Infertility ☐ 04 - STD ☐ 17 - Colposcopy ☐ 08 - Other Medical ☐ 10 - Social Sevices ☐ 09 - Nutrition ☐ 13 - Substance Abuse ☐ 14 - Abuse/Violence ☐ 11 - None

17. MEDICAID BILLING (Complete top section for CCare)

| Supplies Billed | Qty. | Unit Price | Supplies Billed | Qty. | Unit Price |
|---|---|---|---|---|---|
| 01-Orals | | | 07-Condoms, Male | | |
| 16-EC | | | 08-Condoms, Fem. | | |
| 14-Patch | | | 17-Ring | | |
| 15-Mirena IUS | | | 18-Sponge | | |
| 03-Copper IUD | | | 19-Subdermal Implants | | |
| 04-Depo Provera | | | 20-Cycle Beads | | |
| 05-Diaphragm | | | 21-Skyla IUS | | |
| 06-Spermicide | | | 22-Liletta IUS | | |

17A. THIRD PARTY RESOURCE CODES
(Complete if client has other insurance coverage.)
1 - Explanation Code ___
2 - Other Insurance Paid ___.___