

CHILDREN'S SPECIAL HEALTH SERVICES FLOW SHEET (DHHS 2809)

This flow sheet is designed to monitor children with special needs through adolescence. Health problems which cannot be documented adequately with the code abbreviations require a SOAP or Narrative note on the Notes (DHHS 2803). Record the letter "N" from the code in the appropriate box on the Children's Special Health Services Flow Sheet to reference information in the Notes.

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| 1.-6. | NAME, NUMBER, ETC | In the blank space in the top left on the front, attach the computer generated label or emboss the information imprinted on the patient's identification card or manually record the patient's name (last name, first name, and middle initial), identification number, date of birth (MM-DD-YYYY), race and ethnicity, gender, and county of residence. |
| 7. | ENGLISH SPEAKING | Check "Yes" or "No" as appropriate. If "No", record the language spoken. |
| 8. | INTERPRETER | Check "Yes" or "No" as appropriate. If "Yes", record who is providing interpretation. |
| 9. | ALLERGIES | List all patient's allergies: food, drugs, insects, environment. Record in <u>red ink</u> if possible. |
| 10. | CLINIC TYPE | Check as appropriate. |
| 11. | DATE/AGE | Enter the date of the assessment and age of the child at the time of the visit at the top of each successive column. |
| 12. | INFORMANT/RELATIONSHIP | Record informant's relationship to the patient. As appropriate, note if informant is not able to provide needed information. |
| 13. | CURRENT PROBLEM;
COMPLAINT; PARENTAL
CONCERNS | Record reason for the visit, including complaints or parental concerns. Use informant's words if possible. Update at each visit. Record the following information with updates as needed: Date and Age of Onset; Course and Duration; Effect of Treatment; and Referral Source. |
| 14. | IMMUNIZATION STATUS
REFERRAL/FOLLOW-UP | Record current status of immunizations. Indicate need for immunizations or follow-up to determine status. |
| 15. | CURRENT PROVIDER
FOR WELL CHILD CARE/
MEDICAL HOME | Record the name of the physician/health care provider/ medical home generally contacted. Record date of last well visit. |
| 16. | OTHER MEDICAL OR
HEALTH CARE PROBLEMS/
PROVIDERS | Identify and record other medical or health issues affecting this patient and providers as indicated. |
| 17. | CURRENT MEDICATIONS | Record all over the counter or prescription drugs that patient takes on a regular basis. |

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| 18. | SPECIAL THERAPIES | Record any speech, occupational, physical, nutrition therapies; Child Service Coordination, Early Intervention, Special Education this patient receives. |
| 19. | DURABLE MEDICAL EQUIPMENT | Record any special equipment the patient needs or uses on a regular basis and any repair needed for that equipment. |
| 20. | SIGNATURE | Record the full legal signature of the health professional responsible for the above information. |
| 21. | EDUCATION/COUNSELING PROVIDED | Record education/counseling provided for each diagnosis and treatment including clinical findings; treatments; and special therapies. |
| 22. | REFERRALS | Record by type or name, referrals to other health care providers, agencies, or immunizations. |
| 23. | DATE OF NEXT VISIT | Record the date given to the patient for the next scheduled visit. |
| 24. | SIGNATURE | Record the full legal signature of the health professional responsible for the information in items 20-22. |