Family Planning Records Review

Agency:_____ Date:_____Reviewer:

= Yes, 0 = No, NA = Not applicable, SC = See Comments

CVR # or PT #	1	2	3	4	5	6	7	8	9	10	Comments
A. Identifying Information											
1. Name and address											
2. Date of birth											
3. How to contact											
4. Amount of income and adjusted fee level											
B. History											
1. Family											
2. Medical, General											
a. Rubella											
b. Allergies											
c. DES											
d. Tobacco											
e. Drugs											
f. Alcohol											
g. STD											
h. Medications											

CVR # or PT #	1	2	3	4	5	6	7	8	9	10	Comments
3. Surgical											
4. OB/GYN											
a. Contraceptive Use											
5. Up-dated annually											
C. Physical Exam											
1. Height											
2. Weight											
3. Blood pressure											
4. Thyroid											
5. Heart											
6. Lung											
7. Breast											
a. Self-exam instructions											
8. Abdomen											
9. Extremities											
10. Pelvic											
11. Rectal											
12. Clinical impression or diagnosis											
13. Prescription											
14. Return to clinic schedule											
D. Laboratory											
1. Hb &/or Hct (if indicated)											

CVR # or PT #	1	2	3	4	5	6	7	8	9	10	Comments
2. Pap smear (if indicated)											
3. Urine sugar & protein (if indicated)											
4. G.C. culture (when indicated)											
5. Pregnancy test (PRN)											
6. Chlamydia screening (high risk criteria used)											
E. General											
1. Record of dispensing											
2. Informed consent											
a. For general clinic services											
b. For specific method											
3. Nutrition assessment											
4. Nutrition counseling (O.C., obesity or anemia)											
5. Pregnancy counseling											
6. Immunizations for patients 19 years & under											
7. Treatment, referral and F.U. (general)											
a. Hct below 37 or Hgb below 12											
b. Positive RPR/GC - CHLAMYDIA											
c. Elevated B.P.											
d. Class III, IV & V Pap smears											
8. All entries signed & all Lab slips initialed											
9. All entries dated											
10. Lab slip is complete for chlamydia testing											
11. Chlamydia follow-up											

Recommendations: