OREGON CLINIC VISIT RECORD

A. LAST NAME ________________________________ B. FIRST NAME __________________________ C. M.I. ____

D. SOC. SEC. NO. |__|__|__|--|__|__|--|__|__|__|__| E. RHAF ID NO. |__|__|__|__|__|__|__|__|

ITEMS A-E only required when billing RH Access Fund. Item D only required for those who have a SSN.

1. SITE/CLINIC NO. |__|__|__|__|__|__|__|

2. CLIENT NO. |__|__|__|__|__|__|__|__|__|

3. DATE OF VISIT |__|__|__|__|2|0|__|__|

4. DATE OF BIRTH |__|__|__|__|__|__|__|__|

5. SEX AT BIRTH ☐ 1-Female ☐ 2-Male

6. ETHNICITY ☐ 8-Unknown/Not Reported
☐ 6-Hispanic or Latino ☐ 9-Not Hispanic or Latino

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

7. ADDITIONAL DEMOGRAPHIC (check if applicable)
☐ 5-Limited English Proficiency

8. ZIP CODE |__|__|__|__|__|

10. INCOME AND HOUSEHOLD SIZE

a. Monthly Income	
b. Household Size	

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

9. ASSIGNED SOURCE OF PAYMENT (CHECK ONE)
☐ 02-Title XIX (OHP) ☐ 04-Private Insurance
☐ 03-WA Take Charge ☐ 05-Full Fee
☐ 11-OVP ☐ 07-Other
☐ 12- RH Access Fund

13B. 14B. PROVIDER OF MEDICAL SERVICES/ COUNSELING/EDUCATION SERVICES
(Mark all that apply)
☐ 1-Physicians (MD, DO, ND)
☐ 2-PA, NP, CNM
☐ 3-RNs, LPNs
☐ 4-Other service providers, health educators, social workers, clinic aides and lab technicians

7a. CLIENT'S PREVIOUS TEST DATES – Females Only

	MO. YR.
1-Chlamydia (age ≤24) ☐ 1-Never ☐ 2-Unk ☐ 3-Date:	|__|__|__|__|
2-Pap (age ≥21) ☐ 1-Never ☐ 2-Unk ☐ 3-Date:	|__|__|__|__|

13A. MEDICAL SERVICES (Check all applicable)

Visit & Lab Services
☐ 01-Annual Visit
☐ 41-Telehealth Visit
☐ 06-Breast Exam
☐ 09-Pelvic Exam
☐ 23-Hgb/Hct
☐ 24-Urine dip strip/Urinalysis
☐ 45-Language Assistance
☐ 25-Pap Test Conventional
☐ 26- Pap Test Liquid-Based
☐ 36-Other Lab or Exam
☐ 37-No Lab or Exam

Contraceptive Related Services
☐ 17-Diaphragm/Cap Fit
☐ 19-IUD/IUS Insert
☐ 22-IUD/IUS Removal
☐ 38-Hormone Implant Insert
☐ 39-Hormone Implant Removal
☐ 40-Hormonal injection
☐ 48-EC-Immediate Need
☐ 46-EC-Future Need
☐ 20-Vasectomy Procedure
☐ 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

STI Related Services
☐ 29-Chlamydia Test
☐ 13-Chlamydia Treatment
☐ 28-Gonorrhea Test
☐ 10-STI Treatment
☐ 15-Wart Treatment
☐ 16-Herpes Test
☐ 30-Wet Mount
☐ 43-HIV test
☐ 47-Syphilis Test
☐ 50-HPV Test

14A. EDUCATION/COUNSELING (Check all applicable)
☐ 01-Contraceptive
☐ 02-Fert. Aware Method
☐ 03-Sterilization
☐ 04-Infertility
☐ 05-Tobacco
☐ 06-Substance Abuse
☐ 07-Pregnancy options
☐ 08-Preconception
☐ 09-STI/HIV prevention
☐ 12-Phys. Activity/Nutrition
☐ 13-Abstinence
☐ 15-Behavioral Health
☐ 16-Abnormal Pap
☐ 17-Encourage Parental/Family involvement
☐ 18-Relationship Safety

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

OREGON CLINIC VISIT RECORD

ORHP

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

13-Abstinence
06-Condom, External
19-Condom, Internal
23-Contraceptive gel
04-Diaphragm
11-Hormonal Implant
16-Hormonal Injection
17-Hormonal Patch
03-IUD
15-IUS
08-NFP/FAM
02-Oral Contraceptives
07-Spermicide
21-Sponge
01-Tubal Sterilization
20-Withdrawal
18-Vaginal Ring
14-Vasectomy
09-Other Method
10-None

BEFORE VISIT |__|__| **AFTER VISIT** |__|__|

15B. IF NONE AT THE END OF THIS VISIT, GIVE REASON.

PREGNANT: ☐ 1-Planned ☐ 8-Unplanned
☐ 3-Seeking Pregnancy ☐ 7-Other

16. REFERRAL INFORMATION (Check all that apply)

☐ 01-Prenatal
☐ 02-High Risk Pregnancy
☐ 03-Abortion
☐ 15-Adoption
☐ 04-STI
☐ 05-Tubal Sterilization
☐ 18-Vasectomy
☐ 06-Infertility
☐ 16-Breast Evaluation
☐ 12-Mammography or U.S.
☐ 17-Abnormal Cervical Cyto.
☐ 10-Social Services
☐ 13-Substance Abuse
☐ 14-Abuse/Violence
☐ 19-Genetic Counseling

Complete the below sections if billing RH Access Fund or OVP

12. PURPOSE OF VISIT (Check One)	
☐ 11 – Low	☐ 09 – Supply-only Visit
☐ 12 – Moderate	☐ 08 – Vasectomy Referral
☐ 13 – High	

9A. DIAGNOSIS CODES:

1. |__|__|__|.|__|__|__|
2. |__|__|__|.|__|__|__|
3. |__|__|__|.|__|__|__|
4. |__|__|__|.|__|__|__|
5. |__|__|__|.|__|__|__|
6. |__|__|__|.|__|__|__|

9B. WAS INSURANCE BILLED FOR THIS VISIT?
☐ 1-No ☐ 2-Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

17. SUPPLY BILLING

Supply	Qty.	Unit price	Supply	Qty.	Unit Price
01-Orals			21-Skyla IUS		
16-EC			22-Liletta IUS		
14-Patch			23-Kyleena IUS		
15-Mirena IUS			24-Annual Ring		
03-Copper IUD			25-Contraceptive gel		
04-Depo Provera			30-Folic Acid		
05-Diaphragm			31-Azithromycin		
06-Spermicide			32-Doxycycline		
07-Condoms, External			33-Erythromycin		
08-Condoms, Internal			34-Levofloxacin		
12-Cervical Cap			35-Ofloxacin		
17-Monthly Ring			36-Ceftriaxone		
18-Sponge			37-Cefixime		
19-Subdermal implant			38-Gentamicin		
20-Cycle Beads			39-Penicillin G		
			40-Metronidazole		

17A. THIRD PARTY RESOURCE CODES (Complete if client has other insurance coverage)

1 – Explanation Code |__|__|
2 – Other Insurance Paid |__|__|__|__|.|__|__|