PCBH Program Chart Note

Draft 10-01-10 pr 415-255-3706, Page 1

DATE	TIME
9-27-2010	10:00 AM
PCBH PROVIDER	
SMITH	

CAUTION: Federal and State laws protecting confidential patient information apply to patient information contained in this completed form.

PATIENT INFORMATION (sticker may be affixed)

LAST NAME	FIRST NAME	M.I.
Jones	Sam	L.

ALIASES	SSN	DOB	MRN
None	456-78-910	5-21-80	276514

CONTACT INFORMATION

2007 Turk #42D

REFERRAL

REFERRING PROVIDER	PC CLINIC	DATE OF REFERRAL
Jones	CHC	29 Sept 2010

PRIMARY REASONS FOR REFERRAL: Chronic Pain

ASSIGNED PCP, IF DIFFERENT: Same

TYPE OF PCBH VISIT

X SAME DAY X INITIAL VISIT

❑ SCHEDULED ❑ FOLLOW-UP / LAST VISIT (date):

X INDIVIDUAL ❑ GROUP/CLASS

❑ COUPLE ❑ FAMILY ❑ PHONE

FIRST TIME SEEN BY PCBH PROGRAM: X NO X YES, THEN:

X PCBH SERVICES EXPLAINED X PATIENT GAVE VERBAL CONSENT

IF PATHWAY, FOCUS IS: Chronic Pain

1. SUBJECTIVE NOTES

LIFE CONTEXT:
- ✓ LIVES WHERE? HOW LONG? WITH WHOM?
- ✓ IF HOMELESS, HOW LONG SINCE PERM HSD?
- ✓ LEGAL / CRIMINAL?
- ✓ WORKS / OBTAINS ECONOMIC SUPPORT?
- ✓ FAMILY? FRIENDS?
- ✓ RELAXATION?
- ✓ EXERCISE?
- ✓ FUN?
- ✓ SOCIAL / COMMUNITY?

HEALTH / HEALTH RISK:
- ✓ CHRONIC DISEASE(S)?
- ✓ ADHERENCE TO MEDICATIONS
- ✓ ADHERENCE TO OTHER TREATMENT?
- ✓ ETOH / DRUGS?
- ✓ TOBACCO?
- ✓ RISK AND SAFETY?

OTHER FACTORS IMPACTING HEALTH AND USE OF HEALTH CARE SERVICES:
- ✓ HISTORY OF HEAD INJURY
- ✓ LEARNING DISABILITY / ADHD
- ✓ ACCULTURATION STRESS
- ✓ HEALTH LITERACY CONCERNS
- ✓ CHRONIC DISEASE

To what extent is (reason for referral) a problem for you? Scale 1-10: 10

- ✓ TIME?
- ✓ TRIGGERS?
- ✓ TRAJECTORY?
- ✓ WHAT MAKES BETTER?
- ✓ WHAT MAKES WORSE?
- ✓ SOLUTIONS TRIED?
- ✓ RESULTS?

Lives alone, receives disability. Did well in high school. Moved to SF and got a job as a waiter after graduation- "I was good at it". No legal problems.

No connection to his family.

Has two friends in his building.

Likes to go to the park and listen to music. To relax, watches TV, movies. Does not exercise.

No chronic disease(s). Drinks a few beers daily. Denies use of drugs except pot occasionally. No SI / HI, "but I get the blues sometimes can't get out much any more, I hurt and really don't have the money". Smokes 10 cigarettes / day – "don't want to quit".

"Pain today in right ankle (rated as 10, 1-10 scale and 10 = extreme). Pain as a problem in his life, rated as 10 (a big problem). Started 9 years ago after motorcycle accident--"Crushed my ankle."

Present daily, increases with walking. Interferes with many activities. Gets out several times a week, tends to "over do it and then pays". Medications help, but "need more".

2. OBJECTIVE NOTES

DUKE		PHYSICAL HLTH	MENTAL HLTH	SOCIAL HLTH	APPEARANCE
		20	40	60	X WNL ❑ OTHER:
PSC-17 PARENT	TOTAL SCORE	INTERNALIZING	ATTENTION	EXTERNALIZING	BEHAVIOR X WNL ❑ OTHER:
PSC-17 YOUTH	TOTAL SCORE	INTERNALIZING	ATTENTION	EXTERNALIZING	MOOD X WNL ❑ OTHER:

PRIOR SURVEY DATE:

COMPARISON TO PRIOR SUGGESTS:
❑ IMPROVEMENT ❑ STABILIZED ❑ DECLINE ❑ N/A

3. ASSESSMENT

Chronic pain with some symptoms of depression, secondary to isolation and financial constraints

BRIEF INTERVENTIONS PROVIDED (reference checklist):

1. Discussed pacing and learning to "check-in" and adjust level of activity and effort
2. Discussed importance of scheduling social activities (seeing friends) and pleasurable activities (park)
3. Provided information about the Quality of Life Class

4. PLAN

RECS TO PATIENT

1. Practice noticing pain level once per hour and making a choice about level of effort
2. Schedule 2 pleasurable activities/day, go to park on Sundays
3. Attend Quality of Life Class (1st Mon, 1 - 2)

RECS TO PCP

Communicated directly to referring provider?
❑ Yes ❑ No

1. Use Duke scores to monitor treatment impact
2. Support above behavioral changes
3. Encourage attendance of Quality of Life Class

FOLLOW-UP APPOINTMENT, if indicated

WITH PCBH PROVIDER (date) 2 weeks

APPOINTMENT WITH PCP (date) as planned

VISIT SCALING ANSWERS

How confident are you that you can carry out the plan we've made: Scale 1-10: 7

How helpful was this visit? Scale 1-10: 6

REFERRAL MADE TO NONE

❑ MH CLINIC: _____ APPT:_____

❑ SA PROGRAM: _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

SIGNATURE: Leslie Smith, LCSW DATE: 9-20-2010 TIME: 10:30