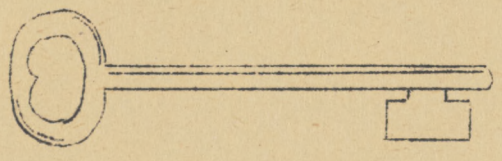

TO

PUBLIC HEALTH VISITORS RECORD FORMS

WAR RELOCATION CENTER
POSTON-ARIZONA
-1943-

(1510)

INDEX

GENERAL INSTRUCTIONS

Purpose

"To contribute to the care of the patient and his family,

To improve future health services,

To furnish data on which to base an accounting of stewardship."1/

In order to accomplish these objectives the instructions as outlined herewith must be followed without deviation.

Required forms

General Schedule
Weekly Report
Cross Reference Card
Individual Health Record
Household Record
Tickler File
Monthly Report
Refer Slip
School Health Record

Report Year

The calendar year is the report year; enumeration is begun anew each year when the first service is rendered. A person under care, or supervision at the close of one year, but who is "carried over" into the following year or who returns at any time during the following year is admitted as of the current calendar year when the first visit is made.

Admissions

Individuals are admitted through the field, office or clinic when the first service is rendered according to the primary type of service. When the primary type of service changes for a period of one month or more, or when any communicable disease occurs, the patient is admitted again in accordance with this change. When service is resumed for the original condition, he is not re-admitted. Extremely brief and relatively unimportant morbidity service should be recorded as a visit but not an admission, if the patient has already been admitted.

All individuals are admitted to service through field, office or clinic the first time visiting service and/or medical care is rendered. Cross Reference Card, Individual Health Record and Household Record should be filled out for each person at the time of admission, unless these are available from the inactive file. If a "follow-up" visit is contemplated, a Tickler Card is also made out.

Individuals who come to the clinic to obtain medicine or advice for someone ill in the home are not admitted to service. If the physician prescribes in the clinic in "absentia", his advice is recorded on the absent individual's health record in red ink. The information should state the patient was not seen.

1/ Supervision in Public Health Nursing--Hodgson, p. 207

Enumeration of Procedures

Whenever actual service is rendered, it must be recorded on the Individual health record.

A single call at home is to be counted as one visit if service is rendered to only one person, as two visits if two persons are served and so on, provided an entry is made on the record of each individual.

A service to a school child seen in school is not reported as a field visit, but if a follow-up call is made to the home, it would then be classed as such.

A contact with an individual where two or more services are performed is recorded only once, according to the PRIMARY purpose of the visit. If a chronic condition is complicated by an acute condition, the patient is admitted for the acute condition and the visit is counted in that category even though the patient was admitted previously for the chronic condition.

Classification of Visits

Visits to cases:
Visits in which a person is seen, and where service is rendered. This includes bedside care, and visits of instruction and demonstration, etc.

Visits in behalf of cases:
Those visits made to someone other than patient or a visit or telephone call to a physician or health officer relative to the care of the case. This means if a patient is seen in the field and the visitor later follows this up with a conference with a physician or a visiting nurse, etc., two or more visits are recorded for this patient.

Filing

As cases are admitted during the year, the records are transferred from the "inactive" to the "active" file. At the end of each calendar year all records are reviewed, then placed in the "inactive" file.

Weekly Reports

Weekly reports should be filed according to week and month.

Cross Reference Cards -- file alphabetically in:

a. Active file
b. Inactive file
c. Deceased file

When a patient dies, that notation is made on the Cross Reference Card which is then filed in a section marked "deceased" in the inactive file.

Family Folders containing Household Record and Individual

Health Records are filed numerically in:

a. Active file
b. Inactive file

When a patient dies, that notation is made on the Household Record and Individual Health Record. The latter is removed from the family folder and placed alphabetically in a manila folder marked "deceased", which is placed in the "Inactive" family folder file.

Correspondence

Correspondence regarding patients should be summarized on the Individual Health Record, then filed chronologically in a manila folder marked "Patient Correspondence".

Information from "Refer Slip" is to be copied on the Individual Health Record. These forms are filed in a separate manila folder as above.

Writing Records

At the beginning of each day the visitor selects according to the tickler file the records of the cases to be visited, reviews last few entries and makes plans for her visit. The records are taken into the home and the information is recorded there as part of the visit. This enables the visitor to keep current with changes and additional information, gives continuity to her teaching and makes the patient cognizant of the instruction he is receiving.

GENERAL SCHEDULE

Purpose

To provide a plan whereby an effective public health service can be rendered. A general schedule outlining the program to be followed and the areas to be visited regularly each week of every month is to be compiled at the beginning of each new calendar year. Copies of this should be submitted to the Director and Assistant Director of Public Health Visiting, the health officer, and the nurse supervising the clinic and public health visitors.

WEEKLY REPORT

Purpose

To serve as a weekly schedule for daily activities.
To furnish information for compiling the monthly report.

Method of Recording

Name -- Record visitor's name.
Date -- Record the date.
Name column -- Record the name of each patient seen.

V - Column --Record code number according to type of service rendered.
A Column -- Record the admissions.
Summary of Visiting Services -- Record at the end of the day the total number of visits and admissions made according to each of the code under appropriate headings. Place totals at the end of the week in the sum total columns.

CROSS REFERENCE CARD

Purpose

To furnish a record of the admissions to visiting and clinic service.
To identify the patient with the family group and personal history.

Method of Recording

Family Number -- Record the number assigned to the family; it must be identical to the one on Household and Individual Health Records.
Name -- Record person's name; surname first.
Address -- Record present location of individual.
Father's name -- Record full name; surname first.
Mother's name -- Record full name; surname first, including maiden name.
Diagnosis or service -- Record physician's diagnosis, type of service rendered, and change in service.
Code -- Record the code # identifying the type of service rendered when admitted. Place A in front of the number the first time the case is admitted and each time thereafter when the type of service changes.
Flags --
The following flags are placed on the Cross Reference Card to indicate certain specific conditions for which the individual is receiving service:

Dark green ---------- Active tuberculosis
Light green ---------- Contact tuberculosis
White ---------- Suspect tuberculosis
Red ---------- Venereal Disease
Dark blue ---------- Prenatal
Light blue ---------- Infants
Orange ---------- Trachoma
Black ---------- Malaria
Yellow ---------- Crippled Children

Flags are retained on the Cross Reference Cards until the end of the calendar year when they are removed If the condition indicated by the flag no longer exists.

INDIVIDUAL HEALTH RECORD

Purpose

To contain all pertinent data relative to the individual's health and service rendered, such as: hospital, clinic, field medical and public health visitor's visits.

To show the purpose and content of each visit.

To show the patient's response to teaching and results obtained.

To furnish information for a study of the nursing service.

Method of Recording

Family number -- Record the number assigned the family; this must be indentical with the Household Record and Cross Reference Card numbers.

Name -- Record the individual's name; surname first.

Sex -- Record the individual's sex; indicate by M and F.

Place of birth -- Record place where the individual was born.

Birthdate -- Record month, day, and year of birth. (1/12/40).

Address -- Record where individual lives.

Communicable Disease History -- Record past and current communicable diseases history with dates. If individual has not had any such diseases, the date that the information is requested should be recorded as "none to date."

Immunizations -- Record all immunizations when they have been completed. If a person has been vaccinated for smallpox, state whether or not scar is present.

Tests -- Record all tests given and their results such as Wassermann, Shick, Dick, Tuberculin, G. C. Smears, sputum examinations, X-rays, and urinalysis if pertinent.

Other History -- Record history or conditions not included under communicable disease, immunizations, tests. To summarize, old hospital reports, clinic reports, etc.

Date -- Record month, day and year each time service is rendered.

Physician's findings -- Record physician's diagnosis of the disease or the type of visiting service for which the patient was admitted.

T.P.R. -- Record temperature, pulse, and respiration.

Conditions found, service rendered, results -- Record the public health visitor's visits. The information should be specific and summarize conditions found, show what was taught and/or demonstrated, response and/or reaction of individual served.

Each time a visit is recorded, indicate the code.
Example: A - 8 shows that the individual was admitted as a prenatal; 3 shows that a tuberculosis visit was made.

Each visit should be indented starting under the space "Conditions Found" and on the following line brought over to T.P.R. column.

Each entry should be initialed by the visitor. An open line should be left before recording a new admission.

Clinic remarks, physician's diagnosis and orders, hospital reports, etc., are to be copied in RED ink. All correspondence should be summarized with the date referring to where the original correspondence is filed.

HOUSEHOLD RECORD

Purpose

To record pertinent information on each family relative to the individual members, O.P. D. number, birth dates, death dates, cause of death, occupation or school, C.D. History, completed immunizations tests, and other health problems.

To summarize health problems and make specific plans in accordance with the family resources whereby their problems can be remedied or solved.

Method of Recording

Name -- Record surname.
Address -- Record address.
Date of birth -- Record month, day, and year of birth, indicate numerically 6/10/40.
Date of death -- Record month, and year of death.
Cause of death -- Record cause of death (verify if possible with physician).
Occupation or School Record -- Record individual's occupation or grade in school.
C.D.History -- Record communicable diseases according to code.
Complete Immunizations -- Record immunizations that have been completed by an X under appropriate heading according to code.
Tests -- Record tests given with date, name and result.
Other Health Problems -- Record major problems or chronic conditions such as blindness, loss of arm, leg, etc., asthma, cardiac, etc.
Pertinent Information -- Record other pertinent information such as cooperation, financial need, etc. Always place date before each recording.

Line #1 -- Record name of head of the house.
Line #2 -- Record wife's given name; write maiden name in parenthesis.
Line #3 to 10 --Record all children born to man and wife listed in order of birth. If a son or daughter is married, indicate this under column "Occupation". If step-children of either husband and wife or both living in the household, their names should be recorded after children of present marriage.

Line #11 to 14 -- Record name of others living in the home, such as distant relatives, grandchildren, in-laws, friend, etc.
Relationship -- Record individual's relationship to the above family. For example, husband #3, or brother #1
Problems and Plans -- To be recorded on the reverse (back) side of the record. Original problems and plans should be stated on the left hand side according to the attached example. These should be reviewed at least once a year.

TICKLER FILE

Purpose

To enable the visitor to plan her work systematically in relation to home visits, records, meetings, clinics, etc.

Equipment

File Box to hold 4 x 6 cards
Monthly guide cards (12)
Current guide cards (31)
Tickler card (see example)

Work Card (see example)

Tickler Card

Surname _____			Area					Family No. _____			
Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.

Work cards -- plain cards as necessary (Title with capitals) for:

CLINICS, SCHOOL, MEETINGS, REPORTS, etc.

CLINIC

Procedure for Using

Place "Tickler cards" and "Work cards" as of the month behind the date when cases are to be visited or the work carried out. Each time a case has been visited, indicate this under the month by a straight line on the Tickler card.

File the cards daily after the visit is recorded whenever the case is to be visited again in accordance with the general schedule.

MONTHLY STATISTICAL REPORT

Purpose

To summarize numerically the amount of work accomplished for the month.

Method of Recording Heading

Camp -- Record camp number.
Name -- Record visitor's name.
Month -- Record month and year after 19 ___.

Explanation of Form

First column -- Lists code numbers identifying the types of services rendered.
Second column - Lists services "to or in behalf of" individuals.
Third column -- Record the total number of field visits for the month.
Fourth column - Record the total number of admissions to each service for the month.

Definition of Specific Items

Morbidity Service is service rendered to those acute or chronically ill; it includes actual bedside care, demonstration and instruction in bedside care, instruction relative to protection against infection, collection of epidemiological data, and general hygiene during convalescence.

1. Non communicable disease service is service rendered to patients with diseases not listed as reportable by the State Board of Health; it includes chronic and adult orthopedic.
2. Crippled Children Service is service rendered to crippled children. Unless otherwise specified by State Law, a "Crippled child" is defined for the purpose of tabulation as any person under 21 years of age having orthopedic types of deformity connoted by the term "crippled".
3. Communicable is service rendered to patients having a communicable disease; it includes actual care and supervisory visits for the purpose of care and control of those communicable diseases listed as reportable by the State Board of Health.
4. Trachoma is service rendered to diagnosed, arrested, contact, and suspect cases.
5. Tuberculosis Control is service rendered to diagnosed, arrested, contact, and/or suspect cases.
6. V. D., Lues is service rendered to diagnosed, arrested, contact and/or suspect cases of syphilis.
7. V. D., G. C. is service rendered to diagnosed, contact, and suspect cases of gonorrhea.

Maternity service is service rendered to pregnant cases including antepartum and postpartum periods.

8. Antepartum care -- Care during pregnancy.
9. Postpartum care -- Care for first 6-8 weeks, following

delivery.

Health Supervision Service is service rendered for continuous health supervision of supposedly well individuals of any age group. Health supervision relates to such aspects of health as the nutrition of the individual, formation of habits of personal hygiene, clothing, exercise, rest, social and mental adjustments; observation of physical defects and assistance in securing correction according to medical advice, and encouraging immunizations, vaccinations, and physical examinations for the protection of health.

10. Infant is a child from birth to one year of age.
11. Pre-school is a child between one and six years, not attending school. A child under continuous health supervision but passing from one age group to another during the report year is admitted once as an infant and once as a pre-school. The same is true for other age groups.
12. School is service rendered to apparently well individuals six years to eighteen for girls and twenty-one for boys.
13. Adult is service rendered to women over 18 and men over 21 years of age.
14. Special projects are special activities of limited duration which promote some particular phase of the public health visiting program.
15. Informative visits are calls to get acquainted, to secure for the Household Record, and/or to determine health needs and conditions where no individual service is rendered.
16. Unresultant visits are visits which result in no further such as: when the patient is not at home or when the service desired is not health service.
17. Sanitation visits are visits made for the purpose of keeping healthful premises.

TOTALS -- VISITING SERVICE - Place totals for each column under appropriate spaces.

Clinic is a group of people who come together for examination and/or treatment by a physician. Clinics are counted each time held.

New admissions are individuals who receive clinic service for first time during the calendar year. Individuals to whom drugs are dispensed or advice given about a member of his family are not to be admitted to clinic or nursing service.
Number of clinics are the total numbers held.
Total attendance is the total number of patients who attend the clinic, including those admitted as well as those who come in behalf of a patient.

18. Well-Baby -- clinic held for well babies.
19. Pre-school -- clinic held for pre-school children.
20. Others -- Record name of any other type of clinic held with physician.

Group Instruction is health instruction given by the public health visitor. Meetings are held consecutively or intermittently.

21. Home Nursing -- lesson plans and instruction manuals can be obtained through the American Red Cross and State Boards of Health to be used as a guide in planning such lessons.
22. Other -- Record class instruction on any other subject than covered by number 21.
23. Group talks -- Record the number of single talks given.

Immunizations

24-27. Record under appropriate headings only when these are completed. It is not necessary that immunizations be confirmed by a test before being considered as completed. Number is the number of groups done. Total is number of individuals immunized.
28-33. Tests -- Record the same as for immunization.

School work is service rendered by visitor to promote school health work which includes:
Assisting the physician with physical examinations, immunizations and special test, etc.
Conferring with the teachers regarding the physical defects ascertained by the physician.
Demonstrating special health procedures such as daily morning inspection, weighing, measuring, etc.

34. Health examinations are physical examinations given by the doctor with the public health visitor assisting.
35. Demonstrations are demonstrations of certain health procedures given by the visitors to the teachers.
36. Teacher conferences are conferences with the teachers regarding the physical defects found by the physician through the physical examinations.
37. Inspections are pupil inspections done by the visitor to detect skin rashes, etc.
38. P.T.A. Meetings are meetings conducted by the school parents.
39. Others are to list any additional type of school work.

Administrative work is the activity of the visitor concerned with the promotion of her program.

40. General meetings are all general group meetings.
41. Conferences with Supervising Nurse are individual discussions concerned with plans, policies, program and procedures.
42. Staff Conferences are planned group meetings for the public health visitors. Record total hours spent in all types of office work exclusive of time spent with the doctor in clinic service. The hours on records are included in this total.

43. Conferences with P.H.N. are individual conferences with the Director or Assistant Director of the Public Health Visiting Program.
44. Office hours are the total number of hours spent in the office.
45. Studying -- Record total number of hours spent in attending classes and class preparation.
46. Illness -- Record amount of time off duty when ill.

REFER SLIP

The "Patient's Reference and Discharge Notice" is to be used to refer and return information about patients from the field to clinic or clinic to the hospital or the clinic to the field. Such information as is returned is to be copied on the Individual Health Record.

SCHOOL HEALTH RECORD

The "School Health Record" is to be used when physical examinations are given children in school. The public health visitors compiled a "Summary of the School Health Records" for each grade.