COMMUNITY HEALTH NETWORK OF SAN FRANCISCO

NAME

DOB

MRN

PCP

Patient ID / Addressograph or label

OUTPATIENT PROGRESS NOTE
DIABETES GROUP MEDICAL VISIT

(Front of two sides.)

Date: _____ Session #: _____ Brings Meter/ Logbook? □ Yes □ No

Facilitator(s) _____ _____

Last Action Plan: Achieved goal? □ Yes □ Partially □ No Comment: _____

Action Report: _____

_____

New Action Plan: _____ Confidence Score (1-10): _____

New Problems: _____

_____

_____

_____

_____

_____

_____

_____

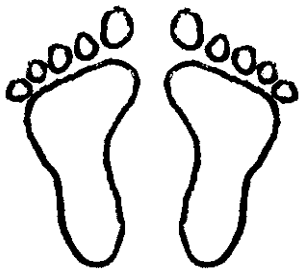
PAIN: NO _____ YES _____ (if yes, continue)

Location	Scale (1-10)	Pattern (I/C)

I = intermittent C= constant

Exam: Wt. _____ Ht. _____ BMI _____ BP _____ P _____ T _____ RBS*_____

***RBS = random blood sugar**



Foot Exam:

Date (if foot exam completed elsewhere): _____

Recent Labs:

Continue on back of page.

COMMUNITY HEALTH NETWORK OF SAN FRANCISCO NAME

OUTPATIENT PROGRESS NOTE DOB
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Problems, including assessments and plans:

1. Diabetes _____

_____

_____

_____

_____ On aspirin? □ Yes □ No

2. _____

_____

_____

_____

3. _____

_____

_____

_____

4. _____

_____

_____

_____

Health education this visit (check all that apply):

□ Diabetes basics	□ Exercise	□ Medications
□ Glucose monitoring	□ Smoking	□ Pain control
□ Nutrition	□ Foot care	□ Sick care
□ Sexual function	□ Coping/ Stress reduction	□ DM complications
□ Alcohol	□ Sx of hypo/ hyperglycemia	□ Other _____

Referrals this visit (check all that apply):

□ Ophthalmology	□ Mental Health	□ Primary Care Provider
□ Podiatry	□ Nutritionist	□ Diabetes Educator
□ Pharmacist	□ Exercise Group	□ Smoking Cessation
□ Stress Reduction	□ Social Worker	□ Other _____

Level of participation in today's session: □ None □ Minimal □ Moderate □ Full Next visit date: _____

Date: _____ Time: _____ Provider: _____ CHN ID #:_____
Print name Signature Title

Medical Record Original