2020 NC Farmworker Health Program Enabling Services Encounter Form

Patient Name: ____________________ Service Date: ____________

Address: ____________________ Provider Name: ____________

____________________ Time Spent w/ Patient: ________

Patient DOB: ____________ Age: ____________ ☐ In-person ☐ Telephone ☐ Video call

CASE MANAGEMENT

Assessment *(circle one)*

Code	Service
100.01	Initial Health Assessment
100.02	Follow Up

Referrals

Referral Type (circle one)

Code	Type	Code	Type
200.01	Primary Care	200.02	Dentist
200.03	Mental Health	200.04	Specialist
200.05	Optometry	200.06	Non-Medical

Referred to: ____________
Referred for: ____________
Date of Appt if made: ____________

Referral Type (circle one)

Code	Type	Code	Type
200.01	Primary Care	200.02	Dentist
200.03	Mental Health	200.04	Specialist
200.05	Optometry	200.06	Non-Medical

Referred to: ____________
Referred for: ____________
Date of Appt if made:

Health Care Plan Referrals

(Circle all that apply)

Code	Service	Code	Service
600.18	ACA/Insurance	300.04	HIV Test
300.07	Bld Pressure	300.03	Immunization
300.08	BMI	300.06	Pap Test
300.02	Dental Varnish		

Interpretation & Transportation

What are you providing this service for?

Code	Service	Code	Service
800.39	Primary care	800.40	Specialty
800.41	Dental	800.42	Behavioral health
800.44	Other	800.46	Social services

Interpretation time (circle one)

400.01 30 min 400.02 45 min 400.03 60+min

Transportation time (circle one)

Code	Time	Code	Time	Code	Time
500.01	15 min	500.03	45 min	500.05	90 min
500.02	30 min	500.04	60 min	500.06	120+ min

Providing Resources

(circle all that apply)

Code	Resource	Code	Resource
600.13	Car Seat	600.10	Sunglasses
600.09	First Aid Kit	600.06	Toiletries
600.12	HIV/Oraquick Test		
600.17	Dental Varnish Applied		
600.14	Dental Supplies		
600.01	Clothing		(Qty.______)
600.15	Colon Cancer Screen Given		
600.21	Colon Cancer Screen Collected		
600.03	Condoms		(Qty.______)
600.08	Folic Acid		(Qty.______)
600.02	Food		(Qty.______)
600.04	OTC meds		(Qty.______)
600.05	Prescriptions		(Qty.______)
600.07	Vitamins		(Qty.______)
600.11	Other: ____________		(Qty.______)

Other Outreach Activities

700.01 BP # ____________
700.02 BMI # ____________
800.XX Unmet Need: ____________
CMSV110.01 RHS-15 screening
800.47 Substance use screening
700.03 Glucose # ____________
700.09 A1C* ____________
**Schedule a departure visit if needed*
700.04 Other: ____________
CMSV120.01 AIR Protocol (pesticides)
700.05 Outreach/ Clinic Services Provided

COVID-19 Case Management *(Circle all that apply)*

CM100.03 Initial COVID-19 assessment*
*date of symptoms onset: ________
CM100.04 COVID-19 follow up
CM700.10 Health department referral
CM700.11 911/ER referral
HE900.70 COVID-19 health education

COVID-19 status *(Choose one)*
- CM900.01 suspected (has symptoms)
- CM900.02 presumed positive (by provider)
- CM900.03 tested positive
- CM900.04 tested negative

If applicable:
CM900.05 recovered CM900.0 high risk CM700.12 fatality

HEALTH EDUCATION

(Circle all that apply)

Code	Topic
900.01	911
900.37	Alcohol/ drug use
900.02	Anemia
900.03	Athlete's Foot
900.04	Back Pain
900.46	Cancer
900.05	Car Seat
900.06	Child Care/Parenting
900.07	Child Development
900.08	Cholesterol
900.48	Clinic Services
900.65	Colon Cancer Screening
900.10	Dental
900.11	Diabetes
900.12	Disaster Preparedness
900.13	Domestic Violence
900.47	DWI
900.14	Emotional Health
900.61	Exercise
900.15	Family Planning
900.16	First Aid
900.17	Folic Acid
900.18	Green Tobacco Sickness
900.09	Heat Illness
900.19	HIV/AIDS/STIs
900.20	Hypertension
900.21	Immunizations
900.22	Insect/Snake Bite
900.63	Insurance/ACA
900.23	Lead Exposure
900.24	Liv. Conditions/Sanitation
900.25	Medication Use
900.26	Nutrition
900.64	PAP Screening
900.28	Personal Hygiene
900.29	Pesticides
900.30	Poisonous Plants
900.31	Pre /Post HIV Counseling
900.32	Prenatal
900.33	Respiratory/Asthma
900.34	Seat Belt
900.35	Skin/Wound Care
900.44	Smoking
900.38	Sun Exposure
900.39	Tuberculosis
900.40	Vision/Eye Care
900.41	Vitamins
900.45	Water Safety
900.42	Other: _____