

Patient _____
Patient ID _____
Time _____
Date _____

Age/DOB _____ FCG _____ CNA _____
Patient/FCG concern: _____
Sufficient Food? Y/N Sufficient Medication? Y/N

1

Patient History and Physical

Vital Signs

Allergies? Y/N
Specify _____

Weight: _____ BP: _____
Pulse: _____ Temp: _____
Resp. Rate: _____

Current Medication	Dosage/Taken	Route
_____	_____	_____
_____	_____	_____
_____	_____	_____

General exam change from last week? Y/N
Specify: _____

2

Assessment

Assessment change from last week? Y/N
Please specify new diagnosis : _____

Estimated weekly ARV adherence rate: _____
Estimated weekly DOTS adherence rate: _____
Patients ADL assessment: _____

3

Plan

Plan change from last week? Y/N Food given? Y/N Specify: _____

Therapy given? Y/N Specify: _____

Referral? Y/N Specify: _____

Medication Given? Y/N

Medication	Dosage/Taken	Route	# of pills given/unavailable
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____