Family Planning Encounter Form

CLIENT INFORMATION TAB

Client Name: _____ **Date of Activity:** _____
(MM/DD/YYYY)

Client Address: _____ **City:** _____ **Zip Code:** _____

County of Residence: _____ **Phone Number:** _____

E-mail: _____

Primary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Secondary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Household Size: _____ **Annual Household Income: $** _____

Have you had a well visit during the last 12 months? (With any provider, not just within the program)

- ☐ No
- ☐ Yes

Do you have a Medical Home?

- ☐ No
- ☐ Yes

Go to Visit Information Tab

Kansas Department of Health and Environment

DAISEY

Family Planning Encounter Form

VISIT INFORMATION TAB

CAREGIVER/ADULT ONLY:

Program:

- ☐ Family Planning (FP)

Do you want to talk about contraception or pregnancy during your visit today?

- ☐ No - I do not want to talk about contraception today because I am here for something else
- ☐ No - This question does not apply to me/I prefer not to answer
- ☐ No - I am already using contraception
- ☐ No - I am unsure or don't want to use contraception
- ☐ No - I am hoping to become pregnant in the near future
- ☐ Yes

Would you (and/or your partner) like to become pregnant in the next year?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Okay either way
- ☐ Currently Pregnant

Do you have a child or children?

- ☐ No
- ☐ Yes - **Do you have someone to turn to for day-to-day support with parenting or raising children?**
  - ☐ No
  - ☐ Yes

Are you pregnant?

- ☐ No - Not pregnant - **In the past year, how often have you used**

Alcohol? (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Tobacco, Nicotine, and/or Vaping Products?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Illegal Drugs? (Including marijuana)

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
- ☐ Yes

☐ Yes - **How often have you used the following substances since you found out that you are pregnant:**

Alcohol (since learning of pregnancy)?

- ☐ I am using alcohol more
- ☐ My alcohol use is about the same
- ☐ I have reduced the amount or frequency of alcohol use
- ☐ I have stopped using alcohol
- ☐ I have never used alcohol

Tobacco, Nicotine, and/or Vaping Products (since learning of pregnancy)?

- ☐ I am using tobacco, nicotine, and/or vaping more
- ☐ My tobacco, nicotine, and/or vaping use is about the same
- ☐ I have reduced the amount or frequency of tobacco, nicotine, and/or vaping use
- ☐ I have stopped using tobacco, nicotine, and/or vaping products
- ☐ I have never used tobacco, nicotine, and/or vaping products

Prescription Drugs for Non-Medical Reasons (since learning of pregnancy)?

- ☐ I am using prescription drugs more
- ☐ My prescription drug use is about the same
- ☐ I have reduced the amount or frequency of prescription drug use
- ☐ I have stopped using prescription drugs
- ☐ I have never used prescription drugs

Illegal Drugs (since learning of pregnancy)?

- ☐ I am using illegal drugs more
- ☐ My illegal drug use is about the same
- ☐ I have reduced the amount or frequency of illegal drug use
- ☐ I have stopped using illegal drugs
- ☐ I have never used illegal drugs

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
- ☐ Yes

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest in doing things

- ☐ Not at all
- ☐ Several days
- ☐ Morer than half the days
- ☐ Nearly every day

Feeling down, depressed, or hopeless

- ☐ Not at all
- ☐ Several days
- ☐ Morer than half the days
- ☐ Nearly every day

Feeling nervous, anxious, or on edge

- ☐ Not at all
- ☐ Several days
- ☐ Morer than half the days
- ☐ Nearly every day

Not being able to stop worrying

- ☐ Not at all
- ☐ Several days
- ☐ Morer than half the days
- ☐ Nearly every day

Do you have someone to turn to for day-to-day support?

- ☐ No
- ☐ Yes

Go to FP Tab

Family Planning Encounter Form

FP TAB

Provider (Staff or Medical providing services to client with highest level of training): (Select one)

- ☐ Physician **Attending physician National Provider Indicator (NPI) Number:**_____
- ☐ Registered Nurse
- ☐ Registered Midwife
- ☐ Nurse Practitioner **Attending physician National Provider Indicator (NPI) Number:**_____
- ☐ Physician Assistant **Attending physician National Provider Indicator (NPI) Number:**_____
- ☐ Doula
- ☐ Certified Health Education Specialist
- ☐ Social Worker
- ☐ Other

Payer for visit: (select all that apply):

- ☐ None (no charge for current services)
- ☐ Medicare (traditional fee-for-service)
- ☐ Medicare (HMO/managed care)
- ☐ Medicaid (traditional fee-for-service)
- ☐ Medicaid (HMO/managed care)
- ☐ Workers' compensation
- ☐ Title programs (e.g., Title III, V, or X)
- ☐ Other government (e.g., TRICARE, VA, etc.)
- ☐ Private insurance/Medigap
- ☐ Private HMO/managed care
- ☐ Self-pay
- ☐ Unknown
- ☐ Other (specify)_____

Client's current method of contraception reported at beginning of visit: (Select all that apply)

- ☐ Non-hormonal water-based vaginal gel contraception
- ☐ Subcutaneous contraceptive implant
- ☐ Hormone releasing intrauterine device contraception
- ☐ Copper intrauterine device contraception
- ☐ Intrauterine device contraception
- ☐ Female sterilization
- ☐ Vasectomy
- ☐ Depot contraception
- ☐ Combined oral contraceptive
- ☐ Progestogen only oral contraception
- ☐ Transdermal contraception
- ☐ Vaginal hormone releasing ring
- ☐ Male Condom
- ☐ Contraceptive diaphragm
- ☐ Female condom
- ☐ Withdrawal contraception
- ☐ Spermicidal contraception
- ☐ Contraceptive sponge
- ☐ Contraception based on fertility awareness
- ☐ Contraception lactational amenorrhea method
- ☐ Male relying on female contraception
- ☐ Postcoital contraception
- ☐ Declines to state contraceptive method
- ☐ No contraceptive precautions **Reason for no contraceptive method use: (Select all that apply)**

- [ ] Sexually abstinent
- [ ] Has same sex partner
- [ ] Sterility
- [ ] Wants to become pregnant
- [ ] Other **Specify reason for no contraceptive method at intake:**

_____

Program Services: (Select all that apply)

- [ ] Contraceptive Follow-up
- [ ] Counseling for Tobacco Use
- [ ] Counseling for Alcohol Use/Substance Use (legal or illegal)
- [ ] Counseling for Mental/Behavioral Health
- [ ] Counseling for Depression
- [ ] Counseling for Intimate Partner Violence
- [ ] Counseling for Human Trafficking
- [ ] Counseling for Diabetes
- [ ] Counseling for Hypertension
- [ ] Counseling to Achieve Pregnancy
- [ ] Education
- [ ] Pregnancy Test
- [ ] STD/STI Treatment
- [ ] Other STD/STI Test_____
- [ ] Other Screening_____

Systolic blood pressure:_____ Diastolic blood pressure: _____

Body Height (metric):_____ Body Weight (metric): _____

Clinical Breast Exam Result: (Select one)

- ◯ Did not conduct Clinical Breast Exam
- ◯ Normal
- ◯ Abnormal **Referral for further evaluation based on the Clinical Breast Exam: (Select one)**
  - ◯ No
  - ◯ Yes

Has the client had a Pap test performed in last 5 years? (Select one)

- ◯ No
- ◯ Yes **Pap test performed at this visit? (Select one)**
  - ◯ No
  - ◯ Yes **LOINC Code:_____**

    Pap Test Result – Coded: (Select one)
    - ◯ Atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
    - ◯ Atypical squamous cells of uncertain significance, probably malignant
    - ◯ Low-grade squamous intraepithelial lesion
    - ◯ High-grade squamous intraepithelial lesion
    - ◯ Squamous cell carcinoma, no International Classification of Diseases for Oncology subtype
    - ◯ Atypical glandular cells on cervical Papanicolaou smear
    - ◯ Atypical glandular cells, favor neoplastic
    - ◯ Adenocarcinoma in situ
    - ◯ Negative for intraepithelial lesion or malignancy
    - ◯ Specimen satisfactory for evaluation
    - ◯ Specimen unsatisfactory for evaluation
    - ◯ Results Pending

HPV test performed at this visit? (Select one)

- ☐ No
- ☐ Yes **LOINC Code:**_____
  - **HPV Test Result – Coded: (Select one)**
    - ☐ Positive
    - ☐ Detected
    - ☐ Negative
    - ☐ Not detected
    - ☐ Equivocal
    - ☐ Indeterminate
    - ☐ Results Pending

Chlamydia test performed at this visit?

- ☐ No
- ☐ Yes **LOINC Code:**_____
- ☐ Chlamydia trachomatis and Neisseria gonorrhoeae combined test **LOINC Code:** _____
  - **Chlamydia Test Result – Coded: (Select one)**
    - ☐ Positive
    - ☐ Detected
    - ☐ Negative
    - ☐ Not detected
    - ☐ Inconclusive
    - ☐ Equivocal
    - ☐ Indeterminate
    - ☐ Not applicable
    - ☐ Quantitative lab
    - ☐ Results Pending

Neisseria gonorrhoeae test performed at this visit? (Select one)

- ☐ No
- ☐ Yes **LOINC Code:**_____
- ☐ Chlamydia trachomatis and Neisseria gonorrhoeae combined test **LOINC Code:** _____
  - **Neisseria gonorrhoeae Test Result – Coded: (Select one)**
    - ☐ Positive
    - ☐ Detected
    - ☐ Negative
    - ☐ Not detected
    - ☐ Inconclusive
    - ☐ Equivocal
    - ☐ Indeterminate
    - ☐ Not applicable
    - ☐ Quantitative lab
    - ☐ Results Pending

HIV Test performed at this visit? (Select one)

- ☐ No
- ☐ Yes **HIV Test Method – LOINC Code:** _____
  - **HIV Test Result – Coded: (Select one)**
    - ☐ Positive
    - ☐ Detected
    - ☐ Negative
    - ☐ Not detected
    - ☐ Inconclusive

- ☐ Equivocal
- ☐ Indeterminate
- ☐ Reactive
- ☐ Non-Reactive
- ☐ Not applicable
- ☐ Quantitative lab

Syphilis test performed at this visit? (Select one)

- ☐ No
- ☐ Yes **Syphilis test performed: Syphilis Test Method – LOINC Code: _____**
  Syphilis Test Result – Coded: (Select one)
  - ☐ Positive
  - ☐ Detected
  - ☐ Negative
  - ☐ Not detected
  - ☐ Inconclusive
  - ☐ Equivocal
  - ☐ Indeterminate
  - ☐ Reactive
  - ☐ Non-Reactive
  - ☐ Not applicable
  - ☐ Quantitative lab ([arb'U]/mL)
  - ☐ Quantitative lab (Titer)

Client's current method of contraception reported at end of visit:

- ☐ Non-hormonal water-based vaginal gel contraception
- ☐ Subcutaneous contraceptive implant
- ☐ Hormone releasing intrauterine device contraception
- ☐ Copper intrauterine device contraception
- ☐ Intrauterine device contraception
- ☐ Female sterilization
- ☐ Vasectomy
- ☐ Depot contraception
- ☐ Combined oral contraception Transdermal contraception
- ☐ Vaginal hormone releasing ring
- ☐ Sheath contraception (Male Condom)
- ☐ Contraceptive diaphragm
- ☐ Female condom
- ☐ Withdrawal contraception
- ☐ Spermicidal contraception
- ☐ Contraceptive sponge
- ☐ Contraception based on fertility awareness
- ☐ Contraception lactational amenorrhea method
- ☐ Male relying on female contraception
- ☐ Postcoital contraception
- ☐ Declines to state contraceptive method
- ☐ No contraceptive precautions **Reason for no contraceptive method use:**
  - ☐ Sexually abstinent
  - ☐ Has same sex partner
  - ☐ Sterility
  - ☐ Wants to become pregnant
  - ☐ Other - **Specify Other Reason:**_____

If Type of Contraceptive Method was selected at end of visit, How was it provided? (Select one)

- ☐ Patient encounter procedure
- ☐ Referral to health worker
- ☐ Prescription

Duration of Visit: (Minutes) _____
(Include number of minutes spent in direct contact with client by ALL service providers during the visit)

Is this Family Planning Visit Confidential?

- ☐ No
- ☐ Yes

Go to End of Visit Tab

END OF VISIT TAB

Were any referrals made for this visit: (select all that apply)

- ☐ No Referrals
- ☐ Behavior Health
- ☐ Breastfeeding
- ☐ Developmental Screening
- ☐ Depression
- ☐ Infant Care
- ☐ Medical Home
- ☐ Prenatal Care
- ☐ Postpartum Care
- ☐ Substance Use
- ☐ Transition
- ☐ Well Visit

Were any health risk screening tools administered at this visit: (select all that apply)

- ☐ No Screening Tools
- ☐ ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)
- ☐ CRAFFT-N (Substance use screening for adolescents)
- ☐ EPDS (Edinburgh Postnatal Depression Scale)
- ☐ GAD-7 (Generalized Anxiety Disorder screening)
- ☐ PHQ-A Patient Health Questionnaire for Adolescents (depression)
- ☐ PHQ-9 Patient Health Questionnaire (depression)
- ☐ SDOH (Social Determinants of Health assessment)
- ☐ Other – **Specify other screening tool:**_____

Please complete the indicated risk screening tools.