CHAP Patient Encounter Flow Sheet

Other					
Other					
Primary					

Date/Time	Pulse	Resp	B/P	Skin	SPO_2	LOC AVPU	Interventions / Procedures / Physician Consult

Date: Time:

Hospital # : SSN#:

Name: (L) (F) (M)

DOB: Age: Sex:

Doctor: Time/Date: / /

Dr.'s Assessment:

CHAM Plan Page # :

CHA/P:

CHA/P:

CHA/P:

Village:

ARC/CHAP Directors Approved 2/2007

INSTRUCTIONS FOR CHAP PATIENT ENCOUNTER FLOW SHEET

This is a Flow Sheet ONLY. This form is to assist the CHA/P in documenting continuing care of a single patient encounter requiring emergency care, care for an extended time, or multiple interventions. The CHA/P still needs to complete the standard PEF or CHAP Emergency Patient Encounter Form and include copies of the CHAP Patient Encounter Flow Sheet when submitting paperwork. The original should remain in the patient chart in the village clinic and copies distributed as per regional guidelines. Remember to press firmly so all copies are legible.

TIME – record the time of day including a.m./p.m. each time a set of vitals is taken and/ or an intervention is completed.

PULSE – rate, rhythm [regular/irregular], quality [strong/weak, fast/slow]

RESP – (Respirations) – rate, rhythm [normal/fast/slow], quality [deep/shallow]

B/P (Blood Pressure) – if high or low for the age of the patient also take manually in other arm.
Record if blood pressure was taken with patient sitting, lying or standing (⚲, ⚬—, ⚲).

SpO_2 and O_2 flow rate – Record SpO_2 before starting oxygen. Be sure to document this reading by stating "room air".
If the patient receives oxygen, document the flow rate, how it is administered (mask, cannula, blow-by) and recheck SpO_2.
If you change the flow rate, remember to recheck and record the changes.

LOC (level of consciousness) – **AVPU** is a helpful reminder. **A**=Alert, **V**=responds to Verbal command, **P**=responds to Painful stimulus, **U**=Unresponsive.

INTERVENTIONS/PROCEDURES

- As you do things to a patient over the course of an encounter, documenting times for each intervention will give the reader a clear view of how things actually unfolded. If many interventions happened at the beginning of the call (the time documented on the front of the PEF) then the Special Care/Other Care site on the PEF can be used as a place to record these interventions.
- Anything you do to the patient can be listed under the Interventions/Procedures/Physician Consult including but not limited to:
  - IV - time, solution, drip set, rate, catheter size and location
  - Splint - time, location, type, circulation, sensation, and movement, (before and after splinting)
  - Medicine administered - time, route, site, and ordering physician
  - Labs - time, test, and result
  - EKG/telemedicine

NOTES:

Always remember to fill out patient information and sign your name at the bottom of the page.

Verbal Order/Read Back- Verbal orders must be read back to the ordering provider when given over the phone. Circle Verbal Order/Read Back and then initial after reading back to the provider.