UCONN HEALTH

AHEC Connecticut Network

UConn Migrant Farm Worker Clinic

(UMFWC) A Program of the CT AHEC Network at UConn Health
in collaboration with UConn Health Professions Schools

Form to Certify Completion of UConn Health's HIPAA Security/Privacy Training

A UConn MFW Clinic Volunteer Requirement

(Certifies compliance for Summer '18 & Academic Year '18-'19)

I ____________________________ *(write your full name)* hereby confirm that I have read and agree to I comply with any of the HIPAA related patient privacy protections before, during and after (in perpetuity) volunteering with the UConn Migrant Farm Worker Clinic, a CT Area Health Education Center (AHEC) sponsored program at UConn Health.

(Before signing at bottom of page three, please read and check off each of the statements below indicating your understand and agreement.)

___ *I understand that Protected Health Information (PHI) includes any type of communication format that includes an individual's health information, which could potentially identify or link back to an individual or patient. The types of communication conveyance formats that are included under the PHI are*

   a. *Electronic (ex. emails, EMR)*
   b. *Paper (ex. access to patient records, access to research data/materials)*
   c. *Media (ex. blogs, social media, etc.)*
   d. *Verbal (ex. comments and conversations)*
   e. *Photos and images (ex. x-rays).*

___ *I understand and agree that some of the following HIPAA considerations may be unique to the UConn Migrant Farm Worker Clinic ("Clinic") as these clinics are most often held outdoors in "open air" environments.*

___ *I understand volunteers are expected to be attentive at all times during these open air "field" clinic because of the potential risk of PHI being overheard un- or intentionally by others because of the clinic's open air environments and therefor* ***I agree to adjust volume of conversations and proximity from others to address this challenge.***

____I understand that another challenge around PHI protection is that often volunteers having only a small amount of HIPAA training and no experience in a clinical setting, often aren't clear what is and isn't allowed. Here's a quick review…

- *WHEN is it appropriate to share PHI? (Pretty much never).*
  Only certain individuals at the MFW Clinic are permitted to share PHI. Only if it relates to their health care treatment on that specific date. Examples include:
  - *When taking vitals and alarmed by very high BP or BG readings, discuss privately with the vitals station lead who will run this info up the "chain of command."*
  - *If you are a health professional student in one of the medical teams interviewing patients, each member is encouraged to add value to discussions by bringing in a different or unique perspective to the patient's review of systems, diagnosis(es), and treatment plan.*
- *WHO volunteers can share it with (no one, regardless of setting). While it is tempting to discuss patients with descriptors while you are with someone who has a shared experience or shared interests, it is never permitted.*

______I certify that I will not share PHI at any time before, during or after clinic.

- *NOT while loading supplies before the clinic with other volunteers in hallways, elevators and offices, lobbies sidewalks, etc.*
- *NOT while loading caravan; not while driving and/or carpooling to/from farms and campuses*
- *NOT at the farm during set up, clinic, breakdown and reloading supplies*
- *NOT On the ride back after clinic to respective campuses*
- *NOT During the days, weeks, months and years that follow the experience with UMFWC in conversations with others (not relatives, not friends, not even graduate school interviewers, etc.)*

______ I certify that I will comply with HIPAA/PHI in all communication and interactions before, during and after the clinics (in perpetuity). A few examples

- *I will not try and view, nor share PHI for any reason (ex. taking selfie with patients and post to social media*
- *I will not text my friends about a patient's shocking diagnosis, discuss any of his treatment in the car that night, nor over the phone later that night, nor have a Skype call with a potential provider over the weekend.*
- *I will not write an article in the school newspaper using any identifying detail (a profile picture of a worker looking to the field), a first name, their country of origin, the name of the farm, or a diagnosis.*

______I understand that as a volunteer at the UConn Migrant Farm Worker Clinic I am expected to maintain a professional conduct and maintain patient confidentiality at all times before, during or after my experiences at the clinic.

_____ *I understand that if I do not understand the concepts listed above that I will review the entire UConn Health HIPAA/HITECH PowerPoint training attached before signing below.*

Printed Name

Affiliated Institution/University/Program **Date of Anticipated Graduation** *(mm/yyyy)*

Original (Handwritten) Signature *(No electronic signatures will be accepted)* **Date**

Completed HIPAA Form must be returned to CT AHEC

(options listed below, choose one):

Option 1) Scan or take picture of HIPAA form and email to CT AHEC/MFW Admin: ctahec@uchc.edu

Option 2) Fax completed form to 860-679-1101
(Please write on top of this form or on a separate cover page "Attn: UConn MFW Clinic Admin")

Option 3) Mail hard copy to**:** **"Attn: MFW Clinic Admin.**
CT AHEC at UConn Health
263 Farmington Avenue (MC 2928),
Farmington, CT 06030-2928"

UCONN HEALTH

UConn Migrant Farm Worker Clinic
Patient/Minor Consent to Photograph/Film:

Section 1: To be completed by farm worker, or subject in photo/film

By signing below, I hereby authorize and allow that any image collected via photograph, movie, film, or videotape will be considered public information and may be used in UConn publications or other authorized publications by UConn Migrant Farm Worker Clinic such as newspapers, magazines, exhibits, or in film on websites or television. Furthermore, I acknowledge that my name may be identified in any such publication(s).

Name of subject(s): ______________________________

If signing for minor, list relationship (ex. "mother")______________________________

Consent/Authorization Signature:______________________________

If subject is a minor, parent/guardian signature above authorizes consent

Date of Consent/Authorization Signature above: ______________________________

Section 2: To be completed by photographer/ volunteer clinic staff

Clinic location: ______________________________

Clinic date: ______________________________

Photo taken by/credit to: ______________________________

Patient(s) in photo: ______________________________

Volunteer #1 in Photo: ______________________________

Volunteer #1 info (ex. "Central AHEC high school student") ______________________________

Volunteer #2 in Photo: ______________________________

Volunteer #1 info (ex. "UConn resident") ______________________________

Description of Photo (action, description of apparel, background activity, etc.):_*Ex. "Shannon McClure, a MPH student, taking BP, pt. Victor Hugo (in red shirt and Nike hat)"* ______________________________

____

____

***Saving this form to shared drive**: Take picture of this form, create file name using word, "Consent," then patient's first initial, their last name, then abbrev. year (ex. "ConsentVHugo17"). Then save in designated Dropbox folder. Original to file in CT AHEC office.*

UCONN HEALTH

UConn Migrant Farm Worker Clinic
Autorización/Consentimiento para Fotografía/Grabación de Pacientes/Menores

Sección 1: Para ser completada por el trabajador agrícola, o sujeto en la fotografía/grabación

Mediante mi firma a continuación, autorizo y permito que cualquier imagen tomada a través de fotografía, grabación o video sea considerada información pública y pueda ser utilizada en publicaciones de UConn y cualquier otra publicación autorizada por UConn Migrant Farm Worker Clínica incluyendo periódicos, revistas, exhibiciones o videos en páginas de internet o televisión. Más aún, reconozco que mi nombre puede ser identificado en cualquiera de estas publicaciones.

Nombre del sujeto: ____________________

Si está firmando por un menor, **explique cómo está relacionada a** este (ej. madre):
____

Firma de Autorización/Consentimiento: ____________________
Si el sujeto es un menor, la firma de uno de los padres o tutor legal autoriza el consentimiento

Fecha de Consentimiento/Autorizacoin: ____________________

Section 2: To be completed by photographer/ volunteer clinic staff

Clinic location: ____________________

Clinic date: ____________________

Photo taken by/credit to: ____________________

Patient(s) in photo: ____________________

Volunteer #1 in Photo: ____________________

Volunteer #1 info (ex. "Central AHEC high school student") ____________________

Volunteer #2 in Photo: ____________________

Volunteer #1 info (ex. "UConn resident") ____________________

Description of Photo (action, description of apparel, background activity, etc.):_*Ex. "Shannon McClure, a MPH student, taking BP, pt. Victor Hugo (in red shirt and Nike hat)"* ____________________

____

***Saving this form to shared drive**: Take picture of this form, create file name using word, "Consent," then patient's first initial, their last name, then abbrev. year (ex. "ConsentVHugo17"). Then save in designated Dropbox folder. Original to file in CT AHEC office.*

UConn Migrant Farm Worker Clinic

Medical Clinic Packing Checklist

HAVE YOU RESTOCKED EVERYTHING?

- Binder for farm with directions
- 8 folding white tables
- 1 exam table
- 1 pop up tent
- Black boxes (2)
- Expandable black folders (2)
- All yellow totes (Only bring Lantern Bin if after mid-July)
- Bag of Condoms and pamphlets (language specific)
- All medication boxes from closet and in office
- Laminated 11 x 17 signs with tear aways for Health Centers

Other considerations:

Lindy: No tent needed (you have clean horse stalls to go for privacy)

Rose's Berry: Only bring 2 tables, 2-3 bins of stools (picnic tables provided)

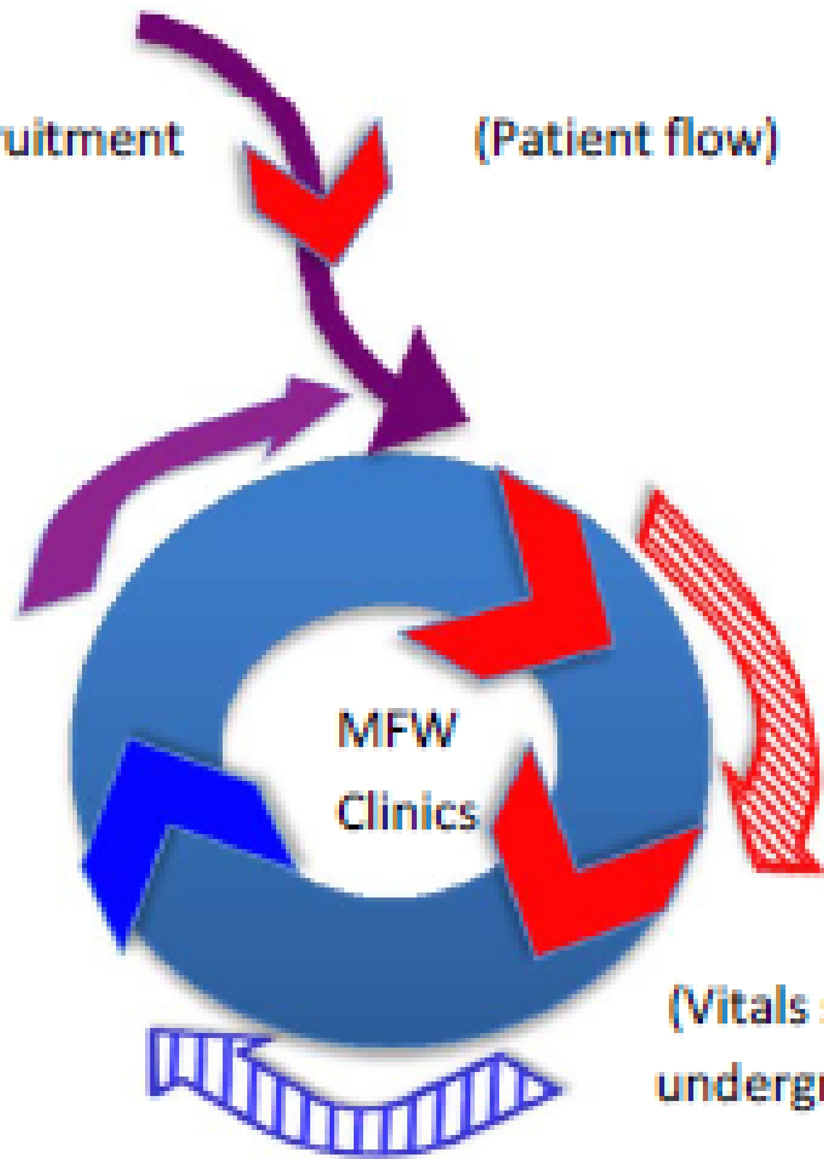
UConn Migrant Farm Worker Clinic Volunteer Sign-In Log

EVERY PERSON IN ATTENDANCE AT EACH CLINIC MUST SIGN IN - NO EXCEPTIONS!!!

Please sign in regardless of your frequency affiliation with the clinic

CT AHEC Office Use ONLY			Farm Name/Location:											Date:	
			Please check category best describing your **current** educational or professional status below												
EXL	DB		Volunteer Name: Please Write Legibly!!!	Precepting Clinician (MD, RPh, PharmD or DMD, etc)	Resident (Please list program, ex. "Family Medicine")	Medical Interpreter	UConn Medical Student	UConn Dental Student	Quinn. PA Student	UConn Pharmacy Student	UConn PT Student	Undergrad Student	High School Student	Other (Please describe current educational or carrer status, ex. "grad. student")	
		1													
		2													
		3													
		4													
		5													
		6													
		7													
		8													
		9													
		10													
		11													
		12													
		13													
		14													
		15													

FOR CT AHEC USE ONLY:
Please ***Initial Date*** Below:
Med Coord. Verified:___________________
Excel sheet updated:___________________
Database updated:___________________


A: Patient Recruitment and Signup
(Patient flow)
A: Form Collection
B: Registration
MFW Clinics
(Vitals station managed by undergrad coordinators)
C: Med Teams

Useful Phrases for Introductions/Frases Utiles

I SPEAK SPANISH (A LITTLE)	Hablo espanol (un poco)
GOOD MORNING	Buenos dias
GOOD AFTERNOON/EVENING	Buenas tardes
GOOD EVENING	Buenas noches
PLEASE SIT DOWN	Por favor sientese
PLEASE HAVE A SEAT	Por favor tome asiento
I AM	Yo soy…
MISS, MRS, MR.	Senorita, Senora, Senor
MY NAME IS…	Mi nobre es (or) Me llamo….
YOUR NAME PLEASE	¿Su nombre por favor?
YOUR LAST NAME	¿Su apellido?
YOUR FIRST NAME	¿Su nombre?
DO YOU UNDERSTAND ENGLISH?	¿Entiende Ingles?
DO YOU SPEAK ENGLISH?	¿Habla Ingles?

USEFUL PHRASES - BLOOD PRESSURE

WITH YOUR PERMISSION…	Con su permiso…
I AM GOING TO…	Voy a…
TAKE YOUR BLOOD PRESSURE	…Tome su presión
PLEASE PLACE YOUR_____ARM HERE	Puédale poner el brazo ____aquí por favor
RIGHT	Derecho
LEFT	Izquierdo
PLEASE RELAX YOUR ARM	Relájese el brazo por favor
YOUR BLOOD PRESSURE IS	Su presión es__________

NOTE: Attending Physicians will counsel patients; please do not counsel patients directly.

Understanding Blood Pressure Results

(Based on AHA recommendation from 11/2017)

Please note: Hypertension (HTN) or High Blood Pressure CANNOT be diagnosed in one reading & goals need to be individualized based on age, genetic factors, etc.

NEW National AHA Guidelines (Nov. 2017)	**Systolic Pressure**		**Diastolic Pressure**
Adult Normal/GOAL:	**<120**	**and**	**<80**
Adults with elevated Hypertension (HTN)	**120-129**	**and**	**<80**
Adults w/possible Stage 1 HTN	**130-139**	**or**	**80-90**
Adults w/possible Stage 2 HTN	**140-179**	**or**	**90-119**
Hypertension Crisis Consult Your Doctor ASAP	**180>**	**and/or**	**120>**

I WOULD LIKE TO GIVE YOU SOME INFORMATION ABOUT CONTROLLING YOUR BLOOD PRESSURE :	Te querrío dar alguna informacion… …sobre controlar su presion

USEFUL PHRASES - BLOOD SUGAR

WITH YOUR PERMISSION… — Con su permiso…

I AM GOING TO TAKE YOUR BLOOD SUGAR LEVEL: — Voy a tomaré su nivel de azúcar en la sangre

HAVE YOU BEEN DIAGNOSED WITH DIABETES? — ¿Le han diagnosticado con diabetes?

WHAT WAS THE LAST MEAL YOU ATE? — ¿Cuándo fue la última vez usted comió?

- DINNER — Cena
- LUNCH (FASTING) — Almuerzo
- DID NOT EAT TODAY (FASTING) — No comió hoy

CAN I "STICK" THE SIDE OF YOUR FINGER TO GET A DROPLET OF BLOOD — ¿Puedo pinchar el lado del dedo para obtener una gota de sangre?

YOUR BLOOD SUGAR IS — Su azúcar es_________

Understanding Blood Sugar Results

(Based on AHA recommendation from 11/2017)

FOR PATIENTS WITH NO KNOWN DIABETES

If patient is…	Blood sugar reading…	Guidelines …	Guidelines in Spanish…
FASTING	LESS THAN 70	MAY BE HYPOGLYCEMIC	demasiado bajo
FASTING	70-100	NORMAL	Normal
FASTING	100-125	HIGH (May have pre-diabetes, counseling required)	Alto
FASTING	126 OR GREATER	VERY HIGH (may be diabetic, need reading above 126 more than once)	Demasiado alto
NON-FASTING (2 hrs after meal)	140	NORMAL	Normal
NON-FASTING (2 hrs after meal)	140-200	HIGH (May have pre-diabetes)	Demasiado alto
NON-FASTING (2 hrs after meal)	200 OR GREATER	MAY HAVE DIABETES (need more than one reading to diagnose)	Puedes tener diabetes

FOR PATIENTS WITH KNOWN DIABETES

If patient is…	Blood sugar reading…	Guidelines…	Spanish diagnosis…
FASTING	LESS THAN 70	TOO LOW (may be hypoglycemic)	Demasiado bajo
FASTING	70-130	NORMAL (within target range)	Normal
FASTING	Above 130	HIGH (May need medication adjustment)	Alto
NON-FASTING (2 hours after meal)	LESS THAN 140	TARGET	Esta bien
NON-FASTING (2 hours after meal)	160 OR GREATER	May need medication adjusted	Puede necesitar medicina

Interpreting Blood Glucose Results

Patients with *NO KNOWN DIABETES*

If patient is…	Blood sugar reading (mg/dL)	Diagnosis	Treatment
RANDOM blood sugar reading	less than140	Normal	None
RANDOM blood sugar reading	140-200	High. **May** have pre-diabetes	Counseling required
RANDOM blood sugar reading	200 or greater	High. **May** have diabetes	Refer to MD
FASTING (before meal or fasted overnight)	Less than 70	Below target range (may be hypoglycemic)	Suggest eating carb-containing food
FASTING (before meal or fasted overnight)	70-100	Normal	None
FASTING (before meal or fasted overnight)	100-125	High. **May** have pre-diabetes	Counseling required
FASTING (before meal or fasted overnight)	126 or greater	High. **May** have diabetes	Refer to MD

Interpreting blood sugar results

In Patients with *KNOWN DIABETES*

If patient is…	Blood sugar reading (mg/dL)	Diagnoses per ADA	Treatment
2-hr POSTPRANDIAL (after meal)	Less than 180	Within ADA's target range	None
2-hr POSTPRANDIAL (after meal)	180 or greater	Above ADA's target range. May need medication or carb-content of meal adjusted	Refer to MD
FASTING (8-hours of empty stomach)	Less than 70	Below ADA's target range (may be hypoglycemic)	Suggest eating carb-containing food
FASTING (8-hours of empty stomach)	70-130	Within ADA's target range	None
FASTING (8-hours of empty stomach)	Above 130	Above ADA's target range. May need medication adjusted	Refer to MD

ADA=American Diabetes Association

Understanding Your Blood Pressure Results

Updated 11/2017

Please note: Hypertension (HTN) or High Blood Pressure CANNOT be diagnosed in one reading & goals need to be individualized based on age, genetic factors, etc.

According to the NEW National American Heart Association Guidelines as of Nov. 2017	**Systolic Pressure**		**Diastolic Pressure**
Adult Normal/GOAL:	**<120**	**and**	**<80**
Adult w/Elevated Hypertension	**120-129**	**and**	**<80**
Adult w/possible Stage 1 HTN	**130-139**	**or**	**80-90**
Adult w/possible Stage 2 HTN	**140-179**	**or**	**90-119**
Hypertension Crisis **Please Consult Your Doctor ASAP**	**180>**	**and/or**	**120>**

If initial blood pressure reading is 140/90 or higher

(which is HTN Stage 2 or moderate to severe high blood pressure (as of 11-2017)

THEN SEE REVERSE FOR NEW PROTOCOL

This is intended for CT AHEC students who may not be proficient in blood pressure screening skills…

Please familiarize yourself with information below including the Blood Pressure Screening Accuracy Protocol & 5 Korotkoff Sounds

(Sample video: https://www.youtube.com/watch?v=VJrLHePNDQ4

NEW PROTOCOL:

If initial blood pressure reading 140/90 or higher

(HTN Stage 2 or moderate to severe high blood pressure (as of 11-2017)

Please take reading again following steps below to ensure accuracy

1. **Ask patient if they recently exercised, drank alcohol, or used nicotine-containing products**, as all of these affect the accuracy of blood pressure measurements. If the cuff squeezes too tightly, this can skew the measurement. If so, record this on the sheet but continue to follow the criteria.
1. Position the patient **seated on the stool with his/her back against the table and his feet flat on the ground.**
2. Measure the patient's arm to select the correct cuff size **(begin with opposite arm used in preliminary screening).**
3. Ensure unobstructed access to the patient's arm, but **do not roll up their shirt** sleeve such that it puts pressure on the arm.
4. Position the **cuff 2-3 centimeters above the patient's antecubital fossa, with the arrow pointing to the center of the fossa.**
5. **Ask the patient not to talk during the exam**, and remind him that you cannot talk either.
6. **Hold the patient's arm at the level of high right atrium**, making **sure to support it with your arm.**
7. **Locate the patient's brachial (pinky finger) side artery** in the arm in which you are measuring the blood pressure.
8. **Inflate the cuff until you no longer feel the patient's pulse, and then inflate it 30 mm Hg beyond that point.**
9. With your stethoscope in your ears and **place diaphragm (round part) placed just below (not touching) the cuff**, begin listening for the Korotkoff sounds *(See sample video on YouTube: **https://youtu.be/VJrLHePNDQ4**)*
10. **Deflate the cuff at a rate of 2 mm Hg per second.**
11. Remove the cuff from the patient and **record the number on appropriate forms.**
12. **Wait one minute.**
13. **Repeat steps 4-11 on the patient's other arm.**

If the **readings are similar** to within 5 mm Hg, **average the two numbers and record** that final number in both the study sheet and the patient's encounter sheet.

If the **readings are different** by more than 5 mm Hg, **wait one more minute and measure the first arm again**. Record that number on both sheets.

HOW TO TAKE & INTERPRET OTHER IMPORTANT VITALS SIGNS

Pulse Rate:

Best to measure pulse rate for a full minute.
Can measure for 30 seconds and multiply by two, or measure for 15 seconds and multiply by 4.

Population	(beats per minute or bpm)
Well conditioned adult athletes	40-60
Adults (& children ages 10+)	60-100
Children ages 1-10:	60-140
Infants to age 1	100-160

If heighted pulse rate, patient may be excited or anxious, or that there is some issue with the heart. Decreased pulse rate usually reflects an athletic heart or medication (e.g. beta blocker).

Respiration Rate (at rest):

Best to measure respiration rate for a full minute. Can measure for 30 seconds and multiply be two, or measure for 15 seconds and multiply by 4.

Population	Breaths per minute
Older Children and Adults	16-20
Children five years of age	25
Infants	34-40

If higher than the normal range, may indicate that the oxygenated blood may not be adequately delivered.

Temperature:

Population	Normal temperature range (in degrees° F)	Fever
Older Children and Adults	(97.8°-99.1°) Homeostasis 98.6°	102°
Infants younger than 3 months	(97.8°-99.1°) Homeostasis 98.6°	100.4°

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2018 ELIGIBILITY / REGISTRATION FORM

[ ] HOH / MSAW [ ] Dependent / Spouse [ ] Dependent / Child [ ] Dependent / Other, specify: _______________

Please see the reverse side for instructions on how to complete the 2018 Eligibility/Registration Form.

Patient's Name: ____________________ ____________________ ____________________ ____________________
First / Middle / First last name / Second last name

Date of Birth [MM/DD/YYYY]: _____/_____/_________ Phone: ____________________________

Gender Identity: [ ] Male [ ] Female [ ] Transgender [ ] Other, specify: __________________ [ ] Declined to answer

Address: _____________________________ Town: _____________________________ State: _______ Zip: __________________

If the patient is a dependent, provide the **name of the migratory / seasonal agricultural worker head of household (HOH)**.

HOH Name: ____ Date of Birth [MM/DD/YYYY]: _____/_____/_____

Have you registered in the CRVFHP in the past? [ ] Yes [ ] No

SECTION I: IF PATIENT IS A DEPENDENT, ONLY ANSWER 1A, 1B & 2, OTHERWISE FULLY COMPLETE 1-3

1A. Within the past 24 months have you or a member of your family worked in agriculture/farming, as your/their principal employment? [ ] Yes [ ] No

1B. Have you or a member of your family stopped migrating to work in agriculture because of a disability or old age? [ ] Yes [ ] No

2. In the past 24 months, have you or a member of your family moved here from outside the Valley to seek employment in agriculture? **If yes**, where did you move from? ___________________________ [ ] Yes [ ] No

3. Employer: What is the name of the farm where you now work or where you last worked? _________________________________

Where is that farm located? Town: ________________________________ State: ________

SECTION II: TO BE COMPLETED FOR ALL PATIENTS

4. Race: [ ] Black/African American including Hispanic/Latino Descent [ ] White including Hispanic/Latino Descent [ ] American Indian/Alaska Native including Hispanic/Latino Descent [ ] Asian [ ] Native Hawaiian [ ] Other Pacific Islander [ ] More than one race [ ] Unreported / Refused to report

5. Country of Origin: [ ] El Salvador [ ] Guatemala [ ] Jamaica [ ] Mexico [ ] Puerto Rico [ ] Other, specify: _____________

6. Hispanic/Latino: [ ] Yes [ ] No

7. Language: Best served in a language other than English? [ ] Yes [ ] No Do you need an interpreter? [ ] Yes [ ] No
If you need an interpreter, in what language? _______________________

8. Housing: [ ] Own [ ] Rent [ ] Shelter [ ] Transitional [ ] Doubling Up [ ] Street [ ] Unknown [ ] Other: _______

9. Health Insurance: [ ] None [ ] Other, specify: ______________________________

10. Smoking Status: [ ] Current every day smoker [ ] Current someday smoker [ ] Former smoker [ ] Never smoker [ ] Smoker, current status unknown [ ] Unknown if ever smoked

11. Veteran: [ ] Yes [ ] No

12. H2A Worker: [ ] Yes [ ] No

13. Sexual Orientation: [ ] Straight (not lesbian or gay) [ ] Lesbian or gay [ ] Bisexual [ ] Something else [ ] Don't know [ ] Declined to answer

SECTION III: ENTER ALL INCOME SOURCES; HOH INCOME INFORMATION SHOULD BE INPUT FOR DEPENDENTS

14. Income: Farm Income: _____________ X _____________ + Other Income: _____________ = _________________
wkly/monthly pay rate X # of wks/months in Valley + other sources of income/benefits = annualized family income

Type of other employment/sources of other income (including those of dependents): __________________________
list other source(s) of income for verification

15. # of Dependents: in the Valley: ________ + outside the Valley: ________ = Total: _______

ACKNOWLEDGEMENT: I understand that I may be asked to pay a co-payment for each visit. Co-pay amounts may vary depending on the service, equipment or supplies provided. I have been informed that services will not be denied because of inability to pay.

AUTHORIZATION: I hereby authorize disclosure of Protected Health Information (PHI) and the subsequent release of records to the Massachusetts League of Community Health Centers, CRVFHP, its funding source, and to the referred / referring Health Provider; the purpose of this authorization is to support and document medical care and / or process payments to migratory and seasonal agricultural workers and their families which are supported directly and indirectly through CRVFHP Voucher and / or Outreach funds in 2017.

____ ____
Patient Signature **Parent / Guardian (if patient is less than 18 years old)**

The CRVFHP reserves the right to verify the information provided above.

Interviewer Signature: ___________________________________ Telephone: (________) _____________________

Agency / Provider: ______________________________________ Date of Application: ________/________/________

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – Outreach**

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2018 ELIGIBILITY / REGISTRATION FORM

Program Eligibility Requirements

Migratory and seasonal agricultural workers (MSAWs) and their families are eligible for services through the CRVFHP while present in the Connecticut River Valley.

A migratory agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who establishes a temporary home for the purposes of such employment. This includes anyone who has been employed as a migratory agricultural worker within the last 24 months as their primary income.

If a former migratory worker stopped working due to disability or old age the worker and his/her dependent family members are considered migratory workers for life and still eligible for the CRVFHP.

A seasonal agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis (as opposed to year-round employment) and who does not establish a temporary home for the purposes of employment. This includes anyone who has been employed as a seasonal agricultural worker within the last 24 months as their primary income.

A person who worked as a migratory agricultural worker but is now working as a construction worker, meat packer, landscaper, etc. is eligible for the CRVFHP for 24 months after stopping farm work. Individuals eligible for services through the CRVFHP are those individuals working in:

- Preparing, irrigating or spraying the fields, nurseries, orchards
- Planting, picking, sorting, packing, or transporting fruits, vegetables, grains, nuts, tobacco, grass, hay or other agricultural products
- Planting trees; working with Christmas trees; picking pine needles or Spanish moss
- Taking care of fish, chickens, ducks, turkeys, cows, goats, sheep, fish, clams, etc.

Persons not eligible include:

- Farm crew leaders who do not work in the fields for wages
- Individuals coming to the Connecticut River Valley for purposes other than agricultural work who have not done agricultural work in the last 24 months

Instructions for completing the Eligibility / Registration Form (reverse side)

1. This Eligibility / Registration Form **must be completed once per calendar year for each patient**. All dependent family members of MSAWs are eligible for primary care services through the CRVFHP, however, an Eligibility / Registration Form must be completed for the HOH first. Please check the appropriate box (HOH or dependent) at the top of form.
2. Print the patient's **complete name,** including all hyphenated or multiple last names.
3. Enter the patient's date of birth in MM / DD / YY (month / date / year) format.
4. Check the patient’s current gender identity. Please check all that apply.
5. Enter the patient's phone number used while in the Valley. Also, list the complete address in the Valley – street, town, state, zip.
6. If the patient is a dependent of a MSAW, record the head of household (HOH) name and HOH date of birth.
7. If the patient has registered for the CRVFHP at any point in the past, please answer “yes.” If this is the first time the patient has ever enrolled in the CRVFHP, answer “no.”
8. Section I: Answer Questions 1A, 1B, 2 and 3 based on the HOH. REMINDER: Questions 1A, 1B, and 2 must be answered for all patients; Question 3 only needs to be answered for the HOH.
   - **To be eligible for CRVFHP services, applicants MUST respond "yes" to Question 1A or 1B or 2.**
9. Section II: If the patient is eligible, record answers to all questions in Section II (Questions 4-13).
   - For Question 8, if the patient is a dependent, the answer should match that of the HOH.
   - For Question 11, veteran status is defined as an individual who has completed service in the Uniformed Services of the United States.
10. Section III: If the patient is eligible, record answers to all questions in Section III (Questions 14 & 15).
    - For Question 13, ask the patient how they think of themselves and check the appropriate sexual identity.
    - **For Question 14, expected annual income MUST be calculated for the entire family in order to determine income as a percent of the current federal poverty level. Include expected income from non-agricultural sources under “Other Income.” Also include expected income of other dependent family members in the same household. If the patient is a dependent and does not receive their own income, record the income of the HOH. REMINDER: This should reflect the total YEARLY income for all those who receive income in the household.**
11. Have the patient or parent / guardian sign the completed application. If the patient or parent / guardian is unavailable to sign and the interviewer has obtained the information necessary to answer all the Questions, the interviewer's signature and the information supplied will be sufficient to determine eligibility.
12. Interviewer must sign the application in the space indicated for “Interviewer Signature” and provide their telephone number, Agency/Provider name and record the date the application was completed (this date serves as the registration date).
13. Interviewer retains yellow copy for Agency / Provider and pink copy for Outreach. Please return completed Eligibility / Registration Form (white copy) via encrypted email or mail to:

    Massachusetts League of Community Health Centers
    Attention: CRVFHP
    40 Court Street, 10th Floor
    Boston, MA 02108

    - **Please do not submit incomplete forms or complete forms that indicate a patient is not eligible for CRVFHP services. They will be returned unprocessed.**
    - **ALL PATIENT-IDENTIFIABLE DOCUMENTATION MAILED TO THE CRVFHP MUST BE MARKED “CONFIDENTIAL.”**
14. **This application remains valid through December 31, 2018.**

2018 REGISTRO
PARA EL PROGRAMA DE SALUD PARA LOS TRABAJADORES AGRÍCOLAS DE LA REGIÓN DEL VALLE DEL RIO CONNECTICUT (CRVFHP)

[ ] JDF / TA [ ] Dependiente / Esposo(a) [ ] Dependiente / Niño(a) [ ] Dependiente / Otro, especifique: _________

Vea las instrucciones al reverso para completar el Formulario de Registro.

Nombre del Paciente: ____________________ ____________________ ____________________ ____________________
Primer nombre / Segundo nombre / Primer apellido / Segundo Apellido

Fecha de nacimiento (mes, día, año): ____/____/______ Teléfono: ___________________________

Identidad de Género: [ ] Hombre [ ] Mujer [ ] Transgénero [ ] Otro, especifique: _________________ [ ] Prefiero no contestar

Domicilio: _______________________________ Ciudad: _______________________ Estado: ______ Código postal: _____________

Si el paciente es un/una dependiente, escriba **el nombre del trabajador agrícola (TA) que es el jefe/la jefa de familia (JDF)**.

JDF (nombre completo): ____ JDF fecha de nacimiento: _____/_____/_____

¿Se ha registrado Ud. en el CRVFHP en el pasado? [ ] Sí [ ] No

SECCIÓN I: LAS PREGUNTAS 1A y 1B TIENEN QUE SER CONTESTADAS POR CADA UNO DE LOS PACIENTES; LA PREGUNTA # 3 SOLAMENTE PARA EL/LA JDF

1A. ¿Durante los últimos 24 meses, usted o algún miembro de su familia ha trabajado principalmente en la agricultura? [ ] Sí [ ] No

1B. ¿Usted o algún miembro de su familia dejó de viajar para trabajar en la agricultura debido a discapacidad o edad avanzada? [ ] Sí [ ] No

2. ¿Durante los últimos 24 meses, Ud. o algún miembro de su familia llegó a este valle para buscar trabajo en la agricultura? [ ] Sí [ ] No

   Si contestó Ud. que sí, ¿Dónde vivía usted antes de llegar aquí? Estado o cuidad/país: _________________________________

3. Empleador: ¿Cuál es el nombre de la granja o el rancho donde trabaja usted ahora o trabajó anteriormente? _________________

   ¿Dónde está ubicada esa granja o rancho? Ciudad ___________________________ Estado __________

SECCIÓN II: COMPLETE LA SIGUENTE INFORMACION POR CADA PACIENTE

4. Raza: [ ] Negro/Afro Americano (incluyendo pendiente de Hispano/Latino) [ ] Blanco (incluyendo pendiente de Hispano/Latino) [ ] Indio Americano/ Nativo de Alaska (incluyendo pendiente de Hispano/Latino) [ ] Asiático [ ] Nativo de Hawái [ ] Islas Pacíficas [ ] Más de una raza [ ] Prefiero no contestar

5. País de Origen: [ ] El Salvador [ ] Guatemala [ ] Jamaica [ ] México [ ] Puerto Rico [ ] Otro, especifique: ___________

6. Hispano/Latino: [ ] Sí [ ] No

7. Traducción: ¿Prefiere Ud comunicarse en un idioma aparte de inglés? [ ] Sí [ ] No¿ Necesita un intérprete? [ ] Sí [ ] No
   ¿En qué idioma necesita un intérprete? ____________________

8. Vivienda: [ ] Dueño/a de casa [ ] Alquila casa/apartamento [ ] Refugio para personas sin hogar [ ] En transición [ ] Vive en casa de otros [ ] Vive en la calle [ ] Desconocido [ ] Otro: _____

9. Seguro de salud: [ ] Ninguno [ ] Otro, especifique: _________________________

10. Estatus de fumar: [ ] Fumador diario corriente [ ] Algún día fumador corriente [ ] Ex fumador [ ] Nunca fumador [ ] Fumador, desconoce su estado corriente [ ] Desconoce si ha fumado alguna vez

11. Veterano/a: [ ] Sí [ ] No

12. H2A trabajador: [ ] Sí [ ] No

13. Orientación Sexual: [ ] Heterosexual (no lesbiana o gay) [ ] Lesbiana o gay [ ] Bisexual [ ] Otro [ ] No estoy seguro [ ] Prefiero no contestar

SECCIÓN III: SI EL PACIENTE ES UN DEPENDIENTE, ESCRIBA LA INFORMACION SALARIAL DEL JDF

14. Ingreso esperado: salario por trabajo agrícola: ____________X ____________+ otros ingresos: ____________ = ____________
    pago mensual/semanal X # de meses/semanas en el Valle + otros ingresos/beneficios = ingreso familiar anual

    Fuente de otros ingresos/beneficios (incluyendo los de dependientes): ________________________________

15. Número de dependientes: en el Valle: ________ + fuera del Valle: ________ = Total: ________

RECONOCIMIENTO: Yo entiendo que se me puede solicitar una aportación (en acuerdo a mis posibilidades económicas) por cada visita médica y que las aportaciones varían dependiendo del tipo de servicio provisto. Se me ha informado que no se me negarán los servicios de salud si yo no puedo pagar la aportación mínima.

AUTORIZACIÓN: Por este medio autorizo el acceso a mi información de salud protegida y el uso subsecuente de todos mi expediente médico a la Liga de Centros de Salud Comunitarios de Massachusetts, el CRVFHP y su fuente de financiamiento, y el proveedor de servicios médicos/dentales; esta autorización es para apoyar y documentar asistencia médica ofrecida a los trabajadores migratorios y estacionales y sus dependientes que han sido apoyados en 2017 directamente e indirectamente por los fondos del CRVFHP.

_______________________________________ _______________________________________
Firma de paciente — Firma de Guardián (si el paciente tiene menos de 18 años)

El CRVFHP reserva el derecho de verificar la información proporcionada.

Firma de Entrevistador: ___________________________________ Teléfono: (________) ________________________

Agencia / Proveedor: _____________________________________ Fecha de Aplicación: ________/________/________

Copia Blanca – CRVFHP (correo) **Copia Amarilla – Agencia / Proveedor** **Copia Rosada - Outreach**

2018 REGISTRO
PARA EL PROGRAMA DE SALUD DE LOS TRABAJADORES AGRÍCOLAS
DE LA REGION DEL VALLE DEL RIO CONNECTICUT (CRVFHP)

Requisitos de Elegibilidad para el CRVFHP

Trabajadores agrícolas migrantes y estacionales y sus dependientes tienen derecho a recibir servicios médicos total o parcialmente cubiertos por el CRVFHP mientras están en el Valle del Río Connecticut.

Un trabajador agrícola migratorio es un individuo cuyo empleo principal es en la agricultura de manera temporal (en lugar de empleo durante todo el año) y que **establece un hogar temporal por el propósito de este tipo de empleo**. Le incluye a alguien que haya sido empleado como trabajador agrícola migratorio en los últimos veinticuatro (24) meses. Si un trabajador migratorio ha dejado de migrar para trabajar debido a discapacidad o por edad avanzada, el trabajador y su familia serán considerados trabajadores migratorios de por vida y todavía tienen derecho a recibir servicios médicos cubiertos por el CRVFHP.

Un trabajador agrícola estacional es un individuo cuyo empleo principal es en la agricultura de manera temporal (en lugar de empleo durante todo un año) y que **no establece un hogar temporal por el propósito de este empleo**.

Una persona que haya sido empleado como trabajador agrícola migratorio y que ahora trabaja en la construcción, empacando carne, jardinería, etc., tiene derecho a recibir servicios médicos cubiertos por el CRVFHP por 24 meses más.

Son elegibles para los beneficios de CRVFHP, aquellos trabajadores agrícolas migratorios y / o estaciónales trabajando en:

- Preparando, regando, o fumigando parcelas, viveros o huertas
- Plantando, labrando, cosechando, sorteando, empacando, o transportando frutas, vegetales granos, nuez, tabaco, pastura, y otros productos agrícolas
- Plantando árboles, trabajando con árboles de navidad, cosechando las ramas de pino o el heno Español
- Cuidando, alimentando, enjaulando, o encorralando pollos, patos, guajolotes, ganado, chivos, borregos, caballos, u otros animales
- Cuidando, alimentando o recogiendo pescado, ostión, ranas, u otro producto de granjas acuáticas

Instrucciones para completar el Formulario de Registro (lado reverso)

1. Este Formulario de Registro debe ser completado **para cada paciente** una vez al año. Tanto los trabajadores agrícolas como sus dependientes tienen derecho a recibir asistencia médica. Registre primero al/la JDF y marque una <<x>> dentro de la casilla [ ] JDF/TA. Registre el dependiente y marque una << x >> en la casilla correspondiente para indicar si el dependiente es cónyuge, hijo, u otro pariente del trabajador.
2. Escriba **el nombre completo del paciente**; incluya dos apellidos.
3. Escriba la fecha de nacimiento del paciente en el formato siguiente: MM / DD / AA (mes, día, año).
4. Indique la identidad de género del paciente; se puede marcar más de una opción
5. Escriba el número telefónico, el domicilio completo y el área postal que el paciente usara durante su estancia en el Valle.
6. Si el paciente es un dependiente de un trabajador agrícola, escriba el nombre y fecha de nacimiento de el/la JDF en el espacio correspondiente.
7. Marque una <<x>> dentro de la casilla correspondiente, si el paciente se ha registrado en el CRVFHP en el pasado.
8. Sección I: Conteste las preguntas 1A, 1B, 2, y 3 usando la información de el/la JDF. AVISO: Las preguntas 1A, 1B y 2 tienen que ser contestados para cada paciente; la pregunta 3 solamente tiene que ser contestado por el/la JDF.
   - **Para ser admitido en el CRVFHP, pacientes deben responder 'sí' a las preguntas 1A o 1B o 2.**
9. Sección II: Si el paciente es elegible para el CRVFHP, conteste todas las preguntas en Sección II (Preguntas 4-13).
   - Para la pregunta 8: si el paciente es un dependiente, la respuesta debe ser igual a la de el/la JDF
   - Para la pregunta 11: ser veterano es una persona que en el pasado fue miembro de los servicios uniformados de los Estados Unidos.
   - Para la pregunta 13: marque la respuesta que mejor refleja cómo el paciente se identifica acerca de su orientación sexual.
10. Sección III: Si el paciente es elegible para el CRVFHP, conteste todas las preguntas en Sección III (Preguntas 14 & 15).
    - Para la pregunta 14: el ingreso anual esperado debe ser calculado para toda la familia para determinar el ingreso total como un porcentaje del nivel de pobreza federal actual. Incluya los ingresos esperados procedentes de fuentes no agrícolas en el espacio indicado "otros ingresos." También incluya el salario previsto de dependientes; si el paciente es un dependiente y no tiene su propio ingreso, anote el salario de el/la JDF.
11. El paciente o el guardián debe firmar la solicitud completada. Si el paciente o el guardián no está disponible para firmar y el entrevistador ha obtenido la información necesaria para responder a todas las preguntas, la firma del entrevistador será suficiente.
12. El entrevistador debe firmar la aplicación en el espacio indicado para la "Firma del Entrevistador" y escribir su número de teléfono, nombre registrado de la Agencia / Proveedor y la fecha en que la aplicación se ha completado (esta fecha es la fecha de registro).
13. Entrevistador guardará la copia amarilla para la Agencia / Proveedor y la copia rosada para Extensión. Por favor entregue el Formulario de Registración (la copia blanca) a través de correo electrónico cifrado o correo a:

    Massachusetts League of Community Health Centers
    Attention: CRVFHP
    40 Court Street, 10th Floor, Boston, MA 02108

    - **Por favor, NO ENTREGUE FORMULARIOS INCOMPLETOS o formularios que indican que un paciente no está calificado para el CRVFHP. Éstos serán devueltos sin procesar.**
    - **TODO TIPO DE DOCUMENTACIÓN CON INFORMACIÓN PRIVADA QUE SE ENVÍA AL CRVFHP DEBE SER INDICADO "CONFIDENCIAL."**
14. **Esta aplicación será válida hasta el 31 de Diciembre de 2018.**

Copia Blanca – CRVFHP (correo) **Copia Amarilla – Agencia / Proveedor** **Copia Rosada - Outreach**

UConn Migrant Farm Worker Clinic Encounter Form

Farm Name/Employer:

First Name: | 1st Last Name (1st apellidos): | 2nd Last Name (2nd apellidos):

Today's Date: | Age: | Gender:

Birth Date: "MM,DD,YY" | Arrival Date to Farm: | Expected Departure Date from Farm :

Race/Ethnicity:

Type of Visit:
☐ Initial (1st time this season) ☐ Follow up (previously registered)

Place of Permanent Residence:

Chief Complaint Today: ☐ Dental ☐ Medical

Cell Phone Number (MUST PROVIDE):

Is this a friend's number #? Y N
Is this a track phone #? Y N

2nd Cell Phone Number (Required if "Y" to right):

If either answered "Y", provide additional cell phone # to the left:

History of Present Illness:

Depression: "In past 2 weeks, have you had…" If score 3 +, use PHQ-9 on reverse

0 (Not at all), 1 (Several days), 2 (+ half time), 3 (Nearly every day)

1. "Little interest or pleasure in doing things?".................... 0…….1…….2…….3
2. "Feeling down, depressed or hopeless?"............................ 0…….1…….2…….3

Body/Mass Index	Vitals:	
Height:	BP:	
Weight:	BG:	
BMI calculation:	P:	
If >, counsel patient? Y / N	RR:	T:

Medications:

Past Medical History:

Diabetes:	BP:
STDs:	HIV:
Asthma:	TB:
Other:	Other:

Family History:

Diabetes:
BP:
Cancer:
Cardiac:

Allergies: To meds: General:

Immunizations:

Physical Exam:

Drugs:
Marijuana:
Heroine:
Cocaine:
Other (street drugs):

Social History:
Tobacco:
Alcohol (EtOH): Y N
{ } 1-4x/wk { } 5-9x/wk { } 10-14x/wk
{ } 15-20x/wk { } 21-25x/wk { } >25/wk
Sex:
Other:

Diagnosis(es) (Ex. Elevated BP=ICD-10 of R03.0):	ICD-10 code(s): [See front of clipboard]	Work-related? [Provider's opinion]	If yes, likelihood of being work related? [Provider's opinion]
		yes / no	Low / Moderate / High
		yes / no	Low / Moderate / High
		yes / no	Low / Moderate / High
		yes / no	Low / Moderate / High

Treatment/Plan:

Follow Up/Referral Needed?: *[If yes, be sure to write what services are needed. Referral Forms can be supplied upon request by Medical Student Coordinators]*

Attending Signature REQUIRED: | Student Signature: | Date:

MANDATORY FOR TEAMS TO COMPLETE - (See PURPLE Section above to complete below)

CPT Coding [REQUIRED: PLEASE CIRCLE ONE]

99201: New Patient Straight forward (10 min)	99202: New Patient Low Complexity (20 min)	99203: New Patient Moderate Complexity (30 min)	99204: New Patient High Complexity (45 min)	99205: New Patient Extreme Complexity (60 min)
99211: Established Patient Straight forward (10 min)	99212: Established Patient Low Complexity (20 min)	99213: Established Patient Moderate Complexity (30 min)	99214: Established Patient High Complexity (45 min)	99215: Established Patient Extreme Complexity (60 min)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

"This single item (above) is an excellent global rating of functional impairment" – (Kroenke, et al)

Scoring the PHQ-9 (Levels of Depressive Symptoms)

5=mild 10=moderate 15=moderately severe 20≥ severe

The UConn Migrant Farm Worker Clinic refers if PHQ-9 Score is 10 or above.
Rationale: "PHQ-9 score of 10≥ has a sensitivity of 88% and specificity of 88% for major depression,"
(Rehabilitation Counseling Bulletin 2014, Vol. 57(4) 246–248 © Hammill Institute on Disabilities, 2014)

If PHQ-9 score=10≥ Complete Referral to a Partnering Health Center

1. Request a Referral Form from medical student leads
2. Complete All Sections
   a. In Section II, Health Center/Facility="*CHS*"
   b. In Section II, Type of Care Needed="*Mental Health*"

PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Nombre de la granja/empleador:			Primero Nombre:	Primero Apellido:	Segundo Apellido:
Fecha de Hoy:	Edad:	Género:			
Fecha de Nacimiento "Mes, Día, Año":	Fecha de Llegada:	Fecha de Salida:	Raza/Identidad Étnica:	Tipo de Consulta	
				□ Inicial (primera vez esta temporada)	□ Consulta segunda (previamente registrado)

Lugar de Residencia Permanente:		Motivo de consulta:	□ Dental	□ Médico
Número de Teléfono (OLIGATORIO):	¿Es de un amigo? S N			
Segundo Numero de Telefono (Obligatorio si "S" a la derecha):	¿Es un teléfono temporal? S N Si respondiste "S", pon une # de teléfono adicional a la izquierda:			

Historia de La Enfermedad Actual:

Depresión: "En las últimas dos semanas, ¿con qué frecuencia Usted ha tenido..." Si la nota es 3 + usa PHQ-9 en otro lado. *0 (Nunca), 1 (Varios días), 2 (más de la mitad de los días), 3 (Casi todos los días)*

1. "¿Poco interés o placer en hacer las cosas?"……….................... 0…….1…….2…….3
2. "¿Sentirse desanimado/a, deprimido/a, o sin esperanza?"............... 0…….1…….2…….3

Indice de Masa Corporal:	Signos Vitales:	
Altura:	Presión:	
Peso:	Azúcar:	
Cálculo de IMC:	P:	
Si >, ¿Aconsejó paciente? S / N	FR:	T:

Medicamentos:

Antecedentes médicos:		Antecedentes familiares:
Diabetes:	Presión:	Diabetes:
ETS:	VIH:	Hipertensión:
Asma:	TB:	Cáncer:
Otro:	Otro:	Cardio:

Alergías:	A medicamentos:	General:

Inmunizaciones:

Examen físico:

Drogas:	Antecedentes sociales:
Marihuana:	Tabaco:
Heroína:	Alcohol (EtOH): Si/No { }1-4x/wk { }5-9x/wk { }10-14x/wk { }15-20x/wk { }21-25x/wk { }>25x/wk
Cocaína:	Sexo:
Otro/ Drogas Ilegales:	Otro:

Diagnóstico(s) (Por ejemplo, presión elevada= ICD-10 of R03.0):	Código(s) de ICD-10: [Frente de el portapapeles]	¿Tiene que ver con trabajo? [Opinión de proveedor de servivios medico]	¿Probabilidad de relación con trabajo? [Opinión de proveedor de servicios medico]
1.		Sí / No	Bajo / Moderado / Alto
2.		Sí / No	Bajo / Moderado / Alto
3.		Sí / No	Bajo / Moderado / Alto
4.		Sí / No	Bajo / Moderado / Alto

Tratamiento/Plan:

¿Consulta Segunda/Referencia? - [Si en el caso afirmativo, asegúrese de escribir que servicios son necesario. Pregunta a los coordinadores de estudiantes de medicina para obtener una forma de referencia]:

Firma de Médico (OBLIGADTORIO)	Firma de Estudiante:	Fecha:

OBLIGATORIO PARA LOS EQUIPOS COMPLETEN - (Vea la seccion PURPURA arriba para completar la seccion abajo)

Código de CPT: [OBLIGATORIO: POR FAVOR ECOJA UNO]

99201: Paciente nuevo Sin complicaciones (10 min)	99202: Paciente nuevo Complejidad baja (20 min)	99203: Paciente nuevo Complejidad moderada (30 min)	99204: Paciente nuevo Complejidad alta (45 min)	99205: Paciente nuevo Complejidad extrema (60 min)
99211: Paciente establecido Sin complicaciones (10 min)	99212: Paciente establecido Complejidad baja (20 min)	99213: Paciente establecido Complejidad moderada (30 min)	99214: Paciente establecido Complejidad alta (45 min)	99215: Paciente establecido Complejidad extrema (60 min)

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? *(Marque con un "□" para indicar su respuesta)*	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Sin apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

Si marcó cualquiera de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil	Un poco difícil	Muy difícil	Extremadamente difícil
☐	☐	☐	☐

"This single item (above) is an excellent global rating of functional impairment" – *(Kroenke, et al)*

Scoring the PHQ-9 (Levels of Depressive Symptoms)

5=mild 10=moderate 15=moderately severe 20≥ severe

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2. Complete All Sections
   a. In Section II, Health Center/Facility="*CHS*"
   b. In Section II, Type of Care Needed="*Mental Health*"

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Resource Guide for Behavioral Health

Emergency Services

FOR ADDICTION TREATMENT 24/7
call the Access Line
1-800-563-4086
(this includes detox and treatment for prescription opioids or heroin addiction)

FIRE/POLICE/AMBULANCE Call 9-1-1

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
1-888-628-9454 (Ayuda en Español)
TTY: 1-800-799-4TTY (4889)
www.suicidepreventionlifeline.org

SUICIDE HELPLINE (INFOLINE) Call 2-1-1

POISON CONTROL
1-800-222-1222 www.aapcc.org

SEXUAL ASSAULT CRISIS SERVICES
English 888-999-5545
Spanish 888-568-8332

WHEELER HELPLINE 24/7
860-747-3434

Connecticut Resources

ACCESS HEALTH CT
Health Insurance Marketplace
1-855-805-4325 TTY 1-855-789-2428
www.accesshealthct.com

ACCESS MENTAL HEALTH CT
www.accessmhct.com

ADVOCACY UNLIMITED, INC.
1-800-573-6929 www.mindlink.org

BEACON HEALTH OPTIONS (CTBHP)
1-877-552-8247 TTY 1-866-218-0525
www.ctbhp.com

CT ALLIANCE TO END SEXUAL VIOLENCE
1-888-999-5545
www.endsexualviolencect.org

CT COALITION AGAINST DOMESTIC VIOLENCE
860-282-7899 www.ctcadv.org
1-888-774-2900 (Crisis Line)

CT COUNCIL ON PROBLEM GAMBLING
1-888-789-7777 (Helpline) www.ccpg.org

CT INFOLINE Call 2-1-1 www.211ct.org

CT NETWORK OF CARE
www.connecticut.networkofcare.org

CT SUICIDE PREVENTION
Call 2-1-1 www.preventsuicidect.org

CT QUITLINE (Tobacco)
1-800-QUIT-NOW
www.quitnow.net/connecticut

CT YOUTH SERVICES ASSOCIATION
www.ctyouthservices.org/Find_A_YSB

CT COMMUNITY FOR ADDICTION RECOVERY
800-708-9145 https://ccar.us

CONNECTICUT CLEARINGHOUSE
A library and resource center on alcohol, tobacco, other drugs, mental health and wellness
1-800-232-4424 www.ctclearinghouse.org

DRUGFREECT.ORG
For prevention, treatment and recovery resources

> Mental health and substance use disorders affect people from all walks of life and all age groups. These are common, recurrent, and often serious, but they are treatable and many people do recover.

FATHERHOOD INITIATIVE OF CT
1-866-6-CTDADS www.ct.gov/fatherhood

GOVERNOR'S PREVENTION PARTNERSHIP
860-523-8042 www.preventionworksct.org

MATCH COALITION, INC.
860-525-9738 www.matchcoalitionct.org

MENTAL HEALTH CT
1-800-842-1501 www.mhconn.org

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) CT
860-882-0236 www.namict.org
Helpline 1-800-950-6264

OPIOID OVERDOSE PREVENTION/ NALOXONE (NARCAN) INITIATIVE
860-418-6993
www.ct.gov/dmhas/cwp/view.asp?q=509650

PROTECTIVE SERVICES FOR THE ELDERLY
888-385-4225

TRUE COLORS (Sexual Minority Youth and Family Services)
860-232-0050 www.ourtruecolors.org

TURNING POINT CT
Website for youth and young adults
www.turningpointct.org

WHEELER CLINIC - NAVIGATION CENTER
1-888-793-3500 www.wheelerclinic.org

Support Groups

AL-ANON/ALATEEN
CT Information 1-888-825-2666
National Information 1-800-344-2666
www.ctalanon.org

ALCOHOLICS ANONYMOUS (AA)
Connecticut 1-866-783-7712
National Information 1-800-344-2666
www.ct-aa.org

CO-DEPENDENTS ANONYMOUS
1-888-444-2359 www.coda.org

FAMILIES ANONYMOUS
1-800-736-9805
www.familiesanonymous.org

GAM-ANON FAMILY GROUPS
CT Hotline
1-800-266-1908
National Information 718-352-1671
www.gam-anon.org

GAMBLERS ANONYMOUS
CT Hotline 1-855-222-5542
National Information 213-386-8789
www.gamblersanonymous.org

MARIJUANA ANONYMOUS
1-800-766-6779
www.marijuana-anonymous.org

MENTAL HEALTH CONNECTICUT
800-842-1501 www.mhconn.org

NAR-ANON
CT Information 1-800-477-6291
www.nar-anon.org

NARCOTICS ANONYMOUS (NA)
CT Information 1-800-627-3543
National Information 1-818-773-9999
www.ctna.org

NATIONAL ALLIANCE ON MENTAL ILLNESS
800.215.3021 www.nami.org

NICOTINE ANONYMOUS
1-877-879-6422 www.nicotine-anonymous.org

OVEREATERS ANONYMOUS
505-891-2664 www.oa.org

Wheeler

CONNECTICUT Clearinghouse
a program of the Connecticut Center for Prevention, Wellness and Recovery

800.232.4424 (phone)
860.793.9813 (fax)
www.ctclearinghouse.org

A Library and Resource Center on Alcohol, Tobacco, Other Drugs, Mental Health and Wellness

National Resources

AIDS NATIONAL HOTLINE
1-800-342-AIDS www.cdc.gov/hiv

CENTERS FOR DISEASE CONTROL AND PREVENTION
1-800-232-4636 www.cdc.gov

MENTAL HEALTH AMERICA
1-800-969-6642 www.nmha.org

NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS
1-888-55-4COAS www.nacoa.org

NATIONAL EATING DISORDERS ASSOCIATION
800-931-2237 www.nationaleatingdisorders.org

NATIONAL ORGANIZATION ON FETAL ALCOHOL SYNDROME
202-785-4585 www.nofas.org

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
1-888-628-9454 (Ayuda en Español)
TTY: 1-800-799-4TTY (4889)
www.suicidepreventionlifeline.org

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)
1-877-726-4727 www.samhsa.gov

State Agencies

CT DEPARTMENT OF CHILDREN AND FAMILIES (DCF)
1-800-842-2288 Careline www.ct.gov/dcf

CT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)
860-418-7000 www.ct.gov/dmhas

CT DEPARTMENT OF PUBLIC HEALTH (DPH)
860-509-8000 www.ct.gov/dph

CT DEPARTMENT OF SOCIAL SERVICES (DSS)
1-800-842-1508 www.ct.gov/dss

CT DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
860-418-6000 www.ct.gov/dds

DMHAS Regional Behavioral Action Organizations (RBHAO)

Region 1
Regional Youth Adult Social Action Partnership (RYASAP)
2470 Fairfield Avenue
Bridgeport CT 06605
203-579-2727 www.ryasap.org
Towns:
Bridgeport, Darien, Easton, Fairfield, Greenwich, Monroe, New Canaan, Norwalk, Stamford, Stratford, Trumbull, Weston, Westport, Wilton

Region 2
Alliance for Prevention & Wellness, A Program of BHcare
435 East Main Street
Ansonia, CT 06401
203-736-8566; Direct line 203-892-6418 www.apw-ct.org
Towns:
Ansonia, Bethany, Branford, Chester, Clinton, Cromwell, Deep River, Derby, Durham, East Haddam, East Hampton, East Haven, Essex, Guilford, Haddam, Hamden, Killingworth, Lyme, Madison, Meriden, Middlefield, Middletown, Milford, New Haven, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Portland, Seymour, Shelton, Wallingford, Westbrook, West Haven, Woodbridge

Region 3
Southeastern Regional Action Council (SERAC)
228 West Town St.
Norwich, CT 06360
860-848-2800 www.sectrac.org
Towns:
Ashford, Bozrah, Brooklyn, Canterbury, Chaplin, Colchester, Columbia, Coventry, East Lyme, Eastford, Franklin, Griswold, Groton, Hampton, Killingly, Lebanon, Ledyard, Lisbon, Mansfield, Montville, New London, North Stonington, Norwich, Plainfield, Pomfret, Preston, Putnam, Salem, Scotland, Sprague, Sterling, Stonington, Thompson, Union, Voluntown, Waterford, Willington, Windham, Woodstock

Region 4
North Central Regional Mental Health Board, Inc.
151 New Park Avenue Ste. 14A
Hartford CT 06106
860-667-6388 www.ncrmhb.org
Towns:
Andover, Avon, Berlin, Bloomfield, Bolton, Bristol, Burlington, Canton, East Granby, East Hartford, East Windsor, Ellington, Enfield, Farmington, Glastonbury, Granby, Hartford, Hebron, Kensington, Manchester, Marlborough, New Britain, Newington, Plainville, Plymouth, Rocky Hill, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks

Region 5
Housatonic Valley Coalition Against Substance Abuse (HVCASA)
9 Stony Hill Road
Bethel, CT 06801
203-743-7741 www.hvcasa.org
Towns:
Barkhamsted, Beacon Falls, Bethel, Bethlehem, Bridgewater, Brookfield, Canaan, Cheshire, Colebrook, Cornwall, Danbury, Goshen, Hartland, Harwinton, Kent, Litchfield, Middlebury, Morris, Naugatuck, New Fairfield, New Hartford, New Milford, Newtown, Norfolk, North Canaan, Oxford, Prospect, Redding, Ridgefield, Roxbury, Salisbury, Sharon, Sherman, Southbury, Thomaston, Torrington, Warren, Washington, Waterbury, Watertown, Winchester, Winsted, Wolcott, Woodbury

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2018 REFERRAL VOUCHER

Is this referral urgent? **NUMBER: 18-**

☐ **Yes** ☐ **No**

SECTION I: Patient Information

Cell phone number (mandatory): (____) _____-_________

Is this a pre-paid or shared phone? Yes _____ No _____

If yes, provide an alternate number: (____) _____-_______

___________________________	________________________	____________________	_____/_____/________
Patient Name - Last	First	Middle	DOB (month/day/year)

____	___________________________	______	________________
Address	Town	State	Zip Code

SECTION II: Referred *TO* Information

Health Center/Health Care Facility patient is being referred to: ____

Reason(s) for appointment/referral: ____

Type of care needed:

☐ Medical	☐ Dental*	☐ Optometry, CPT: ____________ ICD: _______________
☐ Lab	☐ X-ray	☐ Ophthalmology, CPT: ____________ ICD: ___________
☐ Mental health/Substance abuse		☐ Specialty care, specify: __________________________

** Does not include dentures or implants*

Date referral appointment is made for: ________________________

SECTION III: Referred *BY* information

AUTHORIZATION: I hereby authorize disclosure of Protected Health Information (PHI) and the subsequent release of records to the Massachusetts League of Community Health Centers, CRVFHP, its funding source, and to the referred / referring Health Provider; the purpose of this authorization is to support and document medical care and / or process payments to migrant and seasonal agricultural workers and their dependents (MSAWs) which are supported directly and indirectly through CRVFHP Medical Care and / or Enabling/Outreach funds in 2018.

Patient (or Parent / Guardian) Signature: ____________________________________ Date of Referral: ______/______/_______

Health Care Provider (sign): ____________________________________ (print): ______________________________________

Agency / Provider: ____ Date of Referral: ______/______/_______

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – UConn / Outreach** **Gold Copy - Patient**

CONNECTICUT RIVER VALLEY FARMWORKER HEALTH PROGRAM
2018 REFERRAL VOUCHER

Referral Voucher Process *for UConn*:

If UConn deems it necessary to refer an eligible MSAW to a Participating Provider for medical care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy), and
- Submit a completed CRVFHP Referral Voucher Form to the Participating Provider (once per visit; yellow copy).

Referral Voucher Process *for Participating Providers*:

If a Participating Provider deems it necessary to refer an eligible MSAW to an External Referral Provider for specialty care services outside their scope of practice, it must:

- Submit a completed CRVFHP Referral Voucher Form to the League (once per visit; white copy),
- Have a written agreement in place with the External Referral Provider covering the services to which it refers MSAWs/dependents,
- Agree to accept claims from the External Referral Provider for referred, covered specialty care services,
- Agree to reimburse the External Referral Provider on a fee-for-service basis at a rate that does not exceed the External Referral Provider's Medicaid Program rate for medical, dental and / or mental health services, and
- Review these claims for accuracy, completeness and appropriateness before applying to the CRVFHP for payment.

Claims for non-covered services will not be processed or paid.

Instructions for completing the Referral Voucher:

1. ***If UConn***, UConn completes all sections of form retaining pink copy and submitting the yellow copy to Participating Provider.

   or

   If Participating Provider, Participating Provider completes all sections of form retaining yellow copy and Outreach staff retain pink copy for their records/reference.

2. Please note: If a Participating Provider is making a referral outside the health center, the name of the referral agency must be listed in Section II. You must clearly identify documentation related to reimbursement for referred services with the Date of Service and numbered CRVFHP Referral Voucher that substantiates the medical care visit and referral.

3. The white copy (and annual CRVFHP Eligibility/Registration Form) is sent via encrypted email or mail to:

   Massachusetts League of Community Health Centers
   Attention: CRVFHP
   40 Court Street, 10th Floor
   Boston, MA 02108

- **ALL PATIENT-IDENTIFIABLE DOCUMENTATION MAILED TO THE CRVFHP MUST BE MARKED CONFIDENTIAL.**

White Copy – CRVFHP (mail) **Yellow Copy – Agency / Provider** **Pink Copy – UConn / Outreach** **Gold Copy - Patient**

2018 FORMULARIO DE REFERENCIA
PARA EL PROGRAMA DE SALUD PARA LOS TRABAJADORES AGRICOLAS DE LA REGION DEL VALLE DEL RIO CONNECTICUT

¿La referencia es urgente? **Número: 18-**

☐ **Sí** ☐ **No**

SECCIÓN I: Información de Paciente

Número de teléfono celular (obligatorio): (____) _____-_____

¿Su teléfono es pre-pagado o compartido? Sí____ No ____

Sí es, escriba otro número: (____) _____-________

___________________________	________________________	____________________	_____/_____/________
Apellido(s)	Primer Nombre	Segundo Nombre	FDN (mes/día/año)

____	___________________________	______	_______________
Dirección	Ciudad	Estado	Código Postal

SECCIÓN II: Información de Centro de Salud

¿Adónde se refiere el paciente? ____

Origen de cita/referencia: ____

Atención necesaria:

☐ Médico ☐ Dental* ☐ Optometría, CPT: ____________ ICD: ______________

☐ Laboratorio ☐ Radiografía ☐ Oftalmología, CPT: ___________ ICD: ______________

☐ Salud Mental/Servicios de drogadicción ☐ Especialista, especifique: _________________________

** No incluye la prótesis dental o el implante dental*

Fecha de cita: _________________________

SECCIÓN III: Información de quién pide la referencia

AUTORIZACIÓN: Autorizo por este medio el acceso a mi información de salud protegida (ISP) y el uso subsecuente de todos los expedientes de esta visita a la Liga de Centros de Salud Comunitarios de Massachusetts, CRVFHP, su fuente de financiamiento, y al referido proveedor de servicios de salud; el propósito de esta autorización es apoyar y documentar asistencia médica y/o procesar pagos a los trabajadores migratorios y estacionales y a sus dependientes que se han apoyado directamente e indirectamente a través del valle de CRVFHP y/o fondos de alcance en 2018.

Firma de Paciente (o el guardián): _________________________________ Fecha de referencia: ______/______/_______

Firma de Proveedor: ____ (escrito): _______________________________________

Agencia: ____ Fecha de referencia: ______/______/_______

2018 FORMULARIO DE REFERENCIA
PARA EL PROGRAMA DE SALUD PARA LOS TRABAJADORES AGRICOLAS DE LA REGIÓN DEL VALLE DEL RIO CONNECTICUT

El Proceso de completar el Formulario de Referencia para UConn:

En el caso de que UConn no es capaz de proveer la atención médica necesaria a un trabajador agrícola o estacional, se puede hacer una referencia a un centro de salud participativo en el CRVFHP al:

- Entregar a cada visita el formulario de referencia de CRVFHP a la Liga de los Centros de Salud de Massachusetts
- Entregar a cada visita el formulario de referencia de CRVFHP al centro de salud participativo en el CRVFHP

El Proceso de completar el Formulario de Referencia para los Centros de Salud que participan en el CRVFHP:

En el caso de que un centro de salud que participa en el CRVFHP determina que no es capaz de proveer la atención médica necesaria a un trabajador agrícola, se puede hacer una referencia a un proveedor externo para los servicios médicos especiales al:

- Entregar a cada visita el formulario de referencia de CRVFHP a la Liga de los Centros de Salud de Massachusetts
- Establecer un contrato con el proveedor externo que explica en detalle los servicios médicos especiales por los cuales puede ser pagados
- Aceptar los formularios de reclamo del proveedor externo para los servicios médicos especiales
- Aceptar la condición de reembolsar al proveedor externo no más del precio máximo que es pagado por Medicaid para los servicios médicos, dentales, y salud mental
- Revisar los formularios de reclamo para asegurar la precisión antes de solicitar fondos del CRVFHP

Por favor, NO ENTREGUE FORMULARIOS INCOMPLETOS. Éstos serán devueltos sin procesar.

Instrucciones para completar el Formulario de Referencia:

1. ***Para UConn***: Complete todas las secciones de este formulario, guarde la copia rosada, y envíe la copia amarilla al centro de salud participativo en el CRVFHP.

   O

   Para los Centros de Salud participativos en el CRVFHP: Complete todas las secciones de este formulario, guarde la copia amarilla, y envíe la copia rosada al UConn.

2. Tome Nota: Si el proveedor del centro de salud participante refiere a un paciente a otro proveedor médico, no asociado con el centro de salud, tiene que proveer el nombre del lugar/proveedor en Sección II. Además, hay que entregar un documento que contiene los servicios ofrecidos y los gastos, las fechas de cita, y una copia del formulario de referencia para confirmar la cita.

3. Envíe la copia blanca de este formulario (y el Formulario de Registración para 2018) a través de correo electrónico cifrado o correo a:

   Massachusetts League of Community Health Centers
   Attention: CRVFHP
   40 Court Street, 10th Floor
   Boston, MA 02108

   TODO TIPO DE DOCUMENTACIÓN CON INFORMACIÓN PRIVADA QUE SE ENVÍA AL CRVFHP DEBE SER INDICADO "CONFIDENCIAL".

Common Med. Diagnoses	ICD-10
Allergic Rhinitis	J30.9
Allergies to pollen	J30.1
Allergy	T78.40
Anxiety	F41.9
Arrythmia	I49.9
Arthritis	M12.9
Asthma Acute	J45.901
Asthma Chronic	J45.998
Benign prostatic hyperplasia	N40.1
Bronchitis	J40
Bronchitis Asthmatic	J45.9
Carpel Tunnel	G56.01
Cataracts	H26
Chest Pain	R07.9
Chylamidia	A74.9
Cold/fever	**J00**
Conjunctivitis	H10.9
Constipation	K59.00
Costochondritis (chest pain caused by tendons)	R07.89
Cough	**R05**
Cyst	L72.0
Dehydration	**E86.0**
Depression	**F33.9**
Dermatitis	**L30.9**
Diarrehea	R19.7
Dizziness	**R42**
Dyschromia (skin discoloration)	L81.9
Dyspepsia	K30
Eczema	L23.9
Edema	R60.1
Epidydimitis	N45.1
Epistaxis (nosebleed)	R04.0
Fatigue	**R53.83**
Folliculitis	L66.4
Ganglion	M67.4
Gastritis (w/o bleeding)	K29.70
Gastroeneritis	K52.2
Genital Herpes	A60.02
GERD	K21.9
Gout	M10.9
Headache (Tension), Chronic	G44.221
Headache	**R51**
Hearing Loss	H90
Heart Murmur	R01.1
Hemoptysis (blood in sputum)	R04.2
Hypercholesterolemia	E78.0
Hyperlipidemia	E78.5
Hypothyroid	E03.9
Inguinal Hernia	K40.40

Common Med. Diagnoses	ICD-10
Influenza	J11.1
Lactose Intolerance	E73.9
Lipoma (benign soft tissue tumor)	D17.9
Migraine	G43.109
Nasal Conjestion	**R09.81**
Naseau/Vomiting	**R11.2**
Onychomycosis (fungal nail infection)	B35.1
Otitis Media (inflammation of middle ear)	H66.90
Otitis Externa (inflammation of outer ear)	H60.8X9
Palpitation	R00.2
Pelvic Pain	R10.2
Peripheral Edema	R60.9
Peripheral Neuropathy	G90.09
Pharyngitis	J02.9
Plantar Fascitis	M72.2
Post Nasal Drip	R09.82
Poison Ivy	L23.7
Rash - non specific	**R21**
Rhinitis, Chronic	J31.0
Rhinitis, Allergic	J30.9
Routine Gynecological Exam (w/o abnormal findings)	Z01.419
Routine Medical Exam (w/o abnormal findings)	**Z00.00**
Adult Health Maintainance	**V70**
Sebaceous Cyst	L72.3
Sinusitis/Chronic	**J32.9**
Sinusitus-Acute, Maxillary	**J01.00**
STD	A64
Superficial Injury	T07
TB Skin Test	R76.11
Tendonitis	**M77.9**
Testicular Pain	N50.9
Throat Sore	**R07.0**
Thyroid Nodule (Nontoxic)	E04.1
Tobacco Dependence	**F17.299**
Tinea	B35.9
Tinea Cruris	B35.6
Tinea Pedis	B35.3
Upper Respiratory Infection	**J06.9**
Urinary Tract Infection	N39.0
Uticaria (hives)	L50.9
Viral Syndrome	B97.89
Viral Illness	B97.89
Warts	B07.9

Common PT Diagnoses	ICD-10
Back Pain	M54.5
Back (lower) Strain	S39.012
Deltoid strain	848.90
Hip Pain	M25.559
Joint Pain	M25.50

Common PT Diagnoses	ICD-10
Knee Pain	M25.569
Muscle Sprain/Strain	T14.90
Myalgia (muscle pain)	M79.1
Neck Pain	M54.2
Pain in joint of foot/ankle	M25.579
Sciatica	M54.30
Shoulder Pain	M25.519
Quadriceps Strain	T14.90
Wrist Pain	M25.539

Common Dental Diagnoses	ICD-10
Abscess tooth (periapical)	K04.7
Broken teeth	S02.5XXA
Caries	K02.9
Cracked Tooth	K03.81
Dental Calculus	K03.6
Dental Scaling/Cleaning	**Z01.20** (w.o. abnormality) **Z01.21** (w. abnormality)
Dental Sealant	Z98.810
Gingavitis	K05.10
Impacted Tooth	K01.1
Periodontal Disease Chronic	K05.30
Periontal Disease Acute	K05.20
Root Canal	**0CBW0Z0** (upper teeth) **0CBX0Z0** (lower teeth)
Teeth Extraction	K08.409
Tooth Pain	K08.9

Blood Pressure/Glucose Diagnoses	ICD-10
Elevated Blood Pressure	**R03.0**
Hypertension	**I10**
Prehypertension	**R03.0**
Abnormal non-fasting glucose (prediabetes)	R73.09
Hypoglycemia	E16.2
Glucose Intolerance	E74.39
DM, type 1 controlled	E10.9
DM, type 2 controlled	E11.9
DM, type 1, uncontrolled	E10.65
DM, type 2, uncontrolled	E11.65

Common Eye Diagnoses	ICD -10
Allergic Conjunctivitis	H10.9
Astigmatism (type of refractive error)	H52.209
Eye injury	S05.90XA
Glaucoma	H35.9
Hyperopia	H52.03
Itchy Eye	L29.9
Myopia (near sightedness)	H52.10
Pinguecula (yellowish nodule in eye)	H11.159
Presbyopia (focus loss)	H52.4
Ptergium (fleshy growth over eye)	H11.009
Refractive Error	H52.7
Vision Disturbance	H53.9

Common ICD-10 Codes at MFW

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
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Lot # ____________ Exp. Date: ________________

Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
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Patient/Nombre del paciente: ____________________
Doctor: _______________ Date/Fecha: __________
Medication/Medicamento: ____________________
Dose/Dosis: ______________________________
______________________Qty. ________________
Reason/Razón por tomar: ____________________
Lot # ____________ Exp. Date: ________________

New UConn Migrant Farm Worker Clinic Pharmacy Tracking Log

Please Write as Legibly as Possible & Refer to Instruction Page on Reserve as Needed

Farm Name and/or Clinic Location:____ Today's Date: ___________________

Pharmacy Student/s names *(please print)*: ____

Precepting Pharmacist/s (*please print)*: ____

Precepting Physician/s *(please print)*: ____

Pharmacy students to fill ALL sections (except last two columns) Please list only ONE TYPE of ITEM PER LINE...Add lines with the patient's name for each item distributed												
Where can I locate in stock medications, medical supplies, prescription pads,etc.?		In Stock Medications (Rx and OTC) in Various Tackle Boxes (overstock in MFWC Storage)					Medical Supplies in 3 Yellow Bins	Generic Prescription Pad in Yellow Bins labelled "Pharmacy Binder"			Printed Name of Preceptor (PLEASE WRITE LEGIBLY)	Signature of Preceptor
Who can sign off on this form for OTC meds, Rx Meds, Medical Supplies or Paper Prescriptions?		**OTC - ANY preceptor** can sign out **Rx - only UConn SOM Faculty** can sign out					**ALL Preceptors can** sign out	ONLY UConn SOM faculty can sign out				
Patient's Full Name *(Latino patients have 2 last names - include both!)*	Date of Birth *(see clipboard)*	IN STOCK MEDICATION	Quantity	Dosage	Lot #	Exp.	MEDICAL SUPPLY given as part of treatment (ex. size large, high arch insoles)	PRESCRIBED MEDICATION (i.e. Medicaton Rx paper Script)	Quantity	Dosage		