

Home Visits – Adult



User's Manual

Home Visits – Adult

Health District Information System
HDIS (Windows Ver. 5.3)

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CHC Software, Inc.
Health District Information Systems
helpdesk@hdis.org

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Introduction

This program is designed to assist you in organizing a systematic approach to entering your High Risk Pregnancy visits and provides accurate up-to-date records within your health district.

Please review the manual carefully to obtain the maximum benefits. Little or no prior computer experience is necessary to operate this program.

About This Manual

The Home Visit Module is simple to use. ***The maximum benefit with the least time spent will be obtained if you start at the first page of this manual and follow the directions exactly as you enter the first record in your computer.***

Square boxes in this manual surround the key that you are to press on your keyboard. As an example, when you read

ENTER

The word

TYPE is followed by bracketed [] instructions of what to type into a field.

Note: For Technical Support, email: helpdesk@hdis.org



Navigation

Whenever you see one  click the left side of your mouse once.

Whenever you see two  click the left side of your mouse twice.

Navigation Keys For Entering Information

Tab or **ENTER** to move to next field

| **Shift** **Tab** or **Up** to go back one field

Editing Keys

Backspace deletes one character left of cursor

Delete deletes one character

Insert inserting & overwriting modes

When you see a pull-down field, click the arrow to the right to view all your choices.



Starting HDIS

Start

Programs

Health District Info Systems

HDIS

Health District Information System Menu Bar

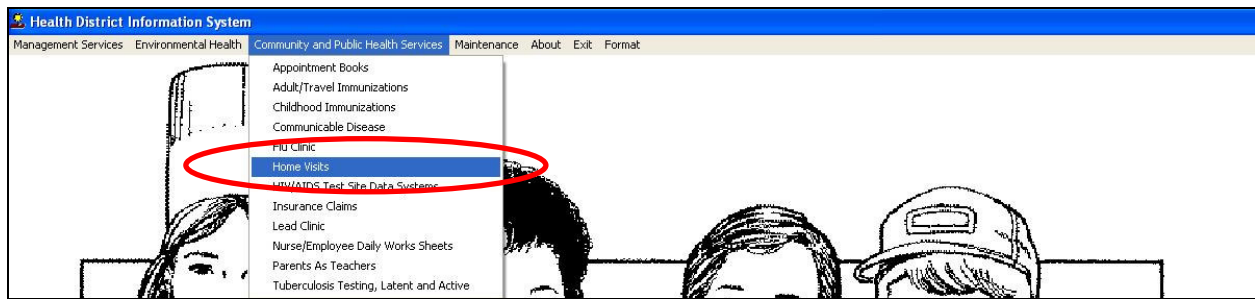
HDIS (Health District Information System) has several different modules designed to assist your health district in its day-to-day operations. The **Home Visits module** is a great addition to these modules and simplifies your record keeping, billing and information management needs.



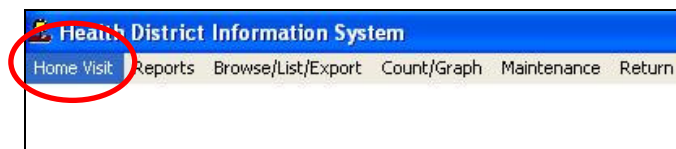
Community and Public Health Services



Home Visits



Home Visit



Entering an Adult Record

[illegible]

When you are ready to enter the Adult portion of the Home Visit module, click the on the client in the grid you wish to enter data for, and then click the **Adult** button.

**** All fields labeled in RED are MANDATORY.**

Encounters

Right-click the **Add Encounter*** button. **Once, you have clicked the Add button, you do not have to click it again to add the information.**

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Encounter*	Right-click to delete the encounter row.
Add Encounter*	Right-click to add an encounter.
Zoom	Click to open the zoom screen.
Print	Click to open the print window.
Modify/Add	Click to modify/add a record.
Close	Click to close the Adult Home Visit windows.

The screenshot shows a software window titled "Encounter". It contains several input fields and dropdown menus for recording patient encounters. The fields are organized into two main sections. The top section includes "Date of Entry" (pre-filled with 07/22/2009), "Date of Service" (pre-filled with //), "Nurse / Outreach Worker" (a dropdown menu), "Program" (a dropdown menu), and "Setting / Activity" (a dropdown menu). The bottom section includes "Billable Time" (a text field), "ICD9" (a dropdown menu), "CPT Code" (a dropdown menu), "Non-Billable Time" (a text field), "Location of PHHV Face to Face Visit" (a dropdown menu), "Travel Time" (a text field), "Vehicle" (a text field), "Mileage" (a text field), "Total Time" (pre-filled with 0), "Return Visit" (pre-filled with //), and four buttons at the bottom: "Previous Encounter", "Next Encounter", "Add to Dailys *", and "Close".

When the Add Encounter button is clicked, the above Zoom screen appears for you to enter the encounter.

Field/Button	Description
Date of Entry	Automatically filled out by the computer.
Date of Service	Enter the date of service.
Nurse/Outreach Worker	Choose the nurse/outreach worker.
Program	Choose the program.
Setting/Activity	Choose the setting/activity.
Billable Time	Enter your billable time.
ICD9	Choose the ICD9 code.
CPT Code	Choose the CPT code.
Non-Billable Time	Enter your non-billable time.
Location of PHHV Face to Face Visits	Choose the location of the face to face visit (mandatory).
Travel Time	Enter your travel time.
Vehicle	Enter your vehicle number.
Mileage	Enter your mileage traveled.
Total Time	Automatically filled out by the computer.
Return Visit	Enter the return visit date (optional)
Previous Encounter	Click to view the previous encounter.
Next Encounter	Click to view the next encounter.
Add to Dailies*	Right click to add the encounter to your daily worksheets.
Close	Click to close the zoom screen.

HRPIO - Intake



HRPIO - Intake

Adult - - - - - Medical Record #: 1812

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Intake Date **Completed By:** **County/Reservation** **Current Age** **Individual / Case #** 1812

Pregnancy History | Risk Factors | Risk Factors (cont.)

EDD

Pregnancies (inc. current)		Live Births	
Living Children		Term	
Miscarriages		Preterm	
Terminations		Total	0

PRETERM LABOR IN PREVIOUS PREGNANCIES ☐ Yes ☐ No ☐ Unknown

MONTH OF FIRST PRENATAL MEDICAL VISIT

GA AT FIRST VISIT TO HIGH RISK PREGNANCY PROJECT (PHHV) (wks)

To add a HRPIO – Intake form, right-click the Add Pregnancy* button.

**** All fields labeled in RED are MANDATORY.**

Adult - - - / / - *** - Medical Record #: 1812

Encounters HRPIO-Intake HRPIO-Outcome LSP Care Plan S.O.A.I.P Assessment Tools Progress Notes(narrative) Progress Notes(Checklist)

Intake Date: / / Completed By: County/Reservation: Current Age: *** Individual / Case #: 1812

Pregnancy History Risk Factors Risk Factors (cont.)

EDD: / / Archive

Pregnancies (inc. current)	Live Births
Living Children	Term
Miscarriages	Preterm
Terminations	Total 0

PRETERM LABOR IN PREVIOUS PREGNANCIES ☐ Yes ☐ No ☐ Unknown

MONTH OF FIRST PRENATAL MEDICAL VISIT:

GA AT FIRST VISIT TO HIGH RISK PREGNANCY PROJECT (PHHV) (wks):

Previous Pregnancy Next Pregnancy Delete Pregnancy* Add Pregnancy* Print Modify/Add

Enter the pregnancy history portion of the intake form.



Risk Factors

Adult - - - / / - *** - Medical Record #: 1812

Encounters HRPIO-Intake HRPIO-Outcome LSP Care Plan S.O.A.I.P Assessment Tools Progress Notes(narrative) Progress Notes(Checklist)

Intake Date: / / Completed By: County/Reservation: Current Age: *** Individual / Case #: 1812

Pregnancy History Risk Factors Risk Factors (cont.)

Risk Factors (Need 1 of the following; check all that apply)

☐ Age 17 or younger

☐ Someone in immediate environment abuses alcohol, tobacco, or drugs

☐ Currently in an abusive relationship (Positive ACOG Domestic Violence screen)

☐ Homeless or multiple residences (> 3 during pregnancy)

☐ Medical Risks: Depression Screen Score: Referred for MH Assessment/Counseling

Asthma	High Blood Pressure	Nutritional Risk - WIC Defined	PID
Gestational Diabetes	Mental Illness/Depression	Obesity	Seizures
Hepatitis B	Multiple Gestation	Previous Hx PTL	UTI's

Other:

STD at intake: ☐ Yes ☐ No ☐ Unknown

Chlamydia	Gonorrhea
Genital Herpes	Syphilis
Genital Warts	Trichomoniasis

Other:

Previous Pregnancy Next Pregnancy Delete Pregnancy* Add Pregnancy* Print Modify/Add

Enter the risk factors portion of the intake form.



Risk Factors (cont)

Health District Information System

Home Visit Reports Browse/List/Export Count/Graph Maintenance Return

Adult - - - / / - - - Medical Record #: 1812

Encounters HRPIO-Intake HRPIO-Outcome LSP Care Plan S.O.A.I.P Assessment Tools Progress Notes(narrative) Progress Notes(Checklist)

Intake Date: / / Completed By: County/Reservation: Enhanced HIV Client: Current Age: Individual / Case #: 1812

Pregnancy History Risk Factors Risk Factors (cont.)

☐ Abuses alcohol, tobacco, or drugs T-ACE Score: Referred for CD Assessment/Counseling

Alcohol	☐	Inhalants	☐	Methamphetamines	☐	PCP	☐
Cocaine/crack	☐	LSD	☐	Opiates/Heroin	☐	Tobacco	☐
Ecstasy	☐	Marijuana	☐				

Other:

OR DEMONSTRATES AN INABILITY TO OBTAIN NECESSARY RESOURCES AND SERVICES AND MEETS 3 OF THE FOLLOWING (check all that apply)

☐ History of physical or sexual abuse	☐ Age 18 or 19
☐ Lack of support system	☐ Age 35 or over
☐ Not educated beyond 12th grade or GED	☐ Limited english proficiency
☐ Physical or developmental disability	☐ Migrant worker or refugee status
☐ No prenatal care in first 20 weeks of gestation	☐ Other (specify):
☐ No dental cleanings in the last year	

MEDICAID	Yes	☐	No	☐	Applied	☐	Referred	☐	Unknown	☐
TANF	Yes	☐	No	☐	Applied	☐	Referred	☐	Unknown	☐
WIC	Yes	☐	No	☐	Applied	☐	Referred	☐	Unknown	☐

Previous Pregnancy Next Pregnancy Delete Pregnancy* Add Pregnancy*

Print Modify/Add

Complete the risk factors portion of the intake form.

Field/Button	Description
Previous Pregnancy	Click to view the previous HRPIO.
Next Pregnancy	Click to view the next HRPIO.
Delete Pregnancy*	Right-click to delete the HRPIO form.
Add Pregnancy*	Right-click to add a HRPIO form.
Print	Click to open the print window.
Modify/Add	Click to modify/add the record.

HRPIO - Outcome



HRPIO - Outcome

Adult - - - / / - *** - Medical Record #: 1812

Encounters | HRPIO-Intake | **HRPIO-Outcome** | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Date of Client Discharge / / **Completed By:** **Current Age** *** ☐ ICM HV Client

Outcome			Medical/Infant Risks						Exit/Comments	
	Delivery Outcome	Method of Delivery	Gender	Birth Wt Gm.	Birth Wt Lb/oz.	Nursery Days	APGAR 1 min	APGAR 5 min	Convert to Grams	
Infant A	☐ Live Birth ☐ Miscarriage ☐ Stillborn	☐ Vaginal ☐ VBAC ☐ Prim C-Sec ☐ Rpt C-Section	☐		Lb. oz.				Date of Live Birth / /	
Infant B	☐ Live Birth ☐ Miscarriage ☐ Stillborn	☐ Vaginal ☐ VBAC ☐ Prim C-Sec ☐ Rpt C-Section	☐		Lb. oz.				Gestational Age 	
Infant C	☐ Live Birth ☐ Miscarriage ☐ Stillborn	☐ Vaginal ☐ VBAC ☐ Prim C-Sec ☐ Rpt C-Section	☐		Lb. oz.				Total # of PHHV Vists 	

Preterm Labor During this Pregnancy ☐ Yes ☐ No ☐ Unknown
Violent/Abusive Relationship during Pregnancy ☐ Yes ☐ No ☐ Unknown **3 or more Residences or Homeless during Pregnancy** ☐ Yes ☐ No ☐ Unknown

Cigarettes	Tobacco	Alcohol/Drugs
Smoked Cigarettes during Pregnancy ☐ Yes ☐ No ☐ Unknown Smoked Cigarettes during Last 3 Months of Pregnancy ☐ Yes ☐ No ☐ Unknown Stopped (Quit) Smoking Cigarettes during Pregnancy ☐ Yes ☐ No ☐ Unknown		

Enter the outcome information.

**** All fields labeled in RED are MANDATORY.**



Medical/Infant Risks

Adult - - - - - Medical Record #: 1812

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Date of Client Discharge: / / Completed By: Current Age: *** ICM HV Client

Outcome | Medical/Infant Risks | Exit/Comments

STD DURING PREGNANCY ☐ Yes ☐ No ☐ Unknown

Chlamydia	☐	Gonorrhea	☐	Syphilis	☐
Genital Warts	☐	Genital Herpes	☐	Trichomoniasis	☐

Other:

MEDICAL RISKS/COMPLICATIONS/INFECTIONS: ☐ Yes ☐ No ☐ Unknown

Anemia	☐	GBS/Group B Strep	☐	Placenta Previa	☐	RH Factor	☐
Breech	☐	Hypertension	☐	Postpartum Depression	☐	Toxemia	☐
ETOH/Substance	☐	Maternal Death	☐	Preeclampsia	☐		
Gestational Diabetes	☐	PID	☐	Preterm Labor	☐		

Other:

Depression Screen Score: Referred for Mental Health Assessment/Counseling ☐

INFANT RISKS/COMPLICATIONS/INFECTION (Indicate A,B, C etc. for multiple births):

Breech	☐	Hyperbilirubinemia	☐	Jaundice	☐	RDS	☐
Cong. Anomalies	☐	In Utero Exposure to Alcohol	☐	Meconium Aspiration	☐	Seizures	☐
Fetal Distress	☐	In Utero Exposure to Substances	☐	Preterm	☐		
Down Syndrome	☐	In Utero Exposure to Tobacco	☐	PROM	☐		

Other:

Print Modify / Add

Enter the medical/infant risks information.



Exit/Comments

Adult - Medical Record #: 1812

Encounters | HRPIO-Intake | **HRPIO-Outcome** | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Date of Client Discharge: Completed By: Current Age: ☐ ICM HV Client

Outcome		Medical/Infant Risks		Exit/Comments
Medicaid	WIC	Referrals Made by PHHV to Community		Exited High Risk Pregnancy Project:
☐ Yes	☐ Yes	☐ MTUPP Quitline	☐ Resources to Obtain Housing	☐ Post Outcome
☐ No	☐ No	☐ Other Tobacco Cessation Resources	☐ Food Resources Other than WIC	☐ Lost to Care
☐ Not Eligible	☐ Not Eligible	☐ Substance Use Cessation Resources	☐ WIC	☐ Moved
☐ Unknown	☐ Unknown	☐ Domestic Violence Resources	☐ Medicaid	☐ Refused
		☐ Mental Health or Support Services	☐ No Referrals Made	☐ Transferred

Other

☐ Clients who received postpartum care within 8 weeks

☐ Infants delivered who received care within 4 weeks

Print Modify / Add

Complete the HRPIO – Outcome form.

LSP (Optional)



LSP

Adult - SMITH, JANE - 01/01/1976 - 33 - Medical Record #: 2

Encounters | HRPIO-Intake | HRPIO-Outcome | **LSP** | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Adult's Last Name: SMITH Adult's First Name: JANE Sex: Date of Birth: 01/01/1976 Individual Number: 2 Family Record Number: 562

Race: Ethnic: Date of LSP: Initial Ongoing Closing Next LSP Due: / /

Medical Codes: Home Visitor: Agency: LAKE Months of Service: Attempted Visits: Completed Visits:

Program: Does mom live with FOB? Does mom read for fun/reads to child?

1. Family	0.0	8. Safety	0.0	15. Employment	0.0	22. Child Dental	0.0	29. Cognitive Ability	0.0
2. BF, FOB, Spous	0.0	9. Rel w HV	0.0	16. Immigration	0.0	23. Immunizations	0.0	30. Housing	0.0
3. Friends	0.0	10. Use of Info.	0.0	17. Prenatal Care	0.0	24. Subs Abuse	0.0	31. Food	0.0
4. Attitude to Preg.	0.0	11. Use of Res.	0.0	18. Sick Care	0.0	25. Tobacco	0.0	32. Transportation	0.0
5. Nurturing	0.0	12. Language	0.0	19. Family Planning	0.0	26. Depression	0.0	33. Health Insurance	0.0
6. Discipline	0.0	13. Educ. < 12 yrs	0.0	20. Child Well Care	0.0	27. Mental Illness	0.0	34. Income	0.0
7. Development	0.0	14. Education	0.0	21. Child Sick Care	0.0	28. Self Esteem	0.0	35. Child Care	0.0

Re-Sort Dates* Previous LSP Next LSP Delete LSP * Add LSP * Zoom Print Modify / Add

The LSP tab is for entering your Life Skills Progression form for your client. To enter the scores, click the Zoom button.

Field/Button	Description
Previous LSP	Click to navigate to the previous LSP.
Next LSP	Click to navigate to the next LSP.
Delete LSP*	Right-click to delete the LSP form.
Add LSP*	Right-click to add a LSP form.
Zoom	Click to open the Zoom screen.
Print	Click to open the Print window.
Modify/Add	Click to modify/add a LSP record.

Adult - SMITH, JANE - 01/01/1976 - 33 - Medical Record #: 2

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Adult's Last Name: SMITH | Adult's First Name: JANE | Sex: | Date of Birth: 01/01/1976 | Individual Number: 2 | Family Record Number: 562

The Life Skills Progression - Number 1

Family &/or Extended Family

0	1	1.5	2	2.5	3	3.5	4	4.5	5
HOSTILE, VIOLENT OR PHYSICALLY ABUSIVE FAMILY RELATIONSHIPS.		SEPARATED, NO CONTACT, NOT AVAILABLE FOR SUPPORT.		CONFLICTED, CRITICAL OR VERBAL ABUSE, FREQUENT ARGUMENTS, RELUCTANT SUPPORT IN CRISIS.		INCONSISTENT OR CONDITIONAL SUPPORT, EMOTIONALLY DISTANT BUT AVAILABLE.		VERY SUPPORTIVE, MUTUALLY NURTURING FAMILY RELATIONSHIPS.	

Score: 0.0 | Comments:

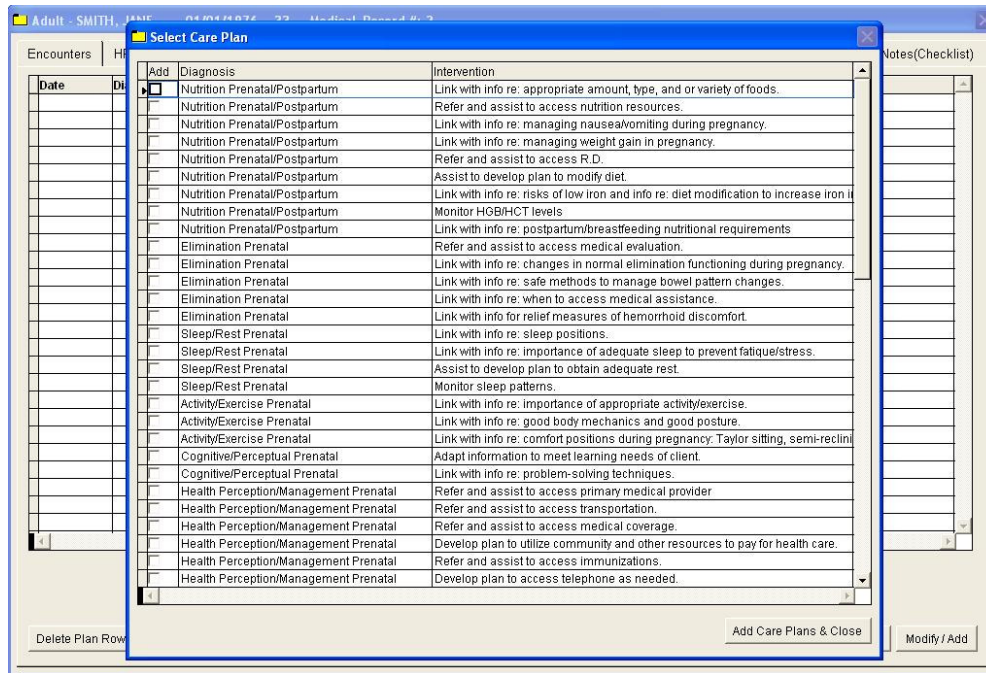
Previous | Next | Close

Re-Sort Dates* | Previous LSP | Next LSP | Delete LSP * | Add LSP * | Zoom | Print | Modify / Add

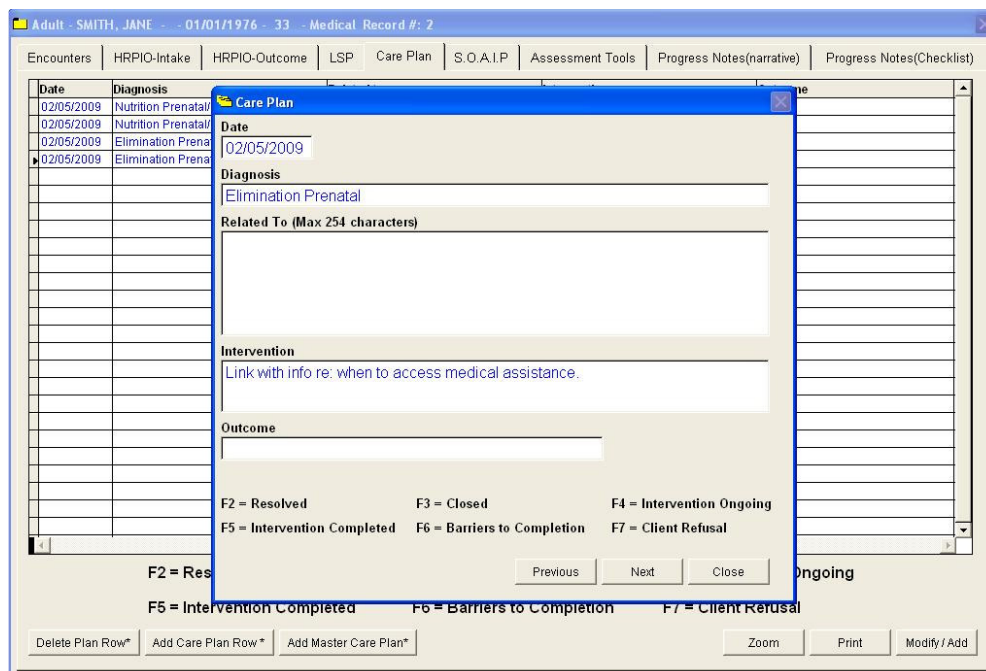
The Zoom screen allows you to navigate through each question of the Life Skills Progression form. To enter the score, simply click on one of the black numbers. You may also enter your own comments for each question. Click the Previous or Next buttons to go to advance through the question.

[illegible]

Field/Button	Description
Delete Care Plan*	Right-click to delete the care plan.
Add Care Plan Row*	Right-click to add a single care plan row.
Add Master Care Plan*	Right click to open the care plan window.
Zoom	Click to open the care plan zoom window.
Print	Click to open the Print window.
Modify/Add	Click to modify or add a care plan record.



The Select Care Plan window allows you to select which care plans that you would like to add to the grid. Put a checkmark in the Add column for which of the care plans you would like to add, when finished click Add Care Plans & Close.



After you have added the care plans, click **Zoom** to navigate through each care plan to enter the client's information.

S.O.A.I.P. (Optional)



S.O.A.I.P.

The S.O.A.I.P. tab is for entering your S.O.A.I.P. notes for your client. To add a row, right-click the Add S.O.A.I.P. Row* button.

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Blank S.O.A.I.P. Row*	Right-click to delete any blank rows in the grid.
Add S.O.A.I.P. Row*	Right-click to add a S.O.A.I.P. note.
Zoom	Click to open the S.O.A.I.P. zoom window.
Print	Click to open the print window.
Modify/Add	Click to modify or add a S.O.A.I.P. record.

The image shows a software window titled "S.O.A.I.P." with a blue border. Inside, there are several input fields and sections. At the top left, there is a "Date" field with a date picker icon and a "Staff" dropdown menu. Below these are five large text areas labeled "Subjective", "Objective", "Assessment", "Intervention", and "Plan", each with a vertical scrollbar on the right. At the bottom of the window, there are four buttons: "Previous S.O.A.P.I.", "Next S.O.A.P.I.", "Spell Check", and "Close".

Enter your S.O.A.I.P. notes and click the close button. To navigate through your notes, use the **Previous** and **Next** buttons. You also have to ability to perform a spell check on your notes with the **Spell Check** button.

[illegible]

Field/Button	Description
Delete*	Right-click to delete a row.
Add Test*	Right-click to add a test to the grid.
Print	Click to open the print window.
Modify/Add	Click to modify or add an assessment tool record.

Progress Notes (Narrative) (Optional)



Progress Notes (Narrative)

To enter your narrative progress notes on the client, right-click the **Add Progress Note*** button.

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Blank Progress Note*	Right click to delete any blank progress notes.
Add Progress Note*	Right-click to add a progress note.
Zoom	Click to open the progress note zoom window.
Print	Click to open the print window.
Modify/Add	Click to modify a progress note record.

Adult - SMITH, JANE - 01/01/1976 - 33 - Medical Record #: 2

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Date	Staff	Notes

Progress Notes

Date:

Staff:

Progress Note

Previous Progress Note | Next Progress Note | Spell Check | Close

Re-Sort Dates* | Delete Blank Progress Note* | Add Progress Note* | Zoom | Print | Modify / Add

Click the **Zoom** button to navigate and enter your progress notes.

Progress Notes (Checklist)



Progress Notes (Checklist)

The **Progress Notes (Checklist)** allows you to enter pre-created forms for the clients. To add on of these forms, enter the screening date and click the **Add Form** button.

Select the form that you wish to add to the grid and click the **Add & Close** button.

Adult - SMITH, JANE - 01/01/1976 - 33 - Medical Record #: 2

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Progress Note(checklist)

Date of Visit: 02/04/2009 Home Visitor: [dropdown]

F2 = ASSESS F3 = PLAN F4 = MONITOR F5 = REFER F6 = EDUCATION

Issue: [text] Focus Area: [text] Intervention: [text]

Notes: [text area]

Choices: [list area]

Buttons: Spell Check, Add to Notes, Next, Previous, Close

Footer: Re-Sort Dates* Add Form Delete Empty Rows* Zoom Print Modify / Add

After the selected form has been added to the grid, you can scroll through each issue by using the **Zoom** button.

Print Button



Print

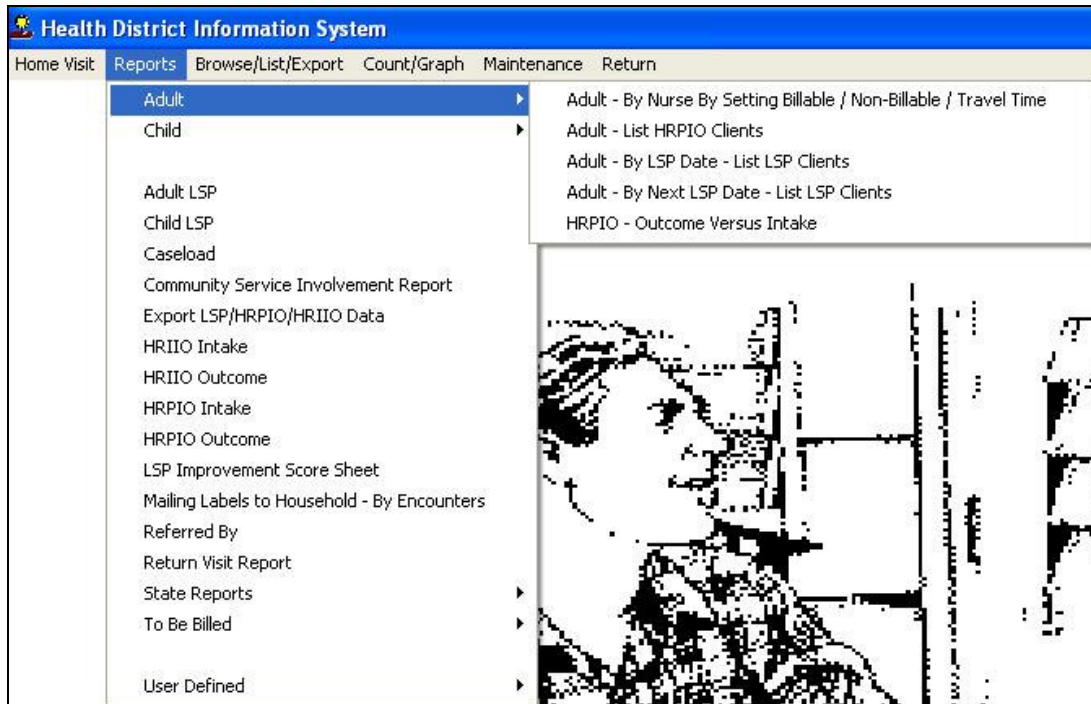
Print: The print button is available on all the tabs

Field/Button	Description
Assessment Tools	Prints a list of assessment tool tests and scores for the client.
Care Plan	Prints the care plan.
Intake Form	Prints the intake form.
Outcome Form	Prints the outcome form.
LSP Form	Prints the LSP form.
LSP Cumulative Scores	Prints the cumulative scores LSP form.
Progress Notes	Prints the progress notes.
Specific Progress Notes	Prints only the Progress Note you have positioned to
Specific Staff Progress Notes	Prints only the Progress Notes for the staff member for the Note you have positioned to
S.O.A.I.P.	Prints the S.O.A.I.P. notes.
Specific S.O.A.I.P.	Prints a specific S.O.A.I.P. note.
T-ACE Form	Prints the T-ACE form.
ACOG Form	Prints the ACOG form.
Encounters	Prints a list of encounters for the dates specified.
Preview	Previews the printout.
Print	Prints the form.
OK	Prints/previews the form.
Close	Closes the print menu.

Reports



Reports



The **Home Visits program** has a set of pre-defined reports to choose from. Each reported will ask for **From date** and **To date**.

The screenshot shows the 'HRIO Intake Report Options' dialog box. It contains the following fields and buttons:

- From HRIO Intake Date: []
- To HRIO Intake Date: []
- Employee: []
- Buttons: Preview, Printer, Filters, OK, Close

You may also preview the report before printing. Also, you have the ability to use filters to build a query.

Reports

Report	Description
Adult – By Nurse By Setting Billable/Non-Billable/Travel Time	Generates a List of Clients and their Billable/Non-Billable/Travel times.
Adult – List HRPIO Clients	Generates a list of HRPIO clients.
Adult – By LSP Date – List LSP Clients	Generates a list of HRPIO clients by date of LSP.
Adult – By Next LSP Date – List LSP Clients	Generates List of LSP Clients by Next LSP due date
HRPIO – Outcome Vs. Intake	Measures outcomes for HRPIO risk factors
Caseload	Generates a caseload of clients by employee and program.
Community Service Involvement	Counts Community Service being used
Export LSP/HRPIO/HRPIO Data	Used by Gallatin County for research purposes
HRPIO Intake	Generates your HRPIO Intake forms in bulk.
HRPIO Outcome	Generates your HRPIO Outcome forms in bulk.
LSP Improvement Score Sheet	Generates the LSP Improvement Score Sheet.
Mailing Labels to Household – By Encounters	Generates mailing labels by encounters.
Referred By	Generates a count report of referrals.
Return Visit Reports	Generates a return visit report for your clients.
State Reports – MCH Block Grant 2006	Generates the 2006 MCH Block Grant reports.
State Reports – MCH Block Grant 2007	Generates the 2007 MCH Block Grant reports.
Public Health Home Visit Quarterly Report	Generates your Quarterly report for Public Health Home Visits.
To Be Billed – Adult – By Date of Entry	Generates a “to be billed” report for your adult clients by date of entry.
To Be Billed – Adult – By Date of Service	Generates “a to be billed” report for your adult clients by date of entry.

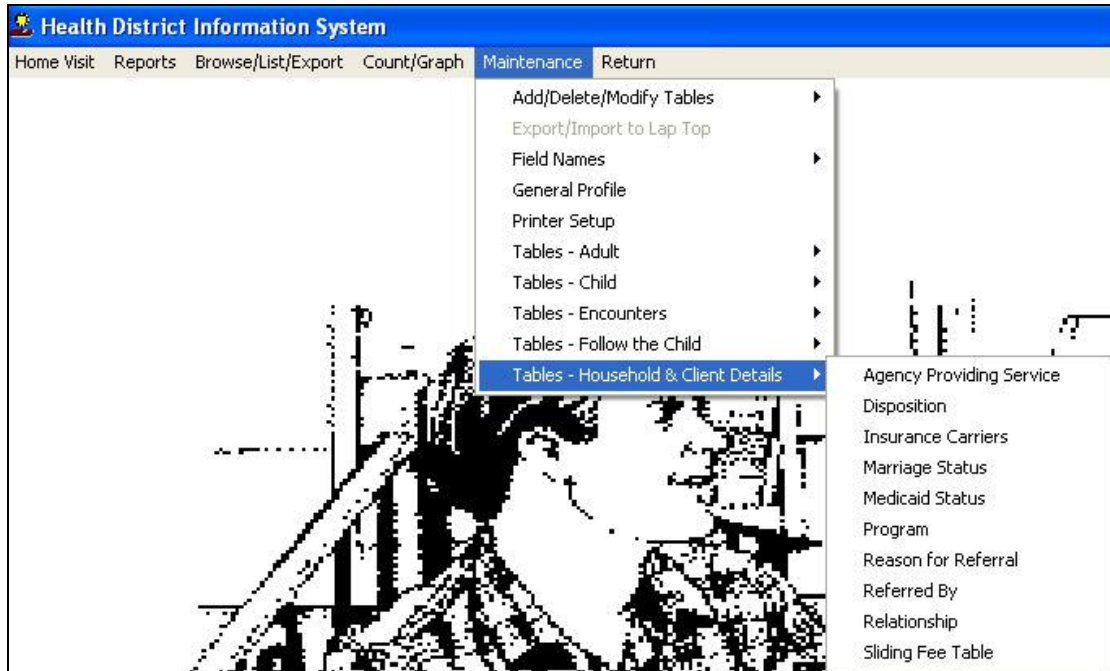
Maintenance - Add/Delete/Modify Tables



Maintenance



The maintenance menu contains a list of the tables that you can modify for your program. For client demographics, there are two selections under the Maintenance Menu where you can add or modify your dropdown selections.



CHC Software, Inc.
Health District Information Systems
helpdesk@hdis.org

CHC Software, Inc.
Health District Information Systems
helpdesk@hdis.org