



NCCHC Recommended Correctional Clinical Guidelines Instructions for Use of Chronic Care Forms

Chronic Disease Initial Baseline Form

This form should be used when seeing a chronic disease patient for the first time. It contains a checklist for all of the chronic diseases identified at that initial visit. The sections on personal risk factors, family history, surgeries/hospitalizations, and general description are to be completed for all patients on their initial assessment. The next sections are historical data to be completed when the patient is entered in the specific clinic for the first visit. Here, any box checked requires elaboration in the space that follows. The physical examination section requires relevant vital signs and those aspects of the examination appropriate for each disease. The next section requests laboratory information that may not be available at this first visit but should be documented if available. The “assessment: diagnoses” section requires listing the diseases assessed and the degree of control based on published definitions of control (available at www.ncchc.org/resources/clinicalguides/definitions.pdf). Where a disease is assessed for which no definition of control has yet been published, the clinician may either check N/A or use his or her clinical judgment. In the education section, details regarding what was discussed with the patient should be given. The plan section should list medication changes along with any orders for tests, immunizations, and monitoring. The final page provides space for any additional history, including symptoms not related to chronic illness. Chronic disease follow-up visits should be indicated; the time frame for the visits should be based on the worst degree of control identified.

Chronic Disease Clinic Follow-Up Form

This form can be used for patients with a single or with multiple chronic diseases. The chronic diseases for which the patient is being followed are listed at the top of the form. Next, the current medications are listed, or a pharmacy profile should be attached. The next section lists required questions for asthma, hypertension, seizure disorder, diabetes, HIV, and HCV. These questions provide information critical to assess the degree of control (except HCV). Next, all patients must be asked about any new symptoms since the last visit; space is provided for elaboration. Patient adherence is reviewed next. The laboratory data section provides space for the clinician to summarize fingerstick or blood pressure monitoring results. The next section is for physical examination relevant to the diseases being assessed. Next the clinician lists the diseases being assessed along with the degree of control and clinical status, which are based on definitions published at <http://www.ncchc.org/resources/clinicalguides/definitions.pdf>. Where a disease is

assessed for which no definition of control has yet been published, the clinician may either check N/A or use his or her clinical judgment. Clinical status refers to more subtle subjective and objective changes since the previous visit. In the plan section,, medication changes should be listed along with any orders for tests, immunizations, and monitoring.

Nursing Chronic Disease Flowsheet

This flowsheet is designed to be used for a nursing chronic disease visit that occurs between a clinician's chronic disease visits. The form allows for vital signs, relevant nursing history, and objective data to be viewed over time in order to assess clinical trends. At the bottom of the form, there is a section for the nurse to sign his or her note and for the clinician to initial that he or she has reviewed the note.

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National Commission on Correctional Health Care
1145 W. Diversey Parkway
Chicago, IL 60614
773-880-1460
773-880-2424 fax
www.ncchc.org