OREGON CLINIC VISIT RECORD

ORHP

A. LAST NAME _____ B. FIRST NAME _____ C. M.I. ____

D. SOC. SEC. NO. |__|__|__|--|__|__|--|__|__|__|__| E. RHAF ID NO. |__|__|__|__|__|__|__|__|

ITEMS A-E only required when billing RH Access Fund. Item D only required for those who have a SSN.

20. PROVIDER NPI _____

1. SITE/CLINIC NO. |__|__|__|__|__|__|__|

2. CLIENT NO. |__|__|__|__|__|__|__|__|__|

3. DATE OF VISIT |__|__|__|__|2|0|__|__|

4. DATE OF BIRTH |__|__|__|__|__|__|__|__|

5. SEX AT BIRTH ☐ 1-Female ☐ 2-Male

6. ETHNICITY ☐ 8-Unknown/Not Reported
☐ 6-Hispanic or Latino ☐ 9-Not Hispanic or Latino

6a. RACE (Mark all that apply)
☐ 1-White ☐ 5-Asian
☐ 2-Black/Afr. Amer. ☐ 6-Other
☐ 3-American Indian ☐ 7-Unknown/Not Reported
☐ 4-Alaska Native ☐ 8-Native Hawaiian/ Pac. Isl.

21. SEXUAL ORIENTATION
☐ 1-Bisexual ☐ 4-Other, something else
☐ 2-Lesbian or Gay ☐ 5-Unknown
☐ 3-Straight or heterosexual ☐ 6-Decline to answer
☐ 7-Don't know what the question is asking

22. GENDER IDENTITY
☐ 1-Woman ☐ 5-Unknown
☐ 2-Man ☐ 6-Decline to answer
☐ 3-Non-binary ☐ 7-Don't know what the question is asking
☐ 4-Other, something else

23. TRANSGENDER IDENTITY
☐ 1-Yes ☐ 5-Unknown
☐ 2-No ☐ 6-Decline to answer
☐ 3-Questioning/ Exploring ☐ 7-Don't know what the question is asking

7. ADDITIONAL DEMOGRAPHIC (check if applicable)
☐ 5-Limited English Proficiency

8. ZIP CODE |__|__|__|__|__|

10. INCOME AND HOUSEHOLD SIZE

a. Monthly Income	
b. Household Size	

18. CLIENT INSURANCE STATUS (check one)
(Principal health insurance covering primary care)
☐ 1-Public Health Insurance ☐ 3-Uninsured
☐ 2-Private Health Insurance ☐ 4-Unknown

24. SYSTOLIC BP:	**26.** HEIGHT:
25. DIASTOLIC BP:	**27.** WEIGHT:

28. TOBACCO SMOKING STATUS:
☐ 1-Current every day ☐ 3-Former
☐ 2-Current some days ☐ 4-Never
☐ 5-Unknown

9. ASSIGNED SOURCE OF PAYMENT (CHECK ONE)
☐ 02-Title XIX (OHP) ☐ 04-Private Insurance
☐ 03-WA Take Charge ☐ 05-Full Fee
☐ 11-OVP ☐ 07-Other
☐ 12- RH Access Fund

13B. 14B. PROVIDER OF MEDICAL SERVICES/ COUNSELING/EDUCATION SERVICES
(Choose up to 4)
☐ 1-Physician (MD, DO, ND) ☐ 4-Other (MA, LPN, Health Educator, etc)
☐ 2-Nurse Practitioner ☐ 5-Physician Associate
☐ 3-RN ☐ 6-Certified Nurse Midwife

13A. MEDICAL SERVICES (Check all applicable)

Visit & Lab Services
☐ 01-Annual Visit
☐ 41-Telehealth Visit
☐ 06-Breast Exam
☐ 09-Pelvic Exam
☐ 23-Hgb/Hct
☐ 24-Urine dip strip/Urinalysis

Contraceptive Related Services
☐ 17-Diaphragm/Cap Fit
☐ 19-IUD/IUS Insert
☐ 22-IUD/IUS Removal
☐ 38-Hormone Implant Insert
☐ 39-Hormone Implant Removal

Pregnancy Related Services
☐ 31-Serum Pregnancy Test
☐ 32-Negative Pregnancy Test

STI Related Services
☐ **29-Chlamydia Test**
☐ 13-Chlamydia Treatment
☐ 28-Gonorrhea Test
☐ 10-Gonorrhea Treatment
☐ 03-Trich Test
☐ 04-Trich Treatment

☐ **45-Language Assistance**
☐ 26-Pap Test
☐ 50-HPV Test
☐ 36-Other Lab or Exam
☐ 37-No Lab or Exam

☐ 40-Hormonal injection
☐ 48-EC-Immediate Need
☐ 46-EC-Future Need
☐ 20-Vasectomy Procedure
☐ 18-Vasectomy Referral Fee

☐ 33-Positive Pregnancy Test
☐ 35-Infertility Screening

☐ 16-Herpes Test
☐ 30-Wet Mount
☐ 43-HIV test
☐ 47-Syphilis Test
☐ 02-Syphilis Treatment

14A. EDUCATION/COUNSELING (Check all applicable)
☐ 01-Contraceptive ☐ 09-STI/HIV prevention
☐ 03-Sterilization ☐ 13-Abstinence
☐ 04-Infertility ☐ 16-Abnormal Pap
☐ 07-Pregnancy options ☐ 17-Parent/Family involvement
☐ 08-Preconception/Achieving pregnancy ☐ 18-Relationship Safety

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29. PREGNANCY STATUS
☐ 1-Pregnant ☐ 2-Not Pregnant ☐ 3-Unknown

19. PREGNANCY INTENTION SCREENING
☐ 1-Yes ☐ 2-No ☐ 3- Okay Either Way
☐ 4-Never ☐ 5-Unsure

30. DO YOU WANT TO TALK ABOUT CONTRACEPTION OR PREGNANCY PREVENTION TODAY?
☐ 1-Yes ☐ 2-No, here for something else
☐ 3-Prefer not to answer ☐ 4-Already using contraception
☐ 5-Unsure/No ☐ 6-Hoping to become pregnant

15A. PRIMARY CONTRACEPTIVE METHOD
(Complete before and after blocks)

06-Condom, External	22-LAM
19-Condom, Internal	02-Oral Contraceptives
23-Contraceptive gel	24-Oral (progestin only)
04-Diaphragm	07-Spermicide
25-Emergency contraception	21-Sponge
11-Hormonal Implant	01-Tubal Sterilization
16-Hormonal Injection	20-Withdrawal
17-Hormonal Patch	18-Vaginal Ring
03-IUD copper	14-Vasectomy
15-IUD with progestin	09-Other Method
26-IUD unspecified	10-None
08-NFP/FAM	27-Decline to answer

BEFORE VISIT |__|__| **AFTER VISIT** |__|__|

15B/15C. IF METHOD IS 'NONE,' GIVE REASON.
☐ 2-Sterile for Non-Contraceptive Reason ☐ 6-Abstinence
☐ 3-Seeking Pregnancy ☐ 7-Other
☐ 9-Same Sex Partner

BEFORE VISIT |__|__| **AFTER VISIT** |__|__|

31. HOW CONTRACEPTION WAS PROVIDED
☐ 1-Onsite ☐ 3-Prescription
☐ 2-Referral ☐ 4-N/A

Complete the below sections if billing RH Access Fund or OVP

12. PURPOSE OF VISIT (Check One)
☐ 11 – Low ☐ 09 – Supply-only Visit
☐ 12 – Moderate ☐ 08 – Vasectomy Referral
☐ 13 – High

9A. DIAGNOSIS CODES:
1. |__|__|__|.|__|__|__| 4. |__|__|__|.|__|__|__|
2. |__|__|__|.|__|__|__| 5. |__|__|__|.|__|__|__|
3. |__|__|__|.|__|__|__| 6. |__|__|__|.|__|__|__|

9B. WAS INSURANCE BILLED FOR THIS VISIT?
☐ 1-No ☐ 2-Yes (Complete 17A.)

9C. SPECIAL CONFIDENTIALITY NEEDS ☐ 1-Yes

17. SUPPLY BILLING

Supply	Qty.	Unit price	Supply	Qty.	Unit Price
01-Orals			21-Skyla IUS		
16-EC			22-Liletta IUS		
14-Patch			23-Kyleena IUS		
15-Mirena IUS			24-Annual Ring		
03-Copper IUD			25-Contraceptive gel		
04-Depo Provera			30-Folic Acid		
05-Diaphragm			31-Azithromycin		
06-Spermicide			32-Doxycycline		
07-Condoms, External			33-Erythromycin		
08-Condoms, Internal			34-Levofloxacin		
12-Cervical Cap			35-Ofloxacin		
17-Monthly Ring			36-Ceftriaxone		
18-Sponge			37-Cefixime		
19-Subdermal implant			38-Gentamicin		
20-Cycle Beads			39-Penicillin G		
			40-Metronidazole		

17A. THIRD PARTY RESOURCE CODES (Complete if client has other insurance coverage)
1 – Explanation Code |__|__|
2 – Other Insurance Paid |__|__|__|__|.|__|__|