

ASSESSMENT DATE:
9/8 **9/9**



COMMUNITY ASSESSMENT & INTERVENTION
CLINICAN REPORT FORM
PAGE 1

HOUSEHOLD ID #

SECTION #

RESIDENT'S NAME

HOUSEHOLD ADDRESS

PHONE #

Date:

Time:

I would prefer follow-up contact by:

Birth date

____ Month ____ Day ____ Year

Home visit: _____

Telephone: _____

Parent/Guardian(where applicable):
Family Members:

Notes:

Blood Pressure: _____

Resp: _____

Pulse: _____

LMP: _____

Temp: _____

Dialysis: Y / N

Current Meds/Last Dose:

Chronic Illness/Surgical History:

Current Complaints:

Allergies:

Plan/RX/Follow-up:

TIER 3 RESPONDENT: _____

Signature: _____

HDHHS TITLE: _____