

Health Resilience Program Encounter Documentation Form March 1, 2014 v7

Client Name: _____ Client ID Number: _____ Dates of Service: _____ to _____

ENCOUNTER TYPE

Face-to-Face
 Phone: # _____
 Digital (email/text): est. # _____
 Other: # _____

Travel Time TOTAL To & From	Encounter Length TOTAL	ATTENDEES <i>(mark all that apply)</i>	ENCOUNTER SETTING <i>(mark all that apply)</i>	ENCOUNTER PURPOSE <i>(mark all that apply)</i>
<input type="checkbox"/> On-Site <input type="checkbox"/> <5 mins <input type="checkbox"/> 5 mins <input type="checkbox"/> 10 mins <input type="checkbox"/> 15 mins <input type="checkbox"/> 30 mins <input type="checkbox"/> 45 mins <input type="checkbox"/> 1 hour <input type="checkbox"/> 1.5 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 2.5 hours <input type="checkbox"/> 3+ hours	<input type="checkbox"/> <5 mins <input type="checkbox"/> 5 mins <input type="checkbox"/> 10 mins <input type="checkbox"/> 15 mins <input type="checkbox"/> 30 mins <input type="checkbox"/> 45 mins <input type="checkbox"/> 1 hour <input type="checkbox"/> 1.5 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> 2.5 hours <input type="checkbox"/> 3+ hours	Self <i>(Initials)</i> : _____ <input type="checkbox"/> Additional Team: _____ <input type="checkbox"/> Client <i>(face-to-face)</i> <input type="checkbox"/> Client <i>(phone/digital)</i> <input type="checkbox"/> Medical staff <input type="checkbox"/> Pharmacy <input type="checkbox"/> Caseworker <input type="checkbox"/> Client's Friends/Family <input type="checkbox"/> Mental Health / Psychiatry <input type="checkbox"/> Addictions staff <input type="checkbox"/> Community Resource staff <input type="checkbox"/> Other:	<input type="checkbox"/> N/A <i>(not face-to-face)</i> <input type="checkbox"/> Client's home <input type="checkbox"/> Community site <input type="checkbox"/> Medical office <input type="checkbox"/> Mental Health office <input type="checkbox"/> Hospital <input type="checkbox"/> Emergency Dept <input type="checkbox"/> SNF/Adult Foster Care <input type="checkbox"/> CareOregon <input type="checkbox"/> Methadone clinic <input type="checkbox"/> Addictions site <input type="checkbox"/> Other:	<input type="checkbox"/> Client Outreach <i>(pre-engagement)</i> <input type="checkbox"/> Ongoing Client Interaction <i>(planned)</i> <input type="checkbox"/> Urgent Intervention <i>(unplanned)</i> <input type="checkbox"/> Attend Client Appointment <input type="checkbox"/> Consultation <input type="checkbox"/> Care/Case Coordination <input type="checkbox"/> Other:

PRIMARY ACTIVITIES during ENCOUNTER *(mark all that apply)*

<input type="checkbox"/> Information Gathering <input type="checkbox"/> Periodic Check-In with Client <input type="checkbox"/> Skills / Problem Solving Training <input type="checkbox"/> Life Enriching and/or Health Promotion Activities <input type="checkbox"/> Side by Side Coordination <input type="checkbox"/> Face-to-Face No Show <input type="checkbox"/> Left Voice Message	<input type="checkbox"/> Advocacy <input type="checkbox"/> Insurance/CO Advocacy & Edu (DME, Benefits, etc.) <input type="checkbox"/> Follow-Up on ED/Inpt <input type="checkbox"/> ED Prevention / Triage <input type="checkbox"/> Health Education / Health Literacy <input type="checkbox"/> Community Resources Education <input type="checkbox"/> Other:	<input type="checkbox"/> Medication Adherence & Support <input type="checkbox"/> Physical Assessment <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Goals Setting / Review <input type="checkbox"/> Motivational Interviewing
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NOTES/COMMENTS