Family Planning Service Form

Which Caregiver/Adult was involved (Client Name)?

_____

Date of Activity: _____
(mm/dd/yyyy)

Provider (Staff or Medical providing services to client with highest level of training): (Select one)
- ○ Physician
- ○ PA/APRN/CNM
- ○ Other
- ○ Registered Nurse

If "Physician" or "PA/APRN/CNM", please provide Attending physician National Provider Indicator (NPI) Number:

_____

Payer for visit: (select all that apply):
- ☐ None (no charge for current services)
- ☐ Medicare (traditional fee-for-service)
- ☐ Medicare (HMO/managed care)
- ☐ Medicaid (traditional fee-for-service)
- ☐ Medicaid (HMO/managed care)
- ☐ Workers' compensation
- ☐ Title programs (e.g., Title III, V, or X)
- ☐ Other government (e.g., TRICARE, VA, etc.)
- ☐ Private insurance/Medigap
- ☐ Private HMO/managed care
- ☐ Self-payOther (specify)
- ☐ Unknown

If Other (specify):

_____

Client's current method of contraception reported at beginning of visit: (Select all that apply)
- ☐ Combined oral contraceptive pills
- ☐ Progestin only contraceptive pills
- ☐ Male condom
- ☐ Female condom
- ☐ IUD Copper
- ☐ IUD unspecified
- ☐ IUD with Progestin
- ☐ Contraceptive patch
- ☐ Diaphragm or cervical cap
- ☐ Implantable rod
- ☐ Sponge
- ☐ Vaginal ring
- ☐ Emergency contraception
- ☐ Female sterilization
- ☐ Fertility awareness-based methods
- ☐ Injectables
- ☐ Lactational amenorrhea method
- ☐ Male relying on female method
- ☐ Spermicide
- ☐ Vasectomy
- ☐ Withdrawal
- ☐ Decline to answer
- ☐ None

Reason for no contraceptive method use: (Select all that apply)
- ☐ Abstinence
- ☐ Same sex partner
- ☐ Sterile for non-contraceptive reasons
- ☐ Seeking pregnancy
- ☐ Other

Specify other reason:

_____

SCREENING QUESTIONS

Screenings Conducted (Select all that apply):
- ☐ Tobacco Use
- ☐ Alcohol Use
- ☐ Substance Use (legal or illegal)
- ☐ Mental/Behavioral Health
- ☐ Depression
- ☐ Intimate Partner Violence
- ☐ Human Trafficking
- ☐ Diabetes
- ☐ Hypertension

Are you pregnant? (Select one)
- ○ Yes
- ○ No
- ○ N/A—Services for infant, child or male

PROGRAM SERVICES

Visit type: (Select one)
- ○ Initial Visit
- ○ Periodic/Follow-up Visit

Program Services: (Select all that apply)
- ☐ Clinical Breast Exam
- ☐ Chlamydia Test
- ☐ Contraceptive Follow-up
- ☐ Counseling for Tobacco Use
- ☐ Counseling for Alcohol Use/Substance Use (legal or illegal)
- ☐ Counseling for Mental/Behavioral Health
- ☐ Counseling for Depression
- ☐ Counseling for Intimate Partner Violence
- ☐ Counseling for Human Trafficking

- ☐ Counseling for Diabetes
- ☐ Counseling for Hypertension
- ☐ Education
- ☐ Gonorrhea Test
- ☐ HIV Test
- ☐ Pap Test
- ☐ Pregnancy Test
- ☐ STD/STI Treatment
- ☐ Syphilis Test
- ☐ Other STD/STI Test
- ☐ Other Screening

Other STD/STI Test Type:

_____

Specify Other Screening Type:

_____

Systolic blood pressure: _____

Diastolic blood pressure: _____

Body Height (metric): _____

Body Weight (metric): _____

Pap test Result: (Select one)
- ○ Did not conduct Pap test
- ○ Normal
- ○ ASC or higher
- ○ HSIL or higher
- ○ Not conclusive

Clinical Breast Exam Result: (Select one)
- ○ Did not conduct Clinical Breast Exam
- ○ Normal
- ○ Abnormal

Referral for further evaluation based on the Clinical Breast Exam: (Select one)
- ○ N/A (select if a CBE was **NOT** performed during visit)
- ○ Yes
- ○ No

Has the client had a Pap test performed in last 5 years? (Select one)
- ○ Yes
- ○ No

Pap test performed at this visit? (Select one)
- ○ Yes
- ○ No

If "Yes" to Pap test performed:
Pap Test Method – LOINC Code:

_____

Pap Test Result – Coded: (Select one)
- ○ Atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
- ○ Atypical squamous cells of uncertain significance, probably malignant
- ○ Low-grade squamous intraepithelial lesion
- ○ High-grade squamous intraepithelial lesion
- ○ Squamous cell carcinoma, no International Classification of Diseases for Oncology subtype
- ○ Atypical glandular cells on cervical Papanicolaou smear
- ○ Atypical glandular cells, favor neoplastic
- ○ Adenocarcinoma in situ
- ○ Negative for intraepithelial lesion or malignancy
- ○ Specimen satisfactory for evaluation
- ○ Specimen unsatisfactory for evaluation

HPV test performed at this visit? (Select one)
- ○ Yes
- ○ No

If "Yes" to HPV test performed:
HPV Test Method – LOINC Code:

_____

HPV Test Result – Coded: (Select one)
- ○ Positive
- ○ Detected
- ○ Negative
- ○ Not detected
- ○ Equivocal
- ○ Indeterminate

Chlamydia test performed at this visit?
- ○ Yes
- ○ No
- ○ Chlamydia trachomatis and Neisseria gonorrhoeae combined test

If "Yes" or "Chlamydia trachomatis and Neisseria gonorrhoeae combined test":
Chlamydia Test Method – LOINC Code:

_____

Chlamydia Test Result – Coded: (Select one)
- ○ Positive
- ○ Detected

- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Not applicable
- Quantitative lab

Neisseria gonorrhoeae test performed at this visit? (Select one)

- Yes
- No
- Chlamydia trachomatis and Neisseria gonorrhoeae combined test

If "Yes" or "Chlamydia trachomatis and Neisseria gonorrhoeae combined test":

Neisseria gonorrhoeae Test Method – LOINC Code: _____

Neisseria gonorrhoeae Test Result – Coded: (Select one)

- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate

HIV Test performed at this visit? (Select one)

- Yes
- No

If "Yes" to HIV test performed:

HIV Test Method – LOINC Code:

_____

HIV Test Result – Coded: (Select one)

- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Reactive
- Non-Reactive
- Not applicable
- Quantitative lab

Syphilis test performed at this visit? (Select one)

- Yes
- No

If "Yes" to Syphilis test performed:

Syphilis Test Method – LOINC Code:

_____

Syphilis Test Result – Coded: (Select one)

- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Reactive
- Non-Reactive
- Not applicable
- Quantitative lab ([arb'U]/mL)
- Quantitative lab (Titer)

Type of Contraceptive Method at end of visit: (Select one)

- Abstinence
- Cervical Cap
- Diaphragm
- FAM/LAM
- Female Condom
- Female Sterilization
- Hormonal Implant
- Hormonal Injection (1 mo.)
- Hormonal Injection (3 mos.)
- IUD/IUS
- Male Condom
- Male: rely on female method(s)
- Oral Contraceptive
- Patch
- Spermicide (Alone)
- Sponge
- Vasectomy
- Vaginal Ring
- Withdrawal or other method*
- Unknown/Not Reported
- None

***Specify Other Contraceptive Method:**

_____

Reason for no contraceptive method: (Select one)

- Pregnant/Seeking Pregnancy
- Other Reasons

Specify Other Reason:

_____

If Type of Contraceptive Method was selected at end of visit, How was it provided? (Select one)

- ○ Provided on site
- ○ Referral
- ○ Prescription

Duration of Visit: (Minutes) _____
(Include number of minutes spent in direct contact with client by ALL service providers during the visit)

Are any referrals needed? (Select one)

- ○ Yes (If yes, fill out the referral form)
- ○ No