


FAMILY PLANNING AND REPRODUCTIVE HEALTH MALE FLOW SHEET

PATIENT LABEL WITH DEMOGRAPHICS			7. HT:	WT:	BMI:	B/P:
8. Physical Exam:			Code	Comments:		
Skin						
HEENT						
Neck/Thyroid						
Lungs						
Heart						
Breasts						
Abdomen						
Musc. Skeletal						
Extremities						
Prostate						
Penis						
Testicles						
Rectum						
9. Labs:						
GC		<input type="checkbox"/> Y <input type="checkbox"/> N		Syphilis		<input type="checkbox"/> Y <input type="checkbox"/> N
Urethral smear		<input type="checkbox"/> Y <input type="checkbox"/> N		HIV		<input type="checkbox"/> Y <input type="checkbox"/> N
Chlamydia		<input type="checkbox"/> Y <input type="checkbox"/> N		Glucose		<input type="checkbox"/> Y <input type="checkbox"/> N
Other _____						

10. Assessment/Plan/Method/Referrals:						
Nurse Interviewer: _____						
Nurse Dispensing if Different from Interviewer: _____						
Examiner Signature: _____						
(These signatures attest that ROS, health history form and required education/counseling have been reviewed and discussed with client)						
6. System Review:			Code	Comments:		
Heat or cold intolerance/thirst						
Weight loss or gain						
Dizziness/fainting/seizures						
Headache						
Blurry or double vision/flashing lights						
Sore throat/non-healing sores in mouth						
Swollen glands in neck						
Coughing up blood/SOB/Wheezing						
SOB with activity/difficulty breathing lying down/chest pain or discomfort						
Swelling						
Breast lumps/pain/discharge						
Nausea						
Yellow eyes or skin						
Rectal bleeding						
Frequency, urgency, burning/blood in urine						
Redness or swelling in joints						
Calf pain with walking						
Ease of bruising or bleeding						
Rashes/growths/lesions						
Other problems						

11. Education/Counseling: Information needed to: (check all that apply)						
<input type="checkbox"/> Make informed decision about family planning R						
<input type="checkbox"/> Use specific methods of contraception and identify adverse effects R						
<input type="checkbox"/> Reduce risk of transmission of STDs and HIV if deemed high risk per history R						
<input type="checkbox"/> Provide reproductive health life planning counseling R						
<input type="checkbox"/> Review immunization history and inform client of recommended vaccine per CDC's ACIP Guidelines and offer, as indicated, or refer to other providers R						
<input type="checkbox"/> Provide preconception counseling R						
<input type="checkbox"/> Understand BMI greater than 25 or less than 18.5 is a health risk (weight management educational materials to be provided to clients if client requests with a BMI of greater than 25 or less than 18.5) R						
<input type="checkbox"/> Stop tobacco use, implementing the 5A counseling approach I						
<input type="checkbox"/> Provide achieving pregnancy counseling I						
<input type="checkbox"/> Provide basic infertility counseling I						
<input type="checkbox"/> Referred for Hepatitis C screening if high-risk (current injection drug use, h/o injection drug use, or HIV positive), or if born between 1945–1965 (one-time screening) I						
12. Client Method Counseling: Individual dialogue covers:						
<input type="checkbox"/> Results of physical assessment and labs (if performed) R						
<input type="checkbox"/> Methods of contraception reviewed by tiered approach R						
<input type="checkbox"/> Provide Emergency Contraception counseling R						
<input type="checkbox"/> Adolescents counseled on abstinence, LARC, and condoms R						
<input type="checkbox"/> How to discontinue the method selected and information on back up method used R						
<input type="checkbox"/> Typical use rates for method effectiveness R						
<input type="checkbox"/> How to use the method consistently and correctly R						
<input type="checkbox"/> Protection from STDs if non-barrier method is chosen R						
<input type="checkbox"/> Warning signs for rare but serious adverse events and what to do if they experience a warning sign (including emergency 24 hour number, where to seek emergency services outside of hours of operation) R						
<input type="checkbox"/> When to return for a follow up (planned return schedule) R						
<input type="checkbox"/> Appropriate referral for additional services as needed R						
<input type="checkbox"/> Yes <input type="checkbox"/> No Teach Back Method used						