

Office of Health Services

Electronic Medical Record

Health Services Recommended Forms
November 2015

PERMISSION LEVELS

MEDICAL

- Medical ARNP
- Medical RN
- Medical LPN
- Medical Clerk
- Regional Nursing Consultant

MENTAL HEALTH

- Clinical Staff MH
- Clinical Staff SA
- Clinical Staff MH/SA
- Licensed MH
- Licensed SA/Certified Prof.
- Licensed MH/SA
- Treatment Team Member

NOTES

- All fields with Red “*” are mandatory
- Text boxes have a minimum of 15 characters, maximum varies.
- Even if answer is NO, a narrative is required, even if it’s “Not Applicable”
- Most text boxes have spell check
- To enter an Electronic Signature, confirm name, username and enter JJIS password

Department of Juvenile Justice System Login




From JJIS System Login, enter User Name and password, select OHS EMR Module and click "Login"

JJIS information is confidential. Users are required by law to maintain this confidentiality and use the information only for Department of Juvenile Justice approved purposes.

Failure to follow these restrictions may result in civil or criminal penalties.

Additional information is available on the DJJ website at:

<http://www.djj.state.fl.us/partners/data-integrity-jjis/access-agreements-policies>

User Name: *
Password: *
System: * 
☐ Change Password?

JJIS Help Desk (850) 921-7832

- ...
- Alerts
- CCC
- Electronic Educational Exit Plan
- JJIS
- OHS EMR Module
- Prevention Web
- RSMS
- SVS



DEPARTMENT OF JUVENILE JUSTICE

Electronic Medical Records

[Logout](#)

Protection of Confidentiality and Security of Healthcare Information.

Access to the Electronic Medical Record and healthcare information is limited to authorized persons with a need to know, to the extent necessary, to perform their job duties. The individual authorized to access a youth's Electronic Medical Record and healthcare information must utilize the User ID, password and electronic signature assigned to him/her by the Department of Juvenile Justice (DJJ). The individual understands that when an authorized individual's User ID and password are used to gain access to the Electronic Medical Record, the User, time of access and healthcare record accessed will be recorded and tracked in the JJIS System, and is subject to audit by the Department.

The confidentiality of healthcare information in the Electronic Medical Record must be maintained as set forth in Federal and State laws, DJJ rules and policies concerning the confidentiality, privacy, security, use and disclosure of healthcare information. Specific State and Federal requirements regarding the protection of healthcare records, particularly substance abuse records, mental health records and HIV-related information which prohibits release or further disclosure of said information without written consent must be followed. The individual understands that any violation of State and Federal law, DJJ rules and policies regarding confidentiality of healthcare information may result in disciplinary action, termination of employment and/or legal action.

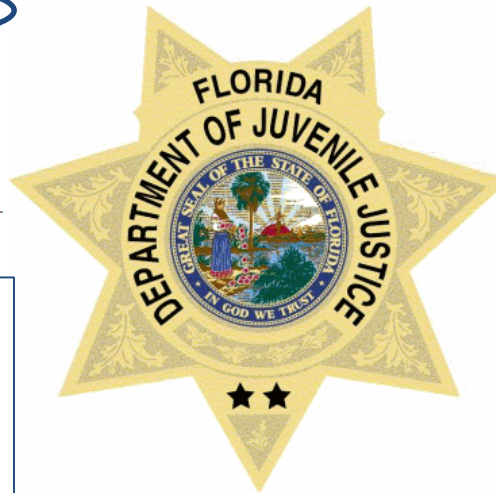
☐ I agree to the DJJ Office of Health Services Terms and Conditions

User Name:

Program Name:

Click [here](#) if you experience problems with the DJJ security certificate.

Select program/facility name from the drop down. Click on GO. Options are limited based on your permission profile



OUR VISION

The children and families of Florida will live in safe, nurturing communities that provide for their needs, recognize their strengths and support their success.

OUR MISSION

To increase public safety by reducing juvenile delinquency through effective prevention, intervention and treatment services that strengthen families and turn around the lives of troubled youth.

Read the confidentiality statement and check the box to agree to the terms and conditions.

Click for Youth Search

Active Youth: Youth's name/DJJ ID [\(Facesheet\)](#) [\(PACT\)](#) [\(PACT MHSA Referral\)](#) [Logout](#)

Active Program

Youth Listing

Facility Youth listed here

Menu Options – Varies with Permissions

Active Youth and Links

Florida Department of Juvenile Justice

OUR VISION
The child... communities that provide for their needs, recognize their strengths and support their success.

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- All youth with a current location of program will appear on tool bar located on left side
- Select youth or complete a youth search
- Once youth desired is selected they will appear as "Active Youth"
- **IMPORTANT** – Check your "Active Youth" listed to ensure correct (the youth you want to work with)
- To hide youth listing tool bar click on "<<" button
- To bring back youth listing tool bar click on ">>" button
- Click Medical Forms to access Core Profile forms

Mandatory/Required Forms

DEPARTMENT OF JUVENILE JUSTICE
Electronic Medical Records
MEDICAL FORMS

User Role: Medical RN

[Home](#) **Active Youth:** [\(Facesheet\)](#) [\(PACT\)](#) [\(PACT MHSA Referral\)](#) [Logout](#)

Youth Search <<

Active Program:
Alachua Regional Juvenile Detention Center

Alachua Regional Juvenile Detention Center
Facility Youth Listing: (39 total)

Facility Youth listed here

OHS Management Reports
MH Referral / Sick Call / MH Review
Mental Health Forms
Medical Forms
Upload Library
Youth History
Pending Actions - 5

Core Profile
Mandatory/Required Forms
Recommended Forms

- ☐ Chronic Physical Health Conditions Roster (PDF)
- ☐ Episodic Care (First Aid/Emergency) Care Log (PDF)
- ☐ Guidelines for Obtaining Parental Signature on the AET (PDF)
- ☐ HIV Youth Consent (PDF)
- ☐ Practitioner's Orders (PDF)
- ☐ Prescription Medication Verification Checklist (PDF)
- ☐ Request for Parent/Guardian Signature Authority for Evaluation and Treatment (PDF)
- ☐ Treatment Flow Sheet: Asthma (PDF)
- ☐ Treatment Flow Sheet: Diabetes (PDF)
- ☐ Treatment Flow Sheet: General (PDF)
- ☐ Treatment Flow Sheet: Hypertension (PDF)
- ☐ Treatment Flow Sheet: Seizure Disorder (PDF)
- ☐ Treatment Flow Sheet: Tuberculosis / INH Therapy (PDF)
- ☐ Treatment Plan Sheet: Asthma (PDF)
- ☐ Treatment Plan Sheet: Diabetes (PDF)
- ☐ Treatment Plan Sheet: General (PDF)
- ☐ Treatment Plan Sheet: Hypertension (PDF)
- ☐ Treatment Plan Sheet: Seizure Disorder (PDF)
- ☐ Treatment Plan Sheet: Tuberculosis / INH Therapy (PDF)
- ☐ Tuberculosis Testing Log (PDF)

The Recommended Forms menu lists forms in alphabetical order.

- For each form to be completed:
1. Select Youth from Facility Youth Listing or by Youth Search
 2. Select Medical Forms
 3. Select Recommended Forms
 4. Select form to be completed

Uploading Signed Forms

Record Count: 0

[View Report](#) [Upload...](#)

Add the Medical Documents for youth.

Document Type:* ☒ Medical Forms ☐ Mental Health Forms

Document Name:* Acknowledgment of Receipt of CPPN or Practitioner Form

Document Date:*

Document Upload:* [Browse...](#)

You must view the document before you can save.

[View](#) [Save](#) [Cancel](#)

Add the Medical Documents for youth.

Document Type:* ☒ Medical Forms ☐ Mental Health Forms

Document Name:* Acknowledgment of Receipt of CPPN or Practitioner Form

Document Date:* 10/15/2015

Document Upload:* C:\Users\hutchinsr\Desktop\CPPN Form Oct 2015.doc [Browse...](#)

You must view the document before you can save.

[View](#) [Save](#) [Cancel](#)

Do you want to open or save **Q0028654176.doc** from **jjiswebqt164**?

[Open](#) [Save](#) [Cancel](#)

PDF forms should be printed, completed and signed as appropriate. Click View Report Link to print form.

Scan the signed document and save to PC.

Click Upload, enter the date of the document.

Click Browse to locate document on PC.

You must click View to confirm correct document is being uploaded.

Click open on the message bar. After viewing document, close and click Save.

File Uploaded Successfully

A message is displayed indicating successful upload.

Uploading Signed Forms

File Uploaded Successfully

[<< Back](#)

Name of Youth:
Date of Birth: DJJID#:

[Add New...](#)


	Document Name	Document Date	Category	Document Type	Modified By	Modified DateTime
Edit	Acknowledgment of Receipt of CPPN or Practitioner	10/15/2015	Medical Forms	Acknowledgment of Receipt of CPPN or Practitioner Form	RN Medical	10/15/2015 04:23 PM
Edit	Immunization Tracking Record	10/05/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/14/2015 01:17 PM
Edit	Sexually Transmitted Infections Screening Form	10/12/2015	Medical Forms	Sexually Transmitted Infections Screening Form	RN Medical	10/12/2015 10:59 AM
Edit	Immunization Tracking Record	10/12/2015	Medical Forms	Immunization Tracking Record	RN Medical	10/12/2015 08:51 AM

When upload is complete, a message is displayed indicating successful upload.

File is listed in the table of uploaded documents.

A message is displayed indicating successful upload.

Chronic Physical Health Conditions Roster (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
CHRONIC PHYSICAL HEALTH CONDITIONS ROSTER

Month/Year: _____ Facility Name: _____

CARDIOVASCULAR

1 Arrhythmia
 2 Cardiomyopathy
 3 Hypertension

GASTROINTESTINAL

1 Inflammatory Bowel Disease
 2 Peptic Ulcer Disease
 3 Other

INFECTION

1 Tuberculosis&DNH
 2 Hepatitis
 3 Staph Aureus
 4 STD
 5 Other

PULMONARY

1 Asthma
 2 Cystic Fibrosis
 3 Other

ENDOCRINE

1 Diabetes
 2 Thyroid Disorder
 3 Short Stature

HEMATOLOGIC

1 Iron Deficiency Anemia
 2 Sickle Cell Anemia
 3 Cancer

MUSCULOSKELETAL

1 Scoliosis
 2 Chronic back pain
 3 Arthritis
 4 Osgood-Schlatter's
 5 Other

NEUROLOGICAL

1 Seizure Disorder
 2 Migraine
 3 Chronic Headache
 4 Other

RENAL

1 Kidney Disease
 2 Hemodialysis
 3 Peritoneal dialysis
 4 UTI
 5 Other


PHYSICAL

1 Blind
 2 Extremely Poor vision
 3 Developmentally Delayed
 4 Hearing Impaired
 5 Speech Impaired
 6 Mobility Impaired
 7 Other

PLACE CHRONIC CONDITION NUMBER, IN THE APPROPRIATE COLUMN THAT MATCHES THE YOUTH'S ACTIVE CHRONIC CONDITION.

DJJID #	Name	Date	Cardiac	GI	Infection	Pulm	End	Hem	Musc	Neur	Renal	Physical

DJJ/OHSFRM 004 07/2007


 HS 004
 Page 1 of 1


Revised October 2006

This is not currently a fillable form and will need to be printed and handwritten.

Youth DJJ ID# and name should be completed.

The box below the applicable medical condition should include the date the youth is seen and the number associated with the condition.


Episodic Care (First Aid/Emergency) Care Log (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
EPISODIC (FIRST AID/EMERGENCY) CARE LOG

Facility Name: _____
Month/Year: _____

Date	Name of Youth	DJJID	Injury/Emergency/ Illness	Treatment Rendered	Staff Initials	REFERRED TO:		
						RN/LPN	MD/ARNP/PA	Off-site MD/Hospital



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Page 1 of 1

*DJJ/OHSFRM 009 06/2014 63M-2**Revised October 2006*

This is not currently a fillable form and will need to be printed and handwritten.

Reminder that all Episodic Care, both on-site and off-site care must be documented.

Guidelines for Obtaining Parental Signature on the AET (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE GUIDELINES FOR OBTAINING PARENTAL SIGNATURE ON THE AET

The Department of Juvenile Justice representative who obtains the signature on the Authority for Evaluation and Treatment should have the parent/guardian read the document, and should then be prepared to answer questions, and generally explain its purpose to the signing parent/guardian. The following is an outline of the types of information that may require clarification:

This document gives the Department general authority to assume responsibility for the provision of physical and mental health care to a youth in the physical custody of the Department, in most circumstances. This authority then includes necessary examinations and tests.

The signing parent or guardian may list those treatments or medications, which he or she prohibits, even though they may fall within the scope of the document. The signing parent should follow-up with a written letter to the Department regarding these treatments or medications.

The parent may revoke the Authority for Evaluation and Treatment at any time. Revocation can be for all treatments, or for specific procedures or services to which the parent previously consented. If the parent revokes the entire Authority for Evaluation and Treatment, the Department may apply for a court order authorizing the Department to provide for the youth's mental and physical health needs. If a specific treatment or procedure is prohibited by the parent/guardian, the Department may seek a court order authorizing that treatment, if it is deemed necessary for the youth's well being by a licensed practitioner.

There may be instances in which the parent will be notified of certain changes in a youth's healthcare status. These instances generally include:

- A prescription medication (which the youth was not currently prescribed at the time of admission) or other treatment is prescribed by a physician (MD), osteopathic physician (DO), dentist, physician assistant (PA) or advanced registered nurse practitioner (ARNP);
- The youth reports repeatedly with the same complaint within certain timeframes;
- The youth is taken off-site for healthcare (unless for health care that by Florida law the youth may consent to without the parent's consent or knowledge, such as for the evaluation and/or treatment of sexually transmitted diseases or pregnancy care);
- The youth has a chronic mental or physical condition and a licensed healthcare practitioner determines that a significant change has occurred in the health status of that youth;
- Depending on the nature of the treatment, notification may be verbal (via telephone or in person) and will be followed by written notification. When required, written notification shall be mailed to the signing parent as soon as feasible after the giving of or initiation of the procedure or treatment. All reasonable attempts will be made to notify the parent/guardian when there is a change in the health status of the youth. It is very important that the parent/guardian notify the Department whenever his/her address or phone number changes, in order that this notification can be accomplished.



- Regarding prescription medications for mental or emotional problems that may be ordered or changed, reasonable attempts will be made to contact the parent/guardian verbally/by telephone prior to making the changes in order to explain the medications and that a detailed notice about these medications will also be sent to the parent/guardian. The parent/guardian will be asked to sign a permission form for these medications and send it back to the facility.
- The Department is not required to notify or contact the parents for the types of services or treatment which, by statute, a youth may consent to without parental knowledge or consent (assessment and treatment for sexually transmitted diseases, assessment/treatment for HIV/AIDS, pregnancy and/or family planning services, and substance abuse treatment).
- The Department is not required to contact the parents for treatment or services that are court-ordered.

For certain procedures and treatments, a separate parental consent form will have to be signed by the parent/guardian. This applies to the following types of healthcare: admission to a hospital for overnight or longer; any surgical procedure; and any procedure or service which is specifically identified in the Authority for Evaluation and Treatment by the parent/guardian as prohibited. For hospital admissions or surgery, the consent form will be that used by the health care provider who is performing the procedure.

The Authority for Evaluation and Treatment also authorizes the facility or program to provide a limited number of over the counter medications, as the youth may request for minor complaints.

In terms of vaccinations, if the person providing the Authority for Evaluation and Treatment to the parent/guardian for signature is aware that a youth is missing certain vaccinations (usually Hepatitis B, tetanus, measles or polio), they can

ask the parent to consent to the necessary vaccinations by initialing on the form *as long as* the parent/guardian is provided the applicable Vaccine Information Statement(s) at the time of signing. The Vaccine Information Statements can be accessed from the Florida Department of Health website (www.doh.state.fl.us) or the DJJ website (www.djj.state.fl.us), Health Services section. If these are not provided, then the parent/guardian should not be asked


to provide their consent.

If a parent/guardian refuses vaccinations for their youth, then they must either provide a "Religious Exemption from Immunization" form or a medical exclusion signed by a Physician, Physician Assistant or Advanced Registered Nurse Practitioner. The Religious Exemption must be obtained from and authorized by the Administrator at the County Health Department. This signed document must then be presented to the Department.



Use these guidelines for obtaining parent or guardian signature on the AET.

HIV Youth Consent (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
HUMAN IMMUNODEFICIENCY VIRUS ANTIBODY TEST
YOUTH CONSENT FORM

NAME OF YOUTH: Youth Name

DJJID#: DJJ ID

FACILITY NAME:

DATE OF BIRTH: DOB

This consent form will permit _____ to test your blood for antibodies.

Facility Name

Testing may be performed by various methods depending on the county or location where you get the test done. By signing the consent you are authorizing testing by one of the approved methods.

Oral (mouth). You put a pad between your cheek and gum for two to five minutes. It finds the antibodies in the blood vessels in your cheek and gum. It is sent to a lab for results and you'll receive the results in 5 to 7 days. Rapid tests. These are tests that give you results quickly. There are 2 types: blood tests and oral (mouth) tests. For the blood test, blood is taken from your finger, and you can get your results in 20 to 60 minutes. For the oral test, a pad is used to swab your gums. Results are ready in 20 minutes.

The antibody test is done by drawing, approximately 5cc's (1 teaspoon), blood from a vein in your arm. When the blood sample is drawn, you may have some discomfort at the site of the needle-stick and a small bruise may develop. Otherwise, there is no risk of physical harm.

This test is taken voluntarily. If you choose not to take the test, you will not lose any services or privileges to which you would otherwise be entitled. Test results will be confidential and will only be given to you in person.

I have been informed about the HIV Antibody Test. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this test procedure. I understand that if I have a positive result, the Department of Health must be notified. I hereby give my informed consent to the HIV Antibody Test.

☐ I consent

☐ I do not consent

Date


Signature of Youth

Printed Name of Youth

Witness Signature

Witness Printed Name

Date



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Page 1 of 1

DJJ/OHSFRM 015 10/2015 63M-2

Revised February 2010

This form should be completed at admission and maintained in the hard copy of the IHCR.

This is not a fillable form.


Practitioner's Orders (PDF)

[illegible]

The is not a fillable form and must be maintained in the hard copy of the IHCR.

This should also be uploaded into the upload documents when the written order is complete.

Prescription Medication Verification Checklist (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
PRESCRIPTION MEDICATION VERIFICATION CHECKLIST

This form is to be used only when a youth or parent/guardian brings medication to a facility

NAME OF YOUTH: Youth Name DJJID#: DJJ ID

FACILITY NAME: _____ DATE: _____

The Medication Verification Process was completed as follows:

1. All contents in the original container were counted with the youth present
Number of total medications: _____
Name and Instructions for each prescribed medication:

Medication:	Route	Frequency	Amount received
a.			
b.			
c.			
d.			
e.			

Precautions Provided: ☐ Yes ☐ No If yes, describe: _____

Youth is on Controlled Medications: ☐ Yes ☐ No

2. Parent/Guardian present to confirm contents of medication containers: ☐ Yes ☐ No
If yes, Parent/Guardian Name: _____

3. Verification of prescription(s) by Pharmacist or Ordering Physician: Provide medication name and description, prescription number, number of pills ordered and number of pills remaining.

4. Pharmacist Name: _____ Date: _____
OR
Physician Name: _____ Date: _____

5. Prescription and contents verbally verified by the Pharmacist/Physician: Yes/No

6. Refer to Designated Health Authority for immediate review: ☐ Yes ☐ No

7. Youth placed on Medical Alert: ☐ Yes ☐ No


8. Route to: ☐ Master Control ☐ Medical Clinic ☐ MOD ☐ Dietary ☐ Admin ☐ Other

Note: Youth and/or Parental signature is verification that the youth has provided prescribed medication and signifies the receipt of confirmed medications.

I affirm that I have provided the most current and correct medication as ordered by the physician.

Youth's Signature: _____ Parent/Guardian Signature: _____
Date: _____ Time: _____

Signature and Printed Name of Person Verifying Medications: _____
Date: _____ Time: _____


 **HS 015**
Page 1 of 1

DJJ/OHSFRM 015 08/2007 Revised October 2006

This is not a required form, but is recommended to document verification of all outside medications received.

This should be uploaded into the document library when completed.

Refusal of Treatment Form (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
REFUSAL OF TREATMENT FORM

NAME OF YOUTH: **Youth Name** DATE: _____
DATE OF BIRTH: **DOB** DJJID#: **DJJ ID**

I, _____ knowing that I have a condition requiring
Name of Youth

medical treatment and care, and having been informed of the benefits of the prescribed care, I willingly have decided for myself to:

PLEASE CHECK ALL APPLICABLE BOXES:

<input type="checkbox"/> Refuse Medication	<input type="checkbox"/> Refuse X-Ray Service
<input type="checkbox"/> Refuse Dental Care	<input type="checkbox"/> Refuse Other Diagnostic Test
<input type="checkbox"/> Refuse Off-Site Appointment	<input type="checkbox"/> Refuse Physical Examination
<input type="checkbox"/> Refuse Laboratory Services	<input type="checkbox"/> Refuse Tuberculosis Skin Test
<input type="checkbox"/> Refuse Immunization	<input type="checkbox"/> Other (Please Specify)

Reason for Refusal: _____
Benefits and potential consequences of refusal (i.e. worsening of medical condition, etc.) explained to the youth: _____


NOTIFY SUPERINTENDENT OR PROGRAM DIRECTOR, DESIGNATED HEALTH AUTHORITY OR DESIGNATED MENTAL HEALTH AUTHORITY OF ALL MEDICAL/MENTAL HEALTH TREATMENT REFUSALS.

Designated Health Authority or Designee Notified: ☐ Yes ☐ No
DHA Response: _____

Youth Signature Date

Nurse Signature Date

Witness Signature Date


 *HS 027*
Page 1 of 1

DJJ/OHSFRM 027 07/2007 *Revised October 2006*

This is not a fillable form. It should be printed and maintained as a hard copy in the IHCR and uploaded into the document library.

Document the exact time that medications or other medical treatments are refused.

Report of On-Site Health Care by Non-Health Care Licensed Staff (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE
REPORT OF ON-SITE HEALTH CARE BY NON-HEALTH CARE STAFF

YOUTH'S NAME
DJJ ID

DATE/TIME OF CARE:
PRINTED NAME OF STAFF MEMBER:
SIGNATURE OF STAFF MEMBER:

I. Instructions:
Direct care and custodial staff who administer first aid/emergency care may document that care on this form. This form is not to be used to document routine administration of ongoing prescription medications or over-the-counter medication administration for minor complaints. This form must be filed in the chronological progress notes of the youth's Individual Health Care Record. If health care staff are available on-site part-time, these forms may be collected and given to health care staff at regularly scheduled hours for their review.

II. Youth Information:
Is youth on Medical Alert? ☐ No ☐ Yes
Youth's Medical Classification (if known): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Youth's allergies (list):

III. Nature of Youth's Complaint (briefly describe):


IV. Over-the-Counter Medication Given (if any, please list medication and dosage):

V. Other Care Given (if any):

VI. Other Action (May check more than one box):
☐ Placed on Medical Alert ☐ Taken to ER by Staff
☐ Placed on Call-out to see Nurse ☐ Taken to ER by ambulance (EMS)
☐ After-Hours Nurse Consulted by Phone ☐ No further Action Required
☐ After-Hours MD, PA, or ARNP Consulted by Phone

VII. Parental Notification
☐ Parent/Guardian contacted by phone and informed of youth's complaint and treatment received.
Name of Parent/Guardian: Date/Time Informed:
☐ Parental Notification not required.
☐ Parent/Guardian called/Unable to contact.
☐ Parental Notification of Health Related Care mailed. (Copy placed in record.)

SIGNATURE OF STAFF MEMBER PROVIDING CARE
PRINTED NAME
DATE/TIME OF CARE



DJJ/OHSFRM 049 06/2014 63M-2
HS 049
Page 1 of 1
Revised December 2006

This is not a fillable form and should be printed and made available for non-licensed staff to document or report the use of JDO/YCW protocols when nursing staff are not on site.

This should be followed by a nursing evaluation documented by the first available on site nursing staff and uploaded into the document library.

Request for Parent/Guardian Signature Authority for Evaluation and Treatment (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE REQUEST FOR PARENT/GUARDIAN SIGNATURE ON THE AUTHORITY FOR EVALUATION AND TREATMENT

DATE OF 1ST NOTICE: _____
DATE OF 2ND NOTICE: _____

NAME OF YOUTH: **Youth Name**
DJJID#: **DJJ ID** DATE OF BIRTH: **DOB**

Dear Parent or Legal Guardian,

According to our records, you are the parent or legal guardian responsible for the health and welfare of the above-referenced youth.

The Department of Juvenile Justice is required to obtain your signature of authorization on the enclosed Authority for Evaluation and Treatment Form (AET) in order to provide your child with the medical treatment he/she may need while in our custody. We will inform you if your son/daughter is placed on any new prescription medications, if medications are changed or if he/she needs more than the usual pediatric/adolescent primary care.

Please read the Authority for Evaluation and Treatment Form and complete the consent portion at the bottom of page 3. Be sure to include your signature, address and phone numbers. Return the completed AET form, via return mail to:

As applicable, Vaccine Information Statement(s) will be included for your review, if according to our records this youth is not up to date in his/her immunizations.

If you have any questions, please contact the Medical Department, or Nurse, by calling telephone number:
number: (____) _____.

Thank you,

_____, RN, ARNP, LPN, MRC
of _____
Medical Department _____ Facility


CC: _____ Juvenile Probation Officer
_____ Medical Record File
_____ Other


Enclosure: Authority for Evaluation and Treatment
Vaccine Information Statements (if applicable)



This form is not a fillable form and should be printed and mailed to the parent/legal guardian with the AET when a current AET is needed.

Treatment Flow Sheet: Asthma (PDF)

		FLORIDA DEPARTMENT OF JUVENILE JUSTICE TREATMENT FLOW SHEET: ASTHMA													
NAME OF YOUTH:		Youth Name						DJJID#:		DJJ ID					
FACILITY NAME:															
		ALLERGIES:													
Who made the diagnosis?															
When and where was it diagnosed?															
If diagnosed prior to commitment, who most recently treated the condition?															
When? Where?															
What treatment was ordered?															
When was treatment last received?															
When were symptoms last experienced?															
Prior treatment confirmed by:		<input type="checkbox"/> Old records in chart						<input type="checkbox"/> Report from facility or MD's office							
		<input type="checkbox"/> Parent/guardian						<input type="checkbox"/> Youth's account							
Age of onset:		Type:		<input type="checkbox"/> Intrinsic <input type="checkbox"/> Extrinsic <input type="checkbox"/> Infectious <input type="checkbox"/> Other											
Triggers:															
Visit date															
Next appt															
Education documented?															
Diet restrictions?															
Other restrictions?															
Special needs?															
Alert log listing?															
Height		Weight													
Temperature															
Pulse		Respiration													
BP															
Peak flow															
Pulse ox. O ₂ sat															
Rales?															
Wheezes?															
Dyspnea?															
PRN inhaler use: >1/day, -1/wk., >1/mo., <1/mo., none															
Exacerbation visits?															
Observation stays?															
Hospitalizations?															
Bronchodilator inh. Rx?															
Steroid inh. Rx?															
Antibiotic Rx?															
P.O. steroid Rx?															
P.O. bronchodilator Rx?															
Other Rx?															


 HS 034
 Page 1 of 1

DJJ/OHSFRM 034 07/2007
Revised October 2006

This is a flow sheet only for summary of chronic care and can not substitute for a Chronological progress note when youth are seen for periodic evaluations.

It is not a fillable form and if used, should be maintained in the IHCR and uploaded into the upload documents.

It is not a fillable form and if used, should be maintained in the IHCR and uploaded into the upload documents.

Treatment Flow Sheet: Diabetes (PDF)

<div style="display: flex; justify-content: space-between; align-items: center;"> <div> FLORIDA DEPARTMENT OF JUVENILE JUSTICE TREATMENT FLOW SHEET: DIABETES </div> </div>											
NAME OF YOUTH: Youth Name				DJJID#: DJJ ID							
FACILITY NAME: _____				ALLERGIES: _____							
Who made the diagnosis? _____											
When and where was it diagnosed? _____											
If diagnosed prior to commitment, who most recently treated the condition? _____											
When? _____				Where? _____							
What treatment was ordered? _____											
When was treatment last received? _____											
When were symptoms last experienced? _____											
Prior treatment confirmed by: <input type="checkbox"/> Old records in chart <input type="checkbox"/> Report from facility or MD's office <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Youth's account											
Age of onset: _____											
Type: _____				Contributing factors: _____				Complications: _____			
Visit date											
Next appointment											
Patient teaching documented?											
Diet											
Other restrictions?											
Special needs?											
Alert log listing?											
Chart cover, H&P, and Problem List show condition											
Height											
Weight											
Blood Pressure											
Heart Rate											
T & R wnl?											
Date of annual work-up											
BMP result											
Serum Cr result											
Date of annual fundoscopic exam?											
Fundoscope results											
Hyperglycemic episodes?											
Hypoglycemic episodes?											
ER or hospital since last visit?											
Insulin?											
Oral anti-diabetic medication?											
Compliant w/ tx?											

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Page 1 of 1

DJJ/OHSFRM 035 07/2007
Revised October 2006

This is a flow sheet only for summary of chronic care and can not substitute for a Chronological progress note when youth are seen for periodic evaluations.

It is not a fillable form and if used, should be maintained in the IHCR and uploaded into the upload documents.

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Treatment Flow Sheet: General (PDF)

<div style="display: flex; justify-content: space-between; align-items: center;"> <div> FLORIDA DEPARTMENT OF JUVENILE JUSTICE TREATMENT FLOW SHEET: GENERAL MEDICAL </div> </div>											
NAME OF YOUTH: Youth Name				DJJID#: DJJ ID							
FACILITY NAME: _____				ALLERGIES: _____							
Who made the diagnosis? _____											
When and where was it diagnosed? _____											
If diagnosed prior to commitment, who most recently treated the condition? _____											
When? _____				Where? _____							
What treatment was ordered? _____											
When was treatment last received? _____											
When were symptoms last experienced? _____											
Prior treatment confirmed by: <input type="checkbox"/> Old records in chart <input type="checkbox"/> Report from facility or MD's office <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Youth's account											
Age of onset: _____											
Type: _____				Physical factors: _____				Psychological factors: _____			
Visit date											
Next appointment											
Patient teaching documented?											
Diet restrictions?											
Other restrictions?											
Special needs?											
Alert log listing?											
Chart cover, H&P, and Problem List show condition											
Height											
Weight											
Blood Pressure											
Heart Rate											
T & R wnl?											
Date of annual physical											
Diagnostic test (Specify)											
Diagnostic test (Specify)											
Diagnostic test (Specify)											
Lab test -											
Lab test -											
Lab test -											
ER or hospital since last visit?											
Medication?											
Compliant w/ rx?											

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DJJ/OHSFRM 036 07/2007
Revised October 2006


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Treatment Flow Sheet: Hypertension (PDF)

FLORIDA DEPARTMENT OF JUVENILE JUSTICE											
TREATMENT FLOW SHEET: HYPERTENSION											
NAME OF YOUTH:		<div style="background-color: #d3d3d3; padding: 2px;">Youth Name</div>					DJJID#:		<div style="background-color: #d3d3d3; padding: 2px;">DJJ ID</div>		
FACILITY NAME:							ALLERGIES:				
Who made the diagnosis? _____											
When and where was it diagnosed? _____											
If diagnosed prior to commitment, who most recently treated the condition? _____											
When? _____ Where? _____											
What treatment was ordered? _____											
When was treatment last received? _____											
When were symptoms last experienced? _____											
Prior treatment confirmed by: <input type="checkbox"/> Old records in chart <input type="checkbox"/> Report from facility or MD's office											
<input type="checkbox"/> Parent/guardian <input type="checkbox"/> Youth's account											
Age of onset: _____											
Type: _____	Physical factors: _____					Psychological factors: _____					
Visit date											
Next appointment											
Patient teaching documented?											
Diet restrictions?											
Other restrictions?											
Special needs?											
Alert log listing?											
Chart cover, H&P, and Problem List show condition											
Height											
Weight											
Blood Pressure											
Diastolic <95 consistently											
Heart Rate											
Abnormal heart sounds?											
T & R wnl?											
Date of annual work-up											
EKG result											
BMP result											
Serum Cr result											
Date of annual fundoscopic exam?											
Fundoscope results											
ER or hospital since last visit?											
Medication											
Compliant w/ tx?											


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DJJ/OHSFRM 037 07/2007
Revised October 2006

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Treatment Flow Sheet: Seizure Disorder (PDF)

<div style="display: flex; justify-content: space-between; align-items: center;"> <div> FLORIDA DEPARTMENT OF JUVENILE JUSTICE TREATMENT FLOW SHEET: SEIZURE DISORDER </div> </div>											
NAME OF YOUTH: Youth Name				DJJID#: DJJ ID							
FACILITY NAME: _____				ALLERGIES: _____							
Who made the diagnosis? _____											
When and where was it diagnosed? _____											
If diagnosed prior to commitment, who most recently treated the condition? _____											
When? _____				Where? _____							
What treatment was ordered? _____											
When was treatment last received? _____											
When were symptoms last experienced? _____											
Prior treatment confirmed by: <input type="checkbox"/> Old records in chart <input type="checkbox"/> Report from facility or MD's office <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Youth's account											
Age of onset: _____											
Cause: <input type="checkbox"/> Idiopathic <input type="checkbox"/> Trauma <input type="checkbox"/> Drug rxn/OD <input type="checkbox"/> Febrile <input type="checkbox"/> Hypoxia <input type="checkbox"/> Hypoglycemia											
<input type="checkbox"/> Neoplasm <input type="checkbox"/> Fluid & electrolyte imbalance <input type="checkbox"/> Other: _____											
Type: <input type="checkbox"/> Simple partial <input type="checkbox"/> Complex partial <input type="checkbox"/> Secondary generalized partial											
<input type="checkbox"/> Grand mal <input type="checkbox"/> Tonic <input type="checkbox"/> Absence <input type="checkbox"/> Myoclonic <input type="checkbox"/> Atonic <input type="checkbox"/> Other: _____											
Pattern: <input type="checkbox"/> Sporadic <input type="checkbox"/> Cyclic <input type="checkbox"/> Reflex - triggers: _____ <input type="checkbox"/> Aura: _____											
Visit date											
Next appointment											
Patient teaching documented?											
Diet restrictions?											
Other restrictions?											
Special needs?											
Alert log listing?											
Chart cover, H&P, and Problem List show condition											
Height											
Weight											
T, P, R, BP wnl?											
Auras?											
Reflexes intact?											
Motor function intact?											
# of seizures since last clinic visit?											
Seizure type?											
Seizure duration?											
ER or hospital since last visit?											
Anticonvulsant drug											
Anticonvulsant drug level											
Level therapeutic?											
Compliant w/ tx?											

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DJJ/OHS/FRM 038 07/2007

Revised October 2006

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Treatment Flow Sheet: Tuberculosis / INH Therapy (PDF)

<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> FLORIDA DEPARTMENT OF JUVENILE JUSTICE TREATMENT FLOW SHEET: TUBERCULOSIS / INH THERAPY </div> </div>											
NAME OF YOUTH: Youth Name				DJJID#: DJJ ID							
FACILITY NAME: _____				ALLERGIES: _____							
Who made the diagnosis? _____											
When and where was it diagnosed? _____											
If diagnosed prior to commitment, who most recently treated the condition? _____											
When? _____				Where? _____							
What treatment was ordered? _____											
When was treatment last received? _____											
When were symptoms last experienced? _____											
Prior treatment confirmed by: <input type="checkbox"/> Old records in chart <input type="checkbox"/> Report from facility or MD's office <input type="checkbox"/> Parent/guardian <input type="checkbox"/> Youth's account											
Date of positive PPD: _____				PPD measurements: _____							
Date of Chest X-ray: _____				<input type="checkbox"/> Negative _____				<input type="checkbox"/> Positive _____			
Sputum culture dates (if any): _____				<input type="checkbox"/> Negative _____				<input type="checkbox"/> Positive _____			
Date of initial LFT: _____				Results: _____							
Date of parental notification: _____				Date treatment begun: _____				Date treatment is to end: _____			
Date repeat PPD due (six months after completion of INH) _____				Repeat PPD Measurement: _____							
Date of visit											
Visit for clinic or monthly tool?											
Next clinic appt											
Monthly tool due											
Patient teaching documented?											
Diet restrictions?											
Other restrictions?											
Special needs?											
Alert log listing?											
Chart cover, H&P, and Problem List show condition											
Height											
Weight											
T, P, R, BP wnl?											
Nine monthly tools scheduled											
Clinic scheduled for 1, 4, 6 & 9 months after start of INH and as ordered											
Date of next LFT											
LFT wnl?											
Medication											
Compliant with tx?											

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DJJ/OHS/FRM 039 07/2007


Revised October 2006

This is a flow sheet only for summary of chronic care and can not substitute for a Chronological progress note when youth are seen for periodic evaluations.

It is not a fillable form and if used, should be maintained in the IHCR and uploaded into the upload documents.

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Treatment Plan Sheet: Asthma (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
TREATMENT PLAN SHEET: ASTHMA

NAME OF YOUTH: Youth Name DATE: _____
DJJID#: DJJ ID ALLERGIES: _____

INITIAL VISIT INFORMATION:

Who made the diagnosis? _____
When and where was it diagnosed? _____
If diagnosed prior to commitment, who most recently treated the condition? _____
When? _____ Where? _____
What treatment was ordered? _____
When was treatment last received? _____
When were symptoms last experienced? _____
Prior treatment confirmed by: ☐ Old records in chart ☐ Report from facility or MD's office ☐ Parent/guardian ☐ Youth's account
Age of onset: _____ Type: ☐ Intrinsic ☐ Extrinsic ☐ Infectious ☐ Other _____
Triggers: _____


S: _____
O: Ht. _____ Wt. _____ T. _____ Pulse _____ Resp. _____ BP _____
Peak flow _____ Pulse oximeter O2 saturation _____
Breath sounds: ☐ Rales? ☐ Wheezes? ☐ Dyspnea ☐ Other: _____
Current medication: _____
Labs: Theophylline level _____ Other labs _____
Frequency of prn inhaler use: ☐ >1/day ☐ >1/wk ☐ >1/mo ☐ <1/mo ☐ none
☐ Exacerbation visit since last clinic visit? ☐ Observation stay for exacerbation since last clinic visit?
☐ Hospitalization for exacerbation since last clinic visit?
☐ Other findings: _____

A: Asthma control is: ☐ Good ☐ Fair ☐ Poor ☐ Resolved without treatment
Medication compliance is: ☐ Good ☐ Fair ☐ Poor
Previous short term goal: _____ ☐ Met ☐ Not Met
Previous long term goal: _____ ☐ Met ☐ Not Met
Other: _____

P: Next visit: ☐ Three months (max.) ☐ Sooner: _____
☐ Asthma resolved - no follow-up indicated - return to clinic if new onset occurs
Diag. Testing: ☐ Pulse oximetry q 3 mos & prn ☐ Peak flow q 3 mos & prn ☐ Other _____
Labs: ☐ Theophylline ☐ Routine ☐ With next visit ☐ On _____ / _____ / _____
☐ Other: ☐ Routine ☐ With next visit ☐ On _____ / _____ / _____
Medication: ☐ Continue current medication: _____
☐ Change medication: _____ ☐ Start: _____
☐ Stop: _____
Diet: ☐ Regular ☐ Other: _____
Exercise: ☐ No restrictions ☐ Other: _____
Adaptation to corrections environment (special needs): ☐ None ☐ Other: _____
Education: ☐ Medication ☐ Inhaler use ☐ Disease process, Diet, Exercise & Adaptation
Care & supervision instructions to medical staff: _____
Care and supervision instructions to youth workers: _____ ☐ Report breathing problems ☐ Other: _____

Goals: Short term: ☐ Complies with treatment ☐ Other: _____
Long term: ☐ No visits for exacerbation ☐ Participates in all activities
☐ Other: _____


Youth Signature _____ Physician Signature _____

 **HS 040**
Page 1 of 1
Revised October 2006

This is an easy to use treatment plan for periodic evaluations (Chronic Care) and may substitute as a chronological progress note when all areas are completed by the practitioner.

This is not a fillable form and should be uploaded into the upload library.

Treatment Plan Sheet: Diabetes (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
TREATMENT PLAN SHEET: DIABETES

NAME OF YOUTH: Youth Name DATE: _____
DJJID#: DJJ ID ALLERGIES: _____

INITIAL VISIT INFORMATION:
Age of onset: _____ Type: _____
Contributing factors: _____ Complications: _____

S: Ht. _____ Wt. _____ T. _____ Pulse _____ Resp. _____ BP _____

O: ☐ Hyperglycemic episodes (>400) since last clinic visit?
☐ Hypoglycemic episodes (<60) since last clinic visit?
☐ ER visit or hospital stay for diabetes complications since last clinic visit?

Date of annual lab workup: _____ Results: _____
Date of annual fundoscopic exam: _____ Findings: _____
Date of biannual glycosylated hemoglobin: _____ Result(goal = 7): _____

Fasting blood sugar: AM _____ NN _____ PM _____ HS _____ Other labs: _____
Neurological status: _____
Cardiovascular status: _____
Exam of feet: _____ Peripheral pulses/skin: _____
Current medication: _____
Current insulin orders: _____
Other findings: _____

A: Blood glucose control is: ☐ Good ☐ Fair ☐ Poor
Diet compliance is: ☐ Good ☐ Fair ☐ Poor
Medication compliance is: ☐ Good ☐ Fair ☐ Poor
Previous short term goal: _____ ☐ Met ☐ Not Met
Previous long term goal: _____ ☐ Met ☐ Not Met
Other: _____

Next visit: ☐ Three months (max.) ☐ Sooner:
Diag. Testing: ☐ Annual fundoscopic exam by optometrist or ophthalmologist
☐ Other: _____
Labs: ☐ Annual basic metabolic profile, serum creatinine, and urinalysis
☐ Other: _____ ☐ Routine ☐ Before next visit ☐ On _____ / _____ / _____


Fasting blood glucose testing: ☐ p.m. ☐ q AM ☐ q NN ☐ q PM ☐ q HS ☐ Other: _____
Insulin: ☐ Continue current medication: _____ ☐ Change current insulin: _____
Other Medication: ☐ Continue: _____
☐ Start: _____
☐ Stop: _____

Diet: ☐ Unmeasured ADA ☐ Other: _____
Exercise: ☐ No restrictions ☐ Other: _____

Adaptation to corrections environment (special needs): ☐ None ☐ Other: _____
Education: ☐ Medication & insulin administration ☐ Disease process, diet, exercise, adaptation, skin care
Care & supervision instructions to medical staff: _____
Care and supervision instructions to youth workers: ☐ Report breathing problems ☐ Other: _____

Goals:
Short term: ☐ Complies with treatment ☐ Other: _____
Long term: ☐ Glycosylated hemoglobin <7 ☐ Participates in all activities
☐ Other: _____

Youth Signature _____ Physician Signature _____


 **HS 041**
Page 1 of 1

DJJ/OHSFRM 041 07/2007 *Revised October 2006*

This is an easy to use treatment plan for periodic evaluations (Chronic Care) and may substitute as a chronological progress note when all areas are completed by the practitioner.

This is not a fillable form and should be uploaded into the upload library.

Treatment Plan Sheet: General (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
TREATMENT PLAN SHEET: GENERAL MEDICAL

NAME OF YOUTH: Youth Name DATE: _____
DJJID#: DJJ ID ALLERGIES: _____

INITIAL VISIT INFORMATION:
Type of Medical Condition: _____ Age of onset: _____
Contributing factors: _____ Complications: _____

S: _____
O: Ht. _____ Wt. _____ T. _____ Pulse _____ Resp. _____ BP _____
Current medications(s): _____
Labs: _____
☐ Exacerbation episode visit since last clinic visit?
☐ ER visit or hospitalization since last clinic visit?
☐ Physical findings: _____

A: Condition control is: ☐ Good ☐ Fair ☐ Poor ☐ Resolved without treatment
Medication compliance is: ☐ Good ☐ Fair ☐ Poor
Previous short term goal: _____ ☐ Met ☐ Not Met
Previous long term goal: _____ ☐ Met ☐ Not Met
Other: _____

P: Next visit: ☐ Three months (max.) ☐ Sooner:
☐ Condition resolved - no follow-up indicated - return to clinic if new onset occurs
Diagnostic Testing: ☐ _____
Labs: _____
☐ Routine ☐ Before next visit ☐ On _____ / _____ / _____
Medication: ☐ Continue current medication: _____
☐ Change medication: ☐ Start: _____
☐ Stop: _____
Diet: ☐ Regular ☐ Other: _____
Exercise: ☐ No restrictions ☐ Other: _____
Adaptation to corrections environment (special needs): ☐ None ☐ Other: _____
Education: ☐ Medication ☐ Disease process, Diet, Exercise & Adaptation
Care and supervision instructions to medical staff: _____
Care and supervision instructions to direct care staff: _____

Goals: Short term: ☐ Complies with treatment ☐ Other: _____
Long term: ☐ _____ ☐ Participates in all activities
☐ Other: _____


Youth Signature _____

Physician Signature _____

This is an easy to use treatment plan for periodic evaluations (Chronic Care) and may substitute as a chronological progress note when all areas are completed by the practitioner.

This is not a fillable form and should be uploaded into the upload library.

Treatment Plan Sheet: Hypertension (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
TREATMENT PLAN SHEET: HYPERTENSION

NAME OF YOUTH: Youth Name DATE: _____
DJJID#: DJJ ID ALLERGIES: _____

INITIAL VISIT INFORMATION:
Age of Onset: _____ Type: _____
Physical Factors: _____ Psychological Factors: _____


S: _____
O: Ht. _____ Wt. _____ T. _____ Pulse _____ Resp. _____ BP _____
Heart sounds: Gallops ☐ Absent ☐ Present _____
Murmurs ☐ Absent ☐ Present _____
Others: _____
Date of annual fundoscopic exam: _____ Findings: _____
Date of annual work-up: _____ EKG result: _____
Current medications(s): _____
Labs: _____
☐ Hypertensive episodes since last clinic visit? _____
☐ Hypotensive episodes since last clinic visit? _____
☐ ER visit or hospital stays for blood pressure since last clinic visit? _____
☐ Other findings: _____

A: Hypertension control is: ☐ Good ☐ Fair ☐ Poor ☐ Resolved without treatment
Medication compliance is: ☐ Good ☐ Fair ☐ Poor
Previous short term goal: ☐ Met ☐ Not Met
Previous long term goal: ☐ Met ☐ Not Met
Other: _____

P: Next visit: ☐ Three months (max.) ☐ Sooner: _____
☐ Hypertension resolved - no follow-up indicated; return to clinic if new onset occurs
Ding. Testing: ☐ Annual fundoscopic exam by optometrist or ophthalmologist
☐ Annual EKG ☐ Other: _____
Labs: ☐ Annual basic metabolic profile, serum creatinine, and urinalysis
☐ Other: _____ ☐ Routine ☐ Before next visit ☐ On _____ / _____ / _____
Medication: ☐ Continue current medication: _____
☐ Change medication: ☐ Start: _____
☐ Stop: _____
Diet: ☐ Regular ☐ Other: _____
Exercise: ☐ No restrictions ☐ Other: _____
Adaptation to corrections environment (special needs): ☐ None ☐ Other: _____
Education: ☐ Medication ☐ Disease process, Diet, Exercise & Adaptation
Care & supervision instructions to medical staff: _____
Care and supervision instructions to direct care staff: _____

Goals: Short term: ☐ Complies with treatment ☐ Other: _____
Long term: ☐ BP \geq _____ & \leq _____ ☐ Participates in all activities
☐ Other: _____


Youth Signature _____ Physician Signature _____

 **HHS 042**
Page 1 of 1
Revised October 2006

This is an easy to use treatment plan for periodic evaluations (Chronic Care) and may substitute as a chronological progress note when all areas are completed by the practitioner.

This is not a fillable form and should be uploaded into the upload library.

Treatment Plan Sheet: Seizure Disorder (PDF)

 **FLORIDA DEPARTMENT OF JUVENILE JUSTICE**
TREATMENT PLAN SHEET: SEIZURE DISORDER

NAME OF YOUTH: Youth Name DATE: _____
DJJID#: DJJ ID ALLERGIES: _____

INITIAL VISIT INFORMATION:

Age of Onset: _____
Type: ☐ Simple Partial ☐ Complex Partial ☐ Aura: _____
☐ Grand Mal ☐ Tonic ☐ Absence ☐ Secondary Generalized Partial ☐ Myoclonic ☐ Other _____
☐ Atonic

S: _____
O: Ht. _____ Wt. _____ T. _____ Pulse _____ Resp. _____ BP _____
Reflexes & Motor Function: ☐ Intact ☐ Deficits: _____
Current medication: _____
Labs: Anticonvulsant level: _____ Other: _____
☐ Seizures since last visit? ☐ How many? _____ Type: _____ ☐ Duration? _____
☐ ER visit or hospitalization for seizures since last clinic visit? _____
☐ Other findings: _____

A: Seizure control is: ☐ Good ☐ Fair ☐ Poor ☐ Resolved without treatment
Medication compliance is: ☐ Good ☐ Fair ☐ Poor
Previous short term goal: _____ ☐ Met ☐ Not Met
Previous long term goal: _____ ☐ Met ☐ Not Met
Other: _____

P. Next visit: ☐ Three months (max.) ☐ Sooner: _____
☐ Seizures resolved - no follow-up indicated - return to clinic if new onset occurs
Diag. Testing: ☐ Reflex assessment q 3 mos & pm ☐ Motor function q 3 mos & pm
Labs: ☐ Anticonvulsant level (notify physician & schedule reevaluation at next visit if level not in therapeutic range)
☐ Routine ☐ Before next visit ☐ On _____ / _____ / _____
☐ Other ☐ Routine ☐ Before next visit ☐ On _____ / _____ / _____

Medication: ☐ Continue current medication: _____
☐ Change medication: ☐ Start: _____
☐ Stop: _____
☐ If youth refuses anticonvulsant medication, medical approval for general population is suspended until
resumption of therapy or reevaluation by physician; segregate youth in safe location for observation, notify physician and
schedule reevaluation at next visit.

Diet: ☐ Regular ☐ Other: _____
Exercise: ☐ No restrictions ☐ Other: _____
Adaptation to corrections environment (special needs): ☐ None ☐ Other: _____
Education: ☐ Medication ☐ Disease process, Diet, Exercise & Adaptation
Care & supervision instructions to medical staff: _____
Care and supervision instructions to direct care staff: _____

Goals: Short term: ☐ Complies with treatment ☐ Other: _____
Long term: ☐ Experiences no seizures ☐ Participates in all activities
☐ Other: _____

Youth Signature _____

Physician Signature _____

This is an easy to use treatment plan for periodic evaluations (Chronic Care) and may substitute as a chronological progress note when all areas are completed by the practitioner.

This is not a fillable form and should be uploaded into the upload library.

Tuberculosis Testing Log (PDF)



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

TUBERCULOSIS TESTING LOG

FACILITY NAME: _____
MONTH/YEAR: _____

The purpose of this log is to maintain a record of all tuberculosis (TB) skin tests TST/PPD administered at a facility, or that are provided by a facility. This log does not take the place of documentation in the Individual Health Care Record.

INSTRUCTIONS

When a youth receives a Tuberculosis skin test at a DJJ facility (or at an off-site health care facility), enter the youth's name, DJJID#, date of administration of test, date test was interpreted, the test result (in millimeters), and whether or not a referral to a physician was made. ALL POSITIVE TB RESULTS (RESULTS WHICH INDICATE POSSIBLE EXPOSURE AND/OR ACTIVE DISEASE) MUST BE REVIEWED BY THE DESIGNATED HEALTH AUTHORITY OR DESIGNEE.

Name of Youth	DJJID#	Date TST/PPD Placed	Date Read	Results (in mm)	Follow-Up

This is not a fillable form.

It is an aggregate log that is not uploaded but rather maintained in the medical clinic and documented monthly.



If you have any questions or problems using the OHS Electronic Medical Records, please contact your local Data Integrity Officer (DIO)

<http://www.djj.state.fl.us/partners/data-integrity-jjis>