Community Health Network

San Francisco General Hospital Medical Center

DIABETES GROUP
PHARMACIST PROGRESS NOTE
IDEALL Health Project

NAME

DOB

MRN

PCP

Client ID / Addressograph or label

Date: _____ Time: _____ Site: FHC GMC Session # _____ Group # _____

Pharmacist: _____

INTERVENTION/ISSUE (check all that apply) :

❑ Medication Instructions/ Review	❑ Refill Issues
❑ Insurance Issues	❑ OTC Medications
❑ Herbals/Dietary Supplements	❑ Cost Issues
❑ Medication Side Effects	❑ Drug-Drug Interactions
❑ Drug-Food Interactions	❑ Drug-Disease Interactions
❑ Other:_____	❑

Problems, with assessment and plans:

1. S/O (Evidence - Subjective/Objective)_____

_____

_____

_____ On aspirin? Yes No

2. A (Assessment)_____

_____

_____

_____

3. P (Plan)_____

_____

_____

_____

Medications changed this visit (check all that apply and describe in above plan):
□ Diabetes □ Blood Pressure □ Lipids □ Aspirin □ Other

Performed "Teach-Back" Method? □ Yes □ No

Client and provider agree on plan? □ Yes □ No

_____ _____ Follow-up: _____
Pharmacist Signature CHN ID#