|  |  |  |  |
| --- | --- | --- | --- |
| **Student Name:**  **Student ID #:** | **Status\*** | **Notes** | **Date**  **Corrected\*\*** |
| Student photo on inside cover |  |  |  |
| Master Problem List |  |  |  |
| Chronic Care Management Plans\*\* |  |  |  |
| Job Corps Health History Form |  |  |  |
| Job Corps Physical Examination Form |  |  |  |
| Job Corps Oral Examination Record\*\* |  |  |  |
| Dental x-rays\*\* |  |  |  |
| Emergency contact information |  |  |  |
| **Consent forms** | | | |
| ETA 6-53 |  |  |  |
| Informed Consent to Receive Mental Health and Wellness Treatment |  |  |  |
| HIPAA Authorization |  |  |  |
| HIPAA Notice |  |  |  |
| HIV Testing Information Sheet |  |  |  |
| Immunizations consent/refusal forms (optional) |  |  |  |
| Elective Oral Examination Consent/Refusal Form (optional) |  |  |  |
| Oral Health Treatment Consent/Refusal Form (optional) |  |  |  |
| Insurance information\*\* |  |  |  |
| Request for release of medical information\*\* |  |  |  |
| SF-600 Chronological Record (progress notes) |  |  |  |
| TEAP assessments, plans, and progress notes\*\* |  |  |  |
| Mental health assessments, plans, and progress notes\*\* |  |  |  |
| Social Intake Form (SIF) or other intake assessment |  |  |  |
| **Immunizations** | | | |
| Td or Tdap |  |  |  |
| IPV |  |  |  |
| MMR |  |  |  |
| Hepatitis B series\*\* |  |  |  |
| VIS of immunizations given\*\* |  |  |  |
| Tuberculosis skin test (Mantoux) results |  |  |  |
| **Laboratory results** | | | |
| HIV antibody |  |  |  |
| Syphilis serology\*\* |  |  |  |
| Hemoglobin or Hematocrit |  |  |  |
| Sickle cell screening\*\* |  |  |  |
| Urinalysis (dipstick) for glucose/protein |  |  |  |
| Entry drug screen (urine) |  |  |  |
| Suspicious and second drug screens\*\* |  |  |  |
| Chlamydia |  |  |  |
| Gonorrhea |  |  |  |
| Pap smear\*\* |  |  |  |
| Documentation of off-center medical care\*\* |  |  |  |
| Referral forms with feedback\*\* |  |  |  |
| Documentation of HIV pretest counseling |  |  |  |
| Documentation of HIV posttest counseling |  |  |  |
| Previous medical records\*\* |  |  |  |
| OWCP forms\*\* |  |  |  |
| MSWR separation treatment plan and referrals\*\* |  |  |  |

**Signature of person completing audit HWM Signature**