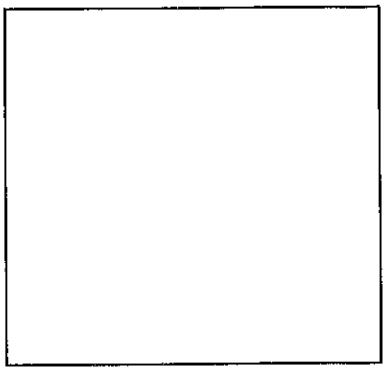
Date: _____

www.discoverccs.org

Medical Student Data Form/Checklist



_____
(Your Name)

_____ _____
(Name of School) (Year of graduation)

(Please Print Neatly):
Name of School Coordinator (who sent you here?):_____

Number of weeks for rotation: 4 6 (please circle)

Start / End Date of Rotation: _____/_____

Phone Number: _____E-mail address: _____

What are your expectations of this rotation? _____
_____
_____

What field of medicine are you leaning towards?
_____

What if any Volunteer/Extracurricular activities are you involved in?
_____
_____

What three words would you use to describe yourself?
_____
_____

Acknowledgement of Receipt

CCS Medical Student Rotation Guidelines

By signing this page you acknowledge that you have received a copy of our CCS Medical Student Rotation Guidelines.

Name of Student _____

Signature of Student _____

Date Signed _____

CCS Vitals Certification:
Name of Trainer _____

Signature of Trainer _____

Date Signed _____

History Certification Sign-Off
Name of Trainer _____

Signature of Trainer _____

Date Signed _____

COMPREHENSIVE
CLINICAL SERVICES, P.C.

Please email me with any questions: ccsmedrotation@discoverccs.org

CCS MEDICAL STUDENT ROTATION GUIDELINES

Requirements:

BE ON TIME!!!!! 2 tardies will require a makeup session

NO Call/No Shows will require 2 makeup sessions

- Stethoscopes and white lab coat
- 4 approved visits a week (sign in each time.... No signature, No Credit)
    - Every provider must have a student before we add a 2nd one
    - One Double day per week
    - Saturdays REQUIRED
        - 6wk require 3 Saturdays
        - 4wk Require 2 Saturdays
- Missed dates require notice via email and a make-up date
    - **Failure to communicate will result in automatic fail**
- 5 min presentation (topic to be approved and to be given IN PERSON)
- Submit evals, cases, logs etc on time

*** Please note LORs will only be given once the rotation has been paid to CCS.

Appearance:

Must always look professional, clean, neat and groomed. Lab coat must be white and look ironed.

Dress Code:

Professional business attire: including but not limited to dresses, dress pants, dress shoes, collared shirts/ blouses and ties

No Jeans, no Gym Shoes, no open toe shoes, no sandals, no low cut shirts, no skirts 2" above the knee, no hanging jewelry of any kind.

Behavior:

Professional, mature, courteous, and respectful at ALL times with staff, providers and clients/patients. Absolutely NO CELL PHONES to be used in session unless the doctor permits it. Cell phones can be used in conference room or atrium outside the office. *No hanging out in the hallways or inner office* (please be quiet as you walk through the halls).

- **No adjusting sign-in time on sign-in sheet**
- **No signing in for other students**
- ***No* religious beliefs expressed or discussed with patients**
- **Office Computers are for ATHENA use *ONLY***
- **Urine screens- MA must be present and will keep forms (Directions attached)**
- ***Never* leave patient unattended- you are done with a patient once they walk out of the door.**

A Guide for Seeing Patients

Learn how to interact with psychiatric patients by supporting the physician.

There are **three important rules** all medical students must be aware of before summoning and assessing patients:

1. Summon patients in the waiting room by their **FIRST name only**.
   a. Calling out the first and last names of patients is a HIPAA violation.
2. Students must never delay the work of the attending physician.
   a. If the physician calls your attention, **STOP whatever you are doing** (regardless if you have not been able to complete the assessment), and escort the patient to the physician's office.
3. Never go into the physician's office unless the physician invites you in.
   a. In order to attend a session, the student must first ask the physician for permission. Only after receiving permission can the student attend the session.

Keeping the above rules in mind, assess the patients in the following order:

1. Summon the patients in the waiting room by first name.
2. Introduce yourself as a medical student.
3. Respectfully escort the patients to the "vital signs room." (Please make Sound Machine is ON)
4. Always ask permission to take their vitals:
   a. Age, blood pressure, height, pulse, and weight.

Patient Name: **Date:**

Age _____ **DX:**_____

Wt _____ **lbs** _____**Refused**

BP _____/_____

Ht ____ **ft** _____**in**

Pulse _____ **bpm**

BMI _____ **Allergies:**_____

5. Ask to verify pharmacy name, number and location.
6. Ask them if they have any allergies.
7. Ask for Past Family History (NEW patients)
8. Ask for Social History (NEW patients)
9. Click SAVE.
10. Administer assessment to patient for Providers on tablet. Save, Print & give to provider (if applicable)
11. Provider will ask patient for permission to have you sit in- in session.
12. Always ask providers if a release is needed for the patient before patient leaves.

Please email me with any questions: ccsmedrotation@discoverccs.org

Urine Testing

Directions:

1. Hand out a urine drug screen cup to patient and send them to the bathroom.
2. While the patient is in the bathroom fill out the top portion of the **Urinanalysis** form including: patient name and date of birth at the top and date of test at the bottom.
3. After the patient returns with the urine sample, note the temperature of the urine from the cup. The green box indicates the temperature. Also note the time was collected on the form.
4. Wait five minutes to interpret results. Afterwards, rip off the paper tab to read results. Note the time results are interpreted on the form.
5. Two lines indicate a negative. One line indicates a positive. If there is even a faint slight second line, it is considered a negative.
6. Note the results on the form.
7. Have the patient sign the form, and have the provider or nurse sign as well.
8. Dump out the urine in the toilet and dispose of the cup in the garbage can in the lab.
9. Place the **Urinalaysis** form in the Medical Assistant Bin.

URINALYSIS RESULTS

COMPREHENSIVE CLINICAL SERVICES
2340 S. Highland Ave Ste 300, Lombard, IL 60148
Phone: 630-261-1210 Fax: 630-261-1211

PATIENT INFORMATION
Last Name:_____ First Name: _____ D.OB._____

Illinois Prescription Monitoring Viewed: Yes ( ) No ( )

TEST CUP RESULTS
Test Lot# _____ Time Collected: _____ Time Interpreted: _____
Temperature _____ Normal (90-100 degree F)

DRUG NAME	SYMBOL	NEGATIVE	POSITIVE	N/A
BUPRENORPHRINE	BUP			
METHAMPHETAMINE	MAMP			
METHADONE	MTD			
BARBITUATE	BAR			
BENZODIAZEPINE	BZO			
MORPHINE	MOP			
ECSTASY	MDMA			
PHENCYCLIDINE	PCP			
MARIJUANA	THC			
OXYCODONE	OXY			
COCAINE	COC			
AMPHETAMINES	AMP			

CERTIFICATION: I hereby agree to submit to a urinalysis for the purpose of testing for drug metabolites. The specimen provided is my own and has not been substituted or adulterated.

_____ _____
PATIENT SIGNATURE DATE

I hereby certify that the specimen provided by the Donor identified above was received and results were confirmed.

_____ _____ COLLECTORS SIGNATURE DATE

Psychiatric H & P

Identifying Information

Patient is a _____ year old, _____ , _____, _____, living in a _____
(age) single/married/divorced, white/black, ect, Male/Female (type of housing)
for _____ years, attending/working _____ at _____, for _____ years, with a _____ education.
type of school/type of job School name/Company highest level of education
This patient first saw psychiatrist _____, diagnosed with _____, treated with
Date diagnosis
_____ and is presently on _____.
medication given all medications they are currently on
The patients main problems at the present time are: 1. _____, 2. _____,
3. _____, 4._____, 5. _____, 6. _____.

Chief Complaint

"_____" (exact words of patient)

History of Present Illness – Chronological history, until today

_____
_____
_____
_____
_____
_____

Medication Side Effects:

Medications prescribed: _____, SE_____, When _____
Medications prescribed: _____, SE_____, When _____
Legal problems: _____
Tobacco use: Y/ N / Quit ; If yes: Pack years _____; If Quit: How long ago_____, Packs prev:_____
Reason for quitting: _____
Caffeine use: Y/N; If yes: how much a week? _____
Alcohol use: Y/N ; If yes: how much a week?_____
Alcohol screen: C.A.G.E. (M>2; F>1)
C – Felt the need to Cut down on drinking? Y/N
A – Have been annoyed with people criticizing your drinking? Y/N
G – Have you ever felt Guilty about drinking? Y/ N
E – Have you even felt the need to drink first thing in the morning? Y/N
Major stressors currently: _____

Past Psych History

Ever hospitalized? Y/N; If yes; how many times:_____ what meds presc:_____
What med helped most?_____ Any SE:_____
History of suicide attempts: Y/N; If yes; how many times: _____, when:_____
Any other diagnoses the patient has rec'd in the past? _____

Medical History:

PCP: _____; Last appoint: _____ Last physical:_____
Current Medications: _____ Known Medication Allergies: _____
Immunizations up-to-date: Y/N Surgeries: Y/N HIV: Y/N
For Females Only:
Sexually Active: Y/N; Safe sex practice: Y/N; Possibility of being pregnant? Y/N, STI? Y?N
Last menstrual period?_____, Length of Menarche:_____, Heaviness: _____
Assoc symp with Menarche_____

Family History:

Parents Ages:_____; Siblings:_____; Kids: _____
Family History of Psychiatric Illness: Y/N; If Y: _____
Family History of Drug/Alcohol/Physical abuse: Y/N; If Y:_____

Developmental History:

Any complications during pregnancy/delivery: Y/N; If Y:_____

Developmental milestones met? Y/N, If N: _____
Required Special Education/I.E.P in school? Y/N

Social History:
"In one sentence, describe your childhood" Ans: _____
History of physical, emotional or sexual abuse: Y/N, If Y: _____
Longest held Job: _____, Longest Relationship: _____
Religion: _____; practicing? Y/N Career Goals: 1: _____, 2: _____

Review Of Systems: - Cardiac/Renal/Hepatic/Endocrine/Neuro
Check and Rule out the following:
Mood – fluctuations? Time frame? Features?
Psychosis – auditory/visual/tactile hallucinations?
Depression - MSIGECAPS
Mania - DIGFAST
Substance abuse – use of drugs? How often?
Suicidal ideation –harming themselves? Plan? Hopelessness? Access to gun?
Homicidal ideation –harming others? Plan? Who? Access to gun?

Mental Status Exam: ASEPTIC
Appearance:(general appearance, alertness, hygiene, grooming)_____
Speech: (volume, rate, tone)_____
Emotion: (Mood, how they feel)
_____
Perception:(Hallucinations, Illusions, derealization)
_____
Thought: (process/content/impulse/judgment)
_____
Insight: (level of illness/need for tx):_____
Cognitive: (alertness, orientation OR mmse)_____

If Req: **MMSE** (total out of 28)
Orientation (10pts): Year? Date? Season? Day? Month? State? County? City? Floor? Building?
Registration (3pts): Repeat these words: Ball, Tree, Fork; # of trials:_____; tell pt to remember them.
Attention/Calc (5pts): Spelt W.O.R.L.D. backward; D. L. R. O. W (get 3 pts if out of order)
Recall (3pts): Ask pt to recall the previous 3 words: BAT, TREE, FORK
Language/Praxis (7pts):

- Show the patient two objects, a wristwatch and pencil, and ask the patient to name them -1pt
- "Repeat the phrase: 'No ifs, ands, or buts.'" -1pt
- "Take the paper in your right hand, fold it in half, and put it on the floor." -3pt
  (The examiner gives the patient a piece of blank paper.)
- "Please read this and do what it says." (Written instruction is "Close your eyes.") -1pt

Working Differential Diagnosis: 1:_____
2:_____
3:_____

Treatment Plan:
1. Safety: Patient is not a danger to self or others. Able to be treated in outpatient program
2. Obtain consent from PCP/ Therapist/ School/ Hospital
3. Need updated physical exam/ Need updated lab workup (CBC, TSH, Lead, Vit D, ect)
4. Get a urine drug screen
5. Consider SSRI/Antipsych/Mood Stabilizers/ Stimulants
6. Refer patient for Counseling/Therapy/CBT
7 Social – Can refer for vocational rehab, educational rehab, AA/NA, Group therapy
8. Cultural – Educate the patient and family members regarding condition/treatment
9. Spiritual – Explore options with patient if willing, refer for life coach for long term plan

Medical Student Rotation Survey

(to be dropped off before last week of rotation)

Please fill out this exit survey. Your feedback helps us to continually improve our medical student rotation program. Thank you.

On a scale from 1-10 (1 being not satisfactory and 10 being extremely satisfied)

1. Orientation 1 2 3 4 5 6 7 8 9 10
2. Clear Instructions 1 2 3 4 5 6 7 8 9 10
3. Easy To Understand 1 2 3 4 5 6 7 8 9 10
4. Clear Instructions 1 2 3 4 5 6 7 8 9 10
5. Facility Cleanliness 1 2 3 4 5 6 7 8 9 10
6. Staff Friendliness 1 2 3 4 5 6 7 8 9 10
7. Overall Experience 1 2 3 4 5 6 7 8 9 10

8. What did you enjoy most about your rotation? Why?

_____

_____

9. What was your least favorite thing about the rotation? Why??

_____

_____

10. Is there anything you would like to see changed about this rotation? Why?

_____

_____

11. Would you recommend the medical rotation program at CCS to other students? Why or Why not?

_____

_____