Print Form

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

CLINICAL CARE CASENOTE

Name: **PARIS ID:**
DOB: **Age:** **PHN:**
Gender: **Phone:**
Home Address:

Casenote Date: **Reason:** **Staff Member:**

MHA Minimum Reporting Requirements [MRR]

☐ First Service Event

Client has experienced violence/abuse towards them in the 12 months prior to referral or during service:

☐ Yes, indicated by client ☐ No

☐ Yes, indicated by other trusted source ☐ Unknown/not asked

Client has made a suicide attempt or engaged in significant intentional self-harm in the last 24 hours:

☐ Yes, indicated by client ☐ No

☐ Yes, indicated by other trusted source ☐ Unknown/not asked

Presenting Demeanor

General Appearance

☐ Clean/Neat ☐ Dishevelled ☐ Poor Hygiene

☐ Other:

Orientation

☐ To Person ☐ To Place ☐ To Time

Speech

☐ Coherent ☐ Disorganized

☐ Other:

Affect

☐ Calm ☐ Anxious ☐ Flat

☐ Agitated ☐ Labile ☐ Angry

☐ Sad ☐ Full Range

☐ Other:

CLINICAL CARE CASENOTE

Name: _____ **PARIS ID:** _____

Behavior

- ☐ Aggressive
- ☐ Avoiding
- ☐ Behaviour contract
- ☐ Compliant with program
- ☐ Confrontational
- ☐ Inappropriate behaviours
- ☐ Medication-seeking
- ☐ Motivated
- ☐ Non-compliant
- ☐ Physically abusive
- ☐ Pleasant
- ☐ Pro-active
- ☐ Stoic
- ☐ Verbally abusive

Warning ☐ 1 ☐ 2 ☐ 3

Reason: _____

☐ Other: _____

Client Activity

- ☐ Acupuncture
- ☐ Alternative Therapy
- ☐ Bed Seeking
- ☐ Close to Bed
- ☐ Isolative
- ☐ Native Spirituality
- ☐ Prayers & Blessings
- ☐ Reading / Hobbies
- ☐ Socializing
- ☐ Watched TV

Attended

- ☐ 12 Step / Self Help Meeting
- ☐ Daytox Orientation
- ☐ Group Session

Saw

- ☐ Counsellor
- ☐ MEIA Liaison
- ☐ Native Courtworker
- ☐ Social worker
- ☐ Street Nurse

Meals

- ☐ Breakfast
- ☐ Lunch
- ☐ Dinner
- ☐ Snacks

Sleep

- ☐ All night
- ☐ On & Off
- ☐ Awake for ☐ Hours
- ☐ Apnea
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Nightmares
- ☐ Outside Appt: _____
- ☐ Other: _____

CLINICAL CARE CASENOTE

Name: _____ **PARIS ID:** _____

Staff Activity

Clinical/ Medical Activities

- ☐ Acupuncture
- ☐ Alternative Therapy
- ☐ Foot Care
- ☐ General Medical Care
- ☐ Home Detox
- ☐ Infectious Disease Care
  Specify: _____

IV PICC Assessment

- ☐ Patent / Stable
- ☐ Complications
- ☐ Replacement

- ☐ Lab Tests Ordered / Taken

Medication

- ☐ IV Antibiotic Therapy
- ☐ Medication Review
- ☐ Missed Antibiotic Dose

Methadone Maintenance Therapy

- ☐ Request for MMT
- ☐ MMT startup
- ☐ MMT Maintenance
- ☐ MMT Taper

- ☐ Nutrition Counselling
- ☐ Pain Management
- ☐ Pharmanet Check
- ☐ Physical Assessment
- ☐ Sobering Observation
- ☐ Transfer to Hospital
- ☐ Withdrawal Management
- ☐ Wound Care

Rehydration

- ☐ Complete
- ☐ Incomplete
- ☐ Refused

Other Staff Activities

- ☐ Accompany to Other Service
- ☐ Advocacy
- ☐ Assessment
- ☐ Care Planning/Review
- ☐ Case Review / Conference
- ☐ Clinical Counselling / Therapy
- ☐ Clinical Education
- ☐ Discharge Planning
- ☐ Harm Reduction Education
- ☐ Housing Search

- ☐ Hygiene Assistance
- ☐ Information Provided

Items Provided

- ☐ Contingency Management
- ☐ Nutrition Supplement

- ☐ Lifeskills Development
- ☐ Parenting Skills Development
- ☐ Support- MCFD
- ☐ Support- MEIA
- ☐ Supportive Counselling

Transportation

- ☐ Taxi
- ☐ Car Ride
- ☐ Saferide
- ☐ Bus Tickets

- ☐ Victim Support
- ☐ Vocational Planning

Other

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Client Emergency

- ☐ Cardiac
- ☐ Overdose
- ☐ Other: _____

- ☐ Suicide Attempt
- ☐ Respiratory

- ☐ Mental Health
- ☐ Seizure

Action taken

- ☐ Transport to ER
- ☐ Other: _____
- ☐ Other: _____

- ☐ 911 Call

- ☐ Discharge Planning

CLINICAL CARE CASENOTE

Name: PARIS ID:

Withdrawal Signs

Date	Time	Concerns	Signs

Referred To

Date Recorded	Referred To	Method	Details about Referral	Outcome

Linked Needs

Need	Identified On

CLINICAL CARE CASENOTE

Name:		PARIS ID:	

Casenotes

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

---------- End of Report ----------