

2300 STUDENT WEEKLY TASK LOG

Blood Pressure Assessment Log, Target: 5+/week

Date	Initial Blood Pressure in mmHg	If BP is over 140/90, was the BP retaken? <small>Yes still elevated, Yes no longer elevated, No, not rechecked</small>	Action taken (see codes below and list all that apply)	Relevant notes

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| <ol style="list-style-type: none"> 1. Counseled patient on medication adherence 2. Patient education on suggested lifestyle modification 3. Referred patient to primary care provider for follow-up. 4. Counseled patient on at-home BP monitoring | <ol style="list-style-type: none"> 5. Scheduled follow-up screening at the pharmacy at a later date 6. Contacted patient's primary care provider with recommendation(s) 7. No action needed/taken. 8. Other: please describe |
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Prediabetes Screening Log, Target: 5+/week

Date	Prediabetes risk test score	Action taken (see codes below and list all numbers that apply)	Relevant notes

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| <ol style="list-style-type: none"> 1. Referred patient to the National DPP (www.ndc3.org) 2. Patient education on suggested lifestyle modification 3. Counseled patient on risk of diabetes 4. Referred patient to primary care provider for follow-up | <ol style="list-style-type: none"> 5. Contacted patient's primary care provider with recommendation(s) 6. Patient screened low risk. No action taken 7. Other: please describe |
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CGM Data Analysis, Target: 1+/week;

Date	Data Reviewed	Action taken (see codes below and list all numbers that apply)	Relevant notes
	Y/N		
	Y/N		
	Y/N		

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| <ol style="list-style-type: none"> 1. Counseled patient on data 2. Patient education on proper CGM usage 3. Referred patient to primary care provider for follow-up | <ol style="list-style-type: none"> 4. Contacted patient's primary care provider with recommendation(s) 5. Other: please describe |
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A1c Point of Care Log; NO TARGET, NDM+UNINSURED PRIORITY

Date POC test taken	Most recent A1c date	Patient current Diabetes diagnosis?	Action taken (see codes below - list all that apply)	Relevant notes
		Yes Not yet		
		Yes Not yet		
		Yes Not yet		

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| <ol style="list-style-type: none"> 1. POC test delivered because patient was overdue on A1c 2. Counseled patient on self-monitoring, blood glucose management. 3. Patient education on recommended lifestyle modifications 4. Referred patient to primary care provider for follow-up | <ol style="list-style-type: none"> 5. Contacted patient's primary care provider with recommendation(s) 6. Contact patient's primary care provider for a DSMES referral 7. No action needed/taken 8. Other: please describe |
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Medication Therapy Management (Comprehensive Medication Review)

Target: 2+/week

Date	Chronic Disease(s) addressed:	Was the MTM done thru...? Medicaid, Payable Platform, Not paid.	Complete Drug Therapy Problem worksheet. Relevant notes:
	HTN DM		
	HTN DM		
	HTN DM		

SDOH Screening Log, Target: 5+/week

Date	AHC HRSN risk score	Action taken (see codes below and list all numbers that apply)	Relevant notes

1. Referred patient to specific community resource; please describe
2. Patient screened low risk. No action taken
3. Other: please describe

Immunization Screening Log, Target: 5+/week

Date	Vaccines indicated (list all that apply) COVID-19, Hep. B, influenza, PCV15, PCV20, Shingrix, Tdap, Td.	Vaccines delivered (list all that apply) COVID-19, Hep. B, influenza, PCV15, PCV20, Shingrix, Tdap, Td.	Reason for not providing vaccine (see codes below and list all that apply)	Relevant notes

1. Patient would like to speak with provider
2. Pharmacy doesn't provide needed vaccine
3. Pharmacy out of stock
4. Other/no reason provided

Blood Pressure Cuff Loaner Program Log, Target: ONCE PER ROTATION

Date	Initial Blood Pressure in mmHg	If BP is over 140/90, was the BP retaken?	Patient current HTN diagnosis?	Action taken (see codes below and list all that apply)	Relevant Notes
			Yes Not yet		
			Yes Not yet		

1. Started patient on pharmacy loaner cuff/RPM program
2. Counseled patient on self-monitoring, hypertension management.
3. Demonstrate how to use a cuff or check for cuff accuracy
4. Referred patient to primary care provider for follow-up
5. Contacted patient's primary care provider with recommendation(s)
6. Other: please describe

Community Referral Resources Validation (SDOH) Target: ONCE PER ROTATION

Date	Community Referral Resources Validated	Action taken (see codes below and list all that apply)	Relevant notes:
	Y/N		

1. Validation details sent to jrue@aboutthepatient.net
2. Spoke directly to a staff member at the community resource
3. Validated housing assistance referral resource
4. Validated food assistance referral resource
5. Validated transportation assistance referral resource
6. Validated utilities assistance referral resource
7. Validated safety assistance referral resource