AN ANALYSIS OF THE VALUE OF RECORDS IN A COUNTY HEALTH DEPARTMENT

A Thesis

Presented to

The Faculty of the School of Nursing

University of Oregon Medical School

and

Oregon State College

In Partial Fulfillment

of the Requirements for the Degree

Bachelor of Science

by

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OUTLINE OF THESIS

An Analysis of the Value of Records in a County Health Department

I Introduction - making the reader acquainted with the problem by:

A. Brief history of early records in general

B. 1838 - English Public Record Act

1. All rolls, records, writs, books, proceedings, decrees, bills, warrants, accounts, papers and documents of a public nature.

2. All forms of data, written or unwritten, that may be employed as sources for reconstruction of the life and activity of man in the past, extending back hundreds of thousands of years and thus enabling him to secure a better prospective on the few thousand of years for which written records exist.

3. More obvious types of records.

(a) written

(1) known to all of us

(2) chief relieance of the historian may be

a. engraven on stone

b. pressed in clay

c. written on papyrus

d. written on parchment

3. characters, symbols or alphabet

4. Poems, songs, epics, legends, historical or imaginative - 13th century - very soon after printing was invented.

C. Unwritten

1. Physical remains.

(a) Human

(1) hair - bones

(b) Geographical

(1) earth's crusts, climate, topography, flora, fauna, soil character, waterways, mountain barriers, plains, deserts and all geographical agencies.

(c) Most important -

(1) clothing, tools, weapons, coins, medals, seals, jewelry, carvings, textiles, glass, burial mounds, temples, shrines, theaters, buildings and dwellings. There is more in a Gothic cathedral than in many tons of written records.

D. Borderline between written and unwritten records

1. Linguistic records, myth, legend, folklore, ballad, epic, anecdote, and tradition, charts, maps, and portraits.

2. A statement of the problem.

(a) Trying to make records alive and of vital importance to a County Health Department, the state, the nation, and to the whole world.

II The value of records as shown by statistics (Public Health Administration in the United States - Smillie, Chapter XVIII, p. 167)

A. Vital statistics - the force of mortality pressing upon a people.

1. Measured by

(a) accurate enumeration of the number and ages of the living,

(b) location, circumstances, and causes of death, and

(c) intelligent abstract of the facts.

B. Essential steps in collecting statistics.

1. Census - a complete enumeration of the population.

2. Registration, accurate recording of vital facts.

3. Statistical analysis of vital facts.

C. Logical interpretation of the analysis with conclusions. National registration of deaths - national registration initiated 1880 (90% completeness of reporting; births - established in 1915.

1. Conventional bases used in expressing vital statistics rates.

(a) Deaths - the number of deaths per 1,000 population.

(b) Birth rate - the number of live births per 1,000 population.

(c) Stillbirth rate - the number of stillbirths per 100 live births

(d) Infant mortality rate - the number of deaths under one year of age per 1,000 live births.

(e) Maternal mortality rate - the number of deaths from puerperal causes per 1,000 live births.

(f) Death rate from specific disease - the number of deaths from that specific cause per 100,000 population.

(g) Death rate of a specific age - number of deaths at that particular age per 100,000 population.

(h) Morbidity rate - the number of cases of a particular disease per 100,000 population.

(i) Case fatality rate - the number of deaths from a specific disease per 100 cases of that disease.

D. The role of the Health Department in the control of communicable disease, specific cases to be given from U. S. Public Health Service Reports.

RURAL HEALTH PRACTICE

by Harry S. Mustard, M.D.

I. Records and Reports - pp 95 - 102

1. System

(a) Uniformity in periodic reports

A. Purpose of -

1. To provide detailed data necessary in handling the individual care or situation in the present or in the future.

2. To provide information for routine administrative guidance.

3. To provide data which, on analysis, will show the amount, character, and distribution of work performed and, perhaps, indicate the effectiveness or lack of effectiveness of the Public Health Program.

4. To provide material which on study will indicate the character make-up and extent of Public Health Problems in the area.

B. The Essential Elements

1. Basic records:

(a) One for each case or situation handled.

2. Supplementary forms

(a) For administrative purposes.

3. Periodic summons

(a) Daily reports of staff workers.

(b) Monthly or quarterly reports to the State Health Department.

(c) Annual reports to the community.

C. Basic Record

1. Who was served

2. By whom, when, where, what was found. What was done about what was found.

D. Index Card - very important

1. A necessity.

E. Family Folders

1. Generalized nursing program.

2. Bring together basic record.

3. Size, $8\frac{1}{2}$ x 11 light cardboard, of good quality preferably not folded.

4. Brief family history, social economic data. Sanitary condition.

5. Filed alphabetically.

(a) Nurses district.

F. Periodic Summaries

1. Semi-annually or annually.

G. Daily Activities

1. Work done.

H. Monthly Statistical and Narrative

1. By health officer.

I. Annual Report

1. Combination of above.

(a) Of interest to State and Nation.

(b) Unusual difficulties.

(c) Changes in personnel.

J. Report to Community

1. Report of work.

2. Recommendations.

3. Changes in plans.

4. Ten or twelve pages.

III. Conclusion

A. Adequate records are a necessity.

B. Now that the same items of service are reported under the same terminology, uniform measurement is made possible with a minimum of effort.

C. Fair and impartial appraisal of services and activities makes it possible to determine and compare the efficiency, interest, and initiative of each local organization.

D. Uniform record system.

1. Has every advantage and no disadvantage in a state.

2. Uniform records it seems could be extended to the nation and internationally.

3. Same items could be reported under the same terminology throughout the entire country.

4. Usefulness of the collected information would be unmeasurably increased.

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2. Recommendations.
3. Changes in plans.
4. Ten or twelve pages.

K. Equipment

1. Property of department.

    (a) Of good quality.

2. Files.

    (a) One size.

3. Guide cards.

    (a) Entries in ink.

    (b) Surname precedes given name.

    (c) Record each day.

Included are samples of the Records of County Health Departments in Oregon.

AN ANALYSIS OF THE VALUE OF RECORDS IN A COUNTY HEALTH DEPARTMENT

First, a brief history of early records in general. One of the earliest written histories that we have of records of any kind is of the "English Public Record Act," which became a law in England in 1838, making the keeping of certain documents compulsory, namely, all rolls, records, writs, books, proceedings, decrees, bills, warrants, accounts, papers and documents of a public nature.

Also, all forms of data written or unwritten that may be employed as sources for reconstruction of the life and activity of man in the past, extending back hundreds of thousands of years and thus enabling him to secure a better prospective on the few thousand of years for which written records exist.

The more obvious types of the written records known to all of us are those engraven on stone, pressed, written on papyrus or parchment, illustrated by characters, symbols or alphabet, written in songs, poems, epic lyrics, historical or imaginative.

The unwritten records of the world are: the physical remains of the humans and animals, which are usually the hair and bones. The geographical are: the earth's crusts, climate topography, flora, fauna, soil character, water ways, mountain barriers, plains, deserts and all geographical agencies. Most important of the unwritten records are: the clothing, tools and weapons, coins, medals, seals, jewelry, carvings, textiles, glass, burial mounds, temples, shrines, theater buildings and dwellings. We have been told that there is more history in a Gothic Cathedral than in many tons of written records.

Borderline between written and unwritten records are the linguistic records, namely: myth, legend, folklore, ballad, anecdote, tradition,

charts, maps and portraits.

These early records have been very valuable to historians and others in giving a written description of the ancient history of the world, including mankind.

Since the English Public Record Act in 1838, written records have been kept, not only of recordings of a public nature, but also by people in business, professional and other lines of work where records have been proven to be valuable, at the present time, as well as a guide to the future workers along professional and industrial lines.

One of the problems of a county health department is to make the records alive and of vital importance, not only to the local department of health, but to the state, the nation and the whole world.

"Smillie" in his book, "Public Health Administration in the United States," Chapter XVIII, page 167, Vital Statistics, records:

"The force of mortality pressing upon a people may in some degree be weighed and measured by accurate enumeration of the number and ages of the living and the location, circumstances and causes of death, and intelligent abstracts of facts."

Vital statistics is the science which considers the application of statistical methods to certain vital facts. The science is a part of a very much broader subject, namely: the science of demography.

"Broadly speaking, demography is a statistical study of human life. It deals with vital facts, such as birth, growth, marriage, sickness, and death, and incidently, with political, social, religious, educational, sanitary and medical matters (Whipple)."

Registration of vital data and their analysis comprise the field of vital statistics. Statistics are facts expressed in figures. Essential steps in collecting statistics are:

1. Census, a complete enumeration of the population.
2. Registration, accurate recording of vital facts.
3. Statistical analysis of vital facts.
4. Logical interpretation of the analysis with conclusions.

National registration, of deaths, was initiated in 1880 with 90 per cent completeness of reporting, of births established in 1915.

Conventional basis used in expressing vital statistical rates are:

Deaths. The number of deaths per thousand population.

Birth Rate. The number of live births per thousand population.

Still Birth Rate. The number of still births per hundred live births.

Infant Mortality Rate. The number of deaths under one year of age per thousand live births.

Maternal Mortality Rate. The number of deaths from puerperal causes per thousand live births.

Death Rate from Specific Disease. The number of deaths from that specific cause per hundred thousand population.

Death Rate of a Specific Age. Number of deaths at that particular age per hundred thousand population.

Morbidity Rate. The number of cases of a particular disease per hundred thousand population.

Case Fatality Rate. The number of deaths from a specific disease per hundred cases of that disease.

The conventional unit of time observed in expressing rates is one year.

The purpose of records in a County Public Health Program are:

1. To assemble all pertinent facts.
2. History, as a basis, for a plan of service.
3. The record is used as a tool to aid in the care of the case, and in the service of the community.
4. Is useful in court to justify a course of action.
5. Is helpful in the administrative control of service.
6. A help to private physicians, by furnishing laboratory services for diagnosis of tuberculosis, cancer, and venereal disease, nursing service to the individual patient and by furnishing forms for statistics originating with the private physician as: birth, deaths, with cause, and communicable diseases.

Nearly three hundred years elapsed between the first recording of births, deaths and marriages by a Colonial Law and a satisfactory vital statistics registration for the country as a whole.

Today, we have fairly adequate laws, regulations and forms for recording the important facts in a Public Health Program.

The early recorded activities relating to public health were vital statistics. Deaths were first made a matter of official record in the United States and, later, births. The reporting of communicable diseases became a requirement as the spreading of disease due to bacteria or viruses became understood. Laws were passed or regulations promulgated requiring that the physician report any communicable diseases which he diagnosed or treated, and this requirement extended to householders, relatives, and next of kin. The physician was, however, the only person reporting, and the habit was not acquired by some physicians except in

what they considered the more important communicable diseases. Physicians seemed reluctant to report some diseases lest it reflect on the standing of their patients.

It may seem amusing that as late as 1912, Minnesota asked physicians to report tuberculosis by number instead of name. A fair-sized portion of the population still considered that the contracting of any communicable disease was a disgrace--probably a hang-over of the ancient idea of punishment being meted out by the Gods. Having tuberculosis was considered in the light of having syphilis or gonorrhea today. The physicians and the public were assured that the health department records were "confidential." In practice this did not seem to be obtained. Many physicians refused to disclose the nature of the illness of their patient if it was a communicable disease. This was especially true of the deaths from syphilis and even tuberculosis.

Then came the visiting nurses, supported entirely by philanthropic contributors; they had to justify the expenditures. The best showing should be made. At first, the recording was much as that of the physician. The number of visits was recorded. Speed of travel was required. Visits brief but many in number, seemingly had to be the motto of many a social-service nurse visitor.

It was not unusual at the staff meetings to see a competition of how many visits could be recorded and how many miles traveled. Results seemed to be a secondary consideration. As health work was extended into the rural districts, here again, a showing had to be made. These first county nurses were sponsored by the Red Cross, Tuberculosis Association, or Philanthropy. Demonstrations were necessary to show the need of the

service. Here again, the recording was simple--usually calls and mileage with a few human interest stories thrown in to make the report not too impossible to read. County commissioners were prone to use the nurses for social service work among the indigent. Physicians began seeing a few nurses even undertaking the treatment of what appeared to them minor ailments. And here, a serious objection was voiced at socialized medicine. The physician had thought of disease as the source of livelihood. He did not see prevention of disease as his duty, nor did there seem any way of renumeration. The nurses were interested in service to patients. They had had their training in hospitals that emphasized the service to the individual. It is true that a public health nurse who gave bedside care to a patient who was seriously ill, received the gratitude of the helpless family. The physician, too, appreciated her efforts, as it was the work he expected of a nurse. Some private physicians donated their services and did immunizations and tuberculin testing in the schools. Mantoux tests, then, became fairly popular, and there again were numbers.

This was the beginning of the public health work. No plans and established routines were available to be followed. Following World War I came the Children's Bureau Program of Maternal Care. Here again, numbers were very much in evidence when the reports were given. A great protest from the medical profession followed. The private physicians thought that the public health nurses were interfering with the doctor-patient relationship.

Slowly, a few public-minded physicians and other citizens began to see the value of better health departments for the cities and counties.

Health departments, in the cities, had been established, principally, to control communicable diseases and to protect food and milk. An outbreak of diphtheria, smallpox, typhoid or poliomyelitis gave the health officer an opportunity to demonstrate preventive medicine. It was typhoid fever at Yakima, Washington, that started the first full-time health department in a rural county in 1911.

It was not until philanthropic organizations understood local public health work that recording of the work done by a health department began to take on its present form. Among those particularly active were The Rockefeller Foundation and The Commonwealth Fund. The United States Public Health Service, by offering small subsidies, helped to establish county health departments, and their most valuable contribution was guidance in organizing, planning and recording of the activities. Narrative reports were written along with statistical summaries of what had been done.

Accomplishments should be the aim of the public health service. These can be recorded in the effects of public health of the people living in the area. A happier, better physical and mental prosperity should become apparent. This seems to have been the objective of the summary records as prepared by the State and Provincial Health Officers' Committee in 1926. It was a difficult transition to go from the entirely numerical to the recording of only the results.

The health officers and the nurses may spend much time in bringing about the necessary understanding that will prompt parents to have their children vaccinated. Nurses often spend much more of their time teaching intelligent and understanding women in the community how to clean an arm

preparatory to vaccination than she would spend in doing this work herself. All this effort can hardly be recorded. To organize a clinic in a rural community or in a city at first must require much time and effort, especially on the part of the nurse. But, is there a better way of teaching public health?

Here is what we have now: The health department of a county, for example, creates sentiment for vaccination or diphtheria immunization in a certain locality.

The following program has been given by Dr. A. E. Bostrum of Linn County:

"Six local women, interested in the children's welfare, are selected, usually by the nurse if she is acquainted in the neighborhood or at the suggestion of the school teacher or principal. She organizes her clinic, arranges a table for the physician in a suitable room, or if a suitable room cannot be found, curtains off a place for the clinic in a gymnasium or in another place. She arranges for every detail. The children are brought in in orderly fashion. Mothers who have children in school make the best assistants. A mother records each child's name at one table. One mother escorts the children to the woman washing arms--two washers are better sometimes. The nurse demonstrates the method. Another helper guides the child to the doctor. The child is seated near the table and by the side of the doctor. The nurse stands by, assisting the doctor or merely observing the work of the entire clinic. Another helper guides the child from the doctor out of the room. She is taught to observe the child carefully. If he looks pale, she takes him by the arm and leads him to a chair, or places him on a couch, and sees that

none faint or fall on the floor--a most unhappy incident. For all this instruction, the nurse does no recording of credits for herself. Still, she has done much public health teaching. Much has she done to establish confidence in the work of the health department. If, unfortunately, an infection or some other accident befalls a patient, the department has the several layworkers who assisted, defending the work of the staff. They know how carefully the technique was carried out--they helped do it. How often the opportunity to make not only real friends but real fighters for the cause of public health has been neglected, because it is easier to do the work than to teach someone else."

Our present way of recording in a Public Health Department is very much as follows:

Family Name (Last)			(First)		P. O. Address	
Given Name	Dates and Types of Service					
	Admitted	Dismissed	Type	Admitted	Dismissed	Type

Oregon State Board of Health 10-41 Index Card Form No. 2

Index Card No. 2

This is a Family Index Card and is designed to make it unnecessary to have a separate card for each member of the family being given service by the health department. In this way, time and filing space will be saved. The index card is the first reference to consider in looking up any recorded activity of the health department. This card is intended as a family index, as well as an individual index, where there is but a single member given service. It gives the family name and the post office accress. The address is repeated usually on the record and may be helpful should there be two heads of families with the same surname as well as given name. This card has the given name for each member receiving service, date admitted, date dismissed, and type of service. The above information is usually sufficient to tell where the record is to be found, but if not, a note should be added giving the location of the record form.

In instances where it is rather certain that only one visit is to be made to a family and that the family is not likely to receive recurrent visits, an index card may be used for the entire recording. The worker fills out the index card and on the back of the card makes the essential notations, indicating on the front of the card that data are on the back. The card is then given to the clerk for filing.

Family Folder No. 1

There have been many health records prepared with many variations. At the present time, simplicity seems to mark the most useful and popular record form. The Dean Committee took a plain sheet of paper and as a heading merely had space for identifying data. This form was adopted by the Oregon State Board of Health and is supplied to the various counties by them.

This record is used for the following services:

1. Communicable disease service.
2. Tuberculosis control.
3. Maternity service.
4. Infant and pre-school hygiene.
5. School hygiene.
6. Morbidity service (non-communicable diseases).
7. Sanitation

Here is provided a family folder that takes care of all the basic recording that is done for the family. Chronologically, every activity is listed in this one form or on the additional data sheets.

The exceptions to the use of this form are, for instance, if but a single call is made to a patient or a single office visit. In such a case it may be sufficient to note on the back of the index card the service rendered. Another exception is the venereal disease records. This work is nearly always done in the Health Department office. Immunizations and tests for immunity and school records are kept separate.

On the outside of the family folder, the family name for identification

Family Name

Address and Directions

Telephone

Family Physician

By Whom Referred

LIST FAMILY MEMBERS AND EXTRA-FAMILIAL CONTACTS PERTINENT TO SERVICES BEING GIVEN

Name	Date of Birth	Summary of Services and Dates						Other Information
		Type	Adm.	Dism.	Type	Adm.	Dism.	
F.								
M.								
Ch.								

Social, Economic and Environmental Notes

Name of Patient	Date	NOTES	Worker

purposes is written at the top of the left-hand side of the form. The family roster should include not only members of the immediate family who are living in the same house, but even in special cases, extra family contacts that are significant to the service being given to the family. "Summary of service and dates" gives at a glance an idea of services rendered. If an individual is being carried for several services, his name may be entered more than once. A second sheet is added as 1-A. Space is provided for social, economic, and environmental data. This information is necessary to have a correct understanding of the public health problem. Such information as the income, living conditions, mental intelligence, social standing, community relationships, religion, reaction of family to other members of the family, occupation of the working members of the family, and many other pertinent items may be noted. The notes on home and office visits begin on the inside of the record form. It is intended that this form should be used for all members of the family receiving public health service. The first column is labeled "Name of Patient." The given name is usually all that is written here. In the next column, the date. Then follows the notes on the patient. This can be written in narrative form. It is assumed that the worker has received the proper professional training that has emphasized the kind of service that is necessary. Here the health officer, the nurse, and the sanitarian all record their visits. This form helps to consolidate the health department as one activity and make for teamwork.

It is important that frequent conferences of all members of the department, and that every record, be gone over by the staff for constructive criticism in order that there may be created that unity

and mutual understanding of our various problems. There needs to be a mutual and sympathetic understanding of one another's problems, in order that each member of the department has the cooperative enthusiasm that is necessary to build a worth-while local public health department.

Communicable Disease Chronological Card No. 6

It is valuable and desirable to have a record of the communicable diseases in the community. The state Department of Health provides the above card for this purpose. Each case of communicable disease that comes to the attention of the health department should be recorded on this form. If the family physician looks after the patient, the simple noting of the disease on the card for recording cases is sufficient. If the health department gives the service, the case is admitted and a record made, either on an index card or in the family folder.

Only one disease is listed on each card. This gives a constantly available summary of the number of each disease during the year. If a line is drawn below the last case reported for each month, monthly totals are readily apparent. A new series of cards should be started at the beginning of each calendar year. These cards should be filed with the last card always at the front of the file.

DISEASE

NAME AND ADDRESS	AGE	SEX	PHYSICIAN	DATE REPORTED	IS THERE A CASE RECORD? YES — INDICATE FILE	NO

SURNAME | GIVEN NAME | DATE OF BIRTH

NAME OF PARENT | ADDRESS | SCHOOL

DATE	IMMUNIZATIONS						TESTS				
	S. POX	DIPH.	SC. F.	TYPH.	WH. C.	TICK	SCH.	DICK	TBC.	KAHN	OTHER

OREGON STATE BOARD OF HEALTH—5-41 IMMUNIZATION CARD FORM No. 3

Immunization Card No. 3

This card is designed for recording immunizations and tests and should be started when the first immunization is given a child. The date will be noted for each immunization or test. For instance, when a diphtheria immunization is completed, the date will be noted, and a (X) check will be placed after the date in the diphtheria column. This same card can be used for recording immunizations later in life for any other protection given the individual. It can be made a record of the individual from birth to death.

Some health departments, when offering the benefits of immunization to all the children in a school, make out a card for each student and the teacher; and the information recorded should be as complete as it can be made. If the individual receives no service, the card will indicate this by an absence of data. These cards should be filed alphabetically.

Venereal Disease Records Form No. 6

On the front page of the Venereal Disease Record is found space for recording data as to case identification, history, physical and contact investigation, while on the back of the record is space for recording treatment and reaction. It is essential that pertinent information be recorded as to the history of the case, treatment previously received, and physical examinations.

An Index Card should be prepared for each venereal disease patient just as for any other case carried by the health department. Dismissed cases should be filed with inactive Family Service Records.

Name | Age | M.F. | S. M. W. D. | Diagnosis

Address and Directions

Occupation | Case No.

Date of Exposure | Suspected Source

Date of Onset | Physician

Previous Treatment

History { Family—Past Illnesses—Obstetrical—Head—Eyes—Ears.
Cardio-respiratory—Gastro-intestinal—Genito-urinary—Neuromuscular—Osseous.

Physical Examination { Skin—Eyes—Ears—Mouth—Pharynx—Lungs—Heart.
Abdomen—Genitals—Lymphatic—Neurological—Extremities.

CONTACTS

NAME	ADDRESS	RELATIONSHIP	AGE	TEST	RES.	TEST	RES.	DISPOSITION

DATE	NOTES	WORKER

School Record Form No. 7

In an effort to reduce the amount of time needed to maintain the school records and in order to make school health data more readily available to the nurse while visiting in the school or in the home, a school work sheet Form No. 7 has been prepared for this purpose.

The schools have a record form to be kept and used by the teacher. The following record-keeping procedure is recommended:

1. Record findings of medical and dental examinations on the "school work sheet."
2. Transfer examination data from these sheets to the teacher's record.
3. For those students who will receive more than a single follow-up visit by the nurse, prepare a Family Service Record and record follow-up notes on it.

This work sheet the nurse may keep in a loose-leaf notebook the entire school year, and when the year is over, she files it for reference for the coming year. Then, when a new sheet is made for the new school year, the pertinent data can be transferred to the new school work sheet. This work sheet is valuable as a summary of the health conditions of the particular school it represents.

School ________ Grade ________ Teacher ________ 19____-19____ Year

Name, Address and Father's Name	Date of Birth	Dates and Results			Vision Test	Hearing Test	Medical and Nursing Findings	Dental Findings	Remarks
		Vacc.	Imm.	Tbc. Test					
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			

Utility Record Form No. 8

This form may be used by health department personnel in recording a variety of services for which none of the other records is especially appropriate. One of the uses of the form will be for general morbidity service performed by the health officer in non-communicable disease situations where family data are not significant, and for which a Family Service Record has, therefore, not been prepared. It may also be used by the sanitation officer as a form on which to record notes on his service. An Index Card should be made for each individual for whom a Utility Record is prepared.

NAME AGE DIAGNOSIS

ADDRESS OCCUPATION

REFERRED BY

DATE	NOTES	WORKER

STATE OF OREGON

UTILITY RECORD FORM NO. 8

Following this procedure the filing is rather simple.

I First of all is the index file--one complete alphabetical file. Then the family and individual case records, each family or individual record having all the data of the individual on it by any and all members of the department giving service to the case. These case records are in an alphabetical file and include all active cases in the:

II a. Family folders

b. Individual records

c. Communicable disease records

School records for children requiring supervision are usually included in the family record as are ante and post partum cases and non-communicable diseases.

Alongside this file, or in a file nearby, is the non-active file for these same records. As soon as a case is closed, the record should be transferred to the inactive file and later should a member of the family again require the same service as was rendered, or other services, the case can be opened again and the record returned to the active file. The transfer of all records to the inactive file is done on the beginning of the fiscal year. Then, as the case is seen again, the record is brought back to the active file, but no record is made of a dismissal. The case is merely counted again as a new case (although old) admitted during the year.

III Communicable disease file--communicable disease chronological card (Form No. 6) separate card or cards for each reportable disease.

IV Immunization card file Form No. 3--the immunization card file is an alphabetical file.

V Venereal disease file Form No. 6--this is a separate file and should be divided into:

a. Active cases

b. Delinquent cases

c. Cases on rest or on vacation

VI School work sheets are filed by number and name of school district for children not receiving recurrent supervision.

VII Child guidance file is a special file set up for this special activity, and the record of each child is kept on special blanks, and each patient's record and correspondence is kept in a separate folder and arranged alphabetically.

VIII The crippled children's file has set up a similar record system to that just described above for the Child Guidance Clinic.

IX A general correspondence file is arranged alphabetically. This correspondence, if it pertains to patients, should have a note added to the family or individual record in File No. II or No. V referring to the correspondence.

If this system is faithfully kept up-to-date and intelligent recording is done, it should be of real service and a time saver to the health department.

Recording and tabulating must never become the main objective of a health department, but must keep its place as the bookkeeping of those who do the public health work, and a picture and a summary of what we have accomplished and guide us to greater and even more useful activities.

TABULATIONS

The "recording" considered previously, has been basic local health department records only. The following pages deal with the tabulations that are made for local reports and, principally, for the reports to the State Board of Health and the Federal Government. Uniformity in reports is required from local health units if there is to be a worth-while basis for comparison. In the appendix we have included B-1427, which is the report form required by the United States Public Health Service and the United States Children's Bureau, also B-1431, Definitions and Instructions for Tabulations of Health Department Sources, approved by the State and Territorial Health Officers' Association, the United States Public Health Service, and the United States Children's Bureau. One other report form, included in the appendix, is used for the convenience it affords in making daily tabulations. It is labeled C-1427. Various items included in the appendix will be discussed on the following pages.

In discussing the basic record forms, we have dealt with the health department patient relations. By serving the individual, we are serving the community. Our records show service to individuals--records of immunizations, physical examinations, nursing visits. In fact, the results obtained are what we wish to evaluate. In 1935 at the annual meeting of the state and territorial health officers, a conference committee on Records and Reports was appointed to work out some forms of accounting of work done that would admit comparison. This committee gave us the definitions and instructions for tabulation for health departments in 1936. These instructions were quite satisfactory.

The general directions are very explicit setting forth the purpose

of the form: permissible adaptations, reporting procedure, reporting year, enumeration of individual and premises, enumeration of cases and admission, enumeration of individuals seen in groups, enumeration of procedure. Then is explained the use of the columns for the quarterly and annual reports. Then we read a general instruction on educational service. Education is the greatest special activity in all health work.

The "Tabulation of Health Department Services" of 1936 was an excellent guide, but it was hardly to be expected that there should not be some misinterpretations. In 1940, the State and Territorial Health Officer's Association, The United States Public Health Service, and the United States Children's Bureau approved the report of the Committee on Records and Reports and thus adopted the Revised Instructions (second section in appendix).

There is some criticism that so much of the work done is not recorded. For example, much preparatory and educational work is necessary in order to have a successful immunization program. This kind of work builds up public health sentiment, and spreads the information of disease prevention. But the one essential point that shows the result of the work is how many were immunized.

Under sanitation, a report from a county of Oregon is likely to look rather one-sided. The state law puts the protection of food and milk and restaurant inspection under the State Department of Agriculture.

These arrangements were made in the early days, possibly to help the farmers produce successfully and sanitation was given secondary consideration. However, should disease break out and the milk be suspected as the source, then, immediately, the problem becomes one for the health officer.

Or, should it appear that food handlers are, or are suspected of spreading disease either as carriers or through tainted food or because of insanitary conditions in a restaurant or other food handling establishments, then, clearly, it becomes the duty of the health department to make the necessary investigations.

To make the enumeration of activities easier, a form of activities report sheet is used by each member every day and is filled out, preferably as each activity is performed. The "code," which is the report form listing items uniformly as in the report form B-1427 is used in the enumeration. To save confusion in the tabulation, form C-1427 (see appendix) is used--one for each month for each individual worker. Each day, the activity report is transferred to this form. At the end of the month, the secretary adds all the C-1427's together, and the result constitutes the figures for the first month of the quarterly report, and similarly the second and third months' totals are assembled. The sum of these three makes the total for the quarter.

Daily Activities Report Sheet

ACTIVITIES REPORT

WORKER | DISTRICT | DAY AND DATE

CODE NO.	VOLUME	NAME AND PLACE	REMARKS

Guide for Reporting Daily Activities

COUNTY DEPARTMENT OF HEALTH ACTIVITIES REPORT

A. COMMUNICABLE DISEASE CONTROL

1. Admission to service
2. Consultations with Phys.

FIELD VISITS

3. Diphtheria
4. Typhoid, para
5. Scarlet Fever
6. Smallpox
7. Measles
8. Whooping Cough
9. Other (specify)

ADMISSIONS TO HOSPITALS

10. Diphtheria
11. Typhoid, para
12. Scarlet Fever

–(d) Serologic tests for syphilis before 5th mo. of pregnancy
–(e) Positive serologic tests
–(f) A. P. cases under syphilitic treatment

13-17 Omitted
18. Public lectures and talks
19. Attendance
20. Enrollment in maternity class
21. Attendance

–(c) Attendance

H. MORBIDITY SERVICE

1. Admissions to medical serv.
2. Admissions to nursing service

14. Anopheles breed. places eliminated
15. Anopheles breed. places controlled
16. Other service (specify)
–(a) Nuisances abated

----

17. Public lectures and talks
18. Attendance

13. Smallpox
14. Other (specify)

IMMUNIZATIONS

15. Smallpox
16. Diphtheria—under 1 year
17. Diphtheria—1 thru 4 years
18. Diphtheria—5 years and over
19. Typhoid Fever
20. Other service (specify)
–(a) Schick Test
–(b) Dick Test

----

21. Public lectures and talks
22. Attendance

(–) Indivs. dismissed from nur. ser.
3. Visits to med. conference
4. Visits to private phys.
5. Field nursing visits
6. Office nursing visits
7. Other service (specify)

Preschool:

8. Indivs. admitted to med. ser.

I. CRIPPLED CHILDREN SERVICE

1. Indivs. reported
2. Indivs. examined at diagnostic clinic

L. LABORATORY SPECIMENS EXAMINED

1. Water—bacteriological
2. Water—chemical
3. Milk or milk products
4. Other food

SUMMARY AND CONCLUSIONS

The early recorded activities relating to public health were vital statistics. Deaths were first made a matter of official record in the United States and, later, births. The reporting of communicable diseases became a requirement as the spreading of disease due to bacteria or viruses became understood. Laws were passed requiring that physicians report any communicable disease which he diagnosed or treated.

In our present health record forms in Oregon, an attempt has been made to present a simple method and a brief way of recording and tabulating the activities of the various departments. It is only necessary to record or tabulate that which contributes either to better care of the patient or is valuable for statistical purposes.

The forms are simple and can be used by the average county health department personnel. The main form, the family folder, is a plain piece of paper ruled and headed by identifying data. The recording consists of the purpose of the call, what he did, and what were the results. The essential points must be kept in mind and in a properly conducted health department where these records are reviewed and criticized in an impersonal manner at monthly, or better, weekly conferences, thinking, interested, human effective health workers will more likely result than if each is left to work things out for himself.

The morbidity case, the communicable disease case, the venereal disease case, the tuberculosis patient, the school child, the pre-school child, the ante partum and post partum case, and the mental case, can all be written in an informative, concise and usually interesting manner. The visits of the sanitarian are added here (if the premises or families are

recorded in the family folder). The venereal disease cases are in a separate file, principally because this is a group treated in the office and regularly over a long period of time.

The index contains all cases ever admitted, and at a glance, one sees which case is not active and the classification under which it is listed. Using one index card for a family simplifies the matter.

The law requires that the child's physical records be kept in the school. Therefore, the school work sheet is of great value, as the nurse has a summary of each room or group. The defects are noted and children admitted to service are recorded in the family folder. This same work sheet is used throughout the year, and this same group gets another sheet for the next year; and the important information is transferred to the new sheet.

The communicable disease card is kept up-to-date and filed alphabetically. At a glance, one can see the immunization a child has been given or the disease that develops immunity.

These few forms give a fairly good picture of the work of the county health department, and at least gives one a sense of simplicity of the recording. Special forms may be used for special reports, for instance, a tuberculosis survey, a child hygiene study, a dental study, but these are special--the every day record that is for daily use is what we have attempted to explain. By diligent observance of the Revised Instructions, the use of the "code," and the daily activities sheets' enumeration, and form C-1427, no difficulty should be experienced in making the monthly, quarterly, and yearly summary form B-1427.

By the use of a weekly register of communicable diseases, these can

be easily tabulated, and so can the laboratory tests if noted as they are done.

The first aim of public health is the service of humanity which should be service to the individual and such service recorded.

A good record should give the worker a feeling of satisfaction, be useful as a source of knowledge of important and useful facts in the community, state and nation, and a step forward in the advancement of Public Health education, in general.

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APPENDIX

1. Tabulation Form, B-1427.
2. Tabulation of Health Department Services, 1940.
   (Revised Instructions)
3. Tabulation Form for Day and Month, C-1427.

B-1427

State ________ County or District ________

Population of Health Jurisdiction ________

Period ________ Year ________

A. COMMUNICABLE DISEASE CONTROL					
1. Admissions to service					
2. Consultations with physicians					
Field visits:					
3. Diptheria					
4. Typhoid fever and paratyphoid fever					
5. Scarlet fever					
6. Smallpox					
7. Measles					
8. Whooping cough					
9. Other (specify)					
Admissions to hospitals:					
10. Diphtheria					
11. Typhoid fever and paratyphoid fever					
12. Scarlet fever					
13. Smallpox					
14. Other (specify)					

Tabulation of Health Department Services
Approved by: State and Territorial Health Officers
United States Public Health Service
United States Children's Bureau

Form No. ________

Approved 1936

State ______________ County or District ______________ Period ______________ Year ______________

A. COMMUNICABLE DISEASE CONTROL (Continued)					
Immunizations (persons immunized):					
15. Smallpox					
16. Diphtheria - under 1 year					
17. Diphtheria - 1 through 4 years					
18. Diphtheria - 5 years and over					
19. Typhoid fever					
20. Other (specify)					
21. Public lectures and talks					
22. Attendance					
B. VENERAL DISEASE CONTROL					
1. Admissions to medical service					
2. Cases transferred to private physicians					
3. Clinic visits					
4. Field visits					
5. Other service (specify)					
6. Public lectures and talks					
7. Attendance					

B-1427

State______ County or District______ Period______ Year______

C. TUBERCULOSIS CONTROL					
1. Individuals admitted to medical service					
2. Individuals admitted to nursing service					
3. Physical examinations in clinics					
4. X-ray examinations					
5. Clinic visits					
6. Visits to private physicians					
7. Field nursing visits					
8. Office nursing visits					
9. Admissions to sanatoria					
10. Other service (specify)					
11. Public lectures and talks					
12. Attendance					
D. MATERNITY SERVICE					
1. Cases admitted to antepartum medical service					
2. Cases admitted to antepartum nursing service					
3. Visits by antepartum cases to medical conferences					
4. Visits by antepartum cases to private physicians					
5. Field nursing visits to antepartum cases					
6. Office nursing visits by antepartum cases					
7. Cases attended by nurses for delivery service					
8. Cases given postpartum medical examination					
9. Cases given postpartum examination by private physicians					
10. Cases admitted to postpartum nursing service					

B-1427

State________ County or District________ Period________ Year________

D. MATERNITY SERVICE (Continued)					
11. Nursing visits to postpartum cases					
12. Other service (specify)					
....					
13. Midwives registered for formal instruction					
14. Midwife meetings					
15. Attendance at meetings					
16. Visits for midwife supervision					
17. Other service (specify)					
....					
18. Public lectures and talks					
19. Attendance					
20. Enrollment in maternity classes					
21. Attendance					
E. INFANT AND PRESCHOOL HYGIENE					
Infants:					
1. Individuals admitted to medical service					
2. Individuals admitted to nursing service					
3. Visits to medical conferences					
4. Visits to private physicians					
5. Field nursing visits					
6. Office nursing visits					
7. Other service (specify)					

B-1427

State __________ County or District __________ Period __________ Year _____

E. INFANT AND PRESCHOOL HYGIENE (Continued)					
Preschool:					
8. Individuals admitted to medical service					
9. Individuals admitted to nursing service					
10. Visits to medical conferences					
11. Visits to private physicians					
12. Field nursing visits					
13. Office nursing visits					
14. Inspections by dentists or dental hygienists					
15. Prophylaxis by dentists or dental hygienists					
16. Other service (specify)					
....					
17. Public lectures and talks					
18. Attendance					
19. Enrollment in infant and preschool classes					
20. Attendance					
F. SCHOOL HYGIENE					
1. Inspections by physicians or nurses					
2. Examinations by physicians					
3. Examinations by physicians with parents present					
4. Individuals admitted to nursing service					
5. Field nursing visits					
6. Office nursing visits					
7. Inspections by dentists or dental hygienists					
8. Prophylaxis by dentists or dental hygienists					
9. Other service (specify)					
....					

State ______ County or District ______ Period ______ Year ______

F. SCHOOL HYGIENE (Continued)					
10. Public lectures and talks					
11. Attendance					
12. Classroom health talks					
13. Attendance					
G. ADULT HYGIENE					
Medical examinations:					
1. Milk-handlers					
2. Other food-handlers					
3. Midwives					
4. Teachers					
5. Other (specify)					
......					
H. MORBIDITY SERVICE					
1. Admissions to medical service					
2. Admissions to nursing service					
3. Clinic visits					
4. Field medical visits					
5. Field nursing visits					
6. Office nursing visits					

State ______ County or District ______ Period ______ Year ______

H. MORBIDITY SERVICE (Continued)					
7. Admissions to hospitals					
8. Total patient-days of hospital service					
9. Individuals admitted to dental service					
10. Refractions					
11. Tonsil and adenoid operations					
12. Other service (specify)					
......					
I. CRIPPLED CHILDREN SERVICE					
1. Individuals reported					
2. Individuals examined at diagnostic clinics					
3. Individuals treated					
4. Individuals admitted to nursing service					
5. Visits to diagnostic clinics					
6. Nursing visits					
7. Other service (specify)					
......					
8. Public lectures and talks					
9. Attendance					
J. GENERAL SANITATION					
1. Approved individual water supplies installed					
2. New privies installed					
3. New septic tanks installed					

B-1427

State________ County or District________ Period________ Year____

J. GENERAL SANITATION (Continued)					
Field visits:					
4. Private premises					
5. Camp sites					
6. Swimming pools					
7. Barber shops and beauty parlors					
8. Schools					
9. Public water supplies					
10. Sewerage plants					
11. Other (specify)					
12. Buildings mosquito proofed					
13. Minor drainnage - linear feet completed					
14. Anopheles breeding places eliminated					
15. Anopheles breeding places controlled					
16. Other service (specify)					
17. Public lectures and talks					
18. Attendance					

State ______ County or District ______ Period ______ Year ______

K. PROTECTION OF FOOD AND MILK					
1. Food-handling establishments registered for supervision					
2. Field visits to food-handling establishments					
3. Dairy farms registered for supervision					
4. Field visits to dairy farms					
5. Milk plants registered for supervision					
6. Field visits to milk plants					
7. Cow tuberculin tested					
8. Animals slaughtered under inspection					
9. Carcasses condemned in whole or in part					
10. Other service (specify)					
11. Public lectures and talks					
12. Attendance					
L. LABORATORY					
Specimens examined:					
1. Water - bacteriological					
2. Water - chemical					
3. Milk or milk products					
4. Other food					
5. Typhoid: blood cultures					
6. Typhoid: Widal					
7. Typhoid: stool cultures					
8. Typhoid: urine cultures					
9. Diphtheria cultures					
10. Syphilis					

B-1427

State__________ County or District__________ Period__________ Year____

L. LABORATORY (Continued)					
11. Undulant fever (human)					
12. Bangs disease (animal)					
13. Typhus fever					
14. Tularemia					
15. Malaria					
16. Gonorrhea					
17. Tuberculosis					
18. Feces for parasites					
19. Urinalysis					
20. Rabies					
21. Other service (specify)					

__________ Health Officer

__________)
__________) Address

__________ Date

B-1427

State ____________ County or District ____________

Population of Health Jurisdiction ____________

Period ____________ Year ________

REPORTABLE DISEASES					
Anthrax (20)					
Chickenpox (44a)					
Diphtheria (10)					
Dysentery (13)					
Gonorrhea (35)					
Hookworm (40)					
Influenza (11)					
Malaria (38)					
Measles (7)					
Meningococcus meningitis (18)					
Ophthalmia neonatorum (35)					
Pellagra (62)					
Pneumonia (107-109)					
Poliomyelitis (16)					
Puerperal septicemia (145)					
Rabies in man (21)					
Rabies in animal					
Scarlet fever (8)					
Smallpox (6)					
Streptococcic sore throat (115a)					

Tabulation of Reportable Diseases
Approved by: State and Territorial Health Officers
United States Public Health Service
United States Children's Bureau

B-1427

Form No. ________

Approved 1936

State ____________ County or District ____________ Period ____________ Year ______

REPORTABLE DISEASES (Continued)					
Syphilis (34)					
Trachoma (38)					
Tuberculosis (23-32)					
Tularemia (44c)					
Typhoid fever (1)					
Typhus fever (3)					
Undulant fever (5)					
Whooping cough (9)					

____________ Health Officer

____________)
____________)Address

____________ Date

B-1427

TABULATION OF HEALTH DEPARTMENT SERVICES
REVISED INSTRUCTIONS

Approved by the State and Territorial Health Officers,

United States Health Service and

the United States Children's Bureau, 1940

- - -

Personal note

Instructions to be followed by

Daily report of

DEFINITION AND INSTRUCTIONS FOR TABULATION OF HEALTH DEPARTMENT SERVICES

General Directions

PURPOSE OF FORM

The tabulation form to which these instructions apply is an instrument devised to assist health department personnel to judge the merits of their programs. It is not the purpose of this form to carry a report of all the activities of a local health agency. The intent is rather to gather a limited amount of information useful to supervisory personnel in judging what an agency's performancy has been and in determining what changes should be made.

Use of the report form will provide some of the information necessary for the computation of health indices valuable in comparing the performances of health departments.

ADAPTATIONS OF THE FORM

All items on the tabulation form may be required for reporting to a State or Federal agency, or at the discretion of the agency concerned (as with the current reports of the United States Public Health Service and the United States Children's Bureau), selected items may be used in lieu of the complete tabulation. In the event any service described by a section of the tabulation is not included in the local program, that particular section obviously need not be completed. However, there should be no change in the wording or numbering of the items on the form except as approved by the State and Territorial health officers, the United States Public Health Service, and the United States Children's Bureau. It is understood, of course, that items which identify the report, describe the area and provide for the signature of the health officer should appear on any modified form just as they do on the tabulation form. Suggestions for altering the form or definitions and instructions will be welcomed by the chairman of the Committee on Records and Reports and should be sent to him in order that they may be considered in the future when revisions are under discussion.

COUNTY OR DISTRICT

The same name should be applied to the county or district that appears on the budget filed with the State health department or other contributing agency, so that the various agencies using these reports may correlate information from several sources.

POPULATION OF HEALTH JURISDICTION

This calls for the number of people living within the jurisdiction of the health department or other agency whose activities are enumerated in this report. For example, if a county contains a town or city whose health work is not included in the report because of separate jurisdiction, then the population listed should be for the area served. The report form should also state what civil divisions have been excluded.

WHOSE ACTIVITIES ARE TO BE COUNTED

The tabulation is intended primarily to express: (1) service performed by the staff of the local health department, (2) service performed by other agencies if supervised or financed in whole or in part by the health department, and (3) action taken by citizens in observance of health laws or upon recommendation of the health department.

The tabulation is also intended to include a limited number of services which are complementary to the program of the health department, such as designated activities of private physicians and hospitalization of communicable disease and tuberculosis cases. These services are to be included irrespective of where budgetary or administrative responsibility may reside. When a private physician participates, under direction, in a program which is administered by the health department, his service is recorded in the same manner as prescribed for that of a regular staff member. A service of a physician to a private patient or health department client may be included where indicated on the tabulation form (visits to private physicians), provided an entry of the service is made on the record of the individual served and is filed by the physician in the health department.

REPORT YEAR

The calendar year should be used as the report year. For purposes of tabulation enumerations are begun anew each year with the first service given. A person who is under care, supervision, or instruction at the close of one year, and who returns at any time during the following year is then considered new and should be counted again. For a comparable count of "admissions to service" as defined below this rule is mandatory. The principle just described also applies to premises under sanitation services.

IDENTIFICATION OF QUARTER REPORTED

The month or months in which the activities reported were performed should be inserted. Reports prepared for the Federal agencies should also be identified as to the quarterly period covered by the report. Thus a report for the second quarter in a report year starting January 1 should be labeled as follows: April, May, June, 2nd quarter.

ENUMERATION OF INDIVIDUALS, PREMISES, AND CASES

The counts included in the tabulation are based on certain procedures through which services are furnished--inspections, examinations, treatments, and visits. There are two varieties of situations to be enumerated. One is a situation in which the interest is in the number of persons (or premises) dealt with, the other is a situation in which the interest is in the condition rather than the person. Thus the tabulation calls for a count of individuals when child hygiene or tuberculosis control or care of crippled children or such long-time services are being enumerated. A count of cases is made when referring to conditions such as pregnancy or acute communicable disease which are usually of shorter duration.

This means that a given person would be counted only once during a year as having tuberculosis control service but might be counted as having two cases of communicable disease. The same person could also be carried for child hygiene service and during the same period of time be given service as a case of acute communicable disease. Moreover, a woman during the time she was receiving maternity service could also receive tuberculosis control service.

ADMISSIONS TO SERVICE

The term "admitted to service" is applied to individuals, premises, and to cases. An admission is counted each time an individual (or premises) or case receives his first visit during the year. Thus for each individual, each premises, and each case served during the report year one admission is counted. Since admissions constitute first visits, a visit should also be counted every time an admission to service occurs.

Examples of how admissions are counted in certain circumstances are:

An individual who has been counted as an admission to infant hygiene and has been discharged because he has become of preschool age during the same year, would be counted as an admission to preschool hygiene when he receives the next service.

An individual previously counted as an admission under tuberculosis control who becomes pregnant and is given service for this condition during the same year should be counted also as a case admitted to antepartum medical or nursing service or both.

An individual may be admitted twice during the year to maternity service if a second pregnancy occurs during the year.

An individual who has been counted as an admission to service for a given condition such as pneumonia, and has been discharged and has another attack of the same or another disease within the year should be then counted as another admission.

VISITS AND OTHER PROCEDURES TO BE COUNTED

Visits, inspections, examinations, treatments, and similar procedures to be counted should meet the following criteria:

1. The service is given by an individual with the professional training required for performing the service.
2. The service is recorded on a case record of the individual (or premises) served, or on an index card sometimes used in place of the more elaborate case record. Services given to groups will not be counted unless a case or index record is made out for each person counted.

The following rules pertain to the method of counting the various procedures:

1. A call at a home by one staff member is counted as one visit if service is given to only one person, as two visits if two persons are served, and so on, provided an entry is made on the record of each individual.
2. A single contact with an individual by one staff member is counted only once. Even if two or more types of service are performed, only one service is to be counted according to the primary purpose of the visit. If a chronic or continuing condition, such as tuberculosis, is complicated by an acute condition, then the individual served is perferably counted as having received service for the acute condition.
3. A contact with an individual by two staff members during a given visit is counted as a service by one member only, preference being given to the staff member performing the major service.
4. A visit to an individual not home or not found, or a casual inquiry about the health of the individual or advice informally given should not be counted. This is not intended to exclude formal indirect contacts with an individual, such as a parent seen in behalf of a child, which service should be counted if recorded. Visits to cases not home or not found, although frequently recorded by agencies, are not to be counted in this tabulation of specified services.
5. A contact made by a technical supervisor should not be counted in this tabulation unless such contact provides a specified service to an individual or premises.
6. As a general rule, with regard to sanitary supervision, the premises form the basis for enumerating field visits. However, when the visit involves premises with several utilities, such as an hotel having a restaurant, a barber shop, and a swimming pool or such as an amusement park having nu-

merous concessions, a separate record is made of each utility or concession seen for a definite purpose and each contact is counted as a separate visit.

RELATION OF "ADMISSIONS TO SERVICE" AND "VISITS"

Because of the rather frequent misunderstanding in the past regarding the counts of admissions to service and the counts of visits, it is important that the following points be emphasized:

1. An individual or case should be counted as an admission only at the time the first visit is made for a specified type of service during the year. No admission is to be counted unless there is service recorded on an index or case record.

2. Conversely, whenever an individual or case is counted as an admission to a specified type of service, a visit should be counted at the same time for the same type of service. The count of visits is to include these first visits as well as later visits. Since a visit is counted at the time of admission, the count of admissions to a given type of service can never exceed the count of visits for the same type of service.

The same relationship exists between the reporting of premises under sanitary supervision and the count of premises registered and visits to such places.

CHECKING PROCEDURES

Before the tabulation sheets leave the local health department offices, certain clerical checks can and should be made. One of the simplist is based on the relationship between admissions and visits as stated above, the admissions accumulated from the beginning of the year should not be greater than the corresponding visits accumulated for the same period. The ratio of admissions to visits also will sometimes indicate to the supervisory staff errors in one or the other of the component counts. There are other relations between different phases of service that can be recognized in a similar way.

DEFINITION OF CERTAIN TERMS USED IN THE TABULATION

1. A medical conference may be described as a contact of an individual with a physician in the health department office or in a field station for the discussion of a personal health problem. A station of the health department is any place where a full or part-time member of the health department staff receives individuals for professional service. It may be the health department office, a school building, a church, a mobile unit, etc. A visit to a private physician's office does not fall in this category.

2. Visits to private physicians refer to visits by cases when the service provided is reported by the physician to the health department and is recorded there on an individual record. As a rule, these individuals will also be receiving some service, commonly nursing, from the health department.

3. Office, clinic, or conference visits are contacts made by health department personnel with individuals in stations of the health department. Clinic or conference visits as used in the tabulation refer to medical services. Services provided by nurses at a conference where patients are not seen by a physician should be counted as office nursing visits. A specific service, other than an inspection, to an individual school child in school by a nurse is not considered as a field visit but as an office visit since the school is a station of the health department. An inspection of a school child would not be counted as a visit to the nurse.

4. Field visits are contacts made by health department personnel with premises or with individuals in their homes, or at places other than stations of the health department.

5. Educational services represent particularly certain procedures susceptible

to mass application although it is presumed that an educational influence pervades the whole program of the health department. The following particular procedures are set apart for special entry in the Tabulation of Health Department Services.

A "public lecture" or a "talk" is construed to mean the orderly presentation of information to a group. A classroom health talk is not to be included, as this type of instruction is an integral part of the school health program and should be tabulated separately. Attendance should be computed as accurately as possible.

A health class is more formal in character than a lecture or a talk; the term "class" implies that a definite number of individuals have agreed to pursue a course of instruction extending over a number of sessions. Attendance is the sum of the number present at each session during the period under consideration.

6. Registration for supervision is in effect admitting a premises to service. A premises is registered but once in a report year for a specified service and the registration is counted at the time the first inspection is made within the year.

SPECIFIC ITEMS

All items appearing in the Tabulation of Health Department Services are not included in the definitions which follow. Those items not included are considered self-explanatory. At several places throughout the tabulation the classification "other service" appears. This item should be used with restraint. Careful consideration of classification will often show that the service can be put into one of the other items. The "other service" classification will be useful in reporting some specific function of a particular local unit which is not common to all areas. This tabulation is not designed to account for all services of, or for the entire time of, local health department staffs.

A. COMMUNICABLE DISEASE CONTROL

1. Admissions to service include persons who are ill with communicable disease, who are suspected of having communicable disease, or who are carriers of the causative organism, provided these persons are seen by the staff of the health department in the home for purposes of care or control. Care should be taken in instances when a case is visited by the nurse at one time and by the Health Officer at another time that only one admission to service is counted. Those receiving immunization services only, are not counted under this item.

2. Consultations with physicians are visits by health department physicians to patients under the care of private physicians for purposes of assisting in the establishment of diagnoses or of giving professional advice of any type to the physicians in charge of the cases.

3-9. Field visits refer only to those made by members of the health department staff to diagnosed or suspected cases and to carriers. Spread and source contacts should not be included unless the visits reveal diagnosed or suspected cases or carriers. Treatments given to patients in a health department station for intestinal parasites are not to be enumerated under this item. Communicable disease visits should be classified according to the disease which the doctor or nurse, at the time of the visit, believes to be the cause of the illness.

10-14. Admissions to hospitals should include all cases and carriers of acute communicable disease hospitalized, irrespective of the agencies operating the hospitals or of the influence of the health department in securing admissions.

15-20. Immunizations refer to those persons who received the approved dos-

age of the appropriate agent for active immunization. If more than one injection is required, the person should not be counted until the series is completed. For tabulation purposes, it is not necessary that immunity be confirmed by a test, although it may be desirable practice. Immunization service may be recorded when the work is performed by the health department or when performed by any other agent, provided pertinent facts are entered in the health department record for the individual immunized.

B. VENEREAL DISEASE CONTROL

1. Admissions to medical service include persons admitted for diagnosis and/or treatment at stations of the health department. Prenatal cases, food-handlers, dairymen, and other persons on whom serodiagnostic tests or urethral or cervical smears are made as part of routine physical examination are not included unless formally admitted to venereal disease clinic facilities of the health department. Persons given prophylaxis for the prevention of venereal disease or advice in regard to sex hygiene are not included in this category but may be enumerated under "other service" (B 5).

2. Cases transferred to private physicians are those included in the preceding item who are actually transferred to private physicians for treatment of venereal disease.

3. Clinic visits are counted only if for diagnosis and/or treatment at health department clinics.

4. Field visits include all visits by the health department personnel for purposes of control or care of venereal disease patients, contacts, and sources of infection.

C. TUBERCULOSIS CONTROL

1. Individuals admitted to medical service include ambulatory patients admitted to diagnostic and/or treatment stations of the health department.

2. Individuals admitted to nursing service are all diagnosed, arrested, and suspected cases visited by health department nurses. Contacts and persons with the childhood type of infection may be included if they are under active supervision and if definite service is given.

A "contact", for purposes of tabulation, is an individual admitted to service because of close association with a diagnosed or suspected case of tuberculosis. A "suspect" is a person on whom a positive diagnosis has not been made but who is placed under observation. An arrested case is classed as a suspect.

3. Physical examinations in clinics comprise all examinations and reexaminations, regardless of physical findings, made at health department diagnostic stations. Such examinations may be for diganosis or check on the progress of the disease. Examinations of contacts, suspects, and persons with the childhood type of disease should be included. The number of examinations rather than of individuals forms the basis of enumeration.

4. X-ray examinations should be counted according to the principle outlined under "Physical examinations" (C 3), and counted irrespective of an accompanying physical examination.

5, 6, 7, 8. Clinic visits, field nursing visits, and office nursing visits refer to service contacts made between the health department staff and diagnosed, suspected, or arrested cases of tuberculosis. Visits to or by contacts and persons with the childhood type of infection may be included if active supervision is being exercised and if definite service is given during the visits.

9. Admissions to sanatoria include all residents of the area who have tu-

berculosis and are admitted to any sanatorium or hospital either in the area or outside the area, irrespective of the agency or person responsible for admission of the patients. Admissions of non-resident patients to sanatoria or hospitals within the area are not counted in local health department work.

D. MATERNITY SERVICE

1. Cases admitted to antepartum medical service include only those given services by physicians employed full-time or part-time or supervised by the health department. Partial services, such as urinalysis or blood pressure reading, by nonmedical attendants are not counted under this item.

6. Office nursing visits by antepartum cases are those visits to the health department nurse, in which individual advisory services are provided.

7. Cases given nursing service at delivery refer to those deliveries at which a nurse employed or supervised by the health department acted as an assistant to the attendant. Only one nursing service should be counted in connection with one delivery. A separate count of the infant should not be made at this time, and, furthermore, although the nurse may stay for a time, leave, and return several times during labor, or another nurse may relieve her during labor, this is still to be counted as only one delivery visit and no count should be recorded unless the nurse is present at time of delivery. Individuals given nursing service at delivery should not be counted as receiving antepartum or postpartum nursing service during labor or at time of delivery.

10. Cases admitted to postpartum nursing service should include all individuals who received nursing care within the six weeks' period following delivery.

13. Midwives under planned instruction are the number of lay women who regularly engage in obstetrical practice and who have registered for organized courses of instruction. They are not to be included unless they are in regular attendance at courses conducted by the health department.

14. Midwife meetings are less formal in character than midwife classes. A staff member of the health department or some other person approved by the health officer must preside if this item is to be tabulated.

16. Visits for midwife supervision are made by members of the health department medical or nursing staff to supervise the practice of individual midwives. This includes observation at time of delivery.

CLASSIFICATION OF CHILDREN FOR HYGIENE SERVICE

For purposes of classifying service to children-

An "infant" is a child under 1 year of age.

A "preschool child" is a child between 1 and 6 years of age who is not attending grade school. A child under 6 years of age in a nursery school or kindergarten is counted as a preschool child.

A "school child" is a child 6 years of age and under 15, regardless of whether he is attending school. If under 6 years but attending grade school, or if 15 years or over and attending school, count as a school child.

A child under continuous health supervision but passing from one age group to another during a calendar year is counted as an admission in each group at the time of the first service during the year in the group into which he has passed; that is, when transferring from infant to preschool or from preschool to school hygiene.

E. INFANT AND PRESCHOOL HYGIENE

Service to be recorded under this section is the usual prophylactic and

health promotion service connoted by the term "hygiene". Care of sick children and reparative dentistry are to be included in "Morbidity Service" (H). Measures for the control of communicable disease, tuberculosis, or venereal disease should be counted in the section devoted to these parts of the program.

1, 8. Infants admitted to medical service and preschool children admitted to medical service are to be counted only when such service is provided by physicians employed full time or part time or supervised by the health department.

2, 9. Infants admitted to nursing service and preschool children admitted to nursing service include infants and preschool children who receive field or office visits by nurses of the health department in the interest of health supervision. Infants given service by the nurse at the time of delivery should not be counted as admissions to infant nursing service. Infants should be admitted to service on first visit following birth.

6, 13. Office nursing visits are those of infants and preschool children to health department nurses, in which individual advisory services are given.

15. Propholaxis by dentists or dental hygienists includes services of the health department, such as the removal of calcareous deposits, cleaning of teeth, and the instruction of persons in care of the mouth.

F. SCHOOL HYGIENE

1. Inspections by physicians or nurses are those observations by health department physicians or nurses for detecting communicable disease, or conditions deviating from the normal, or checking on the correction of physical defects.

2. Examinations by physicians are the more formal types of examinations given by or supervised by the health department, such as those given at stated periods during school like to determine physical status and also the more extensive medical investigations given to students referred for examination because of some special health or behavior problem. The entry in this item should be the total number of examinations by physicians, whether with or without parents present. It will, therefore, include the examinations reported in item F-3. The number of examinations rather than the number of individuals forms the basis of enumeration.

3. Examinations by physicians with parents present (father, mother, or guardian), afford an opportunity for the physicians to discuss the findings with the parents. The examinations counted in this item should also be included in item F-2.

4. Individuals admitted to nursing service. See discussion of Relation of "Admissions to Service" and "Visits" on page 8.

5, 6. Field nursing visits and office nursing visits. See sections 3 and 4 on page 9.

G. ADULT HYGIENE

1-5. Physical examinations include those made by health department physicians of (1) persons engaged in occupations where freedom from certain diseases is required by the health authorities and (2) supposedly well adults who wish information of their physical condition. Laboratory tests or interim inspections for specific communicable diseases do not in themselves constitute a physical examination. The number of examinations rather than the number of individuals forms the basis of enumeration.

H. MORBIDITY SERVICE (Non-communicable disease service)

1, 2. Admissions to medical service and admissions to nursing service in-

clude persons who are provided with medical and/or nursing care on an ambulatory or domiciliary basis through facilities of the health department and who are not listed elsewhere in the tabulation. Care of inmates in penal and custodial institutions, exclusive of what may be regarded as hospital work, should be recorded under these items. The condition rather than the individual forms the basis of enumeration.

3, 4. Clinic visits and field medical visits are those made in the interest of medical care by or to physicians of the health department.

5, 6. Field nursing visits and office nursing visits are those made by or to nurses employed by the health department.

7. Admissions to hospitals include those patients admitted for medical, surgical or obstetrical care to hospital facilities of the health department. Only admissions to the hospital sections of penal and custodial institutions are to be counted in such institutions. The illness rather than the individual forms the basis of enumeration.

8. Patient-days of hospital service are the number of days' care provided in hospital facilities of the health department for medical, surgical or obstetrical patients.

9. Individuals admitted to dental service are to be counted only when reparative dental service has been provided by the health department.

10. 11. Refractions and tonsil and adenoid operations are terms used to describe corrective work performed in facilities of the health department for these physical defects of children. Other corrections are to be counted under "other service". (H 12).

I. CRIPPLED CHILDREN SERVICE

For the purposes of this tabulation, a "crippled child" is defined as any person under 21 years of age who has a physical disability or other type of deformity commonly connoted by the term "crippled".

The visits of the local nurses to crippled children should be so coded that counts of admissions to service and visits can be tabulated. The counts for other services for crippled children are reportable directly to the United States Children's Bureau on special report forms issued by this Bureau (CC-51 and CC-52) and therefore need not be included in this tabulation.

J. GENERAL SANITATION

1. 2, 3. Approved individual water supplies installed, new privies installed, and new septic tanks installed include those sanitary improvements made by or brought about by the health department. However, it must be understood that these items relate to new construction of individual water supplies and excreta disposal facilities which are not connected with the public system.

4-11. Field visits are synonymous with "inspections" as commonly used and include all visits by the health depastment personnel in the interest of sanitation. As was pointed out in "Enumeration of procedures," the count is usually based on the premises. However, in the case of a premises such as a hotel with several utilities or an amusement park having numerous concessions, a separate entry is made on the record of each utility or concession seen for a definite purpose and each contact is counted as a separate visit.

12. Buildings mosquito proofed refer to buildings where people congregate or reside which the health department has been instrumental in making mosquito proof by screening with 16-mesh wire and by stoppage of cracks and holes through which mosquitos might enter.

14. Anopheles breeding places eliminated refer to depressions where water normally collects and which the health department has succeeded in having filled

or drained for the purpose of permanently preventing the breeding of mosquitoes.

15. Anopheles breeding places controlled refer to natural and artificial collections of water which through the efforts of the health department have been treated with approved larvicides for the purpose of preventing breeding of mosquitoes.

K. PROTECTION OF FOOD AND MILK

1. Food-handling establishments registered for supervision comprise the number of places at which food or beverages are produced, processed, or dispensed, and over which the health department regularly exercises sanitary control. Establishments can be registered but once each year, and then only if a complete survey of each premises is made and the findings are recorded. The registration is regarded as an admission to service, consequently the premises is enumerated only at the time of the first visit in the year.

3. Dairy farms registered for supervision include only farms producing milk under provision of milk regulations or ordinances and receiving at least one complete inspection by the health department during the year. As described for food-handling establishments, the registration is counted at the time the first inspection is made.

5. Milk plants registered for supervision are to be considered in the same manner as "Food-handling establishments." The term "milk plants" applies to pasteurizing plants, milk depots, cheese factories, creameries, ice cream factories, and other similar places. The registration is counted at the time the first inspection is made.

7. Cows tuberculin tested include those tested by veterinarians of the health department, and by other veterinarians when testing is required by local milk ordinances.

8. Animals slaughtered under inspection are those animals slaughtered for food under competent antemortem and postmortem inspections by the health department.

9. Carcasses condemned in whole or in part are those condemned by the health department and disposed of in an approved manner.

L. LABORATORY SERVICE

1-21. Specimens examined are those examined by the health department laboratory and/or by other laboratories for the health department.

DEFINITIONS AND INSTRUCTIONS FOR TABULATION OF REPORTABLE DISEASES

Source of list.--The diseases affecting man which appear on the tabulation form are selected from those in the International List of Causes of Death, fourth revision, 1929. The figures in parentheses after the diseases are the International List numbers.

Method of enumeration.--Only reportable diseases coming to the attention of the health department are to be included. A case reported by a school authority, householder, nurse, or other non-medical person is to be regarded as a suspect until the diagnosis has been established and the case is reported by an attending physician or a medical officer of the health department. A report by a veterinarian is accepted for a disease in an animal. A positive laboratory finding alone is not to be accepted in lieu of a clinical diagnosis by a physician, or by a veterinarian if the condition occurs in animals. If any disease listed on the form is not reportable in the State, the omission should be accounted for by placing in the first column opposite the disease the letters N.R. (not reportable).

COUNTY DEPARTMENT OF HEALTH ACTIVITIES REPORT

A. COMMUNICABLE DISEASE CONTROL

1. Admission to service
2. Consultations with Phys.

FIELD VISITS

3. Diphtheria
4. Typhoid, para
5. Scarlet Fever
6. Smallpox
7. Measles
8. Whooping Cough
9. Other (specify)

ADMISSIONS TO HOSPITALS

10. Diphtheria
11. Typhoid, para
12. Scarlet Fever
13. Smallpox
14. Other (specify)

IMMUNIZATIONS

15. Smallpox
16. Diphtheria--under 1 year
17. Diphtheria--1 thru 4 years
18. Diphtheria--5 years and over
19. Typhoid Fever
20. Other service (specify)
-(a) Schick Test
-(b) Dick Test
21. Public Lectures and Talks
22. Attendance

B. VENEREAL DISEASE CONTROL

1. Admissions to medical service
2. Cases transferred to Priv. phys.
3. Clinic visits
4. Field visits
5. Other (specify)
6. Public Lectures and Talks
7. Attendance

C. TUBERCULOSIS CONTROL

1. Individ. admitted to med. serv.
2. Individ. admitted to nur. ser.
-(a) Cases dismissed
3. Physical exam. in clinics
4. X-ray examinations
5. Clinic visits
6. Visits to private physicians
7. Field nursing visits
8. Office nursing visits
9. Admissions to Sanatoria
10. Other service (specify)
-(a) Tuberculin tests given
-(b) Positive reactions
-(c) Medical field visits
11. Public lectures and talks
12. Attendance

D. MATERNITY SERVICE

1. Cases admitted to A.P. med. ser.
2. Cases admitted to A.P. nur. ser.
-(a) Cases dismissed from A.P. nur. ser.
3. Visits by A.P. cases to med. conf.
4. Visits by A.P. cases to Pri. Phys.
5. Field nurs. visits to A.P. cases
6. Office nur. visits by A.P. cases
7. Cases attended by nurse for del. ser.
8. Cases given P.P. medical exam.
9. Cases given P.P. exam by private physician
10. Cases admitted to P.P. nur. ser.
-(a) Cases dismissed from P.P. nur. ser.
11. Nursing visits to P.P. cases
12. Other service (specify)
-(a) Cases having exam. by dentists
-(b) A.P. medical field visits
-(c) Cases given med. delivery service
-(d) Serologic tests for syphilis before 5th mo. of pregnancy
-(e) Positive serologic tests
-(f) A.P. cases under syphilitic treatment
13-17 Omitted
18. Public lectures and talks
19. Attendance
20. Enrollment in maternity class
21. Attendance
-(a) Sessions held
22. Admissions to medical service

E. INFANT AND PRESCHOOL HYGIENE

Infants:

1. Indivs. admitted to med. ser.
2. Indivs. admitted to nurs. serv.
-(a) Under 1 month of age
-(b) Indivs. dismissed from nur. ser.
3. Visits to med. conference
4. Visits to private Phys.
5. Field nursing visits
6. Other nursing visits
7. Other service (specify)

Preschool:

8. Indivs. admitted to med. ser.
9. Indivs. admitted to nur. ser.
-(a) Indivs. dismissed from nur. ser.
10. Visits to medical conference
11. Visits to private physicians
12. Field nursing visits
13. Office nursing visits
14. Inspections by dentists
15. Prophylaxis by dentists
16. Other service (specify)
-(a) Child Guidance Examinations
17. Public lectures and talks
18. Attendance
19. Enrollment in Inf. & Presch. Class

20. Attendance
21. Admissions to preventive dental service.

F. SCHOOL HYGIENE

1. Inspections by phys. or nurse
2. Examinations by physicians
3. Exam. by phys., parents present
4. Indivs. admitted to nurs. ser.
-(a) Indivs. dismissed from nurs. ser.
5. Field nursing visits
6. Office nursing visits
7. Inspection by dentists
8. Prophylaxis by dentists
9. Other service (specify)
-(a) Vision tests
-(b) Hearing tests
-(c) Classes (specify)
-(d) Enrollment
-(e) Sessions held
-(f) Attendance
-(g) Child Guidance Examination
10. Public health lectures and talks
11. Attendance
12. Classroom health talks
13. Attendance
14. Admissions to preventive dental service

G. ADULT HYGIENE

Medical examinations
1. Milk-handlers
2. Other food-handlers
3. Midwives
4. Teachers
5. Other service (specify)
-(a) Mental hygiene examination
- Health Supervision
-(a) Admissions to nursing ser.
-(b) Dismissed from nur. ser.
-(c) Field nursing visits
-(d) Office nursing visits

H. MORBIDITY SERVICE

1. Admissions to medical serv.
2. Admissions to nursing service
-(a) Dismissed from nurs. ser.
3. Clinic visits
4. Field medical visits
5. Field nursing visits
6. Office nursing visits
7. Admission to hospital
8. Total days of hospital service
9. Indivs. admitted to dental ser.
10. Refractions
11. Tonsil and adenoid operations
12. Other service (specify)
-(a) Visits to dental clinic
-(b) Fillings made in dental clinic
-(c) Extractions done in dental clinic
-(d) Indiv. given complete care by dentist
13. Admissions to reparative dental servi...
14. Admissions to preschool
15. Admissions to school
16. Admissions to maternity
17. Others

I. CRIPPLED CHILDREN SERVICE

1. Individ. reported
2. Individs. examined at diagnostic clinic
3. Individs. treated
4. Individs. admitted to nur. ser.
-(a) Individs. dismissed from nur. ser.
5. Visits to diagnostic clinic
6. Nursing visits
7. Other service (specify)
8. Public lectures and talks
9. Attendance

J. GENERAL SANITATION

1. Approved individual water supplies installed
2. New privies installed
3. New septic tanks installed
Field Visits:
4. Private premises
5. Camp sites
6. Swimming pools
7. Barber shops and beauty parlors
8. Schools
9. Public water supplies
10. Sewage plants
11. Other (specify)
-(1. a) Priv. water supplies improved
-(5. a) Tourist
-(5. b) Industrial
-(5. c) Park
-(8. a) School water supplies impr.
-(8. b) School sewage disposal systems impr.
12. Bldgs. mosquite proofed
13. Minor drainage-ft. completed
14. Anopheles breed, places eliminated
15. Anopheles breed. places controlled
16. Other service (specify)
-(a) Nuisances abated
17. Public Lectures and Talks
18. Attendance

K. PROTECTION OF FOOD AND MILK

1. Food-handling estabs. registered
2. Field visits to food-hand. estab.
3. Dairy farms registered
4. Field visits to dairy farms
5. Milk plants regulated for supply
6. Field visits to milk plants
7. Cows tuberculin tested
8. Animals slaughtered under inspection

9. Carcasses condemned in whole or in part
10. Other service (specify)
-(7a) Abortion tests
-(7b) Mastitis tests
11. Public Lectures and Talks
12. Attendance

L. LABORATORY SPECIMENS EXAMINED

1. Water--bacteriological
2. Water--chemical
3. Milk or milk products
4. Other food
5. Typhoid: blood cultures
6. Typhoid: widal
7. Typhoid: stool cultures
8. Typhoid: urine cultures
9. Diphtheria cultures
10. Syphilis
11. Undulant fever (human)
12. Bangs disease (animal)
13. Typhus fever
14. Tularemia
15. Malaria
16. Gonorrhea
17. Tuberculosis
18. Feces for parasites
19. Urinalysis
20. Rabies
21. Other service (specify)

M. ADMINISTRATION

1. Interviews in behalf of service
2. Group meetings attended
-(a) County Health Association
-(b) Committee or Boards
-(c) Professional
-(d) Clinics attended by nurse
-(e) Other
3. Visits to cases not taken under care
4. Demonstrations given
5. Staff conferences attended
6. Publicity (specify)

RECORD FORMS

Form No. 1 - Family Service

Form No. 1A- Family Service Continuation

Form No. 2 - Index Card

Form No. 3 - Immunization Card

Form No. 5 - Venereal Disease Record

Form No. 6 - Communicable Disease Chronological Card

Form No. 7 - School Work Sheet

Form No. 8 - Utility Record

Name of Patient	Date	Notes	Worker

Family Name | Address and Directions

Telephone | Family Physician | By Whom Referred

LIST FAMILY MEMBERS AND EXTRA FAMILIAL CONTACTS PERTINENT TO SERVICES BEING GIVEN

Name	Date of Birth	Summary of Services and Dates						Other Information
		Type	Adm.	Dism.	Type	Adm.	Dism.	
F.								
M.								
Ch.								

Social, Economic and Environmental Notes

FAMILY SERVICE -- FORMS No's. 1 and 1A

This form is the basic record for all family health services. It is intended that it will replace the NOPHN Family Folder and practically all of the former basic service records. The form is not exclusively a nursing record; it is a health department record and may be used by any or all of the staff members. The form should be used for any of the following services;

1. Antepartum or postpartum medical or nursing service.
2. Infant or preschool medical or nursing service.
3. School service requiring follow-up (including all handicapped and crippled children).
4. Tuberculosis service--except tuberculin testing and follow-up of positive reactors prior to X-ray.

When a Family Service Record is already in use, the following services should be recorded in this folder:

1. Communicable Disease--Medical and nursing service.
2. Non-communicable Disease--Medical and nursing service.
3. Follow-up work on positive reactors to tuberculin tests.

In view of the fact that several staff members will be using these records, they must be filed in a single alphabetical file while active. The only exception to this is in instances where part of the service is performed on a conference or clinic basis in some place other than the health department office. The records of patients attending such clinics should be filed alphabetically by clinic group and a notation made on the index card telling where the record may be found.

When Family Service Records are closed because all service to that family has been discontinued--that is, no future visits are scheduled--the records should be taken from the active file and placed in a central inactive file. At the end of the calendar year all active cases are automatically dismissed, but this is purely a statistical procedure and does not indicate that all the records should be transferred to the inactive file.

In order to reduce the volume of notes to be read, to make it possible to remove sheets from the record, and to permit the nurse or doctor to review the cases and adjust their plans for future care, the data recorded on the Family Service Form should be summarized twice a year. The summary should be blocked off from previous recorded data by red lines and should contain a brief resume of services in the past and plans for future care. In following this procedure, the decision as to whether a folder is active should depend entirely upon whether or not another visit is scheduled to a member of the family.

EXAMPLE OF SUMMARY:

> *July 1941 The S. family has moved twice during the past year once back to California and are now living with Mr. S's parents in .... temporarily. Mrs. S. an arrested T.B. case apparently well--fluoroscope check up 4/11/41. Mr. S. working in mill regularly--never examined. Original source unknown--suspect Mr. S's parents. Future plans: Mary, age 5, and John, age 9, need chest re-examined October 1941. Special attention to diets of entire family.*

A. Face sheet information on Family Service Record

1. Family Identification
   a. Family name or individual name as needed.
   b. Address and directions for locating home. (All changes of address should be dated).

c. Telephone number used for communication with the patient.

d. Family physician.

e. By whom referred: Give name of agency or individual.

2. Family roster: Should include not only members of the immediate family who are living in the same house, but also extra-familial contacts (boarders, etc.)

3. Summary of services and dates. Each individual admitted for more than two types of service for which space is provided may be added at the end of the list of names when admitted to additional services. The suggested terminology for describing "Type of Service" follows roughly the classifications used in coding services.

Communicable Disease (except Tbc. and V.D.)	C.D.
Venereal Disease	V.D.
Tuberculosis case	Tbc. Case
Tuberculosis contact	Tbc. Con.
Tuberculosis suspect	Tbc. Susp.
Positive reactor to tuberculin test	Tbn. Pos.
Antepartum	A.P.
Delivery	Del.
Postpartum	P.P.
Infant	Inf.
Preschool	Pre. Sch.
School	Sch.
Crippled Child	C.C.
Morbidity	Morb.

Although most counties should find the above classification satisfactory, there appears to be no great disadvantage in permitting some flexibility in terminology.

4. Other information. Pertinent data relating to the type of service may indicate--results of tests, X-ray--stillbirths, date of death ("Died--1940"), or other significant information which can appear on the line.
Diagnosis of patient: For example, Tuberculosis Service:
Minimal (Pul. 1): mod. advanced (Pul. II) far advanced (Pul. III)

5. Social and economic and environmental notes:

a. Occupation of father or breadwinner: Regularity of work, nature of duties.

b. Income of family: List assets and financial liabilities. Known to public welfare agency or other. Specify agency.

c. Religion: State how it affects their reactions to public health.

d. Reactions of family to other members of the family: Kind of co-operation which family exhibits to health worker.

e. Community relationships: Church and other organizations.

f. Sanitation and housing: Source of water supply excreta disposal facilities, type of house, number of rooms, rent problems of ventilation, screening, food storage.

B. Record of service rendered to individuals

All notes on home, office or clinic visits, when other service record has not been provided, begin on the inside of the record form. All entries made on the reverse side of the record are dated and signed by the worker recording the information. It is intended that this form, whenever practical, should be used not for just one member of the family, but for all members who receive service. In view of this, the first column is labelled "Name of Patient", thereby making it convenient for the worker to pick out

previous notes on services given to any particular member of the family. The chronological aspects of the record are maintained by recording the date of visit in the same way that it has been in the past.

Notes concerning services to individuals in the family should be written in narrative form in as brief, yet adequate way as possible. It is assumed, in omitting from this record form any listing of particular conditions to be checked at each visit, that the worker in his or her professional training has acquired a knowledge of what things are important and necessary in giving patients the best possible kind of care.

As was stated before, this record is not solely a nursing record or solely a medical record, and therefore either the doctor, nurse, or sanitarian should use this same form when giving service to a particular family. Each worker, of course, should initial the notes which he or she writes. When the inside of the Family Service Record is completely filled with notes, the Family Service Continuation Record (Form No. 1A), which is included in this set of forms should be used. It is exactly the same as the inside of the Family Service Record.

GUIDE FOR RECORDING NURSING VISITS ON FAMILY SERVICE FOLDER 1 AND 1A

The following guide for Maternity, Child Health Supervision (Infant and Preschool), School, Tuberculosis, and Morbidity Services has been prepared for the use of the nurses who are responsible for data on the Family Service Record. Since this type of record is a radical departure from the record formerly in use, it is imperative that the worker should include pertinent material which will fulfill the purposes for which any record is intended. Experimental work with these records has shown that improvement in recording is the result of:

(1) Careful planning of the visit or conference and reviewing the purposes for which the visit is to be made;

(2) Describing briefly but clearly the actual nursing service rendered at the time of the visit;

(3) Affording an opportunity to other workers using the record a comprehensive picture of the health supervision rendered to members of the family or individual.

Each individual is entered chronologically, and notes should state:

1. Name of patient
2. Date of visit--a.m. or p.m. This information will affect the interpretation of other data.
   Field Visit-- F.V. Office Visit --O.V.
3. Significant facts regarding history of individual.
   Immunization--disease history--developmental history. (Complete data for each type of service will be appended.
4. Nursing care given:
   a. Suggested Code: Code following entries to eliminate the necessity of writing certain type of care understood to staffmembers.

      TPR: Temperature, pulse, respiration

      B.S. Care: Bedside care

      T: Treatment

      D: Demonstration

      DB: Demonstration bath

      DR: Demonstration returned

      N.B. Care: Newborn care

      HT: Height

      WT: Weight

   b. Include instruction and teaching: Present condition of patient, progress of condition, response to teaching, reaction of family and individual, recommendations and suggestions for care.
   c. Plan for next visit (date) and future supervision.
   d. Report of visit to doctor.
   e. Disposition of case when closed: Indicate patient's condition on dismissal from service. State condition: Whether patient is recovered, improved, unimproved, or is dead.

1. MATERNITY SERVICE

The maternity nursing record assists the nurse in the supervision of the case by helping her to be observant of all factors which affect the progress of the expectant mother. A complete and accurate record is an important tool in evaluating the services rendered and in making future plans for the family.

A. Significant facts regarding history of pregnancy.

1. Months of prenatal care.
2. Date when patient came under care of physician.
3. Home or hospital delivery; date of expected confinement.
4. Length of gestation: term or premature.
5. Number of children, if alive. How long breast-fed.
6. Cause of prematurity, stillbirth or death.
7. Complications of previous pregnancies (syphilis, cardiac).
8. Plans for delivery.

B. Nursing care and supervision.

ANTEPARTUM (AP)

1. Points for discussion:

   T.P.R., blood pressure and urinalysis (in accordance with standing orders), foetal movement, breasts and nipples, sleep and rest, fresh air, elimination, bath--clothing, teeth and dental care, dietary, signs of labor, family attitudes, foetal development, preparation for delivery (demonstration of care).

2. Observation for danger signals of pregnancy: Headache, dizziness, blurring of vision, edema--feeling of apprehension--dyspnoea--epigastric pain or "heartburn"--nausea, vomiting "time of occurrence"--vaginal discharge--vaginal bleeding.

DELIVERY (D)

1. Date, place, by whom delivered, type, hours in labor, sex and condition of newborn, weight, eye prophylaxis.
2. Complications of delivery (hemorrhage, breech presentation).

POSTPARTUM (PP)

1. Nursing care: Code usual items as indicated on Page 4. Note condition of fundus, breast and nipples, lochia, diet, mental attitude.
2. Note results of postpartum examination--whether dismissed as normal or if abnormalities were found.

II. CHILD HEALTH SUPERVISION (Infant--Preschool & School Age)

A child health supervision record assists the nurse in the supervision of well children by helping her to be observant of all factors which might affect the progress of a child toward physical and emotional maturity. This record, to be an effective tool, should contain some definite information.

A. Significant facts regarding history

1. Prenatal and natal conditions: Premature, normal, abnormal, condition of infant at birth, birth weight, birth registration, eye prophylaxis.
2. Developmental history: First sat up--walked--first tooth--first talked (formed sentences).
3. Disease experience: Diagnosis--nursing and/or medical care--immunization history.

B. Nursing care and supervision

1. Concise description of child's condition--General appearance: General build, posture, eyes, ears, nose, throat, teeth, skin, scalp, genitalia, umbilicus.
2. Hygiene: Regularity
   - (a) Sleep and rest (sleeping arrangement)
   - (b) Play--kind
   - (c) Elimination
3. Fresh air
4. Dietary habits
   Food: Kind, adequacy, food habits (interval, regularity, likes and dislikes.
5. Family relationships
   - (a) Compatibility of parents
   - (b) Attitudes

Normal emotional development consists in the progress of an individual from interest in himself and his mother to a gradually increasing number of other persons and things. A child's interests and attitudes furnish us at least a tentative opinion as to his emotional maturity, which may guide in the supervision of the child.

Certain common attitudes shown by children toward other persons and by other persons toward them are suggested below. These are suggestive only and are not to be used if, to the observer, some other word better expresses what is seen. Give an observed incident or remark, if possible, showing basis for the word used, whether the word is one given below or not. Observation plus the mother's or other informant's report is the basis for characterization.

FRIENDLY: A give and take relationship in which there is acceptance of authority, confidence of affection, reasonable assertion of own rights and acknowledgement of those of others.

SHY: Child hangs head, hides face, hides self, attempts in any way to escape contact with an individual.

INDIFFERENT: Gives impression of not caring for another individual--passively ignoring, not focussing upon him when he is discussed, eyeing him absent-mindedly.

ANTAGONISTIC: Active attitude toward another--scolding angrily, calling "dumb", treating with marked lack of consideration.

DOMINEERING: Unnecessary and constant demands upon another individual to conform or to show off. Insistence upon always having own way. The nagging mother or father and the child who rules the family can be so designated.

DEMONSTRATIVE: Excessive display of affection by child; fondling--"Smother love", on part of mother or father.

OVERSUBMISSIVE: One individual doing exactly as the other directs and showing practically no initiative; extremely suggestible.

OVERSOLICITOUS: Unnecessary concern over everything pertaining to another individual--marked apprehension for him--"looking for trouble". Marked curtailing of freedom through insistence on service to the other individual. In child to mother or child to siblings this attitude would be the extremely helpful one of the "Little mother" one.

EXHIBITIONISTIC: The child who demands constant attention and who "shows off" excessively.

6. Summary of mother's learning experience and response to demonstrations.

7. Plan for visit.

8. Use suggested code as indicated on Page 4.

   NBCare: Newborn care (under 1 month).

   DB: Demonstration bath.

Note: When child is sick, admit to morbidity for statistical purposes.

DISPOSITION OF CASE: When child passes from one age group to another, he is dismissed from the infant service and admitted to the preschool services. Summary of record should be made available to teacher when child enters school, and transferred to school health records.

III. SCHOOL SERVICE (Include Handicapped and Crippled Children of school age)

A. Significant facts regarding history of child

1. Present condition.
2. Previous history of difficulty or complaints, school progress, grade placement (i.e., retarded--advanced).
3. Treatment, including institutional or other care.
4. Under care at present?
5. What adjustment is child making? Indicate family relationships.
6. Disease and immunization history.

B. Nursing care and supervision.

1. Defects corrected or conditions under medical or dental treatment.
2. General hygiene: Sleep and rest, food habits, activities.
3. Summarize what was taught, reason for giving care, response to teaching.
4. Reports to physician.
5. Plan for next visit and future supervision.
6. Use suggested code as indicated on Page 4.

C. Relationship to revised Individual School Records furnished by State Department of Education.

1. It is suggested that all referred cases - "screened" by the teacher should be carried for continuous supervision until case is dismissed.

2. Review material in Section on "Index Card" Number 2 and "School Work Sheet" Form Number 7.

Index Card Number 2 Page 11

School Work Sheet Number 7 " 15

IV. TUBERCULOSIS SERVICE

Intelligent nursing supervision in the tuberculosis field required certain guideposts to be effective in the care, supervision, treatment, and rehabilitation of the tuberculosis case. These guideposts consist of data relating to the epidemiology, diagnosis and after-care of the case.

A. Significant facts in history of present illness:

1. State source of exposure, recency and duration, name and relationship to patient.
2. Hemorrhage, pneumonia, and other predisposing causes.
3. Medical care: Name of physician, sanitorium care (dates of admission and discharge), clinic, intervals of medical supervision (dates), medical findings, diagnosis, physicians orders.
4. Occupation of patient: Type of work, nature of duties.

B. Nursing care and supervision:

1. Present condition of patient.
   a. In bed or up; type of work.
   b. Symptoms: T. P. R., fatigue, hemoptysis, cough, hoarseness, night sweats, loss of weight, gastro-intestinal disorders, positive sputum (amount).
   c. Weight: Change of weight.
2. General hygiene and care
   a. Nutrition: Kind of food, adequacy, food habits, appetite.
   b. Cleanliness, disposal of sputum and left-over food, care of dishes and linen, ventilation, own bed--own room, sleep and rest, mental attitude, cooperation of patient.
3. Report to family or sanatorium physician.
4. Plan for next visit.
5. Plan for rehabilitation of patient: (Visit patient discharged from sanatorium within first month). Consider: Interests and aptitudes of patient, recommendations of physician and cooperating agency, facilities for retraining, notation of report to sanatorium.
6. Recording of supervision of family and extra-familial contacts (listed in family roster).

   Date of tuberculin test: Result (positive or negative)

   Date of X-ray (positive or negative)
7. Use suggested code as indicated on Page 4.

Family contacts of known tuberculosis cases are carried on the Family Service Record. Positive reactors not on Family Service Record are carried on the Index Card with entry of visit and findings.

V. MORBIDITY SERVICE (Communicable and non-communicable)

The purpose of a morbidity record is to provide the nurse with information which will insure continuous and satisfactory care and to aid in a constructive program for the patient and guide the nurse in health teaching.

A. Significant facts regarding history of illness

1. Source of infection
2. Diagnosis--name of physician
3. Treatment, includingpast institutional care, complications, condition of patient, symptoms, observation of physical condition, change of weight, fatigue.

B. Nursing care and supervision

1. Medical orders and recommendations concerning plan for care, activities isolation, prophylaxis.

   Results of blood tests, cardiographs, cultures, smears, urinalyses, X-ray examinations, etc.
2. General hygiene: Nutrition, sleeping arrangements, mental attitude,
3. Plan for future supervision.
4. Use suggested code: As indicated on Page 4.

FAMILY NAME (LAST)	(FIRST)	P. O. ADDRESS

GIVEN NAME	DATES AND TYPES OF SERVICE					
	ADMITTED	DISMISSED	TYPE	ADMITTED	DISMISSED	TYPE

OREGON STATE BOARD OF HEALTH 10-41 INDEX CARD FORM NO. 2

SURNAME	GIVEN NAME	DATE OF BIRTH
NAME OF PARENT	ADDRESS	SCHOOL

DATE	IMMUNIZATIONS						TESTS				
	S. POX	DIPH.	SC. F.	TYPH.	WH. C.	TICK	SCH.	DICK	TBC.	KAHN	OTHER

OREGON STATE BOARD OF HEALTH—5-41 IMMUNIZATION CARD FORM NO. 3

INDEX CARD--FORM NO. 2

This is a Family Index Card and is designed to make it unnecessary to have a separate card for **each** member of the family being given service by the health department. In this way, time and filing space will be saved.

The Index Card should serve two purposes: (1) It should disclose whether or not there is another record for a particular client of the health department; (2) it should tell where the record can be found. If entry of the date admitted, date dismissed and type of service being given does not fulfill the second of these requirements, some indication should be noted on the card regarding where the record is located. It is expected, however, that the type of service will usually reveal the location of the record form.

It is suggested that the terminology for "Type of Service" correspond to that on the Family Service Record, but that some individuality in terminology be permitted.

The full name (including surname and given name) of the head of the family should be on each index card. Failure to include the complete name has at times made the index cards less effective than they should be.

There is one other convenient use of which advantage should be taken. In instances where it is rather certain that only one visit is to be made to a family and that the family is not likely to receive recurrent visits at any time in the near future, an Index Card should be prepared by the worker in lieu of a service record and a notation concerning the content of the one visit made on the back of the index card. The cards should then be given to a clerk at the close of the day for checking and filing the same as though they were service records. In this way the information is readily available to workers at future dates. It is recommended that health department personnel use this recording procedure more frequently.

Index Cards, with the exception of those prepared by the worker for recording single visits, are to be prepared by the clerk from actual service records.

An index card will be prepared for each family in which an individual is admitted to service. The name of the head of the household should be placed at the top of the card together with the address. The given name of each member of the family who is receiving the attention of the health department should then be listed in the first column and opposite his name, the date admitted and the type of service should be entered. When any member of the family is dismissed, this date should be entered in the "date dismissed" column. Dismissal is to be predicated solely upon discontinuance of service--not upon the ending of the report year and the beginning of a new one. If one card does not provide sufficient space for the services to the family, a second card should be stapled to the original. If a particular member of the family does not have the same surname as the head of the family and he is being given service by the health department, a separate Index Card should be prepared for that person. This will take care of step-children, grandparents, married daughters and other types of relatives who may be living with the family.

IMMUNIZATION CARD--FORM NO. 3

This card was formerly called a Communicable Disease Card, but because of its more frequent and advantageous use for recording immunizations and tests, it is now called an Immunization Card. Another record form (No. 6) is recommended for listing cases of communicable disease. At the discretion of the local health officer, however, communicable disease information may also be recorded on immunization cards.

Those immunization cards should be prepared by the secretary or clerk from the information contained on the consent slips (if the work is done in the schools or in a clinic) or from information obtained directly from the person immunized or the parents. The cards should be filed alphabetically and not separated by years. If statistical data regarding the number of immunizations performed in various age groups are desired, this information should be obtained from the summary of daily activities rather than from a special filing procedure.

Name Age M F S M W D Diagnosis

Address and Directions

Occupation Case No.

Date of Exposure Suspected Source

Date of Onset Physician

Previous Treatment

History { Family—Past Illnesses—Obstetrical—Head—Eyes—Ears, Cardio-respiratory—Gastrointestinal—Genito-urinary—Neuromuscular—Osseous.

Physical Examination { Skin—Eyes—Ears—Mouth—Pharynx—Lungs—Heart, Abdomen—Genitals—Lymphatic—Neurological—extremities.

CONTACTS

Name	Address	Relationship	Age	Test	Res.	Test	Res.	Disposition

Date	Notes	Worker

Date	Arsenical			Bismuth			Laboratory Results or Remarks	Physician
	No.	Drug	Dose	No.	Drug	Dose		

VENEREAL DISEASE RECORD -- FORM NO. 5

On the front page of the Venereal Disease Record is found space for recording data as to case identification, history, physical and contact investigation, while on the back of the record is space for recording treatment and reaction. It is essential that pertinent information be recorded as to the history of the case, treatment previously received, and physical examination.

Space is provided for recording contact investigation. It is important that the relationship of contacts to the case and other information be accurately and completely recorded on all V. D. records. The lines at the bottom of the page may be used in recording medical or nursing visits for the purposes of case finding or case holding.

The back of the card is the treatment record. It provides 47 spaces for recording treatment given, laboratory findings, reactions, or remarks. The columns labeled "No." are useful for making the number of injections and the length of the courses readily apparent.

Filing: The filing arrangements for the records should be based largely on their convenience to the person who administers the treatment. Probably the most convenient place for the active cases is in a separate file arranged alphabetically. An Index Card should be prepared for each venereal disease patient just as for any other case carried by the health department. Dismissed cases should be filed with the inactive Family Service Records.

EPIDEMIOLOGICAL RECORDING: A separate epidemiological record has been eliminated during the experimental period. The use of this form for recording visits to positive reactors to tuberculin tests was not as great as was expected. Therefore, it is felt that the Family Service, or the Utility record could be used.

However, it is suggested that for those who wish to record a more complete epidemiological investigation for some communicable diseases the front page of the Venereal Disease record, Form No. 5, may be used for this purpose.

DISEASE

NAME AND ADDRESS	AGE	SEX	PHYSICIAN	DATE REPORTED	IS THERE A CASE RECORD?	
					YES INDICATE FILE	NO

STATE OF OREGON

COMMUNICABLE DISEASE CHRONOLOGICAL CARD FORM NO. 6

COMMUNICABLE DISEASE CHRONOLOGICAL CARD--FORM NO. 6

Each case of communicable disease that comes to the attention of the health department should be recorded on this form. There should be one of these cards for each type of communicable disease. When the first card is completely filled a second one should be started.

Cases of each disease should be recorded chronologically on the appropriate card. It is also helpful if the cases are numbered as they are recorded. In this way there is always an up-to-date and readily accessible count of the number of cases of each communicable disease. If a line is drawn below the last case reported for each month, monthly totals are readily apparent. A new series of cards should be started at the beginning of each calendar year. These cards should be filed with the last card always at the front of the file.

Unless the health department assumes supervision of the case, or the patient receives recurrent visits from some member of the staff, the notations on this chronological card will constitute the only record of the case. This card indicates the name and address of the patient, his age and sex, the name of the physician who makes the report, the date reported, and information on whether or not there is a case record for the patient. This last item should be checked "yes" in the appropriate column if there have been recurrent visits, or "no" if there is no case record. Preparation of the card and maintenance of the file should be a responsibility of the office secretary.

SCHOOL ____________________ GRADE ____________ TEACHER ____________________ 19____-19____ YEAR

NAME, ADDRESS AND FATHER'S NAME	DATE OF BIRTH	DATES AND RESULTS			VISION TEST	HEARING TEST	MEDICAL AND NURSING FINDINGS	DENTAL FINDINGS	REMARKS
		VACC.	IMM.	TBC. TEST					
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			

SCHOOL WORK SHEET FORM No. 7

OREGON STATE BOARD OF HEALTH 4/40

STATE PRINTING DEPT.

School ______________________ Grade ______________ Teacher ______________________ 19____-19____ Year

Name, Address and Father's Name	Date of Birth	Dates and Results			Vision Test	Hearing Test	Medical and Nursing Findings	Dental Findings	Remarks
		Vacc.	Imm.	Tbc. Test					
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			
					R. 20/ L. 20/	R. L.			

Oregon State Board of Health 4/40
State Printing Dept.

School Work Sheet Form No. 7

SCHOOL RECORD--Form No. 7

No detailed procedure for school records was included in the experimental record system because of an impending change in the school health program. In an effort to reduce the amount of time needed to maintain the school records and in order to make school health data more readily available to the nurse while visiting in the schools or in the homes, a School Work Sheet (Form No. 7) was suggested.

An agreement has now been reached with the State Department of Education outlining a school health program to be encouraged throughout the State. The program will, in most counties, involve a medical examination for all first grade and new students, observation of health practices and behavior by the teacher, screening by the teacher and nurse of those pupils who are to receive medical examinations, medical examinations of the screened pupils, and follow-up on pupils by the nurse.

A record form to be kept and used by the teacher has already been prepared and distributed. In view of the central position of the teacher in the program, her record will be the most important one in the record system. The doctor and nurse will also need some data to use in their parts of the program. It should not be necessary, however, for the health department to keep a permanent and continuous record for every school child.

The following record keeping procedure is recommended:

1. Record findings of medical and dental examinations on the "School Work Sheet". This procedure applies to examinations of new students as well as those who were screened by the teacher and nurse.
2. Transfer examination data from these sheets to the teacher's record.
3. For those students who will receive more than a single follow-up visit by the nurse prepare a Family Service Record and record follow-up notes on it.

When kept in a loose-leaf notebook or loose-leaf brief case, the sheets will be more convenient to use.

Date	Notes	Worker

Reverse Utility Record Form No. 8

Name ______ Age ______ Diagnosis ______

Address ______ Occupation ______

Referred by ______

Date	Notes	Worker

State of Oregon

Utility Record Form No. 8

UTILITY RECORD--FORM NO. 8

This form may be used by health department personnel in recording a variety of services for which none of the other records is especially appropriate. One of the uses of the form will be for general morbidity service performed by the health officer in non-communicable disease situations where family data are not significant, and for which a Family Service Record has, therefore, not been prepared. It may also be used by the sanitation officer as a form on which to record notes of his services.

These records should be filed in the Family Service Record file. If at any time it is desirable to prepare a Family Service Record for the individual, his former record should be placed in the Family Service Record. An Index Card should be made for each individual for whom a Utility Record is prepared.

OFFICE FILES

1. Index Card File (Form No. 2)
   One complete alphabetical file.
2. Family and individual case records
   a. Active file will contain:
      (1) Active Family Service records (form No. 1)
      (2) Active Utility records (Form No. 8)
      (3) School Records for children receiving recurrent supervision
   b. Inactive file will contain:
      (1) Dismissed Family Service records (Form No. 1)
      (2) Dismissed Utility Records (Form No. 8)
      (3) Dismissed Venereal Disease cases (Form No. 5)
3. Communicable disease file
   Communicable Disease Chronological Card (Form No. 6)
   Separate card or cards for **each** reportable disease.
4. Immunization Card file (Form No. 3)
   One complete alphabetical file
5. Venereal Disease file (Form No. 5)
   a. Active cases
   b. Delinquent cases
   c. Cases on rest or on vacation
6. School record file
   Card should be filed alphabetically by schools for children not receiving recurrent supervision.
7. Child Guidance File containing both case records and correspondence.
8. Crippled Children correspondence file (folders for each case).
9. General correspondence file
   Separate folder for each family when correspondence pertains to an individual patient.

NURSE'S DISTRICT CASE OR TICKLER FILE

A tickler file is a simple device to assist the nurse in planning her field work. This is most **readily** accomplished by arranging the cards according to month of next planned visit. For the current month and for the succeeding one or two months, the cards should be arranged within the month by districts.

Besides being useful for scheduling regular nursing visits, this file may also be used for scheduling attendance of patients at special clinics, or for X-ray examinations.

For further explanation see Manual of Division of Public Health Nursing, Section IV B, subsection 4, "Individual Nurses District Case File", disregarding the part preceding "General Information."

OFFICE PROCEDURES

1. Filing

   The office secretary should have full responsibility for filing all health department records. The records will be available to any staff member at any time, but once the record has been removed from the file, it should be refiled only by the secretary. All records pulled from the files should be returned to a file basket. This rule should be both thoroughly understood and strictly adhered to by every member of the staff.

2. Reporting

   a. Daily Report

   The Daily Report of activities should be completed by each staff member and handed to the clerk either at the close of each day or on the following morning. In instances where certain staff members work routinely out of a center not located in the same town as the health department, daily reports should be sent in at the close of each week.

   b. Monthly Activities Report (C-1427 and Quarterly Tabulation of Health Department Services (B-1427)

   The responsibility for the preparation of these monthly and quarterly reports should be assigned to the clerk of the local health department. The clerk should adhere as closely as possible to a procedure of posting data currently from individual workers' daily reports to the Monthly Activities Report. In this way the monthly report may be readily completed and the totals transferred without delay to the quarterly report at the close of each month. Such a procedure will provide for prompt reporting to the State office at the close of each quarter.

   The daily and monthly reports of individual workers should be carefully checked by the clerk for obvious errors and for reasonableness of the figures reported in items bearing relationships. All errors should be corrected before the monthly totals are transferred to the quarterly report.

C - 1427

State of Oregon, County or District__________

Month__________ Year__________

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