08, 14, 2011

Tzu Chi Medical Volunteer Orientation

Medical Outreach Process Flow, Form Types, and Job Functions

義診流程、工作分類、表格填寫

Agenda
課程內容

- Medical Outreach Departments – 義診部門
- Job Functions – 工作分類
- Medical Outreach Flows – 義診流程
- Department Forms –各科表格
- Activity Report – 活動報導
- References – 參考資料

1. Medical Outreach Departments
義診部門

Department	義診部門
Event Planning	活動規劃
Administration	行政管理
Logistics	後勤支援
Public Relation	公共關係
Job Assignment	任務分配
Registration	註册掛號
Wt & Ht	護理站–身高體重
Lab Testing	檢驗科
Waiting Area	候診區
Adult Medicine	西醫
Dental	牙醫
Vision	眼科
Chiropractic	脊椎科
Acupuncture	中醫
Record Return	病歷回收
Interpreter	翻譯志工
Food Preparation	香積組
Distribution	慈善發放
3-in-1	人文真善美三合一

2. Job Functions
工作分類

- Registration – 註冊
- Flow In Volunteer – 導入志工
- Flow Out Volunteer – 引出志工
- Department Controller – 各科負責人
- Record Return – 病歷回收
- Interpreter – 翻譯
- Food Preparation – 香積
- Distribution – 發放
- Hair Cut – 剪髮
- 3-in-1 – 人文真善美

2.1 Flow In Volunteer
導入志工

- Flow the patient from the Registration Desk to Triage department
- Flow the patient from Main Waiting Area to the respective service department
- Flow the patient from the department waiting area to the consultation or treatment desk

2.2 Flow Out Volunteer
引出志工

- Flow the patient to the Main Waiting Area if the patient requests more services

- Flow the patient to the Record Return Department if the patient already completed all the services requested.

2.3 Department Controller
各科負責人

- Seated the patient.
- Log in the patient number to Department Control Log Sheet.
- Send the patient to treatment and Mark the check in on Service Card.
- Mark the check out on Service Card and flow the patient to Waiting Area or Record Return area.

2.4 Record Return Control
病歷回收

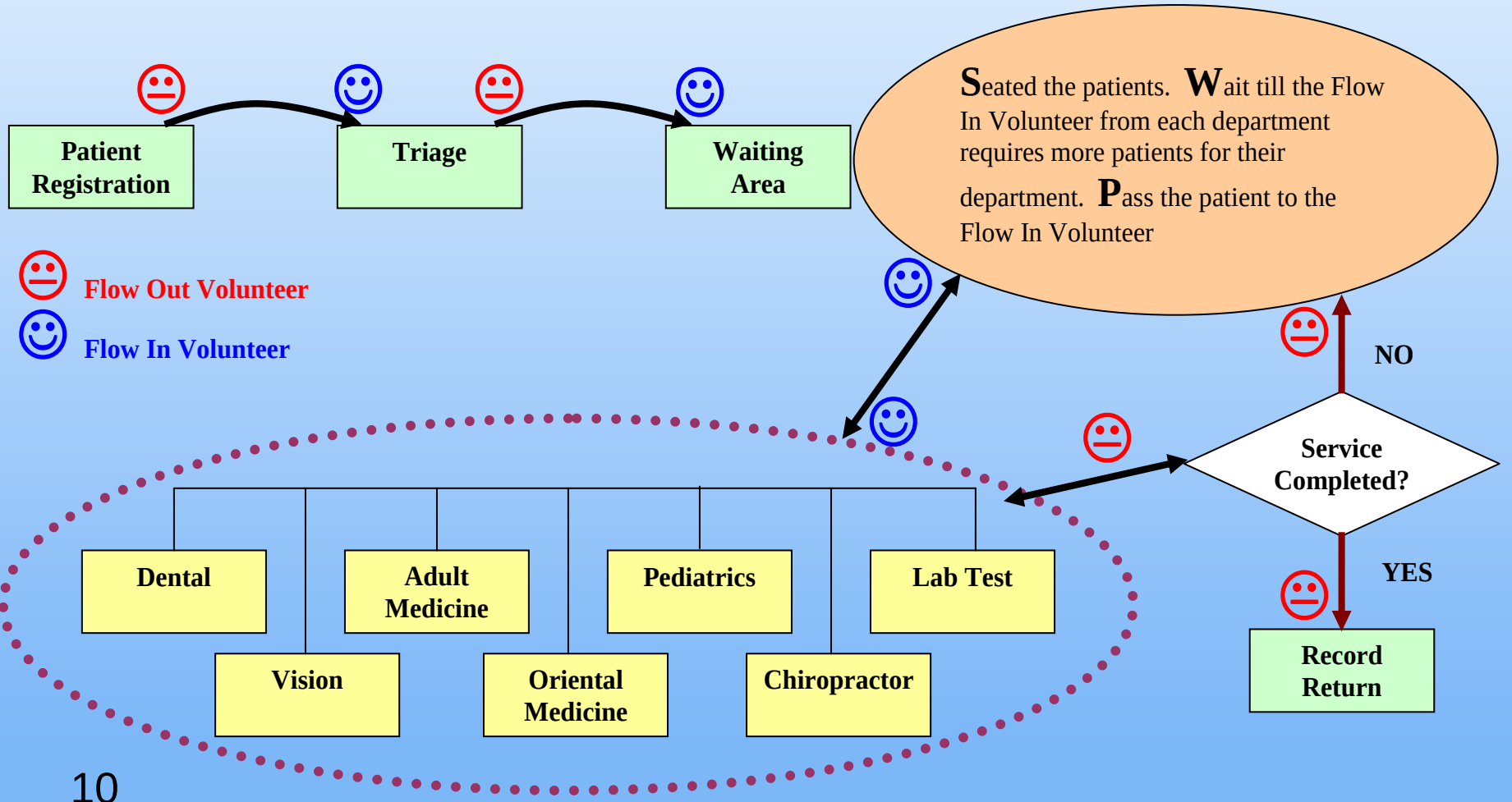
- Express gratitude to our clients for their participation- 感恩看診者的參與
- Check all forms have been signed and dated- 檢查簽名
- Collect Master Number badge- 回收號碼牌
- Collect all medical records- 回收病歷表
- If needed, advise clients the nearest pharmacy to fill prescription - 如有藥單, 解釋那裏可以買藥。
- Make a duplicate copy (with Tzu Chi logo) upon client’s request - 如看診者要求保留病歷表,可爲他們 Xerox。請先摺蓋慈濟Logo，再爲他們 make copy。

3. Process Flow

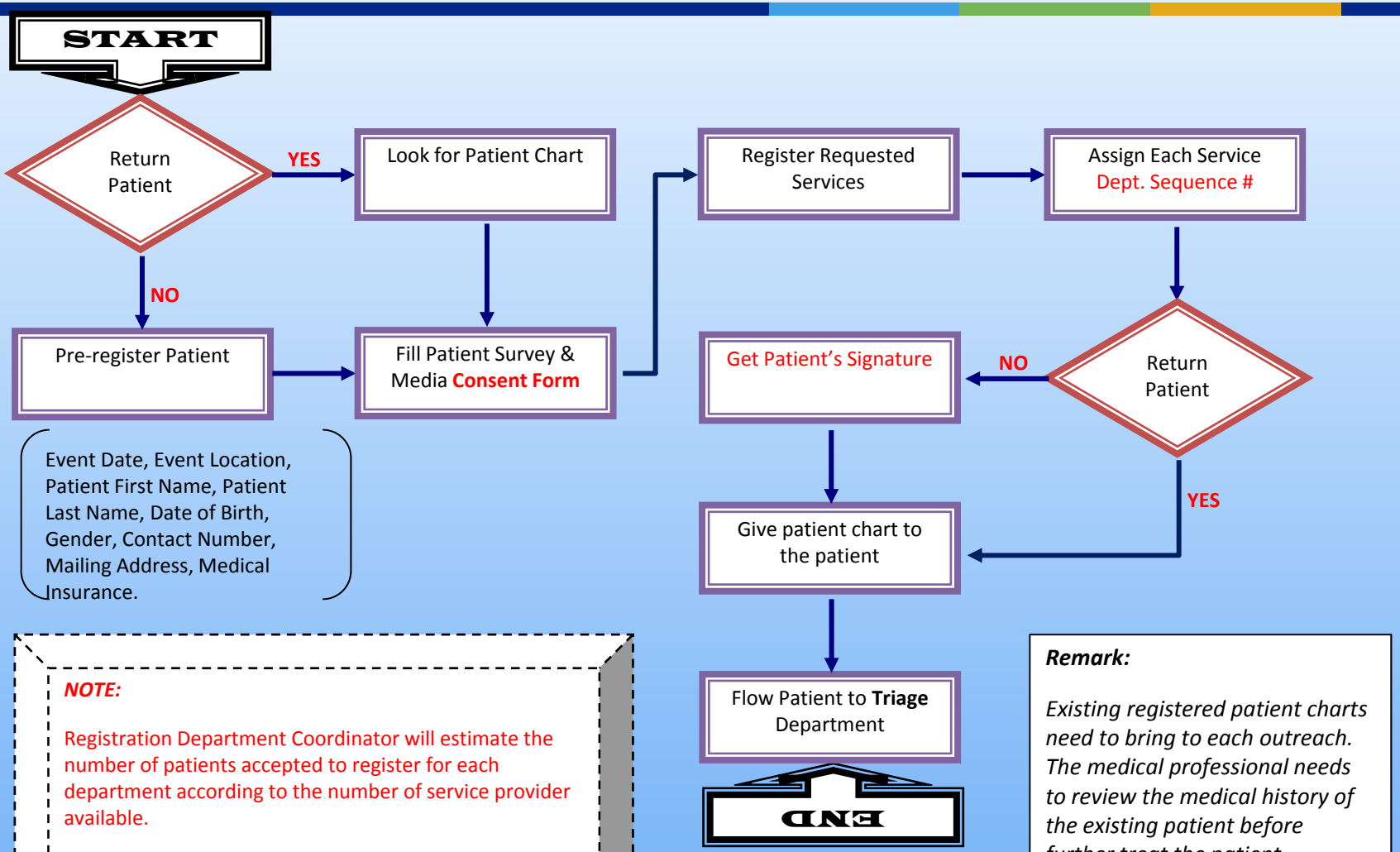
- Overall event flow
- Registration process
- Patient Process flow
- Waiting area flow
- Department flow
- Record Return

3.1 Medical Outreach/Health Fair Flow
義診流程圖

The Overall Process Flow



3.2 Registration Process Flow
註冊流程

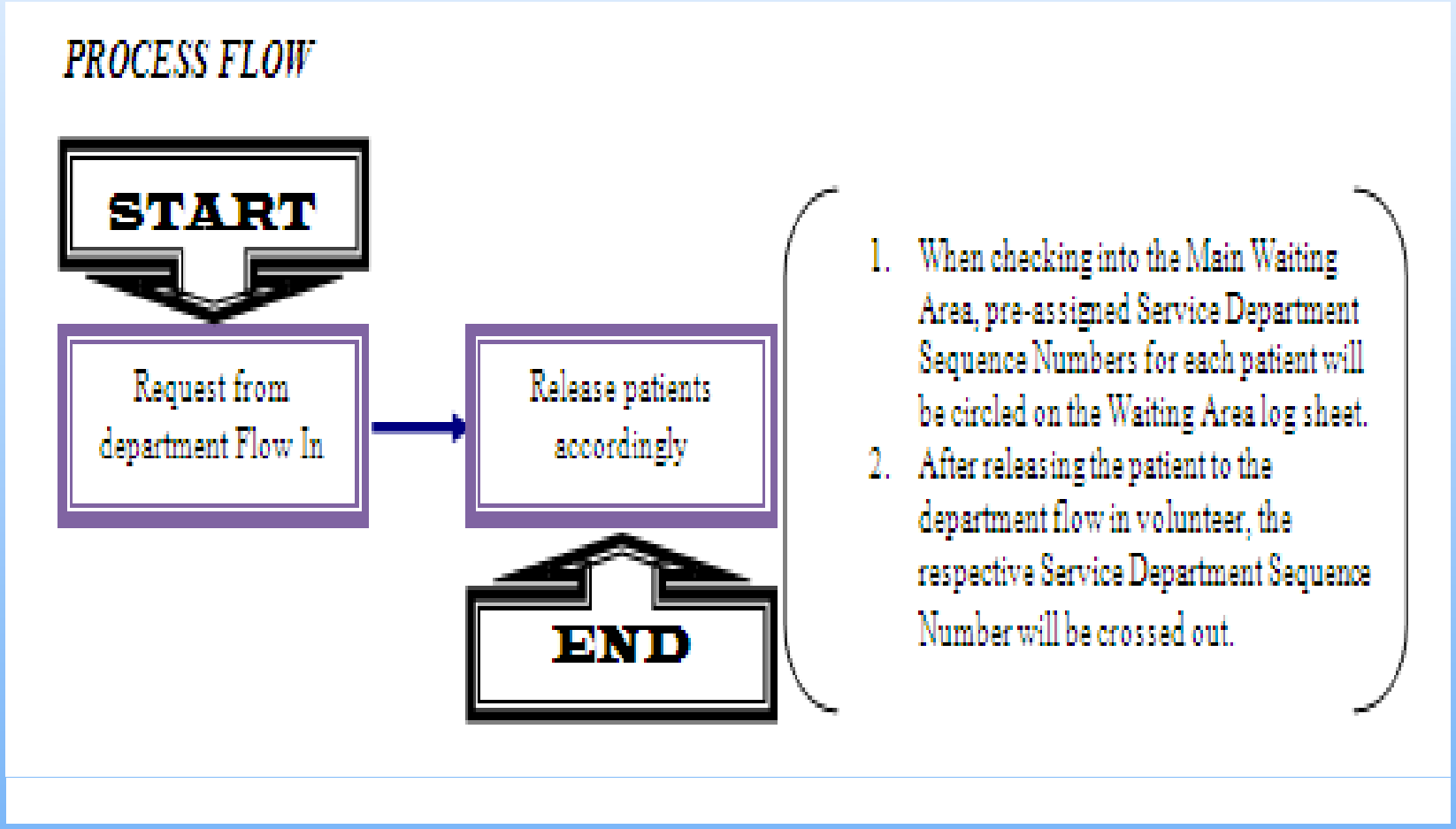


(Estimation is based on the prior experience)

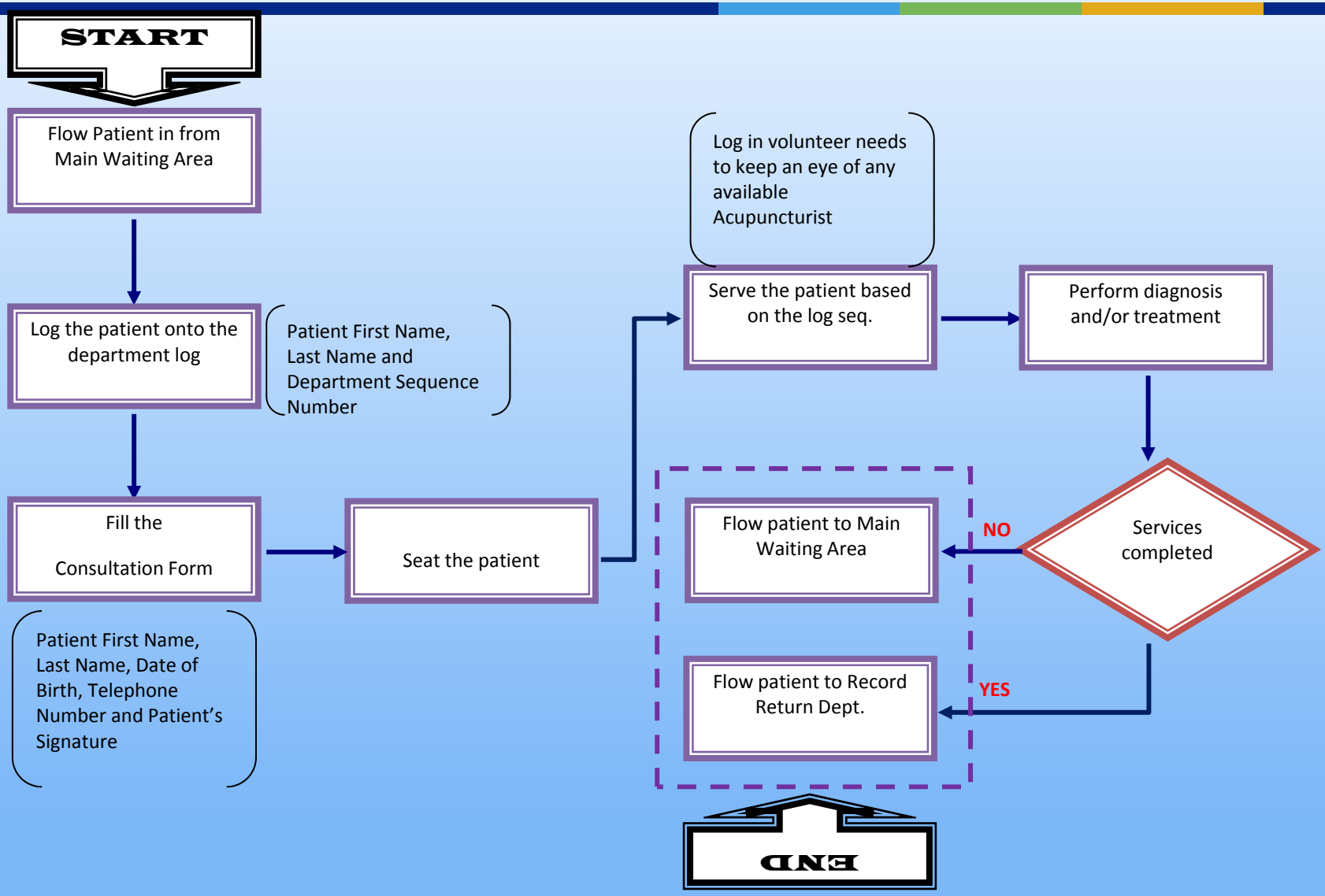
3.3 Patient Process Flow
看診流程

- Patient Registration – 看診者註冊
- Triage – 護理站
- Lab Test – 檢驗科
- Flow Patient to Waiting Area – 候診區
- Flow Patient to Service Dept – 看診區
- Flow Patient to Record Return if Services completed – 看診完畢及病歷歸檔

3.4 Waiting Area Process Flow
候診區流程

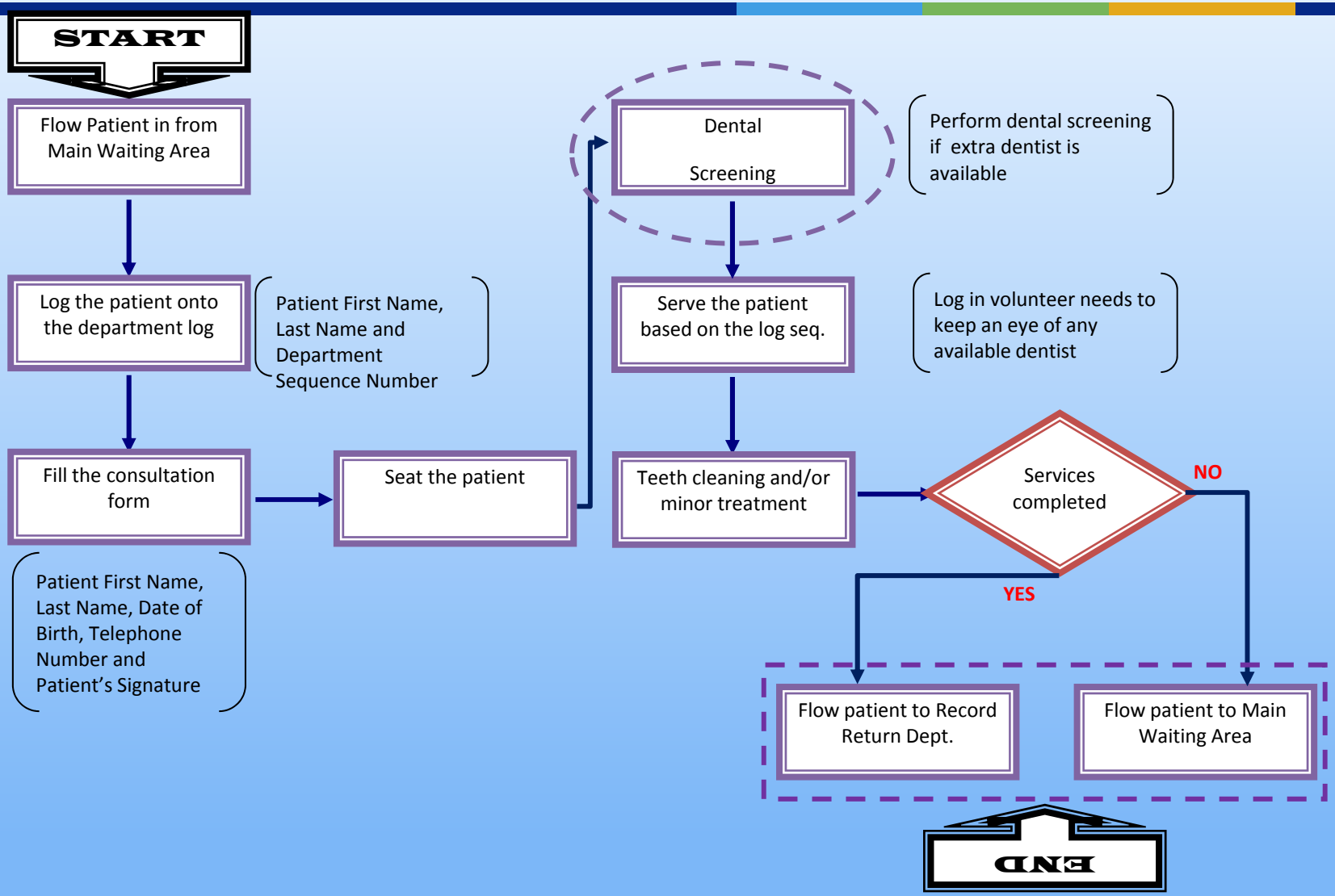


3.5.1 Department Process Flow, Examples
Acupuncture 中醫看診流程



3.5.2 Department Process Flow, Examples

Dental 牙醫看診流程



4. Form Types

- Patient Registration & Consent
- Service Card
- Waiting Area Log Sheet
- Department Control Log Sheet
- Department Consultation Form (Various examples)
- Record Return Log Sheet

4.1 Patient Registration & Consent Form
註冊表及同意書(節錄)

TZU CHI FREE CLINIC, USA – MECIAL TERM
PATIENT REGISTRATION & CONSENT FORM

Date: _____ **Location**: _____ **Chart No**: _____

Patient Name 病人姓名**:** (Last 姓) _____ (First 名) _____
Nombre Del Paciente: (Appellido) (Nombre)

Birthdate 生日**:** _____ **Sex** 性別**:** ☐ Male ☐ Female **Telephone** 電話號碼**:** _____
(Fecha de Nacimiento) Sexo Telefono

Address 住址**:**_____
(Domicilio)

Race / Ethnicity (Check One) Raza / Etnicidad (Marque una caja) 族裔選項 (請擇一)
☐ Asian/Pacific Islander ☐ Hispanic ☐ American Indian/Alaskan Native ☐ African American ☐ White ☐ Other
Language/ Idioma
☐ English/Inglés ☐ Spanish/Español ☐ Chinese/Chino ☐ Other /Otro

Service Category:

☐ **Medical** Medico 西醫	☐ **Dental** Dentista 牙醫	☐ **Acupuncture** Acupunctura 中醫	☐ **Chiropractic** Quiromante	☐ **Blood Test** ☐ **Body Fat** ☐ **Bone Density**	☐ **Vision** ☐ **Hepatitis B**

Vitals:

Wt:	**Ht:**	**Temp:**	**Resp.:**	**Allergy:**
Pulse:	**Blood Pressure:** Ideal = below 120/80 (高壓 120 以下, 低壓 80 以下 = 理想)			

Blood Sugar 血醣 : Fasting = below 120 mg/dl Normal (空腹 低於 120 = 正常)
Non-fasting = over 160 mg/dl Follow Up (非空腹 高於 160 = 追蹤檢查)

Cholresterol 膽固醇 : Ideal = less than 200 (低於 200 = 理想)
Hgb 血紅素 :

I hereby release Tzu Chi Free Clinic and all other organizations associated with this screening, parent and affiliated companies, successors and assignees, and officers, directors, and employees from any and all liability arising from or in any way connected with blood drawing for my blood cholesterol, glucose, hemoglobin measurements, immunizations, or from the data derived there from.

4.2 Service Card
看診卡

MASTER #

SERVICES	SEQ. #	IN	OUT
Lab Test			
Adult Medicine			
Women's Health			
Pediatrics			
Vision			
Dental			
Acupuncture			
Chiropractor			
Hair Cut			

4.3 Waiting Area Log Sheet
候診區控制表

FRESNO MEDICAL TEAM
MULTI SERVICE CATEGORY LOG SHEET

Date: _____ [MM / DD / YYYY]
Location: _____ City: _____

LAB TEST		ADULT MEDICINE		PEDIATRICS		EYE		DENTAL		OB/GYM		CHIROPRACTIC		ACUPUNCTURE	
SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #	SEQ. #	MAST. #
1		1		1		1		1		1		1		1	
2		2		2		2		2		2		2		2	
3		3		3		3		3		3		3		3	
4		4		4		4		4		4		4		4	
5		5		5		5		5		5		5		5	
6		6		6		6		6		6		6		6	
7		7		7		7		7		7		7		7	
8		8		8		8		8		8		8		8	
9		9		9		9		9		9		9		9	
10		10		10		10		10		10		10		10	
11		11		11		11		11		11		11		11	
12		12		12		12		12		12		12		12	
13		13		13		13		13		13		13		13	
14		14		14		14		14		14		14		14	
15		15		15		15		15		15		15		15	
16		16		16		16		16		16		16		16	
17		17		17		17		17		17		17		17	
18		18		18		18		18		18		18		18	
19		19		19		19		19		19		19		19	
20		20		20		20		20		20		20		20	

Fresno Medical Team @ 20080508

4.4 Department Control Log Sheet

附錄二　看診登記表(中醫)

MEDICAL TEAM
ACUPUNCTURE LOG SHEET

Date: _____ [MM / DD / YYYY]
Location: _____ City: _____

NO	DEPT. SEQ. #	NAME (FIRST NAME + LAST NAME)		NO	DEPT. SEQ. #	NAME (FIRST NAME + LAST NAME)

Medical Team @ 20080508

NUMBER OF PATIENTS SERVED: [_____]

4.5 Adult Medicine Consultation Form
西醫病歷表

Tzu Chi Free Clinic, USA
Fresno Medical Team
Patient Consultation Form – Adult Medicine

Consultation Date _____ **Department Number** _____

Patient Name (LAST) _____ **(FIRST):** _____
Nombre Del Paciente: (Appellido) *(Nombre)*

Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female** **Telephone:** ( )
Fecha de Nacimiento *Sexo* *Telefono*

Patient's Signature: _____
La Firma del paciente:

Physical Examination

Weight: _____ *Blood Sugar Test:* _____ *mg/dl* *Temperature:* _____ *Pulse:* _____

Height: _____ *Blood Pressure:* _____ / _____ *mmHg* *Allergy:* _____

Consultation Note

Doctor's Name: _____ *Doctor's Signature:* _____

Revised by Fresno Medical Team @ 20081027

4.6 Acupuncture Consultation Form
中醫病歷表

Tzu Chi Free Clinic, USA
Fresno Medical Team
Patient Consultation Form - Acupuncture

Consultation Date _____ **Department Number** _____

Patient Name: (LAST) _____ **(FIRST)** _____
Nombre Del Paciente: (APPELLIDO) *(NOMBRE)*

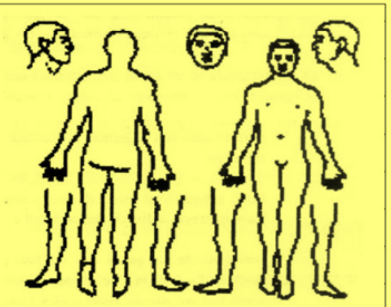
Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female** **Telephone:** ( )
Fecha de Nacimiento: *Sexo:* *Telefono:*

Patient's or Legal Guardian's Signature **Patient's Signature**
La firma De Padre o Guardián Legal *La Firma del paciente:*

Physical Examination

Blood Sugar Test: _____ *mg/dl* *Blood Pressure:* _____ / _____ *mmHg* *Temperature:* _____

Consultation Note



Acupuncturist's Name: _____ *Acupuncturist's Signature:* _____

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4.7 Dental Consultation Form

牙醫病歷表

Tzu Chi Free Clinic, USA
Fresno Medical Team
Patient Consultation Form - Dental

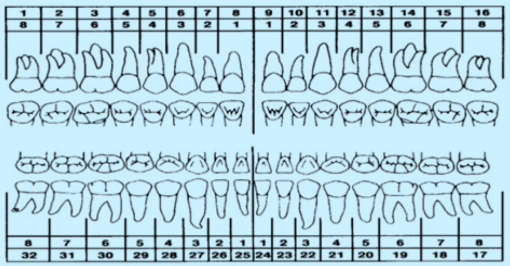
Consultation Date ______ **Department Number** ______

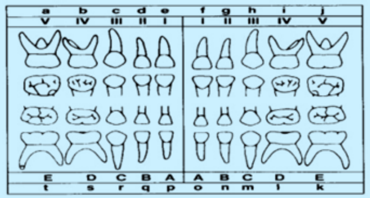
Patient Name: (LAST) ______ **(FIRST)** ______
Nombre Del Paciente: (APPELLIDO) *(NOMBRE)*

Date of Birth: ______ **Sex:** ☐ **Male** ☐ **Female** **Telephone:** ( )
Fecha de Nacimiento: *Sexo:* *Telefono:*

Blood Sugar Test: *mg/dl* **Blood Pressure:** / *mmHg*

Allergies: ______ **Medication:** ______





Tooth	*Services Necessary*

Treatment

Dentist's Name

Dentist's Signature

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CONSENT FOR ORAL TREATMENTS

I hereby authorize and request the performance of dental examination for myself or for

____

I give my consent to any advisable and necessary dental examinations to be administered by the attending dentist or by his/her supervised staff for diagnostic purposes. There records may include examination records, photographs, x-rays, and blood studies.

I understand that this oral examination is only based on my statement and dentist's inspection, palpation, percussion, and may be some available examination technique.

I also understand that the suggestion from this examination can only be as a reference, and I reserve the right to consult with any dentist of my choice outside of Tzu Chi Free Clinic.

1. *WORK TO BE DONE*
   I understand that I am having the following work done: Fillings ________, Extractions ________, Open and Drain ________, Root Canals ________, and other ________.
   (*Initials:* ________)

2. *DRUGS AND MEDICATION*
   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock.
   (*Initials:* ________)

3. *FILINGS*
   I understand that care must be exercised in chewing on fillings especially during 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after-effect of a newly placed filling.
   (*Initials:* ________)

4. *OPEN & DRAIN*
   I understand this procedure is only palliative in nature whose sole purpose is the alleviation of pain due to pulpal trauma, and is by no means final or definitive. I further understand that failure to complete the remainder of the treatment may result in other complications such as recurring pain, infection, facture and eventual loss of the tooth.
   (*Initials:* ________)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made regarding the dental treatment, which I have requested and authorized.

I hereby authorize any doctors or dental auxiliaries of Tzu Chi Free Clinic to proceed with and perform the dental restorations and treatments as explained to me. Should any dispute arise over dental services provided to me, that is, whether any dental services rendered is allegedly unnecessary, unauthorized or was improperly, negligently, or incompetently performed, said dispute will be submitted to Peer Review of Board of Medical Directors. The decision of Peer Review shall be binding on both parties. I have read, understood, and agreed to the above.

Patient Signature	*Parent's or Legal Guardian's Signature*	*Date*
La Firma del paciente	La firma De Padre o Guardián Legal)	Fecha

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4.8 Record Return Log Sheet
病歷回收統計表

FRESNO MEDICAL TEAM
RECORD RETURN LOG SHEET

Date: _____ [MM / DD / YYYY]
Location: _____ City: _____

MASTER NUMBER	FIRST NAME	LAST NAME	YEAR BORN	SERVICE CATEGORY (✓)								OTHERS		
				LAB	MD	PED	EYE	DDS	CHI	ACU	OBG	REF.	Rx(S)	Rx(P)
TOTAL SERVICE COUNT														

Fresno Medical Team @ 20080508

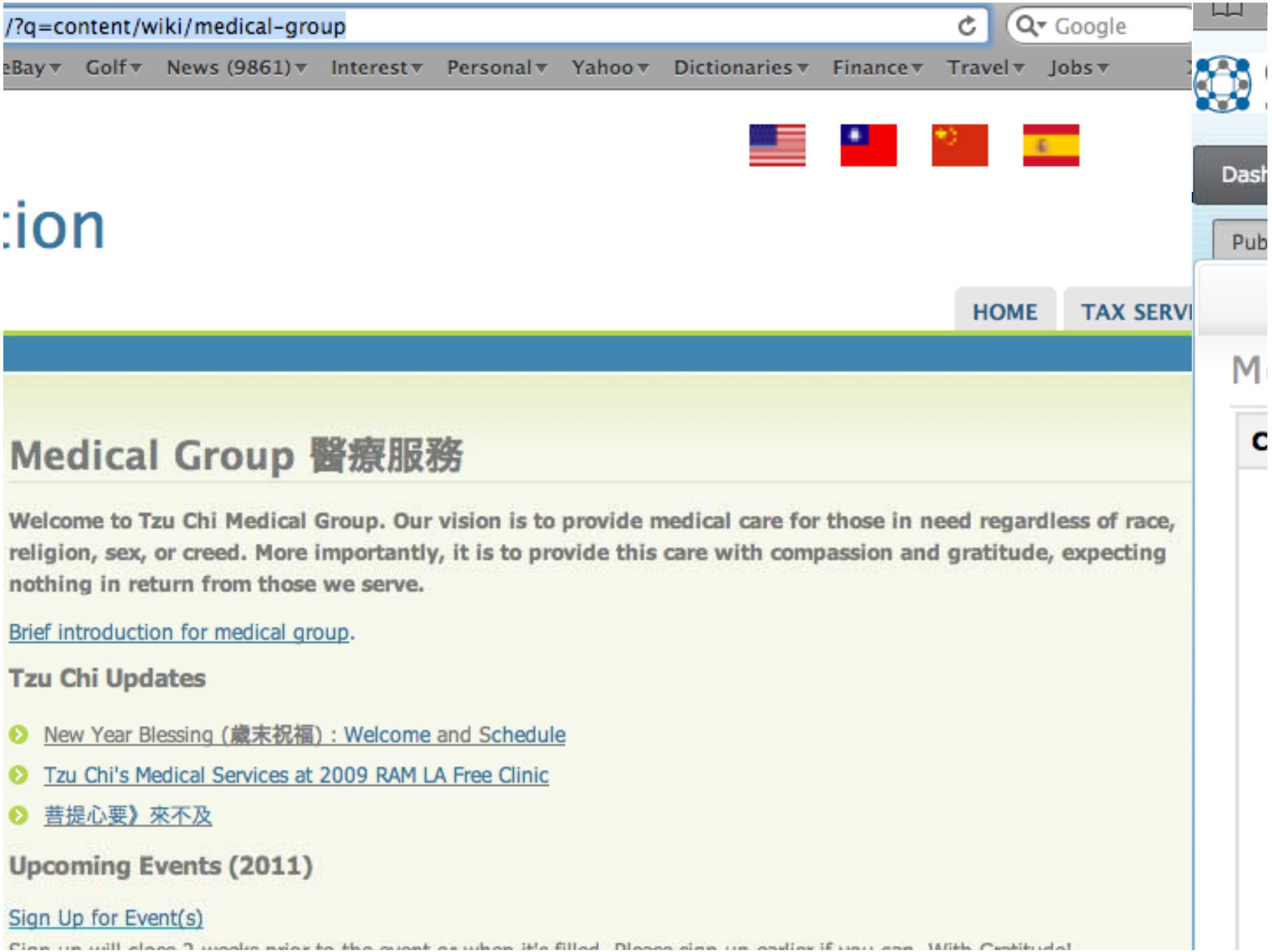
5. References
參考資料

- Tzu Chi Northern California Medical Outreach Guideline

http://www.socialtext.net/outreach/index.cgi?medical_outreach

- TCNW Medical Group Wiki

http://nca.us.tzuchi.org/?q=content/wiki/medical-group


/?q=content/wiki/medical-group
Google
eBay
Golf
News (9861)
Interest
Personal
Yahoo
Dictionaries
Finance
Travel
Jobs
tion
HOME
TAX SERV
Medical Group 醫療服務
Welcome to Tzu Chi Medical Group. Our vision is to provide medical care for those in need regardless of race, religion, sex, or creed. More importantly, it is to provide this care with compassion and gratitude, expecting nothing in return from those we serve.
Brief introduction for medical group.
Tzu Chi Updates
New Year Blessing (歲末祝福) : Welcome and Schedule
Tzu Chi's Medical Services at 2009 RAM LA Free Clinic
菩提心要》來不及
Upcoming Events (2011)
Sign Up for Event(s)

感恩

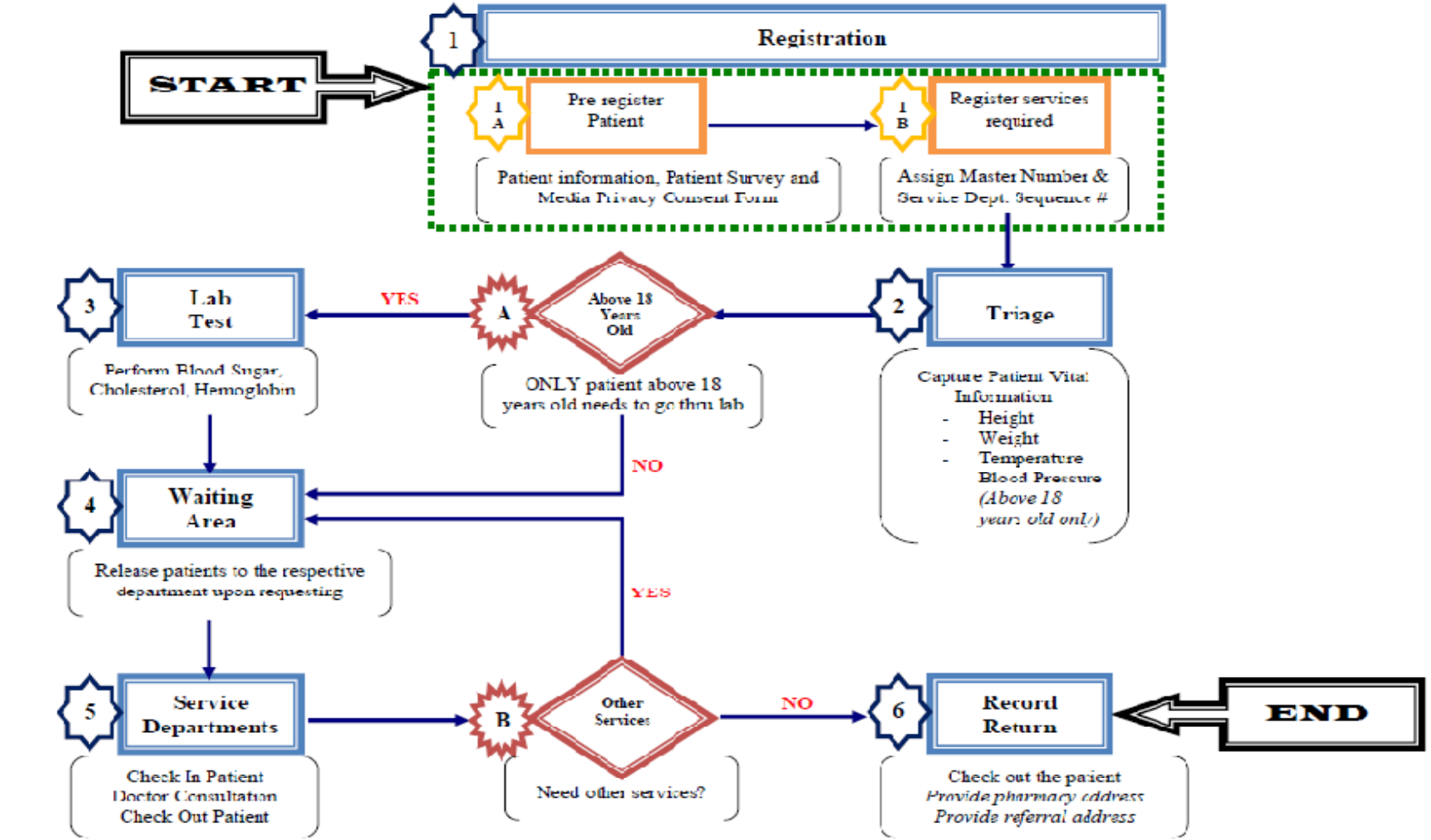
Thank You


TAIWAN 12:21:19
GMT 04:21:19
本聯絡處每周一09:00-12:00 QE II 醫院志工


大愛
Da Ai
World
news
TAIWAN 12:21:04
GMT 04:21:04
主講人:資深慈濟委員 郭孟雍19:30-21:00(07)

Back-up Slides

4. Department Flows / Forms
各科流程及表格



From 4.8. Chiropractic Consultation Form
脊椎科病歷表

Tzu Chi Free Clinic, USA
Fresno Medical Team
Patient Consultation Form – Chiropractic

Consultation Date _____ **Department Number** _____

Patient Name (LAST) _____ **(FIRST):** _____
Nombre Del Paciente: (Appellido) *(Nombre)*

Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female** **Telephone:** ( )
Fecha de Nacimiento *Sexo* *Telefono*

Patient's or Legal Guardian's Signature **Patient's Signature**
La firma De Padre o Guardián Legal *La Firma del paciente:*

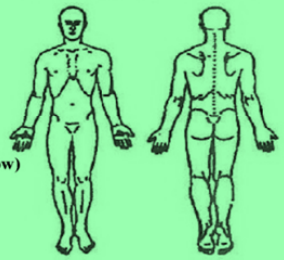
Physical Examination

Weight: _____ ***Blood Sugar Test:*** _____ *mg/dl* ***Temperature:*** _____ ***Pulse:*** _____
Height: _____ ***Blood Pressure:*** _____ / _____ *mmHg* ***Allergy:*** _____

Describe your current problem and how it began:

☐ Headache ☐ Neck pain ☐ Mid-back pain
☐ Low back pain ☐ Arm pain ☐ Leg pain
☐ Other _____

PAIN MAPPING
A=ACHE N=NUMBNESS
P=PAIN B=BURNING
T=TINGLING (PINS & NEEDLES)
MS=MUSCLE SPASMS S=STIFFNESS



Is this? ☐ Work related ☐ Auto related ☐ N/A

Date problem began: _____

How problem began: _____

Current complaint (how do you feel today): (Please circle number below)

1 2 3 4 5 6 7 8 9 10
(No pain) (Unbearable pain)

How often are your symptoms present?
(Intermittent) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

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In the past week, how much has your pain interfered your daily activities (e.g. work, social activities, and household chores)? (Please circle number below)

1 2 3 4 5 6 7 8 9 10
(No interference) (Unable to carry on any activities)

Have you had spinal X-rays, MRI, CT scan for your area(s) of complaint? ☐ Yes ☐ No
Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)
☐ Corticosteroid Use (Cortisone, prednisone, etc)
☐ Taking Birth Control Pills
☐ Numbness in Groin/Buttocks
☐ Dizziness/Fainting
☐ Cancel/Tumor (Explain)
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # weeks
Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbance
☐ Surgeries
☐ Medications

Family History:

☐ Cancel ☐ Diabetes ☐ High Blood Pressure ☐ Hear Problems/Stroke ☐ Arthritis

Remark:

Doctor's Name: _____ ***Doctor's Signature:*** _____

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Form 4.9. Vision Consultation Form
眼科病歷表

Tzu Chi Free Clinic, USA
Fresno Medical Team
Patient Consultation Form – Eye Services

Consultation Date _____ **Department Number** _____

Patient Name: (LAST) _____ **(FIRST)** _____
Nombre Del Paciente: (APPELLIDO) *(NOMBRE)*

Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female** **Telephone:** ( )
Fecha de Nacimiento: *Sexo:* *Telefono:*

Patient's or Legal Guardian's Signature **Patient's Signature**
La firma De Padre o Guardián Legal *La Firma del paciente:*

Physical Examination

Blood Sugar Test: _____ *mg/dl* ***Blood Pressure:*** _____ / _____ *mmHg* ***Temperature:*** _____

Eye Screening Medical Report

Eye Complaints: ☐ Blurred vision ☐ OD ☐ OS ☐ OU
☐ Pain ☐ Yes ☐ No
☐ Other eye complaints: _____

Past Eye History: ☐ Cataract ☐ Glaucoma ☐ Other _____

Medical History: ☐ Diabetes ☐ HTN ☐ Other _____

Medications: _____

Vision: ☐ With glasses ☐ Without glasses
OD: _____ OS: _____

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Refraction: OD: _____ 20/ IOP: _____
OS: _____ 20/ IOP: _____

Visual Fields: Confrontation method ☐ WNL ☐ Other _____

Versions: ☐ Full ☐ Other _____

Pupils: ☐ PERLA ☐ Other _____

Cover Test: ☐ Ortho ☐ Other _____

Cover/Uncover: ☐ Orthopho ☐ Other _____

External Exam: ☐ WNL ☐ Other _____
Orbit: _____ Lids: _____ Lashes: _____ Conj: _____

Slit Lamp Exam: ☐ WNL ☐ Other
Lashes: _____ Conj: _____ Cornea: _____
Ant Chmb: _____ Iris: _____ Lens: _____

Retinal Exam: ☐ Un dilated Direct
☐ Dilated Indirect ☐ WNL ☐ Other _____

Tentative Diagnosis: _____

Recommendation: ☐ Follow up with an Ophthalmologist/Optometrist
☐ Refer to Lens crafter
☐ Other _____

Doctor's Name: _____ ***Doctor's Signature:*** _____

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