Physician Documentation/Dictation Template for Patient Visit Example

If you did it – document it If you thought it – record it

DEMOGRAPHICS

Patient Name
Patient Age
Day, Time and Date of Service
Consultation

New Patient or Established Patient Site of Service Historian (patient or other) Identify physician or non-physician Practitioner performing service

SUBJECTIVE INFORMATION

Chief Complaint or reason for the encounter

Asymptomatic/routine physical/annual visit/preventative visit

HPI: symptoms/complaints:

(location; quality or sensation; severity; duration of complaints onset to present; timing pattern frequency; context; modifying factors; associated signs and symptoms)

ROS: Indicate negative or positive findings. If all systems inventoried, note the negatives and positives for the presenting problems and include a statement "all other systems negative."

(constitutional; ENMT; respiratory; genitourinary; integumentary; psychiatric; hematology/lymphatic; eyes; cardiovascular; gastrointestinal; musculoskeletal; neurologic; endocrine; allergy/immunological)

PFSH: Note the patient's PFSH when appropriate, include immunization status, allergies, current medications and sexual activity (age appropriate). Include past surgeries, education and social habits.

OBJECTIVE EXAM

Document all systems/body areas examined and medically necessary

Constitutional: vitals, general appearance, etc.

Eyes: ocular motility, conjunctiva and lids, optic discs, posterior anterior segments, pupils and irises, appearance

ENMT: nasal mucosa, septum and turbinates, teeth and gums, oropharynx (palates, tongue, tonsils, and posterior pharynx), ears/otoscopic exam, assessment of hearing, tympanic membrane, external appearance Cardiovascular: palpation of hear, ausculatation of hear, carotid arteries, abdominal aorta, femoral arteries, pedal pulses, extremities for edema/varicosities, exam of peripheral vascular system, murmers Respiratory: inspection of chest with mention of symmetry and expansion, assessment of respiratory effort, percussion of chest, palpation of chest, auscultation of lungs

Gastrointestinal: examination of abdomen, examination of liver/spleen, examination for presence of hernia, examination of rectum, anus and perineum, including sphincter tone, hemorrhoids, etc, stool sample for blood (when indicated)

Genitourinary: as appropriate, (male) examination of scrotal contents, tenderness of cord, testicular mass, penis, digital rectal exam of prostate, epedidymides, urethral meatus, sphincter tone, (female) pelvic examination, external genitalia, urethra, bladder, cervix, uterus, adnexa Musculoskeletal: gait and station, digits and nails, joints, bones, muscles of the head, neck, spine, ribs and pelvis and each extremity, percussion or palpation, range of motion, stability or luxation, abnormal movements (specify site) Skin: inspection or palpation, scars, rashes, lesions, tenderness, masses, ulcers, palpation of scalp, inspection of hair of scalp, susceptibility to or the presence of photo damage (site), inspection eccrine glands and aprocrine glands of the skin, location of any hypehydrosis, chromhidrosis, or bomhidrosis, palpation of skin and sub-cu tissue

Neurologic: cranial nerves (specify) noting any deficits, deep tendon reflexes, examination of sensation and method used, evaluation o higher intergrative functions, coordination, and memory

Psychiatric: description of speech, description of thought process, description of associations, description of abnormal or psychotic thoughts, delusions, preoccupation with violence, homicidal or suicidal thoughts, obsessions, description of patient's judgement, mental status examination, mood and affect, fund of knowledge, orientation

Hematology/lymphatic/immunological: palpation of lymph nodes (site) Body Areas: dictate/document each body area examined: head/face, neck, chest (breast/axilla), abdomen, genitalia (groin/buttocks), back including the spine and each extremity

ASSESSMENT AND PLAN

Medical Decision Making – putting your grey matter (brain assessment and plan) to the white matter (paper)

Tests ordered or reviewed, and the reason for all tests ordered

Medications managed/ordered/stopped/changed, IV therapy Risk factors

Status of new problems or established problems

Invasive procedures planned or performed (document risk)

Diagnostic or therapeutic procedures performed (document reason performed)

Patient/family education

Review of old records or decision to obtain past records

Special instructions and follow-up care (referrals, consults, etc)

Diagnosis, working, definitive, changes in treatment and patient's response

Hospital or observation admission or transfer out of facility

TIME

If rendering critical care, dictate/document the total time spent caring for the patient (bedside/unit per day; or other site)

If more than 50% of the visit was spend in counseling and/or coordination of care, dictate/document total time and counseling time with details

If patient visit was prolonged, dictate/document time and circumstance