Sample Documentation Templates

UPHS – Department of Medicine
Subsequent Inpatient Visit Note

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Subsequent Inpatient Visit Note
(Requires 2 of 3 components: history, exam, or medical decision making)

Date: _____ Time: _____

Patient Name:

(1) INTERVAL HISTORY: *HPI: Level 3 = ≥ 4; Level 1 - 2 = ≤ 3*
ROS: Level 3 = 2 - 9; Level 2 = 1; Level 1 = 0
location/quality/duration/timing/severity/context/mod factors/assoc s/s
☐ unable to obtain (indicate reason)
☐ unchanged from _____

MEDICATIONS:
☐ unchanged from _____

(2) MULTI-SYSTEM EXAM: *(any 12 = Level 3; any 6 = Level 2; ≤any 5 = Level 1)* *Elaborate Abnormal Findings*

Constitutional:
☐ *(Document 3)* T: ____ P: ____ BP: ____ RR: ____ WT: ____
☐ See Vital Sign Flow Sheet
☐ APPEARANCE: _____

Eyes: ☐ no scleral icterus
☐ PERRLA

Ears/Nose/Mouth/Throat: ☐ nl teeth, lips, gums
☐ clear oropharynx

Neck: ☐ nl appearance and movements; nl JVP
☐ trachea midline
☐ no thyroid enlargement, masses

Respiratory: ☐ symmetrical chest expansion and respiratory effort
☐ clear to auscultation and palpation

Cardiovascular: ☐ nl sounds; no murmurs, gallops, rubs
☐ no edema

Abdominal: ☐ no tenderness; nl sounds
☐ no hepatosplenomegaly
☐ no hernias present

Lymphatic: no adenopathy *(indicate at least two, if applicable)*
☐ cervical ☐ axillary ☐ inguinal ☐ supraclavicular

Musculoskeletal: ☐ nl gait
☐ no clubbing, cyanosis
☐ nl muscle strength and tone

Skin: ☐ no rash or ulcers
☐ no nodules

Neuro: ☐ non-focal
☐ nl sensation

Psych: ☐ alert, oriented to person, place, time
☐ nl affect

Other:

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Patient Name_____ **MRN#**_____

(3) MEDICAL DECISION MAKING:

Data Review: *(Laboratory/Radiology/Additional Records Reviewed)*

☐ See Lab Report: Data_____

☐ See Radiology Report: Data _____

(Attending reviewed above data _____)

Assessment/Plan: *(Possible Diagnoses/Treatment Options/Additional Testing/Therapeutic Interventions)*

Resident/Fellow Signature: _____ Date: _____ Pager: _____

ATTENDING SUPPLEMENT: *(Minimum 1 element from 2 components: history, exam, or medical decision making)*

I saw and evaluated the patient, and I agree with note by Dr. _____.

Counseling and/or Coordination of Care (time_____)

(>50% of Total Floor Time; Spent Face-to-Face with Patient/Family)

Discussion Points:

DNR Status:

Attending Signature/Print: _____ Date: _____ Time: _____

Total Attending Floor Time (min): _____

Subsequent: ☐ 99231 (15 min) ☐ 99232 (25 min) ☐ 99233 (35 min) ☐ Prolonged Care: Time _____ *(Face-to-Face with Patient Only)*

☐ Discharge Day: Time _____ ☐ Critical Care: Total Cumulative Time _____

☐ -25 (Separately identifiable E/M service on procedure day)