



Name: _____

MRN: _____

DEPARTMENT OF MEDICINE INITIAL HOSPITAL VISIT/INPATIENT CONSULT

☐ HUP

☐ PPMC

Date: _____ Time: _____ ☐ Initial Visit ☐ Consult – Requesting Physician: _____

(Requires all 3 components: History, Exam, and Medical Decision Making)

(1) HISTORY:

Chief Complaint/HPI: 1. (Consult: Level 3-5 = ≥ 4 elements; Level 1-2 = ≤ 3) 2. (Admit: 4 elements required)
(location/quality/duration/timing/severity/context/modifying factors/associated signs/symptoms)

☐ MEDICATION/ALLERGIES REVIEWED: SEE MEDICATION RECONCILIATION FORM AND SCM

ROS: 1. (Consult: Level 4-5 = 10; Level 3 = 2-9; Level 2 = 1; Level 1 = 0) ☐ Remainder Negative ☐ Unable to obtain (indicate reason)
2. (Admit: Level 2-3 = ≥ 10 ; Level 1 = 2-9)

	NI	Comments (positive or pertinent negs)		NI	Comments
Constitutional			Integumentary		
Eyes			Musculoskeletal		
Ears/Nose/Mouth/Throat			Neurological		
Respiratory			Psychiatric		
Cardiovascular			Endocrinologic		
Gastrointestinal			Hematologic		
Genitourinary			Immunologic		

(Address ALL Histories; the term "non-contributory" is acceptable, when appropriate)

PMH: ☐ Unable to obtain (indicate reason)
☐ Non-contributory

Heart Failure: ☐ Yes ☐ No
☐ Systolic ☐ Diastolic
EF: _____ % on _____
NYHA Class ☐ I ☐ II ☐ III ☐ IV

ACE/ARB <input type="checkbox"/> Yes <input type="checkbox"/> No (indicate reason): <input type="checkbox"/> angioedema <input type="checkbox"/> hypotension <input type="checkbox"/> renal dysfx <input type="checkbox"/> hyperkalemia <input type="checkbox"/> other _____	Beta Blocker <input type="checkbox"/> Yes <input type="checkbox"/> No (indicate reason): <input type="checkbox"/> asthma <input type="checkbox"/> hypotension <input type="checkbox"/> bradycardia <input type="checkbox"/> decompensated HF <input type="checkbox"/> other _____
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History of VTE: ☐ Chronic
☐ DVT Location:
☐ PE

Vaccinations:
☐ Pneumovax Date:
☐ Influenza Date:

FH: ☐ Non obtainable ☐ NC

SH: ☐ Non obtainable ☐ NC

☐ ETOH use
☐ Tobacco use
☐ Illicit drug use

Occupation:
Living Situation:

Contact:

PCP:

Date _____

MULTI-SYSTEM EXAMINATION: *Elaborate abnormal findings*

1. (*Consult: Level 4-5 = 2 boxes in 9 systems; Level 3 = any 12; Level 2 = any 6; Level 1 = any 5*) 2. (*Admit: Level 2-3 = 2 boxes in 9 systems; Level 1 = any 12*)

Constitutional: T: _____ P: _____ BP: _____ RR: _____ O2: _____ WT: _____ ☐ Flow Sheet Reviewed

Appearance:

Eyes: ☐ no scleral icterus ☐ PERRLA ☐ nl fundus exam

E/N/M/T: ☐ nl hearing ☐ nl external canals/tympanic membrane
☐ nl teeth, lips, gums ☐ clear oropharynx

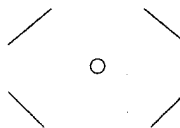
Neck: ☐ nl appearance and movements; nl JVP
☐ trachea midline
☐ no thyroid enlargement, masses

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

Breast: ☐ nl breast symmetry ☐ no masses/tenderness of breast or axillae

Cardiovascular: ☐ nl sounds; no murmurs, gallops or rubs ☐ no JVD
☐ no carotid bruits ☐ nl PMI; no thrill
☐ nl pulses (*indicate*) ☐ femoral ☐ pedal ☐ other:

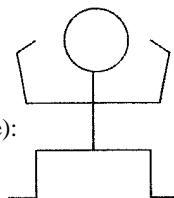
Abdominal: ☐ no tenderness; nl sounds ☐ nop hernias present
☐ no hepatosplenomegaly ☐ nl digital rectal exam
☐ neg hemoccult test



Lymphatic: ☐ no adenopathy ☐ cervical ☐ supraclavicular ☐ axillary ☐ inguinal

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

Skin: ☐ no rashes or ulcers ☐ no nodules
☐ pressure ulcers present on admission (*indicate location/stage*):



Neuro: ☐ nl cranial nerves ☐ nl reflexes ☐ nl sensation

Psych: ☐ alert, oriented to person, place, time
☐ intact memory ☐ nl affect, judgment, insight

Genitourinary: MALE: ☐ nl scrotum; no tenderness or masses ☐ nl penis
☐ nl digital rectal exam or prostate

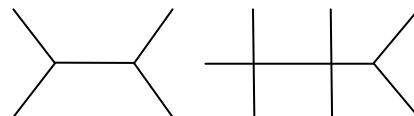
FEMALE: (pelvic exam with or without specimen collection for smear and cultures)
☐ nl external genitalia and vagina ☐ no urethral tenderness
☐ nl bladder; no masses or tenderness
☐ nl cervix; no lesions or discharges ☐ nl uterus
☐ nl adnexa/parametria

Date _____

(3) MEDICAL DECISION MAKING:

Assessment and Plan: *(Possible Dx / Treatment Options / Additional Testing / Therapeutic Intervention)*

Data Review:



EKG

CXR ☐ **NAD**



Present on Admission:

- ☐ Catheter associated urinary tract infection
- ☐ Catheter related blood stream infection

See Attending Supplement

Housestaff/CRNP Signature / Print: _____ MS R1 R2 R3 Fellow CRNP

Date: _____ Time: _____ Pager: _____

Attending Supplement: (Minimum 1 element from 3 components: history, exam, and medical decision making).

I saw and examined the patient, and I agree with the note by Dr/NP/PA _____

- ☐ Discussed w/ other provider:
- ☐ Personally reviewed:
 - ☐ Lab Data ☐ Radiology Reports ☐ Films ☐ ECGs
 - ☐ OSH/Old Records
- ☐ Obtained additional history from family/care providers

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

Consult: ☐ 99251 (20 min) ☐ 99252 (40 min) ☐ 99253 (55 min) ☐ 99254 (80 min) ☐ 99255 (110 min) ☐ Observation Day
Initial: ☐ 99221 (30 min) ☐ 99222 (50 min) ☐ 99223 (70 min) ☐ Critical Care: Total Cumulative Time _____
☐ Prolonged Care: Time: _____ (Face to Face with Patient only) ☐ -25 (Separately identifiable E/M service on procedure day)