

Clinical Decision Support (CDS) Content and Health Level 7 (HL7)- Compliant Knowledge Artifacts (KNARTs)

Primary Care: General Clinical Note - History and Physical Exam Clinical Content White Paper

Department of Veterans Affairs (VA)



**Knowledge Based Systems (KBS)
Office of Informatics and Information Governance (OIIG)
Clinical Decision Support (CDS)**

Clinical Decision Support (CDS) Content and Health Level 7 (HL7)-Compliant Knowledge Artifacts (KNARTs): Primary Care: General Clinical Note - History and Physical Exam Clinical Content White Paper

by Department of Veterans Affairs (VA)

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Table 1. Relevant KNART Information: Primary Care: General Clinical Note - History and Physical Exam

Primary Care KNART	Associated CLIN
General Clinical Note - History and Physical Exam - Documentation Template	CLIN0009CA

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VA Subject Matter Expert (SME) Panel

Name	Title	Project Role
Angela Denietolis, MD	Primary Care Physician, James A. Haley Veterans Hospital, Tampa VA Medical Center (VAMC), Tampa, FL 33612	SME, Primary
Pat Dumas, RN	Clinical Program Director, VA Central Office (VACO), 810 Vermont Avenue NW, Washington, DC 20420	SME, Secondary
Manish Merchant, MD	Health Informatician, Albany VAMC, 113 Holland Avenue, Albany, NY 12208	SME
Timothy Dresselhaus, MD	Chief, Primary Care Service, San Diego VAMC - MEDS, 3350 La Jolla Village Drive, San Diego, CA 92161	SME
David Douglas, MD	Facility Chief Health Informatics Officer, COS – Northwest Innovation Center, Portland VAMC, 3710 SW US Veterans Hospital Road, Portland, OR 97239	E-Consult Expert

Introduction

The VA is committed to improving the ability of clinicians to provide care for patients while increasing quality, safety, and efficiency. Recognizing the importance of standardizing clinical knowledge in support of this goal, VA is implementing the Health Level 7 (HL7) Knowledge Artifact Specification for a wide range of VA clinical use cases. Knowledge Artifacts, referred to as (KNARTs), enable the structuring and encoding of clinical knowledge so the knowledge can be integrated with electronic health records to enable clinical decision support.

The purpose of this Clinical Content White Paper (CCWP) is to capture the clinical context and intent of KNART use cases in sufficient detail to provide the KNART authoring team with the clinical source material to construct the corresponding knowledge artifacts using the HL7 Knowledge Artifact Specification. This paper has been developed using material from a variety of sources: VA artifacts, clinical practice guidelines, evidence in the body of medical literature, and clinical expertise. After reviewing these sources, the material has been synthesized and harmonized under the guidance of VA subject matter experts to reflect clinical intent for this use case.

Unless otherwise noted, items within this white paper (e.g., documentation template fields, orderable items, etc.) are chosen to reflect the clinical intent at the time of creation. To provide an exhaustive list of all possible items and their variations is beyond the scope of this work.

Conventions Used

Conventions used within the knowledge artifact descriptions include:

<obtain>: Indicates a prompt to obtain the information listed

- If possible, the requested information should be obtained from the underlying system(s). Otherwise, prompting the user for information may be required
- The technical and clinical comments associated with a section should be consulted for specific constraints on the information (e.g., time-frame, patient interview, etc.)
- Default Values: Unless otherwise noted, <obtain> indicates to obtain the most recent observation. It is recognized that this default time-frame value may be altered by future implementations

[...]: Square brackets enclose explanatory text that indicates some action on the part of the clinical user, or general guidance to the clinical or technical teams. Examples include, but are not limited to:

[Begin ...], [End ...]: Indicates the start and end of specific areas to clearly delineate them for technical purposes.

[Activate ...]: Initiates another knowledge artifact or knowledge artifact section.

[Section Prompt: ...]: If this section is applicable, then the following prompt should be displayed to the user.

[Section Selection Behavior: ...]: Indicates technical constraints or considerations for the selection of items within the section.

[Attach: ...]: Indicates that the specified item (e.g. procedure or result interpretation) should be attached to the documentation template if available.

[Link: ...]: Indicates that rather than attaching an item (e.g. image), a link should be included in the documentation template.

[Clinical Comment: ...]: Indicates clinical rationale or guidance.

[Technical Note: ...]: Indicates technical considerations or notes to be utilized for KNART authoring and at time of implementation planning.

[If ...]: Indicates the beginning of a conditional section.

[Else, ...]: Indicates the beginning of the alternative branch of a conditional section.

[End if ...]: Indicates the end of a conditional section.

[Check box]: Indicates items that should be selected based upon the section selection behavior.

Chapter 1. Primary Care: General Clinical Note – History and Physical Exam

1.1. Clinical Context

[Begin Clinical Context.]

Capturing clinical information in a structured format greatly enhances its utility as a knowledge object. Applying such an approach to previously unstructured data, such as miscellaneous notes, will greatly increase its value.

Table 1.1. Clinical Context Domains

Target User	Primary Care Clinical providers
Patient	Adult Outpatients
Priority	Routine
Specialty	Primary Care
Location	Outpatient

[End Clinical Context.]

1.2. Knowledge Artifacts

[Begin Knowledge Artifacts.]

This section describes the CDS knowledge artifact that is intended to facilitate documentation of information obtained during an initial primary care new patient visit. The documentation template includes the following sections: Chief complaint, history of present illness, review of systems, sexual assault, annual screening questionnaire, and health literacy assessment.

The knowledge artifact which defines this clinical use case is described in detail in the following sections:

- Documentation Template: Primary Care: General Clinical Note – History and Physical Exam KNART
 - Documents the information obtained during initial primary care new patient visit
 - Includes logic for appropriate display of documentation sections

[End Knowledge Artifacts.]

Chapter 2. Primary Care: General Clinical Note - History and Physical Exam Documentation Template

[Begin Primary Care: General Clinical Note - History and Physical Exam Documentation Template.]

2.1. Knowledge Narrative

[Begin Knowledge Narrative.]

[See Clinical Context in Chapter 1.]

[Technical Note: The Documentation template shall:

- Allow for the efficient documentation of a general clinical note during initial patient evaluation; and
- Adjust content presented to the clinician as needed during the evaluation; and
- Pre-populate with existing data from the patient's medical record for review and editing by the end-user.]

[End Knowledge Narrative.]

2.2. General Clinical Note

[Technical Note: The template will be structured as follows.]

2.2.1. Demographics

[Begin Demographics.]

[Section Prompt: Demographics.]

<obtain> Patient Name
<obtain> Medical Record Number
<obtain> Attending Physician
<obtain> Other Current Clinical Providers
 <obtain> Mental Health Providers
 <obtain> Social Workers
 <obtain> Residents (Include If Current)
 <obtain> Other Providers
<obtain> Date of Birth
<obtain> Age (Years)
<obtain> Sex
<obtain> Self-Reported Gender Identity
<obtain> Race/Ethnicity

<obtain> Preferred Language

[Section Prompt: Translator Needed.]

[Section Selection Behavior: Select only one. Required.]

Yes

No

[End Demographics.]

2.2.2. History

[Begin History.]

[Technical Note: The template will provide links to other targeted KNARTs where additional detail is needed.]

[Technical Note: Any information that can be obtained from the system should pre-populate the section fields in a manner that is apparent to the end user.]

[Technical Note: Any automatically obtained data should be editable by the user of the KNART.]

[Technical Note: The ability for the end user to enter multiples is necessary to be built during authoring.]

[Section Prompt: Visit Reason/Chief Complaint.]

<obtain> Description

[Section Prompt: History of Present Illness.]

<obtain> Details of history of present illness

Past Medical History

[Section Prompt: Past Medical History.]

<obtain> Past Medical History

<obtain> Mental Health History

[Technical Note: Link to future Mental Health History KNART.]

[Section Prompt: Are you currently seeing someone or taking medication for stress-related concerns, or for a mental health concern such as Post-Traumatic Stress Disorder (PTSD)?]

<obtain> Behavioral Health Condition and Treatment History

[Section Prompt: Have you ever received treatment (such as medication or counseling) for a stress-related concern, or for a mental health concern such as PTSD?]

<obtain> Behavioral Health Condition and Treatment History

[Section Prompt: Have you ever been to the Emergency Room or have you ever been hospitalized for a stress-related concern, or mental health concern such as PTSD?]

<obtain> Behavioral Health Condition and Treatment History

Military History

[Section Prompt: Military History.]

<obtain> Primary military occupation

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Documentation Template

<obtain> Secondary military occupations

<obtain> Military Exposure (Agent Orange, etc.)

<obtain> Years of Service

<obtain> Separation from service date

<obtain> Branch of Service

<obtain> Overseas Travel

<obtain> Conflict History

<obtain> Additional Details

Medication History

[Section Prompt: Medication History.]

[Technical Note: Link to future Medication Reconciliation KNART.]

[Technical Note: “Recently Expired Medications” is defined in the VA’s “ESSENTIAL MEDICATION INFORMATION STANDARDS” directive as “within the past 90 to 120 days”. The directive is located at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3119 (follow the links in Appendix A).]

<obtain> Current Prescribed Medications

<obtain> Current Over-the-Counter (OTC) Medications

[Technical Note: The following field should be completed automatically.]

<obtain> Recently Expired Medications

Allergies and Adverse Reactions

[Section Prompt: Allergies and Adverse Reactions.]

<obtain> Allergies and Adverse Reactions

Surgical History

[Section Prompt: Surgical History.]

[Technical Note: Allow for multiple entry.]

<obtain> Surgical Procedure

<obtain> Surgical Date

Family Medical History

[Section Prompt: Family Medical History.]

[Technical Note: Link to Family Health History KNART.]

<obtain> Family Medical History

Preventative Services History

[Section Prompt: Preventative Services History.]

[Technical Note: Provide the following links to the user of this KNART:
<https://www.medicare.gov/coverage/preventive-and-screening-services.html>; <https://www.prevention.va.gov/>;

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https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Men.asp;

https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp]

<obtain> Preventative Services History

Personal and Social History

[Section Prompt: Living Situation/Social Support/Financial Support.]

<obtain> Living Situation

<obtain> Marital Status/Domestic Status

<obtain> Current Occupation

<obtain> Level of Education

<obtain> Additional Personal, Social, and Employment History

[Section Prompt: Substance Use.]

<obtain> Alcohol

<obtain> Tobacco

<obtain> Illicit drug(s)

[Section Prompt: Sexual and Abuse History.]

<obtain> Sexual Activity

<obtain> Sexual Assault/Abuse History

<obtain> Military Sexual Trauma History

<obtain> Physical or Other Assault/Abuse History

[Section Prompt: Disability Rating.]

<obtain> Military disability rating

Review of Systems

[Section Prompt: Review of Systems.]

[Section Prompt: Complete only relevant sections if complete history and physical not intended.]

[Technical Note: Link to Review of Systems KNART (not currently available).]

<obtain> Constitutional Symptoms (for example, fever, weight loss)

<obtain> Eyes

<obtain> Ears, nose, mouth, throat

<obtain> Cardiovascular

<obtain> Respiratory

<obtain> Gastrointestinal

<obtain> Genitourinary

<obtain> Musculoskeletal

<obtain> Integumentary (skin and/or breast)

<obtain> Neurological

<obtain> Psychiatric

<obtain> Endocrine

<obtain> Hematologic/Lymphatic

<obtain> Allergic/Immunologic

[End History.]

2.2.3. Screening

[Begin Screening.]

[Technical Note: The template will provide links to other targeted KNARTs where additional detail is needed.]

[Screen Prompt: Screening.]

<obtain> Health Literacy

<obtain> Cognition

<obtain> Self-Reported Health Rating

<obtain> Nutrition/Diet

<obtain> Exercise/Physical Activity

[Technical Note: Link to Clinical Reminder if there is one available.]

<obtain> Alcohol Use

[Technical Note: Link to Tobacco Assessment and Cessation Counseling KNART.]

<obtain> Tobacco Use

<obtain> Substance Use (Including Prescription Drugs)

[Technical Note: Link to Consult for Depression and Suicide Risk Assessment KNARTs.]

<obtain> Consult for Depression

<obtain> Suicide Risk Assessment

[Technical Note: Link to PTSD Screening and Assessment KNART.]

<obtain> PTSD history

[Clinical Comment: Scale is 0-10 for the pain instrument below.]

<obtain> Pain Level (0-10)

[Section Prompt: Functional Assessment.]

[Technical Note: Provide user a link to the Katz Index of ADLs and Lawton-Brody Instrumental Activities of Daily Living scale:

https://clas.uiowa.edu/socialwork/sites/clas.uiowa.edu.socialwork/files/NursingHomeResource/documents/Katz%20ADL_LawtonIADL.pdf

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<obtain> Safety (Including Fall Risk, If Appropriate)

<obtain> Additional Risk Factors

[Section Prompt: Advance Directive Confirmed Accessible to Providers.]

Yes

<obtain> Additional Details

No

[End Screening.]

2.2.4. Physical Examination

[Begin Physical Examination.]

[Section Prompt: Vital Signs.]

[Technical Note: Any information that can be obtained from the system should pre-populate the section fields in a manner that is apparent to the end user.]

<obtain> Systolic Blood Pressure (BP) (mm Hg)

<obtain> Diastolic BP (mm Hg)

<obtain> Temperature (°F)

<obtain> Heart Rate beats per minutes (bpm)

<obtain> Respiratory rate breaths per minute

<obtain> Oxygen Saturation (%)

<obtain> Height (Inches)

<obtain> Weight (Pounds)

[Technical Note: Body mass index (BMI) should be calculated and provided below, in kilograms per square meter (kg/m²), using the formula BMI = 703 × weight (pounds)/height (inches)².]

<obtain> Body Mass Index (kg/m²)

<obtain> Waist Circumference (Centimeters)

[Section Prompt: Physical Exam.]

<obtain> Head, Eyes, Ears, Nose, Throat (HEENT) Exam

<obtain> Neck Exam

<obtain> Cardiovascular Exam

<obtain> Pulmonary Exam

<obtain> Abdominal Exam

<obtain> Genitourinary Exam

<obtain> Extremities Exam

<obtain> Musculoskeletal Exam

<obtain> Skin Exam

<obtain> Neurological Exam

[Section Prompt: Laboratory Results.]

[Technical Note: The following field should be completed automatically if results are available.]

[Technical Note: Provide access to all lab data, with ability to filter by lab type or date.]

<obtain> Laboratory Test Results

[Section Prompt: Imaging Results.]

[Technical Note: Images should be attached automatically if text is provided for the following field.]

[Technical Note: Provide access to all images, with ability to filter by image type or date.]

<obtain> Imaging Study Reports

<link> Image

[End Physical Examination.]

2.2.5. Assessment and Plan

[Begin Assessment.]

[Section Prompt: Assessment.]

<obtain> Details

□ Assessments and Plan, Including Risks and Benefits of Recommended Treatment, Discussed with Patient

[End Assessment.]

[Begin Plan.]

<obtain> Plan of Treatment

<obtain> Preventive Services

[Technical Note: Provide links to:

National Center for Health Promotion and Disease Prevention's Get Recommended Screening Tests and Immunizations for Men;

https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Men.asp

Get Recommended Screening Tests and Immunizations for Women;

https://www.prevention.va.gov/Healthy_Living/Get_Recommended_Screening_Tests_and_Immunizations_for_Women.asp

U.S. Preventive Services Task Force's (USPSTF) A and B Recommendations;

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<obtain> Preventive Counseling

<obtain> Patient Education

[Technical Note: Provide link www.veteranshealthlibrary.org]

<obtain> Self-Management Education

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[Section Prompt: Medications Plan.]

<obtain> Current Medications

Continue Medications

<obtain> Continued Medications

Discontinue Medications

<obtain> Discontinued Medications

[Technical Note: If either of the following – "Modified Medications" or "New Medications" – are selected, the clinician should be able to select and attach relevant order sets.]

Modified Medications

<obtain> Modified Medications

New Medications

<obtain> New Medications

[Technical Note: Provide link to Medication Reconciliation KNART as available.]

<obtain> Other Plans

[Section Prompt: Consultations?]

<obtain> Consultations

<obtain> Consult specifics

[Section Prompt: Next Visit?]

<obtain> Next visit date

Patient Expresses Understanding and Agrees with Plan

[End Plan.]

[End Primary Care: General Clinical Note - History and Physical Exam Documentation Template.]

Bibliography/Evidence

[Denny, 2008] JC Denny, RA Miller, KB Johnson, and A Spickard. “Development and evaluation of a clinical note section header terminology”. AMIA Annu Symp Proc 2008. 2008. 156-160.

[Goetzel, 2011] RZ Goetzel, P Staley, L Ogden, and et al. “U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. A framework for patient-centered health risk assessments – providing health promotion and disease prevention services to Medicare beneficiaries”. Centers for Disease Control and Prevention Website. Published 2011. Accessed August 29, 2017.

National Center for Health Promotion and Disease Prevention. Get Recommended Screening Tests and Immunizations for Men. Accessed August 29, 2017.

National Center for Health Promotion and Disease Prevention. Get Recommended Screening Tests and Immunizations for Women. Accessed August 29, 2017.

[Section 4103 of the Affordable Care Act] “Medicare coverage and payment of the annual wellness visit providing a personalized prevention plan under Medicare Part B”. FedRegist. 2011. 76. 228. 42 CFR §410, §414, §415, and §495.

The Opioid Therapy for Chronic Pain Work Group. VA/Department of Defense (DoD) Clinical Practice Guideline for Opioid Therapy for Chronic Pain. Published February 2017.

U.S. Preventive Services Task Force. USPSTF A and B Recommendations. Updated April 2017.

Appendix A. Existing Sample VA Artifacts

The following artifacts are from the VA National Primary Care Note Template.

Figure A.1. VA National Primary Care Note Template: VA Primary Care New Patient - Visit/Chief Complaint and Past History Sections

Template: VA PC New Patient

REASON FOR VISIT/CHIEF COMPLAINT:
(Describe symptom, problem, condition, diagnosis in patient's words if possible)
 Acute problem(s) Chronic problem(s) Health maintenance
 Related to MVA/Accident Work-related

(HPI: include location, quality, severity, duration, modifying factors & associated signs/symptoms)

SOURCE(S) OF HISTORY: Patient Family Outside records VA records Unobtainable
(If history obtained from family member, specify which family member)
(If unobtainable, specify reason such as coma, dementia, aphasia, psychosis)

PAST HISTORY:

ADULT ILLNESS: HTN Diabetes CAD/IHD Hyperlipidemia CVA

CHILDHOOD ILLNESS:

SURGERIES

INJURIES:

FEMALE GENDER SPECIFIC HISTORY:
AGE AT MENARCHE:
DATE LAST MENSTRUAL PERIOD:
DESCRIBE MENSES:
BIRTH CONTROL: None Pill Diaphragm
PREGNANCIES/MISCARRIAGES/ABORTIONS:

All None * Indicates a Required Field Preview OK Cancel

Figure A.2. VA National Primary Care Note Template: VA Primary Care New Patient - Female Gender Specific History and Social History Section

Template: VA PC New Patient

FEMALE GENDER SPECIFIC HISTORY:

AGE AT MENARCHE: _____

DATE LAST MENSTRUAL PERIOD: _____

DESCRIBE MENSES: _____

BIRTH CONTROL: None Pill Diaphragm

PREGNANCIES/MISCARRIAGES/ABORTIONS:

Number of full term pregnancies: _____

Number of spontaneous abortions: _____

Number of therapeutic abortions: _____

Number of other types Abortions: _____

Age at first pregnancy: _____

DATE LAST PAP SMEAR: _____ RESULTS: _____

DATE LAST MAMMOGRAM: _____ RESULTS: _____

SOCIAL HISTORY: (HABITS/MARITAL STATUS/MISC)

HABITS: (If pt drinks, indicate amount by clicking first down arrow.
If past hx of alcohol abuse or currently enrolled in alcohol
program click second down arrow)

ALCOHOL? No alcohol in past year (+) Alcohol use

TOBACCO? Lifelong Non-user. Ex-tobacco user Current user.

ILLICIT DRUGS? Never used. Past user. Present user.

(Select to add additional text)

MARITAL/DOMESTIC STATUS:
Living arrangements: _____
 Married. Widowed. Divorced. Single. Separated. Other (give details): _____

All None * Indicates a Required Field Preview OK Cancel

Figure A.3. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status Section

Template: VA PC New Patient

MARITAL/DOMESTIC STATUS:

Living arrangements:

Married. Widowed. with spouse/partner
 with children
 with parents
 with extended family
 with friend/caregiver
 alone
 residential living facility
 nursing home
 homeless
 other:

OTHER: (Include: Education, Work, Hobbies, etc.)

(SOCIAL HISTORY - MILITARY/SEX)

ALLERGIES AS DISPLAYED IN VISTA:

SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX, TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE, POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD, SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS, GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY, MAYONNAISE, HONEY BEE STINGS, GREEN TEA, MUSTARD, STRAWBERRIES, SIMVASTATIN, FOOD DYES, MORPHINE, HEPARIN, APPLE CIDER VINEGAR, ASPIRIN RELATED MEDICATIONS, IBUPROFEN/PSEUDOEPHEDRINE, BEE STINGS, DUST

(Inquire about any changes since Vista was last updated.)

Patient/family state(s): No new allergies (+) New allergies:

MEDICATIONS (as listed in Vista):

Active Outpatient Medications (excluding Supplies):

Active Outpatient Medications	Status
1) ACETAMINOPHEN 325MG TAB TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2) CIMETIDINE 400MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY BEFORE MEALS AS NEEDED FOR STOMACH ACID	ACTIVE

OTC OR NON-VA PRESCRIPTION MEDICATIONS: (List OTC meds, herbals, vitamins & ASA)

All None * Indicates a Required Field Preview OK Cancel

Figure A.4. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History and Military History (Branch of Service)

Template: VA PC New Patient

MARITAL/DOMESTIC STATUS:
Living arrangements:
 Married. Widowed. Divorced. Single. Separated. Other (give details):

OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:
BRANCH OF SERVICE: Was patient a POW? - Yes No
Period of Service:
SPECIFIC YEARS OF SERVICE:
ENVIRONMENTAL EXPOSURE:
Navy
None

SEXUALLY ACTIVE? Yes No
(Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:
(If patient reports abuse click on down arrow and indicate type of abuse)
 Denies abuse Reports abuse: (Type of abuse:)
 Past abuse Recent abuse Ongoing abuse

ALLERGIES AS DISPLAYED IN VISTA:
SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX
TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE
POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD
SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS
GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY
MAYONNAISE, HONEY BEE STINGS, GREEN TEA, MUSTARD, STRAWBERRIES, SIMVASTATIN

* Indicates a Required Field

Figure A.5. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History and Military History Sections (Period of Service)

Template: VA PC New Patient

MARITAL/DOMESTIC STATUS:
Living arrangements: Married. Widowed. Divorced. Single. Separated. Other (give details):

OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:
BRANCH OF SERVICE: Was patient a POW? - Yes No
PERIOD OF SERVICE:
SPECIFIC YEARS OF SERVICE: WWII (Dec 1941-Dec 1946)
ENVIRONMENTAL EXPOSURE: Korean War (July 1950-January 1955)
Vietnam era (Aug 1964-April 1975)
Persian Gulf (Aug 1990-)
Other

SEXUALLY ACTIVE? Yes No
(Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:
(If patient reports abuse click on down arrow and indicate type of abuse)
 Denies abuse Reports abuse: (Type of abuse): Past abuse Recent abuse Ongoing abuse

ALLERGIES AS DISPLAYED IN VISTA:
SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX
TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELK, TAPE, CHOCOLATE, ORANGE JUICE
POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD
SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS
GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY
MAYONNAISE HONEY RER STINGS GREEN TRA MUSTARD STRAWBERRIES STMVASTATIN

All None * Indicates a Required Field Preview OK Cancel

Figure A.6. VA National Primary Care Note Template: VA Primary Care New Patient - Marital/Domestic Status, Social History, Military History and Screen for Physical/Psychological/Sexual Abuse Sections

Template: VA PC New Patient

MARITAL/DOMESTIC STATUS:
Living arrangements: Married. Widowed. Divorced. Single. Separated. Other (give details):

 OTHER: (Include: Education, Occupation, Travel hx, Exercise habits, etc.)

(SOCIAL HISTORY - MILITARY/SEXUAL/ABUSE)

MILITARY HISTORY:
BRANCH OF SERVICE: Was patient a POW? - Yes No
PERIOD OF SERVICE:
SPECIFIC YEARS OF SERVICE
ENVIRONMENTAL EXPOSURE:

SEXUALLY ACTIVE? Yes No
(Comment on: Preference, multiple partners, use of protection, etc.)

SCREEN FOR PHYSICAL/PSYCHOLOGICAL/SEXUAL ABUSE:
(If patient reports abuse click on down arrow and indicate type of abuse)
 Denies abuse Reports abuse: (Type of abuse): Past abuse Recent
physical
psychological
sexual

ALLERGIES AS DISPLAYED IN VISTA:
SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX
TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELK, TAPE, CHOCOLATE, ORANGE JUICE
POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD
SKELAXIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS
GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY
MAYONNAISE HONEY RER STINGS GREEN TRA MUSTARD STRAWBERRIES STMVASTATIN

All None * Indicates a Required Field Preview OK Cancel

Figure A.7. VA National Primary Care Note Template: VA Primary Care New Patient - Allergies as Displayed in Vista, Medications, Over the Counter (OTC) or Non-VA Prescription Medications, and Family History Sections

Template: VA PC New Patient

ALLERGIES AS DISPLAYED IN VISTA:
 SULFA-GYN, LORAZEPAM, SULFABENZAMIDE/SULFACETAMIDE/SULFATHIAZOLE, IODINE, LATEX
 TERAZOSIN, DIPHENHYDRAMINE 12.5MG/5ML ELX, TAPE, CHOCOLATE, ORANGE JUICE
 POWDER FREE GLOVES, SEAFOOD, PENICILLIN, PLASTIC TAPE, VASELINE, GOLDENROD
 SKELAKIN 800MG TAB, BUTTER, ACTIVASE, AMOXICILLIN, DOCUSATE/MINERAL OIL, MANGOS
 GREEN BELL PEPPERS, HAIR SPRAY, MILK, LUBRICANT, VAGINAL, SHELLFISH, CURRY
 MAYONNAISE, HONEY BEE STINGS, GREEN TEA, MUSTARD, STRAWBERRIES, SIMVASTATIN
 FOOD DYES, MORPHINE, HEPARIN, APPLE CIDER VINEGAR, ASPIRIN RELATED MEDICATIONS
 IBUPROFEN/PSEUDOEPHEDRINE, BEE STINGS, DUST
 (Inquire about any changes since VISTA was last updated.)
 Patient/family state(s): No new allergies (+) New allergies:

MEDICATIONS (as listed in Vista):
 Active Outpatient Medications (excluding Supplies):

Active Outpatient Medications	Status
1) ACETAMINOPHEN 325MG TAB TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED FOR PAIN	ACTIVE
2) CIMETIDINE 400MG TAB TAKE ONE TABLET BY MOUTH TWICE A DAY BEFORE MEALS AS NEEDED FOR STOMACH ACID	ACTIVE

OTC OR NON-VA PRESCRIPTION MEDICATIONS: (List OTC meds, herbals, vitamins & ASA)

FAMILY HISTORY: (Include pertinent family history. Inquire about family hx of colorectal cancer, gender specific cancers, DM, CAD/IHD)

REVIEW OF SYSTEMS (Include at least ONE system from one of the following: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Hair, Neuro, Psych, Endocrine, Hematologic/Lymphatic, Allergy/Immune System)

All None * Indicates a Required Field Preview OK Cancel

Figure A.8. VA National Primary Care Note Template: VA Primary Care New Patient - Review of Systems Section

Template: VA PC New Patient

REVIEW OF SYSTEMS (Include at least ONE system from one of the following: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Hair, Neuro, Psych, Endocrine, Hematologic/Lymphatic, Allergy/Immune System)

(Click here for expanded point and click format) Review of Systems

Constitutional:

(+) Positive symptoms reported:

- Fevers, chills, weakness, nights sweats and weight change
- Fevers
- Chills
- Weakness
- Night Sweats
- Weight loss (unintentional)
- Weight gain (unintentional)

(-) Negative for:

- Fevers, chills, weakness, nights sweats and weight change
- Fevers
- Chills
- Weakness
- Night Sweats
- Weight loss (unintentional)
- Weight gain (unintentional)

Eyes:
 Ears:
 Nose:
 Mouth/Dental:

All None * Indicates a Required Field Preview OK Cancel

Figure A.9. VA National Primary Care Note Template: VA Primary Care New Patient - Review of Systems, Eyes Negative for Symptoms Section

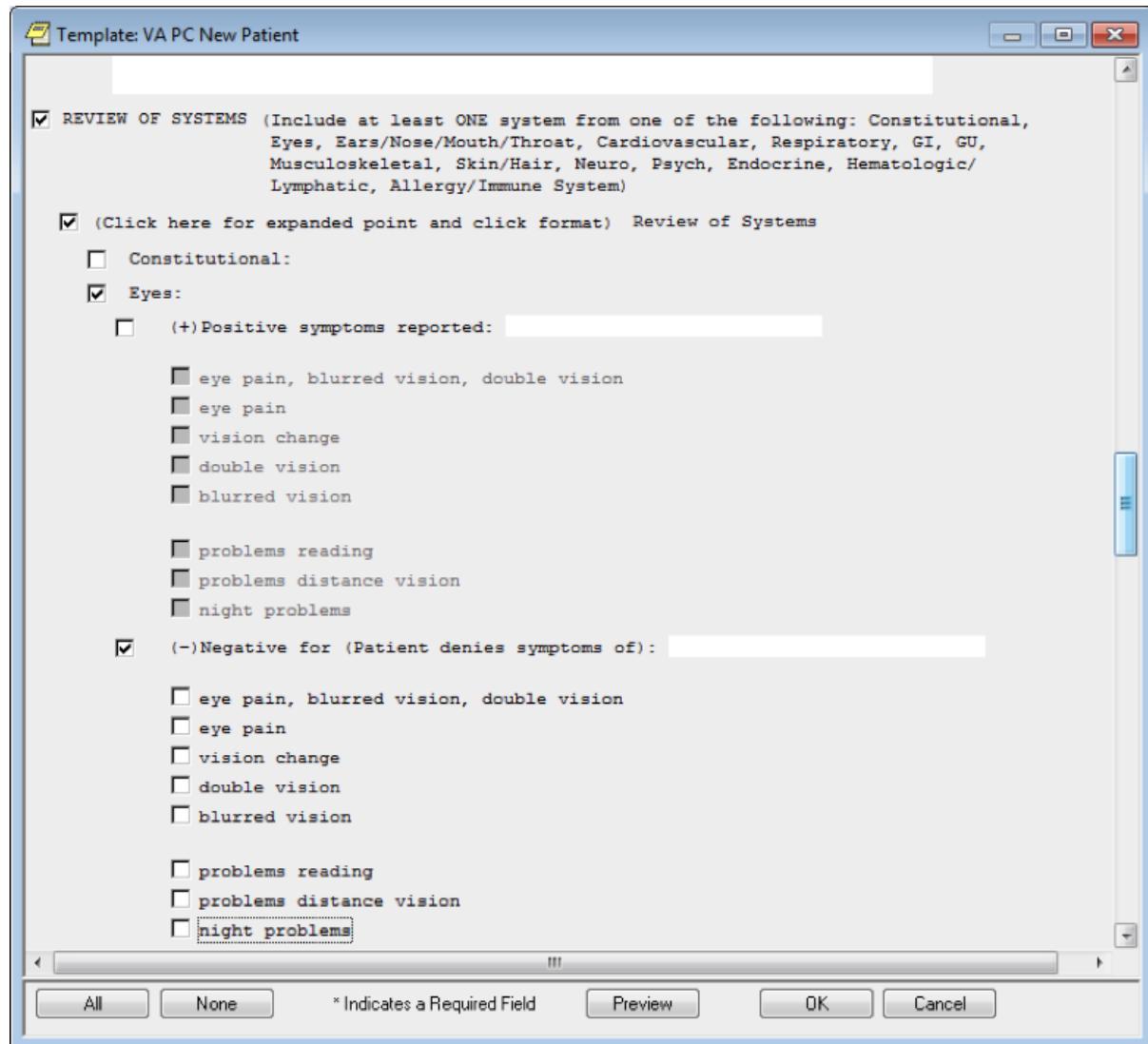


Figure A.10. VA National Primary Care Note Template: VA Primary Care New Patient - Nose Positive Symptoms Reported Section

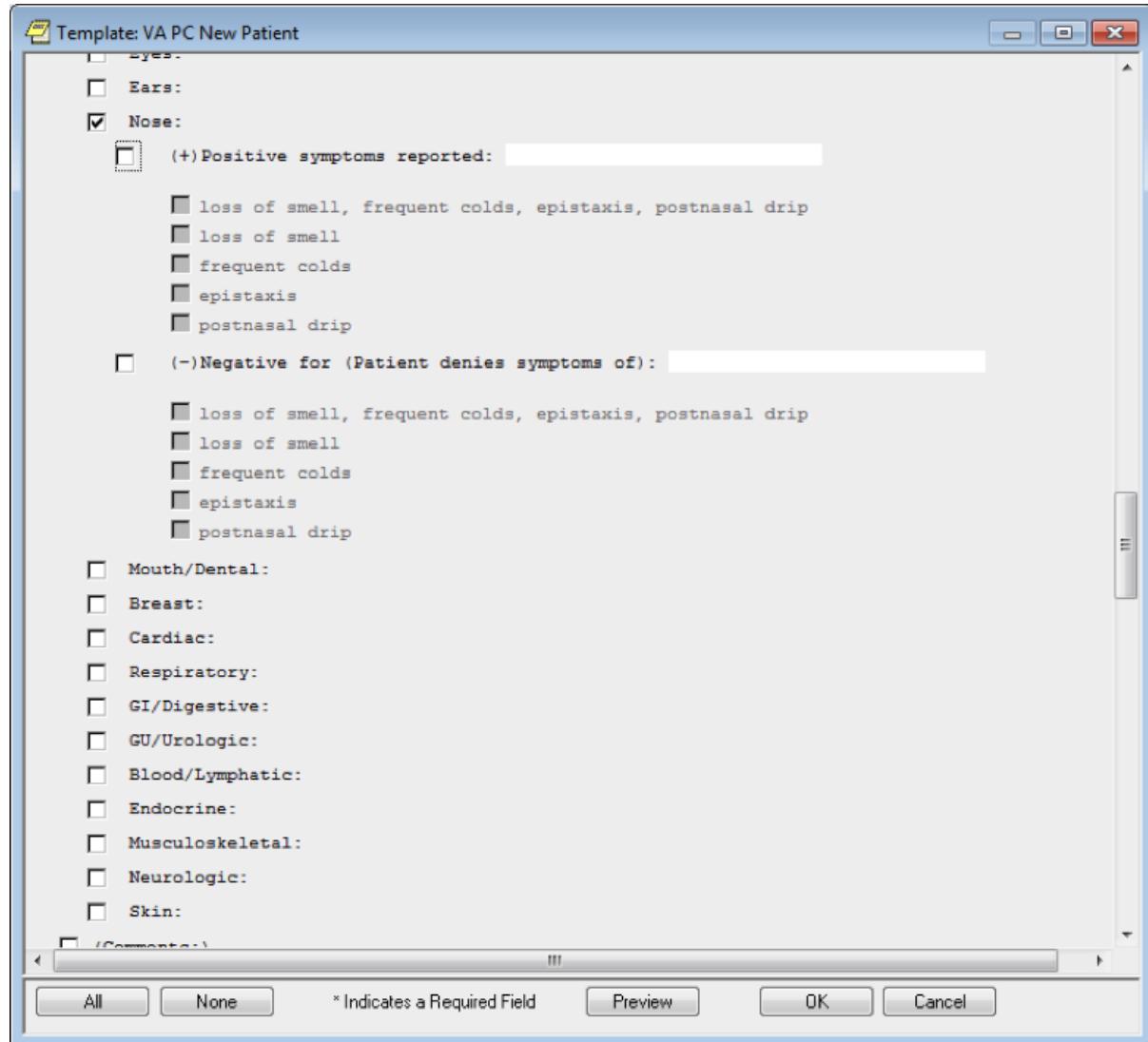


Figure A.11. VA National Primary Care Note Template: VA Primary Care New Patient - Ears with Positive Symptoms Reported and Negative for Symptoms Sections

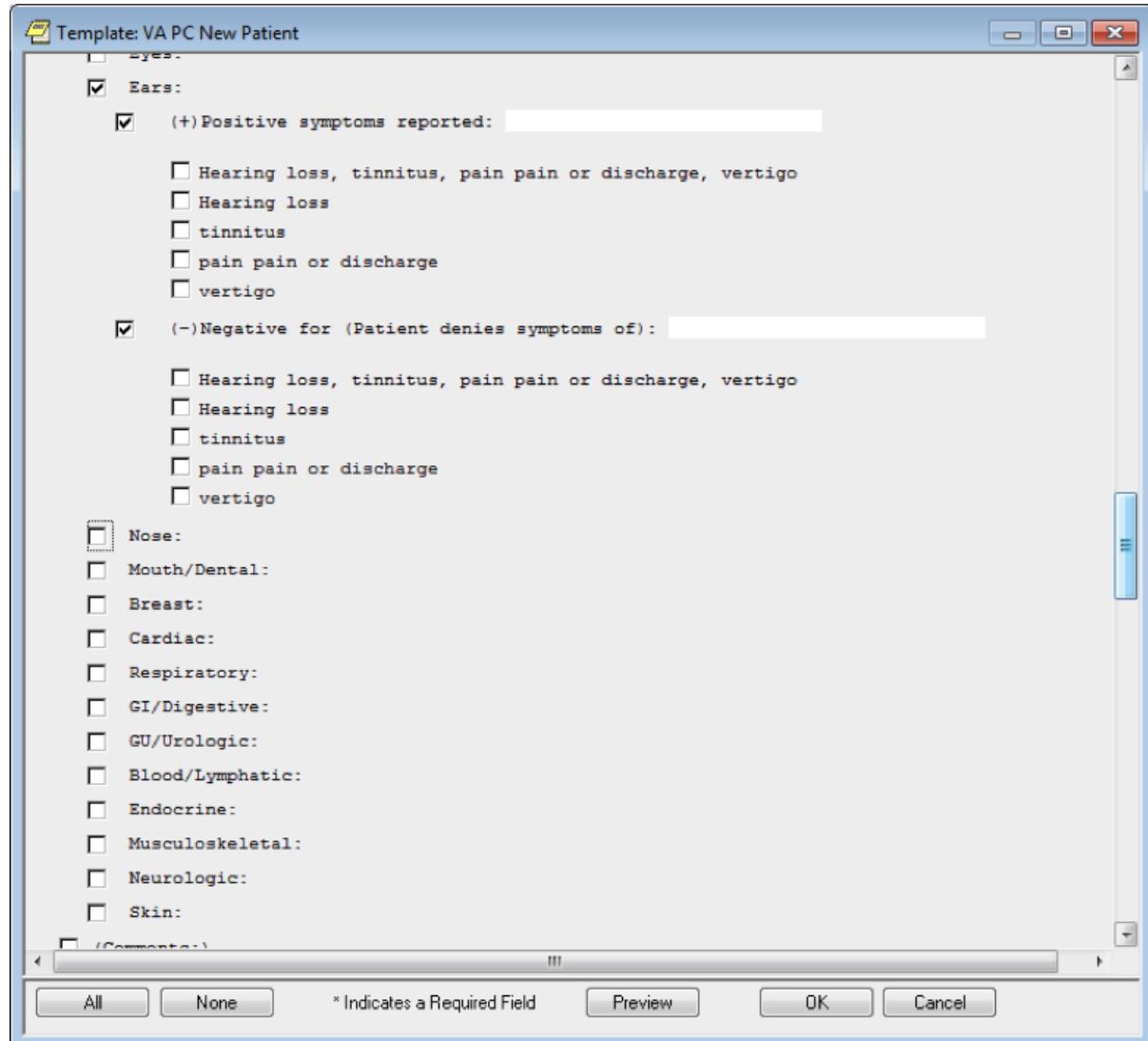


Figure A.12. VA National Primary Care Note Template: VA Primary Care New Patient - Mouth/Dental Section

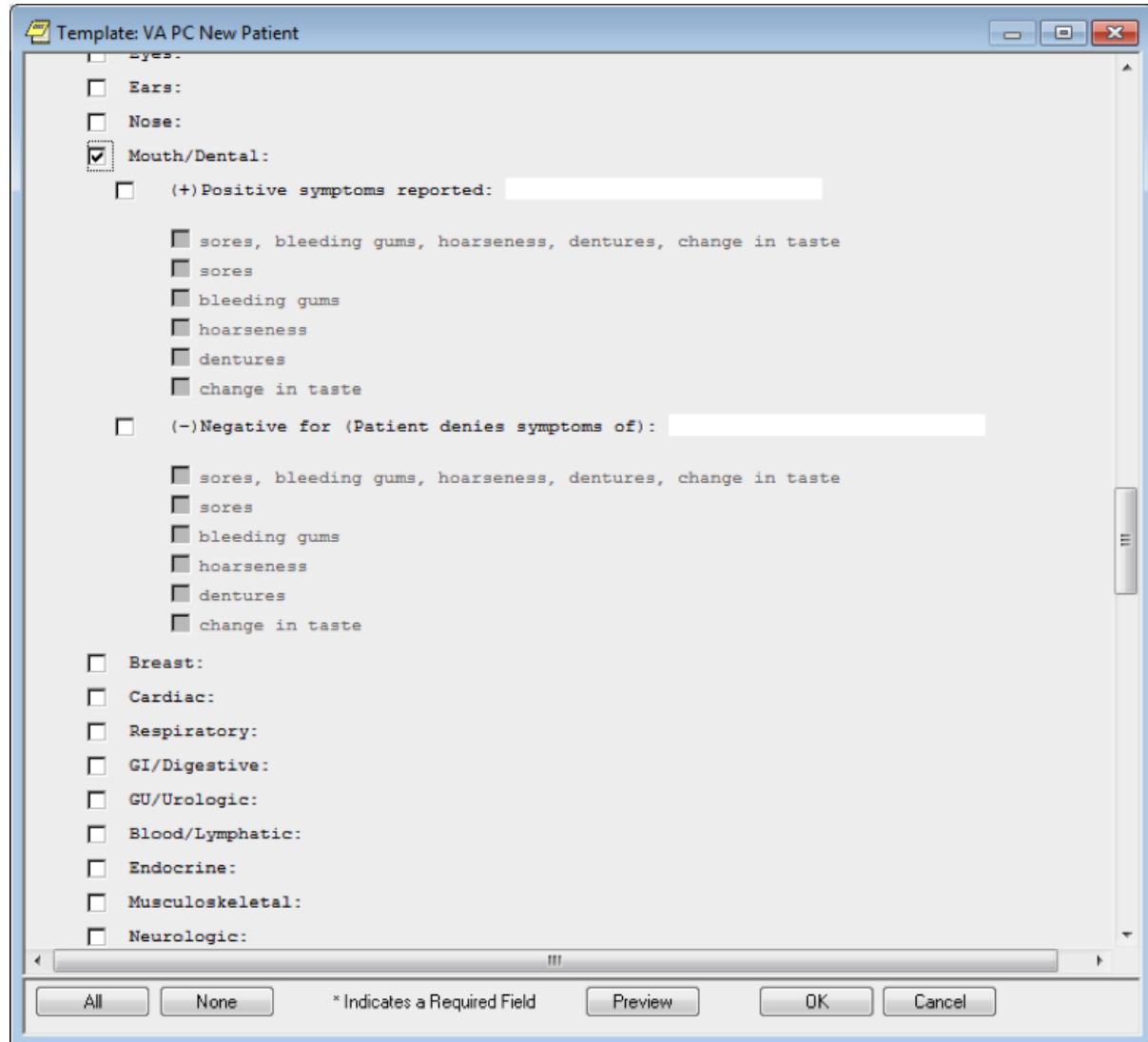


Figure A.13. VA National Primary Care Note Template: VA Primary Care New Patient - Breast Section

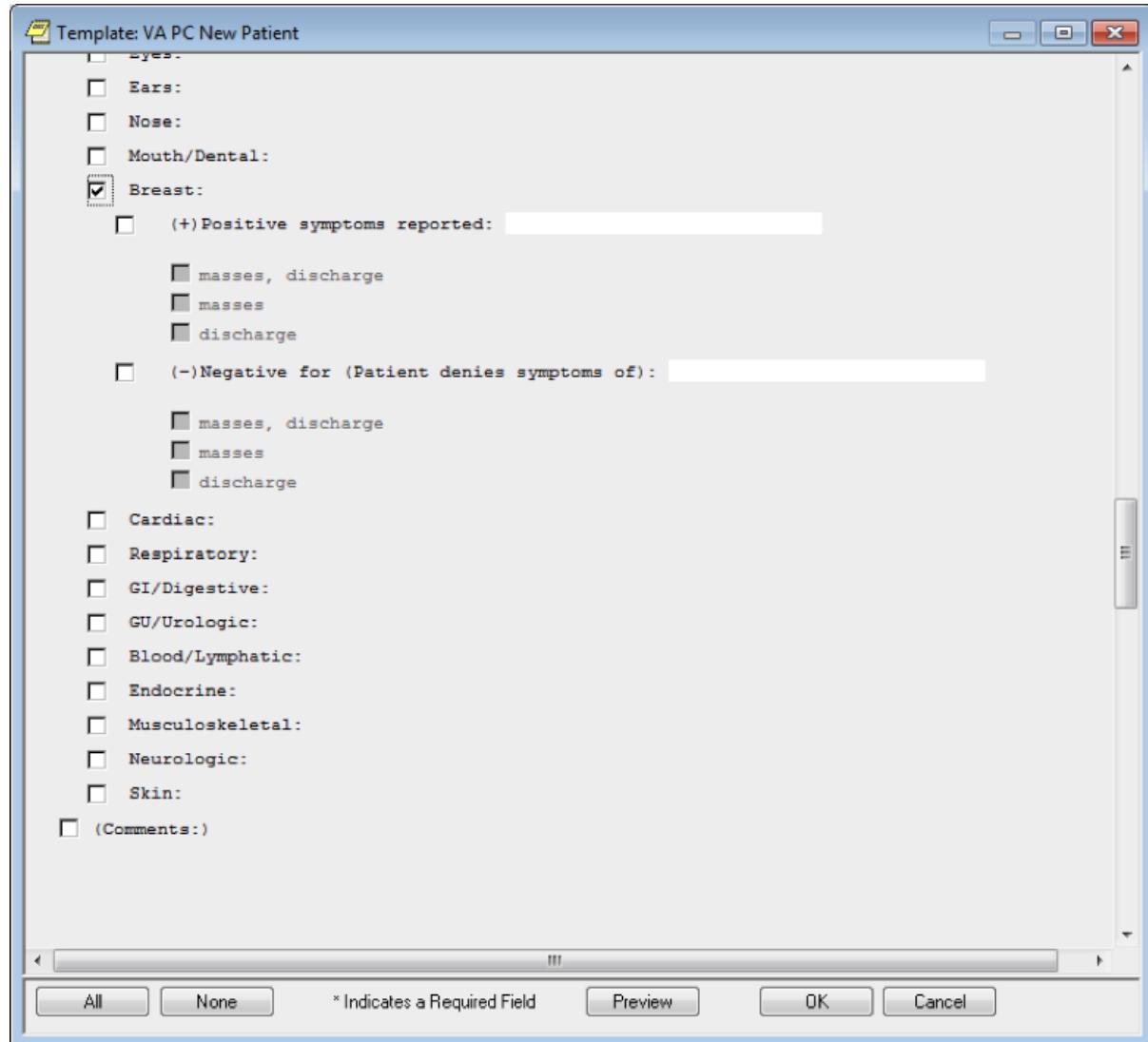


Figure A.14. VA National Primary Care Note Template: VA Primary Care New Patient - Cardiac Section

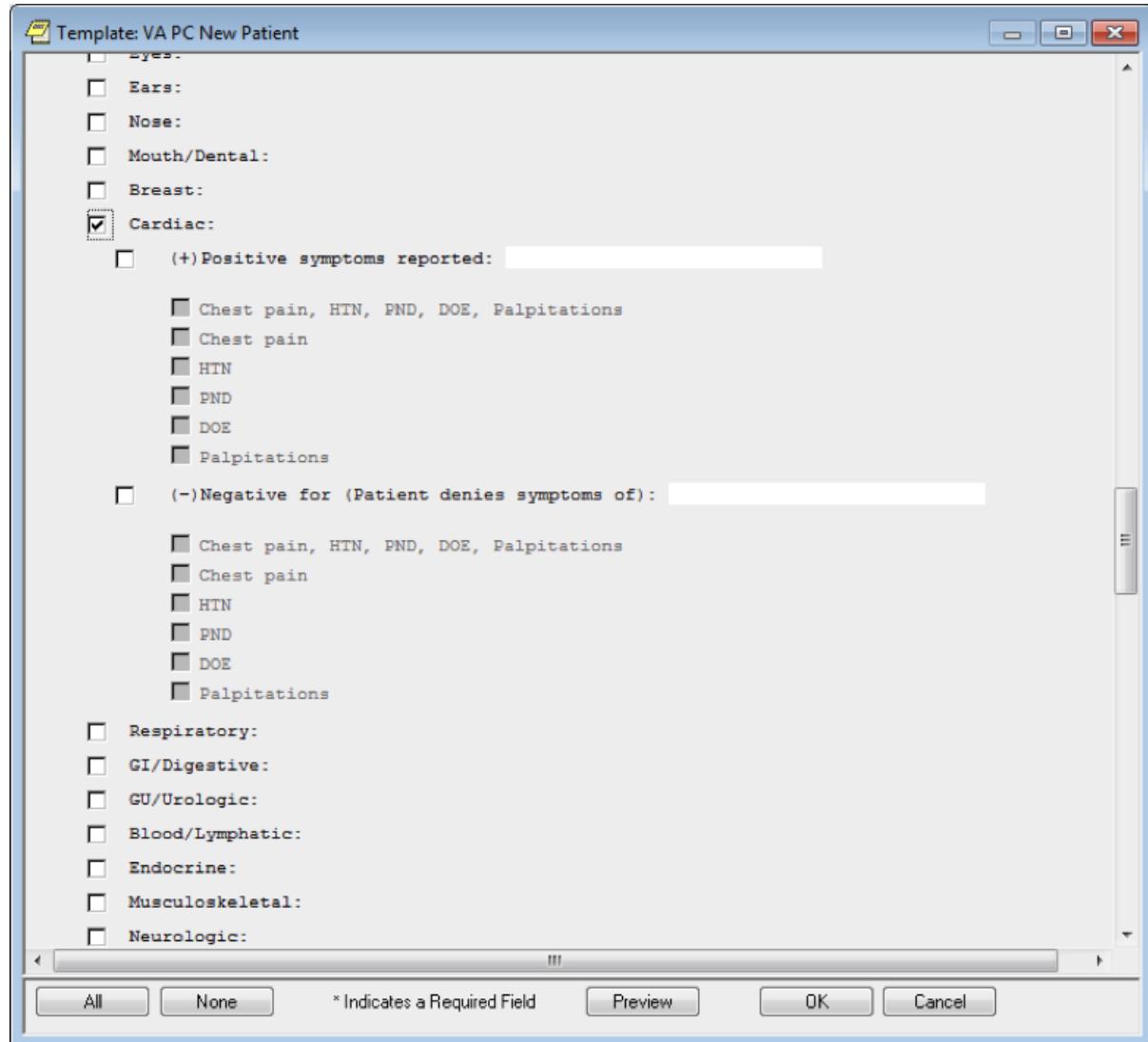


Figure A.15. VA National Primary Care Note Template: VA Primary Care New Patient - Respiratory Section

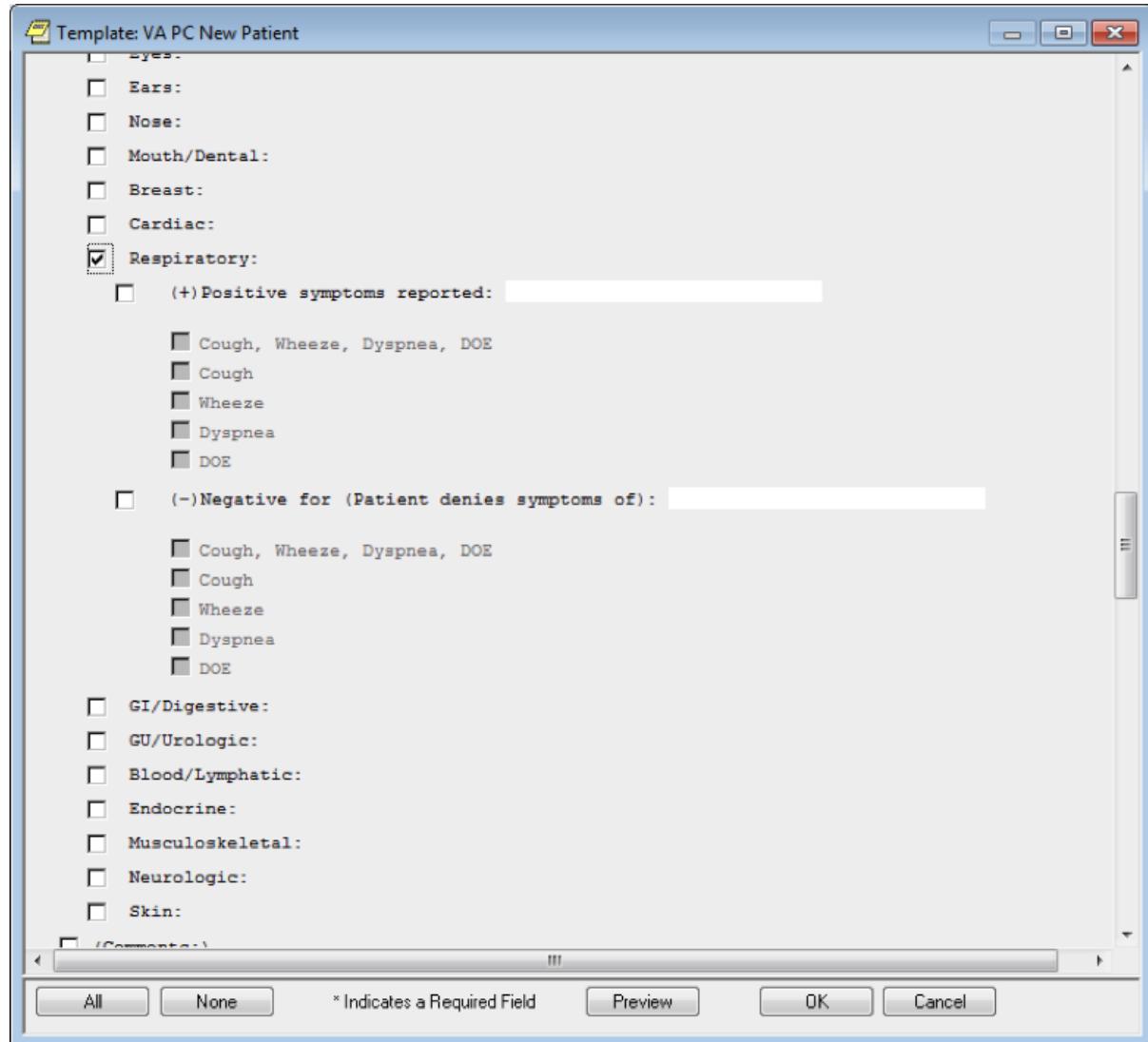


Figure A.16. VA National Primary Care Note Template: VA Primary Care New Patient - Gastroenterology (GI)/Digestive Section

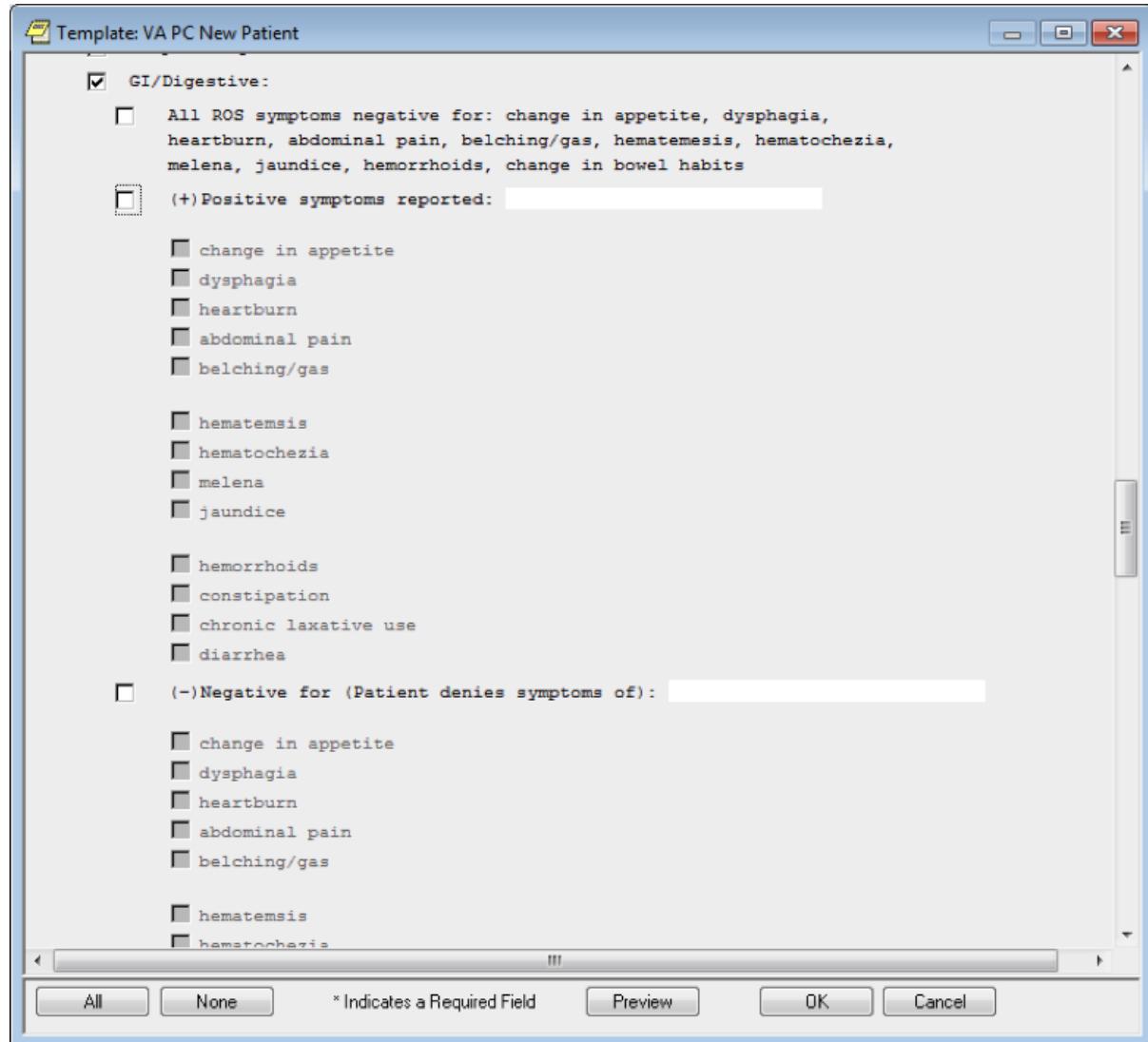


Figure A.17. VA National Primary Care Note Template: VA Primary Care New Patient - Gastroenterology (GI)/Digestive with Negative for Symptoms Section

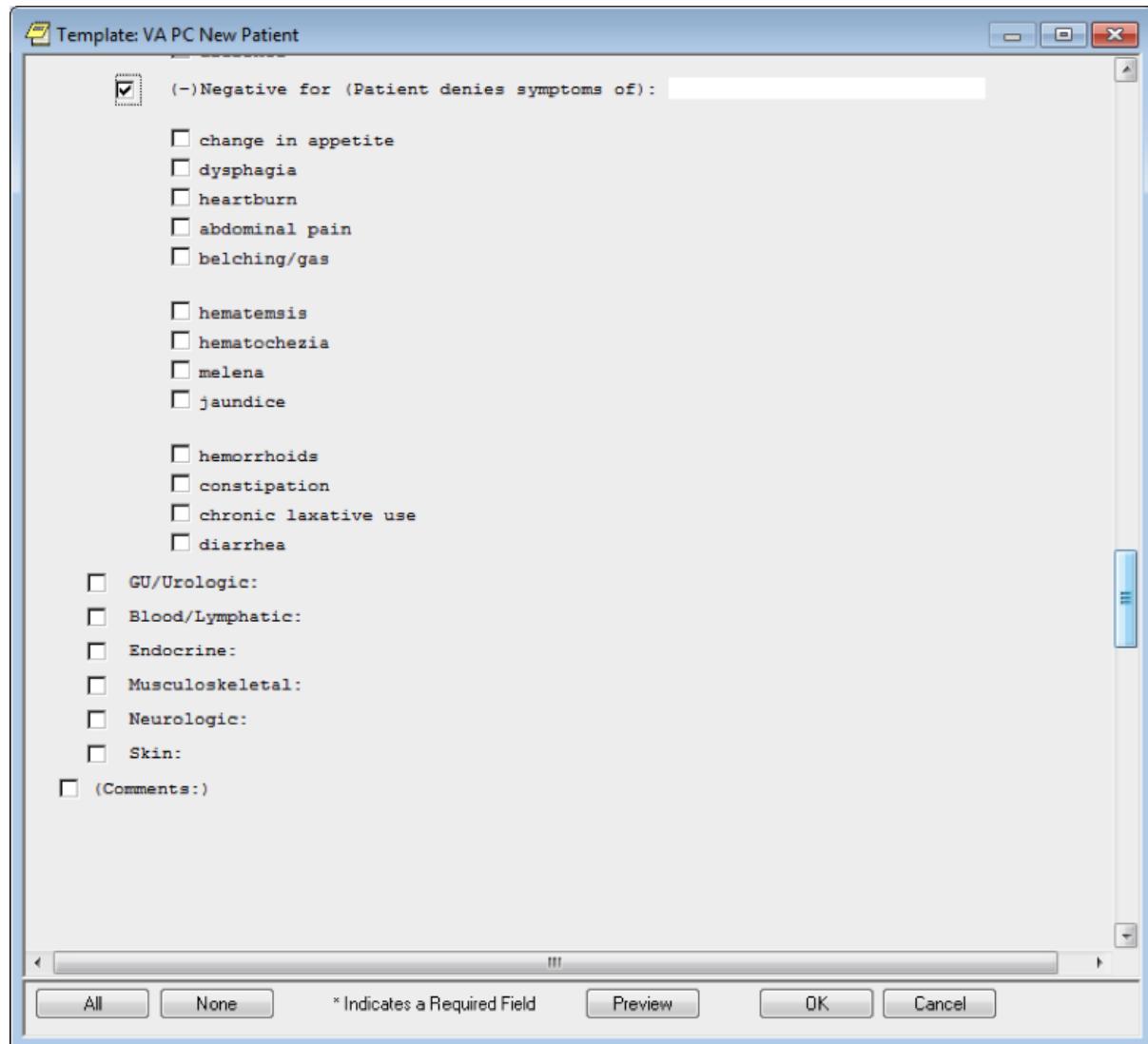


Figure A.18. VA National Primary Care Note Template: VA Primary Care New Patient - Genitourinary (GU)/Urologic and Male GU Sections

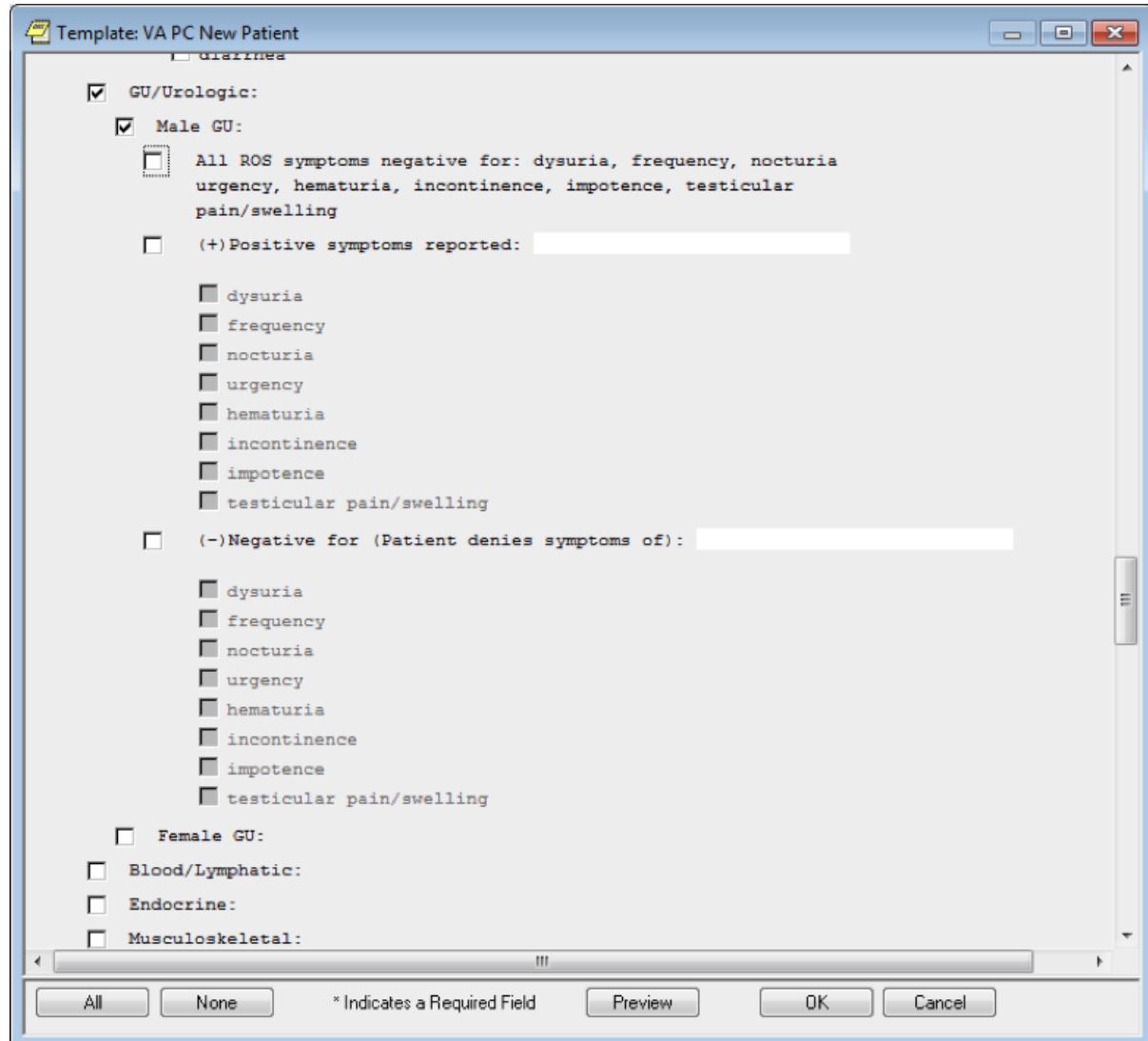


Figure A.19. VA National Primary Care Note Template: VA Primary Care New Patient - Genitourinary (GU)/Urologic and Female GU Sections

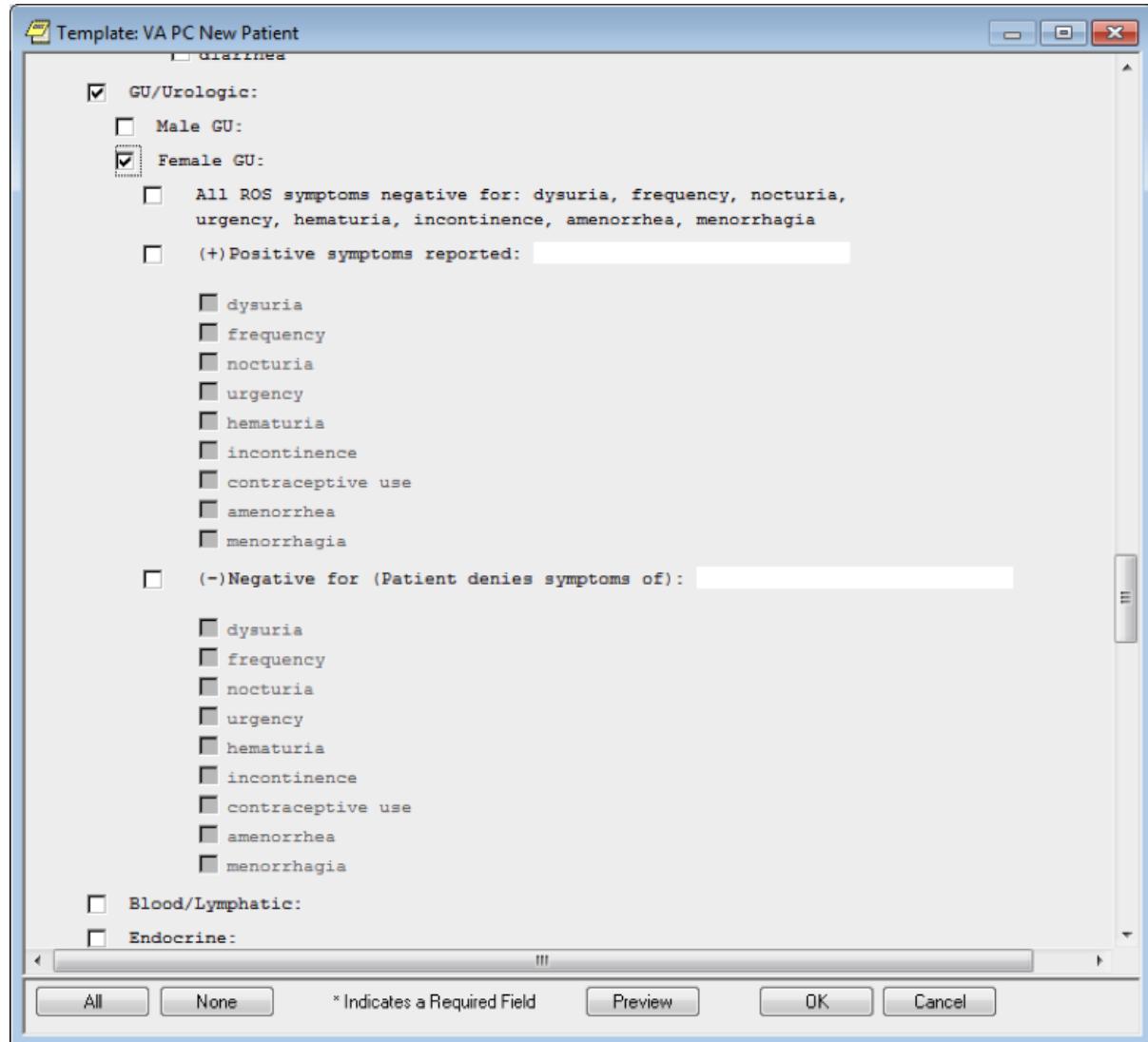


Figure A.20. VA National Primary Care Note Template: VA Primary Care New Patient - Blood/Lymphatic Section

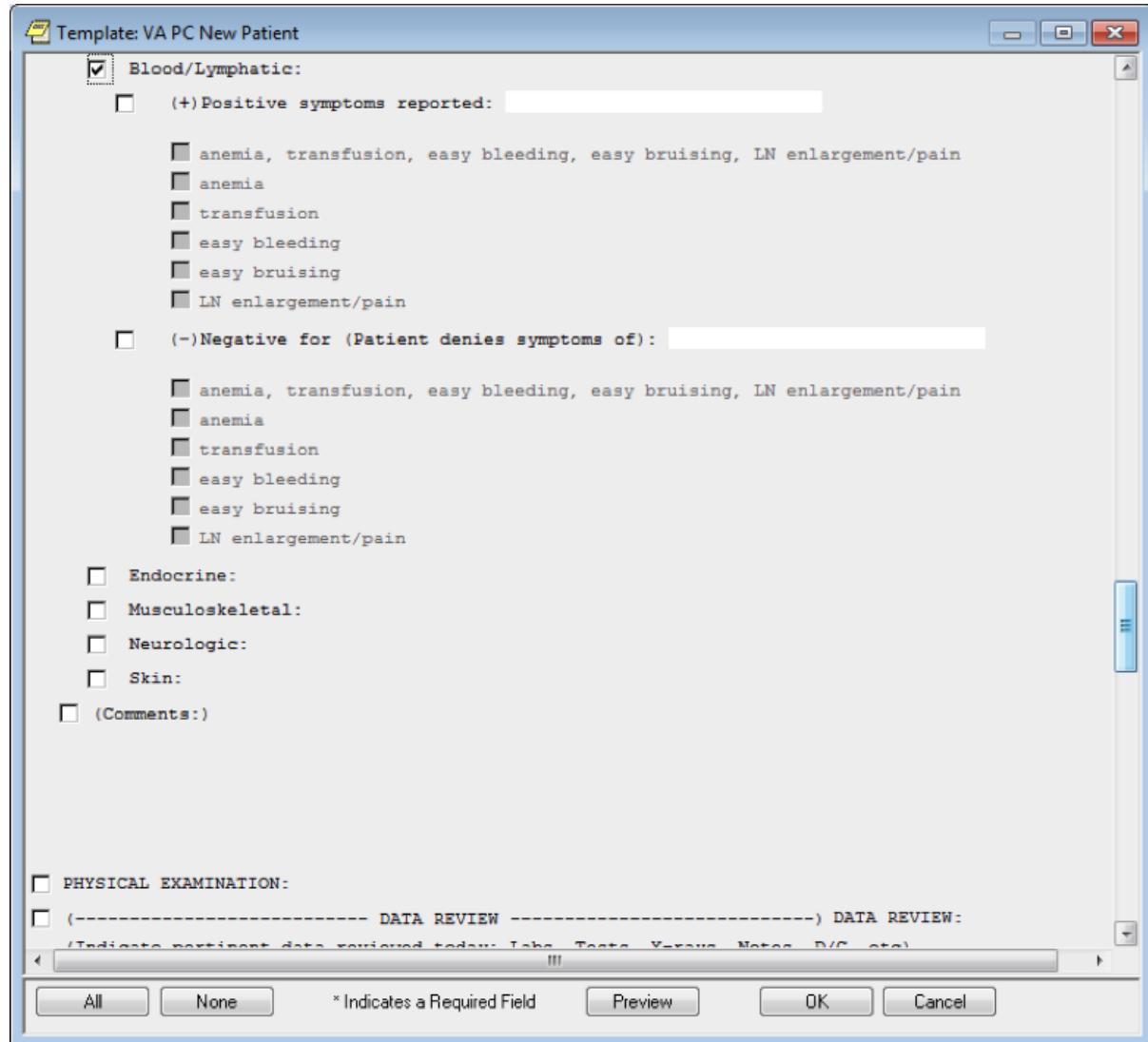


Figure A.21. VA National Primary Care Note Template: VA Primary Care New Patient - Endocrine Section

Template: VA PC New Patient

Blood/Lymphatic:
 Endocrine:
 All ROS symptoms negative for: goiter, thyroid condition, polydipsia, polyuria and polydipsia, chronic prednisone tx
 (+) Positive symptoms reported:
 goiter
 thyroid condition
 polydipsia
 polyuria and polydipsia
 chronic prednisone tx
 (-) Negative for (Patient denies symptoms of):
 goiter
 thyroid condition
 polydipsia
 polyuria and polydipsia
 chronic prednisone tx
 Musculoskeletal:
 Neurologic:
 Skin:
 (Comments:)

PHYSICAL EXAMINATION:
 (----- DATA REVIEW -----) DATA REVIEW:
(Indicate pertinent data reviewed today. Labs, Tests, X-rays, Notes, D/C, etc.)

All None * Indicates a Required Field Preview OK Cancel

Figure A.22. VA National Primary Care Note Template: VA Primary Care New Patient - Musculoskeletal Section

Template: VA PC New Patient

Musculoskeletal:

(-) Negative for (Patient denies symptoms of): _____

Muscle cramps, joint pain or stiffness
 muscle cramps
 joint pain
 joint stiffness
 joint deformity
 joint(s) involved include: _____

(+) Positive symptoms reported: _____

Muscle cramps, joint pain or stiffness
 muscle cramps
 joint pain
 joint stiffness
 joint deformity
 joint(s) involved include: _____

Neurologic:
 Skin:
 (Comments:)

PHYSICAL EXAMINATION:

(----- DATA REVIEW -----) DATA REVIEW:
(Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)
(Click here for expanded point and click data review)

Lab results reviewed.

All None * Indicates a Required Field Preview OK Cancel

Figure A.23. VA National Primary Care Note Template: VA Primary Care New Patient - Neurologic Section

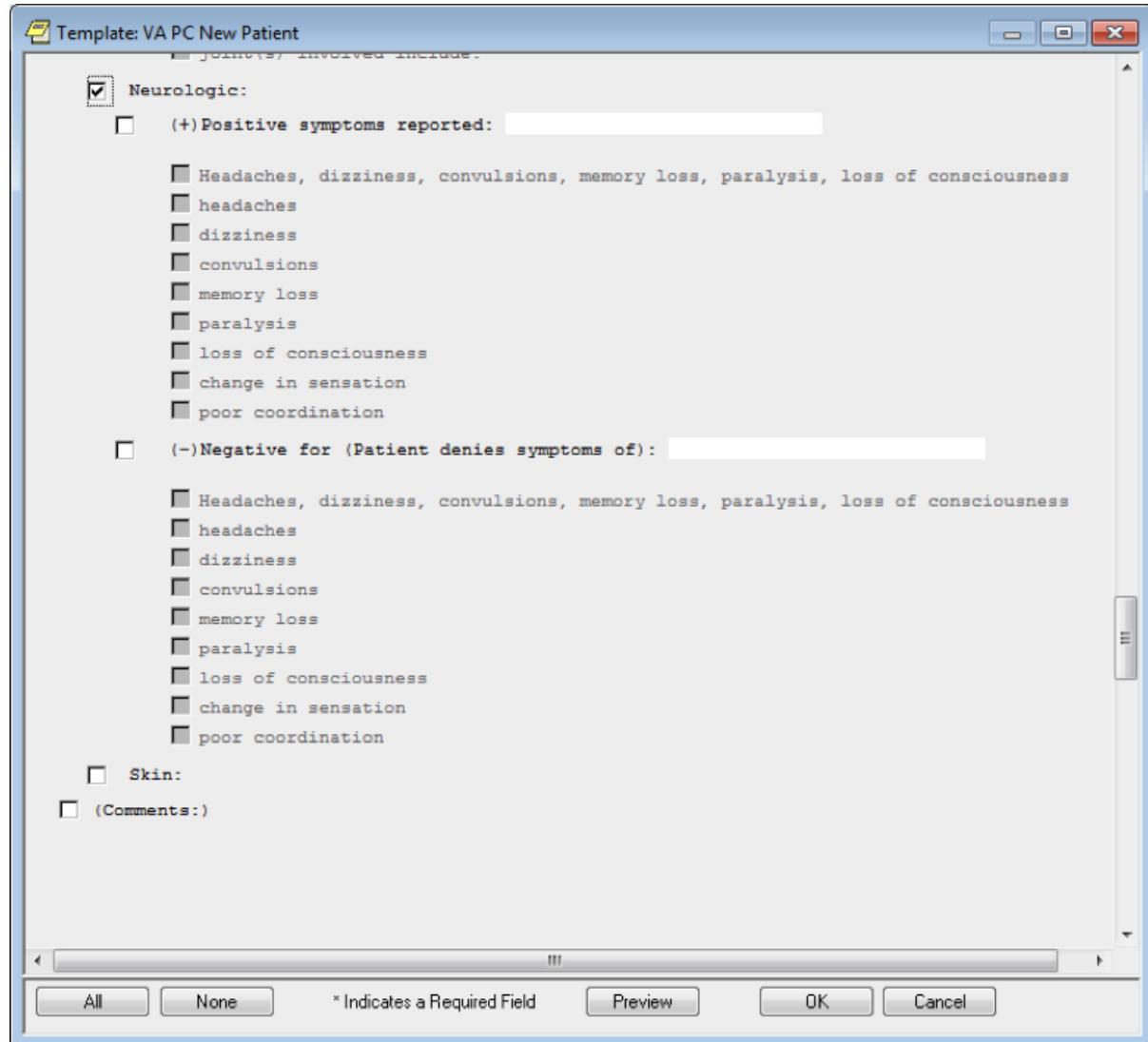


Figure A.24. VA National Primary Care Note Template: VA Primary Care New Patient - Skin Section

Template: VA PC New Patient
poor coordination

Skin:

(+) Positive symptoms reported: _____

Rash, lesions, acne, dry skin, itching, hives
 rash
 skin lesion
 acne
 dry skin
 hives
 itching

(-) Negative for (Patient denies symptoms of): _____

Rash, lesions, acne, dry skin, itching, hives
 rash
 skin lesion
 acne
 dry skin
 hives
 itching

(Comments:)

PHYSICAL EXAMINATION:

(----- DATA REVIEW -----) DATA REVIEW:
(Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)
(Click here for expanded point and click data review)

All None * Indicates a Required Field Preview OK Cancel

Figure A.25. VA National Primary Care Note Template: VA Primary Care New Patient - Skin Section with Added Comments

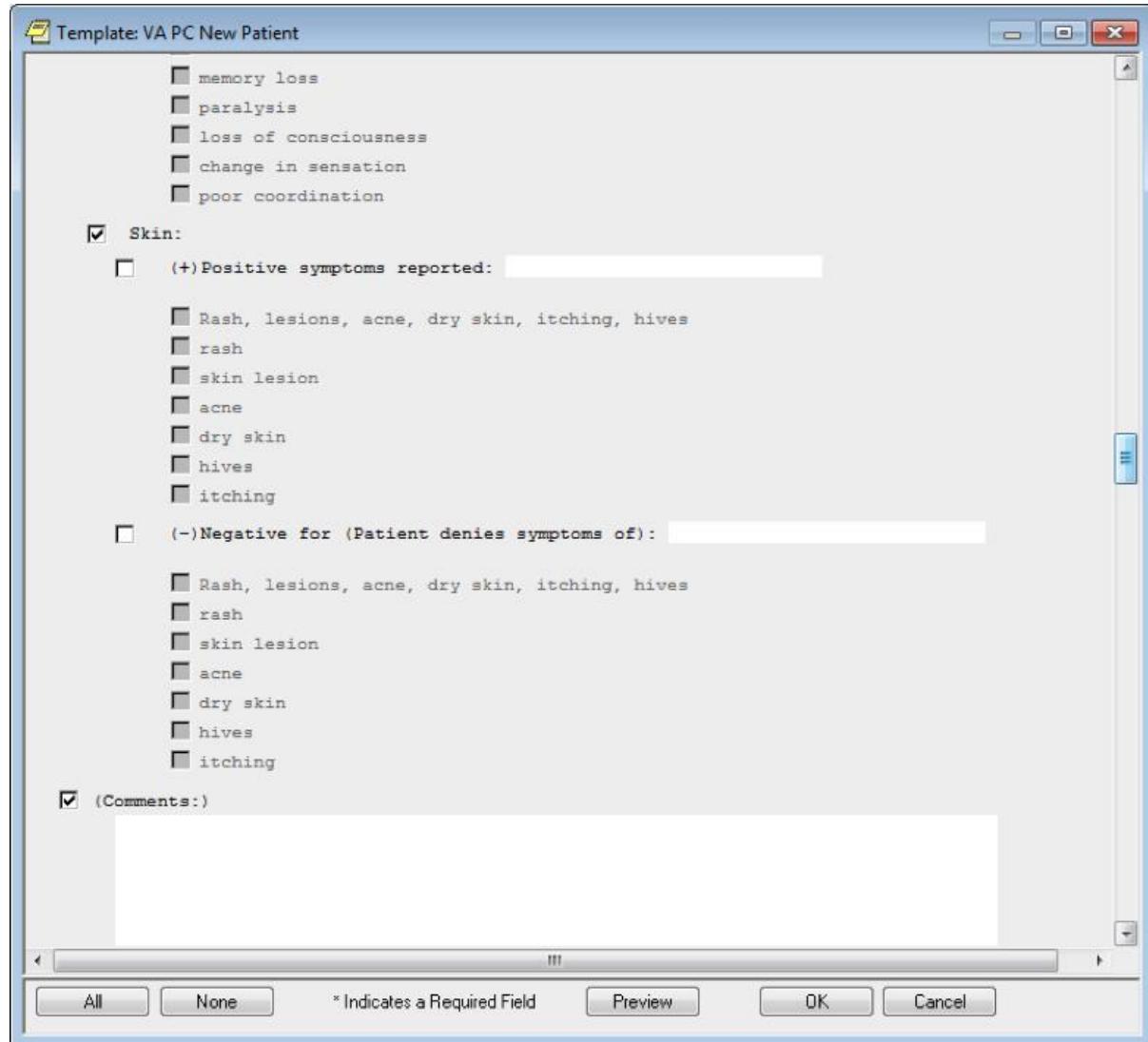


Figure A.26. VA National Primary Care Note Template: VA Primary Care New Patient - Physical Examination and Eye Exam Sections

Template: VA PC New Patient

PHYSICAL EXAMINATION:

(Click to add Vitals to Note ----- CONSTITUTIONAL -----)

VITALS (most recent, as listed in the electronic record):

B/P: 128/95 (07/17/2017 09:31)
 Pulse: 89 (07/17/2017 09:31)
 Temperature: 98 F [36.7 C] (07/17/2017 09:31)
 Weight: 220 lb [100.0 kg] (05/08/2017 08:43)
 Height: 65 in [165.1 cm] (05/08/2017 08:43)
 BMI:
 Pain: 0 (07/17/2017 09:31) (0-10 scale)

APPEARANCE: WD WN NAD Overweight Thin Emaciated

(-----HEAD-----)
 HEAD: (Document pertinent normal & abnormalities in word processing field)
 Not examined. No sign of trauma. Evidence of trauma.

(-----EYES-----)

EYE EXAM - (Document pertinent normal & abnormalities in word processing field)

PUPILS: PERRLA. Anisocoria. Pupil abnormality.

RIGHT EYE: Not examined

LEFT EYE: Not examined

|
 (OTHER PERTINENT FINDINGS:)

(-----ENT-----)
 EAR EXAM - (Document pertinent normal & abnormalities in word processing field)

All None * Indicates a Required Field Preview OK Cancel

Figure A.27. VA National Primary Care Note Template: VA Primary Care New Patient - Ear, Nose, and Throat (ENT), Neck, and Chest Sections

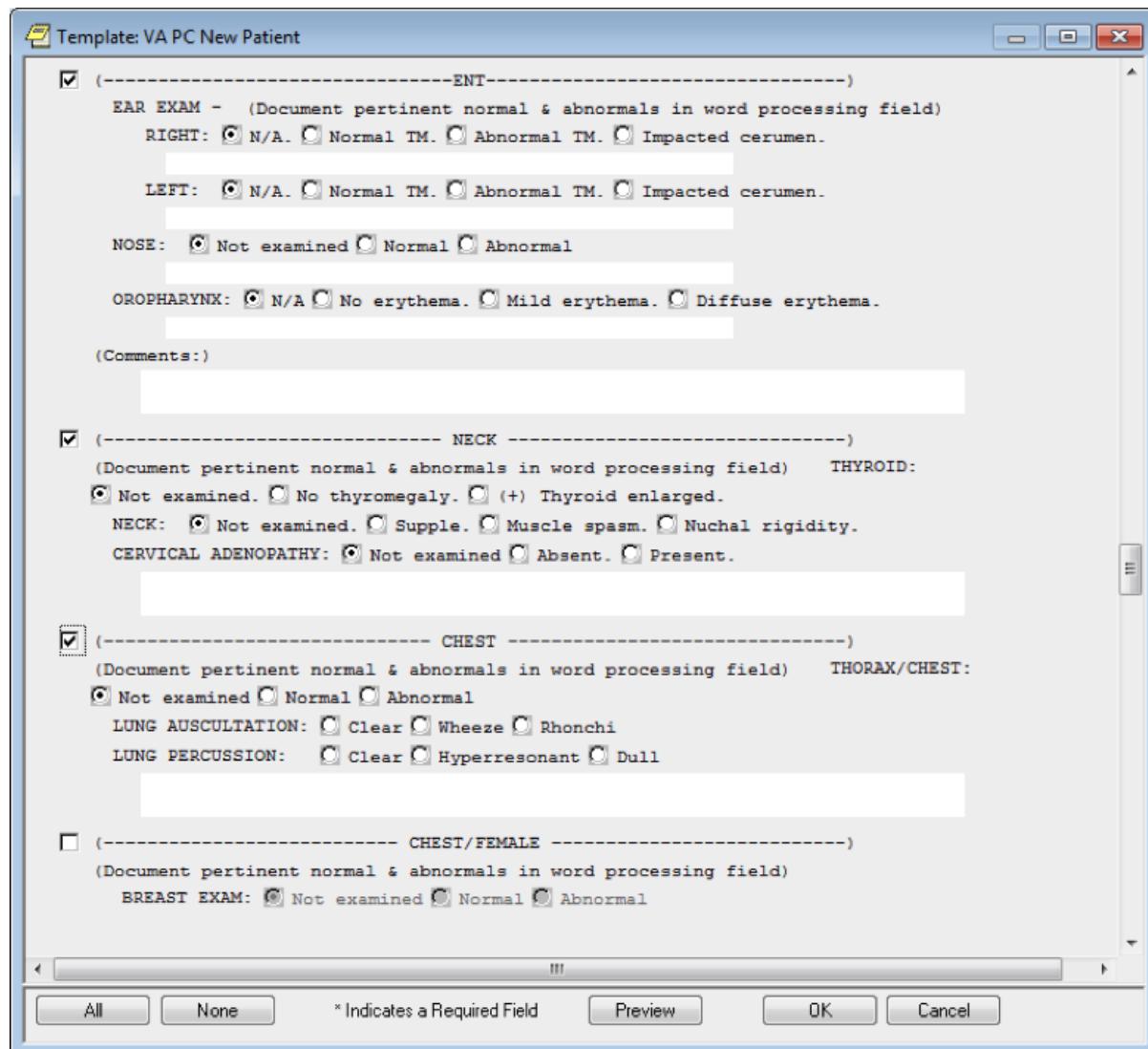


Figure A.28. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections

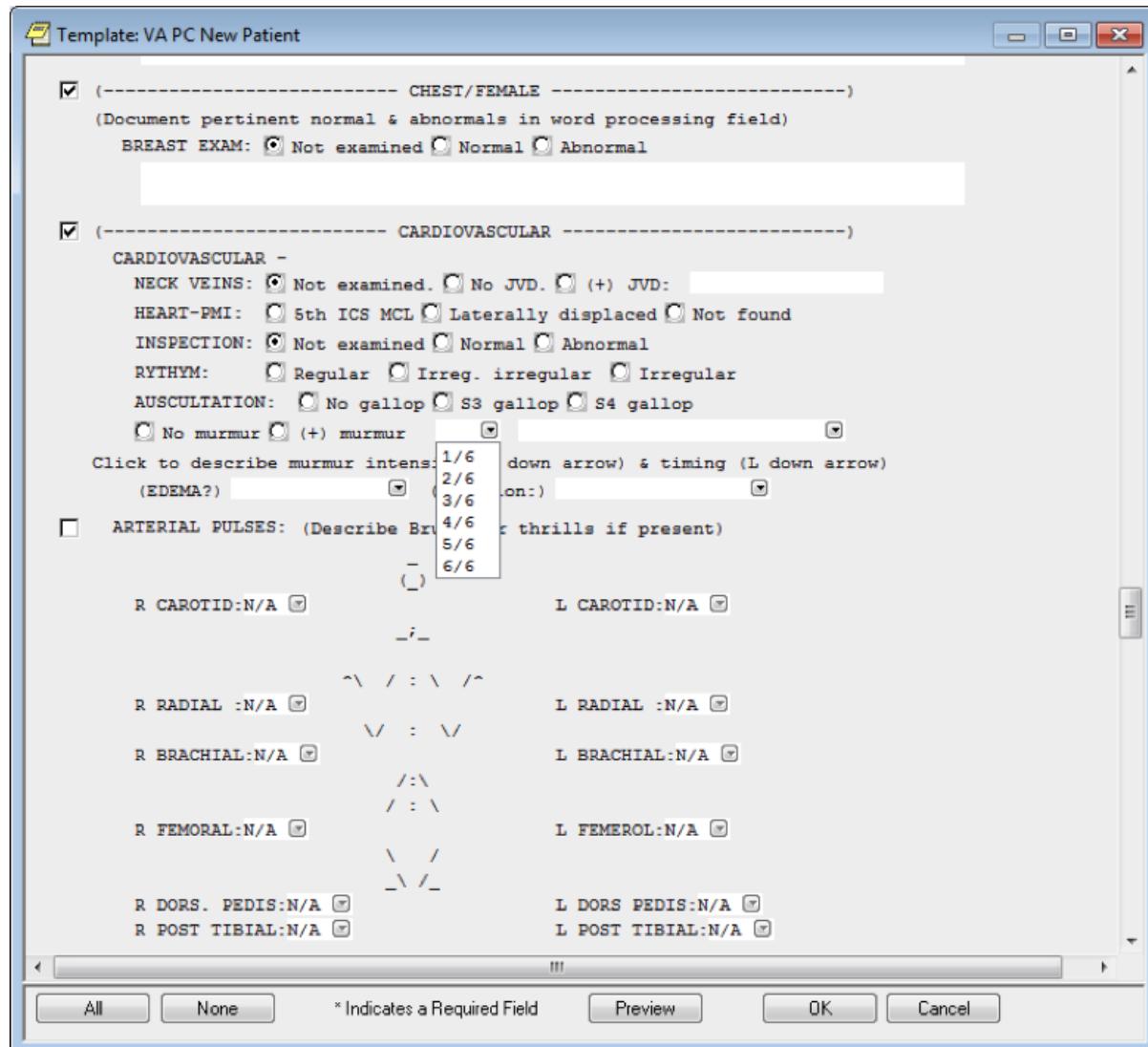


Figure A.29. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections - specifying Auscultation Murmur Drop-down

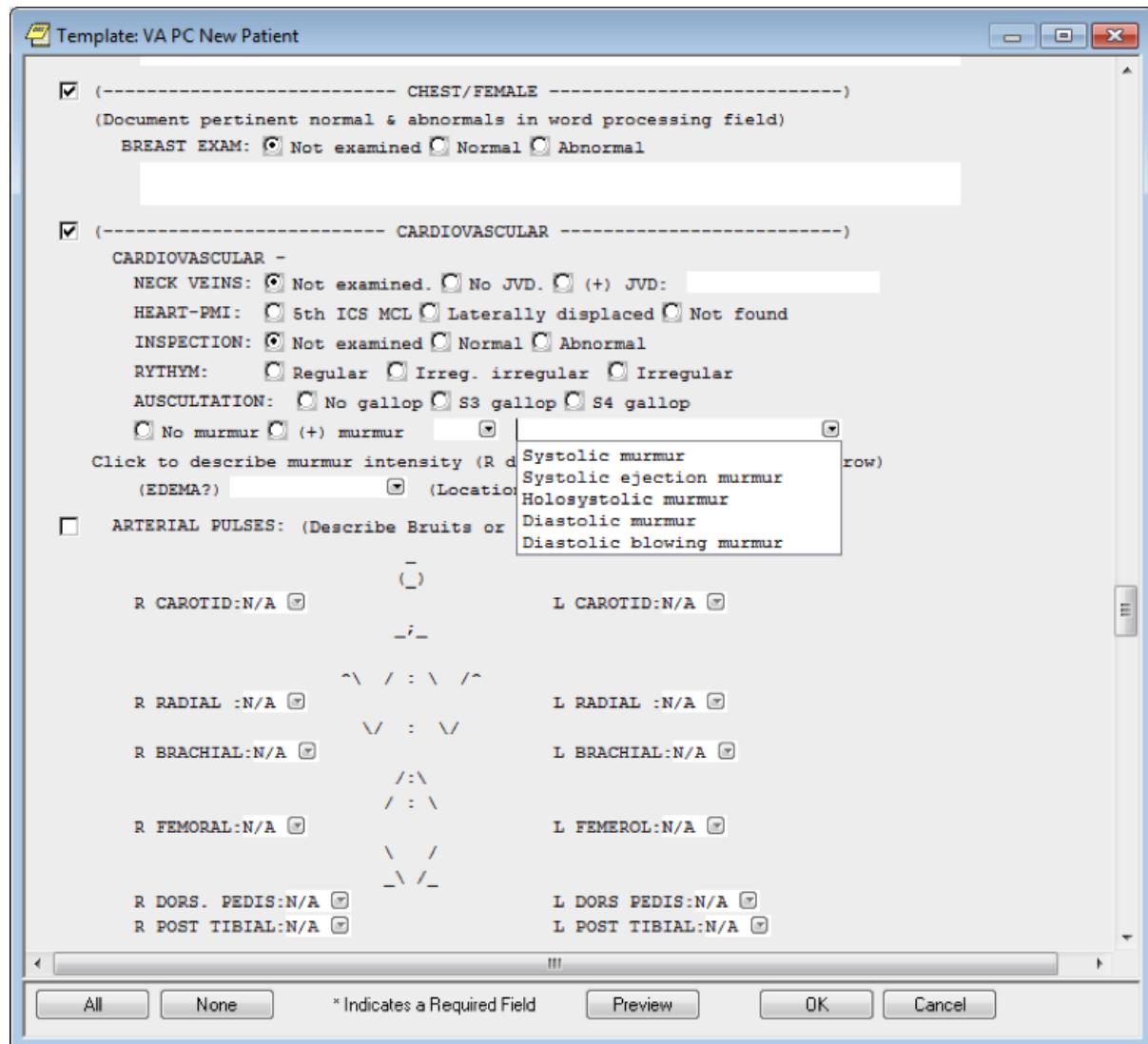


Figure A.30. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections - Specifying Edema Drop-down

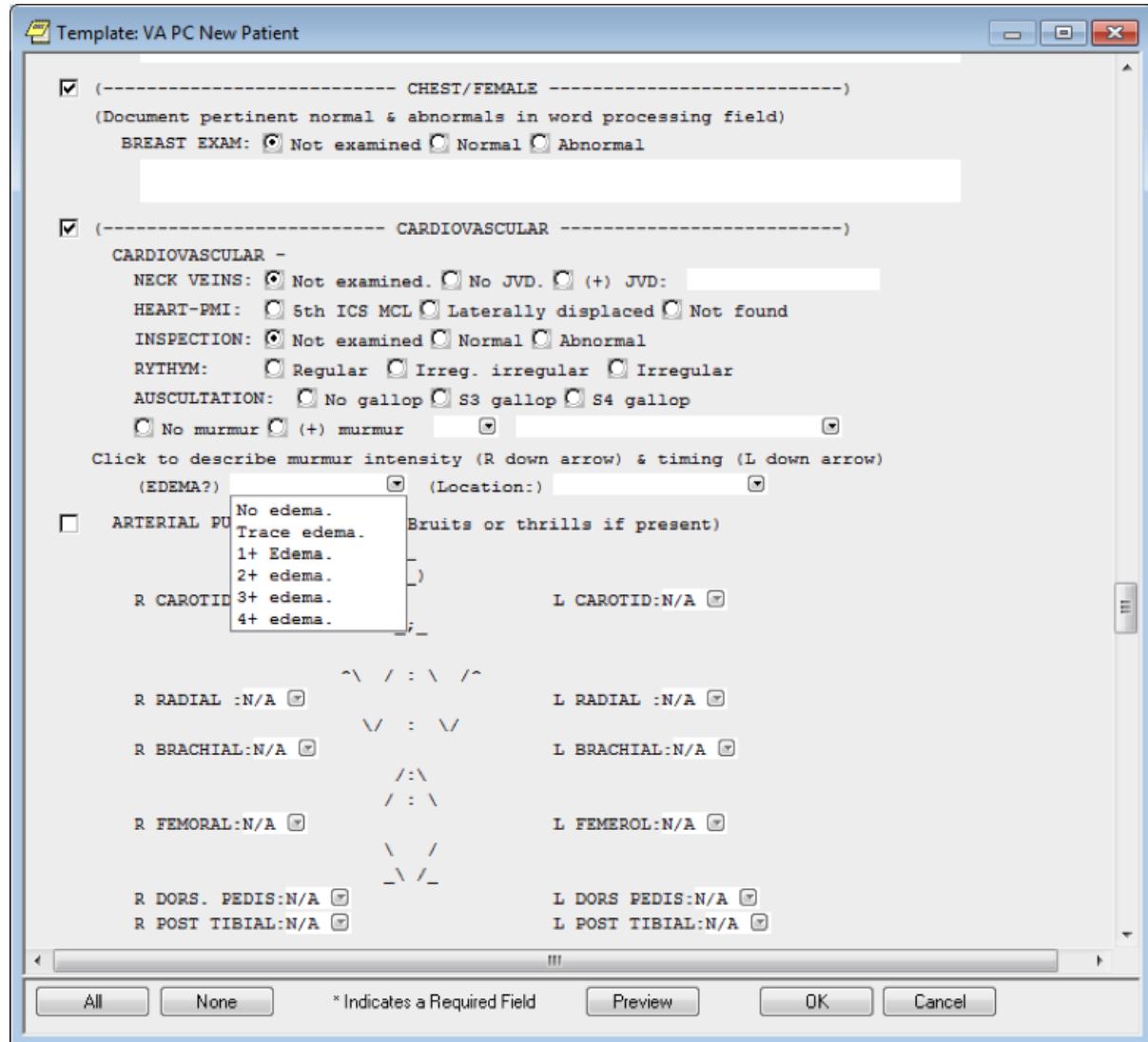


Figure A.31. VA National Primary Care Note Template: VA Primary Care New Patient - Chest/Female and Cardiovascular Sections, Specifying Edema Location

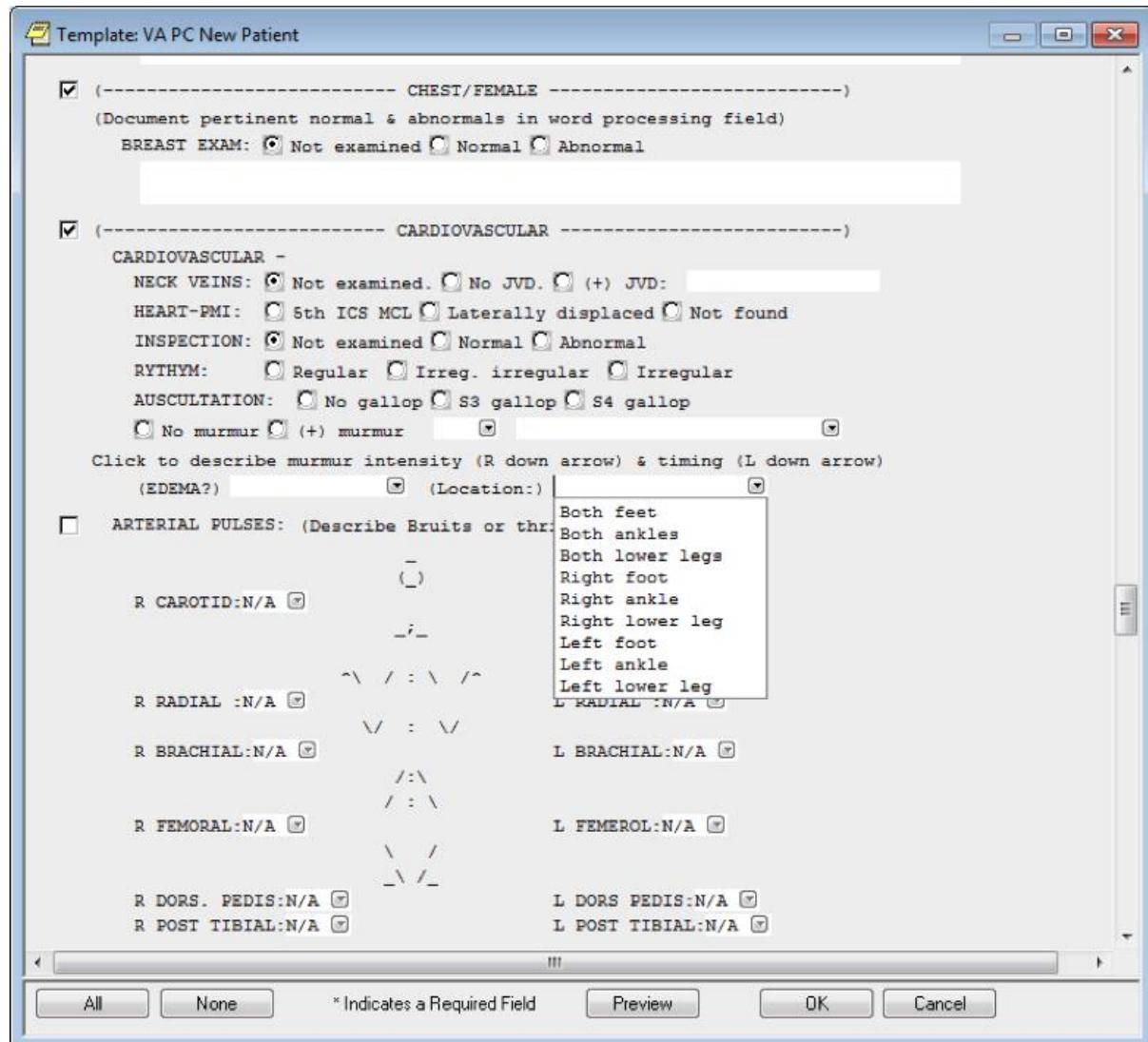


Figure A.32. VA National Primary Care Note Template: VA Primary Care New Patient - Arterial Pulses, R Carotid Section

Template: VA PC New Patient

ARTERIAL PULSES: (Describe Bruits or thrills if present)

R CAROTID: N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> <input type="button" value="3+"/> <input type="button" value="4+"/> R RADIAL : <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> <input type="button" value="3+"/> <input type="button" value="4+"/> R BRACHIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> R FEMORAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> R DORS. PEDIS:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> R POST TIBIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>	L CAROTID:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> <input type="button" value="3+"/> <input type="button" value="4+"/> L RADIAL : N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> L BRACHIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> L FEMEROL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> <input type="button" value="1+"/> <input type="button" value="2+"/> L DORS PEDIS:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/> L POST TIBIAL:N/A <input type="button" value="..."/> <input type="button" value="N/A"/> <input type="button" value="0"/>
---	---

(----- ABDOMEN/GI -----)

ABDOMEN: (Document pertinent normal & abnormalities, scars or hernias in word processing field)

Appearance: Flat. Distended. Ascites.

Palpation: Soft Non-tender Tender Tympanitic Firm

No organomegaly No masses Hepatomegaly Splenomegaly

Bowel sounds: Normal. Decreased. Hyperactive. Absent.

RECTAL: Not Examined. Normal. Pertinent finding (see below):

(----- GU/MALE -----)

MALE GU EXAM: (Document pertinent normal & abnormalities in word processing field)

* Indicates a Required Field

Figure A.33. VA National Primary Care Note Template: VA Primary Care New Patient - Extremities, Musculoskeletal, and Deep Tendon Reflexes Sections

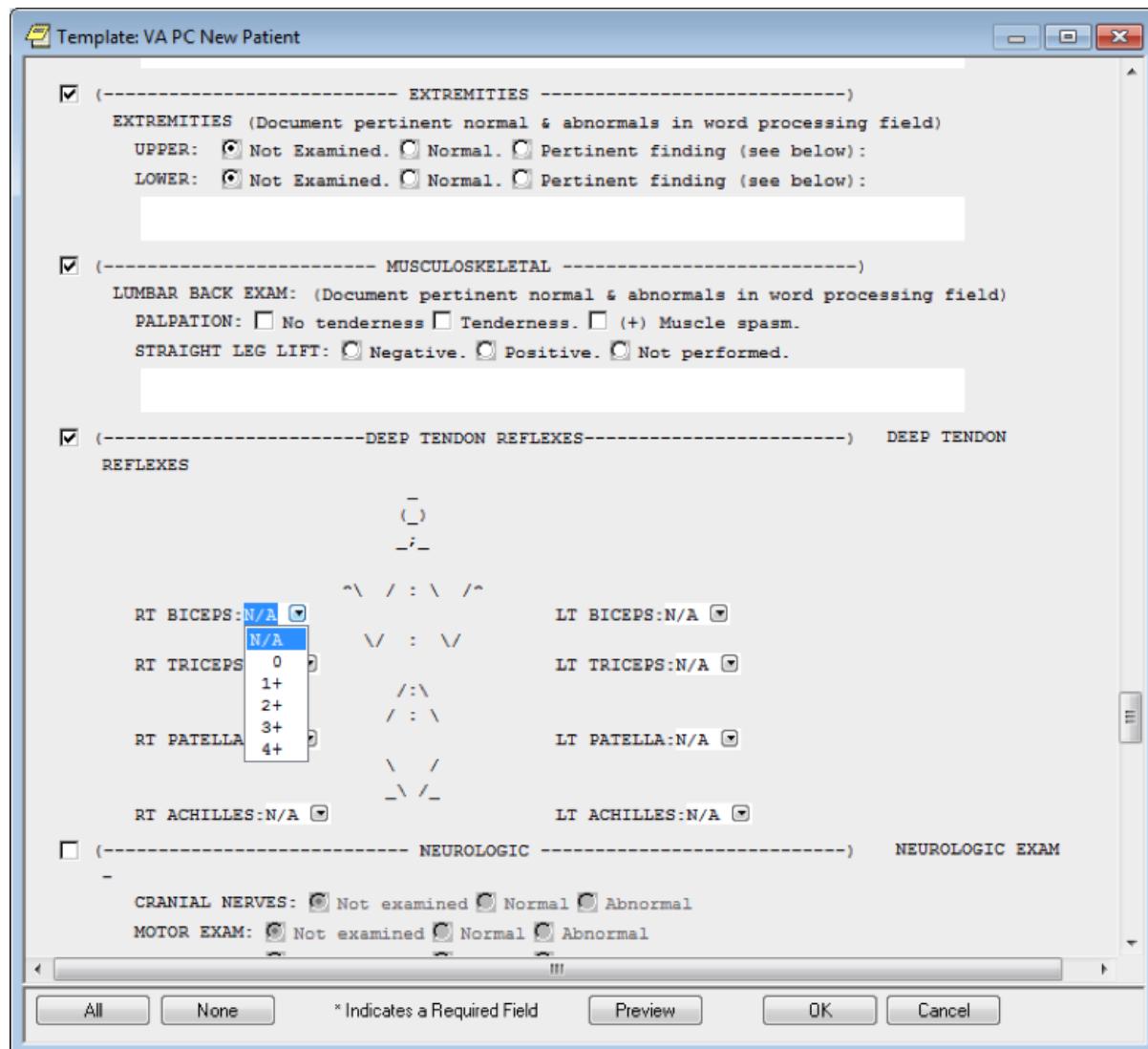


Figure A.34. VA National Primary Care Note Template: VA Primary Care New Patient - Abdomen/Gastroenterology (GI), Genitourinary (GU)/Male, and GU/Female Sections

Template: VA PC New Patient

(----- ABDOMEN/GI -----)

ABDOMEN: (Document pertinent normal & abnormalities, scars or hernias in word processing field)

Appearance: Flat. Distended. Ascites.

Palpation: Soft Non-tender Tender Tympanic Firm

No organomegaly No masses Hepatomegaly Splenomegaly

Bowel sounds: Normal. Decreased. Hyperactive. Absent.

RECTAL: Not Examined. Normal. Pertinent finding (see below):

(----- GU/MALE -----)

MALE GU EXAM: (Document pertinent normal & abnormalities in word processing field)

PROSTATE: Not examined Normal Abnormal

SCROTUM: Not examined Normal Abnormal

PENIS: Not examined Normal Abnormal

(----- GU/FEMALE -----)

PELVIC EXAM: (Document pertinent normal & abnormalities in word processing field)

PERINIUM: Not examined Normal Abnormal

VAGINA: Not examined Normal Abnormal

CERVIX: Not examined Normal Abnormal

BIMANUAL: Not examined Normal Abnormal

RECTAL: Not examined Normal Abnormal

(----- EXTREMITIES -----)

All None * Indicates a Required Field Preview OK Cancel

Figure A.35. VA National Primary Care Note Template: VA Primary Care New Patient - Neurologic, Lymphatics, Dermatology, and Psychiatric Sections

Template: VA PC New Patient

(----- NEUROLOGIC -----) NEUROLOGIC EXAM

CRANIAL NERVES: Not examined Normal Abnormal
 MOTOR EXAM: Not examined Normal Abnormal
 SENSORY: Not examined Normal Abnormal

(----- LYMPHATICS -----)
 (Include location, laterality, size & consistency if palpable) LYMPHATICS: Normal.
 Pertinent finding (see below):

(----- DERMATOLOGY -----)
 (Include turgor, bruising, rash, hair, nails. Lesions: location & size) SKIN: Normal.
 Pertinent finding (see below):

(----- PSYCHIATRIC -----) PSYCHIATRIC:
 (Include assessment of 1) Judgment/insight, 2) Orientation to time, place, person, 3)recent and remote memory, 4) Mood/affect.)
 JUDGMENT: Good Fair Poor Not examined
 INSIGHT: Good Fair Poor Not examined
 ORIENTATION:
 MOOD: Alert Depressed Not evaluated

RECENT MEMORY: Good Fair Poor Not examined
 REMOTE MEMORY: Good Fair Poor Not examined

MMSE SCORE: _____ (Mini-Mental Status Examination)

(----- DATA REVIEW -----) DATA REVIEW:

All None * Indicates a Required Field Preview OK Cancel

Figure A.36. VA National Primary Care Note Template: VA Primary Care New Patient - Psychiatric, Data including Lab Results Reviewed

Template: VA PC New Patient

(----- PSYCHIATRIC -----) PSYCHIATRIC:
 (Include assessment of 1) Judgment/insight, 2) Orientation to time, place, person, 3)recent and remote memory, 4) Mood/affect.)

JUDGMENT: Good Fair Poor Not examined

INSIGHT: Good Fair Poor Not examined

ORIENTATION:

MOOD: Alert Depressed Not evaluated

RECENT MEMORY: Good Fair Poor Not examined

REMOTE MEMORY: Good Fair Poor Not examined

MMSE SCORE: [] (Mini-Mental Status Examination)

(----- DATA REVIEW -----) DATA REVIEW:
 (Indicate pertinent data reviewed today: Labs, Tests, X-rays, Notes, D/C, etc)
 (Click here for expanded point and click data review)

Lab results reviewed.

Date of lab: Jan Results:

Results:
 Unremarkable
 Abnormal
 Remarkable for

Follow-up Action:
 None at this time
 Recheck lab at future visit
 Continue current treatment
 Adjust medication

HbA1C results reviewed.

LDL-cholesterol result reviewed.

Chest X-ray results reviewed.

All None * Indicates a Required Field Preview OK Cancel

Figure A.37. VA National Primary Care Note Template: VA Primary Care New Patient - HbA1c and Low-density lipoprotein (LDL)-cholesterol Results Reviewed

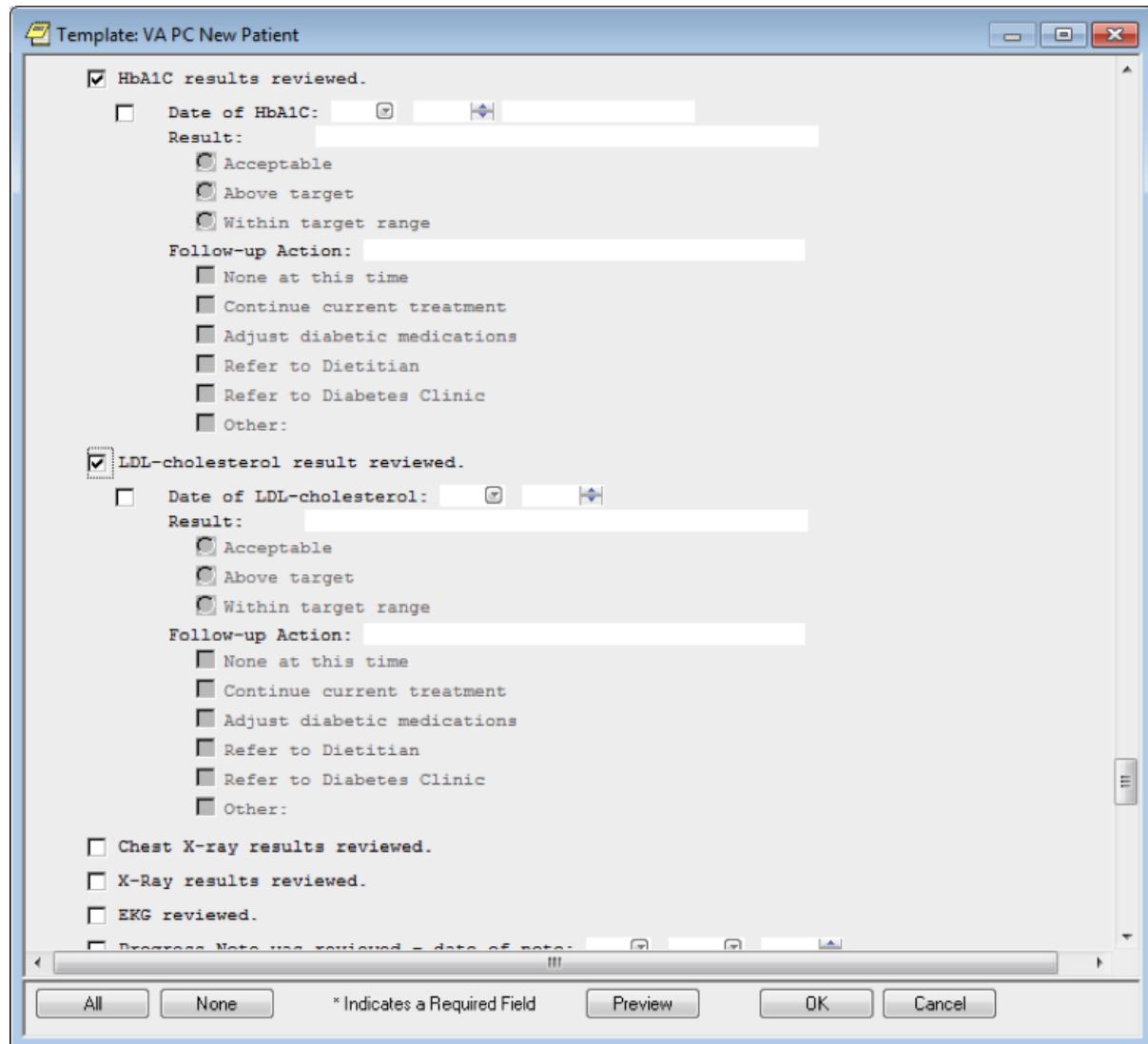


Figure A.38. VA National Primary Care Note Template: VA Primary Care New Patient - X-ray Results Reviewed

Template: VA PC New Patient

Chest X-ray results reviewed.

Date of Chest X-ray:

Results:

Unremarkable
 Abnormal
 Remarkable for

Follow-up Action:

None at this time
 Recheck X-ray at future visit
 Continue current treatment
 CT ordered
 Other:

X-Ray results reviewed.

Date of X-ray:

Results:

Unremarkable
 Abnormal
 Remarkable for

Follow-up Action:

None at this time
 Recheck X-ray at future visit
 Continue current treatment
 CT ordered
 Other:

EKG reviewed.

Progress Note was reviewed - date of note:
(To use the calendar style date box click here -->)

Discharge Summary reviewed - date of summary:
(To use the calendar style date box click here -->)

All None * Indicates a Required Field Preview OK Cancel

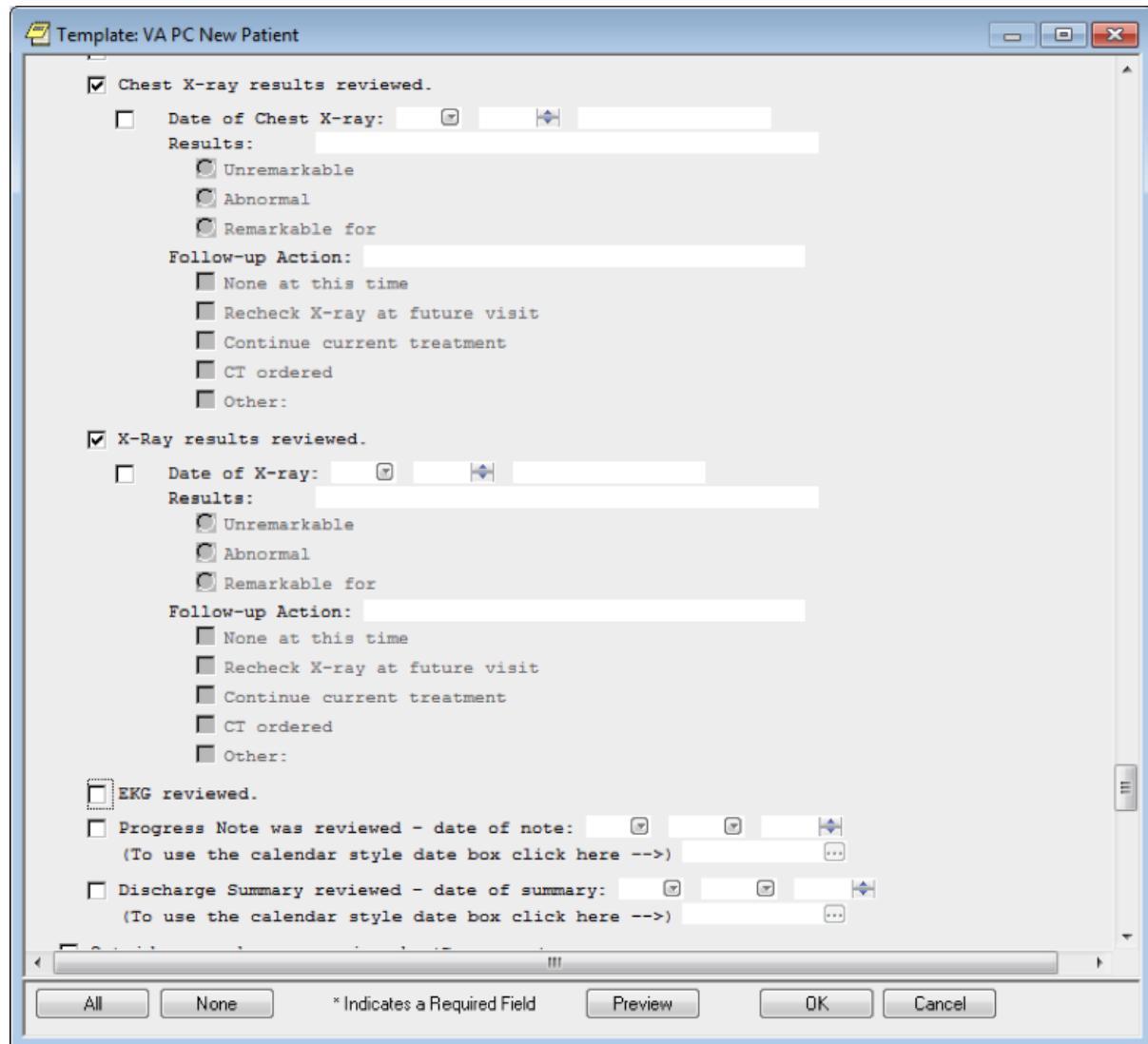


Figure A.39. VA National Primary Care Note Template: VA Primary Care New Patient – Electrocardiogram (EKG) Reviewed

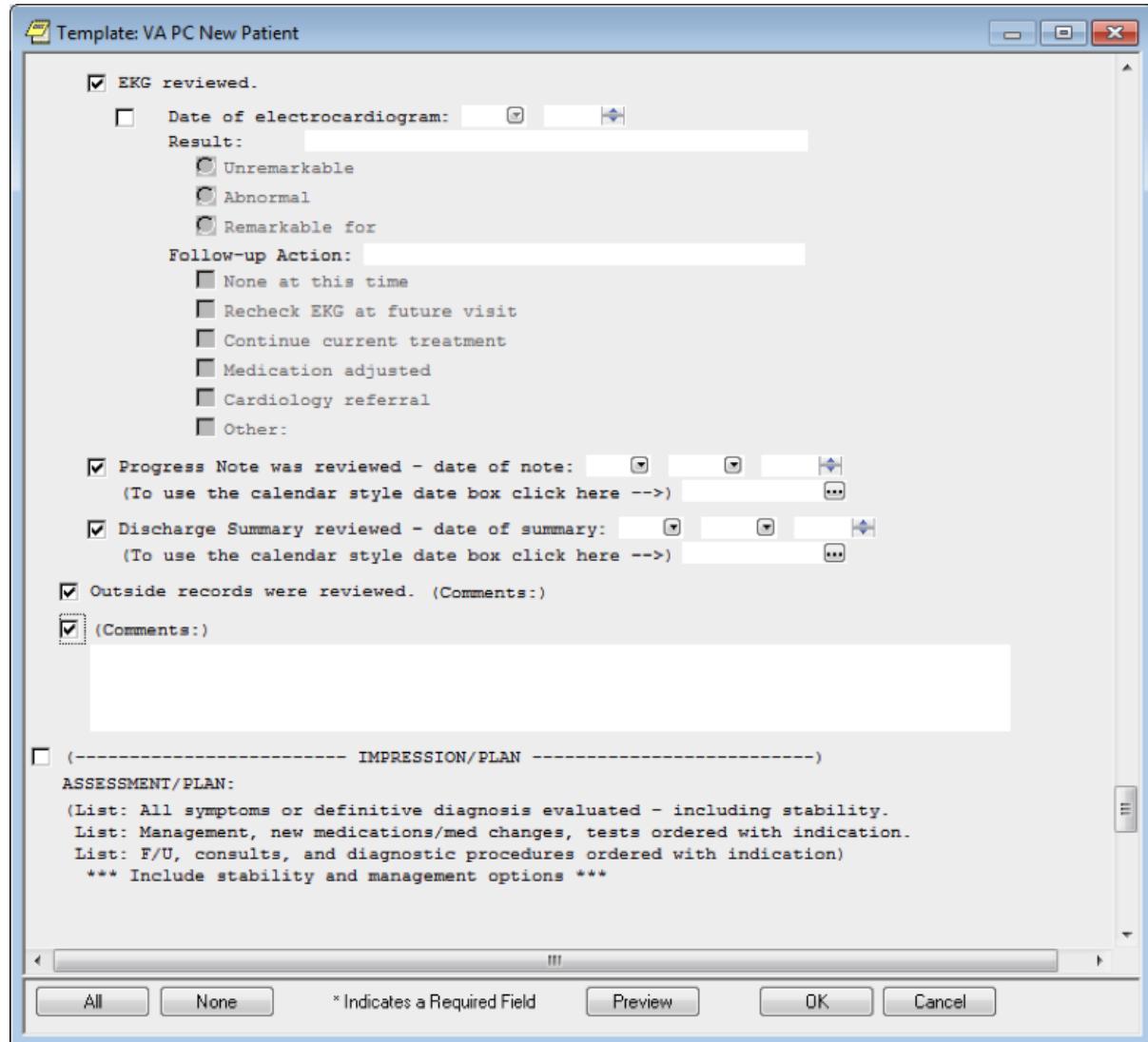


Figure A.40. VA National Primary Care Note Template: VA Primary Care New Patient - Impression/Plan

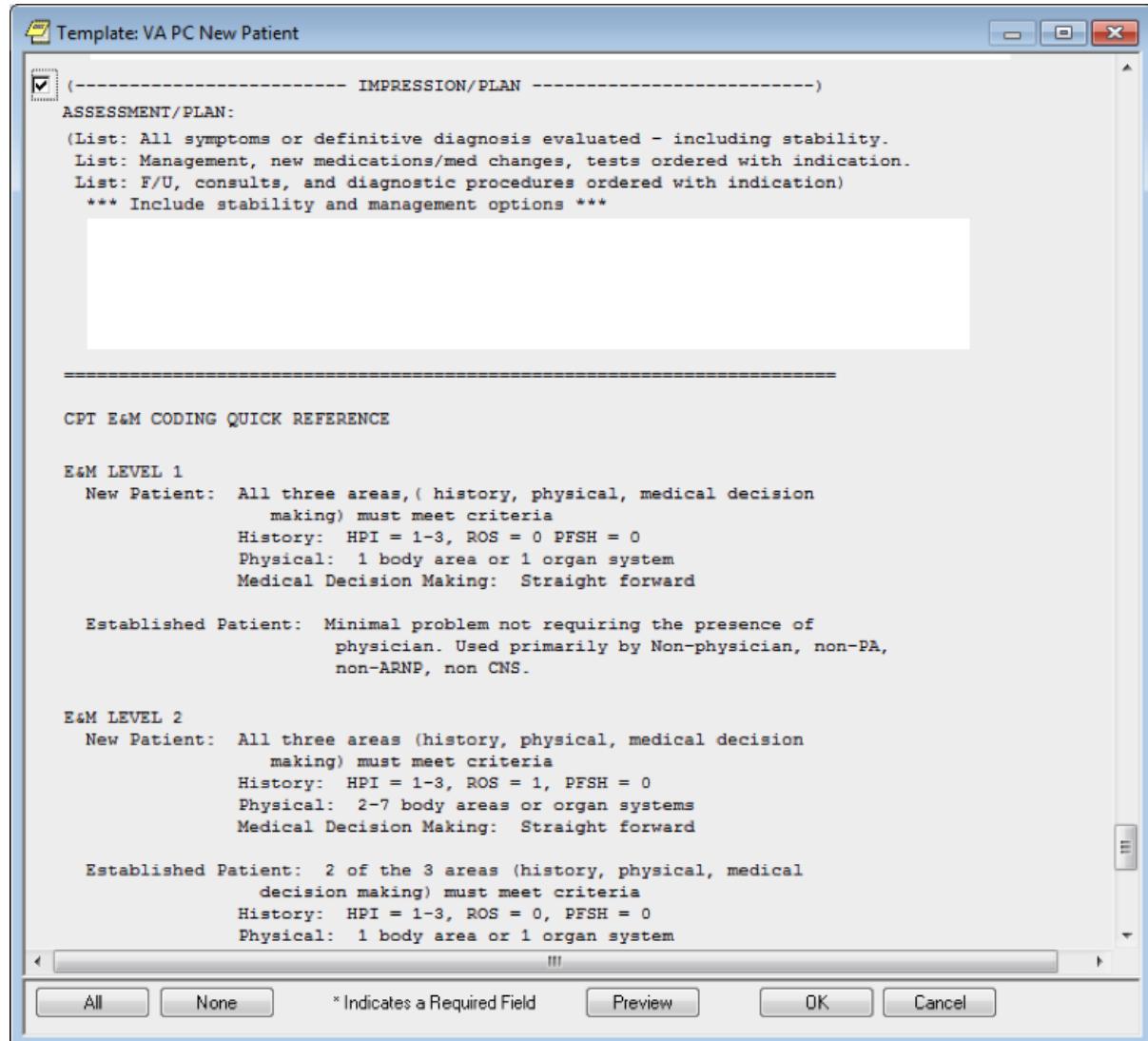


Figure A.41. VA National Primary Care Note Template: VA Primary Care New Patient - Evaluation and Management (E & M) Levels 3-5

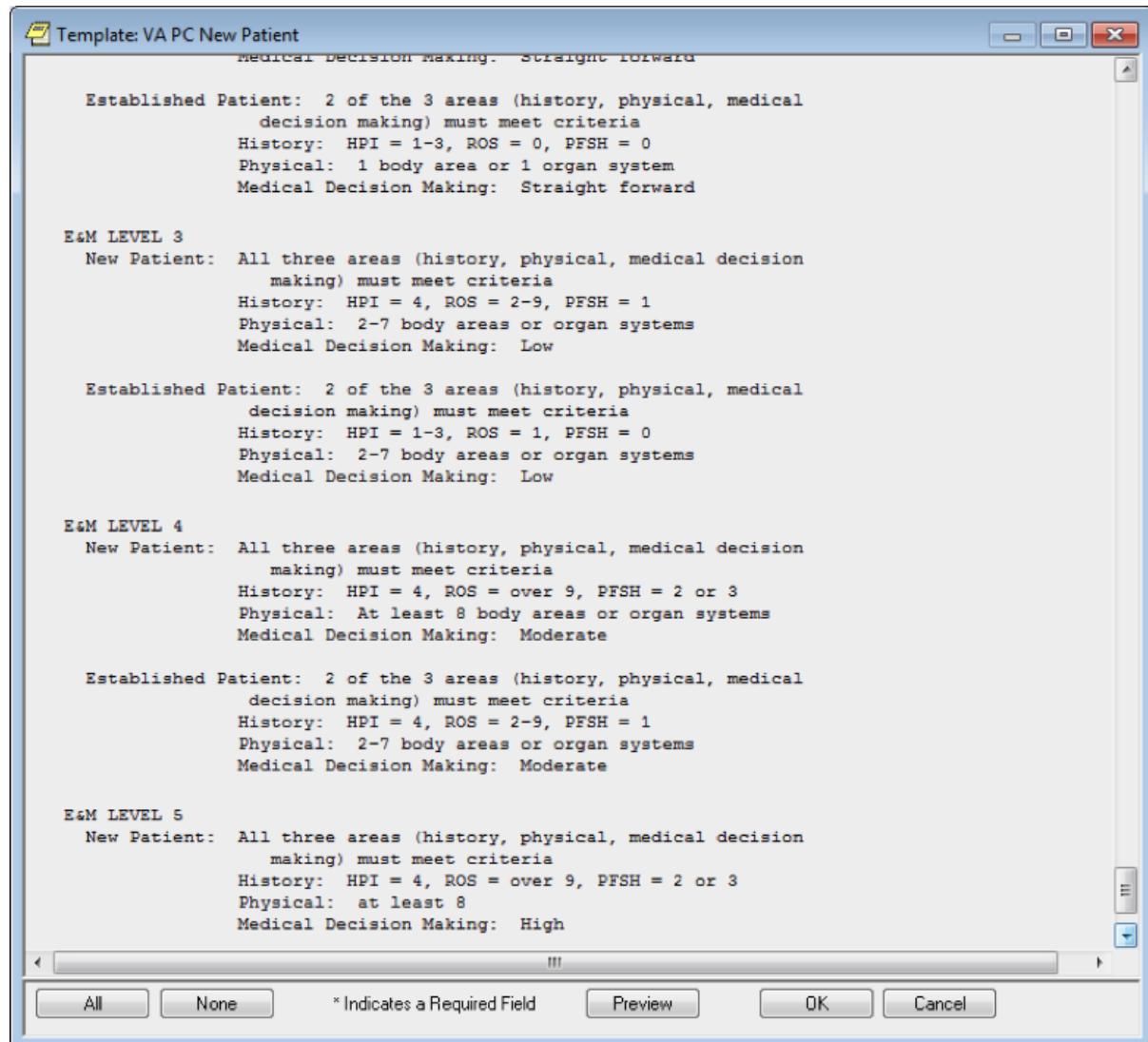


Figure A.42. VA National Primary Care Note Template: VA Primary Care New Patient – Evaluation and Management (E & M) Level 5: Established Patients

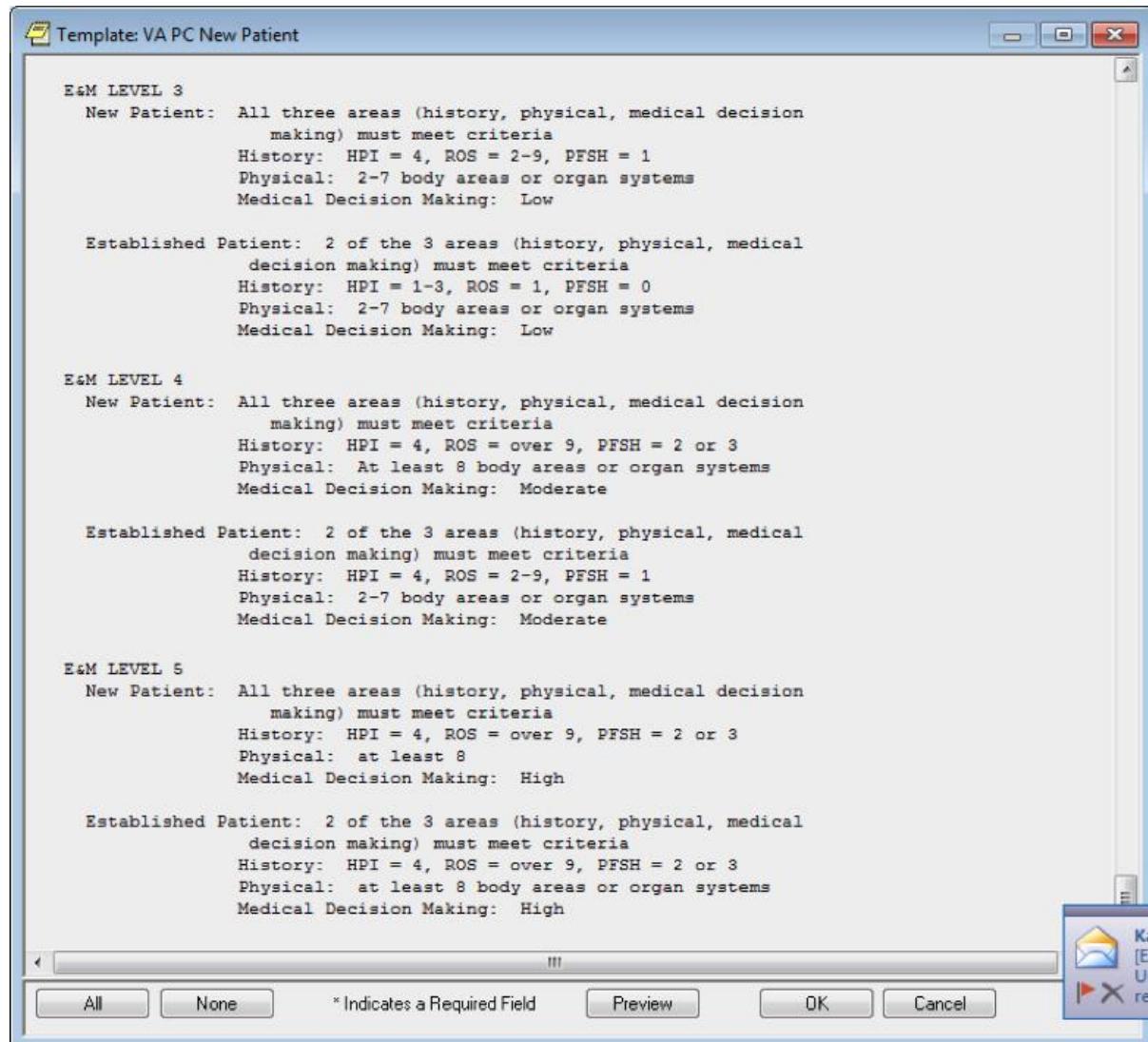


Figure A.43. VA National Primary Care Note Template: VA Primary Care Clinical Reminder Resolution Assessing Care of Vulnerable Elders (ACOVE) Functional Status

KATZ ADL TOOL

Katz ADL Score Notes:
 ADL independence = 1 point
 ADL dependence = 0 point

Bathing: *

1 POINT - Bathes self completely or needs help in bathing only a single part of the body such as back, genital area.
 0 POINT - Needs help bathing more than one body part of the body getting out of tub or shower. Requires total bathing.

Dressing: *

1 point - Gets clothes from closets, etc, puts them on complete with fasteners. May have help tying shoes.
 0 point - Needs help with dressing self or needs to be completely dressed.

Toileting: *

1 POINT - Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.
 0 POINT - Needs help transferring to the toilet, cleaning self or uses bedpan or commode.

Transferring: *

1 POINT - Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.
 0 POINT - Needs help in moving from bed to chair or requires a complete transfer.

Continence: *

1 POINT - Exercises complete self control over urination and defecation.
 0 POINT - Is partially or totally incontinent of bowel or bladder.

Feeding: *

1 POINT - Gets food from plate into mouth without help. Preparation of food may be done by another person.
 0 POINT - Needs partial or total help with feeding or requires parental feeding.

Katz ADL Index Total Points = *
 6 = High (patient independent)
 0 = Low (patient very dependent)

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) SCALE (Lawton)

Begin assessment

Ability to use telephone:

1 point - Operates telephone on own initiative; looks up and dials numbers, etc.
 1 point - Dials a few well-known numbers
 1 point - Answers telephone but does not dial
 0 points - Does not use telephone at all

ACOVE Functional Status :
KATZ ADL TOOL
Katz ADL Score Notes:
 ADL independence = 1 point
 ADL dependence = 0 point

Health Factors: **IADL ASSESSMENT COMPLETED, KATZ ADL INDEX DONE**

* Indicates a Required Field

Appendix B. Basic Laboratory Panel Definition

- Blood Urea Nitrogen
- Calcium
- Chloride
- CO₂ (Carbon Dioxide, Bicarbonate)
- Creatinine
- Glucose
- Potassium
- Sodium

Acronyms

Acronym	Definition
ACOVE	Assessing Care of Vulnerable Elders
BMI	Body Mass Index
BP	Blood Pressure
BPM	Beats Per Minute
CCWP	Clinical Content White Paper
CDS	Clinical Decision Support
CO ₂	Carbon Dioxide
DoD	Department of Defense
E&M	Evaluation and Management
EKG	Electrocardiogram
ENT	Ears, Nose, Throat
GI	Gastroenterology
GU	Genitourinary
HEENT	Head, Eyes, Ears, Nose, Throat
HL7	Health Level 7
KBS	Knowledge Based Systems
KNART	Knowledge Artifact
LDL	Low-density Lipoprotein
OIIG	Office of Informatics and Information Governance
OTC	Over the Counter
PTSD	Post-Traumatic Stress Disorder
SME	Subject Matter Expert
TO	Task Order
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs
VACO	VA Central Office
VAMC	VA Medical Center