

ALL FIELDS REQUIRED

DATE OF SERVICE:

PATIENT NAME:

DOB:

MEMBER ID:

Health Plan:

PROVIDER NAME/CREDENTIAL:

PROGRESS NOTE

Allergies:

Height:

Weight:

BMI:

Sex: Male Female

RR:

HR:

BP:

Oxygen Status: _____% Oxygen

Home Oxygen Use: Yes No

Wheelchair Dependant: Yes No

Chief Complaint:

History of Present Illness:

PATIENT HISTORY

Family History

Family History is Non-contributory

Family History Positive for: CKD Heart Disease Cancer Diabetes Other: _____

Past Surgery / Resolved illness

Social History

Birthplace: _____ Employed: Yes No Retired Disabled Occupation: _____

Primary Language: _____ Married Divorced Widowed Single # Children: _____

If System deferred, check here

PHYSICAL EXAM

(Please complete thoroughly each section unless exam component was deferred-All Abnormals MUST be documented)

GENERAL General Appearance: Well Nourished Well Developed Other:
 Alert Anxious (Level of Distress): No Acute Distress Mild Moderate Severe
 Race: _____ Abnormal Findings:

HEAD Facial Feature Symmetric Skull Normocephalic Hair and Scalp Normal
 Abnormal Exam Findings:

EYES Vision: Normal Abnormal Lids/Lashes: Normal Abnormal Erythema Drainage
 Conjunctivae Pink - No Injection
 PERRLA _____ Scleral Icterus Pale Conjunctivae EOM Normal AV Nicking
Visual Acuity RT-20/____ LT-20/____
 Abnormal Exam Findings:

ENT ENT Inspection Normal Throat Normal Mucus Membranes Pink and Moist Nasal Septum Normal
TM's Normal Auditory Canal Normal Hearing Grossly Intact Sinus Tenderness (Location: _____)
 Abnormal Exam Findings:

NECK Supple Normal No Cervical Adenopathy Thyroid Normal Thyromegaly Nodules Present
JVP Absent JVD Present: Right Left Bilateral
Carotid Bruit(s) Present: Right Left Bilateral
 Abnormal Exam Findings:

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<input type="checkbox"/>	RESPIRATORY	<input type="checkbox"/> Lungs Clear Bilaterally <input type="checkbox"/> No Chest Wall Tenderness <input type="checkbox"/> Cough Absent <input type="checkbox"/> Percussion Normal <input type="checkbox"/> SOB <input type="checkbox"/> Crackles Present-Details: _____ <input type="checkbox"/> Wheezes Present-Details: _____ <input type="checkbox"/> Rhonchi Present-Details: _____ Tracheotomy Present: <input type="checkbox"/> Yes <input type="checkbox"/> No Year placed _____ Abnormal Exam Findings:
<input type="checkbox"/>	CARDIAC	<input type="checkbox"/> Normal S1/ S2 <input type="checkbox"/> S3 Present <input type="checkbox"/> S4 Present <input type="checkbox"/> Rate Normal <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Rhythm Regular <input type="checkbox"/> Rhythm Irregular <input type="checkbox"/> Rubs Present <input type="checkbox"/> No Murmurs If murmur present, please describe location & grade: Abnormal Exam Findings:
<input type="checkbox"/>	VASCULAR	<input type="checkbox"/> Pedal Pulses Normal <input type="checkbox"/> Lower Extremities: <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> No Varicosities <input type="checkbox"/> Venous Stasis Absent <input type="checkbox"/> Hair Loss Noticeable on Lower Externity <input type="checkbox"/> No Cyanosis <input type="checkbox"/> No Ulceration Present <input type="checkbox"/> No Edema <input type="checkbox"/> No Calf Tenderness <input type="checkbox"/> No Clubbing <input type="checkbox"/> Edema Present (please describe location, pitting or nonpitting +1, 2, 3): Abnormal Exam Findings:
<input type="checkbox"/>	CHEST / BREAST	<input type="checkbox"/> Chest Grossly Symmetrical Bilaterally <input type="checkbox"/> Breast Exam Deferred <input type="checkbox"/> No Breast Dimpling <input type="checkbox"/> No Drainage <input type="checkbox"/> No Breast Masses <input type="checkbox"/> No Chest or Breast Nodules <input type="checkbox"/> No Nipple Inversion <input type="checkbox"/> No Axillary Nodes Bilaterally <input type="checkbox"/> Breast(s) Absent: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Implant Status: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive Abnormal Exam Findings:
<input type="checkbox"/>	GI	<input type="checkbox"/> Abdomen Symmetrical <input type="checkbox"/> No Abnormal Distension <input type="checkbox"/> + Mass-Location(s): _____ <input type="checkbox"/> Percussion Within Normal Limits <input type="checkbox"/> Soft <input type="checkbox"/> No Tenderness <input type="checkbox"/> Scars Present <input type="checkbox"/> Hernias Present <input type="checkbox"/> Organomegaly <input type="checkbox"/> AUSCULTATION: Normal Bowel Sounds X 4Q <input type="checkbox"/> BS Hypoactive <input type="checkbox"/> BS Hyperactive <input type="checkbox"/> BS Absent <input type="checkbox"/> Rectal Exam Deferred <input type="checkbox"/> Rectal Exam Reveals: Peri-Rectal Area Normal to Inspection and Palpation <input type="checkbox"/> Stool Brown <input type="checkbox"/> Deep Palpation Normal <input type="checkbox"/> Ostomy present (please specify): _____ <input type="checkbox"/> Stool Guaiac: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Internal or External Hemorrhoid(s) Present <input type="checkbox"/> Sphincter Tone Poor Abnormal Exam Findings:
<input type="checkbox"/>	GU	<input type="checkbox"/> CVA Tenderness: Absent Bilaterally <input type="checkbox"/> Suprapubic Tenderness: Absent <input type="checkbox"/> Urostomy Present: <input type="checkbox"/> Yes <input type="checkbox"/> No Male: <input type="checkbox"/> Prostate Exam Deferred <input type="checkbox"/> Prostate Exam Normal <input type="checkbox"/> Prostate Enlargement <input type="checkbox"/> Tenderness <input type="checkbox"/> Nodules Female: <input type="checkbox"/> Pelvic Deferred <input type="checkbox"/> Pelvic Normal <input type="checkbox"/> Uterus Absent <input type="checkbox"/> Cervix Absent <input type="checkbox"/> Kidney Transplant Status: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Dialysis Status: <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal Exam Findings:
<input type="checkbox"/>	LYMPH	<input type="checkbox"/> Palpation of Lymph nodes (note all that apply): ___Neck ___Axilla ___Groin ___Other Site <input type="checkbox"/> No Lymph Node Enlargement Noted <input type="checkbox"/> Lymphadenopathy Present: <input type="checkbox"/> Anterior Cervical <input type="checkbox"/> Posterior Cervical <input type="checkbox"/> Postauricular <input type="checkbox"/> Submental <input type="checkbox"/> Supraclavicular <input type="checkbox"/> Inguinal <input type="checkbox"/> Axillary Abnormal Exam Findings:

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<input type="checkbox"/>	<p>MUSCULO-SKELETAL</p>	<p> <input type="checkbox"/> No Joint Abnormality <input type="checkbox"/> Amputations (please specify): _____ <input type="checkbox"/> Joint abnormality (please specify joint and abnormality): <input type="checkbox"/> Kyphosis+/- <input type="checkbox"/> Scoliosis +/- <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bouchard's Nodes Present <input type="checkbox"/> Heberden's Nodes Present <input type="checkbox"/> Paronychia Present <input type="checkbox"/> Swelling Present (please specify): Peripheral Joint Exam Findings: Central Joint Exam Findings: Other Abnormal Exam Findings: </p>
<input type="checkbox"/>	<p>SKIN</p>	<p> <input type="checkbox"/> Skin Warm, Dry, Intact <input type="checkbox"/> Good Skin Turgor <input type="checkbox"/> No Rashes <input type="checkbox"/> Poor Skin Turgor <input type="checkbox"/> No Abnormal Lesions <input type="checkbox"/> No Ulcers <input type="checkbox"/> Cyanosis Present <input type="checkbox"/> Diaphoresis Present <input type="checkbox"/> Nails: <input type="checkbox"/> Foot Exam Reveals Callus Present <input type="checkbox"/> Scars <input type="checkbox"/> Ulcers Present - Type of Ulcer: _____ Location: _____ Stage (if pressure sore): _____ Abnormal Exam Findings: </p>
<input type="checkbox"/>	<p>PSYCH</p>	<p> <input type="checkbox"/> Mood and Affect: ____ Normal ____ Depressed ____ Anxious ____ Agitated Abnormal Exam Findings: </p>
<input type="checkbox"/>	<p>NEURO</p>	<p> <input type="checkbox"/> Orientation: Time ____ Place ____ Person ____ Other _____ <input type="checkbox"/> Able to Follow Commands <input type="checkbox"/> Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Total Loss <input type="checkbox"/> Sense of Smell: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Gait _____ <input type="checkbox"/> Balance _____ <input type="checkbox"/> Gross Motor Skills _____ <input type="checkbox"/> Fine Motor Skills _____ <input type="checkbox"/> DTRs (Upper) RT _____ LT _____ <input type="checkbox"/> DTRs (Lower) RT _____ LT _____ <input type="checkbox"/> LOPS (Loss of Protective Sensation) <input type="checkbox"/> Normal Pinprick Sensation <input type="checkbox"/> Tremors <input type="checkbox"/> Coordination _____ <input type="checkbox"/> Vibration: <input type="checkbox"/> RT +/- <input type="checkbox"/> LT +/- <input type="checkbox"/> Speech _____ <input type="checkbox"/> Monofilament Testing: <input type="checkbox"/> RT +/- <input type="checkbox"/> LT +/- <input type="checkbox"/> CN II-XII Abnormal Exam Findings: </p>
<input type="checkbox"/>	<p>MISC</p>	
<p>LAB RESULTS (state specific findings and add diagnosis to assessment / plan)</p>		
<p>RADIOLOGY RESULTS (state specific findings and add diagnosis to assessment / plan)</p>		

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	DIAGNOSIS DESCRIPTION	STATUS OF DIAGNOSIS	PLAN OF CARE
Diagnosis #1:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #2:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #3:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #4:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #5:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #6:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #7:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #8:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #9:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #10:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #11:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:
Diagnosis #12:		<input type="checkbox"/> Active <input type="checkbox"/> Stable <input type="checkbox"/> Declining <input type="checkbox"/> Acute <input type="checkbox"/> End Stage <input type="checkbox"/> Resolved	Plan of Care: Current Rx:

Health Maintenance: At Least 1 PCP visit in the last year Breast Cancer Screening Colorectal Cancer Screening Cholesterol Screening for Members with Diabetes
Cholesterol Screening for Members with Heart Disease Glaucoma Testing
Monitoring Of Members Taking Long-Term Medications: ACE ARB Digoxin Diurectics Anticonvulsants

RTC: **Referrals:**

Other Orders if not specified in above plan of care:

Print Provider Name:

Group Name:

Provider ID:

Tax ID Number:

Provider Address:

City, State, Zip:

Provider Signature: _____ (check one) MD DO NP PA Other **Date:** ___ / ___ / ___