FORMAT FOR *HISTORY AND PHYSICAL* DICTATION

DO NOT SKIP ANY SECTIONS.

CHIEF COMPLAINT: what the patient came in for

HPI: E.g. This is a 51 year old male who came in with chest pain….

REVIEW of SYSTEMS: Too many people skip this section!!!

Past Medical History:

Past Surgical History:

Social History:

Family History:

Allergies

Home Medications

Physical Examination

Vitals:

General appearance:

HEENT:

CVS:

LUNGS:

ABDOMEN:

EXTREMETIES/BACK:

NEURO/PSYCH:

LABS:

RADIOLOGIC STUDIES:

EKG's etc

IMPRESSION AND PLAN (on admission)

1. List the diagnosis in order of importance.

2. Don't forget to also list previous diagnosis which you are treating. Avoid stating things like history of DM unless your "cured" the DM. Just say DM or HTN. Only say history of HTN if patient is currently hypotensive .

3.

4….. etc

Essentially, you are reading your H and P so far, WITHOUT SKIPPING ANY SECTIONS!

State whether the plan of care was discussed with family on admission. It is important to communicate and DOCCUMENT your communication and expectations and goals of care. Also, document patent education where appropriate.

FORMAT FOR *DSICHARGE SUMMARY* DICTATION

DATE OF ADMISSION:

DATE OF DISCHARGE:

ATTENDING AT TIME OF DISCHARGE:

ADMISSION DIAGNOSIS:

1.

2.

3. etc

DISCHARGE DIAGNOSIS:

1. Be sure to include the principal diagnoses first. Don't forget to include all other diagnoses below for conditions the patient already has such as HTN, DM etc. States if conditions from admission resolved on discharge, remained stable etc if the same as above.

2.

3.

4. etc

DISCHARGE MEDICATIONS:

1. be sure to include ALL the medication you want the patient to go home on, not just the new ones. Be sure to state the stop date for medications that are temporart, eg. Antibiotics eg. Zithromax 500mg PO daily until 5/5/2010 or a total of 5 days etc.

2.3.etc

HOSPITAL COURSE: Please include a brief summary of the HPI here Eg. Please see H and P (done by Dr.____ if done by someone else) for details. But in brief, this is a 50 year old male who came in with chest pain…etc., pertinent information.

Then go through the rest of the hospital course. Keep it organized and in chronological order.

DISCHARGE DIET:

CONSULTS:

PROCEDURES:

DISCHARGE CONDITION:

DISCHARGE ACTIVITY:

FOLLOW UP: WHERE, WHEN, WHO etc.

ADDITIONAL INSTRUCTIONS WHEN APPLICABLE:

PENDING LABS:

CC: to other physicians, PMD etc.

FORMAT FOR CONSULTATION REPORT

PATIENT NAME:

DIAGNOSIS:

MEDICAL RECORD #:

ACCOUNT #

DATE OF BIRTH:

LOCATION:

REFERRING PHYSICIAN:

CONSULTING PHYSICIAN:

CONSULTING SERVICE:

DATE OF CONSULTATION:

REASON FOR CONSULTATION:

CONSULTATION REPORT: