Adult Progress Note

NAME: _____ MEMBER ID: _____BIRTHDATE:_____ VISIT DATE: _____
T:_____P:_____ R: _____BP: _____HT: _____BMI:_____WT: _____At Risk for TB: Yes ____No____

Allergies: _____Last PAP & result: _____LMP:_____Last Td: _____ MA/Nurse_____

Present Complaints: _____

LISTING OF CURRENT MEDICATIONS:_____

Comprehensive Pain Screening 0 1 2 3 4 5 6 7 8 9 10 **Advanced Care Planning Discussed** ☐

ADLs (I=Independent; A=Assist Needed; D=Dependent) **Cognitive Skills** (N = Normal; AB = Abnormal) **(Circle one for each)**						**HEALTH EDUCATION**	
Bathing	I	A	D	Perception	N AB	[ ] Breast Self Examination	[ ] Nutrition/Exercise
Dressing	I	A	D	Attention	N AB	[ ] Dental Health	[ ] Sexual Practices/STD
Toileting	I	A	D	Memory	N AB	[ ] Diagnosis/Prognosis	[ ] Substance Abuse
Ambulation/Transfers	I	A	D	Reasoning	N AB	[ ] Injury Prevention	(drugs, tobacco, alcohol)
Continence	I	A	D	Decision Making	N AB	[ ] New Treatment	
Feeding	I	A	D	Problem Solving	N AB	[ ] New Medication(s)	

Unresolved/Continuing Problems:

NORM	ABN.	NE	PHYSICAL EXAMINATION - Comments
			SKIN: no significant lesions
			HEAD: normocephalic, no headache
			EYES: perla, eom satisfactory, vision WNL
			EARS: drums intact, hearing WNL
			NOSE: no abnormality
			THROAT: clear, no infection
			TEETH/GUMS: no caries, good repair, no lesions
			NECK: supple, no adenopathy
			CHEST: symmetrical, no pain
			BREAST: no masses **Last Mammogram & Result:**
			LUNGS: clear to p&a, no rhonchi, no rales
			HEART: regular rate, no cardiomegaly
			ABDOMEN: non-tender, soft, no masses
			SPINE: no abnormalities
			EXTREMITIES: no abnormalities
			LOW BACK: rom normal
			NEURO: dtr=2+, no abnormal findings
			RECTAL: no abnormalities **Last FOBT & Result:**
			PELVIC:

ASSESSMENT:

Current Medications Reviewed: [ ]

Plan: **Pneumococcal Vaccine [ ]**
Td/Tdap Vaccine [ ]
Flu Vaccine [ ]

RTC: **Referral:**

Provider Name:	Provider NPI:	Provider Signature/Title:

IEHP DualChoice Annual Comprehensive Diagnostic Review

DIAGNOSIS REVIEW:
Confirm or Deny the conditions listed below and indicate noted assessment/plan for each condition reviewed:

Diagnosis Source	Code Range/Description	Confirm Condition Y/N	Confirmed Diagnosis Code**	Assessment/Plan
Historical/Prior Year Condition	**XXX-XXX / DIAGNOSIS DESCRIPTION1**		*Special Sorting***	
Associated Condition	**XXX-XXX / DIAGNOSIS DESCRIPTION2**			
Possible Condition	**XXX-XXX / DIAGNOSIS DESCRIPTION3**			
Member-Reported Condition	**XXX-XXX / DIAGNOSIS DESCRIPTION4**			

Provide a listing of all <u>additional</u> diagnoses/conditions assessed during the visit and indicate noted assessment/plan for each condition:

Diagnosis Code	Assessment & Plan

All reviewed conditions are included above: Yes ☐ No ☐

Provider Name:	Provider NPI:	Provider Signature/Title: