Model Progress Note

Banner Health Network

DOCUMENTATION BEST PRACTICE

Required (CMS) on every page: Patient Name, Date of Service (DOS) and an additional patient identifer (ex: Date of Birth [DOB])

Chief Complaint (CC): "Follow-up" alone is not a valid CC. The documentation must describe why the patient is presenting for follow-up.(CMS)

History: History of Present Illness (HPI) driven by the CC and Review of Systems (ROS) driven by the HPI. The HPI must be documented by provider. (CMS)

Exam: Exam driven by the patient history, describing in detail any pertinent positive and negative findings and any chronic findings that affect the care and treatment of the patient. (CMS,WHO)

Medical Decision Making (MDM):
Assessment: Documents each diagnosis, its status and any causal relationships (e.g., diabetic, due to diabetes). Assessment that documents not only conditions being treated, but any and all chronic conditions that affect the care and treatment of the patient.
Assessment must be documented by provider. (CMS)

Plan: Specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education, followed by (ex: followed by cardiologisit) and return visits.
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Authentication in the Electronic Medical Record (EMR):
Authentication by the provider author of the progress note, password-protected to that provider only, at the end of the note (ex: Authenticated by, Approved by), including typed name and credential and the date authenticated. (CMS)

PROGRESS NOTE

Patient: Name **DOS:** 10/08/2015 **DOB:** 10/08/48

Reason for Appointment: Follow-up for diabetes check.

CC: Patient describes progressive loss of sensation in both feet.

Current Medications List: Glyburide 10mg PO q.d.; Lyrica 50mg PO t.i.d.

History of Present Illness: Patient states she is able to move around, including bathroom and kitchen with the help of her cane. Denies any pain or shortness of breath. No change in bowel or bladder habits. She states she takes her Glyburide regularly. She is somewhat successful in following her diet but does not check her sugars often.

Vital Signs: T 98.6; BP 145/97; HR 62; Wt 262lbs; Ht 68"; BMI 40.00
Examination: Patient alert, oriented to person, place and time. No acute distress. Patient is morbidly obese.
Cardiac: RRR no rubs, gallops or murmurs observed.
Lungs: Clear to auscultation (CTA).
Abdomen: Soft non-tender to palpation with colostomy bag intact and functioning, skin dry and intact surrounding pink-light red stoma.
Feet: Peripheral pulses slightly palpable. Left great toe amputation with appropriate healing. Diminished vibratory sensation at right great toe DIP (5 seconds) and no sensation at left great toe.

Assessments:
1. Morbid Obesity (E66.01, Z68.41)
   a. BMI (Z68.41)
   b. Hypertension (I10)
2. Diabetes with complications
   a. Worsening diabetic neuropathy (E11.40)
   b. Diabetic vascular complications (E11.51)
3. Left great toe amputation: Three months ago. Continue to monitor. Patient instructed to return to clinic for any signs of infection. (Z89.412)
4. Functioning colostomy bag: Continue current management. (Z93.3)

Treatment:
1. Morbid Obesity
   a. Obesity: Patient to return in 2 weeks to discuss diet and exercise plan and alternatives. Will determine if patient is open to intensive behavioral therapy (IBT) for obesity management.
   b. Hypertension: discussed need for weight loss, lifestyle changes and possible need for medications. Will return to clinic in 2 weeks for BP monitoring and assessing patient for cardiovascular risks (intensive behavioral therapy for cardiovascular risk managment).
2. Diabetes with Chronic Complications:
   a. Patient counseled on dietary changes.
   b. Continue current dose of glyburide for now.
   c. Diabetic peripheral neuropathy: Increase Lyrica to 100 mg by mouth three times daily.
   d. HbA1c ordered for prior to next visit.
   e. Diabetic eye exam and diabetic education referrals ordered.
   f. Refer to vascular surgery for worsening PAD.
3. Great toe amputation: Continue to monitor. Patient instructed to return to clinic for any signs of infection.
4. Functioning colostomy: Continue current management.

Signed by: Jackson M. Kirby MD, 10/08/2015
Sign off status: Completed

1. Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.
2. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 30 Nov 2012. <http://www.jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.
3. Centers for Medicaid & Medicare Services. "1995 Documentation Guidelines for Evaluation & Management Services." (1999). Medicare Learning Network. Web.
4. World Health Organization. "International Classification of Diseases, Tenth Revision, Clinical Modification, 6th Ed." *National Center for Health Statistics 2011 1-107. Web. 22 Oct. 2012.* <http://www.cdc.gov/nchs/icd/icd10cm.htm>.