Patient Name: ______________________________
D.O.B: ______________________________
Date of Service: ______________________________

HealthCare Partners, IPA
HealthCare Partners, Management Services Organization

OFFICE STAMP

CHIEF COMPLAINT/HPI:

PAST MEDICAL HISTORY:

VITALS

BP: / PULSE: RESP: TEMP: HEIGHT: WEIGHT: BMI:

ALLERGIES

PHYSICAL EXAM

	WNL	ABN
HEENT		
NECK		
CHEST		
BREAST		
HEART		
ABDOM		
PELVIC		
RECTAL		
EXTREM		
NEURO		
SKIN		
EKG		
PFT		

MEDICATIONS

Medications initialed below have been reviewed on D.O.S	INITIAL
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	

DIAGNOSIS Include stage, severity and link diagnosis when required	STATUS Circle one	PLAN
1	STABLE WORSENING IMPROVING	
2	STABLE WORSENING IMPROVING	
3	STABLE WORSENING IMPROVING	
4	STABLE WORSENING IMPROVING	
5	STABLE WORSENING IMPROVING	

For **DIABETIC** patients please check if the test below have been performed during the current calendar year.

☐ HbA1c ☐ Nephro (Urine test) ☐ Diabetic EYE exam

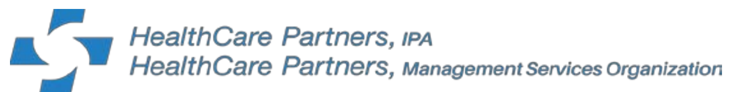
Signature MD / DO / PA / NP

Please Circle **CREDENTIAL**

☐ **Check box if continued on second page**

Form to be used to support coding validation

Patient Name: ______________________________
D.O.B: ______________________________
Date of Service: ______________________________



OFFICE STAMP

DIAGNOSIS Include stage, severity and link diagnosis when required	**STATUS** Circle one	**PLAN**
6	STABLE WORSENING IMPROVING	
7	STABLE WORSENING IMPROVING	
8	STABLE WORSENING IMPROVING	
9	STABLE WORSENING IMPROVING	
10	STABLE WORSENING IMPROVING	
11	STABLE WORSENING IMPROVING	
12	STABLE WORSENING IMPROVING	

ADDITIONAL INFORMATION / IMPRESSION / PLAN / HEALTH EDUCATION / REFERRALS

Signature **MD / DO / PA / NP**
Please Circle **CREDENTIAL**

Form to be used to support coding validation