



**Outpatient  
Osteopathic SOAP Note  
Form Series**

**Usage Guide**

*Second Edition*

*Published by*



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# Outpatient Health Summary

wak SOAP version 5:091102b

Patient's Name		Date	Update:	
Date of Birth		Sex	Home	
Marital Status:	M S D W	Phone Number	k	
Significant Others:		DNR Status	Yes	No
Religion:		Resuscitation	Qualifications:	
Next of Kin:				
Social History:	Employment	Occupation	Education	
	Tobacco	ETOH	Drugs	Sex Hx
Family History:	M	Siblings	Others:	
	F			

Past Medical History				
CPT#	Start Date	Problem / Diagnosis	Medications	Start

Allergies, Adverse Drug Reactions: \_\_\_\_\_

Health Maintenance						Past Surgical History	
Parameter	Dates					Date	Type
DPT/DI/TD							
OPV							
MMR							
HIB							
Influenza							
Hepatitis							
PPD/Tine							
Pneumovax							
H & P							
Eye exam							
Dental exam							
PAP smear							
Mammogram							
Urinalysis							
Hemocult							
Cholesterol							
Sigmoidoscopy							
Others							

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 Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

# Outpatient Osteopathic SOAP Note History Form

wak SOAP version 5:091102b

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

Office of:	
For office use only:	

## HISTORY

**S** (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale:  Not done

NO PAIN	WORST POSSIBLE PAIN

### Section I

**CC**

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### History of Present Illness

Level: HPI

E l e m e n t s	<input type="checkbox"/> Location	OR Status of $\geq 3$ chronic or inactive conditions	<input type="checkbox"/> II	1-3 elements reviewed	
	<input type="checkbox"/> Quality		<input type="checkbox"/> III		
	<input type="checkbox"/> Severity			<input type="checkbox"/> IV	$\geq 4$ elements OR status of $\geq 3$ chronic conditions
	<input type="checkbox"/> Duration				
	<input type="checkbox"/> Timing				
	<input type="checkbox"/> Context				
	<input type="checkbox"/> Modifying factors				
	<input type="checkbox"/> Assoc. Signs and Sx				

Review of Systems (Only ask / record those systems pertinent for this encounter.)  Not done

Level: ROS

	<input type="checkbox"/> Constitutional (Wt loss, etc.)	<b>Section II</b>	<input type="checkbox"/> II	None
	<input type="checkbox"/> Eyes		<input type="checkbox"/> III	1 system pertinent to the problem
	<input type="checkbox"/> Ears, nose, mouth, throat		<input type="checkbox"/> IV	2-9 systems
	<input type="checkbox"/> Cardiovascular		<input type="checkbox"/> V	$\geq 10$ systems
	<input type="checkbox"/> Respiratory			
	<input type="checkbox"/> Gastrointestinal			
	<input type="checkbox"/> Genitourinary			
	<input type="checkbox"/> Musculoskeletal			
	<input type="checkbox"/> Integumentary (skin, breast)			
	<input type="checkbox"/> Neurological			
	<input type="checkbox"/> Psychiatric			
	<input type="checkbox"/> Endocrine			
	<input type="checkbox"/> Hematologic/lymphatic			
	<input type="checkbox"/> Allergic/immunologic			

Past Medical, Family, Social History  Not done

Level: PFSH

	<input type="checkbox"/> Past history / trauma	<b>Section III</b>	<input type="checkbox"/> II	None
	Allergies:		<input type="checkbox"/> III	
	Medications:		<input type="checkbox"/> IV	1 history area
			<input type="checkbox"/> V	$\geq 2$ history areas
	<input type="checkbox"/> Family history			
	<input type="checkbox"/> Social history			

**Overall History = Average of HPI, ROS or PFSH:**  II (1-3 HPI)  III (1-3 HPI, 1 ROS)  IV (4+ HPI, 2-9 ROS, 1 PFSH)  V (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: \_\_\_\_\_ Signature of examiner: \_\_\_\_\_

Not done

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Sex: Male  Female

\* Vital Signs (3 of 7) Wt. \_\_\_\_\_ Ht. \_\_\_\_\_ Temp. \_\_\_\_\_

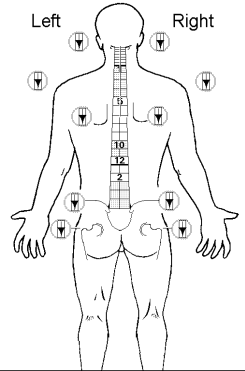
Resp. \_\_\_ Pulse \_\_\_ Reg.  Irreg.  Pt. position for r \_\_\_\_\_

Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Lying \_\_\_\_\_

Office of: \_\_\_\_\_

For office use only: \_\_\_\_\_

Section I



Section II

Section III

**Level of GMS**

<input type="checkbox"/>	<b>II</b>	1-5 elements
<input type="checkbox"/>	<b>III</b>	6+ elements
<input type="checkbox"/>	<b>IV</b>	2+ from each or 6 areas OR 12+ elements in 2+ areas
<input type="checkbox"/>	<b>V</b>	Perform all elements ≥ 9 areas

	Methods Used For Examination					Key to the Severity Scale	Severity				Somatic Dysfunction and Other Systems MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
	All	T	A	R	T		0	1	2	3	
*1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic T1-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T5-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T10-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sacrum / Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvis / Innom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abd. / Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Section IV

Signature of transcriber: \_\_\_\_\_

Signature of examiner: \_\_\_\_\_





# Outpatient Osteopathic SOAP Note Form Series Usage Guide

## Introduction:

The following Outpatient Osteopathic SOAP Note Form Series was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized, and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

## Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. All bold boxed areas are critical to research data and should be filled in. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank or fill in the "not done" rectangle. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

### **Initial Page:**

#### **Outpatient Health Summary**

This page of the system is the front left hand page of a two-section chart system or the front page of a one-section chart. At each patient visit, it provides rapid ID, recall of wishes for care, who and how to call in case of an emergency, and a quick retrieval of past medical, surgical and medication history, consultants and immunizations. This page is reviewed at each patient visit, and all sections are kept current.

## **Section I: Identification and Disposition**

**Patient's Name:** Write in the patient's first and last name.

**Date:** Write in the date this initial summary was started. Use the following format for all dates: month/day/year.

**Update:** Write in the dates that this form is updated. Separate dates by comma's, with the most recent date furthest to the right (month/day/year).

**Date of Birth:** (month/day/year).

**Sex:** Male or Female gender.

**Phone Numbers:** Provide **Home** phone number and a **Work** phone number, if appropriate.

**Marital Status:** Circle the correct letter to indicate if **Married**, **Single**, **Divorced**, or **Widowed**.

**Significant Others:** List them and include living arrangements.

**DNR Status or Resuscitate? (Yes, No) and Qualifications:** Indicate the patient's or guardian's wishes regarding resuscitation by checking the "**Yes**" or "**No**" box. Additional desires or wishes for terminal care can be added here in the **Qualifications** box.

**Religion:** Write in the patient's religion or preference for last rites.

**Next of Kin:** Write in the name of whom should be contacted in case of emergency, should the patient die, or who is the beneficiary.

## **Section II: Social and Family History**

**Social History** is an age-appropriate review of past and current activities that includes significant information about:

**Employment:** Write in the patient's current and past employment, and, if appropriate, places of work. Indicate if patient is retired; indicate any

risk factors associated with the work place, i.e., black lung, asbestos exposure, fumes, etc.

**Occupation:** Write in the patient's areas of training (chemist, teacher, homemaker).

**Education:** Write in the patient's current school status, degrees obtained, or highest grade obtained.

**Tobacco:** Write in pack/years, what form (cigarettes, cigars, chewing tobacco), and quit-dates, if appropriate.

**ETOH (alcohol):** Write in the patient's alcohol use in numbers, what consumed (beer, cocktails), how often (daily, weekly, monthly, yearly). Indicate past abuse and sober date.

**Drugs:** Write in the patient's illicit drug use, past and present, what, when, and for how long.

**Sex Hx** (sexual history): Write in the patient's sexual preference, partners, menstrual history, gravida number, and para number. (The female patient has a gravida number if presently pregnant; otherwise she only has a para number. A para number is a 4-digit number indicating the number of "pregnancies-prematures-abortions-and living children.")

**Family History** is a review of medical events in the patient's family that include significant information about: (**M**other, **F**ather) the health status or cause of death of parents, **Siblings**, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness and/or System Review; diseases of family members which may be hereditary or place the patient at risk.

Use ↑ if the immediate relative (mother, father, sibling, etc.) is living and ↓ if deceased. If deceased, indicate the age of death and cause. List their pertinent health problems or history.

**Others:** List any pertinent health history or information on other relatives, such as maternal grandmother ↓ age 50, breast cancer, etc.

### **Section III: Past Medical History**

**Past Medical History** is a review of the patient's past experiences with illness, injuries, and treatment that includes significant information about:

**CPT #:** Write in any CPT codes that might be helpful for easy reference when coding.

**Start Date of Problem:** Write in the date when a problem began or when a diagnosis was first made (month/day/year).

**Problem / Diagnosis:** Write in the patient's prior illnesses, injuries, and prior hospitalizations, in order of occurrence when possible.

**Medications:** Medications and dosages are listed in order of their initial use. Also list here over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

**Start Date for Medications:** Write in the date that each medication/substance was started and when dosages are/were changed (month/day/year).

**Stop Date for Medications:** Write in the date that each medication/substance was discontinued (month/day/year). Leave blank if the patient currently is taking a medication.

**Allergies, Adverse Drug Reactions:** List medications, foods, animals, etc., that cause allergic reactions or that produced unexpected results. List the nature of the reaction or result.

### **Section IV: Health Maintenance**

**Parameter and Dates:** This is a running list of dates (month/day/year) of the usual immunizations, exams, tests and procedures. There is also a line for "**Others**" write-ins.

### **Section V: Past Surgical History**

**Date and Type:** Surgical dates and types are listed in the order of occurrence (month/day/year).

### **Section VI: Consultants**

**Consultants** are listed, including the consultant's name and specialty.

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**Page 1 of 3:**

**Outpatient Osteopathic SOAP Note History Form**

This page of the system provides the subjective portion of a SOAP note for an outpatient patient visit.

**S:** The Subjective section of the SOAP note.

**Section I: Patient's Name, Date, Age, Patient's Pain Analog Scale, and CC**

**Patient's Name, Date, and Age:** The first and last name of the patient and the date of this visit are recorded (month/day/year). Write in the patient's age in years. If a child, use days up to 1 month, use months up to 1 year, and years of age.

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

**Patient's Pain Analog Scale:** The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have **NO PAIN**, place a mark at the far left side. If this is the **WORST POSSIBLE PAIN** you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time." If the patient doesn't have pain or this information was not obtained, fill in the "**Not done**" rectangle.

**CC** Stands for **Chief Complaint**, which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that is the reason for the encounter. **CC** usually is stated in the patient's words. Extra lines are included here for other details of the subjective history not included in the rest of this section or those needing more space for details.

**Section II. History of Present Illness, Review of Systems, and Past Medical, Family and Social History**

**History of Present Illness (HPI):** The HPI is a chronological description of the development of the patient's present illness, from the first sign

and/or symptom to the present. This includes a description of location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s). Fill in all rectangles and write in the details after each element listed for the history elicited. OR, write in the status of 3 or more chronic or inactive conditions on the lines provided.

**Level: HPI:** This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Fill in the rectangle that applies. The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) or three (99213) code requires 1-3 of the HPI elements to qualify. A level four (99214) or five (99215) code requires  $\geq 4$  HPI elements OR the status of  $\geq 3$  chronic conditions.

**Review of Systems (ROS)** is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT, the following systems review has been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, and Allergic/immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data for other systems that might be affected by any possible management options. Only fill in the rectangle(s) of those systems reviewed at this encounter. Write in any details elicited after each system. If you examine a system and it is normal, fill in the rectangle for that system and write Within Normal Limits (WNL) on that line. If no ROS information was obtained, fill in the "**Not done**" rectangle.

**Level: ROS:** The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) requires no ROS. Level three (99213) requires one system pertinent to the problem. Level four (99214) requires 2-9 systems. Level five (99215)

requires listing of  $\geq 10$  systems. Fill in the rectangle that applies.

**Past Medical, Family, Social History (PFSH):**

**Past history / trauma** is a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries, prior operations, prior hospitalizations, allergies, age-appropriate immunization status, and age-appropriate feeding/dietary status.

**Allergies**, including Adverse Drug Reactions: List medications, food, animals, etc., that cause allergic reactions or produce unexpected results. List the reaction or the result.

**Medications:** Medications and dosages are listed here. Include over-the-counter substances, such as herbs, vitamins, and homeopathic remedies.

**Family history** is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or Systems Review; diseases of family that may be hereditary or place the patient at risk.

**Social history** is an age-appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

Fill in the rectangle(s) and write in any extra history not included on the **Outpatient Health Summary Form**, such as trauma history. If no medical, family or social history was obtained on the **Outpatient Health Summary** or the **Outpatient Osteopathic SOAP Note History Form**, fill in the "Not done" rectangle.

**Level: PFSH:** The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level two (99212) and three (99213) requires that no history areas be present. Level four (99214) requires 1 history area. Level five (99215) requires 2 or more history areas. Fill in the rectangle that applies.

**Overall History:** Fill in the rectangle that indicates the average level determined using the level of HPI, ROS or PFSH provided.

**Signature of examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

**Page 2 of 3:**

**Outpatient Osteopathic SOAP Note Exam Form**

This page of the system provides space for recording vital signs and any visceral and musculoskeletal examination findings obtained during your outpatient exam of a patient.

**O:** The **O**bjective section of the **SO**AP Note.

**Section I: Patient's Name, Date, Sex and Vital Signs**

**Not done:** If none of the objective portion was performed, fill in the **Not done** rectangle.

**Patient's Name:** Write in the patient's first and last name.

**Date:** Write in the date of the patient's visit (month/day/year).

**Sex:** Fill in the correct rectangle for **Male** or **Female** gender.

**Vital Signs:** Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. **Wt.** (weight in pounds, lbs), 2. **Ht.** (height in feet and inches, ft, in), 3. **Temp.** (temperature in degrees Fahrenheit), 4. **Resp.** (rate of respiration in breaths-per-minute), 5. **Pulse** rate (in beats per minute) and whether it is regular (**Reg.**) or irregular (**Irreg.**), 6. **BP** (blood pressure) **Standing, Sitting,** and 7. **Lying** down. If a measurement was not taken, leave the space blank.

**The boxes marked Office of: and For office use only:** can be used to identify research studies, for office record keeping, etc.

**Section II: Objective Section** (continued as blank lines).

Physical exam findings for any areas/systems of the **General Multi-System Examination (GMS)** are recorded in this section. These include: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Cardiovascular, Respiratory, Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, and Psychiatric. The table that follows provides a section where specific musculoskeletal exam findings can be recorded and documented. Gait and station as well as inspection and/or palpation of digits and nails for the musculoskeletal exam can be put into this section to fulfill all elements of the exam that aren't included in the somatic dysfunction table. Overflow data from the musculoskeletal exam can also be put here. Note: If no physical exam was done at this encounter, fill in the **Not done** rectangle at the top of Section I.

**Section III: Horizontal Planes and Level of GMS**

**Horizontal Planes (Diagram):** The diagram can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram can also be used to denote such things as lateral curvatures, the AP weight bearing line, or any other documentation that may be helpful.)

**Level of GMS (General Multi-System):** This is a guide for criteria needed to justify your evaluation and management CPT code in the **Objective** section. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

- II 1-5 elements:** For a level two (99212) visit you must have examined one to five elements identified by a bullet.
- III 6+ elements:** For a level three (99213) visit you must have examined at least six elements identified by a bullet.
- IV 2+ from each of 6 areas OR 12+ elements in 2+ areas:** For a level four (99214) visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems **OR** at least twelve elements identified by a bullet in two or more areas/systems.

- V Perform all elements  $\geq$  9 areas.** For a level five (99215) visit, you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Be advised that for the **Musculoskeletal Exam**, the six areas are: (1) head, face, and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; (6) left lower extremity.

**Warning:** For a comprehensive level of exam, all four of the elements identified in **TART** must be performed and documented for each of four of the six anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

**Section IV: Musculoskeletal Table**

**Methods Used for Examination:** Be sure to blacken in the rectangles indicating the tools used for your examination (**T, A, R, T**). Included in the definition of these components are the criteria required for coding in each body area.

- All:** Indicates that all **TART** criteria were used to examine a region.
- T:** **Tissue Texture Change**, stability, laxity, effusions, tone.
- A:** **Asymmetry**, misalignment, crepitation, defects, masses.
- R:** **Range-of-Motion**, contracture.
- T:** **Tenderness**, pain.

Filling in these squares is a shortcut to a full narrative documentation in the **Somatic Dysfunction and Other Systems** section of this table.

**Region Evaluated:** This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: \*1. **Head and Face**, and **Neck**; \*2. The spine (**Thoracic, Ribs, Lumbar, Sacrum/Pelvis, Pelvis/Innom.**, and **Abd./Other**); \*3. **Right Upper Extremity**; \*4. **Left Upper Extremity**; \*5. **Right Lower Extremity**; and \*6. **Left Lower Extremity**. The

thoracic region is broken down into three parts based on vertebral levels for innervation specificity: **T1-4**, **T5-9**, and **T10-12**. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

**Severity:** This section refers to the severity [None (0), mild (1), moderate (2), severe (3)] of the most affected somatic dysfunction in a region. Fill in one rectangle for each region examined. For regions that are not examined, leave the rectangle empty.

If a rectangle is **not marked** in a region, it is assumed that that region was **not examined**. For regions that are examined, the scale is as follows:

<b>0</b> None	No somatic dysfunction present or background (BG) level.
<b>1</b> Mild	More than background, minor <b>TART</b> elements.
<b>2</b> Moderate	Obvious <b>TART</b> ; in particular <b>Range-of-motion (R)</b> and/or <b>Tissue texture change (T)</b> may or may not be overtly symptomatic.
<b>3</b> Severe	Key lesions observed, significant, symptomatic, stands out; <b>R</b> and/or <b>T</b> elements stand out with minimum search or provocation.

(At the top of the table is a **Key to the Severity Scale**, which provides for a quick review.)

**Somatic Dysfunction & Other Systems:** Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial (FAS), etc., components. Use standard terminology.

If you filled in rectangles under **TART** you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

**Signature of examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

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**Page 3 of 3:**

**Outpatient Osteopathic Assessment and Plan Form**

This page of the system is to be used with the Outpatient Osteopathic SOAP Note History and Exam Forms. It contains the **A**ssessment and **P**lan for completion of a SOAP note. It provides for the **Written Diagnosis, Physician's evaluation of patient prior to treatment, treatment table for OMT**, other instructions and treatments given, coding, instructions, **Minutes spent with the patient, Follow-up, Units, OMT performed, Other Procedures Performed**, and **E/M Code**.

**A:** The **A**ssessment section for the **SOAP** note. This includes patient's name, date, diagnosis and physician's evaluation of patient prior to treatment.

**Section I: Patient's Name and Date**

**Patient's Name:** Write in the patient's first and last name.

**Date:** Write in the date of the patient's visit (month/day/year).

**The boxes marked Office of: and For office use only:** can be used for tracking a research study, for office record keeping, etc.

**Section II: Diagnosis and Evaluation Prior to Treatment:**

**Dx No.** (diagnosis number): Write in your priority numbers in the **Dx No.** column, with "1" being the number of the patient's most severe or addressed diagnosis at this visit.

**ICD Code:** Write in this column the ICD code that corresponds to your diagnosis, if it has not already been written in.

**Written Diagnosis:** Write on this line the description for each of your ICD codes, if not already listed.

**Physician's Evaluation of Patient Prior to**

**Treatment:** This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment as compared to the previous visit(s):

**First visit:** If this is the patient's first visit for a particular problem, mark the square after **First visit**.

**Resolved:** If the problem for which a follow-up visit was requested is resolved, mark the square after **Resolved**. Example: If a patient presents for a follow-up on a musculoskeletal problem, filling in the **Resolved** rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings being found, and that you also filled in the **0** (zero) rectangle in the severity column for that region in the Musculoskeletal Table (found on page 2 of 3).

**Improved:** If the problem for which a follow-up visit is improved, but not totally resolved, mark the rectangle after **Improved**.

**Unchanged:** If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the **Unchanged** rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

**Worse:** If the problem for which a follow-up visit was requested is worse than it was at the last visit, mark the rectangle after **Worse**. This could occur with a musculoskeletal problem if no treatment was started at the prior visit, the patient did something to aggravate their condition, or the patient had a complication or side effect of treatment given at the last visit. This refers to the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e., a

flare-up from the last treatment. Flare-up information can be charted in the **Subjective** section of these forms (found on page 1 of 3).

**Section III: Plan: Region, OMT, Treatment Method and Response**

**P:** The **Plan** Section of the SOAP form. This includes a treatment table for Osteopathic Manipulative treatment. Following the table, it also records **Meds** (medications), **Exercise**, **Nutritional** advice, and **PT** (physical therapy) instructions. **Other** provides space for any additional advice or type of treatment you institute. Also included in this section are areas for coding, **Minutes spent with patient**, **Follow-Up**, **OMT performed**, **Other Procedures Performed**, and **E/M Code**.

**Region** lists musculoskeletal body regions arranged in order based upon CPT categories. They include **Head and Face**, **Neck**, **Thoracic**, **Ribs**, **Lumbar**, **Sacrum**, **Pelvis**, **Abdomen/Other** (viscera falls into this category), **Upper Extremities**, **Lower Extremities**. If no regions are treated, fill in the **All not done** rectangle.

**OMT:** Fill in the **Yes** rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the **No** rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be rectangles for **Methods Used for Examination** and **Severity** rectangles (1, 2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 3).

**Treatment Method:** Listed here are the abbreviations of manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Fill in the rectangles that correspond to the modalities used to treat each region.

- ART:** articular treatment.
- BLT:** balanced ligamentous tension / ligamentous articular strain treatment.
- CR:** cranial treatment / osteopathy in the cranial field / cranial osteopathy.
- CS:** counterstrain treatment.
- DIR:** direct treatment.

- FPR:** facilitated positional release treatment.
- HVLA:** high velocity/low amplitude treatment (thrust treatment).
- IND:** indirect treatment.
- INR:** integrated neuromuscular release.
- LAS:** ligamentous articular strain / balanced ligamentous tension treatment.
- ME:** muscle energy treatment.
- MFR:** myofascial release treatment.
- ST:** soft tissue treatment
- VIS:** visceral manipulative treatment.
- OTH:** any other OMT treatments used.

**Response:** Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The rectangles are indicated as follows:

- R:** The somatic dysfunction is completely Resolved without evidence of it ever having been present.
- I:** The somatic dysfunction is Improved but not completely resolved.
- U:** The somatic dysfunction is Unchanged or the same after treatment as it was before treatment.
- W:** The somatic dysfunction is Worse or aggravated immediately after treatment.

#### **Section IV: Other Treatment Methods Used**

**Meds:** List in this space any medications the patient will continue or new medications that will be started. Risks, benefits, and potential side effects can be listed here.

**Exercise:** List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts.

**Nutrition:** List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

**PT:** List in this space any Physical Therapy modalities your patient currently receives, has received in the office, or that you recommend they receive or do.

**Other:** List in this space anything that does not fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list the topics discussed, the details that were included, the handouts or educational materials given, and what referrals were made.

#### **Section V: Coding**

##### **Complexity / Assessment / Plan (Scoring):**

Only two of the following three categories (**Problems, Risk, Data**) are required for an established visit. Note that there are five levels and five rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate **rectangle** under one of the five levels. The total level for complexity is the average of the three following categories included (Problems, Risk, and Data).

**Problems:** Find which criteria match this visit. This could be **Self-limited, Established problem—improved /stable, Established—worsening, New—no workup, or New—additional workup**. Add points or number of problems that fit this patient in each category. Find the total points under one of the five levels and blacken the appropriate rectangle.

**Risk:** Find which criteria match this visit. This could be **Minimal, Low, Moderate, or High** based on presenting problems, diagnostic procedures, and management options. Find the level of risk under one of the five levels and blacken the appropriate rectangle. OMT is low risk.

**Data:** Find which criteria match this visit. This could be **Lab, Radiology, Medicine, Discuss with performing physician, Obtain records or Hx from others, Review records, discuss with physician, or Visualization of tracing, (or) specimen**.

##### **Traditional Method—Coding by Components:**

For each **History, Examination, and Complexity / Assessment / Plan** section, put a circle around the appropriate composite level. All three areas are required for new patient visits. Then blacken the rectangle in the **Final**



**Level of Service** that denotes the average of the three levels recorded.

**Optional Method—Coding by Time:**

**When the majority of the Encounter** (50% or greater) **is counseling /coordinating, the level is determined by total time.** Blacken the rectangle that indicates how much time was spent counseling: **New patients (minutes)**—10, 20, 30, 45, 60; **Established patients (minutes)**—10, 15, 25, 40). Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient—see the next paragraph.)

**Section VI: Minutes spent with the patient, Follow-up, Units, OMT Performed as above (number of areas), Other Procedures Performed, and E/M Code**

**Minutes Spent With the Patient:** Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the rectangle that best fits your total time.

**Follow-up:** Blacken the rectangles that correspond to when you would like to see the patient again; you must indicate both the number and the **Units**. For example: for a visit in one month, blacken the rectangle above the “1” and also the rectangle above **M** (month). Abbreviations following the **Units** title are: **D** (days), **W** (week), **Y** (year), and **PRN** (as needed).

**OMT performed as above:** Fill in the box for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of YES rectangles in the OMT section of the table on page 3 of 3, and the

number of rectangles in the severity section of the table on page 2 of 3 marked with a 1, 2, or 3. The rectangles are defined as follows:

- 0 areas:** You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- 1-2 areas:** You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- 3-4 areas:** You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- 5-6 areas:** You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- 7-8 areas:** You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.
- 9-10 areas:** You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

**Other Procedures Performed:** In the spaces provided, write in the **CPT Codes** and written diagnosis (**Written Dx**) for each procedure performed, other than OMT.

**E/M Code:** Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (**New**) use 99202, 99203, 99204, 99205. For an established patient visit (**EST**) use 99211, 99212, 99213, 99214, 99215. For a consultation visit (**Consults**) use 99241, 99242, 99243, 99244, 99245.

**Signature of examiner:** Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

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*D: \ Sleszynski / SOAP Note Series Usage Form. Version 5: 091102cw.*

# Outpatient Health Summary

wak SOAP version 5: 091102b

<b>Patient's Name</b> Jane Doe			<b>Date</b> 1/1/01		<b>Update:</b>		
<b>Date of Birth</b> 9/13/1976		<b>Sex</b> F		<b>Home</b> 262-657-5975			
<b>Marital Status:</b> M <input checked="" type="radio"/> D <input type="radio"/> W			<b>Phone Numbers:</b>		<b>Work</b> 847-595-2714		
<b>Significant Others:</b> Boyfriend--John			<b>DNR Status: Resuscitate?</b>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<b>Qualifications:</b>
<b>Religion:</b> Catholic			<b>Next of Kin:</b> Gordon and Shirley Smith--parents				
<b>Social History:</b>		<b>Employment</b> Abbott Labs		<b>Occupation</b> Secretary		<b>Education</b> College x 4 yrs.	
		<b>Tobacco</b> Quit 1999		<b>ETOH</b> 2 beers per wk		<b>Drugs</b> past pot	
						<b>Tobacco</b> Quit 1999	
<b>Family History:</b>			<b>Siblings</b> 1 brother A & W			<b>Others:</b> Maternal GM ↓ breast CA	
			1 sister Asthma				

## Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop
		Sciatica	Proventil inhaler PM	1999	
564.1		IBS	Advil 400 mg TID	9-01	
493.00		Asthma	Synthroid 0.125mg po qd	2000	
244.9	2000	Hypothyroidism	St. John's Wort	10-01	
	1985	MVA injury	Vit. B6, E, B12, C		
250.01		DM Type I	Norflex 100 mg po BID	10/01	
847.1	10/01	Thoracic strain			

**Allergies, Adverse Drug Reactions:** PCN - rash Cat dander, ragweed

## Health Maintenance

## Past Surgical History

Parameter	Dates								Date	Type
	1976	1-77	3-77	1982	1992					
DPT/DI/TD	1976	1-77	3-77	1982	1992				Child	T and A
OPV	11-76	1-77	3-77	1982					1991	Wisdom teeth x 4
MMR	1977								1980	Sutures Rt. forearm
HIB	11-76	1-77	3-77						1993	Fx right wrist
Influenza										
Hepatitis	2-83	3-82	9-82							
PPD/Tine										
Pneumovax										
H & P	2000									
Eye exam	3 / 01									
Dental exam	6 / 01									
PAP smear	2000									
Mammogram										
Urinalysis	2000								PCP	Inveiss
Hemocult									GYN	Azuma
Cholesterol	2000/189									
Sigmoidoscopy										
Others	6-01									

Funded by a grant from the Bureau of Research. © 2002 American Academy of Osteopathy. Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

# Outpatient Osteopathic SOAP Note History Form

wak SOAP version 5: 091102b

Patient's Name Jane Doe Date 1/1/02 Age 25

Office of:	
For office use only:	

## HISTORY

**S** (See Outpatient Health Summary Form for details of history)

**Patient's Pain Analog Scale:**  Not done

Back	Stomach
NO PAIN	WORST POSSIBLE PAIN

**CC** Stomach ache, back pain  
Patient saw chiro—temporary relief only

### History of Present Illness

**Level: HPI**

<b>E</b> <b>l</b> <b>e</b> <b>m</b> <b>e</b> <b>n</b> <b>t</b> <b>s</b>	<input checked="" type="checkbox"/>	Location <u>Mostly mid-epigastric and mid-back</u>	<b>OR</b> Status of $\geq 3$ chronic or inactive conditions <u>Blood sugars—stable</u>	<input type="checkbox"/>	<b>II</b>	1-3 elements reviewed
	<input checked="" type="checkbox"/>	Quality <u>Achy, dull</u>		<input type="checkbox"/>	<b>III</b>	
	<input checked="" type="checkbox"/>	Severity <u>See above back improved after OMT</u>		<input checked="" type="checkbox"/>	<b>IV</b>	$\geq 4$ elements OR status of $\geq 3$ chronic conditions
	<input checked="" type="checkbox"/>	Duration <u>Started 2 days ago—stomach</u>		<input type="checkbox"/>	<b>V</b>	
	<input checked="" type="checkbox"/>	Timing <u>+ flare x 1 d after OMT</u>				
	<input checked="" type="checkbox"/>	Context <u>Better after eating</u>				
	<input checked="" type="checkbox"/>	Modifying factors <u>Bed rest helps</u>				
	<input checked="" type="checkbox"/>	Assoc. Signs and Sx <u>+ weakness with <math>\uparrow</math> discomfort</u>				

**Review of Systems** (Only ask / record those systems pertinent for this encounter.)  Not done

**Level: ROS**

<input type="checkbox"/>	Constitutional (Wt loss, etc.)	<input type="checkbox"/>	<b>II</b>	None
<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<b>III</b>	1 system pertinent to the problem
<input type="checkbox"/>	Ears, nose, mouth, throat	<input checked="" type="checkbox"/>	<b>IV</b>	2-9 systems
<input checked="" type="checkbox"/>	Cardiovascular <u>No palpitations</u>	<input type="checkbox"/>	<b>V</b>	$\geq 10$ systems
<input type="checkbox"/>	Respiratory			
<input checked="" type="checkbox"/>	Gastrointestinal <u><math>\emptyset</math> Nausea or vomiting</u>			
<input checked="" type="checkbox"/>	Genitourinary <u>No pain or burning with urination</u>			
<input type="checkbox"/>	Musculoskeletal			
<input type="checkbox"/>	Integumentary (skin, breast)			
<input type="checkbox"/>	Neurological			
<input type="checkbox"/>	Psychiatric			
<input type="checkbox"/>	Endocrine			
<input type="checkbox"/>	Hematologic/lymphatic			
<input type="checkbox"/>	Allergic/immunologic			

**Past Medical, Family, Social History**  Not done

**Level: PFSH**

<input checked="" type="checkbox"/>	Past history / trauma <u><math>\emptyset</math> trauma</u>	<input type="checkbox"/> <b>II</b> <input type="checkbox"/> <b>III</b> <input checked="" type="checkbox"/> <b>IV</b> <input type="checkbox"/> <b>V</b>	None
	Allergies:		
	Medications: <u>Norflex 100 mg po BID</u>		$\geq 2$ history areas
<input checked="" type="checkbox"/>	Family history <u><math>\downarrow</math> F at 46 yrs of PUD</u>		
<input type="checkbox"/>	Social history		

**Overall History = Average of HPI, ROS or PFSH:**  **II** (1-3 HPI)  **III** (1-3 HPI, 1 ROS)  **IV** (4+ HPI, 2-9 ROS, 1 PFSH)  **V** (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: \_\_\_\_\_ Signature of examiner: SL Sleszynski DO

# Outpatient Osteopathic SOAP Note Exam Form

wak SOAP version 5: 091102b

**O**  Not done

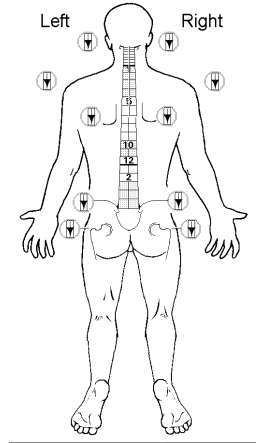
Patient's Name Jane Doe Date 01/01/02 Sex: Male  Female

\* Vital Signs (3 of 7) Wt. 130 lb. Ht. 5'5" Temp. 98.6

Reg.  Pt. position for recording BP:  
 Resp. 20 Pulse 80 Irreg.  Standing \_\_\_\_\_ Sitting 120/80 Lying \_\_\_\_\_

Office of:	
For office use only:	

Abdomen—tender epigastrium, + bowel sounds in 4 quadrants, Ø masses.  
 UE—Bilateral muscle strength 5/5.



**Level of GMS**

<input type="checkbox"/>	<b>II</b>	1-5 elements
<input checked="" type="checkbox"/>	<b>III</b>	6+ elements
<input type="checkbox"/>	<b>IV</b>	2+ from each or 6 areas OR 12+ elements in 2+ areas
<input type="checkbox"/>	<b>V</b>	Perform all elements ≥ 9 areas

	Methods Used For Examination					Key to the Severity Scale	Severity				Somatic Dysfunction and Other Systems	
	All	T	A	R	T		Region Evaluated	Severity				
								0	1	2		3
*1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Head and Face	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parietal area tender to touch	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
*2	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic T1-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	T3 L, Tissue texture change	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T5-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	T5 R, TTC, T7L—VS—GI related	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	T10-12	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	T10 F S R <sub>R</sub>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Myofascial strain	
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sacrum / Pelvis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WNL	
*3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvis / Innom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abd. / Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	↓ mobility greater curvature of stomach	
*4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Shoulder abduction 160 degrees	
*6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lower R	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tender TFL	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Signature of transcriber: \_\_\_\_\_

Signature of examiner: SL Sleszynski DO

# Outpatient Osteopathic Assessment and Plan Form

wak SOAP version 5: 091102b

**A** Patient's Name Jane Doe Date 1/1/02

Office of:	
For office use only:	

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
1	535.40	Gastritis d/t irritation w/o hemorrhage			
2	847.1	Thoracic strain			
9	250.01	Diabetes mellitus Type I—controlled			
8	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
7	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
3	739.2	Somatic Dysfunction of Thoracic	4	739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs	6	739.7	Somatic Dysfunction of Upper Extremity
9	739.3	Somatic Dysfunction of Lumbar	5	739.6	Somatic Dysfunction of Lower Extremity

Physician's evaluation of patient prior to treatment: First visit  Resolved  Improved  Unchanged  Worse

P	All not done Region	OMT		Treatment Method																Response			
		Y	N	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	R	I	U	W	
	Head and Face	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Neck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Thoracic T1-4	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	T5-9	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	T10-12	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Ribs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lumbar	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Sacrum	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Abdomen/Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	Upper Extremity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Lower Extremity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Meds: Add Prilosec 20 mg po qd PT: Hot packs done  
Heat at home to thoracic area  
 Exercise: Shoulder stretches given Other: Emotional support given for 5 minutes  
Obtain H. pylori and flat plate of abdomen—X-ray.  
 Nutrition: Bland diet

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria												Risk: (presenting problem(s), diagnostic procedure(s), Management options)					Data					Maximum Points
Self-limiting		1 (2 max.)		Minimal = Min.		Lab		1		Radiology		1		Medicine		1		1				
Estimated problem improved / stable		OM, back 1		Low		Discuss with performing physician		1		Obtain records or Hx from others		1		Review records, discuss with physician		2		2				
Estimated—worsening		2		Moderate = Mod.		Visualizations of tracing, specimen		2										2				
New—no workup		3 (1 max.)		High																		
New—additional workup		Stomach 4																				

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
* ≤1 pt.	2 pt.	3 pt.	≥4 pt.	* Min.	Low	Mod.	High	≤1 pt.	2 pt.	3 pt.	≥4 pt.			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Requires only 2 above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components					Optional Method—Coding by Time						
History	I	II	III	IV	V	When majority of the encounter is counseling / coordinating, the level is determined by total time					
Examination	I	II	III	IV	V	New patients (minutes)	10	20	30	45	60
Complexity / Assessment Plan	I	II	III	IV	V	Established patients (minutes)	10	15	25	40	
Final level of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Final level of service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All these areas required. Average of three levels of service. Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient:	Follow-up:	Units:
<input type="checkbox"/> 10 <input type="checkbox"/> 15 <input checked="" type="checkbox"/> 25 <input type="checkbox"/> 40 <input type="checkbox"/> 60 <input type="checkbox"/> >60	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	<input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M <input type="checkbox"/> Y <input type="checkbox"/> PRN

OMT performed as Above: 0 areas  1-2 areas  3-4 areas  5-6 areas  7-8 areas  9-10 areas

Other Procedures Performed:	CPT Codes:	Written Dx:
	97010 97110	Hot packs Exercise

E/M Code:	New	EST	Consults
Write 992 plus ...	02 03 04 05 ...	11 12 13 14 15	41 42 43 44 45

Signature of transcriber: \_\_\_\_\_ Signature of examiner: SL Sleszynski DO

# Outpatient Health Summary

wak SOAP version 5: 091102b

<b>Patient's Name</b>		<b>Date</b>		<b>Update:</b>	
<b>Date of Birth</b>	<b>Sex</b>	<b>Phone Numbers:</b>		<b>Home</b>	
<b>Marital Status:</b> M     S     D     W			<b>Work</b>		
<b>Significant Others:</b>	<b>DNR Status: Resuscitate?</b>		<b>Yes</b>	<b>No</b>	<b>Qualifications:</b>
<b>Religion:</b>	<b>Next of Kin:</b>				

<b>Social History:</b>	<b>Employment</b>	<b>Occupation</b>	<b>Education</b>
	<b>Tobacco</b>	<b>ETOH</b>	<b>Drugs</b>
			<b>Sex Hx</b>

<b>Family History:</b>	<b>M</b>	<b>Siblings</b>	<b>Others:</b>
	<b>F</b>		

## Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

**Allergies, Adverse Drug Reactions:** \_\_\_\_\_

## Health Maintenance

## Past Surgical History

Parameter	Dates							Date	Type
DPT/DT/TD									
OPV									
MMR									
HIB									
Influenza									
Hepatitis									
PPD/Tine									
Pneumovax									
H & P									
Eye exam									
Dental exam									
PAP smear								<b>Consultants</b>	
Mammogram									
Urinalysis									
Hemocult									
Cholesterol									
Sigmoidoscopy									
Others									

# Outpatient Osteopathic SOAP Note History Form

wak SOAP version 5: 091102b

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_

Office of:	
For office use only:	

## HISTORY

**S** (See Outpatient Health Summary Form for details of history)

**Patient's Pain Analog Scale:**  Not done

NO PAIN	WORST POSSIBLE PAIN
---------	---------------------

**CC**


### History of Present Illness

**Level: HPI**

<b>E</b> <b>l</b> <b>e</b> <b>m</b> <b>e</b> <b>n</b> <b>t</b> <b>s</b>	<input type="checkbox"/>	Location	OR Status of $\geq 3$ chronic or inactive conditions _____ _____ _____	<input type="checkbox"/>	<b>II</b>	1-3 elements reviewed
	<input type="checkbox"/>	Quality		<input type="checkbox"/>	<b>III</b>	
	<input type="checkbox"/>	Severity		<input type="checkbox"/>	<b>IV</b>	$\geq 4$ elements OR status of $\geq 3$ chronic conditions
	<input type="checkbox"/>	Duration		<input type="checkbox"/>	<b>V</b>	
	<input type="checkbox"/>	Timing		<input type="checkbox"/>		
	<input type="checkbox"/>	Context				
	<input type="checkbox"/>	Modifying factors				
	<input type="checkbox"/>	Assoc. Signs and Sx				

### Review of Systems (Only ask / record those systems pertinent for this encounter.) Not done

**Level: ROS**

<input type="checkbox"/>	Constitutional (Wt loss, etc.)	<input type="checkbox"/>	<b>II</b>	None
<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<b>III</b>	1 system pertinent to the problem
<input type="checkbox"/>	Ears, nose, mouth, throat	<input type="checkbox"/>	<b>IV</b>	2-9 systems
<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	<b>V</b>	$\geq 10$ systems
<input type="checkbox"/>	Respiratory			
<input type="checkbox"/>	Gastrointestinal			
<input type="checkbox"/>	Genitourinary			
<input type="checkbox"/>	Musculoskeletal			
<input type="checkbox"/>	Integumentary (skin, breast)			
<input type="checkbox"/>	Neurological			
<input type="checkbox"/>	Psychiatric			
<input type="checkbox"/>	Endocrine			
<input type="checkbox"/>	Hematologic/lymphatic			
<input type="checkbox"/>	Allergic/immunologic			

### Past Medical, Family, Social History Not done

**Level: PFSH**

<input type="checkbox"/>	Past history / trauma	<input type="checkbox"/>	<b>II</b>	None
	Allergies:	<input type="checkbox"/>	<b>III</b>	
	Medications:	<input type="checkbox"/>	<b>IV</b>	1 history area
		<input type="checkbox"/>	<b>V</b>	$\geq 2$ history areas
<input type="checkbox"/>	Family history			
<input type="checkbox"/>	Social history			

**Overall History = Average of HPI, ROS or PFSH:**  **II** (1-3 HPI)  **III** (1-3 HPI, 1 ROS)  **IV** (4+ HPI, 2-9 ROS, 1 PFSH)  **V** (4+ HPI, 10+ ROS, 2+ PFSH)

Signature of transcriber: _____	Signature of examiner: _____
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 Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

# Outpatient Osteopathic SOAP Note Exam Form

wak SOAP version 5: 091102b

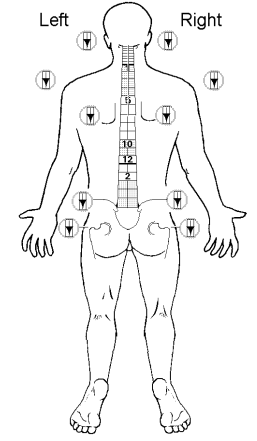
**O**  Not done

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Sex: Male  Female

\* Vital Signs (3 of 7) Wt. \_\_\_\_\_ Ht. \_\_\_\_\_ Temp. \_\_\_\_\_

Reg.  Pt. position for recording BP: \_\_\_\_\_  
 Irreg.  Standing \_\_\_\_\_ Sitting \_\_\_\_\_ Lying \_\_\_\_\_

Office of:	
For office use only:	

Level of GMS		
<input type="checkbox"/>	<b>II</b>	1-5 elements
<input type="checkbox"/>	<b>III</b>	6+ elements
<input type="checkbox"/>	<b>IV</b>	2+ from each or 6 areas OR 12+ elements in 2+ areas
<input type="checkbox"/>	<b>V</b>	Perform all elements ≥ 9 areas

Methods Used For Examination					Key to the Severity Scale				Somatic Dysfunction and Other Systems	
					Region Evaluated					
All	T	A	R	T		0	1	2	3	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
*1					Head and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*2					Thoracic T1-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					T5-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					T10-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Sacrum / Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Pelvis / Innom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*3					Abd. / Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*4					Upper R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*5					Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
*6					Lower R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Extremity L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Signature of transcriber: _____	Signature of examiner: _____
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 Designed to coordinate with Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.



# Outpatient Osteopathic Assessment and Plan Form

wak SOAP version 5: 091102b

**A** Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Office of:	
For office use only:	

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
	739.2	Somatic Dysfunction of Thoracic		739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
	739.3	Somatic Dysfunction of Lumbar		739.6	Somatic Dysfunction of Lower Extremity

Physician's evaluation of patient prior to treatment: First visit  Resolved  Improved  Unchanged  Worse

P <input type="checkbox"/> All not done Region	OMT		Treatment Method														Response				
	Y	N	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	R	I	U	W
Head and Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic T1-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T5-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T10-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen/Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meds: \_\_\_\_\_ PT: \_\_\_\_\_

Exercise: \_\_\_\_\_ Other: \_\_\_\_\_

Nutrition: \_\_\_\_\_

**Complexity / Assessment / Plan (Scoring)** \*Default to level 2—same criteria

Problems	Risk (presenting problem(s), diagnostic procedure(s), Management options)	Data	Maximum Points
Self-limiting	1 (2 max.)	Lab	1
Estimated problem improved / stable	1	Radiology	1
Estimated—worsening	2	Medicine	1
New—no workup	3 (1 max.)	Discuss with performing physician	1
New—additional workup	4	Obtain records or Hx from others	1
		Review records, discuss with physician	2
		Visualization of tracing, specimen	2

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
≤1 pt.	2 pt.	3 pt.	≥4 pt.	Min.	Low	Mod.	High	≤1 pt.	2 pt.	3 pt.	≥4 pt.			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Requires only 2 above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components						Optional Method—Coding by Time					
						When majority of the encounter is counseling / coordinating, the level is determined by total time					
History	I	II	III	IV	V		I	II	III	IV	V
Examination	I	II	III	IV	V	New patients (minutes)	10	20	30	45	60
Complexity / Assessment Plan	I	II	III	IV	V	Established patients (minutes)	10	15	25	40	
<b>Final level of service</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Final level of service</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All these areas required. Average of three levels of service.

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient:  10  15  25  40  60  >60 Follow-up:  1  2  3  4  5  6  7  8  9  10  11  12 Units:  D  W  M  Y  PRN

OMT performed as Above: 0 areas  1-2 areas  3-4 areas  5-6 areas  7-8 areas  9-10 areas

Other Procedures Performed: CPT Codes: \_\_\_\_\_ Written Dx: \_\_\_\_\_

E/M Code: New     EST      Consults

Write 992 plus... 02 03 04 05 ... 11 12 13 14 15 ... 41 42 43 44 45

Signature of transcriber: \_\_\_\_\_ Signature of Examiner: \_\_\_\_\_

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