

CONTINUITY OF CARE

Are you the patient's primary care provider? PRIMCARE

- 1 Yes
 2 No
 3 Unknown

Was patient referred for this visit? REFER

- 1 Yes
 2 No
 3 Unknown

Has the patient been seen in this practice before? SENBEFOR

- 1 Yes, established patient
How many past visits in the last 12 months?
 (Exclude this visit.)

PASTVIS

Visits

Enter F5 if unknown

- 2 No, new patient

PROVIDER'S DIAGNOSIS FOR THIS VISIT

As specifically as possible, list all diagnoses related to this visit, including chronic conditions.

Primary: 1. **VDIAG1 / VDIAG1_LKUP**

Other: 2. **VDIAG2 / VDIAG2_LKUP**

Other: 3. **VDIAG3 / VDIAG3_LKUP**

Other: 4. **VDIAG4 / VDIAG4_LKUP**

Other: 5. **VDIAG5 / VDIAG5_LKUP**

CONDITIONS

Regardless of the diagnoses previously entered, does the patient now have – Mark (X) all that apply. PAT_HAV

- | | | | |
|--|--|--|---|
| 1 <input type="checkbox"/> Alcohol misuse, abuse, or dependence
2 <input type="checkbox"/> Alzheimer's disease/Dementia
3 <input type="checkbox"/> Arthritis
4 <input type="checkbox"/> Asthma
↓
Asthma severity:
ASTH_SEV
1 <input type="checkbox"/> Intermittent
2 <input type="checkbox"/> Mild persistent
3 <input type="checkbox"/> Moderate persistent
4 <input type="checkbox"/> Severe persistent
5 <input type="checkbox"/> Other – Specify
↓
ASTH_SEV_SP
6 <input type="checkbox"/> None recorded
5 <input type="checkbox"/> Attention deficit disorder (ADD)/ Attention hyperactivity deficit disorder (ADHD) | ↓
Asthma control:
ASTH_CON91 <input type="checkbox"/>
Well controlled
2 <input type="checkbox"/> Not well controlled
3 <input type="checkbox"/> Very poorly controlled
4 <input type="checkbox"/> Other – Specify
↓
ASTH_CON_SP
5 <input type="checkbox"/> None recorded | 6 <input type="checkbox"/> Autism spectrum disorder
7 <input type="checkbox"/> Cancer
8 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
9 <input type="checkbox"/> Chronic kidney disease (CKD)
10 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)
11 <input type="checkbox"/> Congestive heart failure (CHF)
12 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)
13 <input type="checkbox"/> Depression
14 <input type="checkbox"/> Diabetes mellitus (DM), Type I
15 <input type="checkbox"/> Diabetes mellitus (DM), Type II | 16 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified
17 <input type="checkbox"/> End-stage renal disease (ESRD)
18 <input type="checkbox"/> Hepatitis B
19 <input type="checkbox"/> Hepatitis C
20 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)
21 <input type="checkbox"/> HIV infection/AIDS
22 <input type="checkbox"/> Hyperlipidemia
23 <input type="checkbox"/> Hypertension
24 <input type="checkbox"/> Obesity
25 <input type="checkbox"/> Obstructive sleep apnea (OSA)
26 <input type="checkbox"/> Osteoporosis
27 <input type="checkbox"/> Substance abuse or dependence
28 <input type="checkbox"/> None of the above |
|--|--|--|---|

SERVICES

Enter all examinations/screenings, laboratory tests, imaging, procedures, treatment, health education/counseling, and other services not listed ORDERED OR PROVIDED. **DIAG_SERVICE**

- | | | | | | |
|---|--|--|---|---|---|
| 1 <input type="checkbox"/> NO SERVICES
Examinations/Screenings
2 <input type="checkbox"/> Alcohol misuse screening (includes AUDIT, MAST, CAGE, T-ACE)
3 <input type="checkbox"/> Breast
4 <input type="checkbox"/> Depression screening
5 <input type="checkbox"/> Domestic violence screening
6 <input type="checkbox"/> Foot
7 <input type="checkbox"/> Neurologic
8 <input type="checkbox"/> Pelvic
9 <input type="checkbox"/> Rectal
10 <input type="checkbox"/> Retinal/Eye
11 <input type="checkbox"/> Skin
12 <input type="checkbox"/> Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)
Laboratory Tests
13 <input type="checkbox"/> BMP (Basic metabolic panel)
14 <input type="checkbox"/> CBC
15 <input type="checkbox"/> Chlamydia test | Laboratory Tests (cont.)
16 <input type="checkbox"/> CMP (Comprehensive metabolic panel)
17 <input type="checkbox"/> Creatinine/Renal function panel
18 <input type="checkbox"/> Culture, blood
19 <input type="checkbox"/> Culture, throat
20 <input type="checkbox"/> Culture, urine
21 <input type="checkbox"/> Culture, other
22 <input type="checkbox"/> Glucose, serum
23 <input type="checkbox"/> Gonorrhea test
24 <input type="checkbox"/> HbA1C (Glycohemoglobin)
25 <input type="checkbox"/> Hepatitis testing/panel
26 <input type="checkbox"/> HIV test
27 <input type="checkbox"/> HPV DNA test
28 <input type="checkbox"/> Lipid profile/panel
29 <input type="checkbox"/> Liver enzymes/Hepatic function panel
30 <input type="checkbox"/> PAP test
31 <input type="checkbox"/> Pregnancy/HCG test
32 <input type="checkbox"/> PSA (prostate specific antigen)
33 <input type="checkbox"/> Rapid strep test | Laboratory Tests (cont.)
34 <input type="checkbox"/> TSH/Thyroid panel
35 <input type="checkbox"/> Urinalysis (UA) or urine dipstick
36 <input type="checkbox"/> Vitamin D test
Imaging
37 <input type="checkbox"/> Bone mineral density
38 <input type="checkbox"/> CT scan
39 <input type="checkbox"/> Echocardiogram
40 <input type="checkbox"/> Other ultrasound
41 <input type="checkbox"/> Mammography
42 <input type="checkbox"/> MRI
43 <input type="checkbox"/> X-ray
Procedures
44 <input type="checkbox"/> Audiometry
45 <input type="checkbox"/> Biopsy
46 <input type="checkbox"/> Cardiac stress test
47 <input type="checkbox"/> Colonoscopy
48 <input type="checkbox"/> Cryosurgery (cryotherapy)/ Destruction of tissue
49 <input type="checkbox"/> EKG/ECG
50 <input type="checkbox"/>
Electroencephalogram (EEG)
51 <input type="checkbox"/> Electromyogram (EMG)
52 <input type="checkbox"/> Excision of tissue
53 <input type="checkbox"/> Fetal monitoring | Procedures (cont.)
54 <input type="checkbox"/> Peak flow
55 <input type="checkbox"/> Sigmoidoscopy
56 <input type="checkbox"/> Spirometry
57 <input type="checkbox"/> Tonometry
58 <input type="checkbox"/> Tuberculosis skin testing/ PPD
59 <input type="checkbox"/> Upper gastrointestinal endoscopy (EGD)
Treatments
60 <input type="checkbox"/>
Cast/splint/wrap
61 <input type="checkbox"/>
Complementary and alternative medicine (CAM)
62 <input type="checkbox"/> Durable medical equipment
63 <input type="checkbox"/> Home health care
64 <input type="checkbox"/> Mental health counseling, excluding psychotherapy
65 <input type="checkbox"/> Occupational therapy
66 <input type="checkbox"/> Physical therapy | Treatments (cont.)
68 <input type="checkbox"/> Radiation therapy
69 <input type="checkbox"/> Wound care
Health Education/ Counseling
70 <input type="checkbox"/> Alcohol misuse counseling
71 <input type="checkbox"/> Asthma education
72 <input type="checkbox"/> Asthma action plan given to patient
73 <input type="checkbox"/> Diabetes education
74 <input type="checkbox"/> Diet/Nutrition
75 <input type="checkbox"/> Exercise
76 <input type="checkbox"/> Family planning/ Contraception
77 <input type="checkbox"/> Genetic counseling
78 <input type="checkbox"/> Growth/ Development
79 <input type="checkbox"/> Injury prevention
80 <input type="checkbox"/> STD prevention
81 <input type="checkbox"/> Stress management
82 <input type="checkbox"/> Substance abuse counseling
83 <input type="checkbox"/> Tobacco use/ Exposure
84 <input type="checkbox"/> Weight reduction | Other services not listed
85 <input type="checkbox"/> Other service – Specify
↓
OTHER_SP
Other service – Specify
↓
OTHER_SP2
Other service – Specify
↓
OTHER_SP3
Other service – Specify
↓
OTHER_SP4
Other service – Specify
↓
OTHER_SP5 |
|---|--|--|---|---|---|

MEDICATION(S) & IMMUNIZATIONS

NOMED=Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit? 1 Yes 2 No Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered, or continued during this visit. Include medications prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication. Enter XXX if medication cannot be found. Enter 0 for No more.

NCMED

		New	Continued
(1)	VMED1 / VMEDOTH1	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)	VMED2 / VMEDOTH2	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)	VMED3 / VMEDOTH3	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)	VMED4 / VMEDOTH4	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)	VMED5 / VMEDOTH5	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(6)	VMED6 / VMEDOTH6	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(7)	VMED7 / VMEDOTH7	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(8)	VMED8 / VMEDOTH8		
(9)	VMED9 / VMEDOTH9	1 <input type="checkbox"/>	2 <input type="checkbox"/>
(10-30)	VMED10-30 / VMEDOTH10-30 (Up to 30 drugs can be listed.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

PROVIDERS

Mark (X) all providers seen at this visit **PROV_SEEN1-7**

- | | |
|--|---|
| 1 <input type="checkbox"/> Physician | 5 <input type="checkbox"/> Mental health provider |
| 2 <input type="checkbox"/> Physician assistant (PA) | 6 <input type="checkbox"/> Other |
| 3 <input type="checkbox"/> Nurse practitioner (NP)/Midwife (CNM) | 7 <input type="checkbox"/> NONE |
| 4 <input type="checkbox"/> RN/LPN | |

TIME SPENT WITH PROVIDER

Enter estimated time spent with **sampled** provider. Enter 0 if no provider seen. **DURATION**

VISIT DISPOSITION

Mark (X) all that apply. **VISIT_DISP**

- | | |
|---|--|
| 1 <input type="checkbox"/> Return to referring physician/provider | 6 <input type="checkbox"/> Return at unspecified time |
| 2 <input type="checkbox"/> Refer to other physician/provider | 7 <input type="checkbox"/> Return as needed (p.r.n.) |
| 3 <input type="checkbox"/> Return in less than 1 week | 8 <input type="checkbox"/> Refer to ER/Admit to hospital |
| 4 <input type="checkbox"/> Return in 1 week to less than 2 months | 9 <input type="checkbox"/> Other |
| 5 <input type="checkbox"/> Return in 2 months or greater | |

TESTS

Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit? LAB_TEST	Most recent result	Date of blood draw										
Total Cholesterol CHOL 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">CHOLRES</div> mg/dL	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">CHOLDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
High density lipoprotein (HDL) HDL 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">HDLRES</div> mg/dL	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">HDLDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
Low density lipoprotein (LDL) LDL 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">LDLRES</div> mg/dL	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">LDLDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
Triglycerides TGS 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">TGSRES</div> mg/dL	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">TGSDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
HbA1c (Glycohemoglobin) A1C 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">A1CRES</div> %	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">A1CDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
Blood glucose (BG) FBG 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">FBGRES</div> mg/dL	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">FBGDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy			
20	0	1										
mm	dd	yyyy										
Serum creatinine SERUM 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">SERUMRES</div> <table style="display: inline-table; vertical-align: middle; margin-left: 5px;"> <tr> <td style="font-size: 0.8em;">mg/dL</td> </tr> <tr> <td style="font-size: 0.8em;">μmol/L</td> </tr> </table>	mg/dL	μmol/L	<div style="border: 1px solid gray; padding: 2px; display: inline-block;">SERUMDATE</div> <table style="display: inline-table; border-collapse: collapse;"> <tr> <td style="border: 1px solid gray; width: 20px; text-align: center;">20</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">0</td> <td style="border: 1px solid gray; width: 20px; text-align: center;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">mm</td> <td style="text-align: center; font-size: 8px;">dd</td> <td style="text-align: center; font-size: 8px;">yyyy</td> <td></td> </tr> </table>	20	0	1		mm	dd	yyyy	
mg/dL												
μmol/L												
20	0	1										
mm	dd	yyyy										

CPT CODES

Enter Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Up to 18 CPT codes can be listed.

CPTCODE1	CPTCODE4	CPTCODE7	CPTCODE10	CPTCODE13	CPTCODE16
CPTCODE2	CPTCODE5	CPTCODE8	CPTCODE11	CPTCODE14	CPTCODE17
CPTCODE3	CPTCODE6	CPTCODE9	CPTCODE12	CPTCODE15	CPTCODE18