

CONTINUITY OF CARE

<p>Are you the patient's primary care provider? PRIMCARE</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown } ↘</p> <p>Was patient referred for this visit? REFER</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p>	<p>Has the patient been seen in this practice before? SENBEFOR</p> <p>1 <input type="checkbox"/> Yes, established patient How many past visits in the last 12 months? (Exclude this visit.)</p> <div style="border: 1px solid black; padding: 2px; display: inline-block; margin: 5px;"> PASTVIS </div> Visits <small>Enter F5 if unknown</small> 2 <input type="checkbox"/> 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 ↓ <div style="border: 1px solid black; padding: 2px; display: inline-block;"> ASTH_SEV_SP </div> 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 ↓ <div style="border: 1px solid black; padding: 2px; display: inline-block;"> ASTH_CON_SP </div> 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 <div style="border: 1px solid black; padding: 2px; margin: 5px; text-align: center;">OTHER_SP</div> Other service – Specify <div style="border: 1px solid black; padding: 2px; margin: 5px; text-align: center;">OTHER_SP2</div> Other service – Specify <div style="border: 1px solid black; padding: 2px; margin: 5px; text-align: center;">OTHER_SP3</div> Other service – Specify <div style="border: 1px solid black; padding: 2px; margin: 5px; text-align: center;">OTHER_SP4</div> Other service – Specify <div style="border: 1px solid black; padding: 2px; margin: 5px; text-align: center;">OTHER_SP5</div>
---	--	---	---	---	---

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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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> <td style="font-size: 1.5em;">↕</td> <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; text-align: center;"> <tr> <td style="border: 1px solid gray; width: 20px;">20</td> <td style="border: 1px solid gray; width: 20px;">0</td> <td style="border: 1px solid gray; width: 20px;">1</td> <td style="border: 1px solid gray; width: 20px;"></td> </tr> <tr> <td style="font-size: 8px;">mm</td> <td style="font-size: 8px;">dd</td> <td style="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