Visit Type: ________________ **Provider:** ______________ **Appt Date:** ______________

Hallway: 1 2 3

Care Manager: ___________

Last CM Appt: _______________

CM Referral: _______________

Patient Name:__________________ DOB: ____________

Dates of Last Exams

☐ Complete Physical
Last: ____________________
☐ Planned Care Visit
Last: ____________________
☐ Medicare Wellness Visit
Last: ____________________
Type:____________________
Next Appt if Sched:__________
Visit Type:_______________

☐ **Care Guidelines Updated**

☐ No MCIR

Care Gaps Identified:

☐
☐
☐
☐

Screening Referrals

☐ Screening Colonoscopy
- ☐ Digestive Health Assoc.
- ☐ _____________ ☐ Done

☐ Last Provider:___________

Diagnostic Referrals

☐ ____________________ Dx:____________________
☐ ____________________ Dx:____________________
☐ Therapy Referrals
☐ ____________________ Dx:____________________

Diagnostic testing

☐ X-Ray _________ ☐ Done
- ☐ Chest X-ray Dx:____________________
- ☐ Other: ____________ Dx:____________________

☐ Spirometry Dx:____________________
- ☐ WFPC ☐ MMC ☐ Done

☐ Mammogram Dx:____________________
- ☐ Diagnostic: Dx:____________________
- ☐ Screening: ☐ Done

Labs

Labs	Today	Next Vis	Dx
☐ Comp Metabolic	☐	☐	Dx:____________________
☐ Basic Metabolic	☐	☐	Dx:____________________
☐ Lipid Panel	☐	☐	Dx:____________________
☐ CBC	☐	☐	Dx:____________________
☐ H&H	☐	☐	Dx:____________________
☐ TSH med check	☐	☐	Dx:____________________
☐ FBS	☐	☐	Dx:____________________
☐ Hemoglobin A1C	☐	☐	Dx:____________________
☐ Microalbumin/CR	☐	☐	Dx:____________________
☐ ALT	☐	☐	Dx:____________________
☐ Chlamydia	☐	☐	Dx:____________________
☐ ______________	☐	☐	Dx:____________________
☐ ______________	☐	☐	Dx:____________________
☐ ______________	☐	☐	Dx:____________________

☐ **BP Re-check**

Follow up call **24** **48**

Checkout ☐ Clinical ☐ Front

☐ Print & Provide Patient Plan
☐ No Plan Needed
☐ Send via Portal
☐ Provider Discharged Pt
☐ No Plan Needed
☐ Print Home Exercise

☐ Well Child
☐ Annual Physical
☐ MWV **Type:**____________
☐ PCV/MWV-2
☐ Med Check **1 2**
☐ Planned Care Visit **1 3 4 6**
☐ Office Visit
☐ No Appointment Needed
☐ Lesion Removal **15 30**
☐ OMT
☐ Other:_______________
☐ Clinical Appointment

Dx:____________________
Dx:____________________

Clinical

Hallway: 1 2 3

Provider: ____________
Appt Date: ____________
Care Manager: ____________
Last CM Appt: ____________
☐ CM Referral: ____________

Patient Name: ____________ **DOB:** ____________

☐ No MCIR

Past Diagnostic
☐ Screening Mammogram
Last: ______ Due: ______
☐ Bone Density
Last: ______ Due: ______
☐ Colonoscopy
Last: ______ Due: ______
Provider: ______
☐ FOBT
Date: ______
☐ Diabetic Eye Exam
Last: ______ Due: ______
☐ Foot Exam
Date: ______

Dates of Last Exams
☐ Complete Physical
Last: ______ Due: ______
☐ Planned Care Visit
Last: ______ Due: ______
☐ Pap
Last: ______ Due: ______
☐ Chlamydia Screening
Last: ______ Due: ______
☐ Medicare Wellness Visit
Last: ______ Due: ______
☐ Depression Screening
Last: ______ Due: ______
☐ Medicare Depression
(G0444) Date: ______
☐ Medicare Alcohol Assessment
(G0442) Date: ______
☐ Medicare Pelvic/Breast
(G0101) Date: ______

Visit Type:
☐ Routine Exam
☐ PCV
☐ OV
☐ Medicare Wellness Visit
☐ PCV/MWV - 2
☐ Well Child

Diagnoses
☐ Hypertension
☐ Hyperlipidemia
☐ Diabetes
☐ Hypothyroidism
☐ Asthma
☐ Cough
☐ COPD
☐ ASHD
☐ Depression/Anxiety
☐ ______
☐ ______
☐ Routine Labs Ordered

Labs	Today	Next Vis
☐ Comp Metabolic	☐	☐
☐ Basic Metabolic	☐	☐
☐ Lipid Panel	☐	☐
☐ CBC	☐	☐
☐ H&H	☐	☐
☐ TSH med check	☐	☐
☐ FBS	☐	☐
☐ Hemoglobin A1C	☐	☐
☐ Microalbumin/CR	☐	☐
☐ ______	☐	☐
☐ ______	☐	☐
☐ ______	☐	☐

In-Office Procedures
☐ ______
☐ ______

☐ **BP Re-check**

Screening Referrals
☐ Screening Colonoscopy
☐ Digestive Health Assoc.
☐ ______ ☐ Done

Diagnostic Referrals
☐ ______
☐ ______
☐ Therapy Referrals
☐ ______ ☐ Done
☐ ______

Diagnostic testing
☐ X-Ray ______ ☐ Done
☐ Chest X-ray
☐ Other: ______
☐ Spirometry
☐ WFPC ☐ MMC ☐ Done
☐ Mammogram
☐ Screening: ☐ Done
☐ Diagnostic:
☐ ______

Checkout ☐ **Clinical** ☐ **Front**
☐ Print & Provide Patient Plan
☐ Print & Provide MW Plan
☐ No Plan Needed
☐ Send via Portal
☐ Provider Discharged Pt
☐ Provide Copy of Labs
☐ ______

Follow Up Appointment
☐ Well Child
☐ Annual Physical
☐ MWV ☐ PCV/MWV-2
☐ Med Check **1 2**
☐ Planned Care Visit **1 3 4 6**
☐ No Appointment Needed
☐ Clinical Appointment

Follow up call ☐ 24 ☐ 48

Diagnosis: ______

Patient Name:

Encounter #:

Diagnoses:

- ☐ Routine Exam (V70.0)
- ☐ Hypertension (401.1)
- ☐ Hyperlipidemia (272.4)
- ☐ IIDM (250.00)
- ☐ ASHD/CAD (414.0)
- ☐ Hypothyroidism (244.9)
- ☐ Obesity (278.00)
- ☐ Depression (311.0)
- ☐ Atrial Fibrillation (427.31)
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Office Procedure:

- ☐ EKG
- ☐ PT/INR
- ☐ Urinalysis
- ☐ Urine Dip
- ☐ Strep Screen
- ☐
- ☐
- ☐

Vaccines:

- ☐ Flu vaccine > 3yrs
- ☐ Flu vaccine high dose
- ☐ Tdap
- ☐ Pneumovax
- ☐ Zostervax
- ☐ Admin 1st vaccine
- ☐ Admin each additional
- ☐ PCV 13
- ☐ PCV 20
- ☐

Labs:

- ☐ Basic metabolic
- ☐ Comp metabolic
- ☐ Lipid panel
- ☐ Hemoglobin A1C
- ☐ CBC
- ☐ CBC w/diff
- ☐ UA
- ☐ UA w/culture
- ☐ Urine culture
- ☐ Microalbumin/CR
- ☐ Staph culture
- ☐ PSA
- ☐ PT/INR
- ☐ TSH cascade
- ☐ TSH med check
- ☐ Vitamin D
- ☐
- ☐
- ☐
- ☐
- ☐

Follow up:

- ☐ Med Check
- ☐ Planned Care Visit
- ☐ Annual Physical
  - ☐ With labs prior
    - ☐ Fasting

In:

- ☐ 1 month
- ☐ 3 months
- ☐ 4 months
- ☐ 6 months
- ☐ 1 year
- ☐ Other:

Diagnostic:

- ☐ Screening Mammogram
- ☐ Bone Density
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Referrals

- ☐ Screening Colonoscopy
  - ☐ Digestive Health Assoc.
  - ☐ Other:
- ☐ Physical Therapy
  - ☐
  - ☐ Other:
- ☐ Other:
- ☐
- ☐ **Update Care Guidelines**
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐