

WRITE THIS INSTEAD

History of Present Illness

Assessment and Plan

THINGS TO RECONSIDER

Chief Complaint

Relevant Physical Exam Data

There is no requirement to include the entire Physical Exam, including vitals. However, **pulling in the relevant items to the diagnoses** and current state of the patient is important to the clinical utility of the note.

Patient Instructions

Generally, your assessment and plan, and instructions have significant overlap, with one written for the patient and the other for yourself. **Consider combining** them and simply writing a more easily interpreted plan.

Abbreviations

Patients will see your notes, **be thoughtful about when abbreviations will be easily understood**, and when the full phrase is more understandable. Software should help with this!

Time Spent

Your time in the chart should be **tracked in the EHR**, and you are not required to list your complete time in your note. However, this is an issue that varies by organization and payer.

THINGS TO DROP FROM YOUR NOTE

Complete Review of Systems, Prior Histories, and Clinical Lists

You are no longer required to document the work you did for review as part of medical decision making in the note. **Keep the items that are relevant** to your History of Present Illness, or Assessment and Plan, but let the rest be shown elsewhere.

History of Present Illness

Patientt is here for follow-up hypertension and high cholesterol, and is feeling well; staying on low salt/low fat diet; taking meds daily without issues or side effects. No need for med renewals. Mean home BP at home for the past three months was 130/70. No home readings > 140/90; no home readings < 100/60. No chest pain, shortness of breath, pedal edema. No other complaints.

Physical Exam

Height – 185 cm Weight – 81.2 kg BMI = 23.7
BP – 128/78 Pulse - 76 RR – 16
Focused exam: normal, no change

Assessment/Plan

1. Hypertension I10
Doing well, well controlled. Last BMP reviewed – all normal. Ordered: Basic Metabolic Panel
2. Hyperlipidemia E78.5
Doing well, well controlled. Last lipid panel reviewed – LDL < 90 Ordered: Basic Metabolic Panel

Patient Instructions

Continue current meds (lisinopril 10mg once in the morning, rosuvastatin 20mg once at bedtime), diet and exercise regimens. Continue monitoring BP at home daily. As long as BPs <140/90 – to see me back in 6 months.

FIVE RECOMMENDATIONS FOR EHRs

- 1 Automate writing in SOAP, and reviewing in APSO
- 2 Combine Patient Instructions and A&P
- 3 Expand abbreviations for patient-facing documents
- 4 Allow linking out to data that is elsewhere in the EMR
- 5 Allow for simple inclusion of discrete exam data



Discuss at your organization



Available in the health record.