OBCE CHART NOTE TEMPLATES GUIDE

Initial Visit Template:

Every page must include Patient ID (name, DOB, and one unique ID number not their social security number) and Provider ID (If a page is two sided, both sides must have identifiers) (OAR 811-015-0005(1)(a))

1. An initial visit, no matter what the presenting complaint/conditions/or circumstance for the visit, must include: (OAR 811-015-0010(3))
    a. Chief complaint for the visit (motor vehicle accident, work injury, GYN/Obstetrical, proctological, minor surgical, physiotherapy, rehab, nutritional or dietary, wellness). (OAR 811-015-0005(1)(c)(A))
        i. Onset of event or events.
        ii. Etiology of complaint (circumstances leading up to the event)
        iii. Significant events that affect the presenting condition or symptom complex (what aggravates or palliates it. Its effect on daily life. Quantify the discomfort level, quality and character of the presenting complaint). (OAR 811-015-0005(1)(c)(B))
        iv. History of management of presenting complaint up to point of initial visit (other provider, urgent care, hospital, emergency room, self-treatment). (OAR 811-015-0005(1)(c)(E))
2. Patient's health history (OAR 811-015-0005(1)(c)(B))
    a. Illnesses
    b. Medications/recreational use of controlled substances
    c. Surgical history
    d. Previous injury history
    e. Family medical history
3. Socioeconomic history (OAR 811-015-0005(1)(c)(B))
    a. Occupation/student/retired
    b. Hobbies/habits
    c. Psycho-social assessment (Example: patient alert x3)

4. Patient evaluation/examination (obtain consent to examine the patient, verbally or written and record in your charts). (OAR 811-015-0005(1)(c)(E))
    a. Always include height, weight, blood pressure, and pulse. You can include additional vital information but the minimum requirements are Ht., Wt., BP., and pulse. (OAR 811-015-0005(1)(c)(C)(i))
    b. Note if you are requesting previous medical records or tests from other providers or facilities.
    c. Depending on the reason for the initial visit, the actual examination will include all pertinent exam findings. Example: Musculoskeletal
        i. Visual inspection
        ii. Postural and ambulation assessment
        iii. Reflexes and motor function, sensory evaluation (if clinically indicated)
        iv. Assessment of ranges of motion (note whether visualized or with instrumentation)
        v. Mensuration, if indicated
        vi. Provocative testing
        vii. Soft tissue assessment
        viii. Static and motion palpation
        ix. Subluxations and articular assessment
        x. Determine if specialized tests are needed. Example: X-rays, MRI, CT, bone scan, bloodwork, urinalysis, etc. Order specialized tests.
5. Review results of the evaluation derived from the above examination, indications, and formulate an assessment of the presenting complaint (diagnosis) (formulate an appropriate treatment plan). (OAR 811-015-0005(1)(c)(C)(iii))
    a. Discuss findings with the patient. Provide the patient with a PARQ. (OAR 811-035-0005(1), (2)(a)(b)(A)(B)(C))
    b. Obtain a verbal or written consent to provide care and record it in the chart note. (OAR 811-015-0070(3))
    c. At the appropriate time, render recommended care and record the patient's response to that care. (OAR 811-015-0005(1)(c)(C)(iii))
    d. Record the recommended next follow up date for the patient according to the treatment plan. (OAR 811-015-0005(1)(c)(C)(iii))

New Incident/Condition/Episode

Must have patient identification, including date of birth and provider identification on every page (if forms are printed front and back, both sides must have identifiers).

1. Reason for return visit (same condition new episode, same problem unchanging, new condition, etc.):
    a. Update patient's personal demographics (address, work status, insurance coverage)
    b. Update patient's health history (changes in health, surgical history, new illness/health condition, new injury history)
    c. Onset of new condition or episode
    d. Contributing factors/etiology to new episode (new injury or illness, exacerbation of old injury, material worsening of old condition, sequel to existing condition, wellness/checkup visit)
    e. Aggravating or palliating factors
2. Evaluation:
    a. If applicable to presenting complaint/clinically indicated, retake Ht., Wt., BP, and pulse (example, if patient has recently lost or gained a significant amount of weight, loss in height or presenting with dizziness or nausea, or had a significant change in urinary or bowel habits).
    b. Exam should include visual inspection; note: redness, swelling, discharge, asymmetry of posture, alteration in ambulation, speech patterns, pupillary response, etc. (obtain a verbal or written consent for new evaluation and record in the file you have obtained it).
    c. If complaint is musculoskeletal/spinal, reassess reflexes, motor function, range of motion, provocative tests, soft tissue assessment, static and motion palpation. If reason for visit is dietary or nutritional consultation, note height, weight, BP, pulse and BMI, etc. Note if there has been dialogue with other providers or ancillary personnel concerning this consultation. If patient has consulted someone else prior to this visit, obtain records of those consultations or tests.
    d. Determine if new diagnostic testing is necessary prior to proceeding to rendering an assessment and treatment recommendations. Discuss with the patient the finding of those tests or new tests and record that you have done so.
    e. Formulate an assessment or diagnosis and treatment plan.

f. Discuss with the patient your recommendations, the benefits, risks, and alternatives to your recommended treatment (PARQ) or recommend a referral for another opinion or treatment from a different discipline. Obtain a written or verbal consent if treatment is to ensue and record it in the file.

g. Provide the care recommended and note the patient's response to care rendered. Note when patient is to follow up with you.

Daily Chart Note

Every page must have patient identification, including date of birth of patient, and provider identification (if records are two sided each page must have both identifiers). (OAR 811-015-0005(1)(B))

1. Each daily chart note must include the patient's subjective report (example: my condition is improving, I am feeling better/worse/same as last visit); if there are new symptoms or a change in the condition, it must be noted. Record what aggravates it and what palliates the symptoms/condition.
2. Record your objective information, note posture ambulation, range of motion, swelling/edema, discoloration, report of pain with palpation, report visual inspection of area of complaint, if appropriate, note neurological information (reflexes, motor function, circulation); note static and motion palpation results, if provocative testing is performed, note responses. Report if there is objective improvement, no change, or worsening of objective findings.
3. Note assessment, if diagnosis has changed, date of amended diagnosis.
4. Record treatment rendered or additional testing (and reason for testing). Note who provided therapies and times and intensities of therapies. Record who authored chart note and date of completion of the chart note.

Accurate Records Chiropractic Clinic
1234 Relevant Info Rd., Suite: PAR-Q
PARTS, OR 97123

Ms. Vera Happy Patient: DOB 01/01/1995 Patient ID# SubLux1234

Initial Visit Template

Date of service: ____/____/____ **Provider Identification**:________________

Patient's Name: ____

Sex/Gender: M__ F__ Non-binary____ **DOB:**___/___/___

Chief Complaint (reason for visit):

____

____

Onset of complaint: ____

Etiology of complaint:____

____

Significant events that affect presenting condition (aggravates/palliates):

____

History of previous management of this condition prior to this visit:

____

____

Patient's health history (illnesses, surgical history, previous injury history, medications, family health history, recreational use of controlled substances, tobacco use):

____

____

____

____

Socioeconomic history (occupation/student/retired/unemployed, hobbies/habits):

____

____

Psycho-social assessment

1- Record if patient is alert and oriented x 3, alert and oriented x 4, alert and oriented x 5

Patient evaluation/examination: (obtain a written or verbal consent to examine the patient and record it in the records)

1- Include in the records height, weight, blood pressure, and pulse as per OAR 811-015-0005 (1)(c)(C)(i)

2- Visual inspection of complaint: Posture________________ Ambulation_________________
____
____
____

3- Reflexes: ____

Motor function: ____

Cranial nerves I-XII: ____

4- Extremity pulses:____

5- Mensuration: ____

6- Provocative testing:
____
____
____

7- Soft tissue assessment:
____
____
____

8- Static and motion palpation (subluxations):
____
____
____

9- Determination of specialized testing (x-rays, MRI, bone scan, blood work, urinalysis, etc.):
____
____

10- Assessment/Diagnosis:
____
____

11- PARQ **(**as per OAR 811-035-0005 (1), (2)(a)(b)(A)(B)(C)**):** Procedures, Alternatives, Risks, Questions. Obtain a written or verbal informed consent and record that you have obtained it in the chart note.
____
____

12- Formulate a treatment plan and note time of reevaluation:
____
____

13- Treatment (record what treatment is rendered, who provides therapies, times and intensities):____
____
____

14- Patient's next recommended visit ____

15- Author of records and date records were completed: ______________________________

Date: _____/_____/_____

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Ms. Vera Happy Patient: DOB 01/01/1995 Patient ID# SubLux1234

New Incident/Condition/Episode Template

Date of service ___/___/___ **Provider Identification**________________

Patient name: ___________________________ DOB ___/___/___

Reason for visit (new condition/new episode/same condition unchanging/worsening):

____

____

Update on personal demographics (address, work, insurance coverage):

____

____

Update on patient's health history:

____

____

Onset of new condition or episode: _____/_____/_____

Contributing factors/etiology:

____

____

Aggravating/palliating:

____

____

Evaluation/examination:

1- If applicable to presenting complaint, retake Ht., Wt., BP, Pulse (example: Pt has lost or gained a significant amount of weight, lost height, has bowel or bladder issues, nausea, dizziness, fever or chills) Height: ______ Weight: ______ BP: ____/____ Pulse: ______

2- Exam should include visual inspection, postural and ambulation assessment, note alteration in speech, pupillary response, color changes, swelling discharge, etc., depending on reason for visit.

____

____

3- If complaint is musculoskeletal, exam would include same as initial evaluation; if it is dietary or nutritional, Ht. Wt., BP, and BMI should be noted along with any co-management of patient including laboratory work or referral notes for other providers. If evaluation is for minor

surgical/GYN, obstetrical or proctologic evaluation, the appropriate procedures should be followed and noted in the records. (Obtain consent to perform the evaluation and note that you have obtained permission in the notes).

____
____

4- Determine if new diagnostic tests are necessary prior to rendering a new diagnosis or assessment. Note the justification for the additional testing and record it in the chart.

5- Formulate a new diagnosis or assessment and treatment plan.

DX: ____

Tx. plan:
____

6- Discuss your assessment and treatment recommendations with the patient, perform another PARQ, and obtain an informed consent to treat the new condition, written or verbal, and note it in your records.

7- Render care to the patient, noting who provided the care and who provides any therapies, noting times and intensities.

____
____

8- Chart who authored the records and the date records were completed.

Provider: _______________________________ Date: ____/____/____

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Ms. Vera Happy Patient: DOB 01/01/1995 Patient ID# SubLux1234

Daily Chart Note Template

Subjective:

Patient's current complaint including, but not limited to: pain, function, and any adjustment for daily living (ADL), symptomatic changes.

Objective:

Static and motion/palpation subluxation levels/soft tissue assessment/range of motion and, if warranted, neurologic assessment.

Assessment:

Diagnosis/assessment of condition, or amendment to original diagnosis.

Plan:

Plan of action including treatment rendered and plan for additional care or diagnostic testing, and who provides services (Doctor, CA, and LMT).

Example:

Monday 03-06-2017

S - My low back pain reduced from last treatment but has returned to the same pain level as before 4/10 over last day or so and now I have right leg pain to my knee.

O - Posture is mildly antalgic, ambulation normal despite extremity complaint, palpation finds L4-5 painful and subluxated. DTRs WNL, no change to motor function, lumbar para spinal muscle tone is moderately hypertonic, lumbar ROM still restricted in F, RR, and LLB.

A - S335XXA Sprain of ligaments lumbar spine.

P - Continue with treatment plan, 1 unit of massage (97124) to lumbar region, diversified manipulation of L4 and L5 (98940) RRV as per Tx plan 2X per week for next 4 weeks. Mary Jones, DC