

1 Patient Information

1 PATIENT DETAILS

Name:	_____	Date of Service:	_____
DOB:	_____	Provider:	_____
Age / Sex:	_____	MRN:	_____
Visit Type:	_____	Affected Body Part / Laterality:	_____

CC Chief Complaint

2 PRIMARY ORTHOPEDIC CONCERN

Document the primary musculoskeletal concern in the patient's own words — location, laterality, and duration...

S Subjective

3 PATIENT-REPORTED SYMPTOMS & ORTHOPEDIC HISTORY

3a ONSET & MECHANISM

Date and circumstances — trauma, overuse, fall, sports injury, work-related injury, or gradual onset...

3b LOCATION & LATERALITY

Specific anatomical site and side affected — joint, bone, tendon, ligament, or spine...

3c PAIN CHARACTERISTICS

Quality, severity, radiation, timing, and progression of pain...

3d FUNCTIONAL LIMITATIONS

Impact on ambulation, ROM, strength, work duties, sports, ADLs, and sleep...

3e PRIOR TREATMENT

Medications, bracing, casting, PT, injections, surgery, activity modification, or prior imaging...

3f ASSOCIATED SYMPTOMS

Swelling, instability, locking, catching, clicking, deformity, numbness, tingling, weakness, fever, or wound concerns...

3g PERTINENT NEGATIVES

Denial of acute neurovascular compromise, open wound, fever, progressive weakness, bowel/bladder dysfunction, or inability to bear weight...

O Objective

4 MEASURABLE & OBSERVED ORTHOPEDIC FINDINGS

V VITAL SIGNS

Temperature: _____
Heart Rate: _____
Oxygen Saturation: _____
Pain Score: _____

Blood Pressure: _____
Respiratory Rate: _____
Weight / BMI: _____

4a INSPECTION

Deformity, swelling, ecchymosis, erythema, surgical incision, wounds, atrophy, or alignment abnormality...

4b PALPATION

Tenderness location, warmth, crepitus, masses, or effusion...

4c RANGE OF MOTION

Active ROM: _____
Limitations (pain / stiffness): _____

Passive ROM: _____

4d STRENGTH

Affected Side (grade/5): _____

Contralateral Side (grade/5): _____

4e STABILITY / SPECIAL TESTS

Ligamentous stability and joint-specific provocative tests as applicable...

4f NEUROVASCULAR STATUS

Sensation: _____
Distal Pulses: _____

Motor Function: _____
Capillary Refill: _____

4g GAIT / FUNCTIONAL TESTING

Weight-bearing status, limp, assistive device use, squat, single-leg stance, or functional limitations...

L Lab & Imaging Results

5 REVIEWED DATA

5a IMAGING STUDIES

X-ray, CT, MRI, ultrasound, fluoroscopy, or post-operative imaging findings...

5b LABORATORY STUDIES

CBC, ESR, CRP, uric acid, cultures, or pre-operative labs if relevant...

5c OTHER DIAGNOSTICS

EMG/NCS, bone scan, arthrocentesis results, or pathology findings if applicable...

A Assessment

6 ORTHOPEDIC CLINICAL INTERPRETATION

Primary orthopedic diagnosis or working diagnosis. Injury classification or fracture type if applicable. Severity, acuity, laterality, and functional impact. Surgical candidacy or post-operative recovery status. Neurovascular status and complication risk. Differential diagnoses if uncertain...

P Plan

7 ORTHOPEDIC MANAGEMENT

7a NON-OPERATIVE TREATMENT

Rest, activity modification, NSAIDs, bracing, casting, immobilization, PT/OT...

7b SURGICAL PLAN

Procedure, laterality, timing, and rationale if indicated...

7c WEIGHT-BEARING STATUS & ACTIVITY RESTRICTIONS

Weight-Bearing Status: _____ Activity Restrictions: _____

7d MEDICATIONS & INJECTIONS

Analgesics, anti-inflammatories, or joint injections prescribed...

7e WOUND / CAST / BRACE CARE & ADDITIONAL WORKUP

Wound, cast, brace, or splint care instructions. Additional imaging, labs, or pre-operative clearance needed...

7f PATIENT EDUCATION

Warning signs and return precautions...

F Follow-Up

8 REASSESSMENT PLAN

Follow-up timeframe and purpose: _____

Repeat imaging, wound check, suture removal, post-op evaluation, rehabilitation progress, or surgical planning...

TIME DOCUMENTATION & BILLING

Total Time: _____ Counseling / Coordination Time: _____ E/M Level: _____ Procedure Code(s): _____

Basis for Billing: _____ Primary ICD-10 Code: _____

Secondary ICD-10 Code(s): _____

PHYSICIAN NAME, MD

SPECIALTY: ORTHOPEDIC SURGERY

DATE

TIME