

1 Patient Information

1 PATIENT DETAILS

Name:	_____	Date of Plan:	_____
DOB:	_____	General Practitioner / PCP:	_____
Age / Sex:	_____	MRN / Patient ID:	_____
Practice / Clinic Name:	_____	Care Setting:	_____
Reason for GP Management Plan:	_____		_____

AM Active Medical Problems

2 CURRENT ACTIVE DIAGNOSES

Current active diagnoses — chronic diseases, recent acute issues, mental health conditions, functional limitations, preventive care gaps, risk factors...

HPI History of Present Illness / Current Status

3 CLINICAL SUMMARY

Concise clinical summary — symptom burden, disease control, duration and progression, recent exacerbations/hospitalizations/specialist encounters, functional impact, patient-reported concerns and goals, pertinent negatives...

ROS Review of Systems

4 FOCUSED REVIEW OF SYSTEMS

Constitutional:	_____	Cardiovascular:	_____
Respiratory:	_____	Gastrointestinal:	_____
Genitourinary:	_____	Musculoskeletal:	_____
Neurological:	_____	Psychiatric / Other:	_____

V Vitals

5 VITAL SIGNS

Temperature:	_____	Blood Pressure:	_____
Heart Rate:	_____	Respiratory Rate:	_____
Oxygen Saturation:	_____	Height / Weight:	_____
BMI:	_____	Pain Score:	_____

PE Physical Examination

6 FOCUSED OR COMPREHENSIVE EXAM

General Appearance:	_____	HEENT:	_____
Cardiovascular:	_____	Respiratory:	_____

Abdomen: _____
Neurological: _____

Musculoskeletal: _____
Skin / Psychiatric: _____

MX Medications

7 MEDICATION RECONCILIATION

Current prescribed medications, OTC and supplements, adherence, side effects, refills, medication changes made, high-risk medications requiring monitoring...

AL Allergies

8 KNOWN ALLERGIES

Medication, food, or environmental allergies — reaction type and severity when known...

LB Recent Lab & Diagnostic Results

9 REVIEWED DATA

Laboratory results (abnormal and significant normal findings), imaging, ECG, screening tests, specialist reports, or hospital discharge summaries...

A Assessment

10 CLINICAL INTERPRETATION BY PROBLEM

Current status of each condition (controlled, uncontrolled, improving, worsening, stable). Severity and risk level. Relevant comorbidities, complications, or red flags. Patient-specific barriers. Medical necessity for ongoing monitoring or coordination...

MP Management Plan

11 PLAN BY PROBLEM / DIAGNOSIS

Medication initiation, continuation, adjustment, or discontinuation. Lifestyle interventions. Monitoring requirements. Diagnostic testing ordered. Preventive care and immunizations. Referrals to specialists or allied health. Patient education and self-management strategies...

PG Patient Goals & Care Coordination

12 GOALS & COORDINATION

12a PATIENT-CENTERED GOALS

Symptom improvement, disease control targets, functional goals, lifestyle goals, QOL priorities, shared decision-making preferences...

12b CARE COORDINATION

Specialist communication: _____

Pharmacy / home health coordination: _____

Barriers (transportation, financial, access): _____

Social work / case management: _____

SR Safety / Risk Assessment

13 RISK FACTORS

Falls Risk: _____ Medication Safety Risk: _____
Mental Health / Self-Harm Risk: _____ Cardiovascular / Metabolic Risk: _____
Infection / Social Vulnerability: _____ Escalation Criteria: _____

FU Follow-Up

14 REASSESSMENT PLAN

Follow-up timeframe and purpose: _____

Reassessment of symptoms, lab results, medication response, disease control, preventive care, specialist recommendations...

TIME DOCUMENTATION & BILLING

Total Time: _____ Counseling / Coordination Time: _____ E/M / Billing Code: _____ Procedure Code(s): _____
Basis for Billing: _____ Primary ICD-10 Code: _____
Secondary ICD-10 Code(s): _____

PHYSICIAN / PROVIDER NAME

SPECIALTY: GENERAL PRACTICE /
FAMILY MEDICINE / INTERNAL
MEDICINE

DATE

TIME