1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME _____ DOB _____

AGE / SEX _____ MRN / PATIENT ID _____

DATE OF SERVICE _____ PROVIDER _____

CREDENTIALS _____ PARENT / GUARDIAN PRESENT _____

VISIT TYPE: PEDIATRIC CONSULTATION / WELL CHILD VISIT / SICK VISIT / FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / INPATIENT / URGENT CARE / EMERGENCY / TELEHEALTH

INFORMANT / COLLATERAL SOURCE _____ PRIMARY CARE PROVIDER, IF APPLICABLE _____

CC CHIEF COMPLAINT

2 PRIMARY PEDIATRIC CONCERN

Primary pediatric reason for the visit in the patient's or caregiver's own words when possible — fever, cough, congestion, sore throat, abdominal pain, vomiting, diarrhea, rash, ear pain, feeding concern, growth concern, behavioral or developmental concern, injury, medication follow-up, chronic disease follow-up, or routine well-child care...

S SUBJECTIVE

3 PATIENT- AND CAREGIVER-REPORTED HISTORY

3a REASON FOR VISIT & HISTORY OF PRESENT ILLNESS

Reason for Pediatric Visit (well-child care / acute illness / chronic condition follow-up / medication management / developmental concern / school concern / injury / hospital follow-up / immunization / care coordination):

History of Present Illness (onset, duration, frequency, severity, progression, triggers, exposures, sick contacts, travel, school or daycare exposures, home treatments tried, medication response, caregiver concerns):

3b SYSTEMS-BASED SYMPTOM REVIEW

Fever / Infectious Symptoms (maximum temperature, duration, method of measurement, antipyretic use and response, chills, fatigue, decreased activity, rash, known exposures):

Respiratory Symptoms (cough, congestion, rhinorrhea, sore throat, wheezing, shortness of breath, work of breathing, chest pain, apnea, cyanosis, inhaler or nebulizer use, asthma history, response to therapy):

Gastrointestinal Symptoms (abdominal pain, vomiting, diarrhea, constipation, reflux, feeding intolerance, appetite change, hydration status, stool pattern, blood in stool, weight change, oral intake):

Genitourinary Symptoms (dysuria, frequency, urgency, hematuria, urinary accidents, enuresis, genital symptoms, testicular pain, menstrual history when age-appropriate, concern for UTI or dehydration):

Skin Symptoms (rash, itching, swelling, lesions, wounds, bruising, bites, allergic reaction, eczema flare, infection signs, distribution, duration, exposures, treatments tried):

Pain / Injury Symptoms (location, severity, mechanism of injury, timing, swelling, bruising, functional limitation, gait change, head injury symptoms, loss of consciousness, prior evaluation):

3c FEEDING, GROWTH, SLEEP & BEHAVIOR

Feeding / Nutrition (feeding pattern, breastfeeding or formula intake if infant, solid food intake, appetite, picky eating, fluid intake, dietary restrictions, food allergies, weight concerns, supplements):

Growth and Development (growth concerns, developmental milestones, speech and language progress, motor development, social development, school readiness, regression, delays, caregiver concerns):

Sleep (schedule, duration, naps, snoring, sleep-disordered breathing symptoms, night waking, nightmares, sleep hygiene, caregiver concerns):

Behavior / Mental Health (attention, hyperactivity, mood, anxiety, irritability, tantrums, aggression, school behavior, peer relationships, screen time, safety concerns):

School / Daycare Functioning (grade or daycare status, attendance, academic performance, behavior, IEP or 504 plan, bullying, social functioning, recent exposures):

3d BACKGROUND HISTORY

Past Medical History (birth history when relevant, prematurity, NICU stay, chronic conditions, surgeries, hospitalizations, allergies, medications, immunization status, prior specialist care):

Family History (asthma, allergies, eczema, cardiac disease, diabetes, seizures, autoimmune disease, developmental delay, genetic conditions, mental health conditions, sudden death):

Social History (household members, caregiving arrangement, daycare or school, smoke exposure, pets, travel, housing concerns, food insecurity, safety concerns, transportation barriers):

Pertinent Negatives (difficulty breathing, cyanosis, dehydration, lethargy, persistent vomiting, severe abdominal pain, stiff neck, seizure, altered mental status, inconsolability, poor perfusion, severe headache, worsening symptoms):

ROS PEDIATRIC REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fever, fatigue, decreased activity, appetite change, or weight change

Cough, congestion, rhinorrhea, sore throat, wheezing, dyspnea, or ear pain

Vomiting, diarrhea, constipation, abdominal pain, reflux, or feeding difficulty

Dysuria, urinary frequency, hematuria, decreased urine output, or enuresis

Rash, itching, swelling, bruising, wounds, or allergic symptoms

Headache, dizziness, seizure, weakness, gait change, or developmental regression

Joint pain, muscle pain, injury, swelling, or activity limitation

Sleep disturbance, behavior change, mood symptoms, or school concerns

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT / LENGTH

WEIGHT

BMI

HEAD CIRCUMFERENCE, IF APPLICABLE

GROWTH PERCENTILES

PAIN SCORE, IF APPLICABLE

5a AGE-APPROPRIATE PHYSICAL EXAMINATION

General Appearance (alertness, activity level, distress, hydration, toxic or non-toxic appearance, interaction with caregiver, consolability, developmental appropriateness):

Head / Eyes / Ears / Nose / Throat (head shape, fontanelle if infant, conjunctiva, pupils, eye drainage, tympanic membranes, ear canals, nasal congestion or discharge, oral mucosa, tonsils, pharynx, dentition, hydration):

Neck (range of motion, lymphadenopathy, stiffness, tenderness, masses, meningeal signs):

Cardiovascular (rate, rhythm, murmurs, pulses, capillary refill, perfusion, cyanosis, edema, signs of hemodynamic instability):

Pulmonary (work of breathing, respiratory effort, retractions, nasal flaring, grunting, breath sounds, wheezing, crackles, stridor, air movement, cough, oxygen requirement):

Abdomen (bowel sounds, distension, tenderness, guarding, rebound, hepatosplenomegaly, masses, hernia, hydration-related findings):

Genitourinary, if assessed (age-appropriate GU findings, external genital exam, diaper rash, testicular findings, Tanner stage if relevant, catheter status):

Musculoskeletal (range of motion, swelling, tenderness, deformity, gait, strength, joint findings, injury findings, spine, age-appropriate motor function):

Skin (rash, lesions, bruising, petechiae, wounds, eczema, infection signs, color, turgor, perfusion, birthmarks):

Neurologic (mental status, tone, strength, reflexes, gait, coordination, cranial nerves, seizure-related findings, developmental appropriateness):

Psychiatric / Behavioral (mood, affect, behavior, cooperation, attention, interaction with caregiver, communication, age-appropriate behavior):

DG DEVELOPMENTAL / GROWTH ASSESSMENT

6 DEVELOPMENT & GROWTH WHEN ASSESSED

Growth chart review — height/length, weight, BMI, and head circumference trends when applicable:

Gross motor and fine motor milestones:

Speech / language milestones and social-emotional development:

Cognitive / school readiness skills; regression or developmental delay:

Screening tool results if used; need for early intervention, school evaluation, therapy, or specialist referral:

PC PREVENTIVE CARE / WELL-CHILD ELEMENTS, IF APPLICABLE

7 PREVENTIVE PEDIATRIC CARE

Immunization status and vaccines due or administered:

Vision screening, hearing screening, dental home and fluoride status:

Nutrition, physical activity, sleep, and screen time counseling:

Safety counseling (car seat or seat belt, helmet use, water safety, firearm safety, smoke and CO detectors, choking prevention, injury prevention):

Puberty, menstrual health, sexual health, or substance use counseling when age-appropriate:

Anticipatory guidance based on age and developmental stage:

SC SCREENING / ASSESSMENT TOOLS

8 TOOLS USED & INTERPRETATION

DEVELOPMENTAL SCREENING

AUTISM SCREENING

PHQ-A / DEPRESSION SCREENING

ANXIETY SCREENING

ADHD RATING SCALES

SOCIAL DETERMINANTS OF HEALTH SCREENING

FOOD INSECURITY SCREENING

LEAD RISK SCREENING

TUBERCULOSIS RISK SCREENING

VISION / HEARING SCREENING

NEWBORN SCREENING FOLLOW-UP

OTHER AGE- OR CONDITION-SPECIFIC TOOL

Score, result, interpretation, informant source, and any limitations:

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Point-of-Care Testing (rapid strep, influenza, COVID-19, RSV, glucose, urinalysis, pregnancy test when clinically appropriate):

Laboratory Studies (CBC, CMP, inflammatory markers, cultures, lead level, anemia screening, lipid screening, thyroid studies, allergy testing, condition-specific labs):

Microbiology (throat culture, urine culture, blood culture, wound culture, respiratory testing, stool testing):

Imaging (X-ray, ultrasound, CT, MRI, echocardiogram, other imaging when clinically indicated):

Prior Records Reviewed (hospital and emergency records, specialist notes, immunization records, growth charts, school reports, therapy records, medication history, prior labs and imaging):

A ASSESSMENT

10 PEDIATRIC CLINICAL INTERPRETATION

Primary or working diagnosis. Differential diagnoses considered. Severity and acuity of illness. Hydration, respiratory, neurologic, or hemodynamic status when relevant. Growth and developmental status. Immunization or preventive care needs. Response to prior treatment or home interventions. Risk factors, comorbidities, exposures, or social factors affecting care. Need for testing, medication, referral, monitoring, higher level of care, or follow-up. Safety concerns or red flags requiring urgent escalation...

P PLAN

11 PEDIATRIC MANAGEMENT BY PROBLEM

Medication plan (dosing, route, frequency, duration, weight-based dosing when applicable, side effects, caregiver instructions). Supportive care (hydration, nutrition, fever care, nasal suctioning, rest, humidification, wound care, symptom management). Diagnostic plan (labs, cultures, imaging, screening tools, repeat testing). Immunization plan (vaccines administered, vaccines due, catch-up schedule, counseling). Developmental or behavioral plan (early intervention, therapy referral, school support, parent guidance, developmental follow-up). Chronic disease plan (adherence, monitoring, specialist coordination, action plan, escalation precautions). Safety and anticipatory guidance. Referral or coordination (specialists, therapy, school, social work, early intervention, nutrition, dentistry, behavioral health, primary care). Caregiver education on diagnosis, expected course, home care, medication use, hydration, return precautions, and when to seek urgent or emergency care...

F FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose (symptom reassessment, test result review, medication response, growth and development monitoring, vaccine completion, chronic disease follow-up, specialist referral follow-through, urgent return precautions):

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

COUNSELING / CAREGIVER EDUCATION TIME

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

PREVENTIVE COUNSELING TIME, IF APPLICABLE

E/M LEVEL: 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215

PREVENTIVE VISIT CODE, IF APPLICABLE

IMMUNIZATION ADMINISTRATION CODE(S), IF APPLICABLE

SCREENING CODE(S), IF APPLICABLE

PROCEDURE CODE(S), IF APPLICABLE

BASIS FOR BILLING: TIME-BASED / MEDICAL DECISION MAKING / PREVENTIVE CARE / PROCEDURE-BASED

PRIMARY ICD-10 DIAGNOSIS CODE + DESCRIPTION

SECONDARY DIAGNOSIS CODE(S), IF APPLICABLE

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY: PEDIATRICS	DATE	TIME