1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: INTERVENTIONAL PULMONOLOGY CONSULTATION / PROCEDURE PLANNING / BRONCHOSCOPY FOLLOW-UP / PLEURAL PROCEDURE FOLLOW-UP / LUNG NODULE EVALUATION / AIRWAY EVALUATION / TELEHEALTH

CARE SETTING: OUTPATIENT / INTERVENTIONAL PULMONOLOGY CLINIC / BRONCHOSCOPY SUITE / PROCEDURE UNIT / HOSPITAL / ICU / TELEHEALTH

PRIMARY PULMONOLOGIST, IF APPLICABLE

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

ONCOLOGY CARE TEAM, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

Document the primary interventional pulmonology-related reason for the visit in the patient's own words when possible, including lung nodule, lung mass, abnormal chest imaging, mediastinal lymphadenopathy, hemoptysis, airway obstruction, tracheal stenosis, pleural effusion, pneumothorax, suspected lung cancer, need for bronchoscopy, biopsy planning, endobronchial ultrasound evaluation, navigational bronchoscopy, pleural catheter management, or post-procedure follow-up.

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

Document patient-reported respiratory symptoms, imaging context, procedural history, cancer risk factors, pleural symptoms, airway symptoms, treatment history, and procedural risk factors.

3a REASON FOR VISIT & SYMPTOMS

Reason for Interventional Pulmonology Evaluation:

Document whether the visit is for lung nodule evaluation, lung mass biopsy, mediastinal staging, bronchoscopy planning, EBUS evaluation, robotic/navigational bronchoscopy, airway obstruction, hemoptysis, pleural effusion evaluation, indwelling pleural catheter management, pneumothorax management, tracheobronchial stenosis, or post-procedure follow-up.

Current Respiratory Symptoms:

Document dyspnea, cough, sputum production, wheezing, chest tightness, pleuritic pain, hemoptysis, fever, weight loss, night sweats, fatigue, hoarseness, stridor, orthopnea, or exercise limitation.

Lung Nodule / Mass History:

Document imaging indication, nodule or mass location, size if known, growth trend, solid/subsolid/ground-glass features, cavitation, spiculation, PET avidity if known, prior imaging comparison, prior biopsy, and patient concern.

Cancer Risk and Oncologic Context:

Document smoking history, occupational exposures, prior malignancy, family history of lung cancer, immunosuppression, radiation exposure, known metastatic cancer, prior chemotherapy/radiation/immunotherapy, and oncology care team involvement.

Mediastinal / Lymph Node Concern:

Document enlarged lymph nodes, PET-avid nodes, suspected staging need, sarcoidosis concern, lymphoma concern, infectious differential, prior node biopsy, and relevant systemic symptoms.

Pleural Disease Symptoms:

Document pleural effusion, recurrent effusion, chest pain, dyspnea relief after drainage, prior thoracentesis, fluid recurrence, pleural catheter output, drainage frequency, catheter discomfort, leakage, fever, or infection symptoms.

Airway Obstruction / Stenosis Symptoms:

Document stridor, wheezing, positional dyspnea, voice change, cough, secretion retention, recurrent pneumonia, prior intubation, tracheostomy history, airway stent history, tumor-related obstruction, and symptom progression.

Hemoptysis History:

Document amount, frequency, color, clots, associated cough, infection symptoms, anticoagulant use, malignancy risk, bronchiectasis history, TB exposure, prior episodes, and severity.

3b PROCEDURAL RISK FACTORS

Prior Pulmonary Procedures:

Include bronchoscopy, EBUS, navigational bronchoscopy, transbronchial biopsy, cryobiopsy, thoracentesis, chest tube, pleuroscopy, pleurodesis, indwelling pleural catheter, airway dilation, stent placement, tumor debulking, or prior procedural complications.

Medication and Anticoagulation History:

Document anticoagulants, antiplatelet agents, NSAIDs, supplements affecting bleeding risk, immunosuppressants, steroids, chemotherapy, targeted therapy, antibiotics, inhalers, oxygen, and peri-procedural medication instructions if discussed.

Medical Risk Factors:

Include COPD, asthma, interstitial lung disease, pulmonary hypertension, sleep apnea, heart failure, coronary artery disease, arrhythmia, kidney disease, liver disease, diabetes, bleeding disorder, thrombocytopenia, immunosuppression, prior anesthesia complications, or difficult airway history.

Oxygen / Ventilatory Support:

Document home oxygen use, flow rate, oxygen saturation trends, CPAP/BiPAP use, ventilator use, tracheostomy status, equipment issues, and baseline respiratory support.

Smoking / Vaping / Exposure History:

Document tobacco history in pack-years, current smoking status, vaping, cannabis inhalation, asbestos, silica, radon, diesel fumes, biomass exposure, occupational dust/fumes, birds, mold, TB exposure, travel, and protective equipment use.

Functional Status and Procedure Tolerance:

Document exercise tolerance, ability to lie flat, baseline dyspnea, frailty, mobility, performance status, prior sedation tolerance, caregiver support, transportation, and ability to comply with post-procedure instructions.

Family History:

Document family history of lung cancer, pulmonary fibrosis, sarcoidosis, tuberculosis, clotting disorder, anesthesia complications, or other pulmonary disease when relevant.

Pertinent Negatives:

Document denial of red-flag symptoms when clinically relevant, including massive hemoptysis, severe dyspnea at rest, chest pain, syncope, fever, oxygen desaturation, unilateral leg swelling, rapidly worsening stridor, severe post-procedure pain, or signs of pleural catheter infection.

ROS INTERVENTIONAL PULMONOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

Dyspnea, cough, wheezing, chest tightness, sputum production, or hemoptysis

Chest pain, pleuritic pain, orthopnea, exercise intolerance, or oxygen desaturation

Fever, chills, night sweats, weight loss, fatigue, or infection symptoms

Hoarseness, stridor, choking, secretion retention, or airway obstruction symptoms

Pleural catheter pain, drainage change, leakage, redness, swelling, or infection symptoms

Bleeding tendency, anticoagulant use, bruising, thrombocytopenia, or prior procedure bleeding

Sedation/anesthesia complications, difficult airway history, or inability to lie flat

Anxiety, cancer-related distress, procedural concerns, or functional limitation

O OBJECTIVE

5 CARDIOPULMONARY EXAMINATION

Document observed interventional pulmonology-relevant findings and cardiopulmonary examination details.

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
RESPIRATORY RATE	OXYGEN SATURATION	OXYGEN FLOW RATE, IF APPLICABLE
HEIGHT	WEIGHT	BMI
PAIN SCORE, IF APPLICABLE	PERFORMANCE STATUS, IF APPLICABLE	

5b EXAMINATION

General Appearance:

Document alertness, distress level, work of breathing, ability to speak in full sentences, oxygen use, frailty, mobility, and overall clinical condition.

Head / Neck / Airway:

Document Mallampati class if relevant, mouth opening, neck mobility, tracheostomy status, stridor, hoarseness, lymphadenopathy, tracheal deviation, and airway risk factors.

Cardiovascular:

Document rate, rhythm, murmurs, edema, pulses, perfusion, JVD, and findings relevant to procedural or anesthesia risk.

Pulmonary:

Document respiratory effort, breath sounds, wheezes, crackles, rhonchi, diminished breath sounds, stridor, pleural rub, cough, secretion burden, oxygen requirement, and focal findings corresponding to imaging.

Chest Wall / Pleural Catheter Site, if applicable:

Document catheter site, dressing status, drainage, erythema, tenderness, leakage, cuff position, catheter function, suture status, and signs of infection or blockage.

Abdomen:

Document distension, ascites, tenderness, hepatomegaly, and findings relevant to pleural effusion or procedural planning.

Extremities:

Document clubbing, cyanosis, edema, calf tenderness, asymmetry, and signs of thromboembolic disease.

Skin:

Document bruising, infection signs, radiation changes, surgical scars, port sites, catheter-related skin findings, or wounds.

Neurologic:

Document mental status, strength, gait, focal deficits, and ability to consent or participate in care.

IM IMAGING / LESION ASSESSMENT

6 PROCEDURE-PLANNING IMAGING

Document imaging findings relevant to procedure planning. Include:

IMAGING MODALITY AND DATE

INDICATION FOR IMAGING

LUNG NODULE/MASS SIZE, LOCATION, AND BRONCHUS SIGN IF AVAILABLE

SOLID, SUBSOLID, GROUND-GLASS, CAVITARY, CALCIFIED, OR SPICULATED FEATURES

GROWTH TREND AND COMPARISON TO PRIOR IMAGING

PET AVIDITY AND SUV IF AVAILABLE

MEDIASTINAL OR HILAR LYMPH NODE STATIONS INVOLVED

PLEURAL EFFUSION SIZE, LATERALITY, LOCULATION, PLEURAL THICKENING, OR PLEURAL NODULARITY

AIRWAY NARROWING, OBSTRUCTION, ENDOBRONCHIAL LESION, STENOSIS, OR TRACHEOBRONCHOMALACIA FINDINGS

EMPHYSEMA, FIBROSIS, BRONCHIECTASIS, PNEUMOTHORAX, ATELECTASIS, OR INFILTRATES

PROCEDURAL TARGET FEASIBILITY AND LIMITATIONS

NEED FOR CT CHEST, PET/CT, ULTRASOUND, BRONCHOSCOPY, BIOPSY, THORACENTESIS, PLEUROSCOPY, OR SURGICAL REFERRAL

PRA PROCEDURE RISK / PRE-PROCEDURE ASSESSMENT

7 READINESS & SAFETY REVIEW

Document procedure readiness and safety review. Include:

PLANNED PROCEDURE AND INDICATION

DIAGNOSTIC OR THERAPEUTIC GOAL

CONSENT STATUS

ANTICOAGULANT/ANTIPLATELET MANAGEMENT

BLEEDING RISK AND PLATELET/COAGULATION STATUS

OXYGEN REQUIREMENT AND RESPIRATORY RESERVE

SEDATION/ANESTHESIA RISK

DIFFICULT AIRWAY RISK

ABILITY TO LIE FLAT

CARDIAC RISK FACTORS

PULMONARY HYPERTENSION RISK

INFECTION RISK

PREGNANCY STATUS WHEN RELEVANT

ALLERGIES TO ANESTHETICS, LATEX, CHLORHEXIDINE, IODINE, ADHESIVES, OR ANTIBIOTICS

NPO STATUS IF APPLICABLE

TRANSPORTATION AND POST-SEDATION SUPPORT

ALTERNATIVES DISCUSSED AND SHARED DECISION-MAKING

PR PROCEDURES PERFORMED, IF APPLICABLE

8 INTERVENTIONAL PULMONOLOGY PROCEDURES

Document interventional pulmonology procedures performed during the encounter. Include procedure name, indication, consent, timeout, anesthesia/sedation, airway management, technique, imaging guidance, samples obtained, immediate findings, hemostasis, patient tolerance, complications, post-procedure imaging, and follow-up plan. Examples may include: Flexible bronchoscopy · Endobronchial ultrasound-guided transbronchial needle aspiration · Robotic bronchoscopy · Navigational bronchoscopy · Transbronchial biopsy · Endobronchial biopsy · Bronchoalveolar lavage · Therapeutic aspiration of secretions · Airway dilation · Airway stent placement or removal · Tumor debulking · Argon plasma coagulation · Cryotherapy / cryobiopsy · Thoracentesis · Chest tube placement · Indwelling pleural catheter placement/removal · Pleuroscopy / medical thoracoscopy · Pleural biopsy · Pleurodesis · Pneumothorax management

BR BRONCHOSCOPY / EBUS DOCUMENTATION, IF PERFORMED

9 BRONCHOSCOPY FINDINGS

Document bronchoscopy-specific findings. Include: Airway anatomy and visualization · Vocal cord findings if assessed · Trachea, mainstem bronchi, lobar and segmental airway findings · Endobronchial lesion, stenosis, malacia, obstruction, bleeding, secretions, or foreign body · Lymph node stations sampled · Number of passes per site · Rapid on-site evaluation if available · Biopsy/BAL/brushings/washings obtained · Bleeding control measures · Airway patency after procedure · Complications if any · Preliminary impression and pending pathology/microbiology

PL PLEURAL PROCEDURE DOCUMENTATION, IF PERFORMED

10 PLEURAL INTERVENTION FINDINGS

Document pleural intervention findings. Include:

LATERALITY AND INDICATION

ULTRASOUND FINDINGS AND FLUID POCKET ASSESSMENT

FLUID VOLUME REMOVED

FLUID APPEARANCE

PLEURAL MANOMETRY IF USED

SYMPTOMS DURING DRAINAGE

SAMPLES SENT

POST-PROCEDURE LUNG EXPANSION

PNEUMOTHORAX ASSESSMENT

CATHETER PLACEMENT DETAILS IF APPLICABLE

DRAINAGE INSTRUCTIONS AND SUPPLIES

COMPLICATIONS IF ANY

FOLLOW-UP IMAGING AND LAB PLAN

L LABORATORY AND DIAGNOSTIC RESULTS

11 REVIEWED & ORDERED

Document interventional pulmonology-relevant results reviewed or ordered. Include:

Pathology / Cytology:

Bronchoscopic biopsy, transbronchial biopsy, EBUS-TBNA, pleural biopsy, pleural fluid cytology, BAL cytology, molecular testing, PD-L1, tumor markers, and pending results.

Microbiology:

BAL culture, sputum culture, AFB, fungal culture, viral testing, pleural fluid culture, Gram stain, TB testing, and sensitivities.

Pleural Fluid Studies:

Cell count, differential, protein, LDH, glucose, pH, albumin gradient, triglycerides, cholesterol, cytology, flow cytometry, ADA, amylase, and culture.

Pre-Procedure Labs:

CBC, platelets, INR/PTT, CMP, renal function, pregnancy test when relevant, type and screen if needed, and anticoagulation monitoring.

Imaging:

Chest X-ray, CT chest, PET/CT, CTA, ultrasound, fluoroscopy, cone-beam CT, MRI, or post-procedure imaging.

Pulmonary / Cardiac Testing:

PFTs, echocardiogram, EKG, oxygen testing, sleep study, ABG/VBG, or cardiology clearance when relevant.

Prior Records Reviewed:

Pulmonology notes, oncology notes, thoracic surgery notes, radiology reports/images, pathology reports, bronchoscopy reports, operative reports, hospital records, medication history, and outside records.

A ASSESSMENT

12 INTERVENTIONAL PULMONOLOGY INTERPRETATION

Provide interventional pulmonology-specific clinical interpretation: Primary interventional pulmonology diagnosis or working diagnosis · Procedure indication and diagnostic/therapeutic target · Differential diagnosis for nodule, mass, lymphadenopathy, pleural effusion, airway obstruction, hemoptysis, or imaging abnormality · Malignancy risk assessment when relevant · Procedural feasibility and expected diagnostic yield · Procedural risk assessment, including bleeding, pneumothorax, sedation, airway, oxygenation, and cardiopulmonary risks · Imaging, pathology, cytology, microbiology, pleural fluid, and pulmonary testing interpretation · Treatment response and post-procedure recovery status when applicable · Need for bronchoscopy, EBUS, biopsy, pleural intervention, airway intervention, repeat imaging, oncology/thoracic surgery referral, hospitalization, or urgent escalation

P PLAN

13 MANAGEMENT BY PROBLEM

Outline interventional pulmonology management by problem. Include:

Lung nodule or mass plan

including imaging review, risk stratification, repeat CT interval, PET/CT, bronchoscopic biopsy, CT-guided biopsy, surgical referral, oncology referral, or surveillance.

Mediastinal lymphadenopathy plan

including EBUS staging, biopsy targets, pathology/microbiology testing, lymphoma workup, sarcoidosis evaluation, infection evaluation, or oncology coordination.

Bronchoscopy plan

including indication, approach, anesthesia, sample types, anticoagulation hold instructions, NPO instructions, transportation, risks/benefits/alternatives, and post-procedure expectations.

Pleural effusion plan

including thoracentesis, pleural fluid studies, repeat drainage, indwelling pleural catheter, pleuroscopy, pleurodesis, malignancy/infection/heart failure evaluation, and symptom monitoring.

Indwelling pleural catheter plan

including drainage schedule, output tracking, dressing care, infection precautions, supply coordination, pleurodesis assessment, and removal criteria.

Airway obstruction or stenosis plan

including bronchoscopy, dilation, stenting, tumor debulking, laser/APC/cryotherapy, secretion clearance, radiation/oncology coordination, and airway emergency precautions.

Hemoptysis plan

including severity assessment, bronchoscopy, CT/CTA, anticoagulation review, infection/malignancy evaluation, bronchial artery embolization referral, and emergency precautions for large-volume bleeding.

Pneumothorax plan

including observation, oxygen, chest tube, valve management, imaging follow-up, recurrence prevention, and thoracic surgery referral when indicated.

Post-procedure plan

including pathology/cytology follow-up, imaging review, complication monitoring, activity restrictions, medication restart instructions, and symptom precautions.

Smoking cessation and risk reduction plan

including counseling, pharmacotherapy, lung cancer screening eligibility, and follow-up support when applicable.

Referral and care coordination plan

with pulmonology, thoracic surgery, oncology, radiation oncology, infectious disease, pathology, radiology, anesthesia, ICU, palliative care, or emergency care when indicated.

Patient education

regarding diagnosis, procedure expectations, risks, alternatives, post-procedure care, warning signs, and when to seek urgent or emergency care.

F FOLLOW-UP

14 NEXT STEPS

Specify follow-up timeframe and purpose, including procedure scheduling, pathology/cytology review, imaging review, pleural catheter check, post-bronchoscopy follow-up, airway reassessment, repeat CT/PET surveillance, oncology coordination, thoracic surgery referral, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

15 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

PROCEDURE COUNSELING TIME

IMAGING REVIEW TIME

PROCEDURE TIME, IF APPLICABLE

PLEURAL CATHETER COUNSELING TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

15a BILLING CONSIDERATIONS — E/M / INTERVENTIONAL PULMONOLOGY CODING

E/M LEVEL: [E.G., 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215]

BRONCHOSCOPY CODE(S), IF APPLICABLE

EBUS / BIOPSY CODE(S), IF APPLICABLE

THORACENTESIS / CHEST TUBE / PLEURAL PROCEDURE CODE(S), IF APPLICABLE

AIRWAY INTERVENTION CODE(S), IF APPLICABLE

IMAGING GUIDANCE CODE(S), IF APPLICABLE

BASIS FOR BILLING: [TIME-BASED / MEDICAL DECISION MAKING / PROCEDURE-BASED / IMAGING REVIEW / TEST INTERPRETATION / CARE COORDINATION]

ICD-10 DIAGNOSIS CODES: [PRIMARY INTERVENTIONAL PULMONOLOGY DIAGNOSIS CODE + DESCRIPTION]

[SECONDARY NODULE / MASS / PLEURAL / AIRWAY / PROCEDURE DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

16 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: INTERVENTIONAL PULMONOLOGY

DATE

TIME