1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: PULMONOLOGY CONSULTATION / FOLLOW-UP / PULMONARY FUNCTION REVIEW / SLEEP-RELATED BREATHING FOLLOW-UP / HOSPITAL FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / PULMONOLOGY CLINIC / HOSPITAL / PULMONARY REHABILITATION / TELEHEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY PULMONARY CONCERN

Document the primary pulmonology-related reason for the visit in the patient's own words when possible, including shortness of breath, chronic cough, wheezing, asthma, COPD, abnormal chest imaging, lung nodule, interstitial lung disease, pulmonary fibrosis, recurrent pneumonia, sleep-disordered breathing, oxygen requirement, pulmonary hypertension concern, post-hospital follow-up, or pulmonary function test review.

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

Document patient-reported respiratory symptoms, disease history, exposures, treatment response, functional limitation, and relevant cardiopulmonary context.

3a PRESENTING SYMPTOMS

Reason for Pulmonology Evaluation:

Document whether the visit is for initial pulmonary consultation, chronic cough evaluation, dyspnea evaluation, asthma management, COPD management, abnormal imaging, lung nodule evaluation, interstitial lung disease evaluation, recurrent infection, oxygen assessment, pulmonary hypertension concern, sleep-related breathing concern, or follow-up of established pulmonary disease.

Dyspnea / Shortness of Breath:

Document onset, duration, progression, exertional threshold, rest symptoms, triggers, positional symptoms, orthopnea, paroxysmal nocturnal dyspnea, associated wheezing, chest tightness, cough, edema, palpitations, and functional impact.

Cough History:

Document duration, dry versus productive cough, sputum color/amount, hemoptysis, nocturnal cough, postnasal drip, reflux symptoms, ACE inhibitor use, infection history, environmental triggers, occupational triggers, and response to prior treatments.

Wheezing / Chest Tightness:

Document frequency, severity, triggers, nocturnal symptoms, exercise symptoms, allergen exposure, rescue inhaler use, response to bronchodilators, and associated asthma or COPD symptoms.

Sputum / Hemoptysis:

Document sputum volume, color, odor, purulence, blood streaking, frank hemoptysis, frequency, associated fever, weight loss, chest pain, infection symptoms, anticoagulant use, and prior evaluation.

3b DISEASE-SPECIFIC HISTORY

Asthma History, if applicable:

Document diagnosis history, triggers, exacerbation frequency, nocturnal symptoms, exercise limitation, rescue inhaler use, controller medication adherence, inhaler technique, oral steroid courses, emergency visits, hospitalizations, intubations, allergy history, and asthma action plan status.

COPD / Chronic Bronchitis / Emphysema History, if applicable:

Document smoking history, exacerbation frequency, baseline symptoms, sputum production, oxygen use, inhaler regimen, pulmonary rehabilitation, hospitalizations, prior spirometry, and history of pneumonia or respiratory failure.

Interstitial Lung Disease / Pulmonary Fibrosis Symptoms, if applicable:

Document progressive dyspnea, dry cough, exercise limitation, oxygen requirement, autoimmune symptoms, occupational exposures, medication exposures, family history, prior imaging, and response to therapy.

Lung Nodule / Abnormal Imaging History:

Document imaging indication, nodule size/location if known, comparison to prior imaging, smoking history, cancer history, occupational exposure, infectious exposure, symptoms, and prior biopsy or surveillance plan.

Respiratory Infection History:

Document pneumonia, bronchitis, recurrent infections, antibiotic courses, hospitalization, culture results, aspiration risk, immune deficiency concern, vaccination status, and recovery trajectory.

Sleep-Related Breathing Symptoms:

Document snoring, witnessed apneas, gasping, daytime sleepiness, morning headaches, insomnia, nocturnal dyspnea, CPAP/BiPAP use, adherence, mask issues, and prior sleep study results.

Oxygen / Ventilatory Support Use:

Document home oxygen prescription, flow rate, use at rest/exertion/sleep, oxygen saturation trends, portable oxygen access, CPAP/BiPAP/ventilator use, adherence, equipment issues, and safety counseling.

Exercise Tolerance and Functional Status:

Document walking distance, stairs tolerance, activities limited by breathing, work limitations, ADLs, pulmonary rehabilitation participation, baseline activity level, and recent decline.

3c EXPOSURES, MEDICATIONS & BACKGROUND

Smoking / Vaping / Inhalational Exposure History:

Document tobacco history in pack-years, current smoking status, vaping, cannabis inhalation, secondhand smoke, biomass exposure, occupational dust/fume exposure, asbestos, silica, mold, birds, hot tubs, farming, chemicals, and protective equipment use.

Medication History and Response:

Document inhalers, nebulizers, oral steroids, antibiotics, antifibrotics, biologics, leukotriene modifiers, oxygen, CPAP/BiPAP, anticoagulants, pulmonary hypertension medications, adherence, side effects, refill needs, and cost/access barriers.

Relevant Medical History:

Include asthma, COPD, ILD, pulmonary hypertension, sleep apnea, heart failure, coronary artery disease, arrhythmia, thromboembolic disease, GERD, allergic rhinitis, aspiration risk, neuromuscular disease, obesity, autoimmune disease, cancer history, or immunosuppression.

Family History:

Document family history of asthma, COPD, pulmonary fibrosis, pulmonary hypertension, cystic fibrosis, alpha-1 antitrypsin deficiency, lung cancer, autoimmune disease, or thromboembolic disease.

Social / Occupational History:

Document occupation, environmental exposures, living situation, pets/birds, home mold/water damage, travel, TB exposure, incarceration/shelter exposure, smoking status, substance use, and barriers to pulmonary care.

Pertinent Negatives:

Document denial of red-flag symptoms when clinically relevant, including severe dyspnea at rest, chest pain, syncope, hemoptysis, cyanosis, fever, unilateral leg swelling, unexplained weight loss, night sweats, oxygen desaturation, or rapidly worsening respiratory symptoms.

ROS PULMONOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

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

Fever, chills, night sweats, weight loss, fatigue, or recurrent infections

Chest pain, palpitations, orthopnea, edema, syncope, or exercise intolerance

Snoring, witnessed apneas, daytime sleepiness, nocturnal dyspnea, or morning headaches

Reflux, aspiration symptoms, dysphagia, postnasal drip, or sinus symptoms

Joint pain, Raynaud symptoms, rash, sicca symptoms, muscle weakness, or autoimmune symptoms

Inhaler side effects, steroid side effects, oxygen issues, CPAP/BiPAP intolerance, or medication adherence barriers

Anxiety, activity limitation, sleep disruption, work limitation, or quality-of-life impact related to respiratory disease

O OBJECTIVE

5 CARDIOPULMONARY EXAMINATION

Document observed pulmonary 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		

5b EXAMINATION

General Appearance:

Document alertness, distress level, work of breathing, ability to speak in full sentences, accessory muscle use, cyanosis, body habitus, mobility, and overall clinical condition.

Head / Eyes / Ears / Nose / Throat:

Document nasal congestion, oral mucosa, pharynx, postnasal drip, Mallampati class if relevant, dentition, and signs of upper airway contribution when assessed.

Neck:

Document jugular venous distention, lymphadenopathy, tracheal position, thyroid findings, accessory muscle use, and neck circumference if relevant to sleep-disordered breathing.

Cardiovascular:

Document rate, rhythm, murmurs, gallops, accentuated P2, edema, pulses, perfusion, and signs of heart failure or pulmonary hypertension.

Pulmonary:

Document respiratory effort, breath sounds, air movement, wheezes, crackles, rhonchi, decreased breath sounds, prolonged expiratory phase, stridor, pleural rub, cough, oxygen requirement, and response to bronchodilator if assessed.

Chest Wall:

Document deformity, tenderness, surgical scars, kyphoscoliosis, barrel chest, respiratory mechanics, and chest expansion when relevant.

Abdomen:

Document distension, hepatomegaly, ascites, tenderness, reflux/aspiration-related findings, and obesity-related respiratory considerations.

Extremities:

Document clubbing, cyanosis, edema, calf tenderness, asymmetry, joint deformities, digital ulcers, and findings relevant to thromboembolic disease or ILD.

Skin:

Document rash, telangiectasias, sclerodactyly, mechanic's hands, cyanosis, bruising, steroid effects, or autoimmune-related findings.

Neurologic:

Document mental status, gait, strength, respiratory muscle weakness, neuromuscular findings, or CO2 retention concerns when relevant.

PFT PULMONARY FUNCTION / RESPIRATORY TESTING

6 TESTS REVIEWED OR PERFORMED

Document pulmonary testing reviewed or performed. Include:

SPIROMETRY RESULTS

FEV1, FVC, FEV1/FVC RATIO

BRONCHODILATOR RESPONSE

LUNG VOLUMES

DLCO

FLOW-VOLUME LOOP INTERPRETATION

PEAK FLOW WHEN RELEVANT

FRACTIONAL EXHALED NITRIC OXIDE IF PERFORMED

6-MINUTE WALK TEST

AMBULATORY OXYGEN TESTING

ARTERIAL OR VENOUS BLOOD GAS WHEN APPLICABLE

OVERNIGHT OXIMETRY

SLEEP STUDY RESULTS WHEN RELEVANT

COMPARISON TO PRIOR TESTING

TEST QUALITY AND LIMITATIONS

IM IMAGING / NODULE / LUNG DISEASE ASSESSMENT

7 CHEST IMAGING REVIEW

Document chest imaging findings when reviewed. Include:

IMAGING MODALITY AND DATE

INDICATION FOR IMAGING

LUNG NODULES: SIZE, LOCATION, MORPHOLOGY, CALCIFICATION, SOLID/SUBSOLID/GROUND-GLASS FEATURES, AND GROWTH TREND

INFILTRATES, CONSOLIDATION, ATELECTASIS, BRONCHIECTASIS, EMPHYSEMA, FIBROSIS, GROUND-GLASS OPACITIES, PLEURAL EFFUSION, PNEUMOTHORAX, LYMPHADENOPATHY, OR MASS

ILD PATTERN WHEN APPLICABLE

COMPARISON TO PRIOR IMAGING

RISK STRATIFICATION WHEN RELEVANT

NEED FOR REPEAT IMAGING, PET/CT, BIOPSY, BRONCHOSCOPY, REFERRAL, OR SURVEILLANCE

INH INHALER / DEVICE TECHNIQUE ASSESSMENT

8 TECHNIQUE & ADHERENCE

Document respiratory medication technique and adherence when assessed. Include:

CURRENT INHALERS AND NEBULIZED THERAPIES

CONTROLLER VERSUS RESCUE USE

FREQUENCY OF RESCUE MEDICATION USE

SPACER USE

INHALER TECHNIQUE OBSERVED

NEBULIZER EQUIPMENT FUNCTION

OXYGEN EQUIPMENT USE

CPAP/BIPAP ADHERENCE AND MASK FIT WHEN APPLICABLE

BARRIERS INCLUDING COST, ACCESS, COGNITION, DEXTERITY, OR MISUNDERSTANDING

EDUCATION PROVIDED AND TEACH-BACK IF PERFORMED

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

Document standardized pulmonary tools used and interpretation, if applicable. Include: Asthma Control Test · COPD Assessment Test · Modified Medical Research Council Dyspnea Scale · Epworth Sleepiness Scale · STOP-Bang · 6-minute walk distance · Borg dyspnea scale · Oxygen desaturation assessment · Pulmonary rehabilitation assessment · Smoking cessation readiness assessment · PHQ-9 / GAD-7 when respiratory symptoms affect mood or function. Include score, result, interpretation, comparison to prior results, and limitations.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Document pulmonology-relevant results reviewed or ordered. Include:

Pulmonary Function Testing:

Spirometry, lung volumes, DLCO, bronchodilator testing, FeNO, methacholine challenge, 6-minute walk test, or cardiopulmonary exercise testing.

Imaging:

Chest X-ray, CT chest, HRCT, CTA chest, PET/CT, V/Q scan, ultrasound, echocardiogram, or imaging relevant to pulmonary disease.

Laboratory Testing:

CBC with differential, eosinophil count, CMP, BNP/NT-proBNP, alpha-1 antitrypsin testing, IgE, allergy testing, autoimmune serologies, inflammatory markers, ABG/VBG, D-dimer when clinically relevant, or infection testing.

Microbiology:

Sputum culture, AFB testing, fungal culture, viral testing, pneumonia testing, TB testing, bronchoalveolar lavage results, or antibiotic sensitivities.

Sleep / Oxygen Testing:

Polysomnography, home sleep apnea test, overnight oximetry, PAP download, ambulatory oximetry, or oxygen qualification testing.

Cardiopulmonary Testing:

Echocardiogram, right heart catheterization, stress test, EKG, Holter monitor, or pulmonary hypertension-related testing when relevant.

Prior Records Reviewed:

Primary care notes, pulmonology records, hospital discharge summaries, ICU records, ED records, imaging reports, PFT reports, sleep study reports, medication history, oxygen supplier documentation, and outside records.

A ASSESSMENT

11 PULMONARY CLINICAL INTERPRETATION

Provide pulmonology-specific clinical interpretation: Primary pulmonary diagnosis or working diagnosis · Differential diagnoses considered for dyspnea, cough, wheeze, imaging abnormality, or hypoxemia · Severity, control status, and trajectory of respiratory disease · Exacerbation history and risk of future exacerbations · Functional limitation and oxygen requirement · Smoking, environmental, occupational, allergic, infectious, cardiac, autoimmune, thromboembolic, aspiration, sleep-related, or medication-related contributors · Pulmonary function, imaging, laboratory, microbiology, and sleep testing interpretation · Medication adherence, inhaler technique, response, side effects, and barriers · Need for medication adjustment, imaging surveillance, PFT monitoring, oxygen assessment, bronchoscopy, biopsy, pulmonary rehabilitation, sleep evaluation, referral, hospitalization, or urgent escalation.

P PLAN

12 PULMONOLOGY MANAGEMENT BY PROBLEM

Outline pulmonology management by problem. Include:

Dyspnea evaluation plan

including PFTs, imaging, cardiac evaluation, oxygen assessment, exercise testing, labs, and referral based on suspected etiology.

Asthma plan

including controller therapy, rescue therapy, inhaler technique, spacer use, trigger avoidance, allergy management, biologic eligibility when relevant, asthma action plan, and exacerbation precautions.

COPD plan

including inhaler optimization, smoking cessation, vaccination, pulmonary rehabilitation, oxygen assessment, exacerbation plan, sputum management, and monitoring.

Chronic cough plan

including evaluation for upper airway cough syndrome, asthma, GERD, ACE inhibitor use, infection, bronchiectasis, ILD, malignancy risk, and targeted treatment trial.

Abnormal imaging or lung nodule plan

including comparison imaging, surveillance interval, malignancy risk stratification, PET/CT, biopsy, bronchoscopy, interventional pulmonology referral, or thoracic surgery referral when indicated.

Interstitial lung disease plan

including HRCT review, autoimmune evaluation, exposure avoidance, antifibrotic or immunosuppressive therapy consideration, oxygen assessment, pulmonary rehabilitation, and specialty coordination.

Respiratory infection plan

including antibiotics if indicated, sputum culture, airway clearance, vaccination, recurrent infection workup, and follow-up imaging when appropriate.

Oxygen and ventilatory support plan

including oxygen prescription, ambulatory testing, nocturnal oxygen assessment, CPAP/BiPAP settings or adherence review, equipment troubleshooting, and safety counseling.

Smoking/vaping cessation plan

including counseling, nicotine replacement, pharmacotherapy, quit plan, behavioral support, lung cancer screening eligibility, and follow-up.

Pulmonary rehabilitation and lifestyle plan

including exercise tolerance, breathing techniques, activity pacing, nutrition, weight management, and functional goals.

Medication plan

including initiation, continuation, dose adjustment, discontinuation, refills, side effects, inhaler teaching, steroid precautions, and monitoring.

Referral and care coordination plan

with primary care, allergy/immunology, sleep medicine, interventional pulmonology, thoracic surgery, cardiology, rheumatology, infectious disease, pulmonary rehabilitation, oxygen supplier, or emergency care when indicated.

Patient education

regarding diagnosis, inhaler use, oxygen safety, trigger avoidance, vaccination, exacerbation plan, red flags, and when to seek urgent or emergency care.

F FOLLOW-UP

13 REASSESSMENT PLAN

Specify follow-up timeframe and purpose, including symptom reassessment, inhaler response, PFT review, imaging surveillance, oxygen reassessment, sleep study or PAP review, lab/microbiology review, smoking cessation follow-up, pulmonary rehabilitation progress, hospital follow-up, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

PULMONARY COUNSELING TIME

INHALER / DEVICE EDUCATION TIME

SMOKING CESSATION COUNSELING TIME, IF APPLICABLE

OXYGEN / PAP COUNSELING TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

TEST REVIEW TIME, IF APPLICABLE

14a BILLING CONSIDERATIONS — E/M / PULMONOLOGY CODING

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

PULMONARY FUNCTION TESTING CODE(S), IF APPLICABLE

6-MINUTE WALK / OXYGEN TESTING CODE(S), IF APPLICABLE

SMOKING CESSATION COUNSELING CODE(S), IF APPLICABLE

SLEEP / PAP MANAGEMENT CODE(S), IF APPLICABLE

CARE COORDINATION CODE(S), IF APPLICABLE

BASIS FOR BILLING: [TIME-BASED / MEDICAL DECISION MAKING / TEST INTERPRETATION / DEVICE MANAGEMENT / SMOKING CESSATION COUNSELING / CARE COORDINATION]

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

[SECONDARY RESPIRATORY / IMAGING / SYMPTOM DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: PULMONOLOGY

DATE

TIME