1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: PEDIATRIC DERMATOLOGY CONSULTATION / FOLLOW-UP / RASH EVALUATION / LESION EVALUATION / ACNE FOLLOW-UP / PROCEDURE FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / PEDIATRIC DERMATOLOGY CLINIC / DERMATOLOGY CLINIC / PRIMARY CARE / TELEHEALTH

PARENT / GUARDIAN PRESENT

INFORMANT / COLLATERAL SOURCE

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CHAPERONE PRESENT, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY PEDIATRIC DERMATOLOGY CONCERN

Document the primary pediatric dermatology-related reason for the visit in the patient's or caregiver's own words when possible, including rash, eczema, acne, birthmark, mole, wart, molluscum, hair loss, nail concern, itching, skin infection, diaper rash, vascular lesion, pigment change, medication reaction, skin lesion, or follow-up of a chronic skin condition.

S SUBJECTIVE

3 PATIENT- & CAREGIVER-REPORTED HISTORY

Document patient- and caregiver-reported skin, hair, nail, mucosal, systemic, medication, exposure, developmental, and treatment history.

3a PRESENTING CONCERN

Reason for Pediatric Dermatology Evaluation:

Document whether the visit is for initial evaluation, follow-up, rash evaluation, eczema management, acne treatment, birthmark evaluation, mole check, wart/molluscum treatment, hair/nail concern, infection concern, medication reaction, skin cancer screening in high-risk patient, biopsy review, or procedure follow-up.

History of Present Illness:

Document onset, duration, location, distribution, progression, severity, recurrence, associated symptoms, triggers, relieving factors, prior episodes, prior evaluations, treatments tried, response to treatment, and caregiver concerns.

Rash History:

Document location, spread, morphology if described, itching, pain, burning, drainage, scaling, crusting, blistering, swelling, fever, systemic symptoms, household contacts, school/daycare exposures, and pattern of flares/remissions.

Eczema / Atopic Dermatitis History:

Document affected areas, itch severity, sleep disruption, scratching, flare frequency, moisturization routine, bathing habits, soap/detergent exposure, topical steroid use, non-steroidal therapies, infection history, food allergy concerns, asthma, allergic rhinitis, and family history of atopy.

Acne History, if applicable:

Document age of onset, lesion type, distribution, severity, flares, menstrual association if applicable, scarring, post-inflammatory hyperpigmentation, prior therapies, response, irritation, adherence, and psychosocial impact.

3b LESION-SPECIFIC HISTORY

Birthmark / Vascular Lesion History:

Document presence at birth or onset timing, growth pattern, color change, ulceration, bleeding, pain, functional impairment, location, prior imaging, prior treatment, and associated syndromic concerns when relevant.

Pigmentary Concern:

Document hyperpigmentation, hypopigmentation, vitiligo-like changes, café-au-lait macules, congenital melanocytic nevi, onset, spread, triggers, family history, and associated systemic or developmental concerns when relevant.

Mole / Skin Lesion History:

Document new or changing lesions, size/color/shape change, itching, pain, bleeding, crusting, ulceration, trauma, prior biopsy, sun exposure, family history of melanoma, and caregiver concern.

Warts / Molluscum / Viral Lesions:

Document number, location, duration, spread, pain, itching, bleeding, prior treatments, household contacts, swimming/gym exposure, immunosuppression, and impact on school or activities.

Hair and Scalp Symptoms:

Document hair shedding, patchy hair loss, scalp itching, scaling, pain, pustules, broken hairs, hair practices, traction, chemical exposure, nutrition, stressors, infection exposure, and prior hair-loss treatment.

Nail Symptoms:

Document discoloration, thickening, pitting, brittleness, lifting, pain, drainage, trauma, fungal exposure, psoriasis history, eczema history, nail biting/picking, and treatments tried.

Diaper / Genital / Perianal Symptoms, if applicable:

Document diaper rash, itching, pain, fissures, discharge, bleeding, hygiene products, wipes, stool/urine exposure, toilet training, constipation, irritation, infection concerns, and chaperone use when examined.

3c EXPOSURES, DEVELOPMENT & BACKGROUND

Medication / Product Exposure History:

Document prescription medications, over-the-counter medications, supplements, recent new medications, topical products, sunscreens, cosmetics, hair products, fragrances, adhesives, diapers/wipes, detergents, and possible allergens or irritants.

Infectious Exposure History:

Document sick contacts, daycare/school exposure, household contacts with rash, travel, animal exposure, insect bites, sports/wrestling exposure, hot tub/pool exposure, fungal exposure, and prior skin infections.

Allergy / Atopy History:

Document eczema, asthma, allergic rhinitis, food allergies, medication allergies, urticaria, anaphylaxis history, and allergy testing if performed.

Birth / Developmental History:

Document prematurity, NICU stay, congenital findings, developmental delay, genetic/syndromic conditions, growth concerns, immunization status when relevant, and congenital skin findings.

Treatment History and Response:

Document topical medications, oral medications, biologics, phototherapy, procedures, wound care, moisturizers, barrier creams, sunscreen, antibiotics, antifungals, antivirals, adherence, side effects, and barriers to treatment.

Past Dermatologic History:

Include eczema, psoriasis, acne, hemangioma, vascular malformation, congenital nevus, alopecia, vitiligo, urticaria, contact dermatitis, recurrent skin infections, keloids, genetic skin disease, or prior dermatologic procedures.

Family History:

Document family history of eczema, asthma, allergies, psoriasis, autoimmune disease, melanoma, non-melanoma skin cancer, alopecia, vitiligo, vascular anomalies, genetic skin disease, or keloid tendency.

Social / Environmental History:

Document daycare/school exposure, sports, hobbies, pets, smoke exposure, sun exposure, sunscreen use, household products, living environment, swimming, occupational exposure for adolescents, and barriers to skin care or medication access.

Pertinent Negatives:

Document denial of red-flag symptoms when clinically relevant, including fever, rapidly spreading rash, severe pain, skin sloughing, mucosal involvement, eye pain, facial/lip/tongue swelling, breathing difficulty, non-blanching rash, purpura, severe medication reaction symptoms, immunosuppression-related concerns, or rapidly changing lesion.

ROS PEDIATRIC DERMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

Rash, itching, pain, burning, swelling, drainage, scaling, crusting, blistering, or ulceration

New, changing, bleeding, painful, or non-healing skin lesion

Eczema flare, sleep disruption from itching, scratching, or skin infection symptoms

Acne, scarring, pigment change, psychosocial impact, or treatment irritation

Hair loss, scalp scaling, scalp pain, nail changes, or mucosal lesions

Fever, fatigue, weight loss, joint pain, photosensitivity, oral ulcers, or systemic symptoms

Medication reaction symptoms, hives, swelling, respiratory symptoms, or mucosal involvement

School/daycare exposure, household rash, insect bites, animal exposure, or infectious contacts

O OBJECTIVE

5 OBSERVED FINDINGS

Document observed pediatric dermatology-relevant findings and age-appropriate examination details.

5a VITALS, IF OBTAINED

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT / LENGTH

WEIGHT

BMI

GROWTH PERCENTILES, IF APPLICABLE

PAIN SCORE, IF APPLICABLE

5b EXAMINATION

General Appearance:

Document alertness, distress level, age-appropriate behavior, interaction with caregiver, scratching, comfort level, hydration status, and overall clinical condition.

Skin Examination:

Document distribution, morphology, color, size, number, configuration, scale, crust, vesicles, bullae, pustules, erosions, ulcers, plaques, papules, nodules, macules, patches, excoriations, lichenification, atrophy, scarring, hyperpigmentation, hypopigmentation, and signs of infection.

Lesion-Specific Examination:

Document lesion location, size, shape, border, color variation, symmetry, elevation, surface changes, tenderness, bleeding, ulceration, dermoscopic features if used, and comparison to prior photographs or measurements.

Full-Body Skin Examination, if performed:

Document areas examined, areas not examined or deferred, caregiver presence, chaperone use when applicable, patient tolerance, benign lesions, suspicious lesions, birthmarks, nevi pattern, scars, and prior procedure sites.

Scalp / Hair:

Document hair density, hair-loss pattern, erythema, scale, pustules, scarring, broken hairs, traction signs, follicular openings, lymphadenopathy if tinea capitis is suspected, and pull test if performed.

Nails:

Document nail plate, nail bed, cuticle, periungual skin, pitting, onycholysis, thickening, discoloration, ridging, splinter hemorrhages, paronychia, trauma, or dystrophy.

Mucosa, if examined:

Document oral, lip, ocular, genital, or perianal mucosal findings, including ulcers, erosions, plaques, pigment changes, discharge, atrophy, tenderness, and exam limitations.

Lymph Nodes, if relevant:

Document cervical, axillary, epitrochlear, inguinal, or regional lymphadenopathy when infection, inflammatory disease, or malignancy is a concern.

Musculoskeletal, if relevant:

Document joint swelling, tenderness, range of motion, dactylitis, enthesitis, gait, or inflammatory arthritis-related findings when assessed.

MD PEDIATRIC DERMATOLOGIC MORPHOLOGY / DISTRIBUTION ASSESSMENT

6 MORPHOLOGY & PATTERN

Document lesion morphology and pattern using dermatologic terminology when applicable. Include:

PRIMARY LESION TYPE

SECONDARY SKIN CHANGES

DISTRIBUTION AND SYMMETRY

BODY SURFACE AREA AFFECTED WHEN RELEVANT

AGE-APPROPRIATE SEVERITY GRADING WHEN APPLICABLE

PRESENCE OF INFECTION, EXCORIATION, LICHENIFICATION, SCARRING, PIGMENT CHANGE, ULCERATION, OR MUCOSAL INVOLVEMENT

DERMOSCOPIC FINDINGS WHEN PERFORMED

COMPARISON WITH PRIOR PHOTOGRAPHS OR MEASUREMENTS

GROWTH, DEVELOPMENT, SLEEP, SCHOOL, ACTIVITY, OR PSYCHOSOCIAL IMPACT

PR PROCEDURES PERFORMED, IF APPLICABLE

7 IN-OFFICE PROCEDURES

Document pediatric dermatologic procedures performed during the visit. Include procedure name, indication, consent from parent/guardian when applicable, assent when appropriate, site verification, anesthesia if used, technique, specimen details, hemostasis, dressing, patient tolerance, complications, aftercare instructions, and pathology follow-up plan. Examples may include: Shave biopsy · Punch biopsy · Excisional biopsy · Cryotherapy · Cantharidin application · Wart treatment · Molluscum treatment · Intralesional injection · Incision and drainage · Skin culture collection · KOH prep · Wood's lamp examination · Suture removal · Wound care / dressing change · Laser treatment for vascular lesion when applicable · Phototherapy counseling or treatment documentation.

ST SCREENING / ASSESSMENT TOOLS

8 SCORES & INTERPRETATION

Document pediatric dermatology-specific tools used and interpretation, if applicable. Include: Body surface area estimate · Eczema Area and Severity Index · Scoring Atopic Dermatitis · Investigator Global Assessment · Psoriasis Area and Severity Index when appropriate · Acne severity grading · Pruritus numeric rating scale or age-appropriate itch scale · Pain scale appropriate for age · Dermatology Life Quality Index or Children's Dermatology Life Quality Index · Infant's Dermatitis Quality of Life Index when applicable · PHQ-9 / GAD-7 when adolescent psychosocial impact is relevant · Medication adherence assessment. Include score, result, interpretation, comparison to prior results, informant source, and limitations.

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED

Document pediatric dermatology-relevant results reviewed or ordered. Include:

Pathology:

Skin biopsy results, margin status, histologic diagnosis, immunostains, direct immunofluorescence, and pending pathology.

Microbiology:

Bacterial culture, fungal culture, viral PCR, HSV/VZV testing, wound culture, KOH prep findings, sensitivities, or tinea testing.

Laboratory Testing:

CBC, CMP, liver function, renal function, hepatitis/TB/HIV screening for systemic therapy, inflammatory markers, autoimmune labs, thyroid testing, ferritin, vitamin D, zinc, IgE, eosinophil count, or medication monitoring labs when relevant.

Allergy / Contact Dermatitis Testing:

Patch testing, allergy testing, suspected allergens, clinical relevance, and avoidance recommendations.

Imaging:

Ultrasound, MRI, CT, or other imaging for vascular anomalies, soft tissue infection, mass, lymph node concern, or systemic involvement when relevant.

Prior Records Reviewed:

Primary care notes, pediatric records, dermatology notes, allergy/immunology records, rheumatology notes, infectious disease records, operative reports, pathology reports, culture results, medication history, prior photographs, and outside records.

A ASSESSMENT

10 PEDIATRIC DERMATOLOGIC INTERPRETATION

Provide pediatric dermatology-specific clinical interpretation: Primary pediatric dermatologic diagnosis or working diagnosis · Differential diagnoses considered · Lesion or rash morphology, distribution, and severity · Acute versus chronic status · Infectious, inflammatory, autoimmune, allergic, medication-related, congenital, genetic, vascular, neoplastic, environmental, or irritant contributors · Presence or absence of concerning features for severe drug eruption, infection, systemic disease, malignancy, or urgent pediatric condition · Impact on sleep, feeding, growth, school, activities, development, or psychosocial well-being · Treatment response, adherence, side effects, and caregiver barriers · Pathology, culture, lab, dermoscopy, imaging, or photograph correlation with clinical findings · Need for biopsy, culture, labs, medication adjustment, procedural treatment, systemic therapy, referral, family education, or urgent escalation.

P PLAN

11 PEDIATRIC DERMATOLOGY MANAGEMENT BY PROBLEM

Outline pediatric dermatology management by problem. Include:

Topical treatment plan

including medication name, application site, frequency, duration, amount, steroid potency counseling, age-appropriate safety precautions, moisturizer/barrier care, and caregiver instructions.

Systemic treatment plan

including oral medications, biologics, immunosuppressants, antibiotics, antifungals, antivirals, antihistamines, monitoring labs, contraindications, weight-based dosing considerations, and safety counseling.

Eczema/dermatitis plan

including gentle skin care, bathing routine, moisturizer regimen, topical anti-inflammatory plan, wet wraps if appropriate, trigger avoidance, infection prevention, and flare plan.

Acne plan

including topical regimen, oral therapy when appropriate, hormonal therapy considerations for adolescents when relevant, irritation management, pregnancy precautions when applicable, adherence support, and scarring prevention.

Wart/molluscum plan

including observation versus treatment, cryotherapy, cantharidin, topical options, contagion counseling, skin irritation precautions, and school/activity guidance.

Infection plan

including culture, antimicrobial selection, hygiene measures, household precautions, decolonization when appropriate, return-to-school/activity guidance, and warning signs.

Birthmark/vascular lesion plan

including observation, photography, measurement, propranolol or other therapy when appropriate, laser referral, imaging, ophthalmology or specialty referral when indicated, and complication precautions.

Hair/nail plan

including fungal testing, scalp care, topical/oral therapy, nutrition evaluation, traction avoidance, family education, and follow-up monitoring.

Procedure plan

including biopsy, cryotherapy, injection, culture, wound care, pathology follow-up, aftercare, pain control, and return precautions.

Medication monitoring plan

including labs, infection risk counseling, immunization considerations, pregnancy precautions for adolescents when relevant, and follow-up schedule.

Sun protection and skin cancer prevention plan

including sunscreen, protective clothing, avoidance of tanning beds, sunburn prevention, self/parent-assisted skin checks, and surveillance interval when indicated.

Referral and care coordination plan

with pediatric dermatology subspecialty services, dermatologic surgery, vascular anomalies clinic, allergy/immunology, rheumatology, infectious disease, genetics, oncology, wound care, primary care, or emergency care when indicated.

Patient and caregiver education

regarding diagnosis, expected course, medication use, skin care routine, contagion precautions when relevant, procedure aftercare, red flags, and when to seek urgent or emergency care.

F FOLLOW-UP

12 REASSESSMENT PLAN

Specify follow-up timeframe and purpose, including treatment response, rash reassessment, lesion monitoring, biopsy/pathology review, culture review, suture removal, medication monitoring, procedure follow-up, chronic disease management, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

CAREGIVER COUNSELING TIME

MEDICATION / SKIN CARE EDUCATION TIME

PROCEDURE TIME, IF APPLICABLE

MEDICATION MONITORING TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

13a BILLING CONSIDERATIONS — E/M / PEDIATRIC DERMATOLOGY CODING

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

BIOPSY CODE(S), IF APPLICABLE

DESTRUCTION / CRYOTHERAPY CODE(S), IF APPLICABLE

INJECTION CODE(S), IF APPLICABLE

CULTURE / KOH / DIAGNOSTIC TEST CODE(S), IF APPLICABLE

PROCEDURE CODE(S), IF APPLICABLE

BASIS FOR BILLING: [TIME-BASED / MEDICAL DECISION MAKING / PROCEDURE-BASED / TEST INTERPRETATION / CHRONIC DISEASE MANAGEMENT]

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

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

SO SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: PEDIATRIC DERMATOLOGY

DATE

TIME