1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: RHEUMATOLOGY CONSULTATION / FOLLOW-UP / MEDICATION MANAGEMENT / BIOLOGIC THERAPY FOLLOW-UP / LAB REVIEW / TELEHEALTH

CARE SETTING: OUTPATIENT / RHEUMATOLOGY CLINIC / INFUSION CENTER / HOSPITAL / TELEHEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

Document the primary rheumatology-related reason for the visit in the patient's own words when possible, including joint pain, joint swelling, morning stiffness, inflammatory arthritis, rheumatoid arthritis, lupus, connective tissue disease, autoimmune disease, gout, vasculitis, muscle weakness, abnormal autoimmune labs, medication monitoring, biologic therapy follow-up, flare evaluation, or chronic musculoskeletal pain.

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

Document patient-reported rheumatologic symptoms, flare pattern, autoimmune features, functional impact, treatment history, medication response, and systemic involvement.

3a PRESENTING SYMPTOMS

Reason for Rheumatology Evaluation:

Document whether the visit is for initial rheumatology consultation, inflammatory arthritis evaluation, autoimmune disease evaluation, established rheumatologic disease follow-up, medication monitoring, biologic therapy management, flare assessment, abnormal serology review, gout management, vasculitis evaluation, connective tissue disease evaluation, or hospital follow-up.

History of Present Illness:

Document symptom onset, duration, progression, affected joints or body regions, symmetry, severity, flare frequency, triggers, relieving factors, prior episodes, previous evaluations, treatments tried, response, and patient concerns.

Joint Pain / Arthritis Symptoms:

Document affected joints, swelling, warmth, redness, stiffness, tenderness, deformity, range-of-motion limitation, inflammatory versus mechanical pattern, morning stiffness duration, gelling phenomenon, and impact on daily activities.

Inflammatory Arthritis Features:

Document prolonged morning stiffness, improvement with movement, nocturnal pain, symmetric small joint involvement, swollen joints, dactylitis, enthesitis, inflammatory back pain, uveitis history, psoriasis, bowel symptoms, and family history.

Flare History:

Document flare onset, duration, frequency, severity, affected areas, functional impact, medication changes, infection or stress triggers, response to steroids/NSAIDs/DMARDs, and current flare status.

Functional Status:

Document ability to walk, climb stairs, grip, dress, bathe, cook, work, exercise, perform ADLs/IADLs, use assistive devices, and any disability or work limitations related to rheumatologic disease.

Constitutional Symptoms:

Document fatigue, fever, weight loss, night sweats, malaise, appetite change, and relationship of constitutional symptoms to disease activity.

3b SYSTEMIC REVIEW

Skin / Mucosal Symptoms:

Document rash, photosensitivity, malar rash, discoid lesions, psoriasis, oral ulcers, nasal ulcers, alopecia, skin thickening, digital ulcers, nodules, livedo, purpura, urticaria, Raynaud symptoms, or nail changes.

Eye Symptoms:

Document dry eyes, eye pain, redness, photophobia, blurry vision, uveitis, scleritis, episcleritis, vision changes, and ophthalmology involvement.

Oral / Sicca Symptoms:

Document dry mouth, dental caries, oral ulcers, dysphagia, parotid swelling, need for water to swallow, and sicca symptom severity.

Cardiopulmonary Symptoms:

Document chest pain, pleuritic pain, dyspnea, cough, wheezing, palpitations, edema, pulmonary hypertension symptoms, interstitial lung disease symptoms, and prior cardiac or pulmonary testing.

Gastrointestinal Symptoms:

Document abdominal pain, diarrhea, blood in stool, reflux, dysphagia, liver disease, inflammatory bowel disease symptoms, medication-related GI symptoms, and NSAID tolerance.

Renal / Urinary Symptoms:

Document hematuria, foamy urine, edema, hypertension, kidney disease history, urinary symptoms, and prior nephrology involvement.

Neurologic Symptoms:

Document numbness, tingling, weakness, foot drop, headache, seizures, cognitive changes, neuropathy symptoms, balance concerns, or neurologic deficits.

Muscle Symptoms:

Document proximal muscle weakness, myalgias, difficulty rising from chair, difficulty lifting arms overhead, dysphagia, dark urine, exercise intolerance, and statin or medication exposure.

Gout / Crystal Arthritis Symptoms, if applicable:

Document episodic monoarthritis, affected joints, redness, swelling, dietary triggers, alcohol intake, kidney stones, tophi, uric acid history, flare medications, urate-lowering therapy, and adherence.

Vasculitis Symptoms, if applicable:

Document purpura, ulcers, neuropathy, sinus symptoms, hemoptysis, renal symptoms, headache, jaw claudication, vision symptoms, limb claudication, constitutional symptoms, and organ involvement.

3c TREATMENT & BACKGROUND

Medication History and Response:

Document NSAIDs, corticosteroids, hydroxychloroquine, methotrexate, leflunomide, sulfasalazine, azathioprine, mycophenolate, cyclophosphamide, biologics, JAK inhibitors, colchicine, allopurinol, febuxostat, infusion therapy, adherence, response, side effects, refill needs, and access barriers.

Immunosuppression / Infection Risk:

Document recent infections, chronic infections, TB/hepatitis history, vaccine status, exposure risks, opportunistic infection history, wound healing, and medication holds around infection or surgery when relevant.

Past Medical and Surgical History:

Include autoimmune disease, inflammatory arthritis, chronic pain, osteoarthritis, osteoporosis, kidney disease, liver disease, malignancy, thromboembolic disease, cardiovascular disease, diabetes, infections, pregnancy history when relevant, and prior surgeries.

Family History:

Document family history of rheumatoid arthritis, lupus, psoriasis, inflammatory bowel disease, ankylosing spondylitis, gout, autoimmune thyroid disease, vasculitis, connective tissue disease, or other autoimmune conditions.

Social / Occupational History:

Document occupation, activity level, tobacco/nicotine use, alcohol use, substance use, diet, exercise, pregnancy intentions when relevant, social support, disability status, medication access, and barriers to care.

Pertinent Negatives:

Document denial of red-flag or systemic symptoms when clinically relevant, including fever, severe weakness, vision loss, jaw claudication, chest pain, severe dyspnea, hemoptysis, hematuria, neurologic deficit, severe infection symptoms, uncontrolled pain, or rapidly progressive swelling.

ROS RHEUMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

Joint pain, swelling, warmth, stiffness, deformity, morning stiffness, or functional limitation

Back pain, inflammatory back symptoms, enthesitis, dactylitis, or tendon pain

Rash, photosensitivity, oral/nasal ulcers, alopecia, Raynaud symptoms, nodules, or skin thickening

Dry eyes, dry mouth, eye pain, redness, photophobia, or vision changes

Fatigue, fever, weight loss, night sweats, or constitutional symptoms

Chest pain, dyspnea, cough, pleuritic pain, palpitations, or edema

Abdominal pain, diarrhea, blood in stool, reflux, dysphagia, or liver symptoms

Hematuria, foamy urine, edema, hypertension, or renal concerns

Numbness, tingling, weakness, headache, seizures, or neurologic symptoms

Medication side effects, infection symptoms, immunosuppression concerns, or adherence barriers

O OBJECTIVE

5 EXAMINATION

Document observed rheumatology-relevant findings and examination details.

5a VITALS

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

5b EXAMINATION

General Appearance:

Document alertness, distress level, fatigue appearance, body habitus, mobility, assistive device use, and overall clinical condition.

Head / Eyes / Ears / Nose / Throat:

Document conjunctival injection, scleral inflammation, dry eyes, oral ulcers, nasal ulcers, salivary pooling, parotid enlargement, mucosal lesions, and dental findings when relevant.

Neck:

Document lymphadenopathy, thyroid findings, range of motion, tenderness, masses, or cervical spine limitation.

Cardiovascular:

Document rate, rhythm, murmurs, rubs, edema, pulses, perfusion, Raynaud changes, digital ischemia, and findings relevant to vasculitis or pulmonary hypertension.

Pulmonary:

Document respiratory effort, breath sounds, crackles, wheezing, pleural rub, oxygen requirement, and findings concerning for interstitial lung disease, pleuritis, or infection.

Abdomen:

Document tenderness, distension, hepatosplenomegaly, ascites, masses, and medication-related or systemic disease findings.

Musculoskeletal:

Document joint tenderness, swelling, warmth, deformity, range of motion, synovitis, effusions, nodules, dactylitis, enthesitis, axial tenderness, muscle tenderness, strength, gait, and functional limitations.

Joint Examination:

Document involved joints systematically, including hands, wrists, elbows, shoulders, hips, knees, ankles, feet, spine, temporomandibular joints, and sacroiliac region when relevant.

Skin:

Document rash, psoriasis, malar rash, discoid lesions, photosensitive rash, purpura, livedo, nodules, tophi, ulcers, sclerodactyly, telangiectasias, calcinosis, digital pits, nail changes, bruising, and injection-site reactions.

Neurologic:

Document mental status, strength, sensation, reflexes, gait, neuropathy findings, focal deficits, and proximal muscle weakness when assessed.

Psychiatric:

Document mood, affect, coping, anxiety, depression symptoms, pain behavior, insight, judgment, and safety concerns when relevant.

DA JOINT / DISEASE ACTIVITY ASSESSMENT

6 ACTIVITY & FINDINGS

Document rheumatologic disease activity and physical findings. Include:

TENDER JOINT COUNT

SWOLLEN JOINT COUNT

MORNING STIFFNESS DURATION

FUNCTIONAL LIMITATIONS

PATIENT GLOBAL ASSESSMENT WHEN AVAILABLE

PROVIDER GLOBAL ASSESSMENT WHEN AVAILABLE

DISEASE ACTIVITY SCORE WHEN USED

FLARE STATUS

EXTRA-ARTICULAR MANIFESTATIONS

DAMAGE OR DEFORMITY

COMPARISON TO PRIOR EXAMINATION

RESPONSE TO CURRENT THERAPY

MM MEDICATION / IMMUNOSUPPRESSION MONITORING

7 SAFETY REVIEW

Document medication safety review and monitoring. Include:

CURRENT DMARDS, BIOLOGICS, JAK INHIBITORS, STEROIDS, NSAIDS, URATE-LOWERING THERAPY, OR OTHER RHEUMATOLOGIC MEDICATIONS

DOSE, ROUTE, FREQUENCY, AND ADHERENCE

RESPONSE AND RESIDUAL SYMPTOMS

SIDE EFFECTS AND TOXICITY SYMPTOMS

INFECTION HISTORY AND MEDICATION HOLDS

LAB MONITORING STATUS

TB, HEPATITIS, HIV, OR OTHER SCREENING WHEN RELEVANT

VACCINE STATUS AND COUNSELING

PREGNANCY INTENTIONS OR CONTRACEPTION COUNSELING WHEN RELEVANT

PERIOPERATIVE MEDICATION GUIDANCE WHEN APPLICABLE

REFILL NEEDS AND INSURANCE/ACCESS BARRIERS

PR PROCEDURES PERFORMED, IF APPLICABLE

8 RHEUMATOLOGY PROCEDURES

Document rheumatology procedures performed during the visit. Include procedure name, indication, consent, site verification, sterile technique, anesthesia if used, approach, aspirated fluid description if applicable, medication injected if applicable, dose, lot number when relevant, patient tolerance, complications, aftercare instructions, and follow-up plan. Examples may include: Joint aspiration · Corticosteroid joint injection · Tendon sheath injection · Bursa injection · Trigger point injection · Musculoskeletal ultrasound · Ultrasound-guided injection · Synovial fluid analysis collection · Infusion therapy documentation · Skin or salivary gland biopsy coordination when relevant

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

Document standardized tools used and interpretation, if applicable. Include: RAPID3 · DAS28 · CDAI / SDAI · HAQ-DI · BASDAI / ASDAS · SLEDAI when applicable · Patient global assessment · Pain scale · Fatigue scale · Fibromyalgia symptom severity score when relevant · Gout flare frequency and serum urate target assessment · FRAX when bone health is relevant · PHQ-9 / GAD-7 when chronic disease impact is relevant · Medication adherence assessment. Include score, result, interpretation, comparison to prior results, and limitations.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Document rheumatology-relevant results reviewed or ordered. Include:

Inflammatory Markers:

ESR, CRP, ferritin, complement levels, and disease-specific inflammatory trends.

Autoimmune Serologies:

ANA, ENA panel, anti-dsDNA, anti-Smith, RNP, SSA/SSB, RF, anti-CCP, ANCA, antiphospholipid antibodies, myositis panel, HLA-B27, complement C3/C4, or other disease-specific serologies.

Medication Monitoring Labs:

CBC, CMP, liver function, renal function, urinalysis, urine protein/creatinine ratio, creatine kinase, aldolase, hepatitis/TB screening, lipid panel for JAK inhibitors, and therapy-specific labs.

Crystal Arthritis Testing:

Serum uric acid, synovial fluid cell count, Gram stain/culture, crystal analysis, and renal function.

Infectious Screening:

TB testing, hepatitis B/C, HIV testing when indicated and consented, vaccine titers, and infection-related labs.

Imaging:

X-rays, ultrasound, MRI, CT, DEXA, chest imaging, sacroiliac imaging, joint imaging, or vascular imaging when relevant.

Cardiopulmonary Testing:

Echocardiogram, PFTs, HRCT, EKG, right heart catheterization, or other testing for systemic autoimmune involvement.

Pathology / Biopsy:

Skin biopsy, temporal artery biopsy, kidney biopsy, muscle biopsy, salivary gland biopsy, synovial biopsy, or other tissue diagnosis when relevant.

Prior Records Reviewed:

Primary care notes, rheumatology notes, hospital records, nephrology notes, dermatology notes, pulmonology notes, ophthalmology notes, imaging reports, lab trends, infusion records, and outside records.

A ASSESSMENT

11 RHEUMATOLOGIC INTERPRETATION

Provide rheumatology-specific clinical interpretation: Primary rheumatologic diagnosis or working diagnosis · Differential diagnoses considered · Disease activity: controlled, low, moderate, high, flare, remission, or uncertain · Presence or absence of synovitis, extra-articular manifestations, systemic involvement, organ-threatening disease, or damage · Functional impact and quality-of-life burden · Lab, imaging, pathology, and exam correlation · Medication response, adherence, side effects, toxicity, and monitoring needs · Infection risk and immunosuppression safety considerations · Pregnancy, fertility, vaccination, perioperative, or comorbidity considerations when relevant · Need for medication initiation, escalation, taper, lab monitoring, imaging, procedure, infusion, referral, hospitalization, or urgent escalation

P PLAN

12 MANAGEMENT BY PROBLEM

Outline rheumatology management by problem. Include:

Diagnostic plan,

including autoimmune serologies, inflammatory markers, medication monitoring labs, urinalysis, imaging, ultrasound, biopsy, synovial fluid analysis, or organ-specific evaluation based on symptoms.

Disease-specific treatment plan,

including DMARDs, biologics, JAK inhibitors, NSAIDs, corticosteroids, colchicine, urate-lowering therapy, immunosuppressants, or supportive treatment when appropriate.

Flare management plan,

including short-term anti-inflammatory therapy, steroid taper or injection when appropriate, infection exclusion, medication adjustment, and monitoring.

Medication monitoring plan,

including lab schedule, toxicity symptoms, infection precautions, vaccine review, pregnancy precautions, drug interactions, refill plan, and adherence counseling.

Steroid-sparing plan,

including escalation or adjustment of long-term therapy, taper strategy, bone protection, glucose/BP monitoring, and risk mitigation.

Joint-specific plan,

including aspiration/injection, physical therapy, occupational therapy, bracing, assistive devices, exercise, and orthopedic referral when indicated.

Systemic involvement plan,

including renal, pulmonary, cardiac, neurologic, dermatologic, ophthalmologic, hematologic, or GI evaluation and subspecialty coordination.

Bone health plan,

including DEXA, calcium/vitamin D assessment, osteoporosis treatment, fall prevention, and steroid-related fracture risk mitigation when relevant.

Lifestyle and risk reduction plan,

including smoking cessation, physical activity, weight management, sleep, nutrition, cardiovascular risk reduction, gout dietary guidance when relevant, and infection prevention.

Referral and care coordination plan

with primary care, nephrology, pulmonology, cardiology, dermatology, ophthalmology, neurology, gastroenterology, orthopedics, physical therapy, occupational therapy, pain management, or emergency care when indicated.

Patient education

regarding diagnosis, disease monitoring, medication use, lab monitoring, flare plan, infection precautions, vaccination, red flags, and when to seek urgent or emergency care.

F FOLLOW-UP

13 REASSESSMENT PLAN

Specify follow-up timeframe and purpose, including disease activity reassessment, flare follow-up, medication monitoring, lab review, imaging review, injection follow-up, infusion monitoring, specialist coordination, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

RHEUMATOLOGY COUNSELING TIME

MEDICATION / IMMUNOSUPPRESSION COUNSELING TIME

PROCEDURE TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

LAB / IMAGING REVIEW TIME, IF APPLICABLE

14a BILLING CONSIDERATIONS — E/M / RHEUMATOLOGY CODING

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

JOINT INJECTION / ASPIRATION CODE(S), IF APPLICABLE

MUSCULOSKELETAL ULTRASOUND CODE(S), IF APPLICABLE

INFUSION MANAGEMENT CODE(S), IF APPLICABLE

MEDICATION MONITORING / HIGH-RISK DRUG THERAPY DOCUMENTATION, IF APPLICABLE

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

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

[SECONDARY AUTOIMMUNE / JOINT / MEDICATION MONITORING / SYMPTOM DIAGNOSIS CODE(S), IF APPLICABLE]

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME | CREDENTIALS | SPECIALTY: RHEUMATOLOGY

DATE | TIME