1. PATIENT INFORMATION

a. Date of visit
   - Month: 2
   - Day: 0
   - Year: 0

b. Sex
   - Female: Yes
   - Male: No

3. REASON FOR VISIT

   a. As specifically as possible, list diagnoses related to this visit including chronic conditions.
      - (1) Primary diagnosis:
        - Arthritis
      - (2) Other:
        - Asthma
        - Cancer
      - (3) Other:
        - Chronic problem, flare-up

6. VITAL SIGNS

   a. Height: 6 ft
   - In: 0 in
   - cm

   b. Weight: 0
   - lbs
   - kg

   c. Temperature: 0
   - F
   - C

   d. Blood pressure: 0
   - mm Hg

7. DIAGNOSTIC/SCREENING SERVICES

   a. Mark (X) all ordered or provided at this visit.
      - Blood tests:
      - CBC (complete blood count)
      - Electrolytes
      - Glucose
      - HgbA1C (glycohemoglobin)
      - Lipids/Cholesterol
      - PSA (prostate specific antigen)
      - Other blood test

   b. Mark (X) if list or ordered or provided at this visit.
      - Tobacco use
      - Other mental health counseling
      - Other non-surgical procedures

10. MEDICATIONS & IMMUNIZATIONS

   a. Include Rx and OTC drugs, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during the visit.

   b. Mark (X) all providers seen at this visit.
      - Physician
      - Physician assistant
      - Nurse practitioner/ Midwife
      - RNL/PNL
      - Other

12. VISIT DISPOSITION

   a. Mark (X) all that apply.
      - No follow-up planned
      - Telephone follow-up planned
      - Other

   b. Mark (X) if follow-up is needed, PRN
      - Physician
      - Other
      - Refer to emergency department

   c. Mark (X) if transfer to another hospital
      - Admit to hospital
      - Other