Tips for Note Writing

CC: should technically be in patient's own words

HPI:
- first line should include only the pertinent medical hx that relates to the chief complaint
- go in to the interview with a differential diagnosis in your mind; can achieve this by chart review beforehand
- ask questions based on your differential diagnosis, use the OLDCARTS method
- update your differential in your mind as the interview progresses
- goal = your reader or listener should be able to read/hear your thought process and by the end of the HPI he/she should know what you will place at the top of your differential
- only include the negative/positive ROS at the end of the HPI that is relevant to the chief complaint; ie if someone presents with knee pain, don't note that the person also has constipation in the HPI, you can report this later
- if recently hospitalized or with recent complicated course, it is helpful to present the past story first in order to put the current situation into perspective = present chronologically

Allergies: list allergies and reactions if known

Medications:
- always do this yourself, NEVER trust the system
- if patients don't know you can call their pharmacy
- for prn medications, often helpful to know how frequently they are actually using them (ie use of albuterol in a patient with asthma can tell you the severity of his/her disease)
- time of last dose for relevant medications (ie immunosuppressants, weekly meds, etc)

PMH/PSH:
- always obtain yourself, the dot phrase will rarely be updated
- list diagnoses and relevant details including year of diagnosis, status (ie last a1c for DM, last EF for CHF, or staging/chemo/xrt information for cancer)
- list years if known for surgeries
- review the med list to look for additional medical problems that the pt does not report
- often helpful to know who the patient's other physicians are; if OSH, helpful to know phone numbers

FH:
- review all family hx
- always ask additional family hx relevant to the chief complaint (ie in a patient who presents with joint pain, always ask about other autoimmune/rheumatologic conditions in the family; or a new patient with concern for cancer ask about other cancers in the family

SH:
- alcohol: ask them to be specific about amount/frequency, if concerned always ask about hx or prior use or withdrawal
- illicits: be specific, always name the drugs and ask specifically about IVDU
- tobacco: ask present or past hx, again quantify
- work: should know this as many times this contributes to our understanding of the chief complaint (ie pt with new lung mass has hx of chemical factory work, or preschool teacher with new diarrheal illness could suggest adenovirus)
- social: important to understand social support especially related to dispo issues (ie does an elderly patient live alone and will need to go to SNF)
    - especially in elderly patients, always assess for ability to perform ADLs
    - ask about home environment
        - ie flights of stairs, a safe or suitable environment ?
        - or ask about home allergens (mold, carpet vs. hardwood), pets, etc if appropriate to the chief complaint

M. Edwards Updated 3/1/19

ROS:

- record both those noted in the HPI and all the rest; make sure to tailor the ROS especially to the HPI
- "ROS otherwise negative" is not acceptable
    - do not know what you have and have not asked
    - cannot bill for this

Exam:

- vitals, complete when inpatient, weight when relevant, peak flow when relevant, etc
- i/os if relevant
    - in chf patients, most helpful to know daily net or admission to date net
- be comprehensive but also tailor to the chief complaint
    - joint pains – do full MSK exam to eval for synovitis
    - easy bruising – look at gums, in nose, rectal to eval for other e/o bleeding
    - specific tests for certain complaints – ie dix hallpike for dizziness

Labs:

- highlight labs pertinent to the chief complaint
    - concern for clot – Ddimer
    - concern for leukemia – cbc and the diff
    - vasculitis – ESR/CRP
    - sarcoid – ACE level
    - rhabdo – CPK, aldolase
    - heart attack – lipids

Imaging:

- all admission imaging
- include past imaging that may be helpful to current complaint
    - ie chest ct 5 years ago with pulm nodule in a patient now with hemoptysis
    - most recent echo in a patient with CHF
    - most recent stress in a patient with CAD

EKG: your read; include tele for daily notes in this area

Assessment:

- who, pertinent medical hx related to chief complaint, chief complaint, what was done initially and since admission, what we are doing going forward
    - IE: 67yo F with hx of HTN, HL, and CAD s/p 3v CABG who presents with chest pain, ruled out for ACS, and now awaiting repeat cath for further evaluation.

Plan:

- order the plan based on the importance of problems, most often the chief complaint is the first problem
- for all the chief complaints include a differential diagnosis
- organize the differential from most likely to least likely
    - often list first, ie unstable angina vs. PE vs. GERD vs. MSK pain; then can justify the reason for and against each
- information for each problem can be listed as follows:
    - pertinent vitals
    - pertinent and pending labs
    - pertinent and pending imaging
    - active medications used for the problem
    - further interventions pending
    - consults and recs

- next problems should be anything else noted on admission that needs to be addressed and is not encompassed by the chief complaint, ie new AKI or hyponatremia or protein gap or lung mass noted on admission labs or imaging
- next should be the chronic medical problems
- review the med list for additional medical problems
- FEN, Proph (GI, DVT)
- Dispo: always include, need to have a plan in place for discharge when appropriate
- Contact: person who is POA or dedicated representative, include contact number in case of emergency
- Code status