Writing General OPD Notes

- Clinical documentation is essential for communication between health care professional to ensure safe and effective care. It also forms the basis of evidence of care to be used for insurance purposes, legal analysis, quality improvement and research.
- Good notes need to be clear, concise and complete, but without duplicating information. They should be completed as soon as possible after an episode of care.
- Do not copy and paste
- Interns should consult for each case. Record who you consulted with and what was communicated

1. NEW PATIENT or PATIENT WITH NO COMPREHENSIVE HISTORY IN OUR SYSTEM

SUBJECTIVE:

- You do not need to write down everything from the list below in your notes, but please consider each aspect as you take the history and include relevant details. Consider the differential diagnosis as you ask questions.
- Remember that if you allow the patient to speak first ('the golden minute') you will often get a lot of information

CC	**** year old female/male patient with PMH of *** is here today for ****
HPI	• Include location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms • Make sure to document presence/absence of RED FLAGS • If multiple presenting problems then make a problem list and tackle each issue separately
ROS	Include pertinent ones from relevant organ system; don't forget **mental health**
ICE	Explore patient's ideas, concerns and expectations – try to find out if there is something in particular they are expecting or worried about
Meds	• Include **generic** name of medication instead of brand, as well as doses and when last taken • Encourage patient to bring all medication to every visit • Don't forget **contraception**!
Allergies	Medication and reaction
PMSH	• Hx of chronic illnesses • Hx of surgery • Any admissions • Hx of transfusions • Obstetric history and **LMP**
FSH	• Work, home, social support structures • NHIF or other insurance • FH of cardiovascular dx/cancer/autoimmune as pertinent • Alcohol, tobacco, drug use • **Spiritual history**
Preventative health	As appropriate to age/gender: • Cardiovascular (BMI, BP, DM screen, CKD screen) • Pap/VIA/HPV • Mammogram • Colon CA screening (FIT or colonoscopy) • Family planning • HIV/Hep B • Immunizations

OBJECTIVE:

(Document what you examined! "*Exam benign*" is not adequate)

- **Appearance/general**
- **Vital signs** (Complete set - any abnormal vitals make sure to comment in your assessment)
- **Focused physical exam** as indicated by history
- **Investigations:** Any from elsewhere. Document to show you have reviewed.

ASSESSMENT AND PLAN:

Impression – what do you think is going on? (not just a summary)
Include your **differential diagnosis**: *"Differential includes ……. Most likely diagnosis is ……."*

Plan for investigations or interventions (if required) – consent should be documented for any propsed interventions

- Review with results (indicate **time** that this is done)
- If addressing **multiple problems** can put assessment and plan for each problem, e.g.:
  # Abdominal pain – Suspect GERD. Negative h pylori.
    - *Trial of antiacid tabs PRN*
    - *Dietary changes*

  # HTN – Not well controlled
    - *increase losartan to 50mg BD, Continue HCTZ 12.5mg OD*
    - *decrease salt in diet, discussed importance of exercise*
    - *check BP at home 2x/week and bring record to next visit*

  # Knee pain – Osteoarthritis right knee, moderate.
    - *PT consult*
    - *Analgesia with diclofenac gel and PCM*
- Be sure to include **follow-up plan and safety netting**
- **ICD-10 diagnosis** – ensure this is accurate, even if you have to change the diagnosis after results; give more than one diagnosis if relevant
- If you have consulted with someone more senior, make sure you document who this was and what was communicated

2. PATIENT ON FOLLOW UP

SUBJECTIVE

CC	*** year old female/male patient with PMH of *** is here today for follow-up of ***
HPI	• Use a **problem list format** again here for chronic illnesses and multiple complaints. Interval history since last visit, how are the symptoms/illnesses progressing. • Any new complaints do a full HPI.
Problem list: e.g.	*# Knee pain: Still having a lot of pain despite PT* *# HTN: Has been compliant with meds and low salt diet. Not checked BP at home* *# Abdominal pain: Improved with dietary changes, only occasionally needing antacid tabs*
Updated medication list	• Include **generic** name of medication instead of brand, as well as doses and when last taken. • Encourage patient to bring all medication to every visit
PMSH	PMSH can be reviewed and verified from previous notes – record that this has been done, but no need to write everything out again if it is correct.

OBJECTIVE

- Appearance/general
- Vital signs
- Focused physical exam as indicated by history
- Investigations: Any new ones from last visit

ASSESSMENT & PLAN

- Document progress and current state, again use problem list format for multiple problems/conditions. Give your impression of what is going on.
- Be sure to include **follow-up plan and safety netting**.
- **ICD-10 diagnosis** – ensure this is accurate, even if you have to change the diagnosis after results; give more than one diagnosis if relevant
- If you have consulted with someone more senior, make sure you document who this was and what was communicated