UNIVERSITY OF MEDICAL CENTER
ENDOCRINOLOGY, DIABETES AND NUTRITION
INPATIENT FOLLOW-UP VISIT NOTE

Phone Fax

PATIENT STAMP

☐ Inpatient F/U ☐ Consultation F/U

Date of Service: _____ **Time:** _____ **Patient Name:** _____

Chief Complaint _____

Interval History _____

Review of Systems _____

Medications: _____

☐ ROS unobtainable (explain in space above)
☐ ROS is completely unchanged from _____ (date)

Teaching Physician History Supplement

Date: _____ Time: _____

☐ I reviewed the resident/fellow's CC, IH, ROS and agree with the above) _____
Initials of TP

PHYSICAL EXAM

System	Element	Resident/Fellow Exam	Teaching Physician Exam
Constitutional	☐ nl general appearance RR: _____ Pulse: _____	BP: _____ Temp: _____	
Ears, Nose, Mouth & Throat	☐ nl nasal mucosa, septum & turb ☐ nl teeth, gums ☐ nl oropharynx		
Neck	☐ nl neck appearance ☐ nl jugular veins ☐ thyroid normal size, without nodules		
Respiratory	☐ nl ausculation ☐ nl chest percussion		
Cardiovascular	☐ reg rhythm, no murm, gallop, rubs ☐ nl carotid pulse, no bruits		
Gastrointestinal	☐ no tenderness or masses ☐ no hepatosplenomegaly		
Lymph Nodes	☐ no neck, supraclav, axil, or ing adenop		
Musculoskeletal	☐ nl muscle strength, tone & motion ☐ nl gait & station		
Extremities	☐ no clubbing, cyanosis or edema ☐ no lesions ☐ nails normal ☐ nl DP, PT pulses		
Skin	☐ no rashes, lesions or ulcers		
Neuro/Psychiatric	☐ alert and oriented ☐ nl mood & affect ☐ CN2-12 intact ☐ light tough, vibratory, proprioception intact ☐ nl DTR		
Other:			

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Patient Name _____ Medical Record No. _____

Problem Focused = 1-5 elements; Expanded Problem Focused = ≥6 elements; Detailed = ≥12 elements;
Comprehensive = all elements for first 6 systems (Constitutional through Gastrointestinal) + 1 element in every other system

NOTABLE LABS:

CBC

SMA-7

T Bili _____
ALT _____
AST _____
AlKP _____

TC	_____	Urine microalbumin	_____	HgbAlc	_____
TG	_____	U/A	_____	TSH	_____
LDL	_____	Calcium	_____	T4	_____
HDL	_____	Phosphorus	_____	T3	_____
		Albumin	_____	Thy. Aby	_____

Other Labs: _____
EKG: _____
Radiologic Studies: _____

Glucose Measurements and Insulin Dose

Date	B	L	D	HS		

Assessment/Plan: 1) amount/complexity of data 2) number of diagnosis and treatment options 3) risk of complications

Patient Name ______________________________ Medical Record No. __________

Teaching Physician: Assessment and plan reviewed with resident/fellow, labs/tests are as above and I confirm/revise the differential diagnosis as follows: ________
Initials of TP

- ❑ I personally performed the key portions of the H&P and reviewed the resident/fellow's documentation.
- ❑ I was present during and observed the resident/fellow perform the key portions of the H&P.
- ❑ I engaged in the E&M without the resident/fellow.

Signature of Resident/Fellow Physician	ID #	Signature of Teaching Physician	ID #
Printed Name of Resident/Fellow Physician		Printed Name of Teaching Physician	

❑ Subsequent Inpatient Care 9923____ (1-3) ❑ Follow-up Consult 9926 ____ (1-3) ❑ Sep Procedure (-25)

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