Outpatient Osteopathic SOAP Note—Follow-up Form

Usage Guide

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Outpatient Osteopathic SOAP Note—Follow-up Form
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Outpatient Osteopathic SOAP Note—Follow-up Form

wak SOAP Follow-up version 2:011403b

Patient's Name _____ Date _____ ☐ Male ☐ Female ☐

Age _____ * Vital Signs (3 of 7) Wt. _____ Temp. _____

Reg. ☐ Pt. position for recording BP

Resp. ____ Pulse ____ Irreg. ☐ Standing_____ Sitting_____ Lying_____

Office of:	
For office use only:	

Section I

S **Patient's Pain Analog Scale:** ☐ Not done

NO PAIN WORST POSSIBLE PAIN

CC: HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated Signs and Sx)

PFSH: ROS: (Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic)

Meds:

Section II

Level: HPI

II	1-3HPI
III	1-3 HPI
IV	4+ HPI
V	4+ HPI

Level ROS

II	None
III	1 ROS
IV	2-9 ROS
V	10 + ROS

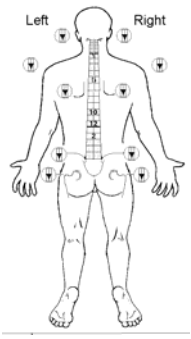
Level of PFSH

II	None
III	None
IV	1 PFSH
V	2 + PFSH

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O

Section III



Level of GMS

☐	II	1-5 elements
☐	III	6 + elements
☐	IV	2 + from each of 6 areas OR 12 + elements in 2 + areas
☐	V	2 + elements from each of 9 areas

Signature of transcriber: _____ Signature of examiner: _____

Funded by a grant from the Bureau of Research.
Designed to coordinate with the Initial Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

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Office of:	
For Office use only:	

Section I

Patient's Name _____ **Date** _____

O (continued)

Exam Method Used

Severity Scale: **0** = No SD or background (BG) levels **1** = More than BG level, minor TART **2** = Obvious TART (esp. R and T), + /- symptoms **3** = Key lesions, symptomatic, R and T stands out

☐ All not done

	All	T	A	R	T	Region	Severity 0	1	2	3	Somatic Dysfunction / Other MS/SNS/PNS/LYM/CV/RESP/GI/FAS/ etc.	OMT Y	N	Treatment Method (Circle Method Used)	Response R	I	U	W
*1						Head and Face	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Neck	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*2						Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Sacrum / Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Pelvis / Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Abd ./ Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*3						Upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*4						Extremity L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*5						Lower R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*6						Extremity L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Section II

Physician's evaluation of patient prior to treatment: First visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

Dx No.	Written Diagnosis	ICD Code
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dx No.	Written Diagnosis	ICD Code
_____	_____	739.0
_____	_____	739.1
_____	_____	739.2
_____	SD Ribs	739.8
_____	SD Lumbar	739.3

Dx No.	Written Diagnosis	ICD Code
_____	SD Sacrum	739.4
_____	SD Pelvis	739.5
_____	SD Abd / Other	739.9
_____	SD Upper Extremity	739.7
_____	SD Lower Extremity	739.6

Section III

P

Meds: PT:

Exercise: Other:

Nutrition:

Section IV

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ☐ W ☐ M ☐ Y ☐ PRN

Complexity / Assessment / Plan (Scoring) **Requires only 2 of the 3 below (Problems, Risk and Data). Level of complexity = average of the 3 categories recorded**

Problems		Risk (presenting problem(s), diagnostic procedure(s), management options)		Data	Maximum Points
Self-limiting	1 (2 max.)	Minimal = Min.		Lab	1
Established problem improved / stable	1	Low		Radiology	1
Established—worsening.	2	Moderate = Mod.		Medicine	1
New—no workup	3 (1 max.)	High		Discuss with performing physician	1
New—additional workup	4			Obtain records or Hx from others	1
				Review records, discuss with physician	2
				Visualization of tracing, specimen	2

Problems Level I	Level II	Level III	Level IV	Level V	Risk Level I	Level II	Level III	Level IV	Level V	Data Level I	Level II	Level III	Level IV	Level V
------	≤1 pt.	2 pt.	3 pt.	≥4 pt.	-------	Min.			High	-------	≤1 pt.	2 pt.	3 pt.	≥4 pt.
☐	☐	☐	☐	☐	☐	☐			☐	☐	☐	☐	☐	☐

Section V

Traditional Method—Coding by Components

Average of three levels equals final level of service.

	I	II	III	IV	V
History					
Examination					
Complexity / Assessment / Plan	--------				
Final level of service	☐	☐	☐	☐	☐

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time
Dictate total time and counseling / coordinating time plus a brief description of topics discussed

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)	---------	10	15	25	40
Final level of service	☐	☐	☐	☐	☐

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed: CPT Codes: _____ _____ _____ Written Dx: _____ _____ _____

Section VI

E/M Code: New ☐ ☐ ☐ ☐ ☐ **EST** ☐ ☐ ☐ ☐ ☐ **Consults** ☐ ☐ ☐ ☐ ☐

Write 992 plus . . . *02 03 04 05 . . . 11 12 13 14 15 . . . 41 42 43 44 45*

Signature of transcriber: _____ Signature of examiner: _____

Funded by a grant from the Bureau of Research.
Designed to coordinate with the Initial Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic SOAP Note---Follow-up Form

Introduction:

The following Outpatient Osteopathic SOAP Note Follow-up Form was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized, and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. Data can be collected and analyzed by a computer. Additions to the form can be made. If data were not obtained for a certain section, leave it blank or fill in the "not done" rectangle. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

Page 1 of 2 "S" Subjective and "O" Objective Form

Section I: Patient's Identification and Vital Signs

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of this visit. Use the following format for all dates: month/day/year.

Sex: Fill in the box after **Male** or **Female** with regards to the patient's gender.

Age: Write in the patient's age in years. If a child, use days up to 1 month, use months up to 1 year, and years of age.

Vital Signs: Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. **Wt.** (weight in pounds, lbs.), 2. **Ht.** (height in feet and inches, ft., in.), 3. **Temp.** (temperature in degrees Fahrenheit), 4. **Resp.** (rate of respiration in breaths-per-minute), 5. **Pulse** (in beats per minute) and whether it is regular (**Reg.**) or irregular (**Irreg.),** 6. **BP** (blood pressure) **Standing**, **Sitting**, and 7. **BP Lying** down. If a measurement was not taken, leave the space blank.

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

Section II: "S" Subjective

S: for the **Subjective** part of the **S**OAP Note.

Patient's Pain Analog Scale: The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have **NO PAIN**, place a mark at the far left side. If this is the **WORST POSSIBLE PAIN** you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time." If the patient doesn't have pain or this information was not obtained, fill in the "**Not done**" rectangle.

CC Stands for **Chief Complaint**, which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that are the reason for the encounter. **CC** usually is stated in the patient's words. Write the **CC** in the open area next to the meds section.

HPI Stands for **History of Present Illness,** which is a chronological description of the development of the patient's present illness, from the first sign and/or symptom to the present. This includes a description of location, quality, severity, duration, timing, context, modifying factors, and

associated signs and symptoms significantly related to the presenting problem(s). Write the **HPI** in the open area next to the meds section and check off those descriptors included to the right of the HPI title. The HPI might also include the status of 3 or more chronic or inactive conditions.

PFSH Stands for **Past Medical, Family, Social History.** The **Past History** is a review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries, prior operations, prior hospitalizations, allergies, age-appropriate immunization status, and age-appropriate feeding/dietary status. The **Family History** is a review of medical events in the patient's family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or Systems Review; diseases of family that may be hereditary or place the patient at risk. The **Social History** is an age-appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors. Write the **PFSH** in the open area next to the meds section.

ROS Stands for **Review of Systems** which is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT, the following systems review has been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI (Gastrointestinal), GU (Genitourinary), Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, and Allergic/Immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data for other systems that might be affected by any possible management options. Write the **ROS** in the open area next to the meds section and check off those descriptors included to the right of the ROS title.

Meds: Write in the current **Medications,** dosage, route and frequency of administration.

Level: HPI: This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Circle the Roman numeral that applies. The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level **II** (99212) or **III** (99213) code requires **1-3 HPI** elements to qualify. A level **IV** (99214) or **V** (99215) code requires **4+ HPI** elements OR mention of the status of ≥ 3 chronic conditions.

Level: ROS: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level **II** (99212) requires no **(none) ROS**. Level **III** (99213) requires **1 ROS** pertinent to the problem. Level **IV** (99214) requires **2-9 ROS**. Level **V** (99215) requires listing of **10+ ROS**. Circle the Roman numeral that applies.

Level: PFSH: The Roman numerals stand for the level of the established outpatient visit for which the patient qualifies. A level **II** (99212) and **III** (99213) requires that no (**none**) history areas be present. Level **IV** (99214) requires **1 PFSH** area. Level **V** (99215) requires **2+ PFSH** areas. Circle the Roman numeral that applies.

Overall History: Fill in the rectangle that indicates the **average** level determined using the level of **HPI, ROS** or **PFSH** provided. A level **II** includes **1-3 HPI**. A level **III** includes **1-3 HPI** and **1ROS.** A level **IV** includes **4+ HPI, 2-9 ROS** and **1 PFSH**. A level **V** includes **4+ HPI, 10+ ROS** and **2+ PFSH.**

Section III: "O" Objective

O: for the Objective part of the S**O**AP Note. Physical exam findings for any areas/systems of the **G**eneral **M**ulti-**S**ystem **E**xamination **(GMS)** are recorded in this section. These include: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Cardiovascular, Respiratory, Chest (Breasts), Gastrointestinal (Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, and Psychiatric. The table that follows on page 2 of 2 provides a section

where specific somatic dysfunctions of the musculoskeletal exam can be recorded and documented.

Horizontal Planes (Diagram): The diagram can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram can also be used to denote such things as lateral curvatures, the AP weight bearing line, or any other documentation that may be helpful.)

Level of GMS (General Multi-System): This is a guide for criteria needed to justify your evaluation and management CPT code in the **O**bjective section. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

- **II** **1-5 elements:** For a level **II** (99212) visit you must have examined one to five elements identified by a bullet.
- **III** **6+ elements:** For a level **III** (99213) visit you must have examined at least six elements identified by a bullet.
- **IV** **2+ from each of 6 areas OR 12+ elements in 2+ areas:** For a level **IV** (99214) visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems **OR** at least twelve elements identified by a bullet in two or more areas/systems.
- **V** **2+ elements from each of 9 areas:** For a level **V** (99215) visit, you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.

Be advised that for the **Musculoskeletal Exam**, the six areas are: (1) head, face, and neck; (2) spine, ribs, and pelvis; (3) right upper extremity; (4) left upper extremity; (5) right lower extremity; (6) left lower extremity.

Warning: For a comprehensive level of exam, all four of the elements identified in **TART** must be performed and documented for each of four of the six anatomic areas plus examination of gait and station and inspection and/or palpation of digits and nails. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

Page 2 of 2 "O" Objective Findings (cont.): "A" Assessment and "P" Plan Form

Section I: Patient's Name and Date

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit (month/day/year).

The boxes marked **Office of:** and **For office use only:** can be used for tracking a research study, for office record keeping, etc.

Section II: Objective Findings (cont.): Musculoskeletal Table

Exam Method Used: Be sure to place an oblique line through the box indicating the tools used for your examination (**T**, **A**, **R**, **T**). Included in the definition of these components are the criteria required for coding in each body area.

- **All:** Indicates that all **TART** criteria were used to examine a region
- **T:** **Tissue Texture Change,** stability, laxity, effusions, tone
- **A:** **Asymmetry,** misalignment, crepitation, defects, masses
- **R:** **Range-of-Motion,** contracture
- **T:** **Tenderness,** pain

Filling in the rectangles is a shortcut to a full narrative documentation in the **Somatic Dysfunction/Other** section of this table.

Region Evaluated: This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: ***1. Head and Face**, and **Neck**; ***2.** The spine (**Thoracic**, **Ribs**, **Lumbar, Sacrum/Pelvis**, **Pelvis/Innom.**, and

Abd./Other); ***3. Right Upper Extremity**; ***4. Left Upper Extremity**; ***5. Right Lower Extremity**; and ***6. Left Lower Extremity**. The thoracic region is broken down into three parts based on vertebral levels for innervation specificity: **T1-4**, **T5-9**, and **T10-12**. This provides for ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

Severity: This section refers to the severity [None (**0**), mild (**1**), moderate (**2**), severe (**3**)] of the most affected somatic dysfunction in a region. Fill in a rectangle for each region examined. For regions that are not examined, leave the rectangle empty.

If a rectangle is **not marked** in a region, it is assumed that that region was **not examined**. For regions that are examined, the scale is as follows:

0 None	No somatic dysfunction present or background (BG) level.
1 Mild	More than background level, minor **TART** elements.
2 Moderate	Obvious **TART**; in particular **R**ange-of-motion (**R**) and/or **T**issue texture change (**T**) may or may not be overtly symptomatic.
3 Severe	Key lesions observed, significant, symptomatic, stands out; **R** and/or **T** elements stand out with minimum search or provocation.

(At the top of the table is a **Key to the Severity Scale**, which provides for a quick review.)

Somatic Dysfunction/Other: Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions, including musculoskeletal (MS), sympathetic nervous system (SNS), parasympathetic nervous system (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial (FAS), etc., components. Use standard terminology.
If you filled in rectangles under **TART**, you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

OMT: Fill in the **Y**es rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the **N**o rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be boxes for **Exam Method Used** and **Severity** (1, 2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 2).

Treatment Method: Listed here are the abbreviations of osteopathic manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Circle the abbreviation that correspond to the modalities used to treat each region.

ART:	articulatory treatment
BLT:	balanced ligamentous tension / ligamentous articular strain treatment
CR:	cranial treatment / osteopathy in the cranial field / cranial osteopathy
CS:	counterstrain treatment
DIR:	direct treatment
FPR:	facilitated positional release treatment
HVLA:	high velocity/low amplitude treatment (thrust treatment)
IND:	indirect treatment
INR:	integrated neuromuscular release
LAS:	ligamentous articular strain / balanced ligamentous tension treatment
ME:	muscle energy treatment
MFR:	myofascial release treatment
ST:	soft tissue treatment
VIS:	visceral manipulative treatment

Response: Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment

immediately after treatment. The rectangles are indicated as follows:

- **R:** The somatic dysfunction is completely **R**esolved without evidence of it ever having been present.
- **I:** The somatic dysfunction is **I**mproved but not completely resolved.
- **U:** The somatic dysfunction is **U**nchanged or the same after treatment as it was before treatment.
- **W:** The somatic dysfunction is **W**orse or aggravated immediately after treatment.

Physician's Evaluation of Patient Prior to Treatment: This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment as compared to the previous visit(s):

First visit: If this is the patient's first visit for a particular problem, mark the rectangle after **First visit.**

Resolved: If the problem for which a follow-up visit was requested is resolved, mark the b rectangle after **R**esolved. Example: If a patient presents for a follow-up on a musculoskeletal problem, filling in the **Resolved** rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings being found, and that you also filled in the **0** (zero) rectangle in the severity column for that region in the Musculoskeletal Table.

Improved: If the problem for which a follow-up visit was requested is improved, but not totally resolved, mark the rectangle after **Improved**.

Unchanged: If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the **Unchanged** rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

Worse: If the problem for which a follow-up visit was requested is worse than it was at the last visit, mark the rectangle after **Worse**. This could occur with a musculoskeletal problem if no treatment was started at the prior visit, the patient did something to aggravate their condition, or the patient had a complication or side effect of treatment given at the last visit. This refers to the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e., a flare-up from the last treatment. Flare-up information can be charted in the **S**ubjective section of these forms (found on page 1 of 2).

Section III: "A" Assessment

A: for the Assessment part of the SO**A**P note

Dx No. (diagnosis number): Write in your priority numbers in the **Dx No.** columns, with "1" being the number of the patient's most severe or addressed diagnosis at this visit.

Written Diagnosis: Write on this line the description for each of your ICD codes, if not already listed.

ICD Code: Write on this line the ICD code that corresponds to your diagnosis, if it has not already been written in.

Note: Somatic dysfunction written diagnoses and ICD codes have been written in for convenience. Only the diagnosis priority number needs to be added if needed.

Section IV: "P" Plan

P: for the Plan part of the SOA**P** note.

Meds: List in this space any medications issues that were addressed or new medications that will be started as a result of this visit. Dosage, route, administration, risks, benefits, and potential side effects can be listed here.

Exercise: List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught, or given as handouts.

Nutrition: List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently receives, has

received in the office, or that you recommend they receive or do.

Other: List in this space anything that does not fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list the topics discussed, the details that were included, the handouts or educational materials given, and what referrals were made.

Minutes Spent With the Patient: Blacken the rectangle that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit (10, 15, 25, 40, 60, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the box that best fits your total time.

Follow-up & Units: Blacken the rectangle that correspond to when you would like to see the patient again; you must indicate both the number and the **Units**. For example: for a visit in one month, blacken the box above the "**1**" and also the rectangle above "**M**" (month).**Units** abbreviations are as follow: **D** (days), **W** (week), **M** (month) **Y** (year), and **PRN** (as needed).

Section V: Determination of Coding for Evaluation and Management

Complexity / Assessment / Plan (Scoring): Only two of the following three categories (**Problems**, **Risk**, **Data**) are required for an established visit. Note that there are five levels and four rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate rectangle under one of the four levels. The total level for complexity is the average of the included areas (**Problems, Risk, and Data**).

Problems: Find which criteria match this visit. This could be **Self-limiting**, **Established problem—improved /stable**, **Established–worsening**, **New—no workup**, or **New—additional workup**. Add points or number of problems that fit this patient in each category. Find **level** of problems by placing the total points under one of the four levels and blacken the appropriate rectangle.

Risk: Find which criteria match this visit. This could be **Minimal**, **Low**, **Moderate**, or **High** based on presenting problems, diagnostic procedures, and management options. Find the **level** of risk under one of the four levels and blacken the appropriate rectangle. OMT is low risk (level III).

Data: Find which criteria match this visit. This could be **Lab**, **Radiology**, **Medicine**, **Discuss with performing physician**, **Obtain records or Hx from others**, **Review records, discuss with physician**, or **Visualization of tracing**, **specimen**. Find the **level** of data by placing the total points under one of the four levels and blacken the appropriate rectangle.

Traditional Method—Coding by Components:

For each **History, Examination,** and **Complexity / Assessment / Plan** section, put a circle around the appropriate composite level. Then blacken the rectangle in the **Final Level of Service** that denotes the average of the three categories recorded.

Optional Method—Coding by Time:

When the majority of the Encounter (50% or greater) is counseling / coordinating, the Final Level of Service is determined by total time spent with the patient. Blacken the appropriate rectangle that indicates the total time of the visit: New patients (minutes)—10, 20, 30, 45, 60; Established patients (minutes)—10, 15, 25, 40. Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient.)

Section VI: Final E/M and CPT Coding

OMT performed as above: Fill in the rectangle for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of **Y**es boxes in the OMT section, and the number of boxes in the severity section marked with a 1, 2, or 3 of the musculoskeletal table on this page. The rectangles are defined as follows:

0 **areas:** You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.

1-2 areas: You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.

3-4 areas: You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.

5-6 areas: You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.

7-8 areas: You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.

9-10 areas: You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

Other Procedures Performed: In the spaces provided, write in the **CPT Codes** and written diagnosis **(Written Dx)** for each procedure performed, other than OMT.

E/M Code: Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (**New**) use 992**02**, 992**03**, 992**04**, 992**05**. For an established patient visit (**EST**) use 992**11**, 992**12**, 992**13**, 992**14**, 992**15**. For a consultation visit (**Consults**) use 992**41**, 992**42**, 992**43**, 992**44**, 992**45**.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign, if this is appropriate.

D: \Sleszynski \ SOAP Note—Follow-up Usage Form
Version 2:011403bw

Outpatient Osteopathic SOAP Note—Follow-up Form

wak SOAP Follow-up version 2:011403b

Patient's Name Renee Jones Date 1/1/98 Sex: Male ☐ Female ▌

Age 25 * Vital Signs (3 of 7) Wt. 130 lb. Ht. 5' 5" Temp. 98°

Reg. ▌ Pt. position for recording BP

Resp. 20 Pulse 80 Irreg. ☐ Standing_____ Sitting 120/80 Lying_____

Office of:	
For office use only:	

S **Patient's Pain Analog Scale:** ☐ Not done

Stomach

NO PAIN ✓ ✓ ✓ ✓ ✓ ✓ WORST POSSIBLE PAIN

CC: HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated Signs and Sx)

PFSH: ROS: (Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic)

Meds:

Norflex 100 mg BID

Stomach ache started 2 days ago

Hurts mostly in the mid epigastric area

Helped with eating or bed rest

ϕ nausea / vomiting

Mild back pain

ϕ radiation

Had a Flare x 1d after last OMT

Poor sleep secondary to pain

Level: HPI

II	1-3HPI
III	1-3 HPI
IV	4+ HPI
V	4+ HPI

Level ROS

II	None
III	1 ROS
IV	2-9 ROS
V	10 + ROS

Level of PFSH

II	None
III	None
IV	1 PFSH
V	2 + PFSH

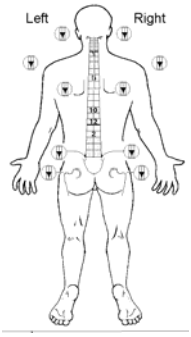
Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ▌ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O

Abdomen - tender epigastrium, bowel sounds are present

∅ masses

UE bilateral muscle strength 5 / 5



Level of GMS

☐	II	1-5 elements
☐	III	6 + elements
▌	IV	2 + from each of 6 areas OR 12 + elements in 2 + areas
☐	V	2 + elements from each of 9 areas

Signature of transcriber: TML Signature of examiner: SLSleszynskiDO

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Designed to coordinate with the Initial Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic SOAP Note—Follow-up Form

wak SOAP Follow-up version 2:011403b

Office of:	
For Office use only:	

Patient's Name Renne Jones **Date** 1/1/98

O (continued)

Exam Method Used

Severity Scale: **0** = No SD or background (BG) levels **1** = More than BG level, minor TART **2** = Obvious TART (esp. R and T), + /- symptoms **3** = Key lesions, symptomatic, R and T stands out

☐ All not done

	All	T	A	R	T	Region	Severity 0	1	2	3	Somatic Dysfunction / Other (MS/SNS/PNS/LYM/CV/RESP/GI/FAS/ etc.)	OMT Y	N	Treatment Method (Circle Method Used)	Response R	I	U	W
*1				/		Head and Face	☐	■	☐	☐		☐	■	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
	/					Neck	☐	☐	■	☐	C2 FSRL with GI reflexes	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
*2	/					Thoracic T1-4	☐	☐	☐	■	T3 FSRL with TT change	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
	/					T5-9	☐	☐	☐	■	T5 FSRR and T7 FSRL with GI	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
						T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
			/			Ribs	☐	☐	■	☐	Myofascial strain	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
	/					Lumbar	☐	■	☐	☐		☐	■	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
	/					Sacrum / Pelvis	■	☐	☐	☐	WNL	☐	■	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Pelvis / Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
		/		/	/	Abd ./ Other	☐	☐	☐	■	GE sphinc. C-clock, G. curve tender	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	■	☐	☐
*3						Upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*4						Extremity L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*5		/			/	Lower R	☐	☐	☐	■	TFL tender	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐
*6		/			/	Extremity L	☐	☐	☐	■	TFL tender	■	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	■	☐	☐	☐

Physician's evaluation of patient prior to treatment: First visit ■ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

Dx No.	Written Diagnosis	ICD Code
1	Gastritis, acute	535.00
2	Thoracic strain	847.1

Dx No.	Written Diagnosis	ICD Code
	SD Head and Face	739.0
5	SD Neck	739.1
3	SD Thoracic	739.2
7	SD Ribs	739.8
	SD Lumbar	739.3

Dx No.	Written Diagnosis	ICD Code
	SD Sacrum	739.4
	SD Pelvis	739.5
4	SD Abd / Other	739.9
	SD Upper Extremity	739.7
6	SD Lower Extremity	739.6

P

Meds: Add Prilosec 20 mg po qd

PT: Hot packs done for 15 minutes for tissue changes in cervicals / thoracics

Exercise: Shoulder rolls given

Other: Emotional support given for 5 minutes

Nutrition: Bland diet

Minutes spent with the patient: ☐ 10 ☐ 15 ■ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ■ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ■ W ☐ M ☐ Y ☐ PRN

Complexity / Assessment / Plan (Scoring) Requires only 2 of the 3 below (Problems, Risk and Data). Level of complexity = average of the 3 categories recorded

Problems		Risk (presenting problem(s), diagnostic procedure(s), management options)		Data	Maximum Points
Self-limiting	1 (2 max.)	Minimal = Min.		Lab	1
Established problem improved / stable	1	Low		Radiology	1
Established—worsening.	2	Moderate = Mod.		Medicine	1
New—no workup	3 (1 max.)	High		Discuss with performing physician	1
New—additional workup	4			Obtain records or Hx from others	1
				Review records, discuss with physician	2
				Visualization of tracing, specimen	2

Problems	Level I	Level II	Level III	Level IV	Level V
	------	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	■	

Risk	Level I	Level II	Level III	Level IV	Level V
	-------	Min.	Low	Mod.	High
	☐	☐	☐	■	☐

Data	Level I	Level II	Level III	Level IV	Level V
	-------	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☐	☐

Traditional Method—Coding by Components

Average of three levels equals final level of service.

	I	II	III	IV	V
History	I	II	III	IV	V
Examination	I	II	III	IV	V
Complexity / Assessment / Plan	-------	II	III	IV	V
Final level of service	☐	☐	☐	■	☐

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time
Dictate total time and counseling / coordinating time plus a brief description of topics discussed

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)	---------	10	15	25	40
Final level of service	☐	☐	☐	☐	☐

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ■ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed:

CPT Codes:	97010	97110	
Written Dx:	Hot packs	Exercise training	

E/M Code: **New** ☐ ☐ ☐ ☐ **EST** ☐ ☐ ☐ ■ ☐ **Consults** ☐ ☐ ☐ ☐ ☐

Write 992 plus . . . 02 03 04 05 . . . 11 12 13 14 15 . . . 41 42 43 44 45

Signature of transcriber: _____ Signature of examiner: SLSleszynskiDO

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Outpatient Osteopathic SOAP Note—Follow-up Form

wak SOAP Follow-up version 2:011403b

Patient's Name _____ Date _____ Sex: Male ☐ Female ☐

Office of:	
For office use only:	

Age _____ * Vital Signs (3 of 7) Wt. _____ Ht. _____ Temp. _____

Reg. ☐ Pt. position for recording BP

Resp. ____ Pulse ____ Irreg. ☐ Standing_____ Sitting_____ Lying_____

S **Patient's Pain Analog Scale:** ☐ Not done

NO PAIN WORST POSSIBLE PAIN

CC: HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying factors, Associated Signs and Sx)

PFSH: ROS: (Constitutional, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic)

Meds:

Level: HPI

II	1-3HPI
III	1-3 HPI
IV	4+ HPI
V	4+ HPI

Level ROS

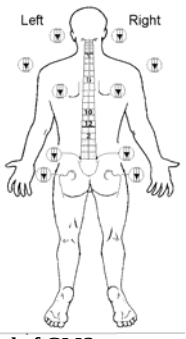
II	None
III	1 ROS
IV	2-9 ROS
V	10 + ROS

Level of PFSH

II	None
III	None
IV	1 PFSH
V	2 + PFSH

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O



Level of GMS

☐	II	1-5 elements
☐	III	6 + elements
☐	IV	2 + from each of 6 areas OR 12 + elements in 2 + areas
☐	V	2 + elements from each of 9 areas

Signature of transcriber: _____ Signature of examiner: _____

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Outpatient Osteopathic SOAP Note—Follow-up Form

wak SOAP Follow-up version 2:011403b

Office of:	
For Office use only:	

Patient's Name _____ **Date** _____

O (continued)

Exam Method Used

Severity Scale: **0** = No SD or background (BG) levels **1** = More than BG level, minor TART **2** = Obvious TART (esp. R and T), + /- symptoms **3** = Key lesions, symptomatic, R and T stands out

☐ All not done

	All	T	A	R	T	Region	Severity 0	1	2	3	Somatic Dysfunction / Other MS/SNS/PNS/LYM/CV/RESP/GI/FAS/ etc.	OMT Y	N	Treatment Method (Circle Method Used)	Response R	I	U	W
*1						Head and Face	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Neck	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*2						Thoracic T1-4	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						T5-9	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						T10-12	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Ribs	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Lumbar	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Sacrum / Pelvis	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Pelvis / Innom.	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
						Abd ./ Other	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*3						Upper R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*4						Extremity L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*5						Lower R	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐
*6						Extremity L	☐	☐	☐	☐		☐	☐	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	☐	☐	☐	☐

Physician's evaluation of patient prior to treatment: First visit ☐ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

A

Dx No.	Written Diagnosis	ICD Code	Dx No.	Written Diagnosis	ICD Code	Dx No.	Written Diagnosis	ICD Code
				SD Head and Face	739.0		SD Sacrum	739.4
				SD Neck	739.1		SD Pelvis	739.5
				SD Thoracic	739.2		SD Abd / Other	739.9
				SD Ribs	739.8		SD Upper Extremity	739.7
				SD Lumbar	739.3		SD Lower Extremity	739.6

P

Meds: PT:

Exercise: Other:

Nutrition:

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60

Follow-up: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Units: ☐ D ☐ W ☐ M ☐ Y ☐ PRN

Complexity / Assessment / Plan (Scoring)

Requires only 2 of the 3 below (Problems, Risk and Data). Level of complexity = average of the 3 categories recorded

Problems		Risk (presenting problem(s), diagnostic procedure(s), management options)		Data	Maximum Points
Self-limiting	1 (2 max.)	Minimal = Min.		Lab	1
Established problem improved / stable	1	Low		Radiology	1
Established—worsening.	2	Moderate = Mod.		Medicine	1
New—no workup	3 (1 max.)	High		Discuss with performing physician	1
New—additional workup	4			Obtain records or Hx from others	1
				Review records, discuss with physician	2
				Visualization of tracing, specimen	2

Problems	Level I	Level II	Level III	Level IV	Level V
	------	≤1 pt. ☐	2 pt. ☐	3 pt. ☐	≥4 pt. ☐

Risk	Level I	Level II	Level III	Level IV	Level V
	--------	Min. ☐	Low ☐	Mod. ☐	High ☐

Data	Level I	Level II	Level III	Level IV	Level V
	-------	≤1 pt. ☐	2 pt. ☐	3 pt. ☐	≥4 pt. ☐

Traditional Method—Coding by Components

Average of three levels equals final level of service.

History	I	II	III	IV	V
Examination	I	II	III	IV	V
Complexity / Assessment / Plan	--------	II	III	IV	V
Final level of service	☐	☐	☐	☐	☐

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time
Dictate total time and counseling / coordinating time plus a brief description of topics discussed

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Established patients (minutes)	---------	10	15	25	40
Final level of service	☐	☐	☐	☐	☐

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed: CPT Codes: _____ _____ _____ _____

Written Dx: _____ _____ _____ _____

E/M Code: New ☐ ☐ ☐ ☐ **EST** ☐ ☐ ☐ ☐ ☐ **Consults** ☐ ☐ ☐ ☐ ☐

Write 992 plus . . . *02 03 04 05 . . . 11 12 13 14 15 . . . 41 42 43 44 45*

Signature of transcriber: _____ Signature of examiner: _____

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