Sample History and Physical Note
Charting Plus™ - Electronic Medical Records
www.foxmeadows.com

Note for Cameron Carre on 04/01/2003 - Chart 18205

Chief Complaint (1/1): This 55 year old male presents today for evaluation of chest pain.
Cardiac associated signs and symptoms: Pain radiating to the arm and shortness of breath.
Cardiac duration: Symptom has existed for an intermittent time.
Cardiac location: Midsternal.
Cardiac onset: Onset of the symptom was 5 months ago.
Cardiac quality: Patient describes discomfort as: pressure.
Cardiac modifying factors: Exertion worsens condition.
Cardiac severity: Severity of condition is worsening.

Patient has the following coronary risk factors: elevated cholesterol for less than 1 year and HTN for 13 years.

Allergies: No known medical allergies.
Medication History: Patient is currently taking hydrochlorothiazide 25 mg tablet (one po daily), Lipitor 20 mg tablet (once daily) usage started on 04/01/2003.
Past Medical History: Cardiovascular Hx: (+) high cholesterol, (+) hypertension, **Psychiatric Hx:** (+) depression, **Neurological Hx:** (+) migraines.
PSH: No previous surgeries.
Social History: Patient is married. Patient admits walking on a treadmill until symptoms begin.
Family History: Patient denies a family history of premature cardiovascular disease.
Review of Systems: Cardiovascular: (+) chest pain, (+) arm pain. The remainder of his review of systems is negative.

General: Patient is a 55 year old male who appears pleasant, in no apparent distress, his given age, well developed, well nourished and with good attention to hygiene and body habitus. Patient communicates with aid of interpreter.
Vital Signs: BP Sitting: 150/90 HR: 74 Weight: 188 lbs.
HEENT: Inspection of head and face shows head that is normocephalic, atraumatic, without any gross or neck masses.
Pupil exam reveals round and equally reactive to light and accommodation.
Conjunctiva and lids reveal no signs or symptoms of infection bilaterally.
Inspection of oral mucosa and tongue reveals no pallor or cyanosis.
Examination of oropharynx reveals the uvula rises in the midline.
Neck: Neck exam reveals neck supple and trachea that is midline, without adenopathy or crepitance palpable.
Thyroid examination reveals smooth and symmetric gland with no enlargement, tenderness or masses noted.
Carotid pulses are palpated bilaterally, are symmetric and no bruits auscultated over the carotid and vertebral arteries.
Jugular veins examination reveals no distention or abnormal waves were noted.
Neck lymph nodes are normal.
Chest: Chest inspection reveals normal expansion.
Chest palpation reveals no abnormal tactile fremitus.
Lungs: Assessment of respiratory effort reveals even respirations without use of accessory muscles, no intercostal retractions noted and diaphragmatic movement normal.
Auscultation of lungs reveal clear lung fields and no rubs noted.
Heart: The apical impulse on heart palpation is located in the left fourth intercostal space in the midclavicular line and no thrill noted.
Heart auscultation reveals rhythm is regular with a paradoxically split second heart sound
Abdomen: Abdomen soft, nontender, bowel sounds present x 4 without palpable masses.
Palpation of liver reveals no abnormalities with respect to size, tenderness or masses.
Palpation of spleen reveals no abnormalities with respect to size, tenderness or masses.
Examination of abdominal aorta shows normal size without presence of systolic bruit.
Extremities: No clubbing, cyanosis, sub-unguinal petechiae or edema observed. Hair growth is normal in the lower extremities.
Pulses: The femoral, popliteal, dorsalis, pedis and posterior tibial pulses in the lower extremities are equal and normal.
The brachial, radial and ulnar pulses in the upper extremities are equal and normal.
Examination of peripheral vascular system reveals full to palpation, varicosities absent, extremities warm to touch and no edema.
Neurological: Oriented to person, place and time.
Mood and affect normal and appropriate to situation.
Musculoskeletal: Muscle strength is 5/5 for all groups tested.
Gait and station examination reveals midposition without abnormalities.
Skin: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor and there is no icterus.

Lymphatics: No lymphadenopathy noted.

Test Results:
Cholesterol: 355 mg/dl.
HDL: 75 mg/dl.
LDL: 130 mg/dl.

Impression:
Midsternal chest pain.

Plan:
The following cardiac risk factor modifications are recommended: avoid consumption of alcohol, control blood pressure and reduce LDL cholesterol to below 120 mg/dl.
Patient was referred to cardiology.

Prescriptions:
Lipitor Dosage: 20 mg tablet Sig: once daily Dispense: 30 Refills: 0 Allow Generic: No

Patient Instructions:
Authorization Form - A, Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office, explained to and obtained from patient

________________________________Dr. Internal, M.D.

Sample Billing Statement
Charting Plus™ - Electronic Medical Records
www.foxmeadows.com

Billing Statement - Tuesday, April 01, 2003

Provider: Dr. Internal, M.D.
Patient: Cameron Carre, Chart 18205
1010 University
WDM, IA 50266

Diagnoses

1. 786.51 Precordial Pain

Treatments

1. 99213 Office or other outpatient visit - est. patient - 15 min.
Related Diagnoses:
Modifiers:
Units:
2. 82465 Cholesterol, Serum Or Whole Blood, Total
Related Diagnoses:
Modifiers:
Units:

Referring Physician:
Date Last Seen: 03/13/2003

Sample Referral Letter
Charting Plus™ - Electronic Medical Records
www.foxmeadows.com

04/01/2003

Full Cardiologist,
1231 8th Street
West Des Moines, IA 50265

Dear Dr. Heart:

Cameron Carre was seen in my office. I have requested that Cameron be seen by you for further evaluation of the cardiac symptoms and a stress echocardiogram. The following is a summary of my findings:

Chief Complaint (1/1): This 55 year old male presents today for evaluation of chest pain.
> **Cardiac associated signs and symptoms:** Pain radiating to the arm and shortness of breath.
> **Cardiac duration:** Symptom has existed for an intermittent time.
> **Cardiac location:** Midsternal.
> **Cardiac onset:** Onset of the symptom was 5 months ago.
> **Cardiac quality:** Patient describes discomfort as: pressure.
> **Cardiac modifying factors:** Exertion worsens condition.
> **Cardiac severity:** Severity of condition is worsening.

Patient has the following coronary risk factors: elevated cholesterol for less than 1 year and HTN for 13 years.

Allergies: No known medical allergies.
Medication History: Patient is currently taking hydrochlorothiazide 25 mg tablet (one po daily), Lipitor 20 mg tablet (once daily) usage started on 04/01/2003.
Past Medical History: Cardiovascular Hx: (+) high cholesterol, (+) hypertension, **Psychiatric Hx:** (+) depression, **Neurological Hx:** (+) migraines.
PSH: No previous surgeries.
Social History: Patient is married. Patient admits walking on a treadmill until symptoms begin.
Family History: Patient denies a family history of premature cardiovascular disease.
Review of Systems: Cardiovascular: (+) chest pain, (+) arm pain. The remainder of his review of systems is negative.

General: Patient is a 55 year old male who appears pleasant, in no apparent distress, his given age, well developed, well nourished and with good attention to hygiene and body habitus. Patient communicates with aid of interpreter.
Vital Signs: BP Sitting: 150/90 HR: 74 Weight: 188 lbs.
HEENT: Inspection of head and face shows head that is normocephalic, atraumatic, without any gross or neck masses.
Pupil exam reveals round and equally reactive to light and accommodation.
There is no conjunctival inflammation nor icterus.
Inspection of oral mucosa and tongue reveals no pallor or cyanosis.
Examination of oropharynx reveals the uvula rises in the midline.
Neck: Neck exam reveals neck supple and trachea that is midline, without adenopathy or crepitance palpable.
Thyroid examination reveals smooth and symmetric gland with no enlargement, tenderness or masses noted.
Carotid pulses are palpated bilaterally, are symmetric and no bruits auscultated over the carotid and vertebral arteries.
Jugular veins examination reveals no distention or abnormal waves were noted.
Neck lymph nodes are normal.
Chest: Chest inspection reveals normal expansion.
Chest palpation reveals no abnormal tactile fremitus.
Lungs: Assessment of respiratory effort reveals even respirations without use of accessory muscles, no intercostal retractions noted and diaphragmatic movement normal.
Auscultation of lungs reveal clear lung fields and no rubs noted.
Heart: The apical impulse on heart palpation is located in the left fourth intercostal space in the midclavicular line and no thrill noted.
Heart auscultation reveals rhythm is regular with a paradoxically split second heart sound
Abdomen: Abdomen soft, scaphoid, nontender; bowel sounds present x 4 without palpable masses.
Palpation of liver reveals no abnormalities with respect to size, tenderness or masses.
Palpation of spleen reveals no abnormalities with respect to size, tenderness or masses.
Examination of abdominal aorta shows normal size without presence of systolic bruit.
Extremities: No clubbing, cyanosis, sub-unguinal petechiae or edema observed. Hair growth is normal in the lower extremities.
Pulses: The femoral, popliteal, dorsalis, pedis and posterior tibial pulses in the lower extremities are equal and normal.

The brachial, radial and ulnar pulses in the upper extremities are equal and normal.
Examination of peripheral vascular system reveals full to palpation, varicosities absent, extremities warm to touch and no edema.

Neurological: Oriented to person, place and time.
Mood and affect normal and appropriate to situation.

Musculoskeletal: Muscle strength is 5/5 for all groups tested.
Gait and station examination reveals midposition without abnormalities.

Skin: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor and there is no icterus.

Lymphatics: No lymphadenopathy noted.

Test Results:
Cholesterol: 355 mg/dl.
HDL: 75 mg/dl.
LDL: 130 mg/dl.

Impression:
Midsternal chest pain.

Plan: Referral to cardiologist for evaluation and stress echocardiogram

Prescriptions:
Lipitor Dosage: 20 mg tablet Sig: once daily Dispense: 30 Refills: 0 Allow Generic: No

Patient Instructions:
Authorization Form - A, Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office, explained to and obtained from patient

If I may be of any further assistance in your evaluation of this patient, please contact me. Let me know your findings and recommendations. Thank you for assisting in the care of this patient.

Sincerely,

Dr. Internal, M.D.

Sample Prescription
Charting Plus™ - Electronic Medical Records
www.foxmeadows.com

Dr. Internal, M.D.
1231 8th Street, Suite 222
West Des Moines, IA 50265

DEA#:
____

Name: Cameron Carre Date: 04/01/2003
Address: 1010 University
West Des Moines, IA 50266
____

Lipitor
20 mg tablet
Once daily

X_____________________________________ X_____________________________________
Substitution Permitted Dispense as written

Refills: 0
Dispense: 30
Allow Generic: No

Sample Patient Instruction
Charting Plus™ - Electronic Medical Records
www.foxmeadows.com

Patient Instructions for Cameron Carre on 04/01/2003

Authorization Form - A
Authorization for Use or Disclosure of Information for Purposes Requested by Physician's Office

I, Cameron Carre, hereby authorize Dr. Internal to (check those that apply):
__ use the following protected health information, and/or
_X_ disclose the following protected health information to Dr. Heart:

Information to be used or disclosed, includes, office exam note with date of service, type of service provided, history, examination findings, lab results, impression, plan, and medications.

This protected health information is being used or disclosed for the following purposes: referral of patient for further cardiac testing and stress echocardiogram

This authorization shall be in force and effect until May 31 or when Dr. Heart has released patient from his care at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Diane Manager at 1231 8th Street, WDM, IA 50265.

I understand that a revocation is not effective to the extent that Dr. Internal has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Dr. Internal will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:
· Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
· Refuse to sign this authorization.

(The use or disclosure requested under this authorization will result in direct or indirect remuneration to the Dr. Internal from a third party.) (If applicable.)

____ Signature of Patient or Personal Representative

____ Date

____ Name of Patient or Personal Representative

____ Description of Personal Representative's Authority

(This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.) © 2001 American Medical Association All Rights Reserved 11/09/01

______________________________ Dr. Internal, M.D.