HONORHEALTH

Patient Label

H & P UPDATE (This section may be used ONLY if an H&P is available in the patient chart and is less than 30 days old)

☐ The patient has been examined. No Significant changes to patient condition upon examination. Proceed with planned procedure.

OR

☐ The patient has been examined. The following changes have been noted:

_____

Proceed with planned procedure.

Date: _____Time_____ Physician Signature: _____

HISTORY & PHYSICAL

HISTORY

CHIEF COMPLAINT: _____

ALLERGIES: _____

MEDICAL HISTORY/COMORBIDITIES: _____

SURGICAL HISTORY: _____

CURRENT MEDICATIONS: _____

PHYSICAL EXAMINATION

Physical examination must include pulmonary status, cardiovascular status, vital signs and involved system.

LUNGS: WNL ☐ OTHER ☐

HEART: WNL ☐ OTHER ☐

VITAL SIGNS: VITAL SIGNS REVIEWED & WNL ☐ OTHER ☐

OTHER: _____

ABNORMAL/RELEVANT PHYSICAL FINDINGS: _____

DIAGNOSIS/IMPRESSION: _____

PLAN OF CARE: _____

Date: _____Time _____ Physician Signature: _____

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Patient Label

HISTORY & PHYSICAL GUIDELINES

PURPOSE: Handwritten History & Physicals are permissible and can be documented in the progress notes or on the H & P form.

POLICY: A history and physical shall be completed or documented on all patient types admitted to the hospital by the end of the day after a patient is admitted to the hospital; prior to surgery on all patients undergoing elective surgery under general or major regional anesthesia; prior to scheduled ambulatory elective, invasive procedures. Medical Staff members shall be responsible for performance and documentation of the history and physical.

Nurse Practitioners may write and dictate history and physical examinations. Physician's Assistants may obtain patient histories and perform physical examinations, which must be reviewed and co-signed on the day of admission by the Attending or sponsoring Physician.

GUIDELINES FROM THE MEDICAL STAFF RULES AND REGS:

A. Medical Staff members shall be responsible for the documentation of the history and physical examination. Dictated consultations may be used as a substitute for, or augmentation to, the history and physical examination.

b. A history and physical examination (H&P) is documented within twenty-four (24) hours of admission for all inpatients. The history and physical, including a pre-operative diagnosis, MUST be documented prior to non-emergent surgery. For surgical patients, the documentation of the history and physical may be postponed if the operating surgeon determines that a life-threatening situation exists. Such a case is documented in the medical record, and the history and physical is available within twenty-four (24) hours.

c. The physician shall use his/her clinical judgment based on his/her assessment of the patient's condition and any co-morbidities in relation to the reason the patient was admitted or to the surgery to be performed when deciding what depth of assessment needs to be performed and what information needs to be included in the update note. The elements of an appropriate history and physical examination include:

1) Chief complaint

2) Reason for admission/admitting diagnosis

3) Details of the present illness and any pertinent co-morbid conditions

4) A record of known current medications or documentation if unavailable

5) Allergies including past medication reactions, if known

6) Appropriate physical examination which includes pulmonary status, cardiovascular status, blood pressure, and vital signs.

7) The course of action planned for the patient's episode of care.

d. **An H&P performed within thirty (30) days prior to admission may also be used for the hospital medical record if it is accompanied by an update note. An update note must entered at the time of admission or within twenty-four (24) hours of admission and/or prior to the procedure. The update note should identify any changes in the patient's medical condition that has occurred since the prior H&P and should reaffirm the necessity for the planned care. History and Physicals older than thirty (30) days are not acceptable.**

e. A history and physical is not required for non-surgical outpatients undergoing diagnostic procedures or elective minor procedures without sedation.

f. All outpatient endoscopy patients will have a History & Physical documented on the Endoscopy Physician Record prior to the procedure. This form will be accepted as the History & Physical report.