New Dynamic Documentation Consultation Note

This note is now available for use by all who document using Dynamic Documentation.

The template is designed to:

- Leverage information entered elsewhere in the chart
- Facilitate communication with other services
- Easily integrate essential regulatory and billing requirements

How is the Note Created?

- **All in yellow are required by compliance/regulatory**
- **Text in red is where the information will pull from and how it functions**
- **Items which display in black are not required but upon review of consult notes documented in our system they are included to capture this need.**

**Date and time of visit**: pulls in current date/time and make editable

______(patients name) is being seen at the request of (Name of the Clinician requesting the consultation pulls from consult order) to evaluate (Reason for the consultation: pulls from reason for consult from consult order and make editable)

*If more than one consult is ordered in the day both will pull in-just delete the one that does not pertain to you*

**HISTORY OF PRESENT ILLNESS**: pulls from workflow charting section

**Hospital Course**: Pulls from Workflow charting section and is multicontributer

**Problem list active/historical**: pulls from Problem list

**Family/Social Hx**: pulls from Social and Family Hx required when relevant

**Birth Hx** pulls from Birth Hx required when relevant

**Procedures**: pulls from lines and procedures form, circumcision, interoperative record-nonconfidential procedures for current encounter

**Subjective/ROS**: Pulls from charting section in Workflow component

**Pertinent physical findings**: Pulls from PE charting section in workflow

**Pertinent diagnostic test findings**-includes diagnostic tests and test complete: Use Dx, lab, medication review section below (same as in Progress note template) and tagging will populate by Clinician

Dx / Imaging tests reviewed: Yes/NA

Lab results reviewed: Yes/NA

Medications reviewed: Yes/NA
Lab results tagging pertinent

Assessment: consultants opinion pulls from workflow based on Nonconfidential “this visit” diagnoses

Recommendations/Plan-use plan section

-Orders entered by the author’s group since midnight the night before document creation

Add time statement-required if billing by time

Routing: Same as current

Background Regulations for Consult Note Requirements

ARTICLE VI – PART A
Section 3. Records of Direct Consultation
Documented reports of a Direct Consultation shall include:
(a) Name of the person requesting the consultation;
(b) Reason for the consultation;
(c) Pertinent history;
(d) Pertinent physical findings;
(e) Pertinent finding for the diagnostic tests;
(f) Consultants opinion;
(g) Recommendations.

All Direct Consultation reports shall be authenticated by the Member or Individual with Privileges performing the Direct Consultation. 76 Consultants are encouraged to communicate their recommendations directly to the Attending Physician as soon as possible after an initial consultation, or at any time that major new recommendations are made. Through discussion with the Attending Physician, consultants are also encouraged to clarify the level of involvement the consultant will have in the continuing care of the patient, including what types of orders will be documented by the consultant.

Consultation progress notes subsequent to a Direct Consultation shall be recorded at the time of observation, documenting the course and results of care within the scope of the consultation sufficient to permit continuity of care and informed transfer of care.

CMS also states all documentation must have the date and time the patient was seen:

- CMS Interpretive Guidelines §482.24(c)(1) All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.
  - The time and date of each entry (orders, reports, notes, etc.) must be accurately documented. Timing establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events.