

**The Miriam Hospital
Administrative Manual**

Subject:
History & Physical
Requirements

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Approved By:

(Director)

(Executive)

I. Purpose

This policy establishes standards for the history and physical examination consistent with legal regulations and accreditation standards. It includes documentation standards for the initial diagnostic evaluation of hospital inpatients, observation patients, a.m. admissions, hospital based outpatient procedure patients and the outpatient physician practice or clinic setting.

II. Policy

- A. It is the responsibility of the Medical Staff to assure that an appropriate medical history and physical examination are performed and documented on patients being admitted for inpatient care, and for operative and invasive procedures in an inpatient or outpatient setting.
- B. A history and physical examination may be performed and documented by the following:
1. A qualified physician (doctor of medicine or doctor of osteopathy) who is a member of the Medical Staff and who, by virtue of education, training and demonstrated competence, is granted clinical privileges to perform specific diagnostic and therapeutic procedures and who is fully licensed to practice medicine in the State of Rhode Island.
 2. Oral and Maxillofacial Surgeons if they possess the clinical privileges to do so in order to assess the medical and surgical risks of the proposed operative and/or other procedure.
 3. Patients admitted to the Hospital for dental and podiatric care shall receive the same comprehensive medical appraisal as patients admitted for other services. Dentists and Podiatrists are responsible for those parts of the patient's history and physical examination that relate, respectively, to dentistry and podiatry. In addition an appropriate H&P must be completed by a qualified physician who is a member of the Medical Staff.
 4. Residents, nurse practitioners and physician assistants may perform part or all of the history and physical examination, provided that the findings, conclusions, and plan of treatment are reviewed by a qualified physician. All H&P's that are performed by house staff must be countersigned by an attending physician.

5. A Department/Division may develop specific History and Physical examination templates for procedural areas with the approval of the Medical Records Committee to meet these requirements.
6. An H&P performed by a qualified practitioner, licensed in the State of Rhode Island, who is not a member of the Medical Staff will be accepted if the content meets the requirements set forth in this policy. In this situation the admitting or operating physician must:
 - ◆ Review the History and Physical examination document
 - ◆ Determine if the information is compliant with the defined minimal content requirements of this policy
 - ◆ Obtain missing information through further assessment
 - ◆ Update information and findings as necessary, which may include, but are not limited to:
 - 1). Inclusion of absent or incomplete required information
 - 2). A description of the patient's condition and course of care since the history and physical examination was performed
 - 3). A signature and date on any document with updated or revised information as an attestation that it is current
7. In the outpatient physician practice or clinic setting, initial and continuing care notes (follow up notes) must comply with currently acceptable coding and documentation guidelines as mandated by CMS and Payers.

III. Procedure:

A complete history and physical by a physician member of the Medical Staff shall be recorded within twenty-four (24) hours of patient admission.

The history and physical should include the chief complaint, details of the present illness, including, allergies and medications, and when appropriate, assessment of the patient's emotional and behavioral status. Relevant social and family history, as well as a physical examination with a complete inventory of body systems, should be fully documented. Included shall be impressions drawn from the history and physical examination and a statement of the plan of treatment.

For outpatient procedures, the content of the H&P will include but is not limited to the following information: pertinent history and indications for the planned procedure, significant medical and surgical history, allergies, current medications, assessment of the patient's current condition including vital signs, cardiac and respiratory status and relevant lab work or other diagnostic test results. The current medications obtained by the Medication Reconciliation process and vital signs obtained by the staff may be reviewed by the physician to meet the assessment requirements.

In the situation where the patient is going to surgery within the first 24-hours of admission, the update to the patient's H&P and the Pre-anesthesia Assessment (PC-13.20) could be accomplished in a combined activity.

History and Physicals (H&P's) will be valid for **30 days**. H&P's greater than 24 hours old, but within 30 days, require an interim note to update the H&P for any changes in patient condition. An interim note is a statement entered into the medical record by the attending physician and signed prior to the procedure, to indicate that an H&P has been reviewed and that:

- a. There are not significant changes to the findings contained in the H&P since the time the H&P was performed, or
- b. There are significant changes and such changes are subsequently documented in the medical record.

An H&P completed greater than 30 days prior to an admission does not meet the requirement for a current H&P and cannot be updated. A new H&P is, therefore, required.

History and physical examination, such as those performed in the office of a member of the Medical Staff **within 30 days** prior to the patient's admission, is acceptable in a format approved by the Hospital, provided there is an interim note when the H&P is greater than 24 hours old.

All H&P's for non-emergency surgical cases are requested to be provided to Pre-Admission Testing by 1:00 p.m. the day before surgery. **If this does not occur the case may be canceled.**

When the history and physical has been dictated, a brief handwritten note is documented in the medical record by the licensed independent practitioner and signed by the physician containing pertinent findings and other information necessary for other clinicians to manage the patient and guide the plan of care within the first 24 hours of admission. If transcribed, the H&P must be authenticated within 24 hours or if available prior to any invasive procedure.

When the history and physical examinations are not recorded and entered into the patient record before an operation or any potentially hazardous diagnostic procedure, the procedure will be canceled, unless the attending practitioner states in writing that such a delay would be detrimental to the patient. In an emergency, when there is no time to record the complete history and physical examination, any known allergies, a progress or admission note describing a brief pertinent and appropriate history and physical findings and a preoperative diagnosis is recorded in the medical record immediately before the surgery whenever possible.

The H&P may be dictated and transcribed, computer generated, or handwritten. It must be legible and documented in a manner that is durable and permanent. Only approved abbreviations are to be entered into the medical record. It should have the content and sequenced format as noted in this policy. All dictated H&P's must be authenticated within 30 days of the discharge.