

# Orthopaedic Surgery Encounter Form

CHARGE CONTROL NO.	DIV. NO.	DIV. NAME				INVOICE NO.	MULT. SURG.?
MRN	PATIENT NAME				ADMIT DATE	DISCHARGE DATE	FSC LIST
CASE	PROVIDER				FSC OVERRIDE	DISC TYPE %	
REFERRING PHYSICIAN		UPIN		INJURY DATE	ADJ. AMT.		
SVC. CTR.	RESIDENT				TIME	THRU DATE	
REFERRAL #	LMP	ONSET	TREATMENT TIME	TYPE			
BILLING AREA	LOCATION	SERVICE DATE	AUTHORIZATION				
	HOSPITAL						
	COMMERCIAL LAB						

## I CHIEF COMPLAINT:

## II HISTORY OF PRESENT ILLNESS (HPI)

Was this an accident? If yes, what was the date and approximate hour of the day? \_\_\_\_/\_\_\_\_/\_\_\_\_ Hour: \_\_\_\_\_  
 Work related? ☐ Yes ☐ No

Location    Quality    Severity    Duration    Timing    Context    Modifying Factors    Associated Signs & Symptoms

## PAST MEDICAL, SOCIAL, FAMILY HISTORY (PFSH)

## III MEDICAL (Illness, Operations, Injuries and Treatment)

## IV SOCIAL (Review of Past & Current Activities)

☐ TOBACCO \_\_\_\_\_ ☐ ETOH \_\_\_\_\_ ☐ LIVING ARRANGEMENTS \_\_\_\_\_

## V FAMILY (Review of Medical Events in Patient's Family)

☐ CAD ☐ IDDM ☐ ARTHRITIS ☐ CA

## VI REVIEW OF SYSTEMS (ROS)

CONSTITUTIONAL	NO COMPLAINT <input type="checkbox"/>	CARDIOVASCULAR	NO COMPLAINT <input type="checkbox"/>
HEMATOLOGICAL/LYMPHATIC	NO COMPLAINT <input type="checkbox"/>	RESPIRATORY	NO COMPLAINT <input type="checkbox"/>
INTEGUMENTARY	NO COMPLAINT <input type="checkbox"/>	PSYCHIATRIC	NO COMPLAINT <input type="checkbox"/>
NEUROLOGICAL	NO COMPLAINT <input type="checkbox"/>	MUSCULOSKELETAL	NO COMPLAINT <input type="checkbox"/>
EARS/NOSE/THROAT/MOUTH	NO COMPLAINT <input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC	NO COMPLAINT <input type="checkbox"/>
GASTROINTESTINAL	NO COMPLAINT <input type="checkbox"/>	ENDOCRINE	NO COMPLAINT <input type="checkbox"/>
EYES	NO COMPLAINT <input type="checkbox"/>	GENITOURINARY	NO COMPLAINT <input type="checkbox"/>

(2) **Problem Focused: CC; 1-3 HPI elements**

(3) **Expanded problem: CC; 1-3 HPI elements; 1 ROS**

(4) **Detailed: CC;  $\geq 4$  HPI elements (acute) or  $\geq 3$  HPI elements (chronic); 2-9 ROS; 1 PFSH element**

(5) **Comprehensive: CC;  $\geq$  HPI elements (acute) or  $\geq 3$  HPI elements (chronic); 10+ ROS; 3 PFSH elements (new or consult) or 2 PFSH elements (established)**

SCORE

# PHYSICAL EXAM

VII

<b>CONSTITUTIONAL</b> – <input type="checkbox"/> Measure any three of following vital signs Height _____ Weight _____ BP Supine _____ BP Sitting/Standing _____ Pulse Rate _____ Respiration _____ Temperature _____		(2) Problem Focused: One to five elements identified by bullet (3) Expanded problem: At least six elements identified by bullet (4) Detailed: At least twelve elements identified by bullet (5) Comprehensive: All elements identified below	<b>SCORE</b>
CARDIOVASCULAR <input type="checkbox"/> Observation and palpation of peripheral vascular system LYMPHATIC <input type="checkbox"/> Palpation of lymph nodes in neck, axillae, groin/or other MUSCULOSKELETAL <input type="checkbox"/> Examination of gait and station		<b>NEUROLOGICAL/PSYCHIATRIC</b> <input type="checkbox"/> Examination of Sensation <input type="checkbox"/> Examination of deep tendon reflexes <input type="checkbox"/> Test Coordination <input type="checkbox"/> Orientation <input type="checkbox"/> Mood and affect	

## JOINT EXAMINATION

## SKIN

INSPECT 4 OF 6 AREAS	• Inspection, percussion, and/or palpation • Range of motion	• Stability • Muscle strength, tone	• Inspection, or • Palpation
<input type="checkbox"/> Head and Neck			
<input type="checkbox"/> Spine, Ribs & Pelvis			
<input type="checkbox"/> L upper extremity			
<input type="checkbox"/> R upper extremity			
<input type="checkbox"/> L lower extremity			
<input type="checkbox"/> R lower extremity			

VIII

**MEDICAL DECISION MAKING:** Circle the appropriate value in each column. Two of the three elements must be met or exceeded to achieve the level.

Number of possible Diagnoses or	Amount and/or complexity	Risk of Complications and/or	Type of Decision Making	Score
Minimal (1)	Minimal or None (<1)	Minimal	◀ Straightforward	2
Limited (2)	Limited (2)	Low	◀ Low Complexity	3
Multiple (3)	Moderate (3)	Moderate	◀ Moderate Complexity	4
Extensive (4+)	Extensive (4+)	High	◀ High Complexity	5

IX

**LEVEL OF CARE CALCULATION:** Initial visit or consultation: score. Follow-up visit; remove lowest score. Choose next lowest.

History

Orthopaedic Examination

Medical Decision Making

LEVEL OF CARE

## CIRCLE LEVEL OF VISIT

## LEVEL 1

## LEVEL 2

## LEVEL 3

## LEVEL 4

## LEVEL 5

CONSULTATIONS	99241 (63110308)	99242 (63110316)	99243 (63110324)	99244 (63110332)	99245 (63110340)
CONFIRM CONSULT.	99271 (63110456)	99272 (63110464)	99273 (63110472)	99274 (63110480)	99275 (63110498)
NEW PT VISIT	99201 (63110357)	99202 (63110365)	99203 (63110373)	99204 (63110381)	99205 (63011399)
ESTAB. PT VISIT	99211 (63110407)	99212 (63110415)	99213 (63110423)	99214 (63110431)	99215 (63110449)

## PROCEDURES (CIRCLE, CHECK OR COMPLETE)

ASPIRATION/INJECTION	20600 (63121693)	20605 (63121685)	20610 (63121677)	20550 (63120042)
	SMALL JOINT BURSA OR GANGLION CYST	INTERMEDIATE JOINT, BURSA OR GANGLION	MAJOR JOINT OR BURSA	TENDON SHEATH, LIGAMENT, TRIGGER POINTS OR CYST
99499 (63110118)	99024 (63110506)	INJECTABLE		
PRE-OP H&P	POST-OP/VISIT	DRUG TYPE: _____ AMOUNT _____ HCPCS Code: _____ SMS CODE: _____		

## FRACTURE CARE (Check and/or complete)

SITE \_\_\_\_\_

\_\_\_\_ Without manipulation \_\_\_\_ With manipulation \_\_\_\_ Initial Treatment Only \_\_\_\_ Follow-up Care Only

\_\_\_\_ Open Treatment CPT Code: \_\_\_\_\_ SMS Code: \_\_\_\_\_ Recasting (specify type) \_\_\_\_\_

Casting Material: \_\_\_\_ Plaster (A4580) \_\_\_\_ Fiberglass (A4590) CPT Code: \_\_\_\_\_ SMS Code: \_\_\_\_\_

X

DIAGNOSIS	DX Code	Description
1		
2		
3		

## MISCELLANEOUS (Complete)

Description: \_\_\_\_\_ HCPCS CPT Code: \_\_\_\_\_

RETURN APPOINTMENT (SPECIFY): WITHIN \_\_\_\_ (WEEKS) WITHIN \_\_\_\_ (MONTHS) OTHER \_\_\_\_

ATTENDING PHYSICIAN SIGNATURE: \_\_\_\_\_ RESIDENT FELLOW SIGNATURE: \_\_\_\_\_