TM-ADD/ADHD INITIAL (100241)

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Category: Neurologic

Scheduled appt type: ____

CC	Initial ADD/ADHD evaluation
HPI	Academic performance: Overall behavior at home: Overall behavior at school: Current medication list reviewed with patient/family
freeform ROS	____

Structured ROS

Pert: not sleeping well	___
Pert: loss of appetite	___
Pert: weight loss or gain	___
Pert: history of relative with unexplained sudden death	___
Pert: family history of early heart disease	___
Pert: family history of heart rhythm disturbance	___
Pert: family history of high blood pressure	___
Denies: diarrhea	___
Denies: constipation	___
Denies: decreased appetite	___
Denies: rashes or dry skin	___
Pert: difficulty sleeping	___
Pert: impulsivity	___
Pert: Fails to pay close attention/makes careless mistakes	___
Pert: Difficulty sustaining attention in tasks/play	___
Pert: Often does not seem to pay attention when being spoken to	___
Pert: Fails to follow through on instructions/finish work	___
Pert: Has difficulty organizing work/tasks	___
Pert: Dislikes/avoids activities that require sustained mental effort	___

Pert: Often loses/misplaces tools needed to complete tasks	___
Pert: Easily distracted by extraneous stimuli	___
Pert: Often forgetful in daily activities	___
Pert: Fidgets w/hands and/or squirms in seat	___
Pert: Leaves seat when inappropriate	___
Pert: Runs/climbs excessively when inappropriate	___
Pert: Difficulty in engaging in quiet play	___
Pert: Talks excessively	___
Pert: Interrupts others	___
Pert: Blurts answers before question completed	___
Pert: Has difficulty awaiting turn	___
Pert: Acts as if "driven by a motor" (always on the go)	___
Reports: updated individual care plan	___
Reports: provided written care plan	___
Reports: assessed and identified barriers to achieving treatment goals	___
Pert: provided additional support/referrals	___
Reports: reviewed and updated medication list for OTC/herbal therapies	___
Reports: provided information for prescriptions written	___
Reports: assessed understanding of medications	___
Reports: assessed barriers to medication adherence	___
Reports: provided education resources for self-management	___
Reports: discussed self-management goals/plans	___
Reports: assessed self-management ability	___
Reports: provided self-management tools to record self care	including available app tools and/or office self-management tool
Reports: counseled on importance of healthy lifestyle habits	___
Reports: reviewed specialist care	___

Structured exam

Pert: general appearance: alert, pleasant, not ill appearing, no distress	____
Pert: conjunctivae & lids: pink & moist	, no pallor or icterus (asked patient/parent to pull down lower eyelids to assess sclera and conjunctiva which was observed via video connection)

Pert: respiratory effort: no retractions, no tachypnea	, also no audible grunting or other indication for increased work of breathing
Pert: extremities: no edema, brisk capillary refill	, with cooperation of patient/parent through video visualization of good perfusion with brisk capillary refill confirmed (asking patient/parent to demonstrate)
Pert: inspection (includes subcutaneous tissue): no rash	, no rash, no petechiae or bruising, marks related to self harm/picking
Pert: age appropriate social/language interaction	____
Pert: mood & affect	____

Remaining template documentation elements

Counseling:	____
Coordination of Care:	____
Diagnosis:	Attn-defct hyperactivity disorder, predom hyperactive type(F90.1)
Assessment:	____
Plan:	History reviewed and exam considered with limitations acknowledged due to nature of virtual visit through a synchronous telecommunications system Spent the following minutes virtual face-to-face with patient/parent(s) discussing current progress and plan of care: Total time of virtual visit: Reviewed with patient/family working diagnosis, proposed medication regimen and medication side effects If indicated/provided, discussed results of completed and scored validated Connors/Vanderbilt surveys with patient/family Reviewed implications of medicine on growth and blood pressure. Baseline growth chart reviewed with patient/family. Assessed patient/family preferences, readiness to change and self-management abilities Target outcomes including improved/optimal school performance, improved

	social functioning and behavior in multiple settings outlined and discussed with family Additional patient-specific target goals outlined if applicable: Potential barriers to compliance with prescribed medication regimen discussed and strategies reviewed (include extra medication to be kept at school nurse's office if applicable) Behavioral therapy/IEP if indicated Appropriate prescriptions written Re-evaluate in: 2-4 weeks Discussed under what circumstances a face-to-face office visit would be appropriate
Patient Instructions:	

Remaining workflow elements

Procedures

Orders
