UCLA-Olive View Internal Medicine
Inpatient Note Guidelines
(revised 12-14-16)

A. History & Physical Admission Note *(annotated if not obvious)*

CC:
HPI: Present chronologically ending with brief ED Course
ROS:
PMH/PSH:
Meds:
Allergies:
FH: Pertinent positive or negative; don't leave blank
SH: In addition to habits, include employment, activity level, housing, home support
PE: Full exam = HEENT, MSK, GU, Skin and full Neuro exam, among others. Pelvic/Rectal only if indicated.
Labs/Studies:
- Include only the relevant data for dx/management – do not need to tag all labs/studies
- Include pertinent outside data for easy reference in the future

Assessment & Plan:
- Summary statement reiterates the cc and key related features, followed by a commitment to an overall impression
- **Clearly document rationale for hospitalization (why patient needs inpatient care – e.g., AMS, unstable VS, critical labs, failed outpt tx, sepsis, frequent neuro checks, etc.)**
  - Avoid "observation", "placement", "FTT" → consider monitoring, malnutrition, dehydration
- List problems by complaint or condition, combining as appropriate, highest priority first
- Be specific regarding etiology and other connections (e.g., "Sepsis secondary to PNA from presumed gram positive organism"; "CKD4 secondary to HTN", etc.) - this helps the coders!
- Specify key problems present on admission (e.g., "Coccyx pressure ulcer, stage II, present on admission")
- Include Nutrition, DVT ppx and CODE status at the end of your problem list
- Dispo: Include plan if known - "anticipate (SNF placement, home IV Abx, etc.) once stable"; as well as PCP name/clinic/contact info.

B. **Daily Progress Note**

Document Reason for Hospitalization: *-- include here or in A&P*
- Explain why pt needs inpatient care and cannot be discharged today (e.g., AMS, unstable VS, critical lab, sepsis, neutropenic fevers, frequent neuro checks, etc.) – *questions? Call UR x3414*

Subjective
- Update on the chief complaint, any new complaints and events overnight. Consider including pain control, bowel/bladder complaints, nutritional status and mobility when appropriate.

VS/Physical Exam
- Daily PE can be pertinent; full PE not needed every day (as opposed to complete admit PE)
- Do not include exam that you did not do (e.g., "CN II-XII intact" on every note unless you are doing it every day)

Labs/Studies:
- Include only pertinent labs and studies (Rads, Cxs, etc) that are new since last note
- Tag only data that is essential to carry over

Assessment/Plan
- Update! Delete outdated info (such as old diff dix) that does not reflect your thinking today.
- List all problems you're managing; state if home meds are continued or held
- For each active problem state acuity (acute vs chronic), severity (e.g., sepsis, severe sepsis, septic shock), type/stage, lateralization, and relation to another process/organ system (e.g., CKD Stage III presumed secondary to DMII and HTN)
- Include dispo plan and anticipated LOS/DC date: "anticipate (SNF placement, home IV Abx, etc.) once medically stable in X days". This is especially important for anticipated DC in the next few days.

C. Discharge Summary *(annotated if not obvious)*

Date of admission:
Date of discharge:
Service/Team:
Attending*: *(* at time of discharge)*
Resident*:
Intern*:

Admitting Diagnosis:
Primary Discharge Diagnosis:
- Include severity of illness (e.g., "acute hypoxemic respiratory failure secondary to pneumonia", instead of writing just pneumonia)
- Include details of diagnosis (e.g., "pneumonia from presumed gram negative organism", instead of pneumonia)
- If patients meets sepsis criteria always include this (e.g., "severe sepsis secondary to pneumonia from presumed gram negative organism" and if condition was present on admission)

Secondary Discharge Diagnoses:
- List all diagnoses, even chronic

Invasive Procedures performed:
Studies performed:
- e.g., CT, MRI, ECHO -- include pertinent results here (don't need to tag complete read) or include in Hospital Course.

Consultations:
Hospital Course:
- Write a summarized HPI, do not tag the entire HPI, just the pertinent facts
- Summarize important points of the patient's hospitalization in a clear, chronological format
    - Usually easier to read and follow if separated by problems; include chronic problems
    - Include pertinent details, but be succinct. This is a summary of important information, not a detailed account of every single thing that happened during the admission.
- Physical exam on discharge

Discharge Plan:
- ***List of problems that need follow up and data for next provider, including:***
    - Medications – complete list with name, dose, frequency
    - Appointments, and reason for f/u
    - Pending labs/studies and who will be following these up
    - Specific instructions for Post-Discharge Clinic or anyone who will f/u with the patient
    - Dispo needs such as SNF, Home IV abx, DME, oxygen, etc.
- ***Code Status:***
- ***Discharge Condition:***
- ***Discharge Activity:***
- ***Discharge Diet:***

Important for all notes:
- Avoid abbreviations whenever possible, especially banned abbreviations (e.g., "u" → units, "QD" → qday)
- Always document the rational for hospitalization (why the patient can't get care at home, in a SNF, etc.) every day until the day of discharge. This is critical for financial reimbursement.
- Notes should be accurate and current as of the day they are written. Delete old/outdated information; tagged information must be edited to reflect the current situation. This is critical for patient care, reimbursement, coding, and medical-legal issues.