

Visit Documentation Form User Guide

for WELL CHILD/11 to 14 years and WELL CHILD/15 to 21 years

The newly revised American Academy of Pediatrics (AAP) adolescent Visit Documentation Forms are designed to provide health care professionals with the resource they need to appropriately document activities within the typical well visit for an adolescent, support appropriate coding, and secure appropriate payment for their activities. With an increase in pay-for-performance programs, quality improvement initiatives, audits, and legal review, documentation is more critical than ever. The AAP adolescent Visit Documentation Forms will assist in simplifying the documentation process and maximize practitioners' time with adolescents. By providing an organized and consistent layout, clinicians can use the forms for more effective documentation, which can improve performance, limit liability, and support efforts to obtain appropriate payment for services. While the electronic medical record will be the future for most medical practices, these documentation forms provide a clear, concise way for practitioners to meet their current documentation needs.

Key Features

Simplified Forms

The Visit Documentation Forms for the 11- to 14-year and 15- to 21-year visits provide the practitioner the option of using a 1-page basic documentation form or a more comprehensive 2-page form. The first page is designed for a more traditional visit with a parent or guardian present. The second page (back side of the form) provides space for a more intensive discussion of psychosocial issues such as substance use, violence prevention, social habits, sexual health, and mental health. This second page would likely be used with an adolescent without the parent or guardian present to allow for a more open and honest conversation.

Reduced Duplication

Like the well-child visit forms for younger ages, the adolescent Visit Documentation Forms extensively reference other key components from the AAP collection of documentation products to decrease duplication. These include references to the Initial History Questionnaire (birth, past, and family histories), Problem List, Medication Record, Bright Futures Previsit Questionnaire (completed by the family prior to the visit), and Vaccine Administration Record.

Universality

No documentation form will completely satisfy all practitioners. However, these forms conform to the most widely recognized set of information that should be obtained during the visit. The

forms are consistent with documentation guidelines to support evaluation and management coding. They also reflect the most current trends in caring for adolescents.

Peer Reviewed

The Visit Documentation Forms have been reviewed by multiple AAP committees, including the Committee on Adolescence, Committee on Coding and Nomenclature, Committee on Medical Liability and Risk Management, Committee on Practice and Ambulatory Medicine, and Council on Clinical Information Technology. This ensures that key components in each area are included on the forms.

Developmental/Psychosocial Screening

While some practitioners may use a structured developmental or psychosocial screening at each visit, space is only provided for universal screenings. (Ample space is available on the back of each form for any additional screenings required.) The Committee on Coding and Nomenclature recommends indicating the name of the tool used, the results of the screening, the informant, and areas of concern somewhere on the form.

Significant Updates

Consistent With Bright Futures and "Recommendations for Preventive Pediatric Health Care"

The AAP Visit Documentation Forms are consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition, and the AAP "Recommendations for Preventive Pediatric Health Care." Forms are organized by visits recommended by age group. The content, particularly the first page of the adolescent forms, is consistent with Bright Futures, as well. The Anticipatory Guidance section on the first page reflects the 5 priorities outlined in the Bright Futures Guidelines and provides practitioners an easy way to document this important activity.

Clinical Issues

The following components are included:

- Space to identify an adolescent with special health care needs
- More comprehensive developmental assessment section
- The most current HEEADSSS method of adolescent assessment
- Documentation for complete, streamlined, and age-specific physical examination

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Conforms to evaluation and management documentation guidelines.

References to Initial History Questionnaire, Previsit Questionnaire, and Problem List decrease need to repeat pertinent information.

Uses most current best practices for evaluation of adolescents.

ACCOMPANIED BY/INFORMANT		PREFERRED LANGUAGE	DATE/TIME	Name	
DRUG ALLERGIES		CURRENT MEDICATIONS		ID NUMBER	
WEIGHT (%)	HEIGHT (%)	BMI (%)	BLOOD PRESSURE	BIRTH DATE	AGE
Visit with: <input type="checkbox"/> Teen alone <input type="checkbox"/> Parent(s) alone <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Teen with parents <input type="checkbox"/> Other					
History <input type="checkbox"/> Previsit Questionnaire reviewed <input type="checkbox"/> Teen has special health care needs <input type="checkbox"/> Teen has a dental home Concerns and questions <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side) Follow-up on previous concerns <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side) Interval history <input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side) Menarche: Age _____ Regularity _____ Menstrual problems _____ <input type="checkbox"/> Medication Record reviewed and updated			Physical Examination <input type="checkbox"/> = NL Bright Futures Priority <input type="checkbox"/> SKIN <input type="checkbox"/> BACK/SPINE <input type="checkbox"/> BREASTS <input type="checkbox"/> GENITALIA SEXUAL MATURITY RATING _____ Additional Systems <input type="checkbox"/> GENERAL APPEARANCE <input type="checkbox"/> HEAD <input type="checkbox"/> EYES <input type="checkbox"/> EARS <input type="checkbox"/> NOSE <input type="checkbox"/> MOUTH AND THROAT <input type="checkbox"/> NECK <input type="checkbox"/> TEETH <input type="checkbox"/> LUNGS <input type="checkbox"/> HEART <input type="checkbox"/> GI/ABDOMEN <input type="checkbox"/> EXTREMITIES <input type="checkbox"/> NEUROLOGIC <input type="checkbox"/> MUSCULO-SKELETAL		
Social/Family History See Initial History Questionnaire. <input type="checkbox"/> No interval change Changes since last visit _____ Teen lives with _____ Relationship with parents/siblings _____			Assessment <input type="checkbox"/> Well teen		
Risk Assessment <small>If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)</small> HOME Eats meals with family <input type="checkbox"/> Yes <input type="checkbox"/> No Has family member/adult to turn to for help <input type="checkbox"/> Yes <input type="checkbox"/> No Is permitted and is able to make independent decisions <input type="checkbox"/> Yes <input type="checkbox"/> No EDUCATION Grade _____ Performance <input type="checkbox"/> NL Behavior/Attention <input type="checkbox"/> NL Homework <input type="checkbox"/> NL EATING Eats regular meals including adequate fruits and vegetables <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks non-sweetened liquids <input type="checkbox"/> Yes <input type="checkbox"/> No Calcium source <input type="checkbox"/> Yes <input type="checkbox"/> No Has concerns about body or appearance <input type="checkbox"/> Yes <input type="checkbox"/> No ACTIVITIES Has friends <input type="checkbox"/> Yes <input type="checkbox"/> No At least 1 hour of physical activity/day <input type="checkbox"/> Yes <input type="checkbox"/> No Screen time (except for homework) less than 2 hours/day <input type="checkbox"/> Yes <input type="checkbox"/> No Has interests/participates in community activities/volunteers <input type="checkbox"/> Yes <input type="checkbox"/> No DRUGS (Substance use/abuse) Uses tobacco/alcohol/drugs <input type="checkbox"/> Yes <input type="checkbox"/> No SAFETY Home is free of violence <input type="checkbox"/> Yes <input type="checkbox"/> No Uses safety belts/safety equipment <input type="checkbox"/> Yes <input type="checkbox"/> No Impaired/Distracted driving <input type="checkbox"/> Yes <input type="checkbox"/> No Has relationships free of violence <input type="checkbox"/> Yes <input type="checkbox"/> No SEX Has had oral sex <input type="checkbox"/> Yes <input type="checkbox"/> No Has had sexual intercourse (vaginal, anal) <input type="checkbox"/> Yes <input type="checkbox"/> No SUICIDALITY/MENTAL HEALTH Has ways to cope with stress <input type="checkbox"/> Yes <input type="checkbox"/> No Displays self-confidence <input type="checkbox"/> Yes <input type="checkbox"/> No Has problems with sleep <input type="checkbox"/> Yes <input type="checkbox"/> No Gets depressed, anxious, or irritable/has mood swings <input type="checkbox"/> Yes <input type="checkbox"/> No Has thought about hurting self or considered suicide <input type="checkbox"/> Yes <input type="checkbox"/> No			Anticipatory Guidance <input type="checkbox"/> Discussed and/or handout given <input type="checkbox"/> PHYSICAL GROWTH AND DEVELOPMENT • Physical activity • Limit TV • Protect hearing • Brush/Floss teeth <input type="checkbox"/> SOCIAL AND ACADEMIC COMPETENCE • Age-appropriate limits • Friends/relationships • Family time • Community involvement • Encourage reading/school • Rules/Expectations • Planning for after high school <input type="checkbox"/> EMOTIONAL WELL-BEING • Regular dentist visits • Decision-making • Mood changes • Sexuality/Puberty <input type="checkbox"/> RISK REDUCTION • Tobacco, alcohol, drugs • Prescription drugs • Sex <input type="checkbox"/> VIOLENCE AND INJURY PREVENTION • Seat belts • Guns • Conflict resolution • Driving restriction • Sports/Recreation safety		
Plan Immunizations (See Vaccine Administration Record.) Laboratory/Screening results: <input type="checkbox"/> Vision <input type="checkbox"/> Cholesterol (18-21 years) <input type="checkbox"/> Referral to _____ Follow-up/Next visit _____ <input type="checkbox"/> See other side			Print Name Signature PROVIDER 1 PROVIDER 2		
HE0499 American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN®			WELL CHILD/15 to 21 years		

Space for nameplate imprint.

Check boxes with space for additional findings.

Check for well teen and space for additional comments.

Allows for documentation of all methods of communicating informally.

Form aligned with recommendations in the Bright Futures Guidelines, 3rd Edition.

The second side of these forms allows for a more comprehensive evaluation of the adolescent. An expanded version of the risk assessment section on page 1 is used, with an additional section on substance use.

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