The newly revised American Academy of Pediatrics (AAP) Visit Documentation Forms are designed to provide health care professionals with the resource they need to appropriately document activities within the typical well-child visit, 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 Visit Documentation Forms will assist in simplifying the documentation process. 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**

**Single-Page Forms**
For each visit from the first week through the 10th year, the Visit Documentation Forms are limited to a single page. The front contains unique prompts for visits, tailored to the recommendations for each visit by age. Check boxes are used where feasible, but space is provided for written information where appropriate. The back of the forms provides space for additional notes as needed, including addressing chronic illnesses and minor illnesses that may coincide with a well visit.

**Reduced Duplication**
To decrease the need for duplication of information, the Visit Documentation Forms extensively reference other key components from the AAP collection of documentation products. 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 also consistent with documentation guidelines to support evaluation and management coding. While efforts have been made to address common documentation requirements for Early and Periodic Screening, Diagnosis, and Treatment, states vary in their required elements. Additional elements may be needed to meet your state’s requirements.

**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.

**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, and the content to be addressed at each visit is consistent. In particular, the Anticipatory Guidance section 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 note body mass index (2 years and older) and blood pressure measurements (3 years and older)
- Space to identify children with special health care needs
- Simplified check box to indicate developmental issues have been covered
- More opportunities to use a check box when the patient’s status is normal
- Documentation for complete, streamlined, and age-specific physical examination
- Space to note blood pressure for children older than 3 years. (Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.)
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for WELL CHILD/2 to 5 days (first week) Through WELL CHILD/10 years

- Checks indicate normal.
- Not checked and no comment indicates not done.

Conforms to evaluation and management (E/M) documentation guidelines.

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

Increased emphasis on psychosocial aspects.

Conforms to E/M requirements for review of systems while focusing on aspects of care appropriate to the child in good health.

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The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.