Pediatric Examination Flow

- Pediatric Exams are to be performed on patients **10 years and younger**.
- Ages 11 and older will be sent an electronic health history intake by the front desk.

1. Patient Summary Form will be filled out in the same order as an adult New Patient Exam.

a) Bring completed paper health histo forms to clinician to review
b) Clinician will meet the patient
c) Complete details on health history that clinician requests, take subjective history, differential diagnoses (if applicable)
d) Clinician will review all history and approve continuation of examination (2nd signature)
e) Proceed with vitals, physical exam form, spinal/orthopedic exam form, and daily macro (EHR).
f) Complete PAIO with ICD-10 code and procedure code (CPT-New patient exam)
g) Have clinician review exams and send to billing (3rd signature) and sign service slip. Intern submits for review, and clinician approves note.
h) At the end of the examination visit, return paperwork to the front desk. It will be placed in a temporary file folder stored at the front desk until the CMR.

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3. In EHR:

- **Subjective** history if patient has a problem. Include differential diagnosis, as appropriate.
- **Objective Daily Note (**PART documentation), **Assessment**, **Patient Care Plan** and **Plan**
- **Intern signs note at completion of all above**

Bring PT summary form, CMR Grade Sheet and appropriate ePSS form (2 copies), ChiroUp Condition Report (2 copies), and ChiroUp Condition Reference (highlighted). After the CMR, the Clinician will deliver the paperwork to the front desk.

S = Signature Required