



APPENDIX B: PRIMARY CARE CONSULT TEMPLATE

Use this template to present patient information (in this order) when consulting the NP/MD

1. Patient Profile

- Patient name
- DOB
- AB Health #

2. Subjective Data

- Chief complaint/Reason for visit
- History of chief complaint/ Presenting illness
 - Onset
 - Location
 - Duration
 - Characteristics/associated symptoms
 - Alleviating and aggravating factors
 - Timing
 - Previous episodes
 - Associated symptoms such as fever, nausea and vomiting.
- Past Medical History
 - Past Medical/Surgical/Obstetrical
 - Family
- Immunization status
- Current meds.-include traditional therapies
- History of Substance Abuse (ETOH/Recreational Drug use, etc.)
- Allergies-including severity of reaction (eg. penicillin-anaphylaxis), medications, foods
 - i. Describe the reaction
- Date and reason for last clinic visit
 - Recent labs / diagnostics (eg. urine culture, hemoglobin results)
 - Last antibiotic used – including date
- Recent hospitalizations
- Review of pertinent systems – focused or general exam

3. Objective Data – Assess systems – *pertinent to the chief complaint, eg. If patient presents with a cough, then examine the respiratory and cardiovascular systems. If patient presents with a sinus infection, examine the respiratory system, cervical/occipital/pre auricular/post auricular/tonsil nodes and the HEENT.*

- Vital Signs
- Weight – for pediatric clients (or adult if weight a factor – CHF, anorexia, >wt loss, etc.)
- General appearance (eg. Unwell)
- HEENT
- Respiratory
- Cardiovascular and peripheral vascular
- Gastro/ABD
- Genito-urinary
- Musculoskeletal
- Neurological



- Psychiatric
 - Endocrine
4. **Analysis / Diagnosis – *To be determined in consultation with the NP/MD***
5. **Plan - *To be determined in consultation with the NP/MD – plan may include:***
- Diagnostics (eg. Labs)
 - Interventions
 - Pharmacological and other therapies
 - Education
 - Referral
 - Follow Up