TITLE: HISTORY AND PHYSICAL EXAMINATION

POLICY:

1. The History and Physical examination, including all updates and assessments, must be written or dictated into the patient's medical record within 24 hours after admission, and prior to surgery or other high risk procedures (except in emergency situations). If the History and Physical has been dictated but not yet recorded in the patient's chart, there must be a statement to that effect.

2. A written History and Physical examination performed by a Physician member of the Medical Staff within 30 days prior to the patient's admission to the hospital, is acceptable; provided that:
   a. a copy is attached to the medical record and
   b. the reassessment must include a review of the History and Physical examination of the patient to reflect any components of the patient's current medical status that may have changed since the prior History and Physical or to address any areas where more current data is needed.
   c. the reassessment must confirm that the procedure or care is still necessary and that the H&P has been updated.
   d. the reassessment must be written or dictated into the patients medical record within 24 hours after admission, and prior to surgery (except in emergency situations). See attachment A “History and Physical Update” (sticker/label)

3. A completed History and Physical examination includes the chief complaint, all pertinent findings and details of the present illness, relevant past, social and family history, an inventory of body systems, a comprehensive physical assessment and provisional assessment encompassing the need for hospitalization.

4. If the History and Physical or the History and Physical examination note is not included in the chart, operative and other high risk procedures will be delayed until requirements are met.

5. The results of any indicated diagnostic tests should be recorded in the Medical Record prior to surgery, any procedures requiring Moderate Sedation, or other high risk procedures.

6. A short term admission History and Physical form may be used to complete a History and Physical if all components of a History and Physical are met.
GUIDELINES:

1. In instances where an emergency operative and other emergent high risk procedures are required, the surgeon may be allowed to perform the operative and other emergent high risk procedures without a History and Physical note. The Physician should record the reason for the emergency in the progress notes prior to the procedure.

Definition: from The Joint Commission IM 6.30, 2008
Operative and other high risk procedures are defined as "procedures including operative, other invasive and non-invasive procedures that place the patient at risk."

Attachment A: History and Physical Update (Sticker/label)

These patient care guidelines explain the procedures or techniques MHS prefers that hospital staff members utilize, but staff may use their judgment in implementing them, including modifying the guidelines for a particular health care situation to fit the circumstances at the time.

APPROVED BY: ________________________________

The office responsible for this Policy is Nursing Administration. Questions about this Memorandum or suggestions for improvement should be directed to the Methodist Health System Vice President for Nursing at MCMC, MDMC, or MMMC.
History and Physical Update

☐ No Change in Patient Status
☐ Procedure/Care still necessary
☐ Patient Status Changed as Noted:

____________________________________
____________________________________
____________________________________

The reassessment must confirm that the procedure or care is still necessary and that the H&P has been updated.

Date/Time: ____________________________

Physician
Signature: ____________________________

Printed Name: ________________________