DATE: _____

PATIENT NAME: _____

PATIENT DOB: _____

COMMUNITY PCP & PHONE NUMBER: _____

CHIEF COMPLAINT

Pneumo Vax: _____ (YEAR) Flu Vax: _____ (YEAR)

PERTINENT EXAM

- ❑ (exam not needed today)

ASSESSMENT PLAN

☐ Time Spent _____ Total # Minutes ☐ > = 50% of total time spent C&C ☐ Time spent FF _____ Total # Minutes

Provider Signature _____

Revised: 8/9/11