APSO CLINICAL DOCUMENTATION TEMPLATE

(SYSTEM-OPTIMIZED • CLINICIAN-FIRST • REVENUE-DEFENSIBLE)

Why APSO

- Clinicians think in **Assessment → Plan first**
- Coders, reviewers, and patients see **clinical intent immediately**
- Reduces cognitive load and scroll fatigue in longitudinal charts

Patient & Encounter Context

Patient Name :.....

DOB / MRN :.....

Date of Service :.....

Encounter Type :.....

Source of History : (Patient, caregiver, chart review)

A – Assessment

Clinical synthesis appears first. This is intentional.

Primary Clinical Assessment

One concise paragraph synthesizing subjective + objective findings

Example :

"Chronic right knee pain with mechanical features, worsened over 6 months, exam notable for medial joint line tenderness and reduced range of motion, concerning for degenerative joint disease."

Differential Diagnosis (if applicable)

- Diagnosis 1 :
- Diagnosis 2 :

Problem Complexity & Risk

- Chronic vs acute
- Comorbidities impacting management
- Risk of progression or complications

Why this matters

CMS reviewers and downstream clinicians assess medical necessity here first.

P – Plan

Actionable, time-bound, and traceable to the assessment.

Diagnosis

- Ordered tests and clinical justification

Treatment

- Medications (dose, duration, rationale)

- Procedures or therapies

Referrals / Care Coordination

- Specialty, urgency, purpose

Patient Education & Shared Decision-Making

What options were discussed and patient preferences noted

Follow-Up

- Interval, modality, and contingency instructions

S – Subjective

Patient voice, summarized not transcribed.

Chief Concern (Patient's Words)

Example :

"My knee pain is stopping me from walking normally."

History of Present Illness . (Use OLDCARTS selectively)

Onset :.....

Location :.....

Duration :.....

Aggravating /

Relieving Factors :.....

Timing :.....

Severity :.....

Patient Goals / Concerns

Explicitly documented to support adherence and trust

Relevant History

Reference structured intake, avoid re-documentation

O – Objective

Facts only. No interpretation.

Vitals

Referenced from flowsheet (date / time)

Physical Examination

- Focused findings relevant to assessment

Diagnostics Reviewed

- Labs (date + key results)

- Imaging (study + impression only)

External Data Reviewed

Prior notes, outside records, devices, registries

One or two sentences linking **Assessment → Plan**

Example:

"Given persistent symptoms despite conservative therapy and exam findings suggestive of degenerative pathology, imaging is necessary to guide further management."

Open Notes Language Check

- ☐ Neutral, respectful language
- ☐ Clear rationale for decisions
- ☐ No stigmatizing or speculative phrasing

Clinician Attestation

Clinician Name / Credentials : .....

Signature / Date : .....

Primary Clinical Assessment

For clinicians

- Assessment-first mirrors diagnostic reasoning
- Less scrolling through narrative to find decisions

For revenue cycle

- Medical necessity is explicit and proximal
- Supports E/M complexity and audit defense

For patients

- Open Notes readers see "**what's wrong**" and "**what's next**" immediately

For informatics teams

- APSO-ready without breaking SOAP data models
- Compatible with structured intake and pre-visit workflows

CERTIFY Health

CERTIFY Health supports **pre-visit readiness**: structured intake, eligibility verification, and patient-submitted context. When subjective and administrative inputs are clean before the encounter, APSO notes become **shorter, clearer, and clinically sharper.**

"To learn more about optimizing your practice with a unified healthcare management system, please connect with the CERTIFY Health team."

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