Practice Details

Idealized TCR Template

Practice Name
Specialists Names, Address, Contact Numbers

Patient:

DOB:

Contact Information:

Attending Physician:

Medical Record #:

Insurance:

Patient Demographics

Date of visit:

Location:

PCP:

Preferred Method of Communication:

Dear Dr……..:
Enclosed is my evaluation of _____ for _____. Thank you kindly for the referral.

Assessment and Plan in ADAPT Format

CARE PLAN:

Assessments:

1. **Anemia (established dx and worsening) ICD9 -xxx.xx - Transition Type: Co-management with Shared Care**

What are you thinking and how will you decide?

1. DECISION MAKING: She is more anemic today with a Hct of 26% but is hemodynamically stable. This is still looking like an anemia of chronic disease. She is normocytic with low serum Fe, high ferritin, normal % transferrin saturation and low TIBC . She has seen <ID> and <orthopedics>. At this point she is not on antibiotics although she insists she probably does have an infection. I will re-evaluate her and search for chronic disease that may be the etiology of her anemia. I don't see an active chronic disease other than osteoarthritis and this is an unlikely etiology. A bone marrow biopsy may be necessary if a source is not found to exclude a myeloproliferative disorder.

What does the patient know and want? What does the PCP need to know?

2. ADVICE TO PATIENT AND PCP: I discussed the potential diagnostic tools that may be needed to evaluate the anemia and after reviewing the following lab tests and discussion with <PCP>, I will call her to set up her next steps. She was given written information on Anemia of Chronic Disease. Her goal is to have enough strength to walk her dog daily. I believe that her level of anemia does not preclude this and perhaps she is deconditioned form her cancer treatment. She was given a walking program handout and advised to see <PCP> to advise her on safe exercise. If she is not improving then I would look for a chemo-induced myopathy as a possible etiology for her weakness although a transfusion may be needed.

What are you going to do?

3. PLAN: We will repeat her labs in 2 weeks and if worsens and no other etiology is found, we will transfuse her. Her treatment goal is Hct >28. If stable or improved, we will continue to

Who is responsible for what?

monitor and see how does with exercise program.

4. TASKS:
    1. Laboratory orders: CBC, LDH, Retic count, Fe, Tibc, MMA to be ordered at <specialist practice> and reviewed by <specialist>. I will discuss with <PCP> whether we will need to explore possible collagen vascular diseases,
    2. Diagnostic Imaging/Procedures: I will discuss with <PCP> whether we will need to do an ultrasound to look for hypersplenism, or a bone marrow biopsy.
    3. Monitoring/Surveillance: If Hct remains stable, <PCP> to monitor CBC every 3 months for first year and send report to us.
    4. Disposition/Follow-up: If the lab tests are with normal limits, I will look for other sources for anemia. If an etiology is found on pending tests, treatment will be addressed accordingly. I will follow-up on these tests and see the patient in 1 week and send the disposition to you. <PCP> participation in the care will be determined when the diagnosis is confirmed.

2. **Fallopian Tube Carcinoma (established dx and in remission) ICD9: xxx.xx: Transition Type: Co-management with principle care of disease**
    1. DECISION MAKING: She received only two cycles of adjuvant chemotherapy due to severe vomiting and reluctance to continue treatment. She is clearly in clinical remission.
    2. ADVICE TO PATIENT AND PCP: Since she was only able to take part of her treatment, I explained to the patient that the future outcome of this cancer would be difficult to determine. We discussed the fact that recurrent disease will be unlikely to be cured and that there will be treatment available for palliation and prolongation of survival. She accepted this and voiced understanding that her cancer is not curable. She wants to discuss Advance Directives with you and information was given to her in order to prepare for the discussion. She responded with sadness and disbelief but appropriately to such news. Her goal is to live as long as possible pain-free and take a cruise next year. I see no barriers to achieving these goals. According to 3 good randomized studies, her average survival time is 4-5 years although we have seen some remarkable responses. There are other chemo options that have less side effects that we can provide when she has a recurrence. Due to the variable response of this cancer to therapy, I recommend that she be a FULL COR. She was educated on symptoms to watch for such as bloating, cough, pain, excessive weight gain (as ascites may be an early sign of recurrent disease), or weight loss.
    3. PLAN: The patient has finished treatment and is now on surveillance. She is not on an active treatment or medications for her cancer. <PCP> will address her psychosocial issues and advance directives.
    4. TASKS:
        1. Laboratory orders: Due to office location, the patient wants tests drawn at your office q 3 months and the results sent to us. Our nurse will send a requisition to <PCP> q 3 months (OR our nurse has discussed the plan with <your care coordinator> who will order tests as outlined).
        2. Diagnostic Imaging/Procedures: Per ACS guidelines, we will repeat PET scan at <specialist office> in 6 months.
        3. Monitoring/Surveillance: There will be no need for routine diagnostic imaging studies unless she has symptoms of recurrence. She will need surveillance over the next 6 years. For the first year she will be seen every 3 months with CBC, LFTs, CA 125. The Second year will be every 4 months, the third every 6 months, and then

yearly thereafter.

4. Disposition/Follow-up: Patient will be seen at office in 3 months after labs received. She was instructed to follow-up with <PCP> within 1 month to review our plan, discuss advance directives and support patient as needed.

3. Technical Procedure CPT xxx.xx:

Problems related to primary diagnosis and their disposition

Secondary Diagnoses:

3. Chronic infection: Her C reactive protein has increased. This is being monitored by <specialty practice> periodically.
4. Neuropathy: She had this before chemotherapy and it doesn't appear to have progressed. <PCP> is following this.
5. Chemotherapy of Brain: No residual effects noted. Should watch for cognition issues.
6. Back Pain: She is seeing <orthopedist> who is providing principle care for this issue

Standard Historical Documentation

CLINICAL DATA:

Subjective:
Chief Complaint:
History of Present Illness (HPI):
Medications:
Allergies:
Past Medical History:
Surgical History:
Social History:
Family History:

Objective:
Physical exam or pertinent findings

Data:
Laboratory
Diagnostic Imaging

Specialist Signature

Cc: other providers

Principles of the note:

1. *Clear, concise documentation of patient's problem, evaluation, supporting evidence and care plan.*
2. *Information is easily accessible to end-user (PCP, specialists, hospitalist, other clinicians etc.) so that they may quickly retrieve the information they need to discuss the care with the patient or make a clinical decision.*
3. *Provides standard of care, evidence-based information in order to:*
    a. *educate the clinician on up-to-date medical/surgical care.*
    b. *facilitate clinician's participation in guiding patients to their best choices in treatment.*
    c. *Aid the clinician to assist patients in adhering to the specialist's treatment plan.*

4. *Explains patient's understanding of condition, patient goals and involvement in their care.*