Section 9 Subject 9.13 Policy 9.13.12	Clinical Policies General Procedures **Problem Summary Lists and Medication Records for Ambulatory Patients**	05/14/94 -Originated 02/05/07 -Reviewed w/ changes -Reviewed w/o changes Clinic Administration -Author

Problem Summary Lists and Medication Records for Ambulatory Patients

Policy

A Problem Summary List (PSL) and Medication Record will be maintained for each patient receiving continuing ambulatory care services for primary care.

Initiation and maintenance of the PSL is the responsibility of the provider.

The PSL should be initiated at the patient's first visit by a health care provider (e.g., physician, medical student, nurse practitioner, physician assistant,). The first visit is defined as the patient's first visit to UTMB for any ambulatory services (specialty or primary)

If a diagnosis cannot be established during the first visit, any other significant information should be documented on the PSL such as Allergies or No Know Drug Allergies (NKDA) or any medications, or procedures the patient has received or the provider may document none known.

The Medication Record is initiated at the first visit; if the patient has no meds it should be indicated on the form.

PSLs may be documented on either paper form or in electronic format.

Action

- Use the PSL for documenting diagnoses/problems/conditions
- Update the list whenever a new diagnosis is identified, resolved, or identified as recurring
- Record chronic problems and their entry (date diagnosed)
- Record surgical procedures and dates
- Indicate known allergies. If there are no known allergies, write none
- Document all medications prescribed, as well as over-the-counter medications and herbals, the dosage, date the medication was started, and the date discontinued if not a routine med. If there are no medications, write NONE and date.
- Record the direction, i.e., how often the medication is to be taken during a designated period