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Ohio Administrative Code

Rule 3335-43-11 History and physical.

Effective: June 23, 2016

(A) History and physical examination.

(1) A history and physical appropriate to the patient and/or the procedure to be completed shall be documented in the medical record of all patients either:

(a) Admitted to the hospital

(b) Undergoing outpatient/ambulatory procedures

(c) Undergoing outpatient/ambulatory surgery

(d) In a hospital-based ambulatory clinic

(2) For patients admitted to the hospital, the history and physical examination shall include at a minimum:

(a) Date of admission

(b) History of present illness, including chief complaint

(c) Past medical and surgical history

(d) Relevant past social and family history

(e) Medications and allergies

(f) Review of systems

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(g) Physical examination

(h) Test results

(i) Assessment or impression

(j) Plan of care

(3) For patients undergoing outpatient/ambulatory procedures or outpatient/ambulatory surgery, the history and physical examination shall include at a minimum:

(a) Indications for procedure or surgery

(b) Relevant medical and surgical history

(c) Medications and allergies or reference to current listing in the electronic medical record

(d) Focused review of systems, as appropriate for the procedure or surgery

(e) Pre-procedure assessment and physical examination

(f) Assessment/impression and treatment plan

(4) For patients seen in a hospital-based ambulatory clinic, the history and physical shall include at a minimum:

(a) Chief complaint

(b) History of present illness

(c) Medications and allergies

(d) Problem-focused physical examination

(e) Assessment or impression

(f) Plan of care

(5) Deadlines and sanctions.

(a) A history and physical examination must be performed by a member of the medical staff, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and be signed, timed and dated.

(b) Patients admitted to the hospital: If the history and physical is performed by the medical staff members designee or other licensed health care professional who is appropriately credentialed by the hospital, the history and physical must be countersigned by the responsible medical staff member.

(c) The complete history and physical examination shall be dictated, written or updated no later than twenty-four hours after admission for all inpatients.

(d) Admitted patients or patients undergoing a procedure or surgery, the history and physical examination may be performed or updated up to thirty days prior to admission or the procedure/ surgery or the visit. If completed before admission or the procedure/ surgery or patients initial visit, there must be a notation documenting an examination for any changes in the patients condition since the history and physical was completed. The updated examination must be completed and documented in the patients medical record within twenty-four hours after admission or before procedure/surgery, whichever occurs first. It must be performed by a member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital, and be signed, timed and dated. In the event the history and physical update is performed by the medical staff members designee or other licensed health care professional who is appropriately credentialed by the hospital, it shall be countersigned, timed and dated by the responsible medical staff member.

(i) For patients undergoing an outpatient procedure or surgery, regardless of whether the treatment, procedure or surgery is high or low risk, a history and physical examination must be performed by a

member of the medical staff, his/her designee, or other licensed health care professional who is appropriately credentialed by the hospital and must be signed or countersigned when required, timed and dated.

(ii) If a licensed health care professional is appropriately credentialed by the hospital to perform a procedure or surgery independently, a history and physical performed by the licensed health care professional prior to the procedure or surgery is not required to be countersigned.

(e) Hospital-based ambulatory clinic: If a history and physical examination is performed by a licensed health care professional who is appropriately credentialed by the hospital to see patients independently, the history and physical is not required to be countersigned.

(f) When the history and physical examination, including the results of indicated laboratory studies and x-rays, is not recorded in the medical record before the time stated for a procedure or surgery, the procedure or surgery cannot proceed until the history, and physical is signed or countersigned when required, by the responsible medical staff member, and indicated test results are entered into the medical record. In cases where such a delay would likely cause harm to the patient, this condition shall be entered into the medical record by the attending responsible medical staff member, his/her designee or other licensed health care professional, who is appropriately credentialed by the hospital, and the procedure or surgery may begin. When there is a disagreement concerning the urgency of the procedure, it shall be adjudicated by the medical director or the medical directors designee.

(g) Ambulatory patients must have a history and physical at the initial visit as outlined in paragraph (A)(4) of this rule.

(h) For psychology, psychiatric and substance abuse ambulatory sites, if no other acute or medical condition is present on the initial visit, a history and physical examination may be performed either:

(i) Within the past six months prior to the initial visit,

(ii) At the initial visit, or

(iii) Within thirty days following the initial visit.