

CLINICAL ASSISTANT RESPONSIBILITIES IN A ROUTINE VISIT

The following description of responsibilities relates to routine follow-up visits, such as a routine diabetes check up. The responsibilities vary for other visit types. For example, physicals include greater emphasis on preventive services, while responsibilities for follow-up visits for minor illnesses and acute visits are much more abbreviated.

PART I. ASSISTANT ONLY

A. HPI

Welcome patient and confirm patient's statement of current problems or symptoms.

Ask appropriate questions for the problems or symptoms, using the "ODD IF HAPPY" mnemonic. (Note: The handbook¹ provides specific questions in this format for 116 symptoms and diseases.)

O: Onset of symptoms – When did this episode start?

D: Description of symptoms – Constant vs. intermittent, detail of the sensation, character of the pain, location of the pain, radiation of the pain, etc.

D: Duration – How long does the symptom last?

I: Intensity – Is it mild, moderate, severe, etc.?

F: Frequency – Does it occur daily, weekly, etc.?

H: History – Is this the first episode, or has it occurred before?

A: Accompanying signs and symptoms – Do any other symptoms/signs accompany this symptom?

P: Precipitating/alleviating factors – What makes it better or worse?

P: Progression of the symptom – Is it getting better or worse?

Y: You have finished the questions for this symptom.

Review "plan" from previous two visits.

Review any appended notes or recent phone notes since previous two visits.

Collect the results of any recently completed diagnostic tests, lab results or emergency department visits.

Review problem list and get patient's update on recent problems.

Update the problem list with dates of important completed tests (colonoscopy, mammogram, etc.).

B. PAST MEDICAL HISTORY

Review and update medication list, removing completed medications.

Determine if patient is compliant with medication schedule.

Determine if patient needs refills.

Ask about side effects from medications.

Encourage patient to bring all current medications to each visit.

C. FAMILY HISTORY, SOCIAL HISTORY AND ALLERGIES

Review and update family history and social history.

Review and update allergy list.

D. REVIEW OF SYSTEMS

Review all appropriate systems. (Note: The handbook¹ can

serve as a guide about which system to review depending on the problems or symptoms that necessitated the visit.)

E. PREVENTIVE CARE UPDATE

Ask briefly about last physical, well-woman exam, mammogram, lipids, etc.

Recommend and document appropriate preventive care plan.

F. POSSIBLE PROCEDURES AND QUESTIONNAIRES

Administer pulse ox, peak flow, UA, etc., when appropriate.

Administer MMSE, Epworth sleepiness scale, Zung scale, bipolar questionnaire, etc., when necessary.

PART II. ASSISTANT AND PHYSICIAN

Physician enters room, greets patient and, in the presence of the patient, obtains verbally from the assistant all the information already gathered.

Physician adds to information as necessary, and assistant records this additional information.

Physician performs pertinent physical exam and communicates findings for documentation by the assistant.

PART III. ASSISTANT AND PHYSICIAN

Physician writes down impressions and plan.

Physician updates problem list if paper charts are used or communicates to assistant, in writing, problem list changes, which the assistant records in the electronic medical record. The problem list must contain information about pertinent tests and when they are needed.

Physician reviews the impressions and plans with the patient and then politely exits, leaving the hard copy of the impressions and plan with the assistant.

PART IV. ASSISTANT ONLY

Document the impressions and plan of the physician. The plan includes tests and labs ordered, referrals initiated, new medications added, medications discontinued, suggested lifestyle changes, work notes with dates given and date expected to return to clinic.

Document any treatments or tests refused by the patient, along with the patient's acknowledgement of possible poor outcome.

Provide patient education concerning disease process, medications, tests ordered or lifestyle changes.

Explain matters of referral process or obtaining further tests at other facilities.

Provide all scripts and review them with patient.

Obtain medication samples and review dosage schedule.

Remind patient to call if necessary and to schedule any recommended return visits.

Close the visit kindly or take the patient to appropriate area of the practice for further in-office testing.