GI Consultation Note

The new referral, with alarm features as an explicit field and the E/M level selected on a path the note can actually support.

Patient / MRN / DOB	
Date of service	*Date _____ · endoscopist _____ · assistant _____ · facility _____*
Referral	*Referring clinician _____ · question asked _____ · new / established patient*
Encounter	*In person / telehealth · POS ___ · start _____ : _____ · stop _____ : _____ · total time ___ min*

A History

Presenting problem	*Onset, duration, character, timing, aggravating and relieving factors, prior workup*
Alarm features	*Weight loss · dysphagia · GI bleeding or melena · anemia · nocturnal symptoms · vomiting · family history of CRC or IBD · age of onset ·* ***present / absent, documented either way***
GI history and medications	*Prior endoscopy dates and findings · abdominal surgery · NSAIDs, PPIs, antibiotics, anticoagulants*
Family and social	*CRC, IBD, celiac, liver disease · alcohol, tobacco, travel*

B Examination and Data

Examination	*Vitals · abdominal exam · rectal exam if indicated and consented*
Data reviewed and interpreted	*Labs · imaging · outside endoscopy or pathology reports ·* ***reviewed and interpreted Y / N***

C Assessment and Plan

Assessment	*Differential with reasoning, not a diagnosis list*
Plan	*Tests ordered · procedures scheduled with indication · medications · patient education · follow-up interval*

D Coding

Level of service	*Selected on* ***total time on the date of the encounter*** *or* ***medical decision making****, never both · 99202 to 99205 new · 99212 to 99215 established · dx _____*

E Attestation

Attestation	*Endoscopist signature _____ · name and credentials _____ · date and time signed _____*

Two fields that do more work than they look like. Alarm features get recorded as present *or absent*. A note that does not mention weight loss or bleeding cannot show you looked, and their presence or absence is what justifies going straight to endoscopy rather than treating empirically. **Data reviewed and interpreted** is what supports medical decision making. E/M is selected on either total time on the date of the encounter or MDM, never both, so record the time and write the assessment as reasoning.