Institutional Handbook of Operating Procedures Policy 09.13.12	
Section: Clinical Policies	Responsible Vice President: EVP and CEO Health System
Subject: General Procedures	Responsible Entity: Clinic Administration

I. Title

Summary Lists for Ambulatory Patients

II. Policy

1. A summary list (SL) shall be maintained for each patient receiving continuing ambulatory care services.
2. Initiation and maintenance of the summary list shall be the responsibility of the health care provider.
3. The summary list shall be initiated at the patient's first visit by a health care provider (e.g., physician, nurse practitioner, physician assistant and nurses). The first visit is defined as the patient's first visit to UTMB for any ambulatory services (specialty or primary).
4. If a diagnosis cannot be established during the first visit, any other significant information should be documented on the summary lists such as Allergies or No Known Drug Allergies (NKDA) or any medications, or procedures the patient has received or the provider may document none known.
5. The Medication Record is initiated at the first visit; if the patient has no meds it should be indicated on the form. Medications shall be reconciled at each encounter.
6. Summary lists shall be documented on either paper form or in electronic format and maintained in the medical record.

III. Procedures

1. Use the summary lists for documenting diagnoses problems/ conditions/significant operative and invasive procedures.
2. Update the summary list whenever a new diagnosis, change in diagnosis, medications, allergies and/or whenever a procedure is performed, identified, resolved, or identified as recurring.
3. Record chronic problems and their entry (date diagnosed).
4. Record surgical procedures and dates.
5. Indicate known allergies. If there are no known allergies, write none.
6. 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.
7. Record the direction, i.e., how often the medication is to be taken during a designated period.

IV. Dates Approved or Amended

Originated: 05/14/1994	
Reviewed with Changes	*Reviewed without Changes*
08/15/2013	12/07/2016

V. Contact Information

Ambulatory Operations
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