ACUTE BLOOD LOSS ANEMIA
PHYSICIAN QUERY FORM

THIS FORM IS A PERMANENT PART OF THE MEDICAL RECORD

Date: ______________________________

Dear Dr. __________________________:

Please return this form by fax to:
(XXX) XXX-XXXX

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. We greatly appreciate your clarification on this issue.

Coder’s Name: __________________________
Coder’s Phone #: _________________________

Patient Name: ____________________________

Admit Date: __________________
Discharge Date: ________________

MR#: __________________________
Acct #: _________________________

The medical record reflects the following clinical findings suggestive of acute blood loss anemia.

<table>
<thead>
<tr>
<th>Check Here if indicator is present</th>
<th>Clinical indicator</th>
<th>Location in the medical record which reflect the clinical findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Significant drop in H&amp;H</td>
<td></td>
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<tr>
<td>Hypotension</td>
<td></td>
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<tr>
<td>GI Bleed</td>
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<tr>
<td>Transfusion(s)</td>
<td></td>
<td></td>
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<tr>
<td>Acute Bleed – other sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tachycardia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please respond to the following question:

Based on your medical judgment of the clinical indicators outlined above, are you treating this patient for a known or suspected acute blood loss anemia?  Acute Blood Loss anemia – [Please document the specific diagnosis in the space below and/or in the medical record (progress notes, dictated report or as an addendum to a dictated report).]

Yes – [If yes, please document your response in the space below and in the body of the medical record (progress notes, dictated report or as an addendum to a dictated report).]

____________________________________________________________________________________________

____________________________________________________________________________________________

No – [If no, please initial in or check the box, and sign and date below. This form will need to be maintained with the medical record.]

Unable to determine – [If so, please initial in or check the box, and sign and date below. This form will need to be maintained with the medical record.]

____________________________________________________________
______________________________________________

Physician Signature  Date