PIH Documentation — Chart Note Templates

Initial Identification Note · Follow-Up Progress Note · Instructions embedded in each field

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Two dot phrases: Type **.pihinitial** at the first visit PIH is identified. Type **.pihfollowup** at every subsequent visit while managing active PIH. Instructions are embedded in each field — read the ■ tip before you fill in the line above it.

DOT PHRASE 1 · .pihinitial — First Visit PIH Is Identified

PIH INITIAL NOTE — Dr. V Aesthetics, PLLC

PATIENT & PROCEDURE

Patient: _____ DOB: _____ Date of this visit: _____

Provider: _____

Procedure performed: _____ Date of procedure: _____

Device / product / settings (if applicable): _____

■ *Record exact date and service. This links PIH to the procedure and establishes the clinical timeline.*

PIH IDENTIFICATION

Date patient first noticed darkening: _____

Reported by: [ ] Patient self-reported [ ] Identified by provider at this visit

Days since procedure at onset: _____

■ *Expected PIH window is 7–14 days post-procedure. Document this — it confirms the timeline is*

■ *clinically consistent with a known biological response, not an immediate procedural complication.*

PATIENT PROFILE

Fitzpatrick type: _____

Modifying risk factors — circle all that apply:

Melasma history / OCP use / Prior PIH / Recent UV exposure / Active retinoid at time of tx / None

■ *FP type and risk factors explain biological susceptibility. This removes any implication that PIH*

■ *was caused by technique — it is a known, unpredictable response in higher FP types.*

CLINICAL PRESENTATION

Location / distribution: _____

Appearance: [ ] Brown/tan — epidermal [ ] Gray/blue-brown — dermal [ ] Mixed

Severity: [ ] Mild [ ] Moderate [ ] Severe

Photos taken and filed in AR today: [ ] Yes [ ] No — reason: _____

■ *Photos are non-negotiable. A written description without photos is incomplete. Epidermal PIH*

■ *(brown/tan) responds faster than dermal (gray/blue) — distinguishing this sets realistic expectations.*

PATIENT EDUCATION PROVIDED — document specifically, not just 'educated patient'

[ ] PIH mechanism explained — biological response to inflammation, not a sign of error

[ ] SPF 50+ required daily — reapply midday — UV exposure reverses all progress

[ ] No heat, picking, scrubbing, or aggressive exfoliation

[ ] Expected timeline reviewed — weeks to months depending on FP type and depth

[ ] When to call — worsening, spreading beyond original area, new symptoms

Patient verbalized understanding: [ ] Yes

■ *'Patient verbalized understanding' is a legal standard, not a formality. If they did not,*

■ *note what was unclear and how it was addressed.*

TREATMENT PLAN INITIATED

Step 1 — Topical protocol:

Cleanser: _____ Freq: _____

HQ-free brightener (Brightalive): _____ Freq: AM + PM

SPF 50+ (Oclipse Smart Tone): _____ Freq: AM — final step, reapply midday

Retinol (introduce wk 3–4 only, once skin stable): _____ Freq: PM 2–3x/wk

4% HQ Pigment Control + Blending Creme (Rx — FP III+ or non-response at wk 6–8): _____

■ *Lead with HQ-free (Brightalive) first — barrier-compromised skin tolerates it better than HQ.*

■ *4% HQ is added only once skin is fully stable. Never call Blending Creme HQ-free — it is 4% HQ Rx.*

Step 2 — Oral adjuncts:

Oral TXA 250mg BID x 8–12 wks: [ ] Prescribed now [ ] Initiate at wk 8 if plateaued

Contraindication screen completed (DVT/PE/pregnancy/renal impairment): [ ] Yes [ ] N/A

Other oral adjuncts: _____

■ *Oral TXA is first-line escalation when topicals plateau. Screen every patient before prescribing —*

■ *DVT/PE history, pregnancy, and renal impairment are contraindications.*

Products dispensed today: _____

PLAN

No further treatments on affected area until PIH is visibly improving: [ ] Confirmed

Next follow-up: _____ Type: [ ] In-person (preferred) [ ] Virtual [ ] Phone

■ *In-person follow-up allows objective clinical comparison. Always preferred over virtual for PIH cases.*

IF PATIENT DECLINED ANY RECOMMENDED ELEMENT — complete this section

Element declined: _____

Full regimen recommended: [ ] Yes Patient's decision documented: [ ] Yes

Limitations and PIH risk explained: [ ] Yes Patient verbalized understanding: [ ] Yes

■ **Undocumented declination is the practice's liability. Even partial declination must be charted.**

Provider signature: _____ Date/time: _____

DOT PHRASE 2 · .pihfollowup — Every Subsequent PIH Management Visit

PIH FOLLOW-UP NOTE — Dr. V Aesthetics, PLLC

Patient: _____ Date of this visit: _____

Provider: _____

Original procedure: _____ Original procedure date: _____

Weeks since procedure: _____ Weeks since PIH onset: _____

■ *Track weeks since onset — this determines which escalation step is clinically appropriate.*

CLINICAL ASSESSMENT

Photos taken and filed today: [ ] Yes [ ] No — reason: _____

Pigmentation vs. last visit: [ ] Improving [ ] Unchanged [ ] Worsened

Provider objective assessment: [ ] On track [ ] Plateaued — escalation indicated [ ] Worsened

■ *Photos at every follow-up allow objective comparison. 'Looks better' in the note is not sufficient —*

■ *document the clinical assessment specifically, especially if escalation is being considered.*

COMPLIANCE REVIEW

SPF 50+ daily: [ ] Yes [ ] No [ ] Inconsistent

Prescribed products used as directed: [ ] Yes [ ] No [ ] Partially

UV exposure, heat events, or product changes since last visit: _____

Compliance concerns noted: _____

■ *Non-compliance is the most common reason PIH stalls. Document it — if the patient is not*

■ *following the plan and the pigment is not improving, the chart needs to reflect that clearly.*

PLAN ADJUSTMENTS

No change — continue current regimen: [ ]

Retinol introduced today (wk 3–4+, skin stable, no irritation): [ ] Product: _____

4% HQ added (FP III–VI / non-response at wk 6–8): [ ] Product: _____

Oral TXA initiated today (wk 8–10, plateaued on topicals): [ ] 250mg BID x 8–12 wks

Contraindication screen completed: [ ] Yes Screen findings: _____

Other oral adjuncts added: _____

In-office escalation discussed: [ ] Yes [ ] No

Option discussed: _____ Planned date: _____

Referral indicated: [ ] Yes [ ] No If yes: _____

■ *Escalation sequence: wk 3–4 add retinol → wk 6–8 add 4% HQ if not responding →*

■ *wk 8–10 add oral TXA if plateaued → wk 10+ consider in-office (peel, laser) if <50% improvement.*

■ **Do not perform chemical peels on active PIH — evidence shows poor response and risk of worsening.**

PATIENT EDUCATION TODAY

[ ] SPF compliance reinforced

[ ] Expected timeline reviewed

[ ] Additional education: _____

Patient verbalized understanding: [ ] Yes

IF PATIENT DECLINED ANY RECOMMENDED ELEMENT — complete this section

Element declined: _____

Limitations and PIH risk explained: [ ] Yes Patient verbalized understanding: [ ] Yes

■ **Document every declination, every visit. This protects the practice if a complaint arises.**

NEXT STEPS

Follow-up scheduled: _____ Type: [ ] In-person [ ] Virtual [ ] Phone

Discharge from active PIH management: [ ] Yes — reason/outcome: _____

■ *Close the case in the chart when PIH has resolved. Document the final outcome explicitly.*

LANGUAGE REMINDER — Do not use in any PIH note:

■ **'Error' / 'mistake' / 'caused by treatment' / 'fault' / 'burned' / 'harmed'**

✓ **PIH is a known, unpredictable biological response to inflammation — document it that way.**

Provider signature: _____ Date/time: _____

■ **DOCUMENTATION IS YOUR PROTECTION: A patient who feels consistently followed up and genuinely cared for is far less likely to escalate a complaint — regardless of outcome. A well-documented PIH case shows proactive management, honest education, and continuity of care.**