18

Circle Positives ~~Strike Negatives~~ Leave Blank if not reviewed

TIME SEEN: 1459 AM / PM ☑ **Nursing Notes Reviewed**

HPI: Levels 1-3: 1-3 Elements; Levels 4-5: 4+ Elements

Historian: Patient / Spouse / Other Family / EMS / Interpreter / Law enforcement

CC: 79 YOF BIBA C SOB x 1 month

worse ~~today~~ over past few days

Pt denies any pain. No relief from Sx's.

Pre ED Tx: ☐ N/A ☐

Pain Quality	Pain Severity	Time Course	Context
Dull	None	Onset:	None
Pressure	Mild	Duration: 1 month	At Rest
Burning	Moderate	Chronic	Walking
Sharp	Severe	Gradual	Exertion
Cramping	Worst	Continuous	Awakening
Tingling	Pain 0-10: 0	Intermittent	After meals
		Gone on Arrival	Stress / Anxiety

0 2 4 6 8 10

Exacerbated By	Relieved By	Associated S & S
~~Nothing~~ Nothing	Nothing	Fever
~~Walking~~ / Moving	Rest	Dizzy / Lightheaded
Resting	Positioning	SOB
Eating		Nausea / Vomiting
Coughing		Diaphoresis
Positioning		
Respiration		

LAST: Liquids _____ **Meal** _____ **BM** _____

ROS: Level 4: 2-9 systems; Level 5: 10+ systems

☐ **Unable to obtain due to: ALOC / Acuity**

☑ Check Negatives Circle Positives

- ☐ GEN i.e.- fever, weak, weight loss
- ☐ EYES i.e.- Pain, Red, Discharge, △ Vision, Diplopia
- ☐ ENT i.e.- Congestion, Ear pain / Discharge, Sore throat, Epistaxis
- ☐ CV i.e.- Chest pain, Palpitations, Edema, SOB, Syncope
- ☐ RESP i.e.- SOB, Cough, Wheeze, Hemoptysis, Sputum
- ☐ GI i.e.- N / V / D, Constipation, ABD Pain, Rectal Bleeding
- ☐ GU i.e.-Dysuria, Frequency, Hematuria, Discharge
- ☐ NEURO i.e.-Headache, Seizure, AMS, Paresthesias
- ☐ MS i.e.- Muscle/Joint Pain, Trauma, Swelling, ↓ ROM neck pain yesterday
- ☐ SKIN i.e.- Rash, Itch, Bruise, Trauma pedal edema x 2-3 days
- ☐ PSYCH i.e. - Anxiety, Depression, Suicidal, Homicidal
- ☐ IMMUN/ALLERG i.e.- Allergies, Hives, HIV +, UTD
- ☐ ENDOCRINE i.e.- Weight loss/gain, Polyuria, Polydipsia
- ☑ **All systems Negative except as noted in HPI and ROS above.**

PAST MEDICAL HISTORY ☐ **NOT OBTAINED DUE TO ALOC / ACUITY**

L4: 1 ELEMENT REQUIRED, L5; REQUIRES 2 OF 3 PAST / FAMILY / SOCIAL

☐ **NO PERTINENT MEDICAL HISTORY**

CARDIOVASC	RESP	GI	GU	OTHER	PSYCH
CAD	~~Asthma~~	Divertics	CRF	~~CVA / TIA~~	Addiction
~~Dysrhythmia~~	COPD	Gallstones	Dialysis	~~DM Type: I II~~	Bi-Polar
Cath	PE	GI Bleed	Stones	Migraines	Depression
~~CHF~~	Pneumonia	GERD	PID	Seizures	Dementia
Hypertension	TB / +PPD	Pancreatitis	UTI	HIV+	Overdose
Murmur	PTX	Hepatitis	Pyelo	Cancer	Psych Hosp
PVD / PVT		PUD	BPH	Dementia	Suicidal
↑ cholesterol				Thyroid	

Past History ☑ Discussed ☐ Unavailable ☑ Records Reviewed

Per records no prior ED visits.

Pt recently had c-diff.

Allergies: ☐ NKDA ACE inhibitors, cephalexin, ciprofloxin

Medications: ☐ Reviewed in Nursing Notes.

PAST SURGICAL HX: ☐ **No Prior Surgeries**

(Date if known)

T & A	CABG	G P	D & C
APPY	Pacemaker	C Sec	TURP
Hernia	AICD	Ectopic	ORIF
Cholecys	PTCA / Stent	Ovarian Cyst	Gastric Bypass
Splenectomy	Transplant	Hysterectomy	Mastectomy / Lumpectomy
AAA	Craniotomy	Tubal Lig	Back Surgery / Laminectomy
	Cancer	Vasectomy	

OTHER:

SOCIAL HX:

To ED with: Spouse / Other family / EMS / Interpreter / Law enforcement

Married / Divorced / Single / Other lives alone, but pt has been in hospital x Dec. 23rd

Domestic Violence: ☐ Denies ☐

Recent Travel: ☐ None ☐

Tobacco: ☐ None ☐ 2nd hand smoke ☐ Past ____ PPD x ____ years

Substance Use: ☐ Denies ☐ Alcohol Past x day/wk ☐ Other

Sexual Activity: ☐ Denies ☐ Last encounter

FAMILY HX: ☐ **No Pertinent History**

☐ Exposure to ill contacts

☐ Same symptoms ☐ Different symptoms

	CAD	CVA	HTN	DM	CA Type	Pulm
Siblings						
Mother						
Father						

09960627 DOB: 09/05/1932 Age: 079Y FC: 0000

JOHNSON, SHIRLEY

420949356 Loc: ED ED AW Sex: F DOS: 03/13/2012

PT: E E

ATT: 07900 MIRHADI, MICHAEL

ADM:

18

PHYSICAL EXAM: Level 4: 2-7 systems; Level 5: 8+ systems

Temp 36.0 O R / Tm P 79 RR 28 B/P 147/67

Pulse Ox 96 % (NML) Low on: (RA) NC / SFM / NRB

☐ Reviewed RN Notes.

☑ Alert ☐ NAD Confused Distress: Mild Moderate Severe

☑ NML Hydration: Tenting Dry Membranes Sunken Eyes ↓ Turgor

☐ GCS Eyes 4 3 2 1 Verbal 5 4 3 2 1 Motor 6 5 4 3 2 1 Total _____

GENERAL APPEARANCE _____

HEENT: R = Right L = Left B = Bilateral

☑ PERRL (R L B) Dilated Constricted Unequal Injected

☑ NML EOM (R L B) Palsy Nystagmus Dysconjugate

☐ NML Fundi (R L B) Papilledema Retinal Hem

☑ NML Conjunctiva (R L B) Icterus ___ D/C ___ Injected ___ Abrasion ___ FB

☐ NML TM's (R L B) ___ Dull ___ Bulge ___ Injected ___ D/C ___ Impacted

☐ NML Nose (R L B) Congested Rhinorrhea Epistaxis

☑ NML Oropharynx (R L B) Abscess Blood Red Vesicles Exudates

NECK:

☑ Non Tender to Palpation Tender: _____ ↑ Lymph Nodes Spasm Kernig's Brudzinski's Meningismus

☑ NML ROM, Supple

RESP:

☑ Non-Labored Tachypnea Bradypnea Retractions: Intercostal Sub / Supra Sternal Resp. Failure Tender Chest Wall Crepitanc

☐ NML Equal BS ↓ Air exchange Wheezes Rales Stridor Rhonchi scattered Bibasilar

CV:

☑ NML Tones No Murmur / Rub JVD Heart Tones - Diminished Distant Absent

Murmur Systolic 1 2 3 4 5 6 / 6 Dias 1 2 3 4 5 6 / 6 ☐ S3 ☐ S4

☐ NML Pulses, Cap Refill Cap Refill _____ sec Pulses: Weak / Absent / Doppl.

Tachycardia Bradycardia Regular Irregular

GI:

☑ Non-Tender Tender: soft McBurneys Rebound Guarding Rigidity

☐ No Organomegaly ↑ Liver ↑ Spleen Mass Pulsatile + / - Distended

☐ NML Bowel Sounds ↑ ↓ BS Absent

☐ NML Rectal Exam ↓ Tone Mass Trauma Heme: Pos / Neg Control: Pos / Neg

☐ No CVAT to Percussion CVAT Percussion _____

GU:

☐ NML Male Ext Genitalia Discharge Tenderness Edema _____

☐ NML Female Ext Genitalia Discharge Tenderness _____

SKIN: ☐ See Anatomical Template

☑ NML Color, Dry, Warm Pale Cyanosis Diaphoresis

☐ Rash: Maculopapular Purpura Vesicles Urticaria Petechiae

☐ Bruising

MS: ☐ See Anatomical Template

☐ Non-tender Tender: Chest Neck Back Pelvis Extremity _____

☐ NML ↓ ROM _____

☐ NML Appearance Deformity / (Swelling) / Discoloration 2+ pitting edema (B) extremities

NEURO / PSYCH:

☑ NML Baseline Mental Status _____

☑ NML CN II-XII ↑ ↓ DTR's _____

☑ NML & Symmetric Motor / Sensory / Reflexes ↓ Motor ↓ Sensory

☐ NML Psych Exam Anxiety ↓ Affect Sad Mood

☐ NML Gait / Cerebellar

OTHER FINDINGS: _____

MEDICAL DECISION MAKING: Required for ALL Levels

RADIOGRAPHIC STUDIES: (Interp by ED Dr. / Radiologist)

(CXR): Infiltrates Cardiomegaly CHF PTX Effusion Nodule NAD

CT: ☐ Brain ☐ Abd ☐ Other: _____

Other: _____

(ECG) / Rhythm Strip: Rhythm NSR Intervals: NML ABNL

Rate 85 ST-T Wave Changes + - ☑ As interpreted by me.

☐ Old ECG Reviewed nonspecific t- were flattened sinus arrythmia, PACs

Repeat ECG ☐ Unchanged ☐ Changed _____

OTHER STUDIES : _____

LABORATORY STUDIES (Circled Labs Reviewed & Normal unless otherwise noted.)

CBC	CHEM	CARDIAC / GI	UA	OTHER
WBC 12.3	Na 127	Bili T/D	KET	B-natriuretic peptide : 114
HGB 11.0	(K)	PT / INR 19.6/1.7	SG	
HCT 34.4	Cl 88	PTT 36.3	LEUK	
PLT 509	CO2	Lipase	NIT	
BAND	GLC 123	A Phos	PROT	
SEG	(BUN)	AST / OT	GLC	
LYMPHS	CR 0.46	ALT / PT	BLD	
MONO	(Ca)	MB 5.1	WBC	
	Mg	CK	RBC	
	PHOS	Trop <0.05	BACT	
			U preg: + -	

Cultures: ☐ Blood ☐ Urine ☐ CSF ☐ Throat ☐ Stool ☐ _____

ABG / VBG: _____ ☐ Dr. drawn.

☐ O2: _____ L / Min NC SFM / NRB ☑ Continuous Cardiac Monitor

☑ IV ☑ Bolus 1000 ml. ☑ NS / LR D5 _____ ☐ PO Challenge

☐ Antibiotics: PO / IV / IM _____

☑ Other Medications / Interventions ASA 162mg CHEW, Albuterol 5mg NE

☐ **Critical Care see dicatated addendum.** Atrovent 0.5mg NEB

☐ **Critical Care Time _____, excludes all separately billable procedures/ time exclusive to this patient.**

Reeval Time: 1933 AM / PM Improved Unchanged

Reassessment: Pt feels better after breathing Tx

Dr. informed pt & family of results. Discussed extensively about Possible Tx & d/c

☐ Consult _____ at _____ AM / PM

☐ ED Care Transferred to Dr. _____ at _____ AM / PM

PHYSICIAN & PATIENT FACE TO FACE, WHEN SEEN BY MIDLEVEL

☐ I have independently evaluated the patient & agree with the Midlevel's findings.

☐ Independent findings: _____

DIFFERENTIAL DIAGNOSIS: (Required for Level 4 & 5)

Abdominal Pain Appendicitis Cholecystitis Gastritis Diverticulitis Viral Illness PUD

Concussion CVA TIA Dementia Migraine Med-Reaction Seizure Syncope

Aortic Dissection ACS Bronchitis CHF COPD Pneumonia Asthma

BPH Prostatitis Epididymitis Urethritis Cystitis Nephrolithiasis

Spont / Threatened AB DFUB Ovarian Cyst UTI

CLINICAL IMPRESSION: (Required for All Levels)

(1) Cough (2) Dyspnea (3) Peripheral edema

DISPOSITION: Admit / (Discharge) / Expired at 1907 AM / PM

Condition: (Stable) Improved Unchanged Critical

Discharge Plan: ☒ See patient discharge instructions ☒ Discussed / Given

☒ RX provided: HCTZ, Azithromycin

SIGNATURE: _____ ID# _____

☐ Dictated Addendum# 709487 ☐ Additional Template _____

☐ CC _____ ☐ CC _____

PA / NP Signature: _____ ID# _____

Adult General (Side 2) Emergency

Disclaimer: All medical record entries made by the scribe were at my direction. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally directed, reviewed, and agree with the discharge instructions and disposition.

Physician Signature _____ Date 03/13 Time 2000

Scribe Signature Brianna Nestvedt Date 03/13 Time 1920

09960627 DOB: 09/05/1932 Age: 079Y FC: 0000

JOHNSON, SHIRLEY

420949356 Loc: ED ED AW Sex: F DOS: 03/13/2012

PT: E E

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