

EMERGENCY PHYSICIAN RECORD
Eye Trauma / Problems

DATE: _____ TIME SEEN: _____ on arrival RM: _____ EMS Arrival
 HISTORIAN: patient spouse paramedics _____
 ___HX / ___EXAM LIMITED BY: _____ unable to obtain

HPI

chief complaint: R / L eye: pain redness irritation foreign body
 vision problem _____

onset / duration: _____ min / hrs / days ago _____

associated symptoms: pain / burning / itching (R / L) _____
 redness / matting / eyelid swelling (R / L) _____
 foreign body sensation (R / L) _____
 decreased / blurred / double vision _____
 sensitivity to light _____
 headache _____

location: RIGHT EYE LEFT EYE BOTH EYES
severity: mild moderate severe (1/10) _____

apparent injury? no yes possibly

context: contact lenses soft / hard _____
 sick contact pink eye _____
 foreign body / direct trauma chemical exposure _____
 by: _____ washed eye(s) at scene with _____
 projectile or penetration injury exposure welding arc / tanning booth _____
 wearing glasses protective _____

Where? home work school _____
 Other injuries? neck head back other _____

modifying factors: none _____

ROS

CONST - recent illness / fever _____
 ENT - nasal drainage _____
 GI - nausea / vomiting _____
 NEURO - numbness / weakness _____
 GU - problems urinating _____
 LNMP _____ preg post-menop _____
 CVS - chest pain _____
 RESP - shortness of breath / cough _____
 MS - neck / back pain _____
 LYMPH - ankle swelling (R / L) _____
 SKIN - rash _____

except as marked positive, all systems above reviewed and found negative

PAST HX _____ no chronic diseases

cardiac disease Afib CAD CHF MI _____
 diabetes Type 1 Type 2 _____
 diet / oral / insulin _____
 hypertension _____
 HIV / steroids _____
 previous eye problem / injury _____
 glaucoma / cataract (R / L) _____
 macular degeneration _____
 prior eye surgeries (R / L) _____
 _____ old records reviewed / summary: _____

Tetanus immun. UTD / given in ED _____
 Meds- none / see nurses note _____
 Allergies- NKDA / see nurses note _____

SOCIAL HX smoker ppd / never / past / quit: _____ ago
 tobacco: use / dependence _____ nicotine: use / dependence _____
 drugs _____ alcohol (recent / heavy / occasional) screening _____

FAMILY HX negative _____

Nursing Assessment Reviewed Vitals Reviewed _____
 V/S BP _____ HR _____ RR _____ Temp _____

PHYSICAL EXAM

General Appearance
 ___no acute distress ___mild / moderate / severe distress
 ___alert ___anxious / lethargic

Examined with Slit Lamp (R / L)

Visual Acuity ___NOTED (see nursing assessment)
 R - 20/ _____ L - 20/ _____
 with correction without correction

General Eye Inspection
 ___no globe trauma ___blunt / penetrating ocular trauma (R / L)
 ___periorbital swelling (R / L)
 ___proptosis (R / L)

Eyelids
 ___nml inspection ___see diagram
 ___everted for ___foreign body under eyelid (R / L)
 exam (R / L) ___edema (R / L)
 ___erythema (R / L)
 ___stye (R / L)

___ecchymosis (R / L)
 ___subcutaneous orbital emphysema (R / L)

Conjunctiva and Sclera
 ___nml inspection ___see diagram
 ___injected (R / L)
 ___exudate (R / L)
 ___foreign material (R / L)
 ___subconjunctival hemorrhage (R / L)
 ___scleral icterus

Circle positives, backslash negatives, check normals

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Time: _____

anesthesia: Tetracaine / other _____

foreign body removal: _____
 with cotton-tip swab / irrigation / needle / burr
 Residual material after foreign body removal
 none / debris / rust ring _____

cornea curettaged for residual material with burr / drill
 Residual material after corneal curettage
 none / debris / rust ring _____

irrigation: R / L eye(s) with _____ mL NS / LR / water _____ Morgan lens
 other: _____

intraocular pressure: RIGHT EYE _____ mm Hg
 LEFT EYE _____ mm Hg
 measured by: Schiøtz tonometry / Tonopen / applanation

PROCEDURES

SKIN
 intact, nml palp _____
 tenderness / swelling _____
 crepitus _____
 pressure ulcer: location _____
 depth / stage: 1 2 3 4 _____

NECK / BACK
 nml inspection _____
 painless ROM _____

RESPIRATORY
 no distress _____
 lungs clear _____
 decreased breath sounds (R/L) _____
 wheezes / rales / rhonchi (R/L) _____

CVS
 heart sounds nml _____
 reg. rate & rhythm _____
 tachycardia / bradycardia _____

ABDOMEN / GU
 non-tender _____
 no organomegaly _____
 tenderness / guarding: _____
 generalized RUD LUQ RLQ LLQ _____
 catheter present _____

NEURO / PSYCH
 oriented x4 _____
 mood / affect nml _____
 disoriented to: _____
 person place time situation _____
 motor / sensory loss (R/L) _____
 depressed affect _____

HEAD / ENT
 nml inspection _____
 pharynx nml _____
 tenderness / swelling _____
 temporal artery tenderness _____
 TM erythema / dullness (R/L) _____
 pre-auricular node (R/L) _____
 pharyngeal erythema / tonsillar exudate _____

Segments
 nml funduscopic (R/L) _____
 unable to examine (R/L) _____
 papilledema (R/L) _____
 exudate (R/L) _____
 hemorrhage(s) (R/L) _____

Anterior Chambers
 nml inspection _____
 see diagram _____
 hyphema (R/L) _____
 cell / flare (R/L) _____
 narrow angle (R/L) _____

RIGHT EYE
 A=abrasion
 D=dye uptake (fluorescein)
 FB=foreign body
 SCH=subconjunctival hem.

LEFT EYE
 A=abrasion
 D=dye uptake (fluorescein)
 FB=foreign body
 SCH=subconjunctival hem.

Corneas
 nml inspection _____
 examined w/ fluorescein (R/L) _____
 foreign body (R/L) _____
 abrasion (R/L) _____
 fluorescein dye uptake (R/L) _____
 corneal ulcer (R/L) _____

EOM's
 intact _____
 palsy / entrapment (R/L) _____

Pupils
 PERRL _____
 nml accommodation _____
 irregular pupillary shape (R/L) _____
 abnml pupillary size _____
 (unequal / miotic / mydriatic)
 R- _____ mm L- _____ mm
 pupil sunken (R/L) _____

SKIN
 see diagram _____
 foreign body (R/L) _____
 abrasion (R/L) _____
 fluorescein dye uptake (R/L) _____
 corneal ulcer (R/L) _____

XRAYS / CT

Xrays done: facial sinus orbits C-spine _____
Interpretation: By me Viewed by me Discsd w/ radiologist
 ___ nml / NAD ___ no fracture ___ nml alignment ___ no FB
 abnml: fracture (see below) STS DJD FB

CT done: head facial bones orbits C-spine _____
Interpretation: By me Viewed by me Discsd w/ radiologist
 ___ nml / NAD _____
 abnml: _____

Fracture:

Skull: frontal parietal temporal occipital basilar: ant mid post
 R/L linear comminuted depressed

Facial: nasal orbit malar maxilla zygoma Le Fort: I II III
 R/L mandible: ramus angle body condyle subcondyle symphysis

C1 fx: arch: ant post burst (Jefferson fx) lateral mass
 : stable unstable nondisplaced displaced

C2 fx: dens: type I II III extension teardrop
 traumatic spondylo (hangman fx): type I II IIIA III
 : stable unstable nondisplaced displaced

C T L: wedge teardrop burst spinous process
 # ___ : stable unstable nondisplaced displaced

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 # ___ : stable unstable nondisplaced displaced

LABS

CBC	Chemistries	UA	ETOH
normal except	normal except	normal except	TOX
WBC _____	Na _____		
Hgb _____	K _____		
Hct _____	CO2 _____	HCG	PT / PTT
Platelets _____	Gluc _____	serum / urine	INR
	BUN _____	POS NEG	
	Creat _____		

PROGRESS

Time _____ unchanged improved re-examined

- ◆ BP Screen - ≥ 18 y / screening / follow-up documented _____
- ◆ Minor head trauma - 2y - 17y / ≥ 18 y / GCS 15 / PECARN risk: high low / CT head _____ see PECARN rule on quality addendum template #200
 ___ measure exclusions: not eligible / refused / not indicated / contraindicated

Discussed with Dr. _____ Time: _____
 will see patient in: ED / hospital / office

Counseled patient / family regarding: _____ Additional history from:
 lab / rad. results diagnosis need for follow-up family caretaker paramedics
 ___ Rx given

___ Tobacco cessation: discussed: plan / trigger / challenges / gave Rx
 ___ Alcohol cessation: discussed: plan / risk / coping measures
 CRIT CARE TIME (excluding separately billable procedures) _____ min

Initial visit unless marked:
 subsequent sequelae

CLINICAL IMPRESSION

Eye - Nontrauma

Blepharitis: R/L up lid lower lid
 : ulcerative seborrheic staph

Central retinal vein occlusion: R/L

Conjunctivitis: R/L acute chronic
 : simple atopic viral epidemic
 follicular mucopurulent GC
 chemical: _____

Chalazion: R/L : up lid lower lid

Corneal ulcer:
 R/L : central peripheral
 w/ hypopyon

Cotton wool spots R/L

Dacryocystitis: R/L : acute chronic

Glaucoma: R/L : acute chronic :
 open-angle angle-closure :
 mild moderate severe

Hypopyon: R/L

Iritis: R/L : acute chronic :
 primary secondary:
 infectious noninfectious

Keratitis: R/L : UV exposure
 punctate herpetic

Ocular hypertension: R/L

Orbital cellulitis: R/L

Periorbital cellulitis: R/L

Retinal artery occlusion: R/L :
 central branch transient

Retinal detachment: R/L

Retinal hemorrhage: R/L

Sty: R/L : up lid lower lid :
 internal external

Vision loss: R/L :
 sudden transient

Eye - Trauma

Chemical exposure: R/L :
 w/ conjunctivitis corneal burn
 substance: _____
 by accident assault unk

Conjunctiva FB: R/L

Conjunctival hemorrhage: R/L

Corneal abrasion: R/L : w/ FB

Corneal FB: R/L

Corneal laceration: R/L :
 w/ loss of intraocular contents

HypHEMA: R/L

Orbit fracture: R/L : floor roof
 w/ entrapment

Penetrating wnd to eyeball / orbit
 : R/L : w/ FB

Scleral laceration: R/L :
 w/ loss of intraocular contents

Other

Diabetes: Type I Type 2 :
 w/ complications _____

w/ retinopathy:
 NPDR: mild mod sv PDR
 w/ macular edema

Eye pain: acute chronic : R/L

DISPOSITION DECISION TIME- _____ home transfer _____

admit ___ POA pressure ulcer / UTI (foley) _____

CONDITION- unchanged improved stable _____

Care transferred to Dr. _____ Time: _____

 Template Complete See Addendum (Dictated / Template # _____) MD / DO

