03 McLaren THUMB REGION

McLaren Thumb Region
1100 S. Van Dyke
Bad Axe, MI 48413 • 989-269-9521

EMERGENCY PHYSICIAN RECORD
Facial / Scalp Injury

DATE:_______ TIME SEEN:_______ on arrival RM:____ *EMS Arrival*

HISTORIAN: patient spouse paramedics________________

__HX / __EXAM LIMITED BY:________________________

☐ unable to obtain

HPI

chief complaint: injury to: head face
mouth lip chin nose forehead

onset / duration:
just prior to arrival
today yesterday__________
__________ min / hrs / days ago

where:
home school neighbor's
park work street

timing:
still present better
gone now

*pain intermittent / lasting*__________
*worse / persistent since*__________

context: fall direct blow incision stab burn

severity of pain: mild moderate severe (1/10)__________

associated symptoms: seizure memory impairment
lost consciousness: *yes no unknown duration:*________*sec / min*
*remembers: event coming to hospital*__________
neck pain headache__________
other injuries__________

ROS

CONST - recent illness / fever_____
EYE - problems with vision_____
ENT - nasal drainage / congestion___
MS - back pain__________
NEURO - numbness / weakness____
GU - problems urinating__________
*LNMP*________ *preg post- menop*

CVS - chest pain__________
RESP - shortness of breath_____
LYMPH - ankle swelling *(R / L)*___
SKIN - rash__________
GI - nausea / vomiting__________

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

▪ *CONST / NEURO / MS components also addressed in HPI*

PAST HX

__no chronic diseases

cardiac disease *Afib CAD CHF MI* hypertension__________
diabetes *Type I Type 2* hepatitis / HIV__________
*diet / oral / insulin*__________ asthma / COPD__________

__old records reviewed / summary:

Tetanus immun. *UTD / given in ED*__________

Meds- __none / see nurses note aspirin coumadin clopidogrel___

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
__alert

__c-collar / backboard *(PTA / in ED)*
__mild / moderate / severe distress________
__anxious / lethargic__________

HEAD

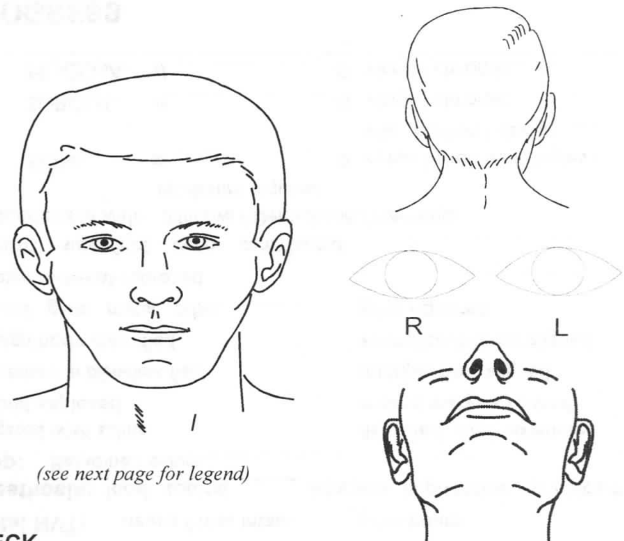
__non-tender
__no swelling
__no obvious trauma

__see diagram
__raccoon eyes / Battle's sign *(R / L)*______

EYES

__lids & conjunctivae nml
__PERRL
__EOMI

__see diagram__________
__unequal pupils *R ____mm L____mm*
__EOM entrapment / palsy *(R / L)*________
__hyphema / retinal detachment *(R / L)*____
__periorbital hematoma *(R / L)*
__subconjunctival hemorrhage *(R / L)*______
__foreign body *(R / L)*__________
__fluorescein uptake__________



(see next page for legend)

NECK

__non-tender
__painless ROM

__see diagram__________
__pain on movement of neck__________

__Nexus criteria neg

__midline tenderness / distracting injury___
__altered mental status / recent ETOH___
__focal neuro deficit__________

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ENT

__nml external exam
__pharynx nml
__no injury to teeth lips or gums

__see diagram
__hemotympanum *(R / L)*
__TM obscured by wax *(R / L)*
__clotted nasal blood *(R / L)*
__nasal septal hematoma *(R / L)*
__dental injury / malocclusion
__laceration *crosses vermillion border*

R L

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

NEURO / PSYCH

__oriented x4
__sensation nml
__motor nml
__CN's nml *(2-12)*
__mood / affect nml

__disoriented to:
person place time situation
__confused / obtunded
__weakness / sensory loss
__facial droop *(R / L)*
__abnormal gait
__depressed mood / affect

RESPIRATORY

__chest non-tender
__no resp. distress
__breath sounds nml

__tenderness / ecchymosis / abrasions
__decreased breath sounds *(R / L)*
__wheezes / rales / rhonchi *(R / L)*

CVS

__heart sounds nml
__reg. rate & rhythm

__tachycardia / bradycardia

ABDOMEN / GU

__non-tender

__see diagram
__tenderness / guarding :
generalized RUQ LUQ RLQ LLQ
__ecchymosis
__catheter present

SKIN

__intact, nml palp

__crepitus
__pressure ulcer: *location*
depth / stage: 1 2 3 4

EXTREMITIES

__non-tender

__see diagram
__tenderness / ecchymosis *(R / L)*

PROCEDURES

Wound Description / Repair: *Time:*

length ____ **cm location** ____

linear stellate irregular flap into: subcut / muscle

clean contaminated *moderately / heavily*

distal NVT: neuro / vasc intact galea intact

anesthesia: local topical ____ lidocaine bupivacaine epi / bicarb

prep: Betadine / other

irrigated with saline
wound explored
to base / in bloodless field
foreign body identified
wood glass metal other
foreign material removed

debrided *mod. /extensive*
wound margins revised
multiple flaps aligned
vermillion border aligned
galea repaired

repair: *superficial deep complicated*

Wound closed with: adhesive / Dermabond / steri-strips
no closure required

SKIN- # ____ ____-0 nylon / prolene / staples / silk / ethilon / dexon
SUBCUT- # ____ ____-0 vicryl / chromic
MUCOSA- # ____ ____-0 vicryl / chromic

PROGRESS

Time ____ unchanged improved re-examined

A=Abrasion
B=Burn
C=Contusion
E=Ecchymosis
FB=Foreign Body
L=Laceration
M=Muscle spasm
PtT=Point Tenderness
PW=Puncture Wound
S=Swelling
T=Tenderness
Ø= without
m=mild
mod=moderate
sv=severe

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XRAYS / CT

Xrays done: skull facial spine: C T L

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: skull facial spine: C T L

Interpretation: ☐ By me ☐ Viewed by me ☐ Discsd w/ radiologist

__nml / NAD

abnml:

Fracture:

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

Facial: R / L nasal orbit malar maxilla zygoma Le Fort: I II III
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 IIA III
: stable unstable nondisplaced displaced

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

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

LABS

CBC normal except	**Chemistries** normal except	**UA** normal except	
WBC	Na		
Hgb	K		
Hct	CO2	HCG	
Platelets	Gluc	serum / urine	
	BUN	POS NEG	
	Creat		

PROGRESS - Continued

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: lab / rad. results diagnosis need for follow-up

Additional history from: 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:

CLINICAL IMPRESSION ☐ subsequent ☐ sequelae

Skin (**R / L ; FB ; specify anatomy)
Laceration:
Abrasion:
Contusion:

Strain (**R / L; specify anatomy)
Neck

Sprain (**R / L; except for spine specify joint & ligament)
Spine: C T L

Ortho (See Xrays / CT)
Fracture: closed / open
Dislocation

Neuro
Concussion
Post-Concussion syndrome
R / L Cerebral: contusion lac traumatic hemorrhage
R / L Epidural Subdural Traumatic SAH
LOC: unknown few sec < min ___sec / mins unk time
Seizure

Other
GSW / Stab / Penetrating injury : to: head neck: ant post thorax
Pain: acute chronic : traumatic neck T-spine
Tooth#___: fx avulsion sublux

DISPOSITION DECISION TIME-___ ☐ home ☐ transfer___ ☐ admit __**POA** pressure ulcer / UTI (foley) ___

CONDITION- ☐ unchanged ☐ improved ☐ stable

Care transferred to Dr___ Time:___

MD / DO

☐ Template Complete ☐ See Addendum (Dictated / Template #___)

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PROCEDURAL SEDATION NOTE

☐ See Nursing notes for V/S monitoring

Sedation type: deep moderate other__________

HPI ☐ see patient template

Indications:__________

last meal__________ Time: __ __ __ __

HPI ☐ see patient's template

prior complications to general anesthesia__________

prior complications to procedural sedation__________

Allergies: __NKDA see nurses note__________

brevital etomidate fentanyl ketamine lidocaine

midazolam morphine nitrous oxide propofol__________

other__________

ASA Classification ______

E. Emergency conditions applies

P1. Normal healthy patient

P2. Patient with a mild systemic disease

P3. Patient with a severe systemic disease

P4. Patient with a severe systemic disease that is a constant threat to life

P5. Moribund patient who is not expected to survive w/o the operation

Physical Exam ☐ see patient's template

AIRWAY

__nml anatomy

__obese__________

__large tongue / teeth__________

__angioedema__________

__abnormal 3-3-2-rule__________

__possible upper airway obstruction__________

__neck immobility__________

Mallampati Classification ______

Class1. Soft palate, anterior / posterior tonsillar pillars, and uvula visible

Class2. Tonsillar pillars and uvula hidden by base of tongue

Class3. Only soft palate visible

Class4. Soft palate not visible

Preparation

__plan explained:__________

to patient *to parent / guardian*

__consent signed (see hospital consent)__________

__oximetry during procedure__________

__capnometry during procedure__________

__IV access obtained__________

__suction immediately available__________

__cardiac monitor used__________

Sedation

__etomidate__________

__fentanyl__________

__ketamine__________

__propofol__________

__versed__________

Reversal

__none__________

__narcan__________

__romazicon__________

Complications during / after procedure - none vomiting apnea O_2 desaturation required BVM-PPV hypotension agitation other__________

Post Sedation Recovery Score ☐ see sedation record

I personally performed ☐ sedation and / or ☐ procedure

Intra-service time: __less than 10 mins __10-22min __23-37 min __38-52 min __53-67 min __68-82 min __83-97 min __98-112 min

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__________ **MD / DO**

☐ Template Complete ☐ See Addendum (Dictated / Template #______)

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