07 McLaren THUMB REGION

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

EMERGENCY PHYSICIAN RECORD
Trunk 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: neck chest back abdomen

onset / duration:
just prior to arrival
today / yesterday_____
_____min / hrs / days ago

where:
home school neighbor's
park work street
_____

context: fall blow incision stab burn GSW

location of pain / injury:
chest_____ neck_____
back: *upper mid lower radiating to: R / L thigh / leg*_____
abdomen: *generalized RUQ LUQ RLQ LLQ*_____

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

associated symptoms: blow to head seizure dizziness
lost consciousness: *yes no unknown duration:* _____*sec / min*
remembers: event coming to hospital

ROS

CONST - recent illness / fever____
ENT - nasal drainage _____
RESP - shortness of breath / cough
NEURO - numbness / weakness___
GU - problems urinating_____
*LNMP*_____ *preg post- menop*

CVS - palpitations_____
GI - nausea / vomiting_____
LYMPH - ankle swelling (*R / L*)___
SKIN - rash_____
PSYCH - depression / hallucinations
_____

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

▪ *NEURO / MS components also addressed in HPI*

PAST HX

__no chronic diseases
cardiac disease *Afib CAD CHF MI* hypertension_____
diabetes *Type 1 Type 2* _____ hepatitis / HIV_____
*diet / oral / insulin*_____ prior injury
__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

cardiac disease_____

☐ 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
__no evidence of trauma
__raccoon eyes / Battle's sign *(R / L)*_____
__laceration / abrasion_____

NECK
__non-tender
__painless ROM
__trachea midline
__vertebral point-tenderness_____
__muscle spasm / decreased ROM_____
__pain on movement of neck_____

EYES
__PERRL
__EOMI
__unequal pupils *R-____mm L-____mm*
__EOM entrapment / palsy *(R / L)*_____
__subconjunctival hemorrhage *(R / L)*_____
__pale conjunctivae_____

ENT
__nml external inspect
__no dental injury
__facial abrasions *(R / L)*_____
__hemotympanum *(R / L)*_____

CVS
__heart sounds nml
__reg. rate & rhythm
__no JVD
__no murmur
__no gallop
__no friction rub
__irregularly irregular rhythm_____
__extrasystoles *(occasional / frequent)*_____
__tachycardia / bradycardia_____
__JVD present_____
__murmur grade ___ /6 *sys / dias*_____
__gallop (S3 / S4)_____
__decreased pulse *(R / L)*_____

Circle (positives), backslash negatives, check √ normals

RESPIRATORY

__chest non-tender
__breath sounds nml
__tenderness / ecchymosis_____
__crepitus / subcutaneous emphysema_____
__splinting / paradoxical movements_____
__flail chest / seat belt bruising
__decreased breath sounds (R / L)_____
__wheezes / rales / rhonchi (R / L)_____

ABDOMEN

__non-tender
__no organomegaly
__rebound / tenderness :
generalized RUQ LUQ RLQ LLQ ____
__mass / organomegaly_____

GENITAL / RECTAL

__nml genital exam
__nml vaginal exam
__nml rectal exam
__heme neg. stool
__perineal hematoma_____
__blood at urethral meatus_____
__catheter present_____
__decreased rectal tone_____

BACK

__no vertebral tenderness
__no external sign of trauma
__see diagram_____
__vertebral point tenderness_____
__CVA tenderness (R / L)_____
__muscle spasm / limited ROM_____
__ecchymosis / abrasion_____
__rib tenderness (R / L)_____

HIPS / PELVIS

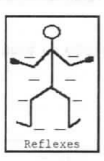
__pelvis stable
__hips non-tender
__see diagram_____
__bony point-tenderness (R / L)_____
__painful / unable to bear weight (R / L)_____

EXTREMITIES

__no evidence of trauma
__nml ROM
__no pedal edema
__see diagram_____
__bony point-tenderness (R / L)_____
__painful / unable to bear weight (R / L)_____
Joint Exam: _____
__limited ROM / ligaments laxity (R / L)_____
__joint effusion (R / L)_____

NEURO / PSYCH

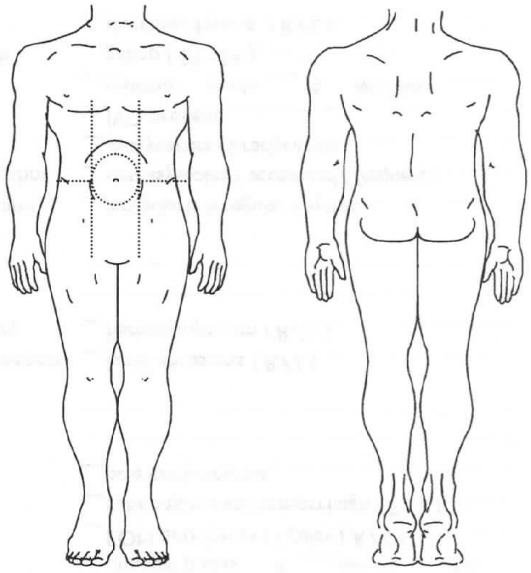
__oriented x4
__CN's nml (2-12)
__sensation nml
__motor nml
__mood / affect nml
__disoriented to: *person place time situation*
__facial asymmetry (R / L)_____
__sensory / motor deficit_____
__unsteady / ataxic gait_____
__depressed mood / affect_____



SKIN

__intact
__warm, dry
__crepitus / diaphoresis_____
__pressure ulcer: *location*_____
depth / stage: 1 2 3 4 _____

A=Abrasion
B=Burn
E=Ecchymosis
FB=Foreign Body
Lac=Laceration
M=Muscle Spasm
PtT=Point Tenderness
S=Swelling
T=Tenderness
Ø=without
m=mild
mod=moderate
sv=severe



PROCEDURES

Wound Description / Repair: *Time:*_____
length_____**cm** **location**_____
linear stellate irregular flap into: subcut / muscle
clean contaminated *moderately / heavily* _____
distal NVT: neuro / vasc intact no tendon injury
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
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_____

LABS

CBC *normal except*
WBC_____
Hgb_____
Hct_____
Platelets_____

Chemistries *normal except*
Na_____
K_____
CO2_____
Gluc_____
BUN_____
Creat_____

UA *normal except*

HCG
serum / urine
POS NEG

ETOH_____
TOX_____
PT/PTT_____
INR_____

EKG

RHYTHM STRIP Rate:_____ Rhythm: *NSR*

EKG ☐Interp. by me ☐Viewed by me ☐Discsd w/ cardiologist
__*nml / NAD* __*nml intervals* __*nml axis* __*nml QRS* __*nml ST/T*
Rate:_____ Rhythm: *NSR sinus tach A-fib* _____
not / *changed from:*_____ *repeat EKG: unchanged /* _____

Circle (positives), backslash negatives, check √ normals

XRAYS / CT / MRI

Xrays done: *CXR KUB pelvis spine: C T L S*

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

__nml / NAD __no fracture __nml alignment __nml soft tissue

abnml: fracture (see below) STS DJD FB

R / L *hemothorax pneumothorax tension pulm. contusion*

CT / MRI done: *chest abdomen pelvis spine: C T L S* __

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

__nml / NAD

abnml:

Fracture:

Rib: R / L *single multiple*

Sternum: *body manubrium xiphoid*

Pelvis: R / L pubic: *superior ramus inferior ramus*

R / L ischium: avulsion ramus tuberosity : *displaced*

R / L acetabulum: ant wall medial post dome : *displaced*

R / L illium: wing ant sup spine ant inf spine : avulsion comminuted linear : *displaced*

Sacrum: transverse: displaced: *ant post* upper-comminuted

vertical fx thru: ala foramen spinal canal : displaced: *mild sv*

Spine fx: *(see page 4 for C1 & C2 fx)*

C T L S: wedge teardrop burst spinous process

#___ : *stable unstable nondisplaced displaced*

C T L S: wedge teardrop burst spinous process

#___ : *stable unstable nondisplaced displaced*

C T L S: wedge teardrop burst spinous process

#___ : *stable unstable nondisplaced displaced*

(n=nondisplaced d=displaced)

Ultrasound / FAST Exam: *heart / pericardium abdomen*

Interpretation: ☐ By me ☐ By radiologist

__nml / NAD

abnml:

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*

__referred to / discussed with Dr._____ Time:_____

will see patient in: ED / hospital / office in _____ days

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 thorax: *ant post* low back

Sprain *(**R / L; except for spine specify joint & ligament)*

Spine: *C T L S*

Ortho / Spine *(See Xrays / CT)*

Fracture: *closed / open*

Dislocation

Disc disorder: degenerative

herniated / bulging disc :

C T L S : *upper mid lower*

w/ radiculopathy myelopathy

CV / Resp *(See Xrays / CT)*

Aorta transection: *abd thoracic*

Cardiac arrest

Cardiac contusion

Hemopericardium

R / L Hemothorax

R / L Pneumothorax *tension*

R / L Pulmonary: *contusion lac*

Respiratory arrest

Abdomen / GI / GU

Hemoperitoneum

Liver: contusion

lac: ___*cm stellate multiple*

Spleen: contusion: *<2cm >2cm*

lac: *<1cm 1-3cm >3cm*

Pancreas:

head: contusion lac: *sm med lg*

body: contusion lac: *sm med lg*

tail: contusion lac: *sm med lg*

Kidney:

R / L : contusion: *<2cm >2cm*

lac: *<1cm 1-3cm >3cm*

Neuro *(See HPI & PE)*

Concussion

LOC: *unknown few sec < min*

___*sec / mins unk time*

Cord compression: *C T L S level*

Cord injury: incomplete complete

: *level C: # ____*

T: # ____

L: # ____ sacral

Radiculopathy: C T L S :

upper mid lower

Sciatica: *R / L w/ low back pain*

Other

Diaphragm rupture

Shock: *traumatic hypovolemic*

Penetrating injury into abd cavity

Pain: acute chronic : *traumatic*

neck thoracic spine low back

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 #_____)

Circle positives, backslash negatives, check ✓ normals

6230.137.07-18 ♦ Reportable Measure

PROGRESS - Continued

*Time*_____ unchanged improved re-examined

XRAYS - Continued

Spine fx:

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*

PROCEDURES

Wound Description / Repair: *Time:*_____

length_____**cm** **location**_____

linear stellate irregular flap into: subcut / muscle

clean contaminated *moderately / heavily* _____

distal NVT: neuro / vasc intact no tendon injury

anesthesia: local topical _____ lidocaine / bupivacaine epi / bicarb

prep: Betadine / other_____

irrigated with saline debrided *mod. /extensive*

wound explored wound margins revised

to base / in bloodless field multiple flaps aligned

foreign body identified: _____

*wood glass metal other*_____ _____

foreign material removed _____

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_____

CHEST TUBE INSERTION

estimated blood loss mL

*Time:*_____ (_____*French*) *Betadine prep*

anesthesia- _____*mL local regional (rib) block lidocaine bupivacaine*

position- mid / anter / post axillary line _____ *interspace*

sutured in place position confirmed on CXR

return- air / blood _____ *connected to suction*

CENTRAL LINE

estimated blood loss_____mL

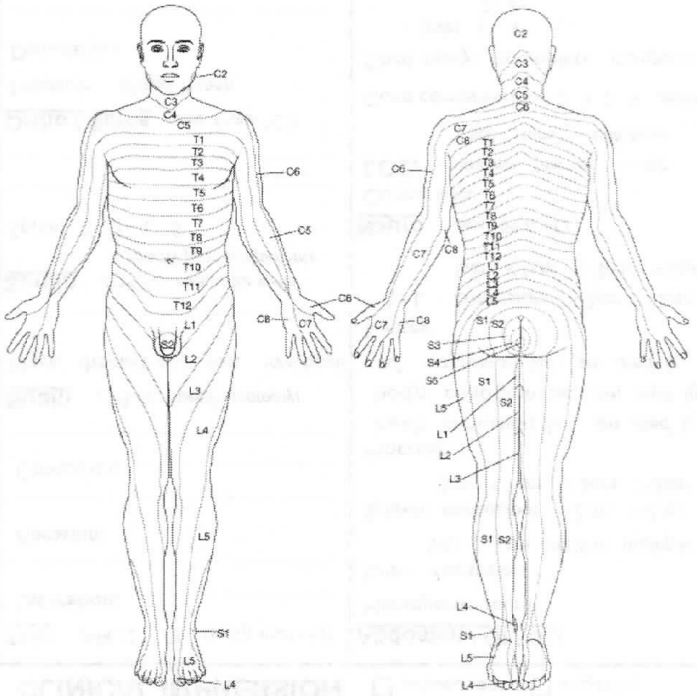
central line placed ___*-lumen* ___*-gauge* *prep: chlorhexidine*

maximum sterile barrier technique U/S assisted: sterile technique

anesthesia- _____*mL local lidocaine /* _____

position- R / L subclavian internal jugular (post / ant / inf approach)
femoral

secured good blood return position confirmed on CXR



Levels of principle dermatomes

C5	Clavicles	T10	Level of umbilicus
C5, 6, 7	Lateral parts of upper limbs	T12	Inguinal or groin regions
C8, T1	Medial sides of upper limbs	L1, 2, 3, 4	Anterior and inner surfaces of lower limbs
C6	Thumb	L4, 5, S1	Foot
C6, 7, 8	Hand	L4	Medial side of great toe
C8	Ring and little fingers	S1, 2, L5	Posterior and outer surfaces of lower limb
T4	Level of nipples	S1	Lateral margin of foot and little toe
		S2, 3, 4	Perineum

_____ ***MD / DO***

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

Circle (positives,) backslash ~~negatives~~, check √ normals