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

EMERGENCY PHYSICIAN RECORD
Hand / Wrist 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: R / L arm elbow forearm
wrist hand palm *thumb index middle ring small*

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

where:
home school neighbor's
park work street

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

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

context: fall blow laceration crush burn
human / animal bite _______________

location of injury:
R- elbow wrist hand fingers
L- elbow wrist hand fingers

modifying factors:
__none
pain on movement__________

ROS

CONST - recent illness / fever____
EYE - problems with vision______
ENT - nasal drainage__________
MS - neck / back pain__________
RESP - shortness of breath / cough
GU - problems urinating________
*LNMP*______ *preg* *post- menop*

GI - nausea / vomiting ________
LYMPH - ankle swelling *(R / L)*___
SKIN - rash_______________
NEURO - headache____________
CVS - chest pain_____________
PSYCH - anxiety / depression____

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

• MS components also addressed in HPI

PAST HX
__no chronic diseases R / L HANDED
cardiac disease *Afib CAD CHF MI* hypertension__________
diabetes *Type I 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
__negative__________

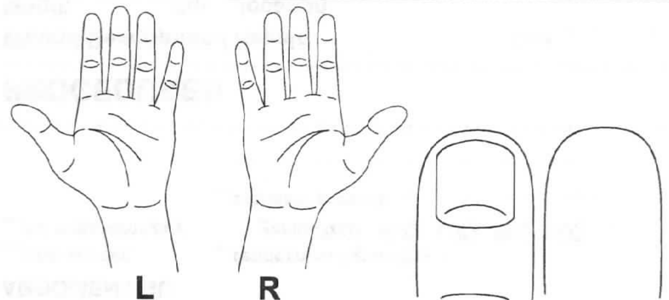
☐ Nursing Assessment Reviewed ☐ Vitals Reviewed __________
*V/S BP*________ *HR*________ *RR*________ *Temp*________

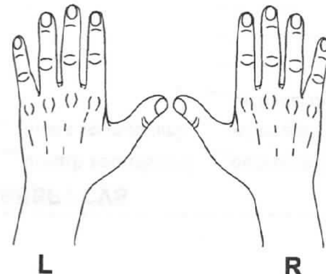
PHYSICAL EXAM

General Appearance
__no acute distress __mild / moderate / severe distress__________
__alert __anxious__________

EXTREMITIES
HAND
__nml inspection __see diagram__________
__non-tender __tenderness *soft-tissue / bony (R / L)*________
__no evidence of FB __swelling / ecchymosis *(R / L)*________
__limited ROM *(R / L)*________
due to: pain / functional deficit
__deformity *(R / L)*________
__nail injury *(R / L)*________finger: #________
complete / partial avulsion subungual hematoma

WRIST
__nml inspection __see diagram__________
__non-tender __tenderness *soft-tissue / bony (R / L)*________
__nml ROM __tenderness in anatomical snuff box *(R / L)*
__wrist pain on axial thumb load *(R / L)*______
__swelling / ecchymosis *(R / L)*________
__limited ROM *(R / L)*________
__deformity *(R / L)*________





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

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Circle (positives) backslash negatives, check √ normals

NEURO

__sensation nml __digital nerve deficit *(R / L)*______
__motor nml *decreased fine touch abnml 2-point discrim.*

__median nerve deficit *(R / L)*______
sensory deficit- lat. 3 ½ fingers / lat palm
motor deficit- pronation / thumb flexion
index & middle finger flexion

__ulnar nerve deficit *(R / L)*______
sensory deficit- med. palm / med. 1 ½ fingers
motor deficit- thumb adduction / fingers adduct.

__radial nerve deficit *(R / L)*______
sensory deficit- dorsolateral hand
motor deficit- wrist drop / thumb extension

VASCULAR

__no vascular compromise __pallor / cool skin / abnml cap refill *(R / L)*______
__pulse deficit *(R / L) radial ulnar*______

TENDONS

__tendon function nml __deficit in tendon function *(R / L)*______
limited extension limited flexion
__tendon injury: abrasion lac: *complete partial*
location: R / L : *f-arm wrist hand digit*
involving:
R / L brachioradialis FCR FCU
palmaris longus FPL FPB
FDS: *2nd 3rd 4th 5th*
FDP: *2nd 3rd 4th 5th*
ECR longus ECR brevis ECU common ext
EPL EPB ext digitorum: *2nd 3rd 4th 5th*
APL APB ext indicis ext digiti minimi

FOREARM / ELBOW / ARM

__uninjured above wrist __see diagram______
__tenderness *soft-tissue / bony (R / L)*______
__swelling / ecchymosis *(R / L)*______
__deformity *(R / L)*______
__limited ROM *(R / L)*______

SKIN

__warm, dry __see diagram______
__intact __diaphoretic / cool / cyanotic______
__pressure ulcer: *location*______
depth / stage: 1 2 3 4 ______

HEAD / ENT

__nml inspection __tenderness______
__pharynx nml __swelling / ecchymosis______

NECK / BACK

__nml inspection __tenderness______
__non-tender __swelling / ecchymosis______

RESP / CVS

__breath sounds nml __decreased breath sounds *(R / L)*______
__heart sounds nml __wheezes / rales / rhonchi *(R / L)*______
__tachycardia / bradycardia______

ABDOMEN / GU

__non-tender __tenderness / guarding :
__no organomegaly *generalized RUQ LUQ RLQ LLQ* ______
__catheter present______

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
digital block ______
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______
NAIL BED- #______ ______-0 ______

Reduction / Splinting / Other: *Time:*______

__procedural sedation (see page 4)______
__local / regional anesthesia ______ lidocaine bupivacaine
__reduced with manipulation______
__post reduction *NV intact alignment good*______

__splint *Velcro OCL / Plaster Aluminum-foam*______
Volar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles
*fingers buddy taped*______
applied by ED Physician / MLP / Tech / Nurse______
examined post splint application *NV intact alignment good*
__digital block: finger______ bupivacaine lidocaine
__subungual hematoma drained *using electrocautery / burr*______
__foreign body removed *with forceps with incision with exploration*
__nail removed *completely partially*______

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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

LABS

CBC	Chemistries	UA	
normal except	*normal except*	*normal except*	ETOH______
WBC______	Na______	______	TOX______
Hgb______	K______	______	______
Hct______	CO2______	HCG	______
Platelets______	Gluc______	serum / urine	______
______	BUN______	POS NEG	______
______	Creat______	______	______

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 /* ______

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
digital block ______

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______

NAIL BED- #______ ______-0 ______

PROGRESS - Continued

*Time*______ unchanged improved re-examined

______ *MD / DO*

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

Circle (positives), backslash negatives, check √ normals

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XRAYS

Xrays done: R elbow f-arm wrist hand ________finger
L elbow f-arm wrist hand ________finger

Interpretation: ☐ By me ☐ Viewed by me ☐ Discsd w/ radiologist
__nml / NAD __no fracture __nml alignment __no FB
abnml: fracture / dislocation (see below) STS effusion fat pad sign FB

Fracture:

Radius: proximal: head neck torus
R / L shaft: transverse oblique spiral segmental comminuted
Galeazzi's greenstick "bent bone"
distal: Colle's Smith's Barton's intra-articular torus styloid
n / d ________

Ulna: proximal: olecranon coronoid process : intra-articular torus
R / L shaft: transverse oblique spiral segmental comminuted
Monteggia's greenstick "bent bone"
distal: styloid transverse oblique comminuted torus
n / d ________

Carpal: navicular: prox ⅓ mid ⅓ distal ⅓ triquetrum lunate
R / L capitate hamate pisiform trapezium trapezoid
n / d ________

Metacarpal: 1st 2nd 3rd 4th 5th : base shaft neck head
R / L Bennett's Rolondo's
n / d ________

Phalanx: proximal shaft distal : 1st 2nd 3rd 4th 5th
R / L n / d ________

Dislocation:
R / L **Elbow:** ant post med lat radial head: ant post med lat
R / L **Wrist:** distal radioulnar radiocarpal midcarpal
carpometacarpal: 1st 2nd 3rd 4th 5th
R / L **MCP:** 1st 2nd 3rd 4th 5th
R / L **IP / PIP / DIP:** 1st 2nd 3rd 4th 5th

(n=nondisplaced d=displaced)

PROGRESS

Time________ unchanged improved re-examined

♦ **BP Screen** - ≥ 18 y / screening / follow-up documented________
__measure exclusions: not eligible / not indicated / contraindicated ________
__referred to / discussed with Dr.________ Time:________
will see patient in: ED / hospital / office in ________ days

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:

CLINICAL IMPRESSION

☐ subsequent ☐ sequelae

Skin (**R / L ; FB ; specify anatomy)
Laceration: ________
Fingertip inj: 1st 2nd 3rd 4th 5th
R / L : subungual hematoma
nail injury nail bed injury
nail avulsion tip amputation
Abrasion: ________
Puncture wound: w/ FB ________
Open bite: ________
Contusion: ________
Burn: thermal electrical
chemical: ________
accident self-harm assault unk
1st, area: ________ ; ____%
2nd, area: ________ ; ____%
3rd, area: ________ ; ____%
Total BSA=____%

Strain
R / L forearm:
flexor: of hand
of digit: 1st 2nd 3rd 4th 5th
extensor: of hand
of digit: 1st 2nd 3rd 4th 5th
R / L hand intrinsic:
1st 2nd 3rd 4th 5th

Sprain R / L :
Wrist: radiocarpal joint carpal
MCP: 1st 2nd 3rd 4th 5th
IP / PIP / DIP: 1st 2nd 3rd 4th 5th

Ortho (See Xrays)
Fracture: closed / open
Dislocation

Neuro
Nerve injury:
R / L : radial ulnar median
at: up-arm f-arm wrist hand

Vascular
Lacerated: artery vein
R / L : brachial radial ulnar
cephalic basilic
at: up-arm f-arm wrist hand

Tendon (See P.E.)
Tendon laceration:

Other
Crush injury: R / L : f-arm hand
digit: 1st 2nd 3rd 4th 5th
Amputation: partial complete
R / L : f-arm hand
digit: 1st 2nd 3rd 4th 5th

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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6230.139.07-18 ♦ Reportable Measure

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