11 McLaren THUMB REGION

McLaren Thumb Region
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EMERGENCY PHYSICIAN RECORD
Lower Extremity 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 *hip thigh* _____ *knee leg ankle foot* ____

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

where:
home school neighbor's
park work street
_____

context: fall twist direct blow incision burn

location of injury:
R: *thigh knee leg ankle foot toe(s)* _____
L: *thigh knee leg ankle foot toe(s)* _____

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

associated symptoms:
unable to bear weight *(R / L)*_____ became dizzy / fainted_____
snapping / popping sensation *(R / L)* seizure_____

ROS

MS - neck / back pain_____
NEURO - headache_____
CONST - recent illness / fever_____
CVS - chest pain_____
GU - problems urinating_____
*LNMP*_____ *preg post- menop*

RESP - shortness of breath / cough
GI - nausea / vomiting _____
LYMPH - ankle swelling *(R / L)*_
SKIN - rash_____
PSYCH - anxiety / depression____
_____

☐ 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*
diabetes *Type I Type 2* _____
*diet / oral / insulin*_____
__old records reviewed / summary:_____

hypertension_____
hepatitis / HIV_____
prior injury_____

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
__alert
__c-collar / backboard *(PTA / in ED)* _____
__mild / moderate / severe distress_____
__anxious_____

EXTREMITIES *(diagram on following page)*

FOOT
__nml inspection
__non-tender
__nml color / temp
__skin intact
__see diagram_____
__tenderness *soft-tissue / bony (R / L)*_____
__swelling / ecchymosis / erythema *(R / L)*__
__deformity *(R / L)*_____
__pulse deficit *(R / L)*

ANKLE
__nml inspection
__non-tender
__nml ROM
__no joint swelling
__skin intact
__see diagram_____
__tenderness *soft-tissue / bony (R / L)*_____
__swelling / ecchymosis / erythema *(R / L)*
__limited ROM *(R / L)*_____
__laxity of ligaments *(R / L)*_____
__deformity *(R / L)*_____

Ottawa Ankle/Foot Rules:
Any pain in the malleolar or midfoot area, and any one of the following:
- Bone tenderness along the distal 6 cm of the posterior edge of the fibula or tibia, or the tip of the lateral or medial malleolus
- Bone tenderness at the base of the 5th metatarsal (for foot injuries)
- Bone tenderness at the navicular bone (for foot injuries)
- An inability to bear weight four steps both immediately and in the ED

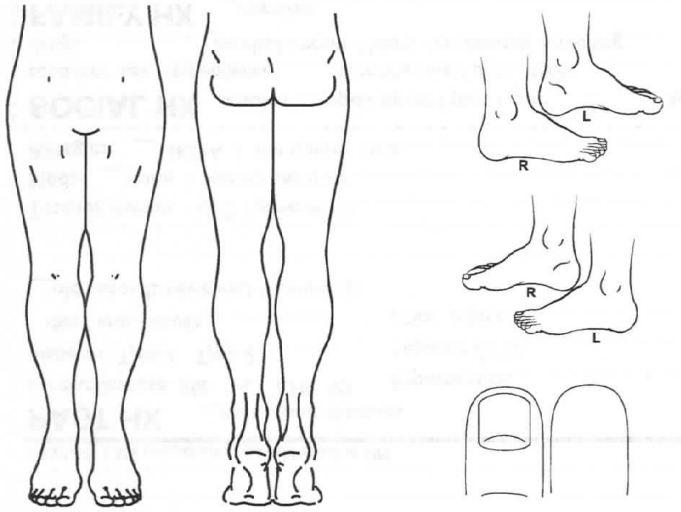
LEG
__nml inspection
__non-tender
__no evidence of ischemia
__see diagram_____
__tenderness *soft-tissue / bony (R / L)*_____
__swelling / ecchymosis / erythema *(R / L)*

KNEE
__nml inspection
__non-tender
__nml ROM
__no joint swelling
__see diagram_____
__tenderness *soft-tissue / bony (R / L)*_____
__swelling ecchymosis / erythema *(R / L)*
__joint effusion *(R / L)*_____
__limited ROM *(R / L)*_____
__deformity *(R / L)*_____

__stable

Ligaments-
__pain / laxity on anterior drawer *(R / L)*___
__pain / laxity on posterior drawer *(R / L)*__
__pain / laxity on medial stress *(R / L)*_____
__pain / laxity on lateral stress *(R / L)*_____

Circle positives backslash negatives, check √ normals



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

THIGH / HIP

__nml inspection
__tenderness *soft-tissue / bony (R / L)*_____
__swelling / ecchymosis *(R / L)*_____
__limited hip ROM *(R / L)*_____
__hip pain on leg movement *(R / L)*_____

NEURO / VASC / TENDON

__sensation nml
__motor nml
__no vascular compromise
__sensory / motor deficit *(R / L)*_____
__pallor / cool skin / abnml cap refill *(R / L)*_____
__pulse deficit *(R / L)*_____
__deficit in tendon function *(R / L)*_____

GAIT

__normal
__limited by pain / unable to bear weight *(R / L)*
__antalgic gait _____
__gait not tested due to pain_____

SKIN

__warm, dry
__intact
__ecchymosis / abrasion / laceration_____
__pressure ulcer: *location*_____
depth / stage: 1 2 3 4 _____

HEAD / ENT

__nml inspection
__pharynx nml
__tenderness_____
__swelling / ecchymosis_____

NECK / BACK

__nml inspection
__non-tender
__tenderness_____
__swelling / ecchymosis_____

RESPIRATORY

__chest non-tender
__breath sounds nml
__tenderness / swelling / ecchymosis / abrasions
__decreased breath sounds *(R / L)*_____
__wheezes / rales / rhonchi *(R / L)*_____

CVS

__heart sounds nml
__tachycardia / bradycardia_____

ABDOMEN / GU

__non-tender
__pelvis stable
__tenderness / guarding :
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
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_____
OTHER- #_____ _____-0 _____

Reduction / Splinting / Other *Time:*_____
__procedural sedation (see page 4)_____
__reduced with manipulation_____
__post reduction *NV intact alignment good / fair / poor*_____
__splint *stirrup / posterior* OCL / plaster
ace wrap / tape crutches post-op shoe
air cast_____
applied by ED Physician / MLP / Tech / Nurse_____
examined post splint application *NV intact alignment good*
__digital block: toe _____ bupivacaine lidocaine
__foreign body removed *with forceps with incision with exploration*
__arthrocentesis betadine prep; ____% lidocaine epi
____mL serous / serosanguinous bloody fluid removed

PROGRESS

*Time*_____ unchanged improved re-examined

Circle (positives,) backslash negatives, check √ normals

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

XRAYS - cont

CXR

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

__nml / NAD __no infiltrates __nml heart size __nml mediastinum

abnml:_____

LABS

CBC	Chemistries	UA	ETOH_____
normal except	*normal except*	*normal except*	TOX_____
WBC_____	Na_____	_____	_____
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

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_____

OTHER- #_____ _____-0 _____

PROGRESS - continued

*Time*_____ unchanged improved re-examined

_____

_____

_____

_____

_____

_____

MD / DO

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

Circle positives, backslash negatives, check √ normals

XRAYS - Lower Extremity

(CXR on pg 4)

Xrays done:

R pelvis hip femur knee lower leg ankle foot toes
L pelvis hip femur knee lower leg ankle foot toes

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

Fracture:

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*

Femur: head: *articular surface* neck: *subcapital transcervical base*
R / L intertrochanteric greater troch lesser troch subtroch
shaft: *transverse oblique spiral segmental comminuted*
distal: supracondylar: *w/ intercondylar*
condyle: *medial lateral* transcondylar
n / d

Patella: *longitudinal transverse comminuted osteochondral*
R / L n / d

Tibia: proximal: *spine tuberosity* condyle: *medial lateral*
R / L shaft: *transverse oblique spiral segmental comminuted*
distal: *med malleolus pilon torus*
n / d

Fibula: proximal: *linear avulsion stress Maisonneuve torus*
R / L shaft: *transverse oblique spiral segmental comminuted*
distal: *lat malleolus comminuted torus*
n / d

Ankle: *lat malleolus med malleolus*
R / L *bimalleolar trimalleolar distal tibial pilon*
n / d

Foot: calcaneus: *body ant process tuberosity*
R / L *extra-articular intra-articular*
talus: *head neck body dome post process lat process*
extra-articular intra-articular avulsion chip fx
navicular cuboid cuneiform: *medial middle lateral*
metatarsal: *1st 2nd 3rd 4th 5th*
toe: *1st 2nd 3rd 4th 5th* : *prox phalanx middle distal*
n / d

Dislocation:

R / L **Hip:** central posterior anterior: *obturator pubic iliac*
R / L **Patella:** *medial lateral*
R / L **Knee:** *anterior posterior medial lateral rotatory*
R / L **Ankle / Foot:** *subtalar midtarsal transmetatarsal Lisfranc*
R / L **Toe:** *1st 2nd 3rd 4th 5th : MTP PIP IP DIP*

(n=nondisplaced d=displaced)

PROGRESS - Continued

♦ **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: *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:
Burn: thermal electrical
chemical:
accident self-harm assault unk
1st, *area:* _____ ; _____%
2nd, *area:* _____ ; _____%
3rd, *area:* _____ ; _____%
*Total BSA=*_____%

Strain
R / L *hip muscle quadriceps hamstring thigh adductor*
R / L lower leg muscle: *ant post Achilles tendon*
R / L foot: *intrinsic muscle*

Sprain
R / L hip: *iliofemoral lig. ischiocapsular lig.*
R / L knee: collateral: *med lat* cruciate: *ant post*
R / L ankle: *calcaneofibular* talofibular: *ant post tibiofibular deltoid*
R / L foot: *tarsal ligament tarsometatarsal lig.*
R / L toe: MTP / IP : *1 2 3 4 5*

Ortho *(See Xrays / CT)*
Fracture: *closed / open*
Dislocation
Achilles Tendon Rupture: R / L
Traumatic Joint Effusion:
R / L *knee ankle*

Neuro
Nerve injury:
R / L : sciatic femoral
tibial peroneal
at: *hip thigh lower leg ankle*

Vascular
Lacerated: artery / vein :
R / L femoral popliteal
peroneal tibial: *ant post*
saphenous: *greater lesser*
at: *hip thigh knee lower leg*

Other
Crush injury:
R / L *thigh knee low leg*
foot toe: 1 2 3 4 5
Amputation: partial complete
R / L at: *hip thigh knee*
lower leg ankle
midfoot toe: 1 2 3 4 5

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

6230.141.07-18 ♦ Reportable Measure