48 McLaren THUMB REGION

McLaren Thumb Region
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EMERGENCY PHYSICIAN RECORD
♦ Syncope / Near-Syncope ♦

DATE:_____ TIME SEEN:_____ on arrival RM:____ *EMS Arrival*
HISTORIAN: patient spouse paramedics_____
__HX / __EXAM LIMITED BY: _____
☐ unable to obtain

Similar symptoms previously_____
*previous diagnosis / tests / workup for this problem*_____
Recently seen / treated by doctor / hospitalized_____

HPI

chief complaint: syncope / near-syncope

witnessed? no yes, by: family friend bystander_____

timing / onset / duration: _____min / hrs / days ago
*last known well date:*_____ *time:*_____
*single episode occurred*_____
*multiple episodes (#_____) began*_____
*most recent episode:*_____

context / position / activity at time of episode(s):
sitting_____
lying down_____
standing for _____*min*
sitting to standing_____
standing up from bath_____
activity-_____

symptoms occurring just prior to episode(s):
none chest pain
headache palpitations
lightheaded racing heart
visual disturbance abd pain
nausea / vomiting back pain
duration of PRECEDING symptoms-

character of event(s):
felt faint / almost passed out_____
collapsed / lost consciousness / became unresponsive_____
seizure activity observed_____
*focal generalized tonic tonic-clonic*_____
duration of LOC: _____*sec / min unknown*
awake and alert after becoming supine_____
confused after event_____
incontinent of urine / stool _____
breathing shallow / stopped _____
lost pulse_____
dextrostick low PTA (_____) / given D50 PTA_____

location of injury: none
head neck face mouth tongue chest abdomen back
RUE LUE RLE LLE _____

associated symptoms:
__none (feels back to normal)
chest pain_____
shortness of breath_____
abdominal pain_____
nausea / vomiting_____
shoulder / arm pain *(R / L)*_____
weakness_____
light-headedness_____
dizziness_____
headache_____

ROS

CONST
recent illness / fever_____
RESP
cough_____
EYES
problems with vision_____
GI
diarrhea_____
black stools_____
GU
problems urinating_____
LNMP_____ preg post - menop
irregular / missed period(s)_____
ENT
sore throat_____
MS
joint pain_____
SKIN
rash_____
LYMPH
swollen glands_____
ankle swelling *(R / L)*_____
NEURO
confusion_____
PSYCH
anxiety / depression_____

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

▪ *CONST / EYES / MS / CVS / RESP / GI / NEURO components also addressed in HPI*

PAST HX __no chronic diseases

cardiac disease *Afib CAD CHF MI*
diabetes *Type 1 Type 2*_____
*diet / oral / insulin*_____
hypertension_____
aneurysm *CNS / abdomen / chest*
CVA / TIA *deficit (R / L)*_____
DVT / PE risk factors: *cast cancer recent surgery leg swelling bedridden paralysis prior DVT/PE*
hepatitis / HIV_____
asthma / COPD_____
GI bleeding_____
seizure disorder_____
__old records reviewed / summary:_____

Surgeries / Procedures __none
cardiac bypass / stent_____
pacemaker / defibrillator_____
carotid endarterectomy_____
cholecystectomy
appendectomy_____
hysterectomy / BTL / C-section_____

Immunizations: *UTD / referred to PCP*_____

Medications __none see nurses note
aspirin coumadin clopidogrel NSAID
BCP's _____

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
sudden cardiac death DVT/PE seizures_____

Circle (positives), backslash negatives, check √ normals

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed _____
V/S BP_____ HR_____ RR_____ Temp_____

PHYSICAL EXAM

General Appearance

__no acute distress
__alert
__mild / moderate / severe distress_____
__anxious / lethargic_____

EENT

__no apparent trauma
__nml eye inspection
__PERRL
__nml ENT inspection
__pharynx nml
__tenderness / swelling / ecchymosis_____
__scleral icterus / pale conjunctivae_____
__unequal pupils *R ___mm L ___mm*
__nasal septal hematoma_____
__pharyngeal erythema / exudate_____
__hemotympanum *(R / L)*_____

NECK / BACK

__neck supple
__non-tender
__no carotid bruit
__cerv. lymphadenopathy_____
__carotid bruit *(R / L)*_____
__neck / back tenderness_____

RESPIRATORY

__no resp. distress
__breath sounds nml
__no pleuritic chest pain
__respiratory distress_____
__wheezes / rales / rhonchi *(R / L)*_____

CVS

__reg. rate & rhythm
__heart sounds nml
__pulses full / equal
__irregularly irregular rhythm_____
__tachycardia / bradycardia_____
__extrasystoles (occasional / frequent)_____
__murmur grade ___ /6 *sys / dias*_____
__gallop (S3 / S4)_____
__JVD present_____
__decreased pulse_____

ABDOMEN / GU

__non-tender
__no organomegaly
__tenderness:_____
generalized RUQ LUQ RLQ LLQ ___
__hepatomegaly_____
__splenomegaly_____
__bruit_____
__catheter present_____

RECTAL

__heme neg stool
__heme positive stool *trace*_____

SKIN

__color nml, no rash
__warm, dry
__intact
__cyanosis / diaphoresis / pallor_____
__skin rash / embolic lesions_____
__pressure ulcer: *location*_____
depth / stage: 1 2 3 4 _____

EXTREMITIES

__non-tender
__nml ROM
__no pedal edema
__calf tenderness *(R / L)*_____
__Homan's sign / cords *(R / L)*_____
__pedal edema *(R / L)*

NEURO / PSYCH

higher functions

__alert
__oriented x4
__no signs of acute CVA
__nml speech / cognition
__mood / affect nml
__disoriented to: *person place time situation*
__abnml response to commands_____
no response eyes open slow inappropriate
__aphasia *expressive / receptive*_____
__speech / cognition abnormalities_____
__abnml response to pain_____
withdraws flexor extensor none

cranial nerves-

__nml *(2-12)*
__EOM palsy *(R / L)*_____
__facial droop *(R / L)*_____
__tongue deviation (to R / L)_____

cerebellar-

__nml as tested
__abnml Romberg test_____
__abnml finger-nose-finger *(R / L)*_____
__abnml gait_____

sensorimotor-

__no motor deficit
__sensation nml
__weakness_____
__sensory deficit_____
__pronator drift *(R / L)*_____
__abnml reflexes_____
__clonus *(R / L)*_____
__tremor_____

PROGRESS

*Time*_____ unchanged improved re-examined

Circle (positives), backslash negatives, check √ normals

XRAYS / CT

CXR

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

__nml / NAD __no infiltrates __nml heart size __nml mediastinum

abnml:_____

Head CT / MRI

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

__nml / NAD _____

abnml:_____

LABS

CBC	Chemistries	Troponin____	UA
normal except	*normal except*	D-Dimer____	*normal except*
WBC_____	Na_____	_____	_____
Hgb_____	K_____	_____	_____
Hct_____	CO2_____	HCG	**ABG**
Platelets_____	Gluc_____	serum / urine	RA /___L O_2
_____	BUN_____	POS NEG	pH_____
_____	Creat_____	_____	pCO2_____
_____	_____	_____	pO2_____
_____	_____	_____	_____

Pulse Ox ____% on RA /____L O_2 Interp: nml / hypoxic Time:_____

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 / _____

Postural Vitals:

lying: BP _____ HR _____

sitting: BP _____ HR _____

standing: BP _____ HR _____

PROGRESS - Continued

Time_____ unchanged improved re-examined

♦ **CVA** - *t-PA given within 3 hrs last known well*_____

♦ **A-Fib / A-Flutter** - ≥ *18 y / oral anticoagulant*_____

♦ **BP Screen** - ≥ *18 y / screening / follow-up documented*_____

__measure exclusions: *not eligible / refused / not indicated / contraindicated*

♦ TPA *given / held reason for hold or delay*_____

__EKG - *delay R/T*_____

__**Aspirin:** ***given / held*** **Reason for hold**_____

__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

Neuro

♦ CVA: *(**specify vessel if known)*

Infarct: thrombotic embolic occlusion, unk type

artery involved:

(R / L) _____

_____

Hemorrhage:

Intracerebral: subcortical cortical intraventricular

SAH brainstem cerebellar

artery involved:

(R / L) _____

_____

TIA: acute recent multiple :

c/w syndrome:

carotid ACA MCA PCA

a. fugax vertebra-basilar

lacunar: motor sensory

Seizure: generalized focal complex partial absence status epilepticus :

w/ hx of epilepsy: idiopathic

*due to drugs:*_____

: sz control: good poor

CV / Resp

Acute MI: *STEMI NSTEMI*

anterior inferior lateral post

Arrhythmia: *PACs PJCs PVCs*

sinus brady sinus tachy

sick sinus syndrome

sinoatrial pauses

♦ *A-fib: paroxysmal chronic*

♦ *A-flutter: typical atypical*

PSVT

AV block: 1st 2nd 3rd

nodal rhythm idoventricular

V tach V flutter torsades

Aortic dissection: *thoracic abd*

Aortic aneurysm: *thoracic abd : w/ rupture*

Pulm embolism *w/ cor pulmonale*

Other

Dehydration

Drug reaction, adverse: _____

GI Bleed: *w/: hematemesis hematochezia melena occult blood*

Hyperventilation syndrome

Hypoglycemia: *w/ coma*

w/ diabetes: Type 1 Type 2

Hypotension: *orthostatic idiopathic post - procedure*

Hypovolemia

Substance abuse: _____

w/: intoxication dependence withdrawal delirium perceptual disturbance

Syncope: *vasovagal orthostatic near syncope*

Signs / Symptoms

Dizziness

Hypoxemia

Nausea / Vomiting / Diarrhea

Weakness

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

♦ Reportable Measure

Disposition Decision

Decision made at:__ __ __ __ Left Dept. at: __ __ __ __

Basis For Discharge Decision:

pt. condition: stable improved unchanged
ambulatory active
drinking fluids eating
pain controlled

pt. exam: stable improved unchanged
alert, oriented

test results: no abnml no serious abnml
min abnml mod abnml

social support: adequate good excellent

follow up: available arranged discussed w/ physician

Basis For Admit Decision:

need for:

further evaluation	IV hydration
add'l testing	IV medication
monitoring	IV antibiotics
telemetry	culture results
pain control	surgery / intensive care

PROGRESS - Continued

*Time*_____ unchanged improved re-examined

_____ *MD / DO*

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

Circle (positives,) backslash negatives, check √ normals