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| --- | --- | --- |
| AMB | Acne | Acne  Discussed face washing (no scrubbing, gentle soap, pat and air dry) no more than 2-3x/day Will start benzoyl/clinda qAM, started 2-3x/week and gradually increase to daily use Then can start Adapalen at night, gradually increase frequency to qHS Wash face before applying alternating medications Acne may worsen before it starts to improve It may take 3-4 months to notice change Follow-up in 3-4 months Will consider course of oral antibiotics at that time |
| AMB | Ankle pain | Ankle Pain  \_ yo \_ complaining of ankle pain L/R: \_ DOI: \_ MOI: \_ "Pop" heard: \_ Swelling: \_ Decreased functions: \_ Able to ambulate: \_ Self-treatment: \_  Location of pain: \_ Quality of pain: \_ Severity of pain: \_ Duration of symptoms: \_ Radiation of symptoms: \_ Aggravating factors: \_ Alleviating factors: \_ Associated symptoms: \_  Objective  Extremities:  Good distal pulses. Sensation to soft touch intact. FROM limited only by swelling and discomfort. Ankle exam: Limited d/t pain and swelling.  Inspection: No obvious bony or soft tissue abnormality. No edema. No ecchymosis. No pes planus or pes cavus. ROM: Normal AROM (dorsiflexion 20, plantar flexion 50, abduction 10, adduction 20, subtalar inversion 5, subtalar eversion 5)  Palpation: No tenderness of the medial and lateral malleoli, calcaneous, talar head, tarsal bones, MTP joints, or phalanges. No tenderness over the deltoid ligament, talofibular ligaments, insertion of the Achilles tendon, or plantar fascia. Ligamentous integrity: No laxity or pain elicited with ankle inversion, eversion. Negative anterior/posterior drawer. Achilles tendon integrity intact per Thompson test. Neuro: Strength: Muscle strength 5/5 and equal bilaterally including: tibialis anterior, EHL, digitorum longus, gastroc/soleus, peroneus longus/brevis, flexor digitorum. Sensation: Normal to light touch and pinprick over distribution of L4, L5, and S1 nerve roots.  Gait: Normal, non-antalgic  Assessment/Plan: Ankle sprain  PRICE, anti-inflammatory given Brace Crutches Handout with home rehab given DLC profile:  Follow-up prn if not gradually improving  Resources:  Ottawa Ankle Rules: Tenderness over malleoli Unable to ambulate Injury occurred > 10 days previous  Ankle X-ray not needed if both are true:  Able to ambulate at injury or in ER for 4 steps  No pain over distal posterior 6 cm of tibia, fibula   Foot X-ray not needed for mid-foot pain if both are true:  Able to ambulate at injury or in ER for 4 steps  No pain at fifth metatarsal base and tarsal navicular   Grading:  First degree lateral ankle sprain: Mild pain and swelling (able to ambulate)  No mechanical instability  Anterior talofibular ligament stretched  Localized tenderness anteriorly   Second degree lateral ankle sprain  Moderate pain and swelling with ecchymosis present  Pain with ambulation  Moderate lateral ankle instability  Partial tear of anterior talofibular ligament   Third degree lateral ankle sprain  Severe ecchymosis and swelling (>4 cm at fibula)  Unable to bear weight  Severe lateral ankle instability  Total disruption of lateral ligaments  Anterior talofibular ligament  Calcaneofibular ligament  Heard "Pop" with immediate pain and swelling   Delayed healing (suspected Talar Dome OCD)  Symptomatic beyond 6 weeks  Persistent crepitus  Locking or catching sensation |
| AMB | Basic ROS-1 | Basic ROS 1  Constitutional: no fever, no chills, no unexplained weight changes HEENT: no headache, no acute change in vision CV: no chest pain, no palpitations Lungs: no SOB, no wheezing Abd: no nausea/ vomiting, no constipation, no diarrhea  Neuro: no numbness/tingling, no new weakness Psyche: not depressed    Basic ROS 2  Constitutional: Denies major changes in health.  Eye: No recent visual problem.  Respiratory: No shortness of breath, No cough.  Cardiovascular: No fatigue, No chest pain, No peripheral edema, No syncope.  Gastrointestinal: No nausea, No abdominal pain, No rectal bleeding.  Hematology/Lymphatics: No bruising tendency, No bleeding tendency.  Endocrine: No unexpected weight changes.  Musculoskeletal: No muscle pain.  Neurologic: No headache. |
| AMB | Biopsy | Shave biopsy  Nodule Likely inflamed mole R/B explained, verbal/written consent obtained Area prepped, 1% lidocaine w/o epi injected for anesthesia Nodule removed as shave biopsy Patient tolerated well, no complications, ebl < 5ml Bandaged, wound care instructions given F/U prn if s/sx infection |
| AMB | Coccydynia | Coccydynia  Acute coccydynia: Initial management is with protection, analgesics, and heat or ice. While it is not possible to put the injured part at rest, patients can protect their coccyx while sitting by leaning forward so that weight is mainly borne on the ischial tuberosities.  "Donut" cushions (pillows with a hole in the center) or "wedge" cushions (with a wedge-shaped section cut out of the back) distribute weight away from the coccyx. Many styles of wedge and donut cushions are sold in pharmacies or on the web. Patients can also make one, by cutting a wedge out of the back of a 2 to 4 inch foam rubber cushion.  It is unclear whether heat or cold applications are preferable; patients should try both and let their symptoms be their guide. Many reviews recommend anti-inflammatory drugs, but there is no research evidence or pathologic rationale for effectiveness beyond their analgesic properties. Coccydynia may be protracted and opioid analgesics should be avoided except in instances of severe pain related to acute trauma.  Diagnostic radiographs are not useful in acute coccydynia, unless there is reason to suspect specific pathology such as infection or cancer. In the absence of concern about these conditions, the significance of radiographic findings is often uncertain and results from radiographs do not change acute management.  Patients should be told that symptoms resolve in most cases, although resolution may occur over weeks or even months, more slowly than most patients expect and want.  Chronic coccydynia: A minority of patients develop chronic coccydynia. These patients are often referred to specialists in pain management (physical medicine and rehabilitation or anesthesiology), or orthopedic surgeons. An algorithm for therapeutic decision-making and treatment in persistent cases, from the point of view of a pain specialist, has been published [8]. Many treatments have been advocated but the evidence base for effectiveness is weak.  Coccydynia (pain in the coccyx) is typically a self-limiting condition, most often related to direct external trauma or repetitive minor trauma. Diagnosis is established by reproducing symptoms with direct pressure on the coccyx during a rectal examination, and the absence of signs of inflammation other than pain and tenderness. (See 'Etiology' above and 'Diagnosis' above.)  We recommend conservative management rather than more invasive therapy, for acute coccydynia (Grade 1C). Conservative treatments include analgesics, protection with donut or wedge pillows and heat or cold applications. We recommend not prescribing opioid medications for this condition, except for patients with pain related to acute trauma (Grade 1C). (See 'Acute coccydynia' above.)  Unless infection or malignancy is suspected, radiographs are not indicated for the acute patient. Patients should be told to expect symptom resolution over weeks to months and should be managed conservatively for at least two months before more aggressive management is tried.  Patients with intractable symptoms should be referred to a specialist with experience in managing coccydynia. In the absence of randomized trials of effectiveness, we suggest management with a series of coccygeal injections containing local anesthetic or local anesthetic plus glucocorticoid (Grade 2C). An alternative option is levator ani massage/stretching and sacrococcygeal joint mobilization. (See 'Local injection' above and 'Manipulation' above.)  We suggest that coccygectomy be performed only as a last resort for intractable cases (Grade 2C). Results of effectiveness from randomized trials are not available and there is a substantial complication rate with this procedure. (See 'Coccygyectomy' above.) |
| AMB | Colonoscopy | Colonoscopy  ROS Constitutional: no fever, no unexplained weight loss, no night sweats HEENT: no congestion, no sore throat Respiratory: no SOB, no cough, no wheezing Cardiovascular: no chest pain, no DOE Gastrointestinal: no dark or bloody stools, no blood on toilet paper, no vomiting, no diarrhea, no constipation, no abdominal pain Genitourinary: no dysuria Hematology/Lymphatics: no easy bruising/bleeding\Musculoskeletal: no new muscle aches/pain Integumentary: no rash Neurologic: no HA, no paresthesias or weakness Psychiatric: no depression   PMHx Heart disease/Murmur: \_ Asthma: \_ COPD: \_ Bleeding Disorder: \_ Self: \_ Family Member: \_ Diabetes: \_ Cancer: \_ Anesthesia Complications: \_ Self: \_ Family: \_ Hypertension: \_ Kidney Disease: \_ Liver Disease: \_ For Women LMP: \_  Preoperative History and Physical for routine screening colonoscopy  ASA category: \_ BMI < 40: \_ Low risk airway: \_ Discussed screening colonoscopy procedure - risks vs benefits Reviewed colon prep, stop whole grains and nuts few days before procedure Stop NSAID/ASA about 1 week before procedure Patient will be contacted with colon prep prior to procedure to pick up medications Patient will be contacted w/ appt time & date Labs and EKG unremarkable  Labs to order  See link and download YKHC guidelines (Pre-anesthesia testing) http://ykhcintranet.ykhc.org/apps/libraryapp/index.cfm?fuseaction=Document.ShowDocumentDetail&id=1283  ASA PS classifications from the American Society of Anesthesiologists  ASA PS 1: Normal healthy patient. No organic, physiologic, or psychiatric disturbance. Excludes the very young and very old; healthy with good exercise tolerance.  ASA PS 2: Patients with mild systemic disease No functional limitations. Has a well-controlled disease of one body system. Controlled hypertension or diabetes without systemic effects. Cigarette smoking without chronic obstructive pulmonary disease (COPD). Mild obesity, pregnancy.  ASA PS 3: Patients with severe systemic disease. Some functional limitation. Has a controlled disease of more than one body system or one major system. No immediate danger of death. Controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms.  ASA PS 4: Patients with severe systemic disease that is a constant threat to life. Has at least one severe disease that is poorly controlled or at end stage. Possible risk of death. Unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure.  ASA PS 5: Moribund patients who are not expected to survive without the operation. Not expected to survive > 24 hours without surgery. Imminent risk of death. Multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy.  ASA PS 6: A declared brain-dead patient who organs are being removed for donor purposes.  Tips for a successful colonoscopy prep  Preparing for a colonoscopy may be uncomfortable and time-consuming, but it needn’t be an ordeal. Here are some things you can do to help it go as smoothly and comfortably as possible:  Make sure you receive your colonoscopy prep instructions well before your procedure date, and read them completely as soon as you get them. This is the time to call your clinician with any questions and to buy the bowel prep she or he has prescribed. Pick up some medicated wipes (for example, Tucks or adult wet wipes with aloe and vitamin E) and a skin-soothing product such as Vaseline or Desitin — you’re going to be experiencing high-volume, high-velocity diarrhea.  Arrange for the time and privacy you need to complete the prep with as little stress as possible. Clear your schedule, and be at home on time to start your prep. If you have children or aging parents who need attention, have someone else be available to them while you’re indisposed.  Water can get boring, so keep a variety of clear liquids on hand. On the day before your colonoscopy — when you’re restricted to clear liquids — you can have popsicles, Jell-O, clear broth, coffee or tea (without milk or creamer), soft drinks, Italian ice, or Gatorade. But take nothing with red, blue, or purple dye. Drink extra liquids before, during, and after your bowel prep (usually until a few hours before your procedure), as well as after your colonoscopy.  To make a bad-tasting liquid prep like PEG or magnesium citrate easier to swallow, try one or more of the following if it doesn’t come flavored: add some Crystal Light or Kool-Aid powder (again, not red, blue, or purple); add some ginger or lime; drink it chilled; drink it through a straw placed far back on your tongue; hold your nose and drink it as quickly as possible; quickly suck on a lemon slice after you finish each glass; hold a lemon or lime under your nose while you drink; suck on a hard candy after each glass.  Wear loose clothing, and stay near the bathroom. Better yet, once the preparation starts to work, stay in the bathroom — because when the urge hits, it’s hard to hold back. Consider setting up shop near the toilet with music, your laptop, magazines, or books.  Diet  A few days before the colonoscopy. Start a eating a low-fiber: no whole grains, nuts, seeds, dried fruit, or raw fruits or vegetables. The day before the colonoscopy. Don’t eat solid foods. Instead, consume only clear liquids like clear broth or bouillon, black coffee or tea, clear juice (apple, white grape), clear soft drinks or sports drinks, Jell-O, popsicles, etc. The day of the colonoscopy. As for the previous day, clear liquid foods only. Don’t eat or drink anything two hours before the procedure  Medications to Avoid for GI Endoscopy Procedures: Upper Endoscopy and Colonoscopy  Some medications (prescription and over-the-counter) can reduce your body’s ability to form blood clots and taking these before GI endoscopy procedures may increase your risk of bleeding during and after these tests. For this reason, it is generally recommended to withhold certain drugs if you are scheduled to have one of these procedures performed. These are sometimes referred to as blood thinners.  The decision about whether to stop any medication is always based on an estimate of the risk of having a significant medical problem during the short time that you are off of them compared to the risk of bleeding complications from the procedure you are to undergo.  For medications used to treat arthritis (regular dose aspirin or nonsteroidal anti-inflammatory drugs, also known as NSAIDs), there is little or no risk to stopping these, but you may have more arthritis pain or swelling. They are usually stopped for four (4) days prior to any procedure. It is safe to take acetaminophen (Tylenol) before an endoscopy for arthritis pain or headaches.  For aspirin (81 or 325 mg daily) used to prevent heart problems, this is usually safe to stop for seven (7) days prior to any procedure. If you have severe heart problems you may need to consult with your heart specialist to determine if it is safe to stop it.  For anti-platelet drugs it is usually important to speak with your heart doctor, vascular surgery specialist, neurologist or primary physician to determine if these are safe to stop. These are usually stopped for seven (7) days prior to any procedure.  For anti-coagulant drugs it is almost always important to consult with the prescribing physician to determine if it is safe to stop them and for how long. For most people who are taking Coumadin (Warfarin) for chronic heart rhythm problems (like atrial fibrillation) it is usually safe to stop it for four (4) days prior to the procedure. However they may be special circumstances where the medication is not stopped or other medications are used to prevent clotting after it is stopped. You should get specific advice from your doctor on how to handle this. |
| AMB | Conjunctivitis | Conjunctivitis  \_ yo \_ c/o red eye Started x days ago: \_ Pain with eye movement: \_ Photophobia: \_ Itching: \_ Seasonal allergies: \_ Discharge: \_ Purulent: \_ Watery with crusting: \_ Change in vision: \_ Self-treatment: \_  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA, \_ conjunctiva redness and swelling, \_ sclera injection, \_ copious watery discharge, EOMI, visual fields intact x 4, reads fine print from > 16 inches away. ENT: NC/AT; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.  Assessment/Plan: Conjunctivitis  Mostly likely viral No concerning signs or symptoms on exam Diligent hand washing and hygiene emphasized Handout with patient information given Do not wear contacts until sx resolve, should throw out case and current lenses F/U prn for severe pain, fever, and/or blurred vision |
| AMB | COPD Screening | COPD: Screening questions  Dyspnea in last 4 weeks (1 point for some of the time, 2 points for most or all of the time): \_ Productive Cough (1 point for some days, 2 points for everyday): \_ Effects function (1 point if agrees, 2 points if strongly agrees): \_ Smoked 100 of more Cigarettes ever (2 points for yes): \_ Age (1 point for 50-60 years old, 2 points for 60 or older): \_   About the score  Score 5-10 — High risk of COPD Score 0-4 — Low risk of COPD https://www.copdfoundation.org/downloads/COPD\_PDF\_Screener.pdf http://www.copdfoundation.org/Screener.aspx The COPD-PS™ has been validated in a diverse population age 35 and older The five questions in the COPD-PS™, culled from a 52-question initial survey, were found to be the most likely to predict COPD The study’s predictive value is 0.59 (AUC) with 88% of COPD cases correctly classified A clinical diagnosis of COPD should be confirmed with spirometry Please visit DRIVE4COPD.COM to learn more about this screener and its validation |
| AMB | DVT Calculator | Conjunctivitis  \_ yo \_ c/o red eye Started x days ago: \_ Pain with eye movement: \_ Photophobia: \_ Itching: \_ Seasonal allergies: \_ Discharge: \_ Purulent: \_ Watery with crusting: \_ Change in vision: \_ Self-treatment: \_  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA, \_ conjunctiva redness and swelling, \_ sclera injection, \_ copious watery discharge, EOMI, visual fields intact x 4, reads fine print from > 16 inches away. ENT: NC/AT; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.  Assessment/Plan: Conjunctivitis  Mostly likely viral No concerning signs or symptoms on exam Diligent hand washing and hygiene emphasized Handout with patient information given Do not wear contacts until sx resolve, should throw out case and current lenses F/U prn for severe pain, fever, and/or blurred vision  Erythromycin ointment for bacterial infection and may provide comfort   DVT calculator (Wells)  Wells Criteria:  Paralysis, paresis or recent orthopedic casting of lower extremity (1 point): \_ Recently bedridden (more than 3 days) or major surgery within past 4 weeks (1 point): \_ Localized tenderness in deep vein system (1 point): \_ Swelling of entire leg (1 point): \_ Calf swelling 3 cm greater than other leg (measured 10 cm below the tibial tuberosity) (1 point): \_ Pitting edema greater in the symptomatic leg (1 point): \_ Collateral non varicose superficial veins (1 point): \_ Active cancer or cancer treated within 6 months (1 point): \_ Alternative diagnosis more likely than DVT (Baker's cyst, cellulitis, muscle damage, superficial venous thrombosis, post phlebitic syndrome, inguinal lymphadenopathy, external venous compression) (-2 points): \_  DVT Risk Score Interpretation  3-8 Points: High probability of DVT 1-2 Points: Moderate probability -2-0 Points: Low Probability |
| AMB | Fracture | Fracture  \_ yo \_ for suspect or r/o fracture Location: \_ DOI: \_ MOI: \_ Pain: \_ Radiation: \_ Paresthesias/cold extremities: \_  Location of pain: \_ Quality of pain: \_ Severity of pain: \_ Duration of symptoms: \_ Radiation of symptoms: \_ Aggravating factors: \_ Alleviating factors: \_ Associated symptoms: \_ |
| AMB | Gastroenteritis | Gastroenteritis  \_ yo \_ c/o nausea/vomiting/diarrhea Started x days ago: \_ Number of times vomited: \_ Number of times diarrhea: \_ Blood in vomitus or stool: \_ Able to hold down liquids: \_ Feeling lightheaded: \_ Abdominal pain: \_ Relieved by defecation or vomiting: \_ Alleviating factors: \_ Aggravating factors: \_ Contacts with similar sx: \_  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; No oral lesions; No erythema, mucus membranes dry \_ moist \_ Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; NABS; No mass; No hepatosplenomegaly, no peritoneal signs GU: Deferred Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.   Assessment/Plan: Gastroenteritis  Viral vs. food poisoning +/- Signs of orthostatic hypotension Liters of NS IVF given: \_  Phenergan prn for nausea, can try Tylenol prn Hydrate, advance diet as tolerated Quarters for 24 hours F/U prn if not gradually improving or if acutely worsens |
| AMB | General exam | Generic exam  Basic Exam 1  General: Alert and oriented, comfortable, cooperative.  Neck: Supple, no goiter, no cervical LAD Respiratory: Lungs are clear to auscultation, respirations are non-labored, and breath sounds are equal.  Cardiovascular: Normal rate, regular rhythm, S1, S2, no murmurs/rubs/gallops, no LE edema, good pulses throughout.  Gastrointestinal: Soft, non-tender, non-distended.  Integumentary: Warm, dry, pink.  Neurologic: No focal deficits.   Basic Exam 2  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.  Neuro: Squats/stands, walks on toes/heels, DTRs 2+ b/l, sensation to soft touch intact |
| AMB | Hypertension | Hypertension  \_ yo \_ for HTN Chest pain: \_ Unusual shortness of breath: \_ Dyspnea on exertion: \_ Frequent/unusual lightheadedness: \_ Orthopnea: \_ Tolerating medications: \_ Compliance with medications: \_ Other: \_  Plan: Hypertension  Encouraged her to buy a home cuff Measure and record BPs 3-4x/week F/U in 1 month to review BPs Can adjust medications as indicated at that time  Emphasized to bring in home cuff so we can compare/calibrate with ours (i.e., r/o white coat) |
| AMB | I & D Abscess | I&D Abscess Boil anesth with \_ml 1% lidocaine.  \_ cm incision made.  \_ exudate expressed.  Packed/ dressed.  Patient tolerated well |
| AMB | Infant exam | Infant  General: No acute distress.  Eye: Normal conjunctiva, Red Reflex x2 seen.  HENT: Normocephalic, Palate intact, Oral mucosa is moist, Anterior fontanelle open/soft/flat.  Neck: Supple, bilateral clavicles wnl.  Respiratory: Lungs are clear to auscultation, Respirations are non-labored, Breath sounds are equal, Symmetrical chest wall expansion.  Cardiovascular: Normal rate, Regular rhythm, No murmur, No edema.  Gastrointestinal: Soft, Non-tender, Non-distended, Normal bowel sounds, No organomegaly.  Genitourinary: Normal genitalia for age and sex, Testes bilaterally descended/nl foreskin.  Musculoskeletal: Normal range of motion, No hip clicks, Normal Barlow's, Normal Ortolani's.  Integumentary: Warm, Dry, Pink.  Neurologic: Alert, Normal sensory, Normal motor function, Moves all extremities appropriately, No focal deficits, normal Startle Reflex. |
| AMB | Insomnia | Insomnia  \_ yo \_ c/o insomniac Started: \_ This is a new problem: \_ Difficulty falling asleep: \_ Difficulty staying asleep: \_ Frequent awakenings: \_ Recent shift work change: \_ Recent travel: \_ No late in the day caffeine, smoking, exercise, alcohol: \_ Tried: \_ Depressed/anhedonia: \_   Objective:  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; TM Clear; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: Good distal pulses. Normal gait. Psyche: Mood euthymic, affect congruent, well groomed, speech and thoughts appropriate   Assessment/Plan: Insomnia  Will give trial of few Ambien Recommend trying OTC melatonin supplement Handout on sleep hygiene and highly recommend sleep routine and good sleep habits Suggested BHOP/MH for sleep training, patient can self-refer at this time If still having problems and needing refill, I will insist that they get sleep training F/U prn |
| AMB | IUD Insertion - Kyleena | Contraception Management - IUD (Kyleena) Insertion:  Patient has not previously used an IUD. She would like Kyleena inserted. The patient has been counseled on her options for contraception including OCP's, patches, vaginal ring, Depo Provera, IUD, Nexplanon, condoms, abstinence, nothing. Patient's previous experience with contraception: \_ Qualitative urine HCG was negative on \_.  LMP was \_. -------------------------------------------------------------------------------------------------------------------------------------------------- Procedure  Written informed consent obtained. Witness present. She has elected to proceed with Kyleena IUD insertion. A safety pause was taken and proper equipment was identified. Bimanual examination reveals that the uterus is \_anteverted \_retroverted \_midline.  A speculum was inserted into the vagina and the cervix was identified.  A swab for a GC/CT test was obtained.  The cervix was prepped with betadine.  The cervix was grasped with a single toothed tenaculum.  The uterus was sounded.  The IUD insertion device was set to the sound depth \_.  The IUD was inserted.  The tenaculum was removed and hemostasis was obtained.  The strings were trimmed.  The speculum was removed.  The patient tolerated the procedure well. The strings were trimmed.  The speculum was removed.  The patient tolerated the procedure well.  Orders:  \_ Ibuprofen 400mg - 800mg po administered in clinic \_ GC/CT to lab \_ Kyleena IUD  Impression and Plan:  Diagnosis: Contraception Management  Patient was given a post IUD insertion instruction sheet.   Patient was told to call if signs of infection or bleeding occur.   Patient was informed that she might have some irregular bleeding for up to 1 week.  Patient was informed that contraception is effective now. |
| AMB | IUD Insertion - Liletta | Contraception Management - IUD (Liletta) Insertion:  Patient has not previously used an IUD. She would like Liletta inserted. The patient has been counseled on her options for contraception including OCP's, patches, vaginal ring, Depo Provera, IUD, Nexplanon, condoms, abstinence, nothing. Patient's previous experience with contraception: \_ Qualitative urine HCG was negative on \_.  LMP was \_. -------------------------------------------------------------------------------------------------------------------------------------------------- Procedure  Written informed consent obtained. Witness present. She has elected to proceed with Liletta IUD insertion. A safety pause was taken and proper equipment was identified. Bimanual examination reveals that the uterus is \_anteverted \_retroverted \_midline.  A speculum was inserted into the vagina and the cervix was identified.  A swab for a GC/CT test was obtained.  The cervix was prepped with betadine.  The cervix was grasped with a single toothed tenaculum.  The uterus was sounded.  The IUD insertion device was set to the sound depth \_.  The IUD was inserted.  The tenaculum was removed and hemostasis was obtained.  The strings were trimmed.  The speculum was removed.  The patient tolerated the procedure well. The strings were trimmed.  The speculum was removed.  The patient tolerated the procedure well.  Orders:  \_ Ibuprofen 400mg - 800mg po administered in clinic \_ GC/CT to lab \_ Liletta IUD  Impression and Plan:  Diagnosis: Contraception Management  Patient was given a post IUD insertion instruction sheet.   Patient was told to call if signs of infection or bleeding occur.   Patient was informed that she might have some irregular bleeding for up to 1 week.  Patient was informed that contraception is effective now. |
| AMB | IUD Removal | Contraception Management - IUD Removal  \_Patient has had a \_Mirena \_Paraguard IUD inserted (\_date) and would like it removed, replaced with \_. \_Patient has had a \_Mirena \_Paraguard IUD inserted (\_date) and would like it removed, not replaced.  The patient has been counseled on her options for contraception including OCP's, patches, vaginal ring, Depo Provera, IUD, Nexplanon, condoms, abstinence, nothing. Patient's choice of contraception after today's visit: \_ Patient's previous experience with contraception: \_ Qualitative urine HCG was negative on \_.  LMP was \_.  Procedure  Verbal informed consent obtained. She has elected to proceed with \_Mirena \_Paraguard IUD removal.  A safety pause was taken and proper equipment was identified.  A speculum was inserted into the vagina and the cervix was identified.  The strings were identified and grasp with \_ ring forceps \_Bozeman clamp.  The patient was asked to cough and the IUD was removed during the distraction.  The IUD was a \_Mirena \_Paraguard and was intact.  Impression and Plan:  Diagnosis: Contraception Management  Patient was told to call if signs of infection or bleeding occur.   Patient was provided with alternative method of contraception: \_ |
| AMB | Knee Pain | Knee Pain  \_ yo \_ complaining of knee pain: \_ L/R: \_ Acute/chronic: \_ DOI: \_ MOI: \_ Location of pain: \_ Quality of pain: \_ Severity of pain: \_ Duration of symptoms: \_ Mechanism of injury: \_ Radiation of symptoms: \_ Aggravating factors: \_ Alleviating factors: \_ Associated symptoms:  Swelling consistent with effusion: \_ Episodes of instability: \_ Episodes of locking: \_ Popping or tearing: \_   Objective  General: No obvious soft tissue or bony abnormality/noticeable edema with ecchymosis: \_ Effusion: \_ Erythema: \_ Warmth: \_ Range of motion: Full active and passive (0-135 extension/flexion, 10 int/ext rotation): \_ ; if not, limitation: \_ Strength: 5/5 hip flexors, quadriceps, hamstrings, gastroc/soleus, ant tibialis: \_ Meniscal integrity: Joint line tenderness: \_ McMurray without palpable clicks: \_ Ligament integrity: MCL or LCL laxity: \_ Lachman: \_ Ant/posterior drawer: \_ Sag sign: \_ Pivot test: \_ |
| AMB | Low Back Pain | Low back pain  \_ yo \_ c/o back pain Started: \_ Hx/o trauma: \_ Similar sx in past: \_ Pain level: \_/10 Interferes with ADLs: \_ Makes it worse: \_ Makes it better: \_ LE numbness/paresthesias: \_ Saddle paresthesias, no bowel/bladder incontinence: \_ Tried: \_  Objective:  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; TM Clear; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Back: No spiny TTP, mild soft tissue TTP, neg straight leg Neuro: Squats/stands, walks on toes/heels, DTRs 2+ b/l, sensation to soft touch intact Gait: Normal   In depth exam  Visualization: No difficulty transitioning from seated position in chair to standing, then seated on exam table.  Inspection: Grossly symmetric and normal cervical/thoracic/lumbar spine without areas of skin abnormality, obvious bony abnormality, or muscle atrophy.  ROM: Normal flexion, extension; normal and symmetric rotation and lateral bending. Palpation: No spinous process tenderness involving cervical, thoracic, or lumbar spine. No paravertebral soft tissue tenderness. No SI joint pain. Straight leg raise: Negative bilaterally Neuro: Muscle strength 5/5 and equal bilaterally involving hip flexors, hip adduction, quadriceps, hamstring, tibialis anterior, EHL, and gastroc/soleus. Sensation normal to light touch/pinprick over the L1, L2, L3, L4, L5, and S1 dermatomes. No saddle anesthesia appreciated. Reflexes: patellar and Achilles reflexes 2+ and equal bilaterally. Babinski not present. Normal rectal tone.  Gait: Stable, non-antalgic   Assessment/Plan: Back pain  No concerning neurologic signs or symptoms PRICE, NSAID, muscle relaxer PT consult: \_ Handout with home rehab give F/U prn |
| AMB | Neuro exam | Neuro exam  Neuro: CN2-12 intact, normal finger to nose/rapid alternating movements/heel to shin/tandem walk, neg pronator drift, neg Rhomberg, 5/5 strength grossly symmetric b/l in UE/LE, DTRs 2+ symmetric throughout, normal gait |
| AMB | Nexplanon Insertion/Removal | Contraception Management - Nexplanon Removal/Insertion  \_Patient has not previously used Nexplanon. She would like a Nexplanon inserted. \_Patient has had a Nexplanon inserted (\_date) and would like it removed, replaced. \_Patient has had a Nexplanon inserted (\_date) and would like it removed, not replaced.  The patient has been counseled on her options for contraception including OCP's, patches, vaginal ring, Depo Provera, IUD, Nexplanon, condoms, abstinence, nothing. Patient's choice of contraception after today's visit: \_ Patient's previous experience with contraception: \_ Qualitative urine HCG was negative on \_.  LMP was \_.  --------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------- Procedure: Nexplanon Removal  Written informed consent obtained. Witness present. She has elected to proceed with Nexplanon removal.   A safety pause was taken and proper equipment was identified.  The \_ arm was positioned and Nexplanon identified.  The removal site was cleansed with ChlorPrep. 2-5 cc of 1% lidocaine \_with \_without epinephrine was injected.  Small incision made with scalpel.  Nexplanon isolated and removed without difficulty. A dressing was placed that included steri strip, bandage and pressure dressing. Bleeding: none Patient tolerated procedure well.   Impression and Plan:  Diagnosis: Contraception Management  The patient was instructed to leave the pressure dressing on for 12 hours.   She was instructed to leave the bandage on for 24 hours.   After that time she may shower and resume normal activities.   She was told to call if signs of infection or bleeding occur.    Patient was provided with instruction (\_and prescription) regarding (\_alternative choice for contraception).  --------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------- Procedure: Nexplanon Insertion  Written informed consent obtained. Witness present. She elected to proceed with Nexplanon.  A safety pause was taken and proper equipment was identified. Patient was counseled on benefits and risks of procedure including but not limited to bleeding, infection, changes in menstrual cycle, spotting with Nexplanon, scaring, difficulty removing device. The \_ arm was positioned and marked at the insertion point 8 cm proximal to the medial epicondyle and 3 cm proximal along the path of insertion.  The insertion area was prepped with ChlorPrep.  2-5 cc of 1% lidocaine \_with \_without epinephrine was injected.  The Nexplanon was removed from the package and was inserted in the usual fashion.  The Nexplanon was palpated by the provider and patient in the \_ arm.   A dressing was placed that included steri strip, bandage and pressure dressing. Bleeding: none Patient tolerated procedure well.   Impression and Plan:  Diagnosis: Contraception Management  The patient was instructed to leave the pressure dressing on for 12 hours.   She was instructed to leave the bandage on for 24 hours.   After that time she may shower and resume normal activities.   She was told to call if signs of infection or bleeding occur.   Patient was informed that contraception is effective within two weeks.  Patient advised that Nexplanon removal is recommended in 3 years or earlier.   Nexplanon card given. |
| AMB | OB Routine | Routine OB  No acute issues Labs reviewed, no concerning findings at this time Discussed concerning signs of bleeding, abdominal pain, loss of fluid, HAs, vision changes, decreased fetal movement F/U in \_ weeks BIB date: \_ Contact information: \_ Cell: \_ Home: \_  Labs/Radiology  12 weeks - Urine Culture: \_ 12-40 weeks – Influenza vaccine: \_ 15-19 weeks - Quad screen: \_ 20 weeks – Anatomy US: \_ 28 weeks - RhoGAM for Rh negative: \_ 26-28 weeks – GST: \_ 26-28 weeks – Hgb/Hct (recheck 4-6 weeks after starting iron if Hg < 10 see algorithm): \_  27-36 weeks – TDaP (every pregnancy): \_ 36 weeks – Hgb/Hct (Bethel protocol): \_ 36 weeks – Group B Strep: \_   Vaccinations:  TDaP – at 27-36 weeks gestation in each pregnancy allows time for maternal Pertussis antibodies to transfer to the baby Hepatitis A Vaccine - Give if travel to endemic area or IVDA in pregnancy Hepatitis B Vaccine - Administer in pregnancy for Hepatitis B risk factor Influenza Vaccine - Indicated if pregnant in Influenza season. Immunize after first trimester Meningococcal Vaccine - Standard indications (dormitory, barracks, travel) Plague Vaccine Polyvalent pneumococcal Vaccine - Vaccinate high risk women before pregnancy. ACIP recommends avoiding during pregnancy Polio Vaccine (live and inactivated) - Avoid during pregnancy in most cases. Use IPV in pregnancy if high risk Polio exposure  Rabies Vaccine  Tularemia Vaccine  Typhoid Vaccine |
| AMB | Plantar Fasciitis | Neuro exam  Neuro: CN2-12 intact, normal finger to nose/rapid alternating movements/heel to shin/tandem walk, neg pronator drift, neg Rhomberg, 5/5 strength grossly symmetric b/l in UE/LE, DTRs 2+ symmetric throughout, normal gait     Plantar fasciitis  \_ yo \_ foot pain Affected foot (L/R): \_ How long: \_ Hx/o trauma/injury: \_ Worse with first few steps in morning or of run: \_ Worse at the end of the day: \_ Worse with prolonged standing: \_ Quality of pain: \_ Severity of pain: \_ Radiation of symptoms: \_ Aggravating factors: \_ Alleviating factors: \_   Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; TM Clear; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait. Foot: No deformity or swelling, no TTP over 5th MT, +ttp along plantar fascia, focal TTP at plantar fascia insertion to calcaneus, N/V intact.  Assessment/Plan: Plantar fasciitis  PRICE, NSAID, handout with home rehab Recommend: orthotics for shoes, low impact activities (bike/elliptical), bike instead of walking/running if possible, regular icing, consider night splints, consider stretching LE upon waking Discussed potentially chronic, waxing and waning nature of this condition F/U prn if not improving |
| AMB | Postpartum visit | Postpartum Check  \_ yo F for postpartum check Delivery date: \_ Term: \_ Vaginal/C-section: \_ Complications: \_ Breastfeeding: \_ Sexually active: \_ Postpartum perineal pain: \_ Support at home: \_ Birth control: \_ Weight loss: \_  Breast: no tenderness, no pain w/ feeding, no abnormal discharge Emotional health: Denies depressed mood, appetite normal, mild fatigue from frequent night-time awakenings to breast feed  Objective  NL VS noted Gen: AOx3, nad HEENT: PERRL, EOMI, op-clear Neck: Supple, no mass CV: RRR, no murmur Lungs: CTA-b Abd: S/nt/nd, uterus not palpable Ext: No calf TTP, no edema Pelvic: Deferred for now CBE: Chaperoned by: \_ . Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple discharge GU: Chaperoned by: \_. Normal appearing female genitalia without lesion. Normal vaginal mucosa without discharge. Cervix normal in appearance. No CMT. Normal bimanual exam.  Assessment/Plan  Postpartum checkup Patient doing well overall No acute issues Pap/breast exam unremarkable Using \_ for contraception F/U prn |
| AMB | PQRST-U: Pain Assessment | PQRST-U: Pain Assessment  Provokes/palliative: \_ Quality: \_ Radiates: \_ Severity: \_ Time: \_ What do ‘you’ think it is: \_ |
| AMB | Pregnancy New | Pregnancy New  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RRR; Normal S1/S2; No MRG Abd: Gravid; soft; flat; non-tender; NABS; S-F height \_\_cm; FHR at \_\_\_ BPM by doptones CBE: Chaperoned by: \_. Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple discharge GU: Chaperoned by: \_. Normal appearing female genitalia without lesion. Normal vaginal mucosa without discharge. Cervix normal in appearance. No CMT. Normal bimanual exam. |
| AMB | Prenatal Labs | Prenatal Labs Hgb | Hct 1st tri \_ Hgb | Hct 3rd tri \_ GC | CT 1st tri \_ GC | CT 3rd tri \_ PAP \_ HIV \_ Quad Screen (MSAFP) \_ Glucola \_ 3 hr Glucola \_ Blood Type and Rh \_ Antibodies \_ PPD \_ Rubella \_ HBs Ag \_ HgbA1c \_ RPR \_ GBS \_ Ultrasound \_ |
| AMB | Prenatal Visit | Prenatal visit  G \_ P \_  \_ w \_ d  EDC \_ Based on \_ LMP \_ 1st trimester US Vaginal bleeding: \_ Loss of fluid: \_ Painful contractions: \_ Fetal movement: \_ Other complaints/concerns: \_   Objective  VS reviewed Gen: AOx3, NAD, well-nourished CV: RRR, no murmur Lungs: CTA-b Abd: gravid, fundal height: \_ cm Position (~36 weeks): \_ Ext: =< 1+ edema, warm and well perfused FHT: \_ |
| AMB | Prostate | Prostate symptoms  Onset/duration: \_ Severity of lower urinary tract sx: \_ Fever: \_ Dysuria: \_ Pain suggestive of stones: \_ Previous urethral instrumentation: \_ Offending Rx (approx. 10% of BPH 2/2 Rx): \_ Anticholinergics (incomplete emptying - IE), antidepressants (e.g. TCA – frequency, IE), antihistamines (IE), bronchodilators (straining), diuretics (freq), opioids (IE), sympathomimetics (strain, IE) History of DM: \_ Tobacco use: \_ Caffeine use, how much: \_ Sexual dysfunction: \_ Neurologic impairment: \_ Personal or family history of prostate or bladder cancer: \_  Severity  AUA SCALE (3-4 point change is clinically significant improvement):     Genitourinary: Digital rectal exam (size, nodules, asymmetry): \_  Assess for bladder distention, motor and sensory deficits of the lower extremities and perineum, and decreased anal sphincter tone to identify neurogenic bladder as a cause of lower urinary tract symptoms independent of BPH  Labs:  PSA (if life expectancy > 10 years) and UA  Benign Prostatic Hyperplasia  Treatment options for bothersome, moderate to severe benign prostatic hyperplasia Lifestyle modifications Losing weight Decreasing evening fluid intake Avoiding excess alcohol, caffeine, or highly seasoned foods Limiting medications known to cause lower urinary tract symptoms  Medications Alpha blockers 5-alpha reductase inhibitors Anticholinergic agents Alpha blockers are effective for bothersome, moderate to severe BPH and are recommended in men not undergoing planned cataract surgery. The combination of alpha blockers and 5-alpha reductase inhibitors is effective for long-term management of BPH and demonstrated large prostates. Anticholinergic agents can benefit selected patients with predominantly irritative lower urinary tract symptoms and a normal post void residual urine measurement.  Medical Therapies for Benign Prostatic Hyperplasia  Nonselective alpha blockers:  Doxazosin (Cardura); 1 mg; titrate to maximum of 8 mg daily; $20 ($80); Orthostatic hypotension requires blood pressure monitoring and dose titration; Less expensive. Terazosin; 1 mg; titrate to maximum of 20 mg daily; $10 (NA)  Selective alpha blockers:  Alfuzosin (Uroxatral); 10 mg; $20 ($400); Low risk of hypotension; No blood pressure monitoring or dose titration. Silodosin (Rapaflo) 8 mg; NA ($170); Retrograde ejaculation. Tamsulosin (Flomax); 0.4 mg; titrate to maximum of 0.8 mg daily; $30 ($190); Decreased ejaculation; Highest risk of intraoperative floppy iris syndrome. 5-alpha reductase inhibitors  Dutasteride (Avodart); 0.5 mg; NA ($155); Ejaculation disorder, decreased libido, erectile dysfunction. No dose titration; Three to six months to take effect; Decreases prostate-specific antigen by 50%; Combination therapy with an alpha blocker ; Recommended in patients with an enlarged prostate Finasteride (Proscar) 5 mg; $10 ($135) Anticholinergic agents  Fesoterodine (Toviaz) 4 to 8 mg; NA ($210); Dry mouth and eyes, constipation; Assess post void residual urine before starting; For patients with predominantly irritative symptoms Oxybutynin extended release (Ditropan XL); 10 mg ; $40 ($175)  Solifenacin (Vesicare) 5 mg; NA ($240)  Tolterodine extended release (Detrol LA) 4 mg; $150 ($265)   Surgery Photo selective vaporization of the prostate Transurethral incision of the prostate Transurethral laser prostatectomy (holmium: yttrium-aluminum-garnet [YAG] laser ablation, enucleation, or resection of the prostate) Transurethral microwave thermotherapy Transurethral needle ablation of the prostate Transurethral resection of the prostate Transurethral vaporization of the prostate  DDx: Benign prostatic hyperplasia Bladder calculi Bladder cancer Bladder irritants (e.g., caffeine) Diabetes mellitus Medication use Anticholinergics (incomplete emptying) Antidepressants, such as tricyclic (frequency, incomplete emptying) Antihistamines (incomplete emptying) Bronchodilators (straining) Diuretics (frequency) Opioid analgesics (incomplete emptying) Sympathomimetic (straining, incomplete emptying) Neurogenic bladder Obstructive sleep apnea (nocturia) Overactive bladder Polyuria (isolated nocturnal, 24-hour polyuria) Prostate cancer Prostatitis Urethral or bladder neck strictures Urethritis/sexually transmitted infections  Urinary tract infection  Notes  The risk of prostate cancer is lower in men with lower urinary tract symptoms and an elevated PSA level than in those without symptoms Post void residual urine measurement using a bladder scanner (normal residual urine is less than 100 mL) should be performed if history and physical examination suggest urinary retention.2,3,13 If significant nocturia is the main symptom, consider using a frequency volume chart that documents date/time, fluid intake, and urine voided (eFigure A) or a sleep study to find alternative causes, such as isolated nocturnal polyuria (more than 33% of urine output at night), 24-hour polyuria (3 L or more of urinary output in 24 hours), or sleep apnea. Frequency volume charts are useful if nocturia (≥ 2 voids per night) is the main symptom. This chart can identify isolated nocturnal polyuria (≥ 33% of urine output occurring at night) or 24-hour polyuria (≥ 3 L of urinary output in 24 hours). |
| AMB | Psyche exam | Psyche Exams  Mental Status  Alert. Appropriately dressed. Oriented to place, person and situation.  Behavior: Cooperative, not needing redirection from this writer or her mother today.  TP: Linear, concrete.  TC: Denies any suicidality, homicidality, or plans of harming self or others; not internally distracted; no delusional statements today.  Speech: NRR and tone, but minimal.  Affect: moderately restricted.  Mood: "OK". Insight - limited.  Judgment: Fair.  Motor: No abnormal movements noted.   Objective  General: The patient is alert & oriented to person, place, time, and situation. He was dressed professionally in BDU's. Interacted appropriately. He exhibited good eye contact, was cooperative, and easy to engage. Speech: Normal volume, rhythm, rate with no pressured speech noted. Tone was slightly constricted but consistent with previous presentations. Good articulation. Mood: 'Good' Affect: Euthymic with full range. No affective lability was noted. Thought Processes: Coherent, linear, logical, and goal directed with no looseness of associations, flight of ideas, tangentiality, or circumstantiality noted. Thought Content: No delusions or paranoia were observed. Perceptions: No auditory or visual hallucinations reported. Suicidal/Homicidal Ideation: He denies SI/HI and denies any intent or plan. Insight: Fair. Judgment: Fair. Suicide Risk Assessment: Low as the patient denies all SI. Violence Risk Assessment: Low as the patient denies all HI. |
| AMB | RUQ Abdominal Pain | RLQ abdominal pain: Appendicitis  Onset: \_ Duration: \_ Nausea: \_ Vomiting: \_ Diarrhea: \_ Fever/chills: \_ Anorexia: \_ Started periumbilical: \_ Pain occurs before vomiting (high sens/med spec): \_  Last bowel movement: \_ Soft and w/o straining: \_ Sexually active: \_ Dysuria: \_ GU discharge: \_ Pregnant/LMP: \_ New activities/injury: \_  Objective  General: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal. ENT: NC/AT; No oral lesions; No erythema. Neck: Supple; No thyromegaly. Lymph: No neck/axillary adenopathy. Chest: CTA; No wheezes/rhonchi/rales. Cardiovascular: RR; Normal S1/S2; No MRG. Abdomen: Soft, flat, NABS; No mass; No hepatosplenomegaly. RLQ pain: \_  McBurneys: \_ Rebound: \_ Guarding: \_ Rovsing LLQ palpation causes RLQ pain): \_ Psoas sign (L lat decubitus, extend at hip): \_ Obturator test (internal rotation of flexed hip): \_ Extremities: No clubbing, cyanosis or edema; Good distal pulses; Normal gait.   Imaging (CT abdomen with contrast vs. US lean children) Labs: No lab marker has sufficient Test Sensitivity to exclude Appendicitis Al-Abed (2014) Am J Surg S0002-9610(14): 00360-2 [PubMed] Complete Blood Count: neutrophilic, leukocytosis Poor predictive value (poor sensitivity and Specificity) Leukocytes normal in 25% of Appendicitis cases High Negative Predictive Value In children, Likelihood Ratio with WBC <10,000 is 0.22 Interpretation Leukocytes range: 10,000 to 20,000 (in 75% of Appendicitis cases) Leukocytosis over 15,000 compels evaluation Higher Leukocytosis suggests appendix perforation C - reactive protein (CRP) Increases within 6-12 hours Test Sensitivity for Appendicitis: 76% Test Sensitivity improves if C-RP remains normal despite >24 hours of symptoms In some studies, normal C-RP at 24 hours had a nearly 100% Negative Predictive Value Urinalysis Sterile pyuria can occur if appendix is adjacent to ureter |
| AMB | SIGECAPS | SIGECAPS  Major Depressive Disorder: At least 5 of the following must be present for at least 2 weeks:  Sleep: Increased or decreased (if decreased often early morning awakening): \_ Interest: Decreased: \_ Guilt/worthlessness: \_ Energy low: Decreased or fatigue: \_ Concentration/difficulty making decisions: \_ Appetite and/or weight increased or decreased: \_ Psychomotor activity: Increased or decreased: \_ Suicidal ideation: \_ |
| AMB | Sore Throat | Sore throat  \_ yo \_ c/o sore throat Started days ago: \_ Fever: \_ Tonsillar exudate: \_ Cough or URI sx: \_ Tender lymph nodes: \_ Aggravating factors: \_ Has tried: \_  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; \_ erythema, \_ exudate Neck: Supple; No thyromegaly Lymph: \_ cervical lymphadenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: Good distal pulses. Normal gait.  Assessment/Plan: Pharyngitis  Strep Score: \_ Rapid strep test: \_ Will send culture and treat as indicated Tylenol/ibuprofen prn Salt water gargles, smooth/wet foods F/U prn if acutely worsening sx  Treatment algorithm: Original Criteria (1 point for each clinical finding)   Tonsillar exudate (+1 point) Tender, anterior cervical adenopathy (+1 point) Cough absent (+1 point) Fever present (+1 point)  Modifiers: Age younger than 15 years: +1 point  Age 15 to 45 years: 0 points  Age over 45 years: -1 points  Interpretation (Clinic and ER probability): Based on original criteria above  Score 0: Streptococcus probability 1% (3% in ER)  Score 1: Streptococcus probability 4% (8% in ER)  Score 2: Streptococcus probability 9% (18% in ER)  Score 3: Streptococcus probability 21% (38% in ER)  Score 4: Streptococcus probability 43% (63% in ER)   Approach: Clinical Suspicion based on Strep Score  Strep Score 4 (or Strep Score 2 if patient unreliable). Treat with antibiotics  Strep Score 2 to 3: Perform rapid antigen test  Antigen test positive: Treat with antibiotics  Antigen test negative: Throat Culture  Strep Score 0 to 1. Provide Pharyngitis Symptomatic Treatment |
| AMB | Synvisc: Knee Pain Injection | Synvisc: Knee pain, injection  R/B of procedure explained, verbal and written consent for injection given Area prepped in usual fashion 21g needle used to inject Synvisc in superior lateral approach No complications, patient tolerated well RTC next week for next injection Ice/Tylenol/NSAID OK for post injection pain |
| AMB | TB Evaluation | TB evaluation  History concerning for active TB: \_ TB converters in household or contacts with active TB: \_ HIV Immunosuppression: \_ Diabetes: \_ Persistent (>3 weeks) cough: \_ Fever: \_ Night sweats: \_ Weight loss: \_ Infection that has not resolved with antibiotics: \_  Chest x-ray (consider radiology consult): Upper lobe infiltrates/cavitation/X-ray worse than clinical presentation: \_  Assessment/Plan: Latent tuberculosis  Labs (CBC, HIV, CMP) and CXR done Does not appear to have active disease on CXR Start tx per YKHC guidelines  Resources  Mary Berliner (contact): 543-0431/545-0440 (to obtain sputum results) Public Health: 543-2110 |
| AMB | Therapeutic Lifestyle | Therapeutic lifestyle generic advise for Assessment/Plan  Encouraged healthy diet, cut down on refined sugars, whole grains OK, fruits/vegetables and lean meats; 150 minutes/week of exercise. |
| AMB | Toenail removal-Ingrown nail | Toenail Removal Assessment/Plan: Ingrown nail  R/L side: \_ R/B explained, verbal/written consent obtained Toe prepped, 1% lido w/o injected for digital block nail cut approx. 1/4 and removed EBL < 10cc Patient tolerated well, no complications Bandaged, wound care instructions given F/U prn if s/sx infection |
| AMB | Trochanteric bursitis | Trochanteric bursitis  \_ yo \_ c/o lateral hip pain Pain overlying greater trochanter: \_ May radiate into knee or ankle or into buttock: \_ Night pain occurs if lying on affected side: \_ Palliative and provocative factors: \_ Worse when standing from seated or lying position: \_ Improves initially on walking: \_ Worse again after walking for >30 minutes: \_ Point tenderness over lateral greater trochanter of hip: \_ Symptoms reproduced on hip adduction: \_ Internal rotation may also provoke: \_  Location of pain: \_ Quality of pain: \_ Severity of pain: \_ Duration of symptoms: \_ Radiation of symptoms: \_ Aggravating factors: \_ Alleviating factors: \_ Associated symptoms: \_  Assessment/Plan: Hip pain/Trochanteric bursitis  DDx includes: Hip Osteoarthritis, Septic hip, Snapping Hip, Trochanteric Fracture, Gluteus medius Tendonitis (Tenderness above greater trochanter), Lumbar Disc Disease or Sciatica (Affects foot, whereas bursitis does not), Bony lesion (e.g. metastasis) S/sx most c/w trochanteric bursitis NSAIDs/APAP, ice, rest/protect Modify activity, low impact activity that does not aggravate Consider physical therapy referral Consider trochanteric bursa injection |
| AMB | Ulnar Neuropathy | Ulnar neuropathyUlnar neuropathyProbably from sleeping on armNo concerning neuro deficits notedCan try wrapping elbow at night to prevent bending and keep from lying on itHandout from “Rouzier: The Sports Medicine Patient Advisor” given with basic explanation of condition, instructions for treatment, and explanations with pictures for home rehabilitation exercises for ulnar neuropathyF/U prn |
| AMB | URI | URI  \_ yo \_ c/o cold/flu symptoms Started x days ago: \_ Cough: \_ Congestion: \_ Sore/throat: \_ Earache: \_ Fevers/chills: \_ Headache/malaise: \_ Sick contacts: \_ Self-treatment: \_   Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal HEENT: NC/AT; oropharynx clear w/o exudate, no lesions; TMs nl landmarks/color/reflex, no sinus TTP Neck: Supple; No thyromegaly Lymph: No cervical lymphadenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; NABS; No mass; No hepatosplenomegaly GU: Deferred Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.  Assessment/Plan: URI  No fevers/chills, lungs clear, pulse ox normal Will treat symptomatically Can try nasal saline rinse, humidifier, Tylenol/ibuprofen, decongestants and throat lozenge Symptoms may persist for a week or longer Emphasized hygiene including hand washing and proper coughing technique F/U prn if not gradually improving or any acute worsening in symptoms Doctors note given: \_ |
| AMB | UTI | UTI  \_ yo \_ c/o urinary sx # of days: \_ Burning: \_ Frequency: \_ Urgency: \_ Strong odor or cloudy: \_ Blood in urine: \_ Fevers/chills: \_ Flank pain: \_ Hx/o previous/frequent UTI: \_ Is this episode similar: \_ UTI post coital: \_ Vaginal complaints (discharge/pain): \_ Has tried: \_  Objective  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly; suprapubic TTP: \_ CVA-T/flank pain: \_ Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.  Assessment/Plan: UTI  Uncomplicated, no f/c, no flank pain UA suggestive of infection Treat with antibiotic F/U prn if symptoms do not improve |
| AMB | Wet Prep | Wet Prep/KOH:  pH \_ 4.5 (> or <) Whiff test: \_ Clue cells: \_ Motile organisms: \_ Buds/hyphae on KOH: \_ |
| AMB | Women exam basic | Woman exam (basic)  Gen: BP/HR/Temp reviewed; A/Ox3; NAD Eyes: PERRLA; Conjunctiva normal ENT: NC/AT; TM Clear; No oral lesions; No erythema Neck: Supple; No thyromegaly Lymph: No neck/axillary adenopathy Chest: CTA; No wheezes/rhonchi/rales CV: RR; Normal S1/S2; No MRG Abd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegaly CBE: Chaperoned by: \_. Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple discharge GU: Chaperoned by: \_. Normal appearing female genitalia without lesion. Normal vaginal mucosa without discharge. Cervix normal in appearance. No CMT. Normal bimanual exam. Ext: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait. |
| ED | Abscess Dressing Change | Abscess Dressing Change Old packing removed. Minimal amount of exudative fluid expressed. Repacked and dressed. Patient tolerated well. |
| ED | Central Line Placement | Central Line Placement  Time: \_ Confirmed: Patient, procedure, side, and site correct.  Consent: Emergent.  Indication: Hemodynamically unstable.  Monitoring: Cardiac, blood pressure, continuous pulse oximetry.  Location: Right. Preparation: Sterile field established, landmarks identified, Skin prepped with chlorhexidine.  Central Venous Line: 4 French triple lumen, Seldinger technique utilized for line placement.  Post-procedure: Adequate blood return observed, adequate fluid flow observed.  Patient tolerated  Complications: None.  Performed by: Self.  Total time: 20 minutes. |
| ED | Chest Tube Insertion | Chest Tube Insertion Time: \_ Confirmed: Patient, procedure, side, and site correct.  Consent: Patient has signed consent.  Indication: Pneumothorax Procedural sedation: \_ mcg IV Fentanyl. Monitoring: Cardiac, blood pressure, continuous pulse oximetry.   Technique  Location: left, mid axillary line.  Anesthesia: 20 ml, 1% lidocaine, not with epinephrine.  Preparation: sterile field established and landmarks identified.   For chest tube insertion:  An incision was made using a # 11 blade,  The fascia and muscle were penetrated,  A 28 French chest tube, was directed inferiorly.  Return: air Secured: with 3 -0 suture, lubricated gauze, adhesive tape.  Post-procedure: Bilateral breath sounds equal, chest x-ray confirms: good tube placement.  Patient tolerated: Well.  Complications: None.  Performed by: Myself. Total time: 30 minutes. |
| ED | Laceration Repair | Laceration repair Confirmed: Patient, procedure, side and site correct Consent: Patient, Has given verbal consent.   Laceration was irrigated with copious amounts of water.  It was then anesthetized with ¬\_ mL of 1% lidocaine.  Area was prepped and draped sterilely.  \_ interrupted sutures used to repair laceration.  Edges were well approximated.  Patient is neurovascularly intact after procedure.  Tolerated well. |
| ED | Lumbar Puncture | Lumbar Puncture Procedure with risks and benefits explained to parent.  Consent obtained, on chart. Patient was prepped & draped in a sterile fashion.  3ml of clear fluid obtained without difficulty.  Sent to lab for analysis.  Patient tolerated procedure well. Moving all extremities post procedure. |
| ED | Paracentesis | Paracentesis After written informed consent obtained, time out performed @: \_ Patient placed supine on medical exam table. Patient was prepped and draped sterilely.  Local anesthesia of skin and subcutaneous tissue to the peritoneum performed on area marked by ultrasound.  10 mL of 1% lidocaine without epi was used. Needle inserted over previously anesthetized tract.  Peritoneal fluid obtained, the catheter advanced over needle, and drainage tube connected to an evacuated container therapeutic paracentesis. Diagnostic analysis fluid sent for cell differential, LDH, glucose, protein, AFB stain and culture, gram stain and culture and other analysis. \_ml of fluid obtained.  Patient tolerated well without complications. |
| ED | Rapid Sequence Intubation | Paracentesis After written informed consent obtained, time out performed @: \_ Patient placed supine on medical exam table. Patient was prepped and draped sterilely.  Local anesthesia of skin and subcutaneous tissue to the peritoneum performed on area marked by ultrasound.  10 mL of 1% lidocaine without epi was used. Needle inserted over previously anesthetized tract.  Peritoneal fluid obtained, the catheter advanced over needle, and drainage tube connected to an evacuated container therapeutic paracentesis. Diagnostic analysis fluid sent for cell differential, LDH, glucose, protein, AFB stain and culture, gram stain and culture and other analysis. \_ml of fluid obtained.  Patient tolerated well without complications.      Rapid Sequence Intubation Pre-oxygenation: Patient at 100% by BVM Pretreatment: None Paralytic & Induction: Etomidate 20 mg IV, Succinylcholine 100mg Placement: 7.0 French ET tube visualized going through the vocal cords with confirmatory ETCO2 Post intubation Sedation: Lorazepam, Fentanyl  Vent Settings Tidal Volume: \_ Resp. Rate: \_ PEEP: \_ Flow rate: \_ FIO2: \_ |
| ED | Shoulder Dislocation-Reduction | Shoulder dislocation reduction Confirmed: Patient, procedure, side, and site correct. Time out @: \_ Consent: Urgent, procedure with risk and benefits explained to the patient. Consent signed by \_ Indication: Shoulder dislocation Monitoring: Cardiac, blood pressure, continuous pulse oximetry.  Location:  Sedation:  Post-procedure: Arm placed in sling. Post reduction films examined and indicated \_ Complications: None.  Performed by: Self Total time: 20 Minutes |
| ED | Trauma/Critical Care | Trauma/Critical Care: Date of trauma: \_ Today’s date: \_ Arrival time: \_  Hospital contacted: \_  1st contact @: \_ Successful: Y N Reason: \_  Outcome: \_   2nd contact @: \_  Successful: Y N  Reason: \_ Outcome: \_  3rd contact @: \_ Successful: Y N Reason: \_ Outcome: \_   Trauma/general surgeon on call: \_  Date / Time trauma accepted for transfer: \_  Air Ambulance activated @: \_ LifeMed Guardian Other ETA: \_ Reason for delays (if any): \_  Note completed and sent with patient: Yes No Other |
| Inpatient | Discharge Disclaimer for Inpatient | Discharge Disclaimer for Inpatient Mom, nurse and RT feel the patient is much improved and stable for discharge with close follow up in the village. |
| Inpatient | ER/Urgent Care Parent Educations Disclaimer | ER/Urgent Care Parent Educations Disclaimer Discussed diagnosis, treatment plan and follow up plan with caregiver and questions answered. Care giver agrees with plan. Patient to return if worse or not improving or for any concerns. |
| Inpatient | On Service Note | On Service Note: Assumed care of this patient this am. Reviewed recent and pertinent past documentation, x-rays, labs, meds, discussed care and clinical status of patient with nursing and RT staff and looked at HCM needs. |
| Pt Letter | Chlamydia | Once you take the antibiotics for Chlamydia, you should not have sex for 7 days. |
| Pt Letter | GST - Positive | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your blood sugar was elevated. You will be contacted to return to clinic for fasting labs so that we can better care for you and your baby. You should not have anything to eat or drink after midnight the night before you return to clinic for those labs.   Ann Glasheen and Susan Botamenko will be contacting you to set that up. |
| Pt Letter | Healthy | Thank you for allowing us to provide your health care. In regards to your recent laboratory testing, your kidney and liver tests look great.   Eating healthy, native foods is very good for you and your diet should include berries, wild greens, and lots of fruits and vegetables - raisins, canned foods, and frozen vegetables count!   To continue to stay healthy, please try to exercise at least 5 times a week for 30 minutes a day.    Avoid all types of tobacco to keep you and your family healthy. |
| Pt Letter | Hepatitis B Carrier Labs - Normal | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, you still have Hepatitis B, but your liver function is good. Please plan to have your labs re-drawn in ~6 months. |
| Pt Letter | HPV - Positive | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your test for cervical cancer (PAP) was normal, but your HPV test showed that you do have the HPV virus. It is recommended that you be followed just a bit more closely so you should have another PAP test in one year. |
| Pt Letter | Jury Duty | Dear M\_,  As you Primary Care Provider, I attest that you are under my care and you should be excused from jury duty due to your medical problems. Feel free to call my case manager, \_ with any questions at \_.  Please fax to U. S. District Court at 907-677-6187.  Thank you. \_ (provider signature) |
| Pt Letter | Lipids - Child Normal | Thank you for allowing us to provide your child’s health care.   In regards to your child’s recent laboratory testing, cholesterol levels are good. The bad cholesterol (LDL and total cholesterol) levels are low and the good cholesterol (HDL) level is high, which is good as it helps to protect your heart.   Eating healthy, native foods is very good for you and diet should include berries, wild greens, and lots of fruits and vegetables - raisins, canned foods, and frozen vegetables count. Eating oatmeal and baked fish are recommended. You should limit or avoid red meat, egg yolks, fried foods, butter, bread, and aguduk as these can raise bad cholesterol.   To continue to stay healthy, please try to exercise at least 5 times a week for 30 minutes a day.   Avoid all types of tobacco to keep you and your family healthy.  Please get your immunizations on time and get your regular well child checks. |
| Pt Letter | Lipids - Elevated No Meds | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your bad cholesterol levels are a bit elevated (LDL and total cholesterol), but no medications are recommended at this time. Instead, you can help to lower these levels with the dietary recommendations below. Your good cholesterol (HDL) level is high, which is good as it helps to protect your heart.   Eating healthy, native foods is very good for you and your diet should include berries, wild greens, and lots of fruits and vegetables - raisins, canned foods, and frozen vegetables count. Eating oatmeal and baked fish are recommended. You should limit or avoid red meat, egg yolks, fried foods, butter, bread, and aguduk as these can raise your bad cholesterol.   To continue to stay healthy, please try to exercise at least 5 times a week for 30 minutes a day.  Avoid all types of tobacco to keep you and your family healthy. |
| Pt Letter | Lipids - Elevated With Meds | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your bad cholesterol levels are elevated (LDL and total cholesterol). We want to lower these levels to protect your blood vessels from getting clogged with fats and cholesterol as this puts you at a higher risk of having a heart attack. A prescription for \_ at \_ mg to take once daily was sent to your pharmacy. You can also help to lower these levels with the dietary recommendations below. Your good cholesterol (HDL) level is high, which is good as it helps to protect your heart.   Eating healthy, native foods is very good for you and your diet should include berries, wild greens, and lots of fruits and vegetables - raisins, canned foods, and frozen vegetables count. Eating oatmeal and baked fish are recommended. You should limit or avoid red meat, egg yolks, fried foods, butter, bread, and aguduk as these can raise your bad cholesterol. Our dietician will contact you to set up an appointment for you and your family to talk more about how dietary changes can lower your cholesterol.  To continue to stay healthy, please try to exercise at least 5 times a week for 30 minutes a day.   Avoid all types of tobacco to keep you and your family healthy.  Please take your cholesterol meds and return to clinic to recheck your labs with us in 6 months. |
| Pt Letter | Lipids - Normal | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your cholesterol levels are good. Your bad cholesterol (LDL and total cholesterol) levels are low. Your good cholesterol (HDL) level is high, which is good as it helps to protect your heart.   Eating healthy, native foods is very good for you and your diet should include berries, wild greens, and lots of fruits and vegetables - raisins, canned foods, and frozen vegetables count. Eating oatmeal and baked fish are recommended. You should limit or avoid red meat, egg yolks, fried foods, butter, bread, and aguduk as these can raise your bad cholesterol.   To continue to stay healthy, please try to exercise at least 5 times a week for 30 minutes a day.    Avoid all types of tobacco to keep you and your family healthy. |
| Pt Letter | Prediabetes | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, one of your tests was slightly elevated and it appears that you may be starting toward developing diabetes. Eating healthy and exercising at least 5 times a week for 30 minutes a day can help prevent this. Our Diabetes Team will be contacting you to set up a meeting to help you learn about what pre-diabetes means and how we can support you in making good choices to prevent you from developing diabetes.  Please contact our Diabetes Team with any questions at 907-543-6133 |
| Pt Letter | STI - Negative | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your sexually transmitted disease test results (HIV, Syphilis, Chlamydia, and Gonorrhea) were negative. Please practice safe sex by using condoms. Remember that you and your partners should be tested for sexually transmitted diseases every time you have a new partner.  Please feel free to call Case Manager Claire Lewis 907-545-4249 if you have any questions. |
| Pt Letter | STI - Positive | Thank you for allowing us to provide your health care.   In regards to your recent laboratory testing, your sexually transmitted disease test results (\_HIV, Syphilis, Chlamydia, and Gonorrhea) were positive for \_. Please go to the clinic for treatment. The Sexually Transmitted Infection (STI) Case Manager, Claire Lewis RN, will be calling you for information about your contacts.  The remaining sexually transmitted disease test results (\_HIV, Syphilis, Chlamydia, and Gonorrhea) were negative. Please practice safe sex by using condoms. Remember that you and your partners should be tested for sexually transmitted diseases every time you have a new partner.  Feel free to call Case Manager Claire Lewis 907-545-4249 if you have any questions. |
| Pt Letter | Vitamin D - Low | Thank you for allowing us to provide your health care. In regards to your recent laboratory testing, your vitamin D level is low. I have sent prescription to your pharmacy for supplemental vitamin D at a dose of 1,000 international units by mouth daily.   If you have any questions, please contact us using the telephone number below. \_ |
| RMT | Amoxicillin trial in the village | Amoxicillin trial in the village ASSESSMENT:  Patient does not have any evidence of an allergy to amoxicillin per history.   PLAN:  Recommend starting Amoxicillin per CHAM by weight today. It is ok to say the physician has ok’ed giving amoxicillin despite allergy recorded for ordering purposes. The first dose should be given in the clinic Patient will stay in clinic for an hour afterwards for observation in waiting room.   If there are no problems with the first dose, then the patient can go home and continue medicine as prescribed. If a rash or any concerns come up, the patient should be brought back to clinic and a tele med picture and RMT should be sent in if rash occurs.   Rash with amoxicillin is common in infants with a viral infection less than 1 year of age. |
| RMT | Bleach Baths | Bleach Baths Patients who have recurrent or severe skin infections such as boils/abscesses, cellulitis, impetigo, or infected eczema may have bacteria living on their skin (colonized) that can be treated with soaking in baths with a small amount of household bleach added (swimming pool strength). By killing the bad bacteria on the skin, there is less chance of getting future infections. Dilute bleach baths should be taken every day for a week, then the baths can be taken 1-2 times per week to help prevent the bad bacteria from re-colonizing the skin and causing more skin infections. INSTRUCTIONS: For a standard sized tub Fill the tub with water and add ¼ cup of household bleach Soak in tub for at least 20 minutes Soap is not required For smaller amounts of water  Use 1.5ml of household bleach for every gallon of water to be used. Please make sure your provider has given you a marked syringe and clear instructions on exactly how to mix the dilute bleach water you will be using. EXAMPLES: 1.5 ml of household bleach for 1 gallon of water 4.5 ml of household bleach for 3 gallons of water 7.5 ml of household bleach for 5 gallons of water 15 ml of household bleach for 10 gallons of water |
| RMT | Dental Not Cleared | Dental NOT cleared This patient is not cleared for dental pre-op travel because \_ Please let the YKHC OR or surgery center schedulers know of cancellation and have appt and surgery rescheduled. Thanks |
| RMT | General Dental Response | Generic Dental RMT Response Patient being seen for dental rehab pre-op travel clearance. Health Aide Vitals and Physical Exam are unremarkable. Limited chart review done  IF: Dental rehab to be done in Anchorage and... No fever in past 48 hours No history of runny nose, nasal discharge, cough, wheezing or congestion in the past week No vomiting or diarrhea No recent exposure to chicken pox or other significant infectious diseases  THEN: Patient is clear for travel for dental rehab.  IF: Dental rehab is to be done in Bethel and... No fever in past 48 hours No history of runny nose, nasal discharge, cough, wheezing or congestion in the past 4 weeks No vomiting or diarrhea No recent exposure to chicken pox or other significant infectious diseases  THEN: Patient is clear for travel for dental rehab. |
| RMT | Infant F/U | Infant Follow Up Return for fever 100.4 or greater, increased cough, trouble breathing, sleeping too much, increased irritability, not drinking or peeing much |
| RMT | Media review | Appreciate the photos of the \_ that were sent to the Bethel provider so that the Health aide could get some help with the diagnosis and treatment plan.   **Diagnosis: \_**  **Plan: \_**  Please give immunizations that are due. |
| RMT | No Longer CPP | No Longer CPP  Patient chart reviewed. No chronic or subspecialty issues requiring CPP care management. Patient is doing so well that he/she is graduated from the CPP registry! :) Please inform the family of this change. |
| RMT | Not CPP | This is not a CPP patient. Please send to regular RMT unless you have a concern that you want addressed by the pediatrician on call :) |
| RMT | Not very sick F/U | Not very sick follow up OK to give Tylenol and Motrin per CHAM. Push fluids; continue symptomatic care; observe closely and return to clinic in 2-3 days if no improvement or sooner if worse |
| RMT | Otitis | Oflaxocin 5 drops to affected ear BID for 10 days. Please have caretaker wick the ear prior to drops. Tylenol and Motrin per CHAM for discomfort. RTC in 7-10days if no improvement or SIW. |
| RMT | Sick child | Sick kid coming on commercial flightPage peds on call if the patient is unable to make a plane today |
| RMT | Sick patient coming in by commercial flight | Sick patient coming in by commercial flight Agree with sending patient on next flight into the ER for further evaluation and treatment. Page peds on call if the patient does not get on the plane today of gets worse before travel |
| RMT | Strep Throat | Strep Throat Please treat with LA Bicillin per CHAM. If family refuses, may give Amoxicillin per CHAM instead. OK to give Tylenol and Motrin per CHAM. Push fluids; continue symptomatic care; observe closely and return to clinic in 2-3 days if no improvement or sooner if worse |
| RMT | This is not a CPP | This is not a CPP patient. Please send to regular RMT unless you have a concern that you want addressed by the pediatrician on call :) |
| WCC | WCC - 12 Month Visit | WCC - 12 MONTH VISIT  12-month old \_male here with \_ for 12-month WCC. No concerns about her health. No significant interval illness. \_he is drinking \_ out of a \_ and taking a variety of table foods. \_he has \_ teeth brushed regularly. No problems with elimination. No problems with sleep. No concerns regarding hearing or vision. \_he speaks a few words and babbles. \_he enjoys playing social games. \_he stands unsupported and \_ walks alone. \_he uses a fine pincer grasp.  IMPRESSION: 12 month old growing and developing as expected. \_% for weight at 9 month and today. Meeting milestones.  Anticipatory Guidance: Immunizations, discipline with time outs and positive distractions, praise good behavior, continue 1 nap a day, bedtime routines, establish teeth brushing routines, 3 meals daily with snacks, provide nutritious food. Switch to whole milk or 2%, limit to 16oz daily, limit juice to 1/2 cup daily, switch from bottle to sippie cup, if giving bottle at bedtime - give water. Encourage self-feeding, visit dentistry by 12 mo, childproof home, "touch supervision", remove guns from home.  PLANS: Immunizations today, Lead and CBC, TB test if possible, refer dental, dental varnish.  FU: 15 MO WCC |
| WCC | WCC - 15 Month Visit | WCC - 15 MONTH VISIT  \_15 month old \_male here with \_mother for 15 MO WCC. \_No concerns. \_No interval illness.  \_he eats a variety of foods with good appetite. \_he drinks \_ milk, \_ daily, as well as juice and water. \_ Teeth are brushed \_. No problems with elimination or sleep. \_ potty-training.  \_Listens to a story, \_imitates activities, may help in house, \_indicates wants by pulling/pointing/grunting, \_brings objects to show, \_hands a book when wants a story, \_says 2-3 words with meaning, \_understands/follows simple commands, \_scribbles. \_Walks well, \_stoops to recover, \_can step backwards, \_puts block in cup, \_drinks from cup.  No concerns regarding hearing or vision.   There are \_ people in the household and \_are children. \_Have running water and \_electricity. \_No smokers in household.   IMPRESSION: 15 month old growing and developing as expected. \_% for weight. Meeting milestones.  Anticipatory guidance: When possible allow child to choose between 2 options. Stranger Anxiety. Use simple clear words and phrases to promote language development and improve communication. Maintain consistent bedtime and nighttime routine Praise good behavior and accomplishments. Brush teeth twice daily with soft brush and water. If nighttime bottle use water only. Review home safety; lock up poisons, cleaning supplies, Keep hot liquids, lighters, matches out of reach.   PLAN: Immunizations, Catch up TB, Lead or CBC PRN, - Dental Varnish  FU: Next WCC at 18 months |
| WCC | WCC - 18 Month Visit | WCC - 18 MONTH VISIT  18-month old \_male here with \_ for WCC. No concerns. No interval illness. \_he eats a variety of foods with good appetite. \_he drinks \_ milk, \_ daily, as well as juice and water. \_ Teeth are brushed \_. No problems with elimination or sleep. \_ potty-training.  No concerns regarding hearing or vision. Speaks 3-6 words. -Points to wants. Laughs in response to others. \_Follows simple directions. \_Knows names of favorite books. Points to at least one body part. Removes garment, tries to help around the house. \_Walks up steps, runs and walks backwards. Climbs well. Tower of 2 cubes, scribbles. \_Uses spoon/cup without spilling.  There are \_ people in the household and \_are children. \_Have running water and \_electricity. \_No smokers in household.   IMPRESSION: 18 month old growing and developing as expected. \_% for weight. Meeting milestones.  Anticipatory guidance: Support emerging independence but reinforce limits and appropriate behavior. Prepare toddler for new sibling by reading books about a new baby. Anticipate anxiety/clinging in new situations. Praise good behavior/accomplishments. Be consistent with discipline/enforcing limits, share with caregivers. Encourage language development by reading and singing and talking to child. Use simple words to describe pictures in books. Read books about using the potty, praise attempts to sit on potty. Remove guns from home, prevent burns, use stair gates, window guards on second story or higher windows. Rear facing car safety seats until highest weight or height.  PLAN: Immunizations, Catch up TB, Lead or CBC PRN, MVI PRN - Dental Varnish  FU: Next WCC at 24 months |
| WCC | WCC - 2 Month Visit | WCC - 2 MONTH VISIT:  2 month old former \_ term \_male here with \_mom for 8 week WCC.  \_No concerns. No interval illness. \_He is \_feeding well.  \_He is sleeping on back. Sleeps with \_mom. \_No concerns regarding hearing or vision.   \_Attempts to look at parent. \_Smiles. ¬\_Is able to console and comfort self. \_Different cries and coos for different needs. \_Is able to hold up head and begins to push up in prone position. \_Has consistent head control in supported sitting position. \_Shows symmetrical movement of arms, legs, head.  \_People living in household \_ of whom are children.  \_Household has running water and electricity. \_No smokers in household.  BIRTH HISTORY: BW: \_ GBS: \_ Apgars: \_ \_Born at \_ YKHC/ANMC at \_weeks by NSVD to a \_ yo G\_P\_.  \_Mother with \_pregnancy complications of \_. \_No L&D complications.  IMPRESSION:  \_2 month old growing and developing as expected \_ Percentile for weight \_Meeting milestones  PLAN:  \_Anticipatory guidance: immunizations, fever protocol, tummy time, rolling over, teething, safe sleeping.  \_Immunizations today  FOLLOW UP:  4 month WCC |
| WCC | WCC - 2 Week Visit | WCC - 2 WEEK VISIT:  HPI: \_2 week old former \_ full term \_male here with \_mother for WCC.  \_No concerns. No interval illness. \_Child is feeding well. \_Copious UOP and BMs daily. \_Sleeping on back. \_Sleeps with \_mom/in crib. \_Has regained birth weight. \_Passed newborn hearing screen. \_ live in household \_ of whom are children.  \_Household has running water; \_electricity; \_no wood stove; \_no smoker.  BIRTH HISTORY: BW: \_ GBS: \_ Apgars: \_ \_Born at \_YKHC at \_weeks by \_NSVD to a \_ yo G\_P\_.  \_Mother with \_pregnancy complications of \_. \_No L&D complications.  IMPRESSION:  Diagnosis: \_2 week old \_male growing and developing as expected. \_% for weight.  \_Has regained birth weight.  \_Breastfeeding well.  PLAN:  Anticipatory guidance:  \_2nd PKU \_Fever protocol \_Safe sleeping \_Breast feeding/formula feeding  FOLLOW-UP: 6-8 week WCC |
| WCC | WCC - 2 Year Visit | WCC - 2 YEAR VISIT  2-year old \_male here with \_ for 2-year WCC. No concerns. No interval illness. \_he eats a variety of foods with good appetite. \_he drinks \_ milk, \_ daily, as well as juice and water. \_ Teeth are brushed \_. No problems with elimination or sleep. \_ potty-training. No concerns regarding hearing or vision. \_ speaks 50+ words and two-word phrases. \_ runs and climbs well. \_ exhibits parallel play with other children and plays with toys appropriately. \_ makes good eye contact, responds to \_ name, and shares joint attention with caregivers.   IMPRESSION: 2 YO with history of \_ growing and developing as expected, meeting all milestones. \_% weight and \_% height.  Anticipatory Guidance: Read, sing, and play games together. Talk about pictures in books, let child tell the story. Encourage interactive play with peers, taking turns. Limit all screen time to no more than 1-2hours per day, no TV/DVD player in bedroom, monitor programs watched. Supervise all play near streets, water safety, remove all guns from home. Forward facing car seat, properly installed in back seat. Promote daily physical activity at home.  PLAN: Immunizations as needed, Lead and CBC, MVI, Dental Varnish  FU: Next WCC at 30 months |
| WCC | WCC - 3 Year Visit | WCC - 3 YEAR VISIT  3 year old generally healthy \_male here with \_mother for WCC. Hx of \_. \_No concerns. \_No interval Illness. \_He eats three small meals and several snacks daily. \_He eats a variety of fruits, vegetables and meats. \_He \_is eating with a fork or spoon. \_He \_is day toilet trained for bowel and bladder. \_No other concerns with elimination. \_He is sleeping \_ hrs a night. \_No concerns about vision or hearing. \_He has self-care skills; \_feeding, \_dressing. \_He enjoys interactive play, \_converses in 2-3 sentences, \_is understandable to others 75% of the time, \_ names a friend, \_knows name, \_identifies self as \_girl/boy, \_builds tower of 6-8 cubes, \_throws ball overhand, \_walks up stairs alternating feet, \_copies a circle, \_draws person with 2 body parts, \_day toilet trained for bowel and bladder. Lives with \_other people in household, \_of whom are children. \_Has running water and \_electricity. \_No smokers in household.   IMPRESSION: 3 YOF growing and developing as expected, meeting all milestones. \_% weight and \_% height.  Anticipatory Guidance: Read, sing, and play games together. Talk about pictures in books, let child tell the story. Encourage interactive play with peers, taking turns. Limit all screen time to no more than 1-2hours per day, no TV/DVD player in bedroom, monitor programs watched. Supervise all play near streets, water safety, remove all guns from home. Forward facing car seat, properly installed in back seat. Promote daily physical activity at home.  PLAN: TB test.   FU: Next WCC at 4 YO. |
| WCC | WCC - 4 Month Visit | 4-month old \_male here with \_mom for 4-month WCC. No concerns. No interval illness. \_he is \_-feeding well, \_taking a multivitamin. \_he has \_ started solids. \_ starting to teethe. No concerns regarding elimination or sleep. \_he is rolling from front to back, pushing up on hands when prone, reaching for and grabbing objects, making good eye contact, and starting to babble.   IMPRESSION: 4 month old growing and developing as expected. \_% weight-for-age. Meeting milestones.  Anticipatory guidance: Continue regular feeding/sleeping routines, put baby to sleep on back, safe sleeping, introducing new foods, Avoid bottle in bed, propping. Don’t leave baby alone in tub, high places, keep hand on baby, Use rear-facing car safety seat in back set. , PLAN: Immunizations today  FU: Next WCC at age 6 MO |
| WCC | WCC - 4 Year Visit | WCC - 4 YEAR VISIT  4 year old generally healthy \_male here with \_mother for WCC. Hx of \_. \_No other concerns. \_No interval Illness. \_He eats three small meals and several snacks daily. \_He eats a variety of fruits, vegetables and meats. \_He \_is eating with a fork or spoon. \_He \_is day toilet trained for bowel and bladder. \_No other concerns with elimination. \_He is sleeping \_ hrs a night. \_He takes a nap during the day. \_He \_doesn’t have nightmares or night terrors. \_No concerns about vision or hearing. Describes features of self, \_listens to stories, \_engages in fantasy play, \_gives first/last name, \_knows what to do if cold/tired/hungry, \_most speech clearly understandable, \_names 4 colors, \_plays board/card games, \_draws a person with 3 parts, \_hops on one foot, \_balances on one foot for 2 second, \_builds a tower of 8 blocks, \_copies a cross, \_brushes own teeth, \_dresses self. Lives with \_other people in household, \_of whom are children. \_Has running water and \_electricity. \_No smokers in household.   IMPRESSION: 4 year old growing and developing as expected. \_th% weight and \_th%. Meeting Milestones.  Anticipatory guidance: Be sure after-school care is safe, positive. Talk to child about school experiences. Show affection/respect, model anger management/self-discipline. Eat breakfast, Eat 5 plus servings fruits veggies a day, limit candy, soda, high fat snack, have at least 2 cups low fat milk or dairy daily. Be active 60 min a day. Limit TV to 2 hrs daily, no TV in bedroom. Smoke detectors/carbon monoxide detectors in home, remove guns from home, teach street safety, water safety.  PLAN: Immunizations today, CBC, LEAD, Dental and Audiology referral  FU: Next WCC at age 5 |
| WCC | WCC - 5 Year Visit | 5 year old generally healthy \_male here with \_mother for WCC. Hx of \_. \_No concerns. \_No interval Illness. \_He eats three small meals and several snacks daily. \_He eats a variety of fruits, vegetables and meats. \_He \_is eating with a fork or spoon. \_He \_is day toilet trained. \_No other concerns with elimination. \_He is sleeping \_ hrs a night. \_No concerns about vision or hearing. Balances on one foot, \_Hops, and \_skip. Able to tie a knot. Shows school readiness skills. \_Has mature pencil grasp, can draw a person with at least \_6 body parts. Prints some letters and numbers. Is able to copy squares and triangles, has \_good articulation and language skills. \_Counts to 10, \_Names 4 plus colors. \_Follows simple directions, Listens and Attends.  Lives with \_other people in household, \_of whom are children. \_Has running water and \_electricity. \_No smokers in household.   IMPRESSION: 5 year old growing and developing as expected. \_% weight-for-age. Meeting Milestones.  Anticipatory guidance: Be sure after-school care is safe, positive. Talk to child about school experiences. Show affection/respect, model anger management/self-discipline. Eat breakfast, Eat 5 plus servings fruits veggies a day, limit candy, soda, high fat snack, have at least 2 cups low fat milk or dairy daily. Be active 60 min a day. Limit TV to 2 hrs daily, no TV in bedroom. Smoke detectors/carbon monoxide detectors in home, remove guns from home, teach street safety, water safety.  PLAN: Immunizations today, Next WCC at 6 YR OLD |
| WCC | WCC - 6 Month Visit | 6-month old \_male here with \_ for 6-month WCC. No concerns. No interval illness. \_he drinks \_ and eats \_. \_he has \_ teeth. No problems with elimination. No problems with sleep. No concerns regarding hearing or vision. \_he babbles, transfers objects hand-to-hand, rolls both directions, sits \_supported, and enjoys looking at faces.   IMPRESSION: 6 month old growing and developing as expected. \_% for weight. Meeting milestones.  Anticipatory guidance: Choose responsible caregivers, engage in interactive, reciprocal play. Talk/sing to, read/play games with baby. Put baby to sleep on back, begin cup, and continue breastfeeding as long as mutually desired. To prevent choking keep small objects, plastic bags, away from baby, limit finger foods to soft bits.  PLAN: Immunizations today  FU: Next WCC at 9 months. |
| WCC | WCC - 6 Year Visit | 6 year old generally healthy \_male here with \_mother for WCC. Hx of \_. \_No concerns. \_No interval Illness. \_He eats three small meals and several snacks daily. \_He eats a variety of fruits, vegetables and meats. \_He \_is eating with a fork or spoon. \_He \_is day toilet trained. \_No other concerns with elimination. \_He is sleeping \_ hrs a night. \_No concerns about vision or hearing. Balances on one foot, \_Hops, and \_skip. Able to tie a knot. Shows school readiness skills. \_Has mature pencil grasp, can draw a person with at least \_6 body parts. Prints some letters and numbers. Is able to copy squares and triangles, has \_good articulation and language skills. \_Counts to 10, \_Names 4 plus colors. \_Follows simple directions, Listens and Attends.  Lives with \_other people in household, \_of whom are children. \_Has running water and \_electricity. \_No smokers in household.    IMPRESSION: 6 YO growing and developing as expected. \_% Weight-for-age and \_% Stature for age.   Anticipatory Guidance: Share meals as family if possible. Prepare child for school: tour school, attend school events, be sure after-school care is safe and positive. Continue Family routines, assign household choes. Eat breakfast, eat 5+ servings of fruits and vegetables a day, limit candy/soda/high-fat snack. Have 2 cups low fat milk daily, Be physically active 60 in a day, limit TV to 2 hours a day. Visit dentist twice daily, brush teeth Three times daily. Street and water safety. Teach children to swim, remove guns from home.   PLAN: Next WCC at age 7 years old |
| WCC | WCC - 9 Month Visit | 9-month old \_male here with \_ for 9-month WCC. No concerns. No interval illness. \_he is drinking \_ and taking solids. \_he has \_ teeth that mother knows to clean. Normal UOP and BM. Sleeps through the night.  No concerns about hearing or vision. \_Has developed apprehension with strangers, \_seeks out parent: \_uses repetitive consonants and vowel sounds, \_points out objects, \_develops object permanence, \_learns interactive games, \_explores environment.  \_Pulls to stand, \_stands holding on, Takes 2 cubes, or transfers cube, \_Dada, \_Mamma, single syllables, Waves bye-bye, \_feeds self.   \_Live in household of whom \_are children. \_Have running water and electricity. \_Wood stove in home.   IMPRESSION: 9 month old infant growing and developing as expected. \_% for weight for age. Meeting milestones  Anticipatory guidance: Separation anxiety, keep consistent daily routines, safe exploration and play, gradually increase table foods, provide 3 meals 2-3 snacks daily. Encourage use of cup, discuss plans for weaning, continue Breastfeeding if mutually desired. Do home safety checks, childproof home, be within arm’s reach (touch supervision) near water.  PLAN: Dental Varnish,   FU: 12 MO WCC |
| WCC | WCC - Newborn Visit1 | WCC - NEWBORN VISIT:  HPI: \_ day old \_full term \_male here with \_mother for weight check and \_repeat bilirubin. \_Breastfeeding q1-2hrs for \_ min per side.  \_Taking \_ oz Similac Advanced q1-2hrs.  \_Mom feels her milk is in. \_Mother hears audible swallow. \_Baby has good latch. \_ #wet diapers and \_ #poopy diapers today. \_Makes brief eye contact with adult when held. \_Cries with discomfort, calms to adult voice. \_Reflexively moves arms and legs. \_Turns head to side when on stomach. \_Hold fingers closed and grasps reflexively. \_Sleeps on back, \_sleeps with mom/ \_in crib. \_Passed Newborn hearing screen.  BIRTH HISTORY: BW: \_ GBS: \_ Apgars: \_ \_Born at \_ YKHC/ANMC at \_weeks by NSVD to a \_ yo G\_P\_.  \_Mother with \_pregnancy complications of \_. \_No L&D complications.  IMPRESSION: Newborn \_male growing and developing as expected. \_% for weight.  \_Has regained birth weight.  \_Breastfeeding well.  PLAN: Anticipatory Guidance:  Mom should continue prenatal vitamins, avoid alcohol.  Cord Care: Air-dry by keeping diaper below navel. Call if bad smell, redness, or fluid from area.  Wash your hands often. Avoid others with cold or flu.  If breastfeeding, feed q1-3hrs daytime and q3hrs night-time for 8-12 feedings in 24hrs.  If formula feeding: Prepare/store formula safely, feed on cue at least 8 times in 24hrs. Hold baby semi-upright. Don’t prop bottle.  Put baby to sleep-on-back, safe sleeping.  Take temp rectally, not by ear or skin.  FOLLOW-UP: 2 week WCC |
| WCC | WCC - Sports Physical | (WCC/Sports Physical) \_-year old \_male here with \_ for \_-year well-child check and sports physical. No concerns about \_ health. No interval illness. Sports review of systems \_negative (see MultiMedia).  \_ eats a variety of foods with good appetite. No problems with elimination. No problems with sleep. \_he brushes \_ teeth \_regularly. \_Takes a MVI.  \_Has seen a dentist and optometrist in the last year  \_No concerns regarding hearing or vision. \_ is entering the \_ grade and is \_ a good student.   HEADSSS review of systems \_ |