|  |  |  |
| --- | --- | --- |
| AMB | Acne | AcneDiscussed face washing (no scrubbing, gentle soap, pat and air dry) no more than 2-3x/dayWill start benzoyl/clinda qAM, started 2-3x/week and gradually increase to daily useThen can start Adapalen at night, gradually increase frequency to qHSWash face before applying alternating medicationsAcne may worsen before it starts to improveIt may take 3-4 months to notice changeFollow-up in 3-4 monthsWill consider course of oral antibiotics at that time  |
| AMB | Ankle pain | Ankle Pain\_ yo \_ complaining of ankle painL/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: \_ObjectiveExtremities: 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-antalgicAssessment/Plan: Ankle sprainPRICE, anti-inflammatory givenBraceCrutchesHandout with home rehab givenDLC profile: Follow-up prn if not gradually improvingResources:Ottawa Ankle Rules:Tenderness over malleoliUnable to ambulateInjury occurred > 10 days previousAnkle 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 1Constitutional: no fever, no chills, no unexplained weight changesHEENT: no headache, no acute change in visionCV: no chest pain, no palpitationsLungs: no SOB, no wheezingAbd: no nausea/ vomiting, no constipation, no diarrhea Neuro: no numbness/tingling, no new weaknessPsyche: not depressed Basic ROS 2Constitutional: 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 biopsyNoduleLikely inflamed moleR/B explained, verbal/written consent obtainedArea prepped, 1% lidocaine w/o epi injected for anesthesiaNodule removed as shave biopsyPatient tolerated well, no complications, ebl < 5mlBandaged, wound care instructions givenF/U prn if s/sx infection  |
| AMB | Coccydynia | CoccydyniaAcute 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 | ColonoscopyROSConstitutional: no fever, no unexplained weight loss, no night sweatsHEENT: no congestion, no sore throatRespiratory: no SOB, no cough, no wheezingCardiovascular: no chest pain, no DOEGastrointestinal: no dark or bloody stools, no blood on toilet paper, no vomiting, no diarrhea, no constipation, no abdominal painGenitourinary: no dysuriaHematology/Lymphatics: no easy bruising/bleeding\Musculoskeletal: no new muscle aches/painIntegumentary: no rashNeurologic: no HA, no paresthesias or weaknessPsychiatric: no depression PMHxHeart 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 colonoscopyASA category: \_BMI < 40: \_Low risk airway: \_Discussed screening colonoscopy procedure - risks vs benefitsReviewed colon prep, stop whole grains and nuts few days before procedureStop NSAID/ASA about 1 week before procedurePatient will be contacted with colon prep prior to procedure to pick up medicationsPatient will be contacted w/ appt time & dateLabs and EKG unremarkableLabs to orderSee link and download YKHC guidelines (Pre-anesthesia testing)http://ykhcintranet.ykhc.org/apps/libraryapp/index.cfm?fuseaction=Document.ShowDocumentDetail&id=1283ASA PS classifications from the American Society of AnesthesiologistsASA 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 prepPreparing 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.DietA 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 procedureMedications to Avoid for GI Endoscopy Procedures: Upper Endoscopy and ColonoscopySome 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 eyeStarted x days ago: \_Pain with eye movement: \_Photophobia: \_Itching: \_Seasonal allergies: \_Discharge: \_Purulent: \_Watery with crusting: \_Change in vision: \_Self-treatment: \_ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: 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 erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.Assessment/Plan: ConjunctivitisMostly likely viralNo concerning signs or symptoms on examDiligent hand washing and hygiene emphasizedHandout with patient information givenDo not wear contacts until sx resolve, should throw out case and current lensesF/U prn for severe pain, fever, and/or blurred vision |
| AMB | COPD Screening | COPD: Screening questionsDyspnea 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 scoreScore 5-10 — High risk of COPDScore 0-4 — Low risk of COPDhttps://www.copdfoundation.org/downloads/COPD\_PDF\_Screener.pdfhttp://www.copdfoundation.org/Screener.aspxThe COPD-PS™ has been validated in a diverse population age 35 and olderThe five questions in the COPD-PS™, culled from a 52-question initial survey, were found to be the most likely to predict COPDThe study’s predictive value is 0.59 (AUC) with 88% of COPD cases correctly classifiedA clinical diagnosis of COPD should be confirmed with spirometryPlease visit DRIVE4COPD.COM to learn more about this screener and its validation |
| AMB | DVT Calculator | Conjunctivitis\_ yo \_ c/o red eyeStarted x days ago: \_Pain with eye movement: \_Photophobia: \_Itching: \_Seasonal allergies: \_Discharge: \_Purulent: \_Watery with crusting: \_Change in vision: \_Self-treatment: \_ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: 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 erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.Assessment/Plan: ConjunctivitisMostly likely viralNo concerning signs or symptoms on examDiligent hand washing and hygiene emphasizedHandout with patient information givenDo not wear contacts until sx resolve, should throw out case and current lensesF/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 Interpretation3-8 Points: High probability of DVT1-2 Points: Moderate probability-2-0 Points: Low Probability  |
| AMB | Fracture | Fracture\_ yo \_ for suspect or r/o fractureLocation: \_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/diarrheaStarted 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: \_ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; No oral lesions; No erythema, mucus membranes dry \_ moist \_Neck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; NABS; No mass; No hepatosplenomegaly, no peritoneal signsGU: DeferredExt: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait. Assessment/Plan: GastroenteritisViral vs. food poisoning+/- Signs of orthostatic hypotensionLiters of NS IVF given: \_ Phenergan prn for nausea, can try Tylenol prnHydrate, advance diet as toleratedQuarters for 24 hoursF/U prn if not gradually improving or if acutely worsens  |
| AMB | General exam | Generic examBasic Exam 1General: Alert and oriented, comfortable, cooperative. Neck: Supple, no goiter, no cervical LADRespiratory: 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 2Gen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyExt: 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 HTNChest pain: \_Unusual shortness of breath: \_Dyspnea on exertion: \_Frequent/unusual lightheadedness: \_Orthopnea: \_Tolerating medications: \_Compliance with medications: \_Other: \_Plan: HypertensionEncouraged her to buy a home cuffMeasure and record BPs 3-4x/weekF/U in 1 month to review BPsCan 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 AbscessBoil anesth with \_ml 1% lidocaine. \_ cm incision made. \_ exudate expressed. Packed/ dressed. Patient tolerated well  |
| AMB | Infant exam | InfantGeneral: 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 insomniacStarted: \_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; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; TM Clear; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: Good distal pulses. Normal gait.Psyche: Mood euthymic, affect congruent, well groomed, speech and thoughts appropriate Assessment/Plan: InsomniaWill give trial of few AmbienRecommend trying OTC melatonin supplementHandout on sleep hygiene and highly recommend sleep routine and good sleep habitsSuggested BHOP/MH for sleep training, patient can self-refer at this timeIf still having problems and needing refill, I will insist that they get sleep trainingF/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 \_.--------------------------------------------------------------------------------------------------------------------------------------------------ProcedureWritten 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 IUDImpression 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 \_.--------------------------------------------------------------------------------------------------------------------------------------------------ProcedureWritten 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 IUDImpression 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 \_.ProcedureVerbal 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: \_ ObjectiveGeneral: 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 painStarted: \_Hx/o trauma: \_Similar sx in past: \_Pain level: \_/10Interferes 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; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; TM Clear; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredBack: No spiny TTP, mild soft tissue TTP, neg straight legNeuro: Squats/stands, walks on toes/heels, DTRs 2+ b/l, sensation to soft touch intactGait: Normal In depth examVisualization: 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 bilaterallyNeuro: 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 painNo concerning neurologic signs or symptomsPRICE, NSAID, muscle relaxerPT consult: \_Handout with home rehab giveF/U prn |
| AMB | Neuro exam | Neuro examNeuro: 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 RemovalWritten 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: nonePatient 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 InsertionWritten 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: nonePatient 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 OBNo acute issuesLabs reviewed, no concerning findings at this timeDiscussed concerning signs of bleeding, abdominal pain, loss of fluid, HAs, vision changes, decreased fetal movementF/U in \_ weeksBIB date: \_Contact information: \_Cell: \_Home: \_Labs/Radiology12 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 babyHepatitis A Vaccine - Give if travel to endemic area or IVDA in pregnancyHepatitis B Vaccine - Administer in pregnancy for Hepatitis B risk factorInfluenza Vaccine - Indicated if pregnant in Influenza season. Immunize after first trimesterMeningococcal Vaccine - Standard indications (dormitory, barracks, travel)Plague VaccinePolyvalent pneumococcal Vaccine - Vaccinate high risk women before pregnancy. ACIP recommends avoiding during pregnancyPolio Vaccine (live and inactivated) - Avoid during pregnancy in most cases. Use IPV in pregnancy if high risk Polio exposureRabies Vaccine Tularemia Vaccine Typhoid Vaccine  |
| AMB | Plantar Fasciitis |  Neuro examNeuro: 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 painAffected 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: \_ ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; TM Clear; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: 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 fasciitisPRICE, NSAID, handout with home rehabRecommend: orthotics for shoes, low impact activities (bike/elliptical), bike instead of walking/running if possible, regular icing, consider night splints, consider stretching LE upon wakingDiscussed potentially chronic, waxing and waning nature of this conditionF/U prn if not improving |
| AMB | Postpartum visit | Postpartum Check\_ yo F for postpartum checkDelivery 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 dischargeEmotional health: Denies depressed mood, appetite normal, mild fatigue from frequent night-time awakenings to breast feedObjectiveNL VS notedGen: AOx3, nadHEENT: PERRL, EOMI, op-clearNeck: Supple, no massCV: RRR, no murmurLungs: CTA-bAbd: S/nt/nd, uterus not palpableExt: No calf TTP, no edemaPelvic: Deferred for nowCBE: Chaperoned by: \_ . Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple dischargeGU: Chaperoned by: \_. Normal appearing female genitalia without lesion. Normal vaginal mucosa without discharge. Cervix normal in appearance. No CMT. Normal bimanual exam.Assessment/PlanPostpartum checkupPatient doing well overallNo acute issuesPap/breast exam unremarkableUsing \_ for contraceptionF/U prn |
| AMB | PQRST-U: Pain Assessment | PQRST-U: Pain AssessmentProvokes/palliative: \_Quality: \_Radiates: \_Severity: \_Time: \_What do ‘you’ think it is: \_ |
| AMB | Pregnancy New | Pregnancy NewObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RRR; Normal S1/S2; No MRGAbd: Gravid; soft; flat; non-tender; NABS; S-F height \_\_cm; FHR at \_\_\_ BPM by doptonesCBE: Chaperoned by: \_. Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple dischargeGU: 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 LabsHgb | 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 visitG \_ P \_ \_ w \_ d EDC \_Based on \_ LMP \_ 1st trimester USVaginal bleeding: \_Loss of fluid: \_Painful contractions: \_Fetal movement: \_Other complaints/concerns: \_ ObjectiveVS reviewedGen: AOx3, NAD, well-nourishedCV: RRR, no murmurLungs: CTA-bAbd: gravid, fundal height: \_ cmPosition (~36 weeks): \_Ext: =< 1+ edema, warm and well perfusedFHT: \_ |
| AMB | Prostate | Prostate symptomsOnset/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: \_SeverityAUA 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 BPHLabs:PSA (if life expectancy > 10 years) and UABenign Prostatic HyperplasiaTreatment options for bothersome, moderate to severe benign prostatic hyperplasiaLifestyle modificationsLosing weightDecreasing evening fluid intakeAvoiding excess alcohol, caffeine, or highly seasoned foodsLimiting medications known to cause lower urinary tract symptomsMedicationsAlpha blockers5-alpha reductase inhibitorsAnticholinergic agentsAlpha 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 HyperplasiaNonselective 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 prostateFinasteride (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 symptomsOxybutynin extended release (Ditropan XL); 10 mg ; $40 ($175) Solifenacin (Vesicare) 5 mg; NA ($240) Tolterodine extended release (Detrol LA) 4 mg; $150 ($265) SurgeryPhoto selective vaporization of the prostateTransurethral incision of the prostateTransurethral laser prostatectomy (holmium: yttrium-aluminum-garnet [YAG] laser ablation, enucleation, or resection of the prostate)Transurethral microwave thermotherapyTransurethral needle ablation of the prostateTransurethral resection of the prostateTransurethral vaporization of the prostateDDx:Benign prostatic hyperplasiaBladder calculiBladder cancerBladder irritants (e.g., caffeine)Diabetes mellitusMedication useAnticholinergics (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 bladderObstructive sleep apnea (nocturia)Overactive bladderPolyuria (isolated nocturnal, 24-hour polyuria)Prostate cancerProstatitisUrethral or bladder neck stricturesUrethritis/sexually transmitted infectionsUrinary tract infectionNotesThe risk of prostate cancer is lower in men with lower urinary tract symptoms and an elevated PSA level than in those without symptomsPost 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 ExamsMental StatusAlert. 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. ObjectiveGeneral: 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: AppendicitisOnset: \_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: \_ObjectiveGeneral: BP/HR/Temp reviewed; A/Ox3; NADEyes: 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, leukocytosisPoor predictive value (poor sensitivity and Specificity)Leukocytes normal in 25% of Appendicitis casesHigh Negative Predictive ValueIn children, Likelihood Ratio with WBC <10,000 is 0.22InterpretationLeukocytes range: 10,000 to 20,000 (in 75% of Appendicitis cases)Leukocytosis over 15,000 compels evaluationHigher Leukocytosis suggests appendix perforationC - reactive protein (CRP)Increases within 6-12 hoursTest Sensitivity for Appendicitis: 76%Test Sensitivity improves if C-RP remains normal despite >24 hours of symptomsIn some studies, normal C-RP at 24 hours had a nearly 100% Negative Predictive ValueUrinalysisSterile pyuria can occur if appendix is adjacent to ureter |
| AMB | SIGECAPS | SIGECAPSMajor 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 throatStarted days ago: \_Fever: \_Tonsillar exudate: \_Cough or URI sx: \_Tender lymph nodes: \_Aggravating factors: \_Has tried: \_ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; \_ erythema, \_ exudateNeck: Supple; No thyromegalyLymph: \_ cervical lymphadenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: Good distal pulses. Normal gait.Assessment/Plan: PharyngitisStrep Score: \_Rapid strep test: \_Will send culture and treat as indicatedTylenol/ibuprofen prnSalt water gargles, smooth/wet foodsF/U prn if acutely worsening sxTreatment 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 pointsInterpretation (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, injectionR/B of procedure explained, verbal and written consent for injection givenArea prepped in usual fashion21g needle used to inject Synvisc in superior lateral approachNo complications, patient tolerated wellRTC next week for next injectionIce/Tylenol/NSAID OK for post injection pain |
| AMB | TB Evaluation | TB evaluationHistory 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 tuberculosisLabs (CBC, HIV, CMP) and CXR doneDoes not appear to have active disease on CXRStart tx per YKHC guidelinesResourcesMary Berliner (contact): 543-0431/545-0440 (to obtain sputum results)Public Health: 543-2110 |
| AMB | Therapeutic Lifestyle | Therapeutic lifestyle generic advise for Assessment/PlanEncouraged 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 nailR/L side: \_R/B explained, verbal/written consent obtainedToe prepped, 1% lido w/o injected for digital blocknail cut approx. 1/4 and removedEBL < 10ccPatient tolerated well, no complicationsBandaged, wound care instructions givenF/U prn if s/sx infection  |
| AMB | Trochanteric bursitis | Trochanteric bursitis\_ yo \_ c/o lateral hip painPain 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 bursitisDDx 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 bursitisNSAIDs/APAP, ice, rest/protectModify activity, low impact activity that does not aggravateConsider physical therapy referralConsider 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 symptomsStarted x days ago: \_Cough: \_Congestion: \_Sore/throat: \_Earache: \_Fevers/chills: \_Headache/malaise: \_Sick contacts: \_Self-treatment: \_ ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalHEENT: NC/AT; oropharynx clear w/o exudate, no lesions; TMs nl landmarks/color/reflex, no sinus TTPNeck: Supple; No thyromegalyLymph: No cervical lymphadenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; NABS; No mass; No hepatosplenomegalyGU: DeferredExt: No clubbing; cyanosis; or edema. Good distal pulses. Normal gait.Assessment/Plan: URINo fevers/chills, lungs clear, pulse ox normalWill treat symptomaticallyCan try nasal saline rinse, humidifier, Tylenol/ibuprofen, decongestants and throat lozengeSymptoms may persist for a week or longerEmphasized hygiene including hand washing and proper coughing techniqueF/U prn if not gradually improving or any acute worsening in symptomsDoctors 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: \_ObjectiveGen: BP/HR/Temp reviewed; A/Ox3; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: 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: UTIUncomplicated, no f/c, no flank painUA suggestive of infectionTreat with antibioticF/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; NADEyes: PERRLA; Conjunctiva normalENT: NC/AT; TM Clear; No oral lesions; No erythemaNeck: Supple; No thyromegalyLymph: No neck/axillary adenopathyChest: CTA; No wheezes/rhonchi/ralesCV: RR; Normal S1/S2; No MRGAbd: Soft; flat; non-tender; NABS; No mass; No hepatosplenomegalyCBE: Chaperoned by: \_. Normal breast contour bilaterally without skin dimpling or color change. No palpable masses bilaterally. No nipple dischargeGU: 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 ChangeOld 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 InsertionTime: \_Confirmed: Patient, procedure, side, and site correct. Consent: Patient has signed consent. Indication: PneumothoraxProcedural 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: airSecured: 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 repairConfirmed: Patient, procedure, side and site correctConsent: 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 PunctureProcedure 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 | ParacentesisAfter 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 |  ParacentesisAfter 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 IntubationPre-oxygenation: Patient at 100% by BVMPretreatment: NoneParalytic & Induction: Etomidate 20 mg IV, Succinylcholine 100mgPlacement: 7.0 French ET tube visualized going through the vocal cords with confirmatory ETCO2Post intubation Sedation: Lorazepam, FentanylVent SettingsTidal Volume: \_Resp. Rate: \_PEEP: \_Flow rate: \_FIO2: \_ |
| ED | Shoulder Dislocation-Reduction | Shoulder dislocation reductionConfirmed: Patient, procedure, side, and site correct. Time out @: \_Consent: Urgent, procedure with risk and benefits explained to the patient. Consent signed by \_Indication: Shoulder dislocationMonitoring: Cardiac, blood pressure, continuous pulse oximetry. Location: Sedation: Post-procedure: Arm placed in sling. Post reduction films examined and indicated \_Complications: None. Performed by: SelfTotal time: 20 Minutes  |
| ED | Trauma/Critical Care | Trauma/Critical Care:Date of trauma: \_Today’s date: \_Arrival time: \_Hospital contacted: \_1st contact @: \_Successful: Y NReason: \_ Outcome: \_ 2nd contact @: \_ Successful: Y N Reason: \_Outcome: \_3rd contact @: \_Successful: Y NReason: \_Outcome: \_ Trauma/general surgeon on call: \_Date / Time trauma accepted for transfer: \_Air Ambulance activated @: \_LifeMed Guardian OtherETA: \_Reason for delays (if any): \_Note completed and sent with patient: Yes No Other |
| Inpatient | Discharge Disclaimer for Inpatient | Discharge Disclaimer for InpatientMom, 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 DisclaimerDiscussed 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 villageASSESSMENT: 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 clinicPatient 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 BathsPatients 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 tubFill the tub with water and add ¼ cup of household bleachSoak in tub for at least 20 minutesSoap is not requiredFor 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 water4.5 ml of household bleach for 3 gallons of water7.5 ml of household bleach for 5 gallons of water15 ml of household bleach for 10 gallons of water |
| RMT | Dental Not Cleared | Dental NOT clearedThis 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 ResponsePatient being seen for dental rehab pre-op travel clearance.Health Aide Vitals and Physical Exam are unremarkable.Limited chart review doneIF: Dental rehab to be done in Anchorageand...No fever in past 48 hoursNo history of runny nose, nasal discharge, cough, wheezing or congestion in the past weekNo vomiting or diarrheaNo recent exposure to chicken pox or other significant infectious diseasesTHEN:Patient is clear for travel for dental rehab.IF: Dental rehab is to be done in Betheland...No fever in past 48 hoursNo history of runny nose, nasal discharge, cough, wheezing or congestion in the past 4 weeksNo vomiting or diarrheaNo recent exposure to chicken pox or other significant infectious diseasesTHEN: Patient is clear for travel for dental rehab. |
| RMT | Infant F/U | Infant Follow UpReturn 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 CPPPatient 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 upOK 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 flightAgree 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 ThroatPlease 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 VISIT12-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 VarnishFU: Next WCC at 18 months  |
| WCC | WCC - 18 Month Visit | WCC - 18 MONTH VISIT18-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 VarnishFU: 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 milestonesPLAN: \_Anticipatory guidance: immunizations, fever protocol, tummy time, rolling over, teething, safe sleeping.\_Immunizations todayFOLLOW 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 feedingFOLLOW-UP:6-8 week WCC |
| WCC | WCC - 2 Year Visit | WCC - 2 YEAR VISIT2-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 VarnishFU: Next WCC at 30 months |
| WCC | WCC - 3 Year Visit | WCC - 3 YEAR VISIT3 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 todayFU: Next WCC at age 6 MO |
| WCC | WCC - 4 Year Visit | WCC - 4 YEAR VISIT4 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 referralFU: 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 todayFU: 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 milestonesAnticipatory 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 \_  |