CHIEF COMPLAINT: [abdominal pain]

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
- Constitutional: [no fever, no chills]
- Eyes: [no discharge]
- ENT: [no sore throat]
- Respiratory: [no cough, no shortness of breath]
- Cardiac: [no chest pain, no palpitations]
- Gastrointestinal: as above
- Genitourinary: [no hematuria]
- Musculoskeletal: [no back pain]
- Skin: [no rashes]
- Neurological: [no headache]

[Otherwise a complete review of systems was obtained and other than the HPI was negative]

abdominal pain including but not limited to appendicitis, cholecystitis, gastritis and urinary tract infection.

abdominal pain in a female including ovarian cyst, urinary tract infection, gastroenteritis and appendicitis

ED ABSCESS DR  Y  C  ED Abscess drainage
Abscess drainage

The patient abscess was located [body part]. [I obtained verbal consent from the patient to drain the abscess who was informed about the possibility of bleeding, pain and worsening of the condition.] The abscess was incised with [a scalpel] and [a large] amount of purulent drainage was expressed. [I irrigated the wound and placed some packing.] [The patient tolerated the procedure well.] The procedure was performed by [myself].

After discussion with [ ] we agreed the patient should be transferred to [observation or admit] status on a [floor, tele, step down or ICU] in [what type of condition].

[DIFFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for ] [ ]
Anoscopy:
The indication for the procedure was [rectal bleeding]. The anoscope was placed in the rectum without difficulty. [findings] [The patient tolerated the procedure well.] The procedure was performed by [myself].

Arthrocentesis:
After verbal informed consent from [patient] explaining the risks including infection and bleeding a arthrocentesis was performed on the [knee]. The arthrocentesis was performed after the patient was prepped and draped in the usual fashion.: [The joint was anesthetized with 1% lidocaine.] Approximately [10 cc] of [clear] fluid was obtained. [There were no complications.]
The procedure was performed by [myself.]

CHIEF COMPLAINT: [

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Constitutional: [no weakness]
Eyes: [no visual changes or eye pain]
ENT: [no dental trauma]
Respiratory: [no chest wall pain, no shortness of breath]
Cardiac: [no palpitations]
Gastrointestinal: [no abdominal pain, no vomiting]
Genitourinary: [no hematuria]
Musculoskeletal: [as above]
Skin: [no lacerations]
Neurological: [no headache]
CHIEF COMPLAINT: [ ]

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Respiratory: [no chest pain, no shortness of breath]
Gastrointestinal: [no abdominal pain, no vomiting]

[Otherwise a complete review of systems was obtained and other than the HPI was negative]

ED AUTO ACC PH Y C ED Auto accident physical

General Appearance: [alert, no distress]
[Eyes:] [pupils equal and round no injection]  
Respiratory: [chest is non tender to palpation] [breath sounds are equal]  
[Cardiac: regular rate and rhythm] []
Gastrointestinal: [soft and non tender, there is no evidence of external or internal trauma by exam.]  
[Neurological:] []
[Skin:] [No laceration or abrasions.]
Musculoskeletal
   [Head: atraumatic without scalp tenderness]  
   [Neck:] [The patient arrived in a cervical collar.] [The cervical spine is non-tender and there is no pain with active range of motion]  
   [Back:] [there is no thoracic or lumbar spine or paraspinal tenderness]  
      [Extremities are non tender to palpation and there is full range of motion of the joints.]

[Differential Diagnosis: after history and physical exam differential diagnosis was considered for] [trauma in an auto accident] [including intracranial, spinal, intrathoracic and intra-abdominal injuries]

ED BACK PAIN D Y C ED Back pain differential

Back pain including but not limited to muscular pain, herniated disc, spine fracture, intra-abdominal causes and urinary tract infection

ED BLADDER IRR Y C ED Bladder irrigation

Bladder irrigation:
A Foley catheter was placed by myself. [The indication for the procedure was hematuria.] [The bladder was irrigated with a toomey syringe by myself.] [Results of the irrigation] [There were no complications.]

An abdominal ultrasound was performed for the indication of [abdominal tenderness and possible urinary retention]. The lower abdomen was scanned looking for bladder distention. By ultrasound there appears to be [a large] amount of retained urine after voiding. [The images were saved on the ultrasound database.] The exam was performed by myself.

Burn treatment:
The [location] [split thickness] burn covers [what percentage] total body surface area. I debrided the wounds and applied [what product] antibiotic ointment to the wound. I dressed the wound with the nurses assistance. The procedure was performed by myself.

General Appearance: [patient is comatose being ventilated]
[Respiratory: breath sounds are bilateral]
[Cardiac: heart sounds are absent] []
[]

[Differential Diagnosis: After history and physical exam differential diagnosis was considered for ] [cardiac arrest including myocardial infarction, arrhythmia, pulmonary embolus and severe electrolyte abnormality]

CHIEF COMPLAINT: [Cardiac arrest]

HISTORY OF PRESENT ILLNESS: [expanded problem focused]

REVIEW OF SYSTEMS: [Unobtainable secondary to cardiac arrest]
ECHOCARDIAGRAM:

A limited transthoracic echocardiogram was performed and interpreted by myself for [a cardiac arrest]. Limited transthoracic echocardiogram: The pericardium was visualized and found to be [negative] for pericardial fluid. Cardiac activity was [negative]. The study was [negative] for pericardial effusion. The study demonstrated [negative] cardiac activity. [The images were saved on the ultrasound database.]

CARDIOVERSON:

The patient was [electrically] cardioverted for [atrial flutter]. The patient was on a continuous cardiac monitor, with airway equipment at the bedside. The patient was on continuous pulse oximetry. The cardioversion was attempted with [50 joules biphasic current]. The cardioversion was [successful]. [The patient tolerated the procedure well with no complications.] [The procedure was performed by myself.]

CENTRAL LINE:

Central line placement:

After verbal informed consent from [patient]; with the risks explained to be bleeding, infection, and collapsed lung; maximal sterile barrier technique was uses including cap, gown, sterile gloves, large sheet, handwashing and chlorhexidine prep. The area anesthetized with 1% lidocaine. The [right] [left] [subclavian vein] was punctured with a 19 gauge finder needle, then a wire introducer was placed, a [8 french cordis] was placed using Seldinger technique. No complications. Blood return low pressure, dark blood. Patient tolerated procedure well. [CXR results:] [good line placement, no pneumothorax]. As interpreted by myself. Radiologist interpretation pending. The procedure was performed by [myself].
CHIEF COMPLAINT: [chest pain]

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Constitutional: [no fever, no chills]
Eyes: [no discharge]
ENT: [no sore throat]
Respiratory: [as above]
Cardiac: [as above]
Gastrointestinal: [no abdominal pain, no vomiting]
Genitourinary: [no hematuria]
Musculoskeletal: [no back pain]
Skin: [no rashes]
Neurological: [no headache]

ED CHEST PAIN B Y C ED Chest pain brief

CHIEF COMPLAINT: [chest pain]

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Respiratory: [as above]
Cardiac: [as above]
Gastrointestinal: [no abdominal pain, no vomiting]

[Otherwise a complete review of systems was obtained and other than the HPI was negative]

ED CHEST PAIN D Y C ED Chest pain differential

chest pain including chest wall pain, myocardial ischemia, pulmonary embolus and pulmonary infectious process.

ED CHEST TUBE Y C ED Chest tube

Chest tube placement:

The indication for the procedure was [a pneumothorax]. A timeout was observed. The patient was prepped in a sterile fashion. The patient was anesthetized with [1% lidocaine with epinephrine]. After blunt dissection a [36] French chest tube was placed in the [5th] intercostal space on the [right] side. The tube was sutured in place and dressed. Post
placement chest x-ray [demonstrated the tube to be in the appropriate position]. Following placement of the tube the patient's condition was [improved]. [The patient tolerated the procedure well there were no complications.] [The procedure was performed by myself.]

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<tr>
<td>ED COCCYX FX</td>
<td>Y</td>
<td>C</td>
<td>ED Coccyx fracture</td>
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After history and physical exam I determined the patient to have a coccyx fracture. I did discuss with the patient the care of this injury at home. The patient was instructed to prevent constipation. Other comfort measures such as a doughnut cushion were also discussed.

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<tr>
<td>ED COMP ROS</td>
<td>Y</td>
<td>C</td>
<td>ED Complete ROS</td>
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REVIEW OF SYSTEMS:
Constitutional symptoms: [as above]
Eyes: [no blurred vision]
Ears, nose, mouth, throat: [no earache]
Cardiovascular: [no chest pain, no palpitations]
Respiratory: [no dyspnea, no cough]
Gastrointestinal: [no abdominal pain, no vomiting]
Genitourinary: [no dysuria]
Musculoskeletal: [no joint pain]
Integumentary: [no rash]
Neurological: [no headache]

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<tr>
<td>ED CONSC SEDAT</td>
<td>Y</td>
<td>C</td>
<td>ED Conscious sedation</td>
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Consious sedation:
A pre-sedation evaluation was completed on the patient at [what time?]. Patient is an appropriate candidate for [procedural sedation]. The risks of the sedation were discussed with the [patient]. [A time out was completed.] The patient was sedated with [what medications?]. [The patient was monitored with continuous pulse oximetry and EKG monitor.] [There were no complications and no significant hypoxemia.] I remained at the bedside for the sedation. The total time I spent in the procedural sedation was [].

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<td>ED CRIT CARE</td>
<td>Y</td>
<td>C</td>
<td>ED Critical care</td>
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I spent a total of [30 minutes] of critical care time in obtaining history, performing a physical exam, bedside monitoring of interventions, collecting and interpreting tests and discussion with consultants but not including time spent performing procedures.

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<tr>
<td>ED CT SCAN</td>
<td>Y</td>
<td>C</td>
<td>ED CT scan</td>
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CT scan of the [head] was obtained. The results of the study are [normal]. The study was read by the radiologist. I viewed the images myself on the PACS system.

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<tr>
<td>ED DENTAL</td>
<td>Y</td>
<td>C</td>
<td>ED Dental</td>
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Dental fixation was performed. The indication for the procedure was [an alveolar ridge fracture]. The teeth [an adjacent fracture] were stabilized using []. The procedure was performed by myself.

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<tr>
<td>ED DISLOC REDUC</td>
<td>Y</td>
<td>C</td>
<td>ED Dislocation reduction</td>
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Dislocation reduction:

The [shoulder] was reduced [in the usual fashion] without complications. Post reduction the patient's neurovascular exam is normal. Post reduction x-ray [demonstrates reduction of the joint to the anatomic position.]

The procedure was performed by [myself].

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<tr>
<td>ED EAR FB REMOV</td>
<td>Y</td>
<td>C</td>
<td>ED Ear foreign body removal</td>
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Ear Foreign Body Removal

The patient's ears were examined with an otoscope. The patient was noted to have a [cerumen impaction] in the [right] canal. The cerumen was removed with [an ear loop]. The patient tolerated the procedure, has been instructed to use cortisporin otic to prevent infection after manipulation.

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<tr>
<td>ED EKG</td>
<td>Y</td>
<td>C</td>
<td>ED EKG</td>
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EKG:
  Indication: [
  Rhythm: [normal sinus rhythm]
  [Axis:] [normal]
  Intervals: [normal]
  QRS: [normal]
  ST segments: [normal]
  INTERPRETATION: [
The EKG was interpreted by myself

The patient was placed on a 3 lead EKG monitor in the Emergency Department. The indication for the monitor was []. The monitor demonstrated [normal sinus rhythm], intervals [normal], QRS [normal morphology]. The EKG monitor was interpreted by myself.

fall in the elderly including intracranial injury, long bone fracture, spinal injury, intrathoracic injury

General Appearance: [alert, no distress]
[ENT, Mouth:] [mucous membranes moist]
  [Dental exam:] [normal dentition]
  [Throat exam:] [no erythema, no tonsilar hypertrophy, no exudates, uvula midline]
[Musculoskeletal:] [Neck:] [no adenopathy, no swelling, supple]
[]
[DIFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for] []

epigastric pain including cholecystitis, peptic ulcer disease, pancreatitis, gastroenteritis
The patient was anesthetized with phenylephrine and lidocaine. The anterior epistaxis was identified. The patient was treated with vasoconstriction, packing, cautery. Following the procedure the patient was re-examined and the bleeding was well controlled. The patient tolerated the procedure well. The procedure was performed by myself.

Esophageal tube placement.

Because of difficulty with the procedure the nurse was unable to place the tube. The tube was placed by me for the following indication: Possible GI bleeding.

Review of Systems:
Cardiovascular: no chest pain, no palpitations
Respiratory: no cough, no dyspnea
Gastrointestinal: no vomiting, no abdominal pain
Musculoskeletal: no back pain

Eye Foreign Body Removal
The right eye was examined using the ophthalmoscope and slit lamp. Tetracaine was administered. The lid was everted and patient was noted to have a foreign body. Foreign body was removed with a needle. There was no remaining debris or rust ring. The patient tolerated the procedure and was instructed to follow up with an ophthalmologist in 1-2 days.

Trauma Ultrasound:
Limited bedside ultrasound was performed and interpreted by myself for the indication of: injury to the trunk utilizing the
thoracoabdominal emergency ultrasound protocol.

Limited transthoracic echocardiogram: The pericardium was visualized and found to be [negative] for pericardial fluid. The study was [negative] for pericardial effusion.

Limited abdominal ultrasound for [blunt abdominal trauma]
1) The right upper quadrant was visualized and was found to be [negative] for intraperitoneal fluid.
2) The left upper quadrant was visualized and found to be [negative] for intraperitoneal fluid.
3) The bladder was visualized and did [not reveal] an anechoic area outside of the adjacent urinary bladder.

The study was felt to be [negative] for free intraperitoneal fluid.

[The images were saved on the ultrasound database.]

ED FB REMOVAL Y C ED Foreign body removal

Foreign body removal:
A [metal, glass, etc.] foreign body was removed from [body part]. [To remove the foreign body a small incision was required.] The procedure was performed [manually, with dissection under local anesthesia, etc]. The procedure was performed by [myself].

ED FB US Y C ED Foreign body ultrasound

A limited ultrasound was performed [for abscess location.] [A fluid filled space was identified for drainage with ultrasound guidance.] The examination and interpretation was performed by myself.

[The images were saved on the ultrasound database.]

ED FEVER AD D Y C ED Adult fever differential

fever in adults including pneumonia, urinary tract infection, viral syndrome, influenza.

ED FEVER PEDS D Y C ED Child's fever differential

a child with a fever including but not limited to otitis media, pneumonia, UTI, serious infectious causes such as meningitis and sepsis and viral syndromes including influenza.
flank pain including musculoskeletal causes, kidney stone, pyelonephritis, intra-abdominal causes such as diverticulitis and appendicitis

Foley catheter placement:

A Foley catheter was placed by [myself]. [The indication for the procedure was urinary retention and the nurse was unable to complete the procedure.] [The were no complications].

The patient had x-rays taken and I confirmed that the patient had a fractured [wrist]. I do not believe that the patient will require reduction at a later date. [A short arm splint was applied.] [After application of the splint I returned and re-examined the patient. The splint was adequately immobilizing the joint and distal to the splint the patients circulation and sensation was intact.]

[Fracture reduction]:

After review of the X-rays I determined that a reduction was required for improved long term function. The [distal radius] was reduced [using traction and manipulation] without complications. A [long arm] splint was applied. Post reduction the patient's neurovascular exam is normal.
Post reduction x-ray [demonstrates improvement in fracture with an acceptable reduction of the fracture.]
The procedure was performed by [myself].

G tube replacement:

After confirming that the tube was out I replaced the G tube using a [] G tube. After placing the tube I confirmed adequate placement [how]. There were no complications. The procedure was performed by [myself].
Mnemonic  Active  Source  Name

ED HEAD INJ D  Y  C  ED Head injury differential

head injury including concussion, skull fracture, intraparenchymal contusion and subdural hematoma

ED HEADACHE D  Y  C  ED Headache differential

headache including subarachnoid hemorrhage migraine headache, meningitis, infectious causes such as pharyngitis, tension headache and sinusitis

ED HOSPITAL CONS  Y  C  ED Hospital consult

HOSPITAL CONSULT:

I was called to see the patient by [hospital protocol, Dr. _____] . The reason for the consult was [].

CHIEF COMPLAINT: []

HISTORY OF PRESENT ILLNESS: [expanded problem focused]

PAST MEDICAL HISTORY: []

PHYSICAL EXAM:

CONSTITUTIONAL:
  Vital Signs: []
  General Appearance: []

DATABASE: []

INTERVENTION: []

DIAGNOSIS: []

PLAN: []

ED HOSPITAL PRO  Y  C  ED Hospital procedure
HOSPITAL CONSULT:

I was called to see the patient by [hospital protocol, Dr. _____]. The [intubation] [was requested] because [].

INTERVENTION:

[]

DIAGNOSIS: []

PLAN: []

ED INTUBATION   Y   C   ED Intubation

Rapid sequence intubation:

Indication for the procedure was [head trauma, airway protection, respiratory failure]. The patient was preoxygenated with 100% oxygen by [face mask]. The patient was given the following IV medications: [etomidate,][fentanyl,][lidocaine,][rocuronium as a defasciculating agent][][succinylcholine,][rocuronium]. The patient was orally endotracheally intubated [under direct visualization] with a [8.0] ETT. [In line stabilization was performed during the procedure.] There was good misting on the tube; breath sounds were auscultated equally bilaterally; good color change with Nellcor End Tidal CO2 detector. Chest X-ray shows ETT [in good position]. The procedure was performed by [myself].

ED IO LINE   Y   C   ED Interosseous line placement

Interosseous Line Placement

Unable to obtain peripheral IV access and decision made to start an interosseous line. The lower leg was flexed and cleansed with betadine. Local lidocaine was infiltrated into the [right] anteromedial tibia, about 1.5 cm distal to the tibial tuberosity. The needle was inserted using the I/O drill. The trocar was removed and blood drawn from the needles. Minimal blood loss.

ED IV PLACEMENT   Y   C   ED IV placement

Insertion of intravenous catheter:
[The nurse requested that I place an intravenous catheter because of technical difficulties with this procedure on this patient.] I prepped the patient's skin with [chlorhexidine]. I placed [an 18 gauge] intravenous catheter in the patient's [body part].

**ED KNEE INJ D Y C ED Knee injury differential**

knee injury including fracture, ACL injury, muscular strain, meniscus injury

**ED LAC REPAIR Y C ED Laceration repair**

Laceration repair:

[Verbal consent was obtained from the patient.] The [wound size] laceration on the [location] [was anesthetized in the usual fashion.] The wound was [scrubbed], draped and explored to its base with a gloved finger. [ ] [There were no deep structures involved.] [No tendon injury was identified.] The wound was repaired with [ ]. The wound repair was [simple]. The procedure was performed by [myself].

**ED LARYNGOSCOPY Y C ED Laryngoscopy**

Laryngoscopy:

A diagnostic laryngoscopy was performed. The indication of the procedure was [stridor, severe sore throat, foreign body sensation]. The procedure was [direct, indirect, fiberoptic]. The findings were [ ]. [The patient tolerated the procedure well.] The procedure was performed by [myself].

**ED LEG SWEL D Y C ED Leg swelling differential**

Leg swelling including hypoalbuminemia, congestive heart failure, cor pulmonale, chronic venous stasis and DVT

**ED LEVEL 3 Y C ED Level 3**

CHIEF COMPLAINT: [

HISTORY OF PRESENT ILLNESS: [Focused history]
Mnemonic Active Source Name

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**ED LEVEL 3 EXPH Y C ED Level 3 extremity physical**

General appearance: [alert no distress]

[DIFFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for ] [ ]

**ED LEVEL 3 PH Y C ED Level 3 physical**

General appearance: [alert no distress]

[Respiratory:] [Chest is non tender, lungs are clear to auscultation]

[Cardiac:] [Regular rate and rhythm] [ ]

[DIFFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for ] [ ]

**ED LEVEL 4 Y C ED Level 4**

CHIEF COMPLAINT: [

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:

Respiratory: [no cough, no dyspnea]
Cardiovascular: [no chest pain, no palpitations]
GI: [no vomiting, no abdominal pain]
Musculoskeletal: [no back pain]

[All other systems negative]

**ED LEVEL 4 P PH Y C ED Level 4 peds physical**

General Appearance: [The child is alert, well hydrated, appropriate and non-toxic appearing]

[ENT, mouth:] [TM s are clear bilaterally, no injection, no evidence of serous otitis]

[Throat:] [There is no erythema or exudates, no tonsillar hypertrophy]

[Neck:] [Supple, non tender, no lymphadenopathy]

[Respiratory: there are no retractions, lungs are clear to auscultation]

[Cardiac: regular rate and rhythm, no murmurs or gallops]
[Gastrointestinal:] [Abdomen is soft, no masses, no apparent tenderness]
[Neurological:] [Alert, appropriate and interactive. The child is moving all extremities and appropriate for age]
[Skin: No rashes, no nodules on palpation.]

[Differential Diagnosis: After history and physical exam differential diagnosis was considered for] []

CHIEF COMPLAINT: []

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
General: [no fever]
Respiratory: [no cough, no apparent shortness of breath]
Gastrointestinal: [no vomiting]
REVIEW OF SYSTEMS:
Constitutional: [no fever, no chills]
Eyes: [no discharge]
ENT: [no sore throat]
Cardiovascular: [no chest pain, no palpitations]
Respiratory: [no cough, no shortness of breath]
Gastrointestinal: [no abdominal pain, no vomiting]
Genitourinary: [no hematuria]
Musculoskeletal: [no back pain]
Skin: [no rashes]
Neurological: [no headache]
[All other systems negative]

ED LEVEL 5 B Y C ED Level 5 brief

CHIEF COMPLAINT: []

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Respiratory: [no cough, no shortness of breath]
Cardiac: [no chest pain, no palpitations]
Gastrointestinal: [no abdominal pain, no vomiting]
[Otherwise a complete review of systems was obtained and other than the HPI was negative]

ED LEVEL 5 P PH Y C ED Level 5 peds physical

General Appearance: [The child is alert, well hydrated, appropriate and non-toxic appearing]
[ENT, mouth:] [TMIs are clear bilaterally, no injection, no evidence of serous otitis]
[Throat:] [There is no erythema or exudates, no tonsillar hypertrophy]
[Neck:] [Supple, non tender, no lymphadenopathy]
[Respiratory: there are no retractions, lungs are clear to auscultation]
[Cardiac: regular rate and rhythm, no murmurs or gallops]
[Gastrointestinal:] [Abdomen is soft, no masses, no apparent tenderness]
[Neurological:] [Alert, appropriate and interactive. The child is moving all extremities and appropriate for age]
[Skin: No rashes, no nodules on palpation.]
[ ]
[Differential Diagnosis: After history and physical exam differential diagnosis was considered for] [ ]
CHIEF COMPLAINT: []

HISTORY OF PRESENT ILLNESS: [must have 4 elements]

REVIEW OF SYSTEMS:
Constitutional: [as above]
Eye: [no discharge]
ENT, mouth: [no hoarseness or stridor]
Cardiovascular: [normal peripheral perfusion]
Respiratory: [as above]
Gastrointestinal: [as above]
Genitourinary: [no perineal irritation]
Musculoskeletal: [no joint swelling]
Integumentary: [no rash]
Neurological: [no seizures]

General Appearance: [alert, no distress]
[Eyes:] [pupils equal and round no pallor or injection]
[ENT, Mouth:] [mucous membranes moist]
Respiratory: [there are no retractions, lungs are clear to auscultation]
Cardiovascular: [regular rate and rhythm]
Gastrointestinal: [abdomen is soft and non tender, no masses, bowel sounds normal]
[Neurological:]
[Skin:] [warm and dry, no rashes]
[Musculoskeletal:] [neck is supple non tender]
[Extremities are symmetrical, full range of motion]
[Psychiatric:] [patient is oriented X 3, there is no agitation]

DIFFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for} []

Laceration repair:
Mnemonic Active Source Name

[Verbal consent was obtained from the patient.] The [wound size] laceration of the lip, measured by the extent of the laceration on the skin [was anesthetized in the usual fashion.] The wound extends past the vermillion border and involves [50%] of the thickness of the lip. The wound was [scrubbed], draped and explored to its base with a gloved finger. [ ] The vermillion border was closed with good approximation of the edges. The wound was repaired with [ ]. The wound repair was for the skin was [simple]. The wound repair for the lip with [layered]. The procedure was performed by [myself].

ED LOWER GI D Y C ED Lower GI bleed differential

lower GI bleeding including diverticulosis, tumor, AVM, hemorrhoid and anal fissure

ED LUMBAR PUNC Y C ED Lumbar puncture

Lumbar puncture:

After verbal informed consent from [patient] explaining the risks including infection, bleeding, and neurologic damage, a lumbar puncture was performed after the patient was prepped and draped in the usual fashion. [The back was anesthetized with 1% lidocaine.] Approximately 4 cc of [clear] fluid was obtained. [There were no complications.] The procedure was performed by [myself.]

ED MRI Y C ED MRI

MRI of the [brain] was obtained. The results of the study are [normal]. The study was read by the radiologist. I viewed the images myself on the PACS system.

ED N/V D Y C ED Nausea and vomiting diff

nausea and vomiting including gastroenteritis, gastritis, appendicitis, medication side effect

ED NAIL TREPH Y C ED Nail trephination

Nail Trephination

Explained the risks and benefits of the procedure with the patient, and patient agrees. The subungal hematoma of the
[right] [great] [toe] was drained successfully using electrocautery. Patient tolerated the procedure well. Minimal blood loss. Dressing applied.

ED NARC CHECK  Y  C  ED Narcotic check

The patient's history on the Illinois Prescription Monitoring Program website was reviewed. The patient [was found to have no recent prescriptions of controlled substances.]

ED NASAL FX  Y  C  ED Nasal fracture

After history and physical exam I determined that the patient had a nasal fracture. I instructed the patient to use ice to the area. [Other discussions included] [ ]

ED NEG FAST EX  Y  C  ED Negative FAST exam

Trauma Ultrasound:

Limited bedside ultrasound was performed and interpreted by myself for the indication of [injury to the trunk] utilizing the thoracoabdominal emergency ultrasound protocol.

Limited transthoracic echocardiogram: The pericardium was visualized and found to be negative for pericardial fluid. The study was negative for pericardial effusion. The study was interpreted by myself.

Limited abdominal ultrasound for [blunt abdominal trauma]

1) The right upper quadrant was visualized and was found to be negative for intraperitoneal fluid.
2) The left upper quadrant was visualized and found to be negative for intraperitoneal fluid.
3) The bladder was visualized and did not reveal an anechoic area outside of the adjacent urinary bladder.

The study was felt to be negative for free intraperitoneal fluid. The study was interpreted by myself. [Images were saved on the ultrasound database.]

ED NG TUBE  Y  C  ED NG tube
**ED NORMAL EKG**

- **Indication:** [chest pain]
- **Rhythm:** Normal sinus rhythm
- **Axis:** Normal
- **Intervals:** Normal
- **QRS:** Normal
- **ST segments:** Normal

**INTERPRETATION:** Normal EKG

The EKG was interpreted by [myself].

**ED OB US**

A limited transabdominal ultrasound was performed on this patient. [She had a positive pregnancy test.] The indication for the study was [to rule out an ectopic pregnancy.] On the examination I found that there [was an IUP.] [Fetal heart tones were]. [I did not see a significant amount of free fluid in the pelvis.]

**Results of the exam:** [positive] for IUP.

[Images were saved on the ultrasound database.]

The examination was performed and interpreted by myself.

**ED PA DICTATION**

**PHYSICIAN DOCUMENTATION:**

Patient initially seen and evaluated by [name] with complaint of [ ]. Please see their dictation for complete details.

[Additionally I obtained the following history:] []

On my examination I found the following:

[ ]

[The midlevel and I discussed the care and disposition of the patient].

[your name ]

I authorize my typed signature that I authenticated this report.
**Diagnostic Paracentesis**

Informed consent was obtained after risks and benefits were explained at length. Patient bladder emptied. Patient positioned with head of bed elevated 45-60 degrees. A time-out was performed. The area of [left/right lower abdomen was prepped and draped in a sterile fashion using betadine/chlorhexidine scrub]. 1% lidocaine was used to numb the region. A [22 gauge] needle was introduced into the peritoneal space and fluid was removed. [A collection catheter was placed in the usual fashion]. No blood was aspirated. [Clear yellow] fluid was retrieved and collected. Approximately [ ] mL of ascitic fluid was collected and sent for laboratory analysis. The [catheter/needle] was removed and no leaking was noted. Blood loss was minimal. The patient tolerated the procedure well without any immediate complications.

**ESTIMATED BLOOD LOSS:** [ ]

**General Appearance:** [The child is alert, well hydrated, appropriate and non-toxic appearing] [Ears:] [TM's are clear bilaterally, no injection, no evidence of serous otitis] [Throat:] [There is no erythema or exudates, no tonsillar hypertrophy] [Neck:] [Supple, non tender, no lymphadenopathy] [Respiratory: there are no retractions, lungs are clear to auscultation] [Cardiac: regular rate and rhythm, no murmurs or g SOPs] [Gastrointestinal: abdomen is soft, no apparent tenderness, no masses, bowel sounds normal] [Neurological:] [Alert, appropriate and interactive. The child is moving all extremities and appropriate for age] [Skin: No rashes, no nodules on palpation.] [ ] [DIFFERENTIAL DIAGNOSIS: After history and physical exam differential diagnosis was considered for] [ ]

**vomiting in a child including gastroenteritis, appendicitis, urinary tract infection, foodborne illness**

**Pelvic exam**

The vulva [was normal no lesions.] The vagina [did not have significant discharge.] The cervix was [closed no bleeding and no purulent drainage.] The uterus [was normal size and non tender.] The adnexa [had no masses and no tenderness.] The exam was performed with a chaperone.
ED PSYCH D Y C ED Psychosis differential

psychosis including chronic psychosis, medication noncompliance, medication side effect, depression and illicit drug use

ED REDUCTION Y C ED Reduction

[Dislocation reduction]:
The [shoulder] was reduced [in the usual fashion] without complications. Post reduction the patient's neurovascular exam is normal. Post reduction x-ray [demonstrates reduction of the joint to the anatomic position.] The procedure was performed by [myself].

ED REG ANESTHES Y C ED Regional anesthesia

Regional anesthesia:
A [dental block] was performed [for what indication]. The block was performed with [Marcaine with epinephrine]. The patient experienced [complete] pain relief. The procedure was performed by myself.

ED RIB FX Y C ED Rib fracture

After the imaging studies were obtained I determined there [was or were] [one rib fractured]. I spent some time counseling the patient on the home care of broken ribs. The patient was instructed to manage the pain and to frequently take deep breaths. The patient was also warned of the potential complications including pneumonia and pneumothorax. The patient was told to return for shortness of breath, productive cough, fevers or worsening pain

ED SACRAL FX Y C ED Sacral fracture

After history and physical exam and images I determined the patient to have a sacral fracture. I did discuss with the patient the care of this injury at home. The patient was instructed to prevent constipation. Other comfort measures such as a doughnut cushion were also discussed.
Conscious sedation:

A pre-sedation evaluation was completed on the patient at [what time]. [A time out was taken.] The patient was sedated with [what medications]. [The patient was monitored with continuous pulse oximetry and EKG monitor.] The total length of time of the sedation was []. [There were no complications and no significant hypoxemia.]

Reduction:

The [shoulder] was reduced [in the usual fashion] without complications. Post reduction the patient's neurovascular exam is normal. Post reduction x-ray [demonstrates reduction of the joint to the anatomic position.]
The procedure was performed by [myself].

ED SEIZURE D Y C ED Seizure differential

a seizure including electrolyte abnormality, medication noncompliance, head injury, breakthrough seizure

ED SIGN OUT Y C ED Sign out

The care of the patient was turned over to [state the physician's name].

I authorize my typed signature that I authenticated this report.

ED SMOKING CESS Y C ED Smoking cessation

I counseled the patient regarding smoking cessation. The indication for the counseling was [chest pain]. The patient was told of the health hazards including COPD, coronary disease, lung and other cancer risks. Smoking cessation handouts were provided. I spent [3 minutes] aside from time for the evaluation and management with the counseling.
<table>
<thead>
<tr>
<th>Mnemonic</th>
<th>Active</th>
<th>Source</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>shortness of breath including pulmonary infectious process, COPD, asthma, pulmonary embolus and congestive heart failure</td>
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<td></td>
</tr>
<tr>
<td>ED SPINE FX</td>
<td>Y</td>
<td>C</td>
<td>ED Spine fracture</td>
</tr>
<tr>
<td>After the images were obtained it was determined that the patient had a spinal fracture. The level of the fracture was []. The description of the fracture is a [body, spinous process, etc] fracture and it was determined that the patient would not require open reduction or inpatient treatment. The fracture [does not] require bracing. [The brace used is a Miami J collar.] The procedure was performed by myself.</td>
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<tr>
<td>ED SPLINT PLACE</td>
<td>Y</td>
<td>C</td>
<td>ED Splint placement</td>
</tr>
<tr>
<td>A [short arm, long arm] splint was applied. After application of the splint I returned and re-examined the patient. The splint was adequately immobilizing the joint and distal to the splint the patient's circulation and sensation was intact.</td>
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<tr>
<td>ED STRIDOR P D</td>
<td>Y</td>
<td>C</td>
<td>ED Peds stridor differential</td>
</tr>
<tr>
<td>stridor a child including croup, tracheomalacia, bacterial tracheitis, epiglottitis</td>
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<td></td>
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<tr>
<td>ED SUTURE REMOV</td>
<td>Y</td>
<td>C</td>
<td>ED Suture removal</td>
</tr>
<tr>
<td>Suture Removal</td>
<td></td>
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<tr>
<td>The patient had [sutures] placed on the [right hand]. The wound appears to [be healing well]. The [sutures] were removed by the physician. The patient tolerated the procedure well and was instructed to return for any signs of infection.</td>
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<tr>
<td>ED SYNOCOPE D</td>
<td>Y</td>
<td>C</td>
<td>ED Syncope differential</td>
</tr>
<tr>
<td>syncope including vasovagal syncope, arrhythmia, dehydration, blood loss</td>
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<tr>
<td>ED TEST PAIN D</td>
<td>Y</td>
<td>C</td>
<td>ED Testicular pain diff</td>
</tr>
<tr>
<td>testicular pain including epididymitis, orchitis, referred pain from kidney stone, inguinal hernia, torsion of the testicle</td>
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<tr>
<td>ED TRANSFER</td>
<td>Y</td>
<td>C</td>
<td>ED Transfer</td>
</tr>
</tbody>
</table>
Patient was transferred to [Lutheran General Hospital] via [ambulance]. The transfer was [emergent], and [was required because the capabilities of the receiving hospital.] Consent for transfer was obtained from [the patient].

See EMTALA for transfer orders.

**ED TRANSV PACER**

**Transvenous pacemaker**

Indication for emergent pacemaker reviewed with patient. Reviewed risks and benefits of the procedure with the patient. Using the previously placed [right internal jugular catheter], a bipolar pacing catheter was advanced into the Cordis. The catheter was advanced to approximately [15] centimeters whereupon the balloon was inflated. It was further advanced into the right atrium and then the right ventricle to a depth of [ ] cm at which point pacing was achieved. The balloon was deflated and the catheter was retracted [ ] cm. The pacer was then advanced an additional [ ] cm and capture was reached at [ ] mAmp. The patient tolerated the procedure well with no immediate complications.

**ESTIMATED BLOOD LOSS:** [

**ED TRIPLE A US**

A limited abdominal ultrasound was performed of the retroperitoneum. The indication for the study was to rule out abdominal aortic aneurysm. On the study [no evidence of AAA was identified.] [The approximate cross sectional measurement of the aorta was][]

Results: [No evidence of aortic aneurysm.]

[The images were saved on the ultrasound database.]

The examination was performed and interpreted by myself.

**ED ULTRASOUND**

Ultrasound of the [] was obtained. The results of the study are [normal]. [The study was read by the radiologist]. [I viewed the images myself on the PACS system].

**ED UPABD PAIN D**
<table>
<thead>
<tr>
<th>Mnemonic</th>
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<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>upper abdominal pain including cholecystitis, gastritis, peptic ulcers disease, pancreatitis</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>upper GI bleeding including ulcer disease, gastritis, Mallory-Weiss tear, esophageal varices</td>
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<tr>
<td>urinary retention including medication side effect, prostatic hypertrophy, neurologic causes</td>
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<tr>
<td>An abdominal ultrasound was performed for the indication of [abdominal tenderness and possible urinary retention]. The lower abdomen was scanned looking for bladder distention. By ultrasound there appears to be [a large] amount of retained urine after voiding. [The images were saved on the ultrasound database.] The exam was performed by myself.</td>
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<tr>
<td>Dynamic ultrasound guidance was used to assist with placement of the central line. The procedure was performed and interpreted by myself.</td>
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<tr>
<td>vaginal bleeding including ectopic pregnancy, menses, miscarriage, dysfunctional uterine bleeding</td>
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</tr>
<tr>
<td>Venipuncture: I performed a venipuncture on this patient to obtain blood for laboratory studies.</td>
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<tr>
<td>vertigo including central causes such as benign positional vertigo, Ménière's disease, viral labyrinthitis and central causes such as CVA, tumor</td>
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</tr>
<tr>
<td>Venipuncture: I performed a venipuncture on this patient to obtain blood for laboratory studies.</td>
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</tbody>
</table>
weakness including electrolyte abnormality, depression, anxiety, CVA, spinal cord abnormality, infectious causes

ED XRAY Y C ED X-ray

X-ray:
[location] was obtained. I viewed the images myself on the PACS system. My interpretation of the images is:[]. The radiologist interpretation had no significant clinical variation from my reading.

ED XRAY PLURAL Y C ED X-rays plural

X-ray:
[locations] were obtained. [I viewed the images myself on the PACS system.] My interpretations of the images are:[]. The radiologist interpretation [had no significant clinical variation from my reading].

PD.PLAN Y C *Plan

Plan:[]

PD.SUBJECTIVE Y C Subjective

Referenced in Active Sections
PD.SUBJECTIVE *EMH-Subjective

[f__Name] has no complaints today.[]

WTS Y C Current Weight

Referenced in Active Sections
PD.PNOBJ *EMH Physical Exam

Patient's current weight is [q__Patient__Weight]