History of Present Illness

HPI - standard	.EDHPI	The patient is a @age@ @sex@ with a history of *** who presents to *** Emergency Department with a chief complaint of ***. Symptoms began *** and have been *** since onset. His *** pain is currently rated as a ***/10 in severity and described as *** with no radiation. Associated symptoms include ***. Symptoms are aggravated with *** and there are no alleviating factors. The patient denies ***. He reports taking *** prior to arrival with *** relief of symptoms. No other reported symptoms at this time.
HPI	.EDHPI	The patient is a @age@ @sex@ with a history of *** who presents to the ED with a chief complaint of ***. He/she states ***. Pain is rated ***/10. Associated symptoms include ***. No alleviating or aggravating factors. The patient denies ***, or any other symptoms. On arrival *** was noted to be in *** condition. Vital signs are as noted below.
HPI	.EDHPI	The patient is a @age@ @sex@ who presents to the ED via *** with a chief complaint of ***. Patient is accompanied by ***. The symptoms began *** and have been *** since onset. Associated symptoms include ***. Symptoms improved with *** and worsened with ***. Pain is located *** , is currently rated a *** out of 10 with *** radiation to ***. The patient denies ***. The patient has a past medical history significant for ***. No other reported symptoms at this time.
HPI	.EDHPI	Patient is a @age@ @sex@ presenting to the emergency department with chief complaint of ***. Symptoms started ***. Pain is rated as a ***/10 and described as *** There are no other associated signs or symptoms, no other modifying factors.
HPI	.EDHPI	The patient is a @age@ @sex@ with a history of *** who presents to *** Emergency Department with a chief complaint of ***. Symptoms began *** and have been *** since onset. Her *** pain is currently rated as a ***/10 in severity and described as *** with no radiation. Associated symptoms include ***. Symptoms are aggravated with *** and there are no alleviating factors. The patient denies ***. She reports taking *** prior to arrival with *** relief of symptoms. No other reported symptoms at this time.

Pertinent Negatives

Headache	.NEGHEADACHE	fevers***, chills***, neck stiffness or pain***, localized weakness***, worst headache of life***, thunderclap headache***, slurred speech***, carbon monoxide exposure***, sinus congestion/pain***, paresthesias***, diplopia***, blurred vision***, recent trauma***, or change in mentation.
Chest Pain	.NEGCHESTPAIN	shortness of breath***, leg pain or swelling***, palpitations***, nausea***, diaphoresis***, arm pain***, cough***, fevers***, personal history of diabetes***, hypertension***, high cholesterol***, or blood clotting disorders***, family history of heart disease***, recent travel***, recent surgery***, or prior DVT/PE.
Shortness of Breath	.NEGSOB	chest pain***, palpitations***, leg swelling***, weight gain***, cough***, hemoptysis***, wheezing***, fevers***, or chills***.
Abdominal Pain	.NEGABDOMINALPAIN	nausea***, vomiting***, diarrhea***, hematochezia***, melanotic stools***, urinary symptoms***, flank pain***, fevers***, chills***, or chest pain***.
Back Pain	.NEGBACKPAIN	lower extremity weakness***, bowel or bladder concerns***, paresthesias***, injury to the back***, or family history of abdominal aortic aneurysm.
Syncope	.NEGSYNCOPE	headache***, confusion***, localized weakness***, seizure activity***, slurred speech***, diplopia***, chest pain***, palpitations***, lightheadedness***, or diabetes mellitus history.
Weakness	.NEGWEAKNESS	chest pain***, palpitations***, shortness of breath***, nausea***, emesis***, syncope***, localized weakness***, gait instability***, facial droop***, slurred speech***, tremors***, diplopia***, seizure activity***, or dysphagia.
Dizziness	.NEGDIZZINESS	chest pain***, palpitations***, shortness of breath***, nausea***, emesis***, syncope***, localized weakness***, gait instability***, facial droop***, slurred speech***, tremors***, diplopia***, seizure activity***, or dysphagia.
Depression	.NEGDEPRESSION	suicidal ideation***, homicidal ideation***, recent suicidal attempt or self injury***, overdose***, alcohol or drug use***, anhedonia***, hyper/insomnia***, feeling of worthlessness*** or helplessness.
Dental Pain	.NEGDENTALPAIN	fevers***, chills***, facial swelling***, dysphagia***, trismus***, headache***, recent trauma***, otalgia***, neck pain***, or history of previous dental pain***.
Fever	.NEGFEVER	headache***, neck stiffness or pain***, chills***, congestion***, sore throat***, cough***, chest pain***, dyspnea***, abdominal pain***, back pain***, altered mental status***, urinary symptoms***, skin rash***, or decreased activity.
Cough	.NEGCOUGH	shortness of breath***, chest pain***, fevers***, wheezing***, nasal congestion***, or sore throat.

Sore Throat	.NEGSORETHOAT	dysphagia***, throat swelling***, voice change***, stridor***, nuchal rigidity***, fevers***, rhinorrhea***, congestion***, or cough***.
Groin Pain (Male)	.NEGMALEGROINPAIN	testicular swelling***, urinary frequency***, urinary urgency***, dysuria***, hematuria***, penile discharge***, back pain***, flank pain***, abdominal pain***, history of STDs***, or history of inguinal hernia***.
GU Complaint (Female)	.NEGGUFEMALE	She denies abnormal vaginal bleeding, discharge or unusual pelvic pain, no dysuria, frequency or hematuria.
Vaginal Bleeding	.NEGVAGINALBLEEDING	current or recent pregnancy (G***P***), dizziness***, or history of STD***.
Motor Vehicle Crash	.NEGMVC	loss of consciousness***, headache***, neck pain***, chest pain***, back pain***, or pain to the extremities***.
Fall	.NEGFALL	loss of consciousness***, hitting head***, chest pain***, back pain***, pain or injury to extremities***.
Seizures	.NEGSEIZURE	syncope***, head injury***, headache***, tremors***, localized weakness***, slurred speech***, dysphagia***, diplopia***, or recent sexual activity***.
Stroke	.NEGSTROKE	localized weakness***, facial droop***, slurred speech***, blurred vision***, diplopia***, numbness***, syncope***.
Urinary Complaint	.NEGURINARY	dysuria***, hematuria***, frequency***, abdominal pain***, flank pain***, back pain***, penile***vaginal*** discharge***, fevers***.
Extremity Injury	.NEGEXTREMITY	trauma or injury to extremity***, localized weakness***, open wounds***, paresthesias***, difficulty ambulating***, swelling***, erythema***, cyanosis***, or other other injuries***.
Pediatric Patient	.NEGPEDS	decreased activity***, sore throat***, headache***, fevers***, chills***, diarrhea***, rash***, abdominal pain***, emesis***, urinary symptoms***, or sick contacts***.

HPI/MDM Addons

Tetanus	.TETANUS	Tetanus vaccination status reviewed: {TETANUS STATUS:5746::"tetanus re-vaccination not indicated"}.
Cardiac Risk Factors	.CARDIACRISKFACTORS	Cardiac Risk Factors: Age, Sex, Overweight/Obesity, Current Everyday Smoker, Hypertension, Hyperlipidemia, Diabetes Mellitus, and Family History of Heart Disease.
Heart Score	.TCPHEARTSCORE	Auto Populates
Chest Pain Quality indicator	.CPQUALITYINDICATOR	Quality Indication: Chest Pain Baby Aspirin upon arrival:Patient did receive 4 baby aspirin.
PERC Rule	.PERCRULE	PERC Rule for Pulmonary Embolism -Age greater than or equal to 50: {YES NO:26005}

		-Heart Rate greater than or equal to 100 bpm: {YES NO:26005} -O2 Sat on Room Air < 95%: {YES NO:26005} -Prior History of Venous Thromboembolism: {YES NO:26005} -Trauma or Surgery within 4 weeks: {YES NO:26005} -Hemoptysis: {YES NO:26005} -Exogenous Estrogen: {YES NO:26005} -Unilateral Leg Swelling: {YES NO:26005} -If all variables are negative, PERC rule can be used to rule out PE. No need for further workup, as <2% chance of PE. -If any criteria are positive, the PERC rule is not satisfied and cannot be used to rule out PE in this patient. PERC Rule {CAN'T:28678} be used to rule out PE.

Review of Systems

Review of Symptoms	.EDROS	10 systems reviewed and all systems negative except as stated in history of present illness.

Medical History

Active Medical History	.PROBLAMB	Auto Populates
Past Medical History	.PMH	Auto Populates
Past Surgical History	.PSH	Auto Populates

Current Medications

Current Medications	.EDPTAMEDS	Auto Populates

Allergies

Allergies	.ALLERGY	Auto Populates

Social History

Social History	.SOC	Auto Populates
Pediatric Social History	.PEDSSOCIALHX	Does/does not*** attend daycare. There is/ no*** passive smoke exposure.

Family History

Family History	.FAMHX	Auto Populates

Vitals

Triage Vitals	.EDTRIAGEVITALS	Auto Populates

General Vitals	.EDVITALS	Auto Populates
Trauma Vitals	.TRAUMAVITALS	Time: *** Temp: *** degrees Celsius Pulse: *** bpm RR: *** bpm BP: *** mmHg SpO2: ***% on ***
Orthostatic Vitals	.ORTHOSTATIC	Auto Populates

Miscellaneous (placed under vitals)

Visual Acuity	.EDVISUALACUITY	Auto Populates
Bladder Scan	.BLADDERSCAN	Auto Populates

Physical Exam

Trauma Exam	.TRAUMAEXAM	Primary Assessment General: Alert and oriented x ***. Back board present, currently in cervical collar. *** distress noted. Airway & Breathing: Airway is patent. Spontaneous respirations. ***Ventilated. Breath sounds are clear and equal bilaterally. Circulation: Skin is warm and well perfused. Disability: GCS *** E***, V***, M***. Exposure: Clothing was cut off and warm blankets applied. Secondary Assessment HEENT: Head: Normocephalic and atraumatic***. Eyes: Pupils are equal, round, and reactive***.EOMFI***. Ears: No otorrhea or hemotympanum. No battle sign***. Nose: No epistaxis or septal hematoma. Throat: Oropharynx clear pink and moist. No active bleeding or intraoral injuries***. Neck: Trachea is midline, no JVD. No midline C spine tenderness ***. Chest: Chest movement is symmetrical. Chest wall nontender with no crepitus or subcutaneous emphysema***. Lungs clear to auscultation bilaterally. CV: Regular rate and rhythm. Normal S1, S2. Heart tones not muffled. No murmurs or rubs. Abdomen: Soft, nondistended, nontender*** without guarding or rebound. Active bowel sounds x4 quadrants. No seat belt sign. Pelvis: Pelvis is stable to rock. No tenderness. GU: No blood at the urethral meatus. Normal rectal tone. Prostate in normal position***. No bleeding noted***. Musculoskeletal: Right upper extremity***. Right lower extremity***. Left upper extremity***. Left lower extremity ***. No midline T or L spine tenderness***. NEURO: Alert and oriented x***. CN2-12 intact. GCS *** .Motor exam reveals +5/5 strength in the upper and lower extremities***. Sensory exam within normal limits to light touch and pinprick. Gait and station not tested. VASCULAR: Radial, femoral, and DP pulses +2/4 bilaterally. SKIN: Pink, warm, and dry***.
Physical Exam	.EDPEX	Nursing note and vitals reviewed. GENERAL: Alert and oriented x3. No significant distress despite ***his complaints.

		HEENT: Normocephalic, atraumatic, PERRLA. EOMI. Pupils are 3 mm and reactive to light. Tympanic membranes are pearly gray. Oropharynx pink and moist. Nares patent bilaterally. NECK: Supple. No lymphadenopathy. No JVD or carotid bruits. CHEST: Clear to auscultation bilaterally. No rhonchi, wheezes, or rales. CARDIOVASCULAR: Regular rate and rhythm without murmur, rubs, or gallops. Normal S1, S2. ABDOMEN: Soft, nontender, nondistended. Normoactive bowel sounds in all 4 quadrants. No rebound or guarding. PELVIS: Stable to rock. No tenderness. GU:******* MUSCULOSKELETAL: No signs of trauma throughout extremities or back. No clubbing, cyanosis or edema. NEUROLOGIC: Alert and oriented x3. Cranial nerves II through XII grossly intact. Motor examination reveals +5/5 strength in triceps, biceps, brachioradialis, intrinsic hand musculature, hip flexors and extensors, knee flexors and extensors, extensor hallucis longus bilaterally. Sensation is intact to light touch and pinprick throughout all 4 extremities, back, trunk, head and neck. Finger-nose intact. Heel-to-shin intact. Gait and station appears normal. Visual fields are full to confrontation. VASCULAR: Radial, femoral, dorsalis pedis and posterior tibial pulses +2/4 bilaterally. SKIN: No signs of acute dermatologic abnormality except as noted. No petechiae, purpura, ecchymosis. Psych: *** suicidal ideation. *** homicidal ideation. Affect ***. Mood ***. *** auditory or visual hallucinations. Judgement and cognition ***.
Pediatric (4 years or less) Physical Exam	.EDPEDS	Nursing note and vitals reviewed. General: Alert. Appropriately interactive. No acute distress noted. HEENT: Normocephalic, atraumatic, pupils are 3 mm equal round and reactive to light. Tympanic membranes pearly gray bilaterally. Oral mucosa pink and moist. No pharyngeal erythema or exudate. Neck: Supple, no lymphadenopathy. Trachea is midline. No lymphadenopathy or masses. Chest: Equal breath sounds bilaterally. No rhonchi, wheezes, or rales. There is no crepitus. Heart: Regular rhythm and rate. No murmurs, rubs, or gallops. Abdomen: Soft, nondistended. No tenderness in all 4 quadrants. Active bowel sounds in all 4 quadrants. No hepatosplenomegaly. Pelvis: Stable. No tenderness noted. GU: Normal genitalia. No lesions, erythema, or ecchymosis noted. Musculoskeletal: The patient moves all extremities spontaneously. No visible deformity. No trauma noted. Neuro: Alert. Spontaneous movement of all 4 extremities. Normal tone noted. No focal deficits noted. Vascular: Radial, femoral, dorsalis pedis and posterior tibial pulses +2/4 bilaterally. Capillary refill is less than two seconds in upper and lower extremities.

		Skin: Pink, warm and dry. No petechiae, ecchymosis, or purpura noted.
Limited Left Lower Extremity Physical Exam	.EDLLE	Nursing note and vitals reviewed. GENERAL: Alert and oriented x3. No significant distress despite his complaints. MUSCULOSKELETAL: ***. The remaining aspects of the left lower extremity are unremarkable. NEUROLOGIC: Alert and oriented x3. Motor examination reveals +5/5 strength in the left hip flexors and extensors, knee flexors and extensors, extensor hallucis longus. Sensation is intact to light touch and pinprick throughout all dermatomes of the left lower extremity. VASCULAR: Left femoral, dorsalis pedis and posterior tibial pulses are +2/4. SKIN: See above. No other signs of acute dermatologic abnormality.
Limited Right Lower Extremity Physical Exam	.EDRLE	Nursing note and vitals reviewed. GENERAL: Alert and oriented x3. No significant distress despite his complaints. MUSCULOSKELETAL: ***. The remaining aspects of the right lower extremity are unremarkable. NEUROLOGIC: Alert and oriented x3. Motor examination reveals +5/5 strength in the right hip flexors and extensors, knee flexors and extensors, extensor hallucis longus. Sensation is intact to light touch and pinprick throughout all dermatomes of the right lower extremity. VASCULAR: Right femoral, dorsalis pedis and posterior tibial pulses are +2/4. SKIN: See above. No other signs of acute dermatologic abnormality.
Limited Left Upper Extremity Exam	.EDLUE	Nursing note and vitals reviewed. GENERAL: Alert and oriented x3. No significant distress despite his complaints. MUSCULOSKELETAL: ***. The remaining aspects of the left upper extremity are unremarkable. NEUROLOGIC: Alert and oriented x3. Motor examination reveals +5/5 strength in the left triceps, biceps, brachioradialis, intrinsic hand musculature. Sensation is intact to light touch and pinprick throughout all dermatomes of the left upper extremity. VASCULAR: Left radial and ulnar pulses are +2/4. SKIN: See above. No other signs of acute dermatologic abnormality.
Limited Right Upper Extremity Exam	.EDRUE	Nursing note and vitals reviewed. GENERAL: Alert and oriented x3. No significant distress despite his complaints. MUSCULOSKELETAL: ***. The remaining aspects of the right upper extremity are unremarkable. NEUROLOGIC: Alert and oriented x3. Motor examination reveals +5/5 strength in the right triceps, biceps, brachioradialis, intrinsic hand musculature. Sensation is intact to light touch and pinprick throughout all dermatomes of the right upper extremity. VASCULAR: Right radial and ulnar pulses are +2/4. SKIN: See above. No other signs of acute dermatologic

		abnormality.
Physical Exam	.EDPEX	Nursing note and vitals reviewed. GENERAL: The patient is lying on cart, is alert and in no evidence of distress. HEENT: Normocephalic, atraumatic. Pupils are equal round and reactive to light. Nares are patent, without epistaxis. There is no rhinorrhea. Pharynx is moist and nonerythematous without exudate. There is no asymmetry of the posterior pharynx. Tympanic membranes are clear bilaterally. There is no hemotympanum. NECK: Supple, trachea is midline. There is no JVD. There is no stridor. There is no midline or paraspinal tenderness to palpation. BACK: There is no midline or paraspinal tenderness to palpation, no evidence of trauma, there is no CVA tenderness, there is no erythema and no increased calor. CHEST: Symmetric, there is no crepitus. There is no visible evidence of trauma to the chest. HEART: Regular without murmur, there are no clicks or rubs. LUNGS: Breath sounds are present and equal bilaterally, there are no rales, rhonchi or wheezes. ABDOMEN: Bowel sounds are present and equal throughout, there is no palpable tenderness, there is no palpable mass, there is no rebound tenderness. PELVIS: Stable, there is no visible trauma to the pelvis. EXTREMITIES: There is no deformity to the extremities. Radial pulses are two over four bilaterally. Capillary refill is less than two seconds to all nail beds of the bilateral hands. SKIN: Warm and dry. There is no rash. There is good skin turgor. NEURO: Patient is alert and oriented times three. Muscle strength is 5/5 throughout. Sensory is intact throughout.
Pediatric (less than 2 years) Physical Exam	.PEDIATRICPHYSICAL	Nursing note and vitals reviewed. HEENT: Normocephalic, atraumatic, pupils are 4 mm equal round and reactive to light, sclera are white, nares are patent, there is no epistaxis. Pharynx is moist and nonerythematous and without exudate. There is no asymmetry of the posterior pharynx. Tympanic membranes are clear bilaterally. Neck: Supple, trachea is midline, there is no JVD, there is no stridor, there is no rigidity, there is no mass, there is no lymphadenopathy. Back: There is no evidence of trauma. Chest is symmetric there are no retractions. There is no crepitus. Heart: Is regular without murmur. Lungs: Breath sounds are present and equal bilaterally, there are no rales, rhonchi or wheezes. Abdomen: Soft and nontender, bowel sounds are present throughout, there is no mass, there is no rebound tenderness. Pelvis: Is stable. There are no hip clicks. Extremities: The patient moves all extremities, there is no visible deformity. Radial pulses are two over four bilaterally. Femoral pulses are two over four bilaterally. Capillary refill is less than two seconds to all nail beds of

		the bilateral hands. Dorsalis pedis pulses are present and equal bilaterally. Skin: Warm and dry, there is good skin turgor. There is no rash present. Neuro: Patient is alert, moves all extremities, is interactive with parent, the patient looks around the room and appears nontoxic.
Back Pain Neurologic Exam	.EDNEURO	5/5 strength in the bilateral lower extremities including plantar flexion and dorsiflexion of the EHL. No foot drop. Normal sensation to light touch. Downgoing toes on Babinski. 2+ patellar and achilles reflexes bilaterally.
Knee Exam	.EDKNEE	Left/Right*** Knee: {Positive/Negative/Unknown:38048} varus stress test. {Positive/Negative/Unknown:38048} valgus stress test. {Positive/Negative/Unknown:38048} anterior drawer test. {Positive/Negative/Unknown:38048} posterior drawer test. {Positive/Negative/Unknown:38048} patellar apprehension. {Positive/Negative/Unknown:38048} patellar ballottement. {Positive/Negative/Unknown:38048} McMurray's test.
Shoulder Exam	.EDSHOULDER	Left/Right*** Shoulder: {Positive/Negative/Unknown:38048} Drop Arm test. {Positive/Negative/Unknown:38048} Empty Can test. {Positive/Negative/Unknown:38048} Yergason's test. {Positive/Negative/Unknown:38048} Hawkins-Kennedy. {Positive/Negative/Unknown:38048} Spurling's test. {Positive/Negative/Unknown:38048} Adson's test.
Lower Extremity Strength Exam	.LESTRENGTH	Strength 5/5 hip flexors, extensors, quadriceps, hamstrings, gastrocnemius, EHL and tibialis anterior.
Upper Extremity Strength Exam	.UESTRENGTH	Strength 5/5 biceps, triceps, deltoids, wrist flexors/extensors and intrinsic muscles of the hands.

ED Course

Orders	.EDENCORDNM	Auto Populates
Medications Administered	.MEDENCR	Auto Populates
Labs	.THISVISITONLY	Auto Populates
Radiology/Imaging	.EDWETREAD	Imaging ordered and reviewed by Dr. ***. Interpreted by radiology. INDICATION: *** INTERPRETATION: (Auto Populates)

Procedures

EKG	.EDEKGINTERPRET	PROCEDURE: EKG. A 12 lead EKG was obtained and interpreted by Dr. ***. INDICATION: ***

		INTERPRETATION: Per my interpretation, this showed a ***. There is a noted ventricular rate of ***bpm, PR interval of ***ms, QRS duration of ***ms, QTc interval of ***ms. Compared to an ECG dated *** there is***.
Laceration Repair	.EDLACERATION	Procedure: Laceration repair A laceration repair was performed by Dr. ***. Consent obtained prior to procedure. All benefits, risks, complications, and alternative treatments discussed with patient. All questions and concerns addressed. A *** cm laceration to the *** was anesthetized using a total of *** mL of *** locally. Injection was performed by Dr. ***. Laceration site was cleansed per nursing protocol. Laceration was then prepped in sterile fashion. Using a sterile technique the wound was probed. There was no evidence of any retained foreign body or injury to the deep lying structures. Using *** a total of *** sutures were used to nicely approximate the tissue edges. The patient tolerated the procedure well. A sterile dressing and triple antibiotic ointment was applied.
Digital Block	.DIGITALBLOCK	PROCEDURE: Digital Block. @now@ The procedure was performed by Dr. ***. Consent given by patient just prior to the procedure. The base if the *** finger was prepped in sterile fashion. I injected ***cc of 0.5% Sensorcaine at the base of the [right/left] digital nerves. There was *** relief of pain. The block was successful. No complications, and the patient tolerated the procedure.
Incision and Drainage	.INCISIONANDDRAINAGE PROC	PROCEDURE: Incision and Drainage @now@ An incision and drainage procedure was performed by Dr. ***. A/An abscess/cyst/pilonidal cyst was seen on the (body area). The area was anesthetized with ***% *** with/without epinephrine, and a total of *** CC's were injected. A/An *** blade scalpel was used to make a single straight incision to the area. There was scant/moderate/copious amount(s) of purulent/serosanguineous/serous/bloody drainage noted. The wound was packed with ***. The patient tolerated the procedure well with no immediate complications.
Splint Application	.SPLINTAPPLICATION	PROCEDURE: Splint Application @now@ An ortho glass (type of splint) was applied to the (location) by Dr. ***. The splinted body part was neurovascularly intact following the procedure. The patient tolerated the procedure well with no immediate complications.

Splint Application	.EDPROCEDURESPLINT	Procedure: *** splint placement Using *** inch Ortho-Glass material I did make and place a *** mold splint that ran from the *** to the ***, the splint was held in place using an Ace wrap. The patient tolerated the splint placement well. After the splint was placed, capillary refill less than 2 seconds to all nail beds of the ***, the patient moves all ***, they were pink warm and dry.
Long Leg Posterior Mold Splint Application	.PLLPMSPLINT	Procedure: Long leg posterior mold splint placement Using *** inch Ortho-Glass material I did make in place a *** long-leg posterior mold splint. The splint ran from the tips of the toes to the mid thigh, the knee was flexed to 30°. The splint was held in place using an Ace wrap. After the splint was placed, capillary refill was less than 2 seconds to all toes of the foot. The toes were pink warm and dry. The patient tolerated a splint placed and well.
Short Leg Posterior Mold Splint	.PSLPMSPLINT	Procedure: Posterior mold short leg splint placement Using *** inch Ortho-Glass material I did make and place a *** short leg posterior mold splint that ran from the tips of the toes to the mid calf, the ankle was dorsiflexed to 90° and the splint was held in place using an Ace wrap. The patient tolerated the splint placement well. After the splint was placed, capillary refill less than 2 seconds to all nail beds of the foot, the patient moves all toes, toes are pink warm and dry.
Ulnar Gutter Splint	.UGSPLINT	Procedure: Ulnar gutter splint placement Using *** inch Ortho-Glass material, I did make and place a *** ulnar gutter splint. The splint ran from the *** to the mid forearm, the splint was held in place using an Ace wrap. The wrist was dorsiflexed 15°. The patient tolerated the splint placement well. After the splint was placed the patient had good sensation to the fingertips and capillary refill was less than 2 seconds to all nail beds of the hand.
Thumb Spica Splint	.TSSPLINT	Procedure: Thumb spica splint placement Using ***inch Ortho-Glass material I did make and place a *** thumb spica splint. The wrist was dorsiflexed 15° and the splint ran from the thumb to the mid forearm. The splint was held in place using ace wrap. After the splint was placed, capillary refill is less than 2 seconds to the thumb, the thumb is warm and dry with good sensation. The patient tolerated the procedure well.

Joint Reduction	.JOINTREDUCTION	Procedure: Joint Reduction Indication: Dislocated joint The procedure was performed by Dr. ***. The risks and benefits of joint reduction were discussed with the patient. Risks include nerve injury and fracture. Consent was obtained. A *** technique was used. The joint was reduced on the *** attempt. The neurovascular status was rechecked and noted to be intact after the procedure. Post reduction films were ordered and revealed ***. The patient tolerated the procedure without complications.
Joint Aspiration/ Arthrocentesis	.JOINTASPIRATION	Procedure: Arthrocentesis. Indication: Rule out septic joint and/or acute gout. The procedure was performed by Dr. ***. The risks and benefits of joint aspiration were discussed with the patient. Risks include infection, bleeding, pain, nerve injury and hemarthrosis. Consent was obtained. The *** was prepped and draped in the usual sterile fashion. The overlying skin and soft tissue was anesthetized with **** . A sterile 18G needle was used to aspirate fluid from the joint, which was then sent to the lab for evaluation. Approximately *** ml were obtained. The patient's skin was cleansed of antiseptic and the puncture site was bandaged. The patient tolerated the procedure without complications.
Arthrocentesis	.ARTHROCENTESIS	Procedure: Arthrocentesis. Indication: Rule out septic joint and/or acute gout. The risks and benefits of joint aspiration were discussed with the patient. Risks include infection, bleeding, pain and hemarthrosis. Consent was obtained. The *** was prepped and draped in the usual sterile fashion. The overlying skin and soft tissue was anesthetized with 2% lidocaine. A sterile 18G needle was used to aspirate fluid from the joint, which was sent to lab for evaluation. Approximately *** milliliters were obtained. The patient's skin was cleansed with *** and the puncture site was bandaged. The patient tolerated the procedure well. Estimated blood loss *** mL. There were no apparent complications.
NurseMaid Reduction	.NURSEMAIDREDUCTION	@now@ Reduction of nursemaid's of upper extremity The procedure was performed by Dr. ***. Patient with history and physical exam suggesting nursemaid’s elbow. Utilizing a supination and flexion movement of the *** elbow a palpable click was felt in flexion. CMS post procedure intact. Within a period of 5-10 minutes the child is utilizing the ext normally. The patient tolerated the procedure well with no complications.

Nail Trepanation	.NLTREPH	PROCEDURE:Nail Trepanation @now@ A nail trepanation was performed by Dr. ***.The patient's *** [what appendage] was anesthetized with a digital block of 1% lidocaine using ***mL. The *** was then trephinated by me with a heated cautery pen. One hole was burned through the nail with release of the subungual hematoma. The *** was then soaked in Cida-Stat to facilitate further drainage of the hematoma. No complications were encountered.
Nail Avulsion	.NAILAVULSION	Procedure: Nail Avulsion Digital block: Pt was given *** cc of a *** in the ***. the nail was removed using sterile forceps and scissors. Wound was cleansed using standard wound protocol with cida-stat. Additional cleaning with saline irrigation and/or sharp debridement *** required. The wound was explored with the following results: no foreign bodies found and no deep structure involvement. Some avulsion of the nail bed. No bony exposure. Wound prepped and draped in a sterile fashion. The pt's nail was shaped using sterile scissors and was suture in place with *** 4-0 Vicryl sutures placed. The patient tolerated procedure well.
Foreign Body Removal	.FOREIGNBODYREMOV	PROCEDURE: Foreign Body Removal @now@ The procedure was performed by Dr. ***. A foreign body was noted to the (body area). The area was anesthetized with ***% *** with/without epinephrine, and a total of *** CC's were used. The patient was/was not sedated. The patient was/was not restrained. A total of ***objects were recovered. The objects recovered were ***. All foreign bodies were removed/foreign body not removed/residual foreign bodies remain. The patient tolerated the procedure well with no immediate complications.
Fecal Disimpaction	.SHFECALDISIMPACTION	Procedure: Fecal disimpaction Using a gloved finger with KY jelly I did manually disimpact a {SMALL, MED, LARGE:100834} amount of hard feculent material from the rectum. Patient tolerated the procedure well.
Conscious Sedation	.PROCSEDATION	@now@ Procedure: Procedural sedation. Aldrete score: *** Time began:*** Time ended:***

		Indication: Anxiolysis and pain control to facilitate procedure. Time out was performed. Presedation checklist was reviewed and completed prior to sedation. The risks and benefits of moderate sedation were discussed with the patient/family. Risks of intubation were discussed with the patient/family. The patients last meal was greater than *** hours prior to sedation. Written consent was obtained. Respiratory therapy staff is present at bedside, monitoring the airway. A preprocedural history and physical exam was performed by myself prior to the procedure. The patient was placed on a cardiac monitor, pulse oximeter, and was given supplemental oxygen via nasal cannula. Nursing staff and a respiratory therapist were in the room. The patient was given *** resulting in adequate sedation. The other procedure was completed and the patient was recovered from the sedation per protocol. I was present in the room until the patient's Aldrete score returned to 9. The patient had no complications during the sedation.
Conscious Sedation	.ERSEDATION	1:42 PM Procedure: Procedural sedation. Aldrete score: *** Time began:*** Time ended:*** Indication: Anxiolysis and pain control to facilitate procedure. Time out was performed. Presedation checklist was reviewed and completed prior to sedation. Diagnosis/System Review: *** Operation Proposed: *** Age: (Auto Populates) Height and Weight: (Auto Populates) Drug Allergies: (Auto Populates) Drug Therapy: (Auto Populates) Labs/Blood Sugar: (Auto Populates) Anesthetic History: ***

		The risks and benefits of moderate sedation were discussed with the patient/family. Risks of intubation were discussed with the patient/family. The patients last meal was greater than *** hours prior to sedation. Written consent was obtained. Respiratory therapy staff is present at bedside, monitoring the airway. A preprocedural history and physical exam was performed by myself prior to the procedure. The patient was placed on a cardiac monitor, pulse oximeter, and was given supplemental oxygen via nasal cannula. Nursing staff and a respiratory therapist were in the room. The patient was given *** resulting in adequate sedation. The other procedure was completed and the patient was recovered from the sedation per protocol. I was present in the room until the patient's Aldrete score returned to 9. The patient had no complications during the sedation.
Slit Lamp Exam - General	.PSLITLAMPEXAM	Slit lamp exam: A slit-lamp exam was completed of the patient's *** eye, there is *** matting or collarette formation involving the eyelashes, there is *** periorbital edema or ecchymosis, the eye was examined through full range of motion, there is *** evidence of retained foreign body. The superior palpebra was everted there is *** evidence of foreign body. There is *** hyphema, *** hypopyon. Anterior chambers are good and equal depth bilaterally. There is *** cell or flare reaction. There is *** evidence of corneal foreign body. The eye was then stained with a fluorescein strip and examined under cobalt light. This showed*** The patient tolerated the procedure well. ***drops of proparacaine were placed in the eye which provided***relief of the discomfort.
Slit Lamp Exam - Foreign Body Removal	.SLITFOREIGN	Slit Lamp Examination and Foreign Body Removal @now@ The patient's *** eye was examined with assistance from slit lamp and *** Proparacaine drops. A foreign body was visualized at the ***. With obtained consent, I, Dr. ***, was able/not able to remove the foreign body with a ***. After removal, fluorescence uptake was noted only to the abrasion left over from having removed the foreign body. The patient's eye was then irrigated with eyewash solution. A final slit lamp exam showed no remaining foreign bodies. The patient tolerated the procedure well with no immediate complications.
Lumbar Puncture	.LUMBARPUNCTURE	PROCEDURE: Lumbar Puncture

		@now@: Time out: A lumbar puncture was performed by Dr. ***. A lumbar puncture was deemed necessary in order to evaluate for infection/altered mental status/subarachnoid hemorrhage. An informed consent was obtained. I used ***% *** with/without epinephrine, and a total of *** CC's were injected. The patient was prepped and draped in the usual sterile fashion. I entered in the L3-L4/L4-L5 interspace. The patient was positioned sitting/left lateral decubitus/right lateral decubitus. A 21 gauge three inch spinal needle was used. *** attempt(s) was/were needed and the fluid appeared ***. A total of *** tubes, with a total volume of ***mL were obtained. The site was cleaned, a pressure dressing was applied, and an adhesive bandage was applied. The patient tolerated the procedure well with no immediate complications.
Lumbar Puncture	.PLUMBARPUNCTURE	Procedure: Lumbar puncture: Indication: Rule out SAH and/or CNS infection. The risks and benefits of a lumbar puncture were discussed with the patient and/or family. Risks include pain at the puncture site, infection, bleeding, and post dural headache. The patient and/or family consented to the procedure. The patient was placed in the left lateral decubitus position with knees and hips and neck flexed. The back was cleansed with*** swabs and draped with sterile drapes. Using *** mL of *** lidocaine and did anesthetize the L4-L5 interspace. Using a ***-gauge spinal needle I did cannulate the spinal canal on *** attempt. There was return of *** CSF. I did collect a total of *** mL of CSF collected in *** test tubes. I did then place the stylette back in the spinal needle and withdrew the needle from the patient's back. I did place a sterile Band-Aid over the puncture site. The patient tolerated the procedure well. After completion, the patient does move all extremities. CSF was sent to lab for analysis.
Chest Tube placement	.CHESTTUBE	Procedure: Chest tube placement performed by Dr. *** The *** (left/right) mid axillary line of the chest wall was prepped and draped in a sterile fashion. The area over the mid-axillary line was anesthetized with *** cc's of ***. Incision with 11 blade scalpel was then made. Afterwards tissue was bluntly dissected over the top of the rib penetrating into the thoracic cavity. A rush of air was noted. A 28 french*** chest tube was then passed into the thoracic cavity without difficulty. The tube was then sutured in place with O-silk. Occlusive dressing was then placed over the

		chest tube. Chest x-ray was obtained which confirms placement as well as expanded ***(right/left) lung.
Intubation	.INTUBATION	PROCEDURE:Intubation @now@ Procedure was completed after the patient presented with respiratory distress by Dr. ***. Intubation was completed via a [***direct oral/ fiberoptic surgical/video]. The patient was preoxygenated via a [***non rebreather mask/BVM]. Prior to intubation the patient was sedated using [***etomidate/fentanyl/see MAR for details]. The patient was also given [succinylcholine/vecuronium]. The patient was then intubated using a [***Miller/Mac] with a [***tube size] [***cuffed] after [***#attempts]. The tube was [***cm at the lip/teeth] and was secured with [***ETT holder/adhesive tape/oral airway]. After intubation there was [positive color change on the CO2 detector/chest rise] along with evidence of [***equal breath sounds/absent breath sounds]. Post-intubation chest x-ray was ordered and interpreted by [***me/radiologist] which showed [***ET tube in appropriate position/too high/too low]. The patient tolerated the procedure well with no immediate complications.
Intubation	.RSI	Procedure: Rapid sequence intubation The patient was preoxygenated with 100% O2. The patient was given *** mg of *** followed by *** mg of ***. The patient was intubated with a *** endotracheal tube, I did visualize the tip of the endotracheal tube passing through the vocal cords. The balloon cuff on the endotracheal tube was inflated, the patient was ventilated with an Ambu bag. End tidal CO2 detector *** immediately change from purple to yellow. Breath sounds were auscultated over the bilateral lung fields. I did auscultate over the epigastrium and there were no air sounds present. I did order a stat portable chest radiograph. The tube was secured by respiratory therapy. The patient tolerated the procedure well. I did review the portable chest radiograph which showed the tip of the endotracheal tube to be *** cm above the carina and in satisfactory position.
G-tube placement	.GTUBE	Patient presents to have feeding tube placed/***replaced. I did gently dilate the tract using/with a ***. A *** gastronomy feeding tube was then gently advanced through the tract. I then inflated the balloon cuff with *** mL of sterile water. Patient tolerated the procedure well. I did then order and review a post placement KUB with contrast. This showed the feeding tube to be ***.
Arterial Line Placement	.EDARTERIALLINEPROC	Arterial Line Placement @NOWM@ Arterial line placement was accomplished with sterile technique: After washing hands a cap, mask and sterile

		gown and sterile gloves were donned prior to the procedure. After cleansing the site with 2% chlorhexidine for cutaneous antisepsis a large sterile sheet was applied to the site. Arterial line placement was considered in order to [***obtain multiple ABG's/avoid respiratory failure/monitor hemodynamic stability]. Arterial line was placed in the [***right radial/left radial/right brachial/left brachial/right femoral/left femoral] after the area was anesthetized with [***local anesthetic] by Dr. ***. Allen's test [***was/was not] normal. I used an [***18/20/22] gauge needle via the [***Seldinger technique] and was successful after [***#attempt]. Post procedure [***line was sutured/dressing was applied] and circulation, motor and sensory were [***normal/unchanged/decreased circulation/weakness/numbness]. The patient tolerated the procedure well with no immediate complications. The procedure was completed by me.
Arterial Line Placement	.PARTERIALLINE	Procedure: *** *** arterial line placement Indication: Continuous blood pressure monitoring. Using sterile technique a *** *** arterial line was placed. The *** *** was cleansed using *** swabs and then draped using a sterile drape. The artery was cannulated with the introducer needle and a guidewire was advanced through the introducer needle. The introducer needle was removed over the guidewire and the arterial catheter was slid into place without difficulty. The guidewire was removed and a transducer line was connected which showed a satisfactory waveform on the monitor. The arterial catheter was sutured in place using a single 0 silk suture. The patient tolerated the procedure well.
Central Line Placement	.EDCENTRALLINEPROC	PROCEDURE: Central Line @NOWM@ Vascular access was needed, and a central line was deemed necessary. The site was marked and I did *** use ultrasound guidance. Central line placement was accomplished with sterile technique: After washing hands a cap, mask and sterile gown and sterile gloves were donned prior to the procedure. After cleansing the site with 2% chlorhexidine for cutaneous antisepsis a large sterile sheet was applied to the site. I used ***% *** with*** Epinephrine, and a total of ***mL was injected into the area. A central line was then placed by myself, Dr. ***. Access was started in the left***right subclavian***internal jugular***femoral. The patient was positioned in ***. A (catheter size) (catheter type;eg, triple lumen catheter) was placed. A successful placement was noted after *** attempt(s). Good blood return was noted, and the line was sutured in place. The patient tolerated the procedure well with no immediate complications.

Imaging	.EDWETREAD	Imaging ordered and reviewed by Dr. ***. Interpreted by radiology. INDICATION: *** INTERPRETATION: @WETREAD@
G-tube placement	.GTUBE	Patient presents to have feeding tube placed/***replaced. I did gently dilate the tract using/with a ***. A *** gastronomy feeding tube was then gently advanced through the tract. I then inflated the balloon cuff with *** mL of sterile water. Patient tolerated the procedure well. I did then order and review a post placement KUB with contrast. This showed the feeding tube to be ***.
No labs or imaging performed for MDM	.HXPEX	History and physical examination do not warrant a lab work-up or imaging at this time.
Cardioversion	.CARDIOVERSION	PROCEDURE: Cardioversion @now@ The procedure was performed by Dr. ***. All benefits and risks of the procedure discussed. Written consent obtained. The patient was placed on telemetry, continuous pulse oximetry and *** L NC oxygen. Peripheral IV established. [Medication/no medication] was given for sedation successfully. *** J biphasic synchronized shock was provided x *** (amount of times) resulting in restoration of *** (what rhythm) with heart rates in the ***. EKG as noted above. No complications noted. *** returned to normal mentation several minutes following completion of the procedure. The patient tolerated the procedure well.
Arterial Blood Gas	.ABGPROC	PROCEDURE: Arterial Blood Gas @now@ *** radial arterial blood gas was carried out by Dr. ***. No anesthetic was used, and *** cc of *** blood was obtained. Direct pressure was held for *** minutes. Patient tolerated the procedure well with no complications.
Epistaxis Management	.EPISTAXISMANAGEMENTPROC	PROCEDURE:Epistaxis Management @now@ Epistaxis management was performed by Dr. ***. Applied [***anesthesia type] to the [***affected nostril] and was left in place prior to procedure. I then applied [***silver nitrate/rhino rocket/anterior pack] to the [***right anterior/left anterior/right posterior/left posterior/right Kiesselbach's area/left Kiesselbach's area]. Post procedure [***bleeding stopped/bleeding decreased/no improvement] was noted.

		There was [***no] recurrence of recent bleed. Patient tolerated the procedure well with no immediate complications.

Calls/Consults/Recheck

Quick Discharge after initial evaluation	.QUICK/EDQUICKDISCHARGE	@NOWM@ Finished *** and discussed plan for discharge and follow up*** with the patient***. *** was agreeable with this plan. All questions answered. ***Return to ED instructions were also discussed at this time.
Recheck/reevaluation	.RECHECK	@NOWM@ Rechecked patient who is resting comfortably. Imaging*** and lab*** results were discussed. The plan for discharge and follow up*** was discussed. Patient*** agrees with plan. Return to ED instructions were also discussed at this time.*** All questions were addressed.
Physician Calls	.CALL	@now@ Discussed the patient's case with Dr. *** (***).
Recheck with RN	.HUDDLE	@now@ Admission/Discharge*** huddle completed with nurse ***. All diagnostic testing and results reviewed, discussed treatment plan, and follow up. Patient *** understands and is agreeable.
Pelvic Exam Performed	.GUEXAM	@now@ Pelvic exam was performed with a female ER staff member present in the room. Findings as above.
Wisconsin Prescription Drug Monitoring Program Check	.WIRX/.WISPDMP	I did review the Wisconsin Prescription Drug Monitoring Program website and found ***

Medical Decision Making

General- medical decision making	.EDMDM	The patient is a @age@ @sex@ who presents to the *** Emergency Department with a chief complaint of ***. EPIC records were reviewed. Lab work was ordered and reviewed. Findings stated above***. A *** was also ordered and reviewed. Imaging shows ***. An EKG was taken and showed a ***. A cardiac monitor and oximeter were placed during the patient's Emergency Department stay. The patient was provided with *** resulting in *** of symptoms. The patient was discharged home*** with a diagnosis of ***. The patient was advised to ***. It was recommended for the patient to follow up with ***. The patient was provided prescriptions for ***. The patient's vital signs and condition *** while undergoing evaluation in the Emergency Department. The patient*** agreed with the plan for care. All questions and concerns were addressed.
Medical decision making	.EDMDM	The patient is a @age@ @sex@ who presents to the ED with a chief complaint of ***. EPIC records were reviewed. A cardiac monitor and oximeter were placed during the patient's Emergency Department stay. Multiple diagnoses considered including but not limited to ***. An IV was ***

		inserted. Lab work and imaging was obtained and reviewed. Findings stated above. An EKG was obtained revealing ***. The patient was provided with *** resulting in *** of symptoms. Clinically ***. Findings and warning symptomology discussed. The patient's vital signs and condition *** while undergoing evaluation in the ED. All questions and concerns were addressed.
Medical decision making	.EDMDM	The patient is a @age@ @sex@ who presents to the ED with a chief complaint of ***. The patient's initial vital signs reviewed. Upon arrival, he appears *** . Epic records were reviewed. Multiple diagnosis considered. Physical examination was significant for ***. Evaluation consist of *** with results significant for ***. The patient was provided with (meds/IVF)*** resulting in *** of symptoms. While in the ED the patient ***. (Leave *** for MD to fill in) The work up was significant for *** and at this time will *** require admission. The patient's vital signs and condition *** while undergoing evaluation in the ED.
Medical decision making	.EDMDM	The patient is a @age@ @sex@, with pertinent medical history for *** who presents to the *** Emergency Department with a chief complaint of ***. Vitals and physical exam are pertinent for ***. EPIC records were reviewed. DDx was considered but not limited to ***. Lab work was ordered and reviewed. Findings stated above***. A *** was also ordered and reviewed. Imaging shows ***. An EKG was taken and showed a ***. A cardiac monitor and oximeter were placed during the patient's Emergency Department stay. The patient was provided with *** resulting in *** of symptoms. The patient was discharged home*** with a diagnosis of ***. ***. The patient was advised to ***. It was recommended for the patient to call *** to schedule a follow up appointment and to return to the ThedaCare Emergency Department as needed if symptoms worsen. The patient was provided prescriptions for ***. The patient's vital signs and condition were closely observed while undergoing evaluation in the Emergency Department. The patient*** agreed with the plan for care. All questions and concerns were addressed.
Medical decision making	.EDMDM	The patient is a @age@ @sex@ who presents to the*** Emergency Department with a chief complaint of ***. EPIC records were reviewed. Multiple diagnoses considered. Physical examination was significant for ***. Lab work was ordered and reviewed. Findings stated above***. A *** was also ordered and reviewed. Imaging shows ***. An EKG was taken and showed a ***. A cardiac monitor and oximeter were placed during the patient's Emergency Department stay. The patient was provided with *** resulting in *** of symptoms. The patient was discharged home*** with a diagnosis of ***. The patient was advised to ***. It was recommended for the patient to follow up with ***. The patient was provided prescriptions for ***. The patient's vital signs and condition *** while undergoing evaluation in the Emergency Department. The patient*** agreed with the plan for care. All questions and concerns were addressed. Patient care is supervised by Dr. ***. Physician to cosign note.

MDM Addons

No labs or imaging obtained	.hxpex	History and physical examination do not warrant a lab work-up or imaging at this time.
Pneumonia Quality Indicator	.PNEUMONIAQUALITYINDICATOR	Quality Indication:Pneumonia 1. Patients current mental status is stable ***. 2. Pulse oximetry on room air is ***%. 3. Empiric antibiotics initiated *** (Vitals Auto Populate)
Critical Care Time	.TDCRITCARE	CRITICAL CARE TIME: *** MINUTES. Critical Care time entailed direct bedside evaluation, formulating and directing treatment plans, speaking with consultants, excluding evaluations of other patients, and time outside any billable procedures.
Critical Care Time	.CRITCARE	CRITICAL CARE TIME IN: *** CRITICAL CARE TIME OUT: *** TOTAL CRITICAL CARE TIME: ***. Critical Care time entailed direct bedside evaluation, formulating and directing treatment plans, speaking with consultants, excluding evaluations of other patients, and time outside any billable procedures.

Final Impression

Diagnosis	.DXS	Auto Populates

Plan

Discharge	.EDDC	The patient is discharged home in *** condition and does not have any further questions or concerns. Discharge instruction attachments include: ***
Admit	.ADMIT	The patient was admitted to the hospital in stable condition under the care of Dr. *** for further evaluation and treatment.
Discharge Instructions	.EDDISCHARGEINSTRUCTIONS	Auto Populates
Disposition	.EDDISPO	Auto Populates
Prescriptions	.EDRXMEDSTART	Auto Populates

Miscellaneous

Blood pressure elevated with no diagnosis of hypertension (place in discharge instructions)	.EDBP	During your emergency department stay your blood pressure was found to be elevated. High blood pressure isn't often diagnosed in the ED due to multiple factors contributing to the reading. Your elevated reading could be due to undiagnosed high blood pressure. We recommend you get your blood pressure rechecked with your primary care provider this week. Please call to schedule this.
Use when the patient	.EDMETFORMIN	You have been given IV Contrast Dye and are known to

received a CT scan with IV contrast and is on Metformin (placed in discharge instructions)		be taking Metformin (Glucophage). It is recommended to HOLD your Metformin for at least 48 hours and contact your doctor within that time for re-evaluation.
Shift Change	.SCRIBESHIFTCHANGE	@now@ I, ***, am assuming scribe role for this document for time noted above for ***.
Scribe Disclaimer	.SCRIBEDISCLAIMER	I, ***, am serving as a scribe to document services personally performed by *** based on my observation and the provider's statements to me.