University Medical Center
ETD Patient Chart
History and Physical Examination

AFFIX PATIENT INFO LABEL HERE

Date / Time: _____
Chief Complaint: _____
_____
Hx.PI: _____
_____

Patient Name _____ **MR#** _____

❑ Continued on Progress Record

❑ Unable to Complete HX & OR ROS Due to PT. Status
❑ Review Pain Assess & Vital Signs – See Triage Note

Allergies
❑ NKA
❑ Noted on Triage Sheet

Medications/DX
❑ None
❑ Noted on Triage Sheet

PAST MEDICAL
❑ Non-Pertinent
❑ Noted on Triage
❑ CAD ❑ DM
❑ HTN ❑ COPD
❑ Asthma ❑ CHF
❑ HIV ❑ CVA
❑ Arthritis
❑ Other: _____

SURGICAL HISTORY
❑ None
❑ Noted on Triage
_____
_____
_____
_____
_____

SOCIAL HISTORY
❑ Noted on Triage

	Yes	No
Smoke:	❑	❑
ETOH:	❑	❑
IVDA:	❑	❑
Drugs:	❑	❑
Work:	❑	❑

Other: _____

FAMILY HISTORY
❑ Noted on Triage
❑ Non-Pertinent
❑ D.M. _____
❑ HTN _____
❑ Cardiac _____
❑ Asthma _____
Other: _____

Neg.	NA	Review of Systems (Circle Abnormalities)
		1. General: Fever Chills Wt. loss Weak
		2. Skin: Rash Lesions Diaphoretic
		3. Eyes: Acuity Changes Glasses/Contacts Pain
		4. ENT: Sore Throat Pain Diff. Swallowing / Hoarseness Hearing Loss / Vertigo / Epistaxis / Congestion
		5. Resp: SOB Cough Sputum Wheezing Asthma Pain Orthopnea Dyspnea on Exertion
		6. CVS: Chest Pain Palpitations
		7. GI: Nausea Vomiting Diarrhea Pain Blood

Neg.	NA	Review of Systems (Circle Abnormalities)
		8. MUSC: _____ pain Swelling
		9. G.U.: Dysuria Frequency Flank Pain Urgency Blood Discharge
		10. GYN: Discharge Pain Excessive Bleeding Parity
		11. LYMPH: _____ Nodes Pain
		12. Neuro: Syncope Seizure Weakness Speech HA Confusion Dizziness
		13. PSYCH: Depression Mood Change Anxiety
		14. HEMA: Bruising Bleeding

PHYSICAL EXAMINATION (NA if not applicable)

General: _____ G.U.: _____
Skin: _____
_____ Gyn: _____
Eyes: _____
ENT: _____
Head / Neck: _____ Neuro: _____
_____
Chest Wall / Breast: _____
Lungs: _____
_____
Heart: _____
_____
Abdomen: _____
_____
Back: _____
Flank: _____ Psych: _____
Rectal: _____
Extremities: _____
_____
Pulses: _____
Lymph: _____

Working Diagnosis: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Patient seen with: _____ ETD Attending

Provider Signature: _____ Date _____

Wound Repair:	Body Area(s)	Simple	Layered
❑ Up to/and 2.5 cm		❑	❑
❑ 2.6 to 5.0 cm		❑	❑
❑ 5.1 to 7.5 cm		❑	❑
❑ 7.6 to 12.5 cm		❑	❑
❑ 12.6 to 20.0 cm		❑	❑
❑ 20.1 to 30.0 cm		❑	❑

❑ Laceration Length(s) ___ cm ___ cm ___ cm

Physician / NP Procedure(s): see Procedure Note(s)

- ❑ Arthrocentesis
- ❑ Burn Care
- ❑ Cath Urethra Foley
- ❑ Central Line
- ❑ Conscious Sedation
- ❑ Debridement
- ❑ Foreign Body Removal
- ❑ I&D
- ❑ Intubation
- ❑ Lumbar Puncture
- ❑ Nasal Packing
- ❑ NGT
- ❑ Ortho Splint
- ❑ Ortho Strapping
- ❑ Reduction of Dislocation
- ❑ Sexual Assault Kit
- ❑ Thrombolysis
- ❑ Other _____

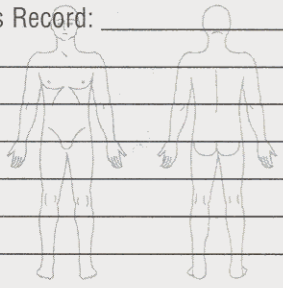
Procedure Note: _____

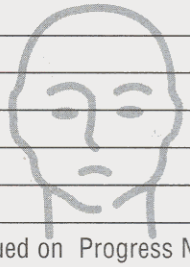
Intubation: Dx: Acute Resp Failure / Acute Pulm Insufficiency / Trauma-GCS: _____ / Other: _____

Intubation: _____

_____ ETT x _____ ; Vocal Chords: Seen / Not Seen; Capnometer: +; Breath Sounds: _____ ❑ ABG / ❑ CXR Ordered.

Interdisciplinary Progress Record: _____





❑ Continued on Progress Note

EMERGENCY TRAUMA ATTENDING LINKAGE NOTE (Note: NA IF not applicable):

Validation: Patient seen and examined with: _____ ; confirmed H&P as documented:

Hx/PE: _____

Impression/Plan: _____

Signature: _____

Procedure(s) Supervised: _____

❑ PMD Paged/Notified Name: _____ Time: _____

❑ Consult Paged/Notified Name: _____ Time: _____

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

University Medical Center

ETD Physician Order Sheet

Doctor's Name	Date	Time	Orders (Check Allergies)	Given by MD	RN Name	Time
			❑ CBC ❑ Differential ❑ Chemscreen ❑ Type & Screen			
			❑ Crossmatch ____ units ❑ U/A ❑ UA/C&S ❑ U/A Pregnancy			
			❑ Urine Toxicology ❑ Blood Cultures X _____ ❑ Blood Cultures Done			
			❑ Troponin ❑ PT ❑ PTT ❑ BNP			
			❑ EKG reason _____			
			❑ X-ray: _____ Clinical Info.			
			❑ Old Chart ❑ Old ECG			
			❑ Diptheria ❑ Tetanus Toxoid			
			Lot #: _____ Expiration Date			

❑ Order continued on another sheet. Remember to use disease specific order sets when possible.

Labs	Chemistry	Urinalysis	ABG #1 #2	ETD Preg. Test	EKG
WBC	Na+	Color	O_2:	Pt. Result	#1
Hgb.	K+	pH	Time	Tested by	
Hct.	Cl-	Sp. Gr.	pH	Date/Time	#2
Platelet	HCO_3	Glucose	PCO_2	Was the internal control+?	
INR	Glucose	Blood	PO_2	Circle Yes or No	**X-Ray**
PT	BUN	Ketone	SAT	Lot #	
PTT	Creatinine	Protein	HCO_3	Exp. Date	
Troponin	Amylase	Urobilin	**CT/Ultrasound**		
BNP	Lipase	Leukest			
AST	Ca++	Nitrite			
ALT	ETOH	WBC/HPF			
	Bili	RBC/HPF			
		Epith.			

University
Medical Center

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Date	Time	Progress Notes

❑ Continued on Progress Record

Pulse Oximeter Alarm On/Lower Alarm Limit Set At _____
Cardiac Monitor
❑ Central ❑ Unit Based
Alarms On/Limits Set at (/)
Blood Pressure Alarms On/Limits Set at (/)

MEDICAL DECISION MAKING

Risks of complications, morbidity and/or mortality, and comorbidities assoc. w/pt's:
Presenting Problems - From this encounter to the next.
Diagnostic Procedures Ordered - During & following.
Management Options Considered

• Minimal • Low • Moderate • High

CRITICAL CARE TIME =

_____ Min. with Patient
_____ Min. with Family
_____ Min. in doc./test review
_____ Min. w/consultants
_____ Total Minutes

ER Service

99281 ❑
99282 ❑
99283 ❑
99284 ❑
99285 ❑
99291 ❑

Signature of resident physician or primary provider:
(Signed) X _____ Date _____

Signature of attending physician:
(Signed) X _____ Date _____

MEDICAL DISCHARGE ORDERS

Final Diagnosis: _____

_____

_____ Time of Admit/Discharge: _____

Disposition: ❑ Admit (Med/Surg ICU Telemetry Obs) ❑ Treat & Release ❑ To L&D ❑ To OR
❑ Walkout ❑ AMA ❑ Transfer to: _____

Condition upon disposition: ❑ Improved ❑ Stable ❑ Unstable ❑ Guarded ❑ Expired

Initial treating provider signature: _____ Time: _____

Patient endorsed to Dr/NP/PA. _____ who accepts responsibility for the further evaluation and treatment of this patient @ _____ am/pm.

Patient endorsed to Dr./NP/PA _____ who accepts responsibility for the further evaluation and treatment of this patient @ _____ am/pm.

Instructions: _____

_____

_____

Final treating provider signature: _____ Time: _____

Please WRITE LEGIBLY. Charges can only be dropped if documentation is legible and complete. Illegible documentation is DISALLOWED in the event of an audit. Include -

Reason for the encounter

- Relevant history-can be gathered in triage and reviewed.
- Physical examination findings
- Prior diagnostic test results
- Appropriate health risk factors
- Document rationale, symptoms or diagnosis for all diagnostics and additional services.
- Assessment, clinical impression and diagnosis (after study)
- Plan for care
- Progress, response to and changes in treatment, and revision of diagnosis after study
- Documentation should prove that counseling and/or coordination of care is provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
- TIME spent on the patient's care, Date and legible identity.

Chief Complaint: Concise statement of factor that is the reason for the encounter, usually in the patient's own words.

8 elements of HPI: Document development of illness from first sign/ symptom to present. Elements include:

1. location
2. quality
3. severity
4. duration
5. timing
6. context
7. modifying factors
8. assoc signs & symptoms

14 Recognized systems for ROS:

(May be recorded by ancillary staff or on a form completed by the patient. Doctor must note supplementing or confirming information recorded.) Inventory of questions to identify symptoms, helps define the problem, clarify the diagnosis, identify testing needs, baseline data.

1. Constitutional symptoms (fever, weight loss),
2. Eyes
3. Ears/Mouth/Nose/Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin/breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic Allergic/Immunologic

3 areas of PFSH: (May be recorded by ancillary staff or on a form completed by the patient. Doctor must note supplementing or confirming information recorded.)

1. **Past History:** The Patient's past experiences with illnesses, operations, injuries and treatments
2. **Family History:** A review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk
3. **Social History:** An age appropriate review of past and current activities.

Examination:

- **'Abnormal' notation without elaboration is INSUFFICIENT, please describe.**
- **'Normal' notation is sufficient for unaffected/ asymptomatic areas.**

Examination

Constitutional

- vitals: 3 of 7 (BP/s-BP/pulse/resp/temp/wt/ht)
- general appearance

Eyes

- conjunctivae & lids
- pupils and irises
- scope of optic disc and posterior segments

Ears, Nose, Mouth and Throat

- external ears and nose
- scope of exterior auditory canals and tympanic membranes
- assess hearing
- nasal mucosa, septum and turbinates
- lips, teeth and gums
- oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, posterior pharynx

Neck

- neck
- thyroid

Respiratory

- assess respiratory efforts
- percussion of chest
- palpate chest
- auscultate lungs

Cardiovascular

- palpate heart
- auscultate heart with notations of abnormal sounds and murmurs
- carotid arteries
- abdominal aorta
- femoral arteries
- pedal pulses
- extremities for edema/varicosities

Chest (Breasts)
- breasts
- palpate breasts and axillae

GI (Abdomen)
- abdomen with notation of presence of masses or tenderness
- liver and spleen
- presence or absence of hernia
- anus, perineum and rectum including sphincter tone, presence of hemorrhoids, rectal masses
- stool sample for occult blood

Genitourinary – Male
- scrotal contents
- penis
- digital rectal exam of prostate gland

Genitourinary – Female
- external genitalia and vagina
- urethra
- bladder
- cervix
- uterus
- adnexa/parametria

Lymphatic

Palpate lymph nodes in at least 2 areas:
- neck
- axillae
- groin
- other

Musculoskeletal
- gait and station
- inspect/palpate digits and nails

Examine joints, bones and muscles of at least one of the following: 1) head and neck; 2) spine, ribs and pelvis; 3) RUE; 4) LUE; 5) RLE; 6) LLE
- inspect/palpate
- assess range of motion
- assess stability
- assess muscle strength and tone

Skin
- inspect skin and subcutaneous tissue
- palpate skin and subcutaneous tissue

Neurologic
- cranial nerves with notation of deficits
- deep tendon reflexes (note pathological reflexes)
- sensation

Psychiatric
- describe patient's judgment and insight
- assess orientation to time, place and person
- assess recent and remote memory
- assess mood and affect

3 components of Medical Decision Making:

Physician must document complexity of establishing a diagnosis and/or selecting a management option as measured by:

1. The number of possible diagnoses and/or the number of management options that must be considered.

1) Established diagnosis, document:
   a) improved, well controlled, resolving, resolved
   b) inadequately controlled, worsening, or failing to change as expected

No established diagnosis, document differential diagnosis, or possible, probable, rule out, (document SYMPTOMS).

2) Document initiation of and changes in treatment: (pt instruct, nursing instruct, therapies, and medications)
3) Document who referral is made to and why.
4) Document who advice is requested from.

2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

1) Document type of diagnostic services ordered, planned, scheduled, or performed at the time of the encounter.
2) Document review of lab, radiology and/or other diagnostic tests. (Entry in progress note acceptable. E.g. "WBC elevated", or initial and date results)
3) Document decision to obtain old records or additional history from any source, including family.
4) "Records reviewed" is INSUFFICIENT. Elaborate – detail the relevant findings or document "Reviewed, no additional relevant findings."
5) Document results of discussion of lab, radiology or other diagnostic test with interpreting doctor.
6) DOCUMENT DIRECT VISUALIZATION AND INDEPENDENT INTERPRETATION of an image, tracing or specimen even if previously or subsequently interpreted by another physician.

3. The risks of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's

Presenting Problem(s) – the risk related to the disease process anticipated between this encounter and the next one.

Diagnostic Procedure(s) Ordered – the risk during and immediately following any procedures or treatment.

Management Options Considered – the risk during and immediately following any procedures or treatment.

1) Document comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality.
2) Document all ordered surgical/invasive procedures ordered, planned or scheduled at the time of the encounter, including type.
3) Document details of all procedures performed in a procedure note.

Document referral or decision to perform surgical or invasive diagnostic procedure on an urgent basis.

Critical Care Service – 99291, 92

(Include:
Document in minutes, time spent:

- Caring for critically ill or critically injured patient, even if not continuous. Must have devoted full attention to the pt and not have provided services to another pt.
- Engaged in work directly related to the critical patient's care, even if not at bedside.
- In conversation with family/decision makers that bears directly on pt management (obtaining history, reviewing treatment, prognosis, discussing treatment or limitations).

Do Not Include:

- Time spent performing separately reportable procedures or services.
- Time spent in activities that do not directly contribute to the treatment of the critical patient.
- Time spent in activities that occur off the unit.

99285 > 30 minutes then = 99291

Emergency E&M – 99284

History: Detailed.
Chief Complaint: Usually presenting problem(s) are high severity/require urgent evaluation by physician, but not an immed. significant threat to life/physiologic function.

HPI: Extended. Physician document min 4 elements.

ROS: Extended. Positives or pertinent negatives for 2 to 9 systems must be individually reviewed.

PFSH: Pertinent. Document at leats **1** specific item in any **1** of past, family, or social history areas as pertinent and directly related to pt problems. Note supp/confirm triage OK.

Examination: Detailed. An exteneded examination of the affected body area(s) and other symptomatic or related organ system(s).

Medical Decision Making: Moderate Complexity.
Document Min 2 of 3:
Multiple Options,
and/or Moderate Doc Review/Tests,
and/or Moderate Risk.

Emergency E&M - 99282

History- Expanded Problem Focused:
Chief Complaint: Usually presenting problem(s) are of low to moderate severity.

HPI: Brief. Physician document min 1 to 3 elements.

ROS: Problem pertinent. Pos and pert negatives for system related to the problem should be documented.

PFSH: Not required.

Examination: Expanded Problem Focused.
A limited examination of the affected body area or organ system and other symptomatic or related organ systems.

Medical Decision Making: Low Complexity.
Document Min 2 of 3:
Limited Options
and/or Limited Doc Review/Tests
and/or Low Risk.

Emergency E&M – 99285

History - Comprehensive:
Chief Complaint: Usually presenting problem(s) are high severity/ pose an immediate significant threat to life or physiologic function.

HPI: Extended. Physician document min 4 elements.

ROS: Complete. if pt condition allows, review at least 10 systems. Pos/ pert negs must be individually reviewed. Note indicating all other systems NEG OK.

PFSH: Complete. Document at least **1** specific item in any **2** of past, family, or social h istory areas as pertinent and directly related to pt problems. Note supp/confirm triage OK.

Examination - Comprehensive: General multi-system examination (Phys doc 8 or more organ systems), **or** a complete exmaination of a single organ system.

Medical Decision Making: High Complexity.
Document Min 2 of 3:
Extensive Options,
and/or Extensive Doc Review/Tests,
and/or High Risk.

Emergency E&M - 99283

History- Expanded Problem Focused:

Chief Complaint: Usually presenting problem(s) are of moderate severity.

HPI: Brief. Physician document min 1 to 3 elements.

ROS: Problem pertinent. Pos and pert negatives system related to the problem should be documented.

PFSH: Not required.

Examination - Expanded Problem Focused:

A limited examination of the affected body area or organ system and other symptomatic or related organ systems.

Medical Decision Making: Moderate Complexity.
Document Min 2 of 3:
Multiple Options
and/or Moderate Doc Review//Tests
and/or Moderate Risk.

Emergency E&M – 99281

History- Problem Focused:

Chief Complaint: Usually presenting problem(s) are self limited or minor.

HPI: Brief. Physician document min 1 to 3 elements.

ROS: Not required.

PFSH: Not required.

Examination: Problem Focused.
A limited examination of the affected body area or organ system.

Medical Decision Making: Straight forward.
Document Min 2 of 3:
Minimal Options
and/or Minimal Doc Review/Tests
and/or Minimal Risk.