



DATE: _____

TIME: _____

Critically ill; injured patient

Total full-attention by attending: first 31-74 min

addtl. 30 min x _____ (total time: _____)

INITIAL ADMISSION NOTE

Attending:

Information from: _____ Patient _____ Family _____ Caregiver

Reason:

1. Present Illness: Main sign/symptom (4/4/4): (location, quality, severity, duration, timing, context, modifiers, associated signs/symptoms)

Home Meds:

Immunizations:

2. Past History (1/3/3): DRUG ALLERGIES:

Medical & Surgical

Social

Family



DATE: _____
TIME: _____

INITIAL ADMISSION NOTE (CONTINUED)

IMPRESSION/DX: (2/3/4): [(New+W/U (4); New (3); Worsened (2); Stable (1); Improved (1); Self-limited (1))] | Σ Dx=

Plan:

Risk (2/3/4)

- | | | |
|--|--|--|
| ² <input type="checkbox"/> OTC drug <input type="checkbox"/> Diet
<input type="checkbox"/> Contrast X-ray <input type="checkbox"/> Arterial puncture | ³ <input type="checkbox"/> Prescrip. Drug <input type="checkbox"/> Proc. Avg. Risk
<input type="checkbox"/> Elective surg./Bx. <input type="checkbox"/> Acute systemic dz
<input type="checkbox"/> Mild exac. ch. dz <input type="checkbox"/> 2 stable ch. dz | ⁴ <input type="checkbox"/> Dz threat function/life <input type="checkbox"/> Rx w/risk/monitoring
<input type="checkbox"/> Emergency procedure <input type="checkbox"/> Procedure w/risk
<input type="checkbox"/> Severe exac. ch. dz <input type="checkbox"/> Parenteral narcotic |
|--|--|--|

COUNSEL > 50% OF (30/50/70) _____ MIN SESSION.

Old records requested: _____
Obtain Hx from family: _____

Signature: _____

..... **TEACHING PHYSICIAN NOTE**

This note is to complement the initial evaluation by trainee MD/student:

_____ from / / _____ Level of billing reflects both.

Key Elements of History:

Key Elements of Physical exam were repeated by faculty: [with medical student: checked areas were examined by faculty but not contributory: areas crossed (X) were relevant as described by # (12/2x9/2x9)]

<p>1. Appearance <input type="checkbox"/> ≥ 3 V.S. <input type="checkbox"/></p> <p>2. Skin/SQ inspec <input type="checkbox"/> palp <input type="checkbox"/></p> <p>3. Conj /lids <input type="checkbox"/> , pupils/iris <input type="checkbox"/> fundus <input type="checkbox"/></p> <p>4. Ext ear/nose <input type="checkbox"/> , otoscopy <input type="checkbox"/> hearing <input type="checkbox"/> , rhinoscopy <input type="checkbox"/> lips/teeth/gum <input type="checkbox"/> , orophary <input type="checkbox"/></p> <p>5. Breast insp <input type="checkbox"/> , B. palp <input type="checkbox"/></p> <p>6. Neck <input type="checkbox"/> , thyroid <input type="checkbox"/></p> <p>7. Resp effort <input type="checkbox"/> , chest percu <input type="checkbox"/> Ch. Palp <input type="checkbox"/> , lung auscul <input type="checkbox"/></p> <p>8. Heart palp <input type="checkbox"/> , H. auscul <input type="checkbox"/> carotid p <input type="checkbox"/> , Femoral p <input type="checkbox"/> pedal p <input type="checkbox"/> , abd Ao <input type="checkbox"/> edema/ varices <input type="checkbox"/></p>	<p>9. Abd palp <input type="checkbox"/> , liver/ spleen <input type="checkbox"/> hernias <input type="checkbox"/> , ano -rectal <input type="checkbox"/> guaic (if indicated) <input type="checkbox"/></p> <p>10. Scrotum/testes <input type="checkbox"/> penis <input type="checkbox"/> , prostate <input type="checkbox"/></p> <p>11. Ext /vagina <input type="checkbox"/> , urethra <input type="checkbox"/> bladder <input type="checkbox"/> , cervix <input type="checkbox"/> uterus <input type="checkbox"/> , adnexa <input type="checkbox"/></p> <p>12. Gait/station <input type="checkbox"/> , digit/nails <input type="checkbox"/> insp /palp <input type="checkbox"/> ROM <input type="checkbox"/> , Stability <input type="checkbox"/> Musc . Strength/tone <input type="checkbox"/></p> <p>13. Neck LN <input type="checkbox"/> , axillae LN <input type="checkbox"/> groin LN <input type="checkbox"/> _____ LN <input type="checkbox"/></p> <p>14. CN: _____ <input type="checkbox"/> DTR/ Babinski <input type="checkbox"/> , sensation <input type="checkbox"/></p> <p>15. Judgement/insight <input type="checkbox"/> orientation <input type="checkbox"/> , memory <input type="checkbox"/> mood/affect <input type="checkbox"/></p>
---	--

DATA: Diagnostic studies evaluated by type; comments are given if needed (O=ordered; R=reviewed; D=discussed; V=visualized) Circle or check (✓) indicates work done ; only very relevant data was written below (2/3/4 points):

Labs/Path: O/R; Radiol: O/R, D, V (2); Med test/Endo: O/R,D,V (2); Path: D,V (2); Old Records Reviewed (2) ___ Requested ___ Σ Da=

IMPRESSION/DX: (2/3/4): [(New+W/U (4); New (3); Worsened (2); Stable (1); Improved (1); Self-limited (1))] Σ Dx=

Plan:

Risk (2/3/4)

<p>② <input type="checkbox"/> OTC drug <input type="checkbox"/> Diet <input type="checkbox"/> Contrast <input type="checkbox"/> Arterial X-ray puncture</p>	<p>③ <input type="checkbox"/> Prescrip. Drug <input type="checkbox"/> Proc. Avg. Risk <input type="checkbox"/> Elective surg./Bx <input type="checkbox"/> Acute systemic dz <input type="checkbox"/> Mild exac. ch. dz <input type="checkbox"/> 2 stable ch. dz</p>	<p>④ <input type="checkbox"/> Dz threat function/life <input type="checkbox"/> Rx w/risk/monitoring <input type="checkbox"/> Emergency procedure <input type="checkbox"/> Procedure w/risk <input type="checkbox"/> Severe exac. ch. dz <input type="checkbox"/> Parenteral narcotic</p>
---	---	--

COUNSEL > 50% OF (30/50/70) _____ MIN SESSION. Signature: _____