PRESENTATION TEMPLATE

Presentation without template:		Presentation WITH template:
H&P: Ms. Smith is a 56yoF who has been having shortness of breath for a week. She is very anxious and has not been sleeping well the past week, as she keeps waking up suddenly gasping for air. She has a history of asthma and has also been using her albuterol. She has been having some leg pain as well which is worse when she walks. The legs are swollen, too. She has been taking her lasix and took an extra dose yesterday. She has been having more shortness of breath walking around the house, where as she used to be able to walk a block. She has not had any recent surgery or long distance travel. No sick contacts. ROS are positive for shortness of breath, leg swelling, anxiety, and leg pain. ROS are negative for headache, fevers, chills, diaphoresis, changes in vision, chest pain, cough, rhinorrhea, wheezing, abdominal pain, nausea, vomiting, diarrhea, constipation, numbness, weakness, falls, extremity pain. PMH includes CHF, CAD, stents, and asthma. She has never blood clots. Her medications include albuterol, lasix, and plavix.	**H&P:** *("Killer first line:")* Ms. Smith is a _(age)_ yo __(M/F)__ with history of ___(pertinent PMH/meds)_____ presenting today with (timeline) of ___(chief complaint)___ . *("OLD CARTS" - additional description of chief complaint.)* It _____(briefly describe timeline, quality, constant/comes/goes, what makes it better or worse, treatments). (Sx for/against Differential #1): It is associated with ____ (pertinent positives). (Sx for/against Differential #2) : She does have ___ (pertinent positives). But does not have ____ (pertinent negatives). (Neg ROS that make Differential #3 unlikely): She does not have _____. (Neg ROS that make Differential #4 unlikely): There is no _____. (Neg ROS that make Differential #5 unlikely): There is no _____.	**H&P:** Ms. Smith is a 56yoF with history of CAD with stents now on plavix, CHF with EF of 30% on lasix, and mild asthma, here with 1 week of slowly worsening shortness of breath. It is worse when she lies down at night and with walking. She used to be able to walk 1 block and now she gets short of breath just walking to the bathroom. She did take an extra dose of lasix which helped a little. (#1- CHF) It is associated with worsening leg swelling bilaterally, that is slightly painful. It is worse at night and sometimes she wakes up gasping, which is affecting her sleep and causing lots of anxiety. (#2- asthma) She does have a history of asthma but in the past has been very well controlled and immediately resolves with albuterol. She did try albuterol and it did not help her shortness of breath. No wheezing or rhinorrhea / itching. (#3- ACS) She is not having any chest pain, diaphoresis, arm pain, or nausea. (#4 - PNA) She is not having any fevers, productive cough or body aches. (#5 - PE) Her leg swelling is bilateral, she has no hx of clots/DVTs, no recent immobility.

Exam: Her temp is 98F, HR is 80, RR is 22, BP of 160/90, and her O2 sat is 90% on RA	**Exam:** Vitals- Interpret! (insert rest of pertinent exam here)	**Exam:** She is afebrile and not tachycardic. Slightly hypertensive at 160/90. Increased respiratory rate of 22, is slightly hypoxic at 90% on RA
Impression: The differential diagnosis includes CHF exacerbation, asthma exacerbation, acute MI, pneumonia or pulmonary embolism. I think we should get: - basic labs - BNP - VBG - d dimer - cardiac enzymes - give oxygen - EKG - CXR - place her on the monitor - give lasix, albuterol neb and ASA - call the cardiologist - monitor urine output - repeat lung exams ** this is not necessarily an incorrect workup, but the presentation style does not let your college know what you are thinking	**Impression:** (Differential #1) "I am concerned the pt is having __(#1)___." or "I think in this patient we need to rule out __(#1)___." (Differential #2/3) "She also might have __(#2/3)___ due to the ___(findings for)___ however she doesn't have ___(findings against)___. (Differential #4 / #5) "I think that this is less consistent with ___(#3)___" or "I don't think she is having __(#4)__ because of _____." (or may be no need to explain why not if you already mentioned the pertinent negatives in your H&P) **Treatments:** I think we should give her ____(oxygen, pain control, tylenol, ASA, place on monitor, give fluids)___	**Impression:** (#1- CHF) I am concerned the patient is having a CHF exacerbation and is fluid overloaded. (#2- asthma) She does have a history of asthma, but her shortness of breath today is not associated with wheezing on exam, and the leg swelling still makes CHF more likely. (#3- ACS) She could be having an MI that is exacerbating the CHF, although she does not have any chest pain. She does have coronary history, though, so I think we need to rule it out. (#4- PNA; #5- PE) I don't think this is consistent with a pneumonia or pulmonary embolism. **Treatments:** I think we should: - place her on the monitor - give oxygen by NC - give her a dose of IV lasix for diuresis - could try an albuterol neb to see if it helps - giver her an ASA in case she is having an MI

"OLD CARTS" for HPI: Onset (timing, acute, gradual) Location Duration (hours, days, intermittent, constant) Characteristics (quality, sharp, aching) Aggravating factors Relieving factors Treatments (previously tried, results) Severity (number scale, mild, severe)	**Workup:** I think we should get ___(lab)___ to look for / rule out ___(# 1/2/3/4)__ And we should get __(imaging/EKG)__ to look for / rule out ___(# 1/2/3/4)__ (consider) I am going to call __consult/PMD__ to ask for __ (consult, records, more hx)__ **Initial Disposition:** (it's ok for this to change!) I think we should… (examples:) - reassess her after the pain medication - do serial abdominal exams - have her follow up with ortho in 1 week - have her return for wound check in 48 hours	**Workup:** I think we should get: - a BNP to assess for fluid overload/CHF - cardiac enzymes to rule out MI - a VBG to look for signs of CO2 retention - a CBC to rule out anemia and infection - a BMP to look for electrolyte abnormalities and assess her renal function - an EKG to rule out MI or arrhythmia - a CXR to look for signs of fluid overload and rule out pneumonia or effusion - monitor urine output after the lasix - I will call her cardiologist to get the most recent echo report and let him know she is here **Initial Disposition:** I think we should… - repeat a lung exam / O2 Sat after diuresis - consider getting a d-dimer to rule out PE if she remains hypoxic and the workup is not consistent with CHF

What can *you* learn in 5 min?

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