STANDARDIZED HAND-OFF MOCK CHART

Background:

You are a post-call intern who has admitted this patient the night prior during your long call. You are preparing to leave for the evening and readying your sign-out. The following is the written history and physical from the patient's admission last night. You will also view a short video clip which is a synopsis of the events which occurred for the patient during your post-call day.

HISTORY AND PHYSICAL

Erma Housemann

Medical Record # 1234567

Primary care physician: Dr. William Harper

Location: General medicine 5th floor

Chief Concern: shortness of breath

History of Present Illness: Mrs. H is a 68y/o Caucasian female with a history of COPD, HTN and DM2 presenting via the ED c/o SOB x 3 days. The patient was in her usual state of health until 3 days prior to admission when she noted increased dyspnea on exertion and an increased oxygen requirement with exertion [her baseline home O2 requirement of 2L NC]. She also notes increasing frequency of requiring nebulizer treatments and they do provide her with intermittent relief from the shortness of breath. The patient does endorse that she has had a productive cough x 3-4 days with thin, clear

sputum. The patient denies chest pain or any other constitutional symptoms [night sweats, fevers, weight loss, etc.]. The patient states that she has not had any sick contacts; she has had her flu shot and is up-to-date on her pneumovax.

Past Medical History:

HTN, diagnosed a number of years ago, well-controlled

DM2, diagnosed 5 years ago, no known complications, last HgBA1C unknown

COPD, diagnosed 7 years ago, baseline 2L oxygen requirement by nasal canula

OA, primarily back and knees, over-the-counter treatment

Past Surgical History:

Not significant

Allergies: NKDA

Medications:

Lisinopril 5mg po daily

Insulin glargine 20 units SQ qHS

Novolog 8 units TID c meals

Fluticasone and salmeterol discus 2 puffs BID

Albuterol MDI 2 puffs PRN

Social History:

Patient lives alone with homemaker services 3x per week

Independent in ADLs, IADLs

Ex-smoker, 2ppd x 22 years; no EtOH; no illicit drug use

Widowed, retired school teacher, one son, one daughter [Jane Houseman 773-234-5678 power of attorney]

PHYSICAL EXAM

VS Temp 37.2°C HR 108 BP 143/78 RR 22 SaO2 95% on 4L NC

HEENT: unremarkable, no cervical lymphadenopathy noted, oropharynx clear

CV: tachycardic, regular rate and rhythm, normal S1, S2, no murmurs rubs or gallops

Pulmonary: diffuse expiratory wheezing heard throughout all lung fields, decreased breath sounds at right base with some dullness to percussion

Abdomen: soft, non-tender, non-distended, +bowel sounds in all four quadrants

Neurologic: non-focal exam

Laboratory data:

	10.1	
11.2		512
	32.1	

140	98	12	
			342
3.2	28	1.0	

Portable chest x-ray reveals dense right lower lobe infiltrate which is new from previous exam and also chronic change c/w COPD

U/A: negative

Urine and blood cultures pending

ASSESSMENT AND PLAN:

68y/o F h/o COPD, HTN, DM2 p/w COPD exacerbation and presumed community acquired pneumonia

1. Shortness of breath→
Likely contributions from both pre-existing lung disease and infectious process
Plan: Albuterol/atrovent nebs q 4hours
Prednisone 60mg po daily
Moxifloxacin 400mg po daily for presumed community acquired pneumonia
Nasal canula oxygen as needed
Chest PT q8hours

#2. Right lower lobe infiltrate→
Likely represents a community-acquired pneumonia given no recent hospitalizations or other risk factors
Plan: empiric antibiotics with Moxifloxacin
Sputum and blood cultures pending

3. HTN→ controlled, chronic, no active issues currently
Plan: Continue lisinopril

4. DM2→ uncertain degree of control
Plan: Check HgB A1C
Continue lantus/lispro/humalog sliding scale
Diabetic diet

#5. Prophylaxis→
Plan: Heparin 5000units SQ q8hours

#6. Code status→ per PCP note, patient is full code; re-address goals of care as appropriate

Interim evaluation of patient:

RN calls because of patient tachypneic and hypotensive. You arrive at the bedside to evaluate the patient and note that indeed her respiratory rate is increased from her admission baseline although she is able to speak in full sentences.

Her mental status is at baseline from the admission and the patient is without complaints. Her vital signs are as follows:

Temperature 37.4°C HR 110 RR 27 BP 100/70 SaO2 95% on 2L NC O2

Physical exam is unchanged from admission; diffuse expiratory wheezes are noted throughout all lung fields.

You order stat albuterol/atrovent nebulizer treatment and inform the nurse that you will have your cross-cover check in on her after the treatment.