

GENERAL SURGERY [H&P] [CONSULT]

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ASSESSMENT:

Primary Diagnosis:

[].

Acute & Active Problems:

[] [n/a].

Resolved Problems:

[] n/a.

Chronic Medical Problems: [none]

DVT Prophylaxis: SCDs. [Lovenox]

GI Prophylaxis: [H2B] [Diet]

Lines | Foley | ETT (placement dates): [n/a]

Consultants: [n/a]

Procedures: [n/a]

PLAN:

[].

[] **Hypercoagulable state due to hospitalization.** Risk mitigation for DVT includes SCDs[and Lovenox].

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Total critical care time: [] **minutes.** This time does not include time spent on separately billable procedures. The patient had a high probability of clinically significant, life-threatening deterioration secondary to the following: []; the patient required my highest level of preparedness to intervene emergently and I personally spent this critical care time directly and personally managing the patient. This critical care time included obtaining a history; examining the patient; pulse oximetry; ordering and review of studies; arranging urgent treatment with development of a management plan; evaluation of patient's response to treatment; frequent reassessment; and, discussions with other providers.

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The patient was seen in [ED] at the request of Dr. []

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CHIEF COMPLAINT: []

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HPI: []

[]

PAST MEDICAL HISTORY: [as above]

PAST SURGICAL HISTORY: [as above]

FAMILY MEDICAL HISTORY: [] Neg for MI, CVA, Cancer, DVTs

SOCIAL HISTORY: Tobacco: [none]. EtOH: [none]. []

ALLERGIES: [NKDA]

MEDICATIONS: [None]

ROS: Pertinent positives— [] —and negatives as above, otherwise negative for the respective fields for the following: Neuro, eyes, ENT, CV, resp, GI, musculoskeletal, GU, skin, psychiatric

PHYSICAL EXAM:

General: • Well nourished, well developed. NAD • 4 point VS reviewed

Eyes: • PER. • Sclera anicteric, lids without lesion

ENT: • No lesions/lacerations to ears or nose • Hearing intact • Oral membranes moist.

Neck: • Supple, Trachea midline • No thyromegaly

Respiratory: • Respirations even and unlabored • CTA B/L

CV: • Regular rate, regular rhythm. No murmur • [B/L] Rad pulses +2, [B/L] DP pulses 2+ • No edema.
No varicosities

GI/Abd: • +ABS • Soft, Not distended, No tenderness. • No umbilical mass. No inguinal masses

GU: • Normal external genitalia • Normal sphincter tone. [Normal prostate]

Lymphatic: • No cervical LAD • No supraclavicular LAD • No epitrochlear LAD

Musculoskeletal:

- *Digits:* Non-tender to palpation. No clubbing. No cyanosis. Capillary refill <2 secs

- *Joints, bone and muscle:*

- **Pelvis:** stable.

- **Extremities:** • No observed deformities x [4]. Normal to palpation x [4]. • Normal ROM x [4]. • Normal joint stability x [4]. • [B/L] Bicep 5/5, [B/L] Triceps 5/5, [B/L] Plantarflex 5/5, [B/L] Dorsiflex 5/5

- **Cervical Spine:** non-tender to palpation. Full ROM with no pain, no neuro symptoms.

- **Lumbar and Thoracic Spine:** normal to palpation without deformities.

Skin: • No rashes or lesions. • No palpable masses

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LABS: Reviewed. []

RADIOLOGY: I have reviewed the images and reports personally. []