- **How do I write a note?**
- **How do I find the patient list?**
- **How do I find my patients?**
- **How do I discharge a patient to home?**
- **How do I discharge a patient to CLC?**
- **How do I discharge a patient to Nursing Facility?**
- **How do I change a patient from Medical Observation to Acute Medicine?**
- **How do I setup follow up appointment for PCP and Specialty Clinic?**
- **How do I consent for blood products?**
- **How do I consent for a procedure (LP, Paracentesis)?**
- **Why is the finish button unclickable on the discharge instructions??!**
- **How do I admit a patient?**
- **How do I consent a patient for travel/transfer?**
- **How do I complete an MRI checklist?**
- **How do I order an MRI if I didn't order after completing the checklist?**
- **Who do I call if a patient doesn't have a PCP assigned?**
- **How do I order a home oxygen evaluation?**
- **How do I complete a non-formulary drug request?**
- **How do I transfer a patient from the ICU to the floor?**
- **How to consent a patient that does not have decision making capacity, for procedure or otherwise, over the phone?**
- **How do I discharge AMA?**
- **How do I link Vista Imaging to CPRS?**
- **How do I see active medications first?**
- **How do I order oral contrast?**
- **How do I page a Scott & White Number?**
- **What additional documentation steps do I need to take if a patient is DNR/DNI?**
- **How do I get access to the Emergency department?**
- **How do I print?**

How to write a note:
Please see the APPENDIX below for templates for Inpatient H&P and progress note, ICU H&P and progress note, death note. Modify as needed.

1) *Under notes tab, go to options > create template > name your template > copy and paste the template from the appendix and modify as needed.*
2) *Click apply*
3) *Repeat for each type of note*
4) *In the ICU, vital signs are in clinicomp which is an app on the desktop*

How do I find my patients?
File > select new patient > on the left side under patient list select provider > enter provider name > save patient listing. You can also search by ward or clinic.

How do I find the patient list?
Windows icon > Computer > S: drive CTX services drive > MED > AA inpatient list

How to discharge a patient to home:

1) *Reconcile all medications. Add new medications from this hospitalization to the outpatient medications list. You can do this through orders > meds (outpt). Don't forget to state the indication.*
   It is very important to make sure that all the medications appear on the discharge instructions correctly because this is what is given to the patient to take home, so this step is crucial. If for some reason you make a change to your outpatient medications after you have already completed the discharge instructions DON'T START OVER. Delete the current medication list. Go to templates > open shared templates > scroll down to patient data objects > click plus box > double click on medication reconciliation discharge > this will add the medications that are most up to date. ***Make sure you place the cursor where you want the medications to show up.***
2) *Next go to notes > new note > acute/extended care discharge instructions*
   - ***If the "finish" button becomes unclickable DO NOT START OVER, simply click on the note tab at the bottom to make sure that the "acute/extended care discharge instructions" note on the left side of your screen under notes is highlighted in blue. This will make the finish button clickable.***
   - ***Complete all the starred boxes or it won't let you continue.***
3) *Next, click on orders > discharge patient > click the type of discharge > accept order for pneumococcal vaccines and MRSA > sign all orders*
   - ***Be careful regular discharge is next to death***
4) *Call clerk on the floor and let them know that you have entered all the discharge information*
5) *Click on Discharge summary tab > click new summary > click on my templates*

How to discharge a patient to CLC:

1) *Notes -> new note -> title CLC request -> follow prompts*
2) *If the patient is accepted, your note will be addended*

3) *Once approval is received, remember to ask the PCC whether it is short term or long term or any additional information they can give you. You will also need the attending physician's phone number who has accepted the patient to CLC. Call the accepting physician to tell them about the patient. Write delayed orders to transfer to CLC. Discharge the patient as you would usually with discharge to: Transfer to CLC.*

How to discharge a patient to Nursing Facility:

Consults -> under all other services - geriatrics -> under residential settings and nursing homes -> community nursing homes. Your note will be addended to let you know the status of placement or the PCC (patient care coordinator during IDT meeting) will let you know. Proceed with regular discharge. As described above.

How to change a patient from Medical Observation to Acute Medicine:

1) *Under orders tab Click "write delayed orders" on the left side of the screen scroll down and click "admit to acute medicine" Treating specialty Acute Medicine Enter attending name. Make sure to enter "place patient on telemetry" under instructions if they need it.*
2) *Sign this order and click on active orders. You will be asked if you want to delete the delayed order set as there are no orders in. Select NO. Go to active orders and press ctrl and select all the orders you want to transfer. Click on action at the top and select copy to new order. Select delayed order, admit to acute medicine. Accept all the new orders and sign.*
3) *Make sure you go back to the active orders and select on discharge patient under patient movement heading on the left side. Under the instructions make sure to enter "Please discharge patient from medical observation and admit to acute medicine. Don't accept the pneumococcal vaccine and MRSA. Sign these.*
4) *Call the clerk and let them know you have entered the delayed orders for acute medicine and discharge orders for medical observation.*
5) *Write a short discharge summary 3- 4 lines stating that you are transferring from obs to acute medicine. Yes, you really have to do this.*

How to setup follow up appointment for PCP and Specialty Clinic:

1) *Click on box at the top of the page where the attending name is listed. This will give you the PACT information which is the PCP clinic name (eg TVC PACT PHY 3 *WH*)*
2) *Click on the box at the top of the screen with the Patient Location eg T4K 4K107-1T*
3) *Click on the new visit tab half way down*
4) *Type in the clinic name and click OK*
5) *Under the patient movement heading click return to clinic*
6) *Under the comments type hospital admission follow up and anything that needs to be followed*
7) *Check the boxes for follow up labs*

How to consent for blood products:

There are two ways to accomplish this:

1) *You can ask the HUC for a paper copy – the easier option albeit less preferable according to the powers that be.*
2) *Grab a WOW (workstation on wheels), login to CPRS, click on tools, select IMED consent, click on all documents folder, type in blood products -> search. In the middle column click on emergency medicine -> consents – basic, -> blood transfusion, complete all the questions, ->*

sign, sometimes the WOW will have a signature pad that works, but I usually have the patient use the mouse to sign it. ***Then click SAVE TO CHART.***

How to consent for a procedure (LP, Paracentesis, Brochoscopy):

Follow the same steps as above however instead of blood products type the procedure you are performing.

How to admit a patient:

Orders -> Admission (OS) -> Follow the prompts. To check whether or not the patient has had a flu vaccine, click on the question mark or alarm clock in the top right corner of the main screen of CPRS. This will have all immunizations listed. You can transfer home meds to inpatient by selecting the meds using CTRL, click on each med and then options-> transfer to inpatient

How to consent a patient for travel/transfer:

Ask the HUC for a travel/transfer form. Fill out the destination and have the patient sign it. Give it back to the HUC to scan in. The risks for travel include motor vehicle accident that may result in serious injury or death. You need to have a witness for an additional signature on this form.

How to complete an MRI checklist:

1) *Grab a WOW (workstation on wheels), go to the patient room, open CPRS -> notes -> new note -> select title: MRI checklist*
2) *complete all of the questions. At the end of the questionnaire you will enter the type of MRI you would like.*
3) ***Sign the note then go to the orders and sign the orders***

How to order an MRI if I didn't order after completing the checklist by mistake:

If you forget to order the MRI after the checklist, don't fret. Click on orders, imaging/radiology, select CT, then under imaging type in the top right corner, click magnetic resonance imaging and pick the specific study as you would usually.

Who to call if a patient doesn't have a PCP assigned:

Call Roger Cringer 41479 and he will assign a PCP.

How to order a home oxygen evaluation:

1) *Click on consults, new consults, click on pulmonary under medicine, click on patients who need/qualify for home oxygen in the bottom left corner.*
2) *On the right side under consults click on Temple Home Oxygen INPT*

How to complete a non-formulary drug request:

This depends on the drug you are requesting. Go to consults -> pharmacy and complete this.

For NOACs – Create a new note, title it MD NOTE (don't put the MD NOTE – SOAP) Click shared templates -> 0 PRIOR AUTHORIZATION DRUG REQUESTS -> ALL INPATIENT RDR/ PRIOR AUTHORIZATION - > select the NOAC you want and follow the prompts -> Finish and sign the note

How to transfer a patient from the ICU to the floor:

1) *Call the MOD 421-8017 to find out which team will be accepting the patient*

2) *Call the team that will receive the patient to give check out and make sure to the attendings name*
3) *Write delayed orders to transfer to acute medicine with name of the accepting attending*
4) *Copy the active orders to the delayed orders*

Control select the orders you want to remain active (don't forget morning labs) -> action -> copy to new order -> delayed transfer to acute medicine

5) *Write a provider handoff note noted -> new note -> provider handoff note -> sign -> make both ICU and accepting attending cosigners*
6) *If there are no beds available on the floor, contact the HUC to release the orders at the end of the day or when the patient has been transferred out of the unit*

How to consent a patient that does not have decision making capacity, for procedure or otherwise, over the phone?

1) *Call the next of kin*
2) *Let them know that they will receive a call from the details clerk*
3) *Call the details clerk at 40684 or 42617 and give them the patient information*
4) *You will then have a 3 way call to obtain consent*
5) *You don't need to do anything else, the details clerk will complete the paperwork*

How do I discharge AMA?

As you would regularly however select AMA. You do not need to write discharge instructions. In the discharge summary you just need to include the brief hospital course. You can setup follow up appointment as above.

How to link Vista Imaging to CPRS?

In the top left corner, you should see a blue person. This means that CPRS is linked to Vista imaging. You can only have one link between these applications. If you see a red person, black person and a blue person that means CPRS is not linked.
To link: click file -> rejoin patient link -> set new context

How do I see 'active' medications first?

Under the meds tab, Click view -> Sort by Group/Status/Location/Drug name

How do I order oral contrast?

Main medical services menu -> Meds -> Gastroview

How do I page a Scott & White Number?

Dial 91 254 724 7508, follow the prompts -> enter the 4 digit pager number -> enter your phone number

What additional documentation steps do I need to take if a patient is DNR/DNI?

Go to notes -> new note -> type life sustaining measures -> complete the prompts. The DNR/DNI order will automatically show un under orders

How do I get access to the Emergency department?

Take your PIV card to the police department, they will add privileges to your card. If it doesn't work you just have to go around to the patient entrance.

How do I print?

Windows icon -> control panel -> under hardware and sound -> view devices and printers -> add a printer -> add a network wireless or Bluetooth printer -> select canon secure print -> go to the printer insert your PIV card and enter your PIV code -> select secure print -> print. DON'T FORGET YOUR PIV card in the printer

APPENDIX

==========

I was called to patient's bedside by the primary nurse after being notified that the patient was unresponsive.

|PATIENT NAME| is a |PATIENT AGE| y/o M/F that demonstrated no respiratory effort with no heart or breath sounds auscultated and was non-responsive to verbal/painful stimuli. No corneal reflex appreciated and pupils were fixed and dilated. Peripheral pulses absent. Prior to entering the room asystole was appreciated on telemetry with no signs of electrical cardiac activity.

Time of death was 00:00h on |TODAY'S DATE| due to sequela of (PROBLEM).

Patient's family wished to defer autopsy. Condolences were offered and chaplain notified for support. These findings were immediately relayed to the attending physician, Dr. ***.

Kurren Desai, MD PGY-1

==========

Discharge Summary

Date of Admission: |CURRENT ADMISSION|

Date of Discharge: |TODAY'S DATE|

Discharge Type: Regular

Reason for hospital stay:
Patient principle diagnosis was:

Other diagnoses/comorbid conditions were:

Procedures:

Consultants:

Vitals:
BP:|BLOOD PRESSURE|
P:|PULSE|
T:|TEMPERATURE|
RR: |RESPIRATION|
OXYGEN SAT: |PULSEOX|
WT:|PATIENT WEIGHT|
BMI: |BMI|

Gen: |PATIENT AGE| y/o BMI |PATIENT BMI| AAOx3 in NAD
HEENT: Atraumatic, normocephalic, PERRL, EOMI, no cervical lymphadenopathy
Neck: No JVD, Trachea midline
CV: normal rate regular rhythm no murmurs
Pulm: clear to auscultation bilaterally no wheezes/crackles
Abdomen: Soft no T/R/D/G, +BS
Extremities: no clubbing, cyanosis, or edema, peripheral pulses palpable
Neuro: Normal mood and affect, grossly normal strength and sensation

Brief Hospital Course:

Patient expressed understanding of the treatment options and was in agreement with the plan for discharge to ***. All questions were answered to patients satisfaction.

Discharge Diet:

Discharge Activity:

Medication Reconciliation:
Outpatient medications were compared with inpatient medications and the following list is the latest reconciled (up to date) list of medications:
|MEDICATION RECONCILIATION DISCHARGE|

All medications and their side effects and reasons for usage were discussed with the patient who voiced understanding and was in agreement with their usage and with the treatment plan.

Discharged To:

Outpatient studies ordered/recommended:

Follow Up:

Kurren Desai, MD PGY-1

Inpatient History & Physical

Date:
Attending Physician:

Chief Complaint:
==========
HPI

|PATIENT NAME| is a |PATIENT AGE| y/o

Patient denies subjective fevers, chills, night sweats, headache, chest pain, palpitations, SOB, wheeze, cough, sputum production, abd pain, N/V/D, constipation, dysuria, swelling, weakness or lightheadedness

In the ED,

==========
Review of Systems
A 10 point constitutional review of systems was performed including General, HEENT, Cardiovascular, Pulmonary, GI, GU, Neurological, Skin, Musculoskeletal, Psych all negative except as per HPI

==========
Past Medical History

|PROBLEM LIST(ACTIVE)|
|GLYCOHEMOGLOBIN|
|LIPID PROFILE|

==========
Surgeries

|SURGICAL HX|
==========
Medications

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```
|ACTIVE/PENDING/EXPIRED MEDICATIONS|

|ACTIVE MEDICATIONS|

Medication Reconciliation:
I have reviewed this list of medications with the Patient and medication
reconciliation was performed and believe this list is accurate and includes all
medications (VA, Non-VA, over-the-counter if any) that the patient is taking as
an outpatient.

================================================================================
Allergies

|ALLERGIES/ADR|

================================================================================
Social History

Tobacco:
Alcohol:
Drugs:

================================================================================
Family History

Non-contributory

================================================================================
Physical Exam

Vitals:
BP:|BLOOD PRESSURE|
P:|PULSE|
T:|TEMPERATURE|
RR: |RESPIRATION|
OXYGEN SAT: |PULSEOX|
WT:|PATIENT WEIGHT|
BMI: |BMI|

General:
  Alert and oriented, appears stated age, laying in bed in NAD
HEENT:
  NC/AT, EOMI, nasal passages non-boggy, non-erythematous, no rhinorhea
  MMM no erythema or exudates
Neck:
  Supple, No thyromegaly, No JVD, No bruit, No LAD
Cardiovascuar:
  Normal Rate, Regular Rhythm, S1/S2 normal, no murmur/gallop/rub
Lungs/Respiratory:
  No respiratory distress, speaking full sentences, CTAB, no wheezes/rales/rhonchi
Abdominal/GI:
  Normoactive bowel sounds. Soft, NTTP, nondistended, no rigidity or guarding
  no rebound tenderness. No HSM
Extremities:
  Radial and DP pulses +2/4 bilaterally, no edema, clubbing, or cyanosis
Skin:
  Warm, dry, no rashes
Neuro:
Speech intact, no slurring, no aphasia, no involuntary movements or tremors
no facial drooping, moves all extremities against gravity

================================================================================
Labs - Reviewed
|CBC (WBC/HGB/HCT/PLT)|

|COMPREHENSIVE METABOLIC PANEL|
 |MAGNESIUM|
 PHOS |PHOSPHORUS|

|LABS LAST 24HRS|
```

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```
==========================================================================
Imaging - Reviewed

==========================================================================
EKGs:
 Date
 -
 - HR / PR / QRS / QT/QTc

================================================================================
Assessment & Plan:
|PATIENT NAME| is a |PATIENT AGE|y/o M/F

#


Code Status: Full; DNI/DNR

Diet:
Lines(when placed)
Antibiotics (day# of #)
Infusions
GI Prophylaxis
DVT Prophylaxis
Family Update

Staff: Dr.



Kurren Desai, MD PGY-1

================================================================================================================
================
Date:
Attending Physician:

================================================================================

|PATIENT NAME| is a |PATIENT AGE| y/o M with PMH significant for *** presenting
with *** and admitted for ***

SUBJECTIVE:
Overall patient has no new complaints overnight. Patient denies any fever,
chills, headaches, cough, palpitations, abdominal pain, nausea, vomiting, diarrhea
shortness of breath or chest pain.

================================================================================
Consult Reports:

================================================================================
|ACTIVE MEDICATIONS|

================================================================================

OBJECTIVE:
|VITALS (24 HOURS)|


PHYSICAL EXAM:
General:
  Alert and oriented, appears stated age, laying in bed in NAD
HEENT:
  NC/AT, EOMI, nasal passages non-boggy, non-erythematous, no rhinorhea
  MMM no erythema or exudates
Neck:
  Supple, No thyromegaly, No bruit, No LAD
Cardiovascuar:
  Normal Rate, Regular Rhythm, no murmur/gallop/rub
```

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```
Lungs/Respiratory:
  No respiratory distress, speaking full sentences, CTAB, no
wheezes/rales/rhonchi
Abdominal/GI:
  Soft, NBS, NTTP, ND, no rigidity, guarding or rebound tenderness. No HSM
Extremities:
  Radial and DP pulses +2/4 bilaterally, no edema, clubbing, or cyanosis
Skin:
  Warm, dry, no rashes

================================================================================
|CBC (WBC/HGB/HCT/PLT)|

|COMPREHENSIVE METABOLIC PANEL|
 |MAGNESIUM|
 PHOS |PHOSPHORUS|

|LABS LAST 24HRS|

================================================================================
Imaging:

================================================================================
ASSESSMENT/PLAN:

|PATIENT NAME| is a |PATIENT AGE|y/o M/F who presented with *** and was admitted for ***

#




Kurren Desai, MD PGY-1


================================================================================================================
================
ICU Critical Care Progress Note

Date:
HD#:
ICU Day#:

SUBJECTIVE:
Overnight Events:

|PATIENT NAME| is a |PATIENT AGE|

================================================================================
Consult Reports:


================================================================================
OBJECTIVE:
24hr Vital Signs:
Temp:
Pulse:
Blood Pressures
        Sys:
        Dias:
        MAP:
Respiratory Rate:
O2Saturation:
In-(); Out-(); Net-()

General: Awake, alert, oriented x 4 (person, place, time, situation), cooperative, NAD. Resting
comfortably in bed
 -or- Intubated and sedated.
HEENT: NC/AT, EOMI, MMM no erythema or exudates
Neck: supple, trachea midline, no palpable adenopathy
```

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```
Cardiac: Normal Rate, Regular Rhythm, S1/S2 normal, no M/R/G
Pulm: Non-labored breaths, clear breath sounds bilaterally, no wheezes or rales
Abd: +BS. Soft, NTTP, no rigidity or guarding
Derm: no rashes, skin is warm
Extremities: No edema, clubbing, or cyanosis. 2+ symmetric radial and DP pulses
Neuro:  Speech intact, no slurring, no aphasia, no involuntary movements or tremors
No facial drooping, moves all extremities against gravity

================================================================================
Labs:
|CBC (WBC/HGB/HCT/PLT)|

|COMPREHENSIVE METABOLIC PANEL|
|MAGNESIUM|
PHOS |PHOSPHORUS|

|LABS LAST 24HRS|
INR:
PTT:
PT:

|LIPID PROFILE|

Microbiology:
Blood Cx -
Urine Cx -
Sputum Cx -
Sputum Gm stain -
================================================================================
Radiology - Reviewed

-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-

================================================================================
EKGs
 Date:
 -
 - HR  / PR  / QRS  / QT/QTc
-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-.-
================================================================================
Vent:
SIMV/AC/BILEVEL/PC
SetRR:      Vt:      FiO2:          PEEP:      P/F:

|ABG|
================================================================================
Meds:
|ACTIVE MEDICATIONS|

================================================================================
Assessment and Plan:

|PATIENT NAME| is a |PATIENT AGE| y o M/F who presented with *** and was admitted for ***

Neurological
------------
#

Cardiovascular
--------------
#

Pulmonary
----------
#

Gastrointestinal
----------------
#

Endocrine
```

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```
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#

Renal/GU
----------
#

Infectious Disease
------------------
#

Hematology/Oncology
-------------------
#

Fluids, Electrolytes & Nutrition
--------------------------------
#


Dermatologic
-------------
#

Psychosocial
-------------
#

Code Status: Full Code; DNI/DNR

ICU Checklist
Diet:
Lines/Tubes (when placed)
Antibiotics (day# of #)
Infusions
GI Prophylaxis
DVT Prophylaxis
Family Update
Sedation/SBT


Staff: Dr.



Kurren Desai, MD PGY-1

================================================================================================
================
Critical Care History & Physical
Date:
Attending Physician:

Chief Complaint:
=============================================================================
HPI

|PATIENT NAME| is a |PATIENT AGE| y/o M/F who presented with *** and was admitted for ***

Patient denies subjective fevers, chills, night sweats, headache, chest pain,
palpitations, SOB, wheeze, cough, sputum production, abd pain, N/V/D,
constipation, dysuria, swelling, weakness, lightheadedness, dizziness or syncope.

=============================================================================
Review of Systems
A 10 point constitutional review of systems was performed including
General, HEENT, Cardiovascular, Pulmonary, GI, GU, Neurological, Skin,
Musculoskeletal, Psych all negative except as per HPI

=============================================================================
Past Medical History
```

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```
|PROBLEM LIST(ACTIVE)|
|GLYCOHEMOGLOBIN|
|LIPID PROFILE|

================================================================================
Surgeries

|SURGICAL HX|
================================================================================
Medications

|ACTIVE/PENDING/EXPIRED MEDICATIONS|

Medication Reconciliation:
I have reviewed this list of medications with the Patient and medication
reconciliation was performed and believe this list is accurate and includes all
medications (VA, Non-VA, over-the-counter if any) that the patient is taking as
an outpatient.

================================================================================
Allergies

|ALLERGIES/ADR|

================================================================================
Social History
Lives with

Tobacco:
Alcohol:
Drugs:
================================================================================
Family History
 Father:
 Mother:
 Brother:
 Sister:
 Children:

- OR -
Non-contributory

================================================================================
Physical Exam

Vitals:
BP:|BLOOD PRESSURE|
P:|PULSE|
T:|TEMPERATURE|
RR: |RESPIRATION|
OXYGEN SAT: |PULSEOX|
WT:|PATIENT WEIGHT|
BMI: |BMI|

Exam:
General: Awake, alert, cooperative, NAD. Resting comfortably in bed
 -or- Intubated and sedated.
HEENT: NC/AT, EOMI, MMM no erythema or exudates
Neck: supple, trachea midline, no palpable adenopathy
Cardiac: Normal Rate, Regular Rhythm, S1/S2 normal, no M/R/G
Pulm: Non-labored breaths, clear breath sounds bilaterally, no wheezes or rales
Abd: +BS. Soft, NTTP, no rigidity or guarding
Derm: no rashes, skin is warm
Extremities: No edema, clubbing, or cyanosis. 2+ symmetric radial and DP pulses
Neuro: Awake, alert, oriented x 4 (person, place, time, situation)
Speech intact, no slurring, no aphasia, no involuntary movements or tremors
no facial drooping, moves all extremities against gravity

***Cranial nerves:
        II - Grossly intact vision
```

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```
        III, IV, VI - EOMI, PERRL
        V - Sensation intact bilaterally along V1, V2, and V3 to touch &
            temperature
        VII - No focal deficits, no facial droop, eyelids close bilaterally.
        VIII - Grossly intact bilaterally
        IX/X - Uvula midline, palate elevates symmetrically
        XI - SCM and Trap 5/5 bilaterally
        XII - Tongue midline, mobile symmetrically

***Reflexes:

***Coordination:
       - Finger to nose intact bilaterally
       - Heel to shin intact bilaterally
       - No dysdiadochokinesia
       -*** No bradykinesia noted with finger tapping or foot stomping.
       -*** Arm rolling and finger rolling intact without satelliting

  - OR -

       - ***Deferred due to current patient condition

================================================================================
Labs/Imaging:  Reviewed
|CBC (WBC/HGB/HCT/PLT)|

|COMPREHENSIVE METABOLIC PANEL|
|MAGNESIUM|
PHOS |PHOSPHORUS|

|LABS LAST 24HRS|

Microbiology:
  Blood Cx -
  Urine Cx -
  Sputum Cx -
  Sputum Gm stain -

================================================================================
Vent:
SIMV/AC/BILEVEL/PC
SetRR:     Vt:  FiO2:     PEEP:      P/F:

|ABG|
================================================================================
Radiology - Reviewed


================================================================================
EKGs
 Date:
 -
 - HR  / PR  / QRS  / QT/QTc
================================================================
Assessment/Plan:

|PATIENT NAME| is a |PATIENT AGE| y o M/F who presented with *** and was admitted for ***

Neurological
------------
#

Cardiovascular
--------------
#

Pulmonary
----------
#

Gastrointestinal
```

Disclaimer: This information was accurate at the time of publishing. Please make changes that occur with system updates for the benefit of future users. Feel free to add any additional information that you think would be useful. Thank you! ***Last updated 06/25/18***

```
----------------
#

Endocrine
-----------
#

Renal/GU
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#

Infectious Disease
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#

Hematology/Oncology
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#

Fluids, Electrolytes & Nutrition
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#

Dermatologic
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#

Psychosocial
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#

Code Status: Full Code; DNI/DNR


ICU Checklist
Diet:
Lines/Tubes (when placed)
Antibiotics (day# of #)
Infusions
GI Prophylaxis
DVT Prophylaxis
Family Update
Sedation/SBT


Staff: Dr.

Kurren Desai, MD PGY-1

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Disclaimer: This information was mostly accurate at the time of publishing. Please make changes that occur with system updates for the benefit of future users. Feel free to add any additional information that you think would be useful. Thank you! ***Last updated 06/25/18***