

<p>Referring Physician _____ PCP</p> <p>Reason for consult _____</p> <p>History of Present Illness <input type="checkbox"/> Patient is Nonverbal. History obtained from _____</p>	<p>Allergies</p> <p><input type="checkbox"/> Allergies reviewed</p> <p><input type="checkbox"/> No drug allergies</p> <p><input type="checkbox"/> No food allergies</p>
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<p>Review of Systems</p> <p>See HPI WNL</p> <p><input type="checkbox"/> <input type="checkbox"/> Constitutional Fatigue, malaise, fever/chills, weight loss, change in appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Eyes Vision changes, New pain, photophobia</p> <p><input type="checkbox"/> <input type="checkbox"/> ENT/mouth Nose bleeds, dental caries, dental abscesses</p> <p><input type="checkbox"/> <input type="checkbox"/> Resp Dyspnea, Cough, Phlegm, Hemoptysis, Wheeze,</p> <p><input type="checkbox"/> <input type="checkbox"/> CV Chest pain, diaphoresis, ankle edema, PND, syncope</p> <p><input type="checkbox"/> <input type="checkbox"/> GI Emesis, dysphagia, GERD, abdominal pain, diarrhea, melena</p> <p><input type="checkbox"/> <input type="checkbox"/> GU Change in urinary habits, hematuria, dysuria</p> <p><input type="checkbox"/> <input type="checkbox"/> Musc Myalgias, recent trauma, bony fractures</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin/breasts Rashes, nonhealing areas, new masses</p> <p><input type="checkbox"/> <input type="checkbox"/> Neuro New paresthesias, gait abnormalities, seizures, muscle weakness</p> <p><input type="checkbox"/> <input type="checkbox"/> Endo Hair loss, polydipsia</p> <p><input type="checkbox"/> <input type="checkbox"/> Heme/lymph Bleeding gums, unusual bruising, swollen lymph nodes</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergy/immun Sinus probs, recurrent infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Psych Mood changes, agitation, psychosis, delirium, dementia</p>	<p>Medications</p> <p><input type="checkbox"/> Medications reviewed</p> <p><input type="checkbox"/> Changes as follows</p>
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<p>Past Medical and Social History</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Malignancy</td> <td><input type="checkbox"/> Prior Intubations</td> <td><input type="checkbox"/> Colonoscopy</td> </tr> <tr> <td><input type="checkbox"/> Cerebral Vascular Disease</td> <td><input type="checkbox"/> Neuromuscular weakness</td> <td><input type="checkbox"/> Steroid use</td> <td><input type="checkbox"/> Mammogram</td> </tr> <tr> <td><input type="checkbox"/> Congestive Heart Failure</td> <td><input type="checkbox"/> Pancreatitis</td> <td><input type="checkbox"/> Chemotherapy</td> <td><input type="checkbox"/> PapSmear</td> </tr> <tr> <td><input type="checkbox"/> COPD</td> <td><input type="checkbox"/> Peripheral Artery Disease</td> <td><input type="checkbox"/> Radiation exposure</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Coronary Artery Disease</td> <td><input type="checkbox"/> Renal Dysfunction</td> <td><input 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Exam	<input type="checkbox"/> Checked box indicates findings are within normal limits
T	*General <input type="checkbox"/> Alert
P	*ENT <input type="checkbox"/> Nasal mucosa <input type="checkbox"/> Dentition <input type="checkbox"/> Oropharynx Mallampati I II III IV
R	*Neck <input type="checkbox"/> Normal to palpation <input type="checkbox"/> Thyroid <input type="checkbox"/> No JVD
BP	*Resp <input type="checkbox"/> Clear to auscultation <input type="checkbox"/> Clear to percussion <input type="checkbox"/> No respiratory distress <input type="checkbox"/> No chest wall defects
Wt	*CV <input type="checkbox"/> Clear S1 S2 <input type="checkbox"/> No murmur <input type="checkbox"/> No gallop <input type="checkbox"/> No rub <input type="checkbox"/> Periph pulses <input type="checkbox"/> No peripheral edema
Sats	*GI <input type="checkbox"/> No palpable masses <input type="checkbox"/> No hepatosplenomegaly <input type="checkbox"/> No hepatjugular reflux
	Lymph <input type="checkbox"/> No lymphadenopathy
	Musc <input type="checkbox"/> Tone <input type="checkbox"/> Gait
	Extrem <input type="checkbox"/> No clubbing <input type="checkbox"/> No cyanosis
	Skin <input type="checkbox"/> No rashes, ecchymoses, nodules, ulcers
	Neuro <input type="checkbox"/> Oriented <input type="checkbox"/> Affect

Labs/Tests **Impression/Plan**

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This pt may benefit from

- Pulmonary Function Test
- Chest CT
- ECHO
- CXR
- Cardiopulmonary Stress Test
- Pneumococcal vaccine
- Influenza vaccine
- PPD Testing
- Sputum cultures
- Pulmonary Rehabilitation
- Smoking cessation aids
- Labs
 - Serum ACE level

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Signature/Date:

CODE STATUS: Full code Do Not Attempt Resuscitation

Data Reviewed: ER Notes Old Chart Nursing Notes & Vitals log Labs Radiology data ECHO ECG Stress Test PFT Diabetic log

Coordination of care: Discuss w/ER MD Discuss w/HCPOA Discuss w/PCP Case Mgmt or SW Pharmacy Nutrition team Physical therapy Respiratory therapy Nursing