

*** Final Report *****DATE/TIME NOTE CREATED:**

08/25/2023 18:30:37

DATE/TIME PATIENT SEEN:**Time seen:** No qualifying data**History was from obtained independent historian:** Patient

Patient arrived via: Private Vehicle

History Limited due to: None

CHIEF COMPLAINT:

vag itching and discharge, bleeding. Recent std tx

HISTORY OF PRESENT ILLNESS:

27 y/o female presents to the ED wanting the results of her STD tests. Pt reports being here in the ED but unsure of when and wasn't given the results. She believes her sexual partner knew he was carrying but didn't tell her.

REVIEW OF SYSTEMS:**Constitutional symptoms:** no fever, no chills.**Skin symptoms:** no rash.**Eye symptoms:** no discharge.**ENMT symptoms:** no nasal congestion.**Respiratory symptoms:** no shortness of breath.**Cardiovascular symptoms:** no chest pain.**Gastrointestinal symptoms:** no nausea, no vomiting.**Genitourinary symptoms:** no dysuria, no hematuria.**Musculoskeletal symptoms:** Reports: no trauma.**Neurologic symptoms:** no altered level of consciousness.

Additional review of systems information: Positive or negative as noted in HPI and ROS, otherwise reviewed and negative or not pertinent.

PHYSICAL EXAM:**VITAL SIGNS:**

| Vital Signs: | Last Charted: | |
|-------------------------------|----------------------|---------------|
| Temperature Temporal | 36.6 degC | (08/25 18:15) |
| Heart Rate | 88 bpm | (08/25 18:15) |
| Respiratory Rate | 18 breaths/min | (08/25 18:15) |
| Systolic BP | 112 mmHg | (08/25 18:15) |
| Diastolic BP | 62 mmHg | (08/25 18:15) |
| Mean Arterial Pressure | 79 mmHg | (08/25 18:15) |
| SpO2/Pulse Oximetry | 99 % | (08/25 18:15) |
| Dosing BMI | 31 | (08/25 18:15) |

SpO2 Interpretation: Normal on Room Air.

General: Alert, no acute distress.

Skin: Warm, dry.

Head: Normocephalic, atraumatic.

Neck: Supple, trachea midline, no tenderness.

Eye: Normal conjunctiva, normal sclera.

Ears, nose, mouth and throat: Normal oral mucosa, moist mucous membranes, External ear: Bilateral, normal, Nose: Bilateral nares, normal.

Cardiovascular: Regular rate and rhythm, No murmur, No edema, no gallop, No cardiac rub, , Arterial pulses: Bilateral, dorsalis pedis, 2+.

PROBLEM LIST/PAST MEDICAL HISTORY:**Ongoing**

Bipolar 1 disorder (Patient Stated)

Historical

No qualifying data

SOCIAL HISTORY:**Home/Environment**

Human Trafficking Red Flags None.

Substance Abuse

Use: Denies use.

Tobacco

Tobacco Use: Never smoker.

MEDICATIONS ORDERED:

No qualifying data available

MEDICATIONS ADMINISTERED:**Given**

Rocephin, 1 g, IntraMuscular

Zithromax, 1000 mg, Oral

HOME MEDICATIONS:**Unchanged**

brompheniramine/dextromethorphan/PSE (Bromfed DM oral syrup) 10 milliliter(s) Oral Three times a day. Refills: 0.

brompheniramine/dextromethorphan/PSE (Bromfed DM oral syrup) 10 milliliter(s) Oral Three times a day as needed Cough. Refills: 0.

brompheniramine/dextromethorphan/PSE (Bromfed DM oral syrup) 10 milliliter(s) Oral Three times a day. Refills: 0.

brompheniramine/dextromethorphan/PSE (Bromfed DM oral syrup) 10 milliliter(s) Oral Three times a day. Refills: 0.

docusate (Dulcolax Stool Softener 100 mg oral capsule) 1 capsule(s) Oral Twice daily as needed for constipation for 30 day(s). Refills: 0.

fluticasone nasal (Flonase 0.05 mg/inh nasal spray) 1 spray(s) Nasal Twice daily. Refills: 0.

fluticasone nasal (Flonase 0.05 mg/inh nasal spray) 1 spray(s) Nasal Twice daily. Refills: 0.

ibuprofen (ibuprofen 600 mg oral tablet) 1 tablet(s) Oral Every 8 hours scheduled. Refills: 0.

lidocaine topical (Lidocaine Viscous 2% mucous membrane solution) 1 application (s) Topical Four times daily as needed for mouth sore pain. Refills: 0.

* Final Report *

Respiratory: Respirations: Regular, Breath sounds: clear throughout, no crackles present, no rales present, no rhonchi present, no wheezes present.

Chest wall: No tenderness, No deformity.

Back: Nontender, Normal range of motion, No CVA tenderness.

Musculoskeletal: Normal ROM, normal strength, no tenderness, no swelling.

Gastrointestinal: Soft, Nontender, No guarding, No rebound, Non distended, Normal bowel sounds.

Lymphatics: No lymphadenopathy.

Neurological: Alert and oriented to person, place, time, and situation, normal motor observed.

Psychiatric: Cooperative, appropriate mood & affect.

MEDICAL DECISION MAKING:

This is a 27 y/o female here with for her STD results. Pt is in no acute distress and is in stable condition. Alternate history obtained from an independent historian: n/a.

- Illnesses evaluated and complexity (list with severity)**

Acute: STD results

Chronic: n/a

- Plan:**

1. Labs: none

2. Radiology: none

3. Medications: Rocephin, Zithromax

- Documents Reviewed:** Nurses notes: The history from nurses notes was reviewed and I agree with what is documented.

- Review of external records performed:** None were available for review

- Social determinants of health:** None were identified

- Decision to de-escalate care and discharge to previous living arrangement was made d/t:** stable acute.

Rationale: Discharge**REEXAMINATION/REEVALUATION:**

08/25/2023 18:44:07

Reassessment at the time of disposition demonstrates that the pt is in no acute distress. Patient has remained hemodynamically stable throughout the entire ED visit and is without objective evidence for acute process requiring urgent intervention or hospitalization. The pt is stable for discharge, counseling is provided as documented below, discussed symptomatic treatment and specific conditions for return. Agrees with course of tx and need for out pt f/u if symptoms continue. Pt is VSS and ready to be d/c home.

| Date Time | Vital Sign(s) | Result(s) |
|-------------------|----------------------|----------------|
| 08/25/23 18:15:00 | Temperature Temporal | 36.6 degC |
| MDT | Heart Rate | 88 bpm |
| | Respiratory Rate | 18 breaths/min |
| | Systolic BP | 112 mmHg |

magic mouthwash (Magic Mouthwash oral suspension) 10 mL Swish and Spit QID 1:1:1 visous lidocaine, Maalox, Benadryl. Refills: 0.

naproxen (Naprosyn 500 mg oral tablet) 1 tablet(s) Oral Twice daily. Refills: 0.

ondansetron (Zofran 4 mg oral tablet) 1 tablet(s) Oral Every 6 hours scheduled as needed Nausea and/or Vomiting. Refills: 0.

ondansetron (Zofran 4 mg oral tablet) 1 tablet(s) Oral Every 6 hours scheduled as needed Nausea and/or Vomiting for 2 day(s). Refills: 0.

oxymetazoline nasal (Afrin Nasal Sinus 0.05% spray) 2 spray(s) Nasal Twice daily. Refills: 0.

oxymetazoline nasal (Afrin Nasal Sinus 0.05% spray) 2 spray(s) Nasal Twice daily. Refills: 0.

oxymetazoline nasal (Afrin Nasal Sinus 0.05% spray) 2 spray(s) Nasal Twice daily. Refills: 0.

phenol topical (Chloraseptic Citrus 1.4% topical spray) 5 spray Oral. Refills: 0.

ALLERGIES:

Afrin

RADIOLOGY/DIAGNOSTIC RESULTS:**Radiology - Last 36 hours (0)**

No results in past 36 hours

Diagnostics - Non-Radiology - Last 36 hours (0)

No results in past 36 hours

* Final Report *

| | |
|------------------------|---------|
| Diastolic BP | 62 mmHg |
| Mean Arterial Pressure | 79 mmHg |
| SpO2/Pulse Oximetry | 99 % |
| Dosing BMI | 31 |

IMPRESSION/PLAN:

Acute lower UTI (urinary tract infection) N39.0

Chlamydia infection A74.9

Trichomoniasis A59.9

Orders:

Decision to Discharge

Decision to Discharge

Primary Assessment

Screenings/History Adults

Triage Part 1

Triage Part 2

DISPOSITION:

Patient condition: Stable

Disposition:

Discharge Home at _19:00

Counseled:

Patient was counseled regarding diagnostics, treatment plan, diagnosis and prescriptions. Patient understood.

PATIENT EDUCATION:

Urinary Tract Infection, Adult, Easy-to-Read

Trichomoniasis

Chlamydia, Female

FOLLOW UP:

| With | When | Contact Information |
|--------------------------|-----------------|--|
| ANNA JEZARI | Within 3-5 days | 1300 MURCHISON STE 100 EL PASO, TX 79902- (915) 577-9090 Busine ss (1) |
| Additional Instructions: | | |

ATTESTATION:

By signing my name below, I, Idalia Reyes, attest that this documentation has been prepared under the direction and in the presence of Dr. Kenneth Berumen, EDMD Electronically Signed: Idalia Reyes, Scribe **08/25/2023**

I, Kenneth Berumen, personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and discharge instructions and agree that the record reflects my personal performance and is accurate and complete. Kenneth Berumen, MD

Signature Line

* Final Report *

Electronically Signed On 08.25.23 19:31 MDT

Reyes, Idalia

Electronically Signed On 08/26/23 08:08 MDT

BERUMEN M.D., KENNETH A

Completed Action List:

- * Perform by Reyes, Idalia on August 25, 2023 18:31 MDT
- * Modify by Reyes, Idalia on August 25, 2023 18:36 MDT
- * Modify by Reyes, Idalia on August 25, 2023 18:44 MDT
- * Modify by Reyes, Idalia on August 25, 2023 19:31 MDT
- * Sign by Reyes, Idalia on August 25, 2023 19:31 MDT Requested by Reyes, Idalia on August 25, 2023 18:31 MDT
- * Modify by BERUMEN M.D., KENNETH A on August 26, 2023 08:08 MDT
- * Sign by BERUMEN M.D., KENNETH A on August 26, 2023 08:08 MDT Requested by Reyes, Idalia on August 25, 2023 19:31 MDT
- * VERIFY by BERUMEN M.D., KENNETH A on August 26, 2023 08:08 MDT

Result type: ED Note-Physician
Result date: August 25, 2023 19:30 CDT
Result status: Auth (Verified)
Result title: STD exposure
Performed by: Reyes, Idalia on August 25, 2023 18:31 MDT
Verified by: BERUMEN M.D., KENNETH A on August 26, 2023 08:08 MDT
Encounter info: 027162223, SIE, 3 - Emergency, 08/25/2023 - 08/25/2023