Heidi Consultation Template & Flokzu Results

Suggested Heidi Template

Explanation

Combination of Dr Wever "Consultation Note Short" and Dr Hardcastle "Orthopedic Surgical Consult - Hip and Knee" (no equivalent found for Dr Groenewald)

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## Referral Context
- [describe the reason for referral including site of symptoms, duration,
injury mechanism, or progressive joint disease]
- [mention referring clinician or service and any specific clinical questions
posed]

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## History of Presenting Complaint
- **Main Complaint:** Pain, deformity, instability, swelling, weakness,
stiffness, numbness
- **Onset & Mechanism:** Trauma, overuse, insidious onset
- **Date of Injury:** [Leave out if not mentioned]
- **Pain:**
  - Location:
  - Severity (VAS 0–10):
  - Aggravating factors:
  - Relieving factors:
- **Instability:** Giving way, frequency, activity-related
- **Functional Limitations:**
- **Previous Treatment:** NSAIDs, physiotherapy, injections, prior surgery

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## Past Medical and Surgical History
- [record previous musculoskeletal issues, joint replacements, trauma,
infections, and systemic comorbidities relevant to surgical risk]

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## Medications and Allergies
- **Prescribed Medications:**
- **Anticoagulants/Analgesics/Supplements:**
- **Known Allergies:**
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## Family and Social History
- **Family History:** Arthritis, connective tissue disease, prosthetic
complications
- **Occupation:** [Leave out if not mentioned]
- **Activities:** (include any sporting or leisure activities that the patient
enjoys doing) [leave out if not mentioned]
- **Mobility Status & Support Systems:**
- **Expectations:** [Leave out if not mentioned]

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## Clinical Examination
(Include everything mentioned during the examination in the correct order:
inspection → palpation → range of motion → special tests)

- **Inspection:**
- **Palpation:**
- **Range of Motion:**
  - Active:
  - Passive:
- **Joint Stability:**
- **Leg Length Discrepancy:**
- **Gait Assessment:**
- **Neurovascular Status:**
- **Special Tests:**

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## Imaging and Investigations
- **Radiographs/MRI/CT/Ultrasound:**
  - [summarize available imaging; include findings such as osteoarthritis
severity, fractures, avascular necrosis]
- **Laboratory Results:**
  - [include relevant lab results, inflammatory markers, infection screens if
available]

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## Clinical Impression
- **Provisional Diagnosis:**
  - •
  - •
- **Differential Considerations:**
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## Management Plan
### TREATMENT PLAN
**Conservative** *(only if surgery not done; mention if conservative treatment
has been exhausted)*:
- Physiotherapy
- Orthotics
- NSAIDs
- Injections

**Interventional** *(if indicated)*:
- Surgery: [specify procedure if discussed]

1. **Proposed Next Steps:**
   - Further imaging
   - Conservative management
   - Surgical consideration
   - Multidisciplinary referral

2. **Patient Discussion:**
   - [record any discussions held with the patient regarding diagnosis,
prognosis, or treatment options]

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*Note: All fields must be completed using only explicitly mentioned
information from the transcript, contextual notes, or clinical note. Omit any
section or bullet point entirely if no relevant information is provided.*
```

Exemplar Results (Notes) in Heidi

Explanation
I created a template in each doctors Heidi called "Consultation - Temp" (with format as in Suggested Heidi Template) and used that to generate the following

from Dr Hardcastle

J Vrey - 6408145010087
11-09-2025

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## Referral Context
Presents with a ten-year history of intermittent, progressively worsening
medial knee pain, which has become constant and severe following a recent long
walk.
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Self-referred for assessment and management, bringing recent knee radiographs.

History of Presenting Complaint
Main Complaint: Pain, stiffness
Onset & Mechanism: Insidious onset approximately ten years ago, with episodes typically occurring annually during winter. The current episode is the most severe and was acutely exacerbated after a prolonged walk. Reports no specific memorable injury but was a rugby player for many years.
Date of Injury:
Pain:
- Location: Medial aspect of the knee.
- Severity (VAS 0–10): Described as excruciating, sufficient to interfere with sleep, requiring a sleeping pill on occasion.
- Aggravating factors: Sitting for prolonged periods (e.g., in a car) leading to stiffness, going down stairs, walking on uneven ground, and deep flexion. The pain can be sharp and knife-like, appearing and disappearing suddenly.
- Relieving factors: Rest initially helped in previous years. Anti-inflammatory medication is no longer effective. Wearing a knee guard provides some relief.
Instability: Reports a feeling that the knee "wants to go" but denies true giving way.
Functional Limitations: Has stopped his regular exercise of walking 5 km four times a week for the past month. Pain interferes with sleep.
Previous Treatment: Has used anti-inflammatory medications, which are no longer effective. Has tried multiple knee guards.

Past Medical and Surgical History
Hypertension, well-controlled with medication.
Experienced transient hypoglycaemic episodes for approximately one year after a COVID-19 infection, which have since resolved.
Previous surgery: Vasectomy.
Past history of playing rugby for many years.

Medications and Allergies
Prescribed Medications: A medication for hypertension.
Anticoagulants/Analgesics/Supplements: Has used anti-inflammatory medications and sleeping pills for the pain.

Known Allergies: None reported.

Family and Social History
Family History:
Activities: Enjoys walking approximately 5 km four times a week.
Mobility Status & Support Systems: Fully mobile, lives with his wife. Is travelling to Venice in one month for his 30th wedding anniversary.
Expectations: Seeks pain relief, particularly in view of his upcoming international travel.

Clinical Examination
Inspection: Small joint effusion noted.
Palpation: Tenderness elicited along the medial joint line. No obvious palpable plica. No pain on patellofemoral compression.
Range of Motion:
- Active:
- Passive: Pain with deep flexion.
Joint Stability: Appears stable.
Leg Length Discrepancy:
Gait Assessment:
Neurovascular Status:
Special Tests:

Imaging and Investigations
Radiographs/MRI/CT/Ultrasound:
- Radiographs of the knee were reviewed. They demonstrate well-preserved joint space with no evidence of significant bone-on-bone osteoarthritis.

Clinical Impression
Provisional Diagnosis:
- • Medial meniscal tear.
Differential Considerations: Medial plica syndrome.

```
## Management Plan
### TREATMENT PLAN
**Interventional** _(if indicated)_:
Surgery: Arthroscopy was discussed as a diagnostic and therapeutic option to
trim a torn meniscus.

1. **Proposed Next Steps:**
- Intra-articular corticosteroid injection performed today to manage
inflammation and symptoms.
- Advised to wear a knee guard for compression to minimise swelling.
- An MRI scan was discussed as an alternative to diagnostic arthroscopy to
confirm the diagnosis non-invasively.
- To provide feedback on his condition on Monday to reassess.

2. **Patient Discussion:**
- Discussed the likely diagnosis of a degenerative medial meniscal tear.
Explained that as the meniscus ages, it can tear without significant trauma,
and his history is typical of this.
- The two primary diagnostic options, MRI versus diagnostic arthroscopy, were
outlined. The benefits of arthroscopy for definitive diagnosis and
simultaneous treatment were explained.
- The risks associated with surgery were discussed, particularly the risk of a
deep vein thrombosis with flying soon after a procedure. The need for blood
thinners and compression stockings if surgery were to proceed before his trip
was mentioned.
- The option of a corticosteroid injection was discussed as a temporising
measure for pain relief ahead of his anniversary trip. It was explained that
the injection is unpredictable and treats the secondary inflammation
(swelling) rather than the underlying mechanical problem of the meniscal tear,
likening it to treating a stone in a shoe by adding an insole.
- Potential side effects of the corticosteroid injection were discussed,
including hot flushes, palpitations, and transient sleep disturbance.
- Decided to proceed with an intra-articular corticosteroid injection today.
Advised to resume walking within limits and monitor his symptoms.
- He will follow up by telephone on Monday, 10/11/2025, to report his
progress. The possibility of a repeat injection closer to his travel date was
discussed, but this would be an exception to standard practice.
```

from Dr Wever

Annarie Fitzgerald - 7210260083082
15-09-2025

Referral Context
- Referred by Dr Japie de Wet for assessment of a right ankle injury sustained in June 2025. Presents with persistent pain, swelling, and numbness despite initial conservative management.
- Initial X-rays suggested a possible ligament tear and a small fracture.

History of Presenting Complaint
- **Main Complaint:** Swelling and numbness in the right foot; multiple sites of pain and pressure sensitivity.
- **Onset & Mechanism:** Twisting injury to the right ankle in June 2025. Symptoms have become progressively worse.
- **Pain:**
- Location: Variable pain in the right foot, including the medial arch, which radiates proximally. Pain is not described as unbearable.
- Severity (VAS 0–10): Low grade; rarely requires analgesia.
- Aggravating factors: Prolonged walking, wearing shoes. Plantarflexion at night causes discomfort.
- Relieving factors: Removing footwear. Sleeping with a splint.
- **Instability:** No specific ankle instability reported, but a history of patellar instability exists.
- **Functional Limitations:** Activity is limited. Difficulty driving long distances due to foot discomfort.
- **Previous Treatment:** Moon boot with crutches (50% weight-bearing) for six weeks. No physiotherapy. A cortisone injection was considered but not administered.

Past Medical and Surgical History
- Previous ankle injury one year prior (untreated).
- Recurrent patellar dislocations (3–4 episodes).
- Previous thumb fracture. History of golfer's elbow and a dislocated elbow.
- Hysterectomy (2015).

Medications and Allergies
- **Prescribed Medications:** Seda 50.
- **Anticoagulants/Analgesics/Supplements:** Infrequent use of analgesia.
- **Known Allergies:** No known allergies to antibiotics.

Family and Social History
- **Family History:** Mother has Multiple Sclerosis.
- **Occupation:** Estate Agent.
- **Mobility Status & Support Systems:** Passively mobile due to pain.

Clinical Examination
- **Inspection:**
- Bilateral puffy swelling over the peroneal tendons.
- Right foot arch appears slightly collapsed compared to the left.
- Left second toe crossover.
- No significant misalignment of the hindfoot.
- Lipoma-like soft tissue swelling over the anterolateral aspect of both ankles, larger on the right.
- **Palpation:**
- Right Foot: Tenderness over the medial arch and superficial peroneal nerve tract.
- Left Foot: Tenderness over the tibialis posterior tendon insertion and metatarsal heads.
- **Range of Motion:**
- Active: Good ankle dorsiflexion bilaterally, not limited by calf tightness.
- Passive:
- **Joint Stability:**
- Right Ankle: Anterior drawer test causes pain but no gross instability. Ligaments feel intact.
- Left Ankle: Appears slightly more lax on anterior drawer testing than the right, but not unstable.
- Generalised hypermobility noted (thumb touches forearm, elbow and knee hyperextension, history of patellar instability).
- **Gait Assessment:** Not performed.
- **Neurovascular Status:**
- Good distal pulses.
- Numbness reported in the right 3rd and 4th toes.
- Sensation of pins and needles over the dorsum of the right foot, consistent with a superficial peroneal nerve traction injury. Positive Tinel's sign over the superficial peroneal nerve.
- Mild numbness reported in the left toes.
- **Special Tests:**
- Positive Mulder's click test bilaterally, suggesting possible Morton's neuroma in the 3rd webspace of both feet.
- Negative grind test of the first MTPJ.

Imaging and Investigations
- **Radiographs/MRI/CT/Ultrasound:**
- **MRI Right Ankle (_date not specified, approx. 3–4 weeks ago_):**
- Moderate ankle joint effusion.
- No significant chondral lesion or arthritis.
- Peroneal tendons appear intact with minimal fluid in the sheath.
- Tibialis posterior tendon is normal.
- ATFL appears thickened but healed.
- Segmental peroneus longus tenosynovitis at the level of the cuboid.
- Reported large dorsal ganglion cyst.
- **Ultrasound (_from referral letter_):**
- Fluid in the peroneus longus and brevis tendon sheaths, confirming tenosynovitis.
- Mild intra-articular effusion.
- **Laboratory Results:**
- **18/08/2025:**
- CRP: 3.1 (Normal)
- ESR: 10 (Normal)
- Serum Uric Acid: 0.27 (Normal)
- Rheumatoid Factor: Negative
- Anti-CCP: Negative

Clinical Impression
- **Provisional Diagnosis:**
- • Bilateral peroneal tenosynovitis, more prominent on the right.
- • Suspected bilateral 3rd webspace Morton's neuroma.
- • Right superficial peroneal nerve traction neuropraxia.
- • Generalised hypermobility.
- • Multiple tender points, suggestive of an underlying systemic inflammatory condition or fibromyalgia.
- **Differential Considerations:**
- Seronegative inflammatory arthropathy.
- Fibromyalgia.

Management Plan
TREATMENT PLAN

Interventional:
- Surgery: Not indicated at this stage.

1. **Proposed Next Steps:**
- **Further imaging:** Ultrasound-guided corticosteroid injection into the peroneal tendon sheaths bilaterally to manage tenosynovitis. Will be performed today.
- **Conservative management:**
- Commence Lyrica for neuropathic pain (neuromas and superficial peroneal nerve).
- Commence Vitamin D supplementation.
- Referral to physiotherapy for ankle rehabilitation and desensitisation therapy for the superficial peroneal nerve.
- Referral for custom-moulded orthotics to improve foot mechanics.
- **Multidisciplinary referral:**
- Urgent blood tests: ANA and HLA-B27.
- Referral to a rheumatologist (Dr Francois Bouwer) for investigation of a possible systemic inflammatory condition. Patient placed on the cancellation list.

2. **Patient Discussion:**
- Discussed the multifactorial nature of the symptoms, with no single anatomical cause identified.
- Explained that the bilateral nature of the symptoms suggests a systemic cause, warranting rheumatological review.
- Discussed the rationale for cortisone injections for the tenosynovitis. Counselled on the minimal risks of tendon degeneration with a limited number of injections. Patient concerned about cost and will discuss injecting the left side with the radiologist.
- Explained the role of Lyrica as a neuromodulator for nerve-related pain and the rationale for physiotherapy and orthotics.
- Advised that surgery is not currently indicated.
- Reassured that continued use of a splint at night for comfort is acceptable.
- Advised a baseline bone density scan from age 55.
- A summary letter will be provided.

ADDENDUM: 16/09/2025

ULTRASOUND-GUIDED INJECTION - RIGHT ANKLE
Thank you for the referral of Annarie Fitzgerald for an ultrasound-guided injection of the peroneal tendon sheath.

Findings:
Ultrasound of the right ankle revealed thickening of the attachment of the

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lateral talar calcaneal fibular ligament complex and a small amount of fluid
within the peroneal tendon sheath.
Ultrasound of the left ankle did not reveal any ligamentous injuries or
peroneal tenosynovitis. There is an incidental ganglion cyst at the anterior
lateral margin of the left talonavicular joint.
No previous imaging was available for comparison.

**Procedure:**
The procedure was explained, and following sterile technique, a combination of
Naropin and cortisone was injected into the right peroneal tendon sheath and
adjacent to the anterior lateral gutter under ultrasound guidance.
After discussion, the patient opted not to have an injection on the left side.
There were no immediate post-procedure complications. The long-term effect is
to be assessed clinically.

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ADDENDUM: 22/09/2025

**BLOOD TEST RESULTS**
- **ANA Screen:**
- ANA Titre (IIF): <1:80 (Negative)
- dsDNA (ELiA): <15 IU/mL (Negative)
- ENA Screen (SSA 52/60): Negative
- **Comment:** An ANA titre of <1:80 is clinically regarded as negative.
- **HLA-B27:** Negative
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from Dr Groenewald

J DE BOD - 7301055011089
11-09-2025

```
## Referral Context
- 52-year-old male presenting with right knee pain, intermittent stiffness,
and instability. Symptoms have worsened over the past two months following a
fall.

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## History of Presenting Complaint
- Main Complaint: Pain, stiffness, posterior fullness, and instability in the
right knee. Also reports right shoulder pain with certain movements.
- Onset & Mechanism: Insidious onset of symptoms, exacerbated by multiple
traumatic events. Worsened over the last two months since the most recent
fall.
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- Date of Injury: History of three falls onto the right knee: one in the early 1990s from a scooter, one last year, and a recent fall from stairs two months ago.
- Pain:
  - Location: Right knee, with intermittent sharp pain on certain movements. Right shoulder.
  - Severity (VAS 0–10):
  - Aggravating factors: Walking (posterior fullness), certain movements (sharp pain and instability).
  - Relieving factors:
- Instability: Reports a feeling of instability and the knee giving way with certain movements.
- Functional Limitations:
- Previous Treatment:

Past Medical and Surgical History
- Hypertension
- Dyslipidaemia
- Previous surgical removal of a parathyroid growth.
- Recurrent kidney stones, treated conservatively.

Medications and Allergies
- Prescribed Medications: On treatment for hypertension and dyslipidaemia.
- Anticoagulants/Analgesics/Supplements:
- Known Allergies: None.

Family and Social History
- Family History:
- Occupation: Works at KWV head office in Paarl.
- Activities: Reports being sedentary, enjoys cooking for his family, does not participate in sports, running, or walking for exercise.
- Mobility Status & Support Systems: Mobilises independently without assistive devices. Non-smoker, uses alcohol socially.
- Expectations:

Clinical Examination
- Inspection:
  - General: Adult male with an increased BMI.

  - Right Knee: No external wounds or injuries. Small effusion palpable.
  - Left Leg: Slight bruising and swelling over the anterior aspect of the tibia. No open wounds.
- Palpation:
  - Right Knee: Subtle posterior medial tenderness on the joint line.
  - Right Shoulder: No tenderness over the AC joint.
- Range of Motion:
  - Active:
    - Right Knee: 0 to 110 degrees.
    - Left Knee: 0 to 120 degrees.
    - Right Shoulder: Forward flexion 0–110, abduction 0–100, internal rotation to T9, external rotation 0–45 degrees.
  - Passive:
- Joint Stability:
  - Right Knee: PCL feels lax. ACL clinically intact with a positive end point after reduction of the tibia. LCL and MCL are clinically intact.
- Leg Length Discrepancy:
- Gait Assessment: Grossly normal gait pattern.
- Neurovascular Status:
  - Right Shoulder: Motor power 5/5 for supraspinatus, infraspinatus, subscapularis, and teres minor.
- Special Tests:
  - Right Knee: Positive posterior tibial sag, positive posterior drawer test, negative McMurray's test. No pain on deep flexion.
  - Right Shoulder: Positive Hawkins' test, positive Job's test, negative scarf test, negative Yergason's test.

Imaging and Investigations
- Radiographs/MRI/CT/Ultrasound:

- Laboratory Results:

Clinical Impression
- Provisional Diagnosis:
  - • Right knee isolated PCL injury.
  - • Right shoulder early impingement syndrome.
- Differential Considerations:
  - • Right knee concomitant meniscal injury or osteochondral defect.

Management Plan

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### TREATMENT PLAN
Conservative:
- Right Knee:
  - Physiotherapy: Directed programme for range of motion and strengthening, focusing on quadriceps and gastrocnemius-soleus complex.
- Right Shoulder:
  - NSAIDs: A two-week course of Celecoxib (Cox-2 inhibitor).

Interventional:

1. Proposed Next Steps:
   - Conservative management for both knee and shoulder.
   - Clinical re-evaluation in three months to assess progress.

2. Patient Discussion:
   - Discussed the nature of the knee and shoulder injuries. The plan for conservative management was explained. He understands and agrees with the proposed plan.
```

Exemplar Flokzu (Prompt) Result

Instruction
Please use the prompts you have generated to construct an example for each doctor of how each of the LLM summaries ([Patient Overview], [Referral Letter], [Consultation Summary] and [Update Letter]) will look based on their respective Exemplar Transcripts and using the Suggested Heidi Template as input

for Dr Harcastle

Patient Overview

Referral Letter

Consultation Summary

Update Letter

for Dr Wever

Patient Overview

Referral Letter

Consultation Summary

Update Letter

for Dr Groenewald

Patient Overview

Referral Letter

Consultation Summary

Update Letter

End of Document

Last Updated: 10 November 2025