Hiedi Pre-Op Consultation Template & Flokzu Results

Suggested Heidi Template

Explanation

Reworked (generalized) Dr Groenewald `Pre-Operative Evaluation - Hip and Knee Arthroplasty/Repair` (no equivalent found for Dr Wever or Groenewald)

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Planned Procedure and Indication:
- [document the proposed surgical intervention, side (right/left/bilateral if applicable), and clinical reasoning for operative decision including symptom severity, failed conservative care, or instability] (Only include if explicitly mentioned in transcript or context, else omit section entirely.)

Surgical History and Relevant Background:
- [detail past surgeries to the same or contralateral site, anesthesia complications, infections, hardware presence, or prior revisions] (Only include if explicitly mentioned in transcript or context, else omit section entirely.)

Medical Comorbidities and Risk Factors:
- [describe cardiovascular, respiratory, metabolic, renal, hematological, or other conditions relevant to surgical risk; include BMI, smoking status, diabetes, immunosuppression, or other pertinent factors] (Only include if explicitly mentioned in transcript or context, else omit section entirely.)

Medications and Allergies:
- [list current medications including anticoagulants, antiplatelets, analgesics, bisphosphonates, corticosteroids, or others relevant to perioperative management; note any allergies] (Only include if explicitly mentioned in transcript or context, else omit section entirely.)

Examination Summary:
- [include preoperative assessment of relevant anatomy, mobility, strength, alignment, deformity, effusion, or signs of inflammation] (Only include if explicitly mentioned in transcript or context, else omit section entirely.)

Investigations:
- [summarize lab results (CBC, coagulation, renal function, infection screen, or others), imaging (X-rays, CT, MRI, or modality-specific), and pre-op risk scoring (e.g. ASA classification or equivalent)] (Only include if explicitly
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mentioned in transcript or context, else omit section entirely.)

Perioperative Optimization Needs:
- [mention any referrals to anesthesia, cardiology, endocrinology,
physiotherapy, or other specialties; include weight management, smoking
cessation, glycemic control, or other optimization plans] (Only include if
explicitly mentioned in transcript or context, else omit section entirely.)

Consent Discussion:
- [record counselling on benefits, risks (e.g. infection, thromboembolism,
bleeding, nerve injury), alternatives, rehabilitation expectations, and shared
decision-making outcome] (Only include if explicitly mentioned in transcript
or context, else omit section entirely.)

Booking and Coordination: [outline surgical date, implant/equipment
requirements, prosthesis registration if applicable, thromboprophylaxis plan,
and communication with theater team or coordinators] (Only include if
explicitly mentioned in transcript or context, else omit section entirely.)

(Never come up with your own patient details, assessment, plan, interventions,
evaluation, and plan for continuing care - use only the transcript, contextual
notes or clinical note as a reference for the information include in your
note. If any information related to a placeholder has not been explicitly
mentioned in the transcript, contextual notes or clinical note, you must not
state the information has not been explicitly mentioned in your output, just
leave the relevant placeholder or omit the placeholder completely.) (Use as
many lines, paragraphs or bullet points, depending on the format, as needed to
capture all the relevant information from the transcript.)
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from Dr Hardcatsle

Anthony Garner 1953-04-08
03/11/2025

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Surgical History and Relevant Background:
Reports a history of a left total knee replacement performed approximately two
to three years ago at Vincent Pallotti Hospital, with a good outcome.
Underwent surgery for spinal stenosis approximately two to three months prior
to this consultation, which successfully resolved his back pain and allowed a
return to sporting activities.
A right knee meniscectomy was performed approximately 50 years ago, which was
an open procedure requiring a one-week hospital stay and a plaster cast.

Medical Comorbidities and Risk Factors:
Reports no significant medical comorbidities, specifically denying a history
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of hypertension or diabetes.
Highly active, participating in CrossFit three times per week, playing golf one to two times per week, and walking his dogs daily.

Medications and Allergies:
Takes two Panadol tablets prophylactically before playing golf to manage right knee pain. Otherwise, does not use analgesia regularly.
No known medical allergies.

Examination Summary:
An old surgical scar is noted on the right knee.
The left knee, which has undergone a total knee replacement, demonstrates a good range of motion from 0 to 110 degrees.
The right knee has a reduced range of motion, from approximately 20 degrees of flexion to 95–100 degrees of flexion, indicating a significant flexion contracture.
There is a slight rectal varus deformity of the right knee.
There is no patellofemoral pain on examination.
No significant joint effusion was noted in the right knee.
Dorsalis pedis pulse is good.
There is no significant Trendelenburg gait.
Reports no hip pain or discomfort on examination.
The limp is attributed to discomfort from the right knee and the fixed flexion deformity.

Investigations:
X-rays demonstrate grade 4, bone-on-bone osteoarthritis of the right knee.

Consent Discussion:
Discussed the findings and clinical picture. Explained that despite the advanced radiographic changes (grade 4 osteoarthritis), his current high level of function (CrossFit, golf, daily walks) and minimal impact on activities of daily living do not strongly indicate a need for surgical intervention at this time.
Advised that a total knee replacement is an option, but carries risks and a significant recovery period, which may not be justifiable given his current activity levels. The goal of surgery would be to improve symptoms, and at present, the symptoms are minimal. A replacement could potentially worsen his functional state.
It was highlighted that his pain is well-managed with occasional Panadol for golf, and his quality of life is not significantly compromised. The development of a limp is noted but is not, in itself, an indication for a knee replacement.
Counselled that he is better off with his native joint for as long as it remains functional. The strengthening from CrossFit is likely beneficial for providing stability and proprioceptive control.

Advised on the potential risks of regular Panadol use, including the need for kidney function monitoring and the risk of stomach ulcers if taken daily for extended periods.
Discussed the natural progression of arthritis and explained that he should monitor for worsening symptoms, such as increased pain frequency, pain that limits activities, or the need for more regular analgesia. These would be indicators to reconsider surgery.
It was agreed that the current management will be conservative.

Booking and Coordination:
A follow-up appointment in six months is recommended to reassess his symptoms and functional status.
It was agreed to defer any consideration of surgery until at least June of next year, after his planned family visit in December and a golf tour in May.

from Dr Wever

Rebecca Hugo
16/20/2025

Planned Procedure and Indication:
- Left ankle arthroscopy, syndesmosis stabilisation (TightRope procedure), lateral ligament repair/reconstruction (modified Brostrom) with internal brace augmentation, and medial head of gastrocnemius release.
- The indication is chronic left ankle instability with a suspected chronic syndesmotic injury, which has failed to respond to conservative measures. The aim is to restore stability, alleviate pain, and allow a return to normal activities and work.

Surgical History and Relevant Background:
- Reports multiple previous left ankle ligament tears (four times).
- Previous torn ligaments in the right ankle many years ago, but it is now stable.

Medical Comorbidities and Risk Factors:
- History of cervical cancer approximately 10 years ago, treated with oral chemotherapy agents. In remission, but follow-up is pending.
- History of skin cancer.
- Reports hyperflexibility/generalised ligamentous laxity.
- Occupation as a chef involves standing for extended periods (up to 18 hours per day).

Medications and Allergies:
- No current regular medications.
- Allergy to latex.

Examination Summary:
- Inspection: Mild swelling around the left ankle. A bony prominence is noted over the anterolateral aspect. Hindfoot alignment is neutral to slight valgus bilaterally. Normal arches are present.
- Palpation:
- Tenderness over the anterior aspect of the deltoid ligament on the medial side.
- Significant tenderness over the lateral ankle ligaments, specifically the anterior talofibular ligament (ATFL).
- Tenderness in the mid-substance of the Achilles tendon.
- Marked tenderness over the anterior inferior tibiofibular ligament (AITFL) and syndesmosis.
- Tenderness on the plantar aspect of the heel, centrally. Squeezing the heel is less tender.
- Range of Motion and Stability:
- Left ankle dorsiflexion is limited compared to the right, suggesting calf tightness (gastrocnemius contracture). This improves with knee flexion.
- Gross instability demonstrated on the anterior drawer test of the left ankle. The right ankle is stable.
- Pain is elicited with the fibular translation test and squeeze test, suggestive of a syndesmotic injury.
- Pain at the back of the ankle with forced dorsiflexion, and sharp pain in the front with the thumb pushing up, suggesting anterior ankle impingement.
- Strength and Neurovascular:
- Peroneal strength is graded as 4/5 but functionally weak.
- Good pulses are palpable.
- Sensation is intact and equal on the dorsum of both feet. No Tinel's sign over the superficial peroneal nerve. History of intermittent pins and needles over the dorsum of the foot and toes, which has improved with reduced activity.

Investigations:
- X-ray (Left Ankle, 11/11/2025): No fracture or dislocation visible. Joints appear congruent.
- MRI (Left Ankle):
- Evidence of a chronic syndesmotic injury with fluid tracking up into the syndesmosis. The AITFL is noted by the radiologist as normal, but clinical correlation suggests otherwise.
- Mild thickening and scarring of the ATFL, consistent with chronic injury.
- Increased signal in the deltoid ligament, suggestive of an injury.
- Mid-substance Achilles tendinosis with tendon thickening.
- Articular cartilage appears well-preserved with no significant chondral lesions.
- Some fluid is present in the ankle joint.

Consent Discussion:
- A detailed discussion was held regarding the diagnosis of chronic left ankle instability, syndesmotic injury, and gastrocnemius contracture.
- The proposed surgical plan, including arthroscopy, syndesmotic stabilisation, lateral ligament repair with internal brace augmentation, and gastrocnemius release, was explained.
- The expected benefits of surgery are to restore stability and reduce pain.
- The risks were discussed, including but not limited to infection (2-3%), bleeding, deep vein thrombosis (DVT, low risk but will consider prophylaxis with Ecotrin for two weeks post-operatively due to cancer history), nerve injury (superficial peroneal nerve numbness/irritability), persistent pain, complex regional pain syndrome (CRPS), and failure of the repair.
- It was explained that an internal brace would likely be used to augment the ligament repair due to generalised laxity and the chronicity of the injury, to reduce the risk of re-tear. The very low risk of a reaction to the synthetic material was mentioned.
- The post-operative recovery protocol was outlined in detail: two weeks non-weight-bearing in a cast, followed by weight-bearing as tolerated in a boot for up to six weeks with specific physiotherapy. A return to comfortable shoes is expected at 6-8 weeks, with a full recovery taking up to a year.
- It was clarified that returning to full work duties by December would be challenging.
- A shared decision was made to proceed with surgery.

Booking and Coordination:
- A provisional surgical date has been offered for next week Thursday or the following week (23/10/2025 or 30/10/2025), pending medical aid authorisation.
- The plan is for an overnight hospital stay for pain management.
- The secretary will assist with obtaining medical aid authorisation from Bestmed and will inform of any potential shortfalls.
- Required equipment will include an arthroscopy set, a TightRope system for the syndesmosis, and an internal brace for the lateral ligament augmentation.
- A formal consent form and summary letter will be emailed prior to the surgery.
- Post-operative thromboprophylaxis with Ecotrin for two weeks will be considered.
- Physiotherapy will commence post-operatively with a specific protocol.

ADDENDUM NOTE

Date: 28/10/2025
Patient: Rebecca Hugo (DOB: 02/01/1987)

Following telephonic communication with the patient, the following points have been noted for the upcoming theatre case and recovery period:

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**Allergies:**

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Reports a significant allergy to both latex and plaster glue.

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Request for non-latex gloves and equipment, and the use of micropore tape or
similar post-operatively.

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**Anaesthetic Considerations:**

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Has a history of rapid body temperature fluctuations (both drops and rises)
during post-operative recovery, which is dependent on the anaesthetic drugs
used. This is noted for monitoring purposes.
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from Dr Groenewald

Tomas Miller
01/09/2025

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Planned Procedure and Indication:
- Closed reduction +/- open reduction and percutaneous K-wire fixation of a
right distal ulna Salter-Harris type II growth plate injury.
- Closed reduction of the right distal radius fracture.
- Indicated due to displaced fractures with plastic deformation and growth
plate involvement, with a risk of malunion with non-operative management.

Surgical History and Relevant Background:
- No previous surgeries.

Medical Comorbidities and Risk Factors:
- No known medical comorbidities.

Medications and Allergies:
- No current medications.
- No known allergies.

Examination Summary:
- On 01/08/2025: Distal forearm deformity noted. Right hand and digits are
well-perfused with a capillary refill time of less than two seconds.
Spontaneous movement of fingers present. Neurologically intact with no
paraesthesia.
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Investigations:
- X-ray (01/08/2025): Right distal radius greenstick fracture with plastic deformation and a Salter-Harris type II fracture of the distal ulna involving the distal radioulnar joint.
- Post-operative X-ray (02/08/2025): Satisfactory reduction of both fractures. Two K-wires are in situ stabilising the distal ulna fracture.
- Follow-up X-ray (04/09/2025): Early bridging callus visible at the fracture site.

Consent Discussion:
- Discussed the procedure, benefits, risks (including malunion if not corrected surgically), and alternatives with the patient's father. Consent obtained for operative management. Patient to remain NPO prior to surgery.

Booking and Coordination:
- Booked for the emergency list on 01/08/2025 for closed reduction and K-wire fixation.
- Operation performed on 02/08/2025 at Vergelen Medical Clinic Hospital.
- Equipment: Basic orthopaedic tray and K-wire tray.
- Implants: Two 1.2mm K-wires.

- Surgical Note (02/08/2025):
- Under general anaesthesia and fluoroscopic guidance, closed reduction of the distal radius and ulna fractures was performed.
- A satisfactory reduction was achieved.
- Two 1.2mm K-wires were passed percutaneously from the distal ulna across the fracture site into the ulnar shaft.
- Wires were cut short, bent, and padded.
- A below-elbow circular cast was applied.

- Post-operative Plan:
- Neurovascular observations every hour for 12 hours, then four-hourly.
- Physiotherapy referral for active range of motion exercises of the digits.
- Discharged with analgesia.

- Progress Note (03/08/2025):
- Day 1 post-operative. Hand remains well-perfused with a capillary refill time of less than two seconds and good digital movement.
- Discharged home with analgesia.
- Parents counselled on the warning signs of compartment syndrome.
- Follow-up in two weeks for wound inspection and conversion of the circular cast to a volar back slab.

- Progress Note (14/08/2025):
- Two weeks post-operative.

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- Wrist is less swollen, with skin wrinkling present.
- Digits are stiff; active movement encouraged.
- Circular cast removed. A moulded volar below-elbow back slab was applied.
- Follow-up scheduled in two weeks for clinical review, X-rays, and potential
removal of K-wires.

- Progress Note (04/09/2025):
- Five weeks post-operative.
- Volar splint and both K-wires removed.
- Two small, clean puncture wounds noted with no signs of pain or pin tract
sepsis.
- Clinically stable. X-rays show early bridging callus.
- Counselled to avoid strenuous activities for another four weeks.
- To commence gentle biokinetics training.
- Follow-up scheduled in six weeks with a new X-ray and clinical review.
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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

Pre-Op Consultation Summary

for Dr Wever

Pre-Op Consultation Summary

for Dr Groenewald

Pre-Op Consultation Summary

End of Document

Last Updated: 12 November 2025