

## SmartPhrase List for BRIAN DESNOYERS

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ADVANCEDCAREDISCUSSION  
@SERIOUSILLNESSCONVERSATION@

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BDABG  
@1(phartpoc)@ / @1(pco2artpoc)@ / @1(po2artpoc)@ / @1(hco3artpoc)@

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### BDABNVITALS

{Blank single:19197::"well-appearing", "ill-appearing", "chronically ill-appearing"}, {Blank single:19197::"alert", "confused and disoriented", "unresponsive"}, {Blank single:19197::"afebrile", "febrile to @LASTENCTE@"}, {Blank single:19197::"normotensive", "non-hypotensive", "slightly hypertensive", "hypotensive", "hypertensive"}, {Blank single:19197::"nontachycardic", "bradycardic", "tachycardic"}, {Blank single:19197::"breathing comfortably and sitting well on room air", "in respiratory distress", "requiring NC", "requiring BiPAP", "intubated"}

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### BDADMITTEDPENDINGORDERS

Pt was signed out by prior ED team as accepted for admission by the inpatient team awaiting the admission orders. Per the prior attending's report, there were no active ED issues requiring evaluation, re-evaluation, management or follow-up. Therefore, I was not involved in the patient's care.

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### BDAMALONG

I have provided information to the patient regarding their condition, the treatment required, and the risks and benefits of treatment as well as lack of treatment and potential alternative treatments. I explained to the patient that they currently had a medical condition of: \*\*\* and I am concerned that they have \*\*\* or other serious pathology \*\*\* even despite \*\*\*.

My proposed course of evaluation and treatment and that of any consultants is: \*\*\* Benefits would include: possible diagnosis or excluding of \*\*\* or an alternative serious condition such as \*\*\*, which if identified early would lead to appropriate intervention in a timely manner lessening the burden of disability and death.

The patient is aware of the suspected diagnosis of \*\*\* and acknowledges understanding of the reasons for recommended continued medical care. Risks discussed with the patient include, but are not limited to \*\*\* death, disability, injury to others, mental impairment and loss of current lifestyle.

The patient demonstrates sufficient capacity to assume the risk and there is no evidence of drugs, alcohol, trauma or mental disability that impairs decision making. Specifically, they were able to verbally state back in a coherent manner their current medical condition/current diagnosis, the proposed course of treatment, and the risks, benefits, and alternatives of treatment versus leaving against medical advice.

The patient was given proper f/u & d/c info and told they are welcome back to ER for evaluation & treatment at any time.

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### BDAMARISKS

Risks including but not limited to {Blank multiple:19196::"death", "permanent disability", "prolonged hospitalization", "prolonged illness"}.

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### BDAMASHORTMDM

Clinically sober, awake & alert, mentating well, ambulating without assistance, tolerating PO well, AOx3 and able to make medical decisions. Risks and benefits of further imaging and/or workup discussed with patient,

patient agrees and requests AMA discharge. Risks of AMA discussed with patient included (but not limited to) death, permanent disability, worsening clinical condition, delay of diagnosis, and permanent injury. The team discussed with the patient that they are welcome to return at any time to seek care. Patient was discharged with recommended outpatient follow-up, warning signs given for return.

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#### BDATTENDINGPRESENT

An attending physician was present for the procedure OR the procedure was performed by an Advanced Practice Provider

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#### BDBASICHPI

@NAME@ is a @AGE@ @SEX@ with {PMHx:36630} presenting {Blank single: 19197:: "via EMS", ""} {Blank single: 19197:: "from home", "from facility", ""} with \*\*\*

{Patient denies:44848}.

{Interpreter:46349}

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#### BDBUPINIT

Offered medication assisted treatment with patient and he would be interested in initiating buprenorphine at this time. On time of assessment, COWS score is \*\*\* which suggests moderate withdrawal.

-Given {Blank single:19197::"lower", "moderate", "severe > 13"} COWS score, recommended initiating Suboxone at {Blank single:19197::"2", "4", "8"} mg dose.

-Reassess every 30-60 minutes. At reassessments, if patient's withdrawal symptoms are not relieved, consider an additional 2 to 4 mg doses up to a cumulative total of 16 mg.

-At time of discharge, send a prescription for the total daily dose of what ever was sufficient for symptom management in the emergency department. Can prescribe split into twice daily dosing.

-Refer patient to Road-to-care for further follow-up.

-Continue adjunctive therapies and supportive care including p.o./IV hydration, electrolyte repletion as needed, benzodiazepines, hydroxyzine.

-If patient is requiring more than 16 total milligrams of buprenorphine, reengage the tox service.

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#### BDCASTPRECAUTIONS

**Don't get your cast wet, don't put anything in the cast, if you have extreme pain or numbness to the area please return immediately to get evaluated.**

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#### BDCCUCARDIOGENICSHOCK

CHF management: Strict I's and O's, daily weights, twice daily electrolytes and replete to goal of K > 4, Mg > 2.

Afterload: \*\*\* ACEi, ARB, nitroprusside

Preload: \*\*\* Lasix

Contractility: \*\*\* dobutamine or milrinone

HOLDING home \*\*\*

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#### BDCCUCARDSECTION

**Coronary:**

**Preload:**

**Afterload:**

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## **Contractility:**

## **GDMT:**

## **Rhythm:**

## **Devices/Monitoring**

## **Cardiomyopathy:**

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### **BDCCUGDMT**

Beta-blocker (ex. metoprolol): \*\*\*

Mineralocorticoid antagonist (ex. spironolactone): \*\*\*

RAAS inhibitor (e.g. ACEi or ARB): \*\*\*

SGLT2 inhibitor: defer

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### **BDCCUPLANSTEMI**

- NPO @ MN for \*\*\*
  - Risk modification: Ordered TSH, Hb A1c, and lipid panel
  - TTE ordered
  - Cardioprotection:
  - Anti-platelet:
  - Beta Blocker:
  - ACE/ARB/ARNI:
  - Lipid modifying medication:
  - Angina:
  - On telemetry
  - Cardiac diet
- 

### **BDCCUPOSTCATHDCINSTRUCTIONS**

## **Post Catheterization Discharge Instructions:**

Please call UMASS at 508-334-3452 with any of the following concerns listed below. Please let the office know you have just had a procedure to expedite the phone call:

- Signs of a very bad reaction. These include wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat. Go to the ER right away.
  - Signs of infection. These include a fever of 100.4°F (38°C) or higher, chills, very bad sore throat, ear or sinus pain, cough, more sputum or change in color of sputum, pain with passing urine, mouth sores, or wound that will not heal.
  - Signs of wound infection. These include swelling, redness, warmth around the wound; too much pain when touched; yellowish, greenish, or bloody discharge; foul smell coming from the cut site; cut site opens up.
  - Problems with taking your medications -> especially if you are not able to pick up a medication from the pharmacy
  - Arm or leg where the catheter was put in changes color, is cool to touch, or is numb
  - Bleeding at the catheter site that does not stop, even with pressure
  - You are not feeling better in 2 to 3 days or you are feeling worse
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**General Instructions:**

- You should remain relatively inactive for 24 hours. Avoid vigorous activity for one week.
- You may feel discomfort in the puncture site area for a few days. Tylenol should relieve the discomfort.
- Do not manipulate the wrist or arm access site for 24 hours. The area may be bruised (black and blue) but if the area grows larger than when you left the hospital, notify your physician.

**Activity:**

- You may shower in the AM.
- Do not lift, pull or push anything greater than 10lbs. (about a gallon of milk) for one week or until site has healed.
- Do not drive for two days.
- You may resume your usual exercise program in one week. If you have had a heart attack, refer to cardiac rehab instructions.

**Wound Care:**

- Remove the bandage in the shower (if not already done).
- Gently wash the area with soap and dry thoroughly.
- Do not apply creams, powders or salves. An antibacterial ointment may be applied and the site covered with a bandaid or bandage.
- Bruising may occur - this will be darkest by 48 hours and then will slowly resolve over 1-2 weeks.
- Look at the site daily for one week for signs of infection (redness or drainage).

**Medications:**

- Your nurse will review any medications with you.
- If you have nitroglycerin prescriptions to fill before you get home, your nurse will review with you how to take it.
- Do NOT stop or miss any doses of Aspirin or Plavix/Brilinta/Prasugrel, unless advised to by your cardiologist.
- If you are taking Omeprazole, do NOT stop taking your Plavix.
- If you are taking **Metformin (Glucophage, Avandament, Fortamet, Metaglip)** do NOT take for TWOdays **following** the procedure.
- If you are taking **Coumadin (Warfarin)**, resume taking this tonight unless otherwise instructed.

**Follow-up Care:**

- You should be seen by your Cardiologist or Primary Care Doctor within four weeks.
- If your Cardiologist is at UMMHC and you need to schedule or change your appointment, **please call the UMMHC Cardiology Clinic at 508-334-3452.**

**Call the Cardiac Cath Lab at University Campus (774-443-8943) if you have any questions, Monday - Friday. 8:00am - 5:00pm.**

**Call UMMMC at 508-334-1000 and ask for the Cardiology Fellow if you are having problems after 5:00pm or on the weekend.**

**BDCCUPOSTMIDISCHARGEINSTRUCITONS**

You came to the hospital with chest pain. Based on lab work and EKGs, we determined you were having a heart attack. We treated you with medications and performed a catheterization of the arteries that supply your heart which showed blockage of your arteries. We placed a stent at the blockage site to better keep the artery open. You tolerated these interventions well and are being discharged home in fair condition with some follow-up appointments and changes to your medications.

Please monitor your right wrist for any increased bleeding, bruising, swelling, numbness or tingling. Please call UMass Cardiology (508-334-3452) if you notice any of these symptoms and let the office know you have just had a procedure to expedite the phone call

**Activity Restrictions:**

Right arm restrictions until cath site healed  
No driving for 48 hours after catheterization  
No baths or soaking for one week, no scrubbing or soaking catheterization site  
Do not lift more than 10 pounds for the next week  
No work until follow up

**NEW MEDICATIONS:**

You are on the following NEW MEDICATIONS:

\*\*\*Aspirin, 81mg a day. You may need to be on this for the rest of your life. Do not stop this medication unless it is stopped by your CARDIOLOGIST.

\*\*\*Rosuvastatin (Crestor) which is a medication used to help reduce cholesterol levels in the blood and reduce plaque buildup in the heart arteries.

\*\*\*Atorvastatin (Lipitor) which is a medication used to help reduce cholesterol levels in the blood and reduce plaque buildup in the heart arteries.

\*\*\*Brilinta (ticagrelor) which helps prevent platelets from sticking together in the blood and keep your heart stent open. You will be on this for at least one year. Do NOT under any circumstance stop taking this without talking to your CARDIOLOGIST.

\*\*\*Prasugrel (Effient) which helps prevent platelets from sticking together in the blood and keep your heart stent open. You will be on this for at least one year. Do NOT under any circumstance stop taking this without talking to your CARDIOLOGIST.

\*\*\*Metoprolol (Toprol) which is a medication used to help decrease the work load of the heart after having a heart attack.

\*\*\*Nitroglycerin, which is a medication that can help relieve chest pain. Take one tab under your tongue. You can repeat this dose every 5 minutes as you need to, for a total of 3 doses. If your pain does not improve after 2 doses, please call your doctor or 911.

**CARDS CLINIC/ADDRESS**

55 Lake Avenue North, Worcester MA. ACC building (attached to parking garage) on UMASS medical center university campus, 4th floor cardiology. Call 508-334-3452 with any questions.

\*\*\*The anticoagulation clinic on the 1st floor of the Hahnemann Campus (281 Lincoln Street, Worcester, MA 01605) of UMass Memorial Medical Center

Someone from the clinic will call you to set up the appointment; if you do not hear from them within 1-2 days, please call 508-793-5200

**IF STARTED ON BLOOD THINNERS:**

Please monitor for any signs of bleeding now that you are on new blood thinning medication. This includes black or tarry stools, any blood in the toilet with bowel movements or urination, or any trauma that could result in internal bleeding (ie: car accident, fall). Please call your provider right away should you notice any of these findings. Please note it may take longer for minor cuts / scrapes to heal/stop bleeding and you will likely need to apply pressure.

Please call the Cardiology Clinic with UMASS at 508-334-3452 with any concerns for increased bleeding, bruising, swelling, numbness or tingling from your right wrist used for the angiogram. Please let the office know you have just had a procedure to expedite the phone call.

**Synopsis of INSTRUCTIONS**

1. Please take all of your medicines as prescribed - please note that we have discharged you on aspirin, clopidogrel (Plavix), atorvastatin (Lipitor), and nitroglycerin tablets as needed.
2. Please attend all of your follow-up clinic appointments.
3. Do not stop taking your aspirin and clopidogrel (Plavix)\*\*\* Prasugrel (Effient)\*\*\* without the instruction of your cardiologist as doing so will increase the risk of another heart attack.

4. For chest pain you can take a nitroglycerin tablet under the tongue every five minutes for a total of three tablets, and then call 911 if you are still having chest pain after the 2nd dose.
5. If you experience worsened breathing in the next 30 days or chest pain not resolved by nitroglycerin seek medical attention.
6. Follow a heart healthy diet.
7. If you smoke, please stop. If you don't, please don't start. If you need further assistance your primary care practitioner can act as a resource. Smoking will significantly increase the risk of having a heart attack.
8. Complete cardiac rehabilitation - referral will be made for you.
9. Do not lift anything over ten pounds for the first week after your cardiac catheterization. Please monitor your right wrist for any increased bleeding, bruising, swelling, numbness or tingling. Please call the clinic at 508-334-3452 if you notice any of these symptoms and let the office know you have just had a procedure to expedite the phone call.

Please call with any of the following concerns listed below. Please let the office know you have just had a procedure to expedite the phone call:

Signs of a very bad reaction. These include wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat. Go to the ER right away.

Signs of infection. These include a fever of 100.4°F (38°C) or higher, chills, very bad sore throat, ear or sinus pain, cough, more sputum or change in color of sputum, pain with passing urine, mouth sores, or wound that will not heal.

Signs of wound infection. These include swelling, redness, warmth around the wound; too much pain when touched; yellowish, greenish, or bloody discharge; foul smell coming from the cut site; cut site opens up.

Problems with taking your medications -> especially if you are not able to pick up a medication from the pharmacy

Arm or leg where the catheter was put in changes color, is cool to touch, or is numb

Bleeding at the catheter site that does not stop, even with pressure

You are not feeling better in 2 to 3 days or you are feeling worse

### **General Instructions:**

You should remain relatively inactive for 24 hours. Avoid vigorous activity for one week.

You may feel discomfort in the puncture site area for a few days. Tylenol should relieve the discomfort.

Do not manipulate the wrist or arm access site for 24 hours. The area may be bruised (black and blue) but if the area grows larger than when you left the hospital, notify your physician.

### **Activity:**

You may shower in the AM.

Do not lift, pull or push anything greater than 10lbs. (about a gallon of milk) for one week or until site has healed.

Do not drive for two days.

You may resume your usual exercise program in one week. If you have had a heart attack, refer to cardiac rehab instructions.

### **Wound Care:**

Remove the bandage in the shower (if not already done).

Gently wash the area with soap and dry thoroughly.

Do not apply creams, powders or salves. An antibacterial ointment may be applied and the site covered with a bandaid or bandage.

Bruising may occur - this will be darkest by 48 hours and then will slowly resolve over 1-2 weeks.

Look at the site daily for one week for signs of infection (redness or drainage).

### **Medications:**

Your nurse will review any medications with you.

If you have nitroglycerin prescriptions to fill before you get home, your nurse will review with you how to take it.

Do NOT stop or miss any doses of Aspirin or Plavix/Brilinta/Prasugrel, unless advised to by your cardiologist.

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Call UMMC at 508-334-1000 and ask for the Cardiology Fellow if you are having problems after 5:00pm or on the weekend.

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#### **BDCDUPENDINGMANAGEMENT**

Pt was signed out by prior ED team as signed out to CDU awaiting CDU management. Per the prior attending's report, there were no active ED issues requiring evaluation, re-evaluation, management or follow-up. Therefore, I was not involved in the patient's care.

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#### **BDCENTRALLINENOTSTERILE**

All attempts made to ensure full sterility of central line as dictated by hospital policy and clinical condition, however due to emergent circumstances, and/or patient compliance, and/or unforeseen circumstance full sterility of line cannot be guaranteed.

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#### **BDCENTRALLINESTD**

Procedural supplies: **Triple lumen**

Catheter size: **7 Fr**

Catheter length (cm): **15**

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#### **BDCIWAFLOW**

@FLOW(607235)@

@FLOWSTAT(607235)@

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#### **BDCODESTROKE**

##### **HPI:**

Patient is a @AGE@ @SEX@ with {PMHx:36630} who presents as a code stroke activation with \*\*\*. Last known well \*\*\*.

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#### **PATIENT HISTORY:**

@MEDICALHX@

@SURGICALHX@

@TOBHX@

@DRUGHX@

@ALCHX@

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**REVIEW OF SYSTEMS:**  
@ROSBYAGE@

**PHYSICAL EXAM:**  
@PHYSICALEXAM@

**RESULTS:**

**Labs:** @EDLABS@

**Imaging:** @WETREAD@

@EDMDM@

Patient is a @AGE@ @SEX@ with {PMHx:36630} who presents as a code stroke activation with \*\*\*, last known well \*\*\*. Patient taken immediately to CT scan and neuro team at bedside.

DDx includes CVA versus ICH. Also considering other toxic metabolic or infectious etiologies.

Plan for \*\*\* stroke imaging and labs. Disposition to be determined by labs, imaging, and neurology team recommendations.

**Amount and/or complexity of data reviewed:**

**Additional history required from:** \*\*\*

**Diagnosis or treatment limited by the following social determinants of health:** \*\*\*

**Medical records reviewed (previous or outside encounter data):**

**Previous labs:** \*\*\*

**Previous imaging:**

\*\*\*

**Previous EKG:** \*\*\*

**Notes reviewed:**

\*\*\*

**Current encounter data review/independent interpretation:**

**EKG (reviewed in the absence of a cardiologist):** \*\*\*

**XR:** \*\*\*

**US:** \*\*\*

**Discussion with providers:**

Specialist neurology regarding the patient's presentation concerning for possible stroke

@EDCOURSE@

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**BDCONCUSSIONDISCHARGEINST**

As discussed in the Emergency Department prior to discharge, you have been diagnosed with a concussion. Concussions are common after a strong head injury. For the vast majority of people, concussions last several weeks. Concussion symptoms vary from person to person. They usually involve headaches, difficulty concentrating, feeling like you are in a fog, and/or speaking more slowly than usual for you. If the concussion symptoms last longer than 2 weeks, follow-up with your primary care provider.

While your brain is healing, a second injury (even if it is minor) can have catastrophic consequences. This is called "Second Impact Syndrome." It is extremely rare, but has been reported when an athlete who had a concussion goes back to playing their sport too early, and has a second (even very minor) head injury. These patients may die from the second injury, so it is extremely important that you avoid having any more head

injuries when you have a concussion.

For the first 2 days after the injury, avoid doing any reading, and anything that makes you concentrate hard. This includes texting, reading on a computer screen, laptop, or smartphone, reading books, magazine text, or newspapers (all of these things make your brain work, when it needs rest). After that limit the amount of computer/cellphone/laptop use, cutting back still further if your symptoms worsen.

If you had a CT scan and there was no evidence of bleeding on the scan, you do not need to return to the Emergency Department unless you are taking a blood thinner like Warfarin (Coumadin), Apixaban (Eliquis), Dabigatran (Pradaxa), or Rivaroxaban (Xarelto). These medications are blood thinners and you can have more bleeding if you are taking these medications.

If you had the injury right before bedtime, it might be helpful to have someone wake you up once during the night to make sure that you are okay (there is no scientific evidence that this helps, but there is no harm in it either). If the injury happened in the early evening or earlier, this is not necessary, since you've been observed for 4-6 hours before heading to bed.

Return to the Emergency Department for confusion or increasing drowsiness, severe headache and/or vomiting, numbness or weakness in one arm or leg, seizure, or any new or concerning symptoms.

<https://www.cdc.gov/headsup/providers/tools.html>

[https://www.cdc.gov/headsup/providers/return\\_to\\_activities.html](https://www.cdc.gov/headsup/providers/return_to_activities.html)

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#### BDCONSIDERPAIN

Considered pain control medication including morphine or acetaminophen but patient declining pain control medications due to improvement in pain this time.

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#### BDCONTRASTEXTRAV

#### PATIENT HOME CARE INSTRUCTIONS FOR CONTRAST EXTRAVASATION

Today \*\*\* (date) during your radiology procedure, some of the intravenous (IV) contrast dye (identify type of contrast and cc's) which was injected into the vein in your \*\*\* (insert site of injection) arm leaked into the tissue surrounding the vein instead of staying in the vein. This is called an "extravasation". Sometimes the contrast dye produces swelling and bruising of the skin and may be accompanied by some minor discomfort. To help resolve the swelling and bruising you should elevate the affected extremity above the level of the heart, if tolerable. Remove tight bands such as watches from the affected extremity until the swelling has resolved. Apply cold compresses or cold packs for 15-60 minutes at a time over 2-4 hours. This will help to decrease the swelling and minimize any pain that you might be having.

Immediately following your CT exam if the radiologist feels that a plastic surgery consult is necessary Radiology will arrange an appointment for you. Should you choose to change your appointment time please call the Plastic Surgery Wound Clinic at 508-334-9686. Please bring this Contrast Extravasation instruction sheet with you.

In rare circumstances, one or more of the following signs may occur after the initial 4 hours. If you experience one or more of these symptoms and they do not subside please go to the nearest Emergency Department for evaluation. Please bring this Contrast Extravasation instruction sheet with you.

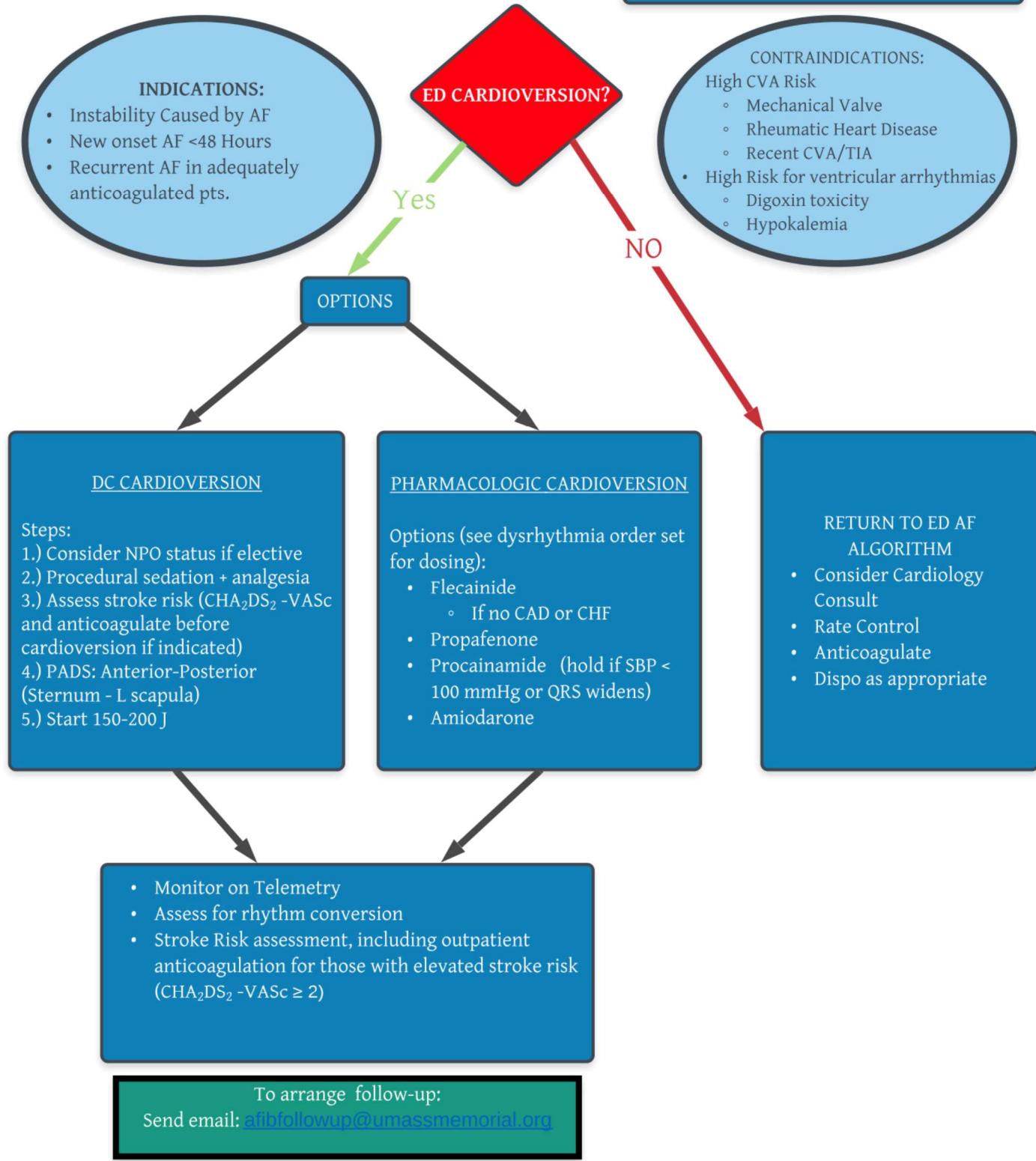
- Increasing swelling or pain
- Change in sensation to the affected extremity
- Skin blistering or ulceration
- Change in blood flow to the extremity

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#### BDCPGAFIB

# University / Memorial Emergency Department Non-Valvular A-fib Cardioversion Algorithm

\*Note: Rate control before cardioversion is optional



**BDCPGBIPAPCHECKLIST****BiPAP Intercampus Transfer Checklist**

- |   |                          |
|---|--------------------------|
| 1. Is the patient anticipated to have an uncomplicated airway should unanticipated intubation be required during transport (i.e. reassuring airway assessment and no history of airway difficulty)? | <input type="checkbox"/> |
| 2. Is the patient's GCS > 12?   | <input type="checkbox"/> |
| 3. Is the patients respiratory rate < 28 bpm  | <input type="checkbox"/> |
| 4. Is the pt's O <sub>2</sub> saturation > 93% Yes OR is the pt stable on NIPPV FIO <sub>2</sub> < 60%  | <input type="checkbox"/> |
| 5. 1+ hours post-NIPPV initiation is the arterial pH > 7.3 OR is the venous pH > 7.23?  | <input type="checkbox"/> |
| 6. Is the patient hemodynamically stable, including HR < 110 and not requiring vasopressors?  | <input type="checkbox"/> |
| 7. Has the patient been on the transport team's ventilator, mask and ETCO <sub>2</sub> for at least 20 minutes with adequate seal?  | <input type="checkbox"/> |
| 8. Has the Attending Physician evaluated the patient within 10 minutes of departure and indicated that the patient is stable for transport on NIPPV?  | <input type="checkbox"/> |

**BDCPGEXTUBATION**

UMMMC Emergency Department Extubation Clinical Practice Guideline - Updated 12/29/20

**Principles:**

Extubation ideally should be performed in an ICU/OR/PACU setting. However, when faced with ICU capacity constraints leading to prolonged ED LOS, a subset of intubated patients in the ED may benefit from ED extubation to avoid prolonged intubation that is no longer clinically necessary.

To ensure safety, ED extubation processes shall parallel established ICU processes as appropriate, but ED extubations shall have more stringent inclusion and exclusion criteria to minimize risk of need for reintubation. ICU bed assignment decisions/algorithms should not be influenced by potential for ED extubation. Delay of transfer to an ICU setting in anticipation that the patient may be a candidate for ED extubation in the future is not appropriate.

ED extubation is performed only with the approval of the attending responsible for the patient's care (generally, the ED attending, but may be the Trauma attending for patients under their care)

**Criteria:**General Inclusion Criteria

1. Intubated for <48 hours
2. **Airway:** No report of difficult airway/intubation
3. **Breathing:** Minimal vent support (Saturation ≥ 95% on FiO<sub>2</sub> ≤ 40%; PEEP ≤ 5), Respiratory rate ≤ 30/min, and resolution of acute respiratory failure
4. **Circulation:** Hemodynamically stable: SBP >100, HR <130
5. **Special Criteria:** CMO/withdrawal of ventilatory support → see Palliative Care/CMO section

Specific ED Extubation Clinical Scenario Selection Criteria

1. Resolved Intoxication/OD (Ex: GHB, EtOH)
2. Resolved Status Epilepticus (Ex: Intubated for airway protection, now resolved)
3. Intubated for safety/facilitation of workup (Ex: combative patient Intubated for patient and/or staff safety to facilitate safe evaluation and treatment and underlying etiology anticipated to be resolved)
4. Resolution of acute respiratory failure: primary attending feels trigger for respiratory failure was transient or has resolved/improved to point that intubation no longer required (Ex: chemical inhalation leading to bronchospasm, allergic reaction)
5. Palliative care/CMO (Ex: CMO pt intubated before code status known, devastating illness/injury and pt made CMO while in ED)

### Exclusion Criteria

1. History of (or high risk of) difficult airway
2. Acute lung injury and/or acute airway/pharyngeal injury
3. Cervical spine injury or instability
4. Plan for imminent operation or transport
5. Current use of vasopressors, hemodynamically unstable, or felt likely to decompensate within 12 hours
6. Active cardiac ischemia
7. Current/recent unstable arrhythmia
8. High fever
9. Severe secretions concerning for airway compromise

### **Procedure:**

#### Assess Patient Readiness for Extubation

1. **Spontaneous Awakening Trial (SAT):** Ensure pt not paralyzed (from RSI or drip) Turn off sedative and allow time to clear Consider allowing dexmedetomidine, and/or fentanyl Pt is alert and follows motor commands appropriately Ask to lift head off bed, nod yes/no to questions, hold arm(s) up, give thumbs up or show 2 fingers If no concerns: proceed
2. **Spontaneous Breathing Trial (SBT):** SBT as tolerated Head of bed up  $\geq 45^\circ$  RT to set PEEP 5–8cm, PSV 5cm; Maintain FiO<sub>2</sub>  $\leq 40\%$  Minimum 15–30 minutes in duration \***Discontinue SAT or SBT for:** Severe agitation, RR > 30, Sat < 90%, HR > 130, SBP >180, mental status depression, diaphoresis, signs of respiratory muscle fatigue, new arrhythmia or hemodynamic instability
3. **At end of SAT/SBT, calculate Rapid Shallow Breathing Index (RSBI)\***  $>105$ : Halt protocol  $<105$ : Proceed with protocol \*RSBI (breaths/min/L) = f/VT (f = respiratory rate; VT = tidal volume in L)
4. **"Extubation Time Out"** Must include at least attending, RT and RN to ensure no concerns Considerations include:
  - a. Is patient awake enough to protect airway?
  - b. Is the patient able to generate a good cough? **If the answer is NO to either: Halt protocol**
  - c. Are there copious secretions?
  - d. Is there a history of difficult airway or upper airway obstruction?

#### **If the answer is YES to either: Halt protocol**

#### Extubation Steps

1. Attending, RN, RT at bedside (attending or designee orders extubation in EHR - RT may place verbal order)
2. Airway supplies immediately available, AMBU/mask and suction connected
3. Ensure rescue options are available in rare case they are needed
  - a. Non-rebreather mask/neb saline
  - b. HiFlow NC
  - c. Bipap
  - d. Racemic epinephrine/cool mist\*risk for requiring these rescue measures is low in all patients based on selection criteria in this guideline, although slightly greater risk in patients intubated >48 hours. May consider extubation directly to one of the above at the discretion of the attending physician.
4. HOB >45; Suction ETT and oropharynx
5. RT deflates cuff, asks patient to cough, removes tube, and suction oropharynx
6. Provide Immediate supplemental humidified oxygen
7. Close Observation for 1 hour, encourage coughing and suction
8. For any respiratory distress immediately alert attending physician and consider hiflow, or bipap as an alternative

#### **Palliative Care/CMO - Withdrawal of Ventilatory Support Procedure:**

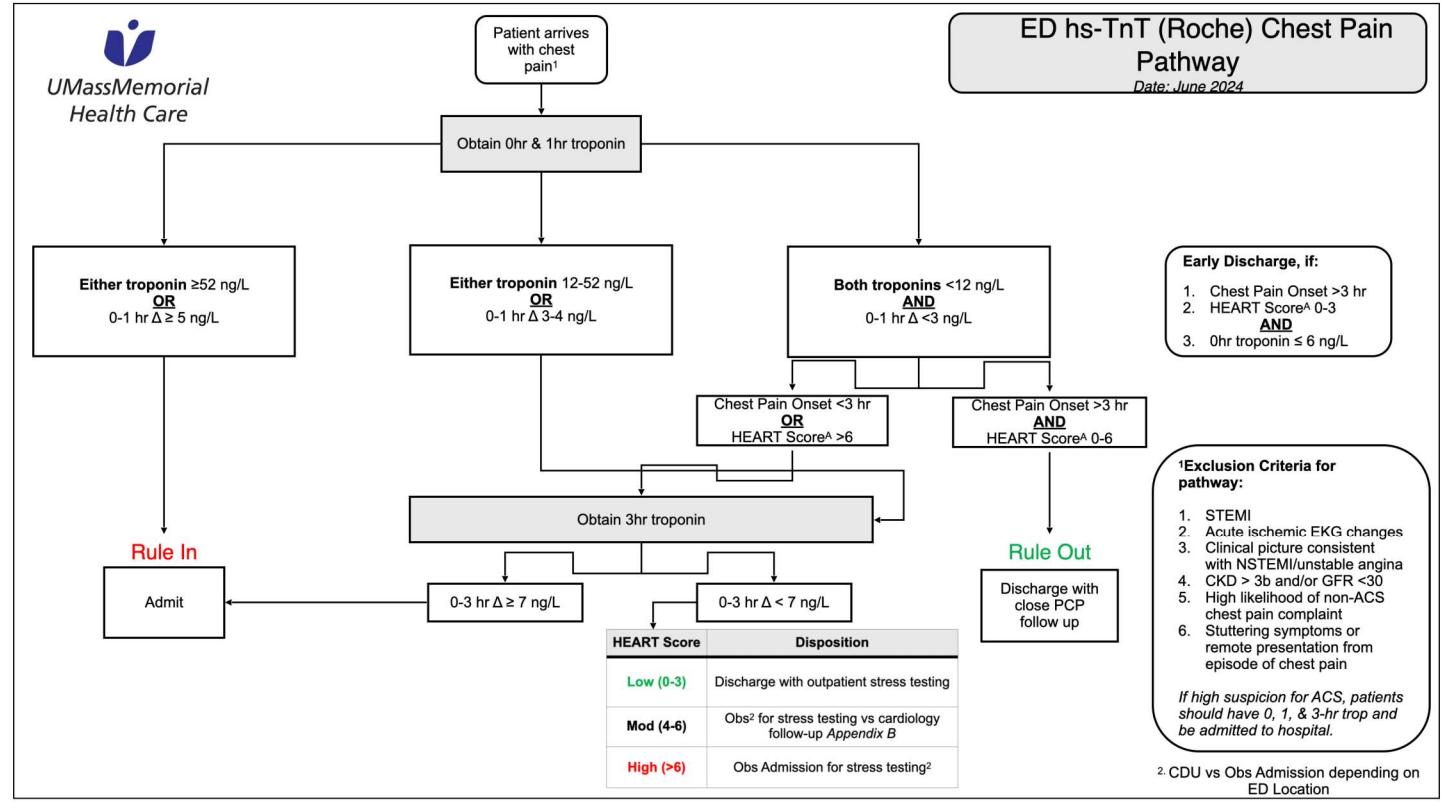
- 1 In cases for which the health care proxy and family clearly request/support withdrawal of ventilatory support, attending physician may consider extubation in the ED
- 1 If any reluctance expressed by proxy or family, extubation should be deferred for further investigation

- 2 Consider palliative care and ethics consults as appropriate  
2 Engage SW to assist with assessing for cultural/religious/spiritual needs of patient/family  
3 Please contact New England Donor Services (NEDS) as early as feasible (prior to CMO discussions is ideal), to facilitate NEDS's ability to have optimal organ donation discussions with family. Continue to call at time of death for all patients for potential tissue donation screening.  
4 "CMO Extubation Time Out" Attending, RN and RT have joint discussion to ensure no concerns before proceeding  
5 The primary goal is patient comfort: Ensure reliable IV access Ensure tube feeds stopped for several hours to minimize risk of aspiration Ensure pt not paralyzed (from RSI or drip neuromuscular blockade) in order to assess for discomfort  
6 Initiate medications for relief of **anticipated** discomfort Start/adjust appropriate opioid drip, bolus as needed Benzodiazepine as needed If patient is comfortable and no discomfort is expected, no pre-medication is needed  
7 Consider family/companion wishes to be present or not for extubation and after extubation  
8 Deflate cuff, remove ET tube, suction oropharynx  
9 Provide supplemental oxygen as appropriate  
10 Regular re-assessment of patient for comfort level  
Signs of discomfort may include: tachypnea, labored breathing, gasping, nasal flaring, tachycardia, diaphoresis, grimacing, restlessness and/or excessive secretions.  
Adjust opioids and/or benzodiazepines as needed  
\*If anticipated prolonged post-extubation course, consider admission to med/surg service

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- 1 Michigan: West J Emerg Med. 2020 May; 21(3): 532–537. Descriptive Analysis of Extubations Performed in an Emergency Department-based Intensive Care Unit  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234716/>
- 2 Weingart:[https://hwcdn.libsyn.com/p/f/b/4/fb4e7688a789892a/trauma\\_extubation.pdf?c\\_id=2764816&cs\\_id=2764816&expiration=1604517963&hwt=95ef4620b488b20a3f3f99089e75a272](https://hwcdn.libsyn.com/p/f/b/4/fb4e7688a789892a/trauma_extubation.pdf?c_id=2764816&cs_id=2764816&expiration=1604517963&hwt=95ef4620b488b20a3f3f99089e75a272)  
<https://emcrit.org/emcrit/extubation/>
- 3 Gray: <https://emcrit.org/wp-content/uploads/2010/11/SaraGray-ED-Extubation.pdf>
- 4 Nwakanma CC, Wright BJ. Extubation in the Emergency Department and Resuscitative Unit Setting. Emerg Med Clin North Am. 2019 Aug;37(3):557-568. doi: 10.1016/j.emc.2019.03.004. Epub 2019 May 21. PMID: 31262421.
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- 7 Ornico SR, Lobo SM, Sanches HS, et al. Noninvasive ventilation immediately after extubation improves weaning outcome after acute respiratory failure: a randomized controlled trial. Crit Care. 2013;17(2):R39. Published 2013 Mar 4. doi:10.1186/cc12549
- 8 Yang, K. L. & Tobin, M. J. A prospective study of indexes predicting the outcome of trials of weaning from mechanical ventilation. *N. Engl. J. Med.* **324**, 1445–1450 (1991). FOAM Sources:
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[https://hwcdn.libsyn.com/p/f/b/4/fb4e7688a789892a/trauma\\_extubation.pdf?c\\_id=2764816&cs\\_id=2764816&expiration=1604517963&hwt=95ef4620b488b20a3f3f99089e75a272](https://hwcdn.libsyn.com/p/f/b/4/fb4e7688a789892a/trauma_extubation.pdf?c_id=2764816&cs_id=2764816&expiration=1604517963&hwt=95ef4620b488b20a3f3f99089e75a272)  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234716/>  
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<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3672522/>

## BDCPGHSTROP



### HEART Score for Chest Pain Patients (High Sensitivity Troponin)

History	Highly Suspicious	2
	Moderately Suspicious	1
	Slightly Suspicious	0
ECG	Significant ST-deviation	2
	Non-specific repolarization/LBBB/Paced	1
	Normal	0
Age	≥ 65	2
	45-64	1
	< 45	0
Risk Factors	≥ 3 Risk Factors for CAD	2
	1 to 2 Risk Factors	1
	No Risk Factors	0
Troponin	> 19 ng/L	2
	6-19 ng/L	1
	< 6 ng/L	0

- For patients with HEART Score of 4-6 not meeting Rule-Out or Rule-In Criteria
- Consider discharge with PCP or cardiology follow up if 0, 1, and 3 hour troponins all < 12 ng/L and 0-3 hr Δ < 3

- Consider observation (or 72-hour cardiology follow-up if pain free and no EKG changes)
  - Observation admission if unable to obtain prompt follow-up or if patient has EKG changes
- 

## BDCPGLVAD

VAD Program

UMass Memorial Healthcare

Worcester, Massachusetts 02215

### STANDARD OPERATING PROCEDURE: CARE AND MANAGEMENT OF VAD PATIENTS PRESENTING TO THE EMERGENCY DEPARTMENT

#### Principle

The SOP will set forth guidelines for the care and management of VAD patients at UMMHC who present to the Emergency Department.

#### Scope

These following guidelines will be used by the VAD team and Emergency Department to ensure that those patients who are identified as VAD patients in the Emergency Department are treated with the following special consideration and care.

#### Procedure:

1. The UMMHC VAD patient is educated by the VAD team to call the VAD coordinator on call (508-713-3237) or to call the page operator at 508-334-1000 and ask for the VAD attending on call for any issues that are considered high risk and/or life threatening.
2. A VAD team representative will triage the phone call and if a direct admission is not appropriate will refer the patient to the Emergency Department. The VAD team representative will call TRAC with the patient's medical information for ED staff. TRAC will send a blast page to the VAD Coordinator (5823), 3 Lakeside ICU/SDU resource nurses, CTS APP on call (0101), nursing supervisor, ED, HF (0300), STEP (7837), VAD MD on call. If the VAD patient arrives to ED without prior notification, please refer to section 3 and call the VAD Coordinator on call at 508-713-3237 or page (5823).
3. When the patient arrives and registers, there will be a FLAG indicating that the patient has an VAD. The ED staff should notify the resource nurse in 3LICU/3LSDU and page 0101(CTS APP) that the VAD cart will need to be brought down and attached to the patient. The VAD patient and family member (who is also VAD trained) should be placed in an examination room. If the patient is stable the ED should call 3L Stepdown and ask for the VAD cart in 3LICU to be brought down for patient name, with specified device (Heartmate3). The 3L Stepdown nurse will not stay with the stable VAD patient in the ED. If the patient is unstable the ED should call 3LICU Resource (774-502-0380) and ask for the VAD cart to be brought down which is located on 3LICU for patient, Name, with specified device (Heartmate 3). For unstable VAD patients, the CTS APP will stay with the patient until they are transferred to 3LICU.
4. If the VAD patient is having any concern for stroke or TIA call Neuro/stroke code immediately
5. Driveline dressing should **not be removed** unless instructed by VAD team member. Driveline dressings are assessed using sterile technique at all times (sterile gloves, mask, gown).
6. Diagnostics:  
Standard: CBC with Diff, INR, comprehensive metabolic panel, LFT's to include LDH, CK, BNP, Tn, Lactate if indicated  
If suspect VAD thrombosis: plasma free hemoglobin, u/a  
If suspect infection: blood cultures, urine culture  
CXR  
EKG  
KUB if requested by VAD team (if red heart alarm need KUB of both internal and external driveline)  
Head CT for suspected neurologic changes or head trauma

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#### VAD Notes:

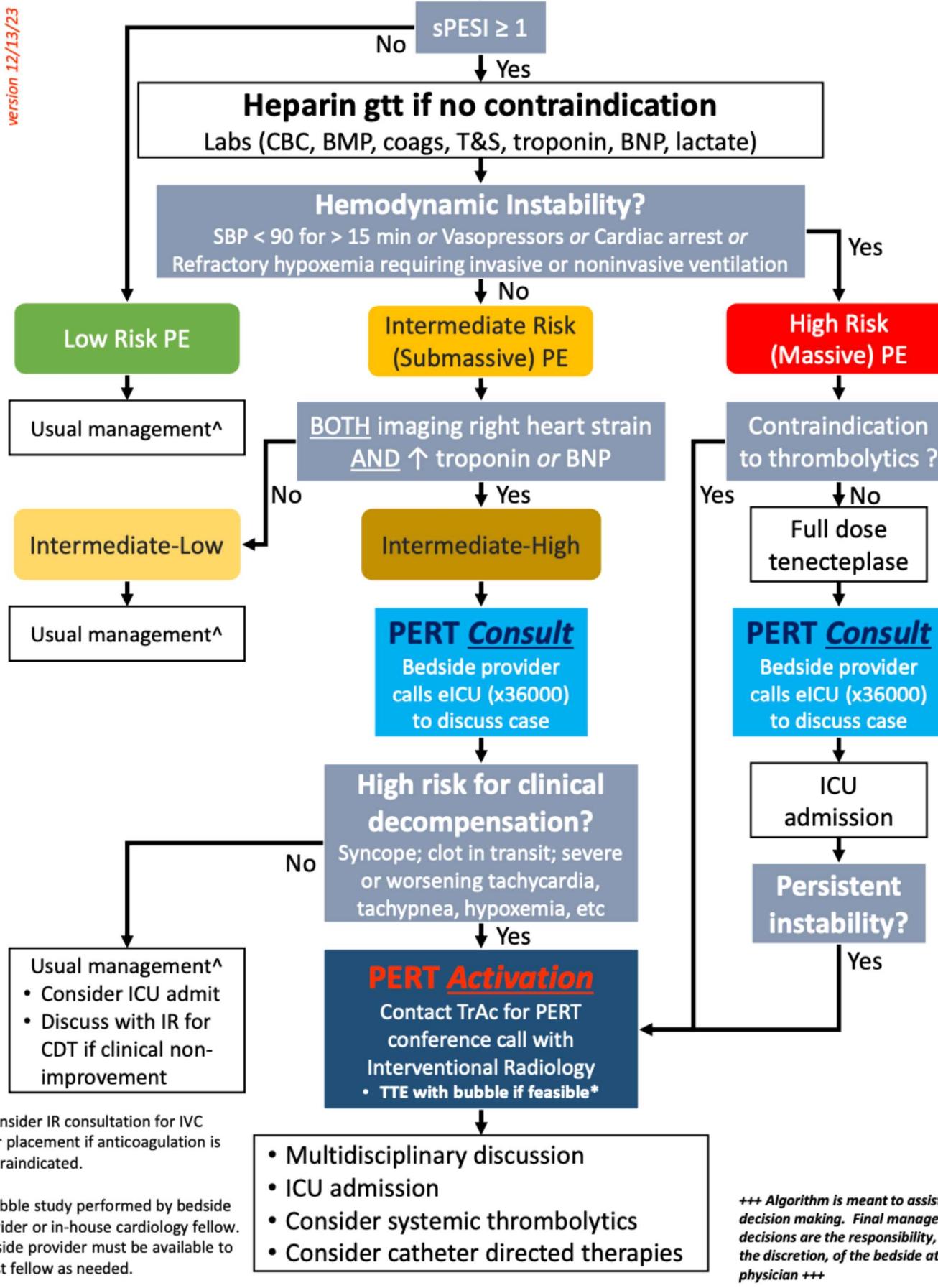
- VAD patients may not have a palpable pulse. Use a Doppler to check the BP and do not use an automated cuff
- Follow AHA Recommendations for ACLS in VAD patients (VAD patients may not have a pulse but will have electrical conduction so you can interpret for arrhythmias)
- Defibrillation is allowed as indicated by ACLS algorithm. Avoid placing pads directly over the pump/pump pocket (Left chest)
- VT/VF may be well tolerated in a patient with VAD support allowing time for IV anti-arrhythmics and/or conscious sedation prior to DCCV
- Allow patients family member/caregiver to remain with patient at ALL TIMES as they are expert in managing VAD equipment
- Removing the dressing at the driveline exit site requires strict sterile technique including sterile gloves and mask, patient and any one on room must wear a mask. Avoid dressing removal unless absolutely necessary or as directed by a member of the VAD team. Recommended that it is done by a VAD competent provider.
- VAD team member is always available by page at 5823 (LVAD) or the VAD phone 508-713-3237.
- VAD patients can only be admitted to 3L stepdown or 3L ICU where VAD competent nurses are trained to care for them

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BDCPGPERT

# Pulmonary Embolism: Confirmed or Highly Suspected

version 12/13/23



## BDCPGSEIZURE

### Clinical Practice Guideline for Management of First-Time Seizure

**Background:** The purpose of this guideline is to standardize the evaluation and treatment of adult patients presenting to the emergency department (ED) with a first-time seizure. This guideline applies to patients over the age of 18 who do not have any prior history of seizures and present to the ED for evaluation of a seizure without any apparent provoking factors. This guideline does not apply to pediatric patients, patients with a known seizure disorder, patients who have a provoked seizure, or patients who present in status epilepticus.

#### Diagnostic Studies

- Serum glucose and sodium; baseline CBC and CMP to be used for neurology follow up
- CT head without contrast
- hCG in women of childbearing age
- Lumbar puncture for immunocompromised patients

#### Neurology Consultation

- For outpatient neurology follow up, place an Ambulatory Referral to Neurology with “seizure” or “epilepsy” as the referral reason
- Emergent neurology consultation in the ED is not necessary for patients who return to their baseline mental status and do not have structural brain disease

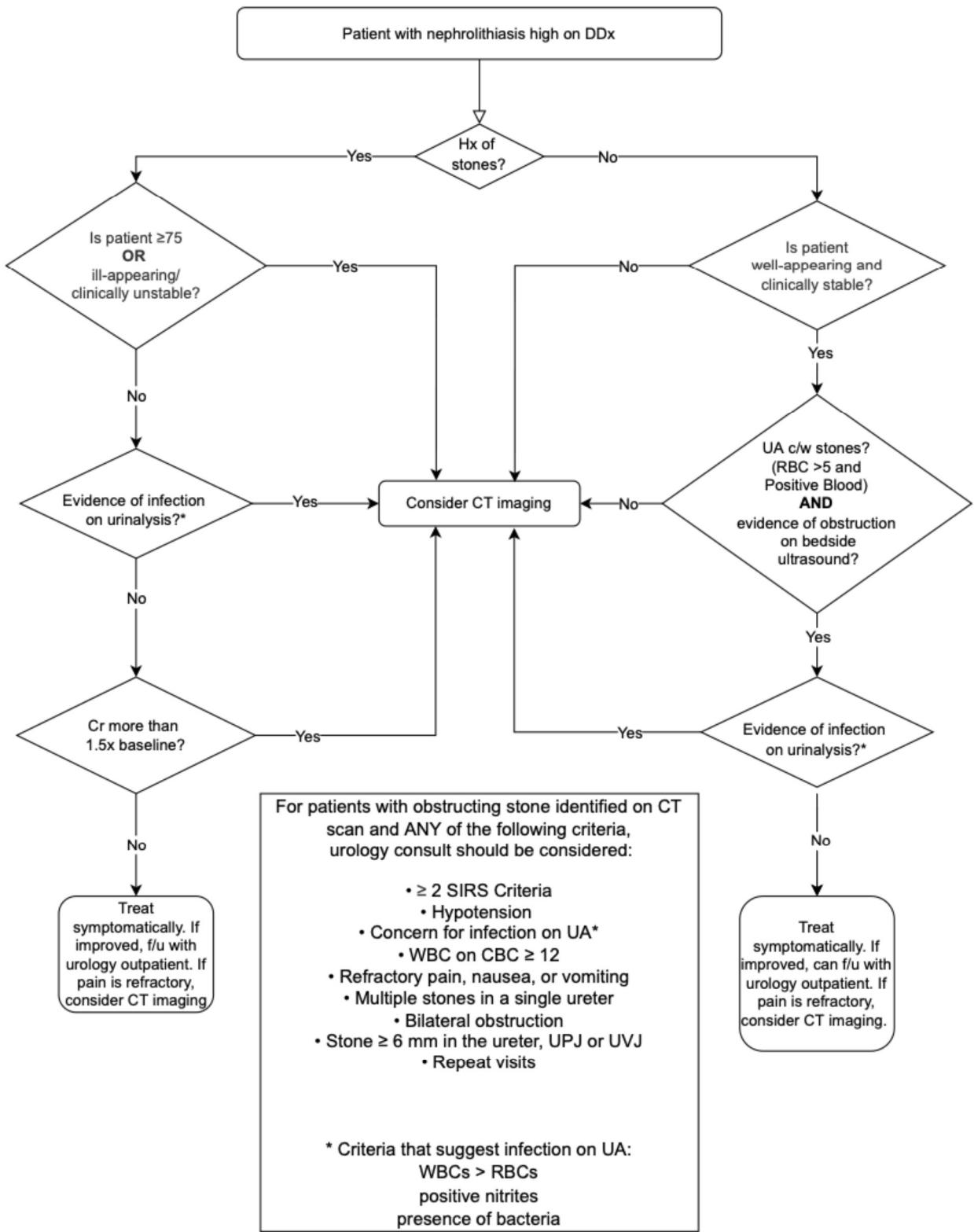
#### Disposition

- Admission is not required for patients who return to neurologic baseline in the ED
- Antiepileptic drugs are not necessary for patients with provoked or unprovoked first-time seizure who have no structural brain disease
- Counseling and discharge instructions should be provided to patients, including instructions not to operate a motor vehicle for 6 months until cleared by the RMV [consider using the “ED New Onset Seizure” discharge SmartSet]

#### References

1. 2. 3. 4. ACEP Clinical Policies Committee; Clinical Policies Subcommittee on Seizures. Clinical policy: Critical issues in the evaluation and management of adult patients presenting to the emergency department with seizures. Ann Emerg Med. 2004 May;43(5):605-25.
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BDCPGSTONE



## Plan for Outpatient Management of First Time Kidney Stones

For patients presenting to emergency department with first-time diagnosis of uncomplicated kidney stones, if the emergency provider feels a non-emergent CT scan is indicated, can call the urology resident and request that they order the scan, and then place an ambulatory referral to urology on discharge from the Emergency Department.

## **BDCRITAP**

Patient is critically ill and seen in the {Blank single:19197::"Emergency Department", "ICU"}, case discussed with staff and the multi-disciplinary team. Current assessment and plan by system:

### **Neuro:**

- \*\*\*
- Sedation: {Blank multiple:19196::"ketamine", "midazolam", "propofol", "precedex"}
- Analgesia: {Blank multiple:19196::"morphine", "fentanyl gtt", "fentanyl PRN", "Dilaudid gtt", "Dilaudid PRN", "\*\*\*\*", "None"}
- Multimodal Pain Control: {Blank multiple:19196::"Acetaminophen", "NSAIDS", "Lidocaine patch", "Epidural", "\*\*\*\*", "None"}

### **Cardio:**

- \*\*\*
- Telemetry
- Judicious PRN IVF bolus
- I have ordered {Sepsis IVF volume:41194} of IV fluids for this patient, rather than 30ml/kg because this patient has {Reason not Giving 30ml/kg:41195}.
- Maintain MAP >{Blank single:19197::"60", "65", "70"}
- {sepsisexam:32971}
- Titrate Vasopressor support: {Blank multiple:19196::"Norepinephrine", "Vasopressin", "Epinephrine", "Epidural", "Phenylephrine", "Dobutamine", "\*\*\*\*"}
- Titrate Vasodilator for Blood Pressure Control MAP/SBP <\*\*\*: {Blank multiple:19196::"Hydralazine", "Nicardipine", "Esmolol", "Nitroglycerin", "Labetalol", "Nitroprusside", "\*\*\*\*"}

### **Pulm:**

- \*\*\*
- O2 delivery: {Blank single:19197::"Intubated on Full Vent Support", "Intubated on \*\*\*\*", "BIPAP", "CPAP", "HiFlow", "Supplemental O2 nasal cannula", "none", "\*\*\*\*"}
- @VENTSETTINGS@
- Head-Up Position (30 degrees) if intubated
- Continuous numeric end tidal Co2 if intubated
- Continuous Pulse Ox
- Pulm Toilet
- Wean O2 support if able

### **Renal:**

- \*\*\*
- Foley per sedation protocol
- Monitor UOP, strict I/O's
- MIVF: {Blank single:19197::"None", "LR @", "NS @", "D5 @", "D5NS @"}
- Trend chemistry panel
- Replete electrolytes as needed

### **GI:**

- \*\*\*
- Enteric access: {Blank single:19197::"NGT", "OGT", "PEG"}
- NPO Status: {Blank single:19197::"Yes", "No", "No, ordered for diet", "\*\*\*\*"}
- Ulcer PPx: {Blank single:19197::"PPI", "Famotidine", "none"}

### **Heme/Onc:**

- \*\*\*
- DVT PPx: {Blank single:19197::"SQH", "Lovenox", "Contraindicated per \*\*\*", "SCD", "on heparin gtt", "none"}

### **ID:**

-\*\*\*

- Cultures Sent: {Blank multiple:19196::"Blood", "Urine", "Septum"}
- {Blank multiple:19196::"Streptococcal urinary antigen", "Legionella urinary antigen"}
- {Blank multiple:19196::"Covid", "Influenza", "RSV"}
- ABX: {Blank multiple:19196::"Vancomycin", "Zosyn", "Ceftriaxone", "Cefazolin", "Cetepime", "Levofloxacin", "Azithromycin", "Clindamycin", "Ertapenem", "Meropenem", "Linezolid", "Amikacin", "Metronidazole", "\*\*\*\*"}

### **Endo:**

-\*\*\*

- Glucose: {Blank single:19197::"periodic FSBG", "ISS", "glycemic protocol"}
- Stress Dose Steroids: {Blank single:19197::"Yes", "No"}

### **Trauma/Ortho:**

-\*\*\*

- Injury List:

### **Lines/Tubes:**

- Central Line: {Blank single:19197::"No", "R-IJ", "L-IJ", "R-femoral", "L-femoral", "R-subclavian", "L-subclavian", "\*\*\*\*"}
- Arterial Line: {Blank single:19197::"No", "R-radial", "L-radial", "R-femoral", "L-femoral", "R-axillary", "L-axillary"}
- Line Status: {Blank single:19197::"Full Sterile", "Resuscitation Line"}

### **Dispo/Code Status:**

- Admit to ICU
  - Code status: {Blank single:19197::"Did not discuss; no changes", "Presumed Full Code", "Full Code", "DNR", "DNR/DNI", "Comfort Measures Only", "\*\*\*\*"}
  - HCA: {Blank single:19197::"self", "unknown", "guardian", "in chart"}
  - ICU is aware and is currently pending ICU bed
- 

### **BDCRITAPSHORT**

#### **ICU holding orders:**

- Code Status: {Blank single:19197::"Did not discuss; no changes", "Presumed Full Code", "Full Code", "DNR", "DNR/DNI", "Comfort Measures Only", "\*\*\*\*"}
  - HCA: {Blank single:19197::"self"}
  - Relevant home meds: \*\*\*
  - Analgesia/sedation: {Blank multiple:19196::"morphine", "fentanyl gtt", "fentanyl PRN", "Dilaudid gtt", "Dilaudid PRN", "\*\*\*\*", "None"} {Blank multiple:19196::"ketamine", "midazolam", "propofol", "precedex"}
  - O2 delivery: {Blank single:19197::"Intubated on Full Vent Support", "Intubated on \*\*\*\*", "BIPAP", "CPAP", "HiFlow", "Supplemental O2 nasal cannula", "none", "\*\*\*\*"}
  - DVT pptx: {Blank single:19197::"SQH", "Lovenox", "Contraindicated per \*\*\*\*", "SCD", "on heparin gtt", "none"}
  - Glucose: {Blank single:19197::"periodic FSBG", "ISS", "glycemic protocol"}
  - Diet: {Blank single:19197::"NPO", "ordered"}
  - SUP: {Blank single:19197::"PPI", "Famotidine", "none"}
  - Bowel reg: \*\*\*
  - Urinary catheter: \*\*\*
  - BMP, Mg daily - replete lytes as necessary
  - CBC daily
- 

### **BDCSPINECLEAR**

Patient re-evaluated for cervical spine precautions. Cervical collar in place. CT of the cervical spine showed no evidence of fracture. On exam, patient denied any bony tenderness of the cervical spine on palpation. Patient had pain free ROM to 30 degrees in extension as well as flexion, 45 degrees in right and left rotation. Collar removed, no further need for cervical spine precautions.

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**BDCSPINECLEAR**

Patient seen and evaluated by Trauma Team for cervical spine precautions. Patient is alert and oriented x 3. Patient reports no pain to cervical spine. Patient reports no midline cervical tenderness and able to demonstrate full range of motion to 30 degrees in extension as well as flexion, 45 degrees in right and left rotation without pain/discomfort. No neurological deficits noted in upper extremities during evaluation. Cervical Collar removed. No further need for cervical spine precautions.

@SIG@

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**BDCXRINTERPRETATION**

{Blank single: 19197:: "No acute cardiopulmonary process", "ETT in position, enteric tube below diaphragm", "No consolidation appreciated", "No consolidation appreciated, with peribronchial wall thickening likely in the setting of a viral process", "No consolidation appreciated, upper tracheal narrowing/steeple sign"} as interpreted by this ED physician in the absence of a pending formal radiology read.

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**BDDATASECT**

**Data**

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@EDLABS@

@EDIMAGING@

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**BDDCABDPAIN**

You were seen in the emergency department for abdominal pain. You were evaluated and {Blank single:19197:::"your vitals and exam were reassuring.", "your vital signs, exam and labs and imaging were reassuring.", "your vital signs, exam and labs were reassuring."} Your pain may be due to \*\*\*.

{Blank single:19197:::"You have been given a prescription for an antacid which you should take as instructed.", "You have been given a prescription for an anti-nausea medicine which you should take as instructed.", "You should follow up with your primary care doctor in the next 2-3 days if your pain does not improve."}

Please seek immediate medical attention if you develop any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

---

**BDDCABSCESS**

You were seen in the emergency room for a skin infection. You were evaluated, and {Blank single:19197:::"your abscess did not require drainage", "your abscess was drained"}.

{Blank single:19197:::"You should see your primary care doctor in 2-3 days if the infection is worsening or does not improve.", "You have been given a prescription for an antibiotic to help treat the infection. You should follow up with your primary care physician to ensure the infection is clearing."}

You should soak the area at least three times daily in warm water and apply pressure using warm compresses to gently help the remaining fluid drain out.

Please seek immediate medical attention if they develop any fevers, chills, worsening pain, drainage, or any other new, changing, or worsening symptoms. Otherwise, please follow up with their regular doctor regarding this visit.

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**BDDCAFIBRVR**

You were seen in the emergency room for a rapid heart rate and were found to be in atrial fibrillation. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*","You were evaluated, and your imaging showed \*\*\*","You were evaluated, and \*\*\*","You were evaluated and you were found to have \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your exam was reassuring","You were evaluated, and your work up was reassuring"}. You received medications in the emergency department to bring your heart rate down and were asymptomatic in the emergency department.

We have prescribed you medication to help you control your heart rate which you should take until you follow-up with electrophysiology. We have placed an electrophysiology referral for you to follow-up with them in the next week.

Patients with atrial fibrillation have increased risk of blood clots and stroke. As discussed, {Blank single:19197::"we did not prescribe you anticoagulation at this time due to \*\*\*", "we prescribed you anticoagulation (a 'blood thinner') which you should take as directed"}. You should also follow up with your primary care physician regarding this visit.

Please seek immediate medical attention if you develop any passing out, lightheadedness, chest pain, shortness of breath, fevers, chills, headaches, or any other new, changing, or worsening symptoms.

---

**BDDCALLERGY**

You were seen in the emergency department for an allergic reaction. You were evaluated, and your symptoms have now resolved.

You have been observed for several hours in the Emergency Department and you are stable for discharge at this time. You can take Benadryl and Pepcid, which are available over the counter, to help control your symptoms at home.

\*\*\*You have also been given a prescription for steroids, please take them as directed.

\*\*\*You have also been prescribed an epinephrine auto-injector (EpiPen) which you can use as needed for a severe allergic reaction. Please see the attached instructions.

Please seek immediate medical attention if you develop any rashes, difficulty breathing or swallowing, lip/mouth/tongue swelling, difficulty breathing, fevers, chills, nausea, vomiting, headaches, or any other new, changing, worsening symptoms. Otherwise, please follow-up with your regular doctor regarding this visit.

---

**BDDCANIMALBITE**

You were seen in the emergency room for an animal bite. {Blank single:19197::"You were evaluated, and your exam was reassuring","You were evaluated, and \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your imaging showed \*\*\*","You were evaluated, and your wounds were cleaned and dressed"}. {Blank single:19197::"You have been given a prescription for antibiotics which you should take as prescribed"}

It is VERY important to keep the area clean by washing it 2-3 times a day with soap and water.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,","redness, swelling, pus, or worsening pain around the wounds"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCANKLESPRAIN**

You were seen in the emergency room for an ankle injury. You were evaluated, and your imaging was reassuring. Your symptoms are most likely due to an ankle sprain.

{Blank single:19197::"You should follow up with your primary care doctor in 2-3 days if the pain does not improve or worsens.", "You have been given an air cast and crutches to help you walk, but you should move the joint as much as you can tolerate."}

Rest, Ice, Elevate and Compress the ankle as needed.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any worsening pain or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

It is possible that you may have, or develop a persistent functional disability. You may develop persistent pain. If you develop persistent pain or have any functional disability, specialty evaluation and/or more advanced imaging may be required. Please follow-up with your primary care doctor to organize subspecialty follow up if has not been arranged already as well as potentially more advanced imaging options, such as outpatient magnetic resonance imaging of the area of concern. Please return to the emergency department if symptoms worsen or you have new concerning symptoms regarding your increased pain or functional disability.

---

**BDDCASTHMA**

You were seen in the emergency room for shortness of breath. You were evaluated, and were likely having an asthma exacerbation. You were treated and your symptoms improved.

{Blank single:19197::"You have been given a prescription for steroids. For the next 24 hours, you should use your albuterol inhaler every 4 hours. The following day, you can space to every 6 to 8 hours and then continue to space it out until you don't require regular use any longer."}

Please seek immediate medical attention if you develop any worsening shortness of breath, chest pain, headaches, nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

**BDDCBACKPAIN**

You were seen in the emergency room for {Blank single:19197::"back pain"}. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your work up was reassuring", "You were evaluated, and your exam was reassuring"}. {Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*", "You should follow up with \*\*. The information to make this appointment has been included in this paperwork", "If you have persistent pain, you should follow up"}

with your primary care physician regarding this visit"}.

You may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

You have been given a prescription for {Blank single:19197::"an antibiotic","a medicine to help with nausea and vomiting","a muscle relaxant"}, which you should take as prescribed. {Blank single:19197::"You have been given a print out prescription that you should take to a pharmacy as soon as possible","The prescription has been sent to the pharmacy listed in this paperwork"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"difficulty urinating or passing stool, loss of control of urine or stool, numbness to your legs or groin, increasing difficulty walking, fevers, chills"}, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCBELLSPALSY

You were seen in the emergency room for {Blank single:19197::"a facial droop"}. You were evaluated, and you most likely have a condition called Bell's Palsy. There are many potential causes, for example a recent viral illness.

You have been given a prescription for steroids and an anti-viral medication to treat the condition. You may continue to experience symptoms for some time, and if they are still present within 1-2 weeks, you should follow up with neurology.

You should use artificial tear eye drops at least four times a day, but can use them as often as feels comfortable. At nighttime, you should use an artificial tear gel as well as soft paper tape to tape your eye closed to avoid injury from dryness.

Please seek immediate medical attention if you develop any worsening weakness or numbness elsewhere in your body, worsening symptoms, headaches, nausea, vomiting, vision changes, eye discharge, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCBLOODTRANSFUSION

You were seen in the emergency room for {Blank single:19197::"low blood levels"}. You were evaluated, and you were transfused. You should follow up with your primary care physician regarding this visit.

You had a reassuring exam without evidence of bleeding, but will need short term follow up with your primary care provider for further evaluation.

Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCBURN

**You were seen in the ER for a burn.**

We recommended daily soap and water washes to keep the area clean. Keep the affected area elevated whenever possible.

**You can take Motrin three times a day to help control the swelling.**

You should follow up with {Blank single:19197::"your primary care physician"} in \*\*\* days to have the wound re-checked. The information to make this appointment has been included in this paperwork.

Please seek immediate medical attention if you develop any worsening pain, redness, swelling, pus draining or for any other new changing or worsening symptoms.

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#### BDDCCELLULITIS

**You were seen in the emergency room for a skin infection. You were evaluated, and it is most likely a cellulitis.**

{Blank single:19197::"You should see your primary care doctor in 2-3 days if the infection is worsening or does not improve.", "You have been given a prescription for an antibiotic to help treat the infection. You should follow up with your primary care physician to ensure the infection is clearing."}

Please seek immediate medical attention if they develop any fevers, chills, worsening pain, drainage, or any other new, changing, or worsening symptoms. Otherwise, please follow up with their regular doctor regarding this visit.

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#### BDDCCHESTPAIN

**You were seen in the emergency department for chest pain. You were evaluated and {Blank single:19197::"your work up was remarkable for \*\*\*", "all of your tests and imaging were reassuring"}. {Blank single:19197::"Your pain is most likely caused by \*\*. You should follow up with your primary care doctor regarding this pain.", "You should follow up with your primary care doctor regarding this pain.", "You should follow up with your primary care physician as soon as possible to schedule a stress test.", "You should follow up with your primary care doctor regarding this pain so you can discuss if you need to have a stress test done."}**

Please seek immediate medical attention if you develop any worsening chest pain, shortness of breath, nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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#### BDDCCHFE

**You were seen in the emergency department for {Blank single:19197::"chest pain", "shortness of breath"}. You were evaluated, and your labs and imaging were all reassuring. You likely have a build up of fluid in your body that is causing your symptoms, and you should see your primary care doctor for long term management of this issue.**

{Blank single:19197::"You have been given a short prescription for a fluid pill to help you with this issue until you can see your primary care provider. "}

Please seek immediate medical attention if you develop any worsening shortness of breath, headaches, nausea, vomiting, chest pain, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCCONSTIPATION**

You were seen in the emergency department for {Blank single:19197::"constipation","abdominal pain"}. You were evaluated and your {Blank single:19197::"labs and imaging were notable for \*\*\*,","exam was reassuring","labs and imaging were reassuring"}. You may be experiencing pain from constipation. We have given you a prescription for {Blank single:19197::"Miralax"} which should help improve your symptoms.

Please seek immediate medical attention if you develops any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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**BDDCCOUGH**

You were seen in the emergency department for a cough. You were evaluated and {Blank single:19197::"your exam was reassuring","your chest x-ray did not show any concerning findings","all of your labs and imaging were reassuring"}. {Blank single:19197::"Please see your primary care doctor within a week if your symptoms have worsened","You were given a breathing treatment that helped improve your symptoms, please see your primary care doctor or return here if your symptoms worsen or do not improve."}

Please seek immediate medical attention if you develop any worsening chest pain, difficulty breathing, fevers, chills, or any other new, changing or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit to ensure your symptoms are improving.

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**BDDCCOVID**

You were evaluated in the ED for an illness including {Blank single:19197::"respiratory symptoms and a fever.", "respiratory symptoms.", "fever.", "cough."} We evaluated you and feel that it is safe to discharge you home with outpatient follow-up at this time. You {Blank single:19197::"were tested positive for COVID-19.", "tested positive for \*\*.", "did not test positive for COVID but have symptoms consistent with a viral illness."} We have included some general information about COVID-19 and how to keep yourself healthy. These instructions are good guidelines for any respiratory illness.

The best ways to prevent spread of infections are:

- 1) Wash your hands frequently
- 2) Cough into your elbow
- 3) Sanitize your hands and surfaces in your home frequently
- 4) If possible, have sick family members use a separate bedroom where he they can recover without sharing immediate space with others
- 5) Wear a face mask when you are around close contacts
- 6) As much as possible, avoid household members who may be at increased risk of complications from infections (.e.g., people >65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions).

Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCCSPINEFX**

You were seen in the emergency room for \*\*\*. You were evaluated, and your imaging showed a cervical spine fracture. You should follow up with \*\*\* in \*\*\* days. The information to make this appointment has been included in this paperwork.

You must keep the hard collar on at all times, including when you are in the shower. You have been given a set of replacement pads as well as teaching about how to change them safely after the shower.

Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCDIVERTICULITIS**

You were seen in the emergency department for abdominal pain. You were evaluated and you were found to have diverticulitis.

At this time, you are appropriate for treatment with antibiotics at home.

You have been given a prescription for an antibiotic, which you should take as prescribed. {Blank single:19197::"The prescription has been sent to the pharmacy listed in this paperwork","You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.

Please seek immediate medical attention if you develop any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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**BDDCDVT**

You were seen in the emergency room for left leg swelling. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your exam was reassuring", "You were evaluated, and your work up was reassuring"}. {Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*", "You should follow up with \*\*\*. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit"}.

We started you on anticoagulation medicine to help treat your blood clots. Please take that medication as directed. As discussed, this can increase your risk of bleeding including bleeding if you were to fall. Please see attached instructions regarding this. Based on our discussion today, the benefits of starting this medicine now likely outweigh the risk, but you should discuss if that remains the case in the future for discussion with your primary care provider.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCEARPAIN**

You were seen in the emergency room for {Blanks single:19197::"ear pain"}. You were evaluated, and

{Blanks single:19197::"your exam was reassuring","you appear to have an ear infection"}. {Blank single:19197::"You should follow up with your regular doctor within a week if your symptoms do not improve or sooner if they worsen.", "You have been given a prescription for an antibiotic to help resolve your symptoms."}

Please seek immediate medical attention if your pain worsens, you develop any worsening headaches, swelling of behind your ears, fevers, chills, nausea, vomiting, or for any other new, changing or worsening symptoms or if your symptoms do not improve. Otherwise please follow up with your regular doctor regarding this visit.

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#### BDDCEMH

You were seen in the ER for mental health reasons. You were evaluated, and you do not require emergency evaluation by a mental health provider. However, please do not hesitate to return if you need additional services.

If you have been deemed safe to return home but would like emergent mental health help, please call the Community Health Link (CHL) Mobile Team at 1-866-549-2142.

Please seek immediate medical attention if you feel like hurting yourself or anyone else or killing yourself or anyone else, if you feel depressed, or for any other new, changing or worsening symptoms. Otherwise, please follow up with your regular doctor and use the resources provided below.

### Worcester Community Resource Guide

#### Mental Health and Substance Use Referral Lines

1. Department of Mental Health Information and Referral line: 800-221-0053
2. Massachusetts Substance Abuse Information and Education Helpline (<http://www.helpline-online.com/>): 800-327-5050

#### Mental Health Services: Community Providers

1. South Bay Community Services , Worcester : 508-521-2200
2. Counseling and Assessment Clinic of Worcester: 508-756-5400
3. Shrewsbury Youth and Family Services: 508-845-6932

#### Community Mental Health Centers: Mental, Physical, & Dental Health

1. Edward M. Kennedy Community Health Center (Worcester) 508-852-1805
2. Family Health Center of Worcester 508-860-7800

#### Emergency Mental Health Services

1. Emergency Mental Health-UMASS Memorial Triage Telephone Line: 866-549-2142

#### Community HealthLink—Worcester County

1. PES (Psychiatric Emergency Services)—Metrowest and Framingham: 800-977-5555, 800-640-5432
2. Department of Mental Health Crisis Intervention Services—Worcester 508-856-3562

#### Mental Health Support and Advocacy Groups

1. Bipolar & Unipolar Depression Support Group-Worcester: 508-864-4759
2. NAMI—MetroWest Chapter Help Line: 508-875-1544

#### Free Medical Clinics

1. St. Anne's Free Medical Program (Shrewsbury): 508-754-7920
2. Akwaaba Free Medical Clinic (Worcester): 508-767-1311
3. Guild of Our Lady of Providence Free Medical Program at St. Bernard's (Worcester): 508-798-6818

#### Suicide Hotlines: National & Statewide

1. National Suicide Prevention Lifeline 800-273-TALK (8255)
  2. Samaritans Statewide Helpline: 617-247-0220, 508-875-4500, 877-870-4673
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3. Veterans Crisis Line: 800-273-TALK (8255)-Press 1

#### Rape Crisis Hotline

1. Rape Crisis Center of Central Massachusetts: 800-870-5905 (Español) 800-223-5001

#### Domestic Violence Resources

1. Day Break 24hr Hotline Support: 508-755-9030
2. SafeLink (Massachusetts Statewide Domestic Violence Hotline): 877-785-2020

#### Pediatric Resources

1. Youth Mobile Crisis Unit \*Medicaid Insurance Coverage Only\* Worcester Team: 1-866-549-2142  
North/Central Worcester Team: 1-800-977-5555

#### Elder Services Resources

1. Elder Services of Worcester Area: 508-756-1545

#### Parental Stress Hotline

1. Parents Helping Parents: 1-800-632-81888 ([www.parentshelpingparents.org](http://www.parentshelpingparents.org))

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#### BDDCEPIDIDYMITIS

You were seen in the emergency room for groin pain. You were evaluated, and your imaging did not show any concerning findings. Your symptoms are most likely due to a testicular infection.

You have been given a prescription for {Blank single:19197::"an antibiotic","a medicine to help with nausea and vomiting"}, which you should take as instructed. {Blank single:19197::"The prescription has been sent to the pharmacy listed in this paperwork","You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.

Please seek immediate medical attention if you develop any fevers, chills, worsening groin pain, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCEPISTAXIS

You were seen in the emergency room for a nose bleed. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*","You were evaluated, and \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your exam was reassuring","You were evaluated, and your work up was reassuring","You were evaluated, and the bleed had stopped on my evaluation","You were evaluated, and the bleeding stopped in the emergency room","You were evaluated, and the bleeding was stopped with something called a rhino rocket, which will have to be removed in 2-3 days}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*","Your symptoms may be due to \*\*\*",""}{Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*","You should follow up with \*\*. The information to make this appointment has been included in this paperwork","You should follow up with your primary care physician regarding this visit","You should follow up with ENT (ear, nose and throat) to have this removed. The information to make this appointment has been included in this paperwork","You should follow up with your primary care physician regarding this visit"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"worsening bleeding, lightheadedness, passing out,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCETOH**

You were seen in the emergency room for {Blank single:19197::"drug overdose","alcohol intoxication"} . You were evaluated, and do not appear to have any severe injuries. You are now able to walk on your own and are tolerating fluids/food.

You are clinically, but not legally sober. Do not drive/operate machinery until you are. You were observed and discharged in improved condition. Using {Blank single:19197::"drugs","alcohol"} is dangerous to your health, please read the attached instructions.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, chest pain, shortness of breath, vision changes, or any other new, changing, or worsening symptoms or if your symptoms do not resolve.

If you would like to quit, detox information is available on request. {BDOPTDETOXLIST (Optional):46650}

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**BDDCEXPOSURE**

You were seen in the ER after exposure to a bodily fluid. You were evaluated and do not appear to have any serious injury, however due to your exposure, labs were sent to confirm you do not have any infectious disease. You should follow up with infectious disease clinic within one day, the number for which has been provided in this paperwork. You will also find information about Employee Health Services, please follow these instructions as well.

Because of the nature of your exposure,{Blank single:19197::"you were started on prophylactic treatment for Hepatitis B and HIV. You have been given a prescription for medications to take for one month, please follow up about this prescription at your infectious disease appointment." "you did not require any prophylactic treatment. Please follow up regarding this recommendation at your infectious disease appointment."}

Employee Health Services

291 Lincoln Street

Worcester, MA 01605

PATIENT INFORMATION SHEET

EMPLOYEE BODY FLUID EXPOSURE

Call or visit Employee Health on the next business day. Employee health is open Monday through Friday 7a-7p except on holidays.

Employee Health will ensure the proper follow-up including:

- o Completion of a First Report of Employee Injury (FREI). If you have already completed the FREI, please bring it with you to Employee Health.
  - o Specific details of your exposure:
    - Mechanism of injury (needle stick, eye splash)
    - Immunity to hepatitis B virus
    - Tetanus vaccine status
    - Source patient name, medical record number.
  - o Review of labs done in the ED
  - o Review of medication/s, if any, prescribed in the ED
  - o Contact the HIV coordinator/ provider who will then attempt to obtain consent from the source patient for HIV and hepatitis testing.
- If you have been prescribed medications, take them as prescribed. If additional medications are needed, they will be ordered by Employee Health.

Prescriptions:

- o Clinical and State employees: Rx can be filled at the UMASS pharmacy, located on the University Campus.
  - o OR:
-

- Clinical employees may fill script/s at CVS. Explain that it is a Worker's Compensation Injury.
  - State employees may fill script/s at Rite Aide or Walgreen's. Explain that it is a Worker's Compensation Injury.
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#### BDDCEYEPAIN

You were seen in the emergency room for {Blanks single:19197::"eye pain","a foreign body in your eye"}. You were evaluated, and your eye exam was {Blanks single:19197::"notable for \*\*\*","notable for a foreign body","notable for redness","reassuring"}.

{Blank single:19197::"You should follow up with your primary care doctor within a week if your symptoms persist or sooner if they worsen.", "You should follow up with ophthalmology in their clinic for any worsening or persistent symptoms.", "You should follow up with ophthalmology in their clinic in the next few days, the number is 508-334-6855."}

{Blank single:19197::"You were sent a prescription for an eye antibiotic that you should take as directed.", ""}

Please seek immediate medical attention if you develop any sudden vision changes, eye pain, headaches, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCFACIALFRACTURE

You were seen in the emergency room for \*\*\*. You were evaluated, and you were found to have a facial fracture.

{Blank single:19197::"You should follow up with your primary care doctor within a week for persistent pain or sooner if your symptoms worsen", "You should follow up with plastic surgery if you have persistent pain or deformity. The information to make this appointment has been included in this paperwork."}

To protect your facial fractures, you must follow these recommendations: Do not blow your nose, do not apply any pressure to your face, keep your head of bed elevated to at least 30 degrees.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, bleeding, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCFLU

You were seen in the emergency department for flu like symptoms. You were evaluated and {Blank single:19197::"your workup was notable for \*\*\*","your workup was reassuring","all of your labs and imaging were reassuring"}. You {Blank single:19197:: "most likely have the flu or another similar viral illness","tested positive for the flu"}.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

{Blank single:19197:: " ","A prescription for a medication to help with your nausea has been sent to the pharmacy listed in this paperwork, please take it as prescribed"}

Please seek immediate medical attention if you develop any worsening chest pain, difficulty breathing, fevers, chills, or any other new, changing or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit to ensure your symptoms are improving.

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**BDDCFOREIGNBODYGI**

You were seen in the emergency room after swallowing a \*\*\*. You were evaluated, {Blank single:19197::"and the object had to be removed emergently by the GI doctors", "and your imaging showed that the object has passed into your stomach, and nothing else needs to be done as it will pass in your stool", "and you were able to expel the object"}.

Please seek immediate medical attention if you develop any nausea, vomiting, belly pain, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCGASTRO**

You were seen in the emergency department for {Blank single:19197::"diarrhea", "abdominal pain", "vomiting"}. You were evaluated and {Blank single:19197::"your exam was reassuring", "all of your labs were reassuring", "all of your labs and imaging were reassuring", "your symptoms improved with treatment", "your work up was reassuring and your symptoms improved with treatment"}. You most likely have a viral gastroenteritis.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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**BDDCGENERIC**

You were seen in the emergency room for \*\*\*. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your exam was reassuring", "You were evaluated, and your work up was reassuring"}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*", "Your symptoms may be due to \*\*\*", " "}{Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*", "You should follow up with \*\*. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCHEADACHE**

You were seen in the emergency department for a headache. {Blank single:19197::"After evaluation and observation", "After evaluation and imaging"}, your evaluation did not show evidence of medical conditions requiring emergent intervention at this time, and your pain improved with medication in the ED.

If your pain persists, you may take alternating doses of {Blank single:19197::"500", "1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400", "800", "600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please follow up with your primary care physician within two days.

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**Return to the Emergency Department if you experience worsening or uncontrolled pain, vision changes, recurrent vomiting, difficulty with normal activities, abnormal behavior, difficulty walking, numbness, weakness, or any other concerning symptoms.**

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#### BDDCHEADINJURY

You were seen in the emergency department after a head injury. {Blank single:19197::"After evaluation and observation","After evaluation and imaging"}, we did not find any emergent concerns.

{Blank single:19197::"You should follow up with your primary care doctor within a week for a re-evaluation.","You had a laceration to your head that was repaired with \*\*\*, which should be removed in 7-10 days by your primary care doctor or other health care professional. Please wash the area daily with soap and water."}

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any headaches, confusion, persistent vomiting, or for any other new, changing, worsening symptoms, or if symptoms do not resolve. Otherwise, please follow-up with your regular doctor within a week.

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#### BDDCHIPPAIN

You were seen in the emergency department for hip pain. You were evaluated, and {Blank single:19197::"your exam was reassuring","your imaging did not show any concerning findings"}. Your pain may be due to \*\*\*.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any worsening difficulty with walking, change in color of your leg, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCHTN

You were seen in the emergency room for high blood pressure. You were evaluated, and your {Blank single:19197::"work up","physical exam"} was {Blank single:19197::"notable for \*\*\*","reassuring"}.

It is important that you follow up with your primary care doctor as soon as possible about getting your blood pressure under better control.

Please seek immediate medical attention if you develop any severe, headaches, nausea, vomiting, chest pain, shortness of breath, stop urinating, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCHYPOGLYCEMIA**

You were seen in the emergency room for hypoglycemia. You were evaluated, and your work up was reassuring. Your symptoms are most likely due to \*\*\*.

Please seek immediate medical attention if you develop any headaches, lightheadness, mental status changes, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCKIDNEYSTONE**

You were seen in the emergency department for pain. You were evaluated, and your {Blank single:19197::"your symptoms are consistent with having a kidney stone","your imaging was positive for a kidney stone"}. It is important that you stay well hydrated.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

{Blank single:19197::"You were sent a prescription for the medication tamsulosin to help expel the stone, which you can stop taking once the stone has passed.", ""}

{Blank single:19197::"You should follow up with your primary care doctor within a week if the pain persists or sooner if it worsens","You should follow up with urology regarding this issue. The information to make this appointment has been included in this paperwork."}

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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**BDDCLACREPAIR**

You were seen in the emergency room after a \*\*\* injury. You were evaluated, and your wound was repaired.

You should see your primary care doctor in \*\*\* days to have the {Blank single:19197::"staples","stitches"} removed.

Please wash the area daily with soap and water and keep the wound otherwise clean and dry.

Please seek immediate medical attention if you develop any redness around the area, pain, oozing, fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**BDDCLIGHTHEADED**

You were seen in the ER for lightheadedness. You were evaluated, and {Blank single:19197::"your workup was notable for \*\*\*","your exam was reassuring","all of your labs and imaging were reassuring","all of your labs were reassuring"}. {Blank single:19197::"Your symptoms may have been caused by \*\*\*","Your symptoms may have been caused by dehydration"}.

Please seek immediate medical attention if you pass out or if you develop any headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCMIGRAINE

You were seen in the emergency department for a migraine. You were treated, and your symptoms improved.

Please seek immediate medical attention if you develop any worsening headaches, nausea, vomiting, altered mental status, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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#### BDDCMISCARRIAGE

You were seen in the emergency room for vaginal bleeding. You were evaluated, and unfortunately you are likely to be miscarrying. You should follow up with OB/GYN. The information to make this appointment has been included in this paperwork.

Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCMVC

You were seen in the emergency department for after a motor vehicle collision. You were evaluated, {Blank single:19197:: "and do not appear to have any serious injuries","and your imaging did not show any fractures or severe injury"}.

You may experience muscle pain over the next several days as a result of the impact. You may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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#### BDDCPEDICONSTIPATIONCLEANOUT

##### **Constipation: Pediatric Management**

The first step to treating your child's constipation is a good cleanout with a stool softener and a stimulant laxative.

Then, in the "maintenance phase", your child will take a daily dose of stool softener for at least several months to a year. Treating constipation can take a long time, but we'll follow along with you to be sure your child gets back to a normal stool pattern of passing soft stools comfortably every day or every other day.

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## **Part One: Cleanout Phase**

Do the clean out when there is access to a bathroom for 24-48 hours. The goal is to have several bowel movements that are loose or watery. Your child will take two medicines.

Start on Friday if your child is in school. Give the first dose on Friday afternoon and the second dose on Saturday morning if needed.

- **Cleanout medicine 1: Stool softener – polyethylene glycol (Miralax, Glycolax or PEG)**

Polyethylene glycol brings water into the bowels. Mix the polyethylene glycol with the amount of clear liquid recommended. Plan to give 4 ounces every 15 minutes or 8 ounces every 30 minutes until complete. You may use clear liquid such as juice, water or tea. Have your child drink lots of liquids when they are on these medications to prevent dehydration.

- **Cleanout medicine 2: Stimulant laxatives – Senna or bisacodyl**

See the charts on the next page for your child's medicines and doses. Give as directed.

Plan to repeat this cleanout in one week.

## **Part Two: Maintenance Phase to keep bowels regular**

### **Long-term daily stool softener given for at least 6 to 12 months**

As soon as your child completes the first cleanout, give polyethylene glycol once daily as indicated in the maintenance dosing chart below. It needs to be taken daily for at least 6 to 12 months and often longer. Mix the medicine with liquid, such as juice, tea or water. It's very important to mix the medicine with the full amount of liquid suggested. You can increase or decrease the dose as needed to achieve mashed potato consistency stools.

## **Toileting Routine and Diet Recommendations**

To help make stooling comfortable and regular, we recommend you help your child with this routine:

- Toileting habits: If possible, sit on the toilet 2-3 times a day after meals for at least 5 minutes without lots of distractions – avoid games, books and electronics as much as possible.
- Toileting position: Knees should be hip level and feet flat against the ground or on a footstool to relax buttocks.
- Diet: Your child does not need excess fiber or water, but should drink enough water or liquids so that the urine is clear and eat a healthy diet with 5 servings a day of fruits/vegetables plus 2 servings of fiber (whole grains, bran, barley).

To help your child understand all of this, Watch "[The Poo in You](#)" video on You Tube with your child. It's great!

## **Follow Up Visit Recommendations**

Please schedule a follow up with pediatrician within 1-2 days.

## **First Part: 2 day Cleanout Phase – Use stool softener and a stimulant laxative Cleanout**

### **Medicine 1: Stool softener – polyethylene glycol (Miralax, Glycolax or PEG) Stool Softener**

Medicine Name	How Often	Child's Weight (kg)	Child's Weight (lbs)	Miralax Dose	Mix with Clear Liquid
Polyethylene glycol (Miralax, Glycolax or PEG) 1 Capful = 17 grams. Use the cap that comes on the medicine bottle.  Dosing: 3 grams/kilogram/day	4 ounces every 15 minutes or 8 ounces every 30 minutes until complete  1 time in	10 to 19.9 kg	22 to 43 lbs	<input type="checkbox"/> 2 – 3 capfuls	8 – 12 ounces

Each capful should be mixed with 4 ounces of liquid	the afternoon and repeat the following morning	20 to 29.9 kg	44 to 65 lbs	<input type="checkbox"/> 4 – 5 capful	16 – 20 ounces
		30 to 39.9 kg	66 to 87 lbs	<input type="checkbox"/> 5 - 7 capfuls	20 – 28 ounces
		40 to 49.9 kg	88 to 109 lbs	<input type="checkbox"/> 7 - 9 capfuls	28 – 36 ounces
		50 to 69.9 kg	110 to 154 lbs	<input type="checkbox"/> 9 - 12 capfuls	36 - 48 ounces
		70 kg and over	Over 154 lbs	<input type="checkbox"/> 3 g/kg/day	4 ounces for 17 grams

### Cleanout Medicine 2: Stimulant Laxative – choose either Senna or bisacodyl Stimulant Laxative

Medicines you can buy at the drugstore come in many strengths. Be sure to check the strength of the medicine on the bottle – usually written as milligrams per ml or mg alone.	Medicine Name	How Often	Child's Weight (kg and lbs)	Child's Age	Dose
<b>Senna</b> Available at these strengths over the counter: - 8.6 mg tablet - 15 mg chocolate chew (ExLax)	1 time in the afternoon and repeat the following morning *If no adequate stool after the first day, double the chocolate chew dose	10 to 25 kg 22 to 55 lbs	2 to 6 years	<ul style="list-style-type: none"><li>• <u>½ tablet or</u></li><li>• <u>¼ chocolate chew</u></li></ul>	
		25 to 40 kg 55 to 88 lbs	6 to 12 years		
		40 kg+ 88 lbs and over	12 years+		
<b>Bisacodyl</b> 5 mg tablet by prescription or over the counter	1 time in the afternoon and repeat the following morning	15 to 40 kg 23 to 88 lbs	3 to 10 years	<input type="checkbox"/> 1 tablet	
		40 kg + 88 lbs and over	10 years +	<input type="checkbox"/> 1 to 2 tablets	

### Second Part: Maintenance Phase – Use a stool softener Stool Softener

	Medicine Name	How Often	Child's Weight (kg)	Child's Weight (lbs)	Miralax Dose	Mix with Clear Liquid
<b>Polyethylene glycol</b> (Miralax, Glycolax or PEG) 1 Capful = 17 grams. Use the cap that comes on the medicine bottle. Dosing: 1 gram/kilogram/day Max	1 time a day	10 to 14.9 kg	22 to 32 lbs	<input type="checkbox"/> ½ - 1 capful	4 to 8 ounces	
		15 to 19.9 kg	33 to 43 lbs	<input type="checkbox"/> 1 capful		
		20 to 24.9 kg	44 to 54 lbs	1 – 1 ½ capfuls		

Daily Dose: 34 grams

	You can increase or decrease the dose as needed to achieve mashed potato consistency stools.	25 to 29.9 kg	55 to 65 lbs	1 1/2 - 2 capfuls	8 ounces
		30 kg and over	Over 66 lbs	<input type="checkbox"/> 2 capfuls	8 ounces

#### BDDCPEDICROUP

@FNAME@ was seen in the Emergency department for cough, which is consistent with croup. It is caused by a virus. Symptoms are often worse at night and wake the child from sleep. Symptoms also seem to improve in the morning but worsen as the day goes on. Most children improve in three to seven days.

Your child was treated with steroid called dexamethasone and responded well. This illness should improve with time. Please be sure your child gets plenty of rest and drinks lots of fluids.

#### Home treatments for croup include:

Using a cool mist humidifier

Taking the child into a steamed bathroom

Taking the child outside into cool, moist, night air

Drinking lots of fluids

You can give @FNAME@ Tylenol for fever control.

If @FNAME@ is older than 6 months, you can also use Ibuprofen/Motrin.

If your child has high fevers, worsening cough, difficulty breathing or any other new or concerning symptoms, please return to the ED for further evaluation. Otherwise follow up with pediatrician tomorrow.

#### BDDCPEDIFEBrileSeizure

@NAME@ was seen in the emergency department for febrile seizure. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your exam was reassuring", "You were evaluated, and your work up was reassuring"}. You should follow up with your pediatrician in the next few days to discuss further evaluation.

Please see the additional instructions below about febrile seizures.

Please seek immediate medical attention if you develop any additional seizure that lasts 5 minutes or longer, frequent vomiting, severe headache, neck pain or stiffness, develops bruising/tiny red dots on the skin that look like broken blood vessels, your child becomes blue, difficulty breathing, behavior changes, inability to tolerate feeding, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. You should also contact your pediatrician if your child has another seizure that lasts less than 5 minutes, refuses to drink, still has a fever after 2 to 3 days, or develops any additional issues. Otherwise, please follow up with your regular doctor regarding this visit.

#### Over-The-Counter Pain Medicine Dosing Chart

##### Acetaminophen (Tylenol-type medicine)

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs

							(500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

### Ibuprofen (Motrin or Advil-type medicine)

May be given every 6-8 hours as needed to relieve pain or fever  
Should NOT be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

### Febrile Seizure: How to Care for Your Child

Febrile seizures are uncontrolled full-body movements or convulsions that happen during a fever (febrile means feverish). They usually stop on their own without treatment and don't cause brain damage or any other permanent problems. Febrile (FEH-bryle) seizures can be frightening to see, but they're usually not a sign of serious illness.



### Care Instructions

- Give any medicines prescribed by your child's health care provider.
- Let your child rest if he or she feels sleepy.
- Encourage your child to drink fluids.

- If your child is uncomfortable from a fever, don't give aspirin. If the health care provider says it's OK, give one of these medicines exactly as directed:
  - acetaminophen (such as Tylenol® or a store brand)
  - **OR**
  - ibuprofen (such as Advil®, Motrin®, or a store brand). **Don't give to babies under 6 months old.**
- Set up a follow-up visit with your health care provider as directed.

If your child has another seizure:

- Gently lower your child to the floor on his or her side to prevent choking.
- Move objects out of the way so your child isn't injured.
- Keep track of the time and make note of your child's color and breathing.
- Don't try to hold or restrain your child.
- Don't put anything in your child's mouth.
- Don't try to give your child fever-reducing medicine until the seizure is over and your child is fully awake.
- Don't try to lower a fever by putting your child in water.

**Call 911 if your child's seizure lasts 5 minutes or longer, or if your child becomes blue in the face or has trouble breathing.**

#### Call Your Health Care Provider if...

Your child:

- has another seizure that lasts less than 5 minutes
- refuses to drink
- still has a fever after 2 or 3 days
- develops a new symptom or specific problem, such as vomiting or diarrhea, cough or congestion, a rash, foul-smelling pee or pain when peeing (urinating), or if you think your child has belly, ear, or throat pain

#### Go to the ER if...

Your child:

- has another seizure that lasts longer than 5 minutes
- is very fussy or cranky
- is hard to wake up
- has frequent vomiting
- has a severe headache
- has neck pain or stiffness
- develops bruising or tiny red dots on the skin that look like broken blood vessels
- looks dehydrated; signs include dizziness, drowsiness, a dry or sticky mouth, sunken eyes, crying with few or no tears, or peeing less often (or having fewer wet diapers)

**Call 911 if your child has a seizure that lasts 5 minutes or longer, or if your child becomes blue in the face or has trouble breathing.**

#### More to Know

**Are tests needed to diagnose a febrile seizure?** Most of the time, no special tests are needed. Health care providers can diagnose a febrile seizure if it is brief, happens to a child 6 months to 5 years old during a fever, and the child recovers quickly. If any testing is needed, it would focus on finding the reason for the fever.

**Why do kids get febrile seizures?** No one knows why febrile seizures happen, although experts think they're linked to some viruses and the way that some children's developing brains react to high fevers.

**Will my child have another febrile seizure?** Sometimes kids who have had one febrile seizure will have another (usually within 1 to 2 years). Kids who are younger than 15 months old at the time of their first febrile seizure are more likely to have another one. Most kids outgrow having febrile seizures by the time they're 5 years old. Having a febrile seizure doesn't mean a child has a seizure disorder (epilepsy). Having had a febrile seizure only slightly increases a child's chances of developing a seizure disorder.

**Can I stop my child from having another febrile seizure?** It's not possible to prevent a febrile seizure by giving fever-reducing medicines like acetaminophen or ibuprofen. These medicines can help to keep children comfortable. But parents shouldn't worry that a seizure will happen if they don't give their child medicine.

**BDDCPEDIHEADINJURY**

@FNAME@ was seen in the emergency department for after a motor vehicle collision. You were evaluated and after period of observation the emergency department, {Blank single:19197::"and do not appear to have any serious injuries","and your imaging did not show any fractures or severe injury"}.

You are able to tolerate eating and drinking while in the emergency department and had a reassuring exam.

Please see the included information below about car seat safety.

If there is any concern for pain, please see the dosing chart for Tylenol and ibuprofen below.

Please seek immediate medical attention and/or follow-up with your pediatrician if you develop any behavior changes, difficulty tolerating feeding, persistent vomiting, headaches, nausea, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if their symptoms do not resolve. Otherwise, please follow up with your pediatrician regarding your visit.

**Patient Education****Car Seat Safety****About this topic**

A properly installed car seat is the best protection for your child when traveling by car. Safety belts are made for adults and will not protect a child in a wreck. A car seat can lessen the risk of a serious injury or death. The best car seat is not the most expensive one. It is the one that best fits your child's weight, size, age, and your car.

Choosing your car seat:

- Select a car seat with a label saying that it meets or exceeds US Federal Motor Safety Standard 213.
- Make sure your car seat is right for your child's weight and height. This will change as your child grows.
- Register your car seat. Fill out the registration card or go to the company's website. This will help you get notice of any recalls or problems.
- Be sure you know the complete history of a car seat. Do not use a seat if it is expired, has missing parts or a missing instruction manual, or has a recall.
- Look for the manufacture date and model number on your car seat. Use this information to check online or call the manufacturer to make sure the seat does not have any safety recalls.

Installing a car seat:

- It is best if your seat is installed or checked by someone who is trained to install car seats.
- Always read your car seat manual and your car's manual before you install your car seat. Your car's manual will tell you the best place in the back seat to secure the car seat.
- Your car may have lower anchors and tethers for children (LATCH), the Universal Anchorage System (UAS), or International Standards Organization Fix (ISOFIX) that is used to secure the car seat.
- You can also use the seat belt instead of the LATCH system.
- Thread the seat belt or UAS strap through the child seat as shown in the seat's instructions.
- Push down on the child seat using your knee while you tighten the seat belt or UAS strap.
- If your car seat has lower anchors or the ISOFIX system, check the seat instructions for how to install the car seat.
- Attach the top tether strap to the top of the car seat and fasten to the top anchor on the car. Check your car's manual if you are not sure where to find this.
- Once the car seat is installed, it should not move more than 1 inch (2.5 cm) side to side and front and back at the seat belt path.

## **General**

Use a rear-facing car seat as long as possible for infants and toddlers. Once your child reaches the rear-facing height or weight allowed by their seat, move them to a forward-facing car seat. Your child should stay in a forward-facing seat until they reach the height or weight limits for the forward-facing seat. Many seats are safe for children up to 65 pounds.

When your child outgrows the forward-facing seat, use a booster seat with a lap and shoulder belt. Keep using this seat until your child is at least 4 feet 9 inches tall (145 cm) and 8 to 12 years old. Be sure the lap and shoulder belt fit the right way for the best protection. Your child should not move to the front seat of the car until they are at least 13 years old.

### **Kinds of Car Seats:**

#### **Rear-Facing Car Seat**

- Use until your child reaches the height or weight allowed for the seat.
- Protects their head, neck, and spinal cord and lowers the risk of injury in a car crash.
- Thread the harness straps at or just below your child's shoulder.
- Place the chest clip at armpit level.
- The harness must be snug against your child. You should not be able to pinch up any harness at your child's shoulders.
- Put the seat handle as recommended by the manufacturer.
- Keep your child in this seat as long as the car seat will allow.

#### **Forward-Facing Car Seat**

- Use when your child outgrows the height or weight allowed for the rear-facing seat.
- Protects their forward movement in a crash with a 5-point harness.
- Thread the harness straps at or just above your child's shoulders.
- Place the chest clip at armpit level.
- The harness must be snug against your child. You should not be able to pinch up any harness at your child's shoulders.
- Keep your child in this type of car seat until they outgrow the height or weight measurements.
- Types:
  - **Convertible Seat** – This seat can change from rear-facing to a forward-facing seat. It can be used with babies and toddlers. This seat allows your child to stay in the rear-facing position longer.
  - **Combination Seat** – This seat can be used as a forward-facing seat when your child outgrows the rear-facing position. As your child grows, it can be used as a booster seat after your child outgrows the forward-facing height or weight limits for the seat.
  - **All-in-One Seat** – This seat can change from rear-facing to a forward-facing seat. It also becomes a booster seat as your child grows. This seat allows your child to stay in the rear-facing position longer. Check how much your child should weigh and how tall they need to be to advance from rear-facing to forward-facing to a booster seat.

#### **Booster Seat**

- Use when your child outgrows their forward-facing car seat. This most often happens when the child is about 65 pounds or more. Follow directions about weight and height limits of the seat.
- Position the adult seat belt so it fits over the stronger parts of your child's body.
- Your child must use the lap and shoulder belt with a booster seat.
- Keep your child in a booster seat until the adult seat belt fits the right way. Most of the time this happens when a child is between 8 and 12 years old and is over 4 feet 9 inches (145 cm) tall.
- Types:
  - **Booster Seat with High Back** – This seat will boost the child's height so the seat belt fits properly. It also provides head and neck support and is good for cars that don't have head rests.
  - **Backless Booster Seat** – This seat will boost the child's height so the seat belt fits properly. It does not provide head and neck support. It is good for vehicles that have head rests.

#### **Will there be any other care needed?**

- Do not add things like bunting bags, head-huggers, trays, or comfort straps that are not approved for use with your specific car seat.
- Do not put anything under or behind your child's body. Tuck a blanket over your child after your child is secured.
- Do not leave your child alone in the car.
- Children should ride in the back seat of the car until at least age 13.

- If a child pushes the shoulder belt behind them, it may be a sign the seat belt is not fitting them the right way. They may be too small to use just a seat belt.

### Where can I learn more?

American Academy of Pediatrics

<https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Updates-Recommendations-on-Car-Seats-for-Children.aspx>

American Academy of Pediatrics

<https://www.healthychildren.org/English/safety-prevention/on-the-go/Pages/Car-Safety-Seat-Checkup.aspx>

### Last Reviewed Date

2018-09-17

### Consumer Information Use and Disclaimer

This information is not specific medical advice and does not replace information you receive from your health care provider. This is only a brief summary of general information. It does NOT include all information about conditions, illnesses, injuries, tests, procedures, treatments, therapies, discharge instructions or life-style choices that may apply to you. You must talk with your health care provider for complete information about your health and treatment options. This information should not be used to decide whether or not to accept your health care provider's advice, instructions or recommendations. Only your health care provider has the knowledge and training to provide advice that is right for you.

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### Over-The-Counter Pain Medicine Dosing Chart

#### Acetaminophen (Tylenol-type medicine)

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

#### Ibuprofen (Motrin or Advil-type medicine)

May be given every 6-8 hours as needed to relieve pain or fever

Should **NOT** be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab

77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

#### BDDCPEDIHEADINJURYPECARN

@FNAME@ was seen in the emergency department for after a head injury. You were evaluated and after period of observation the emergency department, {Blank single:19197::"and do not appear to have any serious injuries","and your imaging did not show any fractures or severe injury"}.

You are able to tolerate eating and drinking while in the emergency department and had a reassuring exam.

If there is any concern for pain, please see the dosing chart for Tylenol and ibuprofen below.

Please seek immediate medical attention and/or follow-up with your pediatrician if you develop any behavior changes, difficulty tolerating feeding, persistent vomiting, headaches, nausea, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if their symptoms do not resolve. Otherwise, please follow up with your pediatrician regarding your visit.

#### Over-The-Counter Pain Medicine Dosing Chart

##### **Acetaminophen (Tylenol-type medicine)**

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

##### **Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever

Should **NOT** be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab

77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

#### BDDCPEDIHEADLAC

@FNAME@ was seen in the emergency department after head injury and laceration. She is a reassuring evaluation in the department. The laceration was repaired with stitches.

**You are able to tolerate eating and drinking while in the emergency department and had a reassuring exam.**

**If there is any concern for pain, please see the dosing chart for Tylenol and ibuprofen below.**

**Please seek immediate medical attention and/or follow-up with your pediatrician if you develop any behavior changes, difficulty tolerating feeding, persistent vomiting, headaches, nausea, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if their symptoms do not resolve. Otherwise, please follow up with your pediatrician regarding your visit.**

#### Caring for my stitches:

Do not wash the area for the first 24-48 hours after the suturing. After 24 hours you may gently wash the wound with soap and water once a day, pat it dry afterwards. Apply an antibiotic ointment after you wash the wound to keep a thick scab from forming over the stitches. Bathing is allowed 48 hours after the suturing, but do not allow the wound to be submerged in water (no bath or swimming).

#### When should the stitches be taken out?

Your stitches should dissolve without requiring removal. You should follow-up for the reevaluation in the pediatrician's office. If you do not have a primary care doctor, this can be done at urgent care or here in the ER.

Call your doctor right away or return to the Emergency Room if:

- There is a red streak or area that spreads from the wound
- The wound looks infected (redness, pus)
- A stitch comes out too early

#### Over-The-Counter Pain Medicine Dosing Chart

##### Acetaminophen (Tylenol-type medicine)

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

**Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever  
 Should NOT be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

**BDDCPEDINASALFOREIGNBODY**

@FNAME@ was seen in the emergency department after a nasal foreign body that was removed in the emergency department. She had a reassuring repeat evaluation in the department after removal.

**You are able to tolerate eating and drinking while in the emergency department and had a reassuring exam.**

If there is any concern for pain, please see the dosing chart for Tylenol and ibuprofen below.

Please seek immediate medical attention and/or follow-up with your pediatrician if you develop any fever, behavior changes, difficulty tolerating feeding, nosebleeds that do not stop, persistent vomiting, headaches, nausea, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if their symptoms do not resolve. Otherwise, please follow up with your pediatrician regarding your visit.

**Over-The-Counter Pain Medicine Dosing Chart****Acetaminophen (Tylenol-type medicine)**

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

**Ibuprofen (Motrin or Advil-type medicine)**  
May be given every 6-8 hours as needed to relieve pain or fever  
Should NOT be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

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#### BDDCPEDIOTITIS

@FNAME@ was seen in the emergency department today for fever and ear pain. @FNAME@ has an ear infection. An antibiotic has been prescribed. Take this antibiotic fully, even if your child is feeling better.

Please be sure your child gets plenty of rest and drinks lots of fluids

You can give @FNAME@ Tylenol for fever control.

If @FNAME@ is older than 6 months, you can also use Ibuprofen/Motrin.

Please follow-up with your pediatrician in the next 1-2 days.

Please return to the emergency department if your child experiences persistent fever despite medications, severe weakness or lethargy, not acting appropriately, difficulty swallowing or taking fluids by mouth, chest pain, shortness of breath, persistent vomiting, abdominal pain, persistent diarrhea, bloody / black tarry stools, pain with urination or decrease in urine production, lack of improvement over the next 1-2 days, or other concerning symptom(s).

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#### BDDCPEDIURI

@FNAME@ was seen in the emergency department today for cough. After a thorough evaluation, these symptoms are most consistent with a viral illness. This illness should improve with time. Please be sure your child gets plenty of rest and drinks lots of fluids

You can give @FNAME@ Tylenol for fever control.

If @FNAME@ is older than 6 months, you can also use Ibuprofen/Motrin.

Cough suppressants are **not** recommended by the American Academy of Pediatrics.

Please follow-up with your pediatrician in the next 1-2 days.

Please return to the emergency department if your child experiences persistent fever despite medications, severe weakness or lethargy, not acting appropriately, difficulty swallowing or taking fluids by mouth, chest

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pain, shortness of breath, persistent vomiting, abdominal pain, persistent diarrhea, bloody / black tarry stools, pain with urination or decrease in urine production, lack of improvement over the next 1-2 days, or other concerning symptom(s).

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**BDDCPEDIVOMITING**

@FNAME@ was seen in the emergency department for nausea and vomiting. In the emergency department @FNAME@ was able to tolerate some fluids with medications.

It is important that you continue to give @FNAME@ fluids to keep them hydrated.

Give them small sips of fluids. Big gulps of fluid can make them vomit more.

You can use electrolyte-fluids (like Pedialyte or Gatorade), frozen pops (like Pedialyte pops), or a mixture of half apple juice and half water.

If @FNAME@ has high fevers, uncontrolled nausea/vomiting, abdominal pain, lethargy, or decreased urine output, please return to the emergency department.

We may have prescribed a medication to help with symptoms. If symptoms persist after the medication, please return to the emergency department.

Please contact their Pediatrician tomorrow to monitor symptoms and schedule a follow up appointment.

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**BDDCPEGREPLACE**

**You were seen in the emergency department because your feeding tube was displaced. We replaced it here, and confirmed correct placement with an x-ray.**

**Please follow up with the doctor that regularly manages your feeding tube within the next week.**

**Please seek immediate medical attention if you develop any additional issues with the tube, nausea, vomiting, abdominal pain, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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**BDDCPNA**

You have been evaluated in the Emergency Department today for fevers and cough. Your evaluation, including chest x-ray and blood testing, suggests that your symptoms are due to a pneumonia.

You have been prescribed antibiotics which you should take as directed. You should complete the antibiotics even if you begin to feel better.

Please follow up with your primary care physician within 2-5 days.

Return to the Emergency Department if you experience any worsening fevers, worsening shortness of breath, fatigue, dizziness, lightheadedness, or any other new or concerning symptoms.

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**BDDCSANE**

**You were seen in the emergency department after an assault and had a SANE evaluation.**

**You received prophylactic postexposure medications Emergency Department.**

{Blank single: 19197::" You have been given pregnancy prophylaxis. Please see the attached instructions. This should be taken as soon as possible within 120 hours after the assault."}

**{Blank single: 19197::"We have sent your prescriptions to complete your courses of doxycycline and**

metronidazole. Please see the attached instructions regarding these medications. You should avoid extended sun exposure and alcohol while taking these medications."}

{Blank single: 19197::"At this time you are declining labs or HIV postexposure prophylaxis.", "You have been given a 7 day starter kit of HIV post-exposure prophylactic medications. You have been sent a prescription for the remainder of your supply which can be filled at the retail pharmacy. Please see the attached instructions regarding these medications."}

Please follow-up with your PCP for reevaluation and additional workup as appropriate.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCSEIZURE

You were seen in the emergency room for a seizure. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*","You were evaluated, and your imaging showed \*\*\*","You were evaluated, and \*\*\*","You were evaluated and you were found to have \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your exam was reassuring","You were evaluated, and your work up was reassuring"}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*","Your symptoms may be due to \*\*\*," "}{Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*","You should follow up with \*\*\*. The information to make this appointment has been included in this paperwork","You should follow up with your primary care physician regarding this visit"}.

{Blank single:19197::"We have sent you a neurology referral for which you should follow-up.", "Please follow-up with your neurologist and continue to take your antiseizure medications as prescribed."}

You should not drive, swim alone, operate heavy machinery, or perform any activity which would be dangerous feet of a seizure until you are cleared by your PCP or neurologist. By Massachusetts law, you may not drive for 6 months after seizure. Due to the risk of injuries if you have another seizure, please observe the following seizure and fall precautions:

1. No standing or climbing to heights without a harness.
2. No water activities alone, including using a bathtub/jacuzzi, swimming, waterskiing, diving, sailing/boating/fishing, etc.
3. No operating heavy machinery or using sharp moving objects without supervision.
4. Avoid contact and extreme sports that may expose you to higher risk for head trauma. You may continue to stay physically active including engaging in sports.
5. Observe local driving laws. You need to be seizure free for 6 months before resuming driving in Massachusetts. Outside of Massachusetts, please check with the local Department of Motor Vehicle (DMV) regarding local driving laws.
6. Consider wearing a medical bracelet that says "seizure/epilepsy" when traveling alone.
7. Avoid potential seizure triggering factors. These factors may include: sleep deprivation/poor sleep quality, excessive stress, excessive caffeine or alcohol consumption, flashing lights, low blood sugar, dehydration, or illness (especially involving vomiting and diarrhea).

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, recurrent seizures, difficulty walking or moving her arms and legs, slurred speech, difficulty with normal activities, no abnormal behavior, vision changes, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCSHINGLES

You were seen in the emergency department for {Blank single:19197::"rash and pain"}. You were evaluated and {Blank single:19197::"your work up was remarkable for \*\*\*", "all of your tests and imaging were reassuring"}. {Blank single:19197::"Your pain is most likely caused by {Blank single:19197::"shingles"}". You should follow up with your primary care doctor regarding this pain."}, "You should follow up with your primary care doctor regarding this pain.", "You should follow up with your primary care physician as soon as possible to schedule a stress test.", "You should follow up with your primary care doctor regarding this pain so you can discuss if you need to have a stress test done."}

We have sent your prescription for an antiviral medication which you should take as directed. For pain, please take \*\*\*.

Please seek immediate medical attention if you develop any worsening chest pain, shortness of breath, nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

---

#### BDDCSORETHROAT

You have been evaluated in the Emergency Department today for your sore throat. Your evaluation suggests your symptoms are due to {Blank single:19197::"a viral infection", "a bacterial infection"}.

{Blank multiple:19196::"Please take your prescribed antibiotics as directed for the full course of the medication.", "You have been given a dose of steroids that may help with your symptoms."}

Please follow up with your primary care physician within two days.

If your pain persists, you may take alternating doses of Tylenol (aka acetaminophen) and Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol (1,000mg) at 9 am, you can take Motrin (600mg) at noon and then Tylenol again at 3 pm. Take NSAIDS such as motrin with food. Do not exceed 4,000mg of tylenol in a single day. This approach will give you increased pain control and maximum length of relief from symptoms.

Return to the Emergency Department if you experience worsening or uncontrolled pain, tongue swelling, difficulty swallowing, change in your voice, difficulty breathing, fevers 100.4°F or greater, recurrent vomiting, or any other concerning symptoms.

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#### BDDCSYNCOPE

You were seen in the ER after {Blank single:19197::"almost passing out", "passing out"}. You were evaluated, and your work up was {Blank single:19197::"notable for \*\*\*", "reassuring"} . {Blank single:19197::"You may have been dehydrated."}

Please seek immediate medical attention if you develop any chest pain, repeat episodes of fainting, severe headaches, vision changes nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

#### BDDCUTI

You were seen in the emergency room for {Blank single:19197::"abdominal pain", "urinary symptoms"}. {Blank single:19197::"You were evaluated, and your exam was reassuring", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your work up was reassuring", "You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and you were found to have a urinary tract infection", "You were

evaluated, and your imaging showed \*\*\*". {Blank single:19197::"Your symptoms are most likely due to \*\*\*", "You should follow up with \*\*. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit"}.

You have been given a prescription for an antibiotic, which you should take as prescribed. {Blank single:19197::"The prescription has been sent to the pharmacy listed in this paperwork", "You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

#### BDDCVAGBLEEDING

You were seen in the emergency room for vaginal bleeding. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your and exam were reassuring", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your exam was reassuring", "You were evaluated, and your work up was reassuring"}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*", "Your symptoms may be due to abnormal uterine bleeding", " "}

{Blank single:19197::"You should follow up at your already scheduled appointment with gynecology", "You should follow up with gynecology in the next few days. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit"}. You should also follow-up with your primary care provider about this visit.

{Blank single:19197::"Please take 324 mg ferrous sulfate three times daily (iron supplementation) until you follow up with gynecology."}

Please seek immediate medical attention if you develop any worsening or uncontrolled bleeding, shortness of breath, feeling lightheaded, chest tightness, abdominal cramping, severe abdominal pain, {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### BDDCVERTIGO

You have been evaluated in the Emergency Department today for dizziness. Your evaluation suggests that your symptoms are most likely due to peripheral vertigo.

You have been prescribed meclizine to help relieve your symptoms. Please take your prescription as directed. Avoid driving or operating heavy machinery while taking the medication as this can increase your risk of falls. You can also try Epley Maneuvers at home to help relieve your symptoms- instructions are available online.

Please follow up with your primary care doctor in 2-3 days.

Return to the ER immediately for worsening or uncontrolled symptoms, worsening headache, chest pain, shortness of breath, persistent vomiting, vision changes, fainting, or for any other concerning symptoms.

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#### BDDDXBODYFLUIDEXPOSURE

Potential body fluid exposure. Lower risk of a disease but unknown source patient.

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**BDDDXPEDIMYOSITIS**

- Myositis.
  - Exam not consistent with GBS.
  - Exam less consistent with referred Legg calf Perthes disease.
  - Lower concern for transient synovitis.
  - Lower concern for septic arthritis, Lyme arthritis.
- 

**BDDDXURI**

- Viral URI (COVID, flu, RSV), other.
- No exudates, lymphadenopathy c/f strep.
- Lower concern GC/chlamydia.
- Based on history and exam, doubt epiglottitis, Ludwig's, PTA, RPA深深 neck space infection.
- History less consistent with pneumonia.
- No Rucho rigidity and intact neuroexam with no concern for meningitis.

Plan: Will check mini RVP.

Will give acetaminophen and ibuprofen for comfort.

Chest x-ray not indicated this time as there are no focal pulmonary exam findings and patient has had a short duration of symptoms.

His mini RPP is pending, did discuss with patient care for URI symptoms at home.

Discussed that we have Tamiflu and Paxlovid as antiviral options if the patient test positive for COVID or flu.

Discussed side effects of medications in addition to benefits and efficacy given patient's time course and based on discussion, risks of medications likely do not outweigh benefits.

Discussed return precautions including potential development of superimposed pneumonia later and plan to follow-up with PCP.

---

**BDDDXABDPAIN**

- AAA, aortic dissection; not hypertensive, no sharp/tearing pain radiating to the back, equal blood pressure and pulses.
  - No clinical evidence of complete bowel obstruction. Exam not consistent with acute abdomen.
  - Perforated viscus: Patient without sudden pain, no rebound or guarding.
  - Mesenteric ischemia or other bowel ischemia: Patient without pain out of proportion to exam. No known A-fib/other risk factors.
  - Upper abdominal causes including hepatobiliary/gallbladder, pancreatitis, peptic ulcer disease.
  - Lower abdominal causes including appendicitis, hernia, diverticulitis, torsion, ectopic.
  - Renal colic/pyelonephritis.
  - Low concern for ACS.
  - DKA.
  - Lower concern EtOH/tox.
  - No evidence of significant electrolyte derangement causing or as a result of symptoms..
  - No evidence of significant GI bleeding.
- 

**BDDDXAFIBRVR**

- Primary A-fib with RVR.
  - Secondary A-fib.
  - Anemia.
  - Infection including pneumonia, UTI.
  - Based on exam and history, lower concern for medication induced, CHF exacerbation, pneumothorax, PE, tamponade, ACS, thyrotoxicosis.
- 

**BDDDXAGMA**

- Lactic acidosis
  - Acute renal failure
-

- Ketoacidosis (DKA, alcoholic, starvation)
  - Toxicologic: Acetaminophen, aspirin
    - Increased osm gap: Methanol, ethylene glycol
    - Normal osm gap: Salicylate toxicity, iron toxicity, INH
- 

#### BDDDXALLERGICREACTION

- Presentation not consistent with anaphylaxis.
  - Low concern for angioedema.
  - No obvious new exposures and no known exposure to poison ivy.
  - No ingestion of seafood or other history concerning for scombroid.
  - Low suspicion for toxic shock syndrome, asthma exacerbation, or drug toxicity.
- 

#### BDDDXAMS

- Hemodynamic: BP \*\*\*, perfusion \*\*\*
  - Thermoregulatory: Temp \*\*\*
  - Respiratory: SpO<sub>2</sub> \*\*\*, VBG \*\*\*
  - Metabolic: electrolytes including BUN and calcium independently reviewed by me \*\*\*; no evidence of cirrhosis to suggest hyperammonemia
  - Intracranial: CT brain \*\*\*; based on neurologic exam, concern for CVA is \*\*\*
  - Infectious: CXR \*\*\*, UA \*\*\*, remainder of exam without localizing source; low suspicion for CNS infection given \*\*\*
  - Cardiac: See ECG interpretation below; troponin \*\*\*
  - Hematologic: \*\*\* evidence of severe anemia, TTP, or DIC
  - Endocrine: thyroid function \*\*\*; risk for adrenal insufficiency \*\*\*
  - Toxicologic: medication list reviewed notable for \*\*\*; doubt opioid overdose given normal pupil size and lack of bradypnea, salicylates \*\*\*, \*\*\* no additional appreciable toxidrome
  - Epileptic: risk for non-convulsive status is \*\*\*
- 

#### BDDDXANKLEINJURY

- Suspect acute ankle injury including sprain. No evidence of dislocation on exam.
  - Lower concern for other distal leg fracture based on exam (including tibial plateau, tibial shaft).
  - No evidence of any hindfoot, midfoot, forefoot tenderness or laxity on exam. Pain is well localized to \*\*\*.
  - No evidence of septic joint or effusion.
  - Based on history and exam, lower concern for other nonmusculoskeletal cause of symptoms such as peripheral vascular disease, trench foot, neuropathy, skin or soft tissue infection.
- 

#### BDDDXAPAPOVERDOSE

- APAP overdose.
- Potential concern for coingestion.
- Airway maintained, no evidence of respiratory compromise at this time.
- Presentation without findings concerning for CVA, sepsis, hypothyroidism, ischemic CVA, intracranial bleed.

Plan: Monitor telemetry and pulse oximetry.

POC Glucose, CBC, BMP, LFTs, PT/INR, immediate and 4 hour APAP level, salicylate level, ethanol level, i-STAT VBG.

Toxicology consult.

Section 12, suicide precautions.

ECG: Normal Sinus Rhythm. No overt ischemic findings and no prolongation of QTc or QRS intervals.

---

#### BDDDXAPX

- Given history and exam, presentation most consistent with anaphylaxis.
  - Low suspicion for toxic shock syndrome, asthma exacerbation, or drug toxicity.
-

**BDDDXARTERIAL LIMB ISCHEMIA**

- Concern for acute limb ischemia in the setting of arterial occlusion.
- Less likely chronic peripheral artery disease given acute onset of symptoms.
- Given history, lower concern for autoimmune, vasospastic, or other similar etiologies.
- No evidence of infection/diabetic foot infection.

**BDDDXBACKPAIN**

- Nonspecific/musculoskeletal injury.
- Low concern for vertebral fracture.
- Presentation not consistent with AAA rupture, cauda equina.
- No midline tenderness suggestive of compression fracture.
- No IV drug use, no spinal point tenderness or other signs suggestive of epidural abscess.
- Herniated disc.
- Kidney stone, pyonephritis.
- Doubt PE given absence of shortness of breath, patient sitting well on room air, not tachycardic.

**BDDDXBELLSPALSY**

- Presentation most consistent with Bell's palsy.
- Lyme disease.
- Lower concern for Ramsay Hunt syndrome.
- Unlikely CVA, trigeminal neuralgia, botulism, MG, ICH.

**BDDDXBRADY**

- Myocardial Infarction (RCA lesion)
- Infection
- Hypothyroidism
- Hyperkalemia
- Hypoglycemia
- Dehydration
- Intoxication (beta blockade, calcium channel blockade, clonidine, digoxin, opiates, alcohol or other).

**BDDDXCAUSTIC INGESTION**

- No evidence of skin or eye irritation.
- No evidence of wheezing or trigger for asthma exacerbation.
- No dysphagia, drooling, ongoing vomiting, or symptoms concerning for GI tract injury.
- No dysphonia, stridor, respiratory distress or evidence of laryngeal/tracheal injury.

**BDDDXCHEST PAIN**

- ACS/NSTEMI.
- Aortic dissection; not hypertensive, no sharp/tearing pain radiating to the back, equal blood pressure and pulses.
- PE; patient without pleuritic chest pain, new oxygen requirement, hemoptysis or other symptoms suggestive of clinically significant PE.
- Pneumothorax less consistent with exam.
- Tamponade; not hypotensive, no evidence of Becks triad.
- Patient without history of retching, recent endoscopy, or other historical or exam findings concerning for esophageal rupture.
- Patient without history of cocaine use.
- Endocarditis/myocarditis/pericarditis.
- Pneumonia; patient without fever or productive cough.
- GERD.

- Shingles, no dermatomal vesicular rash.
  - Musculoskeletal.
- 

#### BDDDXCORNEALABRASION

- Corneal abrasion.
  - Intraocular and corneal foreign bodies.
  - Corneal ulceration.
  - Various etiologies of iritis.
  - Various etiologies conjunctivitis.
- 

#### BDDDXCOUGH

- URI (including COVID, RSV, influenza).
  - Pneumonia.
  - LRI including bronchitis.
  - Sinusitis.
  - Asthma, COPD.
  - Allergic/rhinitis.
  - Low concern for TB.
  - Doubt ACS/CHF.
  - Medication, ACE inhibitor.
- 

#### BDDDXDENTALABSCCESS

- Dental abscess/periapical abscess/pulpitis.
  - No evidence of PTA, RPA, Ludwig angina and patient has no uvular deviation, full range of motion of neck, no exudate bilateral tonsillar beds, no elevated tongue, no lymphadenopathy appreciated.
- 

#### BDDDXDYSP

- COPD exacerbation, asthma exacerbation.
  - CHF/ACS.
  - Viral URI (including COVID, influenza, RSV).
  - Pneumonia.
  - PE. Given alternative explanation for shortness of breath as above, lower concern for acute PE.
  - Pneumothorax.
  - No history or exam evidence to suggest anaphylaxis.
- 

#### BDDDXEMH

- Presentation not consistent with acute organic causes to include delirium, dementia or drug induced disorders (acute ingestions or withdrawal; no evidence of toxicome).
  - Given the H&P, I suspect this patient is \*\*\*suicidal/homicidal/gravely disabled and will require psychiatric care
- 

#### BDDDXEPISTAXIS

- Suspect atraumatic epistaxis that {Blank single:19197::"is", "is not"} is well controlled at this time. Appears {Blank single:19197::"anterior"} on exam.
  - Coagulopathy.
  - No obvious nasal tumor on exam.
  - No overt evidence of AVM.
- 

#### BDDDXETOH

- Airway maintained.
  - Unlikely intracranial bleed, opioid intoxication or coingestion, sepsis, hypothyroidism.
-

- Suspect likely transient course of intoxication with expected improvement of symptoms as patient metabolizes offending agent.
  - Potential development of hypoglycemia in case of alcohol intoxication. (Ordered for FSBG.)\*\*\*
- 

#### BDDDXFAILURETOTHRIVE

- Delirium on dementia. MDD, psychosis.
  - Infection including viral, pneumonia, urinary tract. No clear specific infectious source based on history.
  - No concern for stroke based on neuroexam and history.
  - Lower concern for immunodeficiency, endocrine, cancer.
  - CHF, hepatic failure.
  - Medication side effect/interaction.
- 

#### BDDDXFALLELD

- Initial considerations in this patient included intracranial hemorrhages including subarachnoid, subdural epidural hemorrhages, brain contusions, delayed intracranial hemorrhages, cervical spine fractures and dislocations, spinal cord injuries, musculoskeletal injuries, syncope from cardiac etiologies including dysrhythmia and other neurologic etiologies including cerebrovascular accident (CVA) and transient ischemic attack (TIA), and fall syndromes (history of recurrent falls) among others.
  - Significant concern for musculoskeletal injury in this patient including \*\*\*.
- 

#### BDDDXFLANKPAIN

- Presentation c/w renal colic. {Blank single: 19197:: "Will defer imaging to evaluate given patient's prior history.", "No evidence of hydronephrosis on bedside ultrasound.", "Will get imaging with \*\*\*."}
  - Lower concern for aortic dissection, AAA or other vascular catastrophe based on history and exam.
  - {Blank single: 19197:: "No symptoms to suggest pyelonephritis or potential infected stone.", "Will rule out infected stone/pyelonephritis with UA."}
  - Low suspicion for AKI, obstructive nephropathy given exam and history.
  - Lower concern for biliary colic, pancreatitis, appendicitis, genital torsion, serious bacterial illness, or other emergent primary abdominal pathology.
  - Skin without evidence of dermatomal vesicular rash at area of pain, no evidence of shingles.
  - Doubt lower lobe PNA.
  - Given history and exam, lower suspicion for atypical appendicitis, genital torsion, acute cholecystitis, AAA, aortic dissection, serious bacterial illness or other emergent intraabdominal pathology.
  - Location less specific of torsion/epididymitis \*\*\*.
  - No evidence of any MSK injury, rib fracture. No recent trauma.
- 

#### BDDDXGENERALIZEDWEAKNESSNONMUSC

Broad differential for nonneuromuscular weakness.

- ACS
- Arrhythmia
- Severe infection/sepsis
- Hypoglycemia
- Periodic paralysis, electrolyte disturbance
- Does not seem to have any evidence of respiratory failure.
- Symptomatic anemia
- Severe dehydration
- Hypothyroidism
- Polypharmacy
- Does have good peripheral pulses and is able to bear weight in bilateral lower extremities.

Plan: Already evaluated with ECG, CBC, chemistry, urinalysis and culture, chest x-ray, head CT and code stroke imaging. Also checked CK and TSH.

---

**BDDDXHA**

- Primary headache: cluster, migraine, tension
  - Sinusitis: no recent URI symptoms, sinus tenderness
  - No history of trauma to suggest traumatic ICH.
  - No historical features to suggest space occupying lesions: n/v, anticoagulation, immunosuppression, cancer, infection, syncope, worse in AM
  - Lower concern for SAH without history of severe instantly peaking headache, neck stiffness, vomiting. No history of syncope (although not sensitive finding). \*\*\* consider Ottawa SAH rule
  - No history of trauma, unilateral symptoms, neck pain to suggest carotid dissection
  - Meningitis: \*\*\* no fever, neck stiffness, photophobia, rash; Encephalitis: no fever, AMS
  - Encephalopathy/HTN encephalopathy: dBP < 120, no AMS, no vision changes
  - IIH/pseudotumor: less likely 2/2 no visual symptoms, not \*\*\* typical overweight/young
  - CO poisoning: no clear history of exposure, no weakness or n/v
  - Temporal arteritis; \*\*\*age > 55, tender temporal artery, jaw pain
  - Low concern acute glaucoma given character of pain, pain, visual disturbance, pupillary exam findings.
  - Pre-eclampsia: incorrect patient population \*\*\*
- 

**BDDDXHIP**

- Musculoskeletal injury including hip fracture, dislocation. Patient neurovascularly intact with lower concern for neurovascular injury.
  - Pelvic fracture.
  - Lower concern for atraumatic causes of hip pain including bursitis, abscess, septic arthritis, avascular necrosis.
- 

**BDDDXHTN**

- Hypertensive emergency.
  - No exam evidence of stroke.
  - Incorrect patient population for preeclampsia/eclampsia.
  - Lower concern for ACS.
  - Lower concern for secondary causes such as hyperthyroidism, renal artery stenosis or kidney disease, medication/drug use.
- 

**BDDDXHYPERGLYCEMIA**

- Nonketotic hyperglycemia.
  - HHS.
  - DKA, with {Blank single:19197::"lower","some"} concern for euDKA. Patient {Blank single:19197::"is","is not"} taking SGLT2 inhibitor.
  - Sepsis. Based on history and exam, low concern for infection triggering hyperglycemia.
  - \*\*\* use plan smartphrase
- 

**BDDDXHYPOGLYCEMIA**

- Medication induced. Patient {is/is not:21397} prescribed insulin, {is/is not:21397} prescribed sulfonylurea, {is/is not:21397} prescribed a beta-blocker.
  - Possible systemic illness including infection.
  - Lower concern for acute adrenal insufficiency based on history and exam.
  - At this time, lower concern for alternative cause such as insulin secreting tumor pending further evaluation.
- 

**BDDDXHYPONATREMIA**

- Current volume status assessment: {Blank multiple:19196::"euvolemic", "hypovolemic", "hypervolemic"}
  - Medications: no new med changes, patient not taking hydrochlorothiazide, sulfonylureas (glipizide, glyburide), large amounts of NSAIDs, bupropion, SSRIs, TCAs, carbamazepine \*\*\*
  - Hypovolemic
-

- No evidence of significant GI losses, burns, pancreatitis, peritonitis
    - No significant thiazide use/abuse
    - Nephropathy iso RTA/CKD, endocrine
  - Hypervolemic
    - ARF (high urine Na)
    - Nephrotic syndrome, cirrhosis, CHF (low urine Na)
  - Euvolemic
    - SIADH
    - Hypothyroidism
    - Medication induced (see above)
    - Glucocorticoid deficiency
    - H2O intoxication
  - Pseudohyponatremia
    - No evidence of significant hyperglycemia
    - Pending serum studies
- 

#### BDDDXINGUINALHERNIA

- Suspect likely left inguinal hernia (seems {Blank single:19197::"direct", "indirect"} by history). No evidence of strangulation or incarceration.
  - Exam less consistent with lymphadenitis, cellulitis, epididymitis, torsion, spermatocele, varicocele.
  - No evidence of Fournier's gangrene or STI.
- 

#### BDDDXJAUNDICE

- Hepatocellular cause including viral, alcoholic hepatitis, ischemic hepatitis, toxin/medication (acetaminophen, phenytoin, isoniazid), autoimmune hepatitis, CHF/shock liver.
  - Cholestatic cause including stricture, neoplasm, choledocholithiasis, cholecystitis, cholangitis.
  - Hemolytic causes.
- 

#### BDDDXKNEEINJURY

Musculoskeletal knee injury including knee dislocation, fracture, meniscal/ligamentous injury. No evidence of patellar dislocation, patellar tendinitis.

---

#### BDDDXKNEEPAINATRAUMATIC

- Arthritis including osteoarthritis.
  - No evidence of acute knee injury including dislocation, fracture. No evidence of tendon rupture, patellar pathology.
  - Patellofemoral pain syndrome.
  - Exam not concerning for bilateral septic joint or bursitis.
  - No leg swelling or other symptoms suggestive of bilateral DVT.
  - Lower concern for gout/pseudogout.
  - Could theoretically have Lyme arthritis or similar, however less suggestive given the patient's history.
- 

#### BDDDXLEEDEMAASYM

- DVT.
  - Cellulitis.
  - Neurovascularly intact in the extremity.
  - No evidence of compartment syndrome.
  - No trauma history with low concern for fracture.
  - No medication use including NSAIDs, birth control, steroids.
  - Venous stasis.
  - Thrombophlebitis.
  - Edema asymmetric with lower concern for causes of bilateral pedal edema including CHF, pretibial
-

myxedema, renal failure, liver failure, hypoalbuminemia.

---

#### BDDDXMELENA

- Suspect likely upper GI bleeding based on history with differential including peptic ulcer disease, gastritis, esophagitis.
  - {Blank single:19197::"Higher concern for possible malignancy given the patient's history."}
  - No history of retching or signs or symptoms to suggest esophageal tear.
  - No known history of varices.
  - Lower concern for other mimics including hemoptysis, vaginal bleeding, ENT bleeding, dietary changes.
- 

#### BDDDXMVC

- Laceration, abrasion, skin or soft tissue injury.
  - MSK injury/strain, fracture.
  - Low suspicion for spine fracture or other acute spinal syndrome.
  - Low concern for pneumothorax, pulmonary contusion, cardiac contusion, aortic/vertebral dissection, hollow organ injury, acute traumatic abdomen, significant hemorrhage.
  - Low concern for facial fractures, ICH or traumatic ICH, C-spine injury.
- 

#### BDDDXNASALFOREIGNBODY

- Nasal foreign body.
- There does not appear to be an associated infection or injury with this nasal foreign body or significant edema.
- Item is not a button battery, magnet, or other object requiring further management.

Plan: Foreign body removal as below. Initially attempted "parents kiss" technique but unsuccessful likely due to hole in middle of foreign body.

Anticipate discharge with strict return precautions and follow up with primary MD within 1-2 days for further evaluation

Additional MDM on reevaluation listed in ED course below. In summary, the foreign body was removed by me using \*\*\*alligator forceps technique after one attempt. Postprocedure reevaluation of the nares demonstrates an intact nasal septum with no septal hematoma or residual foreign body. There is low concern for prolonged foreign body or significant edema requiring prophylactic antibiotics.

---

#### BDDDXNECKPAIN

- Musculoskeletal neck pain, torticollis.
- Based on meds, exam, low concern for dystonic reaction.
- Radiculopathy.
- No hemophilia, anticoagulation to suggest epidural hematoma.
- No cancer history, no trauma, no IVDU, no weakness or sensorimotor deficits with lower concern for compressive mass, fracture/dislocation, epidural abscess. No evidence of cord compression, transverse myelitis.

Plan: Pain control with multimodal pain therapy as below.

Cervical x-ray not indication, low concern fx or dislocation, no midline tenderness, or history of trauma.

---

#### BDDDXNVD

- No clinical evidence of complete bowel obstruction. Exam not consistent with acute abdomen.
  - {Blank single:19197::"Low", "some"} concern for bowel ischemia.
  - No evidence of significant GI bleeding.
  - Low concern for ACS.
  - DKA.
  - Pancreatitis.
-

- Appendicitis.
  - Lower concern EtOH/tox.
  - Electrolytes without significant abnormalities 2/2 vomiting and serum creatinine at baseline.
- 

#### BDDDXOPTHOPAINFULREDEYE

- Extraocular causes (no pain with extraocular movements concerning for orbital cellulitis or cavernous sinus thrombosis, carotid cavernous fistula, cluster headache).
  - External eye disease.
  - Corneal disease including keratitis or corneal abrasion.
  - Chalazion/style, blepharitis.
  - Conjunctivitis.
  - Acute glaucoma.
  - Scleritis.
  - Uveitis.
- 

#### BDDDXOPTHPAINLESSMONOCULARVISIONLOSS

- CRAO
  - CRVO
  - CVA
  - OAG
  - Lower c/f PRES
  - Ret detachment
  - Vitreous hemorrhage
- 

#### BDDDXOTORRHAGIA

- Temporal bone fracture or other traumatic injury.
  - Soft tissue injury, including to external or middle ear likely in the setting of anticoagulation.
  - Given that otorrhagia is bilateral, lower concern for internal carotid artery bleeding.
- 

#### BDDDXPALPSNOARRH

- Patient without hypotension, syncope, presyncope, exertional symptoms, CHF symptoms.
  - Possible arrhythmia.
  - Based on history, low concern for ACS, cardiomyopathy.
  - Symptoms are not consistent with worsening/severe valvular disease.
  - Patient does not have a pacemaker.
  - Low concern for cardiomyopathy.
  - Tox: EtOH, caffeine, cocaine, medications such as digoxin.
  - Patient without other symptoms of hyperthyroidism, anemia.
  - Patient without hypoxia, dyspnea, or other symptoms suggestive of clinically significant PE.
- 

#### BDDDXPARONYCHIA

- Paronychia {Blank single:19197::"with", "without"} significant purulence.
  - No evidence of felon.
  - No evidence of tendon involvement/flexor tenosynovitis, hand deep space infection.
  - Not c/w hand-foot-mouth. No oral lesions.
  - Not c/w fight bite.
- 

#### BDDDXPEDIABDPAINLOWER

- No evidence of acute abdomen or SBO. Nonbilious emesis and well-appearing with lower concern for malro.
  - Appendicitis.
  - Constipation.
-

- Low concern foreign body.
  - Functional.
  - Gastroenteritis.
  - No evidence of hernia.
  - Mesenteric adenitis.
  - UTI.
  - Torsion.
    - Patient has no hx of abdominal surgery and abdomen is soft, non-tender; low suspicion for obstruction, low suspicion for appendicitis
    - No neurodeficits, equal pupils, lower concern for neurologic cause of vomiting.
- 

#### BDDDXPEDIAPPY

- Acute appendicitis.
  - Mesenteric adenitis.
  - Gastroenteritis.
  - UTI including pyelonephritis.
  - No evidence of bowel obstruction on exam.
  - Torsion. No evidence of testicular swelling, erythema, pain on exam. \*\*\*
  - Lower concern for DKA.
- 

#### BDDDXPEDIASTHMAEXACERBATION

- Acute asthma exacerbation.
- URI, viral infection including flu, COVID, RSV.
- Lower concern for focal pneumonia based on exam.
- Lower concern foreign body aspiration.
- Exam less c/w croup.
- No evidence of trauma.

Plan: Patient monitored on {Blank multiple:19196::"telemetry","pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint. Will send mini RVP.

Steroids and stacked nebs.

Reassessment.

Dispo pending above. If able to space, anticipate discharge home.

---

#### BDDDXPEDIBRUE

- Presentation consistent with BRUE and there was concern for brief period of \*\*\*. Time of event of \*\*\*. Patient has returned to baseline. No prior BRUE episodes. Immediately after sleeping \*\*\*.
  - Low concern for pertussis, bronchiolitis.
  - No evidence of nonaccidental trauma.
  - Lower concern for arrhythmia.
  - Patient is otherwise feeding well with reassuring presentation.
- 

#### BDDDXPEDICHESTPAIN

- Precordial catch syndrome: chest pain with deep inspiration.
  - Idiopathic.
  - No evidence of recent trauma to suggest clear history of musculoskeletal etiology.
  - No recent illnesses or symptoms suggest myocarditis or pericarditis.
  - Symmetric bilateral breath sounds with low concern for pneumonia or pneumothorax.
  - Patient without clear pleurisy, new oxygen requirement, hemoptysis or other symptoms suggestive of clinically significant PE. There is no lower extremity edema.
  - Gastrointestinal etiology including gastritis, esophagitis.
  - Lower concern for cardiac etiology at this time.
-

- No history of substance/cocaine use.
- 

#### BDDDXPEDICONSTIPATION

- Based on exam and history, abdominal pain is likely 2/2 constipation.
- Low suspicion for appendicitis given that patient is not febrile, has no focal RLQ tenderness, no other signs of peritonitis.
- Low suspicion for ovarian cyst, ovarian torsion.
- History less consistent with urinary tract infection. Low concern for STI/PID.
- Other diagnosis to consider: mesenteric adenitis, musculoskeletal pain, viral gastroenteritis

Plan: {Blank multiple:19196::"Given history and time course, can defer urine testing at this time.", "HCG", "UA, urine culture"}.

P.o. trial.

{Blank single:19197: "Evaluation and Management Considered but not Performed (medications, diagnostics or observation/admission): Considered abdominal imaging/KUB, but ultimately not indicated due to plan to be ordered by pediatrician and ultimately unlikely to change management at this time.", "KUB"}

Plan for discharge with bowel regimen, instructions for "cleanout."

---

#### BDDDXPEDICOUGHACUTE

- Suspect viral URI (including influenza, COVID, RSV). {Blank multiple:19196::"+sick contacts", "+daycare"}
- {Blank single: 19197::"No", "Mild"} wheezing or symptoms suggestive of bronchiolitis.
- Exam not consistent with croup, no seal bark cough, no stridor, no fever, no wheezing/rhonchi.
- Exam less consistent with foreign body. Patient without choking, drooling, asymmetric breath sounds or wheezing.
- Low concern for pneumonia given time course, exam. No asymmetric pulmonary exam findings.
- Lower concern for causes of chronic cough including allergic rhinitis, asthma, pertussis, reflux, sinusitis.

#### BDDDXPEDICROUP

- Suspect croup with viral etiology.
- Lower concern for bacterial tracheitis. Nontoxic-appearing.
- Lower concern for foreign body based on history and exam.
- Patient is vaccinated with lower concern for epiglottitis, nontoxic-appearing and without drooling.
- Patient without voice changes, neck stiffness, or other symptoms of RPA.
- Other viral etiology or pneumonia.

#### BDDDXPEDIDKA

- DKA.
  - Cerebral edema in the setting of DKA.
- Other causes of metabolic acidosis including salicylate toxicity, lower concern for acetaminophen toxicity.
- Infection, recent URI per history. Lower concern for SBI.

Plan: Given initial concern for DKA, patient ordered for i-STAT labs. Initial basic labs and serial blood sugars.

VBG: @1(phvenpoc)@ / @1(pco2venpoc)@ / @1(po2venpoc)@ / @1(hco3venpoc)@

Initial K: \*\*\*, initial gap: \*\*\*.

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint. IV access x 2.

Given concern for significant electrolyte shifts in the setting of DKA, patient will require frequent lab monitoring, telemetry, and continuous reevaluation.

IV fluid hydration according to DKA protocol as below. Plan to replete fluid deficit over 36 to 48 hours in PICU. Initial new onset diabetes labs per protocol as below.

Insulin GTT at 0.1 units/kg/h.

Double bag system ordered from pharmacy.

---

Will send salicylate level.

Will discuss with PICU and endocrine.

CT head to rule out cerebral edema.

Family updated & understand plan and agree with recommendations.

[https://www.icloud.com/numbers/037M0oC\\_WSIHjJokz797hVcsg](https://www.icloud.com/numbers/037M0oC_WSIHjJokz797hVcsg)

#### BDDDXPEDIEYESWELLING

- Orbital cellulitis. No red flags such as proptosis, pain with extraocular movements, decreased extraocular movements, decreased visual acuity, pupillary defect.
- Preseptal cellulitis.
- Hordeolum, chalazion.
- HSV, herpes zoster but no vesicles present.

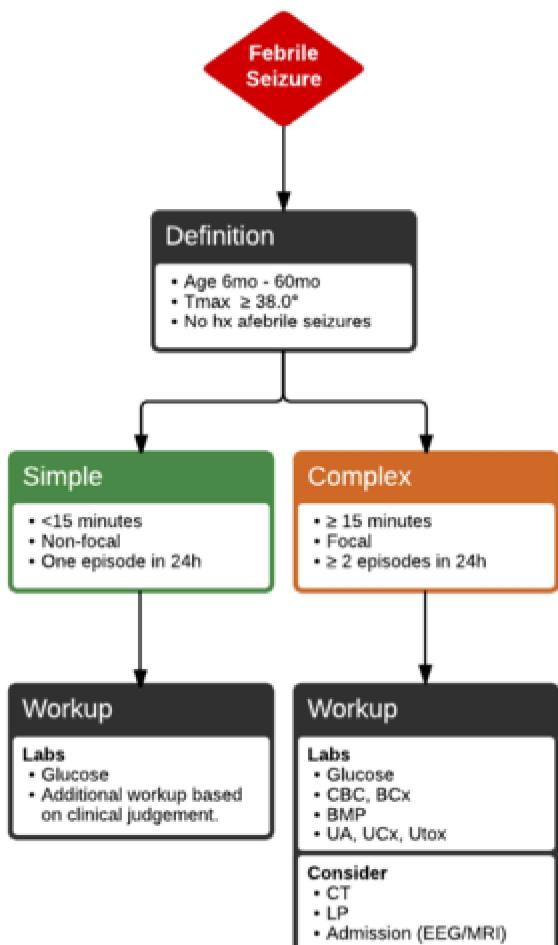
#### BDDDXPEDIFEBRILESEIZURE

- Simple febrile seizure.
- Suspect source is viral URI (including influenza, COVID, RSV). {Blank multiple:19196::"+sick contacts","+daycare"}
- Low clinical suspicion for PNA, UTI. No meningismus or findings/history suggestive of meningitis, SBI.
- Volume status reassuring.

Plan: Conservative management with antipyretics.

Observe for return to baseline. {Plan by System (Optional):46705}

Workup with FSBG, RVP, urinalysis.



Additional MDM on reevaluation listed in ED course below. In summary, patient with reassuring workup, improvement in fever and vitals, and return to baseline mental status. \*\*\* Return precautions reviewed, with patient and family at bedside, including signs of pneumonia, serious bacterial infection, respiratory distress, dehydration, or any new or concerning symptoms. Additional verbal discharge instructions were given and discussed with the patient and family. Advised pediatrician follow-up in 1 to 2 days. Family in agreement with plan.

---

#### BDDDXPEDIFEVERUNKNOWNORIGIN

Broad differential for fever of unknown origin includes:

- Serious bacterial infection including sepsis, meningitis, pneumonia.
  - URI, viral inc COVID, flu, RSV.
  - UTI.
  - AOM.
  - Exam not c/w Kawasaki disease.
- 

#### BDDDXPEDIFUSSY

- GI causes including intussusception, GERD, anal fissure.
  - Hair tourniquet, trauma, insect bites, burns.
  - Colic, torsion.
  - Exposure/tox.
  - Exam and history less consistent with occult infection.
  - Corneal abrasion.
- 

#### BDDDXPEDIHA

- Primary headache: cluster, migraine, tension
  - Sinusitis: no recent URI symptoms, sinus tenderness
  - Lower concern for strep pharyngitis, viral illness based on exam.
  - No fever, neck stiffness, photophobia\*\*\*, rash or symptoms suggest meningitis.
  - No red flag symptoms requiring further imaging to rule out space occupying lesions: n/v, anticoagulation, immunosuppression, cancer, infection, syncope, worse in AM
  - No history of trauma to suggest traumatic ICH.
  - No evidence of hydrocephalus\*\*\*: macrocephaly, full fontanelle, somnolence, vomiting
  - No history of trauma, unilateral symptoms, neck pain to suggest carotid dissection
  - Doubt SAH based on history.
  - Encephalopathy/HTN encephalopathy: dBP < 120, no AMS, no vision changes
  - IIH/pseudotumor: less likely 2/2 no visual symptoms, not \*\*\* typical overweight
  - CO poisoning: no clear history of exposure, no weakness or n/v
- 

#### BDDDXPEDIHEADINJURYLESSTHAN2

- Given mechanism, history, and physical exam findings, there is a low probability of serious injury to include intracranial bleed, skull fracture, DI, or high risk of decompensation.

Plan: Given the lack of a severe mechanism, GCS 15 or lack of AMS, no occipital/parietal scalp hematoma, and no LOC, risk of obtaining a CT scan outweighs the potential benefit.

Will plan for observation, p.o. challenge, reassurance and reassessment.

Anticipate discharge with pediatrician follow-up.

---

#### BDDDXPEDIHEADINJURYOLDERTHAN2

- Given mechanism, history, and physical exam findings, there is a low probability of serious injury to include intracranial bleed, skull fracture, DI, or high risk of decompensation.

The patient is a GCS of 15, is not altered, has no or minimal LOC history, and mechanism is of low energy. In

this group, PECARN rules demonstrate an exceptionally low risk of serious intracranial injury and the risk of obtaining a CT scan outweighs the potential benefit.

Will plan for observation, as needed pain control, p.o. challenge, reassurance and reassessment.

Dissipate discharge with pediatrician follow-up.

---

#### BDDDXPEDIHEADTRAUMA

- Mild/moderate TBI.
  - Low concern for ICH, fracture
  - Based on exam and history, doubt orbital trauma, maxillofacial trauma, scalp laceration, skull fracture.
- 

#### BDDDXPEDIHEADTRAUMAOLD

- Given mechanism, history, and physical exam findings, we have a low probability of serious injury to include intracranial bleed or skull fracture, DAI, or high risk of decompensation.
  - The patient has a GCS of 15 and is not altered, and has no or minimal LOC history. The mechanism is of low energy. In this group, PECARN rules demonstrate an exceptionally low risk of serious intracranial injury and obtaining further imaging is likely to be of little or no benefit.
  - Concussion.
- 

#### BDDDXPEDIHEMATURIA

- Glomerulonephritis/nephrotic syndrome including poststreptococcal glomerulonephritis.
  - IgA nephropathy.
  - UTI.
  - Lower concern for congenital urinary tract abnormality.
  - No known history of sickle cell disease.
  - No evidence of blunt trauma.
  - No travel to endemic areas with concern for schistosomiasis.
  - Low concern for look-alike's including medications, GI bleeding, red-colored food.
- 

#### BDDDXPEDIHERPANGINA

- Herpangina in the setting of viral illness.
- No evidence of hand or foot lesions to suggest hand-foot-mouth/coxsackie.
- At this time, fever not greater than 5 days he does not meet other criteria for Kawasaki disease with lower concern at this time.
- Low concern for bacterial infection or strep pharyngitis at this time.

Plan: Will check mini RVP and strep testing.

Will give acetaminophen, Maalox, and liquid Benadryl for symptom control.

Anticipate discharge home with Maalox/liquid Benadryl mixture.

---

#### BDDDXPEDIHIPPAIN

- Transient synovitis. No preceding known recent illness.
  - Legg calf Perthes disease.
  - SCFE.
  - Musculoskeletal injury, fracture.
  - Osteosarcoma.
  - Inflammatory including JIA, rheumatic fever.
  - Lower concern for septic arthritis, Lyme arthritis as patient is able to bear weight, has been afebrile, no evidence of effusion or overlying skin changes.
  - Age and history less consistent with developmental dysplasia of the hip.
- 

#### BDDDXPEDIHSP

- IgA vasculitis given patient's abdominal symptoms, rash, polyarthralgias primarily affecting the knees and

ankles.

- No significant abdominal tenderness to suggest intussusception requiring ultrasound.
  - Reactive arthritis, potentially in setting of recent infection or post strep reactive arthritis.
  - No evidence of glomerulonephritis or PSGN (strep testing pending from outside hospital).
  - Doubt Perthes, SCFE.
  - Low concern for septic arthritis.
  - Other inflammatory, JIA.
- 

#### BDDDXPEDIHYPOTHERMIAEONATE

- Environmental.
  - Neonatal hyperbilirubinemia.
  - Feeding difficulty.
  - Electrolyte disturbance, metabolic.
  - SBI.
- 

#### BDDDXXPEDIINFANTILECOLIC

- Infantile colic, milk allergy, FPIES, GERD.
  - Pyloric stenosis: male, prematurity, age, "hungry vomiter."
  - Other obstructive abnormality.
  - Infectious etiology including viral illness, low concern for sepsis, meningitis.
  - UTI.
  - Lower concern for intracranial cause of symptoms.
  - Congenital/metabolic/endocrine.
- 

#### BDDDXXPEDIKNEEPAINSPORTS

- Exam well localized to knee with low concern for hip/other lower extremity pathology.
  - Musculoskeletal knee injury without evidence of knee dislocation, fracture, meniscal/ligamentous injury. No evidence of patellar dislocation. Exam not suggestive of tendon rupture (patellar or quad).
  - Patellar tendinitis.
  - Patellofemoral pain syndrome.
  - Osgood-Schlatter disease: Although pain not well localized to tibial tubercle, no prominence/swelling evident.
  - Low concern for oncologic etiology of symptoms.
  - Infectious/post-infectious: Exam and history not concerning for septic joint or bursitis. No evidence of effusion, warmth, fevers. History less suggestive of Lyme arthritis or similar. No polyarthritis, history not suggestive of Rheumatic fever.
- 

#### BDDDXPEDIMYOSITIS

- Suspect myositis given history. Likely in the setting of viral infection. Lower concern for medication induced, metabolic, autoimmune or other similar causes symptoms.
  - No urinary symptoms to suggest rhabdo. Will evaluate for rhabdomyolysis and kidney injury with labs.
  - No recent signs or symptoms to suggest Lyme disease.
  - No recent hypothermia.
  - Low concern for significant electrolyte abnormalities.
  - No evidence of compartment syndrome.
  - Low suspicion for oncologic process, other causes of myositis including rheumatologic or endocrine causes given brevity of symptoms.
  - Well localized without concern for septic arthritis.
- 

#### BDDDXPEDIOTITIS

- Acute otitis media supported by exam with evidence of middle ear inflammation. Viral versus bacterial.
  - No evidence of associated otitis externa.
  - No mastoid edema, tenderness, evidence of nerve palsy, or other symptoms of mastoiditis.
-

- Low concern for other external ear pathologies.
  - Upper respiratory infection.
- 

#### BDDDXPEDIRADVSBRONCHIOLITIS

- Reactive airway disease/asthma exacerbation.
  - URI, viral infection including flu, COVID, RSV.
  - Bronchiolitis.
  - Lower concern for focal pneumonia based on exam.
  - Lower concern foreign body aspiration.
  - Exam less c/w croup.
  - No evidence of trauma.
- 

#### BDDDXPEDIRECTALPROLAPSE

- Rectal prolapse.
  - Low concern for ileocecal intussusception, prolapsing rectal polyp, prolapsing rectal duplication cyst, and rectal hemorrhoids.
- 

#### BDDDXPEDISEIZURENEW

- First-time epileptic seizure, afebrile.
  - No known fever or concern for febrile seizure.
  - No evidence of meningitis, encephalitis.
  - Low concern for abuse, EtOH/toxic ingestion.
  - Syncope.
  - History less consistent with breath-holding spell, hyperventilation syndrome.
  - Migraine headache.
- 

#### BDDDXPEDISEVEREVOMITING

- Patient's significant severe pain and vomiting potentially worse in the left lower quadrant concerning for potential ovarian torsion.
  - Patient sudden onset pain and bilious vomiting concerning for potential obstructive etiology of symptoms including malrotation plus or minus volvulus. No evidence of foreign body. No prior history of abdominal surgeries that could cause adhesions. Patient's exam otherwise less consistent with bowel obstruction.
  - Perforated viscus: Patient without sudden pain, no rebound or guarding.
  - Upper abdominal causes including hepatobiliary/gallbladder, pancreatitis, peptic ulcer disease.
  - Other lower abdominal causes including appendicitis, hernia, diverticulitis, torsion, ectopic.
  - Patient with no prior history of cyclical vomiting syndrome.
  - Lower concern for infectious causes such as sepsis, viral illness, gastroenteritis.
  - Less likely renal causes such as renal colic/pyelonephritis.
  - DKA.
  - Lower concern EtOH/tox.
  - Normal electrolytes.
  - No evidence of significant GI bleeding.
  - Negative hCG.
- 

#### BDDDXPEDIURI

- Suspect viral URI (including influenza, COVID, RSV). {Blank multiple:19196::"+sick contacts", "+daycare"}
  - Volume status reassuring without evidence of clinically significant dehydration.
  - {Blank single:19197::"No", "Mild"} wheezing or symptoms suggestive of bronchiolitis.
  - Exam not consistent with croup, no seal bark cough, no stridor, no fever, no wheezing/rhonchi.
  - Exam less consistent with foreign body. Patient without choking, drooling, asymmetric breath sounds or wheezing.
  - Low concern for pneumonia given time course, exam. No asymmetric pulmonary exam findings.
  - Lower concern for causes of chronic cough including allergic rhinitis, asthma, pertussis, reflux, sinusitis.
-

- Lower concern for primary gastrointestinal etiologies including appendicitis, obstructive etiology. Low concern for DKA.
  - No meningismus or symptoms concerning for meningitis/encephalitis.
- 

#### BDDDXPEDIVOMITINGMIDAGE

- Appendicitis.
  - Foreign body ingestion.
  - No evidence of external trauma or abuse.
  - No polyuria, polydipsia, weight loss or symptoms of DKA.
  - Concern for gastroenteritis as above.
- 

#### BDDDXPEDIVOMITINGNEWBORN

- Obstructive etiology including pyloric stenosis. History less c/w esophageal stenosis, intestinal stenosis, duodenal atresia, malrotation.
  - Milk allergy, FPIES, GERD.
  - Metabolic.
  - Afebrile, no evidence infectious etiology.
  - Lower concern for neurologic etiology.
- 

#### BDDDXPODAGRA

- Suspect gout flare/podagra with gout affecting the first metatarsophalangeal joint.
  - Trauma, although no clear history of trauma.
  - Osteoarthritis.
  - Low concern for malignancy or septic arthritis based on exam. Low concern for overlying cellulitis at this time requiring antimicrobials.
- 

#### BDDDXPOISONIVT

- Concern for likely poison ivy contact dermatitis given patient's history and diffuse rash consistent with contact dermatitis.
  - Some concern for either early cellulitis versus developing cellulitis in the setting of scratching of lesions.
  - Based on timeframe, less consistent with acute allergic reaction.
  - Less consistent with angioedema.
  - Presentation not consistent with anaphylaxis given that there is only skin involvement and timeframe has been greater than 24 hours.
- 

#### BDDDXPVDTOE

- Need to rule out pain 2/2 acute/subacute (on chronic) ischemia. \*\*\* Pulses on exam.
  - Foot infection/diabetic foot infection.
  - MSK injury.
  - Pain 2/2 diabetic neuropathy.
  - Ingrown toenail.
  - Exam and history not consistent with trench foot.
- 

#### BDDDXRECTALPAIN

- Low concern for clinically significant rectal bleeding.
  - No exam evidence of anal fissure, external hemorrhoid.
  - No evidence of anal fistula, mass, malignancy, tag.
  - No infectious symptoms or signs of anorectal abscess. No evidence of pilonidal cyst.
  - Constipation.
  - History not consistent with Crohn's disease.
  - No evidence of rectal foreign body, no history of anything per rectum.
  - No receptive anal intercourse and based on history lower concern for GC/chlamydia, syphilitic fissure.
-

- Exam not consistent with rectal prolapse.
- 

BDDDXRENALCOLIC  
@BDDDXFLANKPAIN@

---

#### BDDDXSEIZUREBREAKTHROUGH

- Breakthrough seizure in the setting of known seizure disorder.
  - Patient not in status.
  - Electrolytes WNL.
  - Patient not on isoniazid.
  - No evidence of trauma suggestive of ICH.
  - No infectious symptoms or meningismus to suggest meningitis or encephalitis.
  - Patient not taking or using significant months of alcohol, benzos, barbiturates, baclofen for potential withdrawal.
  - Low concern for other syncope given patient's presentation.
- 

#### BDDDXSHOCK

- High concern for septic shock in the setting of significant infection with \*\*\* sources.
  - Other causes of distributive shock.
    - Doubt neurogenic.
    - Lower concern for adrenal crisis, toxicologic.
    - Exam less consistent with anaphylaxis.
  - Obstructive shock.
    - PE.
    - No exam evidence of tension pneumothorax, cardiac tamponade, severe aortic stenosis.
    - Low concern for air embolism based on history.
  - Hypovolemic.
    - Traumatic and nontraumatic hemorrhagic shock.
  - Exam less consistent with cardiogenic shock.
    - No evidence of severe CHF on exam/ultrasound. \*\*\*
    - ACS. Acute severe valvular dysfunction.
    - Lower concern for significant drug toxicity (beta-blocker, calcium channel blocker, bupropion overdose).
    - Myocarditis.
    - No evidence of myocardial contusion.
- 

#### BDDDXSHOULDERMSK

- Low concern for acute traumatic injury.
  - Radiculopathy.
  - Impingement.
  - Tear.
- 

#### BDDDXSICKLE

- Sickle cell pain/vaso-occlusive crisis.
  - Concern for acute chest syndrome although no respiratory distress.
    - Differential also includes pneumonia, asthma, pulmonary hypertension, PE but no significant evidence on exam.
  - No infectious symptoms.
  - No abdominal pain on exam.
- 

#### BDDDXSICKLECELLFEVER

- Acute chest syndrome, although no respiratory distress.
-

- No evidence of pneumonia, pulmonary hypertension, PE.
  - No pain to suggest sickle cell pain/vaso-occlusive crisis.
  - No abdominal pain on exam.
  - No prior history of UTIs.
  - No evidence of osteomyelitis.
  - Lower concern for serious bacterial infection.
- 

#### BDDDXSORETHROAT

- Viral (COVID, flu, RSV). Including mono.
  - Strep, no exudates, lymphadenopathy.
  - Lower concern GC/chlamydia.
  - History and exam not suggestive of foreign body.
  - Based on history and exam, doubt epiglottitis, Ludwig's, PTA, RPA深深 neck space infection.
- 

#### BDDDXSTEMI

- Concern for STEMI given ECG, exam and history.
  - Further workup pending emergent cath lab intervention.
- 

#### BDDDXSTROKE

- Patient presents with symptoms concerning for acute CVA versus TIA.
  - History less consistent with dissection, AMI.
  - FSBG without evidence of hypoglycemia.
  - Basic labs pending, will differential also includes metabolic derangement such as hepatic/uremic encephalopathy.
  - Medication/tox.
  - Lower concern of seizure/postictal Todd's paralysis.
  - Patient with preceding headache and the symptoms could be associated with migraine although patient with no prior history of migraines \*\*\*.
- 

#### BDDDXSYNCOPE

- Reflex syncope including vasovagal syncope given the patient's clear history of prodromal symptoms including dry mouth, sweating, nausea prior to event\*\*\*.
  - Doubt cardiogenic syncope given presence of prodrome and lack of apparent risk factors; no family history of sudden cardiac death. Doubt acute life-threatening arrhythmia, structural heart disease, electrical conduction abnormality or ACS.
  - No murmur or exertional symptoms to suggest obstructive process.
  - Doubt pulmonary embolism given lack of concerning historical features, normal vitals, and lack evidence of deep vein thrombosis on exam. Exam, history not suggestive of vascular catastrophes including PE, thoracic dissection, AAA rupture. Patient not tachycardic, sitting well on room air, not short of breath, has no prior history of blood clots, has no family history of hypercoagulable state.
  - No historical or exam features to suggest volume loss, anemia, or acute infection.
  - Doubt subarachnoid hemorrhage given intact neurologic status and normal exam. Doubt acute neurologic catastrophe including ICH given lack of trauma, risk factors for spontaneous ICH.
- 

#### BDDXTACHYCARDIA

- Patient without infectious symptoms at this time
  - Hyperthyroidism
  - Pulmonary embolism
  - Pericarditis
  - Dehydration
  - Anemia
  - Doubt endocrine/pheochromocytoma
  - Drug/alcohol withdrawal or intoxication
-

---

**BDDDXTESTICULARPAIN**

- Need to rule out testicular torsion.
  - Testicular trauma.
  - Epididymitis.
  - No exam evidence of cellulitis or Fournier's gangrene.
  - Hydrocele, varicocele, spermatocele, hematocoele.
  - Less consistent with testicular rupture.
- 

**BDDDXTHROMBOCYTOPENIA**

- Increased platelet destruction.
    - ITP.
    - TTP.
    - HUS
    - DIC.
    - Viral infection including HIV, VZV, EBV.
    - Autoimmune destruction.
    - Mechanical valve.
    - Help syndrome: Incorrect patient population.
    - Splenic sequestration crisis: No history of sickle cell disease or cirrhosis
  - Decreased platelet production.
    - Congenital.
    - Viral infections.
    - B12 or folate deficiency.
  - Drug-induced: No history of significant alcohol use, recent antibiotic use, aspirin/NSAID use, thiazide diuretic use
- 

**BDDDXTRAUMAPREGNANCY**

- Exam less consistent with uterine rupture without significant shock, abdominal distention, abnormal contour, and with reassuring FHR pattern.
  - No significant abdominal pain, uterine tenderness, vaginal bleeding contractions, or fetal bradycardia to suggest placental abruption.
  - Symptoms not suggestive of preterm labor.
- 

**BDDDXVAGBLEEDINGNONPREG**

- Need to rule out pregnancy, trauma, dyscrasias, infection. No evidence of retrained foreign body.
  - Adenomyosis.
  - Dysfunctional uterine bleeding.
  - Endometriosis.
  - Fibroids.
  - No evidence of retained IUD.
  - No exam evidence of vaginal trauma.
  - Other systemic causes were lower concern for cirrhosis, coagulopathy, hypothyroidism.
  - Anemia in the setting of bleeding.
- 

**BDDDXVAGBLEEDINGPREGEARLY**

- Implantation bleeding.
  - Ectopic pregnancy.
  - Subchorionic hematoma.
  - First trimester abortion.
  - Gestational trophoblastic disease, no evidence of hypertension. Small pregnancy.
  - GYN: Cervicitis, fibroids.
-

## BDDDXVAGBLEEDINGPREGLATE

Placenta previa.

Vasa previa.

No reported vaginal trauma.

Low concern for placental abruption, not hypertensive, no trauma, no smoking, no cocaine abuse, no prior history of C-section/prior placental abruption.

Doubt placenta accreta (no prior C-section/uterine surgery, no known low-lying placenta, not grand multipara).

Fetal heart rate reassuring with no evidence of IUFD.

Patient is Rh+/-\*\*\*.

---

## BDDDXVAGINITIS

- Vulvovaginitis including BV, Candida, trichomonas.
  - Contact vulvovaginitis.
  - Atrophic vaginitis.
  - Lichen sclerosus.
  - GC/chlamydia infection.
  - Vaginal foreign body.
  - Urinary tract infection.
- 

## BDDDXVERTIGO

- BPPV
  - History and exam less consistent with a central cause \*\*\* TIA
  - The patient ha not had recent URI, no change in hearing to suggest labyrinthitis. Similarly no tinnitus or change in hearing to suggest Ménière's disease.
  - Patient will be an atypical patient population for MS. \*\*\*
  - No unilateral hearing loss or signs concerning for acoustic neuroma.
  - No recent neck trauma, neck pain or, or symptoms concerning for carotid artery dissection.
- 

## BDDDXWITHDRAWAL

- Alcohol withdrawal.
  - Based on exam and history, lower concern for intoxication, other toxidromes or withdrawal states, infection, metabolic derangements.
  - Normal appearing gait, patient alert and oriented, not confabulatory, no ophthalmoplegia and intact cranial nerve exam.
- 

## BDDEATHNOTE

### Death Pronouncement Note

I was called to the patient's bedside to pronounce that patient @NAME@ has died. {Death Assessment:27521}. Family and @ATTPROV@ were notified. The family {Accepts/Declines:26802} autopsy. Patient pronounced dead on @DBLINK(EPT,115)@ @DBLINK(EPT,116)@.

@FLOW(500050)@  
@FLOW(3040104817)@  
@FLOW(304010484801)@  
@FLOW(500200)@  
@FLOW(500280)@

Brian Desnoyers, MD MPH PGY-2

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

---

# Local Detox List

The list below has been compiled by our social work team and contains the phone numbers of many local detox programs. Please call these programs to arrange for detox placement.

<b>Facility</b>	<b>Location</b>	<b>Telephone</b>	<b>Notes</b>
<b>AdCare</b>	Worcester	508-799-9000	HMO/Medicare/No Free Care
<b>Andrew House</b>	North Quincy	617-479-9320	Mass Health/Free Care
<b>BayRidge</b>		781-477-6940	No Free Care
<b>Bournewood Hospital</b>	Brookline	617-469-0300	HMO/Medicare/No Free Care
<b>Baldpate Hospital</b>	Georgetown	978-352-2131	HMO/Medicare/No Free Care
<b>Bridge to Recovery</b>	Boston	617-471-9600	Medicare/Mass Health/Free Care
<b>Brockton Addiction</b>	Brockton	800-734-3444	Medicare/Mass Health/Free Care
<b>Brockton, Catholic Charities</b>	Brockton	508-584-9210	Medicare/Mass Health/Free Care
<b>CAB-Boston</b>	Boston	800-763-5363	Medicare/Mass Health/Free Care
<b>CAB-Danvers</b>	Danvers	800-323-2224	Medicare/Mass Health/Free Care
<b>Carlson Recovery</b>	Springfield	413-794-3971	Medicare/Mass Health/Free Care
<b>Dimock Detox</b>	Roxbury	617-442-9661	HMO/Medicare/Mass Health/Free Care
<b>Community Health Link</b>	Worcester	508-860-1200	HMO/Medicare/Mass Health/Free Care
<b>Clinton Hospital</b>	Clinton	978-368-3732	Medicare and Free Care only
<b>Emerson Hospital</b>	Concord	978-287-3520	HMO/Medicare/No Free Care
<b>Faulkner Hospital</b>	Jamaica Plain	617-983-7711	HMO/Medicare/No Free Care
<b>Gosnold</b>	Falmouth	800-444-1554	HMO/Mass Health/Limited Free Care
<b>High Point</b>	Plymouth	800-233-4478	HMO/Mass Health/Limited Free Care
<b>Holyoke Detox</b>	Holyoke	413-538-9400	
<b>HRI</b>		617-731-3216	
<b>Lowell Community Health</b>	Tewksbury	978-858-0533	HMO/Mass Health/Free Care
<b>McGee Unit</b>	Pittsfield	413-442-1400	HMO/Medicare/Mass Health/Free Care
<b>NORCAP</b>	Foxboro	800-331-2900	HMO/Medicare/Mass Health/No Free Care
<b>Providence Hospital</b>	Holyoke	800-274-7724	HMO/Medicare/Mass Health/Free Care
<b>St. Elizabeth's</b>	Brighton	617-789-2574	HMO/Medicare/No Free Care
<b>Somerville Hospital</b>	Somerville	617-591-4227	HMO/Medicare/Mass Health/Free Care
<b>Spectrum</b>	Westboro	508-898-1570	HMO/Medicare/Mass Health/Free Care
<b>SSTAR</b>	Fair River	800-937-3610	HMO/Medicare/Mass Health/Free Care
<b>Veteran's Administration</b>	Bedford	781-687-2354	Veterans Only
<b>Veteran's</b>	Brockton	508-583-4500	Veterans Only

**Administration****BDDIDNOTEVALUATE**

I received this resident signout. Patient discharged by prior resident prior to me assuming care or evaluating this patient.

**BDDIRECTTOCT****Direct to CT Initial Evaluation Note**

I was alerted by clinical staff of the imminent arrival of a potentially critical patient. I met the patient emergently in the CT scanner upon arrival. Given the potential high acuity, history was obtained from EMS regarding events prior to arrival to facilitate rapid imaging. Initial concern was for intracranial hemorrhage or stroke. I discussed the case with the {Trauma/Neurology:42600}. I was involved in the initial care of this patient to determine if they were stable for continued care in the general emergency department.

CT images were personally reviewed and significant for \*\*\*.

@EDCOURSE@

**BDEDCONSIDERED**

{Evaluation and management considered but not performed (medications, diagnostics or observation/admission) (Optional):47283}

**BDEDDCTEXT**

Return precautions reviewed with patient at bedside, including any new or concerning symptoms. Additional verbal discharge instructions were given and discussed with the patient and/or family. Advised PCP follow-up in 1 to 2 days. Patient in agreement with plan.

**BDEDHANDOFFNOTE****ED Continuation of Care****Handoff**

@EDHNDSUMMARY@@EDHNDEVENTS@

**Plan**

@EDHNDTODO@ {Plan by System (Optional):46705}

**ED Course**

{BDSIGNOUTDISPOED (Optional):46405}{BD SHIFTEVENTS:46412} @EDCOURSE@  
@EDMDM@  
{BDEDNOTEPROCEDURES:46410}

@DIAGP@ {Complexity of Problems Addressed at the Encounter:47059}  
@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

**BDEDNOTEPROCEDURESECTION****Procedures**

@PROCDOC@

---

BDEDNOTEWRITER

## History

@HPIBEGIN@

@RFV@

@SFHPI@

@NAME@ is a @AGE@ @SEX@ with {PMHx:36630} presenting {Blank single: 19197:: "via EMS", "via triage", ""} {Blank single: 19197:: "from home", "from facility", "from group home", "from detox", "from scene", "from \*\*\*", ""} with \*\*. \*\*\*

{Patient denies:44848}. {Pediatric Additional ROS Components (Optional):46873}

{External history:46348}

{Insert review of prior medical record.:46425}

{Interpreter:46349}

@HPIEND@@HISTORYBEGIN@

@PMH@ {PMH See HPI (Optional):46680}

@PSH@

@FAMHX@

@SOCH@

@VAPEHX@

@SOGIDOC@

@HISTORYEND@@ROSBEGIN@

@UMMHCRSBYAGE@

@BDROS@

@ROSEND@

## Physical Exam

@PEBEGIN@

@EDTRIAGEVITALS@

@PHYSEXAM@

@PEEND@

## Data

@EDLABS@

---

@EDIMAGING@

@EDMEDADMINS@

## Medical Decision Making and ED Course

@BDMDMTEMPLATE@

@EDMDM@

@EDCOURSE@

{Insert procedure documentation.:46410}{Insert documentation for face-to-face evaluation for restraints.:47848}

@DIAGP@ {Complexity of Problems Addressed at the Encounter:47059}

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

---

BDEDNOTEWRITERTRAUMA

## History

@HPIBEGIN@

@RFV@

@SFHPI@

@NAME@ is a @AGE@ @SEX@ with {PMHx:36630} presenting {Blank single: 19197:: "via EMS", "via triage", ""} {Blank single: 19197:: "from home", "from facility", "from group home", "from detox", "from \*\*\*", ""} with {Trauma levl:37830} s/p {Trauma injury:37831}. \*\*\*

\*\*\*

{Patient denies:44848}. {Pediatric Additional ROS Components (Optional):46873}

{External history:46348}

{BDEDPRIORRECORDREVIEW:46425}

{Interpreter:46349}

@HPIEND@@HISTORYBEGIN@

@PMH@ {PMH See HPI (Optional):46680}

@PSH@

@FAMHX@

@SOCH@

@VAPEHX@

@SOGIDOC@

@HISTORYEND@@ROSBEGIN@

@UMMHCROSBYAGE@

@BDROS@

---

@ROSEND@

## Physical Exam

@PEBEGIN@

@EDTRIAGEVITALS@

@PHYSEXAM@

Constitutional:

{constitutional trauma exam:46726}

GCS: E{(4) Spont / (3) Voice / (2) Pain / (1) None:46721::0} V{(5) Oriented / (4) Confused / (3) Inapp words / (2) Incomprehensible / (1) None:46722::0} M{(6) Obeys / (5) Localizes / (4) Withdraws / (3) Decorticate / (2) Decerebrate / (1) None:46723}

HEENT:

{HEENT trauma exam:46727}

C-collar in place? {YES:33793::"yes"}

Cardiovascular:

{cardiovascular trauma exam:46728}

Pulmonary:

{pulm trauma exam:46729}

Abdominal:

{abdominal trauma exam:46730}

Musculoskeletal:

{MSK trauma exam:46731}

Skin:

{skin trauma exam:46732}

Neurological:

{neuro trauma exam:46733}

\*\*\*

@PEEND@

## Data

@EDLABS@

@EDIMAGING@

@EDMEDADMINS@

## Medical Decision Making and ED Course

@BDMDMTRAUMA@

@ORDERSNMENCNOHXMED@

{Evaluation and Management Considered but not Performed (medications, diagnostics or observation/admission) (Optional):47283}

@EDMDM@

@EDCOURSE@

{BDEDNOTEPROCEDURES:46410}

---

@DIAGP@ {Complexity of Problems Addressed at the Encounter:47059}  
@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

---

BDEDORDERS  
@ORDERSNMENCNOHXMED@

---

BDEDPRIORRECORDREVIEW  
Patient's prior medical record reviewed including notes from {BD PRIOR RECORD REVIEW TYPES (Optional):46681} and was notable for: \*\*\*

---

BDEDPRIORRECORDREVIEWOLD  
Patient's prior medical record reviewed including notes from {Blank multiple:19196::"PCP", "pediatrician", "SNF", "prior hospitalization", "prior ED visit(s)", "transferring ED", "neurology", "pulmonology", "cardiology", "specialist(s)"} and was notable for: \*\*\*

---

BDEDSIGNOUTNOTE  
**ED Continuation of Care**

Sign out from {Current, Previous, wildcard:1601111125}

{BDSIGNOUTDISPOED (Optional):46405}{BDSHIFTEVENTS:46412}  
@EDCOURSE@  
@EDMDM@

{Insert procedure documentation.:46410}{Insert documentation for face-to-face evaluation for restraints.:47848}

@DIAGP@ {Complexity of Problems Addressed at the Encounter:47059}  
@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

---

BDEDSIGNOUTTEMPLATE  
**ED Continuation of Care**

@TODAYDATE@  
@NOWED@

Sign out from Dr. {Current, Previous, wildcard:1601111125}

@AGE@ @SEX@ with PMH \*\*\*.  
P/w \*\*\*.  
\*\*\*

Exam notable for \*\*\*.  
Workup notable for \*\*\*.

Plan:  
• \*\*\*

@EDMDM@

@EDCOURSE@

---

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

---

BDEDTRAUMANOTE2

## History

@HPIBEGIN@

@RFV@

@NAME@ is a @AGE@ @SEX@ who presents {Trauma levl:37830} s/p {Trauma injury:37831}.

\*\*\*

History provided by EMS and medical records.

@HISTORYBEGIN@

@PMH@  
@PSH@  
@FAMHX@  
@SOCH@  
@VAPEHX@  
@SOGIDOC@

@ROSBEGIN@  
@UMMHCRSBYAGE@  
ROS as noted in the HPI.  
@ROSEND@

## Physical Exam

@PEBEGIN@

@VITALSM@

@PHYSEXAM@

Vitals and nursing note reviewed.

Constitutional:

{constitutional trauma exam:46726}

GCS:

E{(4) Spont / (3) Voice / (2) Pain / (1) None:46721:::0}

V{(5) Oriented / (4) Confused / (3) Inapp words / (2) Incomprehensible / (1) None:46722:::0}

M{(6) Obeys / (5) Localizes / (4) Withdraws / (3) Decorticate / (2) Decerebrate / (1) None:46723}

HEENT:

{HEENT trauma exam:46727}

C-collar in place? {YES:33793:::"yes"}

Cardiovascular:

{cardiovascular trauma exam:46728}

Pulmonary:

{pulm trauma exam:46729}

Abdominal:

{abdominal trauma exam:46730}

Musculoskeletal:

{MSK trauma exam:46731}

---

Skin:

{skin trauma exam:46732}

Neurological:

{neuro trauma exam:46733}

\*\*\*

@PEEND@

## Medical Decision Making and ED Course

Assessment and Plan:

@AGE@ @SEX@ presenting {Trauma lev1:37830} s/p {Trauma injury:37831}. Trauma team at bedside.

On arrival to the trauma bay, patient had a GCS of {GCS15:46720}. Airway: {mp airway:46724}. Trachea was {TRACHEA ASSESSMENT:21358::"midline"}. Cervical spine precautions maintained with cervical collar. Breath sounds {TRAUMA BREATH SOUNDS H&P:26688::"Clear to auscultation bilaterally"}. EFAST exam: {eFAST:46725}. Vital signs: {VITAL SIGN ASSESSMENT:33164::"stable"}.

Secondary exam as above, most notable for \*\*\*.

This patient was seen and managed in coordination with the trauma service. Please see the trauma H&P for further details of their assessment and plan.

Plan for trauma labs and {trauma imaging:46734}. Disposition to be determined by labs, imaging, and trauma team. Patient signed out to the pods at \*\*\*.

@EDMDM@

@EDCOURSE@

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN @CSN@

---

BDEDTRAUMANOTE

## History

@HPIBEGIN@

@RFV@

@SFHPI@

@NAME@ is a @AGE@ @SEX@ with {PMHx:36630} presenting {Blank single: 19197:: "via EMS", "via triage", ""} {Blank single: 19197:: "from home", "from facility", "from group home", "from detox", "from \*\*\*", ""} with \*\*\*. \*\*\*

{Patient denies:44848}. {Pediatric Additional ROS Components (Optional):46873}

{External history:46348}

{BDEDPRIORRECORDREVIEW:46425}

{Interpreter:46349}

---

@HPIEND@@@HISTORYBEGIN@

@PMH@ {PMH See HPI (Optional):46680}

@PSH@

@FAMHX@

@SOCH@

@VAPEHX@

@SOGIDOC@

@HISTORYEND@@@ROSBEGIN@

@UMMHCRSBYAGE@

See HPI. A 10-point review of systems was performed and negative except for as noted in HPI.

@ROSEND@

## Physical Exam

@PEBEGIN@

@EDTRIAGEVITALS@

@PHYSEXAM@

@PEEND@

## Data

@EDLABS@

@EDIMAGING@

## Medical Decision Making and ED Course

@AGE@ @SEX@ with {PMHx:36630} p/w \*\*\*.

On initial evaluation, patient {bdmdmvitals:46370}. Exam notable for {bdmdmexams:46371}.

Differential diagnosis includes but is not limited to:

\*\*\*

Plan: \*\*\* {Plan by System (Optional):46705}

@ORDERSNMENCNOHXMED@

Additional MDM on reevaluation listed in ED course below. In summary, \*\*\*. {BDSHIFTEVENTS:46412} {ECG and imaging interpretation:46364:::1}

@EDMDM@

@EDCOURSE@

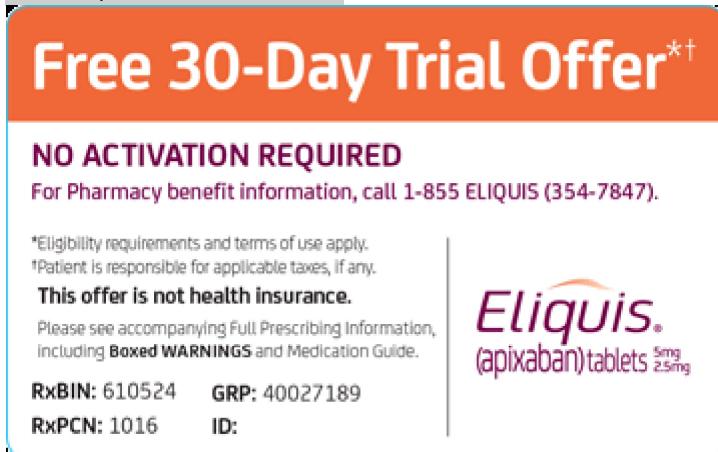
{BDEDNOTEPROCEDURES:46410}

@DIAGP@ {Complexity of Problems Addressed at the Encounter:47059}  
@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

#### BDEKGINTERPRETATION

ECG interpreted by me in the absence of a cardiologist. Rhythm is {Blank single:19197::"A-flutter", "A-fib", "sinus bradycardia", "sinus tachycardia", "normal sinus"}. Rate of \*\*\*. {Blank single:19197::"\*\*\* mm ST elevations in \*\*\*, \*\*\* mm ST depressions in \*\*\*, "T-wave inversions in \*\*\*, "No acute ischemic changes"}. {Blank single:19197::"No previous EKG on file.", "Changes are new from previous EKG.", "Similar to prior EKG.", " "}

#### BDELIQUISTRIALCARD



750426732

**To the Pharmacist** For processing assistance, please call McKesson Pharmacy Support at 1-866-279-4730.

- Please dispense the 30-day supply of ELIQUIS product at no co-pay for the patient
- Transmit claims to McKesson using RxBIN 610524
- McKesson requires valid Prescriber ID#, Patient Name, DOB, and RxPCN for claim adjudication
- This card must be accompanied by a prescription for ELIQUIS and can only be used by 1 patient
- This card is good for the first fill only

Group: 40027189 ID: 750426732

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##### ELIGIBILITY REQUIREMENTS:

You may be eligible for the Free 30-Day Trial Offer for ELIQUIS® (apixaban) if:

- 1 You have not previously filled a prescription for ELIQUIS;
- 2 You have a valid 30-day prescription for ELIQUIS;
- 3 You are being treated with ELIQUIS for an FDA-approved indication that an HCP has planned for more than 35 days of treatment;
- 4 You are 18 years of age, or older; and
- 5 You are a resident of the United States, Puerto Rico, or other select U.S. Territory.

##### TERMS OF USE:

- 1 Eligible patients who present a Free 30-Day Trial card together with a valid 30-day prescription for ELIQUIS at participating pharmacies can receive a free 30-day supply (up to 74 tablets) of ELIQUIS. Patient is responsible for applicable taxes, if any. This offer may not be redeemed on prescriptions written for longer than 30 days.
- 2 This offer is limited to one use per patient per lifetime and is non-transferrable. By redeeming this offer, you certify that you have not previously filled a prescription for ELIQUIS.
- 3 The Free 30-Day Trial for the specified prescription cannot be combined with any other rebate/coupon, free trial, or similar offer. No substitutions are permitted.
- 4 Patients, pharmacists, and prescribers cannot seek reimbursement for the Free 30-Day Trial of

- ELIQUIS from health insurance or any third party, including state or federally funded programs.
- 5 Patients may not count the Free 30-Day Trial of ELIQUIS as an expense incurred for purposes of determining out-of-pocket costs for any plan, including true out-of-pocket costs, (TrOOP), for purposes of calculating the out-of-pocket threshold for Medicare Part D plans.
- 6 Activation and use of the Free 30-Day Trial card must take place by December 31, 2024. This card expires on December 31, 2024.
- 7 Only valid in the United States, Puerto Rico, and other select U.S. Territories; this offer is void where restricted or prohibited by law.
- 8 Bristol-Myers Squibb and Pfizer reserve the right to rescind, revoke, or amend this offer at any time without notice.
- 9 This Free 30-Day Trial card may not be sold, purchased, traded, or counterfeited. Reproductions of this card are void.
- 10 This offer is not conditioned on any past, present, or future purchase, including refills.
- 11 **The ELIQUIS Free 30-Day Trial offer is not health insurance.**

**BY USING THIS CARD, YOU AND YOUR PHARMACIST UNDERSTAND AND AGREE TO COMPLY WITH THESE ELIGIBILITY REQUIREMENTS AND TERMS OF USE.**

**ELIQUIS 360 Support Program is a LoyaltyScript® Program ISSUER: (80840)**

**To the pharmacist:** For processing assistance, please call McKesson Pharmacy Support at 1-866-279-4730.

**Please see Medication Guide including "What is the most important information I should know about ELIQUIS" on the following pages.**

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---

**BDEMHCLEAR**

Based on evaluation of the patient, there is no evidence of current medical condition likely to deteriorate precluding evaluation by EMH staff to determine need for further emergent evaluation and/or management. EMH has been informed and agreed to evaluate the patient

---

**BDEMHSIGNOUT**

@AGE@ @SEX@ with PMH \*\*\*.  
P/w \*\*\*.

Dispo: {Blank single:19197::"EMH eval", "IPBS"}

Section 12: {Blank single:19197::"yes", "yes, scanned", "yes, filled out digitally", "no, voluntary", "no, needs capacity eval before leaving", "no, no capacity"}

Home Meds: {Blank single:19197::"ordered", "not ordered", "N/A, no home meds", "N/A, not taking"}

Diet: {Blank single:19197::"ordered", "not ordered"}

COVID Status: {Blank single:19197::"negative", "positive", "pending"}

24 hr events: {Blank single:19197::"no acute events"}

@DIETORDERS@

---

**BDEVALFALL**

A 12-lead EKG was obtained with {Blank single:19197::"no evidence of dysrhythmia, ischemia or infarction", "\*\*\*\*"}. A point-of-care glucose was obtained with {Blank single:19197::"no evidence of hypoglycemia", "\*\*\*\*"}. Patient was noted to have a neurological exam with no evidence of focal deficits\*\*\*. Head to toe exam {Blank single:19197::"without evidence of other injuries", "\*\*\*\*"}. {Blank single:19197::"Canadian Head/c-spine CT rules were applied and patient did not fall into the low risk category so a CT was obtained. This showed no significant findings.", "Canadian Head/c-spine CT"}

---

Rule could not be applied to this patient and there is clinical concern for a head or c-spine injury because of \*\*\* so CT head/c-spine were obtained and showed no significant intracranial hemorrhage and no evidence of acute spinal injuries.", "Canadian Head/c-spine CT Rule was applied and patient did fall into the low risk category so a head CT was not obtained."}

---

#### BDEXAMCHESTPAIN

cardiac auscultation without murmurs rubs or gallops, lungs clear to auscultation bilaterally with no wheezing and good air movement bilaterally, no chest wall crepitus or rashes, no reproducible tenderness, soft nontender abdomen, no lower extremity edema.

---

#### BDEXAMCODE

unresponsive, pulseless, in {Presenting rhythm:42300} on initial rhythm check, {Blank single:19197::"intubated in field", "ventilations via BVM", "trach"}, no sign of external trauma, pupils dilated and fixed

---

#### BDEXAMCOPD

decreased air movement bilaterally with diffuse wheezes, cardiac auscultation without murmurs rubs or gallops, requiring supplemental oxygen, soft nontender abdomen, no lower extremity edema

---

#### BDEXAMDENTALABSCESS

small abscess over the interdental papilla of {Blank single: 19197::"left", "right"} {Blank single: 19197::"lower", "upper"} {Blank single: 19197::"incisor", "cuspid", "premolar", "molar"} with mild gingival thickening, otherwise pink and supple gingival tissues, {Blank single: 19197::"with", "without"} active discharge, no uvular deviation, full range of motion of the neck, no exudate on the bilateral tonsillar beds, no elevated tongue, no lymphadenopathy appreciated

---

#### BDEXAMNEURO

alert and oriented x 4, PERRL, no appreciable cranial nerve deficits, no dysmetria, normal appearing gait, no appreciable motor or sensory deficits, \*\*\* Dix-Hallpike, cardiac auscultation without MRG, lungs CTAB.

---

#### BDEXAMPEDIAPPY

MMM, soft abdomen with tenderness primarily in the right lower quadrant, normal active bowel sounds, no surgical scars, no CVA tenderness, normal appearing testicles \*\*\*, pain with ambulation and jumping

---

#### BDEXAMPEDIBRONCHIOLITIS

rhonchorous lung sounds, without wheezing, no retractions, mildly tachypneic, TMs clear, volume status WNL with flat fontanelles

---

#### BDEXAMPEDIDKA

intact mental status with GCS 15/no appreciable cranial nerve/pupillary/sensory/motor deficits, dry mucous membranes, no evidence of oral candidiasis, no meningismus, hyperpnea/Kussmaul respirations with otherwise clear lung fields and no wheezing/stridor, cap refill less than 2 seconds with no murmur appreciated on cardiac auscultation, soft nontender nondistended abdomen

---

#### BDEXAMPEDIFEBrILESEIZURE

clear lung sounds bilaterally, without wheezing/stridor, no retractions, {Blank single:19197::"not", "mildly", "initially"} tachypneic, TMs clear, volume status WNL {Blank single:19197::"with flat fontanelles", "with cap refill < 2 sec", "based on exam"}, no murmur appreciated, abdomen soft/ND/NT w/o HSM, no meningismus, no focal deficits and good tone throughout

---

**BDEXAMPEDIFUSSY**

head to toe exam without evidence of injuries or hair tourniquet, no evidence of burns, oral exam without evidence of burn/trauma, head to toe exam without any evidence of nonaccidental trauma, no appreciable toxicodrome, soft nontender abdomen without masses, testicular exam with normal-appearing testicles, rectal exam without fissures

---

**BDEXAMPEDIHEADINJURY**

GCS 15, no evidence of occipital parietal scalp hematoma, no evidence of contusion, no lacerations appreciated, no hemotympanum, and no evidence of other injuries on head to toe exam

---

**BDEXAMPEDIHERPANGINA**

multiple oral lesions/vesicles/ulcers that are tender when probed, no hand or foot lesions, lungs clear to auscultation bilaterally, soft nontender abdomen without rebound or guarding, uvula midline without evidence of peritonsillar abscess or deep neck space infection

---

**BDEXAMPEDIMYOSITIS**

bilateral calf tenderness with pain with dorsiflexion and no evidence of any joint tenderness or swelling, patient able to walk without a limp, no bony TTP, no pain with internal and external rotation of the hip, no knee tenderness to palpation or with ROM, 2+ peripheral pulses, clear lung sounds bilaterally, without wheezing/stridor, no retractions, {Blank single:19197::"not", "mildly", "initially"} tachypneic, TMs clear, volume status WNL {Blank single:19197::"with flat fontanelles", "with cap refill < 2 sec", "based on exam"}, no murmur appreciated, abdomen soft/ND/NT w/o HSM

---

**BDEXAMPEDINEONATE**

anterior fontanelle open and flat, moist mucous membranes, upper lip/lower lip/lingual frenulum intact without injury, no evidence of meningismus, lungs clear to auscultation bilaterally, well-perfused with cap refill less than 2 seconds, soft nondistended abdomen, good tone

---

**BDEXAMPEDINOTAPPY**

MMM, soft nontender abdomen, normoactive bowel sounds, no surgical scars, no CVA tenderness, normal appearing testicles \*\*\*, no pain with ambulation and jumping

---

**BDEXAMPEDIRAD**

coarse lung sounds with expiratory wheeze, mild subcostal retractions, mildly tachypneic, TMs clear, volume status WNL with flat fontanelles

---

**BDEXAMPEDIURIREASSURING**

clear lung sounds bilaterally, without wheezing/stridor, no retractions, {Blank single:19197::"not", "mildly", "initially"} tachypneic, TMs clear, volume status WNL {Blank single:19197::"with flat fontanelles", "with cap refill < 2 sec", "based on exam"}, no murmur appreciated, abdomen soft/ND/NT w/o HSM

---

**BDEXAMSORETHROAT**

posterior oropharynx with cobblestoning, uvula midline without deviation or edema, mild tonsillar erythema without exudate, full neck range of motion without neck stiffness, TMs clear, no stridor, no palpable lymph nodes, soft nontender abdomen without exam evidence of splenomegaly

---

**BDEXAMTOX**

head to toe exam without any injuries, soft nontender abdomen without right upper quadrant or other tenderness, moist mucous membranes, not diaphoretic, PERRL with 4 mm pupils, normoreflexic without

---

clonus, neuroexam intact

---

#### BDEXAMTRAUMA

cardiac auscultation without murmurs rubs or gallops, lungs clear to auscultation bilaterally with bilateral breath sounds, chest wall without tenderness, head to toe exam notable for \*\*\*

---

#### BDEXAMTRAUMALONG

##### Constitutional:

{constitutional trauma exam:46726}

GCS: E{(4) Spont / (3) Voice / (2) Pain / (1) None:46721:::0} V{(5) Oriented / (4) Confused / (3) Inapp words / (2) Incomprehensible / (1) None:46722:::0} M{(6) Obeys / (5) Localizes / (4) Withdraws / (3) Decorticate / (2) Decerebrate / (1) None:46723}

##### HEENT:

{HEENT trauma exam:46727}

C-collar in place? {YES:33793:::"yes"}

##### Cardiovascular:

{cardiovascular trauma exam:46728}

##### Pulmonary:

{pulm trauma exam:46729}

##### Abdominal:

{abdominal trauma exam:46730}

##### Musculoskeletal:

{MSK trauma exam:46731}

##### Skin:

{skin trauma exam:46732}

##### Neurological:

{neuro trauma exam:46733}

---

#### BDEXAMURI

alert and oriented x 4, PERRL, lungs clear to auscultation bilaterally, posterior oropharynx with cobblestoning, uvula midline without deviation or edema, mild tonsillar erythema without exudate, full range of motion of neck without neck stiffness, no stridor, no palpable lymph nodes, no appreciable cranial nerve deficits, no dysmetria, normal appearing gait, no appreciable motor or sensory deficits, cardiac auscultation without MRG, soft nontender abdomen without evidence of splenomegaly

---

#### BDEXAMUTIALTERED

patient alert and oriented x 3, good strength, no CVA or suprapubic tenderness on exam, soft nontender abdomen, lungs clear to auscultation bilaterally, patient responding to external visual stimuli, reassuring neurologic exam without focal deficits

---

#### BDEXTHXEMSRELIABLE

Additional patient history per HPI was obtained from EMS including details about initial presentation, en route medication administration, and circumstances leading to transport, which are critical for diagnostic evaluation and treatment planning.

---

#### BDEXTHXEMSUNRELIABLE

Additional patient history per HPI was obtained from EMS due to the patient's altered mental status, including details about initial presentation, en route medication administration, and circumstances leading to transport, which are critical for diagnostic evaluation and treatment planning.

---

#### BDEXTHXOTHER

Additional patient history per HPI was obtained from {Blank multiple:19196::"family", "facility"}. Due to the patient's confusion, their history requires collateral communication of events/history.

---

#### BDEXTHXPEDI

History obtained in HPI given with assistance of family/guardian as described in HPI given patient's age. Because patient is a minor, they require help with communication of events/history. History obtained from {Blank single:19197::"mother", "father", "fathers", "mothers", "parents", "grandparent", "grandparents", "family"} at bedside.

---

#### BDGENDCINST

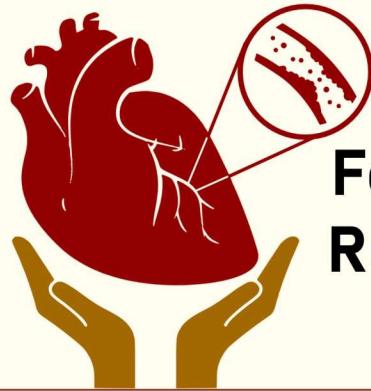
You have been evaluated in the Emergency Department today for \*\*\*. Your evaluation, including \*\*\*, suggests that your symptoms are due to \*\*\*.

Please follow up with your primary care physician within two days.

Return to the Emergency Department if you experience \*\*\*.

---

#### BDGRACE1



# GRACE-1

## For Adult Patients with Recurrent\*, Low-risk\*\* Chest Pain

### CRITERIA

### RECOMMENDATIONS

- |  |   |
|--|---|
| 1 Pain > 3 hours   | A single, high sensitivity troponin to reasonably exclude ACS within 30 days                                    |
| 2 Normal stress test within the past 12 months                                 | Repeat stress testing to decrease 30-day MACE NOT recommended   |
| 3 For all adult patients with recurrent, low-risk chest pain                   | No recommendation on hospitalization (neither inpatient or observation stay)                                    |
| 4 With non-obstructive (< 50%) CAD on prior angiography in past 5 years        | Referral for expedited outpatient testing rather than inpatient admission                                       |
| 5 With no occlusive CAD (0% stenosis) on prior angiography in the past 5 years |   |
| 6 With no coronary stenosis on CCTA within past 2 years                        | No further diagnostic testing other than a single high-sensitivity troponin to exclude ACS within those 2 years |
| 7 For all adult patients with recurrent, low-risk chest pain                   | Depression and anxiety screening tools are recommended to evaluate healthcare use and return                    |
| 8 For all adult patients with recurrent, low-risk chest pain                   | Referral for anxiety and depression management are recommended  |

\*Recurrent Chest Pain: Two or more prior emergency department visits with chest pain in a 12-month period that did NOT demonstrate evidence of acute coronary syndrome (ACS) or flow-limiting coronary stenosis



\*\*Low Risk: HEART Score < 4 points or another validated tool (ie. HEART Pathway or TIMI score) for disease related poor-outcome within 30 days requiring ECG for risk stratification

---

**BDHEARTECGCRITERIA****HEART ECG Finding Criteria**

Ref: <https://www.ahajournals.org/doi/10.1161/JAHA.120.020082>

- |   |  |
|---|--|
| 2 | • ST-segment depressions $\geq 0.05$ mV in 2 contiguous leads (half a small box)   |
|   | • TWI $\geq 1$ mm in 2 contiguous leads excluding III, V1, aVR (one small box)   |
| 1 | • BBB, paced rhythms, T-wave flattening in two or more contiguous leads other than isolated III, LVH (see this <a href="#">ref</a> on example LVH criteria), repol abnormalities (may include BER), contiguous q-waves |
| 0 | • None of the above, Includes isolated PVCs  |
- 

**BDHPIAPX**

- + Skin-mucosal tissue involvement.
  - + Respiratory symptoms such as wheezing, SOB/respiratory distress
  - + Cardiovascular signs such as hypotension
  - + GI symptoms such as nausea and diarrhea
  - + Cutaneous hives/erythema
- Airway protected.  
No uvular or laryngoeedema.
- 

**BDHPIBACKPAIN**

Denies sudden onset or other unexplained changes in bladder or bowel control (retention or incontinence).

Denies sudden onset or otherwise unexplained lower extremity weakness. Denies saddle numbness, hypoesthesia, or anesthesia.

Patient not currently on anti-coagulation and without recent blunt back trauma.

Denies unexplained weight loss, night sweats. No history of malignancy, tuberculosis, immunosuppression.

Denies IVDU.

No known history of aortic pathology.

Denies h/o urinary tract stones. Denies dysuria.

Denies F/N/V/D.

---

**BDHPIINTRO**

@NAME@ is a @AGE@ @SEX@ with PMH @PMHLIST@

presenting to the ED {Blank single:19197:: "via EMS from \*\*\* with \*\*\*, "via EMS with", "via EMS s/p", "s/p", "from \*\*\* with \*\*\*, "with"} \*\*\*.

---

**BDHPIPEDIMVC**

Mechanism of accident: \*\*\*

Patient's location in car: \*\*\*

Patient's use or restraints: {Blank single:19197:: "rear facing car seat", "front facing car seat", "lap belt", "lap/shoulder belt", "no"}

Air bag deployment: {Blank single:19197:: "front", "side", "yes", "no"}

Any other occupant injured: {Blank single:19197:: "yes", "no"}

Car able to be driven away: {Blank single:19197:: "yes", "no"}

Report of patient's symptoms prior to arrival: ({Blank single:19197:: "+", "-"}) CHI/LOC, ({Blank single:19197:: "+", "-"}) neck injury/pain, ({Blank single:19197:: "+", "-"}) abdominal pain, ({Blank single:19197:: "+", "-"}) ambulatory after injury

---

**BDHPISEIZURE**

No history of immunosuppression.

No recent fevers known.

No recent ABX use, no history of VP shunt.

---

No recent toxic exposures including no antihyperglycemic overdose.

No unilateral weakness.

No recent trauma.

#### BDHPISORETHROAT

Patient describes symptoms of sore throat x \*\*\* days.

Pain viewed as moderate.

No exacerbating or relieving factors.

No fever, endorses cough.

Denies neck stiffness or vomiting.

No muffled voice.

No IVDU or known HIV exposure. No new rash, abdominal pain, nausea, vomiting.

#### BDHPITEMPLATE

@NAME@ is a @AGE@ @SEX@ with {PMHx:36630} presenting {Blank single: 19197:: "via EMS", "via triage", ""} {Blank single: 19197:: "from home", "from facility", "from group home", "from detox", "from \*\*\*", ""} with \*\*\*

{Patient denies:44848}.

{External history:46348}

{BDEDPRIORRECORDREVIEW:46425}

{Interpreter:46349}

#### BDHPITOOTHPAIN

No fevers. No steroid use or immunosuppressive state.

No pus from mouth. No e/o tooth fracture, avulsion, or bleeding socket.

No recent facial trauma.

Otherwise well w no changes to vision, dysphonia, dysphagia.

No e/o RPA, PTA, Ludwig's angina, periapical abscess.

No e/o gingival hyperplasia or concern for drug reaction.

#### BDHSPDISCHARGEINSTRUCTIONS

Brayden Michael Mulcahy **was seen in the emergency department for rash, abdominal pain, joint swelling. Your symptoms may be suggestive of IgA vasculitis (also sometimes known as Henoch-Schönlein purpura). You should follow up with your pediatrician in the next few days to discuss further evaluation. You will need multiple visits with the pediatrician for monitoring and to monitor your kidney function.**

**Please seek immediate medical attention if you develop any fevers, inability to walk, behavior change, confusion, changes in urine, severe belly pain, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

#### Over-The-Counter Pain Medicine Dosing Chart

##### Acetaminophen (Tylenol-type medicine)

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs

							(500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

**Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever  
Should NOT be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

**BDICUDAILYSUMMARY**

**Daily Summary:**

Flowsheet	
I/O	@IOBRIEF@
Drips/Sedation	
Vent	@VENTSETTINGS@
Plastic	@LINES@
Labs	
Imaging	
Micro	@MICROLABS@

**BDICUGLOBALS**

{global Issues:304012100}

**BDICUPLAN**

@PATIENTSUMMARY@

**Neuro:**

@BDICUPLANSECTION@

**Cardiac:**  
@BDICUPLANSECTION@

**Pulm:**  
**# No active issues**  
*Home meds: none \*\*\*.*  
\*\*\*

@VENTSETTINGS@

- \*\*\*

**GI:**  
@BDICUPLANSECTION@

**Renal:**  
@BDICUPLANSECTION@

**ID:**  
@BDICUPLANSECTION@

**Endocrine:**  
@BDICUPLANSECTION@

**Heme:**  
@BDICUPLANSECTION@

**Other:**  
@BDICUPLANSECTION@

**Globals:**

**# DVT PPX:** \*\*\*

**# GI PPX:** \*\*\*

{global Issues:304012100}

---

**BDICUPLANENDO**

- ICU glycemic protocol.
- Avoid hypoglycemia.
- FSBS goal: 100-180.

---

**BDICUPLANNEURO**

Requiring sedation to tolerate intubation/ventilation:  
Requiring me to be frequently at bedside assessing and titrating sedation regimen to achieve goal RASS.  
- fentanyl and propofol/versed infusion for sedation

- prn fentanyl
- goal RASS 0 to -1
- daily sedation holiday

#### Acute POSTOP / TRAUMATIC pain:

Requiring me to be frequently at bedside assessing and titrating multimodal pain regimen to achieve adequate effect.

- tylenol/motrin ATC
- oxycodone prn
- dilaudid PCA / dilaudid IV prn for breakthrough pain
- toradol course x48 hours
- lidoderm patch, neurontin
- bupivacaine epidural, titrations as per pain service
- monitor for adequate analgesia

#### Delirium prevention:

- promote sleep hygiene as high risk for ICU related delirium

---

#### BDICUPLANSECTION

#### # No active issues

*Home meds: none \*\*\*.*

\*\*\*

- \*\*\*

---

#### BDICUPLANVENT

@VENTSETTINGS@

- Wean sedation to facilitate SBT trial.
- Daily evaluation for extubation readiness.

---

#### BDICUPROG

#### CRITICAL CARE PROGRESS NOTE

#### PATIENT SUMMARY

@PATIENTSUMMARY@

@RRHLOS@

#### SUBJECTIVE

\*\*\*

#### 24 Hour Interval History:

@INTERVALHISTORY@

#### OBJECTIVE

@VSRANGES@

@IOBRIEF@

---

**Physical Exam:**\*\*\*

Constitutional: NAD, Oriented to person, place, and time, Well-developed, Well-nourished

HEENT: Normocephalic, atraumatic, MMM

Neck: Normal ROM, Neck supple, No JVD present

Cardiovascular: RRR, No gallop, rub, or murmurs, intact distal pulses

Pulmonary/Chest: CTAB, No wheezes, rales, or crackles, Effort normal

Abdominal: Soft, +BS, nontender, non-distended, No rebound or guarding

Musculoskeletal: Normal ROM, No pedal edema, No tenderness or deformity

Neurological: A&O x3, no gross deficits

Skin: Warm and dry, No rash noted, Non diaphoretic, No erythema,

Psychiatric: Normal mood, behavior and affect, Short and long term memory appear intact

**Lines/Drains/Airway:**

@LDALINES@

@VENTSETTINGS@

**Medications:**

@CMEDSIP2@

@FLUIDSGROUPER@

**Laboratory Data:**

@LABRCNTIP(wbc:7,hgb:7, hct:7,PLT:7)@

@LABRCNTIP(NA:7,K:7,CL:7,co2:7,bun:7,creatinine:7,glucose:7)@

@LABRCNTIP(albumin:7,prot:7,bilirubin:7,bilidir:7,alkphos:7,alt:7,ast:7)@

@LABRCNTIP(INR:7,aPTT:7)@

**Microbiology data:**

I have personally reviewed all micro data.

@MICROLABS@

**Radiographic Data:**

I have personally reviewed all radiographic data.

@RISRSLTIMP2@

@IMAGINGECHOLAST@

**Hospital Problems:**

@HPROBL@

**ASSESSMENT & PLAN**

@PATIENTSUMMARY@

**Neuro:**

**Cardiovascular:**

**Pulm:**

---

GI:

Renal/GU:

ID:

Endocrine/Nutrition:

Heme/Onc:

MSK/Skin:

Psych:

Other:

**VTE Prophylaxis:**  
@ANTICOAG@

@FLOW(607620)@

@CODESTATUS@

{global Issues:304012100}

**Discharge Planning/Placement:**

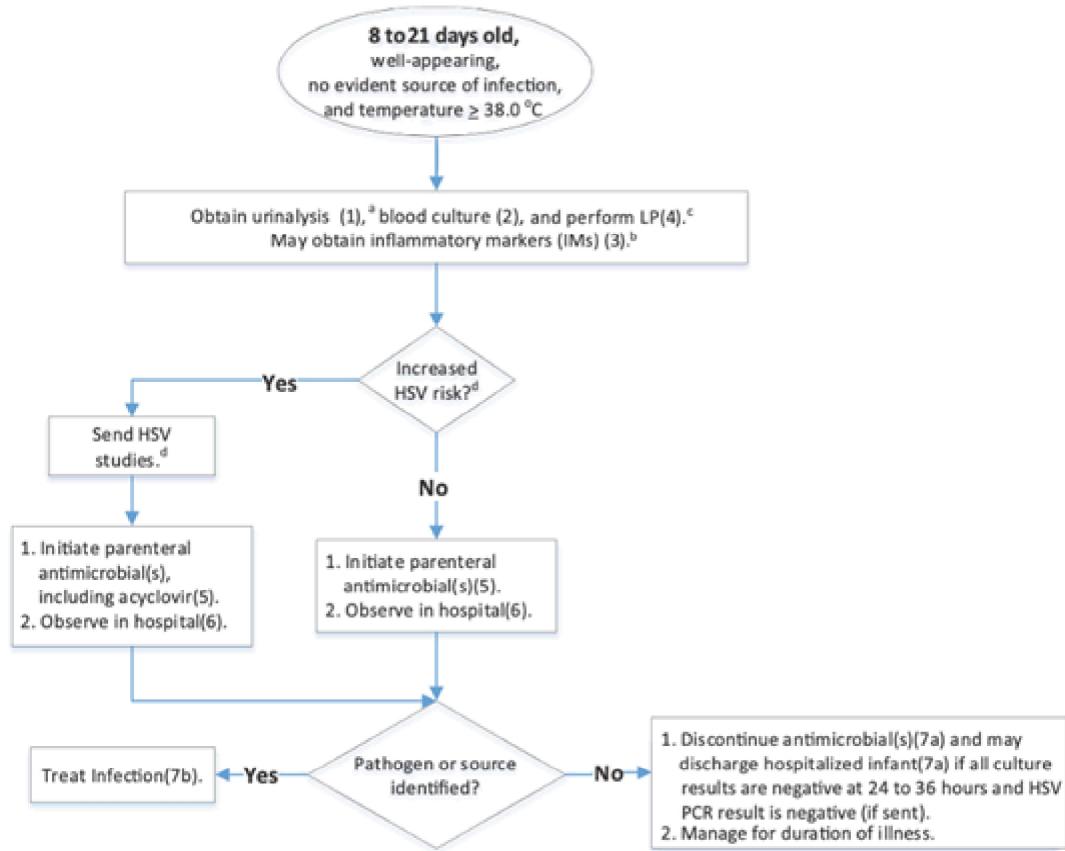
I have discussed the plan of care with: Attending, Fellow, and Interdisciplinary team

**Signature:**  
@SIG@

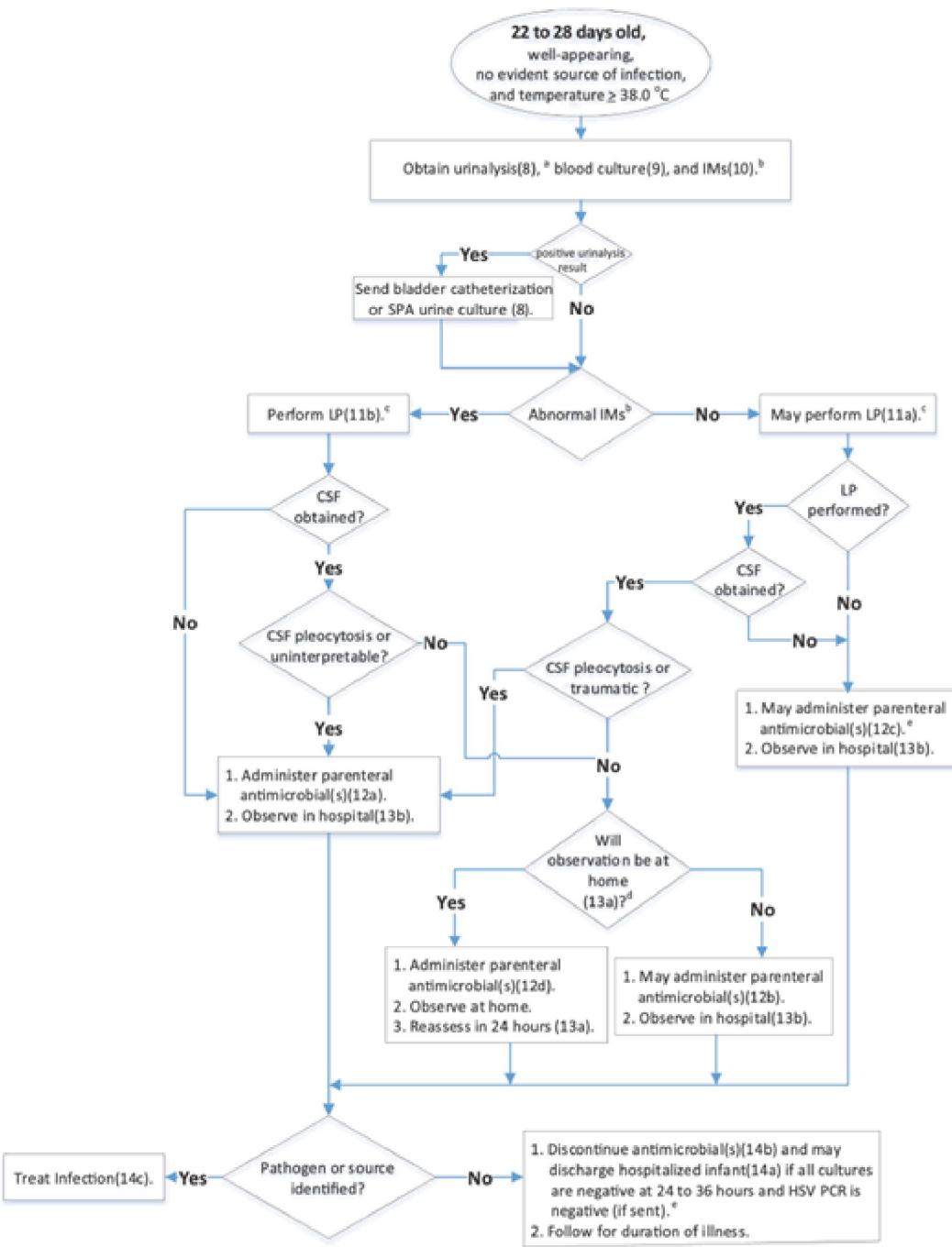
*\*\*Portions of this note were generated using Nuance Dragon Medical One voice recognition software. Please excuse any minor errors in grammar or syntax.*

---

BDIMAGEFEVER08TO21DAYS

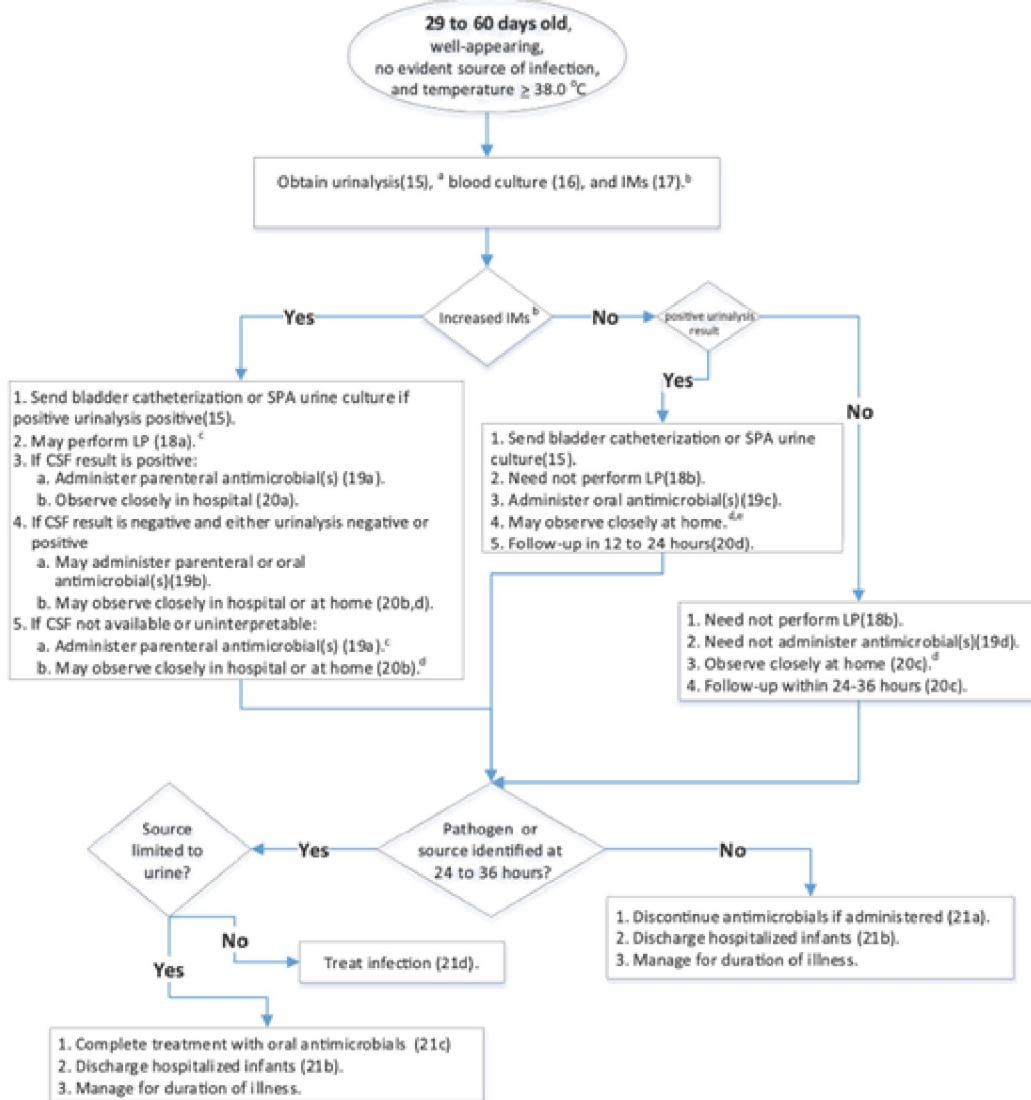


BDIMAGEFEVER22TO28DAYS



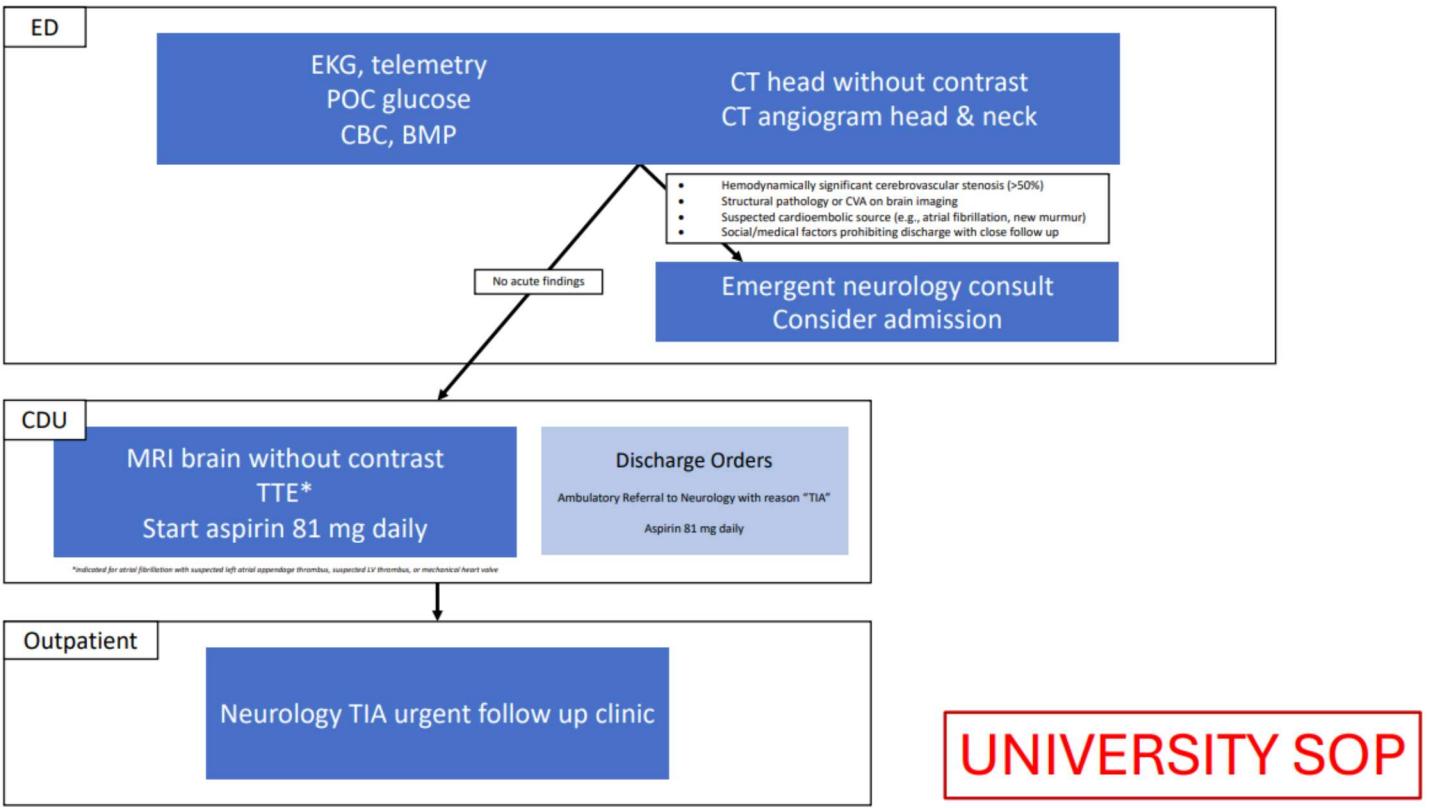

---

BDIMAGEFEVER29TO60DAYS




---

BDIMAGETIACPG



#### BDINCIDENTALFINDINGS

#### Radiology Incidental Findings

You have an incidental finding(s) found on your radiology studies during your evaluation in the Emergency Department. An incidental finding means that you have an abnormality on imaging which was not necessarily related to the focus of your emergency evaluation and treatment today but does require further investigation to ensure that it is not dangerous to your health. It is essential that this incidental finding is communicated promptly to your doctor and/or appropriate specialist so they can determine the most appropriate next steps for evaluating and treating the incidental finding as necessary. When we discover such findings, we will communicate the finding to you and may include a copy of the specific report in your discharge papers. In this way, you can know what the finding is, and you can share the information with your family and outpatient doctors.

These findings are as follows:

\*\*\*

In the case of a radiology report, it may include the medical terms describing the finding and recommended follow-up including type of testing and recommended time frame. These are general recommendations only, so you should discuss the incidental finding with your primary care doctor and/or appropriate specialist regarding your specific follow-up needs based on your specific case. If the radiology report is included in your discharge paperwork, it is for education and communication purposes so you know about this incidental finding and can have it evaluated by your primary care doctor and/or appropriate specialist. It is not designed to provide you with a medical diagnosis or to provide you with treatment/services. UMass Memorial Medical Center is not liable or responsible for your specific follow-up of these findings. Medical information changes frequently so you cannot consider this radiology report and general recommendations to be complete or exhaustive.

#### BDINPATIENTDISCHARGEINSTRCTIONSCHF

You were admitted to the hospital with congestive heart failure. This does not mean that your heart is failing, rather it means your heart is not pumping blood as effectively as it should. As a result, fluid may accumulate in

your lungs, abdomen and legs. Fluid build up can lead to shortness of breath, cough, weight gain, swelling in your legs, bloating in your abdomen or feeling week and tired. You received a diuretic or fluid pill while in the hospital to help remove this fluid. It is important for you to continue taking a water pill after discharge.

**In addition, it is important you follow these tips at home to help you stay well:**

- 1) Immediately upon returning home take your weight on a reliable digital scale and record this number. This is your "dry weight or goal weight".
  - 2) Weigh yourself daily at the same time each day ( preferably just upon waking up, after urinating and in similar clothes). If you gain 3 pounds overnight or 5 pounds in a week please contact your cardiologist to adjust your diuretic or fluid pill.
  - 3) Consume less than 2 grams (2000 milligrams) of salt and no more than 2 liters or 64 ounces of fluid a day.
  - 4) Take all your medicines as prescribed.
  - 5) Attend all follow up appointments with your practitioners.
  - 6) If you develop worsening shortness of breath, cough, trouble lying flat in bed at night and weight gain as described above, please call your cardiologist
- 

**BDINPATIENTGENERICDCINST**

You were in the hospital for \*\*\*

**APPOINTMENTS**

*It is important for you to go to your appointments please see below*

- 1) Please go to your \*\*\*
- 2) Please see your primary care physician (PCP) within 1-2 weeks of leaving the hospital.

.@AFUTAPPT@

@FollowupDC@

**REHABILITATION INSTRUCTIONS**

1. \*\*\*

**MEDICATIONS**

You were started on a few new medications during the hospital stay. As follows:

@AVSMEDLISTPLAINTEXTCOMPACT@

Take all medications as prescribed and do not stop taking your medications without speaking to your doctor. Please continue to take all your medications as prescribed prior to admission unless this has been stopped or changed in this summary.

Please refer to the attached literature regarding your \*\*\*

**Please call your PCP and/or specialist if:**

- If you notice worsening symptoms like \*\*\*
- Please seek medical treatment immediately.

**Please return to the hospital if:**

- If you develop fever or chills, severe chest pain, severe shortness of breath, bloody vomiting, bloody stools.
- If you have any other symptoms that worry you.

Finding a Primary Care Provider (PCP): If you need to find a new primary care provider, you can call 1-855-UMASSMD (1-855-862-7763). You will speak with an operator who will help you find a doctor accepting new

patients in your area.

Thank you for choosing University of Massachusetts Medical Center and for allowing us to participate in your care.

---

BDINTERPRETER  
@FLOWWITHDATE(17060)@

---

BDINTERPRETERMINE  
@FLOW(17060:::2)@

---

BDLETTERTOPCP  
Re:  
@NAME@  
DOB: @BDAY@  
MRN: @MRN@  
CSN: @CSN@  
Service date: @ANSVCDATE@

Dear Dr. @PCP@,

I wish to inform you of the hospitalization of your patient, @NAME@.  
You are identified in the patient's medical record as their primary care provider.

Additional details: \*\*\*

Sincerely,

@MENONRES@

---

BDMDMALTERED

This patient presents with acute undifferentiated altered mental status. Glucose is \*\*\*. Patient's airway is \*\*\*.

Prior records reviewed, notable for: \*\*\*

Differential includes the following etiologies:

- Hemodynamic: BP \*\*\*, perfusion \*\*\*
- Thermoregulatory: Temp \*\*\*
- Respiratory: SpO2 \*\*\*, VBG \*\*\*
- Metabolic: electrolytes including BUN and calcium independently reviewed by me \*\*\*; no evidence of cirrhosis to suggest hyperammonemia
- Intracranial: CT brain \*\*\*; based on neurologic exam, concern for CVA is \*\*\*
- Infectious: CXR \*\*\*, UA \*\*\*, remainder of exam without localizing source; low suspicion for CNS infection given \*\*\*
- Cardiac: See ECG interpretation below; troponin \*\*\*
- Hematologic: \*\*\* evidence of severe anemia, TTP, or DIC
- Endocrine: thyroid function \*\*\*; risk for adrenal insufficiency \*\*\*
- Toxicologic: medication list reviewed notable for \*\*\*; doubt opioid overdose given normal pupil size and lack of bradypnea, salicylates \*\*\*; \*\*\* no additional appreciable toxicidrome
- Epileptic: risk for non-convulsive status is \*\*\*

ECG as independently interpreted by me:

Time: \*\*\*

Rate: \*\*\*

Rhythm: \*\*\*

Axis: \*\*\*

Intervals: \*\*\*

ST segments / T waves: \*\*\*

Chest X-ray independently interpreted by me: \*\*\*

Patient's anticipated disposition is \*\*\*

---

#### BDMDMBACKPAINLOWRISK

This is a @AGE@ @SEX@ with PMH \*\*\* presenting with \*\*\* days of lower back pain.

On initial evaluation, patient well-appearing, normotensive. Patient ambulatory. Exam notable for musculoskeletal tenderness in the \*\*\* lumbar region.

This patient presents with back pain most consistent with musculoskeletal back pain. Differential diagnoses includes lumbago versus musculoskeletal spasm / strain versus sciatica. No back pain red flags on history or physical as per HPI. Presentation not consistent with malignancy (lack of history of malignancy, lack of B symptoms), fracture (no trauma, no bony tenderness to palpation), cauda equina (no bowel or urinary incontinence/retention, no saddle anesthesia, no distal weakness), AAA, viscous perforation , pulmonary embolism, renal colic, pyelonephritis (afebrile, no CVAT, no urinary symptoms).

Given the clinical picture, no indication for imaging at this time, but patient may be suitable for outpatient imaging with the PCP.

ED Workup: Defer imaging and labwork for outpatient follow up at this time.

Plan: pain control, supportive care, reassess

Disposition: Anticipate discharge. Strict return precautions discussed with patient with full understanding. Advised patient to follow up promptly with primary care provider.

---

#### BDMDMCHESTPAINMODRISK

@AGE@ @SEX@ presents with chest pain.

Prior medical records reviewed by me are notable for: \*\*\*

ECG as independently interpreted by me:

Time: \*\*\*

Rate: \*\*\*

Rhythm: \*\*\*

Intervals: \*\*\*

Axis: \*\*\*

ST segments / T waves: \*\*\*

Other: \*\*\*

Chest X-ray independently reviewed and interpreted by me: \*\*\*

I have personally reviewed the patient's labs, which are notable for: \*\*\*

No overt evidence of ACS at this time given negative ED workup, however, given patient's baseline risk factors

and history, concern for possible coronary source of chest pain; therefore opt for further assessment prior to discharge. Doubt pulmonary embolism given lack of risk factors, lack of hemoptysis, normal vitals, and no evidence of deep vein thrombosis. Doubt aortic dissection given character of pain, lack of neurologic symptoms, intact distal pulses, and well appearance. Doubt pneumonia given lack of fever or productive cough and no focal lung findings. Doubt esophageal rupture given lack of history of vomiting and normal vitals.

Plan: observation / inpatient for further risk stratification

---

#### BDMDMCHESTPAINOBS

@AGE@ @SEX@ presents with chest pain.

Prior medical records reviewed by me are notable for: \*\*\*

ECG as independently interpreted by me:

Time: \*\*\*

Rate: \*\*\*

Rhythm: \*\*\*

Intervals: \*\*\*

Axis: \*\*\*

ST segments / T waves: \*\*\*

Other: \*\*\*

Chest X-ray independently reviewed and interpreted by me: \*\*\*

I have personally reviewed the patient's labs, which are notable for: \*\*\*

No overt evidence of ACS at this time given negative ED workup, however, given patient's baseline risk factors and history, concern for possible coronary source of chest pain; therefore opt for further assessment prior to discharge. Doubt pulmonary embolism given lack of risk factors, lack of hemoptysis, normal vitals, and no evidence of deep vein thrombosis. Doubt aortic dissection given character of pain, lack of neurologic symptoms, intact distal pulses, and well appearance. Doubt pneumonia given lack of fever or productive cough and no focal lung findings. Doubt esophageal rupture given lack of history of vomiting and normal vitals.

Plan: observation / inpatient for further risk stratification

---

#### BDMDMCOD

E

@AGE@ @SEX@ with {PMHx:36630} presenting with out-of-hospital cardiac arrest. \*\*\*

Initial rhythm: {Presenting rhythm:42300}

Downtime prior to compressions: \*\*\*

On initial evaluation, patient unresponsive, pulseless, in {Presenting rhythm:42300::0} on initial rhythm check, {Blank single:19197::"intubated in field", "ventilations via BVM", "trach"}, no sign of external trauma, pupils dilated and fixed, no lower extremity edema or evidence of DVT, soft non-distended abdomen, no evidence of fistula or track marks.

No cardiac activity on initial ultrasound.

Cardiac compressions were performed by staff in order to sustain blood flow. The patient was ventilated and oxygenated. The patient received appropriate ACLS measures and these were repeated as necessary throughout the resuscitation. CPR was performed under my direct supervision and guidance.

ETT placement confirmed by laryngoscopy. \*\*\*

Femoral A-line placed for hemodynamic monitoring. \*\*\*

See documentation and Code Navigator for medications and times given.

---

@CODENAR@

@EDMEDADMINS@

At \*\*\*, {Blank single:19197::"after discontinuation of resuscitation, I did not observe spontaneous breathing or appreciate heart sounds on auscultation. There was no palpable radial pulse. The patient did not respond to nail bed stimuli. I examined the patient and there was no pupillary response to light. Patient was pronounced deceased."}

---

#### **BDMDMCORNEAL**

Patient presented with eye pain and redness with associated [photophobia, foreign body sensation, and decreased visual acuity] in the setting of recent [describe injury] suggestive of corneal abrasion. Patient noted to have corneal abrasion on fluorescein examination with [slit lamp/wood's lamp] of the [right/left] eye. No evidence of foreign bodies with eversion of the [right/left] eyelid. Patient [reports/denies] contact lens use, and has no other findings suggestive of corneal ulceration at this time. No evidence of a positive Seidel test or other findings suggestive of globe perforation on evaluation in the ED. No evidence of corneal foreign body on exam.

---

#### **BDMDMFALLELD**

@AGE@ @SEX@ presents with history and exam consistent with likely mechanical fall {Blank single:19197::"without", "with"} soft tissue abrasions {Blank single:19197::"without", "with"} evidence of significant intracranial injury at this time. Patient is {Blank single:19197::"not on anticoagulation", "taking \*\*\*"}. Patient presented \*\*\* hours after a fall at \*\*\* potentially consistent with likely mechanical fall.

Initial considerations in this patient included intracranial hemorrhages including subarachnoid, subdural epidural hemorrhages, brain contusions, delayed intracranial hemorrhages, cervical spine fractures and dislocations, spinal cord injuries, musculoskeletal injuries, syncope from cardiac etiologies including dysrhythmia and other neurologic etiologies including cerebrovascular accident (CVA) and transient ischemic attack (TIA), and fall syndromes (history of recurrent falls) among others.

On initial evaluation, patient well-appearing, normotensive, comfortable at this time. {Blank single:19197::"Initially not describing any pain.", "Initially describing pain \*\*\*."} A 12-lead EKG was obtained with {Blank single:19197::"no evidence of dysrhythmia, ischemia or infarction", "\*\*\*"}. A point-of-care glucose was obtained with {Blank single:19197::"no evidence of hypoglycemia", "\*\*\*"}. Patient was noted to have a neurological exam with no evidence of focal deficits\*\*\*. Head to toe exam {Blank single:19197::"without evidence of other injuries", "\*\*\*"}. {Blank single:19197::"Canadian Head/c-spine CT rules were applied and patient did not fall into the low risk category so a CT was obtained. This showed no significant findings.", "Canadian Head/c-spine CT Rule could not be applied to this patient and there is clinical concern for a head or c-spine injury because of \*\*\* so CT head/c-spine were obtained and showed no significant intracranial hemorrhage and no evidence of acute spinal injuries.", "Canadian Head/c-spine CT Rule was applied and patient did fall into the low risk category so a head CT was not obtained."}

A gait assessment was performed in the ED {Blank single:19197::"with cane", "with walker", "with assistance"} and {Blank single:19197::"noted to be unremarkable", "notable for slow, unsteady gait"}. The patient lives {Blank single:19197::"alone", "at a facility", "with family"} and was noted to have someone who is able to check up on them over the next several days.

Prior to discharge, we discussed return precautions, specifically emphasizing the signs of delayed intracranial hemorrhage, and close follow up with primary care provider in the next 2-3 days to discuss ways to decrease fall risk{Blank single:19197::" and consideration of whether the benefits of anticoagulation outweigh the risks", ""}, and communicated to patient/family/facility\*\*\*. Tylenol for pain control. Avoid aspirin, NSAIDs, or other blood thinners. Head trauma instructions provided in discharge instructions.

---

#### **BDMDMHEADINJURY**

Patient presenting with head trauma. Patient's neurological exam was non-focal and unremarkable. {Blank single:19197::"Canadian Head CT Rule was applied and patient did not fall into the low risk category so a head CT was obtained. This showed no significant findings.", "Canadian Head CT Rule was applied and patient did fall into the low risk category so a head CT was not obtained."} At this time, it is felt that the most likely explanation for the patient's symptoms is concussion. I also considered SAH, SDH, Epidural Hematoma, IPH, skull fracture, migraine but this appears less likely considering the data gathered thus far. Patient provided \*\*\*. Patient remained stable and neurologically intact while in the emergency department. Discussed warning signs that would prompt return to ED. Head trauma handout was provided. Discussed in detail concussion management. No sports or strenuous activity until symptoms free. Return to emergency department urgently if new or worsening symptoms develop.

**Impression:**

Concussion

\*\*\*

**Plan**

Discharge from ED

Tylenol for pain control. Avoid aspirin, NSAIDs, or other blood thinners.

Advised patient on supportive measures for cognitive rest - avoid use of cognitive function for at least  $\geq$  hours. This means no tv, books, texting, computers, etc. Limit visitors to the house.

Head trauma instructions provided in discharge instructions

Instructed Pt to monitor for neurologic symptoms, severe HA, change in mental status, seizures, loss of consciousness. Instructed Pt to f/up w/ PCP in \*\*\* days or ETC should symptoms worsen or not improve. Pt verbally expressed understanding and all questions were addressed to Pt's satisfaction.

---

**BDMDMLACREPAIR**

This is a @AGE@ @SEX@ with PMH \*\*\* presenting with a \*\*\*centimeter \*\*\* laceration to the \*\*\*.

On initial evaluation, patient afebrile, normotensive, well-appearing.

Wound inspected under direct bright light with good visualization. Area with linear laceration across soft tissue through adipose without exposure of muscle belly or tendon\*\*\*. No overt foreign body. Area hemostatic. Neurovascular exam congruent with above. Area extensively irrigated with sterile normal saline under pressure. Laceration repaired in simple fashion as described in separate procedure note. Patient tolerated procedure well and neurovascular exam intact and unchanged post repair with intact distal pulses and cap refill \*\*\*. Cautious return precautions discussed w/ full understanding. Wound care discussed. Prompt follow up with primary care physician discussed and return for suture removal in \*\*\* days.

---

**BDMDMLACREPAIRSIMPLE**

This is a @AGE@ @SEX@ with past medical history of \*\*\* presenting after \*\*\*.

On evaluation, patient {Blank single:19197::"well appearing and normotensive", "\*\*\*\*"}. Patient has approximately \*\*\* cm laceration to \*\*\* with bleeding well controlled. No foreign bodies. Neurovascularly intact. Wound inspected under bright light with good visualization. Area with {Blank single:19197::"linear", "jagged", "stellate", "\*\*\*\*"} laceration across soft tissue without deeper probing duration. No overt foreign body. Area hemostatic. Wound probed, cleansed, repaired with stitches as detailed in separate procedure note. Area extensively irrigated with sterile normal saline under pressure. Patient tolerated procedure well and neurovascular exam intact and unchanged postrepair with intact distal pulses and cap refill. Wound care discussed. Patient instructed to follow-up with her PCP and to have sutures removed at PCP, urgent care, ED. Cautions return precautions discussed with full understanding. {Blank single:19197::"Patient received tetanus vaccine in the emergency department.", "Last tetanus vaccine \*\*\*\*, \*\*\*\*"}

---

**BDMDMMVALOWRISK**

This is a @AGE@ @SEX@ presenting subacutely after a motor vehicle accident with \_ pain. Normal

---

appearing without any signs or symptoms of serious injury on secondary trauma survey. Low suspicion for ICH or other intracranial traumatic injury. No seatbelt signs or abdominal ecchymosis to indicate concern for serious trauma to the thorax or abdomen. Pelvis without evidence of injury and patient is neurologically intact.

Stable gait, tolerating PO. Will give pain control, plain films\_, CT\_, likely discharge

---

#### BDMDMOPIOID

@AGE@ @SEX@ with PMH \*\*\* p/w suspected opioid overdose after snorting what he thought was heroin or fentanyl. Received \*\*\* IN\*\*\* Narcan via EMS.

On initial evaluation, patient alert, afebrile, normotensive, nontachycardic, breathing comfortably and sitting well on room air. Exam notable for skin exam without evidence of any injuries or abscesses. Breathing comfortably with good bilateral breath sounds, lungs clear to auscultation.

Differential diagnosis includes:

- Presentation most consistent with opioid ingestion.
- Airway maintained.
- Unlikely intracranial bleed, opioid intoxication or coingestion, sepsis, hypothyroidism.
- Suspect likely transient course of intoxication with expected improvement of symptoms as patient metabolizes offending agent.

Plan: Patient monitored on pulse oximetry and sitting well.

Normal point-of-care glucose.

Anticipate reevaluation and likely discharge after sober reeval.

@BDEDORDERS@

Additional MDM on reevaluation listed in ED course below. In summary, on reevaluation, patient with any evidence of trauma, no evidence of any abscesses, patient tolerating p.o. ambulating well. Discharged in stable condition back to \*\*\* via \*\*\* with Narcan discharge kit and referral to Road to Care.

---

#### BDMDMPARESTHESIASLOWRISK

This @AGE@ @SEX@ patient presents with paresthesias.

Differential diagnoses includes \*\*\*. Presentation not consistent with emergent neurologic etiologies to include brain / spinal cord nerve root or nerve problem given history & physical. Presentation not consistent with immune phenomenon to include GBS or vasculitis. Presentation not consistent with toxins to include botulism, diphtheria, tick-borne illnesses, heavy metal poisoning. Presentation not consistent with acute drug toxicity or metabolic issues.

Plan: labs\*\*\*, CT brain\*\*\*, supportive care, reassessment

---

#### BDMDMSEPSIS

@AGE@ @SEX@ presents with \*\*\*.

Prior records reviewed, notable for: \*\*\*

Prior echocardiogram results: \*\*\*

History and exam consistent with sepsis, likely source is \*\*\*. Doubt acute intra-abdominal process given associated symptoms and benign abdominal exam. Doubt CNS infection given intact mentation and non-focal neurologic exam. No evidence of necrotizing soft tissue infection.

ECG as interpreted by me:

Time: \*\*\*

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Rate: \*\*\*  
Rhythm: \*\*\*  
Intervals: \*\*\*  
Axis: \*\*\*  
ST segments / T waves: \*\*\*  
Other: \*\*\*

Chest x-ray results independently interpreted by me: \*\*\*

Labs interpreted by me, notable for: \*\*\*

Patient has the following risk factors necessitating judicious use of fluids: \*\*\*. Therefore will initiate resuscitation with \*\*\*.

Plan: antibiotics, reassessment; consider additional fluid resuscitation or vasoactive medications based on response to initial treatment; anticipate admission.

---

#### BDMDMSYNCOPELOWRISK

@AGE@ @SEX@ presents with syncope.

ECG as independently interpreted by me:

Time: \*\*\*  
Rate: \*\*\*  
Rhythm: \*\*\*  
Intervals: \*\*\*  
Axis: \*\*\*  
ST segments / T waves: \*\*\*  
Other: \*\*\*

History without concerning features. Doubt cardiogenic syncope given presence of prodrome and lack of apparent risk factors; no family history of sudden cardiac death. No murmur or exertional symptoms to suggest obstructive process. Doubt pulmonary embolism given lack of concerning historical features, normal vitals, and lack evidence of deep vein thrombosis on exam. No historical or exam features to suggest volume loss, anemia, or acute infection. Doubt subarachnoid hemorrhage given intact neurologic status and normal exam.

Plan: discharge with further outpatient workup

---

#### BDMDMTEMPLATE

@AGE@ @SEX@ with {PMHx:36630} p/w \*\*\*.

On initial evaluation, patient {bdmdmvitals:46370}. Exam notable for {bdmdmexams:46371}.

Differential diagnosis includes but is not limited to:  
\*\*\*

Plan: \*\*\* {Plan by System (Optional):46705}

@BDEDORDERS@

Additional MDM on reevaluation listed in ED course below. In summary, \*\*\*. {BDSHIFTEVENTS:46412}  
{Evaluation and Management Considered but not Performed (medications, diagnostics or  
observation/admission) (Optional):47283}  
{ECG and imaging interpretation:46364:::1}

---

## **BDMDMTRAUMA**

Patient is a @AGE@ @SEX@ with {PMHx:36630} who presents {Trauma levl:37830} s/p {Trauma injury:37831}. Trauma team at bedside.

### Primary survey:

On arrival to the trauma bay, patient had a GCS of {GCS15:46720}.

Airway: {mp airway:46724}, Trachea was {TRACHEA ASSESSMENT:21358::"midline"}.

Breathing: {TRAUMA BREATH SOUNDS H&P:26688::"Clear to auscultation bilaterally"}

{WITH/WITHOUT:22847} supplemental oxygen.

Circulation: Blood pressure {ASSESSMENT; AN CARDIOVASCULAR:20205}, heart rate {EXAM; HEART RATE:23399}.

Management: {Trauma Bay Primary Management:47539}

Disability: GCS: E{GCS Eyes:26704}, V{GCS Verbal (Adult):26725}, M{GCS Motor (Adult):26723}

Blood glucose level: {Blank single:19197::"WNL"}

### Secondary survey:

Pertinent positives on visual inspection: \*\*\*

Pertinent positives on palpation: \*\*\*

Logroll with C-spine maintained: {WITH/WITHOUT:22847} step-offs/deformities {SPINE LOCATION:29159} tenderness.

### Adjuncts:

EFAST exam: {eFAST:46725}

{Other trauma bay imaging (Optional):47540}

Plan for trauma labs and {trauma imaging:46734}. Disposition to be determined by labs, imaging, and trauma team.

{Other trauma interventions initiated in trauma bay:47541}

Patient stable to proceed to CT for further imaging.

This patient was seen and managed in coordination with the trauma service. Please see the trauma H&P for further details of their assessment and plan.

Please see continuation of care from ED/trauma resident for further information.

---

## **BDMDMTRAUMAED**

Patient is a @AGE@ @SEX@ with {PMHx:36630} who presents {Trauma levl:37830} s/p {Trauma injury:37831}. Trauma team at bedside. FAST exam {POS NEG:22779}.

### Primary survey:

Airway: Patient speaking in full sentences.

Breathing: Symmetrical chest rise SpO<sub>2</sub> greater than 95% \*\*\*supplementary oxygen.

Circulation: Blood pressure\*\*\*heart rate\*\*\*

\*\*\*IV fluids

Disability: GCS:

Blood glucose level:

### Secondary survey:

Pertinent positives on palpation:

Logroll with C-spine maintained: \*\*\*Step-offs/deformities \*\*\*pain

Patient stable to proceed to CT for further imaging.

Please see continuation of care from ED/trauma resident for further information.

---

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**BDMDMURI**

This is a @AGE@ @SEX@ with PMH \*\*\* presenting with \*\*\* days of \*\*\*. Patient with\*\*\* recent travel and with\*\*\* sick contacts.

On initial evaluation, patient is well-appearing, normotensive, afebrile. No stridor. Breathing comfortably. Exam notable for tonsillar erythema and swelling. Minimal sinus tenderness.

This patient presents with symptoms suspicious for likely viral upper respiratory infection. Based on history and physical doubt sinusitis. COVID test was sent off and negative\*\*\*. Do not suspect underlying cardiopulmonary process. I considered, but think unlikely, dangerous causes of this patient's symptoms to include ACS, CHF or COPD exacerbations, pneumonia, pneumothorax. Patient is nontoxic appearing and not in need of emergent medical intervention.

---

**BDMGDRUGS**

Drugs to be avoided in patients with MG

- Telithromycin: antibiotic for community acquired pneumonia. The US FDA has designated a “black box” warning for this drug in MG. Should not be used in MG.
  - Fluoroquinolones (e.g., ciprofloxacin, moxifloxacin and levofloxacin): commonly prescribed broadspectrum antibiotics that are associated with worsening MG. The US FDA has designated a “black box” warning for these agents in MG. Use cautiously, if at all.
  - Botulinum toxin: avoid.
  - D-penicillamine: used for Wilson disease and rarely for rheumatoid arthritis. Strongly associated with causing MG. Avoid
  - Quinine: occasionally used for leg cramps. Use prohibited except in malaria in US.
  - Magnesium: potentially dangerous if given intravenously, i.e. for eclampsia during late pregnancy or for hypomagnesemia. Use only if absolutely necessary and observe for worsening.
  - Macrolide antibiotics (e.g., erythromycin, azithromycin, clarithromycin): commonly prescribed antibiotics for gram-positive bacterial infections. May worsen MG. Use cautiously, if at all.
  - Aminoglycoside antibiotics (e.g., gentamycin, neomycin, tobramycin): used for gram-negative bacterial infections. May worsen MG. Use cautiously if no alternative treatment available.
  - Corticosteroids: A standard treatment for MG, but may cause transient worsening within the first two weeks. Monitor carefully for this possibility (see Table 1).
  - Procainamide: used for irregular heart rhythm. May worsen MG. Use with caution.
  - Desferrioxamine: Chelating agent used for hemochromatosis. May worsen MG.
  - Beta-blockers: commonly prescribed for hypertension, heart disease and migraine but potentially dangerous in MG. May worsen MG. Use cautiously.
  - Statins (e.g., atorvastatin, pravastatin, rosuvastatin, simvastatin): used to reduce serum cholesterol. May worsen or precipitate MG. Use cautiously if indicated and at lowest dose needed.
  - Iodinated radiologic contrast agents: older reports document increased MG weakness, but modern contrast agents appear safer. Use cautiously and observe for worsening.
- 

**BDNALTREXONEINIT**

@AGE@ @SEX@ with history of daily alcohol use presenting for intoxication. Discussed medication assisted treatment and offered initiation of naltrexone to reduce cravings and alcohol intake. Patient declines at this time. Communicated that this resource continues to exist in the emergency department should they change their mind at any point in the future.

---

**BDNEGROS**

{Patient denies:44848}.

---

**BDNLVITALS**

well-appearing, alert, afebrile, normotensive, nontachycardic, breathing comfortably and sitting well on room air

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#### BDNLVITALSNOBP

well-appearing, alert, afebrile, nontachycardic, breathing comfortably and sitting well on room air

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#### BDOBDCINSTRUCTIONSCSPORTUGUESE

Instruções de alta pós-parto

As primeiras seis semanas após o parto do seu bebê são conhecidas como período pós-parto. Este guia foi elaborado para responder às perguntas mais frequentes e ajudá-lo a compreender as muitas mudanças que seu corpo experimentará nas próximas semanas. Se você tiver alguma dúvida durante a sua estadia no UMass Memorial Hospital, pergunte à sua enfermeira. Depois de sair do hospital, ligue para o consultório do seu médico se tiver alguma dúvida

#### QUANDO LIGAR PARA SEU MÉDICO:

- Temperatura de 100,4 F ou superior
- Sangramento intenso (embeber um absorvente higiênico em menos de uma hora)
- Dor intensa e persistente que não é controlada por medicamentos
- Micção frequente com dor ou queimação
- Corrimento fétido da vagina
- Dores de cabeça que não melhoraram com medicação
- Mudanças na sua visão
- Dor epigástrica intensa (dor abaixo da caixa torácica)
- Preocupação com depressão ou ansiedade, especialmente se isso impedir você de cuidar de si mesmo ou do bebê
- Quaisquer outras preocupações

Aqui estão as melhores maneiras de entrar em contato com qualquer um de nossos funcionários durante a semana:

{Blank single:19197:: "UMass OB/GYN Office: 508-334-6255", "Community Women's Clinic: 508-334-6388"}

#### GERENCIAMENTO DA DOR:

Após o parto, o útero continua a se contrair e essas contrações são chamadas de “dores pós-parto”. As dores pós-parto tendem a ser mais agudas após o segundo ou terceiro bebê. Estas contrações duram alguns dias e às vezes são mais fortes durante a amamentação do bebê, devido à estimulação hormonal do reflexo de descida do leite. Mesmo que você sinta algum desconforto, as contrações são um sinal positivo de que seu bebê está amamentando bem. Você também pode sentir desconforto devido à episiotomia ou incisão cesariana.

O medicamento prescrito pelo seu médico deve controlar o desconforto. À medida que você se sentir melhor, poderá descobrir que analgésicos vendidos sem receita, como aspirina, Tylenol Tm ou ibuprofeno, podem ser tudo de que você precisa para controlar a dor. As doses recomendadas para medicamentos são:

- Motrin / Ibuprofeno 600 mg a cada 6 horas conforme necessário
- Tylenol 650 mg a cada 4 horas conforme necessidade
- Oxicodona 5 ou 10 mg a cada 4 horas conforme necessário

#### GESTÃO PERINEAL:

Se você teve uma ruptura ou episiotomia no momento do parto, poderá sentir inchaço dos tecidos do períneo. Por favor, siga estas instruções:

- Use absorventes para captar o fluxo, NÃO TAMPÕES. Troque as almofadas com frequência.
- Encha a garrafa perineal com água morna e enxágue bem a região perineal após urinar e a cada evacuação.
- Tome dois a três banhos de assento por dia em uma banheira cheia de dez a quinze centímetros de água.

água morna.

Você também pode usar pomada medicamentosa, espuma ou spray na área perineal. Os cuidados com o períneo devem continuar em casa até que o desconforto desapareça, geralmente dentro de sete a dez dias. Se a sua ruptura ou episiotomia ficar mais dolorida e vermelha em vez de melhorar, ligue para o consultório do seu médico.

#### NASCIMENTO CESARIANO:

Um parto cesáreo inclui todas as alterações normais do corpo que ocorrem após o parto vaginal, bem como a cicatrização de uma incisão cirúrgica abdominal. Seis semanas é um período realista para esperar que essa cura ocorra. Durante a sua internação hospitalar, você será incentivado a se movimentar com a maior freqüência possível. Chegando em casa, caminhar é uma excelente forma de exercício até a consulta pós-parto. Adie qualquer exercício extenuante por pelo menos seis semanas. Você pode tomar banho, mas não mergulhar (por exemplo, tomar banho ou nadar) no nível da incisão. Certifique-se de manter sua incisão limpa e seca. NÃO ESFREGUE A INCISÃO. Ligue para o consultório do seu médico se a drenagem incisional se tornar constante ou excessiva, ou se surgirem faixas vermelhas ou sensibilidade intensa ao redor da incisão.

Durante seis semanas, você não deve levantar nada mais pesado do que 2,5 a 4,5 quilos (meio galão de leite pesa 2,5 quilos). Não há problema em levantar seu bebê! Você não deve levantar mantimentos, cestos de roupa suja ou usar aspirador de pó. Ao fazer levantamentos leves, certifique-se de dobrar os joelhos e não a cintura. Não prenda a respiração; prender a respiração ao levantar aumenta a pressão na pélvis.

Não dirigir por 4 semanas ou enquanto estiver tomando analgésicos narcóticos. Se você sentir alguma dor ao mover as pernas repentinamente, seus reflexos ficarão mais lentos e você não será um motorista seguro. Durante cerca de 6 semanas após a cirurgia, você também corre o risco de desenvolver coágulos sanguíneos nas pernas. Por isso, se você estiver dirigindo de carro, pare pelo menos a cada hora para poder caminhar. A ação dos grandes músculos das pernas ajuda a bombeiar o sangue. Se você ficar sentado em uma posição apertada por muito tempo, aumentará o risco de formar um coágulo com risco de vida.

#### CORRIMENTO VAGINAL (LÓQUIA):

Após o parto, você pode esperar um corrimento vaginal com sangue chamado lóquios. Esse fluxo pode durar de quatro a seis semanas. A cor dos seus lóquios deve mudar do vermelho brilhante visto logo após o parto para um marrom mais escuro e finalmente para um tom cremoso. O aumento da atividade pode resultar em sangramento mais intenso ou no retorno a uma cor mais vermelha. Você deve limitar sua atividade até que o sangramento diminua. Ligue para o seu médico se tiver sangramento excessivo, secreção com mau cheiro, dor abdominal aguda ou febre repentina. Após o parto vaginal ou cesáreo, é melhor tomar banho de chuveiro ou banho de esponja até instruções em contrário.

#### MENSTRUAÇÃO:

Seu ciclo menstrual geralmente reaparece entre a 4<sup>a</sup> e a 12<sup>a</sup> semana após o parto, se não estiver amamentando. Pode levar vários meses para restabelecer um ciclo regular. O primeiro período menstrual pode ser mais intenso que o normal.

#### Cuidados com os seios para promover a produção de leite:

Seus seios podem ficar mais pesados e firmes entre três a cinco dias após o parto. Este é o aumento na produção de leite que você e seu bebê esperavam. Continue alimentando seu bebê oito a doze vezes por dia para promover o fluxo de leite da mama. Os seios devem ficar mais macios e leves após a mamada. Usar um sutiã de apoio e bem ajustado pode ajudar durante esse período. Você pode achar confortável usar um sutiã de suporte macio e leve à noite. Não durma com sutiã com armação. Entre em contato com o consultório do seu médico se tiver algum dos seguintes sinais de infecção mamária:

- Temperatura elevada acima de 100,4 F
- Vermelhidão localizada e inchaço da mama
- Sensibilidade localizada e dor na mama.

Cuidados com as mamas para desencorajar a produção de leite: Seus seios podem responder às mudanças hormonais do nascimento e iniciar a produção de leite, mesmo que seus planos sejam alimentar seu bebê com

fórmula. Para minimizar a estimulação da produção de leite, sugerimos o uso de um sutiã que proporcione um suporte firme e confortável para os seios inchados ou mais cheios do que o normal. Bolsas de gelo aplicadas por 20 minutos a cada duas ou três horas também aliviarão o inchaço. Algumas mulheres usam um envoltório frouxamente aplicado para segurar as bolsas de gelo no lugar. Tylenol Tm, ibuprofeno ou aspirina podem ser usados para alívio da dor. Esse período de desconforto geralmente se resolve em 48 a 72 horas, mas pode durar até duas semanas.

#### Relações Sexuais:

Por favor, não coloque nada na vagina antes da consulta de acompanhamento com seu médico. NÃO são permitidas relações sexuais durante seis semanas ou até depois do exame pós-parto e da discussão sobre contracepção. Isso ajuda a evitar infecções e permite que a parede vaginal e o útero cicatrizem e recuperem a força. Quando o seu médico indicar que é seguro retomar as relações sexuais, você poderá inicialmente achar desconfortável porque os tecidos vaginais ainda podem estar sensíveis. A lubrificação vaginal é menor do que o normal devido à diminuição do nível de estrogênio. Usar um agente lubrificante pode ajudar a minimizar o desconforto. Lembre-se de que você pode engravidar logo após o nascimento do seu bebê. Consulte a seção sobre contracepção e discuta isso com seu parceiro antes de ocorrerem relações sexuais.

#### Contracepção:

Existem várias formas de controle de natalidade que você pode usar. Isso inclui pílulas anticoncepcionais, Nexplanon, injeções Depo-Proverai e DIU. Cada um tem suas próprias vantagens e desvantagens, e seu médico pode discutir suas opções antes de você deixar o hospital ou durante sua primeira consulta. Mais uma vez, lembre-se de que você pode engravidar logo após o parto, mesmo que esteja amamentando e não tenha menstruação normal. Visite [www.bedsider.org](http://www.bedsider.org) para obter informações precisas e fáceis de ler sobre controle de natalidade.

#### Dieta:

Você pode retomar sua dieta habitual após o parto.

#### Atividade Geral:

Durante a primeira e segunda semana, descanse durante o dia. Concentre sua energia em seu bebê. Atribua tarefas domésticas a outros membros da família após o parto. Durante a terceira semana, você poderá dirigir um carro e aumentar sua atividade física. Se o sangramento aumentar ou se você sentir contrações ou dor durante a atividade, reduza as atividades imediatamente e ligue para o consultório do seu médico para obter orientação.

NÃO LEVANTE nada mais pesado que o seu bebê. Sua incisão requer de quatro a seis semanas para cicatrizar completamente. Se você tiver outras crianças que desejam ser seguradas, incentive-as a subir em seu colo, em vez de você as levantar. OUÇA SEU CORPO. Quando você se sentir cansado, tente descansar. Lembre-se de que você está se recuperando de um acontecimento físico e emocional que teve um efeito enorme em seu corpo.

#### Emoções pós-parto:

Várias novas mães podem experimentar mudanças emocionais após o parto. No passado, esses sentimentos eram rotulados de “tristeza pós-parto” e raramente eram levados a sério. Hoje é reconhecido que as alterações emocionais pós-parto podem evoluir para graves problemas de depressão e devem ser tratadas por um médico. O estresse durante a gravidez (especialmente a preocupação indevida com a imagem corporal), a ansiedade quanto à responsabilidade da maternidade e as alterações endócrinas básicas podem causar alterações psicológicas entre três e 30 dias após o parto. Em algumas causas, a depressão pode ocorrer até um ano depois.

Os primeiros sintomas incluem insônia, inquietação, fadiga, irritabilidade, dores de cabeça e rápidas mudanças de humor. Mais tarde, os sintomas podem aumentar significativamente e incluir falta de apetite, preocupação irracional com trivialidades, confusão ou incoerência, desconfiança e comportamento irracional.

Pacientes deprimidas centram seus sentimentos na relação mãe-filho, seja excessivamente preocupadas com o bem-estar do bebê ou sentindo-se incapazes de cuidar dele. Procure tratamento imediato para esses

distúrbios entrando em contato com seu obstetra para encaminhamento psiquiátrico.

Qualquer mulher que teve um bebê no último ano pode ser afetada, independentemente de quantas gestações sem complicações e ajustes pós-parto ela teve. Se você sentir que está apresentando alguns dos sintomas de tristeza pós-parto, depressão ou psicose, há ajuda disponível. Todos os sintomas, dos mais leves aos mais graves, são temporários e tratáveis com apoio e ajuda profissional qualificada.

Se precisar de apoio adicional ao lidar com as emoções pós-parto, não hesite em entrar em contato com o consultório ou ligar para a Linha Direta Nacional de Saúde Mental Materna em 1-833-9HELP4MOMS (1-833-943-5746).

#### BDOBDCINSTRUCTIONSNSVD

#### Postpartum Discharge Instructions

The first six weeks following the delivery of your baby are known as the postpartum period. This guide was designed to answer the most commonly-asked questions and help you understand the many changes that your body will experience over the next few weeks. If you have any questions during your stay at UMass Memorial Hospital, please ask your nurse. Once you leave the Hospital, please call your doctor's office with any questions

#### **WHEN TO CALL YOUR DOCTOR:**

- Temperature of 100.4 F or above
- Heavy bleeding (soaking a sanitary pad in less than an hour)
- Persistent severe pain that is not controlled by medications
- Frequent urination with pain or burning
- Foul smelling discharge from your vagina
- Headaches that do not improve with medication
- Changes in your vision
- Severe epigastric pain (pain below your rib cage)
- Concern about depression or anxiety especially if it prevents you from taking care of yourself or infant
- Any other concerns

#### **Here are the best ways to contact any of our staff on weekdays:**

{Blank single:19197:: "UMass OB/GYN Office: 508-334-6255", "Community Women's Clinic: 508-334-6388 "}

#### **PAIN MANAGEMENT:**

After delivery, your uterus continues to contract, and these contractions are referred to as "afterbirth pains." Afterbirth pains tend to be more acute after the second or third baby. These contractions will last a few days and are sometimes stronger while nursing your baby, due to the hormonal stimulation of the milk letdown reflex. Even though you may experience some discomfort, contractions are a positive sign that your baby is nursing well. You may also experience discomfort from your episiotomy or cesarean incision.

The medicine prescribed by your doctor should control the discomfort. As you feel better, you may find that over-the-counter analgesics such as aspirin, Tylenol Tm, or ibuprofen may be all you need for pain control. Recommended doses for medications are:

- Motrin / Ibuprofen 600 mg every 6 hours as needed
- Tylenol 650 mg every 4 hours as need

#### **PERINEAL MANAGEMENT:**

If you had a tear or episiotomy at the time of delivery, you may experience swelling of the tissues of the perineum. Please follow these instructions:

- Use pads to catch flow, NOT TAMPONS. Change pads frequently.
- Fill your perineal bottle with warm water, and rinse your perineal area well after urinating and every bowel

movement.

- Take two to three sitz baths each day in a tub filled with four to six inches of warm water.

You may also wish to use medicated ointment, foam, or spray on the perineal area. Care of the perineum should be continued at home until the discomfort subsides, usually within seven to ten days. If your tear or episiotomy becomes more painful and red instead of getting better, please call your doctor's office.

### **VAGINAL DISCHARGE (LOCHIA):**

Following your delivery, you can expect a bloody vaginal discharge called lochia. This flow may last four to six weeks. The color of your lochia should change from the bright red seen just after delivery to a darker brown and finally to a creamy tone. Increased activity may result in heavier bleeding or a return to a redder color. You should limit your activity until the bleeding decreases. Please call your doctor if you experience excessive bleeding, foul smelling discharge, acute abdominal pain, or a sudden fever. Following your vaginal or cesarean delivery, it is best to take showers or sponge baths until instructed otherwise.

### **MENSES:**

Your menstrual cycle usually reappears between the 4th and 12th week after delivery, if not breastfeeding. It may take several months to reestablish a regular cycle. The first menstrual period may be heavier than usual.

### **Breast Care For Promoting Milk Production:**

Your breasts may feel heavier and firmer sometime between three to five days after delivery. This is the increase in milk production you and your baby have been anticipating. Continue feeding your baby eight to twelve times each day to promote milk flow from the breast. Breasts should feel softer and lighter after a feeding. Wearing a supportive, properly-fitting bra may help during this time. You may find it comfortable to wear a soft, light support bra at night. Do not sleep in an underwire bra. Please contact your doctor's office if you have any of the following signs of breast infection:

- Elevated temperature above 100.4 F
- Localized redness and swelling of breast
- Localized tenderness and a painfulbreast.

**Breast Care for Discouraging Milk Production:** Your breasts may respond to the hormonal changes of birth and begin milk production even though your plans are to feed your baby formula. To minimize the stimulation of milk production, we suggest wearing a bra that provides firm comfortable support for breasts that are swollen or fuller than usual. Ice packs applied for 20 minutes every two to three hours will relieve swelling as well. Some women use a loosely-applied ace wrap to hold the ice packs in place. Tylenol Tm, ibuprofen or aspirin may be used for pain relief. This period of discomfort usually resolves itself within 48 to 72 hours, but may last up to two weeks.

### **Sexual Relations:**

Please don't put anything in your vagina prior to your follow-up visit with your doctor. NO sexual relations are allowed for six weeks or until after your postpartum examination and discussion about contraception. This helps avoid infection and allows the vaginal wall and uterus time to heal and regain strength. When your physician indicates it is safe to resume sexual relations, you may initially find it uncomfortable because the vaginal tissues may still be tender. Vaginal lubrication is lower than usual because of your decreased estrogen level. Using a lubricating agent may help minimize your discomfort. Please remember that you can become pregnant soon after the birth of your baby. Refer to the section on contraception, and discuss this with your partner before sexual relations occur.

### **Contraception:**

There are several forms of birth control that you may use. These include birth control pills, Nexplanon, Depo-Proverai injections and IUDs. Each has its own advantages and disadvantages, and your doctor can discuss your options before you leave the Hospital or during your first office visit. Again, please remember that you can become pregnant soon after your delivery, even if you are breast feeding and not having normal periods. Please visit [www.bedsider.org](http://www.bedsider.org) for accurate and easy to read information about birth control.

**Diet:**

You may resume your usual diet following your delivery.

**General Activity:**

During the first and second week, be sure to rest during the day. Focus your energy on your baby. Assign housework to other family members following your delivery. During the third week, you may drive a car and increase your physical activity. If bleeding becomes heavier or if you experience contractions or pain during the activity, please reduce the activities immediately and call your doctor's office for advice.

**Postpartum Emotions:**

A number of new mothers may experience emotional changes following delivery. In the past, these feelings were labeled "postpartum blues" and were rarely taken seriously. Today, it is recognized that postpartum emotional changes may evolve into serious problems of depression and should be treated by a physician. Stress during pregnancy (especially undue concern about body image), anxiety about the responsibility of mothering, and basic endocrine changes can cause psychological changes anywhere from three to 30 days after childbirth. In some cases, depression can occur up to a year later.

Early symptoms include insomnia, restlessness, fatigue, irritability, headaches, and rapid mood changes. Later, symptoms may increase significantly to include lack of appetite, unreasonable concern over trivialities, confusion or incoherence, suspiciousness, and irrational behavior.

Depressed patients center their feelings on the mother-child relationship, either being excessively concerned about the baby's welfare or feeling incapable of caring for the baby. Seek treatment immediately for these disorders by contacting your obstetrician for a psychiatric referral.

Any woman who has had a baby in the last year can be affected regardless of how many uncomplicated pregnancies and postpartum adjustments she has had. If you feel that you are experiencing some of the symptoms of postpartum blues, depression or psychosis, there is help available. All of the symptoms, from the mildest to the most severe, are temporary and treatable with support and skilled professional help.

**If you need additional support while dealing with postpartum emotions, please do not hesitate to reach out to the office or to call the national Maternal Mental Health Hotline at 1-833-9HELP4MOMS (1-833-943-5746).**

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**BDOBDCINSTRUCTIONSNSVDPORUTGUESE**

Instruções de alta pós-parto

As primeiras seis semanas após o parto do seu bebê são conhecidas como período pós-parto. Este guia foi elaborado para responder às perguntas mais frequentes e ajudá-lo a compreender as muitas mudanças que seu corpo experimentará nas próximas semanas. Se você tiver alguma dúvida durante a sua estadia no UMass Memorial Hospital, pergunte à sua enfermeira. Depois de sair do hospital, ligue para o consultório do seu médico se tiver alguma dúvida

**QUANDO LIGAR PARA SEU MÉDICO:**

- Temperatura de 100,4 F ou superior
- Sangramento intenso (embeber um absorvente higiênico em menos de uma hora)
- Dor intensa e persistente que não é controlada por medicamentos
- Micção frequente com dor ou queimação
- Corrimento fétido da vagina
- Dores de cabeça que não melhoraram com medicação
- Mudanças na sua visão
- Dor epigástrica intensa (dor abaixo da caixa torácica)
- Preocupação com depressão ou ansiedade, especialmente se isso impedir você de cuidar de si mesmo ou

do bebê

- Quaisquer outras preocupações

Aqui estão as melhores maneiras de entrar em contato com qualquer um de nossos funcionários durante a semana:

{Blank single:19197:: "UMass OB/GYN Office: 508-334-6255", "Community Women's Clinic: 508-334-6388"}

#### GERENCIAMENTO DA DOR:

Após o parto, o útero continua a se contrair e essas contrações são chamadas de “dores pós-parto”. As dores pós-parto tendem a ser mais agudas após o segundo ou terceiro bebê. Estas contrações duram alguns dias e às vezes são mais fortes durante a amamentação do bebê, devido à estimulação hormonal do reflexo de descida do leite. Mesmo que você sinta algum desconforto, as contrações são um sinal positivo de que seu bebê está amamentando bem. Você também pode sentir desconforto devido à episiotomia ou incisão cesariana.

O medicamento prescrito pelo seu médico deve controlar o desconforto. À medida que você se sentir melhor, poderá descobrir que analgésicos vendidos sem receita, como aspirina, Tylenol Tm ou ibuprofeno, podem ser tudo de que você precisa para controlar a dor. As doses recomendadas para medicamentos são:

- Motrin / Ibuprofeno 600 mg a cada 6 horas conforme necessário
- Tylenol 650 mg a cada 4 horas conforme necessidade

#### GESTÃO PERINEAL:

Se você teve uma ruptura ou episiotomia no momento do parto, poderá sentir inchaço dos tecidos do períneo. Por favor, siga estas instruções:

- Use absorventes para captar o fluxo, NÃO TAMPÕES. Troque as almofadas com frequência.
- Encha a garrafa perineal com água morna e enxágue bem a região perineal após urinar e a cada evacuação.
- Tome dois a três banhos de assento por dia em uma banheira cheia de dez a quinze centímetros de água morna.

Você também pode usar pomada medicamentosa, espuma ou spray na área perineal. Os cuidados com o períneo devem continuar em casa até que o desconforto desapareça, geralmente dentro de sete a dez dias. Se a sua ruptura ou episiotomia ficar mais dolorida e vermelha em vez de melhorar, ligue para o consultório do seu médico.

#### CORRIMENTO VAGINAL (LÓQUIA):

Após o parto, você pode esperar um corrimento vaginal com sangue chamado lóquios. Esse fluxo pode durar de quatro a seis semanas. A cor dos seus lóquios deve mudar do vermelho brilhante visto logo após o parto para um marrom mais escuro e finalmente para um tom cremoso. O aumento da atividade pode resultar em sangramento mais intenso ou no retorno a uma cor mais vermelha. Você deve limitar sua atividade até que o sangramento diminua. Ligue para o seu médico se tiver sangramento excessivo, secreção com mau cheiro, dor abdominal aguda ou febre repentina. Após o parto vaginal ou cesáreo, é melhor tomar banho de chuveiro ou banho de esponja até instruções em contrário.

#### MENSTRUAÇÃO:

Seu ciclo menstrual geralmente reaparece entre a 4<sup>a</sup> e a 12<sup>a</sup> semana após o parto, se não estiver amamentando. Pode levar vários meses para restabelecer um ciclo regular. O primeiro período menstrual pode ser mais intenso que o normal.

Cuidados com os seios para promover a produção de leite:

Seus seios podem ficar mais pesados e firmes entre três a cinco dias após o parto. Este é o aumento na produção de leite que você e seu bebê esperavam. Continue alimentando seu bebê oito a doze vezes por dia para promover o fluxo de leite da mama. Os seios devem ficar mais macios e leves após a mamada. Usar um sutiã de apoio e bem ajustado pode ajudar durante esse período. Você pode achar confortável usar um sutiã de suporte macio e leve à noite. Não durma com sutiã com armação. Entre em contato com o consultório do

seu médico se tiver algum dos seguintes sinais de infecção mamária:

- Temperatura elevada acima de 100,4 F
- Vermelhidão localizada e inchaço da mama
- Sensibilidade localizada e dor na mama.

Cuidados com as mamas para desencorajar a produção de leite: Seus seios podem responder às mudanças hormonais do nascimento e iniciar a produção de leite, mesmo que seus planos sejam alimentar seu bebê com fórmula. Para minimizar a estimulação da produção de leite, sugerimos o uso de um sutiã que proporcione um suporte firme e confortável para os seios inchados ou mais cheios do que o normal. Bolsas de gelo aplicadas por 20 minutos a cada duas ou três horas também aliviarão o inchaço. Algumas mulheres usam um envoltório frouxamente aplicado para segurar as bolsas de gelo no lugar. Tylenol Tm, ibuprofeno ou aspirina podem ser usados para alívio da dor. Esse período de desconforto geralmente se resolve em 48 a 72 horas, mas pode durar até duas semanas.

#### Relações Sexuais:

Por favor, não coloque nada na vagina antes da consulta de acompanhamento com seu médico. NÃO são permitidas relações sexuais durante seis semanas ou até depois do exame pós-parto e da discussão sobre contracepção. Isso ajuda a evitar infecções e permite que a parede vaginal e o útero cicatrizem e recuperem a força. Quando o seu médico indicar que é seguro retomar as relações sexuais, você poderá inicialmente achar desconfortável porque os tecidos vaginais ainda podem estar sensíveis. A lubrificação vaginal é menor do que o normal devido à diminuição do nível de estrogênio. Usar um agente lubrificante pode ajudar a minimizar o desconforto. Lembre-se de que você pode engravidar logo após o nascimento do seu bebê. Consulte a seção sobre contracepção e discuta isso com seu parceiro antes de ocorrerem relações性uais.

#### Contracepção:

Existem várias formas de controle de natalidade que você pode usar. Isso inclui pílulas anticoncepcionais, Nexplanon, injeções Depo-Proverai e DIU. Cada um tem suas próprias vantagens e desvantagens, e seu médico pode discutir suas opções antes de você deixar o hospital ou durante sua primeira consulta. Mais uma vez, lembre-se de que você pode engravidar logo após o parto, mesmo que esteja amamentando e não tenha menstruação normal. Visite [www.bedsider.org](http://www.bedsider.org) para obter informações precisas e fáceis de ler sobre controle de natalidade.

#### Dieta:

Você pode retomar sua dieta habitual após o parto.

#### Atividade Geral:

Durante a primeira e segunda semana, descance durante o dia. Concentre sua energia em seu bebê. Atribua tarefas domésticas a outros membros da família após o parto. Durante a terceira semana, você poderá dirigir um carro e aumentar sua atividade física. Se o sangramento aumentar ou se você sentir contrações ou dor durante a atividade, reduza as atividades imediatamente e ligue para o consultório do seu médico para obter orientação.

#### Emoções pós-parto:

Várias novas mães podem experimentar mudanças emocionais após o parto. No passado, esses sentimentos eram rotulados de “tristeza pós-parto” e raramente eram levados a sério. Hoje é reconhecido que as alterações emocionais pós-parto podem evoluir para graves problemas de depressão e devem ser tratadas por um médico. O estresse durante a gravidez (especialmente a preocupação indevida com a imagem corporal), a ansiedade quanto à responsabilidade da maternidade e as alterações endócrinas básicas podem causar alterações psicológicas entre três e 30 dias após o parto. Em algumas causas, a depressão pode ocorrer até um ano depois.

Os primeiros sintomas incluem insônia, inquietação, fadiga, irritabilidade, dores de cabeça e rápidas mudanças de humor. Mais tarde, os sintomas podem aumentar significativamente e incluir falta de apetite, preocupação irracional com trivialidades, confusão ou incoerência, desconfiança e comportamento irracional.

Pacientes deprimidas centram seus sentimentos na relação mãe-filho, seja excessivamente preocupadas com

o bem-estar do bebê ou sentindo-se incapazes de cuidar dele. Procure tratamento imediato para esses distúrbios entrando em contato com seu obstetra para encaminhamento psiquiátrico.

Qualquer mulher que teve um bebê no último ano pode ser afetada, independentemente de quantas gestações sem complicações e ajustes pós-parto ela teve. Se você sentir que está apresentando alguns dos sintomas de tristeza pós-parto, depressão ou psicose, há ajuda disponível. Todos os sintomas, dos mais leves aos mais graves, são temporários e tratáveis com apoio e ajuda profissional qualificada.

Se precisar de apoio adicional ao lidar com as emoções pós-parto, não hesite em entrar em contato com o consultório ou ligar para a Linha Direta Nacional de Saúde Mental Materna em 1-833-9HELP4MOMS (1-833-943-5746).

#### BDOBDCINSTRUCTIONSNSVDSpanish

#### Instrucciones de alta posparto

Las primeras seis semanas después del nacimiento de su bebé se conocen como período posparto. Esta guía fue diseñada para responder las preguntas más frecuentes y ayudarlo a comprender los numerosos cambios que experimentará su cuerpo durante las próximas semanas. Si tiene alguna pregunta durante su estadía en UMass Memorial Hospital, consulte a su enfermera. Una vez que salga del hospital, llame al consultorio de su médico si tiene alguna pregunta.

#### CUÁNDO LLAMAR A SU MÉDICO:

- Temperatura de 100,4 F o superior
- Sangrado abundante (remojar una toalla sanitaria en menos de una hora)
- Dolor intenso y persistente que no se controla con medicamentos.
- Micción frecuente con dolor o ardor.
- Secreción vaginal con mal olor.
- Dolores de cabeza que no mejoran con medicación
- Cambios en tu visión.
- Dolor epigástrico intenso (dolor debajo de la caja torácica)
- Preocupación por la depresión o la ansiedad, especialmente si le impide cuidar de sí mismo o del bebé.
- Cualquier otra inquietud

Estas son las mejores formas de contactar a cualquiera de nuestro personal durante los días de semana:  
{Blank single:19197:: "Oficina de obstetricia y ginecología de UMass: 508-334-6255", "Clínica comunitaria para mujeres: 508-334-6388 "}

#### EL MANEJO DEL DOLOR:

Después del parto, el útero continúa contrayéndose y estas contracciones se denominan “dolores de placenta”. Los dolores posparto tienden a ser más agudos después del segundo o tercer bebé. Estas contracciones durarán unos días y en ocasiones serán más fuertes mientras amamantas a tu bebé, debido a la estimulación hormonal del reflejo de bajada de la leche. Aunque puedas sentir algunas molestias, las contracciones son una señal positiva de que tu bebé está amamantando bien. También puede experimentar molestias debido a la episiotomía o la incisión de la cesárea.

El medicamento recetado por su médico debe controlar las molestias. A medida que se sienta mejor, es posible que todo lo que necesite para controlar el dolor sea analgésicos de venta libre como aspirina, Tylenol Tm o ibuprofeno. Las dosis recomendadas de medicamentos son:

- Motrin/Ibuprofeno 600 mg cada 6 horas según sea necesario
- Tylenol 650 mg cada 4 horas según necesidad

#### MANEJO PERINEAL:

Si tuvo un desgarro o una episiotomía en el momento del parto, puede experimentar hinchazón de los tejidos del perineo. Siga estas instrucciones:

- Utilice toallas sanitarias para captar el flujo, NO TAMPONES. Cambie las almohadillas con frecuencia.
- Llene su biberón perineal con agua tibia y enjuague bien el área perineal después de orinar y de cada defecación.
- Tome dos o tres baños de asiento cada día en una tina llena de cuatro a seis pulgadas de agua tibia.

También es posible que desee utilizar un ungüento, espuma o aerosol medicinal en el área perineal. El cuidado del perineo debe continuarse en casa hasta que desaparezcan las molestias, normalmente entre siete y diez días. Si su desgarro o episiotomía se vuelve más doloroso y rojo en lugar de mejorar, llame al consultorio de su médico.

#### SECRECIÓN VAGINAL (LOQUIOS):

Después del parto, puede esperar un flujo vaginal con sangre llamado loquios. Este flujo puede durar de cuatro a seis semanas. El color de sus loquios debe cambiar del rojo brillante que se ve justo después del parto a un marrón más oscuro y finalmente a un tono cremoso. El aumento de la actividad puede provocar un sangrado más intenso o un retorno a un color más rojo. Debe limitar su actividad hasta que disminuya el sangrado. Llame a su médico si experimenta sangrado excesivo, secreción maloliente, dolor abdominal agudo o fiebre repentina. Después del parto vaginal o cesárea, lo mejor es ducharse o bañarse con esponja hasta que se le indique lo contrario.

#### MENSTRUO:

Su ciclo menstrual suele reaparecer entre la cuarta y la duodécima semana después del parto, si no está amamantando. Pueden ser necesarios varios meses para restablecer un ciclo regular. El primer período menstrual puede ser más abundante de lo habitual.

#### Cuidado de los senos para promover la producción de leche:

Es posible que sus senos se sientan más pesados y firmes entre tres y cinco días después del parto. Este es el aumento en la producción de leche que usted y su bebé estaban anticipando. Continúe alimentando a su bebé de ocho a doce veces al día para promover el flujo de leche del pecho. Los senos deben sentirse más suaves y livianos después de amamantar. Usar un sostén que le brinde soporte y que le quede bien puede ayudar durante este tiempo. Puede que le resulte cómodo usar un sostén suave y ligero por la noche. No duermas con un sostén con aros. Comuníquese con el consultorio de su médico si tiene alguno de los siguientes signos de infección mamaria:

- Temperatura elevada por encima de 100,4 F
- Enrojecimiento localizado e hinchazón de la mama.
- Sensibilidad localizada y dolor en el pecho.

Cuidado de los senos para desalentar la producción de leche: Sus senos pueden responder a los cambios hormonales del nacimiento y comenzar la producción de leche aunque sus planes sean alimentar a su bebé con fórmula. Para minimizar la estimulación de la producción de leche, sugerimos usar un sostén que brinde un soporte firme y cómodo para los senos hinchados o más llenos de lo habitual. Las bolsas de hielo aplicadas durante 20 minutos cada dos o tres horas también aliviarán la hinchazón. Algunas mujeres usan una envoltura de ace que se aplica sin apretar para mantener las bolsas de hielo en su lugar. Se pueden utilizar Tylenol Tm, ibuprofeno o aspirina para aliviar el dolor. Este período de malestar suele resolverse por sí solo en un plazo de 48 a 72 horas, pero puede durar hasta dos semanas.

#### Relaciones sexuales:

No coloque nada en su vagina antes de su visita de seguimiento con su médico. NO se permiten relaciones sexuales durante seis semanas o hasta después de su examen posparto y discusión sobre anticoncepción. Esto ayuda a evitar infecciones y permite que la pared vaginal y el útero tengan tiempo para sanar y recuperar fuerza. Cuando su médico le indique que es seguro reanudar las relaciones sexuales, al principio puede resultarle incómodo porque los tejidos vaginales aún pueden estar sensibles. La lubricación vaginal es menor de lo habitual debido a la disminución del nivel de estrógeno. Usar un agente lubricante puede ayudar a minimizar su malestar. Recuerde que puede quedar embarazada poco después del nacimiento de su bebé. Consulte la sección sobre anticoncepción y coméntelo con su pareja antes de tener relaciones sexuales.

#### **Anticoncepción:**

Existen varias formas de control de la natalidad que puede utilizar. Estos incluyen píldoras anticonceptivas, Nexplanon, inyecciones de Depo-Provera y DIU. Cada uno tiene sus propias ventajas y desventajas, y su médico puede analizar sus opciones antes de que abandone el hospital o durante su primera visita al consultorio. Nuevamente, recuerde que puede quedar embarazada poco después del parto, incluso si está amamantando y no tiene períodos normales. Visite [www.bedsider.org](http://www.bedsider.org) para obtener información precisa y fácil de leer sobre anticonceptivos.

#### **Dieta:**

Podrá reanudar su dieta habitual después del parto.

#### **Actividad General:**

Durante la primera y segunda semana, asegúrese de descansar durante el día. Concentre su energía en su bebé. Asigne tareas del hogar a otros miembros de la familia después del parto. Durante la tercera semana podrás conducir un coche y aumentar tu actividad física. Si el sangrado se vuelve más abundante o si experimenta contracciones o dolor durante la actividad, reduzca las actividades inmediatamente y llame al consultorio de su médico para recibir asesoramiento.

#### **Emociones posparto:**

Varias madres primerizas pueden experimentar cambios emocionales después del parto. En el pasado, estos sentimientos se denominaban “tristeza posparto” y rara vez se tomaban en serio. Hoy en día, se reconoce que los cambios emocionales posparto pueden derivar en graves problemas de depresión y deben ser tratados por un médico. El estrés durante el embarazo (especialmente la preocupación excesiva por la imagen corporal), la ansiedad por la responsabilidad de ser madre y los cambios endocrinos básicos pueden causar cambios psicológicos entre tres y 30 días después del parto. En algunas causas, la depresión puede ocurrir hasta un año después.

Los primeros síntomas incluyen insomnio, inquietud, fatiga, irritabilidad, dolores de cabeza y cambios rápidos de humor. Más tarde, los síntomas pueden aumentar significativamente e incluir falta de apetito, preocupación irrazonable por trivialidades, confusión o incoherencia, suspicacia y comportamiento irracional.

Los pacientes deprimidos centran sus sentimientos en la relación madre-hijo, ya sea estando excesivamente preocupados por el bienestar del bebé o sintiéndose incapaces de cuidarlo. Busque tratamiento de inmediato para estos trastornos comunicándose con su obstetra para obtener una derivación psiquiátrica.

Cualquier mujer que haya tenido un bebé en el último año puede verse afectada independientemente de cuántos embarazos sin complicaciones y ajustes posparto haya tenido. Si siente que está experimentando algunos de los síntomas de la tristeza posparto, la depresión o la psicosis, hay ayuda disponible. Todos los síntomas, desde los más leves hasta los más graves, son temporales y tratables con apoyo y ayuda profesional calificada.

Si necesita apoyo adicional mientras enfrenta las emociones posparto, no dude en comunicarse con la oficina o llamar a la línea directa nacional de salud mental materna al 1-833-9HELP4MOMS (1-833-943-5746).

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#### **BDOBDCINSTRUCTIONSSECTION**

#### **Postpartum Discharge Instructions**

The first six weeks following the delivery of your baby are known as the postpartum period. This guide was designed to answer the most commonly-asked questions and help you understand the many changes that your body will experience over the next few weeks. If you have any questions during your stay at UMass Memorial Hospital, please ask your nurse. Once you leave the Hospital, please call your doctor's office with any questions

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**WHEN TO CALL YOUR DOCTOR:**

- Temperature of 100.4 F or above
- Heavy bleeding (soaking a sanitary pad in less than an hour)
- Persistent severe pain that is not controlled by medications
- Frequent urination with pain or burning
- Foul smelling discharge from your vagina
- Headaches that do not improve with medication
- Changes in your vision
- Severe epigastric pain (pain below your rib cage)
- Concern about depression or anxiety especially if it prevents you from taking care of yourself or infant
- Any other concerns

**Here are the best ways to contact any of our staff on weekdays:**

{Blank single:19197:: "UMass OB/GYN Office: 508-334-6255", "Community Women's Clinic: 508-334-6388 "}

**PAIN MANAGEMENT:**

After delivery, your uterus continues to contract, and these contractions are referred to as "afterbirth pains." Afterbirth pains tend to be more acute after the second or third baby. These contractions will last a few days and are sometimes stronger while nursing your baby, due to the hormonal stimulation of the milk letdown reflex. Even though you may experience some discomfort, contractions are a positive sign that your baby is nursing well. You may also experience discomfort from your episiotomy or cesarean incision.

The medicine prescribed by your doctor should control the discomfort. As you feel better, you may find that over-the-counter analgesics such as aspirin, Tylenol Tm, or ibuprofen may be all you need for pain control. If you were prescribed Percocet, do not take tylenol at the same time since they both contain similar medications. Recommended doses for medications are:

- Motrin / Ibuprofen 600 mg every 6 hours as needed
- Tylenol 650 mg every 4 hours as needed
- Oxycodone 5 or 10 mg every 4 hours as needed

**PERINEAL MANAGEMENT:**

If you had a tear or episiotomy at the time of delivery, you may experience swelling of the tissues of the perineum. Please follow these instructions:

- Use pads to catch flow, NOT TAMPONS. Change pads frequently.
- Fill your perineal bottle with warm water, and rinse your perineal area well after urinating and every bowel movement.
- Take two to three sitz baths each day in a tub filled with four to six inches of warm water.

You may also wish to use medicated ointment, foam, or spray on the perineal area. Care of the perineum should be continued at home until the discomfort subsides, usually within seven to ten days. If your tear or episiotomy becomes more painful and red instead of getting better, please call your doctor's office.

**CESAREAN BIRTH:**

A cesarean birth includes all the normal body changes that happen after vaginal delivery as well as healing of an abdominal surgical incision. Six weeks is a realistic time to expect this healing to occur. During your hospital stay, you will be encouraged to move around as frequently as possible. Once home, walking is an excellent form of exercise until your postpartum visit. Delay any strenuous exercise for at least six weeks. You may shower but no soaking (eg bathing or swimming) at the level of your incision. Be sure to keep your incision clean and dry. DO NOT RUB THE INCISION. Please call your doctor's office if incisional drainage becomes constant or excessive, or if red streaks or severe tenderness develop around the incision.

For six weeks, you should not lift anything heavier than five to ten pounds (a half gallon of milk weighs 5 pounds). It Is okay to lift your baby! You should not be lifting groceries, laundry baskets, or using a vacuum.

When doing even light lifting, make sure that you bend at the knees and not at the waist. Don't hold your breath; holding your breath when you lift increases pressure in your pelvis.

No driving for 4 weeks or while taking narcotic pain medication. If you feel any pain when you move your legs suddenly, your reflexes will be slowed and you will not be a safe driver. For about 6 weeks after surgery, you are also at risk for developing blood clots in your legs. Because of this, if you are driven in a car, stop at least every hour so you can walk around. The action of the large muscles in the legs helps pump blood. If you sit in a cramped position for too long, you increase your risk of forming a life-threatening clot.

### **VAGINAL DISCHARGE (LOCHIA):**

Following your delivery, you can expect a bloody vaginal discharge called lochia. This flow may last four to six weeks. The color of your lochia should change from the bright red seen just after delivery to a darker brown and finally to a creamy tone. Increased activity may result in heavier bleeding or a return to a redder color. You should limit your activity until the bleeding decreases. Please call your doctor if you experience excessive bleeding, foul smelling discharge, acute abdominal pain, or a sudden fever. Following your vaginal or cesarean delivery, it is best to take showers or sponge baths until instructed otherwise.

### **MENSES:**

Your menstrual cycle usually reappears between the 4th and 12th week after delivery, if not breastfeeding. It may take several months to reestablish a regular cycle. The first menstrual period may be heavier than usual.

### **Breast Care For Promoting Milk Production:**

Your breasts may feel heavier and firmer sometime between three to five days after delivery. This is the increase in milk production you and your baby have been anticipating. Continue feeding your baby eight to twelve times each day to promote milk flow from the breast. Breasts should feel softer and lighter after a feeding. Wearing a supportive, properly-fitting bra may help during this time. You may find it comfortable to wear a soft, light support bra at night. Do not sleep in an underwire bra. Please contact your doctor's office if you have any of the following signs of breast infection:

- Elevated temperature above 100.4 F
- Localized redness and swelling of breast
- Localized tenderness and a painful breast.

**Breast Care for Discouraging Milk Production:** Your breasts may respond to the hormonal changes of birth and begin milk production even though your plans are to feed your baby formula. To minimize the stimulation of milk production, we suggest wearing a bra that provides firm comfortable support for breasts that are swollen or fuller than usual. Ice packs applied for 20 minutes every two to three hours will relieve swelling as well. Some women use a loosely-applied ace wrap to hold the ice packs in place. Tylenol Tm, ibuprofen or aspirin may be used for pain relief. This period of discomfort usually resolves itself within 48 to 72 hours, but may last up to two weeks.

### **Sexual Relations:**

Please don't put anything in your vagina prior to your follow-up visit with your doctor. NO sexual relations are allowed for six weeks or until after your postpartum examination and discussion about contraception. This helps avoid infection and allows the vaginal wall and uterus time to heal and regain strength. When your physician indicates it is safe to resume sexual relations, you may initially find it uncomfortable because the vaginal tissues may still be tender. Vaginal lubrication is lower than usual because of your decreased estrogen level. Using a lubricating agent may help minimize your discomfort. Please remember that you can become pregnant soon after the birth of your baby. Refer to the section on contraception, and discuss this with your partner before sexual relations occur.

### **Contraception:**

There are several forms of birth control that you may use. These include birth control pills, Nexplanon, Depo-Provera injections and IUDs. Each has its own advantages and disadvantages, and your doctor can discuss your options before you leave the Hospital or during your first office visit. Again, please remember that you can become pregnant soon after your delivery, even if you are breast feeding and not having normal periods. Please visit [www.bedsider.org](http://www.bedsider.org) for accurate and easy to read information about birth control.

**Diet:**

You may resume your usual diet following your delivery.

**General Activity:**

During the first and second week, be sure to rest during the day. Focus your energy on your baby. Assign housework to other family members following your delivery. During the third week, you may drive a car and increase your physical activity. If bleeding becomes heavier or if you experience contractions or pain during the activity, please reduce the activities immediately and call your doctor's office for advice.

**DO NOT LIFT** anything heavier than your baby. Your incision requires four to six weeks to completely heal. If you have other children who want to be held, encourage them to climb up in your lap rather than you lifting them. **LISTEN TO YOUR BODY.** When you feel tired, try to rest. Remember that you are recovering from a physical and emotional event that has had an enormous effect on your body.

**Postpartum Emotions:**

A number of new mothers may experience emotional changes following delivery. In the past, these feelings were labeled "postpartum blues" and were rarely taken seriously. Today, it is recognized that postpartum emotional changes may evolve into serious problems of depression and should be treated by a physician. Stress during pregnancy (especially undue concern about body image), anxiety about the responsibility of mothering, and basic endocrine changes can cause psychological changes anywhere from three to 30 days after childbirth. In some cases, depression can occur up to a year later.

Early symptoms include insomnia, restlessness, fatigue, irritability, headaches, and rapid mood changes. Later, symptoms may increase significantly to include lack of appetite, unreasonable concern over trivialities, confusion or incoherence, suspiciousness, and irrational behavior.

Depressed patients center their feelings on the mother-child relationship, either being excessively concerned about the baby's welfare or feeling incapable of caring for the baby. Seek treatment immediately for these disorders by contacting your obstetrician for a psychiatric referral.

Any woman who has had a baby in the last year can be affected regardless of how many uncomplicated pregnancies and postpartum adjustments she has had. If you feel that you are experiencing some of the symptoms of postpartum blues, depression or psychosis, there is help available. All of the symptoms, from the mildest to the most severe, are temporary and treatable with support and skilled professional help.

**If you need additional support while dealing with postpartum emotions, please do not hesitate to reach out to the office or to call the national Maternal Mental Health Hotline at 1-833-9HELP4MOMS (1-833-943-5746).**

**BDOBDCINSTRUCTIONSSECTIONSPANISH**

Instrucciones de alta posparto

Las primeras seis semanas después del nacimiento de su bebé se conocen como período posparto. Esta guía fue diseñada para responder las preguntas más frecuentes y ayudarlo a comprender los numerosos cambios que experimentará su cuerpo durante las próximas semanas. Si tiene alguna pregunta durante su estadía en UMass Memorial Hospital, consulte a su enfermera. Una vez que salga del hospital, llame al consultorio de su médico si tiene alguna pregunta.

**CUÁNDO LLAMAR A SU MÉDICO:**

- Temperatura de 100,4 F o superior
- Sangrado abundante (remojar una toalla sanitaria en menos de una hora)
- Dolor intenso y persistente que no se controla con medicamentos.
- Micción frecuente con dolor o ardor.

- Secreción vaginal con mal olor.
- Dolores de cabeza que no mejoran con medicación
- Cambios en tu visión.
- Dolor epigástrico intenso (dolor debajo de la caja torácica)
- Preocupación por la depresión o la ansiedad, especialmente si le impide cuidar de sí mismo o del bebé.
- Cualquier otra inquietud

Estas son las mejores formas de contactar a cualquiera de nuestro personal durante los días de semana:  
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#### EL MANEJO DEL DOLOR:

Después del parto, el útero continúa contrayéndose y estas contracciones se denominan “dolores de placenta”. Los dolores posparto tienden a ser más agudos después del segundo o tercer bebé. Estas contracciones durarán unos días y en ocasiones serán más fuertes mientras amamantas a tu bebé, debido a la estimulación hormonal del reflejo de bajada de la leche. Aunque puedas sentir algunas molestias, las contracciones son una señal positiva de que tu bebé está amamantando bien. También puede experimentar molestias debido a la episiotomía o la incisión de la cesárea.

El medicamento recetado por su médico debe controlar las molestias. A medida que se sienta mejor, es posible que todo lo que necesite para controlar el dolor sea analgésicos de venta libre como aspirina, Tylenol Tm o ibuprofeno. Las dosis recomendadas de medicamentos son:

- Motrin/Ibuprofeno 600 mg cada 6 horas según sea necesario
- Tylenol 650 mg cada 4 horas según necesidad
- Oxicodona 5 o 10 mg cada 4 horas según sea necesario

#### MANEJO PERINEAL:

Si tuvo un desgarro o una episiotomía en el momento del parto, puede experimentar hinchazón de los tejidos del perineo. Siga estas instrucciones:

- Utilice toallas sanitarias para captar el flujo, NO TAMPONES. Cambie las almohadillas con frecuencia.
- Llene su biberón perineal con agua tibia y enjuague bien el área perineal después de orinar y de cada defecación.
- Tome dos o tres baños de asiento cada día en una tina llena de cuatro a seis pulgadas de agua tibia.

También es posible que desee utilizar un ungüento, espuma o aerosol medicinal en el área perineal. El cuidado del perineo debe continuarse en casa hasta que desaparezcan las molestias, normalmente entre siete y diez días. Si su desgarro o episiotomía se vuelve más doloroso y rojo en lugar de mejorar, llame al consultorio de su médico.

#### NACIMIENTO POR CESÁREA:

Un parto por cesárea incluye todos los cambios corporales normales que ocurren después del parto vaginal, así como la curación de una incisión quirúrgica abdominal. Seis semanas es un tiempo realista para esperar que se produzca esta curación. Durante su estadía en el hospital, se le alentará a moverse con la mayor frecuencia posible. Una vez en casa, caminar es una excelente forma de ejercicio hasta la visita posparto. Retrase cualquier ejercicio extenuante durante al menos seis semanas. Puede ducharse pero no sumergirse (por ejemplo, bañarse o nadar) al nivel de la incisión. Asegúrese de mantener su incisión limpia y seca. NO FROTE LA INCISIÓN. Llame al consultorio de su médico si el drenaje de la incisión se vuelve constante o excesivo, o si se desarrollan rayas rojas o dolor severo alrededor de la incisión.

Durante seis semanas, no debe levantar nada que pese más de cinco a diez libras (medio galón de leche pesa 5 libras). ¡Está bien levantar a su bebé! No debe levantar la compra, los cestos de la ropa sucia ni utilizar la aspiradora. Al levantar incluso un peso ligero, asegúrese de doblar las rodillas y no la cintura. No contengas la respiración; contener la respiración cuando levanta aumenta la presión en la pelvis.

No conducir durante 4 semanas o mientras esté tomando analgésicos narcóticos. Si siente algún dolor al mover las piernas repentinamente, sus reflejos se ralentizarán y no será un conductor seguro. Durante aproximadamente 6 semanas después de la cirugía, usted también corre el riesgo de desarrollar coágulos de sangre en las piernas. Por esta razón, si viaja en automóvil, deténgase al menos cada hora para poder caminar. La acción de los músculos grandes de las piernas ayuda a bombear sangre. Si permanece sentado en una posición apretada durante demasiado tiempo, aumenta el riesgo de que se forme un coágulo que ponga en peligro su vida.

#### SECRECIÓN VAGINAL (LOQUIOS):

Después del parto, puede esperar un flujo vaginal con sangre llamado loquios. Este flujo puede durar de cuatro a seis semanas. El color de sus loquios debe cambiar del rojo brillante que se ve justo después del parto a un marrón más oscuro y finalmente a un tono cremoso. El aumento de la actividad puede provocar un sangrado más intenso o un retorno a un color más rojo. Debe limitar su actividad hasta que disminuya el sangrado. Llame a su médico si experimenta sangrado excesivo, secreción maloliente, dolor abdominal agudo o fiebre repentina. Después del parto vaginal o cesárea, lo mejor es ducharse o bañarse con esponja hasta que se le indique lo contrario.

#### MENSTRUO:

Su ciclo menstrual suele reaparecer entre la cuarta y la duodécima semana después del parto, si no está amamantando. Pueden ser necesarios varios meses para restablecer un ciclo regular. El primer período menstrual puede ser más abundante de lo habitual.

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Es posible que sus senos se sientan más pesados y firmes entre tres y cinco días después del parto. Este es el aumento en la producción de leche que usted y su bebé estaban anticipando. Continúe alimentando a su bebé de ocho a doce veces al día para promover el flujo de leche del pecho. Los senos deben sentirse más suaves y livianos después de amamantar. Usar un sostén que le brinde soporte y que le quede bien puede ayudar durante este tiempo. Puede que le resulte cómodo usar un sostén suave y ligero por la noche. No duermas con un sostén con aros. Comuníquese con el consultorio de su médico si tiene alguno de los siguientes signos de infección mamaria:

- Temperatura elevada por encima de 100,4 F
- Enrojecimiento localizado e hinchazón de la mama.
- Sensibilidad localizada y dolor en el pecho.

Cuidado de los senos para desalentar la producción de leche: Sus senos pueden responder a los cambios hormonales del nacimiento y comenzar la producción de leche aunque sus planes sean alimentar a su bebé con fórmula. Para minimizar la estimulación de la producción de leche, sugerimos usar un sostén que brinde un soporte firme y cómodo para los senos hinchados o más llenos de lo habitual. Las bolsas de hielo aplicadas durante 20 minutos cada dos o tres horas también aliviarán la hinchazón. Algunas mujeres usan una envoltura de ace que se aplica sin apretar para mantener las bolsas de hielo en su lugar. Se pueden utilizar Tylenol Tm, ibuprofeno o aspirina para aliviar el dolor. Este período de malestar suele resolverse por sí solo en un plazo de 48 a 72 horas, pero puede durar hasta dos semanas.

#### Relaciones sexuales:

No coloque nada en su vagina antes de su visita de seguimiento con su médico. NO se permiten relaciones sexuales durante seis semanas o hasta después de su examen posparto y discusión sobre anticoncepción. Esto ayuda a evitar infecciones y permite que la pared vaginal y el útero tengan tiempo para sanar y recuperar fuerza. Cuando su médico le indique que es seguro reanudar las relaciones sexuales, al principio puede resultarle incómodo porque los tejidos vaginales aún pueden estar sensibles. La lubricación vaginal es menor de lo habitual debido a la disminución del nivel de estrógeno. Usar un agente lubricante puede ayudar a minimizar su malestar. Recuerde que puede quedar embarazada poco después del nacimiento de su bebé. Consulte la sección sobre anticoncepción y coméntelo con su pareja antes de tener relaciones sexuales.

#### Anticoncepción:

Existen varias formas de control de la natalidad que puede utilizar. Estos incluyen píldoras anticonceptivas,

Nexplanon, inyecciones de Depo-Proverai y DIU. Cada uno tiene sus propias ventajas y desventajas, y su médico puede analizar sus opciones antes de que abandone el hospital o durante su primera visita al consultorio. Nuevamente, recuerde que puede quedar embarazada poco después del parto, incluso si está amamantando y no tiene períodos normales. Visite [www.bedsider.org](http://www.bedsider.org) para obtener información precisa y fácil de leer sobre anticonceptivos.

**Dieta:**

Podrá reanudar su dieta habitual después del parto.

**Actividad General:**

Durante la primera y segunda semana, asegúrese de descansar durante el día. Concentre su energía en su bebé. Asigne tareas del hogar a otros miembros de la familia después del parto. Durante la tercera semana podrás conducir un coche y aumentar tu actividad física. Si el sangrado se vuelve más abundante o si experimenta contracciones o dolor durante la actividad, reduzca las actividades inmediatamente y llame al consultorio de su médico para recibir asesoramiento.

**NO LEVANTE** nada que pese más que su bebé. Su incisión requiere de cuatro a seis semanas para sanar por completo. Si tiene otros niños que quieren que los cargue, animelos a subirse a su regazo en lugar de que usted los levante. **ESCUCHA A TU CUERPO.** Cuando te sientas cansado, intenta descansar. Recuerda que te estás recuperando de un evento físico y emocional que ha tenido un efecto enorme en tu cuerpo.

**Emociones posparto:**

Varias madres primerizas pueden experimentar cambios emocionales después del parto. En el pasado, estos sentimientos se denominaban "tristeza posparto" y rara vez se tomaban en serio. Hoy en día, se reconoce que los cambios emocionales posparto pueden derivar en graves problemas de depresión y deben ser tratados por un médico. El estrés durante el embarazo (especialmente la preocupación excesiva por la imagen corporal), la ansiedad por la responsabilidad de ser madre y los cambios endocrinos básicos pueden causar cambios psicológicos entre tres y 30 días después del parto. En algunas causas, la depresión puede ocurrir hasta un año después.

Los primeros síntomas incluyen insomnio, inquietud, fatiga, irritabilidad, dolores de cabeza y cambios rápidos de humor. Más tarde, los síntomas pueden aumentar significativamente e incluir falta de apetito, preocupación irracional por trivialidades, confusión o incoherencia, suspicacia y comportamiento irracional.

Los pacientes deprimidos centran sus sentimientos en la relación madre-hijo, ya sea estando excesivamente preocupados por el bienestar del bebé o sintiéndose incapaces de cuidarlo. Busque tratamiento de inmediato para estos trastornos comunicándose con su obstetra para obtener una derivación psiquiátrica.

Cualquier mujer que haya tenido un bebé en el último año puede verse afectada independientemente de cuántos embarazos sin complicaciones y ajustes posparto haya tenido. Si siente que está experimentando algunos de los síntomas de la tristeza posparto, la depresión o la psicosis, hay ayuda disponible. Todos los síntomas, desde los más leves hasta los más graves, son temporales y tratables con apoyo y ayuda profesional calificada.

Si necesita apoyo adicional mientras enfrenta las emociones posparto, no dude en comunicarse con la oficina o llamar a la línea directa nacional de salud mental materna al 1-833-9HELP4MOMS (1-833-943-5746).

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**BDOBDCSUMMARY**

**DISCHARGE SUMMARY**  
**UMASS MEMORIAL HEALTH CARE**

**Date of Admission:** @ADMITDT@

**Date of Discharge:** @TODAYDATE@

---

**Admission Diagnoses:**

1. \*\*\*
2. \*\*\*

**Discharge Diagnoses:** Same**Procedures:** {Blank single:19197::"LTCS", "RLTCS", "RLTCS and BTL", "none"}**Hospital Course:** @NAME@ a @AGE@ year old @GRAVIDAPARA@ who presented at \*\*\*w\*\*\*d GA with \*\*\*. {Blank single:19196::"Her labs were remarkable for \*\*\*, "Her labs were unremarkable", "She was given BMZ on \*\*\*, "She did not receive BMZ", "She was given Magnesium \*\*\*, "She did not receive Magnesium", "She was not seen by NICU", "She received a NICU consultation"}. Please refer to full H&P for further details. \*\*\***DELIVERY:** On \*\*\* @NAME@, had a {Blank single:19197::"NSVD", "VAVD", "1LTCS", "RTLCS"}. For more detail please see delivery report.**POSTPARTUM:** The patient's {Blank single:19197::"postoperative", "postpartum"} course was {Blank single:19197::"uncomplicated", "complicated by \*\*\*".} Bowel and bladder functions returned in appropriate time. The patient was out of bed and ambulating on postpartum day #1. Pain was well controlled with PO pain medications. The postoperative hematocrit was \*\*\*. The patient denied any complaints of N/V/SOB/CP/F/C, dizziness, palpitations or headache. {Blank single:19197::".", "The patient's incision remained c/d/i throughout her hospital stay."} The patient remained afebrile and was ready for discharge on post {Blank single:19197::"partum", "operative"} day #{Blank single:19197::"2", "3", "4", "5"} in excellent condition.**Discharge Medications:**

@DCMEDLIST@

**Discharge Instructions:** She was instructed to call for fever greater than 100.4F, vaginal bleeding more than 1 pad per hour, pain not controlled by prescribed medications, difficulty moving her bowels or emptying your bladder, headaches, visual changes, right upper quadrant / epigastric pain, {Blank single:19197::", "signs of infection around her incision including redness, pain, foul odor or discharge,"} signs of postpartum depression such as the inability to care for herself or her infant, or for any other concerns.

\*\*\*Still pregnant

She was instructed to call for vaginal bleeding, decreased fetal movement, contractions, leakage of fluid, fever greater than 100.4F, headaches, visual changes, right upper quadrant / epigastric pain, or any other concerns.

**Condition at Discharge:** Stable**Discharge Destination:** Home**Results pending at time of discharge:** {Blank single:19197::"none", "placenta pathology", "\*\*\*\*"}**Follow Up:** She plans to follow up \*\*\*

@AFUTAPPT@

**Postpartum Birth Control:** \*\*\***Electronically Signed by:** @ME@**Date:** @TD@    **Time:** @NOW@

**{Blank single:19197::"OB H&P", "TRIAGE NOTE"}**

**Name:** @NAME@  
**MRN:** @MRN@  
**DOB:** @DOB@

**Patient's Obstetrician:** \*\*\*  
**Attending Physician Today:** \*\*\*

**CHIEF COMPLAINT:** \*\*\*

**SUBJECTIVE:**

@NAME@ is a @AGE@, @GPREFRESH@ with @EDD@ at @GA1@ gestation who presents \*\*\*

Pt denies {Blank single:19196::"dec FM", "ctx", "VB", "LOF"}. Pt denies {Blank single:19196::"fever", "headache", "visual changes", "RUQ/epigastric pain", "worsening lower extremity edema", "dysuria", "hematuria"}.

Denies Hx of {Blank single: 19196::"asthma", "diabetes", "high blood pressure", "blood clots or bleeding disorders"}

She is followed by Dr. \*\*\* for {Blank single:19197::"an uncomplicated pregnancy", "a pregnancy complicated by:"}.

@FLOWWITHDATE(17060)@

**OBSTETRIC HISTORY:** \*\*\*updated  
@OBHIST@

**GYNECOLOGIC HISTORY:**

Abnormal PAP's or cervical procedures: {Blank single:19197::"Denies"}  
STI's: {Blank single:19197::"Denies"}

**PMH:** \*\*\*updated @MEDICALHX@

**SURGICAL HISTORY:** \*\*\*updated @SURGICALHX@

**MEDICATIONS:** @PTAMEDS2@

**ALLERGIES:** @ALLERGYTABLECOLLAPSE@

**SOCIAL HISTORY:** \*\*\* Denies tobacco/alcohol/drugs

**OBJECTIVE:**

**Vitals:** @VSRANGES@

**BP:** {Blank single:19197::"Normal range", "Mild - \*\*\*", "Severe - \*\*\*"}

**GEN:** {Blank single:19197::"NAD", "Uncomfortable"}

**ABD:** gravid/nontender

**Toco:** q \*\*\*

**FHT:** Baseline \*\*\*, {Blank single:19197::"mod variability", "min variability", "marked variability"}, {Blank single:19197::"+ accels", "- accels"}, {Blank single:19197::"- decels", "\*\*\*\*"}

**SSE:** {Blank single:19197::"Deferred", "Pool \*\*\*/fern \*\*\*"}

**SVE:** \*\*\*

**BSUS:** {Blank single:19197::"Deferred", "Vertex", "Breech"}

**Prenatal labs: Labs:**

<b>Blood type:</b> @PRENATALLABSVALUEONLY(ABO)	<b>Rubella:</b> @PRENATALLABSVALUEONLY(RUBELLAIG)
---	--

<p>RH,ABOBLOODYTYPE,BLOODYTYPE,R HTYPE,RH)@</p> <p><b>Antibody Screen:</b> @PRENATALLABSVALUEONLY(ABYS CREEN,LABANTI)@</p> <p><b>Last CBC</b> (@PRENATALLABSDATEONLY(PLT) @):</p> <p>WBC: @PRENATALLABSVALUEUNITS(WBC )@</p> <p>Hgb: @PRENATALLABSVALUEUNITS(HGB) @</p> <p>Hct: @PRENATALLABSVALUEUNITS(HCT) @</p> <p>Platelets: @PRENATALLABSVALUEUNITS(PLT) @</p>	<p>G,RUBELLAANTI)@</p> <p><b>Varicella:</b> @PRENATALLABSVALUEONLY(VARICELLA GG,VARICELLAZO,VARIIGGABEXT,VARICEL LAZO,VZVABIGGOUTS)@ (immune &gt; 165)</p> <p><b>Syphilis:</b> @PRENATALLABSVALUEONLY(TPALLIDUM, RPRDXWR,RPRDXWR,TPALLIDUMAB,SYPHI LISABSI,VDRLCSF,PARTICLEAGG,TREPONE MAPA,RPRMONITOR,RPRTITER)@</p> <p><b>Hep B surface antigen:</b> @PRENATALLABSVALUEONLY(HEPBSAG,H EPBSAGINTER,HEPATITISB)@</p> <p><b>Hep C antibody:</b> @PRENATALLABSVALUEONLY(HEPCAB)@</p> <p><b>HIV:</b> @PRENATALLABSVALUEONLY(HIVAGAB4,H IVAGAB4,HIVAGAB4INT)@</p>
<p><b>1hr GTT:</b></p> <ul style="list-style-type: none"> <li>• @PRENATALLABSGTT1HR(GTT1 HR)@</li> </ul> <p><b>3hr GTT:</b></p> <ul style="list-style-type: none"> <li>• Fasting:@PRENATALLABSGTT3H R(GTTFAST)@</li> <li>• 1hr:@PRENATALLABSGTT3HR(GT T1HR)@</li> <li>• 2hr:@PRENATALLABSGTT3HR(GT T2HR)@</li> <li>• 3hr:@PRENATALLABSGTT3HR(GT T3HR)@</li> </ul>	<p><b>Gonorrhea:</b> @PRENATALLABSVALUEDATE(GCRES,NEI SSERIAGO,EXTGONSCRN)@</p> <p><b>Chlamydia:</b> @PRENATALLABSVALUEDATE(CHRES,CHL AMYDIATR)@</p> <p><b>Group B Strep:</b> @PRENATALLABSVALUEDATE(GROUPB,GA SRESULT,STREPGRPB,GRPBSTRREF)@</p>
<p><b>Toxicology</b></p> <p>Fentanyl</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(FENTANY L)@</li> </ul> <p>Norfentanyl</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(NORFENT ANYL)@</li> </ul> <p>Heroin</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(HEROINM ETAB)@</li> </ul> <p>Opiates</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(OPIATES, OPIATEUR)@</li> </ul> <p>Morphine</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(MORPHIN E)@</li> </ul> <p>Norhydrocodone</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(NORHYDR OCODO)@</li> </ul> <p>Codeine</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(CODEINE) @</li> </ul>	<p>Methadone</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(METHADONE)@</li> </ul> <p>Methadone Metabolite</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(METHADONEME )@</li> </ul> <p>EPPD</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(EDDP)@</li> </ul> <p>Cocaine Metabolites</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(COCAINEMETA,C OCAINEGCMS)@</li> </ul> <p>Benzoylecgonine</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(BENZOYLECGON )@</li> </ul> <p>Amphetamines</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(METHAMPHU)@</li> </ul> <p>Methamphetamines</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(METHAMPHU)@</li> </ul> <p>Barbiturates</p> <ul style="list-style-type: none"> <li>• @PRENATALLABSTOX(BARBITURATES, BARBSCRUR)@</li> </ul> <p>PCP</p>

Oxycodone	• @PRENATALLABSTOX(PHENCYCLIDIN)@
Hydrocodone	• @PRENATALLABSTOX(BENZODIAZEPI,BENZOU)@
Hydromorphone	Marijuana
Hydromorphone	• @PRENATALLABSTOX(MARIJUANAME,CANNASCRNUR)@

**Labs:**

@LABRCNTIP(wbc,hgb,hct,PLT)@

@LABRCNTIP(HCT:3,PLT:3,CREATININE:3,AST:3,ALT:3,PROTCREATRUR:3,PROTEIN24HR)@

**ASSESSMENT AND PLAN:**

@NAME@ is a @AGE@ year old @GPREFRESH@ at @GA@, who presents for \*\*\*

**IOL** {Blank single:19197::"at term", "for \*\*\*", "\*\*\*\*"}

- Admit to L&D
- Toco / EFM for monitoring
- Labs: {Blank single:19197::"CBC, T&S","CBC, CMP, Urine P:Cr, T&S"}
- Induction agent: {Blank single:19197::"AROM","foley + pitocin","pitocin","cervical ripening balloon","miso and cervical balloon","miso","expectant"}
- GBS: {Blank single:19197::"Positive - Plan to start \*\*\* once in active labor", "Positive - \*\*\* ordered to start now", "Pending - Plan to start \*\*\* once in active labor", "Pending - \*\*\* ordered to start now", "Pending", "Negative"}
- Pain Control: {Blank single:19197::"desires epidural", "desires IV medication PRN","does not desire pain medications", "undecided"}
- PPBC: \*\*\*

**{Blank single:19197::"LTCS","RLTCS"}**

- Admit to L&D
  - CBC / T&S
  - Routine prophylactic abx prior to procedure. {Blank single:19197::"Ancef 2g","Gentamicin/Clindamycin given allergies","Azithromycin added given pt is laboring and/or ruptured."}
  - R/B/A: Reviewed risks of cesarean section including bleeding, need for blood transfusion, infection, damage to surrounding structures including fetus, uterus, fallopian tubes, ovaries, bowel, bladder, ureters, blood vessels and nerves.
- {Blank single:19197::" - Reviewed alternatives to tubal ligation and risks including risk of failure (<1%). Discussed with patient that if she does become pregnant, there is a high risk of an ectopic pregnancy and that she should seek immediate medical attention. Also discussed risk regret, however patient states that she is 100% certain that she no longer wants any more children."}
- PPBC: \*\*\*

**Possible** {Blank single:19196::"Labor","PROM","PPROM","Preterm Labor"}

- {Blank single:19196::"Pool and fern negative","Cervix remains unchanged over labor check", "}. No evidence of {Blank single:19196::"labor","PROM","PPROM", " "}. {Blank single:19196::"AFI \*\*\*, MVP \*\*\*, " " "}
- FHT: NST reactive
- BP: {Blank single:19197::"Severe", "Mild", "Normal"}
- {Blank single:19197::"Discharged home with precautions to call or return with contractions, bleeding, leakage of fluid or decreased fetal movement.", "Discharged home with precautions to call or return with contractions, bleeding, leakage of fluid or decreased fetal movement. Also to call or return with headaches, visual changes or right upper / epigastric pain."}

## **Decreased FM**

- FHT: NST reactive and reassuring
- Amniotic fluid: {Blank single:19197::"Normal"}.
- Pt reassured by {Blank single:19196::"cat I FHT", "feeling movement currently", "seeing fetal movement on US"}
- BP: {Blank single:19197::"Severe", "Mild", "Normal"}
- {Blank single:19197::"Discharged home with precautions to call or return with contractions, bleeding, leakage of fluid or decreased fetal movement.", "Discharged home with precautions to call or return with contractions, bleeding, leakage of fluid or decreased fetal movement. Also to call or return with headaches, visual changes or right upper / epigastric pain."}

\*\*\*

All of the patient's questions were answered to her satisfaction and she was in agreement with the above plan of care.

The patient was discussed with Dr. \*\*\*, who is in agreement with the above discussed plan of care.

@ME@@@TODAYDATE@

---

BDOBID

@NAME@ is a @AGE@ @GP@ @GESTAGE@

---

BDOBPECLABS

@1(HCT)@<@1(PLT)@, @1(CREATININE)@/@1(AST)@/@1(ALT)@, spot @1(PROTCREATRUR)@

---

BDOBPLANHTN

# gHTN

- Labs: CBC, CMP, Urine P:Cr, T&S
  - BP checks per unit protocol
- 

BDOBPROGLABOR

### Labor Progress Note

Name: @NAME@

MRN: @MRN@

DOB: @DOB@

S: {Blank single:19197::"Strip check only, patient not seen.", "Patient comfortable.", "Patient uncomfortable.", "Patient feeling rectal pressure.", "\*\*\*\*"} @FLOWWITHDATE(17060)@

#### OBJECTIVE: VITALS: @VSRANGES@

FHT: \*\*\* baseline, \*\*\* variability, \*\*\* accels, \*\*\* decels; Category \*\*\* tracing

Toco: ctx q\*\*\* mins

\*\*\*labor course

#### ASSESSMENT/ PLAN:

@NAME@ is a @AGE@ year old @GRAVIDAPARA@ at @GA@, {Blank single:19197::"here in active labor", "here for IOL for \*\*\*", "here for IOL at term"}.

- Cat {Blank single:19197::"I", "II", "III"} FHT. {Blank single:19197::"FSE/IUPC", "FSE/TOCO", "EFM/IUPC", "TOCO/EFM"} for monitoring.

- {Blank single:19197::"Expectant management for now", "Active management with \*\*\*", "Active management with \*\*\*"}

---

with pitocin, currently at \*\*\*"}]

- Anticipate NSVD.

Plan of care under @ATTENDINGPROVIDER@.

@ME@ @TODAYDATE@

---

BDOBPROGPOSTOPCHECK

### POD0 Postoperative Progress Note

**PATIENT:** @NAME@

**MRN:** @MRN@

**S:** Patient feels pain is present, but well-controlled with current pain medications. Minimal vaginal bleeding upon nursing checks. She is not yet ambulating. She has her foley catheter in place draining {Blank single:19197::"clear yellow", "blood tinged", "\*\*\*"} urine. She is tolerating PO without nausea or vomiting. She is {Blank single:19197::"not yet passing flatus", "passing flatus"}. \*\*\*

@INTERPRETERCONDITIONAL@@FLOWWITHDATE(17060)@

**O:** @VSRANGES@

Gen: NAD

CV: Regular rate, normal rhythm. No murmurs, rubs, gallops.

Resp: CTABL, no wheezes, rhonchi, rales.

Abd: Soft, appropriately tender. Fundus firm. Incision with bandage in place, which is clean, dry, and intact.

Ext: Scant peripheral edema and calves nontender. SCDs in place.

GU: Foley in place draining {Blank single:19197::"clear yellow", "blood tinged", "\*\*\*"} urine.

**A&P:** @AGE@ @GP@, POD0 s/p \*\*\*LTCS\*\*\*, doing well.

#### Routine

-continue current postoperative pain medications

-encourage ambulation and PO intake

-Foley catheter to be removed 6-8 hours postoperatively. Will then await spontaneous void.

-expect D/C home POD\*\*\*

\*\*\*

@ME@@TD@

---

BDOBPROGPOSTPARTNSVD

**Name:** @NAME@

**MRN:** @MRN@

### Vaginal Delivery Post Partum Progress Note

**SUBJECTIVE:** Patient reports that pain is present, but is well-controlled with current pain medications. Lochia is {Blank single:19197::"minimal", "equal to a period", "more than a period"}. Voiding {Blank single:19197::"independently", "with foley catheter in place"}.

She is {Blank single:19197::"passing flatus", "not yet passing flatus"}.

She is {Blank single:19197::"ambulating independently", "not yet ambulating"}.

She is tolerating PO intake without nausea or vomiting.

She denies fevers, chills, CP, SOB, palpitations, dizziness, or light headedness, headaches, vision changes, RUQ pain, worsening lower extremity edema.

---

@FLOWWITHDATE(17060)@

**OBJECTIVE:**

**Vital Signs:** @VSRANGES@

**Physical exam:**

GEN: No acute distress

CVS: {Blank single:19197::"Deferred", "Warm and well perfused", "Regular rate and rhythm, no murmurs, rubs, or gallops"}

PULM: {Blank single:19197::"Deferred", "Clear to auscultation bilaterally, no wheezes, rhonchi, or rales", "No respiratory distress"}

ABD: Soft, appropriately tender. Fundus firm and at umbilicus {Blank single:19197::".", ". Bandage c/d/i", ".

Incision c/d/i with staples", ". Incision clean, dry, and intact with steri strips"} No rebound, guarding, or rigidity.

EXT: {Blank single:19197::"No edema", "Scant peripheral edema"} and calves non-tender.

**ASSESSMENT /PLAN:**

@FNAME@ is a @AGE@ year old @GRAVIDAPARA@ PPD#\*\*\* status post \*\*\*VD, doing well.

**Routine**

- PPD1 Hct \*\*\*
- Continue current pain medications
- Routine postpartum care including ambulation and PO intake as tolerated
- PP birth control: {Blank single:19197::"Desires \*\*\* for post partum birth control.", "Undecided for post partum birth control.", "Declines post partum birth control.", "Will discuss."}
- Anticipate discharge home on PPD2

\*\*\*

All of the patient's questions were answered to her satisfaction and she was in agreement with the above plan of care.

@ME@ UMass Memorial Medical Center  
@TODAYDATE@

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BDOBPROGPOSTPARTSECTION

**Name:** @NAME@

**MRN:** @MRN@

**Cesarean Section Post Partum Progress Note**

**SUBJECTIVE:** Patient reports that pain is present, but is well-controlled with current pain medications.

Lochia is {Blank single:19197::"minimal", "equal to a period", "more than a period"}. Voiding {Blank single:19197::"independently", "with foley catheter in place"}.

She is {Blank single:19197::"passing flatus", "not yet passing flatus"}.

She is {Blank single:19197::"ambulating independently", "not yet ambulating"}.

She is tolerating PO intake without nausea or vomiting.

She denies fevers, chills, CP, SOB, palpitations, dizziness, or light headedness, headaches, vision changes, RUQ pain, worsening lower extremity edema.

@FLOWWITHDATE(17060)@

**OBJECTIVE:**

**Vital Signs:** @VSRANGES@

---

I/O: @IOBRIEFMR@

**Physical exam:**

GEN: No acute distress

CVS: {Blank single:19197::"Deferred", "Warm and well perfused", "Regular rate and rhythm, no murmurs, rubs, or gallops"}

PULM: {Blank single:19197::"Deferred", "Clear to auscultation bilaterally, no wheezes, rhonchi, or rales", "No respiratory distress"}

ABD: Soft, appropriately tender. Fundus firm and at umbilicus {Blank single:19197::".", ". Bandage c/d/i", ". Incision c/d/i with staples", ". Incision clean, dry, and intact with steri strips"}. No rebound, guarding, or rigidity.

EXT: {Blank single:19197::"No edema", "Scant peripheral edema"} and calves non-tender.

**ASSESSMENT /PLAN:**

@FNAME@ is a @AGE@ year old @GRAVIDAPARA@ POD@PODS@, s/p \*\*\*LTCS for \*\*\*, doing well.

**Routine**

- POD1 Hct \*\*\*
- Continue current pain medication
- Encourage ambulation
- PP birth control: {Blank single:19197::"Desires \*\*\* for post partum birth control.", "Undecided for post partum birth control.", "Declines post partum birth control.", "Desires to defer discussion to PPV.", "Will discuss."}
- Anticipate DC home POD3-4

\*\*\*

All of the patient's questions were answered to her satisfaction and she was in agreement with the above plan of care.

@ME@ UMass Memorial Medical Center  
@TODAYDATE@

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**BDOBTODOLABORLIST**

LR/HR\*\*\*: Attdg\*\*\*: @AGE@ | @GRAVIDAPARA@ | @GESTAGE@ | GBS\*\*\* | Vtx\*\*\*

**Labor Course:** p/w \*\*\* for \*\*\* (date\*\*\*)

Date\*\*\* Time\*\*\*: \*\*\*/\*\*\*/\*\*\*

- Language\*\*\*
- OB/GYN/PMH/PSH hx\*\*\*
- Most recent EFW\*\*\*
- NKDA\*\*\*

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**BDOBTODOPPLIST**

Attending\*\*\*: PPD\*\*\* (NSVD) or PPD\*\*\* (VBAC) or PPD\*\*\* (VAVD) or POD\*\*\* (\*\*LTCS for \*\*\*)

Language\*\*\*

- Meds: \*\*\*

[ ] POP @ \*\*\*

[ ] Date\*\*\* am hct \*\*\*

- PPBC: \*\*\*, [ ] dc summary [ ] tasks\*\*\*only if faculty/CWC

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**BDOTCPAININST**

You may experience muscle pain over the next several days as a result of the impact. You may take alternating doses of {Blank single:19197::"500", "650", "1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400", "800", "600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

**BDPATCHTRIAL**

Considered administration of platelets in the setting of antiplatelet therapy given spontaneous cerebral hemorrhage, however this is likely inferior to the state of care per the PATCH trial  
[https://doi.org/10.1016/S0140-6736\(16\)30392-0](https://doi.org/10.1016/S0140-6736(16)30392-0).

---

**BDPCPLETTERED**

Hello @PCP@,

This is to let you know that the patient @NAME@ (DOB: @DOB@) has you listed as their PCP and they were seen in the emergency department for \*\*\*.

They had a {Blank single: 19197:: "reassuring workup in the emergency department", "workup showing \*\*\*"}.

They will likely need short-term follow up in clinic.

{Blank single: 19197:: "Their workup was also notable for incidental findings including: \*\*\*."}

@EDIMAGING@

@EDLABS@

---

**BDPECARNCSPINE**

PECARN C-spine Rule			
Parameter	Assessment	Definitions	Present?
Altered mental status	Physical exam	GCS less than 15 AVPU < A Other findings of AMS	{Blank single:19197::"No","Yes"}
Focal neurologic deficits	Physical exam	Paresthesias Loss of sensation Motor weakness Other focal neurologic findings	{Blank single:19197::"No","Yes"}
Complaint of neck pain	History: Symptoms	Greater than 2 years old	{Blank single:19197::"No","Yes"}
High risk MVC	History: Mechanism	Head and collision Rollover car Ejected from vehicle Document same crash Speed greater than 55 mph	{Blank single:19197::"No","Yes"}
Diving	History: Mechanism		{Blank single:19197::"No","Yes"}
Substantial torso injuries	Physical exam	Thorax including clavicles, abdomen, flanks, back, pelvis (e.g. rib fracture, pelvic fracture, visceral or solid organ injury)	{Blank single:19197::"No","Yes"}
Torticollis	Physical exam	Limited range of motion and difficulty moving the neck noted history of physical exam	{Blank single:19197::"No","Yes"}
Predisposing conditions	History: PMHX		{Blank single:19197::"No","Yes"}
ANY parameter present = positive rule: x-ray			
ALL parameters absent = negative rule: no x-ray			

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## **BDPEDIABDPAINDISCHARGEINST**

Your child has been evaluated in the emergency department today for abdominal pain. Their evaluation was not suggestive of any emergent condition requiring medical intervention at this time, however, some abdominal problems may take more time to appear. Therefore, it is important for you to watch for any new symptoms or worsening of the current condition.

Please follow up with your pediatrician regarding this visit.

Return to the Emergency Department immediately if your child has worsening abdominal pain, persistent fevers of 100.4°F or greater, recurrent vomiting, blood in vomit, blood in stool, dark tarry stool, or any other concerning symptoms.

---

## **BDPEDICONCUSSIONRESOURCES**

### **Concussion Resources**

[Heads Up | HEADS UP | CDC Injury Center](http://www.cdc.gov/headsup/index.html) ([www.cdc.gov/headsup/index.html](http://www.cdc.gov/headsup/index.html))

[Brain Injury Basics - Brain Injury Association of America \(biausa.org\)](http://biausa.org)

[Resources and concussion treatment centers | Mass.gov](http://Mass.gov)

[Concussion Support & Resources | Concussion Legacy Foundation \(concussionfoundation.org\)](http://concussionfoundation.org)

[Concussion Resources & Facts | Concussion.org](http://Concussion.org)

### **Concussion Treatment Centers**

UMass Sports Medicine Clinic (Worcester) 855-862-7763

Spaulding Outpatient Center: (Boston) 617-952-6200, (Foxborough) 857-307-3202, (Pawtucket) 401-729-2919, (Lexington) 781-860-1742

Cantu Concussion Center at Emerson Health (Concord) 978-287-8250

Baystate Health Sports Medicine (Springfield) 413-794-5600

Mass General Youth Sports Concussion Clinic 617-724-9722

Sports Concussion New England 617-959-1010

Boston Children's Hospital Brain Injury Clinic 617-355-6388

Boston Children's Hospital Sports Concussion Clinic 617-355-3501

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# Concussion Signs

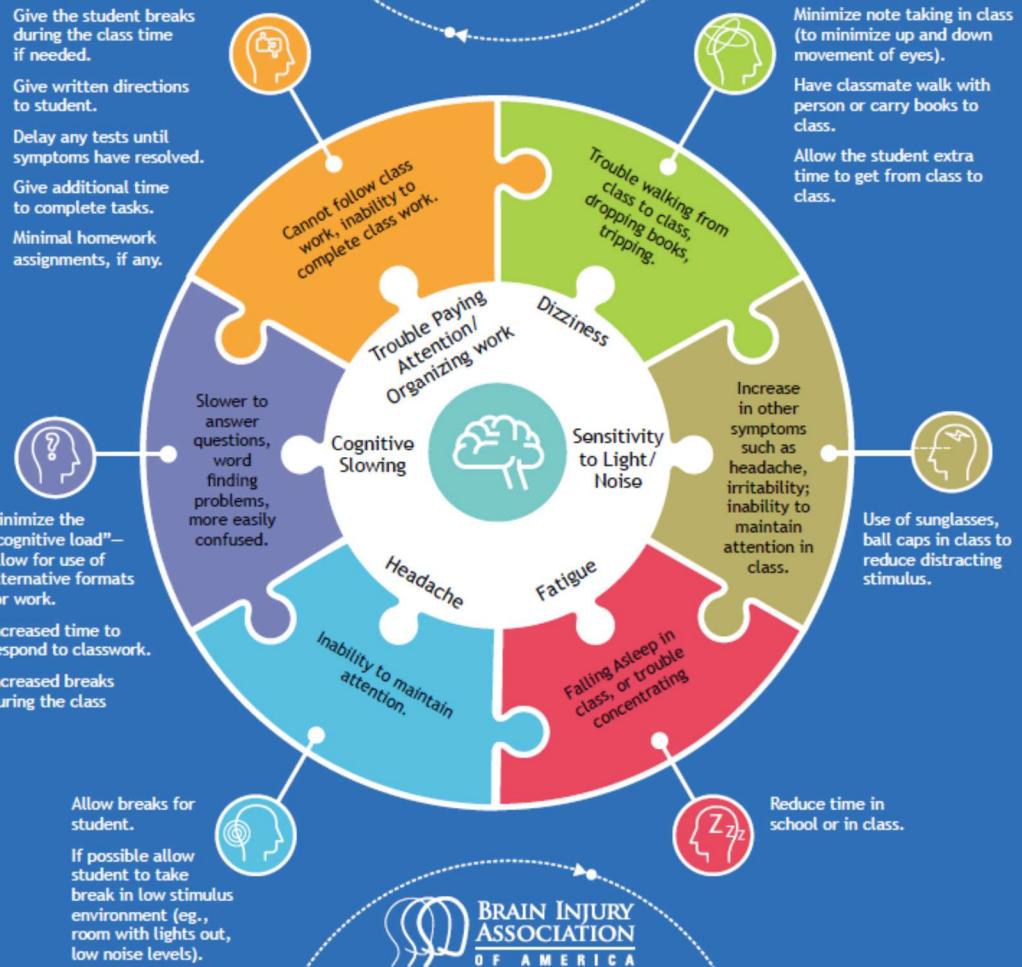
Concussion can present in a number of ways. This infographic describes common issues people experience after a concussion.



©2020 Brain Injury Association of America

# Concussion Tips & Tricks for the Classroom

Toll-Free  
**1-800-444-6443**  
National Brain Injury  
Information Center



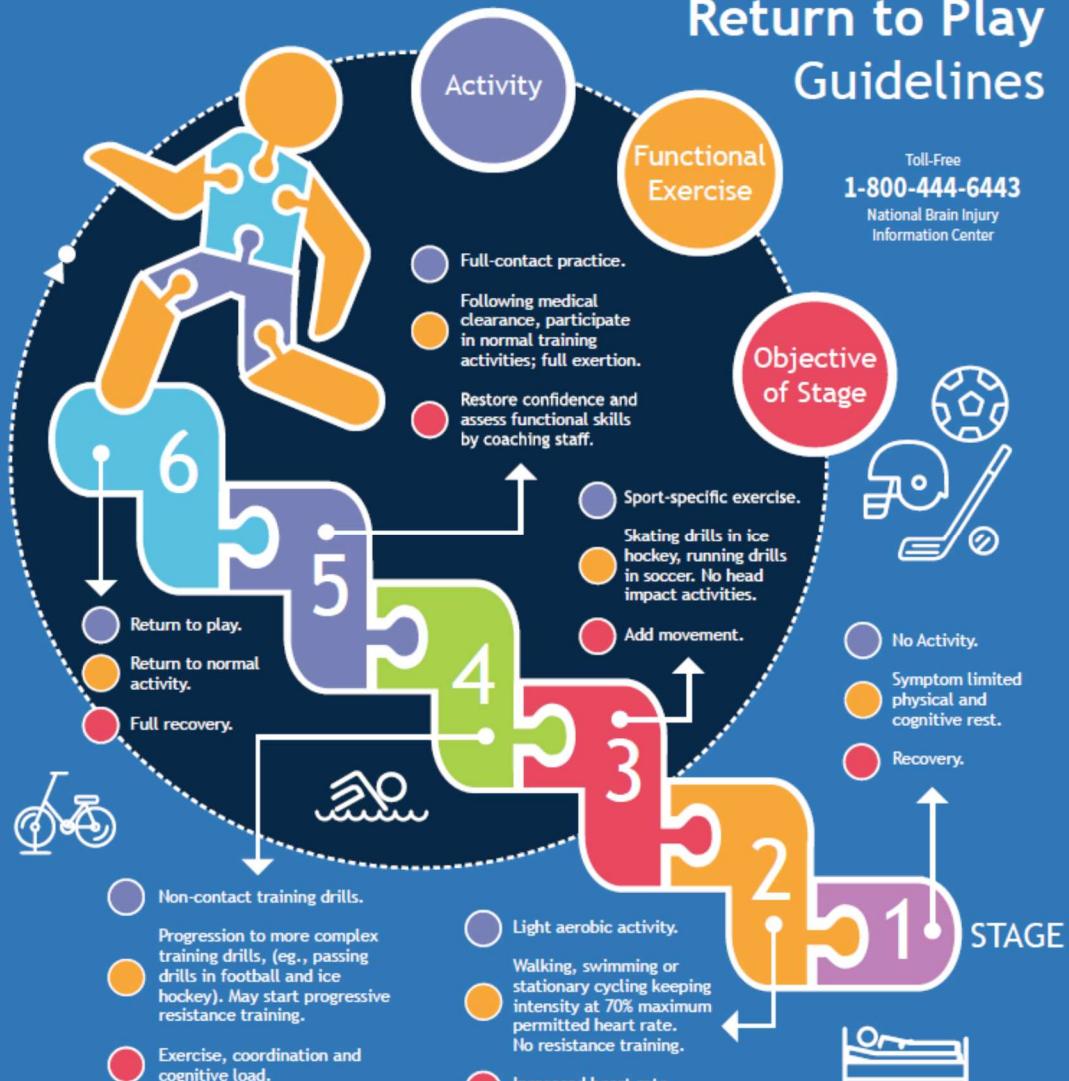
 **BRAIN INJURY  
ASSOCIATION  
OF AMERICA**

[www.biausa.org](http://www.biausa.org)

©2020 Brain Injury Association of America

# The Graduated Return to Play Guidelines

Toll-Free  
**1-800-444-6443**  
National Brain Injury  
Information Center



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## BDPEDICONSTIPATIONDISCHARGE

Your child has been evaluated in the emergency department today for abdominal pain. Their evaluation was not suggestive of any emergent condition requiring medical intervention at this time, however, some abdominal problems make take more time to appear. Therefore, it is important for you to watch for any new symptoms or worsening of the current condition.

Your imaging was consistent with constipation. You had a bowel movement in the emergency department after an enema. We have prescribed a medication which you should take for the constipation. \*\*\*

Please follow up with your pediatrician regarding this visit.

Return to the Emergency Department immediately if your child has worsening abdominal pain, persistent fevers of 100.4°F or greater, recurrent vomiting, blood in vomit, blood in stool, dark tarry stool, or any other concerning symptoms.

**BDPEDICROUPDISCHARGEINSTRUCTIONS**

@NAME@ was seen in the emergency department for shortness of breath. Your child has been diagnosed with croup. This is usually caused by a viral infection of the upper airways and voice box (larynx). You may have noticed that your child had a rough, barking cough. This is one of the most common signs of croup. You may also have noticed a wheezing and rattling sound (stridor) when your child took a breath. It can be scary for parents and children. Your child may be given a medicine that eases swollen airways. Here are instructions for caring for your child at home.

**Home care**

- Keep your child as calm as possible. This may help them breathe better. Offer their favorite toy or book, sing their favorite song, or reassure them with words.
- Make sure your child is drinking enough fluids. This helps prevent dehydration.
- Cool or moist air can help your child breathe easier:
  - Use a cool-air humidifier or vaporizer. Turn it on next to your child's bed during and after an attack.
  - During an attack, have your child sit up and breathe in the humidified air.
  - Take your child into the bathroom, close the door, and steam up the room by running hot water through the shower. Sit with your child in the bathroom, not in the shower. Hold your child to reduce the chance that they may get too close to the hot water and get burned.
  - Take your child outside to breathe in the cool night air. Wrap your child in warm clothing or blankets if the weather is chilly.
- Don't let people smoke in your home. Smoke can make your child's cough worse.
- Sleep in the same room as your child so you are quickly available if the croup gets worse during the night.
- A fever of 100°F ( 37.7°C) to 101°F ( 38.3°C) is common in a child with croup:
  - Follow your healthcare provider's advice on treating your child's fever.
  - Before giving your child any medicine, read the label. Make sure you are giving the right dose for their age and weight. Never give a child adult medicines.
  - Use over-the-counter (OTC) medicines such as ibuprofen or acetaminophen to reduce your child's fever, if advised by the provider. But never give ibuprofen to children younger than 6 months old.
  - Don't give OTC cough and cold medicines to a child younger than 6 years old unless directed by the provider.
  - Don't give aspirin to a child or teen unless directed by the provider. Taking aspirin can put your child at risk for Reye syndrome. This is a rare but very serious disorder. It most often affects the brain and the liver.

Please follow-up with your pediatrician in the next few days for reevaluation.

Please return for care if you notice a whistling sound (stridor) because ladder with each breath, have stridor while resting, having difficulty swallowing or drooling, sucking in of the skin around the ribs 1 breathing (retractions), severe cough, pale blue-colored skin, unable to speak cramping sounds, or any other new or concerning symptoms.

**BDPEDIDCTEXT**

Return precautions reviewed, with patient and family at bedside, including any new or concerning symptoms. Additional verbal discharge instructions were given and discussed with the patient and family. Advised pediatrician follow-up in 1 to 2 days. Family in agreement with plan.

**BDPEDIDDDXTODDLERFRACTURE**

- Musculoskeletal injury to left lower extremity. Suspect tibial injury but differential also includes injury to foot, femur.
- No evidence of any nonaccidental injury.
- No evidence of other injuries on exam.
- Based on history, lower concern for causes of atraumatic bone and joint pain.

BDPEDIDKACALC

[https://www.icloud.com/numbers/037M0oC\\_WSIHjJokz797hVcsg](https://www.icloud.com/numbers/037M0oC_WSIHjJokz797hVcsg)

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**BDPEDIEPIDYMITISDISCHARGEINSTRUCTIONS**

You have been evaluated in the Emergency Department today for right testicular pain. Your evaluation, including ultrasound, suggests that your symptoms are due to epididymitis.

We tested your urine which was not consistent with infection but a urine culture is still pending.

Please continue with scrotal support, acetaminophen and ibuprofen as needed for pain control, and short periods of cold therapy to manage symptoms as needed.

Please follow up with your pediatrician within two days. You should also follow-up with the urologist.

Return to the Emergency Department if you experience any fever, chills, worsening pain, nausea, vomiting, penile discharge, or any other new or concerning symptoms.

---

**BDPEDIFEVERUNKNOWNDISCHARGEINSTRUCTIONS**

@NAME@ was seen in the emergency department for fever. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*","You were evaluated, and your imaging showed \*\*\*","You were evaluated, and \*\*\*","You were evaluated and you were found to have \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your exam was reassuring","You were evaluated, and your work up was reassuring"}. You should follow up with your pediatrician in the next few days to discuss further evaluation.

**Please seek immediate medical attention if you develop any difficulty breathing, behavior changes, inability to tolerate feeding, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

**Over-The-Counter Pain Medicine Dosing Chart**

**Acetaminophen (Tylenol-type medicine)**

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

**Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever

Should NOT be used for infants under 6 months age

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Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

#### BDPEDIFRACTURE

@FNAME@ was treated in the emergency department for a broken or misaligned bone.

#### If a splint or cast was placed:

1. Do not let it get wet. You must cover it and seal it with a plastic bag when bathing or showering. It might be easier to give sponge baths until the cast is taken off.
2. If the cast gets wet, use a hair dryer on the cool setting for 5 to 10 minutes. Repeat as needed.
3. If the cast gets too wet and will not dry, call the orthopedic office. Your child may need to have a new one put on.

For the first few days, the fingers or toes on the injured limb may be swollen. To help the swelling go down:

1. Put cold packs over the injury (place a cloth in between the splint and the cold pack).
2. Keep the hurt arm or leg raised above the level of the heart as much as possible.
  - Fingers must be higher than your child's elbow.
  - Toes should be higher than the level of their nose.

\*\*\* If your child required sedation, they may seem more tired for the next 12 hours. Please watch them closely.

- The first meal after sedation should be something light. No spicy foods.
- Do not allow your child to participate in physical sports.
- It is okay for them to take any prescribed medications.

#### Over-The-Counter Pain Medicine Dosing Chart

##### **Acetaminophen (Tylenol-type medicine)**

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	

72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab
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**Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever  
Should **NOT** be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

**BDPEDIHXFAMILY**

History obtained with assistance of family as described in HPI given patient's age.

**BDPEDIINTUSSDISCHARGEINSTRUCTIONS**

Your child was seen in the emergency department for intussusception. This is a medical problem in which the intestine slides inside and other parts similar to the way that a telescope collapses. This can cause blood flow to the intestines to become blocked which can cause damage if not treated.

In the emergency department you were seen by surgery and had an air enema with special x-rays to help reduce the issue.

You can have your child go back to normal activity as soon as they feel up to it. Intussusception can sometimes come back as you should watch for signs of abdominal pain that gets worse, vomiting, crying spells without a cause and drawing the legs up towards the belly. You can continue with normal diet.

Please follow-up with your patient's pediatrician.

These return for care if you have any fever, worsening belly pain, returning fussiness, fatigue, dark mucus-like stools, pale skin, or any other new or concerning symptoms.

**BDPEDINVDDISCHARGEINSTRUCTIONS**

Your child has been evaluated in the emergency department today for nausea, vomiting and diarrhea. Their evaluation was not suggestive of any emergent condition requiring medical intervention at this time, however, some abdominal problems may take more time to appear. Therefore, it is important for you to watch for any new symptoms or worsening of the current condition.

In the emergency department, the patient was able to stay hydrated by drinking fluids.

Vomiting with watery diarrhea requires oral rehydration solutions. If your child refuses oral rehydration solutions, you can use "half-strength" Gatorade or "half-strength" apple juice made by diluting equal

amounts with water. After 4 hours without vomiting, you can increase the amount of fluids. After 8 hours without vomiting, you can return to regular fluids and begin gradually adding back solid foods. It is okay to return to completely normal diet in about 24 to 48 hours.

Please follow up with your pediatrician regarding this visit. \*\*\* Zofran

Return to the Emergency Department immediately if your child has worsening abdominal pain, persistent fevers of 100.4°F or greater, recurrent vomiting, blood in vomit, blood in stool, dark tarry stool, or any other concerning symptoms.

#### BDPEDIOSBEHAVIOR

Behavior: {Blank single: 19197::"normal", "inconsolable", "sleeping less", "more active", "fussy", "less responsive", "sleeping poorly", "less active", "crying more", "sleeping more"}; Intake amount: {Blank single: 19197::"eating and drinking normally", "drinking less than usual", "eating less than usual", "refusing to eat or drink"}; Urine output: {Blank single: 19197::"normal", "increased", "decreased", "absent"}; Last void: {Blank single: 19197::"less than 6 hours ago", "6 to 12 hours ago", "13 to 24 hours ago", "more than 24 hours ago"}.

#### BDPEDIURIDISCHARGEINSTRUCTIONS

@NAME@ was evaluated in the emergency department for an illness including {Blank single:19197::"respiratory symptoms and a fever.", "respiratory symptoms.", "fever.", "cough."} We evaluated you and feel that it is safe to discharge you home to follow up with your pediatrician. You {Blank single:19197::"had viral testing performed in the emergency department that was negative", "had viral testing performed in the emergency department that was positive for \*\*\*"}.

Please follow up with your pediatrician in the next few days.

Please return to the emergency department if your child experiences persistent fever despite medications, severe weakness or lethargy, not acting appropriately, difficulty swallowing or taking fluids by mouth, chest pain, shortness of breath, persistent vomiting, abdominal pain, persistent diarrhea, bloody / black tarry stools, pain with urination or decrease in urine production, lack of improvement over the next 1-2 days, or other concerning symptom(s).

The best ways to prevent spread of infections are:

- 1) Wash your hands frequently
- 2) Cough into your elbow
- 3) Sanitize your hands and surfaces in your home frequently
- 4) If possible, have sick family members use a separate bedroom where he they can recover without sharing immediate space with others
- 5) Wear a face mask when you are around close contacts
- 6) As much as possible, avoid household members who may be at increased risk of complications from infections (.e.g., people >65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions).

#### Over-The-Counter Pain Medicine Dosing Chart

##### Acetaminophen (Tylenol-type medicine)

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
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12-17 lbs	6-8 kg	2 mL	½ supp				
18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

### **Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever  
Should **NOT** be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

### **BDPEDIVACCINESUTD**

Patient {Blank single: 19197::"is", "is not"} up-to-date on routine childhood vaccines.

### **BDPENDINGCDU**

Pt was signed out by prior ED team as accepted for CDU. Per the prior attending's report, there were no active ED issues requiring evaluation, re-evaluation, management or follow-up. Therefore, I was not directly involved in the patient's care.

### **BDPLANACSEPARATION**

Plain film imaging.

Pain control with \*\*\*.

There is no skin tenting and distal neurovascular exams are appropriate. Patient's symptoms not typical for other emergent conditions such as shoulder dislocation, arterial injury.

Initial imaging notable for AC separation grade \*\*\* and will be discharged home.

Patient ordered for sling, range as tolerated.

Patient discharged with strict return precautions and plan to follow up in ortho clinic.

### **BDPLANAKI**

- Daily BMP.
- Avoid nephrotoxic agents.
- Renally dose medications.
- Strict I/Os.

## **BDPLANALLERGICREACTION**

Vitals monitored while in emergency department. @BDTELEPULSEOX@

Antihistamine.

Considered giving epinephrine, but ultimately not indicated due to no concern for anaphylaxis at this time.

Considered steroid course but also not indicated at this time.

Discussed avoiding potential exposures including make-up, soaps, detergents, new foods.

Will continue antihistamine at home.

Anticipate discharge home with strict return precautions and follow-up with PCP in 1 to 2 days.

---

## **BDPLANAPX**

Observe on telemetry and pulse oximetry.

{Blank multiple:19196::"Patient already received epinephrine and Benadryl at \*\*\*.", "0.3-0.5mg IM Epi in ED", "Solu-Medrol (methylprednisolone) 125mg IV", "Benadryl 25-50 IV", "Pepcid (famotidine) 20mg IV", "IVF", "Zofran 4mg IV".}

After observation, anticipate discharge home with EpiPen, steroids.

{Blank multiple:19196::"Discharge with new EpiPen script.", "Patient already has unused EpiPen."}

---

## **BDPLANASTHMA**

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

Stacked nebs, steroids, magnesium.

Will send the RVP and chest x-ray.

I-STAT VBG, basic labs.

Plan for reevaluation, attempt to space nebs. Dispo pending response.

---

## **BDPLANCHESTPAIN**

In the emergency department, patient monitored on telemetry and pulse oximetry due to increased likelihood of arrhythmia depending on etiology of chest pain.

Basic labs, LFTs, lipase.

Chest x-ray. ECG.

Serial troponins.

Dispo per chest pain pathway.

---

## **BDPLANCOPDE**

Monitor on telemetry and pulse oximetry, supplemental oxygen based on COPD goal saturations.

Stacked nebs, steroids, reevaluation and space as able.

Ambulatory pulse ox trial.

Initial workup with VBG, basic labs, troponin, proBNP.

Chest x-ray mini RVP for infectious workup.

Dispo pending reevaluation and spacing.

---

## **BDPLANDKA**

Basic labs, serial blood sugars.

IV fluid hydration.

POC glucose monitoring (Q1H), BMP (Q2H), blood gas, UA, serum ketones, CBC, LFTs / lipase, infectious workup (lactate/blood cultures, CHEST X-RAY)\*\*\*, IVF, IV Insulin therapy, serial reassessment, admission for treatment of hyperglycemia.

Initial K: \*\*\*, initial gap: \*\*\*.

Will place in line for ICU pending gap closure.

---

## **BDPLANETOHWITHDRAWAL**

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

Periodic FSBG to monitor for hypoglycemia.

BMP, electrolytes.

Withdrawal management: {Blank multiple:19196::"phenobarb load", "CIWA protocol with PRN phenobarb", "CIWA protocol with PRN benzos"}.

Electrolyte repletion.

---

#### BDPLANEXPOSURE

Will sent post-exposure labs as below. Will send hCG.\*\*\*

Area extensively cleaned with soap and water and rinse at bedside.

Vaccines:

HBV: \*\*\*

HIV: Given risk profile based on patient's exposure, will have risk-benefit discussion with patient about postexposure prophylaxis. Based on that discussion, the patient has decided to \*\*\*.

Patient will follow up with \*\*\*.

---

#### BDPLANFEVERUNKNOWNORIGIN

Antipyretics with {Blank single: 19197::"acetaminophen", "acetaminophen and ibuprofen"}.

Follow AAP guidelines as detailed below.

{Blank single: 19197::"@BDIMAGEFEVER08TO21DAYS@", "@BDIMAGEFEVER22TO28DAYS@", "@BDIMAGEFEVER29TO60DAYS@"}.

---

#### BDPLANHYPERGLYCEMIA

Basic labs, serial blood sugars.

IV fluid hydration.

Given the current history & physical, including current glucose level, the current presentation is consistent with acute, asymptomatic hyperglycemia. Plan to treatment supportively. No indication for further infectious workup at this time.

Will give patient his p.m. dose of \*\*\*

Ambulation trial and reevaluation afterward.

Anticipate PCP follow-up and referral to diabetes clinic afterward.

---

#### BDPLANHYPONATREMIASEVERE

Monitor patient on telemetry and pulse oximetry given risk of decompensation.

Workup: Basic labs, serum osmolality, serum uric acid, TSH, urinalysis, urine sodium/electrolytes, urine uric acid, urine urea, urine creatinine, urine osmolality.

Monitor I's and O's. Patient currently producing urine.

Frequent BMPs. Every \*\*\* hours neurochecks.

Consider 3% or DDAVP pending nephrology consult.

Anticipate ICU versus floor admission depending on sodium level.

---

#### BDPLANICUPOSTARREST

##### **Neuro:**

# Postarrest, TTM protocol

# Intubated, sedated

- Continue Versed and fentanyl for RASS goal -5.
  - TTM protocol: Initiated phase 1 (cooling) from emergency department on 6/27.
  - Buspirone 30 mg every 8 hours per TTM protocol.
-

**Cardiac:**

- # Cardiac arrest, postarrest care
- # Likely ACS, coronary artery disease
- # Shock, cardiogenic/postarrest with evidence of endorgan dysfunction

Coronary:

- Continuous cardiac monitoring.
- Aspirin, P2 Y12 load.
- Heparin gtt. ISO ACS.
- Holding home medications.
- Risk factor screening: TSH, A1c, lipid panel.
- TTE post arrest.
- Trend troponin till peak.

Preload:

- Defer diuresis for now in the setting of shock.
- Daily I's and O's, weights, CVP monitoring.

Afterload:

- Continue Levophed max concentrate with goal MAP 60 to 70 mmHg.

Contractility:

- Deferred contractility agents.

GDMT:

- Hold home medications as above.

Rhythm:

- Status post V-fib arrest.

Devices/monitoring:

**Pulm:**

# Intubated and sedated

Patient intubated in the emergency department for airway protection. GCS 3 at the time. No preferential movements noted prior to paralysis and intubation.

@VENTSETTINGS@

- Continue ventilation per TTM protocol, wean when able.

**GI:**

**Renal:**

# ARF

Baseline serum creatinine 2.7. Initial serum creatinine postarrest 1.10.

@BDPLANAKI@

**ID:**

---

**Endocrine:**

- ICU glycemic protocol.

**Heme:**

# Leukocytosis

Leukocytosis on arrival with WBC 15.5 postarrest.

**Other:**

---

**BDPLANKIDNEYSTONE**

CBC, BMP, CTAP, UA, HCG \*\*\*, reassess. \*\*\* CXR if c/f PNA.

Analgesia with toradol.

\*\*\* Stable infected stone: Ciprofloxacin 500mg PO BID x 7 days

\*\*\* Septic infected stone: Ceftriaxone 1g IV and admission to Medicine

---

**BDPLANPEDIASTHMA**

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint. Will continue to re-evaluate and monitor patient given risk for worsening respiratory distress/failure due to bronchoconstriction already noted on exam.

Inhaled medications: {Blank multiple:19196::"Duoneb x 3 back-to-back", "Continuous"}

Steroids: {Blank single:19197::"Dexamethasone 0.6mg/kg PO or IM (max 16 mg)", "Solu-Medrol 2 mg/kg IV"}

Adjunctive medications: {Blank multiple:19196::"Magnesium sulfate 50 mg/kg (max 2 g) w/ 20ml/kg NS bolus", "Terbutaline 10 mcg/kg IV or SQ PRN q15-30min (max of 3 doses)", "Epinephrine 0.01 mg/kg IM", "None"}

Oxygen therapy and ventilation: {Blank single:19197::"N/A", "NC", "NIV"}

May need admission to the hospital if no adequate response to staked nebs. Will attempt to stabilize and reassess.

Evaluation and management considered but not performed (medications, diagnostics or observation/admission): Considered admission, but medical evaluation is reassuring and there is no indication for hospitalization at this time. and Considered CXR, but ultimately not indicated due to symmetric breath sounds with low c/f obstruction or lobar PNA.

---

**BDPLANPEDIBRONCHIOLITIS**

@BDTELEPULSEOX@

Supportive care and antipyretics.

Mini RVP. Symmetric exam with history suggesting viral illness, and thus CXR not indicated at this time.

Anticipate discharge home based on re-evaluation after observation after supportive care and PO trial to ensure adequate home hydration.

Additional MDM on reevaluation listed in ED course below. In summary, patient found to be {Blank single: 19197:: "RSV+", "COVID+", "FLU+", "with neg RVP"}. Patient with reassuring reevaluation in the emergency department with minimal work of breathing. Has been tolerating p.o. Will plan to discharge home with plan to follow-up with pediatrician. Strict return precautions discussed and family is agreeable with plan.

---

**BDPLANPEDIBRUE**

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department

given potential adverse effects of medication and/or decompensation given their chief complaint.  
Will check ECG and FSBG.

No respiratory symptoms. At baseline at this time.

{Blank single:19197::"Will observe in the emergency department and anticipate close pediatrician follow up for low risk BRUE.", "Will admit for observation given high risk BRUE with \*\*\*."}

#### BDPLANPEDI CROUP

Initial presentation consistent with {Blank single:19197::"mild","moderate","severe"} croup.

Patient monitored on {Blank multiple:19196::"telemetry","pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

Will give dexamethasone and racemic epinephrine. Plan for 3-hour reevaluation.

*Dexamethasone (0.15-0.6mg/kg PO/IV/IM, max 10mg) and rac epi (0.05 mL per kg, max dose: 0.5 mL).*

Avoiding albuterol as contraindicated with croup.

Mini RVP sent.

Chest x-ray and soft tissue neck x-ray. \*\*\* Consider insp/exp or lat decub films to rule out foreign body.

#### BDPLANPEDI FEBRILE WELL APPEARING 8 TO 21

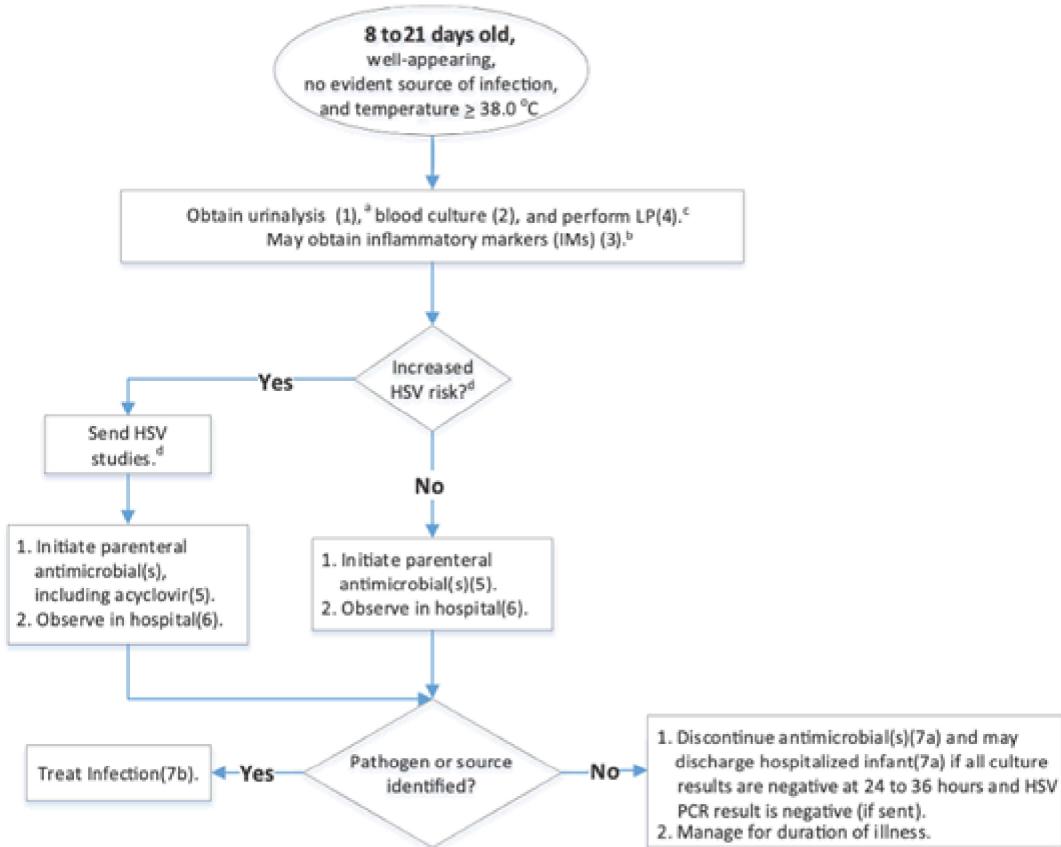
Antipyretics PRN with {Blank single:19197::"acetaminophen","acetaminophen and ibuprofen"}.

Will consider this a true fever at home despite not being rectal temp.

Follow AAP guidelines as detailed below. Will check urinalysis, blood culture, inflammatory markers, and perform LP.

Patient is not at elevated HSV risk and mother with negative HSV.

Anticipate starting antibiotics (amp/gent) and admitting for further observation.



#### BDPLANPEDIHYPOTHERMIA NEONATE

Patient monitored on {Blank multiple:19196::"telemetry","pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

Passive rewarming. \*\*\* Reassuringly, patient has so far been maintaining temperature here and is otherwise

well-appearing.

Will start with glucose, passive rewarming.

Basic infectious workup including labs, cultures, urine, chest x-ray, CRP, TSH \*\*\*. Will check serum bilirubin as part of lab workup.

Consider LP.

---

#### BDPLANPEDIMVC

Patient with reassuring exam here, tolerating p.o.

Given lack of severe mechanism, GCS change or other evidence of head or other trauma, will plan for observation, p.o. challenge, reassurance and plan for follow-up with pediatrician.

---

#### BDPLANPEDIMYOSITIS

Will check mini RVP.

BMP and CK.

NS bolus. Continue fluid hydration, analgesia, avoid NSAIDs while pending labs.

Re-evaluation.

Anticipate d/c home with return precautions and pediatrician follow-up.

---

#### BDPLANPEDISICKLECELLFEVER

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint. {Plan by System (Optional):46705}

Given that I have concern for severe exacerbation of chronic illness related to infection or acute chest syndrome, patient ordered for CBC, CMP, type and screen, reticulocyte count, blood cultures, chest x-ray. No evidence of any musculoskeletal pain requiring further imaging.

Empiric Rocephin.

Follow-up pain plan as needed.

Symptomatic management of fever.

Discuss with hematology after workup above.

Dispo pending workup.

---

#### BDPLANPEDITODDLERFRACTURE

Ibuprofen for pain control.

Initial plain film imaging.

Anticipate orthopedic consult pending imaging. If imaging negative, would likely involve orthopedics anyway for casting in setting of potential toddler's fracture.

---

#### BDPLANPEDIURI

Antipyretics and symptom control with {Blank multiple:19196::"acetaminophen", "ibuprofen", "ondansetron"}.

Will send mini RVP.

Evaluation and management considered but not performed (medications, diagnostics or observation/admission): Considered CXR, but ultimately not indicated due to duration of symptoms, exam, history more consistent with viral etiology than bacterial pneumonia.

Reassessment, PO trial.

Patient monitored on pulse oximetry while in the emergency department given potential decompensation given their chief complaint.

Anticipate discharge home pending above.

---

#### BDPLANSEIZURENEW

Monitor patient on telemetry and pulse oximetry given potential for decompensation and respiratory depression in the setting of recently received seizure medications.

FSBG. ECG. Basic labs, CBC and CMP to be used for neurology follow-up.

---

CT head without contrast.

{Blank single:19197::"hCG not indicated.", "hCG"}

{Blank single:19197::"Lumbar puncture not indicated, the patient is not immunocompromised."}

If patient returns to baseline mental status and does not have evidence of structural brain disease on CT head, will plan to discharge home with urgent neurology follow-up.

---

#### BDPLANSEPSIS

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

{sepsisexam:32971}

Fluid resuscitation: I have ordered {Sepsis IVF volume:41194} of IV fluids for this patient, rather than 30ml/kg because this patient has {Reason not Giving 30ml/kg:41195}.

Pressors: {Vasopressors started for Septic Shock:34082}

Antimicrobials: {Antibiotics in Sepsis:34254}

Source control: {Blank single:19197::"N/A", "IR consult", "surgery consult", "foley exchange", "line exchange", "bedside I&D"}

Workup: {Blank multiple:19196::"Labs", "I-STAT lactate w/ VBG", "urine", "CXR", "ECG", "pan-scan ordered due to concern for additional source and limited history", "CTAP" }

Anticipate dispo to {Places; hospital units:60085}.

---

#### BDPLANSTEMI

Patient placed on monitor, with telemetry and pulse oximetry and pads.

ECG showing \*\*\* STEMI. Cath lab activated.

STEMI labs.

Limited point of care echo performed during STEMI evaluation without significant findings.

IVF ordered for pre-load dependent MI. \*\*\*

Ticag, heparin bolus. Received ASA load by EMS.

Zofran ordered for nausea. \*\*\*

---

#### BDPLANSTROKEACTIVATION

Code stroke activation.

Initial code stroke labs and imaging. Initial infectious workup.

Code stroke head imaging notable for \*\*\*.

Follow-up neurology recommendations.

---

#### BDPMHSEEHPI

See HPI for pertinent past medical history.

---

#### BDPREVATTENDING

{Current, Previous, wildcard:1601111125}

---

#### BDREEVALMVC

patient with imaging notable for \*\*\*. Patient remained hemodynamically appropriate with no focal neurologic exam. Patient reevaluated and is not altered and has no distracting injury. Patient with stable gait and tolerating p.o.\*\*\* Follow-up plan with\*\*\* discussed. Otherwise expect self-limiting course or pain, patient understands that pain may get worse in the next 24 hours. Discussed that some injuries from similar incidents can present in delayed fashion the patient given strict return precautions and instructions for follow-up care.

---

#### BDRISKLEVEL

{Complexity of Problems Addressed at the Encounter:47059}

---

**BDRROS**

See HPI. A 10-point review of systems was performed and negative except for as noted in HPI.

---

**BDSIGEVENTNOTE****Significant Event Note**

@TODAYDATE@ @NOW@:

\*\*\*

@SIG@

---

**BDSIGNEDOUT**

The patient has remained hemodynamically stable during stay here in the ED. Signed out to oncoming team, pending completion of workup and/or reevaluation.

---

**BDSIGNEDOUTEMH**

Patient received in signout from prior provider team. On my reevaluation, patient in no acute distress. Significant additional ongoing management listed in ED Course below. Patient continues to await EMH evaluation.

---

**BDSIGNOUT**

@AGE@ @SEX@ with PMH \*\*\*.

P/w \*\*\*.

\*\*\*

Exam notable for \*\*\*.

Workup notable for \*\*\*.

Plan:

- \*\*\*
- 

**BDSIGNOUTADMIT**

I received this patient in signout. This patient was admitted by the prior resident prior to me assuming care of this patient.

---

**BDSIGNOUTDC**

I received this patient in signout. This patient was discharged per the prior resident prior to me assuming care of this patient.

---

**BDSIGNOUTHO**

@HNDSUMMARY@

Plan:

@HNDDTODO@

Additional MDM on reevaluation listed in ED course below. In summary, \*\*\*.

---

**BDSINUSPRECAUTIONS**

1. DO NOT blow your nose for at least two weeks.
-

2. DO NOT forcibly spit for one week.
  3. DO NOT smoke or use smokeless tobacco; smoking greatly inhibits the healing process, especially in the sinuses.
  4. Sneeze with your MOUTH OPEN. If the urge to sneeze arises, do not sneeze through your nose and avoid pinching nostrils.
  5. Drink without a straw for one week.
  6. Avoid swimming for one month and strenuous exercise (e.g. heavy lifting) for one week.
- 

#### BDSOBERREEVAL

@AGE@ @SEX@ presents for alcohol intoxication. Patient has a reassuring exam without any signs of trauma and denies any physical complaints. On re-evaluation, the patient is tolerating PO and ambulating without difficulty. Patient discharged home in stable condition. Given instructions/indications for return.

---

#### BDSYNCOPEMIDRISK

---

#### BDTELEPULSEOX

Patient monitored on {Blank multiple:19196::"telemetry", "pulse oximetry"} while in the emergency department given potential adverse effects of medication and/or decompensation given their chief complaint.

---

#### BDTOXCONSULTNOTE

@CERMSGREFRESH(745284:35000011,,,1)@

##### Toxicology Initial Consult Note

@CERMSGREFRESH(745284:35000012,,,1)@

**CONSULT TYPE:** {ED TOXICOLOGY CONSULT TYPE:46030}

@UMMHCEDCONSULTREASON@

@BRIEFCONSULTTEXT@@@HPICCBEGIN@@@UMMHCIIPHPI@

@HPICCEND@@@SUBJECTIVEBEGIN@

@UMMHCIPCONSULTROSTREATMENT@

@EDMEDADMINS@

@UMMHCIIPHPPMHPSH@

@UMMHCIPCONSULTMEDALG@

@UMMHCIIPHSH@

@OBJECTIVEBEGIN@@@UMMHCIHPVS@

@UMMHCIHPPE@

@BDTOXEXAM@

@UMMHCIPHPLAB@

@UMMHCIPCONSULTOTHERDATAREVIEW@

@CERMSGREFRESH(745284:35000022,,,1)@@ASSESSMENTPLANBEGIN@

@UMMHCIHPASSESSMENTPLAN@

@CERMSGREFRESH(745284:35000023,,,1)@@UMMHCIPCONSULTGLOBALPLANOFCARE@

@UMMHCIHPFOOTER@

#### BDTOXEXAM

Pupils: {PUPILS ASSESS:21299}, {Blank single:19197::"reactive", "sluggish", "fixed"}

Nystagmus: {Nystagmus findings:13855}

Respirations: {Blank single:19197::"tachypnea", "bradypnea", "hyperventilation", "hypoventilation", "apnea", "ventilated"}

Bowel sounds: {BOWEL SOUNDS PMR:29077}

Skin: {Blank single:19197:"WNL", "wet", "dry"}

DTR: {Reflexes absent/diminished/normal/increased:32195}

---

Clonus: {CLONUS RESPONSE:29149}

BDTOXHANDOFFGEN  
@ROOMBED@  
@NAME@ @MRN@  
@PATIENTSUMMARY1@  
@EDHNDTTODO@

BDTRANSLATEDDISCLAIMER

The text below was translated with the help of online dictation software. Please excuse any errors.

BDVBG

@1(phvenpoc)@ / @1(pco2venpoc)@ / @1(po2venpoc)@ / @1(hco3venpoc)@

BDXARELTOTRIAL

Here's your XARELTO withMe  
Trial Offer Card  
Free 30-day Trial Offer

**Xarelto withMe**



## Free 30-day Trial Offer

**BIN:** 610020

**GROUP:** 99992170

**ID:** 26149468811

**PCN:** If required use "PDMI"

Please read the full Prescribing Information, including Boxed Warnings, and Medication Guide for XARELTO®, and discuss any questions you have with your doctor.

PROGRAM REQUIREMENTS APPLY.

BIN: 610020 GROUP: 99992170

ID: 26149462411

PCN: If required use "PDMI"

Please read the full Prescribing Information, including Boxed Warnings, and Medication Guide for XARELTO®, and discuss any questions you have with your doctor.  
PROGRAM REQUIREMENTS APPLY.

Please read the full Prescribing Information, including Boxed Warnings, and Medication Guide for XARELTO®, and discuss any questions you have with your doctor.

Pharmacists: Please see below for processing instructions.  
Non-Transferable. Patient must submit a valid prescription.

Patient: Present this offer along with a signed 30-day prescription for XARELTO® to your pharmacist. Terms expire at end of each calendar year. The program may change or end without notice, including in specific states. To be eligible for the XARELTO withMe 30-day Trial Offer, you must have been prescribed XARELTO®, except if you are taking XARELTO® 10-mg tablet or 1 mg/mL oral suspension. By using the XARELTO withMe Trial Offer, you confirm that you have read, understood, and agree to the program requirements, which can be found in the XARELTO withMe Trial Offer Brochure. Patients enrolled in a Medicare Part D plan are eligible for this free 30-day trial offer but may not submit a claim for the costs paid by this program to count toward true out-of-pocket (TrOOP) costs. For additional questions, please call 888-XARELTO (888-927-3586), Monday–Friday, 8:00 am–8:00 pm ET. Pharmacist: Submit claim using BIN: 610020. You will be reimbursed for the face value offer plus a dispensing fee, provided you and the customer have complied with the terms of this offer. For pharmacy processing questions, please call 866-562-6187, Monday–Sunday, 8:00 am–12:00 am ET. Conditions of Use: Limit one trial offer for a 30-day supply of XARELTO® per lifetime; no refills. No purchase required. The selling, purchasing, trading, or counterfeiting of this card is prohibited by federal law, and such activities may result in imprisonment for not more than 10 years or fines not more than \$250,000, or both. Claim shall not be submitted to any public or private third-party payer or any federal or state healthcare program for reimbursement. OFFER CANNOT BE COMBINED WITH ANY OTHER COUPON, DISCOUNT, PRESCRIPTION SAVINGS CARD, FREE TRIAL, OR OTHER OFFER. Offer good only in the United States and its territories. Void where prohibited, taxed, or limited by law.

---

**BEDEXAMPEDIRSV**  
{bdmdmexams:46371}

---

**BEDEXAMPEDITRAUMA**  
no occipital or parietal scalp hematoma, mental status at baseline, no ecchymosis or signs of trauma, soft nontender abdomen, no hemotympanum and normal-appearing TMs, moving all extremities appropriately with no apparent pain during range of motion, active and well-appearing

---

**BJOBLABORPROG**

**Labor Progress Note**

**Name:** @NAME@  
**MRN:** @MRN@  
**DOB:** @DOB@

S: {Blank single:19197::"Strip check only, patient not seen.", "Patient comfortable.", "Patient uncomfortable.", "Patient feeling rectal pressure.", "\*\*\*\*"}

**OBJECTIVE: VITALS:** @VSRANGES@

**FHT:** \*\*\* baseline, \*\*\* variability, \*\*\* accels, \*\*\* decels; Category \*\*\* tracing

**Toco:** ctx q\*\*\* mins

---

\*\*\*labor course

**ASSESSMENT/ PLAN:**

@NAME@ is a @AGE@ year old @GRAVIDAPARA@ at @GA@, {Blank single:19197::"here in active labor", "here for IOL for \*\*\*", "here for IOL at term"}.

- Cat {Blank single:19197::"I", "II", "III"} FHT. {Blank single:19197::"FSE/IUPC", "FSE/TOCO", "EFM/IUPC", "TOCO/EFM"} for monitoring.
- {Blank single:19197::"Expectant management for now", "Active management with \*\*\*", "Active management with pitocin, currently at \*\*\*"}
- Anticipate NSVD.

Plan of care discussed with Dr. \*\*\*

@SIG@  
@TODAYDATE@

---

**BOXES**



**DVBICUHOSPCOURSE**

**ICU Course by System from @ADMITDT@ to @TODAYDATE@**

**Neuropsych:**

**Cardiovascular:**

**Pulm:**

**GI:**

**Renal/GU:**

**ID:**

**Endocrine:**

**Heme/Onc:**

---

**MSK/Skin:**

**Other:**

---

DVBICUPROG

## CRITICAL CARE PROGRESS NOTE

### **PATIENT SUMMARY**

@PATIENTSUMMARY@

@RRHLOS@

### **SUBJECTIVE**

\*\*\*

### **24 Hour Interval History:**

@INTERVALHISTORY@

### **OBJECTIVE**

@VSRANGES@

@IOBRIEF@

### **Physical Exam:\*\*\***

Constitutional: NAD, Oriented to person, place, and time, Well-developed, Well-nourished

HEENT: Normocephalic, atraumatic, MMM

Neck: Normal ROM, Neck supple, No JVD present

Cardiovascular: RRR, No gallop, rub, or murmurs, intact distal pulses

Pulmonary/Chest: CTAB, No wheezes, rales, or crackles, Effort normal

Abdominal: Soft, +BS, nontender, non-distended, No rebound or guarding

Musculoskeletal: Normal ROM, No pedal edema, No tenderness or deformity

Neurological: A&O x3, no gross deficits

Skin: Warm and dry, No rash noted, Non diaphoretic, No erythema,

Psychiatric: Normal mood, behavior and affect, Short and long term memory appear intact

### **Lines/Drains/Airway:**

@LDALINES@

@VENTSETTINGS@

### **Medications:**

@CMEDSIP2@

@FLUIDSGROUPER@

### **Laboratory Data:**

@LABRCNTIP(wbc:7,hgb:7, hct:7,PLT:7)@

---

@LABRCNTIP(NA:7,K:7,CL:7,co2:7,bun:7,creatinine:7,glucose:7)@  
@LABRCNTIP(albumin:7,prot:7,bilitot:7,bilidir:7,alkphos:7,alt:7,ast:7)@  
@LABRCNTIP(INR:7,aPTT:7)@

**Microbiology data:**

I have personally reviewed all micro data.

**@MICROLABS@**

**Radiographic Data:**

I have personally reviewed all radiographic data.

**@RISRSLTIMP2@**

**@IMAGINGECHOLAST@**

**Hospital Problems:**

**@HPROBL@**

**ASSESSMENT & PLAN**

**Neuro:**

**Cardiovascular:**

**Pulm:**

**GI:**

**Renal/GU:**

**ID:**

**Endocrine/Nutrition:**

**Heme/Onc:**

**MSK/Skin:**

---

**Psych:**

**Other:**

**VTE Prophylaxis:**

@ANTICOAG@

@FLOW(607620)@

@CODESTATUS@

{global Issues:304012100}

**Discharge Planning/Placement:**

I have discussed the plan of care with: Attending, Fellow, and Interdisciplinary team

**Signature:**

Daniel Belza, MD PGY-3  
Internal Medicine Resident  
Pager: 1407

*\*\*Portions of this note were generated using Nuance Dragon Medical One voice recognition software. Please excuse any minor errors in grammar or syntax.*

---

DVBPCP

Dear Dr. \*\*\*,

Your patient \*\*\* was admitted to UMass Memorial Hospital on \*\*\* for \*\*\*. Please reach out if you have any questions.

-Daniel Belza, MD

---

ECHO

palilalia

---

JCGCRITAP

---

**Neuro:**

-\*\*\*

-Sedation: {sedation drugs:44851}

-Analgesia: {CC pain meds:44850}

-Multimodal Pain Control: {CC multimod pain:44849}

**Respiratory:**

-\*\*\*

---

- {Blank single:19197::"Intubated on Full Vent Support", "Intubated on \*\*\*", "BIPAP", "CPAP", "HiFlow", "Supplemental O2 \*\*\*", "none", "\*\*\*"}
- Head-Up Position (30 degrees) if intubated
- Continuous numeric end tidal Co2 if intubated
- Continuous Pulse Ox
- Pulm Toilet
- Wear O2 support if able
- CXR?

#### **Cardiovascular:**

- \*\*\*
- Telemetry
- Judicious PRN IVF bolus
- Maintain MAP >{Blank single:19197::"60", "65", "70"}
- Titrate Vasopressor support: {CC vasopress:39742}
- Titrate Vasodilator for Blood Pressure Control MAP/SBP <\*\*\*: {CC VasoDILators:39743}

#### **Digestive:**

- \*\*\*
- NPO Status: {Blank single:19197::"Yes", "No", "\*\*\*"}
- Enteral Access: {Blank single:19197::"OGT", "NGT", "\*\*\*"}
- Ulcer PPx: {Blank single:19197::"PPI", "Famotidine", "none"}

#### **Renal/Genitourinary:**

- \*\*\*
- Urinary Catheter: {Blank single:19197::"Foley in place", "Purewick", "\*\*\*"}
- Monitor UOP, strict I/O's
- Daily BMP, electrolytes

#### **Musculoskeletal:**

- \*\*\*
- Stress Dose Steroids: {Blank single:19197::"Yes", "No"}
- Glycemic control {Blank single:19197::"ICU Glycemic protocol", "ACHS sliding scale"}

#### **Hematologic:**

- \*\*\*
- Anemia; CBC q
- DVT PPx: {Blank single:19197::"SQH", "Lovenox", "Contraindicated per \*\*\*", "SCD", "on heparin gtt", "none"}

#### **Infectious/Inflammatory:**

- \*\*\*
- Cultures Sent: {CC culture sent:44852}
- {Antibiotics in Sepsis:44853}

#### **Immune:**

#### **Trauma/Ortho:**

- \*\*\*
- Injury List:

---

**JCGPEDIDC**

You were evaluated in the emergency department for \*\*\*. Your child's exam was reassuring and was well appearing and not concerning acute pathology.

Please follow up with your pediatrician in \*\*\*

For fever, you can alternate between taking ibuprofen and acetaminophen.

Children's Ibuprofen (100mg/5mL): Take \*\*\* mL every 6 hours as needed

Children's Acetaminophen (160mg/5mL): Take \*\*\* mL every 6 hours as needed

You may alternate between these two so you can give something every 3 hours.

Please return to the emergency department if your child experiences difficulty breathing, shortness of breath, worsening cough, fevers that do not improve with tylenol or motrin or inability to tolerate oral intake with <3 diapers/24 hours.

---

**LICENSENUMBER**

3014741

---

**MMDCCONCUSSION****Concussion Resources**

[Heads Up | HEADS UP | CDC Injury Center](http://www.cdc.gov/headsup/index.html) ([www.cdc.gov/headsup/index.html](http://www.cdc.gov/headsup/index.html))

[Brain Injury Basics - Brain Injury Association of America \(biausa.org\)](http://biausa.org)

[Resources and concussion treatment centers | Mass.gov](http://Mass.gov)

[Concussion Support & Resources | Concussion Legacy Foundation \(concussionfoundation.org\)](http://concussionfoundation.org)

[Concussion Resources & Facts | Concussion.org](http://Concussion.org)

**Concussion Treatment Centers**

UMass Sports Medicine Clinic (Worcester) 855-862-7763

Spaulding Outpatient Center: (Boston) 617-952-6200, (Foxborough) 857-307-3202, (Pawtucket) 401-729-2919, (Lexington) 781-860-1742

Cantu Concussion Center at Emerson Health (Concord) 978-287-8250

Baystate Health Sports Medicine (Springfield) 413-794-5600

Mass General Youth Sports Concussion Clinic 617-724-9722

Sports Concussion New England 617-959-1010

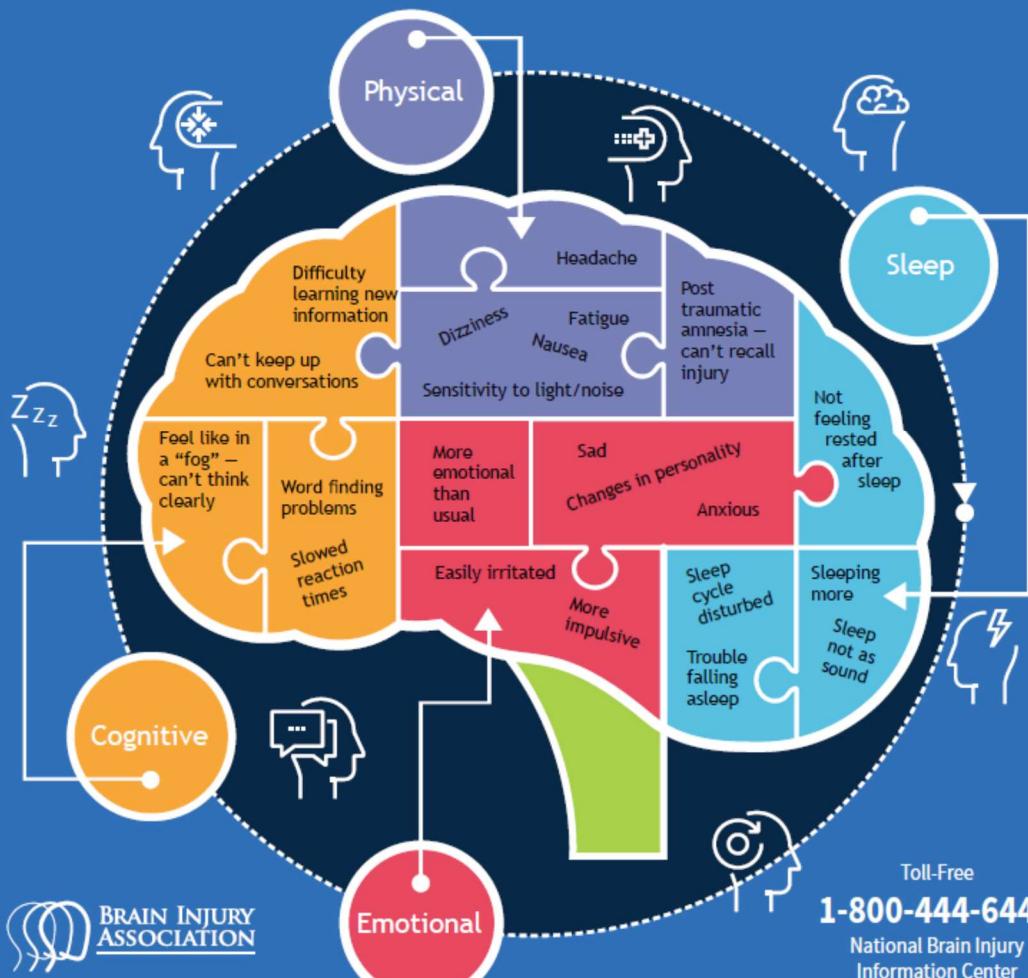
Boston Children's Hospital Brain Injury Clinic 617-355-6388

Boston Children's Hospital Sports Concussion Clinic 617-355-3501

---

# Concussion Signs

Concussion can present in a number of ways. This infographic describes common issues people experience after a concussion.



©2020 Brain Injury Association of America

# Concussion Tips & Tricks for the Classroom

Toll-Free  
**1-800-444-6443**  
National Brain Injury  
Information Center

Give the student breaks during the class time if needed.

Give written directions to student.

Delay any tests until symptoms have resolved.

Give additional time to complete tasks.

Minimal homework assignments, if any.

Minimize the "cognitive load"—allow for use of alternative formats for work.

Increased time to respond to classwork.

Increased breaks during the class.

Allow breaks for student.

If possible allow student to take break in low stimulus environment (e.g., room with lights out, low noise levels).

Cannot follow class work, inability to complete class work.

Trouble Paying Attention/  
Organizing work

Dizziness

Sensitivity to Light/  
Noise

Minimize note taking in class (to minimize up and down movement of eyes).

Have classmate walk with person or carry books to class.

Allow the student extra time to get from class to class.

Cognitive Slowing



Headache

Fatigue

Falling Asleep in class, or trouble concentrating

Increase in other symptoms such as headache, irritability; inability to maintain attention in class.

Use of sunglasses, ball caps in class to reduce distracting stimulus.

Reduce time in school or in class.



[www.biausa.org](http://www.biausa.org)

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# The Graduated Return to Play Guidelines

Toll-Free  
**1-800-444-6443**  
National Brain Injury  
Information Center



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MPTRAUMA

## History

@HPIBEGIN@

@RFV@

@NAME@ is a @AGE@ @SEX@ who presents {Trauma lev1:37830} s/p {Trauma injury:37831}.

\*\*\*

History provided by EMS and medical records.

@HISTORYBEGIN@

@PMH@  
@PSH@  
@FAMHX@  
@SOCH@  
@VAPEHX@  
@SOGIDOC@

@ROSBEGIN@  
@UMMHCROSBYAGE@  
ROS as noted in the HPI.  
@ROSEND@

## Physical Exam

@PEBEGIN@  
@VITALSM@  
@PHYSEXAM@

Vitals and nursing note reviewed.

Constitutional:

{constitutional trauma exam:46726}

GCS: E{(4) Spont / (3) Voice / (2) Pain / (1) None:46721:::0} V{(5) Oriented / (4) Confused / (3) Inapp words / (2) Incomprehensible / (1) None:46722:::0} M{(6) Obeys / (5) Localizes / (4) Withdraws / (3) Decorticate / (2) Decerebrate / (1) None:46723}

HEENT:

{HEENT trauma exam:46727}

C-collar in place? {YES:33793:::"yes"}

Cardiovascular:

{cardiovascular trauma exam:46728}

Pulmonary:

{pulm trauma exam:46729}

Abdominal:

{abdominal trauma exam:46730}

Musculoskeletal:

{MSK trauma exam:46731}

Skin:

{skin trauma exam:46732}

Neurological:

{neuro trauma exam:46733}

\*\*\*

@PEEND@

## Medical Decision Making and ED Course

Assessment and Plan:

@AGE@ @SEX@ presenting {Trauma levl:37830} s/p {Trauma injury:37831}. Trauma team at bedside.

On arrival to the trauma bay, patient had a GCS of {GCS15:46720}. Airway: {mp airway:46724}. Trachea was {TRACHEA ASSESSMENT:21358:::"midline"}. Cervical spine precautions maintained with cervical collar. Breath sounds {TRAUMA BREATH SOUNDS H&P:26688:::"Clear to auscultation bilaterally"}. EFAST exam: {eFAST:46725}. Vital signs: {VITAL SIGN ASSESSMENT:33164:::"stable"}.

Secondary exam as above, most notable for \*\*\*.

This patient was seen and managed in coordination with the trauma service. Please see the trauma H&P for further details of their assessment and plan.

Plan for trauma labs and {trauma imaging:46734}. Disposition to be determined by labs, imaging, and trauma team. Patient signed out to the pods at \*\*\*.

@EDMDM@

@EDCOURSE@

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN @CSN@

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#### MWCSCLEAR

The c-collar was removed, the patient's cervical neck range of motion was tested in all directions and no pain was noted by patient. Repeated cervical spine exam otherwise reassuring.

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#### MWHPI

@NAME@ is a @AGE@ @SEX@ {MW1LPMH:36083} here with \*\*\*

\*\*\*

---

#### MWMDDMMV

C

Initially, {mwmdmqvitals:36444}

Overall, {initial eval:34694}

{mw mdm mvc concern reassure:40892}

-\*\*\*

{MDM Ending:40252}

**Michael Weiner, MD**

**UMass Emergency Medicine**

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#### MWMDMPEDI

Initially, {mwmdmqvitals:36444}

Overall, {initial eval ped:40351}

{mw pedi common mdm:40916}

-\*\*\*

{MDM Pedi Ending:40840}

**Michael Weiner, MD**

**UMass Emergency Medicine**

---

#### MWMDMPSYC

H  
Overall, {initial eval:34694}  
-\*\*\*  
-Based on my evaluation, patient has no indication of medical problems that are likely to deteriorate or decompensate during further management.  
-Case discussed with {psych or PES:40878}.  
-{MW psych home meds:40879}  
-{MW S12 status:40880}

**Michael Weiner, MD**  
**UMass Emergency Medicine**

---

MWMDMQUIC  
K  
-On my initial evaluation of the patient, {initial eval:34694}  
{Continue:41968}  
{MDM Ending:40252}

---

MWMDMSTROK  
E  
Initially, {mwmdmqvitals:36444}  
Overall, {initial eval:34694}  
{mw stroke work up:40957}  
-\*\*\*  
{mw neuro discussion time:40958}  
{mw stroke fu:40960}

**Michael Weiner, MD**  
**UMass Emergency Medicine**

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MWMDMTRAUM  
A  
-{mwmdmqvitals:36444}  
-{initial eval:34694}  
-{mw nexus:42726}  
-{Continue:41968}  
{Discharge or Not:40961}

**Michael Weiner, MD**  
**UMass Emergency Medicine**

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MWMEDCLEA  
R  
Based on my evaluation, patient has no indication of medical problems that are likely to deteriorate or decompensate during further management.

---

MWNEGATIVEROS  
{mwnegativeROS:38038}

---

---

RSO

Resident signout: @AGE@ @SEX@

---

SIG

Brian Desnoyers, MD MPH PGY-2

---

SO

@AGE@ @SEX@ with {PMHx:36630}.

P/w \*\*\*.

\*\*\*

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#### TADCHEADINJURY

You were seen in the emergency department today for your head injury. After thorough evaluation including a full neurologic exam we do not see any evidence that you sustained a severe brain injury. You may have symptoms of postconcussive syndrome and may need to gradually resume both use of screens and reading as well as athletic activities.

Please follow-up with your primary care doctor for further evaluation and treatment.

You may take acetaminophen 1000 mg every 6 to 8 hours (DO NOT exceed 3000 mg in a 24 hour period) and \*\*\*ibuprofen 400mg every 4-6 hours as needed for pain. You may take both of these medications at the same time or alternate every few hours. Certain over-the-counter remedies may also contain this type of medication, so if you are taking alternative remedies, please read the labels carefully to ensure you are not taking too much.

Please return to the emergency department immediately if you experience worsening headache, double vision, difficulty speaking or swallowing, vomiting, imbalance or difficulty walking, numbness or weakness in her extremities, feeling confused or acting abnormally, or other concerning symptom

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#### TADCHEADLACERATION

You were seen in the emergency department today for your head injury. After thorough evaluation including a full neurologic exam we do not see any evidence that you sustained a severe brain injury. You may have symptoms of postconcussive syndrome and may need to gradually resume both use of screens and reading as well as athletic activities.

You had an injury to your skin known as a laceration. Your laceration was repaired with \*\*\*.  
{talacerationoptions:41636}

You will likely have a scar. The best way to reduce the chance of a scar is to use sun block or keep the area covered when outside for six months to a year after the sutures / staples / glue are no longer in place.

You may shower and let water or soap run over the area but do not scrub the area. Do not soak the area or go swimming while the stitches are in place.

The first two weeks after the stitches are removed the wound is still vulnerable. Please try to avoid repeat tension on the area as it may reopen and no longer be able to be repaired.

Please follow-up with your primary care doctor for further evaluation and treatment.

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You may take acetaminophen 1000 mg every 6 to 8 hours (DO NOT exceed 3000 mg in a 24 hour period) and \*\*\*ibuprofen 400mg every 4-6 hours as needed for pain. You may take both of these medications at the same time or alternate every few hours. Certain over-the-counter remedies may also contain this type of medication, so if you are taking alternative remedies, please read the labels carefully to ensure you are not taking too much.

Please return to the emergency department immediately if you experience worsening headache, double vision, difficulty speaking or swallowing, vomiting, imbalance or difficulty walking, numbness or weakness in her extremities, feeling confused or acting abnormally, redness or swelling or pus at the site of your cut, fever, or other concerning symptom.

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#### TADCP

If you do not have a primary care doctor, please call 1-855-UMASS-MD to schedule an appointment with a primary care doctor at UMASS Memorial.

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#### TAGIABDDCINSTRUCTIONS

You were seen in the emergency department for abdominal pain. You were evaluated and {Blank single:19197::"your vitals and exam were reassuring.", "your vital signs, exam and labs and imaging were reassuring.", "your vital signs, exam and labs were reassuring."} Your pain may be due to \*\*\*.

{Blank single:19197::"You have been given a prescription for an antacid which you should take as instructed.", "You have been given a prescription for an anti-nausea medicine which you should take as instructed.", "You should follow up with your primary care doctor in the next 2-3 days if your pain does not improve."}

**Please seek immediate medical attention if you develop any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.**

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#### TAGIABSCESSDCINSTRUCTIONS

You were seen in the emergency room for a skin infection. You were evaluated, and {Blank single:19197::"your abscess did not require drainage", "your abscess was drained"}.

{Blank single:19197::"You should see your primary care doctor in 2-3 days if the infection is worsening or does not improve.", "You have been given a prescription for an antibiotic to help treat the infection. You should follow up with your primary care physician to ensure the infection is clearing."}

**You should soak the area at least three times daily in warm water and apply pressure using warm compresses to gently help the remaining fluid drain out.**

**Please seek immediate medical attention if they develop any fevers, chills, worsening pain, drainage, or any other new, changing, or worsening symptoms. Otherwise, please follow up with their regular doctor regarding this visit.**

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#### TAGIALERGYDCI

You were seen in the emergency department for an allergic reaction. You were evaluated, and your symptoms have now resolved.

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**Please seek immediate medical attention if you develop any difficulty breathing, fevers, chills, nausea, vomiting, headaches, or any other new, changing, worsening symptoms. Otherwise, please follow-up with your regular doctor regarding this visit.**

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#### TAGIAMADC

The patient @NAME@ requested to leave. I considered this to be leaving against medical advice. I personally discussed that following with them:

That they currently had a medical condition of: \*\*\* and I am concerned that they have \*\*\* or other serious pathology \*\*\* even despite \*\*\*.

My proposed course of evaluation and treatment and that of any consultants is: \*\*\* Benefits would include: possible diagnosis or excluding of \*\*\* or an alternative serious condition such as \*\*\*, which if identified early would lead to appropriate intervention in a timely manner lessening the burden of disability and death

Risks of leaving before this had been completed include: misdiagnosis, worsening illness leading up to and including prolonged or permanent disability or death. Specific risks pertinent, but not all inclusive, of their current medical condition include but are not limited to: \*\* I also discussed alternatives including: \*\*\*

Despite this they stated they wanted to leave due to \*\*\* and refused further evaluation, treatment, or admission at this time.

They appear clinically sober, to be mentating appropriately, free from distracting injury, have controlled pain, appear to have intact insight, judgement, and reason and in my opinion have the capacity to make this decision.

Specifically, they were able to verbally state back in a coherent manner their current medical condition/current diagnosis, the proposed course of treatment, and the risks, benefits, and alternatives of treatment versus leaving against medical advice.

They understand that they may return to seek medical attention here at whatever time they want. I highly advised them to return to the Emergency Department immediately if they experienced any: \*\*\*, reconsidered treatment a/o admission, or had any other concerns. This would be without any repercussions.

I recommended they follow-up with an Emergency Department or \*\*\* within 24 hours for further evaluation and treatment.

They were discharged against medical advice.

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#### TAGIANIMALBITEDCINSTRUCTIONS

You were seen in the emergency room for an animal bite. {Blank single:19197::"You were evaluated, and your exam was reassuring", "You were evaluated, and \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your imaging showed \*\*", "You were evaluated, and your wounds were cleaned and dressed"}. {Blank single:19197::"You have been given a prescription for antibiotics which you should take as prescribed"}.

**It is VERY important to keep the area clean by washing it 2-3 times a day with soap and water.**

**Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath", "redness, swelling, pus, or worsening pain around the wounds"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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#### TAGIANKLESRAINTDCINSTRUCTIONS

You were seen in the emergency room for an ankle injury. You were evaluated, and your imaging was reassuring. Your symptoms are most likely due to an ankle sprain.

{Blank single:19197::"You should follow up with your primary care doctor in 2-3 days if the pain does not improve or worsens.", "You have been given an air cast and crutches to help you walk, but you should move the joint as much as you can tolerate."}

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**Rest, Ice, Elevate and Compress the ankle as needed.**

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any worsening pain or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

It is possible that you may have, or develop a persistent functional disability. You may develop persistent pain. If you develop persistent pain or have any functional disability, specialty evaluation and/or more advanced imaging may be required. Please follow-up with your primary care doctor to organize subspecialty follow up if has not been arranged already as well as potentially more advanced imaging options, such as outpatient magnetic resonance imaging of the area of concern. Please return to the emergency department if symptoms worsen or you have new concerning symptoms regarding your increased pain or functional disability.

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#### TAGIASTHMADCINSTRUCTIONS

You were seen in the emergency room for shortness of breath. You were evaluated, and were likely having an asthma exacerbation. You were treated and your symptoms improved.

{Blank single:19197::"You have been given a prescription for steroids. For the next 24 hours, you should use your albuterol inhaler every 4 hours. The following day, you can space to every 6 to 8 hours and then continue to space it out until you don't require regular use any longer."}

Please seek immediate medical attention if you develop any worsening shortness of breath, chest pain, headaches, nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIBACKPAINDCINSTRUCTIONS

You were seen in the emergency room for {Blank single:19197::"back pain"}. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your work up was reassuring", "You were evaluated, and your exam was reassuring"}. {Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*", "You should follow up with \*\*. The information to make this appointment has been included in this paperwork", "If you have persistent pain, you should follow up with your primary care physician regarding this visit"}.

You may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

You have been given a prescription for {Blank single:19197::"an antibiotic", "a medicine to help with nausea and vomiting", "a muscle relaxant"}, which you should take as prescribed. {Blank

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single:19197::"You have been given a print out prescription that you should take to a pharmacy as soon as possible","The prescription has been sent to the pharmacy listed in this paperwork"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"difficulty urinating or passing stool, loss of control of urine or stool, numbness to your legs or groin, increasing difficulty walking, fevers, chills"}, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIBELLSPALSYDCINSTRUCTIONS

You were seen in the emergency room for {Blank single:19197::"a facial droop"}. You were evaluated, and you most likely have a condition called Bell's Palsy. There are many potential causes, for example a recent viral illness.

You have been given a prescription for steroids and an anti-viral medication to treat the condition. You may continue to experience symptoms for some time, and if they are still present within 1-2 weeks, you should follow up with neurology.

You should use artificial tear eye drops at least four times a day, but can use them as often as feels comfortable. At nighttime, you should use an artificial tear gel as well as soft paper tape to tape your eye closed to avoid injury from dryness.

Please seek immediate medical attention if you develop any worsening weakness or numbness elsewhere in your body, worsening symptoms, headaches, nausea, vomiting, vision changes, eye discharge, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIBLOODTRANSFUSIONDC

You were seen in the emergency room for {Blank single:19197::"low blood levels"}. You were evaluated, and you were transfused. You should follow up with your primary care physician regarding this visit.

Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIBURNDCINSTRUCTIONS

You were seen in the ER for a burn.

We recommended daily soap and water washes to keep the area clean. Keep the affected area elevated whenever possible.

You can take Motrin three times a day to help control the swelling.

You should follow up with {Blank single:19197::"your primary care physician"} in \*\*\* days to have the wound re-checked. The information to make this appointment has been included in this paperwork.

Please seek immediate medical attention if you develop any worsening pain, redness,

**swelling, pus draining or for any other new changing or worsening symptoms.**

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**TAGICASTPRECAUTIONS**

**Don't get your cast wet, don't put anything in the cast, if you have extreme pain or numbness to the area please return immediately to get evaluated.**

---

**TAGICELLULITISDCINSTRUCTIONS**

**You were seen in the emergency room for a skin infection. You were evaluated, and it is most likely a cellulitis.**

**{Blank single:19197::"You should see your primary care doctor in 2-3 days if the infection is worsening or does not improve.", "You have been given a prescription for an antibiotic to help treat the infection. You should follow up with your primary care physician to ensure the infection is clearing."}**

**Please seek immediate medical attention if they develop any fevers, chills, worsening pain, drainage, or any other new, changing, or worsening symptoms. Otherwise, please follow up with their regular doctor regarding this visit.**

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**TAGICERVICALFRACTUREDCINSTRUCTIONS**

**You were seen in the emergency room for \*\*\*. You were evaluated, and your imaging showed a cervical spine fracture. You should follow up with \*\*\* in \*\*\* days. The information to make this appointment has been included in this paperwork.**

**You must keep the hard collar on at all times, including when you are in the shower. You have been given a set of replacement pads as well as teaching about how to change them safely after the shower.**

**Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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**TAGICHESTPAINDCINSTRUCTIONS**

**You were seen in the emergency department for chest pain. You were evaluated and {Blank single:19197::"your work up was remarkable for \*\*\*", "all of your tests and imaging were reassuring"}. {Blank single:19197::"Your pain is most likely caused by \*\*\*. You should follow up with your primary care doctor regarding this pain.", "You should follow up with your primary care doctor regarding this pain.", "You should follow up with your primary care physician as soon as possible to schedule a stress test.", "You should follow up with your primary care doctor regarding this pain so you can discuss if you need to have a stress test done."}**

**Please seek immediate medical attention if you develop any worsening chest pain, shortness of breath, nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.**

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**TAGICHFDCINSTRUCTIONS**

**You were seen in the emergency department for {Blank single:19197::"chest pain", "shortness of breath"}. You were evaluated, and your labs and imaging were all reassuring. You likely have a build up of fluid in your body that is causing your symptoms, and you should see your primary care doctor for long term management of this issue.**

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{Blank single:19197::"You have been given a short prescription for a fluid pill to help you with this issue until you can see your primary care provider. "}

Please seek immediate medical attention if you develop any worsening shortness of breath, headaches, nausea, vomiting, chest pain, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGICLEARCSPINE

Patient re-evaluated for cervical spine precautions. Cervical collar in place. {Blank single:19197::"Imaging of cervical spine showed no evidence of fracture", " "}. On exam, patient denied any bony tenderness of the cervical spine on palpation. Patient had pain free ROM to 30 degrees in extension as well as flexion, 45 degrees in right and left rotation. Collar removed, no further need for cervical spine precautions.

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#### TAGICLICKED

I clicked on but then did not see this patient.

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#### TAGICLINICALIMPRESSIONNOTMINE

This patient was signed out to another area of the hospital, and as such I was not responsible for completing their discharge.

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#### TAGICONSTIPATIONDCINSTRUCTIONS

You were seen in the emergency department for {Blank single:19197::"constipation", "abdominal pain"}. You were evaluated and your {Blank single:19197::"labs and imaging were notable for \*\*\*", "exam was reassuring", "labs and imaging were reassuring"}. You may be experiencing pain from constipation. We have given you a prescription for {Blank single:19197::"Miralax"} which should help improve your symptoms.

Please seek immediate medical attention if you develops any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

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#### TAGICORNEALABRASIONDCINSTRUCTIONS

You were seen in the emergency room for eye pain. You were evaluated, and you appear to have a corneal abrasion. You have been given a prescription for an antibiotic ointment for your eye which you should use as instructed.

You should follow up with ophthalmology in their walk in clinic in the next few days, the number has been provided for you in this paperwork.

Please seek immediate medical attention if you develop any sudden vision changes, eye pain, headaches, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGICOUGHDCINSTRUCTIONS

You were seen in the emergency department for a cough. You were evaluated and {Blank}

single:19197:: "your exam was reassuring", "your chest x-ray did not show any concerning findings", "all of your labs and imaging were reassuring"}. {Blank single:19197:: "Please see your primary care doctor within a week if your symptoms have worsened", "You were given a breathing treatment that helped improve your symptoms, please see your primary care doctor or return here if your symptoms worsen or do not improve."}

Please seek immediate medical attention if you develop any worsening chest pain, difficulty breathing, fevers, chills, or any other new, changing or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit to ensure your symptoms are improving.

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#### TAGICOVID

You were evaluated in the ED for an illness including {Blank single:19197:: "respiratory symptoms and a fever.", "respiratory symptoms.", "fever.", "cough."}. We evaluated you and feel that it is safe to discharge you home with outpatient follow-up at this time. You {Blank single:19197:: "were not tested for COVID-19.", "were tested for COVID-19, you will be contacted if it is positive."}. It is more likely that you have another illness other than COVID-19. However, we have included some general information about COVID-19 and how to keep yourself healthy. These instructions are good guidelines for any respiratory illness.

{Blank single:19197:: "YOU SHOULD STAY IN ISOLATION UNTIL YOU GET THE RESULTS OF YOUR VIRAL TESTING. YOU SHOULD CALL THE HOSPITAL IN 2-3 DAYS TO GET THIS RESULT, OR LOOK FOR IT ON MYCHART. REGARDLESS OF THE RESULT, YOU SHOULD STAY IN ISOLATION UNTIL A WEEK AFTER YOUR SYMPTOMS HAVE RESOLVED."}

This does NOT mean that you have COVID-19. This information was made available by the CDC and includes ways to protect you and your family. Most people with respiratory illnesses, including COVID-19, are best served by healing in the comfort of their home and do not require hospitalization. However if you develop any new, worsening, or changing symptoms, it is always appropriate to call your doctor or return to the ER. These symptoms include, but are not limited to, worsening chest pain, shortness of breath, or inability to keep yourself hydrated. These recommendations are appropriate for all other respiratory and cold viruses including the flu.

The best ways to prevent spread of infections are:

- 1) Wash your hands frequently
  - 2) Cough into your elbow
  - 3) Sanitize your hands and surfaces in your home frequently
  - 4) If possible, have sick family members use a separate bedroom where he they can recover without sharing immediate space with others
  - 5) Wear a face mask when you are around close contacts
  - 6) As much as possible, avoid household members who may be at increased risk of complications from infections (.e.g., people >65 years old, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions).
- 

#### TAGICPPLAN

ED Plan: EKG, cxr, serial trops, cbc, bmp

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#### TAGICXRREAD

No acute cardiopulmonary process as interpreted by this ED physician in the absence of a formal radiology read.

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**TAGIDAILYLABS**

@LABRCNTIP(wbc:3,hgb:3,hct:3,PLT:3)@  
@LABRCNTIP(NA:3,K:3,CL:3,co2:3,bun:3,creatinine:3,glucose:3)@  
@LABRCNTIP(CALcium:3,MG:3,Phos:3)@  
@LABRCNTIP(BILITOT:3,BILIDIR:3,Alkphos:3,AST:3,ALT:3,Lipase:3,Amylase:3)@  
@LABRCNTIP(PT:3,INR:3,aPTT:3)@  
@LABRCNTIP(Lactate:3)@  
@LABRCNTIP(Trop:3)@  
@LABRCNTIP(pH:3,pCO2:3,pO2:3,Co2:3)@

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**TAGIDEATH**

Time of death was called at \*\*\*. Exam at this time was as follows:

GENERAL: ill-appearing, unresponsive

HEENT: midrange nonreactive pupils

NECK: no palpable carotid pulse

PULMONARY: no air movement on auscultation, no chest rise

CARDIOVASCULAR: heart sounds absent, no palpable peripheral pulse

ABDOMEN: soft, nondistended

EXTREMITIES: no edema

SKIN: cool, dry

NEUROLOGIC: no spontaneous movement

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**TAGIDIDNOTPARTCIPATE**

I had initially opened this patients chart and assigned myself but did not ultimately participate in the care of this patient as other physicians were already seeing the patient.

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**TAGIDIVERTICULITISDCINSTRUCTIONS**

**You were seen in the emergency department for abdominal pain. You were evaluated and you were found to have diverticulitis.**

**At this time time, you are appropriate for treatment with antibiotics at home.**

**Please follow a clear liquid diet for the next 3 days and then a low-fiber diet for the next few weeks until your symptoms improve and you follow up with your regular doctor's or surgery clinic.**

**You have been given a prescription for an antibiotic, which you should take as prescribed. {Blank single:19197:::"The prescription has been sent to the pharmacy listed in this paperwork","You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.**

**Please seek immediate medical attention if you develop any worsening nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.**

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**TAGIEARLYCOVIDTEST**

You were seen in the emergency room today with concern for COVID. While your test done today was negative, if you are having symptoms it is possible that you still may have COVID and it was too early for a positive result. You should continue to isolate for as long as you have symptoms to avoid additional exposures.

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**TAGIEARPAINDCINSTRUCTIONS**

You were seen in the emergency room for {Blanks single:19197::"ear pain"}. You were evaluated, and {Blanks single:19197::"your exam was reassuring","you appear to have an ear infection"}. {Blank single:19197::"You should follow up with your regular doctor within a week if your symptoms do not improve or sooner if they worsen.", "You have been given a prescription for an antibiotic to help resolve your symptoms."}

Please seek immediate medical attention if your pain worsens, you develop any worsening headaches, swelling of behind your ears, fevers, chills, nausea, vomiting, or for any other new, changing or worsening symptoms or if your symptoms do not improve. Otherwise please follow up with your regular doctor regarding this visit.

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**TAGIEDNOTEWRITERTEMPLATE****HPI**

@NAME@ is a @AGE@ @SEX@ w/ {Blank single:19197::"unknown past medical history", "no pertinent past medical history", "extensive past medical history most significant for \*\*\*", "no stated past medical history", "a hx of \*\*\*"} who presents to ED {Blank single:19197::"via EMS from \*\*\* with", "via EMS with", "via EMS s/p", "s/p", "from \*\*\* with", "with"} \*\*\*. \*\*\*

@SFHPI@

@HPIEND@@HISTORYBEGIN@

@PMH@

@PSH@

@FAMHX@

@SOCH@@HISTORYEND@

**REVIEW OF SYSTEMS**

@UMMHCRSBYAGE@

**PHYSICAL EXAM**

@VITALSMULTIPLE@

@PHYSEXAM@

**LABS**

@EDLABS@

**IMAGING**

@EDIMAGING@

**MEDICATIONS GIVEN IN ED**

@EDMEDS@

---

@EDMDM@

@EDCOURSE@

@NAME@ DOB: @DOB@ MRN: @MRN@ CSN: @CSN@

{UMMH ED ATTESTATION TO NOTES - ATTENDING:1601111100}

@NAME@ DOB: @BDAY@ MRN: @MRN@ CSN: @CSN@

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#### TAGIEKGINTERPRETATION

EKG interpreted by me in the absence of a cardiologist. Rhythm is {Blank single:19197::"A-flutter", "A-fib", "sinus bradycardia", "sinus tachycardia", "normal sinus"}. Rate of \*\*\*. {Blank single:19197::"\*\*\* mm ST elevations in \*\*\*, \*\*\* mm ST depressions in \*\*\*, "T-wave inversions in \*\*\*, "No acute ischemic changes"}. {Blank single:19197::"No previous EKG on file.", "Changes are new from previous EKG.", "Unchanged from prior EKG."}

---

#### TAGIEMHREADY

@AGE@ @SEX@ presents for evaluation of \*\*\*. {Blank single:19197::"Patient denies any active plan for suicide or homicide, but requests a voluntary evaluation by EMH", "Evaluated by me in EMH per their request", "Arrived on Section 12", "Arrived on Section 12 filed by \*\*\*, "Placed on Section 12"}. Patient has been evaluated and no life-threatening medical issues have been identified at the present time and patient is medically appropriate for mental health evaluation. Disposition per EMH.

---

#### TAGIENDOFDC

or for any other new, changing or worsening symptoms or if your symptoms do not improve. Otherwise please follow up with your regular doctor regarding this visit.

---

#### TAGIEPIDIDYMITISDCINSTRUCITONS

You were seen in the emergency room for groin pain. You were evaluated, and your imaging did not show any concerning findings. Your symptoms are most likely due to a testicular infection.

You have been given a prescription for {Blank single:19197::"an antibiotic", "a medicine to help with nausea and vomiting"}, which you should take as instructed. {Blank single:19197::"The prescription has been sent to the pharmacy listed in this paperwork", "You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.

Please seek immediate medical attention if you develop any fevers, chills, worsening groin pain, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIEPISTAXISDISCHARGE

You were seen in the emergency room for a nose bleed. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed

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\*\*\*\*", "You were evaluated, and \*\*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your exam was reassuring", "You were evaluated, and your work up was reassuring", "You were evaluated, and the bleed had stopped on my evaluation", "You were evaluated, and the bleeding stopped in the emergency room", "You were evaluated, and the bleeding was stopped with something called a rhino rocket, which will have to be removed in 2-3 days}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*\*", "Your symptoms may be due to \*\*\*\*", "}{Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*\*", "You should follow up with \*\*. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit", "You should follow up with ENT (ear, nose and throat) to have this removed. The information to make this appointment has been included in this paperwork", "You should follow up with your primary care physician regarding this visit"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"worsening bleeding, lightheadedness, passing out,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

#### TAGIETOHDC

You were seen in the emergency room for {Blank single:19197::"drug overdose", "alcohol intoxication"} . You were evaluated, and do not appear to have any severe injuries. If you would like to quit, detox information is available on request.

You are clinically, but not legally sober. Do not drive/operate machinery until you are. You were observed and discharged in improved condition. Using {Blank single:19197::"drugs", "alcohol"} is dangerous to your health, please read the attached instructions.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, chest pain, shortness of breath, vision changes, or any other new, changing, or worsening symptoms or if your symptoms do not resolve.

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#### TAGIEXPOSUREDCI

You were seen in the ER after exposure to a bodily fluid. You were evaluated and do not appear to have any serious injury, however due to your exposure, labs were sent to confirm you do not have any infectious disease. You should follow up with infectious disease clinic within one day, the number for which has been provided in this paperwork. You will also find information about Employee Health Services, please follow these instructions as well.

Because of the nature of your exposure,{Blank single:19197::"you were started on prophylactic treatment for Hepatitis B and HIV. You have been given a prescription for medications to take for one month, please follow up about this prescription at your infectious disease appointment.", "you did not require any prophylactic treatment. Please follow up regarding this recommendation at your infectious disease appointment."}

Employee Health Services

291 Lincoln Street

Worcester, MA 01605

PATIENT INFORMATION SHEET

EMPLOYEE BODY FLUID EXPOSURE

Call or visit Employee Health on the next business day. Employee health is open Monday through Friday 7a-7p except on holidays.

Employee Health will ensure the proper follow-up including:

- o Completion of a First Report of Employee Injury (FREI). If you have already completed the FREI, please bring it with you to Employee Health.
  - o Specific details of your exposure:
-

- Mechanism of injury (needle stick, eye splash)
  - Immunity to hepatitis B virus
  - Tetanus vaccine status
  - Source patient name, medical record number.
- o Review of labs done in the ED
  - o Review of medication/s, if any, prescribed in the ED
  - o Contact the HIV coordinator/ provider who will then attempt to obtain consent from the source patient for HIV and hepatitis testing.  
If you have been prescribed medications, take them as prescribed. If additional medications are needed, they will be ordered by Employee Health.

Prescriptions:

- o Clinical and State employees: Rx can be filled at the UMASS pharmacy, located on the University Campus.
- o OR:
  - Clinical employees may fill script/s at CVS. Explain that it is a Worker's Compensation Injury.
  - State employees may fill script/s at Rite Aide or Walgreen's. Explain that it is a Worker's Compensation Injury.

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**TAGIEYEPAINDCINSTRUCTIONS**

**You were seen in the emergency room for {Blanks single:19197::"eye pain","a foreign body in your eye"}. You were evaluated, and your eye exam was {Blanks single:19197::"notable for \*\*\*","notable for a foreign body","notable for redness","reassuring"}.**

**{Blank single:19197::"You should follow up with your primary care doctor within a week if your symptoms persist or sooner if they worsen.", "You should follow up with ophthalmology in their clinic for any worsening or persistent symptoms.", "You should follow up with ophthalmology in their clinic in the next few days, the number is 508-334-6855."}**

**Please seek immediate medical attention if you develop any sudden vision changes, eye pain, headaches, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

---

**TAGIFACIALFXDCINSTRUCTIONS**

**You were seen in the emergency room for \*\*\*. You were evaluated, and you were found to have a facial fracture.**

**{Blank single:19197::"You should follow up with your primary care doctor within a week for persistent pain or sooner if your symptoms worsen", "You should follow up with plastic surgery if you have persistent pain or deformity. The information to make this appointment has been included in this paperwork."}**

**To protect your facial fractures, you must follow these recommendations: Do not blow your nose, do not apply any pressure to your face, keep your head of bed elevated to at least 30 degrees.**

**Please seek immediate medical attention if you develop any headaches, nausea, vomiting, bleeding, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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**TAGIFACIALPRECAUTIONS**

**To protect your facial fractures, you must follow these recommendations: Do not blow your nose, do**

**not apply any pressure to your face, keep your head of bed elevated to at least 30 degrees.**

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## TAGIFEVERMYTHS

### FEVER MYTHS and FACTS

Many parents have false beliefs myths about fever. They think fever will hurt their child. They worry and lose sleep when their child has a fever. This is called fever phobia. In fact, fevers are harmless and often helpful. Let these facts help you better understand fever.

**MYTH.** My child feels warm, so she has a fever.

**FACT.** Children can feel warm for a many reasons. Examples are playing hard, crying, getting out of a warm bed or hot weather. They are "giving off heat". Their skin temperature should return to normal in 10 to 20 minutes. About 80% of children who act sick and feel warm do have a fever. If you want to be sure, take the temperature. These are the cutoffs for fever using different types of thermometers:

- Rectal, ear or forehead temperature: 100.4° F (38.0° C) or higher
- Oral mouth temperature: 100° F (37.8° C) or higher
- Under the arm Armpit temperature: 99° F (37.2° C) or higher

**MYTH.** All fevers are bad for children.

**FACT.** Fevers turn on the body's immune system. They help the body fight infection. Normal fevers between 100° and 104° F (37.8° - 40° C) are good for sick children.

**MYTH.** Fevers above 104° F (40° C) are dangerous. They can cause brain damage.

**FACT.** Fevers with infections don't cause brain damage. Only temperatures above 108° F (42° C) can cause brain damage. It's very rare for the body temperature to climb this high. It only happens if the air temperature is very high. An example is a child left in a closed car during hot weather.

**MYTH.** Anyone can have a seizure triggered by fever.

**FACT.** Only 4% of children can have a seizure with fever.

**MYTH.** Seizures with fever are harmful.

**FACT.** These seizures are scary to watch, but they stop within 5 minutes. They don't cause any permanent harm. They don't increase the risk for speech delays, learning problems, or seizures without fever.

**MYTH.** All fevers need to be treated with fever medicine.

**FACT.** Fevers only need to be treated if they cause discomfort. Most fevers don't cause discomfort until they go above 102° or 103° F (39° or 39.5° C).

**MYTH.** Without treatment, fevers will keep going higher.

**FACT.** Wrong, because the brain has a thermostat. Most fevers from infection don't go above 103° or 104° F (39.5°- 40° C). They rarely go to 105° or 106° F (40.6° or 41.1° C). While these are "high" fevers, they also are harmless ones.

**MYTH.** With treatment, fevers should come down to normal.

**FACT.** With treatment, most fevers come down 2° or 3° F (1° or 1.5° C).

**MYTH.** If you can't "break the fever", the cause is serious.

**FACT.** Fevers that don't come down to normal can be caused by viruses or bacteria. The response to fever medicines tells us nothing about the cause of the infection.

**MYTH.** Once the fever comes down with medicines, it should stay down.

**FACT.** It's normal for fevers with most viral infections to last for 2 or 3 days. When the fever medicine wears off, the fever will come back. It may need to be treated again. The fever will go away and not return once the body overpowers the virus. Most often, this is day 3 or 4.

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**MYTH.** If the fever is high, the cause is serious.

**FACT.** If the fever is high, the cause may or may not be serious. If your child looks very sick, the cause is more likely to be serious.

**MYTH.** The exact number of the temperature is very important.

**FACT.** How your child looks is what's important. The exact temperature number is not.

**MYTH.** Oral temperatures between 98.7° and 100° F (37.1° to 37.8° C) are low-grade fevers.

**FACT.** These temperatures are normal. The body's normal temperature changes throughout the day. It peaks in the late afternoon and evening. A true low-grade fever is 100° F to 102° F (37.8° - 39° C).

**SUMMARY.** Keep in mind that fever is fighting off your child's infection. Fever is one of the good guys.

Barton D. Schmitt, M.D., FAAP

Last Reviewed: 10/20/2014

Last Revised: 10/20/2014

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#### TAGIFLUDCINSTRUCTIONS

You were seen in the emergency department for flu like symptoms. You were evaluated and {Blank single:19197::"your workup was notable for \*\*\*","your workup was reassuring","all of your labs and imaging were reassuring","your exam is reassuring"}. You {Blank single:19197:: "most likely have the flu or another similar viral illness","tested positive for the flu"}.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

{Blank single:19197:: " ","A prescription for a medication to help with your nausea has been sent to the pharmacy listed in this paperwork, please take it as prescribed"}.

Please seek immediate medical attention if you develop any worsening chest pain, difficulty breathing, fevers, chills, or any other new, changing or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit to ensure your symptoms are improving.

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#### TAGIFOREIGNBODYDCINSTRUCTIONS

You were seen in the emergency room after swallowing a \*\*\*. You were evaluated, {Blank single:19197::"and the object had to be removed emergently by the GI doctors","and your imaging showed that the object has passed into your stomach, and nothing else needs to be done as it will pass in your stool","and you were able to expel the object"}.

Please seek immediate medical attention if you develop any nausea, vomiting, belly pain, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

#### TAGIGASTROENTERITISDCINSTRUCTIONS

You were seen in the emergency department for {Blank single:19197::"diarrhea","abdominal pain","vomiting"}. You were evaluated and {Blank single:19197::"your exam was reassuring","all of your labs were reassuring","all of your labs and imaging were reassuring","your symptoms improved with treatment","your work up was reassuring and your symptoms improved with treatment"}. You most likely have a viral gastroenteritis.

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**Please seek immediate medical attention if you develop any headaches, nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.**

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**TAGIGENERICDCINSTRUCTIONS**

You were seen in the emergency room for \*\*\*. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*","You were evaluated, and your imaging showed \*\*\*","You were evaluated, and \*\*\*","You were evaluated and you were found to have \*\*\*","You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your exam was reassuring","You were evaluated, and your work up was reassuring"}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*","Your symptoms may be due to \*\*\*",""}{Blank single:19197::"You should follow up at your already scheduled appointment with \*\*\*","You should follow up with \*\*\*. The information to make this appointment has been included in this paperwork","You should follow up with your primary care physician regarding this visit"}.

**Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

---

**TAGIGETTINGSIGNOUT**

S/o from Dr. \*\*\*

Plan: \*\*\*

HPI: @AGE@ @SEX@ \*\*\*

Seen with: \*\*\*

---

**TAGIGIVINGSIGNOUT**

S/o plan: \*\*\*

S/o given to Dr. \*\*\*

---

**TAGITUBEREPLACEDCINSTRUCTIONS**

**You were seen in the emergency department because your feeding tube was displaced. We replaced it here, and confirmed correct placement with an x-ray.**

**Please follow up with the doctor that regularly manages your feeding tube within the next week.**

**Please seek immediate medical attention if you develop any additional issues with the tube, nausea, vomiting, abdominal pain, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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**TAGIHEADINJURYDCINSTRUCTIONS**

**You were seen in the emergency department after a head injury. {Blank single:19197::"After evaluation and observation","After evaluation and imaging"}, we did not find any emergent concerns.**

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{Blank single:19197::"You should follow up with your primary care doctor within a week for a re-evaluation.", "You had a laceration to your head that was repaired with \*\*\*, which should be removed in 7-10 days by your primary care doctor or other health care professional. Please wash the area daily with soap and water."}

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any headaches, confusion, persistent vomiting, or for any other new, changing, worsening symptoms, or if symptoms do not resolve. Otherwise, please follow-up with your regular doctor within a week.

---

#### TAGIHIPPAINDCINSTRUCTIONS

You were seen in the emergency department for hip pain. You were evaluated, and {Blank single:19197::"your exam was reassuring", "your imaging did not show any concerning findings"}. Your pain may be due to \*\*\*.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any worsening difficulty with walking, change in color of your leg, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

#### TAGIHPINTRO

@NAME@ is a @AGE@ @SEX@ w/ {Blank single:19197::"no pertinent pmh", "extensive past medical history most significant for \*\*\*", "no stated past medical history", "a hx of \*\*\*"} who presents to ED {Blank single:19197::"via EMS from \*\*\* with \*\*\*", "via EMS with", "via EMS s/p", "s/p", "from \*\*\* with \*\*\*", "with"}

---

#### TAGIHIPPMHINTRO

@NAME@ is a @AGE@ @SEX@ w/ hx of \*\*\* who presents to ED with

@PMH@

---

#### TAGIHTNDCINSTRUCTIONS

You were seen in the emergency room for high blood pressure. You were evaluated, and your {Blank single:19197::"work up", "physical exam"} was {Blank single:19197::"notable for \*\*\*", "reassuring"}.

It is important that you follow up with your primary care doctor as soon as possible about getting your blood pressure under better control.

**Please seek immediate medical attention if you develop any severe, headaches, nausea, vomiting, chest pain, shortness of breath, stop urinating, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

---

**TAGIHPOGLYCEMIADCINSTRUCTIONS**

**You were seen in the emergency room for hypoglycemia. You were evaluated, and your work up was reassuring. Your symptoms are most likely due to \*\*\*.**

**Please seek immediate medical attention if you develop any headaches, lightheadness, mental status changes, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

---

**TAGIINCIDENTALFINDINGS**

**Radiology Incidental Findings**

You have an incidental finding(s) found on your radiology studies during your evaluation in the Emergency Department. An incidental finding means that you have an abnormality on imaging which was not necessarily related to the focus of your emergency evaluation and treatment today but does require further investigation to ensure that it is not dangerous to your health. It is essential that this incidental finding is communicated promptly to your doctor and/or appropriate specialist so they can determine the most appropriate next steps for evaluating and treating the incidental finding as necessary. When we discover such findings, we will communicate the finding to you and may include a copy of the specific report in your discharge papers. In this way, you can know what the finding is, and you can share the information with your family and outpatient doctors.

In the case of a radiology report, it may include the medical terms describing the finding and recommended follow-up including type of testing and recommended time frame. These are general recommendations only, so you should discuss the incidental finding with your primary care doctor and/or appropriate specialist regarding your specific follow-up needs based on your specific case. If the radiology report is included in your discharge paperwork, it is for education and communication purposes so you know about this incidental finding and can have it evaluated by your primary care doctor and/or appropriate specialist. It is not designed to provide you with a medical diagnosis or to provide you with treatment/services. UMass Memorial Medical Center is not liable or responsible for your specific follow-up of these findings. Medical information changes frequently so you cannot consider this radiology report and general recommendations to be complete or exhaustive.

---

**TAGIJUSTLACDCINSTRUCTION**

**You were also seen for a \*\*\* injury. You were evaluated, and your wound was repaired.**

**You should see your primary care doctor in \*\*\* days to have the {Blank single:19197::"staples","stitches"} removed.**

**Please wash the area daily with soap and water and keep the wound otherwise clean and dry.**

**Please seek immediate medical attention if you develop any redness around the area, pain, oozing, fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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**TAGIKIDNEYSTONESDCINSTRUCTIONS**

You were seen in the emergency department for pain. You were evaluated, and your {Blank single:19197::"your symptoms are consistent with having a kidney stone","your imaging was positive for a kidney stone"}. It is important that you stay well hydrated.

If your pain persists, you may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

{Blank single:19197::"You should follow up with your primary care doctor within a week if the pain persists or sooner if it worsens","You should follow up with urology regarding this issue. The information to make this appointment has been included in this paperwork."}

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

---

**TAGILACREPAIRDCINSTRUCTIONS**

You were seen in the emergency room after a \*\*\* injury. You were evaluated, and your wound was repaired.

You should see your primary care doctor in \*\*\* days to have the {Blank single:19197::"staples","stitches"} removed.

Please wash the area multiple times daily with soap and water and keep the wound otherwise clean and dry.

Please seek immediate medical attention if you develop any redness around the area, pain, oozing, fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

---

**TAGILIDODERM**

You have been given a prescription for a pain patch called a Lidoderm Patch, but you can ask the pharmacy for an over-the-counter alternative if this is not covered by your insurance.

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**TAGILIGHTHEADEDDCINSTRUCTIONS**

You were seen in the ER for lightheadedness. You were evaluated, and {Blank single:19197::"your workup was notable for \*\*\*","your exam was reassuring","all of your labs and imaging were reassuring","all of your labs were reassuring"}. {Blank single:19197::"Your symptoms may have been caused by \*\*\*","Your symptoms may have been caused by dehydration"}

Please seek immediate medical attention if you pass out or if you develop any headaches, nausea,

**vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

---

#### TAGIMACSMMDM

@AGE@ presents for \*\*\*. Patient was worked up for ACS, though differential also includes msk pain, \*\*\*. EKG {Blank single:19197::"remarkable for \*\*\*", "without any acute ischemic changes"}. Trops were {Blank single:19197::"elevated to \*\*\*", "negative x1 w/ second pending", "negative x 2"}. CBC and BMP {Blank single:19197::"were remarkable for \*\*\*", "were unremarkable"}. CXR {Blank single:19197::"remarkable for \*\*\*", "without any acute cardiopulmonary process identified"}. Given HEART score of \*\*\*, {Blank single:19197::"patient was admitted for continued ACS work up", "patient was admitted to the CDU with plan for stress test", "patient was discharged to home with plan for follow up with his PCP regarding potential need for a stress test"}. Dispo: Pt was {Blank single:19197::"signed out to inpatient floor in stable condition", "signed out to ICU in stable but critical condition", "signed out to \*\*\* in the CDU in stable condition", "signed out to following resident Dr. \*\*\*", "dc'd to home in stable condition. Given instructions about indications for return. Pt is in agreement with discharge plan."}

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#### TAGIMDKAMDM

@AGE@ @SEX@ presents for \*\*\*. {Blank single:19197::"Patient is not a known diabetic, however this appears to be new onset", "History of T2DM", "History of T1DM on \*\*\*"}. Given pt's presentation of symptoms, concern for DKA. Fingerstick blood sugar was \*\*\*. Initial VBG showed a pH of \*\*\*, bicarb of \*\*\*. Initial I-STAT potassium was \*\*\*, with anion gap of \*\*\*. Patient given a bolus of normal saline and then started on maintenance fluids, with normal saline and orders to initiate D5 infusion at appropriate blood sugar level. Initiated on an insulin drip of 0.14\*\*\*U/kg/hr. Written to have fingerstick sugar checked every one hour and BMP repeated every 2 hours.

---

#### TAGIMEDICALCLEARANCEDISPO

You were seen in the emergency room for {Blank single:19197::"medical evaluation by a physician"}. {Blank single:19197::"You were evaluated, and your imaging did not show any concerning findings", "You were evaluated, and your labs showed \*\*\*", "You were evaluated, and your imaging showed \*\*\*", "You were evaluated, and \*\*\*", "You were evaluated and you were found to have \*\*\*", "You were evaluated, and your labs and imaging were reassuring", "You were evaluated, and your work up was reassuring", "You were evaluated, and your exam was reassuring"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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#### TAGIMENTALHEALTHDISCHARGEINSTRUCTIONS

You were seen in the ER for mental health reasons. You were evaluated, and you do not require emergency evaluation by a mental health provider. However, please do not hesitate to return if you need additional services.

If you have been deemed safe to return home but would like emergent mental health help, please call the Community Health Link (CHL) Mobile Team at 1-866-549-2142.

Please seek immediate medical attention if you feel like hurting yourself or anyone else or killing yourself or anyone else, if you feel depressed, or for any other new, changing or worsening symptoms. Otherwise, please follow up with your regular doctor and use the resources provided below.

## **Mental Health and Substance Use Referral Lines**

1. Department of Mental Health Information and Referral line: 800-221-0053
2. Massachusetts Substance Abuse Information and Education Helpline (<http://www.helpline-online.com/>): 800-327-5050

## **Mental Health Services: Community Providers**

1. South Bay Community Services , Worcester : 508-521-2200
2. Counseling and Assessment Clinic of Worcester: 508-756-5400
3. Shrewsbury Youth and Family Services: 508-845-6932

## **Community Mental Health Centers: Mental, Physical, & Dental Health**

1. Edward M. Kennedy Community Health Center (Worcester) 508-852-1805
2. Family Health Center of Worcester 508-860-7800

## **Emergency Mental Health Services**

1. Emergency Mental Health-UMASS Memorial Triage Telephone Line: 866-549-2142

## **Community HealthLink—Worcester County**

1. PES (Psychiatric Emergency Services)—Metrowest and Framingham: 800-977-5555, 800-640-5432
2. Department of Mental Health Crisis Intervention Services—Worcester 508-856-3562

## **Mental Health Support and Advocacy Groups**

1. Bipolar & Unipolar Depression Support Group-Worcester: 508-864-4759
2. NAMI—MetroWest Chapter Help Line: 508-875-1544

## **Free Medical Clinics**

1. St. Anne's Free Medical Program (Shrewsbury): 508-754-7920
2. Akwaaba Free Medical Clinic (Worcester): 508-767-1311
3. Guild of Our Lady of Providence Free Medical Program at St. Bernard's (Worcester): 508-798-6818

## **Suicide Hotlines: National & Statewide**

1. National Suicide Prevention Lifeline 800-273-TALK (8255)
2. Samaritans Statewide Helpline: 617-247-0220, 508-875-4500, 877-870-4673
3. Veterans Crisis Line: 800-273-TALK (8255)-Press 1

## **Rape Crisis Hotline**

1. Rape Crisis Center of Central Massachusetts: 800-870-5905 (Español) 800-223-5001

## **Domestic Violence Resources**

1. Day Break 24hr Hotline Support: 508-755-9030
2. SafeLink (Massachusetts Statewide Domestic Violence Hotline): 877-785-2020

## **Pediatric Resources**

1. Youth Mobile Crisis Unit \*Medicaid Insurance Coverage Only\* Worcester Team: 1-866-549-2142  
North/Central Worcester Team: 1-800-977-5555

## **Elder Services Resources**

1. Elder Services of Worcester Area: 508-756-1545

## **Parental Stress Hotline**

1. Parents Helping Parents: 1-800-632-81888 ([www.parentshelpingparents.org](http://www.parentshelpingparents.org))

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TAGIMHTN

@AGE@ @SEX@ presents for elevated blood pressure. \*\*\*. BP here today is \*\*\*, VS are otherwise {Blank}

single:19197::"notable for \*\*\*\*", "within normal limits"]. Physical exam is {Blank single:19197::"notable for \*\*\*\*", "notable for \*\*\* but otherwise benign", "unremarkable"}. Patient does not have any symptoms concerning for hypertensive emergency for example altered mental status, vision changes, severe chest pain, difficulty breathing, abdominal pain, anuria or any other evidence of end-organ injury. EKG was done and {Blank single:19197::"shows no signs of acute ischemic change"}. {Blank single:19197::"As the patient is well appearing and does not have any acutely concerning symptoms, I do not believe any other work up is indicated at this time", "Work up including CBC, CMP sent and without any clinically significant findings"}. They have been instructed to follow up with their primary care physician regarding long-term management of their blood pressure. Dispo: Pt was {Blank single:19197::"signed out to inpatient floor in stable condition", "signed out to ICU in stable but critical condition", "signed out to CDU in stable condition", "signed out to following resident, Dr. \*\*\* with plan for \*\*\*\*", "dc'd to home in stable condition}. Given instructions about indications for return. Pt is in agreement with discharge plan."}

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#### TAGIMIGRAINEDCINSTRUCTIONS

**You were seen in the emergency department for a migraine. You were treated, and your symptoms improved.**

**Please seek immediate medical attention if you develop any worsening headaches, nausea, vomiting, altered mental status, fevers, chills, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.**

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#### TAGIMISCARRIAGEDCINSTRUCTIONS

**You were seen in the emergency room for vaginal bleeding. You were evaluated, and unfortunately you are likely to be miscarrying. You should follow up with OB/GYN. The information to make this appointment has been included in this paperwork.**

**Please seek immediate medical attention if you develop any fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.**

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#### TAGIMMEDICALCLEARANCE

Patient presented to the emergency room because "medical clearance" was requested by \*\*\*. The patient has been evaluated at this time, and based on the history they provided and my physical exam, there are no life-threatening medical concerns that prevent them from returning to \*\*\*. Dispo: Dc'd to \*\*\* in stable condition. Given instructions about indications for return. Pt understands and is in agreement with dc plan.

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#### TAGIMMIGRAINEMDM

@AGE@ @SEX@ presents for evaluation of a severe headache. \*\*\*. Symptoms are consistent with a migraine. Treated with a migraine cocktail consisting of {Blank multiple:19196::"IV fluids", "benadryl", "reglan", "toradol"}. On reassessment, {Blank single:19197::"patient persistently symptomatic", "patient has symptomatically improved"}. Dispo: Pt was {Blank single:19197::"signed out to inpatient floor in stable condition", "signed out to ICU in stable but critical condition", "signed out to CDU in stable condition", "signed out to following resident, Dr. \*\*\* with plan for \*\*\*\*", "dc'd to home in stable condition}. Given instructions about indications for return. Pt is in agreement with discharge plan."}

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#### TAGIMVCDC

You were seen in the emergency department for after a motor vehicle collision. You were evaluated, {Blank single:19197:: "and do not appear to have any serious injuries","and your imaging did not show any fractures or severe injury"}.

You may experience muscle pain over the next several days as a result of the impact. You may take alternating doses of {Blank single:19197::"500","1000"} mg of Tylenol (aka acetaminophen) and {Blank single:19197::"400","800","600"} mg of Motrin (aka Advil, Ibuprofen). For example, if you take Tylenol at 9 am, you can take Motrin at noon and then Tylenol again at 3 pm. This approach will give you increased pain control and maximum length of relief from symptoms. Alternatively, you can take both medications together every 6 hours.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding your visit.

#### TAGISCIATICADCINSTRUCTIONS

You were seen in the emergency department for back pain. You were evaluated, and your exam was reassuring. You most likely are experiencing worsening symptoms of your known\*\*\* sciatic pain.

Please seek immediate medical attention if you develop any worsening numbness or tingling, urine or fecal incontinence, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

#### PATIENT INFORMATION

##### Sciatica

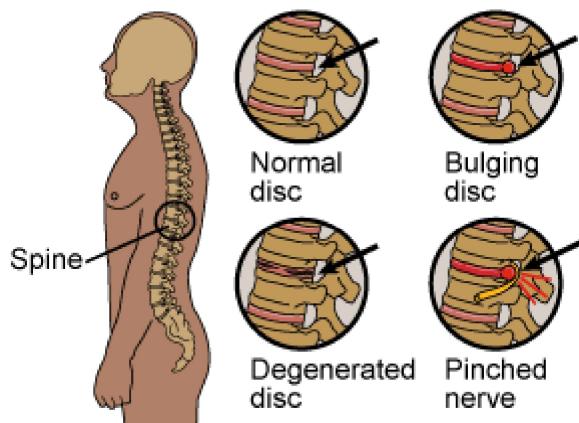
###### About this topic

You may have pain, weakness, numbness, and tingling that runs from your buttocks down the back of your leg to your feet. This is called sciatica. It happens when something is pressing on or bothering the sciatic nerve.

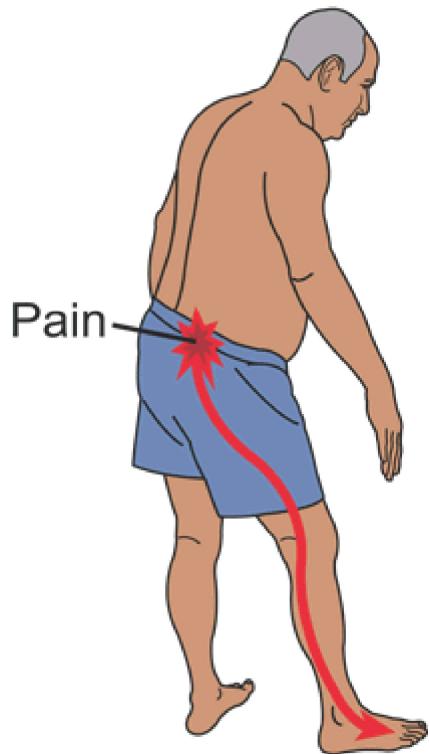
This large nerve starts in your lower back. It runs all the way down the back of your leg.

Sciatica is a sign of some other health problem that involves the nerve. It most often happens on just one side. Most of the time, sciatica will get better without needing surgery. Treating the health problem that is causing the pain can make this condition go away.

##### Spine



# Sciatica



## What are the causes?

You may have pressure on the nerves from wear and tear over time. You may also have a problem with one of the discs in your spine. It could be bulging out or collapsing and putting pressure on the nerve. The spaces where the nerves leave the spine may become narrow. One of the bones might slip forward slightly and cause pressure. Other things that may cause this problem include injuries, trauma, infection, pressure from a muscle, or tumors.

## What can make this more likely to happen?

This condition often starts when you are between 30 and 50 years of age. It is more common in the lower back and you are more likely to have problems if you have had a back injury. Other things, like being overweight or having a job where you do a lot of lifting and twisting, can make you more likely to have this problem. Having others in your family with low back pain or sciatica also increases your risk. Smoking or having diabetes raises your risk for sciatica.

## What are the main signs?

- Pain that shoots from your lower back into one buttock or leg. The pain becomes worse with sitting or standing for a long period of time. Coughing and sneezing may make it worse. The pain may be a mild ache or a sharp burning sensation. You may have more pain if you lift your leg straight up when lying down.
- Weakness in the leg or foot, especially when bending the knee or pointing the foot down
- Numbness or tingling in the leg or foot
- Trouble walking
- Loss of bowel or bladder control. This is rare but needs attention right away.

## How does the doctor diagnose this health problem?

The doctor will do an exam and feel around your lower back and buttocks. Your doctor may have you move and push and pull on your legs to test your motion and strength. Your doctor may have you raise one leg straight up off the exam table. Your doctor may also have you do things like squatting and walking on your toes and heels. Your doctor may check the feeling and reflexes in your legs to look for nerve problems.

## The doctor may order:

- X-ray
- CT or MRI scan
- Nerve conduction tests

- Lab tests

How does the doctor treat this health problem?

- Rest
- Ice
- Heat may be used later but not right away. Heat can make swelling worse.
- Crutches, cane, or walker if you are having trouble walking
- Physical therapy (PT) for treatments to lessen pain and for instruction on exercises to help the problem
- Chiropractor
- Surgery may be needed if other treatment plans do not work.

Are there other health problems to treat?

Treating the health problem that is causing the pain most often makes this condition go away.

What drugs may be needed?

The doctor may order drugs to:

- Help with pain and swelling

The doctor may give you a shot of an anti-inflammatory drug called a corticosteroid. This will help with swelling.

Talk with your doctor about the risks of this shot.

What problems could happen?

- Long-term back pain
- Loss of feeling or movement in the legs or feet
- Weight gain, less muscle strength and flexibility, weaker bones
- Need for surgery
- Infection
- Loss of bowel and bladder function

What can be done to prevent this health problem?

- Stay active and work out to keep your muscles strong and flexible. Warm up slowly and stretch before you exercise.
- Use good posture.
- Use proper ways to lift and bend:
  - ◆ Spread your feet apart so you have a good base of support. Then, bend with your knees when you pick up something from the ground.
  - ◆ When lifting and moving an object, keep your back straight. Keep the object as close to your body as possible. Do not twist. Instead, move your feet to the direction you are going.
- Take breaks often when seated for long periods of time. Get up and walk around from time to time.
- If you stand for long periods, put one leg up on a small stool for a while. Then, change legs.
- If you sleep on your side, put a pillow in between your knees to keep your back and legs in a good position.
- Use good supportive footwear. Avoid high heels.
- Keep a healthy weight.

Where can I learn more?

American Academy of Orthopaedic Surgeons

<http://orthoinfo.aaos.org/topic.cfm?topic=a00351>

Last Reviewed Date

2015-08-27

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## TAGISEIZUREDCINSTRUCTIONS

You were seen in the ER after a seizure. You were evaluated, and your physical exam was reassuring. However, you should follow up with Neurology regarding this visit. The number has been provided for you in this paperwork.

Please seek immediate medical attention if you develop any headaches, nausea, vomiting, vision changes, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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## Patient Education

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### Seizures

#### The Basics

[Written by the doctors and editors at UpToDate](#)

**What are seizures?** — Seizures are waves of abnormal electrical activity in the brain. Seizures can make you pass out, or move or behave strangely. Most seizures last only a few seconds or minutes.

Epilepsy is a condition that causes people to have repeated seizures. But not everyone who has had a seizure has epilepsy. Problems such as low blood sugar or infection can also cause seizures. Other problems such as anxiety or fainting spells can cause events that look like seizures.

**What are the symptoms of a seizure?** — There are different kinds of seizures. Each causes a different set of symptoms.

People who have "tonic clonic" or "grand mal" seizures often get stiff and then have jerking movements. People who have other types of seizures have less dramatic changes. For instance, some people have shaking movements in just 1 arm or in a part of their face. Other people suddenly stop responding and stare for a few seconds.

**Should I see a doctor or nurse if I have a seizure?** — If you have never had a seizure before and you have one, you (or whoever is with you) should **call for an ambulance (in the US and Canada, dial 9-1-1)**. Having a seizure can be a sign that something is wrong with your brain.

**How are seizures treated?** — The right treatment for seizures depends on what is causing them. If you have seizures because of an infection, you will probably need treatments to get rid of the infection. On the other hand, if you have repeated seizures because of epilepsy, you will probably need anti-seizure medicines, also called "anti-convulsants."

People sometimes need to try different medicines before they find a treatment that works well. Seizures can be hard to control. But if you work with your doctor, chances are good that you will find a treatment that works.

**Do anti-seizure medicines cause side effects?** — Yes. Anti-seizure medicines can cause side effects. They can make you feel tired or clumsy, or cause other problems. If you are bothered by side effects, tell your doctor about it. He or she can work with you to find the medicine or dose that causes the fewest problems. Most of the side effects from these medicines are mild, but there are 2 rare side effects that are very serious:

- **Anti-seizure medicines can increase the risk of becoming suicidal (wanting to kill yourself).** Speak to your doctor or nurse right away if you start to feel depressed or have thoughts of harming yourself.
- **Anti-seizure medicines can cause a rare but serious skin rash.** Speak to your doctor or nurse right away if you notice a new rash while taking an anti-seizure medicine.

**What if anti-seizure medicines do not work for me?** — If you keep having seizures even after trying different medicines, you might have other options. Some people have surgery to remove the part of their brain that is causing seizures. Others get a device put in their chest that helps control seizures.

Until you have your seizures under control, DO NOT DRIVE. The laws that say when a person with seizures can drive are different depending on where the person lives. Ask your doctor if you can safely drive and about the laws where you live.

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Also, if your seizures are not under control make sure to take other safety steps. For example, do not swim without someone else nearby who could help you if you started having a seizure. And avoid activities that could result in you falling from a height.

**How can I reduce my chances of having more seizures? —** You can:

- Take your medicines exactly as directed — at the right times, and at the right doses.
- Tell your doctor about any side effects you have. That way the 2 of you can find the best medicine for you.
- Be careful not to let your prescription run out. (Stopping anti-seizure medicine suddenly can put you at risk of seizure.)
- While on anti-seizure medicines, check with your doctor before starting any new medicines. Anti-seizure medicines can interact with prescription and non-prescription medicines, and with herbal drugs. Mixing them can increase side effects or make them not work as well.
- Avoid alcohol. Alcohol can increase the risk of seizures, affect the way seizure medicines work, and increase side effects from anti-seizure medicines.

**What should my family members do if they see me having a seizure? —** Ask your doctor what your family members should do. Some people will have seizures from time to time, and they might not need to see a doctor every time. But if you have a seizure that lasts longer than 5 minutes or if you do not wake up after a seizure, your family members should **call for an ambulance (in the US and Canada, dial 9-1-1)**.

Your family members should **not** try to put anything in your mouth while you are having a seizure. But they should make sure you do not bang against any hard surfaces.

**What if I want to get pregnant? —** If you take anti-seizure medicines, speak to your doctor or nurse before you start trying to get pregnant. Some anti-seizure medicines can hurt an unborn baby. You might need to switch medicines before you get pregnant.

All topics are updated as new evidence becomes available and our [peer review process](#) is complete.

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#### TAGISTREPDCINSTRUCTIONS

@NAME@ was seen in the emergency room for \*\*\*. You were evaluated, and your work up was reassuring, and a strep test was positive.

{Blank single:19197::"You have been given a prescription for an antibiotic that should help resolve your symptoms.", "You were given a shot of antibiotics that should resolve your symptoms." }

Please seek immediate medical attention if you develop any difficulty swallowing, breathing, headaches, nausea, vomiting, chest pain, shortness of breath, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**TAGISYNCOPEDCINSTRUCTIONS**

You were seen in the ER after {Blank single:19197::"almost passing out","passing out"}. You were evaluated, and your work up was {Blank single:19197::"notable for \*\*\*, "reassuring"} . {Blank single:19197::"You may have been dehydrated."}

Please seek immediate medical attention if you develop any chest pain, repeat episodes of fainting, severe headaches, vision changes nausea, vomiting, or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**TAGIUTIDCINSTRUCTIONS**

You were seen in the emergency room for {Blank single:19197::"abdominal pain","urinary symptoms"}. {Blank single:19197::"You were evaluated, and your exam was reassuring","You were evaluated, and \*\*\*","You were evaluated and you were found to have \*\*\*, "You were evaluated, and your labs and imaging were reassuring","You were evaluated, and your work up was reassuring","You were evaluated, and your imaging did not show any concerning findings","You were evaluated, and your labs showed \*\*\*, "You were evaluated, and you were found to have a urinary tract infection","You were evaluated, and your imaging showed \*\*\*"}. {Blank single:19197::"Your symptoms are most likely due to \*\*\*, "You should follow up with \*\*\*. The information to make this appointment has been included in this paperwork","You should follow up with your primary care physician regarding this visit"}.

You have been given a prescription for an antibiotic, which you should take as prescribed. {Blank single:19197::"The prescription has been sent to the pharmacy listed in this paperwork","You have been given a print out prescription that you should take to a pharmacy as soon as possible"}.

Please seek immediate medical attention if you develop any {Blank single:19197::"fevers, chills, headaches, nausea, vomiting, chest pain, shortness of breath,"} or any other new, changing, or worsening symptoms or if your symptoms do not resolve. Otherwise, please follow up with your regular doctor regarding this visit.

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**TIMESTAMP**

@TODAYDATE@ @NOW@

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**TYLENOLIB****Over-The-Counter Pain Medicine Dosing Chart****Acetaminophen (Tylenol-type medicine)**

May be given up to every 4 hours as needed to relieve pain or fever

Weight (lbs)	Weight (kg)	Children's suspension (160mg/5mL)	"Feverall" suppository (120mg)	Children's chew tabs (80mg)	Junior chew tabs (160mg)	Adult tabs (325mg)	Adult extra strength tabs (500mg)
6-11 lbs	3-5 kg						
12-17 lbs	6-8 kg	2 mL	½ supp				

18-23 lbs	9-10 kg	4 mL	1 supp				
24-35 lbs	11-16 kg	5 mL	1 supp	2 tabs			
36-47 lbs	17-21 kg	7.5 mL	2 supp	3 tabs			
48-59 lbs	22-27 kg	10 mL	2 supp	4 tabs	2 tabs	1 tab	
60-71 lbs	28-32 kg	12.5 mL		5 tabs	2.5 tabs	1 tab	
72-95 lbs	33-43 kg	15 mL			3 tabs	1.5 tabs	1 tab

**Ibuprofen (Motrin or Advil-type medicine)**

May be given every 6-8 hours as needed to relieve pain or fever  
Should NOT be used for infants under 6 months age

Weight (lbs)	Weight (kg)	Children's suspension (100mg/5mL)	Junior strength tabs (100mg chew or swallow)	Adult tabs (200mg tabs)
12-15 lbs	5-7 kg	2 mL		
16-23 lbs	8-10 kg	4 mL		
24-32 lbs	11-14 kg	5 mL	1 tab	
33-42 lbs	15-19 kg	7.5 mL	1.5 tabs	
43-54 lbs	20-24 kg	10 mL	2 tabs	1 tab
55-65 lbs	25-29 kg	12.5 mL	2.5 tabs	1 tab
66-76 lbs	30-34 kg	15 mL	3 tabs	1 tab
77-90 lbs	35-41 kg		3.5 tabs	1 tab
91-130 lbs	42-60 kg			2 tabs

**\*\*Ask your pharmacy for droppers and oral syringes if needed\*\***

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