The purpose of this document is to show you how to write common ward/consult notes and dictations.

CONSULT NOTES

A good consult note contains the following elements, and should be prepared in this order:

HISTORY

ID and **RFR (reason for referral)**
- ID = Gender and age
- Include occupation and handedness if a hand consult

HPI
- Hand injuries: Mechanism, time of injury, any treatment so far
- Tetanus status if open wounds

PMHx
- Include PSHx (past surgical history)

Medications
- *Blood thinners*

SocHx
- Include smoking, EtOH, and recreational drug use (esp. IVDU)

Allergies
- Clarify the reaction to any stated allergy

PHYSICAL EXAMINATION

INVESTIGATIONS

ASSESSMENT AND PLAN

Example

ID 28M R-handed, works in construction

RFR Query flexor tenosynovitis

HPI 3d ago puncture wound to volar distal phalanx left index finger from drill bit. Reports pain locally and in palm x1 week. Similar episode hand pain 1 year ago without Hx trauma, resolved spontaneously. Denies fevers and chills. Tetanus UTD.

PMHx Healthy. Appendectomy @6yo

Meds None

SocHx Lives with girlfriend. Nonsmoker, no EtOH, no rec drug use

ALL None

O/E Looks well. BP 130/90, HR 75 bpm, RR12, SaO2 99% room air, afebrile.
R hand mildly swollen compared to L, mild palmar erythema. All digits NVI.
R index: swollen with 0.5 mm puncture wound mid DP radially, no purulence. Pain on passive extension but no tenderness over flexor sheath, no fusiform swelling, and digit held in neutral position.
Wound explored and irrigated in sterile conditions under local anaesthesia: maximal wound depth is to subcutaneous tissue only

Ix WBC 6.0
XR R hand: normal

A+P Inconsistent with flexor tenosynovitis as wound not adjacent to flexor sheath and pain began before injury.
Likely tenosynovitis given previous episode with spontaneous recovery.
Rx given for Naproxen x1 week. F/U Dr. X in 1 week, or call office if worsening or becomes unwell.

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PROGRESS NOTES (FOR INPATIENTS)

All progress notes should begin with a line summarizing the patient.
The remainder of the note follows the format "SOAP":

Subjective
- How is the patient feeling, any concerns
- Pain control, nausea/vomiting
- Ambulating?
- Tolerating diet?

Objective
- Vital signs
- Drain outputs
- Urine output if relevant
- Findings on physical examination

Assessment
- How is the patient doing overall, what are the issues

Plan
- Summarize plan for each issue

Example
55F POD #3 bilateral immediate breast reconstruction with DIEP flaps
S: Patients feels well, pain controlled. Eating well. Ambulating.
O: AVSS. JP output: #1 50cc, #2 60cc – both serosanguinous. Flaps: good colour, cap refill, turgor. Both warm. Small blue discoloration lateral aspect right breast, 2x1 cm. Abdomen soft. Incisions clean, dry and intact.
A/P: Doing well. Continue to monitor flaps as per protocol. Reassess lateral aspect right breast this afternoon.

ADMISSION ORDERS

For this, you can use of the mnemonic AD DAVID.

Admit to Plastic Surgery, under Dr. Surgeon
Diagnosis
Diet
Activity
Vitals
IVF, **I**nvestigations, **I**ns and outs
Drugs (the 5 P's)

- Pain (analgesia)
- Puke (anti-emetic)
- Prophylactic (anti-coagulation)
- Pus (antibiotic)
- Precedent medications (restart appropriate home meds)

Example
Admit to Plastic Surgery, under Dr. X
Diagnosis: Flexor tenosynovitis L D3

NPO (patient is pre-op. May be NPO @ midnight if OR not planned until following day)
AAT (activity as tolerated); Splint L hand
Vitals q8h (vitals can be more frequent if patient unstable)
IV RL @ 100cc/hr while NPO (note: maintenance IVF should be based on the 4:2:1rule)
CBC, lytes, BUN, Cr, PTT, INR qAM x2
Monitor ins and outs (for unstable patients)
Group and screen (or type and cross if ++ blood loss probable in OR – check with staff/seniors if this is needed)
EKG (if >40y pre-op)
CXR (if >50y pre-op)
Ancef 1g IV x1 on call to OR (Clindamycin 600mg IV x1 if pen-allergic)
Antibiotics for infection need to be prescribed around the clock: check with your staff/senior which you should prescribe
Gravol 25-50 mg PO/IV q6h PRN
Dressing orders (check with staff/seniors)
Patients home meds
Anaesthesia consult (if patient has other co-morbidities and high risk for surgery)

Please note that all orders should be reviewed and co-signed by a resident. Be mindful of patient's allergies before ordering medications.

OR NOTE

Pre-Operative Dx:
Post-Operative Dx:
Procedure:
Surgeon:
Assistants:
Anaesthesia:
EBL:
Complications:
Disposition:

Example
Pre-Operative Dx: Dupuytren's contracture
Post-Operative Dx: Same
Procedure: Palmar fasciectomy R D4 + D5
Surgeon: Dr. Martin
Assistants: Willoughbail (R3), Ramjam (R2)
Anaesthesia: Bier block with neurolept anaesthesia, Dr. X
EBL: nil
Complications: None
Disposition: Extubated in OR. Stable to recovery room

POST-OPERATIVE ORDERS

For this, you can again use of the mnemonic AD DAVID.

Admit to Plastic Surgery, under Dr. Surgeon
Diagnosis

Diet
Activity
Vitals
IVF, **I**nvestigations, **I**ns and outs
Drugs (the 5 P's)

- Pain (analgesia)
- Puke (anti-emetic)
- Prophylactic (anti-coagulation)
- Pus (antibiotic)
- Precedent medications (restart appropriate home meds)

Example (post-op orders, patient for same day discharge)
Admit to Plastic Surgery, under Dr. Martin
Diagnosis: Flexor tenosynovitis L D3

Sips to DAT
AAT (activity as tolerated)
Splint L hand
Vitals q8h
IV RL @ 100cc/hr; SLIV (Saline lock IV) when drinking well
Tylenol #3 PO 1 -2 tabs q4h PRN
Gravol 25-50 mg PO/IV q6h PRN
*No DVT prophylaxis (patient ambulatory, low risk for DVT/PE)
*No home meds
Discharge home when well
Rx on chart
F/u with Dr. Martin in 2 weeks

Please note that all orders should be reviewed and co-signed by a resident. Be mindful of patient's allergies before ordering medications.

DISCHARGE SUMMARY

Date of admission:
Date of discharge:
Admission diagnosis:
Discharge diagnosis:
Operations performed in hospital:
History of presenting illness:
- Describe reason for admission and relevant clinical information

Course in hospital:
- Any major events, was the patient well or unwell, etc.

Investigations in hospital:
- Include if any significant findings

Discharge medications:
Discharge plan:
- Who the patient is following up with
- Any issues the GP needs to follow up on
- Dressings (CCAC)
- Return to ER if...

Example
Date of admission: June 20, 2015
Date of discharge: June 30, 2015
Admission diagnosis:
1. Scald burn to bilateral thighs, TBSA = 15%

Discharge diagnosis:
1. Second degree scald burns to bilateral thighs, TBSA = 15%
2. Hypertension

Operations performed in hospital: Split thickness skin grafting left thigh June 23
History of presenting illness: Ms. X is a 65 yo F admitted to Hamilton General Hospital on June 22 after sustaining scald burns to her thighs from hot tea. She was transferred to our hospital from Brantford due to concerns of full thickness burns of TBSA 15%. She was admitted for monitoring and wound management as we suspected she may require skin grafting.
Course in hospital: It became apparent on the second day of admission that her left thigh burns were deep partial thickness and wound benefit from split thickness skin grafting to expedite healing. This procedure occurred on June 23, 2015. Post-operatively she was stable, though she was hypertensive throughout her admission with systolic pressures in the 180s. She was started on hydrochlorothiazide. The patient was kept in hospital until her dressings were manageable by CCAC on an outpatient basis.
Investigations in hospital: Routine bloodwork was unremarkable.
Discharge medications:
1. Hydrochlorothiazide 12.5 mg PO daily
2. Tylenol #3 x 40 tabs
3. Colace x 20 days

Discharge plan:
1. CCAC will be providing dressing changes q2days.
2. She will return for reassessment at the outpatient burn clinic on X day.
3. We kindly ask her family doctor, Dr. Y, to follow up on her hypertension and adjust her medications as necessary.