VASCULAR CONSULTATION-H&P

NAME: ____ ***date:*** ________________

CC: _____ carotid ____
_____ aorta ____
_____ lower ext ____
_____ other ____

HPI (4)
_____ dm _____ htn_____ cva ______________________________________
_____ chol _____ mi _____ tia ______________________________________
_____ angina ____
_____ pain-severity ____1 ____2 ___3 ______________________________
_____ precipitating factors ______________________________________
_____ relieving factors ______________________________________
_____ duration ____
_____ associated signs/symptoms ______________________________________

Reviewed w/pt by MD ________________________

PMH Surgical & Medical
- _____ Vascular operations ______________________________________
- _____ Cabg/Valve ______________________________________
- _____ Ptca ______________________________________
- _____ Pta ______________________________________
- _____ Abd. Surg. ______________________________________
- Other pertinent ______________________________________

SH ___ smoking ___ quit ______________________________________
___ working ___ retired ______________________________________

FH ___ cva ___ mi ___ AAA ___ pvd ______________________________

Reviewed w/pt by MD ________________________

PATIENT TO COMPLETE THIS SECTION *(PHYSICIAN REVIEW)*

ALLERGIES (medications, food, tape, etc.) ____
____

MEDICATIONS (drug, dose, frequency) ____
____
____
____

_______ see nursing sheet\mar _______ see attached sheet (we will copy your list)

REVIEW of SYSTEMS (10) Y=yes N=no Do you have or have you experienced

- Constitutional _____ fatigue _____ weight loss _____ cancer
- Opth _____ glaucoma _____ visual loss
- Cv _____ congestive heart failure _____ irregular heart rhythm
- Gi _____ ulcer disease _____ bloody stools
- Gu _____ kidney disorder _____ prostate history
- MusSkl _____ arthritis _____ spinal disorder
- Neu _____ syncope (black out) _____ dizziness
- Endo _____ hyperthyroid _____ hypothyroid
- Resp _____ short of breath _____ asthma _____ emphysema
- Hem _____ blood clots _____ varicose veins or vein stripping

Reviewed w/pt by MD ________________________

SAH fax = 494-6891 **ADA fax = 494-6874**

____

Physician Signature Date Time

Patient Identification Label

NAME: ____ **date:**__________________

EXAM (Y=yes, N=no) (detailed, level 3=6 areas) (comp., level 4,5=all 9 areas)

- Constitutional
  - Vitals (3 of 7) BPlt ____ BPrt ___ P ____ R ___ T ____ H ___ Wt ____
  - Appearance ______ wdwn ______ healthy, no distress
- Eyes
  - Inspection _____ conjunctivae normal _____ lids normal
  - Exam _____ EOMI _____ pupils reactive, symmetrical
- Neck
  - Overall appearance _____ normal (no masses, crepitance, or tracheal deviation)
  - Thyroid _____ normal (no masses, tenderness, or enlargement)
- Respiratory
  - Effort _____ unlabored, no restrictions
  - Auscultation _____ lungs clear, no wheeze or crackles
- Cardiovascular (2 required)
  - Auscultation _____ RRR _____ murmur
  - Carotid bruits _____ right _____ left
  - Femoral pulse _____ right _____ left (0=absent, 4=normal)
  - Popliteal pulse _____ right _____ left
  - Post. Tibial pulse _____ right _____ left
  - Dorsalis pedis _____ right _____ left
  - Extremities _____ edema _____ varicosities
- Gastrointestinal
  - Abdomen _____ normal (no masses or tenderness)
  - Organomegaly _____ normal (no spleen or liver enlargement)
- Lymphatic (lymph nodes)
  - Palpation _____ neck normal _____ groin normal
- Skin _____ normal (no rashes, lesions, or ulcers)
  - Palpation _____ normal (no induration or nodules)
- Psychiatric _____ alert, oriented x 3
  - Mood, affect _____ normal (no depression, agitation, or severe anxiety)

Lab, Radiology:____

____

IMPRESSION: **1.**____

2.____

PLAN: **1.**____

2.____

Referring Physician: ____

Medical decision level: ___ minimal (1 or 2) ___ low (3) ___ mod. (4) ___ high (5)

Discussion (options, risk, benefit):______________________________________

	1	2	3	4	5
Outpatient Consult	15	30	40	60	80
Inpatient Counsult	20	40	55	80	110

______Minutes spent with patient; unit/floor time > 50% counseling/care coordination regarding:____

____

Physician Signature Date Time

Patient Identification Label

Patient Information OR Sticker Here:

Patient Name:_____________________________

DOB:____________________________________

DOS:____________________________________

Resident/Teaching Physician Attestations

Resident Attestation:
I discussed the patient with Dr. ________________ who agrees with the patient's plan of care as written with changes noted.

Resident ____________________________ Date: ____________ Time: ______

Teaching Physician Attestation:
I have seen and examined the patient, discussed with the Resident and I agree with the plan of care as written, with changes noted.

____________________________ Date: _____________ Time: _______
Attending Physician