Presentation of Newly-Admitted Patient:

1. Referring physician
2. ID: Age , gender, profession living with … / alone at home / NH / retirement home
3. CC: Main symptom x duration
4. Relevant Past Medical History: depending on chief complaint (not all)
5. HPI: Chronological with admit to ED visit as point of reference (no months, days of week, dates)
    a. *Baseline functioning (ADL / IADL) if patient elderly / disabled*
    b. "Well until 4 days previous to admission"
    c. Should include onset, course, duration, location, radiation, character, intensity, precipitating factors, aggravating factors, relieving factors, associated symptoms
    d. Also need: Previous similar experience, risk factors (where applicable), relevant family history, impact and patient and family
    e. Why patient went to ED on that particular day and how arrived (EMS vitals, observations)
    f. Abnormal triage vitals and what was done in ED
6. Medications / allergies
    a. Generic / grouped
7. Social
    a. Smoking / EtOH / recreational drugs
    b. CCAC
    c. Code Status / SDM
    d. ADL / IADL (if not mentioned previously)
8. Exam
    a. General Observations
    b. Vitals
    c. Systems
9. Investigations
    a. Labs / ECG / Radiology / Other
10. Summary
    a. One to two sentence history summary. One sentence for abnormal exam findings. One sentence for abnormal investigations (pertinent positives only)
11. Impression
    a. Trainee tries to explain abnormalities found in summary
12. Issues / Plan