Presentation Tips

1. Mention referring physician or nurse practitioner (must be a staff physician / NP)
    a. Needed for billing purposes and medico-legal reasons
2. Have compete ID
    a. Mention job (previous job if retired), with whom they are living and if outside Toronto
3. Keep chief complaint succinct
    a. Should be a single SYMPTOM with duration (exceptions to this)
4. Only include Relevant Past Medical History in HPI
    a. You should mention past medical history after HPI
5. HPI
    a. Present chronologically with point of reference being presentation to hospital and starting with when last well / at baseline
        i. Presentation should be in countdown format (2 months ago, 3 weeks ago, etc.)
    b. Report why they came to ED at that particular time (why not sooner?)
    c. Report how they got to ED (EMS, car / cab / TTC, walked)
    d. List risk factors for possible items on differential
        i. For CP, need to mention all cardiac risk factors
    e. Mention what has happened in ED
        i. Triage vitals, treatments and response, significant investigations
    f. Comment on baseline function (related to CC or ADLs) and change
    g. Add important details for certain conditions
        i. COPD (CO2 retention, Home O2, ICU)
        ii. Cancer (when diagnosed, treatments (Sx, Rads, Chemo))
        iii. DM (diet, OHA, insulin)

6. Medications
    a. Use generic names
    b. Group medications together (DM meds, anti-HTN meds)

7. Social
    a. Need to comment on recent / habitual use of nicotine / EtOH / recreational drugs
    b. For purposes of treating / anticipating withdrawal
    c. Code status needed (both in regards to VSA and if ill)
    d. Comment on home supports (family / CCAC)
    e. Comment on substitute decision maker (even if patient competent)

8. Exam
    a. Include general observation prior to vitals
    b. Vitals that you report here are taken from when you examined patient
    c. Vitals not given in detail – should be as time saw patient
    d. Report what you can actually hear / see / feel (breath sounds instead of air entry)
    e. Do not give diagnoses / opinion : “rhythm felt like afib”; “murmur sounded like AS”
    f. Have standardized order of systems

9. Summary
    a. One sentence each for history / examination / investigation abnormal findings