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# SUCCESS ON THE WARDS

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a student-to-student guide to getting the most out of your third year

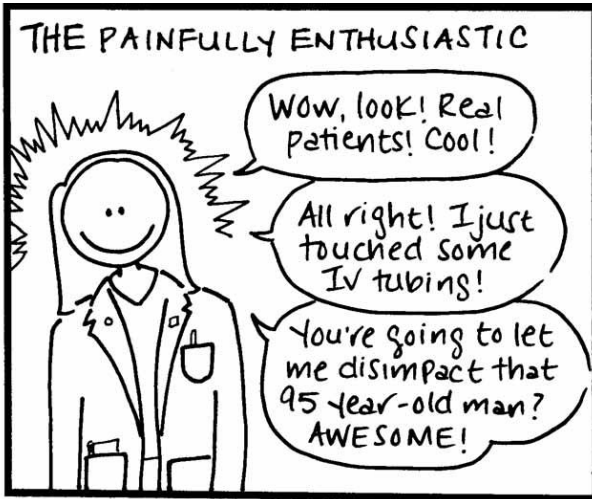
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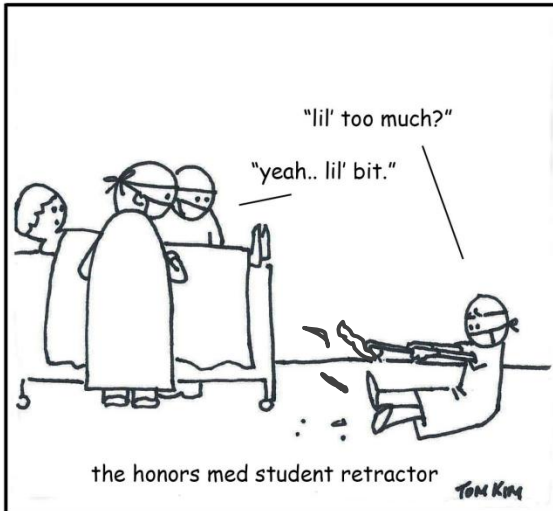
(hopefully)



by Michelle Au

(hopefully not)

## mons hubris by tom kim



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# TABLE OF CONTENTS

*SUCCESS ON THE WARDS*

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INTRODUCTION ..... 3

THE WARD TEAM ..... 4

WHAT IS JUNIOR YEAR? ..... 5

RULES TO LIVE BY ..... 7

BASIC CHARTING INFORMATION AND TIPS

    The Electronic Medical Record ..... 9

    Using Powerchart and Epic ..... 9

    Dot Phrases ..... 10

    Documenting Lab Values ..... 10

    History and Physical ..... 11

    The SOAP Note ..... 12

CASE PRESENTATION ..... 13

ADMISSION AND DISCHARGE ..... 16

    Prescriptions ..... 18

THE ROTATIONS

    Lay of the Land ..... 19

    Guide to the Patient Room ..... 19

    Key People on the Floor ..... 20

    NMH Pager ..... 21

    Books & References ..... 21

**MEDICINE** ..... 22

**SURGERY** ..... 27

**OBSTETRICS & GYNECOLOGY** ..... 31

**PEDIATRICS** ..... 40

**PSYCHIATRY** ..... 44

**NEUROLOGY** ..... 47

**PRIMARY CARE** ..... 49

THIRD YEAR TIMELINE ..... 51

PATIENT PRIVACY ..... 52

SAFETY ISSUES (Needle Sticks, Security) ..... 53

STUDENT CODE OF CONDUCT ..... 55

ABUSIVE BEHAVIOR ..... 56

MEDICAL STUDENT DUTY HOURS POLICY ..... 57

CLERKSHIP TRANSPORTATION REIMBURSEMENT POLICY ..... 59

CONCLUSION ..... 60

APPENDIX (ABBREVIATIONS) ..... 61

HOSPITAL SLANG ..... 66

HELPFUL PHONE NUMBERS ..... 67

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# Introduction

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*To the Feinberg M3 Class:*

**Welcome** to the twenty-third edition of *Success on the Wards!* Your third year promises to be a fun, challenging, exciting and rewarding opportunity. At times, though, it may seem overwhelming, intimidating and frustrating. We hope that this booklet will help ease some of the confusion and worry and, at least a little bit, prepare you for what lies ahead.

Though difficult, the first two years of medical school were something that you were used to—you spent your time in the library or the classroom (or neither). But, as you look forward to this year with excitement, we're sure many of you have that sinking feeling in the pit of your stomach that you have no clue what you're doing. Rest assured, none of us did (well, maybe a few...you know who you are). Generations of medical students before you have experienced that same feeling, have survived and more importantly, thrived! But much like learning how to swim, you will learn the most by simply jumping in. The information in this booklet is designed to help you float in the beginning. As the year progresses, you'll realize that you no longer need it and are gaining the confidence all your lecturers, deans and upperclassman promised you would find.

The next two clinical years of medical school will provide some of the most influential and rewarding experiences of your life. You will learn from and work alongside your peers, mentors, future colleagues, and, most importantly, your patients. Hopefully, these experiences will guide your decisions about the rest of your career. So make sure to study hard, pay attention, have fun and, of course, keep this book close at hand. Good luck!

*—The Class of 2012*

If you have any suggestions for ICC or this guide, please contact Dr. Amy Kontrick or Lisa Wittig so future classes may benefit.

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# The Ward Team

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The members of the team are described below. Students are an integral member and may be most knowledgeable about a patient.

**ATTENDING PHYSICIAN** has completed a residency and possibly a fellowship and is a member of the Northwestern faculty. They are ultimately responsible for the patient's care and will thus make or approve all major decisions.

**FELLOW** has completed a residency program and is now in subspecialty training, e.g. cardiology, vascular surgery, high-risk obstetrics, etc. As a junior student, your contact with these individuals will occur in the setting of a subspecialty consult clinic, operating room, or on rounds. Fellows are, in general, exceptionally knowledgeable about their specialty and slightly less overworked than residents. Thus, they make excellent teachers.

**RESIDENT** is anyone in their residency training, usually referring to doctors with more than one year of postgraduate training (PGY-2 and above). Since attendings typically round once a day, the resident is in charge of the daily work of the team. Besides helping the intern in managing the team's patients, he or she is also primarily responsible for the education of students. Clerkship evaluations are most often solicited from residents.

**INTERN** is in the first year of postgraduate training (PGY-1). The intern is primarily responsible for the moment-to-moment patient care. You may be paired with an intern who will work with you on the patients you are assigned. The intern usually has many tasks to be completed through the day, so any work you can do to help out will be greatly appreciated. In return, they can show you the ropes around the hospital, teach you about your patients, and offer a good evaluation of your performance to the resident. Helping the intern with their work can be an excellent learning experience and makes their lives much easier (therefore, they are much happier and less stressed).

**SENIOR STUDENT** is a fourth-year medical student who is taking an elective or a sub-internship (Sub-I). He or she has the responsibilities of an intern and is supervised by the resident. The fourth-year student will not be responsible for your evaluation but they can be a great resource for all of those silly questions that you have but are afraid to ask the residents. Remember, they were in your shoes a year ago so they can really help you make the transition.

**JUNIOR STUDENT** That's you! Described fully in the next section.

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# What is Junior Year?

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The goal of the junior clerkships is to begin to learn the clinical skills of a physician and expose you to different fields. You will learn to apply the knowledge and skills from M1 and M2 year to actual patient care. This is a challenging endeavor, but you will slowly improve as the year progresses. Especially in the beginning, you will frequently find that you lack knowledge of a particular disease process or the skills to perform a certain procedure. No one expects you to know everything. But, they do expect that you try to find the information and teach yourself (this is where PBL skills come in handy...and Up To Date). As the year progresses, we promise that your clinical judgment, problem solving skills, time management and efficiency, and ability to manage patients issues will continue to develop.

## Your Role

Your first priority is to learn as much as possible. Read, read, read. Carry something with you at all times to read because spare time on the wards is unpredictable.

Aside from learning, your second priority is to make the lives of your team easier. Every day, write the daily progress notes for the patients you are following. In addition to helping you integrate your knowledge, these steps will help organize your thoughts about your patients, force you to think through a clinical plan, and ensure that you are up-to-date on your patients. Be a team player. Taking a detailed history and physical (H&P), following up laboratory results, getting films from radiology, or drawing blood provides you with an opportunity to refine your clinical skills, gain more patient care responsibilities, and help the whole team to finish their day's work earlier so that everyone can go home or have more time to teach you. Medical students spend more time with patients and can often learn about their questions, fears & concerns, and can partner with the nurse to make sure these are addressed. Use your residents and attendings as mentors—they are here to teach you but that's a second priority to patient care.

## Daily Schedule

The routine varies with every rotation. The first day of each rotation is orientation where you will receive your clinical assignment and be informed of the typical schedule. On most rotations, you are responsible for pre-rounding on all of your individual patients. This involves seeing the patient and collecting all relevant new information including vitals, lab results, etc. After this, the team rounds, typically with the attending and makes decisions about the daily tasks.

For the rest of the day, you may go into the operating room, see your patients individually, help coordinate their care, contact patient's private physicians and follow-up on results of tests. Efficiency is a critical skill to learn and refine. You will get better as the

year progresses. At the end of the day, sign-out rounds are usually done to update the team members and hand off patients to the on-call resident.

## **What to Keep in Your White Coat**

At a minimum, you should carry a pen, scratch paper, stethoscope, and penlight. Some people like to carry a Maxwell's. As mentioned before, ALWAYS have something to read. The items in your coat will vary slightly with every rotation:

- Medicine: reflex hammer, tongue depressors, ECG calipers
- Surgery: trauma shears, staple/suture removal kits, 4x4s, tape (all available in supply room except shears)
- Ob/Gyn: pregnancy wheel, contraception book, passport (all 3 given during orientation)
- Peds: tongue depressors, stickers, milestone cheat sheet, immunization schedule
- Psych: MMSE card
- Neuro: reflex hammer, tuning fork, MMSE card, safety pins

## **How You're Evaluated**

The specifics are different on each rotation and should be explicitly explained to you on your first day. In general, your evaluation will be based on some combination of how you perform on the wards (your clinical evaluation) and how you perform on the written SHELF and practical OSCE exams. The SHELF is a multiple-choice, nationwide test administered by the NBME that will have clinical-vignette questions similar to those you saw on Step 1, although with longer question stems and a more clinical focus. You will learn more about the OSCE exam but it is basically an extension of COM, PEX, and the M2CSA.

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# Rules to Live By

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## The Ten Commandments (plus a few extras)

1. **REMEMBER THAT THERE IS A PERSON ON THE OTHER END.** Patients deserve our time, help, and most importantly our respect. Check with your resident or attending before revealing any potentially sensitive information to a patient. You are often not the appropriate person for this role.
2. **BE ENTHUSIASTIC.** This is pretty self-explanatory but hard to remember when you're overworked. Remember anyway.
3. **ASSERTIVENESS.** Patients appreciate it if doctors or medical students explain what they're doing and why, with appropriate certainty. Tread the line between assertiveness and cockiness carefully. During rounds or 'pimp sessions', volunteer answers if you know them. (But always give the person to whom the question is asked a chance to answer first!) If you don't know, say so (see #1).
4. **READ.** Assertiveness is best when accompanied by knowledge. Start with reading about your patients. You will remember things better if you have a patient to connect to the disease, procedure or treatment.
5. **RESPECT YOUR FELLOW CLASSMATES.** Learn with, not at the expense of, your colleagues. Never put down or show up another student. Your team will spot "brown-nosing" and back-stabbing easily. Give your classmates a heads-up if you're going to present an article. Remember, good students can make each other look better.
6. **TAKE CARE OF YOURSELF.** Despite the fact that medical students are "lowest on the totem pole," you do not have to suffer. Eat when you can, sleep when you can. Always carry around a snack in your pocket (especially on surgery and Ob/Gyn). When you learn to strike a perfect work-life balance, let the rest of us know how!
7. **BE FRIENDLY WITH SUPPORT STAFF,** especially the nurses. Introduce yourself and learn their names. The nurses know more than you do about how the hospital functions and day-to-day clinical care—ask them. During pre-rounds, always turn to the nurse as a resource about what happened overnight.
8. **BE ON TIME.** Even if your residents aren't.
9. **ASK QUESTIONS.** This demonstrates interest and an eagerness to learn. It is better, however, to focus on clinical decision making skills and questions that can only be answered by someone with experience. Recognize when it may not be a good time to ask a question and save it for later.
10. **SEEK FEEDBACK.** It is your responsibility to find out how your team regards you. Ask specific questions and you will get more helpful answers. It is often helpful to sit down at the halfway mark of the rotation and ask for formal feedback.

11. **BE ACCOUNTABLE.** Post a schedule of your lectures and give your team your pager number. Check-in throughout the day but don't annoy your residents. Update them and offer to help with their work if you have free time.
12. **WORK HARD AND TAKE INITIATIVE.** Being a medical student, it is almost a given that you are a hard worker. But, you need to show it. Volunteer to take on an extra patient. Offer to stay a little longer at the end of the day to help out. But, remember #6 (and #5).
13. **KNOW YOUR PATIENTS BETTER THAN ANYONE ELSE.** Even though it might not always feel like it, you have the most time. Spending time with patients carries a responsibility to communicate their fears, questions & concerns to the team and make sure they are addressed. Your residents will appreciate it and it makes you look like you are on top of things.
14. **REMEMBER HUMILITY.** As a medical student, you should show the appropriate respect to the residents and attendings who were once in your position. Do not try to outsmart, embarrass, or correct them in the middle of conference (or ever).
15. **LOOK PRESENTABLE.** You are a member of the team in a professional environment. Socks or pantyhose should always be worn, and open-toe shoes are a violation of Occupational Safety and Health Administration (OSHA) rules, and risk your own safety. Jeans and denim are prohibited by hospital policy. NMH and Illinois Department of Public Health regulations require that scrub attire must not be worn outside hospital buildings. If you leave the OR or area where scrubs are required, scrubs must be covered at all times by closed lab coats or disposable lab coats, even in cases when you have no intention of returning to the designated unit. DO NOT wear scrubs, even with a cover, in neighborhood restaurants and shops.
16. **BE PREPARED TO BE ON-CALL THE FIRST NIGHT.** This is a possibility on some rotations.
17. **PREPARE/PRACTICE FOR ORAL PRESENTATIONS.** Always expect to present your patient, whether you have admitted them or picked them up. Your oral presentation is your time to show what you know and how you have assessed your patient. This is often the only way for your attending to evaluate you, in addition to what he or she hears about you secondhand from your resident.



### *Remember Patient Confidentiality.*

*Respect your patients. Corridors, elevators, stairwells, Au Bon Pain, and other public locations are inappropriate areas to talk about patients, even if you leave out their name. There have been incidents in which patients' families have complained to the hospital. And plus, it's just bad form.*

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# Basic Charting Information & Tips

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One of your duties will be writing the progress note and orders for patients. Keep in mind that the primary purpose of the note is to communicate. So, write clearly and concisely. Excessively long notes may not be read, and bare notes may not convey enough information or thought. Also, try not to use abbreviations as they are rarely standardized.

At the beginning of all written notes, remember to indicate which service you represent and your individual status, e.g. “Neurology MS3 Progress Note.” At the end of all your notes and orders, print your name and indicate your status and pager number. In Powerchart, there are note titles specifically for medical students to help identify your note as a student note.

In the Assessment/Plan section of your note, give your impression of patient management and recommendations. However, always state them as considerations unless you have discussed them with your team. For example, “consider Celexa 20mg PO daily to treat major depression.” Your assessment and plan should not differ too much from your teammates’. Never make statements that directly question the recommendations or judgment of others.

Also, remember that the patient’s chart is a legal document. Thus, if you are using paper charts and you make a mistake, cross out the mistake once, write “error” or “eri” and initial it. On the computer, “in error” the note and write an addendum correcting the error. You must sign your notes and orders and have them cosigned by an intern or resident.

## The Electronic Medical Record

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- Electronic records make it easy to copy and paste. So be sure you are not plagiarizing other people’s notes. You can often copy forward your own progress notes, but be sure to update daily information, assessments, and plans. It is a liability to enter incorrect information in the medical record.
- SAVE, SAVE, SAVE, SAVE!! Especially whenever you step away from a computer. Losing a note is not something you want to experience.
- Dot phrases are your friend (available on PowerChart and Epic). Try typing “.cbc\_chem” or “.vitals” in Powerchart.
- Some residents will have you sign and forward your notes; others will have you forward your unsigned note. Ask them what they prefer.
- Always remember that the EMR is a legal document and is permanent. Be accurate and respectful.

## Using Powerchart and Epic

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**Powerchart:** You will get Powerchart training, and your ability to use it will increase with time. Until then, here are a few pointers.

- Use dot phrases! You will learn to use and create these in training. They can be used as shortcuts for different types of notes as well as for standard text within notes, saving you lots of time.

- Use MAR View to check on patients meds, including how much and when they were given.
- Use the “NEW RESULTS” tab . This is a great way to find out the most recent studies, labs, etc... that you might not even know were ordered.

**EPIC:** You will be trained to use it there if you are doing rotations there. At NMH it is most useful for reviewing patient charts to find out about outpatient workups, care, and labs.

## Dot Phrases

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Making dot phrases is an excellent way to speed up your note writing.

1. In Powerchart, type out the text you would like to have readily available.
  2. Highlight the text and right-click, select “save as auto-text.”
  3. Follow instructions on screen. Do not forget to start the name of a phrase with a period.
- 

## Feinberg School of Medicine Policy on the Electronic Medical Record for students:

*“It is never appropriate for a student to copy and paste elements of another person’s H&P or patient care note into their own note and portray it as their work. All information, other than structured data elements contained within the medical record (vital signs, lab results, medication records, etc) should reflect the student’s ability to gather and present patient data. If a student copies and pastes their own note from a previous day, it should reflect all relevant changes in the patient’s condition and progression in their understanding/analysis of the patient’s underlying disease process. Inappropriate copying and pasting of another person’s work will be considered a transgression of the student code of conduct and a professionalism form may be submitted to the Dean’s office.”*

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## Documenting Laboratory Values

One of the most commonly ordered tests is the **basic chemistry panel**, previously referred to as “Chem-7” (right), since it provides a quick assessment of electrolytes, renal function, and serum glucose. Another common test is the **complete blood count (CBC)** (left). The following skeleton or “fishbone” is used:

```

      \ Hgb /           Na | Cl | BUN /
WBC ----- Plts   ----- Glucose
      / Hct \           K | HCO3 | Cr \

```

It is also recommended that you include the MCV and RDW to rule out or help evaluate anemia as well as the differential if it was ordered, e.g. %Neut if you suspect bacterial infection.

The traditional method to report **arterial blood gas (ABG)** results is:

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FiO2 / pH / pCO2 / pO2 / HCO3 / BE / O2 saturation

```

Frequently, the  $\text{FiO}_2$  is left out if the patient is on room air ( $\text{FiO}_2=21\%$ ), and the anion gap is appended to the end to help evaluate acid-base disturbances.

## History and Physical (H&P)

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One of the goals of your medical education is to become proficient at writing H&Ps. You should periodically ask for feedback regarding your write-ups from both your attendings and residents. Initially, your H&Ps will be long and detailed in order to show your superiors how much you know and understand about your patient. The assessment and plan is your opportunity to demonstrate your thought process and show your ability to create a differential. At the beginning, you may require some support from your residents to organize this. Gradually, with your growing knowledge, confidence, and experience, your H&Ps will become concise and efficient, and you will be able to completely formulate differentials on your own.

On Medicine you present the patient to the attending the day after you do the H&P. Some teams will allow you to work on an H&P overnight and leave it unsigned until after presenting the patient to the attending the next morning. Other teams will expect you to commit to a plan before you leave for the night, using the daily progress note the next day as a place for a more updated plan.

A note about abbreviations: Abbreviations can be confusing and dangerous. There are specific prohibitions in Joint Commission accreditation standards against using abbreviations for medication names. Do not ever abbreviate a diagnosis. See the abbreviation section in this guide for more information, but in general, stay away from abbreviations wherever possible.

## Other Important Charting Notes

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Code status/advance directive/decision maker: Helpful to get in a habit of asking patients this, though check with your team to make sure the conversation is appropriate at that time. Does patient make his/her own medical decisions? See the Advance Directive note in PowerChart. Is there a Power of Attorney for Health Care (POAHC) – who is named, with what limits if any? The document should be in the paper record and scanned into PowerChart under the Advance Directive note. Any physician can assess for capacity to make medical decisions.

## The SOAP Note

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The daily progress note documents:

- Significant patient events overnight
- The patient's current condition
- The current therapeutic reasoning and plan.

The level of detail expected in a SOAP note is highly dependent on the rotation. See each individual rotation section for more tips.

### **S - Subjective:**

Any events overnight? (fever, emesis, bowel mvmt, ambulation, etc.)

How the patient is feeling today, according to him/her!

You may document patient care-related discussions, i.e. informed consent, in this section as appropriate

### **O - Objective:**

Vitals (Temp, HR, RR, BP, O<sub>2</sub> sat)

Ins and Outs

Focused Physical Exam (Gen, Heart, Lungs, Abd, etc.)

Recent lab values and test results

### **A - Assessment:**

Most important part of your note

One-liner with YOUR assessment of what is going on: i.e. "55yo man with hx of ... who presented with ..., LIKELY DUE TO ..."

It is okay to be wrong, but it helps to go over your assessment with an intern/resident prior to writing.

Include a justification of your diagnosis or assessment.

### **P - Plan:**

Typically organized by problems (ICU and Surgery may use organ systems)

Start with pt's chief complaint or most pressing issue, i.e. "1) Chest pain."

If not already discussed in Assessment, may include a phrase or two as to likely etiology, i.e. "likely cardiac in nature, given pt's history."

What you are going to do to address the problem, i.e. start/continue meds, check labs, send X-rays, get Echo.

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# The Case Presentation

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This is how your attendings and/or senior residents assess your clinical reasoning skills.

Presentation skills require experience and knowledge, so expect to grow over time.

Throughout the year, you will learn to formulate and convey a well-ordered, concise summary of the pertinent clinical information.

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## Important tips

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- Present in order. One of the most common criticisms of student presentations is that they are “disorganized.” The SOAP/H&P format is a good standard to follow.
- If Review of Systems is non-contributory, state “non-contributory” (okay in presentations, not in notes). Otherwise, say “ROS remarkable for history of joint pain related to arthritis.” If it is relevant to the patient’s chief complaint, it belongs in the HPI.
- Offer YOUR assessment and plan. Be prepared to justify.
- DO NOT READ. You may refer to notes while presenting, but reading from the page is tedious for everyone. Try highlighting important history/labs beforehand if you do plan to use notes.
- State only pertinent information. This is a lose-lose situation as a medical student because we often don’t know what is pertinent and have been trained to err on the side of thoroughness. Use your best judgment and learn from your (and other students’!) mistakes.

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## H&P Presentation Structure

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Consider your presentation a persuasive argument in which you provide evidence for your differential diagnosis.

### **One-liner:**

Patient’s name, age, race, sex, chief complaint and any relevant past medical history.

### **HPI:**

- You can abbreviate this for the purposes of presentation
- Plan to include:
  - Description of symptoms i.e. OLDCARTS
  - Chronologic development of symptoms in days prior to admission
  - Include pertinent positive symptoms, as well as pertinent negatives

### **PMHx:**

- Simply a list of medical conditions which the patient has had
- Elaborate only on those with special relevance

### **MEDS:**

- List ONLY the names unless otherwise directed by an attending or resident
- Also include any drug allergies here

**SOCIAL Hx:**

- Condense to relevant details: “lives with husband, employed as secretary, smokes one pack per day for last 20 years, no alcohol or illicit.”

**FAM Hx:**

- Only include something that might point in the way of one diagnosis or another. It’s ok to say here (but not in your note!) that family history is non-contributory.

**PEX:**

- Begin with a description of the patient and vital signs. If vital signs are all within normal limits, it is usually ok to say so without mentioning specific numbers. Have them on hand just in case.
- List the pertinent positive and negative findings in their respective organ systems.
- Not every organ system needs to be presented every time.
- Always include lungs, heart, and abdomen (if normal, state: “heart regular, lungs clear, abdomen benign.”)

**LABS/STUDIES:**

- Include pertinent (pointing toward or away from a diagnosis) laboratory values and results from tests or procedures.
- Have the other labs that were done readily available just in case you thought one was less important than it actually was.
- Be prepared to look at and thoughtfully discuss any imaging that was done.

**ASSESSMENT:**

- Finish with a summary statement that includes what you think is going on, and what you want to do about it. Offer YOUR assessment, plan and justification.
- This is your moment of glory, where you show everything you have learned. DON’T let your presentation trail off!

**FOR EXAMPLE:**

The following is provided as a very brief example, which should be tailored to the clerkship and attending preferences:

*Mr. Foley is a 53 year old, white male with a history of stage III prostate cancer diagnosed 2 years ago s/p radical prostatectomy with adjuvant radiation therapy, who presents with intermittent, non-radiating lower back pain x 2 months. Pain began gradually and has increased to 8/10. Pain is worse at night but independent of position. He has been taking Advil without relief. He denies history of trauma to area, change in urination, change in bowel habits, weakness of proximal muscles, fevers, and chills.*

*He has chronic urinary retention for which he takes bethanecol. He has no known drug allergies. He denies ethanol and tobacco usage. Family history is noncontributory.*

*On physical exam, the patient is a cachectic male in no acute distress. Vital signs are stable. Lungs clear, heart regular, abdomen soft and nontender with palpable liver edge at 2 cm below costal margin. Back exam significant for point tenderness over L4-L5. Neuro exam with 5/5 strength throughout, sensation intact to light touch bilaterally, and a negative straight leg raise test.*

*Basic chemistry panel and CBC were within normal limits except for calcium of 11.5; alk phos of 150. His most recent PSA one month ago was 10, increased from three months previously which was 5.*

*In summary, the patient is a 53 year old male with history of prostate cancer who now presents with back pain, point tenderness on exam, hypercalcemia and elevated alk phos and PSA. This likely represents metastasis to the lumbar vertebrae. The enlarged liver may represent liver metastasis. Our plan is to start Vicodin for the pain, obtain a bone scan to evaluate for bone metastasis, and obtain abdominal CT to evaluate for liver metastasis.*

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# Admission and Discharge

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## Admission Orders

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With electronic medical records, it is unlikely that you will be writing orders on the floor.

However, you **WILL BE EXPECTED TO WRITE ORDERS** (typed freehand from memory) on the OSCE exam for Surgery and Pediatrics.

A good way to learn is to practice writing a set of orders for patients your team is admitting, then have your intern/ resident take a look at them. This will give you experience, as well as demonstrate that you are being proactive about your learning.

There are numerous different mnemonics used. Pick one and stick to it. Here, we use **ADC VANDALISM**.

**Admit:** Ward, Hospital care team names and contact info

12 E, Attending: Dr. Shapiro, Intern: John Smith, pager #5-1234

**Diagnosis:** Primary reason for admission or if post-op

Chest pain.  
s/p laparoscopic appendectomy

**Condition:** Stable or not (of limited use, since you may hear that “a dead patient is stable”).

Stable. Fair. Critical.

**Vitals:** Which? How often? When to notify house officer?

Vitals q6h per protocol. Please also check pulse ox. Call h.o. (house officer) for T>100.5 <96, HR>120 <50, RR>20 <12, BP>160/110 <90/60, O2sat <92%, glucose <70 >200, urine output <300cc/8h.

**Allergies:** Include reactions if known. “NKDA” if none.

Penicillin - rash/swelling

**Nursing orders:** Things that need to be monitored/checked.

Strict I/O q shift, Daily weights, Accu-check qAM, Foley to gravity, NG tube to LIWS (low intermittent wall suction), Incentive spirometer 10x/1h when awake, TEDs and SCDs while not ambulating.

**Diet:** Choices include the following:

NPO after midnight (for procedures). NPO.  
General diet. Clears. Mechanical soft.  
TLC diet. ADA diet. Renal diet.  
Continuous G-tube feedings.

**Activity:** Typically ad lib. Remember non-weight bearing (NWB) for Ortho.

Ad lib. Up with assist. Strict bedrest. OOB (out of bed) to chair. NWB left leg (no weight bearing).

**Labs:** Specify what, when, how often, and for how long.

CBC, Chem 7 + Ca, Mg qAM x 3d. LFTs and ESR now.

**IVF:** Type and infusion rate (more important for surgery). “HLIV” (heplock IV) if none.

D5 0.45 NS @ 125 cc/h.

**Special Studies:** Diagnostic tests and consults.

CXR PA/Lat. CT brain w/wo contrast.

**Medications:** Be sure to specify these four:

- 1) drug name (generic or trade)
- 2) dosage
- 3) administration route (PO, IV, IM, SQ, PR)
- 4) frequency (QD, QAM, QHS, BID, q 8 hrs, etc.)

Pepcid 20 mg PO QHS  
Colace 100 mg PO BID  
Norco 10/325 mg, 1 tab PO q4-6 hours PRN pain  
Heparin 5000U SQ q8h



*Tip:* On SURGERY, when writing post-op orders, remember the following five classes: pain meds, DVT prophylaxis, antibiotics, peptic ulcer prophylaxis, patient’s home medications

## Discharge Notes

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The bane of house-staff paperwork. Flatter yourself by volunteering to help with these.

**Admission Date:**

**Discharge Date:**

**Admission Diagnosis:** keep it general (e.g. Abdominal Pain)

**Previous Diagnosis:** what other diagnoses the patient had coming in

**Discharge Diagnosis:**

**Attending:**

**Referring Physician:**

**Continuity Physician:**

**Procedures:** include anything out of the ordinary (e.g. PPD, imaging, scopes)

**Consults:**

**Complications:**

**Hospital Course:** If the patient is complicated, the best way to approach this is to organize it by problem/organ system.

**Condition at Discharge:** “improved” (we hope!) If not stable or good, explain.

**Disposition:** Discharged home, skilled nursing facility, etc.

**Discharge Medications:** Make note of changed medications.

**Instructions:** Include please call your doctor if you experience any concerning symptoms.

**Follow-up Plan:** Appointment date/time, physician/clinic, contact info

Review all medications the patient reported before hospitalization and reconcile with all medications prescribed after discharge. NEVER write ‘resume previous medications’ (prohibited by The Joint Commission). Give the patient a complete list with name, medication, dose, frequency, route, reason for the medication, and how to take each.

## Prescriptions

To prescribe outpatient meds, use prescription stationery (“scrip pads”) when discharging patients on medications. Use patient stickers to mark the patient’s name. As always, write the drug name, dosage, route of administration, dosing frequency, indication for drug, number of pills to dispense (“Disp”), and number of refills (“R”). Be sure to spell out the numbers of pills and refills or strike any zeroes, so they cannot be altered. Hand the script to an MD to sign. Controlled substances will also require their DEA number.

John Q. Smith	April 1, 2011
Norco 10/325mg	
Sig: Take 1 tab PO every 4-6 hrs PRN pain	
Disp: 30 (thirty)	
Refills: Ø	_____

You can also specify substitution with a generic drug. Generics usually save the patient money and are required by the Food and Drug Administration (FDA) to have 80% bioequivalence of the brand name drug.

<p><b>PRESCRIPTION SHORTHAND:</b>  <b>Abbreviations are not recommended for patient safety reasons, but you may see these used.</b></p> <p>sig      label (Latin: signa)  T          one (used to substitute for numerical digit)  T:T        two (used to substitute for numerical digit)  T:T:T three (used to substitute for numerical digit)  tab        tablet (Latin: tabella)  BID        twice per day  TID        three times a day (Latin: ter in die)  q          every (Latin: quaque)  qAM        every morning  qh or q<sup>o</sup>    every hour  qhs        at hour of sleep  qid        four times per day  qMWF     every Monday, Wednesday, and Friday  qod        every other day  qPM        every evening  qwk        every week  PRN:      As needed (Latin: Pro re nata; "as the circumstance arises")  Ø          no or none</p>	<p><b>Official JCAHO Abbreviation “Do Not Use” List</b></p> <p>U – instead write "unit"  IU – instead write "International Unit"  Q.D., QD, q.d., qd – instead write "daily"  Q.O.D., QOD, q.o.d, qod – instead write "every other day"  Trailing zero (X.0 mg) – instead write "X mg"  Lack of leading zero (.X mg) – instead write 0.X mg  MS, MSO4 and MgSO4 – write "morphine sulfate" or "magnesium sulfate"</p>
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# The Rotations

## Lay of the Land

### NMH

Floor	Units [East/West]	
16	General Medicine	Gen Medicine/Short Stay
15	Cardiology	Heart Failure/Pulmonary
13, 14	Medicine	Medicine [14W:] Ortho/Spine
12	General Surgery	Urology/Gen Surg
11	Transplant/Gen Surg	Surgical Tele
10	Neuro/Spine	Neuro/Spine/ENT
9	MICU, Dialysis	NICU
8	CCU, SICU	Echo, Cardiac Cath, EP, Nuclear Med
7	CVICU	EEG, Labs
6	<b>Scrub machines</b> , Paging Services office, surgery resident room	
5	Primary surgical suites, post-op recovery rooms	
4	Neuroradiology reading room, US, MRI, CT, GI lab, IR	
3	Health Learning Center, Conference Rooms, Auditorium	
2	Cafeteria, NM Academy	
M	Mezzanine (ED), Observation Unit	
1	Emergency Department, ED CT, ED Radiology	

### Prentice Women's Hospital

Floor	Units
16	Med Onc/Palliative
15	Heme/Stem
14	Gyne/Gyn-Onc
11,12,13	Postpartum, Newborn nursery
10	NICU
8	Labor & Delivery, L&D surgical suites
6	Gyn surgical suites, locker rooms, <b>scrub machines</b>
5	Dermatology, MFM, Ob/Gyn offices
4	Lynn Sage Breast Surg clinic, Mammograms
3	Classrooms, auditorium
2	Cafeteria
1	Triage

### Stone Pavilion

7<sup>th</sup> Floor: Psych ward -> moving in Fall 2011 to Galter

### Olson Pavilion

6<sup>th</sup> Floor: Ambulatory surgery

[Other new units opening in Galter this fall!]

## Guide to the Patient Room

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As you enter AND leave any patient room for ANY reason whatsoever, clean your hands every time without exception. Random mystery audits are conducted constantly and you may well be stopped if you fail to do this. Use the hand gel or soap and water. Observe and follow any additional isolation directions on the door signs.

### Bed:

The entire bed, and its head and tail, can each be raised and lowered independently.

The controls sit outside the bed rails. There are also simplified controls inside the rails for patient use. The bed rails are released by a small lever underneath.

Falls are a serious hospital safety issue. **If you raise the bed or lower a rail, make sure to restore it to its original position before leaving the room.**

**Table:** Can be adjusted to jut out directly over the bed. Used for meals, and sometimes also as a workspace when doing procedures. You can raise/lower it via the release lever on the side. Some models have an expandable lower leaf or even a fold-out mirror.

**Remote control:** Adjusts the TV and room lights. Can also call the floor secretary, who can dispatch the patient's nurse.

**IV pump:** Delivers continuous infusions of fluids and medications to the patient at a set rate, which is indicated on a display. The infused substances hang in bags above, which are labeled with the names of the substance and the patient. The pump has a battery and sits on a wheeled pole, which can be unplugged and taken to the bathroom (or on a walk around the floor!)



*Tip #1:* if the pump keeps beeping, this may mean that a bag is empty and needs to be replaced, or that the tubing between the pump and patient is kinked. Check for an obvious obstruction (is the patient laying on the tubing?), and if none is found, contact the patient's nurse. You can silence the beeping briefly by pressing the yellow "Silence" button.



*Tip #2:* if IV infusions are no longer needed, the tubing can be disconnected with the IV catheter left in place (e.g., still in the patient's arm), allowing the patient to walk around freely. The remaining catheter is called a heparin lock ("hep-lock") IV.

**Sequential compression devices (SCDs):** Consists of a small machine and two pneumatic compression sleeves. The machine sits near the tail of the bed and periodically inflates/deflates the sleeves, which are usually worn around the calves, to prevent DVTs

**Thromboembolic devices (TEDs):** This is a fancy name for tight knee-high stockings that are worn around the calves. They also help prevent DVTs, and are often used in combination with SCDs.

**Nasal cannula:** A pair of prongs that sit in the nose and deliver supplemental oxygen (2 to 6 liters/minute). The tubing goes around the ears and attaches to a port on the wall.

Next to the port is a gauge, which looks like a thermometer with a little ball inside that indicates the rate of oxygen delivery (in L/min), and a knob that adjusts this rate.

**Face mask:** Used for patients who require additional oxygen. It comes in several varieties, which are beyond the scope of this text.

## Key People on the Floor

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Medicine is a team effort. Getting to know the other members can help you stay on top of your patients and will also make you look like a star.

**Unit secretary:** One of the most important people on the floor. Can locate a patient's nurse, tell you where a patient has gone, help find a piece of equipment, and otherwise make life easier in numerous ways.

**Nurses:** An invaluable source of information about your patients, the floor, and the hospital in general. If you make an effort to keep them informed about your team's plans, they will appreciate it. Don't be afraid to ask them questions!

**Charge nurse:** Manage most aspects of the floor. Among other things, they supervise other nurses and stay on top of all patient arrivals and departures.

**Nurse practitioners:** Work with the medical team to manage a subset of patients and help out with many other miscellaneous tasks.

**Social workers:** Help with the myriad social aspects of a hospital stay, including coordinating social support services, obtaining funding, locating housing for visiting families, and finding a place for patients to go after they leave the hospital and helping them to get a ride there.

**Case managers:** Assist with discharge planning. They review medical records daily and help determine whether a patient still needs to be in the hospital, and if not, where they should go.

**Others:** You may also encounter respiratory therapists, radiology technicians, phlebotomists, nutritionists, chaplains, hospital volunteers, and many others. As usual, it pays to get to know them!

## The NMH Pager Directory

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You can find the paging website through NMConnect or Infoplex. Pay attention to the paging etiquette – it is strongly adhered to (most of the time).

### Paging Etiquette

Make sure you are paging the right person at a reasonable time of day.

Always use your first and last name when paging.

Don't leave the phone that you've paged someone to; give the person time to get back to you (around 15 minutes).

Never page someone to your pager.

Change your battery if you hear your pager beeping/vibrating.

## Books & References

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### Suggested Pocketbooks and electronic references for all rotations:

ePocrates (PDA/iPhone) or Tarascon Pocket Pharmacopoeia (Book): Medication reference including indications, available dosing/form, and generic-trade name cross referencing.

UCentral: Includes access to Medline journals, Davis's Drug Guide, Harrison's Manual of Medicine, NU News, Pocket Guide to Diagnostic Tests, and Taber's Cyclopedic Medical Dictionary. Available free online through the Galter website

Medscape Mobile: a great free resource covering a wide variety of topics. Available online at <http://www.medscape.com/public/mobileapp>

Pocket Medicine (aka "the Green Book"): An excellent source of reference on the wards, especially for the medicine clerkship. Great differential diagnosis, work-up, and treatment plans in an efficient outline format.

Maxwell's: Concise guide of normal lab values, dermatomes, etc. Bare-bones but useful information.

Sanford Guide to Antimicrobial Therapy: a guide to choosing the appropriate antibiotic for a given disease or pathogen. Can be a little intimidating at first, but very useful once you get the hang of it!

# MEDICINE

The medical student H&P is usually the most comprehensive and complete H&P in the medical record, usually more so than the resident or attending note. Remember that your note is part of the permanent medical record, so document accurately and truthfully. If you do not perform a part of the physical exam, *do not* write that it is normal in your note. On this clerkship, *never* use the phrase “non-contributory” in your written H&P.

## Medicine H&P:

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**CC:** A few words on why the patient presents. Quote the patient if you can, and always include the duration of the complaint. For example: instead of “arm pain,” you should write “arm pain x 3 days.”

**HPI:** Tell the story. Try to maintain chronology, but include significant past medical history, pertinent demographic information (age/sex), OLD CARTS, and relevant Review of Systems.

Most attendings prefer a few words right after the opening sentence of the relevant PMHx (e.g., '55 yo woman with hx of breast cancer, HTN, CHF presents with R arm pain. Her breast cancer was diagnosed 4 years ago, treated with chemo/XRT, followed with biannual mammograms without evidence of recurrence most recently 2 months ago')

Since most patients are admitted by way of the Emergency Department, students often struggle with how and where to include information obtained in the ED (e.g. CT scan). We've found that it varies based on the attending, so your best bet is to take note of what the attending wants, then adjust your HPI accordingly. If a patient is admitted for dehydration or hypovolemia, for example, include the amount of fluid the patient was given by bolus in the ED.

**Review of Systems:** (ROS can also be placed just before the PEX section, helpful to make a dotphrase and alter accordingly)

**GEN:** Fatigue? Weight loss/gain? Appetite? Lightheadedness/dizziness?  
Fever/chills? Night sweats?

**HEENT:** Headaches? Sinus/nasal congestion? Hearing/vision changes? Ear pain?  
Sore throat? Dysphagia/odynophagia? Hoarseness?

**PULM:** Chest pain? Shortness of breath? Dyspnea on exertion? Cough?

**CV:** Chest pain? Palpitations? Orthopnea? Syncope?

**GI:** Abdominal pain? Nausea/vomiting? Diarrhea/constipation? Changes in bowel habits? Hemoptysis?

**GU:** Dysuria? Nocturia? Hematuria? Urgency? Frequency? Flank pain?  
Incontinence? If female: LMP or age at menopause? If male: ED?

**VASC:** Lower extremity edema? Claudication?

**MUSCULOSKELETAL:** Myalgias/artralgias? Stiffness?

**NEURO:** Numbness/tingling? Weakness? Memory loss?

**HEME:** Easy bruising or bleeding?

**SKIN:** Rashes? Abnormal hair growth/loss?

**PSYCH:** Mood? Anxiety/depression?

**PMH/PSH:** Ask specifically about major or common diseases (HTN, CAD, HL, DM) and account for all meds on med list. If that patient has a significant illness, ask specifics

(for example, any CHF hospitalizations, for RF, dialysis schedule). Ask about prior hospitalizations (e.g. for CHF exacerbation).

**Meds:** Medication name, dosage, route, and frequency. Before presenting your patients to the attending, find out why your patient is on each and every one of his/her meds. You'll likely be asked!

**Allergies:** Medication/Reaction

**Family Hx:** At a minimum, ask about the patient's mother, father, and siblings. Alive and healthy? What health problems? Specifically ask if anyone had diabetes, HTN, heart disease, stroke, or cancer? Remember to include ages and, if deceased, the cause of death.

**Social Hx:** Tobacco, EtOH, drug use, and sexual activity. Career. If retired, include work history. Living situation (what kind of domicile and with whom). "Patient communicates comfortably in [language]."

**Physical Exam:** (making a dotphrase for this would be helpful, but be careful. The physical exam is easy to lie about. It is not necessary to check for femoral bruits on every patient, so don't say that you did. Measuring JVD is a helpful skill, but certainly not needed on every patient. Make sure you really measured, if you say it is normal.)

**VS:** Temp (route), Pulse, RR, BP (at time of interview), orthostatics (if thought to be hypovolemic).

**GEN:** A&Ox? Pleasant? Cooperative? Sitting/laying? In distress? Well-nourished or cachectic?

**HEENT:** NCAT? PERRLA? EOMI? Sclera anicteric? Oropharynx clear, erythematous, or with exudate or lesions?

**NECK:** Neck supple? Thyromegaly? Lymphadenopathy? JVD or bruits?

**CHEST:** Normal respiratory effort? Clear to percussion and auscultation  
Rales/rhonchi/wheezes?

**CV:** Regular rate & rhythm? PMI palpable? PMI location? Normal S1/S2? No S3/S4, murmurs, rubs or gallops, or clicks?

**ABD:** BS normoactive? Soft? Non-tender? Non-distended? Hepatosplenomegaly?  
Liver span/palpable? Surgical scars?

**PULSES:** Normal? Without carotid, abdominal or femoral bruits?

**EXT:** Clubbing/cyanosis/edema? Full range of motion? No fluctuation/crepitus?  
Cool or warm to touch?

**NEURO:** There are six components. Document what you actually do. Better to say "sensory normal to soft touch in hands and feet" than "grossly intact." "Grossly intact" usually means you didn't really test. Every patient does not need all 12 cranial nerves tested. You might just check extra-ocular motion or sensory in the face. Tell us what you did. Check some reflexes on every patient. This is how you learn how to do them. Describe which motor tests were done, "5/5 throughout" has little meaning. (See Neurology section for more detailed exam)

**Labs:** Include CBC (with diff), Chem 7, and other labs done in the ED.

**Imaging:** X-rays, CT, MRI, US, EKG. Include your own assessment when you can, not just a copy-paste of the report. Be sure to note whose assessment you are giving (i.e. your own, the radiologist's, your intern's, etc.)

**A/P:** The assessment and plan are usually the most difficult elements of the H&P for the junior student and are often wrong (and time-consuming!) early in the clerkship; this shouldn't discourage you from putting something down (some students feel more comfortable writing "CONSIDER" before each recommendation). In the assessment, don't forget to include age/sex, an abbreviated restatement of the chief complaint and HPI, and a ranked differential diagnosis based on symptoms, signs, PEX, and other studies.

For the plan: some attendings want it systems based (i.e. Respiratory, CV, GI, etc.), but most seem to prefer it problem based (i.e. “Chest Pain,” “Difficulty breathing,” etc). Some residents like you to number each element of the plan for organizational purposes. Remember to include diet/F/E/N, TEDs, SCDs, DVT prophylaxis, ulcer prophylaxis, IV fluids, electrolyte replacement, pending studies, and disposition (the floor to which they are getting admitted). Also be sure to account for all medications, including any held medications.

## **Medicine SOAP:**

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**S:** Include patient’s status, significant overnight events, pain control, sleep, toleration of diet and brief ROS.

**O: Vitals:** Include the patient’s current temperature (Tc) as well as maximum temperature in the last 24 hours (Tm), pulse (including range over 24 h), blood pressure (range over 24 h), respiratory rate, and pulse ox (on oxygen or room air). Ins and Outs should be recorded both over past 24 h and for each 8 h shift.

**PEX:** As in the H&P, although this should be more focused and may include fewer organ systems (General, CV, Lungs, Abdomen, and Extremities is a good bare minimum, place any other system with a problem you are following).

**Labs:** Patients usually have daily CBCs (with differential) and basic chemistry panels so it is helpful to date the labs. Don’t forget to follow up on any pending labs from the previous day.

**Imaging:** Follow up on any pending imaging from the previous day. Use your own assessment when you can, and be sure to note whose assessment you are giving (i.e. your own, the radiologist’s, your intern’s, etc.)

**A:** Very similar to what you did for the H&P, but perhaps less detailed. Highlight any changes from your original assessment based on new labs, imaging, etc.

**P:** Again, similar to the H&P. Students commonly forget to reflect medications that were added, discontinued or dosage changed. It is helpful to add which day number in a course of medication the patient is on, i.e., “day 2 of 7”. In the context of a progress note, “disposition” refers to the plans for discharge. When in doubt, “discharge per attending” is usually a safe answer.

## **Recommended References, Textbooks, and Pocketbooks:**

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- **MKSAP:** Collection of patient cases with questions; harder than expected for examination. This is the one resource that the vast majority of students use in preparation for the shelf exam.
- **Pocket Medicine (aka “The Green Book”):** An excellent source of reference on the wards. Great differential diagnosis, work-up, and treatment plans in an efficient outline format. A must-have text for the medicine rotation.
- **The Only EKG Book You’ll Ever Need: Interpretation of EKGs** is really important, as it is a common “pimping point” by many attendings, and it is expected that you know how to interpret them when you start on the wards! This is a concise, well-organized EKG book.
- **UpToDate:** This is the first resource most students use on the wards to find a quick answer to a clinical question. And, since you can now access UpToDate anywhere via the Galter website, this is an especially valuable resource.

- Step Up To Medicine: A well-organized, comprehensive, very readable text that blends a bullet-outline format with comprehensive paragraphs. Contains x-rays, ECGs, mnemonics and “Quick Hit” pearls. A good text to read throughout the clerkship.

### Testing / Grading:

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**SHELF:** The Medicine SHELF examination consists of 100 questions. Students often struggle with timing as the stems to each question are usually long and take a while to digest. Also keep in mind that most shelf exams have about 7 questions at the very end that have 12 or so possible answers. The key to success seems to be doing plenty of practice questions and starting to read early.

**OSCE:** The OSCE is an assessment of your clinical skills that usually takes place on the last week of the clerkship. It consists of 4-6 stations with standardized patients with corresponding computer stations, where you will be expected to develop differentials, think about management, and write admission orders. The OSCE is written by Feinberg faculty and so reflects much of what was taught in didactic sessions and the wards.

**GRADING:** Your grade on medicine is heavily based on your clinical evaluations, so spend a lot of time reading up on your patients and being the best ward clerk that you can be. Each inpatient month counts for 30%, the shelf for 20%, OSCE for 10%, and your specialty month for 10%.

**Top 20 Pearls for Pimping:**

<p><b>Reading a CXR:</b>  <b>Airway</b>  <b>Bones</b>  <b>Cardiac silhouette</b>  <b>Diaphragms</b>  <b>Effusions</b>  <b>Fields</b>  <b>Gastric bubble</b>  <b>Hardware</b></p>	<p><b>Deriving a Diff Dx:</b>  <b>Metabolic</b>  <b>Infectious</b>  <b>Neoplastic</b>  <b>Traumatic</b>  <b>Cardiovascular</b>  <b>Allergic/Autoimmune</b>  <b>Neurologic</b>  <b>Drug Reaction</b>  <b>Youth (Congenital)</b></p>	<p><b>Causes of ESR &gt;100:</b>  Temporal Arteritis  Chronic Infxn (Osteo, SBE, TB, abscess)  Thyroiditis  Vasculitis  Multiple Myeloma</p>	<p><b>Etiologies of AKI:</b>  Prerenal (most common):  decr volume  renal vasoconstriction  Intrinsic:  ATN  AIN  glomerulonephritis  Postrenal:  bladder neck obstruction  b/l ureteral obstruction</p>
<p><b>“Don’t-miss” Causes of Chest Pain:</b>  Myocardial Infarction  Aortic Dissection  Pulmonary Embolism  Pneumothorax  Esophageal perf.</p>	<p><b>Eosinophilia:</b>  Neoplasm  Allergy  Asthma  Churg-Strauss  Parasites</p>	<p><b>Light’s criteria:</b>  TPeff/TPserum &gt;0.5  LDHeff/LDHserum &gt; 0.6  LDHeff &gt; 2/3 upper limit of normal of LDHserum</p>	<p><b>Lupus:</b>  Serositis  Oral Aphthous ulcers  Arthritis  Photosensitivity  Blood (ITP, Hemolytic Anemia)  Renal Nephritis  ANA (almost always +)  Immunology (dsDNA, anti-Sm, low C)  Neurologic (Lupus Psychosis)  Malar Rash  Discoid Rash</p>
<p><b>Anion Gap Acidosis:</b>  Methanol  Uremia  DKA  Paraldehyde  INH/ Iatrogenic  Lactic Acid  Ethylene Glycol  Salicylates</p>	<p><b>Obstruction, sm bowel:</b>  Adhesions  Bulges  Cancer</p> <p><b>Obstruction, lg bowel:</b>  Cancer  Diverticulitis  Volvulus</p>	<p><b>Lower GI Bleeds:</b>  Hemorrhoids  Diverticulosis  IBD  Ischemic Colitis  AVM’s  Upper GI bleed</p>	<p>Dx with ≥4 of these criteria, sensitivity is ~75%, specificity is ~95%</p>
<p><b>Mortality Benefit in CHF:</b>  Beta-blocker  ACE inhibitor  Spironolactone if Class IV CHF  AICDs</p>	<p><b>ECG changes with PE:</b>  Sinus tachycardia  Specific but not sensitive:  S1Q3T3 sign - an S wave in lead I, Q wave in lead III, and inverted T wave in lead III</p>	<p><b>Common bone mets:</b>  Breast  Lung  Thyroid  Kidney  Prostate  “BLT w/ Kosher Pickle”</p>	<p><b>Emergent Dialysis:</b>  Acidosis / hypoAlbumin / Anorexia  Electrolyte imbalance (inc K)  Ingested toxins  Overload (volume)  Uremia with Sx (cns changes)</p>
<p><b>Potassium repletion:</b>  Goal &gt; 4.0  Every 10 mEq K will raise serum K by 0.1  PO: K-Dur, can give 40-60 mEq at once  IV: KCl 10 mEq IV peripherally; need central line to give 20 mEq</p>	<p><b>Magnesium Repletion:</b>  Goal &gt; 2.0</p> <p>Each 1 g Mg will raise serum Mg by 0.1-0.2</p> <p>Give IV in multiples of 2 grams</p>	<p><b>IV Fluids (4:2:1 rule):</b>  4ml/kg/hr for first 10kg  2ml/kg/hr for second 10kg  1ml/kg/hr for remaining kg</p> <p>Shortcut for pts &gt;60kg:  Weight in kg + 40 = cc/hr</p>	<p><b>CHADS2 Score:</b>  Risk stratification for anticoagulation in A-fib  CHF = 1 pt  HTN = 1 pt  Age &gt; 75yo = 1 pt  DM = 1 pt  Stroke or TIA hx = 2 pts</p> <p>Score ≥ 2 : warfarin (unless poor candidate)</p>
<p><b>Modified Wells criteria for Pulmonary Embolism</b></p> <p>PE as likely or more likely than alternate dx; clinical s/sx of DVT 3 each  HR &gt; 100 bpm; prior DVT or PE 1.5 each  Immobilization (bed rest ≥= 3 d) or surgery w/in 4 wks 1.5  Hemoptysis or malignancy 1 each</p> <p>Score ≤= 4: PE unlikely, no CTA; consider D-dimer. Score &gt;4: PE likely, order CTA</p>			

# SURGERY

## Surgery H&P:

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Usually, either the H&P will already be completed in the office prior to surgery and found in the Epic note, or you can use the short H&P forms/PowerNote found in PowerChart.

Each service will need different information. In general you need to focus on:

**Brief HPI:** Why patient is having surgery, what type of surgery is being done, left/right side

**Past Surgical History:** Include any bad reactions to anesthesia

**Past Medical History:** As per usual.

**Hardware:** e.g. artificial heart valves, artificial joints, etc.

**Current Medications:** As per usual.

**Drug Allergies:** Include reactions to the medication, e.g. hives

## The Postoperative Note:

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**Pre-op diagnosis:** Initial preoperative diagnosis

**Post-op diagnosis:** Final postoperative diagnosis (often “same”)

**Procedure:** What procedure was performed and which side

**Surgeon:** Attending(s)

**Assistants:** Resident(s) and Student(s)

**Anesthesia:** Local, Regional, or General/GETA (general endotracheal intubation), MAC (monitored anesthesia care - IV)

**Fluids:** IV fluids in mL. Specify crystalloid, colloid, blood products

**EBL:** estimated blood loss; minimal or amount in mL

**UOP:** urine output; none or amount in mL

**Drains:** Type, location, and how much has drained

**Findings:** Gross pathology as well as significant normal findings

**Specimen:** What specimens were taken to the lab

**Complications:** i.e. “None” – Ask attending/resident before putting down any complication other than “none”

**Condition:** Stable/unstable, intubation status

**Disposition:** Usually to recovery room, PACU, floor, etc.



**REMEMBER:** Ask the anesthesiologist for IVF, EBL and UOP

## Surgery SOAP:

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*The day of surgery is POD #0, the next day is POD #1.*

**S:** Postoperative: acute events overnight, incisional pain, flatus, hiccups (a sign of bowel obstruction), bowel movements, urination (if no Foley), nausea/vomiting, fevers/chills/sweats, CP/SOB, pain control (PO, IV, # of times PCA was admin.), whether tolerating PO (if eating), and ambulation

**O: Vitals:** Tmax, Tcurrent, HR, RR, BP, SpO2 (if applicable)  
**I/Os:** Total over past 24hrs  
**UOP:** over past 24hrs in 8hrs intervals in chronological order (i.e. “200/800/750 for total of 1750ml/24hrs”)  
**Drain Outputs:** over past 24hrs in 8hr intervals, list each drain separately  
**GEN:** A&Ox3, NAD  
**CV:** RRR, no m/r/g  
**ABD:** soft, +/-BS, NT/ND  
**INCISION:** c/d/i (clean/dry/intact), erythema/serosanguinous drainage, dressing in place/removed, with steri-strips/staples if present  
**EXT:** no warmth, tenderness, edema (signs of DVT)  
**Labs, Imaging, Pathology Results, Other Studies, etc**

**A/P:** POD# \_\_, s/p [procedure] for [reason]. AFVSS, patient is doing \_\_\_\_ .  
**Pulm:** on \_\_L NC, wean O2, encourage IS  
**GI:** wait for return of bowel function, +/- flatus  
**GU:** d/c foley? Good UOP? Voiding freely?  
**Pain:** well-controlled on: epidural, PCA, PO meds?  
**Prophy:** SCDs/TEDs, ambulation, SubQ Heparin  
**FEN:** IVF@ \_\_, diet (i.e. ADAT = advance diet as tolerated)  
**Path:** pathology pending  
 Dispo: PT/OT?; continue inpatient management; per attending; transfer to floor, etc.  
 Other: miscellaneous; antibiotics, monitor liver, check thyroid, endocrine, etc

## **Duties in Surgery**

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### **In the OR:**

1. Bring the Patient In: Help anesthesia bring the patient to the OR from pre-op
2. Move the Patient to the Table: Help move patient from bed to table
3. Remove Bed: once patient is on table, put bed in hallway, pen OR # to bed
4. Put on TEDs/SCDs: ask nurse for these and put on patient
5. Help drape/Position/Strap down patient. Also a good time to pull your gloves and a gown
6. Ask the nurse if you may place the foley
7. Participate in the preop sign-in and time out. Learn the elements of each
8. Retract: Expect to be the person retracting
9. Cut Suture: Be ready with suture scissors when resident/attending is suturing, on most sutures leave 1cm long suture tails. Ask “how long” if unsure.
10. Retrieve Bed: When patient extubated, bring bed back in
11. Transport Patient: Help transport patient to PACU, floor, etc.
12. Procedure Note: Put in a procedure note. (If possible, do in OR before extubation)

### **Hints/Tips for Surgery:**

1. Look at the OR schedule (in Powerchart, ask resident how to find) the DAY BEFORE.
2. Learn the pertinent operative anatomy/pathophysiology prior to each surgery. It’s difficult to impress an attending with your knowledge of anatomy, but not knowing it can look quite bad. Know why they are having surgery, the indications/contraindications, etc.
3. Practice knot tying: If you tie well, they will likely let you tie more. Learn two-hand tied first. Know them left and right-handed. Later, you can learn one-handed. Make it a point/ask your residents for a practice session in NCASE.

4. Cutting suture, expect to get yelled at: Pay attention and be ready with suture scissors when asked to cut. If there is any doubt on where to cut or how long to leave the tails: ASK.
5. Be nice to Scrub/Circulating Nurses: Stay on their good side as they can be very helpful at guiding you in the OR. Learn their names, and be friendly.
6. DO NOT touch the instrument table: NEVER touch this table, ALWAYS ask the scrub nurse to pass you instruments.
7. Observe Sterile Field: If you have any doubt whether or not you can touch something, DO NOT TOUCH IT. When gowned and gloved and not standing at the table, keep your hands above your waist and on your abdomen at all times. You don't want to infect your patient!
8. Learn to place a Foley: This is a great way to help in the OR. The more you help to get everything ready beforehand, the more the residents and attending will let you do during the procedure. See NEJM website for a great video on foley placement.
9. General Surgery Call Tips: carry **bandage scissors**, for traumas put in the trauma note, for consults put in the consult H&P.

### **Recommended References and Textbooks:**

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- o Surgical Recall: An useful pocketbook for surgery rotation. Quick and easy to read. Answers to many typical pimp questions and many good mnemonics.
- o Pestana Review: A word/pdf file passed down throughout the generations on M3 zip file. Great review for the shelf.
- o NMS Surgery Casebook (the red book): Tons of comprehensive case studies. A nice alternative or supplement to practice questions and textbooks.
- o Casefiles – Surgery: Another solid basic review of the essentials of surgery.
- o Netter's Atlas of Anatomy: Will suffice for all your anatomy needs. Read the night before a surgery for a good anatomy review.
- o USMLE World Question Bank: Helpful but currently <300 surgery specific questions. A few medicine subspecialty questions are helpful but there's a heavy focus on trauma.

### **Testing/Grading (likely to change):**

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There are 3 components to the final surgery grade:

- the OSCE,
- your clinical evaluations, and
- the Shelf.

Each component is essentially equally weighted. To get honors you must score above the class average of your current surgery group on all 3 components. To get a high-pass you must score above average in 2 of the 3 components. Be prepared and be fast, but be thorough on both the OSCE and Shelf. The surgery Shelf and OSCE are among the hardest tests of the year. Plan your studying and preparation accordingly.

The average for the clinical evaluations is around 7.1 and you will get an evaluation from each attending and senior resident that you work with. Each evaluation is weighted equally, **regardless** of the duration of time spent with that particular attending/resident. For example, your evaluation from your month-long general surgery attending is equal to your evaluation from outpatient attending with whom you work 1-2x/week.

The average on the shelf exam is usually in the low 70s. The shelf is difficult and covers a lot of medicine material. It can be thought of as the surgical management of medical patients. The OSCE is long and difficult – many consider this the hardest OSCE of the year. Be prepared and be fast. It can be helpful to practice/simulate the OSCE in groups.

There is also a midterm, an in-house test that contains some slides/photos. It is derived directly from the learning objectives and lectures. The average on the test is usually between 50-60%. While the midterm does not factor into honors/high-pass, it is used to calculate the overall grade to determine pass vs. fail.

**Pearls for Pimping:**

<p><b>Post Op Fever:</b>          Wind - atelectasis, pneumonia          Water - UTI          Wound - Infection          Womb - endometritis, uterine infxn (if C-Section)          Walking - DVT          Wonder-Drugs - Medications</p>	<p><b>Compartment Syndrome:</b>          Pain          Paresthesia          Pallor          Paralysis          Poikilothermia          *NOT pulselessness*</p>	<p><b>Anterior Mediastinal Mass (4 T's):</b>          Thymoma          Terrible (T-cell) Lymphoma          Teratoma          Thyroid Goiter</p>
<p><b>Sepsis:</b>          Systemic Inflammatory Response Syndrome (SIRS)=          Temperature: ↑ or ↓          Tachycardia          Tachypnea          Leukopenia or Leukocytosis          Hypotension          Sepsis = SIRS + Infxn          Septic Shock = Sepsis unresponsive to fluids (must use pressors)</p>	<p><b>Hematuria (ITS):</b>  <b>I</b> Infection          Infarction          Iatrogenic (drugs)  <b>T</b> Trauma          Tumor          TB  <b>S</b> Stone          Sickle cell          cystitis</p>	<p><b>Fistula that fails to close:</b>          Foreign Body          Radiation          Infection          Epithelialization          Neoplasm          Distal obstruction</p>
<p><b>Appendicitis:</b>          Rovsing's Sign          Psoas Sign          Obturator Sign          McBurney's Sign</p>	<p><b>Ascending Cholangitis:</b>          Charcot's Triad:          Jaundice          Fever (with rigors)          RUQ Pain</p>	<p><b>Septic (Ascending) Cholangitis:</b>          Reynold's Pentad:          Charcot's Triad plus          Hypotension          Altered Mental Status</p>
<p><b>Layers of the abdominal wall:</b>          1. Skin, then fat          2. Scarpa's fascia          3. External oblique          4. Internal oblique          5. Transversus abdominis          6. Transversalis fascia          7. Preperitoneal fat          8. Peritoneum</p>		<p><b>Arcuate Line:</b>          Superior to the arcuate line, the internal oblique aponeurosis splits to envelope the rectus abdominis muscle. Inferior to the arcuate line, the internal oblique and transversus abdominis aponeuroses merge and pass superficial (i.e. anteriorly) to the rectus muscle</p>

# OBSTETRICS & GYNECOLOGY

## Obstetrics H&P:

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**CC:** A few words on why the patient presents, usually a symptom such as “my water broke.” Quote the patient if you can.

**HPI:** Start with age and G\_P\_\_\_\_\_ @ \*\*\* of weeks dated by (LMP and first trimester ultrasound, usually abbreviated LMP=FTUS if consistent), admitted for: \_\_\_\_\_. Describe the reason for coming to the hospital as you would for other rotations. Be sure to ask about vaginal bleeding, pain, contractions (frequency, intensity, when they started), loss of fluid (what color, what time), and fetal movement.

### G\_P\_ Notation:

- G = gravida → number of lifetime pregnancies, including current
  - P = para → results of pregnancies (Term/Preterm/Abortion/Living children)
- Ex.: a currently pregnant pt with one prior full term delivery would be a G2P1001

**Prenatal Course:** Complications (diabetes, hypertension, hyperemesis gravidum, any antepartum hospitalizations and treatments, if Rh neg did the pt receive Rhogam at 28wks)

**Ultrasounds:** Most uncomplicated patients will have a growth ultrasound (Level I) at 20wks

**PMH:** As per usual

**PSH:** Particularly any abdominal surgeries

**POBHX:** # of pregnancies; # of births; Ask about date, route of delivery, duration of labor, birth weight, gender, anesthesia requirement and any complications (including postpartum hemorrhage, pre-eclampsia, etc)

**Meds:** As per usual, including prenatal vitamins

**Allergies:** As per usual.

**Social Hx:** EtOH, tobacco, illicit. Specify if used during pregnancy. “Patient communicates comfortably in [language].”

**Family Hx:** History of birthing complications or birth defects, mental retardation, bleeding diatheses, clotting disorders, HTN, DM, CAD, gynecancers

### Physical Exam:

#### Vitals, GEN, CV, LUNGS

**ABD:** Gravid, nontender, fundal height, estimated fetal size by Leopold’s maneuver

**EXT:** Note if edema is present (1+? 2+?) or absent, reflexes/DTRs (including clonus)

**FHT:** (fetal heart tones) For patients on continuous external fetal monitoring in the hospital

4 components:

- Baseline HR (normal 110-160)
- Variability [absent (0), minimal (1-5), moderate (normal, 6-25), marked (>25)]
- Accelerations (generally a 15x15 increase from baseline)
- Decelerations (early, late, variable)

**TOCO:** (tocometer measures uterine contractions) q\*\*\* min; level of Pitocin (mU/min)

**SVE:** (sterile vaginal exam) Dilation/Effacement/Station (done by the resident or attending; students write “deferred” or “per [examiner]”).

**Prenatal Labs:** Blood type /Rh status /Rubella /RPR /Hep B  
SAg/HIV/Gonorrhea/Chlamydia/GBS status @ 35-37wks

**A/P:** Age, G\_P\_\_\_\_ at \*\*\* weeks admitted for \_\_\_\_\_.

1. Dating: by LMP/US (which trimester was the ultrasound performed)/IVF/IUI
2. Maternal Well Being (MWB): usually “reassuring,” AF, normal BPs, include any major PMH
3. Fetal Well Being (FWB): Reassuring? Reactive? Category of FHT tracing? EFW: lbs.
4. Labor: Expectant management? Induce/Augment with Pit? AROM?
5. Route of Delivery (ROD): Vertex? Confirmed by Leopolds/BSUS?
6. Prenatal labs (PNL): Maternal blood type, Rh status, Rubella immune, HIV, RPR
7. GBS: neg/pos; if pos, antibiotics given
8. Other issues (e.g. gestational diabetes, other medical issues etc.)

Obstetrics Presentation One-Liner Ex. “Sally Jones is a 32-year-old G3 P1102 who presents at 32 weeks, 5 days by 1st trimester ultrasound with complaints of regular, painful uterine contractions.”

## Labor SOAP Note

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*This is written every two hours while patient is laboring.*

**S:** Any pain? Feeling contractions? Rectal pressure?

**O:** **VS:** Temp, HR, BP

**FHT:** Baseline, variability, accels, decels (early, variable or late)

**TOCO:** q\*\*\*min; level of Pit (mU/min)

**SVE:** Dilation/Effacement/Station (done by the resident or attending; students write “deferred” or “per [examiner]”).

**A/P:** Age, G\_P\_\_\_\_ @ \*\*\* weeks in latent/active labor.

**MWB:** How is the mother doing? Does she need pain meds? Are pain meds helping her?

**FWB:** Reassuring. Cat \_\_\_ tracing. EFW.

**Labor:** Cont pit (dose) or expectant management. Stage of labor. Include any change in labor.

**GBS status:** If positive, then indicate antibiotic given and # doses.

## Delivery Note:

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*There is a specific “AdHoc” form in PowerChart for this (OB Delivery Note).*

**Procedure:** NSVD/LFVD/Primary LTCS/Repeat CS/Classical CS

**PreOp Dx:** # of weeks pregnant. # of hours in 2nd stage of labor. If C/S, give reason why.

**PostOp Dx:** Same

**Attending:** \*\*\*

**Assistant(s):** Resident and/or student present for delivery

**Anesthesia:** Typically CLE (epidural) or spinal (for C/S)

**EBL:** For C/S ask anesthesiologist (for vaginal delivery this is estimated or measured together with attending)

**IVF:** For C/S, ask anesthesiologist (include crystalloid, colloid and any blood products given)

**UOP:** For C/S, ask anesthesiologist or measure from foley bag

**Findings:** \*\*Viable M/F infant. Weight (grams). Apgars at 1 and 5 minutes. \*\*Placenta delivered via: manual expression/extraction/spontaneous. Intact? 3 Vessel Cord? Abnl? \*\* If C/S, note status of uterus, tubes, and ovaries bilaterally. \*\*The nurse will typically write the weight and Apgars on whiteboard, look before asking.

**Lacerations:** If perineal, indicate the degree of laceration (1st – 4th degree) and type of suture material used.

**Specimen:** Indicate if cord blood collected or cord segment for gases.

**Complications:** \*\*\*

**Condition:** Good/Fair/Poor

**Disposition:** LDR (for vaginal deliveries) or RR (for C/S) with infant (or infant to SCN-special care nursery)

**Dictation:** (Resident or attending does dictation)

### **Post Partum Progress Note for a Cesarean Section:**

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**S:** Ask about pain control, diet (and if tolerating), nausea, vomiting, flatus, ambulation, voiding, vaginal bleeding (lochia), and breastfeeding (and how it is going and long-term plans). Ask about post partum birth control plans. Ask about circumcision for male neonates.

**O:** **VS and I/O's:** Include UOP over 24hrs (calculate rate per hr).

**CV:** RRR. no m/r/g

**LUNGS:** CTAB, no wheezes/crackles

**ABD:** +/- BS. Soft. Appropriately tender. ND. Uterus firm @ 1-2cm above/below umbilicus. \*\*Be sure to have pt lying flat for abdominal exam.

**INCISION:** c/d/i (clean, dry, intact), steris/staples

**EXT:** Check edema/calf tenderness, SCDs in place? \*\* If not, please replace them.

**Labs:** If POD #1. Typically CBC.

**A/P:** Age, G\_P\_\_\_\_ POD # s/p (type of C/S) for (indication), doing well.

CVS/Heme: A/VSS. CBC appropriate for EBL (or pending)

GU: adequate UOP overnight, plan d/c foley, and await void

FEN/GI: HLIV (hep-lock IV); Advance diet to general (ADAT)

Neuro: transition to PO pain meds

Proph: SCDs, encourage ambulation

Breastfeeding: Lactation consultant PRN

PPBC: post partum birth control plan

\*\* Include blood type and rubella status in your note- pt may need Rhogam or

MMR postpartum

POD #1: Remove bandage (ask resident for the attending's preference)

POD #2: Continue above recommendations. Advance diet if not already on general.

POD #3: Continue above recommendations.



*Tip:* Staples are usually removed on POD #3 for TRANSVERSE INCISION ONLY. Staples stay in vertical incisions for 7-10 days. DO NOT REMOVE STAPLES WITHOUT ASKING YOUR RESIDENT. Apply Benzoin and steri-strips perpendicular to incision.

### **Post Partum Progress Note for a Vaginal Delivery:**

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**S:** Same as for C/S postop note

**O:** Same as for C/S postop note

**A/P:** Age, PPD # \_\_\_ s/p NSVD (or LFVD/OFVD/VAVD), doing well.

Same as for C/S



*Tip:* Some residents prefer a systems-based approach to the plan. Be sure to ASK!

### **Gynecology H&P (Outpatient or Inpatient):**

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**HPI:** Start with age and G\_P\_ \_ \_ \_ , followed by chief complaint (irregular vaginal bleeding, pelvic pain, vaginal discharge, etc). Write the HPI as you would for other rotations, asking about duration of symptoms, quality and characteristics of symptoms, aggravating/ameliorating factors. You will often need to include pertinent information such as menopausal status, menstrual cycle length and timing, history of other episodes of irregular bleeding, pain, discharge, etc. Include GI/GU complaints or pertinent positives/negatives here as well.

**PMHx:** (HTN, Obesity, etc)

**PSHx:** (Examples, D&C x 1 in 1980s, C/S in 1995)

**Meds:** \*\*\*

**Allergies:** \*\*\*

**OBHx:**

Include date of each pregnancy and outcome (Ex. FTSVD, FTC/S, TAB). Include gestational age of any miscarriage, abortion, preterm delivery. Include weight of delivered infants, any pregnancy-related complications, and degree of lacerations if present.

**GynHx:**

Menstrual history notation: (Date of last menstrual period) –cycle length/duration of bleeding. Age of menarche/menopause.

+/- History of STDs – which ones, dates- were they and their partner treated

+/- History of PID

+/- History of abnormal paps, date of last pap

+/- History of fibroids or ovarian cysts

**Sexual Hx:**

+/- sexually active, with (male/female) partners x (length of time)

# Lifetime partners

+/- use of birth control – which methods and when?

+/- condom use

**Social Hx:**

Marital Status; with whom do they live?

Tobacco/EtOH/Illicits

+/- Hx of Domestic Violence, +/- current Domestic Violence

**FamHx:** as usual (be certain to ask about breast/ovarian/uterine/colon CA and bleeding/clotting disorders)

**ROS:** as usual

**Physical Exam:**

Vitals (Temp, HR, BP, RR, Pox)

General: \*\*\*

Neck: \*\*\*

CV: \*\*\*

Chest: \*\*\*

Abd: \*\*\*

Ext: \*\*\*

Breasts: +/- skin changes, dimpling/erythema, +/- masses or tenderness, +/- nipple discharge, +/- axillary lymphadenopathy

Pelvic:

Ext Genitalia: B/U/S; normal pubic hair distribution, nontender, no masses, no lesions

Vagina: no discharge, no lesions, normal rugation, +/- blood in vault (amount)

Cervix: no gross lesions, blood at os, smooth, no CMT

Uterus: # of weeks size, position (anteverted, midline, retroverted?), smooth/irregular, nontender?, mobile?

Adnexa: non-enlarged, any masses or fullness

RV: normal rectal tone, supple RV septum without fluid wave or nodularity, no masses, soft brown stool, hemoccult negative, \*\* ask resident or attending before performing a rectal exam

**A/P:** Age, G\_P \_\_\_\_ with \_\_\_\_\_

1. Evaluate pt's complaint and list your diagnosis with appropriate differential dx
2. Routine Health Screening and Management (pap smear, bilateral screening mammogram, fasting lipid panel, monthly SBE/SBE teaching)
3. Follow-up

**Gynecology OP Note: (PowerChart has Power Note with checkboxes)**

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**Pre-Op Dx:** \*\*\*

**Post-Op Dx:** \*\*\*

**Procedure:** \*\*\*

**Surgeon:** \*\*\*

**Assistant:** Include resident(s) and medical student(s)

**Anesthesia:** Usually either GETA (general) or CLE (epidural) or MAC (monitored anesthesia care) with paracervical block

**EBL:** estimated blood loss; ask Anesthesiologist for amount

**IVF:** amount given during surgery; ask Anesthesiologist for amount (include crystalloid, colloid and any blood products administered intraop)

**UOP:** usually measured via foley; ask Anesthesiologist for amount

**Findings:** From both exam under anesthesia (EUA) and intra-op findings (liver, stomach, uterus, fallopian tubes, ovaries, etc)

**Specimen:** What you removed and where it went (for frozen section, routine pathology, etc.)

**Complications:** i.e. "None" – Ask attending/resident before putting down any complication other than "none"

**Drains:** Foley cath to gravity, subcutaneous JP drain, etc.

**Disposition:** Good condition, extubated to PACU

**Dictation:** Resident or Attending will do the dictation.

## Gynecology SOAP Note:

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**S:** Ask about pain control, fever, nausea, vomiting, diet (and if tolerating), flatus, ambulation, voiding, vaginal bleeding, CP, and SOB.

**O:** **VS and UOP:** If not in computer, be sure to ask nurse/PCT . You must document UOP in cc/hr.

**GEN:** A&Ox3. NAD.

**CV:** RRR. no m/r/g

**LUNGS:** CTAB. No wheezes, crackles.

**ABD:** +/- BS. Soft. Mod distension. Appropriate tenderness.

**INCISION:** c/d/i. No erythema or drainage. No fluctuance or ecchymosis. (Remove bandage on POD #1 unless specifically told not to, POD#2 for all ONC patients)

**EXT:** Note edema, calf tenderness, and +/- SCDs/TEDs

**Labs/Studies:** Usually will trend CBC every day, trend from pre-op hgb.

**A/P:** Age, POD # \_\_\_ s/p (procedure) for (indication), doing well postop.

CVS/Heme: Afebrile, normal vitals. AM CBC pending (or result and its trend from pre-op). Include any perioperative heart meds here (beta blockers/other anti-hypertensives and if given or held).

Resp: Pt on (RA, NC, etc) and saturating well. Incentive spirometer by bedside and being used?

FEN/GI: IVF and their rate, plan for TKO or HLIV, diet and ADAT

GU: adequate UOP; plan d/c foley?

Pain/Neuro: How well is their pain controlled? Transition to PO meds?

Other medical problems and their tx (e.g., endo for pts with thyroid issues, DM)

GYN: comment on vaginal bleeding or any need for hormone therapy

Path: Pending if not back yet

Dispo: continue hospital care or per attg

## Gynecology Postop Discharge Instructions:

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**Admit Date:** \*\*\*

**D/C Date:** \*\*\*

**Procedure:** \*\*\*

**Meds:** Write out in plain language. Patients usually leave with:

Norco 10/325mg 1 to 2 tabs PO Q4 to 6 hrs prn for pain; Disp: 30 (no refills)

Motrin 600mg 1 tab PO Q6 hrs prn for pain; Disp: 60 (no refills)

Colace 100mg 1 tab PO BID; Disp 60 (3 refills)

\*\* If Hgb low (<10 typically): Ferrous Sulfate 325mg 1 tab PO BID; Disp: 60 (3 refills)

**Stairs:** As tolerated

**Lifting:** No more than 10-15lbs for 2 wks (if minor surgery), 4 wks (if laparoscopy) and 8wks (if laparotomy)

**Diet:** No restrictions

**Driving:** Not while taking pain meds (Norco)

**Other:** Call if: temp>100.4, uncontrolled pain, severe nausea or vomiting, or with any questions. In case of questions or emergency, call Dr \*\*\* at (the phone number) or 911



*Tip:* Be sure to fill out the appropriate D/C form and write out the prescriptions. This is good to do on POD #0 to assist residents.

### **Duties on OB:**

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**Daytime** (Hours are typically 5:30AM to 7PM.)

1. Check in with residents. Check the board for patients to pick up at the beginning of the day after signout. Always follow PAC and Winfield Moody patients.
2. Write H&Ps on new patients throughout the day. (This is best done before or just as a resident is assigned to the patient – keep up with the board and ask chief if you may do an H&P if not yet assigned to a resident).
3. Check on your patients every 2 hours and write a labor progress note. (However, if pushing with another patient, that takes priority).
4. Work with nurse when patient is pushing (see above – never leave your patient if you have started pushing with her!)
5. Gown up promptly for delivery (always wear the blue-knee high boots!) and be ready to be an active participant in the delivery (obviously attending and patient dependent).
6. Follow patients to C/S or be willing to go to a C/S at any time during the day.

**Night Float** (Hours are typically 5PM to 6AM.)

1. Largely the same as days in regards to picking up and following patients.
2. When on Gyne call, page your resident at the beginning of the shift. Plan to see consults in ER with the Gyne on-call resident. If nothing is going on then you will stay on L&D and see patients.
3. Always have something to read as nights can range from very busy to very slow.

### **Duties on Gyne:**

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#### **In The OR**

1. Check to see if the patient needs antibiotics. Get them from the pharmacy if necessary (someone will show you where the pharmacy is on the first day).
2. Take bed out to the hallway, and help roll it back in after the surgery.
3. Write your name on the board and give your badge to the circulating nurse.
4. Pull your gloves and a gown and give to scrub nurse or put on table in sterile fashion.
5. Introduce yourself to the circulating and scrub nurses.
6. Put SCDs on the pt's legs.
7. Exam under anesthesia with resident and/or attending.
8. Place foley catheter with resident assistance.

#### **On The Floors**

1. Daily SOAP notes and orders done and in chart by 6:15am (team dependent) so resident can add addendum.

2. Take off bandage in AM of POD #1 unless specifically told not to (POD#2 for oncology). If you are concerned about the appearance of the incision, please find your resident to examine it.
3. Check POD #1 CBC.
4. D/C instructions and scripts.
5. PostOp check and note (evening of surgery if patient gets to the floor prior to signout time).
6. PM checks (no note needed, but done to update team) – Diet changes? Pain control? Voiding? Flatus? New orders?
7. Follow-up on pathology

## Commonly Used OB/GYNE Abbreviations

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Ab – abortion (includes elective (EAb), therapeutic (Tab), and miscarriages/spontaneous (SAb))  
 AFI – amniotic fluid index  
 AFXSS – afebrile, vital signs stable  
 AMA – advanced maternal age  
 AROM – artificial rupture of the membranes  
 ASC-H – atypical squamous cells cannot exclude high-grade intraepithelial lesion  
 ASC-US – atypical squamous cells of undetermined significance  
 AUB – abnormal uterine bleeding  
 $\beta$ HCG – beta human chorionic gonadotropin  
 BPP – biophysical profile  
 BSO/LSO/RSO – bilateral/left/right salpingo-oophorectomy (removal of fallopian tubes/ovaries)  
 BSUS – bedside ultrasound  
 BV – bacterial vaginosis  
 C/D/I – clean/dry/intact  
 CI – cervical insufficiency  
 CKC – cold knife cone biopsy  
 CLE – continuous lumbar epidural (epidural)  
 CPD – cephalopelvic disproportion  
 C/S – C-section  
 Ctx or Ucx – contractions  
 D&C – dilatation & curettage  
 D&E – dilatation & evacuation  
 DMPA – Depo-Provera  
 DUB – dysfunctional uterine bleeding  
 EAB – elective abortion  
 ECV – external cephalic version  
 EDC – est. date of confinement (same as EDD)  
 EDD – est. date of delivery (same as EDC)  
 EFW – est. fetal weight  
 EUA – exam under anesthesia  
 FAS – fetal alcohol syndrome  
 FF – fundus firm  
 FHT – fetal heart tracing/tones  
 FM – fetal movement  
 FSE – fetal scalp electrode  
 FT – full term  
 FTP – failure to progress  
 FWB – fetal well being  
 GA – gestational age  
 GBS/GBBS – group B  $\beta$ -hemolytic streptococcus  
 GETA – general endotracheal anesthesia  
 GLT – glucose loading test  
 GPs – Gravida (number of pregnancies) and Para (number of births in this order: Term, Preterm, Abortions, Living)  
 GTT – glucose tolerance test  
 HDS – hemodynamically stable  
 HELLP – hemolysis, elevated LFTs, low platelets

HPL – human placental lactogen  
 HSG – hysterosalpingography  
 ICSI – intracytoplasmic sperm injection  
 IUFD – intrauterine fetal death  
 IUGR – intrauterine growth restricted  
 IUP – intrauterine pregnancy  
 IUCP – intrauterine pressure catheter  
 LBW – low birth weight  
 LEEP – loop electrosurgical excision procedure  
 LFVD/OFVD – low/outlet forceps-assisted vaginal delivery  
 LGA – large for gestational age  
 LGV – lymphogranuloma venereum  
 LMP – last menstrual period (first day)  
 LOF – loss of fluids (water breaking)  
 LOT – left occiput transverse  
 LTCS – low transverse C-section  
 LTL – laparoscopic tubal ligation  
 LTV – long-term variability  
 MAC – conscious sedation (type of anesthesia)  
 MSAFP – maternal serum AFP  
 MWB – maternal well being  
 NR NST – non-reactive NST  
 NST – nonstress test  
 NSVD – normal spontaneous vaginal delivery  
 NT – nuchal translucency  
 NTD – neural tube defect  
 OCP – oral contraceptive pill  
 OCT – oxytocin challenge test  
 PCOD – polycystic ovarian disease  
 PCOS – polycystic ovarian syndrome  
 PDIOL – post dates induction of labor  
 PGYNHx – past GYNE history  
 PID – pelvic inflammatory disease  
 PIH – pregnancy induced HTN  
 Pit – pitocin  
 PMP – post-menopausal  
 POBHx – past OB history  
 POD – post op day (0=day of surgery)  
 PP – post partum  
 PPBC – post partum birth control  
 PPRM – preterm premature rupture of membranes  
 Pre-X – pre-eclampsia  
 PROM – premature rupture of membranes  
 ROM – rupture of membranes  
 RPR – rapid plasma reagin  
 SAB – spontaneous abortion  
 SERM – selective estrogen receptor modulator  
 SGA – small for gestational age  
 SROM – spontaneous rupture of membranes  
 SUI – stress urinary incontinence  
 SVD – spontaneous vaginal delivery  
 TAB – therapeutic abortion

TAH – total abdominal hysterectomy  
TPAL – term, preterm, aborted, living  
TVH – total vaginal hysterectomy  
TOA – tubo-ovarian abscess  
TOLAC – trial of labor after Cesarean  
TOCO – tocometer (measures frequency of contractions)

TSST – toxic shock syndrome toxin  
UPI – uteroplacental insufficiency  
U/S – ultrasound  
UUI – urge urinary incontinence  
VBAC – vaginal birth after Cesarean  
VDRL – Venereal Disease Research Laboratory  
VTOL – Vaginal trial of labor

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**Recommended References, Textbooks, and Pocketbooks:**

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- **Beckmann's Obstetrics and Gynecology:** Same book from SBM. An easy and concise read with helpful tables, figures, and diagrams. Helpful practice questions at the end of the book.
- **Case Files: OB/GYN:** Excellent preparation for Shelf and OSCE. For many students a must read. Case based, so easy to work through.
- **BluePrints: OB/GYN:** Excellent review book, great preparation for Shelf and OSCE. Similar extent of material and detail as Beckmann.
- **ACOG questions:** Check Blackboard under OB/GYN -> Learning Resources. An excellent review for the shelf.
- **USMLE World questions:** A good batch of ~200 supplemental questions, good shelf preparation.

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**Testing:**

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**SHELF:** 100 question shelf exam. 130 minutes to complete.

**OSCE:** Typically 6 stations:

- OB exam: evaluate a pregnant pt (fundal height, FHT, due date, pregnancy related question/concern)
- Gyne exam (know how to use speculum and find the cervix)
- Oral exam question with an attending
- Internet research skills: answer a clinical question, similar to PBL
- Review pt chart and write A/P
- Clinical identification: evaluate pictures and write A/P

**Pediatric H&P:**

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**CC:****HPI:** "4mo boy/girl with PMH significant for \*\*\* presents with \_\_\_\_\_."

- Drinking/eating/peeing/pooping – quantify in bottles/dirty diapers? Last bowel movement and consistency?
- Feeding history - breast milk/formula type; how much and how often? Is this normal for him?
- How much is he sleeping? More/less than usual? Is he easily arousable? Is he more fussy than usual? Is he consolable?
- How high of fever? What dosages of meds?

**PMH/SurgHx:** Hospitalizations/ER visits? Who is his PMD? Hx of asthma/allergies/eczema? If hx of asthma: any intubations, times albuterol needed/wk? Immunizations up to date (UTD)?**Meds:** As usual.**Allergies:** Be specific about rxns to determine intolerance vs. allergy.**BirthHx:**

- Pregnancy: Term length, method of delivery, APGARs, complications
- Prenatal hx: Care, weight gain, complications
- Birth: Birth weight, gestational age, GBS status, fevers/abx, length of stay in hospital
- Maternal hx: GP and age of mom, drugs/EtOH/tobacco, STDs

**Diet:** Breast milk/Type of formula/Normal milk (and type)? How much, how often? Any solid foods (if age-appropriate)?**Social Hx:** Who lives at home? Environment? Apt/house? Pets? Smokers? Who does he spend time with during the day (care taker, day care, school, etc)? Recent travel? Recent sick contacts?

- School: type, grade, time spent on hmwk, clubs/sports, friends/bullies
- Activities: exercise, TV/comp/videogames, reading
- Sleep: bedtime, snoring/OSA, nocturesis
- Elimination: amt of each, # of diapers, potty trained?
- Oral hygiene: brushing teeth? With assistance? Going to dentist? Cavities?
- Misc: changes in mood, vision/hearing test, safety

**Developmental Hx:** Assess milestones: social & emotional, fine motor, gross motor, language, cognitive**Family Hx:** Hx of asthma/allergies/eczema? Childhood diseases, genetic disorders, cancer, SIDS, inbreeding, miscarriages, early deaths, congenital anomalies, dev delay, sickle cell, seizures?**ROS:** As usual.**PEX:****VS:** T/HR/RR/BP**GROWTH:** height/weight/head circumference (if <2yo) and %iles, BMI**GEN:** alertness, playfulness, consolability, hydration status, respiratory status, social interactions, responsiveness, nutritional status**HEAD:** NCAT, AFOSF. If less than 2yo, assess anterior and posterior fontanelles.**EYES:** PERRL, EOMI, tear production, corneal light reflex, red reflex, strabismus.**EARS:** TM pearly-gray? Red? Intact?**NOSE:** nares patent, nasal polyps, nasal flaring**THROAT:** Oropharynx clear? MMM? Erythema or exudates?**NECK:** soft, supple, no LAD

**CV:** RRR, nml S1S2, no m/r/g

**LUNGS:** CTAB, no wheezes (nasal flaring, tracheal tugging, subcostal retractions, accessory muscle use?)

**ABD:** soft, NTND, +/-BS, no HSM

**BACK:** Sacral dimple, +/- hair tuft

**GU:** Tanner Stage, nml ext genitalia (for males: circumcised penis, testes descended bilaterally)

**RECTAL:** Anus patent

**EXT:** good cap refill or WWP (warm and well-perfused), no c/c/e.

**SKIN:** no rashes, angiomas, jaundice, acrocyanosis, mottling, birthmarks

**NEURO:** CNII-XII grossly intact, "appropriate", MAEW (moves all extremities well).  
Tone/strength/reflexes (root, suck, grasp, Moro, stepping).

*\* Above PE (and history) is a fairly comprehensive list of what you should assess.*

*Some attendings/residents will not want/expect you to record such a detailed exam, especially if findings are normal.*

**Lab/Studies:** For cultures, always report as "NGTD x how many days" or "pending."

**A/P:** 4mo infant presenting with \*\*\*. Discuss differential diagnosis and then break down plan by system (may only have main issue and FEN depending on level of complexity of patient).

## Pediatric SOAP:

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**S:** What happened overnight - per mom, per nursing staff, per pt. Update on main issue. Eating (tolerating PO? any emesis?), peeing, pooping.

**O: VS:**

- Tmax for last 24hr - note fever spikes (and when, what was done for it)
- Tcurrent
- HR + 24hr range
- RR + 24hr range
- BP + SBP range/DBP range over 24hr
- O<sub>2</sub> sat + 24hr range
- Daily weight
- **I/Os** 24hr total in (break down by IV/PO) over 24hr total out = total up or down. E.g. 500 in (300 PO, 200 IV)/600 out = -100 down.
- **UOP:** Look specifically at urine output (record as cc/kg/hr, >1 is nml) and stool output (record as cc/kg/day, <20 is nml).

**PEX:** GEN, HEENT, RESP, CV, ABD, EXT, NEURO

**Labs:** As above.

**A/P:** As above.



### Tips for Examining Kids:

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- Always start with the heart and lungs first. This way, if he/she starts crying, you've already gotten a chance to listen.
- Don't be afraid of asking the mom and dad to help you hold the child. Chances are, they've been to the doctor's before, and know how to help you look in the ears, etc.
- Let the kids play with your stethoscope, penlight, etc., while you're examining them. This way, they won't be afraid when you use them!
- For toddlers, try to get down to their level when you're talking to them. Literally.

- CAUTION: Parents tend to throw around the words "lethargic" and "irritable," when they mean "sleepy" or "irritable." When we say a child is lethargic (and not easily arousable) or irritable (and not consolable), those can be clue words for meningitis...so just be careful when you use those words!

### Commonly Used Peds Abbreviations

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ABC – apnea, bradycardia, cyanosis	NBN – Newborn Nursery
AFOF – anterior fontanelle open and flat	NEC – necrotizing enterocolitis
AGA – appropriate for gestational age	NICU – Neonatal Intensive Care Unit
BPD – bronchopulmonary dysplasia	NNB – normal newborn
CBG – capillary blood gases	OFC – Occipitofrontal circumference
CLD – chronic lung disease	PAL – Peripheral Alimentation Line
CPS – Child Protective Services	PDA – patent ductus arteriosus
ECMO – extracorporeal membrane oxygenation	PIE – pulmonary interstitial emphysema
FAS – fetal alcohol syndrome	PKU – phenylketonuria
GBS – grp B streptococcus	POAL – PO ad lib
HMD – hyaline membrane disease	PTD – prior to delivery
HMF – human milk fortifier	PVL – periventricular leukomalacia
ICH – intracranial hemorrhage	ROP – retinopathy of prematurity
IDM – infant of a diabetic mother	SGA – small for gestational age
IICU – Infant Intensive Care Unit	SIDS – sudden infant death syndrome
IRDS – idiopathic respiratory distress syndrome	TORCH – (titers for) toxoplasmosis, rubella, cytomegalovirus, herpes
IVH – intraventricular hemorrhage	TTNB – transient tachypnea of the newborn
LGA – large for gestational age	UAC – umbilical arterial catheter
MAS – meconium aspiration syndrome	UVC – umbilical venous catheter
MR – mental retardation	
NB – newborn	

### Commonly Used Medications:

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Acetaminophen 10-15mg/kg/dose PO q4-6  
 Ibuprofen 10mg/kg/dose PO q6-8 (for >6 mo old)  
 Amoxicillin 80-90 mg/kg/d PO divided BID  
 Omnicef 14 mg/kg PO daily  
 Clindamycin 15 mg/kg/dose IV q8  
 Clindamycin 10 mg/kg/dose PO q8  
 Orapred 1-2 mg/kg/day PO (for asthma exacerbation)

### Pediatric Vital Signs:

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Age	RR	HR	BP
0-1 mo	30-80	110-190	52-95/25-72
1 mo	30-50	100-170	64-105/30-68
6 mo	30-50	100-170	60-110/40-72
1 yr	20-40	100-160	66-110/40-72
2 yrs	20-30	100-160	74-110/40-72
4 yrs	20-25	80-130	79-112/45-75
8 yrs	15-25	70-100	85-118/48-75
12+ yrs	15-20	60-100	95-125/50-84

Reference p. 447 Nelson's Essential of Pediatrics

Urine output >1 ml/kg/hr  
 Stool output <20 g/kg/d (>20 g/kg/d = diarrhea)

### **Recommended References, Textbooks, and Pocketbooks:**

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- **CLIPP Cases:** You are required to do at least 20 of them. Accessible via Blackboard. Covers peds topics in a case-based manner. Printable summary pages included at the end of each case are helpful for studying. Students have had mixed responses on the helpfulness of these cases.
- **Case Files Pediatrics:** Pediatrics is a very broad field and the cases in this book will help touch on the main topics that are tested on the shelf exam. Most students have found this book very beneficial.
- **Pretest Pediatrics:** Most students have found this book helpful for practice questions spanning the field of pediatrics. It is especially helpful for the subspecialties that you are not able to rotate on during the clerkship.
- **Blueprints Pediatrics:** Not necessary for all students, but about half of the students surveyed have found it helpful for a general overview of peds.

### **Testing / Grading (subject to change):**

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**SHELF:** 100 question shelf exam.

**OSCE:** Consists of talking to “parents” about their children. The physical exam is given on a card. Involves counseling to parents and an admission order set.

**GRADING:** Clinical: 60%, Shelf: 20%, OSCE: 15%, Professionalism/Nutrition: 5%



# PSYCHIATRY

## Psychiatry H&P:

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**CC:** Describe CC, as you would do with any H&P

**HPI:** Include age, sex, and both past medical and past psychiatric history. Include symptom onset, course and duration, as well as significance (why presented now?). Include living situation, employment, recent stressors and funding status if pertinent. Also include presence of any suicidal/homicidal ideation, and auditory/visual hallucinations.

### Psych ROS:

- Think: DAMPS = depression, anxiety, mania, psychosis, substance abuse
- Assess mood (depression screen ask SIGECAPS; mania/hypomania/mixed episodes ask DIGFAST) – see below for meaning of mnemonics.
- Assess anxiety (excessive worry, panic attacks, obsessions, compulsions, social anxiety)
- Assess psychosis (including A/VH, paranoia, delusions, disorganized thinking/behavior)
- Assess functionality (missed work or unemployment, ADLs)
- Assess chemical dependency
- Pt's subjective sense of cognition (concentration and memory)



All psych encounters include a suicidality screen. If there is any potential suicidality contact the nurse to implement precautions immediately.

### Past Psych Hx:

- Previous inpatient hospitalizations – when, where, why
- Previous outpatient tx – therapist/psychiatrist and when last seen, meds used, how long tx lasted, and if it was beneficial.
- Get written consent to speak with therapist if possible.
- Previous suicide attempts/aborted attempts/self-destructive behavior (such as cutting)

### Chem Dependency:

- Current use of EtOH (CAGE screen), drugs (ask about specific drugs), and tobacco – quantity, frequency, pattern of use, last use, triggers.
- If positive drug abuse, ask about history of withdrawal seizures, DTs, blackouts
- Be sure to ask when first used, if there have been periods of sobriety, rehab/detox/AA/NA programs attended.

**PMH/PSH:** List PMH as you would for any patient. Ask specifically about seizure d/o, h/o head trauma and LOC, stroke, and in women with children ask about post-partum depression

**Meds:** List meds prior to admission and while in hospital. List use of PRN meds. Don't forget herbal, over the counter meds and birth control.

**Allergies:** Document medication and reaction.

**Family Hx:** h/o depression, bipolar d/o, anxiety, "nervous breakdowns," psychosis, suicide attempts, psych hospitalizations, and pertinent family medical hx.

**Social Hx:** Include living situation, significant others, social support system, education level, employment status, source of income, legal problems, abuse hx.

**MENTAL STATUS EXAM (MSE):** *This is the equivalent of the PEX for psych!*

**APPEARANCE/BEHAVIOR:** appearance relative to age, race, dress, hygiene, behavior, eye contact, cooperativeness, alertness, orientation

**SPEECH:** rate (accelerated/slowed/normal), rhythm (halting/hesitancy/stuttering), volume (loud/soft/normal), lack of spontaneity? Hyperverbal?

**MOOD:** in the pt's words.

**AFFECT:** objective sense of pt's mood: range (constricted/full/labile), intensity, mood congruent/incongruent with affect?

**THOUGHT CONTENT:** passive or active SI, intent, plan, HI, A/VH, paranoia, delusions, obsessions, ruminations, etc.

**THOUGHT PROCESS:** linear, focused and goal oriented? Disorganized, flight of ideas/logical/illogical/tangential/circumstantial?

**COGNITION:** MMSE (mini mental) score and mistakes

**INSIGHT:** poor/fair/good/excellent. Does he/she understand his/her condition?

**JUDGEMENT:** poor/fair/good/excellent. Is pt making good decisions for themselves and others in their care?

**Labs/Studies:** Usually includes urine tox, +/- CBC, chem, HIV, RPR, etc.

**Assessment:** Brief statement of overall impression.

- **Axis I:** Primary psychiatric dx (major depressive d/o, somatization d/o, panic d/o, schizophrenia, bipolar d/o, autism spectrum disorders, conduct disorder)
- **Axis II:** Personality d/o and mental retardation. (Don't dx a personality d/o for the first time in the hospital. It is not a dx that can be made in that setting. Instead, write "DEFERRED".)
- **Axis III:** List any purely medical problems here.
- **Axis IV:** Psychosocial stressors (chronic mental illness, financial or employment stressors, relationship strain)
- **Axis V:** Global Assessment of Functioning – Found in DSM IV

**Plan:** Include suggestions for placement, workup (bloodwork or imaging), collateral information to be obtained, med suggestions, suggestions for additional consults, suggestions of how to deal with family, etc.

## Psychiatry SOAP:

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**S:** Events o/n. Use of PRN meds (found in MAR)

**O: VS:**

**Mental Status Exam:** as above

**A/P:** Brief Impression

Med suggestions, placement suggestions, suggestions of additional consults, f/u on outpatient treatment options.

## References/Textbooks:

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- First-Aid for Psychiatry: Many students find this concise book a useful summary of important points, similar format as First-Aid USMLE Step 1.
- Casefiles Psychiatry: Presentation of a case and discussion, similar to others in Casefiles series.
- Pretest Psychiatry: High yield psychiatry questions many find helpful for shelf studying.

**Testing:**

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SHELF: 100 questions. This exam is traditionally very difficult to finish due to long question stems.

OSCE: 2 patients that require you to be document a thorough mental status exam and formulate management plans. Also be able to perform and document a mini-mental status exam.

**Commonly Used Psych Abbreviations:**

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ADL – activities of daily living  
A/VH – auditory or visual hallucinations  
BPD – borderline personality disorder  
Chem Dep – chemical dependency  
DIGFAST – mnemonic for mania  
MDD – major depressive disorder  
MDE – major depressive episode  
MR – mental retardation  
MSE – Mental Status Exam (see above)  
MMSE – Mini-mental Status Exam, aka Folstein test  
NA – narcotics anonymous  
SI – suicidal ideation  
SIGECAPS – mnemonic for depression

DIGFAST :  $\geq 3$  for mania  
Distractibility  
Irritability  
Grandiosity  
Flight of ideas  
Activity (Inc, goal-directed)  
Speech (Pressured)/Sleep (decr need)  
Thoughtlessness/Talkativeness  
Suicidality

SIGECAPS:  $\geq 4$  for depression  
Sleep (Inc or Dec)  
Interests (Dec)  
Guilt  
Energy (Dec)  
Concentration (Dec)  
Appetite (Inc or Dec)  
Psychomotor retardation/agitation

# NEUROLOGY

## Neurology H&P:

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*While similar to a medicine note, the following are differences:*

**HPI:** Pt is a \_\_yo right-handed/left-handed M/F with a PMH significant for (neurologic diseases) presenting with (chief complaint)

**Physical Exam:**

**Gen:** NAD

**Neck:** no carotid bruits

**Lung:** CTAB

**CV:** rrr, no m/r/g

**Neuro Exam:**

**Mental Status Exam:** Alert and oriented to person, place and time.

**Higher Intellectual Functions (HIF):** e.g. Mini mental 24/30 unable to recall 3 objects at 5 min and unable to spell “world” backwards

**Language:** Comprehension/fluency/naming and repetition intact, talk about reading and writing if pertinent

**CN I:** not tested

**CN II:** Visual fields full to confrontation. If visual acuity is tested say what it is eg. 20/20. Pupils equal round and reactive to light and accommodation.

**CN III, IV, VI:** EOMI w/o dysconjugate gaze, no nystagmus or ptosis

**CN V:** Mastication intact; facial sensation normal

**CN VII:** Face symmetrical

**CN VIII:** Hearing grossly intact to finger rub bilaterally

**CN IX, X:** Uvula is midline and palate elevates equally

**CN XI:** Sternocleidomastoid and trapezius muscles 5/5 strength bilaterally.

**CN XII:** Tongue protrudes midline without atrophy or fasciculations.

**Motor:** Strength 5/5 in upper and lower extremities bilaterally (mention atrophy and fasciculations if present). No pronator drift. Tone is normal (mention tremor: resting or intentional if present, also mention cogwheeling or rigidity if present). No pronator drift.

- Grade 0: No muscle movement
- Grade 1: Muscle movement without joint motion (fasciculations)
- Grade 2: Moves with gravity eliminated
- Grade 3: Moves against gravity but not resistance
- Grade 4: Moves against gravity and light resistance
- Grade 5: Normal strength

**Reflexes:** Symmetrical reflex in upper and lower extremities in following tested reflexes: biceps, triceps, brachioradialis, patellar and achilles. Plantar reflexes (Babinski) downgoing bilaterally. 2+ is normal, 1+ decreased, 3+ brisk.

**Sensation:** Sensation intact to pinprick, light touch, vibration, proprioception.

**Coordination:** No finger-to-nose or heel-to-shin dysmetria. Rapid alternating movements are normal.

**Gait and Stance:** Normal gait and stance. Able to walk on heels, toes, and in tandem. Romberg negative; stance maintained without sway.

**A/P:** It is important to bring everything together in your assessment. Talk about the significant symptoms, exam findings labs and images that led you to think one way or another.



*Remember:* The most important thing in neurology is to localize the lesion.

## Neurology SOAP:

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- S:** Similar to medicine SOAP
- O:** Similar to medicine SOAP. Should include a full neurological exam:
- MSE:**
- A&O x 3 (alert and oriented to person, place, and time)
  - Mini mental 24/30 unable to recall 3 objects at 5 min and unable to spell “world” backwards
- CN:**
- Always document all CN as shown above in the H&P. Usually not acceptable to write “II-XII intact”
- Motor:**
- 5/5 is normal
  - Be sure to check for pronator drift and examine distal and proximal muscle groups.
- Reflexes:**
- 2+ is normal (scale 0-4, 0 =absent)
  - Check biceps, triceps, brachioradialis, patellar and Achilles
  - Assess Babinski (flexor response (toes down) is normal)
- Coordination:** Assess finger to nose, fast finger movements, rapid alternating movements, heel to knee, Romberg
- Sensory:** Assess light touch, pinprick, proprioception and temp.
- Gait:** Describe their gait. Can they walk on the toes? Heels? In tandem?
- A/P:** Similar to medicine SOAP

### Definitions you should know:

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States of Normal and Impaired Consciousness: (*From Adams & Victor’s Principles of Neurology, 9 edition.*)

**Normal Consciousness:** This is the condition of the normal person when awake. Aware of self and environment.

**Confusion:** Inattentive, disoriented. Unable to think clearly, and coherently. Could only follow the simplest commands inconsistently and briefly.

**Drowsiness and Stupor:** Physical activity and speech are reduced.

**Drowsiness:** unable to stay awake without external stimuli.

**Stupor:** patient can be aroused only by repeated strong external stimuli and cannot sustain such state without repeated external stimulation.

**Coma:** Pt. appears asleep and is not aroused by external or inner stimuli.

### References/Textbooks:

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- Clinical Neurology by Gelb: This is the recommended textbook by the clerkship director. It is an easy read and covers what you need to know for the floors and shelf.
- Casefiles Neurology: Cases and discussions of common neurological presentations. Easy read and many find it very helpful for the shelf.
- Pretest Neurology: High yield practice questions, helpful for shelf preparation.
- High Yield Neuroanatomy: Great review of neuroanatomy! Good basis for neurological principles. Not always a necessary book, but can definitely help with the basics.

### Testing:

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Like other clerkships, there is a shelf exam at the end of the rotation. 100 questions, with some long question stems. Also like other shelf exams, this is thought to be a challenging test. There is also an OSCE at the end of the rotation.

# PRIMARY CARE

## What to Expect

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You will have the option of working in a family medicine, internal medicine, or occasionally pediatric clinic, all of which will provide a different experience, but with the same underlying principles of outpatient care. You may be expected to travel, so be prepared to factor in commuting time. If you have this rotation in the beginning of the year, use it as a refresher course for honing your PEX skills, as they may be a little rusty after studying for Boards. If you have this rotation near the end of the year, think of it as a culmination of all you have learned from previous clerkships and as a way to apply the various skills you have picked up along the way.

The format of your day will vary from clinic to clinic, but will be much like any CSA exam you have taken. You may shadow your preceptor for the first day or so, but make sure you express your wish to see patients on your own. Because of the high volume of patients, you may end up helping out your preceptor, but beware that if you take too long, you end up slowing them down. Efficiency is the key (aka focused histories and physicals). Become familiar with the patient's chart beforehand and always keep a look out for interesting patients, as you can present them during Weekly Report.



You will get to know your attending very well during this clerkship. Be as helpful and interested as possible. Your attending could be an excellent source for a letter of recommendation!

There is an OSCE that mimics the USMLE Step 2 CS format at the 2 week mark but it does not contribute towards your grade. There is no shelf exam, but rather an in-house test developed by the department. Use this rotation as a way to brush up on physical exam skills and focus your differentials. For example, if you are not comfortable with the otoscopic exam, ask your patients if you can take a look at their ears (time permitting). Remember, for outpatient medicine, a patient will more likely have an uncommon presentation of a common diagnosis rather than a common presentation of an uncommon diagnosis.

## Weekly Report and LCLG:

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- Weekly Report: 10 minute presentation (H&P) of an interesting case and discussion of important learning points. Make sure to have read up on the relevant topics and be prepared to be asked questions by your colleagues or group facilitator. When you are not presenting, be engaged, contribute ideas, and ask relevant questions.
- LCLG: 8 minute presentation of any topic of your choice relevant to primary care during the third week. You choose two topics to create concise handouts and pick one to present on LCLG day; most students utilize powerpoint for the presentation. Start early and work hard on this. Ask your preceptor for feedback. Not only is it a great learning opportunity for a topic you're interested in, but it is also a large portion of your final grade.

**References/Textbooks:**

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- Primary Care Medicine: Excellent reference for the clerkship as well as recommended reading. Will be available online on the Galter website.
- Primary Care Mentor: Brief overview of common presentations, will be lent to you on the first day of the clerkship.

Otherwise, same books as medicine!

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# Third Year Timeline

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**July '11 – May '12**

Attend monthly career development sessions in IDM

Complete personal profile at the Careers in Medicine (CiM) website at: <http://www.aamc.org/students/cim/start.htm>

**November '11**

1<sup>st</sup> draft of CV due in AWOME

**Jan '12/Feb '12**

Find an advisor by contacting the Career Advising Coordinator in the departments you are interested in: [http://www.feinberg.northwestern.edu/AWOME/Current\\_Students/Counseling/Career/Specialties/index.html](http://www.feinberg.northwestern.edu/AWOME/Current_Students/Counseling/Career/Specialties/index.html)

If uncertain about specialty, contact Dr. Sandy Sanguino, Dr. Marianne Green or Dr. Thomas for assistance

Can begin requesting letters of recommendation from faculty, but not necessary yet (due in October 1)

Attend department specialty information sessions

Curriculum vita should be in good shape to share with advisors and letter writers as needed

Investigate M4 electives and begin applying (program deadlines range from January through May)

Schedule Step 2

**March '12**

Schedule M4 Year (specifics will be discussed in IDM)

**May '12/June '12**

Work on Personal Statement

Research residency programs of interest through FREIDA website

**July '12/Aug '12**

Receive ERAS token and begin ERAS application

Sign up for application and matching services (ERAS, NRMP, SF match, AUA, military)

Submit MSPE worksheet

Letters of Recommendation should be requested and submitted

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# Patient Privacy

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*Respect the privacy of patients at all times.*

**Failing to protect the confidentiality of health information is:**

- Against the law (placing the medical school, hospital, and yourself in legal jeopardy)
- Unethical and undermining to the patient-physician relationship

**Reminders regarding the basics:**

- It is the patient's right to have confidential medical records. Health Insurance Portability and Accountability Act of 1996 (HIPAA): ensures that individuals moving from one health plan to another will have continuity of coverage and that their privacy and the confidentiality of their health information is protected.
- You are only allowed to look at charts or printed/electronic medical records of patients with whom you are involved in their care. Example: if your friend is in the hospital and you are curious as to how he/she is doing, it is a violation for you to look at their records if you are not involved in their care. The hospital tracks who is looking at the charts and the reason they are looking.
- Regarding your own medical record within NMH. The nursing staff claims it is a HIPAA violation. It is inappropriate to access your own medical records at NMH. You do have the right to the information, but you should follow the established process, which requires completing an authorization form and presenting it to the NMH Medical Records Department. When you obtained your login, you agreed to this. All access to electronic records is recorded and can be audited at any time.
- Never disclose patient information without the patient's permission. Do not talk about a case to those not involved in the case. If you are ever unsure if disclosure is appropriate check with a more senior member on your care team beforehand.
- NEVER talk about patients in public places like elevators, hallways, cafeterias, or anywhere else where somebody might overhear the conversation. You don't know who is listening and it could be very damaging to a patient's privacy. It is unprofessional in the eyes of your superiors and may result in a formal reprimand.
- Don't throw papers with identifiable patient information into unlocked trash bins or other containers. Special containers for such disposal confidential materials are available and are marked as "confidential" or "HIPAA" and are typically located at nursing stations on every floor. Do not dispose of this information at home.
- Turn off computer screens and log off programs that contain patient information when you are finished. Don't leave any source containing patient information where others might be able to look at them.

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# Safety Issues

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## Needle Sticks

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If stuck with a contaminated needle, or otherwise subjected to contamination by bodily fluids from a patient, there is a small but very real risk of acquiring a serious infection from the host. **If such an incident does occur, you are automatically excused from whatever you are doing.** It is to your benefit to report all incidents because, if necessary, you will need to prove that you were infected during your training in order to claim the disability insurance offered through the medical school.

**Remember that your health comes first!**

Medical attention can include *cleansing and treating any wound, obtaining both your blood and the host blood for testing, and the provision of counsel on follow-up treatment and testing.* At the time of any potential contamination, you should excuse yourself from the activity under way and immediately call or go to the site specified below:

- NMH** Corporate Health 312-926-8282  
*If it is after hours or on a weekend, the office will be closed, but an answering service will take your call and will page the nurse on call.*
- RIC** Corporate Health 312-926-8282  
*If it is after hours or on a weekend, the office will be closed, but an answering service will take your call and will page the nurse on call.*
- CMH** Employee Health 3-2273  
Needle Stick Pager (NAB 103)
- VA** Employee Health (Room 1480) 312-569-7159  
*Needle Stick Hotline or ER report immediately to VA Employee Health (7 North Damen) during regular work hours (Mon-Fri 8 AM - 4PM) and to the Emergency Department at all other times.*
- MacNeal** Report the incident to your chief resident or Dr. Zawacki. Proceed to Employee Health ext. 3427 (before 4 PM ) or to the ED ext. 6000 (after 4 PM).

If at a physician's office or other site, you would still contact Corporate Health at NMH.

While the exact reporting procedure varies from hospital to hospital, the first step is to contact the appropriate person immediately. This individual deals with such incidents on a routine basis. He or she can order testing of the patient and you, provide counseling regarding the need and desirability of further testing or treatment, and answer any questions you may have.



**Remember:** In order to minimize your risk of exposure, follow the universal precautions. Wear gloves, eye protection, and facemask during procedures. Treat all patients and bodily fluids as if they are infected. Wash your hands frequently. NEVER recap needles, and dispose of all sharp objects immediately after use. If you follow standard precautions consistently, they will become second nature.

For your own information and for patients who ask, it is important to differentiate between confidential and anonymous testing. Confidential testing is done at a medical

institution, and the result becomes part of the medical record, which is available to insurance companies and may affect future insurability. Anonymous testing is done by “neutral” organizations like Family Planning and state/county health agencies, and only the patient will know the result. Consider this issue before being tested.

You should not receive any bills for treatment, but if you do, send them to:

Christopher Johnson  
Director, Office of Risk Management  
Northwestern University  
2020 Ridge Avenue #240  
Evanston, IL 60208-4335

Phone: 847-491-8518 Fax: 847-467-7475  
E-mail: cljohnson@northwestern.edu

If you become aware of an error (wrong order, medication, technical problem with a procedure, etc) you need to make sure it is reported for appropriate follow up. NETS (Northwestern Event Tracking System) is available on every NMH computer from the home page. It takes about 2 minutes to enter an event. Good Catch or Near Miss reports are also very welcome and will be followed up. You can report anonymously or provide your name. You can also report by phone to 6-RISK at any time, and for serious events you should use the phone rather than the online system.

If you are involved in a medical error you should reach out for support. Your resident, attending or clerkship director are good resources. If you are part of the team involved in a devastating event such as a patient suicide, be sure to ask for and accept support.

## Security

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As medical students, we can have difficult hours: early mornings and late nights. These are the logical times you should be aware of your surroundings, but remember crimes can occur at any time.

**To further reduce your risk of becoming a victim, be “street smart”!** Stay in well traveled areas and be alert of your surroundings. Look like you know what you are doing. Do not carry or wear expensive jewelry or bulging wallets. If you feel threatened, get attention by running and crying out for help. Many times you will be asked to travel to different locations around the city and surrounding suburbs. Remember to always use caution when using public transit and attempt to travel in groups. Incidents can occur anywhere, recently there has been an increase in crimes located in the Gold Coast area, so always be prepared. Don't every carry laptops (you will never need them). Limit your use of smart phones or iPads during transit as these have become targeted devices in thefts. Avoid public transportation during strange hours. When in doubt, a cab might be the safest bet, especially when taking call from McNeal or Children's during peds. If you have questions about the general safety of an area, talk to hospital personnel. Most likely, they have been working at the hospital or office for several years and know the places you should avoid.

Safety in the hospital has also been a concern. Although most patients don't appear to be hostile or capable of inflicting physical harm, you should always be conscious of your surroundings and when in doubt immediately vacate the area. Although these events are rare, care should always be taken.

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# Student Code of Conduct

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*The 1999–2000 Medical Student Senate developed the following “Code of Conduct” (revised in 2011) to emphasize students’ commitment to certain principles. The Code of Conduct now serves as a guide for continuing discussion and reflection among students and faculty members regarding the nature of honor and integrity, professional responsibility, and respect.*

## **Honor and Integrity**

- I will neither give nor receive impermissible assistance on academic examinations and assignments.
- I will abide by the Feinberg School of Medicine’s policies and procedures, including those regarding plagiarism, use and distribution of controlled substances, and downloading copyrighted material, as outlined in the Student Handbook.

## **Professional Responsibility**

- I will commit myself to life-long learning, and pledge to contribute to the advancement of medicine.
- I will be a patient advocate and speak up on behalf of my patients.
- I will keep all information that I receive about patients in confidence from anyone outside of the medical team.
- I will not engage in inappropriate relationships with patients or members of my medical team.
- I will not give a false impression of my medical knowledge and skill, and will not falsify medical records.
- I will ask for academic and personal support from my peers and superiors when necessary, and offer similar help as needed.

## **Respect**

- I will treat all people equitably without regard to age, race, gender, religion, ethnicity, disability, socioeconomic status, disease status, sexual orientation, or political ideology.
- I will collaborate with members of the medical school community to promote an environment that supports teamwork.

**By signing this Code of Conduct, I pledge to abide by the Code and to report any infraction. I understand that failure to do so is itself a violation of the Code of Conduct.**

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# Abusive Behavior

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Over the past few years, a growing awareness of abusive behavior by faculty, housestaff, and others toward medical students and junior housestaff has appeared in the medical education literature. A preponderance of the reported incidents occurred during the junior and senior medical school years, when the difference in power is greatest. While there is reason to believe that such incidents are relatively infrequent during clerkships, they are not absent.

## **What is Abuse?**

Abuse can be a subjective entity depending on the perceptions of the victim. However, it is not the rare outburst of verbal invective, directed at whoever happens to be nearby. Such events do happen and are unpleasant, but are not intended to be abusive. However, recurring comments of an insulting or demeaning nature directed intentionally toward a specific person or group of people is abuse. So too is any physical contact of a disciplinary or harassing nature, repeated requests for the use of a student's time to carry out personal tasks or errands, or any threat of grade retribution as a penalty for action or inaction unrelated to educational or patient duties. These are inappropriate and unprofessional behaviors.

## **The Response**

The issue of student abuse has been discussed at the Curriculum Committee, Deans' meetings, individual departmental meetings, and housestaff orientation programs.

When an abusive situation arises, the student should first attempt to confront the abuser and inform the senior resident if necessary. If the abuse continues or if the student anticipates retribution, the student should then approach the appropriate department representative with the case. At the beginning of each clerkship, the director should identify specific individuals that will accept reports of suspected incidents. All clerkships outline a clear plan of action for abusive behavior. Furthermore, the incident(s) should be reported as soon as possible, so that corrective actions can be made.

In addition, Dean John X. Thomas (312-503-1691) should be alerted to any suspected incident. This is particularly important if it is felt that a departmental authority does not understand or does not want to be concerned with pursuing the issue.

NMH has a Physician Health Committee, chaired by Joan Anzia MD, which addresses abusive behavior. You can contact her confidentially if needed.

Also, be liberal with your utilization of the Student Senate. The members of the Senate have been elected to represent the student voice and to serve as your advocates when the opportunity arises. If at any time you feel that your concerns as a student are not being heard, inform your senator.

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# Medical Student Duty Hours Policy

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## Background

- During the clinical years, Feinberg medical students should assume an increasing level of professional responsibility, learning to care for patients with dedication, integrity, and compassion. One of the challenges of becoming a physician is learning to fulfill one's clinical responsibilities without sacrificing one's own physical and mental health. The clinical years should provide an environment in which students can attend both to their education and to their personal well-being as they develop into physicians.

## Policy

- Medical students must not be required to work more than resident physicians, whose duty hours are regulated by the ACGME.
- Duty hours are defined as any clinical work or required educational experiences (e.g. conference, lectures, exams); they do not include time at home to study or travel time to and from clinical sites.
- Medical students must not work more than 80 hours per week.
- Medical students must not work more than 24 consecutive hours caring for patients. After 24 hours, they may continue to work for up to 6 hours for continuity of care or classroom experiences, but may not assume care for new patients during this time.
- Medical students must not be scheduled for call the night before an exam.
- Medical students are dismissed from ward duties by midnight before IDM. Students on call the same day/night of IDM are to report immediately after IDM has concluded to their medical teams. Students not on call are dismissed after IDM.
- At *minimum*, medical students must receive an average of one day off per week over a four week rotation.
- With the exception of Thanksgiving, University holidays (e.g. Independence Day, Labor Day, Memorial Day, Martin Luther King Day) shall be treated like weekend days, on which students may be on call. For all rotations except sub-internships, the Thanksgiving Holiday shall be observed beginning at 6pm on the Wednesday before Thanksgiving and ending on Sunday evening; these count as days off. During sub-internship rotations, medical students may be required to work during the Thanksgiving holiday.

## Monitoring

- Within the limitations above, the clerkship directors are responsible for setting medical student schedules on each individual rotation. All scheduling shall be done with the students' best educational interests in mind.
- Any concerns about duty hours should be discussed with the clerkship director. Students should report any violations of this duty-hours policy to Dr. John X. Thomas; student grades shall not be affected by such reporting.

## **Professionalism**

- At times, it might seem like a good idea to attend that extra meeting the morning before IDM or to show up early in order to carry that extra patient. However, respecting the medical student hour policy also shows respect towards your fellow colleagues and classmates.
- Intentionally disregarding the medical student hour policy has a tendency to backfire—attending and residents can tell if you're trying to look better than the other students on your team. It can also negatively impact the working relationship you have with your fellow teammates.
- On the other hand, if you're carrying more patients than you can handle, or are finding that you have to come in far earlier than other students to write notes, you might want to think about talking with your team. You can ask how to become more efficient with your time, or simply let them know that you feel overwhelmed. Your team will generally appreciate your honesty.

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# Clerkship Transportation Reimbursement Policy

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As part of their required clerkship curriculum, students may be assigned to a clinic or hospital site outside of the Chicago Campus. When students must travel off campus, they are expected to take University shuttles, mass public transportation or their own vehicle.

In specific situations, students traveling off campus may be reimbursed for travel via Metra, personal car or, in unusual circumstances, taxi. Please note that some clerkships provide transportation options at little or no cost to students. Students should utilize these options. In cases where the clerkship does not provide transportation options, a student may qualify for travel reimbursement to their primary assigned site.

Whether traveling by taxi or Metra (counter ticket purchase price only) reimbursement will consist of the one-way cost minus the cost of CTA public transportation. For personal vehicles there is a \$5 deduction. Please note students will be reimbursed from the Chicago campus or home, whichever is shortest, up to a maximum of \$30 each way.

Reimbursements may be issued when:

- A student is **required** to start clerkship work before 6 AM.
- A student is **required** to work later than 9:30 PM or, for those at the Jesse Brown VA, after the last shuttle.
- A student traveling to an outpatient facility or McNeal Hospital that is readily accessible by public transportation (Metra, CTA) will be reimbursed for Metra travel less the cost of CTA public transportation. If traveling by car or taxi students are expected to travel together whenever possible.

All requests will be reviewed by the appropriate clerkship coordinator/director for validation and the AWOME for adherence to department and Northwestern University policies and guidelines.



**Please Note:** This policy is subject to change without notice. Please consult [http://www.feinberg.northwestern.edu/AWOME/Current\\_Students/ClerkshipReimbursement/index.html](http://www.feinberg.northwestern.edu/AWOME/Current_Students/ClerkshipReimbursement/index.html) for the most current and detailed version.

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# Conclusion

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Your junior year will be fascinating beyond your wildest imagination and will test you at every corner. You will see and do many things that you may never have the chance to do again—deliver a baby, replace a knee, comfort a terminally ill patient in palliative care, have a real difficult conversation with a real patient, observe and diagnose mental and psychiatric disorders, operate on an ill patient, participate in a code, hold someone's life in your hand and help to save it.

The student's experience is team-dependent. Unfortunately, there is no standard of resident teaching as there is a standard of medical care, so rise to the challenge and make the best of the situation. As with any working environment and life in general, there can be personality differences, prejudices, and unfair treatment. Although one should try to resolve those conflicts as smoothly as possible, sometimes it is better to simply accept such circumstances.

Remember that you are here to learn. Never forget that it is a privilege to be here and you should utilize every day and value every experience. If your resident is able to finish all the floor work because you helped, there will be more time for teaching. Teamwork allows for a more enjoyable working atmosphere.

Towards the end of your third year, you may feel compelled to declare your future profession. Your mind will likely change many times throughout this year, as you become encouraged by some experiences, evaluations, and teachers (and occasionally discouraged by others). Whatever the challenges, you will succeed.

Have a fantastic year and welcome to the wards!

—*The Class of 2012*

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# Appendix

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## Abbreviations

The following represents a very extensive list of commonly and uncommonly used abbreviations. The use of abbreviations is strongly discouraged for diagnoses or procedures, and we would like to see much less use of abbreviations overall. Some of these are EXPLICITLY prohibited by The Joint Commission and others are just bad practice which has led to *medical error and patient harm*. For example:

- GBS – can mean gallbladder series, gastric bypass surgery, group B streptococci, Guillain-Barre Syndrome
- HSG – can mean herpes simplex genitalis or hysterosalpingography
- OCP – can mean ocular cicatricial pemphigoid, oral contraceptive pills or ova, cysts, parasites
- MR – can mean mitral regurgitation or mental retardation
- PE – has been used by some to mean physical exam, pulmonary embolism, or pulmonary effusion

We have put a ~~line~~ through the abbreviations that should absolutely NOT be used, but have still included them below because you may run into them on the wards.

2/2	secondary to	ARF	acute renal failure
T	one (used to substitute for numerical digit)	AROM	artificial rupture of membranes; active range of motion
TT	two (used to substitute for numerical digit)	AS	aortic stenosis
TTT	three (used to substitute for numerical digit)	ASA	acetylsalicylic acid (aspirin)
AAA	abdominal aortic aneurysm	ASAP	as soon as possible
<del>Ab</del>	<del>antibody or abortion</del>	ASD	atrial septal defect
Abx	antibiotics	ATN	acute tubular necrosis
Abd	abdomen	AXR	abdominal x-ray
ABG	arterial blood gas	BAL	brochioalveolar lavage
ABI	ankle brachial index	BID	twice per day
a.c.	before meals (Latin: ante cibum)	B/L	bilateral
AC & BC	air conduction and bone conduction of ear	BRBPR	bright red blood per rectum
ACS	acute coronary syndrome	Bx	biopsy
ACTH	adrenocorticotrophic hormone	<del>e</del>	<del>with</del>
ADA diet	American Diabetic Association diet	CA	cancer
ADH	anti-diuretic hormone (vasopressin)	CABG	coronary artery bypass
ADLS	activities of daily living skills	CAP	community acquired pneumonia
ad lib	at liberty	c/b	complicated by
AFB	acid fast bacilli (think tuberculosis)	C/D/I	clean/dry/intact (in regard to incisions)
Afib	atrial fibrillation	CHF	congestive heart failure
AFP	alpha fetoprotein	CIS	carcinoma in situ
AFVSS	afebrile, vital signs stable	CKD	chronic kidney disease
AI	aortic insufficiency	CM	costal margin or cardiomegaly
AIN	acute interstitial nephritis	CMH	Children's Memorial Hospital
AKA	above the knee amputation	CMV	cytomegalovirus
AKI	acute kidney injury	CN	cranial nerve
ALL	allergies; also acute lymphocytic leukemia	c/o	complains of
AMA	against medical advice (signing out of hospital); advanced maternal age	coags	coagulation factors (tested with PT/PTT)
AML	acute myelocytic (or myelogenous) leukemia	COPD	chronic obstructive pulmonary disease
ANA	anti-nuclear antibody	CP	chest pain or cerebral palsy
ANC	absolute neutrophil count	CPAP	continuous positive airway pressure
AOX3	alert and orient to time, place, and person	<del>CPM</del>	<del>continue present management</del>
AP	anteroposterior	CRF	chronic renal failure
A+P	auscultation and percussion	CRI	chronic renal insufficiency
A/P	assessment/plan	C+S	culture and sensitivity
aPPT	activated partial thromboplastin time (PTT)	C-section	cesarean section
appy	appendectomy	C/S	cesarean section
AR	aortic regurgitation	CS	chemstrips (measures serum glucose)
ARDS	adult respiratory distress syndrome	CSF	cerebrospinal fluid

CSOM	chronic suppurative otitis media	FFP	fresh frozen plasma
CT	computerized tomography	FH	Family History
CTA	clear to auscultation (in lung exam); CT angiogram	FHR	fetal heart rate
CV	cardiovascular	FHS	fetal heart sounds
CVA	cerebral vascular accident (stroke)	FHT	fetal heart tones
CVAT	costovertebral angle tenderness	FIO2	fraction of inspired oxygen
CVP	central venous pressure	<del>FLK</del>	<del>funny looking kid (**not very professional**)</del>
c/w	consistent with	FM	face mask
Cx	culture	FNA	fine needle aspiration
CXR	chest x-ray	FOB	foot of bed
D5	5% dextrose in saline solution	F.P.	Family Planning
D5LR	5% dextrose in lactated ringer's solution	FROM	full range of motion
D5W	5% dextrose in water	FSH	follicle stimulating hormone
D+C	dilatation and curettage	FSP	fibrin split products (same as FDP)
d/c	discontinue or discharge	FT IUP	full term intrauterine pregnancy
DCFS	Department of Children and Family Services	FTA-Abs	fluorescent treponemal antibody absorption
D+E	dilatation and evacuation	FTT	failure to thrive
DI	diabetes insipidus	f/u	follow up
DIC	disseminated intravascular coagulation	FUO	fever of unknown origin
DJD	degenerative joint disease	fx	fracture
DKA	diabetic ketoacidosis	gb	gallbladder
DM	diabetes mellitus	GBM	glioblastoma multiforme
DNR	do not resuscitate (supportive measures only)	GC	gonococcus
DOE	dyspnea on exertion	GDM	gestational diabetes mellitus
DM	diabetes mellitus	GERD	gastroesophageal reflux disease
DP	dorsalis pedis artery	GGO	ground glass opacity
DPT	diphtheria, pertussis, tetanus immunization	GI	gastrointestinal, gastroenterology
DT's	delirium tremens	gm%	grams per hundred milliliters of serum
DTR	deep tendon reflexes	GNB	gram-negative bacilli
DUB	dysfunctional uterine bleeding	GOETT	general oral endotracheal tube
DVT	deep vein thrombosis	GP	gravidity (# pregnancies), parity (# births categorized as TPAL - term, preterm, abortions, living children)
Dx	diagnosis	GPC	gram-positive cocci
<del>Dz</del>	<del>disease</del>	GSW	gunshot wound
EBL	estimated blood loss	gt. or gtt.	drop or drops (Latin: gutta)
ECT	electroconvulsive therapy	GTT	glucose tolerance test
ECG	electrocardiogram	GU	genitourinary
ED	estimated date of confinement (referring to pregnancy)	GYN	gynecology
EEG	electroencephalogram	HA or h/a	headache
EFM	external fetal monitor	HAL	hyperalimentation
EFW	estimated fetal weight	HAV	Hepatitis A virus
EGD	esophagogastroduodenoscopy	Hb	hemoglobin
EKG	electrocardiogram	HBHC	home based health care
ELISA	enzyme linked immunosorbent assay	HBV	Hepatitis B virus
EMG	electromyogram	HCG	human chorionic gonadotropin
ENT	ear, nose, and throat	Hct	hematocrit
EOM	extraocular movements	HD	hemodialysis; hospital day (followed by a number)
EOMI	extraocular movements intact	HDS	hemodynamically stable
EPS	electrophysiological study/service	HEENT	head, eyes, ears, nose, throat
ERCP	endoscopic retrograde choleangiopancreatogram	HEU	Health Evaluation Unit (the VA's ER)
ESRD	end stage renal disease	Hgb	hemoglobin
ESR	erythrocyte sedimentation rate	H/H	hemoglobin/hematocrit
ESWL	extracorporeal shock wave lithotripsy	HIT	heparin-induced thrombocytopenia
ETT	endotracheal tube	H-J	reflux hepato-jugular reflux
EXT	extremities	HL	hyperlipidemia
FB	foreign body	h/o	history of
FBS	fasting blood sugar	H/O	hemocult
f/c/s	fevers/chills/sweats	H.O.	house officer
FDP	fibrin degradation products (same as FSP)	HOB	head of bed
FDLMP	first day last menstrual period	HOH	hard of hearing
FEN	fluids, electrolytes, and nutrition	hpf	high power field (referring to microscope)

HPI	history of present illness	mg%	milligrams per hundred milliliters
HR	heart rate	MI	myocardial infarct; mitral insufficiency
HRCT	high resolution CT	MICU	medical intensive care unit
h.s.	bedtime (Latin: hora somni)	MMM	mucus membranes moist (oral exam)
HSG	hystosalpingogram	MR	mitral regurgitation
HSM	hepatosplenomegaly	MRA	magnetic resonance angiogram
HTN	hypertension	m/r/g	murmurs/rubs/gallops (cardiac exam)
hx	history	MRI	magnetic resonance imaging
ICU	Intensive Care Unit	MRSA	methicillin-resistant staph aureus (think isolation)
I+D	incision and drainage	MS	mitral stenosis or multiple sclerosis
ID	infectious disease	MVC	motor vehicle collision
IDDM	insulin dependent diabetes mellitus	MVI	multivitamin
IFM	internal fetal monitor	MVP	mitral valve prolapse
ILD	interstitial lung disease	NABS	normoactive bowel sounds
IM	intramuscular	NAD	no acute/apparent distress
IO or I/O	fluid intake (e.g. IVF) and output (e.g. urine, stool, drains)	NC	nasal cannula
IPPB	intermittent positive pressure breathing	NCAT	normocephalic, atraumatic (a normal head)
ITP	idiopathic thrombocytopenic purpura	NEC	necrotizing enterocolitis
IUD	intrauterine device	NG	nasogastric tube
IUFD	intrauterine fetal death	NGTD	no growth to date
IUGR	intrauterine growth retardation	NICU	neonatal or neurosurgical intensive care unit
IUP	intrauterine pregnancy	NIDDM	non-insulin dependent diabetes mellitus
IV	intravenous	NKDA	no known drug allergies
IVAC	a type of infusion pump	NI or nml	normal
IVDA	intravenous drug abuse	NMH	Northwestern Memorial Hospital
IVDU	intravenous drug use	Ø	no or none
IVF	IV fluids	NPO	nothing by mouth (Latin: nil per os)
IVP	<del>IV push or intravenous pyelogram</del>	NS	normal saline; night sweats
IVPB	IV piggyback	NSAID	non-steroidal anti-inflammatory drug
JRA	juvenile rheumatoid arthritis	NSR	normal sinus rhythm
JVD	jugular venous distention	NSVD	normal spontaneous vaginal delivery
KUB	kidneys, ureters, bladder (referring to abdominal x-ray)	NT	nasotracheal (referring to suctioning)
L	left	NTND	nontender, nondistended
LAD	lymphadenopathy; left axis deviation; left anterior descending artery	NTG	nitroglycerin
LBBB	left bundle branch block	n/v/d/c	nausea/vomiting/ diarrhea/constipation
LBIV	large bore IV	O <sub>2</sub> sat	oxygen saturation
LDH	lactate dehydrogenase	OB	obstetrics
LE	lower extremity (leg)	OBS	organic brain syndrome
LFT	liver function test	OCP	oral contraceptive pills
LGA	large for gestational age	OCOR	on call to the OR (referring to OR meds)
LH	luteinizing hormone	ØD	right eye
LIH	left inguinal hernia	OM	otitis media
LLE	left lower extremity (left leg)	OOB	out of bed (referring to activity)
LLL	left lower lobe (referring to lung)	o/p	outpatient
LLQ	left lower quadrant (referring to abdomen)	OP	oropharynx
LMA	laryngeal mask airway	OPV	oral polio vaccine
LMP	last menstrual period	OR	operating room
LP	lumbar puncture	os	mouth
L/S	lecithin/sphingomyelin ratio	ØS	left eye
LUE	left upper extremity (left arm)	OT	occupational therapy
LUL	left upper lobe (referring to lung)	ØU	both eyes
LVEF	left ventricular ejection fraction	p	after (Latin: post)
L VH	left ventricular hypertrophy	P	pulse
MAL	mid-axillary line	PA	posterior-anterior
MAOI	monoamine oxidase inhibitor	PAC	premature atrial contraction
MAP	mean arterial pressure	Pap	Pap smear, Papanicolaou cytologic test
MCH	mean corpuscular hemoglobin	PAS	para-amino salicylic acid
MCHC	mean corpuscular hemoglobin concentration	PAT	paroxysmal atrial tachycardia
MCL	mid-clavicular line	p.c.	after meals (Latin: post cibum)
MCV	mean corpuscular volume	PCA	patient controlled analgesia
		PCN	penicillin
		PCO	polycystic ovary

PDA	patent ductus arteriosus	RAI	radioactive iodine
PDR	Physician's Desk Reference	RBBB	right bundle branch block
PE	physical examination; pulmonary embolus	RBC	red blood count
PEEP	positive end expiratory pressure	r/c/g/m	rubs, clicks, gallops, murmurs
PERL	pupils equal and react to light	RDS	respiratory distress syndrome
PERRLA	pupils equal, round, and reactive to light and accommodation	RDW	red cell distribution width
PFC	persistent fetal circulation	REM	rapid eye movement
PFT	pulmonary function tests	Rh	Rhesus blood factor
PG	prostaglandins	RHD	rheumatic heart disease
PHx	past history	RIA	radioimmunoassay
PID	pelvic inflammatory disease	RIH	right inguinal hernia
PKU	phenylketonuria	RLE	right lower extremity (right leg)
Plt	platelets	RLQ	right lower quadrant (referring to lung)
PMD	primary care physician	RLQ	right lower quadrant (referring to abdomen)
PMH	past medical history	r/o	rule out
PMH	past medical history	ROC	resident on call
PMH	postmenopausal	ROM	range of motion
PMI	point of maximum impulse (referring to heart)	ROS	review of systems
pmns	polymorphonuclear leukocytes (i.e. neutrophils)	RPR	rapid plasma reagent (syphilis test)
PM&R	Physical Medicine & Rehabilitation	RR	Recovery Room
PND	paroxysmal nocturnal dyspnea	RRR	regular rate and rhythm (referring to heart)
p.o.	by mouth (Latin: per os)	RT	radiation therapy
POD	postoperative day (followed by a number)	RTA	renal tubular acidosis
polys	polymorphonuclear leukocytes	RTC	return to clinic
post-op	post-operative	RUL	right upper lobe (referring to lung)
PP	post-partum	RUE	right upper extremity (right arm)
PPTL	post-partum tubal ligation	RUQ	right upper quadrant (referring to abdomen)
PPD	purified protein derivative (for tuberculin test)	RVH	right ventricular hypertrophy
p.r.	per rectum (suppository)	RYGB	Roux-en-y gastric bypass
PRBC's	packed red blood cells	Rx	prescription, treatment, or therapy
prn	when necessary (Latin: pro re nata)	s	without (Latin: sine)
PROM	premature rupture of membrane or passive range of motion	SiS2	first and second heart sounds
PSH	past surgical history	SBE	subacute bacterial endocarditis
PSVT	paroxysmal supraventricular tachycardia	SBFT	small bowel follow-through
ψ	psychiatry	SBO	small bowel obstruction
pt	patient	SCDs	sequential compression devices
PT	prothrombin time; posterior tibial artery; physical therapy	SCM	sternocleidomastoid
PTA	prior to admission	sed rate	sedimentation rate (ESR)
PTCA	percutaneous transluminal coronary angioplasty	SEM	systolic ejection murmur
PTH	parathyroid hormone	SGA	small for gestational age
PTT	partial thromboplastin time	SH	social history
PUD	peptic ulcer disease	SICU	surgical intensive care unit
PVC	premature ventricular contraction	sig	label (Latin: signa)
PVD	peripheral vascular disease	SL	sublingual (e.g. for nitroglycerin)
PWH	Prentice Women's Hospital	SLE	systemic lupus erythematosus
q	every (Latin: quaque)	SMA	sequential multiple analysis (chemistry laboratory tests – usually sodium, potassium, chloride, bicarbonate, BUN, creatinine, and glucose)
qAM	every morning	SOB	shortness of breath
qh or q <sup>o</sup>	every hour	SOM	serous otitis media
qhs	at hour of sleep	sono	sonogram (ultrasound)
qD	daily (Latin: quaque die)	s/p	status post
qid	four times per day	SP	speech pathology
qMWF	every Monday, Wednesday, and Friday	sp gr	specific gravity
qod	every other day	SQ	subcutaneous
qPM	every evening	SROM	spontaneous rupture of membranes
qwk	every week	SSCP	substernal chest pain
R	right	STAT	immediately (Latin: statim)
RA	rheumatoid arthritis	svc	service
		SVT	supraventricular tachycardia
		T	temperature
		T3	triiodothyronine

<i>T<sub>3</sub>-RU</i>	<i>triiodothyronine resin uptake</i>	<i>UE</i>	<i>upper extremity (arm)</i>
<i>T<sub>4</sub></i>	<i>serum thyroxine</i>	<i>U/O</i>	<i>urine output</i>
<i>T+A</i>	<i>tonsillectomy and adenoidectomy</i>	<i>URI</i>	<i>upper respiratory infection</i>
<i>tab</i>	<i>tablet (Latin: tabella)</i>	<i>U/S</i>	<i>ultrasound</i>
<i>TAH-BSO</i>	<i>total abdominal hysterectomy with bilateral salpingo-oophorectomy</i>	<i>UTC</i>	<i>up to chair (referring to activity)</i>
<i>TB</i>	<i>tuberculosis (think isolation)</i>	<i>UTI</i>	<i>urinary tract infection</i>
<i>TBG</i>	<i>thyroxine binding globulin</i>	<i>VA</i>	<i>Veterans' Administration</i>
<i>TBSA</i>	<i>total body surface area</i>	<i>VATS</i>	<i>video-assisted thoracoscopic surgery</i>
<i>T+C</i>	<i>type and crossmatch</i>	<i>VDRL</i>	<i>serologic syphilis test</i>
<i>TCA</i>	<i>tricyclic antidepressant</i>	<i>VF</i>	<i>visual field</i>
<i>TED</i>	<i>thromboembolic device</i>	<i>VFVTC</i>	<i>visual field full to confrontation</i>
<i>TENS</i>	<i>transcutaneous electrical nerve stimulator</i>	<i>Vfib</i>	<i>ventricular fibrillation</i>
<i>TFT</i>	<i>thyroid function tests</i>	<i>VNA</i>	<i>Visiting Nurse Association</i>
<i>TIA</i>	<i>transient ischemic attack</i>	<i>V/Q</i>	<i>ventilation/perfusion</i>
<i>tid</i>	<i>three times a day (Latin: ter in die)</i>	<i>VRE</i>	<i>vancomycin-resistant enterococcus (think isolation)</i>
<i>TKO</i>	<i>to keep open (referring to IV rates)</i>	<i>VS</i>	<i>vital signs</i>
<i>TL</i>	<i>tubal ligation</i>	<i>VSD</i>	<i>ventricular septal defect</i>
<i>TLC</i>	<i>therapeutic lifestyle change</i>	<i>VSS</i>	<i>vital signs stable</i>
<i>TM</i>	<i>tympanic membrane</i>	<i>VT</i>	<i>ventricular tachycardia</i>
<i>TMJ</i>	<i>temporal mandibular joint</i>	<i>v-tach</i>	<i>ventricular tachycardia</i>
<i>TOA</i>	<i>tubal ovarian abscess</i>	<i>w+d</i>	<i>warm and dry (referring to skin)</i>
<i>TORCH</i>	<i>toxoplasmosis, other (syphilis), rubella, CMV, herpes</i>	<i>WBC</i>	<i>white blood count</i>
<i>tPA</i>	<i>tissue plasminogen activator</i>	<i>WDWN</i>	<i>well developed, well nourished</i>
<i>TPN</i>	<i>total parenteral nutrition</i>	<i>WNL</i>	<i>within normal limits</i>
<i>T+S</i>	<i>type and screen</i>	<i>w/c</i>	<i>wheelchair</i>
<i>TSH</i>	<i>thyroid stimulating hormone</i>	<i>w/e/e</i>	<i>warmth/erythema/edema (on extremities exam)</i>
<i>TTP</i>	<i>thrombotic thrombocytopenic purpura</i>	<i>w/u</i>	<i>work up</i>
<i>TUR</i>	<i>transurethral resection</i>	<i>XRT</i>	<i>radiation therapy</i>
<i>TURP</i>	<i>transurethral resection of the prostate</i>	<i>ZE</i>	<i>Zollinger-Ellison</i>
<i>Tx</i>	<i>treatment</i>		
<i>UA or U/A</i>	<i>urinalysis</i>		

## **Hospital Slang (we don't condone using some of these)**

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**Bounceback** – after a discharge, the patient is re-admitted back to your service

**Crumping/Crashing** – patient condition suddenly deteriorates. May also be a noun:  
“Did you hear about the crump on the 12th floor?”

**COW** – computer on wheels

**Curbside** – getting a specialist's opinion without a formal consult

**To “gas” someone** – to draw an ABG on them

**Getting burned** – any future problems with a patient that you should have been able to prevent

**Getting numbers** – writing down vitals, I/O's and labs for overnight patients, usually in the surgery rotation

**Laying some eyes** – checking up on your patient without spending much time talking to them

**Prerounding** – getting vital/labs/test results, then doing a brief overnight history and PE before “rounds”

**PIMPed** – Put In My Place

**Rescue page** – sending a pretend page to somebody to ‘rescue’ them out of an arduous task

**Run the list (RTL)** – going through the list of patients on your service, updating everyone on new information

**Scut work** – the work that no one wants to do; usually the work of the third year med student (just kidding; Abuse Policy Violated...)

**Sign out** – done at the end of the shift, passing pertinent information to the overnight team

**Snowed/Snowballed** – receiving too much narcotics or benzos, leaving the patient in an altered state

**Tuck'em in** – checking on your patients before you leave for the day

**Update the list** – filling in the pertinent info from the day, or adding new patients to the list; sometimes AdHoc in Powerchart, sometimes an excel file on the NMH server

**Zebbras** – rare and/or obscure diseases

## **NMH Helpful Phone Numbers**

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All numbers starting with a 5; outside line is 312-695-xxxx

All numbers starting with a 6; outside line is 312-926-xxxx

### **Hospital Operator**

Dial 5-1000 or 0 from an in-house phone.

### **General**

Cardiac arrest: 5-5555

LISTEN to dictations: 6-1199

EPIC helpdesk: 5-HELP

### **Patient Services**

Case Management: 6-2272

Social Work: 6-2060

PT: 3229

OT: 6-2526

### **Pharmacy**

Analgesic Dosing Service:  
5-7246 (pager), 6-3382 (office)

Anticoagulation Dosing Service:  
5-6548, 6-8670 (office)

### **Clinic**

NMFF GMC: 5-8630

GMC resident line: 5-8211

Physician Referral Svcs: 6-8400

Direct Admission PTC: 5-4600

### **Imaging Locations**

Echo Reading – Rm 8-216

XR Viewing – Rm 4-328

CT Body Viewing – Rm 4-546

MR Viewing – Rm 4-525

Nuclear Cardiology – 8-140

\*\* After 5PM, go to ED viewing to review films with radiologists

### **Radiology**

Protocol CT: 6-5314

CT Scheduling: 6-6366

IR: 6-5200

Feinberg MRI: 6-4333

Neuroradiology: 6-5245

Inpatient Rads: 6-5105

US (general): 6-7032

After hours Reading 1<sup>st</sup> Fl 6-7038

Cardiac Cath 8<sup>th</sup> Fl 6-5135

Cardiac Stress 8<sup>th</sup> Fl 6-7486

CT ordering/protocol 4<sup>th</sup> Fl 6-5314

CT Body Reading 4<sup>th</sup> Fl 6-5894

CT Head Reading 4<sup>th</sup> Fl

ECHO/Nuclear Cardio 8<sup>th</sup> Fl 6-2629

General Radiology 4<sup>th</sup> Fl 6-5150

Interventional Radiology 4<sup>th</sup> Fl 6-5200

MRI Protocol/Read Triage 4<sup>th</sup> Fl 6-4333

MR Fax 6-6452

Nuclear 6-2320

Ultrasound ordering 4<sup>th</sup> Fl 6-7032

Ultrasound Reading 4<sup>th</sup> Fl 6-2761

Vascular 8<sup>th</sup> Floor 6-2746

### **Labs**

Specimen Receiving 7<sup>th</sup> Fl 6-7970

ABG 8<sup>th</sup> Fl 6-5174

Autopsy Olson 6-3212

Blood Bank 7<sup>th</sup> Fl 6-2513

Chemistry 7<sup>th</sup> Fl 6-7536

Cytopathology 7<sup>th</sup> Fl 6-7008

Flow Cytometry 7<sup>th</sup> Fl 6-7360

Heme/Cell Count 7<sup>th</sup> Fl 6-3200

Hemostasis 7<sup>th</sup> Fl 6-2428

Micro 7<sup>th</sup> Fl 6-3202

Specimen receiving: 6-7970

Surgical Path: 6-3211

Pathology 7<sup>th</sup> Fl

Send Out 7<sup>th</sup> Fl 6-1200

**Cardiac**

Cardiac arrest: 5-5555  
 Emergency hotline: 5-5555  
 Cardiac Cath Lab: 6-5135  
 Cardiac Echo: 6-7483  
 Cardiac Stress Test: 6-8662  
 Cardiology pager: 5-7458  
 Echo reports: 6-7483  
 Echo scheduling: 6-7483  
 EKG pager: 6-6935

**Psych**

Chem Dep Inpt Consult: 6-8411  
 Psych Consult: 6-8411

**GI/Renal**

GI Lab: 6-2425  
 Dialysis (inpatient): 6-1696

**Miscellaneous**

Ethics consult: 5-ETHX (5-3849)  
 Nutrition (inpatient): 6-7437  
 RIC: 238-6000  
 13E Nursing Station: 6-2356  
 13W Nursing Station: 6-2381  
 14E Nursing Station: 6-2365  
 14W Nursing Station: 6-2358  
 15 E Nursing Station: 6-2362  
 15 W Nursing Station: 6-3099  
 MICU 9E: 6-5140  
 CCU 8E: 6-5172  
 OR desk: 6-5150/6  
 Pharmacy: 6-2552  
 ER 1<sup>st</sup> Fl: 6-1588  
 Dialysis 9<sup>th</sup> Fl: 6-1696

**Available Consults By Web Paging**

Allergy/Immunology  
 Anesthesia  
 Cardiology – Floor Consults  
 Cardiology ICU Consults – CCU Fellow  
 Cardiology – EP/Heart Failure/ Cath Separate  
 Cardiac Surgery  
 Dermatology  
 Endocrine  
 ENT  
 Ethics  
 General Surgery  
 GI – Gen or Interventional  
 Heme/Onc – Benign or Malignant  
 Heme/Onc – ER/Transfer/Triage  
 Hepatology  
 Hospitalist  
 Infectious Disease – Med/Neuro  
 ID – Surg/HemeOnc  
 ID – Transplant  
 IR MD on-call – (Emergencies)  
 Neurology  
 Neurosurgery  
 Orthopedic Surgery  
 Pain Service (Anesthesia - Interventional)  
 Palliative Care (End of Life and Analgesic C/S)  
 Plastic Surgery  
 Pulmonary  
 Pulmonary HTN  
 Rad Oncology (Emergencies only)  
 Nephrology – Acute, Chronic, Transplant  
 Rheumatology  
 Thoracic Surgery  
 Urology  
 Vascular Surgery

\*\*Handouts with CMH and VA phone numbers will be given to you at each specific hospital.

**Notes**

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