Medical Presentation and Assessment / Plan

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Video Communications and Distance Learning Division

Faculty

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Objectives

- To ensure we are giving the best medical presentation in order to receive the best management plan from the collaborating physician
- To review the documentation of the assessment and plan

Medical Presentation

- Presentations are the way in which we tell medical stories to one another
- When you present, ask yourself if you've described the story in an accurate way
- Will the listener be able to "see" the patient the same way that you do?

Medical Presentation

- It is the job of the presenter to share the pertinent facts of a patient's case with the collaborating physician to establish a clear diagnosis and treatment plan
- The presenter should strive to include details to support the proposed plan of care

Phone Presentation

Basic structure for phone consult

- **Age/Gravida/Para**
- **Chief Complaint**
- **Vitals/labs /LMP**
- **History of present illness; include relevant ROS**
- **Other active medical problems**

Phone Presentation

- **Medications**
- **Brief social history if relevant**
- **Physical examination (pertinent findings only)**
- **Assessment and plan**

Medial Presentation

- **Physical Examination**

a. **General description – be colorful, allow the listener to visualize the patient. "The speculum exam was done the cervix is smooth and pink and scant amount of blood noted in vaginal vault"**

b. **Mention the relevant positive findings and relevant negative findings.**

Phone Consult Template Compliments of Kristy Wilkinson, RN

- Patient Name: EHR Acct #: County:
- Age: DOB: LMP: G: P: FT: Pre: AB: L:
- BP: Initial: Consecutive BP (if elevated or previous visit BP):
- Weight: BMI:
- Allergies: HCG Results:
- Medications:
- Contraceptive Method:
- Significant Medical History:
- Significant Family History:
- Tobacco/Drug Use:
- Reason for Consult:
- **The nurse must follow up the phone conversation with an email to the collaborating physician within 72 hours. The email must include the following:
- All the above (Put the name of the County and EHR Acct in subject line)
- Include the Nurse's number in case need for contact
- cc the Nurse Practitioner
- -Scan finished email in patient EHR
- With consults sent: If you don't get a response in week from the MD on call, then send the MD on call that you sent the consult to a 1stirs notes email reminder.
- **Assign EHR provider note once completed to MD for review. Before assigning your note
- make a statement in the note: " as per phone consult, I am dispensing.."

Assessment

- **This is your impression of the patient based on the subjective and objective data. This is your opportunity to pull all of your subjective and objective findings together**
- **Concise summary of the patient and any major problems**

Written Assessment Example

- Age
- Gravida/Para
- Vital Signs (Pertinent)
- Labs (Pertinent)
- Pertinent Medical History
- Reason for visit today

Assessment Example

- 35 year old, G2 P2, negative pregnancy test with history of migraines with aura in for FPA established on Depo and desires to continue with current method with no specific complaints today.

Assessment Example

- 23 yo G1P1 with history of Hypertension X 2 years and controlled with PO meds, under care of PMD. In for FPA and desires to continue with Depo. No complaints today.

Assessment Example

- Vaginitis-Wet Prep- Trichomoniasis
- Anemia-history of iron deficiency-stable with hgb 12.0

PLAN

- What you are going to do about your impressions
- What interventions are done during the visit
- What medications have been prescribed or changed
- What is the follow-up

PLAN

- What further testing or investigations are required
- Who you consulted and what is your consult question
- Referrals to various specialties

Plan

- The plan can be documented in several different ways.
- One way of documenting the plan is in the narrative format.
- Another way the plan can be documented is by enumeration.

Plan Example

- 1-Contraceptive management-Continue with Depo per protocol X one year, Report SE, Calcium with Vit D daily
- 2-Migraines with aura-Report changes in migraines
- 3-BMI 39- Diet and weight management discussed

Plan Example

- History of Hypertension- Controlled-managed by PMD with PO meds
- History of Hypertension-uncontrolled B/P 150/100 and non-compliant with PO meds-OK for limited Depo and will reassess in 3 months at supply visit

Plan Example

- Consult: See HPI. Phone consult to Dr. Maxwell for contraception management and per our conversation will continue with Depo per protocol X one year
- Consult: See HPI. Will continue with Depo per protocol X one year. Do you concur with this management plan?

Plan Example

- Vaginitis-Trichomoniasis will treat per protocol with Flagyl 2 grams po stat, no alcohol, partner referral discussed and PDPT dispensed X one dose
- Anemia-history-Iron rich foods with Vit. C

Incomplete Assessment/Plan

- Assessment and Plan:
- A: GYN Exam appears WNL
- P: Pap due2020 2. BSE reviewed and encouraged 3. Depo IM/SQ x 1yr 4. Exercise encouraged 5. RTC 3m
- CONSULT: BMI 42 Age 33. May patient have Depo with monitoring and counseling?

Documentation Tips

- For the EHR message- In the subject line put 'Consult' and attach the patient

Documentation Tips

- The Nurse should always call the physician prior to entering the consult in EHR note. The nurse should 'cc' their supervisor and their NP(s). The NP should 'cc' their supervisors including their NP Senior.

Documentation Tips

- Please remember if you assign any lab or results for the review of the physician, you still need to append your original note and add your question or statement, so the MD knows why you are sending the lab or result.

Documentation Tips

- For example on the original physical exam note that you signed, append the note and state," Dr. Thomas please see thyroid results. I am referring this patient for evaluation to Dr. XYZ, Endocrinologist and will continue with Depo. Do you concur with my management plan?"

Documentation Tips

- For pap consult on a patient that has not been in EHR the consult will still be done through Lotus notes

Conclusion

- A consult is not a one-way handover; it's a way to ask for help that leads to shared responsibility and collaborative decision-making
- Consults are a requirement for all NPs
- The phone consult and written note should mirror
- Document your assessment and plan in a complete clear method


thank you
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