**Typing Templates to Copy into OSCAR EMR**

**Note** the title in Templates will not copy into the encounter note – If you want that to appear in your note you must also have it in the body of the template.

**Flu shot**

Indication:

No previous allergy to egg or rxn to flu shot

RBSEs reviewed

P: Flu shot given

**Allergy Shot**

vial

arm

dosage ml

Patient advised to remain in waiting room for 20 minutes and report any reactions.

**RX Refill**

The patient is here for medication refills.

There are no stated side effects.

Compliance is good.

**UTI**

S: urinary symptoms x day.

Urine C&S

dysuria, frequency, urgency, hematuria.

fever abdo or flank pain. NV.

bowel symptoms. vaginal sx.

O: ABDO - soft, nontender, no HSM, no masses. normal BS. No CVA tenderness. DRE deferred.

A: UTI

P: abx rx given

Conservative measures discussed

FU PRN

**URTI**

x day history of URTI symptoms.

Non-productive cough, cough, sore throat, low grade fever. No ear pain

no SOB

O: Looks well.

mild coryza. pharynx red, no nodes

chest clear, no rhonchi, no wheeze

A Viral URTI

P symptomatic treatment

analgesic, rest , fluids.

RTC if increase fever, SOB, more unwell.

**Cough**

Appears well, NAD

H&N - norm TMs, norm orophar, no cervical LA

Resp - breathing easily, clear to bases bilat, no adventitious sounds

**Mental Health**

Sleep:

Exercise:

Alcohol:

Drugs:

Stressors:

A: Mental Health Assessment:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

P: Self care

Regular exercise

Supportive counselling

**PAP**

Contraception

Currently using

LMP:

Cycles:

Last pap:

No migraines

Non-smoker

No DVT/PE history

No breast pathology, liver disease, DM1, or hypertension

Other meds:

Sexually active:

STI screening:

O: Breasts N no masses

cervix normal uterus AV/AF normal size

Adnexa Normal vulva normal

A: Well-routine screen

P: PAP, C&S

**Post Partum**

O: Breasts N. Vulvar laceration well healed. Speculum inserted easily. No Discharge. Cervix N Uterus N Adnexa N

A: N post partum mom

P: resume activities. PAP and C&S done

**Post partum Pap**

O:Breasts N. Mood and rapport N

Vulva well healed. Vag, cervix adnexa all N

P:PAP C&S

Birth control options discussed, will use condoms for now

**Menopause**

LMP:

Menopause symptoms:

Vasomotor:

Vaginal symptoms:

Concentration:

Mood:

Sleep:

Aches/pains:

Urinary (stress, urge, prolapse):

Activity/Diet:

Smoking:

EtOH:

Fam Hx (DM, HTN, heart dis, STROKE, Cancer, osteoporosis, coag dis):

Osteoporosis screen:

Ca, Vit D (1200mg/d and 1000IU/D):

BMD

Cardiac Hx (last fasting labs)

Mammogram Hx

PAP Hx

FOB

Exam: BP

Pelvic

A/P

http://www.menopauseandu.ca/

**CPX - Female**

Screening:

Mammo:

PAP:

BW:

Colon ca screening:

BMD:

Diet:

Exercise:

Alcohol:

Smoking:

Vaccines:

O/E:

H/N: Normal ENT, thyroid normal, fundi normal

CVS: Normal S1S2, no EHS.

Resp: Clear, GAEB, no crackles/wheezes.

Breasts: Normal, no masses.

Abdo: Benign, no HSM, no masses.

Skin: No concerning nevi.

PV: Normal external, normal cervix, normal bimanual

DRE: Normal

**CPX Male**

Concerns:

ROS:

No visual/hearing changes. No h/a. No syncope/vertigo.

No SOB/cough/change in exercise tolerance/CP

N appetite. No reflux. No abd pain. Reg BMs

N urination, no hematuria. No stress/urg incontinence

No Gu concerns.

No skin changes. No joint pains

Screening:

Exercise-

Diet, Ca/Vit D-

FBS/Lipids-

colon ca-

PSA-

Chart and FamHx updated.

Wt

Ht

BP

H&N - Perl. N fundi. N oral mucosa. N TM bilat. No cervical LN. thyroid N.

CVS - N S1S2, no murmurs.

RESP - clear

ABDO- soft, non-tender, no mass, no HSM. normal BS. DRE deferred

GU- testes normal, prostate normal

Skin N

Reflexes WNL

A: healthy Male

P:

CBC, Fglc, Cholesterol, GFR

**2 Month well baby visit and vaccinations**

Parental concerns:

Sleep:

Feeds: BF/formula

Development: meeting all developmental milestones as per Rourke

Safety: sleep safety discussed

Growth: growing well along curve

O/E: Alert, active, NAD

Appears well, active

Ant fontanelle soft

+red reflex bilat

+S1/S2, no EHS, no murmurs

GAEB, no crackles, no wheeze

neg Ortolani/Barlow

Good tone

Skin clear

N GU exam

Vaccinations: 2 month vaccines given, well tolerated

A/P: Well 2 month old baby growing well on curve and meeting all developmental milestones

1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min

2. F/U at 4 months or sooner PRN

**4 Month well baby visit and vaccinations**

Parental concerns:

Sleep:

Feeds: BF/formula

Development: meeting all developmental milestones as per Rourke

Safety: car seat discussed

Growth: growing well along curve

O/E: Alert, active, NAD

Appears well, active

Ant fontanelle soft

+red reflex bilat

+S1/S2, no EHS, no murmurs

GAEB, no crackles, no wheeze

neg Ortolani/Barlow

Good tone

Skin clear

N GU exam

Vaccinations: 4 month vaccines given, well tolerated

A/P: Well 4 month old baby growing well on curve and meeting all developmental milestones

1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min

2. F/U at 6 months or sooner PRN

**6 Month well baby visit and vaccinations**

Parental concerns:

Sleep:

Feeds: BF/formula, solid foods ??

Development: meeting all developmental milestones as per Rourke

Safety: teeth cleaning discussed

Growth: growing well along curve

O/E:

Appears well, active

Ant fontanelle soft

+red reflex bilat

+S1/S2, no EHS, no murmurs

GAEB, no crackles, no wheeze

neg Ortolani/Barlow

Good tone

Skin clear

N GU exam

Vaccinations: 6 month vaccines given, well tolerated

A/P: Well 6 month old baby growing well on curve and meeting all developmental milestones

1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min

2. F/U at 9 months optional, otherwise at 12 months and sooner PRN

**12 Month well baby visit and vaccinations**

Parental concerns:

Sleep:

Feeds: BF, cow's milk, cup>bottle

Diet:

Development: meeting all developmental milestones as per Rourke

Safety: home safety discussed

Growth: growing well along curve

O/E: Alert, active, NAD

Appears well, active

Ant fontanelle soft

+red reflex bilat, cover/uncover test N

+S1/S2, no EHS, no murmurs

GAEB, no crackles, no wheeze

Skin clear

N GU exam

Vaccinations: 12 month vaccines given, well tolerated

A/P: Well 12 month old baby growing well on curve and meeting all developmental milestones

1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min

2. F/U at 15 months optional, otherwise at 18 months or sooner PRN

**18 Month well baby visit and vaccinations**

Parental concerns:

Sleep:

Feeds:

Diet: no bottles

Development: meeting all developmental milestones as per Rourke

Teeth: dental care discussed

Growth: growing well along curve

O/E: Alert, active, NAD

Appears well, active

Ant fontanelle closed

+red reflex bilat

+S1/S2, no EHS, no murmurs

GAEB, no crackles, no wheeze

Skin clear

N GU exam

Vaccinations: 18 month vaccines given, well tolerated

A/P: Well 18 month old baby growing well on curve and meeting all developmental milestones

1. Vaccines: discussed s/e of vaccines, remain in clinic for 15 min

2. F/U at 2 years or sooner PRN

**Sick Child**

Unwell for x days

Fever, cough, wheeze, rhinorrhea, ear tugging, vomiting, diarrhea, rash

No difficulty breathing

Eating less, but drinking, voiding appropriately

Good energy level

Sick contacts

No recent travel

Vaccinations UTD

O-Interactive, alert

T , HR , RR

H&N: TMs normal bilaterally,oropharynx normal, no lymphadenopathy

Resp: GAEB, no adventitious sounds

Benign abdo

Derm: normal

A/P

URTI

Supportive care

Reviewed red flags for urgent follow up - persistent fever more than 5 days, resp distress, dehydration, lethargy, parental concern

**Viral Gastro**

fever last night felt warm, no temp taken

vomit last night

not complaining of abdo pain

tolerating food and fluids

good urine output

diarrhea

no blood in vomit or stool

no ill contact

no recent travel

no recent urti symptoms

O: looks well, no resp distress, no inc wob

T - 37.5, RR 20, HR 95

HEENT N, TMS N

skin N

abdo benign

HS normal

lungs clear, no wheeze, good a/e to bases

A: viral gastroenteritis

P:

Supportive care discussed

ensure hydration, minimum 6 wet diapers per 24hr

follow up asap if not tolerating po fluids and not urinating

Reviewed red flags for urgent follow up - dehydration, blood in stool or vomit, worsening sx

**Abd Exam**

O: BS normal

No distension

Soft, non-tender

No masses

No HSM

No CVA tenderness

DRE deferred

**Knee Exam**

Appearance- No deformity

Gait N.

Palpation- No effusion. no red, warmth

ROM - Normal. Normal strength 5/5. Neurovasc intact. Tender <joint line, bursa, popliteal>. <no> Mass.

Special tests - Thessaly <neg>. McMurray <neg>. Ligaments intact.

**Shoulder Exam**

Inspection - no deformity or atrophy, no winging

Palpation - tenderness AC joint/subacromial area/bicipital groove/pectoralis tendon

ROM - pain with <>. limited <>. Rotator cuff intact.

Special tests:

**Back Exam**

Subjective:

Perianal numbness

Other numbness/tingling

Incontinence

IVDU

Constitutional Sx

Night pain

Hx ca/immunosuppression

Recent trauma

Objective:

Normal gait, heel, toe

Normal back ROM lat/ant/post

No skin chagnes/edema/ecchymosis

Neg SLR and neg tripod test

Normal neurovascular exam feet, normal strength / sensation legs

Normal knee/ankle reflexes.

Assessment:

Mechanical low back pain, no red flags.

Plan:

Conservative strategies discussed: stretching, heat, core strengthening/yoga, activation

PT and Massage prn

RTC if red flags occur (reviewed with pt) or sx not alleviated in 6/52 or worsen/change.

**Neuro Exam**

Neuro: Normal gait, heel, toe.

Normal romberg, no pronator drift.

Normal CN 2-12 incl PERLA, EOM, pharyngeal mvt.

Normal strength / sensation x 4 extrems.

Normal cerebellar incl rep mvts R&L.

No clonus/rigidity.

**Concussion**

O:

ENT: normal Tms

neg battle sign

equal and reactive pupillary reflex

normal cranial nerve exam

normal motor/sensory exam of the extremities

2+ bilateral reflexes

A: concussion

P:

more than 20 mins counseling re concussion

will need to take it easy

went over red flags and when to seek medical attention rightaway

gave note to be off work for a week and rest

follow up in one week

advi/tylenol prn for headaches.

**IUD Counselling**

1. Reviewed absolute contraindications to IUD, including:

Pregnancy or possible pregnancy

Current pelvic inflammatory disease (PID), cervicitis, or chlamydial or gonococcal genital infection

Known allergy to any constituent of the device

Immunosuppression or conditions leading to increased susceptibility to infection, including HIV/AIDS, leukemia, IV drug abuse.

Undiagnosed irregular genital tract bleeding

Wilson's disease (for copper IUD)

Acute liver disease, jaundice or liver carcinoma (for Mirena IUD)

Breast carcinoma (for Mirena IUD)

2. Reviewed relative contraindications to the use of an IUD, including:

Valvular heart disease

Past history of PID

Presence of a prosthesis, which is potentially at risk from any blood-borne bacteremia (or bacterial contamination)

Abnormalities of the uterus resulting in a distorted cavity or a cavity that sounds to less than 6.0cm

History of ectopic pregnancy.

Cervical stenosis.

Uterine fibroids or congenital uterine anomaly

Severe primary dysmenorrhoea or menorrhagia (for copper IUD)

3. Reviewed complications associated with IUD insertion, including:

Uterine perforation: The perforation rates for devices available in Canada are approximately 0.6 incidents per 1,000 insertions. Perforation is more likely to occur when the device is inserted post-partum.

PID: In the Women's Health Study, the relative risk of PID was 3.8 in the first month after insertion, reaching baseline risk after four months and remaining unchanged thereafter. Patient is aware that cultures will be taken for gonorrhea and Chlamydia on the day of IUD insertion.

Expulsion: Expulsion rate is highest in the first year and especially if the IUD is inserted immediately postpartum. Up to 10% of women will have expulsion of their IUD.

4. Reviewed Mirena IUD vs copper T-IUD vs

IUD chosen:

Prescription written

Appointment booked during menses (if possible)

Patient advised to take ibuprofen 400 mg approx. 1 hour prior to IUD appointment

**IUD Insertion**

\_\_ IUD insertion

LMP:

Intercourse in last 2 weeks:

Current contraception:

Any vaginal symptoms (discharge, pruritis):

Last pap:

STI risk:

Gono/chlam:

Preg test:

Consent form signed. No questions.

48hrs: nothing in vagina

Back up for 7d

Patient premedicated with:

Procedure reviewed, verbal consent obtained:

On exam: Bimanual exam revealed anteverted/RV/midposition uterus.

A speculum was placed in the vagina.

Sterile precautions

Cervix disinfected x 3

The cervix was grasped with a tenaculum. The uterus was sounded to \_\_\_\_cm.

Os finders were not/ were needed.

The IUD was inserted without complications.

The strings were cut at 3 cm.

The instruments were removed from the patient's vagina, with good hemostasis.

Overall insertion was easy / somewhat difficult/ difficult

IUD lot:

A/P

IUD insertion.

F/U in 4-6wks; then yearly; replace in 5years.

F/U sooner if abdominal pain, fever, bleeding

RTC/ED if fever, increasing and persistent abdominal pain or vaginal bleeding, foul smelling discharge.

**Driving elderly**

1. Have you noticed any change in your driving

2. Do others honk at you or show signs or irritation

3. Have you lost any confidence in your overall driving

4. Have your ever become lost

5. Have you ever forgotten where you were going 6. Do you think that at present you are an unsafe driver

7. have you had any accidents the last year

8. Any minor fender benders in parking lots

9. Have you received any traffic citations

10. Have others criticized your driving or refused to drive with you

11. Do you need a co-pilot with you?

**Functional Assessment / CPX**

START TIME:

END TIME:

Patient was asked to attend clinic for a CPx because of decreased functional ability, related to medical conditions, including:

Recent Hospitalization: n/a

Family Concerns: n/a

CFS Frailty Score: n/a

Cognition: n/a

Mood:

Falls/Ambulation/Gait: n/a

Bowel/Bladder dysfunction: n/a

Family Supports: n/a

Abnormal blood work: n/a

Hypertension: n/a

Diabetes: n/a

Other Cardiovascular risk factors: A. Fib

Other:

HISTORY gathered at this exam:

MOOD/VALUES:

"What is your understanding of your current physical health?"

"How would you describe your mental health or your mood?"

"What gets you up in the morning?"

"What brings you joy?"

"What could you not imagine living without?"

"Who have you shared this information with? and/or "Who would you like to know about it?"

MEMORY:

"has anyone complained about your memory?"

NO/ YES, explanation –

"Are you worried about your memory?"

NO/ YES, explanation -

MMSE/MOCA

Score/ not done because:

PHYSICAL FUNCTION

Frailty Score?

Instrumental Activities of Daily Living:

Housework: n/a

Preparing meals: n/a

Taking medications as prescribed: n/a

Managing money: n/a

Shopping for groceries or clothing: n/a

Use of telephone or other form of communication: n/a

Transportation within the community: n/a

Activities of Daily Living:

Moving around own house safely: n/a

Bathing and showering : n/a

Dressing: n/a

Self-feeding: n/a

Personal hygiene and grooming: n/a

Toileting & personal hygiene: n/a

Physical Activity Outside Home:

describe exercise regime or regular movement in community, e.g. walking the dog, getting groceries

SOCIAL SUPPORTS:

robust / limited / negligible / absent

FINANCE ISSUES:

"Do you ever have have issues with making ends meet in a month?"

No/ Yes, any details?

ADVANCE PLANNING:

In addition to "preferences/values" info above:

Do you know who you would want to make medical decisions for you if you could not yourself?"

Name: // Relationship: // Are they aware of your choice?

Do you have the following legal documents?

POA: no/yes/not sure

Will: no/yes/ not sure

Rep Agreement: no/yes/ not sure

Vaccination Status:

Flu: n/a

TD: n/a

Pneumovax: n/a

Others: n/a

PHYSICAL EXAM

MSK: grossly normal

Gait: grossly normal

Neuro: grossly normal

Tremour: absent

Memory: MMSE/MOCA

Vision: grossly normal

Hearing: grossly normal

Vital Signs (BP, wt, HR)

(enter in Oscar form)

Other PE: n/a

ASSESSMENT

Active Issues/Diagnosis

PLAN

Medication List, updated in "OTHER MEDS" section

Referrals

Other Advice