

Sign Out Sheet: General Format

(please use same method as interns/residents at your site; this will be electronic at UNC)

Data to include:

Patient name, Age, Location, Medical Record Number

Brief summary of pertinent problems

Anticipated Problems and recommendations

Needs for follow up or things to be checked during the night

Code Status

Important Family Contact

Heads up: is the patient getting sick? Is the patient nearing discharge?

Allergies/reactions to prior medications/treatments

Need for IV, cultures

Discharge Summary: General Format

Patient Name:

Medical Record Number:

Admission Date:

Discharge Date:

Attending Physician:

Dictated by:

Primary Care Physician:

Referring Physician:

Consulting Physician(s):

Condition on Discharge:

Final Diagnosis: *(list primary diagnosis FIRST)*

Procedures: *(list dates, complications)*

History of Present Illness *(can refer to dictated/written HPI)*

Laboratory/Data *(be BRIEF, just the most PERTINENT results that need to be followed)*

Hospital Course *(by PROBLEM LIST.... NOT BY DATE ---)*

Discharge Medications *(MOST IMPORTANT – LIST MEDS THAT ARE DIFFERENT FROM
ADMISSION MEDICATIONS)*

Discharge Instructions *(diet, activity, discharged to home/nursing facility, etc)*

Follow up Appointments

Code Status

Dictated by...

AI Log Card

Name:

Diagnostic Decision Making:

- Formed a differential diagnosis
- Interpreted tests using predictive values, LR

Case Presentation

- Recorded complete H/P
- Dictated H/P
- Recorded follow up notes with daily plan
- Presented new patient
- Did discharge summary
- Dictated discharge summary

History taking and Physical exam

- Did independent new patient hx/PE

Communication

- Updated families and patients
- Called consultants
- Called primary care providers
- Did sign out
- Discussed advanced directives
- Got informed consent
- Assessed capacity
- Discussed bad news

Organization

- Developed a daily to do list
- Developed organization system

Test interpretation

- Interpreted cbc, chem. Panel, cxr, ekg, u/a, fluid
- Communicated test results in lay terms to patient/family

Therapeutic decision making

- Involved patients/families in decision making
- Assessed risks/benefits and costs in treatment decisions

Self directed learning

- Formed clinical questions based upon patient issues
- Identified resources at individual site

CQI:

- Had opportunity to critically evaluate individual care: PBLI
- Identified system wide issues that impact care: SBP

Professionalism: Had significant responsibility for patient care

Internal Medicine:

P=personally saw, T=team, R=read/lecture

- Abdominal pain
- Acute renal failure
- Arrythmia
- Chest pain
- Fever
- Acute GI bleed
- Hypertension/HTN urgency
- Electrolyte disorder
- Pain management
- Pulmonary edema
- Respiratory distress
- Seizure
- Nausea/vomiting
- Dehydration
- Hypotension
- Mental status changes
- Glycemic control
- Shock
- COPD
- Pneumonia
- Anemia
- DVT/PE prophylaxis
- Stroke
- Advanced directives/end of life care
- Delirium and agitation
- UTI/urosepsis
- Falls

Mid Rotation Evaluation done? Yes/No

Comments/Issues: