**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

Notes:

This is a @AGE@ @SEX@ [-\*\*\*-]

Historian: Patient

Pain Location: [-Diffuse-]

Mechanism: [-Direct blow-]

Recent Head Injury [-No-]

Complicating Factors: None

Occurred: [-\*\*\*-] prior to arrival. Patient currently has symptoms. Symptoms are [-Worse, Persistent-]

Severity: Maximum: [-Severe-], Current: [-Moderate-]

Quality: [-Achy, Pressure-]

Associated with: [-Injury as described, Headache, No Nausea or Vomiting-]

Exacerbated by: [-Nothing-]

Relieved by: [-Nothing-]

Intracranial Bleeding risks: [-Age, Blood thinners, Mechanism, Alcohol-]

**HPI:**

PMH: @HXPMH@

@PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: @SOCX@

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: Patient in a good state of baseline health.

EYES: [-No vision changes-]

ENT: [-No Epistaxis or facial pain-]

CARDIOCVASCULAR: No Chest Pain

RESPIRATORY: No SOB

GI: [-No nausea, no vomiting-]

GU: No incontinence, No retention.

MUSCULOSKELETAL: [-No arthralgia-]

SKIN: [-No Laceration-]

HEME: No easy bleeding

PSYCH: No anxiety

NEUROLOGIC: [-No headaches-]

**PHYSICAL EXAM:**

@VS@

GENERAL: Vital signs reviewed, well appearing, Patient appears [-comfortable-], Alert and lucid

HEAD: [-Normocephalic, atraumatic.-]

EYES: Normal to inspection

ENT: Normal ENT inspection. OP Moist. [-No pain on palpation of the bony prominences of the face-]

NECK: Supple, normal inspection. [-Pain on palpation \*\*\*.-] No pain on palpation of the spine. Normal ROM

CARD: Regular rate and rhythm, heart sounds normal

RESP: No respiratory distress, breath sounds normal

BACK: [-Normal Inspection-]

MUSC: [-Normal ROM-]

SKIN: [-Color normal-]

NEURO: Patient is alert, lucid and oriented times 3. EOMI, facial and jaw muscle strength intact, hearing grossly intact, speech is without dysarthria, and shoulder shrug is strong. No focal motor, sensory or cerebellar deficits are noted. Speech and gait are normal. Patient has 5/5 muscle strength in the upper and lower extremities. Sensory exam is intact to lite touch on arms and legs bilaterally. [-Cerebellar exam is intact on "finger to nose" ,"heel shin" and gait is stable.-] [-Patient has no pronator drift. Romberg signs are absent.-]

PSYCH: Mood/ affect normal.

**MEDICAL DECISION MAKING**:

Differential diagnoses: [-Scalp, Facial-] Contusion. [-Evidence for Mild-] Concussion. In the setting of no loss of consciousness, Glascow coma scale of 15, and normal neurologic exam, I did not feel a CT scan of the head was needed. The patient is instructed to return with changes in behavior, decreased level of consciousness, or increased pain. The patient may also return with poorly controlled nausea, vomiting, or Dizziness.

**RESULTS:**

Labs: @RESULTRCNT(48h)@

Imaging: @EDORD@

**URGENT CARE COURSE**:

Medications, medical history, allergies, surgical history, hospitalizations, family history, social history, ROS and vitals entered by medical assistant and reviewed by myself.

[-I discussed with the patient the diagnosis, treatment plan, indications for return to the urgent care or emergency department, and for expected follow-up. The patient verbalized an understanding. The patient is asked if there are any questions or concerns. We discuss the case, until all issues are addressed to the patient's satisfaction.-]

Follow up plan per the discharge instructions urgent care or emergency department in the next 12-24hrs if increasing symptoms, significant changes, pain, or concerns.

Patient's PCP is @PCP@.

**DIAGNOSIS:**

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*