**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

Notes:

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

Historian: [-Patient-]

PRECIPITATING FACTORS: [-\*\*\* stress, Drug abuse, Alcohol abuse, Change in medication-]

Occurred: [-\*\*\*-] prior to arrival. Time course: [-Gradual-]

Quality: [-Dysphoric, Somatic complaints-]

Associated with: [-Alcohol use, Dysphoria, School/work problems, Self injury-]

Symptoms are: [-Worse-], Currently Symptomatic [-Persistent-].

Severity: Maximum: [-Severe-]

Risk Factors: [-Previous suicide attempts, Alcohol abuse, Substance abuse, Access to firearm-]

**HPI:**

PMH: @HXPMH@

PSurg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social:

**SOCIAL:**

[-@SOCX@-]

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: No fever

CARDIOCVASCULAR: No Chest Pain.

RESPIRATORY: No Cough, [-No SOB-]

GI: No vomiting

GU: No urine changes

MUSCULAOSKELETAL: No arthralgia

SKIN: No rash

HEME: No easy bleeding

PSYCH: [-As described-]

NEUROLOGIC: No headaches

**PHYSICAL EXAM:**

@VS@

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

HEAD: Atraumatic

EYES: Normal to inspection

ENT: OP moist, Nares patent

NECK: Normal inspection, No JVD. No thyromegaly.  Normal Range of Motion.

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: Awake, alert, and lucid. No motor deficits

PSYCH: [-mood/affect normal, Normal insight and concentration-].

**MEDICAL DECISION MAKING** :

The patient’s history reveals significant [-anxiety, depression-]. The patient denies stimulant or substance abuse which could cause anxiety. No rapid cycling between mania and depression. No signs or symptoms suggestive of psychosis. With no suicidal or homicidal ideation, or hallucinations, this patient is safe for outpatient management. Will start with a primary care provider, consideration of thyroid testing, electrolyte evaluations, and a baseline CBC may be appropriate. The patient understands that psychiatric evaluation may also be helpful.

[-Not-] Male

[-Not-] Aged16-24; 65+

[-No-] Increased depression

[-No-] Previous attempt

[-No-] Ethanol abuse

[-Not-] Psychotic

[-Not-] Lacking social support

[-No-] Organized Plan

[-No-] Risk due to lack of significant other

[-No-] Sickness

[-No-] Request for admission

[-No-] Access to firearms

0-2 = low risk

3-4= Mild risk

5-6= Significant risk

7-10 =very high risk

**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.

@MEDADMIN@

**DIAGNOSIS:**

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*