

Learner Instructions

Patient's Name: Leah Patterson

Age: 35 year-old female

Setting: Emergency Department

Primary vs Sign-out patient: sign-out

Initial Chief Complaint on arrival to the ED:

Back pain

Patient Information Presented at Sign-Out:

35-year-old female with no significant PMHx presenting for evaluation of 2-3 days of atraumatic, constant, aching, moderate lower back pain that began without trigger. She has had no fevers, weakness, urinary or bowel problems, or history of intravenous drug use.

Her vital signs and physical exam over the course of the evaluation are as follows:

Vital signs:

Initial Triage Vitals: HR 70 BP 120/70 mmHg RR 18 Sat 100% RA T 98.8 F (oral)

Observation Admit Vitals HR 72 BP 118/68 mmHg RR 16 Sat 100% RA T 98.6 F (oral)

Current Vitals: HR 68 BP 116/68 mmHg RR 16 Sat 100% RA T 98.6 F (oral)

Exam (abnormal findings bolded):

General: Well-developed, well-nourished female resting comfortably in no acute distress.

HEENT: Normocephalic, atraumatic, no conjunctival injection or pallor, sclera non-icteric, PERRLA, nasal mucosa pink, moist mucous membranes, oropharynx without evidence of erythema, tonsillar enlargement or exudates.

Neck: No cervical lymphadenopathy, no thyromegaly, or mass.

Cardiovascular: No jugular venous distension, regular rhythm, normal S1 and S2, no murmurs, rubs, or gallops. Radial and DP pulses 2+ bilaterally. No edema.

Pulmonary: Thorax is symmetric without increase in anteroposterior diameter. Lungs clear to auscultation, no rales, wheezes, rhonchi, or rubs.

Abdomen: Flat, no hepatosplenomegaly, soft, non-tender to palpation in all quadrants.

Musculoskeletal: full range of motion in all joints, no evidence of swelling or deformity. **Mild bilateral lower paraspinous muscle tenderness.**

Neuro: Alert and oriented x 3. CNs II – XII symmetric, sensation to light touch grossly intact, 5/5 strength in all extremities. Gait steady without evidence of ataxia.

Psych: Affect full range. Speech is fluent, no SI or HI.

She did not undergo any testing or imaging.

She received tylenol and ibuprofen, and continues to have mild pain.

The sign-out plan from the initial team was to discharge the patient after she received her medications.

Your Task:

1. Reassess and the update
2. Discharge the patient from the emergency department
3. This simulation is focused on communication. This case is not an assessment of your medical decision making. You do not need to order additional emergency department tests or admit this patient.
* When you are finished, you can tell her that the nurse will be in shortly to give her paperwork and take out her IV