Learner Instructions

Patient's Name: Sedgwick Clark
Age: 35 year-old male
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 male with no significant PMHx presenting for evaluation of 2-3 days of atraumatic, constant, aching, moderate lower back pain that began without trigger. He has had no fevers, weakness, urinary or bowel problems, or history of intravenous drug use.

His 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 male 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 al 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.

He did not undergo any testing or imaging.

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

The sign-out plan from the initial team was to discharge the patient after he received his 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 him that the nurse will be in shortly to give him his paperwork and take out his IV