Learner Instructions

Patient's Name: Michelle Watson
Age: 45 year-old female
Setting: Emergency Department
Primary vs. Sign-Out Patient: Primary

Initial Chief Complaint on arrival to the ED:
Shortness of Breath

Patient Information from initial H&P:

45 year old female with history of HTN and tobacco use, who presents with shortness of breath, which she describes as a sensation of not being able to take a full breath, that started this morning without trigger. She has no fever, cough, wheezing, hemoptysis, pleuritic pain, calf swelling, chest pain, or exertional symptoms.

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

Vital signs:

Initial Triage Vitals:	HR 86 BP 134/76 mmHg RR 18 Sat 100% RA T 98.6 F (oral)
Current Vitals:	HR 72 BP 128/70 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 al joints, no evidence of swelling or deformity.
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.

The results of her diagnostic work-up are indicated here:

CBC			**CHEMISTRY**		
WBC	7.4	(3.5-10.5)	SODIUM	139	(135-148)
RBC	5.01	(4.2-5.8)	POTASSIUM	4.1	(3.5-5)
HEMOGLOBIN	14.2	(13.0-17.5)	CHLORIDE	107	(95-108)
HCT	42.6	(38.0-50)	BICARB	24	(24-32)
MCV	89	(80-99)	BUN	15	(0-20)
MCH	30	(27-34)	CREATININE	0.7	(0-1.7)
MCHC	34.2	(33-35.5)	GLUCOSE	98	(65-110)
RDW	14.8	(11-15)	CALCIUM	9.2	(8.5-10.5)
PLATELET	187	(140-390)			
			Troponin	0.00	(<0.05)
			BNP	10.0	(<100)
			DDIMER	110	(<500)
			Respiratory Viral Panel		NEGATIVE

EKG: Normal Sinus Rhythm, Rate 83, normal axis, normal intervals, no ST elevation or depressions.

CXR: No acute cardiopulmonary process.

Your initial plan was to discharge the patient if her workup was normal.

The patient's shortness of breath is still present, and she is awaiting the results of testing done in the ED.

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.
4. * When you are finished, you can tell her that the nurse will be in shortly to give her paperwork and take out her IV