

Learner Instructions

Patient's Name: Gianna Lewis

Age: 35 year-old female

Setting: Emergency Department

Primary vs Sign-Out: primary

Initial Chief Complaint on arrival to the ED: Dizziness

Patient Information from HPI

35-year-old female with no significant PMHx presenting for evaluation of dizziness, which she describes as room spinning sensation that occurs when she turns her head, lasts minutes, self resolves, and does not occur at rest. She has no associated headache, neck pain, vision changes, numbness, weakness, chest pain, or difficulty breathing. She has had no trauma or neck manipulation.

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.

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. Normal cerebellar exam.

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

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)			

ECG: NORMAL SINUS RYHTHM. NORMAL ECG

The patient feels well and has not had recurrence of her symptoms.

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