VA Templates, 2014-2015

Instructions and Disclaimer:

Disclaimer: These are templates to assist you in completing VA required documentation and to facilitate patient care. These templates have auto-populated/pre-recorded items from CPRS. If an item is auto-populated or pre-recorded, it is still your responsibility to ensure the information is correct, up-to-date, and reflects the current situation.

Instructions: You can create templates in CPRS that can really speed things up. To create a new template Go to Note --> click drop down box for template --> r. click on "My Templates" --> click create new template. You can change the name to whatever template name you want.

This will create a white text box which you can put your template in. Copy/paste any of the following templates into the white box.

To insert the new template into CPRS; Go to note → new note → double click the template under "My Templates"

Table of Contents: (use Ctrl + F to quickly locate desired template, e.g. Crtl F "MICU H&P #1" to locate a template of MICU History and Physical

VA CCU

CCU H&P #1

HISTORY AND PHYSICAL
Chief Complaint:
History of Present Illness:
|PATIENT FIRST_LAST NAME| is a |PATIENT AGE| year old |PATIENT SEX| with a past medical history of [...] who presented
Past Medical History:

Past Surgical History:

Family History:
Maternal:
Paternal:
Siblings:
Social History:
Alcohol:
Tobacco:
Other drugs:
Lives with:
Occupation:
Children:
Allergies:
|ALLERGIES/ADR|
Review of Symptoms:
- General: No weight change, weakness, fevers, chills or night sweats.
- HEENT: No headaches, acute vision changes, congestion, or drainage.
- Mouth/Throat: No dysphagia or odynophagia. No bleeding of gums.
- Cardiac: No chest pain, palpitations, dyspnea on exertion, orthopnea, paroxsysmal nocturnal dysnea, or peripheral edema.
- Respiratory: No shortness of breath, wheezing, coughing or sputum production.
- GI: No change in frequency and consistency of bowel movements. No nausea, vomiting, diarrhea, constipation, hematochezia, melena, or jaundice. No change in appetite.
- Urinary: No frequency, dysuria, or hematuria.
- Musculoskeletal: No muscle weakness, pain, joint swelling and redness, arthritis, or gout.
- Neurologic: No loss of sensory, motor, or cognitive processes. No tingling, paralysis, or seizures.
- Endocrine: No diabetes, heat/cold intolerance, polyuria.
- Psychiatric: No changes in mood or feelings of depression.

Objective:
Vitals:
- Temp: |TEMPERATURE|
- Pulse: |PULSE|
- BP: |BLOOD PRESSURE|
- RR: |RESPIRATION|
- POx: |PULSE OXIMETRY|
- BMI: |BMI|

General:
HEENT: EOMI, PERRLA, MMM, oropharynx without erytherma or exudate
Neck: Supple, no thyromegaly, no cervical LAD. No JVD noted.
Cardiovascular: Normal rate, regular rhythm. Normal S1 and S2. No M/R/G.
Chest: CTA (B)
Back: No spinal tenderness. No CVAT.
Abdomen: Soft, non-tender, nondistended. Normal bowel sounds. No organomegaly on exam.
Extremities:Warm and well perfused with 2+ pulses in all extremities.
Skin: No rashes or lesions noted.
Psych: Appropriate mood and affect.
Labs:
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|
|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|

|LR PO4|
|LR WBC|
|LR HGB|
|LR HCT|
|LR PLTS|
|LR TRIGLYCERIDE|
|LR LDL CHOLESTEROL|
|LR HDL|
Imaging:

Last Echo:

EKG:

Meds:
|ALL ACTIVE MEDICATIONS|
Assessment:
|PATIENT FIRST_LAST NAME| is a |PATIENT AGE| year old |PATIENT SEX|
Plan:
- NSTEMI/ACS: TIMI ***; GRACE ***. CRUSADE score ***.
- ASA 325 then 81mg qd
- Atorvastatin 80mg qd
- UTox.
- Beta-blocker: ***
- Start Heparin gtt // LMWH ***
- Plavix load *** then 75mg qd.
- Nitrates: ***
- Plan for LHC ***.
- New Onset Heart Failure: NYHA ***; Profile *** (NTproBNP: ***) on admission.
- Acute on Chronic Systolic Heart Failure Exacerbation: NYHA ***; Profile *** (NTproBNP: ***) on admission. LVEF ***.
- Acute on Chronic Diastolic Heart Failure Exacerbation: NYHA ***; Profile *** (NTproBNP: ***) on admission. Grade *** diastolic dysfunction.
- Acute on Chronic Mixed Systolic and Diastolic Heart Failure Exacerbation: NYHA ***; Profile *** (NTproBNP: ***) on admission. LVEF ***; Grade *** diastolic dysfunction.
- Etiology:
- Beta-Blocker:
- Diuretic regimen:
- Afterload reduction:
- 2g Na. Daily weights. Strict I/O. BID lytes.
- TTE. TSH/FT4. UTox. ***LHC
- Tobacco Cessation:
- Patient is not a current smoker.
- Patient is a current smoker. Discussed health risks of smoking with the patient who now requests assistance with tobacco cessastion. Patient is interested in nicotine patches which we will prescribe at time of discharge.
- Patient is a current smoker. Discussed health risks of smoking with the patient who now requests assistance with tobacco cessastion. Patient is interested in bupropion which we will prescribe at time of discharge.
- Patient is a current smoker. Discussed health risks of smoking, especially related to cardiovascular disease, but patient is not interested in smoking cessation at this time.
- Flu vaccine:
- Patient has already recieved a flu vaccine this season.
- Patient has not recieved a flu vaccine this season and is amenable to receiving one at time of discharge.
- Patient has not recieved a flu vaccine this season but does not want one despite discussion of health risks.
- Pneumococcal vaccine:
- Patient is up to date on his pneucoccal vaccination.
- Patient needs a pneumococcal vaccine which will be given at time of discharge.
- Patient does not want a pneumococcal vaccine despite discussion of health risks.
- Nausea:
- Pain:
- Fluids:
- Diet:
- DVT PPx:
- GI PPx:
FULL CODE

CCU H&P#2

CC:
HPI:

REVIEW OF SYSTEMS:
General: No fatigue, fever, chills, night sweats, change in weight, change in appetite.
HEENT: No headaches, vision changes, change in hearing, or dysphagia.
Respiratory: No cough or shortness of breath.
Cardiovascular: No chest pain, DOE, palpitations, PND, orthopnea, BLE edema, claudication, syncope or
pre-syncope.
Gastrointestinal: No abdominal pain, nausea, vomiting, diarrhea, constipation, hematochezia, melena,
or hematemesis.
Genitourinary: No burning on urination, increased frequency, urgency, nocturia, incomplete emptying,
weak stream, or hematuria.
Musculoskeletal: No joint stiffness, swelling or pain. No muscle pain or weakness.
Neurologic: No numbness, tingling, weakness, loss of speech, dizziness, or seizure activity.
Hematologic: No easy bruising/bleeding.
Psychiatric: No depression, anxiety, or memory loss.
Skin: No rashes, itching, or change in skin/hair/nail appearances
PAST MEDICAL HISTORY:
PAST CARDIAC HISTORY:
Last Echo:
Last Cath:
Last Stress Test:
PAST SURGICAL HISTORY:
SOCIAL HISTORY:
FAMILY HISTORY:
Allergies:
|ALLERGIES/ADR|
Home Medications:
|OUTPATIENT MEDS|
Current Medications:
|ACTIVE MEDICATIONS|
VITALS:
T: |TEMPERATURE|
HR: |PULSE|
BP: |BLOOD PRESSURE|
RR: |RESPIRATION|
SaO2: |PULSE OXIMETRY|
WEIGHT: |PATIENT WEIGHT|
BMI: |BMI|
EXAM:
Gen: NAD, AOX3
Eyes: PERRL, EOMI, No conjunctival pallor, non-icteric scleral
ENT: Normal O/P, no erythema, no exudate, no ulcers or petechiae
Neck: supple, no LAD or thyromegaly
Chest: CTAB no wheezing or crackles, normal respiratory effort, no clubbing or cyanosis
Heart: normal JVP, RRR, no murmurs, no edema, extremities warm
Abdomen: soft, NTND, no masses or organomegaly, active BS
Skin: warm and dry
Neuro: CN2-12 intact, sensation to light touch intact and equal bilat, motor strength 5/5 throughout, reflexes 2+, normal gait

Labs reviewed:
|LR WBC|
|LR HGB|
|LR HCT|
|LR PLTS|
|LR IRON|
|LR %IRON SATURATION|
|FERRITIN OBJ|
|B12 OBJ|

Folate =
|LR TSH|
|LR OCCULT BLOOD 1|
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|
|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|
|LR PO4|
|LR PROTEIN,TOTAL|
|LR ALBUMIN|
|LR BILIRUBIN,TOTAL|
|LR AST|
|LR ALT|
|LR ALK PHOS|
|LR GGT|
|LR INR|
|LR CHOLESTEROL|
|LR TRIGLYCERIDE|
|LR LDL CHOLESTEROL|
|LR HDL|
|LR A1C|
|LR VIT D, 25-OH TOTAL|

Micro:
Abx:
Imaging reviewed:
CXR-
EKG-
Assessment/Plan:
***

Tobacco use:
- counseled on cessation
- offered treatment
Diet:
DVT ppx:
GI ppx:
Code Status:
Emergency Contact:
Dispo:
I have reviewed the veteran's outpatient med list with veteran and reconciled all inpatient medications as appropriate.

CCU PN #1

I discussed the patient's assessment and plan of care with the supervising practitioner of record for this episode of care. The supervising practitioner is Dr. *** who agrees with my assessment and plan.
Subjective/Overnight events:

Objective:
Allergies:
|ALLERGIES/ADR|
Medications:
|ACTIVE MEDICATIONS|
VITALS:
T: |TEMPERATURE|
HR: |PULSE|
BP: |BLOOD PRESSURE|
RR: |RESPIRATION|
SaO2: |PULSE OXIMETRY|
Intake:
Output:

Net:
Net since admission:
Admission Weight:
Today's Weight: |PATIENT WEIGHT|
PHYSICAL EXAM:
GEN: A/Ox 3, NAD
HEENT: PERRL, EOMI, no oral ulcers
Neck: supple, no LAD
Chest: CTAB, normal respiratory effort, no clubbing or cyanosis
Heart: normal JVP, RRR, no murmurs, no edema,extremities warm
Abdomen: soft, NTND, active BS
Skin: warm and dry
Lines:
Drains:
Micro:
Abx:
Labs/imaging reviewed, significant for:
Assessment/Plan:
***

Diet:
DVT ppx:
GI ppx:
Code Status:
Emergency Contact:
Dispo:

MICU

MICU H&P #1

CC:
HPI:

REVIEW OF SYSTEMS:
General: No fatigue, fever, chills, night sweats, change in weight, change in appetite.
HEENT: No headaches, vision changes, change in hearing, or dysphagia.
Respiratory: No cough or shortness of breath.
Cardiovascular: No chest pain, DOE, palpitations, PND, orthopnea, BLE edema, claudication, syncope or
pre-syncope.
Gastrointestinal: No abdominal pain, nausea, vomiting, diarrhea, constipation, hematochezia, melena,
or hematemesis.
Genitourinary: No burning on urination, increased frequency, urgency, nocturia, incomplete emptying,
weak stream, or hematuria.
Musculoskeletal: No joint stiffness, swelling or pain. No muscle pain or weakness.
Neurologic: No numbness, tingling, weakness, loss of speech, dizziness, or seizure activity.
Hematologic: No easy bruising/bleeding.
Psychiatric: No depression, anxiety, or memory loss.
Skin: No rashes, itching, or change in skin/hair/nail appearances

PAST MEDICAL HISTORY:
Has/has not been intubated before

PAST SURGICAL HISTORY:
SOCIAL HISTORY:
FAMILY HISTORY:
Allergies:
|ALLERGIES/ADR|
Home Medications:
|OUTPATIENT MEDS|

Current Medications:
|ACTIVE MEDICATIONS|
VITALS:
T: |TEMPERATURE|
HR: |PULSE|
BP: |BLOOD PRESSURE|
RR: |RESPIRATION|
SaO2: |PULSE OXIMETRY|
WEIGHT: |PATIENT WEIGHT|
BMI: |BMI|
EXAM:
Gen: NAD, AOX3
Eyes: PERRL, EOMI, No conjunctival pallor, non-icteric scleral
ENT: Normal O/P, no erythema, no exudate, no ulcers or petechiae
Neck: supple, no LAD or thyromegaly
Chest: CTAB no wheezing or crackles, normal respiratory effort, no clubbing or cyanosis
Heart: normal JVP, RRR, no murmurs, no edema, extremities warm
Abdomen: soft, NTND, no masses or organomegaly, active BS
Skin: warm and dry
Neuro: CN2-12 intact, sensation to light touch intact and equal bilat, motor strength 5/5 throughout, reflexes 2+, normal gait

Labs reviewed:
|LR WBC|
|LR HGB|
|LR HCT|
|LR PLTS|
|LR IRON|
|LR %IRON SATURATION|
|FERRITIN OBJ|
|B12 OBJ|
Folate =
|LR TSH|
|LR OCCULT BLOOD 1|
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|
|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|
|LR PO4|
|LR PROTEIN,TOTAL|
|LR ALBUMIN|
|LR BILIRUBIN,TOTAL|
|LR AST|
|LR ALT|
|LR ALK PHOS|
|LR GGT|
|LR INR|
|LR CHOLESTEROL|
|LR TRIGLYCERIDE|
|LR LDL CHOLESTEROL|
|LR HDL|
|LR A1C|
|LR VIT D, 25-OH TOTAL|

Micro:
Abx:
Imaging reviewed:
CXR-
EKG-
Assessment/Plan:
***
#Hypoxemic/Hypercapnic Respiratory Failure

Tobacco use:

- counseled on cessation
- offered treatment
Diet:
DVT ppx:
GI ppx:
Code Status:
Emergency Contact:
Dispo:
I have reviewed the veteran's outpatient med list with veteran and reconciled all inpatient medications as appropriate.

MICU PN#1

I discussed the patient's assessment and plan of care with the supervising practitioner of record for this episode of care. The supervising practitioner is Dr. *** who agrees with my assessment and plan.

Ventilator:
Mode
Settings

Last ABG:

Pressors/Inotropes/Sedation:

Antibiotics

Lines:

Procedures:

Subjective/Overnight events:

Objective:
Allergies:
|ALLERGIES/ADR|
Medications:
|ACTIVE MEDICATIONS|
VITALS:
T: |TEMPERATURE|
HR: |PULSE|
BP: |BLOOD PRESSURE|
RR: |RESPIRATION|
SaO2: |PULSE OXIMETRY|
Intake:
Output:
Net:
Net since admission:
Today's Weight: |PATIENT WEIGHT|
PHYSICAL EXAM:
GEN: A/Ox 3, NAD
HEENT: PERRL, EOMI, no oral ulcers
Neck: supple, no LAD
Chest: CTAB, normal respiratory effort, no clubbing or cyanosis
Heart: normal JVP, RRR, no murmurs, no edema,extremities warm
Abdomen: soft, NTND, active BS
Skin: warm and dry
Lines:
Drains:
Micro:
Abx:
Labs
|LR ALBUMIN|
|LR ALT|
|LR AST|
|LR GGT|
|LR ALK PHOS|

|LR BILIRUBIN,TOTAL|
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|
|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|
|LR PO4|
|LR CPK MB|
|LR WBC|
|LR HCT|
|LR HGB|
|LR PLTS|
|PT W/INR (AFTER 11/01/05)|
|LR PTT (AFTER 11/1/05)|

Assessment/Plan:
***

Diet:
DVT ppx:
GI ppx:
Code Status:
Emergency Contact:
Dispo:

VA Wards

VAW H&P#1

H&P
PATIENT NAME/SSN: |PATIENT NAME| |PATIENT SSN|
ADMISSION DATE:|CURRENT ADMISSION|
CHIEF COMPLAINT:
HISTORY OF PRESENT ILLNESS:
ROS:
GEN: Denies weakness, fatigue, weight loss, weight gain, insomnia, change in appetite, headaches, fevers, chills, sweats
HEENT: Denies blurry vision, vision loss, cataracts, glaucoma, Denies dysphagia, odynophagia, LAD, neck pain, thyroid problems, hearing loss, tinnitus, vertigo
CV: Denies orthopnea, PND, DOE, SOB, LE edema, palpitations, chest pain
PULM: Denies cough, hemoptysis, wheezes, bronchitis, asthma
GI: Denies nausea, vomiting, diarrhea, constipation, hemetemesis, melena, bright red blood per rectum, change in stool
GU: Denies dysuria, hematuria, urgency, frequency, discharge, nocturia, incontinence
MS: Denies weakness, muscle aches, joint pain, back pain, neck pain
Neuro: Denies numbness, tingling, tremors, syncope, seizures
PMHx:
PSHx:
SHx:
FHx:
Allergies: |ALLERGIES/ADR|
Meds:
|ALL ACTIVE MEDICATIONS|
PHYSICAL EXAM:
HEIGHT: |PATIENT HEIGHT|
WEIGHT: |PATIENT WEIGHT|
TEMP: |TEMPERATURE|
PULSE: |PULSE|
RESP: |RESPIRATION|

BP: |BLOOD PRESSURE|
GEN: WDWN, NAD, AxOx3
HEENT: PERRL, EOMI, anicteric. OP clear, no LAD or thyromegaly. no JVD
CV: normal rate, regular rhythm no m/r/g
PULM: CTAB, no wheezes, rales, or rhonchi
GI: soft, nontender, nondistended, +bs, no rebound or guarding
EXT: warm and well perfused, no clubbing, cyanosis, or edema. 2+ DP
NEURO: CN 2-12 grossly intact, Strength intact 5/5 bilaterally. DTRs 2+ bilaterally. Sensation intact
Labs:
|LR HGB A1C|
|LR TSH|
|LR CHOLESTEROL|
|LR TRIGLYCERIDE|
|LR HDL|
|LR LDL CHOLESTEROL|
|LR ALBUMIN|
|LR ALT|
|LR AST|
|LR GGT|
|LR ALK PHOS|
|LR BILIRUBIN,TOTAL|
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|
|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|
|LR PO4|
|LR CPK MB|
|LR WBC|
|LR HCT|
|LR HGB|
|LR PLTS|
|PT W/INR (AFTER 11/01/05)|
|LR PTT (AFTER 11/1/05)|
ASSESSMENT:
PLAN:

VAW PN#1

Progress Note
R1 Med D Progress Note
SUBJECTIVE:
OBJECTIVE:
RECENT VITALS:
TEMP:|TEMPERATURE|
B/P:|BLOOD PRESSURE|
RESP:|RESPIRATION|
PULSE:|PULSE|
Physical Exam:
General: NAD. AAOx3.
Neck:
HEENT: Mucous membranes pink and moist, normal OP
Resp: breathing unlabored, lungs clear to auscultation bilaterally.
CV: RRR. Normal S1 and S2. No m/g/r.
Abd: soft, nontender, nondistended, normal bowel sounds noted throughout.
Ext: no edema. 2+ pulses in all extremities
Neuro: cranial nerves II-XII grossly intact. Sensory and motor grossly intact.
Medications:
|ACTIVE MEDICATIONS|
Labs:
|LR SODIUM|
|LR POTASSIUM|
|LR CHLORIDE|
|LR CO2|
|LR BUN|

|LR CREATININE|
|LR GLUCOSE|
|LR CALCIUM|
|LR MAGNESIUM|
|LR PO4|
|LR CPK MB|
|LR WBC|
|LR HCT|
|LR HGB|
|LR PLTS|
Ca/Mg/Phos
PT/INR
ASSESSMENT/PLAN:
Prophy/diet/discharge
FULL CODE

Pre-op

Pre-op #1

PRIME PRE-OP CONSULT RESULT
Patient: |PATIENT FIRST_LAST NAME|
Date of Birth: |PATIENT DATE OF BIRTH|
Planned Surgery:
Anticipated Date of Surgery:
History of Present Illness:
|PATIENT FIRST_LAST NAME| is a |PATIENT AGE| year old |PATIENT SEX| with a past medical history significant for [...] who presents for pre-operative evaluation.
The patient has/has not tolerated surgery without any adverse events in the past.
Functional status:
High Risk Surgery:
Ischemic heart disease:
History of heart failure:
History of CVA:
Insulin therapy for Diabetes:
Serum Cr > 2:
Snoring:
Tiredness/daytime somnolence:
Observed apneic episodes:
HTN:
BMI > 35:
Age > 50:
Neck circumference > 15.75in:
Male:
Past Medical History:

Past Surgical History:
Family History:
Maternal:
Paternal:
Siblings:
Social History:
Alcohol:
Tobacco:
Other drugs:
Allergies: |ALLERGIES/ADR|
ROS:
Gen: No fevers, chills, or recent weight changes.
HEENT: No headaches, acute vision changes, congestion, or drainage.
Neck: No sore throat or dysphagia.
Chest: No SOB or cough at baseline.
Heart: No chest pain, palpitation, DOE, orthopnea, or PND. No peripheral edema.
GI: No changes in bowel movements. No nausea, vomiting, hematochezia, or melena. No abdominal pain.
GU: No dysuria, gross hematuria, frequency, urgency, or nocturia.
Neuro/MSK: No muscle weakness/paralysis or loss of sensation. No muscle or joint pains.
Psych: No depression or thoughts of self harm.
Objective:

Vitals:
- Temp: |TEMPERATURE|
- Pulse: |PULSE|
- BP: |BLOOD PRESSURE|
- RR: |RESPIRATION|
- POx: |PULSE OXIMETRY|

General:
HEENT: EOMI, PERRLA, MMM, oropharynx without erytherma or exudate
Neck: Supple, no thyromegaly, no cervical LAD. No JVD noted.
Cardiovascular: Normal rate, regular rhythm. Normal S1 and S2. No M/R/G.
Chest: CTA (B)
Back: No spinal tenderness. No CVAT.
Abdomen: Soft, non-tender, nondistended. Normal bowel sounds. No organomegaly on exam.
Extremities:Warm and well perfused with 2+ pulses in all extremities.
Skin: No rashes or lesions noted.
Psych: Appropriate mood and affect.
Labs:

Imaging:

Meds:
|ALL ACTIVE MEDICATIONS|
Assessment:
|PATIENT FIRST_LAST NAME| is a |PATIENT AGE| year old |PATIENT SEX|
Recommendations:
Cardiac:
RCRI:
Pulmonary:
STOP-BANG:
Recommend close perioperative monitoring and post-operative pulmonary toilet.
Medications:
*ASA for primary prevention: recommend holding for ~7 day prior to surgery and restart 24-48hrs afterwards to minimize bleeding risk.
*ASA for secondary prevention: would not recommend holding ASA prior to surgery. If this is deemed to be a high bleeding risk surgery, can hold ASA for 3-5 days preoperatively with the recognition that the patient will be at an increased risk of an MI.
*ACEI/ARB: hold ACEI/ARB on the day of the surgery.
*SSRI: hold *** for *** prior to surgery.