TSINEWPATIENTEVAL

@DEPARTMENTLOGIN@

THORACIC SURGERY NEW PATIENT EVALUATION

Pt. Name/Age/DOB: @NAME@ @AGE@ @DOB@
Medical Record Number: @MRN@

Date of service: @TD@ @NOW@

Requesting/Referring Physician: *** {REQUESTING/REFERRING PHYSICIAN:24763}

Reason for Consultation: Evaluation regarding {Right/left:16020} ***

Assessment:
{Blank single:19197::"potential", "proven"} {Blank single:19197::"clinical", "pathologic"} AJCC/UICC 8th edition stage ***, (T***N***M***) *** of the ***

Plan:
Further evaluation or risk assessment needed prior to surgery:
***
Surgical procedure proposed: ***

Date: ***

Medical Center: ***

Expected benefits, usual risks including but not limited to infection, post-op pneumonia, bleeding, heart attack, stroke, prolonged air leak, respiratory failure, atrial fibrillation, a *** % probability of surgery survival, characteristics of expected recovery from surgery and alternatives were discussed with the patient & ***. Issues particular to this procedure include ***. We discussed patient preferences & nonsurgical options. Procedures, Alternatives, Risks, Questions (PARQ) conference was held. The patient consents. All questions were addressed.

The goal of this surgery is do it accurately and safely. In the case of minimally invasive surgery, if these goals are in jeopardy, then the procedure may need to be converted from a minimally invasive to an open approach.

Antiplatelet / anticoagulation management:
Patient was advised regarding management of these medications. {YES/NO/N/A :21578}
Plan: ***

Smoking cessation counseling: {YES/NO/N/A :21578}, if yes please see worksheet in chart. {Blank single:19197::"99406: 3-10 minutes", "99407: >10 minutes"}

The patient has been considered for protocol enrollment of the following studies:
***

A total of *** minutes were spent face-to-face with the patient and greater than 50% of that time was spent on counseling.

History of Present Illness: Information is gathered from ***.

History: Patient is a @AGE@ @SEX@ who ***

Tobacco history: {TOBACCO TYPE USED:24765}
*** packs for *** years = *** pack years
Year quit: ***

Marijuana use: {YES/NO/N/A :21578}
Active? {YES/NO/N/A :21578}
If active, amount: ***

Alcohol (CNPP & CDC definitions): {ALCOHOL USE:24770}

ECOG / Zubrod / WHO Performance Status: {ECOG/ZUBROD/WHO PERFORMANCE STATUS:24766}

MRC Dyspnea index: {MRC DYSPNEA INDEX:24767}
Home oxygen: {YES/NO/N/A :21578}

Nutritional Status: Unintended weight loss in the last 3 months: {YES/NO/N/A :21578} / *** lbs.

Pain scale (0/10): *** Cause of chronic pain: ***
Opioid dependence: {YES/NO/N/A :21578}

Imaging:
Chest X-ray: Date: *** Location performed: ***. Results: ***

Chest CT scan: Date: *** Location performed: ***. Results: ***

PET/CT: Date: *** Location performed: ***. Results: ***

Risk assessment:
EKG: Date: *** Location performed: ***
Results: ***

PFT: Date ***
Results: ***

Allergies:
@ALLERGY@

Current Medications:

@CMED@

Past Medical History:
@PROB@
@PMH@
@PSH@
***

Family History:
@FAMHX@

Social History:
@SOCHX@

Review of Systems:
I reviewed the 13 organ system review with the patient and it is positive for: ***
The remainder of the 13 organ-system review is negative.

Objective:
@VITALS@
***

Physical Examination:
Constitutional: Well-developed, well-nourished @SEX@, in no distress. ***
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light. No scleral icterus. ***
ENMT: Normocephalic atraumatic; oropharynx clear with moist mucous membranes, no mucosal ulcerations, normal hard and soft palate. ***
Neck: Trachea midline, full range of motion, supple, no thyromegaly, no surgical scars. ***
Respiratory: Normal chest symmetry, clear to auscultation, normal respiratory effort, no intercostal retractions. ***
Cardiovascular: Regular rate & rhythm, no murmurs/rubs/gallops, no peripheral edema, peripheral pulses normal. ***
Chest: No surgical scars present or open wounds, no deformities. ***
Gastrointestinal: Soft, non-tender, no masses, bowel sounds present. ***
Lymphatic: No cervical or supraclavicular adenopathy. ***
Musculoskeletal: Normal range of motion. Exhibits no edema or tenderness. ***
Skin: Warm and dry without any erythema, rashes or obvious lesions. ***
Neurologic: Alert and oriented to person, place, and time. No cranial nerve deficit. Gait normal. ***
Psychiatric: Mood, affect and judgment normal.

Labs: I reviewed the patients laboratory studies available and they are notable for {Blank single:19197::"no recent labs", "no abnormalities", "***"}

Electronically signed by: @MECRED@ @TD@ @NOW@
@LOCATION@

cc:
@NAME@

Participating care providers: ***

This note was transcribed using speech recognition software. As a result there may be unintended grammatical and/or spelling errors. Every attempt is made to have correct dictation. If there are any questions or errors please contact our office.