THE UNIVERSITY OF ZAMBIA

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF COMMUNITY & FAMILY MEDICINE

INITIAL PRESENTATION TEMPLATE

__*(NAME)*__ is a __*(AGE/GENDER)*__ with a past medical history of __*(pertinent PMH, HIV status, etc)*__ who presented to Chilenje _____ days ago with __*(chief complaint and history)*__.

Explain the pertinent things that have happened from the time since they came to the hospital until now (medications, tests, working diagnosis, etc.), and any pertinent changes in clinical condition. Summarize only the important details, do not review every step and do not flip/read through the book, particularly if we now have a new working diagnosis.

Current status: How is the patient doing today? Better / the same / worse? What is this based on?

Current medications: Verify on the drug chart what they are actually receiving including dosing and frequency. If something was ordered but they are not receiving it, then explain why.

ALLERGIES (only present if there are any)

MEDICAL AND FAMILY HISTORY

PAST MEDICAL HISTORY/Hospitalizations

PAST SURGICAL HISTORY

CHILDREN: BIRTH Hx / DEVELOPMENT / VACCINES / PREVIOUS HOSPITALIZATIONS

Relevant Family History: *This should include information relevant to their condition, not just DEATH.*

SOCIAL: Who they live with, what they do for work and fun. Who is their support? Recent travel. Smoking, drinking, drug use.

VITALS: BP_____ (*verify manually if indicated)* HR_____ RR_____ O2_____ Temp_____

PHYSICAL EXAM: *Do a full exam on all patients. Present the pertinent positives and negatives by system. Do not present everything that was done if it is not pertinent.*

GEN
HEENT
CV
RESP
ABD
GU
LYMPH
MSK
SKIN
NEURO
PSYCH

Assessment and plan

** *NAME* is a *AGE/GENDER* with a past medical history of (*pertinent PMH, HIV status, etc)* who has been admitted with *diagnosis* .

*Mention if the diagnosis is confirmed or suspected and how confident you are on the diagnosis.
If you are unsure, create a differential and what needs to be done to determine if this is the diagnosis.

*Look up things you are unsure about. If you do not yet have answers, include questions that you want to look up an evidence-based answer to.

* The plan needs to include medical thinking. Why investigations are being ordered. When therapeutic interventions should be stopped, when to escalate to more invasive measures)

1. PROBLEM (Diagnosis)
    - Diagnostics and treatments (why and timing)
    - Chronic care quality metrics associated with the diagnosis
    - Preventative measures related to the diagnosis
2. PROBLEM (Diagnosis)

DISPOSITION / DISCHARGE CRITERIA

What needs to be done in order for this patient to go home (discharge milestones), and what steps are being taken to achieve this? When is it safe for discharge and what resources do they need prior to leaving? Decide when the patient should be followed up in OPD and the OPD plan.