**QUB Phase 3 Case Template 2015-16**

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| **Student name:** | | | Student QUB Number | | |
| **Patient Initials** | | Date of Birth | Date of Admission | | Consultant |
| Age | Date of Assessment | |
| **PRESENTING COMPLAINT(s)**  .....................................................................................................................................................................................................................................  ..................................................................................................................................................................................................................................... | | | | | |
| **HISTORY OF PRESENTING COMPLAINT***.*  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  ....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  ..................................................................................................................................................................................................................................... | | | | | |
| **Past Medical and Surgical History** *Use checklist, add others; add approximate date(s) and details as free text* | | | | | |
| *Previous MI No/Yes*  *Angina No/Yes*  *CVA/TIA No/Yes*  *Hypertension No/Yes*  *Diabetes No/Yes* | *Hyperlipidaemia No/Yes*  *Asthma No/Yes*  *COPD No/Yes*  *Previous TB No/Yes*  *Previous cancer No/Yes* | | | *Jaundice/hepatitis No/Yes*  *Previous DVT / PE No/Yes*  *Epilepsy No/Yes*  *Rheumatic Fever No/Yes*  *Arthritis/joint problems No/Yes.* | |
| *FURTHER RELEVANT DETAILS*  .....................................................................................................................................................................................................................................  .....................................................................................................................................................................................................................................  ..................................................................................................................................................................................................................................... | | | | | |
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| **MEDICATIONS USED AT TIME OF ADMISSION (copy sheet if required)** | | | | | |
|  | ***Drug name*** | ***Dose &***  ***Route*** | ***Indication in this patient*** | ***Mechanism of action*** | ***Specific adverse effects.*** |
| **1** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
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| **9** |  |  |  |  |  |
| **10** |  |  |  |  |  |
| **11** |  |  |  |  |  |
|  | **Drug Allergies or Sensitivities**  *.................................................................................................................................................*  *.................................................................................................................................................* | | | **Other Therapy Issues** *(E.g. Oxygen, Home Nebuliser, TPN, PEG Feeding, Dialysis )*  *...................................................................................................................................................*  *...................................................................................................................................................* | |

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| SOCIAL HISTORY Single / Married / Widowed / Divorced / Partner*Living arrangements* *(alone, with partner, nursing home etc)* ........................................................................................... ***Main Carer*:** ..........................................................................................................................................................................................  ***Occupation history***................................................................................................................................................................................  ***Previous Occupations:*** ...........................................................................................................................................................................  ***Home assistance received*** *(statutory and informal; eg district nurse, care assistants, meals on wheels etc)*  **................................................................................................................................................................................................................**  ***Smoking History:*** Non-Smoker Current Smoker ............ Ex- Smoker................. until………………Pack years………………............  ***Alcohol:***  Units per week\_\_\_\_\_\_\_\_\_\_\_\_ Details:…………………………………………………………………………………......................  **FUNCTIONAL STATUS**  *Mobility*.....................................................................................................................................................................................................  *Self-care abilities including*.........................................................................................................................................................................  *Continence / Hearing / Eyesight*..................................................................................................................................................................  *Other relevant social and functional issues*................................................................................................................................................... |
| **FAMILY HISTORY** *(relevant illnesses in first degree relatives)*  ..............................................................................................................................................................................................................  ............................................................................................................................................................................................................... |
| **SYSTEMS REVIEW {NOT COVERED IN HISTORY ABOVE}** *( circle if present; use as checklist only)*  **CVS:** *Angina**Hypertension SOB / PND Claudication**Oedema**Palpitations**Cholesterol**Normal/Elevated/Unknown*  Details...........................................................................................................................................................................................................................  **RS** *ET = ............. Yards / Miles SOB**Cough**Sputum*Haemoptysis*Chest Pain**Night Sweats**Wheeze*  Details...........................................................................................................................................................................................................................  **GIT** *Weight Loss**Anorexia**Nausea**Vomiting**Heartburn**Jaundice**Abdominal Pain**Diarrhoea**Constipation**Blood PR*  Details...........................................................................................................................................................................................................................  **GUT** *Frequency**Nocturia**Hesitancy**Haematuria**Pain/dysuria**Incontinence*  Details...........................................................................................................................................................................................................................  **CNS:** *Headache**Other pain / paraesthesia**Blackout**Dizziness**Weakness**Depression**Anxiety**Memory problems**Sleep**Visual problems*  Details...........................................................................................................................................................................................................................  **ENDOCRINE:** *Diabetes* *Weight loss/gain**Other......................................*............................................................................................  Details...........................................................................................................................................................................................................................  **MUSCULOSKELETAL**  *Joint pains Lifting and carrying problems Muscle aches Back problems*  *Limp/Mobility problems Swelling or stiffness Manage stairs Dress without difficulty*  Details...........................................................................................................................................................................................................................  **MENSTRUAL and OBSTETRIC HISTORY**  *Age at menarche*................ *Pregnancies and miscarriages*................ *Age at menopause*................   *Cervical smear/ mammogram/self examination history if relevant*……………………...............................  Details...........................................................................................................................................................................................................................  **SKIN** *rash**single lesions* *itch* (Details).................................................................................... |

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| **EXAMINATION FINDINGS: *Height****\_\_\_\_\_\_\_* ***Weight****\_\_\_\_\_* ***BMI****\_\_\_\_\_\_\_*  **Temp**........... **oC Pulse**..............**bpm BP**.........../.............  **RR**.............**/min SaO2** =.................% Breathing................... **PEFR**....................*L/Min*  *Anaemia/Pallor* *Clubbing* *Cyanosis* *Jaundice* *Lymphadenopathy*................................................... *Nutritional state*  *Legs*  *Skin* *Thyroid* .....................................................................................................  **CVS**  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  **RS**  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  **ABDOMEN (GUT and GIT)**  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ................................................................................................................................................................................. **PR:** *Not done / Normal / Abnormal* |
| **MUSCULOSKELETAL** *Please complete as fully as required in your patient (eg if patient has osteoarthritis of the hip you do not need to do REMS for all the other joints, if not symptomatic. If your patient has Rheumatoid arthritis you will normally need to examine all the joints)*  **GALS screen** *(cover the 3 GALS questions in history)*   |  |  |  | | --- | --- | --- | |  | Appearance | Movement | | Gait |  |  | | Arms |  |  | | Legs |  |  | | Spine |  |  | | ***Comments*** |  |  |   **Regional examination**   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Hand & Wrist** | | **Elbow** | | |  | Right | Left | Right | Left | | **Look** |  |  |  |  | | **Feel** |  |  |  |  | | **Move** |  |  |  |  | | **Function** |  |  |  |  | | **Special Tests\*** |  |  |  |  | |  | **Shoulder** | | **Hip** | | |  | Right | Left | Right | Left | | **Look** |  |  |  |  | | **Feel** |  |  |  |  | | **Move** |  |  |  |  | | **Function** |  |  |  |  | | **Special Tests\*** |  |  |  |  | |  | **Knee** | | **Ankle & Foot** | | |  | Right | Left | Right | Left | | **Look** |  |  |  |  | | **Feel** |  |  |  |  | | **Move** |  |  |  |  | | **Function** |  |  |  |  | | **Special Tests\*** |  |  |  |  | |  | **Spine** | | | | |  |  | | | | | **Look** |  | | | | | **Feel** |  | | | | | **Move** |  | | | | | **Function** |  | | | | | **Special Tests\*** |  | | | |   **\*** Special tests (eg tests for carpal tunnel syndrome, testing for a painful arc, Thomas’ test, Trendelenberg test etc |

**NERVOUS SYSTEM AND HIGHER MENTAL FUNCTIONS (if relevant to the case)**

|  |  |  |  |  |  |  |  |  |
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| **General Assessment** | | | | |  | **Upper and lower limb Neurological System** | | |
| **GCS** *(****Glasgow Coma Score***)*Total* /15 | | | | |  | **Abnormal Movements or fasciculation** *No / Yes* | | |
| *Eyes* /4 | *Motor* /6 | | *Verbal* /5 | |  | **Muscle Wasting** *No / Yes* | | |
| **Mini-mental score** | | | *Total* /10 | |  | **Upper limb** | **Right** | **Left** |
| **Cognition:** | *Normal / Impaired* | | | |  | **Power**  Shoulder Ab/Ad |  |  |
| **Neck Stiffness** *No / Yes* | | |  | |  | Elbow Flex/Ext |  |  |
| **Photophobia** *No / Yes* | | |  | |  | Wrist F/E |  |  |
| **Speech** *Normal / Dysphasia / Dyarthria / Dysphonia* | | | | |  | Fingers |  |  |
| **Swallowing**  *Not assessed / Safe / Unsafe* | | | | |  | **Tone** |  |  |
| **Hearing** *Normal Impaired* | | | | |  | **Coordination** |  |  |
| **Eyesight** *Normal Impaired+type…………………….* | | | | |  | **Biceps Jerk** |  |  |
| **Continence** *Normal Impaired* | | | | |  | **Triceps Jerk** |  |  |
| **Gait / Transfers** *Not Tested / Normal / Abnormal* | | | | |  | **Supinator Jerk** |  |  |
| **Romberg Test** *Not Tested / Normal / Abnormal* | | | | |  | **Sensation** |  |  |
| **Cranial Nerves** | | | | |  |  | | |
|  | | **Right** | | **Left** |  | **Lower limb** | **Right** | **Left** |
| **Pupil appearance** | |  | |  |  | **Power**  Hip Flex/Ext |  |  |
| **Pupillary Reflexes** | |  | |  |  | Knee F/E |  |  |
| **Visual Acuity** | |  | |  |  | Ankle F/E |  |  |
| **Visual Fields** | |  | |  |  | Toes |  |  |
| **Optic Discs / Fundi** | |  | |  |  | **Tone** |  |  |
| **Eye Movements ( III, IV VI)** | |  | |  |  | **Coordination** |  |  |
| **Nystagmus No / Yes** | |  | |  |  | **Knee Jerk** |  |  |
| **V** | |  | |  |  | **Ankle Jerk** |  |  |
| **VII** | |  | |  |  | **Plantars (↑ or ↓)** |  |  |
| **IX/ X** | |  | |  |  | **Sensation** |  |  |
| **X1** | |  | |  |  | Regarding tendon reflexes please use the following scale: 0 = absent +/- = present with reinforcement + = present and normal ++ = brisk +++ = pathologically brisk CL = sustained clonus | | |
| **XII** | |  | |  |  |
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| **Mini-Mental Score *(Score 0-10)***  **Glasgow Coma Score *(Coma = score below 8)*** *Age*  *42 West St, Salford, M6 (Recall address at end)*  *Name of hospital*  ***EYES BEST MOTOR RESPONSE BEST VERBAL RESPONSE*** *Year*  *4 = Open spontaneously 6 = Obeys commands 5= Orientated Recognise 2 people*  *3 = Open to speech 5 = Localises pain 4= Confused Date of Birth*  *2 = Open to pain 4 = Flexion withdrawal 3= Inappropriate words Dates of World War II*  *1 = Never open 3 = Decerebrate flexion 2= Incomprehensible sounds Present Monarch*  *2 = Decerebrate extension 1= Silent Count down from 20*  *1 = No response Time (to nearest hour)* | | | | | | | | |

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| **SUMMARY** *(A 1-2 line summary of the main symptoms/presenting problem and major positive examination findings*)  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  ............................................................................................................................................................................................................................................  …………………………………………………………………………………………………………………………………………………………….  **ESSENTIAL TESTS AND RESULTS:** *List all essential tests and results and why they would help manage this patient. Additional space overleaf*   1. ....................................................................................................................................................................................................... 2. ....................................................................................................................................................................................................... 3. ....................................................................................................................................................................................................... 4. ....................................................................................................................................................................................................... 5. 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**2.**..................................................................................................................................................................................................................  **3.**..................................................................................................................................................................................................................  **4.**..................................................................................................................................................................................................................  **5.**..................................................................................................................................................................................................................  **PROBLEM LIST** *(List other all diagnoses, social and medical issues ie. problems that may relate to patient management*)  **1.**............................................................................................................**6**…................................................................................................  **2.**............................................................................................................**7**....................................................................................................  **3.**............................................................................................................**8**....................................................................................................  **4.**............................................................................................................**9**....................................................................................................  **5.**............................................................................................................**10**..................................................................................................  **MANAGEMENT** *(Include new therapies, discontinuation of existing medications, proposed procedures, diet and fluid changes, IV access, instructions for nursing staff, discussions with senior medical colleagues*)   1. .......................................................................................................................................................................................................................... 2. .......................................................................................................................................................................................................................... 3. .......................................................................................................................................................................................................................... 4. .......................................................................................................................................................................................................................... 5. .......................................................................................................................................................................................................................... 6. ..........................................................................................................................................................................................................................   **INFORMATION GIVEN to patient and/or family/carers at the time of admission:**  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| **SUMMARY OF TEST RESULTS** Use inpatient notes and if necessary use the laboratory and radiology systems (with a staff member to help you login). Not all these are performed and many others may be. | | | |
| Haematology  **Hb.…......**  **WCC..….....**  **Platelets..…**  **MCV..........**  **ESR.............**  **Blood film:** | Biochemistry  **Na+.....……...**  **K+........…....**  **Urea....…......**  **Creatinine....…......**  **eGFR....…......**  **Glucose..............**  **C-reactive protein............** | Arterial blood gases\*  **pH............ 7.35-7.45**  **pCO2....... 4.5-6.0**  **pO2......... 12.0-15.0**  **Bicarb............. 21-28**  **Base Excess..........** | Gases on Oxygen  **pH............…….**  **pCO2........…….**  **pO2............……**  **Bicarb.............…**  **Base Excess...........**  **If patient on Oxygen:**  **FiO**2**......... % or  ....... L Nasal** |
| Liver function tests (LFTs) Normal / Abnormal  Bilirubin........ Albumin........ Alkaline Phos........ ALT........ AST........ GammaGT........  **Calcium++............ *Troponin T……….(give times of any values relative to admission/symptoms)***  ***PT......... Secs INR........APTT.........* *Poisons and toxicology tests……………. (give time relative to admission)***  ***Thyroid Function Tests Normal / Abnormal……………..* *Autoantibody ……… …………..***  **Other Blood Tests:**   1. ....................................................................................................................................................................................................................... 2. ................................................................................................................................................................................................................... ... 3. .......................................................................................................................................................................................................................   **Urine Dipstick Test: *No record.... Normal....*** *Protein.......... Blood........... Ketones........ Leucocytes...........*  **Cultures:Blood / CSF /Urine / Sputum / Stool / *.......................................................................................................***  (Details).................................................................................................................................................................................................................  ECG Normal / Abnormal Rate................. Rhythm............................... Axis or BBB.......................  ***Acute Anterior MI changes. Acute Inferior MI changes Changes of old MI Anterior / Inferior Non-specific repolarization changes***  ***Other changes…………………………………………………………………………………………………………………*** CXR-Report……………………………………………………………………. Other Imaging Tests ***…………….. …………………..……………………………***  ***…………….. …………………..……………………………***  ***…………….. …………………..……………………………***  ***…………….. …………………..……………………………***  ***…………….. …………………..……………………………***  ***cxr drawing***  ***………………………………………………………………………..…………………………………………………………………*** | | | |
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| **INVASIVE INVESTIGATIONS (Endoscopy, ERCP, Biopsy, Laparoscopy, etc.)** Use inpatient notes and if necessary radiology systems, (with a staff member to help you login), to obtain the most relevant results | |
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| **INTERPRETATION OF TEST RESULTS:** (As they relate to the history, examination and initial diagnosis/differential diagnoses.)  ***……………………………………………………………………………………………………………………………………………………***  ***……………………………………………………………………………………………………………………………………………………***  ***……………………………………………………………………………………………………………………………………………………***  ***……………………………………………………………………………………………………………………………………………………*** | |
| **OPERATIONS AND THERAPEUTIC PROCEDURES (Invasive Procedures, etc.)** Comment on the following: preoperative preparation, prophylaxis, anaesthesia, positioning, asepsis, incision, technique, closure, recovery, postoperative care, adjuvant therapies, complications, outcome, prognosis.  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ...................................................................................................................................................................................................................................... | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **MEDICATIONS STARTED IN HOSPITAL** | | | | | | ***Drug name*** | ***Dose &***  ***Route*** | ***Mode of action*** | ***Indications for use***  ***ie why commenced now*** | ***Major adverse***  ***effects*** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |   **PROGRESS NOTES DURING ADMISSION *(Please read the inpatient notes and summarise the major events here showing progress in investigation and management )*** | |
| ***Date*** |  |
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**Discharge and Follow-Up**

**Not discharged at time of case-completion**

**Discharge to: Home / Residential Home / Nursing Home / Stroke bed / Other..………....... Planned Discharge Date....................**

**Follow-Up: GP / Clinic *(Which Consultant)....…...................... When ?..............................Weeks / Months.***

**Follow up tests required to be performed at clinic *………………………………………………………………***

**Important Messages To GP *e.g. Tests or Follow-up action required…………………………………..........…...........................................***

**Services Required *No services needed / Home Help / Meals on wheels / District Nurse / Other..........……………...................***

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| ***Discussion and reflective commentary:*** *You must limit this to no more than 2 sides.*  At the beginning state what your commentary will focus upon. Use recent references either medium-large textbook(s) or Medline references.  We would like to emphasize linking your commentary with your patient. There is no need to include detailed textbook descriptions of the patient’s primary disease. The successful student will display knowledge of the diagnosis by reference to the (presence or absence of) symptoms, signs, investigations, problems and response to treatment illustrated by the present case.  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  ......................................................................................................................................................................................................................................  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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Completed by student (signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Attachment Start date: | D | D | M | M | Y | Y |

Please use black ink and CAPITAL LETTERS

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| Student Number: |  |  |  |  |  |  |  |  |

Assessor’s signature:

GMC Number

Date:

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Assessor’s name:

|  |  |  |  |
| --- | --- | --- | --- |
| Student surname: |  | Hospital: |  |
| Student forename: |  | Attachment: |  |
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| --- | --- | --- | --- |
|  | Low | Average | High |
| Complexity of case |  |  |  |

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| **Please grade the following areas (√)** | Well below average | Below average | Average | Above average | Well above average |  |
| History of presenting complaint |  |  |  |  |  |  |
| Medication table |  |  |  |  |  |  |
| Examination |  |  |  |  |  |  |
| Diagnosis and differential diagnoses |  |  |  |  |  |  |
| Management plan |  |  |  |  |  |  |
| Commentary |  |  |  |  |  |  |
| Presentation |  |  |  |  |  |  |
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| **Anything especially good?** | **Suggestions for development** |
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This assessment can be graded by any senior doctor (Specialist trainee or above).

Please copy and return to the coordinator for the specialty/undergraduate office.