TRU SIMULATION HOSPITAL - Emergency Physician Report

PHN:8765309	Patient: Watson, Finlay		DOB: June, 15, 1965
Admission date: 3 days ago	Height: 188cm	Weight: 79.37 kg	Allergies: Penicillin

Primary Concern: Increasing chest pain unrelieved with rest. Increasing in frequency, intensity and duration.

Admission orders: Admit to cardiology. Follow Non-STEMI protocol.

History: 56-year old. 9 months of subtle chest pain (CP) /Shortness of breath (SOB) on exertion (very mild). 3 weeks of more significant CP on exertion. Often having CP/SOB at 5 am as well, waking him from sleep. Unable to walk more than a few stairs without having to stop and rest due to significant chest pain.

Past Medical History: 3 stents at age 43. L femoral artery occlusion 2018

Nursing Triage Notes:

States midsternal chest pain than never goes away. States unable to do any activity without chest pain that radiates into left arm. Denies pain in jaw. Denies nausea but becomes short of breath with exertion.

Physical Exam

Neuro: alert and orientated x3 . GCS 15. Normal cranial nerves. Grossly normal motor power/sensation in all 4 limbs. Normal finger-nose bilateral. Normal gait. Normal receptive and expressive language.
Head and Neck: no lymphadenopathy, normal pharynx
Respiratory: normal work of breathing, O2Sats 97% on room air, denies cough, lung sounds clear
CVS: normal S1 S2 heart sounds, no murmurs, normal pulses and perfusion, BP 150/85,
Abdo: soft, non-tender. No guarding or rebound. No organomegaly noted.
Legs: non-tender, no edema.

Investigations:

Chest X ray: Clear ECG: ECG shows regular sinus rhythm, no ST elevation, possible q wave deflection Labs: Hs-Tnl 89 ng/L (H)

Impression: NSTEMI

Plan: Referral made to cardiac center for early invasive management percutaneous coronary intervention (PCI). As per the protocol, this patient is considered high risk/unstable for another myocardial event based on his history, symptoms, and positive cardiac markers.

Date: day of admission

Time: *time of admission*

Physician Signature:

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