

## **Sunnybrook Dragon Templates**

*Instructions: Download and set up a new profile on the Powermic Mobile app if not already completed. Once launched and paired on your device and Sunnycare, click the flame symbol button and select "Manage Auto-texts". Then select the "+" sign and copy and paste the below templates! Be sure to create your verbal cue. Templates are inserted by saying "insert [verbal name of template]". This symbol [] indicates a field that you can jump to using the arrow buttons on your device to write your note hands free! Please note these are templates made by Dr. Bri Lago (CMR 2024-2025 year), so please feel free to edit as you wish and make more templates that fit your practice/note writing style. Hope this helps!!*

### **Apple Powermic Mobile link:**

<dmic://config/?NmsToken=NTMxOTk1RjktRDUxRS00NjVELUI1NjMtRjA4RkUxMDRCMTNF&NmsBaseUrl=nms-ca.nuancehdp.com>

### **Android Powermic Mobile link:**

<http://config/?NmsToken=NTMxOTk1RjktRDUxRS00NjVELUI1NjMtRjA4RkUxMDRCMTNF&NmsBaseUrl=nms-ca.nuancehdp.com>

### **Discharge summary blurb (should be included for ALL patient discharges!)**

Please return to the Emergency Department if []

We recommend that you make an appointment with your family physician 1 to 2 weeks after discharge to reassess your general good health after returning home.

If you have questions about your admission or do not hear about any follow-up appointments, please call the appointment clinic directly, or email [GIMclinic@sunnybrook.ca](mailto:GIMclinic@sunnybrook.ca).

We wish you all the best with your ongoing recovery!

### **Post Discharge Clinic:**

You are booked for a follow-up in the GIM Post-Discharge Clinic on [] at []. The clinic is located at CG-13 (C wing, Ground floor, room 13). If you have questions about your admission or need to call about your appointment, you can either email [postdischarge.rrc@sunnybrook.ca](mailto:postdischarge.rrc@sunnybrook.ca) or call 416-480-5108.

### **Bridging Care Clinic:**

Because you do not have a family physician, you have been referred to the bridging care clinic to follow-up on your hospital stay and to get connected to a community family doctor. The clinic is located

at Sunnybrook Hospital in the B-wing B1-11 CONNECT Clinic. Your appointment date and time is []. If you need to reschedule please call 416-480-4269. Don't forget to bring your OHIP card and current medications.

**Basic GIM Admission Consult Template:**

GIM CONSULT NOTE

ID: []

RFR: []

PMHx:

- 1.
- 2.
- 3.
- 4.

Home Meds:

- 1.
- 2.
- 3.
- 4.

Allergies: []

Social History: []

GOC: []

HPI:

[]

Physical Exam:

Vitals:

General:

Cardio:

Resp:

GI:

GU:

Skin/ID:

Investigations:

Labs:

Imaging:

Assessment and Plan:

In summary, this [] presents with []

They will be admitted to hospital for the following issues:

1. []

2. []

3. []

# Best Practices

- DVTp: []

- GOC: []

- Contacts: []

- Allied health: []

- Held home meds: []

- Consults: []

- Dispo: []

[Your name/level/program here]

Reviewed with Dr. [], SMR

On behalf of Dr. [], [] Team GIM

**Progress/SOAP Note:**

GIM Progress Note

ID: []

S:

[]

O/E:

Vitals: []

AOx3, conversational, NAD. CVS normal S1/S2, no EHS/murmurs. Resp GAEB, no crackles/wheeze. Abdo nondistended, SNT. JVP 2cm, MMM, no peripheral edema. No skin lesions appreciated.

Key Ix:

A/P:

[]

[Your name/level/program here]

on behalf of Dr. [], Team GIM Staff

## Dr. Mario Corrado (PGY3) Templates

### GIM CONSULT NOTE - Team []

**Date of Consult:** []

**Referring Physician:** []

**Reason for Referral:** []

**ID:** [] is a [] known for [] now presenting with []. Medicine has been asked to see for []

**Code Status:** []

#### Past Medical History

1 -

2 -

#### Medications (Home)

1 -

2 -

#### Medications (Current Inpatient)

1 -

2 -

#### Social History

- Living Situation: From []

- Baseline function: independent with bADLs and iADLs; does not use walking aids

- Employment: []

- Smoking: Lifelong nonsmoker []

- Alcohol: None reported []

- Recreational Drug Use / IV Drug Use: None reported []

## Family History

- Not applicable []

## Allergies

- NKDA []

## History of Presenting Illness

Patient assessed at bedside []. Briefly, []

In the ED []

On my assessment at bedside, patient reports [] Otherwise on ROS, no CP, SOB, palpitations, dizziness, presyncopal symptoms, syncope, cough, hemoptysis, NVD, abdo pain, S/S of GIB, LUTS. No fevers, chills, drenching night sweats or weight changes. No recent medication changes, recent travel, known sick contacts

## Physical Exam

Triage Vitals: []

Most Recent Vitals: []

General: AOx3, NAD, speaking comprehensibly in full sentences

CV: Normal S1S2, no EHS, no murmurs. JVP 2cm ASA, no peripheral edema. Moist mucous membranes, cap refill <2s in extremities x3, PPPx4

Resp: GAEB, no adventitia, no clubbing

Abdo: soft, non-tender, non distended. No guarding, no rigidity, no rebound tenderness. No jaundice, no stigmata of liver disease, no asterixis

Neuro: PERRLA. GCS []. Cranial nerves II-XII normal on screening exam, no focal neurological deficits.

Power is 5/5 and intact sensation in upper and lower extremities bilaterally and symmetrically. Reflexes are 2/4 for biceps, brachioradialis and patellar. Plantar responses are downgoing. Normal tone.

Finger-to-nose testing is normal bilaterally with no dysmetria or intention tremor, no dysdiadochokinesia

Extremity: No peripheral edema, no calf swelling/tenderness/erythema, [] no evidence of wounds or infection on examination of extremities

## Investigations

Blood Work:

[]

ECG: []

TTE: []

### **Radiology**

CXR: []

### **Assessment & Plan**

In summary, [] is a [] known for [] who now presents with [] History notable for []. Physical exam notable for []. Investigations demonstrate [].

Overall, patient's presentation is []

We will admit to Medicine Team [] under Dr. [] for management of the followig issues:

1. []

-

**Plan:** []

2. []

-

**Plan:** []

3. []

-

**Plan:** []

**4. Best Practices:**

- DVT prophylaxis:
- Diet/Activity:
- Fluids:
- Bowel Regimen:
- Home Meds: high risk meds reviewed, medications held: []
- Consults:
- Allied Health:
- Goals of care:
- SDM/contact info:
- EDD:
- Dispo:
- CODE STATUS:

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Internist

## GIM SENIOR MEDICAL RESIDENT NOTE

Date of Consult: []

Please see comprehensive note from Dr. [] for full details. Patient seen, reviewed and examined.

Briefly, [] is a [] known for [] who now presents with [] History notable for []. Physical exam notable for []. Investigations notable for [].

Overall, patient's presentation is []

We will admit to Medicine Team [] under Dr. [] for management of the following issues:

1. []

-

Plan: []

2. []

-

Plan: []

3. []

-

Plan: []

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Internist

## **GIM PRONUNCIATION OF DEATH**

ID: []

Admitted on []

Called to bedside by nursing staff because of absent vital signs and unresponsiveness

On my assessment there were no spontaneous movements, and the patient was without any response to tactile or verbal stimuli. The patient's pupils were fixed and dilated. No breath or heart sounds were auscultated. No carotid pulses were palpable.

Examination:

Unresponsive to voice

Absent heart sounds and respiratory efforts for full 2 minutes

Corneal reflexes absent

Death declared at []. Death Certificate completed and provided to the Charge Nurse.

Family and MRP updated.

Our sincerest condolences to the patient's loved ones.

Sincerely,

[Your name/level/program here]

## Procedure Templates

### **ARTERIAL LINE PROCEDURE NOTE**

Date: []

Time: []

Indication: Hemodynamic monitoring

Resident: []

Attending: []

A time-out was completed verifying correct patient, procedure, site, positioning, and special equipment if applicable. Allen's test was performed to ensure adequate perfusion. The patient's <right/left> wrist was prepped and draped in sterile fashion. 1% Lidocaine was used to anesthetize the area. A <18G/20G> Arrow arterial line was introduced into the <radial/femoral> artery. The catheter was threaded over the guidewire and the needle was removed with appropriate pulsatile blood return. A sterile dressing was then applied. Perfusion to the extremity distal to the point of catheter insertion was checked and found to be adequate. <Attending/Resident> was present for the entire procedure.

Estimated Blood Loss: []

The patient tolerated the procedure well and there were no complications.

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Intensivist

## CENTRAL LINE PROCEDURE NOTE

Date: []

Time: []

Indication: []

Resident: []

Attending: []

The CDC Central Line Insertion Practices form was completed by an independent observer (\_\_) starting with the first handwash prior to starting sterile technique. A time out was performed. My hands were washed immediately prior to the procedure. I wore a surgical cap, mask with protective eyewear, full gown and sterile gloves throughout the procedure. The patient was placed in Trendelenburg position. LEFT / RIGHT chest region was prepped using chlorhexidine scrub and draped in sterile fashion using a full drape and sterile probe cover and sterile gel employed. The medial and lateral heads of the sternocleidomastoid muscle were identified as was the carotid pulse. The Internal Jugular vein was identified using the ultrasound. Anesthesia was achieved over the vein using 1% lidocaine. Using real-time out of plane guidance, the introducer needle was inserted into the Internal Jugular vein under direct ultrasound visualization. Venous blood was withdrawn. The syringe was removed and a guidewire was advanced into the introducer needle. The guidewire was visualized in the Internal Jugular Vein by ultrasound. A small incision was made at the skin surface with a scalpel and the introducer needle was exchanged for a dilator over the guidewire. After appropriate dilation was obtained, the dilator was exchanged over the wire for a \_\_ central venous catheter. The wire was removed and the catheter was sutured in place at \_ cm. A sterile sorbaview shield was placed over the catheter at the insertion site. The patient tolerated the procedure without any hemodynamic compromise. At time of procedure completion, all ports aspirated and flushed properly. Post-procedure chest x-ray is pending at this time.

Estimated blood loss is [].

The patient tolerated the procedure well and there were no complications.

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Intensivist

## LUMBAR PUNCTURE PROCEDURE NOTE

Date: []

Time: []

Indication: []

Resident: []

Attending: []

The indication and risks of the procedure were discussed with the patient. Specific risks discussed included []

A time-out was performed. My hands were washed immediately prior to the procedure. I wore sterile gloves throughout the procedure. The patient was placed in the [] position with help from the nursing staff. The area was cleansed and draped in usual sterile fashion using betadine scrub. Anesthesia was achieved with 1% lidocaine. A 20-gauge 3.5-inch spinal needle was placed in the [] lumbar interspace. On the [] attempt, [] colored cerebral spinal fluid was obtained. The opening pressure was [] cm H<sub>2</sub>O. CSF was collected into 4 tubes. These were sent for [], including 1 tube to be held for further analysis if needed. A sterile bandaid was placed over the puncture site. The patient had no immediate complications and tolerated the procedure well.

Estimated blood loss is [].

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Physician

## PARACENTESIS PROCEDURE NOTE

Date: []

Time: []

Indication: []

Resident: []

Attending: []

The indication and risks of the procedure were discussed with the patient. Specific risks discussed included []

A time-out was performed. My hands were washed immediately prior to the procedure. I wore sterile gloves throughout the procedure. The area was cleansed and draped in usual sterile fashion using chlorhexidine scrub. An appropriate pocket was identified in the [] of the abdomen using ultrasound. The [] of the abdomen was prepped and draped in a sterile fashion using chlorhexidine scrub. [] cc of 1% lidocaine was used to numb the skin, soft tissue and peritoneum. The paracentesis catheter was inserted and advanced with negative pressure until \_ colored fluid was aspirated. Approximately [] mL of ascitic fluid was collected and sent for laboratory analysis including []. The catheter was then connected to the vacutainer and [] liters of additional [] color ascitic fluid were drained. The catheter was removed and no leaking was noted. A bandaid was placed over the puncture wound. The patient tolerated the procedure well without any immediate complications.

Estimated blood loss is [].

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Physician

## THORACENTESIS PROCEDURE NOTE

Date: []

Time: []

Indication: []

Resident: []

Attending: []

The indication and risks of the procedure were discussed with the patient. Specific risks discussed included []

A time out was performed and the chest x-ray was reviewed, the appropriate side was confirmed and marked. My hands were washed immediately prior to the procedure. I wore sterile gloves throughout the procedure. The patient was prepped and draped in a sterile manner using chlorhexidine scrub after the appropriate level was percussed and confirmed by ultrasound. 1% lidocaine was used to anesthetize the skin, subcutaneous tissue, superior aspect of the rib periosteum and parietal pleura. A finder needle was then introduced over the superior aspect of the rib to locate the pleural fluid; [] colored fluid was aspirated at a depth of approximately \_ cm. A 10-blade scalpel was used to nick the skin at the insertion site. The catheter needle was then introduced through the skin incision into the pleural space using negative aspiration pressure until fluid returned. The thoracentesis catheter was then threaded without difficulty. [] ml of [] colored fluid was removed without difficulty. The catheter was then removed. No immediate complications were noted during the procedure. A post-procedure chest x-ray is pending at the time of this note. The fluid will be sent for [] studies.

Estimated blood loss is [].

Sincerely,

[Your name/level/program here]

On behalf of Dr. [], Staff Physician