TRIAGE CHIEF COMPLAINT:
@CHIEFCOMPLAINT@

HPI:
@NAME@ is a @AGE@ @SEX@ in @ROOMBED@ who presents from *** to the ED with back pain. Onset ***. Reports ***

Red Flags:
Trauma/fall/injury: {YES***/NO:60}
Focal weakness or numbness: {YES***/NO:60}
Incontinence/retention of bowel/bladder: {YES***/NO:60}
Groin numbness: {YES***/NO:60}
Recent spine procedure/surgery/injection: {YES***/NO:60}
Fevers: {YES***/NO:60}
IVDU: {YES***/NO:60}
Malignancy: {YES***/NO:60}
Immunocompromised, steroid use, or malignancy: {YES***/NO:60}

Patient is without additional complaints or concerns at this time.

REVIEW OF SYSTEMS:

CONST:	***Denies recent illness, unintended weight loss
EYES:	***Denies vision change
ENT:	***Denies sore throat
CV:	***Denies chest pain, lightheadedness, syncope
RESP:	***Denies shortness of breath
GI:	***Denies abdominal pain, nausea, vomiting, diarrhea, constipation, dark/bloody stools
GU:	***Denies dysuria, hematuria
MSK:	***Denies extremity pain
SKIN:	***Denies rash
NEURO:	***Denies headache, neck pain/stiffness

PAST MEDICAL HISTORY:
@PMHR@

SURGICAL HISTORY:
@PSHR@

FAMILY HISTORY:
@FAMHXR@

SOCIAL HISTORY:
@SOCHX@

I have reviewed and verified the above past medical, family, and social history.

CURRENT MEDICATIONS:
@COPMEDS@

ALLERGIES:
@ALG@

PHYSICAL EXAM:
VITAL SIGNS: The Initial Triage assessment is as follows:
@FLOWDT(4796:first)@
Vitals during ED course were reviewed and are as charted.

Const: *** @SEX@ appearing stated age sitting up in bed. No acute distress and non-toxic. Conversant and interactive with staff and cooperative w/ exam.
Eyes: PER, Conjunctiva normal. ***
Head: NC/AT. ***
ENMT: Normal external ears and nose. MMM, Oropharynx clear. ***
Neck: No midline ttp, deformities, nor step-offs of the C-spine. Painless NROM***. Symmetric. Trachea midline. No stridor.
CVS: ***, +S1/S2, no murmurs or gallops. Peripheral pulses intact and equal in all four extremities. ***
Pulm/Chest: No respiratory distress. CTAB***.
ABD: ***Soft, NDNT, No r/g, No HSM. No pulsatile masses. No CVAT.
Rectal: ***
Back: *** midline ttp, deformities, or step-offs of T/L/S-spine. *** paraspinal muscle ttp. ROM: ***. SLR: ***.
Ext: Nontender extremities without deformity.
Skin: Warm, Dry. No rashes or lesions. ***
Neuro: CN II-XII grossly intact as tested. Motor full in bilateral upper and lower extremities. Sensation to soft touch grossly intact. B/L EHL: ***. Gait: ***
Psych: AAOx3. Normal mood. Appropriate affect. ***

EKG: as interpreted by myself
Findings: {EKG RHYTHM;CARD:15980}. Rate: ***. Ectopy: ***. Axis: {EKG AXIS:13156:o:"normal"}. Intervals: PR: ***, QRS: ***, QTc: ***. *** ST-T wave abnormalities.
Comparison: ***
Impression: ***

RADIOLOGY:

I have personally reviewed the images. The radiologist interpretation reveals:
@EDINTERP@

LAB RESULTS:
@EDLABS@

PROCEDURES:
***

ED COURSE & MEDICAL DECISION MAKING:
Pertinent labs, imaging studies, and nursing notes from current visit reviewed.

Chart Reviewed By Myself. ***
NarX: ***

@AGE@ @SEX@ p/w ***. On presentation, vital signs ***. No focal neuro deficits and *** red flags for back pain. ***

The patient received the following medications in the ED:
@EDMEDS@

FINAL IMPRESSION:
@DIAGX@

DISPOSITION:
D/C home. Conservative outpatient management with the below medications for control of back pain. D/C instructions were given, including avoid heavy lifting, activity as tolerated, gentle stretching and ROM exercises, weight loss, and ice/warm compresses. ***

DISCHARGE MEDICATIONS:
@EDPTMEDSTART@

***Patient/family counseled at bedside and all questions answered. Verbal and written discharge instructions including return precautions were given. Patient advised to follow-up with PCP and/or the referred physician in the next 1-2 days. Usual and customary treatment and medications side effects/warnings were discussed. Patient/guardian demonstrates capacity to understand these instructions and verbalized understanding and agreement with the plan of care. Patient was seen and discussed with the attending physician, Dr. @ATTPROV@. Patient was discharged in stable condition.

*** - D/w ***
*** - D/w ***

Rationale for Hospitalization: ***

Patient/family were counseled at bedside, they verbalized understanding and agreement with the plan of care, and all questions were answered. Patient was seen and discussed with the attending physician, Dr. ***.

DISPOSITION DECISION TIME:
See ED Timeline

Electronically Signed By: @MELICENSE@ @TD@ @NOW@