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Internal Medicine Consult Template – Example + Tips for Success

Patient ID

- Age, gender, from where (home, retirement home, no fixed address) and with whom (alone, family)
- Presenting with…… Quick summary of what their symptoms are bringing them in. Don't always use the emergency department's diagnosis – some investigations might be missing and it might not be the correct diagnosis
- Example sentence: 65 year old female from home with husband presenting with a 2 week history of shortness of breath

Referring physician

- For billing purposes, write the ED doc's name in – *optional at Sunnybrook, necessary at UHN/Epic sites*

Past medical history/surgical history (often lumped together on GIM)

- Do not trust the last note to be complete! Go through ConnectingOntario and go through past physician notes. Try to find a past GIM consult note or ID/Geriatrics consult note, these usually have the most detail
- Try to put the medical conditions relevant to the presenting complaint higher up – ex: COPD in shortness of breath example above osteoporosis; CAD with prior CABG in chest pain above recurrent UTIs; etc.
- Try to find relevant details especially for the relevant PMHx points to the case. This is helpful to put in PMHx to have right upfront in the note and when presenting to say right away
    - Ex: COPD: who is the physician who follows them (Resp vs. Family doctor), what are their latest PFTs, have they ever been in the ICU for BiPAP/intubation
    - Ex. CHF: What is their most recent echo, ejection fraction, who are they followed by
    - Ex. Diabetes: What is their HbA1c, who follows them, how do they manage their diabetes (are they diet-controlled, on PO meds, on insulin, etc.)

Medications

- A current patient list is the best source of information. Ask the patient if they have a list, a blisterpack, or their bottles of their meds with them (sometimes patients bring them in bags)
- People over age 65 may have their medications listed on Connecting Ontario BUT look at the date the medications were filled – medications filled in 2022 are likely not being used right now
- Blister packed medications will usually be filled every 1 week. If using a blister pack, there may be additional medications that are NOT in the blister pack so don't forget these! (e.g. PRN pain meds, a Lasix sliding scale, prednisone taper, a new medication just prescribed, etc.)

- Try to put the source of where you got the medication information in the heading (ex: from Connecting Ontario, from patient's spouse, from patient's list)
- There are certain medications that need to be given overnight/caught up from the daytime as the ED didn't give them: Sinemet (for Parkinson's disease), atrial fibrillation rate/rhythm control agents (I have had a patient go into unstable AFib because I ordered the meds for the morning rather than ordering the meds to be given overnight to make up for the missed ones from the daytime), anti-seizure medications, Lasix, anticoagulation. There are likely many others, so use your discretion and when in doubt discuss with your senior and/or pharmacy if needed!

Allergies: Confirm the ones in the chart with the patient/caregiver

Social history:

- Who does the patient live with right now? If in a retirement home, do they have children/friends who support them?
- ADLs and iADLs – what is their level of independence? Do they have gait aids, do they drive?
- Smoking
- Alcohol
- Recreational drug use
- Are there designated POAs for healthcare and finance?
- Employment; if the patient is retired, what did they do prior (relevant for basic assessment of education/anticipated healthcare literacy, exposures/risk factors, stressors)
- For certain instances, where the patient was born is important, when they moved to Canada, how often they return to the country they were born in (ex: when concerned for TB)
- Goals of care: May choose to include this here under its own heading to make it obvious, then restate it under "Best Practices" in the assessment and plan. It is so important to at least initiate this conversation overnight, especially if the person is sick! Some people feel very strongly about their code status and are very well informed, and if you don't ask, you won't know! Patients and families may not be prepared to make a firm decision overnight and that's generally okay (unless they are very ill and an urgent decision is needed regarding palliation for example), but they should be informed that the default is Full Code and what that means.

Family History: Not always necessary but you can ask in relevant situations. Relevant when looking for early MI/early stroke, any rheumatological/endocrine condition, etc.

HPI

- Tell the story of why the patient decided to come in. If they were recommended to come in by another physician – ex. their family doctor or the Ophthalmology clinic, say that up front, and put that in the short patient ID at the top. It may be relevant to briefly

summarize a recent clinic visit or previous admission if it impacts the story of why they came in.
    - Ex: Patient had a recent long admission including >2mo in ICU for bad urosepsis, discharged home on oral antibiotics with a Foley in place, but now coming in with fevers and urinary symptoms, or maybe seen in ID clinic and found to have ongoing bacteremia so referred to ED.
- Try to tell things in a chronological order if possible, but always prioritize the most concerning sx – ex: chest pain, thunderclap headache
- List out the accompanying relevant symptoms up front: E.g. shoulder pain, diaphoresis, vomiting, shortness of breath, palpitations, leg swelling, PND, orthopnea with chest pain
    - OPQRST for each applicable sx. Relieving and aggravating factors, current tx being used
    - Did the pt miss any of their relevant meds?
- The last paragraph of the HPI should be a summary of what treatment has been done before this point – what did the ED doc give. Ex: Lasix 80mg IV x1 was given at 1900

Exam

- 1) Vitals: Most recent vitals first. If the patient has had abnormal vitals in their ED stay, ex fever, tachycardia, hypotension, list them and what time they were at. Usually recommend formatting as:
    - Triage:
    - Repeat:
- 2) General inspection: This is a general sense – does the patient look sick? Are they tachypneic, using accessory muscles? Do they have a tremor? Are they sweaty? Are they very disheveled/physically unkempt? Anything that you notice that is relevant
- 3) Neuro: This does not need to be a full thorough neuro exam unless relevant, but should include some basic information, e.g. level of alertness/consciousness, orientation, lack of asymmetry noted of face/limbs, moving all 4 limbs, etc.
- 4) Cardio: precordial exam, heaves/thrills, is the rhythm regular, fast (palpate the radial artery) - a normal exam would usually comment on normal S1, S2, no extra heart sounds, no murmurs, regular rhythm
    - JVP can be put in this section or can be put in a separate section labelled Volume
    - Peripheral exam: symmetry, edema (pitting/non-pitting), warmth, tenderness
- 5) Resp: Typically focus on inspection, auscultation – commenting on air entry and adventitious breath sounds
- 6) GI: inspection (in a cirrhosis exam you can comment on more findings), percussion, palpation, auscultation in the cases where you need to hear bowel sounds.
    - Put ascites exam/hepatosplenomegaly, Murphy's etc. as applicable here
- 7) +/- MSK, derm as fit for the case

Investigations:

- Early on, recommend writing out all investigations. Make sure to look through all tabs – biochem, micro, radiology, pathology if relevant etc. depending on the EMR
- If it helps you to remember, highlight, underline, or bold the things that are most relevant so you don't forget to bring them up on review
- When applicable, trend abnormal results, on the same EMR or on Connecting Ontario if there are no results on Epic/Sunnycare – example, is this anemia new? What is their baseline creatinine? Did they always have abnormal LFTs? In a patient with CKD with an elevated troponin (often seen in CKD) – is their troponin lower or higher than their baseline? Etc.

Assessment

- This is the most challenging piece and a big part of the learning in medical school and residency! There is an art to this section and many people do it differently. You will develop your own style. Your style may also change depending on the specific case and type of consult you are doing
- Always start with a summary and put the patient's (abbreviated) past medical history and presenting complaint, ex: "65 year old female with a history of COPD presenting with a 2 week history of shortness of breath"
- Then, try to put in the pieces of the investigations/physical exam/other history points that are relevant and help to build the story. Ex: "Investigations reveal an elevated BNP and pulmonary edema on chest xray. On exam, she has bilateral peripheral edema and an elevated JVP. Other findings include an acute on chronic AKI and microcytic anemia"
- You can put in the primary paragraph what the leading differential diagnosis is and the possible cause. You can also put that in the plan section below under each action item

Plan

- Divide up each concern that needs to be addressed in the patient's presentation and number them. Try to be objective in labelling things and then providing a differential for the problem.
- Consider the following structure for each issue:
    - Differential + rationale for most likely cause(s)
    - Investigations
    - Management
    - +/- contingency planning
- You can also consider the following framework: Causes, Complications, Comorbidities (i.e. how does this interact with their other health problems, or are there other associated conditions which may be included in the same issue or become their own issue)
- Ex:

1. Shortness of breath
    - Leading differential diagnosis is congestive heart failure (no recent echocardiogram) given constellation of lab and physical exam findings.

        - In the case of heart failure – you always need to think of the trigger of the heart failure ("Causes") in a patient who has existing heart failure. This patient has new heart failure so the cause needs to be worked up (many possible differentials for this such as myocardial ischemia, tachycardia in the case of a pt with AFib, valve issues, metabolic stress, etc.)
    - Other differentials include worsening COPD, infection, etc….
    - Investigations: list out all the pending investigations that you have ordered, Echocardiogram, blood culture…
    - Management: Trial of Lasix 40mg IV x1 now then reassess in the AM
    - Contingency planning: Low threshold for consulting ICU for possible BiPAP if worsens clinically and consider an additional dose of Lasix overnight

2. Acute on chronic kidney injury

- Patient's Creatinine on admission was 210 on a background of 110. Leading differential cause is cardiorenal given volume overload on exam.
- Investigations: urinalysis, urine lytes, bladder ultrasound…. Etc
- Management: monitor urine output, continue to trend Cr, no specific management beyond diuresis overnight

3. Anemia

- Same thing as above, list out what you think the leading cause might be, the differential, and investigations you've ordered

Go through and list all the issues and follow a similar format.

The last section to include is Housekeeping/Best Practices which is a series of things to think about for each patient that is more miscellaneous:

Housekeeping/Best Practices:

- Diet: heart healthy diet, fluid restricted <1500, any dietary restrictions – lactose free, allergies, etc….
- Activity: "as tolerated" is when there are no restrictions (You may see the shortform AAT). Consider if the patient has restrictions, ex: Does the patient have a broken leg and should not be weight bearing?
- DVT prophylaxis: Is the patient on standard Enoxaparin 40mg sc QHS? Are they on a blood thinner at home – Apixaban 5mg po BID? Think about SHOULD they be on a blood thinner. Are they ambulatory? Are they bleeding? Are you considering a scope for GI bleed and should hold the patient's apixaban? Considering a liver biopsy/any type of biopsy? Think about how soon this can happen and whether you should hold this starting now
- Family contacts: Ex: Daughter/POA Personal Care Karen can be reached at _____
- Put who formal SDM/POA in this section for easy access
- Consider including the patient's language of preference if this is different than English

- Disposition: can say on admission TBD if you're not sure. If the person is young and healthy you can say with more certainty "home when well".
- Allied health supports: who have you already consulted vs. who will you need to consult. Ex: PT/OT have been consulted, consult Dietician on Monday AM as patient has been losing weight
- CODE STATUS!! Difficult to get used to filling out but important to at least initiate this conversation overnight. Sometimes the patient gets admitted and the conversation never happens. It would be terrible if a patient were to code and they are DNR/DNI but no one knows, then a code will be run on them which is against their actual wishes. It is also helpful to introduce the topic overnight, so that a patient and their family can think about how they wish to proceed with their care and this can be followed up with the team in the morning.
    - Consider saying one of the following:
        - "Sometimes when people are in hospital, even if they aren't very sick, bad things can happen suddenly like the heart or the lungs stop working. Have you ever thought about what you might want your doctors to do for you in that situation?"
        - "Whenever someone comes into hospital, it is mandatory that we discuss with them about their Code Status. Is that something you have heard of or talked about before?"
    - You can use these prompts to see if they have strong feelings about their code status and to open an educational conversation about life support measures like CPR, intubation, ICU, etc. even if they aren't ready to make a firm decision or they are Full Code
    - Speak with your senior if you have any concerns about how to approach these conversations, as they can be very challenging and take practice!

- Finally, sign your name, who you reviewed with, and who your staff is, Ex.:
    - Alessandra Ceccacci IM R1, reviewed with Dr. Yang, R2/SMR, for Dr. Shumak (Red Team GIM)