

Guidelines for ED Notes

1. Chief complaint
2. Identifying data
3. HPI
4. PMHx/PSHx
5. Allergies
6. Meds
7. SocHx
8. Family history
9. ROS (ok to have pertinent positives and negatives, followed by the statement “all other systems were reviewed and were negative)
10. VS
11. PE (only need to include detail where it is pertinent. In general, it is a good idea not to say things like “nonfocal”, “normal”, or “within normal limits”. For example, if you have a patient with abdominal pain and you did not do a full neuro exam but the patient seems grossly intact, don’t say “grossly intact”. Include specifics about what you do know, such as “Alert and oriented x3. Pupils equal. Normal gait.”
12. Assessment:
 - a. define the acute problem (e.g. This is a 63 yo male with a history of CAD presenting with stuttering CP of 3 days duration.)
 - b. list a differential diagnosis (need not be very broad)
 - c. pick your one or two most likely diagnoses and support why you think these are likely
13. Plan:
 - a. tests ordered
 - b. specific plans if the key tests are positive or negative (for example, we will do an ECG and if he is having a STEMI, call a STEMI alert, if there are no ECG changes, we will order a troponin)
 - c. if the plan includes discharge, need to plan for follow up.
14. Test results
15. Reassessment note: After the results were back, what decision did you make regarding patient disposition? Admit? Discharge and follow up? ALL ED patients should get follow up with someone. This part of the note can be narrative and will vary greatly depending on the patient.