**General Surgery Rotation Guidelines for Junior Residents**

Welcome to the General Surgery rotation! You will be busy and work hard but we hope you find the rotation as fun, challenging and rewarding as we do.

**BEFORE YOUR ROTATION**

* Get in touch with your senior resident the week before to exchange contact information and to know where and when to meet with the team on Tuesday morning.
* Remind your team of any exam, appointments or vacations for your rotation.
* Let your team know what are the specific objectives you want to achieve
* Make sure you have your red dot. Go down to the OR and talk to the Clinical Educator to book a session PRIOR to starting your rotation.
* Make sure you have a dictation code, access to scrubs, as well as computer, PCS, EntryPoint, Connecting Ontario and Wellsoft login. It is also imperative that you know your KHSC email login is as this is how you will receive important patient handover.

Your call schedule/team assignments should be emailed to you by the beginning of the rotation by Sierra Slegtenhorst at KGH ext. 6590. Contact Sierra at [sierra.slegtenhorst@kingstonhsc.ca](mailto:sierra.slegtenhorst@kingstonhsc.ca) to confirm we have your current e-mail address to ensure you are receiving this information.

You will not be on call more than 2 weekends during a 4 week block rotation. You will have a maximum of 1 in 4 overnight call consistent with PARO guidelines, Up to one (1) week of vacation may be requested for each block rotation. Vacations/lieu days are granted on a first come/first serve basis depending on service coverage requirements.

**JUNIOR RESPONSIBILITIES**

* Reminding your senior of exams/lieu days/appointments before the rotation and at the end of each week to help them plan the next week schedule
* Getting morning handover from the junior on call before AM rounds
* AM rounding with senior
* Helping senior to stay up to date with morbidity/mortality information
* Discharging patients
* Following up on investigations/consults during the day
* Attending clinics/ORs
* Seeing consults and attending all traumas while on call or Team 4
* Handing over (at least verbally) every evening at 17:00 to the junior on call
* Attending Wednesday discharge planning rounds (around 11:00 AM on Kidd6, you will be notified of exact time the day off)
* Teaching medical students
* If on Team 1: getting cases ready for Thursday AM teaching (ask senior about it)

**\*\*When your senior is in the OR\*\*** and you need to talk to them about anything, from a concern you have to a consult you need to review, walk up to the OR and talk to them.

**STRUCTURE**

There are seven general surgery teams and you will be associated with one of them:

For each service block, you will be assigned to one general surgery team (see below). You will ideally send the majority of your time with this team. You may be assigned to the acute care service (Team 4) for one week and you may be asked to help on another team if coverage is needed. There are no scheduled clinics for team 4. However, you will see acute care surgery consults (appendicitis,cholecystitis,SBOs etc) and assist in the OR.

**Team 1 (Colorectal)** -

Dr. P.H. Macdonald – Service Chief (Colorectal)

Dr. S. Patel (Colorectal)

Dr. A. Caycedo (Colorectal)

**Team 2 (HPB)** -

Dr. D. Jalink – Service Chief (Hepatopancreaticobiliary)

Dr. S. Bennett (Hepatopancreaticobiliary)

Dr. S. Nanji (Hepatopancreaticobiliary)

**Team 3 (Oncology/Pediatrics)** –

Dr. S. Merchant – Service Chief (Surgical Oncology)

Dr. G. R. Walker (Breast, Endocrine)

Dr. J. Engel (Breast, Surgical Oncology)

Dr. A. Winthrop (Pediatric)

Dr. M. Kolar (Pediatric)

**Team 4 - Acute Care** **Service** (rotating staff person)

**Team 5 (Thoracics)** –

Dr. K. Reid – Service Chief (Thoracics)

Dr. W. Chung (Thoracics)

**Team 6 (Bariatric)** –

Dr. B. Zevin – Service Chief (Bariatric)

Dr. D. Robertson (Bariatric)

Dr. P. Szasz (Bariatric)

**Team 7 (Head & Neck Oncology and Otolaryngology)** -

Dr. T. Phillips – Service Chief (Head & Neck Oncology)

Dr. J. Franklin (Head & Neck Oncology)

Dr. N. Cohen (Head & Neck Oncology and Otolaryngology)

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| Location | Description |
| Kidd 1 | Emergency Department  Radiology Department  Endoscopy Suite  Ambulatory Treatment Unit (across from ED) |
| Kidd 2 | Kidd 2 ICU (patients managed by ICU team)  Operating Rooms |
| Kidd 3 | Thoracic Surgery |
| Davies 4 ICU | Step Down ICU (patients managed by individual services) |
| Davies 5 | Surgical Short Stay Unit |
| Kidd 6 | General Surgery |
| Connell 6 | Call rooms |
| Burr 2 | Paloschi Teaching Room (Wednesday AM teaching)  General Surgery Attending Offices |
| Victory 3 | Dr. Jones (Program Director)  Sierra Slegtenhorst (Postgraduate Program Coordinator) |

Map of KGH: <http://www.kgh.on.ca/en/patientsandvisitors/Documents/KGH%20Level1%20Map%20with%20Directory_English_Final%2020150527.pdf>

Other important resources:

Don’t forget that KHSC is a teaching hospital. Being a good doctor starts with knowing your limits. There are always people willing to help you and give you advice. Don’t be scared to ask other services for help. ICU and anesthesia are also in house. Also remember there are always staff physicians present in the Emergency Department.

Charge Nurses - Kidd 6: Erin Lowry is a very approachable individual and an excellent resource for ward issues. Be sure to introduce yourself to her on the first day of your rotation.

RACE team - don’t be scared to touch base with the race nurse if you are worried about a patient. The race team consists of an ICU nurse and a respiratory therapist. They are linked to an ICU or ER doctor who can provide excellent advice. Do your best to contact your senior first. Most issues were seen several times by your senior already!

CCAC (Community Care Access Team) - There are specific forms depending on the care requested. Case Manager who is assigned to the service will assess eligibility for admission for in-home healthcare and support services. Remember, all patients with a new stoma, home IV antibiotics or wound packing will require a CCAC referral, try to plan ahead and submit the online forms 1-2 days prior to discharge.

Physiotherapy - includes both chest assessment and care, and mobilization, progressing from day 1 post-op to discharge. To consult them a yellow consult sheet must be filled and an order placed in the chart.

Occupational Therapy - assesses and provides interventions related to 1.Activities of daily living 2.Home safety including kitchen safety 3.Cognition 4.Wheelchair seating and mobility 5.Pressure redistribution 6. Splinting and Collars. To consult them a yellow consult sheet must be filled and an order placed in the chart.

Dietitian - consult for nutritional assessment, development and recommendations for nutrition care plan for high-risk patients (i.e. malnutrition or patients at risk for malnutrition, tube feeding, TPN etc.) In patients who need TPN, orders must be co-signed at noon. To consult them a yellow consult sheet must be filled and an order placed in the chart.

Social Work - assists patients and their families to cope with the personal and environmental stresses associated with illness, trauma and hospitalization, as well as facilitating the discharge planning process. Interventions include patient education, counseling, treatment planning, vocational rehabilitation and marital and other family concerns. To consult them a yellow consult sheet must be filled and an order placed in the chart.

Pharmacy – Our pharmacist is available to consult with physicians to search current and replacement medications and to make suggestions therefore. Bonnie Ralph on pager 536-7615.

ET (Enterostomal Therapy) – manage stoma care, special wound care (e.g. vac dressing) and specialty beds. To consult them a yellow consult sheet must be filled and an order placed in the chart.

NB: Unit clerks can call in consults for the above services.

One of the most important parts of being a good junior resident is attempting to problem solve. If you don’t know an answer, attempt to solve it prior to asking your senior.

**TEACHING**

The General Surgery academic half-day is Wednesday morning in the Burr 2 Paloschi Conference Room. Ward rounds need to be completed by 07:00 when teaching starts.

The Academic Schedule can be found at the following link: https://docs.google.com/spreadsheets/d/1QJwZKAdiWrD\_yjq7CfXqzLzL\_Yl3mw72-j8K1uPOC7s/edit?usp=sharing

Trauma Rounds occur at 07:30 on the last Wednesday of each month during the academic year and the General Surgery Academic Half-day follows. Team 2 has service specific teaching on Monday morning 08:30-10:30 in Burr 2 Paloschi Conference Room.

**EVALUATIONS**

* Two different types of daily written evaluations are available: clinic and OR. The evaluation forms are available in clinics and most OR and OR lounges. You have to make sure to have at least 2 evaluations filled every week. There are drop boxes in the OR lounges or you can bring them directly to Nicole or Kim.
* **If you are a surgical resident,** do not forget to enter all procedures including scoping, trauma (when TTL) and OR activities in your E-Logbook. This is crucial to apply for fellowships and jobs. There is a T-Res app available for your smartphone. If you use the app, synchronize your activities often to avoid losing data.

A Resident evaluation meeting takes place at the end of each rotation. The Faculty, Chief Residents and the Charge Nurse from Kidd 6 participate in this evaluation meeting. Contact the Service Chief’s secretary to make an appointment with the Service Chief before the end of your rotation to receive your evaluation.

You will have the opportunity to evaluate us through MedTech as well. Feed back to the services and attending staff is not released until there are a significant number of evaluations, so that no individual respondent can be identified.

**ROUNDING**

* You will round with the senior/chief resident on your service each morning. They will set a time for you and your team. We usually start on Kidd 6.
* First, get overnight handover from the junior who was on call the night before
* The clerks should have the bloodwork ready (i.e. written on little stickers) and lists printed. However, you should still arrive ~ 5 - 10 mins before rounding time to check up on things that might have been missed by the clerks (e.g. chest X-rays, cultures, etc.)
  + Bloodwork is usually only not all back when we start rounding as phlebotomists start drawing blood at 6 AM. You should follow-up on bloodwork after rounds including correcting electrolytes, follow up cultures and change antibiotics as appropriate.
* Help the senior resident keep track of mortalities and morbidities (wound infection, UTI, pneumonia, abscess, etc).
* You will round as a team. The senior resident will read the vitals, check outputs, etc. They will be responsible for talking to the patient and examining the patient as well. The clerk and you alternate at scribing what the patient says and what is found on exam. Write legible and pertinent progress notes (see last page for example). If you have ideas regarding the patient care please speak up!
* IF you are not the person performing the physical examination, make sure to specify: physical examination performed by Dr. X. and get the resident in question to co-sign your note.
* It is during this point that the junior resident should check what should be optimized (e.g. DVT prophylaxis, involving physiotherapy when needed, are there lines/foley caths that need to be pulled out?)
* After seeing the patient, you will need to co-sign the orders the clerks have written (as per the senior resident). Check to make sure the orders are written properly (guess who gets called when the orders are wrong/unclear!).
* TIPS TO ENSURE EFFICIENT ROUNDING: Have your clerks carry a few forms with them (e.g. X-ray reqs, yellow consult sheets, CCAC requisitions).
* Have DC summaries for those being discharged completed

**DISCHARGING PATIENTS**

Discharge Rounds: every Wednesday after teaching, there are multidisciplinary discharge rounds in the conference room on Kidd6, at 1100. A resident from the team should be present. It is important that the person who attends these rounds have a clear understanding of the patient’s medical conditions and concerns regarding discharge difficulties for each of the patients on your service for this meeting. Discuss the issues brought up at these rounds with your senior.

One of your main responsibilities as a junior resident will be to discharge patients:

* Make sure you write complete discharge orders on the green order sheet (see example at the end of the document). ***The patient is responsible to make an appointment with his own family doctor.***
* Before a patient is discharged, they will need a printed discharge summary. These are done on PCS.
  + When preparing a discharge summary, make sure to fill all tabs. Best resources to get pertinent info: yellow consult sheet, clinic (including preop clinic) note, operative note, progress notes. If a medical student filled it, use it as a teaching tool and give the student feedback on it. Make sure the family doctor and the attending doctor is listed to receive a copy of the summary (last tab).
  + After verifying the MAR, provide patient with a script for the appropriate pain medication (e.g. Morphine 5mg 10(ten) tabs), stool softener and any new medication changed or started during the hospital stay (e.g. patient seen by Cardiology, Metoprolol increased). When appropriate, prescribe antibiotics.
  + The most important part of the discharge summary is the “instructions to the patient”. The senior usually mentions them to the patient during rounds. It should be transcribed in the discharge summary. It should include reminder about follow-up, restrictions, what to do with dressing/staples, when to seek medical help. If you are not sure about what to write, look at a day surgery discharge sheet. You can also clarify the instructions with your senior.
* Make sure you click “Save Complete” once you are done the discharge summary. “Save partial” if you would like to save the changes but keep working on it at a later time. If you were a med student at Queen’s, you might need to call ITS to ensure you have this option. Print, sign the script (with your CPSO number of course) and put it with the chart. Don’t forget LU codes! C’est tout!
* \* If a patient passes away, a discharge summary still needs to be completed; ensure that you specift this in the discharge summary.

**Ensure that the clerks are updating discharge summaries throughout the rotation. Also, if a patient has an anticipated discharge date in the next few days make sure everything is up-to-date. Completing discharge summaries the morning of discharge delays patient discharge and causes STRESS trying to get everything done prior to clinic/OR.**

**CLINICS/ORs**

* During the day, your senior will send you to the OR/clinics. Ideally, you will be informed of what clinic/OR you will be going to beforehand so that you can prepare. You can ask your senior where you will be going.
* Most clinics are at HDH J5 (except Peds clinic in COPC and some of Dr. Engel’s clinics are at the Cancer Center) and most of them start at 8 am or 1 pm. Verify where it is and what time it starts at in PCS. Be on time. There is a shuttle between the two hospitals. . HDH is a 15 min walk!
* Always bring “clinic-appropriate” clothes. We try to let you know in advance where you will be going, but sometimes there are last minute changes. Remember – no scrubs outside of the hospital!
* In clinics, you will be responsible to dictate a clinic note. Instruction sheets are available from Medical Transcription (Kidd 1, across from the Radiology Department). Instructions are also posted in the team rooms where you will be dictating.

The weekly schedule can be found in the following link: <https://docs.google.com/spreadsheets/d/1LZpmtl0kVyfAfBBMYdhieXUA9cl67FO_bu0R5_ZWIzA/edit#gid=985716725>

**IN THE OR**

* OR starts at 7:45 (except on Wednesday, 8:15). Try to be there on time for the brief. It is a security check with the whole team and the patient. Introduce yourself to the team members
* Write your name, status (ex R1) and glove size on the white board
* Ask the OR nurse to coach you at inserting Foleys! It’s your best chance to practice
* While the anesthesia team is getting the patient ready, write the postoperative orders. If the medical student wrote them, review them and give the student feedback.
* Make sure with your team members that it is appropriate for you to scrub - give your gloves and gown to the scrub nurse if it is. When scrubbing, the gowning order is done by seniority. When the patient is getting draped, if you are not actively participating in the draping, stay close to a sterile tray to avoid getting contaminated. We will let you know where to stand around the patient when the sterile drapes are installed.

**ANSWERING PAGES**

* During the day, you will be answering pages from the nurses regarding your patients. These pages will range from “We need a Tylenol order” to “We’ve called RACE on your patient”. Make sure you answer them in a timely fashion.
* Touch base with your senior for any question or if there is an unstable patient. If there is any concern, make sure to always physically assess the patient and write a note in the progress note.
* If you are scrubbing in a case, make sure you leave your pager on the OR room desk and kindly remind the circulating nurse to return your page if you hear it go off.
* When you are on team 4 you will also carry the trauma pager. If there is a trauma activation let your senior know as again YOU are carrying the pager, switchboard does not automatically activate the senior.

TIP: try to contact the wards before a big OR case or a Trauma to let them know you will be busy. Make sure to call them afterwards! Also, to decrease the amount of pages, you can set up a time where you go up to every floor to deal with non-urgent issues (often around 11pm).

**TEAM 4 - ACUTE CARE SERVICE (DAYTIME)**

* If you are on the acute care service (Team 4), you will be responsible for covering all traumas and consults from the Emergency Department (Thoracic, Pediatric Surgery and General Surgery).
* All consults (inpatient and Emerg) go through to the GenSurg consult pager, which will be carried by the senior/chief resident on team 4. They will distribute the consults between the junior resident and the medical students. If you are paged regarding a consult, please direct the page to your senior
* There is an MSAP clinic on Thursday’s at 1300 in Armstrong 4
* ORs will occur through varying times during the week depending on emergency OR availability

**ON-CALL**

* Junior call is in-hospital call
* NG insertion is a very common task for the junior resident: if you are unfamiliar with it, ask your senior to coach you through one. Don’t forget to ask for a portable CXR to confirm NG tube placements
* While on call, you will be the first call for all the general surgery patients. Every night at 5 pm, you should receive handover from the other junior residents (or the senior resident if the junior is post call) regarding issues to follow-up with at night. On the weekend, the junior on call the night before will give you handover and the trauma pager before you start rounding. The residents rounding on the other teams should give you handover before they leave the hospital.
* Print a list of each team and write notes/to do lists. It’s the only way to keep track and give appropriate handover the next day.
* You will also be carrying the trauma pager and completing consults from the ED.

**All consults** should be triaged by the senior resident on call, who will assign them appropriately. This is similar to consults during the day.

**Calls from other hospitals**: should be directed to the attending. Only the attending can accept patients from other centers. However, HDH ER functions as an extension of KGH ER.

**Patient admitted directly to our service:** need a history and physical as well admission orders on every chart. If they are pre-op, make sure you prep them for the OR with NPO IV orders, appropriate blood work, investigations and consults. You can put in the admission orders right away, but review them with your senior as if they were consults. Unfortunately these transfers can show up on the floor in the middle of the night and can sometimes have scarce documentation. Connecting Ontario is a valuable resource to help sort out these transfer patients.

**Getting urgent imaging** this section only applies for IVR, CT, MRI, and ultrasounds. It does not apply to portable X-rays.

* If a patient needs urgent imaging (e.g. CT or US), you will need to fill out a requisition as you would during a normal day. However, you will need to get in touch with
  + Day: the radiology attending responsible of that specific imaging modality (ie. CT abdomen and pelvis; contact the staff on for CT Body)
  + Evening and weekend: the radiology resident on call. You can page him/her or go down to the radiology department. They will often be in the back room reading scans. You will have to discuss with them why you think this needs to happen in a timely fashion.

Then you should walk the req back to the imaging suite or office as per what the radiology staff says

**Booking an OR case**

* After a patient is admitted and consented for surgery, you may be asked to book the case. This involves going up to the OR front desk and filling out an emergency booking form. You will need to bring up a patient’s sticker.

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| Case | To be done within | Example Cases |
| A Case | Immediately | Unstable perforated viscus |
| B Case | 2-8 hours | Appendicitis |
| C Case | 8-24 hours | Cholecystitis |

* You will touch base with both the charge nurse (7070) and the anesthesiologist on call (7071). When you call the anesthesiologist, you will be responsible for communicating the major comorbidities and any other concerns there might be during the surgery (e.g. they are a smoker, they have one kidney).
* After you have done both of these tasks, you will hand the form to the clerk at the front desk who will then put the patient on the electronic board.

TIPS:

* You may be asked to get an anesthesia consult. During the night or the weekend, you won’t have to do anything besides talking to 7071. However, during the weekday, you will have to phone in a consult to the anesthesia consult line.
* If you are unsure of the urgency of the case, talk to your senior resident. “A” and “B” cases will go first even if it is late at night. If you book an “A” or a “B”, verify when you talk to the charge nurse (7070) if you or your attending need to talk to another service who was supposed to operate and got “bumped” by your case.
* You should not be asked to consent a patient for surgery unless you are confident that you can outline the surgical procedure, details, alternatives, and all of the necessary intraoperative and post-operative risks. If this is not the case, please identify this to your senior who will be happy to help.

**TRAUMA**

* Every morning, there is a trauma test page through the trauma pager. Call back switch board to confirm you received the page (Dial 4444).
* When there is a trauma, you will receive a page on the trauma pager. It usually specifies when the trauma will arrive or if it is already here. Call back switch board to confirm. Let your senior know a trauma is coming.
* Got down to Section A at least 5 minutes before the planned time of arrival. Introduce yourself to the trauma team captain and the trauma team leader in charge of the future trauma and get more information on the future patient. Let your senior know as soon as you have information on the patient.
* When the trauma arrives:
  + Put gloves and gown on. Wear a mask with shield in case of penetrating chest trauma.
  + The patient is usually brought to A 1, 2 or 3
  + There will be a trauma team captain (usually a senior EM or GS resident) in charge of the trauma. There is always an attending present. They will tell you when it is your turn to assess the patient (usually right after Anesthesia assess the airways)
  + You will examine the chest, abdomen and pelvis (including ruling out blood at the urethra and genital trauma) and report your findings loud and clear to the trauma team leader
  + The trauma team leader or senior general surgery resident will often do a bedside FAST ultrasound of the abdomen. Discuss the result with them
  + The other services will do their own assessments. Stay in the room and available to help (e.g. to turn the patient)
  + If the patient seems to have thoracic or abdominal injuries, call your senior (if you have not done it yet!). Follow the patient to CT scan and immediately review the images with the radiology resident.
  + If the patient does NOT seem to have thoracic or abdominal injuries, and you are very busy with other consults, ask the trauma team leader to be excused of following the patient to CT scan. Tell them to touch base with you if imaging reveals anything that should be reassessed by our team. Regardless, you should always F/U the result of the imaging to complete your Trauma consult sheet.
  + Fill the General Surgery Trauma consult sheet. Review with your senior.

**CONSULTS IN THE ED**

* **All consults from the ED should go to the senior first to be triaged**. If you get consults trough your personal pager or the trauma pager, redirect them to the senior. Always let your senior know you got called for a consult. Alternatively if you get approached by a staff in the ER regarding a consult, please direct them to the senior.
* If a clinical clerk was sent to see the patient first, you will likely have to review the consult with them. Give the clerk a brief timeline to ensure the consult gets done within an appropriate time (usually 30 mins). If you are not busy with other stuff, try to look up some of the patient’s past medical history/review imaging while your clerk is doing the consult. If the patient is a direct consult to surgery, you might want to order bloodwork/imaging BEFORE your clerk sees the patient, or simply see the patient with the clerk. This will save you time.
* After you review the consult with your clerk, go see the patient. See if anything additional is required for the consult. If you are satisfied, review the patient with your senior resident.
* If you are admitting the patient, use the standardized admission order package for surgery (EntryPoint). Make sure you put parameters for blood pressure medications, oral hypoglycemic meds (including eating/non eating insulin sliding scales for ALL diabetic patients) and verify with your senior if you are unsure which medication to hold (e.g. Plavix, ASA, Coumadin…)
* If the patient is being admitted to D4-ICU, you fill out the D4 admission orders, not the regular surgery admission orders (The order set is critical care for patients not requiring invasive ventilation).
* For patents who are discharged home, a consult note will need to be dictated. This will likely be done by your senior but check to see if they would prefer you to do it. Simply call the dictation line and use the work type “4” and then when finished press “6” to expedite the transcription.

TIPS: When completing a consult, fill out the **back page of the “yellow” sheet**. Photocopy a sheet to carry with you for handover.

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| ***EXAMPLE OF A PROGRESS NOTE*** |
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| *Date, time General Surgery – Postop day 2 cholecystectomy* |
| *S – Patient’s pain well controlled with oral medication, passing flatus, no BM yet, tolerating a regular diet, ambulating on his own. Denies chest pain or SOB.* |
| *O- 145/82 HR75 RR16 Sat 97% RA Tmax (24hr) 36.8C* |
| *(Also where you would put JP, NG or Foley output/24hr. Each output needs to be noted separately)*  *Physical examination performed by Dr. Ko PGY3* |
| *Abdomen soft non tender, BS present 4Q. Incisions clean and dry* |
| *A – 47 male postop day 2 cholecystectomy – stable and ready to go home* |
| *P – Discharge home today.* |
| *Follow up with Dr Engel In 4 to 6 weeks.* |
| *No lifting over 10 lbs for the next 6 weeks.* |
| *Follow up with family physician in 1 to 2 weeks (if something specific to follow up on or staples to remove, don’t forget to say it!)* |
| *Come back to Emergency if experience fever, nausea, vomiting, worsening abdominal pain or purulent discharge from wounds.* |
| *Signature, R1*  *Dr. Ko PGY3* |
| ***EXAMPLE OF DISCHARGE ORDERS*** |
| *Date, time* |
| * *D/C home* |
| * *D/C IV* |
| * *F/U with Dr Engel In 4 to 6 weeks* |
| * *Script and D/C summary on chart* |
| * *Staple remover to go (if appropriate)*   *Signature, R1* |

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| ***EXAMPLE OF A DISCHARGE SUMMARY*** |
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| ***COURSE*** |
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| *Mr. Jones is a 24 year old male who presented to KGH emergency department with a history, physical, and ultrasound consistent with appendicitis. He was admitted to the General Surgery service.* |
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| *Mr. Jones underwent a laparoscopic appendectomy on July 1, 2015. The appendix was perforated. He tolerated the procedure well and was transferred to the General Surgery ward in stable condition. Post-operatively, he remained on IV antibiotics. He was transitioned to oral antibiotics when his white count has normalized.* |
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| *He was discharged home on July 3, 2015 in stable condition. At the time of discharge, he was ambulating well, tolerating a regular diet, and his pain was well controlled with oral analgesics. He will follow-up with Dr. Engel in 4-6 weeks.* |
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| ***PRESCRIPTIONS*** |
| *Ciprofloxacin 500 mg PO BID. M: 10 days LU Code: 336* |
| *Flagyl 500 mg PO BID. M: 10 days* |
| *Morphine 5mg. 1 – 2 Tabs PO q4h prn M: (30) Thirty Tabs. No repeats.* |
| *Colace 100 mg PO BID M: 2 weeks.*  *Signature, R1*  *CPSO #* |
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| ***INSTRUCTIONS*** |
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| *1) Please seek medical attention if you have fevers, chills, or concerns regarding your wound. 2) Do not drive or operate heavy machinery while taking narcotic medication. 3) No heavy lifting more than 10 lbs for four weeks. 4) You have dissolvable stitches. There are little tapes over your wound that will fall off in 7 - 10 days. (OR You have staples. Please see your family doctor to remove your staples on postop day 10-14) 5) You will have a follow-up appointment with Dr. Engel in 4-6 weeks. You will be contacted for an appointment. 6) Please make an appointment with your family doctor in 1-2 weeks for routine care (OR please see your family doctor to have your staples removed.)* |
| *7) Please complete your course of antibiotics. Do not drink alcohol while you are taking Flagyl as it may cause vomiting.* |

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| ***EXAMPLE OF ADMISSION ORDERS*** |
| * *Date, time Allergies : Penicillin (mouth swelling)* |
| * *Admit to General Surgery team 1 – Dr.Robertson.* |
| * *Dx: Small Bowel Obstruction* |
| * *NPO (meds with sips and ice chips for comfort)* |
| * *AAT* |
| * *Vitals q4h x 24 hours + PRN, then vitals qshift and PRN.* |
| * *CBC, lytes, creat daily x 3* |
| * *IV RL @ 100 cc/hr* |
| * *NG placement to be confirmed by X-ray.* * *NG to low wall suction* * *NG replacements with 1:1 IV NS + 20MEQ KCL* |
| *Signature, cc3*  *Co-sign \_\_\_\_\_ R1* |

**EXAMPLE OF A CONSULT NOTE**

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| --- | --- |
| **ID**: 40 y/o F  **RFR**: ?cholecystitis  **HPI**: 8 hour history of constant right upper quadrant pain. + nausea, - vomiting, + fever. Described as 7-8/10 pain. No relief with oral analgesics. Has had 3 previous episodes of RUQ pain in past. Family doc has performed U/S showing gallstones. Awaiting outpatient surgical consultation. | **PMHx**: Hypercholestermia  **Meds**: Crestor 10 mg PO Daily  **Allergies**: Penicillin (unknown reaction), no food, no latex allergies.  **PSx**: C- section  **FHx**: mother and sister have both had cholecystectomy  **Social history**: Works as a secretary at Empire life. Lifetime non-smoker. Social EtOH. |
| **O/E**: 120/80, HR 85, 98% on RA, T37.0  Overweight female. Appears uncomfortable. Non-toxic.  Normal Heart Sounds. Lungs clear.  Abdomen soft, non-distended. Previous C-section scar. Tender in RUQ with a positive Murphy’s sign.  **Ix**: WBC: 11.0 no left shift. Hgb 130, Platelets 300. Electrolytes normal  AST 50, ALT 50, ALP 110, Bili 12, Lipase 30  **U/S**: distended gallbladder, positive sonographic murphy’s sign, thickened gallbladder wall, pericholecystic fluid,  No intrahepatic or extrahepatic duct dilataion.  **IMPRESSION**: Cholecystitis. Ddx: biliary colic (unlikely given ultrasound findings) and choledocholithasis (normal bilirubin and no duct diltation)  **PLAN**:  1) Admit to General Surgery – Dr. Jalink.  2) NPO, IV fluids  3) Book for Laparoscopic Cholecystectomy  4) Will discuss with senior resident and attending  John Dorian, R1, July 1, 2015 0800 hrs | |

**Common Medication Orders**

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| Pain | |  |
| Tylenol 650 mg PO q4hr PRN (max 4gr/day) | | |
| Morphine 5-10 mg PO q4hr PRN  Morphine 2.5-5 mg SC q2hr PRN (BT)  Or | | |
| Dilaudid 1-2 mg PO q4hr PRN  Dilaudid 0.5-1 mg SC q2hr PRN (BT) | | |
| Antibiotics | |
| Ceftriaxone 1gr IV q24hr | | |
| Flagyl 500mg PO/IV q12hr | | |
| Ciprofloxacin 500 mg PO/IV q12hr | | |
| Pip Tazo 3.375g IV q6hr | | |
| Antiemetics | |
| Gravol 25-50 mg PO/IV q6hr PRN | | |
| Ondansetron 4-8 mg PO/IV q8hr PRN | | |
| Stemetil 5-10 mg PO/IV q8hr PRN | | |
| Stool Softeners | |
|  | |
| Senokot 17.2mg PO qHS PRN (stimulant, do not give if small bowel obstruction) | |
| Milk of Magnesia 15-30cc PO BID PRN | |
| Lactulose15-30cc PO BID PRN | |
| PEG3350 17g PO daily PRN | |
| Glycerine suppository PR daily PRN | |
| Bisacodyl 10mg PO or 1 suppository PR daily PRN (stimulant, do not give if SBO) | |
| Other common meds | | |
| Heparin 5000U sc q12hr ( often if have epidural in situ)  OR  Dalteparin 5000U sc q24hr | | |
| Ranitidine 50mg IV or 150mg PO q12hr PRN | | |
| Pantoloc 40mg PO/IV daily | | |
| Zopiclone 7.5mg PO qHS PRN | | |