Patient Workup Process

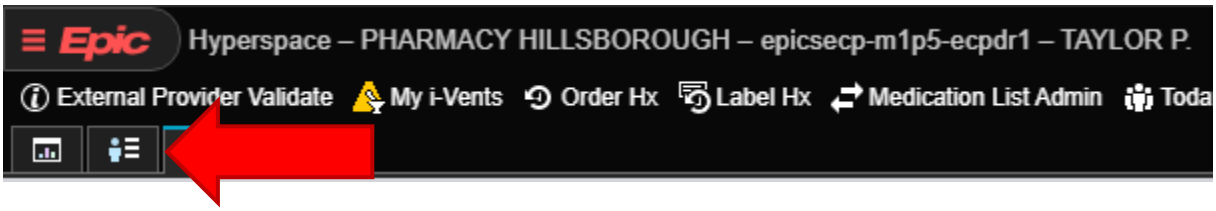
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Objective

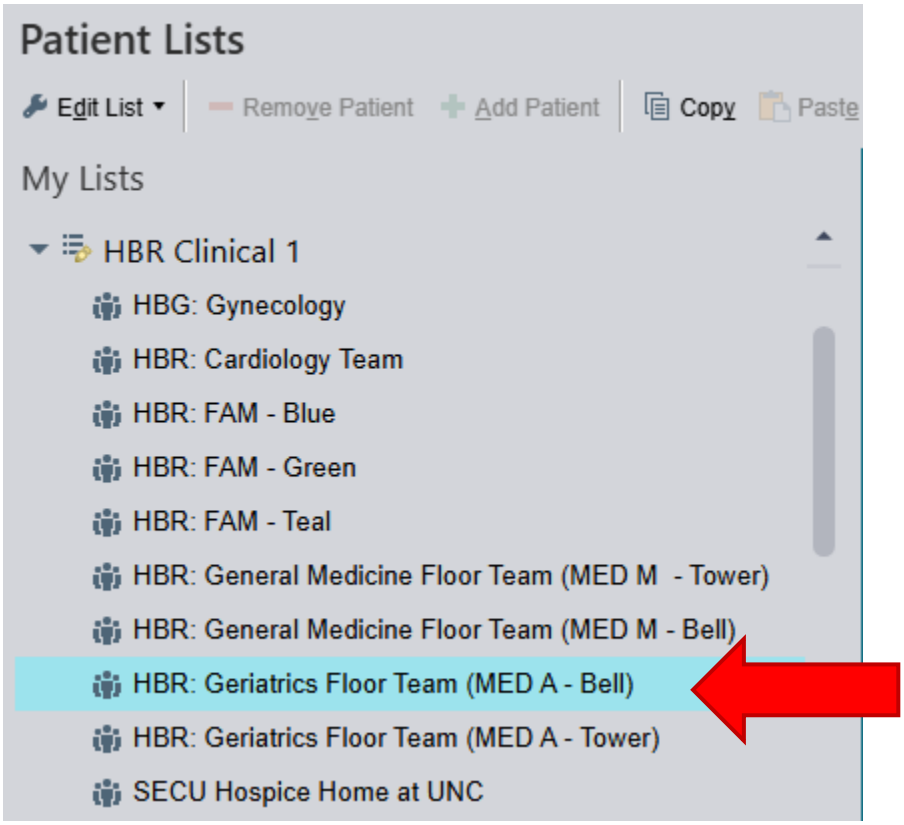
The goal of this document is to support students in developing a consistent and thorough approach to patient workups. By offering an initial framework for reviewing patient data and formulating recommendations, this resource is designed to build clinical reasoning skills and promote organized thinking. Students should view this as a learning tool rather than a fixed requirement, with the expectation that their approach will naturally evolve throughout the rotation and beyond.

Printing the Patient Report

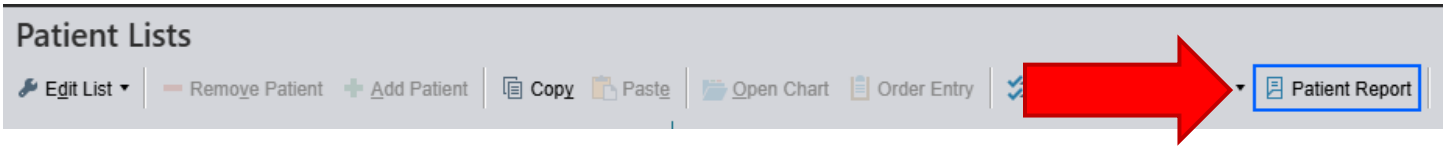
1.) Navigate to the Patient Lists tab in Epic



2.) In the My Lists Panel, select the team that you are covering for the shift.



3.) In the toolbar directly above the team name, select Patient Report.



4.) Send the report to the appropriate printer

Confidentiality Reminder

Patient reports must only be printed within the institution or sent via an institution-approved email account. Reports should not be saved, photographed, or sent to personal devices (e.g., personal laptops, tablets, iPads, cell phones, etc.) to protect patient privacy and comply with institutional policies.

Patient Workup Guide

This section outlines a foundational approach to working up your assigned patients. The goal is not memorization, but to help you develop a consistent, organized way of thinking through each patient's clinical picture. Over time, your workups should become more efficient, targeted, and personalized to your own clinical reasoning style. Use the patient report as your starting point, then supplement with chart review as needed.

1.) Patient overview
- Begin with a brief snapshot of who the patient is and why they are hospitalized.
- Include:
  - Age and sex
  - Chief complaint
  - Primary reason for admission
  - Hospital day (if applicable)
- *Example: Popeye the Sailor Man is a 68-year-old male with a chief complaint of increased cough and shortness of breath with concern for a COPD exacerbation, hospital day 1.*

2.) Past Medical History
- List the patient's relevant chronic conditions
- Focus on:
  - Conditions related to the current admission
  - Comorbidities that impact medication decisions (e.g., CKD, cirrhosis, DM, etc.)
- You do not need to include every historical diagnosis – prioritize what matters for today's care.
- *Example: PSM has a past medical history significant for COPD, HTN, and tobacco use disorder.*

3.) Medication Review
- Review the patient's medication profile with attention to appropriateness and safety.
- Include:
  - Home medications (and whether they were continued, held, or discontinued)
  - Current inpatient medications
  - High-risk medications (e.g., anticoagulants, insulin, opioids, antimicrobials, etc.)
- Consider
  - Indication

    - Dose, route, frequency, and indication
    - Renal or hepatic adjustments
    - Drug-drug interactions
    - Opportunities for optimization or simplification
- *Example: At home, PSM takes 1 inh of Trelegy 200/62.5/25 mcg/inh daily, benazepril 10 mg daily, and albuterol PRN 1-2 inh/week. While admitted, PSM has azithromycin 500 mg PO QDay x 5 days, lisinopril 10 mg PO daily and Breo Ellipta 100-25 mcg/inh 1 inh daily.*

4.) Allergies and Adverse Reactions
- Review reported drug allergies/intolerances and reactions
- Distinguish between true allergies, intolerances, and side effects
- *Example: PSM has a charted allergy to PCNs with a rash as a child, but no relevant allergies to report based on current problems.*

5.) Relevant Labs and Diagnostics
- Identify and <u>trend</u> key labs related to the patient's condition and medications
    - Focus on
        - Vitals
        - Renal function (serum creatinine, creatinine clearance, eGFR)
        - Electrolytes
        - CBC
        - Drug specific labs
- Review relevant diagnostics and imaging related to the patient's conditions and medications
    - Focus on
        - Cultures and sensitivities
        - X-rays and ultrasound impressions
        - Echocardiograms
- *Example: WBC 8.5 K/µL (WNL), temperature 98F (WNL), CXR shows no acute infiltrates, BP 120/80 stable x2 days, and oxygen saturation 90% on room air.*

6.) Assessment
- This is where you synthesize the information you've gathered
- Assess:
    - What are the patient's active problems?
    - What are we doing to address these problems?
    - How are they responding to current therapy?
    - Are there any medication related concerns or gaps?
- Think critically rather than reciting data
- *Example: PSM is experiencing a COPD exacerbation characterized by increased dyspnea and worsening cough without changes in sputum purulence or volume. He is hemodynamically stable, afebrile, and without laboratory or imaging findings suggestive of infection. Current inhaled therapy does not reflect his home regimen, and antibiotic therapy may not be indicated based on presentation.*

7.) Plan and Recommendations
- Outline your pharmacy-focused plan
- Include:
    - Continue current therapy with rationale or suggested changes

    - Monitoring parameters
    - Anticipated follow up needs
- *Example:*
    - *Escalate inhaled therapy by increasing Breo Ellipta from 100/25 mcg to 200/25 mcg 1 inhalation daily to better align with PSM's home ICS dose*
    - *Add Incruse Ellipta 62.5 mcg 1 inhalation daily to provide formulary therapeutic interchange LAMA and approximate the home triple therapy regimen.*
    - *Discontinue azithromycin as the patient does not report increased sputum purulence and does not meet criteria for antibiotic therapy in a COPD exacerbation.*
    - *Continue PRN albuterol and monitor respiratory status and oxygen requirements.*
    - *Continue lisinopril (therapeutic interchange for benazepril) and monitor vitals.*

Internal Documentation Expectations

Pharmacy Sign Out

The pharmacy sign out section should be used only for time-sensitive information, such as following up on medication levels. Please be sure to use the standard sign-out format.

Pharmacy Plan

The pharmacy plan section is where you should briefly document the patient's overall clinical picture. For most patients, a problem-based approach works best. In situations where a problem-based format is not ideal, a systems-based workup is acceptable.

Updates and Approval

Please do not update the pharmacy sign out or pharmacy plan without preceptor approval. For small or brief documentation changes, add comments during provisional verification. For new admissions, use the yellow My Sticky Note feature to add notes after completing your independent patient workup time.