SECTION
1

Case Taking

- Interrogation of the patient (history)
- General physical examination of the patient

Significance of Case Taking

The systematically interrogation, physical examination of the patient and maintenance of records are essential for providing a good emergency medical care in the very busy A&E department with doctors and paramedical staff, working under great pressure to handle the serious/sick patients as priorities, besides frequently facing medicolegal problems. The relevance/significance of each criterion is:

Age — Some diseases/disorders are common in certain age groups, i.e.
- *Neonatal:* Heart disease, CNS disorders, meningocele, cleft palate, cleft lip, tongue tie, hydrocephalus, club foot.
- *Infancy:* Respiratory infections, CHF, vomiting, jaundice, hiccup, rickets, scurvy, bed wetting, delayed speech, Wilms' tumor, umbilical hernia.
- *Childhood:* Respiratory infections, measles, asthma, diarrhea, malaria, juvenile diabetes, appendicitis, asthma, osteomyelitis, osteosarcoma.
- *Adults:* Rheumatoid arthritis, migraine.
- *Elders:* Hypertension, heart failure, osteoarthritis, Alzheimer's disease, falls, senile osteoporosis, SE prostate, pneumonia, carcinomas.

Religion
- Carcinoma penis less common in those having circumcision.

Sex
- Hemophilia affects males only, although transmitted through females.
- Carcinoma lips, tongue, GI tract, more prevalent in males.
- Hysteria – more in females.

Occupation — Some ailments more common in certain professions (trades), i.e.
- Internal derangement knee (IDK) common in footballers and mine workers.
- Intestinal colic – due to lead poisoning – common in painters.
- Housemaid knee – common in maids.
- Hydated cyst disease – common in dogs, domestic animals' caretakers.

Address
- *Travel hazards:* Exposure to infections, e.g. sleeping sickness (African countries), hydated disease (Australia), influenza infection (prone areas).

Interrogation of the Patient (history): Includes

Particulars of the patient

Surname ..... First name ..... A&E no .....
Age/DOB ..... Sex ..... Date .....
Son/daughter/wife of ..... Time .....
Occupation .....
Address ..... Tel .....
DOA ..... DOD .....
Diagnosis .....
A&E consultant/Dr I/C .....

Complaints (Symptoms) and their Duration

Inquire the patient (parents/attendants in case of a child/unconscious patient):

- What are his/her currently troubling (chief) complaints?
- Symptoms recorded in a chronological manner of their appearance, i.e. pain in the chest, dyspnea, swelling of feet.
- Either write down how many (weeks, days, months) last, the complaints started/ mention the exact date, e.g.

Patterns:

- Weeks: (no. of weeks/total no. of weeks per year – symbol)
  13/52 Pain in the chest
  09/52 Dyspnea
  05/52 Swelling of feet
- Days: (no. of days/weekly – symbol)
  92/7 Pain in the chest
  61/7 Dyspnea
  31/7 Swelling of feet
- Date:
  14.5.2009 Pain in the chest
  15.5.2009 Dyspnea
  20.5.2009 Swelling of feet
- Months: (no. of months/total no. of months per year – symbol)
  3/12 Pain in the chest
  2/12 Dyspnea
  1/12 Swelling of feet
- Pain in the chest Three months
  Dyspnea Two months
  Swelling of feet One month

History of Present Illness

This covers the period from appearance of first symptom to the present time. Let the patient narrate his/her own history of complaints and do not put any leading questions having their own readymade answers.

Inquire The patient/accompanied person of unconscious/accidental case and the mother/accompanied person in case of a young child, about:

- How did the symptoms start?
- What happened next?

- Whether symptoms started suddenly or gradually?
- Whether any relief from complaints during the whole period?
- What sort of treatment taken and whether any relief or not?

Past History Record any ailments suffered by the patient prior to current one, in a chronological manner, along with their duration.
Child: Record development milestones, e.g. head holding, sitting, crawling, standing, teething, smile, speech, walking.

Personal History

- Whether married or single, number of children and their health condition?
- Habits, diet, appetite, bowl and urinary conditions.
- Any addiction – drugs, smoking, alcohol abuse, etc.
- History of menstrual cycle (female patient) – normal or abnormal, i.e. amenorrhea, epimenorrhea, menorrhagia, metrorrhagia, dysmenorrhea.
- Any history of miscarriage, postmenopausal condition, vaginal discharge.

Family History (Inquire)

- About the condition of health of parents, children, and other family members living along with. Anybody suffering from similar ailments.
- Any death in the family and the cause of death.
- Any family history of diabetes, hypertension, congestive heart failure, asthma, tuberculosis, hemophilia, cancer.

Pediatric History (Inquire the mother or accompanying person)

- Number of children in the family, any dead and the cause of death.
- Was it a normal delivery and full time child?
- Was the child breastfed?
- Digestion and bowl habits.
- Any previous illnesses (measles, whooping cough, chickenpox, scarlet fever, fits, nausea, vomiting, diarrhea, sore throat, running nose and ears).
- Immunization status (when were primary/booster/repeat doses given) of BCG, polio, DPT, measles, hepatitis B, hib, MMR, typhoid and tetanus toxoid.

Special Interrogation (Systemic Review)

To inquire about the involvement of a particular organ/system, thought to be affected most and about nature of the disease, i.e.

Cardiovascular System (Inquire about)

- History of rheumatic fever, scarlet fever, diphtheria, or sore throat.
- *Chest pain*: One of the most presenting complaints. *Inquire about its* site, character, localization, radiation, duration, factors which precipitate, or relieve it, any medication.
- *Dyspnea*: Is it present at rest or on exertion – relieved by rest?

- Any history of orthopnea – relieved by sitting.
- *Palpitation:* Inquire about any rapid, forceful, irregular heart beating.
- *Fatigueness:* Is there easy fatigability – relieved by rest.
- *Edema feet:* Is there swelling of feet?

Respiratory System (Inquire about)

- History of tuberculosis, exposure to fumes/dust, smoking
- Sneezing
- *Cough:* Inquire about its character and frequency, is it dry or purulent one, any association with chest pain
- *Expectoration:* Inquire about its quality and quantity
- *Hemoptysis:* Any spitting or coughing of blood
- *Dyspnea:* May appear at rest or on exertion
- *Cyanosis:* More marked, if the patient is cold
- Chest pain
- *Cold:* Running nose, nasal block

Nervous System (Inquire about)

- History of fits/seizure, paralysis, mental disorders, drugs/alcohol abuse
- Headache, giddiness, vertigo
- Memory and concentration
- Sleep
- Weakness of any limb
- Proximal muscle weakness
- Tremors
- Tingling sensation
- Feeling ground like cotton wool
- Urinary bladder sphincter control
- Bowel sphincter control

Blood (Inquire about)

- Any history of bleeders in the family, any passage of blood per rectum, any passage of black-colored stools
- Any breathlessness on exertion, muscular weakness, headache
- Swelling of feet.

Gastrointestinal Tract and Abdomen (Inquire about)

- *Diet:* Quality and quantity of food
- *Appetite:* Decreased or increased
- *Pain:* Site – localised or referred; character – throbbing, dull or aching; duration – any interval of relief from pain, relation to meals
- History of peptic ulcers
- Heartburn (retrosternal burning)
- *Dysphasia:* Any difficulty in swallowing
- *Flatulence and dyspepsia:* Relation to food, any relief to pain

- Nausea
- *Vomiting:* Frequency, quantity, quality, relation to food and pain
- Hematemesis
- *Constipation:* Bowl habits – regular or irregular. Any history of use of purgatives
- *Diarrhea:* Frequency, quality, quantity, relation to meals, passing of blood/slime
- Any history of tenesmus during defecation
- History of piles
- *Liver/gallbladder:* Any pain in region of liver, any history of jaundice, any change in colour of urine or stools

Genitourinary System (Inquire about)

- History of renal disorders
- *Pain:* Site, character – dull, aching or severe colicky, localized or referral to groin or testicles
- *Urinary symptoms:* Frequency, urgency, hesitancy, dribbling, overflow, nocturia, dysuria
- Nausea, vomiting, drowsiness, headache, fever, puffiness of face, edema ankle
- History of prostate enlargement
- History of hydrocele

Obstetric and Gynecology System (Inquire about)

- *Menstrual history:* Menarche, cycle, loss, pain, IMB, PCB, LMP
- Vaginal discharge, cervical smear, contraception
- Obstetric history
- Gynecological – any bleeding per vaginum, vaginal discharge, pain abdomen

Eye (Inquire about)

- Vision – any disturbance of vision
- Any complaint of halos around lights, flashes
- Pain – irritable, dull-ache or severe
- Headache
- Discharge from eye(s) – watery, or purulent.

Ear, Nose, Throat (ENT) (Inquire about)

- Earache
- Discharge – watery/purulent
- Deafness – any hearing loss
- Tinnitus – any ringing sensation
- Vertigo – any hallucination of movement.

Bones/Joints Disorders (Inquire about)

- History of rheumatism, gout, tuberculosis, syphilis, leucorrhea, diabetes mellitus, shifting joint pains.

Physical Examination (Includes)

- General physical examination (GPE)
- Local examination
- Examination of different systems/parts of the body

Physical examination (preliminary and detailed examination).

General Physical Examination (GPE): Observe

- *Appearance:* Build, nutrition, presence or absence of anemia, jaundice, cyanosis, clubbing, edema
- *Intelligence:* Expression
- *Attitude:* Helplessness, keeping limbs in a particular position
- *Facial expression*: Tense, nervous, toxic, fatigue
- Pulse: Rate, rhythm, volume
- *Respiration:* Rate, rhythm, thoracic or abdominal
- Temperature
- Blood pressure

Local Examination: **The interrogation of the patient leads to the system/organ of the body to be examined first.** Examination includes:

Inspection	Looking at the patient's body
Palpation	Feeling the parts of the body
Percussion	Listening the sounds elicited by tapping the part with finger
Auscultation	Listening body's sounds with a stethoscope

Examination of Different Systems/Parts of the Body

Observe — Begin with the head and neck, and proceeds downwards, i.e.

Head — *Skull:* Size, shape: Hydrocephalus, bossing of fore-/hind-head (rickets)

- *Hair:* Color, texture
- *Eyes:*
  - Orbits–exophthalmos/enophthalmos/proptosis
  - Eyeballs – strabismus (squint)
    nystagmus (oscillatory movements)
  - Eyelids – ptosis, edema, inflammation (blepharitis), entropion/ectropion
  - Pupils – size, equally, reaction to light and accommodation
  - Conjunctiva – anemia, jaundice, trachoma, inflammation, tumor
  - Cornea – size – glaucoma
    curvature – conical
    surfaces – corneal reflex, ulcer, opacity
  - Sclera – myopia, scleritis
  - Iris – color, iritis
  - Lens – cataract
  - Vitreous – fluidity, hemorrhage, foreign body, opacity
  - Visual acuity – testing distant/near vision
  - Ocular tension (IOP) – testing by:
    - ◊ Palpating eyeball with eyes open, and by
    - ◊ Tonometer

- Fundus examination with an ophthalmoscope
- Optic disc status, e.g. papilledema, hemorrhage, inflammation
- Retinopathy (diabetic/hypertensive)

• *Ears:*
- Foreign body in the ear
- Discharging ear
- Audiometry – hearing assessment

• *Face:* Expression, shape, paralysis, puffiness
- Mouth – shape, cleft lip, lips – pale or cyanotic, fissures (cracks) on lips
- Tongue – appearance, protrusion (any deviation), tongue-tie, ulcer
- Teeth and gums–hygiene, no. of missing teeth, any denture worn, any bleeding gums
- Soft palate – movements
- Tonsil – normal/swollen

Neck
- Any engorgement (distension) of neck veins
- Thyroid – normal/swollen
- Lymph nodes – any enlargement

Chest inspection
- Shape of chest – any deformity: Rickety rosary (rickets)
- Respiration – rate, rhythm, volume
- Pulsations/dilated vessels
- Apex beat

Palpation
- Local tenderness
- Tracheal position, apex beat

Percussion Cardiac dullness

Auscultation Heart sounds, murmurs, breath sounds

Spine (Inspection and Palpation)
- *Deformity:* Kyphosis – posterior curvature common in thoracic region.
  Lordosis – anterior curvature common in lumbar region.
  Scoliosis – lateral curvature – right/left side.
- Local tenderness.

Abdomen Inspection
- Size, shape, distension, abdominal movements, dilated vessels, umbilicus, any operational or wound scar.
- Hernial sites – impulse on coughing.

Palpation and Percussion: Local tenderness, any rigidity, (resentment to palpation esp. by a child c/o pain abdomen)
- Any palpable swelling, liver, spleen, kidneys, inguinal glands
- Genitalia
  - Male – penis, scrotum, testicles
  - Female – external genitalia (if indicated)

Auscultation Peristaltic sounds

P/R (Per rectum) examination

Gynaecology and Obstetrics Examination

Rules — The examiner should explain about the purpose of examination, what is about to be done, and verbal/written consent to be taken in advance. Presence of female staff/attendant is desirable/required as per rules.

Breast Examination
- Any pigmentation of skin, discoloration of skin
- Any retraction of nipple
- Any swelling visible/palpable
- Any discharge from nipples
- Any enlargement (palpable) of axillary glands.

Abdominal examination: Described in appropriate sections

P/V — If indicated

Limbs — Upper and lower limbs

Inspection
- Appearance – shape and size – deformity, shortening
- Nutrition – built, any muscular wasting
- Edema – any swelling of feet and thighs

Palpation
- Muscle tone, power, reflexes, sensations
- Any pitting edema over ankles and thighs
- Local tenderness

Pulsations — Radial, femoral, posterior tibial, dorsalis pedis

Lymph nodes — Any enlargement

Measurements — Shortening, muscular wasting

Movements — Active and passive

Neurological Examination

- *Higher centres:* Mental status, intelligence, emotional status, speech
- Cranial nerves
- Trunk, gait

Upper and lower limbs:

Inspection — Any muscular wasting, skin – pale/cyanotic/red/shining, dry or moist, trophic ulcers, nails – any brittleness

Palpation — Muscle power, tone, reflexes, sensations

Provisional Diagnosis: As a routine, diagnosis of common diseases should be commonly preferred over rare diseases.

Investigations Include

Routine examination: Blood, urine, stools, vomitus, sputum and CSF.
- *Hematology:* Complete blood count (CBC): Hemoglobin, RBC, PCV, MCV, MCH, MCHC, TLC and DLC, platelet, BT and CT, ESR
- *Biochemistry:* Blood sugar – fasting, PP and random.
- *Serum electrolytes:* Sodium, potassium, chloride, calcium, phosphorus, magnesium, iron, amylase, lipase, CPK-MB, CPK-NAC, troponin-T/I.

- *Serology:* Mantoux test, widal test, Coombs' test, pregnancy test, CRP, RA factor, VDRL, HBsAg (rapid/ELISA), HIV (rapid/ELISA), HAV-IgM, HEV-IgM, torch IgG/IgM, HCV (rapid/ELISA), flocculation tests – Kahn test and Price's precipitation reaction (PPR) for syphilis.
- *Liver function tests (LFT):* Serum bilirubin, SGOT, SGPT, serum proteins – total/albumin/globulin, serum alkaline phosphatase.
- *Renal function tests (RFT):* Serum creatinine, serum uric acid, BUN.
- *Lipid profile:* Serum cholesterol, triglycerides, HDL, LDL, VLDL.
- *Hormones and tumor markers:* TSH, FSH, LH, prolactin, testosterone, PSA, AFP.
- *Urine examination:* Color, reaction, specific gravity, albumin, blood, deposits, electrolytes, Bence Jones protein, ketones.
- *Stool examination:* Amoebiasis/bacteria
- *Sputum examination:* Any foreign body (AFB)
- *Vomitus examination:* AFB
- *Cerebrospinal fluid (CS) examination:* Bacterial infections
- Microbiology
- Blood culture and sensitivity, pus culture and sensitivity, AFB culture, urine and stool culture and sensitivity, throat swab culture and sensitivity.

Special Investigations: Depending on the system affected, e.g.

- CXR (X-ray chest)
- X-ray of affected part
- Ultrasound, MRI, CT scan, myelography
- ECG, sonography, angiography
- Hysteroscopy, hysterosalpingography, hysterosonography, colposcopy, laparoscope, pregnancy testing, endometrial biopsy
- Bone densitometry
- EEG

Note: **These are described in appropriate sections**

Clinical Diagnosis: Clinical diagnosis at this stage should be complete and precise as much as possible. It is made on the basis of interrogation of the patient, examination, and investigations.

Treatment and Progress: Daily recording of following:

- Treatment given, i.e. medicines, etc.
- Procedures include operations performed.
- *Monitoring:* Daily progress esp. of acute cases, i.e. recording of general condition of the patient, pulse, respiration, temperature, blood pressure, changes in the size of inflammatory swelling, treatment being received. All investigation reports to be recorded in the case sheet. If any surgery performed, then operation notes to be recorded by the doctor incharge of the case.

Completion of Hospital Record (Discharge Summary)

Recording of condition of patient at time of discharge from the hospital (Table 1.1)

Table 1.1: Discharge summary

Surname ..... First name ..... A&E no .....
Age/DOB ..... Sex ..... Date .....
Son/daughter/wife of ..... Time .....
Address ..... Tel .....
DOA ..... DOD .....
Diagnosis .....
A&E consultant/Dr I/C .....
Complaints .....
.....
Present illness .....
.....
Past history .....
.....
GP examination .....
.....
Treatment and investigations .....
.....
Condition at time of discharge: Fully cured, relieved of symptoms/signs, or any complication/death. In case of death, postmortem examination report to be entered in the hospital records. Instructions to the patient at time of discharge: Schedule of medicines use, any precaution to be taken, date of check up at the hospital/GP's clinic.
Signature ..... Date .....

Referral System

Always inform the GP prior to the discharge of a patient for follow-up purpose, instructions/information to GP about discharged patient (Table 1.2).

Table 1.2: Referral letter to the GP

Dear Dr .....
Patient ..... Attended A&E department on .....
Diagnosis .....
Investigation .....
Treatment given .....
Aftercare (follow-up) .....
Yours sincerely
Signature ..... Date .....

Table 1.3: Proforma

Surname ..... First name ..... A&E no .....
Age/DOB ..... Sex ..... Date .....
Son/daughter/wife of ..... Time .....
Address ..... Tel .....
DOA ..... DOD .....
Diagnosis .....
A&E consultant/Dr I/C .....

Case taking

Chief complaint .....

.....

.....

History of present illness .....

.....

.....

Past history .....

.....

.....

Personal history

Marital status: Single/married/widow/widower ..... Children .....

Diet .....

Smoking ..... Alcohol ..... Drugs abuse .....

Physical activity .....

Family history

Father .....

Mother .....

Siblings .....

Interrogation in case of a young child .....

(Inquire the mother or accompanying person) .....

Delivery status ..... Normal ..... Full time .....

Postnatal ..... Cyanosis ..... Jaundice .....

Birth weight ..... Breastfed ..... Diet .....

Habits ..... Eating ..... Sleep .....

Bowel ..... Bladder ..... Bed wetting .....

Development milestones ..... Head holding ..... Crawling .....

Sitting ..... Standing ..... Teething .....

Smile ..... Speech ..... Walking .....

Immunization status ..... BCG ..... Polio .....

DPT ..... Measles ..... Hepatitis B .....

Chickenpox .....

Special interrogation of the patient (systemic review):

Cardiovascular system

History of rheumatic fever, scarlet fever, diphtheria, or sore throat.

Chest pain .....

Dyspnea .....

Orthopnea .....

Palpitation .....

Fatigueness .....

Edema feet .....

Respiratory system

History of tuberculosis .....
History of exposure to fumes/dust .....
History of smoking .....
Cough ..... Sneezing .....
Cold ..... Running nose ..... Nasal block .....
Expectoration .....
Hemoptysis .....
Dyspnea .....
Cyanosis .....
Chest pain .....

Nervous system

History of fits/seizure, paralysis, mental disorders .....
Drugs abuse ..... Alcohol abuse .....
Headache ..... Giddiness ..... Vertigo .....
Memory and concentration ..... Sleep .....
Weakness of limb/limbs ..... Muscle weakness .....
Tremors ..... Tingling sensation .....
Urinary bladder sphincter control ..... Bowel sphincter control .....

Blood system

History of bleeders in the family .....
History of malena .....
Dyspnea on exertion .....
Weakness .....
Headache .....
Palpitation .....
Edema feet .....

Gastrointestinal tract and abdomen system

Diet .....
Appetite .....
Abdominal pain .....
History of peptic ulcers .....
Heartburn (retrosternal burning) .....
Dysphasia .....
Flatulence and dyspepsia .....
Nausea ..... Vomiting ..... Diarrhea .....
Hematemesis .....
Diarrhea .....
Constipation .....
History of piles .....
Liver/gallbladder .....

Genitourinary system

History of renal disorders .....

Pain .....

Urinary symptoms:

Frequency ..... Urgency ..... Hesitancy .....

Dribbling ..... Overflow .....

Nocturia ..... Dysuria .....

Nausea ..... Vomiting ..... Drowsiness .....

Headache ..... Fever .....

Puffiness of face ..... Edema ankle .....

Prostate enlargement ..... Hydrocele .....

Obstetric and gynecology system

Menstrual history: Menarche ..... Cycle ..... Loss .....

Pain ..... IMB ..... PCB ..... LMP .....

Vaginal discharge ..... Contraception .....

Obstetric history .....

Gynecological:

Bleeding per vaginum ..... Vaginal discharge .....

Pain abdomen .....

Eye

Vision ..... Halos around lights .....

Pain (eye-strain) ..... Headache .....

Discharge ..... Watery ..... Purulent .....

Diplopia .....

ENT

Earache ..... Deafness .....

Discharge ..... Watery ..... Purulent .....

Tinnitus ..... Vertigo .....

Sneezing ..... Stuffiness .....

Nasal discharge ..... Epistaxis .....

Sore throat ..... Cough ..... Expectoration .....

Bones and joints disorders

History of rheumatism ..... Gout .....

Tuberculosis ..... Diabetes mellitus .....

Syphilis ..... Urethral discharge .....

Leukorrhea ..... Trauma .....

Examination of the Patient

General physical examination (GPE)

Appearance .....

Intelligence .....

Attitude .....

Facial expression .....
Pulse .....
Respiration .....
Temperature .....
Blood pressure: SBP ..... DBP .....

Local examination (system/organ of the body to be examined first)

Inspection .....
Palpation .....
Percussion .....
Auscultation .....

Examination of different systems/parts of the body

Head and neck

Skull hydrocephalus ..... Bossing of fore-/hind-head .....
Hair .....

Eyes

Orbits ..... Eyeballs .....
Eyelids ..... Pupils .....
Conjunctiva .....
Cornea .....
Sclera ..... Iris .....
Lens ..... Vitreous .....
Visual acuity ..... Ocular tension (IOP) .....
Fundus examination with an ophthalmoscope .....
Ears .....
Audiometry .....
Face .....

Mouth

Shape ..... Lips .....
Tongue .....
Teeth and gums .....
Soft palate ..... Tonsil .....
Neck .....
Thyroid ..... Lymph nodes .....

Chest

Inspection: Shape of chest .....
Respiration .....
Pulsations/dilated vessels .....
Apex beat .....
Palpation: Local tenderness .....
Tracheal position ..... Apex beat .....
Percussion: Cardiac dullness .....
Auscultation: Heart sounds/murmurs .....
Breath sounds .....
Deformity ..... Local tenderness .....

Spine Abdomen

Inspection: Size ..... Shape .....
Distension ..... Dilated vessels .....
Abdominal movements .....
Umbilicus ..... Scar .....
Hernial sites – impulse on coughing .....

Palpation and Percussion

Local tenderness ..... Rigidity .....
Swelling .....
Liver ..... Spleen .....
Kidneys ..... Inguinal glands .....
Genitalia: Male – penis, scrotum, testicles .....
Female – external genitalia (if indicated) .....
Auscultation: Peristalsis sounds .....
P/R (per-rectum) examination .....

Gynecology and obstetric examination

Breast: Skin pigmentation/discoloration .....
Nipple retraction ..... Discharge from nipples .....
Swelling ..... Axillary lymph nodes .....
Abdominal examination .....
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.....
P/V examination .....
.....

Limbs: Upper and lower limbs

Inspection: Shape ..... Size .....
Built ..... Muscle wastings .....
Edema feet/thighs .....
Palpation: Muscle tone ..... Power .....
Reflexes ..... Sensations .....
Edema ankles/thigh ..... Local tenderness .....
Pulsations: Radial ..... Femoral .....
Posterior tibial ..... Dorsalis pedis .....
Lymph nodes enlargement .....
Measurements .....

Neurological examination

Higher centres:

Intelligence ..... Emotional status .....
Speech .....
Cranial nerves .....
Trunk ..... Gait .....

Upper and lower limbs:

Muscular wasting ..... Skin .....

Trophic ulcers ..... Nails .....

Muscle power ..... Muscle tone .....

Reflexes ..... Sensations .....

Examination of a young child

Height ..... Weight ..... Head circumference .....

Chest circumference ..... Midarm circumference .....

Anterior fontanel ..... Clubbing ..... Koilonychia .....

Immunization status ..... BCG scar ..... Umbilicus .....

Pallor ..... Jaundice ..... Cyanosis .....

Provisional diagnosis .....

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Investigations

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Clinical diagnosis .....

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Treatment and progress

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Signature ..... Date .....

Table 1.4: Completion of hospital record

Fully cured, relieved of symptoms/signs .....

Complication/death .....

Postmortem examination report .....

Instructions to the patient at the time of discharge:

Schedule of medicines use .....

Precaution to be taken .....

Date of follow-up (check up) at the hospital/GP's clinic .....

Signature ..... Date .....

Referral System

Instructions/information to GP about discharged patient:

Table 1.5: Referral system

Dear Dr .....
Patient ..... Attended A&E Department on .....
Diagnosis .....
Investigation .....
Treatment given .....
.....
.....
.....
Aftercare (follow up) .....

Yours sincerely

Signature ..... Date .....

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