Use the Episodic/Focused SOAP Template and create an episodic/focused note about the patient in the case study to which you were assigned using the episodic/focused note template provided in the Week 5 resources. Provide evidence from the literature to support diagnostic tests that would be appropriate for each case. List five different possible conditions for the patient's differential diagnosis, and justify why you selected each.

Case Study.

A 48-year-old male with a history of diabetes mellitus type 2 complains of not being able to feel his toes in the left foot. He also complains of numbness in the heel of the right foot and a tingling sensation.

Episodic/Focused SOAP Note Template

Patient Information:

Initials, Age, Sex, Race

S.

CC (chief complaint) a BRIEF statement identifying why the patient is here - in the patient's own words - for instance "headache", NOT "bad headache for 3 days".

HPI: This is the symptom analysis section of your note. Thorough documentation in this section is essential for patient care, coding, and billing analysis. Paint a picture of what is wrong with the patient. Use

LOCATES Mnemonic to complete your HPI. You need to start EVERY HPI with age, race, and gender (e.g., 34-year-old AA male). You must include the seven attributes of each principal symptom in paragraph form not a list. If the CC was “headache”, the LOCATES for the HPI might look like the following example:

Location: head

Onset: 3 days ago

Character: pounding, pressure around the eyes and temples

Associated signs and symptoms: nausea, vomiting, photophobia, phonophobia

Timing: after being on the computer all day at work

Exacerbating/ relieving factors: light bothers eyes, Aleve makes it tolerable but not completely better

Severity: 7/10 pain scale

Current Medications: include dosage, frequency, length of time used and reason for use; also include OTC or homeopathic products.

Allergies: include medication, food, and environmental allergies separately (a description of what the allergy is ie angioedema, anaphylaxis, etc. This will help determine a true reaction vs intolerance).

PMHx: include immunization status (note date of last tetanus for all adults), past

major illnesses and surgeries. Depending on the CC, more info is sometimes needed

Soc Hx: include occupation and major hobbies, family status, tobacco & alcohol use (previous and current use), any other pertinent data. Always add some health promo question here - such as whether they use seat belts all the time or whether they have working smoke detectors in the house, living environment, text/cell phone use while driving, and support system.

Fam Hx: illnesses with possible genetic predisposition, contagious or chronic illnesses. Reason for death of any deceased first degree relatives should be included. Include parents, grandparents, siblings, and children. Include grandchildren if pertinent.

ROS: cover all body systems that may help you include or rule out a differential diagnosis You should list each system as follows: General: Head: EENT: etc. You should list these in bullet format and document the systems in order from head to toe.

Example of Complete ROS:

GENERAL: Denies weight loss, fever, chills, weakness or fatigue.

HEENT: Eyes: Denies visual loss, blurred vision, double vision or yellow sclerae. Ears, Nose, Throat: Denies hearing loss, sneezing, congestion, runny nose or sore throat.

SKIN: Denies rash or itching.

CARDIOVASCULAR: Denies chest pain, chest pressure or chest discomfort. No palpitations or edema.

RESPIRATORY: Denies shortness of breath, cough or sputum.

GASTROINTESTINAL: Denies anorexia, nausea, vomiting or diarrhea. No abdominal pain or blood.

GENITOURINARY: Burning on urination. Pregnancy. Last menstrual period, MM/DD/YYYY.

NEUROLOGICAL: Denies headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control.

MUSCULOSKELETAL: Denies muscle,

back pain, joint pain or stiffness.

HEMATOLOGIC: Denies anemia, bleeding or bruising.

LYMPHATICS: Denies enlarged nodes. No history of splenectomy.

PSYCHIATRIC: Denies history of depression or anxiety.

ENDOCRINOLOGIC: Denies reports of sweating, cold or heat intolerance. No polyuria or polydipsia.

ALLERGIES: Denies history of asthma, hives, eczema or rhinitis.

O.

Physical exam: From head-to-toe, include

what you see, hear, and feel when doing your physical exam. You only need to examine the systems that are pertinent to the CC, HPI, and History. Do not use “WNL” or “normal.” You must describe what you see. Always document in head to toe format i.e. General: Head: EENT: etc.

Diagnostic results: Include any labs, x-rays, or other diagnostics that are needed to develop the differential diagnoses (support with evidenced and guidelines)

A.

Differential Diagnoses (list a minimum of 3 differential diagnoses).Your primary or presumptive diagnosis should be at the top of the list. For each diagnosis, provide supportive documentation with evidence based guidelines.

P.

This section is not required for the assignments in this course (NURS 6512) but will be required for future courses.

References

You are required to include at least three evidence based peer-reviewed journal articles or evidenced based guidelines which relates to this case to support your diagnostics and differentials diagnoses. Be sure to use correct APA 7th edition formatting.