Learner Instructions

Patient's Name: Astrid Tomas
Age: 44 year-old female
Setting: Emergency Department
Primary v Sign-Out: sign-out

Initial Chief Complaint on arrival to the ED:
Dizziness

Patient Information from HPI
44-year-old female with PMH significant for HTN and hypothyroidism presenting for evaluation of dizziness, which she describes as lightheadedness when she stands up. This did not occur at rest and improved after drinking fluids and taking rests. She has no associated headache, neck pain, vision changes, numbness, weakness, chest pain, or difficulty breathing. She has had no trauma or neck manipulation.

She was admitted to the ED with initial negative troponin and normal EKG. She received IV fluids in the ED.

Her vital signs and physical exam over the course of the evaluation are as follows:

Vital signs:

Initial Triage Vitals:	HR 70	BP 120/70 mmHg	RR 18	Sat 100% RA	T 98.8 F (oral)
ED Admit Vitals	HR 72	BP 118/68 mmHg	RR 16	Sat 100% RA	T 98.6 F (oral)
Current Vitals (laying down)	HR 68	BP 116/68 mmHg	RR 16	Sat 100% RA	T 98.6 F (oral)
Current Vitals (sitting)	HR 70	BP 112/65 mmHg	RR 17	Sat 100% RA	T 98.6 F (oral)
Current Vitals (standing)	HR 72	BP 109/63 mmHg	RR 17	Sat 100% RA	T 98.6 F (oral)

Exam (abnormal findings bolded):

General: Well-developed, well-nourished female resting comfortably in no acute distress.
HEENT: Normocephalic, atraumatic, no conjunctival injection or pallor, sclera non-icteric, PERRLA, nasal mucosa pink, moist mucous membranes, oropharynx without evidence of erythema, tonsillar enlargement or exudates. No nystagmus.
Neck: No cervical lymphadenopathy, no thyromegaly, or mass.

Cardiovascular: No jugular venous distension, regular rhythm, normal S1 and S2, no murmurs, rubs, or gallops. Radial and DP pulses 2+ bilaterally. No edema.
Pulmonary: Thorax is symmetric without increase in anteroposterior diameter. Lungs clear to auscultation, no rales, wheezes, rhonchi, or rubs.
Abdomen: Flat, no hepatosplenomegaly, soft, non-tender to palpation in all quadrants.
Musculoskeletal: full range of motion in al joints, no evidence of swelling or deformity.
Neuro: Alert and oriented x 3. CNs II – XII symmetric, sensation to light touch grossly intact, 5/5 strength in all extremities. Gait steady without evidence of ataxia. Normal cerebellar exam.
Psych: Affect full range. Speech is fluent, no SI or HI.

Today's lab

CBC			**CHEMISTRY**		
WBC	7.4	(3.5-10.5)	SODIUM	139	(135-148)
RBC	5.01	(4.2-5.8)	POTASSIUM	4.1	(3.5-5)
HEMOGLOBIN	14.2	(13.0-17.5)	CHLORIDE	107	(95-108)
HCT	42.6	(38.0-50)	BICARB	24	(24-32)
MCV	89	(80-99)	BUN	15	(0-20)
MCH	30	(27-34)	CREATININE	0.7	(0-1.7)
MCHC	34.2	(33-35.5)	GLUCOSE	98	(65-110)
RDW	14.8	(11-15)	CALCIUM	9.2	(8.5-10.5)
PLATELET	187	(140-390)			
			TROPONIN (x2)	0.01	(0.00-0.03)
			TSH	1.2	(0.5-243)

ECG: NORMAL SINUS RYHTHM. NORMAL ECG
CXR: THERE ARE NO CARDIOPULMONARY ABNORMALITIES. NORMAL CXR

The patient still feels dizzy and lightheaded, but improved since admission. She has received IV fluids during her emergency department stay.

The sign-out plan from the initial team was to discharge the patient if she can ambulate safely with improved dizziness.

Your Task:

1. Reassess and the update
2. Discharge the patient from the emergency department

3. This simulation is focused on communication. This case is not an assessment of your medical decision making. You do not need to order additional emergency department tests or admit this patient.
4. When you are finished, you can tell her that the nurse will be in shortly to give her paperwork and take out her IV.