Patient room: 551
Patient name: Roland Johansen
Patient age: 65
POD: 1
Status/post (surgery): robot assisted right partial nephrectomy

Summary statement: (START HERE when presenting) Roland Johansen is a 65-year-old man POD 1 s/p robot assisted right partial nephrectomy

Subjective:

- Pain: Well controlled, some tenderness around incision site
- Nausea or vomiting? (y/n) no
- Passing gas? (y/n) passed gas x2
- Had a bowel movement? (y/n) not yet
- Ambulating? (y/n) walked around the hall 1x
- Other: Is wondering if he can drink a milkshake this morning

Objective:

Vitals
BP: 122-140/75-83
HR: 68-80
TMax: 99
Resp: 16

I/O
PO: 800 cc
IV: 1.5L
UOP: 1.1L

Labs
BMP:
Cr = .9

Physical Exam
Abdomen: Soft, non-tender, non-distended. Incisions clean, dry, intact.
Bowel sounds noted
Extremities: Well-perfused, normal color, contour, no pitting edema

Assessment:
Roland Johansen is a 65 yo male s/p right partial nephrectomy following appropriate post-operative course.
Plan:
Neuro: Acute post-operative pain well managed on IV Tylenol Q6h and PRN oxycodone, plan to advance to PO Tylenol for d/c
CV: HDS
Resp: Continue to ween off nasal O2 1L
GI: Advance to regular diet
GU: Remove foley catheter, discontinue IV fluids
Infectious:
Heme: DVT prophylaxis includes compression boots and ambulation
Endo:
Dispo: Discharge today, follow up in 2 weeks for post-op appointment

Patient room:
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- Had a bowel movement? (y/n)
- Ambulating? (y/n)
- Other:

Objective:

Vitals	I/O	Labs	Physical Exam
BP:			
HR:			
TMax:			
Resp			

Assessment:

Plan:
Neuro:
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Vitals	I/O	Labs	Physical Exam
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Assessment:

Plan:
Neuro:
CV:
Resp:
GI:
GU:
Infectious:
Heme:
Endo:
Dispo:

Tips for presenting:

- Surgeons like presentations short, to the point, and focused on the problem at hand
- Omit irrelevant findings (i.e., their finger hurts because they got a paper cut last night) even if the patient tells you about it in the AM
- As an M3, it is good to announce the sections you're reading because people easily can tune you out and think you didn't say a section (even if you did) so I personally always will announce "subjectively" x,y,z "objectively" x,y,z etc.
- If vital signs were all within normal range say "vitals were within range" BUT make sure to have the numbers just in case you're asked. If you had an irregular vital sign over night, make sure to document the time it occurred at. For example, if they had an episode of tachycardia where HR was 135, say, "patient had a HR of 135 at 6pm last night with a downward trend to normal range." This is important because the surgeons want to know if it was a single reading that was alarming or if it's a persistent trend and something to be concerned about
- If labs were ordered, make sure to document them and again only read the pertinent positives (some services specifically may want you to list certain values, i.e., urology wants to know the creatinine even if it within range)
- Perform only a targeted physical exam, always check the incision sites, a good acronym for them is "clean, dry, and intact" or c/d/i.
- The plan is really hard as an M3 and nobody expects you to do it perfectly, but you DO want to at least attempt the plan. Many M3's won't even try and I was complimented often for always giving it a shot. TIPS:
    - Always go read the overnight notes from the care team because frequently these include the resident's plan which you should use!
    - Ask the sub-I or intern or junior resident what the "standard post op protocol" is for the surgery the patient had. This will really help you decide what to include in your plan and how soon to advance everything.
    - Considerations to make in your plan with surgery:
        - Neuro = post op pain, is the patient's pain under control? Could you add something to help? I sometimes suggested adding IV Toradol or even adding an abdominal binder or ice pack and this was always commented on as a good thing to look for ways to help manage uncontrolled pain. If a patient is going home, make sure they are advanced off all IV meds.
        - GI = post op diet! Many patients are NPO (no food) after surgery and its important to think about when to advance them to a clear liquid diet or even a regular diet. This varies by surgery and by surgeon as well as patient's ability to tolerate food without nausea. Make sure patients are having gas or some bowel movement before suggesting a regular diet though. You can also include adding a bowel regimen (laxatives) for patients with any surgeries that could be stressed with straining.
        - GU = if the patient has a foley catheter, this is often removed the day after surgery and should be added to your plan! You can also modify the IV fluids if you see the patient is having a lot of urine output and are taking enough fluids by mouth.
        - Infectious = if a patient has an indwelling catheter, antibiotics are usually added to the plan and can be included
        - Heme = prophylactic DVT prevention is given after many inpatient surgeries, Lovenox or Heparin can be suggested if the patient will be in the hospital for a day or more! You can also include ambulation or compression boots as part of this prophylaxis.
        - Dispo = include in here where you think the patient is headed for the day. Staying on the floor? Going home?
    - Also, it is FINE if your plan is just "continue care management as is" if there are no changes. If there are only 1 or 2 things to do, you do NOT need to list every system, just go in order and can say something like "plan today is to remove foley, discontinue IVF, and discharge." If there is nothing to add to a system, no need to list it.
- The best advice someone gave me for surgery presentations was to "**speak soft and carry a big stick**" which sounds weird but basically only present the bare minimum information BUT make sure to have all the numbers and information in case you are asked about it as a follow-up question. This shows you are prepared with the information but keeping it pertinent.