



# 8C - Altered Mental Status

Time: \_\_\_\_\_ Primary MD: \_\_\_\_\_  
Room: \_\_\_\_\_ Specialist: \_\_\_\_\_

Mode of Arrival: private auto  
EMS  
police  
wheelchair van  
Historian: patient  
family  
friend  
caretaker  
EMS  
old chart  
Hx limited by: AMS  
unconscious  
dementia  
acuity  
Prehospital orders: [ ] see EMS flowsheet



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Chief Complaint: mental status change

Positives  
Negatives

## History of Present Illness:

Duration: \_\_\_\_\_ minutes / hours / days / weeks / months / years  
Onset: just prior to arrival today @: \_\_\_\_\_ yesterday

Timing: unknown  
abrupt  
gradual  
progressive  
still occurring  
improved  
worse  
resolved  
Quality of Alteration: memory problem  
confusion  
disorientation  
agitation  
loss of consciousness  
Severity of Alteration: mild  
moderate  
severe  
\_\_\_\_\_ (1-10)

Modifying Factors:  
Aggravating: [ ] none  
unknown  
new medication / dose  
removal of home O2  
noncompliant  
nighttime

Alleviating: [ ] none  
holding medication dose  
uses O2  
daylight  
compliant with medications

Associated Symptoms: unknown  
diarrhea  
shortness of breath  
rash  
nausea  
vomiting  
fever  
chest pain  
urinary complaints  
rigors  
extremely swelling / pain  
headache  
[ ] none

Context: unknown  
chronic dementia  
not eating / drinking  
fever  
CO exposure  
ETOH use / abuse  
headache  
HIV +  
diabetes mellitus  
renal failure  
head injury / trauma  
overdose / medication reaction  
psychiatric history  
seizure  
H/O of liver failure  
[ ] none

## Narrative:

Other Data Reviewed: EKG:  
respiratory therapy:  
old records: [ ] requested [ ] reviewed  
[ ] summarized [ ] unavailable  
additional Hx from family / caretaker / other  
Prior Similar Episodes: workup:  
diagnosis:  
treatment:

## Review of System

Constitutional: fever  
chills  
malaise  
Eyes: vision problem  
discharge  
eye pain  
ENT: ear pain  
hearing loss  
nasal / sinus  
congest / disch  
sore throat  
CV: chest pain  
CAD Hx  
syncope  
Respiratory: cough  
shortness of breath  
GI: abdominal pain  
N / V / D  
GU: dysuria  
discharge  
LMP: \_\_\_\_\_  
MSK: myalgias  
pain:  
DVT / PE Hx  
Skin: pruritus  
rash  
Neurologic: headache  
numbness  
weakness  
Heme / Lymph: easy bruising  
nodes  
CA  
blood thinners  
All / Imm: hay fever  
arthritis  
HIV  
[ ] All systems reviewed & negative except as noted above.

## Family, Social History:

Medications: [ ] see nursing note  
Allergies: [ ] see nursing note  
[ ] NKDA  
[ ] nursing note reviewed  
Past Medical History: [ ] negative [ ] noncontributory  
hypertension cardiac disease neurologic disease  
lung disease AMI CVA  
COPD CAD ischemic  
asthma angina hemorrhagic  
CHF- migraines  
cardiomyopathy seizure disorder  
IDDM / NIDDM SVT renal disease  
AFib CRF  
PVCs dialysis  
ventricular- valve disease DVT / PE  
dysrhythmias  
valve disease PUD / GERD

Surgical History: [ ] negative [ ] noncontributory  
CABG appendectomy cholecystectomy  
splenectomy valve replacement

Family History: [ ] unknown [ ] noncontributory  
CAD hypertension CVA  
father diabetes mellitus cancer  
mother  
sibling

Social History: tobacco alcohol drugs  
\_\_\_\_\_ ppd social THC  
\_\_\_\_\_ yrs daily cocaine  
quit \_\_\_\_\_ yrs binge \_\_\_\_\_ amphetamines  
occupation: \_\_\_\_\_

Positives  
Negatives

Physical Exam:

[ ] Nursing record reviewed  
[ ] Vital signs reviewed  
**Vital Signs:**  
BP: \_\_\_\_\_ / \_\_\_\_\_ L  
BP: \_\_\_\_\_ / \_\_\_\_\_ R  
HR: \_\_\_\_\_  
RR: \_\_\_\_\_  
Temp: \_\_\_\_\_ ° F / C  
Pulse Ox: \_\_\_\_\_ % RA / \_\_\_\_\_ L O2

**General Appearance:**  
[ ] alert  
[ ] oriented  
[ ] well-perfused  
**Distress:**  
[ ] no acute  
[ ] mild  
[ ] moderate  
[ ] severe

**Eyes:** [ ] exam limited by urgency of condition  
[ ] PERRL / EOMI anisocoria / gaze palsy  
[ ] conjunctivae clear conjunctivae injected / discharge

**ENT:**  
[ ] TMs nl TMs red - R / L  
[ ] nose nl discharge - clear / colored / \_\_\_\_\_  
[ ] pharynx nl pharynx red / exudate  
[ ] mucosa moist dry mucosa

**Neck:**  
[ ] supple meningismus  
[ ] nontender tender \_\_\_\_\_

**Respiratory:**  
[ ] no distress distress - mild / moderate / severe  
[ ] lungs clear wheezing / rales / rhonchi / reduced - R / L

**Cardiovascular:**  
[ ] RRR irregular rhythm / tachycardia / bradycardia  
[ ] no murmur murmur - grade \_\_\_\_\_ / 6 - systolic / diastolic  
[ ] S1, S2 nl gallop - S3 / S4 / rub  
[ ] no JVD JVD \_\_\_\_\_ cm  
[ ] pulses nl pulse deficit \_\_\_\_\_

**Abdominal:**  
[ ] soft guarded  
[ ] nontender tender: epigastric - R / L - upper / lower / mid / diffuse  
[ ] nondistended distended  
[ ] bowel sounds nl abnormal bowel sounds - increased / decreased / absent  
[ ] CVA nontender CVA tenderness - R / L  
[ ] guaiac-negative guaiac-positive

**Musculoskeletal:**  
[ ] head atraumatic trauma \_\_\_\_\_  
[ ] chest nontender tender ribs \_\_\_\_\_  
[ ] spine nontender tender T-spine / L-spine \_\_\_\_\_  
[ ] extrs nontender tender extremity \_\_\_\_\_  
[ ] no edema edema - 1 2 3 4 + R / L  
[ ] nl capillary refill delayed capillary refill \_\_\_\_\_ seconds

**Skin:**  
[ ] color nl pallor / cyanosis / jaundice  
[ ] warm / dry cool / diaphoretic  
[ ] no rash rash \_\_\_\_\_

**Neurologic:**  
[ ] A&O x3 confused / agitated / obtunded  
[ ] CN nl as tested CN palsy \_\_\_\_\_  
[ ] motor nl motor deficit \_\_\_\_\_  
[ ] sensory nl sensory deficit \_\_\_\_\_  
[ ] tone nl hypertonic / hypotonic - R / L \_\_\_\_\_  
[ ] coordination nl abnormal coordination - R / L \_\_\_\_\_  
[ ] gait nl abnormal gait \_\_\_\_\_

**Psychiatric:**  
[ ] nl affect depressed / anxious / delusional

COMMENTS:

Medical Decision Making:

**Differential Dx:**  
infection - CNS / systemic kidney failure psychiatric  
CVA / SDH OD / intox - drugs / postictal  
hypoxemia withdrawal trauma  
endocrine hypovolemia toxidrome  
liver failure electrolytes other:

Potential Diagnoses

Laboratory Data: Note results

**CBC:** [ ] nl [ ] nl except WBC Hct plts polys bands  
**Chem:** [ ] nl [ ] nl except Na K Cl CO2 bands  
**LFTs:** [ ] nl [ ] nl except AST ALT T-bili AlkPh BUN Cr Glu  
**UA:** [ ] nl [ ] nl except RBC WBC nitrites LE bacteria  
**Tox:** [ ] pos for BAL ASA APAP  
**CSF:** [ ] nl [ ] nl except RBC WBC protein Glu cell count  
Gram stain:  
BNP INR D-dimer ammonia

**ABG:** pH \_\_\_\_\_ PO2 \_\_\_\_\_ PCO2 \_\_\_\_\_  
**Cardiac Enzymes:**  
time: \_\_\_\_\_ CK-MB \_\_\_\_\_ CK \_\_\_\_\_ troponin \_\_\_\_\_

**CXR:** [ ] nl [ ] interpreted by me [ ] reviewed / discussed with Radiology  
[ ] abnl \_\_\_\_\_

**CT** \_\_\_\_\_ [ ] reviewed / discussed with Radiology

**EKG** \_\_\_\_\_ see EKG interp. \_\_\_\_\_ addendum

**Physician-Supervised Infusion Therapy:** given over 60 / 90 / 120 / \_\_\_\_\_ min

**indications:** dehydration / nausea / vomiting / pain \_\_\_\_\_

**fluids:** \_\_\_\_\_ mL NS / LR \_\_\_\_\_ **response:** improved hydration

**additives:** \_\_\_\_\_ **response:** improved nausea / vomiting  
improved pain

[ ] see procedure addendum # \_\_\_\_\_

**ED Course / Additional Data:**  
[ ] reevaluated: time: \_\_\_\_\_ [ ] improved [ ] unchanged

Rx:

[ ] **Faculty Note:** I interviewed and examined the patient. I discussed with PA/resident and agree with their evaluation and plan as documented here.

**Consultation:**  
Discussed with Dr. \_\_\_\_\_ time: \_\_\_\_\_  
Recommends: \_\_\_\_\_  
Will see in: [ ] ED [ ] floor [ ] ICU [ ] cath lab [ ] office in \_\_\_\_\_ days.

[ ] **Vital signs reviewed prior to disposition.**

**Disposition:**  
[ ] discharge [ ] admit floor / telemetry / ICU / cath lab  
[ ] discharge instructions  
[ ] transfer to: \_\_\_\_\_  
via POV / ground EMS / helicopter  
[ ] Counseled pt / fam regarding probable diagnosis and disposition plan.  
[ ] Pt / fam agrees to t/u in ED for worsening sx/s / confusion / HA / weakness.

Condition: [ ] unchanged [ ] improved [ ] stable [ ] serious [ ] critical  
[ ] see addendum [ ] critical care time: \_\_\_\_\_

Clinical Impression:

\_\_\_\_\_  
PA, Resident Signature MD/DO

\_\_\_\_\_  
ED Physician Signature MD/DO

[ ] dictation [ ] written addendum # \_\_\_\_\_  
[ ] copy to PMD  
[ ] template complete

L2-3: 2-4 organ/areas; L4: 5-7 organ/areas; L5: 8+ organ/areas

L1: straightforward; L2-3: low/complex; L4: moderate; L5: high

Not for Clinical Use