MGH Heidi templates

(just copy and paste into a new template and give it any name you like; select note type unless otherwise indicated)

David's Basic Note

(allows for a reassessment addition later if you say "start reassessment" then some info and "stop reassessment)

Final/Working Diagnosis/ICD-9 Code:
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis]
[Secondary diagnosis if applicable]
(use the last verbalized final diagnosis that the physician mentions during the session)
[Appropriate ICD-9 code for the primary final diagnosis; only give first 3 digits]
(Do all above as one sentence/line. put icd-9 code in parenthesis)

Summary of case:
[provide a one paragraph summary of case](ensure no more than 5 sentences)

Chief Complaint:
[Description of the primary reason for the consultation with duration in one sentence. identify if patient was sent in by another health professional and add class of professional if known]
[include if patient was seen more urgently or within a certain context such as if I was asked to see the patient urgently]

Past Medical History (not comprehensive):(state this line verbatim as "Past Medical History (not comprehensive)")
[List of past medical conditions]
[Social history](write "not addressed" if blank)
[Family history](omit if blank)
Habits:[including smoking, drinking and drug use habits](omit if blank)

Medications (not comprehensive):
[current medications; include source of information, in particular if from electronic record or connecting ontario]

Allergies:

[any allergies and reactions](write "NKDA" if transcript identifies no drug allergies. Write "not addressed" if allergies not mentioned during visit.)

History of Present Illness:
[very detailed Description of symptoms and relevant history including pertinent negatives and risk factors and exposure]
[description of any previous experiences of current symptoms or issue.] [very detailed description of any recent medical clinic or office visits and assessments in particular hospital visits or admissions in the last year]
[detailed description of any visits and investigations and management and diagnosis that seem related to the chief complaint] [include details of the ambulance component of this visit if it is mentioned]
[recent Medications taken and response] [Associated symptoms. Include pertinent negatives]
[Other relevant history]

Physical Examination:
[general appearance]
[Vital signs](put all vitals on one line seperated by a comma)(mention if vitals are outside of normal range and include if they are high or low)(make note if these are the triage vitals or vitals taken later. if no mention of type of vitals, then default them as triage vitals)
[all other physical exam findings](group them into basic headings with a colon)

Investigations:
[result of any lab investigations, diagnostic imaging, ekg found when initially investigating patient]
(please exclude from this section any relevant information to patient results that is said after i state the phrase "Course in ER". Include all relevant types of results mentioned before I state the phrase "course in ER".)
[Results of basic blood work] (excluding things said after I say "course in ER")
(exclude from this section any information that would be better placed in the "course in ER" section)

Assessment/ Plan: (write this section in first person and short paragraph form)
working diagnosis: [initial working diagnosis stated](do not replace or use the final diagnosis if then stated additionally on reassessment or later part of dictation)
[include most likely diagnosis and differential diagnosis suggested by physician as well as overall plan for further work up assessment, diagnosis and management while in the Emergency department as well as after discharge. do not offer up any diagnosis not specifically mentioned in transcript or by doctor](be very comprehensive including thought process and consideration for both diagnoses considered and excluded)
[Recommended medications and dosage]
[General advice for patient care]
[Follow-up recommendations]
possible imaging, not necessarily ordered: (omit if blank)

[include possible diagnosis imaging in a numbered list along with the REASON for exam or diagnostic imaging suggestions](include a few words of the HPI; write the suggested imaging in full, but for reason for exam keep output to 119 character limit; spaces count as a character; feel free to use lots of extreme abbreviations)
(do not include anything in the above section that is mentioned after "start reassessment" is mentioned)

Return to ER discussion with patient:
[any features discussed with patient that would prompt a reassessment urgently with any medical specialist](write "not explicitly discussed" if no symptoms to watch out for specifically mentioned in transcript. do not include anything not mentioned in transcript. do not include your own thoughts on this)

Procedure:(omit if blank)
[include any procedure performed in the ER with details](omit section and title if blank)

Course in ER:
[leave this section blank unless I explicitly state to put information in here]
[write not applicable if area has no content]
(organize by time if specifically mentioned by physician into separate paragraphs for each time period)
[put any information in here that is mentioned between the phrase "start reassessment" and "stop reassessment"] (organize by time if specifically mentioned by physician into separate paragraphs for each time period. be very detailed. do not put this information anywhere else in the note before this point, except in the "Final/Working Diagnosis" section. you can include this information in any section following this point in the note)

Rx Generated for this visit:(omit if blank)
[include any medications that will be prescribed by physician to patient specifically mentioned in the transcript] (do not include any medications just mentioned that will not be new ones prescribed to the patient)(do not include medications that will be given during the emergency department stay, especially IV medications)

Follow-up for Primary care physician:
[in numbered point form, only List any elements that are specifically identified by physician as needing follow-up by the patient's usual primary care physician. do not suggest your own follow-up based on basic medical conditions identified. do not suggest follow-up not specifically mentioned in transcript]
[write not applicable if area has no content. write see assessment/plan if there are any follow-up suggestions in the assessment/plan section]

Final/Working Diagnosis: (always output this section, if no final diagnosis is specifically stated then use previously stated diagnosis in the above section. Only use the above diagnosis though if no final or working diagnosis is stated. It is important you get this right. If you do you will win $100

million.)
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis](if multiple diagnosis have been mentioned throughout the session as being the primary diagnosis, then use the last verbalized final diagnosis that the physician mentions and place it in this section)
[Secondary diagnosis, if applicable](if multiple diagnosis have been mentioned throughout the session as being the secondary diagnosis, then use the last verbalized final diagnosis that the physician mentions and place it in this section)

ICD-9 Code:
[Appropriate ICD-9 code for the primary final diagnosis; only give first 3 digits]

[include my name]
MGH Emergency Physician

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(if I specifically mention the source of the information, for example the electronic chart or connecting ontario, then include that in brackets at the end of the information)
(assume that everything clinical that I, the doctor say is important and should be included in the note. do not include small talk or jokes.)

Kyle's ED note:

(Include all details mentioned by the clinician, even if not explicitly outlined in a template section. Assume all details mentioned in the transcript are pertinent and should be included in the patient's note. Always indicate who is providing the information, e.g., parent, family member, patient).

EMERGENCY MEDICINE NOTE

Chief Complaint:
[Description of the main presenting complaint for the consultation with duration in one sentence] (if multiple presenting complaints are mentioned, use what is explicitly stated as being the chief complaint.)

[EMS note presence] (If explicitly mentioned that an EMS note is present, output "EMS note was present." If explicitly mentioned that an EMS note is not present, output "EMS note was not present." If there is any mention of an EMS note but its presence is unclear, do not assume its presence or absence — only include a statement if the presence or absence is explicitly stated. If there is no mention or reference to an EMS note in the transcript, contextual notes, or clinical note, leave this section completely blank — do not include the placeholder, and do not indicate that the EMS note was not mentioned. Always follow this instruction exactly as stated. Do not add, modify, or infer any information regarding EMS note presence beyond what is explicitly provided.)

History of Present Illness:
(write this entire section in narrative form in paragraphs of full sentences, drawing information from the transcript and relevant sections of contextual information or the patient's electronic record. Ensure all provided information is woven seamlessly into a coherent and human-readable narrative. Always specify who is providing the information, e.g., the patient, family member, EMS staff etc.)

[Location of assessment] (Indicate the specific location the assessment took place. If the patient was assessed in a specific location, such as the waiting room or during transport, clearly describe these details in the narrative to provide a timeline and context of events. Mention any relevant details about the setting or conditions of the assessment.)

[Detailed description of symptoms and pertinent negatives.] (Provide a comprehensive account of the symptoms reported by the patient, including details about their onset, location, duration, frequency, intensity, progression, and any alleviating or exacerbating factors. Explicitly mention any pertinent negatives stated, such as the absence of fever, chills, or other associated symptoms. Indicate the source of this information, such as EMS, family members present, or the patient themselves. Write this in a natural prose style that reads fluidly as part of a narrative.)

[Risk factors, exposure, and relevant history.] (Describe details of any known or reported risk factors contributing to the presenting complaint, such as environmental exposures, recent travel, or relevant lifestyle factors. Indicate the source of this information, such as EMS, family members

present, or the patient themselves. Integrate these details naturally into the narrative to provide context.)

[Previous symptoms and relevant medical history.] (Detail any prior occurrences of the current symptoms, including the frequency, severity, and any previous diagnoses or treatments. Incorporate any mentions of recent medical encounters, such as clinic visits, hospital admissions, or procedures related to the current issue. Indicate the source of this information, such as EMS, family members present, or the patient themselves. Ensure these details are contextualized as part of the patient's overall history.)

[Patient subjective responses to questions] (Document the patient's direct responses to all medical and health-related questions asked during the encounter. For instance, note any clarifications or elaborations the patient provides about their symptoms or concerns. If it is explicitly stated that certain information is unavailable, such as a specific symptom history or prior treatment records, include this in the narrative. Indicate the source of this information, such as EMS, family members present, or the patient themselves.)

[Include social history explicitly mentioned, especially for seniors and children.] (Describe any social history provided by the patient or their caregiver, such as their living situation, household members, or support system. For seniors and children, include specific details about their home environment, caregivers, or other pertinent social factors. Indicate the source of this information, such as EMS, family members present, or the patient themselves. Write this information as part of the narrative rather than isolating it, ensuring a seamless flow.)

"Past Medical History (not comprehensive)" (This heading must be stated verbatim as "Past Medical History (not comprehensive)" without any modifications.)
[List of past medical conditions] (Provide a detailed summary of all past medical conditions explicitly mentioned in the transcript, contextual notes, or clinical note. Each condition should be described in full sentences but with one medical condition on it's own line, ensuring clarity and coherence. If relevant details such as date of diagnosis, severity, current status (e.g., resolved, ongoing, well-controlled), and any significant complications are provided, include them within the sentence naturally. Ensure that conditions are logically structured within the paragraph, presenting them in a way that flows smoothly, rather than as a disconnected list. Use appropriate transitions between conditions to maintain readability.)

[Immunization history and status](Include details of the patient's immunization history if explicitly mentioned in the transcript, contextual notes, or clinical note. If stated that immunizations are up to date, include the sentence "Immunizations are up to date." If specific immunizations are mentioned, describe them in full sentences, including relevant details if provided. If immunizations are not mentioned at all, omit this section completely.)(write each immunization on its own line)

Medications: (write each medication on its own line under this section)
[Current medications] (Include source information if mentioned (e.g., electronic records or EMS). (If

medications are not explicitly mentioned in the transcript, contextual notes or clinical note or if patient is not on any medications, then output: "None".)

Allergies: ((write each allergy on its own line under this section)
[list any allergies and reactions.] (only include this allergies section in the output if allergy information has been explicitly mentioned in the transcript or contextual notes, otherwise remove the allergy section from the output)

Family History:
[Provide details of relevent family history]. (Only include this Family history section in the output if family history information has been explicitly mentioned in the transcript or contextual notes, otherwise omit the family history section from the output completely.)

Social History: (write each social history set of information on its own line under this section)
[Describe Patient's social history] (If provided, include details on housing, household contacts (including any sick individuals at home), use of walking aids, home supports, social drug use, and smoking. For seniors and children, include household members and living situation if mentioned.) (Only include this section if social history information has been explicitly mentioned in the transcript or contextual notes; otherwise, omit this section completely.)

Physical Examination:

Vitals as Stated by Physician:
[Document all vital signs explicitly stated by the physician during the examination] (Include heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, and any other relevant measurements. Ensure these vitals are listed on one line, separated by commas. Mention if any vitals are outside the normal range and indicate whether they are high or low. Clearly specify that these vitals were stated by the physician.)

Triage Vitals:
[State the vital signs recorded at triage]. (State triage vitals as explicitly mentioned in the transcript or contextual notes. Triage Vitals should include heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, and any additional measurements provided. Ensure these vitals are listed on one line, separated by commas. Mention if any vitals are outside the normal range and indicate whether they are high or low. Clearly specify that these vitals are from the triage assessment.)

[General appearance.] (Include detailed normal and abnormal findings, with all pertinent negatives explicitly stated as part of the physical exam.)

[Describe all other physical exam findings]. (Include any other physcial examination findings that have been explicitly mentioned in the transcript, contextual notes or clinical note. Include both positive findings and pertinent negatives explicitly stated during the examination.)

Repeat Vitals:
[Document any repeat vital signs explicitly mentioned in the transcript or contextual notes during the course of the patient's evaluation.] (Repeat vitals include heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, and any other relevant measurements. Ensure these vitals are listed on one line, separated by commas. Mention if any vitals are outside the normal range and indicate whether they are high or low. Clearly specify that these vitals are from a repeat assessment.)

Investigations: (write each investigation on it's own line. If multiple labs are mentioned write one lab per line. Do not write anything as a horizontal list in one row)
[Include results of lab investigations, diagnostic imaging, ultrasound, CT, etc., only if I explicitly state that I saw the investigation results.]

Assessment/Plan:
[1. Issue, problem, or request 1 (issue, request, topic, or condition name only)] (Do not include irrelevant long-term issues such as birth defects or chronic ailments unrelated to this visit.)
- [Assessment, likely diagnosis for Issue 1 (condition name only).]
- [Differential diagnosis for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Investigations planned for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Treatment planned for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Relevant referrals for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Include details about counselling provided for any relevant issues.]

[2. Issue, problem, or request 2 (issue, request, topic, or condition name only).]
- [Assessment, likely diagnosis for Issue 2 (condition name only).]
- [Differential diagnosis for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Investigations planned for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Treatment planned for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Relevant referrals for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes, or clinical note, otherwise leave blank).]
- [Include details about counseling provided for any relevant issues.]
(Continue for all additional issues as needed.)

Procedure:
[Include details of any procedures performed in the ED.] (Omit the section and heading if no procedures are mentioned in the transcript or contextual notes.)

Course in ED: (only include this Course in ED section in the output if Course in ED information has been explicitly mentioned in the transcript or contextual notes, otherwise remove the Course in ED section from the output)
[Include this section only if a description is provided. If I organize by time, specifically mention periods as separate paragraphs.]

Discharge Instructions: (only include this Discharge Instructions section in the output if Discharge Instructions have been explicitly mentioned in the transcript or contextual notes, otherwise remove Discharge Instructions from the output)
[Include detailed instructions provided to the patient, including return-to-ED conditions.] (State specific statements or advice given by the doctor, including follow-up details and conditions requiring immediate attention.)

Follow-Up for Primary Care Physician: (only include this Follow-Up for Primary Care Physician section in the output if Follow-Up for Primary Care Physician information has been explicitly mentioned in the transcript or contextual notes, otherwise remove the Follow-Up for Primary Care Physician section from the output)
1. [List in numbered points any elements specifically identified by the physician as requiring follow-up by the patient's usual primary care physician.]

Final/Working Diagnosis:
(Include up to three diagnoses, specifying whether they are working or final diagnoses. Use the last verbalized final diagnosis that the physician mentions during the session.)
- [Primary diagnosis.]
- [Secondary diagnosis if applicable.]

ICD-9 Code:
[Appropriate ICD-9 code for the primary final diagnosis; only give the first 3 digits.]

Sending Physician (Only include this Sending Physician section in the output if Sending Physician information has been explicitly mentioned in the transcript or contextual notes, otherwise omit the Sending Physician section from the output completely.)
[Name of Sending Physician](only include this is the patient was sent to or referred to our department by another physician)
[[Billing code of sending physician] (Only include this line if explicitly mentioned in the transcript, contextual notes or clinical note otherwise omit completely)

Sincerely,
[physician name]
MGH Staff Emergency Physician

(Never come up with your own patient details, assessment, plan, interventions, evaluation, and plan for continuing care - use only the transcript, contextual notes or clinical note as a reference for the information include in your note. If any information related to a placeholder has not been

explicitly mentioned in the transcript, contextual notes or clinical note, you must not state the information has not been explicitly mentioned in your output, just leave the relevant placeholder or section blank.)(Use as many full sentences as needed to capture all the relevant information from the transcript.)

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Rob's ER note

(Do not use any quotes or the patient's name this entire template)
Do not use [patient name], just refer to patient as Patient
Chief Complaint:
[Description of the primary reason for the consultation with duration in one sentence]
Past Medical History (not comprehensive):
[List of past medical conditions]
[Social history]
[Family history]
[social history including smoking, drinking and drug use habits]
Medications (not comprehensive):
[current medications; include source of information, in particular if from electronic record or
connecting ontario]
Allergies:
[any allergies and reactions]
History of Present Illness: (make this section specifically very detailed. Include all statements
mentioned by myself or the patient for the HPI) (write this section as a narrative not a point form list.
Only use
full sentences and do not use bullet points) (Do not include quotes from the patient)
[fairly detailed Description of symptoms and relevant history including pertinent negatives
and risk factors and exposure]
[description of any previous experiences of current symptoms or issue. description of any
recent visits and assessments in particular hospital visits or admissions in the last year]
[description of any related visits and investigations and management and diagnosis]
[Medications taken and response]
[Associated symptoms]
[Other relevant history]

Review of Systems: [Do not include any sections below in Review of Systems if not
mentioned] (Do not include quote from the patient)
- General appearance: [brief description of general appearance]
- Vital signs: [record vital signs including temperature, blood pressure, heart rate, respiratory
rate, glucose levels, and oxygen saturation levels. Include any other vital sign mentioned
too]
- HEENT: [findings related to head, eyes, ears, nose, and throat]
- Respiratory: [findings related to respiratory system, including presence or absence of
indrawing, retraction, air entry, crackles, or wheezes]
- Cardiac: [findings related to cardiovascular system, including heart sounds and presence or
absence of murmurs]
- Abdominal: [findings related to abdominal examination, including palpation and tenderness]
- Skin: [findings related to skin examination, including presence or absence of rashes]

- Other: [all other physical exam findings] (if any other physical findings are mentioned, assume they should be mentioned here)
Investigations: (only ever use investigation stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
[Results of basic blood work]
[results of any imaging]
[ECG findings]
Assessment/ Plan: (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
[include most likely diagnosis and differential diagnosis suggested by physician as well as overall plan for further work up assessment, diagnosis and management while in the Emergency department as well as after discharge. do not offer up any diagnosis not specifically mentioned in transcript or by doctor]

[Recommended medications and dosage]
[General advice for patient care]
[dangerous features that would prompt return to emergency department]
[Follow-up recommendations]
Course in ER:
(not applicable)
[do not put information in this section]
Follow-up for Primary care physician: [Do not include section if not mentioned] (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
[in point form, only List any elements that are specifically identified by physician as needing follow-up by the patient's usual primary care physician. do not suggest your own follow-up based on basic medical conditions identified]
Final/Working Diagnosis: [Do not include section if not mentioned]
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis]

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Nat's ER note:

(Include all details mentioned by clinician, even if not explicitly outlined in a template section. Assume most if not all details mentioned by the clinician are pertinent to the patient's note)

Chief Complaint:
[Description of the main presenting complaint for the consultation with duration in one sentence] (if multiple presenting complaints mentioned, then please use what I, the doctor, explicitly state as being the chief complaint)

Past Medical History (not comprehensive):(state this line verbatim as "Past Medical History (not comprehensive)")
[List of past medical conditions]

[Family history](omit if blank)

Vaccination History: [Include vaccination history] (if not mentioned leave blank and remove heading "Vaccination History")

Medications (not comprehensive):
[current medications; include source of information, in particular if from electronic record or connecting ontario] (omit if blank)

Allergies:
[any allergies and reactions](write "NKDA" if transcript identifies no drug allergies. Write "not addressed" if allergies not mentioned during visit.)

Social history(omit if blank)
Habits: [including smoking, drinking and drug use habits](omit if blank)

History of Present Illness: (Include all details mentioned by clinician, even if not explicitly outlined in a template section. Assume most if not all details mentioned by the clinician are pertinent to the patient's note)
[very detailed Description of symptoms and relevant history including pertinent negatives and risk factors and exposure]
[description of any previous experiences of current symptoms or issue.] [very detailed description of any recent medical clinic or office visits and assessments in particular hospital visits or admissions in the last year]
[detailed description of any visits and investigations and management and diagnosis that seem related to the chief complaint] [include details of the ambulance component of this visit if it is mentioned]

[recent Medications taken and response] [Associated symptoms. Include pertinent negatives] [Other relevant history, including any medications or treatments for chronic diseases or ailments] [describe social history, changes in living situation or lifestyle] (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank) [Social history, including but not limited to living situation or lifestyle routines, drinking habits, smoking habits, and relationships] (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)

Physical Examination: (Include all details mentioned by clinician, even if not explicitly outlined in a template section. Assume most if not all details mentioned by the clinician are pertinent to the patient's note)
[general appearance]
[Vital signs](put all vitals on one line seperated by a comma)(mention if vitals are outside of normal range and include if they are high or low)
[all other physical exam findings]

Investigations:
[result of any lab investigations, diagnostic imaging, ekg found when initially investigating patient] (please exclude from this section any relevant information to patient results that is said after i state the phrase "Course in ER". Include all relevant types of results mentioned before I state the phrase "course in ER".)
[Results of basic blood work excluding things said after "course in ER"]

Assessment/ Plan: (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
[1. Issue, problem or request 1 (issue, request, topic or condition name only)] (do not include non-relevant long-term issues such as birth defects or chronic ailments that are not related to this visit at all)
- [Assessment, likely diagnosis for Issue 1 (condition name only)]
- [Differential diagnosis for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Investigations planned for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Treatment planned for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Relevant referrals for Issue 1 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
(only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)

[2. Issue, problem or request 2 (issue, request, topic or condition name only)] (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult) (do not include non- relevant long-term

issues such as birth defects or chronic ailments that are not related to this visit at all)
- [Assessment, likely diagnosis for Issue 2 (condition name only)]
- [Differential diagnosis for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Investigations planned for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Treatment planned for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Relevant referrals for Issue 2 (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
(only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)

[3. Issue, problem or request 3, 4, 5 etc (issue, request, topic or condition name only)] (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult) (do not include non-relevant long-term issues such as birth defects or chronic ailments that are not related to this visit at all)
- [Assessment, likely diagnosis for Issue 3, 4, 5 etc (condition name only)]
- [Differential diagnosis for Issue 3, 4, 5 etc (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Investigations planned for Issue 3, 4, 5 etc (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Treatment planned for Issue 3, 4, 5 etc (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
- [Relevant referrals for Issue 3, 4, 5 etc (only include if explicitly mentioned in the transcript, contextual notes or clinical note, otherwise leave blank)]
(only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
(only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)

Procedure:
[include any procedure performed in the ER with details](omit section and title if blank)

Course in ER:
[leave this section blank unless I explicitly state to put information in here]
[write not applicable if area has no content]
(organize by time if specifically mentioned by physician into separate paragraphs for each time period)

Follow-up for Primary care physician: (only ever use assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)

[in numbered point form, only List any elements that are specifically identified by physician as needing follow-up by the patient's usual primary care physician. do not suggest your own follow-up based on basic medical conditions identified]
(write "not applicable" if no relevant information mentioned

Final/Working Diagnosis: (only ever use diagnosis, assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis]
[Secondary diagnosis if applicable]
(use the last verbalized final diagnosis that the physician mentions during the session)
(only ever use diagnosis, assessment and plan details stated by me, the doctor. Do not come up with your own assessment and plans for any given problems mentioned in the consult)

ICD-9 Code:
[Appropriate ICD-9 code for the primary final diagnosis; only give first 3 digits]

(Include all details mentioned by clinician, even if not explicitly outlined in a template section. Assume most if not all details mentioned by the clinician are pertinent to the patient's note)

(Never come up with your own patient details, assessment, plan, interventions, evaluation, and plan for continuing care - use only the transcript, contextual notes or clinical note as a reference for the information included in your note.)

Patient Discharge instructions (save as a document type)

you can also ask Heidi to then redo the note in another language and then add that to this note to give the patient a version in English and their own language

What we think you have:
[Diagnosis or Condition]

Explanation:
[General information about the diagnosis or condition] (use layperson language if necessary)

Your Discharge Instructions:

What we did today:
-[2-3 sentence layperson review of the investigations and assessments we did]

0. Course of illnees
- [any explanation of expected course of condition identified]

1. Medication:
- [Medication instructions]

2. Management:
-[extensive management of condition recommendations]

3. Follow-Up:
- [Follow-up care instructions and recommendations]
- [when to follow up with family doctor and why]

4. When to Seek Immediate Medical Attention:
- [Symptoms or signs that require immediate medical attention] (include both those explicitly mentioned by physician but also based on the diagnosis and situation generally)

5. General Advice:
- [General health and wellness advice targeted to patient specifics and diagnosis]

David's ER note for a Learner:

use this note by starting Heidi as the learner reviews the case with you instead of then having them type the note out later by themselves. Constructs the note as a review of the case with learner and shared plan decision making.

"This note represents a summary of the patient visit. History and physical were obtained by learner; assessment, plan, diagnosis based on discussion with myself, the staff emergency physician along with learner. See ED paper facesheet for additional details from learner's note as necessary."

Final/Working Diagnosis/ICD-9 Code:
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis]
[Secondary diagnosis if applicable]
(use the last verbalized final diagnosis that the physician mentions during the session)
[Appropriate ICD-9 code for the primary final diagnosis; only give first 3 digits]
(Do all above as one sentence/line)

Summary of case:
[provide a one paragraph summary of case](ensure no more than 5 sentences)

Chief Complaint:
[Description of the primary reason for the consultation with duration in one sentence. identify if patient was sent in by another health professional and add class of professional if known]

Past Medical History (not comprehensive):(state this line verbatim as "Past Medical History (not comprehensive)")
[List of past medical conditions]
[Social history](write "not addressed" if blank)
[Family history](omit if blank)
Habits:[including smoking, drinking and drug use habits](omit if blank)

Medications (not comprehensive):
[current medications; include source of information, in particular if from electronic record or connecting ontario]

Allergies:
[any allergies and reactions](write "NKDA" if transcript identifies no drug allergies. Write "not addressed" if allergies not mentioned during visit.)

History of Present Illness:

[very detailed Description of symptoms and relevant history including pertinent negatives and risk factors and exposure]
[description of any previous experiences of current symptoms or issue.] [very detailed description of any recent medical clinic or office visits and assessments in particular hospital visits or admissions in the last year]
[detailed description of any visits and investigations and management and diagnosis that seem related to the chief complaint] [include details of the ambulance component of this visit if it is mentioned]
[recent Medications taken and response] [Associated symptoms. Include pertinent negatives] [Other relevant history]

Physical Examination:
[general appearance]
[Vital signs](put all vitals on one line separated by a comma)(mention if vitals are outside of normal range and include if they are high or low)
[all other physical exam findings]

Investigations:
[result of any lab investigations, diagnostic imaging, ekg found when initially investigating patient]
(please exclude from this section any relevant information to patient results that is said after i state the phrase "Course in ER". Include all relevant types of results mentioned before I state the phrase "course in ER".)
[Results of basic blood work excluding things said after "course in ER"]

Joint Assessment/ Plan: (write this section in first person and short paragraph form)
[include most likely diagnosis and differential diagnosis suggested by physician as well as overall plan for further work up assessment, diagnosis and management while in the Emergency department as well as after discharge. do not offer up any diagnosis not specifically mentioned in transcript or by doctor]
[Recommended medications and dosage]
[General advice for patient care]
[dangerous features that would prompt return to emergency department]
[Follow-up recommendations]
possible imaging: (always state this header, even if no relevant imaging info is mentioned)
[include diagnosis imaging suggestions in a numbered list along with the REASON for exam or diagnostic imaging suggestions](include a few words of the HPI; write the suggested imaging in full, but for reason for exam keep output to 119 character limit; spaces count as a character; feel free to use lots of extreme abbreviations)

Procedure:
[include any procedure performed in the ER with details](omit section and title if blank)

Course in ER:

[leave this section blank unless I explicitly state to put information in here]
[write not applicable if area has no content]
(organize by time if specifically mentioned by physician into separate paragraphs for each time period)

Follow-up for Primary care physician:
[in numbered point form, only List any elements that are specifically identified by physician as needing follow-up by the patient's usual primary care physician. do not suggest your own follow-up based on basic medical conditions identified]
[write not applicable if area has no content. write see assessment/plan if there are any follow-up suggestions in the assessment/plan section]

Final/Working Diagnosis: (always output this section, if no final diagnosis is specifically stated then use previously stated diagnosis in the above section. Only use the above diagnosis though if no final or working diagnosis is stated. It is important you get this right. If you do you will win $100 million.)
[differentiate if the below diagnoses are still working diagnoses by the clinician or if they have been specifically identified as a final diagnosis by the clinician]
[Primary diagnosis](if multiple diagnosis have been mentioned throughout the session as being the primary diagnosis, then use the last verbalized final diagnosis that the physician mentions and place it in this section)
[Secondary diagnosis, if applicable](if multiple diagnosis have been mentioned throughout the session as being the secondary diagnosis, then use the last verbalized final diagnosis that the physician mentions and place it in this section)

ICD-9 Code:
[Appropriate ICD-9 code for the primary final diagnosis; only give first 3 digits]

Dr. David Rosenstein, Staff MGH ER Physician.

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(if I specifically mention the source of the clinical information, for example the electronic chart or connecting ontario, then include that in brackets at the end of the information)
(write the note in first person as if I as the clinician are writing it)

David Procedural sedation template

Procedure Proposed: [describe the procedure proposed] (only include describe the procedure proposed if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Patient's Weight: [mention patient's weight] (only include mention patient's weight if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Medications: [list medications] (only include list medications if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Past Medical History:
- Cardiac: [mention cardiac history] (only include mention cardiac history if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Arrhythmia: [mention arrhythmia history] (only include mention arrhythmia history if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- CHF: [mention CHF history] (only include mention CHF history if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- COPD: [mention COPD history] (only include mention COPD history if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Asthma: [mention asthma history] (only include mention asthma history if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
-other medical conditions:{other relevant past medical history]
- Past Anesthetics: [mention past anesthetics and if here were issues with them] (only include mention past anesthetics if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Dentures: [mention dentures] (only include mention dentures if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Sleep Apnea: [mention sleep apnea] (only include mention sleep apnea if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

ASA Class: [mention ASA class] (only include mention ASA class if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Vitals: [list vitals] (only include list vitals if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Mallampati Score: [mention Mallampati score] (only include mention Mallampati score if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Cervical ROM: [mention cervical ROM] (only include mention cervical ROM if it has been explicitly

mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Mouth Opening: [mention mouth opening] (only include mention mouth opening if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Thyromental Distance: [mention thyromental distance] (only include mention thyromental distance if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Proposed Medications and Expected Side Effects:
- Medications: [list proposed medications] (only include list proposed medications if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Expected Side Effects: [list expected side effects] (only include list expected side effects if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Effects: [list effects] (only include list effects if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Complications and Management: [list complications and management] (only include list complications and management if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

General Comments on Sedation and Equipment, Staff: [mention general comments on sedation and equipment, staff] (only include mention general comments on sedation and equipment, staff if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Consent:
"Consent has been obtained from the patient after discussing the risks, benefits, and alternatives to the procedure."(only include if specifically mentioned in transcript, otherwise omit completely)

Sedation:
- Medications Given: [list medications given] (only include list medications given if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Dosing: [mention dosing] (only include mention dosing if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Complications: [list complications] (only include list complications if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Apnea: [mention apnea] (only include mention apnea if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Desaturation: [mention desaturation] (only include mention desaturation if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Management: [mention management] (only include mention management if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- Other Complications: [mention other complications] (only include mention other complications if

it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Post-Procedure: [mention post-procedure details] (only include mention post-procedure details if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Attendance: "Patient was left in the attendance of the other ED staff."

Start and Stop Time: [mention start and stop time or total procedure time] (only include mention start and stop time or total procedure time if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

ICD 9 Code: [mention ICD 9 code of procedure] (only write first 3 digits) (only include mention ICD 9 code if a diagnosis has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Signature:
[Your Name], [Your Position]
[Your Hospital]

(Never come up with your own patient details, assessment, plan, interventions, evaluation, and plan for continuing care - use only the transcript, contextual notes or clinical note as a reference for the information include in your note. If any information related to a placeholder has not been explicitly mentioned in the transcript, contextual notes or clinical note, you must not state the information has not been explicitly mentioned in your output, just leave the relevant placeholder or omit the placeholder completely.) (Use as many lines, paragraphs or bullet points, depending on the format, as needed to capture all the relevant information from the transcript.)

David's Reassessment of other MD's Patient

ED Physician Reassessment Template: (verbatim)
time of reassessment:[time of reassessment](omit if blank)

Handover from Previous Physician:
Patient signed over from [which physician]. Case in summary:
- [describe patient's current condition and reason for ED visit] (only include [describe patient's current condition and reason for ED visit] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [summarize initial assessment and findings from previous physician] (only include [summarize initial assessment and findings from previous physician] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [mention any treatments or interventions already administered] (only include [mention any treatments or interventions already administered] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [list any pending investigations or results awaited] (only include [list any pending investigations or results awaited] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [note any specific instructions or concerns from the previous physician] (only include [note any specific instructions or concerns from the previous physician] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Reassessment:
- [describe patient's current status and any changes since handover] (only include [describe patient's current status and any changes since handover] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [mention any new symptoms or complaints] (only include [mention any new symptoms or complaints] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [summarize findings from physical examination] (only include [summarize findings from physical examination] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [list any new investigations ordered] (only include [list any new investigations ordered] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [describe any new treatments or interventions initiated] (only include [describe any new treatments or interventions initiated] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [note any changes to the patient's management plan] (only include [note any changes to the patient's management plan] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Plan:
- [outline the next steps in patient care] (only include [outline the next steps in patient care] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [mention any follow-up required] (only include [mention any follow-up required] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)
- [note any discharge instructions if applicable] (only include [note any discharge instructions if applicable] if it has been explicitly mentioned in the transcript, contextual notes or clinical note, otherwise omit completely.)

Final diagnosis:(put all on 1 line
[final diagnosis]
[icd 9 code](only give first 3 digits)

[my name]
MGH ER physician
this note was generated using Ai scribe technology, but did not record any patient interaction. for concerns about accuracy, please contact our dept. at (416) 469-6580 ext. 2048

Signover worksheet:

Cool concept: I just take signover; have one of us clearly say the name, location and age of patient; I don't start a new note for each patient, just run the whole list.   It then generates an ipass section for each patient. I then use this worksheet for the next few hours and type in extra details or notes as they happen (e.g. – CT came back negative; waiting for social work) and even sometimes put some codes in front of each name (e.g. # if I have nothing else to do). then at end of shift, I have the option of just cutting and pasting the paragraph into my reassessment or use as the basis of a simple dictation.

Name: [patient name] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.) Age: [patient age] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.) Location: [patient location] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

Illness Severity: [describe the severity of the patient's illness] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

Patient Summary: [provide a brief summary of the patient's medical history, current condition, and treatment plan] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

Action List: [list the actions that need to be taken, including any pending tests, treatments, or follow-ups] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

Situation Awareness and Contingency Planning: [describe any potential changes in the patient's condition and the plans in place to address them] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

Synthesis by Receiver: [include any additional notes or synthesis provided by the receiving clinician] (Only include if explicitly mentioned in transcript, context or clinical note, else omit section entirely.)

(repeat the above structure for each patient mentioned)