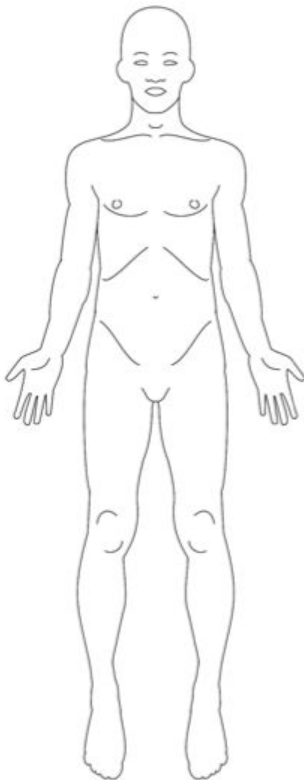


Oral Boards Standard Process:

- **Intro:** "What do I see when I walk in the room?"
- **Vitals:** Ask for full vitals, Ask for POC glucose
- **Primary Survey:** Assess Airway, Breathing and Circulation (Disability/Exposure prn)
- **Sick or Stable:** Decide if patient is currently Sick (intervene immediately) or Stable (collect more history)
- **Initial Action:** as indicated, place 2x LBIV, O2, cardiac monitor, pulse ox, IVF, EKG, procedures prn (intubate, needle thora, central line, etc), send stat labs and imaging, initial meds (pain, D50, blood, empiric antibiotics, etc), POCUS?
- **HPI:** Obtain HPI from patient +/- family +/- EMS
- **Additional History:** Past Med/Surg Hx, Family Hx, Social Hx (etoh, drugs, smoking), Allergies, Meds, DNR/DNI as needed?, PMD? ID sources of supplemental history (EMS, family, nursing home, chart review) if information is limited.
- **Physical Exam:** Perform a focused, relevant physical exam; do not forget full skin, GU or rectal exams as appropriate
- **Additional Action:** Labs, Imaging, Meds, Procedures prn, Consults prn based on your working differential
- **Reassess:** ask RN for repeat vitals and reassess patient status, determine response to interventions
- **Ask for Results**
- **Act on Results:** additional testing, meds, consults prn
- **Diagnosis:** Verbalize your working or final diagnosis
- **Update:** Update the patient, family, PMD as needed
- **Disposition** Home, Admit, Transfer

Case #1



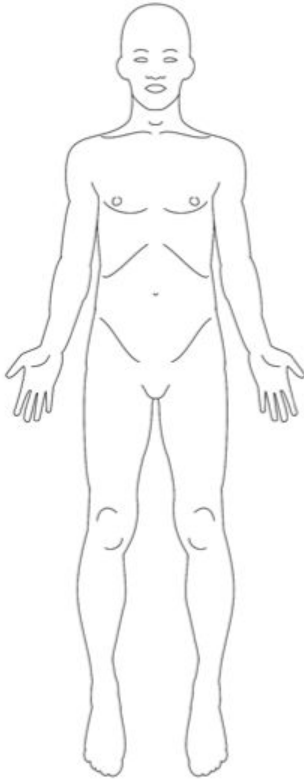
CC:	Extra:	EMS?	Family?	PMD?	Code?	
Vitals: HR BP RR Sat Temp Wt Gluc	Primary:	A	B	C	D	E
History	Action		Outcome			
PMH/PSH						
Meds						
Allergies						
Social						
Family						
Physical						
HEENT						
Heart						
Lungs						
Abd						
Ext						
Neuro						
Back						
Skin						
? GU Rectal Lymph Psych	Dx		Dispo			

NOTES:

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- **Reassess:** ask RN for repeat vitals and reassess patient status, determine response to interventions
- **Ask for Results**
- **Act on Results:** additional testing, meds, consults prn
- **Diagnosis:** Verbalize your working or final diagnosis
- **Update:** Update the patient, family, PMD as needed
- **Disposition** Home, Admit, Transfer

Case #2



CC:	Extra:	EMS?	Family?	PMD?	Code?	
Vitals: HR BP RR Sat Temp Wt Gluc	Primary:	A	B	C	D	E
History	Action		Outcome			
PMH/PSH						
Meds						
Allergies						
Social						
Family						
Physical						
HEENT						
Heart						
Lungs						
Abd						
Ext						
Neuro						
Back						
Skin						
? GU Rectal Lymph Psych	Dx		Dispo			

NOTES: