

Diagnosis

Laceration - lip
Prescriptions

Keflex PO 500 mg(s). Sig: 1 QID . - Duration: x 3 days < MD 6/10/2008 23:02>

Disposition

Provider documentation to be completed on HMED.

Disposition - Discharge from ED: home . Condition: stable . The patient

is to follow up with the Emergency Department . Aftercare: Laceration
Keep clean and dry. Antibiotic ointment twice daily. Sutures out here
in 5
days.

Private Physician(s)
Chief Complaint

Chief complaint/quote: Bit to top of lip by puppy tonight.
History of Present Illness

HPI text: This is a 17 year old white male with a chief complaint of lip
laceration. He got a new puppy and the puppy bit him on his upper lip.
His
dad was concerned that he would require laceration repair.

Additional HPI: The patient reports last tetanus shot 2 years ago.
Review of Systems

Review of systems is as indicated in the HPI. All other systems were
reviewed and were negative.

Medications

Home medications: Wellbutrin PO - every day
Abilify PO- every day

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Attention deficit/Hyperactivity
disorder

Appendectomy

Patient has not been diagnosed with antibiotic resistant
infection.

Vaccinations are up to date.

Social History

Additional Social History: dad at the bedside

VITAL SIGNS

Initials/Date/Time Temp(C) Rt. Pulse Resp Syst Diast Pos. O2 O2
DelPain

Sat

Sc

EZF 6/10/2008 22:35 36.8 0 94 20 137 79 S 100 .R/A

3

Physical Exam

SKIN: there is a 1 cm laceration located on the upper lip left side; vertical through the vermilion border through the superficial dermis; no

gross contamination noted; wound was visualized and inspected in a bloodless field; no deep structures such as muscularis appear injured

NEURO: motor and sensation function were normal distal to the laceration

MUSCULOSKELETAL: no bony tenderness at site of injury
Procedures

Laceration repair:Laceration length is specified in the physical exam documentation. The affected area was cleansed with hibiclens and with normal saline. Local anesthesia obtained with 2% Lidocaine0.25ml .

Wound

exploration showed the following: no foreign body. Laceration was closed

with . Skin was closed with simple interrupted stitches of 7-0 prolene

. Wound dressed with antibacterial ointment. Suture/staple removal in 5 days

. I discussed the following with the patient/family: signs and symptoms of

infection and proper wound care . The repair required alignment of vermilion border. ASB 06/10/08 23:59

Progress Notes

Medical Decision-Making

The patient's prior medical records were reviewed.

INITIAL ASSESSMENT AND PLAN: The patient's laceration requires repair (see Procedure note).