

Diagnosis

Laceration - face

Disposition

Provider documentation to be completed on HMED.

Copy to:

Disposition - Discharge from ED: home . Condition: stable . The patient is to follow up with the Emergency Department , 5 day(s) . Recheck immediately for new or worsening symptoms. . Wound/injury: use cool compresses for comfort and . Return if any new concerns develop, you are feeling worse or . Aftercare: Laceration . Pediatric (English) return for suture removal in 5 days any signs of infection (redness, warmth, tenderness, drainage) . Medications: use Tylenol (acetaminophen) for pain or fever

Medication instructions: No changes

Private Physician(s)

Chief Complaint

Chief complaint/quote: Fell off bunk bed and hit right eyebrow. Fall was not witnessed, but child was alert and not crying. Has 1.5 cm laceration to right eyebrow. Minimal bleeding.

History of Present Illness

HPI text: This is a 2 year old female who was brought to the ED by her mother for evaluation of a laceration. The patient has a laceration to the medial aspect of the right eyebrow that extends towards the nasal bridge.

Bleeding is controlled on presentation. Mom states the patient was playing with his sister in their room when the patient came upstairs stating she had hurt her head. Mom reports blood coming down the patient's face and believes she may have fallen off the bunk bed. The incident was unwitnessed by the mother. Activity is WNL and there are no other injuries or acute medical concerns.

Review of Systems

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

Medications

Home medications: Patient not currently taking any medications.

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

NO SIGNIFICANT PAST MEDICAL OR SURGICAL HISTORY.

Patient has not been diagnosed with antibiotic resistant infection.

Vaccinations are up to date.
Social History

Living arrangement: Patient lives with parent(s)
Family History

There is no significant family history of and any medical condition pertinent to the patient's current presentation

VITAL SIGNS

Initials/Date/Time	Temp(C)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2	O2
DelPain									
								Sat	
Sc									
JZS 6/13/2008 22:24	36.8	O	129	20				97	.R/A
LH 6/13/2008 23:33			146	20	131	70	S	98	.R/A
LH 6/13/2008 23:42			149	17	126	81	L	100	.R/A
LH 6/13/2008 23:47			185	19	123	87	L	100	2 L
LH 6/13/2008 23:51			151	21	135	94	L	97	2 L
LH 6/14/2008 00:00			146	22	126	60	L	97	.R/A

Height and Weight

Weight: 14.0 kg. (30.9 lbs.)

Physical Exam

GENERAL: no acute distress

NEURO: alert and cooperative; normal mental status

CARDIOVASCULAR: regular rhythm; strong, symmetric peripheral pulses

PULMONARY: no respiratory distress; clear and equal breath sounds bilaterally

FACE: 2.5 cm laceration in the right eyebrow extending nasally to the nasal bridge. Edges aligned nicely. No bony step-offs. No ocular or nasal trauma. Extraocular muscles intact.

Procedures

Consent: I performed the conscious sedation and the associated procedure.

After discussing risks, benefits, and alternatives, the plan for sedation was consented to by the patient's parent(s). A respiratory therapist was present at time of sedation. The patient was placed on continuous pulse

oximetry, continuous cardiac monitoring and oxygen. The patient was medicated with Ketamine 45mg. Duration of sedation: 20 minutes.
Cardiac

Monitor: stable and normal sinus rhythm. Respiratory status remained stable. Blood pressure remained stable. I reassessed the patient after recovery from sedation. SZA 06/14/08 00:01

Laceration repair:Laceration length is specified in the physical exam

documentation. The affected area was cleansed with Shur-Clens and irrigated with normal saline. Local anesthesia obtained with 1% Lidocaine without epinephrine . Wound exploration showed the following: no foreign body. Laceration was closed with . Skin was closed with 6 simple interrupted stitches of 6-0 nylon . Wound dressed with antibacterial ointment and pressure dressing. Suture/staple removal in 5 days . I discussed the following with the patient/family: signs and symptoms of infection, proper wound care and ways to minimize the scar SZA
06/14/08
00:04

Medications Administered

: Zofran ODT 2mg tab PO, MD 6/13/2008 23:02

Given: Yes PO Dose: 2 mg(s), RN 6/13/2008 23:05

: Ketamine HCl Intramuscular Give: 45 mg(s), MD
6/14/2008 00:09

Given: Yes IM. Location: Left thigh, RN 6/13/2008 23:24

Progress Notes

Medical Decision-Making

Medical Decision-making:

patient tolerated primary repair under conscious sedation well. Wound care instructions were addressed along with scar minimization techniques. I requested the mother return in five days for suture removal or sooner if concerns of infection develop. Patient had no loss of consciousness and no signs of facial bone trauma.

Patient Discussion

The diagnosis was discussed with the patient and/or the patient's family. The treatment plan, as specified under disposition documentation, was discussed with the patient and/or the patient's family. The patient and/or the patient's family have expressed understanding and comprehension of the plan.