Electronic Health Record (EHR) Stookey OMT SOAP Note

As a mandatory requirement for successful completion of your OMT Stookey Rotations you will be required to submit 1 SOAP note during your Year 3 Stookey rotation and 1 SOAP note during your Year 4 Stookey Rotation on a patient of your choice documented in the WVSOM Greenway PrimeSuites' EHR.

You will create each patient in the EHR. They will need to be de-indentified by using **your login ID** as the patient's last name. The first name will be StookeyYear3 and StookeyYear4 (see example below):

jpatton, StookeyYear3
jpatton, StookeyYear4

Enter the Patient's Date of Birth and Sex. Please **Do not** enter a Social Security number or use the Patient's real name.

In order to get credit for this assignment you will need to email your SWC Director, Administrative Assistant and Jenny Patton and Rebekah Brookman - jpatton@osteo.wvsom.edu and rbrookman@osteo.wvsom.edu **when you have completed each case**. The case will be forwarded to the appropriate grader who will accept or reject the case. Rejected cases must be **redone within 10 days** to receive credit.

SOAP notes will be rejected for: 1) failure to use OMT; 2) absence of any required section including Application of Osteopathic Principles. Rejected cases must be redone **within 10 days** to receive credit.

The following elements must be included to receive credit for this exercise (see sample Stookey OMT SOAP note):

- SUBJECTIVE - MUST include:
  - Age
  - Chief Complaint
  - History of Present Illness **(problem focused)**
  - Patient History **Enter History on Facesheet**
  - Review of systems **(pertinent)**
- OBJECTIVE (include vital signs, postural/structural exam at least 3 regions related to chief complaint, pertinent orthopedic, pertinent neurologic, pertinent visceral)
- ASSESSMENT **(include problem and somatic dysfunction diagnoses)**
- PLAN (include OMT and response, other treatments, diagnostic testing, follow-up)
- APPLICATION OF OSTEOPATHIC PRINCIPLES **(rationale for any OMT listed in Plan)**

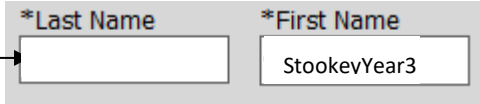
Logon to the Greenway EHR, please use the login information below. Username and Password that were originally assigned to you has been disabled.

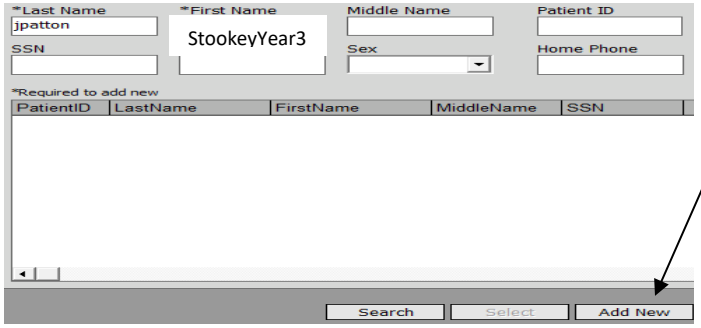
- **Username = stookey**
- **Password = wvsom**

Log on to the PrimeSUITE EHR.

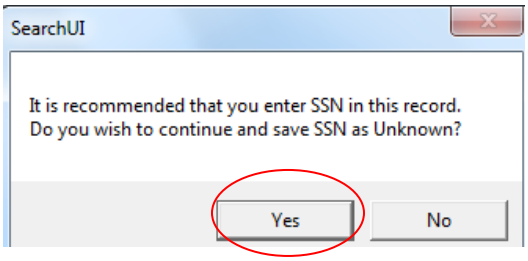
- **Username = stookey**
- **Password = wvsom**

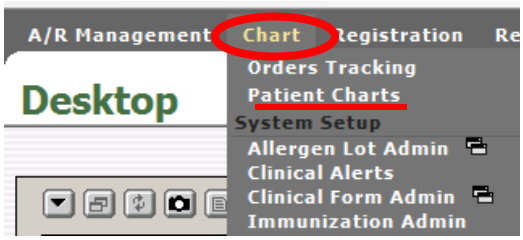
1. Click on the **"Search for Patient Icon"** located at the top left hand corner of your screen
2. Enter **YOUR** ***"EHR Log-In ID"*** as the Patient's Last Name
3. Enter ***"StookeyYear 3" or "StookeyYear4"*** as the Patient's First Name



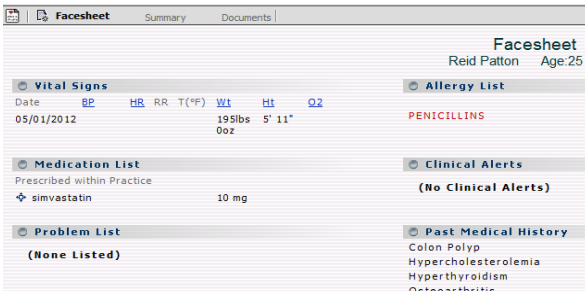


4. Click on ***"Add New".***
5. Click ***"Yes"*** to add Pt. without a SSN.

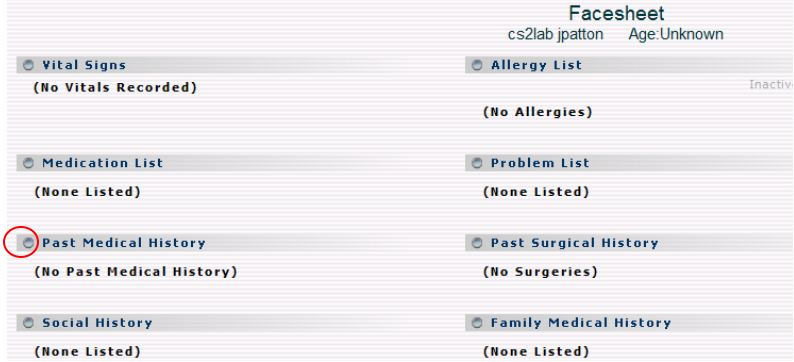




6. Click on ***"Chart"*** from the menu
7. Select ***"Patient Charts"*** to display the patient's facesheet.

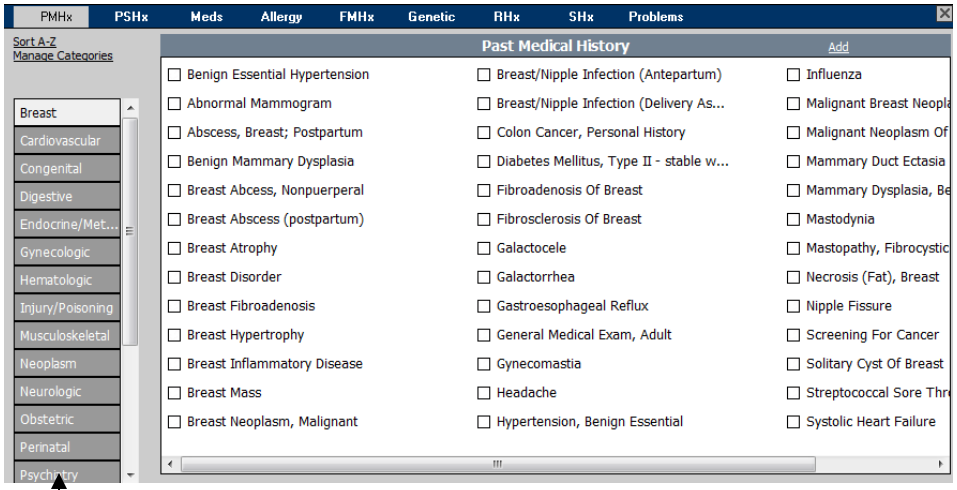


Add Patient History

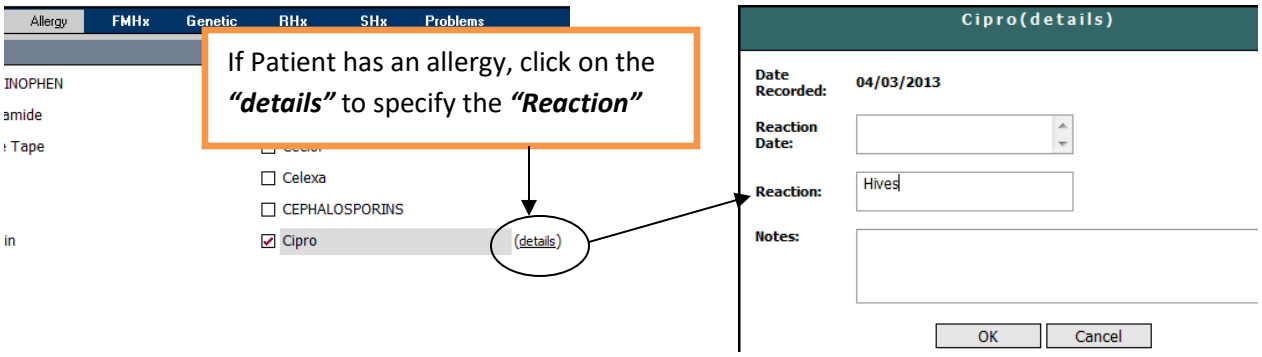


Add Patient History (Allergies, Medications, Past Medical, Family, Surgical and Social History)

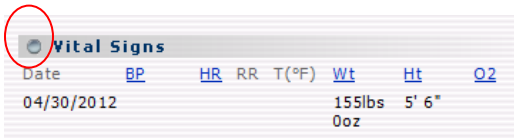
Click on the ○ that is located beside "Past Medical History" history section, then access each tab in the history window.



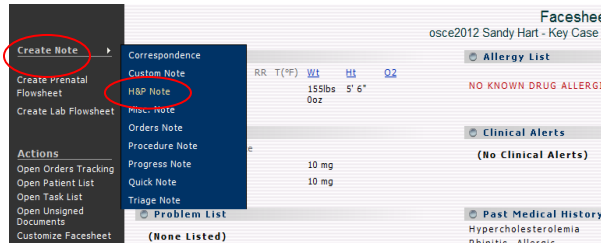
History sections are separated by categories.

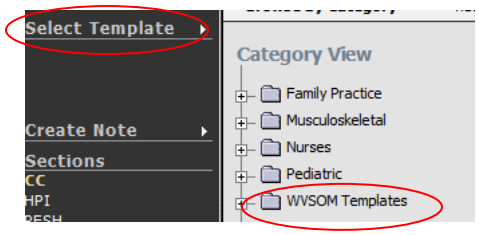


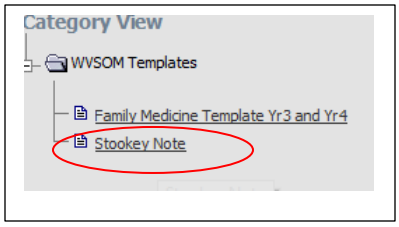
Document Encounter

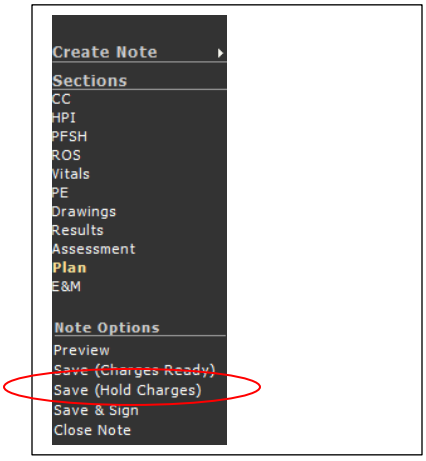


- Click on the ○ that is located beside the ***"Vital Signs"***
- Click on ***"Add New Vitals"***





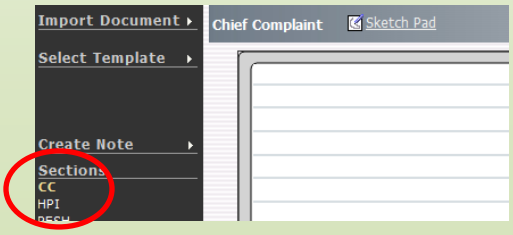


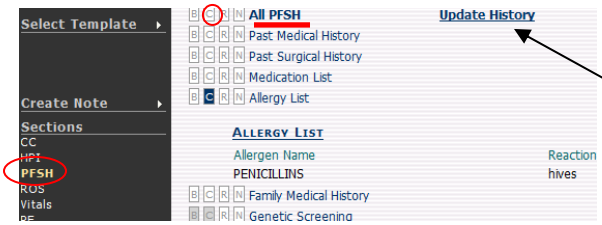


- Click on ***"Create Note"*** (located on the left hand side of the Facesheet).
- Select **"H&P Note"**
- **Click on "Select Template"**
- **Click on "WVSOM Templates**
- **Select "Stookey Note"**
- **Under Note Options (located to the left hand side) click on "Save and Hold Charges" to establish note in the EHR, continue to click on Save and Hold Charges as you are documenting your H&P note, there is no automatic save.**

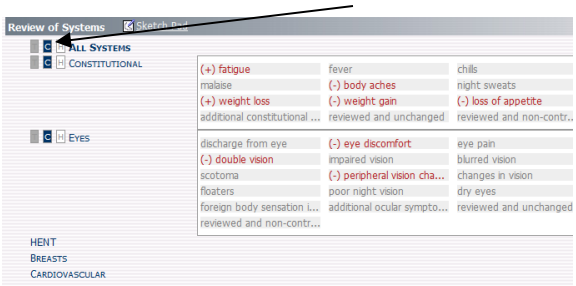
- Click on **"CC"** (Chief Complaint) then Sketch Pad and free text Information

- Click on **HPI** and then Sketch pad and free text Information



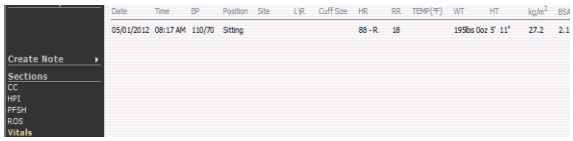


- Click on **"PFSH"** located on the left hand side under ***"sections"***
- Click **C** for **"All PFSH"**
- If you realized that you forgot to add something to the facesheet, click on Facesheet add information, **BUT FIRST SAVE YOUR NOTE**
  a. Click directly back on Note, DO NOT create a new note
  b. Update the note with the information you just added – click on PFSH, click on **Update History**



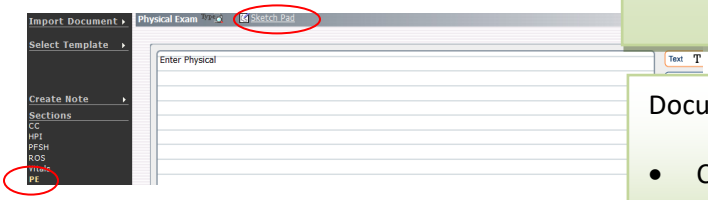
Document the ***Review of Systems (ROS)***

- Click on ***"ROS"*** located on the left hand side under ***"Sections"***
- Click on "C" for All Systems
- Enter Associated ROS:
    a. Click one time to mark as patient denies/negative (-)
    b. Click on symptom twice to mark as positive/admits(+)



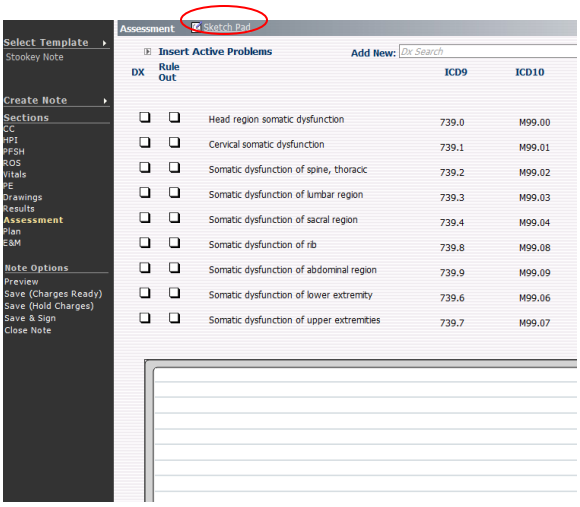
Review the **Patient Vitals**

- Click on ***"Vitals"*** and review
- If you do not see your vitals on the note click on the magic wand over to the right hand side, double click on vitals and then Update



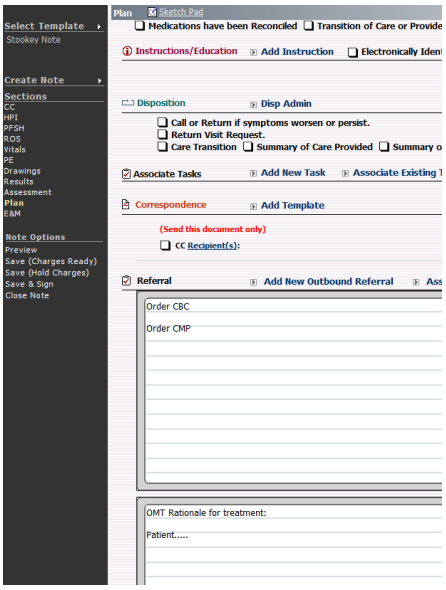
Document the ***Physical Exam (PE)***

- Click on ***"PE"*** located on the left hand side under ***"Sections"***
- Click on the **"Sketch Pad"** and enter the "**PE**".



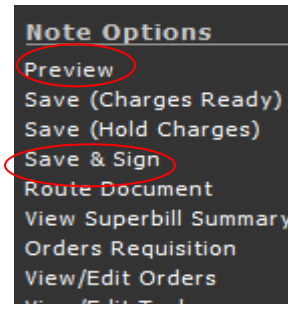
Document the ***Assessment***

- Click on ***"Assessment"*** located on the left hand side under ***"Sections"***
- Select the Appropriate Somatic Dysfunction Diagnosis by click in the box. If documenting other Diagnosis(es) click on the sketch pad and free text them in.



Document the ***Plan***

- Click on ***"Plan"*** located on the left hand side under ***"Sections"***
- Click on the sketch pad and free text the plan.
- **Click on the sketch pad again to free text your OMT Rationale for Treatment, this must show in the Plan section or note will be rejected.**



- Click on ***"Preview"*** located to the left hand side under ***"Note Options".***
    - ***After reviewing your note, close out of the Preview Note.***
- Click on **"Save and Sign"** located on the left hand side under **"Note Options"**

In order to get credit for this assignment you will need to email **your SWC Director** and Jenny Patton and Rebekah Brookman - jpatton@osteo.wvsom.edu and rbrookman@osteo.wvsom.edu **when you have completed each case**.

SEE SAMPLE NOTE BELOW

Sample Note – Stookey SOAP note with Discussion of Rationale for OMM

Mr. H. is a 58 year old male who presents for initial evaluation of lower back pain. His pain is located throughout his lumbar area "maybe worse on the right", it occasionally radiates to the right groin. It started approximately one and half weeks ago. He denies any trauma or inciting event. On further questioning, he spent about an hour on his hands and knees pulling weeds and took a break when he heard the phone ring. He noticed his back pain shortly after that and it got more intense over the next 24 hours and he noticed difficulty taking deep breaths. He went to the ER for evaluation "because of the shortness of breath"; he had an EKG, labs (pt is not sure what was done but asked the records be sent to us), and a CT of the chest and abdomen. "They didn't find anything; they said I sprained my back". He was released home with a prescription for Norco, and Flexeril and advised to follow up with us if the pain didn't resolve within a week. He took the medication for 2 days, "but it made me foggy headed and didn't seem to help much anyway." The pain is constant with varying intensity (7/10 at worst, 3/10 at best, 6/10 currently). He describes it as "pulling" and occasionally "sharp and burning; sometimes I can't even stand up straight". Sitting sometimes helps to relieve his pain. Heat "sometimes helps to take the edge off a bit." Ibuprofen was not effective. Pain is worse with standing, walking, and lying flat. He still has difficulty taking deep breaths. Time of day makes no difference.

He denies any numbness, tingling, weakness, change in strength, or change in sensation. He denies any urinary or fecal incontinence or retention. He denies any recent fever or chills. He denies any abdominal discomfort, pulsation, diarrhea, constipation, or black or bloody stools. He denies any dysuria, polyuria, or hematuria.

Current medications and supplements: Lisinopril (20 mg q day), Fish oil (2000mg, BID), and aspirin (81mg q day)

Allergies: no known drug allergies.

PMH/Surgical Hx: Hypertension. Colonoscopy at age 50 "clean as a whistle" per pt.

Social Hx: Pt has never smoked. He drinks "about a beer a week". No recreational drug use.

Family Hx: no family hx of aortic aneurysm, vasculitis, diverticulitis, or cancer. Father and paternal grandfather both suffered myocardial infarctions in their 60s.

Objective

Vitals: BP: 136/92, Pulse: 94, Respirations: 18 breaths per minute, Temperature: 98.6 F, Weight: 175 lbs General: Alert and oriented, no acute distress but appears very uncomfortable
CV: Regular rate and rhythm; normal S1 and S2 without any clicks, rubs, or murmurs. Dorsalis pedis pulses 2/4 bilaterally. No lower extremity edema.
Lungs: Clear to auscultation bilaterally. No use of accessory muscles while breathing quietly, but pt did show somewhat increased use of the SCM muscles and scalenes when asked to take a deep breath.
Abdomen: Rounded. Normal bowel sounds in all 4 quadrants. Soft, no guarding. RLQ is tender to deep palpation but no other tenderness to palpation. No rebound tenderness. No pulsations. No hepatomegaly or splenomegaly. No palpable masses. Negative heel jar test. Negative Rovsing sign. Mildly positive obturator sign. Positive psoas sign.
Musculoskeletal: Stooped posture, pain worse with standing upright. Hypertonicity of the thoracic and lumbar paraspinal muscles bilaterally. Decreased lumbar extension. No point tenderness or step off deformity of the spinous processes. Hip flexion normal bilaterally. Hip extension restricted on the right (only about 5 degrees passive extension), left hip extension is normal. Right hip restricted in internal rotation (approx. 20 degrees internal rotation), left hip internal rotation is normal. Right hip external rotation slightly reduced (approx. 40 degrees; pain improves slightly with external rotation until about 30 degrees, then gets worse). Left hip external rotation is normal. Right hip abduction restriction (approx. 10 degrees abduction). Left hip abduction is normal. Adduction normal in both hips, but produces some pain in the RLQ when tested. Apparent short leg on the right (right medial malleolus is superior to the left in the supine position). Right functional scoliosis in the lower thoracic and lumbar spine. Decreased thoracic excursion on the left with respiration.
Neuro: Gait is slower than normal and somewhat stooped; no apparent ataxia or dystonia. Light touch, deep pressure, and pin-prick sensation intact in all lower extremity dermatomes bilaterally. Lower extremity DTRs (patella and Achilles) 2/4 and equal bilaterally. Seated and supine straight-leg-raise tests negative bilaterally (right side does increase back pain, but does not cause any pain radiating into the leg or foot).

Osteopathic Structural Exam:

Thoracic: T6 FRS right. Paraspinal hypertonicity bilaterally. T7-L4 NSlRr.
Ribs: Left ribs 5 and 6 posterior subluxation
Abdomen: Diaphragm rotated right; restricted in inhalation
Lumbar: L1 and L2 FRS right. L5 ERS right. Paraspinal hypertonicity bilaterally.
Pelvis: Right anterior innominate with inflare.
Sacrum: Left on left sacral torsion.
Lower extremity: Right iliopsoas tenderpoint. Right hip restricted in extension, internal rotation, external rotation and abduction. Fascial pull from the abdomen, through the pelvis, and into the right thigh (to approx. mid-thigh).

Assessment

1) Low back pain – acute; most likely psoas syndrome
2) Somatic dysfunction of the lower extremity
3) Somatic dysfunction of the pelvis
4) Somatic dysfunction of the sacrum
5) Somatic dysfunction of the lumbar spine
6) Somatic dysfunction of the abdomen
7) Somatic dysfunction of the ribs
8) Somatic dysfunction of the thorax

Plan

Discussed the use of heat and ice. Discussed the importance of high-quality nutrition, adequate hydration and sleep for the healing process. Described and demonstrated two stretches for the iliopsoas: the first is a purely passive stretch; the second is an active stretch. Recommended the use of the passive stretch for the next 5-7 days and then progressing to the active stretch if tolerated.

OMT is indicated for the somatic dysfunction contributing to his condition and I believe he will benefit from it. OMT to 7 regions. Verbal consent was obtained. Pt treated with a variety of techniques including counterstrain, muscle energy, myofascial release, articulatory, ligamentous articular strain, and soft tissue techniques. Pt tolerated the treatment well and was able to stand upright "for the first time since this started" immediately after treatment. Pt was advised that he may experience a temporary increase in soreness after today's treatment, but that should resolve within a couple of days. He was instructed to call us if symptoms worsen.
Re-evaluate in 2 weeks.

Application of Osteopathic Principles

Shortening the iliopsoas for a prolonged period followed by rapid lengthening resulted in a reflexive contraction of the muscle. This induced an anterior rotation of the right innominate with a compensatory torsion of the sacrum. The anterior rotation of the left hemi-innominate also resulted in a functional short leg on the right side which exacerbated his problem by inducing a postural shift whenever he stood up. The origin of the psoas at L1-4 explains the flexion dysfunction at L1 and L2 and his difficulty standing upright or lying flat (when the iliopsoas would be lengthened somewhat and the dysfunctional segments taken into their barriers). The lumbar dysfunctions in turn induced a dysfunction in the abdominal diaphragm which impaired Mr. H.'s ability to take deep breaths. This was further exacerbated by the posterior subluxation of ribs 5 and 6 on the left, which impaired respiratory mechanics. These subluxations were either induced by or reinforced by the type II dysfunction at T6, rotating to the left. The iliopsoas was treated with counterstrain to resolve the reflexive contraction and re-establish a normal resting length and tone in the muscle. The pelvis and sacrum were treated to correct the functional short leg and reduce his postural shift. The lumbar spine and abdominal diaphragm were treated to further reduce mechanical dysfunction and reduce postural strain. Treatment of the diaphragm, as well as the ribs and the thoracic spine, was performed to improve respiratory mechanics thereby reducing the work of breathing and also improving the intrathoracic negative pressure with inspiration that aids the movement of fluids and the healing process.