TM-FUSSY INFANT (100193)

____

Category: Constitutional

Scheduled appt type: ____

CC	fussy baby
HPI	History of trauma: History of exposure to ill contacts: Change in feeding habits:
freeform ROS	____

Structured ROS

Denies: fever/chills	___
Reports: not sleeping well	___
Denies: loss of appetite	___
Reports: whining or crankiness	fussy, but calmed by parent/caregiver
Denies: red eyes or eye drainage	___
Denies: difficulty swallowing	___
Denies: runny nose and/or nasal congestion	___
Denies: daytime cough	___
Denies: nighttime cough disturbing sleep	___
Denies: vomiting	___
Denies: diarrhea	___
Denies: rashes or dry skin	___

Structured exam

NL: general appearance: alert, pleasant, not ill appearing, no distress	____
NL: conjunctivae & lids: pink & moist	, no pallor or icterus (asked patient/parent to pull down lower eyelids to assess sclera and conjunctiva which was observed via video connection)
NL: external ears & nose	____
NL: nares (nasal mucosa, septum and turbinates): clear	through video connection anterior nares inspected and clear without nasal flaring
NL: oropharynx: moist mucous membranes, without pharyngeal	, through video connection limited oropharynx inspection completed and normal

erythema or intraoral lesions	
NL: without meningeal signs	patient/parent asked to flex and extend neck without any difficulty on visualization or compensatory elevation of shoulders
NL: respiratory effort: no retractions, no tachypnea	, also no audible grunting or other indication for increased work of breathing
NL: extremities: no edema, brisk capillary refill	, with cooperation of patient/parent through video visualization of good perfusion with brisk capillary refill confirmed (asking patient/parent to demonstrate)
NL: Findings:	no evidence of hair tourniquet on visualization of all digits
NL: range of motion: FROM without pain	observed patient moving all 4 extremities equally without asymmetry and asked parent to manipulate while observed without apparent discomfort
NL: inspection (includes subcutaneous tissue): no rash	, no rash, no petechiae or bruising or other markings of skin

Remaining template documentation elements

Counseling:	____
Coordination of Care:	____
Diagnosis:	Fussy infant (baby)(R68.12)
Assessment:	____
Plan:	Discussed with parent(s) no identifiable pathology noted for fussy behavior History reviewed and exam considered with limitations acknowledged due to nature of virtual visit through a synchronous telecommunications system Child not ill appearing, no worrisome symptoms or findings, not acting ill, no excessive tearing to suggest corneal abrasion, using all 4 extremities well, normal level of interaction, no evidence of hair tourniquet Differential could include viral illness, sleep disturbance, underlying mild viral illness, GI distress (gas, mild GER), colic Suggest: observe only. Continue daily routines Call if no better in 2-3 days, sooner for change including high fever, poor feeding, respiratory distress, lethargy or irritability that

	doesn't respond to simple calming measures of rocking/cuddling, etc. Discussed under what circumstances a face-to-face office visit would be appropriate to add more information including above concerns. Recheck in office prn
Patient Instructions:	

Remaining workflow elements

Procedures

Orders
