TM-ECZEMA (100227)

____

Category: Skin

Scheduled appt type: ____

CC	____
HPI	Age of onset of skin symptoms: History of allergies/asthma: Family history of allergies, asthma or eczema:
freeform ROS	____

Structured ROS

Denies: fever/chills	___
Pert: not sleeping well	___
Denies: red eyes or eye drainage	___
Pert: itching/rubbing of eyes	___
Pert: runny nose and/or nasal congestion	___
Pert: itching/rubbing of nose	___
Pert: daytime cough	___
Pert: nighttime cough disturbing sleep	___
Pert: wheezing or difficulty breathing	___
Reports: rashes or dry skin	___
Denies: pigmentation changes	___
Pert: itching of skin	___
Pert: painful areas of skin	___
Pert: weeping or crusting of skin	___
Pert: personal or family history of MRSA	___
Pert: animal allergies	___
Pert: seasonal allergies (pollens)	___
Pert: sensitive to indoor allergies (dust, mold)	___
Pert: food allergies	___
Pert: history of childhood asthma	___
Pert: history of recurrent infections	___
Pert: Family history of atopic disease	___

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 erythema or intraoral lesions	, through video connection limited oropharynx inspection completed and normal
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)
ABNL: inspection (includes subcutaneous tissue): no rash	+ generally dry skin with erythematous patches/scaling, no evidence of secondary infection

Remaining template documentation elements

Counseling:	____
Coordination of Care:	____
Diagnosis:	Eczema(L20.9)
Assessment:	____
	History reviewed and exam considered with limitations acknowledged due to nature of virtual visit through a synchronous telecommunications system Signs and symptoms most consistent with eczema/atopic dermatitis Discussed with parent/patient nature of condition and expectations to manage not "cure" skin findings Discussed daily moisturizer using unscented/dye free products Bathing: warm water, soak 15-20 minutes, wash with soap quickly. Pat skin dry then moisturize. Avoid chemical irritants/use hypoallergenic

Plan:	detergents/soaps and no fabric softener/dryer sheets Discussed creams and lotions contain alcohol that causes stinging when applied to inflamed/excoriated skin. If indicated, treatment regimen adjusted to ointment based products. For flares (at first sign of itching/scratching): Patient/family instructed to apply medication sparingly, wait 30 minutes, then apply a layer of moisture on top. Use antihistamines (discussed over the counter products and dosing) for itching/scratching and/or interference with sleep. Discussed need to prevent secondary infection (keep nails short, minimize scratching). Call if no better 1-2 weeks, sooner for change/concerns. Discussed under what circumstances a face-to-face office visit would be appropriate Recheck in office prn
Patient Instructions:	

Remaining workflow elements

Procedures

Orders
