Consultation Dictation Template

1. Requesting Source
2. History of Present Illness
3. Past Medical History
4. Allergies
5. Medications
6. Review of Systems
   a. Constitutional
   b. Eyes
   c. Ears
   d. Nose
   e. Throat
   f. Lungs
   g. Heart
   h. GI
   i. GU
   j. Neuro
7. Social History
8. Family History
9. Physical Exam (default listed below)
   a. General: the patient is a well-developed, well-nourished individual with no gross deformities. Speech and voice are grossly normal.
   b. Face: Normal facial movement, no lesions or scars. No palpable parotid masses. No temporomandibular joint clicking or grinding.
   c. Ears: Normal external ears. Normal external auditory canals. Tympanic membranes are intact and mobile bilaterally. Hearing is grossly within normal limits.
   d. Nose: No significant deformity of the external nose. The septum is midline with normal inferior turbinates and normal nasal mucosa.
   e. Oral cavity: Normal dentition. The lips, gingivolabial and gingivobuccal sulci, tongue, hard palate, floor of mouth, and retromolar trigone are normal and symmetrical. The oral mucosa is healthy.
   f. Oropharynx: The uvula is midline. The soft palate, tonsillar fossae, base of tongue, and posterior pharyngeal walls are normal and symmetrical. The oropharyngeal mucosa is normal.
   g. Larynx: Indirect laryngoscopy reveals normal and symmetrical false vocal folds, epiglottis, true vocal folds, and pyriform sinuses. The posterior commissure demonstrates no evidence of gastroesophageal reflux (skip if not seen in consult)
   h. Neck: No thyromegaly. No masses palpated within the anterior or posterior triangles.
   i. Cranial nerves: Cranial nerves II-XII are grossly intact.
10. Radiology, Labs, etc.
11. Impression and Plan