

General Hospital – Sample Bronchoscopy Note

Patient Name: Mabel Davis
MRN: 123456789
Account #: 987654

Procedure Date: 4/6/2008 11:05 am
Admit Type: Outpatient
Note Status: Finalized

Procedure: Bronchoscopy
Provider: Henry Gulliver, MD (Doctor)
Referring MD: John Anderson, MD
Indications: Left Upper Lobe Nodule

Medications: Midazolam 2 mg IV, Atropine/Lidocaine 4% nebulizer 0.5 mg

Procedure:

A History and Physical has been performed. Patient meds and allergies have been reviewed. The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered and informed consent was obtained. Patient identification and proposed procedure were verified prior to the procedure in the pre-procedure area by the physician and the nurse. Mental Status Examination: normal. Airway Examination: normal oropharyngeal airway, Mallampati Class I (tonsillar pillars visualized). Respiratory Examination: clear to auscultation. CV Examination: normal. ASA Grade Assessment: P2 A patient with mild systemic disease. After reviewing the risks and benefits, the patient was deemed in satisfactory condition to undergo the procedure. The anesthesia plan was to use moderate sedation / analgesia (conscious sedation). Immediately prior to administration of medications, the patient was re-assessed for adequacy to receive sedatives. The heart rate, respiratory rate, oxygen saturations, blood pressure, adequacy of pulmonary ventilation, and response to care were monitored throughout the procedure. The physical status of the patient was re-assessed after the procedure.

After obtaining informed consent, the bronchoscope was introduced through the right nostril and advanced to the tracheobronchial tree. The bronchoscopy was accomplished without difficulty. The patient tolerated the procedure well.

Findings:

The nasopharynx/oropharynx appears normal. The larynx appears normal. The vocal cords move normally with phonation and breathing. The subglottic space is normal. The trachea is of normal caliber. The carina is sharp. The tracheobronchial tree was examined to at least the first subsegmental level. Bronchial mucosa and anatomy are normal in the right lung; there are no endobronchial lesions, and no secretions.

Left Lung Abnormalities: A medium sized non-obstructing erythematous, and flat lesion was found in the left mainstem bronchus. Brushings were obtained and sent for cell count, cytology, bacterial culture, viral smears & culture, and fungal and AFB analysis. An endobronchial biopsy was performed using a forceps and sent for routine cytology.

Complications:

No complications

Impression:

A lesion was found in the left mainstem bronchus. Biopsied.

Recommendation:

- Await test results.
- Follow up in clinic in one week.

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CPT Code(s):

31625, Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with bronchial or endobronchial biopsy(s), single or multiple sites

ICD Code(s):

786.6, Swelling, Mass, or Lump in Chest
 519.19 Other diseases of trachea and bronchus

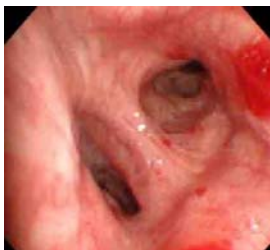
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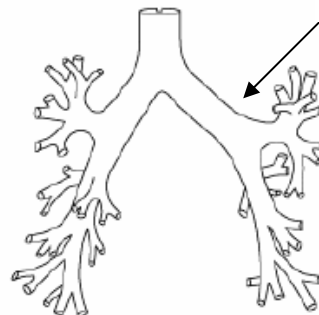
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E-signed by Henry Gulliver, MD

Electronically signed by: Henry Gulliver, MD
 Signed Date: 4/6/2008 11:18:48
 Number of Addenda: 0
 Note generated on: 4/6/2008 11:05 am



Left mainstem bronchus: Non-obstructing lesion



Tracheobronchial Tree