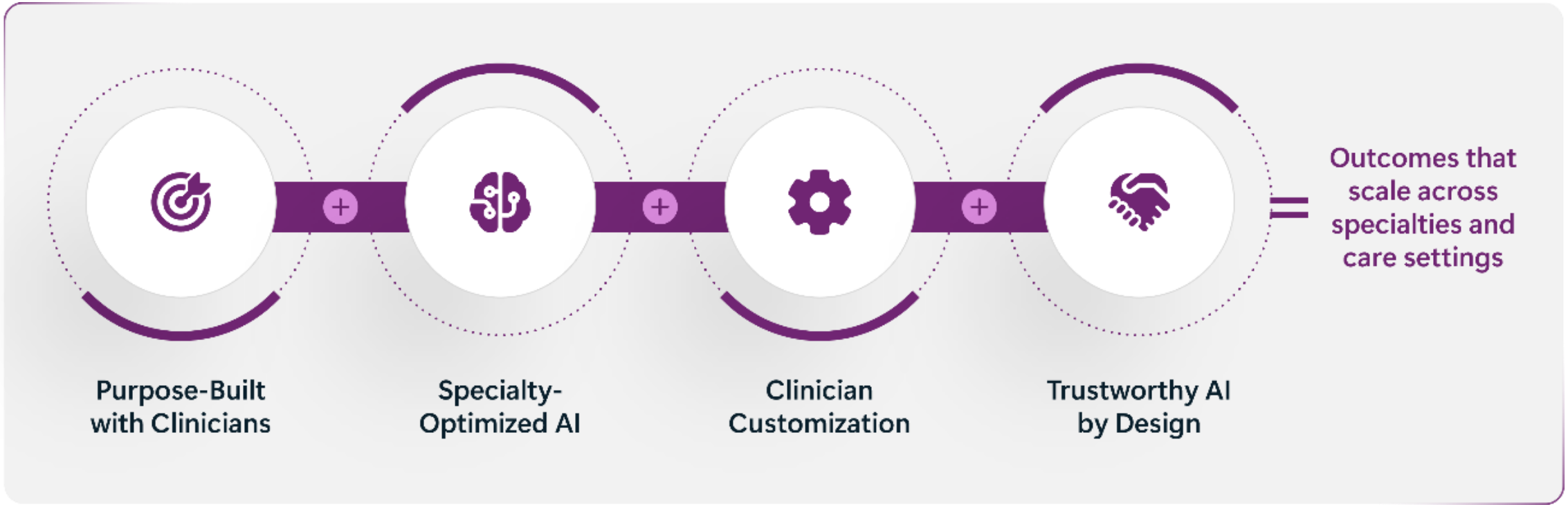
Microsoft

UK Speciality Specific Optimisation

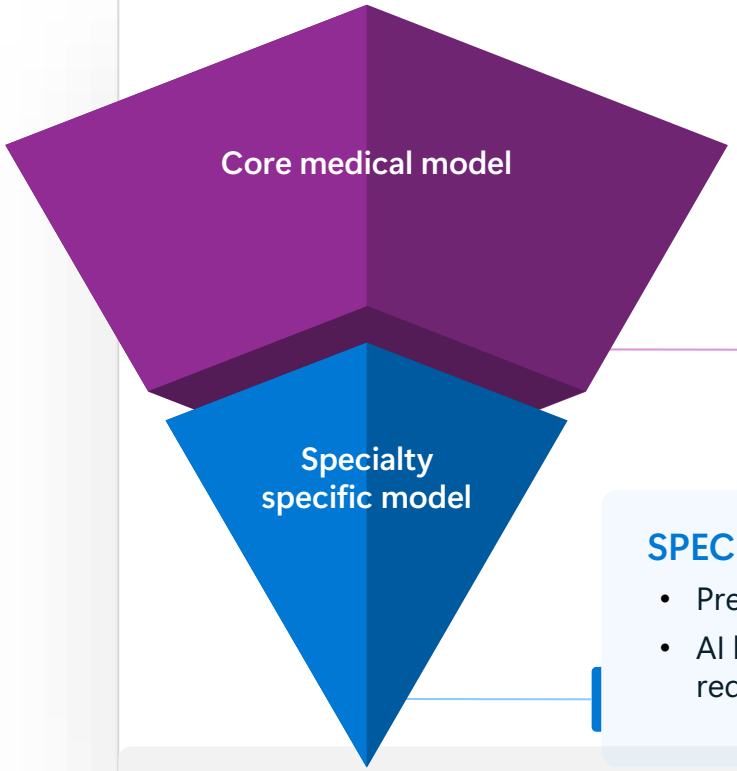
Aug 2025

AI Model



AI Model

AI models



CORE MEDICAL MODEL WITH SOME SPECIALTY REFINEMENT

- Broad range of medical terminology and documentation standards with increased capture of specialty specific content.
- Summary may contain inaccuracies for specialized content.
- Content is viewable in the transcript and provides base for further specialized AI learning.

SPECIALTY SPECIFIC MODEL

- Precise capture of specialty specific content.
- AI has matured to incorporate specialty requirements in unique notes,

Our model training is on **real clinical encounters** verified by medical professionals ensuring it meets the medical community's documentation requirements.

Specialty Model Development

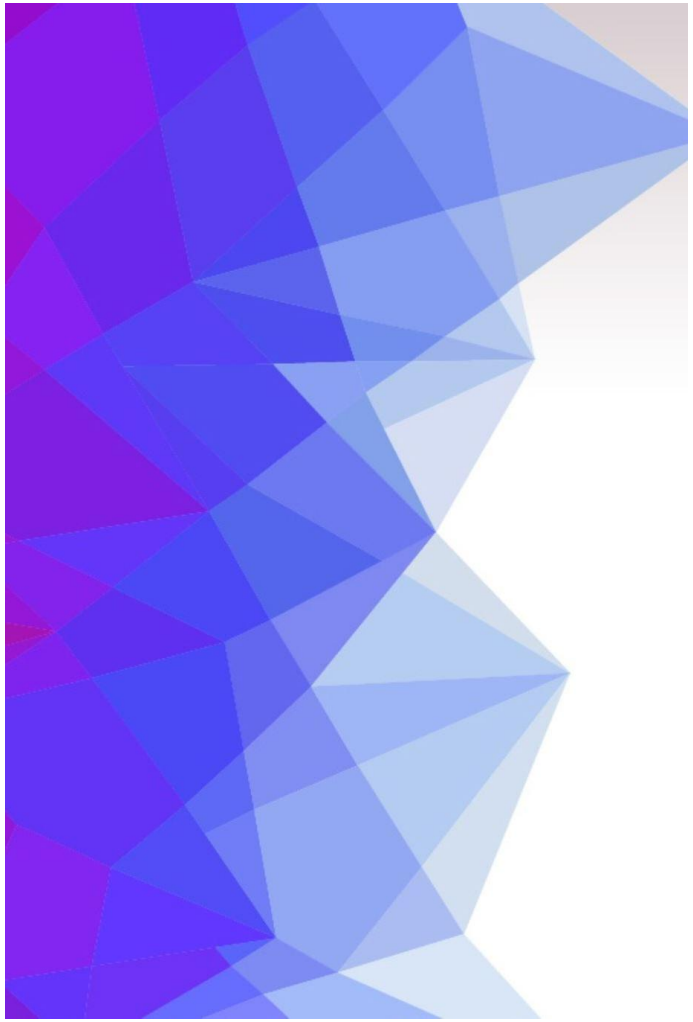
Prioritized work for specialty specific optimization and rapid response improvements

Unique specialty models development based on

- Customer insights
- Microsoft clinician experts' knowledge and research
- National association recommendations
- Collaboration with early access specialty specific clinicians

Continue focus on additional subspecialty requirements overlay

Overview of improvements



- HPI captures specialty specific content
- Physical exam includes required specialty specific subheadings and findings
- Exam findings will be based on the transcript, converting colloquial conversation to medical terminology
- Results content written in appropriate section depending on the source of the information and specialty requirements
- The Assessment and Plan section provides precise terminology required for specialty-specific diagnosis and treatments, formatted in a bulleted list or paragraph
- Past procedures written in appropriate section depending on the source of the information
- Overall documentation design according to specialty recommendations

Benefits of Specialty Specific Refinement

- Enhances accuracy in medical documentation and patient care.
- Reduces clinician cognitive burden and potential errors.
- Facilitates faster and more efficient patient data processing.
- Improves clinician satisfaction and adoption of technology.

UK Specialty Enhancement Plan

Currently Live	Late Sept	October
Neurology	Ophthalmology	Emergency Medicine
Oncology		
Psychiatry/Psychology		
Cardiology		
Paediatrics		

Best practice

BEST PRACTICE NOTE:
Beginning in April 2025, Dragon Copilot introduced specialty-specific AI enhancements designed to meet the unique documentation requirements of different medical communities. These enhancements reduce the need for editing the clinical summaries and documents that Dragon Copilot generates.

- The **Primary** specialty setting in your Dragon Copilot profile (***Settings*** > ***Profile***) determines the AI model used to generate the summaries for your note. These summaries and the combined transcript of your recordings contribute to the generated content in your documents.
- Select "**No format change**" as the default format option for your summary sections in ***Settings*** > ***Style & Format*** to generate summaries in specialty-specific format, then consider other format options and customizable templates to achieve your desired note outcome.
- Consult the *Learning library* for more information about the Specialty enhancements in Dragon Copilot.

Additional notes

- The recommendation to select "No format change" for their sections is to allow them to see the full speciality output as intended.
- If users do not like the speciality output they are free to change this by customising their settings for each section.
- Applying their own style or customisable templates to an individual section will not disable the speciality model for the other sections.
- If users want to disable the speciality model altogether they can do so by selecting a different primary specialty (e.g. Selecting 'other' in the speciality selection list)
- The primary speciality selected determines the speciality model received. The secondary speciality has no effect on speciality model.

Speciality examples

Neurology

Targeted Improvements:

1. Structured Neurological Examination: Emphasis on standardised subheaders for documentation, that cover all core domains: general appearance, mental status, cranial nerves, motor examination, reflexes, sensory, gait & station (Gait and Romberg).

2. Enhanced Clinical Context:
Richer history-taking: hand dominance, developmental milestones, head injuries, family history.

Use of direct patient quotes to capture subjective experience e.g. “worst headache of my life”.

3. Medication Documentation: Clear separation of current vs. previous medications.

4. Neurologically Relevant Review of Systems:
Broader and more targeted symptom capture across systems.

Neurology: General Model Note Output

PRESENTING COMPLAINTS OR ISSUE:
The patient presents for memory testing.
He reports a decline in his short-term memory, which has led to him undergoing cognitive evaluation. His children have noticed a change in his memory, including an incident where he left his car running while he went to lunch with his two children. He often forgets a word on the list if he starts moving.

He has a history of a small stroke, which has led to confusion and compromised his ability to identify complex information, causing him to lose track of his tasks. His previous occupation involved survivability data for the military equipment, crash tests, and domestic violence.

He suffers from constant headaches, which he attributes to nerve damage from a neck operation. His sleep is satisfactory. He also uses a CPAP machine for snoring.

He suffers from seasonal depression, which is well managed with medication, although he's not currently on an antidepressant.

He underwent neuropsychological evaluation with doctor Y, who referred him to doctor S, and neuropsychologist. He saw doctor S about six months ago who informed him that his memory is satisfactory but expressed concern about his visual learning.

SOCIAL CONTEXT
He's not working currently. He moved here 10 years ago. He worked in the airport. He has three grown daughters, and 9 grandchildren.

FAMILY HISTORY
His father had dementia and Alzheimer’s.

CLINICAL REVIEW OF SYSTEMS

INVESTIGATION RESULTS
Testing
Memory testing: patient was able to recall 3 out of 3 words. Patient was able to spell the word “world” backwards.

ASSESSMENT AND PLAN
1. Memory loss
His distractedness and inattention appeared to be more problematic than dementia. An amyloid pet scan will be ordered to exclude the possibility of Alzheimer's disease. He reports a history of a small stroke which he which may contribute to his memory issues. He has undergone an evaluation approximately 6 months ago, which indicated his memory was OK but highlighted concerns with visual learning. The results of his evaluation will be tracked down.

Neurology: Specialty Note Output

PRESENTING COMPLAINTS OR ISSUE
The patient is a 68-year-old right-handed male presents with concerns regarding memory decline.
Reports indicate a noticeable deterioration in short term memory, described as forgetting one out of three tasks if distracted. An incident was noted where he left his car running while having lunch with his grandsons, an unusual behavior for him. He also has difficulty recalling words from short-term memory if interrupted. Despite these challenges, he continues to drive, albeit more cautiously, and manages his finances without issues.
The onset of memory issues followed a small stroke, which has resulted in confusion and difficulty processing complex information. His professional background includes working with survivability data for military equipment and crash tests.
He experienced constant headaches, attributing to nerve damage from a previous neck injury. Sleep quality is maintained, and he uses a CPAP machine for snoring. Seasonal depression is present but well managed, although he is not currently on an antidepressant.
A neuropsychological evaluation by doctor Y led to a referral to doctor S who assessed him approximately 6 months ago. Doctor S reported satisfactory memory function but noted concerns with visual learning.

Past Medical History
-Small stroke leading to memory issues and confusion
-Constant headaches due to nerve damage from neck injury
-Seasonal depression
Past surgical history:
-Neck surgery resulting in nerve damage
Family history:
-Father had dementia, and possibly Alzheimer's, with significant decline in the last six years of life
-Mother maintained good memory

SOCIAL CONTEXT
The patient is currently retired. He relocated to the area 10 years ago. His previous employment involved conducting survivability data analysis for military equipment, including crash testing period he also worked at an airport and grocery store. He is married and has three grown daughters and 9 grandchildren. He is originally from Scotland.
He does not consume alcohol, tobacco, or recreational drugs. His sleep is generally good, and he uses a CPAP machine for sleep apnea. He typically stays up until he is very tired before going to sleep ensuring a decent night's rest. He did not report any significant caffeine intake.

INVESTIGATION RESULTS

Neurological testing:

Memory testing on 24/10/2024, able to recall 3 out of 3 words, able to spell the word “world” backwards

ASSESSMENT AND PLAN

1. Memory loss

The patient presents with destructiveness and inattention, which appear to be more problematic than dementia. There is a history of a small stroke, which may contribute to the memory issues. Neuropsychological evaluation conducted approximately 6 months ago indicated memory was intact with highlighted concerns with visual learning. The results of this evaluation will be tracked down. Amyloid PET scan will be requested to exclude the possibility of Alzheimer's disease.

Oncology

Targeted Improvements:

- Optimised Presenting complaints or Issues section (HPI) now generates separate oncologic and interval histories for better integration with existing documentation practices.
- Additional focus is placed upon patient reported side effects and their management.
- Optimised exam includes optional sub-headers for ECOG performance score, Karnofsky Performance Status, nonspecific symptoms, and other oncology specific examination sub-headers.
- Investigation Results content is directed to either the HPI or results section based on source of information. The verbiage used to document results has also been updated. The content of the results section is more accurate, avoiding the use of adjectives to describe results such as "WBC: Good".

Oncology: Presenting complaints or Issues section (HPI)

General Content

The patient is a 78-year-old female who presents for a new patient visit to establish care for a history of DCIS.

She underwent a right breast lumpectomy on 20/01/2020, following the detection of a calcification in her right breast during a routine mammogram in 10/2019. An ultrasound conducted on 03/11/2019 revealed a mass at the 2 o'clock position, 11 cm from the nipple in the retroareolar region, measuring 0.4 x 2 x 3 cm. Subsequent pathology results from an ultrasound-guided core needle biopsy performed on 12/05/2019 indicated grade 2, ER positive, PR positive DCIS. The lumpectomy successfully removed an 8 mm tumor with negative margins, and 5 lymph nodes were also excised, which were benign. She reports no complications or concerns post-procedure and has been diligently performing self-breast exams without detecting any abnormalities. She received radiation therapy post-lumpectomy but declined endocrine therapy. Her last mammogram, conducted in 01/2021, was normal.

She experiences back and knee pain, which have been attributed to age-related changes.

She has high cholesterol, a relatively new diagnosis, and is currently attempting to manage it through exercise and dietary modifications under the supervision of her primary care physician.

Specialty-specific Content

The patient is a 78-year-old female with a history of ductal carcinoma in situ (DCIS), stage 0, ER/PR positive, in the right breast. An ultrasound conducted on 03/11/2019 revealed a mass at the 2 o'clock position, 11 cm from the nipple in the retroareolar region, measuring 0.4 x 2 x 3 cm. She underwent a right breast lumpectomy on January 20, 2020, which successfully removed an 8 mm tumor with negative margins, and five lymph nodes were excised, all benign. Post-lumpectomy, she received radiation therapy but declined endocrine therapy. Her last mammogram in January 2021 showed no evidence of recurrence.

Since her last visit, the patient reports feeling well with no complications or concerns post-procedure. She has been performing self-breast exams regularly and has not detected any abnormalities. She experiences back and knee pain, attributed to age-related changes, and has been managing her newly diagnosed high cholesterol through exercise and dietary modifications under her primary care physician's guidance. There have been no hospitalizations or new symptoms reported since her last visit.

Oncology: Examination Findings (Physical Examination)

General Content

The patient is fully active (ECOG 0), with no acute distress. Abdomen, cardiovascular and respiratory exams are normal. No oedema or swelling is noted in the extremities. No headaches or dizziness noted. No fever, chills or night sweats reported.

Specialty-specific Content

General: ECOG 0
HEENT: No acute distress, no visual changes, no hearing loss.
Cardiovascular: Regular rate and rhythm, no murmurs, no chest pain.
Respiratory: Lungs clear to auscultation bilaterally, no shortness of breath.
Abdomen: Soft, non-tender, no hepatosplenomegaly, no abdominal pain.
Extremities: No edema, no swelling.
Skin: No rashes, no lesions.
Neurological: No focal deficits, no headaches, no dizziness.
Lymphatic: No lymphadenopathy.
Hematologic: No fevers, chills, or night sweats.
Psychiatric: No depression, no anxiety.

Oncology: Assessment and Plan

General Content

1. Elevated liver enzymes.
Elevated liver enzymes were noted, potentially due to a recent upper respiratory infection and potential liver irritation. The levels are not significantly high to warrant any immediate changes in the treatment plan. She was advised to continue her current medication regimen, including acyclovir, azithromycin, and Bactrim. She was also reminded to stay hydrated.
2. GVHD (Graft Versus Host Disease).
The possibility of GVHD recurrence was discussed, with a reduction in risk over time. Continuation of Jakafi was advised, and it was recommended to stay away from large gatherings during the flu season until the end of May. She was advised to wear a mask during church activities and other public gatherings. A pulmonary function test is scheduled for the end of January or early February to monitor lung function.
3. Medication Management.
She is currently taking acyclovir, azithromycin, estradiol, famotidine, Seretide, folic acid, Levothyroxine, magnesium, Montelukast, Pantoprazole, Ruxolitinib 5 mg, tacrolimus, Triamcinolone Acetonide, and Ursodeoxycholic Acid. The dose of tacrolimus has been reduced from 3 capsules to 2 capsules twice a day. She will continue tapering the dose by skipping the evening dose every 2 weeks, aiming to be on 2 capsules in the morning and 1 in the evening in 14 weeks.

Follow-up
Return in 7 weeks for follow-up after the pulmonary function test.

Specialty-specific Content

1. GVHD (Graft Versus Host Disease)
The patient has a history of GVHD with lung involvement. The risk of recurrence was discussed, noting that the risk decreases over time. The patient is currently on Jakafi, and it was advised to continue this medication. She was instructed to avoid large gatherings during the flu season until the end of May and to wear a mask during church activities and other public gatherings. A pulmonary function test is scheduled for the end of January or early February to monitor lung function.
The treatment plan includes continuing Jakafi, with the goal of preventing GVHD recurrence. The patient will remain on acyclovir, azithromycin, and Bactrim as prophylactic measures. The potential side effects of Jakafi, including immunosuppression and increased infection risk, were discussed. Supportive care measures include staying hydrated and avoiding exposure to infections.
The patient expressed concerns about the possibility of GVHD recurrence and the need for lifelong medication. It was explained that while GVHD can potentially recur, the risk decreases over time, and if it does recur, it is usually of a lower grade. The importance of continuing medication to prevent progression was emphasised.
2. Elevated liver enzymes
Elevated liver enzymes were noted, potentially due to a recent upper respiratory infection and potential liver irritation. The levels are not significantly high to warrant any immediate changes in the treatment plan. She was advised to continue her current medication regimen, including acyclovir, azithromycin, and Bactrim. She was also reminded to stay hydrated.
3. Medication Management
The patient is currently taking acyclovir, azithromycin, estradiol, famotidine, Seretide, Folic acid, Levothyroxine, magnesium, Montelukast, Pantoprazole, Ruxolitinib 5 mg, tacrolimus, Triamcinolone Acetonide, and Ursodeoxycholic Acid. The dose of tacrolimus has been reduced from 3 capsules to 2 capsules twice a day. She will continue tapering the dose by skipping the evening dose every 2 weeks, aiming to be on 2 capsules in the morning and 1 in the evening in 7 weeks.
Follow-up
Return in 7 weeks for follow-up after the pulmonary function test.

Psychiatry/Psychology

Targeted Improvements:

Presenting complaints or Issues section (HPI) : Model to include interim history, social and psychiatric histories, substance use information, pertinent negatives, and results.

Physical Exam: Will be abbreviated to general appearance and skin. Focus is on Mental Status Exam to include information listed below.

Mental Status Examination
General Behavior:
Speech Characteristics:
Mood and Affect:
Thought Processes:
Thought Content:
Harmful Thoughts:
Perceptual Disturbances:
Sensorium and Cognitive Function:
Insight and Judgment:
Motivation:

Assessment and Plan: Model to include problems, content of therapy, clinical impressions, therapeutic intervention, plan, follow-up and risk factors.

Psychiatry: Presenting complaints or Issues section (HPI)

General Content

The patient presents via virtual visit for evaluation of anxiety. She reports feeling fatigued and slightly anxious. Her anxiety appears to be circumstantial, and she suspects it is due to Obsessive-Compulsive Disorder (OCD) and contamination. She has noticed that she washes her hands frequently, approximately 10 times a day, and sanitizes after touching unclean things. She typically washes her hands until they feel right, lasting 20 to 40 seconds. If her anxiety increases, she washes her hands for 1.5 to 2 minutes. Her mood is overall disconnected, anxious, and tired. She experienced headaches after coughing last night and this morning, a common occurrence for her due to a brain aneurysm. Accompanying symptoms include chest pain, which she attributes to hiccups, a symptom she often experiences. She suspects a heart attack and a cerebral aneurysm, which she believes have increased her anxiety. She is considering N-acetylcysteine (NAC) while working towards cannabis (TCH) cessation. Her depression is mild. She is sleeping well but struggles to get up in the morning and to make herself go to bed. Trazodone is effective in helping her sleep. She is a night owl and wants to enjoy her evening, which she feels does not help. She needs to work on sleep hygiene. Her eating was stable for a few weeks, but this week it has gone backwards, causing significant anxiety about her weight gain. She weighs herself daily. She has tried various methods to reduce her weight but finds it challenging. She has reduced her meals to one meal a day, tends to eat heavily on liquids, and has started to restrict her diet. She reports no thoughts of self-harm or harm to others.

Specialty-specific Content

Interim History:
The patient reports feeling "tired, a little anxious," and describes her anxiety as being heightened due to physical symptoms such as headaches and chest pain. She has been experiencing these symptoms more frequently and attributes them to her OCD, particularly health-related obsessions. She mentions that her anxiety is "up a little bit" but otherwise feels fine. She has been managing her OCD symptoms better this week, reducing the frequency of excessive handwashing. She describes her mood as "disconnected, anxious, and tired."

Social History:
- Works at an addiction clinic
- Lives with a partner
- Engages in cannabis (TCH) use, primarily in the evenings

Psychiatric History:
- Diagnosed with OCD and anxiety
- Currently taking Trazodone for sleep
- Previous trials of multiple medications with varying success
- Mild depression, managed with current medication regimen

Substance Use:
- THC use primarily in the evenings
- No identified cannabis use disorder but working towards cessation

Results:
- No lab or psychological testing results provided during this encounter

Past Surgical History:
- No past surgical history reported

Psychiatry: Physical Examination

General Content

General: Well-developed, well-nourished patient.
Vital Signs: Blood pressure, heart rate, respiratory rate, and temperature are within normal limits.
Mental Status: The patient presents with a depressed mood, flat affect, and diminished concentration. He demonstrates a negative self-perception and feelings of hopelessness.
Skin: No abnormalities or lesions are observed.
Neurological: Cranial nerves are intact, and there are no signs of focal neurological deficits.

Specialty-specific Content

General Physical Appearance: The patient appears tired and somewhat anxious but is cooperative and engaged during the session.
Skin: No visible signs of self-harm or physical abuse.

General Behavior: The patient is cooperative and engaged, though appears tired and somewhat anxious.
Speech Characteristics: Speech is normal in rate, volume, and articulation.
Mood and Affect: The patient reports feeling disconnected, anxious, and tired. Affect is congruent with mood.
Thought Processes: Thought processes are logical and goal-directed.
Thought Content: No delusions or obsessions noted.
Harmful Thoughts: The patient denies any thoughts of self-harm or harm to others.
Perceptual Disturbances: No hallucinations or perceptual disturbances reported.
Sensorium and Cognitive Functions: The patient is alert and oriented to person, place, and time.
Insight and Judgment: Insight and judgment appear to be intact.
Motivation: The patient is motivated to manage anxiety and OCD symptoms and is open to discussing medication options.

Psychiatry: Assessment and Plan

General Content

1. Anxiety.
She reports feeling anxious and experiencing chest pain due to hiccups, which she associates with a heart attack. She also mentions increased anxiety due to headaches and concerns about a brain aneurysm or tumor. Her anxiety appears to be situational and related to health concerns, a subset of OCD. She is currently on medication for anxiety, which she feels is helping. NAC 600 mg will be started at bedtime to help with anxiety. Potential side effects and the lack of significant interactions with her current medications were discussed. She will monitor her response to the medication and adjust the dosage if necessary.
2. Obsessive-Compulsive Disorder (OCD).
She reports OCD symptoms, including excessive hand washing and sanitizing after touching things perceived as unclean. She has been working on reducing the frequency of hand washing from three times in a row to once or twice. She will continue to work on these behaviors and monitor her progress.
3. Depression.
She reports mild depression and fatigue. Her current medication regimen appears to be helping, and she feels her mental health is better than it used to be. No changes to her current medications are planned.
4. THC Use.
She is working towards THC cessation and inquired about NAC for this purpose. Although there is limited research on NAC for THC cessation, it may help with anxiety. She will start NAC 600 mg at bedtime and monitor its effects.

Specialty-specific Content

Problems:
- Anxiety
- Obsessive-Compulsive Disorder (OCD)
- Depression
- THC Use
- Sleep Hygiene

Content of Therapy:
- Discussed the patient's anxiety related to health concerns, including chest pain from hiccups and headaches.
- Explored OCD symptoms, particularly excessive hand washing and sanitizing behaviors.
- Addressed the patient's mild depression and fatigue.
- Discussed THC cessation and the potential use of NAC for anxiety and THC cravings.

Clinical Impression:
The patient presents with situational anxiety primarily related to health concerns, which is a subset of OCD. She reports mild depression and fatigue, with her current medication regimen providing some relief. OCD symptoms, including excessive hand washing, are being managed with gradual behavioral changes. She is working towards THC cessation and is interested in using NAC to assist with this goal.

Therapeutic Intervention:
- Cognitive-behavioral strategies to reframe anxiety and reduce OCD behaviors.
- Psychoeducation on the use of NAC for anxiety and its potential benefits for THC cessation.

Plan:
- Start NAC 600 mg at bedtime to help with anxiety and monitor its effects.- Continue working on reducing the frequency of hand washing and sanitizing behaviors.
- Maintain current medication regimen for depression and anxiety

Follow-up:
- Next appointment in two weeks to assess the response to NAC and progress on behavioral interventions.- Goals for the next session include evaluating the effectiveness of NAC, further reducing OCD behaviors, and improving sleep and eating habits.

Notes & Risk Factors:
- No current risk factors for harm to self or others.- Protective factors include ongoing therapy, medication adherence, and support from the treatment team.

Cardiology

Targeted Improvements:

Social history:
Captures social history with more structured subheaders (e.g. subheaders for occupation, exercise, smoking etc)

Family history:

Arranged into bullet points

Results:
Incorporated specific diagnostic test names as headers in the results section with the findings for each listed below each header as bullet points.

Incorporated the use of accepted medical abbreviations for results (FBC, ECG etc)

Physical exam:

Formatted exam with system headers and incorporated medical shorthand where appropriate to match generally used formatting for cardiology exams.

Assessment and Plan:

Updated format to output of diagnosis with bulleted list below which includes interventions, recommendations, referrals, orders, etc.

Updated to avoid use of “history of”, “the patient”, and repetitive content and to include the use of precise medical terminology. Updated to concise, fragmented sentences.

Cardiology

General Medical Model

Family history

Her father had a heart attack in his early 60s and was a smoker. Her mother had hypertension.

Social history

She does not smoke. She works as a nurse. She lives alone. She has good family support from her parents and brother

Physical exam

Lungs were auscultated.
Heart sounds normal

Vital Signs
Blood pressure is 140/76. Heart rate is 86

Results

Laboratory Studies
Blood work from 10/2023 indicates poorlycontrolled diabetes.

Imaging
Echocardiogram shows borderline low pumping function but still normal

Testing
Endoscopy revealed gastritis.",

Specialty Specific Model

Family history:

- Father: Heart attack in his early 60s, smoked but stopped later.
- Mother: Hypertension.

Social history:

Occupations: Nurse
Exercise: Light exercise, walks 1 to 2 hours a day if not at work, does squats at home
Tobacco: Does not smoke

Physical exam
Blood Pressure: 140/76
Heart Rate: 86
Heart: Heart rate is 86. No murmurs or abnormal sounds noted.
Musculoskeletal: Tenderness noted on the left anterior side of the chest and side of the left breast.

Results

Blood tests
- Blood glucose test: 10/2024, Poorly controlled

Diagnostic Testing
- Echocardiogram: Borderline low but still normal pumping function
- Endoscopy: 20/07/2025, Gastritis

Cardiology

General Medical Model

Assessment and Plan

1. Chest discomfort.
Her symptoms appear to be sporadic, not exacerbated by physical exertion, but can be severe.The pain does not exhibit any alterations with deep breathing. The symptoms appear to be atypical, making angina an unlikely diagnosis. Given her age and type 1 diabetes, she is at an elevated risk for coronary artery disease. However, her recent diagnosis of gastritis could potentially account for her symptoms. Chest pain is common in non-HSS patients and can often be musculoskeletal, although the absence of tenderness and lack of change with movement makes this less likely. Gastritis could also be a potential cause. A CT coronary angiogram will be arranged to exclude cardiac involvement. If her symptoms resolve or completely resolve, she will contact via email, and the test will be cancelled.

2. Type 1 diabetes.
Her diabetes is not well controlled, as evidenced by her most recent blood work. This increases her risk for coronary artery disease.

3. Gastritis.
She has been diagnosed with gastritis following an endoscopy 2 days ago. She has been taking omeprazole for about a month, but it has not significantly improved her chest pain. She has a follow-up gastric appointment on 07/17/24.

Specialty Specific Model

Assessment and Plan

1. Chest pain:

- Atypical and not suggestive of angina; not triggered by physical exertion and does not subside with rest.
- Elevated risk for coronary artery disease due to type 1 diabetes and poorly controlled blood glucose levels.
- Recent diagnosis of gastritis could potentially explain symptoms.
- Musculoskeletal causes unlikely due to absence of tenderness or pain exacerbation with movement.
- Response to GTN spray cannot be used as a definitive diagnostic tool, as it can also alleviate esophageal spasms.
- CT coronary angiogram will be arranged to definitively exclude cardiac-related chest pain.
- Contact to cancel the procedure if symptoms improve or resolve completely.

2. Type 1 diabetes mellitus:
- Diabetes not well-controlled as indicated by last blood tests in 10/2024.
- Continue current medication regimen, including Lantus and dapagliflozin 5 mg.
- Restart metformin in modified release form due to stomach irritation.
- Continue monitoring blood glucose levels closely.

3. Gastritis:
- Diagnosed following an endoscopy 2 days ago.
- Continue taking omeprazole.
- Follow-up appointment with gastroenterology scheduled for 17/07/2025.

Follow-up:
- Follow-up appointment scheduled for 17/07/2025.
- Contact if symptoms improve or resolve completely to cancel the CT coronary angiogram.

Paediatrics

Targeted Improvements:

- **HPI**

Added subheaders relating to paediatrics e.g. peri-natal and developmental history.

- **Social history**

Enhanced social history capture tailored around paediatrics e.g. capture of educational history, sleeping patterns and diet.

- **PE**

Subheaders for system examinations e.g. growth measurements, respiratory, cardiovascular, gastrointestinal etc.

Paediatrics

General Medical Model

History of presenting illness

The patient is a 2-year-old child. She is accompanied by her parents. The patient's mother reports that the child's sleep pattern remains consistent, with occasional instances of her spending approximately 2 hours in the crib. The child's sleep duration typically extends from 12 to 14 hours, inclusive of a daytime nap lasting between 1 to 1.5 hours. The child is currently residing at home with her parents, with plans to commence preschool at St. Anthony's in 09/2024. The child is socially active, participating in dance classes every Tuesday and previously engaged in swimming lessons. The child has a history of ear infection and diaper rash, both of which have resolved. She has no difficulties with bowel movements, although attempts at toilet training have been unsuccessful. The child is highly active and has recently been introduced to chewable vitamins and probiotics. She maintains good oral hygiene, brushing her teeth daily, and has no known food allergies. The child's mother has observed a skin condition resembling keratosis pilaris on the back of her arms, which is being managed with the application of moisturizers.

Physical Exam

Lungs are clear on both sides. Heart has a regular rate and rhythm. No murmurs detected. Abdomen is soft with no organomegaly.

Specialty Specific Model

History of presenting illness

The patient is a 2-year-old child. She is accompanied by her parents.
Diet, Intake & Output: Patient eats well balanced meals inclusive of vegetable and fruits. She consumes chewable vitamins and probiotics. No known food allergies. She has no difficulties with bowel movements, although attempts at toilet training have been unsuccessful.

Sleep: The child's sleep duration typically extends from 12 to 14 hours, inclusive of a daytime nap lasting between 1 to 1.5 hours. The patient's mother reports that the child's sleep pattern remains consistent, with occasional instances of her spending approximately 2 hours in the crib.
Birth History: Mother reports patient was born vaginally, 5 days late. No history of birth trauma or complications.
Past Medical/Surgical History: The child has a history of ear infection and diaper rash, both of which have resolved.

Social history

Living arrangements: The child is currently residing at home with her parents,
School: plans to commence preschool at St. Anthony's in 09/2024.
Hobbies: Dance classes and swim lessons

Physical Exam

Cardiovascular: Regular rate and rhythm, no audible murmur, normal distal pulses.
Lungs / Chest: Lungs clear to auscultation bilaterally, no rales, rhonchi, or wheezes, normal respiratory effort.
Abdomen: Normal active bowel sounds, soft, non-tender, non-distended, no hepatosplenomegaly, no mass.