VISE Assignment/Phone Call

1. **Summarize:** Identify the chief complaint (CC) and present pertinent facts only from the history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), social history (SH), mental status exam, and interview. OLDCARTS
2. **Narrow the Differential Diagnosis:** Identify three (3) possible diagnoses related to the summary above using appropriate medical terms.
3. **Analyze:** Rank the selected diagnoses and provide a rationale for each. Thoroughly uses substantial key positive and negative findings to argue for or against a diagnosis.
4. **Probe the Preceptor/Instructor:** Identify learning gaps, points of confusion, or dilemmas by asking questions to tap into the preceptor or faculty member's knowledge base. (3 questions)
5. **Propose a Plan:** Propose a diagnostic plan to narrow the differential or confirm the diagnosis. Propose a therapeutic plan to manage the problem. Treatment, patient education. Follow-up? Preceptors/instructors will provide feedback on what was done well and what requires improvement.
6. **Self-Directed Learning:** Reflect on your performance. What knowledge is needed to provide an accurate and comprehensive client presentation?

Patient: Judith Unterborn

Mrs. Unterborn is a 63-year-old female client presenting at the clinic complaining of bladder infection symptoms that began after "sitting on a nasty toilet" 2 days ago. Ms. Unterborn developed symptoms after this experience 2 days ago and states that the symptoms are localized to her urinary tract. She states that she is uncomfortable, constantly has the urge to urinate and that her urine is yellow and cloudy. She states that urinating helps the constant urge to go but that relief does not last. She has not tried any treatment regimens. Client states pain level is a 0/10 as she is not in pain, just uncomfortable. No fevers. The client indicates no recent sexual intercourse. The client is a smoker and smokes 1 pack a day. Client reports no history of alcohol or recreational drug use. Past medical history includes Type 2 diabetes that is not well-controlled. Patient received blood work at previous visit 1 month ago that revealed an A1C of 8.4. Patient has not been monitoring blood sugar at home but has been following a diabetic diet. Patient has no significant past surgical history. The client's vital signs are WNL. A UA was performed and revealed yellow, slightly cloudy urine with a pH of 6.0, the presence of large 3+ leukocytes, 30mg of protein, 500mg of glucose, and a trace of blood.

My differential diagnoses are based on the client's history and physical key findings and are listed from most likely to least likely and I believe this could be a urinary tract infection, ketoacidosis, or overactive bladder.