**Pt case study 1:** Work through each section from seeing them on the schedule to treating them after their evaluation. Describe/list the thought process, critical thinking, & clinical reasoning as you would be if they were right in front of you.

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| **Pt case #1A/The schedule shows**: Female coming in for 30 min consult for hand tremor. This is meaningful to them bc it impacts their ability to play the guitar. |

1. What is the purpose of a consult?
2. What comes to your mind first?
3. How are you going to achieve that purpose?
4. List the questions you are going to ask & why you are going to ask them.

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| Question | Clinical Reasoning |
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1. List the tests & measures (TM) you are going to perform, why you are performing them, & what ea tests.

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| TM | Clinical Reasoning | What it measures/tells you |
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1. What findings would warrant a referral back to the MD? Describe/list your clinical reasoning.

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| Findings for MD referral | Clinical Reasoning |
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1. What findings would warrant a referral to a neurologist? Describe/list your clinical reasoning.

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| Findings for Neuro referral | Clinical Reasoning |
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1. What findings would warrant PT? Describe/list your clinical reasoning.

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| Findings for PT referral | Clinical Reasoning |
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1. What findings would warrant HEP recommendations and no rehab or referral to MD? Describe/list your clinical reasoning.

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| Findings for no referral, just HEP | Clinical Reasoning |
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1. What did you learn about your processing and clinical reasoning?
2. Did you get stuck or find one aspect easier or harder? Why/why not?

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| **Pt case #1B/Consult Subjective (15 min):** Female, early 20’s, 30 min consult for hand tremor. Pt presented for a consult due to concern re left hand/finger tremors; ambidextrous. She has had these symptoms for a while. Dropping things, after standing her hands get numb and she then starts to feel disoriented, having some balance difficulties. Hands will shake uncontrollably, "violent", and after this resolves the baseline tremor is worse for the rest of the day. LE's have some tremor w/limited WB positions to include short sit figure 4 so avoids that position. It is impacting her ability to play her guitar which she plays daily. (+) Raynaud's & immediate family hx of it, no official dx by MD. Recent dx of PTSD. She has anxiety/panic attacks and her body response is quiet. Corrected vision w/glasses. She also has a visual perception learning disorder. |

1. What comes to your mind first?
2. What other questions do you want to ask? Why?
3. What TM do you want to perform? Remember you only have 30 min.

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| TM | Clinical Reasoning | What it measures/tells you |
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1. How does #14 compare to #5, why are they the same or different? Did your critical thinking/processing or clinical reasoning change? Why or why not?
2. Do you have any hypothesis on what TM’s might be (+) or (-)? Why or why not? Copy your TM table and add a column to answer this question, see below for example.

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| TM | (+) or (-) | Why/why not |
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| **Pt case #1C/Consult Objective (15 min):** Female, early 20’s, 30 min consult for left hand tremor. TM’s below:(-): - UE/LE Myotomes (gross 5/5 bilateral UE/LE strength)- UE/LE RAMS, LE Clonus(+): - Cervical flex standing reported some zaps along her spine, mm tightness (no electrical type symptoms when performed seated)Grip strength screen, squeeze test: mod strengthUE/LE DTR’s: mostly hypo w/2 absent |

1. Are these tests same or different from what you would have done? Why or why not?
2. What does this information tell you?

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| Info | Tells me |
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1. What are you going to do next? Why?

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| Next step | Why |
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1. Write an assessment statement from the information that you know to date.

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| **Pt case #1D/Eval post consult:** Female, early 20’s. Now presents for eval after consult. She has not established or seen a medical provider as recommended.  |

1. What is the purpose of this eval?
2. What is your initial hypothesis?
3. List the questions you are going to ask & why you are going to ask them.

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| Question | Clinical Reasoning |
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1. List the tests & measures (TM) you are going to perform, why you are performing them, & what ea tests.

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| TM | Clinical Reasoning | What it measures/tells you |
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1. Did you learn anything new about your processing and clinical reasoning?
2. Did you get stuck or find one aspect easier or harder? Why/why not?

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| **Pt case #1E/Eval subjective (x15 min):** Female, early 20’s, left hand tremor. She presents to PT now for an eval. She reported no changes since consult. Tingling and numbness & a little bit of confusion ("just feels like even the brain fog that comes w/anxiety, stop processing, and hard time speaking") the evening of the consult and occurred a couple more days. "Fairly recent thing", over the past 2 wks, sudden loss of feeling in hands, medial aspect and spreads (stays in the palm, does breathing and used to help more; usually starts in the left hand, more in the left hand as well, will spread to both hands if stand up but usually subsides more quickly if sitting down). Wanted to drive the other night but decided not to bc she felt "off kilter". Fatigue, "noticed that's been, always had a little bit w/general depression fatigue, noticing when it shouldn't be happening w/more sleep, mm fatigue, last week just exhausted all of the time". Symptoms subside when sitting down, when playing her guitar, it is fine re posture & symptoms (shaking in high stress situations, don't go fully numb but will lock up). She reported that every time she looks down she has pn at base of back of eyes. When on zoom she has a hard time figuring out what to focus on, difficulty focusing eyes. In a dark room recently and it looked like things were moving. Change in speech, can be really bad at times where she doesn't want to speak, hard to put thought into words or physically hard to speak. She stated that in general she doesn't feel like she has any spatial sense & runs into things, "forget how to move sometimes". Rx: Concerta (36 mg QD). Zolpidem (5 mg). Hydroxyzine (25 mg TID). |

1. What comes to your mind now, any changes, why?
2. Does this subjective add to the consult subjective? Does it change your mind about anything, why or why not?
3. Make a list of any new concerns and why they are concerning. How do these compare to your initial concerns?

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| Concern | Clinical Reasoning |
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1. What TM do you want to perform? You only have 45 min.

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| TM | Clinical Reasoning | What it measures/tells you |
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1. How does #30 compare to #24?
2. Do you have any hypothesis on what TM’s might be (+) or (-)? Why or why not? Copy your TM table and add a column to answer this question, see below for example.

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| TM | (+) or (-) | Why/why not |
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1. Are you feeling more confident in your referral decisions & is there a change in urgency?
2. What is ea medication for? What are the side effects? Could the side effects be contributing to her presentation?

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| **Pt case #1F/Eval Objective (45 min):** Female, early 20’s, left hand tremor. Observation: no speech impairments noted during sessionCN Result Confrontation (CN 2) Positive: (delayed or absent in left eye left low quad; delayed right eye)Finger Rustle (CN 8 Coch) Negative (Normal)Convergence (CN 3,4,6) Negative (Normal)Facial Sensation (CN 5) Negative (Normal)Smile (CN 7) Negative (Normal)Frown (CN 7) Negative (Normal)Trapezius / SCM (CN 11) Negative (Normal)Comments CN: held select testing due to COVID-19VOMS- Smooth Pursuits--- horizontal: bilateral nystagmus w/left & right & when return to neutral gaze, symptoms lose focus, tingling feeling "temple"--- vertical: bilateral nystagmus w/left & right & when return to neutral gaze, symptom lose focus – Saccades--- horizontal: nystagmus bilaterally- VOR--- horizontal: bilateral nystagmus, symptom "confusing" (task not confusing, produced symptom of confusion)- Convergence--- (-)Head Thrust: - to the right: nystagmus bilaterally- to the left: (-) nystagmusFixation: - Symptoms exacerbated w/fixation on thumb and w/EC)Dix-Hallpike:- right--- down into position: (+), symptom disorientation, blurry vision, no nystagmus bilaterally--- returning to long sitting: (+), symptoms more intense than long sit > supine, 30-60 sec, no nystagmus bilaterally- left --- down into position: (+), reproduction of symptoms, no nystagmus bilaterally--- returning to long sitting: (+), symptoms more intense than long sit > supine, seated afterwards some numbness in hands, no nystagmus bilaterallyModified CTSIB = 120 sec / 120 sec- condition 1: 30 sec- condition 2: 30 sec- condition 3: 30 sec- condition 4: 30 secDynamic Gait re balance & symptoms- intact:--- Gait speed, able to demo adequate/norm change from preferred speed to slow and fast speeds--- Head rot vertical and horizontal--- Pivot turnCervical- compression: pressure in eyes brain, chill in arms- distraction: hard time focusingVAT (seated, cervical ext > 45 deg rot) - right: hurts left eye, dizzy afterwards- left: farther left she looks, "can still see everything but it is kinda not foggy can see clearly but not seeing things correctly", little bit dizziness afterwards not as bad as the other side**Consult TM Reminder:** - (-): UE/LE Myotomes (gross 5/5 bilateral UE/LE strength), UE/LE RAMS, LE Clonus- (+): Cervical flex standing reported some zaps along her spine, mm tightness (no electrical type symptoms when performed seated)- Grip strength screen, squeeze test: mod strength - UE/LE DTR’s: mostly hypo w/2 absent |

**Pt Case #1 F: Continued:**

1. Are these tests same or different from what you would have done? Why or why not?
2. What does this information tell you?

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| Info | Tells me |
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1. What are you going to do next? Why?

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| Next step | Why |
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1. Write an assessment statement from the information that you know to date.
2. Write the goals for this POC. List why you made them and what made you decide not to address the other impairments if appropriate.

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| **Pt case #1G/Eval Assessment Statement:** Female pt in her early 20’s presented for PT eval today after PT consult due to concerns of neurologic symptoms, some of which are chronic in nature (i.e. bilateral hand/fingers & LE tremor). Subjective report, signs, & symptoms are complex and requires a referral to a neurologist for differential dx. Today noted that VOR is impaired. Saccades & smooth pursuit reproduce symptoms and demo's bilateral nystagmus & in addition to exacerbation of symptoms w/fixation indicate a possible central dysfunction. Symptoms impact her ability to complete daily activities, drive, play the guitar, communicate, and participate in zoom. Concerning subjective report: "Violent" finger "shaking" w/precise movement noted most w/playing her guitar & once it stops her baseline tremor is worse the rest of the day. She also reported dropping things, when standing hands go numb and she feels disoriented, balance difficulties, LE tremors in decreased WB positions so avoids them (i.e. short sit figure 4), after consult had onset of tingling/numbness in her hands w/a little bit of confusion "brain fog...stop processing, and hard time speaking" which occurred later that day and occurred 2 other days, recent onset (last 2 wks) sudden loss of feeling along 5th metacarpal which spreads into the rest of her hand (subsides if sits down), fatigue (more than that associated w/depression), pn behind eyes when look down, change in speech so severe that she doesn't want to talk, hard to put thought into words or difficulty w/motor aspect of speech (speech impairment not noted during PT), & in general she doesn't feel like she has any spatial sense & runs into things, "forget how to move sometimes".LTG: (8 Weeks) | Pt to demonstrate mod indep w/VOR training to decrease fatigue and improve daily function and participation. |

1. Thoughts?
2. What would you have done differently w/this case?

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| **FEEDBACK for improvements of the case:** |