Appendix 1: Neuromuscular Disease Patient History Competency Checklist

History/Interview	Y / N	Comments
Obtains a focused, complete and appropriate history based on presenting problem		
Significant PMHx		Renal, drugs, alcohol, toxins, tumor, endocrinopathy, porphyrias, sexual history, autoimmune, infection, gammaglobuinemia
Initial symptoms		Age of onset, congenital vs acquired
Associated work-up		
1. scans		
2. lab work		
3. biopsy		
4. dysphagia eval		
5. EMG/NCV		
6. LP		
7. tensilon test		
8. neurophysiological tests (VEP, BAER, SEP)		
Initial intervention		
1. pharmacologic		
2. respiratory support		
3. acute medical treatment		
4. surgical intervention		
Hospital course		
1. neurologic		
2. pulmonary		
3. cardiac		
4. infectious		
5. GI/nutrition		
6. vascular		
7. endocrine		
8. genitourinary		
9.other		
Functional status at time of transfer		
Past medical history		
Allergies		
Medication list		

Review of systems		
Family/Social History		
1. EtoH/tobacco		
2. illicit drugs		
3. where do they live		
4. who do they live with		
5. drive?		
6. education level		
7. prior functional level		
Questions patients/family clearly and effectively utilizing appropriate language		

Appendix 2: Neuromuscular Disease Patient Physical Exam Competency Checklist

Exam	Y/N	Comments
Appropriately selects/constructs physical exam elements based on history obtained and conducts a relevant thorough clinical exam		
Positions patient comfortably and in such a way as to satisfactorily perform exam elements		
Competently performs selected exam elements according to attached sheet		
Interpretation/Clinical Application		
Accurately interprets data		
Compiles complete medical and rehab problem list		
Accurately identifies disease process and resultant impairments, disabilities, handicaps; understands the type and cause of disorder		
Is familiar with prognostic indicators		
Makes appropriate treatment recommendations: medications, therapy, nursing interventions, safety measures, precautions, f/u tests		
Patient/Practitioner Interaction		
Greets patient/family in a friendly, warm manner		
Introduces self appropriately		
Explains exam fully to patient/family, utilizing appropriate terminology		
Explains examination findings and treatment options in a clear and concise manner		
Ensures thorough closure of the interaction/patient and family understanding of information, allowing ample time for questions		
Demonstrates sensitivity to patient privacy/modesty		
Conducts self in a confident, courteous and attentive manner		
Demonstrates empathy, compassion and sincerity in all communications		

System/Body Area	Element of Examination
Constitutional	• measure any three of seven vital signs: sit/stand BP, supine BP, pulse, respiration, temperature, height, weight) • general appearance of patient (grooming, development, deformities, body habitus, nutrition)
Eyes/Head/Face	• opthalmoscopic examination of optic discs • inspection of conjunctivae and lids • examination of pupils and irises • up gaze and sustained lateral gaze • light reaction • facial expression: smile • voice-read: 2-5 minutes
Ears, Nose, Mouth, Throat	• external inspection of ears and nose • otoscopic examination of external auditory canals and tympanic membrane • assessment of hearing • inspection of nasal mucosa, septum, turbinates

	• inspection of lips, teeth, gum • examination of oropharynx: oral mucosa, salivary glands, palate, tonsils, tongue
Neck	• examination of neck • examination of thyroid
Cardiovascular	• examination of carotid arteries • auscultation of heart with notation of abnormal sounds and murmurs • examination of peripheral vascular system by observation (swelling, varicosities) and palpation (pulses, temperature, edema, tenderness) • palpation of heart (size, location, thrills) • examination of carotid arteries, abdominal aorta, femoral arteries (pulse, amplitude, bruits)
Respiratory	• assessment of respiratory effect • percussion of chest • palpation of chest • auscultation of lungs
Musculoskeletal	• examination of gait and station • muscle strength in upper and lower extremities • muscle tone in upper and lower extremities with notation of any abnormal movements
Chest	• inspection of breasts, palpation of breasts, axillae
Gastrointestinal	• examination of abdomen with notation of masses tenderness • examination of liver and spleen • examination for presence or absence of hernia • exam of anus, perineum, rectum when indicated • stool sample when indicated
Skin	• inspection/palpation of skin and subcutaneous tissue
Genitourinary	• when indicated
Lymphatic	• palpation of lymph nodes- neck, axillae, groin, other
Neurologic	• orientation to time, place and person • recent and remote memory • attention span and concentration • language • fund of Knowledge • 2^{nd} cranial nerve (visual acuity, visual fields, fundi) • 3^{rd}, 4^{th}, and 6^{th} cranial nerves (pupils, eye movements) • 5^{th} cranial nerve(facial sensation, corneal reflex) • 7^{th} cranial nerve (facial symmetry, strength) • 8^{th} cranial nerve (hearing with tuning fork, whispered voice and/or finger rub) • 9^{th} cranial nerve (spontaneous or reflex palate movement) • 11^{th} cranial nerve (shoulder shrug strength) • 12^{th} cranial nerve (tongue protrusion) • examination of sensation • examation of deep tendon reflexes in upper and lower extremities • test coordination (e.g. finger to nose, RAMs) • Lhermitte Sign (passive neck flexion: tingling electric like sensation down the

	shoulders, ack and thighs) • Babinski sign	
Overall Procedure competency		
Date		
Reviewer Signature		

Appendix 3: Oral Chart Simulated Recall Case: Myasthenia Gravis

The patient is a 57 yo female c/o left eyelid drooping in the afternoon for 2 months. In the last 2 weeks, patient developed right eyelid drooping and also required frequent eye closing in the afternoon. One week prior patient started to experience difficulty chewing, coughing when drinking water. In the acute hospital, patient was put on a pureed diet with nectar thick liquid. **BASED ON THE ABOVE INFORMATION, ANSWER THE FOLLOW QUESTION:** **WHAT OTHER INFORMATION DO YOU NEED?**		
Appropriate resident response:	**Data supplied to resident:**	**Resident Independently Asks Questions**
Any visual problems?	Diplopia	
Timing of symptoms?	Better in the am	
Any other weakness?	Bilateral hips and shoulders	
Numbness?	No	

Pain?	No	
Tone?	No	
Bowel/bladder?	No	
Any history of tumor?	No	
Any trauma?	No	
Recent travel?	No	
PMHx?	HTN on HCTZ, well controlled	

Medications?	HCTZ, multivitamin	
If you are satisfied with the information the resident requested, provide the resident with the following prompt: What tests will you order?		
CT chest Anti-ACHR CT/MRI head SMA 12 CBC Lyme titer NCS/EMG rep stim	Negative Pending Negative Normal Elevated WBC Pending Normal NCS, 27% decrement with low frequency rep stim	
If you are satisfied with the information the resident requested, provide the resident with the following prompt: **BASED ON THE ABOVE FINDINGS, WHAT IS YOUR WORKING DIAGNOSIS FOR THIS PATIENT**? – Myasthenia Gravis **WHAT MEDICATIONS WOULD YOU EXPECT THE PATIENT TO BE ON?**		
If you are satisfied with the information the resident requested, provide the resident with the following prompt: **Hospital Course:** Aspiration Pneumonia On PE noted decreased BS in the right upper lobe. Patient exhibiting a low grade fever- 100.7^{o}F elevated WBC- 14,000 with left shift. **WHAT IS YOUR IMMEDIATE MANAGEMENT OF THIS PROBLEM?**		
Appropriate resident response:	**Data supplied to resident:**	**Resident Independently Asks Questions**

Stat CXR NPO STAT NGT for feeding IV Antibiotics Chest PT, incentive spirometry	RUL infiltrate	
If you are satisfied with the information the resident requested, provide the resident with the following prompt: Patient is now afebrile for 4 days, clinically improved. The NGT is inadvertently pulled out during a transfer. **WHAT IS YOUR MANAGEMENT OF THIS PROBLEM?**		
Appropriate resident response:	**Data supplied to resident:**	**Resident Independently Asks Questions**
Order bedside dysphagia evaluation	Results: tolerates puree with honey thick liquids	
MBS	Mild oral and pharyngeal dysphagia	
Diet order	Pureed with honey thick liquids	
If you are satisfied with the information the resident requested, provide the resident with the following prompt: Patient's voice quality has been compromised since the tube was pulled out. **WHAT IS YOUR MANAGEMENT?**		

Appropriate resident response:	**Data supplied to resident:**	**Resident Independently Asks Questions**
ENT consult	Reveals decreased adduction of vocal cords on one side with minimal local inflammatory changes	

If you are satisfied with the information the resident requested, provide the resident with the following prompt:

Functional Status: Patient c/o inability to get OOB, comb hair, etc. PE reveals proximal shoulder strength 2/5 for flexion, ext, abd, add; elbow 3+/ flex/ext; hand 4/5 wrist flex/ext. Proximal hip strength 3/5 flex/ext; knee 3/5 flex/ext, ankle 4/5 df/pf. Patient transfers sit to stand with max assist. Ambulating with rolling platform walker and mod assist.

BASED ON THE ABOVE IMFORMATIO, ANSWER THE FOLLOWING QUESTIONS:

Question	**Appropriate Response**	**Y/N**
What are the PT orders?	Activity modifications- am sessions Energy conservation Do not exercise to fatigue ROM Strengthening with light resistance Mat exercise Transfers Ambulation with assistive device Fall precautions One time pulse oximetry during therapy, if less than 92% contact MD Cardiac precautions: hold for HR >120 or <55; hold for sys BP >160/<100, diastolic >100 or <55	

OT orders?	ADL eval and treat ROM/strengthening of BUE Transfer training	
Speech orders?	Dysphagia follow up Oral muscle exercise- avoid fatigue Laryngeal exercises	

If you are satisfied with the information the resident requested, provide the resident with the following prompt:

Discharge Planning: After 2 weeks in rehab, the patient is transferring with supervision, ambulating with distant supervision for level surfaces; stairs with CG. Family training has been completed and the patient is ready for discharge.

BASED ON THE ABOVE INFORMATION, ANSWER THE FOLLOWING QUESTIONS:

Question	**Appropriate Response**	**Y/N**
What are your dc orders for this patient?	Diet- puree with honey thick liquids MBS in two weeks Continue PT/OT/Speech in outpatient setting f/u with neurologist f/u with physiatrist in 4 weeks medication reconciliation	

Do you need to prompt the resident in any area of the treatment recommendation? If you are not satisfied with the resident's response, please return to the previous prompt. If you are satisfied with the information the resident requested, the chart stimulated recall exercise is finished.

Resident signature	Examiner signature	Date