**Mid Rotation site evaluation:**

For the mid-site evaluation, I presented two patients, who presented to the ER with a similar complaint of lower abdominal pain. I decided to present these two patients because both presentations were very similar but their management differed drastically. Both patient's clinical presentation of N/V, vaginal bleeding, lower abdominal pain and lab value of UCG positive forced me to consider ectopic pregnancy. One patient was exhibiting more pain than other but the patient with more pain was diagnosed with normal Intrauterine pregnancy while the patient with less pain was diagnosed with ruptured ectopic pregnancy.This was eye opening moment for me because as a future provider, I have to be careful how I manage patient based on pain scale. Every individual has a different pain threshold and management or ddx should not be depended on the pain threshold. PA Rachwalski agreed with the ddx and he also cautioned against narrowing the ddx too much because that can prevent from taking care of the patient effectively. I loved the fact that PA Rachwalski encouraged me to think of other differential diagnoses and discuss an effective management plan. Furthermore, he advised me to ask about pertinent risk factors related to ectopic pregnancy, which could also help to formulate effective differentials. Overall, I found PA Rachwalski very helpful and an amazing critique, who suggested ways I could improve my H&P and improve my interaction with the patients.

**End of rotation site evaluation:**

For the final site evaluation, I presented a patient who came to the ED complaining of constipation and left sided flank pain. Based on patient presentation of left sided flank pain, CVA tenderness and anorexia made me think more of Nephrolithiasis than SBO. However, the patient presented a different story to my preceptor, which led to a different diagnostic test of a plain abdominal X-ray (to rule out SBO) and non contrast CT (to rule out nephrolithiasis). For the future, PA Rachwalski suggested that I should order a CT with contrast because Xray is not an effective tool in ruling out SBO. Also, based on patient age, colorectal cancer should be in the ddx and if I get a CT without contrast, I might miss an important life saving ddx. Also, he cautioned against getting fixed with one differential as that might cause harm to the patient. For example, for this patient if the CT without contrast did not show nepthorolithidis then CT with contrast might have been ordered, which is unnecessary exposure for the patient. Additionally, PA Rachwalski suggested collecting history regarding colonoscopy and family history of colon cancer on this type of patient . PA Rachwalski provided constructive ways, I could formulate a wide range of differential diagnosis. Overall he gave effective recommendations that can be utilized to improve the H&P in the future and became a better future PA.