CDI Clinical Scenario 2

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

DISCHARGE SUMMARY

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
DISCHARGE DT:

LOC:
RM#:
MR#:
DOB:
ADM:
PCP:

DISCHARGE DIAGNOSES:
1. Chronic obstructive pulmonary disease exacerbation, on home oxygen 2 liters nasal cannula.
2. No definite pneumonia.
3. Paroxysmal atrial fibrillation, new, started on Digoxin and apixaban. No congestive heart failure.
4. Hypertension.
5. History of fall in the hospital without any stroke or head bleed.
6. Accidental subarachnoid cyst on the left occipital area.

DIAGNOSTIC DATA:
1. Chest x-ray results: COPD, no definite infiltrate or CHF.
2. Echocardiogram showed ejection fraction normal, mild pulmonary hypertension, ____ normal. No pericardial effusion.
3. BNP less than 430.
4. CT of the head: No CVA. No head bleed with accidental arachnoid cyst on the occipital area.

HOSPITAL COURSE: A 78-year-old, white male, got admitted with COPD exacerbation. Chest x-ray was recently normal. He was given antibiotic Levaquin plus nebulizer treatment including Spiriva, on home oxygen 2 liters nasal cannula, saturating around 96%. During the hospital stay, he developed AFib for which cardiology consulted. Digoxin and apixaban were started. He has no CHF. BNP less than 430. No pedal edema. No CHF on chest x-ray. He is stable at this time. Blood pressure 155/69, respirations 16, temperature 98 degrees Fahrenheit, oxygen saturation 97% on 2 liters nasal cannula and heart rate is 88. No pedal edema.

DISCHARGE MEDICATIONS:
1. Apixaban 5 mg p.o. b.i.d.
2. Digoxin 0.125 mg p.o. daily.
3. Cardizem CD 120 mg p.o. daily.
4. Claritin 10 mg p.o. daily.
5. Zebeta 5 mg p.o. daily.
6. Prednisone 20 mg p.o. daily for 3 days and then 10 mg p.o. daily for 3 days and then discontinue.

PLAN:
1. Continue home oxygen 2 liters nasal cannula continuously.
2. Follow up with PCP, Dr. Hobbs in Tahlequah in 1 week.

CODE STATUS: FULL CODE.

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HISTORY & PHYSICAL

PATIENT:		**LOC:**	MA.MA
ACCOUNT:		**RM#:**	.
PHYSICIAN:		**MR#:**	
ATTENDING:		**DOB:**	'
ADMIT DATE:	10/15/15	**DDT:**	
		PCP:	

Admission History and Physical

REASON FOR THIS ADMISSION: Acute exacerbation of COPD.

HISTORY OF PRESENT ILLNESS: The patient is a 78-year-old male, who is a known previous smoker, who has chronic obstructive pulmonary disease. He is followed by Dr. ' He presented to the Emergency Room with complaints of increasing shortness of breath for the last day. There has been no nausea, vomiting, diarrhea or constipation. He denies having a fever. He has a moist cough, but is nonproductive. Upon reporting to the Emergency Room, the patient was noted to have a temperature of 36.6, his blood pressure was a bit low at 100/64. A chest x-ray shows COPD, but no distinct infiltrates and his white count was 19,400. He, clinically, was felt to have an acute exacerbation of COPD and the patient was admitted to the hospital for further evaluation and treatment.

PREVIOUS MEDICAL HISTORY: Known chronic obstructive pulmonary disease. He has been admitted to the hospital for similar events in the past. Other previous medical history includes a history of hypertension. Previous surgeries include open cholecystectomy for gangrenous gallbladder. He also has a history of gastroesophageal reflux disease.

MEDICATIONS: Present list of medications are as follows:
1. Xanax 0.25 mg at bedtime.
2. Brovana 15 mcg inhaled b.i.d.
3. Coreg 3.125 mg b.i.d.
4. Cozaar 100 mg p.o. a day.
5. Diltiazem 120 mg p.o. a day.
6. Prednisone 5 mg a day.
7. Prilosec 20 mg a day
8. Zyrtec 10 mg p.o. a day.
9. Advair Diskus 250/50 one inhalation twice a day.
10. Atrovent 0.5 mg inhaled q.i.d.
11. Zoloft 100 mg a day.
12. Tramadol 50 mg b.i.d. p.r.n.

ALLERGIES: TO TETRACYCLINE.

SOCIAL HISTORY: The patient lives at home with his wife. He stopped smoking in 1997, but has a 60-pack year history of smoking in the past. No history of illicit drug use. No history of alcohol abuse or use.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS:
ENT: The patient is edentulous. He denies other problems. There has been no complaints of nasal congestion or sore throat.
CARDIOVASCULAR: Denies chest pain, PND, orthopnea or palpitations.
PULMONARY: A shortness of breath with moist cough as stated above. He denies chest pain.

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
PHYSICIAN:	**MR#:**
ATTENDING:	**DOB:**
ADMIT DATE:	**DDT:**
	PCP:

GASTROINTESTINAL: A history of gastroesophageal reflux disease as stated above. He states that it is relieved with milk and also with Tums.
GENITOURINARY: Negative.
ORTHOPEDIC: Negative.
The rest of the 10-point review of systems is negative.

PHYSICAL EXAMINATION:
GENERAL: The patient is an advanced age male. He does not appear in acute respiratory distress.
VITAL SIGNS: As follows: BP 100/64, temperature is 36.6, respirations are 22 and pulse is 90.
HEENT: Reveals the head to be normocephalic and atraumatic. Oral mucosa is moist. He is edentulous.
NECK: Supple. There is no lymphadenopathy. There are no carotid bruits auscultated.
LUNGS: Reveal bilateral rhonchi. No wheezes or rales were noted.
CARDIOVASCULAR: Normal heart tones. There are no extrasystoles. No murmurs or gallops noted.
ABDOMEN: Soft and there is no hepatosplenomegaly. There is no tenderness noted. Right upper quadrant scar is noted from previous cholecystectomy. There are no intra-abdominal bruits.
GENITOURINARY: Deferred.
RECTAL: Deferred.
EXTREMITIES: Reveal no clubbing, no cyanosis and there is no edema. Both lower extremities are warm.

LABORATORY DATA: CBC: White count is 19,400 with a hemoglobin of 12.7, a hematocrit of 37 and a platelet count of 217,000. Chemistry: Sodium is 136, potassium is 4.7, chloride 100, carbon dioxide is 26, BUN is 27 and creatinine is 1.4. Liver enzymes are within normal limits and glucose is 139.

IMPRESSION:
1. Acute exacerbation of chronic obstructive pulmonary disease.
2. History of gastroesophageal reflux disease.
3. Hypertension.

PLAN:
1. Holding most of his antihypertensive medications.
2. Start the patient on vigorous pulmonary toilet as well as IV steroids and IV antibiotics.
3. The patient states that he needs a pneumonia vaccine and an influenza vaccine prior to his discharge from the hospital.

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CONSULTATION

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
CONSULTING PHYSICIAN:	**MR#:**
CONSULTATION DICT DATE:	**DOB:**
ATTENDING PHYSICIAN:	**ASD:**
DDD:	**PCP:**

DATE OF CONSULTATION: 10/20/2015

Cardiology Consultation.

REASON FOR CONSULTATION: Atrial fibrillation with rapid ventricular response.

HISTORY OF PRESENT ILLNESS: A 78-year-old gentleman admitted with acute exacerbation of COPD, has been doing reasonably well until he went into atrial fibrillation early this morning, he has been complaining of more shortness of breath, denied palpitations, chest pain, but he has been feeling dizzy somewhat recently. His heart rate was about 130 when I saw him and he was significantly tachypneic. An echocardiogram was done at the bedside and showed normal left ventricular systolic function.

PAST MEDICAL HISTORY:
1. COPD.
2. Hypertension.
3. Cholecystectomy.
4. Reflux disease.
5. Anxiety.

MEDICATIONS: His list is in the chart and was reviewed. Of note, he was on diltiazem for hypertension prior to admission, but he has not taken it currently.

ALLERGIES: TETRACYCLINE.

SOCIAL HISTORY: He has history of heavy smoking, quit in 1997. No drinking or drug use. He is ambulatory, lives with his wife.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: On 12-point system review, the patient has dyspnea at rest and on exertion. Denies chest pain, palpitations. He does have occasional dizziness, otherwise negative.

LABORATORY FINDINGS: Potassium is 4.6, sodium is 138. BUN 23, creatinine is 1. White count is 8.9, hemoglobin is 11.8, platelet count is 223.

PHYSICAL EXAMINATION:

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
CONSULTING PHYSICIAN:	**MR#:**
CONSULTATION DICT DATE:	**DOB:**
ATTENDING PHYSICIAN:	**ASD:**
DDD:	**PCP:**

VITAL SIGNS: Blood pressure was 106/68, heart rate was in the 120s to 130s, respiratory rate is about 35, temperature is 97.8.
HEENT: Atraumatic and normocephalic.
NECK: Supple. He did have JVD. No thyromegaly, lymphadenopathy or carotid bruits.
CHEST: Decreased breath sounds bilaterally with some rhonchi.
HEART: Irregularly irregular with normal S1, S2. Tachycardic. No murmur, rub or gallop.
ABDOMEN: Soft. Bowel sounds are positive. No organomegaly or masses.
EXTREMITIES: No cyanosis, clubbing or edema.
NEUROLOGIC: Awake, oriented, no focal deficits.
SKIN: No rash or jaundice.
GENERAL: The patient looks tachypneic, was in mild distress.

ASSESSMENT:
1. Acute onset of atrial fibrillation with rapid ventricular rate.
2. Congestive heart failure, probably due to the atrial fibrillation.
3. Chronic obstructive pulmonary disease exacerbation.
4. History of hypertension.
5. The patient's CHADS score is 2.

RECOMMENDATIONS:
1. Rule out myocardial infarction.
2. D-dimer.
3. Anticoagulation with Lovenox.
4. Rate control. I will start him on digoxin and we will switch his Coreg to bisoprolol 5 mg daily.
5. Cardizem p.r.n. in addition to the long-acting Cardizem, which was restarted.
6. Lasix 40 mg now.
7. Thyroid functions.

Thank you for allowing me the opportunity to contribute to this gentleman's care.

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CONSULTATION

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
CONSULTING PHYSICIAN:	**MR#:**
CONSULTATION DICT DATE:	**DOB:**
ATTENDING PHYSICIAN:	**ASD:**
DDD:	**PCP:**

DATE OF CONSULTATION: 10/16/2015

Pulmonary Consultation

REASON FOR CONSULTATION: Pulmonary management. The patient has dry cough, increasing dyspnea and wheezing.

HISTORY OF PRESENT ILLNESS: A 78-year-old male patient with history of COPD, has home oxygen and home nebulizer machine, systemic hypertension, presented with a 1-day history of cough, chest congestion, increasing dyspnea and wheezing. He was seen by the emergency physician. His white blood count is elevated at 19.4 with increased neutrophils. Chest x-ray, no acute infiltrate. He denies nausea, vomiting, diarrhea, constipation or abdominal pain. The patient reports generalized weakness. He presented to the Emergency Department. He was in respiratory distress, respiratory rate 30 breaths per minute. He was seen by the emergency physician and he had wheezing in the Emergency Department. The patient was placed on oxygen, bronchodilators via nebulizer breathing treatment, IV Solu-Medrol, IV antibiotic and was subsequently admitted for further management. I was asked to see this patient for pulmonary management. The patient was seen in his room and his daughter is in the room at the bedside. The patient states he is breathing much better.

PAST MEDICAL HISTORY: COPD. He has home nebulizer machine and home oxygen, systemic hypertension. Influenza infection in February 2015. Gastroesophageal reflux disease.

PAST SURGICAL HISTORY: Status post cholecystectomy for gangrenous bladder.

ALLERGIES: TETRACYCLINE.

SOCIAL HISTORY: History of heavy tobacco smoking in the past. He smoked 60-pack years. He quit smoking tobacco in 1997. No alcohol abuse. No IV drug abuse. The patient lives at home with his wife.

FAMILY HISTORY: Noncontributory.

OCCUPATIONAL HISTORY: Retired, worked for a glass company.

REVIEW OF SYSTEMS:
GENERAL: Feels weak.
ENT: No nose bleed or earache.

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
CONSULTING PHYSICIAN:	**MR#:**
CONSULTATION DICT DATE:	**DOB:**
ATTENDING PHYSICIAN:	**ASD:**
DDD:	**PCP:**

EYES: No diplopia or photophobia.
CARDIAC: No loss of consciousness. No recent MI.
GASTROINTESTINAL: No hematemesis or rectal bleeding.
URINARY: No hematuria or dysuria.
SKIN: No rash, bites or wound.
PSYCHIATRIC: No hallucinations or suicidal ideation.
NEUROLOGIC: No recent stroke or seizures.
RESPIRATORY: He has dry cough, increasing dyspnea and wheezing. No hemoptysis. He has history of COPD, home oxygen and home nebulizer machine.

CURRENT MEDICATIONS:
1. Tylenol.
2. Xanax.
3. Albuterol nebulizer treatment every 6 hours.
4. Lovenox.
5. Levaquin.
6. Claritin.
7. Solu-Medrol.
8. Protonix.
9. Zoloft.
10. Ultram.
11. Spiriva.
12. Flomax.

FAMILY HISTORY: Noncontributory.

PHYSICAL EXAMINATION:
GENERAL: A 78-year-old pleasant male patient was seen in his room. His daughter is in the room at the bedside. The patient states breathing better.
VITAL SIGNS: Temperature 36.6, respirations 18, pulse 76, blood pressure 117/75 and pulse ox 98% on oxygen 2 liters per minute nasal cannula.
HEENT: EOMI.
NECK: Supple. No JVD, no adenopathy.
LUNGS: Decreased breath sounds bilaterally. Decreased air movement bilaterally. No rales, no rubs. There are rare expiratory wheezes scattered bilaterally.
HEART: Regular rhythm. No thrill, no lift, no rub and no gallop.
ABDOMEN: Soft and nontender. No rebound or guarding.
EXTREMITIES: No edema, clubbing or cyanosis.
NEUROLOGIC: The patient is awake, follows simple commands and moves all 4 extremities. He has

PATIENT:	**LOC:**
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CONSULTATION DICT DATE:	**DOB:**
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DDD:	**PCP:**

generalized weakness.

LABORATORY DATA: WBC 19.4, hemoglobin 12.7, platelet 217 and neutrophil 88%. Sodium 136, potassium 4.7, BUN 27, creatinine 1.4 and glucose 139. Liver enzymes normal. Cardiac enzymes normal. Albumin 3.7.

DIAGNOSTIC DATA: Chest x-ray in the Emergency Department revealed no acute infiltrate. The lungs are clear. No effusion and no consolidation.

IMPRESSION:
1. Acute exacerbation of chronic obstructive pulmonary disease.
2. Acute bronchitis.
3. Dehydration.
4. Acute kidney injury.
5. Gastroesophageal reflux disease.
6. Systemic hypertension.
7. Leukocytosis with increased neutrophils.

PLAN:
1. Oxygen, keep saturation above 93%.
2. DuoNeb bronchodilator via nebulizer breathing treatment.
3. Levaquin antibiotic.
4. Solu-Medrol systemic steroids.
5. Spiriva bronchodilator 1 capsule inhaled daily.
6. Lovenox subcutaneously to prevent deep venous thrombosis.
7. Rapid influenza test.
8. Blood cultures times 2.
9. Follow up CBC.
10. Yearly flu vaccine and Pneumovax as indicated.
11. Venous ultrasound of lower extremities to rule out thromboembolic disease.

The case was discussed with the patient and his daughter. I answered all their questions to their satisfaction.

Full pulmonary function test when his condition is stable. This could be done on outpatient basis.

This consultation is appreciated. I will follow with you.

TRANSINT

HOSPITALIST PROGRESS NOTE

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

LOC:
RM#:
MR#:
DOB:
DDD:

Assess/Plan General Adult

- Patient Problems
Active Problems List:
Active problem(s)

AKI (acute kidney injury) (Acute) N17.9
Acute bronchitis (Acute) J20.9
COPD with acute exacerbation (Acute) J44.1
Hypertension (Acute) I10
Leukocytosis (Acute) D72.829

- Additional Planning
Plan Notes:
10/23/15 15:57
Imp: 78 y/o M with h/o COPD on home O2, HTN, GERD, now admitted with resp failure secondary to acute COPD exacerbation/bronchitis, with hospitalization c/b new onset Afib w/ RVR, improved, now with CTH showing the presence of a possible large arachnoid cyst.

Plan: Neurology eval
Prednisone taper
Continue bronchodilators and supplemental O2 to keep SpO2 above 92%
Levofloxacin day 6/7
Rate control with Dig, Diltiazem and bisoprolol
Dig level on Monday
After extensive discussion of both myself and and his wife decision was taken to continue the AC with Eloquis
Appreciate Dr recommendations
Continue other meds
Plan discussed in detail with patient and wife and questions were answered to their satisfaction

My Orders (last 16 hours):
My Orders

	Category	Date Time	Status
Unit Secretary notify consult ONCE	Care	10/23/15 07:05	Active
Consult Neurology Routine	Cons	10/23/15 07:03	Active
Basic Metabolic Panel DAILY	Lab	10/23/15 05:06	Completed
Basic Metabolic Panel DAILY	Lab	10/24/15 06:00	Ordered

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV: 10/15/15
DOCUMENT: 10/23/15

LOC:
RM#:
MR#:
DOB:
DDD:

Basic Metabolic Panel DAILY	Lab	10/25/15 06:00	Ordered
CBC w Automated Diff DAILY	Lab	10/23/15 05:06	Completed
CBC w Automated Diff DAILY	Lab	10/24/15 06:00	Ordered
CBC w Automated Diff DAILY	Lab	10/25/15 06:00	Ordered
Manual Differential Routine	Lab	10/23/15 05:06	Completed

Consults: cardiology, neurology
Plan Discussed with: patient, wife

Subjective -Daily PN

- Subjective Report
Patient reports: Reports: other (This AM, Mr feels better, denies CP, palpitations, abd pain, dizziness or any other complaints. CT head done yesterday showed)

General Adult - Physical Exam

- Consitiution
Vitals (last 24 hours):

Vital Signs

	Temp	Pulse	Resp	BP	Pulse Ox
10/23/15 15:00		59 L	18		98
10/23/15 11:57	36.2 C	62	16	112/76 L	99
10/23/15 08:24		53 L	18		96
10/23/15 08:00	36.6 C	55 L	18	125/67 L	
10/23/15 04:00	36.4 C	77	17	110/62 L	
10/23/15 03:00		90	18		99
10/23/15 00:00	36.7 C	64	18	114/70 L	
10/22/15 23:09		55 L			
10/22/15 20:41		91	18		98
10/22/15 20:00	36.3 C	63	17	106/97 H	
10/22/15 18:41		75	18	103/62 L	
10/22/15 16:00	36.3 C	60	18	120/69 L	

I&O (last 24 hours):
Intake & Output

	10/22/15 06:59	10/23/15 06:59	10/24/15 06:59
Intake Total	332	960	260

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV: 10/15/15
DOCUMENT: 10/23/15

LOC:
RM#:
MR#:
DOB:
DDD:

Output Total	406	1002	2
Balance	-74	-42	258
Oral Intake			
Oral	332	960	260
Meals Consumed			
Breakfast	50%	100%	100%
Lunch	75%	100%	75%
Dinner		100%	
Urine Amount			
Void	400	1000	
Output Non-Measured			
Number of times incontinent of urine	3		
Number of voids	3	2	2
BM	1	0	0

General appearence: In no acute distress

- Eyes
Eye: PERRL, EOMI

- ENMT
ENMT: mucosa moist, other (no thrush)

- Cardio/Respiratory
Cardiovascular: regular rate & rhythm, S1, S2+
Respiratory: other (decreased breath sounds at bases)

- Gastrointestinal
Abdomen: soft, non-tender, bowel sounds present, non-distended

- Extremities
Extremity lower: other (no tenderness on palpation over b/l hips or knees; motor 5/5 over all extremities)

- Neurological
Neurologic: other (AAO X 3, CN 3-12 grossly intact, senation intact, motor 5/5)

General Adult - Diagnostic

- Results
Results: labs reviewed, CT scan reviewed

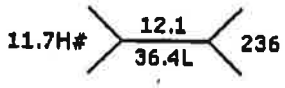
HOSPITALIST PROGRESS NOTE

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

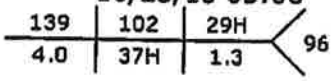
LOC:
RM#:
MR#:
DOB:
DDD:

Result Diagrams:

10/23/15 05:06



10/23/15 05:06



Lab results (last 24 hours):
Laboratory Tests

	10/23/15 05:06	Range/Units
WBC	11.7 H D	(3.8-11.0) K/mm3
RBC	3.71 L	(4.50-5.20) M/mm3
Hgb	12.1	(11.5-16.0) gm/dL
Hct	36.4 L	(40.5-52.5) %
MCV	98.1	(80.0-100.0) fL
MCH	32.6	(26.0-34.0) pg
MCHC	33.2	(31.0-37.0) g/dL
RDW	16.0 H	(11.5-14.5) %
Plt Count	236	(130-400) K/mcL
Neut % (Auto)	Not Reportable	
Lymph % (Auto)	Not Reportable	
Neut #	Not Reportable	
Lymph #	Not Reportable	
Total Counted	100	
Seg Neutrophils %	73	(40-74) %
Lymphocytes % (Manual)	14 L	(23-61) %
Monocytes % (Manual)	13 H	(2-8) %
Seg Neutrophils #	8.50 H	(1.52-8.14) K/mm3
Lymphocytes #	1.60	(0.87-6.71) K/mm3
Monocytes # (Manual)	1.50 H	(0.08-0.88) K/mm3
Platelet Estimate	Appear Adequate	(Adequate)
RBC Morphology	Normocytic, -chromic	
Sodium	139	(136-145) mmol/L
Potassium	4.0	(3.5-5.1) mmol/L
Chloride	102	(98-107) mmol/L
Carbon Dioxide	37 H	(21-32) mmol/L
Anion Gap	0 L	(7-16) mmol/L
BUN	29 H	(7-18) mg/dL

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

LOC:
RM#:
MR#:
DOB:
DDD:

Consults: cardiology, pulmonary
Plan Discussed with: patient, wife

Subjective -Daily PN

- Subjective Report
Patient reports: Reports: other (Patient examined, resting in bed, wife at bedside, feels better, dyspnea improved, minimal cough, denies CP, palpitations. Now back in SR, no recurrent episodes of tachycardia. Afebrile, normotensive. Started on dig and full dose anticoagulation.)

General Adult - Physical Exam

- Consitiution
Vitals (last 24 hours):

Vital Signs

	Temp	Pulse	Resp	BP	Pulse Ox
10/21/15 12:00	36.3 C	59 L	18	138/79 L	100
10/21/15 09:00		54 L	16		100
10/21/15 08:00	36.2 C	65	17	130/75 L	98
10/21/15 07:00					100
10/21/15 04:00	36.4 C	74	18	100/69 L	
10/21/15 03:51		62	18		97
10/21/15 00:00	36.4 C	72	18	102/71 L	
10/20/15 20:33		66			
10/20/15 20:31		58 L	20		98
10/20/15 20:00	36.4 C	72	18	98/68 L	
10/20/15 16:00	36.2 C	71	18	95/68 L	
10/20/15 15:35		86	20		96
10/20/15 13:54					95

I&O (last 24 hours):
Intake & Output

	10/20/15 06:59	10/21/15 06:59	10/22/15 06:59
Intake Total	300	830	
Output Total	3	6	
Balance	297	824	
Oral Intake			

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

LOC:
RM#:
MR#:
DOB:
DDD:

Oral	300	830	
Meals Consumed			
Breakfast		100%	
Lunch		100%	
Dinner		75%	
Output Non-Measured			
Number of times incontinent of urine	3	4	
Number of voids		2	
BM		1	

- ENMT
ENMT: mucosa moist

- Neck
Neck: non-tender, supple

- Cardio/Respiratory
Cardiovascular: regular rate & rhythm, S1, S2+
Respiratory: clear to auscultation, aerating well

- Gastrointestinal
Abdomen: soft, non-tender, bowel sounds present, non-distended

- Extremities
Extremity lower: other (no edema, + peripheral pulses)

General Adult - Diagnostic

- Results
Results: labs reviewed
Result Diagrams:

10/21/15 08:56

10.7	12.4 / 37.1L	218

10/21/15 08:56

138	100	30H#	198H
3.8	29	1.3	

Lab results (last 24 hours):

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

LOC
RM#:
MR#:
DOB:
DDD:

Laboratory Tests

	10/20/15 13:40	10/20/15 13:54	10/20/15 18:01	Range/Units
WBC				(3.8-11.0) K/mm3
RBC				(4.50-5.20) M/mm3
Hgb				(11.5-16.0) gm/dL
Hct				(40.5-52.5) %
MCV				(80.0-100.0) fL
MCH				(26.0-34.0) pg
MCHC				(31.0-37.0) g/dL
RDW				(11.5-14.5) %
Plt Count				(130-400) K/mcL
Neut % (Auto)				
Lymph % (Auto)				
Neut #				
Lymph #				
Total Counted				
Seg Neutrophils %				(40-74) %
Lymphocytes % (Manual)				(23-61) %
Monocytes % (Manual)				(2-8) %
Seg Neutrophils #				(1.52-8.14) K/mm3
Lymphocytes #				(0.87-6.71) K/mm3
Monocytes # (Manual)				(0.08-0.88) K/mm3
Platelet Estimate				(Adequate)
RBC Morphology				
D-Dimer		861 H		(100-399) ng/mL
Sodium				(136-145) mmol/L
Potassium				(3.5-5.1) mmol/L
Chloride				(98-107) mmol/L
Carbon Dioxide				(21-32) mmol/L
Anion Gap				(7-16) mmol/L
BUN				(7-18) mg/dL
Creatinine				(0.7-1.3) mg/dL
Est GFR (African Amer)				(>59) mL/min
Est GFR (Non-Af Amer)				(>59) mL/min
Glucose				(74-106) mg/dL
Calculated Osmolality				(275-300) mosm/kg
Calcium				(8.5-10.1) mg/dL
Magnesium				(1.8-2.4) mg/dL
CK-MB (CK-2)	1.0		1.0	(< 5.0) ng/mL
Troponin I	0.018		0.018	(<= 0.056) ng/mL

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:
DOCUMENT:

LOC:
RM#:
MR#:
DOB:
DDD:

Triglycerides				(48-352) mg/dL
Cholesterol				(< 200) mg/dL
LDL Cholesterol				mg/dL
VLDL Cholesterol				mg/dL
HDL Cholesterol				(40-60) mg/dL
TSH		3.821 H		(0.358-3.740) mcIU/mL
Free T4		1.1		(0.8-1.5) ng/dL

	10/21/15 00:18	10/21/15 05:29	10/21/15 08:56	Range/Units
WBC			10.7	(3.8-11.0) K/mm3
RBC			3.81 L	(4.50-5.20) M/mm3
Hgb			12.4	(11.5-16.0) gm/dL
Hct			37.1 L	(40.5-52.5) %
MCV			97.4	(80.0-100.0) fL
MCH			32.5	(26.0-34.0) pg
MCHC			33.4	(31.0-37.0) g/dL
RDW			15.8 H	(11.5-14.5) %
Plt Count			218	(130-400) K/mcL
Neut % (Auto)			Not Reportable	
Lymph % (Auto)			Not Reportable	
Neut #			Not Reportable	
Lymph #			Not Reportable	
Total Counted			100	
Seg Neutrophils %			81 H	(40-74) %
Lymphocytes % (Manual)			14 L	(23-61) %
Monocytes % (Manual)			5	(2-8) %
Seg Neutrophils #			8.60 H	(1.52-8.14) K/mm3
Lymphocytes #			1.40	(0.87-6.71) K/mm3
Monocytes # (Manual)			0.50	(0.08-0.88) K/mm3
Platelet Estimate			Appear Adequate	(Adequate)
RBC Morphology			Normocytic, - chromic	
D-Dimer				(100-399) ng/mL
Sodium			138	(136-145) mmol/L
Potassium			3.8	(3.5-5.1) mmol/L
Chloride			100	(98-107) mmol/L
Carbon Dioxide			29	(21-32) mmol/L
Anion Gap			9	(7-16) mmol/L
BUN			30 H D	(7-18) mg/dL

PROGRESS NOTE

PATIENT:	**LOC:**
ACCOUNT:	**RM#:**
ATTENDING:	**DOB:**
PHYSICIAN:	**MR#:**
DICT DATE:	**ASD:**
DDD:	**PCP:**

DATE OF PROGRESS NOTE: 10/18/2015

SUBJECTIVE: The patient continues to have shortness of breath and cough. Condition is better since admission. No nausea, vomiting, abdominal pain, arm and leg weakness, or vision problem.

PHYSICAL EXAMINATION:
VITAL SIGNS: T-max 36.3, pulse 64, respiration 19, blood pressure 132/76 and O2 sat 98% on 2 liter oxygen.
HEENT: Atraumatic, normocephalic. Pupils reactive. Throat is clear. No thrush.
NECK: Supple. No JVD. No stridor.
CARDIOVASCULAR: S1, S2 normal.
LUNGS: Decreased air entry bilaterally. Right-sided rhonchi present.
ABDOMEN: Soft, nontender, no rebound.
EXTREMITIES: Warm and well perfused.

Medications were reviewed.

LABORATORY DATA: White count is 16.4, H&H 11 and 35, platelets are 223, and neutrophils 88%. Sodium 137, potassium 4.2, BUN 27, creatinine 1.1, magnesium is 2.3. Last three troponins were negative. UA showed glucose of 500. Influenza is negative. Blood culture negative from 10/06/16. Venous Doppler negative. Renal ultrasound showed chronic outlet obstruction issues. Chest x-ray from 10/15/2015 revealed no acute process.

DIAGNOSES:
1. Acute chronic obstructive pulmonary disease exacerbation.
2. Acute bronchitis.
3. Hypertension.
4. Leukocytosis, probably due to steroids.

PLAN: Continue levofloxacin. Continue prednisone. I asked the patient to do chest x-ray, he declined. He wants to wait. I will order blood tests again in the morning and follow the CBC and BMP. Continue Levaquin for now. Continue Spiriva and albuterol. Discussed with the patient regarding patient care and treatment.

TRANSINT:XTB176550 C: 10/19/2015 07:02:25
T: 10/19/2015 07:02:20 D: 10/18/2015 17:32:27
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<Electronically signed by

Please sign all notes clearly with name and professional identity

Date	Time	Doctor	Nurse/Ancillary Services
	11:45 AM	Cardio:	
		∅ complaints	
		Chest	CTA 2 BS
		Heart	reg S. S
		Abd	soft
		Ext	c/c/E
		Neuro	∅ focal
		A: PAF in SR	
		fell yesterday (slipped & fell ∅ L.O.C.).	
		LVH	
		Rec. Resume Eliquis	
		stable for discharge from my perspective	
		f/u in 2-3 weeks	
		[signature]	
10-23	15	Pulm team	
		PT is breathing easy	
	490144	lungs ↓BS bilat ∅ wheeze	
		Heart RR old S1S2	
		Plan O2, HHN gradually.	
		with help.	
10-24-15 # 490144			
1PM			
D/C home			

DO NOT USE ABBREVIATIONS LIST: U, IU, QD, QOD, X.0, O.X, MS, MS04, and MgSO

INTEGRATED PROGRESS RECORD

PN500 REV. 11/12

Please sign all notes clearly with name and professional identity

Date	Time	Doctor	Nurse/Ancillary Services
	10:30AM		Hospitalist Progress Note.
			Patient examined, feels fine, had an episode of fall.
			Patient was going in the bathroom and slipped and fell.
			Denied dizziness, LOC, CP, palpitations, hip, knee
			pain. No other complaints.
			PE (VS) 98/66 67, 18 Tm 36.6. 99% 2LNC.
			HEENT: anicteric sclerae, MMM, no bruising.
			Chest: decreased breath sounds at bases.
			CV: reg S_1S_2, distant
			Abd: soft, NT, ND, (+)BS.
			Ext: (+) peripheral pulses, no edema.
			Neuro: AAOx3, motor 5/5 all extremities, shrugs shoulders
			no facial asymmetry, tongue midline, finger → nose OK.
			Labs: (13.9) 12.4 / 237 / 37 — 10.7 — 136 | 100 | 32 | 151 — 4.1 | 33 | 1.2 | 8.7.
			Meds: Dig 0.125, Bethanechol 20, Bisoprolol 5 QD, Eliquis 5 BID,
			Xanax, Bumex BID, Lasix 20 BID, Prozac, Levofloxacin d5,
			Prednisone 30, Flonase, Zoloft
			Imp/Plan: 78 y/o M c h/o COPD, HTN, GERD now admitted
			c resp. failure 2/2 AECOPD/bronchitis now c new onset
			Afib c RVR now s/p mechanical fall.
			- Neurological intact however because patient is on
			anticoagulation therefore stat CT Head.
			- Continue levofloxacin d5, taper Prednisone to 20 QD.
			- Hold Eliquis for now.
			- continue other meds.
			- Check orthostatics, neurochecks Q2 for 4 hrs then Q4

DO NOT USE ABBREVIATIONS LIST: U, IU, QD, QOD, X.0, O.X, MS, MS04, and MgSO

ED PHYSICIAN RECORD

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:

LOC:
RM#:
MR#:
DOB:
DEP:

HPI-General Adult

- Nursing RIA
Chief Complaint: Dyspnea/Shortness of Breath
Arrival mode: Walk In
Subjective assessment: sob, hx of COPD O2 dependent.

- Physician HPI
Time Seen by Provider: 10/15/15 18:24
Narrative History of Present Illness:
Patient presents with increased shortness of breath for the last hour. Patient denies any nausea vomiting, diarrhea or constipation. Patient reports mild chest several months ago however none today. Patient denies any cough, lower extremity swelling or pain. Patient reports subjective chills and fever.
PCP: Paul W Hobbs

Review of Systems

Review of systems: All systems negative except as marked
Constitutional: Denies: malaise, fever
Skin: Denies: rash
Allergy/Immune response: Denies: hives
Eyes: Denies: redness
ENT: Denies: earache
Respiratory: Reports: SOB (shortness of breath), wheezing. Denies: cough-non productive, cough-productive (sputum), hemoptysis
Cardiovascular: Denies: chest pain, DOE (dyspnea on exertion), orthopnea
GI: Denies: nausea, constipation, abdominal pain, melena, hematemesis
GU: Denies: flank pain, dysuria

Histories PDOC

- PMH-General
Allergies/Adverse Reactions:
Allergies

tetracycline [Tetracycline] Allergy (Verified 10/15/15 18:30)
Rash-Hives

Home Medications:
Active Scripts

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:

LOC:
RM#:
MR#:
DOB:
DEP:

Medication	Instructions	Recorded
ALPRAZolam [Xanax]	0.25 mg PO BEDTIME	10/15/15
Carvedilol	3.125 mg PO BID	10/15/15
Diltiazem HCl	120 mg PO DAILY	10/15/15
Losartan Potassium [Cozaar]	100 mg PO DAILY	10/15/15
Prednisone [Rayos]	5 mg PO DAILY	10/15/15
arformoterol NEB [Brovana]	15 mcg INH BID	10/15/15
cetirizine [Zyrtec]	10 mg PO DAILY	10/15/15
fluticasone - salmet DISK [Advair DISKUS 250-50 mcg]	1 puff INH BID	10/15/15
ipratropium bromide NEB [Atrovent]	0.5 mg INH QID	10/15/15
omeprazole [PriLOSEC]	20 mg PO DAILY	10/15/15
sertraline [Zoloft]	100 mg PO DAILY	10/15/15
tiotropium INH [Spiriva]	1 puff INH DAILY	10/15/15
traMADol [Ultram]	50 mg PO BID PRN PRN	10/15/15

- Medical History
Past medical history: Yes

- Cancer
Type of cancer: No cancer history

- Hematological
Hematological problems and conditions: No hematological history

- Immune and Autoimmnue
Immune and autoimmune problems and conditions: No immune or autoimmune history

- Neurological
Neurological problems and conditions: No neurological history

- Psychiatric/Psychosocial
Psychiatric and psychosocial problems and conditions: No psychiatric or psychosocial history

- Cardiovascular
Cardiovascular problems and conditions: CAD, Hypertension

- Pulmonary
Pulmonary problems and conditions: Chronic bronchitis, COPD

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:

LOC:
RM#:
MR#:
DOB:
DEP:

- Gastrointestinal
Gastrointestinal problems and conditions: GERD

- Urinary
Urinary problems and conditions: No genitourinary history

- Reproductive
Reproductive problems and conditions: No reproductive history

- Endocrinological
Endocrinological problems and conditions: No endocrinological history

- Musculoskeletal
Musculoskeletal problems and conditions: Back problems, Other

- Surgical History
Past surgical history: Yes
History of anesthesia reaction: No
History of malignant hyperthermia: No

- Gastrointestinal
Gastrointestinal surgeries: Cholecystectomy

- Family History
Family history: No
Maternal: CAD, Cancer

- Tobacco Use
Smoked tobacco use: Former Smoker
Smokeless tobacco used: No

- Alcohol Use
Alcohol use: No

- Other Substance Use
Other Substance Use: None

- Tetanus Status
Tetanus status: Up to date

- Functional Screening
Decline in ADL function within past 7 days: Yes
Decline in mobility or ambulation within past 7 days: Yes
Decline in upper limb mobility within past 7 days: No

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:

LOC:
RM#:
MR#:
DOB:
DEP:

- Physical Impairments
Hearing impaired: No
Vision impaired: No

Physical Exam
Vital Signs:
First Response Vitals

Pulse	Resp	Pulse Ox
96	30 H	95
10/15/15 18:04	10/15/15 18:04	10/15/15 18:04

Basic physical exam: vital signs reviewed, HEAD: atraumatic / normocephalic, ENT: normal mucus membranes, NECK: supple, full range of motion, C / V: regular rate and rhythm, normal pulses, ABD: soft, non-tender, ABD: no distention, EXT: neurovascular intact, SKIN: no rashes, warm / dry, NEURO: alert / orient, non-focal
General: alert and oriented x 3
Head / Eyes: atraumatic, normocephalic
Neck: supple / no meningismus, non-tender, full range of motion
Respiratory / Chest: no tenderness, moderate distress, wheezes
Cardiovascular: regular rate and rhythm, normal heart sounds, normal capillary refill
Abdomen: soft / non-tender, no guarding / rebound, no distention
Back: normal inspection, full range of motion
Skin: normal color
Lymphatic: no adenopathy

Results/Interpretation
Results:
Laboratory Tests

	10/15/15 18:49	Range/Units
WBC	19.4 H	(3.8-11.0) K/mm3
RBC	4.04 L	(4.50-5.20) M/mm3
Hgb	12.7	(11.5-16.0) gm/dL
Hct	39.0 L	(40.5-52.5) %
MCV	96.5	(80.0-100.0) fL
MCH	31.4	(26.0-34.0) pg
MCHC	32.6	(31.0-37.0) g/dL
RDW	15.7 H	(11.5-14.5) %
Plt Count	217	(130-400) K/mcL

PATIENT:
ACCOUNT:
PHYSICIAN:
ATTENDING:
ADM/SERV:

LOC:
RM#:
MR#:
DOB:
DEP:

Neut % (Auto)	Not Reportable	
Lymph % (Auto)	Not Reportable	
Neut #	Not Reportable	
Lymph #	Not Reportable	
Sodium	136	(136-145) mmol/L
Potassium	4.7	(3.5-5.1) mmol/L
Chloride	100	(98-107) mmol/L
Carbon Dioxide	26	(21-32) mmol/L
Anion Gap	10	(7-16) mmol/L
BUN	27 H	(7-18) mg/dL
Creatinine	1.4 H	(0.7-1.3) mg/dL
Est GFR (African Amer)	> 59	(>59) mL/min
Est GFR (Non-Af Amer)	49 L	(>59) mL/min
Glucose	139 H	(74-106) mg/dL
Calculated Osmolality	278	(275-300) mosm/kg
Calcium	8.9	(8.5-10.1) mg/dL
Calcium Adj for Albumin	9.1	(8.2-10.0) mg/dL
Total Bilirubin	0.7	(0.2-1.0) mg/dL
AST	28	(15-37) IU/L
ALT	24	(12-78) IU/L
Total Alk Phosphatase	66	(46-116) U/L
Troponin I	< 0.017	(<= 0.056) ng/mL
NT-Pro-B Natriuret Pep	374	(<450) pg/mL
Serum Total Protein	7.3	(6.4-8.0) g/dL
Albumin	3.7	(3.4-5.0) gm/dL

- ECG Interpretation-Basic
** 1st
Rhythm: normal sinus rhythm (lleft), PVCs present, other (left axis deviation no ischemic changes)

- Chest X-Ray Interpretation
** 1st
General: no acute disease, no infiltrate, normal lung markings, normal heart size

MDM-General Adult

- Visit Orders
Visit Orders:
Visit Orders

	Category	Date Time	Status

PATIENT: **LOC:**
ACCOUNT: **RM#:**
PHYSICIAN: **MR#:**
ATTENDING: **DOB:**
ADM/SERV: **DEP:**

ADM [Admission Status] Routine	ADT	10/15/15 19:34	Active
Transfer Routine	ADT	10/15/15 19:31	Ordered
BiPAP/CPAP Stat	Care	10/15/15 18:24	Active
EKG/ECG Stat ED	Care	10/15/15 18:24	Active
Notify Rt Of Neb PRN Nur	Care	10/15/15 18:25	Active
Telemetry Monitor (Remote) Continuous	Care	10/15/15 19:35	Active
CXR [Chest 1 View] [RAD] Stat	Exams	10/15/15 18:24	Taken
CBC w Automated Diff Stat	Lab	10/15/15 18:49	Results
Comprehensive Metabolic Panel Stat	Lab	10/15/15 18:49	Completed
Manual Differential Stat	Lab	10/15/15 18:49	Results
NT-Pro-B-Type Natriuretic Pept Stat	Lab	10/15/15 18:49	Completed
Troponin I Stat	Lab	10/15/15 18:49	Completed
albuterol NEB [Proventil 0.5%] 10 mg NEB X1ED STA	Med	10/15/15 18:24	Discontinued
methylPREDNISolone sod succin [Solu-MEDROL] 125 mg IV X1ED STA	Med	10/15/15 18:24	Discontinued

Narrative Medical Decision Making:
Patient presents with significant shortness of breath. Patient started on BiPAP with significant improvement. Patient given Solu-Medrol and our long breathing treatment. Chest x-ray demonstrates no acute disease however patient has elevated white blood cell count. Patient will be admitted to the hospital service

- Critical Care
Critical Care (excluding separately billable procedures): 30-74 minutes
Critical care time includes: patient management by me, time spent at bedside, reviewing test results, reviewing imaging, discussing patient care

Discharge Dispo ED*

- Clinical Impresson
Clinical Impression)(:
COPD exacerbation, Leukocytosis
Disposition: Inpatient ADM
Condition: Fair
If you were referred for follow up: please contact your physician's office as directed.

<Electronically signed by , MD>10/15/15 1941