I moved in 1-1-10

3-22-10

LODI MEMORIAL HOSPITAL
ADMISSION HISTORY & PHYSICAL

DATE
03/22/2010

Stroke

PRIMARY CARE DOCTOR
Edmund A. Freund, MD

CHIEF COMPLAINT
Altered mental status.

HISTORY OF PRESENT ILLNESS
A 67-year-old white female, history of congestive heart failure, ejection fraction of 25%, was brought in by family member with a complaint of altered mental status, described as decreased memory, confused, disoriented, and does not engage in conversation, per sister. According to the sister, the last time she was found to have normal mentation was Friday when she talked to the patient, and then she did not talk to her on Sunday, but then today the sister called her roommate to go and get the patient because she was still in her room sleeping, which was not usual for her. Then the sister started to talk to the patient and found that her memory decreased significantly. She kept repeating questions and did not remember what was going on and what she did with her sister before Saturday. The patient did not engage in conversation much, and she did not remember the date, the time, where she was, and kept asking her sister for these things. Thus, it made the sister worried and that is why the sister told the roommate to bring the patient to the hospital for further evaluation.

The patient graduated from college with her history degree, but then worked in a retail store. Per the sister, the patient was usually previously very sharp and they enjoyed talking with each other pretty much and was very opinionated about everything, but now it seems like she does not have any opinion for anything. The patient presented to the ED with elevated blood pressure; otherwise, unremarkable and was found to have a right hemianopsia. Then, she got a CT of the head done without contrast that showed developing left temporal ischemic CVA, and that is the reason why the patient was consulted by hospitalist service for further evaluation and management. The patient was given aspirin 325 mg 1 tab p.o. x1 in the ER and then hospitalist service was consulted.

REVIEW OF SYSTEMS
CONSTITUTIONAL: The patient denies any fever, chills, tiredness, or fatigue.
CARDIOVASCULAR: No chest pain. No shortness of breath. No palpitations.
PULMONARY: No hemoptysis. No shortness of breath.
GI: No nausea or vomiting. No diarrhea.
GU: No dysuria. No frequency, urgency.
EXTREMITIES: No edema.

M053082 V021223581
PARVIN, MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen, Bao Q MD
03/22/10 PTU 1
Dict. Dr. Bao Q Nguyen, MD

3.22.10

NEUROLOGICAL: Alert, awake, but the patient is confused, amnestic, incoherent, disoriented, but denies any neurological deficits. Denies any visual changes except for incidental finding by ED attending in the ER.

All other review of systems were reviewed and are negative.

PAST MEDICAL HISTORY
1. Cardiovascular disease status post CABG.
2. Congestive heart failure with ejection fraction of 25%.
3. Diabetes mellitus type 2.
4. Stage III chronic kidney disease.
5. Hypertension.
6. Hypothyroidism.
7. Depression and anxiety.

PAST SURGICAL HISTORY
The patient does not recall what prior surgery she had in the past. However, per sister, the patient knew everything about her surgery before all of this happened. The patient had an ICD placement, CABG in 2004, right wrist surgery, and appendectomy.

SOCIAL HISTORY
Denies smoking. Denies drinking. Denies IVDA. The patient is a widow. No children. Currently lives with a roommate and in close contact with her sister by telephone daily.

FAMILY HISTORY
Reviewed, but not relevant.

MEDICATIONS
1. Lasix 80 mg 1 tab p.o. daily.
2. K-Dur 20 mEq b.i.d.
3. Coreg 12.5 mg b.i.d.
4. Levoxyl 100 mcg 1 tab p.o. daily.
5. Lisinopril 20 mg 1 tab p.o. daily.
6. Lovastatin 40 mg 1 tab p.o. daily.
7. Omeprazole 20 mg b.i.d.
8. Clonidine 0.1 mg b.i.d.
9. Plavix 75 mg 1 tab p.o. daily.
10. Nitroglycerin p.r.n.
11. Novolin N 50 units a.m. and 30 units p.m.
12. Novolin R 13 units a.m. and 6 units p.m.
13. Vitamin E.
14. Multivitamin.

ALLERGIES
SULFA.

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332-10

LODI MEMORIAL HOSPITAL
DISMISSAL SUMMARY

ADMISSION DATE
03/22/2010

DISCHARGE DATE
03/26/2010

PRIMARY CARE PHYSICIAN
Edmund Freund, MD

ADMISSION DIAGNOSES
1. Altered mental status, more likely secondary to left temporal ischemic cerebrovascular accident.
2. Acute left temporal ischemic cerebrovascular accident.
3. Right hemianopsia.
4. Insulin-dependent diabetes mellitus, type 2.
5. Hypertension.
6. History of chronic kidney disease, stage 3.
7. Hypothyroidism.
8. Depression, anxiety.

DISCHARGE DIAGNOSES
1. Left temporal ischemic cerebrovascular accident with right hemianopsia and amnesia.
2. Diabetes mellitus, type 2, insulin dependent.
3. Systolic dysfunction and congestive heart failure, ejection fraction of 30%.
4. Hypertension.
5. Dyslipidemia.
6. History of depression and anxiety.
7. Hypothyroidism.
8. Chronic kidney disease, stage 3.

PROCEDURES DURING HOSPITALIZATION
None.

CONSULTATION DURING HOSPITALIZATION
Neurology.

PERTINENT STUDIES DURING HOSPITALIZATION
1. CT of the head without contrast x2 showed left temporal lobe consistent with acute stroke.
2. The patient also had bilateral carotid Doppler, showed no significant findings.
3. She also had a cardiac echocardiogram done that showed ejection fraction of 30%, but no vegetation, no thrombus.

BRIEF HISTORY FOR ADMISSION

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PARVIN, MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen Bao Q MD
03/22/10 3S 1
Dict. Dr. Bao Q Nguyen, MD

3.22.10

LODI MEMORIAL HOSPITAL
DISMISSAL SUMMARY

This is a 67-year-old white female, history of congestive heart failure, ejection fraction of 25%, was brought in by family member with complaint of altered mental status described as
For admission this is a 67 years old, white female, history of congestive heart failure, ejection fraction of 25% was brought in by family member because complete complaint of altered mental status described as decreased memory, confused, disoriented, and does not engage in conversation. In the ER the patient got a head CT done and was found to have left temporal lobe CVA with right hemianopsia. For that reason, the patient got admitted to medical floor with telemetry monitor.

HOSPITAL COURSE
With her clinical presentation, the patient got admitted to a medical floor with telemetry monitor, and she was started on Aggrenox with low-dose aspirin because she was already on Plavix. The patient was also resumed back on her statin as well as her other home medications for her CHF, and she was also added Zetia to her current medications because her cholesterol is not under control. Because of new-onset CVA, the patient got workup with bilateral carotid Doppler described as above, as well as cardiac echocardiogram described as above. The patient was also consulted with Dr. Yao, neurologist, who has no further recommendations, and the patient unable to get MRI done because of she has history of pacemaker. The patient was also evaluated with speech therapist, who recommended therapy 3 to 5 times a week. After being admitted to the hospital and started on new medication, the patient clinically stable and her memory slowly improved over the hospital course, but she still has very bad short-term memory and not back to her baseline mentation. Because of history of diabetes, insulin dependent, and no one at home to help her out except for her sister, who is legally blind, thus she could not help her with insulin subcutaneously, but she is able to do anything else for her. For that reason, the patient was recommended to go to skilled nursing for rehab and diabetic teaching prior to discharge back to home. Otherwise there are no other acute issues for this patient during hospital stay. The patient now deemed to be stable to be transferred to skilled nursing for continuation of rehab.

DISCHARGE CONDITION
The patient hemodynamically stable, clinically stable. No acute distress. She can speak in full sentences but still has memory deficit.

DISPOSITION
Skilled nursing and rehabilitation.

DISCHARGE MEDICATIONS
The patient will be discharged to skilled nursing facility with the following medication.
1. Aspirin 81 mg 1 tablet p.o. daily.
2. Aggrenox 1 tablet p.o. b.i.d.
3. Coreg 12.5 mg 1 tablet p.o. b.i.d.

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03/16/43 67 F
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03/22/10 3S 1
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322-10

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COPY

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PARVIN, MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen, Bao Q MD
03/22/10 3S 1
Dict. Dr. Bao Q Nguyen, MD

LODI MEMORIAL HOSPITAL
CONSULTATION REPORT

DATE OF CONSULTATION
03/22/2010

REFERRING PHYSICIAN
Bao Nguyen, MD, hospitalist

REASON FOR CONSULTATION
Possible stroke and altered level of consciousness.

HISTORY
The patient is a 67-year-old obese Caucasian, right-handed female, who woke up this morning not feeling well. The rest of the day she cannot recall very well. Obvously the patient was brought in by family or friends, that she was not focused, unable to concentrate, and no reported focal weakness, numbness, falls, motor convulsions or seizures. The patient was brought in and could not remember much of the day. However, the patient is not comatose. She had a chronic headache, but no significant change with that. She denied dizziness, vertigo, loss of sensation or motor function at this time in the early evening time when I did the consultation. The patient does have remarkable elevation of blood pressure in the 180s/120s on initial admission. However, the patient did not have fevers, chest pain, palpitations or any atrial fibrillation at the initial evaluation. Her head CT without contrast was read as a left temporal lobe linear zone of decreased density is seen suggesting developing stroke. This was compared to the 01/26/2010 study. There is no bleeding, no other abnormalities. The patient told me in January she had headache and this was checked for that reason. She denied any history of stroke or TIA or similar episodes. She denied any epilepsy. At this time, the patient is basically back to normal state, however, she does have problems keeping up her memory, she asked me twice who I was after I repeated telling her I was the consulting neurologist. She cannot tell me her family doctor's name.

On admission, other significant findings included glucose of 247, BUN 24, creatinine 1.19. GFR 45, albumin 3.2. Liver enzymes normal. CBC is basically normal. Sedimentation rate is 24. Urinalysis is remarkable for glucose 500, protein 30, WBC 21-50.

REVIEW OF SYSTEMS
She stated last night when she went to bed, she was in her normal health state. She did not have any fever, chills, chest pain, palpitations, shortness of breath, cough, depression, anxiety, nausea, vomiting, diarrhea, bloody stools or urine.

PAST MEDICAL HISTORY
1. CVD.
2. Congestive heart failure.

M053082 V021223581
PARVIN,MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen,Bao Q MD
03/22/10 3S 1
Dict. Dr. Weiping Yao, MD

I moved in 1-1-10

322-10

LODI MEMORIAL HOSPITAL
ADMISSION HISTORY & PHYSICAL

DATE
03/22/2010

Stroke

PRIMARY CARE DOCTOR
Edmund A. Freund, MD

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PARVIN,MARY JEAN
03/16/43 67 F
Att. Dr. Nguyen Bao Q MD
03/22/10 PTU 1
Dict. Dr. Bao Q Nguyen, MD

Lodi Memorial Hospital
975 S. Fairmont • Lodi, CA 95240
(209) 334-3411

R

A/PT 3

EMERGENCY DEPARTMENT RECORD

Resuscitative Emergent Urgent Routine

03/22/10 M053082 67 /F
V021223581 BD:03/16/43
PARVIN, MARY JEAN
MCAB PHYSER ER

RAV

NAME - LAST	FIRST	DATE
Parvin	Mary Jean	3-22-10

TIME | CHIEF COMPLAINT | NURSE

TIME IN ROOM: 1215

NURSES SIGNATURE / INITIALS

BROUGHT BY: ☒ SELF ☐ PARENT ☐ RELATIVE ☐ POLICE ☐ BLS ☐ ALS ☐ OTHER

ENTERED: ☐ CARRY ☐ WALK ☒ W/C ☐ GURNEY

TIME	O² Sat	T	P	R	BP	ALLERGIES
12:08	98	36.6	73	18	184/125	SULFA

PHYSICIAN'S REPORT TIME:

DM on Insulin, ↑BP
CAD.

meds –

DISCHARGE IMPRESSION ▶ Acute TIA

DISPOSITION VIA ▶ ☐ HOME ☒ HOSPITAL ☐ TRANSFER ☐ CORONER ☐ OTHER ☐ WALKED ☐ CARRIED ☐ WC ☐ GURNEY ☐ AMBULANCE

CONDITION: Stable
WITH:

CALLED | ARRIVAL | TIME / INITIAL
PHYSICIAN | RESPOND

OTHER INSTRUCTIONS

☐ DICTATED ☐ CALL BACK ☐ COMPLETE

PHYSICIAN'S SIGNATURE [signature] M.D. | P.A. SIGNATURE | DATE 3 22 10

PHYSICIAN'S ORDERS

X-RAY

ORDER TIME	
	☐ CXR ☐ CXRP
	☐ CERVICAL SPINE
	☐ LUMBAR SPINE
	☐ PELVIS ☐ ABD
	☐
	☐

ULTRASOUND

ORDER TIME	
	☐ LEG
	☐ PELVIC/OBUS
	☐ GALLBLADDER/ABD US

CT / CONTRAST

ORDER TIME	
1240	☒ HEAD ⊕ ⊖ (circled ⊖)
	☐ CHEST ⊕ ⊖
	☐ ABD/PELVIS ⊕ ⊖
	☐ SPINE ☐ C ☐ T ☐ L

PROCEDURES

ORDER TIME	
	☐ EKG ☐ MONITOR
	☐ FOLEY ☐ NG TUBE
	☐ I & O CATH
	☐ IV
	☐
	☐
	☐

(Stroke Scale)

LAB TESTS

ORDER TIME	
1215	☒ CBC
1215	☐ BMP ☒ CMP
	☐ BC x 1 ☐ BC x 2
	☐ LACTIC ACID
	☐ AMI ☐ TROPONIN
	☐ BNP
	☐ AMYLASE ☐ LIPASE
	☐ HEPATITIS AB PANEL
	☐ FREE T4, TSH
	☐ D-DIMER
	☐ PT ☐ PTT
	☐ URINE DIP
1215	☒ URINE MICRO ☐ C&S ☐
	☐ URINE HCG Results: + or –
	☐ QUANT. HCG
	☐ CHLAMYDIAL C&S
	☐ GC C&S
	☐ WET MOUNT
	☐ SPUTUM AFB
	☐ SPUTUM GRAMSTAIN C&S
	☐ ABG
1215	☒ FSBS Results: 256
	☐ T&C ____ UNITS PRBC
	☐ ABO/RH; ANTIBODY SCREEN IF RH NEG
	☐ T&C FFP
	☐ EtOH
	☐ AMMONIA
	☐ ACETAMINOPHEN LEVEL
	☐ SALICYLATE LEVEL
	☐ DIGOXIN LEVEL
	☐ DILANTIN LEVEL
	☐ DEPOKOTE LEVEL
	☐ TEGRETOL LEVEL
	☐
	☐

3/22/10

V2J223581

Lodi Memorial Hospital
975 S. Fairmont Avenue • P.O. Box 3004 • Lodi, California 95241 • 209/334-3411 • 209/368-3745 (fax)

ECHOCARDIOGRAPHY REPORT

PATIENT: Parvin, Mary

REF PHYS: B. Nguyen, M.D.

DATE OF STUDY: 3/23/10 SEX: F AGE: 67 MED REC #: M053082

TECHNICIAN: MC IP: 304 OP: ____ TAPE #: XC DOB: 03/16/43

DIAGNOSIS/CLINICAL HISTORY: AMS, CVA

CARDIAC DIMENSION - M-MODE	NORMAL VALUES	MEASURED VALUES
Left Atrium	1.9-4.0 cm	4.0
Aortic Root Diameter	2.0-3.8 cm	3.6
Aortic Cusps Separation	1.5-2.6 cm	1.9
Right Ventricle (diastole)	0.7-2.6 cm	—
Left Ventricle (end diastole-LVED)	3.5-5.6 cm	6.3
Left Ventricle (end systole-LVES)		4.6
Intervent. Septal Thickness (IVS-ed)	0.7-1.1 cm	1.4
Left Posterior Wall Thickness (LVPW-ed)	0.7-1.1 cm	1.4
Shortening Fraction	25-40%	27%

HT: 65" WT: 239 lbs.

TECHNICIAN COMMENTS:

Technically difficult study.

DOPPLER DATA	
Max TR Velocity	301
Max TR Gradient	36
Max AOV Velocity	
Max AOV Gradient	
Mean AOV Gradient	
AVA cm2	
MV E/A Ratio	0.6
Max MV Velocity	
Max MV Gradient	
Mean MV Gradient	
P½T	
MVA (P½T) cm2	
MV E/E	20.9

PHYSICIAN INTERPRETATION: