M053082 V025938127
PARVIN, MARY JEAN
03/16/43 71 F
OSHIMA 06/28/14 MCAB

Card: Stenzler
PCP: Freund

Circle or check affirmatives, backslash (\) negatives.

Lodi Memorial Hospital

EMERGENCY PROVIDER RECORD

45

Altered Mental Status

Sepsis / HHNC / Seizure / ICH / CO / CVA

DATE: 6/28/14 TIME: 11 47 ROOM: 6 ✓ EMS Arrival

HISTORIAN: (patient) family (EMS) (NH records)

UNABLE TO OBTAIN HISTORY DUE TO:

HPI

chief complaint: (decreased mental status) / (confusion)
low blood sugar / diabetic fever (Fall)

onset / duration: unknown onset, Fall this a.m.
gradual-onset / sudden-onset / intermittent / constant
upon waking (cannot confirm onset)
gone now better (continues in ED) more than 3 hours

character of altered mental status:
(disoriented) / (confused) / combative / agitated / trouble concentrating
unresponsive / seizure activity / decreased responsiveness

context: A responsible res[illegible]
found unresponsive / unknown duration
by (nursing home staff) bystander family:
dextrostick PTA ( ) given D50 / Narcan PTA
good / marginal / no response
recent / heavy alcohol intake (beer / wine / liquor)
last drink:
drug abuse / overdose
trauma head injury
infection / other ill contacts

71 y/o ♀ pt presents to the ER c̄ ALOC & confusion, unknown onset. Pt had a fall today; Ø LOC or injury. Pt denies fever or dysuria. She does say "I don't feel very good" c̄ ⊕ nausea.

baseline Cognitive:
(alert, oriented x3)
alert but disoriented
alert but confused
poor alertness
memory loss

Gait:
walks w/o assistance
uses a cane / walker
walks only w/ assistance
stands for transfers
unable to walk

associated symptoms:
fever / chills / sweaty
chest pain
neck / back pain
hurts to breathe / short of breath
headache
new weakness
RUE RLE LUE LLE
R / L facial general (diffuse)

altered sensation
RUE RLE LUE LLE R / L facial
(falling) injury
decreased ability to stand / walk
weak difficult off balance
cannot walk cannot stand
fainting / dizzy
involuntary seizure / movements

Similar symptoms previously

Recently seen / treated by doctor

ROS

"I don't feel very good"

CONST
recent illness

EYES / ENT
vision change / problems
sore throat / dental problems
trouble swallowing

CVS / PULMONARY
palpitations
cough bloody / productive

GI / GU
(nausea) / vomiting
abdominal pain
diarrhea / black / bloody stool
problems urinating
Ø hematuria or dysuria

FEMALE GENITAL
LNMP preg post-menop

MUSCLE SKELETAL / SKIN / LYMPH
joint pain
leg / ankle swelling
rash
swollen glands

NEURO (see HPI) / PSYCH
depression / anxiety

☒ all systems neg except as marked

PAST HX

RELATED PAST HX
confusion / dementia
(CVA) / TIA bleed deficit
(diabetes) Type I (Type 2)
diet / oral / insulin neuropathy
hepatitis / cirrhosis
overdose
seizure disorder
✓ old records reviewed / summary: CKD, Cellulitis

(cardiac disease)
angina MI (CHF)
GI bleeding
(hyperlipidemia)
(hypertension)
immunosuppressed AIDS
insect bite
lung disease asthma COPD

Surgeries / Procedures __none
__any recent surgery
(appendectomy)
(CABG)
cholecystectomy
hysterectomy / BTL / C-section
(pacemaker) / AICD
tonsillectomy

Imaging previous CT / MRI / US date
☐ Immunization UTD

Medications __none (see nurses note)
aspirin clopidogrel warfarin LMWH
NSAID acetaminophen narcotic chronic
new medications

Allergies __NKDA
see nurses note
(antibiotic) Sulfa
Morphine, Latex

SOCIAL HX smoker drugs
alcohol (recent / heavy / occasional) occupation
(living situation) alone family friend group (care facility) Arbor

FAMILY HX stroke migraines CAD HTN
Reviewed, Not Relevant

☒ Nursing Assessment Reviewed ☒ Initial Vital Signs Reviewed ☐ Telemetry
BP 127/64 HR 69 RR 16 Temp 36.7
Pulse Ox 96 % ✓ RA __ O_2 Interp ✓ nml __ hypoxic

PHYSICAL EXAM

Somnolent But arousable

EXAM LIMITED BY:
General Appearance
__appears well
__alert
✓ airway intact
__mild / moderate / severe distress Obese
__lethargic / obtunded / combative
__apneic Somnolent but arousable

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TFORMS

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NEURO

higher functions
✓ cognition nml
__ oriented x3
✓ no evidence of acute CVA
cranial nerves-
✓ nml as tested
cerebellar-
✓ nml as tested
sensorimotor-
✓ sensation nml
✓ motor nml
__ reflexes nml

__ abnml serial 7's / inattentive / memory loss
__ disoriented to time / place / person
__ abnml response to commands
no response eyes open slow inappropriate
__ abnml response to pain
withdraws flexor extensor none
__ dysarthria / aphasic *expressive receptive*
__ facial palsy *forehead: involved spared*
__ tongue deviation (to R / L)
__ abnml Romberg / gait / finger-nose test
__ abnml gait / ataxia
__ weakness / hemiplegia / dyspraxia
__ pronator drift
__ altered light-touch / pin-prick / 2-pt discrimin
__ tremor / abnml movements
__ Babinski reflex
__ asterixis

PSYCH

mental status
✓ appearance nml
__ kinetics nml
__ mood / affect nml
✓ speech nml
__ thought content nml
__ thought process nml
__ judgment / insight

__ disheveled / poor eye contact
__ increase / decrease psychomotor
__ depressed / tearful / anxious / paranoid
__ labile / flat / agitated
__ non-communicative / pressured / (slow)
__ rambling / tangential
__ suicidal / homicidal ideation / plan
__ grandiosity / hallucinations *vis / aud*
__ thought blocking / loose associations
__ disorganized / flight of ideas
__ poor insight / poor judgment

HEENT

✓ head atraumatic
✓ PERRL
__ visual fields nml
✓ EOM's intact
✓ ENT inspection nml
✓ oropharynx nml

__ tenderness / swelling / ecchymosis
__ raccoon eyes / Battle's sign
__ scleral icterus / pale conjunctivae
__ unequal pupils R ___ mm L ___ mm
__ abnml funduscopic / papilledema
__ EOM palsy / nystagmus
__ TM blood
__ deprsd gag reflex / handles secretions poorly
__ dry membranes
__ pharyngeal erythema / dental decay / exudate

NECK

✓ supple
✓ non-tender

__ cervical lymphadenopathy
__ stiff neck / meningismus
__ carotid bruit
__ Kernig's sign / Brudzinski's sign

RESPIRATORY

✓ no resp. distress
✓ breath sounds nml

__ respiratory distress
__ wheezes / rales / rhonchi

CVS

✓ reg. rate & rhythm
✓ heart sounds nml

__ tachycardia / bradycardia / irreg. irreg. rhythm
__ JVD present
__ murmur *grade ___ /6 sys / dias*
__ gallop (S3 / S4)
__ decreased pulse(s)

ABDOMEN / GI

✓ non-tender
✓ no organomegaly

__ guarding / tenderness
__ hepatomegaly / splenomegaly / mass
abd obese but soft, non-tender

EXTREMITIES

✓ non-tender
✓ nml ROM
✓ no pedal edema

__ tenderness
__ pedal edema
__ Homan's sign

SKIN

✓ color nml, no rash
✓ warm, dry

__ cyanosis / diaphoresis / pallor / ecchymosis
__ rash / embolic lesions
__ decubitus

EKG

(EKG) (interp by ED provider) Rate 70 __ NSR __ A-fib paced
__ *nml intervals* __ *nml axis* __ *nml QRS* __ *non-specific ST/TW changes*
(*diagnosis*) __ *nml* ✓ *abnml*

LABS, & XRAYS

Lipase 30

Normal lab value ranges are included on the original lab report

CBC	Chem			UA
(nml) except	(nml) (except)	AST 20	PT	nml except
WBC 6.0	Na 140	Alk Phos 104	INR	
(Hgb) 10.4	(K) 5.7	(Ammonia) 73	PTT	
(Hct) 31.3	CO2 26	TSH	**Blood Tox**	Preg Test + -
platelets 158	Gluc 79	T4	ASPIRIN <4.0	**Urine Tox**
segs	(BUN) 84	D-Dimer	APAP <10.0	*(circle)*
bands	(Creat) 2.56	Lactate	BAL Ø	cocaine / PCP
	HCO3	(Troponin) 0.07	TCA	amphetamine
		(BNP) 618		opioids / THC

ABGs FiO2 ___ /RA pH ___ pO2 ___ pCO2 ___
CSF clear xanthochromia bloody prot ___ gluc ___
WBC ___ PMN ___ lymph ___ RBC ___

(CXR) Cardiomegaly. Small (L) pleural effusion.
☐ Interp. by me ☒ Reviewed by me ☐ Discsd w/ radiologist ☒ read by radiologist
__ *nml / NAD* __ *no infiltrates* __ *nml heart size* __ *nml mediastinum*
Mild CHF. *Old CXR- unchanged date:*

(CT Scan / MRI) (brain) *contrast / (non-contrast)*
nml / NAD Age related atrophic and chronic white matter Δ's. Remote (L) occipital infarct.

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PROGRESS

☐ see additional template: # 94 51a
Time ___ unchanged improved re-examined

pt. c AMS [illegible] N/V/D
[illegible] [illegible], [illegible]
on exam, [illegible] focal neuro deficit
[illegible] [illegible] NAD, CXR mild CHF [illegible] [illegible]
__ Poison control consulted [illegible] [illegible]
☐ patient ambulating / mentating at pre-event baseline [illegible]
Discharge VS: BP ___ *HR* ___ *RR* ___ *Temp* ___
✓ Discussed with Dr. Rahman Time: 1452
will see patient in: ED / hospital / office

Counseled patient / family regarding:
(lab / rad. results) (diagnosis) (need for follow-up)
__ prior records ordered
☐ Rx given

Additional history from:
family caretaker paramedics
__ holding orders written

CRITICAL CARE TIME *(excluding time for other separate services)* ☐ *30-74 min* ☐ *75-104 min* ___ *min*

CLINICAL IMPRESSION

① (ALTERED MENTAL STATE)	Insulin Reaction *Hypoglycemia*
COMA	Meningitis
DELIRIUM	Overdose *Hypnotic / Narcotic*
Alcohol Intoxication	Seizure *post-ictal*
Carbon Monoxide Intoxication	Sepsis
Cerebrovascular Accident	Status Epilepticus *non-convulsive*
② (Hepatic Encephalopathy)	Subarachnoid Hemorrhage
HHNC	Subdural Hematoma
Hypernatremia / Hyponatremia	Uncal Herniation ④ Hyperkalemia
Intracranial Hemorrhage	
③ Chronic Renal Insufficiency, acute exacerbation	⑤ Elevated Troponin

Present On Admission *decubitus / UTI w/ foley*

Disposition Order Time 1500
DISPOSITION- ☐ home ☒ admitted ☐ OBS ☐ expired
☐ AMA *(see AMA template #73)* ☐ transferred
CONDITION- ☒ unchanged ☐ improved ☒ stable
Care transferred to ___ MD / DO / MLP Time: ___

___ ***NP / PA IDX Provider #*** ___

☐ I personally evaluated and examined the patient in conjunction with the MLP and agree with the assessment, treatment plan and disposition of the patient as recorded by the MLP.

6/28 -1555

T. Russell scribing for Dr. Oshita
(Scribe name) (Provider name)

☒ I have reviewed the information recorded by the scribe for accuracy and agree with its contents.

[signature] (MD) / DO IDX Provider #
Masaru Oshita, MD
IDX #70411

☒ Template Complete ☐ Written Addendum

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ED SCANNED

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