Lodi Memorial Hospital

Brief Note

Date 06/29/13
Quach,Truong MD - HOSP

M053082 V024774473
PARVIN,MARY JEAN
03/16/43 70 F ER HOLD

Brief Note

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See dictated note: 412440.

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<Electronically signed by Truong - HOSP Quach, MD> 06/29/13 1038

06/27/13 M053082 70 /F
V024774473 BD:03/16/43
PARVIN, MARY JEAN
MCAB OSHIMA ER H

PHYSICIAN ORDERS

PATIENT NAME PARVIN, MARY

DIAGNOSIS: CHF EF 25%, CKD IV, BLE Cellulitis, Near Syncope, DM, HTN
Hypoglycemia

ADMIT TO: ☐ Acute Hospital ☒ Skilled Nursing Facility (SNF-A) ☐ Physical Rehabilitation Unit ☐ Custodial level of services (SNF-B)

REHAB POTENTIAL: ☐ Good ☒ Fair ☐ Poor

TUBERCULOSIS SCREENING

☐ Initiate TB screening per facility policy

History of Positive TST: ☐ Yes ☐ No Chest X-Ray (CXR) _____ Month / Year

☐ Initiate MRSA screening per facility policy

ADVANCE DIRECTIVES

PATIENT HAS AN ADVANCED DIRECTIVE FOR HEALTH CARE
☐ Yes ☐ No

CODE STATUS DISCUSSED WITH
☐ Patient ☐ Family

MENTAL CAPACITY

	Yes	No
Patient has mental capacity to participate in own care.	☒	☐
Patient has mental capacity to understand diagnosis, prognosis, and treatment options.	☒	☐

Physician Orders for Life-Sustaining Treatment (POLST)

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**
☐ **Comfort Measures Only:** Medication, Positioning, Wound Care, Measures to relieve pain and suffering, Oxygen, Suction, Manual txt of airway obstruction PRN for comfort. ATB to promote comfort. **Transfer** if comfort needs cannot be met in current location
☐ **Limited Additional Interventions:** Includes care described above. Medical Txt, ATB, IV fluids, Non-invasive positive airway pressure. Do not intubate. Generally avoid intensive care.
☐ **Do Not Transfer to hospital for medical interventions. Transfer** if comfort needs cannot be met in current location
☐ **Full Treatment:** Includes care described above. Use intubation, Advanced Airway Interventions, Mechanical Ventilation, and Defibrillation/Cardioversion as indicated. **Transfer** to hospital if indicated. Includes Intensive care.
☐ No artificial nutrition by tube
☐ Defined trial period of artificial nutrition by tube _____.
☐ Long-term artificial nutrition by tube.
☐ Additional Orders: _____

SPECIAL SERVICES

☒ Physical therapy evaluation and treatment
☐ Speech therapy evaluation and treatment
☐ Occupational therapy evaluation and treatment
☐ Respiratory evaluation and treatment

☐ O2 @ _____ L / min. via: ☐ Mask ☐ Cannula ☐ Non-Re-breather
☐ Ventilator
☐ Tracheostomy

ALLERGIES

Sulfa
Morphine
Latex

DIET

☐ NPO ☐ Regular ☒ No added salt
☒ Carbohydrate Controlled Calories: _____
☐ Low fat / Low cholesterol
☐ Mechanically altered ☐ Pureed
☒ Other: Fluid restriction 1.5 L/day

ACTIVITY

☒ As tolerated w/ assists
☐ Bedrest
☐ BRP ☐ Bedside Commode
☐ Weight-bearing restrictions _____ lbs.
☐ Other: _____

ANALGESIA

☒ Tylenol 325 mg 2 tabs via PO every 4 hours PRN mild pain/discomfort
☐ Tylenol Elixir 20ml (650mg) via _____ every 4 hours PRN mild pain/ discomfort

Other _____

BOWEL AND BLADDER CARE

☐ Foley catheter to gravity drainage. Change PRN non-patency / leaking
- Diagnosis _____

☒ MOM 30ml PO every 3 days PRN constipation
☒ Bisacodyl suppository 10mg rectally every 3 days PRN constipation if MOM not effective

ADDITIONAL ORDERS & MEDICATION DIAGNOSIS

☑ Call Transferring Physician TRUONG QUACH, MD at 209-334-3411 for clarification of any orders.
(MD Name)

See Transfer Med List
Accucheck qAC/HS
Reg. Insulin Sliding Scale

Blood Sugar	Novolog. Insulin Coverage	MD Preference
Less than or equal to 150	0 Units	
151-200	3 Units	
201-250	5 Units	
251-300	7 Units	
301-350	10 Units	
351-400	15 Units	

Less than 70 or greater than 400, call MD.

Physician Signature _____ Date: 6/29/13 Time: 1020

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INTERFACIL

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MCAB OSHIMA ER H

Lodi Memorial Hospital
975 S. Fairmont Ave.
P.O. Box 3004
Lodi, California 95241
(209) 334-3411

(Completed form AND copy of face sheet must accompany patient upon interfacility transfer)

PATIENT NAME			TRANSFER DATE 6/29/13
ADMIT TO: ARBOR	PRIMARY CARE PHYSICIAN FREUND		M.D. TO FOLLOW
NEAREST RELATIVE / GUARDIAN TIFFANY ANDERSON	RELATIONSHIP COUSIN		PHONE 625-8587

NURSING ASSESSMENT

VS PRIOR TO TRF	Temp:	Pulse:	Resp:	B/P:	O2 Sat:	Pain level:
RECENT FALLS	Date: 6/27/13	Injuries: Ø				

COMMUNICATION

☒ No Problem ☐ Hearing Impaired R - L
☐ Aphasic ☐ Vision Impaired R - L
☐ Non-English speaking – Primary Language_____
☐ Needs Spell Board ☐ Lip Reads ☐ Mouths Words

How "Yes" / "No" is communicated:

ACTIVITY

Ambulation:
☐ Independent
☒ Max/mod assist ☐ Total assist
☒ Uses walker / cane / crutches
☐ Hemiplegia R - L
☐ Paraplegia
☐ Bedrest
☐ W/C Bound

BOWEL / BLADDER

☐ Bowel - ☒ Continent ☐ Incontinent
☐ Bladder - ☒ Continent ☐ Incontinent
☐ Foley size_____
• Balloon size_____
• Date placed D/C'd 6-29-13 1030
☐ Colostomy
☐ Urostomy
Date of last BM: 6-27-13

PERSONAL ITEMS SENT

☐ Dentures ☐ Upper ☐ Lower
☐ Partial ☐ Upper ☐ Lower
☐ Hearing Aid
☐ Right ☐ Left
☒ Glasses AT Home
☐ Contact Lenses
☐ Prosthesis_____
☐ Other_____

Ø All NATURAL Teeth

ADLs

☒ Independent
☐ Minimum Assist
☐ Moderate Assist
☐ Total Care

FEEDING

☒ Independent ☐ Needs Assistance
☐ Dependent
☐ Tube Feedings: NG / PEG / J-Tube
Formula_____ Rate ml's/hr____
☐ H20 Flush

MENTAL STATUS

☒ Alert ☒ Oriented ☐ Confused
☐ Forgetful ☐ Agitated ☐ Combative
☐ Wanderer ☐ Noisy ☐ ALOC
☐ Follows Commands

KNOWN ORGANISMS: ☒ MRSA ☐ VRE ☐ ESBL ☐ C-diff ☐ Other Infectious Diseases:

SKIN ASSESSMENT

	Location	Description	Size	Stage
☐ Pressure Ulcer				
☐ Non-Pressure Skin Concerns (e.g. Skin tears, Incontinence Associated Dermatitis, Surgical Incision, etc.)				

SITES		SIZE	INSERTED
IV			
Drain			
Other			

Date of last skin assessment:_____

☐ Other: Bil lower extremities - redness

☐ O2 :

☐ Restraints: Type: Reason:

☐ Other

IMMUNIZATION HISTORY

Yes No
☐ ☒ Influenza / Flu Shot_____ Month / Year

Yes No
☐ ☐ Tetanus_____ Month / Year

Yes No
☒ ☐ Pneumonia Vaccine_____ Month / Year

CORONERS CASE

Coroners Case: ☐ No
☐ Yes, related to:_____

Comments:

Released 6-29-13 1100

The above assessment was completed by: RN/LVN Date: Time: