AMERICAN MEDICAL RESPONSE - SAN JOAQUIN

Pre-Hospital Care Report

AMR

PCRID: 2012090504004559866 Case #: 02017208 Pt #: 2 of 1 Unit ID: 8S105 Date: 9/5/2012

Dispatch Information 02017208

Time Call Received:	03:28:20 3:30 AM			**From Location:**	
Time Dispatched:	03:29:00	**Time Transporting:**	03:53:00	2 N. AVENA AVE, Lodi CA 95240	**MCI Declaration:** No
Time Enroute:	03:29:00	**Time Transport Arrived:**	03:59:00		**Initial Response Mode:** Lights and Siren
Time at Scene:	03:34:00	**Time Available:**	04:17:32		**Final Response Mode:** Lights and Siren
Time at Pt Side:	03:35:00	**Time Cancelled:**		**To Location:** Lodi Memorial Hospital ER 975 S. Fairmont, Lodi CA 95240	
Responder On Scene:	Lodi Fire Department ,				**PD Case Number:**
Nature of Call:	Blood Draw				
ALS Assessment:	AMR Paramedic			**Caller Name:** _LODI POLICE DEPT	

Patient Demographics 02017208

Name:	PARVIN, MARY JEAN	**DOB:**	3/16/1943	**Age Estimated:** No	
Address:	2 N. AVENA AVE	**Ethnicity:**	Not Applicable	**Age:** 69 years **Months:** **Days:**	
City, State, Zip:	Lodi, CA 95240	**Physician:**	LMH DR FRUEND	**Gender:** Female	**Weight:** 130 Kg
Phone:	(209)333-8121 **Cell:**	**Name of Employer:**		**Employer Phone:**	
SSN:	7161	**Responsible Party:**	PARVIN, MARY JEAN	**Phone:** (209)333-8121	

Hospital Visit Number:

Physical Findings 02017208

Head:	Normal
Head:	Hot/Warm to Touch
Neck:	Hot/Warm to Touch
Neck:	Normal
Chest:	Normal
Chest:	Hot/Warm to Touch
Abdomen:	Hot/Warm to Touch
Abdomen:	Normal
Pelvis:	Hot/Warm to Touch
Pelvis:	Normal
Back:	Hot/Warm to Touch
Back:	Normal
Extremities:	Normal
Extremities:	Hot/Warm to Touch

History Of Present Illness 02017208

Chief Complaint: Gradual onset N/A Weakness None provoked by None since 2 Days .
Secondary Complaint: Gradual onset N/A Fever None provoked by None since 2 Days .
Patient's Complaint: UNSTEADY ON PTS FEET
HPI:
Primary Symptom:
Mechanism of Injury:
Safety Equipment:
Contributing Factors:
Environmental Factors:
Factors Affecting Delivery Of Care:

09/05/12 M053082 69 /F
V023912512 BD:03/16/43
PARVIN, MARY JEAN
MCAB DONAKE ER

Past Medical History 02017208

History: HTN, Pacemaker, Diabetes, MRSA, C-DIF, HIGH CHOLESTROL, Depression, ChF
Allergies: MORPHINE ,
Medications: HTN MEDICATIONS , INSULIN , CARDIAC MEDS
Immunizations:
Advanced Directives:
Allergy Band:

Impression 02017208

Primary Impression: Neuro - Vertigo/Dizzy
Secondary Impression:
Other Impression: GENERAL WEAKNESS

Narrative 02017208

☐ Special Study

AOS to find pt walking out to gurney with a cc of weakness and unsteady on her feet. pt has been increasingly getting worse over the past 2 days with dizziness and weakness. pt fell earlier but has no neck/spinal/back pain. pt assisted to gurney, transported to lmh er. per pts cousin tiffany who has power of attorney, she stated no iv antibiotics. pt arrived lmh er with pt care, report, hx given to Stevannie-Rn in rm 14 with ID given to registration. pt hx of MRSA and C-DIF 4 months ago.

Treatment and Response 02017208

PTA	Time	Medic	Procedure
	03:40:00	Rosewall, Jessie,AMR	Glasgow Coma Scale - Eyes: 4 , Verbal: 5 , Motor: 6 . Total : 15 . GCS Score Qualifier: Patient Baseline .. Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Lung Sounds - Upper Right Lung: Normal , Upper Left Lung: Normal , Lower Right Lung: Normal , Lower Left Lung: Normal . . Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Pain Scale - 1 on a scale of 10..
	03:40:00	Rosewall, Jessie,AMR	Pulse Oximetry - 89 % on Room Air . Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Pupils - Normal (PERL) .. Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Skin Assessment - Normal color, Hot temperature, Normal moisture, <2 seconds capillary refill.. Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Temperature - . Successful: Yes
	03:40:00	Rosewall, Jessie,AMR	Vital Signs - BP: 162 / 66 , Pulse at: Radial , Pulse Rate: 78 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 24 , Respiration Depth: Normal , Respiration Effort: Normal ,. Successful: Yes
	03:42:00	Rosewall, Jessie,AMR	EKG - Indication: Protocol/Standing Order , Type: 4 Lead Monitor , Paramedic Interpretation: Paced Rhythm , Ectopy: None , Elevation: No , Depression: No , .
	03:42:00	Rosewall, Jessie,AMR	OXYGEN - 4.000 LPM Nasal Cannula , Result: Improved . Medication Authorization: Protocol (Standing Order) ..
	03:42:00	Rosewall, Jessie,AMR	Neurological Exam - Mental: Alert, Oriented, Memory Intact Vision: Normal . Hearing: Normal . Facial Muscles: Equal on both sides . Arms: Normal . Legs: Normal . Sensory: Can feel light touch . Coordination: Intact . .
	03:50:00	Rosewall, Jessie,AMR	Blood Glucose - 210 mg/dL..
	03:53:00	Rosewall, Jessie,AMR	Glasgow Coma Scale - Eyes: 4 , Verbal: 5 , Motor: 6 . Total : 15 . GCS Score Qualifier: Patient Baseline .. Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Lung Sounds - Upper Right Lung: Normal , Upper Left Lung: Normal , Lower Right Lung: Normal , Lower Left Lung: Normal . . Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Pulse Oximetry - 96 % on O2 . Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Pupils - Normal (PERL) .. Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Skin Assessment - Normal color, Hot temperature, Normal moisture, <2 seconds capillary refill.. Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Temperature - . Successful: Yes
	03:53:00	Rosewall, Jessie,AMR	Vital Signs - BP: 155 / 109 , Pulse at: Radial , Pulse Rate: 76 , Pulse Regularity: Regular , Pulse Strength: Normal , Respirations: 22 , Respiration Depth: Normal , Respiration Effort: Normal ,. Successful: Yes
	03:54:00	Rosewall, Jessie,AMR	EKG - Indication: Protocol/Standing Order , Type: 4 Lead Monitor , Paramedic Interpretation: Paced Rhythm , Ectopy: None , Elevation: No , Depression: No , .
	03:55:00	Rosewall, Jessie,AMR	Vascular Access - 18 gauge Peripheral IV TKO Wrist Left with 1000 ml cc bag. in 1 attempts. Indication: Per Protocol . Total Volume: 250 . Solution: Normal Saline . Result: Improved .. Successful: Yes

09/05/12 M053082 69 /F
V023912512 BD:03/16/43
PARVIN, MARY JEAN
MCAB DONAKE ER

Patient Disposition 02017208

Disposition:	Transported-To Hospital ER/ED	**Receiving Hospital:**	Lodi Memorial Hospital	**MD Consult:**	☐
Est. Time Death:		**Other Hospital:**		**Base Physician:**	
Mode of Transport:		**Personal Items:**		**Transport Priority:**	No Lights and Siren
Air Request By:		**First Respond Assist:**	☐	**Change In Priority:**	No Lights and Siren
Reason For Air:		**Base Hospital:**		**Mileage Scene:**	0.0
Destination Decis:	Patient/Family Request	**Base Hosp Contact:**	☐	**Mileage Hospital:**	1.8
Hosp Divert From:		**Base Contact Time:**		**Total Mileage:**	1.8
Physician Order:					
Consult Sign Name:		**Consult Signature:**			
Consult Sign Title:					
Consult Sign Date:					
Transfer Reason:		**Transfer Time:**		**Transporting Agency:**	
Transporting Unit Number:		**Transporting Case Number:**		**New Primary Caregiver:**	

Patient Medical Insurances 02017208

MEDICARE ECS ASSIGNED MEDICARE/AMBULANCE, PO BOX 2003, CHICO, CA 95927, (800)421-2560, Policy#:566627161A,

1st Attendant: Rosewall, Jessie,AMR	**2nd Attendant:** Bradley, Chad,AMR	**3rd Attendant:**
Number: P19576	**Number:** 10-7885	**Number:**
Certification: Paramedic	**Certification:** EMT	**Certification:**
Caregiver Name:	**Hospital Signature:**	

Agency:
Certification:

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PARVIN, MARY JEAN
MCAB DONAKE ER

Lodi Memorial Hospital
975 South Fairmont Avenue
Lodi, CA 95240-5179

MEDICATION RECONCILIATION PATIENT DISCHARGE SUMMARY

Patient Name: PARVIN,MARY JEAN
Admit Date: 09/05/12
Date of Birth: 03161943 **Age/Sex:** 69/F
Unit Number: M053082 **Account Number:** V023912512
Discharge Date: 09/09/12 **Patient Status:** DIS IN
Attending/Admitting Physician: Quach,Truong MD - HOSP

Patient Allergies: latex
Patient AdvReactions: Sulfa(Sulfonamide Antibiotics) (Sulfa (Sulfonamide Antibiotics))
morphine

Stop taking these medications

Naproxen ** (Naprosyn **)
500 Milligram(s) ORAL
Twice daily
Discontinued By: SHI,BEIEN MD 09/09/12 @ 12:02pm
Discontinued Reason: Medication changed

Last updated by: MOEDE,KATHERINE Date/Time: 09/05/12 @ 5:02pm

14

09/05/12 M053082 69 /F
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PARVIN, MARY JEAN
MCAB PHYSER ER

Circle or check affirmatives, backslash (\) negatives.

Lodi Memorial Hospital

EMERGENCY PROVIDER RECORD
General Adult

24

DATE 9/5/12 TIME: 0446 ROOM: 14 (EMS Arrival)
HISTORIAN: (patient) family EMS
UNABLE TO OBTAIN HISTORY DUE TO:

PCP: Dr. Freund

HPI

chief complaint: weakness

onset / duration: x2 days

timing:	severity:	modifying factors:
(still present)	mild	(none)
better	moderate	
gone now	(severe)	
worse		

context:
recent trauma history 69 y/o ♀ c/o weakness x 2 days alone & chills, sweats, productive cough but denies a fever or any pain. Per pt, was bit by her cat 2 days ago and (R) leg is now red.

quality: generalized

location: generalized

Similar symptoms previously

Recently seen / treated by doctor

ROS

CONST
fever / (chills) (sweats)
recent illness
(weakness) / weight loss x2 days
EYES / ENT
vision *change / problems*
sore throat / dental problems
nasal drainage / congestion
CVS / PULMONARY
chest pain
hurts to breathe / short of breath
(cough) *bloody / (productive)* phlegm
GI / GU
abdominal pain
nausea / vomiting
last BM
diarrhea / black / bloody stools
problems urinating
painful urination

FEMALE GENITAL
LNMP ____ preg post-menop

MUSCLE SKELETAL / SKIN / LYMPH
calf / leg pain (R) leg redness
neck / back pain cat bite 2 days ago
joint pain
leg / ankle swelling
(rash)
swollen glands
NEURO / PSYCH
headache
fainting / dizzy
lost feeling / power
difficulty walking *cane walker*
difficulty with speech
confusion / dementia
depression / anxiety
☒ all systems neg except as marked

PAST HX

cardiac disease
A-Fib angina (CHF) *MI*
(diabetes) *Type 1 Type 2*
diet / oral / insulin neuropathy
eye / sinus disease *glaucoma*
GI disease
GERD / liver disease / cholelithiasis
hepatitis pancreatitis ulcer
(hypertension)
old records reviewed / summary:

(hyperlipidemia)
immunosuppressed *AIDS steroids*
kidney disease *calculi UTI dialysis*
lung disease *asthma COPD*
neuro / psych problems
(CVA) / TIA *bleed deficit*
seizure disorder / depression
skin disorder (MRSA)
Hx: C.Diff

PERC Rule: greater than or = to 50yo / HR greater than or = to 100 / RA SAO2 less than or = to 94 / prior DVT, PE / surg, trauma less than or = to 4wks / hemoptysis / hormone tx / unilat leg swelling / clin susp PE. (all neg, less than 2% risk PE)
Wells Criteria for PE
3 pts each: clinically suspect DVT / most likely due to PE
1.5 pt: each: HR greater than 100 / immobilization or surgery past 4 weeks / prior DVT or PE
1 pt: each: hemoptysis / cancer treatment in the past 6 mos
LOW(0-2pts) (3.6%) MOD(3-6pts) (20.5%) HIGH(greater than 6pts) (66%) Wells PE

Surgeries / Procedures none CABG, AICD
appendectomy
cardiac bypass / stent / pacemaker
cholecystectomy
endoscopy upper / lower
hysterectomy / BTL / C-section
indwelling device *line / port*
foley catheter / dialysis graft

Imaging prior CT / MRI / US *date*

Medications none (see nurses note)
aspirin clopidogrel warfarin LMWH
NSAID acetaminophen BCP narcotic
recent antibiotic

Allergies NKDA
(see nurses note)
antibiotic Sulfa
morphine, latex

SOCIAL HX

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

FAMILY HX

reviewed not relevant

☒ Nursing Assessment Reviewed ☒ Initial Vital Signs Reviewed ☐ Telemetry
BP 189/100 HR 78 RR 18 Temp 36.6
Pulse Ox 95 % (RA) O_2 *Interp* (nml) hypoxic

PHYSICAL EXAM

EXAM LIMITED BY:
General Appearance
appears well
alert
mild / moderate / severe distress
anxious / lethargic

TFORMS

10229302431

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ABG: pO_2 50.5
HCO_3 29
O_2 sat 88.5

Lactic acid: 1.2
PCT: 0.39

AST: 38
ALT: 2

HEENT
- ✓ head atraumatic
- ✓ eyes nml inspection
- ✓ PERRL
- __ visual fields nml
- __ ENT inspection nml
- __ pharynx nml
- __ no signs of dehydration

__ trauma *Raccoon eyes / Battle's sign*
__ scleral icterus / pale conjunctivae
__ EOM palsy / anisocoria
__ purulent nasal drainage
__ dental decay / gum disease
__ pharyngeal erythema / exudate
__ oral lesions / dry mucous membranes

NECK
- ✓ nml inspection
- __ thyroid nml

__ thyromegaly / lymphadenopathy
__ stiff neck / Kernig's / Brudzinski's sign
__ carotid bruit
__ see diagram

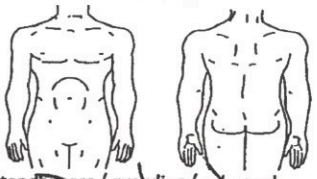
RESPIRATORY
- ✓ chest non-tender
- ✓ no resp. distress
- ✓ breath sounds nml

__ wheezes / rales / rhonchi

CVS
- ✓ reg. rate & rhythm
- ✓ no murmur
- ✓ no gallop

__ irregularly irregular rhythm
__ extrasystoles (occasional / frequent)
__ tachycardia / bradycardia
__ PMI displaced laterally
__ JVD present
__ murmur grade ___ /6 sys / dias
__ gallop (S3 / S4)
__ friction rub
__ decreased pulse(s)
R carotd ___ fem ___ dors ped
L carotd ___ fem ___ dors ped

T=tenderness
R=rebound
m=mild
mod=moderate
sv=severe



ABDOMEN / GI
- ✓ non-tender
- __ no organomegaly
- __ nml bowel sounds
- __ no distension

__ tenderness / guarding / rebound
__ abnml bowel sounds
__ hepatomegaly / splenomegaly / mass
__ bruit

FEMALE GENITAL
- __ external exam nml
- __ speculum exam nml
- __ bimanual exam nml

__ vaginal bleeding / discharge
__ cervical motion tenderness
__ adnexal tenderness / mass (R / L)
__ enlarged / tender uterus

MALE GENITAL
- __ nml inspection

__ tenderness / swelling *testicular / inguinal*

RECTAL
- __ non-tender
- __ prostate exam nml

__ black / bloody / heme pos. stool
__ tenderness / mass / nodule
__ heme pos. stool

BACK
- __ nml inspection

__ CVA tenderness (R / L)

EXTREMITIES
- __ non-tender
- __ full ROM
- __ nml appearance
- __ no pedal edema

__ pedal edema
__ calf tenderness
__ joint swelling
cellulitis, redness, warmth
(R) leg from ankle to knee

NEURO
- ✓ oriented x3
- __ CN's nml as tested
- __ sensation nml
- __ motor nml

__ disoriented to *person / place / time*
__ facial droop
__ weakness / sensory loss
__ slurred / abnml speech

PSYCH
- ✓ mood / affect nml

__ depressed mood / flat affect

SKIN
- __ no embolic lesions
- ✓ color nml, no rash
- ✓ warm, dry

__ cyanosis / diaphoresis / pallor
skin rash / abscess / cellulitis (R) leg
__ decubitus → intertrigo sub

09/05/12 M053082 69 /F
V023912512 BD: 03/16/43
PARVIN, MARY JEAN
MCAB PHYSER ER

LABS, EKG & XRAYS

Blood cx (x2): pending

**Normal lab value ranges are included on the original lab report*

CBC	Chem		UA
nml except	nml except	BNP 1541 CKMB 2.87	nml except
WBC 21.0	Na 138	D-Dimer	Troponin 0.07 protein: 100
Hgb 13.1	K 4.6	PT	CKMB glucose: 100
Hct 36.9	CO2 23	INR	Troponin blood: small
platelets 235	Glu 247		CKMB
segs 79	BUN 59		Troponin
bands 12	Creat 1.89		
lymphs 6			

Rhythm Strip Rate ___ Rhythm *NSR / PVC* ___

EKG *interp by ED provider* Rate 67 __ NSR __ A-fib Atrial sensed ventricular paced rhythm

__ nml intervals __ nml axis __ nml QRS ✓ non-specific ST/TW changes

diagnosis __ nml (abnml)

Repeat EKG- __ unchanged Old EKG- (unchanged) date: 10/18/10

CXR 1 view

(X) interp. by me (X) Reviewed by me ☐ Discsd w/ radiologist ☐ read by radiologist

__ nml / NAD __ no infiltrates __ nml heart size __ nml mediastinum

cardiomegaly Old CXR- __ unchanged date: 5/13/12 CHF resolved, no infiltrates

CT Scan / MRI / Ultrasound pacemaker

chest abdomen other contrast / non-contrast

__ nml / NAD

PROGRESS

☐ see additional template: # 94 51a ___

Time ____ unchanged improved re-examined

Discharge VS: BP ___ HR ___ RR ___ Temp ___

☐ patient ambulating / mentating at pre-event baseline

✓ Discussed with Dr. Quach Time: 0527

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)* (X) 30-74 min ☐ 75-104 min 45 min

CLINICAL IMPRESSION

- Congestive Heart Failure
- Hypokalemia
- ♦Myocardial Infarction *acute*
- ♦Pneumonia (05.16)
- Pulmonary Embolism
- UTI / Pyelonephritis

Acute Cellulitis RLE
poorly controlled DM - Hyperglycemia

Present On Admission *decubitus / UTI w/ foley* ___

Disposition Order Time 0527

DISPOSITION- ☐ home (X) admitted ☐ OBS ☐ expired ___
☐ AMA *(see AMA template #73)* ☐ transferred ___

CONDITION- ☐ unchanged ☐ improved ☐ stable guarded

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.

V. Sandoval scribing for Dr. Donaghy
(Scribe name) (Provider name)

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

Kevin J. Donaghy, M.D.
IDX #35893

___ *MD / DO IDX Provider #* ____

(X) Template Complete ☐ Written Addendum

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10229302432

Dict # 366693

SCANNED IN ED

LODI MEMORIAL HOSPITAL
EMERGENCY ROOM REPORT

DATE
09/05/2012

Addendum to hand-written ER note.

MEDICAL DECISION MAKING
The patient is a 69-year-old woman who presents today with generalized weakness. This sounds like it has been going on for about 2 weeks, but much much worse over the past 2 days. This correlates with the time she was scratched and bitten by her cat in her legs 2 days ago. She has subsequently developed cellulitis in her right leg. The erythema, warmth and tenderness go up about 1/2 to 2/3 of the way up her calf. There are 2 healing wounds, one on the posterior and one on the medial side. Neither one appears to be purulent or draining. There is no fluctuance palpable. The patient also presents hypoxic. She was 95% on supplemental O2 on arrival. We did a room air gas, she had a pO2 of 50. She has had a cough with some productive sputum, as well as chills and sweats for the past couple of days, so I am covering her with Zosyn and vancomycin for the cellulitis as well as additional azithromycin for the possibility of occult pneumonia.

I have had a long discussion with both the patient and with her cousin, Tiffany, about our clinical impression and our plan of care. Her cousin Tiffany identifies herself as the patient's power of attorney, although the document I reviewed in her computerized records from 2010 lists two other people. Nevertheless, the patient is lucid and capable of making her own decisions at present, so it is a moot point currently.

Clinically, the patient appears dehydrated. She has an acutely elevated BUN. She has chronically elevated creatinine which does not appear much different her mouth is dry. Her urine specific gravity was on the high side at 1.020, so I am hydrating her as part of the treatment of her infection. She does have a history of CHF and she has an elevated BNP today at 1500, however, she does not appear volume overloaded. Her chest x-ray looked markedly improved compared with 05/13/2012 when she had CHF present.

I have discussed the patient with Dr. Quach who has kindly agreed to evaluate her for admission.

CLINICAL IMPRESSION

1. Acute cellulitis, right lower extremity.
2. Hypoxia with possible pneumonia.
3. Poorly controlled diabetes with hyperglycemia.

DISPOSITION
Admitted to hospitalist service in guarded condition.

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F
Att. Dr. Quach,Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Kevin Donaghy, MD - ER

LODI MEMORIAL HOSPITAL
EMERGENCY ROOM REPORT

Critical care time for this patient exclusive of separately reportable procedures. This 45 minutes is inclusive of time at the bedside, time ordering and interpreting studies, treatment of the patient's cellulitis potential early sepsis (although her sepsis markers are currently negative,) review of records, discussions with the patient and her family, coordination of care with the admitting physician.

cc: Edmund A. Freund, MD MD

JOB # 366693
DD: 09/05/12 0550
DT: 09/05/12 0633
Report#:0905-0009
DONAK/WM
cc:Edmund A Freund, MD - ER
Kevin Donaghy, MD - ER

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F
Att. Dr. Quach,Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Kevin Donaghy, MD - ER

E-Signed By:
Kevin Donaghy, MD - ER
E-sign Date: 09/07/12E-Sign Time: 1629

Co-sign Date: Time:

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F
Att. Dr. Quach,Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Kevin Donaghy, MD - ER

DATE

9-5-12 1^{30}pm — CARDS

CC: fatigue, cat bite

#366807

A: 1. CHF exacerbation, systolic
2. Tropinemia, 2/2 #3, #1
? ACS, ɸ chest pain syndrome
3. HTN emergency
4. Ⓡ LE cellulitis
5. Hx AICD/PPM
6. CKD

EKG: AV paced
tele paced

CXR: mild CHF

rec: ^ lasix IV to PO tomorrow, ASA 81 daily
Continue tele, strict I/O, daily wt.
Serial CE/EKG, titrate NTG off, keep SBP ≤ 150/90
Echocardiogram
Continue home anti-HTN / titrate prn
Rx underlying cellulitis per 1° svc
Will follow - review old records.

⊛ Get office records

[signature]
RANDHAWA.

6170-43 (4/24/07)

PROGRESS NOTES

Lodi Memorial Hospital

MC53080 V023912512
PARVIN, MARY JEAN
03/16/43 69 F
QUACH, TRUONG MD - HOSP
09/05/12 MCAB IN

Patient Name: PARVIN,MARY JEAN
Unit No: M053082

EXAM#	TYPE/EXAM	RESULT
001135754	XRAY/CHEST SINGLE VIEW PORTABLE	

History: Dyspnea.

Comparison May 13, 2012.

Pacemaker is noted. Wire sternal sutures are in place. Heart is large. Pulmonary vasculature slightly engorged. The lungs appear clear and there are no effusions.

Impression: Mild CHF.

D/T: RBR/
Date Dictated: 09/05/2012 07:25:06
Date Transcribed: 09/05/2012 07:24:26
Doc ID: 266118
Job ID: 366704

This document was electronically signed by Richard B. Rankin, M.D. on 09/05/2012 07:25:07.

** REPORT SIGNED IN OTHER VENDOR SYSTEM 09/05/2012 **
Reported By: RANKIN, RICHARD B MD

CC: Donaghy,Kevin MD - ER; UNKNOWN FAMILY DOCTOR

Technologist: PASCUA, FLOYD
Transcribed Date/Time: 09/05/2012 (0725)
Transcriptionist: EWS
Printed Date/Time: 09/10/2012 (0001)

Name: PARVIN,MARY JEAN
Phys: Donaghy,Kevin MD - ER
DOB: 03/16/1943 Age: 69 Sex: F
Acct No: V023912512 Loc: 488 A
Exam Date: 09/05/2012 Status: DIS IN
Radiology No: 00003311

Date 09/05/12
Quach,Truong MD - HOSP

History & Physical

H&P

DATE

5 September 2012

PRIMARY CARE PHYSICIAN

Ed Freund

CHIEF COMPLAINT

Weakness

HISTORY OF PRESENT ILLNESS

69 year female with past medical history of diabetes, hypertension, chronic kidney disease, CHF with ejection fraction of 30% presented EGD because of weakness for the last 2 days. Patient states that about 2 days ago, she had stepped on a cat which in response, scratched her and bit her in the right lower extremity. Since yesterday, she started noticing redness in the right leg. She also noticed some coughing and phlegm production since yesterday. She admits to having fever and chills but had not actually taken her temperature home. She also filling general malaise and overall weakness compared to a baseline. She stated she does take her medication regularly.

REVIEW OF SYSTEMS

She has no headaches, no vision changes, no stiff neck, no nausea vomiting, no chest pain, no shortness of breath, no abdominal pain, no flank pain, no swelling in the extremities, no dysuria, no dizziness, no syncope. Otherwise, all other systems reviewed and are negative.

PAST MEDICAL HISTORY

CHF with ejection fraction of 30%, coronary artery disease, diabetes, hypertension, CVA, chronic kidney disease stage III, hypothyroid, depression, anxiety.

PAST SURGICAL HISTORY

Appendectomy, CABG, AICD placement.

FAMILY MEDICAL HISTORY

Date 09/05/12
Quach,Truong MD - HOSP

Reviewed and is noncontributory

SOCIAL HISTORY

Denies any tobacco use, no alcohol use. Patient currently lives with her daughter.

ALLERGIES

See below

HOME MEDICATIONS
See Reconcile Meds

PHYSICAL EXAMINATION

Vitals

Bedside Pulse Oximetry	97	09/05/12 0552
Blood Pressure	215/136	09/05/12 0552
Pulse Rate	81	09/05/12 0552
Respiratory Rate	20	09/05/12 0552
Temperature	36.6	09/05/12 0409

GENERAL APPEARANCE:

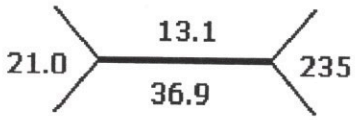
Elderly female, obese, lying in bed, appears to be in no distress, on nasal cannula.
HEENT:
Normocephalic, atraumatic, EOMI, PERRLA, oropharynx pink moist.
CHEST:
Decreased breath sounds at the left base.
HEART:
Regular rate rhythm, normal S1-S2
ABDOMEN:
Positive for bowel sounds, soft, nontender
EXTREMITIES:
Right lower extremity with abrasions just posterior to the ankle area, erythema and calor, minimal tenderness to palpation
NEUROLOIGICAL:
Alert and oriented x3, nonfocal

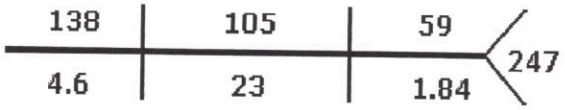
M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ER
Electronically signed by: Quach,Truong MD - HOSP 09/05/12 0639

Date 09/05/12
Quach,Truong MD - HOSP

LABORATORIES DATA AND STUDIES
[ ]Laboratory - CBC/MP

09/05/12 0433:





	Lab	
Base Excess	-2.1 mmol/L L	09/05/12 0507
HCO3	21.9 mmol/L L	09/05/12 0507
O2 Saturation	88.5 % L	09/05/12 0507
pCO2	35.2 mmHg	09/05/12 0507
pH	7.411	09/05/12 0507
pO2	50.5 mmHg L	09/05/12 0507
B-Natriuretic Peptide	1541 pg/mL H	09/05/12 0433
Creatine Kinase	287 IU/L H	09/05/12 0433
Procalcitonin	0.39 ng/mL	09/05/12 0433
Troponin I	0.07 ng/mL H	09/05/12 0433
Band Neutrophils %	12 % H	09/05/12 0433
Lymphocytes % (Manual)	6 % L	09/05/12 0433
Neutrophils % (Manual)	79 %	09/05/12 0433

CXR- prelim, LLL infiltrate vs atelectasis with small pleural effusion.

ASSESSMENT AND PLAN
Hypertensive emergency
#CHF exacerbation
#Troponinemia
#Right lower extremity cellulitis
#Right base pneumonia versus CHF with small pleural effusion
#Possible early sepsis
#History of coronary artery disease/CVA

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Date 09/05/12
Quach,Truong MD - HOSP

#Diabetes
#Chronic kidney disease, stage III
#Hypothyroid

We will admit the patient to ICU for nitro drip. We will start on empiric IV antibiotics. Follow with serial cardiac enzymes. Low-dose diuresis with careful monitoring of blood pressure. Aspirin and continuation of cardiac meds. Tetanus shot in ED. Accu-Chek every 4 hours, with insulin sliding scale for now. Monitor renal function. Check thyroid function tests.

Critical care time: 65 minutes.

CODE STATUS
Full code

LENGTH OF STAY
3-5 days

Allergies
Coded Allergies:
latex (Mild, Rash 07/02/12)
Converted from Drug Class Allergy: Latex
Sulfa(Sulfonamide Antibiotics) (Sulfa (Sulfonamide Antibiotics)) (Severe, Convulsions 07/02/12)
Converted from Ingredient Allergy: Sulfa Drugs
morphine (Severe, DIFFICULTY OF BREATHING 07/02/12)

Home Medications
Active Scripts
Lortab 10/500 (Hydrocodone Bit/Acetaminophen) 1 TAB PO Q8
#90 TAB
Prov: FREUND,EDMUND MD 07/02/12
Lisinopril ** 20 MG PO DAILY
#30 TAB Ref 6
Prov: FREUND,EDMUND MD 07/03/12
ONGLYZA (Saxagliptin Hydrochloride) 5 TAB PO DAILY
#30 TAB Ref 5
Prov: FREUND,EDMUND MD 07/03/12
Carvedilol 12.5 MG PO BID
#60 TAB Ref 6

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ER
Electronically signed by: Quach,Truong MD - HOSP 09/05/12 0639

Prov: FREUND,EDMUND MD 08/30/12
Furosemide 80 MG PO DAILY
#30 TAB Ref 6
Prov: FREUND,EDMUND MD 08/30/12
Lexapro (Escitalopram Oxalate) 20 MG PO DAILY
#30 TAB Ref 6
Prov: FREUND,EDMUND MD 08/30/12
Micardis (Telmisartan) 1 TAB PO DAILY
#30 Ref 6
Prov: FREUND,EDMUND MD 08/30/12
Ambien ** (Zolpidem **) 5 MG PO DAILY
#30 TAB Ref 3
Prov: FREUND,EDMUND MD 08/30/12

Reported Medications

Januvia ** (sitaGLIPtin PHOSPHATE **) 100 MG PO DAILY
Pepcid ** (Famotidine **) 20 MG PO BID
Micro-K ** (Potassium Chloride **) 20 MEQ PO DAILY
Novolog (Insulin Aspart) 100 UNIT IJ TID
Pepcid ** (Famotidine **) 20 MG PO BID
Lovastatin 40 MG PO DAILY
Prilosec ** (Omeprazole **) 20 MG PO BID
Naprosyn ** (Naproxen **) 500 MG PO BID
Levothroid (Levothyroxine Sodium) 100 MCG PO DAILY
Catapres (Clonidine Hcl) 0.2 MG PO BID
Lantus Refill (Insulin Glargine,Hum.rec.anlog) 1 - 100 U SUB-Q BID
#1 BOX
Micardis (Telmisartan) 1 TAB PO DAILY
Zetia ** (Ezetimibe **) 10 MG PO DAILY
Nitrolingual ** (Nitroglycerin **) 0.4 MG TL OTO
Aspirin ** 81 MG PO BID
Accu-Chek Active Test Strip (Blood Sugar Diagnostic) 1 STRIP
Vitamin D3 ** (Cholecalciferol**) 400 UNITS PO DAILY
#1 BTL
ALLERGIST SYRINGE (SYRINGE W-NEEDLE,DISPOSAB,1ML) 1 mL IJ
Easy Comfort Insulin Syringe (Syringe W-Ndl, Disp,Insul,1ML) 0.5 mL IJ
Lexapro (Escitalopram Oxalate) 20 MG PO DAILY

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PARVIN,MARY JEAN
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Electronically signed by: Quach,Truong MD - HOSP 09/05/12 0639

Date 09/05/12
Quach, Truong MD - HOSP

Ambien (Zolpidem Tartrate) 5 MG PO DAILY
#30 TAB Ref 3

Discontinued Reported Medications
Carvedilol 12.5 MG PO BID
Furosemide 80 MG PO DAILY
Ambien ** (Zolpidem **) 5 MG PO DAILY
Micardis (Telmisartan) 1 TAB PO DAILY

CC:
Freund, Edmund MD-Mills

M053082 V023912512
PARVIN, MARY JEAN
03/16/43 69 F ER
Electronically signed by: Quach, Truong MD - HOSP 09/05/12 0639

Lodi Memorial Hospital

Progress Note

Date 09/05/12
Qureshi,Muhammad R MD - HOSP

Subjective

Subjective
Subjective HPI
Patient denies any complaints, feels better than before. Denies any chest pain or shortness of breath at this time. Does c/o cat bite and cat scratch couple of days ago with resultant redness in the RLE since yesterday. In the Er patient was also found to be hypertensive and started on nitro drip and now SBP in 160s-170s on 10mcg/min of nitro drip.
History obtained from- Patient, Old chart, Nurse, Chart
PCP/Admit Date

Primary Care Physician Freund,Edmund MD-Mills
Phone number 334-8540
Admit Date 09/05/12
Length of Stay 1

Estimated length of stay 3-5 days
History and Physical reviewed? Yes

Objective

Vitals & I&O
Vitals & I&O
Vital Signs

Date	Temp	Pulse	Resp	B/P	Pulse Ox	FiO2
09/05	36.6	75-82	18-22	143-215/66-136	95-98	

Intake and Output

	09/05 0600
Intake Total	
Output Total	150
Balance	-150
Output, Urine	150
Patient	105.2 kg

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ICU
Electronically signed by: Qureshi,Muhammad R MD - HOSP 09/05/12 1113

Date 09/05/12
Qureshi,Muhammad R MD - HOSP

Weight	
Weight Measurement Method	Bed

Results
Results

Laboratory Tests

	09/05 0800	09/05 0507
Blood Gas		
Specimen Type		ARTERIAL PUNCTURE
Puncture Site		RADIAL,RIGHT
pH (7.350 - 7.450)		7.411
pCO2 (35.0 - 45.0 mmHg)		35.2
pO2 (75.0 - 85.0 mmHg)		50.5 L
HCO3 (22.0 - 26.0 mmol/L)		21.9 L
Base Excess (-2.0 - 2.0 mmol/L)		-2.1 L
O2 Saturation (96.0 - 97.0 %)		88.5 L
ABG Carboxyhemoglobin (<1.6 % THgb)		0.2
ABG O2 Capacity (16.0 - 24.0 mL/dL)		18.7
Allen Test		POS
Hemoglobin (12.0 - 16.0 g/dL)		13.5
Hematocrit (37.0 - 47.0 %)		40.0
Oxyhemoglobin (94.0 - 97.0 %)		88.1 L
Methemoglobin (0.4 - 1.5 g/dL)		0.3 L
Respiration Rate (/MIN)		24.0
FiO2 % (%)		21.0
Chemistry		
Creatine Kinase (38 - 234 IU/L)	243 H	
Troponin I (0.01 - 0.06 ng/mL)	0.09 H	
Urines		
Urine Color (YELLOW)		YELLOW
Urine Appearance (CLEAR)		CLEAR

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Date 09/05/12
Qureshi,Muhammad R MD - HOSP

Urine pH (5.5 - 8.0)		6.0
Ur Specific Gravity (1.005 - 1.025)		1.020
Urine Protein (NEGATIVE mg/dL)		100 H
Urine Glucose (UA) (NEGATIVE mg/dL)		100 H
Urine Ketones (NEGATIVE mg/dL)		NEGATIVE
Urine Blood (NEGATIVE)		SMALL H
Urine Nitrite (NEGATIVE)		NEGATIVE
Urine Bilirubin (NEGATIVE)		NEGATIVE
Urine Urobilinogen (0.2 - 1.0 E.U./dL)		0.2
Ur Leukocyte Esterase (NEGATIVE)		NEGATIVE
Urine RBC (0 - 2 rbc/hpf)		1-2
Urine WBC (0 - 5 wbc/hpf)		<1 WBC PER 3 FIELDS
Ur Squamous Epith Cells (NONE - FEW epi/hpf)		RARE
Urine Bacteria (NONE SEEN)		NONE SEEN
Urine Mucus		SMALL

Chemistry	09/05 0500	09/05 0433	09/05 0433	09/05 0433	09/05 0433
Lactic Acid (0.5 - 2.2 mmol/L)			1.2		
Creatine Kinase (38 - 234 IU/L)				287 H	
Troponin I (0.01 - 0.06 ng/mL)				0.07 H	
B-Natriuretic Peptide (< 176 pg/mL)					1541 H
Procalcitonin (<= 0.5 ng/mL)		0.39			
Toxicology					
Vancomycin Trough (<=20.0 mcg/mL)	< 0.1				

Chemistry	09/05 0433
Sodium (134 - 143 mmol/L)	138
Potassium (3.6 - 5.1 mmol/L)	4.6
Chloride (98 - 107 mmol/L)	105
Carbon Dioxide (22 - 32 mmol/L)	23
BUN (8 - 21 mg/dL)	59 H
Creatinine (0.44 - 1.03 mg/dL)	1.84 H

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Estimated GFR	27.2
BUN/Creatinine Ratio (6.0 - 20.0)	32.1 H
Glucose (70 - 110 mg/dL)	247 H
Calcium (8.9 - 10.3 mg/dL)	9.1
Total Bilirubin (0.1 - 2.0 mg/dL)	0.9
AST (15 - 41 IU/L)	38
ALT (14 - 54 IU/L)	25
Alkaline Phosphatase (38 - 126 IU/L)	82
Total Protein (6.1 - 7.9 g/dL)	6.7
Albumin (3.5 - 4.8 g/dL)	3.6
Globulin (2.0 - 3.8 gm/dL)	3.1
Albumin/Globulin Ratio (1.2 - 2.5)	1.2
Hematology	
WBC (5.0 - 9.5 K/mm3)	21.0 H
RBC (3.70 - 5.50 M/uL)	4.15
Hgb (12.0 - 16.0 g/dL)	13.1
Hct (37.0 - 47.0 %)	36.9 L
MCV (80.0 - 99.0 fl)	88.9
MCH (27.0 - 33.0 pg)	31.5
MCHC (31.8 - 36.2 g/dL)	35.5
RDW (10.0 - 16.4 %)	17.1 H
Plt Count (140 - 450 K/mm3)	235
MPV (7.5 - 10.5 fl)	8.2
Neut % (37 - 80 %)	88.7 H
Lymph % (10.0 - 50.0 %)	5.2 L
Mono % (<12.0 %)	5.4
Eos % (<7.0 %)	0.2
Baso % (<2.5 %)	0.4
Neutrophils % (Manual) (37 - 80 %)	79
Band Neutrophils % (0 - 6 %)	12 H
Lymphocytes % (Manual) (10 - 50 %)	6 L
Monocytes % (Manual) (2 - 12 %)	3
Absolute Neutrophils (2.40 - 7.56 K/uL)	18.60 H
Absolute Lymphocytes (0.96 - 4.75 K/uL)	1.08
Absolute Monocytes (0.10 - 1.00 K/uL)	1.14 H
Absolute Eosinophils (0.00 - 0.45 K/uL)	0.05

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ICU

Electronically signed by: Qureshi,Muhammad R MD - HOSP 09/05/12 1113

Date 09/05/12
Qureshi,Muhammad R MD - HOSP

Absolute Basophils (0.00 - 0.20 K/uL)	0.09
Platelet Estimate (ADEQUATE)	ADEQUATE
Poikilocytosis (NEGATIVE)	1+
Anisocytosis (NEGATIVE)	1+
Ovalocytes (NONE SEEN)	1+
Stomatocytes (NONE SEEN)	1+ H

Test results personally reviewed & interpreted? Yes
Medical records reviewed Yes

Medications

Allergies

Coded Allergies:

latex (Mild, Rash 07/02/12)
Converted from Drug Class Allergy: Latex
Sulfa(Sulfonamide Antibiotics) (Sulfa (Sulfonamide Antibiotics)) (Severe, Convulsions 07/02/12)
Converted from Ingredient Allergy: Sulfa Drugs
morphine (Severe, DIFFICULTY OF BREATHING 07/02/12)

Current Medications

Current Medications
Sodium Chloride 1000 ml Q20M IV (DC)
Piperacillin Sod/Tazobactam Sod 4.5 gm NOW ONE IV (DC)
Sodium Chloride 100 ml
Vancomycin HCl 300 ml PROTOCOL IV (DC)
Azithromycin 250 ml .STK-MED ONE IV (DC)
Azithromycin 500 mg NOW ONE IV (DC)
Dextrose 250 ml
Nitroglycerin/Dextrose 250 ml TITRATE IV
Omeprazole 40 mg 06-DAILY PO
Acetaminophen 650 mg Q6PRN PRN PO
Acetaminophen/Hydrocodone Bitart 5 mg Q4PRN PRN PO (CAN)
Clindamycin Phosphate/Dextrose 50 ml Q8H IV
Insulin Aspart 0 PRN PRN SUB-Q (DC)
Magnesium Hydroxide 30 ml DAILY PRN PRN PO

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Ondansetron HCl 4 mg Q6PRN PRN IV
Vancomycin HCl 250 ml PROTOCOL IV (CKD)
Vancomycin HCl 300 ml Q24H IV (DC)
Levofloxacin/Dextrose 150 ml .STK-MED ONE IV (DC)
Insulin Aspart Enter units administered
PRN PRN SUB-Q
Levofloxacin/Dextrose 150 ml Q48H IV
Acetaminophen/Hydrocodone Bitart 5 mg Q4PRN PRN PO (DC)
Acetaminophen/Hydrocodone Bitart 5 mg Q4PRN PRN PO (PEND)
Aspirin 81 mg DAILY PO
Carvedilol 12.5 mg BID PO
Clonidine 0.2 mg BID PO
Docusate Sodium 100 mg BID PO
Ezetimibe 10 mg DAILY PO
Escitalopram Oxalate 20 mg DAILY PO (CKD)
Furosemide 40 mg Q12 IV
Levothyroxine Sodium 100 mcg DAILY PO
Lisinopril 20 mg DAILY PO
Heparin Sodium (Porcine) 5000 unit TID SUB-Q
Simvastatin 40 mg HS PO
Vancomycin HCl 250 ml Q24H IV (CKD)

Exam

Date 09/05/12
General Appearance Alert, Oriented X3, Cooperative, No Acute Distress
HEENT Atraumatic, PERRLA, EOMI, Mucous Membr. moist/pink
Respiratory Crackles (Bibasilar)
Neck Supple, No JVD, No thyromegaly
Cardiovascular Regular, No murmur, No rub
Abdomen Normal Bowel Sounds, Soft, No Tenderness
Extremities No Clubbing, No Cyanosis, No Edema, Normal Pulses, Erythema of the RLE from ankle to midway upto calf with no tenderness or fluctuation. Small healing wound on the posterior aspect of ankle with no drainage or fluctuation. Appears to be healing well with scab formation.
Neurological No Focal Deficits, Normal Speech

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ICU
Electronically signed by: Qureshi,Muhammad R MD - HOSP 09/05/12 1113

Date 09/05/12
Qureshi,Muhammad R MD - HOSP

Psych/Mental Status Mental Status Normal, Mood Normal

Nursing Clinical Data
Pain (1-10): 0 No Pain
Reason- MRSA

Assessment/Plan
Problems & Plan
Problems
Hypertensive emergency:
Cont. carvidelol and clonidine and keep titrating nitroglycerin drip off. Will also restart lisinopril. Creatinine appears to be at the baseline.

#Acute on Chronic Systolic CHF exacerbation:
Could be secondary to hypertensive emergency. LVEF was 30% on echo on 03/23/10. Cont. home meds and gentle diuresis for now. Strict I's and O's and daily weight. Will consult cardiology and case d/e patient's cardiologist Dr.Stanzler.

#Troponinemia:
Likely mild troponin leak from CHF and hypertensive emergency. Cont. to monitor troponin levels. Cont. aspirin, carvedilol, lisinopril and zocor for now. Cardiology consult.

#Right lower extremity cellulitis:
Likely secondary to cat scratch and cat bite. No obvious abscess and no drainage. Patient has already received zithromax which will cover bartonella henselae and will switch other antibiotics to unasyn to cover for pasturella multocida. Cont. to monitor for now. Will also obtain wound nurse consult.

#History of coronary artery disease/CVA:
Cont. home meds for now.

#Diabetes Mellitus:
Cont. accuchecks with sliding scale coverage for now.

#Chronic kidney disease, stage IV:
Stable. Creatinine appears to be at the baseline. Cont. to monitor for now. Avoid nephrotoxics and adjust medications according to level of renal functioning.

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ICU
Electronically signed by: Qureshi,Muhammad R MD - HOSP 09/05/12 1113

Lodi Memorial Hospital

Progress Note

Date 09/05/12
Qureshi,Muhammad R MD - HOSP

#Hypothyroidism:
Cont. synthroid for now. Will check TSH and Free T4 levels.

CODE STATUS:
D/W patient and she wishes to be DNR/DNI. Patient states that she don't think she will have any good quality of life if she is revived and that's why she wants to be DNR/DNI. Will change code status.

Chronic Problems:
Cellulitis and abscess of leg
Chronic kidney disease stage 4 (GFR 15-29)
Congestive heart failure
Diabetes mellitus type 2
Essential hypertension
Hyperglycemia

Critical care time without billable procedural time 45 minutes plus
Daily plan discussed with- Patient/family, Nurse

Core Measure

Core Measure
DVT Prophylaxis Heparin

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F ICU
Electronically signed by: Qureshi,Muhammad R MD - HOSP 09/05/12 1113

LODI MEMORIAL HOSPITAL
CONSULTATION REPORT

DATE OF CONSULTATION
09/05/2012

CARDIOLOGY CONSULTATION

REFERRING PHYSICIAN
Muhammad Qureshi, MD

REASON FOR CONSULTATION
Acute congestive heart failure exacerbation.

HISTORY OF PRESENT ILLNESS
The patient is a pleasant 69-year-old female with past medical history of congestive heart failure and coronary artery disease who presents to the hospital with 2 to 3 days of progressive fatigue, weakness and constitutional symptoms. She also reported recently getting bit a household cat on the right lower extremity. She was experiencing fever and lower extremity pain, discomfort and swelling; therefore, came to the emergency department via EMS for further evaluation and management.

Upon arrival, the patient was noted to be severely hypertensive with blood pressure in the 200s over 130s. She denied any recent chest pain, shortness of breath, PND, orthopnea, dyspnea on exertion. She has been compliant with her medications. She was last seen by Dr. Stenzler, per patient, several with weeks ago and had a followup scheduled for today for routine cardiac care. The patient was started on IV antibiotics and also received IV fluids for possible underlying dehydration. She was started on nitroglycerin drip for hypertensive emergency and admitted to the intensive care unit for further evaluation. Further laboratory workup including cardiac enzymes demonstrated abnormal results; therefore, cardiology was consulted for further evaluation and management. Currently the patient is resting in bed comfortably and without any chest pain or shortness of breath. Telemetry demonstrates a paced rhythm without any arrhythmias. An EKG demonstrates AV pacing and nonspecific ST-T changes. Further interpretation is not possible due to paced rhythm. Repeat EKG is pending at this time.

REVIEW OF SYSTEMS
GENERAL: Positive fevers and chills.

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F
Att. Dr. Quach,Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Tejpal Randhawa, MD

E-Signed By:
Tejpal Randhawa, MD
E-sign Date: 09/07/12E-Sign Time: 1148

Co-sign Date: Time:

NEUROLOGICAL: Positive history of CVA.
OTOLARYNGOLOGY: Negative for snoring or sleep apnea, sinus problems, hearing loss, oral infections.
ENDOCRINE: Diabetes mellitus.
PULMONARY: Negative for cough, sputum production, wheezing, or pulmonary embolus.
CARDIAC: Positive coronary artery disease, positive ischemic cardiomyopathy.
GI: Negative for reflux, peptic ulcer disease; black, tarry or bloody stools; diverticular disease.
GU: Negative for kidney stones, dysuria, hematuria, urgency.
HEMATOLOGY/ONCOLOGY: Negative for malignancy, DVT, easy bruising, anemia.
MUSCULOSKELETAL: Negative for arthritis or low back pain.
RENAL: Chronic kidney disease.

PAST CARDIAC HISTORY
1. Coronary artery disease status post PCI and coronary artery bypass graft x2 vessels in 2004.
2. Ischemic cardiomyopathy with AICD.
3. Left temporal lobe CVA.
4. Chronic kidney disease.
5. Hypertension.
6. Dyslipidemia.
7. Diabetes mellitus type 2.

PAST MEDICAL HISTORY
1. Depression.
2. Morbid obesity.
3. Anxiety.
4. Hypothyroidism.

PAST SURGICAL HISTORY
1. As above with coronary artery bypass graft x2 vessels in 2004 and vein graft to the LAD and SVG to the PDA.
2. Appendectomy.
3. AICD _____.

ALLERGIES
SULFA.

M053082 V023912512
PARVIN, MARY JEAN
03/16/43 69 F
Att. Dr. Quach, Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Tejpal Randhawa, MD

E-Signed By:
Tejpal Randhawa, MD
E-sign Date: 09/07/12E-Sign Time: 1148

Co-sign Date: Time:

MEDICATIONS AT HOME
Please see the list.

SOCIAL HISTORY
The patient denies any smoking, alcohol or substance abuse. She is currently a widow and has no children. She lives in Lodi, California.

FAMILY HISTORY
Unknown for any premature CAD or sudden cardiac death.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure currently is 140s over 70s, heart rate 60, respiratory rate of 18-22, O2 saturation 95% on 2 L nasal cannula, temperature is afebrile.
GENERAL: The patient is mildly somnolent.
HEENT: Eyes: There is no xanthelasma. Ears, nose, mouth and throat are normal. There is good dentition. Mucous membranes are moist without pallor or cyanosis. Dentition is fair.
NECK: Supple. JVP is approximately 8 cm of water.
RESPIRATORY: The breathing is unlabored. The lungs are clear to auscultation bilateral anteriorly. There are no rales or wheezes.
CARDIOVASCULAR: PMI is nondisplaced. S1, and S2 are normal. There are no murmurs, rubs, or gallops.
ABDOMEN: Soft. Bowel sounds are present.
RECTAL: Deferred to primary care physician.
MUSCULOSKELETAL: There is normal gait. The patient would be able to exercise on a treadmill.
EXTREMITIES: Mild right lower extremity edema with tenderness, swelling, and redness. Pulses are 1+ bilateral and equal.
SKIN: There are no ulcers or evidence of stasis dermatitis.
NEUROLOGIC: The patient is fully alert and oriented to person, place and time. The patient has normal affect.

LABORATORY STUDIES
Demonstrate chest x-ray with mild CHF. Heart is large. Pulmonary vasculature is slightly engorged. The lungs appear clear and there are no effusions.

M053082 V023912512
PARVIN,MARY JEAN
03/16/43 69 F
Att. Dr. Quach,Truong MD - HOSP
09/05/12 4S 1
Dict. Dr. Tejpal Randhawa, MD

E-Signed By:
Tejpal Randhawa, MD
E-sign Date: 09/07/12E-Sign Time: 1148

Co-sign Date: Time:

AMI panel on admission demonstrated CPK of 287, troponin I 0.07, repeat CPK is elevated at 243, troponin I 0.09. BNP is 1541. Lactic acid 1.2. Sodium 138, potassium 4.6, creatinine 1.8, BUN of 59, glucose 247. LFTs are within normal range. WBC 21.0, hemoglobin 13.1, platelet count 235 with a left shift, 12% bandemia is also noted.

ASSESSMENT
1. Congestive heart failure exacerbation, acute.
2. Troponinemia, most likely secondary to congestive heart failure exacerbation as well as hypertensive emergency. I am unable to exclude an acute coronary syndrome; however, the patient did not have chest pain syndrome.
3. Hypertensive emergency.
4. History of automatic implanted cardioverter/defibrillator due to nonischemic cardiomyopathy.
5. History of chronic kidney disease.
6. History of diabetes mellitus type 2.
7. Right lower extremity cellulitis status post cat bite.

RECOMMENDATIONS
1. Continue telemetry monitor.
2. Strict ins and outs and daily weight.
3. Serial cardiac enzymes and EKG.
4. Titrate nitroglycerin off as long as blood pressure is less than 150/90.
5. Resume home medications and change Lasix IV to p.o. tomorrow morning.
6. Continue Aspirin 81 mg daily, statin, beta blockers and ACE inhibitor.
7. Check echocardiogram for LVEF, wall motion, diastolic function, PA systolic pressure, and valvular function.
8. Treat underlying cellulitis per primary service.

I do not have access to the latest office records as they are currently in the process of being transferred to the intensive care unit and the patient's chart. Further recommendations are pending at this time. Thank you, Dr. Qureshi, for this interesting consult.

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LODI MEMORIAL HOSPITAL
CONSULTATION REPORT

cc: Kevin Donaghy, MD MD
Dr. Qureshi; Dr. Stenzler

JOB # 366807
DD: 09/05/12 1342
DT: 09/05/12 1443
Report#:0905-0117
RANDT/WM
cc:Kevin Donaghy, MD - ER

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