Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Discharge Documentation

10 days. He is, otherwise, not to do any heavy lifting or bending for 3 days. His right groin is healing well. There is no bruise or hematoma. Patient's vital signs at the time of discharge, blood pressure 103/56, heart rate 61, respirations 20, temperature 97, pulse oximetry 95% on room air.

A copy of angiogram CD has been provided to the patient.

DIAGNOSTIC DATA: His lab data from 06/12, white count 4.3, hemoglobin 14.9, hematocrit 45, platelet count is 162. Glucose 90, BUN 14, creatinine 1. Sodium 141, potassium 4, chloride 103, bicarbonate 26. Troponin 11.015 x3. Albumin is 4.3. Liver function tests are normal.

Chest x-ray on 06/12/2012, revealed fibrosis at the right apex, atelectasis of the right base. No evidence of consolidation. Mediastinum appears to be satisfactory. Trachea is midline. Heart size upper normal.

Patient to resume his home medications. He has been given the name of Dr. Nguyen, GI surgeon at UCI, to consider surgery for his GE-junction disease. He wants also the name of a surgeon at other facility. I will try to obtain one at UCLA or
Cedars-Sinai and give it to him. Follow up in my office in 10 days.

DISPOSITION:

MEDICATION RECONCILIATION:
REFER TO MEDICATION RECONCILIATION LIST

Dictated By:_____
Chandrahas Agarwal, MD

CA/5554643
DD: 06/14/2012 13:43
TD: 06/15/2012 03:27

Job #: 804184
SSI File#: 0069000000004061420121339286555
CC:
Ninh Nguyen, MD
Umesh C. Shah, MD
David Berry, MD 919094561255

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Discharge Documentation

Transcribed by: CONTRIBUTOR_SYSTEM
Transcribed Date/Time: 06/15/2012 03:42 AM

Signed by: Agarwal M.D., Chandrahas
Signed Date/Time: 06/16/2012 12:03 PM

Document Name: Patient Clinical Summary
Result Status: Modified
Performed By: Vertulfo RN,Erlyn V (6/14/2012 14:56 PDT)
Authenticated By: Vertulfo RN,Erlyn V (6/14/2012 14:56 PDT)

Patient Clinical Summary

San Antonio Community Hospital
Clinical Discharge Instructions

PERSON INFORMATION
Name: HANNA MD, ADEL S
MRN: 918505 **FIN#:**3050679

PHYSICIANS
Admitting Physician: Agarwal M.D., Chandrahas
Attending Physician: Khan M.D., Faraaz O; Razo M.D., Paul R.; Agarwal M.D., Chandrahas
PCP:

Comment:

PATIENT EDUCATION INFORMATION
Instructions:

Medication Leaflets:

Follow up:

With:	Address:	When:
Chandrahas Agarwal	160 E. Artesia St., Ste. 255 Pomona, CA 91767 (909) 620-0900 Business (1)	In 10 days 06/24/2012

Comments:

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Discharge Documentation

MEDICATION LIST

Continue These Medications:

acetaminophen (acetaminophen 325 mg oral tablet) 2 tab Oral every 4 hours as needed for pain (mild)
aspirin (Aspirin Adult Low Strength)
atenolol (atenolol 50 mg oral tablet) 50 mg Oral every day
clobetasol topical (Temovate) 0.4 % Topical 2 times a day
esomeprazole (Nexium 40 mg oral delayed release capsule) 40 mg Oral 2 times a day
fluticasone nasal (Flonase) 1 puff Pharynx 2 times a day

Comment:

Document Name:	Patient Discharge Summary
Result Status:	Modified
Performed By:	Vertulfo RN,Erlyn V (6/14/2012 14:56 PDT)
Authenticated By:	Vertulfo RN,Erlyn V (6/14/2012 14:56 PDT)

Patient Discharge Summary

San Antonio Community Hospital
Patient Discharge Instructions

Name: HANNA MD, ADEL S
Current Date: 06/14/12 14:56:50
Discharge Date with Instructions:
DOB: 3/29/1946 12:00 AM **MRN:** 918505 **FIN:** 3050679
Patient Address: 3019 SONG OF THE WINDS CHINO HILLS CA 91709
Patient Phone: (909) 342-9908

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Discharge Documentation

Admitting Physician: Agarwal M.D., Chandrahas
Attending Physician: Khan M.D., Faraaz O; Razo M.D., Paul R.; Agarwal M.D., Chandrahas
Consulting Physician:

San Antonio Community Hospital would like to thank you for allowing us to assist you with your healthcare needs. The following includes patient education materials and information regarding your injury/illness. Follow-up: Please make an appointment with your physician within two weeks (unless otherwise instructed).

HANNA MD, ADEL S has been given the following list of follow-up instructions, prescriptions, and patient education materials:

FOLLOW-UP INSTRUCTIONS

With:	**Address:**	**When:**
Chandrahas Agarwal	160 E. Artesia St., Ste. 255 Pomona, CA 91767 (909) 620-0900 Business (1)	In 10 days 06/24/2012

Comments:

MEDICATIONS

Continue These Medications:
acetaminophen (acetaminophen 325 mg oral tablet) 2 tab Oral every 4 hours as needed for pain (mild)
aspirin (Aspirin Adult Low Strength)
atenolol (atenolol 50 mg oral tablet) 50 mg Oral every day
clobetasol topical (Temovate) 0.4 % Topical 2 times a day
esomeprazole (Nexium 40 mg oral delayed release capsule) 40 mg Oral 2 times a day
fluticasone nasal (Flonase) 1 puff Pharynx 2 times a day

I, HANNA MD, ADEL S, have received the attached patient education materials/instructions and have verbalized understanding:

_____ _____ _____ _____

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Discharge Documentation

Patient Signature Date Provider Signature Date

Patient education materials, if any, will display below

Prescription leaflets, if any, will display below

San Antonio Community Hospital Promotes Healthy Living for All Patients

LIVING SMOKE FREE

SMOKING FACTS

When a cigarette smoker inhales, about 25% of the nicotine in the smoke reaches the brain within six seconds. A "Pack-a-day" smoker gets between 50,000 and 70,000 such nicotine "jolts" a year.

Nicotine causes the heart to beat much faster. Blood pressure rises and harmful substances pour into the blood. Combined with the stress caused by carbon monoxide in cigarette smoke, more than 120,000 heart attack deaths occur yearly among U.S. smokers.

SECOND HAND SMOKE

Second hand smoke is the combination of smoke from a burning cigarette and smoke exhaled by a smoker. The smoke that burns off the end of a cigarette or cigar contains more harmful substances than the smoke inhaled by the smoker.

If you do not smoke, but are exposed to second-hand smoke on a regular basis, your body is absorbing nicotine and other harmful substances just as the smokers body is doing. In the U.S., 37,000 annual deaths are related to second-hand smoke.

DO NOT SMOKE!!

If you would like more information on avoiding second-hand smoke or if you would like help to quit smoking, please contact the following community resource:

CALIFORNIA SMOKERS HOTLINE: 1-800-NO-BUTTS (Six languages and hearing impaired)

If you have Congestive Heart Failure (CHF) or have ever had congestive heart failure, these are guidelines that we recommend for better health.

CHF Discharge Instructions

Call your Doctor right away if the following occurs:

More Shortness of Breath than usual, especially when active or when lying flat

Weight gain or 2 - 3+ pounds overnight or 4 pounds or more in a week.

Discharge Documentation

Dizziness or fainting episodes

Extreme tiredness

Swollen ankles or feet

Lack of appetite, Abdominal bloating or pain, nausea or vomiting

Constant cough

Chest pain

Skipped beats or very slow heart rate (50 beats per minute or less)

Activity and Rest:

Plan your day to include balanced periods of rest and activity

Put your feet up to reduce ankle swelling

Avoid extreme temperatures

Medications:

Know the purpose and side effects of your medications

Report any side effects without delay to your doctor

Your doctor will prescribe medications to improve the way your heart pumps and rids your body of extra water

Take medication as directed. Never skip a dose or discontinue a medication without letting your doctor know

Know your medication names, dosage and schedule. Get a refill before you run out.

If you have questions regarding dosages of your medications, contact your doctor.

Always keep an Up – To – Date List of the medications you are taking with you.

Diet:

The blanks below with an asterick (*) will only be completed by your nurse or physician if you actually have a diagnosis of CHF

· Your Doctor has prescribed * _____ Diet.

· Sodium *_____ milligrams / day

· Do not add extra salt to your diet. Follow a diet low in cholesterol and fat, particularly saturated fat.

· Ask your doctor if limiting your fluids is necessary.

· Your doctor has limited your fluids to *_____ ounces / 24 hours

· Rest 1 hour after meals before doing any activity

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Discharge Documentation

· Limit foods that have caffeine (e.g. Coffee, Tea, Cola and Chocolate) to 1-2 cups per day because of their stimulating effects.

· Check with your Doctor about drinking alcohol. If OK, limit to 2 ounces per day

Weigh Yourself Daily:

· Weigh yourself daily in the morning and record your weight. Report any sudden weight gain of 2-3 pounds overnight or 4 pounds or more in one week to your doctor.

· Your weight when discharged was _____ pounds

Exercise:

Check with your Doctor before starting any exercise program. Exercise can increase muscle strength, flexibility and improve your ability to do other things. Avoid pushing, pulling, or raising heavy objects above the shoulder.

Walking is one exercise that may be recommended. Start with a 3-5 minute warm-up of light, slow stretching. Walk at a comfortable pace, making sure you can easily carry on a conversation while exercising. Slowly increasing the distance is okay as strength improves. End you walking sessions with a cooling down period by gradually slowing down.

Physician Written Orders

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL

PHYSICIAN'S ORDERS

Male HANNA, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., C iandra
MRN:918505 FIN:3050679

DATE: 06/12/12
TIME: ☐ AM 2200 ☒ PM

Nexium 40 mg po X1 dose now.
TORB DR. ~~Chaudhary~~ Choudhary / B Pmanzano RN

noted by: B Pmanzano RN 06/12/12 2215

12° / B Pmanzano RN 06/13/12 0630

SAN ANTONIO COMMUNITY HOSPITAL

PHYSICIAN'S ORDERS

DATE: 6/13/12
TIME: 1627 ☐ AM ☒ PM

Tylenol supp 650mg PR today x 1 dose
T.O.R.B. Dr. C Agarwal RN

noted 6/13/12 1644

12° RN 6/13/12 1805
12° RN 6/14/12 0600

SA000057

#4531 (Rev. 2/11) mm

Patient:	**HANNA MD, ADEL SHAKER**				
MRN:	918505	**DOB/Age/Sex:**	3/29/1946	76 years	Male
FIN:	3050679	**Admit/Disch:**	6/12/2012	6/14/2012	
Patient Type:	Day Patient	**Admitting:**			
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.				

Progress Notes

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

HANNA, ADEL S
Male DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., Chandra
MRN:918505 FIN:3050679

PROGRESS RECORD

DATE	TIME	NOTE DATE OF EXAMINATION, PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, RECORD OF TREATMENT GIVEN AND RESULT, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNATURE OF PHYSICIAN MAKING OBSERVATIONS.
6/14/12		Card. f/u. Comfortable.
	1:30pm	Rt-groin is healing
		well. c/o epigastric discomfort
		after eating.
		B.P-103/52 HR=61/min
		Heart: S1+S2 regular
		Lungs: clear
		Ø edema
		Rt-groin is healing well.
		A&P: GERD
		No significant cardiac
		cause. EF=60%
		D/C Home
80 4184		Resume home meds.
		F/u with me after 10 days.
		No heavy lifting or bending x3 days.
		C. Agarwal
		[illegible]

SA000065

PROGRESS RECORD

#3071 (Rev 9/10) mm

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

PROGRESS RECORD

DATE	TIME	NOTE DATE OF EXAMINATION, PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, RECORD OF TREATMENT GIVEN AND RESULT, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNATURE OF PHYSICIAN MAKING OBSERVATIONS.

Patient Name: HANNA MD, ADEL SHAKER
Date of Birth: 3/29/1946

MRN: 918505
FIN: 3050679

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

PROGRESS RECORD

Hanna Adel

DATE	TIME	NOTE DATE OF EXAMINATION, PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, RECORD OF TREATMENT GIVEN AND RESULT, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNATURE OF PHYSICIAN MAKING OBSERVATIONS.
6/12/12	7:00 pm	Card. Consult. Full chart reviewed.
803795		66 yr old male (physician)
		1. C.P.
		2. GE reflux
		3. Fever
		Lab, noted.
		ECG non sp.
		Card echo noted
		Plan: Coronary angiography in AM.
		The risks & complications including
		but not limited to bleeding, CVA, MI & death.
		Pt. understands & wishes to proceed.
		[signature]

SA000065

PROGRESS RECORD

#3071 (Rev 9/10) mm

Facility: SARH

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

PROGRESS RECORD

DATE	TIME	NOTE DATE OF EXAMINATION, PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, RECORD OF TREATMENT GIVEN AND RESULT, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNATURE OF PHYSICIAN MAKING OBSERVATIONS.
6/13/12	11:35AM	Card. P/U: Comfortable B-P 142/85 HR = 67/min Heart: S1 S2 regular Lungs: Clear & edema CTnI: < 0.015 x 3 ECG: NSR, 1° AVB LVH. Asst: Chest pain - ? hypercholesterolemia angina. Cardiac cath done. No complications No significant flow obstructive CAD LVEF = 60%

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

HANNA MD, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., ChandraMale
MRN:918505 FIN:3050679

CCL DIAGNOSTIC PROGRESS NOTE

PRELIMINARY REPORT
(Final Report Pending Review)

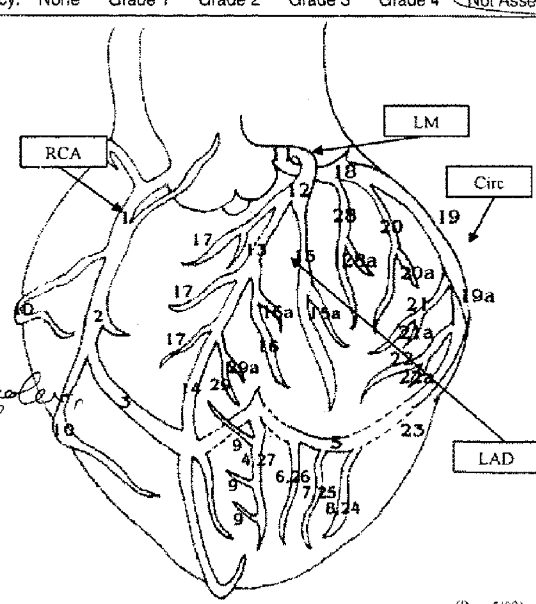
DATE	TIME	NOTE DATE OF EXAMINATION, PROGRESS OF CASE, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, RECORD OF TREATMENT GIVEN AND RESULT, CONDITION ON DISCHARGE, INSTRUCTIONS TO PATIENT, SIGNATURE OF PHYSICIAN MAKING OBSERVATIONS.		
6/13/12		Diagnostic Procedure: LHC + LV gram + Rt FA angio		
11:20 Am		Coronary Vasculature	Percent Stenosis	Graft Stenosis (if Applicable)
		Left Main	NL %	n/a
		Proximal LAD	NL %	D, - Mild [illegible]
		Mid/Distal LAD	Mild luminal % irreg.	%
		Circumflex	NL % 1 OM, - NL	%
		Ramus	Absent %	%
		RCA Large	% Mid RCA 10-20%, Narrow	
		4 Fr m Ejection Fraction: 60 %	LV Wall Motion: (Normal) Abnormal	
		Valve Findings→ Mitral Stenosis:	Yes No (Not Assessed)	
803924		Mitral Insufficiency: (None) Grade 1 Grade 2 Grade 3 Grade 4 Not Assessed		
		Aortic Stenosis: Yes (No) Not Assessed		
		Aortic Insufficiency: None Grade 1 Grade 2 Grade 3 Grade 4 (Not Assessed)		

NYHA Class I II III IV

Rt FA angio: NL Insertion above the bifurcation
F7 2-4 min
Contrast 110 ml
Pt tolerated the procedure well. There were no complications.

Cardiologist Signature: [signature]

Date: 6/13/12 11:25 Am



SA000079

(Rev. 5/09) mm

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Consultation Notes

Document Name: Consultation Physician
Result Status: Auth (Verified)
Performed By: Agarwal M.D.,Chandrahas (6/12/2012 19:04 PDT)
Authenticated By: Agarwal M.D.,Chandrahas (6/16/2012 12:06 PDT)

CONSULTATION

Patient: HANNA, ADEL
Account#: 3050679
MR#: 0918505
Physician: Chandrahas Agarwal, MD PCODE: 12
Location: EDMH EM15
Report: CONSULTATION

DATE OF CONSULTATION: 06/12/2012
REQUESTING PHYSICIAN: Faraaz Khan, MD

REASON FOR CONSULTATION: Chest pain.

HISTORY OF PRESENT ILLNESS: This is a 66-year-old gentleman who is well known to me and is my regular office patient. He called me around 3:00, stating that he was having chest pain and wants to go to the emergency room and was directed to come to San Antonio Community Hospital Emergency Room. He came here by private auto. He is currently in the ER, comfortable and in no distress. He was evaluated by Dr. Khan and a CT angiogram was ordered. His cardiac enzymes are normal. The patient states that he has been having this pain in the epigastric area which radiates to the right side of the neck, and then he feels a swelling and cannot swallow for the past 3 months. He had an EGD done by Dr. Umesh Shah at the Four Seasons Surgery Center about 2 weeks ago and was told that his esophagus was normal. He had a colonoscopy done and 2 polyps removed. the patient is concerned because of he was told a few years ago that his esophagus looks like liver and had a Barrett esophagus secondary to hiatal hernia and reflux. He cannot understand why it is normal now. He was given Nexium 40 mg b.i.d. He was also treated for H. pylori with triple antibiotics including clarithromycin, amoxicillin and Flagyl. The patient was today sitting and working at this desk when he developed severe epigastric pain, radiating to the substernal area in the right side of the neck again and felt like there was swelling and he could not swallow anything. He cannot even drink tea. The pain does not happen with walking, exertion or climbing stairs. It only happens when he is sitting.

PAST MEDICAL HISTORY: Significant for cholecystectomy. He had laparoscopic surgery for hiatal hernia which was complicated by perforation of the esophagus leading to bilateral empyema. He was in a

Consultation Notes

San Francisco hospital for 61 days and now has since recovered. He has a hiatal hernia with gastroesophageal reflux which causes him pain. He also has a history of asymptomatic PVCs. He has mild hypercholesterolemia and mild hypertension.

MEDICATIONS: Home medications are atenolol 30 mg daily for the past 30 years, Nexium 40 mg b.i.d., aspirin 81 mg daily.

ALLERGIES: None specified.

SOCIAL HISTORY: Does not smoke. Works as a psychiatrist at Chino Men's Correctional Facility.

PHYSICAL EXAMINATION:
GENERAL: Very pleasant gentleman resting comfortably in bed in no distress. Wears corrective glasses. He has a friend at bedside.

VITAL SIGNS: Blood pressure 146/91, heart rate 64, respiratory rate 20, pulse oximetry 99%. Pain 7 on a scale of 10 but he is very comfortable.

HEENT: Head normocephalic. No trauma noted. Pupils were equal, round and reactive to light.

NECK: No bruit. Thyroid not enlarged.

LUNGS: Clear.

HEART: S1, S2 are audible. Rhythm is regular. No murmurs, rubs or gallops could be appreciated.

ABDOMEN: Soft, nontender. Bowel sounds heard well. Liver, spleen, kidneys not felt. Scar noted in the right upper quadrant.

EXTREMITIES: No edema. Distal pulses palpable. Deep tendon reflexes are 1-2+ bilaterally.

NEUROLOGIC: No focal deficits noted.

LABORATORY DATA: EKG shows sinus rhythm with PVCs, otherwise unremarkable. Heart rate is 61.

CPK 50, MB less than 0.5, troponin less than 0.015. Glucose 90, BUN 14, creatinine 1.0, sodium 141, potassium 4.0, chloride 103. First set of _____, troponin 0.015 and MB of 0.6. White count 4.3, hemoglobin 14.9, hematocrit 45, platelets 162. Pro time 10.8, INR 1.02, PTT 26.2. Chest x-ray _____ at the right apex along with atelectasis or fibrosis at the right base, minimal atelectasis at the

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Consultation Notes

left base, no evidence of any area of consolidation.

ASSESSMENT:
1. Patient with chest pain who appears most likely of gastric or esophageal origin.
2. Hypertension.
3. Premature ventricular complexes.
4. CT scan finding suggestive of mucosal edema of the distal esophagus which may be causing his pain.

RECOMMENDATIONS: The patient is scheduled for cardiac catheterization tomorrow because he is very anxious and requests angiogram be done. I have explained to him the risks and complications of cardiac catheterization including but not limited to bleeding, stroke, myocardial infarction and death which he understands and wishes to proceed. We will discuss with him the CT angiogram findings, especially the mucosal edema of the distal esophagus.

Dictated By:_____
Chandrahas Agarwal, MD

CA/5555206
DD: 06/12/2012 19:09
TD: 06/12/2012 19:52

Job #: 803795
SSI File#: 0069000000030612201219042788 3
CC:
Faraaz O. Khan, MD
Umesh C. Shah, MD

Transcribed by: CONTRIBUTOR_SYSTEM
Transcribed Date/Time: 06/12/2012 07:56 PM

Signed by: Agarwal M.D., Chandrahas
Signed Date/Time: 06/16/2012 12:06 PM

Consents

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, CA 91786

Male HANNA, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., C tandra
MRN:918505
FIN:3050679

CONSENT TO SURGERY OR SPECIAL PROCEDURE

1. Your doctors have recommended the operation or procedure listed on the signature page (page 3).

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the doctor(s) performing the procedure, may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the doctor named below (or in the event the doctor is unable to perform or complete the procedure, a qualified substitute doctor), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of *San Antonio Community Hospital* to whom the doctor(s) performing the procedure may assign designated responsibilities. The hospital maintains personnel and facilities to assist your doctors in their performance of various surgical operations and other special diagnostic or therapeutic procedures. However, the persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology, or pathology are not employees or agents of the hospital or of doctor(s) performing the procedure. They are independent medical practitioners. **INITIALS:**

2. Name of the practitioner (s) who is/are performing the procedure or administering the medical treatment: Dr. Chandrahas Agarwal
   (First and Last Name(s))

Operations and procedures carry the risk of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

- The nature of the operation or procedure, including other care, treatment or medications;
- Potential benefits, risks or side effects of the operation or procedure, including potential problems that might occur during recuperation;
- The likelihood of achieving treatment goals;
- Reasonable alternatives and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment; and
- Any independent medical research or significant economic interests your doctor may have related to the performance of the proposed operation or procedure.

SA000226

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, CA 91786

Male HANNA, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., C iandra
MRN:918505 FIN:3050679

CONSENT TO SURGERY OR SPECIAL PROCEDURE

Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed operation or procedure at any time prior to its performance.

3. If your doctor determines that there is a reasonable possibility that you may need a blood transfusion as a result of the surgery or procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the various options for blood transfusion, including predonation by yourself or others. You also have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait.

   Transfusion of blood or blood products involves certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV), and you have a right to consent or refuse consent to any transfusion. You should discuss any questions that you may have about transfusions with your doctor.

4. By your signature below, you authorize the pathologist to use his or her discretion in disposition or use of any member, organ or tissue removed from your person during the operation or procedure set forth above, subject to the following conditions (if any):

   _____

5. During this procedure an authorized member of the medical staff or any representative thereof, may photograph and/or video you or any part of your body for purposes directly related to the medical care rendered. **INITIALS:**

6. During this procedure a product representative may be present. The product representative will not assist in the surgery/procedure. **INITIALS:**

7. If applicable, your initials here indicate that you have received "A Women's Guide to Breast Cancer Diagnosis and Treatment.": **INITIALS:**

8. In accordance with Hospital Policy, any patient on a Do Not Resuscitate Status will have this status suspended during this surgical procedure. **INITIALS:**

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, CA 91786

Male HANNA, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., C landra
MRN:918505 FIN:3050679

CONSENT TO SURGERY OR SPECIAL PROCEDURE

9. **NAME OF OPERATION OR PROCEDURE:**

RIGHT AND/OR LEFT HEART CATHETERIZATION, LEFT VENTRICULAR ANGIOGRAM WITH SELECTIVE CORONARY ARTERIOGRAMS.
POSSIBLE PERCUTANEOUS CORONARY INTERVENTION
POSSIBLE CORONARY ARTERY BYPASS GRAFT SURGERY

PATIENT SIGNATURE

10. Your signature on this form indicates that:

- you have read and understand the information provided in this form;
- your doctor has adequately explained to you the operation or procedure and the anesthesia set forth above, along with the risks, benefits, and alternatives, and the other information described above in this form;
- you have had a chance to ask your doctors questions;
- you have received all of the information you desire concerning the operation or procedure and the anesthesia; and
- you authorize and consent to the performance of the operation or procedure and the anesthesia.

Date: 6/13/12 Time: 03:45 a.m. (AM)/PM

Signature: Hanna M.D
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate name and relationship: _____

Witness: Brenda P. Manzano Name: Brenda P. Manzano
(Signature) *(Print)*

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (*patient or patient's legal representative*) _____ in the patient's or legal representative's primary language _____ (*identify language*). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM/PM

Signature: _____ Name: _____
(Interpreter) *(Print name)*

3 of 3
5100 (Rev. 1/09)

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

HANNA, ADEL
DOB: 03/29/1946 GENDER: Male
MRN: 918505
FIN:

CONSENT FOR EMERGENCY SERVICES

The undersigned consents to any procedures that may be performed during this visit, including emergency treatment or services, which may include but are not limited to laboratory procedures, radiology examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered under the general and special instructions of the emergency physician, primary care physician or surgeon.

All physicians and surgeons furnishing services to the patient including the emergency physician, radiologist, pathologist, anesthesiologist and any other independent medical practitioners are not employees or agents of the hospital.

I agree to accept full financial responsibility for services rendered to the patient.

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786
Hospital

DECLINED
Patient

By E101029
(It's duly authorized representative)

Patient's Agent or Representative

Date & Time 06/12/12 16:01:36

Self
Relationship Patient

01R0018

#5015 (01/12) mm

* Auth (Verified) *

SAN ANTONIO REGIONAL HOSPITAL
999 SAN BERNARDINO ROAD • UPLAND, CALIFORNIA 91786

HANNA MD, ADEL SHAKER
DOB: 3/29/1946
Gender: Male
MRN # 918505
PNO # 5210547

CONDITIONS OF SERVICES
(OUTPATIENT)

CONSENT TO MEDICAL AND SURGICAL PROCEDURES
The person who signs below as the patient, or the representative on behalf of the patient, consents to be cared for as an outpatient at San Antonio Regional Hospital. This outpatient care may include, but is not limited to: laboratory procedures, x-ray examination including use of contrast injections, medical or surgical treatment or procedures, telehealth services, local anesthesia, and services provided to the patient under the general and special instructions of the patient's physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital. This outpatient condition of services and consent will remain in effect for up to twelve (12) months from date of signature and will apply to all outpatient services provided at San Antonio Regional Hospital during this period of time.

NURSING CARE
This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

EDUCATIONAL CONSENT
The hospital is, in part, an educational facility participating in the training of physicians, medical students, student nurses, and other health care personnel. I agree that they may participate in my care to the extent deemed appropriate by the medical staff or hospital personnel, and I consent to the demonstration, observation and admission of treatment or procedures by such persons under the supervisor of the members of the medical staff or hospital personnel.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS
ALL PHYSICIANS AND SURGEONS PROVIDING SERVICES TO ME, INCLUDING THE RADIOLOGISTS, PATHOLOGISTS, EMERGENCY PHYSICIANS, ANESTHESIOLOGISTS, NURSE PRACTITIONERS, PHYSICIAN'S ASSISTANTS, COUNSULTING PHYSICIANS AND OTHERS, ARE NOT EMPLOYEES, REPRESENTATIVES OR AGENTS OF THE HOSPITAL. They have been granted the privilege of using the hospital for the care and treatment of their patients, but they are not employees, representatives or agents of the hospital. They are independent practitioners and WILL BILL SEPARATELY. I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

Initials: _____

PERSONAL BELONGINGS
As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, eyeglasses, dentures, hearing aids, cell phones, laptops, or other personal electronic devices, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless I receive a written receipt for a greater amount from the hospital.

Initials: _____

01R0043

50000369 (05/19)

*** Auth (Verified) ***

FINANCIAL AGREEMENT
I agree to promptly pay all hospital bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I receive services from the hospital. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. Payment of estimated hospital liability may be required for non-emergent services. I have received information on the hospitals financial assistance policy and I understand I may request further assistance to determine if I may qualify. I authorize the hospital, collection agency or other entity contracted with the hospital, to verify employment and to obtain credit reports about me/legal representative from national credit bureaus in connection with payment of my account, past or present. The patient/legal representative will comply with all authorization and insurance certification requirements. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

I/legal representative agree, by providing my phone number(s) including a landline and/or a wireless phone number, consent to receive calls and/or text messages including autodialed calls and artificial or prerecorded messages from the hospital, physicians, agents and independent contractors (including service agencies and collection agencies) regarding hospital/medical services and any related financial obligations. I acknowledge that text messages may be susceptible to certain privacy and security risks, such as being viewed by others with access to the phone or device on which the text is received or stored. This consent applies to all services and billing associated with the patient account(s).

Initials: _____

ASSIGNMENT OF ALL RIGHTS AND BENEFITS
I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorization of direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to the assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital to perfect, confirm, or validate this assignment.

HEALTH PLAN CONTRACTS
This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the patient financial services office. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if the hospital or the physicians providing services to me contract with my health plan.

RELEASE OF INFORMATION
The hospital may use and disclose patient identifiable health information for purposes of treatment, payment and health care operations and as otherwise required or permitted by law and hospital policy. For example, the hospital may release patient information from records to any person or company which is or may be responsible to pay for the hospital's services, including Medicare, Medi-Cal, insurance companies, health care plans and/or workers' compensation carriers. In addition, State law requires the hospital to report certain cases of infectious disease and cancer to governmental health agencies. For all other purposes, the patient's written authorization permitting release of identifiable health information to others will be obtained. Please see the hospital's Notice of Privacy Practices for details regarding your rights concerning the use and disclosure of patient identifiable health information.

Initials: _____

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS DOCUMENT
My initial acknowledges my receipt of the Notice of Privacy Practices, and Patient Rights Document.

Initials: _____

CONSENT TO PHOTOGRAPH
I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images, for purposes of my diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

*** Auth (Verified) ***

ADVANCE DIRECTIVE ACKNOWLEDGEMENT
I have been given written materials about my right to accept or refuse medical treatment. I have been informed of my right to formulate an Advance Directive. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. I understand that the terms of any Advance Directive that I have signed will be followed by the health care facility and my caregivers to the extent permitted by law. *If I have an Advance Directive, I will present it at each admission.*

I HAVE signed an Advance Directive _____ I HAVE given a copy to the Hospital _____

I CHOOSE NOT to give a copy to the hospital _____ I DO NOT have an Advance Directive _____

LENGTH OF OUTPATIENT CONDITION OF SERVICES
I understand and agree that this outpatient condition of services and consent will remain in effect for up to twelve (12) months from date of signature and will apply to all outpatient services provided at San Antonio Regional Hospital during this period of time.

Initials: _____

After reviewing this document, please initial one of the options below:

The undersigned acknowledges that he/she has read the foregoing and agrees that they **do not wish to receive** a signed or unsigned copy of this document but understand that one is available upon request.

Initials: _____

I certify that I have read the foregoing and **have received** an unsigned copy thereof. I understand that a signed copy is available upon request.

Initials: _____

07/09/2021 15:25:22

Date: _____ Time: _____ AM/PM

Signature: _____
(patient/legal representative)

Patient

If signed by someone other than the patient, indicate relationship: _____

Print name: _____
(legal representative)

E102977

Signature: _____ Print name: E102977
(witness) (witness)

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Contracts provisions above.

07/09/2021 15:25:26

Date: _____ Time: _____ AM/PM

Signature: _____
(financially responsible party)

Print name: _____
(legal representative)

Address: _____

_____

Phone number: _____

E102977

Signature: _____ Print name: E102977
(witness) (witness)

60000369 (05/19)

Patient:	**HANNA MD, ADEL SHAKER**				
MRN:	918505	**DOB/Age/Sex:**	3/29/1946	76 years	Male
FIN:	3050679	**Admit/Disch:**	6/12/2012	6/14/2012	
Patient Type:	Day Patient	**Admitting:**			
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.				

Perioperative Record

* Transcribed *

SAN ANTONIO COMMUNITY HOSPITAL
999 San Bernardino Road, Upland, California 91786

Male HANNA MD, ADEL S
DOB: 03/29/1946 66 Years
Attn:
MRN:918505
FIN:3050679

Patient Questionnaire for CT Examination

Patient Name: Adel S. Hanna, M.D
Date of Birth: 3-29-46
Date of Exam: 6-12-12

Are you currently taking any of these Medications?

Metformin (generic)..	☐ Yes* ☒ No	Metaglip	☐ Yes* ☒ No	Glumetza	☐ Yes* ☒ No
Avandamet	☐ Yes* ☒ No	ActoPlus Met....	☐ Yes* ☒ No	Prardmet	☐ Yes* ☒ No
Glucophage	☐ Yes* ☒ No	Duetact	☐ Yes* ☒ No	Janumet	☐ Yes* ☒ No
Glucophage XR.....	☐ Yes* ☒ No	Fortamet	☐ Yes* ☒ No		
Glucovance	☐ Yes* ☒ No	Riomet.....	☐ Yes* ☒ No		

List all current medications you are taking: *(use back for more space)*
Nexium 40 mg BID / Atenolol 50 mg QHS / Aspirin 81 QHS

Have you had IV contrast for a CT or any other x-ray exam before? ☒ Yes ☐ No
Have you had IV contrast for a CT or any other x-ray exam in the last 48 hours? ☐ Yes* ☒ No
When _____ *Where* _____ *Type of exam* _____
Have you had this same examination before? *When* 10 Yrs *Where* Irvin ☒ Yes ☐ No
Have you ever had a reaction to the IV contrast? *Describe* _____ ☐ Yes* ☒ No
~~Date of last menstrual period~~: _____ Are you or do you THINK you are pregnant? ☐ Yes* ☐ No
Are you breast feeding? ☐ Yes* ☐ No
Do you have any known allergies? *(Medications, food, environmental)* Reglan ☒ Yes ☐ No
Type & Reaction EPS
Type & Reaction _____
Are you diabetic? No ☐ Yes* ☐ No
Do you have any problems related to your kidneys or urinary system? N.P. ☐ Yes* ☐ No
Do you have high blood pressure or any history of heart disease? ☒ Yes* ☐ No
Do you have asthma or history of asthma? ☐ Yes* ☒ No
Any history of CANCER? If YES, type & date diagnosed NONE ☐ Yes ☐ No
Have you had any blood drawn recently? *Date* 6/12 *Where* here - San Antonio ☐ Yes ☐ No
Any previous SURGERY? *Date/Type* Cholecystectomy 86 / Nissen Fundoplication 90 ☐ Yes ☐ No
Date/Type _____
Any recent trauma or injury? *Date/Type* NONE ☐ Yes ☐ No

Signature of patient or person completing this form: Hanna MD

Information Below to Be Completed by Radiology Personnel

BUN 14 **Creatinine** 1.0 **eGFR** 760

If patient answers *YES to any of the above, review with LIP.

Name of Physician Contacted: Hani L Berry MD. **Date/Time:** 6/12/12

_____ **Exam Cancelled per Physician** _____ **Physician Requests To Proceed with Exam**

Contrast Type ~~Isovue~~ 370 **Technologists / RN Name / Signature:** D Thamp

SA000281

#5299 (Rev. 8/10) mm

* Auth (Verified) *

SAN ANTONIO COMMUNITY HOSPITAL

999 San Bernardino Road, Upland, California 91786

HANNA MD, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., ChandraMale
MRN:918505 FIN:3050679

Cardiac Catheterization Laboratory
Consolidated Procedural Assessment Form

Instructions: Shaded areas must be completed. If an H&P is not on the chart, the Short Form H&P section is required.

History & Physical Update History and Physical Reassessed:
☑ I have examined the patient and there are **no changes** from previous assessment.
☐ Changes to H&P noted in progress notes.
☐ Relevant assessment changes: _____
Date: 6/12/12 Time: 10:50 am Physician Signature: C. Agarwal

Short Form History and Physical if no H&P on chart
Date: _____ Time: _____
Chief Complaint: _____
History of Present Illness _____
(Past Illness, Social and _____
family history) _____
Allergies: NKA List: _____
Medications: None List: _____

Bleeding Tendencies: ☐ Yes ☐ No

Physical Examination Check the corresponding box if normal
Head and Neck: ☐ _____
Heart and Lungs: ☐ _____
Abdomen: ☐ _____
Extremities: ☐ _____
Diagnostic Data/Lab Results: _____
Impression: _____
Planned Procedure: _____

Pre/Post Anesthetic/Sedation Evaluation if Medical Information Questionnaire is completed, skip to shaded area
Informed Consent Verification Ht: _____ Wt: _____ Last PO Intake: _____ V/S: BP_____ T_____ P_____ R_____
Previous Anesthesia: _____ Pertinent Physical Findings: _____

ASA
Class I A normally healthy Patient
Class II A patient with mild systemic disease
Class III A patient with severe systemic disease
Class IV A patient with severe systemic disease that is a constant threat to life
Class V A moribund patient who not expected to survive without the procedure
Class E Emergency

Anesthesia/Sedation Plan: Circle One Moderate Sedation Local General
ASA Score: Circle One I II III IV V E

☑ By my signature below, I certify that I have discussed that nature of the procedure that has been recommended, the risks, complications, and expected benefits or effects of the procedure: and any alternatives to the treatment and their risks and benefits
☑ By my signature below, I certify that I have discussed and answered all questions related to the nature of the anesthesia/sedation that has been recommended, the risks, complications and expected benefits or effects of the procedure: and any alternatives to the treatment and their risks and benefits, which are understood and accepted by the acknowledgement of the patient.
☑ Patient reassessed immediately prior to induction/administration of anesthesia
Date: 6/12/12 Time: 10:55 am Physician Signature: C. Agarwal
☑ Immediate Post-Anesthesia/Sedation Evaluation
Pt. tolerated the procedure well. There were no complications. B.P. 159/93 HR-59/min
Physician Signature: C. Agarwal Date: 6/12/12 Time: 11:15 AM

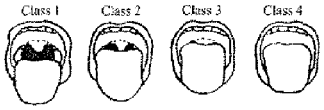
AIRWAY ASSESSMENT MALLAMPATI CLASSIFICATION - ON BACK SIDE

SA000009

*** Auth (Verified) ***

Airway Assessment, Mallampati Classification: *(Please circle the appropriate class)*

Class 1 - soft palate, fauces, uvula, anterior and posterior pillars visible
Class 2 - soft palate, fauces uvula visible
Class 3 - soft palate, base of uvula visible
Class 4 - soft palate not visible



* Auth (Verified) *

San Antonio Community Hospital

The Universal Protocol Safety Checklist For Verifying Correct Patient and Procedure

HANNA MD, ADEL S
DOB: 03/29/1946 66 Years
Attn: Agarwal M.D., ChandraMale
MRN:918505 FIN:3050679

Mark your initials in column when complete. Signature required for identification of initials only. Part of Patient Record.

Date 10-13-12 Signature

Signature

Preprocedural Verification:

Done prior to patient leaving the pre-procedure area (may be done in procedure room due to nature of procedure (e.g. radiology/, isolation procedures).

Guidelines:

Objective: To make sure that all relevant documents and related information or equipment are available before the start of all procedures requiring informed consent.

Who: The Team who provides care
- Identifies correctly labeled information
- Matches the patient's 2 identifiers (name, account number)
- Assesses patient's expectations and the team's understanding of the intended patient, procedure, and site/side

What- Verify availability of:
- Relevant documents, e.g. as H&P, Informed Consent by Surgeon, Patient Consent , and/or Pre-Anesthesia assessment
- Signed consent (procedure and physician)
- Correct diagnostic and radiology test results
- Any required blood products, implants, devices or special equipment

When to verify: At the time :
- Procedure scheduled
- Pre-admitted for testing and assessment
- Admitted to facility
- Transferred to another caregiver
- Prior to patient leaving the pre-procedure room

Where: In Pre-Procedure Room if applicable

How:
- Address missing information or discrepancies

Note: Document Universal Protocol on this form even when documented elsewhere in medical record. The documentation need not necessarily list all of the matters reviewed, the discussions held or the actual time it was carried out. (Refer to Universal Protocol Policy in Hospital Policy/Procedure Manual, Clinical Section, #8610C.21010

Mark the procedure Site (if applicable)

Guidelines:

Objective: To identify without ambiguity the intended site for the procedure.

Who: Marked by the **physician** directly involved and present at the time the procedure
- Patient awake, involved and aware.
- It is not recommended to have patient sign site

What: Mark all procedures that involve incisions, percutaneous punctures, or insertion of instruments. Take into consideration:
- Surface (flexor, extensor)
- Spine level (cervical, thoracic, lumbar) with additional intra-op xray for exact verterbral level (scout film).
- Specific digit or lesion to be treated
- Laterality: Those involving laterality of organs but where incision(s) or approaches may be from the mid-line or from natural orifice, mark the site and make a note of the laterality.
- Site marking not required for sternotomy, C-sections, single organ laparotomy or laparoscopic cases unless lateralized, urgent situations when practitioner has not left patient's bedside before procedure, obvious wound or lesion at site of intended procedure, interventional procedures for which the catheter/instrument insertion site is not predetermined (cardiac cath, pacemaker insertion), or modality directed procedure (eg. bx immediately after site determined by fluoro, or ultrasound).

When: Before patient moved to the procedure room when applicable

Where: In Pre-Procedure Room when applicable

How:
- Physician make a mark (his/her initials preferred) on site/side
- At or near the procedure/incision site.
- Mark sufficiently permanent to remain visible after draping.
- Defined, alternative process for cases in which it is technically or anatomically impossible or impractical to mark the site, such as mucosal surfaces, perineum, premature infants or for pt. refusal, a distinct "downtime" ID wrist band may be used on affected side/or a suture tie may be used to tie around limb.
- Minimally invasive procedures to treat a lateralized organ (Left, Right, or bilateral) is marked at/near the insertion site with physician initials.
- Teeth. The tooth name(s) and # in H&P

"Time out" Final Site Verification

Guidelines:

Objective: To perform Time Out Process

Who: All procedural team members.
- Initiated by a designated member of the procedural team (e.g. RN, physician, or Technolcgist
- When working alone (e.g. PICC line insertion) perform same verification process during the time out pause

What: Active participation of time out process for verification and confirmation

When: Occurs immediately prior to procedure
- Only need one pause when anesthesia occurs in same location where procedure is done or when same team is performing multiple components during a single procedure
- A separate Time Out is Needed when Anesthesia is done separate from procedure room (e.g. Nerve block in Holding Room) or when there is a separate team performing a secondary procedure

Where: In Procedure Room

How:
- Other activities are suspended without compromising patient safety.
- All team members use a brief verbal acknowledgement to concur with information.
- Any team member may interrupt and delay procedure to address discrepancy

Time-out Process Addresses
- Correct patient and account number
- Correct consent and surgeon
- Correct side and site are marked by Dr.
- Site mark visible after draping
- Correct patient position
- Availability of blood, implants, or special equipment when needed
- Relevant images and results are properly labeled and appropriately displayed
- Need for antibiotic including antibiotic protocol, or fluids for irrigation purposes
- Safety precautions based on patient history or medication use
- Sterility indicators confirmed for color changes

Revised 3/19/09

#5231 Rev 04/09

SA000238

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Electrocardiogram

*** Auth (Verified) ***

HANNA, ADEL S MD | ID:0918505 | 12-JUN-2012 17:33:47 | SAN ANTONIO COMMUNITY HOSPITAL-ER ROUTINE RECORD

29-MAR-1946 (66 yr)
Male
0lb
Room:15
Loc:1

Vent. rate	74	BPM
PR interval	180	ms
QRS duration	84	ms
QT/QTc	430/477	ms
P-R-T axes	29 -6 26	

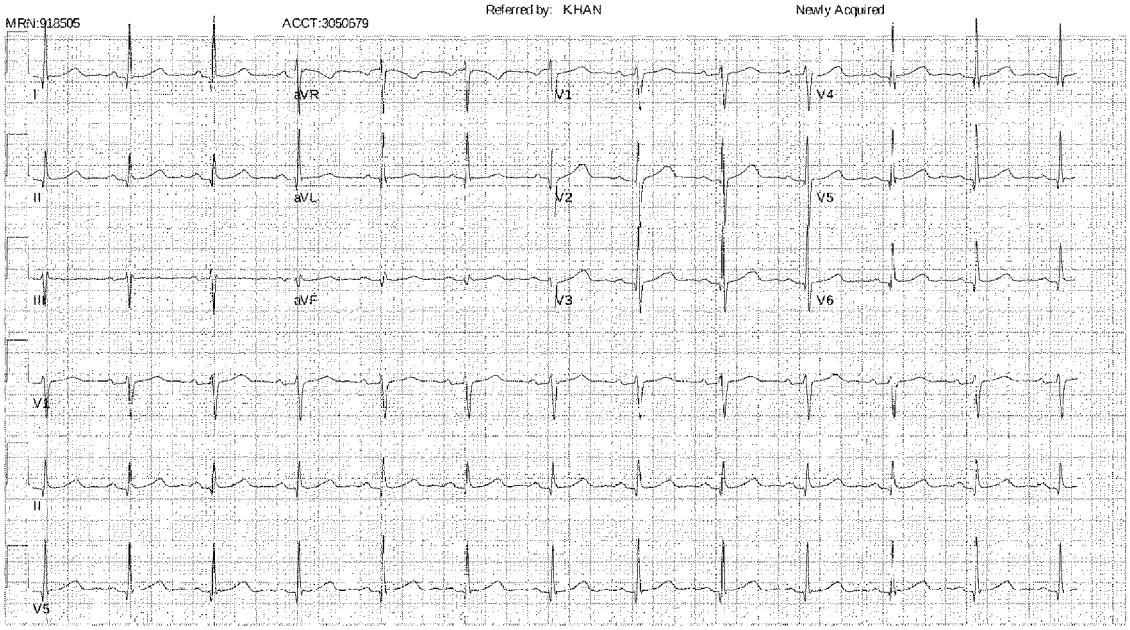
*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Minimal voltage criteria for LVH, may be normal variant
Cannot rule out Inferior infarct , age undetermined
Abnormal ECG
When compared with ECG of 12-JUN-2012 16:13,
Premature ventricular complexes are no longer Present

Technician:K SCARD
Test ind:

Referred by: KHAN

Newly Acquired

MRN:918505 ACCT:3050679



25mm/s 10mm/mV 40Hz 7.1.1 12SL 237 CID: 31

EID:Newly Acquired EDT: ORDER:

Page 1 of 1

*** Auth (Verified) ***

HANNA MD, ADEL
*** PID / NAME MISMATCH ***
29-MAR-1946 (66 yr)
Male

Room:15
Loc:1

ID:0918505

12-JUN-2012 16:13:31

SAN ANTONIO COMMUNITY HOSPITAL-ER ROUTINE RECORD

Vent. rate	61	BPM
PR interval	164	ms
QRS duration	84	ms
QT/QTc	440/442	ms
P-R-T axes	31 13	41

Sinus rhythm with occasional Premature ventricular complexes
Otherwise normal ECG

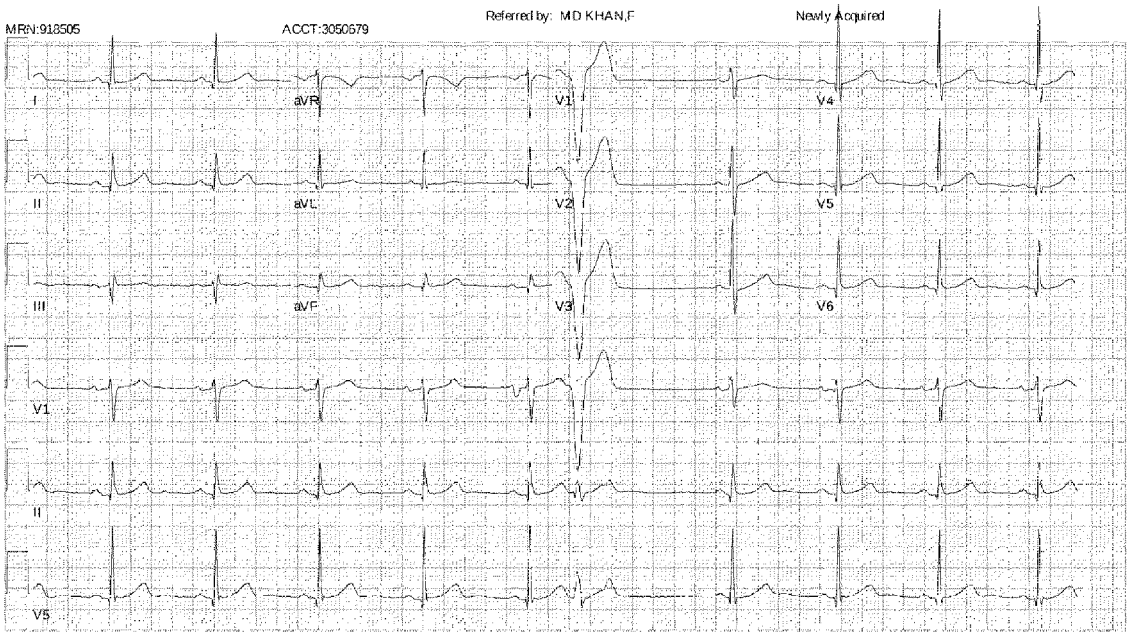
Technician: PC
Test ind:

Referred by: MD KHAN,F

Newly Acquired

MRN:918505

ACCT:3050679



25mm/s 10mm/mV 40Hz 7.1.1 12SL 237 CID: 31

EID:Newly Acquired EDT: ORDER:

Page 1 of 1

Facility: SARH

*** Auth (Verified) ***

HANNA, ADEL S MD | ID:0918505 | 13-JUN-2012 08:33:39 | SAN ANTONIO COMMUNITY HOSPITAL-3RD ROUTINE RECORD

29-MAR-1946 (66 yr)
Male
01b
Room:346
Loc:8

Vent. rate	60	BPM
PR interval	210	ms
QRS duration	88	ms
QT/QTc	442/442	ms
P-R-T axes	24 -2 37	

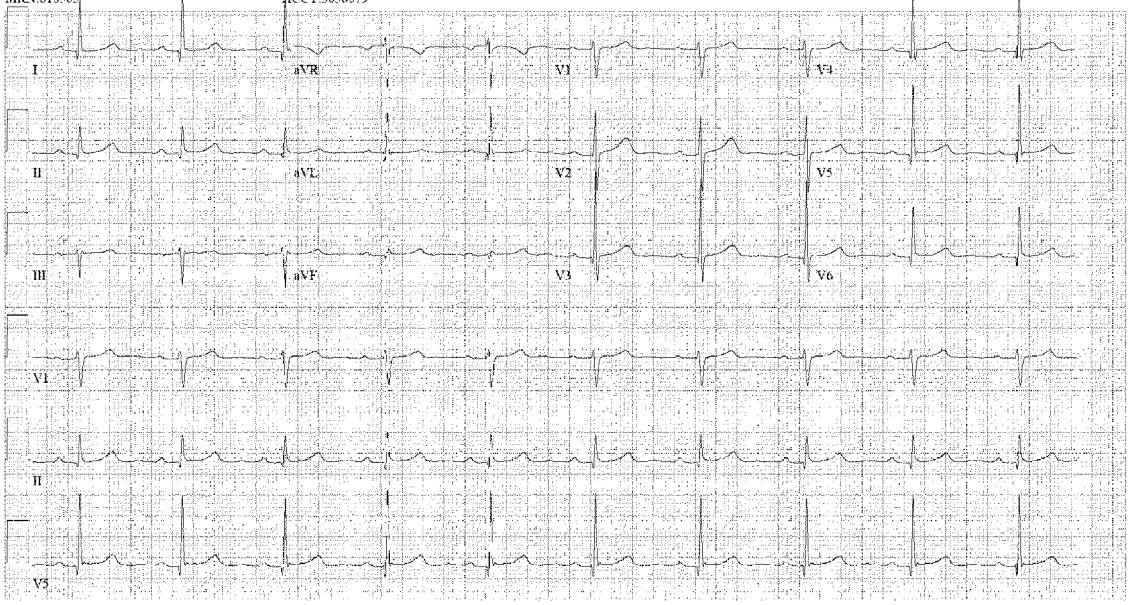
Sinus rhythm with 1st degree A-V block
Minimal voltage criteria for LVH, may be normal variant
Borderline ECG
When compared with ECG of 12-JUN-2012 17:33,
PR interval has increased
Minimal criteria for Inferior infarct are no longer Present

Technician:M N CARD
Test ind:

Referred by: AGARWAL

Newly Acquired

MRN:818505 ACCT:3050679



25mm/s 10mm/mV 40Hz 7.1.1 12SL 235 CID: 3

EID:Newly Acquired EDT: ORDER:

Page 1 of 1

*** Auth (Verified) ***

HANNA, ADEL S MD | ID:0918505 | 12-JUN-2012 16:13:31 | SAN ANTONIO COMMUNITY HOSPITAL-ER ROUTINE RECORD

29-MAR-1946 (66 yr)
Male
0lb
Room:15
Loc:1

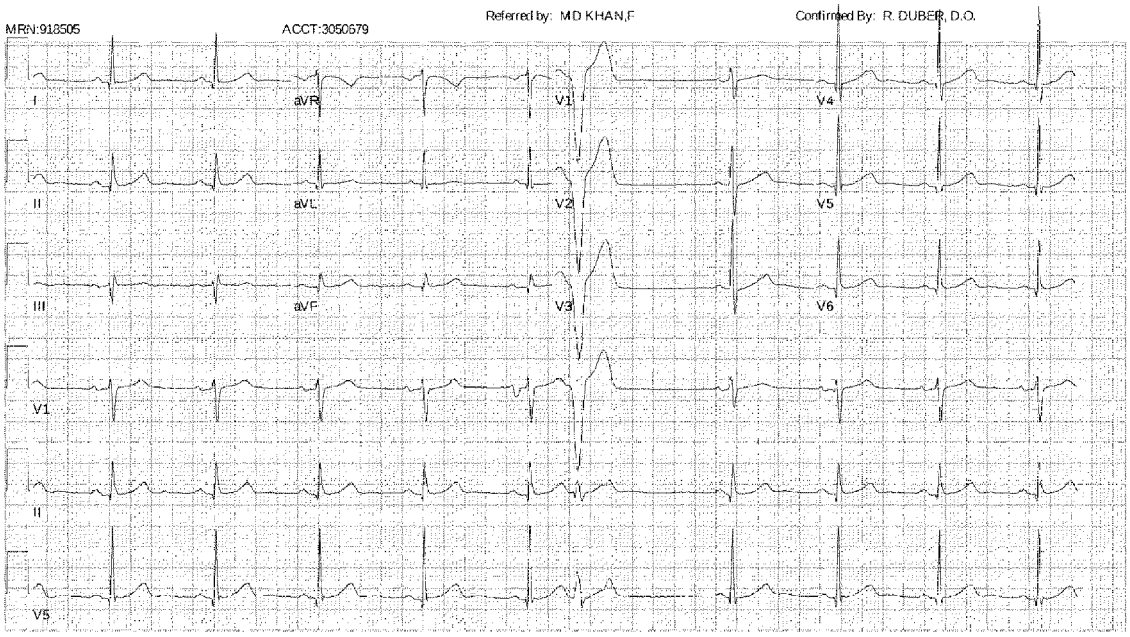
Vent. rate	61	BPM
PR interval	164	ms
QRS duration	84	ms
QT/QTc	440/442	ms
P-R-T axes	31 13	41

Sinus rhythm with occasional Premature ventricular complexes
Otherwise normal ECG
When compared with ECG of 10-MAR-2006 07:07,
Premature ventricular complexes are now Present

Technician: PC
Test ind:

Referred by: MD KHAN,F
Confirmed By: R. DUBER, D.O.

MRN:918505 ACCT:3050679



25mm/s 10mm/mV 40Hz 7.1.1 12SL 237 CID: 31

EID:90 EDT: 14:00 15-JUN-2012 ORDER:

Page 1 of 1

Facility: SARH

*** Auth (Verified) ***

HANNA, ADEL S MD | ID:0918505 | 12-JUN-2012 17:33:47 | SAN ANTONIO COMMUNITY HOSPITAL-ER ROUTINE RECORD

29-MAR-1946 (66 yr)
Male
0lb
Room:15
Loc:1

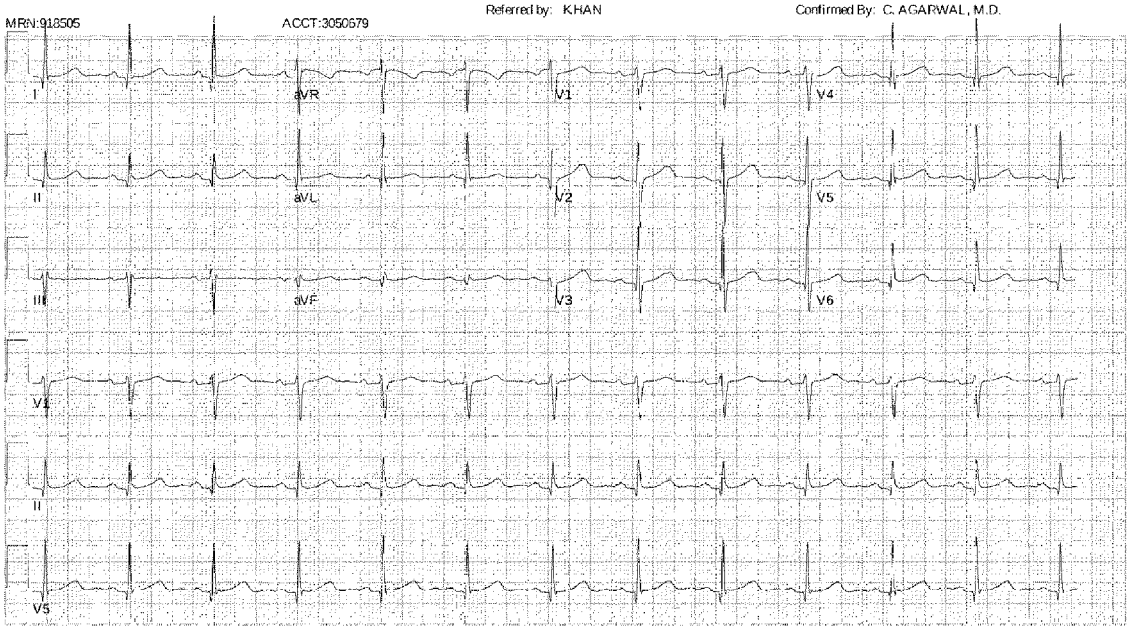
Vent. rate	74	BPM	
PR interval	180	ms	
QRS duration	84	ms	
QT/QTc	430/477	ms	
P-R-T axes	29 -6 26		

*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Minimal voltage criteria for LVH, may be normal variant
Abnormal ECG
When compared with ECG of 12-JUN-2012 16:13,
Premature ventricular complexes are no longer Present

Technician:K SCARD
Test ind:

Referred by: KHAN
Confirmed By: C. AGARWAL, M.D.

MRN:918505 ACCT:3050679



25mm/s 10mm/mV 40Hz 7.1.1 12SL 237 CID: 31

EID:37 EDT: 16:05 14-JUN-2012 ORDER:

Page 1 of 1

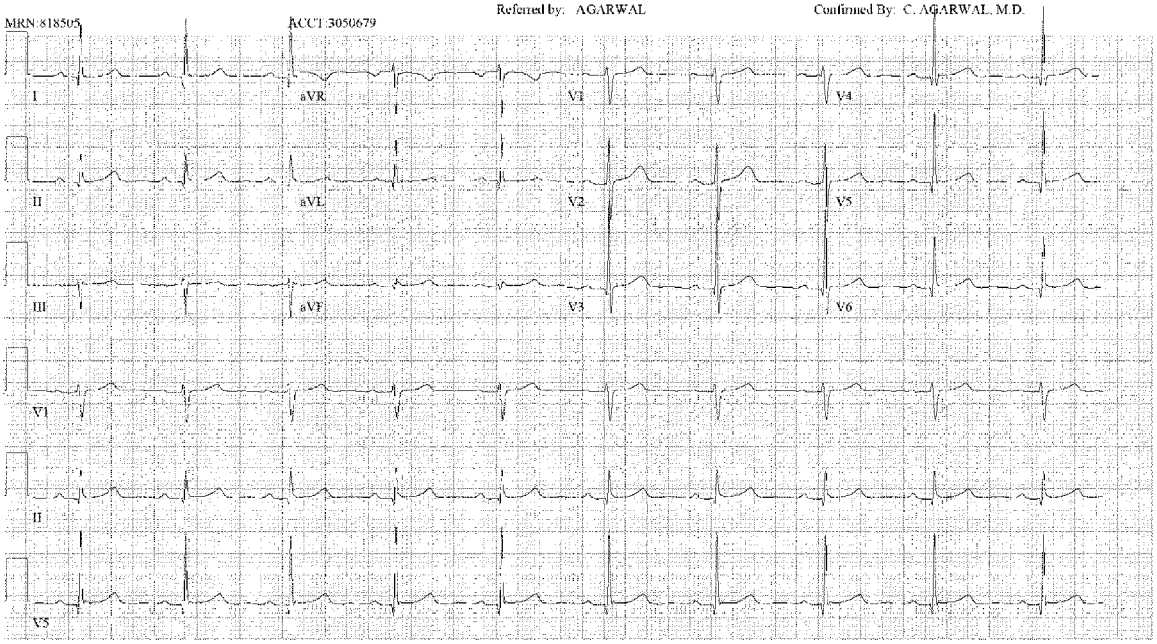
*** Auth (Verified) ***

HANNA, ADEL S MD ID:0918505 13-JUN-2012 08:33:39 SAN ANTONIO COMMUNITY HOSPITAL-3RD ROUTINE RECORD

29-MAR-1946 (66 yr)	Vent. rate	60	BPM	Sinus rhythm with 1st degree A-V block
Male	PR interval	210	ms	Minimal voltage criteria for LVH, may be normal variant
0lb	QRS duration	88	ms	Borderline ECG
Room:346	QT/QTc	442/442	ms	When compared with ECG of 12-JUN-2012 17:33,
Loc:8	P-R-T axes	24 -2 37		PR interval has increased
				Minimal criteria for Inferior infarct are no longer Present

Technician:M N CARD
Test ind:

Referred by: AGARWAL Confirmed By: C. AGARWAL, M.D.



25mm/s 10mm/mV 40Hz 7.1.1 12SL 235 CID: 3 EID:37 EDT: 16:05 14-JUN-2012 ORDER:

Page 1 of 1

Patient:	**HANNA MD, ADEL SHAKER**				
MRN:	918505	**DOB/Age/Sex:**	3/29/1946	76 years	Male
FIN:	3050679	**Admit/Disch:**	6/12/2012	6/14/2012	
Patient Type:	Day Patient	**Admitting:**			
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.				

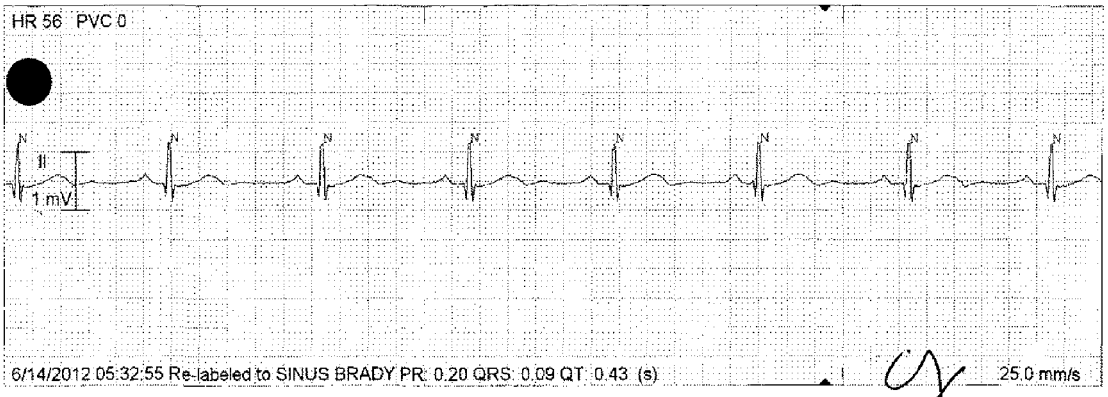
Telemetry Strip

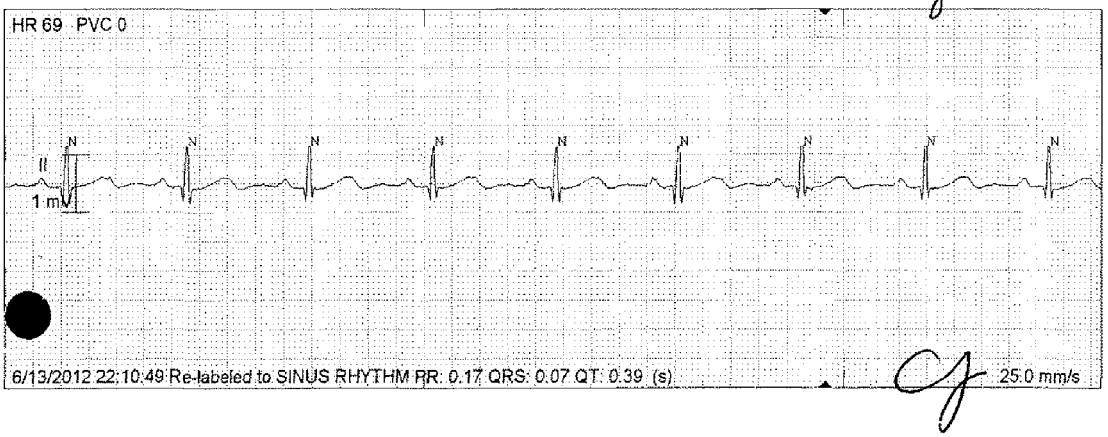
*** Auth (Verified) ***

HANNA, ADEL

346-B

Alarm Review

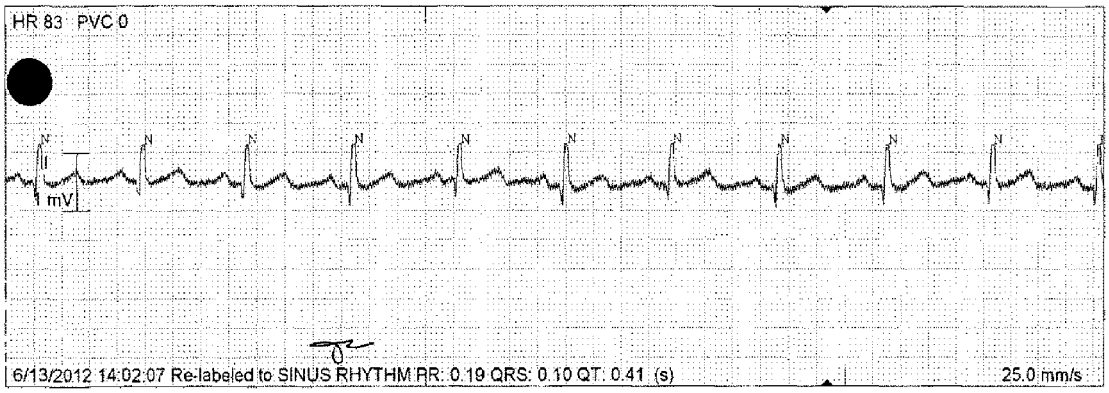




*** Auth (Verified) ***

HANNA, ADEL 346-B

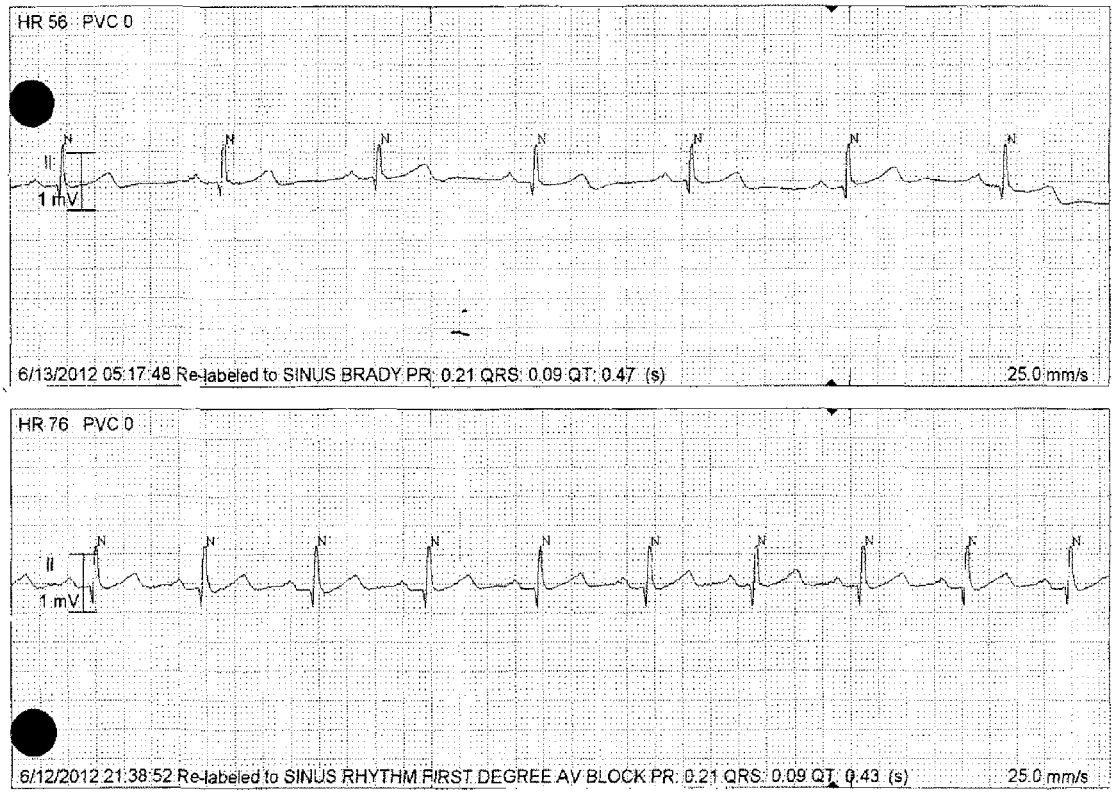
Alarm Review



*** Auth (Verified) ***

HANNA, ADEL 346-B

Alarm Review



BPM

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiology Procedures

Document Name: Cardiac Procedures
Result Status: Auth (Verified)
Performed By: Agarwal M.D.,Chandrahas (6/13/2012 11:28 PDT)
Authenticated By: Agarwal M.D.,Chandrahas (6/16/2012 12:04 PDT)

CARDIAC PROCEDURES

Patient: HANNA, ADEL
Account#: 3050679
MR#: 0918505
Physician: Chandrahas Agarwal, MD PCODE: 12
Location: 3DOUW 346B
Report: CARDIAC PROCEDURE

PROCEDURE DATE: 06/13/2012

INDICATION: Chest pain, hypertension, gastroesophageal reflux disease with history of fundoplication, hiatal hernia.

PROCEDURE:
1. Left heart catheterization.
2. Selective left and right coronary angiography.
3. Left ventriculography.
4. Right femoral artery angiography.

PROCEDURE IN DETAIL: After informed consent was obtained, the patient was brought to the cardiac catheterization lab in a fasting state. A time-out was called by Sidney, RN. Then the patient was given 1 mg of Versed and 50 mcg of fentanyl IV. Using 1% lidocaine, local anesthesia of the right groin was achieved. Under fluoroscopic and anatomic landmark guidance, the right femoral artery was cannulated by an 18-gauge Cook needle, and a 6-French sheath with sidearm was placed after using a J-tipped wire. Through this, a 6-French JL4 diagnostic catheter was advanced which engaged the left coronary ostium without difficulty, and left coronary angiography was performed in LAO, RAO with cranial and caudal angulation. This catheter was a little bit short but was able to engage the left coronary ostium. This catheter was then withdrawn and exchanged for a 6-French JR4 diagnostic catheter which engaged the right coronary ostium without difficulty, and right coronary angiography was then performed in the LAO, RAO and AP cranial projection. This catheter was then withdrawn and exchanged for a 6-French pigtail catheter which crossed the aortic valve without difficulty, and left ventriculography was then performed in the RAO projection. There was no gradient across the aortic valve on pull-back. This catheter was then withdrawn. The right femoral artery angiography was performed through the right femoral artery sheath in RAO caudal projection.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiology Procedures

The patients blood pressure was 168 systolic. He was given 15 mg of hydralazine and the blood pressure subsequently was 147 systolic. The right femoral artery sheath was removed and hemostasis obtained by direct manual compression in the cardiac catheterization lab. The patient tolerated the procedure well. There were no complications.

The patient was explained the findings of the angiogram, and continued medical treatment was advised with cardiac risk factor reduction for no significant coronary artery disease. The patient was given an additional 1 mg of Versed at the end of the procedure.

TOTAL FLUOROSCOPY TIME: 2.4 minutes.

CONTRAST USED: 120 mL.

FINDINGS:
HEMODYNAMICS: The left ventricular pressure is 169/3 with end-diastolic of 21. Aortic root pressure was 161/81 with mean of 110. No gradient across the aortic valve on pull-back.

LEFT VENTRICULOGRAPHY: Left ventriculography reveals normal left ventricular wall motion. Ejection fraction is 60% on visual assessment. There is no mitral regurgitation.

CORONARY ANGIOGRAPHY: Coronary angiography reveals the left main coronary artery to be normal. The left anterior descending coronary artery only has mil luminal irregularities. It reaches up to the apex and wraps around the apex. The 1st diagonal branch is a medium caliber vessel with no significant disease. The circumflex coronary artery is normal. The 1st obtuse marginal is small. The 2nd obtuse marginal is a larger vessel and is also normal. The circumflex coronary artery itself is normal. The right coronary artery is a large caliber vessel with mild luminal irregularities up to 10% to 20% in the midpart. It is a 4.0-mm vessel. It is a dominant vessel and otherwise has no significant disease. The right femoral artery is normal. Insertion site is above the bifurcation.

CONCLUSION:
1. Normal left ventricular function, ejection fraction 60%, no mitral regurgitation.
2. Mild coronary artery disease involving the mid left anterior descending in the form of luminal irregularities and the mid right coronary artery as noted above with a right dominant system.

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Cardiology Procedures

Dictated By:_____
Chandrahas Agarwal, MD

CA/5554610
DD: 06/13/2012 11:31
TD: 06/13/2012 21:41

Job #: 803924
SSI File#: 0069000000060613201211282813 7
CC:

Transcribed by: CONTRIBUTOR_SYSTEM
Transcribed Date/Time: 06/13/2012 09:44 PM

Signed by: Agarwal M.D., Chandrahas
Signed Date/Time: 06/16/2012 12:04 PM

Cardiac Catheterization

*** Auth (Verified) ***

SACH - Cardiac Catheterization Lab

PATIENT DATA

DATE	ACCOUNT	MRN	ROOM#
6/13/2012	3050679	918505	

ACCESSION	EMPI	ADMIT DATE
		6/13/2012

PATIENT	SSN#	RACE
HANNA, ADEL		

ADDRESS 1	ZIP	PHONE

ADDRESS 2	INSURANCE

GENDER	HEIGHT (IN)	HEIGHT (CM)	PID
MALE	68	172	

DOB	AGE	BSA (M2)	WEIGHT (LB)	WEIGHT (KG)	FLUORO (MIN)
3/29/1946	66 y	1.91	172	78.1	2.4

KNOWN ALLERGIES: REGLAN

CONTRAST #1	USED #1 (ML)	CONTRAST #2	USED #2 (ML)	TOTAL (ML)	CREAT CLR.
Isovue	120			120	80.3

LAB VALUES

HGB	HCT	WBC	PLT	PT	INR	PTT	GLU	K+	NA+	BUN	CREAT
14.9					1.02			4			1

HGB (g/l)	HCT (SI)	GLU (mmol/l)	K+ (mmol/l)	NA+ (mmol/l)	BUN (mmol/l)	CREAT (umol/l)	CREAT CLR (ml/s)
149			4			88.4	1.341

EVENT TIMES

PATIENT IN	READY	PHYS PAGED	BEGIN TIME	END TIME	PATIENT OUT
10:11:11	10:40:37		10:48:09	11:04:56	11:32:47

PROCEDURE

Left Heart Cath/ Coronary Angio with LV gram

STAFF

Agarwal, Chandrahas MD	Physician
Hendricks, Sydney RN	Nurse
Segura, Michael RT	Scrub
Gonzalez, Enrique RT	X-Ray Tech

* Auth (Verified) *

CASE SYNOPSIS

Name: HANNA, ADEL	Date: 6/13/2012
MRN: 918505	Left Heart Cath/ Coronary Angio with LV gram

Pre Procedure Notes

06/13/2012 10:11:11	Patient arrived to holding/prep/recovery area: via gurney/bed w/ ACLS RN/RT and monitor from 3rd DOU West (Telemetry)
06/13/2012 10:11:12	Plan of Care: Hemodynamics will remain stable.
06/13/2012 10:11:12	Plan of Care: Cardiac rhythm will remain stable.
06/13/2012 10:11:12	Plan of Care: Comfort level will be maintained.
06/13/2012 10:11:12	Plan of Care: Respiratory function will remain adequate.
06/13/2012 10:11:12	Plan of Care: Temperature will be maintained.
06/13/2012 10:11:12	Plan of Care: Patient/Family verbalizes understanding of procedure.
06/13/2012 10:11:12	Plan of Care: Procedure tolerated without complications.
06/13/2012 10:11:12	Plan of Care: Recovers from procedure without complications.
06/13/2012 10:11:18	Pre-Op check list performed and documented in ICIS.
06/13/2012 10:11:19	ID Band on patient, ID and account number verified.
06/13/2012 10:11:19	Informed Consent and Physician verified.
06/13/2012 10:11:49	NPO Status: NPO since 1900 YESTERDAY
06/13/2012 10:11:54	Family not available.
06/13/2012 10:11:57	Aldrete Color: Pink (2)
06/13/2012 10:11:57	Aldrete Consciousness: Fully awake (2)
06/13/2012 10:11:57	Aldrete Circulation: BP +/- 20 mmHg of pre-anesthetic level (2)
06/13/2012 10:11:57	Aldrete Respirations: Able to deep breathe and cough (2)
[redacted]3/2012 10:11:57	Aldrete Activity: Able to move 4 extremities (2)
[redacted]3/2012 10:11:57	Total Aldrete Score: 10
06/13/2012 10:17:21	Dr. Agarwal here and speaking to patient. ^FreeText^
06/13/2012 10:21:33	Patient sent to cath lab procedure room.
06/13/2012 10:40:52	Pre Distal Pulses: Bilateral DP & PT present with doppler

Medication(s)

06/13/2012 10:41:48	**All medications administered per verbal orders of Dr. Agarwal , after read back by Sydney Hendricks, RN**
06/13/2012 10:47:00	**{Conscious Sedation} [m] Fentanyl 50 mcg IV (Given By: Hendricks, Sydney RN)**
06/13/2012 10:47:04	**{Conscious Sedation} [m] Versed 1 mg IV (Given By: Hendricks, Sydney RN)**
06/13/2012 11:08:41	**[m] Hydralazine: 15 mg IV (Given By: Hendricks, Sydney RN)**
06/13/2012 11:08:43	**{Conscious Sedation} [m] Versed 1 mg IV (Given By: Hendricks, Sydney RN)**
06/13/2012 11:29:01	**{Conscious Sedation} [m] Fentanyl 50 mcg IV (Given By: Hendricks, Sydney RN)**

* Auth (Verified) *

CASE SYNOPSIS

Name: HANNA, ADEL	Date: 6/13/2012
MRN: 918505	Left Heart Cath/ Coronary Angio with LV gram

Diagnostic Procedure Notes

06/13/2012 10:40:37	Patient prepped with Chloraprep and draped in the usual sterile manner, site: RIGHT groin region.
06/13/2012 10:47:35	TIME OUT TAKEN Correct Patient and Account Number.
06/13/2012 10:47:35	TIME OUT TAKEN Correct Consent and Physician.
06/13/2012 10:47:35	TIME OUT TAKEN Correct Site (if appropriate).
06/13/2012 10:47:35	TIME OUT TAKEN Safety Precautions Based on Patient History or Medication Use.
06/13/2012 10:48:09	Local anesthetic to RIGHT groin region with Lidocaine 1%
06/13/2012 10:52:17	Percutaneous vascular access obtained to the RIGHT Femoral artery, wire advanced without difficul ty. {Diagnostic Wire} Merit Medical J Tip Fixed Core (035) 150cm - Qty: 1 Each Part #: 808
06/13/2012 10:52:34	Sheath inserted over the wire into the RIGHT Femoral artery. {Sheath} Merit Medical 6 FR Prelude I ntro Sheath 11cm - Qty: 1 Each Part #: 783
06/13/2012 10:53:13	Catheter inserted and advanced over the wire. {Diagnostic} Boston Scientific 6 FR FL4 Impulse Cat heter - Qty: 1 Each Part #: 261
06/13/2012 10:54:27	LCA angiography performed in multiple views.
06/13/2012 10:57:49	Catheter exchanged over the wire. {Diagnostic} Boston Scientific 6 FR FR4 Impulse Catheter - Qty: 1 Each Part #: 237
06/13/2012 10:59:17	RCA angiography performed in multiple views.
06/13/2012 11:01:24	Catheter exchanged over the wire. {Diagnostic} Boston Scientific 6 FR Pigtail 145 Impulse Catheter - Qty: 1 Each Part #: 240
06/13/2012 11:03:37	LV Ventriculogram performed. Settings: 12 ml/sec for 36 ml total
06/13/2012 11:04:54	Catheter removed over the wire.
06/13/2012 11:08:57	Signed By: Agarwal, Chandrahas MD
[redacted]3/2012 11:23:43	Signed By: Hendricks, Sydney RN

* Auth (Verified) *

CASE SYNOPSIS

Name: HANNA, ADEL	Date: 6/13/2012
MRN: 918505	Left Heart Cath/ Coronary Angio with LV gram

Post Procedure Notes

06/13/2012 11:04:56	Procedure complete.
06/13/2012 11:05:48	RIGHT femoral angiography performed for closure device eval.
06/13/2012 11:11:49	Arterial sheath(s) - removed with manual compression for 15 mins . A D-Stat hemostasis patch was used. {Closure Device} Vascular Solutions D-Stat Dry Hemostatic Bandage - Qty: 1 Each Part #: 918
06/13/2012 11:20:25	Report called to Tiffany RN on 3rd DOU West
06/13/2012 11:22:59	Total Fluoro Time: 2.4 mins
06/13/2012 11:23:03	Total Fluoro (mGy) dose: 1055.98
06/13/2012 11:23:06	Total Contrast 1: Isovue 120 ml's
06/13/2012 11:23:14	Post ECG Rhythm: Sinus Rhythm
06/13/2012 11:23:16	Post Distal Pulses: Unchanged from pre-assessment.
06/13/2012 11:23:19	Aldrete Color: Pink (2)
06/13/2012 11:23:19	Aldrete Consciousness: Arousable (1)
06/13/2012 11:23:19	Aldrete Circulation: BP +/- 20 mmHg of pre-anesthetic level (2)
06/13/2012 11:23:19	Aldrete Respirations: Able to deep breathe and cough (2)
06/13/2012 11:23:19	Aldrete Activity: Able to move 4 extremities (2)
06/13/2012 11:23:19	Total Aldrete Score: 9
06/13/2012 11:23:21	Patient comfort level: No chest pain, shortness of breath or other complaints.
06/13/2012 11:23:24	IV Site: Unchanged from pre assessment.
[redacted]13/2012 11:23:28	Post instructions given. Patient / Family / Significant Other verbalizes understanding.
[redacted]3/2012 11:23:34	Site status: No bleeding/hematoma noted.
06/13/2012 11:32:47	Patient transferred via gurney/bed with ACLS RN/RT and monitor to 3rd DOU West (Telemetry)

CHARGES

06/13/2012 11:13:57	($) Left Heart Cath/ Coronary Angiography w/ LV gram

* Auth (Verified) *

Sedation

Name: HANNA, ADEL | **Date: 6/13/2012**

MRN: 918505 | **Proc: Left Heart Cath/ Coronary Angio with LV gram**

CURRENT MEDICATIONS

PERTINENT HISTORY

LAST MEAL TIME | SUPPLEMENTAL O2

Sedation Agents

AGENT	DOSE	ROUTE	DATE	TIME	INITIALS
Fentanyl	50 mcg	IV	06/13/2012	10:47:00	SH
Versed	1 mg	IV	06/13/2012	10:47:04	SH
Versed	1 mg	IV	06/13/2012	11:08:43	SH
Fentanyl	50 mcg	IV	06/13/2012	11:29:01	SH

Reversing Agents

AGENT	DOSE	ROUTE	DATE	TIME	INITIALS

* Auth (Verified) *

Sedation

Name: HANNA, ADEL | **Date: 6/13/2012**

MRN: 918505 | **Proc: Left Heart Cath/ Coronary Angio with LV gram**

DATE/TIME	HR	SEQUENCE	NIBP	TEMP	SPO2	ETCO2	RESP	LOC	LOP	RHYTHM
06/13/2012 10:31:00	60	PRE			NO D.		16	4	0	Sinus Rhythm
06/13/2012 10:36:00	62	PRE			95		15	4	0	Sinus Rhythm
06/13/2012 10:41:57	56	PRE	166 / 95		95		17	4	0	Sinus Bradycardia
06/13/2012 10:46:00	54	PRE	142 / 97		95		19	4	0	Sinus Bradycardia
06/13/2012 10:51:00	51	DURING	148 / 101		94		18	3	0	Sinus Bradycardia
06/13/2012 10:56:00	63	DURING	161 / 93		95		15	3	0	Sinus Rhythm
06/13/2012 11:01:00	60	DURING	163 / 86		93		16	3	0	Sinus Rhythm
06/13/2012 11:06:00	64	POST	159 / 93		95		15	3	0	Sinus Rhythm
06/13/2012 11:10:25	71	POST	145 / 94		92		16	3	0	Manual
06/13/2012 11:15:01	68	POST	141 / 85		96		15	3	0	Sinus Rhythm
06/13/2012 11:20:01	70	POST	142 / 87		96		15	3	0	Sinus Rhythm
06/13/2012 11:25:01	68	POST	153 / 84		97		16	3	0	Sinus Rhythm

Level of Consciousness
0 = Unresponsive
1 = Sedated, difficult to arouse
2 = Sedated, easy to arouse
3 = Asleep
4 = Awake, Alert

Level of Pain
0 = No Pain
1 = Minimal Pain
2 = Minimal Pain
3 = Minimal to Moderate Pain
4 = Minimal to Moderate Pain
5 = Moderate Pain
6 = Moderate Pain
7 = Moderate to Severe Pain
8 = Moderate to Severe Pain
9 = Severe Pain
10 = Severe Pain

* Auth (Verified) *

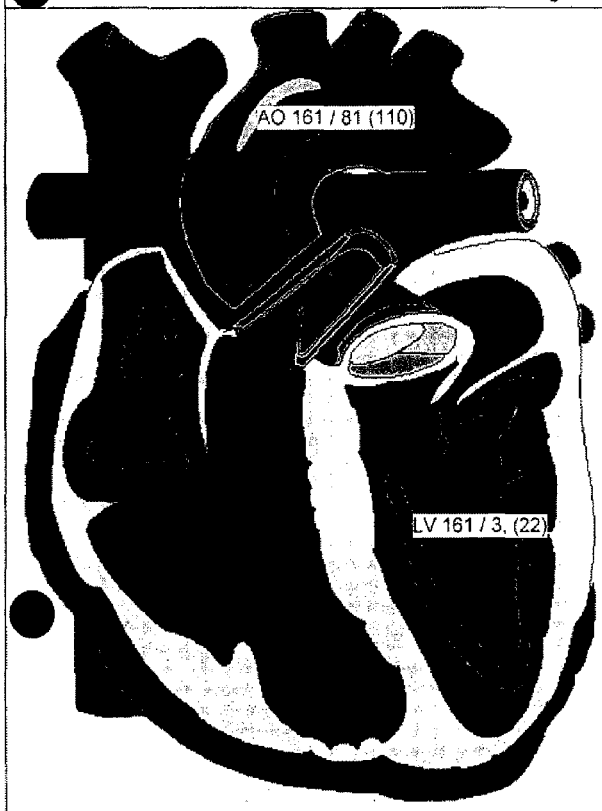
HEMODYNAMICS

Name: HANNA, ADEL | **Date: 6/13/2012**

MRN: 918505 | **Proc: Left Heart Cath/ Coronary Angio with LV gram**

nd: CONDITION 1 BSA: 1.91 m^2 Hgb: 14.9 Hgb (g/l): 149.00 K_{O2} 133 Est O_2 254.03 ml

Heart Rate: 62



Samples

ECG	6		62	10:40:26
AO	161 / 81	(110) SA	54	10:54:01
LV	161 / 3,	22	56	11:02:10
LV	169 / 3,	21	58	11:02:16
LVp	146 / 1,	18	61	11:04:31
AOp	155 / 79	(108)	60	11:04:36

Morphology: Normal Heart

Resistance(D/S) (D/DI)		O2 Content(ml/l)	O2 Difference(ml/l)	Flows (l/min)	
PVR:		SA O2:	SA-SV (AV):	Qp:	Qpi:
TPVR:		SV O2:	PV-PA (VA):	Qs:	Qsi:
SVR:		PV O2:	PV-SV (VV):	Qe:	Qei:
TSVR:		PA O2:		Qp/Qs:	
PVR/SVR:				L>R:	
TPVR/TSVR:				R/L:	

CO(l/min) SV(ml)	CO	CI
Fick	*	
Thermal		
Angio		

* Used In Calculations

Valve	P-p	mean	msec	HR	cm^2	index
Aortic						
Mitral:						
Pulmic:						
Tricus:						
Other:						

Angio LV	RV
Diast:	
Syst:	
EF:	
RF:	

HANNA, ADEL MRN: 918505, DOB: 3/29/1946 — 7 — Printed On: 06/13/2012 11:33:19
Attending: Agarwal, Chandrahas MD — CaseID: WA000068
SACH - Cardiac Catheterization Lab — Xper.IM - Philips

* Auth (Verified) *

PROCEDURE LOG

Name: HANNA, ADEL | **Date: 6/13/2012**

MRN: 918505 | **Proc: Left Heart Cath/ Coronary Angio with LV gram**

6/13/2012 10:11:11	Patient arrived to holding/prep/recovery area: via gurney/bed w/ ACLS RN/RT and monitor from 3rd DOU West (Telemetry) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Hemodynamics will remain stable. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Cardiac rhythm will remain stable. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Comfort level will be maintained. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Respiratory function will remain adequate. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Temperature will be maintained. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Patient/Family verbalizes understanding of procedure. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Procedure tolerated without complications. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:12	Plan of Care: Recovers from procedure without complications. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:18	Pre-Op check list performed and documented in ICIS. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:19	ID Band on patient, ID and account number verified. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:19	Informed Consent and Physician verified. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:49	NPO Status: NPO since 1900 YESTERDAY (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:54	Family not available. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Aldrete Color: Pink (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Aldrete Consciousness: Fully awake (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Aldrete Circulation: BP +/- 20 mmHg of pre-anesthetic level (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Aldrete Respirations: Able to deep breathe and cough (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Aldrete Activity: Able to move 4 extremities (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 10:11:57	Total Aldrete Score: 10 (Entered By: Hendricks, Sydney RN)
6/13/2012 10:17:21	Dr. Agarwal here and speaking to patient. ^FreeText^ (Entered By: Hendricks, Sydney RN)
6/13/2012 10:21:33	Patient sent to cath lab procedure room. (Entered By: Hendricks, Sydney RN)
[redacted]/2012 10:31:00	HR: 60, PRE, LOC: 4 , LOP: 0 , RESP: 16, SPO2: NO DATA, NOTES: Sinus Rhythm
[redacted]/2012 10:36:00	HR: 62, PRE, LOC: 4 , LOP: 0 , RESP: 15, SPO2: 95, NOTES: Sinus Rhythm
6/13/2012 10:40:37	Patient prepped with Chloraprep and draped in the usual sterile manner, site: RIGHT groin region. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:40:52	Pre Distal Pulses: Bilateral DP & PT present with doppler (Entered By: Hendricks, Sydney RN)
6/13/2012 10:41:48	**All medications administered per verbal orders of Dr. Agarwal , after read back by Sydney Hendricks, RN (Entered By: Hendricks, Sydney RN)**
6/13/2012 10:41:57	HR: 56, PRE, NIBP: 166 / 95 , LOC: 4 , LOP: 0 , RESP: 17, SPO2: 95, NOTES: Sinus Bradycardia
6/13/2012 10:46:00	HR: 54, PRE, NIBP: 142 / 97 , LOC: 4 , LOP: 0 , RESP: 19, SPO2: 95, NOTES: Sinus Bradycardia
6/13/2012 10:47:00	**{Conscious Sedation} [m] Fentanyl 50 mcg IV (Given By: Hendricks, Sydney RN) (Entered By: Hendricks, Sydney RN)**
6/13/2012 10:47:04	**{Conscious Sedation} [m] Versed 1 mg IV (Given By: Hendricks, Sydney RN) (Entered By: Hendricks, Sydney RN)**
6/13/2012 10:47:35	TIME OUT TAKEN Correct Patient and Account Number. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:47:35	TIME OUT TAKEN Correct Consent and Physician. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:47:35	TIME OUT TAKEN Correct Site (if appropriate). (Entered By: Hendricks, Sydney RN)
6/13/2012 10:47:35	TIME OUT TAKEN Safety Precautions Based on Patient History or Medication Use. (Entered By: Hendricks, Sydney RN)
6/13/2012 10:48:09	Local anesthetic to RIGHT groin region with Lidocaine 1% (Entered By: Hendricks, Sydney RN)
6/13/2012 10:51:00	HR: 51, DURING, NIBP: 148 / 101 , LOC: 3 , LOP: 0 , RESP: 18, SPO2: 94, NOTES: Sinus Bradycardia
6/13/2012 10:52:17	Percutaneous vascular access obtained to the RIGHT Femoral artery, wire advanced without difficulty. {Diagnostic Wire} Merit Medical J Tip Fixed Core (035) 150cm - Qty: 1 Each Part #: 808 (Entered By: Hendricks, Sydney RN)
6/13/2012 10:52:34	Sheath inserted over the wire into the RIGHT Femoral artery. {Sheath} Merit Medical 6 FR Prelude Intro Sheath 11cm - Qty: 1 Each Part #: 783 (Entered By: Hendricks, Sydney RN)
[redacted]/2012 10:53:13	Catheter inserted and advanced over the wire. {Diagnostic} Boston Scientific 6 FR FL4 Impulse Catheter - Qty: 1 Each Part #: 261 (Entered By: Hendricks, Sydney RN)
6/13/2012 10:54:27	LCA angiography performed in multiple views. (Entered By: Hendricks, Sydney RN)

* Auth (Verified) *

PROCEDURE LOG

Name: HANNA, ADEL | **Date: 6/13/2012**

MRN: 918505 | **Proc: Left Heart Cath/ Coronary Angio with LV gram**

6/13/2012 10:56:00	HR: 63, DURING, NIBP: 161 / 93 , LOC: 3 , LOP: 0 , RESP: 15, SPO2: 95, NOTES: Sinus Rhythm
6/13/2012 10:57:49	Catheter exchanged over the wire. {Diagnostic} Boston Scientific 6 FR FR4 Impulse Catheter - Qty: 1 Each Part #: 237 (Entered By: Hendricks, Sydney RN)
6/13/2012 10:59:17	RCA angiography performed in multiple views. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:01:00	HR: 60, DURING, NIBP: 163 / 86 , LOC: 3 , LOP: 0 , RESP: 16, SPO2: 93, NOTES: Sinus Rhythm
6/13/2012 11:01:24	Catheter exchanged over the wire. {Diagnostic} Boston Scientific 6 FR Pigtail 145 Impulse Catheter - Qty: 1 Each Part #: 240 (Entered By: Hendricks, Sydney RN)
6/13/2012 11:03:37	LV Ventriculogram performed. Settings: 12 ml/sec for 36 ml total (Entered By: Hendricks, Sydney RN)
6/13/2012 11:04:54	Catheter removed over the wire. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:04:56	Procedure complete. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:05:48	RIGHT femoral angiography performed for closure device eval. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:06:00	HR: 64, POST, NIBP: 159 / 93 , LOC: 3 , LOP: 0 , RESP: 15, SPO2: 95, NOTES: Sinus Rhythm
6/13/2012 11:08:41	**[m] Hydralazine: 15 mg IV (Given By: Hendricks, Sydney RN) (Entered By: Hendricks, Sydney RN)**
6/13/2012 11:08:43	**{Conscious Sedation} [m] Versed 1 mg IV (Given By: Hendricks, Sydney RN) (Entered By: Hendricks, Sydney RN)**
6/13/2012 11:08:57	Signed By: Agarwal, Chandrahas MD (Entered By: Agarwal, Chandrahas MD)
6/13/2012 11:10:25	HR: 71, POST, NIBP: 145 / 94 , LOC: 3 , LOP: 0 , RESP: 16, SPO2: 92, NOTES: Manual
6/13/2012 11:11:49	Arterial sheath(s) - removed with manual compression for 15 mins . A D-Stat hemostasis patch was used. {Closure Device} Vascular Solutions D-Stat Dry Hemostatic Bandage - Qty: 1 Each Part #: 918 (Entered By: Hendricks, Sydney RN)
6/13/2012 11:13:57	(S) Left Heart Cath/ Coronary Angiography w/ LV gram (Entered By: Hendricks, Sydney RN)
[redacted]/2012 11:15:01	HR: 68, POST, NIBP: 141 / 85 , LOC: 3 , LOP: 0 , RESP: 15, SPO2: 96, NOTES: Sinus Rhythm
[redacted]/2012 11:20:01	HR: 70, POST, NIBP: 142 / 87 , LOC: 3 , LOP: 0 , RESP: 15, SPO2: 96, NOTES: Sinus Rhythm
6/13/2012 11:20:25	Report called to Tiffany RN on 3rd DOU West (Entered By: Hendricks, Sydney RN)
6/13/2012 11:22:59	Total Fluoro Time: 2.4 mins (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:03	Total Fluoro (mGy) dose: 1055.98 (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:06	Total Contrast 1: Isovue 120 ml's (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:14	Post ECG Rhythm: Sinus Rhythm (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:16	Post Distal Pulses: Unchanged from pre-assessment. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Aldrete Color: Pink (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Aldrete Consciousness: Arousable (1) (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Aldrete Circulation: BP +/- 20 mmHg of pre-anesthetic level (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Aldrete Respirations: Able to deep breathe and cough (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Aldrete Activity: Able to move 4 extremities (2) (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:19	Total Aldrete Score: 9 (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:21	Patient comfort level: No chest pain, shortness of breath or other complaints. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:24	IV Site: Unchanged from pre assessment. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:28	Post instructions given. Patient / Family / Significant Other verbalizes understanding. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:34	Site status: No bleeding/hematoma noted. (Entered By: Hendricks, Sydney RN)
6/13/2012 11:23:43	Signed By: Hendricks, Sydney RN (Entered By: Hendricks, Sydney RN)
6/13/2012 11:25:01	HR: 68, POST, NIBP: 153 / 84 , LOC: 3 , LOP: 0 , RESP: 16, SPO2: 97, NOTES: Sinus Rhythm
6/13/2012 11:29:01	**{Conscious Sedation} [m] Fentanyl 50 mcg IV (Given By: Hendricks, Sydney RN) (Entered By: Hendricks, Sydney RN)**
6/13/2012 11:32:47	Patient transferred via gurney/bed with ACLS RN/RT and monitor to 3rd DOU West (Telemetry) (Entered By: Hendricks, Sydney RN)

* Auth (Verified) *

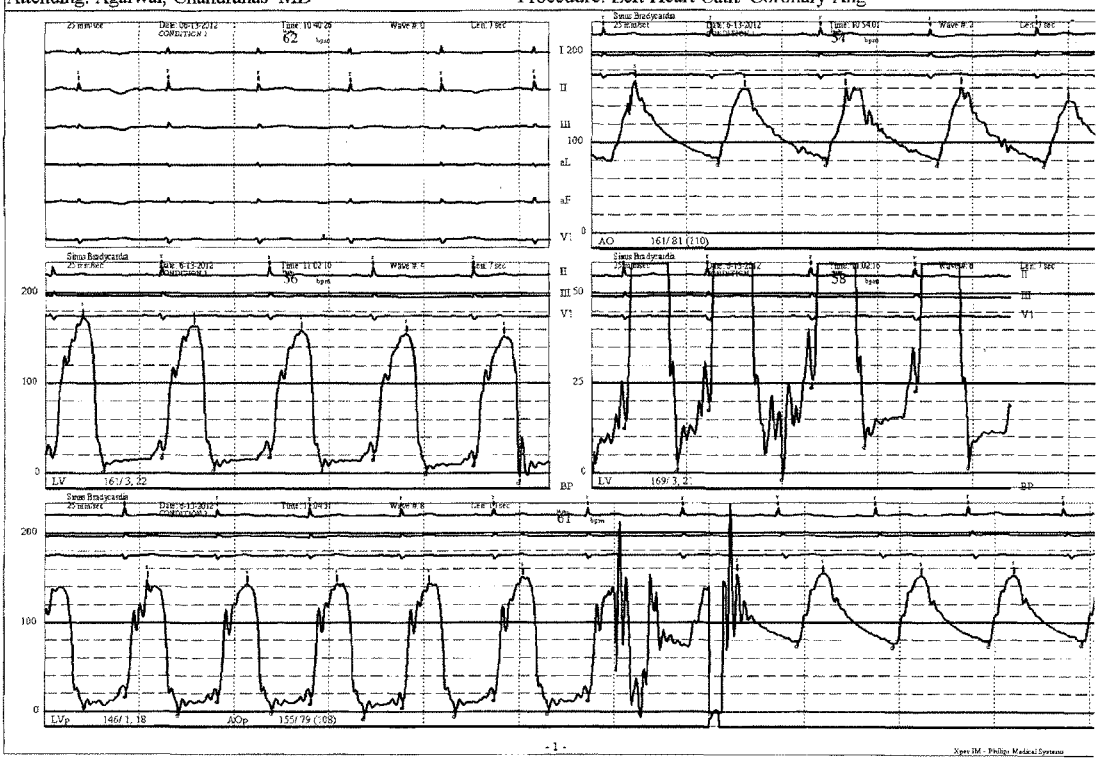
PROCEDURE LOG

Name: HANNA, ADEL	Date: 6/13/2012
MRN: 918505	Proc: Left Heart Cath/ Coronary Angio with LV gram

Signed By: Agarwal, Chandrahas MD On Jun 13 2012 11:08AM

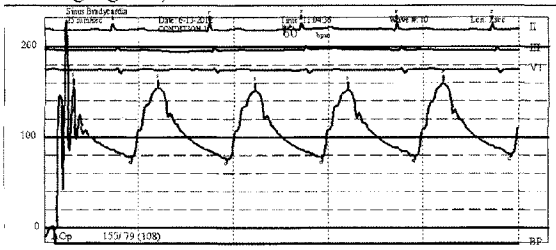
Signed By: Hendricks, Sydney RN On Jun 13 2012 11:23AM

HANN[redacted]ADEL I[redacted]918505 6-[redacted]2012
Attending: Agarwal, Chandrahas MD
Procedure: Left Heart Cath/ Coronary Ang



Patient Name: HANNA MD, ADEL SHAKER
Date of Birth: 3/29/1946

HANN[redacted]ADEL I[redacted]918505 6-[redacted]2012
Attending: Agarwal, Chandrahas MD Procedure: Left Heart Cath/ Coronary Ang



* Auth (Verified) *

Xper IM - Philips Medical Systems

* Auth (Verified) *

Patient Charges

Name: HANNA, ADEL | **Date:** 6/13/2012

MRN: 918505 | **Proc:** Left Heart Cath/ Coronary Angio with LV gram

ACCT: 3050679

Charge Code	Charge Description	Part Number	Processed	Credit	Cost	Qty	Total Cost	CPT	Mod
437-1101	6 FR FL4 Impulse Catheter	261			0.00	1	0.00		
437-1101	6 FR FR4 Impulse Catheter	237			0.00	1	0.00		
437-1101	6 FR Pigtail 145 Impulse Catheter	240			0.00	1	0.00		
437-1115	6 FR Prelude Intro Sheath 11cm	783			0.00	1	0.00		
437-1280	D-Stat Dry Hemostatic Bandage	918			0.00	1	0.00		
437-1104	J Tip Fixed Core (035) 150cm	808			0.00	1	0.00		
437-0008	Left Heart Cath/ Coronary Angio with LV gram				0.00	1	0.00	93458	

Total Charges $0.00

Patient:	**HANNA MD, ADEL SHAKER**				
MRN:	918505	**DOB/Age/Sex:**	3/29/1946	76 years	Male
FIN:	3050679	**Admit/Disch:**	6/12/2012	6/14/2012	
Patient Type:	Day Patient	**Admitting:**			
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.				

IBEX

* Auth (Verified) *

San Antonio Community Hospital
EMERGENCY FLOW SHEET RECORD
Name: Hanna, Adel S Age: 66Y MR: 0918505 Acct: 3050679

VITAL SIGNS	MWI	MIP2	MIP2	JMU
TIME	6/12/2012 20:00	6/12/2012 18:59	6/12/2012 17:43	6/12/2012 16:04
BP	151/96	136/98	159/98	146/91
PULSE	76	72	65	64
RESP	12	18	18	20
TEMP				97.4 ta
PAIN	0	0	5	7
O2 SAT	97 on ra	97 on ra	99 on ra	99 on ra

Name: Hanna, Adel S Age: 66Y MR: 0918505 Acct: 3050679
Prepared: Tue Jun 12, 2012 21:34:01 by Page: 1

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

Patient Data

Complaint: CHEST PAIN
Triage Time: Tue Jun 12, 2012 16:06
Urgency: ESI – 2 (Emergent)
Bed: ED ED
Initial Vital Signs: 6/12/2012 16:04
BP:146/91
P:64
O2 sat:99 on ra
ED Attending: Razo, MD, Paul
Primary RN: Wirtz, RN, Marc
R:20
T:97.4 ta
Pain:7

HPI CHEST PAIN

TIME: Patient seen at 16:25, by Dr. Khan. (16:36 TMR)
CHIEF COMPLAINT: Patient presents for evaluation of chest pain, ongoing. (16:36 TMR)
HISTORIAN: History provided by patient, 66 YOM presents to the ED with c/o CP. Pt sts that pain is mostly located in his lt side. Pt sts that pain has been off and on for x 2 weeks. Pt reports that pain became constant 1 hour ago today. Pt also c/o numbness/tingling in lt shoulder and difficulty swallowing. Pt sts that he has never had CP like this before. Pt tried taking ASA last night but was given no relief. Pt has hx of hiatal hernias. Pt denies any cause for stress but family sts that his job has been very stressful as of late. (18:44 TMR)
LOCATION: Symptoms are localized, lt side. (17:18 TMR)
TIME COURSE: are constant. (17:19 TMR)
ASSOCIATED WITH: No associated diaphoresis, Associated with nausea, No associated vomiting. (17:21 TMR)
PRIMARY DOCTOR: Patient has PMD, Dr. Agarwal (cardiologist). (18:43 CEC)

PAST MEDICAL HISTORY

MEDICAL HISTORY: Flu vaccine not up to date, Tetanus not up to date, Pneumococcal vaccine not up to date, Past medical history includes neurological disease, migraine headaches. (16:06 JMU)
SOCIAL HISTORY: Patient has no smoking history, Patient drinks socially, Patient denies drug use. (16:06 JMU)
NURSING NOTES REVIEWED: Nursing notes were reviewed and confirmed. (19:31 TMR)

CURRENT MEDICATIONS (16:09 JMU)

Aspirin Adult Low Strength

ALLERGY (16:06 JMU)

Reglan

KNOWN ALLERGIES

Reglan

ROS (17:21 TMR)

CARDIOVASCULAR: Historian reports chest pain, radiation to, the arm.
GI: Historian reports nausea, Historian denies vomiting.
NOTES: All systems reviewed, negative except as described above.

PHYSICAL EXAM

CONSTITUTIONAL: Vital signs reviewed, Patient alert and oriented to person, place and time, anxious. (17:24 CEC)
HEAD: Head exam included findings of head atraumatic, normocephalic. (17:25 CEC)
EYES: Extraocular muscles intact, Conjunctiva normal, Sclera normal. (17:25 CEC)
ENT: Pharynx exam normal, not injected, no swelling, symmetrical, Ears and nose normal to inspection. (17:25 CEC)
NECK: Trachea midline, no meningeal signs, no jugular venous distention. (17:25 CEC)

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

RESPIRATORY CHEST: Breath sounds clear, mildly hyperventilating. (17:24 CEC)
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal. (17:25 CEC)
ABDOMEN MALE: Abdominal exam included findings of abdomen nontender, no distension, no peritoneal signs. (17:25 CEC)
LOWER EXTREMITY: no cyanosis, no edema. (17:25 CEC)
NEURO: Neuro exam findings include patient oriented to person, place and time, Speech normal, no focal motor deficits. (17:25 CEC)
SKIN: Skin exam included findings of skin warm, dry. (17:25 CEC)
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Normal affect. (17:25 CEC)

RADIOLOGY INTERPRETATION (19:14 FKK)
CHEST: Chest CT, Other findings: Result type: CT Chest w/ Contrast
Result Date: 12 June 2012 18:03 PDT
Result Status: Transcribed
Result title/Subject: CT Chest w/ Contrast
Performed by/Author: Nelson RT, Mary T on 12 June 2012 18:03 PDT
Encounter info: 3050679, SACH, Emergency, 06/12/2012 –
* Preliminary Report *
Reason For Exam
Chest Pain;Chest Pain
Report
CT SCAN OF THE CHEST WITH CONTRAST
Clinical History: Chest pain.
Technique: Axial images were obtained on a Toshiba Aquilion CT scanner. Coronal reformations were created from the axial images.
Contrast: 95 mL of Isovue–370 (iopamidol) IV.
Findings: There are diffuse rib deformities on the right that could be related to previous surgery or trauma, or a combination of surgery and trauma. There are emphysematous changes in the lung apices. Old granulomatous changes with calcification are present. There is also evidence of mild atelectasis, fibrosis, or infiltrate, particularly at the right lung base. This most likely represents chronic change.
I do not see evidence of pulmonary embolus and no evidence of an aortic dissection, and I am unable to detect any significant coronary artery calcification.
There appears to be a small hiatus hernia, and there also appear to be small metallic clips indicating previous surgery in the region of the EG junction, and there may be some very mild thickening of the distal gastric esophageal mucosa, but I do not see evidence of obstruction.
The gallbladder is surgically absent.
IMPRESSION:
I do not see evidence of pulmonary embolus or aortic dissection.
There has been previous surgery at the GE junction with small metallic densities and a small hiatus hernia, possibly very mild esophageal mucosal edema of the distal esophagus.
Extensive deformities of the ribs consistent with trauma, surgery, or a combination of both, along with pleural calcification, granulomatous changes, and emphysematous changes.
Evidence of fibrosis and/or atelectasis, possibly mild infiltrate at the right base. This is difficult to determine because I do not have any previous images for comparison in a patient who has had the chronic changes as noted above.
Signature Line
***** Preliminary Report *****
Dictated: 06/12/2012 18:33 Berry M.D., David L.
Transcribed by: JN 06/12/12 18:38.

EKG INTERPRETATION (16:52 CEC)

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by Emergency Department Physician, 12 lead EKG shows normal sinus rhythm, Rate (beats per minute): 61bpm, Time: 1613, interpreted by Dr. Khan, with infrequent premature ventricular complexes, Conduction normal, ST segments normal, T waves normal, Axis normal, Clinical impression:, non-specific EKG.

ED SUMMARY

RE-EVALUATION: PSYCHIATRIST PRESENTS W/ CP SINCE YEST; ANXIOUS ON EXAM; 2 SETS CARDIAC MARKERS NEG; CT ANGIO CHEST OFFICIAL RESULT PENDING; PT'S PMD CARDIO DR. AGARWAL MADE AWARE; HE WILL FU THE RESULT AND ACCEPTS PT TO TELE W/ LIKELY CATH TOMORROW, AS PT HAS ONGOING CP; HE WILL COME SEE PT IN ED W/ ORDERS TO FOLLOW; STABLE FOR ADMIT; PT HAD TRANSIENT RELIEF W/ ATIVAN. (18:35 FKK)

Dr. Agarwal here at bedside. (18:45 CEC)

CT ANGIO SUGGESTIVE OF INTERMITTENT HIATAL HERNIA VOLVULUS W/ EDEMA OF THE DISTAL ESOPHAGUS; DR. AGARWAL IN ED NOW AND APPRISED OF THIS FINDING; HE WILL OBTAIN APPROPRIATE CONSULTS; OF NOTE, PT WAS SCOPED BY HIS GI W/IN THE PAST FEW WEEKS W/ NEGATIVE FINDINGS. (19:15 FKK)

INTERVENTIONS: Administered: IV fluids, ASA, Ativan. (18:33 CEC)

PATIENT STATUS: Patient has improved since arrival to emergency department. (18:33 CEC)

DISCUSSED WITH: Discussed this case with Dr. Choudhary (on call for Dr. Agarwal) at 1829, he will have Dr. Agarwal call in himself. (18:29 CEC)

Discussed this case with Dr. Agarwal (pt's cardiologist) at 1832, he gave admission orders. (18:32 CEC)

PATIENT PLAN: The patient will be admitted to the hospital, Initial physician orders were written for patient as discussed with admitting physician. (18:32 CEC)

The patient will be admitted to the hospital. (18:35 FKK)

FLOWSHEET (16:06 JMU)

VITAL SIGNS

PHYSICIAN / N.P. NOTES (18:35 FKK)

ATTENDING NOTE: I have personally seen and examined this patient. I have fully participated in the care of this patient including the ordering of all medication(s) and intervention(s). I have reviewed all pertinent clinical information. I agree with the management and disposition of this patient., All medical record entries made by the Scribe were at my direction and personally dictated by me. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and emergency department course for this patient. I have also personally directed, reviewed, and agree with the discharge instructions and disposition.

DIAGNOSIS (19:15 FKK)

FINAL: PRIMARY: Chest pain Unspecified, ADDITIONAL: Hiatal hernia, R/O GASTRIC VOLVULUS.

ORDERS

Smoking Status -- Denies: Status: Active
Reason: P. (16:06 JMU)

CBC: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 16:48. (16:10 JMU)

PT: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 17:07. (16:10 JMU)

Troponin-I: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 17:11. (16:10 JMU)

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

Oxygen to keep Sa02 >94%: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 16:57. (16:10 JMU)
XR Chest Portable in ER (2-View if in lobby): Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 16:48. (16:10 JMU)
Cardiac & B/P monitoring,: Ordered for: Khan, MD, Faraaz
Status: Done by Papavero, RN, Annette Tue Jun 12, 2012 16:23. (16:10 JMU)
12 Lead EKG: Ordered for: Khan, MD, Faraaz
Status: Done by Papavero, RN, Annette Tue Jun 12, 2012 16:23. (16:10 JMU)
Chest Pain Protocol Implemented: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 16:57. (16:10 JMU)
Obtain old EKG: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 16:57. (16:10 JMU)
CK-MB: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 17:11. (16:10 JMU)
PTT: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 17:07. (16:10 JMU)
**Saline Lock*:* Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 16:57. (16:10 JMU)
Keep patient NPO: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 16:57. (16:10 JMU)
Metabolic Panel - COMPREHENSIVE: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 17:24. (16:10 JMU)
Continuous Pulse Ox: Ordered for: Khan, MD, Faraaz
Status: Done by Papavero, RN, Annette Tue Jun 12, 2012 16:23. (16:10 JMU)
CT Angio Chest w/ Contrast: Ordered for: Khan, MD, Faraaz
Status: Active. (16:35 FKK)
** Continuous Pulse Ox:* Ordered for: Khan, MD, Faraaz
Status: Active
Reason: P. (16:37 MIP2)
Troponin-I: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 18:07. (17:26 FKK)
REPEAT CARDIAC MARKERS: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 17:33. (17:26 FKK)
CK-MB: Ordered for: Khan, MD, Faraaz
Status: Done by System Tue Jun 12, 2012 18:06. (17:26 FKK)
12 Lead EKG: Ordered for: Khan, MD, Faraaz
Status: Done by McCullough, RN, Mariana Tue Jun 12, 2012 17:49. (17:48 MIP2)
Ready for Admit: Ordered for: Khan, MD, Faraaz
Status: Active. (18:05 FKK)

DISPOSITION

PATIENT: Disposition Type: Inpatient, Disposition: Admit to Telemetry, Condition: Stable. (18:35 FKK)
Disposition Type: Observation. (18:36 FKK)
Disposition Type: Inpatient, Patient left the department. (21:33 MWI)
NOTES: I agree with all verbal orders. (18:35 FKK)

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
Ativan	1 mg	IV Push	Given	18:27 6/12/2012
Sodium Chloride 0.9%, Intravenous	Bolus 300ml, then rate 100 mL/hr	IV Infusion	Given	17:15 6/12/2012
Ativan	1 mg	IV Push	Given	16:50 6/12/2012
*Aspirin Adult Low Strength	162 mg	Oral	Given	16:11 6/12/2012

*Additional information available in notes, Detailed record available in Medication Service section.

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

PRESCRIPTION
No recorded prescriptions

TRIAGE (16:06 JMU)
PATIENT: NAME: Hanna, Adel S, AGE: 66, GENDER: male, DOB: Fri Mar 29, 1946, TIME OF GREET: Tue Jun 12, 2012 16:02, RACE: Other, KG WEIGHT: 77.1, HEIGHT: 172cm, PHONE: 909902-1147, MEDICAL RECORD NUMBER: 0918505, ACCOUNT NUMBER: 3050679.
ADMISSION: URGENCY: ESI - 2 (Emergent), ADMISSION SOURCE: Walk-In, BED: ED 15.
VITAL SIGNS: BP 146/91, Pulse 64, Resp 20, Temp 97.4 ta, Pain 7, O2 Sat 99, on ra, Time 6/12/2012 16:04.
COMPLAINT: CHEST PAIN.
PROVIDERS: TRIAGE NURSE: Julio Murillo, RN.
TRIAGE NOTES: chest pain x 1 hr with SOB.
RAPID TRIAGE ASSESSMENT: Patient arrives ambulatory, Patient appears, uncomfortable, Patient is co-operative, Patient's skin is pink, warm, and dry, Patient is alert and oriented x 3, Patient converses normally and is able to speak in full sentances, Patient's respiratory pattern normal, Patient's cap refill within normal limits.
NUTRITIONAL ASSESSMENT/FUNCTIONALITY: Patient appears well nourished, Patient has normal appetite, Patient's weight is appropriate, Patient has no recent weight change, Patient can manage their activities of daily living.
ABUSE/NEGLECT: Patient denies suicidal ideation, Denies abuse/neglect, no suspicion of domestic violence identified.

MEDICATION SERVICE
Aspirin Adult Low Strength: Order: Aspirin Adult Low Strength (Aspirin) - **Dose:** 162 mg : Oral
Notes: Give if not taken within previous 24 hours and patient has no allergies to aspirin
Ordered by: Sara Nohemi Caldwell, MD
Entered by: Julio Murillo, RN Tue Jun 12, 2012 16:11
Documented as given by: Julio Murillo, RN Tue Jun 12, 2012 16:11
Patient, Medication, Dose, Route and Time verified prior to administration.
Amount Given: 162mg PO in triage, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.
Ativan: Order: Ativan (Lorazepam) - **Dose:** 1 mg : IV Push
Ordered by: Faraaz Khan, MD
Entered by: Faraaz Khan, MD Tue Jun 12, 2012 16:35
Documented as given by: Mariana McCullough, RN Tue Jun 12, 2012 16:50
Patient, Medication, Dose, Route and Time verified prior to administration.
Time Administered: 1645, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, IV SITE #1 IVP, Given over 1-2 minutes.
Ativan: Order: Ativan (Lorazepam) - **Dose:** 1 mg : IV Push
Ordered by: Faraaz Khan, MD
Entered by: Faraaz Khan, MD Tue Jun 12, 2012 18:19
Documented as given by: Mariana McCullough, RN Tue Jun 12, 2012 18:27
Patient, Medication, Dose, Route and Time verified prior to administration.
Time Administered: 1825, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, IV SITE #1 IVP, Given over 1-2 minutes.
Sodium Chloride 0.9%, Intravenous: Order: Sodium Chloride 0.9%, Intravenous (Sodium Chloride) - **Dose:** Bolus 300ml, then rate 100 mL/hr : IV Infusion
Ordered by: Faraaz Khan, MD

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

Entered by: Faraaz Khan, MD Tue Jun 12, 2012 16:35
Documented as given by: Mariana McCullough, RN Tue Jun 12, 2012 17:15
Patient, Medication, Dose, Route and Time verified prior to administration.
Time Administered: 1715, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, IV SITE #1 1st bag hung, via primary tubing, IV SITE #1 on IV pump.

NURSING ASSESSMENT: CARDIOVASCULAR

NURSING NOTES: Notes: 1630 patient complains of intermittent CP yesterday that is now constant 1 hour ago. Pain to center of chest, crushing, radiating to jaw and neck 5/10. History of angioplasty. States he feels like it is difficulty to swallow. Patient has had recent GI work up and was diagnosed with hiatal hernia and reflux. (16:56 MIP2)

Notes: recieved report from mariana M RN. Pt has had CP since yesterday but got worse today. Pt is axox4 with 0/10 pain now. Pt has normal RR and HR. Pt is aware of being admitted to the hospital. (20:22 MWI)

CONSTITUTIONAL: History obtained from patient, Patient appears, uncomfortable, Patient cooperative, Patient alert, Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color. (16:56 MIP2)

Gait steady, History obtained from patient, Patient appears comfortable, Patient cooperative, Patient alert, Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color. (20:22 MWI)

PAIN: Pain assessed using pain scale, on a scale 0-10, patient states pain 0. (20:22 MWI)

CARDIOVASCULAR: Cardiovascular assessment findings include heart rate normal, Heart rhythm normal sinus, No associated diaphoresis, no associated dyspnea, no associated dizziness, no associated edema, no associated palpitations, no associated syncopal episode, Patient does not have JVD, Right radial pulse +3(easily palpated, considered normal), Left dorsalis pedis pulse +3(easily palpated, considered normal), Right dorsalis pedis pulse +3(easily palpated, considered normal), Left radial pulse +3(easily palpated, considered normal), Notes: Nausea present, no vomitting. Tingling to left shoulder. (16:56 MIP2)

Notes: 1730 Patient states pain is beginning to increase and rate at 5/10 to center of chest. Repeat ekg done and repeat cardiac markers drawn. Patient awaiting CT. NSR on the monitor. Friend at the bedside. (17:43 MIP2)

Cardiovascular assessment findings include heart rate normal, Heart rhythm normal sinus, No associated diaphoresis, no associated dyspnea, no associated dizziness, no associated edema, no associated palpitations, no associated syncopal episode, Patient does not have JVD, Notes: 1850 Patient talking with Dr. Agarwal at the bedside. Respirations are even and unlabored. No distress noted. PAtient denies having any CP at this time. Friend at the bedside. Patient to be admitted. (18:59 MIP2)

Cardiovascular assessment findings include heart rate normal, Heart rhythm normal sinus, No associated diaphoresis, no associated dyspnea, no associated dizziness, no associated edema. (20:22 MWI)

RESPIRATORY/CHEST: Respiratory assessment findings include respiratory pattern normal, Respirations regular, Conversing normally, no signs of distress, no retractions noted, no cyanosis, Breath sounds clear in all lung fields. (16:56 MIP2)

Respiratory assessment findings include respiratory pattern normal, Respirations regular, Conversing normally, no signs of distress, Breath sounds clear in all lung fields. (20:22 MWI)

MORSE FALL RISK (ADULT): Safety Level Fall Risk: Low (0-24)-Low Risk Fall Prevention interventions implemented:. (16:56 MIP2)

SAFETY: Side rails up, Bed in lowest position, Family at bedside, Call light within reach, Hospital ID band on. (16:56 MIP2)

Side rails up, Bed in lowest position, Call light within reach, Hospital ID band on. (20:22

*** Auth (Verified) ***

SAN ANTONIO COMMUNITY HOSPITAL
PRIMARY

MWI)
VITAL SIGNS: BP: 151, / 96, Pulse: 76, Resp: 12, Pain: 0, O2 sat: 97, ra. (20:22 MWI)

NURSING ASSESSMENT: SKIN (20:22 MWI)
SKIN: Skin assessment findings include skin warm, Skin dry, Skin normal in color, Notes: Pt has blanchable redness to the L and R buttocks.
BRADEN SCALE: (4) Sensory perception has no impairment, (4) Skin is rarely moist, (3) Patient walks occasionally, (4) No mobility limitations, (3) Adequate nutrition, (2) Patient has potential problem with friction and shear, Braden Risk Total: 20.

NURSING PROCEDURE: *NURSE NOTES* (19:20 MIP2)
NURSES NOTES: Shift change report given, to Rick Harris RN and Marc Wirtz RN, Provided opportunity to answer questions.

NURSING PROCEDURE: ADMISSION (20:53 MWI)
ADMISSION: Patient admitted to:, Telemetry-Inpatient, Room Number:, 346B, Report called at 2051, Report called to RN, Brenda M RN, Provided opportunity to answer questions, Skin Integrity is intact, Patient transported via gurney, Transported with monitor, Transported with advanced life support care, Transported with medical records, Transported with Saline Lock, Accompanied by ERT, Accompanied by RN.

NURSING PROCEDURE: COMMUNICATIONS (18:27 NGD)
COMMUNICATIONS: Physician, Contacted/Paged at 1825, Dr. Choudhary on call for Dr. Agarwal, Consult, Page # 1, Returned call at 1827. Call transferred to MD, cardio consult.

NURSING PROCEDURE: INTAKE AND OUTPUT (20:56 MWI)
INTAKE AND OUTPUT: IV intake(ml): 500, Total Intake (ml): 500ml, Total Output (ml): 0ml, Grand Total: Intake is greater than output by 500mls.

NURSING PROCEDURE: INTERVENTIONS
INTERVENTIONS: Provider at bedside, 1625, Name of provider: Khan. Oxygen Therapy started. SAO2 99%. Patient placed on Cardiac Monitor, patient is in normal sinus rhythm, EKG done, Labs drawn during IV start. (16:57 MIP2)
CT, Patient to CT @ 1743. (17:44 MIP2)
CT, Patient returned from CTat 1805. (18:05 MIP2)

NURSING PROCEDURE: IV (16:56 MIP2)
IV SITE 1: IV established, to the right antecubital, using a 20 gauge catheter, in one attempt, Site prepped with chloraprep, Labs drawn at time of placement, labeled in the presence of the patient and sent to lab, Notes: By Annette Papavero RN.
FOLLOW-UP SITE 1: After procedure, no drainage at IV site, After procedure, no swelling at IV site, After procedure, no redness at IV site.

Key:
CEC=Zzcurley, SCRIBE, Caroline FKK=Khan, MD, Faraaz JMU=Murillo, RN, Julio MIP2=McCullough, RN, Mariana MWI=Wirtz, RN, Marc NGD=De Guzman, UC, Nerissa SNC=Caldwell, MD, Sara Nohemi TMR=Zzrobinson, SCRIBE, Tay

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Coding Documentation

Document Name: Coding Summary
Result Status: Transcribed
Performed By:
Authenticated By:

CODING DATE: 09/09/2012 FINAL
SAN ANTONIO COMMUNITY HOSPITAL

APC	DESCRIPTION
0080	Diagnostic Cardiac Catheterization

ADMIT DX:

REASON FOR VISIT DX:
786.50 UNSPECIFIED CHEST PAIN

FINAL DX:
PRINCIPAL:
786.50 UNSPECIFIED CHEST PAIN

SECONDARY:

530.81	ESOPHAGEAL REFLUX
553.3	DIAPHRAGMATIC HERNIA WITHOUT MENTION OF OBSTRUCTION OR GANGRENE
401.9	UNSPECIFIED ESSENTIAL HYPERTENSION
427.69	OTHER PREMATURE BEATS
427.89	OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
414.01	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY
272.0	PURE HYPERCHOLESTEROLEMIA
V58.66	Long-Term (Current) Use of Aspirin
V45.89	OTHER POSTSURGICAL STATUS
V03.82	NEED FOR PROPHYLACTIC VACCINATION AGAINST STREPTOCOCCUS PNEUMONIAE [PNEUMOCOCCUS]

PROC	APC	PYMT STAT	DESCRIPTION	DOCTOR NAME	DATE
93458	0080		Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for	Agarwal M.D., Chandra	06/13/2012

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Coding Documentation

coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven

NOTE: The code number assigned matches the documented diagnosis and / or procedure in the patient's chart. However, the narrative phrase printed from the coding software may appear abbreviated, or result in slightly different terminology.

Coded By: Amrhein, Anita
Date Saved: 09/09/2012 21:05

Computed Tomography

Exam	Accession Number	Exam Date/Time	Ordering Provider
CT Chest w/ Contrast	CT-12-0011821	6/12/2012 18:03 PDT	Khan M.D.,Faraaz O

Report

CT SCAN OF THE CHEST WITH CONTRAST

Clinical History: Chest pain.

Technique: Axial images were obtained on a Toshiba Aquilion CT scanner. Coronal reformations were created from the axial images.

Contrast: 95 mL of Isovue-370 (iopamidol) IV.

Findings: There are diffuse rib deformities on the right that could be related to previous surgery or trauma, or a combination of surgery and trauma. There are emphysematous changes in the lung apices. Old granulomatous changes with calcification are present. There is also evidence of mild atelectasis, fibrosis, or infiltrate, particularly at the right lung base. This most likely represents chronic change.

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Computed Tomography

Report

I do not see evidence of pulmonary embolus and no evidence of an aortic dissection, and I am unable to detect any significant coronary artery calcification.

There appears to be a small hiatus hernia, and there also appear to be small metallic clips indicating previous surgery in the region of the EG junction, and there may be some very mild thickening of the distal gastric esophageal mucosa, but I do not see evidence of obstruction.

The gallbladder is surgically absent.

IMPRESSION:

I do not see evidence of pulmonary embolus or aortic dissection.

There has been previous surgery at the GE junction with small metallic densities and a small hiatus hernia, possibly very mild esophageal mucosal edema of the distal esophagus.

Extensive deformities of the ribs consistent with trauma, surgery, or a combination of both, along with pleural calcification, granulomatous changes, and emphysematous changes.

Evidence of fibrosis and/or atelectasis, possibly mild infiltrate at the right base. This is difficult to determine because I do not have any previous images for comparison in a patient who has had the chronic changes as noted above.

***** *Final Report* *****

Dictated: 06/12/2012 18:33 Berry M.D., David L.

Electronically signed: 06/12/2012 19:32
Radiologist: Berry M.D., David L.
Transcribed by: JN 06/12/12 18:38

Diagnostic Radiology

Exam	Accession Number	Exam Date/Time	Ordering Provider
XR Chest Portable in ER	XR-12-0040365	6/12/2012 16:21 PDT	Khan M.D.,Faraaz O

Report

CHEST, ONE VIEW, PORTABLE AT 1616 HOURS

Clinical History: Chest pain.

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Diagnostic Radiology

Report

There are no previous chest films for comparison.

Heart size is upper normal. The mediastinum appears to be satisfactory with the trachea midline. There is accentuation of the aortic arch and elongation of the descending aorta. There is evidence of mild atelectasis and/or infiltrate or fibrosis at the right base. Minimal atelectasis at the left base. There also appear to be fibrotic changes at the right lung apex. No evidence of pneumothorax.

IMPRESSION:

Fibrosis at the right apex, along with atelectasis and/or fibrosis at the right base and minimal atelectasis at the left base.

No evidence of an area of consolidation.

***** *Final Report* *****

Dictated: 06/12/2012 16:33 Berry M.D., David L.

Electronically signed: 06/12/2012 16:48
Radiologist: Berry M.D., David L.
Transcribed by: JN 06/12/12 16:36

San Antonio Regional Hospital

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Hematology/Coagulation

Legend: c=Corrected, *=Abnormal, C=Critical, L=Low, H=High, f=Footnote, ^=Interp Data, R=Result Comment

Collected Dt/Tm	Procedure	Result	Reference Range	Units	Verified Dt/Tm
6/12/2012 16:25 PDT	PTT	26.2 R1	[24.7-31.4]	sec(s)	6/12/2012 17:07 PDT
6/12/2012 16:25 PDT	INR	1.02 R2			6/12/2012 17:07 PDT
6/12/2012 16:25 PDT	PT	10.8	[8.8-12.0]	sec(s)	6/12/2012 17:07 PDT
6/12/2012 16:25 PDT	WBC	**4.3** L	[4.4-9.1]	kUnit/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	RBC	5.22	[4.6-5.4]	M/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	Hgb	14.9	[13.6-16.3]	gm/dL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	HCT	45	[35.8-56.8]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	Platelet	162	[150-450]	kUnit/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	MCV	86	[80-99]	fL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	MCH	29	[28.3-31.1]	pg	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	MCHC	33	[30-36]	gm/dL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	RDW	14.4	[<22]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	MPV	9.7	[7.4-10.4]	fL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	% Neutro	59	[45-76]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	% Lymph	31	[6-42]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	% Mono	6	[3-8]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	% Eos	4	[0-8]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	% Basophil	0	[0-1]	%	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	# Neutro	2.5	[1.8-7.0]	kUnit/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	# Lymph	1.3	[1.2-4.0]	kUnit/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	# Mono	0.3	[0.0-0.8]	kUnit/mcL	6/12/2012 16:48 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Hematology/Coagulation

Legend: c=Corrected, *=Abnormal, C=Critical, L=Low, H=High, f=Footnote, ^=Interp Data, R=Result Comment

Collected Dt/Tm	Procedure	Result	Reference Range	Units	Verified Dt/Tm
6/12/2012 16:25 PDT	# Eos	0.1	[0.0-0.6]	kUnit/mcL	6/12/2012 16:48 PDT
6/12/2012 16:25 PDT	# Basophil	0.0	[0.0]	kUnit/mcL	6/12/2012 16:48 PDT

Result Comments
R1: PTT
NEW REFERENCE RANGES AS OF 10302008~~ Target PTT Ranges for Pharmacy to~ Dose/Monitor patients on continuous~ heparin infusion:~ 55-70 sec. for low dose prophylaxis~ 70-85 sec. for DVT,AMI,Ischemic~ Stroke.~ 85-100 sec. for Pulmonary Embolism
R2: INR
SUGGESTED THERAPEUTIC RANGE~ Standard Dose: INR 2.00-3.00~ High Dose: INR 2.50-3.50~ Use INR only for patients on~ stable anticoagulant therapy.

Chemistry

Legend: c=Corrected, *=Abnormal, C=Critical, L=Low, H=High, f=Footnote, ^=Interp Data, R=Result Comment

Collected Dt/Tm	Procedure	Result	Reference Range	Units	Verified Dt/Tm
6/13/2012 06:06 PDT	Troponin I	<0.015 R3	[0.000-0.045]	ng/mL	6/13/2012 06:46 PDT
6/12/2012 17:39 PDT	Troponin I	<0.015 R3	[0.000-0.045]	ng/mL	6/12/2012 18:07 PDT
6/12/2012 17:39 PDT	Creatine Kinase	50	[38-224]	unit/L	6/12/2012 18:07 PDT
6/12/2012 17:39 PDT	CPK,Iso	**<0.5 L**	[0.5-3.6]	mcg/L	6/12/2012 18:07 PDT
6/12/2012 16:25 PDT	Troponin I	<0.015 R3	[0.000-0.045]	ng/mL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Sodium Lvl	141	[134-146]	mmol/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Potassium Lvl	4.0	[3.3-5.2]	mmol/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Chloride Lvl	103	[99-113]	mmol/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	CO2	26	[21-32]	mmol/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	AGAP	12 R4	[5-15]	mmol/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Glucose Lvl	90	[60-110]	mg/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	BUN	14	[6-22]	mg/dL	6/12/2012 17:11 PDT

San Antonio Regional Hospital

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Chemistry

Legend: c=Corrected, *=Abnormal, C=Critical, L=Low, H=High, f=Footnote, ^=Interp Data, R=Result Comment

Collected Dt/Tm	Procedure	Result	Reference Range	Units	Verified Dt/Tm
6/12/2012 16:25 PDT	Creatinine Lvl	1.0	[0.5-1.2]	mg/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	GFR,Estimated	>60.00 R5	[>60.00]	mL/m/1.73m2	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Calcium Lvl	9.2	[8.0-10.3]	mg/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Total Protein	8.1	[6.4-8.2]	gm/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Albumin Lvl	4.3	[3.4-5.0]	gm/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Alk Phos	**46** L	[50-136]	unit/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	AST	18	[1-37]	unit/L	6/12/2012 17:25 PDT
6/12/2012 16:25 PDT	ALT	34	[30-65]	unit/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Bili Total	0.5	[0-1.1]	mg/dL	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	Creatine Kinase	58	[38-224]	unit/L	6/12/2012 17:11 PDT
6/12/2012 16:25 PDT	CPK,Iso	0.6	[0.5-3.6]	mcg/L	6/12/2012 17:11 PDT

Result Comments

R3: Troponin I
(NOTE)~Myocardial infarction should be diagnosed according~to the Universal Definition of Myocardial Infarction~(ESC/ACC J Am Coll Cardiology 2007:50:2173-2195).~These criteria require troponin (cTN) elevations a-~bove the 99th percentile of a normal reference~population in conjuction with clinical findings of~ischemia: i.e. chest pain of at least 20 minutes~duration, ECG changes of ischemia, development~of pathologic Q waves, loss of myocardium by imag-~ing, regional wall motion abnormalities, rising or~falling cTN values. Detectable cardiac troponin~levels indicate myocardial muscle damage. About~50% of these elevations reflect ischemic heart~disease, either infarction, unstable angina or~stable angina. However, renal failure, heart~failure, cardiomyopathy, myocarditis, atrial fib-~rillation, tachycardia, pulmonary embolism and~other conditions must also be considered. Thus,~troponin elevations must be correlated with the~overall clinical findings.~~~This assay employs the Siemens Dimension VISTA CTNI~methodology using a homogeneous sandwich chemilum-~inescent immunoassay based on LOCI(R) Technology.~Troponin I values obtained with other assay methods~cannot be used interchangeably.

R4: AGAP
NEW AGAP REF. RANGE AS OF 010812: 5 TO 15 MMOL/L

R5: GFR, Estimated
~If patient is African-American, please~multiply the result by 1.210.~Stable creatinine presumed. Ignore eGFR~in dialysis patients. Interpret with~caution in patients with acute renal failure.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activity Forms

Adult Activities of Daily Living Entered On: 06/14/2012 1:40 PDT
Performed On: 06/13/2012 22:00 PDT by Martinez, Karissa C

ADLs
Activity Status ADL : In bed
Activity Assistance : Independent
Range of Motion Left Upper Extremity : Active
Range of Motion Right Upper Extremity : Active
Range of Motion Left Lower Extremity : Active
Range of Motion Right Lower Extremity : Active

Martinez, Karissa C - 06/14/2012 1:38 PDT

ADLs II
Hygiene Assistance Grid
Bed Bath : Independent
Foot Care : Independent
Hair Care : Independent
Oral Care : Independent
Peri Care : Independent

Martinez, Karissa C - 06/14/2012 7:00 PDT

Patient Safety : Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Martinez, Karissa C - 06/14/2012 1:38 PDT

Adult Activities of Daily Living Entered On: 06/13/2012 12:03 PDT
Performed On: 06/13/2012 10:00 PDT by Caler RN, Tiffany A

ADLs
Activity Status ADL : In bed
Activity Assistance : Independent
Assistive Device : None
Range of Motion Left Upper Extremity : Active
Range of Motion Right Upper Extremity : Active
Range of Motion Left Lower Extremity : Active
Range of Motion Right Lower Extremity : Active

Caler RN, Tiffany A - 06/13/2012 12:03 PDT

Adult Activities of Daily Living Entered On: 06/12/2012 21:43 PDT
Performed On: 06/12/2012 22:00 PDT by Perez, Noami M

ADLs
Activity Status ADL : Ambulating in room, Bathroom privileges
Activity Assistance : Independent

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activity Forms

Assistive Device : None
Positioning/Pressure Reducing Devices : Pillow
Range of Motion Left Upper Extremity : Active
Range of Motion Right Upper Extremity : Active
Range of Motion Left Lower Extremity : Active
Range of Motion Right Lower Extremity : Active
Gait Distance : 20ft(Converted to: 20ft 0inch, 6m)
Ambulation Patient Effort : Good

Perez, Noami M - 06/12/2012 21:42 PDT

Admit/Discharge/Transfer Forms

Nursing Discharge/Transfer Summary Entered On: 06/14/2012 14:56 PDT
Performed On: 06/14/2012 14:55 PDT by Vertulfo RN, Erlyn V

Readiness for Discharge
Discharge Readiness Criteria : Alert, oriented, and able to care for self at home
Spokesperson Notified of Discharge : Other: patient doesn't want us to call anyone,he does it himself

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Discharge Belongings
Belonging Condition Satisfactory Discharge : Yes

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Education
Home Caregiver Present for Session : No
Barriers to Learning : None evident
Depart Instructions : Yes - patient/family/caregiver verbalizes understanding of instructions given
Teaching Method : Explanation

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Post-Hospital Education Adult Grid
Activity Expectations : Verbalizes understanding
Importance of Follow-Up Visits : Verbalizes understanding
Pain Management : Verbalizes understanding
Plan of Care : Verbalizes understanding
When to Call Healthcare Provider : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Health Maintenance Education Adult Grid
Allergies : Verbalizes understanding
Diet/Nutrition : Verbalizes understanding
Smoking Cessation : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Medication Education Adult Grid
Med Dosage, Route, Scheduling : Verbalizes understanding
Med Generic/Brand Name, Purpose, Action : Verbalizes understanding
Med Preadministration Procedures : Verbalizes understanding
Med Special Administration, Storage : Verbalizes understanding

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit/Discharge/Transfer Forms

Medication Precautions : Verbalizes understanding
Safety, Medication : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Safety Education Newborn Grid
Safety, Fall : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

DC Information
Discharged to : Home independently

Vertulfo RN, Erlyn V - 06/14/2012 14:55 PDT

Pre-Discharge Screening Entered On: 06/14/2012 13:52 PDT
Performed On: 06/14/2012 13:52 PDT by Vertulfo RN, Erlyn V

Hi Risk Infection (MRSA) DC Screening
Patient MRSA Positive This Visit : No
High Risk Infection Criteria on Disch : None

Vertulfo RN, Erlyn V - 06/14/2012 13:52 PDT

Intrahospital Transfer Entered On: 06/13/2012 12:07 PDT
Performed On: 06/13/2012 12:00 PDT by Caler RN, Tiffany A

Patient Arrival
Patient Arrival Date/Time : 06/13/2012 12:00 PDT
Transported From : cath lab
Patient Condition on Arrival : Stable
Patient Arrival Note : pt awake and oriented times 3, no acute distress, VSS. Pt NSR on tele. Rt groin with D stat intact and no sign of hematoma.

Caler RN, Tiffany A - 06/13/2012 12:04 PDT

Basic Admission Information Entered On: 06/12/2012 21:34 PDT
Performed On: 06/12/2012 21:28 PDT by Perez, Noami M

Vital Signs
Temperature Temporal Artery : 97.2degF(Converted to: 36.2degC) (LOW)
Heart Rate Monitored : 98bpm (HI)
Respiratory Rate : 20br/min
Mean Arterial Pressure. Cuff : 103mmHg
Systolic Blood Pressure : 136mmHg
Diastolic Blood Pressure : 86mmHg
SpO2 : 99%
Oxygen Therapy : Room air

Admit/Discharge/Transfer Forms

Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Perez, Noami M - 06/12/2012 21:28 PDT

Height/Weight
Height/Length Measured : 172.00cm(Converted to: 5ft 8inch, 5.64ft, 67.72inch)
Weight Measured Kg : 78.100kg(Converted to: 172lb 3oz, 172.181lb)
BSA Measured : 1.93
Body Mass Index Measured : 26.40m2

Perez, Noami M - 06/12/2012 21:28 PDT

Admit Belongings
Belongings in Patient's Possession : Shoes, Shirt, Pants, Cell Phone (Biomed Contacted), Rings, Watch, Wallet, Eyeglasses
Patient Instructions of Belongings : Do not leave containers or belongings in bed, Do not leave containers or belongings on meal tray, Advised that hospital staff cannot watch belongings, Advised that hospital staff is not responsible for damages, Advised that hospital staff is not responsible for losses, Advised to send belongings home, Advised to send valuables (i.e. money, credit cards) to Security

Perez, Noami M - 06/12/2012 21:28 PDT

Safety
Room Orientation/Facility Policy Reviewed : Yes
Room Orientation/Policy Reviewed With : Patient
Patient Safety : Bag/mask setup in room, Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Demonstrates Ability to Use Call Light Successfully : Yes

Perez, Noami M - 06/12/2012 21:28 PDT

Adult Admission Assessment Entered On: 06/12/2012 22:31 PDT
Performed On: 06/12/2012 21:15 PDT by Manzano RN, Brenda P

Height/Weight
Height/Length Measured : 172.00cm(Converted to: 5ft 8inch, 5.64ft, 67.72inch)
~~{ [172.00cm] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Treatment Height/Length Dosing : 172.00cm
~~{ [172.00cm] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Weight Measured Kg : 78.100kg(Converted to: 172lb 3oz, 172.181lb)
~~{ [78.100kg] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Treatment Weight Dosing : 78.100kg
~~{ [78.100kg] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
BSA Measured : 1.93
~~{ [1.93] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Body Mass Index Measured : 26.40m2

Manzano RN, Brenda P - 06/12/2012 23:59 PDT
~~{ [26.40m2] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

General
Level of Consciousness : Awake
~~{ [Awake] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Admit/Discharge/Transfer Forms

Distress : None
~~{ [None] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Affect/Behavior : Calm
~~{ [Calm] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Skin Description : Dry
~~{ [Dry] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Skin Color : Normal for ethnicity
~~{ [Normal for ethnicity] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Skin Temperature : Warm
Manzano RN, Brenda P - 06/12/2012 23:59 PDT
~~{ [Warm] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Subjective
Pain Symptoms Self Report : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Pain Goal Numeric : 3
~~{ [3] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Suicidal Ideation : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
General Symptoms : Denies
~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Cardiopulmonary Symptoms : Denies
~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
GI Symptoms : Denies
~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Bowel Movement Last Date : 06/12/12
~~{ [06/12/12] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Genitourinary Symptoms : Denies
~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Neurological/Neuromuscular Symptoms : Denies
Manzano RN, Brenda P - 06/12/2012 23:59 PDT
~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Comfort Measures
Comfort Measures Grid
Comfortable Environment : Yes
~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Quiet Environment : Yes
~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Relaxation : Yes
~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Rest : Yes
~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~
Warm Blanket Application : Yes
Manzano RN, Brenda P - 06/12/2012 23:59 PDT
~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Cardiovascular
Heart Rhythm : Regular
~~{ [Regular] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Admit/Discharge/Transfer Forms

Nail Bed Color : Pink

~~{ [Pink] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Edema : None

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [None] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Pulses Grid

Radial Pulse, Left : 2+ Normal

~~{ [2+ Normal] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Radial Pulse, Right : 2+ Normal

~~{ [2+ Normal] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Dorsalis Pedis Pulse, Left : 2+ Normal

~~{ [2+ Normal] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Dorsalis Pedis Pulse, Right : 2+ Normal

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [2+ Normal] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Respiratory

Cough : None

Manzano RN, Brenda P - 06/12/2012 23:58 PDT

Respirations : Unlabored, Symmetrical

~~{ [Unlabored, Symmetrical] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Respiratory Pattern Description : Regular

~~{ [Regular] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

All Lobes Breath Sounds : Clear

~~{ [Clear] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Pulse Oximetry Monitoring : Intermittent

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [Intermittent] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Neuro Assess/Checks

Orientation : Oriented x 3

~~{ [Oriented x 3] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Sensory Perception Braden : No impairment

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [No impairment] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Glasgow Coma

Eye Opening Response Glasgow : Spontaneously

~~{ [Spontaneously] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Best Verbal Response Glasgow : Oriented

~~{ [Oriented] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Best Motor Response Glasgow : Obeys simple commands

~~{ [Obeys simple commands] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Glasgow Coma Score : 15

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [15] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Musculoskeletal

Activity Braden : Walks occasionally

~~{ [Walks occasionally] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Mobility Braden : No limitations

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Admit/Discharge/Transfer Forms

~~{ [No limitations] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

ADL Assistance Level : Independent

~~{ [Independent] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Level of Assistance - Self Care-Mobility : No change from baseline

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [No change from baseline] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Gastrointestinal

Abdomen Description : Symmetric, Soft

~~{ [Symmetric, Soft] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Bowel Sounds All Quadrants : Present

~~{ [Present] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Nutrition Braden : Adequate

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [Adequate] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Genitourinary

Bladder Distention : Absent

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [Absent] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Integumentary

Skin Integrity : Intact (no broken skin)

~~{ [Intact (no broken skin)] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Minor Skin Abnormality : None

~~{ [None] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Moisture Braden : Rarely moist

~~{ [Rarely moist] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Friction and Shear Braden : Potential problem

~~{ [Potential problem] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Braden Score : 20

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [20] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Order Details

Transport Mode Order Detail : Gurney

~~{ [Gurney] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

IV Order Detail : Yes

~~{ [Yes] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Pregnant Order Detail : N/A

~~{ [N/A] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Oxygen Order Detail : No

~~{ [No] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

EKG Monitor : No

~~{ [No] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Preferred Language : English

Manzano RN, Brenda P - 06/12/2012 23:59 PDT

~~{ [English] - previously charted by Manzano RN, Brenda P at 06/12/2012 22:29 PDT};~~

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit/Discharge/Transfer Forms

Adult Patient History Entered On: 06/12/2012 22:27 PDT
Performed On: 06/12/2012 21:10 PDT by Manzano RN, Brenda P

General Info
Preferred Name : Adel hANNA

Manzano RN, Brenda P - 06/12/2012 23:57 PDT
~~{ [Adel] - previously charted by Manzano RN, Brenda P at 06/12/2012 21:45 PDT};~~

Admitted From : ER
Mode of Arrival : Gurney
Reason for Admission : Medical treatment
Information Given By : Patient
Preferred Communication Mode : Verbal
Preferred Language : English
Pregnancy Status : N/A

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Health History I
Cardiovascular Past Medical History Grid
Denies Cardiovascular History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Respiratory Past Medical History Grid
Other : Self, Allergic Rhinitis

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Gastrointestinal Past Medical Hx Grid
Reflux Disease : Self, Reflux esophagitis

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Genitourinary Past Medical Hx Grid
Denies Genitourinary History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Health History II
Musculoskeletal Past Medical Hx Grid
Denies Musculoskeletal History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Ocular Medical History Grid
Other : Self, use reading glasses

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Endocrine/Metabolic Past Med Hx Grid
Denies Metabolic History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Neurological Past Medical History Grid
Denies Neurological History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Hematologic Past Medical History Grid
Denies Hematologic History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Immunologic Medical History Grid
Denies Immunologic History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Admit/Discharge/Transfer Forms

Chronic Pain History Grid
Denies Chronic Pain : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Psychiatric Past Medical History Grid
Denies Psychiatric History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Gynecologic Medical History Grid
Denies Gynecologic History : Self

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Is this an Oncology patient? : No

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Health History III
MRI/MRA First Screening, Patient History Includes : None

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Allergy
Allergies (Active)

REGLAN	*Estimated Onset Date:* Unspecified ; *Created By:* CONTRIBUTOR_SYSTEM , IBEX; *Reaction Status:* Active ; *Substance:* REGLAN ; *Updated By:* CONTRIBUTOR_SYSTEM , IBEX; *Reviewed Date:* 06/12/2012 21:34 PDT

Pneumococcal Vaccine Screening
Ready to Screen for Pneumococcal Vaccine : Yes
Is Pt under 18 or a Post Partum Pt? : No
Pneumococcal Vaccine History : Has never received vaccine
Pneumococcal Vaccine Contraindications : No contraindications
Pneumococcal Vaccine Indications : 65 yrs of age or older

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Infectious Disease Screening I
Patient has history of MRSA : No
Patient has history of VRE : No
Admission to ICU/CCU : No
Patient transferred from Skilled Nursing Facility : No
Pt discharged from acute care hospital in last 30 day : No
Patient Receiving In-patient Dialysis : No
Joint Replacement Surgery is Scheduled : No
Cardiac Surgery is Scheduled : No
Patient Has Diarrhea on Admission : No
Contact Isolation Precautions in Place : No

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Infection Control Education
Home Caregiver Present for Session : No
Barriers to Learning : None evident
Teaching Method : Explanation

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Infection Control Education Grid

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit/Discharge/Transfer Forms

Handwashing : Verbalizes

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Nutrition
Home Diet : Regular
Appetite : Good
Eating Difficulties : None
Feeding Ability : Complete independence
Weight Change in Last 6 Months : No change

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : No
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
History of Skin Breakdown/Decubitus Ulcers : No

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Nutritional Risk Score : 0

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Functional
Living Situation : Home independently

Manzano RN, Brenda P - 06/12/2012 21:45 PDT

Social Habits
Alcohol Use Grid

Alcohol Use :	Current
Type :	Other: cognac / whiskey
Frequency :	Occasionally
	Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Tobacco Use Grid

Tobacco Use :	Other: ex-smoker
Type :	Cigarettes
Last Use :	31 years ago
	Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Recreational Drug Use Grid

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit/Discharge/Transfer Forms

Drug Use :	None
	Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Psychosocial
Domestic Concerns : None
Concerns About Family Members at Home : No
Emotional Support Available : Yes

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Abuse Indicators
Abuse Indicators : No indicators of abuse

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Cultural/Spiritual
Religious Preference : christian othodox
Social Cause Band Present : No

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Advance Directive/Decision Maker
Advanced Directives : Yes
Name Of Alternative Decision Maker : 1. Yolla 909-261-0624
2. Irma 909-374-7216

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Advance Directive - Yes
Advance Directive Location : Family to bring in copy from home
Agent Name and Number : Irma Kawaguchi
909-374-7216
Alternative Decision Maker : Named by patient to make medical decisions
Name Of Alternative Decision Maker : Yolla terz- friend
Irma Kawaguchi
Spokesperson : Yolla Terz 909-261-0624
Irma 909-374-7216

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Educ Needs
Patient/Family Education Needs : Immunizations, Safety, fall, Treatments/Procedures/Tests

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Learning Style Preference Adult Grid
Patient : None

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

DC Needs
Discharge To, Anticipated : Home independently
Home Treatments, Anticipated : None
Home Caregiver Name/Relationship : Irma- friend
Home Equipment, Anticipated : None

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Admit Belongings
Belongings in Patient's Possession : Shoes, Shirt, Pants, Cell Phone (Biomed Contacted), Rings, Watch, Wallet, Eyeglasses

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit/Discharge/Transfer Forms

Patient Instructions of Belongings : Do not leave containers or belongings in bed, Do not leave containers or belongings on meal tray, Advised that hospital staff cannot watch belongings, Advised that hospital staff is not responsible for damages, Advised that hospital staff is not responsible for losses, Advised to send belongings home, Advised to send valuables (i.e. money, credit cards) to Security

Manzano RN, Brenda P - 06/12/2012 22:16 PDT

Assessment Forms

Adult Ongoing Assessment Entered On: 06/14/2012 16:04 PDT
Performed On: 06/14/2012 15:45 PDT by Vertulfo RN, Erlyn V

General
Level of Consciousness : Awake
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Subjective
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Left : 1+ Thready
Dorsalis Pedis Pulse, Right : 1+ Thready

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Respiratory
Respirations : Unlabored, Symmetrical

Assessment Forms

Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Nutritional Risk Score : 1

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Integumentary
Skin Integrity : Intact (no broken skin)
Minor Skin Abnormality : None

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Braden/Other
Sensory Perception Braden : No impairment
Moisture Braden : Rarely moist
Activity Braden : Walks occasionally
Mobility Braden : No limitations
Nutrition Braden : Adequate
Friction and Shear Braden : No apparent problem
Braden Score : 21
Pressure Reduction Surface : Versacare
Positioning/Pressure Reducing Devices : Pillow
Turning Assessment : Turns independently

Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Peripheral IV
Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Discontinue
Laterality :	Right

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

IV Site :	Antecubital
Comments	(Comment: patient d/c home [Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT])
	Vertulfo RN, Erlyn V - 06/14/2012 16:02 PDT

Adult Ongoing Assessment Entered On: 06/14/2012 12:22 PDT
Performed On: 06/14/2012 12:00 PDT by Vertulfo RN, Erlyn V

General
Level of Consciousness : Awake
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Left : 1+ Thready
Dorsalis Pedis Pulse, Right : 1+ Thready

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Neuro Assess/Checks
Orientation : Oriented x 3, Follows commands
Hallucinations Present : None
Extremity Movement : Equal
Pupils Equal, Round, Reactive to Light, and Accommodation : Yes
Facial Symmetry : Symmetric
Gait : Steady
Characteristics of Speech : Clear
Aspiration Risk : None

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Nutritional Risk Score : 1

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Integumentary
Skin Integrity : Intact (no broken skin)
Minor Skin Abnormality : None

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Braden/Other
Sensory Perception Braden : No impairment
Moisture Braden : Rarely moist

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Activity Braden : Walks occasionally
Mobility Braden : No limitations
Nutrition Braden : Adequate
Friction and Shear Braden : No apparent problem
Braden Score : 21
Pressure Reduction Surface : Versacare
Positioning/Pressure Reducing Devices : Pillow
Turning Assessment : Turns independently

Vertulfo RN, Erlyn V - 06/14/2012 12:21 PDT

Morse Fall Risk Scale Entered On: 06/14/2012 8:14 PDT
Performed On: 06/14/2012 8:00 PDT by Vertulfo RN, Erlyn V

Morse Fall Risk
History of Fall in Last 3 Months Morse : No
Presence of Secondary Diagnosis Morse : Yes
Use of Ambulatory Aid Morse : None, bedrest, wheelchair, nurse
IV/Heparin Lock Fall Risk Morse : Yes
Gait Weak or Impaired Fall Risk Morse : Normal, bedrest, immobile
Mental Status Fall Risk Morse : Oriented to own ability
Morse Fall Risk Score : 35

Vertulfo RN, Erlyn V - 06/14/2012 8:13 PDT

Education
Home Caregiver Present for Session : No
Barriers to Learning : None evident
Teaching Method : Explanation

Vertulfo RN, Erlyn V - 06/14/2012 8:13 PDT

Fall Prevention Education Topics Grid
Action if Fall Occurs : Verbalizes understanding
Assistive Equipment Use : Verbalizes understanding
Bed Height : Verbalizes understanding
Call Light Use, Conventional : Verbalizes understanding
Call Light Use, Special : Verbalizes understanding
Environmental Management : Verbalizes understanding
Eyeglasses Use : Verbalizes understanding
Fall Prevention Protocol : Verbalizes understanding
Fall Risk Factors : Verbalizes understanding
Handrail/Grab Bar Use : Verbalizes understanding
Night Light Use : Verbalizes understanding
Nonskid Footwear Use : Verbalizes understanding
Personal Article Availability : Verbalizes understanding
Safety Aids : Verbalizes understanding
Side Rails for Support : Verbalizes understanding
Transfer/Mobility Techniques : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 8:13 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Adult Ongoing Assessment Entered On: 06/14/2012 8:21 PDT
Performed On: 06/14/2012 8:00 PDT by Vertulfo RN, Erlyn V

General
Level of Consciousness : Sleeping/Easily aroused
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Other: poor appetite
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Comfort Measures
Comfort Measures Grid
Warm Blanket Application : Yes
Comfortable Environment : Yes
Encourage Visitors : Yes
Positioning : Yes
Positive Self-Talk : Yes
Pressure Relief : Yes
Quiet Environment : Yes
Relaxation : Yes
Rest : Yes

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Left : 1+ Thready
Dorsalis Pedis Pulse, Right : 1+ Thready

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place
Bleeding Assessment : No bleeding noted
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Bleeding Precautions Education
Importance of ongoing monitoring : Verbalizes understanding
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Neuro Assess/Checks
Orientation : Oriented x 3, Follows commands
Hallucinations Present : None
Extremity Movement : Equal
Pupils Equal, Round, Reactive to Light, and Accommodation : Yes
Facial Symmetry : Symmetric
Gait : Steady
Characteristics of Speech : Clear
Aspiration Risk : None
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Glasgow Coma
Eye Opening Response Glasgow : Spontaneously
Best Verbal Response Glasgow : Oriented
Best Motor Response Glasgow : Obeys simple commands
Glasgow Coma Score : 15
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Musculoskeletal
Denies Musculoskeletal Problems : Yes
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Gastrointestinal
Abdomen Description : Symmetric, Soft
Bowel Sounds All Quadrants : Present
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change
Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Nutritional Risk Factors

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Nutritional Risk Score : 1

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Genitourinary
Urinary Elimination : Voiding, no difficulties

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Integumentary
Skin Integrity : Intact (no broken skin)
Minor Skin Abnormality : None

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Braden/Other
Sensory Perception Braden : No impairment
Moisture Braden : Rarely moist
Activity Braden : Walks occasionally
Mobility Braden : No limitations
Nutrition Braden : Probably inadequate
Friction and Shear Braden : No apparent problem
Braden Score : 20
Pressure Reduction Surface : Versacare
Turning Assessment : Turns independently

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Peripheral IV
Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Catheter Type :	Over the needle
Site Condition :	No complications
Drainage Description :	None
Dressing/ Activity :	Dry, Intact, Transparent
Flow/ Patency :	No complications

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

	Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Safety
Patient Safety : Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Isolation & Infection Prevention Education
Infection Control Education Grid
Handwashing : Verbalizes

Vertulfo RN, Erlyn V - 06/14/2012 10:56 PDT

Education
Home Caregiver Present for Session : No
Barriers to Learning : None evident
Teaching Method : Explanation

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Adult Ongoing Education Grid
Activity Expectations : Verbalizes understanding
Allergies : Verbalizes understanding
Bathing/Hygiene : Verbalizes understanding
Cough/Deep Breathing : Verbalizes understanding
Diet/Nutrition : Verbalizes understanding
(Comment: patient has poor appetite [Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT])
Med Dosage, Route, Scheduling : Verbalizes understanding
Medication Precautions : Verbalizes understanding
Medication Side Effects : Verbalizes understanding
Med Generic/Brand Name, Purpose, Action : Verbalizes understanding
Oral Care : Verbalizes understanding
Pain Management : Verbalizes understanding
Plan of Care : Verbalizes understanding
Safety, Fall : Verbalizes understanding
When to Call Healthcare Provider : Verbalizes understanding

Vertulfo RN, Erlyn V - 06/14/2012 8:15 PDT

Adult Ongoing Assessment Entered On: 06/14/2012 4:20 PDT
Performed On: 06/14/2012 4:00 PDT by Jaques RN, Callee M

General
Level of Consciousness : Awake
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

(Comment: Patient awake and up to bathroom. Steady gait. No dizziness. No signs of distress [Jaques RN, Callee M - 06/14/2012 4:17 PDT])
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Comfort Measures
Comfort Measures Grid
Comfortable Environment : Yes

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Cardiovascular Detailed Assessment : Yes
Cardiac Rhythm/Pacemaker : Yes

Jaques RN, Callee M - 06/14/2012 4:17 PDT

CV Detailed
Pulses Detailed Grid
Posttibial Pulse, Left : 2+ Normal
Posttibial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Neuro Assess/Checks
Orientation : Oriented x 3

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Nutritional Risk Score : 1

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Integumentary
Skin Integrity : Intact (no broken skin), Incision present (see detailed assessment)
Minor Skin Abnormality : None

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Incision/Wounds
Incision/Wound Routine Documentation

	Incision/Wound #1
Location :	Right, Groin
Type :	Unable to visualize, dressing intact
Drainage :	None
Dressing :	Dry, Intact, Other: destat
	Jaques RN, Callee M - 06/14/2012 4:17 PDT

Braden/Other
Pressure Reduction Surface : Versacare
Turning Assessment : Turns independently

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Peripheral IV

Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Site Condition :	No complications
Dressing/ Activity :	Dry, Intact
Flow/ Patency :	No complications
	Jaques RN, Callee M - 06/14/2012 4:17 PDT

Safety

Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Jaques RN, Callee M - 06/14/2012 4:17 PDT

Nursing Note Entered On: 06/14/2012 1:16 PDT
Performed On: 06/14/2012 1:00 PDT by Jaques RN, Callee M

Nursing Note

Nursing Narrative Note : Encourage pt to drink fluids due to no voiding after catheter removal. Patient stated he voided a small amount after catheter removal while in restroom.

Jaques RN, Callee M - 06/14/2012 1:13 PDT

Adult Ongoing Assessment Entered On: 06/14/2012 0:37 PDT
Performed On: 06/14/2012 0:00 PDT by Jaques RN, Callee M

General

Level of Consciousness : Sleeping/Easily aroused
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Subjective

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Pain Goal Numeric : 0
Suicidal Ideation : No
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Cardiovascular
Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/14/2012 4:20 PDT

Cardiovascular Detailed Assessment : Yes

Jaques RN, Callee M - 06/14/2012 4:20 PDT

Heart Rhythm : Regular

Jaques RN, Callee M - 06/14/2012 0:33 PDT

CV Detailed
Pulses Detailed Grid
Posttibial Pulse, Left : 2+ Normal
Posttibial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/14/2012 4:20 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place
Bleeding Assessment : No bleeding noted

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Neuro Assess/Checks
Orientation : Oriented x 3

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Nutritional Risk Score : 1

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Integumentary
Skin Integrity : Intact (no broken skin), Incision present (see detailed assessment)

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Incision/Wounds
Incision/Wound Routine Documentation

	Incision/Wound #1
Location :	Right, Groin
Type :	Unable to visualize, dressing intact
Drainage :	None
Dressing :	Dry, Other: destat
	Jaques RN, Callee M - 06/14/2012 0:33 PDT

Braden/Other
Pressure Reduction Surface : Versacare
Turning Assessment : Turns independently

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Peripheral IV
Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Site Condition :	No complications
Drainage Description :	None
Dressing/ Activity :	Dry, Intact, Transparent
Flow/ Patency :	No complications

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

	Jaques RN, Callee M - 06/14/2012 0:33 PDT

Safety
Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Jaques RN, Callee M - 06/14/2012 0:33 PDT

Morse Fall Risk Scale Entered On: 06/13/2012 22:39 PDT
Performed On: 06/13/2012 23:00 PDT by Jaques RN, Callee M

Morse Fall Risk
History of Fall in Last 3 Months Morse : No
Presence of Secondary Diagnosis Morse : Yes
Use of Ambulatory Aid Morse : None, bedrest, wheelchair, nurse
IV/Heparin Lock Fall Risk Morse : Yes
Gait Weak or Impaired Fall Risk Morse : Normal, bedrest, immobile
Mental Status Fall Risk Morse : Oriented to own ability
Morse Fall Risk Score : 35

Jaques RN, Callee M - 06/13/2012 22:38 PDT

Adult Ongoing Assessment Entered On: 06/13/2012 22:38 PDT
Performed On: 06/13/2012 20:00 PDT by Jaques RN, Callee M

General
Level of Consciousness : Awake
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Nausea
(Comment: Denied zofran at this time [Jaques RN, Callee M - 06/13/2012 22:29 PDT])
Cardiopulmonary Symptoms : Denies

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

GI Symptoms : Nausea, Other: poor appetite. Dry heaving. Patient complains of discomfort from a hiatal hernia.
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Comfort Measures
Comfort Measures Grid
Warm Blanket Application : Yes
Comfortable Environment : Yes
Enhance Sense of Personal Control : Yes
Meditation Facilitation : Yes
Positioning : Yes
Promote Bedtime Routines : Yes
Quiet Environment : Yes
Relaxation : Yes
Rest : Yes
Uninterrupted Periods of Sleep : Yes

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Cardiovascular Detailed Assessment : Yes

Jaques RN, Callee M - 06/13/2012 22:29 PDT

CV Detailed
Pulses Detailed Grid
Posttibial Pulse, Left : 2+ Normal
Posttibial Pulse, Right : 2+ Normal

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place
Bleeding Assessment : No bleeding noted

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Neuro Assess/Checks
Orientation : Oriented x 3
Hallucinations Present : None
Extremity Movement : Equal
Facial Symmetry : Symmetric

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Neurological Strengths Grid

	Left Upper Extremity	Right Upper Extremity	Left Lower Extremity	Right Lower Extremity
Strength :	Strong	Strong	Strong	Strong
Tone :	Normal	Normal	Normal	Normal
	Jaques RN, Callee M - 06/13/2012 22:29 PDT	Jaques RN, Callee M - 06/13/2012 22:29 PDT	Jaques RN, Callee M - 06/13/2012 22:29 PDT	Jaques RN, Callee M - 06/13/2012 22:29 PDT

Gait : Steady
Characteristics of Speech : Clear
Aspiration Risk : None

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Glasgow Coma
Eye Opening Response Glasgow : Spontaneously
Best Verbal Response Glasgow : Oriented
Best Motor Response Glasgow : Obeys simple commands
Glasgow Coma Score : 15

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Gastrointestinal
Abdomen Description : Symmetric, Soft
Bowel Sounds All Quadrants : Present
Stool Description : Clots

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Poor
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Nutritional Risk Score : 1

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Genitourinary
Urinary Elimination : Indwelling catheter
Urine Color : Yellow
Urine Description : Clear

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Integumentary
Skin Integrity : Intact (no broken skin), Incision present (see detailed assessment)
Mucous Membrane Color : Pink
Mucous Membrane Description : Moist
Minor Skin Abnormality : None
Skin Turgor : Elastic

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Incision/Wounds
Incision/Wound Routine Documentation

	Incision/Wound #1
Location :	Right, Groin
Type :	Unable to visualize, dressing intact
Drainage :	None
Dressing :	Dry, Intact, Other: destat covering
Comments	(Comment: Site is soft. No masses. [Jaques RN, Callee M - 06/13/2012 22:29 PDT])
	Jaques RN, Callee M - 06/13/2012 22:29 PDT

Braden/Other
Sensory Perception Braden : No impairment
Moisture Braden : Rarely moist
Activity Braden : Walks occasionally
Mobility Braden : No limitations
Nutrition Braden : Probably inadequate

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Friction and Shear Braden : Potential problem
Braden Score : 19
Pressure Reduction Surface : Versacare
Positioning/Pressure Reducing Devices : Pillow
Turning Assessment : Turns independently

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Peripheral IV

Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Catheter Type :	Over the needle
Site Condition :	No complications
Drainage Description :	None
Dressing/ Activity :	Dry, Intact, Transparent
Flow/ Patency :	No complications
	Jaques RN, Callee M - 06/13/2012 22:29 PDT

Safety

Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Education

Barriers to Learning : None evident
Teaching Method : Explanation

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Adult Ongoing Education Grid
Med Dosage, Route, Scheduling : Verbalizes understanding
Safety, Fall : Verbalizes understanding
When to Call Healthcare Provider : Verbalizes understanding

Jaques RN, Callee M - 06/13/2012 22:29 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 19:31 PDT
Performed On: 06/13/2012 18:45 PDT by Caler RN, Tiffany A

Assessment

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 19:31 PDT

Incision/Wound Routine

Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft, no hematoma
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 19:31 PDT

Braden/Other

Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 19:31 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 19:30 PDT
Performed On: 06/13/2012 17:45 PDT by Caler RN, Tiffany A

Assessment

Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 19:30 PDT

Incision/Wound Routine

Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 19:30 PDT

Braden/Other

Pressure Reduction Surface : Versacare

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Caler RN, Tiffany A - 06/13/2012 19:30 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 16:56 PDT
Performed On: 06/13/2012 16:45 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:55 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 16:55 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:55 PDT

Adult Ongoing Assessment Entered On: 06/13/2012 17:13 PDT
Performed On: 06/13/2012 16:00 PDT by Graf , Cara

Vital Signs
Numeric Pain Score : 9

Graf , Cara - 06/13/2012 17:04 PDT

General
Level of Consciousness : Awake
Distress : Mild
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Graf , Cara - 06/13/2012 17:04 PDT

Subjective
Pain Symptoms Self Report : Yes

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Nausea
Cardiopulmonary Symptoms : Denies
GI Symptoms : Nausea, Other: Reports substernal chest pain from chronic esophagitis
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Graf , Cara - 06/13/2012 17:04 PDT

Rapid Pain Assessment
Primary Pain Location : Head
Laterality : Bilateral
Primary Pain Quality : Other: Throbbing
Patient Preferred Pain Tool : Numeric rating
Numeric Pain Scale : 9
Numeric Pain Score : 9

Graf , Cara - 06/13/2012 17:04 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Graf , Cara - 06/13/2012 17:04 PDT
Graf , Cara - 06/13/2012 17:04 PDT

Pulses Grid
Dorsalis Pedis Pulse, Left : Doppler

Caler RN, Tiffany A - 06/13/2012 17:23 PDT

Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Right : 1+ Thready

Graf , Cara - 06/13/2012 17:04 PDT

Cardiovascular Detailed Assessment : Yes

Graf , Cara - 06/13/2012 17:04 PDT

Cardiac Rhythm
Cardiac Rhythm : Normal sinus rhythm

Caler RN, Tiffany A - 06/13/2012 17:23 PDT

Monitoring Lead : II
Atrial Rhythm : Regular
Ventricular Rhythm : Regular

Graf , Cara - 06/13/2012 17:04 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place
Bleeding Assessment : No bleeding noted

Graf , Cara - 06/13/2012 17:04 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Pulse Oximetry Monitoring : Intermittent
Suction : None

Graf , Cara - 06/13/2012 17:04 PDT

Neuro Assess/Checks
Orientation : Oriented x 3
Hallucinations Present : None
Extremity Movement : Equal
Facial Symmetry : Symmetric
Gait : Unable to assess
Characteristics of Speech : Clear
Aspiration Risk : None

Graf , Cara - 06/13/2012 17:04 PDT

Glasgow Coma
Eye Opening Response Glasgow : Spontaneously
Best Verbal Response Glasgow : Oriented
Best Motor Response Glasgow : Obeys simple commands
Glasgow Coma Score : 15

Graf , Cara - 06/13/2012 17:04 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Good
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Graf , Cara - 06/13/2012 17:04 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Graf , Cara - 06/13/2012 17:04 PDT

Nutritional Risk Score : 1

Graf , Cara - 06/13/2012 17:04 PDT

Genitourinary
Urinary Elimination : Indwelling catheter
Urine Color : Yellow
Urine Description : Clear

Graf , Cara - 06/13/2012 17:04 PDT

Integumentary

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Skin Integrity : Wound present (see detailed assessment)

Graf , Cara - 06/13/2012 17:04 PDT

Incision/Wounds

Incision/Wound Routine Documentation

	Incision/Wound #1
Location :	Right, Groin
Type :	Puncture
Drainage :	None
Dressing :	Dry, Other: Dstat
Comments	(Comment: area soft [Caler RN, Tiffany A - 06/13/2012 17:23 PDT])
	Caler RN, Tiffany A - 06/13/2012 17:23 PDT

Braden/Other

Pressure Reduction Surface : Versacare

Graf , Cara - 06/13/2012 17:04 PDT

Safety

Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Graf , Cara - 06/13/2012 17:04 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 16:08 PDT
Performed On: 06/13/2012 15:45 PDT by Caler RN, Tiffany A

Assessment

Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:08 PDT

~~{ [Incision present (see detailed assessment)] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT},~~

Incision/Wound Routine

Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture Caler RN, Tiffany A - 06/13/2012 16:08 PDT { [Puncture] ~~- previously~~

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

	~~charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~
Location :	Right, Groin Caler RN, Tiffany A - 06/13/2012 16:08 PDT ~~{[Right, Groin] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~
Surrounding Tissue :	Other: soft, no signs hematoma Caler RN, Tiffany A - 06/13/2012 16:08 PDT ~~{[Other: soft, no signs hematoma] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~
Drainage :	None Caler RN, Tiffany A - 06/13/2012 16:08 PDT ~~{[None] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~
Dressing :	Other: D stat dry and intact Caler RN, Tiffany A - 06/13/2012 16:08 PDT ~~{[Other: D stat dry and intact] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

	Caler RN, Tiffany A - 06/13/2012 16:07 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:08 PDT
~~{ [Versacare] - previously charted by Caler RN, Tiffany A at 06/13/2012 16:07 PDT};~~

Focused Assessment - Integumentary Entered On: 06/13/2012 16:07 PDT
Performed On: 06/13/2012 14:45 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 16:06 PDT
Performed On: 06/13/2012 14:15 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:06 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 16:05 PDT
Performed On: 06/13/2012 13:45 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:04 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 16:04 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:04 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Focused Assessment - Integumentary Entered On: 06/13/2012 16:04 PDT
Performed On: 06/13/2012 13:15 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:03 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft, no signs hematoma
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 16:03 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:03 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 16:03 PDT
Performed On: 06/13/2012 12:45 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 16:02 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

	Caler RN, Tiffany A - 06/13/2012 16:02 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 16:02 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 12:32 PDT
Performed On: 06/13/2012 12:30 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)
Skin Temperature : Warm
Skin Turgor : Elastic
Minor Skin Abnormality : None

Caler RN, Tiffany A - 06/13/2012 12:29 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 12:29 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 12:29 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 12:29 PDT
Performed On: 06/13/2012 12:15 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 12:28 PDT

Incision/Wound Routine

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft
Drainage :	None
Dressing :	Other: D stat dry and intact
	Caler RN, Tiffany A - 06/13/2012 12:28 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 12:28 PDT

Focused Assessment - Integumentary Entered On: 06/13/2012 12:26 PDT
Performed On: 06/13/2012 12:00 PDT by Caler RN, Tiffany A

Assessment
Skin Integrity : Incision present (see detailed assessment)

Caler RN, Tiffany A - 06/13/2012 12:25 PDT

Incision/Wound Routine
Incision/Wound Routine Ultra Grid

	Incision/Wound #1
Type :	Puncture
Location :	Right, Groin
Surrounding Tissue :	Other: soft, no signs of hematoma
Drainage :	None
Dressing :	Other: D stat intact
	Caler RN, Tiffany A - 06/13/2012 12:25 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Caler RN, Tiffany A - 06/13/2012 12:25 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Adult Ongoing Assessment Entered On: 06/13/2012 15:58 PDT
Performed On: 06/13/2012 12:00 PDT by Graf , Cara

Vital Signs
Numeric Pain Score : 4

Graf , Cara - 06/13/2012 15:48 PDT

General
Level of Consciousness : Awake
Distress : Mild
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Graf , Cara - 06/13/2012 15:48 PDT

Subjective
Genitourinary Symptoms : Retention, Other: pt unable to urinate unless he stands and is having pain from full bladder, MD paged.

Caler RN, Tiffany A - 06/13/2012 16:09 PDT

Pain Symptoms Self Report : Yes
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Nausea, Other: Reports having substernal pain from chronic esophagitis
Neurological/Neuromuscular Symptoms : Denies

Graf , Cara - 06/13/2012 15:48 PDT

Rapid Pain Assessment
Primary Pain Location : Suprapubic
Patient Preferred Pain Tool : Numeric rating
Numeric Pain Scale : 4
Numeric Pain Score : 4

Graf , Cara - 06/13/2012 15:48 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Graf , Cara - 06/13/2012 15:48 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Left : Doppler
Dorsalis Pedis Pulse, Right : Doppler

Graf , Cara - 06/13/2012 15:48 PDT

Cardiac Rhythm

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Cardiac Rhythm : Normal sinus rhythm

Caler RN, Tiffany A - 06/13/2012 16:09 PDT

Monitoring Lead : II
Atrial Rhythm : Regular
Ventricular Rhythm : Regular

Graf , Cara - 06/13/2012 15:48 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place
Bleeding Assessment : No bleeding noted

Graf , Cara - 06/13/2012 15:48 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None
Suction : None

Graf , Cara - 06/13/2012 15:48 PDT

Neuro Assess/Checks
Orientation : Oriented x 3
Hallucinations Present : None
Extremity Movement : Equal
Facial Symmetry : Symmetric
Gait : Unable to assess
Characteristics of Speech : Clear
Aspiration Risk : None

Graf , Cara - 06/13/2012 15:48 PDT

Glasgow Coma
Eye Opening Response Glasgow : Spontaneously
Best Verbal Response Glasgow : Oriented
Best Motor Response Glasgow : Obeys simple commands
Glasgow Coma Score : 15

Graf , Cara - 06/13/2012 15:48 PDT

Gastrointestinal
Abdomen Description : Symmetric, Soft
Bowel Sounds All Quadrants : Present

Graf , Cara - 06/13/2012 15:48 PDT

Nutrition
Nutrition Information Reassessed : Reassess - changes noted, see following documentation for details
Home Diet : Regular
Appetite : Good
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Graf , Cara - 06/13/2012 15:48 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : Yes

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No
Geriatric Surgical Patient : No
Lactation : No

Graf , Cara - 06/13/2012 15:48 PDT

Nutritional Risk Score : 1

Graf , Cara - 06/13/2012 15:48 PDT

Genitourinary
Urinary Elimination : Other: difficulty voiding
~~*Urine Color :* Yellow [IN ERROR]~~

~~{ [Yellow] - previously charted by Graf , Cara at 06/13/2012 15:48 PDT (Not Validated) };~~
~~*Urine Description :* Clear [IN ERROR]~~

Graf , Cara - 06/13/2012 16:09 PDT
~~{ [Clear] - previously charted by Graf , Cara at 06/13/2012 15:48 PDT (Not Validated) };~~

Integumentary
Skin Turgor : Elastic

Caler RN, Tiffany A - 06/13/2012 16:09 PDT

Skin Integrity : Incision present (see detailed assessment)
Mucous Membrane Color : Pink
Mucous Membrane Description : Moist

Graf , Cara - 06/13/2012 15:48 PDT

Incision/Wounds
Incision/Wound Routine Documentation

	Incision/Wound #1
Location :	Right, Groin
Type :	Puncture
Drainage :	None
Dressing :	Other: D stat intact
Comments	(Comment: No hematoma, area soft [Caler RN, Tiffany A - 06/13/2012 16:09 PDT])
	Graf , Cara - 06/13/2012 16:09 PDT

Braden/Other
Pressure Reduction Surface : Versacare

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Graf , Cara - 06/13/2012 15:48 PDT

Safety
Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
Graf , Cara - 06/13/2012 16:09 PDT
Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions
Graf , Cara - 06/13/2012 15:48 PDT

Education
Adult Ongoing Education Grid
Postoperative Instructions : Verbalizes understanding
(Comment: pt given post cath instructions [Caler RN, Tiffany A - 06/13/2012 16:09 PDT])
Caler RN, Tiffany A - 06/13/2012 16:09 PDT

Bleeding Precautions Entered On: 06/13/2012 12:07 PDT
Performed On: 06/13/2012 11:27 PDT by Caler RN, Tiffany A

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place, Coagulation studies monitored
Bleeding Assessment : No bleeding noted
Caler RN, Tiffany A - 06/13/2012 12:07 PDT

Adult Ongoing Assessment Entered On: 06/13/2012 10:07 PDT
Performed On: 06/13/2012 8:00 PDT by Graf , Cara

General
Level of Consciousness : Drowsy
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm
Graf , Cara - 06/13/2012 10:02 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 0
Suicidal Ideation : No
General Symptoms : Denies
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies
Graf , Cara - 06/13/2012 10:02 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Comfort Measures
Comfort Measures Grid
Quiet Environment : Yes
Relaxation : Yes
Rest : Yes

Graf , Cara - 06/13/2012 10:02 PDT

Cardiovascular
Heart Rhythm : Regular
Nail Bed Color : Pink
Edema : None

Graf , Cara - 06/13/2012 10:02 PDT

Pulses Grid
Radial Pulse, Left : 2+ Normal
Radial Pulse, Right : 2+ Normal
Dorsalis Pedis Pulse, Left : 2+ Normal
Dorsalis Pedis Pulse, Right : 2+ Normal

Graf , Cara - 06/13/2012 10:02 PDT

Cardiac Rhythm
Cardiac Rhythm : Sinus bradycardia

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Monitoring Lead : II
Atrial Rhythm : Regular
Ventricular Rhythm : Regular

Graf , Cara - 06/13/2012 10:02 PDT

Bleeding Precautions
Bleeding Precautions : Bleeding precautions in place, Coagulation studies monitored
Bleeding Assessment : No bleeding noted

Graf , Cara - 06/13/2012 10:02 PDT

Respiratory
Respirations : Unlabored, Symmetrical
Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None
Pulse Oximetry Monitoring : Intermittent
Suction : None

Graf , Cara - 06/13/2012 10:02 PDT

Resp Detailed
Breath Sounds Detailed Assessment Grid
LUL : Clear
RUL : Clear
RML : Clear
LLL : Clear
RLL : Clear

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Neuro Assess/Checks
Orientation : Oriented x 3
Hallucinations Present : None

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Extremity Movement : Equal
Facial Symmetry : Symmetric

Graf , Cara - 06/13/2012 10:02 PDT

Neurological Strengths Grid

	Left Upper Extremity	Right Upper Extremity	Left Lower Extremity	Right Lower Extremity
Strength :	Strong	Strong	Strong	Strong
Tone :	Normal	Normal	Normal	Normal
Sensation :	Intact	Intact	Intact	Intact
	Graf , Cara - 06/13/2012 10:02 PDT	Graf , Cara - 06/13/2012 10:02 PDT	Graf , Cara - 06/13/2012 10:02 PDT	Graf , Cara - 06/13/2012 10:02 PDT

Gait : Unable to assess
Characteristics of Speech : Clear
Aspiration Risk : None

Graf , Cara - 06/13/2012 10:02 PDT

Glasgow Coma
Eye Opening Response Glasgow : Spontaneously
Best Verbal Response Glasgow : Oriented
Best Motor Response Glasgow : Obeys simple commands
Glasgow Coma Score : 15

Graf , Cara - 06/13/2012 10:02 PDT

Musculoskeletal
Denies Musculoskeletal Problems : Yes

Graf , Cara - 06/13/2012 10:02 PDT

Gastrointestinal
Abdomen Description : Symmetric, Soft
Bowel Sounds All Quadrants : Present

Graf , Cara - 06/13/2012 10:02 PDT

Nutrition
Nutrition Information Reassessed : Reassess - changes noted, see following documentation for details
Home Diet : Regular
Appetite : Good
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Graf , Cara - 06/13/2012 10:02 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : No
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

History of Skin Breakdown/Decubitus Ulcers : No

Graf , Cara - 06/13/2012 10:02 PDT

Nutritional Risk Score : 0

Graf , Cara - 06/13/2012 10:02 PDT

Genitourinary
Bladder Distention : Absent

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Urinary Elimination : Voiding, no difficulties

Graf , Cara - 06/13/2012 10:02 PDT

Integumentary
Mucous Membrane Description : Moist

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Skin Integrity : Intact (no broken skin)
Mucous Membrane Color : Pink
Minor Skin Abnormality : None
Skin Turgor : Elastic

Graf , Cara - 06/13/2012 10:02 PDT

Braden/Other
Sensory Perception Braden : No impairment
Moisture Braden : Rarely moist
Activity Braden : Walks occasionally
Mobility Braden : No limitations
Nutrition Braden : Adequate
Friction and Shear Braden : Potential problem
Braden Score : 20
Pressure Reduction Surface : Versacare
Positioning/Pressure Reducing Devices : Pillow
Turning Assessment : Turns independently

Graf , Cara - 06/13/2012 10:02 PDT

Peripheral IV
Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Catheter Type :	Over the needle
Site Condition :	No complications
Drainage Description :	None
Dressing/ Activity :	Dry
Flow/ Patency :	No complications
	Graf , Cara - 06/13/2012 10:02 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Safety
Patient Safety : All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Patient Safety Signs Displayed : Bleeding Precautions, Fall precautions

Graf , Cara - 06/13/2012 10:02 PDT

Education
Barriers to Learning : None evident
Teaching Method : Explanation

Graf , Cara - 06/13/2012 10:02 PDT
Graf , Cara - 06/13/2012 10:02 PDT

Adult Ongoing Education Grid
When to Call Healthcare Provider : Verbalizes understanding

Caler RN, Tiffany A - 06/13/2012 11:24 PDT

Plan of Care : Verbalizes understanding
Planned Procedure : Verbalizes understanding

Graf , Cara - 06/13/2012 10:02 PDT

Adult Ongoing Assessment Entered On: 06/13/2012 3:55 PDT
Performed On: 06/13/2012 4:00 PDT by Manzano RN, Brenda P

General
Level of Consciousness : Awake
Distress : None
Affect/Behavior : Appropriate, Calm, Cooperative
Skin Description : Dry
Skin Color : Normal for ethnicity
Skin Temperature : Warm

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Subjective
Pain Symptoms Self Report : No
Pain Goal Numeric : 3
Suicidal Ideation : No
Cardiopulmonary Symptoms : Denies
GI Symptoms : Denies
Genitourinary Symptoms : Denies
Neurological/Neuromuscular Symptoms : Denies

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Cardiac Rhythm
Monitoring Lead : II
Cardiac Rhythm : Normal sinus rhythm

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Respiratory
Respirations : Unlabored, Symmetrical

Assessment Forms

Respiratory Pattern Description : Regular
All Lobes Breath Sounds : Clear
Cough : None
Pulse Oximetry Monitoring : Intermittent

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Nutrition
Nutrition Information Reassessed : Reassessed, no changes noted
Home Diet : Regular
Appetite : Good
Eating Difficulties : None
Weight Change in Last 6 Months : No change

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Nutritional Risk Factors
Constipation : No
Diarrhea : No
Nausea : No
Vomiting : No
Anorexia Disease/Bulimia Nervosa : No
TPN Feedings : No
Enteral Feedings : No
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
Impaired Nutritional Intake : No
History of Skin Breakdown/Decubitus Ulcers : No

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Nutritional Risk Score : 0

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Integumentary
Skin Integrity : Intact (no broken skin)
Mucous Membrane Color : Pink
Mucous Membrane Description : Moist
Minor Skin Abnormality : None
Skin Turgor : Decreased

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Braden/Other
Pressure Reduction Surface : Versacare
Turning Assessment : Turns independently

Manzano RN, Brenda P - 06/13/2012 3:54 PDT

Adult Ongoing Assessment Entered On: 06/13/2012 1:55 PDT
Performed On: 06/13/2012 0:05 PDT by Manzano RN, Brenda P

General
Level of Consciousness : Sleeping/Easily aroused
~~{ [Sleeping/Easily aroused] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Distress : None

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

~~{ [None] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Affect/Behavior : Calm

~~{ [Calm] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Skin Description : Dry

~~{ [Dry] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Skin Color : Normal for ethnicity

~~{ [Normal for ethnicity] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Skin Temperature : Warm

Manzano RN, Brenda P - 06/13/2012 1:55 PDT

~~{ [Warm] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Subjective

Pain Symptoms Self Report : No

~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Pain Goal Numeric : 3

~~{ [3] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Suicidal Ideation : No

~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

General Symptoms : Denies

~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Cardiopulmonary Symptoms : Denies

~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

GI Symptoms : Denies

~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Genitourinary Symptoms : Denies

~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Neurological/Neuromuscular Symptoms : Denies

Manzano RN, Brenda P - 06/13/2012 1:55 PDT

~~{ [Denies] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Respiratory

Respirations : Unlabored, Symmetrical

Manzano RN, Brenda P - 06/13/2012 1:55 PDT

~~{ [Unlabored, Symmetrical] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Nutrition

Nutrition Information Reassessed : Reassessed, no changes noted

~~{ [Reassessed, no changes noted] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Home Diet : Regular

~~{ [Regular] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Appetite : Good

~~{ [Good] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Eating Difficulties : None

~~{ [None] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Weight Change in Last 6 Months : No change

Manzano RN, Brenda P - 06/13/2012 1:55 PDT

~~{ [No change] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Nutritional Risk Factors

Constipation : No

~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Assessment Forms

Diarrhea : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Nausea : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Vomiting : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Anorexia Disease/Bulimia Nervosa : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
TPN Feedings : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Enteral Feedings : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Fluid Intake Less Than 50% of Normal in Last 3 Days : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Impaired Nutritional Intake : No
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
History of Skin Breakdown/Decubitus Ulcers : No
Manzano RN, Brenda P - 06/13/2012 1:55 PDT
~~{ [No] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Nutritional Risk Score : 0
Manzano RN, Brenda P - 06/13/2012 1:55 PDT
~~{ [0] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Integumentary
Skin Integrity : Intact (no broken skin)
~~{ [Intact (no broken skin)] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Minor Skin Abnormality : None
Manzano RN, Brenda P - 06/13/2012 1:55 PDT
~~{ [None] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Braden/Other
Pressure Reduction Surface : Versacare
~~{ [Versacare] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~
Turning Assessment : Turns independently
Manzano RN, Brenda P - 06/13/2012 1:55 PDT
~~{ [Turns independently] - previously charted by Manzano RN, Brenda P at 06/13/2012 1:54 PDT};~~

Morse Fall Risk Scale Entered On: 06/12/2012 23:12 PDT
Performed On: 06/12/2012 23:00 PDT by Manzano RN, Brenda P

Morse Fall Risk
History of Fall in Last 3 Months Morse : No
Presence of Secondary Diagnosis Morse : No
Use of Ambulatory Aid Morse : None, bedrest, wheelchair, nurse
IV/Heparin Lock Fall Risk Morse : Yes
Gait Weak or Impaired Fall Risk Morse : Normal, bedrest, immobile
Mental Status Fall Risk Morse : Oriented to own ability

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Assessment Forms

Morse Fall Risk Score : 20

Manzano RN, Brenda P - 06/12/2012 23:11 PDT

Communication Forms

Order Entry Details Entered On: 06/14/2012 8:14 PDT
Performed On: 06/14/2012 8:00 PDT by Vertulfo RN, Erlyn V

Order Details
Transport Mode Order Detail : Wheelchair
IV Order Detail : Yes
Pregnant Order Detail : N/A
Oxygen Order Detail : No
Nurse Collect Blood Specimen : No
EKG Monitor : No
Preferred Language : English
Poor Historian Order Detail : No

Vertulfo RN, Erlyn V - 06/14/2012 8:14 PDT

Order Entry Details Entered On: 06/13/2012 22:26 PDT
Performed On: 06/13/2012 20:00 PDT by Jaques RN, Callee M

Order Details
Transport Mode Order Detail : Wheelchair
IV Order Detail : Yes
Pregnant Order Detail : N/A
Oxygen Order Detail : No
Nurse Collect Blood Specimen : No
EKG Monitor : No
Preferred Language : English
Poor Historian Order Detail : No

Jaques RN, Callee M - 06/13/2012 22:26 PDT

Clinician Notification/Collaboration Entered On: 06/13/2012 16:31 PDT
Performed On: 06/13/2012 16:27 PDT by Caler RN, Tiffany A

Clinician Notification
Name of Clinician Contacted : Agarwal M.D., Chandrahas
Staff Reason for Call : Condition
Method of Contact : Telephone

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Communication Forms

Information Provided : MD informed that pt having headache and is nauseated and unable to take PO tylenol. Tylenol suppository ordered. MD aware pt already recieved zofran for nausea, MD does not want to order any other anti-nausea medication at this time.
Action : Orders received

Caler RN, Tiffany A - 06/13/2012 16:27 PDT

SBAR Note Entered On: 06/13/2012 13:03 PDT
Performed On: 06/13/2012 12:52 PDT by Caler RN, Tiffany A

SBAR
Situation : Pt informed that urinary catheter insertion has risk of infection and trauma. Pt verbalized understanding and wants to proceed with foley insertion.

Caler RN, Tiffany A - 06/13/2012 13:02 PDT

Clinician Notification/Collaboration Entered On: 06/13/2012 13:01 PDT
Performed On: 06/13/2012 12:50 PDT by Caler RN, Tiffany A

Clinician Notification
Name of Clinician Contacted : Agarwal M.D., Chandrahas
Staff Reason for Call : Condition
Method of Contact : Telephone
Information Provided : MD returned 2nd page and informed pt in extruciating pain from full bladder and bladder scan shows 685 ml. Order for foley cath recieved, MD wants pt to be aware of risk of trauma and infection. MD also made aware that pt is going to stand and urinate if no catheter inserted.
Action : Orders received

Caler RN, Tiffany A - 06/13/2012 12:58 PDT

SBAR Note Entered On: 06/13/2012 12:45 PDT
Performed On: 06/13/2012 12:40 PDT by Caler RN, Tiffany A

SBAR
Situation : Pt still reports severe pain from full bladder, MD re-paged. Pt reporting that he is going to stand if we do not put catheter in. Pt informed on importance of keeping flat in bed and not getting up.

Caler RN, Tiffany A - 06/13/2012 12:43 PDT

SBAR Note Entered On: 06/13/2012 12:24 PDT
Performed On: 06/13/2012 12:21 PDT by Caler RN, Tiffany A

SBAR

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Communication Forms

Situation : pt reports pain from full bladder and still unable to use urinal. Bladder distended and bladder scan shows 685 ml of urine in bladder, MD re-paged.

Caler RN, Tiffany A - 06/13/2012 12:21 PDT

Clinician Notification/Collaboration Entered On: 06/13/2012 12:10 PDT
Performed On: 06/13/2012 12:05 PDT by Caler RN, Tiffany A

Clinician Notification
Name of Clinician Contacted : Agarwal M.D., Chandrahas
Staff Reason for Call : Condition, Patient concerns
Method of Contact : Telephone
Information Provided : MD informed that pt unable to urinate laying down and would like a urinary catheter. MD does not want a cath at this time, MD wants to be called at 1300 if still unable to urinate.
Action : No orders received

Caler RN, Tiffany A - 06/13/2012 12:07 PDT

Order Entry Details Entered On: 06/13/2012 8:21 PDT
Performed On: 06/13/2012 8:00 PDT by Caler RN, Tiffany A

Order Details
Transport Mode Order Detail : Gurney
IV Order Detail : Yes
Pregnant Order Detail : N/A
Oxygen Order Detail : No
EKG Monitor : No
Preferred Language : English
Poor Historian Order Detail : No

Caler RN, Tiffany A - 06/13/2012 8:21 PDT

Epidemiology Forms

Central Line Reporting Entered On: 06/14/2012 8:14 PDT
Performed On: 06/14/2012 8:00 PDT by Vertulfo RN, Erlyn V

Central Line Reporting
Central Line in Place at 0800 : No

Vertulfo RN, Erlyn V - 06/14/2012 8:14 PDT

Central Line Reporting Entered On: 06/13/2012 8:22 PDT
Performed On: 06/13/2012 8:00 PDT by Caler RN, Tiffany A

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Epidemiology Forms

Central Line Reporting
Central Line in Place at 0800 : No

Caler RN, Tiffany A - 06/13/2012 8:21 PDT

Lines, Tubes, Devices Forms

Urinary Catheter Insertion/Discontinuation Entered On: 06/13/2012 22:46 PDT
Performed On: 06/13/2012 21:30 PDT by Jaques RN, Callee M

Urinary Catheter
Urinary Catheter Activity Type : Discontinue
Urinary Catheter Insertion Site : Urethral
Urinary Catheter Size : 16 French
Urinary Catheter Type : Indwelling/Continuous
Urinary Catheter Balloon Inflation : 10 mL sterile water
Urinary Catheter Drainage System : Dependent drainage bag
Urine Description : Clear
Urinary Catheter Procedure Tolerance : Good
Urinary Catheter Procedure Response : Expected

Jaques RN, Callee M - 06/13/2012 22:46 PDT

Urinary Catheter Insertion/Discontinuation Entered On: 06/13/2012 13:26 PDT
Performed On: 06/13/2012 12:55 PDT by Caler RN, Tiffany A

Urinary Catheter
Urinary Catheter Activity Type : Insert
Urinary Catheter Insertion Site : Ureteral
Urinary Catheter Size : 18 French
Urinary Catheter Type : Indwelling/Continuous
Urinary Catheter Balloon Inflation : 10 mL sterile water
Urinary Catheter Drainage System : Dependent drainage bag
Urine Output Initial : 700.0mL
Urine Description : Clear
Urinary Catheter Procedure Tolerance : Good
Urinary Catheter Procedure Response : Expected

Caler RN, Tiffany A - 06/13/2012 13:25 PDT

Peripheral IV Insertion/Care/Removal Entered On: 06/12/2012 23:11 PDT
Performed On: 06/12/2012 23:00 PDT by Manzano RN, Brenda P

Peripheral IV

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Lines, Tubes, Devices Forms

Peripheral IV Assessment Grid

	Peripheral IV #1
IV Activity :	Assess
Laterality :	Right
IV Site :	Antecubital
Catheter Type :	Over the needle
Site Condition :	No complications
	Manzano RN, Brenda P - 06/12/2012 23:11 PDT

Pain Management Forms

PRN Response Entered On: 06/13/2012 13:38 PDT
Performed On: 06/13/2012 13:32 PDT by Caler RN, Tiffany A

PRN Medication Response
PRN Medication Effective : Yes
PRN Medication Effectiveness Evaluated : Numeric rating scale (0-10)

Caler RN, Tiffany A - 06/13/2012 13:38 PDT

Numeric Pain Scale (0-10)
Location : Abdomen
Numeric Pain Scale : 3
Numeric Pain Score : 3

Caler RN, Tiffany A - 06/13/2012 13:38 PDT

Point of Care Testing Forms

Intake and Output Entered On: 06/14/2012 15:52 PDT
Performed On: 06/14/2012 16:00 PDT by Rodriguez, Valerie M

I&O
Oral Intake : 240mL
Lunch : 90%

Rodriguez, Valerie M - 06/14/2012 15:52 PDT

Intake and Output Entered On: 06/14/2012 12:26 PDT
Performed On: 06/14/2012 12:00 PDT by Rodriguez, Valerie M

I&O

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

Oral Intake : 240mL
Urine Count Unmeasured : 1
Stool Count : 1
Breakfast : 95%

Rodriguez, Valerie M - 06/14/2012 12:26 PDT

Vital Signs Entered On: 06/14/2012 12:28 PDT
Performed On: 06/14/2012 12:00 PDT by Rodriguez, Valerie M

Vital Signs
Temperature Temporal Artery : 97.0degF(Converted to: 36.1degC) (LOW)
Heart Rate Monitored : 61bpm
Respiratory Rate : 20br/min
Mean Arterial Pressure, Cuff : 72mmHg
Systolic Blood Pressure : 103mmHg
Diastolic Blood Pressure : 56mmHg (LOW)
SpO2 : 95%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Rodriguez, Valerie M - 06/14/2012 12:27 PDT

Intake and Output Entered On: 06/14/2012 8:25 PDT
Performed On: 06/14/2012 8:00 PDT by Rodriguez, Valerie M

I&O
Oral Intake : 0mL

Rodriguez, Valerie M - 06/14/2012 8:25 PDT

Vital Signs Entered On: 06/14/2012 8:25 PDT
Performed On: 06/14/2012 8:00 PDT by Rodriguez, Valerie M

Vital Signs
Temperature Temporal Artery : 99.0degF(Converted to: 37.2degC)
Heart Rate Monitored : 64bpm
Respiratory Rate : 20br/min
Mean Arterial Pressure, Cuff : 86mmHg
Systolic Blood Pressure : 119mmHg
Diastolic Blood Pressure : 70mmHg
SpO2 : 96%
Oxygen Therapy : Room air

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Rodriguez, Valerie M - 06/14/2012 8:25 PDT

Weight Entered On: 06/14/2012 7:00 PDT
Performed On: 06/14/2012 6:00 PDT by Martinez, Karissa C

Weight
Weight Measured Kg : 77.200kg(Converted to: 170lb 3oz, 170.197lb, 2,723.150oz)

Martinez, Karissa C - 06/14/2012 7:00 PDT

Intake and Output Entered On: 06/14/2012 5:01 PDT
Performed On: 06/14/2012 4:00 PDT by Martinez, Karissa C

I&O
Oral Intake : 0mL
Urine Count Unmeasured : 1

Martinez, Karissa C - 06/14/2012 5:01 PDT

Vital Signs Entered On: 06/14/2012 5:02 PDT
Performed On: 06/14/2012 4:00 PDT by Martinez, Karissa C

Vital Signs
Temperature Temporal Artery : 97.6degF(Converted to: 36.4degC) (LOW)
Heart Rate Monitored : 64bpm
Respiratory Rate : 18br/min
Mean Arterial Pressure, Cuff : 87mmHg
Systolic Blood Pressure : 117mmHg
Diastolic Blood Pressure : 72mmHg
SpO2 : 95%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Martinez, Karissa C - 06/14/2012 5:01 PDT

Intake and Output Entered On: 06/14/2012 1:40 PDT
Performed On: 06/14/2012 0:00 PDT by Martinez, Karissa C

I&O
Urine Count Unmeasured : 1

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Point of Care Testing Forms

Martinez, Karissa C - 06/14/2012 1:40 PDT

Oral Intake : 0mL

Martinez, Karissa C - 06/14/2012 1:38 PDT

~~*Urine Voided :* 0mL [IN ERROR]~~

Martinez, Karissa C - 06/14/2012 1:40 PDT

~~{ [0mL] - previously charted by Martinez, Karissa C at 06/14/2012 1:38 PDT};~~

Vital Signs Entered On: 06/14/2012 1:41 PDT
Performed On: 06/14/2012 0:00 PDT by Martinez, Karissa C

Vital Signs
Temperature Temporal Artery : 98.6degF(Converted to: 37.0degC)
Heart Rate Monitored : 71bpm
Respiratory Rate : 18br/min
Mean Arterial Pressure, Cuff : 71mmHg
Systolic Blood Pressure : 96mmHg
Diastolic Blood Pressure : 59mmHg (LOW)
SpO2 : 96%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Martinez, Karissa C - 06/14/2012 1:40 PDT

Intake and Output Entered On: 06/13/2012 20:33 PDT
Performed On: 06/13/2012 20:00 PDT by Martinez, Karissa C

I&O
Oral Intake : 300mL
Urine Output Catheter : 250mL

Martinez, Karissa C - 06/13/2012 20:32 PDT

Vital Signs Entered On: 06/13/2012 20:33 PDT
Performed On: 06/13/2012 20:00 PDT by Martinez, Karissa C

Vital Signs
Temperature Temporal Artery : 97.8degF(Converted to: 36.6degC) (LOW)
Heart Rate Monitored : 70bpm
Respiratory Rate : 18br/min
Mean Arterial Pressure, Cuff : 98mmHg
Systolic Blood Pressure : 133mmHg
Diastolic Blood Pressure : 80mmHg

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

SpO2 : 95%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Martinez, Karissa C - 06/13/2012 20:33 PDT

Intake and Output Entered On: 06/13/2012 16:57 PDT
Performed On: 06/13/2012 16:00 PDT by Werner, Brittany A

I&O
Oral Intake : 0mL
Urine Output Catheter : 1,200mL
Emesis Count : 1

Werner, Brittany A - 06/13/2012 16:57 PDT

Vital Signs Entered On: 06/13/2012 16:58 PDT
Performed On: 06/13/2012 16:00 PDT by Werner, Brittany A

Vital Signs
Temperature Temporal Artery : 97.6degF(Converted to: 36.4degC) (LOW)
Heart Rate Monitored : 67bpm
Respiratory Rate : 20br/min
Mean Arterial Pressure, Cuff : 98mmHg
Systolic Blood Pressure : 130mmHg
Diastolic Blood Pressure : 82mmHg
SpO2 : 95%
Oxygen Therapy : Room air
Numeric Pain Scale : 7
(Comment: Headache and nausea. [Werner, Brittany A - 06/13/2012 16:57 PDT])
Numeric Pain Score : 7

Werner, Brittany A - 06/13/2012 16:57 PDT

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Point of Care Testing Forms

Vital Signs Entered On: 06/13/2012 17:26 PDT
Performed On: 06/13/2012 15:45 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 68bpm
Mean Arterial Pressure, Cuff : 98mmHg
Systolic Blood Pressure : 130mmHg
Diastolic Blood Pressure : 82mmHg

Werner, Brittany A - 06/13/2012 17:26 PDT

Vital Signs Entered On: 06/13/2012 17:25 PDT
Performed On: 06/13/2012 14:45 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 66bpm
Mean Arterial Pressure, Cuff : 95mmHg
Systolic Blood Pressure : 116mmHg
Diastolic Blood Pressure : 85mmHg

Werner, Brittany A - 06/13/2012 17:25 PDT

Vital Signs Entered On: 06/13/2012 17:25 PDT
Performed On: 06/13/2012 13:45 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 73bpm
Mean Arterial Pressure, Cuff : 94mmHg
Systolic Blood Pressure : 125mmHg
Diastolic Blood Pressure : 79mmHg

Werner, Brittany A - 06/13/2012 17:25 PDT

Vital Signs Entered On: 06/13/2012 17:25 PDT
Performed On: 06/13/2012 13:15 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 64bpm
Mean Arterial Pressure, Cuff : 99mmHg
Systolic Blood Pressure : 135mmHg
Diastolic Blood Pressure : 81mmHg

Werner, Brittany A - 06/13/2012 17:25 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

Vital Signs Entered On: 06/13/2012 17:24 PDT
Performed On: 06/13/2012 12:45 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 63bpm
Mean Arterial Pressure, Cuff : 104mmHg
Systolic Blood Pressure : 145mmHg (HI)
Diastolic Blood Pressure : 83mmHg

Werner, Brittany A - 06/13/2012 17:24 PDT

Vital Signs Entered On: 06/13/2012 17:24 PDT
Performed On: 06/13/2012 12:15 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 67bpm
Mean Arterial Pressure, Cuff : 113mmHg
Systolic Blood Pressure : 158mmHg (HI)
Diastolic Blood Pressure : 90mmHg

Werner, Brittany A - 06/13/2012 17:24 PDT

Intake and Output Entered On: 06/13/2012 14:51 PDT
Performed On: 06/13/2012 12:00 PDT by Werner, Brittany A

I&O
Oral Intake : 0mL
Urine Voided : 500mL

Werner, Brittany A - 06/13/2012 14:51 PDT

Vital Signs Entered On: 06/13/2012 14:52 PDT
Performed On: 06/13/2012 12:00 PDT by Werner, Brittany A

Vital Signs
Temperature Temporal Artery : 96.9degF(Converted to: 36.1degC) (LOW)
Heart Rate Monitored : 72bpm
Respiratory Rate : 19br/min
Mean Arterial Pressure, Cuff : 106mmHg
Systolic Blood Pressure : 131mmHg
Diastolic Blood Pressure : 93mmHg (HI)
SpO2 : 95%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

Numeric Pain Score : 0

Werner, Brittany A - 06/13/2012 14:52 PDT

Vital Signs Entered On: 06/13/2012 17:24 PDT
Performed On: 06/13/2012 12:00 PDT by Werner, Brittany A

Vital Signs
Heart Rate Monitored : 67bpm
Mean Arterial Pressure, Cuff : 106mmHg
Systolic Blood Pressure : 131mmHg
Diastolic Blood Pressure : 93mmHg (HI)

Werner, Brittany A - 06/13/2012 17:23 PDT

Intake and Output Entered On: 06/13/2012 9:01 PDT
Performed On: 06/13/2012 8:00 PDT by Werner, Brittany A

I&O
Oral Intake : 0mL
Urine Voided : 450mL

Werner, Brittany A - 06/13/2012 9:01 PDT

Vital Signs Entered On: 06/13/2012 9:01 PDT
Performed On: 06/13/2012 8:00 PDT by Werner, Brittany A

Vital Signs
Temperature Temporal Artery : 97.5degF(Converted to: 36.4degC) (LOW)
Heart Rate Monitored : 67bpm
Respiratory Rate : 19br/min
Mean Arterial Pressure, Cuff : 104mmHg
Systolic Blood Pressure : 142mmHg (HI)
Diastolic Blood Pressure : 85mmHg
SpO2 : 94%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Werner, Brittany A - 06/13/2012 9:01 PDT

Weight Entered On: 06/13/2012 5:35 PDT
Performed On: 06/13/2012 6:00 PDT by Perez, Noami M

Patient:	**HANNA MD, ADEL SHAKER**		
MRN:	918505	**DOB/Age/Sex:**	3/29/1946 76 years Male
FIN:	3050679	**Admit/Disch:**	6/12/2012 6/14/2012
Patient Type:	Day Patient	**Admitting:**	
Attending:	Khan M.D.,Faraaz O ; Razo M.D.,Paul R.		

Point of Care Testing Forms

Weight
Weight Measured Kg : 78.100kg(Converted to: 172lb 3oz, 172.181lb, 2,754.897oz)

Perez, Noami M - 06/13/2012 5:35 PDT

Intake and Output Entered On: 06/13/2012 5:35 PDT
Performed On: 06/13/2012 4:00 PDT by Perez, Noami M

I&O
Oral Intake : 0mL
Urine Voided : 800mL
Stool Count : 0

Perez, Noami M - 06/13/2012 5:35 PDT

Vital Signs Entered On: 06/13/2012 5:36 PDT
Performed On: 06/13/2012 4:00 PDT by Perez, Noami M

Vital Signs
Temperature Temporal Artery : 97.9degF(Converted to: 36.6degC)
Heart Rate Monitored : 55bpm
Respiratory Rate : 18br/min
Mean Arterial Pressure, Cuff : 82mmHg
Systolic Blood Pressure : 119mmHg
Diastolic Blood Pressure : 63mmHg
SpO2 : 96%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Perez, Noami M - 06/13/2012 5:35 PDT

Intake and Output Entered On: 06/13/2012 2:34 PDT
Performed On: 06/13/2012 0:00 PDT by Perez, Noami M

I&O
Oral Intake : 0mL

Perez, Noami M - 06/13/2012 2:34 PDT

Vital Signs Entered On: 06/13/2012 2:35 PDT
Performed On: 06/13/2012 0:00 PDT by Perez, Noami M

Vital Signs

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Point of Care Testing Forms

Temperature Temporal Artery : 97.2degF(Converted to: 36.2degC) (LOW)
Heart Rate Monitored : 98bpm (HI)
Respiratory Rate : 20br/min
Mean Arterial Pressure, Cuff : 103mmHg
Systolic Blood Pressure : 136mmHg
Diastolic Blood Pressure : 86mmHg
SpO2 : 99%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0

Perez, Noami M - 06/13/2012 2:34 PDT

Treatments/Procedures Forms

CCL Pre-Procedural Check List Entered On: 06/13/2012 9:36 PDT
Performed On: 06/13/2012 10:00 PDT by Caler RN, Tiffany A

Vital Signs
Temperature Temporal Artery : 97.5degF(Converted to: 36.4degC) (LOW)
Heart Rate Monitored : 67bpm
Respiratory Rate : 19br/min
Mean Arterial Pressure, Cuff : 104mmHg
Systolic Blood Pressure : 142mmHg (HI)
Diastolic Blood Pressure : 85mmHg
SpO2 : 94%
Oxygen Therapy : Room air
Numeric Pain Scale : 0 = No pain
Numeric Pain Score : 0
Pain Goal Numeric : 0

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

Height/Weight
Height/Length Measured : 172.00cm(Converted to: 5ft 8inch, 5.64ft, 67.72inch)
Treatment Height/Length Dosing : 172.00cm
Weight Measured Kg : 78.100kg(Converted to: 172lb 3oz, 172.181lb)
Treatment Weight Dosing : 78.100kg
BSA Measured : 1.93
Body Mass Index Measured : 26.40m2

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

Allergy
Allergies (Active)
REGLAN — *Estimated Onset Date:* Unspecified ; *Created By:* CONTRIBUTOR_SYSTEM , IBEX; *Reaction Status:* Active ; *Substance:* REGLAN ; *Updated By:* CONTRIBUTOR_SYSTEM , IBEX; *Reviewed Date:* 06/13/2012 7:36 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Treatments/Procedures Forms

CCL Pre-Procedural Check List
CCL NPO (Last Ate) : 06/12/2012 19:00 PDT
CCL Last Voided - Time : 06/13/2012 10:30 PDT
CCL Pre-op Medications : none
Cath Nurse - CCL Checklist : Hendricks RN, Sydney S

Hendricks RN, Sydney S - 06/13/2012 10:58 PDT

CCL Pre-Procedural Check List
Prep : Done
Film Pre-Op Teaching : Not done
Pamplet Pre-Op Teaching : Not done
Verb Understand Pre- Op Teaching : Done

Hendricks RN, Sydney S - 06/13/2012 10:58 PDT

History & Physical : Not done
(Comment: consult note done [Caler RN, Tiffany A - 06/13/2012 9:38 PDT])
Urinalysis : Not ordered

Caler RN, Tiffany A - 06/13/2012 9:38 PDT

Hospital Arm Band in Place : Done
Procedural Consent : Done
Chem 7 : Done
CBC : Done
PT/PTT : Done
Type & Cross Match : Not ordered
Blood Ordered : Not ordered
Blood Band : Not ordered
Chest X-Ray : Done
EKG : Done
Skin Condition Assessed : Done
Verbal Instruction Pre-Op Teaching : Done

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

CCL Patient Taking Lovenox : No

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

CCL Personal Belongings
Dentures-Full or Partial : None
Bridges, Caps, Crowns : None
Loose Teeth, Braces : None
Jewelry : In place
Contact Lenses : None
Prosthesis : None
Hearing Aids : None

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

Unit Nurse - CCL Checklist : Caler RN, Tiffany A

Caler RN, Tiffany A - 06/13/2012 9:32 PDT

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Care Plans

Medical

Plan: Cath Lab - Post Procedure
Status: Discontinued
History: Initiated at 6/13/2012 11:27 PDT electronically signed by Agarwal M.D.,Chandrahas
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM

Plan: Cath Lab - Pre Procedure
Status: Discontinued
History: Initiated at 6/12/2012 19:00 PDT electronically signed by Agarwal M.D.,Chandrahas
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM

Nursing

Plan: IPOC Adult
Phase: IPOC Nursing Adult; Status: Discontinued
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM
Sub-phase: IPOC Falls - Adult NSG; **Status:** Completed
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P
Completed at 6/14/2012 16:05 PDT electronically signed by SYSTEM
Outcome: Remains free from fall **Expectation:** Met
Result: Met (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Met (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Met (Charted at 6/13/2012 05:17 PDT by Manzano RN,Brenda P)
Intervention: Determine risk of falling **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:17 PDT by Manzano RN,Brenda P)
Intervention: Initiate Fall Risk Protocol **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:17 PDT by Manzano RN,Brenda P)
Intervention: Eliminate environmental hazards **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Educate: Fall prevention measures. **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Sub-phase: IPOC Cardiovascular - Adult NSG; **Status:** Discontinued
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Care Plans

Nursing

Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM

Outcome: No complaints of chest pain **Expectation:** Met
Result: Met (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Met (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Met (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Outcome: H&H levels stabilized **Expectation:** Met
Result: Met (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Met (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Met (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor cardiopulmonary symptoms **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor edema **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:00 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor fluid balance **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor for bleeding. **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor for changes in vascular status **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor peripheral pulses and nail beds **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Weigh patient, daily **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Educate: energy conservation techniques **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Care Plans

Nursing

Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Educate:Notify RN of chest pain or SOB **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Sub-phase: IPOC Pain/Comfort - Adult NSG; **Status:** Discontinued
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM
Outcome: Achieves pain management goal **Expectation:** Met
Result: Met (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Met (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Met (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor for level of sedation. **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Determine if opioid naive or tolerant **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Administer pain meds PRN **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Organize tasks for optimal patient rest. **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Ask pt to describe previous pain mgmt **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Ask pt to describe experience w/pain **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Determine pts current med use **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Care Plans

Nursing

Intervention: Medicate before painful activities **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Provide emotional support **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Collaborate with Pain Management Nurse **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Phase: IPOC Age Specific; Status: Discontinued
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM
Sub-phase: IPOC Age Specific 65 - 79 Years NSG; **Status:** Discontinued
History: Initiated at 6/12/2012 22:29 PDT electronically signed by Manzano RN,Brenda P
Discontinued at 6/14/2012 16:05 PDT electronically signed by SYSTEM
Outcome: Received care appropriate to age. **Expectation:** Met
Result: Met (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Met (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Met (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Apply lotion to skin after bathing **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Assess skin integrity frequently **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Be aware of need for warmer environment **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Continue with pain assess and management **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Explore individual support system **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Care Plans

Nursing

Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Involve family with care **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Keep environment safe **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Monitor bowel elimination q24 hours. **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Provide adequate nutrition **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)
Intervention: Use adjunct analgesics with caution **Expectation:** Done
Result: Done (Charted at 6/14/2012 05:49 PDT by Jaques RN,Callee M)
Result: Done (Charted at 6/13/2012 17:01 PDT by Caler RN,Tiffany A)
Result: Done (Charted at 6/13/2012 05:18 PDT by Manzano RN,Brenda P)

Immunizations

Vaccine: influenza virus vaccine O1
Date Given: 11/15/2021 17:35 PST
Admin Person: Dionisio RN,Rexie T
Site: Left Deltoid
Amount: 0.5mL
Manufacturer: Seqirus, A CSL Company
Expiration: 6/30/2022
Lot #: P100369129

Order Comments
O1: influenza virus vaccine, inactivated (influenza virus vaccine, inactivated - preservative free)
Ordered secondary to documenting Indications for protocol Influenza vaccine

Vaccine: influenza virus vaccine
Date Given: 11/1/2011

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Immunizations

Vaccine: pneumococcal 23-polyvalent vaccine O2
Date Given: 11/15/2021 17:35 PST
Admin Person: Dionisio RN,Rexie T
Site: Right Deltoid
Amount: 0.5mL
Manufacturer: Merck & Company Inc
Expiration: 1/14/2023
Lot #: 0021995

Order Comments
O2: pneumococcal 23-polyvalent vaccine
Ordered secondary to documenting Indications for protocol Pneumococcal vaccine

Vaccine: pneumococcal 23-polyvalent vaccine O3
Date Given: 6/13/2012 21:29 PDT
Admin Person: Jaques RN,Callee M
Site: Right Upper Arm
Amount: 0.5mL
Manufacturer: MERCK & CO., INC.
Expiration: 8/18/2013
Lot #: 0087ae

Order Comments
O3: pneumococcal 23-polyvalent vaccine
Ordered secondary to documenting Indications for protocol Pneumococcal vaccine

Vaccine: SARS-CoV-2 (Moderna) mRNA-1273 vaccine
Date Given: 1/26/2021
Lot #: 025I20A

Vaccine: SARS-CoV-2 (Moderna) mRNA-1273 vaccine
Date Given: 12/29/2020
Lot #: 025L20A

Intake and Output

INTAKE		6/12/2012 - 6/13/2012			6/13/2012 - 6/14/2012		
All time in PDT		0600 - 1800	1800 - 0600	Total	0600 - 1800	1800 - 0600	Total
Normal Saline intravenous solution 1,000 mL(1000 mL Sodium Chloride 0.9%)	mL	-	466.6667	466.6667	865	-	865
sodium chloride	mL	-	-	-	-	6	6
Oral Intake	mL	-	0	0	0	300	300

San Antonio Regional Hospital

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Intake and Output

INTAKE		6/12/2012 - 6/13/2012			6/13/2012 - 6/14/2012		
All time in PDT		**0600 - 1800**	**1800 - 0600**	**Total**	**0600 - 1800**	**1800 - 0600**	**Total**
12 Hour Total	mL	**-**	**466.6667**		**865**	**306**	
24 Hour Total	mL		**466.6667**			**1171**	

OUTPUT		6/12/2012 - 6/13/2012			6/13/2012 - 6/14/2012		
All time in PDT		**0600 - 1800**	**1800 - 0600**	**Total**	**0600 - 1800**	**1800 - 0600**	**Total**
Urine Output Catheter	mL	-	-	-	1200	250	1450
Urine Output Initial	mL	-	-	-	700	-	700
Urine Voided	mL	-	800	800	950	-	950
Emesis Count		-	-	-	1	-	1
Stool Count		-	0	0	-	-	-
Urine Count		-	-	-	-	2	2
12 Hour Total	mL	**-**	**800**		**2850**	**250**	
24 Hour Total	mL		**800**			**3100**	

INTAKE		6/14/2012 - 6/15/2012		
All time in PDT		**0600 - 1800**	**1800 - 0600**	**Total**
Al hydroxide/Mg hydroxide/simethicone	mL	15	-	15
sodium chloride	mL	3	-	3
Oral Intake	mL	480	-	480
12 Hour Total	mL	**498**	**-**	
24 Hour Total	mL		**498**	

OUTPUT		6/14/2012 - 6/15/2012		
All time in PDT		**0600 - 1800**	**1800 - 0600**	**Total**
Stool Count		1	-	1
Urine Count		1	-	1
12 Hour Total	mL	**-**	**-**	
24 Hour Total	mL		**-**	

Clinical Range Total from 6/12/2012 to 6/15/2012

Total Intake (mL)	Total Output (mL)	Fluid Balance (mL)
2135.6667	**3900**	**-1764.3333**

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Activity ADLs

Procedure	Reference Range	Recorded Date / Time / By: 6/14/2012 15:45 PDT Vertulfo RN,Erlyn V	6/14/2012 12:00 PDT Vertulfo RN,Erlyn V	Units
Positioning/Pressure Reducing Devices		Pillow	Pillow	
Pressure Reduction Surface		Versacare	Versacare	
Turning Assessment		Turns independently	Turns independently	

Procedure	Reference Range	Recorded Date / Time / By: 6/14/2012 08:00 PDT Vertulfo RN,Erlyn V	6/14/2012 04:00 PDT Jaques RN,Callee M	Units
Pressure Reduction Surface		Versacare [O9]	Versacare	
Turning Assessment		Turns independently [O9]	Turns independently	

Procedure	Reference Range	Recorded Date / Time / By: 6/14/2012 00:00 PDT Jaques RN,Callee M	6/13/2012 22:00 PDT Martinez,Karissa C	Units
Activity Status ADL		-	In bed [O4]	
Activity Assistance		-	Independent [O4]	
Pressure Reduction Surface		Versacare	-	
Turning Assessment		Turns independently	-	

Procedure	Reference Range	Recorded Date / Time / By: 6/13/2012 20:00 PDT Jaques RN,Callee M	6/13/2012 18:45 PDT Caler RN,Tiffany A	Units
Positioning/Pressure Reducing Devices		Pillow [O7]	-	
Pressure Reduction Surface		Versacare [O7]	Versacare	
Turning Assessment		Turns independently [O7]	-	

Procedure	Reference Range	Recorded Date / Time / By: 6/13/2012 17:45 PDT Caler RN,Tiffany A	6/13/2012 16:45 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		Versacare	Versacare	

Procedure	Reference Range	Recorded Date / Time / By: 6/13/2012 16:00 PDT Graf ,Cara	6/13/2012 15:45 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		Versacare	**Versacare [c1]**	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Activity ADLs

Corrected Results
c1: Pressure Reduction Surface
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from Versacare on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	14:45 PDT	14:15 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Pressure Reduction Surface		Versacare	Versacare	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	13:45 PDT	13:20 PDT	
	Recorded By	Caler RN,Tiffany A	Graf ,Cara	
Procedure	**Reference Range**			**Units**
Pressure Reduction Surface		Versacare	Versacare	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	13:15 PDT	12:45 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Pressure Reduction Surface		Versacare	Versacare	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	12:30 PDT	12:15 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Pressure Reduction Surface		Versacare	Versacare	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	12:00 PDT	10:00 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Activity Status ADL		-	In bed [O5]	
Activity Assistance		-	Independent [O5]	
Assistive Device		-	None [O5]	
Pressure Reduction Surface		Versacare	-	

	Recorded Date	6/13/2012	
	Recorded Time	08:00 PDT	
	Recorded By	Graf ,Cara	
Procedure	**Reference Range**		**Units**
Positioning/Pressure Reducing Devices		Pillow [O8]	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Activity ADLs

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 08:00 PDT Recorded By Graf ,Cara	Units
Pressure Reduction Surface		Versacare [O8]	
Turning Assessment		Turns independently [O8]	

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 04:00 PDT Recorded By Manzano RN,Brenda P	Units
Pressure Reduction Surface		Versacare	
Turning Assessment		Turns independently	

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 00:05 PDT Recorded By Manzano RN,Brenda P	Recorded Date 6/12/2012 Recorded Time 22:00 PDT Recorded By Perez,Noami M	Units
Activity Status ADL		-	See Below [T1 O6]	
Activity Assistance		-	Independent [O6]	
Assistive Device		-	None [O6]	
Positioning/Pressure Reducing Devices		-	Pillow [O6]	
Pressure Reduction Surface		**Versacare [c2]**	-	
Turning Assessment		**Turns independently [c3]**	-	
Ambulation Patient Effort		-	Good [O6]	

Textual Results
T1: 6/12/2012 22:00 PDT (Activity Status ADL)
Ambulating in room, Bathroom privileges

Corrected Results
c2: Pressure Reduction Surface
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Versacare on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Versacare on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c3: Turning Assessment
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Turns independently on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Activity ADLs

Corrected Results
c3: Turning Assessment
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Turns independently on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O4: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O5: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O6: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Nutrition ADLs

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	16:00 PDT	12:00 PDT	
	Recorded By	Rodriguez,Valerie M	Rodriguez,Valerie M	
Procedure	**Reference Range**			**Units**
Breakfast Percent		-	95	%
Lunch Percent		90	-	%

Hygiene ADLs

	Recorded Date	6/13/2012	
	Recorded Time	22:00 PDT	
	Recorded By	Martinez,Karissa C	
Procedure	**Reference Range**		**Units**
Bed Bath		Independent O4	
Foot Care		Independent O4	
Hair Care		Independent O4	
Oral Care		Independent O4	
Peri Care		Independent O4	

Order Comments
O4: Activities of Daily Living Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Safety ADLs

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Patient Safety Signs Displayed		See Below T2 O9	See Below T3	
Patient Safety		See Below T9 O9	See Below T10	

Textual Results
T2: 6/14/2012 08:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T3: 6/14/2012 04:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T9: 6/14/2012 08:00 PDT (Patient Safety)
Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T10: 6/14/2012 04:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

	Recorded Date	6/14/2012	6/13/2012	
	Recorded Time	00:00 PDT	22:00 PDT	
	Recorded By	Jaques RN,Callee M	Martinez,Karissa C	
Procedure	**Reference Range**			**Units**
Patient Safety Signs Displayed		See Below T4	-	
Patient Safety		See Below T11	See Below T12 O4	

Textual Results
T4: 6/14/2012 00:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T11: 6/14/2012 00:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T12: 6/13/2012 22:00 PDT (Patient Safety)
Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	20:00 PDT	16:00 PDT	13:20 PDT	
	Recorded By	Jaques RN,Callee M	Graf ,Cara	Graf ,Cara	
Procedure	**Reference Range**				**Units**
Patient Safety Signs Displayed		See Below T5 O7	See Below T6	See Below T7	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Safety ADLs

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 20:00 PDT Jaques RN,Callee M	6/13/2012 16:00 PDT Graf ,Cara	6/13/2012 13:20 PDT Graf ,Cara	Units
Patient Safety		See Below T13 O7	See Below T14	-	

Textual Results
T5: 6/13/2012 20:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T6: 6/13/2012 16:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T7: 6/13/2012 13:20 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T13: 6/13/2012 20:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T14: 6/13/2012 16:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:00 PDT Graf ,Cara	6/13/2012 08:00 PDT Graf ,Cara	6/12/2012 21:28 PDT Perez,Noami M	Units
Patient Safety Signs Displayed		-	See Below T8 O8	-	
Patient Safety		See Below T15	See Below T16 O8	See Below T17 O10	

Textual Results
T8: 6/13/2012 08:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T15: 6/13/2012 12:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T16: 6/13/2012 08:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T17: 6/12/2012 21:28 PDT (Patient Safety)
Bag/mask setup in room, Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Activities of Daily Living

Safety ADLs

Order Comments
O4: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O10: Basic Admission Information
Order entered secondary to inpatient admission.

ADL Evaluation Index

	Recorded Date	6/12/2012	
	Recorded Time	21:15 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	Reference Range		Units
Level of Assistance -Self Care-Mobility		No change from baseline c4 O11	

Corrected Results
c4: Level of Assistance - Self Care-Mobility
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No change from baseline on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No change from baseline on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Admit-Transfer-Discharge

Admission Information

	Recorded Date	6/14/2012	6/13/2012	
	Recorded Time	08:00 PDT	20:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
Languages		English O13	English O14	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit-Transfer-Discharge

Admission Information

	Recorded Date	6/13/2012	6/12/2012	
	Recorded Time	08:00 PDT	21:15 PDT	
	Recorded By	Caler RN,Tiffany A	Manzano RN,Brenda P	
Procedure	**Reference Range**			**Units**
Languages		English O15	**English** c6 O11	

Corrected Results
c6: Languages
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from English on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from English on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

	Recorded Date	6/12/2012	6/12/2012	
	Recorded Time	21:10 PDT	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	Manzano RN,Brenda P	
Procedure	**Reference Range**			**Units**
Mode of Arrival		-	Gurney O12	
Reason for Admission		-	Medical treatment O12	
Admitted From		-	ER O12	
Preferred Name		**Adel hANNA** c5 O12	-	
Information Given by		-	Patient O12	
Languages		-	English O12	
Preferred Communication Mode		-	Verbal O12	

Corrected Results
c5: Preferred Name
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:57 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Adel on 6/12/2012 23:57 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Correction performed on 6/12/2012 22:16 PDT by Manzano RN, Brenda P

Order Comments
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.
O12: Admission History Adult
Order entered secondary to inpatient admission.
O13: Order Entry Details
Order entered secondary to inpatient admission.
O14: Order Entry Details
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Admit-Transfer-Discharge

Admission Information

Order Comments
O15: Order Entry Details
Order entered secondary to inpatient admission.

Admission Orientation

	Recorded Date	6/12/2012	
	Recorded Time	21:28 PDT	
	Recorded By	Perez,Noami M	
Procedure	**Reference Range**		**Units**
Room Orientation/Facility Policy Review		Yes O10	
Room Orientation/Policy Reviewed With		Patient O10	
Demos Ability-Uses Call Light w/Success		Yes O10	

Order Comments
O10: Basic Admission Information
Order entered secondary to inpatient admission.

Automation

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	16:00 PDT	15:45 PDT	
	Recorded By	Rodriguez,Valerie M	Vertulfo RN,Erlyn V	
Procedure	**Reference Range**			**Units**
Positioning/Pressure Reducing Devices		-	Pillow	
Pressure Reduction Surface		-	Versacare	
Turning Assessment		-	Turns independently	
Lunch Percent		90	-	%

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	12:00 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Rodriguez,Valerie M	
Procedure	**Reference Range**			**Units**
Positioning/Pressure Reducing Devices		Pillow	-	
Pressure Reduction Surface		Versacare	-	
Turning Assessment		Turns independently	-	
Breakfast Percent		-	95	%

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Pressure Reduction Surface		Versacare O9	Versacare	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/14/2012 08:00 PDT Vertulfo RN,Erlyn V	6/14/2012 04:00 PDT Jaques RN,Callee M	Units
Turning Assessment		Turns independently O9	Turns independently	
Patient Safety Signs Displayed		See Below T2 O9	See Below T3	
Patient Safety		See Below T9 O9	See Below T10	

Textual Results
T2: 6/14/2012 08:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T3: 6/14/2012 04:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T9: 6/14/2012 08:00 PDT (Patient Safety)
Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T10: 6/14/2012 04:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/14/2012 00:00 PDT Jaques RN,Callee M	6/13/2012 22:00 PDT Martinez,Karissa C	Units
Activity Status ADL		-	In bed O4	
Activity Assistance		-	Independent O4	
Pressure Reduction Surface		Versacare	-	
Turning Assessment		Turns independently	-	
Bed Bath		-	Independent O4	
Foot Care		-	Independent O4	
Hair Care		-	Independent O4	
Oral Care		-	Independent O4	
Peri Care		-	Independent O4	
Patient Safety Signs Displayed		See Below T4	-	
Patient Safety		See Below T11	See Below T12 O4	

Textual Results
T4: 6/14/2012 00:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T11: 6/14/2012 00:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Night light, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked
T12: 6/13/2012 22:00 PDT (Patient Safety)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Textual Results
T12: 6/13/2012 22:00 PDT (Patient Safety)
Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	20:00 PDT	18:45 PDT	
	Recorded By	Jaques RN,Callee M	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Positioning/Pressure Reducing Devices		Pillow O7	-	
Pressure Reduction Surface		Versacare O7	Versacare	
Turning Assessment		Turns independently O7	-	
Patient Safety Signs Displayed		See Below T5 O7	-	
Patient Safety		See Below T13 O7	-	

Textual Results
T5: 6/13/2012 20:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T13: 6/13/2012 20:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	17:45 PDT	16:45 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Pressure Reduction Surface		Versacare	Versacare	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	16:00 PDT	15:45 PDT	
	Recorded By	Graf ,Cara	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Pressure Reduction Surface		Versacare	**Versacare** c1	
Patient Safety Signs Displayed		See Below T6	-	
Patient Safety		See Below T14	-	

Textual Results
T6: 6/13/2012 16:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T14: 6/13/2012 16:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Fall precautions, ID band check, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Corrected Results
c1: Pressure Reduction Surface
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from Versacare on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 14:45 PDT Caler RN,Tiffany A	6/13/2012 14:15 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		Versacare	Versacare	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:45 PDT Caler RN,Tiffany A	6/13/2012 13:20 PDT Graf ,Cara	Units
Pressure Reduction Surface		Versacare	Versacare	
Patient Safety Signs Displayed		-	See Below T7	

Textual Results
T7: 6/13/2012 13:20 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:15 PDT Caler RN,Tiffany A	6/13/2012 12:45 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		Versacare	Versacare	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:30 PDT Caler RN,Tiffany A	6/13/2012 12:15 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		Versacare	Versacare	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:00 PDT Graf ,Cara	6/13/2012 12:00 PDT Caler RN,Tiffany A	Units
Pressure Reduction Surface		-	Versacare	
Patient Safety		See Below T15	-	

Textual Results
T15: 6/13/2012 12:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 10:00 PDT Caler RN,Tiffany A	6/13/2012 08:00 PDT Graf ,Cara	Units
Activity Status ADL		In bed O5	-	
Activity Assistance		Independent O5	-	
Assistive Device		None O5	-	
Positioning/Pressure Reducing Devices		-	Pillow O8	
Pressure Reduction Surface		-	Versacare O8	
Turning Assessment		-	Turns independently O8	
Patient Safety Signs Displayed		-	See Below T8 O8	
Patient Safety		-	See Below T16 O8	

Textual Results
T8: 6/13/2012 08:00 PDT (Patient Safety Signs Displayed)
Bleeding Precautions, Fall precautions
T16: 6/13/2012 08:00 PDT (Patient Safety)
All monitor alarms on and settings verified, Bag/mask setup in room, Bed in low position, Bleeding Precautions, Call device within reach, Cardiac monitor electrodes in place, Fall precautions, ID band check, Non-Slip footwear, Personal items within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 04:00 PDT Manzano RN,Brenda P	Units
Pressure Reduction Surface		Versacare	
Turning Assessment		Turns independently	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 00:05 PDT Manzano RN,Brenda P	6/12/2012 22:00 PDT Perez,Noami M	Units
Activity Status ADL		-	See Below T1 O6	
Activity Assistance		-	Independent O6	
Assistive Device		-	None O6	
Positioning/Pressure Reducing Devices		-	Pillow O6	
Pressure Reduction Surface		**Versacare** c2	-	
Turning Assessment		**Turns independently** c3	-	
Ambulation Patient Effort		-	Good O6	

Textual Results
T1: 6/12/2012 22:00 PDT (Activity Status ADL)
Ambulating in room, Bathroom privileges

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Corrected Results
c2: Pressure Reduction Surface
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Versacare on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Versacare on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c3: Turning Assessment
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Turns independently on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Turns independently on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

	Recorded Date	6/12/2012
	Recorded Time	21:28 PDT
	Recorded By	Perez,Noami M
Procedure	**Reference Range**	**Units**
Patient Safety	See Below T17 O10	

Textual Results
T17: 6/12/2012 21:28 PDT (Patient Safety)
Bag/mask setup in room, Bed in low position, Call device within reach, Cardiac monitor electrodes in place, ID band check, Mobility support items readily available, Night light, Non-Slip footwear, Personal items within reach, Sensory aids within reach, Side rails up x2, Traffic path in room free of clutter, Wheels locked

	Recorded Date	6/12/2012
	Recorded Time	21:15 PDT
	Recorded By	Manzano RN,Brenda P
Procedure	**Reference Range**	**Units**
Level of Assistance -Self Care-Mobility	**No change from baseline** c4 O11	

Corrected Results
c4: Level of Assistance - Self Care-Mobility
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No change from baseline on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No change from baseline on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Automation

Order Comments
O4: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O5: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O6: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O10: Basic Admission Information
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Cardiovascular

Cardiovascular Assessment

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	**Reference Range**			**Units**
Cardiopulmonary Symptoms		Denies	Denies	
Nail Bed Color		Pink	Pink	
Heart Rhythm		Regular	Regular	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Cardiopulmonary Symptoms		Denies O9	Denies	
Nail Bed Color		Pink O9	Pink	
Heart Rhythm		Regular O9	Regular	

	Recorded Date	6/14/2012	6/13/2012	6/13/2012	
	Recorded Time	00:00 PDT	20:00 PDT	16:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	Graf ,Cara	
Procedure	**Reference Range**				**Units**
Cardiopulmonary Symptoms		Denies	Denies O7	Denies	
Nail Bed Color		-	Pink O7	Pink	
Heart Rhythm		Regular	Regular O7	Regular	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Cardiovascular Assessment

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 13:20 PDT Recorded By Graf ,Cara	Recorded Date 6/13/2012 Recorded Time 08:00 PDT Recorded By Graf ,Cara	Recorded Date 6/13/2012 Recorded Time 04:00 PDT Recorded By Manzano RN,Brenda P	Units
Cardiopulmonary Symptoms		Denies	Denies O8	Denies	
Nail Bed Color		Pink	Pink O8	-	
Heart Rhythm		Regular	Regular O8	-	

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 00:05 PDT Recorded By Manzano RN,Brenda P	Recorded Date 6/12/2012 Recorded Time 21:15 PDT Recorded By Manzano RN,Brenda P	Units
Cardiopulmonary Symptoms		**Denies** c7	**Denies** c8 O11	
Nail Bed Color		-	**Pink** c9 O11	
Heart Rhythm		-	**Regular** c10 O11	

Corrected Results

c7: Cardiopulmonary Symptoms
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c8: Cardiopulmonary Symptoms
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c9: Nail Bed Color
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Pink on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Pink on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Cardiovascular Assessment

Corrected Results
c10: Heart Rhythm
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Regular on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Regular on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Pulses Assessment

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	Reference Range			Units
Radial Pulse,Left		2+ Normal	2+ Normal	
Radial Pulse,Right		2+ Normal	2+ Normal	
Dorsalis Pedis Pulse,Left		1+ Thready	1+ Thready	
Dorsalis Pedis Pulse,Right		1+ Thready	1+ Thready	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
Radial Pulse,Left		2+ Normal O9	2+ Normal	
Radial Pulse,Right		2+ Normal O9	2+ Normal	
Posttibial Pulse,Left		-	2+ Normal	
Posttibial Pulse,Right		-	2+ Normal	
Dorsalis Pedis Pulse,Left		1+ Thready O9	-	
Dorsalis Pedis Pulse,Right		1+ Thready O9	-	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Pulses Assessment

	Recorded Date	6/14/2012	6/13/2012	
	Recorded Time	00:00 PDT	20:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	
Procedure	Reference Range			Units
Radial Pulse,Left		2+ Normal	2+ Normal [O7]	
Radial Pulse,Right		2+ Normal	2+ Normal [O7]	
Posttibial Pulse,Left		2+ Normal	2+ Normal [O7]	
Posttibial Pulse,Right		2+ Normal	2+ Normal [O7]	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	18:30 PDT	17:30 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Posttibial Pulse,Left		2+ Normal	2+ Normal	
Posttibial Pulse,Right		2+ Normal	2+ Normal	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	
Dorsalis Pedis Pulse,Right		Doppler	Doppler	

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	16:30 PDT	16:00 PDT	15:45 PDT	
	Recorded By	Caler RN,Tiffany A	Graf ,Cara	Caler RN,Tiffany A	
Procedure	Reference Range				Units
Radial Pulse,Left		-	2+ Normal	-	
Radial Pulse,Right		-	2+ Normal	-	
Posttibial Pulse,Left		2+ Normal	-	2+ Normal	
Posttibial Pulse,Right		2+ Normal	-	2+ Normal	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	Doppler	
Dorsalis Pedis Pulse,Right		Doppler	1+ Thready	Doppler	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	14:45 PDT	14:15 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Posttibial Pulse,Left		2+ Normal	2+ Normal	
Posttibial Pulse,Right		2+ Normal	2+ Normal	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	
Dorsalis Pedis Pulse,Right		Doppler	Doppler	

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	13:45 PDT	13:20 PDT	13:15 PDT	
	Recorded By	Caler RN,Tiffany A	Graf ,Cara	Caler RN,Tiffany A	
Procedure	Reference Range				Units
Radial Pulse,Left		-	2+ Normal	-	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Pulses Assessment

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:45 PDT Caler RN,Tiffany A	6/13/2012 13:20 PDT Graf ,Cara	6/13/2012 13:15 PDT Caler RN,Tiffany A	Units
Radial Pulse,Right		-	2+ Normal	-	
Posttibial Pulse,Left		2+ Normal	-	2+ Normal	
Posttibial Pulse,Right		2+ Normal	-	2+ Normal	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	Doppler	
Dorsalis Pedis Pulse,Right		Doppler	Doppler	Doppler	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:45 PDT Caler RN,Tiffany A	6/13/2012 12:30 PDT Caler RN,Tiffany A	Units
Posttibial Pulse,Left		2+ Normal	2+ Normal	
Posttibial Pulse,Right		2+ Normal	2+ Normal	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	
Dorsalis Pedis Pulse,Right		Doppler	Doppler	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:15 PDT Caler RN,Tiffany A	6/13/2012 12:00 PDT Caler RN,Tiffany A	6/13/2012 08:00 PDT Graf ,Cara	Units
Radial Pulse,Left		-	-	2+ Normal [O8]	
Radial Pulse,Right		-	-	2+ Normal [O8]	
Posttibial Pulse,Left		2+ Normal	2+ Normal	-	
Posttibial Pulse,Right		2+ Normal	2+ Normal	-	
Dorsalis Pedis Pulse,Left		Doppler	Doppler	2+ Normal [O8]	
Dorsalis Pedis Pulse,Right		Doppler	Doppler	2+ Normal [O8]	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/12/2012 21:15 PDT Manzano RN,Brenda P	Units
Radial Pulse,Left		**2+ Normal** [c11 O11]	
Radial Pulse,Right		**2+ Normal** [c12 O11]	
Dorsalis Pedis Pulse,Left		**2+ Normal** [c13 O11]	
Dorsalis Pedis Pulse,Right		**2+ Normal** [c14 O11]	

Corrected Results
c11: Radial Pulse, Left
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Pulses Assessment

Corrected Results

c11: Radial Pulse, Left
Corrected from 2+ Normal on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c12: Radial Pulse, Right
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c13: Dorsalis Pedis Pulse, Left
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c14: Dorsalis Pedis Pulse, Right
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from 2+ Normal on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments

O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Cardiovascular

Cardiac Rhythm Analysis

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	**Reference Range**			**Units**
Cardiac Rhythm		Normal sinus rhythm	Normal sinus rhythm	
Monitoring Lead		II	II	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Cardiac Rhythm		Normal sinus rhythm O9	Normal sinus rhythm	
Monitoring Lead		II O9	II	

	Recorded Date	6/14/2012	6/13/2012	
	Recorded Time	00:00 PDT	20:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Cardiac Rhythm		Normal sinus rhythm	Normal sinus rhythm O7	
Monitoring Lead		II	II O7	

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	16:00 PDT	13:20 PDT	12:00 PDT	
	Recorded By	Graf ,Cara	Graf ,Cara	Caler RN,Tiffany A	
Procedure	**Reference Range**				**Units**
Cardiac Rhythm		Normal sinus rhythm	-	Normal sinus rhythm	
Monitoring Lead		II	II	-	
Atrial Rhythm		Regular	Regular	-	
Ventricular Rhythm		Regular	Regular	-	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Caler RN,Tiffany A	Manzano RN,Brenda P	
Procedure	**Reference Range**			**Units**
Cardiac Rhythm		Sinus bradycardia O8	Normal sinus rhythm	
Monitoring Lead		II O8	II	
Atrial Rhythm		Regular O8	-	
Ventricular Rhythm		Regular O8	-	

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505 **DOB/Age/Sex:** 3/29/1946 76 years Male
FIN: 3050679 **Admit/Disch:** 6/12/2012 6/14/2012
Patient Type: Day Patient **Admitting:**
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

Cardiovascular

Cardiac Rhythm Analysis

Order Comments
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Cardiac Rhythm/Pacemaker

	Recorded Date	6/14/2012	
	Recorded Time	04:00 PDT	
	Recorded By	Jaques RN,Callee M	
Procedure	**Reference Range**		**Units**
Cardiac Rhythm/Pacemaker		Yes	

Cardiovascular Detailed Assessment

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	04:00 PDT	00:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	
Procedure	**Reference Range**			**Units**
Cardiovascular Detailed Assessment		Yes	Yes	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	20:00 PDT	16:00 PDT	
	Recorded By	Jaques RN,Callee M	Graf ,Cara	
Procedure	**Reference Range**			**Units**
Cardiovascular Detailed Assessment		Yes O7	Yes	

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Cardiovascular Medical History

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Denies Cardiovascular History		Self O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Clinician Communication

Notification to Clinicians

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 16:27 PDT Caler RN,Tiffany A	6/13/2012 12:50 PDT Caler RN,Tiffany A	Units
Name of Clinician Contacted		Agarwal M.D., Chandrahas	Agarwal M.D., Chandrahas	
Staff Reason for Call		Condition	Condition	
Method of Contact		Telephone	Telephone	
Information Provided		See Below T18	See Below T19	
Action -Clinician Notification		Orders received	Orders received	

Textual Results

T18: 6/13/2012 16:27 PDT (Information Provided)
MD informed that pt having headache and is nauseated and unable to take PO tylenol. Tylenol suppository ordered. MD aware pt already recieved zofran for nausea, MD does not want to order any other anti-nausea medication at this time.

T19: 6/13/2012 12:50 PDT (Information Provided)
MD returned 2nd page and informed pt in extruciating pain from full bladder and bladder scan shows 685 ml. Order for foley cath recieved, MD wants pt to be aware of risk of trauma and infection. MD also made aware that pt is going to stand and urinate if no catheter inserted.

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:05 PDT Caler RN,Tiffany A	Units
Name of Clinician Contacted		Agarwal M.D., Chandrahas	
Staff Reason for Call		Condition, Patient concerns	
Method of Contact		Telephone	
Information Provided		See Below T20	
Action -Clinician Notification		No orders received	

Textual Results

T20: 6/13/2012 12:05 PDT (Information Provided)
MD informed that pt unable to urinate laying down and would like a urinary catheter. MD does not want a cath at this time, MD wants to be called at 1300 if still unable to urinate.

Comfort Measures

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/14/2012 08:00 PDT Vertulfo RN,Erlyn V	Units
Comfort Measures Blanket Application		Yes O9	
Comfort Measures Comfortable Environment		Yes O9	
Comfort Measures Encourage Visitors		Yes O9	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Comfort Measures

Procedure	Reference Range	Recorded Date 6/14/2012 Recorded Time 08:00 PDT Recorded By Vertulfo RN,Erlyn V	Units
Comfort Measures Positioning		Yes [O9]	
Comfort Measures Positive Self-Talk		Yes [O9]	
Comfort Measures Pressure Relief		Yes [O9]	
Comfort Measures Quiet Environment		Yes [O9]	
Comfort Measures Relaxation		Yes [O9]	
Comfort Measures Rest		Yes [O9]	

Procedure	Reference Range	Recorded Date 6/14/2012 Recorded Time 04:00 PDT Recorded By Jaques RN,Callee M	Units
Comfort Measures Comfortable Environment		Yes	

Procedure	Reference Range	Recorded Date 6/13/2012 Recorded Time 20:00 PDT Recorded By Jaques RN,Callee M	Recorded Date 6/13/2012 Recorded Time 08:00 PDT Recorded By Graf ,Cara	Units
Comfort Measures Blanket Application		Yes [O7]	-	
Comfort Measures Comfortable Environment		Yes [O7]	-	
Comfort Measure Enhance Sense of Control		Yes [O7]	-	
Comfort Measures Meditation Facilitation		Yes [O7]	-	
Comfort Measures Periods of Sleep		Yes [O7]	-	
Comfort Measures Positioning		Yes [O7]	-	
Comfort Measures Promote Bedtime Routine		Yes [O7]	-	
Comfort Measures Quiet Environment		Yes [O7]	Yes [O8]	
Comfort Measures Relaxation		Yes [O7]	Yes [O8]	
Comfort Measures Rest		Yes [O7]	Yes [O8]	

Procedure	Reference Range	Recorded Date 6/12/2012 Recorded Time 21:15 PDT Recorded By Manzano RN,Brenda P	Units
Comfort Measures Blanket Application		**Yes** [c15 O11]	
Comfort Measures Comfortable Environment		**Yes** [c16 O11]	
Comfort Measures Quiet Environment		**Yes** [c17 O11]	
Comfort Measures Relaxation		**Yes** [c18 O11]	
Comfort Measures Rest		**Yes** [c19 O11]	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Comfort Measures

Corrected Results

c15: Comfort Measures Blanket Application
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c16: Comfort Measures Comfortable Environment
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c17: Comfort Measures Quiet Environment
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c18: Comfort Measures Relaxation
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c19: Comfort Measures Rest
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Yes on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Comfort Measures

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Endocrine / Metabolic

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Denies Metabolic History		Self O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Falls Information

	Recorded Date	6/14/2012	
	Recorded Time	08:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	
Procedure	**Reference Range**		**Units**
History of Fall in Last 3 Months Morse		No	
Presence of Secondary Diagnosis Morse		Yes	
Use of Ambulatory Aid Morse		None, bedrest, wheelchair, nurse	
IV/Heparin Lock Fall Risk Morse		Yes	
Gait Weak or Impaired Fall Risk Morse		Normal, bedrest, immobile	
Mental Status Fall Risk Morse		Oriented to own ability	
Morse Fall Risk Score		35	

	Recorded Date	6/13/2012	
	Recorded Time	23:00 PDT	
	Recorded By	Jaques RN,Callee M	
Procedure	**Reference Range**		**Units**
History of Fall in Last 3 Months Morse		No O16	
Presence of Secondary Diagnosis Morse		Yes O16	
Use of Ambulatory Aid Morse		None, bedrest, wheelchair, nurse O16	
IV/Heparin Lock Fall Risk Morse		Yes O16	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Falls Information

	Recorded Date	6/13/2012	
	Recorded Time	23:00 PDT	
	Recorded By	Jaques RN,Callee M	
Procedure	Reference Range		Units
Gait Weak or Impaired Fall Risk Morse		Normal, bedrest, immobile O16	
Mental Status Fall Risk Morse		Oriented to own ability O16	
Morse Fall Risk Score		35 O16	

	Recorded Date	6/12/2012	
	Recorded Time	23:00 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	Reference Range		Units
History of Fall in Last 3 Months Morse		No O17	
Presence of Secondary Diagnosis Morse		No O17	
Use of Ambulatory Aid Morse		None, bedrest, wheelchair, nurse O17	
IV/Heparin Lock Fall Risk Morse		Yes O17	
Gait Weak or Impaired Fall Risk Morse		Normal, bedrest, immobile O17	
Mental Status Fall Risk Morse		Oriented to own ability O17	
Morse Fall Risk Score		20 O17	

Order Comments
O16: Morse Fall Risk Assessment
This order was placed by Discern Expert.
O17: Morse Fall Risk Assessment
This order was placed by Discern Expert.

Functional

Functional - General Information

	Recorded Date	6/12/2012	6/12/2012	
	Recorded Time	22:00 PDT	21:15 PDT	
	Recorded By	Perez,Noami M	Manzano RN,Brenda P	
Procedure	Reference Range			Units
ADL Assistance Level		-	**Independent** c20 O11	
Gait Distance		20 O6	-	ft

Corrected Results
c20: ADL Assistance Level
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Independent on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Functional

Functional - General Information

Corrected Results
c20: ADL Assistance Level
Corrected from Independent on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	Reference Range		Units
Living Situation		Home independently O12	

Order Comments
O6: Activities of Daily Living Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.
O12: Admission History Adult
Order entered secondary to inpatient admission.

Gastrointestinal

Gastrointestinal Assessment

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	Reference Range			Units
GI Symptoms		Denies	Denies	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
GI Symptoms		Other: poor appetite O9	Denies	
Abdomen Description		Symmetric, Soft O9	-	

	Recorded Date	6/14/2012	6/13/2012	6/13/2012	
	Recorded Time	00:00 PDT	20:00 PDT	16:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	Graf ,Cara	
Procedure	Reference Range				Units
GI Symptoms		Denies	See Below T21 O7	See Below T22	
Abdomen Description		-	Symmetric, Soft O7	-	
Stool Description		-	Clots O7	-	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Gastrointestinal

Gastrointestinal Assessment

Textual Results
T21: 6/13/2012 20:00 PDT (GI Symptoms)
Nausea, Other: poor appetite. Dry heaving. Patient complains of discomfort from a hiatal hernia.
T22: 6/13/2012 16:00 PDT (GI Symptoms)
Nausea, Other: Reports substernal chest pain from chronic esophagitis

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	13:20 PDT	08:00 PDT	
	Recorded By	Graf ,Cara	Graf ,Cara	
Procedure	**Reference Range**			**Units**
GI Symptoms		See Below T23	Denies O8	
Abdomen Description		Symmetric, Soft	Symmetric, Soft O8	

Textual Results
T23: 6/13/2012 13:20 PDT (GI Symptoms)
Nausea, Other: Reports having substernal pain from chronic esophagitis

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	04:00 PDT	00:05 PDT	
	Recorded By	Manzano RN,Brenda P	Manzano RN,Brenda P	
Procedure	**Reference Range**			**Units**
GI Symptoms		Denies	**Denies** c21	

Corrected Results
c21: GI Symptoms
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

	Recorded Date	6/12/2012	
	Recorded Time	21:15 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
GI Symptoms		**Denies** c22 O11	
Abdomen Description		**Symmetric, Soft** c23 O11	
Bowel Movement Last Date		**06/12/12** c24 O11	

Corrected Results
c22: GI Symptoms
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Gastrointestinal

Gastrointestinal Assessment

Corrected Results
c22: GI Symptoms
Corrected from Denies on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c23: Abdomen Description
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Symmetric, Soft on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Symmetric, Soft on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c24: Bowel Movement Last Date
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Bowel Sounds Assessment

	Recorded Date	6/14/2012	6/13/2012	6/13/2012	
	Recorded Time	08:00 PDT	20:00 PDT	13:20 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	Graf ,Cara	
Procedure	Reference Range				Units
Bowel Sounds All Quadrants		Present O9	Present O7	Present	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Gastrointestinal

Bowel Sounds Assessment

	Recorded Date	6/13/2012	6/12/2012	
	Recorded Time	08:00 PDT	21:15 PDT	
	Recorded By	Graf ,Cara	Manzano RN,Brenda P	
Procedure	**Reference Range**			**Units**
Bowel Sounds All Quadrants		Present O8	**Present** c25 O11	

Corrected Results
c25: Bowel Sounds All Quadrants
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Present on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Present on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Gastrointestinal Medical History

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Reflux Disease Medical History		Self, Reflux esophagitis O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

General

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	Reference Range			Units
General Symptoms		Denies	Denies	
Distress		None	None	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
General Symptoms		Denies O9	Denies	
Distress		None O9	None	

	Recorded Date	6/14/2012	6/13/2012	6/13/2012	
	Recorded Time	00:00 PDT	20:00 PDT	16:00 PDT	
	Recorded By	Jaques RN,Callee M	Jaques RN,Callee M	Graf ,Cara	
Procedure	Reference Range				Units
General Symptoms		-	Nausea R6 O7	Nausea	
Distress		None	None O7	Mild	

Result Comments
R6: General Symptoms
Denied zofran at this time

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	13:20 PDT	08:00 PDT	04:00 PDT	
	Recorded By	Graf ,Cara	Graf ,Cara	Manzano RN,Brenda P	
Procedure	Reference Range				Units
General Symptoms		Denies	Denies O8	-	
Distress		Mild	None O8	None	

	Recorded Date	6/13/2012	6/12/2012	
	Recorded Time	00:05 PDT	21:15 PDT	
	Recorded By	Manzano RN,Brenda P	Manzano RN,Brenda P	
Procedure	Reference Range			Units
General Symptoms		**Denies** c26	**Denies** c27 O11	
Distress		**None** c28	**None** c29 O11	

Corrected Results
c26: General Symptoms
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

General

Corrected Results

c26: General Symptoms
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c27: General Symptoms
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c28: Distress
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c29: Distress
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Denies Chronic Pain		Self [O12]	

Order Comments

O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

General

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Genitourinary

Genitourinary Assessment

Procedure	Reference Range	Recorded Date: 6/14/2012, Recorded Time: 15:45 PDT, Recorded By: Vertulfo RN,Erlyn V	Recorded Date: 6/14/2012, Recorded Time: 12:00 PDT, Recorded By: Vertulfo RN,Erlyn V	Units
Genitourinary Symptoms		Denies	Denies	

Procedure	Reference Range	Recorded Date: 6/14/2012, Recorded Time: 08:00 PDT, Recorded By: Vertulfo RN,Erlyn V	Recorded Date: 6/14/2012, Recorded Time: 04:00 PDT, Recorded By: Jaques RN,Callee M	Units
Genitourinary Symptoms		Denies O9	Denies	
Urinary Elimination		Voiding, no difficulties O9	-	

Procedure	Reference Range	Recorded Date: 6/14/2012, Recorded Time: 00:00 PDT, Recorded By: Jaques RN,Callee M	Recorded Date: 6/13/2012, Recorded Time: 21:30 PDT, Recorded By: Jaques RN,Callee M	Units
Genitourinary Symptoms		Denies	-	
Urine Description		-	Clear	

Procedure	Reference Range	Recorded Date: 6/13/2012, Recorded Time: 20:00 PDT, Recorded By: Jaques RN,Callee M	Recorded Date: 6/13/2012, Recorded Time: 16:00 PDT, Recorded By: Graf ,Cara	Units
Genitourinary Symptoms		Denies O7	Denies	
Urinary Elimination		Indwelling catheter O7	Indwelling catheter	
Urine Color		Yellow O7	Yellow	
Urine Description		Clear O7	Clear	

Procedure	Reference Range	Recorded Date: 6/13/2012, Recorded Time: 12:55 PDT, Recorded By: Caler RN,Tiffany A	Recorded Date: 6/13/2012, Recorded Time: 12:00 PDT, Recorded By: Graf ,Cara	Units
Urinary Elimination		-	Other: difficulty voiding	
Urine Description		Clear	-	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Genitourinary

Genitourinary Assessment

	Recorded Date	6/13/2012	6/13/2012
	Recorded Time	12:00 PDT	08:00 PDT
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A
Procedure	**Reference Range**		**Units**
Genitourinary Symptoms		See Below T24	-
Bladder Distention		-	Absent O8

Textual Results
T24: 6/13/2012 12:00 PDT (Genitourinary Symptoms)
Retention, Other: pt unable to urinate unless he stands and is having pain from full bladder, MD paged.

	Recorded Date	6/13/2012	6/13/2012
	Recorded Time	08:00 PDT	04:00 PDT
	Recorded By	Graf ,Cara	Manzano RN,Brenda P
Procedure	**Reference Range**		**Units**
Genitourinary Symptoms		Denies O8	Denies
Urinary Elimination		Voiding, no difficulties O8	-

	Recorded Date	6/13/2012	6/12/2012
	Recorded Time	00:05 PDT	21:15 PDT
	Recorded By	Manzano RN,Brenda P	Manzano RN,Brenda P
Procedure	**Reference Range**		**Units**
Genitourinary Symptoms		**Denies c30**	**Denies c31 O11**
Bladder Distention		-	**Absent c32 O11**

Corrected Results
c30: Genitourinary Symptoms
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c31: Genitourinary Symptoms
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Denies on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Genitourinary

Genitourinary Assessment

Corrected Results
c32: Bladder Distention
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Absent on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Absent on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Catheterization Information

	Recorded Date	6/13/2012
	Recorded Time	21:30 PDT
	Recorded By	Jaques RN,Callee M
Procedure	**Reference Range**	**Units**
Urinary Catheter Activity Type		Discontinue
Urinary Catheter Insertion Site		Urethral
Urinary Catheter Size		16 French
Urinary Catheter Type		Indwelling/Continuous
Urinary Catheter Balloon Inflation		10 mL sterile water
Urinary Catheter Drainage System		Dependent drainage bag
Urinary Catheter Procedure Tolerance		Good
Urinary Catheter Procedure Response		Expected

	Recorded Date	6/13/2012
	Recorded Time	12:55 PDT
	Recorded By	Caler RN,Tiffany A
Procedure	**Reference Range**	**Units**
Urinary Catheter Activity Type		Insert
Urinary Catheter Insertion Site		Ureteral
Urinary Catheter Size		18 French
Urinary Catheter Type		Indwelling/Continuous
Urinary Catheter Balloon Inflation		10 mL sterile water

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Genitourinary

Catheterization Information

	Recorded Date	6/13/2012	
	Recorded Time	12:55 PDT	
	Recorded By	Caler RN,Tiffany A	
Procedure	**Reference Range**		**Units**
Urinary Catheter Drainage System		Dependent drainage bag	
Urinary Catheter Procedure Tolerance		Good	
Urinary Catheter Procedure Response		Expected	

Genitourinary Medical History

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Denies Genitourinary History		Self O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Gynecology / Obstetrics

Gynecology/Obstetrics Information

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Pregnancy Status		N/A O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Gynecology/Obstetrics Medical History

	Recorded Date	6/12/2012	
	Recorded Time	20:04 PDT	
	Recorded By	Manzano RN,Brenda P	
Procedure	**Reference Range**		**Units**
Denies Gynecologic History		Self O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Head and Neck

Ocular Medical History

	Recorded Date	6/12/2012
	Recorded Time	20:04 PDT
	Recorded By	Manzano RN,Brenda P
Procedure	**Reference Range**	**Units**
Ocular,Other Medical History	Self, use reading glasses O12	

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.

Infection Control

	Recorded Date	6/14/2012	6/14/2012
	Recorded Time	13:52 PDT	08:00 PDT
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V
Procedure	**Reference Range**		**Units**
High Risk Infection Criteria on Disch		None	-
Patient MRSA Positive This Visit		No	-
Central Line in Place at 0800		-	No O18

	Recorded Date	6/13/2012	6/12/2012
	Recorded Time	08:00 PDT	20:04 PDT
	Recorded By	Caler RN,Tiffany A	Manzano RN,Brenda P
Procedure	**Reference Range**		**Units**
Patient has history of MRSA		-	No O12
Patient has history of VRE		-	No O12
Patient transferred from SNF		-	No O12
Pt discharge from acute hosp last 30 day		-	No O12
Contact Isolation Precautions in Place		-	No O12
Joint Replacement Surgery is Scheduled		-	No O12
Admission to ICU/CCU		-	No O12
Cardiac Surgery is Scheduled		-	No O12
Patient Has Diarrhea on Admission		-	No O12
Patient Receiving In-patient Dialysis		-	No O12
Central Line in Place at 0800		No O19	-

Order Comments
O12: Admission History Adult
Order entered secondary to inpatient admission.
O18: Central Line Reporting
Required Data Collection
O19: Central Line Reporting
Required Data Collection

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Braden Assessment

	Recorded Date	6/14/2012	6/14/2012
	Recorded Time	15:45 PDT	12:00 PDT
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V
Procedure	**Reference Range**		**Units**
Sensory Perception Braden		No impairment	No impairment
Moisture Braden		Rarely moist	Rarely moist
Activity Braden		Walks occasionally	Walks occasionally
Mobility Braden		No limitations	No limitations
Nutrition Braden		Adequate	Adequate
Friction and Shear Braden		No apparent problem	No apparent problem
Braden Score		21	21

	Recorded Date	6/14/2012	6/13/2012
	Recorded Time	08:00 PDT	20:00 PDT
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M
Procedure	**Reference Range**		**Units**
Sensory Perception Braden		No impairment [O9]	No impairment [O7]
Moisture Braden		Rarely moist [O9]	Rarely moist [O7]
Activity Braden		Walks occasionally [O9]	Walks occasionally [O7]
Mobility Braden		No limitations [O9]	No limitations [O7]
Nutrition Braden		Probably inadequate [O9]	Probably inadequate [O7]
Friction and Shear Braden		No apparent problem [O9]	Potential problem [O7]
Braden Score		20 [O9]	19 [O7]

	Recorded Date	6/13/2012	6/12/2012
	Recorded Time	08:00 PDT	21:15 PDT
	Recorded By	Graf ,Cara	Manzano RN,Brenda P
Procedure	**Reference Range**		**Units**
Sensory Perception Braden		No impairment [O8]	**No impairment** [c33 O11]
Moisture Braden		Rarely moist [O8]	**Rarely moist** [c34 O11]
Activity Braden		Walks occasionally [O8]	**Walks occasionally** [c35 O11]
Mobility Braden		No limitations [O8]	**No limitations** [c36 O11]
Nutrition Braden		Adequate [O8]	**Adequate** [c37 O11]
Friction and Shear Braden		Potential problem [O8]	**Potential problem** [c38 O11]
Braden Score		20 [O8]	**20** [c39 O11]

Corrected Results
c33: Sensory Perception Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No impairment on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Braden Assessment

Corrected Results

c33: Sensory Perception Braden
Corrected from No impairment on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c34: Moisture Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Rarely moist on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Rarely moist on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c35: Activity Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Walks occasionally on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Walks occasionally on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c36: Mobility Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No limitations on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from No limitations on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c37: Nutrition Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Adequate on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Adequate on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c38: Friction and Shear Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Potential problem on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Braden Assessment

Corrected Results
c38: Friction and Shear Braden
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Potential problem on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c39: Braden Score
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Incision/Wound Care

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/14/2012 04:00 PDT Jaques RN,Callee M	6/14/2012 00:00 PDT Jaques RN,Callee M	Units
Incision/Wound #1 Type		See Below T25	See Below T26	
Incision/Wound #1 Location		Right, Groin	Right, Groin	
Incision/Wound #1 Drainage		None	None	
Incision/Wound #1 Dressing		Dry, Intact, Other: destat	Dry, Other: destat	

Textual Results
T25: 6/14/2012 04:00 PDT (Incision/Wound #1 Type)
Unable to visualize, dressing intact
T26: 6/14/2012 00:00 PDT (Incision/Wound #1 Type)
Unable to visualize, dressing intact

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 20:00 PDT Jaques RN,Callee M	6/13/2012 18:45 PDT Caler RN,Tiffany A	Units
Incision/Wound #1 Type		See Below T27 R7 O7	Puncture	
Incision/Wound #1 Location		Right, Groin R7 O7	Right, Groin	
Incision/Wound #1 Surrounding Tissue		-	Other: soft, no hematoma	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Incision/Wound Care

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	20:00 PDT	18:45 PDT	
	Recorded By	Jaques RN,Callee M	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Incision/Wound #1 Drainage		None R7 O7	None	
Incision/Wound #1 Dressing		See Below T29 R7 O7	Other: D stat intact	

Textual Results
T27: 6/13/2012 20:00 PDT (Incision/Wound #1 Type)
Unable to visualize, dressing intact
T29: 6/13/2012 20:00 PDT (Incision/Wound #1 Dressing)
Dry, Intact, Other: destat covering

Result Comments
R7: Incision/Wound #1 Drainage, Incision/Wound #1 Dressing, Incision/Wound #1 Location, Incision/Wound #1 Type
Site is soft. No masses.

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	17:45 PDT	16:45 PDT	
	Recorded By	Caler RN,Tiffany A	Caler RN,Tiffany A	
Procedure	Reference Range			Units
Incision/Wound #1 Type		Puncture	Puncture	
Incision/Wound #1 Location		Right, Groin	Right, Groin	
Incision/Wound #1 Surrounding Tissue		Other: soft	Other: soft	
Incision/Wound #1 Drainage		None	None	
Incision/Wound #1 Dressing		Other: D stat intact	Other: D stat intact	

	Recorded Date	6/13/2012	
	Recorded Time	16:00 PDT	
	Recorded By	Graf ,Cara	
Procedure	Reference Range		Units
Incision/Wound #1 Type		Puncture R8	
Incision/Wound #1 Location		Right, Groin R8	
Incision/Wound #1 Drainage		None R8	
Incision/Wound #1 Dressing		Dry, Other: Dstat R8	

Result Comments
R8: Incision/Wound #1 Drainage, Incision/Wound #1 Dressing, Incision/Wound #1 Location, Incision/Wound #1 Type
area soft

	Recorded Date	6/13/2012	
	Recorded Time	15:45 PDT	
	Recorded By	Caler RN,Tiffany A	
Procedure	Reference Range		Units
Incision/Wound #1 Type		**Puncture c40**	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Incision/Wound Care

	Recorded Date Recorded Time Recorded By	6/13/2012 15:45 PDT Caler RN,Tiffany A	
Procedure	**Reference Range**		**Units**
Incision/Wound #1 Location		**Right, Groin** c41	
Incision/Wound #1 Surrounding Tissue		**Other: soft, no signs hematoma** c42	
Incision/Wound #1 Drainage		**None** c43	
Incision/Wound #1 Dressing		**Other: D stat dry and intact** c44	

Corrected Results

c40: Incision/Wound #1 Type
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from Puncture on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

c41: Incision/Wound #1 Location
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from Right, Groin on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

c42: Incision/Wound #1 Surrounding Tissue
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

c43: Incision/Wound #1 Drainage
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from None on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

c44: Incision/Wound #1 Dressing
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

	Recorded Date Recorded Time Recorded By	6/13/2012 14:45 PDT Caler RN,Tiffany A	6/13/2012 14:15 PDT Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Incision/Wound #1 Type		Puncture	Puncture	
Incision/Wound #1 Location		Right, Groin	Right, Groin	
Incision/Wound #1 Surrounding Tissue		Other: soft	Other: soft	
Incision/Wound #1 Drainage		None	None	
Incision/Wound #1 Dressing		Other: D stat intact	Other: D stat intact	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Incision/Wound Care

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:45 PDT Caler RN,Tiffany A	6/13/2012 13:20 PDT Graf ,Cara	Units
Incision/Wound #1 Type		Puncture	Puncture R9	
Incision/Wound #1 Location		Right, Groin	Right, Groin R9	
Incision/Wound #1 Surrounding Tissue		Other: soft	-	
Incision/Wound #1 Drainage		None	None R9	
Incision/Wound #1 Dressing		Other: D stat intact	-	

Result Comments
R9: Incision/Wound #1 Drainage, Incision/Wound #1 Location, Incision/Wound #1 Type
No hematoma, area soft

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:15 PDT Caler RN,Tiffany A	Units
Incision/Wound #1 Type		Puncture	
Incision/Wound #1 Location		Right, Groin	
Incision/Wound #1 Surrounding Tissue		Other: soft, no signs hematoma	
Incision/Wound #1 Drainage		None	
Incision/Wound #1 Dressing		Other: D stat intact	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:45 PDT Caler RN,Tiffany A	6/13/2012 12:30 PDT Caler RN,Tiffany A	Units
Incision/Wound #1 Type		Puncture	Puncture	
Incision/Wound #1 Location		Right, Groin	Right, Groin	
Incision/Wound #1 Surrounding Tissue		Other: soft	Other: soft	
Incision/Wound #1 Drainage		None	None	
Incision/Wound #1 Dressing		Other: D stat intact	Other: D stat intact	

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:15 PDT Caler RN,Tiffany A	6/13/2012 12:00 PDT Caler RN,Tiffany A	Units
Incision/Wound #1 Type		Puncture	Puncture	
Incision/Wound #1 Location		Right, Groin	Right, Groin	
Incision/Wound #1 Surrounding Tissue		Other: soft	See Below T28	
Incision/Wound #1 Drainage		None	None	
Incision/Wound #1 Dressing		Other: D stat dry and intact	Other: D stat intact	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Incision/Wound Care

Textual Results
T28: 6/13/2012 12:00 PDT (Incision/Wound #1 Surrounding Tissue)
Other: soft, no signs of hematoma

	Recorded Date	6/13/2012	
	Recorded Time	12:00 PDT	
	Recorded By	Caler RN,Tiffany A	
Procedure	Reference Range		Units
Incision/Wound #1 Dressing		Other: D stat intact [R9]	

Result Comments
R9: Incision/Wound #1 Dressing
No hematoma, area soft

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Integumentary Assessment

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	Reference Range			Units
Skin Color		Normal for ethnicity	Normal for ethnicity	
Skin Temperature		Warm	Warm	
Skin Description		Dry	Dry	
Skin Integrity		Intact (no broken skin)	Intact (no broken skin)	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
Skin Color		Normal for ethnicity [O9]	Normal for ethnicity	
Skin Temperature		Warm [O9]	Warm	
Skin Description		Dry [O9]	Dry	
Skin Integrity		Intact (no broken skin) [O9]	See Below [T30]	

Textual Results
T30: 6/14/2012 04:00 PDT (Skin Integrity)
Intact (no broken skin), Incision present (see detailed assessment)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Procedure	Reference Range	Recorded Date/Time/By: 6/14/2012 00:00 PDT Jaques RN,Callee M	Recorded Date/Time/By: 6/13/2012 20:00 PDT Jaques RN,Callee M	Units
Skin Color		Normal for ethnicity	Normal for ethnicity O7	
Skin Temperature		Warm	Warm O7	
Skin Description		Dry	Dry O7	
Skin Integrity		See Below T31	See Below T32 O7	
Skin Turgor		-	Elastic O7	
Mucous Membrane Color		-	Pink O7	
Mucous Membrane Description		-	Moist O7	

Textual Results
T31: 6/14/2012 00:00 PDT (Skin Integrity)
Intact (no broken skin), Incision present (see detailed assessment)
T32: 6/13/2012 20:00 PDT (Skin Integrity)
Intact (no broken skin), Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date/Time/By: 6/13/2012 18:45 PDT Caler RN,Tiffany A	Recorded Date/Time/By: 6/13/2012 17:45 PDT Caler RN,Tiffany A	Units
Skin Integrity		See Below T33	See Below T34	

Textual Results
T33: 6/13/2012 18:45 PDT (Skin Integrity)
Incision present (see detailed assessment)
T34: 6/13/2012 17:45 PDT (Skin Integrity)
Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date/Time/By: 6/13/2012 16:45 PDT Caler RN,Tiffany A	Recorded Date/Time/By: 6/13/2012 16:00 PDT Graf ,Cara	Units
Skin Color		-	Normal for ethnicity	
Skin Temperature		-	Warm	
Skin Description		-	Dry	
Skin Integrity		See Below T35	See Below T36	

Textual Results
T35: 6/13/2012 16:45 PDT (Skin Integrity)
Incision present (see detailed assessment)
T36: 6/13/2012 16:00 PDT (Skin Integrity)
Wound present (see detailed assessment)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 15:45 PDT Caler RN,Tiffany A	6/13/2012 14:45 PDT Caler RN,Tiffany A	Units
Skin Integrity		**See Below** T37 c51	See Below T38	

Textual Results
T37: 6/13/2012 15:45 PDT (Skin Integrity)
Incision present (see detailed assessment)
T38: 6/13/2012 14:45 PDT (Skin Integrity)
Incision present (see detailed assessment)

Corrected Results
c51: Skin Integrity
Date and time corrected from 6/13/2012 16:07 PDT on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A
Corrected from Incision present (see detailed assessment) on 6/13/2012 16:08 PDT by Caler RN, Tiffany A; Caler RN, Tiffany A; Caler RN, Tiffany A

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 14:15 PDT Caler RN,Tiffany A	6/13/2012 13:45 PDT Caler RN,Tiffany A	Units
Skin Integrity		See Below T39	See Below T40	

Textual Results
T39: 6/13/2012 14:15 PDT (Skin Integrity)
Incision present (see detailed assessment)
T40: 6/13/2012 13:45 PDT (Skin Integrity)
Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 13:20 PDT Graf ,Cara	6/13/2012 13:15 PDT Caler RN,Tiffany A	Units
Skin Color		Normal for ethnicity	-	
Skin Temperature		Warm	-	
Skin Description		Dry	-	
Skin Integrity		See Below T41	See Below T42	
Mucous Membrane Color		Pink	-	
Mucous Membrane Description		Moist	-	

Textual Results
T41: 6/13/2012 13:20 PDT (Skin Integrity)
Incision present (see detailed assessment)
T42: 6/13/2012 13:15 PDT (Skin Integrity)

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Textual Results
T42: 6/13/2012 13:15 PDT (Skin Integrity)
Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:45 PDT Caler RN,Tiffany A	6/13/2012 12:30 PDT Caler RN,Tiffany A	Units
Skin Temperature		-	Warm	
Skin Integrity		See Below T43	See Below T44	
Skin Turgor		-	Elastic	

Textual Results
T43: 6/13/2012 12:45 PDT (Skin Integrity)
Incision present (see detailed assessment)
T44: 6/13/2012 12:30 PDT (Skin Integrity)
Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 12:15 PDT Caler RN,Tiffany A	6/13/2012 12:00 PDT Caler RN,Tiffany A	Units
Skin Integrity		See Below T45	See Below T46	
Skin Turgor		-	Elastic	

Textual Results
T45: 6/13/2012 12:15 PDT (Skin Integrity)
Incision present (see detailed assessment)
T46: 6/13/2012 12:00 PDT (Skin Integrity)
Incision present (see detailed assessment)

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 08:00 PDT Caler RN,Tiffany A	6/13/2012 04:00 PDT Manzano RN,Brenda P	Units
Skin Color		Normal for ethnicity O8	Normal for ethnicity	
Skin Temperature		Warm O8	Warm	
Skin Description		Dry O8	Dry	
Skin Integrity		Intact (no broken skin) O8	Intact (no broken skin)	
Skin Turgor		Elastic O8	Decreased	
Mucous Membrane Color		Pink O8	Pink	
Mucous Membrane Description		Moist O8	Moist	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Procedure	Reference Range	Recorded Date / Recorded Time / Recorded By: 6/13/2012 00:05 PDT Manzano RN,Brenda P	6/12/2012 21:15 PDT Manzano RN,Brenda P	Units
Skin Color		**Normal for ethnicity** c45	**Normal for ethnicity** c46 O11	
Skin Temperature		**Warm** c47	**Warm** c48 O11	
Skin Description		**Dry** c49	**Dry** c50 O11	
Skin Integrity		**Intact (no broken skin)** c52	**Intact (no broken skin)** c53 O11	

Corrected Results

c45: Skin Color
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Normal for ethnicity on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Normal for ethnicity on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c46: Skin Color
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Normal for ethnicity on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Normal for ethnicity on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c47: Skin Temperature
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Warm on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Warm on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c48: Skin Temperature
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Warm on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Corrected Results
c48: Skin Temperature
Corrected from Warm on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c49: Skin Description
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Dry on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Dry on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c50: Skin Description
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Dry on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Dry on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c52: Skin Integrity
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Intact (no broken skin) on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Intact (no broken skin) on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
c53: Skin Integrity
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Intact (no broken skin) on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Intact (no broken skin) on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Integumentary Assessment

Order Comments
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Skin Abnormality Information

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	15:45 PDT	12:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Vertulfo RN,Erlyn V	
Procedure	Reference Range			Units
Minor Skin Abnormality		None	None	

	Recorded Date	6/14/2012	6/14/2012	
	Recorded Time	08:00 PDT	04:00 PDT	
	Recorded By	Vertulfo RN,Erlyn V	Jaques RN,Callee M	
Procedure	Reference Range			Units
Minor Skin Abnormality		None [O9]	None	

	Recorded Date	6/13/2012	6/13/2012	6/13/2012	
	Recorded Time	20:00 PDT	12:30 PDT	08:00 PDT	
	Recorded By	Jaques RN,Callee M	Caler RN,Tiffany A	Graf ,Cara	
Procedure	Reference Range				Units
Minor Skin Abnormality		None [O7]	None	None [O8]	

	Recorded Date	6/13/2012	6/13/2012	
	Recorded Time	04:00 PDT	00:05 PDT	
	Recorded By	Manzano RN,Brenda P	Manzano RN,Brenda P	
Procedure	Reference Range			Units
Minor Skin Abnormality		None	**None [c54]**	

Corrected Results
c54: Minor Skin Abnormality
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/13/2012 01:54 PDT on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/13/2012 01:55 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.
DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Integumentary

Skin Abnormality Information

	Recorded Date	6/12/2012
	Recorded Time	21:15 PDT
	Recorded By	Manzano RN,Brenda P
Procedure	**Reference Range**	**Units**
Minor Skin Abnormality	**None** c55 O11	

Corrected Results
c55: Minor Skin Abnormality
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from None on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O7: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O9: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Intrasedation

	Recorded Date	6/13/2012	6/13/2012	6/13/2012
	Recorded Time	16:00 PDT	08:00 PDT	04:00 PDT
	Recorded By	Graf ,Cara	Graf ,Cara	Manzano RN,Brenda P
Procedure	**Reference Range**			**Units**
Pulse Oximetry Monitoring		Intermittent	Intermittent O8	Intermittent

	Recorded Date	6/12/2012
	Recorded Time	21:15 PDT
	Recorded By	Manzano RN,Brenda P
Procedure	**Reference Range**	**Units**
Pulse Oximetry Monitoring	**Intermittent** c56 O11	

Corrected Results
c56: Pulse Oximetry Monitoring
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Intrasedation

Corrected Results
c56: Pulse Oximetry Monitoring
Corrected from Intermittent on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Corrected from Intermittent on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments
O8: Ongoing Assessment Adult
Order entered secondary to inpatient admission.
O11: Admission Assessment Adult
Order entered secondary to inpatient admission.

Measurements

Measurements

	Recorded Date	6/14/2012	6/13/2012	
	Recorded Time	06:00 PDT	09:32 PDT	
	Recorded By	Martinez,Karissa C	Caler RN,Tiffany A	
Procedure	**Reference Range**			**Units**
Weight		77.200	78.100	kg
Weight Dosing		-	78.100	kg
Height/Length		-	172.00	cm
Treatment Height/Length Dosing		-	172.00	cm
BSA Measured		-	1.93	
Body Mass Index		-	26.40	m2

	Recorded Date	6/13/2012	6/12/2012	
	Recorded Time	06:00 PDT	21:28 PDT	
	Recorded By	Perez,Noami M	Perez,Noami M	
Procedure	**Reference Range**			**Units**
Weight		78.100	78.100 O10	kg
Height/Length		-	172.00 O10	cm
BSA Measured		-	1.93 O10	
Body Mass Index		-	26.40 O10	m2

	Recorded Date	6/12/2012	6/12/2012	
	Recorded Time	21:15 PDT	16:06 PDT	
	Recorded By	Manzano RN,Brenda P		
Procedure	**Reference Range**			**Units**
Weight		**78.100** c57 O11	-	kg
Weight Estimated		-	77.1	

Patient: HANNA MD, ADEL SHAKER
MRN: 918505
FIN: 3050679
Patient Type: Day Patient
Attending: Khan M.D.,Faraaz O ; Razo M.D.,Paul R.

DOB/Age/Sex: 3/29/1946 76 years Male
Admit/Disch: 6/12/2012 6/14/2012
Admitting:

Measurements

Measurements

	Recorded Date	6/12/2012	6/12/2012	
	Recorded Time	21:15 PDT	16:06 PDT	
	Recorded By	Manzano RN,Brenda P		
Procedure	**Reference Range**			**Units**
Weight Dosing		**78.100** c58 O11	-	kg
Height/Length		**172.00** c59 O11	-	cm
Height/Length Estimated		-	172	
Treatment Height/Length Dosing		**172.00** c60 O11	-	cm
BSA Measured		**1.93** c61 O11	-	
Body Mass Index		**26.40** c62 O11	-	m2

Corrected Results

c57: Weight
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c58: Weight Dosing
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c59: Height/Length
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c60: Treatment Height/Length Dosing
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c61: BSA Measured
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

c62: Body Mass Index
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:59 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P
Date and time corrected from 6/12/2012 20:04 PDT on 6/12/2012 23:58 PDT by Manzano RN, Brenda P; Manzano RN, Brenda P; Manzano RN, Brenda P

Order Comments

O10: Basic Admission Information
Order entered secondary to inpatient admission.