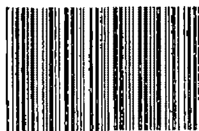
ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
11/ /08		RI Fluid Note
		pt seen, [illegible] discussed under supervision of attending Dr.
		pt is 6[illegible]y/o [illegible] PMH of Migraine
		pt came in c/o dizziness, abd pain,
		PE reveals dehydrated mucus membrane, skin is good turgor
		dry, warm.
		136 | 104 | 22 <164 GFR: >60.
		3.6 | 25.4 | 0.94
		pt will be hydrated at 100 ml/hr NS
		Jayr[illegible] / Takka DO
	11/20/08 720	Internal Medicine consult dictated
		A ① Abdominal pn / SBO
		② Dehydration / Azotemia
		③ Depression / Anxiety
		④ Migraine
		Pt [illegible] [illegible]
		[signature]

PROGRESS NOTES



100-002

PATIENT I.D.

HANNA, ADEL S
V00000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

PHSI-100-002 (5/07)

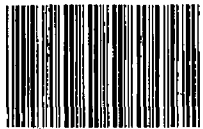
PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

PROGRESS NOTES

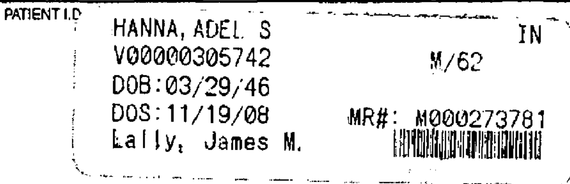
DATE	TIME	NOTES

PROGRESS NOTES



100-002

PATIENT I.D



HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.

PHSI-100-002 (5/07)

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
		Surgery
		62 yr. Male physician
		h/o 1986 Nissen fundoplication for HH.
		complicated by ruptured esophagus + [illegible] Empyema.
		2006 — open cholecystectomy
11/20/08		h/o prior Abd pain
	8:30 A	sharp chills / general malaise x 1 wk. Tues
		↓ BM. & vomiting ? dehydration
		Vomited x 2. ⊘ blood
		Came to ER → [illegible] ⊕ [illegible] SBO
		Surgery consult requested.
		No Abd pain Now. NG7 discomfort
		PMH — Med: Atenolol — Allergies: [illegible]
		Migraine
		Dyspepsia
		HTN
		PE: AF VSS
		NG7 → [illegible]
		AAOx3, [illegible] NAD
		chest: clear Card [illegible]
Colonoscopy in 2006.		Abd: soft NT ND
		open cholecystectomy [illegible] well healed
		⊘ HERNIAS [illegible]
		rectal exam: [illegible]

PROGRESS NOTES

100-002

PATIENT I.D.

HANNA, ADEL S IN
V00000305742 M/62
DOB: 03/29/46
DOS: 11/19/08 MR#: M000273781
Lally, James M.

PHSI-100-002 (5/07)

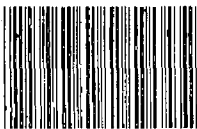
PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
		7.0 > 13/39 < 142 CMP OK
		11/19 CT Ab/P: SBO transition zone (R) mid abd. nl appendix. Diverticula —
		11/19 Abd xray: dil SBO
		11/20 Abd xray: slight improvement in dil SBO. NGT in duodenum
		Imp: dil SBO likely 2° adhesions. [illegible] BM while in hospital
		No Abd pain Now. Abd nl WBC. benign Abd exam. slight improvement in Abd xray
		Nonoperative Mgmt for Now — cont NGT, NPO
		Rec: Abd xray in AM. OOB ambulate. DVT prophylaxis
		[signature]

PROGRESS NOTES

PROGRESS NOTES



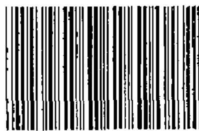
100-002

PATIENT I.D.
HANNA, ADEL S IN
V00000305742 M/62
DOB: 03/29/46
DOS: 11/19/08 MR#: M000273781
Lally, James M.

PHSI-100-002 (5/07)

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
11/20/08	1050	R, PN
		Pt seen, eval, discussed under supervision of attending Dr. Takhar.
		NG tube set to low intermittent suction, pt c/o
		slight throat and epigastric discomfort starting
		p NG tube placement requesting Gaviscon and lozenges.
		VS: T 97.5 P 81 R 18 BP 112/70 SpO2 96% on RA
		Gen: NAD, AAOx4 NG tube to Drainage
		CV: RRR s m/g/r
		Pulm: CTA (B) s wh/r/rh
		Abd: (+) Diffuse TTP, (+) Mild/Minimal Guarding
		ø Rebound
		Ext: ø c/c/e, Pulses x 4
		Labs: 137 / 106 / 26 / 88 Ca 7.6 30 (10.9) / 142
		(3.4) / 24.9 / 0.7 (39)
		CXR: Bibasilar Discoid Atelectasis
		Repeat KUB: Slight Improvement in Distal SBO,
		Feeding Tube tip in Distal Stomach / Duodenum
		A/P: - Distal SBO: NG tube draining,
		Slight improvement in Distal SBO, Dr. Oh
		consulted / following, non-operative management
		at this time. Will make NPO p midnight
		and Repeat KUB in AM.
		- Acute Intractable Abd Pain 2° Distal SBO
		- Acute Intractable Nausea and Diarrhea c
		improved c Zofran, Phenergan,
		and NG Tube, Cont Zofran prn
		- Epigastric / Esophagitis ? likely 2° NG tube
		placement Cepacol Lozenges prn, Protonix prn
		- Dehydration c cont IVF at maintenance
		rate. BUN 26.0 Recheck in AM
		- Bibasilar Discoid Atelectasis: OOB c Assist,
		IS 10x / hour while awake
		- Electrolyte Imbalance (↓K, ↓Phos, ↓Ca): Given KPhos
		Recheck in AM. [signature] Resident / Takhar DO



PROGRESS NOTES

100-002

PATIENT I.D.
HANNA, ADEL S
V00000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

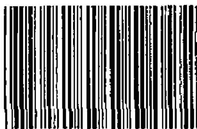
PROGRESS NOTES

PHSI-100-002 (5/07)

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
		Surgery
		POD # 2.
		No Abd pain
		passing flatus / BM
11/21		PE) Abd VSS
	8:45	diet: clear liquids
	Am	Abd soft NT ND
		NGT. 100 + 50 ml last 24 hrs
		3.4) 13 / 38 (141
		A/P) Abd xray this Am
		small bowel in the pt PSBO
		obtain CT Abd/pelvis with IV/PO contrast
		if PO contrast in colon by 6 hrs
		d/c NGT
		start oral full liq diet
		possible d/c Am on Sat
		[signature]

PROGRESS NOTES



100-002

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.

PHSI-100-002 (5/07)

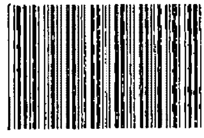
PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
	11/21/[illegible] 6:15	Med [illegible]
		[illegible]
		[illegible]
		[illegible]
	11/10	[illegible]
	[illegible]	[illegible]
		[illegible]
	[illegible]	[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]

PROGRESS NOTES

PROGRESS NOTES



100-002

PHSI-100-002 (5/07)

PATIENT I.D.

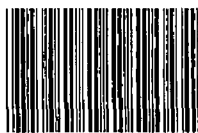
HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
		Surgery
		· POD #2.
		· No Abd pain
		passing flatus [illegible]
11/21		[illegible] AP VSS
		chest: clear [illegible]
	8:45	Abd soft NT ND
		NGT. 100 + 80 [illegible] 250 [illegible]
		3.4) 13/38 (141
		Ap) · Abd xray this Am
		start [illegible] in [illegible] PSDO
		· obtain CT Abd/pelvis c IV/PO contrast
		if PO contrast in colon by 6 hrs
		d/c NGT
		start on Full liq diet
		possible d/c Home on Sat
		[signature]

PHSI-100-002 (5/07)

PROGRESS NOTES

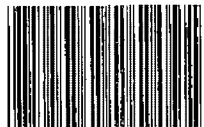


100-002

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M00027781
Lally, James M.

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
11/24/08	0925	R. PN
		Pt. seen, examined, discussed under supervision of attending,
		Dr. Takhar
		Pt. resting comfortably, ∅ new c/o overnight.
		Cont. drainage NG Tube c̄ Greenish output, Still no BM
		Vs: T 97.8 P67 R20 BP 118/74 SpO2 98% on RA
		Gen: NAD
		CV: RRR
		Pulm: CTA (B)
		Abd: soft, (+) BS, NT/ND
		Ext: ∅ C/C/E
		Labs: 137 / 106 / 11.0 < 70 Ca 7.9 3.4 > 12.8 < 141 ∅ MRSA Nares
		4.1 / 24.9 / 0.8 Phos 1.9 / 38
		KUB: Slight decrease in SBO pattern
		A/P: – Distal SBO: NG Tube c̄ continued drainage,
		Slight improvement each day x 2 per serial KUB's.
		Dr. Oh, Gen Sx, following. CT Scan Abd/Pelvis
		c̄ Contrast 6 hours before CT. Still
		non-operative at this time, per Dr. Oh.
		– Acute Intractable Abd Pain 2° Distal SBO:
		Resolving / Res (?)
		– Acute Intractable Nausea / Diarrhea: Resolving
		– Bibasilar Discoid Atelectasis: OOB c̄ Asg
		Cont IS 10x/hour while awake
		– Electrolyte Imbalance (↓K, ↓Phos, ↓Ca):
		Give Neutra phos IV, Recheck.
		– Migraine HA: cont. Atenolol
		– MDD: Cont Lexapro
		– Dehydration: cont IVF
		[signature]
		Rooty DO PGY / Takhar, DO
		[signature]



PROGRESS NOTES

100-002

PHSI-100-002 (5/07)

HANNA, ADEL S IN
V00000305742 M 62
DOB: 03/29/46
DOS: 11/19/08 MR#: M00027378 1
Lally, James M.

PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

PROGRESS NOTES

DATE	TIME	NOTES
[illegible]		[illegible]
	[illegible]	[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
		[illegible]
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		[illegible]
		[illegible]
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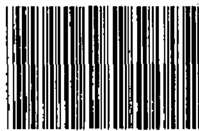
		[illegible]
		[illegible]
		[illegible]
		[illegible]

PROGRESS NOTES



100-002

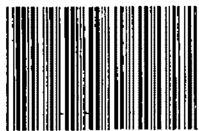
PATIENT I.D.
HANNA, ADEL S
V00000305742
M/62
DOB:03/29/46
DOS:11/19/08
MR# M000273?31
Lally, James M.

PHSI-100-002 (5/07)

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
		Surg
		No Abd'l cysts [illegible]
		seen Bob. Ad/f OK
		AP USG
11/21/08		AP: soft NT ND
	5:30pm	Chest: Clear Card: nml
		CT Abd: ⊖ SBO
		residual Hx
		? healed sigmoid colon
		[illegible] 13/38 [illegible] OK
		Imp) · residual Hx
		· tolerated full liq diet and [illegible]
		@ Nurse
		· Seen Bob.
		pt anxious to go home.
		will contact me if any problems
		· F/u in my office wednesday
		to the hospital — then Dr. Jay
		[signature]

PROGRESS NOTES



100-002

PHSI-100-002 (5/07)

PATIENT I.D.

HANNA, ADEL S.
V00000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M000273731

PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

DATE	TIME	NOTES
11/21/08	2040	R1 D/C Note
		pt seen, eval, discussed under supervision of attending Dr. Takhar.
		pt is 62y/o male c̄ ∅ PMH except migraine
		· Manifestation: abd pain, N/V. ↓ urine output
		· Underlying pathology: SBO, dehydration, diverticulosis
		severity: required hospitalization
		Instigating factors: SBO, diverticulitis, renal failure.
		Complication: sepsis, coma, death.
		VS: T:98.6 P:62 R:20 BP: 137/91 pain: ∅
		· Activity: as tolerated
		· diet: diverticulosis diet
		· pt agreeable to be D/C.
		pt is to F/U c̄ Dr Dh Nov 26.08.
		F/U c̄ PCP Dr Agarwal.
		pt got better over the hospital course ∅ SBO on CT scan (repeated)
		∅ abd pain, tolerated Full liquid diet.
		POC: Irma (wife) 909-374-7216.
		Dict # 713730
		Jang R1 DO / Takhar DO
		C
		Q

PROGRESS NOTES

100-002

PHSI-100-002 (5/07)

PATIENT I.D.

HANNA, ADEL S IN
V00000305742 M/62
DOB: 03/29/46
DOS: 11/19/08 MR#: M000273781
Lally, James M.

PROGRESS NOTES

DIAGNOSIS	1.	M.D. ORDER
	2.	M.D. ORDER

Objectives: (Check One)
- ☐ Liquefy / mobilize secretions
- ☐ Relieve bronchospasm
- ☐ Reinflate lung parenchyma
- ☐ Prevent atelectasis
- ☐ Increase inspiratory capacity
- ☐ Improve arterial blood gases
- ☐ ____
- ☐ ____

Entry 1

DATE: 11/20/08
TIME: 1730

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW | INITIAL: SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S. (circled)

MEDICATIONS: ☐ Check Order ☐ MAR Initiated
OTHER: I.S. instruct
Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED (circled) 6. OTHER
ANTERIOR R L / POSTERIOR R L

COUGH EFFORT: NONE, POOR, MOD, STRONG, NTS

SECRETIONS: SMALL, MODERATE, LARGE, NO RETURN
CONSISTENCY: THICK, THIN, NORMAL, PURULENT
COLOR: WHITE, YELLOW, CLEAR, BLOODY, OTHER ____

PT INTERFACE: MP (circled) MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | DURATION: 10 | VT/PRESS | NEW CIRCUIT SPACER

RESPIRATIONS: NO DISTRESS (circled) SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS (circled) SUPINE SIT TRENDELENBURG
TOLERANCE: WELL (circled) FAIR POOR
TX RESULTS: IMPROVED NO CHANGE ADVERSE REACTION: YES NO (circled)
ORIENTATION: ALERT (circled) ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

PT. Educated on: ____ ☐ Other ____
- ☒ Deep Breath / Cough IS X 10 Breaths
- ☐ Disease Process @ 2250 cc c
- ☐ Smoking Cessation good effort
- ☐ Oxygen Therapy R/A
- ☐ Bronchodilator Therapy ____

SIGNATURE: [illegible] RCP

Entry 2

DATE:
TIME:

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW | INITIAL: SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S.

MEDICATIONS: ☐ Check Order ☐ MAR Initiated
OTHER: ____
Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED 6. OTHER
ANTERIOR R L / POSTERIOR R L

COUGH EFFORT: NONE, POOR, MOD, STRONG, NTS

SECRETIONS: SMALL, MODERATE, LARGE, NO RETURN
CONSISTENCY: THICK, THIN, NORMAL, PURULENT
COLOR: WHITE, YELLOW, CLEAR, BLOODY, OTHER ____

PT INTERFACE: MP MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | DURATION | VT/PRESS | NEW CIRCUIT SPACER

RESPIRATIONS: NO DISTRESS SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS SUPINE SIT TRENDELENBURG
TOLERANCE: WELL FAIR POOR
TX RESULTS: IMPROVED NO CHANGE ADVERSE REACTION: YES NO
ORIENTATION: ALERT ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

PT. Educated on: ____ ☐ Other ____
- ☐ Deep Breath / Cough ____
- ☐ Disease Process ____
- ☐ Smoking Cessation ____
- ☐ Oxygen Therapy ____
- ☐ Bronchodilator Therapy ____

SIGNATURE: ____

Entry 3

DATE:
TIME:

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW | INITIAL: SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S.

MEDICATIONS: ☐ Check Order ☐ MAR Initiated
OTHER: ____
Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED 6. OTHER
ANTERIOR R L / POSTERIOR R L

COUGH EFFORT: NONE, POOR, MOD, STRONG, NTS

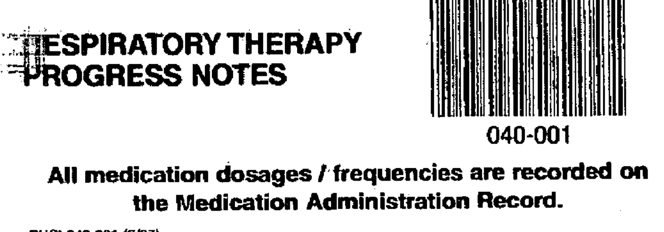
SECRETIONS: SMALL, MODERATE, LARGE, NO RETURN
CONSISTENCY: THICK, THIN, NORMAL, PURULENT
COLOR: WHITE, YELLOW, CLEAR, BLOODY, OTHER ____

PT INTERFACE: MP MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | DURATION | VT/PRESS | NEW CIRCUIT SPACER

RESPIRATIONS: NO DISTRESS SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS SUPINE SIT TRENDELENBURG
TOLERANCE: WELL FAIR POOR
TX RESULTS: IMPROVED NO CHANGE ADVERSE REACTION: YES NO
ORIENTATION: ALERT ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

PT. Educated on: ____ ☐ Other ____
- ☐ Deep Breath / Cough ____
- ☐ Disease Process ____
- ☐ Smoking Cessation ____
- ☐ Oxygen Therapy ____
- ☐ Bronchodilator Therapy ____

SIGNATURE: ____



RESPIRATORY THERAPY PROGRESS NOTES

040-001

PATIENT: HANNA, ADEL S
V00000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

All medication dosages / frequencies are recorded on the Medication Administration Record.

ROOM #: 228

PHSI-040-001 (6/07)

DIAGNOSIS	1.	M.D. ORDER
	2.	M.D. ORDER

Objectives: (Check One)
- ☐ Liquefy / mobilize secretions
- ☐ Relieve bronchospasm
- ☐ Reinflate lung parenchyma
- ☐ Prevent atelectasis
- ☐ Increase inspiratory capacity
- ☐ Improve arterial blood gases
- ☐ ______
- ☐ ______

DATE

TIME

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW — INITIAL — SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S.

MEDICATIONS: ☐ Check Order ☐ MAR Initialed OTHER: ______ Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED 6. OTHER — ANTERIOR (R L) POSTERIOR (R L)

COUGH EFFORT: NONE POOR MOD STRONG NTS

SECRETIONS: SMALL MODERATE LARGE NO RETURN
CONSISTENCY: THICK THIN NORMAL PURULENT
COLOR: WHITE YELLOW OTHER ____ CLEAR BLOODY

PT INTERFACE: MP MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | **DURATION** | **Vt/PRESS** | **NEW CIRCUIT SPACER**

PT. Educated on: ______ ☐ Other ______
- ☐ Deep Breath / Cough ______
- ☐ Disease Process ______
- ☐ Smoking Cessation ______
- ☐ Oxygen Therapy ______
- ☐ Bronchodilator Therapy ______

RESPIRATIONS: NO DISTRESS SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS SUPINE SIT TRENDELENBURG
TOLERANCE: WELL FAIR POOR
TX RESULTS: IMPROVED NO CHANGE **ADVERSE REACTION: YES NO**
ORIENTATION: ALERT ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

SIGNATURE: ______

RESPIRATORY / ABG PFT / OXIMETRY

DATE

TIME

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW — INITIAL — SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S.

MEDICATIONS: ☐ Check Order ☐ MAR Initialed OTHER: ______ Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED 6. OTHER — ANTERIOR (R L) POSTERIOR (R L)

COUGH EFFORT: NONE POOR MOD STRONG NTS

SECRETIONS: SMALL MODERATE LARGE NO RETURN
CONSISTENCY: THICK THIN NORMAL PURULENT
COLOR: WHITE YELLOW OTHER ____ CLEAR BLOODY

PT INTERFACE: MP MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | **DURATION** | **Vt/PRESS** | **NEW CIRCUIT SPACER**

PT. Educated on: ______ ☐ Other ______
- ☐ Deep Breath / Cough ______
- ☐ Disease Process ______
- ☐ Smoking Cessation ______
- ☐ Oxygen Therapy ______
- ☐ Bronchodilator Therapy ______

RESPIRATIONS: NO DISTRESS SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS SUPINE SIT TRENDELENBURG
TOLERANCE: WELL FAIR POOR
TX RESULTS: IMPROVED NO CHANGE **ADVERSE REACTION: YES NO**
ORIENTATION: ALERT ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

SIGNATURE: ______

DATE

TIME

THERAPY: IPPB, MED. NEB, AEROSOL, USN, PK FLOW — INITIAL — SUCTION, PD & P, SPUTUM INDUC, CMN, MDI, I.S.

MEDICATIONS: ☐ Check Order ☐ MAR Initialed OTHER: ______ Diluent: NS H_2O

AUSCULTATION: 1. CLEAR 2. RHONCHI 3. RALES 4. WHEEZES 5. DECREASED 6. OTHER — ANTERIOR (R L) POSTERIOR (R L)

COUGH EFFORT: NONE POOR MOD STRONG NTS

SECRETIONS: SMALL MODERATE LARGE NO RETURN
CONSISTENCY: THICK THIN NORMAL PURULENT
COLOR: WHITE YELLOW OTHER ____ CLEAR BLOODY

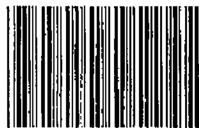
PT INTERFACE: MP MSK MS NC BLOWBY SPACER | C.R. / / | R.R. / / | **DURATION** | **Vt/PRESS** | **NEW CIRCUIT SPACER**

PT. Educated on: ______ ☐ Other ______
- ☐ Deep Breath / Cough ______
- ☐ Disease Process ______
- ☐ Smoking Cessation ______
- ☐ Oxygen Therapy ______
- ☐ Bronchodilator Therapy ______

RESPIRATIONS: NO DISTRESS SOB LABORED
POSITION: FOWLERS SEMI-FOWLERS SUPINE SIT TRENDELENBURG
TOLERANCE: WELL FAIR POOR
TX RESULTS: IMPROVED NO CHANGE **ADVERSE REACTION: YES NO**
ORIENTATION: ALERT ASLEEP UNRESPONSIVE RESPONDS TO STIMULI CONFUSED

SIGNATURE: ______

RESPIRATORY THERAPY PROGRESS NOTES



040-001

All medication dosages / frequencies are recorded on the Medication Administration Record.

PHSI-040-001 (6/07)

PATIENT I.D.

ROOM #______

TAPE# PAC'S

DATE: 11/20/08 PATIENT NAME:

TIME: MEDICAL RECORD NUMBER:

ROOM#: 228S HEIGHT: 5'8" WEIGHT: 165# Age 62 y

TECHNOLOGIST: DOCTOR(S):

PATIENT HISTORY: SOB

Hx HTN

COMMENTS: pt REFUSES, STATES HE doesn't NEED IT c cardiac workup c angiogram was done by Dr. C. Agrawal in 2005 as/pt Call for those Results

VELOCITIES

AOV: M/S AI: M/S

MV: M/S MR: M/S

TV: M/S TR: M/S

PV: M/S PI: M/S

RVSP mmHg

AREAS

AVA: CM^2

MVA: CM^2

ESTIMATED EJECTION FRACTION

2D %

M-MODE %

LA: LV:

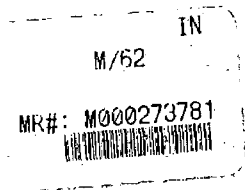
RA: RV:

IVC:

THIS IS NOT A PHYSICIAN'S REPORT. TO BE USED BY THE PHYSICIAN IN THEIR INTERPRETATION

Chino Valley Medical Center
5451 WALNUT AVENUE
CHINO, CALIFORNIA 91710

ADDRESSOGRAPH


HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.

I hereby authorize dispensation of a formulary equivalent (under the formulary system) unless the particular drug is encircled and manufacturer listed. Non-Proprietary Equivalent Drug may be dispensed unless checked ☐

TIME: 2045 **DATE:** 11/19/08 **ALLERGY:**

Admit: Med/Surg.
Dx: acute SBO.
Cond: Guarded
VS: per protocol
All: reglan (dystonic rxn)
Activity: Bedrest
Nursing: NG tube intermittent low suction

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jay Rino / Takbadd					
TRANSCRIBER SIGNATURE	DATE 11/20/08	TIME 0109	NOTING RN'S SIGNATURE	DATE 11/20/08	TIME 0200
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2350			

TIME: 2040 **DATE:** 11/19/08 **ALLERGY:**

Diet: NPO.
IVF: 100ml/hr NS
tylenol 650mg PO q4h PRN temp >100.4 or HA
colace 100mg PO BID PRN constipation
Zofran ~~Phenergan 12.5mg~~ 4mg IV q6h PRN N/V
Morphine 2mg IV q4h PRN pain
ativan 1mg IV q4h PRN anxiety

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jay Rino / Takbadd					
TRANSCRIBER SIGNATURE	DATE 11/20/08	TIME 0109	NOTING RN'S SIGNATURE	DATE 11/20/08	TIME 0200
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2350			

TIME: 2040 **DATE:** 11/19/08 **ALLERGY:**

protonix 40mg IV q day ~~PRN~~ GERD
ambien 5mg PO qhs PRN Insomnia may repeat x1
please add CMP/I Mg, Phos (poss Imbalance?), lipid panel (poss CAD)
coag panel (poss coagulopathy) to ER blood if not done
UA c cks if + (poss UTI). UDS (poss abuse) if not done
~~CXR (poss PNA) if not done~~
EKG, Echo to be read by Dr. Agarwal (poss HF)

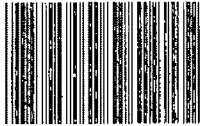
T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jay Rino / Takbadd					
TRANSCRIBER SIGNATURE	DATE 11/20/08	TIME 0109	NOTING RN'S SIGNATURE	DATE 11/20/08	TIME 0200
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2350			

HANNA, ADEL S
V000003305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781 M/62 IN

ORDERS

PHYSICIAN'S ORDER SHEET



120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

I hereby authorize dispensation of a formulary equivalent (under the formulary system) unless the particular drug is encircled and manufacturer listed. Non-Proprietary Equivalent Drug may be dispensed unless checked ☐.

TIME: 2100 **DATE:** 11/19/08 **ALLERGY:**

✓ Toradol 30mg IV q6h (PRN pain x 6)
✓ ampicillin 1gm IV q8h (SBO / poss sepsis)
✓ atenolol 50mg po qhs (migraine prophylaxis)
✓ Benadryl IV 25mg x1 PRN agitation
✓ Consult Dr. Quinonez (SBO) who may participate in pt's care and management Pose Lyp Taleon Jay
– BMP (poss renal failure) CBC (poss sepsis) in am 11/20/08

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jan Rino Takhar					
TRANSCRIBER SIGNATURE	**DATE**	**TIME**	**NOTING RN'S SIGNATURE**	**DATE**	**TIME**
[illegible]	11/20/08	0109	[illegible]	11/20/08	0201
24 HR CHART CHECK BY NURSE	**DATE**	**TIME**			
Yayin Chang RN	11/20/08	2350			

HANNA, ADEL S
V000000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781
M/62 IN

TIME: 2100 **DATE:** 11/19/08 **ALLERGY:**

✓ Consult Dr. Amin who may participate in pt's care and management (Abd pain)

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jan Rino Takhar					
TRANSCRIBER SIGNATURE	**DATE**	**TIME**	**NOTING RN'S SIGNATURE**	**DATE**	**TIME**
[illegible]	11/20/08	0109	[illegible]	11/20/08	0201
24 HR CHART CHECK BY NURSE	**DATE**	**TIME**			
Yayin Chang RN	11/20/08	2350			

HANNA, ADEL S
V000000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781
M/62 IN

TIME: 2300 **DATE:** 11/19/08 **ALLERGY:**

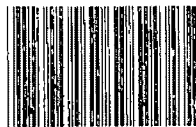
– ativan 2mg IV q4h PRN agitation.

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jan Rino Takhar					
TRANSCRIBER SIGNATURE	**DATE**	**TIME**	**NOTING RN'S SIGNATURE**	**DATE**	**TIME**
[illegible]	11/20/08	0109	[illegible]	11/20/08	0201
24 HR CHART CHECK BY NURSE	**DATE**	**TIME**			
Yayin Chang RN	11/20/08	2350			

HANNA, ADEL S
V000000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781
M/62 IN

PHYSICIAN'S ORDER SHEET



120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

I hereby authorize dispensation of a formulary equivalent (under the formulary system) unless the particular drug is encircled and manufacturer listed. Non-Proprietary Equivalent Drug may be dispensed unless checked ☐.

TIME: 320 **DATE:** 11/20/08 **ALLERGY:**

\. Na kphos 20meq IV in 250ml NS ē lidocaine 25mg over 4hrs (↓ phos)
\ - KUB in am (SBO)

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jareino Takhano					
TRANSCRIBER SIGNATURE	DATE 11/20/08	TIME 0340	NOTING RN'S SIGNATURE	DATE 11/20/08	TIME 0400
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2300			

TIME: 600 **DATE:** 11/20/08 **ALLERGY:**

· Cancel Dr. Quianzon's consult (refuses)
Consult Dr. Oh (SBI) who may participate in pt's care and management. Done by Takhan Jay.

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Jareino Takhano					
TRANSCRIBER SIGNATURE	DATE 11/20/08	TIME 0610	NOTING RN'S SIGNATURE	DATE 11/20/08	TIME 0620
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2300			

TIME: 0655 **DATE:** 11/20/08 **ALLERGY:** Reglan

Foley Cath to Gravity (↓UOP) ~~pt attempts to void now. Hold if able to urinate > 600~~
Strict I&O's for 24° (↓UOP)
UA C&S if ⊕ as prev ordered (poss sepsis)
Urine Na and

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
[signature] Takhano	11/20/08	0656			
TRANSCRIBER SIGNATURE	DATE 11-20-08	TIME 0850	NOTING RN'S SIGNATURE	DATE 11-20-08	TIME 0925
24 HR CHART CHECK BY NURSE Yayin Chang RN	DATE 11/20/08	TIME 2300			

HANNA, ADEL S
V000000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000027371
M/62

PHYSICIAN'S ORDER SHEET

120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

I hereby authorize dispensation of a formulary equivalent (under the formulary system) unless the particular drug is encircled and manufacturer listed. Non-Proprietary Equivalent Drug may be dispensed unless checked ☐.

TIME: 11/20/08	DATE: 7:25 A	ALLERGY:		
① UA, C&S to R/O dx				
② add 40mEq KCl in IV				
③ Chem 7, CBC 11/21/08				
T/O Dr.:		Read Back / RN Signature:		
PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
TRANSCRIBER SIGNATURE	DATE 11-20-08	TIME 0850	NOTING RN'S SIGNATURE	DATE 11-20-08	TIME 0920
24 HR CHART CHECK BY NURSE	DATE 11/20/08	TIME 2350			

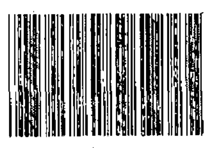
TIME: 1130	DATE: 11/20/08	ALLERGY:		
Gaviscon 15mL PO QID prn (indigestion)				
T/O Dr.		Read Back / RN Signature:		
PHYSICIAN SIGNATURE Root DOH / Takhar, DO	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
TRANSCRIBER SIGNATURE	DATE 11-20-08	TIME 1200	NOTING RN'S SIGNATURE	DATE 11-20-08	TIME 1345
24 HR CHART CHECK BY NURSE	DATE 11/20/08	TIME 2350			

TIME: 1230	DATE: 11/20/08	ALLERGY:		
Cepacol Lozenges 1 PO Q4° PRN sore throat				
T/O Dr. Root		Read Back / RN Signature:		
PHYSICIAN SIGNATURE Root DOH / Takhar DO	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
TRANSCRIBER SIGNATURE	DATE 11-20-08	TIME 1240	NOTING RN'S SIGNATURE	DATE 11-20-08	TIME 1345
24 HR CHART CHECK BY NURSE	DATE 11/20/08	TIME 2350			

HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781
M/62 IN

ORDERS

PHYSICIAN'S ORDER SHEET



120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

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TIME: 1635 **DATE:** 11/20/08 **ALLERGY:**

NPO p̄ Midnight (SBO)
Engerage 15 10 /hour while awake (Bibasilar Discoid Atelectasis)
OOB c̄ Nsg (B) Bibasilar Discoid Atelectasis)
KUB in AM 11/21/08 (SBO)
Decrease IVF to 90 mL/hour (Maintenance Rate)
Please add Phos to AM Labs 11/21/08 (↓Phos)

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Sanpreet Takhar DO					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
S. [illegible]	11-20-08	1730	[illegible]	11/20/08	1745
24 HR CHART CHECK BY NURSE	DATE	TIME			
Yaqin Chang RN	11/20/08	2330			

TIME: 2010 **DATE:** 11/20/08 **ALLERGY:**

Hold po meds at this time

T.O R.B: Tang / Yaqin Chang RN

T/O Dr.: Tang Read Back / RN Signature: Yaqin Chang RN

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Sanpreet Takhar DO					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
Yaqin Chang RN	11/20/08	2120	Yaqin Chang RN	11/20/08	2120
24 HR CHART CHECK BY NURSE	DATE	TIME			
Yaqin Chang RN	11/20/08	2330			

TIME: 2130 **DATE:** 11/20/08 **ALLERGY:**

· Atenolol 50mg po qhs x1 now. (pt insists for poss orthopnea)
– NPO p̄ midnite. (SBO)

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Sanpreet Takhar DO					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
Yaqin Chang RN	11/20/08	2130	Yaqin Chang RN	11/20/08	2130
24 HR CHART CHECK BY NURSE	DATE	TIME			
Yaqin Chang RN	11/20/08	2330			

HANNA, ADEL S
V000000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
MR#: M000273781
M/62

ORDERS

PHYSICIAN'S ORDER SHEET

120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

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TIME: 8:40A **DATE:** 11/21/08 **ALLERGY:**

CT Abd pelvis w/ IV + PO contrast
(wait 6 hrs from po contrast via NGT until CT Scan)
(dw Dr. [illegible] DOR)

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
[signature]					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE 11/21/08	TIME 0850
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S
V000000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN M, 62 MR#: M000273781

TIME: **DATE:** **ALLERGY:** [illegible]

Call me with CT A/P results today

OK to clamp NGT p PO contrast given

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
[signature]					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE 11/21/08	TIME 0850
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S
V000000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN M, 62 MR#: M000273781

TIME: 0945 **DATE:** 11/21/08 **ALLERGY:**

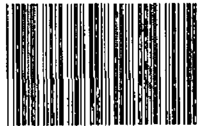
Na Phosph Rider 40 meq in 250mL NS over 4 hours (↓Phos)
CBC, BMP c̄ Phos in AM 11/22/08 (Elect [illegible])
Cont OOB c̄ Nsg (Bibasilar Discoid Atelectasis)

T/O Dr.: ________ Read Back / RN Signature: ________

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
[signature] Resident DOR / [illegible]					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE 11/21/08	TIME 0955
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S
V000000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN M, 62 MR#: M000273781

PHYSICIAN'S ORDER SHEET



120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

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TIME: 1940 **DATE:** 11/21/08 **ALLERGY:**

May remove NG Tube.
Start on Full liquid diet as tolerated.
May have Atenolol (home medication) 50mg tonight via Pharmacy

T/O Dr.: Oh, Anthony Read Back / RN Signature: [illegible]

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
TRANSCRIBER SIGNATURE [illegible]	DATE 11/21/08	TIME 1950	NOTING RN'S SIGNATURE	DATE	TIME
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S V00000305742 DOB:03/29/46 DOS:11/19/08 Lally, James M. M/62 MR#: M000273781

TIME: 8:30 **DATE:** 11/21/08 **ALLERGY:**

[illegible] (for Dr. [illegible] - OK).

F/u [illegible] office wed 11/26

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
Oh					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S V00000305742 DOB:03/29/46 DOS:11/19/08 Lally, James M. M/62 MR#: M000273781

TIME: 2040 **DATE:** 11/21/08 **ALLERGY:**

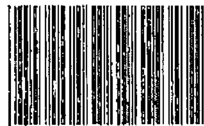
- D/C pt home via private auto
- D/C IV
- Diet: ~~Diet~~ FCK (liver/cirrhosis diet)
- Activity: as tolerated
- Meds / see additional orders
- F/U c̄ PCP Dr. Agarwal and Dr. Oh on Nov 26.08.

T/O Dr.: Read Back / RN Signature:

PHYSICIAN SIGNATURE	DATE	TIME	PHYSICIAN SIGNATURE FOR T/O	DATE	TIME
[illegible] Takhar MD					
TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
24 HR CHART CHECK BY NURSE	DATE	TIME			

HANNA, ADEL S V00000305742 DOB:03/29/46 DOS:11/19/08 Lally, James M. M/62 MR#: M000273781

PHYSICIAN'S ORDER SHEET



120-001

DO NOT WRITE IN THIS AREA.

PHSI-120-001 (1/08) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

Patient Name: HANNA,ADEL S
Unit No: M000273781

[illegible]#	TYPE/EXAM	RESULT
0005337624	RAD/XR ABD: FLATPLT-(KUB)	

Supine abdomen:

FINDINGS: An NG tube appears to terminate in the region of the second/third portion of the duodenum. Air is scattered throughout both large and small bowel loops. Several of the jejunal bowel loops demonstrate a slight increase gaseous distention from normal. This however appears improved when compared to November 20, 2008. No abnormal calcifications can be seen.

IMPRESSION:
Slight decrease in small bowel ileus pattern.

DICTATED: 11-21-08/0721
Teleradiology

CORRECTION: 11-21-08/0724 (nom)

** REPORT SIGNATURE ON FILE 11/21/2008 **
Reported By: Jeanine McNeil, M.D.
Signed By: Fahim Gheybi, M.D.

CC: James M. Lally; Matthew Root; Daljinder Takhar

Technologist: FREDERICK A. PUFFER,RT(R)
Transcribed Date/Time: 11/21/2008 (0724)
Transcriptionist: RDMN
Printed Date/Time: 11/21/2008 (1521)

11/19 → 11/21/08 (N) TAKDA

PAGE 1 FLOOR COPY

[illegible]O VALLEY MEDICAL CENTER
[illegible] WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL S
Phys: Root, Matthew
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: [illegible]
Exam Date: 11/21/2008 Status: ADM IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	**TYPE/EXAM**	**RESULT**
000537487	CT/CT-ABDOMEN+PELVIS W/O CON	

CT Abdomen and Pelvis without IV contrast:

Indication: Pain.

Findings: Limited evaluation of lung bases shows bibasilar discoid atelectasis. Pleural calcifications are seen in the right base. In the abdomen, patient is status post cholecystectomy. Rest of the abdominal solid organs is normal in appearance. There is no free fluid collection identified. Small nonspecific mesenteric nodes are seen. There is moderate dilation of proximal small bowel seen. A transition point is identified in the right mid abdomen. The distal small bowel and colon are not dilated. These findings are consistent with small bowel obstruction. Normal appendix is identified. Degenerative spurring is seen the lumbar spine.

In the pelvis, the bladder is normal. Scattered diverticula are seen in the sigmoid colon. No adenopathy is seen. A tiny free fluid is seen in the pelvis. Bony structures of pelvis are within normal limits.

Impression:
1. Findings consistent with small bowel obstruction with a transition point in the right mid abdomen.
2. Status post cholecystectomy.
3. Normal appendix is identified.
4. Tiny nonspecific free pelvic fluid.
5. Scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis.

Critical value: The above findings were reported by telephone to Chino Valley Medical Center at 8:10 p.m. on 11/19/08.

DICTATED: 11-19-08/1955
Teleradiology

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537487	CT/CT-ABDOMEN+PELVIS W/O CON	

<Continued>

CORRECTION: 11-20-08/0741 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Aaron Jun, M.D.
Signed By: Peter Phan,MD

CC: Pranav Kachhi

Technologist: DANIELLE BASS,RT(R)
Transcribed Date/Time: 11/20/2008 (0741)
Transcriptionist: RDMVD
Printed Date/Time: 11/26/2008 (1245)

PAGE 2 Signed Report

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537488	RAD/XR CHEST: 1V (AP/PA)	

SINGLE VIEW CHEST:

Findings: Single view of chest shows bibasilar discoid atelectasis. There is no other focal infiltrate seen. Heart size and mediastinal width are within normal limits. No pleural effusion is seen.

CONCLUSION:
Bibasilar discoid atelectasis.

DICTATED: 11-19-08/1937
Teleradiology

CORRECTION: 11-20-08/0737 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Aaron Jun, M.D.
Signed By: Peter Phan,MD

CC: Pranav Kachhi

Technologist: DANIEL DIAZ,RT(R)
Transcribed Date/Time: 11/20/2008 (0737)
Transcriptionist: RDMVD
Printed Date/Time: 11/26/2008 (1245)

PAGE 1 Signed Report

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537497	RAD/XR ABD: FLATPLT-(KUB)	

Supine portable AP chest/abdomen-11/19/08 at 2138 hours:

Indication: NG tube placement.

Findings: Nasogastric tube is in place with its tip near the region of the EG junction/gastric fundus; would recommend advancing the tube 6 to 8 cm. Multiple air-distended loops of central small bowel suggestive for distal small bowel obstruction. No evident free air/mass or abnormal abdominal calcifications; the visualized osseous structures appear intact. No other significant findings.

IMPRESSION:
Nasogastric tube in place as described recommend advancing tube 6 to 8 cm; findings suggestive for a distal small bowel obstruction.

DICTATED: 11-20-08/0107
Teleradiology

CORRECTION: 11-20-08/0801 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Gary Harris,MD
Signed By: Peter Phan,MD

CC: Pranav Kachhi; James M. Lally; Daljinder Takhar

Technologist: LINDA K NGUYEN,RT
Transcribed Date/Time: 11/20/2008 (0801)
Transcriptionist: RDMVD
Printed Date/Time: 11/26/2008 (1245)

PAGE 1 Signed Report

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537522	RAD/XR ABD: FLATPLT-(KUB)	

KUB time 5:40 a.m. 11/20/08:

Findings: Compared with 11/19/08.

There is slight decrease in dilatation of numerous dilated small bowel loops. Feeding tube tip is in distal stomach/duodenum. Cholecystectomy clips are noted. No free air is seen.

Impression:
Slight improvement in distal small bowel obstruction. Feeding tube tip is in distal stomach/duodenum.

DICTATED: 11-20-08/0629
Teleradiology

CORRECTION: 11-20-08/0802 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Atul Patel, M.D.
Signed By: Peter Phan,MD

CC: Yoonjung Jang; James M. Lally; Daljinder Takhar

Technologist: FREDERICK A. PUFFER,RT(R)
Transcribed Date/Time: 11/20/2008 (0802)
Transcriptionist: RDMVD
Printed Date/Time: 11/26/2008 (1245)

PAGE 1 Signed Report

Name: HANNA,ADEL S
Phys: Jang,Yoonjung
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/20/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537624	RAD/XR ABD: FLATPLT-(KUB)	

Supine abdomen:

FINDINGS: An NG tube appears to terminate in the region of the second/third portion of the duodenum. Air is scattered throughout both large and small bowel loops. Several of the jejunal bowel loops demonstrate a slight increase gaseous distention from normal. This however appears improved when compared to November 20, 2008. No abnormal calcifications can be seen.

IMPRESSION:
Slight decrease in small bowel ileus pattern.

DICTATED: 11-21-08/0721
Teleradiology

CORRECTION: 11-21-08/0724 (nom)

** REPORT SIGNATURE ON FILE 11/21/2008 **
Reported By: Jeanine McNeil, M.D.
Signed By: Fahim Gheybi, M.D.

CC: James M. Lally; Matthew Root; Daljinder Takhar

Technologist: FREDERICK A. PUFFER,RT(R)
Transcribed Date/Time: 11/21/2008 (0724)
Transcriptionist: RDMN
Printed Date/Time: 11/26/2008 (1244)

PAGE 1 Signed Report

Name: HANNA,ADEL S
Phys: Root, Matthew
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/21/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	**TYPE/EXAM**	**RESULT**
000537683	CT/CT-ABDOMEN+PELVIS W/WO CON	

CT abdomen and pelvis with and without contrast:

History: The patient is being evaluated for possible small bowel obstruction.

Procedure: Images were obtained through the abdomen and pelvis prior to and following infusion of contrast material.

Findings: There is minimal patchy right basilar atelectasis. The cardiac silhouette does not appear enlarged. The nasogastric tube terminates in the descending duodenum. No peripancreatic changes are noted. The kidneys show no abnormal calcifications. The liver and spleen show no abnormal calcifications and no areas of abnormal enhancement or attenuation. The gallbladder is surgically absent. No adrenal masses are noted. The kidneys show no areas of abnormal enhancement. The distal common bile duct appears minimally prominent measuring 1 cm in the head of the pancreas. Multiple loops of fluid and contrast-filled small bowel are present. No focally dilated small bowel loops are noted. There is no wall thickening. There is no inflammatory change. A normal appendix is visualized.

The colon shows lack of distention versus edema to the sigmoid colon. There is no marked inflammatory change. No free intraperitoneal gas or fluid is appreciated. The prostate appears somewhat prominent.

Impression:
1. The nasogastric tube terminates in the descending duodenum.
2. There is no pattern of small bowel obstruction.
3. There is lack of distention versus thickening to the wall of the sigmoid colon without marked adjacent inflammatory change.

DICTATED: 11-21-08/1804
Teleradiology

Name: HANNA,ADEL S
Phys: Oh, Anthony S
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/21/2008 Status: DIS IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000537683	CT/CT-ABDOMEN+PELVIS W/WO CON	

<Continued>

CORRECTION: 11-22-08/0617 (nom)

** REPORT SIGNATURE ON FILE 11/24/2008 **
Reported By: Monika Kief-Garcia, M.D.
Signed By: Steven R Cobb, M.D.

CC: James M. Lally; Anthony S Oh; Daljinder Takhar

Technologist: JIM QUIROZ, R.T.
Transcribed Date/Time: 11/22/2008 (0618)
Transcriptionist: RDMN
Printed Date/Time: 11/26/2008 (1245)

PAGE 2 Signed Report

Name: HANNA,ADEL S
Phys: Oh, Anthony S
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/21/2008 Status: DIS IN
Radiology No:

Renaissance Radiology
Medical Group (951) 680-1671
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, HannM000273781

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: ACCESSION: 537683
DATE OF SERVICE: 11-21-2008 MODALITY: CT
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: SMALL BOWEL OBSTRUCTION

CT abdomen and pelvis with and without contrast.

History: The patient is being evaluated for possible small bowel obstruction.

Procedure: Images were obtained through the abdomen and pelvis prior to and following infusion of contrast material.

Findings: There is minimal patchy right basilar atelectasis. The cardiac silhouette does not appear enlarged. The nasogastric tube terminates in the descending duodenum. No peri-pancreatic changes are noted. The kidneys show no abnormal calcifications.

The liver and spleen show no abnormal calcifications and no areas of abnormal enhancement or attenuation. The gallbladder is surgically absent. No adrenal masses are noted. The kidneys show no areas of abnormal enhancement. The distal common bile duct appears minimally prominent measuring 1 cm in the head of the pancreas. Multiple loops of fluid and contrast filled small bowel are present. No focally dilated small bowel loops are noted. There is no wall thickening. There is no inflammatory change. A normal appendix is visualized.

The colon shows lack of distention versus edema to the sigmoid colon. There is no marked inflammatory change. No free intraperitoneal gas or fluid is appreciated. The prostate appears somewhat prominent.

Impression: The nasogastric tube terminates in the descending duodenum.

CHANGE IN PATIENT CARE: ☐ YES ☐ NO

QUALITY ASSURANCE ☐ AGREE ☐ DISAGREE

Renaissance Radiology
Medical Group
(951) 486-4040
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL,
SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN:
DATE OF SERVICE: 11-21-2008
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: SMALL BOWEL OBSTRUCTION

There is no pattern of small bowel obstruction.

There is lack of distention versus thickening to the wall of the sigmoid colon without marked adjacent inflammatory change.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Monika Kief-Garcia, M.D.
11-21-2008 6:04 pm Pacific Time

Renaissance Radiology
Medical Group
(951) 486-4040
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL,

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN:
DATE OF SERVICE: 11-21-2008
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: SMALL BOWEL OBSTRUCTION

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Medical Group (951) 680-1671
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, HannM000273781
SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: ACCESSION: 537683
DATE OF SERVICE: 11-21-2008 MODALITY: CT
EXAMINATION REQUESTED: CT PELVIS
REASON FOR EXAM: ; Add'l Info: SMALL BOWEL OBSTRUCTION

Please see accompanying CT of the abdomen which includes findings within the pelvis.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Monika Kief-Garcia, M.D.
11-21-2008 6:04 pm Pacific Time

CHANGE IN PATIENT CARE:

☐ YES ☐ NO

QUALITY ASSURANCE

☐ AGREE ☐ DISAGREE

Renaissance Radiology
Medical Group
(951) 680-1671
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, HannM000273781

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: ACCESSION: 537624
DATE OF SERVICE: 11-21-2008 MODALITY: XR
EXAMINATION REQUESTED: ABDOMEN/KUB
REASON FOR EXAM: ; Add'l Info: sbo

Supine abdomen

An NG tube appears to terminate in the region of the second/third portion of the duodenum. Air is scattered throughout both large and small bowel loops. Several of the jejunal bowel loops demonstrate a slight increase gaseous distention from normal. This however appears improved when compared to November 20. No abnormal calcifications can be seen.

IMPRESSION: Slight decrease in small bowel ileus pattern.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Jeanine A. McNeill, M.D.
11-21-2008 7:21 am Pacific Time

CHANGE IN PATIENT CARE:

☐ YES ☐ NO

QUALITY ASSURANCE

☐ AGREE ☐ DISAGREE

Patient Name: HANNA,ADEL S
Unit No: M000273781

████#	TYPE/EXAM	RESULT
000537488	RAD/XR CHEST: 1V (AP/PA)	

SINGLE VIEW CHEST:

Findings: Single view of chest shows bibasilar discoid atelectasis. There is no other focal infiltrate seen. Heart size and mediastinal width are within normal limits. No pleural effusion is seen.

CONCLUSION:
Bibasilar discoid atelectasis.

DICTATED: 11-19-08/1937
Teleradiology

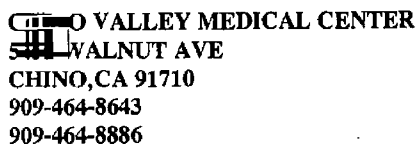
CORRECTION: 11-20-08/0737 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Aaron Jun, M.D.
Signed By: Peter Phan,MD

CC: Pranav Kachhi

Technologist: DANIEL DIAZ,RT(R)
Transcribed Date/Time: 11/20/2008 (0737)
Transcriptionist: RDMVD
Printed Date/Time: 11/20/2008 (1319)

PAGE 1 FLOOR COPY



Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: ADM IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

#######	TYPE/EXAM	RESULT
0005 37487	CT/CT-ABDOMEN+PELVIS W/O CON	

CT Abdomen and Pelvis without IV contrast:

Indication: Pain.

Findings: Limited evaluation of lung bases shows bibasilar discoid atelectasis. Pleural calcifications are seen in the right base. In the abdomen, patient is status post cholecystectomy. Rest of the abdominal solid organs <u>is</u> normal in appearance. There is no free fluid collection identified. Small nonspecific mesenteric nodes are seen. There is moderate dilation of proximal small bowel seen. A transition point is identified in the right mid abdomen. The distal small bowel and colon are not dilated. These findings are consistent with small bowel obstruction. Normal appendix is identified. Degenerative spurring is seen the lumbar spine.

In the pelvis, the bladder is normal. Scattered diverticula are seen in the sigmoid colon. No adenopathy is seen. A tiny free fluid is seen in the pelvis. <u>Bony</u> structures of pelvis are within normal limits.

Impression:

1. Findings consistent with small bowel obstruction with a transition point in the right mid abdomen.
2. Status post cholecystectomy.
3. Normal appendix is identified.
4. Tiny nonspecific free pelvic fluid.
5. Scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis.

Critical value: The above findings were reported by telephone to Chino Valley Medical Center at 8:10 p.m. on 11/19/08.

DICTATED: 11-19-08/1955
Teleradiology

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: ADM IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

████# TYPE/EXAM	RESULT
000537487 CT/CT-ABDOMEN+PELVIS W/O CON	

<Continued>

CORRECTION: 11-20-08/0741 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Aaron Jun, M.D.
Signed By: Peter Phan,MD

CC: Pranav Kachhi

Technologist: DANIELLE BASS,RT(R)
Transcribed Date/Time: 11/20/2008 (0741)
Transcriptionist: RDMVD
Printed Date/Time: 11/20/2008 (1320)

PAGE 2 FLOOR COPY

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: ADM IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

#####	TYPE/EXAM	RESULT
000537497	RAD/XR ABD: FLATPLT-(KUB)	

Supine portable AP chest/abdomen-11/19/08 at 2138 hours:

Indication: NG tube placement.

Findings: Nasogastric tube is in place with its tip near the region of the EG junction/gastric fundus; would recommend advancing the tube 6 to 8 cm. Multiple air-distended loops of central small bowel suggestive for distal small bowel obstruction. No evident free air/mass or abnormal abdominal calcifications; the visualized osseous structures appear intact. No other significant findings.

IMPRESSION:
Nasogastric tube in place as described recommend advancing tube 6 to 8 cm; findings suggestive for a distal small bowel obstruction.

DICTATED: 11-20-08/0107
Teleradiology

CORRECTION: 11-20-08/0801 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Gary Harris,MD
Signed By: Peter Phan,MD

CC: Pranav Kachhi; James M. Lally; Daljinder Takhar

Technologist: LINDA K NGUYEN,RT
Transcribed Date/Time: 11/20/2008 (0801)
Transcriptionist: RDMVD
Printed Date/Time: 11/20/2008 (1320)

PAGE 1 FLOOR COPY

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL S
Phys: Kachhi, Pranav
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/19/2008 Status: ADM IN
Radiology No:

Patient Name: HANNA,ADEL S
Unit No: M000273781

#####	TYPE/EXAM	RESULT
0000337522	RAD/XR ABD: FLATPLT-(KUB)	

KUB time 5:40 a.m. 11/20/08:

Findings: Compared with 11/19/08.

There is slight decrease in dilatation of numerous dilated small bowel loops. Feeding tube tip is in distal stomach/duodenum. Cholecystectomy clips are noted. No free air is seen.

Impression:
Slight improvement in distal small bowel obstruction. Feeding tube tip is in distal stomach/duodenum.

DICTATED: 11-20-08/0629
Teleradiology

CORRECTION: 11-20-08/0802 (vdm)

** REPORT SIGNATURE ON FILE 11/20/2008 **
Reported By: Atul Patel, M.D.
Signed By: Peter Phan,MD

CC: Yoonjung Jang; James M. Lally; Daljinder Takhar

Technologist: FREDERICK A. PUFFER,RT(R)
Transcribed Date/Time: 11/20/2008 (0802)
Transcriptionist: RDMVD
Printed Date/Time: 11/20/2008 (1320)

PAGE 1 FLOOR COPY

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL S
Phys: Jang,Yoonjung
DOB: 03/29/1946 Age: 62 Sex: M
Acct No: V00000305742 Loc: 228 B
Exam Date: 11/20/2008 Status: ADM IN
Radiology No:

Online Radiology Medical Group, Inc

1770 Iowa Avenue, Suite 280
Riverside, CA 92507
Phone: 951-786-0801
Fax: 951-680-1671
Email: QA@onlineradiology.com

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, M000273781

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: jang ACCESSION: 537522
DATE OF SERVICE: 11-20-2008 MODALITY: XR
EXAMINATION REQUESTED: ABDOMEN
REASON FOR EXAM: reposition ng tube; Add'l Info:

KUB time 5:40 am 11/20/08

Compared with 11/19/08

There is slight decrease in dilatation of numerous dilated small bowel loops. Feeding tube tip is in distal stomach/duodenum. Cholecystectomy clips are noted. No free air is seen.

Impression:
1. Slight improvement in distal small bowel obstruction. Feeding tube tip is in distal stomach/duodenum.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Atul Patel, M.D.
11-20-2008 6:29 am Pacific Time

☐ INFORMATION ONLY ☐ MINOR DISCREPANCY ☐ NO CHANGE IN CARE
☐ MAJOR DISCREPANCY ☐ CHANGE IN CARE

Online Radiology Medical Group, Inc

1770 Iowa Avenue, Suite 280
Riverside, CA 92507
Phone: 951-786-0801
Fax: 951-680-1671

Email: QA@onlineradiology.com

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, M000273781

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: ACCESSION: 537497
DATE OF SERVICE: 11-19-2008 MODALITY: XR
EXAMINATION REQUESTED: CHEST 1V
REASON FOR EXAM: ng tube placement; Add'l Info:

Critical Value call in progress. Second report with details of Critical Value call will be issued

Supine portable AP chest/abdomen-11/19/08 at 2138 hrs

Indication: NG tube placement

Findings:

1. Nasogastric tube is in place with its tip near the region of the EG junction/gastric fundus; would recommend advancing the tube 6 to 8 cm
2. Multiple air distended loops of central small bowel-suggestive for distal small bowel obstruction
3. No evident free air/mass or abnormal abdominal calcifications; the visualized osseous structures appear intact
4. no other significant findings

IMPRESSION: Nasogastric tube in place as described-recommend advancing tube 6 to 8 cm; findings suggestive for a distal small bowel obstruction

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Gary Harris, M.D.
11-20-2008 1:07 am Pacific Time

☐ INFORMATION ONLY ☐ MINOR DISCREPANCY ☐ NO CHANGE IN CARE
☐ MAJOR DISCREPANCY ☐ CHANGE IN CARE

Renaissance Radiology
Medical Group
(951) 486-4040
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL,

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN:
DATE OF SERVICE: 11-19-2008
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: R/O APPY

Evidence for acute diverticulitis.

Critical value: The above findings were reported by telephone to Chino Valley Medical Center at 8:10 p.m. on 11/19/08.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Aaron Jun, M.D.
11-19-2008 7:55 pm Pacific Time

Renaissance Radiology
Medical Group (951) 486-4040
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL,

SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN:
DATE OF SERVICE: 11-19-2008
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: R/O APPY

Renaissance Radiology
Medical Group
(951) 680-1671
(951) 786-0801

FINAL REPORT

CHINO VALLEY MEDICAL CENTER

PATIENT NAME: HANNA, ADEL, HannM000273781
SEX: M DOB: 3-29-1946

REFERRING PHYSICIAN: ACCESSION: 537487
DATE OF SERVICE: 11-19-2008 MODALITY: CT
EXAMINATION REQUESTED: CT ABDOMEN
REASON FOR EXAM: ; Add'l Info: R/O APPY

Critical Value call in progress. Second report with details of Critical Value call will be issued

CT Abdomen and Pelvis without IV contrast.

Indication: Pain.

Findings: Limited evaluation of lung bases shows bibasilar discoid atelectasis. Pleural calcifications are seen in the right base. In the abdomen, patient is status post cholecystectomy. Rest of the abdominal solid organs are normal in appearance. There is no free fluid collection identified. Small nonspecific mesenteric nodes are seen. There is moderate dilation of proximal small bowel seen. A transition point is identified in the right mid abdomen. The distal small bowel and colon are not dilated. These findings are consistent with small bowel obstruction. Normal appendix is identified. Degenerative spurring is seen the lumbar spine.

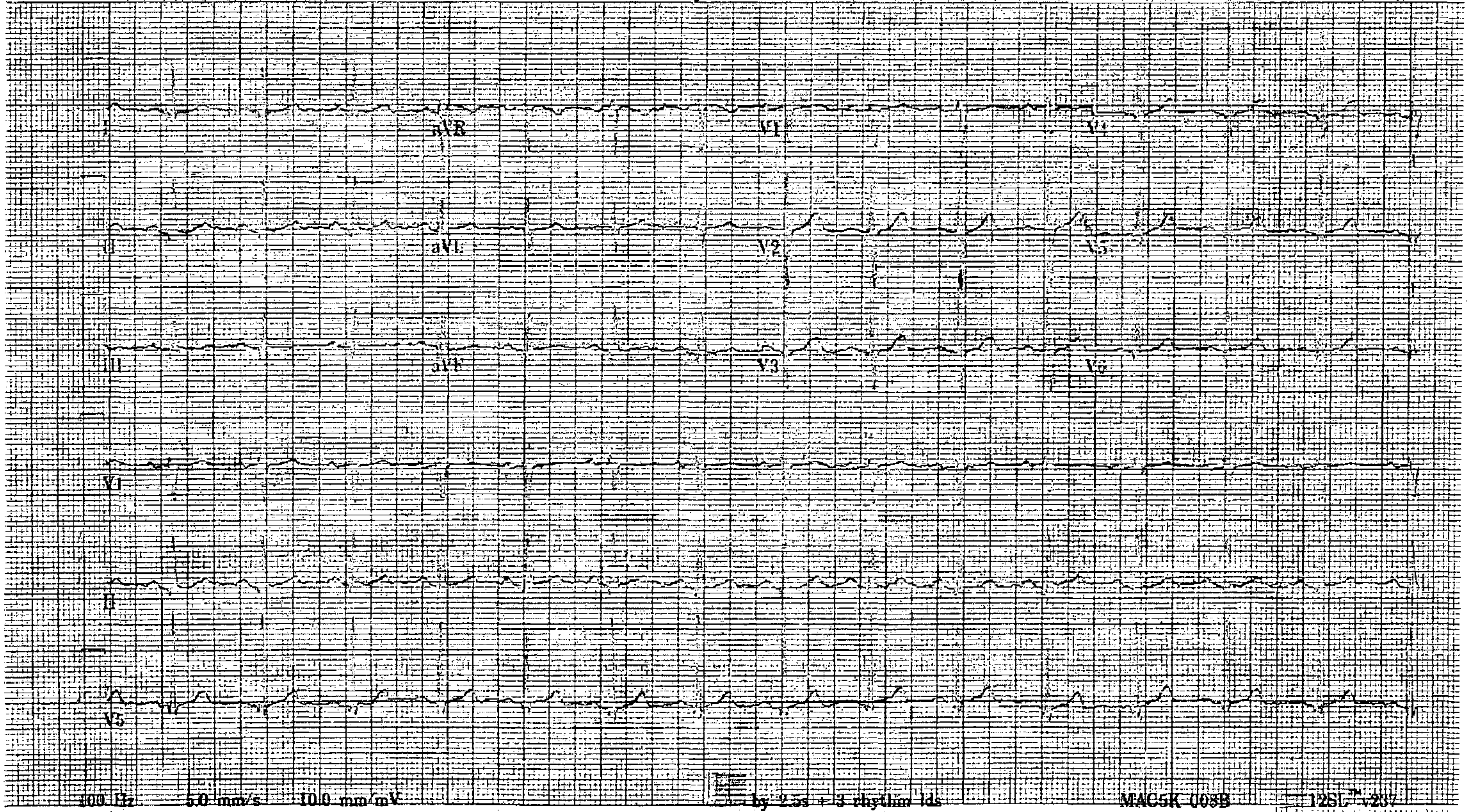
In the pelvis, the bladder is normal. Scattered diverticula are seen in the sigmoid colon. No adenopathy is seen. A tiny free fluid is seen in the pelvis. Bone structures of pelvis are within normal limits.

Impression:

1. Findings consistent with small bowel obstruction with a transition point in the right mid abdomen.
2. Status post cholecystectomy.
3. Normal appendix is identified.
4. Tiny nonspecific free pelvic fluid.
5. Scattered diverticula are seen in the sigmoid colon without CT

CHANGE IN PATIENT CARE:
☐ YES ☐ NO

QUALITY ASSURANCE
☐ AGREE ☐ DISAGREE


HANNA, ADEL
ID: V305742
19-Nov-2008 19:17:07
CHINO VALLEY MEDICAL CENTER ER
29-Mar-1946
Male
Room: ER4
Vent. rate 89 bpm
PR interval 158 ms
QRS duration 90 ms
QT/QTc 358/435 ms
P-R-T axes 54 48 38
Normal sinus rhythm
Normal ECG
Technician:
Test ind:
HANNA, ADEL
V00000305742
DOB:03/29/46
DOS:11/19/08
ER
M/62
MR#: M000273781
Referred by: KACHHI MD
Unconfirmed
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
V1
II
V5
100 Hz
5.0 mm/s
10.0 mm/mV
by 2.5s + 3 rhythm lds
MAC5K 008B
12SL v237

MEDICATION RECONCILIATION FORM / ORDER SHEET

For use upon **ADMISSION or TRANSFER**

To be completed upon admission or intra-facility transfer. The purpose of this form is to document the medications / supplements that a patient is taking, then this information used as a reference when new medication orders are written (to reconcile existing orders with new orders).

ALLERGIES: [illegible]

MEDICATIONS BEING TAKEN WHEN:

☒ ADMITTED on 11/19/08 ☐ TRANSFERRED on ___/___/___

Source Of Information For This Form: ☒ Patient ☒ Pt. Family / Advocate

☐ Actual Vials / Containers ☐ MAR ☐ Other ______

This list created by [illegible] (DR) (RN) (LVN)

Medication / Herbal	Dose	Route	Frequency	Last Dose	Indication	Continue Upon Admission / Transfer
Atenolol	50mg	PO	daily			☒ NO ☐ YES
Lomet	2.5-5mg	PO	daily			☒ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

PHYSICIAN:

Upon ☒ *Admission* ☐ *Transfer*

I have reviewed the medications to the right and my orders are as indicated below:

Dr. [illegible]

Date / Time: 11/19/08 2200

NEW ORDERS Time: Date:

Dr. Signature: ______ T/O Dr.: ______ Read Back / RN: ______

Patient's Pharmacy / Phone (if known)

MEDICATION RECONCILIATION FORM / ORDER SHEET FOR USE UPON ADMISSION OR TRANSFER

PHSI-180-001A (6/07)

180-001A

WHITE - CHART **CANARY** - PHARMACY

PATIENT:
HANNA, ADEL
V00000305742
DOB: 03/29/46
DOS: 11/19/08
ER
M/62
MR# M000273781

MEDICATION RECONCILIATION FORM / ORDER SHEET

For use upon **DISCHARGE**

NOT A MEDICATION ORDER

This form is to be completed by hospital personnel - in lay terms - upon discharge. The purpose of this form is to list the medications / supplements that this patient is taking when discharged. This information will be used by the next caregiver if changing or adjusting medication orders is needed.

A

Patient Name: ______________________

Age: ______ Address: ______________________

ALLERGIES:

B

DISCHARGE MEDICATIONS

Space Below For Reconciliation Use By Next Provider

Medication / Herbal	Dose	Route	Frequency	Last Dose	Indication
Atenolol	50 mg	po	before bedtime		migraine prophylaxis
Lexapro	15 mg	po	once a day		depression
Zomig	2.5 mg	po	as needed		migraine
Tylenol	500 mg	po	2x/day as needed		fever

C

COMPLETED BY: ______________________ ☐ DR ☐ RN ☐ LVN ☐ ________ Date ________

MEDICATION RECONCILIATION FORM FOR USE AT DISCHARGE

180-001D

PHSI-180-001D (6/07)

WHITE - CHART CANARY - PATIENT PINK - PHARMACY

PATIENT I.D.

HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
TN
M/62
MR#: M000273781

T 3205

MAR Date 11/20/08

Page ______ of ______

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

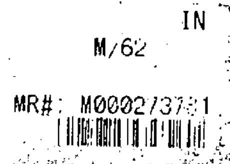
Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
Tylenol 650mg po q4h PRN-Temp>100.4 or HA					
COLACE 100mg po. BID. PRN-Constipation					
ZOFRAN-4mg IV q6h PRN-N/V					
MORPHINE 2mg IV q4h PRN-PAIN					
ATIVAN 1mg IV q4h PRN-ANXIETY					
AMBIEN 5mg p.o. qhs. PRN-INSOMNIA May Repeat x1					
TORADOL 30mg IV q6h. PRN PAIN x6					~~2300~~ [initials]
BENADRYL IV 25mg x1 PRN-AGITATION					
ATIVAN 2mg IV q4h PRN-AGITATION					

Signature	Initials	Signature	Initials	Signature	Initials
				[signature]	[initials]

Patient Name			Patient No.
Room	Age	Pt. Weight	Pt. Height
Diagnosis			
Allergies REGLAN			
Physician's Name			

PATIENT IDENTIFICATION

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M0002737?1
Lally, James M.



24 Hour MAR
T3205 Rev. 03/00 (RC# 0259003)

CHART

T 3205

MAR Date 11/20/08

Page ________ of ________

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
IVF 100mL/hr. NS.					~~2230~~ [initials]
PROTONIX 40mg IV qday					
AMPICILLIN 1gm IV q8h					
~~ALEN~~ MIC DV					
ATENOLOL 50mg po. q hs.					(2230) NPO
NG tube to intermittent low suction					

Signature	Initials	Signature	Initials	Signature	Initials
				[signature]	[initials]

Patient Name			Patient No.
Room	Age	Pt. Weight	Pt. Height
Diagnosis			
Allergies REGLAN			
Physician's Name			

PATIENT IDENTIFICATION

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR# M000273751
Laily, James M.

24 Hour MAR
T3205 Rev. 03/00 (RC# 0259003)

CHART

T 3205

MAR Date 11/20/08 Page ____ of ____

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
IVF NS @ 100 ml/hr			See below		
Protonix 40 mg IV QD			0430 pt		
Ampicillin 1gm IV q8°			0500 pt	1300 ar	2100 ur
Atenolol 50mg p.o. qHS				Hold	2100 11/?? NPO
K phos 20 meq in 250 ml NS c̄ lidocaine 25 mg. over 4 hrs.			0600 pt		
add 40 meq & KCL in IV				1300 ar	
Cepacol Lozenges 1 PO Q4 PRN (sore throat)				1300 ar	
Foley cath to Gravity				pt voiding	
NGT to intermittent low suction					

Signature	Initials	Signature	Initials	Signature	Initials
		Yajun Chang RN	ur	[illegible]	pt
				A. [illegible]	ar

Patient Name	Patient No.	PATIENT IDENTIFICATION
Room / Age / Pt. Weight	Pt. Height	HANNA, ADEL S IN
Diagnosis		V00000305742 M/62
Allergies		DOB:03/29/46
Physician's Name		DOS:11/19/08 MR#: M000273781
		Lally, James M.

24 Hour MAR
T3205 Rev. 03/00 (RC# 0259003)

CHART

T 3205

MAR Date 11/20/08 Page ___ of ___

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
Tylenol 650mg P.O q4h PRN temp >100.4 or HA					
Colace 100mg P.O BID PRN constipation					
Zofran 4mg IV q4h PRN N/V					
Morphine 2mg IV q4h PRN pain					
Ativan 1mg IV q6h PRN Anxiety					
Ativan 2mg IV q4h PRN agitation			~~0440~~ [illegible] BP 109/70		~~1815~~ ar
Ambien 5mg P.O qHS PRN insom MR x1					
Toradol 30mg IV q6h PRN pain x4					
Benadryl 25mg IV x1 PRN agitation					
GAVISCON 15ml PO QID PRN (Indigestion)				~~1500~~ ar	

Signature	Initials	Signature	Initials	Signature	Initials
		Yaym Chang RN	YW	A. [illegible]	ar

Patient Name	Patient No.
Room / Age / Pt. Weight	Pt. Height
Diagnosis	
Allergies	
Physician's Name	

PATIENT IDENTIFICATION

HANNA, ADEL S.
V0000030[illegible]742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M00027[illegible]781

24 Hour MAR
T3205 Rev. 03/00 (RC# 0259003)

CHART

T 3205

MAR Date 11-20-08

Page ____ of ____

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
IVF NS @ 90ml/hr c̄ 40 meq KCL					~~1810~~ UC
Atenolol 50mg po QHS x 1̄ now	11/20				2130 UW
NPO p̄ Midnight					
QOD c̄ NSG					

Signature	Initials	Signature	Initials	Signature	Initials
		Yayun Chang RN	UC	Q. Dey	Q

Patient Name			Patient No.
Room	Age	Pt. Weight	Pt. Height
Diagnosis			
Allergies			
Physician's Name			

PATIENT IDENTIFICATION

HANNA, ADEL S TN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273751
Lally, James M.

24 Hour MAR
T3205 Rev. 03/00 (RC# 0259003)

CHART

T 3201

CHINO VALLEY MEDICAL CENTER
MEDICATION
ADMINISTRATION
RECORD

PAGE: 1

HANNA, ADEL S
ACCT: V00000305742
DR: Lally, James M.
DIAGNOSIS: SMALL BOWEL OBSTRUCTION
NOTHING BY MOUTH

ROOM: MU 228 B
AGE: 62 SEX: M
ADMITTED: 11/19/08
HT/WT: 172.72cm/ 75.29g

VERIFIED BY: YW

ALLERGIES: METOCLOPRAMIDE HCL

ADMINISTRATION PERIOD: 0000 11/21/08 TO 2359 11/21/08

******* SCHEDULED MEDS *******	START/STOP	0000-0759	0800-1559	1600-2359
PANTOPRAZOLE SODIUM (PROTONIX IV) 40 MG INTRAVEN. Q24H RX #: 001436173 COMMENTS: DILUTE VIAL W/10ML NS FOR INJ. SLOW IVP OVER 2 MINUTES. ** NO FILTER REQUIRED **	11/19/08 12/19/08		0900 Y	2100
ATENOLOL (TENORMIN) 50 MG ORAL HS RX #: 001436177 COMMENTS: ** BLACK BOX WARNING, REFER TO MICROMEDEX FOR PRECAUTIONS AND MONITORING PATIENTS **	11/19/08 12/19/08	Hold		2100
NPO (Hold po meds)	11/20			
NA PHOSPH [illegible] 4 [illegible] in 250cc NS over 4 Hours	11/21/08			1905
Atenolol, 50mg tonight via Pharmacy				

* ~~NG tube to low intermittent suction~~ D/C
May remove NG tube

Full liquid diet as tolerated.

MEDS NOT GIVEN	INJ SITES	** PRINT NAME **	INITIALS	SIGNATURE
P-ASLEEP	1-RT ABDOMEN	Ya Yun Chang	YW	Ya Yun Chang RN
O-OFF UNIT	2-LT ABDOMEN	[illegible] Stuges	AS	[illegible]
R-REFUSED	3-RT UPPER ARM			
S-NPO/STUDIES	4-LT UPPER ARM			
T-NPO/SURGERY	5-RT UOQ (BUTTOCKS)			
N/V-NAUSEA	6-LT UOQ (BUTTOCKS)			
	7-RT ANT. THIGH			
	8-LT ANT. THIGH			

T 3201

CHINO VALLEY MEDICAL CENTER
MEDICATION
ADMINISTRATION
RECORD

PAGE: 2

HANNA,ADEL S
ACCT: VD0000305742
DR: Lally, James M.
DIAGNOSIS:SMALL BOWEL OBSTRUCTION
NOTHING BY MOUTH

ROOM: MU 228 B
AGE: 62 SEX: M
ADMITTED: 11/19/08
HT/WT: 172.72cm/ 75.29g

VERIFIED BY: UW

ALLERGIES: METOCLOPRAMIDE HCL

ADMINISTRATION PERIOD: 0000 11/21/08 TO 2359 11/21/08

******* IV MEDS *******	START/STOP	0000-0759	0800-1559	1600-2359
SOD CHL 0.9% MBP 50ML 50 ML Q8 AMPICILLIN SODIUM (AMPICILLIN SODIUM) 1 GM RATE: 100 MLS/HR INTRAVEN. RX #: 001436176 COMMENTS: *** RN TO MIX *** BREAK SEAL AND MIX WELL PRIOR TO ADMINISTRATION INFUSE OVER 30 MINUTES.	11/19/08 11/26/08	0600 UW	1400	2200
0.9% NACL W/ KCL 40MEQ/L PREMI 1 L Q11H RATE: 90 MLS/HR INTRAVEN. RX #: 001436756 *** FLOOR STOCK ITEM ***	11/20/08 12/20/08	0500	1100	1600

MEDS NOT GIVEN	INJ SITES	** PRINT NAME **	INITIALS	SIGNATURE
P-ASLEEP	1-RT ABDOMEN	Ya Yun Chang	UW	Yayun Chang
Q-OFF UNIT	2-LT ABDOMEN	[illegible]	B	[illegible]
R-REFUSED	3-RT UPPER ARM			
S-NPO/STUDIES	4-LT UPPER ARM			
T-NPO/SURGERY	5-RT UOQ (BUTTOCKS)			
N/V-NAUSEA	6-LT UOQ (BUTTOCKS)			
	7-RT ANT. THIGH			
	8-LT ANT. THIGH			

T 3201

CHINO VALLEY MEDICAL CENTER
MEDICATION
ADMINISTRATION
RECORD

VERIFIED BY: UW

HANNA,ADEL S
ACCT: V00000305742
DR: Lally, James M.
DIAGNOSIS:SMALL BOWEL OBSTRUCTION
NOTHING BY MOUTH

ROOM: MU 228 B
AGE: 62 SEX: M
ADMITTED: 11/19/08
HT/WT: 172.72cm/ 75.29g

ALLERGIES: METOCLOPRAMIDE HCL

ADMINISTRATION PERIOD: 0000 11/21/08 TO 2359 11/21/08

******* PRN MEDS *******		START/STOP	0000-0759	0800-1559	1600-2359
ACETAMINOPHEN (TYLENOL) ORAL Q4HP COMMENTS: FOR TEMP > 100.4 OR HEADACHE ACETAMINOPHEN IS NOT TO EXCEED 4GM/DAY! *** FLOOR STOCK ITEM ***	650 MG RX #: 001436169	11/19/08 12/19/08			
DOCUSATE SODIUM (COLACE) ORAL BIDP COMMENTS: FOR BM *** FLOOR STOCK ITEM ***	100 MG RX #: 001436170	11/19/08 12/19/08			
MORPHINE SULFATE (MORPHINE SULFATE) INTRAVEN. Q4HP COMMENTS: * PRN PAIN MAY CAUSE DROWSINESS *** FLOOR STOCK ITEM ***	2 MG RX #: 001436171	11/19/08 11/22/08			
ZOLPIDEM TARTRATE (AMBIEN) ORAL HSPMRX1 COMMENTS: INSOMNIA. *** FLOOR STOCK ITEM ***	5 MG RX #: 001436174	11/19/08 11/22/08			
KETOROLAC TROMETHAMINE (TORADOL) INTRAVEN. Q6HP COMMENTS: * PRN PAIN, UP TO 6 DOSES ** BLACK BOX WARNING, REFER TO MICROMEDEX ** *** FLOOR STOCK ITEM ***	30 MG RX #: 001436175	11/19/08 11/24/08			
DIPHENHYDRAMINE HCL (BENADRYL STERI-DOSE INJ) INTRAVEN. PRN COMMENTS: * X1 PRN AGITATION MAY CAUSE DROWSINESS *** POTENTIAL FOOD-DRUG INTERACTIONS *** *** PLEASE PROVIDE PATIENT WITH EDUCATION MATERIALS *** *** FLOOR STOCK ITEM ***	25 MG RX #: 001436178	11/19/08 11/26/08			

MEDS NOT GIVEN	INJ SITES	** PRINT NAME **	INITIALS	SIGNATURE
P-ASLEEP	1-RT ABDOMEN	Ya Yun Chang	UW	Yayun Chang RN
Q-OFF UNIT	2-LT ABDOMEN	[illegible]	[illegible]	[illegible]
R-REFUSED	3-RT UPPER ARM			
S-NPO/STUDIES	4-LT UPPER ARM			
T-NPO/SURGERY	5-RT UOQ (BUTTOCKS)			
N/V-NAUSEA	6-LT UOQ (BUTTOCKS)			
	7-RT ANT. THIGH			
	8-LT ANT. THIGH			

T 3201

CHINO VALLEY MEDICAL CENTER
MEDICATION
ADMINISTRATION
RECORD

VERIFIED BY: UW

HANNA,ADEL S
ACCT: V00000305742
DR: Lally, James M.
DIAGNOSIS:SMALL BOWEL OBSTRUCTION
NOTHING BY MOUTH

PAGE: 4
ROOM: MU 228 B
AGE: 62 SEX: M
ADMITTED: 11/19/08
HT/WT: 172.72cm/ 75.29g

ALLERGIES: METOCLOPRAMIDE HCL

ADMINISTRATION PERIOD: 0000 11/21/08 TO 2359 11/21/08

******* PRN MEDS *******		START/STOP	0000-0759	0800-1559	1600-2359
LORAZEPAM (ATIVAN) INTRAVEN. Q4HP COMMENTS: AGITATION. CAUTION: MUST BE REFRIGERATED! MAY CAUSE DROWSINESS *** FLOOR STOCK ITEM ***	2 MG RX #: 001436391	11/20/08 11/22/08			
CETYLPYRIDINIUM CHLORIDE (CEPACOL LOZ) MUCOUS MEM Q4HP COMMENTS: FOR SORE THROAT *** FLOOR STOCK ITEM ***	1 EA RX #: 001436543	11/20/08 12/20/08			
AL HYD/MG HYD/SIMETH PLUS (MYLANTA/MAALOX PLUS) ORAL QIDP COMMENTS: SUBS. FOR GAVISCON PER FORMULARY. PRN INDIGESTION; SHAKE WELL. 5oz bottle.	15 ML RX #: 001436571	11/20/08 12/20/08			
Zofran 4mg IV Q6° PRN		11/19			
Ativan ī mg IV Q4° PRN		11/19			

MEDS NOT GIVEN	INJ SITES	** PRINT NAME **	INITIALS	SIGNATURE
P-ASLEEP	1-RT ABDOMEN	Ya Yun Chang	UW	Yayun Chang RN
Q-OFF UNIT	2-LT ABDOMEN	[illegible]	[illegible]	[illegible]
R-REFUSED	3-RT UPPER ARM			
S-NPO/STUDIES	4-LT UPPER ARM			
T-NPO/SURGERY	5-RT UOQ (BUTTOCKS)			
N/V-NAUSEA	6-LT UOQ (BUTTOCKS)			
	7-RT ANT. THIGH			
	8-LT ANT. THIGH			

HANNA,ADEL S

Admitted: **11/19/08 at 2033**
Room/Bed: **228 B**
Attending: **Lally, James M.**

Chino Valley Medical Center

CNASSG
Acct: V00000305742
Unit: **M000273781**

Personal Belongings Inventory 11/19/08 2305 SGS

Inventory Date: 11/19/08 Inventory Time: 2303 Performed By: Salibaba,Selina G
Reason For Inventory: ADMISSION (DU,IC,MU,PE)

-N Contacts -Y Glasses Disposition: PATIENT WEARING/TAPED

-N Full Dentures Disposition:
-N Partial Upper -N Lower Disposition:
-N Hearing Aid Disposition:

-N Prosthesis Describe: Disposition:
-N Assistive Device : Disposition:

Jewelry: NONE-NO JEWELRY Jewelry:
Describe: Describe:
Disposition: Disposition:

Jewelry: Jewelry:
Describe: Decribe:
Disposition: Disposition:

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:
:
-Y Electrical Appliances Describe: IPHONE
-N Eng. Dept Notified To Evaluate Electrical Appliance
Other Item(s) Of Value To The Patient: WHITE PANTS, BROWN JACKET, WHITE SHIRT
: BLACK SANDALS
Disposition: BELONGINGS KEPT BY PT
Compared to Previous Belongings List: N/A

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up. If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends, I Release Chino Valley Medical Center From Any Liability For Lost Valuables. I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times, And I Understand That The Hospital Assumes No Liability For Such Equipment.

PATIENT: X Hanna [signature] Date: 11/19/08
WITNESS: George [signature]

By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge.

PATIENT: ______________________ Date: ______________

WITNESS:

Monogram	Initials	Name	Nurse Type
SGS	CNASSG	Salibaba,Selina G	CNA

HANNA,ADEL S Page: 1

Admitted: **11/19/08 at 2033** **CNASSG**
Room/Bed: **228 B** Chino Valley Medical Center Acct: V00000305742
Attending: **Lally, James M.** Unit: **M000273781**

Personal Belongings Inventory 11/21/08 2053 SGS

Inventory Date: 11/21/08 Inventory Time: 2053 Performed By: Salibaba,Selina G
Reason For Inventory: DISCHARGE

-N Contacts -Y Glasses Disposition: PATIENT WEARING/TAPED

-N Full Dentures Disposition:
-N Partial Upper -N Lower Disposition:
-N Hearing Aid Disposition:

-N Prosthesis Describe: Disposition:
-N Assistive Device : Disposition:

Jewelry: NONE-NO JEWELRY Jewelry:
Describe: Describe:
Disposition: Disposition:

Jewelry: Jewelry:
Describe: Decribe:
Disposition: Disposition:

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:
:
-Y Electrical Appliances Describe: IPHONE
-N Eng. Dept Notified To Evaluate Electrical Appliance
Other Item(s) Of Value To The Patient: WHITE PANTS, BROWN JACKET, WHITE SHIRT
: BLACK SANDALS
Disposition: BELONGINGS KEPT BY PT
Compared to Previous Belongings List: N/A

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up. If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends, I Release Chino Valley Medical Center From Any Liability For Lost Valuables. I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times, And I Understand That The Hospital Assumes No Liability For Such Equipment.

PATIENT:________________ Date:__________
WITNESS:________________

By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge.

PATIENT: Date: 11/21/08
WITNESS:

Monogram	Initials	Name	Nurse Type
SGS	CNASSG	Salibaba,Selina G	CNA

PATIENT INFORMATION	PHYSICAL EXAM
NAME: LAST Hanna FIRST Adel	BP: 131/88 T: 98.5 P: 90 R: 20 HT: 5'8 WT: 167
MR: 273781 DATE: 11/19/2008	GEN: NAD A/O x 3
DOB: 3/29/46 TIME: 21:30	
SEX: Male RACE: Caucasian	EENT: PERRL, EOMI ø a/c, ø icterus
CC: Abdominal pain with Nausea x 2 days	
HPI: 62 y.o. Male is brought to E.R by wife with 2 day h/o Abd pain 5/10, chills, fever, Dizzyness, Diarrhea, generalized body aches. Pt states he is unable to tolerate food or drink for 2 days. No urinary output for 2 days. Abd pain is crampy and fever was treated with tylenol	HEART: RRR, ø m/r/g cap refill ≤2 sec
	LUNGS: CTA (B) ø w/r/r (+) BS throughout
	ABDOMEN: ⊖ Distended (+) guarding mildly tender to palpation in 4 quadrants
	RECTAL / GU: pt deferred exam
PRIMARY PHYSICIAN: Dr. Agarwal	EXT. / OSTEO: mm strength 5/5, (B) pedal pulse equal
SNF / B & C: Home	
PAST HISTORY (MEDICAL & SURGICAL): Migraines, Depression, Cholecystectomy - 1986, Hiatal Hernia Repair 1992, Complications from surgery included perforated viscus and empyema, Angiogram and Cardiolyte ⊖	NEURO / PSYCH: no focal deficit. DTP +2/4 in achilles and patella
	SKIN: warm dry, good turgor CN I-XII intact
	DIAGNOSTIC DATA (LABS, X-RAYS, ETC.): CT: small bowel obstruction with transition point in (R) mid abdomen, tiny nonspecific free pelvic fluid, Scattered diverticula no evidence of acute diverticulitis. EKB: Normal Sinus rhythm WBC 15.6, Hgb 15.6 / Hct 45, Plt 177; Na 136, Cl 102, BUN 22.0; K 3.6, CO2 25.4, Creat 0.94, Glu 124
ALLERGIES (RXN): Reglan	
MEDICATIONS (DOSE): Atenolol 50mg QD for Migraine prophylaxis, lexapro 15mg QD for Depression, Zomig 2.5mg PRN Migraine, tylenol 500mg BID for fever	
	DIAGNOSIS: Intractable acute abdominal pain, SBO, Intractable acute Nausea and diarrhea, Dehydration, Migraines, depression possible a/c s/a HF
SOCIAL HISTORY: ø smoke, Drink occasionally, ø drug, Married - lives with wife	
	PLAN: Admit to Med Surge, hydrate at 100ml/hr NS, NG tube for low intermittent suction, Ampicillin 1g IV q 8, Protonix IV 40mg QD, EKG and Echo to R/o HF, Surgical consult
FAMILY HISTORY: Brother - Heart dz	
REVIEW OF SYSTEMS: HEENT: (+) Sore throat (+) High frequency hearing loss (R) ear Lungs: ⊖ nonproductive cough ⊖ SOB Heart: ⊖ CP ⊖ Palpitations Abdomen: (+) Pain 4 quadrants more so in epigastric (+) Nausea Pain 5/10 MSK: (+) generalized Body Aches	CODE STATUS DETERMINED / VERIFIED ☒ YES ☐ NO
	☒ FULL ~~DNR~~ ☐ MODIFIED
	NEXT OF KIN NOTIFIED ☒ YES ☐ NO
	NAME / PHONE # Irma 909) 374-7216
	H & P DICTATION #: 74310
	SIGNATURES: [signatures] M. Marquez / Dr. Jang / Dr. Talha

ATTENDING NOTE:

Patient was seen and evaluated at the time of service. The Patient's case was discussed and reviewed with the housestaff at time of the visit.

Given a history of Abd pain the exam and assessment shows (i) Intractable Abd pain / Partial SBO (STATE FINDINGS OF SIGNIFICANCE)

I agree / revise Plan of Care as follows ____

Attending Signature: [signature] Date & Time: 11/19/08 22:02

PATIENT I.D.

TEACHING SERVICE ADMISSION NOTE

130-005

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.

PHSI-130-005 (5/07)

FOOD - DRUG INTERACTION SHEET

If you are taking a drug, the food you eat could affect the speed and amount of absorption of your medication. Please refer to the following chart to determine how you should take your medication(s). Medications should be taken with a full glass of water to decrease the chances of nausea and vomiting unless instructed otherwise.

ANTICOAGULANTS

Warfarin
Coumadin

- Limit foods and/or nutritional supplements high in vitamin K
- Limit caffeine
- Avoid fried or boiled onions
- Avoid cranberry juice

ANTIARRHYTHMICS

Digitalis
Digitoxin
Crystodigin
Digitoxin
Digoxin
Lanoxin
Lanoxicap
Quinidine

- Take separately from high bran fiber or high pectin foods
- Maintain diet high in potassium - low in sodium
- Avoid licorice
- Best if taken on empty stomach
- Use caution when taking potassium supplements

ANTIBIOTICS

Ciprofloxacin
Doxycycline
Tetracycline
Quinolone

- Take separately from dairy foods, foods high in calcium content
- Limit caffeine
- Take magnesium, calcium, iron or zinc supplements separately

Penicillin

- Take with water on empty stomach
- Avoid acidic beverages

ANTIDEPRESSANT, MAOI

Phenelzine
Nardil

- Avoid foods high in pressor amines/tyramines (Contact Department of Nutritional Services for detailed information)
- Limit Caffeine
- May need pyruvic supplement

ANTIPSYCHOTIC

Lithium

- Drink 8 - 10 cups of water daily.
- Maintain consistent level of salt/ sodium intake daily
- Do not begin a low sodium diet
- Take after a meal or snack
- Limit caffeine intakes: coffee, tea, colas

FOODS HIGH IN:

VITAMIN K
Leafy green vegetables, broccoli, cabbage, caulifower, lettuce, peas, spinach, turnip greens, green herbal teas

PROTEIN
Meat, fish, milk, eggs, poultry, cheese, peanut butter

CALCIUM
Milk, cheese, Ice cream, yogurt, salmon, leafy green vegetables, tofu, corn tortillas, sardines

BRAN FIBER
Bran bread, bran cereals

IRON
Iron fortified cereals, organ meats, meat, fish, poultry, raisins

PECTIN
Apples, broccoli, brussel sprouts, pears, spinach, sweet potatoes

POTASSIUM
Avocado, artichokes, bananas, milk, legumes, mushrooms, peaches, raisins, tomatoes, dates, figs, melons, nectarines, potatoes, rhubarb, turnip greens

VITAMIN C
Oranges and/or other citrus fruit or juices, tomatoes and/or juice, strawberries, pineapple and/or juice

TYRAMINE
Aged cheese, aged meat, anchovies, avocados, beer, broad beans, pickled herring, sausages, sour cream, soy sauce, wine, brewers yeast, meat extracts, yogurt, fava beans, snow peas

SODIUM
Table salt/ garlic salt/ onion salt, food or seasonings containing greater than 450mg per serving

Your dietitian can provide additional food & drug interaction information.

Instruction
Given By: ____________________ ____________
Date/Time

If you have any questions about Adverse Drug Reactions or how to take your medication, please consult your pharmacist or physician.

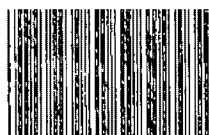
I understand the instructions and have received verbal instruction.

PATIENT OR
RESP. PARTY: ____________________

DATE: 11/21/08

(REFER TO BACKER)

FOOD-DRUG INTERACTION PATIENT EDUCATION



180-008

PATIENT I.D.
HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M00027378
Lally, James M.

PHSI-180-008 (9/07) WHITE - CHART CANARY - PATIENT

DIURETICS (Loop-K depleting)

Bumex Dyazide Edecrin Esidrix Hydrochlorothiazide Hygroton Lasix Maxzide Zaroxolyn	• Increase intake of foods high in potassium and/or supplement with potassium • Avoid licorice • Low sodium diet recommended

IRON SUPPLEMENTS

Ferrous Fumarate
  Femiron
Ferrous gluconate
  Fergon
Ferrous sulfate
  Feosol
	• Do not take with bran or high fiber supplements
	• Take separately from caffeine
	• Take separately from dairy foods and/or calcium
	• Take with foods high in vitamin C
	• Take with meat

TAKE WITH MEALS
(To avoid stomach upset)

Amitriptyline
Allopurinol (Zyloprin)
Carbamazepine (Tegretol)
Cimetidine (Tagament)
Doxycycline
Extrogens
Hydrocortisone
Imuran
Isoniazid
KCL (Micro K & other K supplements)
Metronidozole
MVI/minerals
Niacin
Nitrofurantoin
Oral Hypoglycemics
Pancrease
Prednisone
Propanolol
Quinine
Salicylates
Spironolactone
Sulfasalazine
Thioridazine
Thorazine
Trazodone
Trental
Macrodantin
Meclizine
NSAID (Non-Seroidal Anti-Inflammatory Agents)

NOT TO BE TAKEN WITH ALCOHOLIC BEVERAGES

Amantadine (Symmetrel)
Anticonvulsants
Antihistamines
Barbiturates
Carbamazepine (Tegretol) - Avoid all forms of grapefruit
Darvocet N 100
Doxycyline
Disulfiram
Metronidazole
  Flagyl
Narcotic Analgesics
Nitrates
Oral Diabetic Agents
Propranolol
Sedatives/Hypnotics
Tranquilizers
Tylenol & Codeine
Vicodin

ABDOMINAL PAIN

(check the applicable condition/ criteria)

Admission may be indicated for **ANY ONE** of the following:

I. Continued pain not relieved by symptomatic treatment
II. Diagnosed or suspected condition requiring hospital monitoring (e.g., peritoneal signs)
III. Hemodynamic instability
IV. Care requiring that nothing be taken orally for a prolonged period of time
V. Development of abnormal vital signs after outpatient evaluation
VI. Worsening findings on examination (e.g., increased tenderness, focal findings)
VII. Worsening findings on diagnostic testing
VIII. Possible Surgery
IX. Suspected Sepsis
X. Other______________________________

Physician Signature

11/19/08 2015
Date/Time

Addressograph

Inpatient Admission Criteria

MR#
Visit ID#
Admit Dt:

HANNA, ADEL
V00000305742
DOB 03/29/46
DOS 11/19/08
ER
M/62
MR#: M000273781

PHSI –210-001 (09/07)

1. NONE ( ) **ALLERGIES**
2. Reglan (Gastric)
3.

DATE 11/19/08

USE BALL POINT PEN - PRESS FIRMLY - ORDERS ARE BEING COPIED

LEVELS OF CARE

1. **CODE STATUS:**

- ☒ Full Code
- ☐ No Code
- ☐ Modified Code
  - ☐ No drugs, as defined in ACLS guidelines
  - ☐ No Intubation
  - ☐ No Chest Compression
  - ☐ No Cardioversion/Defibrillation
  - ☐ Comfort measures only/Palliative Care

* Orders for less than full CPR require documentation of discussion with patient (if competent) and/or family.
* Orders must be rewritten whenever level of care changes, along with appropriate documentation by MD.

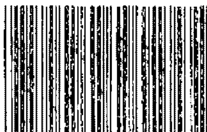
2. **ONGOING TREATMENT:**

- ☐ No intubation/respirator
- ☐ No ACLS drugs/pressor agents
- ☐ No tube feedings for food.
- ☐ No I.V. Fluids
- ☐ No intravenous medications
- ☐ No dialysis
- ☐ No blood transfusions
- ☐ No labs or diagnostic procedures
- ☐ No antibiotics

☐ **Code status has been reassessed and a new order sheet has been placed at the front of the chart; This order sheet is no longer valid. See new order sheet.**

☐ Unless Checked, Generic Items Will Be Supplied Per Policy	RN'S SIGNATURE AND TIME 11/19/08 2340	PHYSICIAN'S SIGNATURE AND TIME 2/50

LEVELS OF CARE PHYSICIAN ORDER



100-041

PATIENT I.D.

IN
HANNA, ADEL S M/62
V00000305742
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.

PHSI-100-041 (5/07)

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

Age/Sex: 62 M Attending: Lally, James M.
Location: MU Admitted: 11/19/08 at 2033
Room/Bed: 228-B Status: DIS IN

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	1910	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	1926	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

DR KACHHI AT BEDSIDE FOR EXAM. 12 LEAD EKG COMPLETED BY M. DIAZ, EMT. RESULT TO DR KACHHI.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	1920	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	1926	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

BLOOD DRAWN BY JOHN, PHLEBOTOMIST.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	1925	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	1926	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

PT TRANS TO CT VIA GUERNEY WITH JIM, CT TECH.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	1931	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	1931	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

RETURNED FROM CT. PCXR COMPLETED AT BEDSIDE BY XRT.

Note Type **Description**
No Type NONE

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By		Nurse Type	
Occurred:	11/19/08	1935	SA	Alvarez,Stacey	LVN	Category
Recorded:	11/19/08	1944	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

SALINE LOCK STARTED WITH GOOD BLOOD RETURN NOTED. IV FLUSHED WITH 5 ML NS & TAPED SECURELY IN PLACE. NS BOLUS STARTED VIA PUMP PER ORDERS. PT TOLERATED WELL. SITE CLEAR. SPOUSE REMAINS AT BEDSIDE. PILLOW GIVEN, LIGHTS DIMMED FOR COMFORT.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	11/19/08	1944	SA	Alvarez,Stacey	LVN	Category
Recorded:	11/19/08	1944	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

MEDICATED WITH ZOFRAN & ATIVAN IVP BY D. LOPEZ, RN.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	11/19/08	2005	SA	Alvarez,Stacey	LVN	Category
Recorded:	11/19/08	2013	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

PT RE-EVAL'D BY DR KACHHI.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	11/19/08	2013	SA	Alvarez,Stacey	LVN	Category
Recorded:	11/19/08	2013	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

PT REQUEST TO " MAKE PHONE CALLS BEFORE INSERTING NG TUBE". PT ALLOWED PRIVACY.

Note Type	Description
No Type	NONE

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2021	AS	Serpas,Ulises	RN	
Recorded:	11/19/08	2021	AS	Serpas,Ulises	RN	ED Nursing Notes

Abnormal? N **Confidential?** N

PLEASE ENTER FULL NAMES OF LVN/RN

Patient data collected by (LVN):STACEY ALVAREZ
Assessment reviewed and completed by (RN): JOHN DEL VALLE

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2035	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2052	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

MRSA PROTOCOL EXPLAINED TO PT & SPOUSE. NASAL SWAB OBTAINED PER PROTOCOL.
SPECIMEN SENT TO LAB PER ORDERS.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2040	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2046	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

ATTEMPTED TO INSERT NG TUBE INTO LT NARE. MIN BLEEDING NOTED. PT COUGHING &
REQUESTED TUBE TO BE REMOVED. TUBE DC'D PER REQUEST. PT REQUESTING " VERSED OR
SOMETHING". STS, " MY THROAT IS VERY SENSITIVE". DR KACHHI INFORMED.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2050	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2051	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

PT MEDICATED WITH ATIVAN IVP BY D. LOPEZ, RN

Note Type **Description**
No Type NONE

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2059	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2059	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N Confidential? N

RESIDENT & MED STUDENT AT BEDSIDE FOR EXAM.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2059	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2059	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N Confidential? N

REPORT CALLED TO M/S. SPOKE WITH BEN, RN.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2100	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2109	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N Confidential? N

MEDICATED WITH UNASYN IVPB BY J. DEL VALLE, RN.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2120	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2136	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N Confidential? N

NG TUBE INSERTED INTO LT NARE W/O DIFF. PT STILL ANXIOUS BUT DECREASED SINCE ATIVAN GIVEN. SPOUSE REMAINS AT BEDSIDE. TUBE AUSCULTATED & ASPIRATED PLACEMENT. YELLOW GASTRIC SECRETIONS ASPIRATED. NG TUBE TO LOW WALL SUCTION.

Note Type	Description
No Type	NONE

Patient: HANNA,ADEL S
Account #: V00000305742 **Unit #:** M000273781

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2136	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2136	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

LINDA, XRT AT BEDSIDE FOR PKUB FOR TUBE PLACEMENT.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2138	SA	Alvarez,Stacey	LVN	
Recorded:	11/19/08	2143	SA	Alvarez,Stacey	LVN	ED Nursing Notes

Abnormal? N **Confidential?** N

PT TRANS TO M/S RM 228 AWAKE, ALERT, & ORIENTED VIA GUERNEY. RESP EVEN &
UNLABORED. NO SOB/DYSPNEA/COUGH NOTED PRESENTLY. NG TUBE INTACT LT NARE CLAMPED
FOR TRANSPORT. IV NS TKO INTO LT HAND. SITE CLEAR. ALL BELONGINGS SENT WITH PT
TO FLOOR. SPOUSE ACCOMPANIED PT TO FLOOR. PT TRANS BY D. LOPEZ, RN

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/19/08	2200	BT	Trinidad,Bienvenido	RN	
Recorded:	11/19/08	2352	BT	Trinidad,Bienvenido	RN	Nurse Notes

Abnormal? N **Confidential?** N

ADMITTED PT FROM ER VIA GUERNEY WITH DX SBO.PT AWAKE ALERT AND VERBALLY
RESPONSIVE,ABLE TO MAKE NEEDS KNOWN.NGT TO L NARES INTACT.C/O ABD PAIN 3/10 TO
"UNCOMFORTABLE FEELING".HEADCHE TO DULL 5/10.BACK PAIN 7/10 FROM MID-BACK TO R
SIDE OF THE BACK.IV TO LH INTACT.PT VERBALIZES NO URINE OUTPUT X 2DAYS,STARTED
WITH EPISODES OF DIARRHEA,N/V LAST NOC."CANNOT HOLD ANYTHING IN".LAST EPISODE
OF VOMITING TO WATERY EMESIS.ALSO WITH CHILLS AND FEVER LAST NOC.WILL CONTINUE
TO MONITOR.AWAITING FOR KUB RESULT FOR GT PLACEMENT.TO PLACE ON LOW
INTERMITTENT SUCTION AS ORDERED.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/20/08	0233	BT	Trinidad,Bienvenido	RN	
Recorded:	11/20/08	0235	BT	Trinidad,Bienvenido	RN	Nurse Notes

Abnormal? N **Confidential?** N

RECEIVED KUB RESULT FOR NGT PLACEMENT.NGT IN PLACED -RECOMMEND ADVANCING TUBE

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By		Nurse Type	(Continued) Category
Occurred:	11/20/08	0233	BT	Trinidad,Bienvenido	RN	Category
Recorded:	11/20/08	0235	BT	Trinidad,Bienvenido	RN	Nurse Notes

6-8CM,FINDINGS SUGGESTIVE FOR DISTAL SBO.ADVANCED NGT 6 CM.WILL ORDER ANOTHER KUB TO CHECK PLACEMENT.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/20/08	0559	BT	Trinidad,Bienvenido	RN	Category
Recorded:	11/20/08	0623	BT	Trinidad,Bienvenido	RN	Nurse Notes

Abnormal? N **Confidential?** N

K-PHOS INFUSING AT THIS TIME.ADMINISTERED AMPICILLIN IV ATB AND WELL TOLERATED.NO ASE NOTED.ADMINISTERED TORADOL 30 MG IV X1 FOR ABD PAIN WITH GOOD RELIEF.ATIVAN 2 MG IV ADMINISTERED FOR RESTLESSNESS.KUB DONE AWAITING FOR RESULT.WILL CONTINUE TO MONITOR.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/20/08	0650	BT	Trinidad,Bienvenido	RN	Category
Recorded:	11/20/08	0652	BT	Trinidad,Bienvenido	RN	Nurse Notes

Abnormal? N **Confidential?** N

DR. GHOLSTON MADE AWARE.NO URINE OUTPUT SINCE ADMISSION.DENIES BLADDER DISCOMFORT OR DISTENTION.OFFERED IF HE WANTS TO BE CATHETHERIZED BUT STRONGLY REFUSED.NGT TO LOW INTERMITTENT SUCTION STARTED.KUB RESULT -NGT IN STOMACH/DUODENUM.WILL ENDORSE TO AM SHIFT.

Note Type **Description**
No Type NONE

	Date	Time	By		Nurse Type	Category
Occurred:	11/20/08	0800	ATS	Schroer,Anthea T	RN	Category
Recorded:	11/20/08	2006	ATS	Schroer,Anthea T	RN	Nurse Notes

Abnormal? N **Confidential?** N

ALERT AND ORIENTED. NGT TO WALL INTERMITTENT SUCTION SCANTY GREEN FLUID IN CANISTER. NPO. DR. A. OH IN TO SEE PT THIS AM. ABDOMEN SOFT AND ROUND, ACTIVE BOWEL SOUNDS. NS INFUSING 100 CC HOUR TO LEFT HAND. RECEIVES AMPICILLIN IV.VSS. NO PAIN AT THIS TIME. CALL LIGHT WITHIN REACH.

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By	Nurse Type	(Continued)
Occurred:	11/20/08	0800	ATS Schroer,Anthea T	RN	Category
Recorded:	11/20/08	2006	ATS Schroer,Anthea T	RN	Nurse Notes

Note Type **Description**
No Type NONE

	Date	Time	By	Nurse Type	
Occurred:	11/20/08	1443	TLF Frost,Teri L	RT	Category
Recorded:	11/20/08	1445	TLF Frost,Teri L	RT	Multidisciplinary Notes

Abnormal? N **Confidential?** N

***PT REFUSES ECHO.STATES ITS NOT NECESSARY AND THE DR CAN CALL DR C AGARWAL FOR COMPLETE CARDIAC WORK UP REPORT.

Note Type **Description**
No Type NONE

	Date	Time	By	Nurse Type	
Occurred:	11/20/08	1741	ATS Schroer,Anthea T	RN	Category
Recorded:	11/20/08	1741	ATS Schroer,Anthea T	RN	Nurse Notes

Abnormal? N **Confidential?** N

DR. HANNA REFUSED 2ND EKG TO BE DONE.

Note Type **Description**
No Type NONE

	Date	Time	By	Nurse Type	
Occurred:	11/20/08	1958	YYC Chang,Ya Yun	RN	Category
Recorded:	11/20/08	2001	YYC Chang,Ya Yun	RN	Nurse Notes

Abnormal? N **Confidential?** N

SEEN PT RESTING IN BED, A/O X3, RESP EVEN AND NOT LABORED TO ROOM AIR, ABDL SOFT AND NON-DISTENDED W/ACTIVE BS, NO BM TODAY. NG TUBE TO LIS W/ GREENISH DRAINAGE NOTED. DENIES PAIN OR NAUSEA/VOMITING, NPO MAINTAINS, ON AMPICILLIN 1GM IVPB Q8H. VOIDED VIA URINAL WELL, IVF, SAFTY MAINTAINS, CALL LIGHT W/IN REACH.

Note Type **Description**
No Type NONE

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By	Nurse Type	Category
Occurred:	11/20/08	2001	ATS Schroer,Anthea T	RN	
Recorded:	11/20/08	2004	ATS Schroer,Anthea T	RN	Nurse Notes

Abnormal? N **Confidential?** N

PT RESTING QUIETLY AT THIS TIME. NGT TO INTERMITTENT SUCTION. ADMIN MORPHINE 2 MG IV X 1 THIS SHIFT. CEPACOL LOZENGES FOR SORE THROAT. URINE AMBER. NPO EXCEPT GAVISCON 15 ML PRN. NS & 40K INFUSING. 100 CC DARK GREEN FLUID IN SUCTION CANISTER. VSS.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	11/20/08	2020	YYC Chang,Ya Yun	RN	
Recorded:	11/20/08	2200	YYC Chang,Ya Yun	RN	Nurse Notes

Abnormal? N **Confidential?** N

CLRIFIED W/ DR. JANG THAT PT WILL BE HOLD PO MEDICATION AT THIS TIME.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	11/20/08	2150	YYC Chang,Ya Yun	RN	
Recorded:	11/20/08	2203	YYC Chang,Ya Yun	RN	Nurse Notes

Abnormal? N **Confidential?** N

MEDICATED ATENOLOL 50 MG PO ADMINISTERED AS PT REQUIRED. BP=116/78, HR=80. TOLERATED W/ WATER, MADE AWARE OF NPO, VERBALIZES THE UNDERSTANDING. CONTINUE TO MONITOR.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	0622	YYC Chang,Ya Yun	RN	
Recorded:	11/21/08	0622	YYC Chang,Ya Yun	RN	Nurse Notes

Abnormal? N **Confidential?** N

SLEPT FAIR AT NIGHT, NG TO LIS DRAINAGES TO 50ML OF GREENISH OUTPUT. DENIES PAIN/DISCOMFORT NOTED, ABDL SOFT AND NOT DISTENDED W/ ACTIVE BS, NO BM, IVF, AMPICILLIN IVPB GIVEN AS DUE TIME, SAFTY MAINTAINS, CALL LIGHT W/IN REACH.

Note Type	Description
No Type	NONE

Patient: HANNA,ADEL S
Account #: V00000305742 **Unit #:** M000273781

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1148	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1153	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

RECEIVED PATIENT ALERT AND ORIENTED TIMES FOUR. IV INTACT AND NG TO SUCTION AND WITH DRAINAGE THAT IS OILY BROWN IN APPEARANCE. BOWEL SOUNDS ARE HYPOACTIVE AND ABDOMEN IS DISTENDED AND FIRM. LUNGS ARE CLEAR BUT DIMINISHED AND ENCOURAGE TO DEEP BREATH. PATIENT DENIES PAIN AT THIS TIME. FOR CT OF THE ABDOMEN TODAY AND DR OH WAS IN TO SEE AND ORDERS PENDING. ADVISED THE PATIENT THAT THE NG WILL BE REMOVED IF THE PATIENTS CT IS NEGATIVE OR WITH MARKED IMPROVEMENT. PATIENT IS ANXIOUS TO KNOW THE RESULTS. WILL BE PREPPING FOR PROCEDURE AS INDICATED AND ADVISED ABOUT THE NEED TO CLAMP THE NG AND IF NAUSEA WILL REATTACH AND SUCTION OUT IF INDICATED. PATIENT CONTINUED ON IV ANTIBIOTICS AND NO ADVERSE REACTION NOTED. PULSES STRONG AND SKIN IS WARM AND DRY. VITALS AT THIS TIME AT 97.8, 67, 20, 118/74, 98% ON ROOM AIR. WILL CONTINUE TO UPDATE WITH PLAN OF CARE.
T

Addendum: 11/21/08 at 1154 by PAS Stubbs,Pauline A. RN
FOR 800AM ASSESSMENT.

Note Type	Description
Intervention	Shift Reassessment +

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1154	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1154	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

STARTED PREP AND NG CLAMPED AS INDICATED. GIVEN ABOUT 120CC EVERY HALF AN HOUR AND SO FAR TOLERATED WELL AND NO COMPLAINTS OF NAUSEA AT THIS TIME.

Note Type	Description
Intervention	Routine Care: MED/SURG/TELE +

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1450	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1451	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

VISITORS AT THE BEDSIDE. PATIENT DENIES PAIN AND DENIES NAUSEA. TOLERATE THE GASTROGRAPHIN WELL. CONTINUED TO MONITOR AND NG TO REMAIN CLAMPED AS INDICATED.

Note Type	Description
Intervention	Routine Care: MED/SURG/TELE +

Patient: HANNA,ADEL S
Account #: V00000305742 Unit #: M000273781

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1855	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1857	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

CALLED DR OH WITH RESULTS OF THE CT OF THE ABDOMEN. AWAITING CALL BACK AT THIS TIME. PATIENT IS ANXIOUS TO EAT AND TO GO HOME. PATIENT REMOVED THE NG PRIOR TO ORDER AND ADVISED THE STAFF HE DID SO AND KNOWS THERE IS NO OBSTRUCTION ANYMORE. PATIENT REMINDED STAFF HE IS A DOCTOR AND VERSED IN THESE MATTERS. CALLED DR OH AGAIN AND AWAITING CALL BACK AT THIS TIME.

Note Type	Description
Intervention	Routine Care: MED/SURG/TELE +

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1929	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1931	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

PAGED DR AGAIN MAKING A TOTAL OF FOUR PAGES. AWAITING CALL BACK AT THIS TIME. PATIENT HAS HAD AN ISSUE ABOUT THE HYPERTENSIVE MEDICATIONS LAST NIGHT AND WILL REQUEST ALONG WITH FOOD AN ORDER FOR HIS MEDICATIONS IF DR OKS. PATIENT DENIES NAUSEA OR VOMITING AND DENIES PAIN. HE DOES THOUGH STATE HE IS WEAK AND HUNGERY. AWAITING CALL BACK AT THIS TIME.

Note Type	Description
Intervention	Routine Care: MED/SURG/TELE +

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	1948	PAS Stubbs,Pauline A.	RN	
Recorded:	11/21/08	1950	PAS Stubbs,Pauline A.	RN	Nurse Notes

Abnormal? N **Confidential?** N

DR OH CALLED BACK AND STATES CAN REMOVE NG AND START ON FULL LIQUID DIET TONIGHT. PATIENT CAN HAVE HIS ATENOLOL THIS EVENING AS WELL. POSSIBLE DISCHARGE TOMORROW IF TOLERATES WELL.

Note Type	Description
Intervention	Routine Care: MED/SURG/TELE +

Patient: HANNA,ADEL S
Account #: V00000305742 **Unit #:** M000273781

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	2020	MPR Ragaza,Maureene P.	RN	
Recorded:	11/21/08	2021	MPR Ragaza,Maureene P.	RN	Nurse Notes

Abnormal? N **Confidential?** N

AWAKE AND AMBULATING IN THE ROOM. NO RESP. DISTRESS NOTED. DENIES PAIN. FULL LIQUID DIET TOL. NO N/V. WILL CONT.TO MONITOR. CALL LIGHT WITHIN REACH.

Note Type	Description
Intervention	Shift Reassessment +

	Date	Time	By	Nurse Type	Category
Occurred:	11/21/08	2130	MPR Ragaza,Maureene P.	RN	
Recorded:	11/21/08	2135	MPR Ragaza,Maureene P.	RN	Nurse Notes

Abnormal? N **Confidential?** N

SEEN BY DR. OH. ORDERS NOTED FOR D/C HOME. DISCHARGE INSTRUCTIONS GIVEN TO PT. AND VERBALIZED UNDERSTANDING. IN NO APPARENT DISTRESS.

Note Type	Description
No Type	NONE

ADM: Quickstart Form 11/19/08 2202 BT

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62

ADM: Quickstart Form 11/19/08 2303 SGS

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62

ADM: Quickstart Form 11/19/08 2305 SGS

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62

ADM: Quickstart Form 11/21/08 2053 SGS

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62

ADMISSION ASSESSMENT HISTORY 11/19/08 2203 BT

== History Obtained == Date: 11/19/08 Time: 2203
Signature: Trinidad Bienvenido

== ARRIVAL INFORMATION ==
Time of Arrival: 2200 Mode of Arrival: GUERNEY
Arrived From: EMERGENCY DEPT Accompanied By: NURSE

== Source of Information ==
Patient: Y Other (name/relationship):
Chief Complaint: BOWEL OBSTRUCTION
Primary Diagnosis: SMALL BOWEL OBSTRUCTION

== VITAL SIGNS ==
Temperature/F: 99.7 Temp Source: TEMPORAL ARTERY
Pulse: 94 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 18 Respiration Source: OBSERVED
Blood Pressure: 118/82 BP Source: AUTOMATIC Site: RIGHT UPPER ARM
O2 in use: N Liter Flow/FIO2: Pulse Oximetry: Y SpO2%: 96 Probe Location: HAND RT

== ADMISSION HEIGHT/WEIGHT/ALLERGIES ==
Height - Feet: 5 In: 8 OR Cm: 172.72
Weight - Lb: 166 Oz: OR Kg: 75.29
Weight Source: BEDSCALE
Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKOA

== PAIN SCREEN ==
C/O Pain: Y *** Chest Pain to be Documented on Cardiac Problem ***
When Pain is Present:
Pain Location: ABDOMEN
Pain Scale: 3/10
Describe the Pain: OTHER (SEE COMMENT)
Onset: ACUTE
What Increases the Pain: :
What Relieves the Pain: :

ADMISSION ASSESSMENT HISTORY 11/19/08 2203 BT

Pain Control Goal:
Comment: DESCRIBE PAIN ON ABD AS UNCOMFORTABLE PAIN BACK 7 /10
: TO DULL PAIN

== DEMOGRAPHIC DATA == Marital Status: M Occupation: DOCTOR
Primary Language: ENGLISH Understands English:
Religion: CHRISTIAN
Beliefs Affecting Care:
Spiritual Coordinator Visit Requested:

Contact Person: HANNA,TAMER Relationship: SO
Home Phone: (909)342-9968 Work Phone: (949)413-8670 Cell/Pager:
Add'l Contact Information:

==PATIENT HISTORY==
Medical History: MIGRAINE HEADACHE

Surgical History: CHOLECYSTECTOMY 1986 HIATAL HERNIA REPAIR 1992 NOSE SURGERY(
CHRONIC SINUSITIS,DEVIATED NASAL SEPTUM,REDUCTION OF INFERIOR TER
Has Patient Ever Received Pneumococcal Vaccine: Y

== HOME MEDS == Med/Dose/Frequency/Last Dose *Include ALL over the counter meds
1. SEE MEDICATION RECONCILIATION FORM 4.
2. 5.
3. 6.

==HOME MEDS== (CONTINUED)
7. 14.
8. 15.
9. 16.
10. 17.
11. 18.
12. 19.
13. 20.
Home Med Comment:

== SUBSTANCE USE HISTORY ==
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: Y Type: WHISKY
Amount/How Often: OCCASSIONAL Number of Years: 15
Other Substance Use (comment):

== INFECTION RISK SCREEN ==
Admitted from a Skilled Nursing Facility: 0 NO
PEG Tube: 0 NO
Tracheostomy: 0 NO
Central Line: 0 NO -Total Score: 0
Hospitalized in the Last 30 Days: 0 NO =Infection Risk=
Decubitus Ulcer/Open Surgical Wound: 0 NO Low: Y
History of TB, HIV, or Hepatitis: 0 NO Moderate (1-2):
History of MRSA or VRE: 0 NO High (3+):

== SOCIAL SERVICES SCREEN ==
1) Does Pt Have an Advance Directive: Y
IF YES: Instruct family to bring in copy to place on chart and notify physician.
What is the intent of the Advance Directive for this hospital stay:

ADMISSION ASSESSMENT-HISTORY 11/19/08 2203 BT

IF OTHER THAN A FULL CODE NOTIFY PHYSICIAN

2) Does pt have a condition which may require additional care when discharged:
Condition:

3) Is the pt now experiencing, or may experience once discharged, any of the following:
Problems with ADLs due to health problems: N
Problems with transportation: N
Mental health and/or substance abuse problems: N
Is Family Involved With Pt: Y
Terminal illness: N
Other:

=== DISCHARGE PLANNING ===
Pt lives with: WIFE
Living Arrangements: HOUSE
Who Will be Taking Patient Home: FAMILY
Anticipated Discharge Destination: HOME
Comment:

=== FAMILY NOTIFICATION ===
Has family been notified of hospitalization: Y
Would you like your family to be notified:
Comment: WIFE AT BEDSIDE

=== CURRENT PHYSICIANS/PRACTITIONERS ===
Document the Names and Phone Numbers of the Physicians/Practitioners Seeing the Patient Prior to This Hospitalization:

Monogram	Initials	Name	Nurse Type
BT	NURTB	Trinidad,Bienvenido	RN
SGS	CNASSG	Salibaba,Selina G	CNA

Standards of Care Reference

The Following STANDARDS OF CARE are Related to the Patient, Family/and or Significant other.
1. Patient Care
2. Patient Education
3. Patient Discharge Planning
4. Patient Safety
5. Patient Rights

1a. The Patient will Receive Care Reflecting an Ongoing Interdisciplinary Process Of Assessment, Problem Identification, Goal Setting, Interventions, And Evaluation Based On His/Her Specific Bio-Psychosocial Needs and Expectations Of Care.
1b. The Patient Will be Involved in the Plan of Care With Attention To Age Specific Needs, Cultural and Religious Beliefs, Confidentiality and Special Communication Needs.

2. The Patient will Receive Education About the Nature of His/Her Health Condition, Procedures, Treatments, Self Care, and Post Discharge Care. Verbalization Of Questions and Concerns Will be Encouraged. Patient Education, Which is an Interactive, Interdisciplinary Teaching Process Is Prioritized Based on the Ongoing Assessment or Individual Learning Needs.

3. The Patient will Participate in Coordinating Resources and Establishing Priorities In Preparation for Discharge.

4. The Patient will Receive Care In An Environment that Minimizes Risk of Injury for Themselves or Others.

5. The Patient will be Supported in His/Her Effort to Retain Personal Identity, Self Worth, Privacy and Autonomy.

STANDARDS OF PRACTICE: ICU

Unless Otherwise Documented, The Following Assessments And Interventions Have Been Completed.

SAFETY:
1. Verify armband, with name and medical record number, in place.
2. Evaluate for Fall Risk q shift and with any change in condition.
3. Initiate safety measures as indicated:
   Side rails up.
   Bed in lowest position
   Bed wheels locked
   Call bell within reach as patient condition allows.
   Essentials within reach
   Patient/family instructed to call for nurse
4. Perform safety rounds at least q2hr and prn
5. Observe standard precautions for infection control: additional precautions as indicated.
6. Keep environment as quiet as possible
7. Orient patient/family/significant other(s) to unit, room, call bell, bed controls, side rails, bed position, safety issues, visiting hours and smoking policy on admission and prn.
8. Monitor equipment in use q shift and prn
9. Accompany/monitor all patients going for procedures/tests unless otherwise ordered. Transport cardiac monitor/emergency meds with patient.
10. Accompany all patients discharged home to entrance of hospital.

PSYCHOSOCIAL:
1. Provide privacy for patient/family/significant other(s).

STANDARDS OF PRACTICE: ICU

2. Identify patient support system: involve appropriately in plan of care.
3. Assess patient/family/significant other(s) for economic, social cultural, religious and environmental factors which may affect patient during hospitalization.
4. Encourage patient/family/significant other(s) to verbalize concerns to health care team.

NURTITION:
1. Monitor nutritional intake.
2. IF ON DIET, >50% of meal eaten and tolerated well.
3. If ordered, advance diet as tolerated.
4. Assist with eating/feeding if indicated.
5. Dietary consult if NPO > 24 hrs.

6. If on enteral nutrition (tube feedings):
   Assess tube placement q 4 hrs and prior to starting feeding/giving meeds.
   Weighted radiopaque feeding tube placement verified by CXR after insertion and prn.
   HOB maintained at 30 degrees as patient condition allows.
   Assess tolerance to feeding solution.
   Check gastric residual q4h for continuous feeding.
   Check gastric residual before each intermittent or bolus feeding. If over 100 cc do not give next feeding.
   Use an enteral feeding pump for continuous feedings.
   Change feeding container/gavage set q24hr.
   Flush feeding tube with 20-50 ml water q shift and prn following medication administration.
   Fill enteral bag with only a 12 hr measure of feeding solution.
   Utilize blue food color in all enteral feedings.
   Provide skin care to nare or tube insertion site daily and prn. Change tape q 24 hr.
   Weigh daily unless pat's condition does not permit it.
   - Medication administration with enteral feedings -
   For medications to be given on full stomach: Stop feeding, flush with 20cc warm H2O, administer med, flush with 20cc warm H2O, resume feeding.

   For medications to be given on empty stomach: stop feeding 30 minutes prior to administration time, flush with 20cc warm H2O, administer medication, flush with 20cc warm H2O, resume feedings 30 minutes after administration.
7. If on parenteral nutrition (TPN/PPN):
   Infuse TPN via patent central line, using an infusion pump.
   Change TPN/PPN solution a minimum of q 24 hr.
   Change tubing q 24 hr.
   Lipids may be piggybacked into the TPN tubing: Change tubing q 24hrs.
   Monitor weight and glucose according to policy.
   Do not infuse TPN via a midline catheter.

ACTIVITIES/ADL'S:
1. Activities performed as ordered:
   Encourage progressive activity.
   Monitor toleration of activity.
   Determine need for and monitor use of assistive devices.
2. If on bedrest:
   Turn/reposition at least q 2hr & prn as condition allows, maintaining proper body alignment and assess skin condition.
   Perform/assist with range of motion exercises q2-4 hr and prn.

3. Assist with hygiene needs daily and prn.

STANDARDS OF PRACTICE: ICU

4. If not performing independently:
   Assist with personal hygiene a minimum of q24hr.
   Offer oral hygiene twice daily and prn.
   If patient intubated or NPO offer oral hygiene q2hr and prn.
5. Change linen as necessary to maintain personal hygiene/comfort.
6. If patient is incontinent:
   Cleanse perineal/perianal area and apply skin barrier after each episode.
   Change bed linens prn to keep dry.
   Establish a bladder/bowel program with fixed voiding schedule if appropriate.
   Toileting offered q2hr and prn.

SKIN INTEGRITY:
1. Perform risk assessment upon admission and daily.
2. Evaluate skin condition q4hr and prn:
   Monitor skin integrity.
   Inspect/assess pressure points.
3. Keep skin clean and dry.
4. Prevent/eliminate pressure, friction and shearing forces on skin.
5. Keep linen clean, dry, and wrinkle free.
6. Initiate appropriate interventions for inactivity, immobility, incontinence, malnutrition and/or decreased sensation/mental acuity with guidelines verified in the Plan of Care.
7. Implementation of specialty beds per bed selection decision-making tree. (Order necessary from MD)
8. Remove/rotate NIBP cuff/pulse oximetry probe q4h & prn.

IF IV/INVASIVE LINES PRESENT:
1. Assess site(s) a minimun of q4h & prn for redness, swelling, and/or pain.
2. Label all IV dressings and tubings with date, time and nurse's initials.
   Use nonporous tape to write dates and times on IV solution bags and tubings.
4. If peripheral IV site present:
   Verify that IV site changed a minimun of q72hr & prn.
   All IV's started out of hospital are changed within 24hr.
   Saline flushes per protocol. Date vials.
5. For all IV/epidural solutions infusing or invasive monitoring solutions:
   Verify IV/pressure solution and monitor ordered rate of infusion and/or site q1hr.
   Verify that IV/pressure solution(s) changed a minimum of q24hr.
   Verify that IV/pressure tubing and transducers changed a minimum of q72hr and with each site change except as noted below:
   -Every 12 hours for Diprivan tubing
   -Every 24 hours for lipid tubing
   -Every 24 hours for TPN tubing
6. If central line present:
   Assess site and apply transparent dressing after insertion of central line.
   Change transparent dressing/caps q72hr and prn.
   Flush unused ports of multi-lumen lines with appropriate solution q8hr and prn following intermittent infusions/blood draws, reserve one lumen for TPN only.
   Dispose of multidose vials q 30 days. Date vials.
   Use IV pump for all infusions.
7. If midline/PICC line present:
   Dressing change and site care done q week by nurse.
   Flush unused ports of mulit-lumen lines with appropriate solution q24hr and prn following intermittent infusions/blood draws (when allowed).
   Use IV infusion pump for all infusions.
8. If implanted port present:
   Access only with a Huber needle.
   Change dressing and access every 7 days.
   If not in use or following intermittent infusion/blood draws, heparinize with appropriate concentration and amount per policy.
   Use an infusion pump for all infusions.
9. If invasive monitoring line(s) in use:
   Transducers zeroed/leveled q shift and prn.
   Zero/level with HOB flat unless condition prohibits, and record HOB position/elevation.
   Maintain system sterility by use of yellow deadender caps/heparin locks on all open ports.
   2:1 heparinized solution unless pt. condition prohibits.
   Maintain pressure bag at 300mmHg.
   Pulmonary Artery Catheter Monitoring:
   -PA/CVP q4hr
   -Hemodynamic profiles will be recorded on insertion of line and q shift or per order. CO injectate to consist of 10cc room air temp NS unless otherwise ordered of patient condition merits iced or low volume.
   -Measure catheter position q shift and prn. Document initial insertion position.

   Arterial catheter Monitoring:
   -Correlate with brachial cuff q8hr and prn.
   -Assess CMS peripherally to arterial catheter q2hr.
   -Arterial line sites to be changes every 5 days.
   Discontinuance of sheaths:
   -Central introducers/side ports: remove prior to transfer from ICU.
   -If patient condition prohibits PIV access, obtain order to maintain prior to transfer from ICU.
10. If irrigation solution in use:
   change solution q24hr.
   Chart all solution/flushes with or without medications on MAR.

PAIN:
1. Pain assessment to be performed each time vital signs are recorded and prn with appropriate interventions:
   Assess location, type, duration and frequency of pain
   Assess intensity of pain using an appropriate tool: self-report, scale 0-10.
2. If IV opiods administered:
   Verify drug and dose to be given.
   Dilute and administer per protocal.

   Monitor sedation level and respiratory rate/quality per policy.
3. If PCA in use:
   Verify medication/program/patency.
   Instruct patient in use.
   Monitor vital signs and sedation level per policy.
4. If epidural catheter in use:
   Verify medications/program/patency.
   Check catheter site/dressing q shift and prn.
   Monitor vital signs and sedation level per policy.
   All prn analgesics/sedatives ordered by anesthesiologist only.

RESPIRATORY:

STANDARDS OF PRACTICE: ICU

1. Assist with coughing, deep breathing and IS at ordered intervals or q4hr while awake and prn as necessary.
2. If patient has respiratory condition, monitor pulse oximetry q1hr or as ordered and titrate O2 to maintain SPO2 per order.
3. If oxygen in use, titrate per respiratory protocal unless ordered otherwise.
4. Special care of ventilated patients:
   ET suction prn.

   Change/date/reposition ET/NT q24hr.
   Establish means of communication.
   Monitor and record ventilator settings on ICU flow sheet.
   Respiratory Therapist present at all planned extubations.
5. If Tracheostomy present:
   Routine tracheostomy care q12hr and prn.
   Cleanse with 1/2 strength H2O2 and NS.
   Cleanse skin around stoma with trach care and prn.
   Verify trach ties as secured and change as ordered suction prn.
   Maintain dry and intact dressing.
   Establish means of communication.
   Keep spare trach of appropriate size at bedside.

CARDIAC:
1. EKG continuously monitored.
2. Alarms verifed as on with settings +/- 30% of patient's baseline.
3. EKG pads changes q24hr and prn.
4. Posting of EKG tracing q4hr, with changes and prn with PR, QRS, & QT intervals measured/evaluated on strip. Posted on Progress Note on chart.

5. Monitor all patients discharged to telemetry with cardiac monitor.
6. For external pacemaker patients:
   Pt to be on bedrest if pacemaker is in use
   Site care q24hr and prn.
7. Chest Pain Orders for all pts with a cardiac diagnosis.

IF VASCULAR PATIENT:
1. Verify appropriate palpated pulses with doppler for post procedure/post op vascular patients.

IF NEURO PATIENT:
1. Use of seizure precautions:
   Padded side rails
   Bed low position
   Airway at bedside
2. Maintain HOB elevated per order.
3. Use of subarachoid hemorrhage precautions:
   Bedrest
   Quiet environment/decrease stimuli
   Limit activity of patient and visitors to room

   Dim lighting
   Use of stool softners per MD order/collaborative preactice
4. If Ventriculostomy present:
   Monitor and record ICP q2hr.

IF ORTHOPEDIC PATIENT:

STANDARDS OF PRACTICE: ICU

1. Maintain weight bearing status as orderd.
2. Utilize immobilizers/breaces/collars as ordered.
3. Monitor CMS of affected extremity q8hr and prn.
4. Apply ice pack to surgical site if ordered.
5. Use pillows under operative lower extremity only if specifically ordered.

IF ANTIEMBOLITIC STOCKINGS ORDERED:
1. Elastic stockings in place, remove q shift and prn for skin assessment.
2. Sequential Compression Device in place while in bed and removed at bathtime and prn for skin assessment or as ordered.

INCISIONS/DRESSINGS:
1. If incision present:
   Site monitored for bleeding/drainage q4h and prn.

   Check incision with each dressing change.
2. If dressing present:
   Check every 4 hrs and prn.
   Dressing changed/reinforced q2hr or as MD ordered.

TUBES/DRAINS:
1. If drainage tube(s) present (JP, hemovac, t-tube, etc.):
   Verify patency.
   Skin care to insertion site(s).
   Measure contents/empty q12hr and prn or as ordered.
2. If foley present:
   Verify patency.
   Maintain closed gravity drainage system.
   Keep bag below level of bladder at all times.
   Pericare daily and prn.
   If foley inserted outside of hospital, change within 24hr.
   Change foley bag for increase in sediment, obstruction, or a break in the closed system.
3. If supra-pubic catheter present:
   Clamp as ordered or verify patency.

   Anchor catheter to thigh.
   Voiding trials as ordered.
4. If NGT present:
   Verify patency/placement of tube q shift and prn unless otherwise ordered.
   Tape securely and change tape q24hr.
   Irrigate tube q shift with 30cc H2O as patient condition allows or as ordered and prn. Change irrigation set q24hrs (graduate/toomy syringe).
   Anti Reflu Valve should be in place when NGT connected to suction.
   Contents measured q12hr and prn.
   Change suction cannister q24hrs.
   Medication Administration through NG Tube:
   -Flush tube with 20cc warm H2O
   -Administer medication in enough volume to maintain tube patency while administering
   -Flush tube with 20 cc warm H2O
   -Clamp tube for 30 minutes after administration.
5. If chest tube(s) present:
   Assess for air leak, SQ air q4h and prn
   Verify patency

STANDARDS OF PRACTICE: ICU

Securely tape chest tube and connecting tubing in place
Dressings to insertion site(s) dry and intact; change per MD order
Maintain water seal chamber/suction as ordered
Maintain chest tube drainage system lower than insertion site
Record amount/color of drainage q12hr, mark on drainage system

I&O:
1. I&O to be monitiored q4hr and recorded q12hr (+)

WEIGHT:
1. Weigh pt on admission and qd if pt's condition permits.

VITAL SIGNS:
1. To be taken on admission and q2hrs (+)
2. Temperatures to be taken q4h unless elevated then q2h (+)

STANDARDS OF PRACTICE: M/S/T

Unless Otherwise Documented, The Following Assessments And Interventions Have Been Completed.

SAFETY:
1. Verify armband, with name and medical record number, in place.
2. Evaluate for Fall Risk q shift and with any change in condition.
3. Initiate safety measures as indicated:
   Side rails up x 2
   Bed in lowest position
   Bed wheels locked
   Call bell within reach at all times
   Essentials within reach
   Patient/family instructed to call for nurse
4. Perform safety rounds at least q2hr and prn
5. Observe standard precautions for infection control: additional precautions as indicated.
6. Keep environment as quiet as possible
7. Orient patient/family/significant other(s) to unit, room, call bell, bed controls, side rails, bed position, safety issues, visiting hours and smoking policy on admission and prn.
8. Monitor equipment in use q shift and prn

PSYCHOSOCIAL:
1. Provide privacy for patient/family/significant other(s).
2. Identify patient support system; involve appropriately in plan of care.
3. Assess patient/family/significant other(s) for economic, social cultural, religious and environmental factors which may affect patient during hospitalization.
4. Encourage patient/family/significant other(s) to verbalize concerns to health care team.

NUTRITION:
1. Monitor nutritional intake.
2. If on diet, > 50% of meal eaten and tolerated well
3. If ordered, advance diet as tolerated
4. Assist with eating/feeding if indicated
5. If on enteral nutrition (tube feedings):
   Assess tube placement q 4hr and prior to feedings/giving meds.
   Assess tolerance to feeding solution.
   Check gastric residual q4hr for continuous feeding.
   Check gastric residual before each intermittent or bolus feeding. If over 100cc notify physician.

STANDARDS OF PRACTICE: M/S/T

   Use an enteral feeding pump for continuous feeding.

   Change feeding container/gavage set q24hr.
   Flush feeding tube with 30-50ml water q4hr and prn following medication administration unless ordered otherwise.
   Provide skin care to nare or tube insertion site daily and prn.
   Weigh daily if on enteral feedings.
   Maintain HOB 30 degrees at all times.
6. If on parenteral nutrition (TPN/PPN):
   Infuse TPN via a patent central line using an IV infusion pump.
   Change TPN/PPN solution a minimum of q24hr.
   Change tubing q24hr.
   Lipids may be piggybacked into the TPN tubing: change tubing q 24hr.
   Monitor weight, glucose and labs according to policy.

ACTIVITIES/ADL'S:
1. Activities performed per activity guidelines or as ordered.
   Encourage progressive activity
   Monitor toleration of activity
   Determine need for and monitor use of assistive devices
2. If on bedrest:
   Turn/reposition at least q2hr as condition allows, maintaining proper body alignment.

   Perform/assist with range of motion exercises q 4hr and prn.
3. Assist with hygiene needs daily and prn.
4. If not performing independently:
   Assist with personal hygiene a minimum of 24hr.
   Offer oral hygiene twice daily and prn.
5. Change linen as necessary to maintain personal hygiene/comfort.
6. If patient is incontinent:
   Cleanse perineal/perianal area and apply skin barrier after each episode
   Change bed linens prn to keep dry
   Offer toileting q2-3hr and prn
   Record BM daily; if no BM > 2 days notify MD for laxative order

SKIN INTEGRITY:
1. Perform risk assessment upon admission and q shift.
2. Evaluate skin condition with each shift assessment:
   Monitor skin integrity
   Inspect/assess pressure points:Refer to Decubitus Protocol
3. Keep skin clean and dry
4. Prevent/eliminate pressure, friction & shearing forces on skin
5. Keep linen clean, dry and wrinkle-free

6. Initiate appropriate interventions for inactivity, immobility, incontinence, malnutrition and/or decreased sensation/mental acuity with guidelines verified in the plan of care.

I&O:
1. I&O measured and documented q 12hrs

WEIGHT:
1. Weigh on admission and qd if pt's condition permits (CHF, Renal Failure, on TPN and enteral feedings)

IF IV/SL PRESENT:
1. If S/L:

STANDARDS OF PRACTICE: M/S/T

Assess site(s) a minimum of q4hr and prn for redness, swelling and/or pain.
2. If IV:
Verify solution and monitor ordered rate of infusion and/or site q4hr and prn.
3. Verify that IV bag changed a minimum of 24hr.
4. Verify that IV site changed a minimum of 72hr and prn as per policy.
Label site with date, time, and initials
5. Verify that IV tubing changed a minimum of 72hr and with each IV site change.
6. Label all IV dressings and tubings with name, time and nurse's initials.
7. If central line present:
Assess site and dressing q12hr
Change dressing/caps q72hr and prn as per policy.
Flush unused ports of multi-lumen lines with appropriate solution q8hr and prn following intermittent infusions/blood draws, reserve one lumen for TPN only as per policy. Follow Venous Access Policy.
Use infusion pumps for all infusions.
8. If implanted port present:
Access only with Huber needle
Change dressing and access q 7 days
If not in use or following intermittent infusions/blood draws, heparinize with appropriate concentration and amount. See Venous Access Policy.
Use an IV infusion pump for all infusions.
9. If patient admitted with a PICC line, physician to be called for orders for care.

PAIN:
1. Pain assessment performed each time vital signs are recorded and prn with appropriate interventions and follow pain management guidelines as per policy. Pain is the 5th Vital Sign.
Assess location, type, duration and frequency of pain.
Assess intensity of pain using an appropriate tool (self report, scale 0-10)
2. If IV opioids administered:
Verify drug and dose to be given
Dilute and administer per protocol
Monitor sedation level and respiratory rate/quality per policy
3. If PCA in use: (Follow PCA protocol)
Verify medication/program/patency
Instruct patient in use
Monitor vital signs and sedation level per policy
4. If epidural catheter in place:(Follow specific MD orders)
Verify medications/program/patency
Check catheter site/dressing q8hr and prn as per policy
Monitor vital signs and sedation level per policy

RESPIRATORY:

1. Assist with coughing and deep breathing at ordered intervals or q4hr and prn as necessary
2. Monitor pulse oximetry prn as appropriate or as ordered.
3. If oxygen in use, titrate per respiratory protocol, unless ordered otherwise.
4. If postoperative:
Turn, cough, deep breath q2hr x 8, then q4hr and prn.
Incentive spirometer as ordered
5. If Tracheostomy present:

STANDARDS OF PRACTICE: M/S/T

Routine tracheostomy care q shift and prn.
Change inner cannula q24hr
Cleanse skin around stoma with trach care and prn
Verify trach ties as secure and change as ordered
Suction prn
Maintain dry and intact dressing
Establish means of communication
Keep spare trach of appropriate size at bedside

IF ANTIEMBOLITIC STOCKINGS ORDERED:
1. Elastic stockings in place, remove at bathtime and prn for skin assessment or as ordered.
2. Sequential Compression Device in place while in bed, remove at bathtime and prn for skin assessment or as ordered.

POSTOPERATIVE OBSERVATION:
1. Postoperative assessment on arrival to floor to include:
Vital signs and level of sedation per policy
Presence of pain and comfort measures
Dressing site(s) & drainage tubes
Appropriate charting on POST OP:SURGICAL ASSESSMENT through the Assessment/Forms routine
2. Monitor pain level with vital signs and level of sedation per policy

INCISIONS/DRESSINGS:
1. If incision present:
Monitor site for bleeding/drainage q4hr and prn
Check with each dressing change or q4hr & prn if no dressing
2. If dressing present:
Check q shift and prn
Change prn unless ordered otherwise
3. If GYN patient, monitor vaginal bleeding q4hr and prn
4. If vaginal packing present:
Check q shift and prn
Remove only as ordered

TUBES/DRAINS:
1. If drainage tube(s) present (JP, hemovac, t-tube, ect).
Verify patency
Skin care to insertion site(s)
Measure contents/empty q12hr or as ordered and prn
2. If foley present:
Verify patency
Maintain closed gravity drainage system
Keep bag below level of bladder at all times
Peri-care daily and prn
3. If supra-pubic catheter present:
Clamp as ordered or verify patency
Anchor catheter to thigh
Bladder training as ordered
4. If NGT present:
Verify patency/placement of tube q shift and prn unless otherwise ordered.
Tape securely and change tape q24hr.
Anti Reflux Valve should be in place when NGT connected to suction.

STANDARDS OF PRACTICE: M/S/T

HOB elevated 30 degrees at all times.
Change suction cannister liner q24hr.
Medication Administration through NGT:
-Flush tube with 20 cc warm H20
-Administer medication in enough volume to maintain tube patency while administering
-Flush tube with 20 cc warm H20
-Clamp tube for 30 minutes after administration

5. If chest tube(s) present:
Assess for air leak. SQ air q4hr and prn
Auscultate breath sounds
Securely tape chest tube and connecting tubing in place
Dressings to insertion site(s) dry and intact; change prn
Maintain water seal chamber/suction as ordered
Maintain chest tube drainage system lower than insertion site
Clamps X2 at bedside

IF ON TELEMETRY:
1. Monitor EKG continuously
2. Interpret and post rhythm strips q4hr and prn
3. Notify physician of rhythm changes
4. Change EKG pads daily

IF ORTHOPEDIC PATIENT:
1. Maintain weight bearing status as ordered
2. Utilize immobilizers/braces/collars as ordered
3. Monitor CMS of affected extremity q8hr and prn
4. Apply ice pack to surgical site if ordered
5. Assess Homan's sign q12hr and prn
6. Use pillows under operative lower extremity only if specifically ordered

REFERENCE - DEFINED PARAMETERS

NEUROLOGICAL Parameters:
--Eyes Open Spontaneously
--Oriented (Person, Place & Time)
--Follows Commands
Speech Clear
--No swallowing difficulty/impairment at present as evidenced by drooling, coughing, choking or complaint of difficulty
--No Headache
--Behavior/Appearance Appropriate (Good Hygiene Appropriate Dress For Season, Well-Groomed, Emotions Appropriate Considering Cultural Variations)
--No current seizure activity noted

EENT Parameters:
--Pupils equal and react briskly to light
--No discharge, redness, pain, edema, blurred or distorted vision with glasses/contacts, noted/complained about eyes
--Able to hear common sounds with and/or without hearing aids (No hearing impairment)

--No Nasal Complaints/Abnormal Assessment Such As Bleeding, Nasal Discharge (Watery, Mucoid, Purulent), Congestion, Stuffiness, Or Difficulty Breathing [illegible]ugh Nares

REFERENCE - DEFINED PARAMETERS

--No Throat Complaints/Abnormal Assessment Such As Sore, Red, Swollen, Hoarseness, Hypertrophied Tonsils, exudate on tonsils, or postnasal drip
--Buccal Mucosa Pink, Moist And Smooth
--Teeth present are intact OR well-fitting dentures

RESPIRATORY Paramters:
--Breath Sounds Clear/Vesicular (Soft, Low-Pitch Sounds) Throughout All Lung Fields And Bronchial Over Major Airways: No Adventitious Breath Sounds Noted
--Respirations Unlabored
--Equal Chest Expansion Noted
--NO Cough Noted
--No Sputum/Secretions Noted
--No Chest Tubes in Place
IF ON OXYGEN: Document Device And Amount Of Oxygen Delivered

CARDIAC Parameters:
--Heart Rate Regular Per Ausculation Or Palpatation
--Heart Sounds Normal (S1 & S2)
--No Syncope/Fainting
--No Dizziness/Vertigo
--Denies Chest Pain
IF ON TELEMETRY: Record rhythm

CIRCULATORY Parameters:
--Strength of the Radial, Dorsalis Pedis , and Posterior Tibial pulses is expected (2+)
--Extremities Warm
--Extremities pink in color
--Denies sensory changes in extremities (no numbness, tingling or loss of sensation)
--No edema noted

MUSCULOSKELETAL Parameters:
--No skeletal deformities noted
--Steady Gait And Balance

--No Weakness Noted In Extremities
--Extremities With Full ROM
--No Joint Swelling/Tenderness Noted

NUTRITIONAL Parameters:
--Diarrhea/Nausea/Vomiting For < 3 Days
--NPO Or Clear Liquids < 3 Days
--Not On Dietary Supplementation (TPN/PPN/TUBE FEEDING)

GATROINTESTINAL Parameters:
--Abdomen Flat Or Evenly Rounded, Soft, Symmetrical And Nontender To Palpation.
--Bowel Sounds Active In All 4 Quadrants (5-30/min)
--Moving bowels within own and no change in consistency
--Denies GI Complaints (Colicky, Cramping, Diarrhea Constipation, Heartburn, Epigastric Burn, Fecal Incontinence, Belching, Hemorrhoids, Regurgitation, Bloody BM, Flatulence, Upset Stomach, Feeling Of Fullness, Decrea[illegible]ppetite, Nausea And/Or Vomiting.)

REFERENCE - DEFINED PARAMETERS

--No GI tubes present for decompression of GI tract

(Do not include tubes here for feeding purposes)

GENITOURINARY Parameters:
--Able To Empty Bladder Per Voiding Without Incontinence Or Catheter (May Use Urinal, BSC, Or Bedpan
OR
No Problems Because Dialysis Patient And Does Not Produce Urine.
--Urine Clear And Yellow To Amber In Color.
--Denies Urinary Complaints/Problems (Burning, Frequency, Urgency, No/Low Urine Output etc.)
--IF FEMALE PATIENT: No Unusual Vaginal Bleeding Or Vaginal Discharge Noted Or Complained.
Vaginal packing in place as ordered
--IF MALE PATIENT: No Penile Discharge Noted Or Coplained.
No Scrotal Edema Noted Or Complained.
--IF DIALYSIS PATIENT: Document type of dialysis and IF FISTULA: Fistula with bruit and thrill

INTEGUMENTARY Parameters:

--General Skin Assessment Is Pink/Ethnic Color, Warm And Dry.
--Skin Intact: No Alteration In Skin Integrity (Such As Abrasion, Blisters, Burn, Decubitus, Bruising, Excoriation, Hives, Incision, Irritation, Lacerations, Lesions, Peeling, Rash, Scaling, Sloughing, Stoma Present, Skin Tears, Ulcerations, Or Wounds.
--No Drainage Tubes Such As Hemovac, JP, Penrose Drain T-TUBE Etc. Present.

PSYCHOSOCIAL Parameters:
--No Mood Swings Noted. Patient's Mood Appropriate For Situation With Regards To Cultural Influences.
--Effective coping skills/patterns with regards to cultural influences
(ineffective coping can be presented as post traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behaviors)
--No altered self perceptions noted such as body image disturbance, feeling of hopelessness, personal identity

disturbance, feeling of powerless, or altered self esteem
--Normal, age-appropriate, growth and development (Erickson'S)
--No signs of suspected abuse
(physical, emotional, neglect, etc.)
Signs include delay in treatment, hesitation to explain, injury inconsistent with history, sites of injury, self neglect, nonspecific complaints, patterned markings, recurrent injuries, or injuries in various stages

PAIN Parameters:
--No chronic or acute pain

REFERENCE - DEFINED PARAMETERS

EDUCATIONAL Parameters:
--No educational barriers identified such as age related issues, HOH, reads only braille, cognitive, cultural deaf, emotional/psychiatric, financial, language, motivational, physical, reading below grade level, cannot read written words, religious, uses sign language only, and/or decreased vision

--Pt/Significant other(s) able to understand verbal instructions well
(no difficulty related to educational barriers)
--Pt/Significant other(s) able to understand written instructions well (no difficulty related to eductional barriers)
--Pt/Significant other(s) able to verbalize knowledge of treatment plan/educational needs well
(no difficulty related to educational barriers)

IV SITE Parameters:
--IV site patent without redness, swelling, tenderness, or temperature

1. REASON FOR ASSESSMENT:
- Y Pt. Reviewed. No Needs Identified; Will Return to Prior Living Arrangement; No Further Intervention Required at This Time.
- Pt. Requires Additional Discharge Planning and has been Referred to the Hospital DC Planner
- Pt. Requires Additional Discharge Planning and is being Managed by an Outside Case Manager. Pt. has been Referred to:
- Pt. Requires Social Service Assistance and has been Referred To the Hospital Social Worker: See QRM Multidisciplinary notes for Further Documentation.
- Pt. Requires Case Management Assistance and has been Referred to the Hospital Case Manager; See QRM Multidisciplinary Notes for Further Documentation.

2. DISCHARGE PLANNING ASSESSMENT: (Prior to Admission)
Patient Lives With:
Contact Name and Number:
Patient Lives In:
Home Safety Barriers:
Independent W/ADL's: Ambulation:
Uses DME: List:
Assistance W/ADL's:
Homecare Assistance:
Provider and # of Hrs.:
Meals on Wheels:
Home Health Care:
Agency Name and #:
Other Resource Used:
:

3. EDUCATIONAL NEEDS:
Patient/Family Have Educational Needs

4. DISCHARGE PLAN:
Summary of Assessment/Plan: PT LIVES WITH HIS SPOUSE AND IS INDEPENDENT WITH
: ADLS NO DC PLANNING NEEDS ANTICIPATED WILL AWAIT PHYSICIAN ADVISEMENT AND FOLLOW AS NEEDED

Reassessment/Follow up Needed: See QRM Multidisciplinary Notes.

=== PATIENT/FAMILY EDUCATION ===
Information Taught:
Instruction Given:

Person Taught:
Person Taught:
Teaching Tools:
Other Tools Used:
Factors Affecting Learning:
Other Factors:
Participation Level:
Evaluation:
Needs Additional Education:
:
Educator:

SS/Discharge Plan Assessment 11/20/08 0758 SM

Discipline:

Monogram	Initials	Name	Nurse Type
SM	SWMS	Montoya,Susan	SS

Chino Valley Medical Center

HANNA, ADEL S IN
V00000305742 M/62
DOB:03/29/46
DOS:11/19/08 MR#: M000273781
Lally, James M.
Addressograph

	Date: ER 11/19 Pre-Hospital Recopied Kardex	Date: 11/19 Day 1 /	Date: 11/20 Day 2 /	Date: Day 3 /	Date: Day 4 /	Date: Day 5 /	Date: Day 6 /
Patient Activity Safety							
Consults							
Diet							
Cardio Pulmonary Tests/Tx.							
AMY, LIP, LFT, Lab Tests MRSAC	CBC, BMP, CK, CKMB, MYO, TROP, PT, PTT, LDH, HDL, CHOL,	MRSAC BMP CMP, MG, PHOS, LIPID PAN.					
Radiology Tests	ABD EKG. CXR. CT-COMBO	EKG.					
Physical Therapy							
Treatments (i.e.; VS, WEIGHTS, I&O)							

IV MEDICATIONS							
MEDICATIONS							
DISCHARGE PLANNING	INDEPENDENT/HOME ☐ NEEDS EQUIP. ☐ S.S. REFERRAL ☐						
TEACHING							

Multidisc.

7a - 7p

7p - 7a

No.

☐ DNR ☐ See Ad. Dir. Code Status: DATE OF LAST BM: (IN PENCIL)

☐ Respiratory Isolation Surgery: Telemetry #

Coordinated Care Manager: Practice Guideline for SBO (diagnosis) DRG # Los:

ROOM 228 B NAME HANNA, ADEL ALLERGY REGLAN DOCTOR DR. LALLY

100006 604.007

HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M
IN
M/62
MR#: M000273781

...INES FOR DIAGNOSIS

IV MEDICATIONS								
MEDICATIONS								
DISCHARGE PLANNING	INDEPENDENT/HOME ☐ NEEDS EQUIP. ☐ S.S. REFERRAL ☐							
TEACHING								

☐ DNR ☐ See Ad. Dir. Code Status: ________ DATE OF LAST BM: (IN PENCIL) ________

☐ Respiratory Isolation Surgery: ________ Telemetry # ________

Coordinated Care Manager: ________ Practice Guideline for SBO (diagnosis) DRG # ________ Los: ________

ROOM 228 B NAME HANNA, ADEL ALLERGY REGLAN DOCTOR DR. LALLY

100006 604.007

HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

NURSING DIAGNOSIS AND/OR PATIENT PROBLEMS	ER/Pre-Admit Pre-Hospital or Updated Careplan	Date ____ Admission Day	Date ____ Day 2	Date ____ Day 3	Date ____ Day 4	Date ____ Day 5	OUTCOMES DISCHARGE Day 6 Date ____

Multidisciplinary Team Date ____ Sig. ____ Date ____ Sig. ____ Date ____ Sig. ____

7a - 7p	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
	Sig. ____	Sig. ____	Sig. ____	Sig. ____	Sig. ____	
7p - 7a	Date ____	Date ____	Date ____	Date ____	Date ____	
	Sig. ____	Sig. ____	Sig. ____	Sig. ____	Sig. ____	

HANNA, ADEL S IN
V00000305742 M/62
DOB: 03/29/46
DOS: 11/19/08 MR#: M000273781
Lally, James M.

No. ____ of ____

-100006 604.007 (REV. 5/00)

PRACTICE GUIDELINES FOR DIAGNOSIS

HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
IN
M/62
MR#: M000273781
Addressograph

Chino Valley Medical Center

	Date: ER 11/19 Pre-Hospital Recopied Kardex	Date: 11/19 Day 1 /	Date: 11/20 Day 2 /	Date: Day 3 /	Date: Day 4 /	Date: Day 5 /	Date: Day 6 /
Patient Activity Safety							
Consults							
Diet							
Cardio Pulmonary Tests/Tx.							
AMY, LIP, LFT, Lab Tests MICROMRSAC	CBC, BMP, CK, CKMB, MYO, TROP, PT, PTT, LDH, HDL, CHOL,	MRSAC. BMP CMP, MG. PHOS, LIPID PAN.					
Radiology Tests	ABD EKG. CXR. CT-COMBO	EKG.					
Physical Therapy							
Treatments (i.e.; VS, WEIGHTS, I&O)							

Age/Sex: 62 M
Unit #: M000273781
Admitted: 11/19/08 at 2033
Status: DIS IN

Attending: Lally, James M.
Account #: V00000305742
Location: MU
Room/Bed: 228-B

HANNA,ADEL S

Chino Valley Medical Center NUR **LIVE**
Patient's Plan of Care

Status: Discharged
Initiated: 11/19/08
Completed:
Protocol:

Printed 11/22/08 at 0926

PROBLEM / GOAL	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
PROBLEM: Impaired Neurological Function *Altered neurologic status related to disease process, trauma and/or surgical procedure	D	11/20 YYC								
* Improve/maintain neuro function/status.	D	11/20 YYC	11/25		* Problem: Neurological +	11/20 YYC		11/20 2011	QS & Q4H IN ICU	D
PROBLEM: Impaired EENT Function Physical or sensory problem identified related to disease process and/or injury	D	11/19 BT								
* Improved/maintain EENT function/status.	D	11/19 BT	11/25		* Problem: EENT +	11/19 BT		11/19 2358	QS & Q4H IN ICU	D
PROBLEM: Impaired GI Function Gastrointestinal problem identified related to disease process, trauma, and/or medications.	D	11/19 BT								
* Improve/maintain GI function/status	D	11/19 BT	11/25		* Problem: Gastrointestional +	11/19 BT		11/19 2358	QS & Q4H IN ICU	D
PROBLEM: Altered GU Function Genitourinary problem identified related to disease process, trauma, and/or surgical procedure.	D	11/19 BT								
* Improve/maintain GU function/status.	D	11/19 BT	11/25		* Problem: Genitourinary +	11/19 BT		11/19 2358	QS & Q4H IN ICU	D
PROBLEM: Altered Nutritional Status Nutritional problem identified related to disease process, trauma and/or surgical process.	D	11/20 YYC								
* Improve/maintain nutritional status	D	11/20 YYC	11/25		* Problem: Nutrition +	11/20 YYC		11/20 2011	QS & Q4H IN ICU	D
PROBLEM: Impaired Musc/Skeletal Function Musculo/Skeletal problem identified related to trauma, disease process, and/or surgical procedure.	D	11/19 BT								
* Improve/maintain musculoskeletal function/status.	D	11/19 BT	11/25		* Problem: Musculoskeletal +	11/19 BT		11/19 2358	QS & Q4H IN ICU	D
PROBLEM: Impaired Respiratory Function Respiratory problem identified related to disease process, injury, and/or immobilization.	D	11/21 PAS								
* Improve/maintain respiratory function/status.	D	11/21 PAS	11/25		* Problem: Respiratory +	11/21 PAS		11/21 1200	QS & Q4H IN ICU	D
Developmental Age 41-65 (MID ADULT) Based on Erickson's eight stages of development. --Developmental Need: -Guide the next generation.	D	11/19 BT								
* Patient will verbalize understanding of lifestyle changes, therapy/treatment options, and resources/support groups that may be beneficial to themselves and their famiy.	D	11/19 BT	11/23		* Age Guidelines: 41-65 (MID ADULT) - PROTOCOL: AGE 41-65	11/19 BT		11/19 2203	VIEW PROTOCOL/DI QS	D
CVMC STANDARD OF CARE See Standard of Care Profile.	D	11/19 BT								
* All Patients Will Receive The Following	D	11/19 BT	11/23		* Shift Reassessment +	11/19 BT		11/19 2203	QS & Q4H IN ICU	D
					* VS: Monitor +	11/19 BT		11/19 2203	AS ORDERED	D
					* I&O: Monitor +	11/19 BT		11/19 2203	Q12H (0559,1759)	D
					* Weight +	11/19 BT				D
					* Notify: MD +	11/19 BT		11/19 2203	WHEN NECESSARY	D

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
					* Nutrition/Activity/ADL Flowsheet +	11/19 BT		11/19 2203	QS BY CAREGIVER	D
					* Education, Patient/Family Teaching +	11/19 BT		11/19 2203	QS BY CAREGIVER	D
					* IV/Invasive Lines: Insert/Remove +	11/19 BT		11/19 2203	INS/REMOVAL/CONVERT	D
					* Pain: Management Of +	11/19 BT		11/19 2203	AS NEEDED	D
					* Care Plan: RN Review +	11/19 BT		11/19 2203	Q12H	D
					* Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT	11/19 BT		11/19 2203	WHEN APPLICABLE	D
					* DIS: Patient Discharge Instructions +	11/19 BT		11/19 2203	ON DISCHARGE	D
STANDARD OF PRACTICE M/S/TELE See Standard of Care Profile - PROTOCOL: S.M/S/TELE	D	11/19 BT								
* PRACTICE GUIDELINES	D	11/19 BT	11/23		* Routine Care: MED/SURG/TELE + VIEW PROTOCOL - PROTOCOL: S.M/S/TELE	11/19 BT		11/19 2203	END OF SHIFT/TX	D
* WITHIN DEFINED PARAMETERS	D	11/19 BT								

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS	SRC
* Inventory Personal Belongings + ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.	11/19 MD		11/19 1916	ADM TX DC	D	AS
* ADMISSION/TRANSFER: Quick Start Form +	11/19 BT		11/19 2202	ON ADMISSION/TRANS	D	AS
* ADM: ADULT Admisson History +	11/19 BT		11/19 2203	ON ADMISSION	D	AS
* ADM: ADULT Admission Assessment +	11/19 BT		11/19 2352	ON ADMISSION	D	AS
* CRM: Social Services Review	11/20 SM		11/20 0758	ON ADMISSION	D	AS
* Nutrition Screen: Adult +	11/20 CBH				D	PS

Monogram	Initials	Name	Nurse Type
BT	NURTB	Trinidad,Bienvenido	RN
CBH	FNHCB	Higgins,Chrystine B	DT
MD	EDDM	Diaz,Michael	EMT
PAS	NURSPA	Stubbs,Pauline A.	RN
SM	SWMS	Montoya,Susan	SS
YYC	NURCYY	Chang,Ya Yun	RN

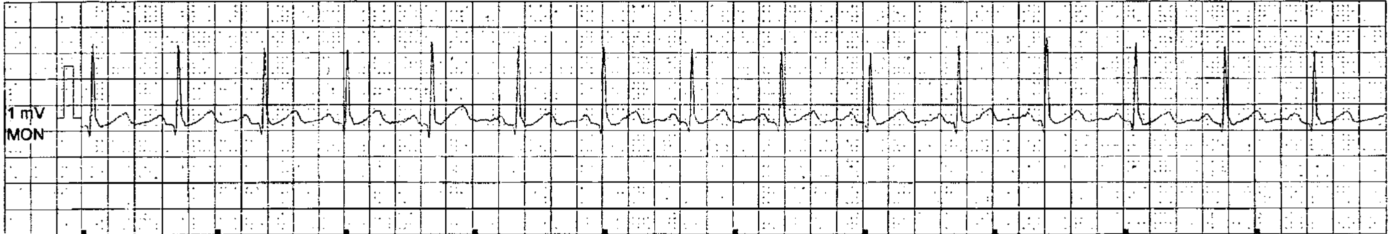
All Strips Report

Data Time: 2008/11/19 20:06:07

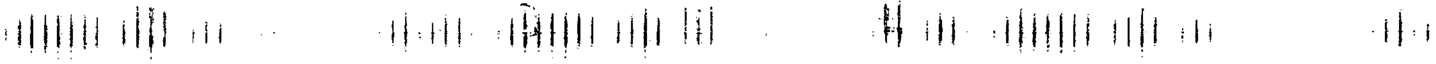
Last Na	HANNA, ADEL V00000305742	ER M/62	ID:	Bed: ER#4
Doctor:	DOB: 03/29/45 DOS: 11/19/08	MR# M00027375 = — cm	Weight: --- lbs = --- kg	

HR(ECG) Resp(ECG): 27 RPM PVC/min: ---

NSR



Print Time: 2008/11/19 20:06 Page 1 Panorama: CSER



8. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL-BASED PHYSICIANS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment ny hospital-based physician of any insurance or health plan benefits otherwise payable to or on alf of the patient for professional services rendered during this hospitalization of for outpatient service, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligation under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

9. HEALTH PLAN OBLIGATION: A list of such plans is available upon request from the Financial Office.

10. RELEASE OF INFORMATION: The hospital will obtain the patient's consent and authorization to release medical information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned has consented to the release of medical information to entities that provide care in post-acute setting. In accordance with the Safe Medical Device Act of 1990, the undersigned agrees that in the event a permanent medical device is implanted the hospital is hereby authorized to notify the manufacturer of patient's name, address, telephone number, and social security number (if available) as well as other information about the implantation. I authorize a copy of my record to be sent to my family physician or physician of referral at time of discharge.

sician Name/Address NONE

I authorize release of information regarding the birth of my child, as applicable.
___ Yes ___ No Initial _______

The hospital is authorized, without further action by or on behalf of the patient to disclose all or any part of the patient's record to any entity which is or may be liable to the hospital, patient or any entity affiliated with patient for all or part of the hospital's or hospital-based physicians' charges for the patient's rvices (including, without limitation, hospital or medical service companies, insurance companies, rkers' compensation carriers, welfare funds, patient's employer, or medical utilization review organization designed by the forgoing).

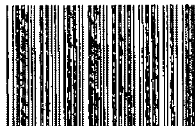
11. HOW YOUR BILL IS DETERMINED: Hospital charges include a basic daily rate, which covers your room, nursing care and food service, or outpatient/emergency services. Additional charges are made for special services ordered by your doctor. Operating room, surgical supplies, medications, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. **Physician charges are billed separately.** In addition to receiving bills for services rendered by the hospital and r personal physician, **you will receive separate bills from hospital-based physicians who ticipate in your care.** These physicians may represent any of the following areas: anesthesiology, radiology, pathology, nuclear medicine, cardiodiagnostics, and the like.

12. PARTICIPATION IN MEDICAL EDUCATION PROGRAM: (NA _______)
It is understood that this hospital is a teaching institution and that unless the hospital is notified to the contrary in writing, the undersigned may participate as a teaching subject in the medical education program of the hospital and may receive treatment by residents, if approved by the undersigned's attending physician, and those clinical students acting under appropriate supervision as required by such medical education and clinical training programs.

13. ORGAN DONATION: California State Law requires hospitals to have a method to identify potential organ and tissue donors. We want you to be aware of the need for organ and tissue donations and to provide you with the opportunity to let your wishes regarding participation be known. Have you signed an organ donor card? ___Yes X No

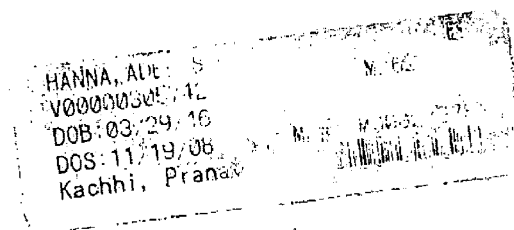
NDITIONS OF MISSION

PAGE 1 OF 2



070-011

PATIENT I.D.



PHSI-070-011 (6/08)

WHITE - CHART YELLOW - PATIENT PINK - BUSINESS OFFICE

CONDITIONS OF ADMISSION

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to procedures which may be performed during this hospitalization or on an outpatient basis, includ[illegible] emergency treatment or services and which may include, but are not limited to, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

2. NURSING CARE: The hospital provides only general-duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that the patient is not provided with such additional care.

3. PERSONAL VALUABLES: It is understood and agreed that the hospital maintain a fireproof safe for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited for loss of any pers[illegible] property which is deposited with the hospital for safekeeping is limited by statute to five hundred dol[illegible] ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

4. CONSENT TO PHOTOGRAPH: Photographs may be recorded to document the patient's progress of care and shall be part of the patient's medical records or physician's office medical record. I consent to this and the use of the same for scientific, education or research purposes if approved. Th[illegible] hospital/physician will retain ownership rights to the photographs as well as to the medical reco[illegible] Photographs may also be taken for the purpose of patient identification.

5. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: All physicians and surgeons furnishing services to the patients, including the radiologist, pathologist, anesthesiologist and the like are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to med[illegible] or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendere[illegible] the patient under the general and special instructions of the physician.

6. EMERGENCY OR LABORING PATIENTS: In accordance with Federal law, I understand my right to receive an appropriate medical screening examination performed by a doctor, or other qualified medical professional, to determine whether I am suffering from an emergency medical condition and, if such a condition exists, stabilizing treatment within the capabilities of the hospital's staff and facilities, even if I cannot pay for these services, do not have medical insurance or I am not entitled to Medicare or Medi-Cal. If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

7. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL: The undersigned irrevocably assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of all insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company or health plan shall discharge said insurance compan[illegible] health plan of any and all obligations under a policy to the extent of such payment. It is underst[illegible] by the undersigned that he/she is financially responsible for allowed charges not paid pursuant to this assignment.

NOTICE BY SIGNING THE CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. IF YOU DO NOT AGREE TO ARBITRATION, PLEASE INITIAL ___.

19. 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 (Paragraph 7) and Assignment of Health Plan Benefits (Paragraphs 8 and 9) set forth above.

Date/Time ___ Financially Responsible Party ___ Witness ___

Translator: I have accurately and completely read the forgoing document to

___
(name of patient / person legally authorized to give consent)

in ___
(the patient's or patient's representatives primary language.)

He/she understood all the terms and conditions and acknowledges his/her agreement thereto by signing this document in my presence.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF SERVICE, WHICH BECOME EFFECTIVE AT THE TIME SERVICE IS RENDERED.

[signature]
PATIENT / PARENT / CONSERVATOR / GUARDIAN

POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY

Wife
RELATIONSHIP TO PATIENT

[signature]
WITNESS

SIGNATURE OF TRANSLATOR

11/19/08
DATE OF SIGNING

1:34 pm
TIME OF SIGNING

Patient unable to sign: ___
(Reason)

CONDITIONS OF ADMISSION

PAGE 2 OF 2

070-011

PATIENT I.D.
HANNA, ADEL S.
V00000309742
DOB: 03/29/46
DOS: 11/19/08
M 62
MR# M0002737?
Kachhi, Pranav

PHSI-070-011 (6/06)

WHITE - CHART YELLOW - PATIENT PINK - BUSINESS OFFICE

CONDITIONS OF ADMISSION

14. FINANCIAL AGREEMENT: Not withstanding section (6), (Emergency or Laboring Patients) I further understand that I am responsible to the hospital and physician(s) for all reasonable charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the hospital, I understand that I will be responsible for collection expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law. In the event that hospital is not paid by third parties within three (3) months from the date of billing for payment, I will promptly make arrangements to pay the outstanding account.

NON-COVERED CHARGES: In the event that insurance does not cover particular procedures, medications, and/or services, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.

15. MEDICARE INSURANCE, BENEFITS AND EXCLUSIONS: If the patient is a Medicare beneficiary or will apply for Medicare benefits, the undersigned certifies that the information given about the patient is correct. It is also agreed and understood that we may release certain medical information about the patient to the Social Security Administration and/or its intermediaries and/or its carriers for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf. Some services may not be covered by Medicare, such as the following: 1) Workers Compensation, 2) Dental, 3) Cosmetic Surgery, 4) Custodial Care, 5) personal comfort Items, and/or any services determined to be unnecessary or unreasonable by Medicare. If the patient is not on file with the Social Security Administration, the usual billing procedures will be used independent of the data access.

16. IF YOU DO NOT HAVE INSURANCE: You may be eligible for the Charity Care and Discounted Payment Program. Please contact the business office.

17. WAIVER OF LIABILITY: I understand that some or all of these services may not be covered by Medicare and that I am financially responsible if these services are denied.

18. ARBITRATION OPTION: It is understood that any dispute as to medical malpractice, as to whether any medical services rendered under this Contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as approved by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Such arbitration shall be in accordance with the current Hospital Arbitration Regulations of the California Hospital Association-California Medical Association (copies available at Hospital's Admissions Office). This Mutual Arbitration Agreement shall apply to any legal claim or civil action in connection with this hospitalization or outpatient service against the Hospital or its employees and any doctor of medicine agreeing in writing to be bound by this provision. The execution of the Mutual Arbitration Agreement shall not be a precondition to the furnishing of services by the Hospital, and this Mutual Arbitration Agreement may be rescinded by written notice from the patient or patient's representative to the Hospital within 30 days of signature. The Mutual Arbitration Agreement shall bind the parties hereto and their heirs, representatives, executors, administrators, successors and assignees.

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedure. These 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 such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed operation or 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 consent to or to refuse any proposed operation or procedure at any time prior to its performance.

2. If your physician 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 physician will inform you of this and will provide you with information regarding blood transfusions. This information concerns the benefits and risks of the various options for blood transfusions, including pre donation by yourself or others. You also have the right to have adequate time before your procedure to arrange for pre donation, but you can waive this right if you do not wish to wait. You should understand that transfusions of blood or blood products involve certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV) and that 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 physician.

3. To make sure that you fully understand the operation or procedure, your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.

   Your signature on this form indicates that: (1) you have read and understood the information provided in this form, (2) the operation or procedure indicated on the back of this form, and its risks, benefits and alternatives have been adequately explained to you by your physician, (3) you have had a chance to ask questions, (4) you have received all of the information you desire concerning the operation or procedure, and (5) you authorize and consent to the performance of the operation or procedure and the anesthesia or sedation.

4. Your physician and surgeons have recommended the procedure(s) indicated on the back of this form.

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervision physician or surgeon named above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of this facility to whom supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants, or employees of the hospital or your supervising physician or surgeon. They are independent contractors and therefore are your agents, servants, or employees.

CONSENT TO SURGERY OR SPECIAL PROCEDURE

PAGE 1 OF 2

020-022

PATIENT I.D.

PHS: 020-022 (6/08)

Report of Operation

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedure. These 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 such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. You also have the right to be informed whether your physician has any independent medical research or economic interests related to the performance of the proposed operation or 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 consent to or to refuse any proposed operation or procedure at any time prior to its performance.

2. If your physician 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 physician will inform you of this and will provide you with information regarding blood transfusions. This information concerns the benefits and risks of the various options for blood transfusions, including pre donation by yourself or others. You also have the right to have adequate time before your procedure to arrange for pre donation, but you can waive this right if you do not wish to wait. You should understand that transfusions of blood or blood products involve certain risks, including the transmission of disease such as hepatitis or Human Immunodeficiency Virus (HIV) and that 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 physician.

3. To make sure that you fully understand the operation or procedure, your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have any questions, you are encouraged and expected to ask them.

   Your signature on this form indicates that: (1) you have read and understood the information provided in this form, (2) the operation or procedure indicated on the back of this form, and its risks, benefits and alternatives have been adequately explained to you by your physician, (3) you have had a chance to ask questions, (4) you have received all of the information you desire concerning the operation or procedure, and (5) you authorize and consent to the performance of the operation or procedure and the anesthesia or sedation.

4. Your physician and surgeons have recommended the procedure(s) indicated on the back of this form.

   Upon your authorization and consent, this operation or procedure, together with any different or further procedures which, in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervision physician or surgeon named above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists, and radiologists from the medical staff of this facility to whom supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants, or employees of the hospital or your supervising physician or surgeon. They are independent contractors and therefore are your agents, servants, or employees.

CONSENT TO SURGERY OR SPECIAL PROCEDURE

PAGE 1 OF 2

020-022

PATIENT I.D.

PHSI 020-022 (6/08)

To HANNA, ADEL
(Name of patient)

5. Your attending physician is Dr. LALLY, JAMES

and your supervising physician or surgeon is Dr. OH, ANTHONY

6. The location of the procedure / surgery is the ☐ LEFT ☐ RIGHT ☐ N/A

Procedure: COMPUTERIZED TOMOGRAPHY OF ABDOMEN AND PELVIS WITH INTRAVENOUS AND ORAL CONTRAST

7. In addition, your signature on this form indicates that:

(1) You authorize the pathologist to use his or her discretion in disposition or use of any member, organ, or other tissue removed from your person during the operation or procedure set forth above.

(2) Your request to forego resuscitative measures will apply while you are in an operating suite or postoperative recovery unless the hospital has obtained, prior to such surgery, a statement from you or your legal representative for health care decisions, to suspend your request to forego resuscitative measures, while in the operating suite or postoperative recovery room.

(3) You understand that there may be health care industry manufacturing representatives or similar visitors present in the operating room, and consent to this at the discretion and approval of the physician and hospital.

(4) You authorize your physician or his or her assistants to make photographs or videotape of the procedure for the purpose of medical research or education provided the photos or film do not reveal your identity or your name.

Date: 11/21/08 Time: 0930 AM / PM Signature: X [signature]
(Patient / Parent / Conservator / Guardian)

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

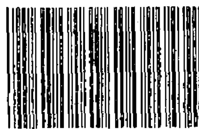
Witness: [signature] Registered Nurse
(Name / Title)

I have explained the risks of the above named procedure and the alternatives and their risks and benefits, and, if applicable, have assured that a copy of "A Patient's Guide to Blood Transfusion" has been given to the above named patient or patient's above name surrogate decision maker:

[signature] MD Date ____________ Time ____________ AM / PM
(Supervising Physician or Surgeon)

CONSENT TO SURGERY OR SPECIAL PROCEDURE

PAGE 2 OF 2



020-022

PATIENT I.D.
HANNA, ADEL S
V00000305742
DOB:03/29/46
DOS:11/19/08
Lally, James M.
IN
M/62
MR#: M000273781

PHSI 020-022 (8/08)

Date of Administration: 11/21/08

PRE-PROCEDURE INFORMATION

- ☐ Patient Complaint/Reason for exam Small Bowel Obstruction
- ☐ Consent Signed (YES)/NO BUN 11.0 CR 0.8 (IF AVAILABLE)
- ☐ Allergy History: (NKA) Other:
- ☐ Diabetic YES/(NO) If Yes, diabetic medication being taken
  Last Dose taken
- ☐ Hx of renal Insufficiency YES/(NO)
- ☐ Pregnant YES/(NO) LMP

IV INFORMATION

- ☐ Existing IV used Left wrist Flushes Freely.
- ☐ Central Venous Line used, Approved by Dr.
- ☐ IV Established 1-2-3-4 Attempt. Time : By
- ☐ IV Discontinued, Cath intact. Time: By

CONTRAST INFORMATION

- ☐ Time of Injection 1722 hrs
- ☐ Contrast Isovue 300/(370) Other
- ☐ Delivered by: Bolus Power Injector ✓
- ☐ Volume Delivered 100 CC Rate of: 2.5cc/Second

IF PATIENT IS A MINOR

- ☐ Patient Weight Contrast given at 1CC/LB or 2CC/KG
- ☐ Total Volume Given to Patient

PATIENT RESPONSE

- ☐ Reaction noted: NO ✓ YES ___ (See Nurses Notes for Detail)
- ☐ Teaching done with verbalized understanding of procedure noted (YES) / NO

FOLEY CATHETER INFORMATION

- ☐ Inserted using sterile technique
  @ By
- ☐ Contrast administered via catheter
  Cystografin CC via DRIP / BOLUS
  Isovue 300 / 370 CC via DRIP / BOLUS
  Other CC via DRIP / BOLUS

CONTRAST RECEIVED RECORD PLACED IN CHART UNDER PHYSICIANS ORDERS (YES)/NO
POST CONTRAST INSTRUCTIONS GIVEN (YES) / NO

Notes

SIGNATURES/TITLE: Jim Quinn RT **DATE:** 11/21/08

Chino Valley Medical Center

5451 WALNUT AVENUE
CHINO, CALIFORNIA 91710

CONTRAST ADMINISTRATION RECORD

WHITE - HIM JACKET YELLOW - JACKET PINK - DEPT.

003829 728.081 (4/02)

ADDRESSOGRAPH

HANNA, ADEL S IN
V00000305742 M/62
DOB: 03/29/46
DOS: 11/19/08 MR#: M00027378 1
Lally, James M.

ADVANCE DIRECTIVE
CM / SS / MDS

EDUCATION MATERIALS

Federal/State Laws and/or regulations require that we provide you with the following:

- ☒ Patient's Rights / Patient's Responsibilities
- ☐ An Important Message from Medicare
- ☒ Notice of Privacy Practices

☐ Inpatients will also receive:

- Your Right to Make Decisions About Medical Treatment
- An Invitation to Become a Member of Your Health Care Safety Team
- Understanding Your Pain
- Patient Safety
- Smoking Cessation Information
- Patient Guide
- Fall Risk Information
- Child Safety Seat
- Pneumococcal Vaccine Information
- Influenza Vaccine Information (During the Current Flu Season)

HEALTHCARE DIRECTIVE

Do you have a Healthcare Directive or a Living Will? ....☑ YES **Proceed to a.** ☐ NO **Proceed to b.**

a. Have you provided us with a copy? ☐ Yes ☑ No

1. If no, then note healthcare wishes below: ______

b. Do you wish to receive information on healthcare directives?............☐ YES ☐ NO

If you would like further information or assistance, please contact Social Services.

I permit Irma Kawaguchi to be involved in the care, treatment and service decisions during this hospital stay.

By signing below, I acknowledge that I have been provided the required **Educational Materials** and **Healthcare Directive** information as requested.

[signature] 11/19/08

Signature of Patient / Patient's Representative   Date / Time

Wife

If other than patient, indicate relationship.   Witness

For staff use only:

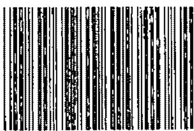
If you are unable to provide any of the above information to the patient because of an emergency treatment situation, describe below the good faith efforts that you made to provide such information to the patient:

______

______

Employee Signature   Date / Time

PATIENT RIGHTS ACKNOWLEDGEMENT



070-013

WHITE - CHART   **CANARY** - PATIENT

PHSI-070-013 (9/07)

Patient I.D.
HANNA, ADEL S
V00000305742
DOB: 03/29/46
DOS: 11/19/08
Kachhi, Pranav
ER
M/62
MR#: M000273781

Chino Valley Medical Center 5451 Walnut Avenue, Chino, CA 91710-2672 Printed 04/16/05 1336

Patient	Med. Rec/Unit #	Service/Location	Status	Date	Account/Transcription #
HANNA, ADEL	M000273781	TELEMETRY	DIS IN	04/15/05	V00000143675

PATIENT AD VIP Conf

Soc Sec No	DOB	Age	Sex	MS	Religion	FC
548-67-8932	03/29/46	59	M	M	CH	09

Race	Ethnicity	Maiden/Other Name	Reimb Class
OT	NON-HISPAN		FFS

Address: 13678 MONTEVERDE DRIVE
CHINO HILLS, CA 91709
Home Ph: (909)902-1147 County: SAN BERNARDINO

PATIENT EMPLOYER
CALIFORNIA INSTITUTE FOR MEN
14901 S CENTRAL AVE POX 128
CHINO,CA 91710
Work Phone: (909)606-7144
Occupation: DOCTOR

OCCURRENCES
11 DATE ONSET OF SYMPTOMS/ILLNESS 04/14/05 2300

GUARANTOR
HANNA, ADEL SS#: 548-67-8932
Address: 13678 MONTEVERDE DRIVE
CHINO HILLS,CA 91709
Home Ph: (909)902-1147 County: SAN BERNARDINO
Relationship to Patient: SELF / SAME AS

PERSON TO NOTIFY
KAWAGUCHI, IRMN Rel: FRIEND
Home Ph:(909)576-4143 Work Ph:

NEXT OF KIN
HANNA, TAMER Rel: SON
Home Ph:(949)413-8670 Work Ph:

INSURANCE #1
BLUE CROSS PRUDENT BUYER
PO BOX 60007
LOS ANGELES CA 900600007
Phone: (800)333-0912

Policy #: CPR226A67822
Coverage #:
Subscriber:
Rel to Pt: SELF / SAME AS PATIENT
Eff.: 08/01/00 to Rel Assign
Group: CB010A-BLUE CROSS PPO

AUTHORIZATION
Auth #:
Ins Verif:
Pro Review:
PA Code:

INSURANCE #2
Phone:

Policy #:
Coverage #:
Subscriber:
Rel to Pt:
Eff.: to Rel Assign
Group:

AUTHORIZATION
Treat/Precert:
Ins Verif:
Pro Review:
PA Code:

ADMISSION/REGISTRATION
Att Phy Lally, James M. Adm Phy Lally, James M. ED Phy Madahar, Ashok K.

Date	Time	Source	Adm. Priority	Rm/Bed	Arrival	Admitting Diagnosis/Reason for Visit	Admitted By
04/15/05	0251	ER	UR	235-B	CAR	CHEST PAIN RULE OUT UNSTABLE ANGINA	ADSDL

CODE NUMBER

CLINICAL SUMMARY

	PRINCIPAL DIAGNOSIS (THE CONDITION, AFTER STUDY, RESPONSIBLE FOR ADMISSION):
	CO-MORBIDITY(IES) (PRE-EXISTING CONDITION LENGTHENING HOSPITAL STAY):
	OPERATION(S)/PROCEDURE(S):

CONSULTANTS: DATE: SURGEON:

CONDITION ON DISCHARGE RECOVERED: ☐ IMPROVED: ☐ UNIMPROVED: ☐ NOT TREATED: ☐ DX: ☐ AHA: ☐ EXPIRED: ☐ AUTOPSY YES ☐ NO ☐

DISCH DISP
ASSEM 5r
ANALYZE
CODED
PERM
DOS 4/15 4/15/05

MDC

DRG

MD/DO

SIGNATURE OF ATTENDING PHYSICIAN

Chino Valley Medical Center

5451 Walnut Avenue, Chino, CA 91710-2672 — Printed 04/15/05 0047

Patient	Med. Rec/Unit #	Service/Location	Status	Date	Account/Transcription #
HANNA, ADEL	M000273781	EMERGENCY DEPART	REG ER	04/15/05	V00000143675

PATIENT AD VIP Conf

Soc Sec No	DOB	Age	Sex	MS	Religion	FC
548-67-8932	03/29/46	59	M	M	CH	09

Race	Ethnicity	Maiden/Other Name	Reimb Class
OT	NON-HISPAN		FFS

Address: 13678 MONTEVERDE DRIVE
CHINO HILLS, CA 91709
Home Ph: (909)902-1147 County: SAN BERNARDINO

PATIENT EMPLOYER

CALIFORNIA INSTITUTE FOR MEN
14901 S CENTRAL AVE POX 128
CHINO, CA 91710
Work Phone: (909)606-7144
Occupation: DOCTOR

GUARANTOR

HANNA, ADEL SS#: 548-67-8932
Address: 13678 MONTEVERDE DRIVE
CHINO HILLS, CA 91709
Home Ph: (909)902-1147 County: SAN BERNARDINO
Relationship to Patient: SELF / SAME AS PATIENT

GUARANTOR EMPLOYER

CALIFORNIA INSTITUTE FOR MEN
14901 S CENTRAL AVE POX 128
CHINO, CA 91710
Work Phone: (909)606-7144
Occupation: DOCTOR

OTHER GUARANTOR

SS#: --
Address:
Home Ph: County:
Relationship to Patient:

OTHER GUARANTOR EMPLOYER

Work Phone:
Occupation:

PERSON TO NOTIFY

KAWAGUCHI, IRMN
13678 MONTEVERDE DRIVE
CHINO HILLS, CA 91709
Home Ph: (909)576-4143 Work Ph:
Relationship to Patient: FRIEND

NEXT OF KIN

HANNA, TAMER
13678 MONTEVERDE DRIVE
CHINO HILLS, CA 91709
Home Ph: (949)413-8670 Work Ph:
Relationship to Patient: SON

INSURANCE #1

BLUE CROSS PRUDENT BUYER
PO BOX 60007
LOS ANGELES CA 900600007
Phone: (800)333-0912

Policy #: CPR226A67822
Coverage #:
Subscriber:
Rel to Pt: SELF / SAME AS PATIENT
Eff.: 01/01/01 to Rel Assign
Group: CB010A-BLUE CROSS PPO

AUTHORIZATION

Auth #:
Ins Verif:
Pro Review:
PA Code:

INSURANCE #2

Phone:

Policy #:
Coverage #:
Subscriber:
Rel to Pt:
Eff.: to Rel Assign
Group:

AUTHORIZATION

Treat/Precert:
Ins Verif:
Pro Review:
PA Code:

INSURANCE #3

Phone:

Policy #:
Coverage #:
Subscriber:
Rel to Pt:
Eff.: to Rel Assign
Group:

AUTHORIZATION

Treat/Precert:
Ins Verif:
Pro Review:
PA Code:

OCCURRENCES

Code	Type	Date	Time
11	DATE ONSET OF SYMPTOMS/ILLNESS	04/14/05	2300

CONDITIONS

Code Type

Special Program

OB/Type of Delivery

Last Hospitalization

Admission Comment

Financial Class
09

ADMISSION/REGISTRATION

Attending Physician

Admitting Physician

Emergency Room Physician
Madahar, Ashok K.

Prim Care Physician
NONSTAFF, PHYS

Family Physician

Other Physician

ADMISSION/REGISTRATION

Date	Time	Source	Adm. Priority	Rm/Bed	Arrival	Admitting Diagnosis/Reason for Visit	Admitted By
04/15/05	0018	HOM	UR		CAR	CHEST PAIN	ADSDL

FOR HIM USE ONLY** ASSEMBLE______ ANALYZE______ CODE______ PERM______ DOS______

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF ADMISSION: 04/15/2005
DATE OF DISCHARGE: 04/15/2005

cc: James M. Lally, D.O.
Raj Yande, RES D.O.

ADMITTING DIAGNOSES:
Chest pain.
Hiatal hernia.
Hypertension.
Dehydration.

CAUSE FOR ADMISSION:
Chest pain x1 day. The patient is a 59-year-old Hispanic male who complained of chest pain, which started at 0930 hours in the morning of 04/15/2005. The patient stated that the pain was 7/10 and it became progressively worse. The pain was retrosternal. The pain became progressively worse at 7/10, was retrosternal and described as a sharp pain, and may wax and wane throughout the course of the day. The patient eventually sought treatment in the emergency department. He was given nitroglycerin and aspirin as well as Nitro paste in the emergency room and his pain decreased to 3/10.

CONSULTATIONS:
None.

PROCEDURE:
EKG was performed in the emergency room and later repeated. The patient was in normal sinus rhythm in both EKGs with no ST segment changes. A chest x-ray was done and it showed no disease. The patient received IV normal saline at 75 cc per hour and cardiac monitoring was performed. The patient remained in normal sinus rhythm in telemetry.

HISTORY & PHYSICAL:
As dictated.

LABORATORY AND STUDIES:
As charted.

SUMMARY OF HOSPITAL COURSE:
The patient was admitted to the direct observation unit, on telemetry, and started with chest pain protocol. His pain remained decreased once on the floor with 2-3/10. Cardiac enzymes were

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF ADMISSION: 04/15/2005
DATE OF DISCHARGE: 04/15/2005

negative x2 sets and as previously described, EKG remained in normal sinus with no acute changes. The patient was reevaluated and found to be stable for discharge.

DISPOSITION:
The patient is being discharged via private automobile.

FOLLOW UP:
He is to follow up with his primary care doctor and has an appointment with Dr. Agarwal, cardiology at 1100 hours today. The patient and family are aware of the diagnoses and procedures and in agreement with the plan of treatment.

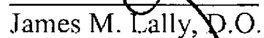
DIET:
The patient is to be on a low cholesterol and low sodium diet.

ACTIVITY:
As tolerated.

MEDICATIONS:
He is to continue his previous home medications.

POINT OF CONTACT:
The patient's son, Tamer Hanna at #949-413-8760.

Raj Yande, RES D.O.



James M. Lally, D.O.

DR: RY/VIN
DD: 04/15/2005 09:45
DT: 04/15/2005 21:45
Job #: 906574

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) 464-8600
Robert M. Bearman, M.D., Medical Director

DISCHARGE SUMMARY REPORT

PATIENT: HANNA,ADEL
REG DR: Lally, James M

ACCT #: V00000143675 LOC: DU
AGE/SX: 59/M ROOM: 235
DOB: 03/29/46 BED: B
STATUS: DIS IN TLOC:

U #: M000273781
REG: 04/15/05
DIS: 04/15/05

**** HEMATOLOGY ****

Day	1							Reference	Units
Date	04/15/05								
Time	0055								
WBC	3.9 L							(4.5-11.0)	K/mm3
RBC	4.85							(4.52-5.90)	M/mm3
HGB	13.8							(13.0-18.0)	g/dL
HCT	42							(42-52)	%
MCV	86							(80-99)	fl
MCH	29							(27-31)	pg
MCHC	33							(32-37)	pg
RDW	13.2							(11.5-14.5)	%
PLT	168							(130-400)	x10^3m
MPV	10.0							(7.4-10.4)	fl
NEUT %	53.6							(40-70)	%
LYMPH %	31.5							(25-45)	%
MONO %	7.1							(2.5-10.0)	%
EOS %	7.2							(0.0-11.0)	%
BASO %	0.6							(0-2)	%
NE#	2.0							(1.8-7.7)	10^3/u
LY #	1.2							(1.0-4.8)	10^3/u
MO #	0.3							(0-0.8)	10^3/u
EO#	0.3							(0-0.5)	10^3/u
BA#	0.0							(0-0.2)	10^3/u
MANUAL DIFF REQ	NO								

**** COAGULATION ****

Day	1							Reference	Units
Date	04/15/05								
Time	0055								
PROTIME	11.8							(10.8-13.34)	sec
INR	1.00							(0-3.0)	
PTT	27.1							(22.00-35.6)	sec

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) [illegible]-8600
Robert M. Bearman, M.D., Medical Director

DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL	59/M	DU	V00000143675	Lally, James M.

**** CHEMISTRY ****

Day	1				
Date	04/15/05				
Time	0835	0055	0055	Reference	Units
NA			139	(135-148)	mmol/L
K			3.9	(3.5-5.1)	mmol/L
CL			107	(98-108)	mmol/L
CO2			26.7	(21-34)	mmol/L
GLUCOSE			105	(71-117)	mg/dL
BUN			21.0 H	(7.0-18.0)	mg/dL
CREAT			1.0	(0.5-1.4)	mg/dL
TOTAL PROT			6.9	(6.3-8.2)	g/dL
ALB			3.7	(3.4-5.0)	g/dL
GLOB			3.2	(1.5-3.5)	g/dL
A/G			1.2	(1.1-1.8)	g/dL
CA			9.0	(8.8-10.5)	mg/dL
BILI TOTAL			0.34	(0.3-1.2)	mg/dL
AST/SGOT			14 L	(15-37)	U/L
ALT/SGPT			33	(30-65)	U/L
ALK PHOS			49 L	(50-136)	U/L
CK	48		62	(21-232)	U/L
AMYLASE		43		(25-115)	U/L
LIPASE		281		(114-286)	U/L
MAGNESIUM		2.5 H		(1.8-2.4)	mg/dL
CHOL			134 L	(135-200)	mg/dL
HDL			31 L	(32-96)	mg/dL
CKMB	0.8(a)	0.8(a)		(0-5.0)	ng/mL
CKMBI	(b)			(0-2.5)	%
MYOGLOBIN		24.0		(12-110)	ng/mL
TROPONIN I	0.07		0.07	(<1.5)	ng/mL

NOTES: (a) ******** CKMB NORMAL RANGE ********

0 - 2.2 ng/mL For Healthy Patients

0 - 5.6 ng/mL For Patients with a History of Cardiac pathologies, but who are currently not experiencing a Myocardial Infarction.

(b) Test not performed
See also (c)

(c) NOTE: CK-MB is inconclusive if only the CK-MB or the CKMB INDEX is elevated, but not both.

Patient: HANNA,ADEL Age/Sex: 59/M Acct#V00000143675 Unit#M000273781

000121 (6/96)

HANNA, ADEL

Admitted: **04/15/05 at 0251**
Room/Bed: **235 B**
Attending: **Lally, James M.**

Chino Valley Medical Center

AGRN04
Acct: V00000143675
Unit: M000273781

DISCHARGE INSTRUCTIONS 04/15/05 0956 RN4

Please bring this sheet with you to your follow up visit with: C. AGARWAL
on (Date/Time): 04/15/05 1100 ** OR **
Call for an appointment before: Physician's Office Number: 909-620-0900
Discharge Date: 04/15/05 Discharge Time: Discharge To: HOME - NO NEEDS
: By: AUTOMOBILE Via: WHEELCHAIR
Accompanied By:
Discharge Comment:
General Condition on Discharge:
Vital Signs: Temperature/F: 97.7 Respirations: 20 Blood Pressure: 102/70 Pulse: 61
Pain Controlled by Oral Medications: YES
Comment:
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool: Y
Comment:
Wound/Incision Assessment:
Photograph Taken On Discharge and Placed On Chart: N
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions: LIGHT ACTIVITY ONLY
Bath: SHOWER Other:
Diet: LOW CHOLESTEROL Calories:
Restrictions:
Additional Education given:
: MD FOLLOW UP :
: WORSENING SYMPTOMS :
: FOOD/DRUG INTERACTIONS :
Comment:

Prescriptions/Education given: N Food/Drug Interaction Form Given: Y
List DC Meds and Time next dose is due (if applicable):
: NONE
:
:
:
Wound/skin care: N
:
:
Special Instructions:
:
:
Sent Home With All Belongings: Y Personal Belongings Inventory Reviewed/Signed: Y
Discharge Instructions Reviewed With: PATIENT Printed Instructions Given: Y

Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health: N
Agency Name/Phone #:
Arranged By:
Other:

If you smoke, it is recommended that you quit. Please contact the American Cancer Society - 800-227-2345 or the American Lung Association - 800-LUNGUSA for assistance.

If you were treated at this hospital for any respiratory condition, such as pneumonia, it is recommended that you follow up with your primary care physician to be evaluated for a pneumococcal vaccine. If you do not have a primary care physician, please contact the local public health clinic to find out where this vaccine may be available.

HANNA,ADEL

Admitted: **04/15/05 at 0251**
Room/Bed: **235 B**
Attending: **Lally, James M.**

Chino Valley Medical Center

AGRNG4
Acct: V00000143675
Unit: M000273781

DISCHARGE INSTRUCTIONS 04/15/05 0956 RN4

I have received a copy of these instructions and they have been explained to me and I understand the instructions.
Patient/Family Signature: ____________ Date: 4.15.05

RN/LVN Signature: ____________ Date: ____________

** This is Part of Patient's Permanent Medical Record **

Monogram	Initials	Name	Nurse Type
RN4	AGRN04	Agency,RN 4	RN

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF EVALUATION: 04/14/2005
TIME SEEN: 0210 Hours

cc:

DISPOSITION AND ADMISSION NOTE

The patient is feeling better 100% pain-free after nitroglycerin. At the time of this dictation, his blood pressure is normal. Heart rate is 58, is in sinus rhythm and saturation is 98%.

TEST RESULTS:
A 12-lead EKG, is also comparable to the one done earlier. Chest x-ray shows atelectasis at the bases, but no acute pathology. Count is normal with no sign of infection, anemia, or platelet count abnormality. Chem-7 shows no electrolyte imbalance, dehydration, metabolic derangement or glucose intolerance. No liver or renal pathology. CK and troponin are normal. No evidence of myocardial damage. Cholesterol is normal.

Given his history, he is very classic in response, is certain and definite. Given these findings, I discussed the case with Dr. Takhar who agreed with admission to the hospital for ongoing care and evaluation. The patient was admitted to telemetry bed.

DIAGNOSTIC IMPRESSION:
1. Chest pain, rule out unstable angina.
2. Hypertension, controlled.
3. Past tobacco abuse.

PULSE OXIMETRY INTERPRETATION:
The pulse oximetry was 97% on room air is normal.

RHYTHM STRIP INTERPRETATION:
The patient is in sinus rhythm with no ectopy, a normal rhythm.

EKG INTERPRETATION:
EKG done at 0050 hours, revealed a heart rate of 69. The patient is in sinus rhythm with no ectopy. Intervals are normal. Axis is normal. No QRS configuration abnormality. The patient has Q waves in leads II, III and aVF and a subtle upward curving of the ST segment, which is nonspecific, but comparable to the EKG done about three hours ago, a borderline EKG.

ACCOUNT #:	V00000143675
PATIENT:	HANNA, ADEL
DATE OF EVALUATION:	04/14/2005
TIME SEEN:	0210 Hours

Ashok K. Madahar, M.D.

DR:	AKM/HIM/FXS
DD:	04/15/2005 02:15
DT:	04/15/2005 04:15
Job #:	906532

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF EVALUATION: 04/15/2005
TIME SEEN: 0034 Hours

cc:

MODE OF ARRIVAL:
Private car.

CHIEF COMPLAINT:
Chest pressure.

PRE-HOSPITAL CARE:
The patient had an EKG done, which was normal.

HISTORY OF PRESENT ILLNESS:
The patient is a 59-year-old Caucasian male, who while attending a meeting this morning, he had a substernal pressure type sensation radiating to his jaw and the right arm. He looked pale and sick to the staff members. They told to him to go home. He went home and rested, tried to fall asleep, but the pain continued rating from 4-7 on a 0/10 scale. He thought it is his hiatal hernia and took Mylanta without any relief. Then the pain continued, eventually he decided to get an EKG done.

The patient is a psychiatrist. He had an EKG done, which was read by machine as normal, but the symptoms continued, thus he came to this hospital for an evaluation.

His coronary risk factors are positive for his age, male gender, past smoking, hypertension, and a strong family history. Three brothers died of sudden death and one brother had quadruple bypass. Three of them were younger than him. His cholesterol is normal.

PAST MEDICAL HISTORY:
Hypertension, migraine headaches, and hiatal hernia.

IMMUNIZATION STATUS:
Unknown.

ALLERGIES:
Reglan.

CURRENT MEDICATIONS:
Diovan.

SOCIAL HISTORY:
The patient is a psychiatrist. He used to be thoracic surgeon in his native country Egypt. He lives with his family.

REVIEW OF SYSTEMS:
GENERAL: No documented fever. Appetite has been good. HEENT: He suffered from migraine headaches. He used to take atenolol and recently changed to Diovan. Denies any strokes, seizures, or blackouts. EYES: No double vision, cataracts, or glaucoma. Does wear corrective lenses. HEMATOLOGIC: No history of anemia or bleeding diathesis. Not on any anticoagulants. Does take a baby aspirin a day. PULMONARY: No cough, cold, or asthma. CARDIOVASCULAR: As per present illness. Seven years ago he had an angiogram, which was normal. GI: History of hiatal hernia and has surgery for it. Denies vomiting of blood or black stool. Recent bowel habit changed. GU: Denies frequency, urgency, or hematuria. Prostate is slightly enlarged. Surgery for hiatal hernia. Rests are negative.

PHYSICAL EXAMINATION:
GENERAL: The patient is a conscious, alert, ambulatory, middle-aged male, in no apparent distress.
VITAL SIGNS: Blood pressure 132/72, pulse 71, respirations 20, and temperature 97.5 degrees.
HEENT: Atraumatic, normocephalic. Nares, pharynx and TMs are clear. Eyes are anicteric. Pupils are equal and reactive to light.
NECK: Supple and nontender on flexion. No lymph node. Trachea is midline.
CHEST: Clear. No wheezing. Bilateral equal air movement.
CARDIOVASCULAR: S1 and S2 are normal. No murmur and no gallops.
ABDOMEN: Soft and nontender. No organomegaly. Bowel sounds are present. Hernia site is normal. CVA is clear and nontender.
NEUROLOGIC: The patient awake, alert, and ambulatory. Cranial nerves are intact. No focality. Reflexes are brisk. Babinski plantar.
EXTREMITIES: No edema or cyanosis. No calf tenderness. No femoral delay or deficit. All pulses are equal.
SKIN: No rashes noted.

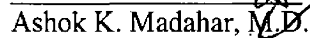
MEDICAL DECISION MAKING:
The patient's history is classic for angina. EKG done at the facility where he was working showed possibly an old inferior wall MI, otherwise unremarkable. EKG done here has similar changes, but nothing acute. Cardiac workup has been initiated.

ACCOUNT #:	V00000143675
PATIENT:	HANNA, ADEL
DATE OF EVALUATION:	04/15/2005
TIME SEEN:	0034 Hours

He will be treated with sublingual nitro, nitro paste, and aspirin. Supplemental O2 has been placed.

FINAL DISPOSITION:
He will require admission for ongoing evaluation of his symptoms.

INTERIM DIAGNOSTIC IMPRESSION:
Chest pain.



Ashok K. Madahar, M.D.

DR:	AKM/ORJ
DD:	04/15/2005 00:58
DT:	04/15/2005 12:58
Job #:	906523

Please sign in and fill out the following information
Por Favor Firme y completa la siguente informacion

Patient's Name: Adel Hanna Time arrived: 12:18
Nombre del paciente Hora que llego

Social Security number: 548-67-8932 Date of Birth 3-24-46
Numero de Seguro Social Fecha de Nacimiento

Home address: 13678 Monteverde Dr. City: Chino Hills Zip: 91709
Domicilio Ciudad Zona Postal

Telephone
Telefono

What is your medical complaint?
Cual es su problema medico?

Physician Name:
Nombre del doctor

Have you ever been in this hospital before? Yes No
Ha venido a este hospital antes? Si No

This area is for the nurse to complete *Solo para la enfermera*

LEVEL: 1 2 3

SEX: M F Infant / Child / Adult

Arrived By: Ambulance Walk-In

Disposition: ☐ Waiting Room pending available bed
☐ ______

Physician Name: ______

Bed # ______ Triage Nurse Name: CHINO VALLEY MEDICAL CENTER

PERMANENT PART OF MEDICAL RECORD

Chino Valley Medical Center
5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710

ER SIGN IN SHEET

000149 780.008 (06/02)

ADDRESSOGRAPH
HANNA, ADEL 59 /M
M000273781 DOB 03/29/46
DOS 04/15/05
ER DR. MADAHAR, ASHOK K.
PRIM DR. NONSTAFF, PHYS

TIME MD	ORDER	TIME CLERK
	GENERAL	
	CBC	
	BMP	
	CMP	
	UA (total)	
	ABDOMEN PANEL	
	Amylase/Lipase	
	LFTs	
	Serum Ammonia	
	HEART	
	EKG	
	Cardiac Panel	
	BNP	
	Troponin	
	PT/PTT/ INR	
	D-Dimer	
	GYN	
	HCG Blood Quantitative	
	Urine: dip stick/HCG POC/HCG by lab	
	Vag Discharge Panel	
	Blood Type & Rh	
	FHTs	
	RESPIRATORY	
	Peak Flow before/after tx.	
	HHN Albuterol 2.5/5.0 mg	
	Atrovent 0.5 mgs	
	Continuous HHN Albuterol	
	Cool Mist Tx	
	Racemic Epinephrine	
	ABG on ______	
	TRAUMA/ACTIVE BLEEDING	
	Hb/HCT	
	Repeat Hb/HCT 1 hour later	
	TC/TS ______ U PRBC	
	PANELS	
	Needlestick	
	Lumber Puncture	
	TOXICOLOGY	
	Urine Drug Screen	
	Digoxin ASA / Acetaminophen	
	EtoH Dilantin Other: ______	
	CULTURES	
	Blood x 1 / 2 / 3	
	Urine / Sputum / Stool	
	Other ______	
	RADIOLOGY	
	CXR	
	C-Spine	
	Other 1	
	2	
	3	
	CT SCAN ______	
	Contrast: IV / PO / Rectal	
	ULTRASOUND	
	MISCELLANEOUS ORDERS	
	1)	
	2)	
	Prior Record in House / EKG / ED	
	Old E.R. Dictation	
	Calls to ______	
	Time: ( ) ( ) ( )	
	Pre-Book Y( ) N( )	
	Time: ______ Call To ______	
	MSE Completed ☐	

CURRENT MEDICATIONS Diovan, ? Hatel ? Henr?

METHOD OF ARRIVAL POV

CHIEF COMPLAINT Chest pain 5'8"

TEMP 97 PULSE 71 RESP 20 B/P 132/72 OX RA 97 WT. 164# kgs LMP ______

0031 TRIAGE | TO ROOM | 0034 M.D. EVAL | VERBAL CONSENT TO TREAT ☐ | Allergies: REGLAN (NKDA)

Physical Exam: Pertinent Findings

REVIEW OF SYSTEMS

GEN: Fever, Wt. loss
EYE: Visual changes, Pain
ENT: Congestion, Sore Throat
Cv: CP: Palpitations, DOE, PND, Edema
RESP. SOB: Cough
GI: Abd pain, N/V/D
GU: Dysuria, Vag bleeding
GYNE: LMP, Gravida, Para, d/c, Sexual history
MUSC / SKEL: Joint pain, Back pain
DERM: Rash Puritis
NEURO: HA, Vertigo
PSYC. Hallucinations, Stress
ENDO. Polyuria, Polydipsia
HEME: Abnormal bruising, Bleeding
PEDS: Birth history, Temp, Birth weight, Feeding behavior, Eye discharge, Bowel habit

PHYSICAL EXAM
List all positive and pertinent negative responses then "all other negative" acceptable)

SYSTEM		ELEMENT
1.	Constitution	Vitals, Appearance
2.	Eyes	Pupils, Conjunctiva, Fundi
3.	Ears, Nose, Mouth & Throat	TM's, Oropharynx
4.	Neck	Masses, Tracheal position, Thyroid
5.	Respiratory	Effort, Auscultation, Percussion
6.	CV	PMI, Murmurs
7.	GI	Tenderness, HSM, Hernias, Rectal
8.	Genitourinary (Female)	Lesions, Bimanual exam
	(Male)	Penis, Testicles, Prostate
9.	Lymphatic	Nodes (axillae, groin, neck)
10.	Musculoskeletal	Gait, Clubbing
11.	Neurological	CNS, DTR's, Sensation
12.	Psychiatric	Orientation, Judgement
13.	Skin	Inspection (Rash, Ulcers)
		Palpitation (Nodules)
		Laceration Size

0145

TIME ORDERED	M.D. ORDERS (Standing and Additional)	MARK DONE & INITIALS	TIME
	(O₂ Via Nasal Cannula) / Mask / Other 2 l/m NC	☐	
	(IV Heplock / Saline Lock) / Bolus of ______	☐	
	IV of ______ to run at rate of ______	☐	
	(Cardiac Monitoring) P.O. Fluid Challenge Pulse Ox	☐	
	☐ Pain Protocol M ☐ Pain Protocol F	☐	
	NTG 0.4mg S/L q 5mts X2	☑ [illegible]	0140
	Nitropaste 1"	☐ [illegible]	0140
	ASA 325mg PO	☑	
		☐ [illegible]	[illegible]
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
	I have reviewed the ED Nursing Notes ☑ I have reviewed the prehospital care documents ☐	☐	

DIAGNOSTIC IMPRESSION
1. CP R/O unstable angina
2. HTN / ? ETOH abuse
3.
4.

☐ Admit here ☐ Transfer to ______	Accepting Physician Dr. Takhar	Time Accepted 0155	Level of Care Tele

Disposition (circle) Home (Admit Here) **Condition on d/c**
Transfer to ______ Accepted By: ______ Time ______ ☐ Stable ☐ Fair ☑ Serious ☐ Critical.
Discharge to (Other): ______ Transfer Via EMT / ACLS / Auto
Expired in ED DOA AMA / LWBS by MD / Eloped Post MD Eval

Dictated Y N (purposely) Job# 906523 / 906532

Examining Physician Signature | Date

ADDRESSOGRAPH

Chino Valley Medical Center
5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710

EMERGENCY DEPARTMENT
PHYSICIAN RECORD

WHITE - CHART CANARY - BUSINESS OFFICE PINK - E.R. PHYSICIAN
000131 780.003 (06/03)

DOB
HANNA, ADEL

Adm 4-15-05 D/C 4-15-05

RUN DATE: 04/16/05 RUN TIME: 0926 RUN USER: HIRG	Chino Valley Med Center EDM **LIVE** EDM Patient Record	PAGE 1

Patient HANNA,ADEL Account No: V00000143675
Age/Sex 59/M Unit No: M000273781

—ER Caregivers— Triage Date 04/15/05
Physician Madahar,Ashok K. Time 0018
Practitioner
Nurse ED Agency RN

PCP Lally, James M.

Stated Complaint CHEST PAIN RULE OUT UNSTABLE ANGINA
Chief Complaint CHEST PAIN
Priority

Departure Disposition XTR TO INTERNAL ACUTE CARE Departure Date 04/15/05
Departure Diagnosis CHEST PAIN R/O UNSTABLE ANGINA Time 0335
Departure Comment

Patient Notes

ED Agency RN - 04/15/05 - 0106
PT TO BED 7. MD HAS EXAMINED. PT ON O2 AT 2L. PT HAS NITRO TO CW. 0.4MG SL. ON MONITOR.

ED Agency RN - 04/15/05 - 0233
LAB RESULTS PENDING. PT HAS NO CHEST PAIN TO REPORT. 0/10 ON PAIN SCALE. WILL CONTINUE TO MONITOR.

ED Agency RN - 04/15/05 - 0334
PT REPORT CALLED TO EDNA. PT TO FLOOR BY GUENEY.

Assessments

Triage

Date 04/15/05 Time 0034 User EDAGRN01 ED Agency RN

Insurance: BLUE CROSS PRUDENT BUYER Patient Age: 59 Workers Comp: N
TRIAGE LEVEL: 1 Temperature/F: 97.5
Time: 0034 Date: 04/15/05 Source: ORAL
Mode: WALK-IN Pulse: 71 Respirations: 20
Informant: PATIENT Blood Pressure: 132/73 SpO2 (%): 97
MICN Run: N Weight - Lb: 165 Oz: Kg: 74.84
Pain Scale:

Chief Complaint: CHEST PAIN
Mode of Injury: N/A Tetanus UTD:
LMP:

Medications: DIOVAN
Allergies:
=== MEDICAL HISTORY ===

Prior Hx: Y	Asthma:	Arrythmia:	DM:	Seizures:
	COPD:	HTN: Y	Liver:	Dementia:
	Cardiac:	CVA:	Renal:	Psych:
	CHF:	TIA:	Thyroid:	Other:

Patient HANNA,ADEL Account No V00000143675
Age/Sex 59/M Unit No M000273781

ED Assessment

Date 04/15/05 Time 0039 User EDAGRN01 ED Agency RN

===NEUROLOGICAL ASSESSMENT===
NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro History:
Speech:
Headaches: Describe:
Behavior/Appearance Inappropriate: Describe:
== GLASGOW COMA SCORE === (Best Response) == PUPIL REACTION CHECK ==
Eye Response: Reaction OD:
Verbal Response: Size:
Motor Response: Reaction OS:
Total: Size:
=== SEIZURE INFORMATION ===
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Duration of Seizure: Seconds
Seizure Comment:
Additional Neuro Assessment Performed and WNL: Y
Memory:
Thought Process:
Weakness: Specify:
Numbness: Specify:
Facial Droop: Describe:
Neuro Comment:
===RESPIRATORY ASSESSMENT===
RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Location:
Breath Sounds: Location:
Effort: Chest Expansion:
Cough: Color:
IF ON OXYGEN
02 @: Via:
Pulse Oximetry: Sp02 (%): Probe Location:
Comment:
====CARDIAC ASSESSMENT====
CARDIAC Assessment Within Normal Limits: N
Chest Pain: Y
Provoked: N
Quality: PRE
Radiating: N Location/Describe:
Pain Level: 2
Time/Duration: ALL DAY
Heart Rate Irregular: N Vertigo/Dizziness: N
Syncope/Fainting: N
Pt placed on 02: N
02 @: Via:
Pt placed on Cardiac Monitor: Y
Cardiac Rhythm: NORMAL SINUS RHYTHM
Comment:
===GASTROINTESTINAL ASSESSMENT===

GASTROINTESTINAL Assessment Within Normal Limits: Y
Abdominal Appearance:
Abdominal Pain: Location:
Nausea: Vomiting: Diarrhea: Constipation:
GI Bleeding:
Emesis: Rectal:
Ostomy:
==Last PO Intake==
Food:
Fluid:
Comment:
GI Comment:
===UROLOGICAL ASSESSMENT===
UROLOGY Assessment Within Normal Limits: Y
Pain/Dysuria:
Burning:
Frequency:
Incontinence:
Hematuria:
Retention:
Anuria:
Foley Cath PTA:
Other:
===GYNECOLOGICAL ASSESSMENT===
GYNECOLOGICAL Assessment Within Normal Limits:
LMP:
EDC: Gestation Weeks: Days:
Gravida: Para: SAB: TAB:
Vaginal Bleeding:
Tissue Passed:
# of Pads Last Hour:
Vaginal Discharge:
Malodorous:
Pelvic Pain:
Describe:
Comment:
===SKIN ASSESSMENT===
SKIN Assessment Within Normal Limits: Y
Skin Color:
Skin Moisture:
Skin Temperature:
Turgor:
Skin Integrity:
Rash:
Type/Describe:
Comment:
===NEUROVASCULAR ASSESSMENT===
NEUROVASCULAR Assessment Within Normal Limits: Y
RA Within Normal Limits:
Temp: Pulse: Sensation: Mobility:
LA Within Normal Limits:
Temp: Pulse: Sensation: Mobility:
RL Within Normal Limits:

Patient HANNA,ADEL Account No V00000143675
Age/Sex 59/M Unit No M000273781

Temp: Pulse: Sensation: Mobility:
LL Within Normal Limits:
Temp: Pulse: Sensation: Mobility:
Comment:
===EYE ASSESSMENT===
EYE Assessment Within Normal Limits: Y
Visual Acuity OD: OS:
Pain: Location: Pain Level:
Foreign Body: Location:
Redness: Location:
Drainage: Location:
Cataract: Location:
Glasses:
Contact Lenses:
Blind:
Comment:
===EAR ASSESSMENT===
EAR Assessment Within Normal Limits Y
Pain: Location: Pain Scale:
Discharge: Location:
Foreign Body: Location:
Hearing Aid: Location:
Tinnitus:
Comment:
===NOSE ASSESSMENT===
NOSE Assessment Within Normal Limits: Y
Pain: :
Foreign Body: :
Deformity: :
Drainage: :
Nasal Packing: :
Comment:

Personal Belongings List

Date 04/15/05 Time 0324 User EDAGRN01 ED Agency RN

Inventory Date: Inventory Time: Performed By: ED Agency RN
Reason For Inventory:

- Contacts -Y Glasses Disposition:

- Full Dentures Disposition:
- Partial Upper - Lower Disposition:
- Hearing Aid Disposition:

- Prosthesis Describe: Disposition:
- Assistive Device : Disposition:

Jewelry: WATCH Jewelry:
Describe: BLACK Describe:
Disposition: BELONGINGS KEPT BY PT Disposition:

Patient HANNA,ADEL Account No. V00000143675
Age/Sex 59/M Unit No. M000273781

Jewelry: Jewelry:
Describe: Decribe:
Disposition: Disposition:

- Wallet Describe: Disposition:
- Purse Describe: Disposition:

Comment:
:

- Electrical Appliances Describe:
- Eng. Dept Notified To Evaluate Electrical Appliance

Other Item(s) Of Value To The Patient: BLACK SHOES, BLACK SOCKS, WHITE SHIRT, GREY
: SHOES
Disposition: BELONGINGS KEPT BY PT

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/
Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up.
If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends,
I Release Chino Valley Medical Center From Any Liability For Lost Valuables.
I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times,
And I Understand That The Hospital Assumes No Liability For Such Equipment.

PATIENT:______________________ Date:__________
WITNESS:______________________

By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge.

PATIENT:______________________ Date:__________

WITNESS:______________________

ED Discharge

Date 04/15/05 Time 0335 User EDAGRN01 ED Agency RN

==DISCHARGE/DISPOSITION==

Home: N
Time:
Accompanied By:
Mode:
Aftercare Instructions Given:
Pt Verbalizes Understanding:

Admit/Transfer/Other: Y
Time: 0335
Disposition: ADMIT
Facility/Room: DOU 235
Accompanied By: NURSE
Mode: GURNEY
Report Called To: EDNA
Personal Belongings Sent With Patient: Y
Patient Belongings Sent with Family: Y

Blood Pressure: 132/73 Pulse: 64 Respirations: 20 Temperature/F: 97.8 SpO2 (%): 97
Pain Level: 0 Condition on Discharge: STABLE
IV DC'd: N Angiocath Intact: Y Foley Cath DC'd: Amount Emptied:
Comment:

Patient: HANNA,ADEL Account No. V00000143675
Age/Sex: 59/M Unit No. M000273781

Radiology

RADIOLOGY
Exam: XR CHEST: 1V (AP/PA)
Date: 04/15/05 Result Code:
Status: SIGNED Follow-up Code:
Ordering Physician: Madahar,Ashok K.

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF ADMISSION: 04/15/2005

CC: Christianson Warren, RES D.O.
James M. Lally, D.O.

CHIEF COMPLAINT:
Chest pain x1 day.

INFORMANT:
The history is obtained from the patient who is alert and oriented to place, person, and time and who appears to be an accurate historian, comprehends and speaks English adequately.

HISTORY OF PRESENT ILLNESS:
The patient is a 59-year-old Middle-Eastern gentleman who has chest pain, started approximately 9:30 a.m. on 04/14/2005. The patient's chest pain was intermittent, but continued to become progressively worse. The patient states that his chest pain was 7/10 and was sharp in nature. The patient has a strong family history of myocardial infarction, so the patient sought medical attention at Chino Valley Medical Center Emergency Department. The patient's primary care physician is Dr. Casciari at 714-639-9401.

PAST MEDICAL HISTORY:
Positive for cholecystectomy in 1987, hiatal hernia in 1994 with Nissen fundoplication in 1994, and hypertension.

ALLERGIES:
Reglan, which gives the patient extrapyramidal symptoms.

MEDICATIONS:
Diovan 80 mg p.o. q.d. for the patient's hypertension.

SOCIAL HISTORY:
The patient denies use of tobacco, which he states that he quit 21 years ago. The patient states that he drinks alcohol approximately once per month and two caffeinated beverages per day. The patient denies recreational drug use. The patient is divorced. The patient is a psychiatrist. The patient's point of contact is his son, Tamer Hanna, at 949-013-8670. The patient currently lives in Chino Hills and he is a full code.

FAMILY HISTORY:
The patient has three brothers who all died of myocardial infarction in their early 50s; however, the patient denies any family history of tuberculosis, cancer, or blood disorders. Family history is positive for diabetes mellitus type 2.

REVIEW OF SYSTEMS:
GENERAL: The patient denies any recent changes in weight, fatigue, fevers, chills, or night sweats.
SKIN: The patient denies any rashes, changes in hair or nails, or skin lesions.
HEENT: The patient denies headache or trauma. The patient has no decreased vision or visual changes. No complaints such as blurriness, increased tearing, or photophobia. The patient denies hearing loss, pain, tinnitus, discharge, or vertigo. The patient denies nasal trauma, pain, obstruction, epistaxis, head cold, discharge, or rhinitis.
ORAL: The patient denies history of soreness of the mouth or tongue. No history of mouth ulcers. The patient does not wear dentures.
THROAT: The patient denies dysphagia, sore throat, laryngitis, or speech defect.
NECK: The patient denies history of goiter, swelling, enlarged nodes, trauma, stiffness, or limitations with range of motion.
BREASTS: The patient denies any masses, pain, discharge, or infection.
RESPIRATORY: The patient states that he has had intermittent chest pain for the last day. The patient denies history of asthma, cough, recent upper respiratory infection, or night sweats.
CARDIOVASCULAR: The patient has had a recent history of chest pain, which is sharp in nature and rated it as 7/10 at its worst. The patient denies dyspnea, cardiac irregularities, orthopnea, palpitations, peripheral edema, cramps, or varicosities.
GASTROINTESTINAL: The patient states that he has a history of gastroesophageal reflux disease and sliding hiatal hernia for which he received a Nissen fundoplication procedure in 1994. The patient denies any food intolerance. No vomiting, hematemesis, pain, jaundice, melena, constipation, and/or diarrhea.
GENITOURINARY: The patient denies frequency, urgency, hesitancy, pyuria, dysuria and/or hematuria, sexually transmitted diseases, or GU surgeries.
METABOLIC: The patient denies any recent changes in appetite or weight.
ENDOCRINE: The patient denies thyroid disease, diabetes mellitus, excessive thirst, change in skin color or texture.
HEMOPOIETIC/BLOOD: The patient denies history of anemia or other blood disorders. No bleeding tendencies.
LYMPHATICS: The patient denies history of enlarged, swollen, and/or tender lymph nodes.
EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: The patient denies history of trauma, arthritis, and fractures, joint and/or low back pain, limitation in range of motion.
NEUROLOGIC: The patient denies history of headache, strokes, seizures, loss of consciousness, paraesthesias, numbness, or changes in thinking or memory.
PSYCHIATRIC: The patient denies history of nervousness, anxiety, mood swings, depression, hallucinations, schizophrenia, psychiatric consultations, medications, or hospitalizations.

PHYSICAL EXAMINATION:
GENERAL: The patient is a 59-year-old Middle-Eastern male who is well developed, well nourished, poorly hydrated, but alert and oriented to person, place, and time.
VITAL SIGNS: Blood pressure 102/70, temperature 97.7 degrees Fahrenheit, pulse 61, respirations are 18, height 5 feet 8 inches, and weight 164 pounds.
HEENT: The patient is normocephalic and atraumatic. The patient has binocular vision. Pupils are equal, round, and reactive to light. Extraocular movements are intact. Funduscopic examination reveals no papilledema or hemorrhages. The pinnae are symmetrical. External auditory canals are intact. No sign of infection. Nose is midline and patent. Septum is without ulcerations and/or perforation. No sign of nasal obstruction. Sinuses are nontender to palpation. Lips are moist and symmetrical. Teeth are in good repair. Tongue is midline and protrudes to the midline without deviation. No sign of ulcerations or leukoplakia. Good phonation without hoarseness. No difficulty with swallowing.
SKIN: Skin is warm and dry with good turgor. Normal color and pigmentation without lesions.
NECK: Supple. Full range of motion. No jugular venous distention. No bruit. No lymphadenopathy. No thyroid enlargement or other masses. Trachea is midline without obstruction.
BREASTS: No masses or changes in skin texture. No sign of dimpling and/or discharge from nipples.
LUNGS: Clear to auscultation. No rhonchi, rales, wheezes, or crepitus noted.
HEART: Regular rate at 61 beats per minute without murmur. Normal S1 and S2. No S3, S4, thrills, friction rubs, or gallops noted.
ABDOMEN: Bowel sounds are present and are normoactive. Abdomen is soft and nontender. No guarding, pinpoint tenderness, or rebound. No organomegaly noted.
GENITALIA: Male: The patient is uncircumcised with no urethral discharge. No lesions noted on the scrotum.
RECTAL: Deferred.
EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: Joint examination reveals no tenderness, swelling, redness, and restrictions of range of motion. No clubbing, cyanosis, or edema.

Radial, femoral, popliteal, and pedal pulses are palpable and equal bilaterally. Upper and lower extremities are normal for size, shape, strength, and symmetry. Homans sign is negative.

Biceps, triceps, brachioradialis, patellar, and deep tendon reflexes are 2+ and equal bilaterally without clonus. Gait is symmetrical and balanced. No involuntary movements are noted. Cervical, thoracic, and lumbar spine is without spasm, nontender to palpation. Range of motion shows no abnormal or asymmetrical changes.

FOOT EXAMINATION: Pulses are strong and equal bilaterally. Temperature is warm. Capillary refill time is 2+. No other lesions noted on the feet bilaterally.

LYMPHATICS: No cervical, axillary, supraclavicular and/or inguinal lymphadenopathy noted.

NEUROLOGIC: The patient's general behavior reveals level of consciousness oriented to person, place, and time.

CN I: The patient is able to perceive smell.

CN II, III, IV, & VI: The patient has binocular vision and visual acuity within normal limits. Passes visual fields to confrontation. Extraocular movements are intact. Pupils are equal and reactive to light and accommodation with no nystagmus present.

CN V: The patient is able to clench jaws, able to move jaw from side to side. Corneal reflexes are intact as demonstrated by spontaneous blink.

CN VII: The patient demonstrates muscles of facial expression, has taste to anterior two-thirds of tongue.

CN VIII: The patient can hear spoken words whispered with no nystagmus present.

CN IX: Taste is intact for the posterior one-third of the tongue.

CN X: Soft palate and uvula pull upward in the midline, positive gag reflex, and good phonation without hoarseness.

CN XI: The patient can turn head in all directions against resistance. The patient can shrug shoulders symmetrically.

CN XII: The patient can protrude tongue in the midline, no atrophy or fasciculations, able to push out cheeks.

Muscle size and strength are within normal limits. No involuntary muscle movements are noted. Coordination appears to be adequate. Babinski – the toes are neutral. Motor and sensory are within normal limits.

ACCOUNT #: V00000143675
PATIENT: HANNA, ADEL
DATE OF ADMISSION: 04/15/2005

DIAGNOSTIC DATA:
CBC, white blood cells were 3.9, hemoglobin was 15.8, hematocrit was 42, and platelets were 168. CMP, sodium was 139, potassium was 3.9, chloride was 107, CO2 was 26.7, BUN was 21, creatinine was 1.0, glucose was 105, total protein was 6.9, albumin was 2.7, and globulin was 3.2. Albumin to globulin ratio was 1.2, calcium was 9.0, total bilirubin was 0.34, AST was 14, ALT was 33, alkaline phosphatase was 29, CK was 62, cholesterol was 134, HDL was 31, and troponin I was 0.07. PT was 11.8, INR was 1.0, PTT was 27.1, amylase was 43, lipase was 281, magnesium was 2.5, CK-MB was 0.8, and myoglobin was 24.

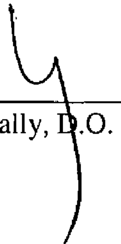
ASSESSMENT:
Chest pain, rule out acute coronary syndrome, hiatal hernia, history of Nissen fundoplication repair, hypertension, and dehydration.

PLAN:
The patient is to be admitted to the definitive observation unit with telemetry with chest pain protocol. The patient will also be given Diovan 80 mg p.o. q.d. for the patient's hypertension. The patient is also to be supplied with p.r.n. medications for the patient's comfort and IV fluid hydration for the patient's dehydration. The care plan was discussed with the patient at length. He is aware and in agreement with plan of treatment.

PROGNOSIS:
Fair.

DISPOSITION:
The patient will be discharged home upon satisfactory clinical resolution of symptoms.

Christianson Warren, RES D.O.



James M. Lally, D.O.

DR: CW/SHA/TRB

DD: 04/15/2005 09:30
DT: 04/15/2005 11:30
Job #: 906567

DATE	TIME	NAME
7/15/05	02:30	Fluid Note
		Pt seen, eval, discussed under supervision of attending, Dr. Lally
		Pt shows evidence of dehydration - BUN - 21 Creat - 1.0
		Pt. given 75 cc/hr NS
		[signature] / Lally
7/15/05	0415	Pt [illegible] CP / [illegible]
		[illegible]
		plan D/C - F/U c cardiology as op & Stress test office for primary care.
		D/C
7/15/05	0900	D/C Note
		Pt. seen and Discussed with Attending Dr Lally DO
		Pt. stable for D/C. Pt will f/u with Dr Agrawal today for stress + eval. Enzyme series Today Before D/C. Resume Home Meds, Pt aware of Diagnosis and plan. F/U with PCP 1 week.
		POC (909) 576 4143 (IRWIN KAWAGUCHI) [signature] / Lally DO.

ADDRESSOGRAPH
V000001436751 #90657
NNA, ADEL
M00273781
59 /M
03/29/46
04/15/05

Chino Valley Medical Center
5451 WALNUT AVENUE
CHINO, CALIFORNIA 91710

PHYSICIAN PROGRESS NOTES

000156 604.016 (4/00)

1. NONE ( ) **ALLERGIES**
2. Reglan
3. ______

DATE 4/15/05

USE BALL POINT PEN - PRESS FIRMLY - ORDERS ARE BEING COPIED

CHEST PAIN ORDERS

- ☐ EMERGENCY Preprinted Orders
- ☐ SALINE LOCK: and flush q shift
- ☐ Keep open I.V. 500ccNS
- ☑ OTHER: NS IV @ 75cc/hr
- ☐ $O_2$3L N.C (for SOB, chest pain or arrhythmias)
- ☐ OTHER:
- ☑ DIET: 2gm Na, low animal fat, 1400 or ______ calories (May have decaffeinated coffee. No caffeinated beverages)
- ☐ OTHER:
- ☑ ORAL FLUIDS INTAKE Ad lib, Limited to: ______
- ☑ ACTIVITY LEVEL: Bed rest: 30 degree elevation
- ☑ May use commode

K. Bravo 4/15/05 0440

LABORATORY:

- ☑ Pulse oximetry on room air (if not done in ER) if less than 92% notify physician.
- ☑ Chest X-ray, Chem 20, Magnesium, Amylase, Lipase, UA & UDS, PT & PTT on admission, if not done in ER. May use Laboratory specimen if within 12 hours of admission
- ☑ EKG on admission and daily X 2
- ☑ CPK on admission and every 8-12 hours X 2 (do isoenzymes, if total above 95)
- ☑ Myoglobin on admission (if not done in the Emergency Department)
- ☑ Troponin on admission (if not done in the Emergency Department) repeat in 8-12 hours X 1.
- ☑ OTHER:

MEDICATION:

- ☑ a. Nitroglycerin 0.4 mg S.L. q 15-30 min. PRN for chest pain
- ☑ b. Morphine Sulfate 2 mg IV q 30 min. PRN moderate chest pain x 2 q 4 hrs PRN
  Morphine Sulfate 4 mg IV q 30 min. PRN severe chest pain x 2 q 4 hrs PRN
- ☑ c. Nitroglycerin 2% ointment, 1" apply to chest wall q 6 hours for chest pain
- ☑ d. Ativan 1 mg po q 6 hours prn anxiety and/or restlessness
- ☑ e. Ambien 5 mg po q hs prn insomnia, may repeat X one if necessary
- ☑ f. Colace 200 mg po daily for BM
- ☑ h. Phenergan 12.5 mg IVP q 4 hours prn nausea and/or vomiting. If SBP is less than 90/mm hg do not give and notify physician.
- ☑ i. Tylenol 650 mg po q 4 hours prn headache and/or temp greater than 100.4.
- ☑ j. Toradol 30 mg IVP X 1, then may give q 6 hours prn chest wall pain (costochondritis)
- ☑ k. Protonix 40 mg IVP X 1, then may give po qd (gerd).
- ☐ OTHER ORDERS:

MEDICAL CENTER
00000143675
HANNA, ADEL
000273781
59 /M

☐ Unless Checked, Generic items Will Be Supplied Per Policy	RN'S SIGNATURE AND TIME	PHYSICIAN'S SIGNATURE AND TIME
	[signature] 4/15/05	[signature]

ATT DR. LALLY, JAMES H.
ADDRESSOGRAPH

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710
CHEST PAIN ORDERS

WHITE - CHART **YELLOW** - PHARMACY

000142 600.017 (2/05)

ALLERGIES	HT	WT
DATE 4/16/05 TIME 0800	READ BACK VO / TO	INITIAL

[illegible]

D/c [illegible]

D/c home now

f/u appt c Dr. Agarwal @ 1100

NURSE NOTED	DATE	TIME	DATE / TIME	PHYSICIAN SIGNATURE OR AUTHENTICATION
24 HR CHART CHECK BY NURSE	DATE	TIME		

VALLEY MEDICAL CENTER 0000143675 59 /M DOB 03/29/46 DOS 04/15/05 PATIENT ID

DATE 04/18/05 TIME 0400	READ BACK VO / TO	INITIAL

Resume Home Meds

Activity As tolerated

NURSE NOTED	DATE	TIME	DATE / TIME	PHYSICIAN SIGNATURE OR AUTHENTICATION
24 HR CHART CHECK BY NURSE	DATE	TIME		[illegible] DO [illegible]

VALLEY MEDICAL CENTER 0000143675 59 /M DOB 03/29/46 DOS 04/15/05 PATIENT ID

DATE	TIME	READ BACK VO / TO	INITIAL

NURSE NOTED	DATE	TIME	DATE / TIME	PHYSICIAN SIGNATURE OR AUTHENTICATION
24 HR CHART CHECK BY NURSE	DATE	TIME		

VALLEY MEDICAL CENTER 0000143675 59 /M DOB 03/29/46 DOS 04/15/05 PATIENT ID

TRC1008 (8/03) IMMS# 236207

PHYSICIAN ORDERS

Patient Name: HANNA,ADEL
Unit No: M000273781

EXAM#	TYPE/EXAM	RESULT
000377313	RAD/XR CHEST: 1V (AP/PA)	

CHEST PORTABLE 4/15/05 #377313:

HISTORY: Chest pain.

FINDINGS: A single portable AP view of the chest is received. No prior studies are currently available for comparison. The examination is notable for evidence of blunting of the right costophrenic angle with fibrotic streaking in the right lung base. Right pleural thickening is considered likely for the blunting in this case. There is minimal bibasilar discoid atelectasis. The heart size is at the upper limits of normal. The aorta is mildly ectatic. The upper lung zones are clear. The pulmonary vascularity is unremarkable.

IMPRESSION:
1. No acute abnormality is demonstrated.
2. Right base fibrosis and pleural thickening.
3. Bibasilar atelectasis.

DICTATED: 04-15-05/1049

** REPORT SIGNATURE ON FILE 04/15/2005 **
Reported By: Steven R. Cobb, M.D.
Signed By: Curtis R. Handler, M.D.

CC: Ashok K. Madahar; PHYS NONSTAFF

Technologist: MICHAEL P. VERKLER,RT(R)
Transcribed Date/Time: 04/15/2005 (1249)
Transcriptionist: RDMG
Printed Date/Time: 04/25/2005 (1030)

PAGE 1 Signed Report

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE
CHINO,CA 91710
909-464-8643
909-464-8886

Name: HANNA,ADEL
Phys: Madahar,Ashok K.
Dob: 03/29/1946 Age: 59 Sex: M
Acct No: V00000143675 Loc: 235 B
Exam Date: 04/15/2005 Status: DIS IN
Radiology No:

11111 04/14/2005 22:01:18 NNA ADEL RIVERSIDE COUNTY REGION MEDICAL
162 lbs 58 ins
Dept: PSYYCH
Room: ETS
Oper: MOT

Rate 74 . Normal sinus rhythm, rate 74
PR 171
QRSD 83
QT 357
QTc 396

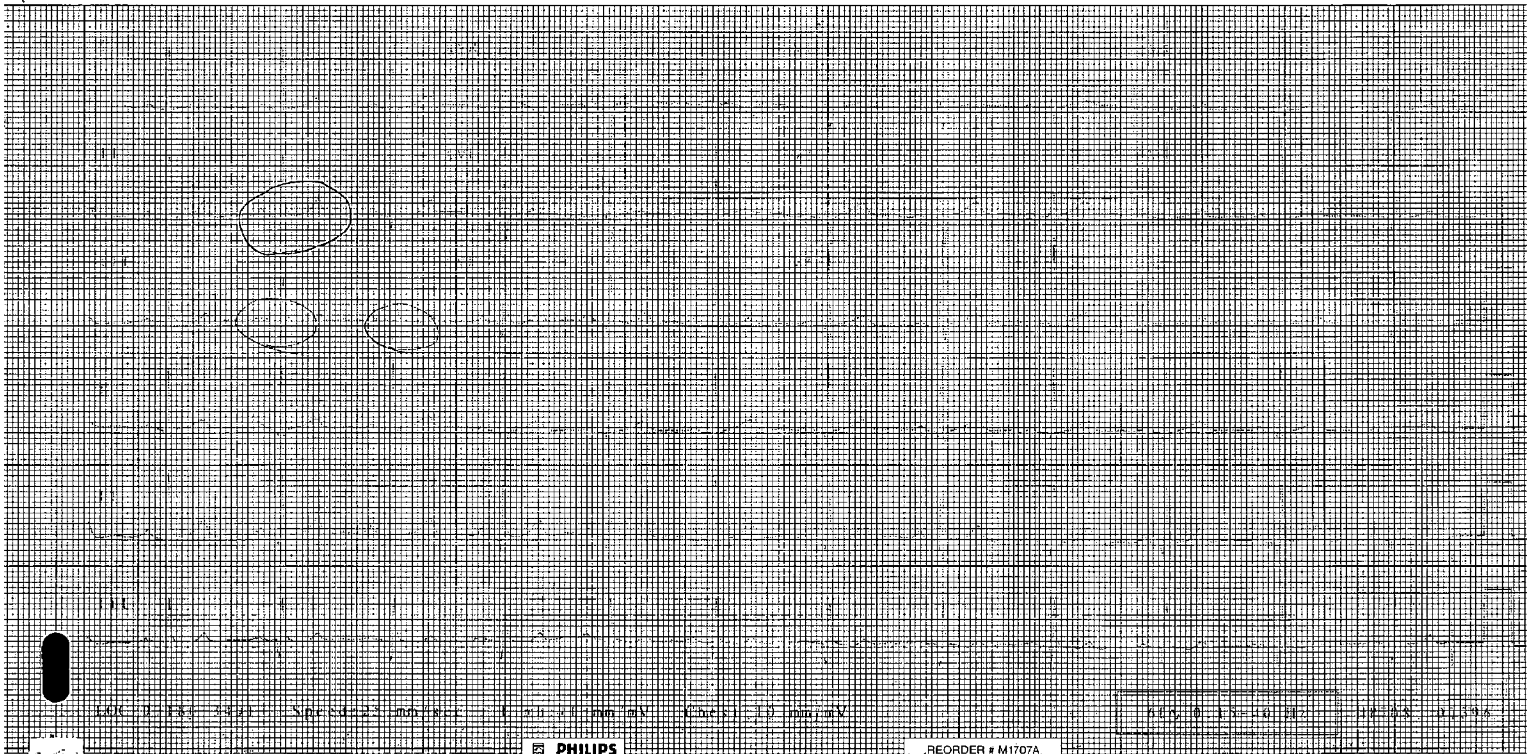
--AXIS--
P 60
QRS 54
T 42

- NORMAL ECG -

SYMPTOM
CHESTPAIN

Requested by:
HANNA

-----------------------------MD



HANNA, ADEL | ID: | 15-Apr-2005 0:50:46 | Chino Valley Medical Center

29-Mar-19

Room: ED-7

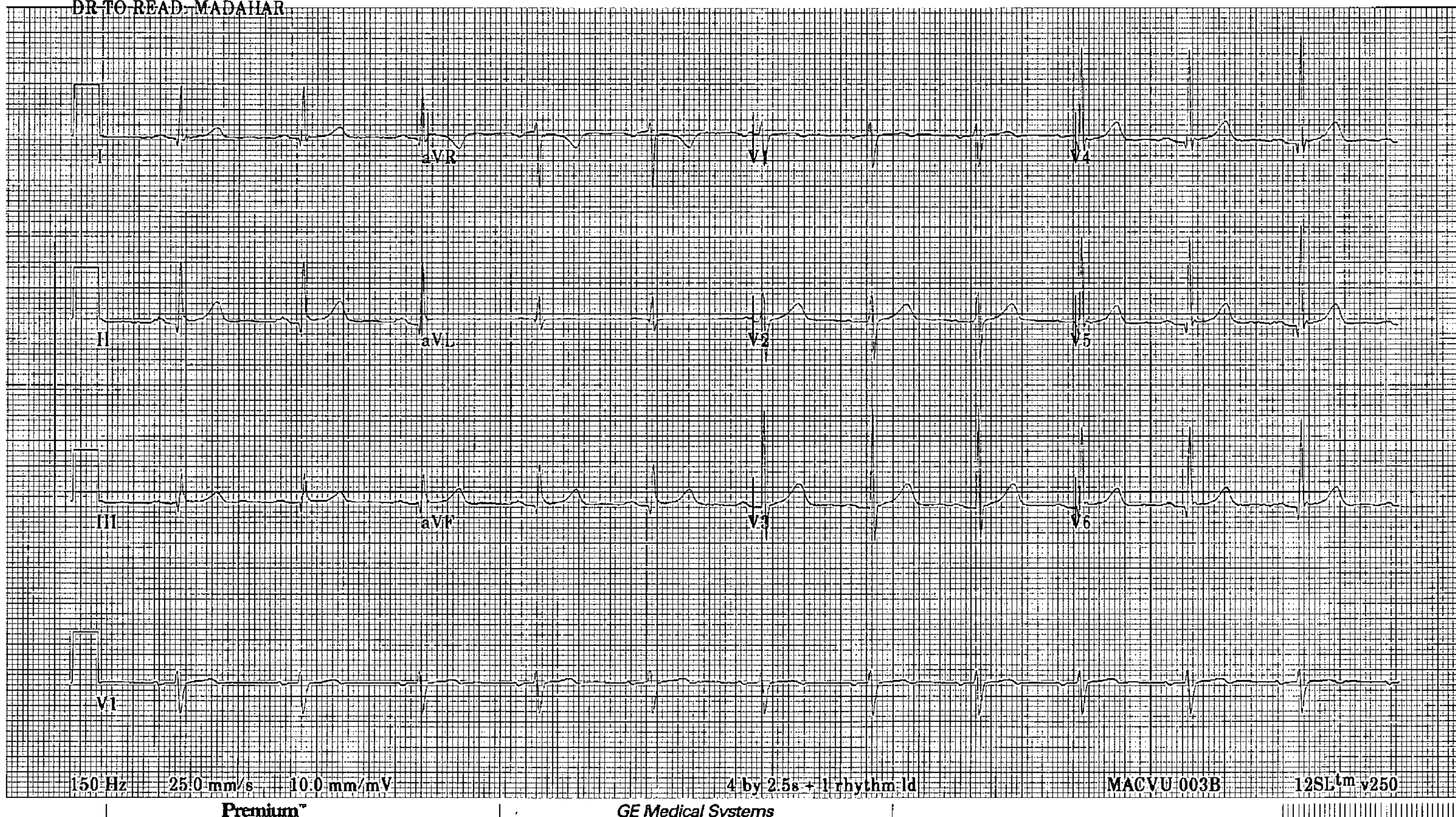
Vent. rate 69 bpm
PR interval 178 ms
QRS duration 88 ms
QT/QTc 386/413 ms
P-R-T axes 55 46 60

Normal sinus r[illegible]m
Normal ECG

Technician: RM

Unconfirmed

DR TO READ: MADAHAR



MAR Date 4/15 PRN ~~REGLAN~~ Page ____ of ____

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
NITRO 0.4 MG SL Q15-30MIN PRN					
MS 2MG IV Q30MIN PRN X2 Q4°					
MS 4MG IV Q30MIN PRN X2 Q4°					
ATIVAN 1MG PO Q6° PRN [illegible]					
AMBIEN 5MG PO QHS PRN MAY RPT X1					
COLACE 200MG PO QD PRN					
PHENERGAN 12.5MG IV Q4° PRN					
TYLENOL 650 MG PO Q4° PRN					
TORADOL 30MG IVP X1 THEN Q6° PRN	4/15		0530 [illegible]		

Signature	Initials	Signature	Initials	Signature	Initials
				[illegible signature]	[illegible]

MEDICAL CENTER

Patient Name	Patient No.
Room	Age	Pt. Weight	Pt. Height
Diagnosis	
Allergies	
Physician's Name	

PATIENT IDENTIFICATION 0000143675

231B HANNA, ADEL 1000273781 59 /M DOB 03/29/46 DOS 04/15/05

ADMIT DR. LALLY, JAMES M.
ATTN DR. LALLY, JAMES M.

24 Hour MAR

000196 Rev. 03/00 (RC# 0259003)

WHITE - CHART **YELLOW** - PHARMACY **PINK** - NURSE

MAR Date 4/15 REGLAN Page ____ of ____

Site Codes: 1. Right Abdomen 2. Left Abdomen 3. Right Upper Arm 4. Left Upper Arm 5. Right Buttock (upper outer quadrant) 6. Left Buttock (upper outer quadrant) 7. Right Anterior Thigh 8. Left Anterior Thigh

Drug Name, Strength, Dosage Form / Dose Rate Route Schedule	Start Time / Date	Stop Time / Date	Time Period To Time/Init./Site	Time Period To Time/Init./Site	Time Period To Time/Init./Site
IV NS @ 75cc/°					
NITRO 2% OINT. 1" CW Q6°			[illegible signature]	1200	1800 LKN
PROTONIX 40MG IVP X1 THEN PO QD	4/15		0430 [illegible]		

Signature	Initials	Signature	Initials	Signature	Initials
				[illegible signature]	[illegible]

VALLEY MEDICAL CENTER
000000143075

Patient Name			Patient No.
Room	Age	Pt. Weight	Pt. Height
Diagnosis			
Allergies			
Physician's Name			

PATIENT IDENTIFICATION
HANNA, ADEL
V000273791
59 /M
DOB 03/29/46
DOS 04/15/05
ADMIT DR. LALLY, JAMES R.
ATTN DR. LALLY, JAMES R.

24 Hour MAR
000196 Rev. 03/00 (RC# 0259003)

WHITE - CHART **YELLOW** - PHARMACY **PINK** - NURSE

PATIENT INFORMATION		PHYSICAL EXAM
NAME: LAST Hanna	FIRST Adel	BP: T: 97.7 P: 61 R: 18 HT: 5'8 WT: 164
MR: M000273781	DATE: 4/15/05	GEN: A&O x 3, NAD
DOB: 3/29/46	TIME: 05:30	
SEX: ♂	RACE: Mid. East.	EENT: EOMI, PERRL
CC: CP x 1 day		HEART: RRR, @ 61 bpm
HPI: CP started @ 09:30. Pt. states that pain was 7/10 at its worst, And became progressively worse		LUNGS: CTA (B)
		ABDOMEN: soft, NT, BS⊕
		RECTAL/GU: Deferred, ø lesions
PRIMARY PHYSICIAN: Dr. Casciari (714) 639-9401		
SNF / B&C:		EXT./OSTEO: WNL
PAST HISTORY (MEDICAL & SURGICAL): ~~3 Brothers ↓↓↓~~ ~~MI~~, Cholecyst -'87, Hiatal hernia '94 HTN, Nissen fundoplication '94		NEURO/PSYCH: AO x 3, NAD
		SKIN: ø lesions
ALLERGIES (RXN): Reglan - EPS		DIAGNOSTIC DATA (LABS, X-RAYS, ETC.): 3.9 > 13.8 / 42 < 169; 139 | 107 | 21 / 3.9 | 26.7 | 1.0 < 105
MEDICATIONS (DOSE): Diovan 80 mg po QD (HTN)		Bili tot - .34 CK - 62 PT - 11.8
		AST - 14 Chol - 134 PTT - 27.1
		ALT - 33 HDL - 31 INR - 1.0
		ALK Phos - 49 Trop I - .07
		DIAGNOSIS: CP R/O ACS, Hiatal hernia, HTN, Dehydration
SOCIAL HISTORY: ø Tobacco, Etoh - 1/month, ø drugs, Divorced, Psychiatrist. Chino Hills		PLAN: Admit to DOU w/ Tele. CP protocol
FAMILY HISTORY: 3 brothers ↓↓↓ 60's - MI		
REVIEW OF SYSTEMS: CP		CODE STATUS DETERMINED/VERIFIED ☑ YES ☐ NO
		☑ FULL ☐ DNR ☐ MODIFIED
		NEXT OF KIN NOTIFIED ☑ YES ☐ NO
		NAME/PHONE # Tamer Hanna - Son (949) 413-8670
		H&P DICTATION #: 906667
		SIGNATURES: [signatures] DO, Lally DO

ATTENDING NOTE:

PATIENT WAS SEEN AND EVALUATED AT THE TIME OF SERVICE. THE PATIENT'S CASE WAS DISCUSSED AND REVIEWED WITH THE HOUSESTAFF AT TIME OF THE VISIT.

GIVEN A HISTORY OF CP, THE EXAM AND ASSESSMENT SHOWS CP [STATE FINDINGS OF SIGNIFICANCE]

I AGREE/REVISE PLAN OF CARE AS FOLLOWS ______

ATTENDING SIGNATURE: [signature] DATE & TIME: 4/16

CHINO VALLEY MEDICAL CENTER

00000143675

HANNA, ADEL
1000273781
59 /M
DOB 03/29/46
DOS 04/15/05

ADMIT DR. LALLY, JAMES M.
ATTN DR. LALLY, JAMES M.

CHINO VALLEY MEDICAL CENTER
TEACHING SERVICE
ADMISSION NOTE

Teaching Service Admit Note; rev 4/13/05

FOOD - DRUG INTERACTION SHEET

If you are taking a drug, the food you eat could affect the speed and amount of absorption of your medication. Please refer to the following chart to determine how you should take your medication(s). Medications should be taken with a full glass of water to decrease the chances of nausea and vomiting unless instructed otherwise.

ANTICOAGULANTS

Warfarin
Coumadin

- Avoid foods and/or nutritional supplements high in vitamin K
- Limit caffeine
- Avoid fried or boiled onions

ANTIARRHYTHMICS

Digitalis
Digitoxin
Crystodigin
Digitoxin
Digoxin
Lanoxin
Lanoxicap
Quinidine

- Take separately from high bran fiber or high pectin foods
- Maintain diet high in potassium - low in sodium
- Avoid licorice
- Best if taken on empty stomach
- Use caution when taking potassium supplements

ANTIBIOTICS

Ciprofloxacin
Doxycycline
Tetracycline

- Take separately from dairy foods, foods high in calcium content
- Limit caffeine
- Take magnesium, calcium, iron or zinc supplements separately

Penicillin

- Take with water on empty stomach
- Avoid acidic beverages

ANTIDEPRESSANT, MAOI

Phenelzine
Nardil

- Avoid foods high in pressor amines (Contact Department of Nutritional Services for detailed information)
- Limit Caffeine
- May need pyruvic supplement

BRONCHIODILATORS

Theophylline
Bronkodyl
Elixophyllin
Slo-bid
Slophyllin
Theobid
TheoDur
Theolair

- Maintain consistent intake of high protein foods
- Limit charbroiled food
- Limit caffeine

FOODS HIGH IN:

VITAMIN K
Leafy green vegetables, broccoli, cabbage, caulifower, green beans, lettuce, peas, spinach, turnip greens, green herbal teas

PROTEIN
Meat, fish, milk, eggs, poultry, cheese, peanut butter

CALCIUM
Milk, cheese, Ice cream, yogurt, salmon, leafy green vegetables, tofu, corn tortillas, sardines

BRAN FIBER
Bran bread, bran cereals

PECTIN
Apples, broccoli, brussel sprouts, pears, spinach, sweet potatoes

POTASSIUM
Avocado, artichokes, bananas, milk, legumes, mushrooms, peaches, raisins, tomatoes, dates, figs, melons, nectarines, potatoes, rhubarb, turnip greens

IRON
Iron fortified cereals, organ meats, meat, fish, poultry, raisins

VITAMIN C
Oranges and/or other citrus fruit or juices, tomatoes and/or juice, strawberries, pineapple and/or juice

SODIUM
Table salt/ garlic salt/ onion salt, food or seasonings containing greater than 450mg per serving

If you have any questions about Adverse Drug Reactions or how to take your medication, please consult your pharmacist or physician. I understand the instructions listed above and have received verbal instruction.

PATIENT OR RESP. PARTY: VALLEY MEDICAL CENTER
000001436 75
DATE: 4-13-05
0002737 81
00 (REFER TO BACKER) 3/29/46
ADDRESSOGRAPH 04/15/05
ADMIT DR. LALLY, JAMES R.
ATTN DR. LALLY, JAMES R.

Chino Valley Medical Center
5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710

FOOD-DRUG INTERACTION INFORMATION SHEET

WHITE - CHART YELLOW - PATIENT

000117 604.030 (5/00)

DIURETICS (Loop-K depleting)

Bumex
Dyazide
Edecrin
Esidrix
Hydrochlorothiazide
Hygroton
Lasix
Maxzide
Zaroxolyn

- Increase intake of foods high in potassium and/or supplement with potassium
- Avoid licorice
- Low sodium diet recommended

IRON SUPPLEMENTS

Ferrous Fumarate
  Femiron
Ferrous gluconate
  Fergon
Ferrous sulfate
  Feosol

- Do not take with bran or high fiber supplements
- Take separately from caffeine
- Take separately from dairy foods and/or calcium
- Take with foods high in vitamin C
- Take with meat

TAKE WITH MEALS

(To avoid stomach upset)

Amitriptyline
Allopurinol (Zyloprin)
Carbamazepine
  (Tegretol)
Cimetidine (Tagament)
Doxycycline
Extrogens
Hydrocortisone
Imuran
Isoniazid
KCL (Micro K & other
  K supplements)
Metronidozole
MVI/minerals
Niacin
Nitrofurantoin
Oral Hypoglycemics
Pancrease
Prednisone
Propanolol
Quinine
Salicylates
Spironolactone
Sulfasalazine
Thioridazine
Thorazine
Trazodone
Trental
Macrodantin
Meclizine
NSAID (Non-Seroidal Anti-Inflammatory Agents)

NOT TO BE TAKEN WITH ALCOHOLIC BEVERAGES

Amantadine (Symmetrel)
Anticonvulsants
Antihistamines
Barbiturates
Darvocet N 100
Doxycyline
Disulfiram
Isoniazid
Muscle Relaxants
Methotrexate
Metronidazole
  Flagyl
Narcotic Analgesics
Nitrates
Oral Diabetic Agents
Propranolol
Sedatives/Hypnotics
Tranquilizers
Tylenol & Codeine
Vicodin
Warfarin

RUN DATE: 04/15/05
RUN TIME: 0018
RUN USER: ADSDL

Chino Valley Medical Center ADM **LIVE**
Nursing Medication Administration Record Form

Patient Name: HANNA,ADEL
Account #: V00000143675
Primary DX: CHEST PAIN

Triage Date: 04/15/05
MR# : M000273781

DOB: 03/29/46 Age: 59
ED Doctor:

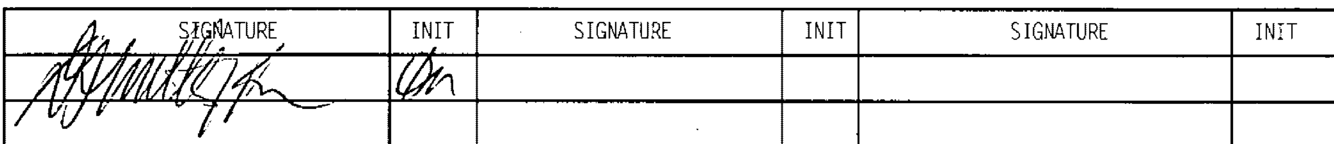
Sex: M

Allergies:

Time	Medication / Dose / Route	Initials	Time	Response	Initials
0100	Nitro 0.4 SL x2	On			
0100	Nitro [illegible] inch CW	On			
0130	ASA 325mg PO	On			

Time	IV Solution	Gauge	Site	Additive	Rate	Infused	Initials

INJECT SITES:	
1-RT ABDOMEN	2-LT ABDOMEN
3-RT UPPER ARM	4-LT UPPER ARM
5-RT BUTTOCK (upper outer quadrant)	6-LT BUTTOCK (upper outer quadrant)
7-RT ANTERIOR THIGH	8-LT ANTERIOR THIGH



SIGNATURE	INIT	SIGNATURE	INIT	SIGNATURE	INIT
[signature]	On				

1. NONE ( ) ALLERGIES
2. Reglan
3.

DATE 4/15/05

USE BALL POINT PEN - PRESS FIRMLY - ORDERS ARE BEING COPIED

LEVELS OF CARE

1. **CODE STATUS:**
   - ☑ Full Code
   - ☐ No Code
   - ☐ Modified Code
     - ☐ No drugs, as defined in ACLS guidelines
     - ☐ No Intubation, or bagging patient
     - ☐ No Chest Compression
     - ☐ No Cardioversion/Defibrillation

* Orders for less than full CPR require documentation of discussion with patient (if competent) and/or family.
* Orders must be rewritten whenever level of care changes, along with appropriate documentation by MD.

2. **ONGOING TREATMENT:**
   - ☐ No intubation/respirator
   - ☐ No ACLS drugs/pressor agents
   - ☐ No tube feedings for food.
   - ☐ No I.V. Fluids
   - ☐ No intravenous medications
   - ☐ No dialysis
   - ☐ No blood transfusions
   - ☐ No labs or diagnostic procedures
   - ☐ No antibiotics

   - ☐ **Code status has been reassessed and a new order sheet has been placed at the front of the chart; This order sheet is no longer valid. See new order sheet.**

☐ Unless Checked, Generic Items Will Be Supplied Per Policy	RN'S SIGNATURE AND TIME	PHYSICIAN'S SIGNATURE AND TIME 02:25

Chino Valley Medical Center

5451 WALNUT AVENUE
CHINO, CALIFORNIA 91710

LEVELS OF CARE

000139 600.013 (11/00)

ADDRESSOGRAPH

V000001643675
HANNA, ADEL 59 /M
M000273781 DOB 03/29/46
DOS 04/15/05

Patient: HANNA,ADEL
Account #: V00000143675 **Unit #:** M000273781

Age/Sex: 59 M **Attending:** Lally, James M.
Location: DU **Admitted:** 04/15/05 at 0251
Room/Bed: 235-B **Status:** DIS IN

	Date	Time	By	Nurse Type	Category
Occurred:	04/15/05	0340	EDM Maniago,Edna D	RN	
Recorded:	04/15/05	0450	EDM Maniago,Edna D	RN	Nurse Notes

Abnormal? N **Confidential?** N

ADMITTED A 59YO M TO RM 235 B PER STRETCHER FROM ER ACCOMPANIED BY NURSE WITH THE CC OF CHEST PAIN. DX CHEST PAIN R/O UNSTABLE ANGINA. PT ALERT AND AWAKE, ORIENTED X3. PLACED IN BED COMFORTABLY. VS TAKEN AND RECORDED. PLACED ON O2 2L/NC, O2 SAT AT 97%, LUNGS CTA. PLACED ON TELE 7, SR, HR 61BPM. IVF NS TO RT HAND INFUSING WELL AT 75CC/HR. MEDS STARTED. DENIES SOB NOR CHEST PAIN AT THIS TIME. NO DISTRESS NOTED. SAFETY PREC NOTED. CALL LIGHT IN REACH

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	04/15/05	0548	EDM Maniago,Edna D	RN	
Recorded:	04/15/05	0549	EDM Maniago,Edna D	RN	Nurse Notes

Abnormal? N **Confidential?** N

SLEPT THE REST OF THE SHIFT, NO S/S PAIN NOTED. NO SOB NOTED. IVF STILL INFUSING WELL. SAFETY PREC NOTED. CALL LLIGHT IN REACH

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	04/15/05	0800	RN4 Agency,RN 4	RN	
Recorded:	04/15/05	0901	RN4 Agency,RN 4	RN	Nurse Notes

Abnormal? N **Confidential?** N

A/A/O.BREATHING EVEN AND UNLABORED,IN NO ACUTE DISTRESS.NO C/O PAIN NOTED AT THIS TIME.

Note Type	Description
No Type	NONE

Patient: HANNA,ADEL
Account #: V00000143675 **Unit #:** M000273781

	Date	Time	By	Nurse Type	Category
Occurred:	04/15/05	0900	RN4 Agency,RN 4	RN	
Recorded:	04/15/05	1129	RN4 Agency,RN 4	RN	Nurse Notes

Abnormal? N **Confidential?** N

DISCHARGE ORDER,GIVEN,DEMONSTRATE UNDERSTANDING.PICKED UP IN STABLE CONDITION.

Note Type	Description
No Type	NONE

ADM Quickstart Form 04/15/05 0359 TMS

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59

ADM Quickstart Form 04/15/05 0424 EDM

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59

ADM Quickstart Form 04/15/05 0554 KGM

Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59

ADMISSION ASSESSMENT 04/15/05 0424 EDM

=== Assessment Obtained --- Date: 04/15/05 Time: 0340
Signature: Maniago,Edna D
=== ARRIVAL INFORMATION ===
Time of Arrival: 0340 Mode of Arrival: GUERNEY
Arrived From: EMERGENCY DEPT Accompanied By: NURSE

=== Source of Information ===
Patient: Y Other (name/relationship):
Chief Complaint: CHEST PAIN
Primary Diagnosis: CHEST PAIN R/O UNSTABLE ANGINA
Surgery/Procedure:
Date of Surgery:

=== VITAL SIGNS ===
Temperature/F: 97.7 Temp Source: ORAL
Pulse: 61 Pulse Source: ARTERIAL LINE
Respirations: 18 Respiration Source: OBSERVED
Blood Pressure: 96/68 BP Source: AUTOMATIC Site: RIGHT UPPER ARM
O2 in use: N Liter Flow/FIO2: Pulse Oximetry: Y SpO2%: 97 Probe Location: HAND RT
IV: NS AT 75CC/HR RT HAND
=== PAIN ASSESSMENT ==
C/O Pain: Y *** Chest Pain to be Documented on Cardiac Problem ***
When Pain is Present:
Pain Location: CHEST
Pain Scale: 7/10
Describe the Pain: PRESSURE
Onset:
What Increases the Pain: :
What Relieves the Pain: : MEDICATION
Pain Control Goal: 0/10
Comment: CAME IN WITH THE CC OF CHEST PAIN
:

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: 5 In: 7 OR Cm: 170.18
Weight - Lb: 164 Oz: OR Kg: 74.38
Weight Source: STANDING SCALE
Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKOA
=== DEMOGRAPHIC DATA === Marital Status: M Occupation: DOCTOR
Primary Language: ENGLISH Understands English:

ADMISSION ASSESSMENT 04/15/05 0424 EDM

Religion: CHRISTIAN
Beliefs Affecting Care:
Spiritual Coordinator Visit Requested:

Contact Person: HANNA,TAMER Relationship: SO
Home Phone: (949)413-8670 Work Phone: Cell/Pager:
Add'l Contact Information:

=== NUTRITION ===
-NUTRITIONAL Assessment Within Normal Limits: Y
Diet at Home: REGULAR
Food Preferences:
Recent Weight Change: Comment:

Nutritional Comment: STATED THAT HE HAS A GOOD APPETITE
:

===PATIENT HISTORY=== ****HISTORY ONLY-NOT for Patient's Current Assessment****
Previous Admits/Surgeries: CHOLECYSTECTOMY, HIATAL HERNIA
:
- Neurological: N
EENT: N
Respiratory: N
Cardiac: N
Hypertension: Y HX HTN
Circulatory: N
Blood Disorder/Clots: N
Musculoskeletal: N
Gastrointestinal: N
Hepatitis: N
Endocrine: N
Diabetes: N
Genitourinary: N
Gynecological:
Skin Disorder: N
Cancer: N
Psychosocial: N
Pain: Y CHEST PAIN
Pregnant: LMP: :
Has Patient Ever Received Pneumococcal Vaccine: N

=== HOME MEDS === Med/Dose/Frequency/Last Dose *Include ALL over the counter meds

Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N
1. DIOVAN 11.
2. 12.
3. 13.
4. 14.
5. 15.
6. 16.
7. 17.
8. 18.
9. 19.
10. 20.
-Referral Needed: Disposition of Medications:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N Type:
Amount/How Often: Number of Years:
Other Substance Use (comment): DENIES USE

=== INFECTION RISK SCREEN ===
Admitted from a Skilled Nursing Facility: 0 NO
PEG Tube: 0 NO
Tracheostomy: 0 NO
Central Line: 0 NO ~Total Score: 0
Hospitalized in the Last 30 Days: 0 NO =Infection Risk=
Decubitus Ulcer/Open Surgical Wound: 0 NO Low: Y
History of TB, HIV, or Hepatitis: 0 NO Moderate (1-2):
History of MRSA or VRE: 0 NO High (3+):

=== ADVANCE DIRECTIVES ===
Advance Directive: N **IF YES**
Copy on Chart: Family will bring in ASAP:
Copy on File at CVMC: Reviewed with Patient/Representative:
The Current Desire for this Patient Regarding Life Support Is as Follows:
Code Status: FULL CODE If DNR, Bright Pink Armband in Place:
Comment:

If the Patient/Agent has Additional Needs/Concerns R/T Adv. Dir.; Social Worker Notified:

=== DISCHARGE PLANNING ===
Pt lives with: FAMILY
Living Arrangements: HOUSE
Does Patient Live with People who Rely on Him/Her: Y
Does Family/Friends Assist with Home Care: Y
Who Will be Taking Patient Home: FAMILY
Anticipated Discharge Destination: HOME
Is Patient Using Homecare/Outside Agency/Facility: N
Name/Phone # of agency:

=== SYSTEM ASSESSMENT ===

~NEUROLOGICAL Assessment Within Normal Limits: Y == PUPIL REACTION CHECK ==
LOC: Reaction OD: BRISK Size: 2
Orientation: Reaction OS: BRISK Size: 2
Responds to: Weakness: Specify:
Speech: Numbness: Specify:
Eye Response: Memory:
Motor Response: Facial Droop:
Thought Process: Describe:
Headaches: Describe: Babinski Reflex Positive:
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Neuro Comment: AWAKE AND ALERT ORIENTED X3 NO NEURO DEFICIT NOTED
:

~EENT Assessment Within Normal Limits: Y
Right Eye: Left Eye:

ADMISSION ASSESSMENT 04/15/05 0424 EDM

Right Ear: Left Ear:
Nasal: Throat/Mouth:
EENT Comment: WDP
:

~RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Cough:
Location: Secretions, Amt:
Effort: Color:
Chest Expansion: Chest Tubes Present:
IF ON OXYGEN SpO2 (%): 97
Oxygen Device: NASAL CANNULA O2 Amount (L/min): 2 FIO2:
Respiratory Comment: DENIES SOB LUNGS CTA
:

~CARDIAC Assessment Within Normal Limits: N
Heart Rate Irregular: N Heart Tones: WNL S1S2
Syncope/Fainting: N Vertigo/Dizziness: N
Chest Pain: Y Pain Quality: PRESSURE
If Radiating, Describe:
Pain Scale: 6/10 Pain Treatment: MEDICATED PRN (SEE MAR)
IF ON CARDIAC MONITOR/TELEMETRY Treatment Outcome: COMPLETE RELIEF OF PAIN
Monitor #: 7 Cardiac Rhythm: NORMAL SINUS RHYTHM
Cardiac Comment: CC OF CHEST PAIN WAS MEDICATED IN ER
: DENIES CHEST PAIN AT THIS TIME

~CIRCULATORY Assessment Within Normal Limits: Y
Extremity Temp: Left Radial Pulse: MODERATE
Extremity Color: Right Radial Pulse: MODERATE
Sensation: Left Pedal Pulse: MODERATE
Edema: Right Pedal Pulse: MODERATE
Circulatory Comment: PULSES PALPABLE NO EDEMA NOTED
:

~MUSCULOSKELETAL Assessment Within Normal Limits: Y
Contractures/Deformities:
Gait/Balance:
Weakness:
Range of Motion:
Joints:
Musculoskeletal Comment: MAES
:

~GASTROINTESTINAL Assessment Within Normal Limits: Y
Abdominal Appearance: Abdominal Pain:
GI Bleeding: N Bowel Sounds: Nausea/Vomiting:
Last BM: 04/14/05 Describe Stool:
Color of Stool:
Ostomy: GI Tube:
Suction: Drainage Color:
GI Comment: ABD NON DISTENDED, NON TENDER, DENIES ABD PAIN, DENIES N/V
:

~GENITOURINARY Assessment Within Normal Limits: Y
Incontinence: Cath: Type: Color:
~ GU Problem:

If Female Bleeding/Discharge: Describe:
If Male Scrotal Edema: Penile Discharge:
=== IF DIALYSIS PATIENT ===
Type of Dialysis: Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage
GU Comment: VOIDS FREELY
:
~INTEGUMENTARY Assessment Within Normal Limits: Y
Abnormalities Photo Documented:
Alteration: Location:
Dressing Type/Condition:
Alteration: Location:
Dressing Type/Condition:
Alteration: Location:
Dressing Type/Condition:
Drainage Tube: Describe:
Skin Comment: INTACT WARM AND DRY
:

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
~Sensory Perception: 4 NOT LIMITED WNL ~Skin Risk Score: 21
Moisure: 3 OCCASIONALY MOIST
Activity: 4 WALKS FREQUENTLY =Risk Score=
Mobility: 4 NO LIMITATIONS Low (16+): Y
Nutrition: 3 ADEQUATE Moderate (13-15):
Friction and Sheer: 3 NO APPARENT PROBLEM High (<13):

~PSYCHOSOCIAL Assessment Within Normal Limits: Y
Fears or Anxiety Related to Hospitalization: Ineffective Coping:
Inadequate Support System:
Suspected Abuse/Neglect: Describe:
Behavior/Appearance Appropriate: Alteration in Growth/Development:
Psychosocial Comment: CALM AND COOPERATIVE OF CARE
:
=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished: 0 NO
Nausea, Vomiting, or Diarrhea for >3 Days: 0 NO
Unintentional Weight Loss >10# in Past Month: 0 NO
~Admitted with Potential Risk Diagnosis: 1 YES
Poor PO Intake for >4 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
~Total Score: 1 =Nutrition Risk=
Low (0-1): Y
Moderate (2-3):
High (4+):

=== FUNCTIONAL STATUS ===
~Has the Patient's Functional Ability Decreased in the Last 6 Months: N
Prior Mobility: Current Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N

=== FALL RISK ASSESSMENT===
~ Mental Status: 0 NOT ALTERED ~Total Score: 0
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED =Fall Risk=

ADMISSION ASSESSMENT 04/15/05 0424 EDM

Elimination Status: 0 NOT ALTERED Low (0-2): Y
Recent History Of Falls: 0 NO FALLS Moderate (3-6):
Patient's Age: 0 < 65 YEARS High (7+):

=== EDUCATION SCREENING ===
Educational Need Priority #1: DISEASE PROCESS
Educational Need Priority #2: MEDICATIONS
Educational Need Priority #3: SAFETY PRECAUTIONS
Educational Need Priority #4: TREATMENT PURPOSE

=== BARRIERS TO LEARNING ===
Physiologic Limitations:
Psychological Limits:
Cognitive Limitations:
Teaching Method Preferred: EXPLANATION
Comment: VERBALIZES UNDERSTANDING

=== SAFETY === Isolation: STANDARD PRECAUTIONS Allergy Bracelet On: Y ID Band On: Y
~Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: RIGHT HAND ~IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 04/15/05

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:

Chest Tube #1 Location: Chest Tube #2 Location:
Drainage: Drainage:
Waterseal Patent: Waterseal Patent:
Connected to Suction: Connected to Suction:
Suction Amount (cm): Suction Amount (cm):
Subcutaneous Air Noted: Subcutaneous Air Noted:
Air Leak: Air Leak:
Dressing Changed/Reinforced: Dressing Changed/Reinforced:

Monogram	Initials	Name	Nurse Type
EDM	NURMED	Maniago,Edna D	RN
KGM	CNAMKG	Bravo,Kathy G	CNA
TMS	CNASTM	Sauceda,Tina M	CNA

Standards of Care Reference

The Following STANDARDS OF CARE are Related to the Patient, Family/and or Significant other.
1. Patient Care
2. Patient Education
3. Patient Discharge Planning
4. Patient Safety
5. Patient Rights

1a. The Patient will Receive Care Reflecting an Ongoing Interdisciplinary Process Of Assessment, Problem Identification, Goal Setting, Interventions, And Evaluation Based On His/Her Specific Bio-Psychosocial Needs and Expectations Of Care.
1b. The Patient Will be Involved in the Plan of Care With Attention To Age Specific Needs, Cultural and Religious Beliefs, Confidentiality and Special Communication Needs.

2. The Patient will Receive Education About the Nature of His/Her Health Condition, Procedures, Treatments, Self Care, and Post Discharge Care. Verbalization Of Questions and Concerns Will be Encouraged. Patient Education, Which is an Interactive, Interdisciplinary Teaching Process Is Prioritized Based on the Ongoing Assessment or Individual Learning Needs.

3. The Patient will Participate in Coordinating Resources and Establishing Priorities In

Preparation for Discharge.

4. The Patient will Receive Care In An Environment that Minimizes Risk of Injury for Themselves or Others.

5. The Patient will be Supported in His/Her Effort to Retain Personal Identity, Self Worth, Privacy and Autonomy.

STANDARDS OF PRACTICE - ICU

Unless Otherwise Documented, The Following Assessments And Interventions Have Been Completed.

SAFETY:
1. Verify armband, with name and medical record number, in place.
2. Evaluate for Fall Risk q shift and with any change in condition.
3. Initiate safety measures as indicated:
   Side rails up
   Bed in lowest position
   Bed wheels locked
   Call bell within reach as patient condition allows.
   Essentials within reach
   Patient/family instructed to call for nurse
4. Perform safety rounds at least q2hr and prn
5. Observe standard precautions for infection control; additional precautions as indicated.
6. Keep environment as quiet as possible
7. Orient patient/family/significant other(s) to unit, room, call bell, bed controls, side rails, bed position, safety issues, visiting hours and smoking policy on admission and prn.
8. Monitor equipment in use q shift and prn

9. Accompany/monitor all patients going for procedures/tests unless otherwise ordered. Transport cardiac monitor/emergency meds with patient.
10. Accompany all patients discharged home to entrance of hospital.

PSYCHOSOCIAL:
1. Provide privacy for patient/family/significant other(s).

STANDARDS OF PRACTICE - ICU

2. Identify patient support system; involve appropriately in plan of care.
3. Assess patient/family/significant other(s) for economic, social cultural, religious and environmental factors which may affect patient during hospitalization.
4. Encourage patient/family/significant other(s) to verbalize concerns to health care team.

NURTITION:
1. Monitor nutritional intake.
2. IF ON DIET, >50% of meal eaten and tolerated well.
3. If ordered, advance diet as tolerated.
4. Assist with eating/feeding if indicated.
5. Dietary consult if NPO > 24 hrs.

6. If on enteral nutrition (tube feedings):
   Assess tube placement q 4 hrs and prior to starting feeding/giving meeds.
   Weighted radiopaque feeding tube placement verified by CXR after insertion and prn.
   HOB maintained at 30 degrees as patient condition allows.
   Assess tolerance to feeding solution.
   Check gastric residual q4h for continuous feeding.
   Check gastric residual before each intermittent or bolus feeding. If over 100 cc do not give next feeding.
   Use an enteral feeding pump for continuous feedings.
   Change feeding container/gavage set q24hr.
   Flush feeding tube with 20-50 ml water q shift and prn following medication administration.
   Fill enteral bag with only a 12 hr measure of feeding solution.
   Utilize blue food color in all enteral feedings.
   Provide skin care to nare or tube insertion site daily and prn. Change tape q 24 hr.
   Weigh daily unless pat's condition does not permit it.
   - Medication administration with enteral feedings -
   For medications to be given on full stomach: Stop feeding, flush with 20cc warm H2O, administer med, flush with 20cc warm H2O, resume feeding.

   For medications to be given on empty stomach: stop feeding 30 minutes prior to administration time, flush with 20cc warm H2O, administer medication, flush with 20cc warm H2O, resume feedings 30 minutes after administration.
7. If on parenteral nutrition (TPN/PPN):
   Infuse TPN via patent central line, using an infusion pump.
   Change TPN/PPN solution a minimum of q 24 hr.
   Change tubing q 24 hr.
   Lipids may be piggybacked into the TPN tubing; Change tubing q 24hrs.
   Monitor weight and glucose according to policy.
   Do not infuse TPN via a midline catheter.

ACTIVITIES/ADL'S:
1. Activities performed as ordered:
   Encourage progressive activity.
   Monitor toleration of activity.
   Determine need for and monitor use of assistive devices.
2. If on bedrest:
   Turn/reposition at least q 2hr & prn as condition allows, maintaining proper body alignment and assess skin condition.
   Perform/assist with range of motion exercises q2-4 hr and prn.

3. Assist with hygiene needs daily and prn.

STANDARDS OF PRACTICE - ICU

4. If not performing independently:
   Assist with personal hygiene a minimum of q24hr.
   Offer oral hygiene twice daily and prn.
   If patient intubated or NPO offer oral hygiene q2hr and prn.
5. Change linen as necessary to maintain personal hygiene/comfort.
6. If patient is incontinent:
   Cleanse perineal/perianal area and apply skin barrier after each episode.
   Change bed linens prn to keep dry.
   Establish a bladder/bowel program with fixed voiding schedule if appropriate.
   Toileting offered q2hr and prn.

SKIN INTEGRITY:
1. Perform risk assessment upon admission and daily.
2. Evaluate skin condition q4hr and prn:
   Monitor skin integrity.
   Inspect/assess pressure points.
3. Keep skin clean and dry.
4. Prevent/eliminate pressure, friction and shearing forces on skin.
5. Keep linen clean, dry, and wrinkle free.

6. Initiate appropriate interventions for inactivity, immobility, incontinence, malnutrition and/or decreased sensation/mental acuity with guidelines verified in the Plan of Care.
7. Implementation of specialty beds per bed selection decision-making tree. (Order necessary from MD)
8. Remove/rotate NIBP cuff/pulse oximetry probe q4h & prn.

IF IV/INVASIVE LINES PRESENT:
1. Assess site(s) a minimum of q4h & prn for redness, swelling, and/or pain.
2. Label all IV dressings and tubings with date, time and nurse's initials.
   Use nonporous tape to write dates and times on IV solution bags and tubings.
4. If peripheral IV site present:
   Verify that IV site changed a minimum of q72hr & prn.
   All IV's started out of hospital are changed within 24hr.
   Saline flushes per protocol. Date vials.
5. For all IV/epidural solutions infusing or invasive monitoring solutions:
   Verify IV/pressure solution and monitor ordered rate of infusion and/or site q1hr.
   Verify that IV/pressure solution(s) changed a minimum of q24hr.
   Verify that IV/pressure tubing and transducers changed a minimum of q72hr

   and with each site change except as noted below:
   -Every 12 hours for Diprivan tubing
   -Every 24 hours for lipid tubing
   -Every 24 hours for TPN tubing
6. If central line present:
   Assess site and apply transparent dressing after insertion of central line.
   Change transparent dressing/caps q72hr and prn.
   Flush unused ports of multi-lumen lines with appropriate solution q8hr and prn following intermittent infusions/blood draws, reserve one lumen for TPN only.
   Dispose of multidose vials q 30 days. Date vials.
   Use IV pump for all infusions.
7. If midline/PICC line present:
   Dressing change and site care done q week by nurse.
   Flush unused ports of mulit-lumen lines with appropriate solution q24hr and prn following intermittent infusions/blood draws (when allowed).
   Use IV infusion pump for all infusions.

STANDARDS OF PRACTICE - ICU

8. If implanted port present:
   Access only with a Huber needle.
   Change dressing and access every 7 days.
   If not in use or following intermittent infusion/blood draws, heparinize

   with appropriate concentration and amount per policy.
   Use an infusion pump for all infusions.
9. If invasive monitoring line(s) in use:
   Transducers zeroed/leveled q shift and prn.
   Zero/level with HOB flat unless condition prohibits, and record HOB position/elevation.
   Maintain system sterility by use of yellow deadender caps/heparin locks on all open ports.
   2:1 heparinized solution unless pt. condition prohibits.
   Maintain pressure bag at 300mmHg.
   Pulmonary Artery Catheter Monitoring:
   -PA/CVP q4hr
   -Hemodynamic profiles will be recorded on insertion of line and q shift or per order. CO injectate to consist of 10cc room air temp NS unless otherwise ordered of patient condition merits iced or low volume.
   -Measure catheter position q shift and prn. Document initial insertion position.

   Arterial catheter Monitoring:
   -Correlate with brachial cuff q8hr and prn.
   -Assess CMS peripherally to arterial catheter q2hr.
   -Arterial line sites to be changes every 5 days.
   Discontinuance of sheaths:
   -Central introducers/side ports: remove prior to transfer from ICU.
   -If patient condition prohibits PIV access, obtain order to maintain prior to transfer from ICU.
10. If irrigation solution in use:
   change solution q24hr.
   Chart all solution/flushes with or without medications on MAR.

PAIN:
1. Pain assessment to be performed each time vital signs are recorded and prn with appropriate interventions:
   Assess location, type, duration and frequency of pain
   Assess intensity of pain using an appropriate tool: self-report, scale 0-10.
2. If IV opiods administered:
   Verify drug and dose to be given.
   Dilute and administer per protocal.

   Monitor sedation level and respiratory rate/quality per policy.
3. If PCA in use:
   Verify medication/program/patency.
   Instruct patient in use.
   Monitor vital signs and sedation level per policy.
4. If epidural catheter in use:
   Verify medications/program/patency.
   Check catheter site/dressing q shift and prn.
   Monitor vital signs and sedation level per policy.
   All prn analgesics/sedatives ordered by anesthesiologist only.

RESPIRATORY:

STANDARDS OF PRACTICE: ICU

1. Assist with coughing, deep breathing and IS at ordered intervals or q4hr while awake and prn as necessary.
2. If patient has respiratory condition, monitor pulse oximetry q1hr or as ordered and titrate O2 to maintain SPO2 per order.
3. If oxygen in use, titrate per respiratory protocal unless ordered otherwise.
4. Special care of ventilated patients:
   ET suction prn.

   Change/date/reposition ET/NT q24hr.
   Establish means of communication.
   Monitor and record ventilator settings on ICU flow sheet.
   Respiratory Therapist present at all planned extubations.
5. If Tracheostomy present:
   Routine tracheostomy care q12hr and prn.
   Cleanse with 1/2 strength H2O2 and NS.
   Cleanse skin around stoma with trach care and prn.
   Verify trach ties as secured and change as ordered
   suction prn.
   Maintain dry and intact dressing.
   Establish means of communication.
   Keep spare trach of appropriate size at bedside.

CARDIAC:
1. EKG continuously monitored.
2. Alarms verifed as on with settings +/- 30% of patient's baseline.
3. EKG pads changes q24hr and prn.
4. Posting of EKG tracing q4hr, with changes and prn with PR, QRS, & QT intervals measured/evaluated on strip. Posted on Progress Note on chart.

5. Monitor all patients discharged to telemetry with cardiac monitor.
6. For external pacemaker patients:
   Pt to be on bedrest if pacemaker is in use
   Site care q24hr and prn.
7. Chest Pain Orders for all pts with a cardiac diagnosis.

IF VASCULAR PATIENT:
1. Verify appropriate palpated pulses with doppler for post procedure/post op vascular patients.

IF NEURO PATIENT:
1. Use of seizure precautions:
   Padded side rails
   Bed low position
   Airway at bedside
2. Maintain HOB elevated per order.
3. Use of subarachoid hemorrhage precautions:
   Bedrest
   Quiet environment/decrease stimuli
   Limit activity of patient and visitors to room

   Dim lighting
   Use of stool softners per MD order/collaborative preactice
4. If Ventriculostomy present:
   Monitor and record ICP q2hr.

IF ORTHOPEDIC PATIENT:

STANDARDS OF PRACTICE: ICU

1. Maintain weight bearing status as orderd.
2. Utilize immobilizers/breaces/collars as ordered.
3. Monitor CMS of affected extremity q8hr and prn.
4. Apply ice pack to surgical site if ordered.
5. Use pillows under operative lower extremity only if specifically ordered.

IF ANTIEMBOLITIC STOCKINGS ORDERED:
1. Elastic stockings in place, remove q shift and prn for skin assessment.
2. Sequential Compression Device in place while in bed and removed at bathtime and prn for skin assessment or as ordered.

INCISIONS/DRESSINGS:
1. If incision present:
   Site monitored for bleeding/drainage q4h and prn.

   Check incision with each dressing change.
2. If dressing present:
   Check every 4 hrs and prn.
   Dressing changed/reinforced q2hr or as MD ordered.

TUBES/DRAINS:
1. If drainage tube(s) present (JP, hemovac, t-tube, etc.):
   Verify patency.
   Skin care to insertion site(s).
   Measure contents/empty q12hr and prn or as ordered.
2. If foley present:
   Verify patency.
   Maintain closed gravity drainage system.
   Keep bag below level of bladder at all times.
   Pericare daily and prn.
   If foley inserted outside of hospital, change within 24hr.
   Change foley bag for increase in sediment, obstruction, or a break in the closed system.
3. If supra-pubic catheter present:
   Clamp as ordered or verify patency.

   Anchor catheter to thigh.
   Voiding trials as ordered.
4. If NGT present:
   Verify patency/placement of tube q shift and prn unless otherwise ordered.
   Tape securely and change tape q24hr.
   Irrigate tube q shift with 30cc H2O as patient condition allows or as ordered and prn. Change irrigation set q24hrs (graduate/toomy syringe).
   Anti Reflu Valve should be in place when NGT connected to suction.
   Contents measured q12hr and prn.
   Change suction cannister q24hrs.
   Medication Administration through NG Tube:
   -Flush tube with 20cc warm H2O
   -Administer medication in enough volume to maintain tube patency while administering
   -Flush tube with 20 cc warm H2O
   -Clamp tube for 30 minutes after administration.
5. If chest tube(s) present:
   Assess for air leak, SQ air q4h and prn
   Verify patency

STANDARDS OF PRACTICE: ICU

Securely tape chest tube and connecting tubing in place
Dressings to insertion site(s) dry and intact; change per MD order
Maintain water seal chamber/suction as ordered
Maintain chest tube drainage system lower than insertion site
Record amount/color of drainage q12hr, mark on drainage system

I&O:
1. I&O to be monitiored q4hr and recorded q12hr (+)

WEIGHT:
1. Weigh pt on admission and qd if pt's condition permits.

VITAL SIGNS:
1. To be taken on admission and q2hrs (+)
2. Temperatures to be taken q4h unless elevated then q2h (+)

STANDARDS OF PRACTICE: M/S/T

Unless Otherwise Documented, The Following Assessments And Interventions Have Been Completed.
SAFETY:
1. Verify armband, with name and medical record number, in place.
2. Evaluate for Fall Risk q shift and with any change in condition.
3. Initiate safety measures as indicated:
   Side rails up x 2
   Bed in lowest position
   Bed wheels locked
   Call bell within reach at all times
   Essentials within reach
   Patient/family instructed to call for nurse
4. Perform safety rounds at least q2hr and prn
5. Observe standard precautions for infection control; additional precautions as indicated.
6. Keep environment as quiet as possible
7. Orient patient/family/significant other(s) to unit, room, call bell, bed controls, side rails, bed position, safety issues, visiting hours and smoking policy on admission and prn.
8. Monitor equipment in use q shift and prn

PSYCHOSOCIAL:
1. Provide privacy for patient/family/significant other(s).
2. Identify patient support system; involve appropriately in plan of care.
3. Assess patient/family/significant other(s) for economic, social cultural, religious and environmental factors which may affect patient during hospitalization.
4. Encourage patient/family/significant other(s) to verbalize concerns to health care team.

NUTRITION:
1. Monitor nutritional intake.
2. If on diet, > 50% of meal eaten and tolerated well
3. If ordered, advance diet as tolerated
4. Assist with eating/feeding if indicated
5. If on enteral nutrition (tube feedings):
   Assess tube placement q 4hr and prior to feedings/giving meds.
   Assess tolerance to feeding solution.
   Check gastric residual q4hr for continuous feeding.
   Check gastric residual before each intermittent or bolus feeding. If over 100cc notify physician.

STANDARDS OF PRACTICE: M/S/T

Use an enteral feeding pump for continuous feeding.

   Change feeding container/gavage set q24hr.
   Flush feeding tube with 30-50ml water q4hr and prn following medication administration unless ordered otherwise.
   Provide skin care to nare or tube insertion site daily and prn.
   Weigh daily if on enteral feedings.
   Maintain HOB 30 degrees at all times.
6. If on parenteral nutrition (TPN/PPN):
   Infuse TPN via a patent central line using an IV infusion pump.
   Change TPN/PPN solution a minimum of q24hr.
   Change tubing q24hr.
   Lipids may be piggybacked into the TPN tubing; change tubing q 24hr.
   Monitor weight, glucose and labs according to policy.

ACTIVITIES/ADL'S:
1. Activities performed per activity guidelines or as ordered.
   Encourage progressive activity
   Monitor toleration of activity
   Determine need for and monitor use of assistive devices
2. If on bedrest:
   Turn/reposition at least q2hr as condition allows, maintaining proper body alignment.

   Perform/assist with range of motion exercises q 4hr and prn.
3. Assist with hygiene needs daily and prn.
4. If not performing independently:
   Assist with personal hygiene a minimum of 24hr.
   Offer oral hygiene twice daily and prn.
5. Change linen as necessary to maintain personal hygiene/comfort.
6. If patient is incontinent:
   Cleanse perineal/perianal area and apply skin barrier after each episode
   Change bed linens prn to keep dry
   Offer toileting q2-3hr and prn
   Record BM daily; if no BM > 2 days notify MD for laxative order

SKIN INTEGRITY:
1. Perform risk assessment upon admission and q shift.
2. Evaluate skin condition with each shift assessment:
   Monitor skin integrity
   Inspect/assess pressure points:Refer to Decubitus Protocol
3. Keep skin clean and dry
4. Prevent/eliminate pressure, friction & shearing forces on skin
5. Keep linen clean, dry and wrinkle-free

6. Initiate appropriate interventions for inactivity, immobility, incontinence, malnutrition and/or decreased sensation/mental acuity with guidelines verified in the plan of care.

I&O:
1. I&O measured and documented q 12hrs

WEIGHT:
1. Weigh on admission and qd if pt's condition permits
   (CHF, Renal Failure, on TPN and enteral feedings)

IF IV/SL PRESENT:
1. If S/L:

STANDARDS OF PRACTICE: M/S/T

Assess site(s) a minimum of q4hr and prn for redness, swelling and/or pain.
2. If IV:
   Verify solution and monitor ordered rate of infusion and/or site q4hr and prn.
3. Verify that IV bag changed a minimum of 24hr.
4. Verify that IV site changed a minimum of 72hr and prn as per policy.
   Label site with date, time, and initials
5. Verify that IV tubing changed a minimum of 72hr and with each IV site change.
6. Label all IV dressings and tubings with name, time and nurse's initials.
7. If central line present:
   Assess site and dressing q12hr
   Change dressing/caps q72hr and prn as per policy.
   Flush unused ports of multi-lumen lines with appropriate solution q8hr and prn following intermittent infusions/blood draws, reserve one lumen for TPN only as per policy. Follow Venous Access Policy.
   Use infusion pumps for all infusions.
8. If implanted port present:
   Access only with Huber needle
   Change dressing and access q 7 days
   If not in use or following intermittent infusions/blood draws, heparinize with appropriate concentration and amount. See Venous Access Policy.
   Use an IV infusion pump for all infusions.
9. If patient admitted with a PICC line, physician to be called for orders for care.

PAIN:
1. Pain assessment performed each time vital signs are recorded and prn with appropriate interventions and follow pain management guidelines as per policy. Pain is the 5th Vital Sign.
   Assess location, type, duration and frequency of pain.
   Assess intensity of pain using an appropriate tool (self report, scale 0-10)
2. If IV opioids administered:
   Verify drug and dose to be given
   Dilute and administer per protocol
   Monitor sedation level and respiratory rate/quality per policy
3. If PCA in use: (Follow PCA protocol)
   Verify medication/program/patency
   Instruct patient in use
   Monitor vital signs and sedation level per policy
4. If epidural catheter in place:(Follow specific MD orders)
   Verify medications/program/patency
   Check catheter site/dressing q8hr and prn as per policy
   Monitor vital signs and sedation level per policy

RESPIRATORY:

1. Assist with coughing and deep breathing at ordered intervals or q4hr and prn as necessary
2. Monitor pulse oximetry prn as appropriate or as ordered.
3. If oxygen in use, titrate per respiratory protocol, unless ordered otherwise.
4. If postoperative:
   Turn, cough, deep breath q2hr x 8, then q4hr and prn.
   Incentive spirometer as ordered
5. If Tracheostomy present:

STANDARDS OF PRACTICE: M/S/T

   Routine tracheostomy care q shift and prn.
   Change inner cannula q24hr
   Cleanse skin around stoma with trach care and prn
   Verify trach ties as secure and change as ordered
   Suction prn
   Maintain dry and intact dressing
   Establish means of communication
   Keep spare trach of appropriate size at bedside

IF ANTIEMBOLITIC STOCKINGS ORDERED:
1. Elastic stockings in place, remove at bathtime and prn for skin assessment or as ordered.
2. Sequential Compression Device in place while in bed, remove at bathtime and prn for skin assessment or as ordered.

POSTOPERATIVE OBSERVATION:
1. Postoperative assessment on arrival to floor to include:
   Vital signs and level of sedation per policy
   Presence of pain and comfort measures
   Dressing site(s) & drainage tubes
   Appropriate charting on POST OP:SURGICAL ASSESSMENT through the Assessment/Forms routine
2. Monitor pain level with vital signs and level of sedation per policy

INCISIONS/DRESSINGS:
1. If incision present:
   Monitor site for bleeding/drainage q4hr and prn
   Check with each dressing change or q4hr & prn if no dressing
2. If dressing present:
   Check q shift and prn
   Change prn unless ordered otherwise
3. If GYN patient, monitor vaginal bleeding q4hr and prn
4. If vaginal packing present:
   Check q shift and prn
   Remove only as ordered

TUBES/DRAINS:
1. If drainage tube(s) present (JP, hemovac, t-tube, ect).
   Verify patency
   Skin care to insertion site(s)
   Measure contents/empty q12hr or as ordered and prn
2. If foley present:
   Verify patency
   Maintain closed gravity drainage system
   Keep bag below level of bladder at all times
   Peri-care daily and prn
3. If supra-pubic catheter present:
   Clamp as ordered or verify patency
   Anchor catheter to thigh
   Bladder training as ordered
4. If NGT present:
   Verify patency/placement of tube q shift and prn unless otherwise ordered.
   Tape securely and change tape q24hr.
   Anti Reflux Valve should be in place when NGT connected to suction.

STANDARDS OF PRACTICE: M/S/T

HOB elevated 30 degrees at all times.
Change suction cannister liner q24hr.
Medication Administration through NGT:
-Flush tube with 20 cc warm H20
-Administer medication in enough volume to maintain tube patency while administering
-Flush tube with 20 cc warm H20
-Clamp tube for 30 minutes after administration

5. If chest tube(s) present:
Assess for air leak, SQ air q4hr and prn
Auscultate breath sounds
Securely tape chest tube and connecting tubing in place
Dressings to insertion site(s) dry and intact; change prn
Maintain water seal chamber/suction as ordered
Maintain chest tube drainage system lower than insertion site
Clamps X2 at bedside

IF ON TELEMETRY:
1. Monitor EKG continuously
2. Interpret and post rhythm strips q4hr and prn
3. Notify physician of rhythm changes
4. Change EKG pads daily

IF ORTHOPEDIC PATIENT:
1. Maintain weight bearing status as ordered
2. Utilize immobilizers/braces/collars as ordered
3. Monitor CMS of affected extremity q8hr and prn
4. Apply ice pack to surgical site if ordered
5. Assess Homan's sign q12hr and prn
6. Use pillows under operative lower extremity only if specifically ordered

REFERENCE - DEFINED PARAMETERS

NEUROLOGICAL Parameters:
--Eyes Open Spontaneously
--Oriented (Person, Place & Time)
--Follows Commands
Speech Clear
--No swallowing difficulty/impairment at present as evidenced by drooling, coughing, choking or complaint of difficulty
--No Headache
--Behavior/Appearance Appropriate (Good Hygiene Appropriate Dress For Season, Well-Groomed, Emotions Appropriate Considering Cultural Variations)
--No current seizure activity noted

EENT Parameters:
--Pupils equal and react briskly to light
--No discharge, redness, pain, edema, blurred or distorted vision with glasses/contacts, noted/complained about eyes
--Able to hear common sounds with and/or without hearing aids (No hearing impairment)

--No Nasal Complaints/Abnormal Assessment Such As Bleeding, Nasal Discharge (Watery, Mucoid, Purulent) Congestion, Stuffiness, Or Difficulty Breathing T[illegible]h Nares

REFERENCE - DEFINED PARAMETERS

--No Throat Complaints/Abnormal Assessment Such As Sore, Red, Swollen, Hoarseness, Hypertrophied Tonsils, exudate on tonsils, or postnasal drip
--Buccal Mucosa Pink, Moist And Smooth
--Teeth present are intact OR well-fitting dentures

RESPIRATORY Paramters:
--Breath Sounds Clear/Vesicular (Soft, Low-Pitch Sounds) Throughout All Lung Fields And Bronchial Over Major Airways: No Adventitious Breath Sounds Noted
--Respirations Unlabored
--Equal Chest Expansion Noted
--NO Cough Noted
--No Sputum/Secretions Noted
--No Chest Tubes in Place
IF ON OXYGEN: Document Device And Amount Of Oxygen Delivered

CARDIAC Parameters:
--Heart Rate Regular Per Ausculation Or Palpatation
--Heart Sounds Normal (S1 & S2)
--No Syncope/Fainting
--No Dizziness/Vertigo
--Denies Chest Pain
IF ON TELEMETRY: Record rhythm

CIRCULATORY Parameters:
--Strength of the Radial, Dorsalis Pedis , and Posterior Tibial pulses is expected (2+)
--Extremities Warm
--Extremities pink in color
--Denies sensory changes in extremities (no numbness, tingling or loss of sensation)
--No edema noted

MUSCULOSKELETAL Parameters:
--No skeletal deformities noted
--Steady Gait And Balance

--No Weakness Noted In Extremities
--Extremities With Full ROM
--No Joint Swelling/Tenderness Noted

NUTRITIONAL Parameters:
--Diarrhea/Nausea/Vomiting For < 3 Days
--NPO Or Clear Liquids < 3 Days
--Not On Dietary Supplementation (TPN/PPN/TUBE FEEDING)

GATROINTESTINAL Parameters:
--Abdomen Flat Or Evenly Rounded, Soft, Symmetrical And Nontender To Palpation.
--Bowel Sounds Active In All 4 Quadrants (5-30/min)
--Moving bowels within own and no change in consistency
--Denies GI Complaints (Colicky, Cramping, Diarrhea Constipation, Heartburn, Epigastric Burn, Fecal Incontinence, Belching, Hemorrhoids, Regurgitation, Bloody BM, Flatulence, Upset Stomach, Feeling Of Fullness, Decrease[illegible]etite, Nausea And/Or Vomiting.)

REFERENCE - DEFINED PARAMETERS

--No GI tubes present for decompression of GI tract

(Do not include tubes here for feeding purposes)

GENITOURINARY Parameters:
--Able To Empty Bladder Per Voiding Without Incontinence Or Catheter (May Use Urinal, BSC, Or Bedpan
OR
No Problems Because Dialysis Patient And Does Not Produce Urine.
--Urine Clear And Yellow To Amber In Color.
--Denies Urinary Complaints/Problems (Burning, Frequency, Urgency, No/Low Urine Output etc.)
--IF FEMALE PATIENT: No Unusual Vaginal Bleeding Or Vaginal Discharge Noted Or Complained.
Vaginal packing in place as ordered
--IF MALE PATIENT: No Penile Discharge Noted Or Coplained.
No Scrotal Edema Noted Or Complained.
--IF DIALYSIS PATIENT: Document type of dialysis and IF FISTULA: Fistula with bruit and thrill

INTEGUMENTARY Parameters:

--General Skin Assessment Is Pink/Ethnic Color, Warm And Dry.
--Skin Intact: No Alteration In Skin Integrity (Such As Abrasion, Blisters, Burn, Decubitus, Bruising, Excoriation, Hives, Incision, Irritation, Lacerations, Lesions, Peeling, Rash, Scaling, Sloughing, Stoma Present, Skin Tears, Ulcerations, Or Wounds.
--No Drainage Tubes Such As Hemovac, JP, Penrose Drain T-TUBE Etc. Present.

PSYCHOSOCIAL Parameters:
--No Mood Swings Noted. Patient's Mood Appropriate For Situation With Regards To Cultural Influences.
--Effective coping skills/patterns with regards to cultural influences
(ineffective coping can be presented as post traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behaviors)
--No altered self perceptions noted such as body image disturbance, feeling of hopelessness, personal identity

disturbance,feeling of powerless, or altered self esteem
--Normal, age-appropriate, growth and development (Erickson'S)
--No signs of suspected abuse
(physical, emotional, neglect, etc.)
Signs include delay in treatment, hesitation to explain, injury inconsistent with history, sites of injury, self neglect, nonspecific complaints, patterned markings, recurrent injuries, or injuries in various stages

PAIN Parameters:
--No chronic or acute pain

REFERENCE - DEFINED PARAMETERS

EDUCATIONAL Parameters:
--No educational barriers identified such as age related issues, HOH, reads only braille, cognitive, cultural deaf, emotional/psychiatric, financial, language, motivational, physical, reading below grade level, cannot read written words, religious, uses sign language only, and/or decreased vision

--Pt/Significant other(s) able to understand verbal instructions well
(no difficulty related to educational barriers)
--Pt/Significant other(s) able to understand written instructions well (no difficulty related to eductional barriers)
--Pt/Significant other(s) able to verbalize knowledge of treatment plan/educational needs well
(no difficulty related to educational barriers)

IV SITE Parameters:
--IV site patent without redness, swelling, tenderness, or temperature

SS/Discharge Plan Assessment	04/15/05 0829

1. REASON FOR ASSESSMENT:
- Y Pt. Reviewed. No Needs Identified; Will Return to Prior Living Arrangement; No Further Intervention Required at This Time.
- Pt. Requires Additional Discharge Planning and has been Referred to the Hospital DC Planner
- Pt. Requires Additional Discharge Planning and is being Managed by an Outside Case Manager. Pt. has been Referred to:
- Pt. Requires Social Service Assistance and has been Referred To the Hospital Social Worker;See QRM Multidisciplinary notes for Further Documentation.
- Pt. Requires Case Management Assistance and has been Referred to the Hospital Case Manager; See QRM Multidisciplinary Notes for Further Documentation.

2. DISCHARGE PLANNING ASSESSMENT: (Prior to Admission)
Patient Lives With:
Contact Name and Number:
Patient Lives In:
Home Saftey Barriers:
Independent W/ADL's: Ambulation:
Uses DME: List:
Assistance W/ADL's:
Homecare Assistance:
Provider and # of Hrs.:
Meals on Wheels:
Home Health Care:
Agency Name and #:
Other Resource Used:
:

3. EDUCATIONAL NEEDS:
Patient/Family Have Educational Needs

4. DISCHARGE PLAN:
Summary of Assessment/Plan: PT LIVES WITH HIS FAMILY NO DC PLANNING NEEDS
: ANTICIPATED WILL AWAIT PHYSICIAN ADVISEMENT AND FOLLOW AS NEEDED

Reassessment/Follow up Needed: See QRM Multidisciplinary Notes.

=== PATIENT/FAMILY EDUCATION ===
Information Taught:
Instruction Given:

Person Taught:
Person Taught:
Teaching Tools:
Other Tools Used:
Factors Affecting Learning:
Other Factors:
Participation Level:
Evaluation:
Needs Additional Education:
:
Educator:

SS/Discharge Plan Assessment	05 0829 SM

Discipline:

Monogram	Initials	Name	Nurse Type
SM	SWMS	Montoya,Susan	SS

Age/Sex: 59 M Attending: Lally, James M.
Unit #: M000273781 Account #: V00000143675
Admitted: 04/15/05 at 2:51am Status: ADM IN

HANNA,ADEL
CVMC: SS/DISCH PLAN ASSESSMENT

Location: DU Room: 235-B
Printed 04/15/05 at 0830
Period ending 04/15/05 at 0830 SWMS

IV MEDICATIONS							
MEDICATIONS							
DISCHARGE PLANNING	INDEPENDENT/HOME ☐ NEEDS EQUIP. ☐ S.S. REFERRAL ☐						
TEACHING							

☐ DNR ☐ See Ad. Dir. Code Status: ______ DATE OF LAST BM: (IN PENCIL) ______

☐ Respiratory Isolation Surgery: ______ Telemetry # 7

Coordinated Care Manager: ______ Practice Guideline for C/P (diagnosis) DRG # ______ Los: ______

ROOM NAME ALLERGY REGLAN DOCTOR

100006 604.007

235 B HANNA LALLY

Chino Valley Medical Center

CHINO VALLEY MEDICAL CENTER

Addressograph

V 13000149675

	Date: Pre-Hospital Recopied Kardex	Date: Day 1 /	Date: Day 2 /	Date: Day 3 /	Date: Day 4 /	Date: Day 5 /	Date: Day 6 /
Patient Activity Safety					DOS	04/15/05	
Consults				ADMIT DR. LALLY, JAMES M. ATTN DR. LALLY, JA PRIM DR. LALLY, JAME			
Diet	2GM NA+ CARDIAC						
Cardio Pulmonary Tests/Tx.	EKG	EKG	EKG				
Lab Tests	CBC, CMP, UA CK, TROP, PT, PTT, HDL, LDL CHOL, MYO CKMB x3 Q8° AMY, LIP, MG						
Radiology Tests	CXR						
Physical Therapy							
Treatments (i.e.; VS, WEIGHTS, I&O)	C/P PROTOCOL O2 3L N.C.						

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0324

975050 Inventory Personal Belongings + A ADM.TX.DC AS
ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.
- Create 04/15/05 0324 RN 04/15/05 0326 RN
- Document 04/15/05 0324 RN 04/15/05 0326 RN
Inventory Date: Inventory Time: Performed By: ED Agency RN
Reason For Inventory:

- Contacts - Y Glasses Disposition:

- Full Dentures Disposition:
- Partial Upper - Lower Disposition:
- Hearing Aid Disposition:

- Prosthesis Describe: Disposition:
- Assistive Device : Disposition:

Jewelry: WATCH Jewelry:
Describe: BLACK Describe:
Disposition: BELONGINGS KEPT BY PT Disposition:

Jewelry: Jewelry:
Describe: Decribe:
Disposition: Disposition:

- Wallet Describe: Disposition:
- Purse Describe: Disposition:
Comment:

- Electrical Appliances Describe:
- Eng. Dept Notified To Evaluate Electrical Appliance

Other Item(s) Of Value To The Patient: BLACK SHOES BLACK SOCKS WHITE SHIRT GREY SHOES
Disposition: BELONGINGS KEPT BY PT

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up.
If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends,
I Release Chino Valley Medical Center From Any Liability For Lost Valuables.
I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times,
And I Understand That The Hospital Assumes No Liability For Such Equipment.

PATIENT:______________________ Date:______________
WITNESS:______________________

By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge.

PATIENT:______________________ Date:______________

Activity Date: 04/15/05 Time: 0324 (continued)

975050 Inventory Personal Belongings + (continued)

WITNESS:

Activity Date: 04/15/05 Time: 0340

Patient Notes: Nurse Notes
- Create 04/15/05 0340 EDM 04/15/05 0450 EDM
Abnormal? N Confidential? N
ADMITTED A 59YO M TO RM 235 B PER STRETCHER FROM ER ACCOMPANIED BY NURSE WITH THE CC OF CHEST PAIN. DX CHEST PAIN R/O UNSTABLE ANGINA. PT ALERT AND AWAKE, ORIENTED X3. PLACED IN BED COMFORTABLY. VS TAKEN AND RECORDED. PLACED ON O2 2L/NC. O2 SAT AT 97%. LUNGS CTA. PLACED ON TELE 7. SR. HR 61BPM. IVF NS TO RT HAND INFUSING WELL AT 75CC/HR. MEDS STARTED. DENIES SOB NOR CHEST PAIN AT THIS TIME. NO DISTRESS NOTED. SAFETY PREC NOTED. CALL LIGHT IN REACH

Activity Date: 04/15/05 Time: 0359

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
- Create 04/15/05 0359 TMS 04/15/05 0359 TMS
- Document 04/15/05 0359 TMS 04/15/05 0359 TMS
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59

Code	Intervention	Sts	Directions	From
1001	Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.	A	WHEN APPLICABLE	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
1070	Shift Reassessment +	A	QS & Q4H IN ICU	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
1500	I&O: Monitor +	A	Q12H (0559,1759)	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
15000	Care Plan: RN Review +	A	Q12H	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
20010	VS: Monitor +	A	AS ORDERED	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
21090	Routine Care: MED/SURG/TELE + VIEW PROTOCOL	A	.END OF SHIFT/TX	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
21400	Nutrition/Activity/ADL Flowsheet +	A	QS BY CAREGIVER	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
22300	IV/Invasive Lines: Insert/Remove +	A	INS/REMOVAL/CONVERT	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
31320	Pain: Management Of +	A	AS NEEDED	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
60010	Notify: MD +	A	WHEN NECESSARY	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			
80010	Education: Patient/Family Teaching +	A	QS BY CAREGIVER	CP
- Create	04/15/05 0359 TMS 04/15/05 0359 TMS			

Intervention Description Sts Directions From
Activity Type Occurred Date Time by Recorded Date Time by Comment Documented Units Change

Activity Date: 04/15/05 Time: 0359

90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP
- Create 04/15/05 0359 TMS 04/15/05 0359 TMS
150010 Weight + A CP
- Create 04/15/05 0359 TMS 04/15/05 0359 TMS
975050 Inventory Personal Belongings + A ADM.TX DC AS
ON ADMISSION & TRANSFER, PRINT OUT &
HAVE PATIENT SIGN COPY.
- Document 04/15/05 0359 TMS 04/15/05 0403 TMS
Inventory Date: 04/15/05 Inventory Time: 0359 Performed By: Sauceda,Tina M
Reason For Inventory: ADMISSION (DU,IC,MU,PE)

-N Contacts -Y Glasses Disposition: BELONGINGS KEPT BY PT

-N Full Dentures Disposition:
-N Partial Upper -N Lower Disposition:
-N Hearing Aid Disposition:

-N Prosthesis Describe: Disposition:
-N Assistive Device : Disposition:

Jewelry: WATCH Jewelry:
Describe: BLACK Describe:
Disposition: BELONGINGS KEPT BY PT Disposition:

Jewelry: Jewelry:
Describe: Decribe:
Disposition: Disposition:

-Y Wallet Describe: BLK 134$ Disposition: BELONGINGS KEPT BY PT
-N Purse Describe: Disposition:
Comment: CELL PHONE PAGER
:

-N Electrical Appliances Describe:
-N Eng. Dept Notified To Evaluate Electrical Appliance

Other Item(s) Of Value To The Patient: BLACK SHOES BLACK SOCKS WHITE SHIRT GREY
: SHOES
Disposition: BELONGINGS KEPT BY PT

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/ Friends, And Have Been Given The Opportunity To Have My Valuables Locked Up.
If I Refuse To Have My Valuables Locked Up Or Sent Home With Family Or Friends, I Release Chino Valley Medical Center From Any Liability For Lost Valuables.
I Have Also Been Advised To Keep Audio/Video Equipment In My Possession At All Times, And I Understand That The Hospital Assumes No Liability For Such Equipment.

PATIENT: ____________________ Date: __________
WITNESS: ____________________

Activity Date: 04/15/05 Time: 0359 (continued)

975050 Inventory Personal Belongings + (continued)
By Signing Below I Indicate I Have All My Belongings At The Time Of Discharge.

PATIENT: ____________________ Date: __________

WITNESS:
1001031 Age Guidelines: 41 65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
- Create 04/15/05 0359 TMS 04/15/05 0359 TMS

Activity Date: 04/15/05 Time: 0403

20010 VS: Monitor + A AS ORDERED CP
- Document 04/15/05 0403 TMS 04/15/05 0405 TMS
Temperature/F: 97.7 Temp Source: ORAL
Pulse: 61 Pulse Source: AUTOMATIC NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 96/68 BP Source: AUTOMATIC
Site: RIGHT UPPER ARM
~ C/O Pain: N
== CNA/LICENSED Documentation ==
Comfort Measures Implemented:
Nurse Notified of Pain:
(If Medicated, Document On Intervention Pain: Management Of)

IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min):
SpO2 (%): 97 FIO2:
Comment: NURSE AWARE OF V/S
150010 Weight + A CP
- Document 04/15/05 0403 TMS 04/15/05 0403 TMS
Weight - Lb: 164 OR Kg:
Oz: 0

Weight Source: STANDING SCALE
Comment:

Activity Date: 04/15/05 Time: 0424

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
- Document 04/15/05 0424 EDM 04/15/05 0424 EDM
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59
1005-A ADM: ADULT Assessment + A ON ADMISSION AS
- Create 04/15/05 0424 EDM 04/15/05 0443 EDM
- Document 04/15/05 0424 EDM 04/15/05 0443 EDM
=== Assessment Obtained === Date: 04/15/05 Time: 0340
Signature: Maniago,Edna D
=== ARRIVAL INFORMATION ===
Time of Arrival: 0340 Mode of Arrival: GUERNEY
Arrived From: EMERGENCY DEPT Accompanied By: NURSE

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)

=== Source of Information ===
Patient: Y Other (name/relationship):
Chief Complaint: CHEST PAIN
Primary Diagnosis: CHEST PAIN R/O UNSTABLE ANGINA
Surgery/Procedure:
Date of Surgery:

=== VITAL SIGNS ===
Temperature/F: 97.7 Temp Source: ORAL
Pulse: 61 Pulse Source: ARTERIAL LINE
Respirations: 18 Respiration Source: OBSERVED
Blood Pressure: 96/68 BP Source: AUTOMATIC Site: RIGHT UPPER ARM
O2 in use: N Liter Flow/FIO2: Pulse Oximetry: Y SpO2%: 97 Probe Location: HAND RT
IV: NS AT 75CC/HR RT HAND

=== PAIN ASSESSMENT ==
C/O Pain: Y *** Chest Pain to be Documented on Cardiac Problem ***
When Pain is Present:
Pain Location: CHEST
Pain Scale: 7/10
Describe the Pain: PRESSURE
Onset:
What Increases the Pain: :
What Relieves the Pain: : MEDICATION
Pain Control Goal: 0/10
Comment: CAME IN WITH THE CC OF CHEST PAIN
:

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: 5 In: 7 OR Cm: 170.18
Weight - Lb: 164 Oz: OR Kg: 74.38
Weight Source: STANDING SCALE
Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKOA

=== DEMOGRAPHIC DATA === Marital Status: M Occupation: DOCTOR
Primary Language: ENGLISH Understands English:
Religion: CHRISTIAN
Beliefs Affecting Care:
Spiritual Coordinator Visit Requested:

Contact Person: HANNA TAMER Relationship: SO
Home Phone: (949)413-8670 Work Phone: Cell/Pager:
Add'l Contact Information:

=== NUTRITION ===
-NUTRITIONAL Assessment Within Normal Limits: Y
Diet at Home: REGULAR
Food Preferences:
Recent Weight Change: Comment:

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)

Nutritional Comment: STATED THAT HE HAS A GOOD APPETITE
:

===PATIENT HISTORY=== ****HISTORY ONLY-NOT for Patient's Current Assessment****
Previous Admits/Surgeries: CHOLECYSTECTOMY HIATAL HERNIA
:
- Neurological: N:
EENT: N:
Respiratory: N:
Cardiac: N:
Hypertension: Y: HX HTN
Circulatory: N:
Blood Disorder/Clots: N:
Musculoskeletal: N:
Gastrointestinal: N:
Hepatitis: N:
Endocrine: N:
Diabetes: N:
Genitourinary: N:
Gynecological:
Skin Disorder: N:
Cancer: N:
Psychosocial: N:
Pain: Y: CHEST PAIN
Pregnant: LMP: :
Has Patient Ever Received Pneumococcal Vaccine: N

=== HOME MEDS === Med/Dose/Frequency/Last Dose *Include ALL over the counter meds

Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N
1. DIOVAN 11.
2. 12.
3. 13.
4. 14.
5. 15.
6. 16.
7. 17.
8. 18.
9. 19.
10. 20.
-Referral Needed: Disposition of Medications:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N Type:
Amount/How Often: Number of Years:
Other Substance Use (comment): DENIES USE

Intervention Description Sts Directions From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)

=== INFECTION RISK SCREEN ===
Admitted from a Skilled Nursing Facility: 0 NO
PEG Tube: 0 NO
Tracheostomy: 0 NO
Central Line: 0 NO -Total Score: 0
Hospitalized in the Last 30 Days: 0 NO =Infection Risk=
Decubitus Ulcer/Open Surgical Wound: 0 NO Low: Y
History of TB, HIV, or Hepatitis: 0 NO Moderate (1-2):
History of MRSA or VRE: 0 NO High (3+):

=== ADVANCE DIRECTIVES ===
Advance Directive: N **IF YES**
Copy on Chart: Family will bring in ASAP:
Copy on File at CVMC: Reviewed with Patient/Representative:
The Current Desire for this Patient Regarding Life Support Is as Follows:
Code Status: FULL CODE If DNR, Bright Pink Armband in Place:
Comment:

If the Patient/Agent has Additional Needs/Concerns R/T Adv. Dir.; Social Worker Notified:

=== DISCHARGE PLANNING ===
Pt lives with: FAMILY
Living Arrangements: HOUSE
Does Patient Live with People who Rely on Him/Her: Y
Does Family/Friends Assist with Home Care: Y
Who Will be Taking Patient Home: FAMILY
Anticipated Discharge Destination: HOME
Is Patient Using Homecare/Outside Agency/Facility: N
Name/Phone # of agency:
=== SYSTEM ASSESSMENT ===

-NEUROLOGICAL Assessment Within Normal Limits: Y == PUPIL REACTION CHECK ==
LOC: Reaction OD: BRISK Size: 2
Orientation: Reaction OS: BRISK Size: 2
Responds to: Weakness: Specify:
Speech: Numbness: Specify:
Eye Response: Memory:
Motor Response: Facial Droop:
Thought Process: Describe:
Headaches: Describe: Babinski Reflex Positive:
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Neuro Comment: AWAKE AND ALERT, ORIENTED X3 NO NEURO DEFICIT NOTED
:

-EENT Assessment Within Normal Limits: Y
Right Eye: Left Eye:

Intervention Description Sts Directions From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)
Right Ear: Left Ear:
Nasal: Throat/Mouth:
EENT Comment: WDP
:

-RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Cough:
Location: Secretions, Amt:
Effort: Color:
Chest Expansion: Chest Tubes Present:
IF ON OXYGEN SpO2 (%): 97
Oxygen Device: NASAL CANNULA O2 Amount (L/min): 2 FIO2:
Respiratory Comment: DENIES SOB, LUNGS CTA
:

-CARDIAC Assessment Within Normal Limits: N
Heart Rate Irregular: N Heart Tones: WNL S1S2
Syncope/Fainting: N Vertigo/Dizziness: N
Chest Pain: Y Pain Quality: PRESSURE
If Radiating, Describe:
Pain Scale: 6/10 Pain Treatment: MEDICATED PRN (SEE MAR)
IF ON CARDIAC MONITOR/TELEMETRY Treatment Outcome: COMPLETE RELIEF OF PAIN
Monitor #: 7 Cardiac Rhythm: NORMAL SINUS RHYTHM
Cardiac Comment: CC OF CHEST PAIN, WAS MEDICATED IN ER
: DENIES CHEST PAIN AT THIS TIME
-CIRCULATORY Assessment Within Normal Limits: Y

Extremity Temp: Left Radial Pulse: MODERATE
Extremity Color: Right Radial Pulse: MODERATE
Sensation: Left Pedal Pulse: MODERATE
Edema: Right Pedal Pulse: MODERATE
Circulatory Comment: PULSES PALPABLE NO EDEMA NOTED
:

-MUSCULOSKELETAL Assessment Within Normal Limits: Y

Contractures/Deformities:
Gait/Balance:
Weakness:
Range of Motion:
Joints:
Musculoskeletal Comment: MAES
:

-GASTROINTESTINAL Assessment Within Normal Limits: Y
Abdominal Appearance: Abdominal Pain:
GI Bleeding: N Bowel Sounds: Nausea/Vomiting:
Last BM: 04/14/05 Describe Stool:
Color of Stool:
Ostomy: G[illegible]be:

Intervention Description Sts Directions From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)
Suction: Drainage Color:
GI Comment: ABD NON DISTENDED, NON TENDER, DENIES ABD PAIN, DENIES N/V
:

~GENITOURINARY Assessment Within Normal Limits: Y
Incontinence: Cath: Type: Color:
~ GU Problem:
If Female Bleeding/Discharge: Describe:
If Male Scrotal Edema: Penile Discharge:
=== IF DIALYSIS PATIENT ===
Type of Dialysis: Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage
GU Comment: VOIDS FREELY
:
~INTEGUMENTARY Assessment Within Normal Limits: Y
Abnormalities Photo Documented:
Alteration: Location:
Dressing Type/Condition:
Alteration: Location:
Dressing Type/Condition:
Alteration: Location:
Dressing Type/Condition:
Drainage Tube: Describe:
Skin Comment: INTACT, WARM AND DRY
:

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
~Sensory Perception: 4 NOT LIMITED-WNL ~Skin Risk Score: 21
Moisure: 3 OCCASIONALY MOIST
Activity: 4 WALKS FREQUENTLY =Risk Score=
Mobility: 4 NO LIMITATIONS Low (16+): Y
Nutrition: 3 ADEQUATE Moderate (13-15):
Friction and Sheer: 3 NO APPARENT PROBLEM High (<13):

~PSYCHOSOCIAL Assessment Within Normal Limits: Y
Fears or Anxiety Related to Hospitalization: Ineffective Coping:
Inadequate Support System:
Suspected Abuse/Neglect: Describe:
Behavior/Appearance Appropriate: Alteration in Growth/Development:
Psychosocial Comment: CALM AND COOPERATIVE OF CARE
:
=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished: 0 NO
Nausea, Vomiting, or Diarrhea for >3 Days: 0 NO
Unintentional Weight Loss >10# in Past Month: 0 NO
~Admitted with Potential Risk Diagnosis: 1 YES
Poor PO Intake for >4 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
~Total Score: 1 =Nutrition Risk=

Intervention Description Sts Directions From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)
Low (0-1): Y
Moderate (2-3):
High (4+):

=== FUNCTIONAL STATUS ===
~Has the Patient's Functional Ability Decreased in the Last 6 Months: N
Prior Mobility: Current Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N

=== FALL RISK ASSESSMENT===
~ Mental Status: 0 NOT ALTERED ~Total Score: 0
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED =Fall Risk=
Elimination Status: 0 NOT ALTERED Low (0-2): Y
Recent History Of Falls: 0 NO FALLS Moderate (3-6):
Patient's Age: 0 < 65 YEARS High (7+):

=== EDUCATION SCREENING ===
Educational Need Priority #1: DISEASE PROCESS
Educational Need Priority #2: MEDICATIONS
Educational Need Priority #3: SAFETY PRECAUTIONS
Educational Need Priority #4: TREATMENT PURPOSE

=== BARRIERS TO LEARNING ===
Physiologic Limitations:
Psychological Limits:
Cognitive Limitations:
Teaching Method Preferred: EXPLANATION
Comment: VERBALIZES UNDERSTANDING

=== SAFETY === Isolation: STANDARD PRECAUTIONS Allergy Bracelet On: Y ID Band On: Y
~Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: RIGHT HAND ~IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 04/15/05

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:

Chest Tube #1 Location: Chest Tube #2 Location:
Drainage: Drainage:
Waterseal Patent: Waterseal Patent:
Connected to Suction: Connected to Suction:
Suction Amount (cm): Suction Amount (cm):
Subcutaneous Air Noted: Subcutaneous Air Noted:

Intervention Description Sts Directions From
Activity Type Occurred Date Time by Recorded Date Time by Comment Documented Units Change

Activity Date: 04/15/05 Time: 0424 (continued)

1005-A ADM: ADULT Assessment + (continued)
Air Leak: Air Leak:
Dressing Changed/Reinforced: Dressing Changed/Reinforced:

Activity Date: 04/15/05 Time: 0444

31231 Problem: Cardiovascular + A QS & Q4H IN ICU CP
Create 04/15/05 0444 EDM 04/15/05 0444 EDM

Activity Date: 04/15/05 Time: 0547

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 04/15/05 0547 EDM 04/15/05 0547 EDM
=== INTAKE: SHIFT TOTAL ===
Ice: IVPB's: Blood/Product:
Oral: 240 Chemo: GU Irrigant.In:
Tube Feeding: TPN: Other Intake:
IV's: 225 Lipids: Total Intake: 465

=== OUTPUT: SHIFT TOTAL ===
BRP: Ostomy: Hemovac #1:
# of Voids/Incont: 0 Jejunostomy: Hemovac #2:
# of Stools: 0 Ileostomy: T-Tube:
Urine: Jackson Pratt #1: GU Irrigant. Out:
Stool, Liquid: Jackson Pratt #2: Dialysis Net:
Emesis: Chest Tube #1: Est. Blood Loss:
NG Tube: Chest Tube #2: Other Output:

Total Output:
=== TOTAL SHIFT FLUID BALANCE === 465

Comment:

21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 04/15/05 0547 EDM 04/15/05 0548 EDM
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Maniago,Edna D Shift: 1900 - 0730

Practice Guidelines Comment:

Patient/Family Education Provided This Shift: Y

Isolation: STANDARD PRECAUTIONS
Restraints in Use: N Describe:
+Total Hrs. In Restraints This Shift: Location:

Activity Date: 04/15/05 Time: 0547 (continued)

21090 Routine Care: MED/SURG/TELE + (continued)
Sitter Used: N Comment:

=== IV ASSESSMENT ===
Throughout Shift:
IV Location: RIGHT HAND ~IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 04/15/05

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment: IVF INTACT AND INFUSING WELL

Activity Date: 04/15/05 Time: 0548

20010 VS: Monitor + A AS ORDERED CP
Document 04/15/05 0548 LJG 04/15/05 0549 LJG
Temperature/F: 97.7 Temp Source: ORAL
Pulse: 61 Pulse Source: ARTERIAL LINE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 102/70 BP Source: AUTOMATIC
Site: RIGHT UPPER ARM
~ C/O Pain: Y
== CNA/LICENSED Documentation ==
Comfort Measures Implemented:
Nurse Notified of Pain:
(If Medicated, Document On Intervention Pain: Management Of)

IF ON OXYGEN
Oxygen Device: NASAL CANNULA O2 Amount (L/min): 2
SpO2 (%): 97 FIO2:
Comment: NURSE AWARE OF V/S
Patient Notes: Nurse Notes
Create 04/15/05 0548 EDM 04/15/05 0549 EDM
Abnormal? N Confidential? N
SLEPT THE REST OF THE SHIFT, NO S/S PAIN NOTED. NO SOB NOTED. IVF STILL INFUSING WELL. SAFETY PREC NOTED. CALL LLIGHT IN REACH

Activity Date: 04/15/05 Time: 0554

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
Document 04/15/05 0554 KGM 04/15/05 0554 KGM
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 59

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 04/15/05 Time: 0800

1001 Agency Documentation + A WHEN APPLICABLE CP
ALL REGISTRY PERSONNEL MUST DOCUMENT
THIS INTERVENTION ONCE PER SHIFT.
Document 04/15/05 0800 RN4 04/15/05 0854 RN4
Agency Documentation Done By: M NACUA **Full Name & Title**
Meditech User ID: AGRN04
Agency Name: HRN
- Time Documented - From: 0700 To: 1930
1070 Shift Reassessment + A QS & Q4H IN ICU CP
Document 04/15/05 0800 RN4 04/15/05 0855 RN4
Reassessment Obtained Date: 04/15/05 Time: 0800

NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro Comment: AWAKE AND ALERT, ORIENTED X3, NO NEURO DEFICIT NOTED
:
EENT Assessment Within Normal Limits: Y
EENT Comment: WDP
:
RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment: DENIES SOB, LUNGS CTA
:
CARDIAC Assessment Within Normal Limits: N
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: NORMAL SINUS RHYTHM Monitor #: 7
Cardiac Comment:
: DENIES CHEST PAIN AT THIS TIME
CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment: PULSES PALPABLE, NO EDEMA NOTED
:
MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: MAES
:
NUTRITIONAL Assessment Within Normal Limits: Y
Nutritional Comment: STATED THAT HE HAS A GOOD APPETITE
:
GASTROINTESTINAL Assessment Within Normal Limits: Y
GI Comment: ABD NON DISTENDED, NON TENDER, DENIES ABD PAIN, DENIES N/V
:
GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: VOIDS FREELY
:
INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment: INTACT, WARM AND DRY
:
PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: CALM AND COOPERATIVE OF CARE
:

==== The Following To Be Documented On Once A Shift ====

Activity Date: 04/15/05 Time: 0800 (continued)

1070 Shift Reassessment + (continued)

=== FALL RISK ASSESSMENT===
~Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED
Elimination Status: 0 NOT ALTERED
Recent History Of Falls: 0 NO FALLS
Patient's Age: 0 < 65 YEARS

Total Score: 0
~=Fall Risk=
Low (0-2): Y
Moderate (3-6):
High (7+):

---BRADEN PRESSURE ULCER RISK ASSESSMENT===
~ Sensory Perception: 4 NOT LIMITED-WNL
Moisure: 3 OCCASIONALY MOIST
Activity: 4 WALKS FREQUENTLY
Mobility: 4 NO LIMITATIONS
Nutrition: 3 ADEQUATE
Friction and Sheer: 3 NO APPARENT PROBLEM

~Skin Risk Score: 21
=Risk Score=
Low (16+): Y
Moderate (13-15):
High (<13):

=== ADVANCE DIRECTIVES ===

Code Status: FULL CODE If DNR, Bright Pink Armband in Place:
Comment:

---ALLERGIES---

Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKOA

--- VALUABLES AT THE BEDSIDE ===

Eyeglasses: :
Contact Lenses: :
Dentures: :
Hearing Aid: :
Prosthesis: :
Comment: CELL PHONE, PAGER
15000 Care Plan: RN Review + A Q12H CP
Document 04/15/05 0800 RN4 04/15/05 0855 RN4
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:
Problem(s) Identified: Developmental Age 41-65 (MID ADULT) Status: A
: CVMC STANDARD OF CARE : A
: STANDARD OF PRACTICE M/S/TELE : A
: PROB: Impaired Cardiac Function : A
: :
: :
: :
: :

Intervention Description Sts Directions From
Activity Type Occurred Date Time by Recorded Date Time by Comment Documented Units Change

Activity Date: 04/15/05 Time: 0800 (continued)

15000 Care Plan: RN Review + (continued)

Patient's Plan of Care was Reviewed and Updated as Needed: Y
31231 Problem: Cardiovascular + A QS & Q4H IN ICU CP
Document 04/15/05 0800 RN4 04/15/05 0857 RN4
Altered Cardiac Function/Status Remains An Active Problem: Y
(if No, consider inactivating or Completing Intervention)
Document Only on Interventions Related to Patient's Altered Status/Function.

=== REASSESSMENT ===
~CARDIAC Assessment Within Normal Limits: N
Heart Rate Irregular: N Heart Tones: WNL S1S2
Syncope/Fainting: N Vertigo/Dizziness: N
Chest Pain: Pain Quality:
If Radiating, Describe:
Pain Scale: Pain Treatment:
Time of Reassessment: Post Intervention Pain Scale:

IF ON CARDIAC MONITOR/TELEMETRY: Cardiac Rhythm: NORMAL SINUS RHYTHM Monitor #: 7
If Rhythm Changed, Physician Notified Date: Time:
Physician Notified:
Intervention/Outcome:

=== PACEMAKER ASSESSMENT ===
AICD/Permanent Pacemaker:
Temporary Pacemaker Type:
Pacemaker Site:
Pacemaker Mode:
Pacer Set Rate:
Vent. MA:
Atrial MA:
Vent Sensitivity:
Capture:
Sense:
Off:

=== HEMODYNAMICS ===
CVP, Arterial, or PA Line Present:
CVP Line Zero Balanced:
CVP (cm H2O): CVP (mmHg):
Noninvasive BP:
Arterial BP:
Arterial Line Zero Balanced:
Art Line Site:
PA Line Site:
PA Line @ (cm):
Waveform:
PA Line Zero Balanced: Line Flushed:
PAP (mmHg): PVR:
PCWP: SVR:
CO (L/min): CI:

Site Care: Specify:
Comment:
=== ADDITIONAL CARDIAC COMMENTS ===
Cardiac Comment:
: DENIES CHEST PAIN AT THIS TIME
80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Document 04/15/05 0800 RN4 04/15/05 0858 RN4
=== PATIENT/FAMILY EDUCATION ===
Information Taught: MEDICATIONS

Activity Date: 04/15/05 Time: 0800 (continued)

80010 Education: Patient/Family Teaching + (continued)
Instruction Given: CALL RN UPON ONSET OF PAIN

Person Taught: PATIENT
Person Taught:
Teaching Tools: VERBAL
Other Tools Used:
Factors Affecting Learning: NONE
Other Factors:
Participation Level: ACTIVE
Evaluation: DEMONSTRATE UNDERSTANDING
Needs Additional Education:
:
Educator: Agency RN 4
Discipline: NURSING
1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Document 04/15/05 0800 RN4 04/15/05 0858 RN4
Patient Notes: Nurse Notes
Create 04/15/05 0800 RN4 04/15/05 0901 RN4
Abnormal? N Confidential? N
A/A/O.BREATHING EVEN AND UNLABORED.IN NO ACUTE DISTRESS.NO C/O PAIN NOTED AT THIS TIME.

Activity Date: 04/15/05 Time: 0829

5058601 QRM: Social Services Review A ON ADMISSION AS
Create 04/15/05 0829 SM 04/15/05 0830 SM
- Document 04/15/05 0829 SM 04/15/05 0830 SM
1. REASON FOR ASSESSMENT:
-Y Pt. Reviewed, No Needs Identified; Will Return to Prior Living Arrangement; No Further Intervention Required at This Time.
- Pt. Requires Additional Discharge Planning and has been Referred to the Hospital DC Planner
- Pt. Requires Additional Discharge Planning and is being Managed by an Outside Case Manager. Pt. has been Referred to:
- Pt. Requires Social Service Assistance and has been Referred To the Hospital Social Worker;See QRM Multidisciplinary notes for Further Documentation.
- Pt. Requires Case Management Assistance and has been Referred to the Hospital Case Manager; See QRM Multidisciplinary Notes for Further Documentation.

2. DISCHARGE PLANNING ASSESSMENT: (Prior to Admission)
Patient Lives With:
Contact Name and Number:
Patient Lives In:
Home Saftey Barriers:
Independent W/ADL's: Ambulation:
Uses DME: List:
Assistance W/ADL's:
Homecare Assistan

Intervention Description Sts Directions From
Activity Type Occurred Date Time by Recorded Date Time by Comment Documented Units Change

Activity Date: 04/15/05 Time: 0829 (continued)

5058601 QRM: Social Services Review (continued)
Provider and # of Hrs.:
Meals on Wheels:
Home Health Care:
Agency Name and #:
Other Resource Used:

3. EDUCATIONAL NEEDS:
Patient/Family Have Educational Needs

4. DISCHARGE PLAN:
Summary of Assessment/Plan: PT LIVES WITH HIS FAMILY NO DC PLANNING NEEDS
: ANTICIPATED WILL AWAIT PHYSICIAN ADVISEMENT AND FOLLOW AS NEEDED

Reassessment/Follow up Needed: See QRM Multidisciplinary Notes.

=== PATIENT/FAMILY EDUCATION ===
Information Taught:
Instruction Given:

Person Taught:
Person Taught:
Teaching Tools:
Other Tools Used:
Factors Affecting Learning:
Other Factors:
Participation Level:
Evaluation:
Needs Additional Education:

Educator:
Discipline:

Activity Date: 04/15/05 Time: 0855

90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP
- Document 04/15/05 0855 WD 04/15/05 0901 WD
Please bring this sheet with you to your follow up visit with: C. AGARWAL
on (Date/Time): 04/15/05 1100 ** OR **
Call for an appointment before: Physician's Office Number: 909-620-0900
Discharge Date: 04/15/05 Discharge Time: Discharge To: HOME - NO NEEDS
: By: AUTOMOBILE Via: WHEELCHAIR
Accompanied By:
Discharge Comment:
General Condition on Discharge:

Activity Date: 04/15/05 Time: 0855 (continued)

90013 DIS: Patient Discharge Instructions + (continued)
Vital Signs: Temperature/F: Respirations: Blood Pressure: Pulse:
Pain Controlled by Oral Medications: YES
Comment:
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool: Y
Comment:
Wound/Incision Assessment:
Photograph Taken On Discharge and Placed On Chart: N
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions: LIGHT ACTIVITY ONLY
Bath: SHOWER Other:
Diet: LOW CHOLESTEROL Calories:
Restrictions:
Additional Education given:
: MD FOLLOW UP
: WORSENING SYMPTOMS
: FOOD/DRUG INTERACTIONS
Comment:

Prescriptions/Education given: N Food/Drug Interaction Form Given: Y
List DC Meds and Time next dose is due (if applicable):
: NONE

Wound/skin care: N

Special Instructions:

Sent Home With All Belongings: Y Personal Belongings Inventory Reviewed/Signed: Y
Discharge Instructions Reviewed With: PATIENT Printed Instructions Given: Y

Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health: N
Agency Name/Phone #:
Arranged By:
Other:

If you smoke, it is recommended that you quit. Please contact the American Cancer Society - 800-227-2345 or the American Lung Association - 800-LUNGUSA for assistance.

If you were treated at this hospital for any respiratory condition, such as pneumonia, it is recommended that you follow up with your primary care physician to be evaluated for a pneumococcal vaccine. If you do not have a primary care physician, please contact the local public health clinic to find out where this vaccine may be available.

Intervention Description Sts Directions From
Activity Type Occurred Date Time by Recorded Date Time by Comment Documented Units Change

Activity Date: 04/15/05 Time: 0855 (continued)

90013 DIS: Patient Discharge Instructions + (continued)

I have received a copy of these instructions and they have been explained to me and I understand the instructions.
Patient/Family Signature:______________________ Date:______________

RN/LVN Signature:______________________ Date:______________
** This is Part of Patient's Permanent Medical Record **

Activity Date: 04/15/05 Time: 0900

Patient Notes: Nurse Notes
- Create 04/15/05 0900 RN4 04/15/05 1129 RN4
Abnormal? N Confidential? N
DISCHARGE ORDER GIVEN,DEMONSTRATE UNDERSTANDING,PICKED UP IN STABLE CONDITION.

Activity Date: 04/15/05 Time: 0956

90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP
- Document 04/15/05 0956 RN4 04/15/05 0956 RN4
Please bring this sheet with you to your follow up visit with: C. AGARWAL
on (Date/Time): 04/15/05 1100 ** OR **
Call for an appointment before: Physician's Office Number: 909-620-0900
Discharge Date: 04/15/05 Discharge Time: Discharge To: HOME - NO NEEDS
: By: AUTOMOBILE Via: WHEELCHAIR
Accompanied By:
Discharge Comment:
General Condition on Discharge:
Vital Signs: Temperature/F: 97.7 Respirations: 20 Blood Pressure: 102/70 Pulse: 61
Pain Controlled by Oral Medications: YES
Comment:
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool: Y
Comment:
Wound/Incision Assessment:
Photograph Taken On Discharge and Placed On Chart: N
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions: LIGHT ACTIVITY ONLY
Bath: SHOWER Other:
Diet: LOW CHOLESTEROL Calories:
Restrictions:
Additional Education given:
: MD FOLLOW UP :
: WORSENING SYMPTOMS :
: FOOD/DRUG INTERACTIONS :
Comment:

Prescriptions/Education given: N Food/Drug Interaction F[illegible]iven: Y

Activity Date: 04/15/05 Time: 0956 (continued)

90013 DIS: Patient Discharge Instructions + (continued)
List DC Meds and Time next dose is due (if applicable):
: NONE
:
:
:
Wound/skin care: N
:
:
Special Instructions:
:
:
Sent Home With All Belongings: Y Personal Belongings Inventory Reviewed/Signed: Y
Discharge Instructions Reviewed With: PATIENT Printed Instructions Given: Y

Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health: N
Agency Name/Phone #:
Arranged By:
Other:

If you smoke, it is recommended that you quit. Please contact the American Cancer Society - 800-227-2345 or the American Lung Association - 800-LUNGUSA for assistance.

If you were treated at this hospital for any respiratory condition, such as pneumonia, it is recommended that you follow up with your primary care physician to be evaluated for a pneumococcal vaccine. If you do not have a primary care physician, please contact the local public health clinic to find out where this vaccine may be available.

I have received a copy of these instructions and they have been explained to me and I understand the instructions.
Patient/Family Signature:______________________ Date:______________

RN/LVN Signature:______________________ Date:______________
** This is Part of Patient's Permanent Medical Record **

Activity Date: 04/15/05 Time: 1338

1000-B ADMISSION/TRANSFER: Quick Start Form + D ON ADMISSION/TRANS AS
- Ed Status 04/15/05 1338 his 04/15/05 1338 his A => D
1001 Agency Documentation + D WHEN APPLICABLE CP
ALL REGISTRY PERSONNEL MUST DOCUMENT
THIS INTERVENTION ONCE PER SHIFT.
- Ed Status 04/15/05 1338 his 04/15/05 1338 his A => D
1005-A ADM: ADULT Assessment + D ON ADMISSION AS
- Ed Status 04/15/05 1338 his 04/15/05 1338 his A => D

Intervention Description							Sts	Directions		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented	Units	Change

Activity Date: 04/15/05 Time: 1338

Activity	Description	Sts	Directions	From
1070	Shift Reassessment +	D	QS & Q4H IN ICU	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
1500	I&O: Monitor +	D	Q12H (0559,1759)	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
15000	Care Plan: RN Review +	D	Q12H	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
20010	VS: Monitor +	D	AS ORDERED	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
21090	Routine Care: MED/SURG/TELE + VIEW PROTOCOL	D	.END OF SHIFT/TX	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
21400	Nutrition/Activity/ADL Flowsheet +	D	QS BY CAREGIVER	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
22300	IV/Invasive Lines: Insert/Remove +	D	INS/REMOVAL/CONVERT	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
31231	Problem: Cardiovascular +	D	QS & Q4H IN ICU	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
31320	Pain: Management Of +	D	AS NEEDED	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
60010	Notify: MD +	D	WHEN NECESSARY	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
80010	Education: Patient/Family Teaching +	D	QS BY CAREGIVER	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
90013	DIS: Patient Discharge Instructions +	D	ON DISCHARGE	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
150010	Weight +	D		CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
975050	Inventory Personal Belongings - ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY	D	ADM TX DC	AS
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
1001031	Age Guidelines: 41-65 (MID ADULT)	D	VIEW PROTOCOL/DI QS	CP
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D
5058601	QRM: Social Services Review	D	ON ADMISSION	AS
Ed Status	04/15/05 1338 his 04/15/05 1338 his			A => D

Monogram	Initials	Name	Nurse Type
EDM	NURMED	Maniago,Edna D	RN
KGM	CNAMKG	Bravo,Katny G	CNA
LJG	CNAGLJ	Garcia,Loretta J	CNA
RN	EDAGRN01	ED Agency RN	RN
RN4	AGRN04	Agency,RN 4	RN
SM	SWMS	Montoya,Susan	SS
TMS	CNASTM	Sauceda,Tina M	CNA
WD	NURDW	DuBois,Wendy	RN
his		automatic by program	

Age/Sex: 59 M
Unit #: M000273781
Admitted: 04/15/05 at 0251
Status: DIS IN

Attending: Lally, James M.
Account #: V00000143675
Location: DU
Room/Bed: 235-B

HANNA, ADEL

Chino Valley Medical Center NUR **LIVE**
Patient's Plan of Care

Status: Discharged
Initiated:
Completed:
Protocol:

Printed 04/16/05 at 1123

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
Developmental Age 41-65 (MID ADULT) Based on Erickson's eight stages of development -Developmental Need: -Guide the next generation.	D	04/15 TMS								
* Patient will verbalize understanding of lifestyle changes, therapy/treatment options, and resources/support groups that may be beneficial to themselves and their famiy.	D	04/15 TMS	04/18		* Age Guidelines: 41-65 (MID ADULT) PROTOCOL: AGE 41-65	04/15 TMS		04/15 0359	VIEW PROTOCOL/DI QS	D
CVMC STANDARD OF CARE See Standard of Care Profile	D	04/15 TMS								
* All Patients Will Receive The Following	D	04/15 TMS	04/18		* Shift Reassessment +	04/15 TMS		04/15 0359	QS & Q4H IN ICU	D
					* VS: Monitor +	04/15 TMS		04/15 0359	AS ORDERED	D
					* I&O: Monitor +	04/15 TMS		04/15 0359	Q12H (0559,1759)	D
					* Weight +	04/15 TMS				D
					* Notify: MD +	04/15 TMS		04/15 0359	WHEN NECESSARY	D
					* Nutrition/Activity/ADL Flowsheet +	04/15 TMS		04/15 0359	QS BY CAREGIVER	D
					* Education: Patient/Family Teaching +	04/15 TMS		04/15 0359	QS BY CAREGIVER	D
					* IV/Invasive Lines: Insert/Remove +	04/15 TMS		04/15 0359	INS/REMOVAL/CONVERT	D
					* Pain: Management Of +	04/15 TMS		04/15 0359	AS NEEDED	D
					* Care Plan: RN Review +	04/15 TMS		04/15 0359	Q12H	D
					* Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.	04/15 TMS		04/15 0359	WHEN APPLICABLE	D
					* DIS: Patient Discharge Instructions +	04/15 TMS		04/15 0359	ON DISCHARGE	D
STANDARD OF PRACTICE M/S/TELE See Standard of Care Profile -PROTOCOL: S M/S/TELE	D	04/15 TMS								
* PRACTICE GUIDELINES	D	04/15 TMS	04/18		* Routine Care: MED/SURG/TELE + VIEW PROTOCOL -PROTOCOL: S M/S/TELE	04/15 TMS		04/15 0359	END OF SHIFT/TX	D
* WITHIN DEFINED PARAMETERS	D	04/15 TMS	04/18							
PROB: Impaired Cardiac Function Cardiac problem related to disease process and/or trauma.	D	04/15 EDM								
* Improve/maintain cardiac function/status	D	04/15 EDM	04/18		* Problem: Cardiovascular +	04/15 EDM		04/15 0444	QS & Q4H IN ICU	D

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS	SRC
* Inventory Personal Belongings + ON ADMISSION & TRANSFER, PRINT OUT & HAVE PATIENT SIGN COPY	04/15 RN		04/15 0324	ADM TX DC	D	AS
* ADMISSION/TRANSFER: Quick Start Form +	04/15 TMS		04/15 0359	ON ADMISSION/TRANS	D	AS
* ADM: ADULT Assessment +	04/15 EDM		04/15 0424	ON ADMISSION	D	AS
* ORM: Social Services Review	04/15 SM		04/15 0829	ON ADMISSION	D	AS

Monogram	Initials	Name	Nurse Type
EDM	NURMED	Maniago, Edna D	RN
RN	EDAGRN01	ED Agency RN	RN
SM	SWMS	Montoya, Susan	SS
TMS	CNASTM	Sauceda, Tina M	CNA

02/15/2023

Dr. [redacted]NNA

DOB 3-29-46

All Strips Report

Data Time: 2005/04/15 00:29:01

Last Name: Hanna
Doctor:

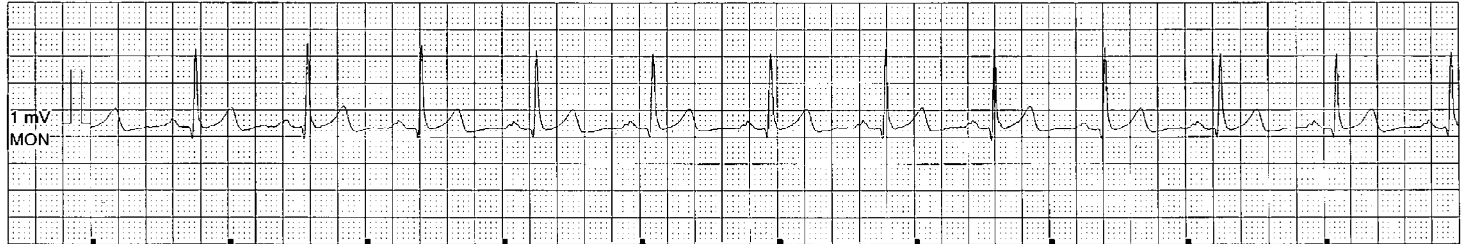
First Name:
Height: --- in = --- cm

ID:
Weight: --- lbs = --- kg

Bed: ER #7

HR(ECG): 73 BPM NIBP: 132 / 72 (101) mmHg ET: 1 Min. SpO2: 96 % PVC/min: ---

ECG Lead II



Print Time: 2005/04/15 00:29

Page 1

Panorama: ER1

CONDITIONS OF ADMISSION

CHINO VALLEY MEDICAL CENTER TURNS NO PATIENT AWAY DUE TO COLOR, CREED, ETHNICITY, DISABILITY OR SOURCE OF PAYMENT

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** The undersigned consents to the procedures which may be performed during this hospitalization or in an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon.

2. **NURSING CARE:** This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and special instructions of the physician. The patient will be under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician.

4. **RELEASE OF INFORMATION:** Upon inquiry, the hospital may make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other condition), general nature of the injury, burn, poisoning or other condition, and general condition. If the patient or the patient's legal representative does not want such information to be released, he/she must make a written request for such information to be withheld. The patient or the patient's legal representative may obtain a separate form for this purpose upon request.

   The hospital will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers.

   Special permission is needed to release this information where the patient is being treated for substance abuse.

5. **PERSONAL VALUABLES:** It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars ($500.00) unless written receipt for a greater amount has been obtained from the hospital by the patient.

6. **CONSENT TO PHOTOGRAPH:** The taking of pictures of medical or surgical progress and the use of the same for scientific, education, or research purposes is approved, provided that identification of the patient, either by writing or depiction for advertising purposes not be permitted without the prior written consent of the patient.

7. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

   NON-COVERED CHARGES: In the event that insurance does not cover particular procedures, medications, and/or services, the undersigned hereby agrees to be personally responsible for payment of such charges, if not prohibited by law.

   AUTHORIZATION TO PAY HOSPITAL BASED PHYSICIANS: The undersigned authorized direct payment of any insurance benefits otherwise payable to the undersigned under my current insurance policy, be made directly to my Physician, Radiologist, Pathologist, Anesthesiologist, or other Hospital based physician, for professional services rendered. Payment not to exceed my indebtedness to the above mentioned assignees. The undersigned also agrees to be individually obligated to pay any balance of said professional service charges not covered by insurance, unless prohibited by law or the terms of an insurance contract between an Insurer and the undersigned's physician radiologist, pathologist, anesthesiologist or other hospital based physician. AUTHORIZATION TO MAKE PAYMENT DIRECTLY TO HOSPITAL BASED PHYSICIANS IS HEREBY GIVEN. Patient will receive separate billings for these services.

8. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the undersigned for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

9. **HEALTH CARE SERVICE PLAN OBLIGATION:** This hospital maintains a list of the health care service plans with which it has contracted. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above mentioned list.

10. **PARTICIPATION IN MEDICAL EDUCATION PROGRAM:** It is understood that this hospital is a teaching institution and that unless the hospital is notified to the contrary in writing, the undersigned may participate as a teaching subject in the medical education program of the hospital and may receive treatment by residents, if approved by the undersigned's attending physician, and those clinical students acting under appropriate supervision as required by such medical education and clinical training programs.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: 4/15/05 TIME: 12:23Am.

SIGNATURE: [signature]
PATIENT/PARENT/CONSERVATOR/GUARDIAN

IF SIGNED BY OTHER THAN PATIENT, INDICATE RELATIONSHIP:

WITNESS: [signature]

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 Care Service Plan Obligation Provisions above.

SIGNATURE: ______ DATE: ______ TIME: ______
FINANCIALLY RESPONSIBLE PARTY

SIGNATURE: CHINO VALLEY MEDICAL CENTER DATE: ______ TIME: ______

V00000143675

Chino Valley Medical Center

ADMISSION PACKET

WHITE - MEDICAL RECORDS **YELLOW** - BUSINESS OFFICE **PINK** - PATIENT

000106 904.001 (09/03)

ADDRESSOGRAPH

HANNA, ADEL 59 /M
H000273781 DOB 03/29/46
DOS 04/15/05

ER DR. MADAHAR, ASHOK K.
PRIM DR. NONSTAFF, PHYS

Acknowledgement of the Information Packet

Our mission is to provide high quality, compassionate health care to the communities we serve. Our notice of Acknowledgement of the Information Packet is to assure that you as a patient have received the following information:

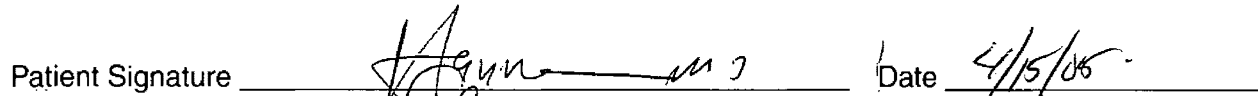
- Notice of privacy practices
- Patient rights and responsibilities
- Advance directives
- Discharge planning, social services and case management
- Your hospital hours and business hours
- Your hospital stay
- Food and nutritional services
- Telephone access and television information
- Pastoral service
- Visitation policy and hours

Our goal is to provide you with quality medical care in a comfortable setting. To help assure that you are given the best care possible you agree:

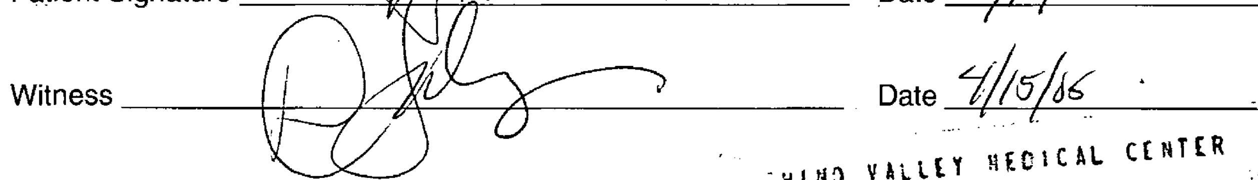
1. To provide all and accurate information regarding one's medical history presenting illness, medications currently taking or allergies to medications.
2. To follow treatment recommendations and take responsibility for one's action with respect to medical care and the consequences of not following that recommended medical regimen.
3. To take responsibility for any financial obligations incurred as a patient.
4. To respect the rights and privacy of other patients.

If you have any questions or need information that is not provided in this packet, please do not hesitate to ask a member of your medical team.

I acknowledge that I have received the Patient Information Packet. Any questions or concerns have been answered to my satisfaction.



Patient Signature ______________ Date 4/15/05



Witness ______________ Date 4/15/05

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

ACKNOWLEDGEMENT OF THE INFORMATION PACKET

WHITE - CHART **CANARY** - BUSINESS OFFICE

000093 906.006 (2/05)

CHINO VALLEY MEDICAL CENTER
V0000[illegible]
ADDRESSOGRAPH
59 /M
HANNA, ADEL
M000273781
DOB 03/29/46
DOS 04/15/05
ER DR. MADAHAR, ASHOK K.
PRIN DR. NONSTAFF, PHYS