ADMINISTRATION PERIOD:	START/ STOP
0000 12/25/14 to 2359 12/25/14	

*** CONTINUED ON PAGE 11 ***

NAME: **HANNA,ADEL S** UNIT #: **M000273781** ACCT #: **V0000603802**

ADMINISTRATION PERIOD:	START/
0000 12/25/14 to 2359 12/25/14 (Continued)	STOP

LEGENDS

ACTIVITY CODES
* - Not Administered
AO - Nursing Acknowledged Order
DC - Pharmacy Discontinue
ED - Pharmacy Edit or Verification
EDDOC - Nursing Edit Document
ENTER - Order Entry
FDOC - File Document

REASON CODES
OTH - OTHER - SEE ADMIN COMMENTS

SITE CODES

ELECTRONICALLY SIGNED BY

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
EDEMD	Bacani,Marlene O RN	NURCL1	Ciupala,Liliana RN	NURDE1	Delaro,Eric RN	NURLJ1	Li,Jing RN

OTHER USERS

USER	USER NAME	USER	USER NAME	USER	USER NAME	USER	USER NAME
DRDALWIDO	Dalrymple,William	DRPERJO	Perez,Jorge	RXLWH	Lin,Wei-Hong	RXWMC	Wong,Mei C

COMBINED ALLERGY HISTORY

DATE	MODULE	USER	ALLERGY DETAILS
09/14/12 1915	MRI	RXMML - Hernandez,Maria L	UCONV by RXMML Allergies: OLD: NEW: Converted from Medical Records Demo Recall Database UCONV by RXMML Other Allergies: OLD: NEW: Converted from Medical Records Demo Recall Database UCONV by RXMML Food Allergies: OLD: NEW: Converted from Medical Records Demo Recall Database ALLERGIES CONVERTED by RXMML Metoclopramide OLD: NEW: Converted from PHA.CVMC Database
12/23/14 1008	EDM	EDMAD - Mamiray-Andrada,Deb	DELETED by EDMAD Allergies: OLD: Allergies: deleted. NEW: TEXT:

*** CONTINUED ON PAGE 12 ***

ADMINISTRATION PERIOD:	START/
0000 12/25/14 to 2359 12/25/14 (Continued)	STOP

Type: Allergy
Severity: Unknown
Text deleted.
Old: RELAN
Date: 09/14/12
DELETED by ELMAD
Food Allergies:
OLD: Food Allergies: deleted.
NEW:
TEXT:
Type: Allergy
Severity: Unknown
Text deleted.
Old: NKFA
Date: 09/14/12
DELETED by ELMAD
Other Allergies:
OLD: Other Allergies: deleted.
NEW:
TEXT:
Type: Allergy
Severity: Unknown
Text deleted.
Old: NKOA
Date: 09/14/12

Personal Belongings Inventory 12/24/14 0949 ED

Inventory Date: 12/24/14 Inventory Time: 0949 Performed By: Deharo,Eric
Reason For Inventory: DISCHARGE

-N Contacts -Y Glasses Disposition: BELONGINGS KEPT BY PT

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

Any Belongings Sent To Hospital Safe: N Any Belongings Sent Home With Family: N

NOTE: Chino Valley Medical Center will only be responsible for items logged at the time of admission. Should Dentures, Hearing Aids, Eye Glasses be brought to the patient after admission, they must be logged with the Primary Nurse or Charge Nurse. Chino Valley Medical Center will not be responsible for any item not logged on the Belongings Form.

<< 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.

PATIENT:_____ Date:_____

WITNESS:_____

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

PATIENT: X _____ Date: 12-24-14

WITNESS: _____

HANNA,ADEL S

Admitted: 12/23/14 at 1149
Room/Bed: 228T B
Attending: Lally, James M.

Chino Valley Medical Center

NURDE1
Acct: V00000603802
Unit: M000273781

Monogram Initials	Name	Nurse Type
ED	NURDE1	Deharo,Eric	RN

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 in vitamin K
- Avoid nutritional supplements high in vitamin K / vitamin E
- Limit caffeine
- Limit fried or boiled onions
- Limit cranberry juice (less than 8 oz. day)
- Limit soybean oil

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 or empty stomach
- Avoid acidic beverages

Zyvox

- Avoid foods high in tyramines

ANTIDEPRESSANT, MAOI

Phenelzine
Nardil

- Avoid foods high in pressor amines/tyramines
- 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, cauliflower, 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 450 mg per serving

Your dietitian can provide additional food & drug interaction information.

Instruction Given By: _____ 12-24-14 1134
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: 12-24-14

(REFER TO BACKER)

Chino Valley Medical Center
5451 Walnut Ave Chino CA 91710

3 EDU

PATIENT ID HANNA, ADEL S
ATTDG DR. Lally, James
03/29/1946 68Y M M000273781
V00000603802 IN 12/23/2014

FOOD-DRUG INTERACTION PATIENT EDUCATION

PHSI-180-008 (12/09) ORIGINAL - CHART COPY -PATIENT PAGE 1 of 2

12/23/2014 12:13

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

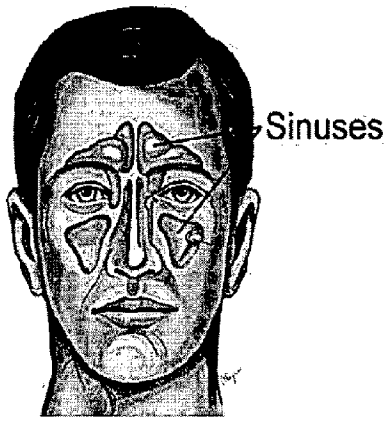
CHINO VALLEY MEDICAL CENTER

Date: 12/23/14
Account No: V00000603802
Unit No: M000273781
Patient: HANNA,ADEL S
Location: DU
Physician: Lally, James M.

Sinusitis

Sinusitis is redness, soreness, and swelling (*inflammation*) of the paranasal sinuses. Paranasal sinuses are air pockets within the bones of your face (beneath the eyes, the middle of the forehead, or above the eyes). In healthy paranasal sinuses, mucus is able to drain out, and air is able to circulate through them by way of your nose. However, when your paranasal sinuses are inflamed, mucus and air can become trapped. This can allow bacteria and other germs to grow and cause infection.

Sinusitis can develop quickly and last only a short time (*acute*) or continue over a long period (*chronic*). Sinusitis that lasts for more than 12 weeks is considered chronic.



CAUSES

Causes of sinusitis include:

- Allergies.
- Structural abnormalities, such as displacement of the cartilage that separates your nostrils (*deviated septum*), which can decrease the air flow through your nose and sinuses and affect sinus drainage.
- Functional abnormalities, such as when the small hairs (*cilia*) that line your sinuses and help remove mucus do not work properly or are not present.

SYMPTOMS

Symptoms of acute and chronic sinusitis are the same. The primary symptoms are pain and pressure around the affected sinuses. Other symptoms include:

- Upper toothache.
- Earache.
- Headache.
- Bad breath.
- Decreased sense of smell and taste.
- A cough, which worsens when you are lying flat.
- Fatigue.
- Fever.
- Thick drainage from your nose, which often is green and may contain pus (*purulent*).
- Swelling and warmth over the affected sinuses.

DIAGNOSIS

Your caregiver will perform a physical exam. During the exam, your caregiver may:

- Look in your nose for signs of abnormal growths in your nostrils (*nasal polyps*).
- Tap over the affected sinus to check for signs of infection.
- View the inside of your sinuses (*endoscopy*) with a special imaging device with a light attached (*endoscope*), which is inserted into your sinuses.

If your caregiver suspects that you have chronic sinusitis, one or more of the following tests may be recommended:

- Allergy tests.
- Nasal culture-A sample of mucus is taken from your nose and sent to a lab and screened for bacteria.
- Nasal cytology-A sample of mucus is taken from your nose and examined by your caregiver to determine if your sinusitis is related to an allergy.

TREATMENT

Most cases of acute sinusitis are related to a viral infection and will resolve on their own within 10 days. Sometimes medicines are prescribed to help relieve symptoms (pain medicine, decongestants, nasal steroid sprays, or saline sprays).

However, for sinusitis related to a bacterial infection, your caregiver will prescribe antibiotic medicines. These are medicines that will help kill the bacteria causing the infection.

Rarely, sinusitis is caused by a fungal infection. In theses cases, your caregiver will prescribe antifungal medicine.

For some cases of chronic sinusitis, surgery is needed. Generally, these are cases in which sinusitis recurs more than 3 times per year, despite other treatments.

HOME CARE INSTRUCTIONS

- Drink plenty of water. Water helps thin the mucus so your sinuses can drain more easily.
- Use a humidifier.
- Inhale steam 3 to 4 times a day (for example, sit in the bathroom with the shower running).
- Apply a warm, moist washcloth to your face 3 to 4 times a day, or as directed by your caregiver.
- Use saline nasal sprays to help moisten and clean your sinuses.

CHINO VALLEY MEDICAL CENTER

Date: 12/23/14
Account No: V00000603802
Unit No: M000273781
Patient: HANNA,ADEL S
Location: DU
Physician: Lally, James M.

- Take over-the-counter or prescription medicines for pain, discomfort, or fever only as directed by your caregiver.

SEEK IMMEDIATE MEDICAL CARE IF:

- You have increasing pain or severe headaches.
- You have nausea, vomiting, or drowsiness.
- You have swelling around your face.
- You have vision problems.
- You have a stiff neck.
- You have difficulty breathing.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 12/18/2006 Document Revised: 03/11/2013 Document Reviewed: 01/01/2013

CHINO VALLEY MEDICAL CENTER

Date: 12/23/14
Account No: V00000603802
Unit No: M000273781
Patient: HANNA,ADEL S
Location: DU
Physician: Lally, James M.

IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

If you are a Medicare patient review the following message from Medicare about your rights.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

* Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
* Be involved in any decisions about your hospital stay, and know who will pay for it.
* Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:
  Health Services Advisory Group (HASG)
  Appeal Line - 800-841-1602
  TDD - 800-881-5980

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON:

* You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
* You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  * If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
  * If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
* If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
* Step by step instructions for calling the QIO and filing an appeal are below.

To speak with someone at the hospital about this notice, call the Director of Case Management at 909-464-8662.

STEPS TO APPEAL YOUR DISCHARGE

* STEP 1: You must contact the QIO no later than your planned discharge date and

CHINO VALLEY MEDICAL CENTER

Date: 12/23/14
Account No: V00000603802
Unit No: M000273781
Patient: HANNA,ADEL S
Location: DU
Physician: Lally, James M.

before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

* Here is the contact information for the CIO:
  Health Services Advisory Group (HASG)
  700 N. Brand Blvd. Suite 370
  Glendale, California 92103
  Appeal Line - 800-841-1602, FAX# - 866-800-8757
  Open 365 days/8-5 PST
* You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
* Ask the hospital if you need help contacting the QIO.
* The name of this hospital is Chino Valley Medical Center. The Provider ID number is 050586.

* STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
* STEP 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
* STEP 4: The QIO will review your medical records and other important information about your case.
* STEP 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  * If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  * If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

* You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  * If you have Original Medicare: Call the QIO listed above.
  * If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
* If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

24 HOUR CHART CHECK

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Metoclopramide (From Metoclopramide HCl)	Drug	Unknown	N	09/14/12	1919	MLM

Current Medications

Rx #	Medication	Dose	Sig/Sch	Route	RF	Start	Stop	Note
002877456	BAYER CHILDREN'S ASP	81 MG	DAILY	PO		12/24/14	01/23/15	
002877455	TENORMIN	50 MG	DAILY	PO		12/24/14	01/23/15	
002877333	COLACE	100 MG	DAILY	PO		12/24/14	01/23/15	
002877332	PRILOSEC	20 MG	ACBK	PO		12/24/14	01/23/15	
002877399	FIORICET	1 TAB	Q4HP/PRN	PO		12/23/14	01/22/15	
002877306	TYLENOL	650 MG	Q6HP/PRN	PO		12/23/14	01/22/15	
002877308	ZOFRAN	4 MG	Q4HP/PRN	IV		12/23/14	01/22/15	
002877305	MORPHINE SULFATE	2 MG	Q3HP/PRN	IV		12/23/14	12/26/14	
002877307	NORCO 7.5/325 TABLET	1 TAB	Q4HP/PRN	PO		12/23/14	12/26/14	
002877281	SODIUM CHL 0.9%	1,000 ML	ONCE/ONE	IV		12/23/14	12/23/14	*DC
002877309	SODIUM CHL 0.9%	1,000 ML	Q16H	IV		12/23/14	12/23/14	*DC
002877282	SODIUM CHL 0.9% IV B	100 ML	ONCE/ONE	IV		12/23/14	12/23/14	*DC
ADD	UNASYN	3 GM						
002877301	UNASYN		.STK-MED	.ROU		12/23/14	12/23/14	*DC
002877283	SUBLIMAZE	25 MCG	ONCE/ONE	IV		12/23/14	12/23/14	*DC
002877181	COMPAZINE	5 MG	ONCE/ONE	IM		12/23/14	12/23/14	*DC
002877180	MORPHINE SULFATE	4 MG	ONCE/ONE	IM		12/23/14	12/23/14	*DC

Admit Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	Admit Orders	TRANS		

RESUSCITATION CODE STATUS Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	RESUSCITATION CODE STATUS	TRANS		

Consultations Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	Unknown	PHYSICIANS CONSULT	TRANS		

Computerized Tomography Orders

Service Date	Service Time	Procedure	Status	Result Code	Report Status
12/23/14	1046	CT-HEAD W/O IV CONTRAST	COMP		Signed

DIAGNOSIS Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	Diagnosis-	TRANS		
12/23/14	1153	Condition	TRANS		

12/24/14

Electrocardiogram Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1737	ELECTROCARDIOGRAM	TRANS		

Food and Nutrition Services Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	L	REGULAR DIET	TRANS		New

Lab Orders

Service Date	Service Time	Procedure	Status
12/23/14	1027	COMPREHENSIVE METABOLIC PANEL	COMP
12/23/14	1027	CBC	COMP
12/23/14	1153	MAGNESIUM	COMP
12/23/14	1153	PHOSPHOROUS	COMP
12/23/14	1153	GLYCOSYLATED HEMOGLOBIN (A1C)	COMP
12/23/14	1153	BRAIN NATRIURETIC PEPTIDE	COMP
12/23/14	1153	THYROID PANEL	COMP
12/23/14	1153	PROTHROMBIN TIME	COMP
12/23/14	1153	PARTIAL THROMBOPLASTIN TIME	COMP
12/23/14	1153	AMYLASE	COMP
12/23/14	1153	LIPASE	COMP
12/24/14	0500	BASIC METABOLIC PROFILE	IN PRO
12/24/14	0500	CBC	IN PRO
12/24/14	0500	LIPID PROFILE	IN PRO

Microbiology Orders

Service Date	Service Time	Procedure	Status	Source	Organism
12/23/14	1153	MRSA CULTURE	IN PRO	NARES	
12/23/14	1232	MRSA CULTURE	CANCEL	Comment: @DUPLICATE ORDE	

Magnetic Resonance Imaging Orders

Service Date	Service Time	Procedure	Status	Result Code	Report Status
12/23/14	1735	MRI BRAIN W/WO CONTRAST	IN PRO		Draft
12/23/14	1735	MRI ANGIO BRAIN	IN PRO		Draft

Pharmacy Orders

Service Date	Service Time	Procedure	Status
12/23/14	1027	MEDICATIONS	DC
12/23/14	1027	MEDICATIONS	DC
12/23/14	1137	INTRAVENOUS	ONE
12/23/14	1137	IVPB	DC
12/23/14	1138	MEDICATIONS	DC
12/23/14	1150	PYXIS MEDICATION	DC
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1405	MEDICATIONS	ACTIVE
12/23/14	1500	INTRAVENOUS	DC

Service Date	Service Time	Specimen to Obtain Orders Procedure	Status	Report Number	Report Status
12/23/14	1153	SPECIMEN TO OBTAIN	TRANS		

Monogram Initials	Name	Nurse Type
MLM	RXMML	Hernandez,Maria L	PTECH

Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Metoclopramide (From Metoclopramide HCl)	Drug	Unknown	N	09/14/12	1919	MLM

Current Medications

Rx #	Medication	Dose	Sig/Sch	Route	RF	Start	Stop	Note
002877456	BAYER CHILDREN'S ASP	81 MG	DAILY	PO		12/24/14	01/23/15	
002877455	TENORMIN	50 MG	DAILY	PO		12/24/14	01/23/15	
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002877308	ZOFRAN	4 MG	Q4HP/PRN	IV		12/23/14	01/22/15	
002877305	MORPHINE SULFATE	2 MG	Q3HP/PRN	IV		12/23/14	12/26/14	
002877307	NORCO 7.5/325 TABLET	1 TAB	Q4HP/PRN	PO		12/23/14	12/26/14	
002877281	SODIUM CHL 0.9%	1,000 ML	ONCE/ONE	IV		12/23/14	12/23/14	
002877309	SODIUM CHL 0.9%	1,000 ML	Q16H	IV		12/23/14	12/23/14	*DC
002877282	SODIUM CHL 0.9% IV B	100 ML	ONCE/ONE	IV		12/23/14	12/23/14	*DC
ADD	UNASYN	3 GM						
002877301	UNASYN		.STK-MED	.ROU		12/23/14	12/23/14	*DC
002877283	SUBLIMAZE	25 MCG	ONCE/ONE	IV		12/23/14	12/23/14	*DC
002877181	COMPAZINE	5 MG	ONCE/ONE	IM		12/23/14	12/23/14	*DC
002877180	MORPHINE SULFATE	4 MG	ONCE/ONE	IM		12/23/14	12/23/14	*DC

Admit Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	Admit Orders	TRANS		

RESUSCITATION CODE STATUS Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	RESUSCITATION CODE STATUS	TRANS		

Consultations Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	Unknown	PHYSICIANS CONSULT	TRANS		

Computerized Tomography Orders

Service Date	Service Time	Procedure	Status	Result Code	Report Status
12/23/14	1046	CT-HEAD W/O IV CONTRAST	COMP		Signed

DIAGNOSIS Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	Diagnosis-	TRANS		
12/23/14	1153	Condition	TRANS		

12/23/14 TA-B

Food and Nutrition Services Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	L	REGULAR DIET	TRANS		New

Lab Orders

Service Date	Service Time	Procedure	Status
12/23/14	1027	COMPREHENSIVE METABOLIC PANEL	COMP
12/23/14	1027	CBC	COMP
12/23/14	1153	MAGNESIUM	COMP
12/23/14	1153	PHOSPHOROUS	COMP
12/23/14	1153	GLYCOSYLATED HEMOGLOBIN (A1C)	COMP
12/23/14	1153	BRAIN NATRIURETIC PEPTIDE	COMP
12/23/14	1153	THYROID PANEL	COMP
12/23/14	1153	PROTHROMBIN TIME	COMP
12/23/14	1153	PARTIAL THROMBOPLASTIN TIME	COMP
12/23/14	1153	AMYLASE	COMP
12/23/14	1153	LIPASE	COMP

Microbiology Orders

Service Date	Service Time	Procedure	Status	Source	Organism
12/23/14	1153	MRSA CULTURE	IN PRO	NARES	
12/23/14	1232	MRSA CULTURE	IN PRO	NARES	

Magnetic Resonance Imaging Orders

Service Date	Service Time	Procedure	Status	Result Code	Report Status
12/23/14	1413	MRI BRAIN W/WO CONTRAST	LOGGED		
12/23/14	1413	MRI ANGIO BRAIN	LOGGED		

Pharmacy Orders

Service Date	Service Time	Procedure	Status
12/23/14	1027	MEDICATIONS	ONE
12/23/14	1027	MEDICATIONS	ONE
12/23/14	1137	INTRAVENOUS	ONE
12/23/14	1137	IVPB	ONE
12/23/14	1138	MEDICATIONS	ONE
12/23/14	1150	PYXIS MEDICATION	ONE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1153	MEDICATIONS	ACTIVE
12/23/14	1405	MEDICATIONS	ACTIVE
12/23/14	1500	INTRAVENOUS	DC

Specimen to Obtain Orders

Service Date	Service Time	Procedure	Status	Report Number	Report Status
12/23/14	1153	SPECIMEN TO OBTAIN	TRANS		

Monogram	Initials	Name	Nurse Type
MLM	RXMML	Hernandez,Maria L	PTECH

Occurred Date	Time by	Author	Recorded Date	Time by	Notes: All Categories Category

12/23/14 1020 MOB Bacani,Marlene O 12/23/14 1023 MOB ED Nursing Notes
Abnormal? N Confidential? N
ED PHYSICIAN AT BEDSIDE FOR PATIENT EVALUATION. MEDICAL SCREENING EXAMINATION COMPLETED BY ED PHYSICIAN.
Note Type Description

No Type None

12/23/14 1041 MOB Bacani,Marlene O 12/23/14 1041 MOB ED Nursing Notes
Abnormal? N Confidential? N
PT TAKEN TO CT SCAN VIA GURNEY.
Note Type Description

No Type None

12/23/14 1051 MOB Bacani,Marlene O 12/23/14 1101 MOB ED Nursing Notes
Abnormal? N Confidential? N
MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS
Note Type Description

No Type None

12/23/14 1130 MOB Bacani,Marlene O 12/23/14 1130 MOB ED Nursing Notes
Abnormal? N Confidential? N
ALL TEST RESULTS COMPLETE, PATIENT READY FOR MD RE-EVALUATION.
Note Type Description

No Type None

12/23/14 1155 MOB Bacani,Marlene O 12/23/14 1159 MOB ED Nursing Notes
Abnormal? N Confidential? N
PT TAKEN TO CT SCAN VIA WHEELCHAIR.
Note Type Description

No Type None

12/23/14 1200 MOB Bacani,Marlene O 12/23/14 1250 MOB ED Nursing Notes
Abnormal? N Confidential? N
PT BACK IN ROOM FROM CT SCAN VIA WHEELCHAIR.
Note Type Description

No Type None

12/23/14 1236 MOB Bacani,Marlene O 12/23/14 1251 MOB ED Nursing Notes
Abnormal? N Confidential? N
MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS.
Note Type Description

No Type None

12/23/14 1325 JL1 Liu,Jing 12/23/14 1629 JL1 Nurse Notes
Abnormal? N Confidential? N
ADMITTED 68 MALE FROM ER, TRANSFERED BY GURNEY, PT AMBULATE TO BED, CHEIF COMPLAINE HEADACHE, UPON ADMISSION PT IS ALERT, ORIENTED, CLEAR SPEECH, NO WEAKNESS, NEURO ASSESSMENT WITHIN NORMAL LIMITS, NO SOB, EVEN UNLABORED BREATH ON ROOM AIR, CLEAR LUNG SOUNDS, DENIES CHEST PAIN, APPLIED TELE#34 WITH SR, ABDOMEN SOFT WITH ACTIVE BS, STRONG PULSES BUE AND BLE, IV TO RIGHT WRIST PATENT WITH IVF AND UNASYN INFUSSING FROM ER, RESUME IV MEDICATION, ORIENTED PT TO ROOM, CALL LIGHT SYSTEM, PT ABLE TO VERBALIZED UNDERSTANDING, VITAL SINGS STABLE, BED IN LOWEST POSITION, KEEP CLOSE MONITOR.
Note Type Description

No Type None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/23/14	1430	JL1	Liu,Jing	12/23/14	1719	JL1	Nurse Notes

Abnormal? N Confidential? N

PT C/O OF HEADACHE 7/10 INTENSITY, FIORICET GIVEN AS ORDERED, PT TOLERATED WELL.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/23/14	1530	JL1	Liu,Jing	12/23/14	1630	JL1	Nurse Notes

Abnormal? N Confidential? N

PT WENT DOWNSTAIR WITH WHEELCHAIR WITH NURSE FOR MRI.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/23/14	1710	JL1	Liu,Jing	12/23/14	1720	JL1	Nurse Notes

Abnormal? N Confidential? N

PT BACK TO MRI, NO CHANGE IN CONDITION, NO C/O OF HEADACHE AT THIS TIME, KEEP CLOSE MONITOR.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/23/14	1917	JL1	Liu,Jing	12/23/14	1917	JL1	Nurse Notes

Abnormal? N Confidential? N

PT RESTING IN BED, NO DISTRESS, NO C/O OF HEADACHE AT THIS TIME, WILL ENDORSE TO COMING SHIFT TO CONTINUE CARE.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/23/14	1935	LC	Ciupala,Liliana	12/24/14	0222	LC	Nurse Notes

Abnormal? N Confidential? N

PT IS A/O X4. SPEECH CLEAR . DX ON ADMISSION HEADACHE. PT DENIES ANY HEADACHE AT THIS TIME. ON TELE# 34 WITH NSR . PT DENIES ANY CHEST PAIN AT THIS TIME. BREATH SOUNDS CTA BILAT. RESPIRATION EVEN AND UNLABORED ON ROOM AIR.IV SALINE LOCKED ON R WRIST. IV SITE CLEAR AND DRY WITHOUT REDNESS OR INFILTRATION NOTED. BOWEL SOUNDS ACTIVE X4. LAST BM ON 12/23/14 WITH FORMED STOOL. PT VOIDS FREELY WITHOUT DYSURIA REPORTED. SKIN INTACT WITHOUT ACTIVE WOUNDS NOTED. SCD'S IN PLACE BLE. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/24/14	0549	LC	Ciupala,Liliana	12/24/14	0550	LC	Nurse Notes

Abnormal? N Confidential? N

PT RESTED WELL. NO C/O HEADACHE DURING THE NIGHT. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR.

Note Type	Description
No Type	None

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
12/24/14	0750	ED	Deharo,Eric	12/24/14	0947	ED	Nurse Notes

Abnormal? N Confidential? N

PT RECEIVED SITTING IN BED, ALERT AND ORIENTED X4, FOLLOWS COMMANDS. TELE # 34 SR, PT DENIES CP AT THIS TIME. BREATH SOUNDS CLEAR BILATERALLY ON RA, UNLABORED RESPIRATIONS. BOWEL SOUNDS ACTIVE X4, LBM 12.23.14, PT DENIES N/V/D. AMBULATORY WITH BRP, VOIDS FREELY. SKIN INTACT, RADIAL/PEDAL PULSES PRESENT AND MODERATE, SCD'S IN USE. PT DENIES HA AT THIS TIME, EXPRESSES PRESSURE TO FOREHEAD. IV TO RIGHT WRIST,SALINE LOCKED, NO REDNESS,SWELLING OR PAIN NOTED AT THIS TIME. PT ORIENTED TO SURROUNDINGS AND USE OF CALL LIGHT, CALL LIGHT

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category

12/24/14 0750 ED Deharo,Eric 12/24/14 0947 ED (continued)

WITHIN REACH, WILL CONTINUE TO MONITOR.

Note Type Description

No Type None

12/24/14 1213 ED Deharo,Eric 12/24/14 1215 ED Nurse Notes

Abnormal? N Confidential? N

PT BEING DISCHARGED AT THIS TIME, REVIEWED WITH PT DISCHARGE INSTRUCTIONS AND PERSONAL BELONGINGS LIST, PT VEBALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS AND IS LEAVING WITH ALL PERSONAL BELONGINGS, IV DC'D CATHETER INTACT, NO REDNESS,SWELLING OR PAIN NOTED AT THIS TIME, SCD'S AND TELE MONITOR REMOVEDE, TELE MONITOR RETURNED TO TELE ROOM. ALL PT'S QUESTIONS ANSWERED, PT STABLE UPON DISCHARGE, NO DISTRESS NOTED, PT ESCORTED TO LOBBY VIA WALKING BY RN ERIC.

Note Type Description

No Type None

12/24/14 1344 SM Montoya-Bell,Susan 12/24/14 1344 SM Case Management Notes

Abnormal? N Confidential? N

INITIAL DISCHARGE PLANNING SCREEN/CHART REVIEWED. PT LIVES WITH HIS SPOUSE AND IS INDDEPENDENT WITH ADLS AND DECISION MAKING. PT DISCHARGED WITH NO FURTHER DC PLANNING COMPLETED.

Note Type Description

No Type None

Monogram	Initials	Name	Nurse Type
ED	NURDE1	Deharo,Eric	RN
JL1	NURLJ1	Liu,Jing	RN
LC	NURCL1	Ciupala,Liliana	RN
MOB	EDBMO	Bacani,Marlene O	RN
SM	SWMS	Montoya-Bell,Susan	SS

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change

Activity Date: 12/23/14 Time: 1020

Patient Notes: ED Nursing Notes
- Create 12/23/14 1020 MOB 12/23/14 1023 MOB
Abnormal? Confidential?
ED PHYSICIAN AT BEDSIDE FOR PATIENT EVALUATION. MEDICAL SCREENING EXAMINATION COMPLETED BY ED PHYSICIAN.

Activity Date: 12/23/14 Time: 1041

Patient Notes: ED Nursing Notes
- Create 12/23/14 1041 MOB 12/23/14 1041 MOB
Abnormal? Confidential?
PT TAKEN TO CT SCAN VIA GURNEY.

Activity Date: 12/23/14 Time: 1051

Patient Notes: ED Nursing Notes
- Create 12/23/14 1051 MOB 12/23/14 1101 MOB
Abnormal? Confidential?
MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS

Activity Date: 12/23/14 Time: 1130

Patient Notes: ED Nursing Notes
- Create 12/23/14 1130 MOB 12/23/14 1130 MOB
Abnormal? Confidential?
ALL TEST RESULTS COMPLETE, PATIENT READY FOR MD RE-EVALUATION.

Activity Date: 12/23/14 Time: 1153

150000	Vital Signs								A			OE
- Create		12/23/14	1153		12/23/14	1153						
1000032	Bilateral Lower Extremity SCD								A			OE
Comment: Thrombotic Prevention												
- Create		12/23/14	1153		12/23/14	1153						

Activity Date: 12/23/14 Time: 1155

Patient Notes: ED Nursing Notes
- Create 12/23/14 1155 MOB 12/23/14 1159 MOB
Abnormal? Confidential?
PT TAKEN TO CT SCAN VIA WHEELCHAIR.

Activity Date: 12/23/14 Time: 1200

Patient Notes: ED Nursing Notes
- Create 12/23/14 1200 MOB 12/23/14 1250 MOB
Abnormal? Confidential?
PT BACK IN ROOM FROM CT SCAN VIA WHEELCHAIR.

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change

Activity Date: 12/23/14 Time: 1236

Patient Notes: ED Nursing Notes
- Create 12/23/14 1236 MOB 12/23/14 1251 MOB
Abnormal? Confidential?
MEDICATED PT AS ORDERED, SEE MAR. WILL MONITOR FOR ADVERSE REACTIONS.

Activity Date: 12/23/14 Time: 1322

1000 B	ADMISSION/TRANSFER: Quick Start Form +									A	ON ADMISSION/TRANS	AS
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
- Document		12/23/14	1322	JL1	12/23/14	1322	JL1					
Patient Type: MED/SURG/TELE									New Admit: Y			
Patient Age: 68									Admit Order Present on Admission: Y			
1001	Agency Documentation +									A	WHEN APPLICABLE	CP
	ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.											
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
1041	Smoking Cessation									A	ON ADMISSION	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
1070	Shift Reassessment -									A	QS & Q4H IN ICU	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
1500	I&C: Monitor +									A	Q12H (0559,1759)	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
15000	Care Plan: RN Review +									A	Q12H	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
20010	VS: Monitor -									A	AS ORDERED	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
21090	Routine Care: MED/SURG/TELE +									A	.BED OF SHIFT/TX	CP
	VIEW PROTOCOL											
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
21100	Nutrition/Activity/ADL Flowsheet +									A	QS BY CAREGIVER	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
22300	IV/Invasive Lines: Insert/Remove +									A	INS/REMOVAL/CONVERT	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
31320	Pain: Management Of +									A	AS NEEDED	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
40250	Position Change +									A	Q2H	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
60010	Notify: MD +									A	WHEN NECESSARY	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
80010	Education: Patient/Family Teaching +									A	QS BY CAREGIVER	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
90010	DIS: Patient Discharge Instructions +									A	ON DISCHARGE	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
150010	Weight +									A		CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
1000461	Pneumococcal Vaccine Assessment									A	ON ADMISSION	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					
1000466	Influenza Vaccine Assessment									A	ON ADM-CCU TO MARCH	CP
- Create		12/23/14	1322	JL1	12/23/14	1322	JL1					

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From / Change
Activity Date: 12/23/14 Time: 1322												
1000481 Multidisciplinary Pt Care Team Notes	Create	12/23/14	1322	JL1	12/23/14	1322	JL1			A	WHEN APPLICABLE	CP
1001034 Age Guidelines: 65+ (OLDER ADULT)	Create	12/23/14	1322	JL1	12/23/14	1322	JL1			A	VIEW PROTOCOL/DI QS	CP
7007777 Critical Result Reporting	Create	12/23/14	1322	JL1	12/23/14	1322	JL1			A	AS NEEDED	CP
9990004 Daily Chart Check	Create	12/23/14	1322	JL1	12/23/14	1322	JL1			A	0600 & 1800	CP
Activity Date: 12/23/14 Time: 1325												
Patient Notes: Nurse Notes	Create	12/23/14	1325	JL1	12/23/14	1629	JL1					
Abnormal? N Confidential? N												
ADMITTED 68 MALE FROM ER, TRANSFERED BY GURNEY, PT AMBULATE TO BED, CHEIF COMPLAINE HEADACHE, UPON ADMISSION PT IS ALERT, ORIENTED, CLEAR SPEECH, NO WEAKKESS, NEURO ASSESSMENT WITHIN NORMAL LIMITS, NO SOB, EVEN UNLABORED BREATH ON ROOM AIR, CLEAR LUNG SOUNDS, DENIES CHEST PAIN, APPLIED TELE#34 WITH SR, ABDOMEN SOFT WITH ACTIVE BS, STRONG PULSES BUS AND BLE, IV TO RIGHT WRIST PATIENT WITH IVF AND UNASYN INFUSSING FROM ER, RESUME IV MEDICATION, ORIENTED PT TO ROOM, CALL LIGHT SYSTEM, PT ABLE TO VERBALIZED UNDERSTANDING, VITAL SINGS STABLE, BED IN LOWEST POSITION, KEEP CLOSE MONITOR.												
Activity Date: 12/23/14 Time: 1430												
Patient Notes: Nurse Notes	Create	12/23/14	1430	JL1	12/23/14	1719	JL1					
Abnormal? N Confidential? N												
PT C/O OF HEADACHE 7/10 INTENSITY, FIORICET GIVEN AS ORDERED, PT TOLERATED WELL.												
Activity Date: 12/23/14 Time: 1457												
20010 VS: Monitor -	Document	12/23/14	1457	DS	12/23/14	1458	DS			A	AS ORDERED	CP
Temperature/F: 97.2 Temp Source: TEMPORAL ARTERY												
Pulse: 60 Pulse Source: AUTOMATIC, NONINVASIVE												
Respirations: 18 Resp Source: OBSERVED												
Blood Pressure: 144/97 BP Source: AUTOMATIC												
Site: LEFT UPPER ARM												
C/O Pain: N Pain Scale: 0/10												
== 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 (%): 96 FIO2:												
Comment:												

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From / Change
Activity Date: 12/23/14 Time: 1511												
4131105 IV: Saline Lock & Flush	Create	12/23/14	1511		12/23/14	1511				A		OE
Activity Date: 12/23/14 Time: 1530												
Patient Notes: Nurse Notes	Create	12/23/14	1530	JL1	12/23/14	1630	JL1					
Abnormal? N Confidential? N												
PT WENT DOWNSTAIR WITH WHEELCHAIR WITH NURSE FOR MRI.												
Activity Date: 12/23/14 Time: 1548												
1005-H ADM: ADULT Admission History +	Create	12/23/14	1548	JL1	12/23/14	1554	JL1			A	ON ADMISSION	AS
Document 12/23/14 1548 JL1 12/23/14 1554 JL1												
=== History Obtained === Date: 12/23/14 Time: 1400												
Signature: Dai,Jing												
=== ARRIVAL INFORMATION ===												
Time of Arrival: 1322 Mode of Arrival: GURNEY												
Arrived From: EMERGENCY DEPT Accompanied By: NURSE												
=== Source of Information ===												
Patient: Y Other (name/relationship):												
Chief Complaint: HEADACHE												
Primary Diagnosis: HEADACHE												
=== VITAL SIGNS ===												
Temperature/F: 97.2 Temp Source: TEMPORAL ARTERY												
Pulse: 60 Pulse Source: AUTOMATIC, NONINVASIVE												
Respirations: 18 Respiration Source: OBSERVED												
Blood Pressure: 144/97 BP Source: AUTOMATIC												
Site: LEFT 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: 169 Oz: 0 OR Kg: 76.65												
Weight Source: BEDSCALE												
=== PAIN SCREEN ===												
C/O Pain: Y *** Chest Pain to be Documented on Cardiac Problem ***												
When Pain is Present:												
Pain Location: HEADACHE												
Pain Scale: 7/10												
Describe the Pain: ACHING												
Onset: INTERMITTENT												
What Increases the Pain: :												
What Relieves the Pain: REST :												
Pain Control Goal: 0/10												
Comment: PT REFUSED PAIN MEDICATION AT THIS TIME												

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/23/14 Time: 1548 (continued)

1005-H ADM: ADULT Admission History + (continued)

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

Contact Person: HANNA,TAMER
Relationship: SO
Home Phone: (909)342-9908
Work Phone: (945)413-8670
Cell/Pager:
Add'l Contact Information:

===PATIENT HISTORY===
Manage Family History: N
Medical History: NONE

Surgical History: NONE

Pneumococcal Vaccination: VACCINE UNAVAILABLE
Pneumococcal Vaccination Date:
Influenza Vaccination: PREVIOUS VACCINATION
Influenza Vaccination Date: 01/08/14
Vaccine Comment: NOT QUALIFIED FOR PNEUMOCOCCAL VACCINATION

=== SUBSTANCE USE HISTORY ===
Smoking Cessation: NEVER SMOKER
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

=== 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: N
IF YES: Family instructed to bring in copy and Physician notified:
What is the intent of the Advance Directive for this hospital stay:
IF OTHER THAN A FULL CODE NOTIFY PHYSICIAN
2) Does pt have a condition which may require additional care when discharged: N

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/23/14 Time: 1548 (continued)

1005-H ADM: ADULT Admission History + (continued)

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: FAMILY
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:

=== CURRENT PHYSICIANS/PRACTITIONERS ===
Document the Names and Phone Numbers of the Physicians/Practitioners Seeing the Patient Prior to This Hospitalization:
DR.
- Edit Results 12/23/14 1548 JL1 12/23/14 1624 JL1
Medical History: MIGRAINE, SINUSITIS [NONE]
Total Score: [0]
Prior to This Hospitalization:
DENIES [DR.]
Edit Results 12/23/14 1548 JL1 12/23/14 1626 JL1
Manage Family History: Y [N]

Activity Date: 12/23/14 Time: 1554

1000466 Influenza Vaccine Assessment A ON ADM-CCT TO MARCH CP
Document 12/23/14 1554 JL1 12/23/14 1555 JL1
***** INFLUENZA VACCINATION (October through March) *****

INFLUENZA VACCINE ASSESSMENT (October through March): Y

(A) INCLUSION CRITERIA: (Patient is qualified to receive vaccine if one or more is selected)
Patient is age 6 months and older: Y

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1555 (continued)

1000466 Influenza Vaccine Assessment (continued)

(B) EXCLUSION CRITERIA: *Do not give if any box is YES*
Received influenza vaccine within the current flu season: Y
Patient has anaphylactic latex allergy:
Hypersensitivity to eggs or other components of vaccine:
(excludes painful injections)
Previous history of hypersensitive reaction to vaccine:
History of bone marrow transplant within the last 6 months:
Patient with an organ transplant during hospitalization:
History of Guillan Barre Syndrome:
Leaves against medical advice (AMA):

(C) INFLUENZA VACCINE ADMINISTRATION:(October through March)
1. At least one inclusion criteria is present: Y
2. At least one exclusion criteria is present: N

IF QUESTION #1 = YES & QUESTION #2 = NO, ORDER INFLUENZA VACCINE:
(age 6-35 months) Thimerosal Preservative-Free Influenza Vaccine 0.25mL IM
(age 3 and older) Influenza Vaccine 0.5mL IM

Influenza Vaccine Ordered: N Influenza Vaccine Given: N
Pt Refused vaccination: N Refusal Reason:

Vaccine Comment: NOT QUALIFIED FOR PNEUMOCOCCAL VACCINATION
PT RECIEVED FLU VACCINE

(D) Education provided regarding vaccination administration/refusal: Y
VACCINE INFORMATION SHEET (VIS) MUST BE GIVEN TO PATIENT
Vaccine Information Statement Given Date: 12/23/14
Vaccine Information Statement Published Date: 08/19/14

Activity Date: 12/23/14 Time: 1555

1000461 Pneumococcal Vaccine Assessment A ON ADMISSION CP
Document 12/23/14 1555 JL1 12/23/14 1555 JL1
********** PNEUMOCOCCAL VACCINATION **********

PNEUMOCOCCAL VACCINE ASSESSMENT (Year Round):

(A) INCLUSION CRITERIA: (Patient is qualified to receive vaccine if one or more is selected)
Patient is 65 years and older: Y
Patient is 5-64 years of age with at least one of the following high risk conditions:
COPD or Pneumonia: (age 19 years and older) Cigarette Smoking:
Diabetes: Functional Asplenia (Sickle Cell Disease):
HIV/AIDS: Anatomical Asplenia (Splenectomy):
(ages 19-64) Asthma: Immunocompromised or Suppressed:
Alcoholism: Candidate For or Recipient Of Cochlear Implant:
CSF Leak: Chronic Liver Disease, Cirrhosis:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1555 (continued)

1000461 Pneumococcal Vaccine Assessment (Continued)
Chronic Renal Failure, ESRD, Nephrotic Syndrome:
Chronic Cardiovascular Disease excluding Hypertension:
(example: Congestive Heart Failure, Cardiomyopathies)
Vaccination Status Unknown:

(B) EXCLUSION CRITERIA: *Do not give if any box is YES*
Received TWO (2) pneumococcal vaccines doses: N
Vaccinated less than 5 years ago: N
Date Received:
Vaccinated since 65 years old: N
Date Received:
Previous history of hypersensitive reaction to vaccine: N
(excludes painful injections)
History of bone marrow transplant within the last 12 months: N
Patient with an organ transplant during hospitalization: N
(Ages 5-18) Received a conjugate vaccine within the previous 8 weeks: N
Received chemotherapy or radiation during this hospitalization, or
less than 2 weeks prior to this inpatient hospitalization: N
(ages 5-18) With asthma and no other high risk conditions: N
Received shingles vaccine (Zostavax) within last 4 weeks: N
Leaves against medical advice (AMA): N
Pregnant: N

(C) PNEUMOCOCCAL VACCINE ADMINISTRATION: (Year Round)
At least one inclusion criteria is present: Y
No exclusion criteria are identified: N
If both YES, order Pneumococcal vaccine (per pharmacy)
Pneumococcal Vaccine Given: N
-IF PT REFUSES A REASON MUST BE ENTERED-
Refusal Reason:

Vaccination Comment: PT NOT QAULIFIED FOR PNEUMOCOCCAL VACCINE

(D) Education provided regarding vaccination administration/refusal: Y
VACCINE INFORMATION SHEET (VIS) MUST BE GIVEN TO PATIENT
Vaccine Information Statement Given Date: 12/23/14
Vaccine Information Statement Published Date: 08/19/14

7000103 ADM: Risk Assessment - Suicide A ON ADMISSION & PRN AS
Create 12/23/14 1555 JL1 12/23/14 1556 JL1
- Document 12/23/14 1555 JL1 12/23/14 1556 JL1
=== SUICIDE RISK ASSESSMENT ===

1. Patient reports current or history of psychiatric illness,
with acute exacerbation of symptoms within the last 30 days: N
2. Patient has positive history of suicide attempt: N
3. Patient voicing suicidal intent/ideation: N

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/23/14 Time: 1555 (continued)

7000103 ADM: Risk Assessment - Suicide (continued)
4. Patient has active suicide plan: N

If patient answered YES to questions #1 or #2 only, refer to Social Services for follow-up.
If patient answered YES to questions #3 and/or #4,IMMEDIATELY institute suicide precautions.

=== SUICIDE PRECAUTIONS ===

Security at bedside or stand-by:
Secure or remove any/all safety hazards:
(weapons, sharp objects, medications, contraband, patient belongings, cords, belts, etc.)
Provide close/continuous supervision:
Notify physician to order psych eval or MAT team assessment:
(for assessment of lethality and recommendations for care)

Activity Date: 12/23/14 Time: 1556

1005-S ADM: ADULT Admission Assessment + A ON ADMISSION AS
- Create 12/23/14 1556 JL1 12/23/14 1600 JL1
- Document 12/23/14 1556 JL1 12/23/14 1600 JL1
=== Assessment Obtained === Date: 12/23/14 Time: 1556
Signature: Listening

NEUROLOGICAL Assessment Within Normal Limits: Y == PUPIL REACTION CHECK ==
LOC: AWAKE/ALERT Reaction OD: BRISK Size: 3
Orientation: PERSON, PLACE AND TIME Reaction OS: BRISK Size: 3
Responds to: VERBAL STIMULUS
Speech: CLEAR
Headaches: Y Describe: ACHING
Recent Seizure Activity: N Seizure Precautions initiated or being utilized: N
Neuro Comment: C/O OF HEADACHE, NO NAUSEA OR VOMITING, NO WEAKNESS

ENT Assessment Within Normal Limits: Y
ENT Comment:

RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Effort:
Location: Chest Expansion:
Cough: Chest Tubes Present:
Secretions, Amt:
Color:
IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min): FIO2: Spo2 (%): 96
Comment: NO SOB, EVEN UNLABORED BREATH ON ROOM AIR

CARDIAC Assessment Within Normal Limits: Y

1005-S ADM: ADULT Admission Assessment + (continued)
Heart Rate Irregular: Heart Tones:
Syncope/Fainting: Vertigo/Dizziness:
Chest Pain: Pain Quality:
If Radiating, Describe:
Pain Scale: Pain Treatment:
IF ON CARDIAC MONITOR/TELEMETRY Treatment Outcome:
Monitor #: 34 Cardiac Rhythm: NORMAL SINUS RHYTHM
Cardiac Comment: DENIES CHEST PAIN

CIRCULATORY Assessment Within Normal Limits: Y
Extremity Temp: Left Radial Pulse: STRONG
Extremity Color: Right Radial Pulse: STRONG
Sensation: Left Pedal Pulse: STRONG
Edema: Right Pedal Pulse: STRONG
Circulatory Comment: NO EDEMA NOTED

MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: AMBULATORY

=== FUNCTIONAL STATUS ===
Has the Patient's Functional Ability Decreased in the Last 6 Months: N
Prior Mobility: Current Mobility: SELFCARE
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N

GASTROINTESTINAL Assessment Within Normal Limits: Y
Last BM: 12/23/14 Describe Stool:
Ostomy: GI Tube:
GI Comment: ABDOMEN SOFT WITH ACTIVE BS

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: VOID FREELY

INTEGUMENTARY Assessment Within Normal Limits: Y
Abnormalities Photo Documented:
Alteration: Location:
Dressing Type/Condition:
Alteration: Location:
Dressing Type/Condition:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1556 (continued)

1005-S ADM: ADULT Admission Assessment + (continued)

Alteration: Location:
Dressing Type/Condition:
Drainage Tube: Describe:
Skin Comment: WARM TO TOUCH, DRY CLEAN

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
Sensory Perception: 4 NOT LIMITED-WNL
Moisture: 4 RARELY MOIST
Activity: 3 WALKS OCCASIONALLY
Mobility: 3 SLIGHTLY LIMITED
Nutrition: 4 EXCELLENT
Friction and Sheer: 3 NO APPARENT PROBLEM
Skin Risk Score: 21
19-23 = No Risk: Y
15-18 = At Risk:
13-14 = Moderate Risk:
10-12 = High Risk:
9 Or Lower = Very High Risk:
Scoring of 18 Or Lower Initiate Skin Integrity Protocol Guidelines

PSYCHOSOCIAL Assessment Within Normal Limits: Y
Fears/Anxiety Related to Hospital Stay: Ineffective Coping: Inadequate Support System:
Suspected Abuse/Neglect: Describe:
Alteration in Growth/Development:
Comment:

=== NUTRITION ===
NUTRITIONAL Assessment Within Normal Limits: Y
Diet at Home: REGULAR
Comment:

=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished: 0 NO
Nausea, Vomiting, or Diarrhea for >3 Days: 0 NO
Unintentional Wt Loss >10# in Past Month: 0 NO
Admitted with Potential Risk Diagnosis: 0 NO
Poor PO Intake for >3 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
Total Score: 0
=Nutrition Risk=
Low (0-1): Y
Moderate (2-3):
High (4+):

=== ASPIRATION RISK SCREENING ===
Impaired Mental Status: 0 NO
Difficulty Swallowing: 0 NO
Food Sticking in Mouth/Throat: 0 NO
Coughing/Choking: 0 NO
Weight Loss: 0 NO
Total Score: 0
=Aspiration Risk=
Low (0-1): Y
Moderate (2):
High (3-5):

=== 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: 2 65+ YEARS
Total Score: 2
=Fall Risk=
Low (0-2):
Moderate (3-6): Y
High (7+):

=== EDUCATION SCREENING ===
Educational Need Priority #1: TREATMENT PURPOSES

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1556 (continued)

1005-S ADM: ADULT Admission Assessment + (continued)
Educational Need Priority #2: SAFETY PRECAUTIONS
Educational Need Priority #3: MEDICATIONS
Educational Need Priority #4: DISEASE PROCESS

=== BARRIERS TO LEARNING ===
Physiologic Limitations: NONE
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: DISCUSSION
Comment:

=== DVT RISK ASSESSMENT ====
Leg Plaster Cast or Brace: 0 NO
Varicose Veins: 0 NO
Hormone Replacement: 0 NO
Admission DX includes: CHF,COPD,MI,Sepsis,Pneumonia: 0 NO
Bed Rest with Limited Activity: 0 NO
Obesity: 0 NO
Major Surgery (> 60 minutes): 0 NO
Family History of DVT/PE: 0 NO
Present Cancer or Chemotherapy: 0 NO
History of SVT, DVT/PE: 0 NO
Hip, Pelvis, or Leg Fracture (< 1 month): 0 NO
Stroke (< 1 month): 0 NO
Paralysis (< 1 month): 0 NO
Patient's Age: 2 60-74 YEARS
Total Score: 2
=DVT Risk=
Low (0-1):
Moderate (2): Y
High (3+):
*** NOTIFY PHYSICIAN IF DVT RISK SCORE > 1 AND DOCUMENT IN PT CARE NOTES ***

=== SAFETY ===
Isolation: STANDARD PRECAUTIONS Allergy Bracelet On: Y ID Band On: Y
Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: RIGHT WRIST IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 12/23/14

1041 Smoking Cessation A ON ADMISSION CP
-> Document 12/23/14 1556 JLI 12/23/14 1556 JLI

----Smoking Cessation Assessment----

Smoking Cessation: NEVER SMOKED

Have you smoked in the last 12 months: N

Do you dip or chew tobacco: N

Approximately how many cigarettes per day:
20 Cigarettes = 1 Pack

Intervention Description Sts Directions From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/23/14 Time: 1556 (continued)

1041 Smoking Cessation (continued)

Level of Dependence:

If you are a Former Smoker, when did you quit:

Patient requests Smoking Cessation Consult:

Initiate information on Smoking Cessation: Initiate Smoking Education Date: 12/23/14

Activity Date: 12/23/14 Time: 1600

31200 Problem: Neurological + A QS & Q4H IN ICU CP
Create 12/23/14 1600 JL1 12/23/14 1600 JL1

Activity Date: 12/23/14 Time: 1710

Patient Notes: Nurse Notes
Create 12/23/14 1710 JL1 12/23/14 1720 JL1
Abnormal? N Confidential? N
PT BACK TO MRI, NO CHANGE IN CONDITION, NO C/O OF HEADACHE AT THIS TIME, KEEP CLOSE MONITOR.

Activity Date: 12/23/14 Time: 1757

20010 VS: Monitor - A AS ORDERED CP
Document 12/23/14 1757 DS 12/23/14 1757 DS
Temperature/P: 98.1 Temp Source: TEMPORAL ARTERY
Pulse: 59 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 156/92 BP Source: AUTOMATIC
Site: LEFT UPPER ARM
C/O Pain: Y Pain Scale: 2/10

== CNA/LICENSED Documentation ==
Comfort Measures Implemented:
Nurse Notified of Pain:
(If Medicated, Document On Intervention Pain: Management Cf)

IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min):
SpO2 (%): 97 FiO2:
Comment:

Activity Date: 12/23/14 Time: 1759

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 12/23/14 1759 JL1 12/23/14 1850 JL1
=== INTAKE: SHIFT TOTAL ===
Ice: Y Oral: 460 IVPB's: Blood/Product:
Tube Feeding: Chemo: GU Irrigant,In:

Intervention Description Sts Directions From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/23/14 Time: 1759 (continued)

1500 I&O: Monitor + (continued)
H2O: TPN: Other Intake:
IV's: 60 Lipids: Total Intake: 460

=== OUTPUT: SHIFT TOTAL ===
BRP: Y # of Voids/Incont: 2 Colostomy: Hemovac #1:
# of Stools: 0 Jejunostomy: Hemovac #2:
Urine: Ileostomy: T Tube:
Stool, Liquid: Jackson Pratt #1: GU Irrigant, Out:
Emesis: Jackson Pratt #2: Dialysis Net:
NG Tube: Chest Tube #1: Est. Blood Loss:
Nephrostomy: Chest Tube #2: Other Output:

Total Output:
=== TOTAL SHIFT FLUID BALANCE === 460

Comment:

Activity Date: 12/23/14 Time: 1826

21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document 12/23/14 1826 DS 12/23/14 1826 DS
=== NUTRITION ===
% Meal Intake
Breakfast: Diet:
Lunch: 100 Diet:
Dinner: 100 Diet:
Comment:

If Appropriate:
PO Nutritional Supplement Taken: N/A Amount Taken:
Supplemental Snacks: N : N/A

=== ACTIVITY/ADL ===
Activity Type: BATHROOM PRIVILEGES
Activity Tolerance: GOOD
Gait: NOT APPLICABLE

=== PERSONAL HYGIENE ===
Bath: SELF
Linen Changed: Y
Oral Hygiene: SELF
Last BM:
Incont (BM): N
Description:

Elimination Comment:
Comment:

Activity Date: 12/23/14 Time: 1850

21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 12/23/14 1850 JL1 12/23/14 1850 JL1
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

Activity Date: 12/23/14 Time: 1850 (continued)

21090 Routine Care: MED/SURG/TELE + (continued)

Signature: Liu,Jing Shift: 0700 - 1930

Practice Guidelines Comment:

Patient/Family Education Provided This Shift: Y

Isolation: STANDARD PROCEDURES
Restraints in Use: N Describe:
+Total Hrs. In Restraints This Shift: Location:
Sitter Used: N Comment:

=== IV ASSESSMENT ===
Throughout Shift: Central Line Present: N
IV Location: RIGHT WRIST -IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 12/23/14

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment: IV SALINE LOCK, PATENT

9990004 Daily Chart Check A 0600 & 1800 CP
Document 12/21/14 1850 JL1 12/23/14 1850 JL1
12 Hour Chart Check Completed: Y
24 Hour Chart Check Completed:
Comment:

This verifies that all current orders have been completed or are in process.

Activity Date: 12/23/14 Time: 1917

Patient Notes: Nurse Notes
- Create 12/23/14 1917 JL1 12/23/14 1917 JL1
Abnormal: N Confidential: N
PT RESTING IN BED, NO DISTRESS, NO C/O OF HEADACHE AT THIS TIME, WILL ENDORSE TO COMING SHIFT TO CONTINUE CARE.

Activity Date: 12/23/14 Time: 1935

1070 Shift Reassessment + A Q8 & Q4H IN ICU CP
Document 12/23/14 1935 LC 12/24/14 0210 LC
Reassesment Obtained Date: 12/23/14 Time: 1935

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

Activity Date: 12/23/14 Time: 1935 (continued)

1070 Shift Reassessment - (continued)

NEUROLOGICAL Assessment Within Normal Limits: N
Neuro Comment: ADMITTED PT FOR HEADACHE.PT IS A/O X4. FOLLOW COMANDS NO N/V, NO WEAKNESS.
: PT DENIES ANY HEADACHE AT THIS TIME. WILL CONTINUE TO MONITOR.
EENT Assessment Within Normal Limits: Y
EENT Comment:
:
RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment: BREATH SOUNDS CTA BTIAT. RESPIRATION EVEN AND UNLABORED ON ROOM AIR.
:
CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: NORMAL SINUS RHYTHM Monitor #: 34
Cardiac Comment: PT DENIES ANY CHEST PAIN AT THIS TIME.
:
CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment: NO EDEMA NOTED
:
MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: SELF AMBULATORY
:
NUTRITIONAL Assessment Within Normal Limits: Y
Nutritional Comment: REGULAR
:
GASTROINTESTINAL Assessment Within Normal Limits: Y
GI Comment: BOWEL SOUNDS ACTIVE X4 QUADS. LAST BM 12/23/14 WITH NORMAL STOOL
:
GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: PT VOIDS FREELY WITHOUT DYSURIA REPORTED.
:
INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment: SKIN INTACT WITHOUT ACTIVE WOUNDS NOTED.
:
PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: PT CALM AND COOPERATIVE WITH CARE.
:

==== The Following To Be Documented On Once A Shift ====

=== FALL Risk ASSESSMENT===
Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED Total Score: 2
Physical Mobility Status: 0 NOT ALTERED =Fall Risk=
Elimination Status: 0 NOT ALTERED Low (0-2):
Recent History Of Falls: 0 NO FALLS Moderate (3-6):
Patient's Age: 2 65+ YEARS High (7+):

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
Sensory Perception: 4 NOT LIMITED-WNL Skin Risk Score: 22

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1935 (continued)

1070 Shift Reassessment + (continued)

Moisture:	4 RARELY MOIST	19-23 = No Risk:	Y
Activity:	4 WALKS FREQUENTLY	15-18 = At Risk:	
Mobility:	4 NO LIMITATIONS	13-14 = Moderate Risk:	
Nutrition:	3 ADEQUATE	10-12 = High Risk:	
Friction and Sheer:	3 NO APPARENT PROBLEM	9 Or Lower = Very High Risk:	

Scoring of 18 Or Lower - Initiate Skin Integrity Protocol Guidelines

=== DVT RISK ASSESSMENT ====

Leg Plaster Cast or Brace:	0 NO
Varicose Veins:	0 NO
Hormone Replacement:	0 NO
Admission DX includes: CHF,COPD,MI,Sepsis,Pneumonia:	0 NO
Bed Rest with Limited Activity:	0 NO
Obesity:	0 NO
Major Surgery (> 60 minutes):	0 NO
Family History of DVT/PE:	0 NO
Present Cancer or Chemotherapy:	0 NO
History of SVT, DVT/PE:	0 NO
Hip, Pelvis, or Leg Fracture (< 1 month):	0 NO
Stroke (< 1 month):	0 NO
Paralysis (< 1 month):	0 NO
Patient's Age:	2 60-74 YEARS =DVT Risk=
Total Score:	2 Low (0-1):
	Moderate (2): Y
	High (3+):

*** NOTIFY PHYSICIAN IF DVT RISK SCORE > 1 AND DOCUMENT IN PT CARE NOTES ***

Sequential Compression Device in place: Y
Chemical Prophy_axis in use: N
Comment: SCD'S IN PLACE BIL

=== SAFETY ===
Isolation: STANDARD PROCEDURES Allergy Bracelet On: Y ID Band On: Y
Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: RIGHT WRIST IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 12/23/14

15000 Care Plan: RN Review + A Q12H CP
- Document 12/23/14 1935 LC 12/24/14 0157 LC
PATIENT PROBLEM LIST AS PRIORTIZED ON CARE PLAN:

Problem(s) Identified:	PROBLEM: Impaired Neurological Function	Status: A
	Developmental Age 66+ (OLDER ADULT)	A
	CVMC STANDARD OF CARE	A
	STANDARD OF PRACTICE W/S/T/LLE	A

15000 Care Plan: RN Review + (continued)

Patient's Plan of Care was Reviewed and Updated as Needed: Y

31200 Problem: Neurological - A QS & Q4H IN ICU CP
- Document 12/23/14 1935 LC 12/24/14 0211 LC
Altered Neurological Status/Function Remains Active Problem: Y
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

-NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro History:
Speech:
Headaches: Describe:
Behavior/Appearance Inappropriate: Describe:

== GLASGOW COMA SCORE === (Best Response)
Eye Response: 4=SPONTANEOUS
Verbal Response: 5=ORIENTED
Motor Response: 6=OBEYS COMMANDS
Total: 15

== PUPIL REACTION CHECK ==
Reaction OD: BRISK Size: 3
Reaction OS: BRISK Size: 3

=== SEIZURE INFORMATION ===
Recent Seizure Activity: N Seizure Precautions Initiated or being Utilized: N
Describe Seizure Event, Duration, Pre/Post Ictal State:

=== ADDITIONAL NEURO ASSESSMENT ===
-Additional Neuro Assessment Performed and WNL: Y
Level of Consciousness:
Orientation:
Responds to:
Memory:
Thought Process:
Weakness: Specify:
Numbness: Specify:
Facial Droop: Describe:
Babinski Reflex Positive:
ICP Monitor:
ICP:
Fluctuations:

=== ADDITIONAL SWALLOWING ASSESSMENT ===
Problems Observed with Swallowing:
Food Texture Tolerated:
Fluid Consistency Tolerated:

Neuro Comment: ADMITTED PT FOR HEADACHE.PT IS A/O X4 . FOLLOW COMANDS NO N/V, NO WEAKNESS.
: PT DENIES ANY HEADACHE AT THIS TIME. WILL CONTINUE TO MONITOR.

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1935

31320 Pain: Management Of + A AS NEEDED CP
Document 12/23/14 1935 LC 12/24/14 0213 LC
*** Chest Pain to be Documented on Cardiac Problem ***
=== PAIN MANAGEMENT ===
Time of Patient's Complaint: 1935
Pain Location: HEADACHE
Pain Scale: 6/10
Describe the Pain:
Onset:
Comment: PT DENIES ANY PAIN AT THIS TIME. WILL CONTINUE TO
: MONITOR.
Comfort Measures Implemented: :
Other Measures Taken:

Time of Reassessment: Post Intervention Pain Scale:
Response to Intervention:

Patient/Family Education Provided: Y

Pain Comment: WILL CONTINUE TO MONITOR

=== Pain Education for Patient/Family ===

Instructions Given Related to:

Pain Management is Part of Treatment Plan: Y
About the Use of the Pain Intensity Rating Scale: Y
Total Absence of Pain is Often not Realistic/Desirable Goal: Y
Choosing a Pain Control Goal, such as Pain Not Worse than 2: Y
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: Y
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control: Y
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: Y

== Other Information Taught ==
:
40250 Position Change + A Q2H CP
Document 12/23/14 1935 LC 12/24/14 0213 LC
= Patient Position Changed =
Right Side: Y Left Side: Supine: Trendelenburg:
Comment: PT TURNS BY HIMSELF
80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Document 12/23/14 1935 LC 12/24/14 0214 LC
=== PATIENT/FAMILY EDUCATION ===
Information Taught: SAFETY PRECAUTIONS
Instruction Given: CALL LIGHT IN REACH AND BED IN LOW POSITION

Person Taught: PATIENT

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/23/14 Time: 1935 (continued)

80010 Education: Patient/Family Teaching + (continued)
Person Taught:
Teaching Tools: DEMONSTRATION
Other Tools Used: VERBAL
Factors Affecting Learning: NONE
Other Factors: NONE
Participation Level: ACTIVE
Evaluation: DEMONSTRATE UNDERSTANDING
Needs Additional Education: N
:
Educator: Ciupala,Liliana
Discipline: NURSING
150000 Vital Signs A OE
Document 12/23/14 1935 LC 12/24/14 0156 LC
100C032 Bilateral Lower Extremity SCD A OE
Comment: Thrombotic Prevention
Document 12/23/14 1935 LC 12/24/14 0156 LC
1001034 Age Guidelines: 66: (OLDER ADULT) A VIEW PROTOCOL/DI QS CP
Document 12/23/14 1935 LC 12/24/14 0214 LC
Patient Notes: Nurse Notes
Create 12/23/14 1935 LC 12/24/14 0222 LC
Abnormal? N Confidential? N
PT IS A/O X4. SPEECH CLEAR . DX ON ADMISSION HEADACHE. PT DENIES ANY HEADACHE AT THIS TIME. ON TELE# 34 WITH NSR . PT DENIES ANY CHEST PAIN AT THIS TIME. BREATH SOUNDS CTA BILAT. RESPIRATION EVEN AND UNLABORED ON RCOM AIR.IV SALINE LOCKED ON R WRIST. IV SITE CLEAR AND DRY WITHOUT REDNESS OR INFILTRATION NOTED. BOWEL SOUNDS ACTIVE X4. LAST BM ON 12/23/14 WITH FORMED STOOL. PT VOIDS FREELY WITHOUT DYSURIA REPORTED. SKIN INTACT WITHOUT ACTIVE WOUNDS NOTED. SCD'S IN PLACE BLE. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR.

Activity Date: 12/23/14 Time: 2246

20010 VS: Monitor - A AS ORDERED CP
Document 12/23/14 2246 AS1 12/23/14 2246 AS1
Temperature/F: 98.7 Temp Source: TEMPORAL ARTERY
Pulse: 62 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 148/87 BP Source: AUTOMATIC
Site: LEFT UPPER ARM
C/O Pain: Y Pain Scale: 2/10

== 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: PT REFUSED PAIN MEDICATION AT THIS TIME

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

Activity Date: 12/24/14 Time: 0547

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 12/24/14 0547 LC 12/24/14 0547 LC
=== INTAKE: SHIFT TOTAL ===
Ice: N Oral: 240 IVPB's: Blood/Product:
Tube Feeding: Chemo: GU Irrigant,In:
H2O: TPN: Other Intake:
IV's: Lipids: Total Intake: 240

=== OUTPUT: SHIFT TOTAL ===
BRP: Y # of Voids/Incont: 2 Colostomy: Hemovac #1:
# of Stools: Jejunostomy: Hemovac #2:
Urine: Ileostomy: T-Tube:
Stool, Liquid: Jackson Pratt #1: GU Irrigant, Out:
Emesis: Jackson Pratt #2: Dialysis Not:
NG Tube: Chest Tube #1: Est. Blood Loss:
Nephrostomy: Chest Tube #2: Other Output:

Total Output:
=== TOTAL SHIFT FLUID BALANCE === 240

Comment:

21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 12/24/14 0547 LC 12/24/14 0548 LC
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice
Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Ciupala,Liliana 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:
Sitter Used: N Comment:

=== IV ASSESSMENT ===
Throughout Shift: Central Line Present: N
IV Location: RIGHT WRIST IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 12/23/14

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Documented Change

Activity Date: 12/24/14 Time: 0547 (continued)

21090 Routine Care: MED/SURG/TELE + (continued)
IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment:

Activity Date: 12/24/14 Time: 0548

9990004 Daily Chart Check A 0600 & 1800 CP
Document 12/24/14 0548 LC 12/24/14 0548 LC
12 Hour Chart Check Completed:
24 Hour Chart Check Completed: Y
Comment: WILL GIVE REPORT TO AM SHIFT

This verifies that all current orders have been completed or are in process.

Activity Date: 12/24/14 Time: 0549

Patient Notes: Nurse Notes
Create 12/24/14 0549 LC 12/24/14 0550 LC
Abnormal? N Confidential? N
PT RESTED WELL. NO C/O HEADACHE DURING THE NIGHT. CALL LIGHT IN REACH AND BED IN LOW POSITION. WILL CONTINUE TO MONITOR.

Activity Date: 12/24/14 Time: 0702

20010 VS: Monitor - A AS ORDERED CP
Document 12/24/14 0702 AS1 12/24/14 0702 AS1
Temperature/F: 98.2 Temp Source: TEMPORAL ARTERY
Pulse: 67 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 142/80 BP Source: AUTOMATIC
Site: LEFT UPPER ARM
C/O Pain: Y Pain Scale: 2/10

== 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: PT REFUSED PAIN MEDICATION AT THIS TIME

Activity Date: 12/24/14 Time: 0750

1070 Shift Reassessment - A Q8 & Q4H IN ICU CP
Document 12/24/14 0750 ED 12/24/14 0941 ED
Reassessment Obtained Date: 12/24/14 Time: 0750

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/24/14 Time: 0750 (continued)

1070 Shift Reassessment + (continued)

NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro Comment:
ENT Assessment Within Normal Limits: Y
ENT Comment:
RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment:
CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: NORMAL SINUS RHYTHM Monitor #: 34
Cardiac Comment: PT DENIES CP AT THIS TIME
CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment:
MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment:
NUTRITIONAL Assessment Within Normal Limits: Y
Nutritional Comment:
GASTROINTESTINAL Assessment Within Normal Limits: Y
GI Comment:
GENITOURINARY Assessment Within Normal Limits: Y
GU Comment:
INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment:
PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment:

**** The Following To Be Documented On Once A Shift ****

=== FALL RISK ASSESSMENT===
Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED Total Score: 2
Physical Mobility Status: 0 NOT ALTERED =Fall Risk=
Elimination Status: 0 NOT ALTERED Low (0-2):
Recent History Of Falls: 0 NO FALLS Moderate (3-6):
Patient's Age: 2 66+ YEARS High (7-):

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
Sensory Perception: 4 NOT LIMITED-WNL Skin Risk Score: 22

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/24/14 Time: 0750 (continued)

1070 Shift Reassessment + (continued)
Moisture: 4 RARELY MOIST 19-23 = No Risk:
Activity: 4 WALKS FREQUENTLY 15-18 = At Risk:
Mobility: 4 NO LIMITATIONS 13-14 = Moderate Risk:
Nutrition: 3 ADEQUATE 10-12 = High Risk:
Friction and Sheer: 3 NO APPARENT PROBLEM 9 Or Lower = Very High Risk:
Scoring of 18 Or Lower - Initiate Skin Integrity Protocol Guidelines

=== DVT RISK ASSESSMENT ====
Leg Plaster Cast or Brace: 0 NO
Varicose Veins: 0 NO
Hormone Replacement: 0 NO
Admission DX includes: CHF,COPD,MI,Sepsis,Pneumonia: 0 NO
Bed Rest with Limited Activity: 0 NO
Obesity: 0 NO
Major Surgery (> 60 minutes): 0 NO
Family History of DVT/PE: 0 NO
Present Cancer or Chemotherapy: 0 NO
History of SVT, DVT/PE: 0 NO
Hip, Pelvis, or Leg Fracture (< 1 month): 0 NO
Stroke (< 1 month): 0 NO
Paralysis (< 1 month): 0 NO
Patient's Age: 2 60-74 YEARS
Total Score: 2 =DVT Risk=
Low (0-1):
Moderate (2): Y
High (3+):
*** NOTIFY PHYSICIAN IF DVT RISK SCORE > 1 AND DOCUMENT IN PT CARE NOTES ***

Sequential Compression Device in place: Y
Chemical Prophylaxis in use: N
Comment: SCD's IN USE

=== SAFETY ===
Isolation: STANDARD PROCEDURES Allergy Bracelet On: Y ID Band On: Y
Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: RIGHT WRIST IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 12/23/14
15000 Care Plan: RN Review + A Q12H CP
- Document 12/24/14 0750 ED 12/24/14 0941 ED
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:
Problem(s) Identified: PROBLEM: Impaired Neurological Function Status: A
: Developmental Age 66+ (OLDER ADULT) : A
: CVMC STANDARD OF CARE : A
: STANDARD OF PRACTICE M/S/TELE : A
:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Units	Change

Activity Date: 12/24/14 Time: 0750 (continued)

15000 Care Plan: RN Review + (Continued)

Patient's Plan of Care was Reviewed and Updated as Needed: Y

31200 Problem: Neurological + A QS & Q4H IN ICU CP
Document 12/24/14 0750 ED 12/24/14 0944 ED
Altered Neurological Status/Function Remains Active Problem: Y
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

~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: 4=SPONTANEOUS Reaction OD: BRISK Size: 3
Verbal Response: 5=ORIENTED Reaction OS: BRISK Size: 3
Motor Response: 6=OBEYS COMMANDS
Total: 15
=== SEIZURE INFORMATION ===
Recent Seizure Activity: N Seizure Precautions Initiated or being Utilized: N
Describe Seizure Event, Duration, Pre/Post Ictal State:

=== ADDITIONAL NEURO ASSESSMENT ===
~Additional Neuro Assessment Performed and WNL: Y
Level of Consciousness:
Orientation: ICP Monitor:
Responds To: ICP:
Memory: Fluctuations:
Thought Process:
Weakness: Specify:
Numbness: Specify:
Facial Droop: Describe:
Babinski Reflex Positive:

=== ADDITIONAL SWALLOWING ASSESSMENT ===
Problems Observed with Swallowing:
Food Texture Tolerated:
Fluid Consistency Tolerated:

Neuro Comment: ADMITTED PT FOR HEADACHE.PT IS A/O X4. FOLLOW COMANDS NO N/V, NO WEAKNESS.

Activity Date: 12/24/14 Time: 0750

31320 Pain: Management Of + A AS NEEDED CP
Document 12/24/14 0750 ED 12/24/14 0944 ED
*** Chest Pain to be Documented on Cardiac Problem ***
=== PAIN MANAGEMENT ===
Time of Patient's Complaint: 0750
Pain Location:
Pain Scale: 0/10
Describe the Pain:
Onset:
Comment:
Comfort Measures Implemented:
Other Measures Taken:

Time of Reassessment: Post Intervention Pain Scale:
Response to Intervention:

Patient/Family Education Provided: Y

Pain Comment: PT DENIES PAIN AT THIS TIME

=== Pain Education for Patient/Family ===

Instructions Given Related to:

Pain Management is Part of Treatment Plan: Y
About the Use of the Pain Intensity Rating Scale: Y
Total Absence of Pain is Often not Realistic/Desirable Goal: Y
Choosing a Pain Control Goal, such as Pain Not Worse than 2: Y
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: Y
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control: Y
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: Y

== Other Information Taught ==

40250 Position Change + A Q2H CP
Document 12/24/14 0750 ED 12/24/14 0944 ED
= Patient Position Changed =
Right Side: Y Left Side: Supine: Trendelenburg:
Comment: PT TURNS BY HIMSELF
80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Document 12/24/14 0750 ED 12/24/14 0944 ED
=== PATIENT/FAMILY EDUCATION ===
Information Taught: SAFETY PRECAUTIONS
Instruction Given: CALL LIGHT IN REACH AND BED IN LOW POSITION

Person Taught: PATIENT

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/24/14 Time: 0750 (continued)

80010 Education: Patient/Family Teaching * (continued)
Person Taught:
Teaching Tools: DEMONSTRATION
Other Tools Used: VERBAL
Factors Affecting Learning: NONE
Other Factors: NONE
Participation Level: ACTIVE
Evaluation: DEMONSTRATE UNDERSTANDING
Needs Additional Education: N
:
Educator: Deharo,Eric
Discipline: NURSING

1001024 Age Guidelines: 66+ (OLDER ADULT) A VIEW PROTOCOL/DI QS CP
Document 12/24/14 0750 ED 12/24/14 0944 ED
Patient Notes: Nurse Notes
Create 12/24/14 0750 ED 12/24/14 0947 ED
Abnormal? N Confidential? N
PT RECEIVED SITTING IN BED, ALERT AND ORIENTED X1, FOLLOWS COMMANDS. TELE # 34 SR, PT DENIES CP AT THIS TIME. BREATH SOUNDS CLEAR BILATERALLY ON RA, UNLABORED RESPIRATIONS. BOWEL SOUNDS ACTIVE X4, LBM 12.23.14. PT DENIES N/V/D. AMBULATORY WITH BRP, VOIDS FREELY. SKIN INTACT, RADIAL/PEDAL PULSES PRESENT AND MODERATE, SCD'S IN USE. PT DENIES HA AT THIS TIME. EXPRESSES PRESSURE TO FOREHEAD. IV TO RIGHT WRIST,SALINE LOCKED, NO REDNESS,SWELLING OR PAIN NOTED AT THIS TIME. PT ORIENTED TO SURROUNDINGS AND USE OF CALL LIGHT, CALL LIGHT WITHIN REACH, WILL CONTINUE TO MONITOR.

Activity Date: 12/24/14 Time: 0949

975030 Inventory Personal Belongings * A ADM.TX.DC AS
ON ADMISSION & TRANSFER. PRINT OUT &
HAVE PATIENT SIGN COPY.
- Create 12/24/14 0949 ED 12/24/14 0950 ED
- Document 12/24/14 0949 ED 12/24/14 0950 ED
Inventory Date: 12/24/14 Inventory Time: 0949 Performed By: Deharo,Eric
Reason for Inventory: DISCHARGE

-N Contacts -Y Glasses Disposition: BELONGINGS KEPT BY PT

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

Any Belongings Sent To Hospital Safe: N Any Belongings Sent Home With Family: N

NOTE: Chino Valley Medical Center will only be responsible for items logged at the time of admission. Should Dentures, Hearing Aids, Eye Glasses be brought to the patient after admission, they must be logged with the Primary Nurse or Charge Nurse. Chino Valley Medical Center will not be responsible for any item not logged on the Belongings Form.

<< RELEASE OF LIABILITY OF VALUABLES KEPT WITH PATIENT >>
By Signing Below I Indicate I Have Been Advised To Send My Valuables Home With Family/

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 12/24/14 Time: 0949 (continued)

975050 Inventory Personal Belongings * (continued)
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.

PATIENT:_____ Date:_____

WITNESS:_____

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

PATIENT:_____ Date:_____

WITNESS:

Activity Date: 12/24/14 Time: 1029

90051 DC: Nursing Discharge Checklist/Assess A ON DISCHARGE AS
- Create 12/24/14 1029 ED 12/24/14 1031 ED
- Document 12/24/14 1029 ED 12/24/14 1031 ED

***** NURSING DISCHARGE ASSESSMENT *****

****

Problem list, medication list, lab test results reviewed: Y
Has the patient been here for 7 days or more: N
Is Pneumococcal/Influenza vaccine assessment up to date: Y
Does the patient have any wounds/incisions: N

Core measure requirements completed (if applicable): Y
Is this a CHF patient: N
Does the patient have anticoagulants (Coumadin,Xarelto,etc): N
Is this a STROKE/TIR patient: N

Education provided to the patient: Y
Health Summary provided to patient: Y
* Instruct pt to bring Health Summary to follow up visit *

== PATIENT DISCHARGE ASSESSMENT ==

Condition Upon Leaving: ABLE TO COMMUNICATE
ALERT
ORIENTED

Feeding: INDEPENDENT Isolation: NONE
Ambulating: INDEPENDENT
Transferring: INDEPENDENT

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 12/24/14 Time: 1029 (continued)

90051 DC: Nursing Discharge Checklist/Assess (continued)

Temperature/F: 98.2
Pulse: 67
Respirations: 18
Blood Pressure: 142/80
SpO2 (%): 97
Oxygen Device:
O2 Amount (L/min):
FIO2: 21

Pain Scale at Discharge: 0/10
Pain Medication Given: NO
Time/Date of Last Dose: See Medication Reconciliation

Additional Instructions:

Saline Lock: N
IV Location:
IV Start/Restart Date:
IV Gauge:

Central Line Present: N
Central Lines:
Date Inserted:
Dressing Changed:

Foley Catheter: N
Foley Catheter:
Date Inserted:

Wounds: N
Wound/Pressure Areas:
Wound care:

Feeding Tube: N
Feeding Tube:
Date Inserted:
Formula:
Rate:
Flush:

Drains: N
Drains:
Date Inserted:

Chest Tubes: N
Chest Tubes:
Date Inserted:

==STROKE DISCHARGE INSTRUCTIONS==

Pt/Pt Representative Provided Stroke Education Material:
Patient Educated on Following Topics:

Reason Stroke Education Not Initiated:

Comments:

==PATIENT DEMONSTRATES UNDERSTANDING OF==

Activation of Emergency Medical System:
Need For Follow-up Medical Care Post Discharge:
Medications Prescribed at Discharge:
Warning Signs/Symptoms of Stroke (FAST):
Risk Factors for Stroke:

Other Patient Education Topics Discussed:

==EDUCATION MATERIALS PROVIDED TO PATIENT==

TIA Brochure:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 12/24/14 Time: 1029 (continued)

90051 DC: Nursing Discharge Checklist/Assess (continued)

Stroke Brochure:

==VTE DISCHARGE INSTRUCTIONS==

VTE Discharge Instructions:

Comments:

Activity Date: 12/24/14 Time: 1213

Patient Notes: Nurse Notes

- Create 12/24/14 1213 ED 12/24/14 1215 SD
  Abnormal? N Confidential? N
  PT BEING DISCHARGED AT THIS TIME, REVIEWED WITH PT DISCHARGE INSTRUCTIONS AND PERSONAL BELONGINGS LIST, PT VERBALIZED UNDERSTANDING OF DISCHARGE INSTRUCTIONS AND IS LEAVING WITH ALL PERSONAL BELONGINGS, IV DC'D CATHETER INTACT, NO REDNESS,SWELLING OR PAIN NOTED AT THIS TIME, SCD'S AND TELE MONITOR REMOVEDE, TELE MONITOR RETURNED TO TELE ROOM. ALL PT'S QUESTIONS ANSWERED, PT STABLE UPON DISCHARGE, NO DISTRESS NOTED, PT ESCORTED TO LOBBY VIA WALKING BY RN ERIC.

Activity Date: 12/24/14 Time: 1216

1000-B	ADMISSION/TRANSFER: Quick Start Form +	D	ON ADMISSION/TRANS	AS
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1001	Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.	D	WHEN APPLICABLE	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1005-H	ADM: ADULT Admission History +	D	ON ADMISSION	AS
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1005-S	ADM: ADULT Admission Assessment +	D	ON ADMISSION	AS
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1041	Smoking Cessation	D	ON ADMISSION	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1070	Shift Reassessment -	D	Q8 & Q4H IN ICU	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
1500	I&C: Monitor +	D	Q12H (0559,1759)	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
15000	Care Plan: RN Review +	D	Q12H	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
20010	VS: Monitor -	D	AS ORDERED	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
21050	Routine Care: MED/SURG/TELE + VIEW PROTOCOL	D	.END OF SHIFT/TX	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D
21400	Nutrition/Activity/ADL Flowsheet +	D	QS BY CAREGIVER	CP
- Ed Status	12/24/14 1216 his 12/24/14 1216 his			A => D

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
Activity Date: 12/24/14 Time: 1216											
22300 IV/Invasive Lines: Insert/Remove +								D	INS/REMOVAL/CONVERT		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
31200 Problem: Neurological +								D	QS & Q4H IN ICU		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
31320 Pain: Management Of +								D	AS NEEDED		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
40250 Position Change +								D	Q2H		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
60010 Notify: MD +								D	WHEN NECESSARY		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
80010 Education: Patient/Family Teaching +								D	QS BY CARE/IVER		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
90013 DIS: Patient Discharge Instructions +								D	ON DISCHARGE		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
90061 DC: Nursing Discharge Checklist/Assess								D	ON DISCHARGE		AS
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
150000 Vital Signs								D			OE
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
150010 Weight +								D			CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
975030 Inventory Personal Belongings + ON ADMISSION & TRANSFER. PRINT O/T & HAVE PATIENT SIGN COPY.								D	ADM.TX.DC		AS
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
1000032 Bilateral Lower Extremity SCD								D			OE
Comment: Thrombotic Prevention											
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
1000461 Pneumococcal Vaccine Assessment								D	ON ADMISSION		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
1000466 Influenza Vaccine Assessment								D	ON ADM-OCT TO MARCH		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
1000481 Multidisciplinary Pt Care Team Notes								D	WHEN APPLICABLE		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
1001034 Age Guidelines: 66+ (OLDER ADULT)								D	VIEW PROTOCOL/DI QS		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
4131105 IV: Saline Lock & Flush								D			OE
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
7000103 ADM: Risk Assessment - Suicide								D	ON ADMISSION & PRN		AS
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
7007777 Critical Result Reporting								D	AS NEEDED		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
9990004 Daily Chart Check								D	0600 & 1800		CP
- 2d Status		12/24/14	1216	his	12/24/14	1216	his				A => D
Activity Date: 12/24/14 Time: 1344											
Patient Notes: Case Management Notes											
- Create		12/24/14	1344	SM	12/24/14	1344	SM				
Abnormal? N Confidential? N											
INITIAL DISCHARGE PLANNING SCREEN/CHART REVIEWED. PT LIVES WITH HIS SPOUSE AND IS INDEPENDENT WITH ADLS AND DECISION MAKING. PT DISCHARGED WITH NO FURTHER											

Activity Date: 12/24/14 Time: 1344 (continued)

Patient Notes: Case Management Notes (continued)
DC PLANNING COMPLETED.

Monogram	Initials	Name	Nurse Type
	ORDALWIDO	Dalrymple,William	Provider
AS1	CNASA1	Sarpong,Alex	CNA
DS	CNASD2	Sarpong,Derek	CNA
ED	NURDE1	Deharo,Eric	RN
JTW1	NURJW1	Wu,Jing	RN
LC	NURCL1	Ciupala,Liliana	RN
MOB	EDBMO	Bacani,Marlene O	RN
SM	SWMS	Montoya-Bell,Susan	SS
nis		automatic by program	

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).
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. 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 meds.
   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 minimun 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 multi-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 protocol.

   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 Trachcostomy 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 verified 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/braces/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, renove 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 monitored 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 liners 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 q8hr & 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 N3T:
-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 Through 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 Parameters:
--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 Auscultation 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)

GASTROINTESTINAL 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 Appetite, 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 Ccplained.
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

Age/Sex: 68 M
Unit #: MOC0273781
Admitted: 12/23/14 at 1149
Status: DIS IN

Attending: Lally, James M.
Account #: V00C00603802
Location: JU
Room/Bed: 226T-B

HANNA,ADEL S

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

Status: Discharged
Initiated: 12/23/14
Completed:
Protocol:

	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	12/23/14 JL1								
* Improve/maintain neuro function/status.	D	12/23/14 JL1	12/27/14		* Problem: Neurological +	12/23/14 JL1		12/23/14 1600	QS & Q4H IN ICU	D
Developmental Age 66+ (OLDER ADULT) Based on Erickson's eight stages of development. --Development Need: - Feel good about how life was lived. - Reminisce. - PROTOCOL: AGE 66+	D	12/23/14 JL1								
* Patient will be able to make informed about health care.	D	12/23/14 JL1			* Age Guidelines: 66+ (OLDER ADULT) - PROTOCOL: AGE 66+	12/23/14 JL1		12/23/14 1322	VIEW PROTOCOL/D1 QS	D
CVMC STANDARD OF CARE See Standard of Care Profile	D	12/23/14 JL1								
* All Patients Will Receive The Following	D	12/23/14 JL1			* Shift Reassessment +	12/23/14 JL1		12/23/14 1322	QS & Q4H IN ICU	D
					* VS: Monitor +	12/23/14 JL1		12/23/14 1322	AS ORDERD	D
					* I&O: Monitor +	12/23/14 JL1		12/23/14 1322	Q12H (0559,1759)	D
					* Weight +	12/23/14 JL1				D
					* Notify: MD +	12/23/14 JL1		12/23/14 1322	WHEN NECESSARY	D
					* Nutrition/Activity/ADL Flowsheet +	12/23/14 JL1		12/23/14 1322	QS BY CAREGIVER	D
					* Education: Patient/Family Teaching +	12/23/14 JL1		12/23/14 1322	QS BY CAREGIVER	D
					* IV/Invasive Lines: Insert/Remove +	12/23/14 JL1		12/23/14 1322	INS/REMOVAL/CONVERT	D
					* Pain: Management Of +	12/23/14 JL1		12/23/14 1322	AS NEEDED	D
					* Care Plan: RN Review +	12/23/14 JL1		12/23/14 1322	Q12H	D
					* Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT	12/23/14 JL1		12/23/14 1322	WHEN APPLICABLE	D
					* DIS: Patient Discharge Instructions +	12/23/14 JL1		12/23/14 1322	ON DISCHARGE	D
					* Smoking Cessation	12/23/14 JL1		12/23/14 1322	ON ADMISSION	D
					* Daily Chart Check	12/23/14 JL1		12/23/14 1322	0600 & 1800	D
					* Position Change +	12/23/14 JL1		12/23/14 1322	Q2H	D
					* Critical Result Reporting	12/23/14 JL1		12/23/14 1322	AS NEEDED	D
					* Pneumococcal Vaccine Assessment	12/23/14 JL1		12/23/14 1322	ON ADMISSION	D
					* Influenza Vaccine Assessment	12/23/14 JL1		12/23/14 1322	ON ADM OCT TO MARCH	D
					* Multidisciplinary Pt Care Team Notes	12/23/14 JL1		12/23/14 1322	WHEN APPLICABLE	D
STANDARD OF PRACTICE M/S/TELE See Standard of Care Profile - PROTOCOL: S.M/S/TELE	D	12/23/14 JL1								
* PRACTICE GUIDELINES	D	12/23/14 JL1			* Routine Care: MED/SURG/TELE + VIEW PROTOCOL - PROTOCOL: S.M/S/TELE	12/23/14 JL1		12/23/14 1322	.END OF SHIFT/TX	D
* WITHIN DEFINED PARAMETERS	D	12/23/14 JL1								

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS	SRC
* Vital Signs	12/23/14				D	OE

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	S	SRC
* ADMISSION/TRANSFER: Quick Start Form +	12/23/14 JL1		12/23/14 1922	ON ADMISSION/TRANS	D	AS
* IV: Saline Lock & Flush	12/23/14				D	OR
* ADM: ADULT Admission History +	12/23/14 JL1		12/23/14 1540	ON ADMISSION	D	AS
* ADM: Risk Assessment - Suicide	12/23/14 JL1		12/23/14 1555	ON ADMISSION & PRN	D	AS
* ADM: ADULT Admission Assessment +	12/23/14 JL1		12/23/14 1556	ON ADMISSION	D	AS
* Inventory Personal Belongings +	12/24/14 ED		12/24/14 0949	ADM,TX,DC	D	AS
ON ADMISSION & TRANSFER, PRINT OUT & HAVE PATIENT SIGN COPY.						
* DC: Nursing Discharge checklist/Assess	12/24/14 ED		12/24/14 1029	ON DISCHARGE	D	AS

Monogram	Initials	Name	Nurse Type
	DRDALWIDO	Dalrymple,William	Provider
ED	NURDEL	Deharo,Eric	RN
JL1	NURLJL	Liu,Jing	RN

CHINO VALLEY MEDICAL CENTER

Alt ,ps Report

Data Time: 12/24/2014 03:36:50

Last Name: HANNA | First Name: ADEL | ID: 273781 12/23 | Bed: 228B *35

Doctor: | Height: --- in = --- cm | Weight: --- lbs = --- kg

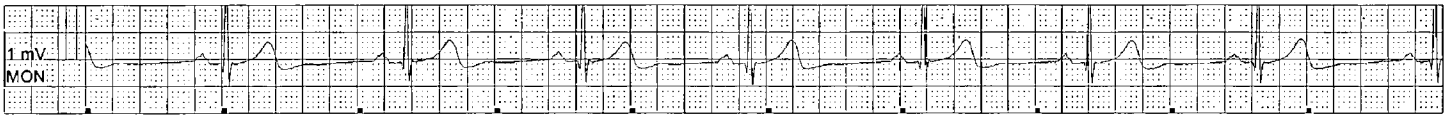
MT Initials_____

HR(ECG): 57 BPM PVC/min: 0

Interpretation:_____ **PR:**_____ **QRS:**_____

Event: Brady

ECG Lead II



CHINO VALLEY MEDICAL CENTER 9990
HANNA, ADEL S
ATT DR. Lally, James M.
03/29/46 M 68 M0000273781
V00000603802 ADM 12/23/14

Validated By: Ayala/CLINICAL COORDINATOR **Date/Time** 12/24/14 /03:40

RN/LVN Signature/Name Printed

Print Time: 12/24/2014 03:37 Page 1 Panorama: TELE3

CHINO VALLEY MEDICAL CENTER

Al. .ps Report

Data Time: 12/23/2014 19:01:50

Last Name: HANNA
Doctor:

First Name: ADEL
Height: — in = — cm

ID: 273781 12/23
Weight: — lbs = — kg

Bed: 228B *36

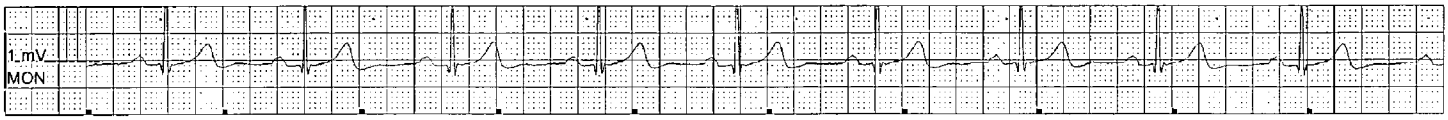
MT Initials

HR(ECG): 59 BPM PVC/min: 0

Interpretation: SB

PR: 19 **QRS:** 08

ECG Lead II



CHINO VALLEY MEDICAL CENTER
HANNA, ADEL S
ATT DR. Lally, James M.
9990
03/29/46 M 68
V00000603802 ADM
M000273781
12/23/14

Validated By: LILIANA CIUPACA / [signature]
RN/LVN Signature/Name Printed

Date/Time 12/23/14 / 19:05

Print Time: 12/23/2014 19:02 Page 1 Panorama: TELE3

DECLARATION OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO PAY BENEFITS

Chino Emergency Medical Associates ("CEMA") at Chino Valley Medical Center

Federal legislation known as COBRA-EMTALA:

1. Requires that any patient who comes to the Emergency Department at *Chino Valley Medical Center* be evaluated, treated, and stabilized regardless of the patient's ability to pay.
2. Prohibits the discussion of financial matters, including fees, contracted insurance relationships, and all other billing issues, that may delay your care.

Please read and acknowledge by signing below that you have read and understand each of the following statements:

1. I understand that CEMA, including its contracted physicians, physician assistants and/or nurse practitioners are independent contractors and are NOT employed by the Hospital. CEMA is a separate entity from the hospital.
2. I understand that CEMA's charges for professional fees (charges related to my exam and treatment) are billed separately from the Hospital's charges.
3. If I am not insured, I am responsible for payment for CEMA's services. Based on a review of my situation CEMA may in its sole discretion offer to me a schedule of payments or a discount consistent with their hardship policy.
4. If I am insured, I am responsible for any co-payments or deductibles associated with my health insurance policy. I understand that CEMA may not be not contracted with my HMO, Health Plan, insurance company, or its designed medical group ("Insurance Company").
5. CEMA does participate in government programs such as Medicare and Medi-Cal. There are Insurance Companies with which CEMA is non-participating, or is a non-contracted provider. For these companies CEMA will accept reasonable reimbursement, which we believe is our billed charges.
6. I understand that my insurance company may not reimburse CEMA for certain medical services (non covered benefits), and that I will not be responsible for unpaid balances if my Insurance Company is regulated by the California Department of Managed Health Care (the "DMHC").
7. As a courtesy, CEMA will bill my Insurance Company. I hereby authorize my Insurance Company to directly pay CEMA all amounts due for medical services provided to me. If the Insurance Company pays me directly then I agree to turn over these payments to CEMA.
8. I understand that if CEMA is non-contracted and the payment from the Insurance Company is less than the billed amount, I remain responsible for the balance of the fees unpaid by a non-DMHC regulated Insurance Company, and I may receive a bill for the unpaid amount.

I hereby authorize CEMA to release any information requested by my Health Plan or insurance company regarding my medical condition, illness or injury, in order to determine the liability for payment. **By providing my contact information below, I hereby consent and authorize CEMA to contact me using any of the information provided (including e-mail or texting) regarding medical/social/healthcare/billing issues of possible relevance or any follow-up or other matter associated with my visit to the emergency department at *Chino Valley Medical Center*.**

If you have any questions regarding CEMA's bill please contact its billing service at **626-447-0296, Extension #254**, or visit **www.ema.us** for further information. By my signature below I agree to all of the terms above.

Signature of Patient or Representative

12/23/14
Date

Please Circle One (Signer Above Is):
Patient | Spouse | Parent or Guardian | Relative | Other

Contact Information *(Please Print Legibly)*

Patient Name:

Patient's E-Mail Address | Patient's Cell Phone

Patient's Home Address

Addressograph

CHINO VALLEY MEDICAL CENTER
HANNA, ADEL S
ATT DR.
03/29/46 M 68 M000273781
V00000603802 PRE 12/23/14

Ver 4; 8/28/09

CHINO VALLEY
MEDICAL CENTER

Ebola Virus Disease (EVD) Screening

1. **Within the past 21 days, have you traveled to Guinea, Liberia, Nigeria, Sierra Leone, or Senegal?**

   Yes **No**

2. **Within the past 21 days have you had contact with a person suspected or known to have EVD?**

   Yes **No**

3. **If you answered yes to either of the above, within the past 21 days have you had:**

• **Fever greater than 36 C or 100.4 F**	**Y**	**N**
• **Severe headache**	**Y**	**N**
• **Muscle pain**	**Y**	**N**
• **Vomiting**	**Y**	**N**
• **Diarrhea**	**Y**	**N**
• **Abdominal pain**	**Y**	**N**
• **Unexplained bleeding**	**Y**	**N**

Print Name: Adel Hanna, MD

Signature _____ **Date:** 12-23-14

10/22/14 revised

CONDITIONS OF ADMISSION

1. 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.

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 A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT. IF YOU DO NOT AGREE TO ARBITRATION, *PLEASE INITIAL* _____.

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

3. 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.

4. PERSONAL VALUABLES: It is understood and agreed that the hospital maintain a fireproof safe for the safe keeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, eye glasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices 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 personal property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

5. 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. The hospital/physician will retain ownership rights to the photographs as well as to the medical records. Photographs may also be taken for the purpose of patient identification.

6. 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 medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

7. 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).

8. 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 company or health plan 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 allowed charges not paid pursuant to this assignment. In the event the undersigned's insurance company or health plan makes payment directly to the undersigned for services provided by the hospital, the undersigned shall remit such payment to the hospital within 15 days of his/her receipt of such payment.

9. 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.
Physician Name/Address N/A

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 services (including, without limitation, hospital or medical service companies, insurance companies, workers' compensation carriers, welfare funds; patient's employer, or medical utilization review organization designed by the forgoing).

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.

11. 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 ✓ No

12. PROPOSITION 65 WARNING: You may be exposed to chemicals commonly used in manufacturing processes for medical and drug products and material constituents in products and their packaging which are known to the State of California to cause cancer and birth defects or other reproductive harm.

13. 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 to any hospital-based physician of any insurance or health plan benefits otherwise payable to or on behalf 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 to the extent permitted by state and federal law.

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

15. 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 your personal physician, **you will receive separate bills from hospital-based physicians who participate in your care.** These physicians may represent any of the following areas: anesthesiology, radiology, pathology, nuclear medicine, cardiodiagnostics, and the like.

16. 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, listed in the hospital charge description master and if applicable the hospital's charity care and discount payment policies and state and federal law 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 in instituted. All delinquent accounts shall bear interest in 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. I authorize the hospital, or collection agancy or other antity contracting with the hospital to obtain credit report about me from the national credit bureaus in connection with payment of my 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.

17. 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) Worker's 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.

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

19. 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.

20. 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.

Hanna M

PATIENT / PARENT / CONSERVATOR / GUARDIAN

POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

WITNESS

SIGNATURE OF TRANSLATOR

12/23/14

DATE OF SIGNING

10:35AM

TIME OF SIGNING

Patient unable to sign: _____
(Reason)

2 COA

CHINO VALLEY MEDICAL CENTER
5451 Walnut Avenue Chino, CA 91710

CONDITIONS OF ADMISSION

PHSI-070-011 CVMC (05/13) PAGE 4 OF 4
ORIGINAL - CHART **COPY1** - BUSINESS OFFICE **COPY2** - PATIENT

PATIENT I.D.

HANNA, ADEL S
ATT DR.
03/29/46 68 M M000273781
V00000603802 PRE 12/23/14

EMERGENCY DEPARTMENT REGISTRATION WORKSHEET

PATIENT NAME: LAST: HANNA (APELLIDO) FIRST: ADEL (PRIMER NOMBRE) MIDDLE INTIAL: S (INICIAL DEL SEGUNDO NOMBRE)
(NOMBRE DEL PACIENTE)

PATIENT'S DATE OF BIRTH: 03 / 29 / 1946 **SEX:** M
(FECHA DE NACIMIENTO) MONTH (MES) DAY (DIA) YEAR (AÑO) *(SEXO)*

PATIENT'S SOCIAL SECURITY NUMBER: 548-67-8932
(NUMERO DEL SEGURO SOCIAL)

PATIENT ADDRESS: 3019 Song of the Winds **APT. #:**
(DOMICILIO DEL PACIENTE) *(NO DE APARTAMENTO)*

CITY: Chino Hills **STATE:** CA **ZIP CODE:** 91709
(CIUDAD) *(ESTADO)* *(CODIGO POSTAL)*

PATIENT'S TELEPHONE: (909) 342-9908
(TELÉFONO DEL PACIENTE)

EMAIL ADDRESS: stmariamedical@yahoo.com
(DIRECCIÓN ELECTRONICA DEL PACIENTE)

PATIENT COMPLAINT: Severe headache
(RAZÓN DE LA CONSULTA)

HAVE YOU EVER BEEN IN THIS HOSPITAL BEFORE? ☒ YES ☐ NO
(¿HA VENIDO A ESTE HOSPITAL ANTES?) ☐ SI ☐ NO

EMERGENCY CONTACT: NAME: IRMA Kawaguchi PHONE: (909) 374-7216
(CONTACTO EN CASO DE EMERGENCIA) *(NOMBRE)* *(TEL.)*

PHYSICIAN NAME:
(NOMBRE DEL DOCTOR)

WERE YOU REFERRED TO ER BY YOUR PHYSICIAN? ☐ YES ☒ NO
(¿FUE REFERIDO A EMERGENCIA POR SU DOCTOR?) ☐ SI ☐ NO

CHINO VALLEY MEDICAL CENTER

EMERGENCY DEPARTMENT REGISTRATION WORKSHEET

PATIENT ID

CHINO VALLEY MEDICAL CENTER
HANNA, ADEL S
ATT DR.
03/29/46 M 68 M000273781
V00000603802 PRE 12/23/14

110-005-CVMC (12/11)

For: ADP03 From: Tripathi,Astha M
Tue Dec 23, 2014 11:49 am Taken by: SPELLCHECK USER ()

ADMISSION REQUEST FROM ED

Patient Name: HANNA,ADEL S
Account Number: V00000603802
Admitting DR: LALJA
Attending DR: LALJA
Diagnosis: INTRACTABLE HEADACHE
Service requested: TELE
Registration Type: IN-PATIENT
Request Date: 12/23/14 Request Time: 1149

EDUCATION MATERIALS:

All patients will receive the following:

- Patient's Rights and Patient's Responsibilities
- An Important Message from Medicare (Medicare/HMO Medicare Only)
- Notice of Privacy Practices
- MRSA Information
- Charity Care & Discounted Payment Program Information

Inpatients will also receive a Patient Guide. Please review for education on the following:

- Your Right to Make Decisions About Your Medical Treatment
- Understanding Your Pain
- Patient Safety
- Smoking Cessation Information
- Pneumococcal Vaccine Information (Publication date 10/6/09)
- Influenza Vaccine Information (During the Current Flu Season) (Publication date 07/26/2013)

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.

Hanna — 12/23/14 10:35AM

Signature of Patient / Patient's Representative — Date / Time

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

CHINO VALLEY MEDICAL CENTER
5451 W[illegible]

PATIENT RIGHTS ACKNOWLEDGEMENT

1 PTRTS

PATIENT I.D.

HANNA,ADEL S
ATT DR.
03/29/46 68 M M000273781
V00000603802 PRE 12/23/14

PHSI-070-013 (04/14)

WHITE - CHART **CANARY** - PATIENT

Chino Valley Medical Center

5451 Walnut Avenue, Chino, CA 91710-2672 — Printed 06/15/07 0804

Patient	Med. Rec/Unit #	Service/Location	Status	Date	Account/Transcription #
HANNA,ADEL	M000273781	GI LAB	REG	SDC 06/15/07	V00000242043

PATIENT — AD: VIP: Conf:

Soc Sec No	DOB	Age	Sex	MS	Religion	FC
548-67-8932	03/29/46	61	M	M	CH	09

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

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

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 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 01/01/07 1000

PERSON TO NOTIFY

KAWAGUCHI,IRMA Rel: FRIEND
Home Ph:(909)374-7216 CELL Work Ph:

NEXT OF KIN

HANNA,TAMER Rel: SON
Home Ph:(949)413-8670 CELL Work Ph:

INSURANCE #1

BLUE CROSS PRUDENT BUYER
PO BOX 60007
LOS ANGELES CA 900600007
Phone: (877)737-7776

Policy #: CPR226A67822
Coverage #:
Subscriber: HANNA,ADEL
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:

ADMISSION/REGISTRATION

Att Phy Shah, Umesh C. Adm Phy ED Phy
PC Phy Agarwal,Chandrahas

Date	Time	Source	Adm.	Priority	Rm/Bed	Arrival	Admitting Diagnosis/Reason for Visit	Admitted By
06/15/07	0803	PHY	EL				EPIGASTRIC PAIN,DIFFICULTY SWALLOWING	ADASA

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: ☐ AMA: ☐ EXPIRED: ☐ AUTOPSY YES ☐ NO ☐

DISCH DISP
ASSEM
ANALYZE
CODED
PERM
DOS 06/19/07

MDC

DRG

MD/DO

SIGNATURE OF ATTENDING PHYSICIAN

DISCHARGE PRESCRIPTION

Addressograph CHINO VALLEY MEDICAL CENTER
V0000242043
HANNA,ADEL 61 /M
M0003273781 DOB 03/29/46
DOS 06/15/07

ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL,CHANDRAHAS

NON PROPRIETARY EQUIVALENT DRUG MAY NOT BE DISPENSED UNLESS CHECKED ☐

Refills Q10

Phone 301-6414

Address

DEA # ST. LIC. #

CHINO VALLEY MEDICAL CENTER 5451 Walnut Ave. Chino, CA 91710

Name HANNA, ADEL Date 06-15-07

Address City , CA

℞

MTOC SL 0.4 mg PRN
bid for one week

CHART COPY

M.D.

Addressograph CHINO VALLEY MEDICAL CENTER
V0000242043
HANNA,ADEL 61 /M
M0003273781 DOB 03/29/46
DOS 06/15/07

ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL,CHANDRAHAS

NON PROPRIETARY EQUIVALENT DRUG MAY NOT BE DISPENSED UNLESS CHECKED ☐

Refills

Phone

Address

DEA # ST. LIC. #

CHINO VALLEY MEDICAL CENTER 5451 Walnut Ave. Chino, CA 91710

Name Date

Address City , CA

℞

CHART COPY

M.D.

Addressograph CHINO VALLEY MEDICAL CENTER
V0000242043
HANNA,ADEL 61 /M
M0003273781 DOB 03/29/46
DOS 06/15/07

ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL,CHANDRAHAS

NON PROPRIETARY EQUIVALENT DRUG MAY NOT BE DISPENSED UNLESS CHECKED ☐

Refills

Phone

Address

DEA # ST. LIC. #

CHINO VALLEY MEDICAL CENTER 5451 Walnut Ave. Chino, CA 91710

Name Date

Address City , CA

℞

CHART COPY

M.D.

006983
604.017
Rev. (7/92)

Date 6-15-07 Age 61 Sex M Race	BP 130/70 T 98 P 80 R 14
Chief Complaint Heartburn	General Condition good
Present Illness S/P H-H repair Screening colonoscopy Past Hx Colon Polyps.	EENT
	Heart
	Lungs NL
	Abdomen
	Extremities
	Specific Findings
Past History H-H repair - complicated c Duo Perforation	
Allergies None	
	Diagnosis GERD - Chest Pain Colon Polyps.
Medications as listed	
	DOCTOR'S SIGNATURE

DATE	PROGRESS NOTES

Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CALIFORNIA 91710

HISTORY / PHYSICAL

000168 504.020 (02/04)

ADDRESSOGRAPH

ACCOUNT #: V00000242043
PATIENT: HANNA, ADEL
DATE OF SURGERY: 06/15/2007

cc:

SURGEON: Umesh C. Shah, M.D.

ASSISTANT:

REFERRING PHYSICIAN: Chandrahas Agarwal, M.D.

ANESTHESIOLOGIST:

PROCEDURES PERFORMED:
Upper GI endoscopy with biopsy.
Colonoscopy with polypectomy.

INDICATIONS:
The patient is a 61-year-old man who is complaining of atypical chest pain, heartburn, indigestion, and prior history of hiatal hernia surgery with some complications. The patient is not responding to the Prilosec over-the-counter. The patient also requesting colon followups. He had a colonoscopy in the past with some polyps removed five years or more ago. The patient is requesting follow-up evaluation.

CONSENT:
The patient was informed about the procedures, the risks, the benefits, and alternatives, possible complications of drug side effects, bleeding, and perforation was discussed. Informed consent was obtained.

PREMEDICATION AND MEDICATIONS USED DURING THE PROCEDURE:
Fentanyl 100 mcg and Versed 5 mg.

PROCEDURE #1:
Upper GI endoscopy and biopsies.

DESCRIPTION OF PROCEDURE:
The patient was placed in the left lateral position. Bite block was given. Olympus video gastroscope was passed through the pharynx into the esophagus without any problems. The scope was advanced over to the cardia. GE junction was around 40 cm. There were no definite inflammatory changes in the lower esophagus. The esophageal sphincter appears to be fairly tight and normal post plication. The scope was advanced into the stomach. Retroflexion was done. Right below the GE junction, there was a small erosion with oozing of the blood. This

appears to be right part of the surgery for the fundal plication. No chronic ulcer of any significance. There is no significant paraesophageal hiatal hernia identified. The scope was then straighten out and advanced all the way through the pylorus into the duodenum. No peptic ulcer disease. Couples of biopsies were done from the antrum to look for H. pylori. The scope was withdrawn and the procedure is terminated.

IMPRESSION:
Status post fundal plication. Some erosion at the GE junction on the retroflex view. This is probably traumatic.

PLAN:
Await the pathology report for H. pylori and treat appropriately if positive. There are no inflammatory changes in the esophagus. Atypical chest pain, difficult to explain for now.

PROCEDURE #2:
Colonoscopy with polypectomy performed under the same sedation. Anal sphincter was lubricated with KY jelly. Olympus video colonoscope was inserted through the anal sphincter into the rectum. Internal hemorrhoid was noted. Some prominent dented line papillae were noted as well. There is no proctitis. The scope was gradually advanced all the way to the cecum. Position of the scope in the cecum was confirmed by the usual criteria. Careful examination upon withdrawal of the scope shows a tiny polyp in the right colon, which was removed using the cautery and snare, and retrieved by suction method. Rest of the colon exam was unremarkable. Few diverticuli noted in the left colon. Retroflexion of the scope in the rectum showed hypertrophic dented papillae, although it has an unusual appearance. After careful consideration, decision was made not to try to remove this because of the pain associated with it. This will be discussed with the patient and plan as a later if necessary.

Umesh C. Shah, M.D.

DR: UCS/GSR/BAS
DD: 06/15/2007 09:54
DT: 06/15/2007 21:54
Job #: 059129508

OPERATIVE REPORT

Chino Valley Medical Center
5451 Walnut Ave. Chino, California 91710 (909) 464-8600

PATHOLOGY CONSULTATION REPORT

Robert M. Bearman, MD, Pathologist
Medical Director

Patient: **HANNA,ADEL**
DOB: 03/29/46
Age/Sex: 61/M
Pt Type: REG SDC
Acct. #: V00000242043
Unit #: M000273781

Specimen Number: **07:S357**
Surgery/Collection Date: 06/15/07
Accession Date: 06/15/07
Completion Date: 06/19/07
Surgeon/Doctor: Shah, Umesh C.

COPIES TO

Agarwal,Chandrahas
Shah, Umesh C.

PRE-OPERATIVE DIAGNOSIS

HX COLON POLYP

POST-OPERATIVE DIAGNOSIS

HEMORRHOIDS, COLON POLYP

SPECIMEN(S) SUBMITTED

RIGHT COLON POLYP

DIAGNOSIS

LARGE INTESTINE RIGHT, COLONOSCOPY
- TUBULAR ADENOMA

GROSS DESCRIPTION

The specimen consists of a single light tan soft round tissue fragment measuring 0.1 cm in diameter. The specimen will be submitted in toto in a single cassette. RMB/at 06/19/07

MICROSCOPIC DESCRIPTION

A microscopic examination has been done.

Case read at:
Desert Valley Hospital
16850 Bear Valley Road
Victorville, CA 92395

Electronically Signed by Bearman,Robert 06/19/07

** END OF REPORT **

MODERATE SEDATION
(Sedation analgesia)

I. PRE-PROCEDURE DIAGNOSIS: Atypical Chest Pain – GERD

II. ASA CLASS:

1. Normal healthy patient.
2. Mild systemic disease (includes smokers). (circled)
3. Severe systemic disease that limits activity.
4. Severe systemic disease that is a constant threat to life.
5. MORIBUND, not expected to survive

III. HISTORY AND PHYSICAL COMPLETED and/or UPDATED PRIOR TO PROCEDURE: (YES)
DATE: 6-15-07 TIME: 9 am

IV. PRE-ANESTHESIA ASSESSMENT:

1. POSSIBILITY OF PREGNANCY?	___YES ✓NO	4. AIRWAY ASSESSMENT:	
2. PROSTHETIC VALVE/HIP?	___YES ✓NO	SLEEP APNEA	___YES ✓NO
3. PREVIOUS ANESTHESIA COMPLICATIONS?	___YES ✓NO	SNORING/OBST.	✓YES___NO
FAMILY HX?	___YES ✓NO	DENT./LOOSE TEETH	___YES ✓NO
		LIMITED NECK ROM	___YES ✓NO

ANESTHESIA PLAN:

PHYSICIAN STATEMENT:
I have discussed risks, benefits, alternatives, and consequences of the sedation/analgesia plan with the patient/guardian. The patient has had all questions answered and agrees to the plan.

MODERATE SEDATION (sedation analgesia) (YES) NO ___ OTHER _____

PHYSICIAN PRE-PROCEDURE RE-ASSESSMENT:
I have completed a re-assessment immediately before sedation administration and the patient remains a candidate for the planned procedure and choice of sedation analgesia. (YES) NO

PHYSICIAN SIGNATURE: [signature] DATE: 6-15-07 TIME: 9 am

V. POST-PROCEDURE:

✓ TOLERATED PROCEDURE WELL/NO ADVERSE EVENTS.
___ PATIENT DID NOT TOLERATE PROCEDURE/CANCELLED/ABORTED.

_____

___ OTHER: _____

DISPOSITION OF PATIENT:
MAY DISCHARGE WHEN DISCHARGE CRITERIA MET. (YES) NO
OTHER: _____
DISCHARGE INSTRUCTIONS REVIEWED WITH PATIENT AND/OR DESIGNEE: (YES) NO

PHYSICIAN'S SIGNATURE: [signature] DATE: 6-15-07 TIME: 9:30 am

I, Adel Hanna, acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure. My doctor has explained the risks of the procedure, advised me of alternative treatments and told me about the expected outcome and what could happen if my condition remains untreated. I also understand that anesthesia services are needed so that my doctor can perform the operation or procedure.

It has been explained to me that **all** forms of anesthesia involve some **risks** and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected *severe complications* with anesthesia can occur and include the remote possibility of *infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death.* I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia. I understand that the type(s) of anesthesia service checked below will be used for my procedure and that the anesthetic technique to be used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her preference, as well as my own desire. It has been explained to me that sometimes an anesthesia technique which involves the use of local anesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anesthesia.

☐ General Anesthesia	Expected Results	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes.
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
☐ Spinal or Epidural Analgesia / Anesthesia	Expected Results	Temporary decreased or loss of feeling and / or movement to lower part of the body.
	Technique	Drug injected through a needle / catheter placed either directly into the spinal canal or immediately outside the spinal canal.
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal".
☐ Major / Minor Nerve Block	Expected Results	Temporary loss of feeling and / or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ Intravenous Regional Anesthesia	Expected Results	Temporary loss of feeling and / or movement of a limb.
	Technique	Drug injected into veins of arm or leg while using a tourniquet.
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels.
☐ Monitored Anesthesia Care	Expected Results	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
☒ Moderate Sedation	Expected Results	Reduced anxiety and pain. Medically controlled state of depressed consciousness in which protective reflexes are maintained.
	Technique	Drug injected into bloodstream or administered orally or rectally.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.

I hereby consent to the anesthesia service checked above and authorize that it be administered by a provider credentialed to provide anesthesia services at this health facility. I also consent to an alternative type of anesthesia, if necessary, as deemed appropriate by them. I expressly desire the following considerations be observed (or write "none"):

I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that I had ample time to ask questions and to consider my decision.

Patient's Signature X Hanna MD Date and Time 6/15/07 08:30 AM

Witness C Hunter M Substitute Signature _____

Relationship to Patient _____

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

CONSENT FOR ANESTHESIA SERVICES

ADDRESSOGRAPH

007528 (6/06) 00.7528

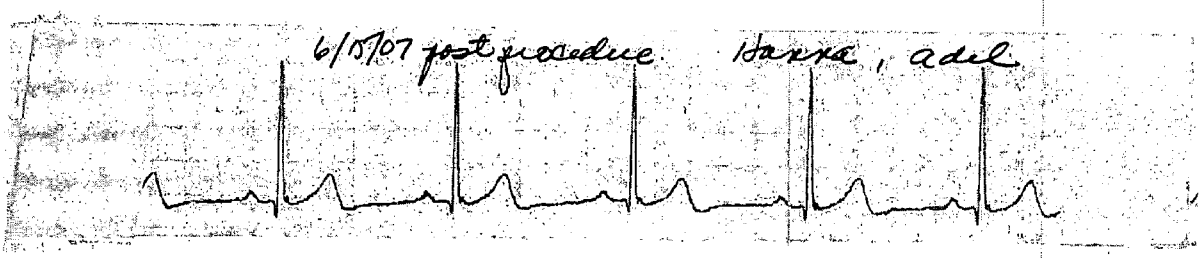
INTRA OP / RECOVERY

MODERATE SEDATION RECORD

Time	Nursing Notes (Addendum)

Rhythm SR.

POST PROCEDURE RHYTHM STRIP



RN SIGNATURE

DISCHARGE / TRANSFER SUMMARY

PATIENT DISCHARGE TO: ☐ N/A

☐ PACU

☐ RM _____

☒ OTHER OPS

report to Chasni

MODE

☐ GURNEY

☐ Bed

☐ RECLINER

☐ W / C

DISCHARGE HOME ONLY

STATUS: ☐ IMPROVED ☐ OTHER see OPS chart

DISCHARGE CRITERIA MET ☐ YES ☐ NO

PHYSICIAN DISCHARGE ORDER ☐ YES ☐ NO

MODE OF TRANSPORTATION ☐ AMBULATES ☐ W/C ☐ GURNEY

ESCORTED BY _____
Name of person taking patient home

Page 4

MODERATE SEDATION RECORD

Pre-procedure assessment by physician:
☐ No changes in patient's condition at this time
☐ Change in patient condition noted: see physician record

Final Verification "Time Out" time: ____
Airway Assessment: ____
ASA Class per physician:
1 2 3 4 5 E ____

PAIN SCALE
Numeric: 0 - 10
(0 = no pain, 10 = worst pain)
Baker / Wong Faces:
0 1 2 3 4 5 6 7 8 9 10

TIME	MEDICATION / ROUTE	SIGNATURE
0855	Fentanyl 50 mg / Versed 2 mg	[signature]
0900	Fentanyl 50 mg / Versed 2 mg	
0915	Versed 1 mg	

PHYSICIAN SIGNATURE: see Doctor Order Sheet

IV RECORD						INTAKE
DATE	IV TYPE & SOLUTION	CATHETER SIZE	SITE	STARTED BY	TIME D'CD IF APPLICABLE	

☐ Biopsy ☐ Banding
☐ Polypectomy ☐ Bicap
☐ Hot Biopsy
☐ Dilatation
☐ PEG Placement
☐ Removal of Foreign Body
☐ Other ____

- SCOPE MODEL # 2 ☐ N/A
- PHOTO ☑ YES ☐ NO ☐ N/A
- ELECTROCAUTERY USED ☑ YES ☐ NO ☐ N/A
- SITE CONDITION ☑ BENIGN ☐ OTHER right thigh
- SITE CONDITION ☐ BENIGN ☐ OTHER ____
- ELECTROCAUTERY UNITS Erbe setting | Gen/Hot bx 2/20

SPECIMENS COLLECTED
☐ NONE ☐ N/A
☑ YES #1 Polyp right Colon

POST-PROCEDURE ASSESSMENT
- COMMUNICATION: ☑ NO APPARENT LIMITATION
  ☐ OTHER ____
- MENTAL STATUS: ☑ AWAKE ☐ COGNITIVE
  ☑ OTHER Drowsy
- RESPIRATION: ☑ UNLABORED ☐ OTHER ____
- SKIN CONDITION: ☑ WNL ☐ OTHER ____
- ABDOMEN: ☑ WNL ☐ NAUSEA ☐ VOMITING
- ALDRETE SCORE: 9/10

NURSING DIAGNOSIS

☑ Anxiety r/t insufficient knowledge of pre-interventional routine and post-interventional alterations / sensations.

PATIENT OUTCOME: Patient will verbalize what to expect and less anxiety after education.

EVALUATION:
☑ Goals Met
☐ Unresolved

☑ Active Pain as evidenced by verbal and /or non-verbal expressions of pain.

PATIENT OUTCOME: Patient's pain characteristics identified, and patient expresses feeling of comfort / relief from pain.

EVALUATION:
☑ Goals Met
☐ Unresolved

☑ Risk for altered respiratory function r/t immobility secondary to sedation / analgesic/ anesthetic effects of medications.

PATIENT OUTCOME: Maintain adequate tidal volume, vital capacity, forced-end expiratory volume without airway intervention

EVALUATION:
☑ Goals Met
☐ Unresolved

MODERATE SEDATION RECORD

PROCEDURE: ESD & Colon | DATE: 6-15-07 | TIME: 0840

PRE-PROCEDURE DIAGNOSIS / PRESENT COMPLAINT: Hx of Colorectal Ca - GERD

POST-PROCEDURE DIAGNOSIS: S/P ESD ulcers are ulceration & active inflammation

PRE-PROCEDURE ASSESSMENT

INTERPRETER
Name: ____
☐ Yes ☐ No ☒ N/A

HISTORY & PHYSICAL ON CHART ☒

SURGICAL CHECK LIST COMPLETED ☒

CURRENT MEDICATIONS: ☐ NONE
see MAR

PT Hx:
see H&P

ALLERGIES: ☐ NKA Reglan

- EDUCATION PATIENT / FAMILY: ☒ YES ☐ NO Colon Polyp
- COMMUNICATION: ☒ NO APPARENT LIMITATION Hemorrhoids ☐ OTHER ____
- MENTAL STATUS: ☒ AWAKE ☐ COGNITIVE ☐ OTHER ____
- RESPIRATION: ☒ UNLABORED ☐ OTHER ____
- SKIN CONDITION: ☒ WARM ☐ DRY ☐ OTHER ____
- SKIN COLOR: ☒ WNL ☐ OTHER ____
- PHYSICAL LIMITATION: ☒ NONE NOTED ☐ OTHER ____
- ABDOMEN: ☐ SOFT ☐ FLAT ☐ ROUNDED ☐ FIRM ☐ DISTENDED ☐ TENDER ☐ OTHER ____
- BOWEL PREP: ☒ YES ☐ NO ☐ RESULTS ____

PRE-PROCEDURE VITAL SIGNS

T	P	R	B/P	O_2 SAT.
97.5	62	20	107/75	99%

Ht	Wt kg:
5'8"	164 lb.

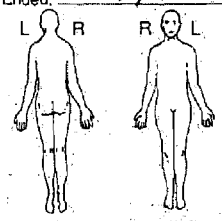
MODE OF ARRIVAL: ☐ W/C ☒ Gurney ☐ Ambulatory ☐ Bedside ☐ Bed

Arrived to Room: 0850 Out: ____
Sedation Began: 0855 Ended: 0915
Procedure Began: 0900 Ended: 0940

EQUIPMENT CHECK LIST

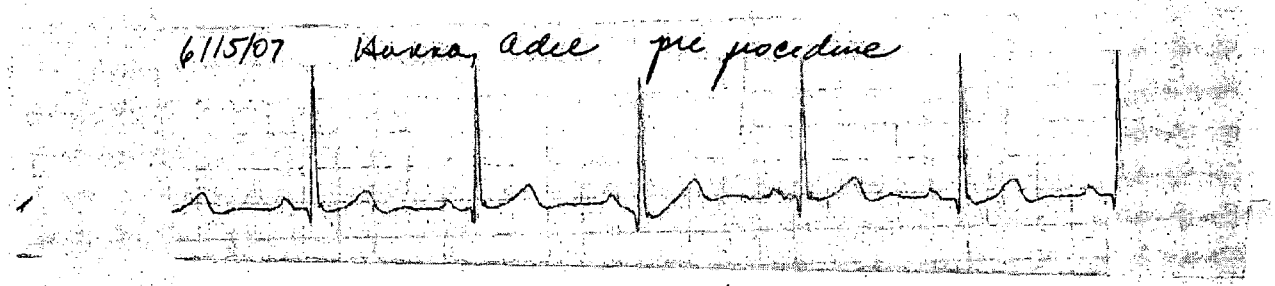
- ☒ CARDIAC MONITOR
- ☒ PULSE OXIMETER
- ☒ BLOOD PRESSURE MONITOR
- ☒ OXYGEN DELIVERY SYSTEM
- ☒ SUCTION EQUIPMENT
- ☒ IV EQUIPMENT / SUPPLIES
- ☒ CRASH CART AVAILABLE
- ☒ MEDICATIONS AVAILABLE
- ☒ REVERSAL MEDICATIONS AVAILABLE

PULSE OX X
IV SITE V
ELECTRODES O
SAFETY STRAP =
GROUND PAD ☐
BP CUFF –



Rhythm SR

PRE-PROCEDURE RHYTHM STRIP



PHYSICIAN Patel ACLS/PALS RN Gvalade TECHNICIAN ESaldana

RCP if applicable ____ X-RAY TECH if applicable ____ Other ____

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
		Gvalade			

MODERATE SEDATION RECORD

020-007

PHSI-020-007 (3/07)

VALLEY MEDICAL CENTER
V0000242043
HANNA, ACEL
A0002273781
61 / F
DOB 03/29/46
DOS 06/15/07
ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL, CHANDRAMAS

INTRA-PROCEDURE / RECOVERY

Oxygen 2 l/min ON 0851 OFF [illegible] ☒ NC ☐ Mask

VITAL SIGNS

	TIME	0850	0853	900	905	0910	0915	0920	0925	0930	0935	0940			
	O2 SAT														
	240														
INVASIVE B/P X X	220														
	200														
NON INVASIVE B/P V ^	180														
HR •	160														
	140														
RESPIRATIONS ○	120														
	100														
	80														
	60														
	40														
	20														
PAIN TEMPERATURE	10	0	0	0	0	0	34	0	0	0	0	0			

Time	BP	HR	Resp BPM
9:43	59	94 / 68 (77)	9
9:40	57	99 / 62 (77) 98	11
9:40	56	/ ( ) 98	13
9:38	53	97 / 58 (79) 98	13
9:35	53	91 / 61 (76) 99	13
9:35	51	/ ( ) 98	15
9:33	52	98 / 60 (75) 98	12
9:30	57	112 / 61 (85) 98	12
9:30	58	/ ( ) 99	12

ALDRETE SCORE

	TIME														
Respiration															
Able to breathe deeply and cough	2	2	2	2	2	2	2	2	2	2	2	2			
Limited effort - splinting or dyspnea	1														
No spontaneous effort	0														
Color															
SaO_2 > 92% on room air	2	2	2	2	2	2	2	2	2	2	2	2			
Supplemental O_2 required to maintain SaO_2 ≥ 90%	1														
SaO_2 ≤ 92% with O_2 supplementation	0														
Consciousness															
Fully Awake	2	2	2	1	1	1	1-2	1-2	1-2	1-2	1-2				
Arousable on Calling	1														
Not Responding	0														
Activity															
Able to move all extremities	2	2	2	2	2	2	2	2	2	2	2	2			
Able to move two extremities	1														
Not able to move upon command	0														
Circulation															
BP +/- 20% Preanesthetic level	2	2	2	2	2	2	2	2	2	2	2	2			
BP +/- 20% - 50% Preanesthetic level	1														
BP +/- 50% Preanesthetic level	0			9	9	9	9-10	9-10	9-10	9-10	9-10	9			
TOTAL:		10	10	10	10	9	9	9-10	9-10	9-10	9-10	9			

INTAKE IV FLUIDS 300cc PO 0 TOTAL 300 cc

OUTPUT URINE 0 EMESIS 0 TOTAL 0

Page 3

DATE: 6-15-07 TIME: 08.15

Mode of Admission: ☑ ambulatory ☐ wheelchair ☐ stretcher / bed

Admitted from: ☑ home ☐ nursing home ☐ Dr. office ☐ other:

Patient History obtained from: ☑ patient ☐ other ☐ family/other (specify) ☐ unable to take history (explain)

✔ = Present / Verified O = Not Present		✔/O	PRE-OP RN	✔/O	OR RN
1.	IDENTIFICATION BAND	✓	CT		
2.	CONSENT(S) SIGNED/WITNESSED				
	A. VERIFICATION INF. CONSENT	✓	CT		
	B. SURGICAL	O	CT		
	C. ANESTHESIA	O	CT		
	D. ADVANCED DIRECTIVES	O	CT		
	E. OTHER:	O	CT		
3.	ADDRESSOGRAPH	✓	CT		
4.	HISTORY AND PHYSICAL	O	CT		
5.	REPORTS				
	A. CXR - REQUIRED ON PTS ≥ 50	O	CT		
	B. EKG - REQUIRED ON PTS ≥ 50	O	CT		
	C. UA	O	CT		
	D. CBC - REQUIRED ON ALL PTS	O	CT		
	E. PT/PTT-REQUIRED ON ALL PTS	O	CT		
	F. CHEM PANEL	O	CT		
	G. TYPE & SCREEN/CROSS	O	CT		
	H. BHCG ☐ POS ☐ NEG	O	CT		
	I. OTHER:	O	CT		
6.	SURGICAL SITE (PROC) VERIFIED	✓	CT		
7.	SURGICAL SITE CHECKED A. SIDE ☐ RIGHT ☐ LEFT	O	CT		
8.	SURGICAL PREP/SHAVE	O	CT		
9.	REMOVED/TAPED				
	A. JEWELRY:	O	CT		
	B. RINGS:	O	CT		
10.	PROSTHETICS				
	A. CONTACT LENSES	O	CT		
	B. GLASSES	✓	CT		
	C. DENTURES/PARTIAL(S)	O	CT		
	D. HEARING AIDS	O	CT		
	E. IMPLANTS:	O	CT		
	F. OTHER:	O	CT		
11.	PACEMAKER: ☐ PERM. ☐ TEMP.	O	CT		
12.	PT. BELONGINGS ☐ NONE ☐ GURNEY/BED/CHAIR ☐ FAMILY	✓	CT		
13.	NPO SINCE: DATE 06/14/07 TIME 0000				
14.	VOIDED @ DATE 06/15/07 TIME 07:00				

Vital Signs

BP 107/75
TEMP. 97.5
PULSE 62
RESP. 20
O_2 SAT 99%
HT. 5'8"
WT. 164 Lbs

ALLERGIES: ☐ NO KNOWN ALLERGIES

Bracelet on:
Medications: Reglan
Food:
Other (tapes, dyes)

IV Site: Rt hand | Gauge/type: #22
IV Fluid: NSTRO | IV Started by: Joan RN

PRE-OP MEDS / TREATMENT GIVEN

TIME	MEDICATION/DOSE	ROUTE	SIGNATURE

TIME	TREATMENT/CARE	SIGNATURE
	☐ TED HOSE ☐ SEQUENTIALS	
	OTHER:	

- COMMUNICATION: ☑ NO APPARENT LIMITATION ☐ OTHER:
- MENTAL STATUS: ☑ AWAKE ☑ COGNITIVE ☐ ANXIOUS ☐ CALM ☐ OTHER:
- RESPIRATION: ☐ UNLABORED ☐ OTHER:
- SKIN CONDITION ☐ WARM ☐ DRY ☐ OTHER:
- SKIN COLOR: ☐ WNL ☐ OTHER:
- PHYSICAL LIMITATION: ☐ NONE NOTED ☐ OTHER:

NURSING NOTES/PATIENT TEACHING:

0 1 2 3 4 5 6 7 8 9 10

0/10 Intensity / Quality
0 Location

ACCUCHECK RESULTS: 0
WHAT FAMILY MEMBERS ARE WAITING? Son

WHERE? ☐ WAITING ROOM ☐ OTHER: will call
PATIENT TELEPHONE NO.: (909) 902-1187
WHO WILL BE DRIVING YOU HOME WHEN DISCHARGED?
NAME: James
PHONE NO.: (909) 413-8670
PRE-OP RN SIGNATURE / INITIALS: C Hunter M
OR RN SIGNATURE / INITIALS:

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

SURGICAL CHECKLIST / PRE-OPERATIVE NURSING ASSESSMENT

007531 00.7531 (7/06)

ADDRESSOGRAPH
CHINO VALLEY MEDICAL CENTER
[illegible] 61 /M
DOB 03/23/46
DOS 06/15/07

POST ENDOSCOPY INSTRUCTIONS - LOWER GI COLONOSCOPY

The medication or sedation which was used to calm you will be acting in your body for the next 24 hours, so you might feel a little sleepy. This feeling will slowly wear off. Because the medicine or sedation is still in your system, for the next twenty-four (24) hours, the adult patient:

SHOULD NOT - Drive a car, operate machinery or power tools.
SHOULD NOT - Drink any alcoholic beverages (not even beer).
SHOULD NOT - Make any important decisions (such as sign important papers). You must be driven home by an adult.

PAIN:
You may experience some pain and/or discomfort associated with your procedure. Gas, abdominal cramping and small amounts of rectal bleeding are normal in the immediate post procedure period. If this continues longer than twenty-four (24) hours after the procedure or if you experience intense abdominal pain, a firm distended abdomen (rigid) or a fever, (101° or greater) notify your physician immediately.

DIET:
You may resume your normal diet when you arrive home, unless you are instructed otherwise by your physician.

FINDINGS: _____

_____

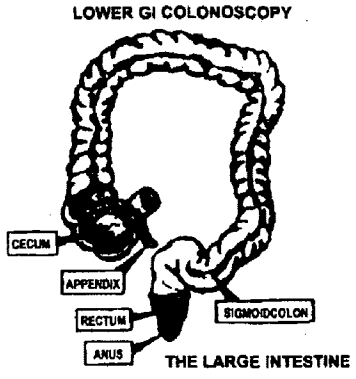
ADDITIONAL INSTRUCTIONS: _____

_____

_____

If you have any questions or concerns, call Dr. U-SMN at phone 591-6414. If you are unable to reach him/her or his/her partner, call or come to Chino Valley Medical Center Emergency Department at 464-8670.

The information/instructions above have been discussed with and a copy given to me or a significant other who demonstrates an adequate level of understanding and will give these instructions for care to the individual responsible for my care.



_____
Patient/Significant Other

UMN
_____
Physician/Nurse

_____
Date and Time

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

POST ENDOSCOPY INSTRUCTIONS
LOWER GI COLONOSCOPY

WHITE - CHART YELLOW - PATIENT
000011 604.028 (5/05)

ADDRESSOGRAPH

POST ENDOSCOPY INSTRUCTIONS - UPPER GI ENDOSCOPY

The medication or sedation which was used to calm you will be acting in your body for the next 24 hours, so you might feel a little sleepy. This feeling will slowly wear off. Because the medicine or sedation is still in your system, for the next twenty-four (24) hours, the adult patient

SHOULD NOT - Drive a car, operate machinery or power tools.
SHOULD NOT - Drink any alcoholic beverages (not even beer).
SHOULD NOT - Make any important decisions (such as sign important papers). You must be driven home by an adult.

PAIN:
It is normal to have a sore throat after an upper GI Endoscopy. It resolves within twenty-four-(24) hours after the procedure. There should be minimal, if any, bleeding with an upper endoscopy. If there is any measurable amount of bleeding, intense abdominal pain or persistent alteration in GI function notify your physician immediately.

DIET:
You may resume your normal diet when you arrive home, unless you are instructed otherwise by your physician.

FINDINGS: - Call Dr Shah with any problems

ADDITIONAL INSTRUCTIONS: - Continue previous medications
- Follow up with Dr. Shah if needs

If you have any questions or concerns, call Dr. [illegible] at phone 591-6414. If you are unable to reach him/her or his/her partner, call or come to Chino Valley Medical Center Emergency Department at 464-8670.

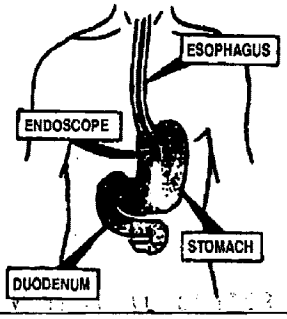
The information/instructions above have been discussed with and a copy given to me or a significant other who demonstrates an adequate level of understanding and will give these instructions for care to the individual responsible for my care.

X [signature]
Patient/Significant Other

[signature]
Physician/Nurse

06/15/07
Date and Time

UPPER GI ENDOSCOPY



Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

POST ENDOSCOPY INSTRUCTIONS
UPPER GI ENDOSCOPY

WHITE - CHART YELLOW - PATIENT
000010 604.027 (5/05)

ADDRESSOGRAPH

POOR ORIGINAL

I hereby authorize dispensation of a formulary equivalent (under the for... and manufacturer listed. Non-Proprietary Equivalent Drug may be ...

TIME: 0820 **DATE:** 6-15-07

Chest X-ray PA + Lat View

Copy From Dr. U. Shah order

UMESH C. SHAH, M.D., INC.
GASTROENTEROLOGY & INTERNAL MEDICINE
12540 TENTH STREET, SUITE B
CHINO, CA 91710
(909) 591-6414 TEL
DEA #
LIC. # A 034187(CA)

NAME Hanna Adel AGE
ADDRESS DATE 6/7/07
Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞ Chest xray PA & lat view
Dx Chest Pain (CP2D)

Refill ____ times
DO NOT SUBSTITUTE ☐
To ensure brand name dispensing, check and initial box.
7BGI1145105

N Signature:

RN'S SIGNATURE	DATE	TIME
Catherine	06/15/07	8:20 AM

E:

N Signature:

RN'S SIGNATURE	DATE	TIME

E:

DISCHARGE PATIENT
DISCHARGE TO: ERIN

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

TRANSCRIBER SIGNATURE	DATE	TIME	NOTING RN'S SIGNATURE	DATE	TIME
24 HR CHART CHECK BY NURSE	DATE	TIME			

PHYSICIAN'S ORDER SHEET

0001

DO NOT WRITE IN THIS AREA.

PHSI-0001 (9/06) WHITE - CHART YELLOW - PHARMACY PINK - NURSING

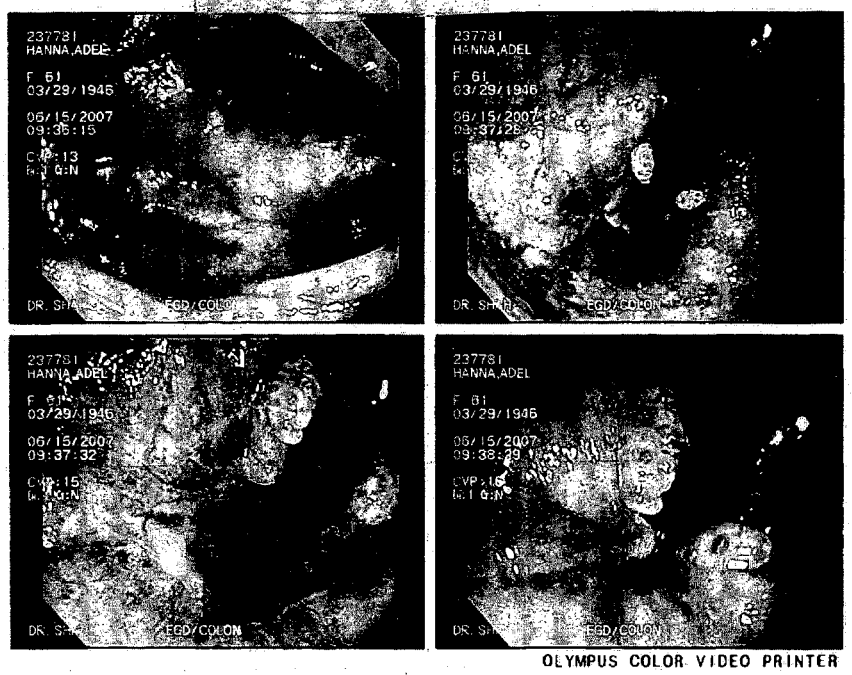
PHYSICIAN ORDERS

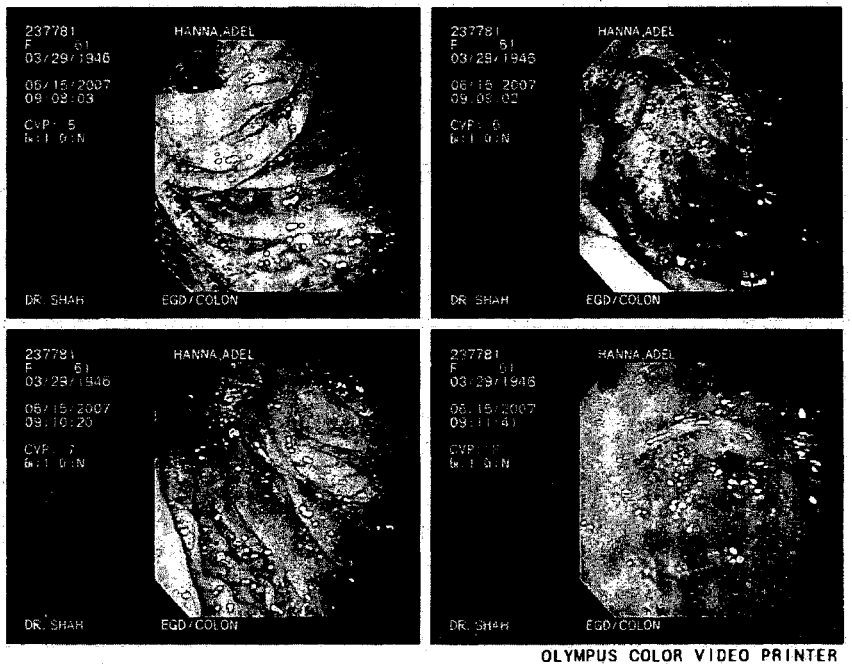
HANNA, ADEL
Acct# V00000242043
DOB: 03/29/46
DOS: 06/15/07
Shah, Umesh C.
M/61 SDC
M0002737781

HANNA, ADEL
Acct# V00000242043
DOB: 03/29/46
DOS: 06/15/07
Shah, Umesh C.
M/61 SDC
M0002737781

HANNA, ADEL
Acct# V00000242043
DOB: 03/29/46
DOS: 06/15/07
Shah, Umesh C.
M/61 SDC
M0002737781

POOR ORIGINAL


237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
09:36:15
EGD/COLON
237781
HANNA,ADEL
F 61
03/29/1946
EGD/COLON
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
09:37:32
EGD/COLON
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
EGD/COLON
OLYMPUS COLOR VIDEO PRINTER

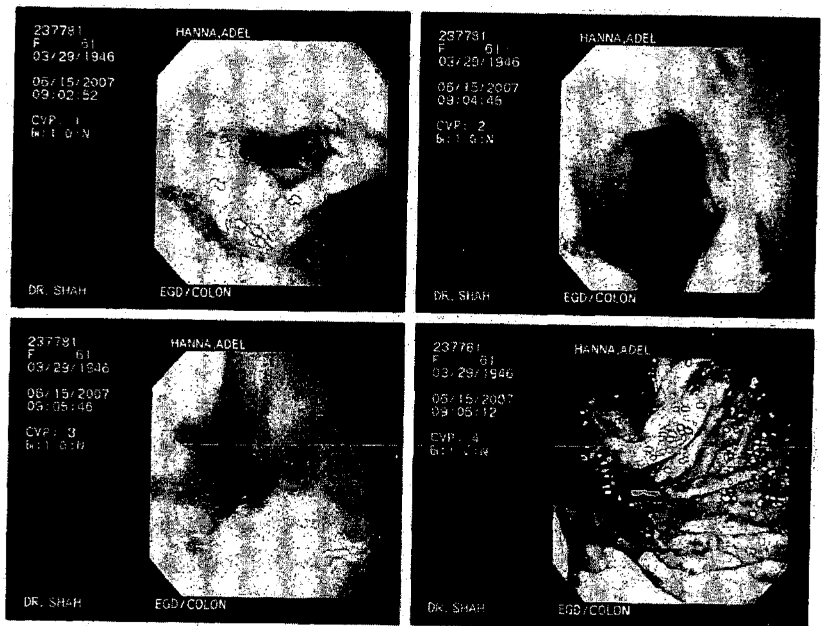

237781
HANNA,ADEL
F 51
03/29/1946
06/15/2007
09:02:03
CVP: 5
DR. SHAH
EGD/COLON
237781
HANNA,ADEL
F 51
03/29/1946
06/15/2007
09:08:02
CVP: 6
DR. SHAH
EGD/COLON
237781
HANNA,ADEL
F 51
03/29/1946
06/15/2007
09:10:20
CVP: 7
DR. SHAH
EGD/COLON
237781
HANNA,ADEL
F 51
03/29/1946
DR. SHAH
EGD/COLON
OLYMPUS COLOR VIDEO PRINTER

ALL ENTRIES MUST BE DATED AND SIGNED
NOTES
DATE
TIME
PROGRESS NOTES
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
09:28:52
DR. SHAH
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
09:29:20
CVP:10
DR. SHAH
EGD/COLON
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
09:29:37
CVP:11
DR. SHAH
237781
HANNA,ADEL
F 61
03/29/1946
06/15/2007
CVP:12
DR. SHAH
EGD/COLON
OLYMPUS COLOR VIDEO PRINTER
0002
PROGRESS NOTES
PHSI-0002 (9/05)

PROGRESS NOTES

ALL ENTRIES MUST BE DATED AND SIGNED

DATE | TIME | NOTES



OLYMPUS COLOR VIDEO PRINTER

V 0000242043
HANNA,ADEL 61 /M
0237781 DOB 03/29/46
DOS 06/15/07
ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL,CHANDRAHAS

0002

PROGRESS NOTES

PHSI-0002 (9/06)

DATE	TIME	PRE-PROCEDURE NOTE
6-15-07	9 am	Indications for procedure: Atypical Chest Pain, GERD, Colon Screen
		Physician Signature

DATE	TIME	POST-PROCEDURE NOTE
6-15-07	930 am	Physician: U. Shah
		Type of Anesthesia: ☐ General ☐ Sedation Analgesia
		Post-Procedure Diagnosis: EGD: Biopsy; Colonoscopy: Polypectomy?
		Operative Procedures Used:
		SIP Nissen Plication - No active inflammation; Colon Polyp - Hemorrhoids.
		Specimen(s) Removed: H-Pylori, Polyp Colon.
		Physician Signature

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

GI LAB MODERATE SEDATION

000147 733.007 (10/05)

ADDRESSOGRAPH

TEST RESULTS FOR HELICOBACTOR PYLORI TEST:
(H. PYLORI TEST WITH PYLORITEK TEST KIT BY G.I. LAB)

POSITIVE: _____

NEGATIVE: ✓

START TIME: 0915 COMPLETED TIME: 1015

READ BY: [signature]

DATE: 6-15-07

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

H. PYLORI RESULTS

WHITE - CHART **YELLOW** - DOCTOR

000091 733.004 (2/99)

ADDRESSOGRAPH

HANNA, ADEL
Acct# V00000242043
DOB:03/29/46
DOS:06/15/07
Shah, Umesh C.

M/61 SDC

M000273781

1. NONE ( ) ALLERGIES
2. Reglan
3.

DATE 6-15-07 0840

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

☐ 1. Emergency Protocol

2. Procedual consent for:
   - ☑ EGD with possible biopsy with Polypectomy with cauterization
   - ☑ Colonscopy with possible biopsy with Polypectomy with cauterization
   - ☐ Esophageal dilatation
   - ☐ Percutaneous endoscopic gastrostomy
   - ☐ Other:

3. Laboratory:
   - ☐ PT PTT
   - ☐ Other:

4. IV:
   - ☐ D5W 500 cc TKO
   - ☑ NS 500 cc TKO

5. Medication:
   - ☐ Compazine IVP
   - ☐ Demerol IVP
   - ☑ Versed IVP 5mg
   - ☐ Valium IVP
   - ☐ Glucagon IVP
   - ☐ Procardia SL
   - ☐ Atropine IVP
   - ☐ Narcan 0.4 mg IVP
   - ☐ Heparin Flush
   - ☐ Romazicon
   - ☐ Sclerosing Solution
   - ☑ Fentanyl 100 mcg.

6. ☑ O_2 2L N.C. p.r.n.

7. ☑ Discharge Home when Discharge Criteria met

☐ Unless Checked, Generic Items May Be Supplied Per Policy	6-15-07 0840 RN'S SIGNATURE, DATE AND TIME Rucalade —	PHYSICIAN'S SIGNATURE, DATE AND TIME

ADDRESSOGRAPH

Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

G I LAB ORDERS

WHITE - CHART YELLOW - DEPARTMENT PINK - NURSING MEDICATION

000144 733.009 (4/05)

T3205

MAR Date 6/15/07 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
NS 500cc @ TKO Rate				8:30 RH / [illegible]	

Signature	Initials	Signature	Initials	Signature	Initials
Joan RN	RN				
Christa RN	CR				

Patient Name | Patient No.

Room | Age | Pt. Weight | Pt. Height

Diagnosis

Allergies Reglan

Physician's Name

PATIENT IDENTIFICATION

[illegible] VALLEY MEDICAL CENTER

0000242043

[illegible] A EL 61 /F

[illegible]3473781 DOB 03/27/45

DOS 06/15/07

[illegible] DR. SHAH, UMESH C.

PRIM DR. AGARWAL, CHANDRAHAS

24 Hour MAR

T3205 Rev. 03/00 (RC# 0259003)

CHART

HANNA, ADEL

Admitted:
Room/Bed:
Attending: **Shah, Umesh C.**

Chino Valley Medical Center

NURLC
Acct: V00000242043
Unit: **M000273781**

Personal Belongings Inventory 06/15/07 0824 CL

Inventory Date: 06/15/07 Inventory Time: 0815 Performed By: Luetum,Chusri
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: NONE-NO JEWELRY Jewelry:
Describe: Describe:
Disposition: Disposition:

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

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:
:

N Electrical Appliances Describe:
N Eng. Dept Notified To Evaluate Electrical Appliance
Other Item(s) Of Value To The Patient: CLOTHING AND SHOES
: #7
Disposition: LOCKED ON UNIT
Compared to Previous Belongings List: NO

<< 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 MS Date: 6/15/07
WITNESS: C Luetum RN

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

PATIENT: Hanna MS Date: 6/15/07
WITNESS: C Luetum

Monogram Initials	Name	Nurse Type
CL	NURLC Luetum,Chusri	RN

T97-6.-55-18 Y24/83

97-1

DATE	TIME	B.P.	HR	RR	O2 SAT	Pain		NOTES
06/15/07	0055	~~93~~ 61	53	18	99%	0/10		Pt is very sleepy but easily arousable and oriented x3
"	10:10	93/56	54	18	99%			
"	10:25	99/46	51	18	99%			
"	10:40	107/48	55	18	99%			
"	~~10:55~~ 11:26	121/66	60	18	99%			
"	11:26	106/73	64	18	99%			

Chino Valley Medical Center

5451 WALNUT AVENUE
CHINO, CALIFORNIA 91710

VITAL SIGNS

000220 804.014 (5/05)

ADDRESSOGRAPH

DATE OF PROCEDURE 6-15-07 TIME 0850

PROCEDURE / PHYSICIAN EGD: Colon / Shah

CONSENT SIGNED YES ✓ NO ____

PROCEDURE VERIFIED YES ✓ NO ____

TIME OUT!!! FINAL VERIFICATION

PATIENT IDENTIFIERS:

- PATIENT ID BAND CHECKED ✓
- MR# MATCHED TO ID BAND ✓
- PATIENT NAME VERIFIED ✓
- PATIENT DATE OF BIRTH VERIFIED ✓

SIGNATURE Guzalde *(MD / DO / RN)*

SIGNATURE J. Hernandez *(RN / LVN / GI TECH)*

C[illegible] VALLEY MEDICAL CENTER

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

GI LAB VERIFICATION CHECKLIST

V [illegible] ADDRESSOGRAPH
P [illegible]
I [illegible]

007174 00.7174 (9/05)

Date 06-14-07

UNIVERSAL ADMISSION FORM

Chino Valley Medical Center

I. Source of Admission

☑ Home ☐ Office ☐ SNF Patient's Primary Language: ☑ English ☐ Spanish ☐ Other ______

Admitting Doctor: U. Shah Surgeon: ______

Primary Care Physician: Dr. Agrawal Consultant: ______

Diagnosis & ICD9s: Epigastric pain, difficulty swallowing

Patient Status

1. ☐ In-Patient ☐ Med-Surg ☐ Peds ☐ DOU ☐ TCU ☐ OB ☐ ICU ☐ Isolation? #Days ______
2. ☑ Out-patient ☐ Observation

II. ADMITTING Information

	Hospital	Clinic/Office	
Laboratory: CBC UA RPR UCG Chem Panel: ______ PT PTT	☐	☐	
CardioPulmonary: EKG ABG ☐ Teach use of incentive spirometer	☐	☐	
Radiology: ☐ Chest X-Ray Other: ______	☐	☐	
Therapy: ☐ Crutch Tng ☐ NWB ☐ Toe-touch ☐ WBAT ☐ ______	☐	☐	

Additional Dr.'s Orders: ______

Noted 6/15/07 [illegible]

Procedure (as stated on consent): EGD/colonoscopy

CPT Codes: ______ Physician Signature: [signature]

III. SURGERY Information Surgery 464-8615

Surgeon: ______ Surgery Date: 06-15-07

1st Assist: ______ Surgery Time: 900

Surgery Length: ☐ ↓ 1 hour ☐ 1 hour ☐ ______ Anesthesia: ☐ Gen ☐ Local ☐ Spinal ☐ MAC

Special requests for equipment: ______

IV. PATIENT Information

Hanna, Adel MD.

Last / First / Middle

13678 Monteverde Dr. CH. (909) 902-1147

Address / City / Zip / Phone

Social Security: 548 - 107 - 8932 Sex: (M) F D.O.B. 03/29/49 Marital Status: D.

Employer ______ Work Phone ______

Spouse's Name ______ (Same Phone Number?) ______

Spouse's Employer ______ Work Phone ______

Subscriber and Responsible Party ______

Insurance #1: Blue Cross PPO Insurance Phone Number ______

Group Number ______ Policy Number ______

Authorization Number ______ TAR Number ______

Other Insurance ______

V. Workers Compensation Information

Industrial Carrier ______ Phone ______

Carrier Address ______ City ______ Zip ______ Phone ______

[Stamp:]
VALLEY MEDICAL CENTER
#000024204 3
HANNA, ADEL
DOB 03/29/45
DOS 06/15/07
ATTN DR. SHAH, UMESH C.
PRIM DR. AGARWAL, CHANDRAHAS

100032 906.002 (02/02)

06/14/2007 11:36 9096281405 USHAH PAGE 01/03

Patient: HANNA,ADEL
Account #: V00000242043 Unit #: M000273781

Age/Sex: 61 M Attending: Shah, Umesh C.
Location: GI Admitted:
Room/Bed: Status: REG SDC

	Date	Time	By	Nurse Type	
Occurred:	06/15/07	1155	CL Luetum,Chusri	RN	Category
Recorded:	06/15/07	1300	CL Luetum,Chusri	RN	Nurse Notes

Abnormal? N **Confidential?** N

PT IS ALERT AND ORIENTED.VITAL SIGNS STABLE.NO C/O PAIN.TAKING ORAL FLUID AND DIET WELL.UP TO BATHROOM WITH ASSISTED,VOIDED.INSTRUCTIONS AND PRESCRIPTION GIVEN.PT IS DISCHARGED HOME VIA W/C TO PRIVATE AUTO.

Note Type	Description
Type	NONE

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT 5 ft 0 in 152.4 cm
CONDITION VISITORS ALLOWED WT 163 lb 15.68 oz 74.38 kg
CMT
VISIT REASON EPIGASTRIC PAIN DIFFICULTY SWALLOWING

Primary Diagnosis:
Date of Surgery/Procedure:

Isolation:

Allergies: REGLAN
Food Allergies: NKFA

Advance Directive: Full Code:
Other/Additional:
Primary Language: ENGLISH

Contact Person: Decision Delegate--See On-Line Doc.
Relationship: Name:
Phone #:
Pager/Cell #: Relationship:

ADM: Quickstart Form DS 06/15/07 0824 CL

Patient Type: ADMIT DAY SURGERY New Admit: Y
Patient Age: 61

Day Surgery Admission 06/15/07 0837 CL

=== DAY SURGERY ADMISSION ===

=== Source of Information ===

Patient: Y
Other (name/relationship):

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: 5 Weight - Lb: 164 Oz: OR Kg: 74.38
In: Weight Source: PATIENT STATED
OR Cm: 152.40
==DEMOGRAPHIC DATA==
Primary Language: ENGLISH Comment: IS MD
Religion: CHRISTIAN Beliefs Affecting Care:
Comment:
Allergies: REGLAN
Other Allergies: NKDA
Contact Person: HANNA,TAMER Alternate Phone #:
Relationship: SO Pager #:
Phone Number: (949)413-8670 CELL Cell Phone #:
=== ADVANCE DIRECTIVES ===

Day Surgery Admission 06/15/07 0837 CL

Advance Directive: N **IF YES** Copy On Chart:
Copy on File at CVMC:
Reviewed with Patient/Representative:

The Current Desire for this Patient Regarding Life Support Is as Follows:
. Y Full Code . Other/Additional

Comment:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N
Amount/How Often: Number of Years:
Currently Using Recreational Drugs: N Type:
How Often: Numbers Of Years:

=== HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)===
Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N
1. ATENOLOL 50MG
2. ANALAPRIL 5 MG
3. NEXIUM 40MG
4. DIFLUCAN 200MG BID
5. WILL TAKE B/P MED IN PM AS USUAL
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18. -Referral Needed:

=== PATIENT MEDICAL HX === ****HISTORY ONLY-NOT for Patient's Current Assessment****
- Neurological: N:
EENT: N:
Cardiac: N:
Respiratory: Y: POSSIBLE MILD ASTHMA
Hypertension: Y: RX
Circulatory: N:
Blood Disorder/Clots: N:
Musculoskeletal: N:
Gastrointestinal: Y: GERD HX COLON POLYPS
Hepatitis: N:
Endocrine: N:
Genitourinary: N:

Day Surgery Admission 06/15/07 0837 CL

Gynecological:
Skin Disorder: N
Cancer: N
Psychological: N
Pain:
Other: N
Pregnant: LMP:
Previous Surgeries: CHOLE (OPEN)

Previous Anesthesia: Y Anesthesia Reaction: N
Family History of Problems with Anesthesia: N

Previous Blood Transfusion: N Blood Reaction:
=== DISCHARGE PLANNING ===
Does Patient Live with People who Rely on Him/Her: N
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:

=== FUNCTIONAL STATUS ===
- Decreased Functional Ability in Last 30 Days: N
Prior: Mobility: Current: Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N ~Referred to Primary Physician: N
=== 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: 0 NO
Poor PO Intake for >4 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
Total Score: 0 ~Nutritional Risk: LOW
~Referred to Primary Physician: N
Already Being Seen by PCP or Specialist for Problem: N
=== EDUCATION SCREENING ===
Education Needs Assessed: Y
Physiologic Limitations: NONE
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: DISCUSSION
Pre Admission Teaching: Y
Education Comment:

Date Of Surgery/Procedure: 06/15/07
Surgical Procedure: EGD COLONOSCOPY
Patient's Description: EGD COLONOSCOPY
History Obtained Date: 06/15/07 Signature: Luetum,Chusri

Day Surgery Admission 06/15/07 0837 CL

===DAY SURGERY ADMISSION ASSESSMENT===
Time of Arrival: 0815
Mode of Arrival: AMBULATORY
Arrival From: HOME
NPO Since: 0000 Date: 06/14/07
AM Meds Taken: NO

=== VITAL SIGNS ===
Blood Pressure: 107/75 Pulse: 62
BP Source: AUTOMATIC Pulse Source: AUTOMATIC NONINVASIVE
Site: LEFT UPPER ARM Respirations: 20
Position: SUPINE (LYING DOWN) Resp Source: OBSERVED
Temperature/F: 97.5 Sp02%: 99
Temp Source: ORA On O2: N LPM:
Pain: N

===PHYSICAL ASSESSMENT DAY OF PROCEDURE===
~NEUROLOGICAL Assessment Within Normal Limits: Y:
EENT Assessment Within Normal Limits: Y:
RESPIRATORY Assessment Within Normal Limits: Y:
CARDIAC Assessment Within Normal Limits: Y:
CIRCULATORY Assessment Within Normal Limits: Y:
MUSCULOSKELETAL Assessment Within Normal Limits: Y:
GASTROINTESTINAL Assessment Within Normal Limits: Y:
GENITOURINARY Assessment Within Normal Limits: Y:
INTEGUMENTARY Assessment Within Normal Limits: Y:
PSYCHOSOCIAL Assessment Within Normal Limits: Y:

Pulse Location #1: Pulse Character #1:
Pulse Location #2: Pulse Character #2:

Assessment Comment:

Patient/Family Education: Y
Education Comment:

=== PATIENT/FAMILY EDUCATION - PRE ADMISSION ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre Admission Teaching As Follows: Y
NPO/Take medications the Morning of Surgery
Report Time to the Hospital
Need to Arrange Transportation Home
No Jewelry, Makeup, Contacts
No Smoking 24 Hours Before Surgery
Do Not Bring Valuables/Money to the Hospital
Pre and Post Op Routines on the Nursing Floor
Out of Facility Testing if Applicable
Pain Management/Scale
Post Op Prescription

Other Teaching/Instructions:
Comment: USING PREP TOADY NPO P MN TO TAKE B/P MED THIS EVENING AS USUAL

Day Surgery Admission 06/15/07 0837 CL

TO REPOT 0800

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Luetum,Chusri
Discipline: NURSING

=== PAIN ASSESSMENT ==

Pain Location:
~Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Pain Location:
~Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Comment:

=== PATIENT/FAMILY EDUCATION - OPS ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre and Post Op Teaching As Follows:
IV Prep If Applicable
Surgery Holding Area Recovery Room
Incentive Spirometer if Applicable

Day Surgery Admission 06/15/07 0837 CL

Where Relatives/Visitors Should Wait
Pain Management in Recovery Room and Outpatient Unit
Will Be Discharged When VS Are Stable, Able to Tolerate P.O.
Liquids, Has Voided, and Can Ambulate Safely

Procedure Teaching As Follows: Y
IV If Applicable
Where the Procedure is Done
Recovery After Procedure and Time Involved
Where Relatives/Visitors Should Wait

Other Teaching/Instructions:
Comment:

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Luetum,Chusri
Discipline: NURSING

Monogram Initials	Name	Nurse Type
CL	NURLC Luetum,Chusri	RN

Administrative Data

TEMPORARY LOCATION

HOLD TRAY: DATE MEAL RELEASE HT 5 ft 0 in 152.4 cm
CONDITION VISITORS ALLOWED WT 163 lb 15.68 oz 74.38 kg
CMT
VISIT REASON EPIGASTRIC PAIN,DIFFICULTY SWALLOWING

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Date of Surgery/Procedure:

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Allergies: REGLAN
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Advance Directive: Full Code:
Other/Additional:
Primary Language: ENGLISH

Contact Person: Decision Delegate--See On-Line Doc.
Relationship: Name:
Phone #:
Pager/Cell #: Relationship:

ADM: QuickStart Form DS 06/15/07 0824 CL

Patient Type: ADMIT: DAY SURGERY New Admit: Y
Patient Age: 61

Day Surgery Admission 06/15/07 0837 CL

=== DAY SURGERY ADMISSION ===

--- Source of Information ---

Patient: Y
Other (name/relationship):

== ADMISSION HEIGHT/WEIGHT/ALLERGIES ==
Height - Feet: 5 Weight - Lb: 164 Oz: OR Kg: 74.38
In: Weight Source: PATIENT STATED
OR Cm: 152.40

==DEMOGRAPHIC DATA==
Primary Language: ENGLISH Comment: IS MD
Religion: CHRISTIAN Beliefs Affecting Care:
Comment:
Allergies: REGLAN
Other Allergies: NKDA
Contact Person: HANNA,TAMER Alternate Phone #:
Relationship: SO Pager #:
Phone Number: (949)413-8670 CELL Cell Phone #:
=== ADVANCE DIRECTIVES ===

Day Surgery Admission 06/15/07 0837 CL

Advance Directive: N **IF YES** Copy On Chart:
Copy on File at CVMC:
Reviewed with Patient/Representative:

The Current Desire for this Patient Regarding Life Support Is as Follows:
Y Full Code Other/Additional

Comment:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N
Amount/How Often: Number of Years:
Currently Using Recreational Drugs: N Type:
How Often: Numbers Of Years:

== HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)==
Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N

1. ATENOLOL 50MG
2. ANALAPRIL 5 MG
3. NEXIUM 40MG
4. DIFLUCAN 200MG BID
5. WILL TAKE B/P MED IN PM AS USUAL
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18. -Referral Needed:

=== PATIENT MEDICAL HX === ****HISTORY ONLY-NOT for Patient's Current Assessment****
- Neurological: N:
EENT: N:
Cardiac: N:
Respiratory: Y: POSSIBLE MILD ASTHMA
Hypertension: Y: RX
Circulatory: N:
Blood Disorder/Clots: N:
Musculoskeletal: N:
Gastrointestinal: Y: GERD HX COLON POLYPS
Hepatitis: N:
Endocrine: N:
Genitourinary: N:

Day Surgery Admission 06/15/07 0837 CL

Gynecological:
Skin Disorder: N
Cancer: N
Psychological: N
Pain:
Other: N
Pregnant: LMP:
Previous Surgeries: CHOLE (OPEN)

Previous Anesthesia: Y Anesthesia Reaction: N
Family History of Problems with Anesthesia: N

Previous Blood Transfusion: N Blood Reaction:
=== DISCHARGE PLANNING ===
Does Patient Live with People who Rely on Him/Her: N
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:

=== FUNCTIONAL STATUS ===
~ Decreased Functional Ability in Last 30 Days: N
Prior: Mobility: Current: Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N ~Referred to Primary Physician: N
=== 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: 0 NO
Poor PO Intake for >4 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
Total Score: 0 ~Nutritional Risk: LOW
~Referred to Primary Physician: N
Already Being Seen by PCP or Specialist for Problem: N
=== EDUCATION SCREENING ===
Education Needs Assessed: Y
Physiologic Limitations: NONE
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: DISCUSSION
Pre Admission Teaching: Y
Education Comment:

Date Of Surgery/Procedure: 06/15/07
Surgical Procedure: EGD COLONOSCOPY
Patient's Description: EGD COLONOSCOPY
History Obtained Date: 06/15/07 Signature: Luetim Chusid

Day Surgery Admission: 06/15/07 0837 CL

==DAY SURGERY ADMISSION ASSESSMENT==
Time of Arrival: 0815
Mode of Arrival: AMBULATORY
Arrival From: HOME
NPO Since: 0000 Date: 06/14/07
AM Meds Taken: NO

=== VITAL SIGNS ===
Blood Pressure: 107/75 Pulse: 62
BP Source: AUTOMATIC Pulse Source: AUTOMATIC, NONINVASIVE
Site: LEFT UPPER ARM Respirations: 20
Position: SUPINE (LYING DOWN) Resp Source: OBSERVED
Temperature/F: 97.5 SpO2%: 99
Temp Source: ORA On O2: N LPM:
Pain: N

==PHYSICAL ASSESSMENT DAY OF PROCEDURE==
~NEUROLOGICAL Assessment Within Normal Limits: Y
EENT Assessment Within Normal Limits: Y
RESPIRATORY Assessment Within Normal Limits: Y
CARDIAC Assessment Within Normal Limits: Y
CIRCULATORY Assessment Within Normal Limits: Y
MUSCULOSKELETAL Assessment Within Normal Limits: Y
GASTROINTESTINAL Assessment Within Normal Limits: Y
GENITOURINARY Assessment Within Normal Limits: Y
INTEGUMENTARY Assessment Within Normal Limits: Y
PSYCHOSOCIAL Assessment Within Normal Limits: Y

Pulse Location #1: Pulse Character #1:
Pulse Location #2: Pulse Character #2:

Assessment Comment:

Patient/Family Education: Y
Education Comment:

=== PATIENT/FAMILY EDUCATION - PRE ADMISSION ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre Admission Teaching As Follows: Y
NPO/Take medications the Morning of Surgery
Report Time to the Hospital
Need to Arrange Transportation Home
No Jewelry, Makeup, Contacts
No Smoking 24 Hours Before Surgery
Do Not Bring Valuables/Money to the Hospital
Pre and Post Op Routines on the Nursing Floor
Out of Facility Testing if Applicable
Pain Management/Scale
Post Op Prescription

Other Teaching/Instructions:
Comment: USING PREP TODAY NPO P MN TO TAKE B/P MED THIS EVENING AS USUAL

Day Surgery Admission 06/15/07 0837 CL

TO REPOT 0800

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Luetum,Chusri
Discipline: NURSING

=== PAIN ASSESSMENT ===

Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
What increases the Pain:
What Relieves the Pain:

Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Comment:
:

=== PATIENT/FAMILY EDUCATION - OPS ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre and Post Op Teaching As Follows:
IV Prep If Applicable
Surgery Holding Area Recovery Room
Incentive Spirometer if Applicable

Day Surgery Admission 06/15/07 0837 CL

Where Relatives/Visitors Should Wait
Pain Management in Recovery Room and Outpatient Unit
Will Be Discharged When VS Are Stable, Able to Tolerate P.O.
Liquids, Has Voided, and Can Ambulate Safely

Procedure Teaching As Follows: Y
IV If Applicable
Where the Procedure is Done
Recovery After Procedure and Time Involved
Where Relatives/Visitors Should Wait

Other Teaching/Instructions:
Comment:

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Luetum,Chusri
Discipline: NURSING

Monogram Initials	Name	Nurse Type
CL	NURLC Luetum,Chusri	RN

FROM NURSING ADMISSION

== EDUCATIONAL ASSESSMENT ==

Primary Language:	ENGLISH
Understands English:	
Religion:	CHRISTIAN
Beliefs Affecting Care:	
Physiologic Limitations:	NONE
Psychological Limits:	NONE
Cognitive Limitations:	NONE
Teaching Method Preferred:	DISCUSSION
Educational Need Priority #1:	
Educational Need Priority #2:	
Educational Need Priority #3:	
Educational Need Priority #4:	
Education Comment:	

Procedure: EGD + Colonoscopy Phone: (909) 902-1147

Anesthetic: ☐ General ☐ Local ☒ MAC ☐ Regional ☐ Spinal

1. Are you having any problems getting up and about? ☐ No ☐ **Yes***

2. Did you have any problems breathing? ☐ No ☐ **Yes***
   ☐ congestion ☐ wheezing ☐ sore throat

3. Did you have any nausea or vomiting? ☐ No ☐ **Yes*** How long did it last? _____
   Did you need any medication for it? ☐ No ☐ Yes
   Was the medication effective? ☐ **No*** ☐ Yes

4. Did you have any pain? _____ / 10 before med.; _____ / 10 after med.
   ☐ No pain med. ordered ☐ Pain not relieved
   ☐ Pain med. effective ☐ **Needed to contact surgeon***

5. Did you have any unexpected bleeding? ☐ No ☐ **Yes***
   Comments: _____

6. Did you have a temperature over 100.5°? ☐ No ☐ **Yes*** (1) No answer 6/18/07 1100

7. Did you have any difficulty with urination? ☐ No ☐ **Yes*** (2) No answer @ 1220

8. Extremity: ☐ N/A ☐ Pink and warm ☐ Normal sensation ☐ Normal movement

9. **Patient contacted surgeon regarding:** _____

10. ***Comments:** _____

11. ☐ Patient instructed to call surgeon for any problems.

12. Please rate your satisfaction with your Outpatient experience: _____ / 10

13. Please rate your satisfaction with your Admitting experience: _____ / 10

14. Do you have any suggestions to improve our Outpatient program?

15. ☒ Unable to reach.

Nurse Signature Laura Carlson Date 6/18-07

Chino Valley Medical Center
5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710

OUTPATIENT POST-OP CALL FORM

101071 786.003 (04/02)

ADDRESSOGRAPH

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0738

1006-A ADM DAY SURGERY: ADULT Procedure + A ON ADMISSION AS
Create 06/14/07 0738 KW 06/14/07 0739 KW
- Document 06/14/07 0738 KW 06/14/07 0739 KW

=== DAY SURGERY ADMISSION ===

=== Source of Information ===

Patient:
Other (name/relationship):

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: Weight - Lb: Oz: OR Kg:
In: Weight Source:
OR Cm:
==DEMOGRAPHIC DATA==
Primary Language: ENGLISH Comment:
Religion: Beliefs Affecting Care:
Comment:
Allergies: REGLAN
Other Allergies: NKOA
Contact Person: HANNA TAMER Alternate Phone #:
Relationship: SO Pager #:
Phone Number: (949)413-8670 Cell Phone #:
=== ADVANCE DIRECTIVES ===
Advance Directive: N **IF YES** Copy On Chart:
Copy on File at CVMC:
Reviewed with Patient/Representative:

The Current Desire for this Patient Regarding Life Support Is as Follows:
. Full Code . Other/Additional

Comment:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: Type:
Amount/How Often: Number of Years:
Currently Using Alcohol:
Amount/How Often: Number of Years:
Currently Using Recreational Drugs: Type:
How Often: Numbers Of Years:

=== HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)==
Currently Taking ASA: Anticoagulants: Steroids: Diet Pills: Herbal Supplement:
1.
2.
3.
4.
5.
6.

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0738 (continued)

Activity Date: 06/14/07 Time: 0738 (continued)
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18. -Referral Needed:

=== PATIENT MEDICAL HX === ****HISTORY ONLY-NOT for Patient's Current Assessment****
- Neurological:
EENT:
Cardiac:
Respiratory:
Hypertension:
Circulatory:
Blood Disorder/Clots:
Musculoskeletal:
Gastrointestinal: Y: GERD HX COLON POLYPS
Hepatitis:
Endocrine:
Genitourinary:
Gynecological:
Skin Disorder:
Cancer:
Psychological:
Pain:
Other:
Pregnant: LMP:
Previous Surgeries:

Previous Anesthesia: Anesthesia Reaction:
Family History of Problems with Anesthesia:
Previous Blood Transfusion: Blood Reaction:
=== DISCHARGE PLANNING ===
Does Patient Live with People who Rely on Him/Her:
Does Family/Friends Assist with Home Care:
Who Will be Taking Patient Home:
Anticipated Discharge Destination:
Is Patient Using Homecare/Outside Agency/Facility:
Name/Phone # of agency:

=== FUNCTIONAL STATUS ===
- Decreased Functional Ability in Last 30 Days:
Prior Mobility: Current Mobility:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0738 (continued)

Activity Date: 06/14/07 Time: 0738 (continued)
Ambulatory Assistive Device Used:
Hygiene Assist: Feeding Assist: -Referred to Primary Physician:
=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished:
Nausea, Vomiting, or Diarrhea for >3 Days:
Unintentional Weight Loss >10# in Past Month:
-Admitted with Potential Risk Diagnosis:
Poor PO Intake for >4 Days:
Unable to Ingest Diet for Age:
Tube Feeding or TPN:
Total Score: -Nutritional Risk: LOW
-Referred to Primary Physician:
Already Being Seen by PCP or Specialist for Problem:
=== EDUCATION SCREENING ===
Education Needs Assessed:
Physiologic Limitations:
Psychological Limits:
Cognitive Limitations:
Teaching Method Preferred:
Pre Admission Teaching:
Education Comment:

Date Of Surgery/Procedure: 06/15/07
Surgical Procedure: EGD COLONOSCOPY
Patient's Description:
History Obtained Date: 06/14/07 Signature: Wagner,Kathleen

==DAY SURGERY ADMISSION ASSESSMENT==
Time of Arrival:
Mode of Arrival:
Arrival From:
NPO Since: Date:
AM Meds Taken:

=== VITAL SIGNS ===
Blood Pressure: Pulse:
BP Source: Pulse Source:
Site: Respirations:
Position: Resp Source:
Temperature/F: SpO2%:
Temp Source: On O2: LPM:
Pain:

==PHYSICAL ASSESSMENT DAY OF PROCEDURE==
-NEUROLOGICAL Assessment Within Normal Limits:
EENT Assessment Within Normal Limits:
RESPIRATORY Assessment Within Normal Limits:
CARDIAC Assessment Within Normal Limits:
CIRCULATORY Assessment Within Normal Limits:
MUSCULOSKELETAL Assessment Within Normal Limits:
GASTROINTESTINAL Assessment Within Normal Limits:

Activity Date: 06/14/07 Time: 0738 (continued)

Activity Date: 06/14/07 Time: 0738 (continued)
GENITOURINARY Assessment Within Normal Limits:
INTEGUMENTARY Assessment Within Normal Limits:
PSYCHOSOCIAL Assessment Within Normal Limits:

Pulse Location #1: Pulse Character #1:
Pulse Location #2: Pulse Character #2:

Assessment Comment:

Patient/Family Education:
Education Comment:

=== PATIENT/FAMILY EDUCATION - PRE ADMISSION ===
Person Taught: Teaching Tools:
Person Taught: Other Tools Used:

Pre Admission Teaching As Follows:
NPO/Take medications the Morning of Surgery
Report Time to the Hospital
Need to Arrange Transportation Home
No Jewelry, Makeup, Contacts
No Smoking 24 Hours Before Surgery
Do Not Bring Valuables/Money to the Hospital
Pre and Post Op Routines on the Nursing Floor
Out of Facility Testing if Applicable
Pain Management/Scale
Post Op Prescription

Other Teaching/Instructions:
Comment:

Participation Level:
Evaluation:
Needs Additional Education:
Educator:
Discipline:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0738 (Continued)

Activity Date: 06/14/07 Time: 0738 (continued)

=== PAIN ASSESSMENT ===

Pain Location:
Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
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=== PATIENT/FAMILY EDUCATION - OPS ===
Person Taught: Teaching Tools:
Person Taught: Other Tools Used:

Pre and Post Op Teaching As Follows:
IV Prep If Applicable
Surgery Holding Area Recovery Room
Incentive Spirometer if Applicable
Where Relatives/Visitors Should Wait
Pain Management in Recovery Room and Outpatient Unit
Will Be Discharged When VS Are Stable, Able to Tolerate P.O. Liquids, Has Voided, and Can Ambulate Safely

Procedure Teaching As Follows:
IV If Applicable
Where the Procedure is Done
Recovery After Procedure and Time Involved
Where Relatives/Visitors Should Wait

Other Teaching/Instructions:
Comment:

Participation Level:
Evaluation:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0738 (continued)

Activity Date: 06/14/07 Time: 0738 (continued)
Needs Additional Education:
Educator:
Discipline:

Activity Date: 06/14/07 Time: 0904

1006-A ADM DAY SURGERY: ADULT Procedure + A ON ADMISSION AS
Document 06/14/07 0904 KW 06/14/07 0907 KW
=== DAY SURGERY ADMISSION ===

=== Source of Information ===
Patient: Y
Other (name/relationship):

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: 5 Weight - Lb: 164 Oz: OR Kg: 74.38
In: Weight Source: PATIENT STATED
OR Cm: 152.40
==DEMOGRAPHIC DATA==
Primary Language: ENGLISH Comment: IS MD
Religion: CHRISTIAN Beliefs Affecting Care:
Comment:
Allergies: REGLAN
Other Allergies: NKDA
Contact Person: HANNA TAMER Alternate Phone #:
Relationship: SO Pager #:
Phone Number: (949)413-8670 Cell Phone #:
=== ADVANCE DIRECTIVES ===
Advance Directive: N **IF YES** Copy On Chart:
Copy on File at CVMC:
Reviewed with Patient/Representative:

The Current Desire for this Patient Regarding Life Support Is as Follows:
Y Full Code Other/Additional

Comment:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N
Amount/How Often: Number of Years:
Currently Using Recreational Drugs: N Type:
How Often: Numbers Of Years:

=== HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)===

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0904 (continued)

Activity Date: 06/14/07 Time: 0904 (continued)
Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N

1. ATENOLOL 50MG
2. ANALAPRIL 5 MG
3. NEXIUM 40MG
4. DIFLUCAN 200MG BID
5. WILL TAKE B/P MED IN PM AS USUAL
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.
17.
18. ~Referral Needed:

=== PATIENT MEDICAL HX === ****HISTORY ONLY-NOT for Patient's Current Assessment****

~ Neurological: N
EENT: N
Cardiac: N
Respiratory: Y POSSIBLE MILD ASTHMA
Hypertension: Y RX
Circulatory: N
Blood Disorder/Clots: N
Musculoskeletal: N
Gastrointestinal: Y GERD HX COLON POLYPS
Hepatitis: N
Endocrine: N
Genitourinary: N
Gynecological:
Skin Disorder: N
Cancer: N
Psychological: N
Pain:
Other: N
Pregnant: LMP:
Previous Surgeries: CHOLE (OPEN)

Previous Anesthesia: Y Anesthesia Reaction: N
Family History of Problems with Anesthesia: N

Previous Blood Transfusion: N Blood Reaction:

=== DISCHARGE PLANNING ===
Does Patient Live with People who Rely on Him/Her: N
Does Family/Friends Assist with Home Care: Y
Who Will be Taking Patient Home: FAMILY

Activity Date: 06/14/07 Time: 0904 (continued)

Activity Date: 06/14/07 Time: 0904 (continued)
Anticipated Discharge Destination: HOME
Is Patient Using Homecare/Outside Agency/Facility: N
Name/Phone # of agency.

=== FUNCTIONAL STATUS ===
~ Decreased Functional Ability in Last 30 Days: N
Prior: Mobility: Current: Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N ~Referred to Primary Physician: N

=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished:
Nausea, Vomiting, or Diarrhea for >3 Days:
Unintentional Weight Loss >10# in Past Month:
~Admitted with Potential Risk Diagnosis:
Poor PO Intake for >4 Days:
Unable to Ingest Diet for Age:
Tube Feeding or TPN:
Total Score: ~Nutritional Risk: LOW
~Referred to Primary Physician:
Already Being Seen by PCP or Specialist for Problem:

=== EDUCATION SCREENING ===
Education Needs Assessed: Y
Physiologic Limitations: NONE
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: DISCUSSION
Pre Admission Teaching: Y
Education Comment:

Date Of Surgery/Procedure: 06/15/07
Surgical Procedure: EGD COLONOSCOPY
Patient's Description: EGD COLONOSCOPY
History Obtained Date: 06/14/07 Signature: Wagner,Kathleen

===DAY SURGERY ADMISSION ASSESSMENT===
Time of Arrival:
Mode of Arrival:
Arrival From:
NPO Since: Date:
AM Meds Taken:

=== VITAL SIGNS ===
Blood Pressure: Pulse:
BP Source: Pulse Source:
Site: Respirations:
Position: Resp Source:
Temperature/F: SpO2%:
Temp Source: On O2: LPM:
Pain:

===PHYSICAL ASSESSMENT DAY OF PROCEDURE===

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0904 (continued)

Activity Date: 06/14/07 Time: 0904 (continued)
-NEUROLOGICAL Assessment Within Normal Limits:
EENT Assessment Within Normal Limits:
RESPIRATORY Assessment Within Normal Limits:
CARDIAC Assessment Within Normal Limits:
CIRCULATORY Assessment Within Normal Limits:
MUSCULOSKELETAL Assessment Within Normal Limits:
GASTROINTESTINAL Assessment Within Normal Limits:
GENITOURINARY Assessment Within Normal Limits:
INTEGUMENTARY Assessment Within Normal Limits:
PSYCHOSOCIAL Assessment Within Normal Limits:

Pulse Location #1: Pulse Character #1:
Pulse Location #2: Pulse Character #2:

Assessment Comment:

Patient/Family Education:
Education Comment:

=== PATIENT/FAMILY EDUCATION - PRE ADMISSION ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre Admission Teaching As Follows: Y
NPO/Take medications the Morning of Surgery
Report Time to the Hospital
Need to Arrange Transportation Home
No Jewelry, Makeup, Contacts
No Smoking 24 Hours Before Surgery
Do Not Bring Valuables/Money to the Hospital
Pre and Post Op Routines on the Nursing Floor
Out of Facility Testing if Applicable
Pain Management/Scale
Post Op Prescription

Other Teaching/Instructions:
Comment: USING PREP TOADY NPO P MN TO TAKE B/P MED THIS EVENING AS USUAL TO REPOT 0800

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N

Educator: Wagner,Kathleen
Discipline: NURSING

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 06/14/07 Time: 0904 (continued)

Activity Date: 06/14/07 Time: 0904 (continued)

=== PAIN ASSESSMENT ==

Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Comment:

=== PATIENT/FAMILY EDUCATION - OPS ===
Person Taught: Teaching Tools:
Person Taught: Other Tools Used:

Pre and Post Op Teaching As Follows:
IV
Surgery Holding Area
Incentive Spirometer if Applicable
Where Relatives/Visitors Should Wait
Pain Management in Recovery Room and Outpatient Unit
Will Be Discharged When VS Are Stable, Able to Tolerate P.O. Liquids, Has Voided, and Can Ambulate Safely
Prep If Applicable
Recovery Room

Procedure Teaching As Follows:
IV If Applicable
Where the Procedure is Done
Recovery After Procedure and Time Involved
Where Relatives/Visitors Should Wait

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/14/07 Time: 0904 (continued)

Activity Date: 06/14/07 Time: 0904 (continued)
Other Teaching/Instructions:
Comment:

Participation Level:
Evaluation:
Needs Additional Education:
:
Educator:
Discipline:

Activity Date: 06/15/07 Time: 0824

1000-B	ADMISSION/TRANSFER: Quick Start Form +	A	ON ADMISSION/TRANS		AS
Create	06/15/07 0824 CL 06/15/07 0824 CL				
- Document	06/15/07 0824 CL 06/15/07 0824 CL				
Patient Type: ADMIT: DAY SURGERY New Admit: Y					
Patient Age: 61					
1321	Pain: OPS Management of +	A	PRN		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
20010	VS: Monitor +	A	PER UNIT POLICY		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
21099	Routine Care: DS/PAIN CL VIEW PROTOCOL	A	END OF SHIFT/TX:LIC		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
22300	TV/Invasive Lines: Insert/Remove +	A	INS/REMOVAL/CONVERT		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
60010	Notify: MD +	A	WHEN NECESSARY		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
80010	Education: Patient/Family Teaching +	A	PRN		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
975050	Inventory Personal Belongings + ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.	A	ADM.TX DC		AS
- Create	06/15/07 0824 CL 06/15/07 0826 CL				
- Document	06/15/07 0824 CL 06/15/07 0826 CL				

Inventory Date: 06/15/07 Inventory Time: 0815 Performed By: Luetum,Chusri
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: NONE-NO JEWELRY Jewelry:

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 0824 (continued)

Activity Date: 06/15/07 Time: 0824 (continued)
Describe: Describe:
Disposition: Disposition:

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

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:
:

-N Electrical Appliances Describe:
-N Eng. Dept Notified To Evaluate Electrical Appliance
Other Item(s) Of Value To The Patient: CLOTHING AND SHOES
: #7
Disposition: LOCKED ON UNIT
Compared to Previous Belongings List: NO

<< 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:_____

1001031	Age Guidelines: 41-65 (MID ADULT)	A	VIEW PROTOCOL/DI QS		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
1557300	Post Op Assessment: Perform +	A			CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				
5010100	Day Surgery: Discharge +	A	ON DISCHARGE		CP
- Create	06/15/07 0824 CL 06/15/07 0824 CL				

Activity Date: 06/15/07 Time: 0837

1006-A	ADM DAY SURGERY: ADULT Procedure +	A	ON ADMISSION		AS
Document	06/15/07 0837 CL 06/15/07 0842 CL				

=== DAY SURGERY ADMISSION ===

=== Source of Information ===

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 0837 (continued)

Activity Date: 06/15/07 Time: 0837 (continued)
Patient: Y
Other (name/relationship):

=== ADMISSION HEIGHT/WEIGHT/ALLERGIES ===
Height - Feet: 5 Weight - Lb: 164 Oz: OR Kg: 74.38
In: Weight Source: PATIENT STATED
OR Cm: 152.40
==DEMOGRAPHIC DATA==
Primary Language: ENGLISH Comment: IS MD
Religion: CHRISTIAN Beliefs Affecting Care:
Comment:
Allergies: REGLAN
Other Allergies: NKOA
Contact Person: HANNA TANER Alternate Phone #:
Relationship: SO Pager #:
Phone Number: (949)413-8670 CELL Cell Phone #:
=== ADVANCE DIRECTIVES ===
Advance Directive: N **IF YES** Copy On Chart:
Copy on File at CVMC:
Reviewed with Patient/Representative:

The Current Desire for this Patient Regarding Life Support Is as Follows:
Y Full Code Other/Additional

Comment:

=== SUBSTANCE USE HISTORY ===
Currently Using Tobacco: N Type:
Amount/How Often: Number of Years:
Currently Using Alcohol: N
Amount/How Often: Number of Years:
Currently Using Recreational Drugs: N Type:
How Often: Numbers Of Years:

=== HOME MEDS (DOSE/FREQ/LAST DOSE/DISP)===
Currently Taking ASA: N Anticoagulants: N Steroids: N Diet Pills: N Herbal Supplement: N
1. ATENOLOL 50MG
2. ANALAPRIL 5 MG
3. NEXIUM 40MG
4. DIFLUCAN 200MG BID
5. WILL TAKE B/P MED IN PM AS USUAL
6.
7.
8.
9.
10.
11.
12.

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 0837 (continued)

Activity Date: 06/15/07 Time: 0837 (continued)
13.
14.
15.
16.
17.
18. -Referral Needed:
=== PATIENT MEDICAL HX === ****HISTORY ONLY-NOT for Patient's Current Assessment****
~ Neurological: N
EENT: N
Cardiac: N
Respiratory: Y POSSIBLE MILD ASTHMA
Hypertension: Y RX
Circulatory: N
Blood Disorder/Clots: N
Musculoskeletal: N
Gastrointestinal: Y GERD HX COLON POLYPS
Hepatitis: N
Endocrine: N
Genitourinary: N
Gynecological:
Skin Disorder: N
Cancer: N
Psychological: N
Pain:
Other: N
Pregnant: LMP:
Previous Surgeries: CHOLE (OPEN)

Previous Anesthesia: Y Anesthesia Reaction: N
Family History of Problems with Anesthesia: N

Previous Blood Transfusion: N Blood Reaction:
=== DISCHARGE PLANNING ===
Does Patient Live with People who Rely on Him/Her: N
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:

=== FUNCTIONAL STATUS ===
~ Decreased Functional Ability in Last 30 Days: N
Prior: Mobility: Current: Mobility:
Ambulatory Assistive Device Used:
Hygiene Assist: N Feeding Assist: N -Referred to Primary Physician: N
=== 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

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/15/07 Time: 0837 (continued)

Activity Date: 06/15/07 Time: 0837 (continued)
-Admitted with Potential Risk Diagnosis: 0 NO
Poor PO Intake for >4 Days: 0 NO
Unable to Ingest Diet for Age: 0 NO
Tube Feeding or TPN: 0 NO
Total Score: 0 -Nutritional Risk: LOW
-Referred to Primary Physician: N
Already Being Seen by PCP or Specialist for Problem: N

=== EDUCATION SCREENING ===
Education Needs Assessed: Y
Physiologic Limitations: NONE
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: DISCUSSION
Pre Admission Teaching: Y
Education Comment:

Date Of Surgery/Procedure: 06/15/07
Surgical Procedure: EGD COLONOSCOPY
Patient s Description: EGD COLONOSCOPY
History Obtained Date: 06/15/07 Signature: Luetum Chusri

==DAY SURGERY ADMISSION ASSESSMENT==
Time of Arrival: 0815
Mode of Arrival: AMBULATORY
Arrival From: HOME
NPO Since: 0000 Date: 06.14.07
AM Meds Taken: NO

=== VITAL SIGNS ==
Blood Pressure: 107/75 Pulse: 62
BP Source: AUTOMATIC Pulse Source: AUTOMATIC, NONINVASIVE
Site: LEFT UPPER ARM Respirations: 20
Position: SUPINE (LYING DOWN) Resp Source: OBSERVED
Temperature/F: 97.5 SpO2%: 99
Temp Source: ORA On O2: N LPM:
Pain: N

==PHYSICAL ASSESSMENT DAY OF PROCEDURE==
-NEUROLOGICAL Assessment Within Normal Limits: Y
EENT Assessment Within Normal Limits: Y
RESPIRATORY Assessment Within Normal Limits: Y
CARDIAC Assessment Within Normal Limits: Y
CIRCULATORY Assessment Within Normal Limits: Y
MUSCULOSKELETAL Assessment Within Normal Limits: Y
GASTROINTESTINAL Assessment Within Normal Limits: Y
GENITOURINARY Assessment Within Normal Limits: Y
INTEGUMENTARY Assessment Within Normal Limits: Y
PSYCHOSOCIAL Assessment Within Normal Limits: Y

Pulse Location #1: Pulse Character #1:
Pulse Location #2: Pulse Character #2:

Activity Date: 06/15/07 Time: 0837 (continued)

Activity Date: 06/15/07 Time: 0837 (continued)

Assessment Comment:

Patient/Family Education: Y
Education Comment:

=== PATIENT/FAMILY EDUCATION - PRE ADMISSION ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre Admission Teaching As Follows: Y
NPO/Take medications the Morning of Surgery
Report Time to the Hospital
Need to Arrange Transportation Home
No Jewelry, Makeup, Contacts
No Smoking 24 Hours Before Surgery
Do Not Bring Valuables/Money to the Hospital
Pre and Post Op Routines on the Nursing Floor
Out of Facility Testing if Applicable
Pain Management/Scale
Post Op Prescription

Other Teaching/Instructions:
Comment: USING PREP TODAY NPO @ MN TO TAKE A/P MED THIS EVENING AS USUAL
TO REPOT 0800

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
Educator: Luetum Chusri
Discipline: NURSING

=== PAIN ASSESSMENT ==
Pain Location:

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 0837 (continued)

Activity Date: 06/15/07 Time: 0837 (continued)
-Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
What Increases the Pain:
What Relieves the Pain:

Comment:

== PATIENT/FAMILY EDUCATION - OPS ===
Person Taught: PATIENT Teaching Tools: VERBAL
Person Taught: Other Tools Used:

Pre and Post Op Teaching As Follows:
IV Prep If Applicable
Surgery Holding Area Recovery Room
Incentive Spirometer if Applicable
Where Relatives/Visitors Should Wait
Pain Management in Recovery Room and Outpatient Unit
Will Be Discharged When VS Are Stable, Able to Tolerate P.O. Liquids, Has Voided, and Can Ambulate Safely

Procedure Teaching As Follows: Y
IV If Applicable
Where the Procedure is Done
Recovery After Procedure and Time Involved
Where Relatives/Visitors Should Wait

Other Teaching/Instructions:
Comment:

Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
Educator: Luetim Chusri
Discipline: NURSING

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 0858

22300 IV/Invasive Lines: Insert/Remove + A INS/REMOVAL/CONVERT CP
Document: 06/15/07 0858 CL 06/15/07 0859 CL
== IV INSERT/DISCONTINUE ===

Insertion/Reinsert -- Date: 06/15/07 # of Attempts: 1
IV Location: RIGHT HAND Catheter Size (ga.): 22
IV Location: Catheter Size (ga.):
Saline Lock: N

Discontinued -- Date:
IV/SL DC'd - Cath. Intact: IV Converted to Saline Lock:

IV Comment: IN FUSING WELL
1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Document: 06/15/07 0858 CL 06/15/07 0859 CL

Activity Date: 06/15/07 Time: 1112

20010 VS: Monitor + A PER UNIT POLICY CP
Document: 06/15/07 1112 CL 06/15/07 1250 CL
Temperature/F: 97.2 Temp Source: ORAL
Pulse: 64 Pulse Source: AUTOMATIC-NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 106/73 BP Source: AUTOMATIC
Site: LEFT 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 (%): 99 FiO2:
Comment:
22300 IV/Invasive Lines: Insert/Remove + A INS/REMOVAL/CONVERT CP
Document: 06/15/07 1112 CL 06/15/07 1250 CL
== IV INSERT/DISCONTINUE ===

Insertion/Reinsert -- Date: # of Attempts:
IV Location: Catheter Size (ga.):
IV Location: Catheter Size (ga.):
Saline Lock:

Discontinued -- Date: 06/15/07
IV/SL DC'd - Cath. Intact: Y IV Converted to Saline Lock: N

IV Comment: SITE CLEAR

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 1112

1557300 Post Op Assessment: Perform + A CP
Document 06/15/07 1112 CL 06/15/07 1252 CL
LOC: AWAKE/ALERT
Pain: N
Nausea: N
Skin Temp: WARM/DRY
Abdominal Appearance: SOFT/ROUND

Respiratory Difficulty: N
Respiratory Rhythm: REGULAR

Extremity Monitored:
Extremity Temp: NOT APPLICABLE
Extremity Color:
Sensation:
Extremity Comment:

Dressing: N
Incision Open To Air:
Location:
Dry and Intact:
Dressing Comment:
Vaginal Bleeding/Disch: N
Comment:

IV Fluid:
IV Fluid Remaining:
Current Rate (cc/hr):
IV Site Condition:
IV Comment:

Tolerating Diet/Fluids: Y
Voided: Y Outpatient Pain Education: Y

Activity Date: 06/15/07 Time: 1155

20010 VS Monitor + A PER UNIT POLICY CP
Document 06/15/07 1155 CL 06/15/07 1254 CL
Temperature/F: 97.6 Temp Source: ORAL
Pulse: 55 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 124/83 BP Source: AUTOMATIC

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 06/15/07 Time: 1155 (continued)

Activity Date: 06/15/07 Time: 1155 (continued)
Site: LEFT 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:
21099 Routine Care: DS/PAIN CL A END OF SHIFT/TX:LIC CP
VIEW PROTOCOL
Document 06/15/07 1155 CL 06/15/07 1255 CL
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Luetum,Chusri Shift: 0700 1930

Practice Guidelines Comment:

1557300 Post Op Assessment: Perform + A CP
Document 06/15/07 1155 CL 06/15/07 1256 CL
LOC: AWAKE/ALERT
Pain: N
Nausea: N
Skin Temp: WARM/DRY
Abdominal Appearance: SOFT/ROUND

Respiratory Difficulty: N
Respiratory Rhythm:

Extremity Monitored: NOT APPLICABLE
Extremity Temp:
Extremity Color:
Sensation:
Extremity Comment:

Dressing: N
Incision Open To Air:
Location:
Dry and Intact:
Dressing Comment:
Vaginal Bleeding/Disch: N
Comment:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 06/15/07 Time: 1155 (continued)

Activity Date: 06/15/07 Time: 1155 (continued)

IV Fluid:
IV Fluid Remaining:
Current Rate (cc/hr):
IV Site Condition:
IV Comment:

Tolerating Diet/Fluids: Y
Voided: Y
Outpatient Pain Education: Y

5010100 Day Surgery: Discharge + A ON DISCHARGE CP
Document 06/15/07 1155 CL 06/15/07 1257 CL
=== PADS ===

Vital Signs (0-2) 2
Activity and Mental Status (0-2) 2
Pain, Nausea, and/or Vomiting (0-2) 2
Surgical Bleeding (0-2) 2
Intake and Output (0-2) 2
Total (0-10) 10
Score >8 Considered Fit for Discharge

==DISCHARGE SUMMARY==

Discharge Date: 06/15/07 Discharge Time: 1155

Discharge To: HOME
Via: WHEELCHAIR
By: AUTOMOBILE
Accompanied By: FRIEND
Sent Home With All Bedside Belongings: Y
Discharge Medications: Y
Discharge Rx/Teach: Y
Printed Instructions Given: Y
Discharge Instructions Reviewed With: PT

Signed By: PT
Given To: PT

Patient/Family Verbalizes Understanding of Instructions: Y

Activity Date: 06/15/07 Time: 1155

Patient Notes: Nurse Notes
Create 06/15/07 1155 CL 06/15/07 1300 CL
Abnormal? N Confidential? N
PT IS ALERT AND ORIENTED.VITAL SIGNS STABLE.NO C/O PAIN.TAKING ORAL FLUID AND DIET WELL.UP TO BATHROOM WITH ASSISTED.VOIDED.INSTRUCTIONS AND PRESCRIPTION GIVEN.PT IS DISCHARGED HOME VIA W/C TO PRIVATE AUTO.

Monogram	Initials	Name	Nurse Type
CL	NURLC	Luetum,Chusri	RN
KW	NURWK	Wagner,Kathleen	RN

	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.	A	06/15 CL								
* Patient will verbalize understanding of lifestyle changes, therapy/treatment options, and resources/support groups that may be beneficial to themselves and their family.	A	06/15 CL			* Age Guidelines: 41-65 (MID ADULT) PROTOCOL: AGE 41-66	06/15 CL		06/15 0824	VIEW PROTOCOL/DT QS	A
DS PROBLEM: Post Op Care Potential for complications related to surgery/procedure. Alteration in comfort related to surgery or procedure.	A	06/15 CL								
* Risk of complications will be minimized and/or identified in a timely manner.	A	06/15 CL			* Post Op Assessment: Perform +	06/15 CL				A
* Patient states they are free from pain or pain controlled and tolerable: comfortable facial expression.	A	06/15 CL			* Pain: OPS Management of +	06/15 CL		06/15 0824	PRN	A
STANDARD OF PRACTICE DS/GI/PM/YAG STANDARD OF CARE - CVMC 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 inter-disciplinary 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 of individual learning needs. 3. The patient will participate in	A	06/15 CL								

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
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 and others. 5. The patient will be supported in his/her effort to retain personal identity, self worth, privacy and autonomy.										
* Patient will receive standardized care as per unit specific standards	A	06/15 CL			* VS: Monitor +	06/15 CL		06/15 0824	PER UNIT POLICY	A
					* Notify: MD +	06/15 CL		06/15 0824	WHEN NECESSARY	A
					* Education, Patient/Family Teaching +	06/15 CL		06/15 0824	PRN	A
					* IV/Invasive Lines, Insert/Remove +	06/15 CL		06/15 0824	INS/REMOVAL/CONVERT	A
					* Day Surgery: Discharge +	06/15 CL		06/15 0824	ON DISCHARGE	A
* PRACTICE GUIDELINES ** DO NOT EDIT OR ALTER THIS STATEMENT** ***ROUTINE CARE/PRACTICE GUIDELINES*** FOR DAY SURGERY/PAIN CLINIC UNLESS OTHERWISE DOCUMENTED, THE FOLLOWING ASSESSMENTS AND INTERVENTIONS HAVE BEEN VERIFIED: Safety 1. Verify armband with name, date of birth, medical record number, medication allergies on patient. 2. Evaluate for Risk of Fall on Admission. Patients determined to be at greater risk for falls will be placed in cubicles that are within sight of the nurses' station and have "fall potential" armband. 3. Initiate safety measures as indicated: *side rails up x 2 *bed in lowest position *bed or chair wheels locked *call bell within reach or patient within direct view of nursing staff at all times *essentials within reach *patient/family instructed to call for nurse 4. Perform safety rounds at least q 2 hrs 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, side rails, safety issues, visiting policy and smoking policy on admission and prn.	A	06/15 CL			* Routine Care: DS/PAIN CL VIEW PROTOCOL - PROTOCOL: S:DS	06/15 CL		06/15 0824	END OF SHIFT/TX LIC	A

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS
8.Monitor equipment in use q 12 hrs and prn.									
9.Patient acknowledges giving informed consent by signing consent form prior to procedure, or physician informed that patient needs more information prior to signing consent.									
10. Pre-op/procedure test results reviewed prior to surgery/procedure and abnormals reported to physician.									
PSYCHOSOCIAL:									
1. Provide privacy for patient, family, significant other(s).									
2. Identify patient support system, and involve appropriately in the 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.									
5. Discuss expected outcomes and realistic expectations with patient/family/significant other(s).									
NUTRITION:									
1. Monitor PO intake.									
2. Diet as ordered. Patient will be able to tolerate PO fluids prior to discharge.									
3. Assist with eating/feeding if needed.									
ACTIVITY:									
1. Activity performed per activity guidelines or as ordered.									
*advise patient to call for assist the first time OOB.									
*monitor how patient tolerates activity.									
*determine the need for and monitor use of assistive devices.									
2. If the patient is unable to reposition him/herself, he/she will be turned or assisted with repositioning q 2 hrs and prn, maintaining body alignment.									
SKIN INTEGRITY:									
1. Evaluate skin condition on admission and document.									
2. Keep skin clean and dry.									
3. Prevent/eliminate pressure, friction, and sheering forces on skin.									
4. Keep linen clean, dry, and									

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS
wrinkle free 5. If incontinent *cleanse perineal/perianal area after each episode *change bed linen prn to keep patient dry *offer toileting q 2 hrs and prn IF IV/SLAINE LOCK PRESENT: 1. Assess site(s) on return from procedure, prior to discharge, and q 4 hrs if the patient stays overnight, and prn, for redness, swelling, and/or pain 2. Verify solution and monitor ordered rate of infusion q 1 hr and prn PAIN: 1. Pain assessment performed on admission, immediately after surgery or procedure, and prior to discharge, with appropriate interventions: *Assess location, type, duration, and frequency of pain *Assess intensity of pain using an appropriate tool. If the patient stays overnight, assess pain each time the VS are taken and prn 2. If IV opoids administered: *verify drug and dose to be given *dilute and administer per protocol *monitor pain relief, sedation level and respiratory rate/quality per policy RESPIRATORY: 1. Monitor pulse oximetry prn as appropriate, or as ordered 2. If postoperative: *turn, cough, and deep breathe q 2 hrs x8, then q 4 hrs and prn *incentive spirometry as ordered 3. If tracheostomy present: *verify trach ties are secure *suction prn *maintain dry and intact dressing *establish means of communication POSTOPERATIVE OBSERVATION: 1. Postoperative/Post Procedure assessment on arrival to unit to include: *VS and level of sedation *presence of pain and comfort measures required *appropriate charting on postop care or post procedure assessment and intervention INCISIONS/DRESSINGS: 1. If incision present, monitor site									

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS
for bleeding/drainage on return to unit, at time of discharge, and prn 2. If dressing present *check on return to unit, at time of discharge, q 8 hrs, and prn *patient instructed to keep dressing dry and intact until follow-up visit to physician unless instructed otherwise by physician 3. If GYN patient, monitor vaginal bleeding on return to unit, q 4 hrs, at discharge, and prn. *If vaginal packing present, remove only per order TUBES/DRAINS 1. If drainage tube(s) present (JP, hemovac, T-tube, etc) *verify patency *empty and measure contents prior to discharge *patients going home with tubes will be taught how to empty and record output 2. If foley present: *verify patency *keep bag below level of bladder at all times *if patient is going home with foley, teach how to empty the drainage bag and switch betwen bedside bag and leg bag IF ORTHOPEDIC PATIENT 1. Maintain weight bearing status as ordered 2. Use immobilizers, braces, or collars as ordered 3. Monitor circulation, sensation, motor response of affected extremity on return to unit, q 8 hrs, on discharge, and prn 4. Apply ice pack to surgical site if ordered									
* WITHIN DEFINED PARAMETERS NEUROLOGICAL parameters: Alert and oriented to person, place, and time Follows commands Balance and gait steady No visual disturbances No numbness Equal extremity strength No paralysis EENT Parameters No discharge, redness, pain, edema, blurred or distorted vision with or without glasses/contacts noted or complained about Able to hear common sounds with	A	06/15 CL							

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS
or without hearing aides (no hearing impairment), no discharge from ears, no ear pain - No nasal complaints/abnormal assessment noted such as bleeding from nares (watery, purulent, mucoid), tenderness, stuffiness, congestion, or difficulty breathing through nares - No throat complaints/abnorma assessment noted such as sore, red, swollen throat, hypertrophied tonsils, exudate on tonsils, postnasal drip or hoarsness - No mouth complaints/abnormal assessment noted such as bleeding, cracking, dryness, inflamation, redness, swelling, or ulceration of membranes. No cleft lip/palate abnormalities. RESPIRATORY Parameters - No abnormal breath sounds - Respirations regular, unlabored - No cough CARDIAC Parameters - No chest pain - Heart rhythm regular CIRCULATORY Parameters - Capillary refill less than 3 seconds - Temperature of extremities warm - No tingling or numbness in extremities - Color of extremities normal for patient - Pedial/dorsalis pedis pulses equally palpable MUSCULOSKELETAL Parameters - No muscle weakness - Full range of motion of extremities - No skeletal deformities - No amputations - No contractures GASTROINTESTINAL Parameters - Active bowel sounds - Abdomen not distended - Abdomen nontender to palpation - Continent of stool GENITOURINARY Parameters - No urinary drainage system - Not on dialysis - Continent of urine - Bladder nondistended - No complaints of frequency, urgency, burning, dysuria								

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS
INTEGUMENTARY Parameters: - Skin warm and dry - Skin normal color for patient - Mucous membranes moist PSYCHOSOCIAL Parameters - No mood swings noted. Patient's mood appropriate for situation with regard to cultural influences. - Effective coping skills/patterns with regard to cultural influences. (Ineffective coping can be presented as post traumatic response, abusive behavior to self, threats of self harm, suicidal thoughts, or violent behavior.) - Adequate support system. - 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 of healing - No fears or anxiety related to hospitalization								

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME DIRECTIONS	STS	SRC
* ADM DAY SURGERY: ADULT Procedure +	06/14 KW		06/14 0738 ON ADMISSION	A	AS
* ADMISSION/TRANSFER: Quick Start Form +	06/15 CL		06/15 0824 ON ADMISSION/TRANS	A	AS
* Inventory Personal Belongings + ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.	06/15 CL		06/15 0824 ADM.TX.DC	A	AS

Monogram	Initials	Name	Nurse Type
CL	NURLC	Luetum,Chusri	RN
KW	NURWK	Wagner,Kathleen	RN

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 [illegible]ny hospital-based physician of any insurance or health plan benefits otherwise payable to or on [illegible]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 [illegible]physician of referral at time of discharge.

[illegible]sician Name/Address Dr. Chah

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 [illegible]vices (including, without limitation, hospital or medical service companies, insurance companies, [illegible]kers' 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, mediations, treatments, tests, oxygen, x-rays and physical therapy are some examples of such services. **Physician [illegible]arges are billed separately.** In addition to receiving bills for services rendered by the hospital and [illegible]r personal physician, **you will receive separate bills from hospital-based physicians who [illegible]rticipate 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 ✓No

[illegible]NDITIONS OF [illegible]MISSION

PAGE 1 OF 2

070-011

PHSI-070-011 (3/07)

WHITE - CHART YELLOW - PATIENT PINK - BUSINESS OFFICE

PATIENT I.D.

HANNA, ADEL SDC
Acct# V000000242043 M/61
DOB: 03/29/46
DOS: 06/15/07
Shah, Umesh C. M000273781

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, inclu 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 a personal property which is deposited with the hospital for safekeeping is limited for loss of any perso property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars ($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. The hospital/physician will retain ownership rights to the photographs as well as to the medical reco 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 responsibil of the patient's physician or surgeon to obtain the patient's informed consent, when required, to med or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendere the patient under the general and special instructions of the physician.

6. EMERGENCY OF 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.

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 of 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 company or health plan of any and all obligations under a policy to the extent of such payment. It is underst by the undersigned that he/she is financially responsible for allowed charges not paid pursuant to 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 URY OR COURT TRIAL. IF YOU DO NOT AGREE TO ARBITRATION, PLEASE INITIAL ~~AH~~

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.

6/15/07 — Date/Time
Blue Cross / Adel Hanna — Financially Responsible Party
Witness

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

Adel S. Hanna, M.D
(name of patient / person legally authorized to give consent)

[redacted]he 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.
HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF SERVICE, WHICH BECOME EFFECTIVE AT THE TIME SERVICE IS RENDERED.

Hanna MD
PATIENT / PARENT / CONSERVATOR / GUARDIAN

POLICY HOLDER OR FINANCIALLY RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

WITNESS

SIGNATURE OF TRANSLATOR

DATE OF SIGNING

TIME OF SIGNING

Patient unable to sign: _____
(Reason)

CONDITIONS OF ADMISSION

PAGE 2 OF 2

070-011

PHSI-070-011 (3/07)

WHITE - CHART **YELLOW** - PATIENT **PINK** - BUSINESS OFFICE

PATIENT I.D.

HANNA, ADEL
Acct# V00000242043
DOB:03/29/46
DOS:06/15/07
Shah, Umesh C.

SDC
M/61
M000273781

CONDITIONS OF ADMISSION

14. FINANCIAL AGREEMENT: Not withstanding section (6), (Emergency or Laboring Patient) 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 with three (3) months for 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) Worker's 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 assigns 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 assigns.

To: Adel Hanna (Name of Patient)

5. Your signature on this form indicates (1) that you have read and understand the information provided in this form, (2) that the operation or procedure set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure and (5) that you authorize and consent to the performance of the operation or procedure.

6. Your attending physician is Dr. Chandrahas Agarwal and your supervising physician or surgeon is Dr. Umesh Shah.

Procedure: Esophagogastroduodenoscopy-Passage of tube through mouth into stomach for purpose of visual inspection of mouth, esophagus, stomach, and upper portion of small bowel, with possible biopsy, polypectomy and cauterization and possible schlerotherapy. Possible Dilation. ☐ Possible Esophageal Variceal Banding

Signature: X Hanna MD Date: 6/15/07 Time: 8:30 am

If signed by other than patient, indicate relationship: (Surrogate decision maker can be family member or someone designated in writing, i.e., power of attorney, court order, etc.)

Witness: C Hunter M Date: 6/15/07 Time: 08-30

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710
INFORMED CONSENT BY PATIENT OR SURROGATE DECISION MAKER ESOP / POSSIBLE DILATION
WHITE - CHART YELLOW - PATIENT
004850 600.007 (12/04)

ADDRESSOGRAPH

Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES THIS MUST BE ACCOMPANIED BY "INFORMED CONSENT BY PHYSICIAN"

Do not complete this form if patient lacks capacity to give consent and no surrogate decision maker is available.

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 procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unknown 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. 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. Your physicians and surgeons have recommended the operations or procedures set forth below.

   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 supervising physician or surgeon named below (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 anesthesiologist, pathologists and radiologists from the medical staff of CHINO VALLEY MEDICAL CENTER to whom the supervising physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as the anesthesiologist, radiologist or pathologist 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.

3. By your signature below you authorize the pathologist to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operation or procedure set forth below.

4. 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 questions you are encouraged and expected to ask them.

To: Adel Hanna (Name of Patient)

5. Your signature on this form indicates (1) that you have read and understand the information provided in this form, (2) that the operation or procedure set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation or procedure and (5) that you authorize and consent to the performance of the operation or procedure.

6. Your attending physician is Dr. Chandrahas Agarwal and your supervising physician or surgeon is Dr. Umesh Shah.

Procedure: Colonoscopy - Viewing of the colon by insertion of a tubular instrument. With possible biopsy, possible polypectomy and possible cauterization.

☐ Possible Hemorroidal Banding

Signature: X [signature] MD Date: 6/15/07 Time: 08:30 am

If signed by other than patient, indicate relationship: (Surrogate decision maker can be family member or someone designated in writing, i.e., power of attorney, court order, etc.)

Witness: [signature] Date: 6/15/07 Time: 08:30 pm

[illegible] VALLEY MEDICAL CENTER

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

INFORMED CONSENT BY PATIENT OR SURROGATE DECISION MAKER COLONOSCOPY

WHITE - CHART YELLOW - PATIENT

000067 600.001 (2/05)

ADDRESSOGRAPH

[illegible] 61 /M
[illegible] DOB 03/[illegible]/46
[illegible] DOS 06/15/07

[illegible] DR. SHAH, UMESH C.
[illegible] DR. AGARWAL, CHANDRAHAS

Chino Valley Medical Center

5451 WALNUT AVENUE, CHINO, CA 91710

AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL DIAGNOSTIC OR THERAPEUTIC PROCEDURES THIS MUST BE ACCOMPANIED BY "INFORMED CONSENT BY PHYSICIAN"

Do not complete this form if patient lacks capacity to give consent and no surrogate decision maker is available.

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 procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unknown 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. 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. Your physicians and surgeons have recommended the operations or procedures set forth below.

   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 supervising physician or surgeon named below (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 anesthesiologist, pathologists and radiologists from the medical staff of CHINO VALLEY MEDICAL CENTER to whom the supervising physician or surgeon may assign designated responsibilities. The person in attendance for the purpose of performing specialized medical services such as the anesthesiologist, radiologist or pathologist 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.

3. By your signature below you authorize the pathologist to use his or her discretion in disposing of any member, organ, or other tissue removed from your person during the operation or procedure set forth below.

4. 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 questions you are encouraged and expected to ask them.

Name/Description of Procedure: EGD + Colonoscopy + Biopsy + Polypectomy

(See reverse side of form for additional instructions and definitions)

Section I to be completed by treating physician

PART I: Complete this section if consent is being given by the patient or a surrogate decision maker.

I, the treating physician, have provided the nature of the above stated procedure in laymen's terms, including the following potential risks, complications, potential/expected benefits, and alternative treatments: _____

I have provided this information to:

☑ Patient (or)

☐ Surrogate Decision Maker: A surrogate decision maker was informed because the patient does not have the capacity at this time to make informed decisions regarding his/her health care for the following reasons (check all that apply):

- ☐ Altered Level of Consciousness
- ☐ Minor not meeting criteria to give consent
- ☐ Other: _____

Name of Surrogate Decision Maker: _____ Relationship: _____

☐ Interpreter Used; Name: _____

☐ See progress notes for additional discussion in this matter.

PART II:

To be completed by treating physician if patient lacks capacity and no surrogate decision maker is available.

I, the treating physician, certify that the patient lacks capacity to give consent and would likely do so if able. Further, there is no surrogate decison-maker available to provide consent in the patient's behalf in spite of diligent efforts to identify and/or contact said person.

The patient has been assessed and has been determined to lack capacity to give consent at this time for the following reasons (check all that apply):

- ☐ Altered Level of Consciousness
- ☐ Minor not meeting criteria to give consent
- ☐ Other: _____

It is necessary to proceed without consent because the recommended procedure is medically emergent and delay in providing this procedure could result in any or all of the following (check all that apply):

☐ Death ☐ Significant/Serious loss of function ☐ Unrelieved, serious pain

☐ See progress notes for additional discussion in this matter.

Physician Signature: _____ Date: 6-15-07

Chino Valley Medical Center

5451 WALNUT AVENUE • CHINO, CALIFORNIA 91710

INFORMED CONSENT BY PHYSICIAN

000069 840.001 (2/05)

ADDRESSOGRAPH

Instructions for completing "Informed Consent by Physician"

1) This form is to be completed by the treating physician

2) This form is to be accompanied by "Informed Consent by Patient/Surrogate Decision-Maker" or similar form relative to a specialized procedure, such as Hysterectomy, Sterilization, Blood Transfusion, etc., unless the patient lacks capacity to give consent and there is no available surrogate decision-maker.

3) Cross out all unused sections-do not leave any section blank.

4) Section I: to be completed if the patient or a surrogate decision maker is able to give consent.

5) Section II to be completed only if patient lacks capacity to give consent and there is no available decision-maker.

6) Definitions:

   a) Adult patient with capacity to consent: patient is 18 years old and can understand the risks and benefits of the procedure that is being offered; an adult with "capacity" *can include mentally ill adults and developmentally disabled (mentally retarded) adults* as long as the physician feels the patient can understand what is being offered.

   b) Minor patient (17 or under) with capacity to consent; patient is one of following:

      - Legally emancipated (15 or older, emancipated via court order or is a self-sufficient minor living on own).
      - On active military duty
      - Receiving pregnancy-related care
      - Being treated for a reportable disease (12 or older)
      - Being treated relative to a rape or sexual assault (12 or older for rape)
      - Being treated for a mental health problem (12 or older)
      - Being treated for a drug/ETOH problem (12 or older)
      - Married
      - Making a blood donation, (17 or older)

   c) Surrogate Decision-Maker can be any one of the following:

      - A family member (or friend if there is no known family) who appears to be acting according to the patient's wishes and best interests
      - An adult designated in writing, such as a Power of Attorney for Healthcare, court order, etc. (Supporting documents need to be on medical record).

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

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

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

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

Hanna MD
Signature of Patient / Patient's Representative

6/15/07
Date / Time

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 (4/07)

Patient I.D.

HANNA, ADEL
Acct# V00000242043
DOB:03/29/46
DOS:06/15/07
Shah, Umesh C.
M/61
SDC
M000273781

Chino Valley Medical Center | 5451 Walnut Avenue, Chino, CA 91710-2672 | Printed 11/19/08 1938

Patient	Med. Rec/Unit #	Service/Location	Status	Date	Account/Transcription #
HANNA,ADEL S	M000273781	EMERGENCY DEPART	REG ER	11/19/08	V00000305742

PATIENT — AD VIP Conf

Soc Sec No: 548-67-8932 | DOB: 03/29/46 | Age: 62 | Sex: M | MS: M | Religion: CH | FC: 09
Race: OT | Ethnicity: NON-HISPAN | Maiden/Other Name: HANNA,ADEL | Reimb Class: FFS

Address: 13678 MONTEVERDE DRIVE
CHINO HILLS,CA 91709
Home Ph: (909)342-9908 | County: SAN BERNARDINO

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

GUARANTOR
HANNA,ADEL S | SS#: 548-67-8932
Address: 13678 MONTEVERDE DRIVE
CHINO HILLS,CA 91709
Home Ph: (909)342-9908 | County: SAN BERNARDINO
Relationship to Patient: SELF / SAME AS PATIENT

GUARANTOR EMPLOYER
CALIFORNIA INSTITUTE FOR MEN
14901 S CENTRAL AVE
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,IRMA
13678 MONTEVERDE DRIVE
CHINO HILLS,CA 91709
Home Ph: (909)342-9908 | Work Ph:
Relationship to Patient: WIFE

NEXT OF KIN
HANNA,TAMER
13678 MONTEVERDE DRIVE
CHINO HILLS,CA 91709
Home Ph: (909)342-9908 | Work Ph: (949)413-8670 CELL
Relationship to Patient: SON

INSURANCE #1
BLUE CROSS PRUDENT BUYER
PO BOX 60007
LOS ANGELES CA 90060
Phone: (877)737-7776

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	11/17/08	1700

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: Kachhi, Pranav
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
11/19/08	1856	HOM	EM		CAR	SHORTNESS OF BREATH,GENERALIZED WEAKNESS,NOT URINA	ADOM

FOR HIM USE ONLY** ASSEMBLE_____ANALYZE_____CODE_____PERM_____DOS_____

ACCOUNT #:	V00000305742
PATIENT:	HANNA, ADEL S.
DATE OF ADMISSION:	11/19/2008
DATE OF DISCHARGE:	11/21/2008

cc:

DISCHARGE DIAGNOSES:
Intractable acute abdominal pain.
Acute small bowel obstruction.
Intractable acute nausea, vomiting, and diarrhea.
Dehydration.
Migraine.
Depression.
Possible acute/chronic systolic/diastolic heart failure.

ADMISSION DIAGNOSES:
Acute small bowel obstruction.
Intractable acute abdominal pain.
Intractable acute nausea, vomiting, and diarrhea.
Dehydration.
Migraine.
Depression.
Possible acute/chronic systolic/diastolic heart failure.
Diverticulosis.

CAUSE FOR ADMISSION:
The patient is a 62-year-old male with past medical history of migraine, depression, and cholecystectomy who was brought in by wife with history of two days of abdominal pain, which is 5/10, cramping, diffuse, and continuous pain with chill, fever, dizziness, diarrhea, and also with generalized body aches. The patient states that he was unable to tolerate food or drinking for two days and no urination for two days. Also, the patient took Tylenol for fever, which helped a little bit. The patient denies chest pain, shortness of breath, or any other complaints.

HISTORY: As dictated.

PHYSICAL: As dictated.

LABS AND STUDIES: As charted.

PROCEDURES:
EKG showed normal sinus rhythm. CT of the abdomen showed findings consistent with small bowel obstruction with transition point in the right mid abdomen status post cholecystectomy.

Normal appendix was identified. X-ray of the pelvis fluid overload noted and scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis. Chest x-ray showed bibasilar discoid atelectasis. KUB showed nasogastric tube in place as described and recommending advanced G-tube placement for findings suggestive for distal small bowel obstruction. Repeat KUB showed slight improvement in the distal small bowel obstruction, feeding tube was within the distal stomach and duodenum. Another repeat KUB showed slight decease in small bowel ileus pattern. Repeat CT of the abdomen without contrast on 11/21/2008 showed nasogastric tube terminated in the ascending duodenum, no pattern of small bowel obstruction, and lack of distention versus thickening of the wall of the sigmoid colon with marked adjacent inflammatory change. IV fluid was running at 100 mL/hour of normal saline.

CONSULTANTS:
Anthony S. Oh, M.D., surgeon.
Mukesh S. Amin, M.D., internist.

HOSPITAL COURSE:
The patient is a 62-year-old male with migraine, depression, and cholecystectomy who came in complaining of diffuse and cramping abdominal pain x2 days with chills, fever, dizziness, and diarrhea. The patient was admitted to medical/surgical with NG tube placement in the ER with intermittent loss of low suction. The patient was put on NPO and IV fluid 100 mL/hour of normal saline with Zofran 4 mg IV q.4h. p.r.n. nausea and vomiting, morphine 2 mg IV q.4h. p.r.n. pain, Ativan 1 mg IV q.4h. p.r.n. anxiety, Protonix 40 mg IV daily for GERD, Ambien 5 mg p.o. at bedtime, Toradol 30 mg IV q.6h. p.r.n. pain, ampicillin 1 g q.8h. for possible sepsis, atenolol 50 mg p.o. at bedtime for migraine prophylaxis was continued, and Benadryl. Dr. Oh was consulted for small bowel obstruction and he recommended NPO, NG tube suction out-of-bed, and DVT prophylaxis. The patient tolerated full liquid diet starting on the discharge date and per Dr. Oh, the patient was okay to be discharged. The patient was also increased Ativan 2 mg IV q.4h. p.r.n. agitation, K-Phos 2 mEq in two liter of normal saline was given for low phosphate, Gaviscon 15 mL p.o. q.i.d. was given p.r.n. for digestion, and Cepacol was given p.o. q.4h. p.r.n. for sore throat. The patient was given incentive spirometer for bibasilar discoid atelectasis, out-of-bed, and decreased IV fluid to 90 mL/hour of normal saline because the patient's BUN and creatinine was improving with less dehydration. Also, sodium phosphate rider was given 40 mEq in 250 mL per normal saline due to the patient's low phosphate. NG tube was removed on 11/21/2008 at 1000 hours, which the patient tolerated well. A repeat CT showed no apparent small bowel obstruction. Upon discharge, the patient's vitals were temperature 98.6 degrees, heart rate 62, respirations 20, blood pressure 137/91, and saturation 96% on room air with no pain. At this point, the patient has no nausea, vomiting, and tolerating full liquid diet without any complication. The patient was agreeable to be discharged. The

patient got better with hospital course. There was no chest pain, abdominal pain, or headache upon discharge and the patient's hydration resolved too.

DISPOSITION:
The patient and family were made well aware of all diagnoses and procedures during their stay. The patient was discharged home by private auto.

DIET: Full liquid diet to regular diet as tolerated.

ACTIVITY: As tolerated.

MEDICATIONS: Atenolol 50 mg p.o. at bedtime for migraine prophylaxis, Lexapro 15 mg p.o. daily for depression, Zomig 2.5 mg p.o. p.r.n. for migraine, and Tylenol 500 mg p.o. b.i.d. for p.r.n. fever.

FOLLOW-UP:
The patient is to follow with Dr. Oh, surgeon on 11/26/2008, also with Dr. Agarwal, his cardiologist, and also with Dr. Shah, the patient's GI doctor for CT result of thickening of sigmoid wall. Due to the patient's comorbid medical condition including SBO, intractable acute abdominal pain, dehydration, migraine, depression, possible acute/chronic systolic/diastolic heart failure, CT result of lack of distention versus thickening to the wall of the sigmoid colon, and diverticulosis, the patient may return to our facility sooner than expected.

POINT OF CONTACT: The patient's point of contact is sister Amon Hanna at #909-374-7216.

Yoonjung Jang, RES D.O.

Daljinder Takhar, D.O.

DR: YJ/SSP
DD: 11/21/2008 21:03
DT: 11/22/2008 06:37
Job #: 059713730

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) 464-8600
Robert M. Bearman, M.D., Medical Director

CO0314

DISCHARGE SUMMARY REPORT

PATIENT: HANNA,ADEL,S ACCT#: V00000305742 LOC: MU U.#: M000273781
AGE/SX: 62/M ROOM: 228 REG: 11/19/08
REG DR: Lally, James M. DOB: 03/29/46 BED: B DIS: 11/21/08
STATUS: DIS IN TLOC:

Microbiology Specimen Summary

Col Date	Time	Specimen #	Source	Sp Desc	P/F	Organisms
> 11/20/08	0900	08:M0011131R	URINE	VOID	P	<none>
> 11/19/08	2011	08:M0011116R	NARES	COMMENT	F	<none>

Source: URINE

URINE CULTURE (*a) Preliminary

Procedure	Result
URINE CULTURE RESULT	No growth overnight

MRSA CULTURE (*a) Final 11/21/08

Procedure	Result
MRSA CULTURE RESULTS	No MRSA Isolated

NOTES: (*a) Desert Valley Hospital 16850 Bear Valley Road, Victorville, CA 92392
Pathologist: Robert M. Bearman, M.D.

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CO0314

DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

**** HEMATOLOGY ****

	Day 3	Day 2	Day 1						
	Date 11/21/08	Date 11/20/08	Date 11/19/08						
	Time 0515	Time 0525	Time 1920					Reference	Units
WBC	3.4 L	3.0 L	4.5					(4.5-11.0)	K/mm3
RBC	4.53	4.60	5.51					(4.52-5.90)	M/mm3
HGB	12.8 L	12.9 BL	15.6					(13.0-18.0)	g/dL
HCT	38 L	39 L	46					(42-52)	%
MCV	84	84	83					(80-99)	fl
MCH	28	28	28					(27-31)	pg
MCHC	34	34	34					(32-37)	pg
RDW	14.5	14.7 H	14.3					(11.5-14.5)	%
PLT	141	142	177					(130-400)	X10^3m
MPV	9.9	10.4	10.0					(7.4-10.4)	fl
NEUT %	53.1	42.5	55.3					(40-70)	%
LYMPH %	30.8	37.7	31.5					(25-45)	%
MONO %	8.2	10.9 H	8.7					(2.5-10.0)	%
EOS %	7.9	8.6	3.8					(0.0-11.0)	%
BASO %	0	0.3	0.7					(0-2)	%
NE#	1.8	1.3 L	2.5					(1.8-7.7)	10^3/u
LY #	1.0	1.1	1.4					(1.0-4.8)	10^3/u
MO #	0.3	0.3	0.4					(0-0.8)	10^3/u
EO#	0.3	0.3	0.2					(0-0.5)	10^3/u
BA#	0.0	0.0	0.0					(0-0.2)	10^3/u
MANUAL DIFF REQ	NO	NO	NO						
TEST COMPLETE?		YES							

**** COAGULATION ****

	Day 1								
	Date 11/19/08								
	Time 1920							Reference	Units
PROTIME	12.1							(10.1-12.8)	sec
INR	1.13							(0-3.0)	
PTT	29.0							(21.7-33.9)	sec

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DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

****** CHEMISTRY ******

Day	3	3	3	2	2	2	1		
Date	11/21/08	11/21/08	11/21/08	11/20/08	11/20/08	11/20/08	11/19/08		
Time	0515	0515	1920	0525	0525	1920	1920	Reference	Units
NA		137			137		136	(135-148)	mmol/L
K		4.1			3.4 L		3.6	(3.5-5.1)	mmol/L
CL		106			106		102	(98-108)	mmol/L
CO2		24.9			24.9		25.4	(21-34)	mmol/L
GLUCOSE		70 L			88		104	(71-117)	mg/dL
BUN		11.0			21.0 H		22.0 H	(7.0-18.0)	mg/dL
CREAT		0.8(b)			0.9(b)		(c)	(0.5-1.4)	mg/dL
GFR NON AFR-AME		(d)			(f)		(g)		ml/min

NOTES: (b) GFR estimate is calculated using the Modification of Diet Renal Disease (MDRD) Equation. The National Kidney Disease Education Program notes that performance of the MDRD Equation has not been tested in children, adults below 18 years of age and over 70 years of age, pregnant women, some patients with extremes of body size, muscle mass or nutritional status. Application of the equation to these patient groups may lead to errors in GFR estimate.

(c) 0.94
See also (b)

(d) > 60
See also (e)

(e) INTERPRETATIVE DATA:
Normal: Greater than or equal to 60 ml/min/1.73 sq. meters
Abnormal: Less than 60 ml/mim/1.73 sq. meters

ALL NORMAL RESULTS WILL BE REPORTED AS >60 INSTEAD OF THE ACTUAL CALCULATED NUMERIC VALUE. ALL ABNORMAL RESULTS WILL BE REPORTED AS THE ACTUAL NUMERIC VALUE

(f) > 60
See also (e)

(g) > 60
See also (e)

CHINO VALLEY MEDICAL CENTER
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DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

CHEMISTRY (continued)

Day	3		2			1			
Date	11/21/08		11/20/08			11/19/08			
Time	0515	0515	1920	0525	0525	1920	1920	Reference	Units
GFR AFRI-AMERI		(h)			(j)		(k)		ml/min
TOTAL PROT							7.5	(6.3-8.2)	g/dL
ALB							3.7	(3.4-5.0)	g/dL
CA		7.9 L			7.6 L		8.4 L	(8.8-10.5)	mg/dL
PHOS	1.8 L		2.1 L	2.3 L				(2.5-4.9)	mg/dL
BILI TOTAL							0.54	(0.2-1.1)	mg/dL
BILI DIR							0.16	(0.0-0.5)	mg/dL
AST/SGOT							13 L	(15-37)	U/L
ALT/SGPT							33	(30-65)	U/L
ALK PHOS							42 L	(50-136)	U/L
CK							38	(21-232)	U/L
LDH							110	(100-190)	U/L
AMYLASE							28	(25-115)	U/L
LIPASE							180	(114-286)	U/L
MAGNESIUM			2.3					(1.8-2.4)	mg/dL
TRIG			118					(30-200)	mg/dL
CHOL			110 L				110 L	(135-200)	mg/dL
HDL			37				36	(32-96)	mg/dL
LDL,DIRECT			60(l)					(20-130)	mg/dL

NOTES: (h) > 60
See also (i)

(i) INTERPRETATIVE DATA:
Normal: Greater than or equal to 60 ml/min/1.73 sq. meters
Abnormal: Less than 60 ml/mim/1.73 sq. meters

ALL NORMAL RESULTS WILL BE REPORTED AS >60 INSTEAD OF THE ACTUAL CALCULATED NUMERIC VALUE. ALL ABNORMAL RESULTS WILL BE REPORTED AS THE ACTUAL NUMERIC VALUE

STAGES OF CHRONIC KIDNEY DISEASE

STAGE	GFR	DESCRIPTION
1	90+	Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease
2	60-89	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease
3	30-59	Moderately reduced kidney function
4	15-29	Severely reduced kidney function
5	<15	Very severe, or endstage kidney failure

(j) > 60
See also (i)

(k) > 60
See also (i)

(l) Concentration (mg/dL) ATP III Guidelines

<100	Desirable
100-129	Near or Above Desirable
130-159	Borderline High
160-189	High
>189	Very High

Reference: JAMA 2001:285,2486-97;Circulation 7/13/2004

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Robert M. Bearman, M.D., Medical Director

CO0314

DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

**** URINE CHEMISTRY ****

	Day	Date	Time	Reference	Units
	2	11/20/08	0900		
NA UR	62			(20-110)	mmol/L

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DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

CHEMISTRY (continued)

Day	3		2			1			
Date	11/21/08		11/20/08			11/19/08			
Time	0515	0515	1920	0525	0525	1920	1920	Reference	Units
VLDL			18.88						mg/dL
CHOL/HDL RISK			3.0(m)					(0.0-5.5)	
CKMB			3.0				1.2(n)	(0-5.0)	ng/mL
CKMBI							(o)	(0-2.5)	%
MYOGLOBIN							37.0	(12-110)	ng/mL
TROPONIN I						0.06		(<1.4)	ng/mL

NOTES: (m)

ESTIMATED CORONARY RISK INTERPRETATION

Cholesterol (mg/dl)		HDL Chol (mg/dL)	Risk Factor (Chol/HDL)	Risk Assess
<200 Desireable level	MALES	>45	<5.0	Decreased
200-239 Borderline High		45	5.0	Average
>239 High Level		<45	>5.0	Increased
	FEMALES	>55	<4.4	Decreased
		55	4.4	Average
		<55	>4.4	Increased

(n) ******** 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.

(o) Test not performed
See also (p)

(p) NOTE: CK-MB is inconclusive if only the CK-MB or the CKMB INDEX is elevated, but not both.

CHINO VALLEY MEDICAL CENTER
5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) 464-8600
Robert M. Bearman, M.D., Medical Director

DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

**** URINE DRUG SCREEN ****

Day 2
Date 11/20/08
Time 0900

		Reference	Units
PCP UR	(q)	(NONE DETECT	
BENZODIAZEPINE	(r)	(NONE DETECT	
COCAINE UR	(s)	(NONE DETECT	
AMPHETAMINE	(t)	(NONE DETECT	
THC UR QUAL	(u)	(NONE DETECT	
OPIATES UR	(v)	(NONE DETECT	
BARBITURATE	(w)	(NONE DETECT	

NOTES:
(q) NONE DETECTED
(r) NONE DETECTED
(s) NONE DETECTED
(t) NONE DETECTED
(u) NONE DETECTED
(v) NONE DETECTED
(w) NONE DETECTED
See also (x)
(x) This Drug Screen method provides only a preliminary analytical test result. A more specific alternate chemical method must be used in order to obtain a confirmed analytical result. Gas chromatography/mass spectrometry (GS/MS) is the preferred confirmatory method. Other chemical confirmatory methods are available. Clinical consideration and professional judgement should be applied to any drug of abuse test result, particularly when preliminary results are used.

CHINO VALL EDICAL CENTER
5451 WALNUT AVE. CHINO, CALIFORNIA 91710 (909) 464-8600
Robert M. Bearman, M.D., Medical Director

CO0314

DISCHARGE SUMMARY REPORT

Patient	Age/Sex	Location	Account#	Attending Physician
HANNA,ADEL S	62/M	MU	V00000305742	Lally, James M.

****** URINALYSIS ******

Day	2								
Date	11/20/08								
Time	0900							Reference	Units
COLOR	(y)								
CLARITY	CLEAR							(CLEAR)	
SPEC GRAV	1.020							(1.005-1.035	
PH	5.0							(5.0 - 7.5)	
LEUK	NEG							(NEGATIVE)	
NITRITE	NEG							(NEGATIVE)	
PROTEIN	NEG							(NEGATIVE)	
GLUCOSE	NEG							(NEGATIVE)	
KETONES	2+ *							(NEGATIVE)	
URO	0.2								
BILIRUBIN	1+ *							(NEGATIVE)	
ICTO	POS *							(NEG)	
BLOOD	NEG							(NEGATIVE)	
COMMENT	(z)								

NOTES: (y) DARK YELLOW
(z) SEE ABOVE RESULT
MICROSCOPIC NOT INDICATED.

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/19/08 Time: 1910

Patient Notes: ED Nursing Notes
- Create 11/19/08 1910 SA 11/19/08 1926 SA
Abnormal? Confidential?
DR KACHHI AT BEDSIDE FOR EXAM. 12 LEAD EKG COMPLETED BY M. DIAZ, EMT. RESULT TO DR KACHHI.

Activity Date: 11/19/08 Time: 1916

975050 Inventory Personal Belongings + A ADM.TX.DC AS
ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.
Create 11/19/08 1916 MD 11/19/08 1919 MD
- Document 11/19/08 1916 MD 11/19/08 1919 MD
Inventory Date: 11/19/08 Inventory Time: 1916 Performed By: Diaz,Michael
Reason For Inventory: ADMISSION (ED STAFF)

-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: Describe:
Disposition: Disposition:

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:

-N Electrical Appliances Describe:
-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:

<< 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.

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/19/08 Time: 1916 (continued)

Activity Date: 11/19/08 Time: 1916 (continued)

PATIENT:_____ Date:_____
WITNESS:_____

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

PATIENT:_____ Date:_____
WITNESS:

Activity Date: 11/19/08 Time: 1920

Patient Notes: ED Nursing Notes
- Create 11/19/08 1920 SA 11/19/08 1926 SA
Abnormal? Confidential?
BLOOD DRAWN BY JOHN, PHLEBOTOMIST.

Activity Date: 11/19/08 Time: 1925

Patient Notes: ED Nursing Notes
- Create 11/19/08 1925 SA 11/19/08 1926 SA
Abnormal? Confidential?
PT TRANS TO CT VIA GUERNEY WITH JIM, CT TECH.

Activity Date: 11/19/08 Time: 1931

Patient Notes: ED Nursing Notes
- Create 11/19/08 1931 SA 11/19/08 1931 SA
Abnormal? Confidential?
RETURNED FROM CT, PCXR COMPLETED AT BEDSIDE BY XRT.

Activity Date: 11/19/08 Time: 1935

Patient Notes: ED Nursing Notes
- Create 11/19/08 1935 SA 11/19/08 1944 SA
Abnormal? Confidential?
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.

Activity Date: 11/19/08 Time: 1944

Patient Notes: ED Nursing Notes
- Create 11/19/08 1944 SA 11/19/08 1944 SA
Abnormal? Confidential?
MEDICATED WITH ZOFRAN & ATIVAN IVP BY D. LOPEZ, RN.

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 11/19/08 Time: 2005

Patient Notes: ED Nursing Notes
- Create 11/19/08 2005 SA 11/19/08 2013 SA
  Abnormal? Confidential?
  PT RE-EVAL'D BY DR KACHHI.

Activity Date: 11/19/08 Time: 2013

Patient Notes: ED Nursing Notes
- Create 11/19/08 2013 SA 11/19/08 2013 SA
  Abnormal? Confidential?
  PT REQUEST TO " MAKE PHONE CALLS BEFORE INSERTING NG TUBE". PT ALLOWED PRIVACY.

Activity Date: 11/19/08 Time: 2021

Patient Notes: ED Nursing Notes
- Create 11/19/08 2021 AS 11/19/08 2021 AS
  Abnormal? Confidential?
  PLEASE ENTER FULL NAMES OF LVN/RN

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

Activity Date: 11/19/08 Time: 2035

Patient Notes: ED Nursing Notes
- Create 11/19/08 2035 SA 11/19/08 2052 SA
  Abnormal? Confidential?
  MRSA PROTOCOL EXPLAINED TO PT & SPOUSE. NASAL SWAB OBTAINED PER PROTOCOL.
  SPECIMEN SENT TO LAB PER ORDERS.

Activity Date: 11/19/08 Time: 2040

Patient Notes: ED Nursing Notes
- Create 11/19/08 2040 SA 11/19/08 2046 SA
  Abnormal? Confidential?
  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.

Activity Date: 11/19/08 Time: 2050

Patient Notes: ED Nursing Notes
- Create 11/19/08 2050 SA 11/19/08 2051 SA
  Abnormal? Confidential?
  PT MEDICATED WITH ATIVAN IVP BY D. LOPEZ, RN

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 11/19/08 Time: 2059

Patient Notes: ED Nursing Notes
- Create 11/19/08 2059 SA 11/19/08 2059 SA
  Abnormal? Confidential?
  RESIDENT & MED STUDENT AT BEDSIDE FOR EXAM.
- Create 11/19/08 2059 SA 11/19/08 2059 SA
  Abnormal? Confidential?
  REPORT CALLED TO M/S. SPOKE WITH BEN, RN.

Activity Date: 11/19/08 Time: 2100

Patient Notes: ED Nursing Notes
- Create 11/19/08 2100 SA 11/19/08 2109 SA
  Abnormal? Confidential?
  MEDICATED WITH UNASYN IVPB BY J. DEL VALLE, RN.

Activity Date: 11/19/08 Time: 2120

Patient Notes: ED Nursing Notes
- Create 11/19/08 2120 SA 11/19/08 2136 SA
  Abnormal? Confidential?
  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.

Activity Date: 11/19/08 Time: 2136

Patient Notes: ED Nursing Notes
- Create 11/19/08 2136 SA 11/19/08 2136 SA
  Abnormal? Confidential?
  LINDA, XRT AT BEDSIDE FOR PKUB FOR TUBE PLACEMENT.

Activity Date: 11/19/08 Time: 2138

Patient Notes: ED Nursing Notes
- Create 11/19/08 2138 SA 11/19/08 2143 SA
  Abnormal? Confidential?
  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

Activity Date: 11/19/08 Time: 2200

Patient Notes: Nurse Notes
- Create 11/19/08 2200 BT 11/19/08 2352 BT
  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 [illegible]HEA.N/V LAST NOC."CANNOT HOLD ANYTHING IN".LAST EPISODE

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/19/08 Time: 2200 (continued)

Patient Notes: Nurse Notes (continued)
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.

Activity Date: 11/19/08 Time: 2202

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
Create 11/19/08 2202 BT 11/19/08 2203 BT
- Document 11/19/08 2202 BT 11/19/08 2203 BT
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62

Activity Date: 11/19/08 Time: 2203

1001 Agency Documentation + A WHEN APPLICABLE CP
ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.
Create 11/19/08 2203 BT 11/19/08 2203 BT
1005-H ADM: ADULT Admission History + A ON ADMISSION AS
Create 11/19/08 2203 BT 11/19/08 2219 BT
- Document 11/19/08 2203 BT 11/19/08 2219 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: NKDA

== PAIN SCREEN ==

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/19/08 Time: 2203 (continued)

Activity Date: 11/19/08 Time: 2203 (continued)
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: :
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)342-9908 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,RESECTION 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):

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/19/08 Time: 2203 (continued)

Activity Date: 11/19/08 Time: 2203 (continued)

=== INFECTION RISK SCREEN ===
Admitted from a Skilled Nursing Facility: 0 NO
PEG Tube: 0 NO
Tracheostomy: 0 NO
Central Line: 0 NO
Hospitalized in the Last 30 Days: 0 NO
Decubitus Ulcer/Open Surgical Wound: 0 NO
History of TB, HIV, or Hepatitis: 0 NO
History of MRSA or VRE: 0 NO

~Total Score: 0
=Infection Risk=
Low: Y
Moderate (1-2):
High (3+):

== SOCIAL SERVICES SCREEN ==
1) Does Pt Have an Advance Directive: N
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:
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.

1070 Shift Reassessment + A Q8 & Q4H IN ICU CP
Create 11/19/08 2203 BT 11/19/08 2203 BT

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/19/08 Time: 2203

1500 I&O: Monitor + A Q12H (0559,1759) CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
15000 Care Plan: RN Review + A Q12H CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
20010 VS: Monitor + A AS ORDERED CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Create 11/19/08 2203 BT 11/19/08 2203 BT
21400 Nutrition/Activity/ADL Flowsheet + A OS BY CAREGIVER CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
22300 IV/Invasive Lines: Insert/Remove + A INS/REMOVAL/CONVERT CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
31320 Pain: Management Of + A AS NEEDED CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
60010 Notify: MD + A WHEN NECESSARY CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
80010 Education: Patient/Family Teaching + A OS BY CAREGIVER CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
150010 Weight + A CP
Create 11/19/08 2203 BT 11/19/08 2203 BT
1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Create 11/19/08 2203 BT 11/19/08 2203 BT

Activity Date: 11/19/08 Time: 2303

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
Document 11/19/08 2303 SGS 11/19/08 2303 SGS
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62
975050 Inventory Personal Belongings + A ADM.TX.DC AS
ON ADMISSION & TRANSFER, PRINT OUT &
HAVE PATIENT SIGN COPY.
Document 11/19/08 2303 SGS 11/19/08 2304 SGS
Inventory Date: 11/19/08 Inventory Time: 2303 Performed By: Sallibaba,Selina G
Reason For Inventory: ADMISSION (OU,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:
Dispositic Disposition:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Charge

Activity Date: 11/19/08 Time: 2303 (continued)

Activity Date: 11/19/08 Time: 2303 (continued)

Jewelry:
Describe:
Disposition:

-N Wallet Describe: Disposition:
-N Purse Describe: Disposition:
Comment:

-N Electrical Appliances Describe:
-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:_____

WITNESS:

Activity Date: 11/19/08 Time: 2305

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
Document 11/19/08 2305 SGS 11/19/08 2305 SGS
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62
975050 Inventory Personal Belongings + A ADM.TX.DOC AS
ON ADMISSION & TRANSFER. PRINT OUT &
HAVE PATIENT SIGN COPY.
Document 11/19/08 2305 SGS 11/19/08 2306 SGS
Inventory Date: 11/19/08 Inventory Time: 2303 Performed By: Saijbaba,Selina G
Reason For Inventory: ADMISSION (DU,IC,MU,PE)

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

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Charge

Activity Date: 11/19/08 Time: 2305 (continued)

Activity Date: 11/19/08 Time: 2305 (continued)
-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:_____

WITNESS:

Activity Date: 11/19/08 Time: 2352

1005-S ADM: ADULT Admission Assessment + A ON ADMISSION AS
Create 11/19/08 2352 BT 11/19/08 2358 BT
Document 11/19/08 2352 BT 11/19/08 2358 BT
=== Assessment Obtained ===
Date: 11/19/08 Time: 2235
Signature: Trinidad,Bienvenido

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/19/08 Time: 2352 (continued)

Activity Date: 11/19/08 Time: 2352 (continued)

NEUROLOGICAL Assessment Within Normal Limits: Y — PUPIL REACTION CHECK —
LOC: Reaction OD: BRISK Size: 3
Orientation: Reaction OS: BRISK Size: 3
Responds to:
Speech:
Headaches: Describe:
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Neuro Comment: ALERT AND ORIENTED X4

EENT Assessment Within Normal Limits: N
EENT Comment: NGT TO NARES

RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Effort:
Location: Chest Expansion:
Cough: Chest Tubes Present:
Secretions, Amt.:
Color:
IF ON OXYGEN SpO2 (%): 96
Oxygen Device: ROOM AIR O2 Amount (L/min): FIO2:
Comment: CLEAR BREATHSOUNDS ON ROOMAIR BREATHING EASY AND NON-LABORED

CARDIAC Assessment Within Normal Limits: Y
Heart Rate Irregular: Heart Tones:
Syncope/Fainting: Vertigo/Dizziness:
Chest Pain: Pain Quality:
If Radiating, Describe:
Pain Scale: Pain Treatment:
IF ON CARDIAC MONITOR/TELEMETRY Treatment Outcome:
Monitor #: Cardiac Rhythm:
Cardiac Comment: DENIES CHESTPAIN AT THIS TIME

CIRCULATORY Assessment Within Normal Limits: Y
Extremity Temp: Left Radial Pulse: STRONG
Extremity Color: Right Radial Pulse: STRONG
Sensation: Left Pedal Pulse: STRONG
Edema: Right Pedal Pulse: STRONG
Circulatory Comment: PALPABLE PULSES NO EDEMA

MUSCULOSKELETAL Assessment Within Normal Limits: N
Musculoskeletal Comment: C/O GENERALIZED WEAKNESS

== FUNCTIONAL STATUS ==

Activity Date: 11/19/08 Time: 2352 (continued)

Activity Date: 11/19/08 Time: 2352 (continued)
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

GASTROINTESTINAL Assessment Within Normal Limits: N
Last BM: 11/19/08 Describe Stool: DIARRHEA
Ostomy: GI Tube:
GI Comment: NGT INTACT.ACTIVE BOWEL SOUNDS NO N/V NOTED AT THIS TIME

GENITOURINARY Assessment Within Normal Limits: N
Incontinence: N Cath: N 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: C/O NO URINE X 2 DAYS

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: SKIN INTACT

==BRADEN PRESSURE ULCER RISK ASSESSMENT==
Sensory Perception: 4 NOT LIMITED-WNL — Skin Risk Score: 18
Moisure: 4 RARELY MOIST
Activity: 1 BEDFAST — -Risk Score-
Mobility: 3 SLIGHTLY LIMITED — 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/Anxiety Related to Hospital Stay: Ineffective Coping: Inadequate Support System:
Suspected Abuse/Neglect: Describe:
Alteration in Growth/Development:
Comment: CALM AND COOPERATIVE WITH CARE

== NUTRITION ==
NUTRITIONAL Assessment [redacted]n Normal Limits: Y

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/19/08 Time: 2352 (continued)

Activity Date: 11/19/08 Time: 2352 (continued)
Diet at Home: REGULAR
Comment: NPO AT THIS TIME

=== NUTRITION RISK SCREENING ===
Appears Underweight/Malnourished: 0 NO — Total Score: 0
Nausea, Vomiting, or Diarrhea for >3 Days: 0 NO
Unintentional Wt Loss >10# in Past Month: 0 NO — =Nutrition Risk=
Admitted with Potential Risk Diagnosis: 0 NO — Low (0-1): N
Poor PO Intake for >4 Days: 0 NO — Moderate (2-3):
Unable to Ingest Diet for Age: 0 NO — High (4+):
Tube Feeding or TPN: 0 NO

=== ASPIRATION RISK SCREENING ===
Impaired Mental Status: 0 NO — Total Score: 0
Difficulty Swallowing: 0 NO — =Aspiration Risk=
Food Sticking in Mouth/Throat: 0 NO — Low (0-1): Y
Coughing/Choking: 0 NO — Moderate (2):
Weight Loss: 0 NO — High (3-5):

=== FALL RISK ASSESSMENT===
Mental Status: 0 NOT ALTERED — Total Score: 3
Sensory Perceptual Status: 0 NOT ALTERED — -Fall Risk-
Physical Mobility Status: 0 NOT ALTERED — Low (0-2):
Elimination Status: 3 ALTERED — Moderate (3-6): Y
Recent History Of Falls: 0 NO FALLS — High (7+):
Patient's Age: 0 < 65 YEARS

=== EDUCATION SCREENING ===
Educational Need Priority #1: ACTIVITY
Educational Need Priority #2: DIET
Educational Need Priority #3: MEDICATIONS
Educational Need Priority #4: SAFETY PRECAUTIONS

=== BARRIERS TO LEARNING ===
Physiologic Limitations: PAIN
Psychological Limits: NONE
Cognitive Limitations: NONE
Teaching Method Preferred: EXPLANATION
Comment:
=== DVT RISK ASSESSMENT ===
Leg Plaster Cast or Brace: 0 NO
Varicose Veins: 0 NO
Hormone Replacement: 0 NO
Admission DX includes: CHF,COPD,MI,Sepsis,Pneumonia: 0 NO
Bed Rest with Limited Activity: 0 NO
Obesity: 0 NO
Major Surgery (> 60 minutes): 0 NO
Family History of DVT/PE: 0 NO
Present Cancer or Chemotherapy: 0 NO
History of SVT, DVT/PE: 0 NO
Hip, Pelvis, or Leg Fracture (< 1 month): 0 NO

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/19/08 Time: 2352 (continued)

Activity Date: 11/19/08 Time: 2352 (continued)
Stroke (< 1 month): 0 NO
Paralysis (< 1 month): 0 NO
Patient's Age: 2 60-74 YEARS
Total Score: 2 — =DVT Risk=
Low (0-1):
Moderate (2): Y
High (3+):
*** NOTIFY PHYSICIAN IF DVT RISK SCORE > 2 AND DOCUMENT IN PT CARE NOTES ***
=== SAFETY ===
Isolation: UNIVERSAL PRECAUTIONS Allergy Bracelet On: Y ID Band On: Y
Restraints in Use: N Describe:

=== IV ASSESSMENT ===
IV Location: LEFT HAND — IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 11/19/08

Activity Date: 11/19/08 Time: 2358

31210	Problem: EENT +			A	QS & Q4H IN ICU	CP
Create	11/19/08 2358 BT	11/19/08 2359 BT				
31260	Problem: Musculoskeletal +			A	QS & Q4H IN ICU	CP
Create	11/19/08 2358 BT	11/19/08 2359 BT				
31270	Problem: Gastrointestional +			A	QS & Q4H IN ICU	CP
Create	11/19/08 2358 BT	11/19/08 2359 BT				
31280	Problem: Genitourinary +			A	QS & Q4H IN ICU	CP
Create	11/19/08 2358 BT	11/19/08 2359 BT				

Activity Date: 11/20/08 Time: 0233

Patient Notes: Nurse Notes
Create 11/20/08 0233 BT 11/20/08 0235 BT
Abnormal? N Confidential? N
RECEIVED KUB RESULT FOR NGT PLACEMENT.NGT IN PLACED -RECOMMEND ADVANCING TUBE 6-8CM.FINDINGS SUGGESTIVE FOR DISTAL SBO.ADVANCED NGT 6 CM.WILL ORDER ANOTHER KUB TO CHECK PLACEMENT.

Activity Date: 11/20/08 Time: 0554

20010	VS: Monitor +			A	AS ORDERED	CP
Document	11/20/08 0554 RMF	11/20/08 0556 RMF				

Temperature/F: 97.5 — Temp Source: ORAL
Pulse: 81 — Pulse Source: AUTOMATIC NONINVASIVE
Respirations: 18 — Resp Source: OBSERVED
Blood Pressure: 112/70 — BP Source: AUTOMATIC
Site: RIGHT UPPER ARM
C/O Pain: Y
== CNA/LICENSED Documentation ==
Comfort Measures Implemented:
Nurse Notified of Pain:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 0554 (continued)

Activity Date: 11/20/08 Time: 0554 (continued)
(If Medicated, Document On Intervention Pain Management Of)

IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min):
SpO2 (%): 96 FIO2:
Comment:

Activity Date: 11/20/08 Time: 0559

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 11/20/08 0559 BT 11/20/08 0620 BT
=== INTAKE: SHIFT TOTAL ===
Ice: N IVPB's: 50 Blood/Product:
Oral: 0 Chemo: GU Irrigant In:
Tube Feeding: TPN: Other Intake:
IV's: 1000 Lipids: Total Intake: 1050

=== OUTPUT: SHIFT TOTAL ===
BRP: N Ostomy: Hemovac #1:
# of Voids/Incont: 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 === 1050

Comment:
21090 Routine Care: MED/SURG/TELE + A END OF SHIFT/TX CP
VIEW PROTOCOL
Document 11/20/08 0559 BT 11/20/08 0620 BT
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice
Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Trinidad,Bienvenido 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:
Sitter Used: N Comment:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 0559 (continued)

Activity Date: 11/20/08 Time: 0559 (continued)

=== IV ASSESSMENT ===
Throughout Shift: Central Line Present: N
IV Location: LEFT HAND -IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 11/19/08
IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment: IV INFUSING WELL
Patient Notes: Nurse Notes
Create 11/20/08 0559 BT 11/20/08 0623 BT
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.

Activity Date: 11/20/08 Time: 0650

Patient Notes: Nurse Notes
- Create 11/20/08 0650 BT 11/20/08 0652 BT
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.

Activity Date: 11/20/08 Time: 0758

5058601 QRM: Social Services Review A ON ADMISSION AS
Create 11/20/08 0758 SM 11/20/08 0758 SM
- Document 11/20/08 0758 SM 11/20/08 0758 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)

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 11/20/08 Time: 0758 (continued)

Activity Date: 11/20/08 Time: 0758 (continued)
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 ADL'S. NO DC PLANNING NEEDS ANTICIPATED. WILL AWAIT PHYSICIAN ADVISEMENT AND FOLLOW AS NEEDED.

Reassessment/Follow up Needed: See ORM 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:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 11/20/08 Time: 0800

Patient Notes: Nurse Notes
- Create 11/20/08 0800 ATS 11/20/08 2006 ATS
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.

Activity Date: 11/20/08 Time: 1417

20010 VS: Monitor + A AS ORDERED CP
Document: 11/20/08 1417 RMV 11/20/08 1417 RMV
Temperature/F: 98.2 Temp Source: ORAL
Pulse: 76 Pulse Source: AUTOMATIC. NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 118/74 BP Source: AUTOMATIC
Site: LEFT 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 (%): 94 FIO2:
Comment:
21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document: 11/20/08 1417 RMV 11/20/08 1418 RMV
== NUTRITION ==
% Meal Intake
Breakfast: 0 Diet:
Lunch: 0 Diet:
Dinner: Diet:
Comment: NPO

If Appropriate:
PO Nutritional Supplement Taken: NONE Amount Taken: 0
Supplemental Snacks: N

== ACTIVITY/ADL ==
Activity Type: BEDREST
Activity Tolerance: FAIR
Gait: NOT APPLICABLE

== PERSONAL HYGIENE ==
Bath: SELF
Linen Changed: Y
Oral Hygiene: SELF
Last BM: 11/19/08
Incont (BM):
Description:
Elimination Comment: NO B.M. AT THIS TIME.
Comment:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 1443

Patient Notes: Multidisciplinary Notes
Create 11/20/08 1443 TLF 11/20/08 1445 TLF
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.

Activity Date: 11/20/08 Time: 1445

1070 Shift Reassessment + A OS & O4H IN ICU CP
Document 11/20/08 1445 ATS 11/20/08 1449 ATS
Reassessment Obtained Date: 11/20/08 Time: 0800

NEUROLOGICAL Assessment Within Normal Limits: N
Neuro Comment: ALERT AND ORIENTED

EENT Assessment Within Normal Limits: N
EENT Comment: NGT TO RT NARE

RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment: 96 % SAT ON RA

CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: Monitor #:
Cardiac Comment: NO CHEST PAIN. BP 112/70 HR 81

CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment: NO EDEMA. PALPABLE PULSES

MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: MOVES ALL EXTREMITIES

NUTRITIONAL Assessment Within Normal Limits: N
Nutritional Comment: CURRENTLY NPO APPEARS ADEQUATLEY NOURISHED

GASTROINTESTINAL Assessment Within Normal Limits: N
GI Comment: ABDOMEN SOFT AND ROUND ACTIVE BOWEL SOUNDS LBM 11/18/08
NO NAUSEA. NGT TO LOW INTERMITENT SUCTION

GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: PT VOIDED 300 CC AMBER URINE THIS AM

INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment: INTACT

PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: CALM.RELAXED AND COOPERATIVE W/ CARE

=== The Following To Be Documented On Once A Shift ===

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 1445 (continued)

Activity Date: 11/20/08 Time: 1445 (continued)

=== FALL RISK ASSESSMENT===
Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED
Elimination Status: 3 ALTERED
Recent History Of Falls: 0 NO FALLS
Patient's Age: 0 < 65 YEARS
Total Score: 3
=Fall Risk=
Low (0-2):
Moderate (3-6): Y
High (7+):

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
Sensory Perception: 4 NOT LIMITED-WNL
Moisure: 4 RARELY MOIST
Activity: 1 BED/AST
Mobility: 3 SLIGHTLY LIMITED
Nutrition: 3 ADEQUATE
Friction and Sheer: 3 NO APPARENT PROBLEM
-Skin Risk Score: 18
=Risk Score=
Low (16+): Y
Moderate (13-15):
High (<13):

=== ADVANCE DIRECTIVES ===

Code Status: If DNR, Purple Armband in Place:
Comment:

===ALLERGIES===

Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKDA

=== VALUABLES AT THE BEDSIDE ===

Eyeglasses: Y : PT WEARING
Contact Lenses: N :
Dentures: N :
Hearing Aid: N :
Prosthesis: N :
Comment:

15000 Care Plan: RN Review + A Q12H CP
Document 11/20/08 1445 ATS 11/20/08 1450 ATS
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:
Problem(s) Identified: Status: A
: CVMC STANDARD OF CARE : A
: STANDARD OF PRACTICE M/S/TELE : A
: PROBLEM: Impaired EENT Function : A
: PROBLEM: Impaired GI Function : A
: PROBLEM: Altered GU Function : A
: PROBLEM: Impaired Musc/Skeletal Function : A
: :

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time	By	Recorded Date Time	By	Comment	Documented Units	Charge

Activity Date: 11/20/08 Time: 1445 (continued)

Activity Date: 11/20/08 Time: 1445 (continued)

Patient's Plan of Care was Reviewed and Updated as Needed: Y
31270 Problem: Gastrointestional + A QS & Q4H IN ICU CP
Document 11/20/08 1445 ATS 11/20/08 1528 ATS
Altered GI 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 ==
-GASTROINTESTINAL Assessment Within Normal Limits: N
Abdominal Appearance: SOFT/ROUND
Bowel Sounds: ACTIVE Last BM: 11/18/08
Describe Stool: FORMED
Abdominal Pain: N
Ostomy: GI Tube:
Suction:
Drainage Color:
Nausea: N Vomiting: N Diarrhea: N Constipation: N GI Bleeding: N
GI Complaint:
GI Comment: ABDOMEN SOFT AND ROUND. ACTIVE BOWEL SOUNDS. LBM 11/18/08
NGT TO RT NARE. DRAINING DARK GREENISH FLUID

== GIRTH MEASUREMENTS ==
Abdominal Girth (inches):
== OSTOMY CARE ==
Ostomy Type: Periostomal Skin:
Ostomy Care Provided: Appliance Changed:
Specify Care Rendered:

== ELIMINATION ==
Enema Given: Type: Results:
Suppository Given: Type: Result:

GI Tube Inserted/Discontinued:
(Do Not Include Tubes Inserted for Feeding Purposes)
GI Tube Inserted (Type): Time:
Attempts: Difficult Insertion:
Epigastric Auscultation:
X-Ray to Verify Placement:
GI Tube Discontinued (Date): Time:
Comment:
31280 Problem: Genitourinary + A QS & Q4H IN ICU CP
Document 11/20/08 1445 ATS 11/20/08 1529 ATS
Altered Genitourinary Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)

*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

Activity Date: 11/20/08 Time: 1445 (continued)

== REASSESSMENT ==
-GENITOURINARY Assessment Within Normal Limits: Y
Incontinence: Uses Diapers: Dysuria Anuria: Polyuria:
Cath: Type:
Color:
Nephrostomy: Nephrostomy Type:
Urinary Complaint/Problems:

Catheter Inserted/Discontinued:
Urinary Catheter Insertion -- Date: Time:
Type: Size (# Fr):
Straight Cath:
Catheter Discontinued -- Date: Time:
Comment:

== POST VOID RESIDUAL ==
Amount of Urine Voided Prior to Catheterization:
If Unmeasurable Urine Prior to Catheterization # of Voids/Incontinent:
Amount of Urine per Straight Cath:

If Female
Vaginal Bleeding: Describe:
Vaginal Discharge: Describe:
Vaginal Packing:

# of Pads Last Hour: Drainage Color:
Tissue Observed in Drainage:
Malodorous: Comment:

If Male
Penile Discharge: Describe:
Scrotal Edema:

== IF DIALYSIS PATIENT ==
Type of Dialysis:
Dialysis Access Comment:
Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage
Comment:

GU Comment: PT VOIDED 300 CC DARK AMBER URINE
31320 Pain: Management Of + A AS NEEDED CP
Document 11/20/08 1445 ATS 11/20/08 1529 ATS
*** Chest Pain to be Documented on Cardiac Problem ***
== PAIN MANAGEMENT ==

Intervention Description | Sts Directions | From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 1445 (continued)

Activity Date: 11/20/08 Time: 1445 (continued)
Time of Patient's Complaint: 0800
Pain Location:
-Pain Scale: 0/10
Describe the Pain:
Onset:
Comment: DENIES PAIN A THIS TIME.

Comfort Measures Implemented:
Other Measures Taken:

Time of Reassessment: Post Intervention Pain Scale:
Response to Intervention:

Patient/Family Education Provided: Y

Pain Comment: WILL MONITOR

== Pain Education for Patient/Family ==

Instructions Given Related to:

Pain Management is Part of Treatment Plan: Y
About the Use of the Pain Intensity Rating Scale: Y
Total Absence of Pain is Often not Realistic/Desirable Goal: Y
Choosing a Pain Control Goal, such as Pain Not Worse than 2: Y
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: Y
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control: Y
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: Y

== Other Information Taught ==

80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
- Document 11/20/08 1445 ATS 11/20/08 1530 ATS
=== PATIENT/FAMILY EDUCATION ===
Information Taught: DEVICES
Instruction Given: EXPLAINED NGT IS TO KEEP PRESSURE OFF STOMACH

Person Taught: PATIENT
Person Taught:
Teaching Tools: VERBAL
Other Tools Used:
Factors Affecting Learning: NONE
Other Factors:
Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N

Intervention Description | Sts Directions | From
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 1445 (continued)

Activity Date: 11/20/08 Time: 1445 (continued)

Educator: Schroer,Anthea T
Discipline:
1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/OI QS CP
- Document 11/20/08 1445 ATS 11/20/08 1530 ATS

Activity Date: 11/20/08 Time: 1547

3774002 Nutrition Screen: Adult + A PS
- Create 11/20/08 1547 CBH 11/20/08 1547 CBH
- Document 11/20/08 1547 CBH 11/20/08 1548 CBH
== NUTRITION SCREENING BY DIET TECHNICIAN == ===SUBJECTIVE===
Patient Comment: NUTRI SCR IN PROGRESS. BUN 21, CHOL 110, K+3.4, NO FDI
Appetite: PT IS NPO
Food Preferences: OFFER MENUS FOR SELECTION WHEN DIET IS ORDERED
Food Allergies: NKFA
Other Allergies: NKOA
Recent Weight Change: Comment: NPO AT THIS TIME.
Nausea: N GI Bleeding: N
Vomiting: N Last BM: 11/18/08
Diarrhea: N Describe Stool: FORMED
Constipation: N GI Tube:
Abdominal Pain: N Feeding Assist: N Dentition:
===OBJECTIVE===
Primary Diagnosis: SMALL BOWEL OBSTRUCTION
Secondary Diagnosis:
Medical History: CHOLE
Diet at Home: REGULAR
Diet Order: NPO (RETURN FOR ORAL DIET ORDER)

Diet Education: N Level: 2 Diet Tech: Higgins,Chrystine B
== 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:

=

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Charge

Activity Date: 11/20/08 Time: 1741

Patient Notes: Nurse Notes
- Create 11/20/08 1741 ATS 11/20/08 1741 ATS
Abnormal? N Confidential? N
DR. HANNA REFUSED 2ND EKG TO BE DONE.

Activity Date: 11/20/08 Time: 1821

21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document 11/20/08 1821 CC 11/20/08 1821 CC

== NUTRITION ==
% Meal Intake
Breakfast: Diet:
Lunch: Diet:
Dinner: 0 Diet: NPO
Comment:

If Appropriate:
PO Nutritional Supplement Taken: Amount Taken:
Supplemental Snacks: :

== ACTIVITY/ADL ==
Activity Type:
Activity Tolerance:
Gait:

== PERSONAL HYGIENE ==
Bath:
Linen Changed:
Oral Hygiene:
Last BM:
Incont (BM):
Description:

Elimination Comment:
Comment:

Activity Date: 11/20/08 Time: 1958

Patient Notes: Nurse Notes
- Create 11/20/08 1958 YYC 11/20/08 2001 YYC
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.

Activity Date: 11/20/08 Time: 2000

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 11/20/08 2000 ATS 11/20/08 2001 ATS

== INTAKE: SHIFT TOTAL ==
Ice:
Oral:
Tube Feeding:
IV's: 1200
IVPB's:
Chemo:
TPN:
Lipids:
Blood/Product:
GU Irrigant,In:
Other Intake:
Total Intake: 1200

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Charge

Activity Date: 11/20/08 Time: 2000 (continued)

Activity Date: 11/20/08 Time: 2000 (continued)

== OUTPUT: SHIFT TOTAL ==
BRP:
# of Voids/Incont:
# of Stools:
Urine: 725
Stool, Liquid:
Emesis:
NG Tube: 100
Ostomy:
Jejunostomy:
Ileostomy:
Jackson Pratt #1:
Jackson Pratt #2:
Chest Tube #1:
Chest Tube #2:
Hemovac #1:
Hemovac #2:
T-Tube:
GU Irrigant, Out:
Dialysis Net:
Est. Blood Loss:
Other Output:

Total Output: 825
== TOTAL SHIFT FLUID BALANCE == 375

Comment:

21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 11/20/08 2000 ATS 11/20/08 2001 ATS
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Schroer,Anthea Shift: 0700 - 1930

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:
Sitter Used: N Comment:

== IV ASSESSMENT ==
Throughout Shift: Central Line Present: N
IV Location: LEFT HAND ~IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 11/19/08

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment: IV INCUSING WELL

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/20/08 Time: 2001

1070 Shift Reassessment + A QS & Q4H IN ICU CP
Document 11/20/08 2001 YYC 11/20/08 2008 YYC
Reassessment Obtained Date: 11/20/08 Time: 2001

NEUROLOGICAL Assessment Within Normal Limits: N
Neuro Comment: AWAKE, ALERT AND ORIENTED X3. DENIES HEADACHE OR DIZZINESS

EENT Assessment Within Normal Limits: N
EENT Comment: NG TUBE INPLACE

RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment: RESP EVEN AND NOT LABORED TO ROOM AIR

CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: Monitor #:
Cardiac Comment: DENIES S/SX DISCOMFORT/CHEST PAIN

CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment:

MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: MOVE ALL EXTREMITIES, NEEDS FEW ASSIST W/ ADLS

NUTRITIONAL Assessment Within Normal Limits: N
Nutritional Comment: NPO AT THIS TIME.

GASTROINTESTINAL Assessment Within Normal Limits: N
GI Comment: ABDL SOFT AND NOT DISTENDED W/ACTIVE BS. NO NAUSEA/VOMITING

GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: VOIDED VIA URINAL WELL

INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment:

PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: CALM AND COOPERATIVE W/NURSING CARE

--== The Following To Be Documented On Once A Shift ==--

== FALL RISK ASSESSMENT==
-Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED
Elimination Status: 3 ALTERED
Recent History Of Falls: 0 NO FALLS
Patient's Age: 0 < 65 YEARS

Total Score: 3
-=Fall Risk=
Low (0-2):
Moderate (3-6): Y
High (7+):

Activity Date: 11/20/08 Time: 2001 (continued)

===BRADEN PRESSURE ULCER RISK ASSESSMENT===
Sensory Perception: 4 NOT LIMITED-WN
Moisure: 4 RARELY MOIST
Activity: 1 BEDFAST
Mobility: 3 SLIGHTLY LIMITED
Nutrition: 3 ADEQUATE
Friction and Sheer: 3 NO APPARENT PROBLEM

-Skin Risk Score: 18
-Risk Score-
Low (16+): Y
Moderate (13-15):
High (<13):

== ADVANCE DIRECTIVES ==

Code Status: FULL CODE If DNR, Purple Armband in Place:
Comment:

==ALLERGIES==

Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKDA

== VALUABLES AT THE BEDSIDE ==

Eyeglasses: Y : PT WEARING
Contact Lenses: N :
Dentures: N :
Hearing Aid: N :
Prosthesis: N :
Comment:

15000 Care Plan: RN Review + A Q12H CP
Document 11/20/08 2001 YYC 11/20/08 2008 YYC
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:

Problem(s) Identified:	Status:
CVMC STANDARD OF CARE	A
STANDARD OF PRACTICE M/S/TELE	A
PROBLEM: Impaired EENT function	A
PROBLEM: Impaired GI function	A
PROBLEM: Altered GU function	A
PROBLEM: Impaired Musc/Skeletal function	A

Patient's Plan of Care was Reviewed and Updated as Needed: Y

31210 Problem: EENT + A QS & Q4H IN ICU CP
Document 11/20/08 2001 YYC 11/20/08 2009 YYC
Altered EENT Function/Status Remains an Active Problem: Y
(If NO, Consider Inactivating or Completing Intervention)

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 11/20/08 Time: 2001 (continued)

Activity Date: 11/20/08 Time: 2001 (continued)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

=== REASSESSMENT ===

EENT Assessment Within Normal Limits: N
Oral Mucous Membranes:
Nasal: NG TUBE TO LT NARES
Throat/Mouth:
Right Eye: Right Ear:
Left Eye: Left Ear:

=== EYE CARE/ADDITIONAL ASSESSMENT ===
Eye Care/Additional Assessment Performed:
Eye Drainage (Describe):
Eye Care Provided (Describe):
Limited Eye Movement: If Yes (Describe):

=== NASAL CARE/ADDITIONAL ASSESSMENT ===
Nasal Care/Additional Assessment Performed:
Nasal Discharge: Describe:
Nasal Packing: If Yes :

EENT Comment: NG TUBE INPLACE

31260 Problem: Musculoskeletal + A QS & Q4H IN ICU CP
Document 11/20/08 2001 YYC 11/20/08 2009 YYC
Altered Musculoskeletal 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 ===
MUSCULOSKELETAL Assessment Within Normal Limits: N
Weakness:
Gait/Balance:
Range of Motion:
Location of Limited ROM:
Joints:
Contractures/Deformities:
Musculoskeletal Comment: MOVE ALL EXTREMITIES, NEEDS FEW ASSIST W/ ADLS

=== TRACTION ===
Traction in Use: N
Type of Traction:

=== CASTS ===
Cast Location:
Cast Type:

Activity Date: 11/20/08 Time: 2001 (continued)

Activity Date: 11/20/08 Time: 2001 (continued)
Extremity:
Weight (lbs):
Hours On This Shift:
Cast Condition:
Extremity Elevated:
Peripheral Pulse Palpable:
Skin Around Cast Intact:

=== PIN CARE ===
Orthopedic Pin Care Given: N
Pin Location:
Pin Site Appearance:
Pin Site Care With:
Dressing to Pin Site:

=== BRACES ===
Brace being Utilized: N
Type of Brace:
Extremity:
Hours On This Shift:
Extremity:
Hours On This Shift:

=== CPM ===
CPM Being Utilized: N
Total Hours in CPM This Shift:
Skin Integrity Checked:
Alignment Checked:
Ortho Comment:
CPM Comment:

31270 Problem: Gastrointestional + A QS & Q4H IN ICU CP
Document 11/20/08 2001 YYC 11/20/08 2009 YYC
Altered GI 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 ===
GASTROINTESTINAL Assessment Within Normal Limits: N
Abdominal Appearance: SOFT/ROUND
Bowel Sounds: ACTIVE
Describe Stool: FORMED
Abdominal Pain: N
Ostomy: N
GI Tube:
Suction:
Drainage Color:
Last BM: 11/18/08
Nausea: N Vomiting: N Diarrhea: N Constipation: N GI Bleeding:
GI Complaint:
GI Comment: ABDL SOFT AND NOT DISTENDED W/ACTIVE BS, NO NAUSEA/VOMITING

=== GIRTH MEASUREMENTS ===
Abdominal Girth (inches):
=== OSTOMY CARE ===
Ostomy Type: Periostomal Skin:
Ostomy Care Provided: Appliance Changed:
Specify Care Rendered:

=== ELIMINATION ===
Enema Given: N Type: Results:
Suppository Given: N Type: Result:

GI Tube Inserted/Discontinued:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 11/20/08 Time: 2001 (continued)

Activity Date: 11/20/08 Time: 2001 (continued)
(Do Not Include Tubes Inserted for Feeding Purposes)
GI Tube Inserted (Type): Time:
Attempts: Difficult Insertion:
Epigastric Auscultation:
X-Ray to Verify Placement:
GI Tube Discontinued (Date): Time:
Comment:

31280 Problem: Genitourinary + A QS & Q4H IN ICU CP
Document 11/20/08 2001 YYC 11/20/08 2009 YYC
Altered Genitourinary Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)

*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

=== REASSESSMENT ===
-GENITOURINARY Assessment Within Normal Limits: Y
Incontinence: Uses Diapers: Dysuria Anuria: Polyuria:
Cath: Type:
Color:
Nephrostomy: Nephrostomy Type:
Urinary Complaint/Problems:

Catheter Inserted/Discontinued:
Urinary Catheter Insertion -- Date: Time:
Type: Size (# Fr):
Straight Cath:
Catheter Discontinued -- Date: Time:
Comment:

=== POST VOID RESIDUAL ===
Amount of Urine Voided Prior to Catheterization:
If Unmeasurable Urine Prior to Catheterization # of Voids/Incontinent:
Amount of Urine per Straight Cath:

If Female
Vaginal Bleeding: Describe:
Vaginal Discharge: Describe:
Vaginal Packing:

# of Pads Last Hour: Drainage Color:
Tissue Observed in Drainage:
Malodorous: Comment:

If Male
Penile Discharge: Describe:
Scrotal Edema:

=== IF DIALYSIS PATIENT ===

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 11/20/08 Time: 2001 (continued)

Activity Date: 11/20/08 Time: 2001 (continued)
Type of Dialysis:
Dialysis Access Comment:
Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage:
Comment:

GU Comment: VOIDED VIA URINAL WELL

31320 Pain: Management Of + A AS NEEDED CP
Document 11/20/08 2001 YYC 11/20/08 2010 YYC
*** Chest Pain to be Documented on Cardiac Problem ***

=== PAIN MANAGEMENT ===
Time of Patient's Complaint: 2000
Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
Comment:
Comfort Measures Implemented:
Other Measures Taken:

Time of Reassessment: Post Intervention Pain Scale:
Response to Intervention:

Patient/Family Education Provided: Y

Pain Comment: DENIES PAIN AT THIS TIME

=== Pain Education for Patient/Family ===

Instructions Given Related to:

Pain Management is Part of Treatment Plan: Y
About the Use of the Pain Intensity Rating Scale: Y
Total Absence of Pain is Often not Realistic/Desirable Goal: Y
Choosing a Pain Control Goal, such as Pain Not Worse than 2: Y
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: Y
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control: Y
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: Y

=== Other Information Taught ===

80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Document 11/20/08 2001 YYC 11/20/08 2011 YYC
=== PATIENT/FAMILY EDUCATION ===
Information T[redacted] SAFETY PRECAUTIONS

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	By	Documented Comment	Documented Units	Sts	Directions	From / Change

Activity Date: 11/20/08 Time: 2001 (continued)

Activity Date: 11/20/08 Time: 2001 (continued)
Instruction Given: ENCOURAGED PT TO USE CALL LIGHT AS NEEDED. CALL LIGHT W/IN REACH

Person Taught: PATIENT
Person Taught:
Teaching Tools: VERBAL
Other Tools Used:
Factors Affecting Learning: FATIGUE
Other Factors:
Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Chang,Ya Yun
Discipline: NURSING

1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Document 11/20/08 2001 YYC 11/20/08 2011 YYC
Patient Notes: Nurse Notes
Create 11/20/08 2001 ATS 11/20/08 2004 ATS
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.

Activity Date: 11/20/08 Time: 2011

31200 Problem: Neurological + A QS & Q4H IN ICU CP
Create 11/20/08 2011 YYC 11/20/08 2011 YYC
31300 Problem: Nutrition + A QS & Q4H IN ICU CP
Create 11/20/08 2011 YYC 11/20/08 2011 YYC

Activity Date: 11/20/08 Time: 2020

Patient Notes: Nurse Notes
Create 11/20/08 2020 YYC 11/20/08 2200 YYC
Abnormal? N Confidential? N
CLRIFIED W/ DR. JANG THAT PT WILL BE HOLD PO MEDICATION AT THIS TIME

Activity Date: 11/20/08 Time: 2107

20010 VS: Monitor + A AS ORDERED CP
Document 11/20/08 2107 REF 11/20/08 2107 REF
Temperature/F: 98.6 Temp Source: ORAL
Pulse: 83 Pulse Source: AUTOMATIC NONINVASIVE
Respirations: 18 Resp Source: OBSERVED
Blood Pressure: 116/78 BP Source: AUTOMATIC
Site: LEFT UPPER ARM
C/O Pain: N

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	By	Documented Comment	Documented Units	Sts	Directions	From / Change

Activity Date: 11/20/08 Time: 2107 (continued)

Activity Date: 11/20/08 Time: 2107 (continued)
== 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:

Activity Date: 11/20/08 Time: 2150

Patient Notes: Nurse Notes
Create 11/20/08 2150 YYC 11/20/08 2203 YYC
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.

Activity Date: 11/21/08 Time: 0547

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 11/21/08 0547 YYC 11/21/08 0548 YYC
=== INTAKE: SHIFT TOTAL ===

Ice:	N	IVPB's:	100	Blood/Product:	0
Oral:	0	Chemo:	0	GU Irrigant.In:	0
Tube Feeding:	0	TPN:	0	Other Intake:	0
IV's:	900	Lipids:	0	Total Intake:	1000

=== OUTPUT: SHIFT TOTAL ===

BRP:	N	Ostomy:	0	Hemovac #1:	0
# of Voids/Incont:	3	Jejunostomy:	0	Hemovac #2:	0
# of Stools:	0	Ileostomy:	0	T-Tube:	0
Urine:	700	Jackson Pratt #1:	0	GU Irrigant. Out:	0
Stool, Liquid:	0	Jackson Pratt #2:	0	Dialysis Net:	0
Emesis:	0	Chest Tube #1:	0	Est. Blood Loss:	0
NG Tube:	50	Chest Tube #2:	0	Other Output:	0

Total Output: 750
=== TOTAL SHIFT FLUID BALANCE === 250

Comment: VOIDED VIA URINAL W/O PROBLEMS. NG LIS TO 50ML.
21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 11/21/08 0547 YYC 11/21/08 0548 YYC
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Chang,Ya Yun Shift: 1900 - 0730

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | By | Recorded Date | Recorded Time | By | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 0547 (continued)

Activity Date: 11/21/08 Time: 0547 (continued)

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:
Sitter Used: N Comment:

=== IV ASSESSMENT ===
Throughout Shift: Central Line Present: N
IV Location: LEFT HAND ~IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 11/19/08

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment: IV SITE INTACT AND PATENT W/IVF

Activity Date: 11/21/08 Time: 0622

Patient Notes: Nurse Notes
Create 11/21/08 0622 YYC 11/21/08 0622 YYC
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.

Activity Date: 11/21/08 Time: 0627

20010 VS: Monitor + A AS ORDERED CP
Document 11/21/08 0627 PB 11/21/08 0628 PB
Temperature/F: 97.8 Temp Source: TEMPORAL ARTERY
Pulse: 67 Pulse Source: AUTOMATIC NONINVASIVE
Respirations: 20 Resp Source: OBSERVED
Blood Pressure: 116/74 BP Source: AUTOMATIC
Site: LEFT UPPER ARM
C/O Pain: N
== CNA/LICENSED Documentation ==
Comfort Measures Implemented:
Nurse Notified of Pain:
(If Medicated, Document On Intervention Pain: Man Of)

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | By | Recorded Date | Recorded Time | By | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 0627 (continued)

Activity Date: 11/21/08 Time: 0627 (continued)

IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min):
SpO2 (%): 98 FIO2:
Comment:

Activity Date: 11/21/08 Time: 0800

1070 Shift Reassessment + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1157 PAS
Reassessment Obtained Date: 11/21/08 Time: 0800

NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro Comment: ALERT AND ORIENTED TIMES FOUR.

EENT Assessment Within Normal Limits: N
EENT Comment: NG TO THE NARE AND ON INTERMITTANT SUCTIONING

RESPIRATORY Assessment Within Normal Limits: N
Respiratory Comment: DIMINSIHED AND ENCOURAGE TO USE SPIROMETER AND TO DEEP BREATH.

CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: Monitor #:
Cardiac Comment: NO CHEST PAIN OR SOB

CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment: PULSES STRONG AND NO EDEMA NOTED

MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: MOVES ALL EXTREMITES WELL

NUTRITIONAL Assessment Within Normal Limits: N
Nutritional Comment: NPO AS INDICATED

GASTROINTESTINAL Assessment Within Normal Limits: N
GI Comment: DISTENDED AND MODERATELY FIRM. HYPOACTIVE BOWEL SOUNDS AND NOTED SBO

GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: URINATING WITHOUT PROBLEMS

INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment: INTACT AND WARM AND DRY

PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: COOPERATIVE WITH CARE

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)
=== The Following To Be Documented On Once A Shift ===

=== FALL RISK ASSESSMENT===
-Mental Status: 0 NOT ALTERED
Sensory Perceptual Status: 0 NOT ALTERED
Physical Mobility Status: 0 NOT ALTERED
Elimination Status: 3 ALTERED
Recent History Of Falls: 0 NO FALLS
Patient's Age: 0 < 65 YEARS
Total Score: 3
=Fall Risk=
Low (0-2):
Moderate (3-6): Y
High (7+):

==BRADEN PRESSURE ULCER RISK ASSESSMENT===
- Sensory Perception: 4 NOT LIMITED-WNL
Moisure: 4 RARELY MOIST
Activity: 1 BEDFAST
Mobility: 3 SLIGHTLY LIMITED
Nutrition: 3 ADEQUATE
Friction and Sheer: 3 NO APPARENT PROBLEM
-Skin Risk Score: 18
=Risk Score=
Low (16+): Y
Moderate (13-15):
High (<13):

=== ADVANCE DIRECTIVES ===

Code Status: FULL CODE If DNR, Purple Armband in Place:
Comment:

==ALLERGIES==

Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKOA

=== VALUABLES AT THE BEDSIDE ===

Eyeglasses: Y : PT WEARING
Contact Lenses: N :
Dentures: N :
Hearing Aid: N :
Prosthesis: N :
Comment:

15000 Care Plan: RN Review + A Q12H CP
Document 11/21/08 0900 PAS 11/21/08 1157 PAS
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:
Problem(s) Identified: Status: A
: PROBLEM: Impaired ENNT Function : A
: PROBLEM: Impaired GI Function : A
: PROBLEM: Altered GI Function : A
: PROBLEM: Altered Nutritional Status : A
: PROBLEM: Impaired Musc/Skeletal Function : A
: Developmental Age 41-65 (MID ADULT) : A

Intervention Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Documented Comment Units Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)
: CVMC STANDARD OF CARE : A
: STANDARD OF PRACTICE M/S/TELE : A
:

Patient's Plan of Care was Reviewed and Updated as Needed: Y
21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document 11/21/08 0800 PAS 11/21/08 1158 PAS
=== NUTRITION ===
% Meal Intake
Breakfast: Diet:
Lunch: Diet:
Dinner: Diet:
Comment: NPO AS ORDERED

If Appropriate:
PO Nutritional Supplement Taken: Amount Taken:
Supplemental Snacks:

=== ACTIVITY/ADL ===
Activity Type: BEDREST
Activity Tolerance: FAIR
Gait: NOT APPLICABLE

=== PERSONAL HYGIENE ===
Bath: SELF
Linen Changed: Y
Oral Hygiene: SELF
Last BM: 11/18/08
Incont (BM):
Description:

Elimination Comment: ENCOURAGED MOBILITY AND OOB AMBULATION
Comment:

- Document 11/21/08 0800 NIV 11/21/08 1323 NIV
=== NUTRITION ===
% Meal Intake
Breakfast: 0 Diet: NPO
Lunch: Diet:
Dinner: Diet:
Comment:

If Appropriate:
PO Nutritional Supplement Taken: NONE Amount Taken: 0
Supplemental Snacks: N :

=== ACTIVITY/ADL ===
Activity Type: BATHROOM PRIVILEGES
Activity Tolerance: FAIR
Gait: SLOW

=== PERSONAL HYGIENE ===
Bath: SELF
Linen Changed: Y
Oral Hygiene: SELF
Last BM: 11/21/08
Incont (BM): N
Description:

Elimination Comment:
Comment:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 0800

22300 IV/Invasive Lines: Insert/Remove + A INS/REMOVAL/CONVERT CP
Document 11/21/08 0800 PAS 11/21/08 1158 PAS
=== IV INSERT/DISCONTINUE ===

Insertion/Reinsert -- Date: # of Attempts:
IV Location: Catheter Size (ga.):
IV Location: Catheter Size (ga.):
Saline Lock:

Discontinued -- Date:
IV/SL DC'd - Cath. Intact: IV Converted to Saline Lock:

IV Comment: INTACT AND NO REDNESS OR SWELLING NOTED

31200 Problem: Neurological + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1158 PAS
Altered Neurological Status/Function Remains Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

~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: BRISK Size: 3
Verbal Response: Reaction OS: BRISK Size: 3
Motor Response:
Total: 9
=== SEIZURE INFORMATION ===
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Describe Seizure Event, Duration, Pre/Post Ictal State:

=== ADDITIONAL NEURO ASSESSMENT ===
~Additional Neuro Assessment Performed and WNL: Y
Level of Consciousness:
Orientation: ICP Monitor:
Responds to: ICP:
Memory: Fluctuations:
Thought Process:
Weakness: Specify:
Numbness: Specify:
Facial Droop: Describe:
Babinski Reflex Positive:

=== ADDITIONAL SWALLOWING ASSESSMENT ===
Problems Observed with Swallowing:
Food Texture Tolerated:
Fluid Consistency Tolerated:

Activity Date: 11/21/08 Time: 0800 (continued)

Neuro Comment: ALERT AND ORIENTED TIMES FOUR.

31210 Problem: EENT + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1158 PAS
Altered EENT Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

=== REASSESSMENT ===

EENT Assessment Within Normal Limits: N
Oral Mucous Membranes:
Nasal: NG TUBE TO LT NARES
Throat/Mouth:
Right Eye: Right Ear:
Left Eye: Left Ear:

=== EYE CARE/ADDITIONAL ASSESSMENT ===
Eye Care/Additional Assessment Performed:
Eye Drainage (Describe):
Eye Care Provided (Describe):
Limited Eye Movement: If Yes (Describe):

=== NASAL CARE/ADDITIONAL ASSESSMENT ===
Nasal Care/Additional Assessment Performed:
Nasal Discharge: Describe:
Nasal Packing: If Yes :

EENT Comment: NG TO THE NARE AND ON INTERMITTANT SUCTIONING

31260 Problem: Musculoskeletal + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1158 PAS
Altered Musculoskeletal Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

=== REASSESSMENT ===
MUSCULOSKELETAL Assessment Within Normal Limits: Y
Weakness:
Gait/Balance:
Range of Motion:
Location of Limited ROM:
Joints:
Contractures/Deformities:
Musculoskeletal Comment: MOVES ALL EXTREMITES WELL

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)

== TRACTION ==
Traction in Use: N
Type of Traction:
Extremity:
Weight (lbs):
Hours On This Shift:

== PIN CARE ==
Orthopedic Pin Care Given: N
Pin Location:
Pin Site Appearance:
Pin Site Care With:
Dressing to Pin Site:

== CPM ==
CPM Being Utilized: N
Total Hours in CPM This Shift: Ortho Comment:
Skin Integrity Checked:
Alignment Checked:
CPM Comment:

== CASTS ==
Cast Location:
Cast Type:
Cast Condition:
Extremity Elevated:
Peripheral Pulse Palpable:
Skin Around Cast Intact:

== BRACES ==
Brace being Utilized: N
Type of Brace:
Extremity:
Hours On This Shift:
Extremity:
Hours On This Shift:

31270 Problem: Gastrointestional + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1159 PAS
Altered GI 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 ==
-GASTROINTESTINAL Assessment Within Normal Limits: N
Abdominal Appearance: DISTENDED/FIRM
Bowel Sounds: ACTIVE Last BM: 11/18/08
Describe Stool: FORMED
Abdominal Pain: N
Ostomy: N GI Tube:
Suction:
Drainage Color:
Nausea: N Vomiting: N Diarrhea: N Constipation: N GI Bleeding: N
GI Complaint:
GI Comment: DISTENDED AND MODERATELY FIRM. HYPOACTIVE BOWEL SOUNDS AND NOTED SBO

== GIRTH MEASUREMENTS ==
Abdominal Girth (inches):
== OSTOMY CARE ==
Ostomy Type: Periostomal Skin:
Ostomy Care Provided: Appliance Changed:
Specify Care Rendered:

Activity Date: 11/21/08 Time: 0800 (continued)

== ELIMINATION ==
Enema Given: N Type: Results:
Suppository Given: N Type: Result:

GI Tube Inserted/Discontinued:
(Do Not Include Tubes Inserted for Feeding Purposes)
GI Tube Inserted (Type): Time:
Attempts: Difficult Insertion:
Epigastric Auscultation:
X-Ray to Verify Placement:
GI Tube Discontinued (Date): Time:
Comment: SBO AND NPO AND WITH NG TO INTERMITTANT SUCTIONING
31280 Problem: Genitourinary + A QS & Q4H IN ICU CP
Document 11/21/08 0800 PAS 11/21/08 1159 PAS
Altered Genitourinary Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)

*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

== REASSESSMENT ==
-GENITOURINARY Assessment Within Normal Limits: N
Incontinence: Uses Diapers: Dysuria Anuria: Polyuria:
Cath: Type:
Color:
Nephrostomy: Nephrostomy Type:
Urinary Complaint/Problems:

Catheter Inserted/Discontinued:
Urinary Catheter Insertion -- Date: Time:
Type: Size (# Fr):
Straight Cath:
Catheter Discontinued -- Date: Time:
Comment:

=== POST VOID RESIDUAL ===
Amount of Urine Voided Prior to Catheterization:
If Unmeasurable Urine Prior to Catheterization # of Voids/Incontinent:
Amount of Urine per Straight Cath:

If Female
Vaginal Bleeding: Describe:
Vaginal Discharge: Describe:
Vaginal Packing:

# of Pads Last Hour: Drainage Color:
Tissue Observed in Drainage:
Malodorous: Comment:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)

If Male
Penile Discharge: Describe:
Scrotal Edema:

== IF DIALYSIS PATIENT ==
Type of Dialysis:
Dialysis Access Comment:
Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage
Comment:

GU Comment: URINATING WITHOUT PROBLEMS
:

31300 Problem: Nutrition + A OS & O4H IN ICU CP
Document: 11/21/08 0800 PAS 11/21/08 1159 PAS
Altered NUTRITIONAL Function/Status Remains Active Problem: Y
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

- NUTRITIONAL Assessment Within Normal Limits: N
Nausea, Vomiting, or Diarrhea for > 3 Days: N
NPO, Poor Appetite, or on Clear Liquids for > 3 Days: Y
Dietary Supplementation (TPN/PPN/Tube Feeding): N

=== NUTRITIONAL SUPPLEMENTS ===
Supplement Taken:
Supplemental Snacks: N :

== TUBE FEEDING ==
Feeding Tube in Place: Type of Feeding:
Feeding Delivered By: If Continuous, Rate (ml/hr):
If Boluses, Amount (ml): Frequency:
Gastric Residual Checked: Amount (ml): Disposition:

Tube Feeding Comment:
Feeding Tube Inserted/Discontinued:
(Do Not Include Tubes Inserted for Gastric Decompression)

Feeding Tube Inserted -- Date: Time:
Site:
Epigastric Auscultation: X-Ray to Verify Placement:

Feeding Tube Discontinued -- Date: Time:

Feeding Tube Insert/DC Comment:
:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Documented Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)

Nutritional Comment: NPO AS INDICATED
:
31320 Pain: Management Of + A AS NEEDED CP
Document: 11/21/08 0800 PAS 11/21/08 1200 PAS
*** Chest Pain to be Documented on Cardiac Problem ***

== PAIN MANAGEMENT ==
Time of Patient's Complaint: 0800
Pain Location: ABDOMEN
~Pain Scale: 0/10
Describe the Pain:
Onset:
Comment:
: DENIES PAIN AT THIS TIME
Comfort Measures Implemented: :
Other Measures Taken:

Time of Reassessment: 0900 Post Intervention Pain Scale: 0/10
Response to Intervention: NO COMPLAINTS OF PAIN

Patient/Family Education Provided: Y

Pain Comment:

== Pain Education for Patient/Family ==

Instructions Given Related to:

Pain Management is Part of Treatment Plan: Y
About the Use of the Pain Intensity Rating Scale: Y
Total Absence of Pain is Often not Realistic/Desirable Goal: Y
Choosing a Pain Control Goal, such as Pain Not Worse than 2: Y
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals: Y
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control: Y
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain: Y

== Other Information Taught ==
:
80010 Education: Patient/Family Teaching + A OS BY CAREGIVER CP
Document: 11/21/08 0800 PAS 11/21/08 1200 PAS
=== PATIENT/FAMILY EDUCATION ===
Information Taught: ACTIVITY
Instruction Given: ENCOURAGED TO DEEP BREATH
ADVISE OF PLAN OF CARE

Person Taught: PATIENT
Person

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 0800 (continued)

Activity Date: 11/21/08 Time: 0800 (continued)
Teaching Tools: VERBAL
Other Tools Used:
Factors Affecting Learning: FATIGUE
Other Factors:
Participation Level: ACTIVE
Evaluation:
Needs Additional Education: N
Educator: Stubbs,Pauline A.
Discipline:

1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Document 11/21/08 0800 PAS 11/21/08 1200 PAS

Activity Date: 11/21/08 Time: 1148

Patient Notes: Nurse Notes
Create 11/21/08 1148 PAS 11/21/08 1153 PAS
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.

Activity Date: 11/21/08 Time: 1154

Patient Notes: Nurse Notes
- Create 11/21/08 1154 PAS 11/21/08 1154 PAS
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.

Activity Date: 11/21/08 Time: 1200

21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document 11/21/08 1200 NIV 11/21/08 1324 NIV
== NUTRITION ==
% Meal Intake

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 1200 (continued)

Activity Date: 11/21/08 Time: 1200 (continued)
Breakfast: Diet:
Lunch: 0 Diet: NPO
Dinner: Diet:
Comment:

If Appropriate:
PO Nutritional Supplement Taken: NONE Amount Taken: 0
Supplemental Snacks: N

== ACTIVITY/ADL ==
Activity Type:
Activity Tolerance:
Gait:

== PERSONAL HYGIENE ==
Bath:
Linen Changed:
Oral Hygiene:
Last BM:
Incont (BM):
Description:

Elimination Comment:
Comment:

31220 Problem: Respiratory + A QS & Q4H IN ICU CP
Create 11/21/08 1200 PAS 11/21/08 1201 PAS

Activity Date: 11/21/08 Time: 1324

20010 VS: Monitor + A AS ORDERED CP
Document 11/21/08 1324 NIV 11/21/08 1327 NIV
Temperature/F: 98.6 Temp Source: TYMPANIC
Pulse: 62 Pulse Source: AUTOMATIC, NONINVASIVE
Respirations: 20 Resp Source: OBSERVED
Blood Pressure: 137/91 BP Source: AUTOMATIC
Site: LEFT 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 (%): 96 FIO2:
Comment:

Activity Date: 11/21/08 Time: 1450

Patient Notes: Nurse Notes
Create 11/21/08 1450 PAS 11/21/08 1451 PAS
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.

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 1755

21400 Nutrition/Activity/ADL Flowsheet + A QS BY CAREGIVER CP
Document 11/21/08 1755 LAB 11/21/08 1755 LAB
=== NUTRITION ===
% Meal Intake
Breakfast: Diet:
Lunch: Diet:
Dinner: 0 Diet: NPO
Comment:

If Appropriate:
PO Nutritional Supplement Taken: Amount Taken:
Supplemental Snacks: :

=== ACTIVITY/ADL ===
Activity Type:
Activity Tolerance:
Gait:

=== PERSONAL HYGIENE ===
Bath:
Linen Changed:
Oral Hygiene:
Last BM:
Incont (BM):
Description:

Elimination Comment:
Comment:
- Edit Results 11/21/08 1755 LAB 11/21/08 1854 LAB
PO Nutritional Supplement Taken: N/A []
Amount Taken: 0 []
Supplemental Snacks: N []
: N/A []
Activity Type: BATHROOM PRIVILEGES []
Activity Tolerance: FAIR []
Gait: SLOW []
Bath: SELF []
Linen Changed: Y []
Oral Hygiene: SELF []
Incont (BM): N []

Activity Date: 11/21/08 Time: 1759

1500 I&O: Monitor + A Q12H (0559,1759) CP
Document 11/21/08 1759 PAS 11/21/08 1926 PAS
=== INTAKE: SHIFT TOTAL ===
Ice:
Oral: 1000
Tube Feeding:
IV's: 900
IVPB's: 50
Chemo:
TPN:
Lipids:
Blood/Product:
GU Irrigant,In:
Other Intake:
Total Intake: 1950

=== OUTPUT: SHIFT TOTAL ===
BRP: Y
# of Voids/Incont:
# of Stools: 4
Urine: 1350
Stool, Liquid:
Ostomy:
Jejunostomy:
Ileostomy:
Jackson Pratt #1:
Jackson Pratt #2:
Hemovac #1:
Hemovac #2:
T-Tube:
GU Irrigant, Out:
[redacted]alysis Net:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 1759 (continued)

Activity Date: 11/21/08 Time: 1759 (continued)
Emesis:
NG Tube:
Chest Tube #1:
Chest Tube #2:
Est. Blood Loss:
Other Output:

Total Output: 1350
=== TOTAL SHIFT FLUID BALANCE === 600

Comment:
21090 Routine Care: MED/SURG/TELE + A .END OF SHIFT/TX CP
VIEW PROTOCOL
Document 11/21/08 1759 PAS 11/21/08 1927 PAS
The Practice Guidelines Appropriate For The Patient And Within The Scope Of My Practice Have Been Met Throughout The Shift: YES NO COMMENT

Signature: Stubbs,Pauline A. Shift: 0700 1930

Practice Guidelines Comment:

Patient/Family Education Provided This Shift: N

Isolation: STANDARD PRECAUTIONS
Restraints in Use: N Describe:
+Total Hrs. In Restraints This Shift: Location:
Sitter Used: N Comment:

=== IV ASSESSMENT ===
Throughout Shift: Central Line Present: N
IV Location: LEFT HAND -IV Site Within Normal Limits: Y
IV Site Condition:
IV Start/Restart Date: 11/19/08

IV Location: IV Site Within Normal Limits:
IV Site Condition:
IV Start/Restart Date:
IV Comment:

Activity Date: 11/21/08 Time: 1855

Patient Notes: Nurse Notes
- Create 11/21/08 1855 PAS 11/21/08 1857 PAS
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

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 1855 (continued)

Patient Notes: Nurse Notes (continued)
ANYMORE. PATIENT REMINDED STAFF HE IS A DOCTOR AND VERSED IN THESE MATTERS.
CALLED DR OH AGAIN AND AWAITING CALL BACK AT THIS TIME.

Activity Date: 11/21/08 Time: 1929

Patient Notes: Nurse Notes
- Create 11/21/08 1929 PAS 11/21/08 1931 PAS
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.

Activity Date: 11/21/08 Time: 1948

Patient Notes: Nurse Notes
- Create 11/21/08 1948 PAS 11/21/08 1950 PAS
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.

Activity Date: 11/21/08 Time: 2000

1070 Shift Reassessment + A QS & Q4H IN ICU CP
Document 11/21/08 2000 MPR 11/21/08 2017 MPR
Reassessment Obtained Date: 11/21/08 Time: 2000

NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro Comment: ALERT AND ORIENTED

EENT Assessment Within Normal Limits: Y
EENT Comment: WDP

RESPIRATORY Assessment Within Normal Limits: Y
Respiratory Comment: RESP EVEN AND UNLABORED

CARDIAC Assessment Within Normal Limits: Y
IF ON CARDIAC MONITOR/TELEMETRY:
Cardiac Rhythm: Monitor #:
Cardiac Comment: DENIES CHEST PAIN

CIRCULATORY Assessment Within Normal Limits: Y
Circulatory Comment: PULSES PALPABLE

MUSCULOSKELETAL Assessment Within Normal Limits: Y
Musculoskeletal Comment: AMBULATORY

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 11/21/08 Time: 2000 (continued)

Activity Date: 11/21/08 Time: 2000 (continued)
NUTRITIONAL Assessment Within Normal Limits: Y
Nutritional Comment: DIET TOL ON FULL LIQUID

GASTROINTESTINAL Assessment Within Normal Limits: Y
GI Comment: ACTIVE BS, NO N/V

GENITOURINARY Assessment Within Normal Limits: Y
GU Comment: VOIDS

INTEGUMENTARY Assessment Within Normal Limits: Y
Skin Comment: INTACT

PSYCHOSOCIAL Assessment Within Normal Limits: Y
Psychosocial Comment: CAEM

=== The Following To Be Documented On Once A Shift ===

=== 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: 4 RARELY MOIST
Activity: 4 WALKS FREQUENTLY
Mobility: 4 NO LIMITATIONS
Nutrition: 2 PROBABLY INADEQUATE
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, Purple Armband in Place:
Comment:

===ALLERGIES===

Allergies: REGLAN
Food Allergies: NKFA
Other Allergies: NKDA

=== VALUABLES AT THE BEDSIDE ===

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2000 (continued)

Activity Date: 11/21/08 Time: 2000 (continued)

Eyeglasses: Y : PT WEARING
Contact Lenses: N :
Dentures: N :
Hearing Aid: N :
Prosthesis: N :
Comment:

15000 Care Plan: RN Review + A Q12H CP
Document 11/21/08 2000 MPR 11/21/08 2012 MPR
PATIENT PROBLEM LIST AS PRIORITIZED ON CARE PLAN:
Problem(s) Identified: Status: A
: PROBLEM: Impaired ENT Function : A
: PROBLEM: Impaired GI Function : A
: PROBLEM: Altered GU Function : A
: PROBLEM: Altered Nutritional Status : A
: PROBLEM: Impaired Musc/Skeletal Function : A
: PROBLEM: Impaired Respiratory Function : A
: Developmental Age 41-65 (MID ADULT) : A
: CVHC STANDARD OF CARE : A
: STANDARD OF PRACTICE M/S/TELE : A

Patient's Plan of Care was Reviewed and Updated as Needed: Y

31320 Pain: Management Of + A AS NEEDED CP
Document 11/21/08 2000 MPR 11/21/08 2019 MPR
*** Chest Pain to be Documented on Cardiac Problem ***

=== PAIN MANAGEMENT ===
Time of Patient's Complaint: 2000
Pain Location:
-Pain Scale:
Describe the Pain:
Onset:
Comment: DENIES PAIN AT THIS TIME
:
Comfort Measures Implemented:
Other Measures Taken:

Time of Reassessment: Post Intervention Pain Scale:
Response to Intervention:

Patient/Family Education Provided:

Pain Comment:

=== Pain Education for Patient/Family ===

Instructions Given Related to:

Pain Management is Part of Treatment Plan:
About the Use of the Pain Intensity Rating Scale:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2000 (continued)

Activity Date: 11/21/08 Time: 2000 (continued)
Total Absence of Pain is Often not Realistic/Desirable Goal:
Choosing a Pain Control Goal, such as Pain Not Worse than 2:
That Effect of Pain Management Interventions will be Reassessed at Frequent Intervals:
About the Importance of Requesting and Receiving Pain Relief
Measures Before Pain Becomes Severe & Difficult to Control:
About the Importance of Notifying Health Care Providers About Any Unrelieved Pain:

== Other Information Taught ==
:

Activity Date: 11/21/08 Time: 2017

31200 Problem: Neurological + A QS & Q4H IN ICU CP
Document 11/21/08 2017 MPR 11/21/08 2017 MPR
Altered Neurological Status/Function Remains Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

-NEUROLOGICAL Assessment Within Normal Limits: Y
Neuro History:
Speech:
Headaches: Describe:
Behavior/Appearance Inappropriate: Describe:

== GLASGOW COMA SCORE === (Best Response)
Eye Response: 4-SPONTANEOUS
Verbal Response: 5-ORIENTED
Motor Response: 6-OBEYS COMMANDS
Total: 15

== PUPIL REACTION CHECK ==
Reaction OD: BRISK Size: 3
Reaction OS: BRISK Size: 3

=== SEIZURE INFORMATION ===
Recent Seizure Activity: Seizure Precautions Initiated or being Utilized:
Describe Seizure Event, Duration, Pre/Post Ictal State:
:

=== ADDITIONAL NEURO ASSESSMENT ===
-Additional Neuro Assessment Performed and WNL:
Level of Consciousness:
Orientation:
Responds to:
Memory:
Thought Process:
Weakness: Specify:
Numbness: Specify:
Facial Droop: Describe:
Babinski Reflex Positive:
ICP Monitor:
ICP:
Fluctuations:

=== ADDITIONAL SWALLOWING ASSESSMENT ===
Problems Observed with Swallowing:
Food Texture Tolerated:
Fluid Consistency Tolerated:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2017 (continued)

Activity Date: 11/21/08 Time: 2017 (continued)

Neuro Comment: ALERT AND ORIENTED

Activity Date: 11/21/08 Time: 2018

31210 Problem: EENT + A QS & Q4H IN ICU CP
Document 11/21/08 2018 MPR 11/21/08 2018 MPR
Altered EENT 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 ==

EENT Assessment Within Normal Limits: Y
Oral Mucous Membranes:
Nasal:
Throat/Mouth:
Right Eye: Right Ear:
Left Eye: Left Ear:

== EYE CARE/ADDITIONAL ASSESSMENT ==
Eye Care/Additional Assessment Performed:
Eye Drainage (Describe):
Eye Care Provided (Describe):
Limited Eye Movement: If Yes (Describe):

== NASAL CARE/ADDITIONAL ASSESSMENT ==
Nasal Care/Additional Assessment Performed:
Nasal Discharge: Describe:
Nasal Packing: If Yes :

EENT Comment: WDP

31220 Problem: Respiratory + A QS & Q4H IN ICU CP
Document 11/21/08 2018 MPR 11/21/08 2018 MPR
Altered RESPIRATORY 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 ==
-RESPIRATORY Assessment Within Normal Limits: N
Breath Sounds: Location:
Breath Sounds: Location:

Effort: Chest Expansion:
Cough: Secretions, Amt:
Color: Cleared by:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2018 (continued)

Activity Date: 11/21/08 Time: 2018 (continued)
IF ON OXYGEN
Oxygen Device: ROOM AIR O2 Amount (L/min): FIO2 (%):
Pulse Oximetry: SpO2 (%): Probe Location:
Pulse Ox Comment:

Respiratory Comment: RESP EVEN AND UNLABORED

Use of Ventilator:

== VENT SETTINGS ==
Type of Ventilator:
Mode:
Set Rate (bpm):
Total Rate (bpm):
Set VT (cc):
Measured VT (cc):
FIO2 (%):
PEEP (cm H2O):
PSV (cm H2O):

== AIRWAYS ==
ETT Size:
Tube Placement:
ETT Position (cm):
(cm to Lipline)

== If Tracheostomy Present ==
Trach Care Provided per Guidelines or as Ordered:
Trach Type:
Trach Size:
Trach Stoma Condition:
Trach Site Drainage:

== IF CHEST TUBES ==
Chest Tube #1 Location:
Drainage:
Waterseal Patent: Air Leak:
Connected to Suction: Suction Amount (cm):
Subcutaneous Air Noted: Dressing Changed/Reinforced:

Chest Tube #2 Location:
Drainage:
Waterseal Patent: Air Leak:
Connected to Suction: Suction Amount (cm):
Subcutaneous Air Noted: Dressing Changed/Reinforced:

31260 Problem: Musculoskeletal + A QS & Q4H IN ICU CP
Document 11/21/08 2018 MPR 11/21/08 2018 MPR
Altered Musculoskeletal 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 ==
MUSCULOSKELETAL Assessment Within Normal Limits: Y
Weakness:
Gait/Balance:
Range of Motion:
Location of Limited ROM:
Joints:
Contractures/Deformities:
Musculoskeletal Comment: AMBULATORY

== TRACTION ==

== CASTS ==

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2018 (continued)

Activity Date: 11/21/08 Time: 2018 (continued)
Traction in Use:
Type of Traction:
Extremity:
Weight (lbs):
Hours On This Shift:

Cast Location:
Cast Type:
Cast Condition:
Extremity Elevated:
Peripheral Pulse Palpable:
Skin Around Cast Intact:

== PIN CARE ==
Orthopedic Pin Care Given:
Pin Location:
Pin Site Appearance:
Pin Site Care With:
Dressing to Pin Site:

== BRACES ==
Brace being Utilized:
Type of Brace:
Extremity:
Hours On This Shift:
Extremity:
Hours On This Shift:

== CPM ==
CPM Being Utilized:
Total Hours in CPM This Shift:
Ortho Comment:
Skin Integrity Checked:
Alignment Checked:
CPM Comment:

31270 Problem: Gastrointestional + A QS & Q4H IN ICU CP
Document: 11/21/08 2018 MPR 11/21/08 2018 MPR
Altered GI 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 ==
-GASTROINTESTINAL Assessment Within Normal Limits: Y
Abdominal Appearance:
Bowel Sounds:
Describe Stool:
Abdominal Pain:
Last BM:
Ostomy:
GI Tube:
Suction:
Drainage Color:
Nausea: Vomiting: Diarrhea: Constipation: GI Bleeding:
GI Complaint:
GI Comment: ACTIVE BS NO N/V

=== GIRTH MEASUREMENTS ===
Abdominal Girth (inches):
== OSTOMY CARE ==
Ostomy Type:
Periostomal Skin:
Ostomy Care Provided:
Appliance Changed:
Specify Care Rendered:

== ELIMINATION ==
Enema Given: N Type:
Results:
Suppository Given: N Type:
Result:

Activity Date: 11/21/08 Time: 2018 (continued)

Activity Date: 11/21/08 Time: 2018 (continued)

GI Tube Inserted/Discontinued:
(Do Not Include Tubes Inserted for Feeding Purposes)
GI Tube Inserted (Type):
Time:
Attempts:
Difficult Insertion:
Epigastric Auscultation:
X-Ray to Verify Placement:
GI Tube Discontinued (Date):
Time:
Comment: NG TUBE DISCONTINUED AS ORDERED

31280 Problem: Genitourinary + A QS & Q4H IN ICU CP
Document: 11/21/08 2018 MPR 11/21/08 2019 MPR
Altered Genitourinary Function/Status Remains an Active Problem: N
(If NO, Consider Inactivating or Completing Intervention)

*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

== REASSESSMENT ==
-GENITOURINARY Assessment Within Normal Limits: Y
Incontinence: Uses Diapers: Dysuria Anuria: Polyuria:
Cath:
Type:
Color:
Nephrostomy: Nephrostomy Type:
Urinary Complaint/Problems:

Catheter Inserted/Discontinued:
Urinary Catheter Insertion -- Date: Time:
Type: Size (# Fr):
Straight Cath:
Catheter Discontinued -- Date: Time:
Comment:

== POST VOID RESIDUAL ==
Amount of Urine Voided Prior to Catheterization:
If Unmeasurable Urine Prior to Catheterization # of Voids/Incontinent:
Amount of Urine per Straight Cath:

If Female
Vaginal Bleeding: Describe:
Vaginal Discharge: Describe:
Vaginal Packing:

# of Pads Last Hour: Drainage Color:
Tissue Observed in Drainage:
Malodorous: Comment:

If Male
Penile Discharge: Describe:
Scrotal Edema:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2018 (continued)

Activity Date: 11/21/08 Time: 2018 (continued)

== IF DIALYSIS PATIENT ==
Type of Dialysis:
Dialysis Access Comment:
Fistula with Bruit/Thrill:
If Quinton or Ash Split Cath, Site Without Redness/Drainage
Comment:

GU Comment: VOIDS

Activity Date: 11/21/08 Time: 2019

31300 Problem: Nutrition + A QS & Q4H IN ICU CP
Document 11/21/08 2019 MPR 11/21/08 2019 MPR
Altered NUTRITIONAL Function/Status Remains Active Problem, Y.
(If NO, Consider Inactivating or Completing Intervention)
*** Document Only on Interventions Related to Patient's Altered Status/Function. ***

~ NUTRITIONAL Assessment Within Normal Limits: Y
Nausea, Vomiting, or Diarrhea for > 3 Days:
NPO, Poor Appetite, or on Clear Liquids for > 3 Days:
Dietary Supplementation (TPN/PPN/Tube Feeding):

== NUTRITIONAL SUPPLEMENTS ==
Supplement Taken:
Supplemental Snacks: N :

== TUBE FEEDING ==
Feeding Tube in Place: Type of Feeding:
Feeding Delivered By: If Continuous, Rate (ml/hr):
If Boluses, Amount (ml): Frequency:
Gastric Residual Checked: Amount (ml): Disposition:

Tube Feeding Comment:
Feeding Tube Inserted/Discontinued:
(Do Not Include Tubes Inserted for Gastric Decompression)

Feeding Tube Inserted -- Date: Time:
Site:
Epigastric Auscultation: X-Ray to Verify Placement:

Feeding Tube Discontinued -- Date: Time:

Feeding Tube Insert/DC Comment:

Nutritional Comment: DIET TOL ON FULL LIQUID

Activity Date: 11/21/08 Time: 2019 (continued)

Activity Date: 11/21/08 Time: 2019 (continued)

80010 Education: Patient/Family Teaching + A QS BY CAREGIVER CP
Document 11/21/08 2019 MPR 11/21/08 2020 MPR
== PATIENT/FAMILY EDUCATION ==
Information Taught: DIET
Instruction Given: FULL LIQUID

Person Taught: PATIENT
Person Taught:
Teaching Tools: VERBAL
Other Tools Used:
Factors Affecting Learning: NONE
Other Factors:
Participation Level: ACTIVE
Evaluation: VERBALIZES UNDERSTANDING
Needs Additional Education: N
:
Educator: Ragaza,Maureene P.
Discipline: NURSING

Activity Date: 11/21/08 Time: 2020

1001031 Age Guidelines: 41-65 (MID ADULT) A VIEW PROTOCOL/DI QS CP
Document 11/21/08 2020 MPR 11/21/08 2020 MPR
Patient Notes, Nurse Notes
Create 11/21/08 2020 MPR 11/21/08 2021 MPR
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.

Activity Date: 11/21/08 Time: 2053

1000-B ADMISSION/TRANSFER: Quick Start Form + A ON ADMISSION/TRANS AS
Document 11/21/08 2053 SGS 11/21/08 2053 SGS
Patient Type: MED/SURG/TELE New Admit: Y
Patient Age: 62
975050 Inventory Personal Belongings + A ADM.TX.DC AS
ON ADMISSION & TRANSFER. PRINT OUT &
HAVE PATIENT SIGN COPY.
Document 11/21/08 2053 SGS 11/21/08 2054 SGS
Inventory Date: 11/21/08 Inventory Time: 2053 Performed By: Salibaba,Selina G
Reason For Inventory: DISCHARGE

N Contacts N Glasses Disposition: PATIENT WEARING/TAPED
N Full Dentures Disposition:
N Partial Upper N Lower Disposition:
N Hearing Aid Disposition:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Charge

Activity Date: 11/21/08 Time: 2053 (continued)

Activity Date: 11/21/08 Time: 2053 (continued)

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

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

Jewelry: Jewelry:
Describe: Describe:
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:_____

WITNESS:

Activity Date: 11/21/08 Time: 2106

90013 DIS: Patient Discharge Instructions + A ON DISCHARGE CP
- Document 11/21/08 2106 MPR 11/21/08 2122 MPR
Please bring this sheet with you to your follow up visit with: DR. AGARWAL AND DR. OH
on (Date/Time): NOV. 26, 2008 ** OR **
Call for an appointment before: 11/26/08 Physician's Office Number: (909)621-7647
Discharge Date: 11/21/08 Discharge Time: 2100 Discharge To: HOME - NO NEEDS
: By: AUTOMOBILE Via: WH[redacted]R

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Charge

Activity Date: 11/21/08 Time: 2106 (continued)

Activity Date: 11/21/08 Time: 2106 (continued)
Accompanied By: SPOUSE
Discharge Comment: DISCHARGE INSTRUCTIONS GIVEN TO PATIENT
General Condition on Discharge:
Vital Signs: Temperature/F: 98.4 Respirations: 20 Blood Pressure: 132/82 Pulse: 64
Pain Controlled by Oral Medications: YES
Comment: DENIES PAIN AT THIS TIME
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool: Y
Comment:
Wound/Incision Assessment: NONE
Photograph Taken On Discharge and Placed On Chart:
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions:
Bath: Other:
Diet: Calories:
Restrictions:
Additional Education given:
: WORSENING SYMPTOMS :
: MD FOLLOW UP :
: NUTRITION/DIET :
Comment:

Prescriptions/Education given: N Food/Drug Interaction Form Given: Y
List DC Meds and Time next dose is due (if applicable):
: ATENOLOL 50MG BY MOUTH EVERY NIGHT
: LEXAPRO 15MG BY MOUTH DAILY (depression)
: ZOMIG 2.5MG BY MOUTH AS NEEDED FOR migraine
: TYLENOL 500MG BY MOUTH TWICE A DAY AS NEEDED FOR FEVER
Wound/skin care:
:
:
Special Instructions: FOLLOW UP APPT WITH DR SHAH FOR THICKENING OF SIGMOID WALL
:
Sent Home With All Belongings: Y Personal Belongings Inventory Reviewed/Signed: Y
Discharge Instructions Reviewed With: PATIENT Printed Instructions Given: Y
Pneumococcal Vaccine Given: N Date Given:
Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health:
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 vac[redacted] If you do not have a primary care physician, please contact

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2106 (continued)

Activity Date: 11/21/08 Time: 2106 (continued)
the local public health clinic to find out where this vaccine may be available.

SPECIAL INSTRUCTIONS FOR THE CARDIAC/CHF PATIENT:
A. Patients with congestive heart failure must weigh every morning,record weight, and avoid smoking.
B. Medication: Know your medications. Don't stop taking your medications or change your dosage unless your doctor tells you to. Keep a list of your current medications. If you have Nitroglycerin, keep it with you at all times.
C. Activity: Start off slowly, plan your activities and get enough rest.
Stop activity if you have any of these signs:
Chest discomfort, severe or unusual fatigue, dizziness or faintness, irregular or rapid heartbeat, shortness of breath.
D. Smoking cessation is recommended. Smoking contributes to medical complications.
E. Call your doctor if:
* Breathing becomes more difficult, or you have a cough with increased sputum or blood
* You notice you're getting tired faster
* Rapid or irregular heartbeat
* You have dizzy spells or you faint
* You begin urinating less frequently
* You think you are having side effects from your medication
* You have tightness or pain in your chest (Not relieved by Nitroglycerin)
* If you have a rapid weight gain of 2 pounds in 1 or 2 days or your feet or ankles swell more than usual

Your physician may have recommended that Home Health provide care to you as a part of your discharge. If so, the hospital staff has made this arrangement in your behalf. However, if you would like to change your care to an alternate agency, the following agencies are being provided for your consideration:

1. Heartland Home Health: (951) 369-8054
2. Visiting Nurses Association: (909) 624-3574
3. Sun Plus:(909) 605-7000

If you would like additional resources, you may contact the hospital social services for for help. Further, if you have an insurance other than Medicare or Medi-Cal, we recommend that you contact your insurance to verify which Home Health agencies are covered by your insurance.

If you are a Medicare patient review the following message from Medicare about your rights.
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
* Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
* Be involved in any decisions about your hospital stay, and know who will pay for it.

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/21/08 Time: 2106 (continued)

Activity Date: 11/21/08 Time: 2106 (continued)
* Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: LUMETRA 415-677-2000 or 800-841-1602

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON:
* You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
* You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
* If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
* If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
* If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
* Step by step instructions for calling the QIO and filing an appeal are below.

To speak with someone at the hospital about this notice, call the Director Of Nursing.

STEPS TO APPEAL YOUR DISCHARGE
* STEP 1: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
* Here is the contact information for the QIO:
Lumetra
One Sansome Street Suite 600
San Francisco 94104-4448
415-677-2000 or 800-841-1602
* You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
* Ask the hospital if you need help contacting the QIO.
* The name of this hospital is Chino Valley Medical Center.
The Provider ID number is 050586.
* STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
* STEP 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
* STEP 4: The QIO will review your medical records and other important information about your case.
* STEP 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/21/08 Time: 2106 (continued)

Activity Date: 11/21/08 Time: 2106 (continued)

* If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
* If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

* You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  * If you have Original Medicare: Call QIO listed above.
  * If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
* If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

Additional Information:

I have received a copy of these instructions and they have been explained to me and I understand the instructions.

Patient/Family Signature:____ _____
RN/LVN Signature:_____ Date:_____

** This is Part of Patient's Permanent Medical Record **

Activity Date: 11/21/08 Time: 2130

Patient Notes: Nurse Notes
Create 11/21/08 2130 MPR 11/21/08 2135 MPR
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.

Activity Date: 11/21/08 Time: 2149

1000-B	ADMISSION/TRANSFER: Quick Start Form +	D	ON ADMISSION/TRANS		AS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
1001	Agency Documentation + ALL REGISTRY PERSONNEL MUST DOCUMENT THIS INTERVENTION ONCE PER SHIFT.	D	WHEN APPLICABLE		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
1005-H	ADM: ADULT Admission History +	D	ON ADMISSION		AS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
1005-S	ADM: ADULT Admission Assessment +	D	ON ADMISSION		AS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
1070	Shift Reassessment +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/21/08 Time: 2149

1500	I&O: Monitor +	D	Q12H (0559,1759)		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
15000	Care Plan: RN Review +	D	Q12H		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
20010	VS: Monitor +	D	AS ORDERED		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
21090	Routine Care: MED/SURG/TELE + VIEW PROTOCOL	D	END OF SHIFT/TX		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
21400	Nutrition/Activity/ADL Flowsheet +	D	QS BY CAREGIVER		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
22300	IV/Invasive Lines: Insert/Remove +	D	INS/REMOVAL/CONVERT		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31200	Problem: Neurological +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31210	Problem: EENT +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31220	Problem: Respiratory +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31260	Problem: Musculoskeletal +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31270	Problem: Gastrointestional +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31280	Problem: Genitourinary +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31300	Problem: Nutrition +	D	QS & Q4H IN ICU		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
31320	Pain: Management Of +	D	AS NEEDED		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
60010	Notify: MD +	D	WHEN NECESSARY		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
80010	Education: Patient/Family Teaching +	D	QS BY CAREGIVER		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
90013	DIS: Patient Discharge Instructions +	D	ON DISCHARGE		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
150010	Weight +	D			CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
975050	Inventory Personal Belongings + ON ADMISSION & TRANSFER. PRINT OUT & HAVE PATIENT SIGN COPY.	D	ADM.TX.DC		AS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
1001031	Age Guidelines: 41-65 (MID ADULT)	D	VIEW PROTOCOL/DI QS		CP
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
3774002	Nutrition Screen: Adult +	D			PS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D
5058601	QRM: Social Services Review	D	ON ADMISSION		AS
Ed Status	11/21/08 2149 his 11/21/08 2149 his				A => D

Monogram	Initials	Name	Nurse Type
AS	EDSA	[redacted],Ulises	RN

Monogram Initials	Name		Nurse Type
ATS	NURSAT	Schroer,Anthea T	RN
BT	NURTB	Trinidad,Bienvenido	RN
CBH	FNHCB	Higgins,Chrystine B	DT
CC	CNACC	Carlos,Claudia	CNA
LAB	CNABLA	Battreall,Lisa A	CNA
MD	EDDM	Diaz,Michael	EMT
MPR	NURRMP	Ragaza,Maureene P.	RN
NIV	CNAVNI	Vega,Norma I	CNA
PAS	NURSPA	Stubbs,Pauline A.	RN
PB	CNABP	Bisong,Priscilla	CNA
REF	CNAFRE	Fuentes,Rosa Elvira	CNA
RMF	CNAFRM	Flores,Rosa Maria	CNA
RMV	CNANRM	Vargas,Rachel M	CNA
SA	EDAS	Alvarez,Stacey	LVN
SGS	CNASSG	Salibaba,Selina G	CNA
SM	SWMS	Montoya,Susan	SS
TLF	CAFTL	Frost,Teri L	RT
YYC	NURCYY	Chang,Ya Yun	RN
his		automatic by program	

Diagnosis: GBO - Intractable acute abd pain, dehydration, migraine, depression, elevated LFTs, poss arc s/p
Code Status (If transferred to an alternate facility) ☒ Full ☐ No CPR ☐ N/A
Discharge to: ☒ Home ☐ SNF ☐ B&C ☐ Acute ☐ Psych
☐ Facility: _____
Discharge Via: ☒ Private Auto ☐ Medical Van ☐ ALS Amb. ☐ BLS Amb. ☐ Other _____
Allergies: ☐ NKDA ☐ NKFA ☒ Allergies: reglan. (dystonic)
Catheter: ☒ None ☐ Foley ☐ Condom ☐ Straight Cath PRN
IV: ☒ None ☐ Heplock ☐ _____ @ _____ cc/hr (No Potassium)
Diet: ☐ Regular ☐ ADA ☐ Cardiac ☐ Renal ☐ Mechanical
☐ Low Protein ☒ Other: liquid diet then as tolerated / brat diet.
Activity: ☐ Bed Rest ☐ Ambulate ☐ BRP Only ☐ Chair ☒ As Tolerated

Medications as Follows: ☐ Prescription written
1. Atenolol 50mg Po qhs (Migraine prophylaxis)
2. Lexapro 10mg po qday (depression)
3. Zomig 2.5mg Po PRN migraine
4. Tylenol 500mg Po BID PRN Fever.
5. _____

Additional Order:
1. F/U c Dr Shah (Pt's GI Dr) for thickening of sigmoid wall.

Follow up with: ☒ Primary Physician within _____ days for an appointment Dr. Agarwal.
☐ Dr. _____ @ _____ within _____ days for Dr. Oh (surgeon) Nov 26. 08.
Working Ability: ☐ May return to work on next business day
☐ Return to work on _____ (Work release note written)
☐ Temporary disability, Length: _____ Reason: _____
☐ Permanent disability (>12 mo.) Reason: _____
☒ N/A
Ancillary Support: ☐ Home Health; Agency: _____
☐ Hospice; Agency: _____
☐ PT/OT/ST (Eval. & Tx); Agency: _____
☐ Durable medical equipment ordered (Rx written):
☒ N/A
☐ Home O_2 ☐ Neb ☐ FWW ☐ 3:1 commode
☐ Hospital Bed ☐ Shower Chair ☐ Other _____
Patient Education: ☐ Recommend Smoking Cessation
☐ Weight Gain +3-5 lbs, *Call your Doctor.*
☒ Worsening Symptoms (Temp, pain, SOB, leg swelling, etc.) *Call your Doctor.*
☐ Wound Care
Rehab Potential: ☐ Good ☐ Fair ☒ Poor ☐ N/A
Patient and/or Family aware of Diagnosis, Prognosis and Plan: ☒ Yes ☐ No
Patient Received Copy ☒ Yes ☐ No

Nurse's Signature	Date	Time
Jayalpa/ Takhar DO	11/21/08	2030
Physician's Signature	Date	Time

Chino Valley Medical Center
5451 WALNUT AVENUE, CHINO, CA 91710

PHYSICIAN DISCHARGE ORDERS AND INSTRUCTIONS

WHITE - CHART YELLOW - NURSING
000165 604.029 (7/06)

ADDRESSOGRAPH
HANNA, ADEL S
V000000305742
DOB: 03/29/46
DOS: 11/19/08
Lally, James M.
IN
M/62
MR#: M0002/3781

HANNA,ADEL S

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

Chino Valley Medical Center

NURRMP
Acct: V00000305742
Unit: M000273781

DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR

Please bring this sheet with you to your follow up visit with: DR. AGARWAL AND DR. OH
on (Date/Time): NOV. 26, 2008 ** OR **
Call for an appointment before: 11/26/08 Physician's Office Number: (909)621-7647
Discharge Date: 11/21/08 Discharge Time: 2100 Discharge To: HOME - NO NEEDS
: By: AUTOMOBILE Via: WHEELCHAIR
Accompanied By: SPOUSE
Discharge Comment: DISCHARGE INSTRUCTIONS GIVEN TO PATIENT
General Condition on Discharge:
Vital Signs: Temperature/F: 98.4 Respirations: 20 Blood Pressure: 132/82 Pulse: 64
Pain Controlled by Oral Medications: YES
Comment: DENIES PAIN AT THIS TIME
Voiding/Adequate Urinary Drainage: YES
Comment:
Patient Passing Flatus/Stool: Y
Comment:
Wound/Incision Assessment: NONE
Photograph Taken On Discharge and Placed On Chart:
Diabetic: N **IF YES** Follow Up To Be Done By:
The Patient Was Given Instructions in the Following:
Activity: MAY RESUME ALL ACTIVITY Restrictions:
Bath: Other:
Diet: Calories:
Restrictions:
Additional Education given:
: WORSENING SYMPTOMS :
: MD FOLLOW UP :
: NUTRITION/DIET :
Comment:

Prescriptions/Education given: N Food/Drug Interaction Form Given: Y
List DC Meds and Time next dose is due (if applicable):
: ATENOLOL 50MG BY MOUTH EVERY NIGHT
: LEXAPRO 15MG BY MOUTH DAILY (depression)
: ZOMIG 2.5MG BY MOUTH AS NEEDED FOR migraine
: TYLENOL 500MG BY MOUTH TWICE A DAY AS NEEDED FOR FEVER.
Wound/skin care:
:
:
Special Instructions: FOLLOW UP APPT. WITH DR. SHAH FOR THICKENING OF SIGMOID
: WALL.
:
Sent Home With All Belongings: Y Personal Belongings Inventory Reviewed/Signed: Y
Discharge Instructions Reviewed With: PATIENT Printed Instructions Given: Y
Pneumococcal Vaccine Given: N Date Given:
Discharge Plan: **TO BE COMPLETED BY QRM STAFF ONLY** Home Health:
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.

DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR

SPECIAL INSTRUCTIONS FOR THE CARDIAC/CHF PATIENT:

A. Patients with congestive heart failure must weigh every morning, record weight, and avoid smoking.
B. Medication: Know your medications. Don't stop taking your medications or change your dosage unless your doctor tells you to. Keep a list of your current medications. If you have Nitroglycerin, keep it with you at all times.
C. Activity: Start off slowly, plan your activities and get enough rest. Stop activity if you have any of these signs:
   Chest discomfort, severe or unusual fatigue, dizziness or faintness, irregular or rapid heartbeat, shortness of breath.
D. Smoking cessation is recommended. Smoking contributes to medical complications.
E. Call your doctor if:
   * Breathing becomes more difficult, or you have a cough with increased sputum or blood
   * You notice you're getting tired faster
   * Rapid or irregular heartbeat
   * You have dizzy spells or you faint
   * You begin urinating less frequently
   * You think you are having side effects from your medication
   * You have tightness or pain in your chest (Not relieved by Nitroglycerin)
   * If you have a rapid weight gain of 2 pounds in 1 or 2 days or your feet or ankles swell more than usual

Your physician may have recommended that Home Health provide care to you as a part of your discharge. If so, the hospital staff has made this arrangement in your behalf. However, if you would like to change your care to an alternate agency, the following agencies are being provided for your consideration:

1. Heartland Home Health: (951) 369-8054
2. Visiting Nurses Association: (909) 624-3574
3. Sun Plus: (909) 605-7000

If you would like additional resources, you may contact the hospital social services for for help. Further, if you have an insurance other than Medicare or Medi-Cal, we recommend that you contact your insurance to verify which Home Health agencies are covered by your insurance.

If you are a Medicare patient review the following message from Medicare about your rights.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

* Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
* Be involved in any decisions about your hospital stay, and know who will pay for it.
* Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: LUMETRA 415-677-2000 or 800-841-1602

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR

IF YOU THINK YOU ARE BEING DISCHARGED TOO SOON:
* You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
* You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  * If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
  * If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
* If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
* Step by step instructions for calling the QIO and filing an appeal are below.

To speak with someone at the hospital about this notice, call the Director Of Nursing.

STEPS TO APPEAL YOUR DISCHARGE
* STEP 1: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  * Here is the contact information for the QIO:
    Lumetra
    One Sansome Street Suite 600
    San Francisco 94104-4448
    415-677-2000 or 800-841-1602
  * You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
  * Ask the hospital if you need help contacting the QIO.
  * The name of this hospital is Chino Valley Medical Center. The Provider ID number is 050586.
* STEP 2: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
* STEP 3: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
* STEP 4: The QIO will review your medical records and other important information about your case.
* STEP 5: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  * If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  * If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

* You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  * If you have Original Medicare: Call QIO listed above.
  * If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
* If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227) or TTY: 1-877-486-2048.

HANNA,ADEL S

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

Chino Valley Medical Center

NURRMP
Acct: **V00000305742**
Unit: **M000273781**

DISCHARGE INSTRUCTIONS 11/21/08 2106 MPR

Additional Information:

I have received a copy of these instructions and they have been explained to me and I understand the instructions.

Patient/Family Signature: X _____
RN/LVN Signature: _____ Date: 11/21/08 2130

** This is Part of Patient's Permanent Medical Record **

Monogram Initials	Name	Nurse Type
MPR	NURRMP Ragaza,Maureene P.	RN

DATE: _____ CHECK IN TIME: _____ AM / PM

EMERGENCY DEPARTMENT TRIAGE SIGN-IN

PATIENT NAME: FIRST: Adel S. (NOMBRE DEL PACIENTE) (PRIMER NOMBRE) LAST: Hanna (APELLIDO)

PATIENTS DATE OF BIRTH: 03 / 29 / 1946 (FECHA DE NACIMIENTO) MONTH (MES) / DAY (DIA) / YEAR (AÑO) **SEX:** M (SEXO)

PATIENTS SOCIAL SECURITY NUMBER: 548-67-8932 (NUMERO DEL SEGURO SOCIAL)

PATIENT ADDRESS: P.O Box 238 Mail (DOMICILIO DEL PACIENTE)

CITY: Chino Hills (CIUDAD) **ZIP CODE:** 91709 (CODIGO POSTAL)

PATIENT'S TELEPHONE: (909) 606-7144 Work (TELEFONO DEL PACIENTE)

PATIENT COMPLAINT: S.O.B. Body ache. Ø Urinary output x 48 (QUE ENFERMEDAD TIENE / QUE LE DUELE)

HAVE YOU EVER BEEN IN THIS HOSPITAL BEFORE? (HA VENIDO A ESTE HOSPITAL ANTES?) ☑ YES ☐ SI ☐ NO ☐ NO

ER CONTACT: NAME: Irma Kawaguchi (CONTACTO EN EL DEPT. DE EMERGENCIA) (NOMBRE) PHONE: (909)374-7216 (TEL.)

PHYSICIAN NAME: Dr. Lally Pol WIFE NUNE (NOMBRE DEL DOCTOR)

NURSING STAFF:

CIRCLE ONE: **AMBULANCE / WALK-IN**

CIRCLE ONE: **ADULT / CHILD / INFANT**

BED: _____

EMERGENCY DEPARTMENT TRIAGE SIGN-IN

110-005

PATIENT I.D.

HANNA, ADEL S
U00000305742
DOB:03/29/46
DOS:11/19/08
Kachhi, Pranay
M/62 ER
MR#: M000273761

PHSI-110-005 (7/08)

TIME MD	ORDER	TIME CLERK	TIME ORDERED	M.D. ORDERS (Standing and Additional)	MARK DONE & INITIALS	TIME
	General			O2 via Nasal Cannula / Mask / Other	☑	
	CBC			IV Saline Lock / Bolus of		1935
	BMP			IV of ______ to run at rate of ______ mls / hr	☐	
	CMP			Cardiac Monitoring Pulse Ox		1935
	UA (total/dip)			☐ Pain Protocol Morphine ☐ Pain Protocol Fentanyl ☐ Pain Protocol Hydromorphone	☐	
	PT/INR			☐ Accu./ ☐ P.O. Fluid Challenge	☐	
	Abdominal Pain Panel				☐	
	LFTs			NS one liter IV Bolus	☐	1935
	Amylase/Lipase			Zofran 4mg IVP	☑	1943
	Serum Ammonia			Ativan one mg IVP	☑	1945
	Heart/Chest Pain			NGT to low intermittent Sx	☐	
	CCU panel			UNASYN 3 grams IVPB	☐	2000
	Thrombolytic panel			☐ Continue additional MD orders Form PHSI 110-003B	☐	
	EKG					
	EKG #2					
	Troponin					
	BNP					
	PT/INR/PTT					
	D-dimer					
	Sepsis					
	Sepsis panel					
	Serum Lactate					
	Culture					
	Blood					
	Vaginal Discharge panel					
	Urine					
	Other					

LAB: Ativan 1mg IVP 2050

X-RAY:

SAO2% ______ ☐ NL ☐ Hypoxemia ☐ Corrective Action

Cardiac Monitor: ☐ NSR ☐ ABNORMAL

EKG:

Informed Consent: The patient was apprised of the risks, benefits, alternatives, and aims of further management, had no further questions, and wished to proceed. Physician's Initials:

Procedures: ☐ Digital Block ☐ ETT Intubation ☐ NG Tube ☐ Gastric Lavage ☐ Cardiovert ☐ CPR/ACLS ☐ Splint/Immobilization ☐ IV ☐ Disloc/Reduction ☐ Central Line ☐ Cerumen Removal ☐ Foley ☐ Epistaxis Control ☐ Lumbar Puncture ☐ Chest Tube ☐ Time Out Performed ASA Score ☐ Sedation

Laceration: ☐ Simple ☐ Intermediate ☐ Complex Wound Length ______
Wound Depth ______ cm Inspection ______
Prep ______ Irrigation ______
Anesthesia ______ Suture Type # ______
Staples ☐ # ______ ☐ Dermabond Dressing: ______

Respiratory: Peak Flow before/after/predicted; HHN Albuterol 2.5mg/5mg, Ipratropium 0.5mg; Racemic Epi 2.25%; ABG on ______
OB/GYN: HCG UA; Quant BHCG; Blood Typ/Rh; FHT's
Trauma/Active Bleeding: Hgb/Hct; TS/TC x ______ units
Toxicology: ETOH; Urine drug screen; Acetaminophen/Aspirin; Medication level; Digoxin; Dilantin; Other
Cultures: Blood x 1 / 2 / 3; Urine / Sputum / Stool; Wound Source
Radiology: CXR; Xray; U/S; CT ABP; Contrast: oral/IV; Vascular
Miscellaneous: Medical Records; Calls to
MSE completed ☐

DIAGNOSTIC IMPRESSION:
1. Acute SBO
2.
3.
4.

☐ Admit ☐ Transfer 223 Accepting Physician: Tacman Institution: CVMC Time Accepted: 2015 Level of care: M/S

Other disposition: ☐ Discharge with After Care Instruction ☐ AMA ☐ LWBS ☐ Eloped ☐ DOA ☐ Expired
Disposition to: ☐ Home ☐ SNF ☐ Convalescent ☐ Other
Transportation: ☐ Auto ☐ Taxi ☐ EMT ☐ Other
Left dept: ☐ Ambulatory ☐ Wheelchair ☐ Gurney ☐ Other
Condition on discharge: ☐ Good ☐ Stable ☐ Fair ☐ Serious ☐ Critical
Signature:
Supervising Physician Signature ID # ______ Date 11/19/08 Time 1905
No Dictation Required ☐ Dictated ☐ Job # 713375

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

EMERGENCY DEPARTMENT PHYSICIAN RECORD / ORDER FORM

110-003

PHSI-110-003A (6/07)

WHITE - CHART YELLOW - PHARMACY PINK - E.R. PHYSICIAN GOLD - BILLING

Documentation & Dictation Guidelines

- Time and Method of Arrival
- Time of first physician contact
- Source of history and competency statement
- Indicate additional or alternative sources of information
- Indicate use of interpreter and identify the interpreter
- CHIEF COMPLAINT/-REASON FOR PRESENTATION/-PRESENT ILLNESS (list if more than one)
- History of Present Illness (be system focused and time & date specific)
- ROS: 10 systems required with 2 elements mentioned from each system for Level 5
  State each system that you have inquired about. They are:

  Constitutional/Eyes/ENT/CVS/Pulmonary/GI/GU/Gyne/Musculoskeletal/Skin/Neuro/ Psych/Endocrine/Hematologic/Immunity/

- Personal – Family – Social –
  - not required for Levels 1,2,3
  - 3 components are:
    - PMH Family History Social History
    - Mention one element from each area to qualify for level 4 & 5

- Physical Exam
- Management
  - Investigations (Diagnostics)
    - EKG, X-Ray, Pulse Oximetry, Monitor Strips require a physician order, interpretation, and mention of any treatment or intervention
  - Intervention & Treatment

- Review of Pre-Hospital Care notes
- Review of Nursing Notes
- Review Previous Medical Records
- INTERVAL NOTES
  - note time and specifics of each re-exam and change of therapy
- Medical Decision Making
- Procedures
- Diagnostic Impression
- Discharge time and plan
- CRITICAL CARE TIME
  - a time driven code requires minimum of 30 minutes of patient dedicated activity and does not include procedure time

CHIEF COMPLAINT: SOB

TEMP 98.8 PULSE 90 RESP 20 B/P 131/100 DX RA _____ WT. _____ kgs

TRIAGE TIME	TO ROOM TIME	M. D. EVAL TIME
1459	1709	1905

Arrival in ER via: ☐ Paramedic/EMT ☐ Automobile ☐ Police Patient is ☐ Ambulatory ☐ Wheelchair ☐ Assisted ☐ Bedridden
☐ Review Prehosp. Notes ☐ _____

Prehospital Treatment:

- Preferred Language ☐ English ☐ Other _____ Translator ☐ Yes ☐ No
- Unable to obtain Hx from patient ☐ Reasons _____
- Other/Additional Sources of Medical Information _____
- **HISTORY OF PRESENT ILLNESS:** (time nature onset, location, severity, duration, quality, modifying factors, associated signs & symptoms, provokes, relieves, context)

_____

_____

_____

REVIEW OF SYSTEMS (circle all positives)

NEG		
☐	**Const:**	fever chills wt loss fatigue ↓ appetite diaphoresis
☐	**Eyes:**	pain discharge redness visual change foreign body
☐	**ENT:**	pain bleeding congestion sore throat dysphagia discharge
☐	**Resp:**	SOB cough sputum wheezing pain
☐	**CV:**	chest pain palpitations DOE PND edema
☐	**GI:**	↓ appetite pain nausea vomiting diarrhea blood constipation
☐	**GU:**	dysuria hematuria flank pain discharge bleeding
☐	**Gyne:**	LMP ☐ NLP Normal _____ Date

NEG		
☐	**Musc:**	bone/joint pain back pain neck pain restricted ROM
☐	**Integ:**	rash skin lesions erythema laceration bruising
☐	**Neuro:**	HA dizziness syncope seizure focal-weakness
☐	**Endo:**	polyuria polydypsia dry-skin temp-intolerance
☐	**Lymph:**	adenopathy tender nodes lymphedema
☐	**Psych:**	hallucinations depression anxiety suicidal ideation
☐	**Immun:**	urticaria rhinitis pruritus immunodeficiency

Additional Comments/other systems: Last PO _____ Last BM _____ Last meds _____

_____

PAST MEDICAL, SOCIAL, FAMILY HISTORY

- **MEDICATIONS:** ☐ None ☐ See AMR ☐ Confirmed – list reviewed _____
- **ALLERGIES:** ☐ See AMR ☐ NKDA ☐ No food allergies ☐ Other Reglan
- **IMMUNIZATIONS:** ☐ UTD ☐ Tet. Current ☐ Pneumovax ☐ Influenza Vac ☐ Other _____
- **MEDICAL:** ☐ None CAD CHF Asthma/COPD CVA HTN Seizures DM ☐ Other _____
- **SURG:** ☐ None CABG Hyst BACK ☐ Other _____
- **FAMILY Hx:** ☐ NEG CAD DM HTN CA Heart Stroke Other: _____

Soc Hx: Tobacco: Alcohol Illicit Drug ☐ Lives alone ☐ SNF ☐ Married ☐ Lives with family

- **EMPLOYMENT** _____ EXPOSURES _____

PHYSICAL EXAMINATION

Infant: ☐ Active ☐ Playful ☐ Fontanelle flat ☐ Well-hydrated ☐ Crying/consolable ☐ Feeding ☐ Good eye contact ounces taken

Const: ☐ Well-developed ☐ Well nourished ☐ Alert ☐ No distress ☐ Oriented x 3 ☐ Memory intact

Psych: ☐ Mood / Affect NL ☐ No Anxiety ☐ No Depression ☐ No Confusion ☐ Non Suicidal _____

Head: ☐ Normocephalic ☐ Atraumatic ☐ No Laceration ☐ No Hematoma ☐ Other _____

Eyes: ☐ PERRL ☐ Conjunctiva NL ☐ Fundi, disc NL ☐ EOMI ☐ Lids NL ☐ Non Icteric ☐ Other _____

ENMT: ☐ External EN NL ☐ TMS NL ☐ Canal NL ☐ Nasal mucosa, septum NL ☐ Oral mucosa, tongue, lips, teeth NL ☐ Oropharynx NL

Neck: ☐ Supple ☐ Nontender ☐ No JVD ☐ No Bruits ☐ No masses ☐ No thyromegaly ☐ No nuchal rigidity _____

Resp: ☐ NL respiratory effort ☐ CTA ☐ BS = bilat ☐ No Wheezing ☐ No Rales
☐ No Rhonchi ☐ No chest wall tenderness/crepitus ☐ Normal to inspection ☐ RR at time of exam _____

CV: ☐ HR at time of exam ☐ RRR ☐ No murmurs/extra sounds ☐ Pulses NL ☐ No edema

GI: ☐ Abdomen NL to inspection ☐ No surgical scars ☐ Nontender ☐ No rebound, guarding ☐ No masses ☐ Liver, spleen NL
☐ bs present ☐ rectal: No mass, guaiac _____

GU: ☐ Male: ☐ penis NL ☐ scrotum NL ☐ prostate NL ☐ no CVA tenderness ☐ Discharge _____
☐ Female: ☐ external genitalia NL ☐ vagina NL ☐ cervix NL ☐ No CMT ☐ uterus NL ☐ adnexae NL
☐ no CVA tenderness

Musc: ☐ Extremities NL to inspection ☐ Digits and nails NL ☐ Extremities NL to palpitation ☐ Gait and stance NL
☐ Spine non tender ☐ No limitations

Neuro: ☐ Mental status NL ☐ Speech NL ☐ CNS II-XII Intact ☐ DTRs symmetric ☐ Sensation NL ☐ Strength NL ☐ Focal weakness None

Skin: ☐ Turgor NL ☐ No rash or lesions ☐ No Ecchymosis ☐ No Laceration ☐ No Puncture ☐ No Diaphoresis

Lymph: ☐ Lymph nodes NL ☐ Nontender ☐ Not enlarged ☐ Other _____

NURSES NOTES REVIEWED ☐ **Comments** _____

EMERGENCY DEPARTMENT PHYSICIAN RECORD / ORDER FORM

110-003

PHSI-110-003A (6/07)

WHITE - CHART YELLOW - PHARMACY PINK - E.R. PHYSICIAN

PATIENT I.D.

HANNA, JOE
V0000305747
DOB: 03/29/46
DOS: 11/19/08
ER
M/62
MSE M00027976

Documentation & Dictation Guidelines

- Time and Method of Arrival
- Time of first physician contact
- Source of history and competency statement
- Indicate additional or alternative sources of information
- Indicate use of interpreter and identify the interpreter
- CHIEF COMPLAINT/-REASON FOR PRESENTATION/-PRESENT ILLNESS (list if more than one)
- History of Present Illness (be system focused and time & date specific)
- ROS: 10 systems required with 2 elements mentioned from each system for Level 5
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- Review of Pre-Hospital Care notes
- Review of Nursing Notes
- Review Previous Medical Records
- INTERVAL NOTES
  - note time and specifics of each re-exam and change of therapy
- Medical Decision Making
- Procedures
- Diagnostic Impression
- Discharge time and plan
- CRITICAL CARE TIME
  - a time driven code requires minimum of 30 minutes of patient dedicated activity and does not include procedure time

RUN DATE: 11/19/08 | Chino Valley Medical Center ADM **LIVE** | PAGE 1
RUN TIME: 1857 | Nursing Medication Administration Record Form
RUN USER: ADOM
Patient Name: HANNA,ADEL | Triage Date: | DOB: 03/29/46 Age: 62 | Sex: M
Account #: V0000305742 | MR# : M000273781 | ED Doctor:
Primary DX: SHORTNESS OF BREATH,GENERALIZED WEAKNESS,NOT URINA

Allergies:

Time	Medication / Dose / Route	Initials	Time	Response	Initials
1943	Zofran 4mg w/ [illegible]				
1945	Ativan 1mg [illegible]		2014		
2050	Ativan 1mg [illegible]		2115		

Time	IV Solution	Gauge	Site	Additive	Rate	Infused	Stop Time	Initials
1935	TLNS	18g	[illegible]	[illegible] flush with 5mL NS	bolus	20 ml	TL	
2100	NS 100 cc	18		3 grams Unasyn	100	100 ml	230	

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

Rec 11-19-08

RUN DATE: 11/20/08 Chino Valley Med Center EDM **LIVE** PAGE 1
RUN TIME 1155 EDM Patient Record
RUN USER: HIRG

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

——ER Caregivers——
Physician Kachhi, Pranav
Practitioner
Nurse Alvarez,Stacey

Arrival Date 11/19/08
Time 1856
Triage Date 11/19/08
Time 1859

PCP

Stated Complaint SMALL BOWEL OBSTRUCTION
Chief Complaint SHORTNESS OF BREATH
Priority **Severity** 9

Departure Disposition XTR TO INTERNAL ACUTE CARE
Departure Diagnosis AC SBO
Departure Comment
Departure Condition

Departure Date 11/19/08
Time 2138

Assessments

Adult Triage

Date 11/19/08 **Time** 1859 **User** Bacani,Marlene O

Insurance: BLUE CROSS PRUDENT BUYER **Patient Age:** 62 **Workers Comp:**
TRIAGE LEVEL: 2 **Temperature/F:** 98.5
Time: 1859 **Date:** 11/19/08 **Source:** ORAL
Mode: WALK-IN **Pulse:** 90 **Respirations:** 20
Informant: PATIENT **Blood Pressure:** 131/88 **SpO2 (%):** 96
MICN Run: N **Weight - Lb:** **Oz:** **Kg:**
Pain Scale:

Chief Complaint: SHORTNESS OF BREATH,GENERALIZED WE
Mode of Injury: ONSET SINCE MON **Tetanus UTD:**
LMP:

Medications: ATENOLOL
Allergies: REGLAN

Suspected Abuse: N

=== MEDICAL HISTORY ===

Prior Hx: Y	**Asthma:**	**Arrythmia:**	**DM:**	**Seizures:**	
	COPD:	**HTN:**	**Liver:**	**Dementia:**	
	Cardiac:	**CVA:**	**Renal:**	**Psych:**	
	CHF:	**TIA:**	**Thyroid:**	**Other:**	MIGRAINE HA

===TRIAGE ABUSE SCREENING===
1. **Story Inconsistent With Injury:**
2. **Delay in Seeking Medical Care:**
3. **Evidence Of:**
   Unexplained Human Bite Marks:
   Unexplained Burns:
   Unexplained Lacerations:
   Unexplained Facial Injuries:
4. **Bruising in Various Stages of Healing:**
5. **Injuries Inconsistent with Age/Level of Activity:**
6. **Oversolicitous Caretaker/Partner:**
7. **Pattern of Injury Visits:**

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

8. Fearful of Caregiver:
9. Depression:
10. Denial of Injury Ever Occurring:
11. Malnourished Patient:
Any YES answer requires documentation of intervention carried out to communicate suspected abuse with charge nurse, ER physician and/or law enforcement, APS or CPS.

Personal Belongings List

Date 11/19/08 **Time** 1916 **User** Diaz,Michael

Inventory Date: 11/19/08 **Inventory Time:** 1916 **Performed By:** Diaz,Michael
Reason For Inventory: ADMISSION (ED STAFF)

-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:
:
-N Electrical Appliances **Describe:**
-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:
<< 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:_____

Patient HANNA,ADEL S Account No. V00000305742
Age/Sex 62/M Unit No. M000273781

ED Assessment

Date 11/19/08 Time 1920 User Alvarez,Stacey

====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: AWAKE, ALERT, & ORIENTED
====RESPIRATORY ASSESSMENT====
RESPIRATORY Assessment Within Normal Limits: Y
Breath Sounds: Location:
Breath Sounds: Location:
Effort: Chest Expansion:
Cough: Color:
IF ON OXYGEN
O2 @: Via:
Pulse Oximetry: SpO2 (%): Probe Location:
Comment: RESP EVEN & UNLABORED. NO SOB/DYSPNEA/COUGH NOTED PRESENTLY.
=====CARDIAC ASSESSMENT====
CARDIAC Assessment Within Normal Limits: N
Chest Pain:
Provoked:
Quality:
Radiating: Location/Describe:
Pain Level:
Time/Duration:
Heart Rate Irregular: Vertigo/Dizziness:
Syncope/Fainting:
Pt placed on O2:
O2 @: Via:
Pt placed on Cardiac Monitor: Y
Cardiac Rhythm: NORMAL SINUS RHYTHM
Comment:
====GASTROINTESTINAL ASSESSMENT====
GASTROINTESTINAL Assessment Within Normal Limits: N

Patient HANNA,ADEL S Account No. V00000305742
Age/Sex 62/M Unit No. M000273781

```
    Abdominal Appearance: SOFT/ROUND
          Abdominal Pain: N    Location:
                  Nausea: Y Vomiting: Y Diarrhea: Y Constipation: N
             GI Bleeding: N
                  Emesis:     Rectal:
                  Ostomy: N
  ==Last PO Intake==
            Food:
           Fluid:
       Comment: C/O VOMITING & DIARRHEA STARTED LAST NOC
    GI Comment:
====UROLOGICAL ASSESSMENT====
UROLOGY Assessment Within Normal Limits: N
       Pain/Dysuria:
            Burning:
          Frequency:
       Incontinence:
          Hematuria:
          Retention:
             Anuria: Y
     Foley Cath PTA:
     Comment: PT STS, " NO URINE OUTPUT IN 2 DAYS".
====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:
          Temp:              Pulse:              Sensation:              Mobility:
```

Patient HANNA,ADEL S Account No. V00000305742
Age/Sex 62/M Unit No. M000273781

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:

I&O

Date 11/19/08 Time 1935 User Alvarez,Stacey

=== INTAKE ===
Oral:
Tube Feeding:
IV's: 5
IVPB's:
Blood/Product:
=== OUTPUT ===
Urine: Source:
# of Voids/Incont:
Void QS:
Emesis:
NG Tube:
# of Stools:
Chest Tube #1:
Chest Tube #2:
Comment:

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

Vital Signs

Date 11/19/08 **Time** 1944 **User** Alvarez,Stacey

=== VITAL SIGNS ===

Blood Pressure:	121/93	**Respirations:**	18
BP Source:	AUTOMATIC	**Resp Source:**	OBSERVED
Pulse:	87	**Temperature/F:**	99.3
Pulse Source:	MONITOR, CARDIAC	**Temp Source:**	ORAL
SpO2 (%):	98	**Pain Level:**	0
On O2:	N		
Comment:	SR W/O ECT.		

Vital Signs

Date 11/19/08 **Time** 2013 **User** Alvarez,Stacey

=== VITAL SIGNS ===

Blood Pressure:	133/81	**Respirations:**	18
BP Source:	AUTOMATIC	**Resp Source:**	OBSERVED
Pulse:	75	**Temperature/F:**	
Pulse Source:	MONITOR, CARDIAC	**Temp Source:**	
SpO2 (%):	99	**Pain Level:**	0
On O2:	N		
Comment:	SR W/O ECT.		

I&O

Date 11/19/08 **Time** 2051 **User** Alvarez,Stacey

=== INTAKE ===
Oral:
Tube Feeding:
IV's: 1000
IVPB's:
Blood/Product:

=== OUTPUT ===
Urine: **Source:**
# of Voids/Incont:
Void QS:
Emesis:
NG Tube:
# of Stools:
Chest Tube #1:
Chest Tube #2:
Comment:

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

Vital Signs

Date 11/19/08 **Time** 2052 **User** Alvarez,Stacey

=== VITAL SIGNS ===

Blood Pressure: 116/90 **Respirations:** 18
BP Source: AUTOMATIC **Resp Source:** OBSERVED
Pulse: 98 **Temperature/F:**
Pulse Source: MONITOR, CARDIAC **Temp Source:**
SpO2 (%): 99 **Pain Level:** 0
On O2: N
Comment: SR W/O ECT.

Vital Signs

Date 11/19/08 **Time** 2130 **User** Alvarez,Stacey

=== VITAL SIGNS ===

Blood Pressure: 105/82 **Respirations:** 18
BP Source: AUTOMATIC **Resp Source:** OBSERVED
Pulse: 106 **Temperature/F:**
Pulse Source: MONITOR, CARDIAC **Temp Source:**
SpO2 (%): 99 **Pain Level:** 0
On O2: N
Comment: ST W/O ECT

ED Discharge

Date 11/19/08 **Time** 2138 **User** Alvarez,Stacey

====DISCHARGE/DISPOSITION====

Home: N **Admit/Transfer/Other:** Y
Time: **Time:** 2143
Accompanied By: **Disposition:** ADMIT
Mode: **Facility/Room:** 228
=ftercare Instructions Given: **Accompanied By:** NURSE
Pt Verbalizes Understanding: **Mode:** GURNEY
Report Called To: BEN, RN
Personal Belongings Sent With Patient: Y
Patient Belongings Sent with Family: Y
Blood Pressure: 105/82 **Pulse:** 106 **Respirations:** 18 **Temperature/F:** 99.3 **SpO2 (%):** 99
Pain Level: 0 **Condition on Discharge:** STABLE
IV DC'd: **Angiocath Intact:** Y **Foley Cath DC'd:** **Amount Emptied:**
Comment: NG CLAMPED FOR TRANSPORT. IV NS TKO LT HAND. SITE CLEAR. ALL BELONGINGS SENT TO FLOOR WITH PT. SPOUSE ACCOMPANIED PT TO FLOOR. PT TRANS BY D. LOPEZ, RN.

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

Patient Notes

Alvarez,Stacey - 11/19/08 - 1910
DR KACHHI AT BEDSIDE FOR EXAM. 12 LEAD EKG COMPLETED BY M. DIAZ, EMT. RESULT TO DR KACHHI.

Alvarez,Stacey - 11/19/08 - 1920
BLOOD DRAWN BY JOHN, PHLEBOTOMIST.

Alvarez,Stacey - 11/19/08 - 1925
PT TRANS TO CT VIA GUERNEY WITH JIM, CT TECH.

Alvarez,Stacey - 11/19/08 - 1931
RETURNED FROM CT. PCXR COMPLETED AT BEDSIDE BY XRT.

Alvarez,Stacey - 11/19/08 - 1935
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.

Alvarez,Stacey - 11/19/08 - 1944
MEDICATED WITH ZOFRAN & ATIVAN IVP BY D. LOPEZ, RN.

Alvarez,Stacey - 11/19/08 - 2005
PT RE-EVAL'D BY DR KACHHI.

Alvarez,Stacey - 11/19/08 - 2013
PT REQUEST TO " MAKE PHONE CALLS BEFORE INSERTING NG TUBE". PT ALLOWED PRIVACY.

Serpas,Ulises 11/19/08 - 2021
PLEASE ENTER FULL NAMES OF LVN/RN

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

Alvarez,Stacey - 11/19/08 - 2035
MRSA PROTOCOL EXPLAINED TO PT & SPOUSE. NASAL SWAB OBTAINED PER PROTOCOL. SPECIMEN SENT TO LAB PER ORDERS.

Alvarez,Stacey - 11/19/08 - 2040
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.

Alvarez,Stacey - 11/19/08 - 2050
PT MEDICATED WITH ATIVAN IVP BY D. LOPEZ, RN

Alvarez,Stacey - 11/19/08 - 2059
RESIDENT & MED STUDENT AT BEDSIDE FOR EXAM.

Patient HANNA,ADEL S Account No. V00000305742
Age/Sex 62/M Unit No. M000273781

Alvarez,Stacey - 11/19/08 - 2059
REPORT CALLED TO M/S. SPOKE WITH BEN, RN.

Alvarez,Stacey - 11/19/08 - 2100
MEDICATED WITH UNASYN IVPB BY J. DEL VALLE, RN.

Alvarez,Stacey - 11/19/08 - 2120
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.

Alvarez,Stacey - 11/19/08 - 2136
LINDA, XRT AT BEDSIDE FOR PKUB FOR TUBE PLACEMENT.

Alvarez,Stacey - 11/19/08 - 2138
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

Treatments

IV Management

Date 11/19/08 Time 1935 User Alvarez,Stacey

====IV MANAGEMENT====
IV ESTABLISHED PTA: N
Established -- Date: 11/19/08
IV Location: LT HAND Catheter Size (ga.): 18
IV Location: Catheter Size (ga.):
IV Location: Catheter Size (ga.):
Discontinued -- Time: Angiocath Intact:
IV Converted to Saline Lock:
Comment: X 1 ATTEMPT

NG Tube

Date 11/19/08 Time 2120 User Alvarez,Stacey

====NASOGASTRIC TUBE====
Nasogastric Tube Inserted: Y Nares: LT
NGT Size: 16F Time: 2120
Attempts: 2 Difficult Insertion: N
Epigastric Auscultation: Y
X-Ray to Verify Placement: Y
Nasgastric Tube Discontinued: Time:
Comment: XR CALLED FOR TUBE PLACEMENT FILMS BY M. ESPINOZA, MT.

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M00027378l

Orders

Date	Time	Procedure	Ordering Provider
11/19/08	1918	AMYLASE	Kachhi, Pranav
11/19/08	1918	BASIC METABOLIC PROFILE	Kachhi, Pranav
11/19/08	1918	CBC	Kachhi, Pranav
11/19/08	1918	CHOLESTEROL	Kachhi, Pranav
11/19/08	1918	CKMB CARDIAC TEST	Kachhi, Pranav
11/19/08	1918	CREATINE KINASE (CK)	Kachhi, Pranav
11/19/08	1918	CT ABDOMEN+PELVIS W/O CON	Kachhi, Pranav
11/19/08	1918	ELECTROCARDIOGRAM	Kachhi, Pranav
11/19/08	1918	HDL CHOLESTEROL	Kachhi, Pranav
11/19/08	1918	HEPATIC FUNCTION PROFILE	Kachhi, Pranav
11/19/08	1918	LACTIC DEHYDROGENASE (LDH)	Kachhi, Pranav
11/19/08	1918	LIPASE	Kachhi, Pranav
11/19/08	1918	MYOGLOBIN BLOOD	Kachhi, Pranav
11/19/08	1918	PARTIAL THROMBOPLASTIN TIME	Kachhi, Pranav
11/19/08	1918	PROTHROMBIN TIME	Kachhi, Pranav
11/19/08	1918	TROPONIN I	Kachhi, Pranav
11/19/08	1918	XR CHEST: 1V (AP/PA)	Kachhi, Pranav

Lab Results

Date	Time	Test	Result	Reference
11/19/08	1920	ALBUMIN	3.7	3.4-5.0 g/dL
11/19/08	1920	ALKALINE PHOSPHATASE	42 L	50-136 U/L
11/19/08	1920	ALT/SGPT	33	30-65 U/L
11/19/08	1920	AMYLASE	28	25-115 U/L
11/19/08	1920	AST/SGOT	13 L	15-37 U/L
11/19/08	1920	BASOPHIL #	0.0	0-0.2 10^3/ul
11/19/08	1920	BASOPHIL %	0.7	0-2 %
11/19/08	1920	BILIRUBIN DIRECT	0.16	0.0-0.5 mg/dL
11/19/08	1920	BILIRUBIN TOTAL	0.54	0.2-1.1 mg/dL
11/19/08	1920	BLOOD UREA NITROGEN	22.0 H	7.0-18.0 mg/dL
11/19/08	1920	CALCIUM	8.4 L	8.8-10.5 mg/dL
11/19/08	1920	CARBON DIOXIDE	25.4	21-34 mmol/L
11/19/08	1920	CHLORIDE SERUM	102	98-108 mmol/L
11/19/08	1920	CHOLESTEROL	110 L	135-200 mg/dL
11/19/08	1920	CKMB TEST FOR CARDIAC	1.2	0-5.0 ng/mL
11/19/08	1920	CKMBI	Test not performed	0-2.5 %
11/19/08	1920	CREATINE KINASE (CK)	38	21-232 U/L
11/19/08	1920	CREATININE SERUM	0.94	0.5-1.4 mg/dL
11/19/08	1920	EOSINOPHIL %	3.8	0.0-11.0 %
11/19/08	1920	EOSINOPHILS #	0.2	0-0.5 10^3/uL
11/19/08	1920	ESTIMATED GFR AFRICAN AMERICAN	> 60	ml/min
11/19/08	1920	ESTIMATED GFR NON AFRI-AMERI	> 60	ml/min
11/19/08	1920	GLUCOSE SERUM	104	71-117 mg/dL
11/19/08	1920	HDL CHOLESTEROL	36	32-96 mg/dL
11/19/08	1920	HEMATOCRIT	46	42-52 %
11/19/08	1920	HEMOGLOBIN	15.6	13.0-18.0 g/dL

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

11/19/08	1920	INTERNATIONAL NORMAL RATIO	1.13	0-3.0
11/19/08	1920	LACTIC DEHYDROGENASE (LDH)	110	100-190 U/L
11/19/08	1920	LIPASE	180	114-286 U/L
11/19/08	1920	LYMPHOCYTE #	1.4	1.0-4.8 10^3/ul
11/19/08	1920	LYMPHOCYTE %	31.5	25-45 %
11/19/08	1920	MANUAL DIFF REQUIRED?	NO	
11/19/08	1920	MEAN CELL HGB CONCENTRATION	34	32-37 pg
11/19/08	1920	MEAN CELL HGB	28	27-31 pg
11/19/08	1920	MEAN CELL VOLUME	83	80-99 fl
11/19/08	1920	MEAN PLT VOLUME	10.0	7.4-10.4 fl
11/19/08	1920	MONOCYTE #	0.4	0-0.8 10^3/ul
11/19/08	1920	MONOCYTE %	8.7	2.5-10.0 %
11/19/08	1920	MYOGLOBIN BLOOD	37.0	12-110 ng/mL
11/19/08	1920	NEUTROPHIL %	55.3	40-70 %
11/19/08	1920	NEUTROPHIL	2.5	1.8-7.7 10^3/uL
11/19/08	1920	PARTIAL THROMBOPLASTIN TIME	29.0	21.7-33.9 sec
[redacted]/19/08	1920	PLATELET COUNT	177	130-400 x10^3mcL
[redacted]/19/08	1920	POTASSIUM SERUM	3.6	3.5-5.1 mmol/L
11/19/08	1920	PROTHROMBIN TIME PATIENT	12.1	10.1-12.8 sec
11/19/08	1920	RED BLOOD CELLS	5.51	4.52-5.90 M/mm3
11/19/08	1920	RED CELL DISTRIBUTION WIDTH	14.3	11.5-14.5 %
11/19/08	1920	SODIUM SERUM	136	135-148 mmol/L
11/19/08	1920	TOTAL PROTEIN SERUM	7.5	6.3-8.2 g/dL
11/19/08	1920	TROPONIN I	0.06	<1.4 ng/mL
11/19/08	1920	WHITE BLOOD CELL	4.5	4.5-11.0 K/mm3

Radiology Results

Date	Time	Procedure Name	Result Code

11/19/2008 1918 CT-ABDOMEN+PELVIS W/O CON

Impression:

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.

11/19/2008 1918 XR CHEST: 1V (AP/PA)

Impression:

CONCLUSION:

Bibasilar discoid atelectasis.

Patient HANNA,ADEL S **Account No.** V00000305742
Age/Sex 62/M **Unit No.** M000273781

Patient Call Log

Call Received by: Espinoza,Maria E **When:** 11/19/08 2009

Call Type: ADMISSION
Caller: DR. TAKHAR

Summary of Call:

PMD called/paged for an ER admission.

Patient V00000305742 HANNA,ADEL

Adult Triage

Date 11/19/08 Time 1859 User Bacani,Marlene O

Insurance: BLUE CROSS PRUDENT BUYER Patient Age: 62 Workers Comp:
TRIAGE LEVEL: 2 Temperature/F: 98.5
Time: 1859 Date: 11/19/08 Source: ORAL
Mode: WALK-IN Pulse: 90 Respirations: 20
Informant: PATIENT Blood Pressure: 131/88 SpO2 (%): 96
MICN Run: N Weight - Lb: Oz: Kg:
Pain Scale:
Chief Complaint: SHORTNESS OF BREATH,GENERALIZED WE
Mode of Injury: ONSET SINCE MON Tetanus UTD:
LMP:

Medications: ATENOLOL
Allergies: REGLAN

Suspected Abuse: N

=== MEDICAL HISTORY ===
rior Hx: Y Asthma: Arrythmia: DM: Seizures:
COPD: HTN: Liver: Dementia:
Cardiac: CVA: Renal: Psych:
CHF: TIA: Thyroid: Other: MIGRAINE HA

===TRIAGE ABUSE SCREENING===
1. Story Inconsistent With Injury:
2. Delay in Seeking Medical Care:
3. Evidence Of:
Unexplained Human Bite Marks:
Unexplained Burns:
Unexplained Lacerations:
Unexplained Facial Injuries:
4. Bruising in Various Stages of Healing:
5. Injuries Inconsistent with Age/Level of Activity:
6. Oversolicitous Caretaker/Partner:
7. Pattern of Injury Visits:
8. Fearful of Caregiver:
. Depression:
0. Denial of Injury Ever Occurring:
11. Malnourished Patient:
Any YES answer requires documentation of intervention carried out to communicate suspected abuse with charge nurse, ER physician and/or law enforcement, APS or CPS.

ACCOUNT #: V00000305742
PATIENT: HANNA, ADEL S.
DATE OF ADMISSION: 11/19/2008

cc: Yoonjung Jang, RES D.O.
James M. Lally, D.O.

INFORMANT: The history was obtained from the patient who is alert and oriented to person, place, and time and who appears to be an accurate historian, comprehends and speaks English adequately.

CHIEF COMPLAINT: Abdominal pain with nausea x2 days.

HISTORY OF PRESENT ILLNESS: The patient is a 62-year-old Caucasian male, brought into the emergency room by his wife with two days' history of abdominal pain. The patient states that his abdominal pain is 5/10, which also is accompanied with chills, fever, dizziness, diarrhea, and generalized body ache. The patient states that he was unable to tolerate the food or drink for two days due to nausea, vomiting, and diarrhea. The patient has no urinary output for two days either. The patient describes the abdominal pain as continuous cramping and generalized everywhere. Also, the patient tried Tylenol to control his fever. The patient has a history of depression and migraine.

PAST MEDICAL HISTORY: Migraine and depression.

PAST SURGICAL HISTORY:
Cholecystectomy in 1986, hiatal hernia repair in 1992. Complication from surgery included perforated viscus and empyema. The patient is status post angiogram and Cardiolite, which was negative.

ALLERGIES: REGLAN, which makes him have shortness of breath and breathing difficulty.

MEDICATIONS: Atenolol 50 mg daily for migraine prophylaxis, Lexapro 15 mg daily for depression, Zomig 2.5 mg p.r.n. migraine, and Tylenol 500 mg p.o. b.i.d. for fever.

SOCIAL HISTORY:
The patient denies smoking and drinks occasionally; however, denies drinking caffeine or recreational drug use. The patient is married. He lives with his wife. His primary care physician is Dr. Agarwal. The patient's code status is FULL CODE. The patient is a physician working in the prison.

FAMILY HISTORY: The patient denies any other cancer, tuberculosis, or blood disorders; however, the patient states that his brother has heart disease.

REVIEW OF SYSTEMS:
GENERAL: The patient denies any recent changes in weight; however, the patient has had fevers, chills, and fatigue for couple of days. He denies night sweats.
SKIN: The patient denies any rashes, changes in hair or nails, or skin lesions.
HEENT: The patient states that he has migraine and has been taking atenolol and Zomig for prophylaxis. The patient denies any trauma. The patient has no decreased vision or visual changes. No complaints such as blurriness, increased tearing, or photophobia. The patient admits to having high frequency hearing loss in the right ear. The patient denies pain. He denies discharge or vertigo. The patient admits to having a sore throat for a couple of days. The patient denies nasal trauma, pain, obstruction, epistaxis, head cold, discharge, or rhinitis.
ORAL: The patient admits he was having soreness of the throat. The patient denies any history of soreness of the mouth or tongue. No history of mouth ulcers. The patient does not wear dentures.
THROAT: The patient denies dysphagia, laryngitis, or speech defect. However, the patient admits to having sore throat for a couple of days. The patient was taking the candies for sore throat.
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, discharges, or infections.
RESPIRATORY: The patient denies chest pain, asthma, recent URI and/or night sweats; however, the patient admits to having nonproductive cough for a couple of days, which is causing shortness of breath.
CARDIOVASCULAR: The patient denies chest pain, pressure, dyspnea, cardiac irregularities, orthopnea, palpitations, or peripheral edema, cramps, and/or varicosities.
GASTROINTESTINAL: The patient admits to having food intolerance due to nausea and vomiting for the last couple of days. Also, complaining of nausea, vomiting, and abdominal pain for a couple of days. However, denies hematemesis, jaundice, melena, constipation, and also admits to having diarrhea.
GENITOURINARY: The patient complains of no urinary output for two days.
METABOLIC: The patient denies any recent changes in weight. The patient has decreased appetite for two days.
ENDOCRINE: The patient denies thyroid disease or 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 or transfusions.
LYMPHATICS: The patient denies history of enlarged, swollen and/or tender lymph nodes.
EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: The patient denies history of trauma, arthritis, fracture, or limited range of motion. The patient complains of generalized body aches.

NEUROLOGIC: The patient complains of history of migraines, which are controlled. The patient denies strokes, seizures, loss of consciousness, paresthesia or numbness, changes in thinking or memory.
PSYCHIATRIC: The patient denies history of nervousness, anxiety, mood swings, hallucinations, schizophrenia, psychiatric consultation or hospitalizations. The patient has history of depression and use of medication for depression, which is Lexapro for the past three years.

PHYSICAL EXAMINATION:
GENERAL: The patient is a 62-year-old male, well developed, well nourished, alert and oriented to person, place, and time.
VITALS: Temperature is 98.5 degrees Fahrenheit, pulse 90 beats per minute, respirations 20, and blood pressure 131/88. Weight is 167 pounds and height 5 feet 8 inches.
HEENT: Normocephalic and atraumatic. The patient has binocular vision. Pupils are equal, round, and reactive to light. Extraocular movements are intact. Funduscopic examination reveals physiologic cup-to-disc ratio without AV nicking or evidence of papilledema, hemorrhages and/or exudates. 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 dry 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 and/or other masses. Trachea is midline without obstruction.
LUNGS: Clear to auscultation bilaterally. No rhonchi, rales, wheezes or crepitus.
HEART: Regular rate at 90 beats per minute without murmur. Point of maximum impulse is in the fifth intercostal space. Normal S1 and S2. No S3, S4, thrill, friction rubs and/or gallops.
ABDOMEN: Bowel sounds are present. Abdomen is soft and tender to palpation in all four quadrants. There is guarding. Negative rebound. No organomegaly noted.
RECTAL: Deferred by the patient.
EXTREMITIES/MUSCULOSKELETAL/OSTEOPATHIC: Joint examination reveals no tenderness, swelling, redness, and restriction 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. Muscle size and strength are within normal limits, 5/5.

Shoulders and iliac crest heights are equal. Thoracic, cervical and lumbar spines are without spasm. Nontender to palpation. Range of motion shows no abnormal or asymmetrical changes. Lateral curvatures are within normal limits.

Paravertebral musculature shows no tissue and/or texture changes or tendency. No costovertebral angle tenderness noted bilaterally.

FOOT EXAMINATION: Pulses are equal. Skin is warm. Capillary refill is within two seconds. There are no varicosities. No stasis ulcers. No deformities. No swollen joints or bone spurs, blisters, friction sites, corns, calluses, erythema, edema, or ulcers. No yellow or thickened nails, tinea or plantar warts.

LYMPHATICS: No cervical, axillary, supraclavicular and/or inguinal lymphadenopathy.

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. No nystagmus.

CN V: The patient is able to clench jaws, able to move jaw from side to side. Corneal reflex is intact as demonstrated by spontaneous blink.

CN VII: The patient demonstrates facial expression and has taste to anterior two-thirds of tongue.

CN VIII: The patient can hear spoken words whispered. No nystagmus.

CN IX: Taste is intact for the posterior one-third of the tongue.

CN X: Soft palate and uvula pull upward in the midline, and good phonation without hoarseness. Positive gag reflex.

CMP and magnesium phosphatase, coag panels and blood are not done. UA and urine drug screen is not done. Echocardiogram is to be read by Dr. Agarwal for possible heart failure. Toradol 30 mg IV every six hours p.r.n. for pain x6, ampicillin 1 mg IV every eight hours for shortness of breath and possible sepsis, atenolol 50 mg p.o. every night for migraine prophylaxis, and Benadryl IV 25 mg x1 p.r.n. for agitation. Consult Dr. Quianzon for small bowel obstruction who may participate in the patient's care. BMP for possible renal failure and CBC for possible sepsis in the a.m. Consult Dr. Aman who may participate in the patient's care and management for abdominal pain.

Care was discussed with the patient's family at length. She is aware and they are in agreement with plan of treatment.

PROGNOSIS:
Guarded.

DISPOSITION:
The patient is to be discharged upon medical treatment.

James M. Lally, D.O.

Yoonjung Jang, RES D.O.

DR: YJ/NKK
DD: 11/19/2008 23:08
DT: 11/20/2008 07:16
Job #: 059713410

ACCOUNT #:	V00000305742
PATIENT:	HANNA, ADEL S.
DATE OF CONSULTATION:	11/20/2008

cc:

REQUESTING PHYSICIAN:	James M. Lally, D.O.
CONSULTING PHYSICIAN:	Mukesh S. Amin, M.D.

REASON FOR CONSULTATION:
Multiple problems, which includes abdominal pain, SBO, azotemia, and dehydration.

Thank you, Dr. Lally, for letting me to evaluate your patient on a full complex medical consultation.

HISTORY OF PRESENT ILLNESS:
This is a very pleasant 62-year-old male with multiple past medical histories, which includes migraine and depression who was essentially admitted with abdominal pain, nausea x2 days, chills, fever, dizziness, and some generalized body ache. The abdominal pain was continuous. The patient was admitted and found to have SBO. NG tube was placed and IV Protonix was started and IV ampicillin was started as well. No fever, chills, and no other associated symptomatology.

PAST MEDICAL HISTORY:
Significant for:
1. Migraine.
2. Depression.

PAST SURGICAL HISTORY:
Significant for:
1. Cholecystectomy.
2. Hiatal hernia repair.
3. Also, complication from surgery as well.

MEDICATIONS:
1. Atenolol.
2. Lexapro.
3. Zomig.
4. Tylenol.

ALLERGIES: REGLAN.

SOCIAL HISTORY:
No smoking. Occasional alcohol use. No drugs.

FAMILY HISTORY: Brother is with heart disease.

REVIEW OF SYSTEMS:
GENERAL: No fever or chills noted in the hospital. HEENT: The patient has sore throat plus high frequency hearing loss. ORAL: Without any soreness. CARDIAC: No chest pain, orthopnea, or palpitations. GASTROINTESTINAL: As per HPI. GENITOURINARY: Negative. MUSCULOSKELETAL: Mild body ache. HEMATOLOGIC: No history of anemia. ENDOCRINE: No history of diabetes mellitus. NEUROLOGIC: No seizure, CVA, or syncope.

PHYSICAL EXAMINATION:
GENERAL: The patient is a well-developed, well-nourished male, currently in no apparent distress.
VITAL SIGNS: Blood pressure is 118/82, pulse 94, respirations 18, and temperature 99.7 degrees.
HEENT: Extraocular muscles are intact. Pupils are equal and reactive to light. Conjunctivae are pink. Sclerae are anicteric. Mucous membranes are dry.
NECK: Supple. No JVD or thyromegaly. No lymphadenopathy. Carotids are 4+ bilaterally without bruit.
LUNGS: Clear.
HEART: Regular rate and rhythm. Normal S1 and S2. Negative S3. No murmur or rub heard.
ABDOMEN: Soft and nontender. Normoactive bowel sounds. Liver and spleen are not palpable.
EXTREMITIES: No cyanosis, clubbing, or edema.
NEUROLOGIC: Nonfocal.

LABORATORY AND DIAGNOSTIC DATA:
EKG showed normal sinus rhythm with nonspecific ST-wave changes. Sodium was 136, potassium 3.6, chloride 102, bicarbonate 25.0, glucose 104, BUN 22, creatinine 0.94, and calcium 8.4. LFTs were normal. Amylase was 28. Cholesterol was 110. ProTime was 12.1. INR was 1.13. WBC count was 4.5, hemoglobin 15.6, and hematocrit 46.

ASSESSMENT:
1. Abdominal pain, small bowel obstruction.
2. Dehydration, azotemia.
3. Depression.
4. Migraine.

ACCOUNT #: V00000305742
PATIENT: HANNA, ADEL S.
DATE OF CONSULTATION: 11/20/2008

PLAN/RECOMMENDATIONS:

1. Agree with current treatment.
2. IV fluids.
3. Follow up chem-7.
4. Add 40 mEq of KCl in IV.
5. UA C&S.
6. Agree with other care plan rendered and we will closely monitor and follow the patient for further evaluation pending the results.

Mukesh S. Amin, M.D.

DR: MSA/TN
DD: 11/20/2008 07:46
DT: 11/20/2008 23:18
Job #: 059713445