Medications (continued)

All Meds and Administrations (continued)

isosorbide mononitrate (IMDUR) 24 hr tablet [575569124]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/27/15 1050
Dose (Remaining/Total): 30 mg (---/---)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1100 - 05/28/15 1801
Route: Oral
Rate/Duration: --- / ---

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 05/28/15 0840 Documented: 05/28/15 0842	Given	30 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 68084-591-11
Performed 05/27/15 1145 Documented: 05/27/15 1146	Not Given Recently Given	30 mg	Oral	Performed by: Kate M Hand, RN Comments: Taken at home

chlorthalidone (HYGROTON) tablet [575569125]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/27/15 1050
Dose (Remaining/Total): 50 mg (---/---)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1100 - 05/28/15 1801
Route: Oral
Rate/Duration: --- / ---

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 05/28/15 0840 Documented: 05/28/15 0842	Given	50 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 51079-058-01, 51079-058-01
Performed 05/27/15 1145 Documented: 05/27/15 1145	Not Given Recently Given	50 mg	Oral	Performed by: Kate M Hand, RN Comments: Taken at home

carvedilol (COREG) tablet [575569126]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/27/15 1050
Dose (Remaining/Total): 12.5 mg (—/—)
Frequency: 2 Times daily with meals
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1100 - 05/28/15 1801
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 05/28/15 0840 Documented: 05/28/15 0842	Given	12.5 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 68084-262-11, 68084-262-11
Performed 05/27/15 1848 Documented: 05/27/15 1849	Given	12.5 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 68084-262-11, 68084-262-11
Performed 05/27/15 1144 Documented: 05/27/15 1144	Not Given Recently Given	12.5 mg	Oral	Performed by: Kate M Hand, RN Comments: Taken at home

clopidogrel (PLAVIX) tablet [575569127]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/27/15 1050
Dose (Remaining/Total): 75 mg (---/---)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1100 - 05/28/15 1801
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information

Medications (continued)

All Meds and Administrations (continued)

Performed 05/28/15 0841 Given Documented: 05/28/15 0842	75 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 0904-6294-61
Performed 05/27/15 1144 Not Given Documented: 05/27/15 Recently Given 1144	75 mg	Oral	Performed by: Kate M Hand, RN

nitroglycerin (NITROSTAT) SL tablet [575569128]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 05/27/15 1050
Dose (Remaining/Total): 0.4 mg (—/—)
Frequency: Every 5 min PRN
Admin Instructions: x 3 doses. Notify MD if no relief after 3 doses.

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1050 - 05/28/15 1801
Route: Sublingual
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

cilostazol (PLETAL) tablet [575602576]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 05/27/15 1050
Dose (Remaining/Total): 100 mg (—/—)
Frequency: 2 Times daily
Admin Instructions: **Caution: Sound alike/look alike medication**

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1100 - 05/28/15 1801
Route: Oral
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 05/28/15 0840 Documented: 05/28/15 0842	Given	100 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 68084-779-11, 68084-779-11
Performed 05/27/15 2148 Documented: 05/27/15 2149	Given	100 mg	Oral	Performed by: Leslie M Best, RN Comments: pt. now states it was coreg that he took earlier. Wants to take the Pletal Scanned Package: 60505-2521-1, 60505-2521-1
Performed 05/27/15 2143 Documented: 05/27/15 2146	Refused	100 mg	Oral	Performed by: Leslie M Best, RN Comments: Pt. states he had this med twice today already. 1st dose given at 1205 but no documentation of 2nd dose. Pt. refuses after explanation of no documentation
Performed 05/27/15 1205 Documented: 05/27/15 1206	Given	100 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 60505-2521-1, 60505-2521-1

aspirin EC tablet [575602600]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 05/27/15 1104
Dose (Remaining/Total): 81 mg (—/—)
Frequency: Daily

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/27/15 1200 - 05/28/15 1801
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 05/28/15 0841 Documented: 05/28/15 0842	Given	81 mg	Oral	Performed by: Kate M Hand, RN Scanned Package: 63739-522-10
Performed 05/27/15 1144 Documented: 05/27/15 Recently Given 1144	Not Given	81 mg	Oral	Performed by: Kate M Hand, RN Comments: Taken at home

Medications (continued)

All Meds and Administrations (continued)

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Care Plan

Multidisciplinary Problems (Active)

There are no active problems.

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Not documented in this visit.
Progress:

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Not documented in this visit.
Progress:

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Not documented in this visit.
Progress:

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Not documented in this visit.
Progress:

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.
Learner Not documented in this visit.
Progress:

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Patient Education (continued)

Education (continued)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Exercise (Resolved)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Patient Education (continued)

Education (continued)

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learning Progress Summary

Patient	Acceptance, Explanation, Handout, Verbalized Understanding by MT at 5/28/2015 0932 Comment: PCI review done. Strong family hx CAD. Compliant with diet and active on his property. Does not want Cardiac Rehab.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learning Progress Summary

Patient	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319
Significant Other	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learning Progress Summary

Patient	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319
Significant Other	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Resolved)

Point: Anticoagulant Therapy (Resolved)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Resolved)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.
Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Resolved)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Resolved)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Resolved)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Resolved)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Resolved)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learning Progress Summary

Patient	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319
Significant Other	Eager, Explanation, Handout, Verbalized Understanding by KH at 5/28/2015 1319

Point: Digoxin (Resolved)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Resolved)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Inotropes (Resolved)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Resolved)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Resolved)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

User Key

Initials	Effective Dates	Name	Provider Type	Discipline
MT	04/02/14 - 02/02/17	Marie Thomas-Stanley, RN	Registered Nurse	Nurse
KH	04/02/14 - 02/02/17	Kate M Hand, RN	Registered Nurse	Nurse

Education Notes

Marie Thomas-Stanley, RN 05/27/15 1210
Pt eating lunch post PCI today. Booklet at bedside. F/u in am.

Discharge Instructions

Discharge Instructions Maurice, Eugene George (MR # 561253820)

Date	Status	User	User Type	Discharge Note
05/28/15 1253	Pended	Kate M Hand, RN	Registered Nurse	Original
Note:				

Heart Catheterization/Intervention

Discharge Instructions

Performed by ***

You have recovered for a short time in the hospital. You should be careful at home for the next 48 hours. Please abide by the following rules:

Discharge Instructions (continued)

1. **Rest and relax today and tomorrow.** To lessen the risk of bleeding from the puncture site, do the following:
   - Limit activity for the next two days. Do not do any unnecessary bending, heavy lifting (greater than 10 pounds, including infants and pets), straining or stair climbing.
   - Keep your leg as straight as possible over the next 12 hours.
   - Hold pressure on the site any time you cough, sneeze, laugh, or strain.
   - You may resume sexual relations when you are able to climb one flight of stairs or walk for 10 minutes without shortness of breath or chest pain.

2. Due to medications you received, **do not** drive, drink alcohol, or make important decisions for the next 48 hours.
   Have someone stay with you tonight.

3. **Observe your puncture site.** You may have a small knot (no larger than an olive) or bruise in the cath site.
   - Report any bleeding, swelling, severe pain, or numbness at the puncture site.
   - If bleeding does occur, press down hard on the site. Lie down and have someone hold pressure for five minutes without letting up. **If bleeding or swelling is rapid or does not stop after holding for 5 minutes, continue to hold pressure and call 911.**
   - If you experience signs that the circulation in your leg, foot, arm or hand is blocked, such as **pain, coolness, tingling or loss of feeling, or change of color of the skin, call your doctor immediately.**

4. **Stent Medication Instructions**:
   I have been informed that my physician has inserted a coronary stent which will require me to take certain medications for a prolonged period of time to reduce the risk of postoperative clotting. I understand that the failure to fill these prescriptions and take the medication as ordered places me at risk for potential serious complications, including but not limited to blood clots, heart attack, and death.

   I acknowledge that I have had the opportunity to ask questions about the stent and required medications, and have had them answered to my satisfaction. _____ (patient initials)

5. **Resume your normal diet, unless otherwise instructed by your doctor.**
   - Continue to drink lots of liquids unless instructed otherwise by the doctor.
   - If you take water pills, insulin, blood thinners, or aspirin, ask your doctor for instructions.
   - **If you take Glucophage, do not take for 48 hours.**
   - If you have heart disease, take nitroglycerin as prescribed for angina. Decrease your heart disease risk by stopping all use of tobacco products.
   - See discharge medication list.

6. **Call you doctor if:**
   - You develop a painful lump in your groin or a lump that is getting larger.
   - You feel lightheaded, faint or clammy.
   - You are unable to urinate.
   - The puncture site looks red or has any discharge (signs of infection).
   - You begin running a fever.

7. If you received **Artery Closure Devices**, please follow these written instructions:

Discharge Instructions (continued)

- Keep the bandage on for 24 hours. Do not remove bandage until after you shower. May shower the morning following procedure.
- Cover puncture site with a Band-Aid after you shower; change the Band-Aid daily after bathing until the site is healed.
- **DO NOT** sit in a hot tub, bathtub, sauna, whirlpool, or swimming pool for 7 days following your procedure.
- If the puncture site looks red or has any discharge, call your doctor. If you have questions or concerns about your procedure, call you doctor.
- If you had an interventional procedure, be sure to keep your stent card in your wallet.
- Inform your regular doctor that you have had a stent placed.

Follow up with your doctor for complete test results.

I have received a copy of this form and understand the instructions.

Responsible Person Signature Date Relationship to Patient

RN Signature Date/Time

Cilostazol Oral tablet

What is this medicine?

CILOSTAZOL (sil OH sta zol) is used to treat the symptoms of intermittent claudication. This condition causes pain in the legs during walking, and goes away with rest. By improving blood flow, this medicine helps people with this condition walk longer distances without pain.

This medicine may be used for other purposes; ask your health care provider or pharmacist if you have questions.

What should I tell my health care provider before I take this medicine?

They need to know if you have any of the following conditions:

- bleeding disorder or hemophilia
- history of heart failure, heart attack, or other heart disease

- an unusual or allergic reaction to cilostazol, other medicines, foods, dyes, or preservatives
- pregnant or trying to get pregnant
- breast-feeding

How should I use this medicine?

Take this medicine by mouth with a full glass of water. Follow the directions on the prescription label. Take this medicine on an empty stomach, at least 30 minutes before or 2 hours after food. Do not take with food. Take your doses at regular intervals. Do not take your medicine more often than directed.

Talk to your pediatrician regarding the use of this medicine in children. Special care may be needed.

Overdosage: If you think you have taken too much of this medicine contact a poison control center or emergency room at once.

NOTE: This medicine is only for you. Do not share this medicine with others.

What if I miss a dose?

If you miss a dose, take it as soon as you can. If it is almost time for your next dose, take only that dose. Do not take double or extra doses.

What may interact with this medicine?

Do not take this medicine with any of the following medications:

- grapefruit juice

This medicine may also interact with the following medications:

- agents that prevent or treat blood clots like enoxaparin or warfarin
- aspirin
- diltiazem
- erythromycin or clarithromycin
- omeprazole
- some medications for treating depression like fluoxetine, fluvoxamine, nefazodone
- some medications for treating fungal infections like ketoconazole, fluconazole, itraconazole

This list may not describe all possible interactions. Give your health care provider a list of all the medicines, herbs, non-prescription drugs, or dietary supplements you use. Also tell them if you smoke, drink alcohol, or use illegal drugs. Some items may interact with your medicine.

What should I watch for while using this medicine?

Visit your doctor or health care professional for regular checks on your progress. It may take 2 to 4 weeks for your condition to start to get better once you begin taking this medicine. In some people, it can take as long as 3 months for the condition to get better.

You may get drowsy or dizzy. Do not drive, use machinery, or do anything that needs mental alertness until you know how this drug affects you. Do not stand or sit up quickly, especially if you are an older patient. This reduces the risk of dizzy or fainting spells. Alcohol can make you more drowsy and dizzy. Avoid alcoholic drinks.

Smoking may have effects on the circulation that may limit the benefits you receive from this medicine. You may wish to discuss how to stop smoking with your doctor or health care professional.

If you are going to have surgery, tell your doctor or health care professional that you are taking this medicine.

What side effects may I notice from receiving this medicine?

Side effects that you should report to your doctor or health care professional as soon as possible:

- allergic reactions like skin rash, itching or hives, swelling of the face, lips, or tongue
- black, tarry stools
- blood in urine or stools
- chest pain
- fast, slow, or irregular heartbeat
- swelling in the legs or ankles
- unusual bleeding, bruising

Side effects that usually do not require medical attention (report to your doctor or health care professional if they continue or are bothersome):

- diarrhea
- headache
- nausea, or upset stomach

This list may not describe all possible side effects. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

Where should I keep my medicine?

Keep out of the reach of children.

Store at room temperature between 15 and 30 degrees C (59 and 86 degrees F). Throw away any unused medicine after the expiration date.

NOTE:This sheet is a summary. It may not cover all possible information. If you have questions about this medicine, talk to your doctor, pharmacist, or health care provider.

Discharge Instructions (continued)

Flowsheets (all recorded)

Custom Formula Data

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 03:26:44	05/27/15 23:10:46	05/27/15 20:37:56
OTHER					
Weight Change (kg)	—	—	0 kg -DI (r) CB (t)	—	—
Visit Weight	—	—	221 lb -DI (r) CB (t)	—	—
% Weight Change Since Birth	—	—	0 -DI (r) CB (t)	—	—
Relevant Labs and Vitals					
Temp (in Celsius)	36.7 -MG	36.7 -MG	36.6 -CB	36.7 -CB	36.7 -CB

Row Name	05/27/15 1300	05/27/15 12:00:07	05/27/15 10:22:14	05/27/15 08:11:01	05/27/15 0714
OTHER					
Weight Change (kg)	—	—	—	—	0 kg -FD
Ideal Body Weight	—	—	—	—	160 lb -FD
Visit Weight	—	—	—	—	215 lb -FD
BMI (Calculated)	—	—	—	—	33.7 -FD
IBW/kg (Calculated) Male	—	—	—	—	66.1 kg -FD
IBW/kg (Calculated) FEMALE	—	—	—	—	61.6 kg -FD
Weight in (lb) to have BMI = 25	—	—	—	—	159.3 -FD
% Weight Change Since Birth	—	—	—	—	0 -FD
Relevant Labs and Vitals					
Temp (in Celsius)	—	36.5 -RB	—	—	36.4 -FD
Adult IBW/VT Calculations					
IBW/kg (Calculated)	—	—	—	—	66.1 -FD
Range Vt 4mL/kg	—	—	—	—	264.4 mL/kg -FD
Low Range Vt 6mL/kg	—	—	—	—	396.6 mL/kg -FD
Adult Moderate Range Vt 8mL/kg	—	—	—	—	528.8 mL/kg -FD
Adult High Range Vt 10mL/kg	—	—	—	—	661 mL/kg -FD
Case Log					
BSA x (CI @3.0)= CO	—	—	—	—	6.42 CO -FD
Aldrete					
Aldrete Score	—	—	10 -MC	10 -MC	—
(RETIRED) Score 5 for each factor					
VTE Total Risk Factor Score	2 -KH	—	—	—	—

Flowsheets (all recorded)

Care Handoff

Row Name	05/28/15 0731	05/27/15 1910	05/27/15 1047		
Care Handoff					
Report Given to	Given to next shift RN -LB	Given to next shift RN -KH	Given to floor -LR		
Name of person receiving report	Kate, RN -LB	Leslie, RN -KH	Kate,RN -LR		
Name of person giving report	Leslie, RN -LB	Kate, RN -KH	L.Richardson, RN -LR		

Flowsheets (all recorded)

Travel Information

Row Name	05/27/15 0713
RETIRED - Travel outside the U.S.	
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -FD

Flowsheets (all recorded)

Aldrete Score

Row Name	05/27/15 10:22:14	05/27/15 08:11:01
Aldrete		
Activity	2 -MC	2 -MC
Respiration	2 -MC	2 -MC
Circulation	2 -MC	2 -MC
Consciousness	2 -MC	2 -MC
Color	2 -MC	2 -MC

Flowsheets (all recorded)

Vital Signs

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
Vital Signs					
Temp	98 °F (36.7 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) MG (t)	—	97.8 °F (36.6 °C) -DI (r) CB (t)	98 °F (36.7 °C) -DI (r) CB (t)
Temp src	Oral -MG	Oral -MG	—	Oral -CB	Oral -CB
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	—	56 -DI (r) CB (t)	59 -DI (r) CB (t)
Heart Rate Source	Monitor -MG	Monitor -MG	—	Monitor -CB	Monitor -CB
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	—	18 -DI (r) CB (t)	18 -DI (r) CB (t)
Respiration Source	visual -MG	visual -MG	—	visual -CB	visual -CB
BP	133/62 -DI (r) MG (t)	137/75 -DI (r) MG (t)	—	119/63 -DI (r) CB (t)	103/51 -DI (r) CB (t)
BP Location	Right arm -MG	Right arm -MG	—	Right arm -CB	Right arm -CB
BP Method	Portable -MG	Portable -MG	—	Portable -CB	Portable -CB
Patient Position	Lying -MG	Lying -MG	—	Lying -CB	Lying -CB
Oxygen Therapy					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—
Pain Assessment					
Currently in Pain	—	—	No -KH	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -KH	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -KH	—	5 -LB
Height and Weight					
Weight	—	—	—	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)	—
Weight Method	—	—	—	Actual -CB	—
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD				
Site Assessment	—	—	Asymptomatic;Clean;Dry;Intact -KH	—	—
Phlebitis Scale	—	—	0 -KH	—	—
Infiltration/Extravasation Scale	—	—	0 -KH	—	—
Line Assessment	—	—	Patent;Saline locked -KH	—	—
Dressing Assesment	—	—	Transparent;Intact;Dry;Clean -KH	—	—
IV Interventions	—	—	Flushed -KH	—	—

Row Name	05/27/15 20:37:56	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16	05/27/15 13:48:17
Vital Signs					
Temp	98.1 °F (36.7 °C) -DI (r) CB (t)	—	—	—	—
Temp src	Oral -CB	—	—	—	—
Pulse	62 -DI (r) CB (t)	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)	56 -DI (r) KH (t)
Heart Rate Source	Monitor -CB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -DI (r) CB (t)	18 -RB	18 -RB	18 -RB	18 -RB
Respiration Source	visual -CB	visual -RB	visual -RB	visual -RB	visual -RB
BP	132/73 -DI (r) CB (t)	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)	119/61 -DI (r) KH (t)	120/62 -DI (r) KH (t)
BP Location	Right arm -CB	Right arm -RB	Right arm -RB	Right arm -RB	Right arm -RB
BP Method	Portable -CB	Portable -RB	Portable -RB	—	—
Patient Position	Lying -CB	Standing -RB	Sitting -RB	—	—
Oxygen Therapy					
SpO2	92 % -DI (r) CB (t)	—	—	—	—
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD				
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm					

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	05/27/15 20:37:56	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16	05/27/15 13:48:17
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD				

Row Name	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07	05/27/15 11:49:11
Vital Signs					
Temp	—	—	—	97.7 °F (36.5 °C) -DI (r) KH (t)	—
Temp src	—	—	—	Oral -RB	—
Pulse	52 -DI (r) KH (t)	51 -DI (r) KH (t)	50 -RB	**(!) 47** -DI (r) KH (t)	53 -DI (r) KH (t)
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	—
Resp	18 -RB	18 -RB	—	—	—
Respiration Source	visual -RB	visual -RB	—	visual -RB	—
BP	131/61 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	135/63 -DI (r) KH (t)	135/63 -DI (r) KH (t)
BP Location	Right arm -RB	Right arm -RB	—	Right arm -RB	—
BP Method	—	—	—	Portable -RB	—
Patient Position	—	—	—	Lying -RB	—
Oxygen Therapy					
SpO2	—	—	—	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)
O2 Device	—	—	—	None (Room air) -RB	—
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD				
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD				

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24
Vital Signs					
Temp	—	—	—	97.6 °F (36.4 °C) -DI (r) KH (t)	—
Pulse	**(!) 49** -DI (r) KH (t)	**(!) 48** -DI (r) KH (t)	—	**(!) 49** -DI (r) KH (t)	**(!) 46** -DI (r) KH (t)
BP	122/65 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	—	123/67 -DI (r) KH (t)
BP Location	Right arm -RB	—	—	—	—
BP Method	Portable -RB	—	—	—	—
Patient Position	Lying -RB	—	—	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	—	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)
O2 Device	None (Room air) -RB	—	—	—	—
Pain Assessment History					
Patient's Stated Pain Goal	—	—	0 (No Pain) -KH	—	—
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD				
Site Assessment	—	—	Asymptomatic;Clean;Dry;Intact -KH	—	—
Phlebitis Scale	—	—	0 -KH	—	—
Infiltration/Extravasation Scale	—	—	0 -KH	—	—
Line Assessment	—	—	Patent;Saline locked -KH	—	—
Dressing Assesment	—	—	Transparent;Intact;Dry;Clean -KH	—	—
IV Interventions	—	—	Flushed -KH	—	—
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV				

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24
	Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD				
Site Assessment	—	—	Asymptomatic;Clean;Dry;Intact -KH	—	—
Phlebitis Scale	—	—	0 -KH	—	—
Infiltration/Extravasation Scale	—	—	0 -KH	—	—
Line Assessment	—	—	Patent;Saline locked -KH	—	—
Dressing Assesment	—	—	Transparent;Intact;Dry;Clean -KH	—	—
IV Interventions	—	—	Flushed -KH	—	—

Row Name	05/27/15 08:10:42	05/27/15 0740	05/27/15 0735	05/27/15 0714
Vital Signs				
Temp	—	—	—	97.6 °F (36.4 °C) -FD
Temp src	—	—	—	Oral -FD
Pulse	—	—	—	(!) 49 -FD
Resp	—	—	—	18 -FD
BP	—	—	—	118/74 -FD
Oxygen Therapy				
SpO2	—	—	—	95 % -FD
O2 Device	Nasal cannula -MC	—	—	—
O2 Flow Rate (L/min)	3 L/min -MC	—	—	—
Numeric Pain Intensity Scale				
Numeric Pain Intensity Score 1	—	—	—	0 -FD
Height and Weight				
Height	—	—	—	67" (1.702 m) -FD
Weight	—	—	—	97.5 kg (215 lb) -FD
Weight Method	—	—	—	Stated -FD
BSA (Calculated - sq m)	—	—	—	2.14 sq meters -FD
BMI (Calculated)	—	—	—	33.7 -FD
Weight in (lb) to have BMI = 25	—	—	—	159.3 -FD
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand				
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD			
Site Assessment	—	Asymptomatic -FD	—	—
Line Assessment	—	Blood return noted -FD	—	—
Dressing Assesment	—	Dry;Clean;Intact -FD	—	—
IV Interventions	—	Flushed -FD	—	—
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm				
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD			
Site Assessment	—	—	Asymptomatic -FD	—
Line Assessment	—	—	Blood return noted -FD	—
Dressing Assesment	—	—	Clean;Dry;Intact -FD	—
IV Interventions	—	—	Flushed -FD	—

Flowsheets (all recorded)

IV Assessment

Row Name	05/28/15 0730	05/27/15 1200	05/27/15 1100	05/27/15 0740	05/27/15 0735
Blood Specimen Collection Status					
Blood Specimen Collection	Lab -KH	—	Lab -KH	—	—
Dominant Hand					
Which is your dominant hand?	—	Right -KH	—	—	—
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD				
Site Assessment	Asymptomatic;Clean;Dry;Intact -KH	—	Asymptomatic;Clean;Dry;Intact -KH	Asymptomatic -FD	—
Phlebitis Scale	0 -KH	—	0 -KH	—	—
Infiltration/Extravasation Scale	0 -KH	—	0 -KH	—	—
Line Assessment	Patent;Saline locked -KH	—	Patent;Saline locked -KH	Blood return noted -FD	—
Dressing Assesment	Transparent;Intact;Dry;Clean -KH	—	Transparent;Intact;Dry;Clean -KH	Dry;Clean;Intact -FD	—
IV Interventions	Flushed -KH	—	Flushed -KH	Flushed -FD	—
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm					
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD				
Site Assessment	—	—	Asymptomatic;Clean;Dry;Intact -KH	—	Asymptomatic -FD
Phlebitis Scale	—	—	0 -KH	—	—
Infiltration/Extravasation Scale	—	—	0 -KH	—	—
Line Assessment	—	—	Patent;Saline locked -KH	—	Blood return noted -FD
Dressing Assesment	—	—	Transparent;Intact;Dry;Clean -KH	—	Clean;Dry;Intact -FD
IV Interventions	—	—	Flushed -KH	—	Flushed -FD

Flowsheets (all recorded)

Assessment

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
Neurological					
Neuro (WDL)	—	—	WDL -KH	—	—
Orientation Level	—	—	Oriented X4 -KH	—	—
Speech	—	—	Clear -KH	—	—
Level of Consciousness (Retired)	—	—	Alert -KH	—	—
tPA Time out					
Weight	—	—	—	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)	—
HEENT					
HEENT (WDL)	—	—	WDL -KH	—	—
Respiratory					
Respiratory (WDL)	—	—	WDL -KH	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—
Cardiac					
Cardiac (WDL)	—	—	X -KH	—	—
Heart Sounds	—	—	S1, S2 -KH	—	—
Cardiac					
Cardiac Regularity	—	—	Regular -KH	—	—
Telemetry Monitor On	—	—	Yes -KH	—	—
Telemetry Box Number	—	—	MX51 -KH	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	WDL -KH	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -KH	—	—
Pulses	—	—	L radial;R radial;L pedal;R pedal -KH	—	—
RUE Neurovascular Assessment					
R Radial Pulse	—	—	+2 -KH	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	—	+2 -KH	—	—
RLE Neurovascular Assessment					
RLE Color	—	—	Appropriate for ethnicity -KH	—	—
RLE Temperature/Moisture	—	—	Warm;Dry -KH	—	—
RLE Sensation	—	—	Present -KH	—	—
R Pedal Pulse	—	—	+2 -KH	—	—
LLE Neurovascular Assessment					
L Pedal Pulse	—	—	+2 -KH	—	—
Integumentary					
Integumentary (WDL)	—	—	WDL -KH	—	—
Braden Scale					
Sensory Perceptions	—	—	4 -KH	—	—
Moisture	—	—	4 -KH	—	—
Activity	—	—	3 -KH	—	—
Mobility	—	—	3 -KH	—	—
Nutrition	—	—	4 -KH	—	—
Friction and Shear	—	—	3 -KH	—	—
Braden Scale Score	—	—	21 -KH	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Drainage Amount	—	—	None -KH	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
Dressing Assesment	—	—	Intact;Dry;Clean -KH	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	WDL -KH	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	1 -KH	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	WDL -KH	—	—
Bowel Sounds (All Quadrants)	—	—	Active -KH	—	—
Genitourinary					
Genitourinary (WDL)	—	—	WDL -KH	—	—
Urinary Source	—	—	Voiding -KH	—	—
Psychosocial					
Psychosocial (WDL)	—	—	WDL -KH	—	—
Needs Expressed	—	—	Denies -KH	—	—
Charting Type					
Charting Type	—	—	Shift assessment -KH	—	—
Cardiac					
Cardiac Rhythm	—	—	Normal sinus rhythm -KH	—	—
Heart Block Type	—	—	Bundle branch block -KH	—	—
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	—	0 -KH	—	—
Symptomatic Depression (View Only)	—	—	0 -KH	—	—
Altered Elimination (View Only)	—	—	0 -KH	—	—
Dizziness/Vertigo (View Only)	—	—	0 -KH	—	—
Gender (Male) View Only	—	—	1 -KH	—	—
Any Administered Benzodiazepines (View Only)	—	—	0 -KH	—	—
Hendrich II Total Score (Calculated) View Only	—	—	2 -KH	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	—	0 -KH	—	—

Row Name	05/27/15 20:37:56	05/27/15 2000	05/27/15 1800	05/27/15 1600	05/27/15 1400
Neurological					
Neuro (WDL)	—	WDL -LB	—	—	—
Orientation Level	—	Oriented X4 -LB	—	—	—
Speech	—	Clear -LB	—	—	—
Level of Consciousness (Retired)	—	Alert -LB	—	—	—
HEENT					
HEENT (WDL)	—	WDL -LB	—	—	—
Respiratory					
Respiratory (WDL)	—	WDL -LB	—	—	—
Oxygen Therapy					
SpO2	92 % -DI (r) CB (t)	—	—	—	—
Cardiac					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/27/15 20:37:56	05/27/15 2000	05/27/15 1800	05/27/15 1600	05/27/15 1400
Cardiac (WDL)	—	X -LB	—	—	—
Cardiac					
Cardiac Regularity	—	Regular -LB	—	—	—
Telemetry Monitor On	—	Yes -LB	Yes -RB	Yes -RB	Yes -RB
Telemetry Audible	—	Yes -LB	Yes -RB	Yes -RB	—
Telemetry Alarms Set	—	Yes -LB	—	—	—
Telemetry Box Number	—	mx51 -LB	mx51 -RB	mx51 -RB	mx51 -RB
Peripheral Vascular					
Peripheral Vascular (WDL)	—	WDL -LB	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -LB	—	—	—
Pulses	—	R radial;L radial;R pedal;L pedal -LB	—	—	—
RUE Neurovascular Assessment					
R Radial Pulse	—	+2 -LB	—	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -LB	—	—	—
RLE Neurovascular Assessment					
RLE Color	—	Appropriate for ethnicity -LB	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -LB	—	—	—
RLE Sensation	—	Present -LB	—	—	—
R Pedal Pulse	—	+2 -LB	—	—	—
LLE Neurovascular Assessment					
L Pedal Pulse	—	+2 -LB	—	—	—
Integumentary					
Integumentary (WDL)	—	WDL -LB	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -LB	—	—	—
Moisture	—	4 -LB	—	—	—
Activity	—	3 -LB	—	—	—
Mobility	—	4 -LB	—	—	—
Nutrition	—	4 -LB	—	—	—
Friction and Shear	—	3 -LB	—	—	—
Braden Scale Score	—	22 -LB	—	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Site Assessment	—	—	—	Other (Comment) Area soft. No hematoma noted -KH	Other (Comment) CDI dressing. Area soft -KH
Drainage Amount	—	—	None -KH	None -KH	None -KH
Dressing Assesment	—	—	Intact;Dry;Clean -KH	Intact;Dry;Clean -KH	Intact;Dry;Clean -KH
Musculoskeletal					
Musculoskeletal (WDL)	—	WDL -LB	—	—	—
RUE	—	Full movement -LB	—	—	—
LUE	—	Full movement -LB	—	—	—
RLE	—	Full movement -LB	—	—	—
LLE	—	Full movement -LB	—	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	1 -LB	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	WDL -LB	—	—	—
Genitourinary					
Genitourinary (WDL)	—	WDL -LB	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/27/15 20:37:56	05/27/15 2000	05/27/15 1800	05/27/15 1600	05/27/15 1400
Psychosocial					
Psychosocial (WDL)	---	WDL -LB	---	---	---
Needs Expressed	---	Denies -LB	---	---	---
Charting Type					
Charting Type	—	Shift assessment -LB	—	—	—
Cardiac					
Cardiac Rhythm	—	Normal sinus rhythm -LB	—	—	—
Heart Block Type	---	Bundle branch block -LB	---	---	---
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	---	4 -LB	—	—	—
Symptomatic Depression (View Only)	---	2 -LB	---	---	---
Altered Elimination (View Only)	—	1 -LB	—	—	—
Dizziness/Vertigo (View Only)	—	0 -LB	—	—	—
Gender (Male) View Only	---	0 -LB	---	---	---
Any Administered Benzodiazepines (View Only)	—	0 -LB	—	—	—
Hendrich II Total Score (Calculated) View Only	—	8 -LB	—	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	0 -LB	—	—	—

Row Name	05/27/15 1325	05/27/15 12:00:07	05/27/15 1200	05/27/15 11:49:11	05/27/15 11:34:20
Oxygen Therapy					
SpO2	---	94 % -DI (r) KH (t)	---	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)
O2 Device	—	None (Room air) -RB	—	—	None (Room air) -RB
Cardiac					
Telemetry Monitor On	---	---	Yes -RB	---	---
Telemetry Box Number	—	—	mx51 -RB	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Site Assessment	Bleeding -KH	—	—	—	—
Dressing	Pressure dressing -KH	---	---	---	---
Dressing Changed	New -KH	---	---	---	---
Dressing Assesment	Intact;Dry;Clean -KH	—	—	—	—
Provider Notification					
Reason for Communication (View Only	Other (comment) Right groin site started bleeding. Pressure held for 20min. -KH	—	—	—	—
Notification Time	1325 -KH	—	—	—	—
Provider Name	Gina Haden, RN -KH	---	---	---	---
Provider Role	Nurse -KH	—	—	—	—
Method of Communication	Call -KH	—	—	—	—

Row Name	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 08:10:42
Neurological					
Neuro (WDL)	---	WDL -KH	---	---	---
Orientation Level	—	Oriented X4 -KH	—	—	—
Speech		Clear -KH			
Level of	---	Alert -KH	---	---	---

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 08:10:42
Consciousness (Retired)					
HEENT					
HEENT (WDL)	—	WDL -KH	—	—	—
Respiratory					
Respiratory (WDL)	—	WDL -KH	—	—	—
Oxygen Therapy					
SpO2	94 % -DI (r) KH (t)	—	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)	—
O2 Device	—	—	—	—	Nasal cannula -MC
O2 Flow Rate (L/min)	—	—	—	—	3 L/min -MC
Cardiac					
Cardiac (WDL)	—	X -KH	—	—	—
Heart Sounds	—	S1, S2 -KH	—	—	—
Cardiac					
Cardiac Regularity	—	Regular -KH	—	—	—
Telemetry Monitor On	—	Yes -KH	—	—	—
Telemetry Box Number	—	MX51 -KH	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	WDL -KH	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -KH	—	—	—
Pulses	—	L radial;R radial;L pedal;R pedal -KH	—	—	—
RUE Neurovascular Assessment					
R Radial Pulse	—	+2 -KH	—	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -KH	—	—	—
RLE Neurovascular Assessment					
RLE Color	—	Appropriate for ethnicity -KH	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -KH	—	—	—
RLE Sensation	—	Present -KH	—	—	—
R Pedal Pulse	—	+1 -KH	—	—	—
LLE Neurovascular Assessment					
L Pedal Pulse	—	+2 -KH	—	—	—
Integumentary					
Integumentary (WDL)	—	WDL -KH	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -KH	—	—	—
Moisture	—	4 -KH	—	—	—
Activity	—	1 S/P PCI -KH	—	—	—
Mobility	—	3 -KH	—	—	—
Nutrition	—	3 -KH	—	—	—
Friction and Shear	—	3 -KH	—	—	—
Braden Scale Score	—	18 -KH	—	—	—
Wound					
Type of Wound (LDA)	—	Surgical -KH	—	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Site Assessment	—	Other (Comment) CDI dressing over site -KH	—	—	—
Surrounding Skin Assessment	—	Clean;Dry;Intact -KH	—	—	—
Drainage Amount	—	None -KH	—	—	—
Dressing	—	Dry dressing -KH	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 08:10:42
Dressing Assesment	—	Intact;Dry;Clean -KH	—	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	X -KH	—	—	—
RUE	—	Full movement -KH	—	—	—
LUE	—	Full movement -KH	—	—	—
RLE	—	Limited movement S/P PCI -KH	—	—	—
LLE	—	Full movement -KH	—	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	4.3 - Ordered bed rest -KH	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	WDL -KH	—	—	—
Bowel Sounds (All Quadrants)	—	Active -KH	—	—	—
Genitourinary					
Genitourinary (WDL)	—	WDL -KH	—	—	—
Urinary Source	—	Voiding -KH	—	—	—
Psychosocial					
Psychosocial (WDL)	—	WDL -KH	—	—	—
Needs Expressed	—	Denies -KH	—	—	—
Charting Type					
Charting Type	—	Admission -KH	—	—	—
Cardiac					
Cardiac Rhythm	—	Sinus bradycardia -KH	—	—	—
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	0 -KH	—	—	—
Symptomatic Depression (View Only)	—	0 -KH	—	—	—
Altered Elimination (View Only)	—	0 -KH	—	—	—
Dizziness/Vertigo (View Only)	—	0 -KH	—	—	—
Gender (Male) View Only	—	1 -KH	—	—	—
Any Administered Benzodiazepines (View Only)	—	0 -KH	—	—	—
Hendrich II Total Score (Calculated) View Only	—	5 -KH	—	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	0 -KH	—	—	—

Row Name	05/27/15 0747	05/27/15 0717	05/27/15 0714		
tPA Time out					
Weight	—	—	97.5 kg (215 lb) -FD		
Oxygen Therapy					
SpO2	—	—	95 % -FD		
Peripheral Vascular					
Peripheral Vascular (WDL)	X -FD	—	—		
Pulses	R pedal;L pedal -FD	—	—		
RLE Neurovascular Assessment					
R Pedal Pulse	+2 -FD	—	—		

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	05/27/15 0747	05/27/15 0717	05/27/15 0714		
LLE Neurovascular Assessment					
L Pedal Pulse	+2 -FD	—	—		
Braden Scale					
Sensory Perceptions	—	4 -FD	—		
Moisture	—	4 -FD	—		
Activity	—	4 -FD	—		
Mobility	—	4 -FD	—		
Nutrition	—	4 -FD	—		
Friction and Shear	—	3 -FD	—		
Braden Scale Score	—	23 -FD	—		

Flowsheets (all recorded)

CCP Vitals, Intake and Output

Row Name	05/28/15 11:23:35	05/28/15 1000	05/28/15 08:18:59	05/28/15 0500	05/28/15 03:26:44
Vitals					
Temp	98 °F (36.7 °C) -DI (r) MG (t)	—	98 °F (36.7 °C) -DI (r) MG (t)	—	97.8 °F (36.6 °C) -DI (r) CB (t)
Temp src	Oral -MG	—	Oral -MG	—	Oral -CB
Pulse	61 -DI (r) MG (t)	—	63 -DI (r) MG (t)	—	56 -DI (r) CB (t)
Heart Rate Source	Monitor -MG	—	Monitor -MG	—	Monitor -CB
Resp	18 -DI (r) MG (t)	—	18 -DI (r) MG (t)	—	18 -DI (r) CB (t)
Respiration Source	visual -MG	—	visual -MG	—	visual -CB
BP	133/62 -DI (r) MG (t)	—	137/75 -DI (r) MG (t)	—	119/63 -DI (r) CB (t)
BP Location	Right arm -MG	—	Right arm -MG	—	Right arm -CB
BP Method	Portable -MG	—	Portable -MG	—	Portable -CB
Patient Position	Lying -MG	—	Lying -MG	—	Lying -CB
SpO2	93 % -DI (r) MG (t)	—	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	—	None (Room air) -MG	—	—
Weight	—	—	—	—	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)
Weight Method	—	—	—	—	Actual -CB
Intake (mL)					
P.O.	—	120 mL -MG	240 mL -MG	—	240 mL -CB
Unmeasured Output					
Urine Occurrence	—	1 -MG	—	1 -CB	—

Row Name	05/27/15 23:10:46	05/27/15 20:37:56	05/27/15 1834	05/27/15 15:25:49	05/27/15 15:24:40
Vitals					
Temp	98 °F (36.7 °C) -DI (r) CB (t)	98.1 °F (36.7 °C) -DI (r) CB (t)	—	—	—
Temp src	Oral -CB	Oral -CB	—	—	—
Pulse	59 -DI (r) CB (t)	62 -DI (r) CB (t)	—	60 -DI (r) KH (t)	60 -DI (r) KH (t)
Heart Rate Source	Monitor -CB	Monitor -CB	—	Monitor -RB	Monitor -RB
Resp	18 -DI (r) CB (t)	18 -DI (r) CB (t)	—	18 -RB	18 -RB
Respiration Source	visual -CB	visual -CB	—	visual -RB	visual -RB
BP	103/51 -DI (r) CB (t)	132/73 -DI (r) CB (t)	—	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)
BP Location	Right arm -CB	Right arm -CB	—	Right arm -RB	Right arm -RB
BP Method	Portable -CB	Portable -CB	—	Portable -RB	Portable -RB
Patient Position	Lying -CB	Lying -CB	—	Standing -RB	Sitting -RB
SpO2	93 % -DI (r) CB (t)	92 % -DI (r) CB (t)	—	—	—
Intake (mL)					
P.O.	120 mL -CB	240 mL -CB	350 mL -RB	—	—
Unmeasured Output					
Urine Occurrence	1 pt did not used urina -CB	—	1 -RB	—	—

Row Name	05/27/15 14:48:16	05/27/15 13:48:17	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204
Vitals					
Pulse	57 -DI (r) KH (t)	56 -DI (r) KH (t)	52 -DI (r) KH (t)	51 -DI (r) KH (t)	50 -RB
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -RB	18 -RB	18 -RB	18 -RB	—
Respiration Source	visual -RB	visual -RB	visual -RB	visual -RB	—
BP	119/61 -DI (r) KH (t)	120/62 -DI (r) KH (t)	131/61 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—
BP Location	Right arm -RB	Right arm -RB	Right arm -RB	Right arm -RB	—
Intake (mL)					
P.O.	320 mL -RB	—	—	—	—
Unmeasured Output					
Urine Occurrence	1 -RB	—	—	—	—

Row Name	05/27/15 12:00:07	05/27/15 11:49:11	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1051
Vitals					
Temp	97.7 °F (36.5 °C) -DI (r) KH (t)	—	—	—	—
Temp src	Oral -RB	—	—	—	—
Pulse	(!) 47 -DI (r) KH (t)	53 -DI (r) KH (t)	(!) 49 -DI (r) KH (t)	(!) 48 -DI (r) KH (t)	—
Heart Rate Source	Monitor -RB	—	—	—	—
Respiration Source	visual -RB	—	—	—	—
BP	135/63 -DI (r) KH (t)	135/63 -DI (r) KH (t)	122/65 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	05/27/15 12:00:07	05/27/15 11:49:11	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1051
BP Location	Right arm -RB	—	Right arm -RB	—	—
BP Method	Portable -RB	—	Portable -RB	—	—
Patient Position	Lying -RB	—	Lying -RB	—	—
SpO2	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	—
O2 Device	None (Room air) -RB	—	None (Room air) -RB	—	—
Unmeasured Output					
Urine Occurrence	1 -RB	—	—	—	—
sodium chloride 0.9% (NS) infusion Start: 05/27/15 0800					
Rate	—	—	—	—	0 mL/hr -KH

Row Name	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 08:10:42	05/27/15 0743	05/27/15 0714
Vitals					
Temp	97.6 °F (36.4 °C) -DI (r) KH (t)	—	—	—	97.6 °F (36.4 °C) -FD
Temp src	—	—	—	—	Oral -FD
Pulse	**(!) 49** -DI (r) KH (t)	**(!) 46** -DI (r) KH (t)	—	—	**(!) 49** -FD
Resp	—	—	—	—	18 -FD
BP	—	123/67 -DI (r) KH (t)	—	—	118/74 -FD
SpO2	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)	—	—	95 % -FD
O2 Device	—	—	Nasal cannula -MC	—	—
Height	—	—	—	—	67" (1.702 m) -FD
Weight	—	—	—	—	97.5 kg (215 lb) -FD
Weight Method	—	—	—	—	Stated -FD
sodium chloride 0.9% (NS) infusion Start: 05/27/15 0800					
Rate	—	—	—	75 mL/hr -FD	—

Flowsheets (all recorded)

Screenings

Row Name	05/28/15 1252	05/28/15 0730	05/27/15 2000	05/27/15 1200	05/27/15 1100
Advance Directives (For Healthcare)					
Have you reviewed your Advance Directive and is it valid for this stay?	---	---	---	Not applicable -KH	---
Advance Directive	---	---	---	Patient does not have advance directive;Patient would not like information -KH	---
Healthcare Agent Appointed	—	—	—	No -KH	—
Pre-existing Allow Natural Death Order	—	—	—	No -KH	—
Information Provided on Healthcare Directives	---	---	---	No -KH	---
Patient Requests Assistance (Retired)	—	—	—	No -KH	—
Nutrition Screen Scoring					
Weight Loss in the past 3 months	—	—	—	1 -KH	—
BMI (Body Mass Index)	—	—	—	0 -KH	—
Appetite	---	---	---	0 -KH	---
Ability to eat/retain food	---	---	---	0 -KH	---
Stress factors	—	—	—	1 -KH	—
Total Nutrition Screen Score	—	—	—	2 -KH	—
ADL Screening					
Patient's Vision Adequate to Safely Complete Daily Activities	---	---	---	Yes -KH	---
Patient's Judgement Adequate to Safely Complete Daily Activities	---	---	---	Yes -KH	---
Patient's Memory Adequate to Safely Complete Daily Activities	—	—	—	Yes -KH	—
Patient Able to Express Needs/Desires	—	—	—	Yes -KH	—
Which is your dominant hand?	---	---	---	Right -KH	---
Dressing	—	—	—	Independent -KH	—
Grooming	—	—	—	Independent -KH	—
Feeding	---	---	---	Independent -KH	---
Bathing	—	—	—	Independent -KH	—
Toileting	—	—	—	Independent -KH	—
In/Out Bed	---	---	---	Independent -KH	---
Walks in Home	---	---	---	Independent -KH	---
Weakness of Legs	—	—	—	None -KH	—
Weakness of Arms/Hands	—	—	—	None -KH	—
Hearing - Right Ear	---	---	---	Functional -KH	---
Hearing - Left Ear	—	—	—	Functional -KH	—
Patient Belongings at Bedside					
(RETIRED)Belongings Sent Home	Yes -KH	---	---	---	---
Braden Scale					
Sensory Perceptions	---	4 -KH	4 -LB	---	4 -KH
Moisture	---	4 -KH	4 -LB	---	4 -KH
Activity	—	3 -KH	3 -LB	—	1 S/P PCI -KH
Mobility	---	3 -KH	4 -LB	---	3 -KH

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	05/28/15 1252	05/28/15 0730	05/27/15 2000	05/27/15 1200	05/27/15 1100
Nutrition	—	4 -KH	4 -LB	—	3 -KH
Friction and Shear	—	3 -KH	3 -LB	—	3 -KH
Braden Scale Score	—	21 -KH	22 -LB	—	18 -KH
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	—	1 -KH	1 -LB	—	4.3 - Ordered bed rest -KH

Row Name	05/27/15 1000	05/27/15 0718	05/27/15 0717	05/27/15 0715
Advance Directives (For Healthcare)				
Advance Directive	—	Patient does not have advance directive;Patient would like information -FD	—	—
Healthcare Agent's Name	—	—	—	Shirley Maurice (wife) -FD
Healthcare Agent's Phone Number	—	—	—	678 910 2476 -FD
Assistive Devices				
Assistive Devices	Eyeglasses -KH	—	—	—
Therapy Consults (RETIRED)				
PT Evaluation Needed (RETIRED)	2 -KH	—	—	—
OT Evalulation Needed (RETIRED)	2 -KH	—	—	—
SLP Evaluation Needed (RETIRED)	2 -KH	—	—	—
Values/Beliefs				
Cultural Preferences Affecting Hospitalization	No -KH	—	—	—
Spiritual Preferences Affecting Hospitalization	No -KH	—	—	—
Nursing Referrals				
Spiritual Health Consult	No -KH	—	—	—
Social Services Consult	No -KH	—	—	—
Patient Belongings at Bedside				
Belongings at Bedside	—	—	—	Clothing -FD
Belongings sent to security (Retired)	—	—	—	No -FD
(RETIRED)Belongings Sent Home	—	—	—	No -FD
Patient Medications				
Medications brought by patient?	—	—	—	No -FD
Suicide/Harm Risk				
Ever harm self (Retired)	—	No -FD	—	—
Current thoughts (Retired)	—	No -FD	—	—
Self harm plan (Retired)	—	No -FD	—	—
Patient information obtained from	—	Patient -FD	—	—
Braden Scale				
Sensory Perceptions	—	—	4 -FD	—
Moisture	—	—	4 -FD	—
Activity	—	—	4 -FD	—
Mobility	—	—	4 -FD	—
Nutrition	—	—	4 -FD	—
Friction and Shear	—	—	3 -FD	—
Braden Scale Score	—	—	23 -FD	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	05/27/15 1000	05/27/15 0718	05/27/15 0717	05/27/15 0715	
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)					
Pressure ulcer present on admission	—	—	No -FD	—	
Discharge Planning					
Living Situation Prior to Admission	Home;Lives with significant other -KH	—	—	—	
Primary Caregiver	Family (relationship) spouse -KH	—	—	—	
Anticipated assistance needed at discharge	Yes -KH	—	—	—	
Barriers to discharge	No Barriers -KH	—	—	—	
Discharge plan consult/Discharge referrals needed	no -KH	—	—	—	
Abuse Assessment					
Safe in Home	Yes -KH	—	—	—	
Do you feel threatened or unsafe in a relationship?	No -KH	—	—	—	
Are you in immediate danger?	No -KH	—	—	—	
Do you feel neglected?	No -KH	—	—	—	
Physical harm?	No -KH	—	—	—	
Verbal harm	No -KH	—	—	—	

Flowsheets (all recorded)

Suicide Risk

Row Name	05/27/15 0718
Suicide/Harm Risk	
Ever harm self (Retired)	No -FD
Current thoughts (Retired)	No -FD
Self harm plan (Retired)	No -FD
Patient information obtained from	Patient -FD
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -FD

Flowsheets (all recorded)

Daily Cares/Safety

Row Name	05/28/15 1200	05/28/15 1000	05/28/15 0800	05/28/15 0730	05/28/15 0500
Safe Environment					
Arm Bands On	ID;Allergies -MG	ID;Allergies -MG	ID;Allergies -MG	—	ID;Allergies -CB
Safety Checks	Call light in reach -MG	Call light in reach -MG	Call light in reach -MG	—	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB
Bed type	Hillrom Clinitron Rite Hite -MG	Hillrom Clinitron Rite Hite -MG	Hillrom Clinitron Rite Hite -MG	—	—
Safety Alarm Verfied	No alarm -MG	No alarm -MG	No alarm -MG	—	—
Side Rails/Bed Safety	3/4 -MG	3/4 -MG	3/4 -MG	—	4/4 -CB
Fall Risk Interventions					
Fall Prevention Interventions	—	—	—	Yellow Armband, Socks;"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Medications reviewed;Adequate room lighting;Room decluttered -KH	—
Fall Prevention Education Reviewed with :	—	—	—	Patient -KH	—
Mobility					
Mobility Intervention	Resting in bed -MG	Resting in bed -MG	Resting in bed -MG	—	Resting in bed -CB
Level of Assistance	Independent -MG	Independent -MG	Independent -MG	—	Independent -CB
Active Range of Motion	—	—	Active;All extremities -MG	—	—
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	Self regulated -MG	—	—
Repositioned	Turns self -MG	Turns self -MG	Turns self -MG	—	—
Anti-Embolism Devices					
Anti-Embolism Devices (View Only)	—	—	—	Not Ordered -KH	—
Nutrition					
Feeding	—	—	—	Able to feed self -KH	—
Appetite	—	—	—	Good -KH	—
Hygiene					
Hygiene Performed	—	—	—	Hand hygiene -KH	Hand hygiene -CB
Performed by	—	—	—	Self -KH	—
Telemetry Details					
Telemetry Monitor On	—	—	—	Yes -KH	—
Telemetry Box Number	—	—	—	MX51 -KH	—

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Safe Environment					
Arm Bands On	ID;Allergies -CB	ID;Allergies -CB	—	ID;Allergies -RB	ID;Allergies -RB
Safety Checks	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB	—	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked -RB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB
Bed type	—	—	—	Hillrom Clinitron Rite Hite -RB	Hillrom Clinitron Rite Hite -RB
Safety Alarm Verfied	—	—	—	No alarm -RB	No alarm -RB
Side Rails/Bed Safety	3/4 -CB	3/4 -CB	—	3/4 -RB	3/4 -RB
Mobility					
Mobility Intervention	Resting in bed -CB	Resting in bed -CB	—	Resting in bed -RB	Resting in bed -RB

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Level of Assistance	Independent -CB	Independent -CB	—	Independent -RB	Independent -RB
Active Range of Motion	—	—	—	Active;All extremities -RB	Active;All extremities -RB
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	—	Self regulated -RB	Self regulated -RB
Repositioned	Turns self -CB	—	—	Turns self -RB	Turns self -RB
Anti-Embolism Devices					
Anti-Embolism Devices (View Only)	—	—	Not Ordered -LB	Not Ordered -RB	Not Ordered -RB
Hygiene					
Hygiene Performed	Hand hygiene -CB	Hand hygiene -CB	—	Hand hygiene -RB	—
Performed by	—	—	—	Self -RB	—
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Visiting -KH
Telemetry Details					
Telemetry Monitor On	—	—	Yes -LB	Yes -RB	Yes -RB
Telemetry Audible	—	—	Yes -LB	Yes -RB	Yes -RB
Telemetry Box Number	—	—	mx51 -LB	mx51 -RB	mx51 -RB
Telemetry Alarms Set	—	—	Yes -LB	—	—

Row Name	05/27/15 1400	05/27/15 1200	05/27/15 1100
Safe Environment			
Arm Bands On	ID;Allergies -RB	ID;Allergies -RB	—
Safety Checks	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB	—
Bed type	Hillrom Clinitron Rite Hite -RB	Hillrom Clinitron Rite Hite -RB	—
Safety Alarm Verified	No alarm -RB	No alarm -RB	—
Side Rails/Bed Safety	3/4 -RB	3/4 -RB	—
Mobility			
Mobility Intervention	Resting in bed -RB	Resting in bed -RB	—
Level of Assistance	Independent -RB	Independent -RB	—
Active Range of Motion	Active;All extremities -RB	Active;All extremities -RB	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	Self regulated -RB	Self regulated -RB	—
Repositioned	Turns self -RB	Turns self -RB	—
Anti-Embolism Devices			
Anti-Embolism Devices (View Only)	—	Not Ordered -RB	Not Ordered -KH
Hygiene			
Hygiene Performed	—	Hand hygiene -RB	—
Performed by	—	Self -RB	—
Telemetry Details			
Telemetry Monitor On	Yes -RB	Yes -RB	Yes -KH
Telemetry Box Number	mx51 -RB	mx51 -RB	MX51 -KH

Flowsheets (all recorded)

Fall Risk Assessment

Row Name	05/28/15 1200	05/28/15 1000	05/28/15 0800	05/28/15 0730	05/28/15 0500
Fall Risk Interventions					
Fall Prevention Interventions	—	—	—	Yellow Armband, Socks;"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Medications reviewed;Adequate room lighting;Room decluttered -KH	—
Fall Prevention Education Reviewed with :	—	—	—	Patient -KH	—
Side Rails/Bed Safety	3/4 -MG	3/4 -MG	3/4 -MG	—	4/4 -CB
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	—	—	0 -KH	—
Symptomatic Depression (View Only)	—	—	—	0 -KH	—
Altered Elimination (View Only)	—	—	—	0 -KH	—
Dizziness/Vertigo (View Only)	—	—	—	0 -KH	—
Gender (Male) View Only	—	—	—	1 -KH	—
Any Administered Benzodiazepines (View Only)	—	—	—	0 -KH	—
Hendrich II Total Score (Calculated) View Only	—	—	—	2 -KH	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	—	—	0 -KH	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	1 -KH	—

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Fall Risk Interventions					
Side Rails/Bed Safety	3/4 -CB	3/4 -CB	—	3/4 -RB	3/4 -RB
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	—	4 -LB	—	—
Symptomatic Depression (View Only)	—	—	2 -LB	—	—
Altered Elimination (View Only)	—	—	1 -LB	—	—
Dizziness/Vertigo (View Only)	—	—	0 -LB	—	—
Gender (Male) View Only	—	—	0 -LB	—	—
Any Administered Benzodiazepines (View Only)	—	—	0 -LB	—	—
Hendrich II Total Score (Calculated) View Only	—	—	8 -LB	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View	—	—	0 -LB	—	—

Flowsheets (all recorded) (continued)

Fall Risk Assessment (continued)

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Only					
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	1 -LB	—	—

Row Name	05/27/15 1400	05/27/15 1200	05/27/15 1100
Fall Risk Interventions			
Side Rails/Bed Safety	3/4 -RB	3/4 -RB	—
Hendrich II Fall Risk Model (View Only)			
Confusion/Disorientation/Impulsivity (View Only)	—	—	0 -KH
Symptomatic Depression (View Only)	—	—	0 -KH
Altered Elimination (View Only)	—	—	0 -KH
Dizziness/Vertigo (View Only)	—	—	0 -KH
Gender (Male) View Only	—	—	1 -KH
Any Administered Benzodiazepines (View Only)	—	—	0 -KH
Hendrich II Total Score (Calculated) View Only	—	—	5 -KH
OTHER			
Any Administered Antiepileptics (Anticonvulsants) View Only	—	—	0 -KH
Get-Up-And-Go Test			
Get-Up-And-Go Test: "Rising from Chair"	—	—	4.3 - Ordered bed rest -KH

Flowsheets (all recorded)

Vital Signs

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 03:26:44	05/27/15 23:10:46	05/27/15 20:37:56
Vital Signs					
Automatic Restart Vitals Timer	Yes -DI (r) MG (t)	Yes -DI (r) MG (t)	Yes -DI (r) CB (t)	Yes -DI (r) CB (t)	Yes -DI (r) CB (t)
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	56 -DI (r) CB (t)	59 -DI (r) CB (t)	62 -DI (r) CB (t)
Heart Rate Source	Monitor -MG	Monitor -MG	Monitor -CB	Monitor -CB	Monitor -CB
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	18 -DI (r) CB (t)	18 -DI (r) CB (t)	18 -DI (r) CB (t)
Respiration Source	visual -MG	visual -MG	visual -CB	visual -CB	visual -CB
BP	133/62 -DI (r) MG (t)	137/75 -DI (r) MG (t)	119/63 -DI (r) CB (t)	103/51 -DI (r) CB (t)	132/73 -DI (r) CB (t)
BP Location	Right arm -MG	Right arm -MG	Right arm -CB	Right arm -CB	Right arm -CB
BP Method	Portable -MG	Portable -MG	Portable -CB	Portable -CB	Portable -CB
Patient Position	Lying -MG	Lying -MG	Lying -CB	Lying -CB	Lying -CB
Temp	98 °F (36.7 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) MG (t)	97.8 °F (36.6 °C) -DI (r) CB (t)	98 °F (36.7 °C) -DI (r) CB (t)	98.1 °F (36.7 °C) -DI (r) CB (t)
Temp src	Oral -MG	Oral -MG	Oral -CB	Oral -CB	Oral -CB
Oxygen Therapy					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)	92 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—

Row Name	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16	05/27/15 13:48:17	05/27/15 13:18:18
Vital Signs					
Automatic Restart Vitals Timer	Yes -RB	Yes -RB	Yes -RB	Yes -RB	Yes -RB
Pulse	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)	56 -DI (r) KH (t)	52 -DI (r) KH (t)
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -RB	18 -RB	18 -RB	18 -RB	18 -RB
Respiration Source	visual -RB	visual -RB	visual -RB	visual -RB	visual -RB
BP	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)	119/61 -DI (r) KH (t)	120/62 -DI (r) KH (t)	131/61 -DI (r) KH (t)
BP Location	Right arm -RB	Right arm -RB	Right arm -RB	Right arm -RB	Right arm -RB
BP Method	Portable -RB	Portable -RB	—	—	—
Patient Position	Standing -RB	Sitting -RB	—	—	—

Row Name	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07	05/27/15 11:49:11	05/27/15 11:34:20
Vital Signs					
Automatic Restart Vitals Timer	Yes -RB	—	—	—	—
Pulse	51 -DI (r) KH (t)	50 -RB	**(!) 47** -DI (r) KH (t)	53 -DI (r) KH (t)	**(!) 49** -DI (r) KH (t)
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	—	—
Resp	18 -RB	—	—	—	—
Respiration Source	visual -RB	—	visual -RB	—	—
BP	125/69 -DI (r) KH (t)	—	135/63 -DI (r) KH (t)	135/63 -DI (r) KH (t)	122/65 -DI (r) KH (t)
BP Location	Right arm -RB	—	Right arm -RB	—	Right arm -RB
BP Method	—	—	Portable -RB	—	Portable -RB
Patient Position	—	—	Lying -RB	—	Lying -RB
Temp	—	—	97.7 °F (36.5 °C) -DI (r) KH (t)	—	—
Temp src	—	—	Oral -RB	—	—
Oxygen Therapy					
SpO2	—	—	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)
O2 Device	—	—	None (Room air) -RB	—	None (Room air) -RB

Row Name	05/27/15 11:19:16	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 08:10:42	05/27/15 0714
Vital Signs					
Automatic Restart Vitals Timer	—	—	—	—	Yes -FD
Pulse	**(!) 48** -DI (r) KH (t)	**(!) 49** -DI (r) KH (t)	**(!) 46** -DI (r) KH (t)	—	**(!) 49** -FD
Resp	—	—	—	—	18 -FD
BP	125/69 -DI (r) KH (t)	—	123/67 -DI (r) KH (t)	—	118/74 -FD
Temp	—	97.6 °F (36.4 °C) -DI (r) KH (t)	—	—	97.6 °F (36.4 °C) -FD
Temp src	—	—	—	—	Oral -FD
Oxygen Therapy					
SpO2	94 % -DI (r) KH (t)	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)	—	95 % -FD
O2 Device	—	—	—	Nasal cannula -MC	—
O2 Flow Rate (L/min)	—	—	—	3 L/min -MC	—

Flowsheets (all recorded)

O2 Therapy

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 03:26:44	05/27/15 23:10:46	05/27/15 20:37:56
Oxygen Therapy					
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)	92 % -DI (r) CB (t)
Row Name	**05/27/15 12:00:07**	**05/27/15 11:49:11**	**05/27/15 11:34:20**	**05/27/15 11:19:16**	**05/27/15 10:50:05**
Oxygen Therapy					
O2 Device	None (Room air) -RB	—	None (Room air) -RB	—	—
SpO2	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	95 % -DI (r) KH (t)
Row Name	**05/27/15 10:48:24**	**05/27/15 08:10:42**	**05/27/15 0714**		
Oxygen Therapy					
O2 Delivery	—	Oxygen -MC	—		
O2 Device	—	Nasal cannula -MC	—		
O2 Flow Rate (L/min)	—	3 L/min -MC	—		
SpO2	96 % -DI (r) KH (t)	—	95 % -FD		

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	05/28/15 0730	05/27/15 1100	05/27/15 0740	05/27/15 0735
[REMOVED] Peripheral IV 05/27/15 22 G Left Hand				
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0730 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 22 G -FD Orientation: Left -FD Location: Hand -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/28/15 -KH Removal Time: 1738 -KH (Retired) Inserted by: dawes RN -FD			
Site Assessment	Asymptomatic;Clean;Dry;Intact -KH	Asymptomatic;Clean;Dry;Intact -KH	Asymptomatic -FD	—
Phlebitis Scale	0 -KH	0 -KH	—	—
Infiltration/Extravasation Scale	0 -KH	0 -KH	—	—
Line Assessment	Patent;Saline locked -KH	Patent;Saline locked -KH	Blood return noted -FD	—
Dressing Assesment	Transparent;Intact;Dry;Clean -KH	Transparent;Intact;Dry;Clean -KH	Dry;Clean;Intact -FD	—
IV Interventions	Flushed -KH	Flushed -KH	Flushed -FD	—
[REMOVED] Peripheral IV 05/27/15 20 G Right Forearm				
IV Properties	Placement Date: 05/27/15 -FD Placement Time: 0735 -FD Present on arrival to hospital?: No -FD Type of Catheter: Straight -FD Size (Gauge): 20 G -FD Orientation: Right -FD Location: Forearm -FD Site Prep: Chlorhexidine -FD Insertion attempts: 1 -FD Successful IV Attempt?: Yes -FD Patient Tolerance: Tolerated well -FD IV Access Problem: No -FD Removal Date: 05/27/15 -KH Removal Time: 1910 -KH (Retired) Inserted by: Dawes Rn -FD			
Site Assessment	—	Asymptomatic;Clean;Dry;Intact -KH	—	Asymptomatic -FD
Phlebitis Scale	—	0 -KH	—	—
Infiltration/Extravasation Scale	—	0 -KH	—	—
Line Assessment	—	Patent;Saline locked -KH	—	Blood return noted -FD
Dressing Assesment	—	Transparent;Intact;Dry;Clean -KH	—	Clean;Dry;Intact -FD
IV Interventions	—	Flushed -KH	—	Flushed -FD

Flowsheets (all recorded)

VTE Screening

Row Name	05/27/15 1300
(RETIRED) Score 2 for each factor	
(RETIRED) Major surgery (greater than 60 minutes, current admission)	0 -KH
(RETIRED) Laproscopic surgery (greater than 60 minutes)	0 -KH
(RETIRED) Arthroscopic surgery (greater than 60 minutes)	0 -KH
(RETIRED) Age 60 - 74 years	2 -KH
(RETIRED) Morbid Obesity (BMI greater than 40 to 50)	0 -KH
(RETIRED) Immobilizing cast or splint	0 -KH
(RETIRED) Central venous catheter	0 -KH
(RETIRED) Malignancy (previous)	0 -KH
(RETIRED) Total Score	2 -KH
Total Risk Factor Score	
VTE Total Risk Factor Score	2 -KH

Flowsheets (all recorded)

Anthropometrics

Row Name	05/28/15 03:26:44	05/27/15 0714
Anthropometrics		
Height	---	67" (1.702 m) -FD
Weight	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)	97.5 kg (215 lb) -FD
Weight Method	Actual -CB	Stated -FD
Weight Change	2.74 -DI (r) CB (t)	0 -FD
BMI (Calculated)	---	33.7 -FD

Flowsheets (all recorded)

Severe Sepsis Screen

Row Name	05/28/15 0700	05/27/15 2000	05/27/15 1325	05/27/15 1100
Severe Sepsis Screening Tool				
Current Sepsis Treatment AND On IV Pressors?	No - Continue Screening -KH	Yes - Stop Screening -LB	—	No - Continue Screening -KH
Antibiotic Therapy (Non-Prophylactic) (View Only)	No- Stop screen if no to both suspected infection and antibiotic -KH	No- Stop screen if no to both suspected infection and antibiotic -LB	—	No- Stop screen if no to both suspected infection and antibiotic -KH
Infection				
Suspected / Documented Infection?	No- Screen for antibiotic therapy -KH	No- Screen for antibiotic therapy -LB	—	No- Screen for antibiotic therapy -KH
Screening Results				
Positive For Severe Sepsis ?	No- Negative for Severe Sepsis -KH	No- Negative for Severe Sepsis -LB	—	No- Negative for Severe Sepsis -KH
Provider Notification				
Reason for Communication (View Only	—	—	Other (comment) Right groin site started bleeding. Pressure held for 20min. -KH	—
Notification Time	—	—	1325 -KH	—
Provider Name	—	—	Gina Haden, RN -KH	—
Provider Role	—	—	Nurse -KH	—
Method of Communication	—	—	Call -KH	—

Flowsheets (all recorded)

Vitals/Pain

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
OTHER					
Patient Position	Lying -MG	Lying -MG	—	Lying -CB	Lying -CB
Weight Method	—	—	—	Actual -CB	—
Vitals					
BP	133/62 -DI (r) MG (t)	137/75 -DI (r) MG (t)	—	119/63 -DI (r) CB (t)	103/51 -DI (r) CB (t)
Temp	98 °F (36.7 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) MG (t)	—	97.8 °F (36.6 °C) -DI (r) CB (t)	98 °F (36.7 °C) -DI (r) CB (t)
Temp src	Oral -MG	Oral -MG	—	Oral -CB	Oral -CB
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	—	56 -DI (r) CB (t)	59 -DI (r) CB (t)
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	—	18 -DI (r) CB (t)	18 -DI (r) CB (t)
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)
Weight	—	—	—	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)	—
Vital Signs					
Heart Rate Source	Monitor -MG	Monitor -MG	—	Monitor -CB	Monitor -CB
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	0 -KH	—	5 -LB

Row Name	05/27/15 20:37:56	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16	05/27/15 13:48:17
OTHER					
Patient Position	Lying -CB	Standing -RB	Sitting -RB	—	—
Vitals					
BP	132/73 -DI (r) CB (t)	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)	119/61 -DI (r) KH (t)	120/62 -DI (r) KH (t)
Temp	98.1 °F (36.7 °C) -DI (r) CB (t)	—	—	—	—
Temp src	Oral -CB	—	—	—	—
Pulse	62 -DI (r) CB (t)	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)	56 -DI (r) KH (t)
Resp	18 -DI (r) CB (t)	18 -RB	18 -RB	18 -RB	18 -RB
SpO2	92 % -DI (r) CB (t)	—	—	—	—
Vital Signs					
Heart Rate Source	Monitor -CB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB

Row Name	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07	05/27/15 11:49:11
OTHER					
Patient Position	—	—	—	Lying -RB	—
Vitals					
BP	131/61 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	135/63 -DI (r) KH (t)	135/63 -DI (r) KH (t)
Temp	—	—	—	97.7 °F (36.5 °C) -DI (r) KH (t)	—
Temp src	—	—	—	Oral -RB	—
Pulse	52 -DI (r) KH (t)	51 -DI (r) KH (t)	50 -RB	(!) 47 -DI (r) KH (t)	53 -DI (r) KH (t)
Resp	18 -RB	18 -RB	—	—	—
SpO2	—	—	—	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)
Vital Signs					
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	—

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 0714
OTHER					
Patient Position	Lying -RB	—	—	—	—
Height Method	—	—	—	—	Stated -FD
Weight Method	—	—	—	—	Stated -FD
BMI (Calculated)	—	—	—	—	33.7 -FD
BSA (Calculated - sq m)	—	—	—	—	2.14 sq meters -FD
Pain Assessment	—	—	—	—	0-10 -FD
Vitals					
BP	122/65 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	123/67 -DI (r) KH (t)	118/74 -FD
Temp	—	—	97.6 °F (36.4 °C) -DI (r) KH (t)	—	97.6 °F (36.4 °C) -FD
Temp src	—	—	—	—	Oral -FD
Pulse	(!) 49 -DI (r) KH (t)	(!) 48 -DI (r) KH (t)	(!) 49 -DI (r) KH (t)	(!) 46 -DI (r) KH (t)	(!) 49 -FD
Resp	—	—	—	—	18 -FD

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 10:50:05	05/27/15 10:48:24	05/27/15 0714
SpO2	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)	95 % -FD
Height	—	—	—	—	67" (1.702 m) -FD
Weight	—	—	—	—	97.5 kg (215 lb) -FD
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	—	0 -FD

Flowsheets (all recorded)

Fall Risk

Row Name	05/27/15 0717
Fall Assessment	
Patient Receiving Sedation	Yes -FD
Fall Risk	Yes -FD
Fall Band Applied	Yes -FD
Yellow socks	Yes -FD

Flowsheets (all recorded)

Pre-op Checklist

Row Name	05/27/15 1200	05/27/15 0718
Patient Verification		
Consents Confirmed	—	Informed -FD
Advance Directive	Patient does not have advance directive;Patient would not like information -KH	Patient does not have advance directive;Patient would like information -FD
Patient ID and Procedure Verified	—	Yes -FD
Correct Procedure	—	Yes -FD
Documents Match	—	Yes -FD
Pacemaker	—	No -FD
Patient has an ICD?	—	No -FD
Prep Verification		
Allergy Band Applied	—	Yes -FD
Date of last liquid	—	05/26/15 -FD
Time of last liquid	—	2200 -FD
Date of last solid	—	05/26/15 -FD
Time of last solid	—	2200 -FD
Disposition of belongings:	—	Remain in room -FD
Transport To	—	Procedure Area -FD
Mode of Transport	—	Stretcher -FD
Transport By	—	RN -FD
Metal Implant Present?	—	No -FD
Pre-op Checklist Completion		
Checklist Completed/Verified?	—	Yes -FD
Location completed at:	—	ARU -FD

Flowsheets (all recorded)

CARDNT HEMODYNAMIC

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 03:26:44	05/27/15 23:10:46	05/27/15 20:37:56
Vitals					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)	92 % -DI (r) CB (t)
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	56 -DI (r) CB (t)	59 -DI (r) CB (t)	62 -DI (r) CB (t)
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	18 -DI (r) CB (t)	18 -DI (r) CB (t)	18 -DI (r) CB (t)
Row Name	**05/27/15 15:25:49**	**05/27/15 15:24:40**	**05/27/15 14:48:16**	**05/27/15 13:48:17**	**05/27/15 13:18:18**
Vitals					
Pulse	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)	56 -DI (r) KH (t)	52 -DI (r) KH (t)
Resp	18 -RB	18 -RB	18 -RB	18 -RB	18 -RB
Row Name	**05/27/15 12:33:20**	**05/27/15 1204**	**05/27/15 12:00:07**	**05/27/15 11:49:11**	**05/27/15 11:34:20**
Vitals					
SpO2	—	—	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)
Pulse	51 -DI (r) KH (t)	50 -RB	**(!) 47** -DI (r) KH (t)	53 -DI (r) KH (t)	**(!) 49** -DI (r) KH (t)
Resp	18 -RB	—	—	—	—
Row Name	**05/27/15 11:19:16**	**05/27/15 10:50:05**	**05/27/15 10:48:24**	**05/27/15 10:23:08**	**05/27/15 10:19:51**
Vitals					
SpO2	—	—	—	100 % -VI	100 % -VI
Heart Rate	—	—	—	50 bpm -VI	44 bpm -VI
Systolic Pressure	—	—	—	—	144 mmHg -VI
Diastolic Pressure	—	—	—	—	67 mmHg -VI
Mean Pressure	—	—	—	—	98 mmHg -VI
Respiration Rate	—	—	—	—	17 breaths/min -VI
SpO2	94 % -DI (r) KH (t)	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)	—	—
Pulse	**(!) 48** -DI (r) KH (t)	**(!) 49** -DI (r) KH (t)	**(!) 46** -DI (r) KH (t)	—	—
Row Name	**05/27/15 10:18:08**	**05/27/15 10:14:33**	**05/27/15 10:13:08**	**05/27/15 10:09:33**	**05/27/15 10:08:08**
Vitals					
SpO2	100 % -VI	100 % -VI	99 % -VI	99 % -VI	99 % -VI
Heart Rate	47 bpm -VI	49 bpm -VI	49 bpm -VI	45 bpm -VI	44 bpm -VI
Systolic Pressure	—	163 mmHg -VI	—	143 mmHg -VI	—
Diastolic Pressure	—	76 mmHg -VI	—	69 mmHg -VI	—
Mean Pressure	—	109 mmHg -VI	—	88 mmHg -VI	—
Respiration Rate	20 breaths/min -VI	20 breaths/min -VI	19 breaths/min -VI	16 breaths/min -VI	15 breaths/min -VI
Row Name	**05/27/15 10:04:31**	**05/27/15 10:03:08**	**05/27/15 09:59:29**	**05/27/15 09:58:08**	**05/27/15 09:54:30**
Vitals					
SpO2	99 % -VI	99 % -VI	98 % -VI	98 % -VI	98 % -VI
Heart Rate	45 bpm -VI	43 bpm -VI	45 bpm -VI	45 bpm -VI	44 bpm -VI
Systolic Pressure	137 mmHg -VI	—	128 mmHg -VI	—	128 mmHg -VI
Diastolic Pressure	68 mmHg -VI	—	68 mmHg -VI	—	66 mmHg -VI
Mean Pressure	88 mmHg -VI	—	93 mmHg -VI	—	96 mmHg -VI
Respiration Rate	16 breaths/min -VI	18 breaths/min -VI	16 breaths/min -VI	14 breaths/min -VI	14 breaths/min -VI
Row Name	**05/27/15 09:53:08**	**05/27/15 09:51:13**	**05/27/15 09:49:23**	**05/27/15 09:48:08**	**05/27/15 09:44:34**
Vitals					
SpO2	98 % -VI	—	98 % -VI	98 % -VI	97 % -VI
Heart Rate	44 bpm -VI	—	45 bpm -VI	47 bpm -VI	46 bpm -VI
Systolic Pressure	—	—	135 mmHg -VI	—	107 mmHg -VI
Diastolic Pressure	—	—	68 mmHg -VI	—	54 mmHg -VI
Mean Pressure	—	—	91 mmHg -VI	—	70 mmHg -VI
Respiration Rate	15 breaths/min -VI	—	16 breaths/min -VI	17 breaths/min -VI	13 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	102 mmHg -VI	—	—	—
AO Diastolic Cath Pressure	—	38 mmHg -VI	—	—	—
AO Mean Cath Pressure	—	60 mmHg -VI	—	—	—
AO Heart Rate	—	45 bpm -VI	—	—	—
Row Name	**05/27/15 09:43:08**	**05/27/15 09:42:55**	**05/27/15 09:39:28**	**05/27/15 09:38:08**	**05/27/15 09:35:37**
Vitals					
SpO2	98 % -VI	—	98 % -VI	97 % -VI	—
Heart Rate	46 bpm -VI	—	45 bpm -VI	44 bpm -VI	—
Systolic Pressure	—	—	120 mmHg -VI	—	—
Diastolic Pressure	—	—	62 mmHg -VI	—	—

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	05/27/15 09:43:08	05/27/15 09:42:55	05/27/15 09:39:28	05/27/15 09:38:08	05/27/15 09:35:37
Mean Pressure	—	—	81 mmHg -VI	—	—
Respiration Rate	14 breaths/min -VI	—	14 breaths/min -VI	19 breaths/min -VI	—
Pressure Summary					
AO Systolic Cath Pressure	—	120 mmHg -VI	—	—	113 mmHg -VI
AO Diastolic Cath Pressure	—	53 mmHg -VI	—	—	49 mmHg -VI
AO Mean Cath Pressure	—	76 mmHg -VI	—	—	72 mmHg -VI
AO Heart Rate	—	44 bpm -VI	—	—	46 bpm -VI

Row Name	05/27/15 09:34:28	05/27/15 09:33:08	05/27/15 09:32:15	05/27/15 09:29:29	05/27/15 09:28:08
Vitals					
SpO2	98 % -VI	97 % -VI	—	96 % -VI	97 % -VI
Heart Rate	46 bpm -VI	45 bpm -VI	—	46 bpm -VI	51 bpm -VI
Systolic Pressure	122 mmHg -VI	—	—	120 mmHg -VI	—
Diastolic Pressure	63 mmHg -VI	—	—	64 mmHg -VI	—
Mean Pressure	84 mmHg -VI	—	—	99 mmHg -VI	—
Respiration Rate	15 breaths/min -VI	14 breaths/min -VI	—	18 breaths/min -VI	15 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	118 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	53 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	77 mmHg -VI	—	—
AO Heart Rate	—	—	45 bpm -VI	—	—

Row Name	05/27/15 09:24:37	05/27/15 09:23:08	05/27/15 09:19:39	05/27/15 09:19:25	05/27/15 09:18:08
Vitals					
SpO2	100 % -VI	99 % -VI	—	99 % -VI	98 % -VI
Heart Rate	41 bpm -VI	45 bpm -VI	—	48 bpm -VI	50 bpm -VI
Systolic Pressure	120 mmHg -VI	—	—	124 mmHg -VI	—
Diastolic Pressure	61 mmHg -VI	—	—	65 mmHg -VI	—
Mean Pressure	94 mmHg -VI	—	—	94 mmHg -VI	—
Respiration Rate	12 breaths/min -VI	13 breaths/min -VI	—	14 breaths/min -VI	16 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	127 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	54 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	82 mmHg -VI	—	—
AO Heart Rate	—	—	48 bpm -VI	—	—

Row Name	05/27/15 09:14:24	05/27/15 09:13:08	05/27/15 09:09:32	05/27/15 09:08:51	05/27/15 09:08:08
Vitals					
SpO2	98 % -VI	98 % -VI	99 % -VI	—	98 % -VI
Heart Rate	44 bpm -VI	46 bpm -VI	45 bpm -VI	—	46 bpm -VI
Systolic Pressure	131 mmHg -VI	—	121 mmHg -VI	—	—
Diastolic Pressure	63 mmHg -VI	—	63 mmHg -VI	—	—
Mean Pressure	88 mmHg -VI	—	86 mmHg -VI	—	—
Respiration Rate	11 breaths/min -VI	15 breaths/min -VI	15 breaths/min -VI	—	16 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	—	112 mmHg -VI	—
AO Diastolic Cath Pressure	—	—	—	53 mmHg -VI	—
AO Mean Cath Pressure	—	—	—	76 mmHg -VI	—
AO Heart Rate	—	—	—	41 bpm -VI	—

Row Name	05/27/15 09:04:23	05/27/15 08:59:29	05/27/15 08:58:08	05/27/15 08:54:29	05/27/15 08:53:08
Vitals					
SpO2	99 % -VI	99 % -VI	99 % -VI	99 % -VI	99 % -VI
Heart Rate	48 bpm -VI	46 bpm -VI	44 bpm -VI	48 bpm -VI	48 bpm -VI
Systolic Pressure	131 mmHg -VI	124 mmHg -VI	—	145 mmHg -VI	—

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	05/27/15 09:04:23	05/27/15 08:59:29	05/27/15 08:58:08	05/27/15 08:54:29	05/27/15 08:53:08
Diastolic Pressure	66 mmHg -VI	65 mmHg -VI	—	72 mmHg -VI	—
Mean Pressure	91 mmHg -VI	97 mmHg -VI	—	84 mmHg -VI	—
Respiration Rate	15 breaths/min -VI	15 breaths/min -VI	14 breaths/min -VI	15 breaths/min -VI	16 breaths/min -VI

Row Name	05/27/15 08:49:28	05/27/15 08:48:08	05/27/15 08:44:28	05/27/15 08:43:08	05/27/15 08:40:39
Vitals					
SpO2	98 % -VI	99 % -VI	98 % -VI	98 % -VI	—
Heart Rate	44 bpm -VI	49 bpm -VI	45 bpm -VI	47 bpm -VI	—
Systolic Pressure	119 mmHg -VI	—	122 mmHg -VI	—	—
Diastolic Pressure	59 mmHg -VI	—	67 mmHg -VI	—	—
Mean Pressure	77 mmHg -VI	—	84 mmHg -VI	—	—
Respiration Rate	14 breaths/min -VI	14 breaths/min -VI	14 breaths/min -VI	14 breaths/min -VI	—
Pressure Summary					
AO Systolic Cath Pressure	—	—	—	—	106 mmHg -VI
AO Diastolic Cath Pressure	—	—	—	—	43 mmHg -VI
AO Mean Cath Pressure	—	—	—	—	65 mmHg -VI
AO Heart Rate	—	—	—	—	30 bpm -VI

Row Name	05/27/15 08:40:31	05/27/15 08:40:19	05/27/15 08:40:13	05/27/15 08:39:39	05/27/15 08:39:27
Vitals					
SpO2	—	—	—	—	98 % -VI
Heart Rate	—	—	—	—	47 bpm -VI
Systolic Pressure	—	—	—	—	104 mmHg -VI
Diastolic Pressure	—	—	—	—	58 mmHg -VI
Mean Pressure	—	—	—	—	81 mmHg -VI
Respiration Rate	—	—	—	—	13 breaths/min -VI
Pressure Summary					
LV Systolic Cath Pressure	111 mmHg -VI	110 mmHg -VI	104 mmHg -VI	—	—
LV Diastolic Cath Pressure	-1 mmHg -VI	3 mmHg -VI	3 mmHg -VI	—	—
LV Heart Rate	45 bpm -VI	45 bpm -VI	50 bpm -VI	—	—
AO Systolic Cath Pressure	—	—	—	103 mmHg -VI	—
AO Diastolic Cath Pressure	—	—	—	46 mmHg -VI	—
AO Mean Cath Pressure	—	—	—	66 mmHg -VI	—
AO Heart Rate	—	—	—	45 bpm -VI	—
LV End Diastolic	15 mmHg -VI	16 mmHg -VI	14 mmHg -VI	—	—

Row Name	05/27/15 08:38:08	05/27/15 08:34:22	05/27/15 08:33:08	05/27/15 08:29:27	05/27/15 08:28:08
Vitals					
SpO2	99 % -VI	97 % -VI	96 % -VI	96 % -VI	97 % -VI
Heart Rate	44 bpm -VI	45 bpm -VI	47 bpm -VI	47 bpm -VI	46 bpm -VI
Systolic Pressure	—	107 mmHg -VI	—	111 mmHg -VI	—
Diastolic Pressure	—	56 mmHg -VI	—	58 mmHg -VI	—
Mean Pressure	—	80 mmHg -VI	—	83 mmHg -VI	—
Respiration Rate	12 breaths/min -VI	14 breaths/min -VI	16 breaths/min -VI	14 breaths/min -VI	14 breaths/min -VI

Row Name	05/27/15 08:24:23	05/27/15 08:23:08	05/27/15 08:19:25	05/27/15 08:18:08	05/27/15 08:14:28
Vitals					
SpO2	100 % -VI	100 % -VI	100 % -VI	100 % -VI	99 % -VI
Heart Rate	48 bpm -VI	44 bpm -VI	44 bpm -VI	45 bpm -VI	46 bpm -VI
Systolic Pressure	128 mmHg -VI	—	134 mmHg -VI	—	128 mmHg -VI
Diastolic Pressure	64 mmHg -VI	—	65 mmHg -VI	—	63 mmHg -VI
Mean Pressure	87 mmHg -VI	—	96 mmHg -VI	—	88 mmHg -VI
Respiration Rate	10 breaths/min -VI	12 breaths/min -VI	13 breaths/min -VI	14 breaths/min -VI	14 breaths/min -VI

Row Name	05/27/15 08:13:08	05/27/15 08:09:31	05/27/15 08:08:11	05/27/15 0714	
Vitals					
SpO2	99 % -VI	100 % -VI	—	—	
Heart Rate	45 bpm -VI	47 bpm -VI	—	—	
Systolic Pressure	—	130 mmHg -VI	—	—	
Diastolic Pressure	—	65 mmHg -VI	—	—	

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	05/27/15 08:13:08	05/27/15 08:09:31	05/27/15 08:08:11	05/27/15 0714
Mean Pressure	—	96 mmHg -VI	—	—
Respiration Rate	12 breaths/min -VI	14 breaths/min -VI	—	—
SpO2	----	----	----	95 % -FD
Pulse	----	----	----	(!) 49 -FD
Resp	—	—	—	18 -FD
AO Pressures				
AO Systolic	—	—	102 mmHg -VI	—
AO Diastolic	—	—	38 mmHg -VI	—
AO Mean	—	—	60 mmHg -VI	—
AO Heart Rate	----	----	45 bpm -VI	----
LV Pressures				
LV Systolic	----	----	111 mmHg -VI	----
LV End Diastolic	----	----	15 mmHg -VI	----
LV dP/dt	—	—	1104 -VI	—
Data Collected				
Hemodynamic Phase	—	—	Phase: Baseline -VI	—

Flowsheets (all recorded)

Cath Lab Pain Assessment

Row Name	05/27/15 10:22:27	05/27/15 08:10:36			
Pain					
Pain	No -MC	No -MC			

Flowsheets (all recorded)

Preop Nurse

Row Name	05/27/15 0712
Pre-op Nurse	
Pre Procedure Nurse	dawes-rust -FD

Flowsheets (all recorded)

Patient Belongings Sent Home

Row Name	05/28/15 1252	05/27/15 0715
Patient Belongings Sent Home		
(RETIRED)Belongings Sent Home	Yes -KH	No -FD
Medications Sent Home		
Medications Sent Home	None to return -KH	—

Flowsheets (all recorded)

Blood Specimen Collection Status

Row Name	05/28/15 0730	05/27/15 1100			
Blood Specimen Collection Status					
Blood Specimen Collection	Lab -KH	Lab -KH			

Flowsheets (all recorded)

Daily Cares

Row Name	05/28/15 1200	05/28/15 1000	05/28/15 0800	05/28/15 0730	05/28/15 0500
Safe Environment					
Arm Bands On	ID;Allergies -MG	ID;Allergies -MG	ID;Allergies -MG	—	ID;Allergies -CB
Safety Checks	Call light in reach -MG	Call light in reach -MG	Call light in reach -MG	—	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB
Bed type	Hillrom Clinitron Rite Hite -MG	Hillrom Clinitron Rite Hite -MG	Hillrom Clinitron Rite Hite -MG	—	—
Safety Alarm Verfied	No alarm -MG	No alarm -MG	No alarm -MG	—	—
Side Rails/Bed Safety	3/4 -MG	3/4 -MG	3/4 -MG	—	4/4 -CB
Fall Risk Interventions					
Fall Prevention Interventions	—	—	—	Yellow Armband, Socks;"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Medications reviewed;Adequate room lighting;Room decluttered -KH	—
Fall Prevention Education Reviewed with :	—	—	—	Patient -KH	—
Mobility					
Mobility Intervention	Resting in bed -MG	Resting in bed -MG	Resting in bed -MG	—	Resting in bed -CB
Level of Assistance	Independent -MG	Independent -MG	Independent -MG	—	Independent -CB
Active Range of Motion	—	—	Active;All extremities -MG	—	—
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	Self regulated -MG	—	—
Repositioned	Turns self -MG	Turns self -MG	Turns self -MG	—	—
Hygiene					
Hygiene Performed	—	—	—	Hand hygiene -KH	Hand hygiene -CB
Performed by	—	—	—	Self -KH	—
Anti-Embolism Devices					
Anti-Embolism Devices (View Only)	—	—	—	Not Ordered -KH	—
Nutrition					
Feeding	—	—	—	Able to feed self -KH	—
Appetite	—	—	—	Good -KH	—
Telemetry Details					
Telemetry Monitor On	—	—	—	Yes -KH	—
Telemetry Box Number	—	—	—	MX51 -KH	—

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Safe Environment					
Arm Bands On	ID;Allergies -CB	ID;Allergies -CB	—	ID;Allergies -RB	ID;Allergies -RB
Safety Checks	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -CB	—	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked -RB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB
Bed type	—	—	—	Hillrom Clinitron Rite Hite -RB	Hillrom Clinitron Rite Hite -RB
Safety Alarm Verfied	—	—	—	No alarm -RB	No alarm -RB
Side Rails/Bed Safety	3/4 -CB	3/4 -CB	—	3/4 -RB	3/4 -RB
Mobility					
Mobility Intervention	Resting in bed -CB	Resting in bed -CB	—	Resting in bed -RB	Resting in bed -RB

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	05/27/15 2300	05/27/15 2100	05/27/15 2000	05/27/15 1800	05/27/15 1600
Level of Assistance	Independent -CB	Independent -CB	—	Independent -RB	Independent -RB
Active Range of Motion	—	—	—	Active;All extremities -RB	Active;All extremities -RB
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	—	Self regulated -RB	Self regulated -RB
Repositioned	Turns self -CB	—	—	Turns self -RB	Turns self -RB
Hygiene					
Hygiene Performed	Hand hygiene -CB	Hand hygiene -CB	—	Hand hygiene -RB	—
Performed by	—	—	—	Self -RB	—
Anti-Embolism Devices					
Anti-Embolism Devices (View Only)	—	—	Not Ordered -LB	Not Ordered -RB	Not Ordered -RB
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Visiting -KH
Telemetry Details					
Telemetry Monitor On	—	—	Yes -LB	Yes -RB	Yes -RB
Telemetry Audible	—	—	Yes -LB	Yes -RB	Yes -RB
Telemetry Box Number	—	—	mx51 -LB	mx51 -RB	mx51 -RB
Telemetry Alarms Set	—	—	Yes -LB	—	—

Row Name	05/27/15 1400	05/27/15 1200	05/27/15 1100
Safe Environment			
Arm Bands On	ID;Allergies -RB	ID;Allergies -RB	—
Safety Checks	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB	Call light in reach;Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on -RB	—
Bed type	Hillrom Clinitron Rite Hite -RB	Hillrom Clinitron Rite Hite -RB	—
Safety Alarm Verified	No alarm -RB	No alarm -RB	—
Side Rails/Bed Safety	3/4 -RB	3/4 -RB	—
Mobility			
Mobility Intervention	Resting in bed -RB	Resting in bed -RB	—
Level of Assistance	Independent -RB	Independent -RB	—
Active Range of Motion	Active;All extremities -RB	Active;All extremities -RB	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	Self regulated -RB	Self regulated -RB	—
Repositioned	Turns self -RB	Turns self -RB	—
Hygiene			
Hygiene Performed	—	Hand hygiene -RB	—
Performed by	—	Self -RB	—
Anti-Embolism Devices			
Anti-Embolism Devices (View Only)	—	Not Ordered -RB	Not Ordered -KH
Telemetry Details			
Telemetry Monitor On	Yes -RB	Yes -RB	Yes -KH
Telemetry Box Number	mx51 -RB	mx51 -RB	MX51 -KH

Flowsheets (all recorded)

Arterial/Venous Sheath Assessment

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
Sheath Insertion Site Location - Assessment					
L Radial Pulse	—	—	+2 -KH	—	—
R Radial Pulse	—	—	+2 -KH	—	—
L Pedal Pulse	—	—	+2 -KH	—	—
RLE Neurovascular Assessment					
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -KH	—	—
RLE Color	—	—	Appropriate for ethnicity -KH	—	—
RLE Temperature/Moisture	—	—	Warm;Dry -KH	—	—
RLE Sensation	—	—	Present -KH	—	—
R Pedal Pulse	—	—	+2 -KH	—	—
Vitals					
Temp	98 °F (36.7 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) MG (t)	—	97.8 °F (36.6 °C) -DI (r) CB (t)	98 °F (36.7 °C) -DI (r) CB (t)
Temp src	Oral -MG	Oral -MG	—	Oral -CB	Oral -CB
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	—	56 -DI (r) CB (t)	59 -DI (r) CB (t)
Heart Rate Source	Monitor -MG	Monitor -MG	—	Monitor -CB	Monitor -CB
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	—	18 -DI (r) CB (t)	18 -DI (r) CB (t)
BP	133/62 -DI (r) MG (t)	137/75 -DI (r) MG (t)	—	119/63 -DI (r) CB (t)	103/51 -DI (r) CB (t)
Patient Position	Lying -MG	Lying -MG	—	Lying -CB	Lying -CB
Oxygen Therapy					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—

Row Name	05/27/15 20:37:56	05/27/15 2000	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16
Sheath Insertion Site Location - Assessment					
L Radial Pulse	—	+2 -LB	—	—	—
R Radial Pulse	—	+2 -LB	—	—	—
L Pedal Pulse	—	+2 -LB	—	—	—
RLE Neurovascular Assessment					
RLE Capillary Refill	—	Less than/equal to 3 seconds -LB	—	—	—
RLE Color	—	Appropriate for ethnicity -LB	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -LB	—	—	—
RLE Sensation	—	Present -LB	—	—	—
R Pedal Pulse	—	+2 -LB	—	—	—
Vitals					
Temp	98.1 °F (36.7 °C) -DI (r) CB (t)	—	—	—	—
Temp src	Oral -CB	—	—	—	—
Pulse	62 -DI (r) CB (t)	—	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)
Heart Rate Source	Monitor -CB	—	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -DI (r) CB (t)	—	18 -RB	18 -RB	18 -RB
BP	132/73 -DI (r) CB (t)	—	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)	119/61 -DI (r) KH (t)
Patient Position	Lying -CB	—	Standing -RB	Sitting -RB	—
Oxygen Therapy					
SpO2	92 % -DI (r) CB (t)	—	—	—	—

Row Name	05/27/15 13:48:17	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07
Vitals					
Temp	—	—	—	—	97.7 °F (36.5 °C) -DI (r) KH (t)
Temp src	—	—	—	—	Oral -RB
Pulse	56 -DI (r) KH (t)	52 -DI (r) KH (t)	51 -DI (r) KH (t)	50 -RB	(!) 47 -DI (r) KH (t)
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -RB	18 -RB	18 -RB	—	—
BP	120/62 -DI (r) KH (t)	131/61 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	135/63 -DI (r) KH (t)
Patient Position	—	—	—	—	Lying -RB
Oxygen Therapy					
SpO2	—	—	—	—	94 % -DI (r) KH (t)

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	05/27/15 13:48:17	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07
O2 Device	----	----	----	----	None (Room air) -RB
Row Name	**05/27/15 11:49:11**	**05/27/15 11:34:20**	**05/27/15 11:19:18**	**05/27/15 1100**	**05/27/15 10:50:05**
Sheath Insertion Site Location - Assessment					
Femoral	—	—	—	Rt -KH	—
L Radial Pulse	—	—	—	+2 -KH	—
R Radial Pulse	----	----	----	+2 -KH	----
L Pedal Pulse	—	—	—	+2 -KH	—
RLE Neurovascular Assessment					
RLE Capillary Refill	----	----	----	Less than/equal to 3 seconds -KH	----
RLE Color	—	—	—	Appropriate for ethnicity -KH	—
RLE Temperature/Moisture	—	—	—	Warm;Dry -KH	—
RLE Sensation	----	----	----	Present -KH	----
R Pedal Pulse	—	—	—	+1 -KH	—
Vitals					
Temp	—	—	—	—	97.6 °F (36.4 °C) -DI (r) KH (t)
Pulse	53 -DI (r) KH (t)	**(!) 49** -DI (r) KH (t)	**(!) 48** -DI (r) KH (t)	—	**(!) 49** -DI (r) KH (t)
BP	135/63 -DI (r) KH (t)	122/65 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	—
Patient Position	----	Lying -RB	----	----	----
Oxygen Therapy					
SpO2	93 % -DI (r) KH (t)	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	—	95 % -DI (r) KH (t)
O2 Device	----	None (Room air) -RB	----	----	----
Row Name	**05/27/15 10:48:24**	**05/27/15 08:10:42**	**05/27/15 08:05:29**	**05/27/15 0747**	**05/27/15 0714**
Sheath Insertion Site Location - Assessment					
L Pedal Pulse	----	----	----	+2 -FD	----
RLE Neurovascular Assessment					
R Pedal Pulse	—	—	—	+2 -FD	—
Vitals					
Temp	—	—	—	—	97.6 °F (36.4 °C) -FD
Temp src	—	—	—	—	Oral -FD
Pulse	**(!) 46** -DI (r) KH (t)	----	----	----	**(!) 49** -FD
Resp	----	----	----	----	18 -FD
BP	123/67 -DI (r) KH (t)	—	—	—	118/74 -FD
Oxygen Therapy					
SpO2	96 % -DI (r) KH (t)	----	----	----	95 % -FD
O2 Device	—	Nasal cannula -MC	—	—	—
O2 Flow Rate (L/min)	—	3 L/min -MC	—	—	—
ACT (Activated Clotting Time) Ref					
Dose (units/kg/hr) Heparin	—	—	*2 Bag back table/flush -LR	—	—

Flowsheets (all recorded)

Patient Belongings

Row Name	05/28/15 1252	05/27/15 0715
Patient Belongings at Bedside		
Belongings at Bedside	—	Clothing -FD
Belongings sent to security (Retired)	—	No -FD
(RETIRED)Belongings Sent Home	Yes -KH	No -FD
Patient Medications		
Medications brought by patient?	—	No -FD

Flowsheets (all recorded)

Adult Immunization Screening

Row Name	05/27/15 1000
Influenza Vaccine (Sept - March 31st)	
Have you received the Influenza Vaccine during this Flu season?	Not Flu Season -KH
Meets Criteria for Influenza Vaccine?	
Patient Meets Criteria For Influenza Vaccine?	Not Flu Season -KH
OTHER	
Have you received the pneumococcal vaccine?	Yes -KH
Pneumococcal Vaccine Screening (Year Round)	
Last Immunization Greater than 5 years?	No -KH
Pneumococcal vaccine CONTRAINDICATIONS(RETIRED)	
Previous immunization (if patient received less than 5 years ago or "ONE TIME BOOSTER" already received) (VIEW ONLY)	Yes -KH
Patient Meets Criteria for Pneumococcal Vaccine? (VIEW ONLY)	
Patient Meets Criteria For Pneumococcal Vaccine? (VIEW ONLY)	No -KH

Flowsheets (all recorded)

Cardiac Rehab Follow-up

Row Name	05/28/15 0900	05/27/15 1200			
Cardiac Rehab follow-up needed?					
Cardiac Rehab Follow up needed?	No PCI review done 5/28 -MT	— PCI (book at bs eating/ hx CABG and stents) -MT			

Flowsheets (all recorded)

Complex Assessment

Row Name	05/28/15 0730	05/27/15 2000	05/27/15 1800	05/27/15 1600	05/27/15 1400
Neurological					
Orientation Level	Oriented X4 -KH	Oriented X4 -LB	—	—	—
Speech	Clear -KH	Clear -LB	—	—	—
Level of Consciousness (Retired)	Alert -KH	Alert -LB	—	—	—
HEENT					
HEENT (WDL)	WDL -KH	WDL -LB	—	—	—
Cardiac					
Cardiac Regularity	Regular -KH	Regular -LB	—	—	—
Heart Sounds	S1, S2 -KH	—	—	—	—
Cardiac Rhythm	Normal sinus rhythm -KH	Normal sinus rhythm -LB	—	—	—
Heart Block Type	Bundle branch block -KH	Bundle branch block -LB	—	—	—
Cardiac Monitor					
Telemetry Monitor On	Yes -KH	Yes -LB	Yes -RB	Yes -RB	Yes -RB
Telemetry Audible	—	Yes -LB	Yes -RB	Yes -RB	—
Telemetry Alarms Set	—	Yes -LB	—	—	—
Telemetry Box Number	MX51 -KH	mx51 -LB	mx51 -RB	mx51 -RB	mx51 -RB
Peripheral Vascular					
Peripheral Vascular (WDL)	WDL -KH	WDL -LB	—	—	—
RLE Capillary Refill	Less than/equal to 3 seconds -KH	Less than/equal to 3 seconds -LB	—	—	—
Pulses	L radial;R radial;L pedal;R pedal -KH	R radial;L radial;R pedal;L pedal -LB	—	—	—
RUE Neurovascular Assessment					
R Radial Pulse	+2 -KH	+2 -LB	—	—	—
LUE Neurovascular Assessment					
L Radial Pulse	+2 -KH	+2 -LB	—	—	—
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -KH	Appropriate for ethnicity -LB	—	—	—
RLE Temperature/Moisture	Warm;Dry -KH	Warm;Dry -LB	—	—	—
RLE Sensation	Present -KH	Present -LB	—	—	—
R Pedal Pulse	+2 -KH	+2 -LB	—	—	—
LLE Neurovascular Assessment					
L Pedal Pulse	+2 -KH	+2 -LB	—	—	—
Integumentary					
Integumentary (WDL)	WDL -KH	WDL -LB	—	—	—
Braden Scale					
Sensory Perceptions	4 -KH	4 -LB	—	—	—
Moisture	4 -KH	4 -LB	—	—	—
Activity	3 -KH	3 -LB	—	—	—
Mobility	3 -KH	4 -LB	—	—	—
Nutrition	4 -KH	4 -LB	—	—	—
Friction and Shear	3 -KH	3 -LB	—	—	—
Braden Scale Score	21 -KH	22 -LB	—	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Site Assessment	—	—	—	Other (Comment) Area soft. No hematoma noted -KH	Other (Comment) CDI dressing. Area soft -KH
Drainage Amount	None -KH	—	None -KH	None -KH	None -KH
Dressing Assesment	Intact;Dry;Clean -KH	—	Intact;Dry;Clean -KH	Intact;Dry;Clean -KH	Intact;Dry;Clean -KH
Gastrointestinal					
Gastrointestinal (WDL)	WDL -KH	WDL -LB	—	—	—
Bowel Sounds (All	Active -KH	—	—	—	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	05/28/15 0730	05/27/15 2000	05/27/15 1800	05/27/15 1600	05/27/15 1400
Quadrants)					
Psychosocial					
Psychosocial (WDL)	WDL -KH	WDL -LB	—	—	—
Needs Expressed	Denies -KH	Denies -LB	—	—	—
Charting Type					
Charting Type	Shift assessment -KH	Shift assessment -LB	—	—	—

Row Name	05/27/15 1325	05/27/15 1200	05/27/15 1100	05/27/15 0747	05/27/15 0717
Neurological					
Orientation Level	—	—	Oriented X4 -KH	—	—
Speech	—	—	Clear -KH	—	—
Level of Consciousness (Retired)	—	—	Alert -KH	—	—
HEENT					
HEENT (WDL)	—	—	WDL -KH	—	—
Cardiac					
Cardiac Regularity	—	—	Regular -KH	—	—
Heart Sounds	—	—	S1, S2 -KH	—	—
Cardiac Rhythm	—	—	Sinus bradycardia -KH	—	—
Cardiac Monitor					
Telemetry Monitor On	—	Yes -RB	Yes -KH	—	—
Telemetry Box Number	—	mx51 -RB	MX51 -KH	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	WDL -KH	X -FD	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -KH	—	—
Pulses	—	—	L radial;R radial;L pedal;R pedal -KH	R pedal;L pedal -FD	—
RUE Neurovascular Assessment					
R Radial Pulse	—	—	+2 -KH	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	—	+2 -KH	—	—
RLE Neurovascular Assessment					
RLE Color	—	—	Appropriate for ethnicity -KH	—	—
RLE Temperature/Moisture	—	—	Warm;Dry -KH	—	—
RLE Sensation	—	—	Present -KH	—	—
R Pedal Pulse	—	—	+1 -KH	+2 -FD	—
LLE Neurovascular Assessment					
L Pedal Pulse	—	—	+2 -KH	+2 -FD	—
Integumentary					
Integumentary (WDL)	—	—	WDL -KH	—	—
Braden Scale					
Sensory Perceptions	—	—	4 -KH	—	4 -FD
Moisture	—	—	4 -KH	—	4 -FD
Activity	—	—	1 S/P PCI -KH	—	4 -FD
Mobility	—	—	3 -KH	—	4 -FD
Nutrition	—	—	3 -KH	—	4 -FD
Friction and Shear	—	—	3 -KH	—	3 -FD
Braden Scale Score	—	—	18 -KH	—	23 -FD
Wound					
Type of Wound (LDA)	—	—	Surgical -KH	—	—
[REMOVED] Surgical 05/27/15 Groin Right					
Incision Properties	Date Documented: 05/27/15 -KH Time Documented: 1100 -KH Location: Groin -KH Wound Location Orientation: Right -KH Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Site Assessment	Bleeding -KH	—	Other (Comment) CDI	—	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	05/27/15 1325	05/27/15 1200	05/27/15 1100	05/27/15 0747	05/27/15 0717
			dressing over site -KH		
Surrounding Skin Assessment	—	—	Clean;Dry;Intact -KH	—	—
Drainage Amount	—	—	None -KH	—	—
Dressing	Pressure dressing -KH	—	Dry dressing -KH	—	—
Dressing Changed	New -KH	—	—	—	—
Dressing Assesment	Intact;Dry;Clean -KH	—	Intact;Dry;Clean -KH	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	WDL -KH	—	—
Bowel Sounds (All Quadrants)	—	—	Active -KH	—	—
Psychosocial					
Psychosocial (WDL)	—	—	WDL -KH	—	—
Needs Expressed	—	—	Denies -KH	—	—
Provider Notification					
Reason for Communication (View Only	Other (comment) Right groin site started bleeding. Pressure held for 20min. -KH	—	—	—	—
Notification Time	1325 -KH	—	—	—	—
Provider Name	Gina Haden, RN -KH	—	—	—	—
Provider Role	Nurse -KH	—	—	—	—
Method of Communication	Call -KH	—	—	—	—
Charting Type					
Charting Type	—	—	Admission -KH	—	—

Flowsheets (all recorded)

Vital Signs

Row Name	05/28/15 11:23:35	05/28/15 08:18:59	05/28/15 0730	05/28/15 03:26:44	05/27/15 23:10:46
Vital Signs					
Temp	98 °F (36.7 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) MG (t)	—	97.8 °F (36.6 °C) -DI (r) CB (t)	98 °F (36.7 °C) -DI (r) CB (t)
Temp src	Oral -MG	Oral -MG	—	Oral -CB	Oral -CB
Pulse	61 -DI (r) MG (t)	63 -DI (r) MG (t)	—	56 -DI (r) CB (t)	59 -DI (r) CB (t)
Heart Rate Source	Monitor -MG	Monitor -MG	—	Monitor -CB	Monitor -CB
Resp	18 -DI (r) MG (t)	18 -DI (r) MG (t)	—	18 -DI (r) CB (t)	18 -DI (r) CB (t)
Respiration Source	visual -MG	visual -MG	—	visual -CB	visual -CB
BP	133/62 -DI (r) MG (t)	137/75 -DI (r) MG (t)	—	119/63 -DI (r) CB (t)	103/51 -DI (r) CB (t)
BP Location	Right arm -MG	Right arm -MG	—	Right arm -CB	Right arm -CB
BP Method	Portable -MG	Portable -MG	—	Portable -CB	Portable -CB
Patient Position	Lying -MG	Lying -MG	—	Lying -CB	Lying -CB
Oxygen Therapy					
SpO2	93 % -DI (r) MG (t)	94 % -DI (r) MG (t)	—	95 % -DI (r) CB (t)	93 % -DI (r) CB (t)
O2 Device	None (Room air) -MG	None (Room air) -MG	—	—	—
Pain Assessment					
Currently in Pain	—	—	No -KH	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -KH	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -KH	—	5 -LB
Height and Weight					
Weight	—	—	—	100.2 kg (220 lb 14.4 oz) -DI (r) CB (t)	—
Weight Method	—	—	—	Actual -CB	—

Row Name	05/27/15 20:37:56	05/27/15 15:25:49	05/27/15 15:24:40	05/27/15 14:48:16	05/27/15 13:48:17
Vital Signs					
Temp	98.1 °F (36.7 °C) -DI (r) CB (t)	—	—	—	—
Temp src	Oral -CB	—	—	—	—
Pulse	62 -DI (r) CB (t)	60 -DI (r) KH (t)	60 -DI (r) KH (t)	57 -DI (r) KH (t)	56 -DI (r) KH (t)
Heart Rate Source	Monitor -CB	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB
Resp	18 -DI (r) CB (t)	18 -RB	18 -RB	18 -RB	18 -RB
Respiration Source	visual -CB	visual -RB	visual -RB	visual -RB	visual -RB
BP	132/73 -DI (r) CB (t)	126/54 -DI (r) KH (t)	121/57 -DI (r) KH (t)	119/61 -DI (r) KH (t)	120/62 -DI (r) KH (t)
BP Location	Right arm -CB	Right arm -RB	Right arm -RB	Right arm -RB	Right arm -RB
BP Method	Portable -CB	Portable -RB	Portable -RB	—	—
Patient Position	Lying -CB	Standing -RB	Sitting -RB	—	—
Oxygen Therapy					
SpO2	92 % -DI (r) CB (t)	—	—	—	—

Row Name	05/27/15 13:18:18	05/27/15 12:33:20	05/27/15 1204	05/27/15 12:00:07	05/27/15 11:49:11
Vital Signs					
Temp	—	—	—	97.7 °F (36.5 °C) -DI (r) KH (t)	—
Temp src	—	—	—	Oral -RB	—
Pulse	52 -DI (r) KH (t)	51 -DI (r) KH (t)	50 -RB	**(!) 47** -DI (r) KH (t)	53 -DI (r) KH (t)
Heart Rate Source	Monitor -RB	Monitor -RB	Monitor -RB	Monitor -RB	—
Resp	18 -RB	18 -RB	—	—	—
Respiration Source	visual -RB	visual -RB	—	visual -RB	—
BP	131/61 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	135/63 -DI (r) KH (t)	135/63 -DI (r) KH (t)
BP Location	Right arm -RB	Right arm -RB	—	Right arm -RB	—
BP Method	—	—	—	Portable -RB	—
Patient Position	—	—	—	Lying -RB	—
Oxygen Therapy					
SpO2	—	—	—	94 % -DI (r) KH (t)	93 % -DI (r) KH (t)
O2 Device	—	—	—	None (Room air) -RB	—

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24
Vital Signs					
Temp	—	—	—	97.6 °F (36.4 °C) -DI (r) KH (t)	—
Pulse	**(!) 49** -DI (r) KH (t)	**(!) 48** -DI (r) KH (t)	—	**(!) 49** -DI (r) KH (t)	**(!) 46** -DI (r) KH (t)

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	05/27/15 11:34:20	05/27/15 11:19:16	05/27/15 1100	05/27/15 10:50:05	05/27/15 10:48:24
BP	122/65 -DI (r) KH (t)	125/69 -DI (r) KH (t)	—	—	123/67 -DI (r) KH (t)
BP Location	Right arm -RB	—	—	—	—
BP Method	Portable -RB	—	—	—	—
Patient Position	Lying -RB	—	—	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) KH (t)	94 % -DI (r) KH (t)	—	95 % -DI (r) KH (t)	96 % -DI (r) KH (t)
O2 Device	None (Room air) -RB	—	—	—	—
Pain Goal					
Patient's Stated Pain Goal	—	—	0 (No Pain) -KH	—	—

Row Name	05/27/15 08:10:42	05/27/15 0714
Vital Signs		
Temp	—	97.6 °F (36.4 °C) -FD
Temp src	—	Oral -FD
Pulse	—	(!) 49 -FD
Resp	—	18 -FD
BP	—	118/74 -FD
Oxygen Therapy		
SpO2	—	95 % -FD
O2 Device	Nasal cannula -MC	—
O2 Flow Rate (L/min)	3 L/min -MC	—
Numeric Pain Intensity Scale		
Numeric Pain Intensity Score 1	—	0 -FD
Height and Weight		
Height	—	67" (1.702 m) -FD
Weight	—	97.5 kg (215 lb) -FD
Weight Method	—	Stated -FD
BSA (Calculated - sq m)	—	2.14 sq meters -FD
BMI (Calculated)	—	33.7 -FD
Weight in (lb) to have BMI = 25	—	159.3 -FD

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
RB	Regina C Baker	05/27/14 - 02/02/17
MG	Marie O Germain	05/27/14 - 02/02/17
LR	Latesha J Richardson, RN	07/25/14 -
FD	Faith A Dawes-Rust, RN	09/03/14 - 02/02/17
CB	Christianise J Baptiste, CNA	04/05/14 - 09/08/16
MT	Marie Thomas-Stanley, RN	04/02/14 - 02/02/17
MC	Margaret C Carroll	09/03/14 - 01/12/17
KH	Kate M Hand, RN	04/02/14 - 02/02/17
LB	Leslie M Best, RN	12/22/14 - 02/02/17
CR	Chris Russell	—
DI	Interface, Doc Flowsheet In	—
VI	Interface, Vs Maclab Incoming	—
EI	Epicweb Interface	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 05/27/2015:

Scan on 5/30/2015 11:24 AM (below)

Scan on 5/27/2015 6:48 AM by Jerri L Mills: ImageNow scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	IP			Unit:	CH 2N TELE
Hospital Service:	Cardiology			Bed:	238/238-01
Admitting Provider:	Abdul M Sheikh, Md			Referring Physician:	
Attending Provider:	Abdul m sheikh	AD: N		Adm Diagnosis:	Coronary arteriosclerosi*
Admission Date:	1/10/2017			Admission Time:	0637

PATIENT

Name	Eugene George Maurice		Sex: Male	DOB:	1/2/1949 (68 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer:	Phone:	Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /MDCR
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE G	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	Co-In:	Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial# April 7, 2020 Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	01/10/2017 0637	IP Adm. Date/Time:	01/10/2017 0905
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Cardiology	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cobb Hospital (CH 2N TELE (CARD))
Admit Provider:	Abdul M Sheikh, MD	Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
01/11/2017 1318	Home Or Self Care	None	None	WellStar Cobb Hospital (CH 2N TELE (CARD))

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.719 **[Principal]**	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	Yes	No		Yes
I10	Essential (primary) hypertension	Yes	No		No
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	Yes	No		No
I73.9	Peripheral vascular disease, unspecified	Yes	No		No
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting	No		No
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting	No		No
E78.5	Hyperlipidemia, unspecified	Yes	No		No
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting	No		No

Events

Admission at 1/10/2017 0637

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Hospital Outpatient Surgery Service: General Surgery

Surgery at 1/10/2017 0805

Unit: CH CARDIAC CATH LAB Room: CH CATH/EP LAB 1
Patient class: Hospital Outpatient Surgery Service: Cardiovascular

Patient Update at 1/10/2017 0905

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Inpatient Service: Cardiology

Transfer Out at 1/10/2017 0959

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Inpatient Service: Cardiology

Transfer In at 1/10/2017 0959

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) Room: CH Cardiac ARU Pool Bed: CH Cardiac ARU Pool
Patient class: Inpatient Service: Cardiology

Transfer Out at 1/10/2017 1118

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) Room: CH Cardiac ARU Pool Bed: CH Cardiac ARU Pool
Patient class: Inpatient Service: Cardiology

Transfer In at 1/10/2017 1118

Unit: WellStar Cobb Hospital (CH 2N TELE (CARD)) Room: 238 Bed: 238-01
Patient class: Inpatient Service: Cardiology

Discharge at 1/11/2017 1318

Unit: WellStar Cobb Hospital (CH 2N TELE Room: 238 Bed: 238-01

All Scans (continued)

Events (continued)

(CARD))
Patient class: Inpatient Service: Cardiology

Allergies as of 1/11/2017

Reviewed on 1/10/2017

No Known Allergies

Immunizations as of 1/11/2017

Immunizations never marked as reviewed

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN	Administered on: 9/26/2016	Dose: 0.5 mL
Site: Left deltoid	Route: Intramuscular	NDC: 49281-399-88
CVX code: 135	VIS date: 8/7/2015	
Manufacturer: Sanofi Pasteur	Lot number: UI700AA	

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA	Administered on: 3/16/2016	Dose: 0.5 mL
Site: Left deltoid	Route: Intramuscular	NDC: 0005-1971-01
CVX code: 133	VIS date: 031616	
Manufacturer: Wyeth-Ayerst	Lot number: M51193	

Medical as of 1/11/2017

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Cancer (HCC) [C80.1]	04/07/2014	—	Provider
Chronic kidney disease [N18.9]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction [I21.3]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

All Scans (continued)

Medical as of 1/11/2017 (continued)

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Discharge Summary - Encounter Notes

Discharge Summary by Michael S Hardee, MD at 1/11/2017 8:52 AM

Author: Michael S Hardee, MD | Service: Cardiology | Author Type: Physician
Filed: 1/11/2017 9:32 AM | Date of Service: 1/11/2017 8:52 AM | Status: Signed
Editor: Michael S Hardee, MD (Physician)
Related Notes: Original Note by Sandra Nerestil, NP (Nurse Practitioner) filed at 1/11/2017 9:15 AM

WellStar Cardiovascular Medicine

Patient Name: Eugene G Maurice
Date of Birth: 1/2/1949
MRN: 561253820
LOS: 1 day

CARDIOVASCULAR MEDICINE DISCHARGE SUMMARY

Admit date:1/10/2017
Discharge date: 1/11/2017
Primary Cardiologist: Abdul Sheikh MD

Discharged Condition: good, stable
Disposition: Discharged to: Home

Discharge Diagnoses

1. CAD, hx CABG in 1992 & PCI's.. LHC 5/15: LM 100%, RCA 100%. LIMA-D1-LAD patent, SVG-PDA 90% ISR, SVG-OM 100%. LHC 5/14: 4.0/15 Resolute DES to prox SVG-OM, 4.0/18 Resolute DES to SVG-PDA, 5/15: 4.0/16 Promus in SVG-PDA (distal to prior stent), 3.5/16, 3.5/38, and 3.0/38 Promus in SVG-OM

1/10/17 LHC:

- Severe native vessel disease.
- Patent LIMA-LAD. Severe ISR (DES) of SVGs to OMs and PDA.
- Preserved EF.
- **Successful POBA of SVGs to OM and PDA with NC/cutting balloons.**Continue long-term dual antiplatelet therapy. Aggressive risk factor modification.

2. PVD

Discharge Summary - Encounter Notes (continued)

Discharge Summary by Michael S Hardee, MD at 1/11/2017 8:52 AM (continued)

3. HTN-controlled
4.HLP- on statin
5.DM, hold Glucophage today, resume in am 1/12/17.

Hospital Course

Mr. Maurice is a 68 y.o. male with hx of CAD, hx CABG in 1992 & PCI's..LHC 5/15: LM 100%, RCA 100%. LIMA-D1-LAD patent, SVG-PDA 90% ISR, SVG-OM 100%. LHC 5/14: 4.0/15 Resolute DES to prox SVG-OM, 4.0/18 Resolute DES to SVG-PDA, 5/15: 4.0/16 Promus in SVG-PDA (distal to prior stent), 3.5/16, 3.5/38, and 3.0/38 Promus in SVG-OM. Hx of HTN, HLP, DM and PVD.

Admitted on 1/10/17 to undergo LHC. S/p LHC 1/10/17-Severe native vessel disease, patent LIMA-LAD. Severe ISR (DES) of SVGs to OMs and PDA, Preserved EF. **Successful POBA of SVGs to OM and PDA with NC/cutting balloons.**Continue long-term dual antiplatelet therapy and Aggressive risk factor modification.

Subjective Data

Mr. Maurice denies chest pain, sob or palpitations

Physical Exam

Temp: [97.5 °F (36.4 °C)-98.6 °F (37 °C)] 97.5 °F (36.4 °C)
Heart Rate: [57-81] 64
Resp: [14-18] 18
BP: (117-158)/(53-74) 135/69

General: no acute distress
Neck: no JVD, no carotid bruit
Cardiovasular: regular rate and rhythm; sem
Lungs: clear to auscultation, no wheezes, rales, or rhonchi; normal respiratory effort
Extremities: no pedal edema. Extremities x4 warm, well-perfused. Right radial and right groin site benign.
Psych: oriented, cooperative

Post Procedure Hematoma
☒ No Hematoma
☐ Hematoma present. Size: ☐ <3 cm ☐ 3-5 cm ☐ 5-10 cm ☐ >10cm

Post PCI complications

No	**Cardiogenic Shock, new onset or acute recurrence** Cardiogenic shock is defined as a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg, and/or cardiac index <2.2 L/min/m2 determined to be secondary to cardiac dysfunction, and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain blood pressure and cardiac index above those specified levels.
No	**Heart Failure, new onset or acute recurrence** Requires new or increased pharmacologic therapy

Discharge Summary - Encounter Notes (continued)

Discharge Summary by Michael S Hardee, MD at 1/11/2017 8:52 AM (continued)

	Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure: unusual dyspnea on light exertion; recurrent dyspnea occurring in the supine position; fluid retention; the description of rales, jugular venous distension, pulmonary edema on physical exam; or pulmonary edema on chest x-ray. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.
No	**CVA** CVA is defined as loss of neurological function caused by an ischemic or hemorrhagic event with residual symptoms lasting at least 24 hours after onset or leading to death.
No	**Tamponade** Tamponade is defined as fluid in the pericardial space compromising cardiac filling and requiring intervention and should be documented by either: 1. Echocardiogram showing pericardial fluid and signs of tamponade such as right heart compromise, or 2. Systemic Hypotension due to pericardial fluid compromising cardiac function.
No	**Vascular complication requiring intervention** Vascular complications can include, but are not limited to, access site occlusions, peripheral embolizations, dissections, pseudoaneurysms and/or AV fistulas. Any noted vascular complication must have had an intervention such as a fibrin injection, angioplasty, or surgical repair to qualify. Prolonged pressure does not qualify as an intervention, but ultrasonic guided compression after making a diagnosis of pseudoaneurysm does qualify.
No	**Bleeding within 72 hours of the procedure start.** **If yes, specify if RP bleed, GI/GU bleed or Other.** Must be associated with any of the following: · Hemoglobin drop of >=3g/dL · Transfusion of whole blood or PRBC · Procedural intervention/surgery at the bleeding site to stop the bleeding

Post Procedure Drop in Hemoglobin

☒ No post procedure drop in hemoglobin > 3g/dl

☐ Post PCI drop in hemoglobin related to hemodilution. No evidence of post-PCI bleeding.

Diagnostics/Radiology

Echo: 3/29/16

- Left ventricular systolic function is normal, ejection fraction is 50-55%.
- The left ventricle cavity is normal size. Mildly increased concentric left ventricle hypertrophy.
- Right ventricle has normal size and normal systolic function.
- There is mild mitral valve regurgitation present.

Ischemic Evaluation:
Conclusion 1/10/17

- Severe native vessel disease.
- Patent LIMA-LAD. Severe ISR (DES) of SVGs to OMs and PDA.
- Preserved EF.
- Successful POBA of SVGs to OM and PDA with NC/cutting balloons.

1. Continue long-term dual antiplatelet therapy.
2. Aggressive risk factor modification.

Coronary Findings
Dominance: Right
Left Main
•Ost LM to LM lesion, 100% stenosed.
Left Anterior Descending
•Ost LAD lesion, 100% stenosed.
•Ost LAD to Prox LAD lesion, 100% stenosed.
Left Circumflex
•Ost Cx lesion, 100% stenosed.
Right Coronary Artery
•Prox RCA lesion, 100% stenosed.

Graft Angiography
LIMA Graft to 1st Diag, Mid LAD
The graft is angiographically normal (0%).
Sequential Vein Graft to 1st Mrg, 2nd Mrg
The conduit type is a SVG.
•Origin to Prox Graft lesion before 1st Mrg, 80% stenosed. The lesion was previously treated with a drug eluting stent and stent (unknown type). The lesion is eccentric.
•PCI: Lesion length: 50mm. This is the culprit lesion. The pre-interventional distal flow is normal (TIMI 3). The lesion was treated by angioplasty only with a BALLOON NC EMERGE 3.00X30MM MR, FLEXTOME CUTTING 3.0 X 15 and BALLOON NC RX 3.50 X 20MM EUPHORA mm balloon(s). Post TIMI flow: 3. The intervention was successful. There were no complications.
•There is a 20% residual stenosis post intervention.
Vein Graft to RPDA
The conduit type is a SVG.
•Origin lesion, 99% stenosed. The lesion was previously treated with a drug eluting stent and stent (unknown type).
•PCI: Lesion length: 20mm. This is the culprit lesion. The pre-interventional distal flow is decreased (TIMI 2). The lesion was treated by angioplasty only with a BALLOON SC EUPHORA RX 2.50X15MM and BALLOON NC RX 3.50 X 20MM EUPHORA mm balloon(s). Post TIMI flow: 3. The intervention

was successful. There were no complications.
•There is a 10% residual stenosis post intervention.

Left Heart
Left Ventricle
The left ventricular systolic function is normal. The ejection fraction is estimated to be 60%.

Ancillary Data

Results from last 7 days

Lab	Units	01/11/17 0428	01/06/17 0911
WBC COUNT	10E9/L	9.8	7.9
HGB	g/dL	11.9*	12.7*
HEMATOCRIT	%	36*	40
PLATELET	10E9/L	136*	160

Results from last 7 days

Lab	Units	01/11/17 0428	01/06/17 0911
SODIUM, S	mmol/L	142	138
CHLORIDE	mmol/L	104	100
CO2	mmol/L	22	23
BUN BLD	mg/dL	23	18
CREATININE, S	mg/dL	1.05	0.93
CALCIUM,TOTAL	mg/dL	9.2	9.3
GFR MDRD NON AF AMER	ml/min/1.73 m2	>60	>60

Discharge Instructions/Medications

Current Discharge Medication List

CONTINUE these medications which have NOT CHANGED

	Details
aspirin, buffered 81 mg Tab	Take 81 mg by mouth daily.
atorvastatin (LIPITOR) 80 MG tablet	Take 1 tablet (80 mg total) by mouth nightly.. *Qty:* 90 tablet, *Refills:* 1
carvedilol (COREG) 12.5 MG tablet	Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals.. *Qty:* 180 tablet, *Refills:* 1

chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily.. *Qty:* 90 tablet, *Refills:* 1 *Associated Diagnoses:* Coronary arteriosclerosis
cilostazol (PLETAL) 100 MG tablet	Take 100 mg by mouth 2 (two) times a day
clopidogrel (PLAVIX) 75 mg tablet	TAKE 1 TABLET DAILY *Qty:* 90 tablet, *Refills:* 1 *Associated Diagnoses:* Coronary artery disease involving native coronary artery without angina pectoris
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 2 tablets (60 mg total) by mouth 2 (two) times a day.. *Qty:* 360 tablet, *Refills:* 1 *Associated Diagnoses:* Coronary artery disease involving native coronary artery of native heart without angina pectoris
ramipril (ALTACE) 10 MG capsule	Take 1 capsule (10 mg total) by mouth 2 (two) times a day.. *Qty:* 180 capsule, *Refills:* 1
blood sugar diagnostic (GLUCOSE BLOOD) strip	cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed.. *Qty:* 100 strip, *Refills:* 2
metFORMIN (GLUCOPHAGE) 500 MG tablet	Take 2 tablets (1,000 mg total) by mouth 2 (two) times a day with meals *Qty:* 360 tablet, *Refills:* 1 HOLD GLUCOPHAGE TODAY. RESUME 1/12/17
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain *Qty:* 30 tablet, *Refills:* 3

Prescribed Post PCI Medications

Check for Yes. Document if No.

☒ **Antiplatelet - Brilinta/Effient/Plavix** If no, because ☐ Hx of bleeding ☐ Allergy ☐ Other:
☒ **Aspirin** If no, because ☐ Hx of bleeding ☐ Allergy ☐ Other:
☒ **ACEI** If no, because ☐ On ARB ☐ A/CKD ☐ Hypotension ☐ Allergy ☐ Other:
☐ **ARB** If no, because ☒ On ACEI ☐ A/CKD ☐ Hypotension ☐ Allergy ☐ Other:
☒ **Beta-blockers** If no, because ☐ Bradycardia/AV block ☐ Hypotension ☐ Allergy ☐ Other:
☒ **Statin** If no, because ☐ Intolerant ☐ Liver Dysfunction ☐ Allergy ☐ Other:
☐ **Non-Statin Lipid Agent** If no, because ☒ On statin ☐ Intolerant ☐ Allergy ☐ Other:

☒ **Smoking cessation discussed** (if current smoker)
☐ **Referred to cardiac rehab**

Wound care: Do not do any unnecessary bending, heavy lifting (greater than 10 pounds), straining for 1 week.

Discharge Summary - Encounter Notes (continued)

Discharge Summary by Michael S Hardee, MD at 1/11/2017 8:52 AM (continued)

Do not sit in a hot tub, bathtub, sauna, whirlpool, or swimming pool for 1 week. Report any bleeding, swelling, severe pain, or numbness at the puncture site. Avoid driving for at least 24 hours post discharge.

Follow-up:
Dr. Sheikh on 1/30/17 at 8 AM Hiram Office
Time Spent on Discharge: > 30 minutes

Signed:
Sandra Nerestil, NP
1/11/2017, 8:52 AM
Wellstar Cardiovascular Medicine
770-424-6893

[redacted]
68yo male s/p CABG admitted for angina. LHC yesterday with severe ISR of SVGs to OM and PDA s/p successful POBA of SVGs to OM and PDA.

S: no CP, SOB

EXAM: RRR w/ 2/6 systolic murmur (heard on adm). Stable rt groin, no edema

A/P
Stable cardiac status
Ok for discharge
F/u with Dr. Sheikh 1/30/17 at 8am

Electronically Signed by Michael S Hardee, MD on 1/11/2017 9:32 AM

H&P - Encounter Notes

H&P by Abdul M Sheikh, MD at 1/10/2017 10:04 AM

Author: Abdul M Sheikh, MD | Service: Cardiology | Author Type: Physician
Filed: 1/10/2017 10:05 AM | Date of Service: 1/10/2017 10:04 AM | Status: Signed
Editor: Abdul M Sheikh, MD (Physician)

H&P reviewed, patient examined prior to procedure, patient's condition unchanged. For LHC today for recurrence of his typical angina. Nature of procedure and risks/benefits d/w patient. Consent obtained. Full office note below.

Abdul M Sheikh, MD

EUGENE G MAURICE
1/2/1949
561253820

HPI
Eugene G Maurice is a 66 y.o. male seen in the office today for follow up of CAD. Has had progression of his symptoms angina. This occurs when he is walking on his treadmill and also when under stress. They have intensified in frequency, not severity. Go away promptly with rest or if he takes a single sublingual nitroglycerin.

H&P - Encounter Notes (continued)

H&P by Abdul M Sheikh, MD at 1/10/2017 10:04 AM (continued)

Could not continue with Ranexa do to cost issues.

ROS

General	denies c/o	Abdominal	denies c/o
Skin	denies c/o	Musculoskeletal	denies c/o
Eyes	denies c/o	Neuro	denies c/o
Ears/nose/throat	denies c/o	Psych	denies c/o
Resp	denies c/o	Endocrine	denies c/o
CV	see HPI	Heme	denies c/o

DATA REVIEW

Data Review

	4/20/16
EKG	3/18/16: SR, IVCD
Echocardiogram	03/29/16 ejection fraction is 50-55%. Mildly increased concentric left ventricle hypertrophy. There is mild mitral valve regurgitation present.
LVEF	50-55% per echo 03/2016
Carotid Duplex	08/20/2014 Hemodynamically significant stenosis of 50-79% in the right internal carotid artery. Essentially normal post-carotid endarterectomy duplex evaluation of the left internal carotid artery. Normal antegrade right and left vertebral artery flow. There has been no significant change from the previous study.
Myocardial Perfusion Imaging, Exercise	5/15: Positive, high risk
Myocardial Perfusion Imaging, Lexiscan	1/08: negative for ischemia
Cardiac Catheterization	5/15: LM 100%, RCA 100%. LIMA-D1-LAD patent, SVG-PDA 90% ISR, SVG-OM 100%.
PCI	5/14: 4.0/15 Resolute DES to prox SVG-OM, 4.0/18 Resolute DES to SVG-PDA, 5/15: 4.0/16 Promus in SVG-PDA (distal to prior stent), 3.5/16, 3.5/38, and 3.0/38 Promus in SVG-OM
Cardiac Surgery	1992: CABG (in Nashville, TN)
Peripheral Vascular Procedures	Right CEA January 2014

PAST MEDICAL HX

he has a past medical history of Other symptoms involving cardiovascular system; Coronary atherosclerosis of native coronary artery; Family history of ischemic heart disease; Other and unspecified hyperlipidemia; Essential hypertension, benign; PVD (peripheral vascular disease); Obesity; Hypertension; Hyperlipidemia; and CAD (coronary artery disease).

SOCIAL HX

H&P - Encounter Notes (continued)

H&P by Abdul M Sheikh, MD at 1/10/2017 10:04 AM (continued)

History	History	History
Smoking status	Alcohol Use	Drug Use No
• Former Smoker -- 1.00 packs/day for 25 years • Types: Cigarettes • Quit date: 04/07/1992	• Yes	
Smokeless tobacco		
• Never Used		

FAMILY HX

family history includes Coronary artery disease in his mother and Other in his brother and mother. There is no history of Anemia, and Arrhythmia, and Asthma, and Clotting disorder, and Fainting, and Heart attack, and Heart disease, and Heart failure, and Hyperlipidemia, and Hypertension, and Stroke, .

ALLERGIES

Allergies as of 04/07/2014

- (No Known Allergies)

MEDICATIONS

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• aspirin, buffered 81 mg Tab	Take 81 mg by mouth daily.		
• carvedilol (COREG) 12.5 MG tablet	Take 12.5 mg by mouth 2 (two) times a day with meals.		
• chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily.	30 tablet	11
• ezetimibe-simvastatin (VYTORIN 10-80) 10-80 mg per tablet	Take 1 tablet by mouth 3 (three) times a week.		
• ramipril (ALTACE) 10 MG capsule	Take 10 mg by mouth 2 (two) times a day.		
• isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 1 tablet (30 mg total) by mouth daily.	30 tablet	4

No current facility-administered medications for this visit.

EXAM

Vitals

Vitals:

	11/29/16 0806
BP:	122/76
Pulse:	64
Weight:	96.2 kg (212 lb)
Height:	67" (1.702 m)

General	Alert, oriented, NAD	Extremities	No edema, normal pulses
Skin	Warm, no rashes	Abdomen	Soft, nt/nd, normal bowel sound
Neck	JVP normal, no bruit	Neuro	Grossly normal
Chest	clear bilaterally, normal effort	Psych	Grossly normal
Cardiac	Regular,2/6 SEM, no r/g, PMI nl		

LABS

Lab Results

Component	Value	Date
POTASSIUM	4.7	2/21/2014
BUN	30*	2/21/2014
CREATININE	1.17	2/21/2014
GFRNONAA	>60	2/21/2014
ALT	30	2/17/2014
AST	26	2/17/2014

No results found for this basename: CHOL, TRIG, HDL, LDLCHOL

Lab Results

Component	Value	Date
HGB	11.1*	2/21/2014
HCT	34*	2/21/2014
PLT	146*	2/21/2014

No results found for this basename: BNP, TSH

ASSESSMENT/PLAN

H&P - Encounter Notes (continued)

H&P by Abdul M Sheikh, MD at 1/10/2017 10:04 AM (continued)

1. **CAD (coronary artery disease)**
2. Essential hypertension, benign
3. PVD (peripheral vascular disease)
4. Hyperlipidemia

Mr. Maurice is a pleasant 67 y.o. male with CAD. Symptoms of chronic stable angina, now progressin.

- Given progression of symptoms, will schedule LHC. He would like to wait until after the holidays.
- Followup in 2 months

Electronically Signed by Abdul M Sheikh, MD on 1/10/2017 10:05 AM

Progress Notes - Encounter Notes

Progress Notes by Dianne W Wehrle, RN at 1/10/2017 10:59 AM

Author: Dianne W Wehrle, RN | Service: — | Author Type: Registered Nurse
Filed: 1/10/2017 11:00 AM | Date of Service: 1/10/2017 10:59 AM | Status: Signed
Editor: Dianne W Wehrle, RN (Registered Nurse)

Report called to floor

Electronically Signed by Dianne W Wehrle, RN on 1/10/2017 11:00 AM

Progress Notes by Jane Abey, RN at 1/11/2017 11:30 AM

Author: Jane Abey, RN | Service: — | Author Type: Registered Nurse
Filed: 1/11/2017 1:51 PM | Date of Service: 1/11/2017 11:30 AM | Status: Signed
Editor: Jane Abey, RN (Registered Nurse)

Patient discharge home, discharge paper work and teaching were provided, dressing at both sites (right groin and left radial) are clean, dry and intact.

Electronically Signed by Jane Abey, RN on 1/11/2017 1:51 PM

Plan of Care - Encounter Notes

Plan of Care by Jane Abey, RN at 1/10/2017 3:59 PM

Author: Jane Abey, RN | Service: — | Author Type: Registered Nurse
Filed: 1/10/2017 3:59 PM | Date of Service: 1/10/2017 3:59 PM | Status: Signed
Editor: Jane Abey, RN (Registered Nurse)

Problem: Pain
Goal: Patient's pain/discomfort is manageable
Assess and monitor patient's pain using appropriate pain scale. Collaborate with interdisciplinary team and initiate plan and interventions as ordered. Re-assess patient's pain level 30 - 60 minutes after pain management intervention.
Outcome: Progressing

Problem: Safety
Goal: Patient will be injury free during hospitalization
Assess and monitor vitals signs, neurological status including level of consciousness and orientation.
Assess patient's risk for falls and implement fall prevention plan of care and interventions per hospital policy.

Ensure arm band on, uncluttered walking paths in room, adequate room lighting, call light and overbed table

Plan of Care - Encounter Notes (continued)

Plan of Care by Jane Abey, RN at 1/10/2017 3:59 PM (continued)

within reach, bed in low position, wheels locked, side rails up per policy, and non-skid footwear provided.
Outcome: Progressing

Problem: Daily Care
Goal: Daily care needs are met
Assess and monitor ability to perform self care and identify potential discharge needs.
Outcome: Progressing

Problem: Psychosocial Needs
Goal: Demonstrates ability to cope with hospitalization/illness
Assess and monitor patients ability to cope with his/her illness.
Outcome: Progressing

Electronically Signed by Jane Abey, RN on 1/10/2017 3:59 PM

Surgery Report

General Information

Date: 1/10/2017 | Time: 0800 | Status: Posted
Location: CH CARDIAC CATH LAB | Room: Cath Lab 1 | Service: Cardiovascular
Patient class: Hospital Outpatient Surgery | Case classification:

Diagnosis Information

Diagnosis
Coronary arteriosclerosis
PVD (peripheral vascular disease) (HCC)
Essential hypertension with goal blood pressure less than 130/85
Hyperlipidemia, unspecified hyperlipidemia type

Case Tracking Events

Event	Time In
In Facility	0637
In ARU Prep	
ARU Prep Complete	0734
Out of ARU Prep	0805
Ready for Procedure	
In Room	0805
Moderate Sedation Begin	0816
Moderate Sedation End	0947
Out of Room	0959
In ARU Recovery	0959
ARU Recovery Complete	
Out of ARU Recovery	1130
Remove from Status Board	1131
In Phase I	
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Anesthesia Ready	
Anesthesia Start	
Anesthesia Stop	
Anesthesia Follow-up Complete	
Anesthesia Follow-up Needed	

Panel Information

Panel 1

Provider	Role	Service
Abdul M Sheikh, MD	Primary	Cardiovascular

Procedure: Left heart cath - bypass graft

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region
N/A			Local	

Left heart cath - bypass graft (N/A) - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: Left ventriculography

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region

Left ventriculography - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: Coronary angiography

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region

Surgery Report (continued)

Panel Information (continued)

Coronary angiography - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: ~

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	

~ - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: ~

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	
N/A					

~ (N/A) - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: PTCA Graft - SVG to OM1 & SVG to RPDA

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	
N/A					

PTCA Graft - SVG to OM1 & SVG to RPDA (N/A) - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: ~

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	

~ - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: Cutting Balloon Angioplasty

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	
N/A					

Cutting Balloon Angioplasty (N/A) - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Staff Info

Staff Type	Staff Member	Start	End	OT
CV Monitor	**Robert Beyerlein**	0805	1000	
CV Scrub Person	**Lauren W Kerns, ARRT**	0805	1000	
CV Circulator	**Julie Kraftzenk, RN**	0805	1000	

Questionnaire Data

None

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Outcomes - Intra-op

Used?	Description (Code)

Surgery Report (continued)

PNDS Information (continued)

Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Diagnoses

Present?	Description (Code)
Yes	Risk for infection (X28)
Yes	Risk for injury (X29)
Yes	Deficient knowledge (X30)
Yes	Acute pain (X38)
Yes	Anxiety (X4)
Yes	Risk for impaired skin integrity (X51)
Yes	Risk for imbalanced body temperature (X57)
Yes	Ineffective breathing pattern (X7)

Log Completed By

Erin Matthews	1/11/2017	1327

Log Verified By

Robert Beyerlein	1/10/2017	0822
Julie Kraftzenk, RN	1/10/2017	0947
Robert Beyerlein	1/10/2017	1001
Abdul M Sheikh, MD	1/10/2017	1003
Erin Matthews	1/11/2017	1505

Addendum Information

Addendum 1 : Erin Matthews - 1/11/17 1505

Item	Line	Old Value	New Value	Description
Log				
1000 - Panel 1 - Procedure	0	7	8	
1000 - Panel 1 - Procedure	8		CUTTING BALLOON ANGIOPLASTY	
1001 - Panel 1 - Procedure Event Key	0	7	8	
1003 - Panel 1 - Resources Source Preference Id	0	7	8	
1003 - Panel 1 - Resources Source Preference Id	8		CUTTING BALLOON ANGIOPLASTY	
1004 - Panel 1 - Pick List Source Preference Id	0	7	8	
1004 - Panel 1 - Pick List Source Preference Id	8		CUTTING BALLOON ANGIOPLASTY	
1005 - Panel 1 - Position	0	7	8	
1006 - Panel 1 - Anesthesia Type	0	7	8	
1008 - Panel 1 - Comments	0	7	8	
1010 - Panel 1 - Laterality (Lrb)	0	7	8	
1010 - Panel 1 - Laterality (Lrb)	8		N/A	
1011 - Panel 1 - Selected Preference Id	0	7	8	
1011 - Panel 1 - Selected Preference Id	8		CUTTING BALLOON ANGIOPLASTY	
1013 - Panel 1 - Procedure Dbc Episode	0	7	8	
1014 - Panel 1 - Ordered Procedure (Eap)	0	7	8	
1015 - Panel 1 - Operative Region	0	7	8	

Surgery Report (continued)

Addendum Information (continued)

1017 - Panel 1 - Procedure Description	0	7	8
1017 - Panel 1 - Procedure Description	8		Cutting Balloon Atherectomy
1018 - Panel 1 - Defaulted Preference Id	0	7	8
1018 - Panel 1 - Defaulted Preference Id	8		CUTTING BALLOON ANGIOPLASTY
1019 - Panel 1 - Procedure Code	0	7	8
1020 - Panel 1 - Wound Class	0	7	8
1025 - Panel 1 - Wound Location	0	7	8
1028 - Panel 1 - Incision Closure	0	7	8
1030 - Panel 1 - Total Time	0	7	8
1035 - Panel 1 - Approach	0	7	8
1070 - Panel 1 - Timing Event	0	16	18
1070 - Panel 1 - Timing Event	17		
1070 - Panel 1 - Timing Event	18		
1075 - Panel 1 - Event Start Time	0	16	18
1080 - Panel 1 - Event End Time	0	16	18
1085 - Panel 1 - Event Time Elapsed	0	16	18
1086 - Panel 1 - Event Procedure	0	16	18
1086 - Panel 1 - Event Procedure	5	PTCA CORONARY	CUTTING BALLOON ANGIOPLASTY
1086 - Panel 1 - Event Procedure	6	PTCA CORONARY	CUTTING BALLOON ANGIOPLASTY
1086 - Panel 1 - Event Procedure	7	PTCA GRAFT	PTCA CORONARY
1086 - Panel 1 - Event Procedure	8	PTCA GRAFT	PTCA CORONARY
1086 - Panel 1 - Event Procedure	9	CORONARY ANGIOGRAPHY	PTCA GRAFT
1086 - Panel 1 - Event Procedure	10	CORONARY ANGIOGRAPHY	PTCA GRAFT
1086 - Panel 1 - Event Procedure	11	LEFT VENTRICULOGRAPHY	CORONARY ANGIOGRAPHY
1086 - Panel 1 - Event Procedure	12	LEFT VENTRICULOGRAPHY	CORONARY ANGIOGRAPHY
1086 - Panel 1 - Event Procedure	13	CORONARY INTERVENTION (PCI)	LEFT VENTRICULOGRAPHY
1086 - Panel 1 - Event Procedure	14	CORONARY INTERVENTION (PCI)	LEFT VENTRICULOGRAPHY
1086 - Panel 1 - Event Procedure	15	LEFT HEART CATHETERIZATION W/ GRAFTS	CORONARY INTERVENTION (PCI)
1086 - Panel 1 - Event Procedure	16	LEFT HEART CATHETERIZATION W/ GRAFTS	CORONARY INTERVENTION (PCI)
1086 - Panel 1 - Event Procedure	17		LEFT HEART CATHETERIZATION W/ GRAFTS
1086 - Panel 1 - Event Procedure	18		LEFT HEART CATHETERIZATION W/ GRAFTS

Diagnosis/Procedure Info

30 - Record Type	1	Diagnosis/Procedure Info
5100 - Diagnosis - Procedure	1	CUTTING BALLOON ANGIOPLASTY
5111 - Diagnosis - Procedure Panel	1	1.00

Patient Positioning

30 - Record Type	1	Patient Positioning
3045 - Positioning Procedure	1	CUTTING BALLOON ANGIOPLASTY
3050 - Procedure Ordinal	1	1.00
3099 - Panel # - Positioning	1	1.00

Addendum 2 : Nellie H Saboura - 1/14/17 1351

Item	Line	Old Value	New Value	Description

Log

1017 - Panel 1 - Procedure Description	6	PTCA Graft	PTCA Graft - SVG to OM1 & SVG to RPDA
1017 - Panel 1 - Procedure Description	7	PTCA Graft Additional	~
1017 - Panel 1 - Procedure Description	8	Cutting Balloon Atherectomy	Cutting Balloon Angioplasty

Surgery Report (continued)

Do Not Proceed History	No information present

Implants

Implants

STARCLOSE SE 6F CLOSURE - LOG328656

Inventory Item: STARCLOSE SE 6F CLOSURE
Implant name: STARCLOSE SE 6F CLOSURE - LOG328656
Manufacturer: ABBOTT VASCULAR
Action: Implanted
Device Identifier:
Serial no.:
Laterality:
Date of Manufacture:
Number Used: 1
Device Identifier Type:
Model/Cat no.: 14679-05
Area: Arterial

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: Yes

Pre-Procedure Verification

H&P note verified?: Yes
Consents verified?: Yes
Site marked?: N/A
Allergies reviewed?: Yes

Surgeons Present: Abdul M Sheikh, MD
Staff Present: Robert Beyerlein, Lauren W Kerns, ARRT, Julie Kraftzenk, RN

Verification Date and Time: 1/10/2017 8:21 AM

Procedures - Orders and Results

EKG SCAN [653604266]

Electronically signed by: **Interface, Transcription Incoming on 01/12/17 0817**
Ordering user: Interface, Transcription Incoming 01/12/17 0817
Authorized by: Provider Scan
Frequency: -
Lab status: Final result

Status: **Completed**
Ordering provider: Provider Scan
Ordering mode: Standard
Quantity: 1

Scan on 1/12/2017 8:17 AM (below)

EKG SCAN [653604266] Resulted: 01/12/17 0817, Result status: Final result

Ordering provider: Provider Scan 01/12/17 0817
Filed by: Interface, Transcription Incoming 01/12/17 0820

Order status: Completed
Result details

Nursing - Orders and Results

CLIP HAIR [645968801]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0755**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Dianne W Wehrle, RN 01/10/17 0702
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [Patient Transfer]

Status: **Discontinued**
Communicated by: Dianne W Wehrle, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:02 AM

NURSING COMMUNICATION [653264215]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Authorized by: Abdul M Sheikh, MD

Status: **Discontinued**
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [653264215] (continued)

Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Automatic Transfer Provider 01/10/17 0959 [Patient Transfer]
Order comments: This was discussed with the patient and/or patient representative.

NOTIFY PHYSICIAN (SPECIFY) [653264217]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131
Order comments: if BUN greater than 30, GFR less than 50, Potassium less than 3.5 or greater than 5.1, Platelet count less than 100,000, INR greater than 1.5

VERIFY INFORMED CONSENT [653264218]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Automatic Transfer Provider 01/10/17 0959 [Patient Transfer]
Order comments: Verify cardiac catheterization consent form is signed, dated, timed, and witnessed prior to start of procedure

NURSING COMMUNICATION [653264219]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

HEIGHT AND WEIGHT [653264220]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Automatic Transfer Provider 01/10/17 0959 [Patient Transfer]

NURSING COMMUNICATION [653264221]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131
Order comments: Hold diuretics and oral hypoglycemic medications including metformin and sulfonylureas (e.g. glipizide, glyburide, glimepiride) the morning of the procedure.

NURSING COMMUNICATION [653264222]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [653264222] (continued)

Order comments: Obtain BBG on call to cath lab and document on pre-procedure checklist.

NURSING COMMUNICATION [653264223]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131
Order comments: Have patient void before transport, no metal snaps on gown, patient may wear dentures, glasses, hearing aids

NURSING COMMUNICATION [653264225]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264226]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264227]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264228]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264229]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264230]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [653264230] (continued)

Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264231]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

NURSING COMMUNICATION [653264232]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

MAINTAIN IV ACCESS [653264402]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

VITAL SIGNS [653293464]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 10:11 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4
Then:	Q2h

Order comments: Check while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

NURSING COMMUNICATION [653293465]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 10:11 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: Remove 5 cc of air at 10:45*(time), if no bleeding occurs, remove remaining air at 5 min after (time), if no bleeding occurs remove band. If bleeding occurs during TR band removal, slowly inject air into the balloon until bleeding stops (up to a maximum inflation of 18cc), monitor radial pulse, wait 30 minutes, then remove 5cc of air, if no bleeding, remove remaining air, if not bleeding remove TR band.

PUNCTURE SITE CARE [653293467]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Nursing - Orders and Results (continued)

PUNCTURE SITE CARE [653293467] (continued)

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4
Then:	Q2h

Order comments: Check while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

POST PROCEDURE SITE ASSESSMENT [653293468]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4
Then:	Q2h

Order comments: Check pulses while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

NEURO/VASCULAR CHECKS [653293469]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4
Then:	Q2h

ORTHOSTATIC BLOOD PRESSURE [653293470]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: Check standing blood pressure post sheath removal when first allowed to stand.

AMBULATE PATIENT [653293471]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: With assistance after bedrest complete. If tolerated, may resume previously ordered activity level

INTAKE AND OUTPUT [653293472]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

STRAIGHT CATH [653293473]

Nursing - Orders and Results (continued)

STRAIGHT CATH [653293473] (continued)

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: If unable to void
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293474]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293475]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293476]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293477]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293478]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293481]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: 1) hold manual pressure one inch proximal to the access site until bleeding stops, and notify MD. 2) If patient has an arm board in place, remove arm board 2 hours after radial hemostasis band is removed
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

NURSING COMMUNICATION [653293482]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Order comments: Deployment time: 9:45
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

Nursing - Orders and Results (continued)

BED REST [653293483]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Order comments: And for 2 hours post sheath removal/closure device placement. May elevate head of bed to 30 degrees, keep punctured leg straight while on bedrest

BED REST [653293484]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Order comments: Complete bedrest while radial compression device in place

DAILY WEIGHTS [653293489]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/11/2017 12:05 AM

Code Status - Orders and Results

FULL CODE [653293480]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Code status: Full Code
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Consult - Orders and Results

IP CONSULT TO CARE COORDINATOR [653293479]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

Questionnaire

Question	Answer
Reason for Consult?	for discharge planning (assess for ability to obtain home meds)

ECG - Orders and Results

EKG, 12-LEAD [653264236]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [Patient Transfer]
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM

Questionnaire

Question	Answer
Reason for Exam:	Chest pain

Order comments: if not done within the past 48 hours for inpatients or 1 week for outpatients. Have results by 6 am

ECG - Orders and Results (continued)

EKG, 12-LEAD [653264236] (continued)

EKG, 12-LEAD [653293491]

Electronically signed by: **Sheila Watkins, RCP on 01/11/17 0755** Status: **Completed**
Ordering user: Sheila Watkins, RCP 01/11/17 0755
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Sheila Watkins, RCP (auto-released) 1/11/2017 7:55 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per Written Order
Lab status: Final result

Questionnaire

Question	Answer
Reason for Exam:	Diagnosis unknown

Order comments: EKG completed

Specimen Information

Type	Source	Collected By
—	—	01/11/17 0412

EKG, 12-LEAD [653293491] Resulted: 01/11/17 2117, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 01/11/17 0755
Filed by: Interface, Muse 01/11/17 2118
Lab Technician: ANNE KANGUE
Order status: Completed
Resulting lab: MUSE
External ID: 616844

Result details
Impression:
Normal sinus rhythm
Left axis deviation
Left bundle branch block
Abnormal ECG
When compared with ECG of 27-MAY-2015 23:43,
No significant change was found
Confirmed by SHEIKH,MD, ABDUL (7498) on 1/11/2017 9:17:01 PM
Acknowledged by: Abdul M Sheikh, MD on 01/11/17 2144

Specimen Information

Type	Source	Collected By
—	—	01/11/17 0412

Components

Component	Value	Reference Range	Flag	Lab
VENT RATE	63	BPM	—	Muse
Atrial Rate	63	BPM	—	Muse
PR Interval	190	ms	—	Muse
QRS Duration	134	ms	—	Muse
QT Interval	408	ms	—	Muse
QTC Calculation	417	ms	—	Muse
P Axis	39	degrees	—	Muse
R Axis	-55	degrees	—	Muse
T Wave Axis	40	degrees	—	Muse

View Image (below)

IV - Orders and Results

INSERT PERIPHERAL IV [645968800]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0755** Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Dianne W Wehrle, RN 01/10/17 0702
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131
Communicated by: Dianne W Wehrle, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:02 AM

IV - Orders and Results (continued)

INSERT PERIPHERAL IV [653264224]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Automatic Transfer Provider 01/10/17 0959 [Patient Transfer]
Order comments: Start two IVs, 20 gauge or larger (preferably in left arm by 6am day of procedure). Saline flush every 8 hours (Avoid Right arm for radial cath)

INSERT PERIPHERAL IV [653264401]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

INT [653264403]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131

Admission - Orders and Results

ADMIT AS INPATIENT [653264429]

Electronically signed by: **Susan Colston, RN on 01/10/17 0905** — Status: **Completed**
Ordering user: Susan Colston, RN 01/10/17 0905 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Per Written Order
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 1/10/2017 9:05 AM

Questionnaire

Question	Answer
Estimated inpatient length of stay?	<2 Midnights
Certification	I certify that inpatient services are reasonable and necessary and have been ordered appropriately. I believe the patient needs to stay at least 2 Midnights. Please see clinical documentation for reason for admission and plans for post hospital care.
Diagnosis	S/P cardiac cath
Admitting Provider	SHEIKH, ABDUL M
Attending Provider	SHEIKH, ABDUL M
Bed Type	Cardiac Telemetry
Hospital Area	WS Cobb Hospital
Bed request comments	PCI bed please

Discharge - Orders and Results

DISCHARGE PATIENT [653293493]

Electronically signed by: **Michael S Hardee, MD on 01/11/17 0933** — Status: **Completed**
Ordering user: Michael S Hardee, MD 01/11/17 0933 — Ordering provider: Michael S Hardee, MD
Authorized by: Michael S Hardee, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Michael S Hardee, MD (auto-released) 1/11/2017 9:33 AM

DISCHARGE PATIENT [653293495]

Electronically signed by: **Sandra Nerestil, NP on 01/11/17 0934** — Status: **Completed**
Ordering user: Sandra Nerestil, NP 01/11/17 0934 — Ordering provider: Sandra Nerestil, NP
Authorized by: Michael S Hardee, MD — Ordering mode: Standard

Discharge - Orders and Results (continued)

DISCHARGE PATIENT [653293495] (continued)

Cosigning events
Electronically cosigned by Michael S Hardee, MD 01/18/17 2109 for Ordering
Quantity: 1
Instance released by: Sandra Nerestil, NP (auto-released) 1/11/2017 9:34 AM

Cardiac Cath - Orders and Results

CARDIAC PROCEDURE [645968792]

Electronically signed by: **Tammy R Riddle Threatt on 11/29/16 0854**
Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Tammy R Riddle Threatt 11/29/16 0854
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Tammy R Riddle Threatt 11/29/2016 8:54 AM
Diagnoses
Coronary arteriosclerosis [I25.10]
PVD (peripheral vascular disease) (HCC) [I73.9]
Essential hypertension with goal blood pressure less than 130/85 [I10]
Hyperlipidemia, unspecified hyperlipidemia type [E78.5]

CARDIAC PROCEDURE [645968792]
Resulted: 01/11/17 1327, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 11/29/16 0854
Order status: Completed
Resulted by: Abdul M Sheikh, MD
Filed by: Erin Matthews 01/11/17 1327
Performed: 01/10/17 0805 - 01/10/17 0959
Accession number: 27861596
Resulting lab: CATH/EP
Result details
Narrative:

· Severe native vessel disease.
· Patent LIMA-LAD. Severe ISR (DES) of SVGs to OMs and PDA.
· Preserved EF.
· Successful POBA of SVGs to OM and PDA with NC/cutting balloons.

1. Continue long-term dual antiplatelet therapy.
2. Aggressive risk factor modification.

Procedures Performed	Chargeables
CORONARY ANGIOGRAPHY [CATH03]	
CORONARY INTERVENTION (PCI) [CATH02]	
CUTTING BALLOON ATHERECTOMY [CATH102]	
LEFT HEART CATHETERIZATION W/GRAFTS [CATH71]	
LEFT VENTRICULOGRAPHY [CATH05]	
PTCA CORONARY [CATH113]	
PTCA GRAFT [CATH114]	
PTCA GRAFT ADDITIONAL [CATH95]	

CARDIAC PROCEDURE [653264425]

Electronically signed by: **Robert Beyerlein on 01/10/17 0859**
Status: **Discontinued**
Ordering user: Robert Beyerlein 01/10/17 0859
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Robert Beyerlein 1/10/2017 8:59 AM
Discontinued by: Robert Beyerlein 01/10/17 0859 [Auto-canceled by study generation.]
Diagnoses
Coronary arteriosclerosis [I25.10]
PVD (peripheral vascular disease) (HCC) [I73.9]
Essential hypertension with goal blood pressure less than 130/85 [I10]
Hyperlipidemia, unspecified hyperlipidemia type [E78.5]

CARDIAC PROCEDURE [653264425]
Resulted: 01/10/17 0859, Result status: In process

Ordering provider: Abdul M Sheikh, MD 11/29/16 0854
Order status: Canceled
Discontinued by: Robert Beyerlein 01/10/17 0859 [Auto-canceled by study generation.]
Filed by: Robert Beyerlein 01/10/17 0859
Accession number: 27982430
Resulting lab: CATH/EP
Result details

Cardiac Cath - Orders and Results (continued)

CORE MEASURES - Orders and Results

NON-PRIMARY PCI [653264216]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Completed**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM

REASON FOR NOT PRESCRIBING STATIN MEDICATION [653293485]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 11:31 AM

Questionnaire

Question	Answer
Reason for not prescribing statin medication?	Other (Please provide additional details)

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [653293497]

Electronically signed by: **Interface, Lab In Sunquest on 01/11/17 0816** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 01/11/17 0816
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: (auto-released) 1/11/2017 9:55 AM

Specimen Information

Type	Source	Collected By
—	—	01/11/17 0816

POC FINGER STICK GLUCOSE [653293497] (Abnormal) Resulted: 01/11/17 0955, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 01/11/17 0816
Order status: Completed
Filed by: Interface, Lab In Sunquest 01/11/17 0955
Resulting lab: WS COBB HOSPITAL LAB
External ID: W14432383
Result details

Specimen Information

Type	Source	Collected By
—	—	01/11/17 0816

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	135	70 - 99 mg/dL	H	CHLAB

Lab - Orders and Results

CBC W/O DIFFERENTIAL [653264233]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [Patient Transfer]

Lab - Orders and Results (continued)

CBC W/O DIFFERENTIAL [653264233] (continued)

Specimen Information

Type	Source	Collected By
—	Blood	—

PROTHROMBIN TIME-INR [653264234]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [Patient Transfer]

Specimen Information

Type	Source	Collected By
—	Blood	—

BASIC METABOLIC PANEL (7) [653264235]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 — Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 7:04 AM
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [Patient Transfer]
Order comments: Fasting

Specimen Information

Type	Source	Collected By
—	Blood	—

CBC W/O DIFFERENTIAL [653293486]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** — Status: **Completed**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Lab status: Final result
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 8:00 PM
Order comments: Notify MD if Hgb decreased by 2 gm/dL from pre-procedure value or Platelet count less than 100,000

Specimen Information

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

CBC W/O DIFFERENTIAL [653293486] (Abnormal)

Resulted: 01/11/17 0502, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 01/10/17 2000 — Order status: Completed
Filed by: Interface, Lab In Sunquest 01/11/17 0502 — Resulting lab: WS COBB HOSPITAL LAB
External ID: W14428733 — Result details

Specimen Information

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

Components

Component	Value	Reference Range	Flag	Lab
WBC COUNT	9.8	3.5 - 10.5 10E9/L	—	CHLAB
RBC Count	3.95	4.32 - 5.72 10E12/L	L	CHLAB
HGB	11.9	13.5 - 17.5 g/dL	L	CHLAB
Hematocrit	36	39 - 50 %	L	CHLAB
MCV	91	81 - 95 fL	—	CHLAB

Lab - Orders and Results (continued)

MCH	30	26 - 34 pg	—	CHLAB
MCHC	33	32 - 36 g/dL	—	CHLAB
RDW	15.4	11.8 - 15.6 %	—	CHLAB
PLATELET	136	150 - 450 10E9/L	L ▼	CHLAB
MPV	9.9	9.4 - 12.4 fL	—	CHLAB

BASIC METABOLIC PANEL (7) [653293487]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 8:00 PM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

BASIC METABOLIC PANEL (7) [653293487] (Abnormal) Resulted: 01/11/17 0538, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 01/10/17 2000
Filed by: Interface, Lab In Sunquest 01/11/17 0539
External ID: W14428733
Order status: Completed
Resulting lab: WS COBB HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

Components

Component	Value	Reference Range	Flag	Lab
Sodium,S	142	136 - 145 mmol/L	—	CHLAB
Potassium	4.3	3.5 - 5.1 mmol/L	—	CHLAB
Chloride	104	98 - 107 mmol/L	—	CHLAB
Co2	22	22 - 29 mmol/L	—	CHLAB
Glucose	126	70 - 99 mg/dL	H ▲	CHLAB
BUN	23	8 - 23 mg/dL	—	CHLAB
CREATININE,S	1.05	0.7 - 1.2 mg/dL	—	CHLAB
ANION GAP	20	12 - 20	—	CHLAB
CALCIUM,TOTAL	9.2	8.8 - 10.2 mg/dL	—	CHLAB
GFR Non-Afric Amer	>60	>59 ml/min/1.73 m2	—	CHLAB
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2	—	CHLAB

LIPID PANEL [653293488]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Jane Abey, RN (auto-released) 1/10/2017 8:00 PM
Order comments: Fasting
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

LIPID PANEL [653293488] (Abnormal) Resulted: 01/11/17 0538, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 01/10/17 2000
Filed by: Interface, Lab In Sunquest 01/11/17 0539
External ID: W14428733
Order status: Completed
Resulting lab: WS COBB HOSPITAL LAB
Result details

Specimen Information

Lab - Orders and Results (continued)

Type	Source	Collected By
—	Blood	75998 01/11/17 0428

Components

Component	Value	Reference Range	Flag	Lab
CHOLESTEROL,TOTAL	109	<200 mg/dL	—	CHLAB
Comment: Interpretive Values: Desirable: <200 mg/dL; Borderline High: 200-239 mg/dL; High: >or=240 mg/dL				
Triglycerides	81	<150 mg/dL	—	CHLAB
Comment: Interpretive Values: Normal: <150 mg/dL; Borderline High: 150-199 mg/dL; High: 200-499 mg/dL; Very High: >or=500 mg/dL				
HDL CHOLESTEROL	36	>39 mg/dL	L	CHLAB
Comment: Interpretive Values: Males: >or=40 mg/dL; Females: >or=50 mg/dL				
LDL	57	<100 mg/dl	—	CHLAB
Comment: Interpretive Values: Optimal: <100 mg/dL; Near or Above Optimal: 100-129 mg/dL; Borderline High: 130-159 mg/dL; High: 160-189 mg/dL; Very High: >or=190 mg/dL				
CHOLES/HDL RATIO	3.0	0.0 - 5.5 Ratio	—	CHLAB
NON-HDL CHOLESTEROL	73	<130 mg/dL	—	CHLAB
Comment: Interpretive Values: Desirable: <130 mg/dL; Above Desirable: 130-159 mg/dL; Borderline High: 160-189 mg/dL; High: 190-219 mg/dL; Very High: >or=220 mg/dL				

Case Request - Orders and Results

CASE REQUEST CATH LAB [653264214]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Quantity: 1 Instance released by: Sandra Nerestil, NP (auto-released) 1/10/2017 7:03 AM
Discontinued by: William J Cox, RN 01/10/17 1057 [The associated case was canceled: Depot Management (duplicate)]

Questionnaire

Question	Answer
Add on case?	Yes
Pre-procedure diagnosis	CP
Case Classification	Class F - Elective

Outpatient Referral - Orders and Results

Outpatient Referral - Orders and Results (continued)

AMB REFERRAL TO CARDIAC REHAB, CONTINUOUS ECG MONITOR [653293451]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** — Status: **Active**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Frequency: Routine 01/11/17 -
Released by: Sandra Nerestil, NP 01/11/17 0852
Acknowledged: Jane Abey, RN 01/11/17 1123 for Placing Order
Diagnoses
Coronary arteriosclerosis [I25.10]
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1

Diet - Orders and Results

DIET, CARDIAC [653293466]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Dianne W Wehrle, RN (auto-released) 1/10/2017 10:12 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Diet: Cardiac
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [Patient Discharge]

Medications - Orders and Results

sodium chloride 0.9% (NS) infusion [645968797]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0755** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Dianne W Wehrle, RN 01/10/17 0702
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Continuous 01/10/17 0800 - 01/10/17 1131
Communicated by: Dianne W Wehrle, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [(Patient Transfer - Internal Use Only)]
Acknowledged: Dianne W Wehrle, RN 01/10/17 0707 for Placing Order Jane Abey, RN 01/10/17 1131 for D/C Order
Package: 0409-7983-09

sodium chloride 0.9 % (NS) flush [653264209]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Authorized by: Sandra Nerestil, NP
PRN reasons: line care
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Frequency: Routine Q1 min PRN 01/10/17 0704 - 01/10/17 1131
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131
Acknowledged: Dianne W Wehrle, RN 01/10/17 0707 for Placing Order Jane Abey, RN 01/10/17 1131 for D/C Order
Admin instructions: INT Flush
Package: 8881-571121
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Released by: Dianne W Wehrle, RN 01/10/17 0704

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User
01/10/17 1131	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Jane Abey, RN
01/10/17 0704	Sandra Nerestil, NP	Sandra Nerestil, NP	Dianne W Wehrle, RN
01/10/17 0703	Sandra Nerestil, NP	Sandra Nerestil, NP	Sandra Nerestil, NP

sodium chloride 0.9% (NS) infusion [653264210]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703
Authorized by: Sandra Nerestil, NP
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Frequency: Routine Continuous 01/10/17 0800 - 01/10/17 1131
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [(Patient Transfer - Internal Use Only)]
Acknowledged: Dianne W Wehrle, RN 01/10/17 0707 for Placing Order Jane Abey, RN 01/10/17 1131 for D/C Order
Admin instructions: **ADD EXTENSION TUBING WITH INITIATION OF THIS IV FLUID**.
Package: 0409-7983-09
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Released by: Dianne W Wehrle, RN 01/10/17 0704

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User

Medications - Orders and Results (continued)

sodium chloride 0.9% (NS) infusion [653264210] (continued)

01/10/17 1131	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Jane Abey, RN
01/10/17 0704	Sandra Nerestil, NP	Sandra Nerestil, NP	Dianne W Wehrle, RN
01/10/17 0703	Sandra Nerestil, NP	Sandra Nerestil, NP	Sandra Nerestil, NP

sodium chloride 0.9% (NS) bolus [653264211]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 Ordering provider: Sandra Nerestil, NP
Authorized by: Sandra Nerestil, NP Ordering mode: Standard
PRN Comment: **START UPON ARRIVAL TO CATH LAB.** see administration instructions.
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Frequency: Routine Continuous PRN 01/10/17 0704 - 01/10/17 1131 Released by: Dianne W Wehrle, RN 01/10/17 0704
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [(Patient Transfer - Internal Use Only)]
Acknowledged: Dianne W Wehrle, RN 01/10/17 0707 for Placing Order Jane Abey, RN 01/10/17 1131 for D/C Order
Admin instructions: **START UPON ARRIVAL TO CATH LAB.** Infuse at 3 mL/kg/hr for 1 hour prior to the procedure, after one hour reduce rate to 1 mL/kg/hr - See second order in panel. (MAXimum infusion rate 300 mL/hr).
Package: 0409-7983-09

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User
01/10/17 1131	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Jane Abey, RN
01/10/17 0704	Sandra Nerestil, NP	Sandra Nerestil, NP	Dianne W Wehrle, RN
01/10/17 0703	Sandra Nerestil, NP	Sandra Nerestil, NP	Sandra Nerestil, NP

sodium chloride 0.9% (NS) infusion [653264212]

Electronically signed by: **Sandra Nerestil, NP on 01/10/17 0703** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 01/10/17 0703 Ordering provider: Sandra Nerestil, NP
Authorized by: Sandra Nerestil, NP Ordering mode: Standard
PRN reasons: other
PRN Comment: **FOR CATH LAB USE ONLY** see administration instructions.
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 01/10/17 0755 for Ordering
Frequency: Routine Continuous PRN 01/10/17 0704 - 01/10/17 1131 Released by: Dianne W Wehrle, RN 01/10/17 0704
Discontinued by: Abdul M Sheikh, MD 01/10/17 1131 [(Patient Transfer - Internal Use Only)]
Acknowledged: Dianne W Wehrle, RN 01/10/17 0707 for Placing Order Jane Abey, RN 01/10/17 1131 for D/C Order
Admin instructions: ** Start reduced rate after 1 hour bolus completed.** After first hour (see first order in panel), reduce rate to 1 mL/kg/hr. (MAXimum infusion rate 100 mL/hr)

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User
01/10/17 1131	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Jane Abey, RN
01/10/17 0704	Sandra Nerestil, NP	Sandra Nerestil, NP	Dianne W Wehrle, RN
01/10/17 0703	Sandra Nerestil, NP	Sandra Nerestil, NP	Sandra Nerestil, NP

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [653264416]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120** Status: **Discontinued**
Mode: Ordering in Verbal with readback mode Communicated by: Julie Kraftzenk, RN
Ordering user: Julie Kraftzenk, RN 01/10/17 0815 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Verbal with readback
Frequency: Routine PRN 01/10/17 0815 - 01/10/17 0959 Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julie Kraftzenk, RN 01/10/17 0815 for Placing Order
Package: 0409-7620-59

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [653264417]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120** Status: **Discontinued**
Mode: Ordering in Verbal with readback mode Communicated by: Julie Kraftzenk, RN
Ordering user: Julie Kraftzenk, RN 01/10/17 0821 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Verbal with readback
Frequency: Routine PRN 01/10/17 0818 - 01/10/17 0959 Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Medications - Orders and Results (continued)

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [653264417] (continued)

Acknowledged: Julie Kraftzenk, RN 01/10/17 0821 for Placing Order
Package: 0409-9094-22

midazolam (VERSED) injection 1 mg/mL [653264418]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0821
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0818 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0821 for Placing Order
Package: 0409-2305-21

lidocaine (XYLOCAINE) local injection 2 % [653264419]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0826
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0826 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0826 for Placing Order
Package: 0409-4277-01

nitroglycerin 200 mcg/mL syringe [653264420]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0827
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0827 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0827 for Placing Order
Package: 0000-0051-96

verapamil (ISOPTIN) injection 2.5 mg/mL [653264421]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0827
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0827 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0827 for Placing Order
Package: 0409-1144-05

Heparin bolus [653264422]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0831
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0830 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0831 for Placing Order
Package: 0409-2720-02

bivalirudin (ANGIOMAX) bolus 5 mg/mL [653264426]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0859
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0859 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0859 for Placing Order
Package: 0000-0052-23

Medications - Orders and Results (continued)

bivalirudin (ANGIOMAX) in NS infusion 250 mg/50 mL (5 mg/mL) [653264427]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120** Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0859
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Continuous PRN 01/10/17 0859 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0859 for Placing Order

Mixture Ingredients

Medication	Ordered Dose	Calculated Dose
bivalirudin (ANGIOMAX)	5 mg/mL	250 mg
sodium chloride (NS) 0.9 %	50 mL	50 mL

Package: 0781-3158-95, 0409-7984-36

iohexol (OMNIPAQUE) injection 350 mg/mL [653264432]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 1120** Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Julie Kraftzenk, RN 01/10/17 0946
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 01/10/17 0945 - 01/10/17 0959
Communicated by: Julie Kraftzenk, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Robert Beyerlein 01/10/17 0959 [(Patient Discharge - Internal Use Only)]

Acknowledged: Julie Kraftzenk, RN 01/10/17 0946 for Placing Order
Package: 0407-1414-91

carvedilol (COREG) tablet [653264433]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Frequency: Routine BID w/ meals 01/10/17 1700 - 01/11/17 1519
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 0904-6301-61
Reordered from: carvedilol (COREG) 12.5 MG tablet [628156462]

atorvastatin (LIPITOR) tablet [653264434]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Nightly 01/10/17 2100 - 01/11/17 1519
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Admin instructions: Concurrent use of atorvastatin (LIPITOR) and GRAPEFRUIT JUICE may result in increased bioavailability of atorvastatin resulting in an increased risk of myopathy or rhabdomyolysis.
Package: 0904-6292-61
Reordered from: atorvastatin (LIPITOR) 80 MG tablet [628156461]

chlorthalidone (HYGROTON) tablet [653264438]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Daily 01/10/17 1200 - 01/11/17 1519
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 51079-058-01
Reordered from: chlorthalidone (HYGROTEN) 50 MG tablet [634790450]

aspirin chewable tablet [653293462]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Daily 01/10/17 1200 - 01/11/17 1519
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]

Medications - Orders and Results (continued)

aspirin chewable tablet [653293462] (continued)

Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 63739-434-01

ramipril (ALTACE) capsule [653264435]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine BID 01/10/17 1200 - 01/11/17 1519 Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 68084-268-11
Reordered from: ramipril (ALTACE) 10 MG capsule [634790449]

cilostazol (PLETAL) tablet [653264436]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine BID 01/10/17 1200 - 01/11/17 1519 Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Admin instructions: **"Caution: Sound alike/look alike medication"**
Package: 0093-2065-06
Reordered from: cilostazol (PLETAL) 100 MG tablet [645968787]

clopidogrel (PLAVIX) tablet [653264437]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine Daily 01/10/17 1200 - 01/11/17 1519 Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 0904-6294-61
Reordered from: clopidogrel (PLAVIX) 75 mg tablet [628156457]

isosorbide mononitrate (IMDUR) 24 hr tablet [653264439]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine BID 01/10/17 1200 - 01/11/17 1519 Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Package: 0904-6450-61
Reordered from: isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet [634790452]

nitroglycerin (NITROSTAT) SL tablet [653264440]

Electronically signed by: **Abdul M Sheikh, MD on 01/10/17 0956** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 01/10/17 0956 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
PRN reasons: chest pain
Frequency: Routine Q5 Min PRN 01/10/17 1130 - 01/11/17 1519 Released by: Jane Abey, RN 01/10/17 1131
Discontinued by: Automatic Discharge Provider 01/11/17 1519 [(Patient Discharge - Internal Use Only)]
Acknowledged: Jane Abey, RN 01/10/17 1131 for Placing Order
Admin instructions: x 3 doses. Notify MD if no relief after 3 doses.
Package: 0071-0418-13
Reordered from: nitroglycerin (NITROSTAT) 0.4 MG SL tablet [645968790]

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - Muse	MUSE	Unknown	Unknown	12/12/12 2214 - Present
20 - CHLAB	WS COBB HOSPITAL LAB	Dr. Marla Franks	3950 AUSTELL RD AUSTELL GA 30106	11/04/13 1208 - 08/28/18 1252
118001 - Cath/EP	CATH/EP	Unknown	Unknown	01/02/13 1112 - Present

Medications

All Meds and Administrations

sodium chloride 0.9% (NS) infusion [645968797]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0702
Dose (Remaining/Total): 75 mL/hr (—/—)
Frequency: Continuous
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 01/10/17 0800 - 01/10/17 1131
Route: Intravenous
Rate/Duration: 75 mL/hr / —

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 01/10/17 0800 Scheduled: 01/10/17 0702	Due	—	—	—

sodium chloride 0.9 % (NS) flush [653264209]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 01/10/17 0704
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush
Status: Discontinued (Past End Date/Time)
Starts/Ends: 01/10/17 0704 - 01/10/17 1131
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

sodium chloride 0.9% (NS) infusion [653264210]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 01/10/17 0704
Dose (Remaining/Total): 75 mL/hr (—/—)
Frequency: Continuous
Admin Instructions: **ADD EXTENSION TUBING WITH INITIATION OF THIS IV FLUID**.
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 01/10/17 0800 - 01/10/17 1131
Route: Intravenous
Rate/Duration: 75 mL/hr / —

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 01/10/17 0800 Scheduled: 01/10/17 0704	Due	—	—	—

sodium chloride 0.9% (NS) bolus [653264211]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 01/10/17 0704
Dose (Remaining/Total): 3 mL/kg/hr (—/—)
Frequency: Continuous PRN
Admin Instructions: **START UPON ARRIVAL TO CATH LAB.** Infuse at 3 mL/kg/hr for 1 hour prior to the procedure, after one hour reduce rate to 1 mL/kg/hr - See second order in panel. (MAXimum infusion rate 300 mL/hr).
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 01/10/17 0704 - 01/10/17 1131
Route: Intravenous
Rate/Duration: — / 1 Hours

Timestamps	Action	Dose / Duration	Route	Other Information
Performed 01/10/17 0722 Documented: 01/10/17 0722	New Bag	3 mL/kg/hr 1 Hours	Intravenous	Performed by: Dianne W Wehrle, RN Scanned Package: 0409-7983-09

sodium chloride 0.9% (NS) infusion [653264212]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 01/10/17 0704
Dose (Remaining/Total): 1 mL/kg/hr (—/—)
Frequency: Continuous PRN
Admin Instructions: ** Start reduced rate after 1 hour bolus completed.** After first hour (see first order in panel), reduce rate to 1 mL/kg/hr. (MAXimum infusion rate 100 mL/hr)
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 01/10/17 0704 - 01/10/17 1131
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

Medications (continued)

All Meds and Administrations (continued)

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [653264416]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0815
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0815 Documented: 01/10/17 0815	Given	2 Bag	Intravenous	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [653264417]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0821
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0842 Documented: 01/10/17 0842	Given	50 mcg	Intravenous	Performed by: Julie Kraftzenk, RN
Performed 01/10/17 0818 Documented: 01/10/17 0821	Given	50 mcg	Intravenous	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN

midazolam (VERSED) injection 1 mg/mL [653264418]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0821
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0847 Documented: 01/10/17 0847	Given	1 mg	Intravenous	Performed by: Julie Kraftzenk, RN
Performed 01/10/17 0818 Documented: 01/10/17 0821	Given	2 mg	Intravenous	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN

lidocaine (XYLOCAINE) local injection 2 % [653264419]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0826
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 01/10/17 0843 Documented: 01/11/17 1111	Given	10 mL	Subcutaneous ---	Performed by: Abdul M Sheikh, MD Documented by: Erin Matthews Comments: right groin
Performed 01/10/17 0826 Documented: 01/11/17 1111	Given	5 mL	Subcutaneous Right Arm	Performed by: Abdul M Sheikh, MD Documented by: Erin Matthews

nitroglycerin 200 mcg/mL syringe [653264420]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0827
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0827 Documented: 01/10/17 0827	Given	200 mcg	Intra-arterial	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN

verapamil (ISOPTIN) injection 2.5 mg/mL [653264421]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0827
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0827 Documented: 01/10/17 0827	Given	2.5 mg	Intra-arterial	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN

Heparin bolus [653264422]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0831
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0830 Documented: 01/10/17 0831	Given	5,000 Units	Intravenous	Performed by: Julie Kraftzenk, RN Comments: verified by dr sheikh

bivalirudin (ANGIOMAX) bolus 5 mg/mL [653264426]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0859
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0859 Documented: 01/10/17 0859	Given	72.15 mg	Intravenous	Performed by: Julie Kraftzenk, RN

bivalirudin (ANGIOMAX) in NS infusion 250 mg/50 mL (5 mg/mL) [653264427]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 0859
Dose (Remaining/Total): 250 mg (—/—)
Frequency: Continuous PRN
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 0859 - 01/10/17 0959
Rate/Duration: — / —

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 01/10/17 0938 Documented: 01/10/17 0939	Stopped	— 0 mL/hr	Intravenous	Performed by: Julie Kraftzenk, RN
Performed 01/10/17 0919 Documented: 01/10/17 0919	New Bag	1.75 mg/kg/hr 33.7 mL/hr	Intravenous	Performed by: Julie Kraftzenk, RN
Performed 01/10/17 0859 Documented: 01/10/17 0859	New Bag	1.75 mg/kg/hr 33.7 mL/hr	Intravenous	Performed by: Julie Kraftzenk, RN

iohexol (OMNIPAQUE) injection 350 mg/mL [653264432]

Ordering Provider: Abdul M Sheikh, MD
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge -

Medications (continued)

All Meds and Administrations (continued)

Ordered On: 01/10/17 0946

Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 0945 Documented: 01/10/17 0946	Given	200 mL	Intra-arterial	Performed by: Abdul M Sheikh, MD Documented by: Julie Kraftzenk, RN Comments: wasted 150 cc

carvedilol (COREG) tablet [653264433]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 01/10/17 1131
Dose (Remaining/Total): 12.5 mg (---/---)
Frequency: 2 Times daily with meals

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1700 - 01/11/17 1519
Route: Oral
Rate/Duration: --- / ---

Timestamps	Action	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	12.5 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 0904-6301-61, 0904-6301-61
Performed 01/10/17 1722 Documented: 01/10/17 1722	Given	12.5 mg	Oral	Performed by: Jane Abey, RN Comments: HR 73BP 112/55 Scanned Package: 0904-6301-61, 0904-6301-61

atorvastatin (LIPITOR) tablet [653264434]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 01/10/17 1131
Dose (Remaining/Total): 80 mg (---/---)
Frequency: Nightly

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 2100 - 01/11/17 1519
Route: Oral
Rate/Duration: --- / ---

Admin Instructions: Concurrent use of atorvastatin (LIPITOR) and GRAPEFRUIT JUICE may result in increased bioavailability of atorvastatin resulting in an increased risk of myopathy or rhabdomyolysis.

Timestamps	Action	Dose	Route	Other Information
Performed 01/10/17 2213 Documented: 01/10/17 2216	Given	80 mg	Oral	Performed by: Sophia B Agyepong, RN Scanned Package: 0904-6292-61, 0904-6292-61

ramipril (ALTACE) capsule [653264435]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 01/10/17 1131
Dose (Remaining/Total): 10 mg (---/---)
Frequency: 2 Times daily

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: --- / ---

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0819 Documented: 01/11/17 0819	Given	10 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 68084-268-11
Performed 01/10/17 2214 Documented: 01/10/17 2216	Given	10 mg	Oral	Performed by: Sophia B Agyepong, RN Scanned Package: 68084-268-11
Performed 01/10/17 1300 Documented: 01/10/17 1321	Not Given Recently Given	10 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

Medications (continued)

All Meds and Administrations (continued)

cilostazol (PLETAL) tablet [653264436]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 100 mg (—/—)
Frequency: 2 Times daily
Admin Instructions: **Caution: Sound alike/look alike medication**
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	100 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 0093-2065-06, 0093-2065-06
Performed 01/10/17 2214 Documented: 01/10/17 2216	Given	100 mg	Oral	Performed by: Sophia B Agyepong, RN Scanned Package: 0093-2065-06, 0093-2065-06
Performed 01/10/17 1200 Documented: 01/10/17 1319	Not Given Recently Given	100 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

clopidogrel (PLAVIX) tablet [653264437]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 75 mg (—/—)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	75 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 0904-6294-61
Performed 01/10/17 1319 Documented: 01/10/17 1319	Not Given Recently Given	75 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

chlorthalidone (HYGROTON) tablet [653264438]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 50 mg (—/—)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	50 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 51079-058-01, 51079-058-01
Performed 01/10/17 1319 Documented: 01/10/17 1319	Not Given Recently Given	50 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

isosorbide mononitrate (IMDUR) 24 hr tablet [653264439]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 60 mg (—/—)
Frequency: 2 Times daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: — / —

Medications (continued)

All Meds and Administrations (continued)

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	60 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 0904-6450-61
Performed 01/10/17 2214 Documented: 01/10/17 2216	Given	60 mg	Oral	Performed by: Sophia B Agyepong, RN Scanned Package: 0904-6450-61
Performed 01/10/17 1200 Documented: 01/10/17 1319	Not Given Recently Given	60 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

nitroglycerin (NITROSTAT) SL tablet [653264440]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 0.4 mg (—/—)
Frequency: Every 5 min PRN
Admin Instructions: x 3 doses. Notify MD if no relief after 3 doses.

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1130 - 01/11/17 1519
Route: Sublingual
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

aspirin chewable tablet [653293462]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 01/10/17 1131
Dose (Remaining/Total): 81 mg (—/—)
Frequency: Daily

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/10/17 1200 - 01/11/17 1519
Route: Oral
Rate/Duration: — / —

Timestamps	Action / Reason	Dose	Route	Other Information
Performed 01/11/17 0818 Documented: 01/11/17 0819	Given	81 mg	Oral	Performed by: Jane Abey, RN Scanned Package: 63739-434-01
Performed 01/10/17 1200 Documented: 01/10/17 1317	Not Given Recently Given	81 mg	Oral	Performed by: Jane Abey, RN Comments: Patient states he took it this morning.

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Care Plan

Multidisciplinary Problems (Active)

Problem: Daily Care

Dates: Start: 01/10/17
Disciplines: Interdisciplinary

Goal: Daily care needs are met

Dates: Start: 01/10/17
Description: Assess and monitor ability to perform self care and identify potential discharge needs.
Disciplines: Interdisciplinary

Intervention: Assess skin integrity/risk for skin breakdown and implement skin integrity plan of care and interventions per policy

Dates: Start: 01/10/17

Intervention: Assist with ADLs as needed

Care Plan (continued)

Multidisciplinary Problems (Active) (continued)

Dates: Start: 01/10/17

Intervention: Encourage independent activity per ability

Dates: Start: 01/10/17

Intervention: Provide oral care

Dates: Start: 01/10/17
Description: Every 2 hours as needed.

Intervention: Include patient/family/caregiver in decisions

Dates: Start: 01/10/17

Problem: Pain

Dates: Start: 01/10/17
Disciplines: Interdisciplinary

Goal: Patient's pain/discomfort is manageable

Dates: Start: 01/10/17
Priority: High
Description: Assess and monitor patient's pain using appropriate pain scale. Collaborate with interdisciplinary team and initiate plan and interventions as ordered. Re-assess patient's pain level 30 - 60 minutes after pain management intervention.
Disciplines: Interdisciplinary

Intervention: Include patient/family/caregiver in decisions related to pain management

Dates: Start: 01/10/17

Intervention: Offer non-pharmocological pain management interventions

Dates: Start: 01/10/17

Problem: Psychosocial Needs

Dates: Start: 01/10/17
Disciplines: Interdisciplinary

Goal: Demonstrates ability to cope with hospitalization/illness

Dates: Start: 01/10/17
Description: Assess and monitor patients ability to cope with his/her illness.
Disciplines: Interdisciplinary

Intervention: Encourage verbalization of feelings/concerns/expectations

Dates: Start: 01/10/17

Intervention: Provide quiet environment

Dates: Start: 01/10/17

Intervention: Assist patient to identify own strengths and abilities

Dates: Start: 01/10/17

Intervention: Encourage patient to set small goals for self

Dates: Start: 01/10/17

Intervention: Encourage participation in diversional activity

Dates: Start: 01/10/17

Intervention: Reinforce positive adaptation of new coping behaviors

Dates: Start: 01/10/17

Intervention: Include patient/family/caregiver in decisions

Dates: Start: 01/10/17

Care Plan (continued)

Multidisciplinary Problems (Active) (continued)

Goal: Collaborate with patient/family/caregiver to identify patient specific goals for this hospitalization

Dates: Start: 01/10/17
Disciplines: Interdisciplinary

Flowsheet:

Taken at 01/11/17 1200
Cultural Preferences Affecting Hospitalization — No by **Jane Abey, RN**
Spiritual Preferences Affecting Hospitalization — No by **Jane Abey, RN**

Problem: Safety

Dates: Start: 01/10/17
Disciplines: Interdisciplinary

Goal: Patient will be injury free during hospitalization

Dates: Start: 01/10/17
Description: Assess and monitor vitals signs, neurological status including level of consciousness and orientation. Assess patient's risk for falls and implement fall prevention plan of care and interventions per hospital policy.

Ensure arm band on, uncluttered walking paths in room, adequate room lighting, call light and overbed table within reach, bed in low position, wheels locked, side rails up per policy, and non-skid footwear provided.
Disciplines: Interdisciplinary

Intervention: Assess patient's risk for falls and implement fall prevention plan of care per policy

Dates: Start: 01/10/17

Intervention: Provide and maintain safe environment

Dates: Start: 01/10/17
Description:

Intervention: Use appropriate transfer methods

Dates: Start: 01/10/17

Intervention: Ensure appropriate safety devices are available at the bedside

Dates: Start: 01/10/17

Intervention: Include patient/family/caregiver in decisions related to safety

Dates: Start: 01/10/17

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Resolved)

Patient Education (continued)

Education (continued)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.
Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Not Started)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Not Started)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Not Started)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Not Started)

Point: Encourage Patient to Monitor Own Pain (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Not Started)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Resolved)

Point: Anticoagulant Therapy (Resolved)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Resolved)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.
Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Resolved)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Non-Steroidal Anti-Inflammatory Drugs (Resolved)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Resolved)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Resolved)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Resolved)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Resolved)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Resolved)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Resolved)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Resolved)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Resolved)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 19:50:47	01/10/17 17:36:48	01/10/17 1200
Vitals					
Pct Wt Change	0 % -DI (r) AK (t)	—	—	—	—
OTHER					
Weight Change (kg)	0 kg -DI (r) AK (t)	—	—	—	—
Visit Weight	227 lb -DI (r) AK (t)	—	—	—	—
Weight/Scale Event	0 -DI (r) AK (t)	—	—	—	—
% Weight Change Since Birth	0 -DI (r) AK (t)	—	—	—	—
Relevant Labs and Vitals					
Temp (in Celsius)	36.7 -AK	36.7 -OO	36.7 -AK	37 -SM	—
VTE Risk Factor: Totals					
General Info Subtotal	—	—	—	—	0 -JA

Row Name	01/10/17 09:48:48	01/10/17 08:08:39	01/10/17 0710	01/10/17 0709	
Adult IBW/VT Calculations					
IBW/kg (Calculated)	—	—	—	66.1 -DW	
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -DW	
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -DW	
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -DW	
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -DW	
Vitals					
Pct Wt Change	—	—	—	0 % -DW	
OTHER					
Weight Change (kg)	—	—	—	0 kg -DW	
Ideal Body Weight	—	—	—	160 lb -DW	
Visit Weight	—	—	—	212 lb -DW	
BMI (Calculated)	—	—	—	33.2 -DW	
IBW/kg (Calculated) Male	—	—	—	66.1 kg -DW	
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -DW	
Weight/Scale Event	—	—	—	0 -DW	
Weight in (lb) to have BMI = 25	—	—	—	159.3 -DW	
% Weight Change Since Birth	—	—	—	0 -DW	
Case Log					
BSA x (CI @3.0)= CO	—	—	—	6.39 CO -DW	
Relevant Labs and Vitals					
Temp (in Celsius)	—	—	36.4 -DW	—	
Aldrete Phase 1					
Aldrete Score	10 -RB	10 -RB	—	—	

Flowsheets (all recorded)

Risk for Readmission

Row Name	01/11/17 1319
OTHER	
Risk for Readmission	4 -SS

Flowsheets (all recorded)

Care Handoff

Row Name	01/11/17 0724	01/10/17 2004
Care Handoff		
Report Given to	Given to next shift RN -SA	—
Name of person receiving report	Jane RN -SA	Sophia RN -JA
Name of person giving report	Sophia RN -SA	Jane RN -JA

Flowsheets (all recorded)

Travel Information

Row Name	01/10/17 0706
RETIRED - Travel outside the U.S.	
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -DW

Flowsheets (all recorded)

Aldrete Score

Row Name	01/10/17 09:48:48	01/10/17 08:08:39
Aldrete		
Activity	2 -RB	2 -RB
Respiration	2 -RB	2 -RB
Circulation	2 -RB	2 -RB
Consciousness	2 -RB	2 -RB
O2 Saturation	2 -RB	2 -RB
Aldrete Score (PAR)	10 -RB	10 -RB

Flowsheets (all recorded)

Vital Signs

Row Name	01/11/17 08:13:32	01/11/17 0705	01/11/17 0418	01/11/17 04:09:39	01/10/17 23:01:08
Vital Signs					
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	—	—	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)
Temp src	—	—	—	Oral -AK	Oral -OO
Pulse	64 -DI (r) MG (t)	—	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)
Heart Rate Source	—	—	—	Monitor -AK	Monitor -OO
Resp	18 -DI (r) MG (t)	—	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)
Respiration Source	—	—	—	visual -AK	visual -OO
BP	135/69 -DI (r) MG (t)	—	—	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)
BP Location	—	—	—	Left arm -AK	Right arm -OO
BP Method	—	—	—	Portable -AK	Portable -OO
Patient Position	—	—	—	Supine -AK	Supine -OO
Oxygen Therapy					
SpO2	94 % -DI (r) MG (t)	—	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)
O2 Device	—	—	—	None (Room air) -AK	None (Room air) -OO
Pain Assessment					
Currently in Pain	—	Yes -JA	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -JA	—	—	—
Pain Intervention(s)	—	Medication (see MAR) -JA	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JA	—	—	—
Height and Weight					
Weight	—	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—
Weight Method	—	—	—	Actual -AK	—
24 Chart Check					
24 hour chart check complete	—	—	Yes -SA	—	—

Row Name	01/10/17 2100	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48
Vital Signs					
Temp	—	—	—	98 °F (36.7 °C) -DI (r) SM (t)	—
Temp src	—	—	—	Oral -AK	—
Pulse	—	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)
Heart Rate Source	—	Monitor -AK	Monitor -AK	Monitor -AK	—
Resp	—	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—
Respiration Source	—	visual -AK	—	visual -AK	—
BP	—	154/70 -DI (r) SM (t)	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)
BP Location	—	Right arm -AK	Right arm -AK	Right arm -AK	—
BP Method	—	Portable -AK	Portable -AK	Portable -AK	—
Patient Position	—	Standing -AK	Sitting -AK	Supine -AK	—
Oxygen Therapy					
SpO2	—	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—
O2 Device	None (Room air) -SA	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -SA	—	—

Row Name	01/10/17 19:25:31	01/10/17 19:09:48	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44
Vital Signs					
Pulse	76 -DI (r) SM (t)	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)
BP	139/66 -DI (r) SM (t)	126/60 -DI (r) SM (t)	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)

Row Name	01/10/17 18:09:43	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48
Vital Signs					
Temp	—	—	—	—	98.6 °F (37 °C) -DI (r) SM (t)
Temp src	—	—	—	—	Oral -SM
Pulse	71 -DI (r) SM (t)	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)
Heart Rate Source	—	—	—	—	Monitor -SM

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	01/10/17 18:09:43	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48
Resp	—	—	—	—	18 -SM
Respiration Source	—	—	—	—	visual -SM
BP	139/66 -DI (r) SM (t)	146/67 -DI (r) SM (t)	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)
BP Location	—	—	—	—	Right arm -SM
BP Method	—	—	—	—	Portable -SM
Patient Position	—	—	—	—	Supine -SM
Oxygen Therapy					
SpO2	—	—	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)

Row Name	01/10/17 14:54:18	01/10/17 14:39:18	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 13:54:22
Vital Signs					
Pulse	68 -DI (r) JA (t)	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)
BP	121/61 -DI (r) JA (t)	117/62 -DI (r) JA (t)	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)

Row Name	01/10/17 13:39:59	01/10/17 13:24:21	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20
Vital Signs					
Pulse	65 -DI (r) JA (t)	64 -DI (r) JA (t)	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)
BP	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)
Oxygen Therapy					
SpO2	—	—	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)

Row Name	01/10/17 12:24:19	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200	01/10/17 1055
Vital Signs					
Temp	98.6 °F (37 °C) -DI (r) JA (t)	—	—	—	—
Pulse	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	—	59 -DW
Resp	—	—	—	—	15 -DW
BP	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)	127/65 -DI (r) JA (t)	—	125/53 -DW
Oxygen Therapy					
SpO2	—	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	—	99 % -DW
O2 Device	—	—	—	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -DW
Pain Assessment					
Currently in Pain	—	—	—	No -JA	—
Which Pain Assessment Tool ?	—	—	—	Numeric (0-10) -JA	—
Pain Intervention(s)	—	—	—	Medication (see MAR) -JA	—
Pain Assessment History					
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -JA	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	0 -JA	0 -DW

Row Name	01/10/17 1037	01/10/17 1027	01/10/17 1020	01/10/17 1004	01/10/17 08:07:03
Vital Signs					
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
BP	132/58 -DW	131/58 -DW	131/58 -DW	146/67 -DW	—
Oxygen Therapy					
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
O2 Device	Nasal cannula -DW	—	Nasal cannula -DW	Nasal cannula -DW	Nasal cannula -RB
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -RB
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -DW	0 -DW	0 -DW	0 -DW	—

Row Name	01/10/17 0710	01/10/17 0709
Vital Signs		
Temp	97.6 °F (36.4 °C) -DW	—
Temp src	Oral -DW	—
Pulse	64 -DW	—
Heart Rate Source	Monitor -DW	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	01/10/17 0710	01/10/17 0709
Resp	16 -DW	—
BP	137/55 -DW	—
Patient Position	Sitting -DW	—
Oxygen Therapy		
SpO2	97 % -DW	—
Numeric Pain Intensity Scale		
Numeric Pain Intensity Score 1	0 -DW	—
Height and Weight		
Height	—	67" (1.702 m) -DW
Weight	—	96.2 kg (212 lb) -DW
Weight Method	—	Stated -DW
BSA (Calculated - sq m)	—	2.13 sq meters -DW
BMI (Calculated)	—	33.2 -DW
Weight in (lb) to have BMI = 25	—	159.3 -DW

Flowsheets (all recorded)

Intake/Output

Row Name	01/11/17 0830	01/11/17 08:13:32	01/11/17 0705	01/11/17 04:09:39	01/10/17 23:01:08
Weights					
Weight	—	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—
Weight Method	—	—	—	Actual -AK	—
Intake (mL)					
P.O.	240 mL -JA	—	—	—	200 mL -AK
Simple Vitals					
Pulse	—	64 -DI (r) MG (t)	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)
Resp	—	18 -DI (r) MG (t)	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)
Numeric Pain Intensity Score 1	—	—	0 -JA	—	—
Urine Output					
Urine Occurrence	—	—	—	1 -AK	1 -AK
Row Name	**01/10/17 19:53:19**	**01/10/17 19:52:21**	**01/10/17 19:50:47**	**01/10/17 19:39:48**	**01/10/17 19:25:31**
Intake (mL)					
P.O.	250 mL -AK	—	—	—	—
Simple Vitals					
Pulse	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)
Resp	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—	—
Numeric Pain Intensity Score 1	—	0 -SA	—	—	—
Urine Output					
Urine Occurrence	1 -AK	—	—	—	—
Row Name	**01/10/17 19:09:48**	**01/10/17 18:54:53**	**01/10/17 18:39:42**	**01/10/17 18:24:44**	**01/10/17 18:09:43**
Simple Vitals					
Pulse	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)
Row Name	**01/10/17 17:55:31**	**01/10/17 17:39:50**	**01/10/17 17:36:52**	**01/10/17 17:36:48**	**01/10/17 14:54:18**
Simple Vitals					
Pulse	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)	69 -DI (r) JA (t)
Resp	—	—	—	18 -SM	—
Row Name	**01/10/17 14:39:18**	**01/10/17 14:24:20**	**01/10/17 14:09:18**	**01/10/17 1400**	**01/10/17 13:54:22**
Intake (mL)					
P.O.	—	—	—	480 mL -JA	—
Simple Vitals					
Pulse	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	—	67 -DI (r) JA (t)
Row Name	**01/10/17 13:39:59**	**01/10/17 13:24:21**	**01/10/17 12:54:21**	**01/10/17 12:39:20**	**01/10/17 1230**
Simple Vitals					
Pulse	65 -DI (r) JA (t)	64 -DI (r) JA (t)	60 -DI (r) JA (t)	63 -DI (r) JA (t)	—
Urine Output					
Urine	—	—	—	—	300 mL -JA
Row Name	**01/10/17 12:24:19**	**01/10/17 12:09:22**	**01/10/17 12:07:46**	**01/10/17 1200**	**01/10/17 1055**
Simple Vitals					
Pulse	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	—	59 -DW
Resp	—	—	—	—	15 -DW
Numeric Pain Intensity Score 1	—	—	—	0 -JA	0 -DW
Row Name	**01/10/17 1037**	**01/10/17 1027**	**01/10/17 1020**	**01/10/17 1004**	**01/10/17 09:38:57**
Simple Vitals					
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
Numeric Pain Intensity Score 1	0 -DW	0 -DW	0 -DW	0 -DW	—
bivalirudin					
bivalirudin Rate	—	—	—	—	0 mL/hr -JK
bivalirudin Concentration	—	—	—	—	5 mg/mL -JK
Row Name	**01/10/17 09:19:08**	**01/10/17 08:59:32**	**01/10/17 08:59:25**	**01/10/17 08:30:42**	**01/10/17 08:27:18**

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	01/10/17 09:19:03	01/10/17 08:59:32	01/10/17 08:59:25	01/10/17 08:30:42	01/10/17 08:27:18
bivalirudin					
bivalirudin Dose (mg/kg/hr)	1.75 mg/kg/hr -JK	1.75 mg/kg/hr -JK	—	—	—
bivalirudin Bolus (mg)	—	—	72.15 mg -JK	—	—
bivalirudin Rate	33.7 mL/hr -JK	33.7 mL/hr -JK	—	—	—
bivalirudin Concentration	5 mg/mL -JK	5 mg/mL -JK	5 mg/mL -JK	—	—
Heparin Drip					
heparin Bolus (Units)	—	—	—	5000 Units verified by dr sheikh -JK	—
heparin Rate	—	—	—	— verified by dr sheikh -JK	—
Concentration	—	—	—	1000 Units/mL -JK	—
verapamil Infusion					
verapamil Dose (mcg/kg/min)	—	—	—	—	*2.5 mg -JK (r) AS (t)
verapamil Concentration	—	—	—	—	2.5 mg/mL -JK (r) AS (t)

Row Name	01/10/17 08:27:07	01/10/17 08:15:37	01/10/17 0722	01/10/17 0710	01/10/17 0709
Weights					
Weight	—	—	—	—	96.2 kg (212 lb) -DW
Weight Method	—	—	—	—	Stated -DW
BSA (Calculated - sq m)	—	—	—	—	2.13 sq meters -DW
sodium chloride 0.9% (NS) bolus					
Bolus Dose	—	—	*3 mL/kg/hr -DW	—	—
Simple Vitals					
Pulse	—	—	—	64 -DW	—
Resp	—	—	—	16 -DW	—
Numeric Pain Intensity Score 1	—	—	—	0 -DW	—
Heparin Drip					
heparin Bolus (Units)	—	*2 Bag -JK (r) AS (t)	—	—	—
Concentration	—	2 Units/mL -JK (r) AS (t)	—	—	—
heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL Start: 01/10/17 0815					
heparin Bolus Dose (Units) (View Only)	—	*2 Bag -JK (r) AS (t)	—	—	—
heparin Concentration (View Only)	—	2 Units/mL -JK (r) AS (t)	—	—	—
nitroglycerin Drip					
nitroglycerin Bolus Dose (mcg)	200 mcg -JK (r) AS (t)	—	—	—	—
nitroglycerin Concentration	200 mcg/mL -JK (r) AS (t)	—	—	—	—

Flowsheets (all recorded)

Assessment

Row Name	01/11/17 08:13:32	01/11/17 0715	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100
Neurological					
Neuro (WDL)	—	WDL -JA	—	—	WDL -SA
tPA Time out					
Weight	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—	—
HEENT					
HEENT (WDL)	—	X -JA	—	—	—
R Eye	—	Impaired vision -JA	—	—	—
L Eye	—	Impaired vision -JA	—	—	—
Respiratory					
Respiratory Pattern	—	Regular -JA	—	—	—
Chest Assessment	—	Chest expansion symmetrical -JA	—	—	—
Bilateral Breath Sounds	—	Clear -JA	—	—	—
Respiratory (WDL)	—	WDL -JA	—	—	WDL -SA
Oxygen Therapy					
SpO2	94 % -DI (r) MG (t)	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	—
O2 Device	—	—	None (Room air) -AK	None (Room air) -OO	None (Room air) -SA
Incentive Spirometer					
Is pt using incentive spirometer?	—	No -JA	—	—	No -SA
IS Tx Not Given	—	Not Indicated -JA	—	—	Not Indicated -SA
Cardiac					
Cardiac (WDL)	—	—	—	—	X -SA
Heart Sounds	—	—	—	—	S1, S2 -SA
Cardiac					
Telemetry Monitor On	—	Yes -JA	—	—	Yes -SA
Telemetry Audible	—	Yes -JA	—	—	Yes -SA
Telemetry Alarms Set	—	Yes -JA	—	—	Yes -SA
Telemetry Box Number	—	mx22 -JA	—	—	mx22 -SA
Peripheral Vascular					
Peripheral Vascular (WDL)	—	WDL -JA	—	—	X -SA
Cyanosis	—	None -JA	—	—	None -SA
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -JA	—	—	Less than/equal to 2 seconds (All extremities) -SA
Pulses	—	R radial;L radial;R pedal;L pedal -JA	—	—	R radial;L radial;R pedal;L pedal -SA
RUE Neurovascular Assessment					
R Radial Pulse	—	+2 -JA	—	—	+2 -SA
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -JA	—	—	+1 -SA
RLE Neurovascular Assessment					
R Pedal Pulse	—	+2 -JA	—	—	+2 -SA
LLE Neurovascular Assessment					
L Pedal Pulse	—	+2 -JA	—	—	+2 -SA
Integumentary					
Integumentary (WDL)	—	X -JA	—	—	X -SA
Skin Color	—	Appropriate for ethnicity -JA	—	—	Appropriate for ethnicity -SA
Skin Condition/Temp	—	Dry;Warm -JA	—	—	Dry;Warm -SA
Skin Integrity	—	Other (Comment) surgical sites -JA	—	—	Other (Comment) punture sites -SA
Skin Location	—	right groin, left radial -JA	—	—	left radial and right groin -SA
Skin Turgor	—	Non-tenting -JA	—	—	Non-tenting -SA
Braden Scale					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	01/11/17 08:13:32	01/11/17 0715	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100
Sensory Perceptions	—	4 -JA	—	—	4 -SA
Moisture	—	4 -JA	—	—	4 -SA
Activity	—	3 -JA	—	—	3 -SA
Mobility	—	3 -JA	—	—	3 -SA
Nutrition	—	3 -JA	—	—	3 -SA
Friction and Shear	—	3 -JA	—	—	3 -SA
Braden Scale Score	—	20 -JA	—	—	20 -SA
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing Assesment	—	Clean;Dry;Intact -JA	—	—	Clean;Dry;Intact -SA
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing Assesment	—	Clean;Dry;Intact -JA	—	—	Clean;Dry;Intact -SA
Musculoskeletal					
Musculoskeletal (WDL)	—	WDL -JA	—	—	WDL -SA
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	0 -JA	—	—	1 -SA
Gastrointestinal					
Gastrointestinal (WDL)	—	WDL -JA	—	—	WDL -SA
Abdomen Inspection	—	Soft -JA	—	—	—
Bowel Sounds (All Quadrants)	—	Active -JA	—	—	—
Last BM Date	—	01/10/17 -JA	—	—	—
Genitourinary					
Genitourinary (WDL)	—	WDL -JA	—	—	WDL -SA
Psychosocial					
Psychosocial (WDL)	—	WDL -JA	—	—	WDL -SA
Charting Type					
Charting Type	—	Shift assessment -JA	—	—	Shift assessment -SA
Cardiac					
Cardiac Rhythm	—	—	—	—	Sinus bradycardia;Normal sinus rhythm -SA
Heart Block Type	—	—	—	—	Bundle branch block -SA
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	0 -JA	—	—	0 -SA
Symptomatic Depression (View Only)	—	0 -JA	—	—	0 -SA
Altered Elimination (View Only)	—	0 -JA	—	—	0 -SA
Dizziness/Vertigo (View Only)	—	0 -JA	—	—	0 -SA
Gender (Male) View Only	—	1 -JA	—	—	1 -SA
Any Administered Benzodiazepines (View Only)	—	0 -JA	—	—	0 -SA
Hendrich II Total Score (Calculated) View Only	—	1 -JA	—	—	2 -SA
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	0 -JA	—	—	0 -SA

Row Name	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 1830	01/10/17 1812

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 1830	01/10/17 1812
Oxygen Therapy					
SpO2	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—	—
O2 Device	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—	—
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Provider Notification					
Reason for Communication (View Only	—	—	—	—	Other (comment) bleeding right grion -JA
Notification Time	—	—	—	1830 -JA	1812 -JA
Provider Name	—	—	—	Raquel DeCamp -JA	Raquel DeCamp -JA
Provider Role	—	—	—	PA -JA	PA -JA
Method of Communication	—	—	—	Call -JA	Perfect Serve -JA
Response	—	—	—	Other (Comment) continue to monitor -JA	Waiting for response -JA

Row Name	01/10/17 17:36:52	01/10/17 17:36:48	01/10/17 1730	01/10/17 1500	01/10/17 1450
Oxygen Therapy					
SpO2	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—	—	—
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Drainage Amount	—	—	Small -JA	—	Moderate -JA
Drainage Description	—	—	Other (Comment) red -JA	—	Other (Comment) red -JA
Treatments	—	—	Other (Comment) pressure -JA	—	Other (Comment) pressure -JA
Dressing	—	—	Gauze stop at 1740 -JA	—	Gauze bleeding stop at 1505 -JA
Dressing Changed	—	—	New -JA	—	New -JA
Dressing Assesment	—	—	Clean;Dry;Intact -JA	—	Clean;Dry;Intact -JA
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Drainage Amount	—	—	—	None -JA	—
Dressing	—	—	—	Gauze -JA	—
Dressing Changed	—	—	—	New -JA	—
Dressing Assesment	—	—	—	Clean;Dry;Intact -JA	—

Row Name	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200
Neurological					
Neuro (WDL)	—	—	—	—	WDL -JA
HEENT					
HEENT (WDL)	—	—	—	—	X -JA
R Eye	—	—	—	—	Impaired vision -JA
L Eye	—	—	—	—	Impaired vision -JA
Respiratory					
Respiratory Pattern	—	—	—	—	Regular -JA
Chest Assessment	—	—	—	—	Chest expansion symmetrical -JA
Bilateral Breath Sounds	—	—	—	—	Clear -JA
Respiratory (WDL)	—	—	—	—	WDL -JA
Oxygen Therapy					
SpO2	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	—	No -JA
IS Tx Not Given	—	—	—	—	Not Indicated -JA

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200
Cardiac					
Cardiac (WDL)	—	—	—	—	X -JA
Cardiac					
Telemetry Monitor On	—	—	—	—	Yes -JA
Telemetry Audible	—	—	—	—	Yes -JA
Telemetry Alarms Set	—	—	—	—	Yes -JA
Peripheral Vascular					
LUE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -JA
LUE Neurovascular Assessment					
LUE Color	—	—	—	—	Appropriate for ethnicity -JA
LUE Temperature/Moisture	—	—	—	—	Warm;Dry -JA
LUE Sensation	—	—	—	—	Present -JA
L Radial Pulse	—	—	—	—	+1 -JA
RLE Neurovascular Assessment					
R Pedal Pulse	—	—	—	—	+2 -JA
LLE Neurovascular Assessment					
L Pedal Pulse	—	—	—	—	+2 -JA
Integumentary					
Integumentary (WDL)	—	—	—	—	X -JA
Skin Color	—	—	—	—	Appropriate for ethnicity -JA
Skin Condition/Temp	—	—	—	—	Dry;Warm -JA
Skin Integrity	—	—	—	—	Other (Comment) surgical -JA
Skin Location	—	—	—	—	left radial, right grion -JA
Skin Turgor	—	—	—	—	Non-tenting -JA
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -JA
Moisture	—	—	—	—	4 -JA
Activity	—	—	—	—	3 -JA
Mobility	—	—	—	—	3 -JA
Nutrition	—	—	—	—	3 -JA
Friction and Shear	—	—	—	—	3 -JA
Braden Scale Score	—	—	—	—	20 -JA
Wound					
Type of Wound (LDA)	—	—	—	Surgical -JA	Surgical -JA
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Closure	—	—	—	Other (Comment) -JA	—
Drainage Amount	—	—	—	None -JA	—
Dressing	—	—	—	Other (Comment) -JA	—
Dressing Changed	—	—	—	New -JA	—
Dressing Assesment	—	—	—	Clean;Dry -JA	—
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	—	WDL -JA
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	—	0 -JA
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	—	WDL -JA
Abdomen Inspection	—	—	—	—	Soft -JA
Bowel Sounds (All	—	—	—	—	Active -JA

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200
Quadrants)					
Genitourinary					
Genitourinary (WDL)	—	—	—	—	WDL -JA
Psychosocial					
Psychosocial (WDL)	—	—	—	—	WDL -JA
Charting Type					
Charting Type	—	—	—	—	Admission -JA
Cardiac					
Cardiac Rhythm	—	—	—	—	Sinus bradycardia -JA
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	—	—	—	0 -JA
Symptomatic Depression (View Only)	—	—	—	—	0 -JA
Altered Elimination (View Only)	—	—	—	—	0 -JA
Dizziness/Vertigo (View Only)	—	—	—	—	0 -JA
Gender (Male) View Only	—	—	—	—	1 -JA
Any Administered Benzodiazepines (View Only)	—	—	—	—	0 -JA
Hendrich II Total Score (Calculated) View Only	—	—	—	—	1 -JA
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	—	—	—	0 -JA

Row Name	01/10/17 1058	01/10/17 1055	01/10/17 1037	01/10/17 1027	01/10/17 1020
Oxygen Therapy					
SpO2	—	99 % -DW	97 % -DW	96 % -DW	95 % -DW
O2 Device	—	Nasal cannula -DW	Nasal cannula -DW	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW
Peripheral Vascular					
LUE Capillary Refill	Less than/equal to 3 seconds -DW	—	—	—	—
LUE Neurovascular Assessment					
LUE Color	Appropriate for ethnicity -DW	—	—	—	—
LUE Sensation	Present -DW	—	—	—	—
L Radial Pulse	+1 -DW	—	—	—	—
Integumentary					
Skin Color	—	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW
Skin Condition/Temp	—	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Cardiac					
Cardiac Rhythm	—	Sinus bradycardia -DW	Normal sinus rhythm -DW	Normal sinus rhythm -DW	Sinus bradycardia -DW

Row Name	01/10/17 1004	01/10/17 08:07:03	01/10/17 0724	01/10/17 0710	01/10/17 0709
tPA Time out					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	01/10/17 1004	01/10/17 08:07:03	01/10/17 0724	01/10/17 0710	01/10/17 0709
Weight	—	—	—	—	96.2 kg (212 lb) -DW
Oxygen Therapy					
SpO2	98 % -DW	—	—	97 % -DW	—
O2 Device	Nasal cannula -DW	Nasal cannula -RB	—	—	—
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -RB	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	X -DW	—	—
Pulses	—	—	R pedal;L posterior tibial;R posterior tibial;L pedal -DW	—	—
RLE Neurovascular Assessment					
R Posterior Tibial Pulse	—	—	+1 -DW	—	—
R Pedal Pulse	—	—	+2 -DW	—	—
LLE Neurovascular Assessment					
L Posterior Tibial Pulse	—	—	+1 -DW	—	—
L Pedal Pulse	—	—	+1 -DW	—	—
Integumentary					
Skin Color	Appropriate for ethnicity -DW	—	—	—	—
Skin Condition/Temp	Dry;Warm -DW	—	—	—	—
Braden Scale					
Sensory Perceptions	—	—	—	3 -DW	—
Moisture	—	—	—	4 -DW	—
Activity	—	—	—	4 -DW	—
Mobility	—	—	—	3 -DW	—
Nutrition	—	—	—	3 -DW	—
Friction and Shear	—	—	—	3 -DW	—
Braden Scale Score	—	—	—	20 -DW	—
Cardiac					
Cardiac Rhythm	Sinus bradycardia -DW	—	—	—	—

Flowsheets (all recorded)

CCP Vitals, Intake and Output

Row Name	01/11/17 0830	01/11/17 08:13:32	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100
Vitals					
Temp	—	97.5 °F (36.4 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)	—
Temp src	—	—	Oral -AK	Oral -OO	—
Pulse	—	64 -DI (r) MG (t)	65 -DI (r) AK (t)	64 -DI (r) AK (t)	—
Heart Rate Source	—	—	Monitor -AK	Monitor -OO	—
Resp	—	18 -DI (r) MG (t)	18 -DI (r) AK (t)	18 -DI (r) AK (t)	—
Respiration Source	—	—	visual -AK	visual -OO	—
BP	—	135/69 -DI (r) MG (t)	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)	—
BP Location	—	—	Left arm -AK	Right arm -OO	—
BP Method	—	—	Portable -AK	Portable -OO	—
Patient Position	—	—	Supine -AK	Supine -OO	—
SpO2	—	94 % -DI (r) MG (t)	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	—
O2 Device	—	—	None (Room air) -AK	None (Room air) -OO	None (Room air) -SA
Weight	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—	—
Weight Method	—	—	Actual -AK	—	—
Intake (mL)					
P.O.	240 mL -JA	—	—	200 mL -AK	—
Unmeasured Output					
Urine Occurrence	—	—	1 -AK	1 -AK	—

Row Name	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48	01/10/17 19:25:31
Vitals					
Temp	—	—	98 °F (36.7 °C) -DI (r) SM (t)	—	—
Temp src	—	—	Oral -AK	—	—
Pulse	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)
Heart Rate Source	Monitor -AK	Monitor -AK	Monitor -AK	—	—
Resp	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—	—
Respiration Source	visual -AK	—	visual -AK	—	—
BP	154/70 -DI (r) SM (t)	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)	139/66 -DI (r) SM (t)
BP Location	Right arm -AK	Right arm -AK	Right arm -AK	—	—
BP Method	Portable -AK	Portable -AK	Portable -AK	—	—
Patient Position	Standing -AK	Sitting -AK	Supine -AK	—	—
SpO2	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—	—
O2 Device	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—	—
Intake (mL)					
P.O.	250 mL -AK	—	—	—	—
Unmeasured Output					
Urine Occurrence	1 -AK	—	—	—	—

Row Name	01/10/17 19:09:48	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44	01/10/17 18:09:43
Vitals					
Pulse	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)
BP	126/60 -DI (r) SM (t)	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)	139/66 -DI (r) SM (t)

Row Name	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48	01/10/17 14:54:18
Vitals					
Temp	—	—	—	98.6 °F (37 °C) -DI (r) SM (t)	—
Temp src	—	—	—	Oral -SM	—
Pulse	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)	68 -DI (r) JA (t)
Heart Rate Source	—	—	—	Monitor -SM	—
Resp	—	—	—	18 -SM	—
Respiration Source	—	—	—	visual -SM	—
BP	146/67 -DI (r) SM (t)	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)	121/61 -DI (r) JA (t)
BP Location	—	—	—	Right arm -SM	—
BP Method	—	—	—	Portable -SM	—
Patient Position	—	—	—	Supine -SM	—
SpO2	—	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—

Row Name	01/10/17 14:39:18	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 1400	01/10/17 13:54:22
Vitals					
Pulse	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	—	67 -DI (r) JA (t)
BP	117/62 -DI (r) JA (t)	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	—	152/70 -DI (r) JA (t)

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	01/10/17 14:39:18	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 1400	01/10/17 13:54:22
Intake (mL)					
P.O.	—	—	—	480 mL -JA	—
Row Name	**01/10/17 13:39:59**	**01/10/17 13:24:21**	**01/10/17 13:09:22**	**01/10/17 12:54:21**	**01/10/17 12:39:20**
Vitals					
Pulse	65 -DI (r) JA (t)	64 -DI (r) JA (t)	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)
BP	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)
SpO2	—	—	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)
Row Name	**01/10/17 1230**	**01/10/17 12:24:19**	**01/10/17 12:09:22**	**01/10/17 12:07:46**	**01/10/17 1055**
Vitals					
Temp	—	98.6 °F (37 °C) -DI (r) JA (t)	—	—	—
Pulse	—	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	59 -DW
Resp	—	—	—	—	15 -DW
BP	—	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)	127/65 -DI (r) JA (t)	125/53 -DW
SpO2	—	—	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	99 % -DW
O2 Device	—	—	—	—	Nasal cannula -DW
Output (mL)					
Urine	300 mL -JA	—	—	—	—
Row Name	**01/10/17 1037**	**01/10/17 1027**	**01/10/17 1020**	**01/10/17 1004**	**01/10/17 08:07:03**
Vitals					
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
BP	132/58 -DW	131/58 -DW	131/58 -DW	146/67 -DW	—
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
O2 Device	Nasal cannula -DW	—	Nasal cannula -DW	Nasal cannula -DW	Nasal cannula -RB
Row Name	**01/10/17 0722**	**01/10/17 0710**	**01/10/17 0709**		
Vitals					
Temp	—	97.6 °F (36.4 °C) -DW	—		
Temp src	—	Oral -DW	—		
Pulse	—	64 -DW	—		
Heart Rate Source	—	Monitor -DW	—		
Resp	—	16 -DW	—		
BP	—	137/55 -DW	—		
Patient Position	—	Sitting -DW	—		
SpO2	—	97 % -DW	—		
Height	—	—	67" (1.702 m) -DW		
Weight	—	—	96.2 kg (212 lb) -DW		
Weight Method	—	—	Stated -DW		
sodium chloride 0.9% (NS) bolus					
Bolus Dose	3 mL/kg/hr -DW	—	—		

Flowsheets (all recorded)

Screenings

Row Name	01/11/17 1200	01/11/17 0715	01/10/17 2100	01/10/17 1200	01/10/17 0711
Advance Directives (For Healthcare)					
Advance Directive	---	---	---	Patient does not have advance directive -JA	---
Healthcare Agent Appointed	---	---	---	Yes -JA	---
Healthcare Agent's Name	—	—	—	wife -JA	—
Pre-existing Allow Natural Death Order	—	—	—	No -JA	—
Information Provided on Healthcare Directives	---	---	---	Yes -JA	---
Patient Requests Assistance (Retired)	—	—	—	No -JA	—
Nutrition Screen Scoring					
Weight Loss in the past 3 months	---	---	---	1 -JA	---
BMI (Body Mass Index)	—	—	—	0 -JA	—
Appetite	—	—	—	0 -JA	—
Ability to eat/retain food	---	---	---	0 -JA	---
Stress factors	—	—	—	0 -JA	—
Total Nutrition Screen Score	—	—	—	1 -JA	—
ADL Screening					
Patient's Vision Adequate to Safely Complete Daily Activities	—	—	—	Yes -JA	—
Patient's Judgement Adequate to Safely Complete Daily Activities	---	---	---	Yes -JA	---
Patient's Memory Adequate to Safely Complete Daily Activities	---	---	---	Yes -JA	---
Patient Able to Express Needs/Desires	—	—	—	Yes -JA	—
Which is your dominant hand?	---	---	---	Right -JA	---
Dressing	—	—	—	Independent -JA	—
Grooming	—	—	—	Independent -JA	—
Feeding	---	---	---	Independent -JA	---
Bathing	---	---	---	Independent -JA	---
Toileting	—	—	—	Independent -JA	—
In/Out Bed	—	—	—	Independent -JA	—
Walks in Home	---	---	---	Independent -JA	---
Weakness of Legs	—	—	—	None -JA	—
Weakness of Arms/Hands	—	—	—	None -JA	—
Hearing - Right Ear	---	---	---	Functional -JA	---
Hearing - Left Ear	---	---	---	Functional -JA	---
Assistive Devices					
Assistive Devices	---	---	---	None -JA	---
Therapy Consults (RETIRED)					
PT Evaluation Needed (RETIRED)	2 -JA	---	---	---	---
OT Evalulation Needed (RETIRED)	2 -JA	---	---	---	---
SLP Evaluation Needed (RETIRED)	2 -JA	—	—	—	—
Values/Beliefs					
Cultural Preferences Affecting	No -JA	—	—	—	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	01/11/17 1200	01/11/17 0715	01/10/17 2100	01/10/17 1200	01/10/17 0711
Hospitalization					
Spiritual Preferences Affecting Hospitalization	No -JA	—	—	—	—
Nursing Referrals					
Spiritual Health Consult	No -JA	—	—	—	—
Social Services Consult	No -JA	—	—	—	—
Suicide/Harm Risk					
Ever harm self (Retired)	—	—	—	No -JA	No -DW
Current thoughts (Retired)	—	—	—	No -JA	No -DW
Self harm plan (Retired)	—	—	—	No -JA	—
Patient information obtained from	—	—	—	Patient -JA	Patient -DW
Braden Scale					
Sensory Perceptions	—	4 -JA	4 -SA	4 -JA	—
Moisture	—	4 -JA	4 -SA	4 -JA	—
Activity	—	3 -JA	3 -SA	3 -JA	—
Mobility	—	3 -JA	3 -SA	3 -JA	—
Nutrition	—	3 -JA	3 -SA	3 -JA	—
Friction and Shear	—	3 -JA	3 -SA	3 -JA	—
Braden Scale Score	—	20 -JA	20 -SA	20 -JA	—
Discharge Planning					
Living Situation Prior to Admission	—	—	—	Home -JA	—
Primary Caregiver	—	—	—	None -JA	—
Is Discharge Transport arranged?	—	—	—	No -JA	—
Anticipated assistance needed at discharge	—	—	—	No -JA	—
Barriers to discharge	—	—	—	No Barriers -JA	—
Discharge plan consult/Discharge referrals needed	—	—	—	n/a -JA	—
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	—	0 -JA	1 -SA	0 -JA	—
Abuse Assessment					
Safe in Home	—	—	—	Yes -JA	— -JA
Do you feel threatened or unsafe in a relationship?	—	—	—	No -JA	— -JA
Are you in immediate danger?	—	—	—	No -JA	— -JA
Do you feel neglected?	—	—	—	No -JA	— -JA
Physical harm?	—	—	—	No -JA	— -JA
Verbal harm	—	—	—	No -JA	— -JA
Abuse Re-Assessment					
Any new signs/symptoms of abuse?	—	—	—	No -JA	—

Row Name	01/10/17 0710	01/10/17 0706
Advance Directives (For Healthcare)		
Have you reviewed your Advance Directive and is it valid for this stay?	—	Not applicable -DW
Advance Directive	—	Patient does not have advance directive;Patient would not like information -DW

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	01/10/17 0710	01/10/17 0706
Information Provided on Healthcare Directives	—	No -DW
Patient Belongings at Bedside		
Belongings at Bedside	—	Clothing -DW
Belongings sent to security (Retired)	—	No -DW
(RETIRED)Belongings Sent Home	—	No -DW
Patient Medications		
Medications brought by patient?	—	No -DW
Braden Scale		
Sensory Perceptions	3 -DW	—
Moisture	4 -DW	—
Activity	4 -DW	—
Mobility	3 -DW	—
Nutrition	3 -DW	—
Friction and Shear	3 -DW	—
Braden Scale Score	20 -DW	—
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)		
Pressure ulcer present on admission	No -DW	—

Flowsheets (all recorded)

Suicide Risk

Row Name	01/10/17 1200	01/10/17 0711			
Suicide/Harm Risk					
Ever harm self (Retired)	No -JA	No -DW			
Current thoughts (Retired)	No -JA	No -DW			
Self harm plan (Retired)	No -JA	—			
Patient information obtained from	Patient -JA	Patient -DW			
Suicide Risk (Retired)					
Is patient at risk for suicide? (Retired)	—	No -DW			

Flowsheets (all recorded)

Daily Cares/Safety

Row Name	01/11/17 0715	01/11/17 0000	01/10/17 2200	01/10/17 2100	01/10/17 1800
Safe Environment					
Arm Bands On	ID;Allergies -JA	ID;Allergies -OO	—	—	ID;Allergies -SM
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -JA	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -OO	—	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked -SM
Bed type	Hillrom Clinitron Rite Hite -JA	—	—	—	Hillrom Clinitron Rite Hite -SM
Safety Alarm Verfied	—	No alarm -OO	—	—	No alarm -SM
Side Rails/Bed Safety	3/4 -JA	3/4 -OO	—	—	3/4 -SM
Fall Risk Interventions					
Fall Prevention Interventions	Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Medications reviewed;Orient to environment;Room decluttered -JA	—	—	—	Needed items within reach;Frequent Visual Checks/Rounding -SM
Fall Prevention Education Reviewed with :	Patient -JA	—	—	—	Patient;Family -SM
Mobility					
Mobility Intervention	Resting in bed -JA	Resting in bed -OO	—	—	Resting in bed -SM
Level of Assistance	Independent -JA	Minimal assist, patient does 75% or more -OO	—	—	Minimal assist, patient does 75% or more -SM
Active Range of Motion	Active -JA	—	—	—	—
Transport Method	Bed -JA	—	—	—	—
Patient Position					
Repositioned	Lying left side;Turns self -JA	Turns self -OO	—	—	Turns self -SM
Anti-Embolism Devices					
Anti-Embolism Devices	Off -JA	—	—	Off -SA	—
Hygiene					
Hygiene Performed	—	—	Linen change;Gown changed;Back rub -AK	—	—
Performed by	—	—	Nursing Staff -AK	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	No -JA	—	—	No -SA	—
IS Tx Not Given	Not Indicated -JA	—	—	Not Indicated -SA	—
Telemetry Details					
Telemetry Monitor On	Yes -JA	—	—	Yes -SA	—
Telemetry Audible	Yes -JA	—	—	Yes -SA	—
Telemetry Box Number	mx22 -JA	—	—	mx22 -SA	—
Telemetry Alarms Set	Yes -JA	—	—	Yes -SA	—

Row Name	01/10/17 1200
Safe Environment	
Arm Bands On	ID;Allergies -JA
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -JA
Bed type	Hillrom Clinitron Rite Hite -JA
Side Rails/Bed Safety	3/4 -JA
Fall Risk Interventions	

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	01/10/17 1200
Fall Prevention Interventions	Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Medications reviewed;Orient to environment;Room decluttered -JA
Fall Prevention Education Reviewed with :	Patient;Family -JA
Mobility	
Mobility Intervention	Resting in bed -JA
Level of Assistance	Independent after set-up -JA
Active Range of Motion	Active -JA
Transport Method	Wheelchair -JA
Anti-Embolism Devices	
Anti-Embolism Devices	Off -JA
Incentive Spirometer	
Is pt using incentive spirometer?	No -JA
IS Tx Not Given	Not Indicated -JA
Telemetry Details	
Telemetry Monitor On	Yes -JA
Telemetry Audible	Yes -JA
Telemetry Alarms Set	Yes -JA

Flowsheets (all recorded)

Vital Signs

Row Name	01/11/17 08:13:32	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100	01/10/17 19:53:19
Vital Signs					
Automatic Restart Vitals Timer	Yes -DI (r) MG (t)	Yes -DI (r) AK (t)	Yes -DI (r) AK (t)	—	Yes -DI (r) SM (t)
Pulse	64 -DI (r) MG (t)	65 -DI (r) AK (t)	64 -DI (r) AK (t)	—	80 -DI (r) SM (t)
Heart Rate Source	—	Monitor -AK	Monitor -OO	—	Monitor -AK
Resp	18 -DI (r) MG (t)	18 -DI (r) AK (t)	18 -DI (r) AK (t)	—	18 -DI (r) SM (t)
Respiration Source	—	visual -AK	visual -OO	—	visual -AK
BP	135/69 -DI (r) MG (t)	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)	—	154/70 -DI (r) SM (t)
BP Location	—	Left arm -AK	Right arm -OO	—	Right arm -AK
BP Method	—	Portable -AK	Portable -OO	—	Portable -AK
Patient Position	—	Supine -AK	Supine -OO	—	Standing -AK
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)	—	—
Temp src	—	Oral -AK	Oral -OO	—	—
Oxygen Therapy					
SpO2	94 % -DI (r) MG (t)	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	—	94 % -DI (r) SM (t)
O2 Device	—	None (Room air) -AK	None (Room air) -OO	None (Room air) -SA	None (Room air) -AK

Row Name	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48	01/10/17 19:25:31	01/10/17 19:09:48
Vital Signs					
Automatic Restart Vitals Timer	—	Yes -DI (r) SM (t)	—	—	—
Pulse	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)
Heart Rate Source	Monitor -AK	Monitor -AK	—	—	—
Resp	—	18 -DI (r) SM (t)	—	—	—
Respiration Source	—	visual -AK	—	—	—
BP	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)	139/66 -DI (r) SM (t)	126/60 -DI (r) SM (t)
BP Location	Right arm -AK	Right arm -AK	—	—	—
BP Method	Portable -AK	Portable -AK	—	—	—
Patient Position	Sitting -AK	Supine -AK	—	—	—
Temp	—	98 °F (36.7 °C) -DI (r) SM (t)	—	—	—
Temp src	—	Oral -AK	—	—	—
Oxygen Therapy					
SpO2	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—	—	—
O2 Device	None (Room air) -AK	None (Room air) -AK	—	—	—

Row Name	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44	01/10/17 18:09:43	01/10/17 17:55:31
Vital Signs					
Pulse	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	73 -DI (r) SM (t)
BP	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)	139/66 -DI (r) SM (t)	146/67 -DI (r) SM (t)

Row Name	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48	01/10/17 14:54:18	01/10/17 14:39:18
Vital Signs					
Automatic Restart Vitals Timer	—	—	Yes -SM	—	—
Pulse	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)	68 -DI (r) JA (t)	67 -DI (r) JA (t)
Heart Rate Source	—	—	Monitor -SM	—	—
Resp	—	—	18 -SM	—	—
Respiration Source	—	—	visual -SM	—	—
BP	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)	121/61 -DI (r) JA (t)	117/62 -DI (r) JA (t)
BP Location	—	—	Right arm -SM	—	—
BP Method	—	—	Portable -SM	—	—
Patient Position	—	—	Supine -SM	—	—
Temp	—	—	98.6 °F (37 °C) -DI (r) SM (t)	—	—
Temp src	—	—	Oral -SM	—	—
Oxygen Therapy					
SpO2	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—	—

Row Name	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 13:54:22	01/10/17 13:39:59	01/10/17 13:24:21
Vital Signs					
Pulse	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	64 -DI (r) JA (t)
BP	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)

Row Name	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:24:19	01/10/17 12:09:22
Vital Signs					

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:24:19	01/10/17 12:09:22
Pulse	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)	61 -DI (r) JA (t)	61 -DI (r) JA (t)
BP	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)
Temp	—	—	—	98.6 °F (37 °C) -DI (r) JA (t)	—
Oxygen Therapy					
SpO2	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)	—	93 % -DI (r) JA (t)

Row Name	01/10/17 12:07:46	01/10/17 1055	01/10/17 1037	01/10/17 1027	01/10/17 1020
Vital Signs					
Automatic Restart Vitals Timer	—	Yes -DW	Yes -DW	Yes -DW	Yes -DW
Pulse	59 -DI (r) JA (t)	59 -DW	60 -DW	60 -DW	57 -DW
Resp	—	15 -DW	14 -DW	16 -DW	15 -DW
BP	127/65 -DI (r) JA (t)	125/53 -DW	132/58 -DW	131/58 -DW	131/58 -DW
Oxygen Therapy					
SpO2	96 % -DI (r) JA (t)	99 % -DW	97 % -DW	96 % -DW	95 % -DW
O2 Device	—	Nasal cannula -DW	Nasal cannula -DW	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW

Row Name	01/10/17 1004	01/10/17 08:07:03	01/10/17 0710		
Vital Signs					
Automatic Restart Vitals Timer	Yes -DW	—	Yes -DW		
Pulse	58 -DW	—	64 -DW		
Heart Rate Source	—	—	Monitor -DW		
Resp	16 -DW	—	16 -DW		
BP	146/67 -DW	—	137/55 -DW		
Patient Position	—	—	Sitting -DW		
Temp	—	—	97.6 °F (36.4 °C) -DW		
Temp src	—	—	Oral -DW		
Oxygen Therapy					
SpO2	98 % -DW	—	97 % -DW		
O2 Device	Nasal cannula -DW	Nasal cannula -RB	—		
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -RB	—		

Flowsheets (all recorded)

O2 Therapy

Row Name	01/11/17 08:13:32	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100	01/10/17 19:53:19
Oxygen Therapy					
O2 Device	—	None (Room air) -AK	None (Room air) -OO	None (Room air) -SA	None (Room air) -AK
SpO2	94 % -DI (r) MG (t)	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	—	94 % -DI (r) SM (t)
Row Name	**01/10/17 19:52:21**	**01/10/17 19:50:47**	**01/10/17 17:36:52**	**01/10/17 17:36:48**	**01/10/17 12:54:21**
Oxygen Therapy					
O2 Device	None (Room air) -AK	None (Room air) -AK	—	—	—
SpO2	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	91 % -DI (r) JA (t)
Row Name	**01/10/17 12:39:20**	**01/10/17 12:09:22**	**01/10/17 12:07:46**	**01/10/17 1055**	**01/10/17 1037**
Oxygen Therapy					
O2 Device	—	—	—	Nasal cannula -DW	Nasal cannula -DW
O2 Flow Rate (L/min)	—	—	—	2 L/min -DW	2 L/min -DW
SpO2	92 % -DI (r) JA (t)	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	99 % -DW	97 % -DW
Row Name	**01/10/17 1027**	**01/10/17 1020**	**01/10/17 1004**	**01/10/17 08:07:03**	**01/10/17 0710**
Oxygen Therapy					
O2 Delivery	—	—	—	Oxygen -RB	—
O2 Device	—	Nasal cannula -DW	Nasal cannula -DW	Nasal cannula -RB	—
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -RB	—
SpO2	96 % -DW	95 % -DW	98 % -DW	—	97 % -DW

Flowsheets (all recorded)

Post Sedation Assessment

Row Name	01/11/17 08:13:32	01/11/17 0715	01/11/17 0705	01/11/17 04:09:39	01/10/17 23:01:08
Vitals					
BP	135/69 -DI (r) MG (t)	—	—	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)
Pulse	64 -DI (r) MG (t)	—	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)
Resp	18 -DI (r) MG (t)	—	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)
SpO2	94 % -DI (r) MG (t)	—	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	—	—	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)
O2 Device	—	—	—	None (Room air) -AK	None (Room air) -OO
Assessment					
Skin Color	—	Appropriate for ethnicity -JA	—	—	—
Skin Condition/Temp	—	Dry;Warm -JA	—	—	—
Numeric Pain Intensity Score 1	—	—	0 -JA	—	—

Row Name	01/10/17 2100	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48
Vitals					
BP	—	154/70 -DI (r) SM (t)	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)
Pulse	—	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)
Resp	—	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—
SpO2	—	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—
Temp	—	—	—	98 °F (36.7 °C) -DI (r) SM (t)	—
Cardiac Rhythm	Sinus bradycardia;Normal sinus rhythm -SA	—	—	—	—
O2 Device	None (Room air) -SA	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—
Assessment					
Skin Color	Appropriate for ethnicity -SA	—	—	—	—
Skin Condition/Temp	Dry;Warm -SA	—	—	—	—
Numeric Pain Intensity Score 1	—	—	0 -SA	—	—

Row Name	01/10/17 19:25:31	01/10/17 19:09:48	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44
Vitals					
BP	139/66 -DI (r) SM (t)	126/60 -DI (r) SM (t)	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)
Pulse	76 -DI (r) SM (t)	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)

Row Name	01/10/17 18:09:43	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48
Vitals					
BP	139/66 -DI (r) SM (t)	146/67 -DI (r) SM (t)	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)
Pulse	71 -DI (r) SM (t)	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)
Resp	—	—	—	—	18 -SM
SpO2	—	—	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)
Temp	—	—	—	—	98.6 °F (37 °C) -DI (r) SM (t)

Row Name	01/10/17 14:54:18	01/10/17 14:39:18	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 13:54:22
Vitals					
BP	121/61 -DI (r) JA (t)	117/62 -DI (r) JA (t)	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)
Pulse	68 -DI (r) JA (t)	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)

Row Name	01/10/17 13:39:59	01/10/17 13:24:21	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20
Vitals					
BP	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)
Pulse	65 -DI (r) JA (t)	64 -DI (r) JA (t)	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)
SpO2	—	—	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)

Row Name	01/10/17 12:24:19	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200	01/10/17 1055
Vitals					
BP	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)	127/65 -DI (r) JA (t)	—	125/53 -DW
Pulse	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	—	59 -DW
Resp	—	—	—	—	15 -DW
SpO2	—	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	—	99 % -DW
Temp	98.6 °F (37 °C) -DI (r) JA (t)	—	—	—	—
Cardiac Rhythm	—	—	—	Sinus bradycardia -JA	Sinus bradycardia -DW

Flowsheets (all recorded) (continued)

Post Sedation Assessment (continued)

Row Name	01/10/17 12:24:19	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200	01/10/17 1055
O2 Device	—	—	—	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -DW
Assessment					
Skin Color	—	—	—	Appropriate for ethnicity -JA	Appropriate for ethnicity -DW
Skin Condition/Temp	—	—	—	Dry;Warm -JA	Dry;Warm -DW
Orient/LOC	—	—	—	—	Sleeping -DW
Numeric Pain Intensity Score 1	—	—	—	0 -JA	0 -DW
Aldrete					
Activity	—	—	—	—	2 -DW
Respiration	—	—	—	—	2 -DW
Circulation	—	—	—	—	2 -DW
Consciousness	—	—	—	—	1 -DW
Color	—	—	—	—	2 -DW
Aldrete Score	—	—	—	—	9 -DW

Row Name	01/10/17 1037	01/10/17 1027	01/10/17 1020	01/10/17 1004	01/10/17 08:07:03
Vitals					
BP	132/58 -DW	131/58 -DW	131/58 -DW	146/67 -DW	—
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
Cardiac Rhythm	Normal sinus rhythm -DW	Normal sinus rhythm -DW	Sinus bradycardia -DW	Sinus bradycardia -DW	—
O2 Device	Nasal cannula -DW	—	Nasal cannula -DW	Nasal cannula -DW	Nasal cannula -RB
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -RB
Assessment					
Skin Color	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	—
Skin Condition/Temp	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW	—
Orient/LOC	Sleeping -DW	Sleeping -DW	Sleeping -DW	WDL -DW	—
Numeric Pain Intensity Score 1	0 -DW	0 -DW	0 -DW	0 -DW	—
Aldrete					
Activity	2 -DW	2 -DW	2 -DW	2 -DW	—
Respiration	2 -DW	2 -DW	2 -DW	2 -DW	—
Circulation	2 -DW	2 -DW	2 -DW	2 -DW	—
Consciousness	1 -DW	1 -DW	1 -DW	2 -DW	—
Color	2 -DW	2 -DW	2 -DW	2 -DW	—
Aldrete Score	9 -DW	9 -DW	9 -DW	10 -DW	—

Row Name	01/10/17 0710
Vitals	
BP	137/55 -DW
Pulse	64 -DW
Resp	16 -DW
SpO2	97 % -DW
Temp	97.6 °F (36.4 °C) -DW
Assessment	
Numeric Pain Intensity Score 1	0 -DW

Flowsheets (all recorded)

VTE Screening

Row Name	01/10/17 1200
Score 1 for each factor (RETIRED)	
(RETIRED) History of prior major surgery (within past 1 month)	0 -JA
(RETIRED) Pregnancy or postpartum (less than 1 month)	0 -JA
(RETIRED) Varicose Veins	0 -JA
(RETIRED) Age 41 to 59 years	0 -JA
(RETIRED) Inflammatory Bowel Disease	0 -JA
(RETIRED) Obesity (BMI 30 to 40)	0 -JA
(RETIRED) Oral Contraceptives	0 -JA
(RETIRED) Hormone Therapy	0 -JA
(RETIRED) Abnormal Pulmonary Function, COPD or Pneumonia (less than 1 month)	0 -JA
(RETIRED) Medical Patient (on bedrest)	0 -JA
(RETIRED) MI (less than 1 month)	0 -JA
(RETIRED) CHF (less than 1 month)	0 -JA
(RETIRED) Sepsis (less than 1 month)	0 -JA
(RETIRED) Swollen Legs (current)	0 -JA
(RETIRED) Total Score	0 -JA
(RETIRED) Score 2 for each factor	
(RETIRED) Major surgery (greater than 60 minutes, current admission)	0 -JA
(RETIRED) Laproscopic surgery (greater than 60 minutes)	0 -JA
(RETIRED) Arthroscopic surgery (greater than 60 minutes)	0 -JA
(RETIRED) Age 60 - 74 years	2 -JA
(RETIRED) Morbid Obesity (BMI greater than 40 to 50)	0 -JA
(RETIRED) Immobilizing cast or splint	0 -JA
(RETIRED) Central venous catheter	0 -JA
(RETIRED) Malignancy (previous)	0 -JA
(RETIRED) Total Score	2 -JA
(RETIRED) Score 3 for each factor	
(RETIRED) History of SVT, DVT/PE	0 -JA
(RETIRED) Family History of DVT/PE	0 -JA
(RETIRED) Age 75	0 -JA

Flowsheets (all recorded) (continued)

VTE Screening (continued)

Row Name	01/10/17 1200
years and over	
(RETIRED) Prior Major Surgery	0 -JA
(RETIRED) BMI > 50	0 -JA
(RETIRED) Venous stasis syndrome	0 -JA
(RETIRED) Hypercoagulable states	0 -JA
(RETIRED) Total Score	0 -JA
(RETIRED) Score 5 for each factor	
(RETIRED) Major surgery (greater than 3 hours)	0 -JA
(RETIRED) Elective Major Lower Extremity Arthroplasty	0 -JA
(RETIRED) Hip, pelvis, or leg fracture (less than 1 month)	0 -JA
(RETIRED) Stroke (less than 1 month)	0 -JA
(RETIRED) Major trauma (less than 1 month)	0 -JA
(RETIRED) Acute Spinal Cord Injury (less than 1 month)	0 -JA
(RETIRED) Paralysis (less than 1 month)	0 -JA
(RETIRED) Mechanical ventilation	0 -JA
(RETIRED) Total Score	0 -JA
Total Risk Factor Score	
VTE Total Risk Factor Score	2 -JA
VTE Prophylaxis Meets Requirements	
Is Recommended VTE Prophylaxis ordered?	Yes -JA

Flowsheets (all recorded)

Anthropometrics

Row Name	01/11/17 04:09:39	01/10/17 0709
Anthropometrics		
Height	---	67" (1.702 m) -DW
Weight	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	96.2 kg (212 lb) -DW
Weight Method	Actual -AK	Stated -DW
Weight Change	7.22 -DI (r) AK (t)	0 -DW
BMI (Calculated)	---	33.2 -DW

Flowsheets (all recorded)

Severe Sepsis Screen

Row Name	01/11/17 0830	01/10/17 2200	01/10/17 1830	01/10/17 1812	01/10/17 1230
Severe Sepsis Screening Tool					
Current Sepsis Treatment AND On IV Pressors?	No - Continue Screening -JA	No - Continue Screening -SA	—	—	No - Continue Screening -JA
Antibiotic Therapy (Non-Prophylactic) (View Only)	No- Stop screen if no to both suspected infection and antibiotic -JA	No- Stop screen if no to both suspected infection and antibiotic -SA	—	—	No- Stop screen if no to both suspected infection and antibiotic -JA
Infection					
Suspected / Documented Infection?	No- Screen for antibiotic therapy -JA	No- Screen for antibiotic therapy -SA	—	—	No- Screen for antibiotic therapy -JA
Screening Results					
Positive For Severe Sepsis ?	No- Negative for Severe Sepsis -JA	—	—	—	No- Negative for Severe Sepsis -JA
Provider Notification					
Reason for Communication (View Only	—	—	—	Other (comment) bleeding right grion -JA	—
Notification Time	—	—	1830 -JA	1812 -JA	—
Provider Name	—	—	Raquel DeCamp -JA	Raquel DeCamp -JA	—
Provider Role	—	—	PA -JA	PA -JA	—
Method of Communication	—	—	Call -JA	Perfect Serve -JA	—
Response	—	—	Other (Comment) continue to monitor -JA	Waiting for response -JA	—

Flowsheets (all recorded)

Vitals/Pain

Row Name	01/11/17 08:13:32	01/11/17 0705	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 19:53:19
OTHER					
Patient Position	—	—	Supine -AK	Supine -OO	Standing -AK
Weight Method	—	—	Actual -AK	—	—
Vitals					
BP	135/69 -DI (r) MG (t)	—	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)	154/70 -DI (r) SM (t)
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	—	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)	—
Temp src	—	—	Oral -AK	Oral -OO	—
Pulse	64 -DI (r) MG (t)	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)	80 -DI (r) SM (t)
Resp	18 -DI (r) MG (t)	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)	18 -DI (r) SM (t)
SpO2	94 % -DI (r) MG (t)	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	94 % -DI (r) SM (t)
Weight	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—	—
Vital Signs					
Heart Rate Source	—	—	Monitor -AK	Monitor -OO	Monitor -AK
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -JA	—	—	—

Row Name	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48	01/10/17 19:25:31	01/10/17 19:09:48
OTHER					
Patient Position	Sitting -AK	Supine -AK	—	—	—
Vitals					
BP	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)	139/66 -DI (r) SM (t)	126/60 -DI (r) SM (t)
Temp	—	98 °F (36.7 °C) -DI (r) SM (t)	—	—	—
Temp src	—	Oral -AK	—	—	—
Pulse	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)
Resp	—	18 -DI (r) SM (t)	—	—	—
SpO2	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—	—	—
Vital Signs					
Heart Rate Source	Monitor -AK	Monitor -AK	—	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -SA	—	—	—	—

Row Name	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44	01/10/17 18:09:43	01/10/17 17:55:31
Vitals					
BP	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)	139/66 -DI (r) SM (t)	146/67 -DI (r) SM (t)
Pulse	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	73 -DI (r) SM (t)

Row Name	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48	01/10/17 14:54:18	01/10/17 14:39:18
OTHER					
Patient Position	—	—	Supine -SM	—	—
Vitals					
BP	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)	121/61 -DI (r) JA (t)	117/62 -DI (r) JA (t)
Temp	—	—	98.6 °F (37 °C) -DI (r) SM (t)	—	—
Temp src	—	—	Oral -SM	—	—
Pulse	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)	68 -DI (r) JA (t)	67 -DI (r) JA (t)
Resp	—	—	18 -SM	—	—
SpO2	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—	—
Vital Signs					
Heart Rate Source	—	—	Monitor -SM	—	—

Row Name	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 13:54:22	01/10/17 13:39:59	01/10/17 13:24:21
Vitals					
BP	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)
Pulse	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	64 -DI (r) JA (t)

Row Name	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:24:19	01/10/17 12:09:22
Vitals					
BP	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)
Temp	—	—	—	98.6 °F (37 °C) -DI (r) JA	—

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20	01/10/17 12:24:19 (t)	01/10/17 12:09:22
Pulse	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)	61 -DI (r) JA (t)	61 -DI (r) JA (t)
SpO2	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)	—	93 % -DI (r) JA (t)

Row Name	01/10/17 12:07:46	01/10/17 1200	01/10/17 1055	01/10/17 1037	01/10/17 1027
Vitals					
BP	127/65 -DI (r) JA (t)	—	125/53 -DW	132/58 -DW	131/58 -DW
Pulse	59 -DI (r) JA (t)	—	59 -DW	60 -DW	60 -DW
Resp	—	—	15 -DW	14 -DW	16 -DW
SpO2	96 % -DI (r) JA (t)	—	99 % -DW	97 % -DW	96 % -DW
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -JA	0 -DW	0 -DW	0 -DW

Row Name	01/10/17 1020	01/10/17 1004	01/10/17 0710	01/10/17 0709	
OTHER					
Patient Position	—	—	Sitting -DW	—	
Weight Method	—	—	—	Stated -DW	
BMI (Calculated)	—	—	—	33.2 -DW	
BSA (Calculated - sq m)	—	—	—	2.13 sq meters -DW	
Pain Assessment	—	—	0-10 -DW	—	
Vitals					
BP	131/58 -DW	146/67 -DW	137/55 -DW	—	
Temp	—	—	97.6 °F (36.4 °C) -DW	—	
Temp src	—	—	Oral -DW	—	
Pulse	57 -DW	58 -DW	64 -DW	—	
Resp	15 -DW	16 -DW	16 -DW	—	
SpO2	95 % -DW	98 % -DW	97 % -DW	—	
Height	—	—	—	67" (1.702 m) -DW	
Weight	—	—	—	96.2 kg (212 lb) -DW	
Vital Signs					
Heart Rate Source	—	—	Monitor -DW	—	
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -DW	0 -DW	0 -DW	—	

Flowsheets (all recorded)

Fall Risk

Row Name	01/10/17 0710
Fall Assessment	
Patient Receiving Sedation	Yes -DW
Fall Risk	Yes -DW
Fall Band Applied	Yes -DW
Yellow socks	Yes -DW

Flowsheets (all recorded)

CARDNT HEMODYNAMIC

Row Name	01/11/17 08:13:32	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 19:53:19	01/10/17 19:52:21
Vitals					
SpO2	94 % -DI (r) MG (t)	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)
Pulse	64 -DI (r) MG (t)	65 -DI (r) AK (t)	64 -DI (r) AK (t)	80 -DI (r) SM (t)	81 -DI (r) SM (t)
Resp	18 -DI (r) MG (t)	18 -DI (r) AK (t)	18 -DI (r) AK (t)	18 -DI (r) SM (t)	—
Row Name	**01/10/17 19:50:47**	**01/10/17 19:39:48**	**01/10/17 19:25:31**	**01/10/17 19:09:48**	**01/10/17 18:54:53**
Vitals					
SpO2	92 % -DI (r) SM (t)	—	—	—	—
Pulse	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	76 -DI (r) SM (t)
Resp	18 -DI (r) SM (t)	—	—	—	—
Row Name	**01/10/17 18:39:42**	**01/10/17 18:24:44**	**01/10/17 18:09:43**	**01/10/17 17:55:31**	**01/10/17 17:39:50**
Vitals					
Pulse	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	73 -DI (r) SM (t)	71 -DI (r) SM (t)
Row Name	**01/10/17 17:36:52**	**01/10/17 17:36:48**	**01/10/17 14:54:18**	**01/10/17 14:39:18**	**01/10/17 14:24:20**
Vitals					
SpO2	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—	—	—
Pulse	72 -DI (r) SM (t)	71 -DI (r) SM (t)	68 -DI (r) JA (t)	67 -DI (r) JA (t)	67 -DI (r) JA (t)
Resp	—	18 -SM	—	—	—
Row Name	**01/10/17 14:09:18**	**01/10/17 13:54:22**	**01/10/17 13:39:59**	**01/10/17 13:24:21**	**01/10/17 12:54:21**
Vitals					
SpO2	—	—	—	—	91 % -DI (r) JA (t)
Pulse	65 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	64 -DI (r) JA (t)	60 -DI (r) JA (t)
Row Name	**01/10/17 12:39:20**	**01/10/17 12:24:19**	**01/10/17 12:09:22**	**01/10/17 12:07:46**	**01/10/17 1055**
Vitals					
SpO2	92 % -DI (r) JA (t)	—	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	99 % -DW
Pulse	63 -DI (r) JA (t)	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	59 -DW
Resp	—	—	—	—	15 -DW
Row Name	**01/10/17 1037**	**01/10/17 1027**	**01/10/17 1020**	**01/10/17 1004**	**01/10/17 09:54:55**
Vitals					
Heart Rate	—	—	—	—	56 bpm -VI
Systolic Pressure	—	—	—	—	157 mmHg -VI
Diastolic Pressure	—	—	—	—	76 mmHg -VI
Mean Pressure	—	—	—	—	104 mmHg -VI
Respiration Rate	—	—	—	—	15 breaths/min -VI
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
Row Name	**01/10/17 09:49:57**	**01/10/17 09:44:51**	**01/10/17 09:39:53**	**01/10/17 09:34:55**	**01/10/17 09:29:52**
Vitals					
SpO2	100 % -VI	100 % -VI	100 % -VI	100 % -VI	100 % -VI
Heart Rate	58 bpm -VI	61 bpm -VI	57 bpm -VI	58 bpm -VI	55 bpm -VI
Systolic Pressure	151 mmHg -VI	158 mmHg -VI	138 mmHg -VI	135 mmHg -VI	145 mmHg -VI
Diastolic Pressure	75 mmHg -VI	70 mmHg -VI	65 mmHg -VI	68 mmHg -VI	62 mmHg -VI
Mean Pressure	105 mmHg -VI	111 mmHg -VI	84 mmHg -VI	85 mmHg -VI	87 mmHg -VI
Respiration Rate	15 breaths/min -VI	16 breaths/min -VI	13 breaths/min -VI	13 breaths/min -VI	14 breaths/min -VI
Row Name	**01/10/17 09:24:52**	**01/10/17 09:19:52**	**01/10/17 09:14:49**	**01/10/17 09:09:51**	**01/10/17 0907**
Vitals					
SpO2	100 % -VI	100 % -VI	99 % -VI	100 % -VI	—
Heart Rate	55 bpm -VI	56 bpm -VI	56 bpm -VI	56 bpm -VI	—
Systolic Pressure	124 mmHg -VI	131 mmHg -VI	131 mmHg -VI	107 mmHg -VI	—
Diastolic Pressure	63 mmHg -VI	62 mmHg -VI	60 mmHg -VI	60 mmHg -VI	—
Mean Pressure	83 mmHg -VI	95 mmHg -VI	78 mmHg -VI	74 mmHg -VI	—
Respiration Rate	15 breaths/min -VI	14 breaths/min -VI	15 breaths/min -VI	12 breaths/min -VI	—
Pressure Summary					
AO Systolic Cath Pressure	—	—	—	—	111 mmHg -VI
AO Diastolic Cath Pressure	—	—	—	—	54 mmHg -VI
AO Mean Cath Pressure	—	—	—	—	75 mmHg -VI
AO Heart Rate	—	—	—	—	56 bpm -VI

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	01/10/17 09:04:45	01/10/17 08:59:46	01/10/17 08:57:02	01/10/17 08:56:56	01/10/17 08:56:28
Vitals					
SpO2	98 % -VI	98 % -VI	—	—	—
Heart Rate	64 bpm -VI	59 bpm -VI	—	—	—
Systolic Pressure	110 mmHg -VI	105 mmHg -VI	—	—	—
Diastolic Pressure	60 mmHg -VI	56 mmHg -VI	—	—	—
Mean Pressure	86 mmHg -VI	71 mmHg -VI	—	—	—
Respiration Rate	17 breaths/min -VI	14 breaths/min -VI	—	—	—
Pressure Summary					
LV Systolic Cath Pressure	—	—	—	92 mmHg -VI	105 mmHg -VI
LV Diastolic Cath Pressure	—	—	—	15 mmHg -VI	9 mmHg -VI
LV Heart Rate	—	—	—	90 bpm -VI	56 bpm -VI
AO Systolic Cath Pressure	—	—	90 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	48 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	54 mmHg -VI	—	—
AO Heart Rate	—	—	59 bpm -VI	—	—
LV End Diastolic	—	—	—	26 mmHg -VI	23 mmHg -VI

Row Name	01/10/17 08:56:24	01/10/17 08:54:48	01/10/17 08:49:48	01/10/17 08:44:50	01/10/17 08:39:43
Vitals					
SpO2	—	97 % -VI	97 % -VI	97 % -VI	98 % -VI
Heart Rate	—	59 bpm -VI	58 bpm -VI	57 bpm -VI	60 bpm -VI
Systolic Pressure	—	103 mmHg -VI	113 mmHg -VI	114 mmHg -VI	116 mmHg -VI
Diastolic Pressure	—	54 mmHg -VI	57 mmHg -VI	58 mmHg -VI	69 mmHg -VI
Mean Pressure	—	67 mmHg -VI	71 mmHg -VI	81 mmHg -VI	76 mmHg -VI
Respiration Rate	—	15 breaths/min -VI	15 breaths/min -VI	21 breaths/min -VI	17 breaths/min -VI
Pressure Summary					
LV Systolic Cath Pressure	103 mmHg -VI	—	—	—	—
LV Diastolic Cath Pressure	9 mmHg -VI	—	—	—	—
LV Heart Rate	60 bpm -VI	—	—	—	—
LV End Diastolic	21 mmHg -VI	—	—	—	—

Row Name	01/10/17 08:36:30	01/10/17 08:34:47	01/10/17 08:29:41	01/10/17 08:24:45	01/10/17 08:19:52
Vitals					
SpO2	—	95 % -VI	96 % -VI	97 % -VI	98 % -VI
Heart Rate	—	60 bpm -VI	61 bpm -VI	57 bpm -VI	57 bpm -VI
Systolic Pressure	—	107 mmHg -VI	119 mmHg -VI	101 mmHg -VI	114 mmHg -VI
Diastolic Pressure	—	54 mmHg -VI	58 mmHg -VI	55 mmHg -VI	59 mmHg -VI
Mean Pressure	—	66 mmHg -VI	72 mmHg -VI	66 mmHg -VI	79 mmHg -VI
Respiration Rate	—	17 breaths/min -VI	27 breaths/min -VI	15 breaths/min -VI	17 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	104 mmHg -VI	—	—	—	—
AO Diastolic Cath Pressure	27 mmHg -VI	—	—	—	—
AO Mean Cath Pressure	65 mmHg -VI	—	—	—	—
AO Heart Rate	59 bpm -VI	—	—	—	—

Row Name	01/10/17 08:14:48	01/10/17 08:10:54	01/10/17 08:07:30	01/10/17 0710	
Vitals					
SpO2	99 % -VI	100 % -VI	—	—	
Heart Rate	55 bpm -VI	69 bpm -VI	—	—	
Systolic Pressure	144 mmHg -VI	165 mmHg -VI	—	—	
Diastolic Pressure	66 mmHg -VI	78 mmHg -VI	—	—	
Mean Pressure	88 mmHg -VI	108 mmHg -VI	—	—	
Respiration Rate	14 breaths/min -VI	12 breaths/min -VI	—	—	
SpO2	—	—	—	97 % -DW	
Pulse	—	—	—	64 -DW	
Resp	—	—	—	16 -DW	

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	01/10/17 08:14:48	01/10/17 08:10:54	01/10/17 08:07:30	01/10/17 0710
AO Pressures				
AO Systolic	—	—	111 mmHg -VI	—
AO Diastolic	—	—	54 mmHg -VI	—
AO Mean	—	—	75 mmHg -VI	—
AO Heart Rate	—	—	56 bpm -VI	—
LV Pressures				
LV Systolic	—	—	92 mmHg -VI	—
LV End Diastolic	—	—	26 mmHg -VI	—
LV dP/dt	—	—	720 -VI	—
Data Collected				
Hemodynamic Phase	—	—	Phase: Baseline -VI	—

Flowsheets (all recorded)

Cath Lab Pain Assessment

Row Name	01/10/17 08:06:58
Pain	
Pain	No -RB

Flowsheets (all recorded)

Preop Nurse

Row Name	01/10/17 0705
Pre-op Nurse	
Pre Procedure Nurse	wehrle -DW

Flowsheets (all recorded)

DCP Assessment

Row Name	01/11/17 1200	01/10/17 1200
Patient Information		
Living Situation Prior to Admission	—	Home -JA
Primary Caregiver	—	None -JA
Discharge Plan		
Is Discharge Transport arranged?	—	No -JA
Barriers to discharge	—	No Barriers -JA
IA/UM Assessments Completed		
UM Assessment Complete	Yes -AP	—

Flowsheets (all recorded)

Daily Cares

Row Name	01/11/17 0715	01/11/17 0000	01/10/17 2200	01/10/17 2100	01/10/17 1800
Safe Environment					
Arm Bands On	ID;Allergies -JA	ID;Allergies -OO	—	—	ID;Allergies -SM
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -JA	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -OO	—	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked -SM
Bed type	Hillrom Clinitron Rite Hite -JA	—	—	—	Hillrom Clinitron Rite Hite -SM
Safety Alarm Verfied	—	No alarm -OO	—	—	No alarm -SM
Side Rails/Bed Safety	3/4 -JA	3/4 -OO	—	—	3/4 -SM
Fall Risk Interventions					
Fall Prevention Interventions	Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Medications reviewed;Orient to environment;Room decluttered -JA	—	—	—	Needed items within reach;Frequent Visual Checks/Rounding -SM
Fall Prevention Education Reviewed with :	Patient -JA	—	—	—	Patient;Family -SM
Mobility					
Mobility Intervention	Resting in bed -JA	Resting in bed -OO	—	—	Resting in bed -SM
Level of Assistance	Independent -JA	Minimal assist, patient does 75% or more -OO	—	—	Minimal assist, patient does 75% or more -SM
Active Range of Motion	Active -JA	—	—	—	—
Transport Method	Bed -JA	—	—	—	—
Patient Position					
Repositioned	Lying left side;Turns self -JA	Turns self -OO	—	—	Turns self -SM
Hygiene					
Hygiene Performed	—	—	Linen change;Gown changed;Back rub -AK	—	—
Performed by	—	—	Nursing Staff -AK	—	—
Anti-Embolism Devices					
Anti-Embolism Devices	Off -JA	—	—	Off -SA	—
Telemetry Details					
Telemetry Monitor On	Yes -JA	—	—	Yes -SA	—
Telemetry Audible	Yes -JA	—	—	Yes -SA	—
Telemetry Box Number	mx22 -JA	—	—	mx22 -SA	—
Telemetry Alarms Set	Yes -JA	—	—	Yes -SA	—
Incentive Spirometer					
Is pt using incentive spirometer?	No -JA	—	—	No -SA	—

Row Name	01/10/17 1200
Safe Environment	
Arm Bands On	ID;Allergies -JA
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -JA
Bed type	Hillrom Clinitron Rite Hite -JA
Side Rails/Bed Safety	3/4 -JA
Fall Risk Interventions	
Fall Prevention	Frequent Visual

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	01/10/17 1200
Interventions	Checks/Rounding;Needed items within reach;Adequate room lighting;Medications reviewed;Orient to environment;Room decluttered -JA
Fall Prevention Education Reviewed with :	Patient;Family -JA
Mobility	
Mobility Intervention	Resting in bed -JA
Level of Assistance	Independent after set-up -JA
Active Range of Motion	Active -JA
Transport Method	Wheelchair -JA
Anti-Embolism Devices	
Anti-Embolism Devices	Off -JA
Telemetry Details	
Telemetry Monitor On	Yes -JA
Telemetry Audible	Yes -JA
Telemetry Alarms Set	Yes -JA
Incentive Spirometer	
Is pt using incentive spirometer?	No -JA

Flowsheets (all recorded)

Arterial/Venous Sheath Assessment

Row Name	01/11/17 08:13:32	01/11/17 0715	01/11/17 04:09:39	01/10/17 23:01:08	01/10/17 2100
Sheath Insertion Site Location - Assessment					
R Radial Pulse	—	+2 -JA	—	—	+2 -SA
L Pedal Pulse	—	+2 -JA	—	—	+2 -SA
R Pedal Pulse	—	+2 -JA	—	—	+2 -SA
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -JA	—	—	+1 -SA
Vitals					
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	—	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)	—
Temp src	—	—	Oral -AK	Oral -OO	—
Pulse	64 -DI (r) MG (t)	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)	—
Heart Rate Source	—	—	Monitor -AK	Monitor -OO	—
Resp	18 -DI (r) MG (t)	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)	—
BP	135/69 -DI (r) MG (t)	—	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)	—
Patient Position	—	—	Supine -AK	Supine -OO	—
Oxygen Therapy					
SpO2	94 % -DI (r) MG (t)	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)	—
O2 Device	—	—	None (Room air) -AK	None (Room air) -OO	None (Room air) -SA
Row Name	**01/10/17 19:53:19**	**01/10/17 19:52:21**	**01/10/17 19:50:47**	**01/10/17 19:39:48**	**01/10/17 19:25:31**
Vitals					
Temp	—	—	98 °F (36.7 °C) -DI (r) SM (t)	—	—
Temp src	—	—	Oral -AK	—	—
Pulse	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)	76 -DI (r) SM (t)
Heart Rate Source	Monitor -AK	Monitor -AK	Monitor -AK	—	—
Resp	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—	—
BP	154/70 -DI (r) SM (t)	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)	139/66 -DI (r) SM (t)
Patient Position	Standing -AK	Sitting -AK	Supine -AK	—	—
Oxygen Therapy					
SpO2	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—	—
O2 Device	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—	—
Row Name	**01/10/17 19:09:48**	**01/10/17 18:54:53**	**01/10/17 18:39:42**	**01/10/17 18:24:44**	**01/10/17 18:09:43**
Vitals					
Pulse	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)
BP	126/60 -DI (r) SM (t)	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)	139/66 -DI (r) SM (t)
Row Name	**01/10/17 17:55:31**	**01/10/17 17:39:50**	**01/10/17 17:36:52**	**01/10/17 17:36:48**	**01/10/17 14:54:18**
Vitals					
Temp	—	—	—	98.6 °F (37 °C) -DI (r) SM (t)	—
Temp src	—	—	—	Oral -SM	—
Pulse	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)	68 -DI (r) JA (t)
Heart Rate Source	—	—	—	Monitor -SM	—
Resp	—	—	—	18 -SM	—
BP	146/67 -DI (r) SM (t)	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)	121/61 -DI (r) JA (t)
Patient Position	—	—	—	Supine -SM	—
Oxygen Therapy					
SpO2	—	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)	—
Row Name	**01/10/17 14:39:18**	**01/10/17 14:24:20**	**01/10/17 14:09:18**	**01/10/17 13:54:22**	**01/10/17 13:39:59**
Vitals					
Pulse	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)
BP	117/62 -DI (r) JA (t)	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)	146/74 -DI (r) JA (t)
Row Name	**01/10/17 13:24:21**	**01/10/17 13:09:22**	**01/10/17 12:54:21**	**01/10/17 12:39:20**	**01/10/17 12:24:19**
Vitals					
Temp	—	—	—	—	98.6 °F (37 °C) -DI (r) JA (t)
Pulse	64 -DI (r) JA (t)	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)	61 -DI (r) JA (t)
BP	147/67 -DI (r) JA (t)	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)	123/62 -DI (r) JA (t)
Oxygen Therapy					
SpO2	—	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)	—

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200	01/10/17 1058	01/10/17 1055
Sheath Insertion Site Location - Assessment					
Upper Extremity	—	—	—	Lt Radial -DW	—
L Pedal Pulse	—	—	+2 -JA	—	—
R Pedal Pulse	—	—	+2 -JA	—	—
Radial Band Assessment - TR Band					
TR Band Radial Compression Device?	—	—	—	Yes -DW	—
(A) Amount of air infused? (ml)	—	—	—	15 ml -DW	—
(B) Amount of Air Released? (ml)	—	—	—	3 ml -DW	—
(C) Amount of Air Remaining? (ml)	—	—	—	12 ml -DW	—
LUE Neurovascular Assessment					
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -JA	Less than/equal to 3 seconds -DW	—
LUE Color	—	—	Appropriate for ethnicity -JA	Appropriate for ethnicity -DW	—
LUE Temperature/Moisture	—	—	Warm;Dry -JA	—	—
LUE Sensation	—	—	Present -JA	Present -DW	—
L Radial Pulse	—	—	+1 -JA	+1 -DW	—
Vitals					
Pulse	61 -DI (r) JA (t)	59 -DI (r) JA (t)	—	—	59 -DW
Resp	—	—	—	—	15 -DW
BP	143/68 -DI (r) JA (t)	127/65 -DI (r) JA (t)	—	—	125/53 -DW
Oxygen Therapy					
SpO2	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	—	—	99 % -DW
O2 Device	—	—	—	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -DW

Row Name	01/10/17 1037	01/10/17 1027	01/10/17 1020	01/10/17 1004	01/10/17 08:30:42
Vitals					
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
BP	132/58 -DW	131/58 -DW	131/58 -DW	146/67 -DW	—
Oxygen Therapy					
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
O2 Device	Nasal cannula -DW	—	Nasal cannula -DW	Nasal cannula -DW	—
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW	—
ACT (Activated Clotting Time) Ref					
Dose (units/kg/hr) Heparin	—	—	—	—	*5000 Units verified by dr sheikh -JK

Row Name	01/10/17 08:15:37	01/10/17 08:07:03	01/10/17 0724	01/10/17 0710	
Sheath Insertion Site Location - Assessment					
L Pedal Pulse	—	—	+1 -DW	—	
R Pedal Pulse	—	—	+2 -DW	—	
L Posterior Tibial Pulse	—	—	+1 -DW	—	
R Posterior Tibial Pulse	—	—	+1 -DW	—	
Vitals					
Temp	—	—	—	97.6 °F (36.4 °C) -DW	
Temp src	—	—	—	Oral -DW	
Pulse	—	—	—	64 -DW	
Heart Rate Source	—	—	—	Monitor -DW	
Resp	—	—	—	16 -DW	
BP	—	—	—	137/55 -DW	
Patient Position	—	—	—	Sitting -DW	
Oxygen Therapy					
SpO2	—	—	—	97 % -DW	
O2 Device	—	Nasal cannula -RB	—	—	

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	01/10/17 08:15:37	01/10/17 08:07:03	01/10/17 0724	01/10/17 0710
O2 Flow Rate (L/min)	—	2 L/min -RB	—	—
ACT (Activated Clotting Time) Ref				
Dose (units/kg/hr) Heparin	*2 Bag -JK (r) AS (t)	—	—	—

Flowsheets (all recorded)

Patient Belongings

Row Name	01/10/17 0706
Patient Belongings at Bedside	
Belongings at Bedside	Clothing -DW
Belongings sent to security (Retired)	No -DW
(RETIRED)Belongings Sent Home	No -DW
Patient Medications	
Medications brought by patient?	No -DW

Flowsheets (all recorded)

CAGE Questionnaire

Row Name	01/10/17 1200
CAGE Questionnaire	
Have you felt the need to cut down on your drinking?	0 -JA
Have you ever felt annoyed by criticizing of your drinking?	0 -JA
Have you ever felt guilty about your drinking?	0 -JA
Have you ever felt you needed an eye-opener?	0 -JA
CAGE Score Total	0 -JA

Flowsheets (all recorded)

Adult Immunization Screening

Row Name	01/11/17 1356
Pneumococcal Screening - Age >=65	
Age >=65 Pneumococcal CONTRAINDICATIONS [Do any of the following exist?]	NONE-Continue Screening -JA
Have you ever had a pneumococcal vaccination?	Yes -JA
Date of the Vaccine? (if Known)	03/16/16 -JA
What type vaccine received ?	Unknown -JA
When did you receive the vaccine?	Received after age 65 OR less than 5 years ago (Follow up with PCP) -JA
Influenza Vaccine (Sept - March 31st)	
Have you received the Influenza Vaccine during this Flu season?	Yes -JA
Date of Immunization?	09/26/16 -JA
Meets Criteria for Influenza Vaccine?	
Patient Meets Criteria For Influenza Vaccine?	No -JA

Flowsheets (all recorded)

Cardiac Rehab Follow-up

Row Name	01/11/17 1100
Cardiac Rehab follow-up needed?	
Cardiac Rehab Follow up needed?	--- CABG hx -MT

Flowsheets (all recorded)

Complex Assessment

Row Name	01/11/17 0715	01/10/17 2100	01/10/17 1830	01/10/17 1812	01/10/17 1730
HEENT					
HEENT (WDL)	X -JA	—	—	—	—
R Eye	Impaired vision -JA	—	—	—	—
L Eye	Impaired vision -JA	—	—	—	—
Respiratory					
Respiratory Pattern	Regular -JA	—	—	—	—
Chest Assessment	Chest expansion symmetrical -JA	—	—	—	—
Bilateral Breath Sounds	Clear -JA	—	—	—	—
Cardiac					
Heart Sounds	—	S1, S2 -SA	—	—	—
Cardiac Rhythm	—	Sinus bradycardia;Normal sinus rhythm -SA	—	—	—
Heart Block Type	—	Bundle branch block -SA	—	—	—
Cardiac Monitor					
Telemetry Monitor On	Yes -JA	Yes -SA	—	—	—
Telemetry Audible	Yes -JA	Yes -SA	—	—	—
Telemetry Alarms Set	Yes -JA	Yes -SA	—	—	—
Telemetry Box Number	mx22 -JA	mx22 -SA	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	WDL -JA	X -SA	—	—	—
Cyanosis	None -JA	None -SA	—	—	—
Capillary Refill	Less than/equal to 2 seconds (All extremities) -JA	Less than/equal to 2 seconds (All extremities) -SA	—	—	—
Pulses	R radial;L radial;R pedal;L pedal -JA	R radial;L radial;R pedal;L pedal -SA	—	—	—
RUE Neurovascular Assessment					
R Radial Pulse	+2 -JA	+2 -SA	—	—	—
LUE Neurovascular Assessment					
L Radial Pulse	+2 -JA	+1 -SA	—	—	—
RLE Neurovascular Assessment					
R Pedal Pulse	+2 -JA	+2 -SA	—	—	—
LLE Neurovascular Assessment					
L Pedal Pulse	+2 -JA	+2 -SA	—	—	—
Integumentary					
Integumentary (WDL)	X -JA	X -SA	—	—	—
Skin Color	Appropriate for ethnicity -JA	Appropriate for ethnicity -SA	—	—	—
Skin Condition/Temp	Dry;Warm -JA	Dry;Warm -SA	—	—	—
Skin Integrity	Other (Comment) surgical sites -JA	Other (Comment) punture sites -SA	—	—	—
Skin Location	right groin, left radial -JA	left radial and right groin -SA	—	—	—
Skin Turgor	Non-tenting -JA	Non-tenting -SA	—	—	—
Braden Scale					
Sensory Perceptions	4 -JA	4 -SA	—	—	—
Moisture	4 -JA	4 -SA	—	—	—
Activity	3 -JA	3 -SA	—	—	—
Mobility	3 -JA	3 -SA	—	—	—
Nutrition	3 -JA	3 -SA	—	—	—
Friction and Shear	3 -JA	3 -SA	—	—	—
Braden Scale Score	20 -JA	20 -SA	—	—	—
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) El (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) El (t), automated removal, RA 1205				
Drainage Amount	—	—	—	—	Small -JA
Drainage Description	—	—	—	—	Other (Comment) red

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	01/11/17 0715	01/10/17 2100	01/10/17 1830	01/10/17 1812	01/10/17 1730
					-JA
Treatments	—	—	—	—	Other (Comment) pressure -JA
Dressing	—	—	—	—	Gauze stop at 1740 -JA
Dressing Changed	—	—	—	—	New -JA
Dressing Assesment	Clean;Dry;Intact -JA	Clean;Dry;Intact -SA	—	—	Clean;Dry;Intact -JA
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Dressing Assesment	Clean;Dry;Intact -JA	Clean;Dry;Intact -SA	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	WDL -JA	WDL -SA	—	—	—
Abdomen Inspection	Soft -JA	—	—	—	—
Bowel Sounds (All Quadrants)	Active -JA	—	—	—	—
Last BM Date	01/10/17 -JA	—	—	—	—
Psychosocial					
Psychosocial (WDL)	WDL -JA	WDL -SA	—	—	—
Provider Notification					
Reason for Communication (View Only	—	—	—	Other (comment) bleeding right grion -JA	—
Notification Time	—	—	1830 -JA	1812 -JA	—
Provider Name	—	—	Raquel DeCamp -JA	Raquel DeCamp -JA	—
Provider Role	—	—	PA -JA	PA -JA	—
Method of Communication	—	—	Call -JA	Perfect Serve -JA	—
Response	—	—	Other (Comment) continue to monitor -JA	Waiting for response -JA	—
Charting Type					
Charting Type	Shift assessment -JA	Shift assessment -SA	—	—	—

Row Name	01/10/17 1500	01/10/17 1450	01/10/17 12:07:46	01/10/17 1200	01/10/17 1058
HEENT					
HEENT (WDL)	—	—	—	X -JA	—
R Eye	—	—	—	Impaired vision -JA	—
L Eye	—	—	—	Impaired vision -JA	—
Respiratory					
Respiratory Pattern	—	—	—	Regular -JA	—
Chest Assessment	—	—	—	Chest expansion symmetrical -JA	—
Bilateral Breath Sounds	—	—	—	Clear -JA	—
Cardiac					
Cardiac Rhythm	—	—	—	Sinus bradycardia -JA	—
Cardiac Monitor					
Telemetry Monitor On	—	—	—	Yes -JA	—
Telemetry Audible	—	—	—	Yes -JA	—
Telemetry Alarms Set	—	—	—	Yes -JA	—
Peripheral Vascular					
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -JA	Less than/equal to 3 seconds -DW
LUE Neurovascular Assessment					
LUE Color	—	—	—	Appropriate for ethnicity -JA	Appropriate for ethnicity -DW
LUE Temperature/Moisture	—	—	—	Warm;Dry -JA	—
LUE Sensation	—	—	—	Present -JA	Present -DW
L Radial Pulse	—	—	—	+1 -JA	+1 -DW
RLE Neurovascular Assessment					
R Pedal Pulse	—	—	—	+2 -JA	—
LLE Neurovascular Assessment					

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	01/10/17 1500	01/10/17 1450	01/10/17 12:07:46	01/10/17 1200	01/10/17 1058
L Pedal Pulse	—	—	—	+2 -JA	—
Integumentary					
Integumentary (WDL)	—	—	—	X -JA	—
Skin Color	—	—	—	Appropriate for ethnicity -JA	—
Skin Condition/Temp	—	—	—	Dry;Warm -JA	—
Skin Integrity	—	—	—	Other (Comment) surgical -JA	—
Skin Location	—	—	—	left radial, right grion -JA	—
Skin Turgor	—	—	—	Non-tenting -JA	—
Braden Scale					
Sensory Perceptions	—	—	—	4 -JA	—
Moisture	—	—	—	4 -JA	—
Activity	—	—	—	3 -JA	—
Mobility	—	—	—	3 -JA	—
Nutrition	—	—	—	3 -JA	—
Friction and Shear	—	—	—	3 -JA	—
Braden Scale Score	—	—	—	20 -JA	—
Wound					
Type of Wound (LDA)	—	—	Surgical -JA	Surgical -JA	—
[REMOVED] Surgical 01/10/17 Groin Right					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Groin -JA Wound Location Orientation: Right -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Closure	—	—	Other (Comment) -JA	—	—
Drainage Amount	—	Moderate -JA	None -JA	—	—
Drainage Description	—	Other (Comment) red -JA	—	—	—
Treatments	—	Other (Comment) pressure -JA	—	—	—
Dressing	—	Gauze bleeding stop at 1505 -JA	Other (Comment) -JA	—	—
Dressing Changed	—	New -JA	New -JA	—	—
Dressing Assesment	—	Clean;Dry;Intact -JA	Clean;Dry -JA	—	—
[REMOVED] Surgical 01/10/17 Arm Left					
Incision Properties	Date Documented: 01/10/17 -JA Time Documented: 1200 -JA Location: Arm -JA Wound Location Orientation: Left -JA Final Assessment Date: 10/10/19 -CR (r) EI (t), automated removal, RA 1205 Final Assessment Time: 1608 -CR (r) EI (t), automated removal, RA 1205				
Drainage Amount	None -JA	—	—	—	—
Dressing	Gauze -JA	—	—	—	—
Dressing Changed	New -JA	—	—	—	—
Dressing Assesment	Clean;Dry;Intact -JA	—	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	WDL -JA	—
Abdomen Inspection	—	—	—	Soft -JA	—
Bowel Sounds (All Quadrants)	—	—	—	Active -JA	—
Psychosocial					
Psychosocial (WDL)	—	—	—	WDL -JA	—
Charting Type					
Charting Type	—	—	—	Admission -JA	—

Row Name	01/10/17 1055	01/10/17 1037	01/10/17 1027	01/10/17 1020	01/10/17 1004
Cardiac					
Cardiac Rhythm	Sinus bradycardia -DW	Normal sinus rhythm -DW	Normal sinus rhythm -DW	Sinus bradycardia -DW	Sinus bradycardia -DW
Integumentary					
Skin Color	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW	Appropriate for ethnicity -DW
Skin Condition/Temp	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW	Dry;Warm -DW

Row Name	01/10/17 0724	01/10/17 0710
Peripheral Vascular		
Peripheral Vascular (WDL)	X -DW	—
Pulses	R pedal;L posterior	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	01/10/17 0724	01/10/17 0710
	tibial;R posterior tibial;L pedal -DW	
RLE Neurovascular Assessment		
R Posterior Tibial Pulse	+1 -DW	—
R Pedal Pulse	+2 -DW	—
LLE Neurovascular Assessment		
L Posterior Tibial Pulse	+1 -DW	—
L Pedal Pulse	+1 -DW	—
Braden Scale		
Sensory Perceptions	—	3 -DW
Moisture	—	4 -DW
Activity	—	4 -DW
Mobility	—	3 -DW
Nutrition	—	3 -DW
Friction and Shear	—	3 -DW
Braden Scale Score	—	20 -DW

Flowsheets (all recorded)

Vital Signs

Row Name	01/11/17 08:13:32	01/11/17 0705	01/11/17 0418	01/11/17 04:09:39	01/10/17 23:01:08
Vital Signs					
Temp	97.5 °F (36.4 °C) -DI (r) MG (t)	—	—	98 °F (36.7 °C) -DI (r) AK (t)	98.1 °F (36.7 °C) -DI (r) AK (t)
Temp src	—	—	—	Oral -AK	Oral -OO
Pulse	64 -DI (r) MG (t)	—	—	65 -DI (r) AK (t)	64 -DI (r) AK (t)
Heart Rate Source	—	—	—	Monitor -AK	Monitor -OO
Resp	18 -DI (r) MG (t)	—	—	18 -DI (r) AK (t)	18 -DI (r) AK (t)
Respiration Source	—	—	—	visual -AK	visual -OO
BP	135/69 -DI (r) MG (t)	—	—	158/66 -DI (r) AK (t)	132/55 -DI (r) AK (t)
BP Location	—	—	—	Left arm -AK	Right arm -OO
BP Method	—	—	—	Portable -AK	Portable -OO
Patient Position	—	—	—	Supine -AK	Supine -OO
Oxygen Therapy					
SpO2	94 % -DI (r) MG (t)	—	—	92 % -DI (r) AK (t)	93 % -DI (r) AK (t)
O2 Device	—	—	—	None (Room air) -AK	None (Room air) -OO
Pain Assessment					
Currently in Pain	—	Yes -JA	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -JA	—	—	—
Pain Intervention(s)	—	Medication (see MAR) -JA	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JA	—	—	—
Height and Weight					
Weight	—	—	—	103.1 kg (227 lb 4.8 oz) -DI (r) AK (t)	—
Weight Method	—	—	—	Actual -AK	—
24 Chart Check					
24 hour chart check complete	—	—	Yes -SA	—	—

Row Name	01/10/17 2100	01/10/17 19:53:19	01/10/17 19:52:21	01/10/17 19:50:47	01/10/17 19:39:48
Vital Signs					
Temp	—	—	—	98 °F (36.7 °C) -DI (r) SM (t)	—
Temp src	—	—	—	Oral -AK	—
Pulse	—	80 -DI (r) SM (t)	81 -DI (r) SM (t)	75 -DI (r) SM (t)	78 -DI (r) SM (t)
Heart Rate Source	—	Monitor -AK	Monitor -AK	Monitor -AK	—
Resp	—	18 -DI (r) SM (t)	—	18 -DI (r) SM (t)	—
Respiration Source	—	visual -AK	—	visual -AK	—
BP	—	154/70 -DI (r) SM (t)	148/69 -DI (r) SM (t)	131/64 -DI (r) SM (t)	140/68 -DI (r) SM (t)
BP Location	—	Right arm -AK	Right arm -AK	Right arm -AK	—
BP Method	—	Portable -AK	Portable -AK	Portable -AK	—
Patient Position	—	Standing -AK	Sitting -AK	Supine -AK	—
Oxygen Therapy					
SpO2	—	94 % -DI (r) SM (t)	94 % -DI (r) SM (t)	92 % -DI (r) SM (t)	—
O2 Device	None (Room air) -SA	None (Room air) -AK	None (Room air) -AK	None (Room air) -AK	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -SA	—	—

Row Name	01/10/17 19:25:31	01/10/17 19:09:48	01/10/17 18:54:53	01/10/17 18:39:42	01/10/17 18:24:44
Vital Signs					
Pulse	76 -DI (r) SM (t)	71 -DI (r) SM (t)	76 -DI (r) SM (t)	71 -DI (r) SM (t)	71 -DI (r) SM (t)
BP	139/66 -DI (r) SM (t)	126/60 -DI (r) SM (t)	123/68 -DI (r) SM (t)	140/63 -DI (r) SM (t)	136/62 -DI (r) SM (t)

Row Name	01/10/17 18:09:43	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48
Vital Signs					
Temp	—	—	—	—	98.6 °F (37 °C) -DI (r) SM (t)
Temp src	—	—	—	—	Oral -SM
Pulse	71 -DI (r) SM (t)	73 -DI (r) SM (t)	71 -DI (r) SM (t)	72 -DI (r) SM (t)	71 -DI (r) SM (t)
Heart Rate Source	—	—	—	—	Monitor -SM

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	01/10/17 18:09:43	01/10/17 17:55:31	01/10/17 17:39:50	01/10/17 17:36:52	01/10/17 17:36:48
Resp	—	—	—	—	18 -SM
Respiration Source	—	—	—	—	visual -SM
BP	139/66 -DI (r) SM (t)	146/67 -DI (r) SM (t)	119/58 -DI (r) SM (t)	—	147/65 -DI (r) SM (t)
BP Location	—	—	—	—	Right arm -SM
BP Method	—	—	—	—	Portable -SM
Patient Position	—	—	—	—	Supine -SM
Oxygen Therapy					
SpO2	—	—	—	90 % -DI (r) SM (t)	91 % -DI (r) SM (t)

Row Name	01/10/17 14:54:18	01/10/17 14:39:18	01/10/17 14:24:20	01/10/17 14:09:18	01/10/17 13:54:22
Vital Signs					
Pulse	68 -DI (r) JA (t)	67 -DI (r) JA (t)	67 -DI (r) JA (t)	65 -DI (r) JA (t)	67 -DI (r) JA (t)
BP	121/61 -DI (r) JA (t)	117/62 -DI (r) JA (t)	133/63 -DI (r) JA (t)	120/64 -DI (r) JA (t)	152/70 -DI (r) JA (t)

Row Name	01/10/17 13:39:59	01/10/17 13:24:21	01/10/17 13:09:22	01/10/17 12:54:21	01/10/17 12:39:20
Vital Signs					
Pulse	65 -DI (r) JA (t)	64 -DI (r) JA (t)	—	60 -DI (r) JA (t)	63 -DI (r) JA (t)
BP	146/74 -DI (r) JA (t)	147/67 -DI (r) JA (t)	149/68 -DI (r) JA (t)	143/64 -DI (r) JA (t)	135/66 -DI (r) JA (t)
Oxygen Therapy					
SpO2	—	—	—	91 % -DI (r) JA (t)	92 % -DI (r) JA (t)

Row Name	01/10/17 12:24:19	01/10/17 12:09:22	01/10/17 12:07:46	01/10/17 1200	01/10/17 1055
Vital Signs					
Temp	98.6 °F (37 °C) -DI (r) JA (t)	—	—	—	—
Pulse	61 -DI (r) JA (t)	61 -DI (r) JA (t)	59 -DI (r) JA (t)	—	59 -DW
Resp	—	—	—	—	15 -DW
BP	123/62 -DI (r) JA (t)	143/68 -DI (r) JA (t)	127/65 -DI (r) JA (t)	—	125/53 -DW
Oxygen Therapy					
SpO2	—	93 % -DI (r) JA (t)	96 % -DI (r) JA (t)	—	99 % -DW
O2 Device	—	—	—	—	Nasal cannula -DW
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -DW
Pain Assessment					
Currently in Pain	—	—	—	No -JA	—
Which Pain Assessment Tool ?	—	—	—	Numeric (0-10) -JA	—
Pain Intervention(s)	—	—	—	Medication (see MAR) -JA	—
Pain Goal					
Patient's Stated Pain Goal	—	—	—	0 (No Pain) -JA	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	0 -JA	0 -DW

Row Name	01/10/17 1037	01/10/17 1027	01/10/17 1020	01/10/17 1004	01/10/17 08:07:03
Vital Signs					
Pulse	60 -DW	60 -DW	57 -DW	58 -DW	—
Resp	14 -DW	16 -DW	15 -DW	16 -DW	—
BP	132/58 -DW	131/58 -DW	131/58 -DW	146/67 -DW	—
Oxygen Therapy					
SpO2	97 % -DW	96 % -DW	95 % -DW	98 % -DW	—
O2 Device	Nasal cannula -DW	—	Nasal cannula -DW	Nasal cannula -DW	Nasal cannula -RB
O2 Flow Rate (L/min)	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -DW	2 L/min -RB
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -DW	0 -DW	0 -DW	0 -DW	—

Row Name	01/10/17 0710	01/10/17 0709
Vital Signs		
Temp	97.6 °F (36.4 °C) -DW	—
Temp src	Oral -DW	—
Pulse	64 -DW	—
Heart Rate Source	Monitor -DW	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	01/10/17 0710	01/10/17 0709
Resp	16 -DW	—
BP	137/55 -DW	—
Patient Position	Sitting -DW	—
Oxygen Therapy		
SpO2	97 % -DW	—
Numeric Pain Intensity Scale		
Numeric Pain Intensity Score 1	0 -DW	—
Height and Weight		
Height	—	67" (1.702 m) -DW
Weight	—	96.2 kg (212 lb) -DW
Weight Method	—	Stated -DW
BSA (Calculated - sq m)	—	2.13 sq meters -DW
BMI (Calculated)	—	33.2 -DW
Weight in (lb) to have BMI = 25	—	159.3 -DW

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
JK	Julie Kraftzenk, RN	09/03/14 - 02/02/17
MG	Marie O Germain	05/27/14 - 02/02/17
SA	Sophia B Agyepong, RN	04/02/14 - 02/02/17
AP	Aleyamma Philip, RN	04/02/14 - 02/02/17
AK	Anna Kangue, CNA	04/05/14 - 02/02/17
AS	Abdul M Sheikh, MD	01/07/17 - 01/12/17
OO	Ololade Olutola, CNA	04/05/14 - 02/02/17
MT	Marie Thomas-Stanley, RN	04/02/14 - 02/02/17
SS	Shawn J Shy, RN	04/02/14 - 02/02/17
DW	Dianne W Wehrle, RN	09/03/14 - 02/02/17
SM	Samantha McGill	11/19/14 - 02/02/17
JA	Jane Abey, RN	01/29/16 - 02/02/17
RB	Robert Beyerlein	10/17/16 - 02/02/17
CR	Chris Russell	—
DI	Interface, Doc Flowsheet In	—
VI	Interface, Vs Maclab Incoming	—
EI	Epicweb Interface	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 01/10/2017:

Scan on 1/12/2017 8:22 AM (below)

Scan on 1/10/2017 7:03 AM by Crystal D Johnson: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	IP			Unit:	CH CARD ARU
Hospital Service:	Cardiology			Bed:	CH Cardiac ARU Pool/CH C*
Admitting Provider:	Abdul M Sheikh, Md			Referring Physician:	
Attending Provider:	Abdul m sheikh	AD: N		Adm Diagnosis:	Palpitations [R00.2]
Admission Date:	5/1/2017			Admission Time:	0645

PATIENT

Name	Eugene George Maurice		Sex: Male	DOB:	1/2/1949 (68 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer:	Phone:	Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977	Co-In: Deductible: Out of Pocket Max:	

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial# April 7, 2020 Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	05/01/2017 0645	IP Adm. Date/Time:	05/01/2017 0703
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Cardiology	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cobb Hospital (CH CARDIAC ARU)
Admit Provider:	Abdul M Sheikh, MD	Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/01/2017 1148	Home Or Self Care	Home	None	WellStar Cobb Hospital (CH CARDIAC ARU)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.119 **[Principal]**	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	Yes	No		Yes
I10	Essential (primary) hypertension	Yes	No		No
E78.5	Hyperlipidemia, unspecified	Yes	No		No
I25.719	Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris	Yes	No		No
I73.9	Peripheral vascular disease, unspecified	Yes	No		No
E66.9	Obesity, unspecified	Yes	No		No
Z68.33	Body mass index (bmi) 33.0-33.9, adult	Exempt from POA reporting	No		No
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting	No		No
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting	No		No
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system	Exempt from POA reporting	No		No
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting	No		No
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting	No		No

Events

Admission at 5/1/2017 0645

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Hospital Outpatient Surgery Service: General Surgery

Patient Update at 5/1/2017 0703

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Inpatient Service: Cardiology

Transfer Out at 5/1/2017 0705

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool
Patient class: Inpatient Service: Cardiology

Transfer In at 5/1/2017 0705

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) Room: CH Cardiac ARU Pool Bed: CH Cardiac ARU Pool
Patient class: Inpatient Service: Cardiology

Transfer Out at 5/1/2017 0809

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) Room: CH Cardiac ARU Pool Bed: CH Cardiac ARU Pool
Patient class: Inpatient Service: Cardiology

Transfer In at 5/1/2017 0809

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) Room: CH CATH Pool Bed: CH Cath/EP Lab Pool

All Scans (continued)

Events (continued)

Patient class: Inpatient — Service: Cardiology

Surgery at 5/1/2017 0809

Unit: CH CARDIAC CATH LAB — Room: CH CATH/EP LAB 1
Patient class: Hospital Outpatient Surgery — Service: Cardiovascular

Transfer Out at 5/1/2017 0842

Unit: WellStar Cobb Hospital (CH CATH/EP LAB) — Room: CH CATH Pool — Bed: CH Cath/EP Lab Pool
Patient class: Inpatient — Service: Cardiology

Transfer In at 5/1/2017 0842

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) — Room: CH Cardiac ARU Pool — Bed: CH Cardiac ARU Pool
Patient class: Inpatient — Service: Cardiology

Discharge at 5/1/2017 1148

Unit: WellStar Cobb Hospital (CH CARDIAC ARU) — Room: CH Cardiac ARU Pool — Bed: CH Cardiac ARU Pool
Patient class: Inpatient — Service: Cardiology

Allergies as of 5/1/2017

Reviewed on 5/1/2017

No Known Allergies

Immunizations as of 5/1/2017

Immunizations never marked as reviewed

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN — Administered on: 9/26/2016 — Dose: 0.5 mL
Site: Left deltoid — Route: Intramuscular — NDC: 49281-399-88
CVX code: 135 — VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur — Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA — Administered on: 3/16/2016 — Dose: 0.5 mL
Site: Left deltoid — Route: Intramuscular — NDC: 0005-1971-01
CVX code: 133 — VIS date: 031616
Manufacturer: Wyeth-Ayerst — Lot number: M51193

Medical as of 5/1/2017

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source

All Scans (continued)

Medical as of 5/1/2017 (continued)

Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Cancer (HCC) [C80.1]	04/07/2014	—	Provider
Chronic kidney disease [N18.9]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction [I21.3]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

H&P - Encounter Notes

H&P by Abdul M Sheikh, MD at 5/1/2017 8:01 AM

Author: Abdul M Sheikh, MD
Filed: 5/1/2017 8:01 AM
Editor: Abdul M Sheikh, MD (Physician)

Service: Cardiology
Date of Service: 5/1/2017 8:01 AM

Author Type: Physician
Status: Signed

EUGENE G MAURICE
1/2/1949
561253820

HPI

Eugene G Maurice is a 66 y.o. male seen in the office today for follow up of CAD. He underwent catheterization and PTCA of stenosed vein grafts earlier this year. Comes back now with recurrent anginal symptoms. Suspicion is of recurrent stenosis within the same grafts. Has also noted intermittent palpitation symptoms. When he has his palpitations he does have some associated chest discomfort.

ROS

General	denies c/o	Abdominal	denies c/o
Skin	denies c/o	Musculoskeletal	denies c/o
Eyes	denies c/o	Neuro	denies c/o
Ears/nose/throat	denies c/o	Psych	denies c/o
Resp	denies c/o	Endocrine	denies c/o
CV	see HPI	Heme	denies c/o

H&P by Abdul M Sheikh, MD at 5/1/2017 8:01 AM (continued)

DATA REVIEW

Data Review

	1/30/17
EKG	**1-11-17 EKG-NSR, LAD, LBBB**
Echocardiogram	**03/29/16 ejection fraction is 50-55%. There is mild mitral valve regurgitation present.**
Carotid Duplex	**08/20/2014 Hemodynamically significant stenosis of 50-79% in the right internal carotid artery. Essentially normal post-carotid endarterectomy duplex evaluation of the left internal carotid artery. Normal antegrade right and left vertebral artery flow. There has been no significant change from the previous study.**
Myocardial Perfusion Imaging, Exercise	**5/15: Positive, high risk**
Myocardial Perfusion Imaging, Lexiscan	**1/08: negative for ischemia**
Cardiac Catheterization	**1-10-17 heart cath-Severe native vessel disease, Patent LIMA-LAD. Severe ISR (DES) of SVGs to OMs and PDA, Preserved EF, Successful POBA of SVGs to OM and PDA with NC/cutting balloons.**
PCI	**5/14: 4.0/15 Resolute DES to prox SVG-OM, 4.0/18 Resolute DES to SVG-PDA, 5/15: 4.0/16 Promus in SVG-PDA (distal to prior stent), 3.5/16, 3.5/38, and 3.0/38 Promus in SVG-OM**
Cardiac Surgery	**1992: CABG (in Nashville, TN)**
Peripheral Vascular Procedures	**Right CEA January 2014**

PAST MEDICAL HX

he has a past medical history of Other symptoms involving cardiovascular system; Coronary atherosclerosis of native coronary artery; Family history of ischemic heart disease; Other and unspecified hyperlipidemia; Essential hypertension, benign; PVD (peripheral vascular disease); Obesity; Hypertension; Hyperlipidemia; and CAD (coronary artery disease).

SOCIAL HX

History	History	History
Smoking status • Former Smoker -- 1.00 packs/day for 25 years • Types: Cigarettes • Quit date: 04/07/1992	Alcohol Use • Yes	Drug Use No
Smokeless tobacco • Never Used		

FAMILY HX

family history includes Coronary artery disease in his mother and Other in his brother and mother. There is no history of Anemia, and Arrhythmia, and Asthma, and Clotting disorder, and Fainting, and Heart attack, and Heart disease, and Heart failure, and Hyperlipidemia, and Hypertension, and Stroke, .

ALLERGIES

Allergies as of 04/07/2014

- (No Known Allergies)

MEDICATIONS

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• aspirin, buffered 81 mg Tab	Take 81 mg by mouth daily.		
• carvedilol (COREG) 12.5 MG tablet	Take 12.5 mg by mouth 2 (two) times a day with meals.		
• chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily.	30 tablet	11
• ezetimibe-simvastatin (VYTORIN 10-80) 10-80 mg per tablet	Take 1 tablet by mouth 3 (three) times a week.		
• ramipril (ALTACE) 10 MG capsule	Take 10 mg by mouth 2 (two) times a day.		
• isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 1 tablet (30 mg total) by mouth daily.	30 tablet	4

No current facility-administered medications for this visit.

EXAM

Vitals

Vitals:

	04/25/17 1606
BP:	118/58
Pulse:	60
Weight:	99.3 kg (219 lb)

Height: 67" (1.702 m)

General	Alert, oriented, NAD	Extremities	No edema, normal pulses
Skin	Warm, no rashes	Abdomen	Soft, nt/nd, normal bowel sound
Neck	JVP normal, no bruit	Neuro	Grossly normal
Chest	clear bilaterally, normal effort	Psych	Grossly normal
Cardiac	Regular,2/6 SEM, no r/g, PMI nl		

LABS

Lab Results

Component	Value	Date
POTASSIUM	4.7	2/21/2014
BUN	30*	2/21/2014
CREATININE	1.17	2/21/2014
GFRNONAA	>60	2/21/2014
ALT	30	2/17/2014
AST	26	2/17/2014

No results found for this basename: CHOL, TRIG, HDL, LDLCHOL

Lab Results

Component	Value	Date
HGB	11.1*	2/21/2014
HCT	34*	2/21/2014
PLT	146*	2/21/2014

No results found for this basename: BNP, TSH

ASSESSMENT/PLAN

1. **CAD (coronary artery disease)**
2. Essential hypertension, benign
3. PVD (peripheral vascular disease)
4. Hyperlipidemia

Mr. Maurice is a pleasant 68 y.o. male with CAD. Now with recurrence of anginal symptoms. Suspicion is of recurrent stenosis within his pain graft to his circumflex and right coronary arteries. Also having palpitations which are new.

- I will schedule him for repeat catheterization. If he does have recurrent stenosis in his vein grafts I

think the best option for him would be redo bypass surgery. His native vessels are not well suited for CTO intervention.

- He will continue his current medications.
- I will have him wear an event recorder given his symptoms of palpitations.

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

Abdul M Sheikh, MD

Electronically Signed by Abdul M Sheikh, MD on 5/1/2017 8:01 AM

Surgery Report

General Information

Date: 5/1/2017 | Time: 0750 | Status: Posted
Location: CH CARDIAC CATH LAB | Room: Cath Lab 1 | Service: Cardiovascular
Patient class: Hospital Outpatient Surgery | Case classification:

Diagnosis Information

Diagnosis
Palpitations
Coronary arteriosclerosis
Coronary artery disease involving native coronary artery of native heart without angina pectoris

Case Tracking Events

Event	Time In
In Facility	0645
In ARU Prep	0705
ARU Prep Complete	
Out of ARU Prep	0807
Ready for Procedure	
In Room	0809
Moderate Sedation Begin	0819
Moderate Sedation End	0838
Out of Room	0842
In ARU Recovery	0843
ARU Recovery Complete	1148
Out of ARU Recovery	1148
Remove from Status Board	1150
In Phase I	
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Anesthesia Ready	
Anesthesia Start	
Anesthesia Stop	
Anesthesia Follow-up Complete	
Anesthesia Follow-up Needed	

Panel Information

Panel 1

Provider	Role	Service
Abdul M Sheikh, MD	Primary	Cardiovascular

Procedure: ~

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region
N/A			Local	

~ (N/A) - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: Left ventriculography

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region

Left ventriculography - Position 1

Body: | Left Arm: | Right Arm:
Head: | Left Leg: | Right Leg:

Procedure: Coronary angiography

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region

Coronary angiography - Position 1

Surgery Report (continued)

Panel Information (continued)

Body:	Left Arm:	Right Arm:
Head:	Left Leg:	Right Leg:

Procedure: Left heart cath - bypass graft

Laterality	Wound Class	Incision Closure	Anesthesia	Op Region	

Left heart cath - bypass graft - Position 1

Body:	Left Arm:	Right Arm:
Head:	Left Leg:	Right Leg:

Staff Info

Staff Type	Staff Member	Start	End	OT
CV Monitor	**Lauren W Kerns, ARRT**	0809	0813	
CV Scrub Person	**Isis Zometa, RCIS**	0809	0842	
CV Circulator	**Julie Kraftzenk, RN**	0809	0842	
CV Monitor	**Kathryn M Vise, RN**	0813	0842	

Questionnaire Data

None

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Diagnoses

Present?	Description (Code)
Yes	Risk for infection (X28)
Yes	Risk for injury (X29)
Yes	Deficient knowledge (X30)
Yes	Acute pain (X38)
Yes	Anxiety (X4)
Yes	Risk for impaired skin integrity (X51)
Yes	Risk for imbalanced body temperature (X57)
Yes	Ineffective breathing pattern (X7)

Log Completed By

Kathryn M Vise, RN	5/1/2017	0843

Log Verified By

Kathryn M Vise, RN	5/1/2017	0823
Rebecca Chism, RN	5/1/2017	0841
Kathryn M Vise, RN	5/1/2017	0843

Surgery Report (continued)

Log Verified By (continued)

Abdul M Sheikh, MD	5/1/2017	0846

Do Not Proceed History

No information present

Implants

Implants

STARCLOSE SE 6F CLOSURE - LOG377622

Inventory Item: STARCLOSE SE 6F CLOSURE
Implant name: STARCLOSE SE 6F CLOSURE - LOG377622
Manufacturer: ABBOTT VASCULAR
Action: Implanted
Device Identifier: 08717648175060
Serial no.:
Laterality: Right
Date of Manufacture:
Number Used: 1
Device Identifier Type: GS1
Model/Cat no.: 14679-05
Area: Arterial

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: Yes

Pre-Procedure Verification

H&P note verified?: Yes
Consents verified?: Yes
Site marked?: N/A
Allergies reviewed?: Yes

Surgeons Present: Abdul M Sheikh, MD
Staff Present: Lauren W Kerns, ARRT, Isis Zometa, RCIS, Julie Kraftzenk, RN, Kathryn M Vise, RN

Verification Date and Time: 5/1/2017 8:23 AM

Nursing - Orders and Results

DAILY WEIGHTS [669536695]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Daily 05/02/17 0600 - Until Specified
Released by: Susan Colston, RN 05/01/17 0845
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order

Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

AMBULATE PATIENT [669536705]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: With assistance after bedrest complete. If tolerated, may resume previously ordered activity level

Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

VITAL SIGNS [669536708]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4

Order comments: Check while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

Nursing - Orders and Results (continued)

VITAL SIGNS [669536708] (continued)

PUNCTURE SITE CARE [669536709]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4

Order comments: Check while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

POST PROCEDURE SITE ASSESSMENT [669536710]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4

Order comments: Check pulses while sheath is intact. Repeat immediately after sheath removal. If oozing check every hour.

NEURO/VASCULAR CHECKS [669536711]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Questionnaire

Question	Answer
Q15 minutes x	4
Q30 minutes x	4
Q2 hours x	6
Then:	Q2h

ORTHOSTATIC BLOOD PRESSURE [669536712]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Check standing blood pressure post sheath removal when first allowed to stand.

INTAKE AND OUTPUT [669536713]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

STRAIGHT CATH [669536714]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844 — Ordering provider: Abdul M Sheikh, MD

Nursing - Orders and Results (continued)

STRAIGHT CATH [669536714] (continued)

Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: If unable to void

NURSING COMMUNICATION [669536715]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536716]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536717]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536718]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536719]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

BED REST [669536720]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: And for 2 hours post sheath removal/closure device placement. May elevate head of bed to 30 degrees, keep punctured leg straight while on bedrest

NURSING COMMUNICATION [669536721]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: This was discussed with the patient and/or patient representative.

NOTIFY PHYSICIAN (SPECIFY) [669536722]

Nursing - Orders and Results (continued)

NOTIFY PHYSICIAN (SPECIFY) [669536722] (continued)

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: if glucose less than 80 OR greater than 400, GFR less than 50 AND patient NOT on dialysis, potassium less than 3.5 or greater than 5.1, platelet count less than 100,000, INR greater than 1.5 (for patients on warfarin).

PROVIDE PATIENT EDUCATION MATERIALS [669536723]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Provide patient/family pre-procedure education and document. Place patient on Cardiac Cath/Intervention Clinical Pathway

VERIFY INFORMED CONSENT [669536724]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Verify cardiac catheterization consent form is signed, dated, timed, and witnessed prior to start of procedure

NURSING COMMUNICATION [669536725]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

HEIGHT AND WEIGHT [669536726]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536727]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Hold diuretics and oral hypoglycemic medications including metformin and sulfonylureas (e.g. glipizide, glyburide, glimepiride) the morning of the procedure.

NURSING COMMUNICATION [669536728]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [669536728] (continued)

Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Obtain BBG on call to cath lab and document on pre-procedure checklist.

NURSING COMMUNICATION [669536729]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Have patient void before transport, no metal snaps on gown, patient may wear dentures, glasses, hearing aids

NURSING COMMUNICATION [669536731]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536732]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536733]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536734]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536735]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [669536736]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536737]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536738]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

NURSING COMMUNICATION [669536739]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Clip bilateral groin and thighs from lower abdomen to knee, and from the medial aspect to the lateral aspect of the thigh

NURSING COMMUNICATION [669536740]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Questionnaire

Question	Answer
Right or Left	Right

Order comments: Clip the arm from the medial aspect to the lateral aspect of the arm (complete groin prep in addition to radial prep)

MAINTAIN IV ACCESS [669537048]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715 — Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD — Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1 — Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Code Status - Orders and Results

Code Status - Orders and Results (continued)

FULL CODE [669536707]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Code status: Full Code
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

ECG - Orders and Results

EKG, 12-LEAD [669537046]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Active**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

Questionnaire

Question	Answer
Reason for Exam:	Chest pain

Order comments: if not done within the past 48 hours for inpatients or 1 week for outpatients. Have results by 6 am

IV - Orders and Results

INSERT PERIPHERAL IV [669536730]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Order comments: Start one IV, 20 gauge or larger (preferably in left arm by 6am day of procedure). Saline flush every 8 hours (Avoid Right arm for radial cath)

INSERT PERIPHERAL IV [669537047]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

INT [669537049]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

Admission - Orders and Results

ADMIT AS INPATIENT [669521893]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242** — Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Susan Colston, RN 05/01/17 0703
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Communicated by: Susan Colston, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 7:03 AM

Questionnaire

Admission - Orders and Results (continued)

ADMIT AS INPATIENT [669521893] (continued)

Question	Answer
Estimated inpatient length of stay?	<2 Midnights
Certification	I certify that inpatient services are reasonable and necessary and have been ordered appropriately. I believe the patient needs to stay at least 2 Midnights. Please see clinical documentation for reason for admission and plans for post hospital care.
Diagnosis	S/P cardiac cath
Admitting Provider	SHEIKH, ABDUL M
Attending Provider	SHEIKH, ABDUL M
Bed Type	Cardiac Telemetry
Hospital Area	WS Cobb Hospital
Bed request comments	PCI bed please

Discharge - Orders and Results

DISCHARGE PATIENT [669536704]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM

Cardiac Cath - Orders and Results

CARDIAC PROCEDURE [653604307]

Electronically signed by: **Tammy R Riddle Threatt on 04/26/17 1016** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Tammy R Riddle Threatt 04/26/17 1016
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Tammy R Riddle Threatt 4/26/2017 10:16 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

Diagnoses
Palpitations [R00.2]
Coronary arteriosclerosis [I25.10]
Coronary artery disease involving native coronary artery of native heart without angina pectoris [I25.10]

CARDIAC PROCEDURE [653604307] Resulted: 05/01/17 0844, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 04/26/17 1016
Resulted by: Abdul M Sheikh, MD
Performed: 05/01/17 0809 - 05/01/17 0842
Resulting lab: CATH/EP
Order status: Completed
Filed by: Abdul M Sheikh, MD 05/01/17 0846
Accession number: 28308410
Result details

Narrative:
- Severe native vessel disease.
- Low normal EF with mild inferobasal hypokinesis.
- Patent LIMA to D1/LAD.
- SVG to PDA with mild ISR proximally and moderate disease in mid segment.
- SVG to OM2/3 occluded.

Procedures Performed	Chargeables
CORONARY ANGIOGRAPHY [CATH03]	
LEFT HEART CATHETERIZATION W/GRAFTS [CATH71]	
LEFT HEART CATHETERIZATION W/O GRAFTS [CATH27]	
LEFT VENTRICULOGRAPHY [CATH05]	

Lab - Orders and Results

HCG,QUANT (FEMALE ONLY) [669521917]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard

Lab - Orders and Results (continued)

HCG,QUANT (FEMALE ONLY) [669521917] (continued)

Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Frequency: AM Draw AM Draw @ 0400 05/02/17 0400 - 1 occurrence
Quantity: 1
Released by: Susan Colston, RN 05/01/17 0845
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Order comments: For all pre-menopausal females capable of pregnancy (exceptions include history of hysterectomy, tubal ligation). Patients refusing pregnancy testing must complete the Statement of Pregnancy / Nursing Conditions and Consent for X-Ray and Nuclear Medicine Exams form prior to procedure.

Specimen Information

Type	Source	Collected By
Blood	Blood	—

CBC W/O DIFFERENTIAL [669537044]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

Specimen Information

Type	Source	Collected By
Blood	Blood	—

BASIC METABOLIC PANEL (7) [669537045]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Order comments: Fasting

Specimen Information

Type	Source	Collected By
Blood	Blood	—

Case Request - Orders and Results

CASE REQUEST CATH LAB [669521926]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Ordering provider: Sandra Nerestil, NP
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Quantity: 1
Instance released by: Sandra Nerestil, NP (auto-released) 5/1/2017 7:15 AM
Discontinued by: Daniel Becigneul, RN 08/06/18 0654 [The associated case was canceled: Scheduling - Error]

Questionnaire

Question	Answer
Add on case?	Yes
Pre-procedure diagnosis	CP
Case Classification	Class E - <24H Non-Urgent

Diet - Orders and Results

DIET, CARDIAC [669536706]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844**
Status: **Discontinued**

Diet - Orders and Results (continued)

DIET, CARDIAC [669536706] (continued)

Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Susan Colston, RN (auto-released) 5/1/2017 8:45 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Diet: Cardiac
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]

DIET, NPO [669521895]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715**
Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Abdul M Sheikh, MD
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Frequency: Routine Effective Midnight 05/02/17 0001 - Until Specified
Diet: NPO
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [Patient Discharge]
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Quantity: 1
Released by: Susan Colston, RN 05/01/17 0845

Questionnaire

Question	Answer
Medications Allowed?	Whole with sips of water

Medications - Orders and Results

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [669521934]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Rebecca Chism, RN 05/01/17 0820
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 05/01/17 0820 - 05/01/17 0842
Acknowledged: Rebecca Chism, RN 05/01/17 0820 for Placing Order
Package: 0409-9094-22
Communicated by: Rebecca Chism, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn M Vise, RN 05/01/17 0842 [(Patient Discharge - Internal Use Only)]

midazolam (VERSED) injection 1 mg/mL [669521935]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Rebecca Chism, RN 05/01/17 0820
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 05/01/17 0820 - 05/01/17 0842
Acknowledged: Rebecca Chism, RN 05/01/17 0820 for Placing Order
Package: 0409-2305-21
Communicated by: Rebecca Chism, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn M Vise, RN 05/01/17 0842 [(Patient Discharge - Internal Use Only)]

lidocaine (XYLOCAINE) local injection 2 % [669521936]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Rebecca Chism, RN 05/01/17 0824
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 05/01/17 0824 - 05/01/17 0842
Acknowledged: Rebecca Chism, RN 05/01/17 0824 for Placing Order
Package: 0409-4277-01
Communicated by: Rebecca Chism, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn M Vise, RN 05/01/17 0842 [(Patient Discharge - Internal Use Only)]

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [669521937]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Rebecca Chism, RN 05/01/17 0827
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 05/01/17 0827 - 05/01/17 0842
Acknowledged: Rebecca Chism, RN 05/01/17 0827 for Placing Order
Package: 0409-7620-59
Communicated by: Rebecca Chism, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn M Vise, RN 05/01/17 0842 [(Patient Discharge - Internal Use Only)]

Medications - Orders and Results (continued)

iohexol (OMNIPAQUE) injection 350 mg/mL [669521938]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 1242** — Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Ordering user: Rebecca Chism, RN 05/01/17 0838
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 05/01/17 0838 - 05/01/17 0842
Communicated by: Rebecca Chism, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn M Vise, RN 05/01/17 0842 [(Patient Discharge - Internal Use Only)]
Acknowledged: Rebecca Chism, RN 05/01/17 0838 for Placing Order
Package: 0407-1414-89

sodium chloride 0.9% (NS) infusion [669536703]

Electronically signed by: **Abdul M Sheikh, MD on 05/01/17 0844** — Status: **Expired**
Ordering user: Abdul M Sheikh, MD 05/01/17 0844
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Continuous 05/01/17 0900 - 2 hours
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Released by: Susan Colston, RN 05/01/17 0845
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Package: 0409-7983-09

sodium chloride 0.9 % (NS) flush [669521922]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Sandra Nerestil, NP
PRN reasons: line care
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Frequency: Routine Q1 min PRN 05/01/17 0845 - 05/01/17 1349
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Released by: Susan Colston, RN 05/01/17 0845
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [(Patient Discharge - Internal Use Only)]
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Admin instructions: INT Flush
Package: 8881-571121

sodium chloride 0.9% (NS) bolus [669521923]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Discontinued**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Sandra Nerestil, NP
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Frequency: Routine Continuous 05/01/17 0845 - 05/01/17 1349
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Released by: Susan Colston, RN 05/01/17 0845
Discontinued by: Automatic Discharge Provider 05/01/17 1349 [(Patient Discharge - Internal Use Only)]
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Admin instructions: Start on arrival to ARU (outpatients) or on arrival to precath holding (inpatients). Infuse at 3 mL/kg/hr for 1 hour prior to the procedure, after one hour reduce rate to 1 mL/kg/hr - See second order in panel. (MAXimum infusion rate 300 mL/hr).
Package: 0409-7984-36

sodium chloride 0.9% (NS) infusion [669521924]

Electronically signed by: **Sandra Nerestil, NP on 05/01/17 0715** — Status: **Expired**
Ordering user: Sandra Nerestil, NP 05/01/17 0715
Authorized by: Sandra Nerestil, NP
Cosigning events
Electronically cosigned by Abdul M Sheikh, MD 05/01/17 1242 for Ordering
Frequency: Routine Continuous 05/01/17 0900 - 2 hours
Ordering provider: Sandra Nerestil, NP
Ordering mode: Standard
Released by: Susan Colston, RN 05/01/17 0845
Acknowledged: Susan Colston, RN 05/01/17 0845 for Placing Order
Admin instructions: "* Start reduced rate after 1 hour bolus completed.** After first hour (see first order in panel), reduce rate to 1 mL/kg/hr. (MAXimum infusion rate 100 mL/hr). Discontinue IV fluids after a total of 3 hours (500 mL max) if cardiac cath has not yet been performed."
Package: 0409-7983-09

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
118001 - Cath/EP	CATH/EP	Unknown	Unknown	01/02/13 1112 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [669521922]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 05/01/17 0845
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/01/17 0845 - 05/01/17 1349
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

sodium chloride 0.9% (NS) bolus [669521923]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 05/01/17 0845
Dose (Remaining/Total): 3 mL/kg/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 05/01/17 0845 - 05/01/17 1349
Route: Intravenous
Rate/Duration: 290 mL/hr / 1 Hours

Admin Instructions: Start on arrival to ARU (outpatients) or on arrival to precath holding (inpatients). Infuse at 3 mL/kg/hr for 1 hour prior to the procedure, after one hour reduce rate to 1 mL/kg/hr - See second order in panel. (MAXimum infusion rate 300 mL/hr).

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 05/01/17 0900 Scheduled: 05/01/17 0845	Due	—	—	—

sodium chloride 0.9% (NS) infusion [669521924]

Ordering Provider: Sandra Nerestil, NP
Ordered On: 05/01/17 0845
Dose (Remaining/Total): 1 mL/kg/hr (—/—)
Frequency: Continuous

Status: Verified (Past End Date/Time)
Starts/Ends: 05/01/17 0900 - 05/01/17 1059
Route: Intravenous
Rate/Duration: 96.6 mL/hr / —

Admin Instructions: "" Start reduced rate after 1 hour bolus completed."" After first hour (see first order in panel), reduce rate to 1 mL/kg/hr. (MAXimum infusion rate 100 mL/hr). Discontinue IV fluids after a total of 3 hours (500 mL max) if cardiac cath has not yet been performed."

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 05/01/17 0900 Scheduled: 05/01/17 0845	Due	—	—	—

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [669521934]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0820

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 05/01/17 0820 Documented: 05/01/17 0820	Given	50 mcg	Intravenous	Performed by: Rebecca Chism, RN

midazolam (VERSED) injection 1 mg/mL [669521935]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0820

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 05/01/17 0820 Documented: 05/01/17 0820	Given	1 mg	Intravenous	Performed by: Rebecca Chism, RN

Medications (continued)

All Meds and Administrations (continued)

lidocaine (XYLOCAINE) local injection 2 % [669521936]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0824
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 05/01/17 0824 Documented: 05/01/17 0824	Given	5 mL	Subcutaneous	Performed by: Abdul M Sheikh, MD Documented by: Rebecca Chism, RN Comments: rt groin

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [669521937]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0827
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 05/01/17 0827 Documented: 05/01/17 0827	Given	2 Bag	Intravenous	Performed by: Abdul M Sheikh, MD Documented by: Rebecca Chism, RN

iohexol (OMNIPAQUE) injection 350 mg/mL [669521938]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0838
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 05/01/17 0838 Documented: 05/01/17 0838	Given	50 mL	Intra-arterial	Performed by: Abdul M Sheikh, MD Documented by: Rebecca Chism, RN Comments: 100cc wasted

sodium chloride 0.9% (NS) infusion [669536703]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 05/01/17 0845
Dose (Remaining/Total): 1.5 mL/kg/hr (—/—)
Frequency: Continuous
Status: Verified (Past End Date/Time)
Starts/Ends: 05/01/17 0900 - 05/01/17 1059
Route: Intravenous
Rate/Duration: 145 mL/hr / —

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 05/01/17 0900 Scheduled: 05/01/17 0845	Due	—	—	—

Historical Medications Entered This Encounter

This print group is not available in inpatient encounters. Please contact a system administrator.

Patient Education

Education

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Not Started)

Patient Education (continued)

Education (continued)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Not Started)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Not Started)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Not Started)

Point: Encourage Patient to Monitor Own Pain (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Not Started)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Discharge Instructions

Discharge Instructions Maurice, Eugene George (MR # 561253820)

Date	Status	User	User Type	Discharge Note
05/01/17 1020	Pended	Susan Colston, RN	Registered Nurse	Original

Note:

Heart Catheterization
Discharge Instructions

Performed by ***

You have recovered for a short time in the hospital. You should be careful at home for the next 48 hours. Please abide by the following rules:

1. **Rest and relax today and tomorrow.** To lessen the risk of bleeding from the puncture site, do the following:
    - Limit activity for the next two days. Do not do any unnecessary bending, heavy lifting (greater than 10 pounds, including infants and pets), straining or stair climbing.
    - Keep your leg as straight as possible over the next 12 hours.
    - Hold pressure on the site any time you cough, sneeze, laugh, or strain.
    - You may resume sexual relations when you are able to climb one flight of stairs or walk for 10 minutes without shortness of breath or chest pain.

2. Due to medications you received, **do not** drive, drink alcohol, or make important decisions for the next 48 hours.
Have someone stay with you tonight.

3. **Observe your puncture site.** You may have a small knot (no larger than an olive) or bruise in the cath site.
    - Report any bleeding, swelling, severe pain, or numbness at the puncture site.
    - If bleeding does occur, press down hard on the site. Lie down and have someone hold pressure for five minutes without letting up. **If bleeding or swelling is rapid or does not stop after holding for 5 minutes, continue to hold pressure and call 911.**
    - If you experience signs that the circulation in your leg, foot, arm or hand is blocked, such as **pain, coolness, tingling or loss of feeling, or change of color of the skin, call your doctor immediately.**

4. **Resume your normal diet, unless otherwise instructed by your doctor.**
    - Continue to drink lots of liquids unless instructed otherwise by the doctor.
    - If you take water pills, insulin, blood thinners, or aspirin, ask your doctor for instructions.
    - **If you take Glucophage, do not take for 48 hours.**
    - If you have heart disease, take nitroglycerin as prescribed for angina. Decrease your heart disease risk by stopping all use of tobacco products.
    - See discharge medication list.

5. **Call you doctor if:**

Discharge Instructions (continued)

- You develop a painful lump in your groin or a lump that is getting larger.
- You feel lightheaded, faint or clammy.
- You are unable to urinate.
- The puncture site looks red or has any discharge (signs of infection).
- You begin running a fever.

6. If you received **Artery Closure Devices**, please follow these written instructions:
   - Keep the bandage on for 24 hours. Do not remove bandage until after you shower. May shower the morning following procedure.
   - Cover puncture site with a Band-Aid after you shower; change the Band-Aid daily after bathing until the site is healed.
   - **DO NOT** sit in a hot tub, bathtub, sauna, whirlpool, or swimming pool for 7 days following your procedure.
   - If the puncture site looks red or has any discharge, call your doctor. If you have questions or concerns about your procedure, call you doctor.
   - If you had an interventional procedure, be sure to keep your stent card in your wallet.
   - Inform your regular doctor that you have had a stent placed.
   - If you have questions or concerns about your procedure , call the Cath Lab at 470-732-3860, M-F 7am-8pm.

Follow up with your doctor for complete test results.

I have received a copy of this form and understand the instructions.

Responsible Person Signature Date Relationship to Patient

RN Signature Date/Time

All Flowsheets

Flowsheets (all recorded)

Encounter Vitals

Row Name	05/01/17 1109	05/01/17 1014	05/01/17 0943	05/01/17 0905	05/01/17 0846
Enc Vitals					
BP	121/89 -SC	110/59 -SC	110/55 -SC	97/53 -SC	106/54 -SC
Pulse	55 -SC	56 -SC	55 -SC	57 -SC	62 -SC
Resp	16 -SC	16 -SC	16 -SC	15 -SC	15 -SC
SpO2	99 % -SC	99 % -SC	97 % -SC	96 % -SC	95 % -SC

Row Name	05/01/17 08:41:15	05/01/17 0714	05/01/17 0712
Enc Vitals			
BP	107/62 -KV	112/55 -SC	—
Pulse	67 -KV	61 -SC	—
Resp	13 -KV	18 -SC	—
Temp	—	97.9 °F (36.6 °C) -SC	—
Temp src	—	Oral -SC	—
SpO2	98 % -KV	96 % -SC	—
Weight	—	—	96.6 kg (213 lb) -SC
Height	—	—	67" (1.702 m) -SC

Flowsheets (all recorded)

Custom Formula Data

Row Name	05/01/17 08:40:51	05/01/17 08:12:10	05/01/17 0714	05/01/17 0712
Vitals				
Pct Wt Change	—	—	—	0 % -SC
OTHER				
Weight Change (kg)	—	—	—	0 kg -SC
Ideal Body Weight	—	—	—	160 lb -SC
Visit Weight	—	—	—	213 lb -SC
BMI (Calculated)	—	—	—	33.4 -SC
IBW/kg (Calculated) Male	—	—	—	66.1 kg -SC
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -SC
Weight/Scale Event	—	—	—	0 -SC
Weight in (lb) to have BMI = 25	—	—	—	159.3 -SC
% Weight Change Since Birth	—	—	—	0 -SC
Adult IBW/VT Calculations				
IBW/kg (Calculated)	—	—	—	66.1 -SC
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -SC
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -SC
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -SC
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -SC
Case Log				
BSA x (CI @3.0)= CO	—	—	—	6.39 CO -SC
Relevant Labs and Vitals				
Temp (in Celsius)	—	—	36.6 -SC	—
Aldrete Phase 1				
Aldrete Score	10 -KV	10 -LK	—	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	05/01/17 1149
OTHER	
Risk for Readmission	3 -SC

Flowsheets (all recorded)

Travel Information

Row Name	05/01/17 0649
RETIRED - Travel outside the U.S.	
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -SC

Flowsheets (all recorded)

Aldrete Score

Row Name	05/01/17 08:40:51	05/01/17 08:12:10
Aldrete		
Activity	2 -KV	2 -LK
Respiration	2 -KV	2 -LK
Circulation	2 -KV	2 -LK
Consciousness	2 -KV	2 -LK
O2 Saturation	2 -KV	2 -LK
Aldrete Score (PAR)	10 -KV	10 -LK

Flowsheets (all recorded)

Screenings

Row Name	05/01/17 0713	05/01/17 0649	05/01/17 0648		
Advance Directives (For Healthcare)					
Have you reviewed your Advance Directive and is it valid for this stay?	—	—	Not applicable -SC		
Advance Directive	Not applicable -SC	—	Patient has advance directive, copy in chart -SC		
Healthcare Agent Appointed	—	—	No -SC		
Pre-existing Allow Natural Death Order	—	—	No -SC		
Information Provided on Healthcare Directives	—	—	No -SC		
Patient Requests Assistance (Retired)	—	—	No -SC		
Patient Belongings at Bedside					
Belongings at Bedside	—	Clothing -SC	—		
Belongings sent to security (Retired)	—	No -SC	—		
(RETIRED)Belongings Sent Home	—	No -SC	—		
Patient Medications					
Medications brought by patient?	—	No -SC	—		
Suicide/Harm Risk					
Ever harm self (Retired)	—	No -SC	—		
Current thoughts (Retired)	—	No -SC	—		
Self harm plan (Retired)	—	No -SC	—		
Patient information obtained from	—	Patient -SC	—		
Braden Scale					
Sensory Perceptions	4 -SC	—	—		
Moisture	4 -SC	—	—		
Activity	4 -SC	—	—		
Mobility	4 -SC	—	—		
Nutrition	3 -SC	—	—		
Friction and Shear	3 -SC	—	—		
Braden Scale Score	22 -SC	—	—		
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)					
Pressure ulcer present on admission	No -SC	—	—		

Flowsheets (all recorded)

Suicide Risk

Row Name	05/01/17 0649
Suicide/Harm Risk	
Ever harm self (Retired)	No -SC
Current thoughts (Retired)	No -SC
Self harm plan (Retired)	No -SC
Patient information obtained from	Patient -SC
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -SC

Flowsheets (all recorded)

Vital Signs

Row Name	05/01/17 1109	05/01/17 1014	05/01/17 0943	05/01/17 0905	05/01/17 0846
Vital Signs					
Automatic Restart Vitals Timer	Yes -SC	Yes -SC	Yes -SC	Yes -SC	Yes -SC
Pulse	55 -SC	56 -SC	55 -SC	57 -SC	62 -SC
Heart Rate Source	Monitor -SC	Monitor -SC	Monitor -SC	Monitor -SC	Monitor -SC
Resp	16 -SC	16 -SC	16 -SC	15 -SC	15 -SC
BP	121/89 -SC	110/59 -SC	110/55 -SC	97/53 -SC	106/54 -SC
Patient Position	Supine -SC	Supine -SC	Supine -SC	Supine -SC	—
Oxygen Therapy					
SpO2	99 % -SC	99 % -SC	97 % -SC	96 % -SC	95 % -SC

Row Name	05/01/17 08:41:15	05/01/17 08:10:21	05/01/17 0714		
Vital Signs					
Automatic Restart Vitals Timer	Yes -KV	—	Yes -SC		
Pulse	67 -KV	—	61 -SC		
Heart Rate Source	—	—	Monitor -SC		
Resp	13 -KV	—	18 -SC		
BP	107/62 -KV	—	112/55 -SC		
Patient Position	—	—	Sitting -SC		
Temp	—	—	97.9 °F (36.6 °C) -SC		
Temp src	—	—	Oral -SC		
Oxygen Therapy					
SpO2	98 % -KV	—	96 % -SC		
O2 Device	—	Nasal cannula -LK	—		
O2 Flow Rate (L/min)	—	2 L/min -LK	—		

Flowsheets (all recorded)

O2 Therapy

Row Name	05/01/17 1109	05/01/17 1014	05/01/17 0943	05/01/17 0905	05/01/17 0846
Oxygen Therapy					
SpO2	99 % -SC	99 % -SC	97 % -SC	96 % -SC	95 % -SC

Row Name	05/01/17 08:41:15	05/01/17 08:10:21	05/01/17 0714
Oxygen Therapy			
O2 Delivery	—	Oxygen -LK	—
O2 Device	—	Nasal cannula -LK	—
O2 Flow Rate (L/min)	—	2 L/min -LK	—
SpO2	98 % -KV	—	96 % -SC

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	05/01/17 1147	05/01/17 1146	05/01/17 08:15:48	05/01/17 08:15:04	05/01/17 0735
[REMOVED] Peripheral IV 05/01/17 20 G Right Hand					
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0720 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Right -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1146 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC				
Site Assessment	—	Asymptomatic;Clean;Dry;Intact -SC	Asymptomatic -RC	—	—
Phlebitis Scale	—	0 -SC	0 -RC	—	—
Infiltration/Extravasation Scale	—	0 -SC	0 -RC	—	—
Line Assessment	—	—	Blood return noted;Patent -RC	—	—
Dressing Assesment	—	Clean;Dry;Intact -SC	—	—	—
IV Interventions	—	—	Flushed -RC	—	—
[REMOVED] Peripheral IV 05/01/17 20 G Left Hand					
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0735 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Left -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1147 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC				
Site Assessment	Asymptomatic;Clean;Dry;Intact -SC	—	—	Asymptomatic -RC	Asymptomatic;Clean;Dry;Intact -SC
Phlebitis Scale	0 -SC	—	—	0 -RC	0 -SC
Infiltration/Extravasation Scale	0 -SC	—	—	0 -RC	0 -SC
Line Assessment	—	—	—	Blood return noted;Patent -RC	Blood return noted -SC
Dressing Assesment	Clean;Dry;Intact -SC	—	—	—	Clean;Dry;Intact -SC
IV Interventions	—	—	—	Flushed -RC	Flushed -SC

Row Name	05/01/17 0731
[REMOVED] Peripheral IV 05/01/17 20 G Right Hand	
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0720 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Right -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1146 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC
Site Assessment	Asymptomatic;Clean;Dry;Intact -SC
Phlebitis Scale	0 -SC
Infiltration/Extravasation Scale	0 -SC
Line Assessment	Blood return noted -SC
Dressing Assesment	Clean;Dry;Intact -SC
IV Interventions	Flushed -SC
[REMOVED] Peripheral IV 05/01/17 20 G Left Hand	
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0735 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Left -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1147 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC

Flowsheets (all recorded)

Anthropometrics

Row Name	05/01/17 0712
Anthropometrics	
Height	67" (1.702 m) -SC
Weight	96.6 kg (213 lb) -SC
Weight Method	Stated -SC
Weight Change	0 -SC
BMI (Calculated)	33.4 -SC

Flowsheets (all recorded)

Interpretation

Row Name	05/01/17 0648
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -SC

Flowsheets (all recorded)

Vitals/Pain

Row Name	05/01/17 1109	05/01/17 1014	05/01/17 0943	05/01/17 0905	05/01/17 0846
OTHER					
Patient Position	Supine -SC	Supine -SC	Supine -SC	Supine -SC	—
Pain Assessment	0-10 -SC	0-10 -SC	0-10 -SC	0-10 -SC	0-10 -SC
Vitals					
BP	121/89 -SC	110/59 -SC	110/55 -SC	97/53 -SC	106/54 -SC
Pulse	55 -SC	56 -SC	55 -SC	57 -SC	62 -SC
Resp	16 -SC	16 -SC	16 -SC	15 -SC	15 -SC
SpO2	99 % -SC	99 % -SC	97 % -SC	96 % -SC	95 % -SC
Vital Signs					
Heart Rate Source	Monitor -SC	Monitor -SC	Monitor -SC	Monitor -SC	Monitor -SC
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -SC	0 -SC	0 -SC	0 -SC	0 -SC

Row Name	05/01/17 08:41:15	05/01/17 0714	05/01/17 0712		
OTHER					
Patient Position	—	Sitting -SC	—		
Height Method	—	—	Stated -SC		
Weight Method	—	—	Stated -SC		
BMI (Calculated)	—	—	33.4 -SC		
BSA (Calculated - sq m)	—	—	2.13 sq meters -SC		
Pain Assessment	—	0-10 -SC	—		
Vitals					
BP	107/62 -KV	112/55 -SC	—		
Temp	—	97.9 °F (36.6 °C) -SC	—		
Temp src	—	Oral -SC	—		
Pulse	67 -KV	61 -SC	—		
Resp	13 -KV	18 -SC	—		
SpO2	98 % -KV	96 % -SC	—		
Height	—	—	67" (1.702 m) -SC		
Weight	—	—	96.6 kg (213 lb) -SC		
Vital Signs					
Heart Rate Source	—	Monitor -SC	—		
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -SC	—		

Flowsheets (all recorded)

Fall Risk

Row Name	05/01/17 0649
Fall Assessment	
Patient Receiving Sedation	Yes -SC
Fall Risk	Yes -SC
Fall Band Applied	Yes -SC
Yellow socks	Yes -SC

Flowsheets (all recorded)

Pre-op Checklist

Row Name	05/01/17 0713	05/01/17 0648
Patient Verification		
History and Physical Completed	No -SC	—
Consents Confirmed	Informed -SC	—
Advance Directive	Not applicable -SC	Patient has advance directive, copy in chart -SC
Patient ID and Procedure Verified	Yes -SC	—
Correct Procedure	Yes -SC	—
Documents Match	Yes -SC	—
Pacemaker	N/A -SC	—
Patient has an ICD?	N/A -SC	—
Pre-op Lab/Test Results Available	In chart -SC	—
Preg Test	n/a -SC	—
Prep Verification		
Allergy Band Applied	Yes -SC	—
Anti-embolism	n/a -SC	—
Pre-op Antibiotic Ordered?	n/a -SC	—
Beta Blocker Not Applicable?	n/a -SC	—
Anticoag Not Applicable?	n/a -SC	—
VTE Assessment Complete?	n/a -SC	—
Enema Given	Not applicable -SC	—
Disposition of belongings:	To family/significant other -SC	—
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -SC	—
Transport To	Procedure Area -SC	—
Mode of Transport	Stretcher -SC	—
Transport By	RN -SC	—
Metal Implant Present?	No -SC	—
Skin Prep for Procedure	Yes -SC	—
VTE Diagnostic Test Performed?	N/A -SC	—
Pre-op Checklist Completion		
Checklist Completed/Verified?	Yes -SC	—
Location completed at:	ARU -SC	—

Flowsheets (all recorded)

CARDNT HEMODYNAMIC

Row Name	05/01/17 1109	05/01/17 1014	05/01/17 0943	05/01/17 0905	05/01/17 0846
Vitals					
SpO2	99 % -SC	99 % -SC	97 % -SC	96 % -SC	95 % -SC
Pulse	55 -SC	56 -SC	55 -SC	57 -SC	62 -SC
Resp	16 -SC	16 -SC	16 -SC	15 -SC	15 -SC
Row Name	**05/01/17 08:41:15**	**05/01/17 08:39:17**	**05/01/17 08:38:06**	**05/01/17 08:34:36**	**05/01/17 08:34:28**
Vitals					
SpO2	—	97 % -VI	98 % -VI	—	—
Heart Rate	—	62 bpm -VI	66 bpm -VI	—	—
Systolic Pressure	—	107 mmHg -VI	124 mmHg -VI	—	—
Diastolic Pressure	—	62 mmHg -VI	67 mmHg -VI	—	—
Mean Pressure	—	74 mmHg -VI	87 mmHg -VI	—	—
Respiration Rate	—	13 breaths/min -VI	14 breaths/min -VI	—	—
SpO2	98 % -KV	—	—	—	—
Pulse	67 -KV	—	—	—	—
Resp	13 -KV	—	—	—	—
Pressure Summary					
LV Systolic Cath Pressure	—	—	—	—	75 mmHg -VI
LV Diastolic Cath Pressure	—	—	—	—	40 mmHg -VI
LV Heart Rate	—	—	—	—	57 bpm -VI
AO Systolic Cath Pressure	—	—	—	82 mmHg -VI	—
AO Diastolic Cath Pressure	—	—	—	35 mmHg -VI	—
AO Mean Cath Pressure	—	—	—	55 mmHg -VI	—
AO Heart Rate	—	—	—	58 bpm -VI	—
LV End Diastolic	—	—	—	—	44 mmHg -VI
Row Name	**05/01/17 08:34:18**	**05/01/17 08:33:47**	**05/01/17 08:33:43**	**05/01/17 08:30:55**	**05/01/17 08:29:24**
Vitals					
SpO2	97 % -VI	—	—	97 % -VI	97 % -VI
Heart Rate	58 bpm -VI	—	—	59 bpm -VI	59 bpm -VI
Systolic Pressure	98 mmHg -VI	—	—	87 mmHg -VI	97 mmHg -VI
Diastolic Pressure	55 mmHg -VI	—	—	58 mmHg -VI	60 mmHg -VI
Mean Pressure	65 mmHg -VI	—	—	71 mmHg -VI	71 mmHg -VI
Respiration Rate	14 breaths/min -VI	—	—	14 breaths/min -VI	13 breaths/min -VI
Pressure Summary					
LV Systolic Cath Pressure	—	79 mmHg -VI	79 mmHg -VI	—	—
LV Diastolic Cath Pressure	—	11 mmHg -VI	12 mmHg -VI	—	—
LV Heart Rate	—	46 bpm -VI	56 bpm -VI	—	—
LV End Diastolic	—	18 mmHg -VI	20 mmHg -VI	—	—
Row Name	**05/01/17 08:28:47**	**05/01/17 08:24:23**	**05/01/17 08:19:19**	**05/01/17 08:14:16**	**05/01/17 08:11:12**
Vitals					
SpO2	—	97 % -VI	100 % -VI	95 % -VI	—
Heart Rate	—	59 bpm -VI	58 bpm -VI	60 bpm -VI	—
Systolic Pressure	—	113 mmHg -VI	133 mmHg -VI	145 mmHg -VI	—
Diastolic Pressure	—	61 mmHg -VI	70 mmHg -VI	75 mmHg -VI	—
Mean Pressure	—	74 mmHg -VI	91 mmHg -VI	93 mmHg -VI	—
Respiration Rate	—	14 breaths/min -VI	18 breaths/min -VI	27 breaths/min -VI	—
AO Pressures					
AO Systolic	—	—	—	—	82 mmHg -VI
AO Diastolic	—	—	—	—	35 mmHg -VI
AO Mean	—	—	—	—	55 mmHg -VI
AO Heart Rate	—	—	—	—	58 bpm -VI
LV Pressures					
LV Systolic	—	—	—	—	75 mmHg -VI
LV End Diastolic	—	—	—	—	44 mmHg -VI
LV dP/dt	—	—	—	—	336 -VI
Pressure Summary					

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	05/01/17 08:28:47	05/01/17 08:24:23	05/01/17 08:19:19	05/01/17 08:14:16	05/01/17 08:11:12
AO Systolic Cath Pressure	77 mmHg -VI	—	—	—	—
AO Diastolic Cath Pressure	32 mmHg -VI	—	—	—	—
AO Mean Cath Pressure	53 mmHg -VI	—	—	—	—
AO Heart Rate	58 bpm -VI	—	—	—	—
Data Collected					
Hemodynamic Phase	—	—	—	—	Phase: Baseline -VI

Row Name	05/01/17 0714
Vitals	
SpO2	96 % -SC
Pulse	61 -SC
Resp	18 -SC

Flowsheets (all recorded)

Cath Lab Pain Assessment

Row Name	05/01/17 08:41:02	05/01/17 08:10:18			
Pain					
Pain	No -KV	No -LK			

Flowsheets (all recorded)

Preop Nurse

Row Name	05/01/17 0648
Pre-op Nurse	
Pre Procedure Nurse	Colston RN -SC

Flowsheets (all recorded)

Patient Belongings

Row Name	05/01/17 0649
Patient Belongings at Bedside	
Belongings at Bedside	Clothing -SC
Belongings sent to security (Retired)	No -SC
(RETIRED)Belongings Sent Home	No -SC
Patient Medications	
Medications brought by patient?	No -SC

Flowsheets (all recorded)

Complex Assessment

Row Name	05/01/17 0716	05/01/17 0713	05/01/17 0712
Neurological			
Neuro (WDL)	—	—	WDL -SC
HEENT			
HEENT (WDL)	—	—	WDL -SC
Respiratory			
Respiratory (WDL)	—	—	WDL -SC
Cardiac			
Cardiac (WDL)	—	—	WDL -SC
Peripheral Vascular			
Peripheral Vascular (WDL)	—	—	X -SC
Pulses	—	—	R pedal;L posterior tibial;R posterior tibial;L pedal;R radial -SC
RUE Neurovascular Assessment			
R Radial Pulse	+2 -SC	—	—
RLE Neurovascular Assessment			
R Posterior Tibial Pulse	+1 -SC	—	—
R Pedal Pulse	+2 -SC	—	—
LLE Neurovascular Assessment			
L Posterior Tibial Pulse	+2 -SC	—	—
L Pedal Pulse	+2 -SC	—	—
Integumentary			
Integumentary (WDL)	—	—	WDL -SC
Braden Scale			
Sensory Perceptions	—	4 -SC	—
Moisture	—	4 -SC	—
Activity	—	4 -SC	—
Mobility	—	4 -SC	—
Nutrition	—	3 -SC	—
Friction and Shear	—	3 -SC	—
Braden Scale Score	—	22 -SC	—
Gastrointestinal			
Gastrointestinal (WDL)	—	—	WDL -SC
Psychosocial			
Psychosocial (WDL)	—	—	WDL -SC
Provider Notification			
Provider Role	—	—	Nurse -SC
Charting Type			
Charting Type	—	—	Admission -SC

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	05/01/17 1147	05/01/17 1146	05/01/17 08:15:48	05/01/17 08:15:04	05/01/17 0735
[REMOVED] Peripheral IV 05/01/17 20 G Right Hand					
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0720 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Right -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1146 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC				
Site Assessment	—	Asymptomatic;Clean;Dry;Intact -SC	Asymptomatic -RC	—	—
Phlebitis Scale	—	0 -SC	0 -RC	—	—
Infiltration/Extravasation Scale	—	0 -SC	0 -RC	—	—
Line Assessment	—	—	Blood return noted;Patent -RC	—	—
Dressing Assesment	—	Clean;Dry;Intact -SC	—	—	—
IV Interventions	—	—	Flushed -RC	—	—
[REMOVED] Peripheral IV 05/01/17 20 G Left Hand					
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0735 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Left -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1147 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC				
Site Assessment	Asymptomatic;Clean;Dry;Intact -SC	—	—	Asymptomatic -RC	Asymptomatic;Clean;Dry;Intact -SC
Phlebitis Scale	0 -SC	—	—	0 -RC	0 -SC
Infiltration/Extravasation Scale	0 -SC	—	—	0 -RC	0 -SC
Line Assessment	—	—	—	Blood return noted;Patent -RC	Blood return noted -SC
Dressing Assesment	Clean;Dry;Intact -SC	—	—	—	Clean;Dry;Intact -SC
IV Interventions	—	—	—	Flushed -RC	Flushed -SC

Row Name	05/01/17 0731
[REMOVED] Peripheral IV 05/01/17 20 G Right Hand	
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0720 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Right -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1146 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC
Site Assessment	Asymptomatic;Clean;Dry;Intact -SC
Phlebitis Scale	0 -SC
Infiltration/Extravasation Scale	0 -SC
Line Assessment	Blood return noted -SC
Dressing Assesment	Clean;Dry;Intact -SC
IV Interventions	Flushed -SC
[REMOVED] Peripheral IV 05/01/17 20 G Left Hand	
IV Properties	Placement Date: 05/01/17 -SC Placement Time: 0735 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 20 G -SC Orientation: Left -SC Location: Hand -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: Colston RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 05/01/17 -SC Removal Time: 1147 -SC Catheter Intact on removal?: Yes -SC Removal Reason : Patient discharged -SC Remaining intact at discharge?: Yes -SC

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
LK	Lauren W Kerns, ARRT	02/03/17 -
SC	Susan Colston, RN	02/03/17 -
KV	Kathryn M Vise, RN	02/03/17 -
RC	Rebecca Chism, RN	02/03/17 -
VI	Interface, Vs Maclab Incoming	—

Flowsheet Notes

Flowsheet Notes (continued)

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 05/01/2017:

Scan on 5/3/2017 11:24 AM (below)

Scan on 5/1/2017 6:47 AM by Crystal D Johnson: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	OP		Unit:	CH CVM AUS	
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found	
Admitting Provider:			Referring Physician:	Sheikh, Abdul M	
Attending Provider:	Abdul m sheikh	AD: N	Adm Diagnosis:	Coronary artery disease *	
Admission Date:	4/9/2018		Admission Time:	1437	

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (69 yrs)
Address:	61 SHOCKLEY WAY			Religion:	Catholic
City:	DALLAS GA 30157-8973			Race:	White or caucasian
County:	PAULDING				
Email Address:	Gene.maurice@sgmservice.*				
Primary Care Provider:	Jeffrey L Tharp, MD			Primary Phone:	678-910-2298

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		Spouse	(678)398-9479		678-910-2476
2. *No Contact Specified*					678-910-2476

GUARANTOR

Guarantor:	MAURICE,EUGENE GEORGE	DOB:	1/2/1949
Address:	61 SHOCKLEY WAY	Sex:	Male
	DALLAS, GA 30157-8973	Home Phone:	678-398-9479
Relation to Patient:	Self	Work Phone:	
Guarantor ID:	123805	Mobile Phone:	678-910-2298

GUARANTOR EMPLOYER

Employer:	Phone:	Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977	Co-In: Deductible:	Out of Pocket Max: $6,700.00

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial# April 7, 2020 Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	04/09/2018 1437	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cardiac Diagnostics (CH CV1 AUSTELL)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
04/10/2018 2359	Home Or Self Care	None	None	WellStar Cardiac Diagnostics (CH CV1 AUSTELL)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.10 **[Principal]**	Atherosclerotic heart disease of native coronary artery without angina pectoris				

Events

Hospital Outpatient at 4/9/2018 1437

Unit: WellStar Cardiac Diagnostics (CH CV1 AUSTELL)
Patient class: Outpatient

Discharge at 4/10/2018 2359

Unit: WellStar Cardiac Diagnostics (CH CV1 AUSTELL)
Patient class: Outpatient

Allergies as of 4/10/2018

Reviewed on 4/9/2018

No Known Allergies

Immunizations as of 4/10/2018

Immunizations never marked as reviewed

Annual Influenza

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI700AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN | Administered on: 9/26/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-399-88
CVX code: 135 | VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur | Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA | Administered on: 9/28/2017 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-401-88
CVX code: 135 | VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur | Lot number: UI842AB

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
CVX code: 88

All Scans (continued)

Immunizations (continued) as of 4/10/2018

Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA	Administered on: 3/16/2016	Dose: 0.5 mL
Site: Left deltoid	Route: Intramuscular	NDC: 0005-1971-01
CVX code: 133	VIS date: 031616	
Manufacturer: Wyeth-Ayerst	Lot number: M51193	

Medical as of 4/10/2018

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Chronic kidney disease [N18.9]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

Hospital Encounter Notes (continued)

Encounter Notes (continued)

No notes exist for this encounter.

Echocardiography - Orders and Results

ECHO 2D PANEL W/ CONTRAST/BUBBLE PRN [735098265]

Electronically signed by: **Abdul M Sheikh, MD on 03/29/18 1611** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 03/29/18 1611 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Final result
Instance released by: Brandy E Vitucci 4/9/2018 2:37 PM
Diagnoses
Coronary artery disease involving native coronary artery of native heart without angina pectoris [I25.10]

Questionnaire

Question	Answer
Reason for exam?	Shortness of breath

ECHO 2D PANEL W/ CONTRAST/BUBBLE PRN [735098265]

Resulted: 04/09/18 2303, Result status: Final result

Order status: Completed
Filed by: Abdul M Sheikh, MD 04/09/18 2307
Accession number: 29362879
Result details
Resulted by: Abdul M Sheikh, MD
Performed: 04/09/18 1448 - 04/09/18 1547
Resulting lab: NONINV CARDIOLOGY

Narrative:
- The left ventricular systolic function is normal, ejection fraction is 50-55%.
- The left ventricular cavity size is normal.
- Left ventricular diastolic function is normal.
- The right ventricular cavity size and systolic function is/are normal.
- There is mild mitral and tricuspid valve regurgitation present.

Components

Component	Value	Reference Range	Flag	Lab
2D LV PW	1.0	cm	—	NonInv Card
TDI e' Lateral	9.85	cm/s	—	NonInv Card
MV Peak A Vel	80.5	cm/s	—	NonInv Card
MV Peak Gradient	4	mmHg	—	NonInv Card
TR Max Vel	213	cm/s	—	NonInv Card
LVOT Peak Vel	96.3	cm/s	—	NonInv Card
Ao Peak Velocity	191	cm/s	—	NonInv Card
AV Mean Gradient	8	mmHg	—	NonInv Card
AV Peak Gradient	15	mmHg	—	NonInv Card
MA Vel - Ea, Medial	7.99	cm/s	—	NonInv Card
LA size (2D)	5.4	cm	—	NonInv Card
Ao root annulus 2D	2.9	cm	—	NonInv Card
LVID, ED	5.2	cm	—	NonInv Card
LVID, ES	3.9	cm	—	NonInv Card
LA size 2D	5.4	cm	—	NonInv Card
LVOT Diameter	1.8	cm	—	NonInv Card
LVOT Area	3	cm2	—	NonInv Card
Ao Valve Area VTI	1.3	cm2	—	NonInv Card
Ao Valve Area Vmax	1.28	cm2	—	NonInv Card
Mitral Annulus Vel EA Lat	9.85	cm/s	—	NonInv Card
Mitral Annulus Vel EA Medial	7.99	cm/s	—	NonInv Card
2D IVSD	0.9	cm	—	NonInv Card
MV Peak E Vel	101	cm/s	—	NonInv Card
2D Ejection Fraction	45	%	—	NonInv Card
FS	24	%	—	NonInv Card
LV Stroke Volume	60	ml	—	NonInv Card
LV Stroke Volume Index	28	ml/m2	—	NonInv Card
E/Ea Medial Annulus	10	—	—	NonInv Card
Ao Valve Index VTI	0.62	cm2/m2	—	NonInv Card
Peak Vel LVOT/AV	0.5	—	—	NonInv Card
Ao Valve Index Vmax	0.61	cm2/m2	—	NonInv Card
LA 2D Index	2.559	cm/m2	—	NonInv Card
LA Dimension, ES	5.4	cm	—	NonInv Card
2D RVID, ED, PLAX	2.5	cm	—	NonInv Card
RVID ED PSAX	2.5	cm	—	NonInv Card
Peak RV-RA Grad S	30	mmHg	—	NonInv Card
2D Asc Ao Diameter	3.1	cm	—	NonInv Card
TV Peak Regurg Velocity	274	cm/s	—	NonInv Card
IVS/LVPW	0.83	—	—	NonInv Card
PV VTI	36.2	cm	—	NonInv Card

Echocardiography - Orders and Results (continued)

MA E/Ea, Lateral	10.25	—	—	Noninv Card
MA E/Ea Medial	12.64	—	—	Noninv Card
Peak Velocity LVOT/AV	0.50	—	—	Noninv Card
E/A ratio	1.25	—	—	Noninv Card
LVOT area	2.54	cm2	—	Noninv Card
LA Volume Index	44.50	mL/m2	—	Noninv Card
RVSP	35.00	mmHg	—	Noninv Card
LA Volume	94.00	cm3	—	Noninv Card
2D Aortic Annulus Diameter	2.90	cm	—	Noninv Card
RA Pressure	5.00	mmHg	—	Noninv Card

Procedures Performed	Chargeables
ECHOCARDIOGRAM 2D COMPLETE WITH CONTRAST [ECH115]	

Reviewed by

Abdul M Sheikh, MD on 04/10/18 1714

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [735098266]

Electronically signed by: **Abdul M Sheikh, MD on 04/09/18 1809** Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Aneesa Pirani, RN 04/09/18 1531
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Q8H 04/09/18 1600 - 04/11/18 0505

Acknowledged: Aneesa Pirani, RN 04/09/18 1531 for Placing Order
Admin instructions: Line care and definity dilution
INT Flush
Package: 8290-306547

Communicated by: Aneesa Pirani, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Discontinued by: Automatic Discharge Provider 04/11/18 0505 [(Patient Discharge - Internal Use Only)]

perflutren lipid microspheres (DEFINITY) injection 1.1 mg/mL [735098267]

Electronically signed by: **Abdul M Sheikh, MD on 04/09/18 1809** Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Aneesa Pirani, RN 04/09/18 1531
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Once 04/09/18 1600 - 1 occurrence
Acknowledged: Aneesa Pirani, RN 04/09/18 1531 for Placing Order
Admin instructions: 1.3cc of activated Definity diluted in 8.7cc NS. Inject slow IV push to opacify to the left ventricular chamber and improve the delineation of the LV endocardial border.
Package: 11994-011-16

Communicated by: Aneesa Pirani, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Per protocol: cosign required
Indications of use: echocardiography imaging adjunct

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
118000 - Noninv Card	NONINV CARDIOLOGY	Unknown	Unknown	01/02/13 1110 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [735098266]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 04/09/18 1531
Dose (Remaining/Total): 3-40 mL (---/---)
Frequency: Every 8 hours
Admin Instructions: Line care and definity dilution
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 04/09/18 1600 - 04/11/18 0505
Route: Intravenous
Rate/Duration: --- / ---
INT Flush

Line	Med Link Info	Comment
Peripheral IV 04/09/18 22 G Right Wrist	04/09/18 1536 by Aneesa Pirani, RN	---

Timestamps	Action	Dose	Route	Other Information
Due 04/11/18 0000 Scheduled: 04/09/18 1531	Due	---	---	---
Due 04/10/18 1600 Scheduled: 04/09/18 1531	Due	---	---	---
Due 04/10/18 0800 Scheduled: 04/09/18 1531	Due	---	---	---
Due 04/10/18 0000 Scheduled: 04/09/18 1531	Due	---	---	---
Performed 04/09/18 1536 Documented: 04/09/18 1536	Given	30 mL	Intravenous	Performed by: Aneesa Pirani, RN

perflutren lipid microspheres (DEFINITY) injection 1.1 mg/mL [735098267]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 04/09/18 1531
Dose (Remaining/Total): 1.3 mL (0/1)
Frequency: Once
Admin Instructions: 1.3cc of activated Definity diluted in 8.7cc NS. Inject slow IV push to opacify to the left ventricular chamber and improve the delineation of the LV endocardial border.
Status: Completed (Past End Date/Time)
Starts/Ends: 04/09/18 1600 - 04/09/18 1535
Route: Intravenous
Rate/Duration: --- / ---

Line	Med Link Info	Comment
Peripheral IV 04/09/18 22 G Right Wrist	04/09/18 1535 by Aneesa Pirani, RN	---

Timestamps	Action	Dose	Route	Other Information
Performed 04/09/18 1535 Documented: 04/09/18 1536	Given	1.3 mL	Intravenous	Performed by: Aneesa Pirani, RN Comments: 1 mL total of diluted definity given

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Patient Education (continued)

Education (continued)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Patient Education (continued)

Education (continued)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.
Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Resolved)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Not documented in this visit.
Progress:

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Resolved)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Not documented in this visit.
Progress:

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Resolved)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.
Learner Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Not documented in this visit.
Progress:

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Not documented in this visit.
Progress:

Patient Education (continued)

Education (continued)

Topic: Medications (MCB) (Resolved)

Point: Anticoagulant Therapy (Resolved)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Resolved)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Resolved)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Resolved)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Resolved)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Resolved)

Description:
Educate patient/family/caregiver on the ACE inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Resolved)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Resolved)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Resolved)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Resolved)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Resolved)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Resolved)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Resolved)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Resolved)

Description:
Discussed purpose and possible side effects of medication.

Patient Education (continued)

Education (continued)

Learner Progress:	Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	04/11/18 0305
OTHER	
Risk for Readmission	8 - BP

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	04/09/18 1500
[REMOVED] Peripheral IV 04/09/18 22 G Right Wrist	
IV Properties	Placement Date: 04/09/18 -AP Placement Time: 1527 -AP Present on arrival to hospital?: No -AP Type of Catheter: Straight -AP Size (Gauge): 22 G -AP Orientation: Right -AP Location: Wrist -AP Site Prep: Chlorhexidine -AP Local Anesthetic: None -AP Inserted by: Arnold Dunn Nuc tech -AP Insertion attempts: 2 -AP Successful IV Attempt?: Yes -AP Patient Tolerance: Tolerated well -AP IV Access Problem: No -AP Removal Date: 04/09/18 -AP Removal Time: 1537 -AP Catheter Intact on removal?: Yes -AP Removal Reason : Per protocol -AP Remaining intact at discharge?: No -AP
Site Assessment	Clean;Dry;Intact -AP
Phlebitis Scale	0 -AP
Infiltration/Extravasation Scale	0 -AP
Dressing Assesment	Clean;Dry;Intact -AP
Dressing Interventions	Gauze Applied -AP

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
AP	Aneesa Pirani, RN	11/13/15 -
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 04/09/2018:

Scan on 4/26/2018 5:18 AM (below)

Scan on 4/9/2018 2:36 PM by Brandy E Vitucci: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

END OF REPORT