Ciox Health
P.O. Box 409900
Atlanta, GA 30384-9900
Fed Tax ID 58 - 2659941
1-800-367-1500

INVOICE

Electronic Delivery Service

Invoice #: **0303631891**
Date: **04/10/2020**

https://edelivery.cioxhealth.com

Ship to:	Bill to:	Records from:
Eugene Maurice, Eugene 61 SHOCKLEY WAY DALLAS,GA 30157-8973	Eugene Maurice, Eugene 61 SHOCKLEY WAY DALLAS,GA 30157-8973	WELLSTAR KENNESTONE HOSPITAL 677 CHURCH ST NE MARIETTA,GA 30060-1101

Requested By: MAURICE, EUGENE **DOB :** 01/02/1949
Patient Name: MAURICE EUGENE

Description	Quantity	Unit Price	Amount
Reproduction Fee-Elect			6.50
Subtotal			6.50
Sales Tax			0.00
Invoice Total			6.50
Balance Due			6.50

Please Note: Your medical record request has been delivered electronically to your Ciox eDelivery account.

Terms: Net 30 days **Please remit this amount : $6.50(USD)**

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Check #_____

Payment Amount $_____

Please return stub with payment.

Please include invoice number on check.
To pay invoice online, please go to https://paycioxhealth.com/pay/ or call 800-367-1500.
Email questions to collections@cioxhealth.com.

CIOX HEALTH

[illegible]
Marietta, GA 30066
(800) [illegible]
[illegible]

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name	EUGENE (First)	MAURICE (Last)	
Street Address	615 HOCKLEY WAY (Street)	(Suite / Apt #)	
	DALLAS (City)	GA (State)	30157 (Zip)
Email Address for record delivery	GENE.MAURICE@SGMSERVICE.COM		
Medical Records Requested			
Patient Name	EUGENE (First)	G (MI)	MAURICE (Last)
Date of Birth	01-02-1949		
Date of Service	06-01-2009 (From)	DATE (To)	

Please provide me with the medical records described above through the Ciox eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on Ciox Health's **eDelivery** website.
- I will receive an email from **CioxHealth.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature Eugene R Maurice Date: 3-31-20

FOR GREATER HEALTH

WELLSTAR Health System

For Internal Purposes
Account Number: _____
Medical Record Number: _____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: EUGENE G. MAURICE Social Security Number (last 4 digits only): 1524
Previous Name, if applicable: _____
Address: 61 SHOCKLEY WAY City: DALLAS State: GA ZIP: 30157
Date of Birth: 01-02-1944 Home Phone: 678-910-2298 Work Phone: N/A

1. WELLSTAR HEALTH SYSTEM FACILITY / FACILITIES

I authorize representatives from the following facility / facilities to disclose the above-named individual's health information as directed below:
(Check one or more)

- ☐ Atlanta Medical Center
- ☐ Atlanta Medical Center South
- ☑ Cobb Hospital
- ☐ Douglas Hospital
- ☐ North Fulton Hospital
- ☑ Kennestone Hospital
- ☑ Paulding Hospital
- ☐ Spalding Regional Hospital
- ☐ Sylvan Grove Hospital
- ☐ West Georgia Medical Center
- ☐ Windy Hill Hospital
- ☑ WellStar Medical Group
  Name(s) of provicer(s): SEE ATTACHED
- ☐ Other: _____

2. RECEIVING PARTY

☐ Please send my health information to:
Name: ELECTRONIC DELIVERY
Address: SEE ATTACHED
City: _____ State: _____ ZIP Code: _____
Phone Number: _____ Fax Number (healthcare provider only): _____

☐ I would like to pick up my medical records in person

☐ I authorize _____ to pick up my medical records in person.
(Name of person authorized to receive the record)

3. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED

☑ Complete medical record *(please specify dates of service)* 06-01-09 to DATE

OR

☐ Partial medical record *(please specify records below)*

Information	Dates	Information	Dates
☐ History and Physical		☐ Office Notes	
☐ Consultations		☐ Operative Reports	
☐ Discharge Summary		☐ Pathology Reports	
☐ Lab Results		☐ EKG Reports	
☐ X-rays		☐ HIV / AIDS Information	
☐ Drug / Alcohol Abuse treatment		☐ Mental Health Treatment	

☐ Other: _____ - *please specify dates of service:* _____

☐ ***You must check this box if you are also requesting Billing Records***

770-810-4193

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION - page 2

4. PURPOSE OF DISCLOSURE

☐ My personal records ☐ Attorney ☑ Disability
☐ Other: VA - DoD DISABILITY CLAIM

5. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, this authorization will expire on 12-31-2020. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.
(insert date or event)

6. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present written revocation to the Health Information Management Department(s) of the WellStar Health System facility or facilities checked above. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees. The fee schedule may be viewed at www.wellstar.org.

8. REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE

I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that WellStar Health System may decline to treat me if I refuse to sign this information only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

9. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

10. RELEASE AND WAIVER

If the health information that I have requested WellStar Health System to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above.

I also release WellStar Health System, each of the WellStar Health System facilities checked above and their officers trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

Eugene D. Maurin
Signature of Patient (or Patient's Legal Representative)

3-31-20
Date

Description of Authority to Act for Patient

NOTE: A COPY OF THIS COMPLETED, SIGNED, AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.

WellStar Medical Group Names and Providers

WellStar Medical Group - East Paulding Primary Care Center - Hiram, GA

Dr. Jeffery Tharp

Susan Ashworth, NP

WellStar Medical Group - Cardiovascular Medicine – Hiram, GA

Dr. Abdul Sheikh

Dr. Anand Kenia

WellStar Medical Group – Urology – Hiram, GA

Dr. Kristan Boren

Dr. Beau Dussealt

ENCOUNTER

Patient Class:	**OP**		Unit:	**KHUROPROC**
Hospital Service:	**No service for patient encounter.**		Bed:	**Room/bed info not found**
Admitting Provider:			Referring Physician:	**Dusseault, Beau N**
Attending Provider:	**Beau n dusseault;David m***	AD: N	Adm Diagnosis:	**Elevated PSA [R97.20]**
Admission Date:	**11/16/2016**		Admission Time:	**0933**

PATIENT

Name	**Eugene George Maurice**	Sex:	**Male**	DOB:	**1/2/1949 (67 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:	**AETNA MEDICARE**	Plan:	**AETNA /MDCR ADV PPO H5521**
Group Number:	**AE35444002800010**	Insurance Type:	**INDEMNITY**
Subscriber Name:	**MAURICE,EUGENE G**	Subscriber DOB:	**01/02/1949**
Coverage	**P O BOX 981106** **EL PASO, TX 79998-1106**	Subscriber ID:	**MEBJ65MH**
		Pat. Rel. to Subscriber:	**Self**
Phone:	**(800)624-0756**	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 9, 2020

Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	11/16/2016 0933	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Outside Hospital	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Kennestone Urology Procedure Center
Admit Provider:		Attending Provider:	Beau N Dusseault, MD	Referring Provider:	Beau N Dusseault, MD

Reason for Visit

Post-op Check

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
11/16/2016 2359	Home Or Self Care	None	None	WellStar Kennestone Urology Procedure Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R97.20 [Principal]	Elevated prostate specific antigen (PSA)				
I10	Essential (primary) hypertension				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
E11.9	Type 2 diabetes mellitus without complications				
K75.9	Inflammatory liver disease, unspecified				
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.02	Long term (current) use of antithrombotics/antiplatelets	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			

Events

Hospital Outpatient at 11/16/2016 0933

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient

Discharge at 11/16/2016 2359

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient

Allergies as of 11/16/2016

Reviewed on 11/16/2016

No Known Allergies

Immunizations as of 11/16/2016

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	

Immunizations (continued) as of 11/16/2016

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

Medical as of 11/16/2016

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

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint

ED Records (continued)

Chief Complaint (continued)

Complaint	Onset	Comment	Last Edited By	Time	Relationship	ED Provider
Post-op Check	11/16/2016		Chrissie Pope, RN	11/17/2016 2:28 PM	None	No

ED Disposition

None

H&P - Encounter Notes

H&P by David M Schmidt, MD at 11/16/2016 10:38 AM

Author: David M Schmidt, MD
Filed: 11/16/2016 10:43 AM
Editor: David M Schmidt, MD (Physician)
Service: Urology
Date of Service: 11/16/2016 10:38 AM
Author Type: Physician
Status: Signed

History and Physical

Chief complaint: psa elevation

History of Present Illness:
Eugene G Maurice is a 67 y.o.male who is seen for Elevated PSA
-no symptoms
-no fhx prostate cancer

Lab Results

Component	Value	Date
PSA	5.3 (H)	09/27/2016
PSA	5.2 (H)	03/17/2016
PSA	3.9	02/04/2015
PSA	4.1 (H)	

Past History

Past Medical History

Diagnosis	Date

- CAD (coronary artery disease)
- Coronary atherosclerosis of native coronary artery
- Diabetes mellitus (HCC)
- Essential hypertension, benign
- Family history of ischemic heart disease
- Hyperlipidemia
- Hypertension
- Infectious viral hepatitis
  as teen/cannont recall what type
- Obesity
- Other and unspecified hyperlipidemia
- Other symptoms involving cardiovascular system
- PVD (peripheral vascular disease) (HCC)

H&P - Encounter Notes (continued)

H&P by David M Schmidt, MD at 11/16/2016 10:38 AM (continued)

Past Surgical History

Procedure	Laterality	Date
• Appendectomy		
• Coronary artery bypass graft *X6*		1992
• Carotid endarterectomy *x2*		
• Coronary stent placement *sheikh*		2014
• Colonoscopy *as of 9/2014 has not had this*		
• Shingles		9/2015

No Known Allergies

(Not in a hospital admission)

Social and Family History

Social History

Substance Use Topics

• Smoking status:	Former Smoker
Packs/day:	1.00
Years:	25.00
Types:	Cigarettes
Quit date:	4/7/1992
• Smokeless tobacco:	Never Used
• Alcohol use	Yes

Family History

Problem	Relation	Age of Onset
• Coronary artery disease	Mother	
• Other *MI*	Mother	
• Other *MI*	Brother	
• Anemia	Neg Hx	
• Arrhythmia	Neg Hx	
• Asthma	Neg Hx	
• Clotting disorder	Neg Hx	
• Fainting	Neg Hx	
• Heart attack	Neg Hx	
• Heart disease	Neg Hx	
• Heart failure	Neg Hx	
• Hyperlipidemia	Neg Hx	
• Hypertension	Neg Hx	
• Stroke	Neg Hx	

H&P - Encounter Notes (continued)

H&P by David M Schmidt, MD at 11/16/2016 10:38 AM (continued)

Pertinent items are noted in the History of Present Illness.

GEN: No acute distress
EYES: EOMI
HEENT: Moist mucus membranes, Sclera non-icteric
CV: Regular rate and rhythm by peripheral pulse
PULM: Easy work of breathing
ABD: Soft, Not tender, Not distended
EXT: No significant lower extremity edema
SKIN: No rashes appreciated
NEURO:No focal deficits

Assessment: PSA elevation

Plan: Prostate biopsy.

David M Schmidt, MD
Wellstar Urology
55 Whitcher St.
Marietta, GA 30060
(p) 770-428-4475
(f) 770-426-1499

Electronically Signed by David M Schmidt, MD on 11/16/2016 10:43 AM

Discharge Instr - Activity - Encounter Notes

Discharge Instr - Activity by Charlotte Hayes, RN at 11/16/2016 11:22 AM

Author: Charlotte Hayes, RN | Service: --- | Author Type: Registered Nurse
Filed: 11/16/2016 11:22 AM | Date of Service: 11/16/2016 11:22 AM | Status: Written
Editor: Charlotte Hayes, RN (Registered Nurse)

Discharge Instructions

1. General Anesthesia or Sedation

Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity

Discharge Instr - Activity - Encounter Notes (continued)

Discharge Instr - Activity by Charlotte Hayes, RN at 11/16/2016 11:22 AM (continued)

You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet

Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan

Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.

Prescriptions

Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care

Your physician may call you with biopsy results.

Special Complications to Watch For

You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

Electronically Signed by Charlotte Hayes, RN on 11/16/2016 11:22 AM

Surgery Report

General Information

Date: 11/16/2016
Location: WS Kennestone Urology Procedure at Tower Road
Patient class:
Time:
Room:
Case classification:
Status: Posted
Service:

Diagnosis Information

No post-op diagnosis codes associated with the log.

Case Tracking Events

Event	Time In
In Facility	
In Pre-Procedure	
In Block Room	
Out Block Room	
Pre-Procedure Complete	
Out of Pre-op	
Anesthesia Ready	
In Room	
Anesthesia Start	1103
Procedure Start	
Procedure End	
Out of Room	
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	1120
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Remove from Status Board	
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	

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

Surgery Report (continued)

PNDS Information (continued)

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)

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: N/A

Pre-Procedure Verification

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

Comments: prostate biopsy

Verification Date and Time: 11/16/2016 11:05 AM

Anesthesia Encounters

Anesthesia Encounter - Episode ID 17822655

Anesthesia Summary - Maurice, Eugene George [561253820] Male 67 y.o. Current as of 11/16/16 1121

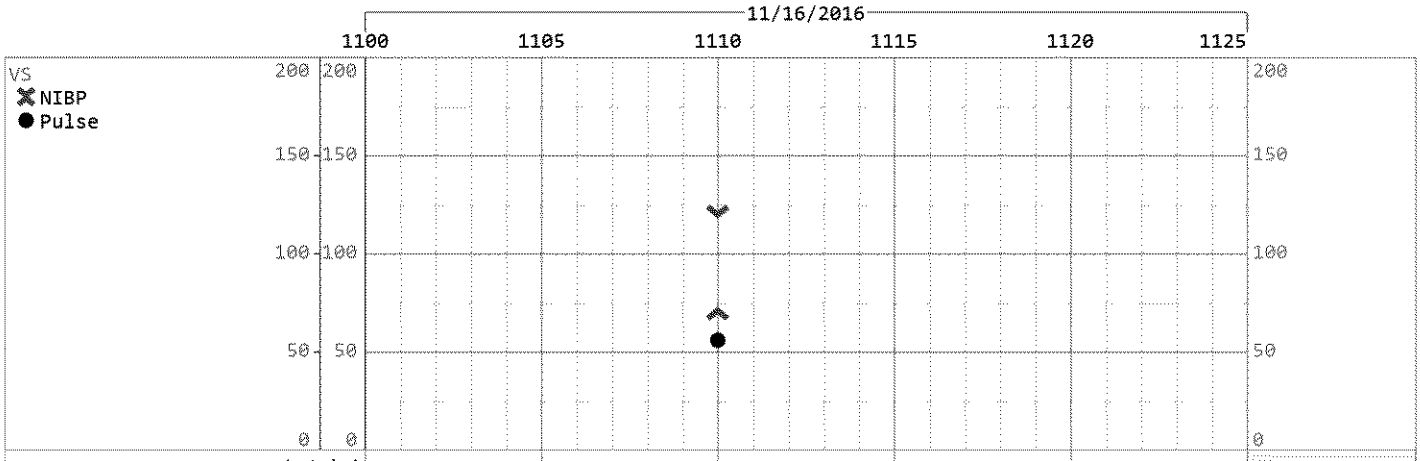
Height: 67" (1.702 m) (11/16/16)
Weight: 100.7 kg (222 lb) (11/16/16)
BMI: 34.8 (11/16/16)
NPO Status: Not recorded
Allergies: No Known Allergies

Procedure Summary

Date: 11/16/16
Anesthesia Start: 1103
Procedure: KUP PROSTATE BIOPSY W NDL
Scheduled Providers: David M Schmidt, MD
Anesthesia Type: MAC

Room / Location: WellStar Kennestone Urology Procedure Center
Anesthesia Stop: 1120
Diagnosis: Elevated PSA
Responsible Provider: Ashkan Yazdanpanah, DO
ASA Status: 2

Anesthesia Encounter - Episode ID 17822655 (continued)



O2	(L/min)		4 → 0			
propofol (DIPRIVAN) 10 m…	(mg)		200			200 mg
lidocaine 2% injection	(mg)		40			40 mg
EKG			Normal Sinus …	Normal Sinus …		
SpO2	(%)		99			
Vent Mode			Spontaneous	Spontaneous		

Staff

11/16/16

Name	Role	Begin	End
Ashkan Yazdanpanah, DO	ANMD	1103	1120

Events

Date	Time	Event
11/16/2016	1103	Anesthesia Start
	1105	Start Data Collection
	1105	Induction
	1111	Emergence
	1113	Stop Data Collection
	1120	Anesthesia Stop
	1120	Handoff I completed my SBAR handoff to the receiving nurse in the PACU.
	1121	Signed/Cosigned and Ready for Procedure

Anesthesia Medical History

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) (HCC)
Obesity	Hypertension
Hyperlipidemia	CAD (coronary artery disease)
Infectious viral hepatitis	Diabetes mellitus (HCC)
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	AKI (acute kidney injury) (HCC)
Cataracts, both eyes	Gout

Substance History

Smoking Status: Former Smoker - 25 pack years
Quit Smoking: 04/07/92
Smokeless Tobacco Status: Never Used
Alcohol use: Yes; 4.0 standard drinks per week
Drug use: No

Surgical History

Anesthesia Encounter - Episode ID 17822655 (continued)

Surgical History (continued)

APPENDECTOMY	CORONARY ARTERY BYPASS GRAFT
CAROTID ENDARTERECTOMY	CORONARY STENT PLACEMENT
COLONOSCOPY	shingles
EGD	VASCULAR SURGERY

Facility Administered Medications

Taken on 11/16/16

ciprofloxacin HCl (CIPRO) tablet	gentamicin (GARAMYCIN) injection 40 mg/mL
lidocaine (XYLOCAINE) local injection 2 %	lactated ringers infusion
~~lidocaine (XYLOCAINE) local injection 2 % (Discontinued)~~	~~propofol (DIPRIVAN) injection 10 mg/mL (Discontinued)~~

Prescription Medications

Within last 14 days from 11/16/16

	Last Taken	Last Updated
ciprofloxacin HCl (CIPRO) 500 MG tablet		
aspirin, buffered 81 mg Tab	Past Week	11/16/16 1029
atorvastatin (LIPITOR) 80 MG tablet	11/15/2016	11/16/16 1029
blood sugar diagnostic (GLUCOSE BLOOD) strip	Taking	10/06/16 0850
carvedilol (COREG) 12.5 MG tablet	11/16/2016	11/16/16 1029
chlorthalidone (HYGROTEN) 50 MG tablet	11/16/2016	11/16/16 1029
clopidogrel (PLAVIX) 75 mg tablet	Past Week	11/16/16 1029
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	11/16/2016	11/16/16 1029
metFORMIN (GLUCOPHAGE) 500 MG tablet	11/15/2016	11/16/16 1029
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	More than a month	11/16/16 1029
ramipril (ALTACE) 10 MG capsule	11/16/2016	11/16/16 1029

Preprocedure Vitals

Current as of 11/16/16 1121

BP: 96/51
Pulse: 53
Resp: 18
SpO2: 99
Temp: 96.2 °F (35.7 °C)
Height: 67" (1.702 m) (11/16/16)
Weight: 100.7 kg (222 lb) (11/16/16)
BMI: **34.8**
IBW: 66.1 kg (145 lb 12.2 oz)
Last edited 11/16/16 1121 by CH
Currently displaying vitals information from multiple entries within 15 minutes of most recent vitals.

Blood Orders

Ordered in last 14 days - Current as of 04/09/20 0952

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	13.3 ˅
HCT	--
Plt	--

Electrolyte Labs (Last 90 days)

	03/17 0914
K+	5.2 ^
Na+	--
Cl-	--
HCO3	

Anesthesia Encounter - Episode ID 17822655 (continued)

Electrolyte Labs (continued) (Last 90 days)

	03/17 0914
	--

Procedure Notes

No procedure notes have been written.

Preprocedure Note

Last edited 11/16/16 1032 by Ashkan Yazdanpanah, DO
Date of Service 11/16/16 1030
Status: Signed

Anesthesia Pre-op Evaluation

Patient Name: Eugene G Maurice
Date of Birth: 1/2/1949 **Age:** 67 yrs **Sex:** Male
MRN: 561253820

Pre-Assessment Information

No Known Allergies

Patient Active Problem List

Diagnosis

- Family history of ischemic heart disease
- Hyperlipidemia
- Essential hypertension, benign
- PVD (peripheral vascular disease) (HCC)
- Obesity
- Hypertension
- CAD (coronary artery disease)
- Type 2 diabetes mellitus, controlled (HCC)

Past Medical History

Diagnosis — Date

- CAD (coronary artery disease)
- Coronary atherosclerosis of native coronary artery
- Diabetes mellitus (HCC)
- Essential hypertension, benign
- Family history of ischemic heart disease
- Hyperlipidemia
- Hypertension
- Infectious viral hepatitis
  as teen/cannont recall what type
- Obesity
- Other and unspecified hyperlipidemia
- Other symptoms involving cardiovascular system
- PVD (peripheral vascular disease) (HCC)

Anesthesia Encounter - Episode ID 17822655 (continued)

Preprocedure Note (continued)

Past Surgical History

Procedure	Laterality	Date
• Appendectomy		
• Coronary artery bypass graft *X6*		1992
• Carotid endarterectomy *x2*		
• Coronary stent placement *sheikh*		2014
• Colonoscopy *as of 9/2014 has not had this*		
• Shingles		9/2015

Social History Main Topics

• Smoking status:	Former Smoker
Packs/day:	1.00
Years:	25.00
Types:	Cigarettes
Quit date:	4/7/1992
• Smokeless tobacco:	Never Used
• Alcohol use	Yes
• Drug use:	No
• Sexual activity:	Not on file

Documented NPO status:
No Data Recorded

Pre-operative Evaluation

Review of Systems/Medical History

General: Patient summary reviewed and Nursing notes reviewed.
Anesthesia History:
Cardiovascular:
(+) hypertension: CAD,

Pulmonary: Negative ROS

Neuro/Psych: - Negative ROS

GI/Hepatic/Renal:
(+) hepatitis, liver disease,

Endo/Other:
(+) diabetes mellitus Type 2,

Physical Exam

Airway:
Mallampati: II
Neck ROM: full
TM distance: >3 FB

Dental:

Patient aware of dental risks.

Anesthesia Plan

ASA: 2
Anesthetic Plan: MAC
Airway Management: supplemental O2

Induction: Intravenous

Anesthetic plan and risks discussed with: Patient.

Electronically signed by Ashkan Yazdanpanah, DO at 11/16/2016 10:32 AM

Anesthesia Encounter - Episode ID 17822655 (continued)

Preprocedure Note (continued)

All Postprocedure Notes

Last edited 11/16/16 1121 by Ashkan Yazdanpanah, DO
Date of Service 11/16/16 1121
Status: Signed

Patient: Eugene G Maurice
* No procedures listed *
Anesthesia type: MAC

Patient location: PACU
Last vitals:
Vitals:

	11/16/16 1116
BP:	(!) 93/46
Pulse:	54
Resp:	18
Temp:	35.7 °C (96.2 °F)
SpO2:	98%

Post vital signs: stable
Level of consciousness: awake, alert, oriented and pre-op baseline

Post-anesthesia pain: adequate analgesia
Airway patency: patent
Respiratory: unassisted
Cardiovascular: stable and blood pressure at baseline
Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting

Anesthesia complications: no

Electronically signed by Ashkan Yazdanpanah, DO at 11/16/2016 11:21 AM

Attestation Information

Staff Name	Date	Time	Type
Ashkan Yazdanpanah, DO	11/16/16	1032	Pre-induction Assessment
Ashkan Yazdanpanah, DO	11/16/16	1033	Present for MAC

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
propofol (DIPRIVAN) 10 mg/mL injection (mg)	200 mg	Given	11/16/16 1109	Ashkan Yazdanpanah, DO	
lidocaine 2% injection (mg)	40 mg	Given	11/16/16 1105	Ashkan Yazdanpanah, DO	

Signoff Status

None

Flowsheets (all recorded)

Agents

Row Name	11/16/16 1113	11/16/16 1105
Agents		
O2	0 L/min -AY	4 L/min -AY

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	11/16/16 0000
Anesthesia Checklist	
Monitors In Use	Anesthesia apparatus checked;Pulse oximeter;O2 analyzer -AY
NIBP Site	Arm R -AY
Cardiac	EKG -AY
Leads	3 -AY

Flowsheets (all recorded)

Agents

Row Name	11/16/16 1113	11/16/16 1105
Agents		
O2	0 L/min -AY	4 L/min -AY

Flowsheets (all recorded)

BP/Pulse

Row Name	11/16/16 1110
BP/Pulse	
NIBP	119/72 -AY
Pulse	56 -AY

Flowsheets (all recorded)

Anesthesia Monitoring

Row Name	11/16/16 1110	11/16/16 1106
Assessment		
EKG	Normal Sinus Rhythm -AY	Normal Sinus Rhythm -AY
Respiratory		
Vent Mode	Spontaneous -AY	Spontaneous -AY
OTHER		
SpO2	—	99 % -AY

User Key

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

Initials	Name	Effective Dates
AY	Ashkan Yazdanpanah, DO	11/16/16 - 12/06/16

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Nursing - Orders and Results

PATIENT EDUCATION (SPECIFY) [645208499]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: C D Allen, RN 11/10/16 1346
Authorized by: David M Schmidt, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]
Order comments: On preparation for the procedure as well as discharge instructions
Communicated by: C D Allen, RN
Ordering provider: David M Schmidt, MD
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 11/16/2016 10:21 AM

MAINTAIN IV ACCESS [645968761]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 11/16/16 1022
Authorized by: Ashkan Yazdanpanah, DO
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]
Communicated by: Sharon H Crider, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 10:44 AM

PATIENT EDUCATION (SPECIFY) [645968779]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Discontinued**
Ordering user: David M Schmidt, MD 11/16/16 1119
Authorized by: David M Schmidt, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]
Ordering provider: David M Schmidt, MD
Ordering mode: Standard
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:22 AM

NURSING OXYGEN ORDERS/INSTRUCTIONS [645968780]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Discontinued**
Ordering user: David M Schmidt, MD 11/16/16 1119
Authorized by: David M Schmidt, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]
Order comments: Discontinue when pulse ox greater than 90%
Ordering provider: David M Schmidt, MD
Ordering mode: Standard
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:22 AM

NURSING COMMUNICATION [645968781]

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [645968781] (continued)

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Discontinued**
Ordering user: David M Schmidt, MD 11/16/16 1119
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:22 AM
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]
Order comments: After patient meets criteria.

DISCHARGE DIET [645968770]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Active**
Ordering user: David M Schmidt, MD 11/16/16 1119
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Frequency: Routine 11/16/16 -
Quantity: 1
Released by: Charlotte Hayes, RN 11/16/16 1122
Acknowledged: Charlotte Hayes, RN 11/16/16 1122 for Placing Order
Order comments: Resume previous diet

DISCHARGE ACTIVITY [645968771]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Active**
Ordering user: David M Schmidt, MD 11/16/16 1119
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Frequency: Routine 11/16/16 -
Quantity: 1
Released by: Charlotte Hayes, RN 11/16/16 1122
Acknowledged: Charlotte Hayes, RN 11/16/16 1122 for Placing Order
Order comments: Resume previous activity

DISCHARGE FOLLOW UP [645968772]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Active**
Ordering user: David M Schmidt, MD 11/16/16 1119
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Frequency: Routine 11/16/16 -
Quantity: 1
Released by: Charlotte Hayes, RN 11/16/16 1122
Acknowledged: Charlotte Hayes, RN 11/16/16 1122 for Placing Order
Order comments: .

IV - Orders and Results

INSERT PERIPHERAL IV [645968760]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 11/16/16 1022
Ordering provider: Ashkan Yazdanpanah, DO
Authorized by: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 10:44 AM
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]

INT [645968762]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 11/16/16 1022
Ordering provider: Ashkan Yazdanpanah, DO
Authorized by: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 10:44 AM
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]

DISCONTINUE IV [645968778]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119**
Status: **Discontinued**
Ordering user: David M Schmidt, MD 11/16/16 1119
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:22 AM
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]

IV - Orders and Results (continued)

Discharge - Orders and Results

DISCHARGE PATIENT [645968777]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1119** Status: **Completed**
Ordering user: David M Schmidt, MD 11/16/16 1119
Authorized by: David M Schmidt, MD
Quantity: 1
Ordering provider: David M Schmidt, MD
Ordering mode: Standard
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:22 AM

Imaging - Orders and Results

KUP PROSTATE BIOPSY W NDL [645208494]

Electronically signed by: **Beau N Dusseault, MD on 10/06/16 0936** Status: **Completed**
Ordering user: Beau N Dusseault, MD 10/06/16 0936
Ordering mode: Standard
Quantity: 1
Instance released by: Chastity Payton 11/16/2016 9:33 AM
Authorized by: Beau N Dusseault, MD
Lab status: Final result
Diagnoses
Elevated PSA [R97.20]

Questionnaire

Question	Answer
Do you have a joint replacement, pacemaker, or any hardware?	No
Have you ever had MRSA or VRE?	No
Have you had C-Diff with active diarrhea or been on treatment for C-diff in the last 6 months?	No

Scheduling instructions
Needs cardiac clearance from sheikh for blood thinners
12 cores; TRUS at time of bx
Clinical stage: T1c
PSA: 5.3
Abx: cipro, gent
With anesthesia

KUP PROSTATE BIOPSY W NDL [645208494] Resulted: 11/16/16 1120, Result status: Final result

Order status: Completed
Filed by: David M Schmidt, MD 11/16/16 1121
Accession number: 27746907
Resulted by: David M Schmidt, MD
Performed: 11/16/16 1107 - 11/16/16 1111
Result details
Narrative:
OPERATIVE NOTE

Name: Eugene G Maurice
DOB: 1/2/1949
MRN: 561253820
DOS: 11/16/2016

Pre-operative Diagnosis: Elevated PSA.

Post-operative Diagnosis: same
Surgeon: David M Schmidt, MD

Assistants: None

Operation:
1. Transrectal ultrasound for guidance of prostate biopsies
2. Transrectal prostate biopsies
3. Periprostatic block for postoperative pain control
(55700, 76942, 64450)

Indications: Eugene G Maurice is a 67 y.o.male who presents for the above procedure due to the above diagnosis. I discussed risks, benefits and alternative treatments with the patient and the patient elected to proceed with the documented plan. All questions were answered. PSA 40.3 ng/mL.

Anesthesia: IV sedation
Complications: None

Imaging - Orders and Results (continued)

EBL: less than 5 mL
IVF: Maintenance
UOP: Unquantifiable

Specimen: 12 cores of prostate tissue labeled by sextant

Findings:
1. Prostate size: 40.3 cubic centimeters by TRUS
2. Asymmetry of the prostate: no
3. Capsule intact:yes
4. Hypoechoic lesions or hyperechoic lesion: No
5. Seminal vesicles: normal

Technique:
The patient confirmed compliance with preoperative enema and antibiotic. The patient was taken to the operative suite. After time out the patient underwent IV sedation per anesthesia. He was then placed in a lateral decubitus position. He was prepped and draped in the standard fashion left lateral decubitus position and time out was performed.

Perioperative antibiotics were given prior to the procedure.

The 7.7 MHz ultrasound probe (GE Model RT 3200 machine) was then placed in the rectum without difficulty. Subsequently 5 mL of 1% plain Marcaine was infiltrated using a spinal needle and ultrasonic guidance into the junction of the seminal vesicle and prostate gland on each side for intraoperative and post operative pain control.

Next, sequential transverse (axial) scans were made in small increments beginning at the seminal vesicles and ending at the prostate apex. Sequential longitudinal (sagittal) scans were made in small increments beginning at the right lateral prostate and ending at the left lateral prostate. Excellent anatomical imaging was obtained with peripheral, transitional, and central zones well defined, as well as the seminal vesicles.

12 biopsies were performed in total. 6 biopsies were obtained from the lateral part of each lobe at the apex, mid-gland, and base . 6 biopsies were additionally taken from the medial part of each lobe spaced evenly from apex to base. Care was taken to avoid the urethra and bladder. Excellent biopsy specimens were obtained. The procedure was tolerated well and the patient transported to recovery in stable condition.

Appropriate patient post procedure education was provided prior to discharge.

Disposition:
1. Follow up path to Dr Dusseault
2. Discharge condition: good
3. Medications: no new medications
4. Diet: resume previous
5. Activity: resume previous

David M Schmidt, MD
WellStar Kennestone Urology Procedure Center
300 Tower Road
Marietta GA 30060-9405
Dept: 770-428-4475
Dept Fax: 678-594-0072

Acknowledged by: Beau N Dusseault, MD on 11/16/16 1556

Pathology and Cytology - Orders and Results

Pathology and Cytology - Orders and Results (continued)

SURGICAL PATHOLOGY-KH [645968785]

Electronically signed by: **Interface, Lab In Copath on 11/16/16 1426** Status: **Completed**
Ordering user: Interface, Lab In Copath 11/16/16 1426 Ordering provider: Beau N Dusseault, MD
Authorized by: Beau N Dusseault, MD Ordering mode: Standard
Quantity: 1 Lab status: Final result
Instance released by: (auto-released) 11/16/2016 2:26 PM

Specimen Information

Type	Source	Collected By
—	—	11/16/16 1425

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

SURGICAL PATHOLOGY-KH [645968785]

Resulted: 11/18/16 1642, Result status: Final result

Ordering provider: Beau N Dusseault, MD 11/16/16 1426 Order status: Completed
Filed by: Interface, Lab In Copath 11/18/16 1643 Resulting lab: WELLSTAR
Result details
Acknowledged by
Beau N Dusseault, MD on 11/18/16 1644
Farrah Khan, MA on 11/21/16 0920
Lisa L Thompson on 08/21/17 1155

Specimen Information

Type	Source	Collected By
—	—	11/16/16 1425

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

Components

Component	Value	Reference Range	Flag	Lab
SURGICAL PATHOLOGY-KH	—	—	—	Wellstar

Comment:
WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060
Phone Number: (770) 793-5505
Fax Number: (770) 793-7919 David Schlosnagle, M.D., Laboratory Director
Patient Name: MAURICE, EUGENE G Accession #: KS16-19418 Patient #: 2065492454\561253820\1\1\ MRN. #: 561253820 Sex: M Location: UASC (KH)
DOB/Age: 1/2/1949 (Age: 67) Location: UASC (KH) Client: Wellstar Kennestone
Hospital Received: 11/16/2016 Admitting Date: 11/16/2016 Collected: 11/16/2016
Final Report: 11/18/2016 16:42 Order Physician: BEAU N DUSSEAULT Admit MD: DAVID M SCHMIDT Other Inst: <Not Provided> Copy To: <Not Provided>
SURGICAL PATHOLOGY-KH REPORT
Pre-Operative Diagnosis:
<Not Provided>
Post-Operative Diagnosis:
<Not Provided>
Clinical History:
790.93 Elevated PSA; value (5.3); DECIPHER
Specimen:
Prostate biopsy x12
Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice	LB	14	1A
2. Maurice	LM	18	2A
3. Maurice	LA	14	3A
4. Maurice	RB	13	4A
5. Maurice	RM	13	5A
6. Maurice	RA	4 and 6	6A
7. Maurice	LLB	12	7A
8. Maurice	LLM	1.5 and 12	8A
9. Maurice	LLA	13	9A
10. Maurice	RLB	14	10A
11. Maurice	RLM	12	11A
12. Maurice	RLA	13	12A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are inked orange. HL/zc/klt
11/16/16

Pathology and Cytology - Orders and Results (continued)

Microscopic Description:
1-12. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis.
ACP/rcd 11/18/16
A PIN4 multiplex immunohistochemical stain (CK5, CK14, p63 and P504S) is performed on blocks 2A, 8A, 9A and 11A. Demonstration of staining of basal cells surrounding the glands of interest and lack of overexpression of p504s support the final diagnosis. Appropriate controls were performed, reviewed and found to exhibit the expected reactivity.

Final Diagnosis:
PROSTATE BIOPSY X 12: BENIGN
1. PROSTATE, LEFT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ATROPHY.
2. PROSTATE, LEFT MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH CHRONIC INFLAMMATION AND ATROPHY.
4. PROSTATE, RIGHT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
5. PROSTATE, RIGHT
MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ACUTE AND CHRONIC INFLAMMATION.
6. PROSTATE, RIGHT APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ATROPHY.
8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

****Electronically Signed Out By**** Aimee C. Popp, M.D.
ACP 11/18/2016

Aimee C.
Popp, M.D.
CPT: 1: G0416
11: 88344
2: 88344
8: 88344
9: 88344

View Image (below)

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (770) 793-7919

David Schlosnagle, M.D., Laboratory Director

Patient Name:	**MAURICE, EUGENE G**			Accession #:	**KS16-19418**
Patient #:	2065492454\561253820\1\1\	MRN. #:	561253820	Sex:	M
Location:	UASC (KH)	DOB/Age:	1/2/1949 (Age: 67)		
Location:	UASC (KH)	Client:	Wellstar Kennestone Hospital	Received:	11/16/2016
Admitting Date:	11/16/2016	Collected:	11/16/2016	Final Report:	11/18/2016 16:42
Order Physician:	BEAU N DUSSEAULT	Admit MD:	DAVID M SCHMIDT	Other Inst:	<Not Provided>
		Copy To:	<Not Provided>		

SURGICAL PATHOLOGY-KH REPORT

Pre-Operative Diagnosis:
<Not Provided>

Post-Operative Diagnosis:
<Not Provided>

Clinical History:
790.93 Elevated PSA; value (5.3); DECIPHER

Specimen:
Prostate biopsy x12

Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice	LB	14	1A
2. Maurice	LM	18	2A
3. Maurice	LA	14	3A
4. Maurice	RB	13	4A
5. Maurice	RM	13	5A
6. Maurice	RA	4 and 6	6A
7. Maurice	LLB	12	7A
8. Maurice	LLM	1.5 and 12	8A
9. Maurice	LLA	13	9A
10. Maurice	RLB	14	10A
11. Maurice	RLM	12	11A
12. Maurice	RLA	13	12A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are inked orange. HL/zc/klt 11/16/16

Microscopic Description:
1-12. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis. ACP/rcd 11/18/16
A PIN4 multiplex immunohistochemical stain (CK5, CK14, p63 and P504S) is performed on blocks 2A, 8A, 9A and 11A. Demonstration of staining of basal cells surrounding the glands of interest and lack of overexpression of p504s support the final diagnosis. Appropriate controls were performed, reviewed and found to exhibit the expected reactivity.

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
Phone Number: (770) 793-5505 677 Church Street
Fax Number: (770) 793-7919 Marietta, Georgia 30060 David Schlosnagle, M.D., Laboratory Director

Final Diagnosis:
PROSTATE BIOPSY X 12: BENIGN

1. PROSTATE, LEFT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ATROPHY.

2. PROSTATE, LEFT MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH CHRONIC INFLAMMATION AND ATROPHY.

4. PROSTATE, RIGHT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

5. PROSTATE, RIGHT MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ACUTE AND CHRONIC INFLAMMATION.

6. PROSTATE, RIGHT APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE WITH ATROPHY.

8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

****Electronically Signed Out By Aimee C. Popp, M.D.****
ACP 11/18/2016 Aimee C. Popp, M.D.

CPT: 1: G0416
11: 88344
2: 88344
8: 88344

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
Phone Number: (770) 793-5505 677 Church Street
Fax Number: (770) 793-7919 Marietta, Georgia 30060 David Schlosnagle, M.D., Laboratory Director

9: 88344

END OF REPORT

CORE MEASURES - Orders and Results

REASON FOR NO MECHANICAL PROPHYLAXIS [645208500]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518** Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode Communicated by: C D Allen, RN
Ordering user: C D Allen, RN 11/10/16 1346 Ordering provider: David M Schmidt, MD

CORE MEASURES - Orders and Results (continued)

REASON FOR NO MECHANICAL PROPHYLAXIS [645208500] (continued)

Authorized by: David M Schmidt, MD
Quantity: 1
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 11/16/2016 10:21 AM

Questionnaire

Question	Answer
If SCDs NOT ordered, indicate reason:	Total Risk Factor Score less than or equal to 1

REASON FOR NO VTE PROPHYLAXIS AT ADMISSION [645968753]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: C D Allen, RN
Ordering user: C D Allen, RN 11/10/16 1346
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Sharon H Crider, RN (auto-released) 11/16/2016 10:21 AM

Questionnaire

Question	Answer
Reason for no pharm VTE prophylaxis at admission?	Patient is at low risk for VTE - No pharm VTE Prophylaxis required

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [645968765]

Electronically signed by: **Interface, Lab In Sunquest on 11/16/16 1048**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 11/16/16 1048
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: (auto-released) 11/16/2016 10:49 AM

Specimen Information

Type	Source	Collected By
---	---	11/16/16 1048

POC FINGER STICK GLUCOSE [645968765] (Abnormal)
Resulted: 11/16/16 1049, Result status: Final result

Ordering provider: David M Schmidt, MD 11/16/16 1048
Order status: Completed
Filed by: Interface, Lab In Sunquest 11/16/16 1049
Resulting lab: WS KENNESTONE HOSPITAL LAB
External ID: W14341764
Result details
Acknowledged by: David M Schmidt, MD on 11/16/16 1513

Specimen Information

Type	Source	Collected By
---	---	11/16/16 1048

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	109	70 - 99 mg/dL	H	KHLAB

POC FINGER STICK GLUCOSE [645968783]

Electronically signed by: **Interface, Lab In Sunquest on 11/16/16 1154**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 11/16/16 1154
Ordering provider: David M Schmidt, MD
Authorized by: David M Schmidt, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: (auto-released) 11/16/2016 11:59 AM

Specimen Information

Type	Source	Collected By
---	---	11/16/16 1154

Point of Care Testing-Docked Device - Orders and Results (continued)

POC FINGER STICK GLUCOSE [645968783] (continued)

POC FINGER STICK GLUCOSE [645968783] (Abnormal) — Resulted: 11/16/16 1158, Result status: Final result

Ordering provider: David M Schmidt, MD 11/16/16 1154
Filed by: Interface, Lab In Sunquest 11/16/16 1159
External ID: W14342647
Acknowledged by: David M Schmidt, MD on 11/16/16 1513

Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
---	---	11/16/16 1154

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	100	70 - 99 mg/dL	H	KHLAB

Diet - Orders and Results

DIET, NPO [645968786]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 11/16/16 1022
Authorized by: Ashkan Yazdanpanah, DO
Quantity: 1
Instance released by: Charlotte Hayes, RN (auto-released) 11/16/2016 11:31 PM

Communicated by: Sharon H Crider, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Diet: NPO
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [Patient Discharge]

Medications - Orders and Results

gentamicin (GARAMYCIN) injection 40 mg/mL [645208498]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518** — Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: C D Allen, RN 11/10/16 1346
Authorized by: David M Schmidt, MD
Frequency: Routine Once 11/16/16 1100 - 1 occurrence
Acknowledged: Charlotte Hayes, RN 11/16/16 1029 for Placing Order

Communicated by: C D Allen, RN
Ordering provider: David M Schmidt, MD
Ordering mode: Per protocol: cosign required
Released by: Sharon H Crider, RN 11/16/16 1021

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Preop - Prophylaxis
Expected days of therapy:	1

Package: 63323-010-02

sodium chloride 0.9 % (NS) flush [645968758]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 11/16/16 1022
Authorized by: Ashkan Yazdanpanah, DO
PRN reasons: line care
Frequency: Routine Q1 min PRN 11/16/16 1044 - 11/24/16 0410
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [(Patient Discharge - Internal Use Only)]
Acknowledged: Charlotte Hayes, RN 11/16/16 1044 for Placing Order
Admin instructions: INT Flush
Package: 8881-579121

Communicated by: Sharon H Crider, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Released by: Charlotte Hayes, RN 11/16/16 1044

lactated ringers infusion [645968759]

Electronically signed by: **Ashkan Yazdanpanah, DO on 11/16/16 1505** — Status: **Discontinued**

Medications - Orders and Results (continued)

lactated ringers infusion [645968759] (continued)

Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 11/16/16 1022
Authorized by: Ashkan Yazdanpanah, DO
Frequency: Routine Continuous 11/16/16 1100 - 11/24/16 0410
Discontinued by: Automatic Discharge Provider 11/24/16 0410 [(Patient Discharge - Internal Use Only)]
Acknowledged: Charlotte Hayes, RN 11/16/16 1044 for Placing Order
Package: 0409-7953-09

Communicated by: Sharon H Crider, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Released by: Charlotte Hayes, RN 11/16/16 1044

ciprofloxacin HCl (CIPRO) tablet [645968763]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Charlotte Hayes, RN 11/16/16 1047
Authorized by: David M Schmidt, MD
Frequency: Routine Once 11/16/16 1100 - 1 occurrence
Acknowledged: Charlotte Hayes, RN 11/16/16 1047 for Placing Order

Status: **Completed**

Communicated by: Charlotte Hayes, RN
Ordering provider: David M Schmidt, MD
Ordering mode: Per protocol: cosign required

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Preop - Prophylaxis
Expected days of therapy:	1

Admin instructions: Avoid aluminum, magnesium, zinc, calcium, antacids, or iron. Take at least 2 hours before or 6 hours after these agents.
Package: 55111-127-01

lidocaine (XYLOCAINE) local injection 2 % [645968766]

Electronically signed by: **David M Schmidt, MD on 11/16/16 1518**
Mode: Ordering in Verbal with readback mode
Ordering user: Charlotte Hayes, RN 11/16/16 1109
Authorized by: David M Schmidt, MD
Frequency: Routine Once PRN 11/16/16 1108 - 11/16/16 1108

Status: **Completed**

Communicated by: Charlotte Hayes, RN
Ordering provider: David M Schmidt, MD
Ordering mode: Verbal with readback
Package: 0409-4277-02

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
12 - Wellstar	WELLSTAR	Unknown	Unknown	10/12/15 1541 - 12/02/19 1533
19 - KHLAB	WS KENNESTONE HOSPITAL LAB	Dr. David Schlosnagle	677 CHURCH ST MARIETTA GA 30060	11/04/13 1206 - 08/28/18 1256

Medications

All Meds and Administrations

gentamicin (GARAMYCIN) injection 40 mg/mL [645208498]

Ordering Provider: David M Schmidt, MD
Ordered On: 11/16/16 1021
Dose (Remaining/Total): 5 mg/kg (Adjusted) (0/1)
Frequency: Once
Status: Completed (Past End Date/Time)
Starts/Ends: 11/16/16 1100 - 11/16/16 1044
Route: Intravenous
Rate/Duration: — / —

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Preop - Prophylaxis	—
Expected days of therapy::	1	—

Line	Med Link Info	Comment
Peripheral IV 11/16/16 22 G Left Hand	11/16/16 1044 by Charlotte Hayes, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 11/16/16 1044 Documented: 11/16/16 1044	Given	400 mg	Intravenous	Performed by: Charlotte Hayes, RN

sodium chloride 0.9 % (NS) flush [645968758]

Ordering Provider: Ashkan Yazdanpanah, DO
Ordered On: 11/16/16 1044
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: 11/16/16 1044 - 11/24/16 0410
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

lactated ringers infusion [645968759]

Ordering Provider: Ashkan Yazdanpanah, DO
Ordered On: 11/16/16 1044
Dose (Remaining/Total): 50 mL/hr (—/—)
Frequency: Continuous
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/16/16 1100 - 11/24/16 0410
Route: Intravenous
Rate/Duration: 50 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 11/16/16 22 G Left Hand	11/16/16 1044 by Charlotte Hayes, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 11/16/16 1044 Documented: 11/16/16 1044	New Bag	50 mL/hr 50 mL/hr	Intravenous	Performed by: Charlotte Hayes, RN

ciprofloxacin HCl (CIPRO) tablet [645968763]

Ordering Provider: David M Schmidt, MD
Ordered On: 11/16/16 1047
Dose (Remaining/Total): 500 mg (0/1)
Frequency: Once
Admin Instructions: Avoid aluminum, magnesium, zinc, calcium, antacids, or iron. Take at least 2 hours before or 6 hours after these agents.
Status: Completed (Past End Date/Time)
Starts/Ends: 11/16/16 1100 - 11/16/16 1047
Route: Oral
Rate/Duration: — / —

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Preop - Prophylaxis	—
Expected days of therapy::	1	—

Timestamps	Action	Dose	Route	Other Information
Performed 11/16/16 1047 Documented: 11/16/16 1047	Given	500 mg	Oral	Performed by: Charlotte Hayes, RN

Medications (continued)

All Meds and Administrations (continued)

lidocaine (XYLOCAINE) local injection 2 % [645968766]

Ordering Provider: David M Schmidt, MD
Ordered On: 11/16/16 1109
Status: Completed (Past End Date/Time)
Frequency: Once as needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 11/16/16 1108 Documented: 11/16/16 1109	Given	10 mL	Other Other	Performed by: David M Schmidt, MD Documented by: Charlotte Hayes, RN Comments: prostate

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.

Patient Education (continued)

Education (continued)

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.

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)

Patient Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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.

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".

Patient Education (continued)

Education (continued)

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)

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 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: 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.

Patient Education (continued)

Education (continued)

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)

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)

Patient Education (continued)

Education (continued)

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	11/16/16 1144	11/16/16 1120	11/16/16 1116	11/16/16 1029
Adult IBW/VT Calculations				
IBW/kg (Calculated)	—	—	—	66.1 -CH
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -CH
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -CH
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -CH
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -CH
Vitals				
Pct Wt Change	—	—	—	0 % -CH
OTHER				
Weight Change (kg)	—	—	—	0 kg -CH
Ideal Body Weight	—	—	—	160 lb -CH
Visit Weight	—	—	—	222 lb -CH
BMI (Calculated)	—	—	—	34.8 -CH
IBW/kg (Calculated) Male	—	—	—	66.1 kg -CH
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -CH
Weight in (lb) to have BMI = 25	—	—	—	159.3 -CH
% Weight Change Since Birth	—	—	—	0 -CH
Relevant Labs and Vitals				
Temp (in Celsius)	—	—	36.7 -CH	36.2 -CH
Case Log				
BSA x (CI @3.0)= CO	—	—	—	6.54 CO -CH
Aldrete Phase 1				
Aldrete Score	10 -CH	6 -CH	—	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	11/24/16 0210
OTHER	
Risk for Readmission	6 -BP

Flowsheets (all recorded)

Travel Information

Row Name	11/16/16 1029
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 -CH

Flowsheets (all recorded)

Aldrete Score

Row Name	11/16/16 1144	11/16/16 1120
Aldrete		
Activity	2 -CH	2 -CH
Respiration	2 -CH	2 -CH
Circulation	2 -CH	0 -CH
Consciousness	2 -CH	1 -CH
O2 Saturation	2 -CH	1 -CH
Aldrete Score (PAR)	10 -CH	6 -CH

Flowsheets (all recorded)

Vital Signs

Row Name	11/16/16 1141	11/16/16 1126	11/16/16 1121	11/16/16 1116	11/16/16 1029
Vital Signs					
Automatic Restart Vitals Timer	Yes -CH	Yes -CH	Yes -CH	Yes -CH	Yes -CH
Pulse	53 -CH	52 -CH	53 -CH	54 -CH	50 -CH
Heart Rate Source	Monitor -CH	Monitor -CH	Monitor -CH	Monitor -CH	Monitor -CH
Resp	18 -CH	18 -CH	18 -CH	18 -CH	18 -CH
BP	140/63 -CH	109/53 -CH	96/51 -CH	(!) 93/46 -CH	174/77 -CH
Temp	—	—	—	96.2 °F (35.7 °C) -CH	97.1 °F (36.2 °C) -CH
Temp src	—	—	—	Axillary -CH	Oral -CH
Oxygen Therapy					
SpO2	99 % -CH	99 % -CH	99 % -CH	98 % -CH	98 % -CH
O2 Device	None (Room air) -CH	Nasal cannula -CH	Nasal cannula -CH	Nasal cannula -CH	None (Room air) -CH
O2 Flow Rate (L/min)	—	3 L/min -CH	3 L/min -CH	3 L/min -CH	—
Pulse Oximetry Type	Intermittent -CH	Continuous -CH	Continuous -CH	Continuous -CH	Continuous -CH
POX Probe Site Changed	No -CH	No -CH	No -CH	No -CH	No -CH

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	11/16/16 1120	11/16/16 1041
[REMOVED] Peripheral IV 11/16/16 22 G Left Hand		
IV Properties	Placement Date: 11/16/16 -CH Placement Time: 1041 -CH Present on arrival to hospital?: No -CH Type of Catheter: Straight -CH Size (Gauge): 22 G -CH Orientation: Left -CH Location: Hand -CH Site Prep: Alcohol -CH Inserted by: Charlotte Hayes RN -CH Insertion attempts: 2 -CH, one unsuccessful by Sharon Martinez RN Successful IV Attempt?: Yes -CH Patient Tolerance: Tolerated well -CH Removal Date: 11/16/16 -CH Removal Time: 1157 -CH Catheter Intact on removal?: Yes -CH Removal Reason : Patient discharged -CH Remaining intact at discharge?: No -CH	
Site Assessment	Asymptomatic;Clean;Dry;Intact -CH	Asymptomatic;Clean;Dry;Intact -CH
Phlebitis Scale	0 -CH	0 -CH
Infiltration/Extravasation Scale	0 -CH	0 -CH
Line Assessment	Infusing -CH	Infusing;Blood return noted -CH
Dressing Assesment	Clean;Dry;Intact;Transparent -CH	Clean;Dry;Intact;Transparent -CH

Flowsheets (all recorded)

Anthropometrics

Row Name	11/16/16 1029
Anthropometrics	
Height	67" (1.702 m) -CH
Weight	100.7 kg (222 lb) -CH
Weight Method	Stated -CH
Weight Change	0 -CH
BMI (Calculated)	34.8 -CH

Flowsheets (all recorded)

Post Op Telephone Call

Row Name	11/17/16 1428
Post-Op	
Do you feel comfortable?	Yes -CP
Are you taking your Medication?	N/A -CP
Is your pain medication working?	N/A -CP
Do you have a fever over 101 F?	No -CP
Are you having any difficulty urinating?	No -CP
Urine Color	Pink -CP
Any nausea or vomiting?	No -CP
Which areas of service were you satisfied with?	Scheduling;Check-In;Pre-Op;Clinical Staff;Physician;Anesthesia Provider;Check-Out -CP

Flowsheets (all recorded)

Interpretation

Row Name	11/16/16 1021
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -SC

Flowsheets (all recorded)

Fall Risk

Row Name	11/16/16 1120	11/16/16 1030
Fall Assessment		
Patient Receiving Sedation	Yes -CH	Yes -CH
Fall Risk	Yes -CH	Yes -CH
Fall Band Applied	Yes -CH	Yes -CH
Yellow socks	Yes -CH	Yes -CH

Flowsheets (all recorded)

Ris Pre Procedure Check list

Row Name	11/16/16 1031
Consent and Procedure	
History and Physical Completed	Yes -CH
Consents Confirmed	Operative;Informed;Anesthesia;Facility -CH
Patient ID and Procedure Verified	Yes -CH
Allergy Band Applied	No -CH
Do you have any metal in your body?	No -CH
Correct Procedure	Yes -CH
Side/Site Confirmed	N/A -CH
Surgeon/Anesthesia Orders Received	Yes -CH
Surgical Prep Complete	Yes -CH
Locker Assignment	4 -CH
Pre-Op Teaching Complete	Yes -CH
NPO After Midnight	Yes -CH
Lab/Testing Checklist	
Blood Glucose Meter (mg/dl)	109 -CH
MD/Anesthesia Notified of Blood Glucose Result	Yes -CH
Urinalysis Results	Abnormal -CH
Abnormal UA Dip results	Blood trace -CH
Microscopy Complete	No -CH
Pre Procedure Testing In Chart	Urinalysis;Glucose Test -CH
Pre- op Checklist	
Anti-embolism	n/a -CH
Pre-Op Medications Given and Charted	Yes -CH
Pre-Op Vitals Documented	Yes -CH
Allergies Verified	Yes -CH
Voided Prior to Procedure	Yes -CH
Remove all that apply:	Glasses/Contacts;Underwear -CH
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -CH
Mode of Transport	Stretcher -CH
Released by (Floor RN or Pre-op RN)	Charlotte Hayes RN -CH
Report given to (healthcare professional/RN)	anesthesia -CH

Flowsheets (all recorded)

Dischage Information

Row Name	11/16/16 1032

As part of our commitment to quality care, we will be calling you within 7-14 days of your procedure. Please provide us with the following information so we can contact you in a way that is best for you.

Contact Number	678-910-2298 -CH
Contact Guidelines	Ok to leave a message for me if you get an answering machine -CH

If you have taken sedation medication or have a scheduled procedure with anesthesia you are required to have a responsible adult present to drive you home after your procedure. If your driver needs to step out for a moment we need a cell/contact number

Driver's Name	Shirley -CH
Relationship to Patient	Spouse/Significant Other -CH
Cell Phone Number	678-910-2476 -CH

Flowsheets (all recorded)

Assessment

Row Name	11/16/16 1119	11/16/16 1030
Preop Assessment		
Skin Condition/Temp	Dry;Intact;Warm -CH	Dry;Intact;Warm -CH
Orient/LOC	Sleeping -CH	WDL -CH
Psychosocial	Calm -CH	Calm -CH
Currently Wearing	—	Glasses -CH
Enema by Patient Prior to Admission?	—	Yes -CH

Flowsheets (all recorded)

Hand Off

Row Name	11/16/16 1115
Post Sedation Care	
Type of Sedation	MAC -CH
Procedure Tolerated:	Well -CH
Report Given at:	1116 -CH
Report received from	anesthesia -CH
Report Given To	Charlotte Hayes RN -CH
Transport Method:	Stretcher;Side rails up x2 -CH

Flowsheets (all recorded)

Patient Assessment in OR Room

Row Name	11/16/16 11:04:54	11/16/16 1032
Patient Assessment		
Name Spelling, DOB, Procedure, Consent Verified	Yes -CH	—
Site Verbally Verified	Yes -CH	—
Site marked by physician or proceduralist?	Not applicable -CH	—
Pt Oriented to the OR Suite, Personnel & Roles	Yes -CH	—
Stretcher	Wheels locked;Side rails up x1 -CH	—
Comfort Assessment Complete	Yes -CH	—
Comfort Actions Taken	Warm blankets;Pillow under head;Pillow between knees/feet -CH	—
SCDs Applied	No (see comment) -CH	—
Plan of Care Reviewed by OR Staff	Yes -CH	—
Type of Anesthesia	MAC -CH	—
Prep Assessmnet		
Operative Site Intact	Yes -CH	Yes -CH
Hair Removal	N/A -CH	N/A -CH

Flowsheets (all recorded)

Assessment in OR post procedure

Row Name	11/16/16 11:06:18
Post Procedure Documentation	
Surgical Wound Classification	III -CH
Preoperative Diagnosis	elevated psa -CH
Postoperative Diagnosis	elevated psa -CH
Procedure Performed (Confirmed by MD and Anesthesia)	Yes -CH

Flowsheets (all recorded)

Procedure Documentation

Row Name	11/16/16 11:05:14
Procedure Assessment	
Patient Position	Lateral up right -CH
Warming Device	Off -CH
Electrocautery	
Electrocautery Used?	No -CH
Procedure Interventions	
Xrays Taken?	No -CH
Imaging Displayed?	Yes -CH
Video/Photography?	No -CH
Laser Used?	No -CH
Specimen Obtained	
Specimen Obtained?	Yes -CH
Specimen Collection	
Specimen Type	Prostate Biopsy -CH
Side	Bilateral -CH
Site location	prostate -CH
Prostate Specimen Location	Lat base;Lat mid;Lat apex;Base;Mid;Apex -CH
Specimen Sent to Pathology	Yes -CH
Specimen Discarded per Surgeon	No -CH
Additional Specimens	No -CH
Dressings	
Dressings	N/A -CH

Flowsheets (all recorded)

Intake/Output

Row Name	11/17/16 1428	11/16/16 1144	11/16/16 1119
Intake (mL)			
P.O.	—	236 mL -CH	—
I.V.	—	200 mL -CH	500 mL -CH
Urine Assessment			
Urine Color	Pink -CP	—	—

Flowsheets (all recorded)

Abuse Screen

Row Name	11/16/16 1030
Abuse Screening	
Do you feel safe at home?	Yes -CH
Have you ever thought about hurting yourself?	No -CH

Flowsheets (all recorded)

Vitals/Pain

Row Name	11/16/16 1141	11/16/16 1126	11/16/16 1121	11/16/16 1116	11/16/16 1029
Height and Weight					
Height	—	—	—	—	67" (1.702 m) -CH
Height Method	—	—	—	—	Stated -CH
Weight	—	—	—	—	100.7 kg (222 lb) -CH
Weight Method	—	—	—	—	Stated -CH
BMI (Calculated)	—	—	—	—	34.8 -CH
BSA (Calculated - sq m)	—	—	—	—	2.18 sq meters -CH
Vitals					
Temp	—	—	—	96.2 °F (35.7 °C) -CH	97.1 °F (36.2 °C) -CH
Temp src	—	—	—	Axillary -CH	Oral -CH
Pulse	53 -CH	52 -CH	53 -CH	54 -CH	50 -CH
Heart Rate Source	Monitor -CH	Monitor -CH	Monitor -CH	Monitor -CH	Monitor -CH
Resp	18 -CH	18 -CH	18 -CH	18 -CH	18 -CH
BP	140/63 -CH	109/53 -CH	96/51 -CH	(!) 93/46 -CH	174/77 -CH
Cardiac Rhythm	Normal sinus rhythm -CH	Normal sinus rhythm -CH	Normal sinus rhythm -CH	Normal sinus rhythm -CH	Normal sinus rhythm -CH
Pain Assessment					
Currently in Pain	No/denies pain -CH	Faces -CH	Faces -CH	Faces -CH	No/denies pain -CH
FACES Pain Rating	—	0 -CH	0 -CH	0 -CH	—
Oxygen Therapy					
SpO2	99 % -CH	99 % -CH	99 % -CH	98 % -CH	98 % -CH
O2 Device	None (Room air) -CH	Nasal cannula -CH	Nasal cannula -CH	Nasal cannula -CH	None (Room air) -CH
O2 Flow Rate (L/min)	—	3 L/min -CH	3 L/min -CH	3 L/min -CH	—
Pulse Oximetry Type	Intermittent -CH	Continuous -CH	Continuous -CH	Continuous -CH	Continuous -CH
POX Probe Site Changed	No -CH	No -CH	No -CH	No -CH	No -CH

Flowsheets (all recorded)

Site Preparation

Row Name	11/16/16 11:04:54	11/16/16 1032
Prep Assessmnet		
Operative Site Intact	Yes -CH	Yes -CH
Hair Removal	N/A -CH	N/A -CH

Flowsheets (all recorded)

Advance Directive

Row Name	11/16/16 1029
Advance Directives (For Healthcare)	
Have you reviewed your Advance Directive and is it valid for this stay?	No -CH
Advance Directive	Patient does not have advance directive -CH

Flowsheets (all recorded)

Assessment

Row Name	11/16/16 1119	11/16/16 1030
Uro Assessment		
Skin Condition/Temp	Dry;Intact;Warm -CH	Dry;Intact;Warm -CH
Orient/LOC	Sleeping -CH	WDL -CH
Psychosocial	Calm -CH	Calm -CH

Flowsheets (all recorded)

Call Complete

Row Name	11/17/16 1427
Completion of Post-op Call	
Post-op Call Complete	Yes -CP

User Key

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

Initials	Name	Effective Dates
CP	Chrissie Pope, RN	12/06/13 - 02/02/17
SC	Sharon H Crider, RN	12/06/13 - 02/02/17
CH	Charlotte Hayes, RN	07/14/15 - 02/02/17
BP	Batch Job Prelude	---

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 11/16/2016:

Scan on 11/17/2016 3:10 PM (below)

Scan on 11/16/2016 9:43 AM by Mary Johnston: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	**OBV**		Unit:	**KHB7EPROCARD**
Hospital Service:	**Cardiology**		Bed:	**B716/B716-01**
Admitting Provider:	**Abdul M Sheikh, Md**		Referring Physician:	
Attending Provider:	**Abdul m sheikh**	AD: N	Adm Diagnosis:	**S/P angioplasty with ste***
Admission Date:	**11/1/2017**		Admission Time:	**0636**

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: **$0.00**	Out of Pocket Max: **$5,900.00**

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 9, 2020 **Chart ID**

Admission Information

Arrival Date/Time:		Admit Date/Time:	11/01/2017 0636	IP Adm. Date/Time:	
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 Kennestone Hospital (KH B7E PROGRESS 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
11/02/2017 1313	Home Or Self Care	None	None	WellStar Kennestone Hospital (KH B7E PROGRESS CARD)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.718 [Principal]	Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris				
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris				
I25.82	Chronic total occlusion of coronary artery				
I48.92	Unspecified atrial flutter				
Z87.891	Personal history of nicotine dependence				
E78.5	Hyperlipidemia, unspecified				
I10	Essential (primary) hypertension				
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system				
E66.9	Obesity, unspecified				
Z68.33	Body mass index (bmi) 33.0-33.9, adult				
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				
Z79.01	Long term (current) use of anticoagulants				
Z79.84	Long term (current) use of oral hypoglycemic drugs				
Z79.82	Long term (current) use of aspirin				
Z79.899	Other long term (current) drug therapy				
Z95.5	Presence of coronary angioplasty implant and graft				

Events

Admission at 11/1/2017 0636

Unit: WellStar Kennestone Hospital (KH CARDIAC ARU) Room: B328 Bed: B328-01
Patient class: Hospital Outpatient Surgery Service: General Surgery

Transfer Out at 11/1/2017 0827

Unit: WellStar Kennestone Hospital (KH CARDIAC ARU) Room: B328 Bed: B328-01
Patient class: Hospital Outpatient Surgery Service: General Surgery

Transfer In at 11/1/2017 0827

Unit: Wellstar Kennestone Hospital (KH CATH/EP) Room: KH CATH Pool Bed: KH CATH Pool
Patient class: Hospital Outpatient Surgery Service: General Surgery

Surgery at 11/1/2017 0827

Unit: KH CARDIAC CATH LAB Room: KH CATH LAB 5
Patient class: Hospital Outpatient Surgery Service: Cardiovascular

Patient Update at 11/1/2017 0833

Unit: Wellstar Kennestone Hospital (KH CATH/EP) Room: KH CATH Pool Bed: KH CATH Pool
Patient class: Hospital Outpatient Surgery Service: Cardiac Cath

Patient Update at 11/1/2017 1216

Unit: Wellstar Kennestone Hospital (KH CATH/EP) Room: KH CATH Pool Bed: KH CATH Pool
Patient class: Observation Service: Cardiac Cath

Transfer Out at 11/1/2017 1235

All Scans (continued)

Events (continued)

Unit: Wellstar Kennestone Hospital (KH CATH/EP) Room: KH CATH Pool Bed: KH CATH Pool
Patient class: Observation Service: Cardiac Cath

Transfer In at 11/1/2017 1235

Unit: WellStar Kennestone Hospital (KH B7E PROGRESS CARD) Room: B716 Bed: B716-01
Patient class: Observation Service: Cardiology

Discharge at 11/2/2017 1313

Unit: WellStar Kennestone Hospital (KH B7E PROGRESS CARD) Room: B716 Bed: B716-01
Patient class: Observation Service: Cardiology

Allergies as of 11/2/2017

Reviewed on 11/1/2017

No Known Allergies

Immunizations as of 11/2/2017

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
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 11/2/2017

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Coronary atherosclerosis of native coronary artery	—	—	Provider

All Scans (continued)

Medical as of 11/2/2017 (continued)

[I25.10]			
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 [I21.9]	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

Discharge Summary - Encounter Notes

Discharge Summary by Diosdado M Irlandez, MD at 11/2/2017 11:31 AM

Author: Diosdado M Irlandez, MD | Service: Cardiology | Author Type: Physician
Filed: 11/2/2017 11:43 AM | Date of Service: 11/2/2017 11:31 AM | Status: Addendum
Editor: Diosdado M Irlandez, MD (Physician)
Related Notes: Original Note by Diosdado M Irlandez, MD (Physician) filed at 11/2/2017 11:43 AM

WellStar Cardiovascular Medicine

Patient Name: Eugene G Maurice
Date of Birth: 1/2/1949
MRN: 561253820
LOS: 0 days

CARDIOVASCULAR MEDICINE DISCHARGE SUMMARY

Admit date:11/1/2017
Discharge date: 11/2/2017
Primary Cardiologist: Sheikh
Discharged Condition: good, stable
Disposition: Discharged to: Home

Discharge Diagnoses

1. CAD
-s/p CABG
2. Hypertension
3. Hyperlipidemia
4. Peripheral Artery Disease
5. Paroxysmal Atrial flutter

Hospital Course

Mr. Maurice is a 68 y.o. male with a hx of CAD and previous CABG. He was seen by CT surgery and turned down for redo CABG. He was admitted to undergo an attempted percutaneous intvention of his chronically occluded left and right coronary arteries. **Yesterday there was an unsuccessful attempt at CTO PCI of the native LCx due to the inability to wire the antegrade segment. Retrograde equipment was able to be advanced to the distal cap but not able to be externalized into the aorta.**

Subjective Data

Mr. Maurice feels well. He denies CP or SOB.

Physical Exam

Temp: [97.8 °F (36.6 °C)-98.5 °F (36.9 °C)] 97.8 °F (36.6 °C)
Heart Rate: [58-74] 67
Resp: [16-20] 18
BP: (110-161)/(61-88) 139/71

Cardiology Diagnostics

- **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: 11/21/17** Unsuccessful attempt at CTO PCI of the native LCx due to inability to wire the antegrade segment. Retrograde equipment was able to be advanced to the distal cap but not able to be externalized into the aorta.

Discharge Summary - Encounter Notes (continued)

Discharge Summary by Diosdado M Irlandez, MD at 11/2/2017 11:31 AM (continued)

Continued medical management at this time

Ancillary Data

Results from last 7 days

Lab	Units	10/27/17 0938
WBC COUNT	10E9/L	8.5
HGB	g/dL	11.6*
HEMATOCRIT	%	37*
PLATELET	10E9/L	176

Results from last 7 days

Lab	Units	11/02/17 0617	10/27/17 0938
SODIUM, S	mmol/L	140	138
CHLORIDE	mmol/L	103	101
CO2	mmol/L	25	24
BUN BLD	mg/dL	15	20
CREATININE, S	mg/dL	0.94	0.88
CALCIUM,TOTAL	mg/dL	9.0	9.2
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:* 3
!! 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
!! blood sugar diagnostic strip	True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9 *Qty:* 100 strip, *Refills:* 2
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:* 3

Discharge Summary - Encounter Notes (continued)

Discharge Summary by Diosdado M Irlandez, MD at 11/2/2017 11:31 AM (continued)

chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily *Qty:* 90 tablet, *Refills:* 3
	Associated Diagnoses: Coronary arteriosclerosis
cilostazol (PLETAL) 100 MG tablet	Take 1 tablet (100 mg total) by mouth 2 (two) times a day *Qty:* 180 tablet, *Refills:* 3
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:* 3
	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:* 3
apixaban (ELIQUIS) 5 mg tablet	Take 1 tablet (5 mg total) by mouth 2 (two) times a day *Qty:* 180 tablet, *Refills:* 3
metFORMIN (GLUCOPHAGE) 500 MG tablet	Take 2 tablets (1,000 mg total) by mouth 2 (two) times a day with meals 2 tablets in am and 1 tablet in pm *Qty:* 360 tablet, *Refills:* 0
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:* 25 tablet, *Refills:* 3

!! - Potential duplicate medications found. Please discuss with provider.

Follow-up: Your Primary Cardiologist or as directed in 5-7 days.

Time Spent on Discharge: 30 minutes

Ms. Nicely as scribe.

Diosdado M Irlandez, MD
11/2/2017
11:42 AM

Electronically Signed by Diosdado M Irlandez, MD on 11/2/2017 11:43 AM

H&P - Encounter Notes

H&P by Abdul M Sheikh, MD at 11/1/2017 8:16 AM

Author: Abdul M Sheikh, MD | Service: Cardiology | Author Type: Physician
Filed: 11/1/2017 8:16 AM | Date of Service: 11/1/2017 8:16 AM | Status: Signed
Editor: Abdul M Sheikh, MD (Physician)

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 and paroxysmal atrial flutter. Known to have significant disease in the bypass grafts to his circumflex and RCA territories. He was seen by CT surgery earlier and was turned down for a redo bypass operation. Continues to have angina, somewhat progressive in nature. Now amenable to undergoing attempted percutaneous intervention of his chronically occluded left and right coronary arteries. Has been taking his medications as instructed.

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

	5/30/17
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: Significant bilateral carotid disease.
Myocardial Perfusion Imaging, Exercise	5/15: Positive, high risk
Myocardial Perfusion Imaging, Lexiscan	1/08: negative for ischemia
Cardiac Catheterization	05/01/2017 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
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 Smokeless tobacco • Never Used	Alcohol Use • Yes	Drug Use No

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:
- apixaban (ELIQUIS) 5 mg tablet, Take 1 tablet (5 mg total) by mouth 2 (two) times a day, Disp: 180 tablet, Rfl: 3
- aspirin, buffered 81 mg Tab, Take 81 mg by mouth daily., Disp: , Rfl:
- atorvastatin (LIPITOR) 80 MG tablet, Take 1 tablet (80 mg total) by mouth nightly, Disp: 90 tablet, Rfl: 3
- blood sugar diagnostic (GLUCOSE BLOOD) strip, cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed.., Disp: 100 strip, Rfl: 2
- blood sugar diagnostic strip, True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9, Disp: 100 strip, Rfl: 2
- carvedilol (COREG) 12.5 MG tablet, Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals, Disp: 180 tablet, Rfl: 3
- chlorthalidone (HYGROTEN) 50 MG tablet, Take 1 tablet (50 mg total) by mouth daily, Disp: 90 tablet, Rfl: 3
- cilostazol (PLETAL) 100 MG tablet, Take 1 tablet (100 mg total) by mouth 2 (two) times a day, Disp: 180 tablet, Rfl: 3
- isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet, Take 2 tablets (60 mg total) by mouth 2 (two) times a day, Disp: 360 tablet, Rfl: 3
- levothyroxine (SYNTHROID, LEVOTHROID) 25 MCG tablet, Take 1 tablet (25 mcg total) by mouth daily 1

(one) hour before breakfast, Disp: 30 tablet, Rfl: 2
• metFORMIN (GLUCOPHAGE) 500 MG tablet, Take 2 tablets (1,000 mg total) by mouth 2 (two) times a day with meals 2 tablets in am and 1 tablet in pm, Disp: 360 tablet, Rfl: 0
• 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, Disp: 25 tablet, Rfl: 3
• ramipril (ALTACE) 10 MG capsule, Take 1 capsule (10 mg total) by mouth 2 (two) times a day, Disp: 180 capsule, Rfl: 3

EXAM

Vitals

Vitals:

	10/10/17 1116
BP:	120/76
Pulse:	76
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

H&P - Encounter Notes (continued)

H&P by Abdul M Sheikh, MD at 11/1/2017 8:16 AM (continued)

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. Does have reocclusion of his vein graft to his circumflex territory. Graft to his RCA, which is also needed multiple interventions, had mild to moderate disease on his most recent catheterization. Was not felt to be a good candidate for redo bypass surgery. Also noted to have newly diagnosed paroxysmal atrial flutter. Presently in sinus rhythm. Has been started on anticoagulant therapy.

- For now we will continue him on his current medical therapy.
- He does feel that his symptoms have progressed enough that he would like to proceed with intervention. The nature of CTO intervention was discussed at length with him, as was done during previous office visits. This includes the need for bilateral arterial access, prolonged procedure times, estimated success rate of 80%. Risks of the procedure, including but not limited to: Death, myocardial infarction, coronary perforation, need for emergent surgery, radiation skin injury, and contrast nephropathy were all discussed. Estimated risk of significant complications was between 1 and 2%.
- After discussing all of the above he wishes to proceed. This will be scheduled for him.
- BMI > 30. We have discussed ideal BMI and nutrition and physical activity. We will continue to monitor on future visits.

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 11/1/2017 8:16 AM

Progress Notes - Encounter Notes

Progress Notes by Nakeisa L Brown, RN at 11/1/2017 10:22 PM

Author: Nakeisa L Brown, RN | Service: — | Author Type: Registered Nurse
Filed: 11/1/2017 10:23 PM | Date of Service: 11/1/2017 10:22 PM | Status: Signed
Editor: Nakeisa L Brown, RN (Registered Nurse)

Progress Notes - Encounter Notes (continued)

Progress Notes by Nakeisa L Brown, RN at 11/1/2017 10:22 PM (continued)

24 Hour Chart Check Completed

Electronically Signed by Nakeisa L Brown, RN on 11/1/2017 10:23 PM

Progress Notes by Diosdado M Irlandez, MD at 11/2/2017 11:30 AM

Author: Diosdado M Irlandez, MD | Service: Cardiology | Author Type: Physician
Filed: 11/2/2017 11:31 AM | Date of Service: 11/2/2017 11:30 AM | Status: Signed
Editor: Diosdado M Irlandez, MD (Physician)

WellStar Cardiovascular Medicine

LOS: 0 days

CARDIOVASCULAR MEDICINE PROGRESS NOTE

Subjective:
Mr. Maurice denies palpitations
There were no acute CV events last night. No chest pain or shortness of breath.

Scheduled Meds:

• aspirin	81 mg	Oral	Daily
• atorvastatin	80 mg	Oral	Nightly
• atropine	0.5 mg	Intravenous	Q5 Min PRN
• carvedilol	12.5 mg	Oral	BID w/ meals
• chlorthalidone	50 mg	Oral	Daily
• cilostazol	100 mg	Oral	BID
• isosorbide mononitrate	60 mg	Oral	BID
• morphine injection	2 mg	Intravenous	Q4H PRN
• nitroglycerin	0.4 mg	Sublingual	Q5 Min PRN

Continuous Infusions:
PRN Meds:atropine, morphine injection, nitroglycerin

Objective:
Visit Vitals

BP	139/71
Pulse	67
Temp	97.8 °F (36.6 °C) (Oral)
Resp	18
Ht	67" (1.702 m)
Wt	97.1 kg (214 lb 1.1 oz)
SpO2	95%
BMI	33.53 kg/m²

Physical Exam:

GEN: NAD
HEENT: no JVD, no masses
CVS: S1S2 RRR without audible M/G/R
LUNGS: CTA bilaterally, no wheezing or use of accessary muscles
ABD: soft/NT/ND
EXT: No C/C/E

Lab Review

Results from last 7 days

Lab	Units	10/27/17 0938
WBC COUNT	10E9/L	8.5
HGB	g/dL	11.6*
HEMATOCRIT	%	37*
PLATELET	10E9/L	176

Invalid input(s): FREET4

Results from last 7 days

Lab	Units	11/02/17 0617	10/27/17 0938
SODIUM, S	mmol/L	140	138
POTASSIUM	mmol/L	4.8	5.4*
CHLORIDE	mmol/L	103	101
CO2	mmol/L	25	24
BUN BLD	mg/dL	15	20
CREATININE, S	mg/dL	0.94	0.88
CALCIUM,TOTAL	mg/dL	9.0	9.2
GFR MDRD NON AF AMER	ml/min/1.73 m2	>60	>60

Assessment/Plan:

Patient Active Problem List

Diagnosis	Date Noted
• S/P angioplasty with stent	11/01/2017
• Coronary arteriosclerosis	10/10/2017
• Angina pectoris (HCC)	
• Elevated PSA	11/28/2016
• Controlled type 2 diabetes mellitus with diabetic peripheral angiopathy without	09/26/2016

Progress Notes - Encounter Notes (continued)

Progress Notes by Diosdado M Irlandez, MD at 11/2/2017 11:30 AM (continued)

gangrene, without long-term current use of insulin (HCC)
- Family history of ischemic heart disease
- Hyperlipidemia, unspecified hyperlipidemia type
- PVD (peripheral vascular disease) (HCC)
- Obesity
- Essential hypertension with goal blood pressure less than 130/85
- Coronary artery disease involving native coronary artery of native heart without angina pectoris

Have reviewed catherization films

Dr. Shiek to discuss plan with several colleagues.

Ok for d/c

meds per d/c summery.

Electronically Signed by Diosdado M Irlandez, MD on 11/2/2017 11:31 AM

Plan of Care - Encounter Notes

Plan of Care by Karen M Wilson, RN at 11/1/2017 7:11 AM

Author: Karen M Wilson, RN | Service: — | Author Type: Registered Nurse
Filed: 11/1/2017 7:11 AM | Date of Service: 11/1/2017 7:11 AM | Status: Signed
Editor: Karen M Wilson, 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 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

Plan of Care - Encounter Notes (continued)

Plan of Care by Karen M Wilson, RN at 11/1/2017 7:11 AM (continued)

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

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

Problem: Discharge Barriers
Goal: Patient's discharge needs are met
Collaborate with interdisciplinary team and initiate plans and interventions as needed.
Outcome: Progressing

Electronically Signed by Karen M Wilson, RN on 11/1/2017 7:11 AM

Surgery Report

General Information

Date: 11/1/2017 | Time: 0830 | Status: Posted
Location: KH CARDIAC CATH LAB | Room: Lab 5 - Cath | Service: Cardiovascular
Patient class: Hospital Outpatient Surgery | Case classification: Class F - Elective

Diagnosis Information

Diagnosis
Coronary arteriosclerosis

Case Tracking Events

Event	Time In
In Facility	0636
In ARU Prep	0644
ARU Prep Complete	0738
Out of ARU Prep	0749
Ready for Procedure	0806
In Room	0827
Procedure Start	0853
Moderate Sedation Begin	0851
Moderate Sedation End	1208
Procedure End	1202
Out of Room	1224
In ARU Recovery	
ARU Recovery Complete	
Out of ARU Recovery	
In ARU PACU Recovery	
ARU PACU Recovery Complete	
Out of ARU PACU Recovery	
Remove from Status Board	1224
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 Needed	
Anesthesia Follow-up Complete	

Panel Information

Panel 1

Provider	Role	Service
Scott A McKee, MD	Assisting	Cardiovascular
Abdul M Sheikh, MD	Primary	Cardiovascular

Procedure: Chronic total occlusion

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

Chronic total occlusion (N/A) - Position 1

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

Procedure: Coronary angiography

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

Coronary angiography (N/A) - Position 1

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

Procedure: Left heart cath - bypass graft

Surgery Report (continued)

Panel Information (continued)

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

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

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

Procedure: Angioplasty-coronary / LCX

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

Angioplasty-coronary / LCX (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	**Camay T Crown, RN**	0820	1224	
CV Scrub Person	**Ethan L Shoemaker, ARRT**	0820	1224	
CV Circulator	**Kathryn Teegarden, RN**	0820	1224	

Questionnaire Data

None

Patient Preparation

Area	Laterality	Scrub	Paint	Hair Removal
Chest Larry				Clipped in Pre-op
Arm Lower Larry	Right			Clipped in Pre-op
Groin Larry	Bilateral			Clipped in Pre-op

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)

Surgery Report (continued)

PNDS Information (continued)

Yes	Risk for imbalanced body temperature (X57)
Yes	Ineffective breathing pattern (X7)

Log Completed By

Kathryn Teegarden, RN	11/1/2017	1226

Log Verified By

Camay T Crown, RN	11/1/2017	0852
Camay T Crown, RN	11/1/2017	1203
Kathryn Teegarden, RN	11/1/2017	1225
Abdul M Sheikh, MD	11/1/2017	1406

Addendum Information

Addendum 1 : Sherri T Rutledge, RN - 11/3/17 1017

Item	Line	Old Value	New Value	Description
Log				
84 - Log Procedure Level	1		ARU Level 2	
8034 - Charge Inventory Location	0	40	41	

Do Not Proceed History

No information present

Implants

Implants

CLOSURE 6 FR PERCLOSE PROGLIDE - LOG432993

Inventory Item: CLOSURE 6 FR PERCLOSE PROGLIDE
Implant name: CLOSURE 6 FR PERCLOSE PROGLIDE - LOG432993
Manufacturer: ABBOTT VASCULAR
Action: Implanted
Device Identifier: 08717648013089
Serial no.:
Laterality: N/A
Date of Manufacture:
Number Used: 1
Device Identifier Type: GS1
Model/Cat no.: 12673-03
Area: Arterial

CLOSURE 6 FR PERCLOSE PROGLIDE - LOG432993

Inventory Item: CLOSURE 6 FR PERCLOSE PROGLIDE
Implant name: CLOSURE 6 FR PERCLOSE PROGLIDE - LOG432993
Manufacturer: ABBOTT VASCULAR
Action: Implanted
Device Identifier: 08717648013089
Serial no.:
Laterality: Right
Date of Manufacture:
Number Used: 1
Device Identifier Type: GS1
Model/Cat no.: 12673-03
Area: Arterial

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: N/A

Pre-Procedure Verification

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

Surgeons Present: Scott A McKee, MD, Abdul M Sheikh, MD
Staff Present: Camay Crooms, RN, Ethan L Shoemaker, ARRT, Kathryn Teegarden, RN

Verification Date and Time: 11/1/2017 8:51 AM

Nursing - Orders and Results

Surgery Report (continued)

NURSING COMMUNICATION [695626732]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626733]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626734]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626735]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626736]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626737]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626738]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626739]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

NURSING COMMUNICATION [695626740]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD

Nursing - Orders and Results (continued)

NURSING COMMUNICATION [695626740] (continued)

Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235
Order comments: Obtain BBG on call to cath lab and document on pre-procedure checklist.

NURSING COMMUNICATION [695626741]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
Order comments: This was discussed with the patient and/or patient representative.

NURSING COMMUNICATION [695626742]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235
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 [695626743]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235
Order comments: Have patient void before transport, no metal snaps on gown, patient may wear dentures, glasses, hearing aids

NURSING COMMUNICATION [695626744]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235
Order comments: Hold diuretics and oral hypoglycemic medications including metformin and sulfonylureas (e.g. glipizide, glyburide, glimepiride) the morning of the procedure.

NOTIFY PHYSICIAN (SPECIFY) [695626746]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235
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).

NURSING COMMUNICATION [695626747]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235

PROVIDE PATIENT EDUCATION MATERIALS [695626748]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
Order comments: Provide patient/family pre-procedure education and document. Place patient on Cardiac Cath/Intervention Clinical Pathway

Nursing - Orders and Results (continued)

PROVIDE PATIENT EDUCATION MATERIALS [695626748] (continued)

NURSING COMMUNICATION [695626749]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

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)

HEIGHT AND WEIGHT [695626750]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

VERIFY INFORMED CONSENT [695626751]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
Order comments: Verify cardiac catheterization consent form is signed, dated, timed, and witnessed prior to start of procedure
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

MAINTAIN IV ACCESS [695626753]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

VITAL SIGNS [695689229]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Status: **Discontinued**
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

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.

PUNCTURE SITE CARE [695689230]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Status: **Discontinued**
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

Questionnaire

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

Nursing - Orders and Results (continued)

PUNCTURE SITE CARE [695689230] (continued)

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

POST PROCEDURE SITE ASSESSMENT [695689231]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [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 [695689232]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

Questionnaire

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

ORTHOSTATIC BLOOD PRESSURE [695689233]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Order comments: Check standing blood pressure post sheath removal when first allowed to stand.

AMBULATE PATIENT [695689234]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Order comments: With assistance after bedrest complete. If tolerated, may resume previously ordered activity level

INTAKE AND OUTPUT [695689236]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

STRAIGHT CATH [695689237]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Order comments: If unable to void

Nursing - Orders and Results (continued)

STRAIGHT CATH [695689237] (continued)

NURSING COMMUNICATION [695689238]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

NURSING COMMUNICATION [695689239]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

NURSING COMMUNICATION [695689240]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

NURSING COMMUNICATION [695689241]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

NURSING COMMUNICATION [695689242]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

BED REST [695689247]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Order comments: And for 3 hours post sheath removal/closure device placement. May elevate head of bed to 30 degrees, keep punctured leg straight while on bedrest

NURSING COMMUNICATION [695689248]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

Questionnaire

Question	Answer
Type:	perclose

Order comments: Deployment time: 12:15

DAILY WEIGHTS [695689251]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**

Nursing - Orders and Results (continued)

DAILY WEIGHTS [695689251] (continued)

Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/2/2017 12:06 AM

Code Status - Orders and Results

FULL CODE [695689228]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Code status: Full Code
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

Respiratory Care - Orders and Results

OXYGEN [695631091]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Frequency: Routine as tolerated 11/01/17 1235 - Until Specified
Released by: Julia Gaddis, RN 11/01/17 1235
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

Questionnaire

Question	Answer
Indications for O2 therapy	Immediate post-op period

ECG - Orders and Results

EKG, 12-LEAD [695626757]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Status: **Completed**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

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

Specimen Information

Type	Source	Collected By
---	---	11/01/17 0725

EKG, 12-LEAD [695626757]
Resulted: 11/01/17 0730, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 11/01/17 0648
Resulted by: Dhaval G Patel, MD
Resulting lab: MUSE
External ID: 1389947
Order status: Completed
Filed by: Interface, Muse 11/01/17 0730
Lab Technician: 19824
Result details

Impression:
SINUS BRADYCARDIA
LEFT AXIS DEVIATION
LEFT BUNDLE BRANCH BLOCK
ABNORMAL ECG
NO PREVIOUS ECGS AVAILABLE
CONFIRMED BY PATEL,MD, DHAVAL (1012) ON 11/1/2017 7:30:15 AM

Specimen Information

ECG - Orders and Results (continued)

Type	Source	Collected By
—	—	11/01/17 0725

Components

Component	Value	Reference Range	Flag	Lab
VENT RATE	59	BPM	—	Muse
Atrial Rate	59	BPM	—	Muse
PR Interval	206	MS	—	Muse
QRS Duration	138	MS	—	Muse
QT Interval	430	MS	—	Muse
QTC Calculation	425	MS	—	Muse
P Axis	46	DEGREES	—	Muse
R Axis	-54	DEGREES	—	Muse
T Wave Axis	100	DEGREES	—	Muse

View Image (below)

EKG, 12-LEAD [695689243]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Completed**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

Questionnaire

Question	Answer
Reason for Exam:	Chest pain

Order comments: Immediately post-procedure

EKG, 12-LEAD [695689244]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Completed**
Ordering user: Scott A McKee, MD 11/01/17 1216 Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD Ordering mode: Standard
Quantity: 1 Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

Questionnaire

Question	Answer
Reason for Exam:	Chest pain

Order comments: For new or increased chest pain, rhythm or ST changes (prior to giving NTG). Notify MD

IV - Orders and Results

INSERT PERIPHERAL IV [695626745]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
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 [695626752]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Quantity: 1 Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM
Discontinued by: Scott A McKee, MD 11/01/17 1235

INT [695626754]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**

IV - Orders and Results (continued)

INT [695626754] (continued)

Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Scott A McKee, MD 11/01/17 1235

Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

Admission - Orders and Results

ADMIT AS OUTPATIENT FOR OBSERVATION [695689227]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1

Status: **Completed**
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Scott A McKee, MD (auto-released) 11/1/2017 12:16 PM

Questionnaire

Question	Answer
Attending Provider	SHEIKH, ABDUL M
Bed Type	Cardiac Telemetry
Bed request comments	Post PCI
Hospital Area	WS Kennestone Hospital
Diagnosis	S/P angioplasty with stent
Admitting Provider	SHEIKH, ABDUL M

Transfer - Orders and Results

BED REQUEST [695631055]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 0842**
Mode: Ordering in Verbal with readback mode
Ordering user: Gregory L Messina, RN 11/01/17 0833
Authorized by: Abdul M Sheikh, MD
Quantity: 1

Status: **Completed**
Communicated by: Gregory L Messina, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Instance released by: Gregory L Messina, RN (auto-released) 11/1/2017 8:33 AM

Questionnaire

Question	Answer
Attending Provider	SHEIKH, ABDUL M
Bed Type	Cardiac Telemetry
Bed Ahead	Yes
Bed request comments	7 blue east stent
Hospital Area	WS Kennestone Hospital

Discharge - Orders and Results

DISCHARGE PATIENT [695689257]

Electronically signed by: **Diosdado M Irlandez, MD on 11/02/17 1145**
Ordering user: Diosdado M Irlandez, MD 11/02/17 1145
Authorized by: Diosdado M Irlandez, MD
Quantity: 1

Status: **Completed**
Ordering provider: Diosdado M Irlandez, MD
Ordering mode: Standard
Instance released by: Diosdado M Irlandez, MD (auto-released) 11/2/2017 11:45 AM

Cardiac Cath - Orders and Results

CARDIAC PROCEDURE [692438349]

Electronically signed by: **Heather Holley on 10/10/17 1207**
This order may be acted on in another encounter.
Ordering user: Heather Holley 10/10/17 1207
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: Heather Holley 10/10/2017 12:07 PM
Diagnoses
Coronary arteriosclerosis [I25.10]

Status: **Completed**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

Cardiac Cath - Orders and Results (continued)

CARDIAC PROCEDURE [692438349] (continued)

CARDIAC PROCEDURE [692438349] Resulted: 11/01/17 1400, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 10/10/17 1207
Resulted by: Abdul M Sheikh, MD
Performed: 11/01/17 0827 - 11/01/17 1224
Resulting lab: CATH/EP
Narrative:
· Unsuccessful attempt at CTO PCI of the native LCx due to inability to wire the antegrade segment. Retrograde equipment was able to be advanced to the distal cap but not able to be externalized into the aorta.
· Continued medical management at this time.

Order status: Completed
Filed by: Abdul M Sheikh, MD 11/01/17 1407
Accession number: 28797534
Result details

Procedures Performed	Chargeables
ANGIOPLASTY - CORONARY [CATH08]	
CHRONIC TOTAL OCCLUSION (CTO) [CATH72]	
CORONARY ANGIOGRAPHY [CATH03]	
LEFT HEART CATHETERIZATION W/GRAFTS [CATH71]	

CORE MEASURES - Orders and Results

REASON FOR NO BETA-BLOCKER AT DISCHARGE [695689245]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Completed**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1

Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

Questionnaire

Question	Answer
Reason for not prescribing beta blocker?	Other (Please provide additional details) Comment - not indicated or already taking

COR109 [695689246]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Completed**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1

Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

Questionnaire

Question	Answer
Reason for not prescribing either ACEI or ARB?	Other (please provide additional details) Comment - not indicated or already taking

REASON FOR NOT PRESCRIBING STATIN MEDICATION [695689249]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Completed**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1

Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM

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 [695626759]

Electronically signed by: **Interface, Lab In Sunquest on 11/01/17 0706** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 11/01/17 0706

Ordering provider: Abdul M Sheikh, MD

Point of Care Testing-Docked Device - Orders and Results (continued)

POC FINGER STICK GLUCOSE [695626759] (continued)

Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: (auto-released) 11/1/2017 7:08 AM
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	11/01/17 0706

POC FINGER STICK GLUCOSE [695626759] (Abnormal) — Resulted: 11/01/17 0708, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 11/01/17 0706
Filed by: Interface, Lab In Sunquest 11/01/17 0708
External ID: W14919912
Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Serum	11/01/17 0706

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	139	70 - 99 mg/dL	H ^	KHLAB
POC-OPERATOR'S ID	26461	—	—	KHLAB

Lab - Orders and Results

BASIC METABOLIC PANEL (7) [695626755]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Order comments: Fasting
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

Specimen Information

Type	Source	Collected By
Blood	Blood	—

CBC W/O DIFFERENTIAL [695626756]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]
Status: **Discontinued**
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Instance released by: Karen M Wilson, RN (auto-released) 11/1/2017 6:48 AM

Specimen Information

Type	Source	Collected By
Blood	Blood	—

BASIC METABOLIC PANEL (7) [695689250]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 8:00 PM
Status: **Completed**
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

Lab - Orders and Results (continued)

BASIC METABOLIC PANEL (7) [695689250] (continued)

BASIC METABOLIC PANEL (7) [695689250] (Abnormal) — Resulted: 11/02/17 0724, Result status: Final result

Ordering provider: Scott A McKee, MD 11/01/17 2000
Filed by: Interface, Lab In Sunquest 11/02/17 0724
External ID: H14860013
Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

Components

Component	Value	Reference Range	Flag	Lab
Sodium,S	140	136 - 145 mmol/L	—	KHLAB
Potassium	4.8	3.5 - 5.1 mmol/L	—	KHLAB
Chloride	103	98 - 107 mmol/L	—	KHLAB
Co2	25	22 - 29 mmol/L	—	KHLAB
Glucose	118	70 - 99 mg/dL	H	KHLAB
BUN	15	8 - 23 mg/dL	—	KHLAB
CREATININE,S	0.94	0.7 - 1.2 mg/dL	—	KHLAB
ANION GAP	17	12 - 20	—	KHLAB
CALCIUM,TOTAL	9.0	8.8 - 10.2 mg/dL	—	KHLAB
GFR Non-Afric Amer	>60	>59 ml/min/1.73 m2	—	KHLAB
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2	—	KHLAB

MAGNESIUM BLOOD [695689254]

Electronically signed by: **Whitney K Rivkin, PA on 11/02/17 0318** — Status: **Completed**
Ordering user: Whitney K Rivkin, PA 11/02/17 0318
Authorized by: Dhaval G Patel, MD
Cosigning events
Electronically cosigned by Dhaval G Patel, MD 11/02/17 0713 for Ordering
Quantity: 1
Instance released by: Whitney K Rivkin, PA (auto-released) 11/2/2017 3:18 AM
Ordering provider: Whitney K Rivkin, PA
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

MAGNESIUM BLOOD [695689254] — Resulted: 11/02/17 0724, Result status: Final result

Ordering provider: Whitney K Rivkin, PA 11/02/17 0318
Filed by: Interface, Lab In Sunquest 11/02/17 0724
External ID: H14860013
Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

Components

Component	Value	Reference Range	Flag	Lab
Magnesium	1.8	1.6 - 2.6 mg/dL	—	KHLAB

TSH W/REFLEX TO FREE T4 [695689255]

Electronically signed by: **Whitney K Rivkin, PA on 11/02/17 0318** — Status: **Completed**
Ordering user: Whitney K Rivkin, PA 11/02/17 0318
Authorized by: Dhaval G Patel, MD
Cosigning events
Electronically cosigned by Dhaval G Patel, MD 11/02/17 0713 for Ordering
Quantity: 1
Ordering provider: Whitney K Rivkin, PA
Ordering mode: Standard
Lab status: Final result

Lab - Orders and Results (continued)

TSH W/REFLEX TO FREE T4 [695689255] (continued)

Instance released by: Whitney K Rivkin, PA (auto-released) 11/2/2017 3:18 AM

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

TSH W/REFLEX TO FREE T4 [695689255] Resulted: 11/02/17 0724, Result status: Final result

Ordering provider: Whitney K Rivkin, PA 11/02/17 0318
Filed by: Interface, Lab In Sunquest 11/02/17 0724
External ID: H14860013
Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Serum	59941 11/02/17 0617

Components

Component	Value	Reference Range	Flag	Lab
TSH W/REFLEX TO FREE T4	1.54	0.27 - 4.20 uIU/mL	—	KHLAB

Comment:
HIGH DOSES OF BIOTIN TAKEN WITHIN 8 HOURS OF BLOOD COLLECTION MAY INTERFERE WITH THE RESULTS OF THIS ASSAY

Outpatient Referral - Orders and Results

AMB REFERRAL TO CARDIAC REHAB [695631092]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Active**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Frequency: Routine 11/02/17 -
Released by: Diosdado M Irlandez, MD 11/02/17 1145
Acknowledged: Julia Gaddis, RN 11/02/17 1158 for Placing Order
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Quantity: 1
Diagnoses
Coronary arteriosclerosis [I25.10] (Added automatically from request for surgery 432993)

Diet - Orders and Results

DIET, NPO [694980094]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Effective Midnight 11/02/17 - Until Specified
Diet: NPO
Discontinued by: Automatic Transfer Provider 11/01/17 1235 [Patient Transfer]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order Julia Gaddis, RN 11/01/17 1236 for D/C Order
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Released by: Karen M Wilson, RN 11/01/17 0648

Questionnaire

Question	Answer
Medications Allowed?	Whole with sips of water

DIET, CARDIAC [695689235]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216** Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Authorized by: Scott A McKee, MD
Quantity: 1
Instance released by: Julia E Branch, RN (auto-released) 11/1/2017 12:35 PM
Ordering provider: Scott A McKee, MD
Ordering mode: Standard
Diet: Cardiac
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [Patient Discharge]

Questionnaire

Question	Answer
Diet, Diabetic: (Consistent Carbohydrate)	2200 kcal

Diet - Orders and Results (continued)

DIET, CARDIAC [695689235] (continued)

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [695626726]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
PRN reasons: line care
Frequency: Routine Q1 min PRN 11/01/17 0648 - 11/01/17 1235 Released by: Karen M Wilson, RN 11/01/17 0648
Discontinued by: Scott A McKee, MD 11/01/17 1235
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order Julia Gaddis, RN 11/01/17 1236 for D/C Order
Admin instructions: INT Flush
Package: 8290-306547

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User
11/01/17 1235	Scott A McKee, MD	Scott A McKee, MD	Julia Gaddis, RN
11/01/17 0648	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Karen M Wilson, RN

sodium chloride 0.9% (NS) bolus [695626727]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Discontinued**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine Continuous 11/01/17 0700 - 11/01/17 1235 Released by: Karen M Wilson, RN 11/01/17 0648
Discontinued by: Scott A McKee, MD 11/01/17 1235 [(Patient Transfer - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order Julia Gaddis, RN 11/01/17 1236 for D/C 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: 0409-7983-09

Ordering & Authorizing Provider Audit Trail

Date/Time	Ordering provider	Authorizing Provider	User
11/01/17 1235	Scott A McKee, MD	Scott A McKee, MD	Julia Gaddis, RN
11/01/17 0648	Abdul M Sheikh, MD	Abdul M Sheikh, MD	Karen M Wilson, RN

sodium chloride 0.9% (NS) infusion [695626728]

Electronically signed by: **Abdul M Sheikh, MD on 10/10/17 1205** Status: **Expired**
Ordering user: Abdul M Sheikh, MD 10/10/17 1205 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Standard
Frequency: Routine Continuous 11/01/17 0700 - 2 hours Released by: Karen M Wilson, RN 11/01/17 0648
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Admin instructions: ** Start reduced rate after 1 hour bolus completed.** (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." After first hour
Package: 0409-7983-09

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [695631053]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 0842** Status: **Discontinued**
Mode: Ordering in Verbal with readback mode Communicated by: Camay Crooms, RN
Ordering user: Camay Crooms, RN 11/01/17 0833 Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD Ordering mode: Verbal with readback
Frequency: Routine PRN 11/01/17 0832 - 11/01/17 1224 Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]
Acknowledged: Camay Crooms, RN 11/01/17 0833 for Placing Order
Package: 0409-7620-59

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [695631057]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408** Status: **Discontinued**

Medications - Orders and Results (continued)

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [695631057] (continued)

Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 0851
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 11/01/17 0851 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 0851 for Placing Order
Package: 0641-6027-01

Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

midazolam (VERSED) injection 1 mg/mL [695631058]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 0851
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 11/01/17 0851 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 0851 for Placing Order
Package: 0409-2305-21

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

lidocaine (XYLOCAINE) local injection 2 % [695631059]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 0853
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 11/01/17 0853 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 0853 for Placing Order
Package: 63323-486-27

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

Heparin bolus [695631060]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 0903
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 11/01/17 0903 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 0903 for Placing Order
Package: 63323-540-57

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

iohexol (OMNIPAQUE) injection 350 mg/mL [695631064]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 1154
Authorized by: Abdul M Sheikh, MD
Frequency: Routine PRN 11/01/17 1153 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 1154 for Placing Order
Package: 0407-1414-89

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

sodium chloride 0.9% (NS) infusion [695631066]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 1213
Authorized by: Abdul M Sheikh, MD
Frequency: Routine Continuous PRN 11/01/17 1212 - 11/01/17 1224

Acknowledged: Kathryn Teegarden, RN 11/01/17 1213 for Placing Order
Package: 0409-7983-09

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]

aspirin chewable tablet [695631067]

Electronically signed by: **Abdul M Sheikh, MD on 11/01/17 1408**
Mode: Ordering in Verbal with readback mode
Ordering user: Kathryn Teegarden, RN 11/01/17 1213
Authorized by: Abdul M Sheikh, MD

Status: **Discontinued**
Communicated by: Kathryn Teegarden, RN
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Verbal with readback

Medications - Orders and Results (continued)

aspirin chewable tablet [695631067] (continued)

Frequency: Routine PRN 11/01/17 1213 - 11/01/17 1224
Discontinued by: Kathryn Teegarden, RN 11/01/17 1224 [(Patient Discharge - Internal Use Only)]
Acknowledged: Kathryn Teegarden, RN 11/01/17 1213 for Placing Order
Package: 63739-434-01

atropine injection 0.1 mg/mL [695631099]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
PRN reasons: other
PRN Comment: bradycardia
Frequency: Routine Q5 Min PRN 11/01/17 1235 - 3 occurrences
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 0409-4911-34

aspirin chewable tablet [695689224]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine Daily 11/02/17 0900 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 63739-434-01
Status
William C Crew, PharmD 11/01/17 1237 (Start: 11/01/17 1300 to 11/02/17 0900)

morphine syringe 2 mg/mL [695689226]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
PRN reasons: moderate pain (4-7)
Frequency: Routine Q4H PRN 11/01/17 1235 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Admin instructions: Every 4 hours as needed for chest pain - call if pain not relieved
Caution: Sound alike/look alike medication.
Document pain score assessment before & after administering medication.
Package: 0409-1890-01

sodium chloride 0.9% (NS) infusion [695631096]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Expired**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine Continuous 11/01/17 1300 - 4 hours
Released by: Julia Gaddis, RN 11/01/17 1235
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 0409-7983-09
Status
Julia Gaddis, RN 11/01/17 1253 (End: 11/01/17 1659 to 11/01/17 1652)

carvedilol (COREG) tablet [695631068]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine BID w/ meals 11/01/17 1700 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 0093-7295-01
Reordered from: carvedilol (COREG) 12.5 MG tablet [669537055]

atorvastatin (LIPITOR) tablet [695631069]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD

Medications - Orders and Results (continued)

atorvastatin (LIPITOR) tablet [695631069] (continued)

Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine Nightly 11/01/17 2100 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 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: 0904-6293-04
Reordered from: atorvastatin (LIPITOR) 80 MG tablet [669537054]

chlorthalidone (HYGROTON) tablet [695631071]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine Daily 11/02/17 0900 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 51079-058-01
Reordered from: chlorthalidone (HYGROTEN) 50 MG tablet [669537056]

cilostazol (PLETAL) tablet [695631070]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine BID 11/01/17 2100 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Admin instructions: **Caution: Sound alike/look alike medication**
Package: 0093-2065-06
Status
William C Crew, PharmD 11/01/17 1236 (Start: 11/01/17 1300 to 11/01/17 2100)
Reordered from: cilostazol (PLETAL) 100 MG tablet [669537057]

isosorbide mononitrate (IMDUR) 24 hr tablet [695631072]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
Frequency: Routine BID 11/01/17 2100 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 for Placing Order
Package: 68084-592-11
Status
William C Crew, PharmD 11/01/17 1237 (Start: 11/01/17 1300 to 11/01/17 2100)
Reordered from: isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet [669537058]

nitroglycerin (NITROSTAT) SL tablet [695631073]

Electronically signed by: **Scott A McKee, MD on 11/01/17 1216**
Status: **Discontinued**
Ordering user: Scott A McKee, MD 11/01/17 1216
Ordering provider: Scott A McKee, MD
Authorized by: Scott A McKee, MD
Ordering mode: Standard
PRN reasons: chest pain
Frequency: Routine Q5 Min PRN 11/01/17 1235 - 11/02/17 1513
Released by: Julia Gaddis, RN 11/01/17 1235
Discontinued by: Automatic Discharge Provider 11/02/17 1513 [(Patient Discharge - Internal Use Only)]
Acknowledged: Julia Gaddis, RN 11/01/17 1236 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 [653604302]

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
13 - Muse	MUSE	Unknown	Unknown	12/12/12 2214 - Present
19 - KHLAB	WS KENNESTONE HOSPITAL LAB	Dr. David Schlosnagle	677 CHURCH ST MARIETTA GA 30060	11/04/13 1206 - 08/28/18 1256
118001 - Cath/EP	CATH/EP	Unknown	Unknown	01/02/13 1112 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [695626726]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 0648
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush
Status: Discontinued (Past End Date/Time)
Starts/Ends: 11/01/17 0648 - 11/01/17 1235
Route: Intravenous
Rate/Duration: — / —

Line	Med Link Info	Comment
Peripheral IV 11/01/17 20 G Left Wrist	11/01/17 0722 by Karen M Wilson, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 0722 Documented: 11/01/17 0722	Given	10 mL	Intravenous	Performed by: Karen M Wilson, RN Scanned Package: 8290-306547

sodium chloride 0.9% (NS) bolus [695626727]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 0648
Dose (Remaining/Total): 3 mL/kg/hr (—/—)
Frequency: Continuous
Status: Discontinued (Past End Date/Time), Reason: (Patient Transfer - Internal Use Only)
Starts/Ends: 11/01/17 0700 - 11/01/17 1235
Route: Intravenous
Rate/Duration: 298 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).

Line	Med Link Info	Comment
Peripheral IV 11/01/17 20 G Left;Lateral Forearm	11/01/17 0721 by Karen M Wilson, RN	—

Timestamps	Action	Dose / Rate / Duration	Route	Other Information
Performed 11/01/17 0854 Documented: 11/01/17 0854	Stopped	0 mL/kg/hr 0 mL/hr 1 Hours	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0721 Documented: 11/01/17 0721	New Bag	3 mL/kg/hr 298 mL/hr 1 Hours	Intravenous	Performed by: Karen M Wilson, RN Scanned Package: 0409-7983-09

sodium chloride 0.9% (NS) infusion [695626728]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 0648
Dose (Remaining/Total): 1 mL/kg/hr (—/—)
Frequency: Continuous
Status: Verified (Past End Date/Time)
Starts/Ends: 11/01/17 0700 - 11/01/17 0859
Route: Intravenous
Rate/Duration: 99.3 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."

Line	Med Link Info	Comment
Peripheral IV 11/01/17 20 G Left;Lateral Forearm	11/01/17 0854 by Kathryn Teegarden, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 11/01/17 1340 Documented: 11/01/17 1340	Stopped	0 mL/kg/hr 0 mL/hr	Intravenous	Performed by: Julia Gaddis, RN
Performed 11/01/17 0854 Documented: 11/01/17 0854	Rate/Dose Change	1 mL/kg/hr 99.3 mL/hr	Intravenous	Performed by: Kathryn Teegarden, RN
Due 11/01/17 0700 Scheduled: 11/01/17 0648	Due	—	—	—

heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL [695631053]

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

Medications (continued)

All Meds and Administrations (continued)

Ordered On: 11/01/17 0833

Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 0832 Documented: 11/01/17 1010	Given	4 Bag	Irrigation	Performed by: Abdul M Sheikh, MD Documented by: Kathryn Teegarden, RN

fentaNYL (PF) (SUBLIMAZE) injection 50 mcg/mL [695631057]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 11/01/17 0851

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 1201 Documented: 11/01/17 1201	Given	25 mcg	Intravenous	Performed by: Kathryn Teegarden, RN Comments: prior to perclose
Performed 11/01/17 1117 Documented: 11/01/17 1117	Given	25 mcg	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 1000 Documented: 11/01/17 1000	Given	25 mcg	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0851 Documented: 11/01/17 0851	Given	50 mcg	Intravenous	Performed by: Kathryn Teegarden, RN

midazolam (VERSED) injection 1 mg/mL [695631058]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 11/01/17 0851

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 1201 Documented: 11/01/17 1202	Given	1 mg	Intravenous	Performed by: Kathryn Teegarden, RN Comments: prior to perclose
Performed 11/01/17 1117 Documented: 11/01/17 1117	Given	1 mg	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 1000 Documented: 11/01/17 1000	Given	1 mg	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0851 Documented: 11/01/17 0851	Given	2 mg	Intravenous	Performed by: Kathryn Teegarden, RN

lidocaine (XYLOCAINE) local injection 2 % [695631059]

Ordering Provider: Abdul M Sheikh, MD

Ordered On: 11/01/17 0853

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 0857 Documented: 11/01/17 0857	Given	5 mL	Intradermal	Performed by: Abdul M Sheikh, MD Documented by: Kathryn Teegarden, RN

Medications (continued)

All Meds and Administrations (continued)

Performed 11/01/17 0853 Documented: 11/01/17 0857	Given	5 mL	Intradermal	Performed by: Abdul M Sheikh, MD Documented by: Kathryn Teegarden, RN

Heparin bolus [695631060]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 0903
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 1024 Documented: 11/01/17 1024	Given	3,000 Units	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0936 Documented: 11/01/17 0936	Given	2,000 Units	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0914 Documented: 11/01/17 0914	Given	3,000 Units	Intravenous	Performed by: Kathryn Teegarden, RN
Performed 11/01/17 0903 Documented: 11/01/17 0903	Given	7,000 Units	Intravenous	Performed by: Kathryn Teegarden, RN

iohexol (OMNIPAQUE) injection 350 mg/mL [695631064]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 1154
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information
Performed 11/01/17 1155 Documented: 11/01/17 1155	Given	250 mL	Intra-arterial	Performed by: Abdul M Sheikh, MD Documented by: Kathryn Teegarden, RN Comments: 50cc wasted

sodium chloride 0.9% (NS) infusion [695631066]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 1213
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: Continuous PRN

Line	Med Link Info	Comment
Unlinked	11/01/17 1822 by Julia Gaddis, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 11/01/17 1822 Documented: 11/01/17 1822	Stopped	0 0 mL/hr	—	Performed by: Julia Gaddis, RN
Performed 11/01/17 1212 Documented: 11/01/17 1213	New Bag	1.5 mL/kg/hr 144 mL/hr	Intravenous	Performed by: Kathryn Teegarden, RN

aspirin chewable tablet [695631067]

Ordering Provider: Abdul M Sheikh, MD
Ordered On: 11/01/17 1213
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Frequency: As needed

Timestamps	Action	Dose	Route	Other Information

Medications (continued)

All Meds and Administrations (continued)

Performed 11/01/17 1213 Given Documented: 11/01/17 1213	81 mg	Oral	Performed by: Kathryn Teegarden, RN

carvedilol (COREG) tablet [695631068]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
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: 11/01/17 1700 - 11/02/17 1513
Route: Oral
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 11/02/17 0853 Documented: 11/02/17 0854	Given	12.5 mg	Oral	Performed by: Julia Gaddis, RN Scanned Package: 0093-7295-01
Performed 11/01/17 1737 Documented: 11/01/17 1737	Given	12.5 mg	Oral	Performed by: Julia Gaddis, RN Scanned Package: 0093-7295-01, 0093-7295-01

atorvastatin (LIPITOR) tablet [695631069]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 80 mg (—/—)
Frequency: Nightly
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/01/17 2100 - 11/02/17 1513
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 11/01/17 2021 Documented: 11/01/17 2021	Given	80 mg	Oral	Performed by: Nakeisa L Brown, RN Scanned Package: 0904-6293-04

cilostazol (PLETAL) tablet [695631070]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
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: 11/01/17 2100 - 11/02/17 1513
Route: Oral
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 11/02/17 0853 Documented: 11/02/17 0854	Given	100 mg	Oral	Performed by: Julia Gaddis, RN Scanned Package: 0093-2065-06, 0093-2065-06
Performed 11/01/17 2021 Documented: 11/01/17 2021	Given	100 mg	Oral	Performed by: Nakeisa L Brown, RN Scanned Package: 0093-2065-06, 0093-2065-06

chlorthalidone (HYGROTON) tablet [695631071]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 50 mg (—/—)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/02/17 0900 - 11/02/17 1513
Route: Oral
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information

Medications (continued)

All Meds and Administrations (continued)

Performed 11/02/17 0853 Given Documented: 11/02/17 0854	50 mg	Oral	Performed by: Julia Gaddis, RN Scanned Package: 51079-058-01, 51079-058-01

isosorbide mononitrate (IMDUR) 24 hr tablet [695631072]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 60 mg (—/—)
Frequency: 2 Times daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/01/17 2100 - 11/02/17 1513
Route: Oral
Rate/Duration: — / —

Timestamps	Action	Dose	Route	Other Information
Performed 11/02/17 0853 Documented: 11/02/17 0854	Given	60 mg	Oral	Performed by: Julia Gaddis, RN Scanned Package: 68084-592-11
Performed 11/01/17 2021 Documented: 11/01/17 2021	Given	60 mg	Oral	Performed by: Nakeisa L Brown, RN Scanned Package: 68084-592-11

nitroglycerin (NITROSTAT) SL tablet [695631073]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
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: 11/01/17 1235 - 11/02/17 1513
Route: Sublingual
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

sodium chloride 0.9% (NS) infusion [695631096]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 3 mL/kg/hr (—/—)
Frequency: Continuous
Status: Dispensed (Past End Date/Time)
Starts/Ends: 11/01/17 1300 - 11/01/17 1652
Route: Intravenous
Rate/Duration: 287 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 11/01/17 20 G Left;Lateral Forearm	11/01/17 1253 by Julia Gaddis, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 11/01/17 1822 Documented: 11/01/17 1822	Stopped	0 mL/kg/hr 0 mL/hr	Intravenous	Performed by: Julia Gaddis, RN
Performed 11/01/17 1339 Documented: 11/01/17 1340	New Bag	3 mL/kg/hr 287 mL/hr	Intravenous	Performed by: Julia Gaddis, RN Scanned Package: 0409-7983-09
Performed 11/01/17 1253 Documented: 11/01/17 1253	New Bag	3 mL/kg/hr 287 mL/hr	Intravenous	Performed by: Julia Gaddis, RN Scanned Package: 0409-7983-09

atropine injection 0.1 mg/mL [695631099]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 0.5 mg (3/3)
Frequency: Every 5 min PRN
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/01/17 1235 - 11/02/17 1513
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

Medications (continued)

All Meds and Administrations (continued)

aspirin chewable tablet [695689224]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 81 mg (---/---)
Frequency: Daily
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/02/17 0900 - 11/02/17 1513
Route: Oral
Rate/Duration: --- / ---

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Due 11/02/17 0900 Scheduled: 11/01/17 1237	Due	---	---	---

morphine syringe 2 mg/mL [695689226]

Ordering Provider: Scott A McKee, MD
Ordered On: 11/01/17 1235
Dose (Remaining/Total): 2 mg (---/---)
Frequency: Every 4 hours PRN
Admin Instructions: Every 4 hours as needed for chest pain - call if pain not relieved
Document pain score assessment before & after administering medication.
Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 11/01/17 1235 - 11/02/17 1513
Route: Intravenous
Rate/Duration: --- / ---
Caution: Sound alike/look alike medication.

(No admins scheduled or recorded for this medication)

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)

Patient Education (continued)

Education (continued)

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.

Point: Demonstrate Handwashing (MCB) (Resolved)

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: 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)

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.

Patient Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

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 (Resolved)

Points For This Title

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.

Point: 0.9 % sodium chloride (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.

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

Patient Education (continued)

Education (continued)

Point: Support Systems (Resolved)

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

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

Point: Spiritual/Emotional Needs (Resolved)

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

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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

Patient Education (continued)

Education (continued)

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".

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Resolved)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Education (continued)

Education (continued)

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 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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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.

Learning Progress Summary

Patient	Acceptance, Explanation, Verbalized Understanding by NB at 11/1/2017 2015
	Acceptance, Explanation, Verbalized Understanding by KW at 11/1/2017 0708

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)

Patient Education (continued)

Education (continued)

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)

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)

Patient Education (continued)

Education (continued)

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.

Learner Progress: Not documented in this visit.

User Key

Initials	Effective Dates	Name	Provider Type	Discipline
KW	02/03/17 -	Karen M Wilson, RN	Registered Nurse	Nurse
NB	02/03/17 -	Nakeisa L Brown, RN	Registered Nurse	Nurse

All Flowsheets

Flowsheets (all recorded)

CARE PLAN MINI-FLOWSHEET DATA

Row Name	11/01/17 0709
Values/Beliefs	
Cultural Preferences Affecting Hospitalization	No -KW
Spiritual Preferences Affecting Hospitalization	No -KW
Discharge Info	
Is there anything else we need to know to provide the best care possible?	no -KW

Flowsheets (all recorded)

Custom Formula Data

Row Name	11/02/17 07:25:45	11/02/17 03:53:02	11/01/17 22:12:48	11/01/17 19:49:06	11/01/17 1845
Vitals					
Pct Wt Change	—	0 % -TA	—	—	0 % -AG
OTHER					
Weight Change (kg)	—	0 kg -TA	—	—	0 kg -AG
Visit Weight	—	214 lb -TA	—	—	215 lb -AG
Weight/Scale Event	—	0 -TA	—	—	0 -AG
% Weight Change Since Birth	—	0 -TA	—	—	0 -AG
Relevant Labs and Vitals					
Temp (in Celsius)	36.6 -RG	36.6 -TA	36.9 -TA	36.8 -TA	—

Row Name	11/01/17 18:11:44	11/01/17 1248	11/01/17 12:45:07	11/01/17 12:11:09	11/01/17 08:32:47
Relevant Labs and Vitals					
Temp (in Celsius)	36.7 -AG	—	36.7 -AG	—	—
Aldrete Phase 1					
Aldrete Score	—	—	—	10 -KT	10 -CC
VTE Risk Factor: Totals					
General Info Subtotal	—	0 -JG	—	—	—
Total Risk Factor Score					
VTE Low Risk Attribute	—	No -JG	—	—	—

Row Name	11/01/17 0718	11/01/17 0657
Vitals		
Pct Wt Change	—	0 % -KW
OTHER		
Weight Change (kg)	—	0 kg -KW
Ideal Body Weight	—	160 lb -KW
Visit Weight	—	211 lb -KW
BMI (Calculated)	—	33 -KW
IBW/kg (Calculated) Male	—	66.1 kg -KW
IBW/kg (Calculated) FEMALE	—	61.6 kg -KW
Weight/Scale Event	—	0 -KW
Weight in (lb) to have BMI = 25	—	159.3 -KW
% Weight Change Since Birth	—	0 -KW
Adult IBW/VT Calculations		
IBW/kg (Calculated)	—	66.1 -KW
Range Vt 4mL/kg	—	264.4 mL/kg -KW
Low Range Vt 6mL/kg	—	396.6 mL/kg -KW
Adult Moderate Range Vt 8mL/kg	—	528.8 mL/kg -KW
Adult High Range Vt 10mL/kg	—	661 mL/kg -KW
Case Log		
BSA x (CI @3.0)= CO	—	6.36 CO -KW
Relevant Labs and Vitals		
Temp (in Celsius)	36.6 -KW	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	11/02/17 1313
OTHER	
Risk for Readmission	8 -DH

Flowsheets (all recorded)

Travel Information

Row Name	11/01/17 0654
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 -KW

Flowsheets (all recorded)

Aldrete Score

Row Name	11/01/17 12:11:09	11/01/17 08:32:47
Aldrete		
Activity	2 -KT	2 -CC
Respiration	2 -KT	2 -CC
Circulation	2 -KT	2 -CC
Consciousness	2 -KT	2 -CC
O2 Saturation	2 -KT	2 -CC
Aldrete Score (PAR)	10 -KT	10 -CC

Flowsheets (all recorded)

Vital Signs

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07
Vital Signs					
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	—	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)	—
Temp src	—	—	Oral -RG	Oral -TA	—
Pulse	61 -DI (r) RG (t)	—	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)
Heart Rate Source	—	—	Monitor -RG	—	—
Resp	16 -DI (r) RG (t)	—	18 -RG	17 -DI (r) TA (t)	—
Respiration Source	—	—	visual -RG	—	—
BP	159/73 -DI (r) RG (t)	—	139/71 -DI (r) RG (t)	—	129/62 -DI (r) NB (t)
BP Location	—	—	Right arm -RG	—	—
BP Method	—	—	Portable -RG	—	—
Patient Position	—	—	Supine -RG	—	—
Oxygen Therapy					
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -JG	—	—	—	—
Height and Weight					
Weight	—	—	—	97.1 kg (214 lb 1.1 oz) -TA	—
Weight Method	—	—	—	Actual -TA	—
Row Name	**11/01/17 22:12:48**	**11/01/17 19:49:06**	**11/01/17 1930**	**11/01/17 1845**	**11/01/17 18:17:07**
Vital Signs					
Temp	98.5 °F (36.9 °C) -DI (r) TA (t)	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—	—
Temp src	Oral -TA	Oral -TA	—	—	—
Pulse	69 -DI (r) TA (t)	65 -DI (r) TA (t)	—	—	72 -DI (r) AG (t)
Heart Rate Source	Monitor -TA	Monitor -TA	—	—	—
Resp	17 -DI (r) TA (t)	17 -DI (r) TA (t)	—	—	—
Respiration Source	visual -TA	visual -TA	—	—	—
BP	122/62 -DI (r) TA (t)	110/63 -DI (r) TA (t)	—	—	146/70 -DI (r) AG (t)
BP Location	Right arm -TA	Right arm -TA	—	—	Right arm -AG
BP Method	Portable -TA	Portable -TA	—	—	Portable -AG
Patient Position	Supine -TA	Supine -TA	—	—	Standing -AG
Oxygen Therapy					
SpO2	93 % -DI (r) TA (t)	94 % -DI (r) TA (t)	—	—	—
O2 Device	None (Room air) -TA	None (Room air) -TA	—	—	None (Room air) -AG
Pain Assessment					
Currently in Pain	—	—	No -NB	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -NB	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -NB	—	—
Height and Weight					
Weight	—	—	—	97.4 kg (214 lb 11.2 oz) -AG	—
Weight Method	—	—	—	Actual -AG	—
Row Name	**11/01/17 18:15:27**	**11/01/17 18:11:44**	**11/01/17 12:45:07**	**11/01/17 1241**	**11/01/17 08:32:31**
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -DI (r) AG (t)	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—
Temp src	—	Oral -AG	Oral -AG	—	—
Pulse	74 -DI (r) AG (t)	—	58 -DI (r) AG (t)	—	—
Heart Rate Source	—	—	Monitor -AG	—	—
Resp	—	20 -DI (r) AG (t)	16 -DI (r) AG (t)	—	—
Respiration Source	—	visual -AG	visual -AG	—	—
BP	161/77 -DI (r) AG (t)	130/61 -DI (r) AG (t)	156/88 -DI (r) AG (t)	—	—
BP Location	Right arm -AG	Right arm -AG	Right arm -AG	—	—
BP Method	Portable -AG	Portable -AG	Portable -AG	—	—
Patient Position	Sitting -AG	Supine -AG	Supine -AG	—	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 12:45:07	11/01/17 1241	11/01/17 08:32:31
Oxygen Therapy					
SpO2	—	—	93 % -DI (r) AG (t)	—	—
O2 Device	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG	None (Room air) -JG	Nasal cannula -CC
O2 Flow Rate (L/min)	—	—	—	—	3 L/min -CC
Pain Assessment History					
Patient's Stated Pain Goal	—	—	4 -JG	—	—

Row Name	11/01/17 0718	11/01/17 0658	11/01/17 0657
Vital Signs			
Temp	97.8 °F (36.6 °C) -KW	—	—
Temp src	Oral -KW	—	—
Pulse	55 -KW	—	—
Heart Rate Source	Monitor -KW	—	—
Resp	16 -KW	—	—
BP	117/58 -KW	—	—
Oxygen Therapy			
SpO2	94 % -KW	—	—
Numeric Pain Intensity Scale			
Numeric Pain Intensity Score 1	—	0 -KW	—
Height and Weight			
Height	—	—	67" (1.702 m) -KW
Weight	—	—	95.7 kg (211 lb) -KW
Weight Method	—	—	Stated -KW
BSA (Calculated - sq m)	—	—	2.12 sq meters -KW
BMI (Calculated)	—	—	33 -KW
Weight in (lb) to have BMI = 25	—	—	159.3 -KW

Flowsheets (all recorded)

Intake/Output

Row Name	11/02/17 11:32:20	11/02/17 0732	11/02/17 07:25:45	11/02/17 0617	11/02/17 0400
Simple Vitals					
Pulse	61 -DI (r) RG (t)	—	67 -DI (r) RG (t)	—	—
Resp	16 -DI (r) RG (t)	—	18 -RG	—	—
Numeric Pain Intensity Score 1	0 -JG	—	—	—	—
magnesium sulfate					
Latest MgSO4 serum level	—	—	—	1.8	—
Urine Output					
Urine	—	1450 mL -RG	—	—	—
Foley Care/ Peri Care	—	—	—	—	Completed -TA
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				

Row Name	11/02/17 03:53:02	11/02/17 03:16:07	11/01/17 22:12:48	11/01/17 2000	11/01/17 19:49:06
Weights					
Weight	97.1 kg (214 lb 1.1 oz) -TA	—	—	—	—
Weight Method	Actual -TA	—	—	—	—
Simple Vitals					
Pulse	—	68 -DI (r) NB (t)	69 -DI (r) TA (t)	—	65 -DI (r) TA (t)
Resp	17 -DI (r) TA (t)	—	17 -DI (r) TA (t)	—	17 -DI (r) TA (t)
Urine Output					
Urine	1400 mL -TA	—	—	—	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Site Assessment	—	—	—	Asymptomatic -NB	—
Phlebitis Scale	—	—	—	0 -NB	—
Infiltration/Extravasation Scale	—	—	—	0 -NB	—
Line Assessment	—	—	—	Saline locked -NB	—
Dressing Assesment	—	—	—	Clean;Dry;Intact -NB	—
IV Interventions	—	—	—	Flushed -NB	—
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				
Site Assessment	—	—	—	Asymptomatic -NB	—
Phlebitis Scale	—	—	—	0 -NB	—
Infiltration/Extravasation Scale	—	—	—	0 -NB	—
Line Assessment	—	—	—	Patent;Infusing -NB	—
Dressing Assesment	—	—	—	Clean;Dry;Intact -NB	—
IV Interventions	—	—	—	Flushed -NB	—

Row Name	11/01/17 1930	11/01/17 1845	11/01/17 1822	11/01/17 18:17:07	11/01/17 18:15:27

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	11/01/17 1930	11/01/17 1845	11/01/17 1822	11/01/17 18:17:07	11/01/17 18:15:27
Weights					
Weight	—	97.4 kg (214 lb 11.2 oz) -AG	—	—	—
Weight Method	—	Actual -AG	—	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG	—	—
Simple Vitals					
Pulse	—	—	—	72 -DI (r) AG (t)	74 -DI (r) AG (t)
Numeric Pain Intensity Score 1	0 -NB	—	—	—	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				

Row Name	11/01/17 18:11:44	11/01/17 1747	11/01/17 1340	11/01/17 1339	11/01/17 1253
sodium chloride 0.9% (NS) infusion					
Rate	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -JG	* There are multiple administrations at this time. Please see the MAR for detailed information. -JG
Simple Vitals					
Resp	20 -DI (r) AG (t)	—	—	—	—
Urine Output					
Urine	—	1000 mL -AG	—	—	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	11/01/17 12:45:07	11/01/17 12:12:43	11/01/17 1200	11/01/17 10:24:35	11/01/17 09:36:42
sodium chloride 0.9% (NS) infusion					
Rate	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -KT	—	—	—
Simple Vitals					
Pulse	58 -DI (r) AG (t)	—	—	—	—
Resp	16 -DI (r) AG (t)	—	—	—	—
Heparin Drip					
heparin Bolus (Units)	—	—	—	3000 Units -KT	2000 Units -KT
Concentration	—	—	—	1000 Units/mL -KT	1000 Units/mL -KT
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Site Assessment	—	—	Asymptomatic -JG	—	—
Phlebitis Scale	—	—	0 -JG	—	—
Infiltration/Extravasation Scale	—	—	0 -JG	—	—
Line Assessment	—	—	Saline locked -JG	—	—
Dressing Assesment	—	—	Clean;Dry;Intact;Occlusive;Transparent -JG	—	—
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				
Site Assessment	—	—	Asymptomatic -JG	—	—
Phlebitis Scale	—	—	0 -JG	—	—
Infiltration/Extravasation Scale	—	—	0 -JG	—	—
Line Assessment	—	—	Patent;Infusing -JG	—	—
Dressing Assesment	—	—	Clean;Dry;Intact;Occlusive;Transparent -JG	—	—

Row Name	11/01/17 09:14:54	11/01/17 09:03:28	11/01/17 0854	11/01/17 08:32:57	11/01/17 0741
sodium chloride 0.9% (NS) infusion					
Rate	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -KT	—	—
sodium chloride 0.9% (NS) bolus					
Bolus Dose	—	—	*0 mL/kg/hr -KT	—	—
Heparin Drip					
heparin Bolus (Units)	3000 Units -KT	7000 Units -KT	—	*4 Bag -KT (r) AS (t)	—
heparin Rate	—	—	—	— -KT (r) AS (t)	—
Concentration	1000 Units/mL -KT	1000 Units/mL -KT	—	2 Units/mL -KT (r) AS (t)	—
heparin (PORCINE) (PF) in 0.9 % sodium chloride 2,000 units/1,000 mL Start: 11/01/17 0832					
heparin Bolus Dose (Units) (View Only)	—	—	—	*4 Bag -KT (r) AS (t)	—
heparin Rate (mL/hr) (View Only)	—	—	—	— -KT (r) AS (t)	—
heparin Concentration (View Only)	—	—	—	2 Units/mL -KT (r) AS (t)	—
[REMOVED] External Urinary Catheter					
External Urinary	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal				

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	11/01/17 09:14:54	11/01/17 09:03:28	11/01/17 0854	11/01/17 08:32:57	11/01/17 0741
Catheter Properties	Date: 01/16/18 -MW Removal Time: 2219 -MW				
Collection Container	—	—	—	—	Standard drainage bag -KW
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				

Row Name	11/01/17 0721	11/01/17 0718	11/01/17 0659	11/01/17 0658	11/01/17 0657
Weights					
Weight	—	—	—	—	95.7 kg (211 lb) -KW
Weight Method	—	—	—	—	Stated -KW
BSA (Calculated - sq m)	—	—	—	—	2.12 sq meters -KW
sodium chloride 0.9% (NS) bolus					
Bolus Dose	*3 mL/kg/hr -KW	—	—	—	—
Simple Vitals					
Pulse	—	55 -KW	—	—	—
Resp	—	16 -KW	—	—	—
Numeric Pain Intensity Score 1	—	—	—	0 -KW	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Site Assessment	—	—	Asymptomatic -KW	—	—
Phlebitis Scale	—	—	0 -KW	—	—
Infiltration/Extravasation Scale	—	—	0 -KW	—	—
Line Assessment	—	—	Blood return noted -KW	—	—
Dressing Assesment	—	—	Clean;Dry;Intact;Occlusive;Transparent -KW	—	—
IV Interventions	—	—	Flushed -KW	—	—
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				
Site Assessment	Asymptomatic -KW	—	—	—	—
Phlebitis Scale	0 -KW	—	—	—	—
Infiltration/Extravasation Scale	0 -KW	—	—	—	—
Line Assessment	Blood return noted -KW	—	—	—	—
Dressing Assesment	Clean;Dry;Intact;Occlusive;Transparent -KW	—	—	—	—
IV Interventions	Flushed -KW	—	—	—	—

Flowsheets (all recorded)

IV Assessment

Row Name	11/01/17 2000	11/01/17 1241	11/01/17 1200	11/01/17 0721	11/01/17 0659
Blood Specimen Collection Status					
Blood Specimen Collection	Lab -NB	—	—	—	—
Dominant Hand					
Which is your dominant hand?	—	Right -JG	—	—	—
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Site Assessment	Asymptomatic -NB	—	Asymptomatic -JG	—	Asymptomatic -KW
Phlebitis Scale	0 -NB	—	0 -JG	—	0 -KW
Infiltration/Extravasation Scale	0 -NB	—	0 -JG	—	0 -KW
Line Assessment	Saline locked -NB	—	Saline locked -JG	—	Blood return noted -KW
Dressing Assesment	Clean;Dry;Intact -NB	—	Clean;Dry;Intact;Occlusive;Transparent -JG	—	Clean;Dry;Intact;Occlusive;Transparent -KW
IV Interventions	Flushed -NB	—	—	—	Flushed -KW
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				
Site Assessment	Asymptomatic -NB	—	Asymptomatic -JG	Asymptomatic -KW	—
Phlebitis Scale	0 -NB	—	0 -JG	0 -KW	—
Infiltration/Extravasation Scale	0 -NB	—	0 -JG	0 -KW	—
Line Assessment	Patent;Infusing -NB	—	Patent;Infusing -JG	Blood return noted -KW	—
Dressing Assesment	Clean;Dry;Intact -NB	—	Clean;Dry;Intact;Occlusive;Transparent -JG	Clean;Dry;Intact;Occlusive;Transparent -KW	—
IV Interventions	Flushed -NB	—	—	Flushed -KW	—
[REMOVED] Arterial Sheath 6 Fr. Right Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: No complications;Catheter intact -KT				
[REMOVED] Arterial Sheath 8 Fr. Left Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, gofball size				

Flowsheets (all recorded)

Assessment

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 0400	11/02/17 03:53:02
Neurological					
Level of Consciousness	—	Alert -JG	—	—	—
Neuro (WDL)	—	WDL -JG	—	—	—
CAM Delirium Assessment					
Feature 1: Acute Onset of Fluctuating Course	—	Negative -JG	—	—	—
CAM Delirium Assessment	—	Negative -JG	—	—	—
tPA Time out					
Weight	—	—	—	—	97.1 kg (214 lb 1.1 oz) -TA
HEENT					
HEENT (WDL)	—	X -JG	—	—	—
R Eye	—	Impaired vision -JG	—	—	—
L Eye	—	Impaired vision -JG	—	—	—
Respiratory					
Respiratory (WDL)	—	WDL -JG	—	—	—
Oxygen Therapy					
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	—	—
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	No -JG	—	—	—
Cardiac					
Cardiac (WDL)	—	WDL -JG	—	—	—
Cardiac					
Cardiac Regularity	—	Regular -JG	—	—	—
Bedside Cardiac Monitor On	—	No -JG	—	—	—
Telemetry Monitor On	—	Yes -JG	—	—	—
Telemetry Audible	—	Yes -JG	—	—	—
Telemetry Alarms Set	—	Yes -JG	—	—	—
Telemetry Box Number	—	5799 -JG	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	WDL -JG	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -JG	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -JG	—	—	—
RUE Neurovascular Assessment					
R Radial Pulse	—	+2 -JG	—	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -JG	—	—	—
RLE Neurovascular Assessment					
RLE Color	—	Appropriate for ethnicity -JG	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -JG	—	—	—
RLE Sensation	—	Present -JG	—	—	—
R Pedal Pulse	—	+1 -JG	—	—	—
LLE Neurovascular Assessment					
LLE Color	—	Appropriate for ethnicity -JG	—	—	—
LLE Temperature/Moisture	—	Warm;Dry -JG	—	—	—
LLE Sensation	—	Present -JG	—	—	—
L Pedal Pulse	—	+2 -JG	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 0400	11/02/17 03:53:02
Integumentary					
Integumentary (WDL)	—	X -JG	—	—	—
Skin Color	—	Appropriate for ethnicity -JG	—	—	—
Skin Condition/Temp	—	Dry;Warm -JG	—	—	—
Skin Integrity	—	Other (Comment);Bruising surgical wounds -JG	—	—	—
Skin Location	—	L and R groin -JG	—	—	—
Skin Turgor	—	Non-tenting -JG	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -JG	—	—	—
Moisture	—	4 -JG	—	—	—
Activity	—	3 -JG	—	—	—
Mobility	—	4 -JG	—	—	—
Nutrition	—	3 -JG	—	—	—
Friction and Shear	—	3 -JG	—	—	—
Braden Scale Score	—	21 -JG	—	—	—
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	—	—	—
Surrounding Skin Assessment	—	Purple;Intact -JG	—	—	—
Closure	—	None -JG	—	—	—
Drainage Amount	—	None -JG	—	—	—
Treatments	—	Site care -JG	—	—	—
Dressing	—	Dry dressing -JG	—	—	—
Dressing Changed	—	Changed -JG	—	—	—
Dressing Assesment	—	Clean;Dry;Intact -JG	—	—	—
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	—	—	—
Surrounding Skin Assessment	—	Intact -JG	—	—	—
Closure	—	None -JG	—	—	—
Drainage Amount	—	None -JG	—	—	—
Treatments	—	Site care -JG	—	—	—
Dressing	—	Dry dressing -JG	—	—	—
Dressing Changed	—	Changed -JG	—	—	—
Dressing Assesment	—	Clean;Dry;Intact -JG	—	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	WDL -JG	—	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	1 -JG	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	WDL -JG	—	—	—
Genitourinary					
Genitourinary (WDL)	—	WDL -JG	—	—	—
Urine Assessment					
Foley Care/ Peri Care	—	—	—	Completed -TA	—
Psychosocial					
Psychosocial (WDL)	—	WDL -JG	—	—	—
Charting Type					
Charting Type	—	Shift assessment -JG	—	—	—
Cardiac					
Cardiac Rhythm	—	Normal sinus rhythm -JG	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 0400	11/02/17 03:53:02
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	0 -JG	—	—	—
Symptomatic Depression (View Only)	—	0 -JG	—	—	—
Altered Elimination (View Only)	—	0 -JG	—	—	—
Dizziness/Vertigo (View Only)	—	0 -JG	—	—	—
Gender (Male) View Only	—	1 -JG	—	—	—
Any Administered Benzodiazepines (View Only)	—	0 -JG	—	—	—
Hendrich II Total Score (Calculated) View Only	—	2 -JG	—	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	0 -JG	—	—	—

Row Name	11/02/17 03:16:07	11/01/17 22:12:48	11/01/17 2000	11/01/17 19:49:06	11/01/17 1930
Neurological					
Level of Consciousness	—	—	—	—	Alert -NB
Neuro (WDL)	—	—	—	—	WDL -NB
CAM Delirium Assessment					
Feature 1: Acute Onset of Fluctuating Course	—	—	—	—	Negative -NB
CAM Delirium Assessment	—	—	—	—	Negative -NB
HEENT					
HEENT (WDL)	—	—	—	—	X -NB
R Eye	—	—	—	—	Impaired vision -NB
L Eye	—	—	—	—	Impaired vision -NB
Respiratory					
Respiratory (WDL)	—	—	—	—	WDL -NB
Oxygen Therapy					
SpO2	94 % -DI (r) NB (t)	93 % -DI (r) TA (t)	—	94 % -DI (r) TA (t)	—
O2 Device	—	None (Room air) -TA	—	None (Room air) -TA	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	No -NB	—	—
IS Tx Not Given	—	—	Not Indicated -NB	—	—
Cardiac					
Cardiac (WDL)	—	—	—	—	WDL -NB
Heart Sounds	—	—	—	—	S1, S2 -NB
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	—	WDL -NB
RUE Neurovascular Assessment					
R Radial Pulse	—	—	—	—	+2 -NB
LUE Neurovascular Assessment					
L Radial Pulse	—	—	—	—	+2 -NB
RLE Neurovascular Assessment					
R Posterior Tibial Pulse	—	—	—	—	+1 -NB
R Pedal Pulse	—	—	—	—	+2 -NB

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/02/17 03:16:07	11/01/17 22:12:48	11/01/17 2000	11/01/17 19:49:06	11/01/17 1930
Integumentary					
Integumentary (WDL)	—	—	—	—	X -NB
Skin Condition/Temp	—	—	—	—	Dry;Warm -NB
Skin Location	—	—	—	—	L and R groin -NB
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -NB
Moisture	—	—	—	—	4 -NB
Activity	—	—	—	—	1 -NB
Mobility	—	—	—	—	4 -NB
Nutrition	—	—	—	—	3 -NB
Friction and Shear	—	—	—	—	3 -NB
Braden Scale Score	—	—	—	—	19 -NB
Wound					
Type of Wound (LDA)	—	—	—	—	Surgical -NB
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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				
Surrounding Skin Assessment	—	—	—	—	Intact -NB
Closure	—	—	—	—	UTA -NB
Treatments	—	—	—	—	Site care -NB
Dressing Changed	—	—	—	—	Changed -NB
Dressing Assesment	—	—	—	—	Clean;Dry;Intact -NB
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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	—	—	—	—	UTA -NB
Dressing Assesment	—	—	—	—	Clean;Dry;Intact -NB
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	—	WDL -NB
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	—	4d Ordered bed rest -NB
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	—	WDL -NB
Last BM Date	—	—	—	—	10/31/17 -NB
Genitourinary					
Genitourinary (WDL)	—	—	—	—	WDL -NB
Psychosocial					
Psychosocial (WDL)	—	—	—	—	WDL -NB
Charting Type					
Charting Type	Reassessment no changes -NB	—	—	—	Shift assessment -NB
Cardiac					
Cardiac Rhythm	—	—	—	—	Normal sinus rhythm -NB
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	—	—	—	0 -NB
Symptomatic Depression (View Only)	—	—	—	—	0 -NB
Altered Elimination (View Only)	—	—	—	—	0 -NB
Dizziness/Vertigo (View Only)	—	—	—	—	0 -NB
Gender (Male) View Only	—	—	—	—	1 -NB
Any Administered Benzodiazepines	—	—	—	—	0 -NB

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/02/17 03:16:07	11/01/17 22:12:48	11/01/17 2000	11/01/17 19:49:06	11/01/17 1930
(View Only)					
Hendrich II Total Score (Calculated) View Only	—	—	—	—	5 -NB
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	—	—	—	0 -NB

Row Name	11/01/17 1845	11/01/17 18:17:07	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 1800
tPA Time out					
Weight	97.4 kg (214 lb 11.2 oz) -AG	—	—	—	—
Oxygen Therapy					
O2 Device	—	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG	—
Cardiac					
Telemetry Monitor On	—	—	—	—	Yes -AG
Telemetry Audible	—	—	—	—	Yes -AG
Telemetry Alarms Set	—	—	—	—	Yes -AG
Telemetry Box Number	—	—	—	—	5799 -AG
Peripheral Vascular					
RLE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -JG
LLE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -JG
RLE Neurovascular Assessment					
RLE Color	—	—	—	—	Appropriate for ethnicity -JG
RLE Temperature/Moisture	—	—	—	—	Warm;Dry -JG
RLE Sensation	—	—	—	—	Present -JG
R Pedal Pulse	—	—	—	—	+2 -JG
LLE Neurovascular Assessment					
LLE Color	—	—	—	—	Appropriate for ethnicity -JG
LLE Temperature/Moisture	—	—	—	—	Warm;Dry -JG
LLE Sensation	—	—	—	—	Present -JG
L Pedal Pulse	—	—	—	—	+2 -JG
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG
Surrounding Skin Assessment	—	—	—	—	Intact -JG
Closure	—	—	—	—	UTA -JG
Drainage Amount	—	—	—	—	None -JG
Dressing	—	—	—	—	Barrier Film;Dry dressing;Gauze -JG
Dressing Assesment	—	—	—	—	Intact;Occlusive;Transparent -JG
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG
Surrounding Skin Assessment	—	—	—	—	Intact -JG
Closure	—	—	—	—	UTA -JG
Drainage Amount	—	—	—	—	None -JG
Dressing	—	—	—	—	Barrier Film;Dry dressing;Gauze -JG

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/01/17 1845	11/01/17 18:17:07	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 1800
Dressing Assesment	—	—	—	—	Clean;Dry;Intact;Occlusive;Transparent -JG

Row Name	11/01/17 1700	11/01/17 1600	11/01/17 1530	11/01/17 1500	11/01/17 1430
Cardiac					
Telemetry Monitor On	—	Yes -AG	—	—	—
Telemetry Audible	—	Yes -AG	—	—	—
Telemetry Alarms Set	—	Yes -AG	—	—	—
Telemetry Box Number	—	5799 -AG	—	—	—
Peripheral Vascular					
RLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
RLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
RLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
R Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
LLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
LLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
L Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	Intact -JG
Closure	UTA -JG	UTA -JG	UTA -JG	None -JG	UTA -JG
Drainage Amount	None -JG	Scant -JG	None -JG	Small -JG	None -JG
Treatments	—	—	—	Site care -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG
Dressing Changed	—	—	—	Changed -JG	—
Dressing Assesment	Intact;Occlusive;Transparent -JG	Occlusive;Intact;Transparent -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	Intact -JG
Closure	UTA -JG	UTA -JG	UTA -JG	None -JG	UTA -JG
Drainage Amount	None -JG	None -JG	None -JG	Small -JG	None -JG
Treatments	—	—	—	Site care -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Gauze;Dry dressing -JG
Dressing Changed	—	—	—	Changed -JG	—
Dressing Assesment	Clean;Dry;Intact;Occlusive;Transparent -JG	Intact;Occlusive;Dry;Clean -JG	Clean;Dry;Intact;Occlusive;Transparent -JG	Clean;Intact;Occlusive;Dry;Transparent -JG	Dry;Clean;Intact -JG

Row Name	11/01/17 1400	11/01/17 1330	11/01/17 1315	11/01/17 1300	11/01/17 12:45:07
Oxygen Therapy					
SpO2	—	—	—	—	93 % -DI (r) AG (t)
O2 Device	—	—	—	—	None (Room air) -AG

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/01/17 1400	11/01/17 1330	11/01/17 1315	11/01/17 1300	11/01/17 12:45:07
Peripheral Vascular					
RLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	—
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	—
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	—
RLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	—
RLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	—
R Femoral Pulse	—	—	—	— -JG	—
R Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	—
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	—
LLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	—
LLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	—
L Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	—
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	—
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	—
Closure	UTA -JG	UTA -JG	UTA -JG	UTA -JG	—
Drainage Amount	None -JG	None -JG	None -JG	None -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	—
Dressing Assesment	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	—
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	—
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	—
Closure	UTA -JG	UTA -JG	UTA -JG	UTA -JG	—
Drainage Amount	None -JG	None -JG	None -JG	None -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	—
Dressing Assesment	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	—

Row Name	11/01/17 1245	11/01/17 1241	11/01/17 08:32:31	11/01/17 0718	11/01/17 0711
Neurological					
Level of Consciousness	—	Alert -JG	—	—	Alert -KW
Neuro (WDL)	—	WDL -JG	—	—	—
CAM Delirium Assessment					
Feature 1: Acute Onset of Fluctuating Course	—	Negative -JG	—	—	—
CAM Delirium Assessment	—	Negative -JG	—	—	—
HEENT					
HEENT (WDL)	—	X -JG	—	—	X -KW
R Eye	—	Impaired vision -JG	—	—	Impaired vision -KW
L Eye	—	Impaired vision -JG	—	—	Impaired vision -KW
Respiratory					
Respiratory Pattern	—	—	—	—	Regular -KW
Chest Assessment	—	—	—	—	Chest expansion symmetrical -KW
Bilateral Breath Sounds	—	—	—	—	Clear -KW

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/01/17 1245	11/01/17 1241	11/01/17 08:32:31	11/01/17 0718	11/01/17 0711
R Breath Sounds	—	—	—	—	Clear -KW
L Breath Sounds	—	—	—	—	Clear -KW
Respiratory (WDL)	—	WDL -JG	—	—	—
Cough	—	—	—	—	None -KW
Oxygen Therapy					
SpO2	—	—	—	94 % -KW	—
O2 Device	—	None (Room air) -JG	Nasal cannula -CC	—	—
O2 Flow Rate (L/min)	—	—	3 L/min -CC	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	No -JG	—	—	—
Cardiac					
Cardiac (WDL)	—	WDL -JG	—	—	—
Heart Sounds	—	—	—	—	S1, S2 -KW
Cardiac Symptoms	—	—	—	—	None -KW
Cardiac					
Cardiac Regularity	—	Regular -JG	—	—	Regular -KW
Bedside Cardiac Monitor On	—	No -JG	—	—	Yes -KW
Bedside Cardiac Audible	—	—	—	—	Yes -KW
Bedside Cardiac Alarms Set	—	—	—	—	Yes -KW
Telemetry Monitor On	—	Yes -JG	—	—	—
Telemetry Audible	—	Yes -JG	—	—	—
Telemetry Alarms Set	—	Yes -JG	—	—	—
Telemetry Box Number	—	5799 -JG	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	WDL -JG	—	—	WDL -KW
RLE Capillary Refill	Less than/equal to 3 seconds -JG	—	—	—	—
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	—	—	—
Pulses	—	—	—	—	R radial;R posterior tibial;L posterior tibial;R pedal;L pedal -KW
RUE Neurovascular Assessment					
R Radial Pulse	—	+2 -JG	—	—	+2 -KW
LUE Neurovascular Assessment					
L Radial Pulse	—	+2 -JG	—	—	+2 -KW
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	—	—	—	—
RLE Temperature/Moisture	Warm;Dry -JG	—	—	—	—
RLE Sensation	Present -JG	—	—	—	—
R Femoral Pulse	— -JG	—	—	—	—
R Posterior Tibial Pulse	—	—	—	—	+1 -KW
R Pedal Pulse	+2 -JG	+2 -JG	—	—	+2 -KW
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	—	—	—
LLE Temperature/Moisture	Dry;Warm -JG	Dry;Warm -JG	—	—	—
LLE Sensation	Present -JG	Present -JG	—	—	—
L Posterior Tibial Pulse	—	—	—	—	+2 -KW
L Pedal Pulse	+2 -JG	+2 -JG	—	—	+2 -KW
[REMOVED] Arterial Sheath 6 Fr. Right Femoral					
Arterial/Venous	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT				

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/01/17 1245	11/01/17 1241	11/01/17 08:32:31	11/01/17 0718	11/01/17 0711
Sheath Properties	Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: No complications;Catheter intact -KT				
[REMOVED] Arterial Sheath 8 Fr. Left Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, gofball size				
Integumentary					
Integumentary (WDL)	—	X -JG	—	—	WDL -KW
Skin Color	—	Appropriate for ethnicity -JG	—	—	—
Skin Condition/Temp	—	Dry;Warm -JG	—	—	—
Skin Integrity	—	Other (Comment) surgical puncture -JG	—	—	—
Skin Location	—	L and R groin -JG	—	—	—
Skin Turgor	—	Non-tenting -JG	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -JG	—	—	—
Moisture	—	4 -JG	—	—	—
Activity	—	1 -JG	—	—	—
Mobility	—	4 -JG	—	—	—
Nutrition	—	3 -JG	—	—	—
Friction and Shear	—	3 -JG	—	—	—
Braden Scale Score	—	19 -JG	—	—	—
Wound					
Type of Wound (LDA)	—	Surgical -JG	Surgical -JG	—	—
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	—	—	—
Surrounding Skin Assessment	—	Intact;Other(Comment) hematoma-soft -JG	—	—	—
Closure	—	UTA -JG	—	—	—
Drainage Amount	—	None -JG	—	—	—
Dressing	—	Barrier Film;Dry dressing;Gauze -JG	—	—	—
Dressing Assesment	—	Clean;Dry;Intact;Occlusive -JG	—	—	—
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	—	—	—
Surrounding Skin Assessment	—	Intact -JG	—	—	—
Closure	—	UTA -JG	—	—	—
Drainage Amount	—	None -JG	—	—	—
Dressing	—	Barrier Film;Dry dressing;Gauze -JG	—	—	—
Dressing Assesment	—	Dry;Clean;Intact;Occlusive;Transparent -JG	—	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	WDL -JG	—	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	4d Ordered bed rest -JG	—	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	WDL -JG	—	—	WDL -KW
Last BM Date	—	10/31/17 per patient -JG	—	—	—
Genitourinary					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	11/01/17 1245	11/01/17 1241	11/01/17 08:32:31	11/01/17 0718	11/01/17 0711
Genitourinary (WDL)	—	WDL -JG	—	—	—
Psychosocial					
Psychosocial (WDL)	—	WDL -JG	—	—	WDL -KW
Charting Type					
Charting Type	—	Admission -JG	—	—	Admission -KW
Cardiac					
Cardiac Rhythm	—	Normal sinus rhythm -JG	—	—	Sinus bradycardia -KW
Hendrich II Fall Risk Model (View Only)					
Confusion/Disorientation/Impulsivity (View Only)	—	0 -JG	—	—	—
Symptomatic Depression (View Only)	—	0 -JG	—	—	—
Altered Elimination (View Only)	—	0 -JG	—	—	—
Dizziness/Vertigo (View Only)	—	0 -JG	—	—	—
Gender (Male) View Only	—	1 -JG	—	—	—
Any Administered Benzodiazepines (View Only)	—	0 -JG	—	—	—
Hendrich II Total Score (Calculated) View Only	—	5 -JG	—	—	—
OTHER					
Any Administered Antiepileptics (Anticonvulsants) View Only	—	0 -JG	—	—	—

Row Name	11/01/17 0658	11/01/17 0657
tPA Time out		
Weight	—	95.7 kg (211 lb) -KW
Braden Scale		
Sensory Perceptions	4 -KW	—
Moisture	4 -KW	—
Activity	4 -KW	—
Mobility	4 -KW	—
Nutrition	4 -KW	—
Friction and Shear	3 -KW	—
Braden Scale Score	23 -KW	—

Flowsheets (all recorded)

CCP Vitals, Intake and Output

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 0732	11/02/17 07:25:45	11/02/17 03:53:02
Vitals					
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	—	—	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)
Temp src	—	—	—	Oral -RG	Oral -TA
Pulse	61 -DI (r) RG (t)	—	—	67 -DI (r) RG (t)	—
Heart Rate Source	—	—	—	Monitor -RG	—
Resp	16 -DI (r) RG (t)	—	—	18 -RG	17 -DI (r) TA (t)
Respiration Source	—	—	—	visual -RG	—
BP	159/73 -DI (r) RG (t)	—	—	139/71 -DI (r) RG (t)	—
BP Location	—	—	—	Right arm -RG	—
BP Method	—	—	—	Portable -RG	—
Patient Position	—	—	—	Supine -RG	—
SpO2	97 % -DI (r) RG (t)	—	—	95 % -DI (r) RG (t)	—
O2 Device	—	None (Room air) -JG	—	None (Room air) -RG	—
Weight	—	—	—	—	97.1 kg (214 lb 1.1 oz) -TA
Weight Method	—	—	—	—	Actual -TA
Output (mL)					
Urine	—	—	1450 mL -RG	—	1400 mL -TA
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				

Row Name	11/02/17 03:16:07	11/01/17 22:12:48	11/01/17 19:49:06	11/01/17 1845	11/01/17 1822
Vitals					
Temp	—	98.5 °F (36.9 °C) -DI (r) TA (t)	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—
Temp src	—	Oral -TA	Oral -TA	—	—
Pulse	68 -DI (r) NB (t)	69 -DI (r) TA (t)	65 -DI (r) TA (t)	—	—
Heart Rate Source	—	Monitor -TA	Monitor -TA	—	—
Resp	—	17 -DI (r) TA (t)	17 -DI (r) TA (t)	—	—
Respiration Source	—	visual -TA	visual -TA	—	—
BP	129/62 -DI (r) NB (t)	122/62 -DI (r) TA (t)	110/63 -DI (r) TA (t)	—	—
BP Location	—	Right arm -TA	Right arm -TA	—	—
BP Method	—	Portable -TA	Portable -TA	—	—
Patient Position	—	Supine -TA	Supine -TA	—	—
SpO2	94 % -DI (r) NB (t)	93 % -DI (r) TA (t)	94 % -DI (r) TA (t)	—	—
O2 Device	—	None (Room air) -TA	None (Room air) -TA	—	—
Weight	—	—	—	97.4 kg (214 lb 11.2 oz) -AG	—
Weight Method	—	—	—	Actual -AG	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG

Row Name	11/01/17 18:17:07	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 1747	11/01/17 1340
Vitals					
Temp	—	—	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—
Temp src	—	—	Oral -AG	—	—
Pulse	72 -DI (r) AG (t)	74 -DI (r) AG (t)	—	—	—
Resp	—	—	20 -DI (r) AG (t)	—	—
Respiration Source	—	—	visual -AG	—	—
BP	146/70 -DI (r) AG (t)	161/77 -DI (r) AG (t)	130/61 -DI (r) AG (t)	—	—

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	11/01/17 18:17:07	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 1747	11/01/17 1340
BP Location	Right arm -AG	Right arm -AG	Right arm -AG	—	—
BP Method	Portable -AG	Portable -AG	Portable -AG	—	—
Patient Position	Standing -AG	Sitting -AG	Supine -AG	—	—
O2 Device	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG	—	—
Output (mL)					
Urine	—	—	—	1000 mL -AG	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -JG

Row Name	11/01/17 1339	11/01/17 1253	11/01/17 12:45:07	11/01/17 1241	11/01/17 12:12:43
Vitals					
Temp	—	—	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—
Temp src	—	—	Oral -AG	—	—
Pulse	—	—	58 -DI (r) AG (t)	—	—
Heart Rate Source	—	—	Monitor -AG	—	—
Resp	—	—	16 -DI (r) AG (t)	—	—
Respiration Source	—	—	visual -AG	—	—
BP	—	—	156/88 -DI (r) AG (t)	—	—
BP Location	—	—	Right arm -AG	—	—
BP Method	—	—	Portable -AG	—	—
Patient Position	—	—	Supine -AG	—	—
SpO2	—	—	93 % -DI (r) AG (t)	—	—
O2 Device	—	—	None (Room air) -AG	None (Room air) -JG	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -KT
sodium chloride 0.9% (NS) infusion					
Rate	* There are multiple administrations at this time. Please see the MAR for detailed information. -JG	* There are multiple administrations at this time. Please see the MAR for detailed information. -JG	—	—	—

Row Name	11/01/17 0854	11/01/17 08:32:31	11/01/17 0741	11/01/17 0721	11/01/17 0718
Vitals					
Temp	—	—	—	—	97.8 °F (36.6 °C) -KW
Temp src	—	—	—	—	Oral -KW
Pulse	—	—	—	—	55 -KW
Heart Rate Source	—	—	—	—	Monitor -KW
Resp	—	—	—	—	16 -KW
BP	—	—	—	—	117/58 -KW
SpO2	—	—	—	—	94 % -KW
O2 Device	—	Nasal cannula -CC	—	—	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Collection Container	—	—	Standard drainage bag -KW	—	—
sodium chloride 0.9% (NS) bolus					
Bolus Dose	*0 mL/kg/hr -KT	—	—	*3 mL/kg/hr -KW	—

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	11/01/17 0854	11/01/17 08:32:31	11/01/17 0741	11/01/17 0721	11/01/17 0718
sodium chloride 0.9% (NS) infusion					
Rate	* There are multiple administrations at this time. Please see the MAR for detailed information. -KT	----	----	----	----

Row Name	11/01/17 0657
Vitals	
Height	67" (1.702 m) -KW
Weight	95.7 kg (211 lb) -KW
Weight Method	Stated -KW

Flowsheets (all recorded)

Screenings

Row Name	11/02/17 0900	11/01/17 1930	11/01/17 1241	11/01/17 0709	11/01/17 0702
Advance Directives (For Healthcare)					
Advance Directive	—	—	Patient does not have advance directive;Patient would not like information -JG	—	Patient does not have advance directive;Patient would not like information -KW
Healthcare Agent Appointed	—	—	No -JG	—	—
Pre-existing Allow Natural Death Order	—	—	No -JG	—	—
Information Provided on Healthcare Directives	—	—	No -JG	—	—
Patient Requests Assistance (Retired)	—	—	No -JG	—	—
Nutrition Screen Scoring (Retired)					
Weight Loss in the past 3 months (Retired)	—	—	1 -JG	—	—
BMI (Body Mass Index)-Retired	—	—	0 -JG	—	—
Appetite (Retired)	—	—	0 -JG	—	—
Ability to eat/retain food (Retired)	—	—	0 -JG	—	—
Stress factors (Retired)	—	—	1 -JG	—	—
Total Nutrition Screen Score (Retired)	—	—	2 -JG	—	—
ADL Screening					
Patient's Vision Adequate to Safely Complete Daily Activities	—	—	Yes -JG	—	—
Patient's Judgement Adequate to Safely Complete Daily Activities	—	—	Yes -JG	—	—
Patient's Memory Adequate to Safely Complete Daily Activities	—	—	Yes -JG	—	—
Patient Able to Express Needs/Desires	—	—	Yes -JG	—	—
Expression of Ideas and Wants	—	—	4 - Express complex messages without difficulty and with speech that is clear and easy to understand -JG	—	—
Which is your dominant hand?	—	—	Right -JG	—	—
Dressing	—	—	Independent -JG	—	—
Grooming	—	—	Independent -JG	—	—
Feeding	—	—	Independent -JG	—	—
Bathing	—	—	Independent -JG	—	—
Toileting	—	—	Independent -JG	—	—
In/Out Bed	—	—	Independent -JG	—	—
Walks in Home	—	—	Independent -JG	—	—
Weakness of Legs	—	—	None -JG	—	—
Weakness of Arms/Hands	—	—	None -JG	—	—
Hearing - Right Ear	—	—	Functional -JG	—	—
Hearing - Left Ear	—	—	Functional -JG	—	—
Assistive Devices					
Assistive Devices	—	—	Eyeglasses -JG	—	—
Therapy Consults (RETIRED)					
PT Evaluation Needed (RETIRED)	—	—	2 -JG	—	—
OT Evaluation	—	—	2 -JG	—	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	11/02/17 0900	11/01/17 1930	11/01/17 1241	11/01/17 0709	11/01/17 0702
Needed (RETIRED)					
SLP Evaluation Needed (RETIRED)	—	—	2 -JG	—	—
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	—	—	—	No -KW	—
Spiritual Preferences Affecting Hospitalization	—	—	—	No -KW	—
Nursing Referrals					
Spiritual Health Consult	—	—	No -JG	—	—
Social Services Consult	—	—	No -JG	—	—
Braden Scale					
Sensory Perceptions	4 -JG	4 -NB	4 -JG	—	—
Moisture	4 -JG	4 -NB	4 -JG	—	—
Activity	3 -JG	1 -NB	1 -JG	—	—
Mobility	4 -JG	4 -NB	4 -JG	—	—
Nutrition	3 -JG	3 -NB	3 -JG	—	—
Friction and Shear	3 -JG	3 -NB	3 -JG	—	—
Braden Scale Score	21 -JG	19 -NB	19 -JG	—	—
Discharge Planning					
Anticipated assistance needed at discharge	—	—	No -JG	—	—
Barriers to discharge	—	—	Line/Drain removal;prescriptions -JG	—	—
Discharge plan consult/Discharge referrals needed	—	—	none -JG	—	—
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	1 -JG	4d Ordered bed rest -NB	4d Ordered bed rest -JG	—	—
Abuse Assessment					
Safe in Home	—	—	Yes -JG	—	—
Do you feel threatened or unsafe in a relationship?	—	—	No -JG	—	—
Are you in immediate danger?	—	—	No -JG	—	—
Do you feel neglected?	—	—	No -JG	—	—
Physical harm?	—	—	No -JG	—	—
Verbal harm	—	—	No -JG	—	—

Row Name	11/01/17 0659	11/01/17 0658	11/01/17 0653	11/01/17 0652	10/10/17 0001
Advance Directives (For Healthcare)					
Have you reviewed your Advance Directive and is it valid for this stay?	—	—	—	Not applicable -KW	—
Advance Directive	—	—	—	Patient does not have advance directive;Patient would not like information -KW	—
Healthcare Agent's Name	—	—	—	wife-Shirley -KW	—
Healthcare Agent's Phone Number	—	—	—	678 910 2476 -KW	—
Pre-existing Allow Natural Death Order	—	—	—	No -KW	—
Information Provided on Healthcare Directives	—	—	—	No -KW	—
Patient Requests Assistance (Retired)	—	—	—	No -KW	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	11/01/17 0659	11/01/17 0658	11/01/17 0653	11/01/17 0652	10/10/17 0001
Patient Belongings at Bedside					
Belongings at Bedside	—	—	Eyeglasses wallet -KW	—	—
Belongings sent to security (Retired)	—	—	No -KW	—	—
(RETIRED)Belongings Sent Home	—	—	No -KW	—	—
Patient Medications					
Medications brought by patient?	—	—	No -KW	—	—
Suicide/Harm Risk					
Ever harm self (Retired)	No -KW	—	—	—	—
Current thoughts (Retired)	No -KW	—	—	—	—
Self harm plan (Retired)	No -KW	—	—	—	—
Patient information obtained from	Patient -KW	—	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -KW	—	—	—
Moisture	—	4 -KW	—	—	—
Activity	—	4 -KW	—	—	—
Mobility	—	4 -KW	—	—	—
Nutrition	—	4 -KW	—	—	—
Friction and Shear	—	3 -KW	—	—	—
Braden Scale Score	—	23 -KW	—	—	—
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 -KW	—	—	—
Discharge Planning					
Living Situation Prior to Admission					Home -KW
Primary Caregiver	—	—	—	—	Family (relationship) -KW
Anticipated assistance needed at discharge	—	—	—	—	No -KW

Flowsheets (all recorded)

Suicide Risk

Row Name	11/01/17 0659
Suicide/Harm Risk	
Ever harm self (Retired)	No -KW
Current thoughts (Retired)	No -KW
Self harm plan (Retired)	No -KW
Patient information obtained from	Patient -KW
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -KW

Flowsheets (all recorded)

Daily Cares/Safety

Row Name	11/02/17 1200	11/02/17 0900	11/02/17 0400	11/01/17 2000	11/01/17 1800
Safe Environment					
Arm Bands On	—	—	—	—	ID;Allergies -AG
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 -AG
Safety Alarm Verfied	—	—	—	—	Bed -AG
Side Rails/Bed Safety	—	—	—	—	3/4 -AG
Mobility					
Mobility Intervention	—	—	—	—	Bedrest -AG
Level of Assistance	—	—	—	—	Minimal assist, patient does 75% or more -AG
Active Range of Motion	—	—	—	—	Active;All extremities -AG
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	—	—	HOB less than 20 -AG
Repositioned	—	—	—	—	Semi Fowler's -AG
Anti-Embolism Devices					
Anti-Embolism Devices	Off -JG	—	—	Off -NB	—
Hygiene					
Foley Care/ Peri Care	—	—	Completed -TA	—	—
Performed by	—	—	Nursing Staff -TA	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	No -JG	—	No -NB	—
IS Tx Not Given	—	—	—	Not Indicated -NB	—
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Visiting -AG
Telemetry Details					
Telemetry Monitor On	—	Yes -JG	—	—	Yes -AG
Telemetry Audible	—	Yes -JG	—	—	Yes -AG
Telemetry Box Number	—	5799 -JG	—	—	5799 -AG
Telemetry Alarms Set	—	Yes -JG	—	—	Yes -AG

Row Name	11/01/17 1600	11/01/17 1400	11/01/17 1241
Safe Environment			
Arm Bands On	ID;Allergies -AG	ID;Allergies -AG	—
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 -AG	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -AG	—
Safety Alarm Verfied	Bed -AG	Bed -AG	—
Side Rails/Bed Safety	3/4 -AG	3/4 -AG	—
Mobility			
Mobility Intervention	Bedrest -AG	Bedrest -AG	—
Level of Assistance	Minimal assist, patient does 75% or more -AG	Minimal assist, patient does 75% or more -AG	—
Active Range of Motion	Active;All extremities -AG	Active;All extremities -AG	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	HOB less than 20 -AG	HOB less than 20 -AG	—
Repositioned	Supine -AG	Supine -AG	—
Anti-Embolism Devices			
Anti-Embolism	—	—	Off -JG

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	11/01/17 1600	11/01/17 1400	11/01/17 1241
Devices			
Incentive Spirometer			
Is pt using incentive spirometer?	—	—	No -JG
Family/Significant Other Communication			
Family/Significant Other Update	Visiting -AG	Visiting -AG	Visiting -AG
Telemetry Details			
Telemetry Monitor On	Yes -AG	—	Yes -JG
Telemetry Audible	Yes -AG	—	Yes -JG
Telemetry Box Number	5799 -AG	—	5799 -JG
Telemetry Alarms Set	Yes -AG	—	Yes -JG

Flowsheets (all recorded)

Discharge Planning

Flowsheets (all recorded)

Vital Signs

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07
Vital Signs					
Automatic Restart Vitals Timer	Yes -DI (r) RG (t)	—	Yes -RG	—	—
Pulse	61 -DI (r) RG (t)	—	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)
Heart Rate Source	—	—	Monitor -RG	—	—
Resp	16 -DI (r) RG (t)	—	18 -RG	17 -DI (r) TA (t)	—
Respiration Source	—	—	visual -RG	—	—
BP	159/73 -DI (r) RG (t)	—	139/71 -DI (r) RG (t)	—	129/62 -DI (r) NB (t)
BP Location	—	—	Right arm -RG	—	—
BP Method	—	—	Portable -RG	—	—
Patient Position	—	—	Supine -RG	—	—
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	—	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)	—
Temp src	—	—	Oral -RG	Oral -TA	—
Oxygen Therapy					
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	—

Row Name	11/01/17 22:12:48	11/01/17 19:49:06	11/01/17 18:17:07	11/01/17 18:15:27	11/01/17 18:11:44
Vital Signs					
Automatic Restart Vitals Timer	Yes -DI (r) TA (t)	Yes -DI (r) TA (t)	—	—	—
Pulse	69 -DI (r) TA (t)	65 -DI (r) TA (t)	72 -DI (r) AG (t)	74 -DI (r) AG (t)	—
Heart Rate Source	Monitor -TA	Monitor -TA	—	—	—
Resp	17 -DI (r) TA (t)	17 -DI (r) TA (t)	—	—	20 -DI (r) AG (t)
Respiration Source	visual -TA	visual -TA	—	—	visual -AG
BP	122/62 -DI (r) TA (t)	110/63 -DI (r) TA (t)	146/70 -DI (r) AG (t)	161/77 -DI (r) AG (t)	130/61 -DI (r) AG (t)
BP Location	Right arm -TA	Right arm -TA	Right arm -AG	Right arm -AG	Right arm -AG
BP Method	Portable -TA	Portable -TA	Portable -AG	Portable -AG	Portable -AG
Patient Position	Supine -TA	Supine -TA	Standing -AG	Sitting -AG	Supine -AG
Temp	98.5 °F (36.9 °C) -DI (r) TA (t)	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—	98.1 °F (36.7 °C) -DI (r) AG (t)
Temp src	Oral -TA	Oral -TA	—	—	Oral -AG
Oxygen Therapy					
SpO2	93 % -DI (r) TA (t)	94 % -DI (r) TA (t)	—	—	—
O2 Device	None (Room air) -TA	None (Room air) -TA	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG

Row Name	11/01/17 12:45:07	11/01/17 1241	11/01/17 08:32:31	11/01/17 0718
Vital Signs				
Automatic Restart Vitals Timer	Yes -DI (r) AG (t)	—	—	Yes -KW
Pulse	58 -DI (r) AG (t)	—	—	55 -KW
Heart Rate Source	Monitor -AG	—	—	Monitor -KW
Resp	16 -DI (r) AG (t)	—	—	16 -KW
Respiration Source	visual -AG	—	—	—
BP	156/88 -DI (r) AG (t)	—	—	117/58 -KW
BP Location	Right arm -AG	—	—	—
BP Method	Portable -AG	—	—	—
Patient Position	Supine -AG	—	—	—
Temp	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—	97.8 °F (36.6 °C) -KW
Temp src	Oral -AG	—	—	Oral -KW
Oxygen Therapy				
SpO2	93 % -DI (r) AG (t)	—	—	94 % -KW
O2 Device	None (Room air) -AG	None (Room air) -JG	Nasal cannula -CC	—
O2 Flow Rate (L/min)	—	—	3 L/min -CC	—

Flowsheets (all recorded)

PA RIsk Score

Row Name	11/02/17 1201	11/02/17 0001	11/01/17 1201
Readmission Risk Score			
Readmission	9 -UE	9 -UE	9 -UE

Flowsheets (all recorded)

O2 Therapy

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 03:16:07	11/01/17 22:12:48
Oxygen Therapy					
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	None (Room air) -TA
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	94 % -DI (r) NB (t)	93 % -DI (r) TA (t)
Row Name	**11/01/17 19:49:06**	**11/01/17 18:17:07**	**11/01/17 18:15:27**	**11/01/17 18:11:44**	**11/01/17 12:45:07**
Oxygen Therapy					
O2 Device	None (Room air) -TA	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG
SpO2	94 % -DI (r) TA (t)	—	—	—	93 % -DI (r) AG (t)
Row Name	**11/01/17 1241**	**11/01/17 08:32:31**	**11/01/17 0718**		
Oxygen Therapy					
O2 Delivery	—	Oxygen -CC	—		
O2 Device	None (Room air) -JG	Nasal cannula -CC	—		
O2 Flow Rate (L/min)	—	3 L/min -CC	—		
SpO2	—	—	94 % -KW		

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	11/01/17 2000	11/01/17 1200	11/01/17 0741	11/01/17 0721	11/01/17 0659
[REMOVED] Arterial Sheath 6 Fr. Right Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: No complications;Catheter intact -KT				
[REMOVED] Arterial Sheath 8 Fr. Left Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, gofball size				
[REMOVED] Peripheral IV 11/01/17 20 G Left;Lateral Forearm					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0700 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left;Lateral -KW Location: Forearm -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 1 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Site Assessment	Asymptomatic -NB	Asymptomatic -JG	—	—	Asymptomatic -KW
Phlebitis Scale	0 -NB	0 -JG	—	—	0 -KW
Infiltration/Extravasation Scale	0 -NB	0 -JG	—	—	0 -KW
Line Assessment	Saline locked -NB	Saline locked -JG	—	—	Blood return noted -KW
Dressing Assesment	Clean;Dry;Intact -NB	Clean;Dry;Intact;Occlusive;Transparent -JG	—	—	Clean;Dry;Intact;Occlusive;Transparent -KW
IV Interventions	Flushed -NB	—	—	—	Flushed -KW
[REMOVED] Peripheral IV 11/01/17 20 G Left Wrist					
IV Properties	Placement Date: 11/01/17 -KW Placement Time: 0710 -KW Present on arrival to hospital?: No -KW Type of Catheter: Straight -KW Size (Gauge): 20 G -KW Orientation: Left -KW Location: Wrist -KW Site Prep: Chlorhexidine -KW Local Anesthetic: None -KW Inserted by: A. Nebel, RN -KW Insertion attempts: 2 -KW Successful IV Attempt?: Yes -KW Patient Tolerance: Tolerated well -KW Removal Date: 01/16/18 -MW Removal Time: 2220 -MW				
Site Assessment	Asymptomatic -NB	Asymptomatic -JG	—	Asymptomatic -KW	—
Phlebitis Scale	0 -NB	0 -JG	—	0 -KW	—
Infiltration/Extravasation Scale	0 -NB	0 -JG	—	0 -KW	—
Line Assessment	Patent;Infusing -NB	Patent;Infusing -JG	—	Blood return noted -KW	—
Dressing Assesment	Clean;Dry;Intact -NB	Clean;Dry;Intact;Occlusive;Transparent -JG	—	Clean;Dry;Intact;Occlusive;Transparent -KW	—
IV Interventions	Flushed -NB	—	—	Flushed -KW	—
[REMOVED] External Urinary Catheter					
External Urinary Catheter Properties	Placement Date: 11/01/17 -KW Placement Time: 0735 -KW Inserted by: patient -KW External Urinary Catheter Sizes: Small -KW Removal Date: 01/16/18 -MW Removal Time: 2219 -MW				
Collection Container	—	—	Standard drainage bag -KW	—	—

Flowsheets (all recorded)

VTE Screening

Row Name	11/01/17 1248
Score 1 for each factor (RETIRED)	
(RETIRED) History of prior major surgery (within past 1 month)	0 -JG
(RETIRED) Pregnancy or postpartum (less than 1 month)	0 -JG
(RETIRED) Varicose Veins	0 -JG
(RETIRED) Age 41 to 59 years	0 -JG
(RETIRED) Inflammatory Bowel Disease	0 -JG
(RETIRED) Obesity (BMI 30 to 40)	1 -JG
(RETIRED) Oral Contraceptives	0 -JG
(RETIRED) Hormone Therapy	0 -JG
(RETIRED) Abnormal Pulmonary Function, COPD or Pneumonia (less than 1 month)	0 -JG
(RETIRED) Medical Patient (on bedrest)	0 -JG
(RETIRED) MI (less than 1 month)	0 -JG
(RETIRED) CHF (less than 1 month)	0 -JG
(RETIRED) Sepsis (less than 1 month)	0 -JG
(RETIRED) Swollen Legs (current)	0 -JG
(RETIRED) Total Score	1 -JG
(RETIRED) Score 2 for each factor	
(RETIRED) Major surgery (greater than 60 minutes, current admission)	0 -JG
(RETIRED) Laproscopic surgery (greater than 60 minutes)	0 -JG
(RETIRED) Arthroscopic surgery (greater than 60 minutes)	0 -JG
(RETIRED) Age 60 - 74 years	2 -JG
(RETIRED) Morbid Obesity (BMI greater than 40 to 50)	0 -JG
(RETIRED) Immobilizing cast or splint	0 -JG
(RETIRED) Central venous catheter	0 -JG
(RETIRED) Malignancy (previous)	0 -JG
(RETIRED) Total Score	2 -JG
(RETIRED) Score 3 for each factor	
(RETIRED) History of SVT, DVT/PE	0 -JG
(RETIRED) Family History of DVT/PE	0 -JG
(RETIRED) Age 75	0 -JG

Flowsheets (all recorded) (continued)

VTE Screening (continued)

Row Name	11/01/17 1248
years and over	
(RETIRED) Prior Major Surgery	0 -JG
(RETIRED) BMI > 50	0 -JG
(RETIRED) Venous stasis syndrome	0 -JG
(RETIRED) Hypercoagulable states	0 -JG
(RETIRED) Total Score	0 -JG
(RETIRED) Score 5 for each factor	
(RETIRED) Major surgery (greater than 3 hours)	0 -JG
(RETIRED) Elective Major Lower Extremity Arthroplasty	0 -JG
(RETIRED) Hip, pelvis, or leg fracture (less than 1 month)	0 -JG
(RETIRED) Stroke (less than 1 month)	0 -JG
(RETIRED) Major trauma (less than 1 month)	0 -JG
(RETIRED) Acute Spinal Cord Injury (less than 1 month)	0 -JG
(RETIRED) Paralysis (less than 1 month)	0 -JG
(RETIRED) Mechanical ventilation	0 -JG
(RETIRED) Total Score	0 -JG
Total Risk Factor Score	
VTE Total Risk Factor Score	3 -JG
VTE Low Risk Attribute	No -JG
VTE Prophylaxis Meets Requirements	
Is Recommended VTE Prophylaxis ordered?	Yes -JG

Flowsheets (all recorded)

Anthropometrics

Row Name	11/02/17 03:53:02	11/01/17 1845	11/01/17 0657
Anthropometrics			
Height	—	—	67" (1.702 m) -KW
Weight	97.1 kg (214 lb 1.1 oz) -TA	97.4 kg (214 lb 11.2 oz) -AG	95.7 kg (211 lb) -KW
Weight Method	Actual -TA	Actual -AG	Stated -KW
Weight Change	-0.29 -TA	1.75 -AG	0 -KW
BMI (Calculated)	—	—	33 -KW

Flowsheets (all recorded)

Severe Sepsis Screen

Row Name	11/02/17 1200	11/01/17 2000	11/01/17 1200
Severe Sepsis Screening Tool			
Current Sepsis Treatment AND On IV Pressors?	No- Continue Screening -JG	No- Continue Screening -NB	No- Continue Screening -JG
Infection			
Suspected / Documented Infection?	No- Screen for antibiotic therapy -JG	No- Screen for antibiotic therapy -NB	No- Screen for antibiotic therapy -JG
Antibiotic Therapy (Non-Prophylactic)	No- Stop screen if no to BOTH suspected infection and antibiotic -JG	No- Stop screen if no to BOTH suspected infection and antibiotic -NB	No- Stop screen if no to BOTH suspected infection and antibiotic -JG

Flowsheets (all recorded)

Vitals/Pain

Row Name	11/02/17 11:32:20	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07	11/01/17 22:12:48
OTHER					
Patient Position	—	Supine -RG	—	—	Supine -TA
Weight Method	—	—	Actual -TA	—	—
Vitals					
BP	159/73 -DI (r) RG (t)	139/71 -DI (r) RG (t)	—	129/62 -DI (r) NB (t)	122/62 -DI (r) TA (t)
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)	—	98.5 °F (36.9 °C) -DI (r) TA (t)
Temp src	—	Oral -RG	Oral -TA	—	Oral -TA
Pulse	61 -DI (r) RG (t)	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)	69 -DI (r) TA (t)
Resp	16 -DI (r) RG (t)	18 -RG	17 -DI (r) TA (t)	—	17 -DI (r) TA (t)
SpO2	97 % -DI (r) RG (t)	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)	93 % -DI (r) TA (t)
Weight	—	—	97.1 kg (214 lb 1.1 oz) -TA	—	—
Vital Signs					
Heart Rate Source	—	Monitor -RG	—	—	Monitor -TA
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -JG	—	—	—	—

Row Name	11/01/17 19:49:06	11/01/17 1930	11/01/17 1845	11/01/17 18:17:07	11/01/17 18:15:27
OTHER					
Patient Position	Supine -TA	—	—	Standing -AG	Sitting -AG
Weight Method	—	—	Actual -AG	—	—
Vitals					
BP	110/63 -DI (r) TA (t)	—	—	146/70 -DI (r) AG (t)	161/77 -DI (r) AG (t)
Temp	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—	—	—
Temp src	Oral -TA	—	—	—	—
Pulse	65 -DI (r) TA (t)	—	—	72 -DI (r) AG (t)	74 -DI (r) AG (t)
Resp	17 -DI (r) TA (t)	—	—	—	—
SpO2	94 % -DI (r) TA (t)	—	—	—	—
Weight	—	—	97.4 kg (214 lb 11.2 oz) -AG	—	—
Vital Signs					
Heart Rate Source	Monitor -TA	—	—	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -NB	—	—	—

Row Name	11/01/17 18:11:44	11/01/17 12:45:07	11/01/17 0718	11/01/17 0658	11/01/17 0657
OTHER					
Patient Position	Supine -AG	Supine -AG	—	—	—
Height Method	—	—	—	—	Stated -KW
Weight Method	—	—	—	—	Stated -KW
BMI (Calculated)	—	—	—	—	33 -KW
BSA (Calculated - sq m)	—	—	—	—	2.12 sq meters -KW
Pain Assessment	—	—	—	0-10 -KW	—
Vitals					
BP	130/61 -DI (r) AG (t)	156/88 -DI (r) AG (t)	117/58 -KW	—	—
Temp	98.1 °F (36.7 °C) -DI (r) AG (t)	98.1 °F (36.7 °C) -DI (r) AG (t)	97.8 °F (36.6 °C) -KW	—	—
Temp src	Oral -AG	Oral -AG	Oral -KW	—	—
Pulse	—	58 -DI (r) AG (t)	55 -KW	—	—
Resp	20 -DI (r) AG (t)	16 -DI (r) AG (t)	16 -KW	—	—
SpO2	—	93 % -DI (r) AG (t)	94 % -KW	—	—
Height	—	—	—	—	67" (1.702 m) -KW
Weight	—	—	—	—	95.7 kg (211 lb) -KW
Vital Signs					
Heart Rate Source	—	Monitor -AG	Monitor -KW	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	0 -KW	—

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Flowsheets (all recorded)

PATT Complete

Row Name	10/31/17 1038
PATT Complete	
PATT Complete	Yes -HS

Flowsheets (all recorded)

Fall Risk

Row Name	11/01/17 0658
Fall Assessment	
Fall Risk	No -KW
Fall Band Applied	No -KW
Yellow socks	No -KW

Flowsheets (all recorded)

Pre-op Checklist

Row Name	11/01/17 1241	11/01/17 0800	11/01/17 0702	11/01/17 0652
Patient Verification				
History and Physical Completed	—	Yes -GM	No update -KW	—
Consents Confirmed	—	Operative;Informed;Blood products -GM	—	—
Advance Directive	Patient does not have advance directive;Patient would not like information -JG	—	Patient does not have advance directive;Patient would not like information -KW	Patient does not have advance directive;Patient would not like information -KW
Patient ID and Procedure Verified	—	Yes -GM	Yes -KW	—
Correct Procedure	—	Yes -GM	Yes -KW	—
Documents Match	—	Yes -GM	—	—
Pacemaker	—	—	No -KW	—
Patient has an ICD?	—	—	No -KW	—
Pre-op Lab/Test Results Available	—	—	In chart -KW	—
Preg Test	—	—	n/a -KW	—
Blood Glucose Meter (mg/dl)	—	—	139 -KW	—
BBG Not Applicable?	—	—	— -KW	—
Prep Verification				
Allergy Band Applied	—	—	Yes -KW	—
Snap Gown Applied	—	—	Yes -KW	—
Anti-embolism	—	—	n/a -KW	—
Pre-op Antibiotic Ordered?	—	—	n/a -KW	—
Beta Blocker Therapy Last Dose Date	—	—	11/01/17 coreg -KW	—
Beta Blocker Last Dose Time	—	—	0515 -KW	—
Anticoagulent Therapy Last Dose Date	—	—	10/31/17 eliquis 10/29/17, aspirin 10/31/17 -KW	—
Anticoagulant Last Dose Time	—	—	0730 -KW	—
VTE Assessment Complete?	—	—	n/a -KW	—
Date of last liquid	—	—	10/31/17 -KW	—
Time of last liquid	—	—	2230 -KW	—
Date of last solid	—	—	10/31/17 -KW	—
Time of last solid	—	—	2200 -KW	—
Void Prior to Procedure	—	—	Yes -KW	—
Void Prior to Procedure Time	—	—	0630 -KW	—
Enema Given	—	—	Not applicable -KW	—
Remove all that apply:	—	—	Underwear -KW	—
Disposition of belongings:	—	—	To family/significant other -KW	—
Required items available	—	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -GM	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -KW	—
Transport To	—	—	Procedure Area -KW	—
Mode of Transport	—	—	Stretcher -KW	—
Transport By	—	—	Tech -KW	—
Released by (Floor RN or Pre-op RN)	—	—	K. Wilson, RN -KW	—
Metal Implant Present?	—	—	Yes -KW	—
Type of Implant (if known)	—	—	coronary stent, sternal wires -KW	—
Pre-op Checklist Completion				
Checklist Completed/Verified?	—	Yes -GM	—	—

Flowsheets (all recorded) (continued)

Pre-op Checklist (continued)

Row Name	11/01/17 1241	11/01/17 0800	11/01/17 0702	11/01/17 0652
Location completed at:	—	Other (please comment) -GM	—	—

Flowsheets (all recorded)

CARDNT HEMODYNAMIC

Row Name	11/02/17 11:32:20	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07	11/01/17 22:12:48
Vitals					
SpO2	97 % -DI (r) RG (t)	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)	93 % -DI (r) TA (t)
Pulse	61 -DI (r) RG (t)	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)	69 -DI (r) TA (t)
Resp	16 -DI (r) RG (t)	18 -RG	17 -DI (r) TA (t)	—	17 -DI (r) TA (t)
Row Name	**11/01/17 19:49:06**	**11/01/17 18:17:07**	**11/01/17 18:15:27**	**11/01/17 18:11:44**	**11/01/17 12:45:07**
Vitals					
SpO2	94 % -DI (r) TA (t)	—	—	—	93 % -DI (r) AG (t)
Pulse	65 -DI (r) TA (t)	72 -DI (r) AG (t)	74 -DI (r) AG (t)	—	58 -DI (r) AG (t)
Resp	17 -DI (r) TA (t)	—	—	20 -DI (r) AG (t)	16 -DI (r) AG (t)
Row Name	**11/01/17 12:25:24**	**11/01/17 12:20:23**	**11/01/17 12:15:41**	**11/01/17 12:10:37**	**11/01/17 12:05:52**
Vitals					
SpO2	—	95 % -VI	96 % -VI	96 % -VI	97 % -VI
Heart Rate	72 bpm -VI	55 bpm -VI	54 bpm -VI	56 bpm -VI	56 bpm -VI
Systolic Pressure	—	—	140 mmHg -VI	116 mmHg -VI	125 mmHg -VI
Diastolic Pressure	—	—	72 mmHg -VI	68 mmHg -VI	70 mmHg -VI
Mean Pressure	—	—	92 mmHg -VI	102 mmHg -VI	92 mmHg -VI
Respiration Rate	—	16 breaths/min -VI	26 breaths/min -VI	33 breaths/min -VI	32 breaths/min -VI
Row Name	**11/01/17 12:00:20**	**11/01/17 11:55:42**	**11/01/17 11:50:42**	**11/01/17 11:45:40**	**11/01/17 11:40:35**
Vitals					
SpO2	99 % -VI	97 % -VI	97 % -VI	98 % -VI	97 % -VI
Heart Rate	53 bpm -VI	55 bpm -VI	65 bpm -VI	56 bpm -VI	59 bpm -VI
Systolic Pressure	131 mmHg -VI	133 mmHg -VI	138 mmHg -VI	113 mmHg -VI	98 mmHg -VI
Diastolic Pressure	81 mmHg -VI	64 mmHg -VI	61 mmHg -VI	47 mmHg -VI	44 mmHg -VI
Mean Pressure	108 mmHg -VI	87 mmHg -VI	83 mmHg -VI	70 mmHg -VI	67 mmHg -VI
Respiration Rate	17 breaths/min -VI	19 breaths/min -VI	27 breaths/min -VI	16 breaths/min -VI	12 breaths/min -VI
Row Name	**11/01/17 11:35:39**	**11/01/17 11:30:49**	**11/01/17 11:30:14**	**11/01/17 11:25:39**	**11/01/17 11:20:42**
Vitals					
SpO2	95 % -VI	96 % -VI	—	96 % -VI	99 % -VI
Heart Rate	55 bpm -VI	56 bpm -VI	—	57 bpm -VI	59 bpm -VI
Systolic Pressure	103 mmHg -VI	102 mmHg -VI	—	132 mmHg -VI	140 mmHg -VI
Diastolic Pressure	43 mmHg -VI	44 mmHg -VI	—	62 mmHg -VI	55 mmHg -VI
Mean Pressure	60 mmHg -VI	65 mmHg -VI	—	86 mmHg -VI	83 mmHg -VI
Respiration Rate	21 breaths/min -VI	16 breaths/min -VI	—	22 breaths/min -VI	26 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	109 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	52 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	75 mmHg -VI	—	—
AO Heart Rate	—	—	56 bpm -VI	—	—
Row Name	**11/01/17 11:19:12**	**11/01/17 11:15:37**	**11/01/17 11:10:32**	**11/01/17 11:05:30**	**11/01/17 11:00:34**
Vitals					
SpO2	—	98 % -VI	98 % -VI	98 % -VI	100 % -VI
Heart Rate	—	58 bpm -VI	58 bpm -VI	58 bpm -VI	60 bpm -VI
Systolic Pressure	—	152 mmHg -VI	160 mmHg -VI	157 mmHg -VI	138 mmHg -VI
Diastolic Pressure	—	71 mmHg -VI	75 mmHg -VI	72 mmHg -VI	68 mmHg -VI
Mean Pressure	—	113 mmHg -VI	121 mmHg -VI	99 mmHg -VI	113 mmHg -VI
Respiration Rate	—	22 breaths/min -VI	22 breaths/min -VI	22 breaths/min -VI	20 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	152 mmHg -VI	—	—	—	—
AO Diastolic Cath Pressure	71 mmHg -VI	—	—	—	—
AO Mean Cath Pressure	101 mmHg -VI	—	—	—	—
AO Heart Rate	58 bpm -VI	—	—	—	—
Row Name	**11/01/17 1056**	**11/01/17 10:55:31**	**11/01/17 10:50:32**	**11/01/17 10:47:44**	**11/01/17 10:45:38**
Vitals					
SpO2	—	98 % -VI	99 % -VI	—	98 % -VI
Heart Rate	—	57 bpm -VI	57 bpm -VI	—	56 bpm -VI
Systolic Pressure	—	140 mmHg -VI	137 mmHg -VI	—	140 mmHg -VI

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	11/01/17 1056	11/01/17 10:55:31	11/01/17 10:50:32	11/01/17 10:47:44	11/01/17 10:45:38
Diastolic Pressure	—	65 mmHg -VI	70 mmHg -VI	—	63 mmHg -VI
Mean Pressure	—	93 mmHg -VI	104 mmHg -VI	—	84 mmHg -VI
Respiration Rate	—	16 breaths/min -VI	19 breaths/min -VI	—	18 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	139 mmHg -VI	—	—	128 mmHg -VI	—
AO Diastolic Cath Pressure	62 mmHg -VI	—	—	58 mmHg -VI	—
AO Mean Cath Pressure	91 mmHg -VI	—	—	83 mmHg -VI	—
AO Heart Rate	57 bpm -VI	—	—	58 bpm -VI	—

Row Name	11/01/17 10:40:33	11/01/17 10:35:25	11/01/17 10:30:32	11/01/17 10:29:06	11/01/17 10:25:27
Vitals					
SpO2	99 % -VI	99 % -VI	98 % -VI	—	98 % -VI
Heart Rate	57 bpm -VI	56 bpm -VI	54 bpm -VI	—	54 bpm -VI
Systolic Pressure	136 mmHg -VI	132 mmHg -VI	126 mmHg -VI	—	126 mmHg -VI
Diastolic Pressure	65 mmHg -VI	65 mmHg -VI	60 mmHg -VI	—	61 mmHg -VI
Mean Pressure	87 mmHg -VI	105 mmHg -VI	91 mmHg -VI	—	85 mmHg -VI
Respiration Rate	16 breaths/min -VI	14 breaths/min -VI	18 breaths/min -VI	—	16 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	—	129 mmHg -VI	—
AO Diastolic Cath Pressure	—	—	—	59 mmHg -VI	—
AO Mean Cath Pressure	—	—	—	83 mmHg -VI	—
AO Heart Rate	—	—	—	57 bpm -VI	—

Row Name	11/01/17 10:20:30	11/01/17 10:15:32	11/01/17 10:13:56	11/01/17 10:10:33	11/01/17 10:05:35
Vitals					
SpO2	97 % -VI	97 % -VI	—	96 % -VI	97 % -VI
Heart Rate	54 bpm -VI	54 bpm -VI	—	55 bpm -VI	54 bpm -VI
Systolic Pressure	115 mmHg -VI	110 mmHg -VI	—	116 mmHg -VI	132 mmHg -VI
Diastolic Pressure	58 mmHg -VI	59 mmHg -VI	—	62 mmHg -VI	63 mmHg -VI
Mean Pressure	72 mmHg -VI	85 mmHg -VI	—	84 mmHg -VI	95 mmHg -VI
Respiration Rate	20 breaths/min -VI	24 breaths/min -VI	—	16 breaths/min -VI	21 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	110 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	51 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	72 mmHg -VI	—	—
AO Heart Rate	—	—	56 bpm -VI	—	—

Row Name	11/01/17 10:00:25	11/01/17 09:55:27	11/01/17 09:53:12	11/01/17 09:50:26	11/01/17 09:45:32
Vitals					
SpO2	98 % -VI	98 % -VI	—	98 % -VI	98 % -VI
Heart Rate	56 bpm -VI	54 bpm -VI	—	54 bpm -VI	57 bpm -VI
Systolic Pressure	141 mmHg -VI	120 mmHg -VI	—	118 mmHg -VI	116 mmHg -VI
Diastolic Pressure	67 mmHg -VI	62 mmHg -VI	—	60 mmHg -VI	55 mmHg -VI
Mean Pressure	88 mmHg -VI	79 mmHg -VI	—	85 mmHg -VI	82 mmHg -VI
Respiration Rate	16 breaths/min -VI	25 breaths/min -VI	—	21 breaths/min -VI	25 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	—	116 mmHg -VI	—	—
AO Diastolic Cath Pressure	—	—	53 mmHg -VI	—	—
AO Mean Cath Pressure	—	—	76 mmHg -VI	—	—
AO Heart Rate	—	—	53 bpm -VI	—	—

Row Name	11/01/17 09:40:27	11/01/17 09:36:44	11/01/17 09:35:22	11/01/17 09:30:23	11/01/17 09:25:22
Vitals					
SpO2	98 % -VI	—	98 % -VI	97 % -VI	97 % -VI
Heart Rate	53 bpm -VI	—	53 bpm -VI	54 bpm -VI	54 bpm -VI

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	11/01/17 09:40:27	11/01/17 09:36:44	11/01/17 09:35:22	11/01/17 09:30:23	11/01/17 09:25:22
Systolic Pressure	113 mmHg -VI	—	110 mmHg -VI	108 mmHg -VI	100 mmHg -VI
Diastolic Pressure	56 mmHg -VI	—	55 mmHg -VI	51 mmHg -VI	48 mmHg -VI
Mean Pressure	71 mmHg -VI	—	70 mmHg -VI	73 mmHg -VI	59 mmHg -VI
Respiration Rate	16 breaths/min -VI	—	23 breaths/min -VI	21 breaths/min -VI	17 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	—	113 mmHg -VI	—	—	—
AO Diastolic Cath Pressure	—	53 mmHg -VI	—	—	—
AO Mean Cath Pressure	—	75 mmHg -VI	—	—	—
AO Heart Rate	—	54 bpm -VI	—	—	—

Row Name	11/01/17 09:23:32	11/01/17 09:20:20	11/01/17 09:15:22	11/01/17 09:15:04	11/01/17 09:10:20
Vitals					
SpO2	—	96 % -VI	96 % -VI	—	96 % -VI
Heart Rate	—	56 bpm -VI	55 bpm -VI	—	54 bpm -VI
Systolic Pressure	—	94 mmHg -VI	87 mmHg -VI	—	91 mmHg -VI
Diastolic Pressure	—	47 mmHg -VI	46 mmHg -VI	—	46 mmHg -VI
Mean Pressure	—	67 mmHg -VI	59 mmHg -VI	—	60 mmHg -VI
Respiration Rate	—	18 breaths/min -VI	14 breaths/min -VI	—	15 breaths/min -VI
Pressure Summary					
AO Systolic Cath Pressure	90 mmHg -VI	—	—	95 mmHg -VI	—
AO Diastolic Cath Pressure	44 mmHg -VI	—	—	45 mmHg -VI	—
AO Mean Cath Pressure	60 mmHg -VI	—	—	63 mmHg -VI	—
AO Heart Rate	48 bpm -VI	—	—	55 bpm -VI	—

Row Name	11/01/17 09:07:56	11/01/17 09:07:51	11/01/17 09:07:46	11/01/17 09:05:26	11/01/17 09:00:26
Vitals					
SpO2	—	—	—	95 % -VI	95 % -VI
Heart Rate	—	—	—	56 bpm -VI	57 bpm -VI
Systolic Pressure	—	—	—	79 mmHg -VI	92 mmHg -VI
Diastolic Pressure	—	—	—	47 mmHg -VI	49 mmHg -VI
Mean Pressure	—	—	—	69 mmHg -VI	62 mmHg -VI
Respiration Rate	—	—	—	20 breaths/min -VI	17 breaths/min -VI
Pressure Summary					
LV Systolic Cath Pressure	—	32767 mmHg -VI	93 mmHg -VI	—	—
LV Diastolic Cath Pressure	—	32767 mmHg -VI	7 mmHg -VI	—	—
LV Heart Rate	—	0 bpm -VI	59 bpm -VI	—	—
AO Systolic Cath Pressure	86 mmHg -VI	—	—	—	—
AO Diastolic Cath Pressure	41 mmHg -VI	—	—	—	—
AO Mean Cath Pressure	56 mmHg -VI	—	—	—	—
AO Heart Rate	56 bpm -VI	—	—	—	—
LV End Diastolic	—	32767 mmHg -VI	17 mmHg -VI	—	—

Row Name	11/01/17 08:55:21	11/01/17 08:50:36	11/01/17 08:45:21	11/01/17 08:40:27	11/01/17 08:35:19
Vitals					
SpO2	95 % -VI	94 % -VI	100 % -VI	100 % -VI	100 % -VI
Heart Rate	55 bpm -VI	54 bpm -VI	55 bpm -VI	53 bpm -VI	55 bpm -VI
Systolic Pressure	93 mmHg -VI	96 mmHg -VI	138 mmHg -VI	135 mmHg -VI	141 mmHg -VI
Diastolic Pressure	48 mmHg -VI	56 mmHg -VI	65 mmHg -VI	70 mmHg -VI	65 mmHg -VI
Mean Pressure	63 mmHg -VI	73 mmHg -VI	85 mmHg -VI	94 mmHg -VI	88 mmHg -VI
Respiration Rate	16 breaths/min -VI	17 breaths/min -VI	15 breaths/min -VI	15 breaths/min -VI	16 breaths/min -VI

Row Name	11/01/17 08:34:19	11/01/17 0718
Vitals		
SpO2	—	94 % -KW
Pulse	—	55 -KW
Resp	—	16 -KW

Flowsheets (all recorded) (continued)

CARDNT HEMODYNAMIC (continued)

Row Name	11/01/17 08:34:19	11/01/17 0718
AO Pressures		
AO Systolic	109 mmHg -VI	—
AO Diastolic	52 mmHg -VI	—
AO Mean	75 mmHg -VI	—
AO Heart Rate	56 bpm -VI	—
Data Collected		
Hemodynamic Phase	Phase: Baseline -VI	—

Flowsheets (all recorded)

Cath Lab Pain Assessment

Row Name	11/01/17 12:11:13	11/01/17 08:32:28
Pain		
Pain	No -KT	No -CC

Flowsheets (all recorded)

Preop Nurse

Row Name	11/01/17 0645
Pre-op Nurse	
Pre Procedure Nurse	kw -KW

Flowsheets (all recorded)

Daily Cares

Row Name	11/02/17 1200	11/02/17 0900	11/02/17 0400	11/01/17 2000	11/01/17 1800
Safe Environment					
Arm Bands On	—	—	—	—	ID;Allergies -AG
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 -AG
Safety Alarm Verfied	—	—	—	—	Bed -AG
Side Rails/Bed Safety	—	—	—	—	3/4 -AG
Mobility					
Mobility Intervention	—	—	—	—	Bedrest -AG
Level of Assistance	—	—	—	—	Minimal assist, patient does 75% or more -AG
Active Range of Motion	—	—	—	—	Active;All extremities -AG
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	—	—	—	HOB less than 20 -AG
Repositioned	—	—	—	—	Semi Fowler's -AG
Hygiene					
Foley Care/ Peri Care	—	—	Completed -TA	—	—
Performed by	—	—	Nursing Staff -TA	—	—
Anti-Embolism Devices					
Anti-Embolism Devices	Off -JG	—	—	Off -NB	—
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Visiting -AG
Telemetry Details					
Telemetry Monitor On	—	Yes -JG	—	—	Yes -AG
Telemetry Audible	—	Yes -JG	—	—	Yes -AG
Telemetry Box Number	—	5799 -JG	—	—	5799 -AG
Telemetry Alarms Set	—	Yes -JG	—	—	Yes -AG
Incentive Spirometer					
Is pt using incentive spirometer?	—	No -JG	—	No -NB	—

Row Name	11/01/17 1600	11/01/17 1400	11/01/17 1241
Safe Environment			
Arm Bands On	ID;Allergies -AG	ID;Allergies -AG	—
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 -AG	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Wheels on chair locked;NonSkid Footwear on;Call light in reach -AG	—
Safety Alarm Verfied	Bed -AG	Bed -AG	—
Side Rails/Bed Safety	3/4 -AG	3/4 -AG	—
Mobility			
Mobility Intervention	Bedrest -AG	Bedrest -AG	—
Level of Assistance	Minimal assist, patient does 75% or more -AG	Minimal assist, patient does 75% or more -AG	—
Active Range of Motion	Active;All extremities -AG	Active;All extremities -AG	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	HOB less than 20 -AG	HOB less than 20 -AG	—
Repositioned	Supine -AG	Supine -AG	—
Anti-Embolism Devices			
Anti-Embolism Devices	—	—	Off -JG

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	11/01/17 1600	11/01/17 1400	11/01/17 1241
Family/Significant Other Communication			
Family/Significant Other Update	Visiting -AG	Visiting -AG	Visiting -AG
Telemetry Details			
Telemetry Monitor On	Yes -AG	—	Yes -JG
Telemetry Audible	Yes -AG	—	Yes -JG
Telemetry Box Number	5799 -AG	—	5799 -JG
Telemetry Alarms Set	Yes -AG	—	Yes -JG
Incentive Spirometer			
Is pt using incentive spirometer?	—	—	No -JG

Flowsheets (all recorded)

Arterial/Venous Sheath Assessment

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07
Sheath Insertion Site Location - Assessment					
L Radial Pulse	—	+2 -JG	—	—	—
R Radial Pulse	—	+2 -JG	—	—	—
LLE Neurovascular Assessment					
LLE Capillary Refill	—	Less than/equal to 3 seconds -JG	—	—	—
LLE Color	—	Appropriate for ethnicity -JG	—	—	—
LLE Temperature/Moisture	—	Warm;Dry -JG	—	—	—
LLE Sensation	—	Present -JG	—	—	—
L Pedal Pulse	—	+2 -JG	—	—	—
RLE Neurovascular Assessment					
RLE Capillary Refill	—	Less than/equal to 3 seconds -JG	—	—	—
RLE Color	—	Appropriate for ethnicity -JG	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -JG	—	—	—
RLE Sensation	—	Present -JG	—	—	—
R Pedal Pulse	—	+1 -JG	—	—	—
Vitals					
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	—	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)	—
Temp src	—	—	Oral -RG	Oral -TA	—
Pulse	61 -DI (r) RG (t)	—	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)
Heart Rate Source	—	—	Monitor -RG	—	—
Resp	16 -DI (r) RG (t)	—	18 -RG	17 -DI (r) TA (t)	—
BP	159/73 -DI (r) RG (t)	—	139/71 -DI (r) RG (t)	—	129/62 -DI (r) NB (t)
Patient Position	—	—	Supine -RG	—	—
Oxygen Therapy					
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	—
Row Name	**11/01/17 22:12:48**	**11/01/17 19:49:06**	**11/01/17 1930**	**11/01/17 18:17:07**	**11/01/17 18:15:27**
Sheath Insertion Site Location - Assessment					
L Radial Pulse	—	—	+2 -NB	—	—
R Radial Pulse	—	—	+2 -NB	—	—
RLE Neurovascular Assessment					
R Posterior Tibial Pulse	—	—	+1 -NB	—	—
R Pedal Pulse	—	—	+2 -NB	—	—
Vitals					
Temp	98.5 °F (36.9 °C) -DI (r) TA (t)	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—	—
Temp src	Oral -TA	Oral -TA	—	—	—
Pulse	69 -DI (r) TA (t)	65 -DI (r) TA (t)	—	72 -DI (r) AG (t)	74 -DI (r) AG (t)
Heart Rate Source	Monitor -TA	Monitor -TA	—	—	—
Resp	17 -DI (r) TA (t)	17 -DI (r) TA (t)	—	—	—
BP	122/62 -DI (r) TA (t)	110/63 -DI (r) TA (t)	—	146/70 -DI (r) AG (t)	161/77 -DI (r) AG (t)
Patient Position	Supine -TA	Supine -TA	—	Standing -AG	Sitting -AG
Oxygen Therapy					
SpO2	93 % -DI (r) TA (t)	94 % -DI (r) TA (t)	—	—	—
O2 Device	None (Room air) -TA	None (Room air) -TA	—	None (Room air) -AG	None (Room air) -AG
Row Name	**11/01/17 18:11:44**	**11/01/17 1800**	**11/01/17 1700**	**11/01/17 1600**	**11/01/17 1530**
LLE Neurovascular Assessment					
LLE Capillary Refill	—	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
LLE Color	—	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
LLE Temperature/Moisture	—	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
LLE Sensation	—	Present -JG	Present -JG	Present -JG	Present -JG

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	11/01/17 18:11:44	11/01/17 1800	11/01/17 1700	11/01/17 1600	11/01/17 1530
L Pedal Pulse	—	+2 -JG	+2 -JG	+2 -JG	+2 -JG
RLE Neurovascular Assessment					
RLE Capillary Refill	—	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
RLE Color	—	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
RLE Temperature/Moisture	—	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
RLE Sensation	—	Present -JG	Present -JG	Present -JG	Present -JG
R Pedal Pulse	—	+2 -JG	+2 -JG	+2 -JG	+2 -JG
Vitals					
Temp	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—	—	—
Temp src	Oral -AG	—	—	—	—
Resp	20 -DI (r) AG (t)	—	—	—	—
BP	130/61 -DI (r) AG (t)	—	—	—	—
Patient Position	Supine -AG	—	—	—	—
Oxygen Therapy					
O2 Device	None (Room air) -AG	—	—	—	—

Row Name	11/01/17 1500	11/01/17 1430	11/01/17 1400	11/01/17 1330	11/01/17 1315
LLE Neurovascular Assessment					
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
LLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
LLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
L Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
RLE Neurovascular Assessment					
RLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
RLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
RLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
RLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
R Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG

Row Name	11/01/17 1300	11/01/17 12:45:07	11/01/17 1245	11/01/17 1241	11/01/17 10:24:35
[REMOVED] Arterial Sheath 6 Fr. Right Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: No complications;Catheter intact -KT				
[REMOVED] Arterial Sheath 8 Fr. Left Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, golfball size				
Sheath Insertion Site Location - Assessment					
Femoral	—	—	Rt -JG	Lt -JG	—
L Radial Pulse	—	—	—	+2 -JG	—
R Radial Pulse	—	—	—	+2 -JG	—
LLE Neurovascular Assessment					
LLE Capillary Refill	Less than/equal to 3 seconds -JG	—	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	—
LLE Color	Appropriate for ethnicity -JG	—	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	—
LLE Temperature/Moisture	Warm;Dry -JG	—	Dry;Warm -JG	Dry;Warm -JG	—
LLE Sensation	Present -JG	—	Present -JG	Present -JG	—
L Pedal Pulse	+2 -JG	—	+2 -JG	+2 -JG	—
RLE Neurovascular Assessment					

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	11/01/17 1300	11/01/17 12:45:07	11/01/17 1245	11/01/17 1241	11/01/17 10:24:35
RLE Capillary Refill	Less than/equal to 3 seconds -JG	—	Less than/equal to 3 seconds -JG	—	—
RLE Color	Appropriate for ethnicity -JG	—	Appropriate for ethnicity -JG	—	—
RLE Temperature/Moisture	Warm;Dry -JG	—	Warm;Dry -JG	—	—
RLE Sensation	Present -JG	—	Present -JG	—	—
R Femoral Pulse	— -JG	—	— -JG	—	—
R Pedal Pulse	+2 -JG	—	+2 -JG	+2 -JG	—
Vitals					
Temp	—	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—	—
Temp src	—	Oral -AG	—	—	—
Pulse	—	58 -DI (r) AG (t)	—	—	—
Heart Rate Source	—	Monitor -AG	—	—	—
Resp	—	16 -DI (r) AG (t)	—	—	—
BP	—	156/88 -DI (r) AG (t)	—	—	—
Patient Position	—	Supine -AG	—	—	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) AG (t)	—	—	—
O2 Device	—	None (Room air) -AG	—	None (Room air) -JG	—
ACT (Activated Clotting Time) Ref					
Dose (units/kg/hr) Heparin	—	—	—	—	*3000 Units -KT

Row Name	11/01/17 09:36:42	11/01/17 09:14:54	11/01/17 09:03:28	11/01/17 08:32:57	11/01/17 08:32:31
[REMOVED] Arterial Sheath 6 Fr. Right Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: No complications;Catheter intact -KT				
[REMOVED] Arterial Sheath 8 Fr. Left Femoral					
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, gofball size				
Oxygen Therapy					
O2 Device	—	—	—	—	Nasal cannula -CC
O2 Flow Rate (L/min)	—	—	—	—	3 L/min -CC
ACT (Activated Clotting Time) Ref					
Dose (units/kg/hr) Heparin	*2000 Units -KT	*3000 Units -KT	*7000 Units -KT	*4 Bag -KT (r) AS (t)	—

Row Name	11/01/17 0718	11/01/17 0711
Sheath Insertion Site Location - Assessment		
L Radial Pulse	—	+2 -KW
R Radial Pulse	—	+2 -KW
LLE Neurovascular Assessment		
L Posterior Tibial Pulse	—	+2 -KW
L Pedal Pulse	—	+2 -KW
RLE Neurovascular Assessment		
R Posterior Tibial Pulse	—	+1 -KW
R Pedal Pulse	—	+2 -KW
Vitals		
Temp	97.8 °F (36.6 °C) -KW	—
Temp src	Oral -KW	—
Pulse	55 -KW	—
Heart Rate Source	Monitor -KW	—
Resp	16 -KW	—
BP	117/58 -KW	—
Oxygen Therapy		

Flowsheets (all recorded) (continued)

Arterial/Venous Sheath Assessment (continued)

Row Name	11/01/17 0718	11/01/17 0711
SpO2	94 % -KW	—

Flowsheets (all recorded)

Patient Belongings

Row Name	11/01/17 0653
Patient Belongings at Bedside	
Belongings at Bedside	Eyeglasses wallet -KW
Belongings sent to security (Retired)	No -KW
(RETIRED)Belongings Sent Home	No -KW
Patient Medications	
Medications brought by patient?	No -KW

Flowsheets (all recorded)

CAGE Questionnaire

Row Name	11/01/17 1200
CAGE Questionnaire	
Have you felt the need to cut down on your drinking?	0 -JG
Have you ever felt annoyed by criticizing of your drinking?	0 -JG
Have you ever felt guilty about your drinking?	0 -JG
Have you ever felt you needed an eye-opener?	0 -JG
CAGE Score Total	0 -JG

Flowsheets (all recorded)

Adult Immunization Screening

Row Name	11/01/17 1200
Pneumococcal Screening - Age >=65	
Age >=65 Pneumococcal CONTRAINDICATIONS [Do any of the following exist?]	NONE-Continue Screening -JG
Have you ever had a pneumococcal vaccination?	Yes -JG
Influenza Vaccine (Sept - March 31st)	
Have you received the Influenza Vaccine during this Flu season?	Yes -JG
Meets Criteria for Influenza Vaccine?	
Patient Meets Criteria For Influenza Vaccine?	No -JG

Flowsheets (all recorded)

Cardiac Rehab Follow-up

Row Name	11/02/17 0824
Cardiac Rehab follow-up needed?	
Cardiac Rehab Follow up needed?	— 11/2-unsuccessful CTO; med tx -RC

Flowsheets (all recorded)

Complex Assessment

Row Name	11/02/17 0900	11/02/17 0400	11/02/17 03:16:07	11/01/17 1930	11/01/17 1800
Neurological					
Level of Consciousness	Alert -JG	—	—	Alert -NB	—
HEENT					
HEENT (WDL)	X -JG	—	—	X -NB	—
R Eye	Impaired vision -JG	—	—	Impaired vision -NB	—
L Eye	Impaired vision -JG	—	—	Impaired vision -NB	—
Cardiac					
Cardiac Regularity	Regular -JG	—	—	—	—
Heart Sounds	—	—	—	S1, S2 -NB	—
Cardiac Rhythm	Normal sinus rhythm -JG	—	—	Normal sinus rhythm -NB	—
Cardiac Monitor					
Bedside Cardiac Monitor On	No -JG	—	—	—	—
Telemetry Monitor On	Yes -JG	—	—	—	Yes -AG
Telemetry Audible	Yes -JG	—	—	—	Yes -AG
Telemetry Alarms Set	Yes -JG	—	—	—	Yes -AG
Telemetry Box Number	5799 -JG	—	—	—	5799 -AG
Peripheral Vascular					
Peripheral Vascular (WDL)	WDL -JG	—	—	WDL -NB	—
RLE Capillary Refill	Less than/equal to 3 seconds -JG	—	—	—	Less than/equal to 3 seconds -JG
LLE Capillary Refill	Less than/equal to 3 seconds -JG	—	—	—	Less than/equal to 3 seconds -JG
RUE Neurovascular Assessment					
R Radial Pulse	+2 -JG	—	—	+2 -NB	—
LUE Neurovascular Assessment					
L Radial Pulse	+2 -JG	—	—	+2 -NB	—
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	—	—	—	Appropriate for ethnicity -JG
RLE Temperature/Moisture	Warm;Dry -JG	—	—	—	Warm;Dry -JG
RLE Sensation	Present -JG	—	—	—	Present -JG
R Posterior Tibial Pulse	—	—	—	+1 -NB	—
R Pedal Pulse	+1 -JG	—	—	+2 -NB	+2 -JG
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	—	—	—	Appropriate for ethnicity -JG
LLE Temperature/Moisture	Warm;Dry -JG	—	—	—	Warm;Dry -JG
LLE Sensation	Present -JG	—	—	—	Present -JG
L Pedal Pulse	+2 -JG	—	—	—	+2 -JG
Integumentary					
Integumentary (WDL)	X -JG	—	—	X -NB	—
Skin Color	Appropriate for ethnicity -JG	—	—	—	—
Skin Condition/Temp	Dry;Warm -JG	—	—	Dry;Warm -NB	—
Skin Integrity	Other (Comment);Bruising surgical wounds -JG	—	—	—	—
Skin Location	L and R groin -JG	—	—	L and R groin -NB	—
Skin Turgor	Non-tenting -JG	—	—	—	—
Braden Scale					
Sensory Perceptions	4 -JG	—	—	4 -NB	—
Moisture	4 -JG	—	—	4 -NB	—
Activity	3 -JG	—	—	1 -NB	—
Mobility	4 -JG	—	—	4 -NB	—
Nutrition	3 -JG	—	—	3 -NB	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	11/02/17 0900	11/02/17 0400	11/02/17 03:16:07	11/01/17 1930	11/01/17 1800
Friction and Shear	3 -JG	—	—	3 -NB	—
Braden Scale Score	21 -JG	—	—	19 -NB	—
Wound					
Type of Wound (LDA)	—	—	—	Surgical -NB	—
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	—	—	—	Other (Comment) -JG
Surrounding Skin Assessment	Purple;Intact -JG	—	—	Intact -NB	Intact -JG
Closure	None -JG	—	—	UTA -NB	UTA -JG
Drainage Amount	None -JG	—	—	—	None -JG
Treatments	Site care -JG	—	—	Site care -NB	—
Dressing	Dry dressing -JG	—	—	—	Barrier Film;Dry dressing;Gauze -JG
Dressing Changed	Changed -JG	—	—	Changed -NB	—
Dressing Assesment	Clean;Dry;Intact -JG	—	—	Clean;Dry;Intact -NB	Intact;Occlusive;Transparent -JG
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	—	—	—	Other (Comment) -JG
Surrounding Skin Assessment	Intact -JG	—	—	—	Intact -JG
Closure	None -JG	—	—	UTA -NB	UTA -JG
Drainage Amount	None -JG	—	—	—	None -JG
Treatments	Site care -JG	—	—	—	—
Dressing	Dry dressing -JG	—	—	—	Barrier Film;Dry dressing;Gauze -JG
Dressing Changed	Changed -JG	—	—	—	—
Dressing Assesment	Clean;Dry;Intact -JG	—	—	Clean;Dry;Intact -NB	Clean;Dry;Intact;Occlusive;Transparent -JG
Gastrointestinal					
Gastrointestinal (WDL)	WDL -JG	—	—	WDL -NB	—
Last BM Date	—	—	—	10/31/17 -NB	—
Urine Assessment					
Foley Care/ Peri Care	—	Completed -TA	—	—	—
Psychosocial					
Psychosocial (WDL)	WDL -JG	—	—	WDL -NB	—
Charting Type					
Charting Type	Shift assessment -JG	—	Reassessment no changes -NB	Shift assessment -NB	—

Row Name	11/01/17 1700	11/01/17 1600	11/01/17 1530	11/01/17 1500	11/01/17 1430
Cardiac Monitor					
Telemetry Monitor On	—	Yes -AG	—	—	—
Telemetry Audible	—	Yes -AG	—	—	—
Telemetry Alarms Set	—	Yes -AG	—	—	—
Telemetry Box Number	—	5799 -AG	—	—	—
Peripheral Vascular					
RLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
RLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
RLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	11/01/17 1700	11/01/17 1600	11/01/17 1530	11/01/17 1500	11/01/17 1430
R Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
LLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
LLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
L Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	Intact -JG
Closure	UTA -JG	UTA -JG	UTA -JG	None -JG	UTA -JG
Drainage Amount	None -JG	Scant -JG	None -JG	Small -JG	None -JG
Treatments	—	—	—	Site care -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG
Dressing Changed	—	—	—	Changed -JG	—
Dressing Assesment	Intact;Occlusive;Transparent -JG	Occlusive;Intact;Transparent -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG
[REMOVED] Surgical 11/01/17 Groin Right					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	Intact -JG
Closure	UTA -JG	UTA -JG	UTA -JG	None -JG	UTA -JG
Drainage Amount	None -JG	None -JG	None -JG	Small -JG	None -JG
Treatments	—	—	—	Site care -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Gauze;Dry dressing -JG
Dressing Changed	—	—	—	Changed -JG	—
Dressing Assesment	Clean;Dry;Intact;Occlusive;Transparent -JG	Intact;Occlusive;Dry;Clean -JG	Clean;Dry;Intact;Occlusive;Transparent -JG	Clean;Intact;Occlusive;Dry;Transparent -JG	Dry;Clean;Intact -JG

Row Name	11/01/17 1400	11/01/17 1330	11/01/17 1315	11/01/17 1300	11/01/17 1245
Peripheral Vascular					
RLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
LLE Capillary Refill	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG	Less than/equal to 3 seconds -JG
RLE Neurovascular Assessment					
RLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
RLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG
RLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
R Femoral Pulse	—	—	—	— -JG	— -JG
R Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
LLE Neurovascular Assessment					
LLE Color	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG	Appropriate for ethnicity -JG
LLE Temperature/Moisture	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Warm;Dry -JG	Dry;Warm -JG
LLE Sensation	Present -JG	Present -JG	Present -JG	Present -JG	Present -JG
L Pedal Pulse	+2 -JG	+2 -JG	+2 -JG	+2 -JG	+2 -JG
[REMOVED] Surgical 11/01/17 Groin Left					
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	—
Surrounding Skin	Intact -JG	Intact -JG	Intact -JG	Intact -JG	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	11/01/17 1400	11/01/17 1330	11/01/17 1315	11/01/17 1300	11/01/17 1245
Assessment					
Closure	UTA -JG	UTA -JG	UTA -JG	UTA -JG	—
Drainage Amount	None -JG	None -JG	None -JG	None -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	—
Dressing Assesment	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	—

[REMOVED] Surgical 11/01/17 Groin Right

Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	Other (Comment) -JG	Other (Comment) -JG	Other (Comment) -JG	—
Surrounding Skin Assessment	Intact -JG	Intact -JG	Intact -JG	Intact -JG	—
Closure	UTA -JG	UTA -JG	UTA -JG	UTA -JG	—
Drainage Amount	None -JG	None -JG	None -JG	None -JG	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	Barrier Film;Dry dressing;Gauze -JG	—
Dressing Assesment	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	Clean;Dry;Intact -JG	—

Row Name	11/01/17 1241	11/01/17 08:32:31	11/01/17 0711	11/01/17 0658
Neurological				
Level of Consciousness	Alert -JG	—	Alert -KW	—
Neuro (WDL)	—	—	WDL -KW	—
HEENT				
HEENT (WDL)	X -JG	—	X -KW	—
R Eye	Impaired vision -JG	—	Impaired vision -KW	—
L Eye	Impaired vision -JG	—	Impaired vision -KW	—
Respiratory				
Respiratory (WDL)	—	—	X -KW	—
Respiratory Pattern	—	—	Regular -KW	—
Chest Assessment	—	—	Chest expansion symmetrical -KW	—
Bilateral Breath Sounds	—	—	Clear -KW	—
R Breath Sounds	—	—	Clear -KW	—
L Breath Sounds	—	—	Clear -KW	—
Cough	—	—	None -KW	—
Cardiac				
Cardiac (WDL)	—	—	X -KW	—
Cardiac Regularity	Regular -JG	—	Regular -KW	—
Heart Sounds	—	—	S1, S2 -KW	—
Cardiac Rhythm	Normal sinus rhythm -JG	—	Sinus bradycardia -KW	—
Cardiac Symptoms	—	—	None -KW	—
Cardiac Monitor				
Bedside Cardiac Monitor On	No -JG	—	Yes -KW	—
Bedside Cardiac Audible	—	—	Yes -KW	—
Bedside Cardiac Alarms Set	—	—	Yes -KW	—
Telemetry Monitor On	Yes -JG	—	—	—
Telemetry Audible	Yes -JG	—	—	—
Telemetry Alarms Set	Yes -JG	—	—	—
Telemetry Box Number	5799 -JG	—	—	—
Pacemaker				
Pacemaker	—	—	No -KW	—
ICD				
ICD	—	—	No -KW	—

[REMOVED] Arterial Sheath 6 Fr. Right Femoral

Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0856 -KT Present On Arrival : No -KT Sheath Size: 6 Fr. -KT Line Orientation: Right -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1202 -KT Removal Reason: Per protocol -KT Initial				

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	11/01/17 1241	11/01/17 08:32:31	11/01/17 0711	11/01/17 0658
	Post Removal Site Assessment: No complications;Catheter intact -KT			
[REMOVED] Arterial Sheath 8 Fr. Left Femoral				
Arterial/Venous Sheath Properties	Placement Date: 11/01/17 -KT Placement Time: 0902 -KT Present On Arrival : No -KT Sheath Size: 8 Fr. -KT Line Orientation: Left -KT Sheath Insertion Site: Femoral -KT Sutured: No -KT Inserted by: Dr. Sheikh -KT Local Anesthetic: Injectable -KT Site Prep: Chlorhexidine -KT Free Flowing Blood Return: Yes -KT Removal Date: 11/01/17 -KT Removal Time: 1203 -KT Removal Reason: Per protocol -KT Initial Post Removal Site Assessment: Hematoma;Catheter intact -KT Hematoma Size (Post Removal): 3 - 5 cm -KT, gofball size			
Peripheral Vascular				
Peripheral Vascular (WDL)	WDL -JG	—	WDL -KW	—
LLE Capillary Refill	Less than/equal to 3 seconds -JG	—	—	—
Pulses	—	—	R radial;R posterior tibial;L posterior tibial;R pedal;L pedal -KW	—
RUE Neurovascular Assessment				
R Radial Pulse	+2 -JG	—	+2 -KW	—
LUE Neurovascular Assessment				
L Radial Pulse	+2 -JG	—	+2 -KW	—
RLE Neurovascular Assessment				
R Posterior Tibial Pulse	—	—	+1 -KW	—
R Pedal Pulse	+2 -JG	—	+2 -KW	—
LLE Neurovascular Assessment				
LLE Color	Appropriate for ethnicity -JG	—	—	—
LLE Temperature/Moisture	Dry;Warm -JG	—	—	—
LLE Sensation	Present -JG	—	—	—
L Posterior Tibial Pulse	—	—	+2 -KW	—
L Pedal Pulse	+2 -JG	—	+2 -KW	—
Integumentary				
Integumentary (WDL)	X -JG	—	WDL -KW	—
Skin Color	Appropriate for ethnicity -JG	—	—	—
Skin Condition/Temp	Dry;Warm -JG	—	—	—
Skin Integrity	Other (Comment) surgical puncture -JG	—	—	—
Skin Location	L and R groin -JG	—	—	—
Skin Turgor	Non-tenting -JG	—	—	—
Braden Scale				
Sensory Perceptions	4 -JG	—	—	4 -KW
Moisture	4 -JG	—	—	4 -KW
Activity	1 -JG	—	—	4 -KW
Mobility	4 -JG	—	—	4 -KW
Nutrition	3 -JG	—	—	4 -KW
Friction and Shear	3 -JG	—	—	3 -KW
Braden Scale Score	19 -JG	—	—	23 -KW
Wound				
Type of Wound (LDA)	Surgical -JG	Surgical -JG	—	—
[REMOVED] Surgical 11/01/17 Groin Left				
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Left -JG 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) -JG	—	—	—
Surrounding Skin Assessment	Intact;Other(Comment) hematoma-soft -JG	—	—	—
Closure	UTA -JG	—	—	—
Drainage Amount	None -JG	—	—	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	—	—	—
Dressing Assesment	Clean;Dry;Intact;Occlusive -JG	—	—	—

Flowsheets (all recorded) (continued)

Complex Assessment (continued)

Row Name	11/01/17 1241	11/01/17 08:32:31	11/01/17 0711	11/01/17 0658
[REMOVED] Surgical 11/01/17 Groin Right				
Incision Properties	Date Documented: 11/01/17 -JG Time Documented: 1244 -JG Location: Groin -JG Wound Location Orientation: Right -JG 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) -JG	—	—	—
Surrounding Skin Assessment	Intact -JG	—	—	—
Closure	UTA -JG	—	—	—
Drainage Amount	None -JG	—	—	—
Dressing	Barrier Film;Dry dressing;Gauze -JG	—	—	—
Dressing Assesment	Dry;Clean;Intact;Occlusive;Transparent -JG	—	—	—
Gastrointestinal				
Gastrointestinal (WDL)	WDL -JG	—	WDL -KW	—
Last BM Date	10/31/17 per patient -JG	—	—	—
Psychosocial				
Psychosocial (WDL)	WDL -JG	—	WDL -KW	—
Charting Type				
Charting Type	Admission -JG	—	Admission -KW	—

Flowsheets (all recorded)

Vital Signs

Row Name	11/02/17 11:32:20	11/02/17 0900	11/02/17 07:25:45	11/02/17 03:53:02	11/02/17 03:16:07
Vital Signs					
Temp	97.3 °F (36.3 °C) -DI (r) RG (t)	—	97.8 °F (36.6 °C) -DI (r) RG (t)	97.9 °F (36.6 °C) -DI (r) TA (t)	—
Temp src	—	—	Oral -RG	Oral -TA	—
Pulse	61 -DI (r) RG (t)	—	67 -DI (r) RG (t)	—	68 -DI (r) NB (t)
Heart Rate Source	—	—	Monitor -RG	—	—
Resp	16 -DI (r) RG (t)	—	18 -RG	17 -DI (r) TA (t)	—
Respiration Source	—	—	visual -RG	—	—
BP	159/73 -DI (r) RG (t)	—	139/71 -DI (r) RG (t)	—	129/62 -DI (r) NB (t)
BP Location	—	—	Right arm -RG	—	—
BP Method	—	—	Portable -RG	—	—
Patient Position	—	—	Supine -RG	—	—
Oxygen Therapy					
SpO2	97 % -DI (r) RG (t)	—	95 % -DI (r) RG (t)	—	94 % -DI (r) NB (t)
O2 Device	—	None (Room air) -JG	None (Room air) -RG	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -JG	—	—	—	—
Height and Weight					
Weight	—	—	—	97.1 kg (214 lb 1.1 oz) -TA	—
Weight Method	—	—	—	Actual -TA	—
Row Name	**11/01/17 22:12:48**	**11/01/17 19:49:06**	**11/01/17 1930**	**11/01/17 1845**	**11/01/17 18:17:07**
Vital Signs					
Temp	98.5 °F (36.9 °C) -DI (r) TA (t)	98.2 °F (36.8 °C) -DI (r) TA (t)	—	—	—
Temp src	Oral -TA	Oral -TA	—	—	—
Pulse	69 -DI (r) TA (t)	65 -DI (r) TA (t)	—	—	72 -DI (r) AG (t)
Heart Rate Source	Monitor -TA	Monitor -TA	—	—	—
Resp	17 -DI (r) TA (t)	17 -DI (r) TA (t)	—	—	—
Respiration Source	visual -TA	visual -TA	—	—	—
BP	122/62 -DI (r) TA (t)	110/63 -DI (r) TA (t)	—	—	146/70 -DI (r) AG (t)
BP Location	Right arm -TA	Right arm -TA	—	—	Right arm -AG
BP Method	Portable -TA	Portable -TA	—	—	Portable -AG
Patient Position	Supine -TA	Supine -TA	—	—	Standing -AG
Oxygen Therapy					
SpO2	93 % -DI (r) TA (t)	94 % -DI (r) TA (t)	—	—	—
O2 Device	None (Room air) -TA	None (Room air) -TA	—	—	None (Room air) -AG
Pain Assessment					
Currently in Pain	—	—	No -NB	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -NB	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -NB	—	—
Height and Weight					
Weight	—	—	—	97.4 kg (214 lb 11.2 oz) -AG	—
Weight Method	—	—	—	Actual -AG	—
Row Name	**11/01/17 18:15:27**	**11/01/17 18:11:44**	**11/01/17 12:45:07**	**11/01/17 1241**	**11/01/17 08:32:31**
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -DI (r) AG (t)	98.1 °F (36.7 °C) -DI (r) AG (t)	—	—
Temp src	—	Oral -AG	Oral -AG	—	—
Pulse	74 -DI (r) AG (t)	—	58 -DI (r) AG (t)	—	—
Heart Rate Source	—	—	Monitor -AG	—	—
Resp	—	20 -DI (r) AG (t)	16 -DI (r) AG (t)	—	—
Respiration Source	—	visual -AG	visual -AG	—	—
BP	161/77 -DI (r) AG (t)	130/61 -DI (r) AG (t)	156/88 -DI (r) AG (t)	—	—
BP Location	Right arm -AG	Right arm -AG	Right arm -AG	—	—
BP Method	Portable -AG	Portable -AG	Portable -AG	—	—
Patient Position	Sitting -AG	Supine -AG	Supine -AG	—	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	11/01/17 18:15:27	11/01/17 18:11:44	11/01/17 12:45:07	11/01/17 1241	11/01/17 08:32:31
Oxygen Therapy					
SpO2	—	—	93 % -DI (r) AG (t)	—	—
O2 Device	None (Room air) -AG	None (Room air) -AG	None (Room air) -AG	None (Room air) -JG	Nasal cannula -CC
O2 Flow Rate (L/min)	—	—	—	—	3 L/min -CC
Pain Goal					
Patient's Stated Pain Goal	—	—	4 -JG	—	—

Row Name	11/01/17 0718	11/01/17 0658	11/01/17 0657
Vital Signs			
Temp	97.8 °F (36.6 °C) -KW	—	—
Temp src	Oral -KW	—	—
Pulse	55 -KW	—	—
Heart Rate Source	Monitor -KW	—	—
Resp	16 -KW	—	—
BP	117/58 -KW	—	—
Oxygen Therapy			
SpO2	94 % -KW	—	—
Numeric Pain Intensity Scale			
Numeric Pain Intensity Score 1	—	0 -KW	—
Height and Weight			
Height	—	—	67" (1.702 m) -KW
Weight	—	—	95.7 kg (211 lb) -KW
Weight Method	—	—	Stated -KW
BSA (Calculated - sq m)	—	—	2.12 sq meters -KW
BMI (Calculated)	—	—	33 -KW
Weight in (lb) to have BMI = 25	—	—	159.3 -KW

User Key

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

Initials	Name	Effective Dates
UE	Epic, User	—
KW	Karen M Wilson, RN	02/03/17 -
RC	Rene M Cline, CST/CFA	02/03/17 -
AS	Abdul M Sheikh, MD	11/01/17 - 11/01/17
NB	Nakeisa L Brown, RN	02/03/17 -
RG	Rachel Gutierrez, CNA	02/03/17 -
GM	Gregory L Messina, RN	02/03/17 -
TA	Tehzeeb Abbasi	02/03/17 -
CC	Camay Crooms, RN	02/03/17 - 07/02/19
DH	Diane Hernandez	02/03/17 - 04/11/18
JG	Julia Gaddis, RN	02/03/17 - 01/04/18
KT	Kathryn Teegarden, RN	02/03/17 -
AG	Anthony Gunter, RN	08/14/17 -
HS	Hollis Sweeney, RN	09/22/17 - 11/27/18
MW	Marlo Wahbeh, RN	09/21/17 - 11/27/18
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 - 11/01/2017:

Scan on 11/4/2017 8:32 AM (below)

Document on 11/2/2017 12:10 PM by Julia E Branch, RN: IP AVS (below)

AFTER VISIT SUMMARY

Eugene G. Maurice Date of birth: 1/2/1949
11/1/2017 - 11/2/2017 WellStar Kennestone Hospital (KH B7E PROGRESS CARD)

Instructions

No changes were made to your medications.

Physicians who cared for you during your hospitalization

Provider	Service	Role	Specialty
Abdul M Sheikh, MD	Cardiology	Attending Provider	Interventional Cardiology
CVM, CARDIOLOGIST	–	Consulting Physician	–

You are allergic to the following

No active allergies

Other instructions
AMB REFERRAL TO CARDIAC REHAB

What's next

	Follow up with Jeffrey L Tharp, MD	176 Charles Hardy Parkway Unit C Hiram GA 30141 678-945-8200
	Call Abdul M Sheikh, MD in 1 week(s)	144 Bill Carruth Parkway Suite 4200 Hiram GA 30141-3749 678-324-4444
NOV 9	Office Visit with Susan E Ashworth, NP **Thursday Nov 9, 2017 1:00 PM (Arrive by 12:45 PM)**	WellStar East Paulding Primary Care Center 176 Charles Hardy Parkway Unit C Hiram GA 30141-1836 678-945-8200

Your Next Steps

Read
☐ **Read these attachments**
- Cardiac Catheterization, Discharge Instructions for (English)

Go
NOV 9 Office Visit 1:00 PM
Arrive by 12:45 PM
Susan E Ashworth, NP
WellStar East Paulding Primary Care Center
176 Charles Hardy Parkway Unit C
Hiram GA 30141-1836
678-945-8200

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

What's next (continued)

DEC 7 **MRI Prostate With & Without Contrast**
Thursday Dec 7, 2017 9:30 AM

Patient should arrive in Registration 30 minutes prior to scan time. The patient's insurance card(s) and photo ID will be requested at this time. Please also bring a list of the patient's current medications. Please alert MRI department if patient has metal implants of any kind.
Patient may not have anything to eat for six(6) hours prior to appointment, liquids only. No intercourse 48 hours prior to exam.

Children will not be allowed in the MRI scan room unless they are the patient.

WellStar Windy Hill Imaging Center in East Cobb
3747 Roswell Road Ne
Marietta GA 30062

Medication List

	Morning	Noon	Evening	Bedtime	As Needed
apixaban 5 mg tablet Commonly known as: ELIQUIS Take 1 tablet (5 mg total) by mouth 2 (two) times a day Dose: 5 mg Given today?: No Next dose due: 11/2		✓		✓	
aspirin, buffered 81 mg Tab Take 81 mg by mouth daily. Dose: 81 mg Given today?: No Next dose due: 11/2			✓		
atorvastatin 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly Dose: 80 mg Given today?: No Next dose due: 11/2			✓		
* **blood sugar diagnostic** strip Commonly known as: glucose blood cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..					
* **blood sugar diagnostic** strip True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9					
carvedilol 12.5 MG tablet Commonly known as: COREG Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals Dose: 12.5 mg Given today?: Yes Next dose due: 11/2	✓		✓		
chlorthalidone 50 MG tablet Commonly known as: HYGROTEN Take 1 tablet (50 mg total) by mouth daily Dose: 50 mg Given today?: Yes Next dose due: 11/3	✓				

Medication List (continued)

	Morning	Noon	Evening	Bedtime	As Needed
cilostazol 100 MG tablet Commonly known as: PLETAL Take 1 tablet (100 mg total) by mouth 2 (two) times a day Dose: 100 mg Given today?: Yes Next dose due: 11/2	✓		✓		
isosorbide mononitrate 30 MG 24 hr tablet Commonly known as: IMDUR Take 2 tablets (60 mg total) by mouth 2 (two) times a day Dose: 60 mg Given today?: Yes Next dose due: 11/2	✓		✓		
metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE Take 2 tablets (1,000 mg total) by mouth 2 (two) times a day with meals 2 tablets in am and 1 tablet in pm Dose: 1000 mg For: type 2 diabetes mellitus Given today?: No Notes to patient: Hold for 48 hrs post cath due to it interacting with contrast dye. Resume 11/3 evening dose.	✓		✓		
nitroglycerin 0.4 MG SL tablet Commonly known as: NITROSTAT Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain Dose: 0.4 mg					✓
ramipril 10 MG capsule Commonly known as: ALTACE Take 1 capsule (10 mg total) by mouth 2 (two) times a day Dose: 10 mg Given today?: No Next dose due: 11/2	✓		✓		

*** This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

Attached Information — Cardiac Catheterization, Discharge Instructions for (English)

Discharge Instructions for Cardiac Catheterization

Cardiac catheterization is a procedure to look for blocked areas in the blood vessels that send blood to the heart. A thin, flexible tube (catheter) is put in a blood vessel in your groin or arm. The healthcare provider injects contrast fluid into your blood, which then flows to your heart. X-rays pictures are taken of your heart. Your provider will review the results with you. Be sure to ask any questions you have before you leave. This sheet will help you take care of yourself at home.

Home care

- Only do light and easy activities for the next 2 to 3 days. Ask for help with chores and errands while you recover. Have someone drive you to your appointments.
- Don't lift anything heavy for a while. Your healthcare team will tell you when it's safe to lift again.
- Ask your healthcare team when you can expect to return to work. Unless your job involves lifting, you may be able to return to your normal activities within a couple of days.
- Take your medicines as directed. Don't skip doses.
- Drink 6 to 8 glasses of water a day. This is to help flush the contrast dye out of your body. Call your healthcare team if your urine has any change in color.
- Take your temperature each day for 7 days. If you feel cold and clammy or start sweating, take your temperature right away and call your healthcare team.
- Check your incisions every day for signs of infection. These include redness, swelling, and drainage. It is normal to have a small bruise or bump where the catheter was inserted. A bruise that is getting larger is not normal and should be reported to your healthcare team. If you see blood forming in the incision, call your healthcare team. Go to the emergency department if you have uncontrolled bleeding from the artery site. This is especially true if you take medicines that make it difficult for your blood to clot. Examples are aspirin, clopidogrel, and warfarin.
- Eat a healthy diet. Make sure it is low in fat, salt, and cholesterol. Ask your healthcare team for diet information.
- Stop smoking. Enroll in a stop-smoking program or ask your healthcare team for help. Stop-smoking programs can be life saving.
- Exercise as your healthcare team tells you to. Your healthcare team may recommend you start a cardiac rehabilitation program. Cardiac rehab is an exercise program in which trained healthcare staff watch your progress and stress on your heart while you exercise. Ask your team how to enroll.
- Don't swim or take baths until your healthcare team says it's OK. You can shower the day after the procedure. Keep the site clean and dry. This keeps the incision from getting wet and infected until the skin and artery can heal.

Follow-up care

- Make a follow-up appointment as advised by our staff. It's common to have a follow-up appointment 2 to 4 weeks after an angioplasty or coronary stent procedure.
- Make a yearly appointment, too. This is to make sure you are still doing well and not having any new symptoms.
- Don't wait for a follow-up appointment if your medicines aren't working or you are having heart-related symptoms.

When to seek medical care

Call your healthcare provider right away if you have any of the following:

- Chest pain
- Constant or increasing pain or numbness in your leg
- Fever of 100.4°F (38.0°C) or higher, or as directed by your healthcare provider
- Symptoms of infection. These include redness, swelling, drainage, or warmth at the incision site.
- Shortness of breath

- A leg that feels cold or appears blue
- Bleeding, bruising, or a lot of swelling where the catheter was inserted
- Blood in your urine
- Black or tarry stools
- Any unusual bleeding

Date Last Reviewed: 10/1/2016

Electronic signature on 11/1/2017 6:40 AM - E-signed

Encounter-Level E-Signatures:

Hosp Consent for Tx/Assgn of Ben/Fin Res (E-Sig) - Received on 11/1/2017

CONSENT TO ROUTINE PROCEDURES AND TREATMENTS & FINANCIAL RESPONSIBILITY STATEMENT

Section I CONSENT TO ROUTINE PROCEDURES AND TREATMENTS

I consent to routine procedures and treatments at a WellStar Health System "WellStar" facility as an outpatient, inpatient, or emergency department patient, depending on my medical needs. Routine procedures and treatments can include testing (for example, x-rays and blood tests), routine care and procedures (for example, intravenous fluids, injections, or bladder or stomach tubes) and evaluation (for example, interviews and physical exams). However, this consent to routine procedures and treatments does not include consent for other invasive procedures (for example, surgery, amniocentesis, or diagnostic tests such as colonoscopy or those requiring the use of contrast material), consent for blood or blood products, general anesthesia, or my participation in research. These circumstances require a separate consent process. I understand it is the responsibility of my physician or surgeon to obtain any required separate consent(s).

I understand that I may receive treatment and healthcare services given by WellStar employees (such as nurses and technicians) and by physicians and other independent medical professionals on the medical staff of WellStar facilities (for example, Emergency Department physicians, radiologists, and surgeons) who are NOT WellStar employees. I understand that the healthcare services provided by these independent medical professionals, using independent medical judgment, at a WellStar facility in no way create any type of employment, partnership, or other relationship other than as an independent contractor. These independent contractors are responsible for their own actions and WellStar shall not be liable for the acts or omissions of any such independent contractors.

While I am a patient at a WellStar facility, I understand that I may be observed by or receive healthcare services from students enrolled in training programs. Students are supervised by instructors, WellStar employees, or other independent medical professionals on the medical staff of the WellStar facility, depending on the type of training program the students are enrolled in. I understand that I have the right to request that someone other than a student provide my care.

I understand that I retain no property rights to any tissue samples or bodily fluids removed from my body (specimens) as part of procedures or treatment given to me. I further understand that WellStar has no obligation to preserve these specimens; that it will retain or dispose of specimens according to its usual practices.

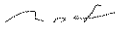
I understand that I have the right to ask questions about a proposed procedure or treatment (including the identity of any person providing or observing treatment and his or her affiliation with WellStar) at any time. I understand the practice of medicine is not an exact science and diagnosis and outcomes of treatment depend upon my medical condition and may involve risks or even death. I understand that no guarantees can be made as to the outcome of my care.

Section II MATERNITY PATIENTS

If I deliver an infant(s) while I am a patient at a WellStar facility, I agree that this same Consent to Routine Procedures and Treatments applies to the infant(s).

Section III EMERGENCY OR LABORING PATIENTS

In accordance with federal law, I understand my right to receive an appropriate medical screening examination performed by a physician or other qualified medical professional to determine whether I am suffering from an emergency medical condition. If such a condition exists, stabilizing treatment will be provided within the capabilities of this WellStar facility and its staff, even if I cannot pay for these services, do not have medical insurance coverage, or am not entitled to Medicare or Medicaid.

Eugene G Maurice	
Patient's Signature	Relationship to Patient
	

All Scans (continued)

Encounter-Level E-Signatures: (continued)

Section IV **ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY**

I assign any right I may have to receive payment from a health insurance plan, ERISA, Medicare, Medicaid, Social Security, or other payor(s) for services rendered by WellStar and the medical professionals caring for me during my treatment. I understand that I am financially responsible for all healthcare services, including amounts that are not covered by my health insurance plan or payor, as appropriate, based on the terms of the health plan contracts or the law. For example, the payment of non-covered services, deductibles, and co-payments is the patient's responsibility. For healthcare services provided by independent medical professionals, I understand that I will receive separate bills and that I am responsible for paying them. I agree to provide WellStar with all health insurance coverage information if I choose to use my insurance for payment of services. I agree to respond to all requests for benefit information and complete any forms required by my insurance plan. I am responsible for understanding and following the terms of my health insurance plan. I authorize WellStar and its medical professionals to submit appeals for payment, including arbitration and formal complaints, on my behalf as required by my insurance company. I also understand that I am financially responsible for collection costs if my account becomes delinquent and that all delinquent accounts will bear interest at the legal rate, unless prohibited by law. I understand that WellStar may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options.

For Medicare/Medicaid Patients: I certify that the information given by me in applying for payment under Title XVII and XIX of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to WellStar or the independent medical professionals providing healthcare services to me. I understand that I am responsible for any remaining balance not covered by other insurance.
If I am signing this form and am not the patient, I understand that I am also responsible for and agree to pay charges not covered by the assignments made in this Section IV, including any Medicare deductibles.

Section V **FINANCIAL ASSISTANCE STATEMENT**

It is WellStar's policy to provide medical care at no cost to qualified members of the WellStar-served communities, and to provide significantly discounted medical care to certain qualified members of our communities faced with financial hardship due to medical misfortune, according to policy. I understand that if payment of my bill creates a financial hardship, I may qualify for assistance with all or part of my medical expenses associated with my treatment at a WellStar facility and that I can call 678-838-5750 for more information.

(Patient Initials) 

Section VI **CONSENT TO PHOTOGRAPHY AND VIDEOTAPING**

Sometimes, WellStar facilities and physicians use patient photographs and videos for identification, clinical, educational, or research-related purposes. These photographs, recordings or videos could be in digital or other formats and may be reproduced for scientific or treatment reasons. I consent to having photographs, recordings or videos taken for patient care, educational, research, or other clinical benefits.

Section VII **NOTICE REGARDING RELEASE OF HEALTH INFORMATION**

As explained in WellStar's Notice of Privacy Practices, WellStar may use and disclose medical information including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), to physicians or other healthcare providers for the purposes of providing treatment, and to payors for the purposes of payment for medical treatment. HIPAA also permits WellStar and its affiliated companies to use medical information for healthcare operations. I expressly authorize WellStar's use and disclosure of my medical information as described in this Section VII.

All Scans (continued)

Encounter-Level E-Signatures: (continued)

Section VIII INPATIENT INFORMATION

I have received a copy of the Patient Admission Packet that includes "Patient Rights and Responsibilities" and information regarding Advance Care Planning. If I am a Medicare beneficiary, I have also received a notice entitled "Important Message from Medicare."

Section IX ADVANCE DIRECTIVE

I have an Advance Directive
Yes:
No:

If yes; I will provide a copy to WellStar. I have been advised that WellStar does not honor Advance Directives in Pre-admission Testing or in the Outpatient Diagnostics and Treatment setting.

Section X PERSONAL VALUABLES

I understand that WellStar is not liable or responsible for lost or damaged personal belongings and valuables (for example, money, jewelry, hearing aids, or dentures) unless placed in a WellStar safe. I will ask family members or friends to take home my personal belongings and valuables. I also understand and will inform the staff if I have dentures, eyeglasses, contact lenses, prosthetics or other items that I need to retain close by for personal functioning to assure safekeeping.

Section XI CONSENT TO CONTACT

By providing a telephone number, I expressly consent and authorize WellStar Health System, any practitioner or clinical provider as well as any of their related entities, agents, or contractors including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I am providing today, have provided previously, or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have to the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by or associated with me and obtained through any source including but not limited to any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically and claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent that I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical, and education information including exchange news, changes to health care law, health care coverage, care followup, and other health care opportunities, goods, and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C. § 7701, et seq. By providing an email address, I represent that I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a telephone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Provider immediately of any change in telephone

All Scans (continued)

Encounter-Level E-Signatures: (continued)

number or email address.

I confirm that I have read and understood and accept the terms of this document, that I am the patient or patient's representative, and that I am authorized to sign this document and accept its terms.

Eugene G Maurice	
Patient's Signature	Relationship to Patient
 Signature captured with Topaz by Maurice,Eugene G at 11/1/2017 6:39:17 AM	 Signature captured with Topaz by Maurice,Eugene G at 11/1/2017 6:39:17 AM

All Scans (continued)

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	**OP**		Unit:	**KHUROPROC**
Hospital Service:	**No service for patient encounter.**		Bed:	**Room/bed info not found**
Admitting Provider:			Referring Physician:	**Dusseault, Beau N**
Attending Provider:	**Beau n dusseault;Nikolas***	AD: N	Adm Diagnosis:	**Elevated PSA [R97.20]**
Admission Date:	**1/16/2018**		Admission Time:	**0123**

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:	

SECONDARY INSURANCE

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

Admission Information

Arrival Date/Time:		Admit Date/Time:	01/16/2018 0123	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Outside Hospital	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Kennestone Urology Procedure Center
Admit Provider:		Attending Provider:	Beau N Dusseault, MD	Referring Provider:	Beau N Dusseault, MD

Reason for Visit

Post-op Check

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
01/23/2018 2359	Home Or Self Care	None	None	WellStar Kennestone Urology Procedure Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
C61 [Principal]	Malignant neoplasm of prostate				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
I48.91	Unspecified atrial fibrillation				
E11.9	Type 2 diabetes mellitus without complications				
I10	Essential (primary) hypertension				
B19.9	Unspecified viral hepatitis without hepatic coma				
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.01	Long term (current) use of anticoagulants	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			

Events

Hospital Outpatient at 1/16/2018 0123

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient

Discharge at 1/23/2018 2359

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient

Allergies as of 1/23/2018

Reviewed on 1/19/2018

No Known Allergies

Immunizations as of 1/23/2018

Immunizations never marked as reviewed

Annual Influenza

All Scans (continued)

Immunizations (continued) as of 1/23/2018

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
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 1/23/2018

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

All Scans (continued)

Medical as of 1/23/2018 (continued)

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 [I21.9]	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

Chief Complaint

Complaint	Onset	Comment	Last Edited By	Time	Relationship	ED Provider
Post-op Check	1/16/2018		Julie K Cooper, RN	1/18/2018 10:11 AM	None	No

ED Disposition

None

H&P - Encounter Notes

H&P by Nikolas P Symbas, MD at 1/16/2018 7:55 AM

Author: Nikolas P Symbas, MD
Filed: 1/16/2018 7:56 AM
Editor: Nikolas P Symbas, MD (Physician)
Service: Urology
Date of Service: 1/16/2018 7:55 AM
Author Type: Physician
Status: Signed

Chief complaint: Elevated PSA

History of Present Illness:

Elevated PSA
-no symptoms
-no fhx prostate cancer
-TRUS bx (-) 11/16/16
-TRUS volume 40gm 11/16

MRI PR4 anterior central lesion

Lab Results

Component	Value	Date
PSA	6.5 (H)	05/30/2017

PSA	5.3 (H)	09/27/2016
PSA	5.2 (H)	03/17/2016
PSA	3.9	02/04/2015
PSA	4.1 (H)	05/15/2014

PMHx

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem list.

Examination:

Visit Vitals

BP	130/67
Pulse	65
Ht	67" (1.702 m)
Wt	96.6 kg (213 lb)
BMI	33.36 kg/m²

Constitutional: Normal development/nutrition
General: No acute distress
Abdomen: Non-tender to palpation
Musculoskeletal: Normal gait and station
Neurologic: CN grossly intact
Psychiatric: Normal judgement/insight, alert and oriented, appropriate mood/affect

Urinalysis:

In-Office UA results:

Assessment/Plan:

Elevated PSA
-if continuing to climb then plan for MRI prostate fusion

H&P - Encounter Notes (continued)

H&P by Nikolas P Symbas, MD at 1/16/2018 7:55 AM (continued)

I discussed risks, benefits and alternative treatments with the patient and the patient elected to proceed with the documented plan. All questions were answered.

Electronically Signed by Nikolas P Symbas, MD on 1/16/2018 7:56 AM

Interval H&P Note - Encounter Notes

Interval H&P Note by Nikolas P Symbas, MD at 1/16/2018 7:56 AM

Author: Nikolas P Symbas, MD | Service: Urology | Author Type: Physician
Filed: 1/16/2018 7:56 AM | Date of Service: 1/16/2018 7:56 AM | Status: Signed
Editor: Nikolas P Symbas, MD (Physician)

H & P reviewed, patient examined, and patient's condition unchanged

Nikolas P Symbas, MD January 16, 2018 7:56 AM

Electronically Signed by Nikolas P Symbas, MD on 1/16/2018 7:56 AM

Source Note

Author: Nikolas P Symbas, MD | Service: Urology | Author Type: Physician
Filed: 1/16/2018 7:56 AM | Date of Service: 1/16/2018 7:55 AM | Status: Signed
Editor: Nikolas P Symbas, MD (Physician)

Chief complaint: Elevated PSA

History of Present Illness:

Elevated PSA
-no symptoms
-no fhx prostate cancer
-TRUS bx (-) 11/16/16
-TRUS volume 40gm 11/16

MRI PR4 anterior central lesion

Lab Results

Component	Value	Date
PSA	6.5 (H)	05/30/2017
PSA	5.3 (H)	09/27/2016
PSA	5.2 (H)	03/17/2016
PSA	3.9	02/04/2015
PSA	4.1 (H)	05/15/2014

PMHx

The following portions of the patient's history were reviewed and updated as appropriate: allergies, current medications, past family history, past medical history, past social history, past surgical history and problem

list.

Examination:

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Urinalysis:

In-Office UA results:

Assessment/Plan:

Elevated PSA
-if continuing to climb then plan for MRI prostate fusion

I discussed risks, benefits and alternative treatments with the patient and the patient elected to proceed with the documented plan. All questions were answered.

Electronically Signed by Nikolas P Symbas, MD on 1/16/2018 7:56 AM

Discharge Instr - Activity - Encounter Notes (continued)

Discharge Instr - Activity by Ramona McNeil, RN at 1/16/2018 8:40 AM

Author: Ramona McNeil, RN | Service: — | Author Type: Registered Nurse
Filed: 1/16/2018 8:40 AM | Date of Service: 1/16/2018 8:40 AM | Status: Written
Editor: Ramona McNeil, RN (Registered Nurse)

Discharge Instructions

1. General Anesthesia or Sedation

Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity

You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet

Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan

Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.

Prescriptions

Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care

Your physician may call you with biopsy results.

Special Complications to Watch For

You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.

Discharge Instr - Activity - Encounter Notes (continued)

Discharge Instr - Activity by Ramona McNeil, RN at 1/16/2018 8:40 AM (continued)

If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

Electronically Signed by Ramona McNeil, RN on 1/16/2018 8:40 AM

Surgery Report

General Information

Date: 1/16/2018
Location: WS Kennestone Urology Procedure at Tower Road
Patient class:

Time:
Room:
Case classification:

Status: Posted
Service:

Diagnosis Information

No post-op diagnosis codes associated with the log.

Case Tracking Events

Event	Time In
In Facility	0123
In Pre-Procedure	
In Block Room	
Out Block Room	
Pre-Procedure Complete	
Out of Pre-op	
Anesthesia Ready	
In Room	
Anesthesia Start	0803
Procedure Start	
Procedure End	
Out of Room	
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	0829
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Remove from Status Board	
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	
Moderate Sedation Begin	
Moderate Sedation End	

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)

Surgery Report (continued)

PNDS Information (continued)

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)

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: No

Pre-Procedure Verification

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

Verification Date and Time: 1/16/2018 8:10 AM

Anesthesia Encounters

Anesthesia Encounter - Episode ID 25701924

Anesthesia Summary - Maurice, Eugene George [561253820] Male 69 y.o.

Current as of 01/16/18 0749

Height: 67" (1.702 m) (01/16/18)
Weight: 94.8 kg (209 lb) (01/16/18)
BMI: 32.7 (01/16/18)
NPO Status: Not recorded
Allergies: No Known Allergies

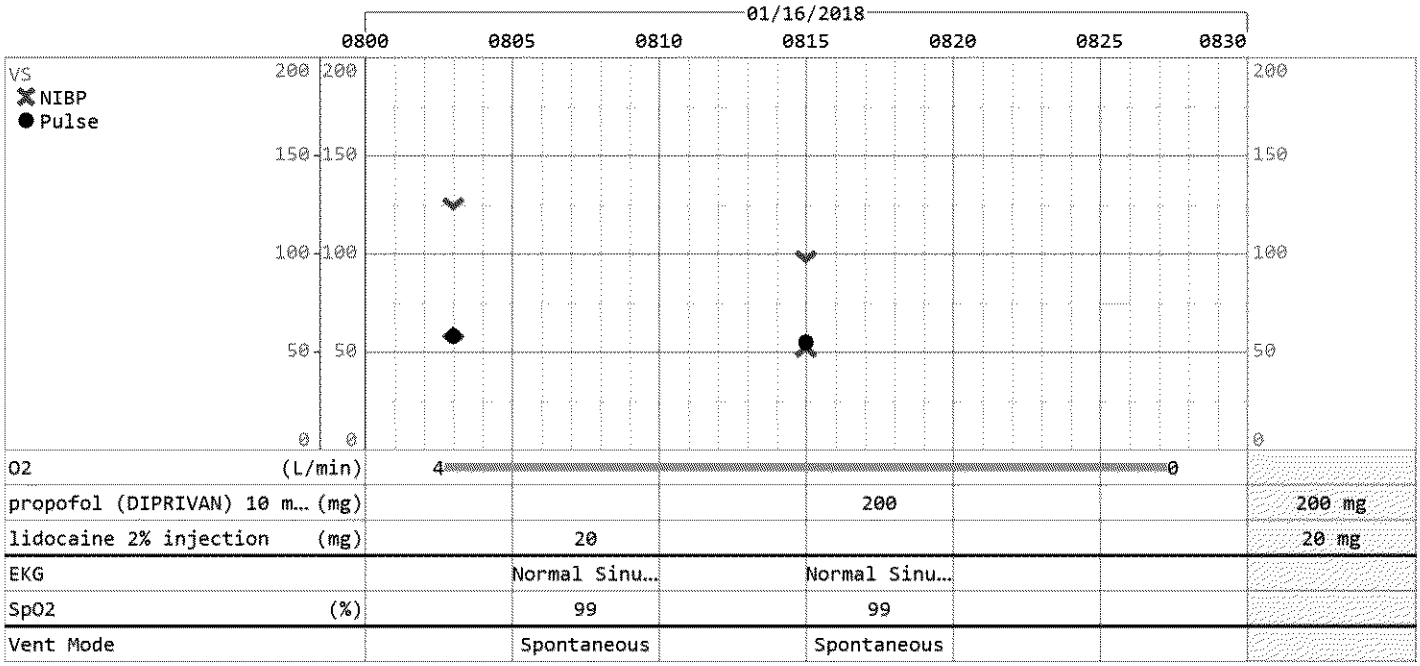
Procedure Summary

Date: 01/16/18
Anesthesia Start: 0803
Procedure: KUP PROSTATE BIOPSY W NDL

Scheduled Providers: Nikolas P Symbas, MD; Ashkan Yazdanpanah, DO
Anesthesia Type: MAC

Room / Location: WellStar Kennestone Urology Procedure Center
Anesthesia Stop: 0829
Diagnosis:
Elevated PSA
Abnormal MRI, pelvis
Responsible Provider: Ashkan Yazdanpanah, DO
ASA Status: 4

Anesthesia Encounter - Episode ID 25701924 (continued)



Staff

01/16/18

Name	Role	Begin	End
Ashkan Yazdanpanah, DO	ANMD	0803	0829

Events

Date	Time	Event
1/16/2018	0749	Signed/Cosigned and Ready for Procedure
	0803	Anesthesia Start
	0805	Induction
	0811	Start Data Collection
	0826	Stop Data Collection
	0829	Handoff to Receiving Nurse I completed my handoff to the receiving nurse during which we: 1. Identified the patient 2. Identified the responsible providers 3. Discussed the surgical procedure and course 4. Reviewed the pertinent medical history and allergies 5. Reviewed intra-op anesthesia management (airway, medications and I&O) 6. Reviewed nerve block expectations (when applicable) 7. Set expectations for post-procedure period and reviewed post-op orders 8. Allowed opportunity for questions and acknowledgement of understanding
	0829	Anesthesia Stop

Anesthesia Medical History

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) (HCC)
Obesity	Hypertension
Hyperlipidemia	CAD (coronary artery disease)
Infectious viral hepatitis	Diabetes mellitus (HCC)
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	AKI (acute kidney injury) (HCC)
Cataracts, both eyes	Gout

Substance History

Smoking Status: Former Smoker - 25 pack years

Anesthesia Encounter - Episode ID 25701924 (continued)

Substance History (continued)

Quit Smoking: 04/07/92
Smokeless Tobacco Status: Never Used
Alcohol use: Yes; 4.0 standard drinks per week
Drug use: No

Surgical History

APPENDECTOMY	CORONARY ARTERY BYPASS GRAFT
CAROTID ENDARTERECTOMY	CORONARY STENT PLACEMENT
COLONOSCOPY	shingles
EGD	VASCULAR SURGERY

Facility Administered Medications

Taken on 01/16/18

gentamicin (GARAMYCIN) injection 40 mg/mL
lactated Ringers infusion

Prescription Medications

Within last 14 days from 01/16/18

	Last Taken	Last Updated
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	Past Week	01/16/18 0727
~~apixaban (ELIQUIS) 5 mg tablet (Discontinued)~~		
apixaban (ELIQUIS) 5 mg tablet	Past Week	01/16/18 0727
aspirin, buffered 81 mg Tab	Past Week	01/16/18 0727
~~atorvastatin (LIPITOR) 80 MG tablet (Discontinued)~~		
atorvastatin (LIPITOR) 80 MG tablet	1/15/2018	01/16/18 0727
blood sugar diagnostic (GLUCOSE BLOOD) strip	1/16/2018	01/16/18 0727
blood sugar diagnostic strip	1/16/2018	01/16/18 0727
~~carvedilol (COREG) 12.5 MG tablet (Discontinued)~~		
carvedilol (COREG) 12.5 MG tablet	1/16/2018	01/16/18 0727
~~chlorthalidone (HYGROTEN) 50 MG tablet (Discontinued)~~		
chlorthalidone (HYGROTEN) 50 MG tablet	1/16/2018	01/16/18 0727
~~cilostazol (PLETAL) 100 MG tablet (Discontinued)~~		
cilostazol (PLETAL) 100 MG tablet	Past Week	01/16/18 0727
~~isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet (Discontinued)~~		
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	1/16/2018	01/16/18 0727
~~metFORMIN (GLUCOPHAGE) 500 MG tablet (Discontinued)~~	~~Taking~~	~~12/08/17 0918~~
~~metFORMIN (GLUCOPHAGE) 500 MG tablet (Discontinued)~~		
metFORMIN (GLUCOPHAGE) 500 MG tablet	1/15/2018	01/16/18 0727
~~nitroglycerin (NITROSTAT) 0.4 MG SL tablet (Discontinued)~~	~~As needed~~	~~12/08/17 0918~~
~~ramipril (ALTACE) 10 MG capsule (Discontinued)~~	~~Taking~~	~~12/08/17 0918~~
ramipril (ALTACE) 10 MG capsule	1/16/2018	01/16/18 0727

Preprocedure Vitals

Current as of 01/16/18 0749

BP: 123/60
Resp: 18
Temp: 97.7 °F (36.5 °C)
Height: 67" (1.702 m) (01/16/18)
BMI: **32.7**
Last edited 01/16/18 0727 by RM

Pulse: 55
SpO2: 99

Weight: 94.8 kg (209 lb) (01/16/18)
IBW: 66.1 kg (145 lb 12.2 oz)

Blood Orders

Ordered in last 14 days - Current as of 04/09/20 0952

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	13.3 ▼
HCT	--

Anesthesia Encounter - Episode ID 25701924 (continued)

Hematology Labs (continued) (Last 90 days)

	03/17 0914
	--

Electrolyte Labs (Last 90 days)

	03/17 0914
K+	5.2 ^
Na+	--
Cl-	--
HCO3	--

Procedure Notes

No procedure notes have been written.

Preprocedure Note

Last edited 01/16/18 0816 by Ashkan Yazdanpanah, DO
Date of Service 01/16/18 0744
Status: Addendum

Anesthesia Pre-op Evaluation

Patient Name: Eugene G Maurice
Date of Birth: 1/2/1949 **Age:** 69 yrs **Sex:** Male
MRN: 561253820

Pre-Assessment Information

No Known Allergies

Relevant Problems

(+) Controlled type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, without long-term current use of insulin (HCC)
(+) Coronary arteriosclerosis
(+) Coronary artery disease involving native coronary artery of native heart without angina pectoris
(+) Essential hypertension with goal blood pressure less than 130/85

Past Medical History:

Diagnosis	Date

- CAD (coronary artery disease)
- Coronary atherosclerosis of native coronary artery

Anesthesia Encounter - Episode ID 25701924 (continued)

Preprocedure Note (continued)

Diabetes mellitus (HCC)
- Essential hypertension, benign
- Family history of ischemic heart disease
- Hyperlipidemia
- Hypertension
- Infectious viral hepatitis
  as teen/cannont recall what type
- Obesity
- Other and unspecified hyperlipidemia
- Other symptoms involving cardiovascular system
- PVD (peripheral vascular disease) (HCC)

Past Surgical History:

Procedure	Laterality	Date
APPENDECTOMY		
CAROTID ENDARTERECTOMY *x2*		
COLONOSCOPY *as of 9/2014 has not had this*		
CORONARY ARTERY BYPASS GRAFT *X6*		1992
CORONARY STENT PLACEMENT *sheikh*		2014
shingles		9/2015

Social History Main Topics

- Smoking status: Former Smoker
  - Packs/day: 1.00
  - Years: 25.00
  - Types: Cigarettes
  - Quit date: 4/7/1992
- Smokeless tobacco: Never Used
- Alcohol use 2.4 oz/week
  2 Glasses of wine, 2 Shots of liquor per week
- Drug use: No
- Sexual activity: Not on file

Documented NPO status:
No Data Recorded

Pre-operative Evaluation

Review of Systems/Medical History

Anesthesia Encounter - Episode ID 25701924 (continued)

Preprocedure Note (continued)

General: Patient summary reviewed and Nursing notes reviewed.
Anesthesia History: No history of anesthetic complications. Patient has no family history of anesthetic complications. No PONV
Cardiovascular:
(+) hypertension: atrial fibrillation, CAD, angina,

Pulmonary: Negative ROS

Neuro/Psych: - Negative ROS

GI/Hepatic/Renal:
(+) hepatitis,

Endo/Other:
(+) diabetes mellitus

Additional Findings: Unstable angina needs ntg
Last 2 days ago

Physical Exam

Airway:
Mallampati: II
Neck ROM: full
TM distance: >3 FB

Cardiovascular: normal exam
Rhythm: regular
Rate: normal

Pulmonary: normal exam
Respiratory Effort: normal
Breath sounds clear to auscultation.

Anesthesia Encounter - Episode ID 25701924 (continued)

Preprocedure Note (continued)

Patient does not have: wheezes

Anesthesia Plan

ASA: 4
Anesthetic Plan: MAC

Airway Management: supplemental O2
Premedication planned: none
Induction: Intravenous

Anesthetic plan and risks discussed with: Patient.

Electronically signed by Ashkan Yazdanpanah, DO at 1/16/2018 8:16 AM

All Postprocedure Notes

Last edited 01/16/18 0927 by Ashkan Yazdanpanah, DO
Date of Service 01/16/18 0927
Status: Signed

Patient: Eugene G Maurice
* No procedures listed *
Anesthesia type: MAC

Patient location: PACU
Post vital signs: post-procedure vital signs reviewed and stable
Level of consciousness: awake, alert and oriented
Post-anesthesia pain: adequate analgesia
Airway patency: patent
Respiratory: room air and unassisted
Cardiovascular: blood pressure at baseline and stable
Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting
Anesthetic complications: No

Anesthesia Encounter - Episode ID 25701924 (continued)

All Postprocedure Notes (continued)

Electronically signed by Ashkan Yazdanpanah, DO at 1/16/2018 9:27 AM

Attestation Information

Staff Name	Date	Time	Type
Ashkan Yazdanpanah, DO	01/16/18	0749	Pre-Induction Assessment
Ashkan Yazdanpanah, DO	01/16/18	0750	Intra-operative Monitoring
Ashkan Yazdanpanah, DO	01/16/18	0750	Personally Performed

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
propofol (DIPRIVAN) 10 mg/mL injection (mg)	200 mg	Given	01/16/18 0817	Ashkan Yazdanpanah, DO	
lidocaine 2% injection (mg)	20 mg	Given	01/16/18 0805	Ashkan Yazdanpanah, DO	

Signoff Status

None

Flowsheets (all recorded)

Agents

Row Name	01/16/18 0826	01/16/18 0803
Agents		
O2	0 L/min -AY	4 L/min -AY

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	01/16/18 0000
Anesthesia Checklist	
Monitors In Use	Anesthesia apparatus checked;Pulse oximeter;O2 analyzer -AY
NIBP Site	Arm R -AY
Cardiac	EKG -AY
Leads	3 -AY

Flowsheets (all recorded)

Agents

Row Name	01/16/18 0826	01/16/18 0803
Agents		
O2	0 L/min -AY	4 L/min -AY

Flowsheets (all recorded)

BP/Pulse

Row Name	01/16/18 0815	01/16/18 0803
BP/Pulse		
NIBP	96/53 -AY	123/62 -AY
Pulse	55 -AY	58 -AY

Flowsheets (all recorded)

Positioning

Row Name	01/16/18 0811
OTHER	
Position	Lateral -AY

Flowsheets (all recorded)

Anesthesia Monitoring

Row Name	01/16/18 0815	01/16/18 0807
Assessment		
EKG	Normal Sinus Rhythm -AY	Normal Sinus Rhythm -AY
Respiratory		
Vent Mode	Spontaneous -AY	Spontaneous -AY
OTHER		
SpO2	99 % -AY	99 % -AY

User Key

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

Initials	Name	Effective Dates
AY	Ashkan Yazdanpanah, DO	01/05/18 - 03/05/18

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Procedures - Orders and Results

EKG SCAN [720826902]

Electronically signed by: **Interface, Transcription Incoming on 01/18/18 1334**
Status: **Completed**
Ordering user: Interface, Transcription Incoming 01/18/18 1334
Ordering provider: Provider Scan
Authorized by: Provider Scan
Ordering mode: Standard
Frequency: -
Quantity: 1
Lab status: Final result

Scan on 1/18/2018 1:34 PM (below)

EKG SCAN [720826902]
Resulted: 01/18/18 1334, Result status: Final result

Ordering provider: Provider Scan 01/18/18 1334
Order status: Completed
Filed by: Interface, Transcription Incoming 01/18/18 1338
Result details

Nursing - Orders and Results

MAINTAIN IV ACCESS [720826879]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Ramona McNeil, RN
Ordering user: Ramona McNeil, RN 01/16/18 0717
Ordering provider: Ashkan Yazdanpanah, DO
Authorized by: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

PATIENT EDUCATION (SPECIFY) [720826881]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0717**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 01/09/18 1016
Ordering provider: Nikolas P Symbas, MD
Authorized by: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

Nursing - Orders and Results (continued)

PATIENT EDUCATION (SPECIFY) [720826881] (continued)

Order comments: On preparation for the procedure as well as discharge instructions

Point of Care Testing - Orders and Results

POCT URINALYSIS DIPSTICK [720826883]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0717**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/09/18 1016
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

Status: **Discontinued**
Communicated by: Sharon H Crider, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM

IV - Orders and Results

INSERT PERIPHERAL IV [720826878]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Ramona McNeil, RN 01/16/18 0717
Authorized by: Ashkan Yazdanpanah, DO
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

Status: **Discontinued**
Communicated by: Ramona McNeil, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM

INT [720826880]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Ramona McNeil, RN 01/16/18 0717
Authorized by: Ashkan Yazdanpanah, DO
Quantity: 1
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

Status: **Discontinued**
Communicated by: Ramona McNeil, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM

Imaging - Orders and Results

KUP PROSTATE BIOPSY W NDL [720826866]

Electronically signed by: **Beau N Dusseault, MD on 12/10/17 1604**
Ordering user: Beau N Dusseault, MD 12/10/17 1604
Ordering mode: Standard
Quantity: 1
Instance released by: Chastity Payton 1/16/2018 6:51 AM
Diagnoses
Elevated PSA [R97.20]
Abnormal MRI, pelvis [R93.5]

Status: **Completed**
Authorized by: Beau N Dusseault, MD

Lab status: Final result

Questionnaire

Question	Answer
Do you have a joint replacement, pacemaker, or any hardware?	No
Have you ever had MRSA or VRE?	No
Have you had C-Diff with active diarrhea or been on treatment for C-diff in the last 6 months?	No

Scheduling instructions
MRI fusion
Abx: cipro, gent
With anesthesia
Lab Results

Component	Value	Date
PSA	7.4 (H)	10/10/2017

KUP PROSTATE BIOPSY W NDL [720826866]

Resulted: 01/16/18 0828, Result status: Final result

Order status: Completed
Resulted by: Nikolas P Symbas, MD

Imaging - Orders and Results (continued)

Filed by: Nikolas P Symbas, MD 01/16/18 0829
Accession number: 29005781
Narrative:
OPERATIVE NOTE

Performed: 01/16/18 0810 - 01/16/18 0823
Result details

Name: Eugene G Maurice
DOB: 1/2/1949
MRN: 561253820
DOS: 1/16/2018

Pre-operative Diagnosis: Elevated PSA.

Post-operative Diagnosis: Prostate nodule.

Surgeon: Nikolas P Symbas, MD

Assistants: None

Anesthesia: IV sedation

Operation:
1. Transrectal ultrasound for guidance of prostate biopsies
2. Transrectal prostate biopsies (with MRI fusion)
3. Periprostatic block for postoperative pain control
(55700, 76942, 64450)

Indications: Eugene G Maurice is a 69 y.o.male who presents for the above procedure due to the above diagnosis. I discussed risks (including specifically bleeding and infection), benefits and alternative treatments with the patient and the patient elected to proceed with the documented plan. All questions were answered.

Nodule: No on DRE 1/16/2018

Complications: None

EBL: less than 5 mL

IVF: Maintenance

Specimen: 12 cores of prostate tissue labeled by sextant, additional biopsies of MRI lesions labelled as:
1. PR4 lesion

Findings:
1. Prostate size: 31 cubic centimeters by MRI
2. PR4 lesion(s)/ROI(s) on MRI. Described as PIRADS 4.

Technique:
The patient confirmed compliance with preoperative enema and antibiotic. The patient was taken to the operative suite. After time out the patient underwent IV sedation per anesthesia. He was then placed in a lateral decubitus position. He was prepped and draped in the standard fashion in the left lateral decubitus position and time out was performed.

Perioperative antibiotics were given prior to the procedure.

The ultrasound probe (Phillips machine) was then placed in the rectum without difficulty. Subsequently 5 mL of 1% plain lidocaine was infiltrated using a spinal needle and ultrasonic guidance into the junction of the seminal vesicle and prostate gland on each side for intraoperative and post operative pain control.

The MR fusion was performed with the Phillips Invivo UroNav machine. After co-registering, the above mentioned lesions were targeted and mpMRI fusion directed samples of these lesions were taken and the needle paths were recorded in the software.

Next, sequential transverse (axial) scans were made in small increments beginning at the seminal vesicles and ending at the prostate apex. Sequential longitudinal (sagittal) scans were made in small increments beginning at the right lateral prostate and ending at the left lateral prostate. Excellent anatomical imaging was obtained with peripheral, transitional, and central zones well defined, as well as the seminal

Imaging - Orders and Results (continued)

vesicles.

Several biopsies were taken from each of the target lesions.

Six biopsies were obtained from the lateral part of each lobe at the apex, mid-gland, and base. Six biopsies were additionally taken from the medial part of each lobe spaced evenly from apex to base. Care was taken to avoid the urethra and bladder. Excellent biopsy specimens were obtained. The procedure was tolerated well and the patient transported to recovery in stable condition.

Appropriate patient post procedure education was provided prior to discharge.

Disposition:
1. Follow up with the Wellstar Urology office as previously directed
2. Discharge to home
3. Discharge condition: good
4. Medications: Resume previous medications but stay off of blood thinners until no blood in urine and stool.
5. Diet: resume previous
6. Activity: no strenuous physical activity for the next 48 hours.
Standard post-biopsy instructions given.

Nikolas P Symbas, MD
Wellstar Urology
(p) 770-428-4475
(f) 770-426-1499

Acknowledged by: Beau N Dusseault, MD on 01/16/18 1028

Pathology and Cytology - Orders and Results

SURGICAL PATHOLOGY-KH [720826893]

Electronically signed by: **Interface, Lab In Copath on 01/16/18 1435**
Ordering user: Interface, Lab In Copath 01/16/18 1435
Authorized by: Beau N Dusseault, MD
Quantity: 1
Instance released by: (auto-released) 1/16/2018 2:35 PM

Status: **Completed**
Ordering provider: Beau N Dusseault, MD
Ordering mode: Standard
Lab status: Edited Result - FINAL

Specimen Information

Type	Source	Collected By
---	---	01/16/18 1434

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

SURGICAL PATHOLOGY-KH [720826893]

Resulted: 01/17/18 1338, Result status: Edited Result - FINAL

Ordering provider: Beau N Dusseault, MD 01/16/18 1435
Filed by: Interface, Lab In Copath 03/15/18 1358
Result details
Acknowledged by
Bradley S McCowan, MD on 03/15/18 1529
Beau N Dusseault, MD on 03/19/18 1549

Order status: Completed
Resulting lab: WELLSTAR

Specimen Information

Type	Source	Collected By
---	---	01/16/18 1434

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

Components

Component	Value	Reference Range	Flag	Lab
SURGICAL PATHOLOGY-KH	---	---	---	Wellstar

Comment:
WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Pathology and Cytology - Orders and Results (continued)

Phone Number: (770) 793-5505
Fax Number: (770) 793-7919 David Schlosnagle, M.D., Laboratory Director
Patient Name: MAURICE, EUGENE G Accession #: KS18-792 Patient #: 2081927043\561253820\1\3\ MRN. #: 561253820 Sex: M Location: UASC (KH)
DOB/Age: 1/2/1949 (Age: 69) Location: UASC (KH) Client: Wellstar Kennestone
Hospital Received: 1/16/2018 Admitting Date: 1/16/2018 Collected: 1/16/2018
Final Report: 1/17/2018 13:38 Order Physician: BEAU N DUSSEAULT Admit MD: NIKOLAS P. SYMBAS Other Inst: <Not Provided> Copy To: <Not Provided>

SURGICAL PATHOLOGY-KH REPORT
Pre-Operative Diagnosis:
<Not Provided>
Post-Operative Diagnosis:
<Not Provided>
Clinical History:
Elevated PSA; Value (7.4) - 790.93; DECIPHER
Specimen:
Prostate biopsy x13
Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maur ice	LB	13	1A
2. Maurice	LM	16 and 3	2A
3. Maurice	LA	16	3A
4. Maurice	RB	16	4A
5. Maurice	RM	14	5A
6. Maurice	RA	13 and 4	6A
7. Maurice	LLB	12	7A
8. Maurice	LLM	15	8A
9. Maurice	LLA	18	9A
10. Maurice	RLB	14	10A
11. Maurice	RLM	16	11A
12. Maurice	RLA	19	12A
13. Maurice	#1ACZP4	21, 12, 10, 7, 6 and 3	13A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The spec imens are inked purple. cs/ch 1/16/18
Microscopic Description:
1-13. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis.
Dr. Jonathon Herbst has reviewed 13A and concurs in the diagnosis of adenocarcinoma.
13A will be sent for Decipher testing.

Final Diagnosis:
PROSTATE, BIOPSIES x13: PROSTATIC ADENOCARCINOMA IN ONE OF THIRTEEN PARTS
1. PROSTATE, LEFT BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
2. PROSTATE, LEFT MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
3. PROSTATE, LEFT APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
4. PROSTATE, RIGHT BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
5. PROSTATE, RIGHT MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
6. PROSTATE, RIGHT APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
7. PROSTATE, LEFT LATERAL BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
8. PROSTAT
E, LEFT LATERAL MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
9. PROSTATE, LEFT LATERAL APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
10. PROSTATE, RIGHT LATERAL BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
11. PROSTATE, RIGHT LATERAL MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
12. PROSTATE, RIGHT LATERAL APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
13. PROSTATE, #1ACZP4, NEEDLE CORE BIOPSY:
- PROSTATIC ADENOCARCINOMA, GLEASON SCORE 6 (3+3), INVOLVING 10% (2 MM) IN 1 OF FIVE CORES.
- ISUP PROGNOSTIC GRADE GROUP 1.

Electronically Signed Out By Burton H. Kim, M.D.
BHK 1/17/2018
Burton H.
Kim, M.D.
CPT: 1: G0416, OTH-K
13: 82859, MT
Addendum
Addendum Comment:
Decipher Biopsy Test is performed (block 13A) at GenomeDX Biosciences Inc. 10355

Pathology and Cytology - Orders and Results (continued)

Science Center Dr Suite 240, San Diego, CA 92121 by
Doug Dolginow, M.D. as
follows. Please see separate report for additional information.
Your Decipher Result - Genomic Low Risk
Decipher Score 0.21
Risk at RP - Percent Likelihood
High Grade Disease (primary Gleason grade 4 or 5) 11.7%
5- Year Metastasis 0.9%
10-Year Prostate Cancer Specific Mortality 1.7%
These results were reported by GenomeDX Biosciences on 2/1/18, and the report was received by WellStar Pathology on 3/15/18.
BHK/gpr 3/15/18
ANAC
Procedure Sign Out Date: 3/15/2018
Electronically Signed By Marla J. Franks, M.D.
Burton H. Kim, M.D.

View Image (below)

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (770) 793-7919

David Schlosnagle, M.D., Laboratory Director

Patient Name:	**MAURICE, EUGENE G**			Accession #:	**KS18-792**
Patient #:	208192704\3\561253820\1\3\	MRN. #:	561253820	Sex:	M
Location:	UASC (KH)	DOB/Age:	1/2/1949 (Age: 69)		
Location:	UASC (KH)	Client:	Wellstar Kennestone Hospital	Received:	1/16/2018
Admitting Date:	1/16/2018	Collected:	1/16/2018	Final Report:	1/17/2018 13:38
Order Physician:	BEAU N DUSSEAULT	Admit MD:	NIKOLAS P. SYMBAS	Other Inst:	<Not Provided>
		Copy To:	<Not Provided>		

SURGICAL PATHOLOGY-KH REPORT

Pre-Operative Diagnosis:
<Not Provided>

Post-Operative Diagnosis:
<Not Provided>

Clinical History:
Elevated PSA; Value (7.4) - 790.93; DECIPHER

Specimen:
Prostate biopsy x13

Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice	LB	13	1A
2. Maurice	LM	16 and 3	2A
3. Maurice	LA	16	3A
4. Maurice	RB	16	4A
5. Maurice	RM	14	5A
6. Maurice	RA	13 and 4	6A
7. Maurice	LLB	12	7A
8. Maurice	LLM	15	8A
9. Maurice	LLA	18	9A
10. Maurice	RLB	14	10A
11. Maurice	RLM	16	11A
12. Maurice	RLA	19	12A
13. Maurice	#1ACZP4	21, 12, 10, 7, 6 and 3	13A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are inked purple. cs/ch 1/16/18

Microscopic Description:
1-13. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis.
Dr. Jonathon Herbst has reviewed 13A and concurs in the diagnosis of adenocarcinoma.
13A will be sent for Decipher testing.

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
Phone Number: (770) 793-5505 677 Church Street
Fax Number: (770) 793-7919 Marietta, Georgia 30060 David Schlosnagle, M.D., Laboratory Director

Final Diagnosis:

PROSTATE, BIOPSIES x13: PROSTATIC ADENOCARCINOMA IN ONE OF THIRTEEN PARTS

1. PROSTATE, LEFT BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
2. PROSTATE, LEFT MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
3. PROSTATE, LEFT APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
4. PROSTATE, RIGHT BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
5. PROSTATE, RIGHT MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
6. PROSTATE, RIGHT APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
7. PROSTATE, LEFT LATERAL BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
8. PROSTATE, LEFT LATERAL MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
9. PROSTATE, LEFT LATERAL APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
10. PROSTATE, RIGHT LATERAL BASE, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
11. PROSTATE, RIGHT LATERAL MID, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
12. PROSTATE, RIGHT LATERAL APEX, NEEDLE CORE BIOPSY: BENIGN PROSTATIC TISSUE.
13. PROSTATE, #1ACZP4, NEEDLE CORE BIOPSY:
- PROSTATIC ADENOCARCINOMA, GLEASON SCORE 6 (3+3), INVOLVING 10% (2 MM) IN 1 OF FIVE CORES.
- ISUP PROGNOSTIC GRADE GROUP 1.

****Electronically Signed Out By Burton H. Kim, M.D.****
BHK 1/17/2018 Burton H. Kim, M.D.

CPT: 1: G0416, OTH-K
13: 82859, MT

Addendum

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
Phone Number: (770) 793-5505 677 Church Street
Fax Number: (770) 793-7919 Marietta, Georgia 30060 David Schlosnagle, M.D., Laboratory Director

Addendum Comment:
Decipher Biopsy Test is performed (block 13A) at GenomeDX Biosciences Inc. 10355 Science Center Dr Suite 240, San Diego, CA 92121 by Doug Dolginow, M.D. as follows. Please see separate report for additional information.

Your Decipher Result - Genomic Low Risk
Decipher Score 0.21

Risk at RP - Percent Likelihood

High Grade Disease (primary Gleason grade 4 or 5)	11.7%
5- Year Metastasis	0.9%
10-Year Prostate Cancer Specific Mortality	1.7%

These results were reported by GenomeDX Biosciences on 2/1/18, and the report was received by WellStar Pathology on 3/15/18.

BHK/gpr 3/15/18

ANAC

Procedure Sign Out Date: 3/15/2018

Electronically Signed By Marla J. Franks, M.D.
Burton H. Kim, M.D.

END OF REPORT

CORE MEASURES - Orders and Results

REASON FOR NO MECHANICAL PROPHYLAXIS [720826882]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0717** Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 01/09/18 1016 Ordering provider: Nikolas P Symbas, MD

CORE MEASURES - Orders and Results (continued)

REASON FOR NO MECHANICAL PROPHYLAXIS [720826882] (continued)

Authorized by: Nikolas P Symbas, MD
Quantity: 1
Ordering mode: Per protocol: cosign required
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM

Questionnaire

Question	Answer
If SCDs NOT ordered, indicate reason:	Total Risk Factor Score less than or equal to 1

REASON FOR NO VTE PROPHYLAXIS AT ADMISSION [720826884]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0717**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/09/18 1016
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Communicated by: Sharon H Crider, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 7:17 AM

Questionnaire

Question	Answer
Reason for no pharm VTE prophylaxis at admission?	Patient is at low risk for VTE - No pharm VTE Prophylaxis required

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [720826886]

Electronically signed by: **Interface, Lab In Sunquest on 01/16/18 0737**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 01/16/18 0737
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Instance released by: (auto-released) 1/16/2018 7:41 AM
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 0737

POC FINGER STICK GLUCOSE [720826886] (Abnormal)
Resulted: 01/16/18 0742, Result status: Final result

Ordering provider: Nikolas P Symbas, MD 01/16/18 0737
Filed by: Interface, Lab In Sunquest 01/16/18 0742
External ID: T15128554
Acknowledged by: Nikolas P Symbas, MD on 01/16/18 0753
Order status: Completed
Resulting lab: WS UROLOGY PROCEDURE CENTER
Result details

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 0737

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	101	70 - 99 mg/dL	H	UROPC
POC-OPERATOR'S ID	49156	—	—	UROPC

POC FINGER STICK GLUCOSE [720826891]

Electronically signed by: **Interface, Lab In Sunquest on 01/16/18 0914**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 01/16/18 0914
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Instance released by: (auto-released) 1/16/2018 9:18 AM
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 0914

Point of Care Testing-Docked Device - Orders and Results (continued)

POC FINGER STICK GLUCOSE [720826891] (continued)

POC FINGER STICK GLUCOSE [720826891] (Abnormal) — Resulted: 01/16/18 0918, Result status: Final result

Ordering provider: Nikolas P Symbas, MD 01/16/18 0914
Filed by: Interface, Lab In Sunquest 01/16/18 0918
External ID: T15129810
Acknowledged by: Nikolas P Symbas, MD on 01/16/18 0922

Order status: Completed
Resulting lab: WS UROLOGY PROCEDURE CENTER
Result details

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 0914

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	129	70 - 99 mg/dL	H	UROPC
POC-OPERATOR'S ID	49156	—	—	UROPC

Diet - Orders and Results

DIET, NPO [720826900]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Ramona McNeil, RN 01/16/18 0717
Authorized by: Ashkan Yazdanpanah, DO
Quantity: 1
Instance released by: Ramona McNeil, RN (auto-released) 1/16/2018 11:31 PM
Communicated by: Ramona McNeil, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Diet: NPO
Discontinued by: Automatic Discharge Provider 01/24/18 0433 [Patient Discharge]

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [720826871]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Ramona McNeil, RN 01/16/18 0717
Authorized by: Ashkan Yazdanpanah, DO
PRN reasons: line care
Frequency: Routine Q1 min PRN - 01/24/18 0428
Discontinued by: Automatic Discharge Provider 01/24/18 0428 [(Patient Discharge - Internal Use Only)]
Acknowledged: Ramona McNeil, RN 01/16/18 0717 for Placing Order
Admin instructions: INT Flush
Package: 8290-306547
Communicated by: Ramona McNeil, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Released by: Ramona McNeil, RN 01/16/18 0717

lactated Ringers infusion [720826872]

Electronically signed by: **Ashkan Yazdanpanah, DO on 01/16/18 1522** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Ramona McNeil, RN 01/16/18 0717
Authorized by: Ashkan Yazdanpanah, DO
Frequency: Routine Continuous 01/16/18 0800 - 01/24/18 0428
Discontinued by: Automatic Discharge Provider 01/24/18 0428 [(Patient Discharge - Internal Use Only)]
Acknowledged: Ramona McNeil, RN 01/16/18 0717 for Placing Order
Package: 0409-7953-09
Communicated by: Ramona McNeil, RN
Ordering provider: Ashkan Yazdanpanah, DO
Ordering mode: Per protocol: cosign required
Released by: Ramona McNeil, RN 01/16/18 0717

gentamicin (GARAMYCIN) injection 40 mg/mL [720826876]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0717** — Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/09/18 1016
Communicated by: Sharon H Crider, RN
Ordering provider: Nikolas P Symbas, MD

Medications - Orders and Results (continued)

gentamicin (GARAMYCIN) injection 40 mg/mL [720826876] (continued)

Authorized by: Nikolas P Symbas, MD
Frequency: Routine Once 01/16/18 0800 - 1 occurrence
Released by: Ramona McNeil, RN 01/16/18 0717
Acknowledged: Ramona McNeil, RN 01/16/18 0717 for Placing Order
Ordering mode: Per protocol: cosign required
Indications of use: prevention of perioperative infection

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Preop - Prophylaxis
Expected days of therapy:	1

Package: 63323-010-02

lidocaine (XYLOCAINE) local injection 2 % [720826887]

Electronically signed by: **Nikolas P Symbas, MD on 01/16/18 0826**
Mode: Ordering in Verbal with readback mode
Ordering user: Ramona McNeil, RN 01/16/18 0812
Authorized by: Nikolas P Symbas, MD
Frequency: Routine Once PRN 01/16/18 0812 - 01/16/18 0812
Status: **Completed**
Communicated by: Ramona McNeil, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Verbal with readback
Package: 0409-4277-02

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
12 - Wellstar	WELLSTAR	Unknown	Unknown	10/12/15 1541 - 12/02/19 1533
527 - UROPC	WS UROLOGY PROCEDURE CENTER	Unknown	300 TOWER RD, STE 150 MARIETTA GA 30060	02/22/17 1825 - 10/28/19 1240

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [720826871]

Ordering Provider: Ashkan Yazdanpanah, DO
Ordered On: 01/16/18 0717
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: - 01/24/18 0428
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

lactated Ringers infusion [720826872]

Ordering Provider: Ashkan Yazdanpanah, DO
Ordered On: 01/16/18 0717
Dose (Remaining/Total): 50 mL/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/16/18 0800 - 01/24/18 0428
Route: Intravenous
Rate/Duration: 50 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 01/16/18 22 G Right Wrist	01/16/18 0740 by Ramona McNeil, RN	—
Unlinked	01/16/18 0920 by Ramona McNeil, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 01/16/18 0920 Documented: 01/16/18 0920	Stopped	0 mL/hr 0 mL/hr	Intravenous	Performed by: Ramona McNeil, RN
Performed 01/16/18 0740 Documented: 01/16/18 0740	New Bag	50 mL/hr 50 mL/hr	Intravenous	Performed by: Ramona McNeil, RN

gentamicin (GARAMYCIN) injection 40 mg/mL [720826876]

Ordering Provider: Nikolas P Symbas, MD
Ordered On: 01/16/18 0717
Dose (Remaining/Total): 5 mg/kg (Adjusted) (0/1)
Frequency: Once

Status: Completed (Past End Date/Time)
Starts/Ends: 01/16/18 0800 - 01/16/18 0741
Route: Intravenous
Rate/Duration: — / —

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Preop - Prophylaxis	—
Expected days of therapy::	1	—

Line	Med Link Info	Comment
Peripheral IV 01/16/18 22 G Right Wrist	01/16/18 0741 by Ramona McNeil, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 01/16/18 0741 Documented: 01/16/18 0741	Given	390 mg	Intravenous	Performed by: Ramona McNeil, RN

lidocaine (XYLOCAINE) local injection 2 % [720826887]

Ordering Provider: Nikolas P Symbas, MD
Ordered On: 01/16/18 0812

Status: Completed (Past End Date/Time)
Frequency: Once as needed

Timestamps	Action	Dose	Route / Site	Other Information
Performed 01/16/18 0812 Documented: 01/16/18 0812	Given	10 mL	Other Other	Performed by: Nikolas P Symbas, MD Documented by: Ramona McNeil, RN Comments: prostate gland

Medications (continued)

All Meds and Administrations (continued)

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)

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 Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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)

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)

Patient Education (continued)

Education (continued)

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)

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

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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)

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: 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.

Patient Education (continued)

Education (continued)

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.

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.

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)

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: 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.

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.

Patient Education (continued)

Education (continued)

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: 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 Progress: Not documented in this visit.

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 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.

Patient Education (continued)

Education (continued)

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: 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.

Patient Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	01/16/18 0853	01/16/18 0839	01/16/18 0830	01/16/18 0727
Vitals				
Pct Wt Change	—	—	—	0 % -RM
OTHER				
Weight Change (kg)	—	—	—	0 kg -RM
Ideal Body Weight	—	—	—	160 lb -RM
Visit Weight	—	—	—	209 lb -RM
BMI (Calculated)	—	—	—	32.7 -RM
IBW/kg (Calculated) Male	—	—	—	66.1 kg -RM
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -RM
Weight/Scale Event	—	—	—	0 -RM
Weight in (lb) to have BMI = 25	—	—	—	159.3 -RM
% Weight Change Since Birth	—	—	—	0 -RM
Relevant Labs and Vitals				
Temp (in Celsius)	—	36.6 -RM	—	36.5 -RM
Adult IBW/VT Calculations				
IBW/kg (Calculated)	—	—	—	66.1 -RM
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -RM
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -RM
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -RM
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -RM
Case Log				
BSA x (CI @3.0)= CO	—	—	—	6.33 CO -RM
Aldrete Phase 1				
Aldrete Score	10 -RM	—	7 -RM	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	01/24/18 0228
OTHER	
Risk for Readmission	12 -BP

Flowsheets (all recorded)

Travel Information

Row Name	01/16/18 0727
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 -RM

Flowsheets (all recorded)

Aldrete Score

Row Name	01/16/18 0853	01/16/18 0830
Aldrete		
Activity	2 -RM	2 -RM
Respiration	2 -RM	2 -RM
Circulation	2 -RM	1 -RM
Consciousness	2 -RM	1 -RM
O2 Saturation	2 -RM	1 -RM
Aldrete Score (PAR)	10 -RM	7 -RM

Flowsheets (all recorded)

Vital Signs

Row Name	01/16/18 0911	01/16/18 0854	01/16/18 0839	01/16/18 0834	01/16/18 0829
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	54 -RM	53 -RM	52 -RM	52 -RM	54 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	18 -RM	18 -RM	17 -RM	16 -RM	16 -RM
BP	110/59 -RM	97/51 -RM	99/52 -RM	93/54 -RM	(!) 89/54 IVF KVO -RM
Calculated MAP	76 -RM	66.33 -RM	67.67 -RM	67 -RM	65.67 -RM
Temp	—	—	97.8 °F (36.6 °C) -RM	—	—
Temp src	—	—	Oral -RM	—	—
Oxygen Therapy					
SpO2	100 % -RM	99 % -RM	100 % -RM	97 % -RM	97 % -RM
O2 Device	None (Room air) -RM	None (Room air) -RM	Nasal cannula -RM	None (Room air) -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	—	1 L/min -RM	1 L/min -RM	1 L/min -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM

Row Name	01/16/18 0727
Vital Signs	
Automatic Restart Vitals Timer	Yes -RM
Pulse	55 -RM
Heart Rate Source	Monitor -RM
Resp	18 -RM
BP	123/60 -RM
Calculated MAP	81 -RM
Temp	97.7 °F (36.5 °C) -RM
Temp src	Oral -RM
Oxygen Therapy	
SpO2	99 % -RM
O2 Device	None (Room air) -RM
Pulse Oximetry Type	Continuous -RM
POX Probe Site Changed	No -RM

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	01/16/18 0830	01/16/18 0739
[REMOVED] Peripheral IV 01/16/18 22 G Right Wrist		
IV Properties	Placement Date: 01/16/18 -RM Placement Time: 0740 -RM Present on arrival to hospital?: No -RM Type of Catheter: Straight -RM Size (Gauge): 22 G -RM Orientation: Right -RM Location: Wrist -RM Site Prep: Alcohol -RM Local Anesthetic: None -RM Inserted by: rmcneil,rn -RM Insertion attempts: 1 -RM Successful IV Attempt?: Yes -RM Patient Tolerance: Tolerated well -RM IV Access Problem: No -RM Removal Date: 01/16/18 -RM Removal Time: 0919 -RM Catheter Intact on removal?: Yes -RM Removal Reason : Patient discharged -RM Remaining intact at discharge?: No -RM	
Site Assessment	Clean;Dry;Intact -RM	Clean;Dry;Intact -RM
Phlebitis Scale	0 -RM	0 -RM
Infiltration/Extravasation Scale	0 -RM	0 -RM
Line Assessment	Infusing -RM	Blood return noted;Infusing -RM
Dressing Assesment	Clean;Dry;Intact -RM	Clean;Dry;Intact -RM

Flowsheets (all recorded)

Anthropometrics

Row Name	01/16/18 0727
Anthropometrics	
Height	67" (1.702 m) -RM
Weight	94.8 kg (209 lb) -RM
Weight Method	Stated -RM
Weight Change	0 -RM
BMI (Calculated)	32.7 -RM

Flowsheets (all recorded)

Post Op Telephone Call

Row Name	01/18/18 1011
Post-Op	
Do you feel comfortable?	No patient had to go to ER the night of the procedure, January 16th, for urinary retention. Catheter was placed in ER and patient is trying to get in touch with Dr. Dusseault's office to make an appointment to be seen to remove catheter. -JC
Are you taking your Medication?	N/A -JC
Is your pain medication working?	N/A -JC
Do you have a fever over 101 F?	No -JC
Are you having any difficulty urinating?	Yes see above comment -JC
Urine Color	Yellow/straw -JC
Any nausea or vomiting?	No -JC
Which areas of service were you satisfied with?	Scheduling;Check-In;Pre-Op;Clinical Staff;Physician;Anesthesia Provider;Check-Out -JC

Flowsheets (all recorded)

Interpretation

Row Name	01/16/18 0725
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -RM

Flowsheets (all recorded)

Fall Risk

Row Name	01/16/18 0728
Hester Davis Fall Risk Assessment	
Last Known Fall	0 -RM
Mobility	0 -RM
Medications	1 -RM
Mental Status/LOC/Awareness	0 -RM
Toileting Needs	0 -RM
Volume/Electrolyte Status	0 -RM
Communication/Sensory	0 -RM
Behavior	0 -RM
Hester Davis Fall Risk Total	4 -RM
Fall Assessment	
Patient Receiving Sedation	Yes -RM
Fall Risk	Yes -RM
Fall Band Applied	Yes -RM
Yellow socks	Yes -RM

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	01/16/18 0911	01/16/18 0854	01/16/18 0839	01/16/18 0834	01/16/18 0829
Vital sign parameters					
BP	110/59 -RM	97/51 -RM	99/52 -RM	93/54 -RM	**(!) 89/54** IVF KVO -RM
Pulse	54 -RM	53 -RM	52 -RM	52 -RM	54 -RM
Calculated MAP	76 -RM	66.33 -RM	67.67 -RM	67 -RM	65.67 -RM
Resp	18 -RM	18 -RM	17 -RM	16 -RM	16 -RM
Temp	—	—	97.8 °F (36.6 °C) -RM	—	—
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM

Row Name	01/16/18 0727
Vital sign parameters	
BP	123/60 -RM
Pulse	55 -RM
Calculated MAP	81 -RM
Resp	18 -RM
Temp	97.7 °F (36.5 °C) -RM
Vital Signs	
Automatic Restart Vitals Timer	Yes -RM

Flowsheets (all recorded)

Ris Pre Procedure Check list

Row Name	01/16/18 0729
Consent and Procedure	
History and Physical Completed	Yes -RM
Consents Confirmed	Operative;Informed;Anesthesia;Facility -RM
Patient ID and Procedure Verified	Yes -RM
Allergy Band Applied	No -RM
Do you have any metal in your body?	No -RM
Correct Procedure	Yes -RM
Side/Site Confirmed	Location confirmed -RM
Surgeon/Anesthesia Orders Received	Yes -RM
Surgical Prep Complete	Yes -RM
Locker Assignment	2 -RM
Pre-Op Teaching Complete	Yes -RM
NPO After Midnight	Yes -RM
Lab/Testing Checklist	
Urinalysis Results	Abnormal -RM
Abnormal UA Dip results	Blood trace;Positive leukocytes -RM
Microscopy Complete	No -RM
Pre Procedure Testing In Chart	Urinalysis -RM
Pre- op Checklist	
Anti-embolism	SCD -RM
Pre-Op Medications Given and Charted	Yes -RM
Pre-Op Vitals Documented	Yes -RM
Allergies Verified	Yes -RM
Voided Prior to Procedure	Yes -RM
Remove all that apply:	Glasses/Contacts;Underwear -RM
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -RM
Mode of Transport	Stretcher -RM
Released by (Floor RN or Pre-op RN)	rmcneil,rn -RM

Flowsheets (all recorded)

Dischage Information

Row Name	01/16/18 0730

As part of our commitment to quality care, we will be calling you within 7-14 days of your procedure. Please provide us with the following information so we can contact you in a way that is best for you.

Contact Number	678-910-2298 -RM
Contact Guidelines	Ok to leave a message for me if you get an answering machine;You may speak to my spouse/significant other. -RM
Spouse/Significant Other Name	Shirley -RM

If you have taken sedation medication or have a scheduled procedure with anesthesia you are required to have a responsible adult present to drive you home after your procedure. If your driver needs to step out for a moment we need a cell/contact number

Driver's Name	Shirley -RM
Relationship to Patient	Spouse/Significant Other -RM
Cell Phone Number	678-910-2476 -RM

Flowsheets (all recorded)

Assessment

Row Name	01/16/18 0830	01/16/18 0728
Preop Assessment		
Skin Condition/Temp	Dry;Intact;Warm -RM	Dry -RM
Orient/LOC	Sleeping -RM	WDL -RM
Psychosocial	Calm -RM	Calm -RM
Currently Wearing	—	Glasses -RM
Enema by Patient Prior to Admission?	—	Yes -RM

Flowsheets (all recorded)

Hand Off

Row Name	01/16/18 0828
Post Sedation Care	
Type of Sedation	MAC -RM
Procedure Tolerated:	Well -RM
Report Given at:	0827 -RM
Report received from	ayaz,md -RM
Report Given To	rmcneil,rn -RM
Transport Method:	Stretcher;Side rails up x2 -RM

Flowsheets (all recorded)

Patient Assessment in OR Room

Row Name	01/16/18 08:09:50	01/16/18 0730
Patient Assessment		
Name Spelling, DOB, Procedure, Consent Verified	Yes -RM	—
Site Verbally Verified	Yes -RM	—
Site marked by physician or proceduralist?	Not applicable -RM	—
Pt Oriented to the OR Suite, Personnel & Roles	Yes -RM	—
Stretcher	Wheels locked;Side rails up x2 -RM	—
Comfort Assessment Complete	Yes -RM	—
Comfort Actions Taken	Warm blankets;Pillow under head;Pillow between knees/feet -RM	—
SCDs Applied	Yes -RM	—
Plan of Care Reviewed by OR Staff	Yes -RM	—
Type of Anesthesia	MAC -RM	—
Prep Assessmnet		
Operative Site Intact	Yes -RM	Yes -RM
Hair Removal	N/A -RM	N/A -RM

Flowsheets (all recorded)

Assessment in OR post procedure

Row Name	01/16/18 08:12:59
Post Procedure Documentation	
Surgical Wound Classification	III -RM
Preoperative Diagnosis	elevated psa, abnormal mri -RM
Postoperative Diagnosis	elevated psa, abnormal mri -RM
Procedure Performed (Confirmed by MD and Anesthesia)	Yes -RM

Flowsheets (all recorded)

Procedure Documentation

Row Name	01/16/18 08:10:58
Procedure Assessment	
Patient Position	Lateral up right -RM
Warming Device	Off -RM
Electrocautery	
Electrocautery Used?	No -RM
Procedure Interventions	
Xrays Taken?	No -RM
Imaging Displayed?	Yes -RM
Video/Photography?	No -RM
Laser Used?	No -RM
Specimen Obtained	
Specimen Obtained?	Yes -RM
Specimen Collection	
Specimen Type	Prostate Biopsy -RM
Side	Bilateral -RM
Site location	prostate gland-13 core -RM
Prostate Specimen Location	Lat base;Lat mid;Lat apex;Base;Mid;Apex -RM
Specimen Sent to Pathology	Yes -RM
Specimen Discarded per Surgeon	No -RM
Additional Specimens	Yes -RM
Specimen Collection	
Specimen Type	Prostate Biopsy -RM
Site location	#1ACZP4 -RM
Prostate Specimen Location	Apex -RM
Specimen Sent to Pathology	Yes -RM
Specimen Discarded per Surgeon	No -RM
Additional Specimens	No -RM
Dressings	
Dressings	N/A -RM

Flowsheets (all recorded)

Intake/Output

Row Name	01/18/18 1011	01/16/18 0921	01/16/18 0829
Intake (mL)			
P.O.	—	236 mL -RM	—
I.V.	—	400 mL -RM	400 mL -RM
Urine Assessment			
Urine Color	Yellow/straw -JC	—	—
Unmeasured Output			
Urine Occurrence	—	1 -RM	—

Flowsheets (all recorded)

Abuse Screen

Row Name	01/16/18 0729
Abuse Screening	
Do you feel safe at home?	Yes -RM
Have you ever thought about hurting yourself?	No -RM

Flowsheets (all recorded)

Vitals/Pain

Row Name	01/16/18 0911	01/16/18 0854	01/16/18 0839	01/16/18 0834	01/16/18 0829
Vitals					
Temp	—	—	97.8 °F (36.6 °C) -RM	—	—
Temp src	—	—	Oral -RM	—	—
Pulse	54 -RM	53 -RM	52 -RM	52 -RM	54 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	18 -RM	18 -RM	17 -RM	16 -RM	16 -RM
BP	110/59 -RM	97/51 -RM	99/52 -RM	93/54 -RM	(!) 89/54 IVF KVO -RM
Cardiac Rhythm	Normal sinus rhythm -RM	Normal sinus rhythm -RM	Normal sinus rhythm -RM	Normal sinus rhythm -RM	Normal sinus rhythm -RM
Pain Assessment					
Currently in Pain	No/denies pain -RM	No/denies pain -RM	No/denies pain -RM	Faces -RM	Faces -RM
FACES Pain Rating	—	—	—	0-No hurt -RM	0-No hurt -RM
Oxygen Therapy					
SpO2	100 % -RM	99 % -RM	100 % -RM	97 % -RM	97 % -RM
O2 Device	None (Room air) -RM	None (Room air) -RM	Nasal cannula -RM	None (Room air) -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	—	1 L/min -RM	1 L/min -RM	1 L/min -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM

Row Name	01/16/18 0727
Height and Weight	
Height	67" (1.702 m) -RM
Height Method	Stated -RM
Weight	94.8 kg (209 lb) -RM
Weight Method	Stated -RM
BMI (Calculated)	32.7 -RM
BSA (Calculated - sq m)	2.11 sq meters -RM
Vitals	
Temp	97.7 °F (36.5 °C) -RM
Temp src	Oral -RM
Pulse	55 -RM
Heart Rate Source	Monitor -RM
Resp	18 -RM
BP	123/60 -RM
Cardiac Rhythm	Normal sinus rhythm -RM
Pain Assessment	
Currently in Pain	No/denies pain -RM
Oxygen Therapy	
SpO2	99 % -RM
O2 Device	None (Room air) -RM
Pulse Oximetry Type	Continuous -RM
POX Probe Site Changed	No -RM

Flowsheets (all recorded)

Site Preparation

Row Name	01/16/18 08:09:50	01/16/18 0730
Prep Assessmnet		
Operative Site Intact	Yes -RM	Yes -RM
Hair Removal	N/A -RM	N/A -RM

Flowsheets (all recorded)

Advance Directive

Row Name	01/16/18 0727
Advance Directives (For Healthcare)	
Have you reviewed your Advance Directive and is it valid for this stay?	No -RM
Advance Directive	Patient does not have advance directive -RM

Flowsheets (all recorded)

Assessment

Row Name	01/16/18 0830	01/16/18 0728
Uro Assessment		
Skin Condition/Temp	Dry;Intact;Warm -RM	Dry -RM
Orient/LOC	Sleeping -RM	WDL -RM
Psychosocial	Calm -RM	Calm -RM

Flowsheets (all recorded)

Call Complete

Row Name	01/18/18 1013
Completion of Post-op Call	
Post-op Call Complete	Yes -JC

User Key

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

Initials	Name	Effective Dates
JC	Julie K Cooper, RN	02/03/17 -
RM	Ramona McNeil, RN	02/03/17 -
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 01/16/2018:

Scan on 1/18/2018 1:35 PM (below)

Document on 1/16/2018 8:40 AM by Ramona McNeil, RN: IP After Visit Summary (below)

AFTER VISIT SUMMARY

Eugene G. Maurice MRN: 561253820 1/16/2018 WellStar Kennestone Urology Procedure Center

Instructions

No changes were made to your medications.

Activity instructions

Discharge Instructions

1. General Anesthesia or Sedation
Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity
You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet
Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan
Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.

Your Next Steps

Read

☐ Read these attachments
- Ultrasound and Biopsy, Transrectal (English)

Go

JAN 30 Follow Up Appointment
11:00 AM
Arrive by 10:45 AM
Beau N Dusseault, MD
WellStar Urology Hiram
148 Bill Carruth Parkway Ste 340
HIRAM GA 30141-3756
770-428-4475

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

Activity instructions (continued)

Prescriptions
Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care
Your physician may call you with biopsy results.

Special Complications to Watch For
You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

What's next

JAN 30 — Follow Up Appointment with Beau N Dusseault, MD
Tuesday Jan 30, 2018 11:00 AM (Arrive by 10:45 AM)
WellStar Urology Hiram
148 Bill Carruth Parkway Ste 340
Hiram GA 30141-3756
770-428-4475

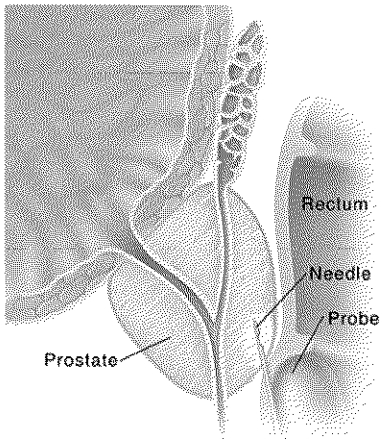
MAR 2 — Follow Up Appointment with Abdul M Sheikh, MD
Friday Mar 2, 2018 8:45 AM (Arrive by 8:30 AM)
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway Ste 4200
Hiram GA 30141-3749
678-324-4444

Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
apixaban 5 mg tablet Commonly known as: ELIQUIS Take 1 tablet (5 mg total) by mouth 2 (two) times a day					
aspirin, buffered 81 mg Tab					
atorvastatin 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly					
* **blood sugar diagnostic** strip Commonly known as: glucose blood cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..					
* **blood sugar diagnostic** strip True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9					
carvedilol 12.5 MG tablet Commonly known as: COREG Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals					
chlorthalidone 50 MG tablet Commonly known as: HYGROTEN Take 1 tablet (50 mg total) by mouth daily					
cilostazol 100 MG tablet Commonly known as: PLETAL Take 1 tablet (100 mg total) by mouth 2 (two) times a day					
isosorbide mononitrate 30 MG 24 hr tablet Commonly known as: IMDUR Take 2 tablets (60 mg total) by mouth 2 (two) times a day					
metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE 2 tablets po in am and 2 in pm					
nitroglycerin 0.4 MG SL tablet Commonly known as: NITROSTAT Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain					
ramipril 10 MG capsule Commonly known as: ALTACE Take 1 capsule (10 mg total) by mouth 2 (two) times a day					

*** This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

Transrectal Ultrasound and Biopsy



A transrectal ultrasound is an imaging test. It uses sound waves to create pictures of a man's prostate gland. Your prostate gland is in front of your rectum. For this test, a special probe (transducer) is placed directly into your rectum. During the test, tissue samples (a biopsy) may also be taken. The test is done by a specially trained technologist called a sonographer.

Getting ready for your test

- You may be asked to clear your bowel before the test. This may be done by injecting liquid into your rectum (an enema). Or it can be done by drinking a special liquid.
- You may be asked not to eat or drink anything after midnight the night before the test.
- Tell your healthcare provider about any medicines, herbs, or supplements you are taking. This includes any over-the-counter medicines such as aspirin or ibuprofen. You might need to stop taking some medicines for a week or so before the test.
- Answer any questions your healthcare provider has about your medical history. This will help tailor the test to your health needs.

During your test

- You may be asked to change into a gown. You will then lie on your side on an exam table, with your knees bent.
- The test is done with a handheld probe. This is a short, slender rod. It has a sterile, disposable cover on it. It is also greased (lubricated) with some gel. It is then gently placed inside your rectum.
- You will feel pressure from the probe. If you feel pain, let your healthcare provider know.
- If a biopsy is needed, you might take medicine before the procedure to make you sleepy. The test is done using a small probe with a very tiny needle on the end. This needle enters your prostate several times and removes tiny samples of tissue. These samples are then sent to a lab to be examined. Any mild pain from the biopsy is usually minor.

After your test

Before leaving, you may need to wait for a short time while the images are reviewed. In most cases, you can go back to your normal routine after the test. If you had a biopsy and took medicine to make you sleepy, you may need to wait until it has worn off before you can go home. You might see some blood in your urine, sperm, or stool for a day or so. This is normal. Your healthcare provider will let you know when your test results are ready.

In some cases, a diagnosis can't be made from the tissue sample that was taken. If this happens, your healthcare provider will talk with you about whether you need another biopsy. Or you may need a different procedure.

When to call your healthcare provider

Call your healthcare provider if you have:

- Very bloody urine or stool
- A fever lasting 24 to 48 hours
- Any other symptoms that your healthcare provider asks you to report, based on your health

Date Last Reviewed: 5/1/2017

Scan on 1/16/2018 7:02 AM by Chastity Payton: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	**IP**		Unit:	**KH G5N SURG**
Hospital Service:	**Hospital Medicine**		Bed:	**G544/G544-01**
Admitting Provider:	**Charu G Prakash, Md**		Referring Physician:	
Attending Provider:	**Douglas e krug;Charu g p***	AD: N	Adm Diagnosis:	**GI bleed [K92.2]**
Admission Date:	**6/17/2018**		Admission Time:	**1451**

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:	

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 9, 2020 **Chart ID**

Admission Information

Arrival Date/Time:	06/17/2018 1436	Admit Date/Time:	06/17/2018 1451	IP Adm. Date/Time:	06/17/2018 1712
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Hospital Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Kennestone Hospital (KH G5N SURGERY)
Admit Provider:	Charu G Prakash, MD	Attending Provider:	Douglas E Krug, MD	Referring Provider:	

Reason for Visit

Shortness of Breath
Fatigue

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/21/2018 1351	Home Or Self Care	None	None	WellStar Kennestone Hospital (KH G5N SURGERY)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
K29.70 [Principal]	Gastritis, unspecified, without bleeding	Yes	No		Yes
K72.00	Acute and subacute hepatic failure without coma	Yes	MCC		Yes
I50.33	Acute on chronic diastolic (congestive) heart failure	Yes	MCC		No
I48.92	Unspecified atrial flutter	Yes	CC		No
D62	Acute posthemorrhagic anemia	Yes	CC		No
N39.0	Urinary tract infection, site not specified	Yes	CC		No
N17.9	Acute kidney failure, unspecified	Yes	CC		No
E87.2	Acidosis	Yes	CC		No
J34.89	Other specified disorders of nose and nasal sinuses	Yes	No		No
I48.0	Paroxysmal atrial fibrillation	Yes	No		No
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris	Yes	No		No
I11.0	Hypertensive heart disease with heart failure	Yes	No		No
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	Yes	No		No
E11.65	Type 2 diabetes mellitus with hyperglycemia	Yes	No		No
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting	No		No
E78.5	Hyperlipidemia, unspecified	Yes	No		No
E66.9	Obesity, unspecified	Yes	No		No
Z68.36	Body mass index (bmi) 36.0-36.9, adult	Exempt from POA reporting	No		No
R00.1	Bradycardia, unspecified	Yes	No		No
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting	No		No
R79.89	Other specified abnormal findings of blood chemistry	Yes	No		No
R04.0	Epistaxis	Yes	No		No
Z85.46	Personal history of malignant neoplasm of prostate	Exempt from POA reporting	No		No
D69.6	Thrombocytopenia, unspecified	Yes	No		No
K29.80	Duodenitis without bleeding	Yes	No		No
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system	Exempt from POA reporting	No		No
Z79.01	Long term (current) use of anticoagulants	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
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting	No		No

All Scans (continued)

Events

ED Arrival at 6/17/2018 1436

Unit: WellStar Kennestone Hospital (KH EMERGENCY)

Admission at 6/17/2018 1451

Unit: WellStar Kennestone Hospital (KH EMERGENCY) Room: 106 Bed: 106
Patient class: Emergency Service: Emergency Medicine

ED Roomed at 6/17/2018 1451

Unit: WellStar Kennestone Hospital (KH EMERGENCY)

Patient Update at 6/17/2018 1712

Unit: WellStar Kennestone Hospital (KH EMERGENCY) Room: 106 Bed: 106
Patient class: Inpatient Service: Hospital Medicine

Pt Class Change at 6/17/2018 1712

Unit: WellStar Kennestone Hospital (KH EMERGENCY) Room: 106 Bed: 106
Patient class: Inpatient Service: Hospital Medicine

Patient Update at 6/17/2018 1719

Unit: WellStar Kennestone Hospital (KH EMERGENCY) Room: 106 Bed: 106
Patient class: Inpatient Service: Emergency Medicine

Transfer In at 6/17/2018 2220

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G362 Bed: G362-01
Patient class: Inpatient Service: Hospital Medicine

Admit from ED at 6/17/2018 2220

Unit: EMH Emergency Department Room: 106 Bed: 106
Patient class: Inpatient Service: Hospital Medicine

Patient Update at 6/18/2018 0719

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G362 Bed: G362-01
Patient class: Inpatient Service: Internal Medicine

Transfer Out at 6/19/2018 1104

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G362 Bed: G362-01
Patient class: Inpatient Service: Internal Medicine

Transfer In at 6/19/2018 1104

Unit: WellStar Kennestone Hospital (KH GI LAB) Room: KH GI POOL Bed: KH GI POOL
Patient class: Inpatient Service: Internal Medicine

Surgery at 6/19/2018 1257

Unit: KH GI/BRONCH Room: KH GI 05
Patient class: Inpatient Service: Gastroenterology

Transfer Out at 6/19/2018 1410

Unit: WellStar Kennestone Hospital (KH GI LAB) Room: KH GI POOL Bed: KH GI POOL
Patient class: Inpatient Service: Internal Medicine

Transfer In at 6/19/2018 1410

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G351 Bed: G351-01
Patient class: Inpatient Service: Internal Medicine

Patient Update at 6/20/2018 1029

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G351 Bed: G351-01
Patient class: Inpatient Service: Hospital Medicine

All Scans (continued)

Events (continued)

Transfer Out at 6/20/2018 1347

Unit: WellStar Kennestone Hospital (KH 3W IMCU) Room: G351 Bed: G351-01
Patient class: Inpatient Service: Hospital Medicine

Transfer In at 6/20/2018 1347

Unit: WellStar Kennestone Hospital (KH G5N SURGERY) Room: G544 Bed: G544-01
Patient class: Inpatient Service: Hospital Medicine

Discharge at 6/21/2018 1351

Unit: WellStar Kennestone Hospital (KH G5N SURGERY) Room: G544 Bed: G544-01
Patient class: Inpatient Service: Hospital Medicine

Allergies as of 6/21/2018

Reviewed on 6/19/2018

Not on File

Immunizations as of 6/21/2018

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
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 6/21/2018

Past Medical History

All Scans (continued)

Medical as of 6/21/2018 (continued)

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider
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
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

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type
-	6/17/2018 14:36	2-Emergent	Car	Self	Hospital Medicine	Emergency

Arrival Complaint

SHORTNESS OF BREATH

Chief Complaint

Complaint	Comment	Last Edited By	Time	Relationship	ED Provider
Shortness of Breath		Naomi Shelton, RN	6/17/2018 2:36 PM	None	No
Fatigue		Naomi Shelton, RN	6/17/2018 2:36 PM	None	No

ED Disposition

ED Disposition	Condition	Comment
Admit	Serious	Eugene G Maurice should be admitted to the hospital.

ED Events

ED Records (continued)

ED Events (continued)

Date/Time	Event	User	Comments
06/17/18 1436	Patient arrived in ED	SHELTON, NAOMI	
06/17/18 1451	Patient roomed in ED	KOFFANA, JOSEPHINE K	
06/17/18 2220	Patient admitted	MANJARRES, DIANA	

ED Provider Notes - ED Notes

ED Provider Notes by Douglas E Krug, MD at 6/17/2018 3:06 PM

Author: Douglas E Krug, MD | Service: — | Author Type: Physician
Filed: 6/22/2018 9:02 AM | Date of Service: 6/17/2018 3:06 PM | Status: Signed
Editor: Douglas E Krug, MD (Physician)

Procedure Orders
1. EKG, ED Documentation [750930077] ordered by Douglas E Krug, MD
2. CRITICAL CARE [751503324] ordered by Douglas E Krug, MD

History

Chief Complaint

Shortness of Breath; Fatigue

Patient has experienced progressive dyspnea over the past 2 months with significant exacerbation over past 2 weeks. There has been significant decreased exercise tolerance. Minimal nonproductive cough and congestion. No frank chest pain. No fever or chills, nausea or vomiting. No abdominal pain. Denies recent change in bowel habits.

History provided by: patient and spouse. No language interpreter was used.
Nursing note reviewed and I agree with the documentation of the past medical, past surgical, social, and family histories.Vitals reviewed.
The primary symptoms include nausea. Primary symptoms do not include headaches or vomiting.
Additional symptoms include shortness of breath.
This is a recurrent problem. The current episode started more than 1 week ago. The onset was gradual. The problem has not changed since onset.Severity at onset was moderate. The severity now is moderate.
Associated symptoms include leg swelling. Pertinent negatives include no headaches, no neck pain, no vomiting and no abdominal pain.

Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis	

as teen/cannont recall what type
- Obesity
- Other and unspecified hyperlipidemia
- Other symptoms involving cardiovascular system
- PVD (peripheral vascular disease) (HCC)

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT *sheikh*		2014
• EGD *Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;*	N/A	6/19/2018
• shingles		9/2015

Family History

Problem	Relation	Age of Onset
• Coronary artery disease	Mother	
• Other *MI*	Mother	
• Other *MI*	Brother	
• Anemia	Neg Hx	
• Arrhythmia	Neg Hx	
• Asthma	Neg Hx	
• Clotting disorder	Neg Hx	
• Fainting	Neg Hx	
• Heart attack	Neg Hx	
• Heart disease	Neg Hx	
• Heart failure	Neg Hx	
• Hyperlipidemia	Neg Hx	
• Hypertension	Neg Hx	
• Stroke	Neg Hx	

Social History

Social History	
• Marital status:	Married
Spouse name:	N/A
• Number of children:	N/A