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

CIOX HEALTH

INVOICE

Electronic Delivery Service

Invoice #: **0303250575**
Date: **04/05/2020**

https://edelivery.cioxhealth.com

Ship to:	Bill to:	Records from:
EUGENE MAURICE MAURICE, EUGENE 61 SHOCKLEY WAY DALLAS,GA 30157-8973	EUGENE MAURICE MAURICE, EUGENE 61 SHOCKLEY WAY DALLAS,GA 30157-8973	WELLSTAR PAULDING 2518 JIMMY LEE SMITH PKWY HIRAM,GA 30141

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)**

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

Invoice #: **0303250575**

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

WELLSTAR. PAULDING HOSPITAL
ECO WEST MEMORIAL
DALLAS, GA 30132
(770) 445-4411
Fax (770) 505-6884

ADMISSION RECORD

CORPORATE NUMBER: 02894730

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	ROOM/BED	AC	SEX	MS	RACE	SERVICE PT	PC	DATE OF BIRTH	AGE	ACCIDENT/WORK DATE	UNIT NUMBER
L1325902325	09/16/13 1525	-		M	M	1	MED PDO	AA	01/02/49	64Y	NO	000286367

NAME AND ADDRESS
MAURICE,EUGENE
61SHOCKLEY WAY
DALLAS GA 30157

SOC-SEC-NO
339-42-1524
PHONE MESSAGE?
(678)398-9479
110

DIAGNOSIS/COMPLAINT
785.9-CARDIOVAS SYS SYMP NEC

PREVIOUS ADMIT NAME | DATE | ARRIVAL MODE

EMPLOYER NAME & ADDRESS

OCCUPATION
EMPLOYED FULL T

ADMITTING PHYSICIAN
SHEIKH,ABDUL M
PUBLICITY | ADM BY

ATTENDING PHYSICIAN
SHEIKH,ABDUL M
ADM TYPE: 3 | ROOM PREF

PRIMARY CARE PHYSICIAN
UNKNOWN,DOCTOR
ADM SRC: 1 | COU OIS: NO | STATION: PDO

GUAR

NAME AND ADDRESS
MAURICE,EUGENE
61SHOCKLEY WAY
DALLAS GA 30157

SOC-SEC-NO | PC
339-42-1524
PHONE MESSAGE?
(678)398-9479
SELF

EMPLOYER NAME & ADDRESS
EMPLOYED FULL T

INSURANCE

INSURANCE 1 & 2
AETNA /MC EPO EC POS II
ATTN CLAIMS DEPT
P O BOX 14079
LEXINGTON KY 40512-4079

325976
MAURICE,EUGENE
W080686151

INSURANCE 3 & 4

MISC

RELATIVE 1

RELATIVE 1 EMPLOYER

CHURCH:
DENOMINATION:
ADVANCE DIRECTIVE:

FUNERAL HOME:
CHART LOCATION:
HOME HEALTH PLAN:

NOTICE OF PRIVACY PRACTICE:
DATE OF PRIVACY PRACTICE:

Insurance information reflects that which the patient provides at time of registration and as such is subject to verification.

CRT Used: HYC

OPT OUT: **PUBLICITY:** **OPT OUT DATE:**

Consultants:

Discharge Date/Time:

Primary Diagnosis:

Other Diagnosis:

Codes:

Primary Procedure:

Other Procedure(s):

Codes CPT Date

Date Physician's Signature

Rev. 04/2011

Cardiovascular Medicine - Hiram
148 Bill Carruth Parkway Suite 100
Hiram, GA 30141
Phone (678) 324-4444
Fax (770) 528-9932

Cerebrovascular Exam

Patient:	Maurice, Eugene	**MR #:**	L000286367	**Gender:**	M
DOB:	01/02/1949 (64yrs)	**Study Date:**	09/17/2013	**Pt. Status:**	Outpatient
Height:		**Weight:**		**BSA:**	
Room/bed:		**Acct #:**	1325902325		

Referring physician: None
Ordering physician: Abdul Sheikh, MD
Interpreting physician: Abdul Sheikh, MD
Sonographer: Melissa Dixon, RDCS

Indications: Other symptoms involving cardiovascular system (785.9).

Study data: Complete study and Doppler flow study including spectral analysis, color and gray scale imaging. Location: Vascular laboratory. Patient status: Outpatient. Study status: Routine.

Impressions

1. 50-69% stenosis involving the right internal carotid artery.
2. 70-79% stenosis involving the left internal carotid artery.
3. The bilateral vertebral arteries are patent with normal antegrade flow.

Findings:
Right common carotid: Mild diffuse disease.
Right internal carotid: Irregular calcific plaque. Moderate diffuse disease. Doppler flow velocities are increased.
Right vertebral: Antegrade flow.
Left vertebral: Antegrade flow.
Left common carotid: Mild diffuse disease.
Left internal carotid: Irregular calcific plaque. Severe diffuse disease. Doppler flow velocities are severely increased.

Arterial flow:

Location	*V sys*	*V ed*
Right CCA - proximal	115 cm/s	14 cm/s
Right CCA - mid	86.6 cm/s	16.1 cm/s
Right CCA - distal	83.1 cm/s	18.9 cm/s
Right ECA	177 cm/s	--
Right ICA - proximal	149 cm/s	35.9 cm/s
Right ICA - mid	119 cm/s	34.8 cm/s
Right ICA - distal	79.4 cm/s	22.8 cm/s
Right vertebral	62.2 cm/s	--
Left CCA - proximal	110 cm/s	15.6 cm/s
Left CCA - mid	114 cm/s	20.1 cm/s
Left CCA - distal	87.3 cm/s	20.3 cm/s
Left ECA	349 cm/s	--
Left ICA - proximal	238 cm/s	54.1 cm/s
Left ICA - mid	98.5 cm/s	29.3 cm/s

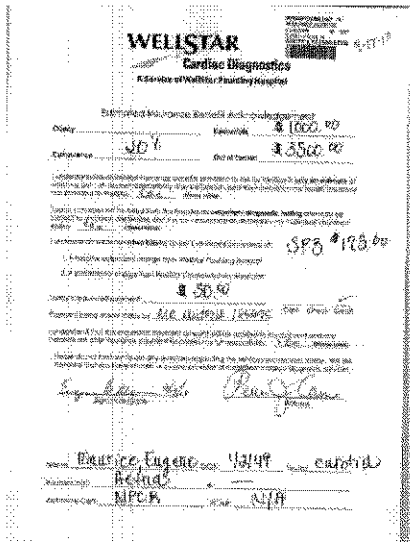
Left ICA - distal	90.8 cm/s	23 cm/s
Left vertebral	43.6 cm/s	--

Velocity ratios:

	Right, V sys	*Left, V sys*
Max ICA/dist CCA	1.79	2.73
Proximal ICA/dist CCA	1.79	2.73
Mid ICA/dist CCA	1.43	1.13
Distal ICA/dist CCA	0.96	1.04

Electronically signed by:

Abdul Sheikh, MD
2013-09-17T13:00:07.297



WELLSTAR

Cardiac Diagnostics

A Service of Wellstar Paulding Hospital

$ 1000.00

$ 3500.00

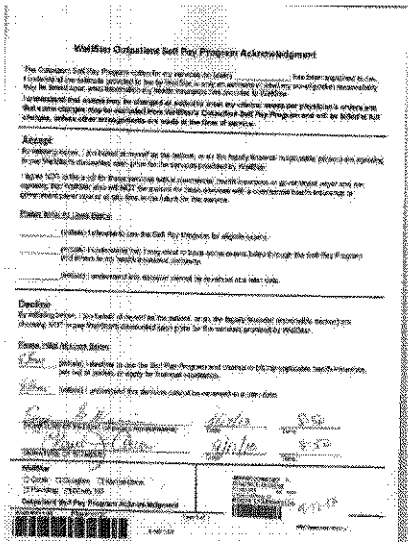
SPS $198.00

$ 50.00

Eugene 12/19 entered

Refund

NPC R



WildBlue Outpatient Self Pay Program Acknowledgment

The Outpatient Self Pay Program refers for any services or tests [illegible] has been explained to me. I understand the estimate provided to me by WildBlue is only an estimate of what my overall costs reasonably may be based upon what information my health insurance has provided to WildBlue.

I understand that estimates may be changed at all points by times any clinical issues per physician's orders and that some charges may be excluded from WildBlue's Outpatient Self Pay Program and will be billed to me separate, unless other arrangements are made at the time of service.

Accept

By initialing below, I, on behalf of myself as the patient, or as the legally financially responsible person(s) am agreeing to pay WildBlue's discounted cash prices for the services provided by WildBlue.

I agree NOT to file a claim for these services with a commercial health insurance or government payer and my signature this contract also will NOT be grounds for basis otherwise with a commercial health insurance or government payer now or at any time in the future for the services.

Please Initial Above Blank

_____ (Initials) I choose to use the Self Pay Program for eligible visits.

_____ (Initials) I understand that I may elect to have my care billed through the Self Pay Program and others to my health insurance company.

_____ (Initials) I understand this agreement cannot be re-visited at a later date.

Decline

By initialing below, I, on behalf of myself as the patient, or as the legally financially responsible person(s) am choosing NOT to pay WildBlue's discounted cash prices for the services provided by WildBlue.

Please Initial Above Below:

_____ (Initials) I decline to use the Self Pay Program and choose to bill my applicable health insurance, per out of pocket, or apply for financial assistance.

_____ (Initials) I understand this decline only affects care which is at a later date.

[illegible] 4/11/18 [illegible]

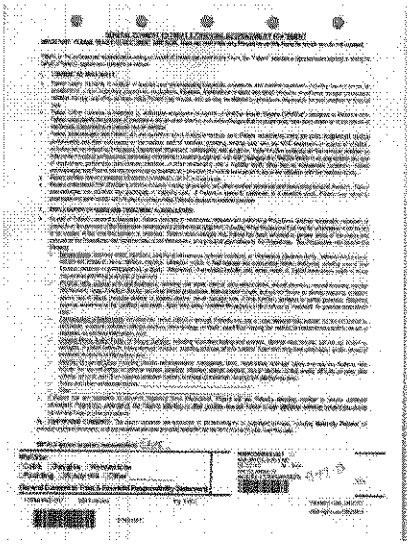
[illegible] 4/11/18 [illegible]

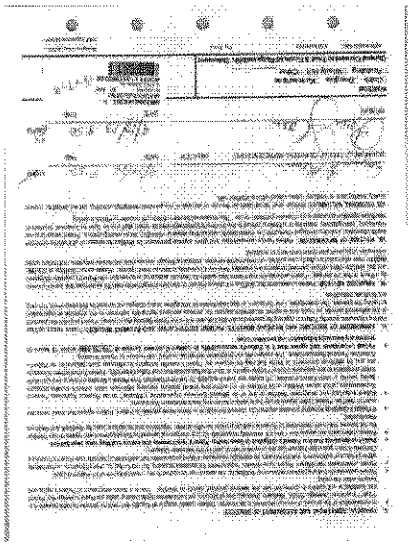
[illegible]

[illegible] 4/11/18

[illegible]

[illegible]





WELLSTAR

Cardiovascular Medicine

PATIENT TRACKING

Date of Visit:	[illegible]
Date of Birth:	[illegible]
Age:	[illegible] yrs
Medical record number:	[illegible]

CURRENT MEDICATIONS, DOSAGE AND NOTE

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

ALLERGIES

[illegible]

IMMUNIZATIONS

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]

CHIEF COMPLAINT

[illegible]

HISTORY OF PRESENT ILLNESS

[illegible]

PAST MEDICAL HISTORY

[illegible]

FAMILY HISTORY

[illegible]

SOCIAL HISTORY

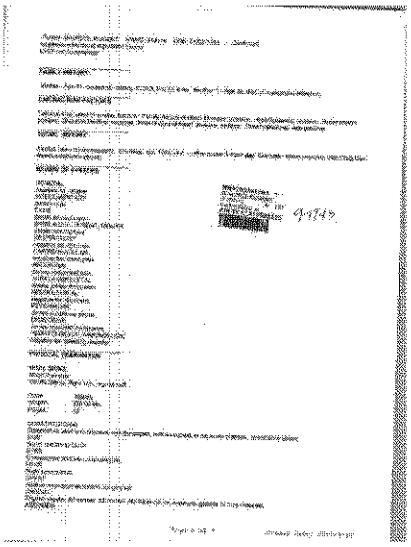
[illegible]

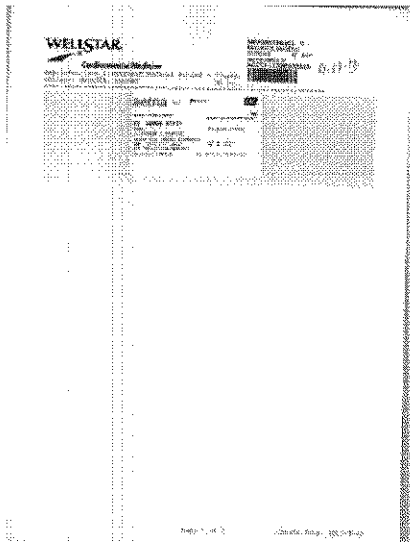
REVIEW OF SYSTEMS

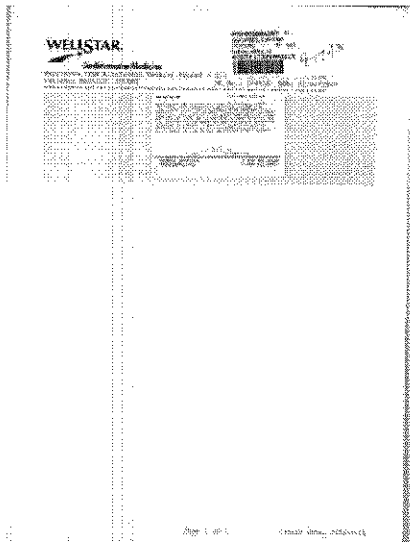
[illegible]

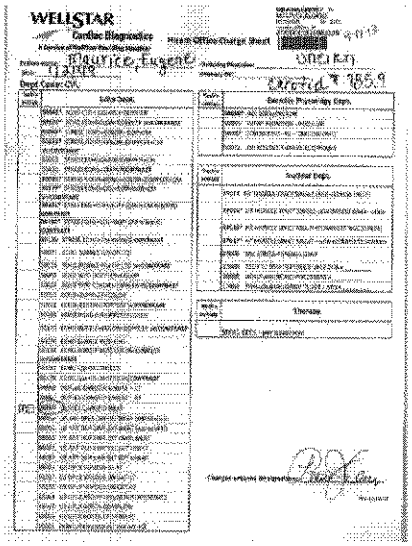
PHYSICAL EXAMINATION

[illegible]




WELLSTAR


WELLSTAR



WELLSTAR

Cardiac Diagnostics

Hospital Office Charge Sheet

Patient name: Maurice, Eugene

Dept Case: CVL

Order Details

Cardiac Physiology Dept.

Nuclear Dept.

Echo

Physician signature required

WELLSTAR PAULDING HOSPITAL
600 WEST MEMORIAL DRIVE
DALLAS GA 30132

FC: AA FINAL

Name: MAURICE,EUGENE G Location: DIS - ODC
DOB: 01/02/49 Age: 64Y Sex: M MR# L000286367
Ordered Date/Time: 12/06/13 1448 Acct#: L1333900413
Ck-In Date/Time: 12/06/13 1447

Ord Dr: ZZCHERVU,ARUN Attend. Dr: ZZCHERVU,ARUN
1700 HOSPITAL SOUTH DRIVE SUITE 502Admit. Dr: ZZCHERVU,ARUN
AUSTELL GA 30106 Ref. Dr:

Chk-in #	Exam	Desc	Ord. Diag.
11443477	48014	PIC CT ANGIO HEAD W+W/O	433.10-OCL CRTD ART WO INFRCT
11443477	48015	PIC CT ANGIO NECK W+W/O	433.10-OCL CRTD ART WO INFRCT

F1 cat-STS

CT ANGIOGRAM OF THE HEAD AND NECK WITH Q3D POSTPROCESSED IMAGES:

HISTORY: Atherosclerotic disease status post CABG. Abnormal carotids. ICD-9 code 433.10.

TECHNIQUE: All stenoses graded using NASCET-like criteria.
90 mL Isovue administered for exam.

COMPARISON: No priors.

FINDINGS CT HEAD:

Sensitivity for hemorrhage is diminished on these postcontrast only images. No large extraaxial collection or parenchymal hemorrhage is documented. Cortical gray-white differentiation is bilaterally preserved without evidence of acute cortical infarct. There is no mass effect or midline shift. There is no hydrocephalus. No abnormal parenchymal or extraaxial enhancement is identified.

Imaging of the orbits is unremarkable. Dural venous sinuses are grossly patent, although this is not a CT venogram.

The paranasal sinuses demonstrate concha bullosa of the right middle turbinate, anatomic variant. Mastoid air cells are bilaterally clear.

IMPRESSION CT HEAD:

No acute intracranial pathology. Preserved appearance to the brain parenchyma. If more sensitive assessment of brain parenchyma is desired, consider MRI.

FC: AA FINAL

Name: MAURICE,EUGENE G Location: DIS - ODC
DOB: 01/02/49 Age: 64Y Sex: M MR# L000286367
Ordered Date/Time: 12/06/13 1448 Acct#: L1333900413
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Ord Dr: ZZCHERVU,ARUN Attend. Dr: ZZCHERVU,ARUN
1700 HOSPITAL SOUTH DRIVE SUITE 502Admit. Dr: ZZCHERVU,ARUN
AUSTELL GA 30106 Ref. Dr:

Checkin-Exam Code Summary
11443477-48014,11443477-48015

FINDINGS, CT NECK:

Neck soft tissues are not well assessed on these early arterial phase images. Nasopharyngeal soft tissues are bilaterally symmetric and fossae of Rosenmller are clear. Oropharyngeal soft tissues are not optimally assessed due to streak artifact from dental hardware. Parapharyngeal fat planes are preserved. There is no discrete enhancing oropharyngeal mass identified. There is a somewhat tortuous course to the bilateral external carotid artery and branch vessels, not to be confused with retropharyngeal lesions. The hypopharynx, including the valleculae and epiglottis, is preserved. The vocal cords are medialized and poorly assessed. There is asymmetry of the piriform sinuses more effaced on the left than right. This may be within normal limits. The subglottic airway is maintained.

Sternotomy wires and CABG grafts are documented including LIMA graft. These are grossly patent, not imaged in their entirety. Prominence to the main pulmonary arteries is noted.

Imaging of the lung apices demonstrates bronchial wall thickening, for example series 7 image 1, bilaterally.

Osseous structures in the neck demonstrate spinal canal and neural foraminal narrowing at multiple levels on a degenerative basis. There is straightening of the cervical lordotic curve which may be positional or reflect muscle spasm. Canal narrowing would be greatest at C4-5 and C5-6. Osseous union of C3-4 and C2-3 anteriorly by osteophytes is suspected.

The bilateral parotid glands are preserved. Submandibular glands are unremarkable. Thyroid is normal in size, not well assessed. No phlegmon, lymphadenopathy or drainable fluid collection is identified in the neck.

IMPRESSION CT NECK:

FC: AA FINAL

Name: MAURICE,EUGENE G Location: DIS - ODC
DOB: 01/02/49 Age: 64Y Sex: M MR# L000286367
Ordered Date/Time: 12/06/13 1448 Acct#: L1333900413
Ck-In Date/Time: 12/06/13 1447

Ord Dr: ZZCHERVU,ARUN Attend. Dr: ZZCHERVU,ARUN
1700 HOSPITAL SOUTH DRIVE SUITE 502Admit. Dr: ZZCHERVU,ARUN
AUSTELL GA 30106 Ref. Dr:

Checkin-Exam Code Summary
11443477-48014,11443477-48015

Status post CABG with grossly patent grafts.

Probable pulmonary arterial hypertension.

Nonspecific bronchial wall thickening may reflect reactive airways disease or acute and/or chronic bronchitis. May be correlated with any respiratory symptoms and smoking history.

Medialized, poorly assessed vocal cords as described.

FINDINGS CT ANGIOGRAM:

Q3D postprocessed images are available. There is a 3-vessel configuration to the aortic arch. On the right, the innominate artery is preserved. There is narrowing of the distal common carotid artery by calcified and noncalcified plaque up to 60%. There is stenosis in the internal carotid artery at its origin of up to 60-70% using NASCET-like criteria. The right vertebral artery remains patent.

On the left, the common carotid artery at its origin is preserved. There is narrowing by calcified and noncalcified plaque distally up to 65%. Artifact degrades images of the internal carotid artery, but narrowing of up to 80% at the left internal carotid artery is suspected by calcified and noncalcified plaque, reference series 604 images 54 and 55.

The left vertebral artery is hypoplastic compared to the right. There is heavily calcified plaque at its origin and its origin may be occluded, although the vessel distal to the origin is patent, series 6 image 194, suggesting that this is just a significant stenosis.

Intracranially, the right vertebral artery remains dominant and the left

FC: AA FINAL

Name: MAURICE,EUGENE G Location: DIS - ODC
DOB: 01/02/49 Age: 64Y Sex: M MR# L000286367
Ordered Date/Time: 12/06/13 1448 Acct#: L1333900413
Ck-In Date/Time: 12/06/13 1447

Ord Dr: ZZCHERVU,ARUN Attend. Dr: ZZCHERVU,ARUN
1700 HOSPITAL SOUTH DRIVE SUITE 502Admit. Dr: ZZCHERVU,ARUN
AUSTELL GA 30106 Ref. Dr:

Checkin-Exam Code Summary
11443477-48014,11443477-48015

vertebral is extremely hypoplastic with majority of flow in a posterior inferior cerebellar artery. Basilar artery remains patent. There is fetal type origin of the bilateral posterior cerebral arteries which remain patent. In the anterior circulation, there is preserved enhancement of bilateral internal carotid arteries, middle cerebral arteries and anterior cerebral arteries. The anterior communicating artery is patent. Atherosclerotic plaquing in the intracranial carotids and cavernous carotids is noted without hemodynamically significant stenosis.

IMPRESSION:

Atherosclerotic disease intracranially with preserved intracranial vessels. Variant intracranial vascular anatomy as described.

Disease in the bilateral carotid arterial systems. On the right, stenosis of up to 60% in the common carotid artery distally and 60-70% in the internal carotid artery.

On the left, stenosis of the common carotid artery of up to 65% distally and up to 80% in the proximal internal carotid artery. Possible high-grade stenosis of the vertebral artery, poorly assessed due to heavy calcification of the atherosclerotic plaque, as well as diminutive vessel caliber. Please see body of report for additional details.

The requesting physician or his or her representative will be informed of the availability of these results through the WellStar F1 system.

2213904 RESNICK/cat-STS
Dictation D/T: 12/06/2013 8:37 p.m.
Workstation: WKH

Transcriptionist- CHERYL THOMPSON
Reading Radiologist- STUART RESNICK MD
Releasing Radiologist- STUART RESNICK MD

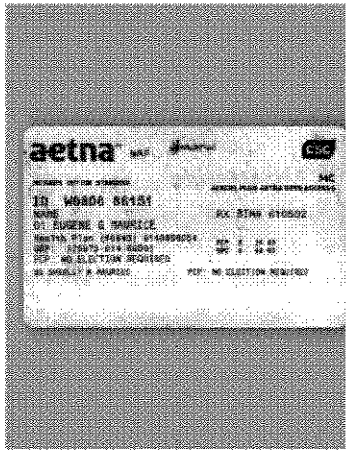
FC: AA FINAL

Name: MAURICE,EUGENE G Location: DIS - ODC
DOB: 01/02/49 Age: 64Y Sex: M MR# L000286367
Ordered Date/Time: 12/06/13 1448 Acct#: L1333900413
Ck-In Date/Time: 12/06/13 1447

Ord Dr: ZZCHERVU,ARUN Attend. Dr: ZZCHERVU,ARUN
1700 HOSPITAL SOUTH DRIVE SUITE 502Admit. Dr: ZZCHERVU,ARUN
AUSTELL GA 30106 Ref. Dr:

Checkin-Exam Code Summary
11443477-48014,11443477-48015

Released Date Time- 12/07/13 1230


aetna
CSC
ID W0804 86151
NAME
01 EUGENE G TAMBLIE
GRP 21573-014-00001
PCP NO SELECTION REQUIRED
01 SHELLY A MAURICE
PCP NO SELECTION REQUIRED

VASCULAR SURGICAL ASSOCIATES

Vascular Surgical Associates, P.C.
1700 Hospital South Drive, Suite 502
Austell, GA 30106
Telephone: 770-944-8315
Fax: 770-745-2290

CT/ MRI Scheduling

Eugene G Maurice

Pending
Diagnosis: CAROTID ARTERY STEN, NO INFARCT
Ordered by Brookie Lanham on 11/26/2013 (Routine)
Performed on 11/26/2013 2:32 PM

CT/MRI Scheduling

PRECERT : Wellstar
Referring Physician:
Arun Chervu, MD
LOCATION
Paulding Imaging Center
Test: CTA Head and Neck, with and without contrast
Diagnosis: 433.10
Comments : GFR: 67/78
Signed by
Electronically Signed By:
Arun Chervu, MD

MR#000286367 R: -
MAURICE,EUGENE G
01/02/49 M 64Y
ZZCHERVU,ARUN
ACCT# L1333900413

12/06/13

Name: Eugene G Maurice
DOB: 01/02/1949

WellStar Outpatient Self Pay Program Acknowledgment

The Outpatient Self Pay Program option for my services on (date) 12/6/13 has been explained to me. I understand the estimate provided to me by WellStar is only an estimate of what my out-of-pocket responsibility may be based upon what information my health insurance has provided to WellStar.

I understand that exams may be changed or added to meet my clinical needs per physician's orders and that some charges may be excluded from WellStar's Outpatient Self Pay Program and will be billed at full charges, unless other arrangements are made at the time of service.

Accept

By initialing below, I (on behalf of myself as the patient, or as the legally financial responsible person) am agreeing to pay WellStar's discounted cash price for the services provided by WellStar.

I agree NOT to file a bill for these services with a commercial health insurance or government payer and am agreeing that WellStar also will NOT file a claim for these services with a commercial health insurance or government payer now or at any time in the future for this service.

Please Initial All Lines Below:

_____ (initials) I **choose** to use the Self Pay Program for eligible exams.

_____ (initials) I understand that I may elect to have some exams billed through the Self Pay Program and others to my health insurance company.

_____ (initials) I understand this decision cannot be reversed at a later date.

Decline

By initialing below, I (on behalf of myself as the patient, or as the legally financial responsible person) am choosing NOT to pay WellStar's discounted cash price for the services provided by WellStar.

Please Initial All Lines Below:

X EBM (initials) I **decline** to use the Self Pay Program and choose to bill my applicable health insurance, pay out of pocket, or apply for financial assistance.

X EBM (initials) I understand this decision cannot be reversed at a later date.

X Eugene B Maurice
SIGNATURE OF PATIENT (or patient representative) — Date: 12/6/13 — Time: 3:00 PM

SIGNATURE OF WITNESS — Date: 12/6/13 — Time: 3:00 PM

WellStar

☐ Cobb ☐ Douglas ☐ Kennestone
☑ Paulding ☐ Windy Hill

Outpatient Self Pay Program Acknowledgment

FORM #WS1183 ITEM #101120

MR#000286367 R:
MAURICE,EUGENE G
01/02/49 M 64Y
2ZCNERVU,ARUN
ACCT# L1333900413

12/06/13

1-WS1183

1-WS1183

Rev. 01/2012
HIM Approved 8/2012

IV. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

- In consideration of the amount of medical expenses to be incurred, Patient hereby assigns all hospital and medical provider benefits payable (i.e. "Payor": Insurance Coverage, ERISA, Medicare, Medicaid, Social Security, etc.) and related rights existing under the Payor coverage that Patient has identified or will identify in connection with the services provided directly to WellStar. This is a direct assignment of Patient's rights and benefits under this policy.
- Patient understands that any payment received by WellStar for this period may be applied to any unpaid bill(s) for which Patient is liable.
- Patient understands that different Payors have different requirements for payment including, but not limited to, pre-certifications, authorizations within 24 hours of admission or that the services be medically necessary. Patient understands that verification of benefits from Patient's Insurance Company is not a guarantee that services are covered or will be paid by the Insurance Company.
- **Patient understands that it is Patient's obligation to know his/her Payor's requirements and ensure that they have been fulfilled.**
- Patient understands and agrees that Patient is financially responsible for any charges not covered by this assignment and agrees to pay WellStar the full balance that is not reimbursed by Patient's medical provider benefits (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries)
- If Patient's insurance company provides payment for covered services in a check made payable to Patient, Patient agrees that these funds are owed to WellStar. Patient further agrees to pay the hospital in full for any funds received in this manner.
- Patient authorizes and designates WellStar or any of its affiliated business organizations ("Affiliates") to be Patient's Authorized Personal Representative, which allows WellStar or its Affiliates to: (1) submit any and all appeals, including arbitration, when Patient's benefits company denies benefits to which Patient is entitled, (2) submit any and all requests for benefit information from Patient's benefits company, and (3) initiate formal complaints to any applicable State or Federal agency or court that has jurisdiction over Patient's benefits. Patient further agrees to execute any and all additional documents or forms that may be required by Patient's benefits company to effectuate such designation as Patient's Authorized Personal Representative. This assignment and designation will remain in effect until revoked by Patient in writing.
- **Patient understands and agrees that it is Patient's responsibility to contact Customer Service at 770-792-5400 within 72 hours to provide any insurance information not provided today.**

V. ASSIGNMENT OF MEDICARE AND MEDICAID BENEFITS, PATIENT CERTIFICATION AND PAYMENT REQUEST: Patient hereby certifies that the information given by Patient in applying for payment under title XVII and XIX of the Social Security Act is correct. Patient requests that payment of the authorized benefits be made and assigned the benefits payable for services rendered during this admission to the physician or organization furnishing the services. The undersigned, if not the patient, is also responsible for and agrees to pay charges not covered by this assignment, including any Medicare deductibles.

VI. FINANCIAL ADVISOR: Patient understands that WellStar will charge Patient its standard chargemaster rates for all services that are not covered by a Payor or that are self-pay. Patient understands that Patient may qualify for financial assistance in connection with Patient's payment obligations and that WellStar offers various payment programs and provides Financial Counselors to discuss these options. (Please contact WellStar at 770-792-5400 for more information on charity care policies, uncompensated services, assistance through various state and federal programs, or if Patient wants information on payment plan options that may be available).

VII. RELEASE OF INFORMATION: Patient hereby acknowledges and gives express permission for WellStar to release all of Patient's protected health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes. Patient consents to the videotaping, photographing, televising or publishing related to this treatment/operation/procedure, which shall only be done for treatment, payment or healthcare operation purposes or as otherwise permitted by law. This release will remain in effect until revoked by Patient in writing.

VIII. PERSONAL VALUABLES: WellStar shall not be liable for the loss or damage of any personal belongings including, but not limited to, money, jewelry, hearing aids, or dentures, unless placed within a WellStar safe.

X Eugene B Maurice — SIGNATURE OF PATIENT (OR PATIENT REPRESENTATIVE)

Self — RELATION

12/6/13 — DATE

5:22 AM/PM — TIME

L. Lindle — WITNESS

12/6/13 — DATE

3:11 AM/PM — TIME

WellStar

☐Cobb ☐Douglas ☐Kennestone

☒Paulding ☐Windy Hill ☐Other _____

General Consent to Treat & Financial Responsibility Statement

MR#000286367 R: -
MAURICE,EUGENE G
01/02/49 M 64Y
ZZCHERVU,ARUN
ACCT# L1333900413

12/06/13

Revision Date 4/2013
HIM Approved 4/2013

GENERAL CONSENT TO TREAT & FINANCIAL RESPONSIBILITY STATEMENT

IMPORTANT: PLEASE READ THIS DOCUMENT AND SIGN. Mark out and initial any Procedure on this Form for which you do not consent.

Patient, or the undersigned representative acting on behalf of Patient (as used in this Form, the "Patient" includes a representative signing or acting on behalf of Patient), agrees and consents as follows:

I. CONSENT TO TREATMENT:

- Patient hereby consents to medical or hospital care encompassing diagnostic procedures and medical treatments including but not limited to: examinations, x-rays, laboratory procedures, medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedures, radiation therapy, and other services which Patient may require, and as may be ordered by physicians responsible for such medical or hospital care.
- Patient further consents to treatment by authorized employees or agents of WellStar Health System ("WellStar") assigned to Patient's care. Patient understands the practice of medicine is not an exact science and acknowledges that no guarantees have been made as to the results of treatments, examinations or medical care at WellStar.
- Patient acknowledges that Patient can ask questions about Patient's medical care. Patient understands there are some independent medical professionals and their employees on the medical staff of WellStar providing medical care who are NOT employees or agents of WellStar, including but not limited to, Emergency Department physicians, radiologists, and surgeons. Patient further understands that services provided by independent medical professionals, exercising independent medical judgment, with staff privileges at a WellStar facility in no way creates any type of employment, partnership, joint venture, franchise, or other relationship with a WellStar facility other than as independent contractor. Patient acknowledges that Patient has the opportunity to question any provider of medical services as to his or her affiliation with the WellStar facility.
- Patient certifies that any personal information provided is correct and accurate.
- Patient understands that WellStar's mission includes training physicians and other medical personnel and conducting medical research. Patient acknowledges that students may participate in Patient's care. If Patient is asked to participate in a research study, Patient may refuse to participate and such refusal will not affect or compromise Patient's access to medical services.

II. EXPLANATION OF RISKS AND TREATMENT ALTERNATIVES:

- As part of Patient's consent to treatment, Patient consents to healthcare professionals performing Procedures deemed reasonably necessary or desirable in the exercise of the healthcare professional's professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained. Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the Procedures, the material risks of the Procedures, and practical alternatives to the Procedures. The Procedures may include the following:
  - Needle Sticks: including shots, injections, peripheral intravenous catheter insertions, or intravenous injections (IV's). Material risks include, but are not limited to: nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scarring, loss of limb function, paralysis or partial paralysis or death. Alternatives (if available) include: oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.
  - Physical tests, assessments and treatments: including vital signs, internal body examinations, wound cleansing, wound dressing, surgical debridement, range of motion checks, and other similar procedures. Material risks include, but are not limited to: allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scarring, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.
  - Administration of Medications: including oral, rectal, topical or through Patient's eye, ear or nose. Material risks include, but are not limited to: perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.
  - Drawing Blood, Bodily Fluids, or Tissue Samples: including laboratory testing and analysis. Material risks include, but are not limited to: paralysis, or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.
  - Insertion of internal tubes: including bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. Material risks include, but are not limited to: internal injuries, bleeding, infection, allergic reaction, loss of bladder control, and/or difficulty urinating after catheter removal. Apart from external collection devices or refusal of treatment, no practical alternatives exist.
  - X-rays and other radiological studies _____
  - Other: _____
- If Patient has any questions or concerns regarding these Procedures, Patient will ask Patient's attending provider to provide additional information. Patient also understands that Patient's attending or other provider may ask Patient to sign additional informed consent documents concerning these or other procedures.

III. CONTINUOUS CONSENTS: The above consents are applicable to all recurring in- or outpatient services, including **Maternity Patients** for prenatal course of treatment, and any repetitive services provided hereafter for the term of one (1) year from this date.

INITIALS (patient or patient representative): EBM

WellStar
☐Cobb ☐Douglas ☐Kennestone
☑Paulding ☐Windy Hill ☐Other _____
General Consent to Treat & Financial Responsibility Statement

MR#000286367 R: -
MAURICE,EUGENE G
01/02/49 M 64Y
ZZCHERVU,ARUN
ACCT# L1333900413

12/06/13

CKER

WELLSTAR

PAULDING HOSPITAL
ECO WEST MEMORIAL
DALLAS,GA 30132
(770) 445-4411
Fax (770) 505-6884

ADMISSION RECORD

CORPORATE NUMBER: 02894730

PATIENT

ACCOUNT NO.	ADMISSION DATE / TIME	ROOM/BED	AC	SEX	MS	RACE	SERVICE	PT	PC	DATE OF BIRTH	AGE	ACCIDENT/WORK DATE	UNIT NUMBER
L14003009B0	01/03/14 1427	-		M	M	1	MED	PDO	35	01/02/49	65Y	NO	000286367

NAME AND ADDRESS
MAURICE,EUGENE G
61 SHOCKLEY WAY
DALLAS GA 301578973

SOC-SEC-NO
339-42-1524
PHONE MESSAGE?
(678)398-9479
110

DIAGNOSIS/COMPLAINT
414.00-COR ATH UNSP VSL NTV/GFT

PREVIOUS ADMIT NAME: MAURICE,EUGENE G
DATE: 12/06/13
ARRIVAL MODE:

EMPLOYER NAME & ADDRESS

OCCUPATION
NOT EMPLOYED

ADMITTING PHYSICIAN: CHENG,ALAN C
PUBLICITY:
ADM BY:

ATTENDING PHYSICIAN: CHENG,ALAN C
ADM TYPE: 3
ROOM PREF:

PRIMARY CARE PHYSICIAN: UNKNOWN,DOCTOR
ADM SRC: 1
COU OIS: NO
STATION: PDO

GUAR

NAME AND ADDRESS
MAURICE,EUGENE G
61 SHOCKLEY WAY
DALLAS GA 301578973

SOC-SEC-NO: 339-42-1524 PC
PHONE MESSAGE?
(678)398-9479
SELF

EMPLOYER NAME & ADDRESS
NOT EMPLOYED

INSURANCE

INSURANCE 1 & 2

AETNA /MDCR HMO OPEN AC
ATTN CLAIMS DEPT
P O BOX 981107
EL PASO TX 79998-1107

MDCR HMO OPE 339421524A
MAURICE,EUGENE G
MEBH34SM

AETNA /MDCR HMO OA PROFE
ATTN CLAIMS DEPT
P O BOX 981107
EL PASO TX 79998-1107

MDCR HMO OPE 339421524A
MAURICE,EUGENE G
MEBH34SM

INSURANCE 3 & 4

MISC

RELATIVE 1
MAURICE,SHIRLEY A
61 SHOCKLEY WAY (678)910-2476
DALLAS GA 30157-8973

SPOUS

RELATIVE 1 EMPLOYER
;

CHURCH:
DENOMINATION:
ADVANCE DIRECTIVE: N

FUNERAL HOME:
CHART LOCATION:
HOME HEALTH PLAN:

PREFERRED LANGUAGE: ENGLISH
NOTICE OF PRIVACY PRACTICE: No
DATE OF PRIVACY PRACTICE:

Insurance information reflects that which the patient provides at time of registration and as such is subject to verification.

CRT Used: CSV

OPT OUT: **PUBLICITY:** **OPT OUT DATE:**

Consultants:

Discharge Date/Time:

Primary Diagnosis:

Other Diagnosis:

Codes:

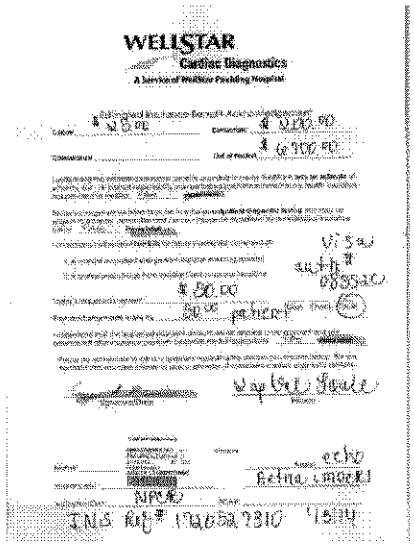
Primary Procedure:

Other Procedure(s):

Codes CPT Date

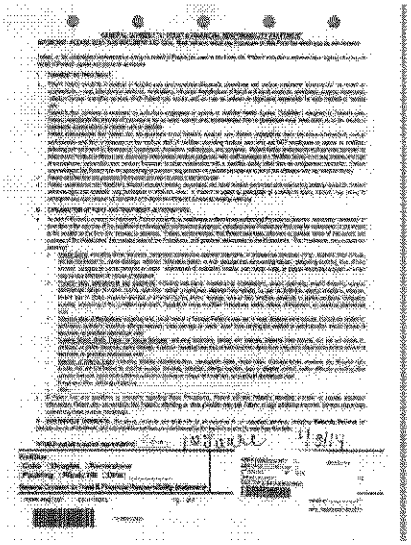
Date Physician's Signature

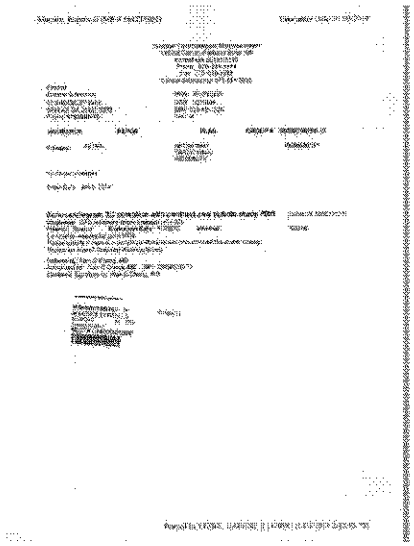
Rev. 04/2011

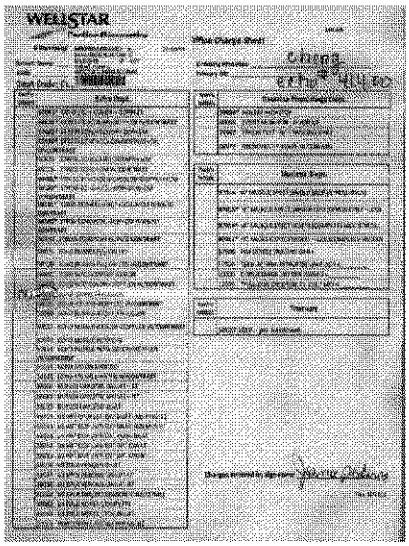


WELLSTAR
Cardiac Diagnostics
A Service of Wellstar Paulding Hospital

$ 35.00 $ 1100.00
$ 650.00
visa
auth #
$50.00
echo






WELLSTAR

ENCOUNTER

Patient Class:	OP		Unit:	PH CVM HIRAM	
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found	
Admitting Provider:			Referring Physician:	Sheikh, Abdul M	
Attending Provider:	Abdul m sheikh	AD: N	Adm Diagnosis:	CAD (coronary artery dis*	
Admission Date:	4/22/2014		Admission Time:	0830	

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (65 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:	AE44245101400012	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:	MEBH34SM
		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 3, 2020 Chart ID 

Admission Information

Arrival Date/Time:		Admit Date/Time:	04/22/2014 0830	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
04/22/2014 2359	Home Or Self Care	None	None	WellStar Cardiac Diagnostics (PH CV1 HIRAM)

Final Diagnoses (ICD-9-CM)

Code	Description	POA	CC	HAC	Affects DRG
414.00 **[Principal]**	Coronary atherosclerosis of unspecified type of vessel, native or graft				

Events

Hospital Outpatient at 4/22/2014 0830

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Discharge at 4/22/2014 2359

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Allergies as of 4/22/2014

Reviewed on 4/7/2014

No Known Allergies

Medical as of 4/22/2014

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [414.00 (ICD-9-CM)]	—	—	Provider
Coronary atherosclerosis of native coronary artery [414.01 (ICD-9-CM)]	—	—	Provider
Essential hypertension, benign [401.1 (ICD-9-CM)]	—	—	Provider
Family history of ischemic heart disease [V17.3 (ICD-9-CM)]	—	—	Provider
Hyperlipidemia [272.4 (ICD-9-CM)]	—	—	Provider
Hypertension [401.9 (ICD-9-CM)]	—	—	Provider
Obesity [278.00 (ICD-9-CM)]	—	—	Provider
Other and unspecified hyperlipidemia [272.4 (ICD-9-CM)]	—	—	Provider
Other symptoms involving cardiovascular system [785.9 (ICD-9-CM)]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [443.9 (ICD-9-CM)]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [794.31 (ICD-9-CM)]	04/07/2014	—	Provider
Aneurysm (HCC) [442.9 (ICD-9-CM)]	04/07/2014	—	Provider
Arrhythmia [427.9 (ICD-9-CM)]	04/07/2014	—	Provider
Asthma [493.90 (ICD-9-CM)]	04/07/2014	—	Provider
Cancer (HCC) [199.1 (ICD-9-CM)]	04/07/2014	—	Provider
Chronic kidney disease [585.9 (ICD-9-CM)]	04/07/2014	—	Provider
Clotting disorder (HCC) [286.9 (ICD-9-CM)]	04/07/2014	—	Provider
Congenital heart disease [746.9 (ICD-9-CM)]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [453.40 (ICD-9-CM)]	04/07/2014	—	Provider
Diabetes mellitus (HCC) [250.00 (ICD-9-CM)]	04/07/2014	—	Provider

Medical as of 4/22/2014 (continued)

Heart failure (HCC) [428.9 (ICD-9-CM)]	04/07/2014	—	Provider
Heart murmur [785.2 (ICD-9-CM)]	04/07/2014	—	Provider
Mitral valve prolapse [424.0 (ICD-9-CM)]	04/07/2014	—	Provider
Myocardial infarction [410.90 (ICD-9-CM)]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [415.19 (ICD-9-CM)]	04/07/2014	—	Provider
Sleep apnea [780.57 (ICD-9-CM)]	04/07/2014	—	Provider
Stroke (HCC) [434.91 (ICD-9-CM)]	04/07/2014	—	Provider
Valvular disease [424.90 (ICD-9-CM)]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Cardiology Diag (Merge Interp) - Orders and Results

NM HEART MYOCARDIAL PERFUSION MULTI SPECT (EXERCISE) [518116929]

Electronically signed by: **Abdul M Sheikh, MD on 04/07/14 1412** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 04/07/14 1412 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Edited Result - FINAL
Instance released by: Laura J Phillips 4/22/2014 8:33 AM
Diagnoses
CAD (coronary artery disease) [414.00 (ICD-9-CM)]

Questionnaire

Question	Answer
Does the patient's weight exceed 350 lbs?	No
Does the patient have any conditions that would prevent them from walking on a treadmill?	No
Do you want beta blocker or calcium channel blocker medications held prior to the procedure?	Yes
Reason for exam?	Coronary Atherosclerosis

NM HEART MYOCARDIAL PERFUSION MULTI SPECT (EXERCISE) [518116929]

Resulted: 04/22/14 1807, Result status: Edited Result - FINAL

Order status: Completed Resulted by: Alan C Cheng, MD
Filed on: 04/22/14 1813 Performed: 04/22/14 0839 - 04/22/14 1024
Accession number: 25187136 Resulting lab: NM/ECHO STRESS
Result details
Narrative:
Cardiovascular Medicine - Hiram
148 Bill Carruth Parkway Suite 100
Hiram, GA 30141
Phone (678) 324-4444
Fax (770) 528-9932

Nuclear Stress Test

Bruce protocol

Patient: Maurice, Eugene G MR #: 561253820 Height: 67 in
DOB: 01/02/1949 (65yrs) Study Date: 04/22/2014 Weight: 225 lb
Acct #: 40000026329 Gender: M
Referring physician: Abdul Sheikh, MD
Ordering physician: Abdul Sheikh, MD
Interpreting physician: Alan Cheng, MD
Nuclear tech: Jeremy Smith CNMT

Clinical indication: Coronary atherosclerosis of unspecified type of vessel native or graft (414.00).

Impressions: Positive: risk/extent of ischemia is low.
Summary:

1. Procedure narrative: The image quality was good. Rotating projection images reveal diaphragmatic attenuation.
2. Stress ECG conclusions: The stress ECG is non-diagnostic. There are resting inferolateral downsloping ST depression and T wave inversions that are highly exagerrated with stress.
3. Myocardial perfusion imaging: There are 2 perfusion defects:

   1) Small, partially reversible, inferior and inferolateral defect of mild severity. There is some diaphramatic artifact here.
   2) Small basal anterior reversible defect of mild severity.
4. Gated SPECT: The calculated left ventricular ejection fraction is 47%. LV global systolic function is depressed.

Study data: Nuclear stress test. Study status: Routine. Consent: The risks, benefits, and alternatives to the procedure were explained to the patient and informed consent was obtained. Procedure: Initial setup. Intravenous access was obtained. Treadmill exercise testing was performed using the Bruce protocol. The patient exercised for 7 min 15 sec, to protocol stage 3, to a maximal work rate of 8.8 mets.

Cardiology Diag (Merge Interp) - Orders and Results (continued)

Baseline ECG: Q waves in I and aVL. ST/T wave changes in inferolateral leads. Normal sinus rhythm. There was an old myocardial infarction.
Stress results: Maximal heart rate during stress was 133 bpm (86% of maximal predicted heart rate). The maximal predicted heart rate was 155 bpm.The target heart rate was achieved. The heart rate response to stress is normal. There is a normal resting blood pressure with an appropriate response to stress. Mild stress-induced chest pain which resolved spontaneously.
Stress ECG: The stress ECG is non-diagnostic. There are resting inferolateral downsloping ST depression and T wave inversions that are highly exagerrated with stress.
Image properties: The image quality was good. Rotating projection images reveal diaphragmatic attenuation.
Myocardial perfusion imaging: Left ventricular size is normal. The TID ratio is 1.12. There are 2 perfusion defects:

1) Small, partially reversible, inferior and inferolateral defect of mild severity. There is some diaphramatic artifact here.
2) Small basal anterior reversible defect of mild severity.
Gated SPECT: The calculated left ventricular ejection fraction is 47%. LV global systolic function is depressed.
Stress protocol:

Stage	HR	BP (mmHg)	Comments
Supine	56	142/76 (98)	weakness, exhaustion, dyspnea, chest tightness at peak, myoview injected at 6min and 50sec into nuclear test
Standing	66	148/74 (99)	
1; 1.7 mph, 10degrees	95	142/78 (99)	
2; 2.5 mph, 12degrees	119	150/84 (106)	
3; 3.4 mph, 14degrees	133		
Immediate post stress	119	158/90 (113)	
Recovery; 2 min	99	144/88 (107)	
Recovery; 5 min	87	136/84 (101)	

Isotope administration:

- Rest Tc[99m]-tetrofosmin 10.9 mCi Prior to imaging
- Stress Tc[99m]-tetrofosmin 30.9 mCi Peak exercise stress
Prepared and electronically signed by

Alan Cheng, MD
2014-04-22T18:07:52.427

Reviewed by

Abdul M Sheikh, MD on 04/23/14 1740

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

All Flowsheets

Flowsheets (all recorded)

Vital Signs

Row Name	
[REMOVED] Peripheral IV 04/22/14 Right Hand	
IV Properties	Placement Date: 04/22/14 -JS Placement Time: 0840 -JS Present on arrival to hospital?: No -JS Type of Catheter: Straight -JS Size (Gauge): 22 G -JS Orientation: Right -JS Location: Hand -JS Site Prep: Alcohol -JS Local Anesthetic: None -JS Insertion attempts: 1 -JS Patient Tolerance: Tolerated well -JS IV Access Problem: No -JS Removal Date: 05/30/14 -SS Removal Time: 1137 -SS (Retired) Inserted by: js -JS

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	04/22/14 0840
Lines/Drains/Airways	
Add Line, Drain, or Airway	Yes -JS
[REMOVED] Peripheral IV 04/22/14 Right Hand	
IV Properties	Placement Date: 04/22/14 -JS Placement Time: 0840 -JS Present on arrival to hospital?: No -JS Type of Catheter: Straight -JS Size (Gauge): 22 G -JS Orientation: Right -JS Location: Hand -JS Site Prep: Alcohol -JS Local Anesthetic: None -JS Insertion attempts: 1 -JS Patient Tolerance: Tolerated well -JS IV Access Problem: No -JS Removal Date: 05/30/14 -SS Removal Time: 1137 -SS (Retired) Inserted by: js -JS

Flowsheets (all recorded)

Procedure Verification

Row Name	04/22/14 0840
Procedure Verification	
Patient ID Verified	Verbal;Armband;Emergency ID Band -JS
Procedure Verified	Yes -JS

User Key

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

Initials	Name	Effective Dates
JS	Jeremy B Smith, CNMT	04/01/14 - 07/24/14
SS	Shawn J Shy, RN	04/02/14 - 02/02/17

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 04/22/2014:

Scan on 4/22/2014 8:47 AM by Laura J Phillips: ImageNow scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	OP	Unit:	PH CVM HIRAM
Hospital Service:	No service for patient encounter.	Bed:	Room/bed info not found
Admitting Provider:		Referring Physician:	Sheikh, Abdul M
Attending Provider:	Abdul m sheikh AD: N	Adm Diagnosis:	Coronary artery disease *
Admission Date:	5/20/2015	Admission Time:	0816

PATIENT

Name	Eugene George Maurice	Sex:	Male	DOB:	1/2/1949 (66 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:			

Admission Information

Arrival Date/Time:		Admit Date/Time:	05/20/2015 0816	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/20/2015 2359	Home Or Self Care	None	None	WellStar Cardiac Diagnostics (PH CV1 HIRAM)

Final Diagnoses (ICD-9-CM)

Code	Description	POA	CC	HAC	Affects DRG
414.01 **[Principal]**	Coronary atherosclerosis of native coronary artery				
413.9	Other and unspecified angina pectoris (HCC)				

Events

Hospital Outpatient at 5/20/2015 0816

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Discharge at 5/20/2015 2359

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Allergies as of 5/20/2015

Reviewed on 5/12/2015

No Known Allergies

Medical as of 5/20/2015

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [414.00 (ICD-9-CM)]	—	—	Provider
Coronary atherosclerosis of native coronary artery [414.01 (ICD-9-CM)]	—	—	Provider
Diabetes mellitus (HCC) [250.00 (ICD-9-CM)]	—	—	Provider
Essential hypertension, benign [401.1 (ICD-9-CM)]	—	—	Provider
Family history of ischemic heart disease [V17.3 (ICD-9-CM)]	—	—	Provider
Hyperlipidemia [272.4 (ICD-9-CM)]	—	—	Provider
Hypertension [401.9 (ICD-9-CM)]	—	—	Provider
Infectious viral hepatitis [070.1 (ICD-9-CM)]	—	as teen/cannont recall what type	Provider
Obesity [278.00 (ICD-9-CM)]	—	—	Provider
Other and unspecified hyperlipidemia [272.4 (ICD-9-CM)]	—	—	Provider
Other symptoms involving cardiovascular system [785.9 (ICD-9-CM)]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [443.9 (ICD-9-CM)]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [794.31 (ICD-9-CM)]	04/07/2014	—	Provider
Aneurysm (HCC) [442.9 (ICD-9-CM)]	04/07/2014	—	Provider
Arrhythmia [427.9 (ICD-9-CM)]	04/07/2014	—	Provider
Asthma [493.90 (ICD-9-CM)]	04/07/2014	—	Provider
Cancer (HCC) [199.1 (ICD-9-CM)]	04/07/2014	—	Provider
Chronic kidney disease [585.9 (ICD-9-CM)]	04/07/2014	—	Provider

All Scans (continued)

Medical as of 5/20/2015 (continued)

Clotting disorder (HCC) [286.9 (ICD-9-CM)]	04/07/2014	—	Provider
Congenital heart disease [746.9 (ICD-9-CM)]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [453.40 (ICD-9-CM)]	04/07/2014	—	Provider
Heart failure (HCC) [428.9 (ICD-9-CM)]	04/07/2014	—	Provider
Heart murmur [785.2 (ICD-9-CM)]	04/07/2014	—	Provider
Mitral valve prolapse [424.0 (ICD-9-CM)]	04/07/2014	—	Provider
Myocardial infarction [410.90 (ICD-9-CM)]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [415.19 (ICD-9-CM)]	04/07/2014	—	Provider
Sleep apnea [780.57 (ICD-9-CM)]	04/07/2014	—	Provider
Stroke (HCC) [434.91 (ICD-9-CM)]	04/07/2014	—	Provider
Valvular disease [424.90 (ICD-9-CM)]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Cardiology Diag (Merge Interp) - Orders and Results

NM HEART MYOCARDIAL PERFUSION MULTI SPECT (EXERCISE) [561347311]

Electronically signed by: **Abdul M Sheikh, MD on 05/12/15 1121** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 05/12/15 1121 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Edited Result - FINAL
Instance released by: Laura J Phillips 5/20/2015 8:16 AM
Diagnoses
Coronary artery disease involving native coronary artery with unspecified angina pectoris [414.01, 413.9 (ICD-9-CM)]

Questionnaire

Question	Answer
Does the patient's weight exceed 350 lbs?	No
Does the patient have any conditions that would prevent them from walking on a treadmill?	No
Do you want beta blocker or calcium channel blocker medications held prior to the procedure?	Yes
Reason for exam?	Precordial Pain

NM HEART MYOCARDIAL PERFUSION MULTI SPECT (EXERCISE) [561347311] Resulted: 05/20/15 2117, Result status: Edited Result - FINAL

Order status: Completed
Filed on: 05/20/15 2124
Accession number: 26249784
Result details
Narrative:
Cardiovascular Medicine - Hiram
148 Bill Carruth Parkway Suite 100
Hiram, GA 30141
Phone (678) 324-4444
Fax (770) 528-9932

Nuclear Stress Test

Bruce protocol

Patient: Maurice, Eugene G MR #: 561253820 Height: 67 in
DOB: 01/02/1949 (66yrs) Study Date: 05/20/2015 Weight: 215 lb
Acct #: 40000335677 Gender: M
Referring physician: Jeffrey Tharp, MD
Sheikh, M
Ordering physician: Abdul Sheikh, MD
Interpreting physician: Paul Guichard, DO
Nuclear tech: Anitra Laury, CNMT

Clinical indication: Coronary atherosclerosis of native coronary artery (414.01).

Impressions: Positive: risk/extent of ischemia is high.
Summary:

1. Stress ECG conclusions: Duke scoring: exercise time of 8 min; maximum ST deviation of 1.5 mm; angina present but did not limit exercise; resulting score is -3.5. This score predicts a moderate risk of cardiac events.
2. Myocardial perfusion imaging: The TID ratio is 0.71. There is a large, moderate, partially reversible defect involving the basal and mid inferolateral wall(s).
3. Gated SPECT: The calculated left ventricular ejection fraction is 39%.

Study data: Nuclear stress test. Study status: Routine. Consent: The risks, benefits, and alternatives to the procedure were explained to the patient and informed consent was obtained. Procedure: Initial setup. Intravenous access was obtained. Treadmill exercise testing was performed using the Bruce protocol. The patient exercised for 8 min, to a maximal work rate of 10.1 mets.

Baseline ECG: There was an old myocardial infarction.
Stress results: Maximal heart rate during stress was 133 bpm (86% of maximal predicted heart rate). The maximal predicted heart rate was 154 bpm. There is

Resulted by: Paul C Guichard, DO
Performed: 05/20/15 0833 - 05/20/15 1127
Resulting lab: NM/ECHO STRESS

Cardiology Diag (Merge Interp) - Orders and Results (continued)

a normal resting blood pressure with a hypotensive response to stress.
Stress ECG: Duke scoring: exercise time of 8 min; maximum ST deviation of 1.5 mm; angina present but did not limit exercise; resulting score is -3.5. This score predicts a moderate risk of cardiac events.
Image properties: The image quality was good.
Myocardial perfusion imaging: The TID ratio is 0.71. There is a large, moderate, partially reversible defect involving the basal and mid inferolateral wall(s).
Gated SPECT: The calculated left ventricular ejection fraction is 39%.
Stress protocol:

Stage	HR	BP (mmHg)	ST/T	Rhythm	Symptoms	Comments
Supine	52					
Standing	62	132/60 (84)				
1; 1.7 mph, 10 degrees	99	130/60 (83)	Anterior ischemia/ block	Ventricular bigeminy	2 out of 10 chest discomfort	
2; 2.5 mph, 12 degrees	122	122/60 (81)	Inverted T-waves, 0.5-1 mm in V4, V5 and V6, II, III, aVL, aVF		7:00 Exhaustion injected at BP decreased with exercise	
3; 3.4 mph, 14 degrees	133					
Immediate post stress	126	70 (89)				
Recovery; 2 min	83	160/60 (93)				
Recovery; 5 min	60	150/70 (97)				

Isotope administration:

- Rest Tc[99m]-tetrofosmin 11 mCi Prior to imaging
- Stress Tc[99m]-tetrofosmin 31 mCi Peak exercise stress

Prepared and electronically signed by

Paul Guichard, DO
2015-05-20T21:17:46.073

Reviewed by

Abdul M Sheikh, MD on 05/22/15 0803

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

Title: Acute MI (MCB) (Not Started)

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

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

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

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

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

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

Point: Recognizing a Heart Attack (MCB) (Not Started)

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 (Not Started)

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) (Not Started)

Point: Emergency Plan for Heart Attack Symptoms (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

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.

All Flowsheets

Flowsheets (all recorded)

Vital Signs

Row Name					
[REMOVED] Peripheral IV 05/20/15 Right Hand					
IV Properties	Placement Date: 05/20/15 -AL Placement Time: 0833 -AL Type of Catheter: Straight -AL Orientation: Right -AL Location: Hand -AL Site Prep: Alcohol -AL Local Anesthetic: None -AL Removal Date: 05/20/15 -AL Removal Time: 1127 -AL (Retired) Inserted by: AL -AL				

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	05/20/15 0833
Lines/Drains/Airways	
Add Line, Drain, or Airway	Yes -AL
[REMOVED] Peripheral IV 05/20/15 Right Hand	
IV Properties	Placement Date: 05/20/15 -AL Placement Time: 0833 -AL Type of Catheter: Straight -AL Orientation: Right -AL Location: Hand -AL Site Prep: Alcohol -AL Local Anesthetic: None -AL Removal Date: 05/20/15 -AL Removal Time: 1127 -AL (Retired) Inserted by: AL -AL

User Key

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

Initials	Name	Effective Dates
AL	Anitra L Laury, CNMT	09/05/14 - 02/02/17

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 05/20/2015:

Scan on 5/20/2015 8:28 AM by Laura J Phillips: ImageNow scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	OP		Unit:	PH CVM HIRAM
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found
Admitting Provider:			Referring Physician:	Sheikh, Abdul M
Attending Provider:	Abdul m sheikh	AD: N	Adm Diagnosis:	Coronary artery disease *
Admission Date:	3/29/2016		Admission Time:	0850

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: No info available	Deductible: No info available Out of Pocket

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:	03/29/2016 0850	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
03/29/2016 2359	Home Or Self Care	None	None	WellStar Cardiac Diagnostics (PH CV1 HIRAM)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.10 **[Principal]**	Atherosclerotic heart disease of native coronary artery without angina pectoris				
E78.4	Other hyperlipidemia				
I10	Essential (primary) hypertension				
I73.9	Peripheral vascular disease, unspecified				

Events

Hospital Outpatient at 3/29/2016 0850

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Discharge at 3/29/2016 2359

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Allergies as of 3/29/2016

Reviewed on 3/18/2016

No Known Allergies

Immunizations as of 3/29/2016

Immunizations never marked as reviewed

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 3/29/2016

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

All Scans (continued)

Medical as of 3/29/2016 (continued)

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

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Echocardiography - Orders and Results

ECHO 2D PANEL W/ CONTRAST/BUBBLE PRN [614013905]

Electronically signed by: **Abdul M Sheikh, MD on 03/18/16 1600** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 03/18/16 1600 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Final result
Instance released by: Sherry D Luoma 3/29/2016 8:51 AM
Diagnoses
Coronary artery disease involving native coronary artery of native heart without angina pectoris [I25.10]
Other hyperlipidemia [E78.4]
Essential hypertension [I10]
PVD (peripheral vascular disease) (HCC) [I73.9]

Questionnaire

Question	Answer
Reason for exam?	Coronary Artery Disease

ECHO 2D PANEL W/ CONTRAST/BUBBLE PRN [614013905] (Abnormal)

Resulted: 03/29/16 1345, Result status: Final result

Order status: Completed Resulted by: Abdul M Sheikh, MD
Filed on: 03/29/16 1345 Performed: 03/29/16 0856 - 03/29/16 0955
Accession number: 27118497 Resulting lab: NONINV CARDIOLOGY
Result details
Narrative:
· 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.

Components

Component	Value	Reference Range	Flag	Lab
2D LV PW	1.41	0.6 - 1.1 cm	A !	NonInv Card
TDI e' Lateral	9.94	cm/s	—	NonInv Card
MV Peak A Vel	81.4	cm/s	—	NonInv Card
MV Peak Gradient	6	mmHg	—	NonInv Card
TR Max Vel	194	cm/s	—	NonInv Card
Ao Peak Velocity	174	cm/s	—	NonInv Card
Ao VTI	39.4	cm	—	NonInv Card
AV Mean Gradient	6	mmHg	—	NonInv Card
AV Peak Gradient	14	mmHg	—	NonInv Card
AV Comp VTI	39.4	cm	—	NonInv Card
RVOT VTI	15.9	cm	—	NonInv Card
PV Mean Gradient	3	—	—	NonInv Card
PV Peak Gradient	6	mmHg	—	NonInv Card
MA Vel - Ea, Medial	8.97	cm/s	—	NonInv Card
LA size (2D)	4.3	cm	—	NonInv Card
Ao root annulus 2D	3.4	cm	—	NonInv Card
LVID, ED	4.98	3.5 - 6.0 cm	—	NonInv Card
LVID, ES	3.67	3.5 - 6.0 cm	—	NonInv Card
LA size 2D	4.3	cm	—	NonInv Card
LVOT Area	3.46	cm2	—	NonInv Card
Mitral Annulus Vel EA Lat	8.97	cm/s	—	NonInv Card
2D IVSD	1.37	cm	—	NonInv Card
MV Peak E Vel	123	cm/s	—	NonInv Card
2D Ejection Fraction	60.2	%	—	NonInv Card
FS	26	%	—	NonInv Card
E/Ea Medial Annulus	13.7	—	—	NonInv Card
Ao Mean Velocity	117	cm/s	—	NonInv Card
Mitral Deceleration Time	187	ms	—	NonInv Card
LA 2D Index	1.95	cm/m2	—	NonInv Card
LA Dimension, ES	4.3	cm	—	NonInv Card
LA Sup-Inf dimension ES, PLAX	4.3	cm	—	NonInv Card
2D RVID, ED, PLAX	2.85	cm	—	NonInv Card
RVID ED PSAX	2.85	cm	—	NonInv Card
Peak RV-RA Grad S	15	mmHg	—	NonInv Card
2D Asc Ao Diameter	3.3	cm	—	NonInv Card
TV Peak Regurg Velocity	194	cm/s	—	NonInv Card

Echocardiography - Orders and Results (continued)

IVS/LVPW	0.97	—	—	Noninv Card
MA E/Ea, Lateral	12.37	—	—	Noninv Card
MA E/Ea Medial	13.71	—	—	Noninv Card
E/A ratio	1.51	—	—	Noninv Card
LVIDD mMode	—	3.5 - 6.0 cm	—	Noninv Card
LVIDS mMode	—	2.1 - 4.0 cm	—	Noninv Card
EF	—	—	—	Noninv Card
LV Area ED	—	cm2	—	Noninv Card
LV Area ES	—	cm2	—	Noninv Card
IVSDMM	—	0.6 - 1.1 cm	—	Noninv Card
Relative Thickness	—	28 - 44 %	—	Noninv Card
LV Mmode PW Thickness ED	—	cm	—	Noninv Card
EF M-Mode	—	%	—	Noninv Card
Mmode IVS/LVPW	—	—	—	Noninv Card
LV EF A2C	—	%	—	Noninv Card
EF Biplane	—	%	—	Noninv Card
Mmode FS	—	28 - 44 %	—	Noninv Card
Mmode LV Vol ES Teich	—	28 - 44 %	—	Noninv Card
Mmode LV Vol index ED Teich	—	28 - 44 %	—	Noninv Card
Mmode LV Vol Index ES Teich	—	28 - 44 %	—	Noninv Card
BSA	—	m2	—	Noninv Card
Mmode LV Vol ED Teich	—	28 - 44 %	—	Noninv Card
LV Stroke Volume	—	ml	—	Noninv Card
LV Stroke Volume Index	—	ml/m2	—	Noninv Card
LV Systolic Volume	—	mL	—	Noninv Card
LV Systolic Volume Index	—	—	—	Noninv Card
LV Volume Single Plane ES	—	mL	—	Noninv Card
LV Volume Index Single Plane ES	—	mL/m2	—	Noninv Card
LV Volume Biplane, ES	—	mL	—	Noninv Card
LV Volume Index Biplane, ES	—	mL/m2	—	Noninv Card
LV Diastolic Volume	—	mL	—	Noninv Card
LV Diastolic Volume Index	—	—	—	Noninv Card
LV Volume Single Plane ED	—	mL	—	Noninv Card
LV Volume Index Single Plane ED	—	mL/m2	—	Noninv Card
LV Volume Biplane, ED	—	mL	—	Noninv Card
LV Volume Index Biplane, ED	—	mL/m2	—	Noninv Card
LV Mass	—	g	—	Noninv Card
LV Mass Index	—	—	—	Noninv Card
E Wave Deceleration Time	—	msec	—	Noninv Card
IVRT	—	msec	—	Noninv Card
MV "A" Wave Duration	—	msec	—	Noninv Card
Pulm Vein S/D Ratio	—	—	—	Noninv Card
Pulm Vein "A" Wave	—	msec	—	Noninv Card
Pulmonic Valve Pk Velocity	—	cm/s	—	Noninv Card
PV Peak D Vel	—	cm/s	—	Noninv Card
LVOT Stroke Volume	—	—	—	Noninv Card
RVOT Stroke Volume	—	—	—	Noninv Card
Qp:Qs Ratio	—	—	—	Noninv Card
LVOT Peak Gradient	—	mmHg	—	Noninv Card
AV LVOT Peak Gradient w/ Amyl Nitrate	—	mmHg	—	Noninv Card
Peak Gradient Valsalva	—	mmHg	—	Noninv Card
S-I Dimension A4C	—	cm	—	Noninv Card
LA Volume	61.0	cm3	—	Noninv Card
LA Volume Index	—	—	—	Noninv Card
LA Volume Index	29.0	mL/m2	—	Noninv Card
Ao Root Diameter mMode	—	cm	—	Noninv Card
Sinus of Valsalva	—	cm	—	Noninv Card
2D Aortic Annulus Diameter	3.4	cm	—	Noninv Card
Aortic Root Area	—	cm2	—	Noninv Card
STJ	—	cm	—	Noninv Card
Proximal Aorta	—	cm	—	Noninv Card
Ascending Aorta	—	cm	—	Noninv Card
Aortic Arch	—	cm	—	Noninv Card
AO Asc Diam 2D	—	cm	—	Noninv Card
MPA Annulus	—	cm	—	Noninv Card
MPA	—	cm	—	Noninv Card
Left Pulmonary Artery	—	cm	—	Noninv Card
Right Pulmonary Artery	—	cm	—	Noninv Card

Echocardiography - Orders and Results (continued)

IVC Ostium	—	cm	—	Noninv Card
Inferior Vena Cava	—	cm	—	Noninv Card
LVOT Diameter	—	cm	—	Noninv Card
LVOT area	—	—	—	Noninv Card
LVOT Peak Vel	—	cm/s	—	Noninv Card
Peak Velocity LVOT/AV	—	—	—	Noninv Card
LVOT VTI	—	cm	—	Noninv Card
AV valve area	—	—	—	Noninv Card
LVOT Mean Gradient	—	mm/Hg	—	Noninv Card
Ao Valve Area	—	cm2	—	Noninv Card
Ao Valve Area VTI	—	cm2	—	Noninv Card
Ao Valve Area Vmax	—	cm2	—	Noninv Card
Ao Valve Index Vmax	—	cm2/m2	—	Noninv Card
Ao Valve Index VTI	—	cm2/m2	—	Noninv Card
VTI LVOT/AV	—	—	—	Noninv Card
Peak Vel LVOT/AV	—	—	—	Noninv Card
AV Comp Diameter	—	cm	—	Noninv Card
AV Comp Area	—	—	—	Noninv Card
AV Comp SV	—	—	—	Noninv Card
Ao Regurg Vel ED	—	cm/s	—	Noninv Card
Ao Regurg Grad ED	—	mm/Hg	—	Noninv Card
AV Deceleration Retrograde	—	cm/s2	—	Noninv Card
AV Regurg P 1/2 Time	—	ms	—	Noninv Card
AV Vena Contracta	—	cm	—	Noninv Card
PISA AR VN Nyquist	—	cm/s	—	Noninv Card
AV Radius PISA	—	cm	—	Noninv Card
AR Max Vel	—	cm/s	—	Noninv Card
AV Area PISA	—	—	—	Noninv Card
MV Mean Gradient	—	mmHg	—	Noninv Card
MV VTI	—	cm	—	Noninv Card
MV Area By Continuity Eq	—	—	—	Noninv Card
MV Pressure 1/2 Time	—	ms	—	Noninv Card
MV valve area p 1/2 method	—	—	—	Noninv Card
MV Area Pressure 1/2 Time	—	cm2	—	Noninv Card
MV Area Index Pressure 1/2 Time	—	cm2/m2	—	Noninv Card
MV Area Index LVOT Cont	—	cm2/m2	—	Noninv Card
MV Area Planimetry	—	cm2	—	Noninv Card
MV Area LVOT Cont	—	cm2	—	Noninv Card
MV Area-PISA	—	—	—	Noninv Card
PISA MS Radius	—	cm	—	Noninv Card
Vn Nyquist MS	—	cm/s	—	Noninv Card
Mitral Mean Vel D	—	cm/s	—	Noninv Card
PISA MS Angle Cor	—	deg	—	Noninv Card
MV Comp VTI	—	cm	—	Noninv Card
MV Comp Diameter	—	cm	—	Noninv Card
MV Comp area	—	—	—	Noninv Card
MV regurgitant SV 1	—	—	—	Noninv Card
MV Vena Contracta	—	cm	—	Noninv Card
MV Radius - MR	—	cm	—	Noninv Card
MR Max Vel	—	cm/s	—	Noninv Card
MR PISA EROA	—	—	—	Noninv Card
MV Peak E Vel	—	cm/s	—	Noninv Card
MV Deceleration Slope	—	cm/s2	—	Noninv Card
TV Mean Gradient	—	mmHg	—	Noninv Card
TV Peak Gradient	—	mmHg	—	Noninv Card
TV VTI	—	cm	—	Noninv Card
TV Valve Area by Continuity Equation	—	—	—	Noninv Card
TV Stenosis Pressure 1/2 Time	—	ms	—	Noninv Card
TV Valve Area by P 1/2 Method	—	—	—	Noninv Card
TV Peak E Vel	—	cm/s	—	Noninv Card
TV Valve Area	—	cm2	—	Noninv Card
TV Rest Pulmonary Artery Pressure	—	mmHg	—	Noninv Card
RA Pressure	5.00	mmHg	—	Noninv Card
RVSP	20.00	mmHg	—	Noninv Card
TV Comp VTI	—	cm	—	Noninv Card
TV Comp Diameter	—	cm	—	Noninv Card
TV Comp Area	—	—	—	Noninv Card
TV Comp SV	—	—	—	Noninv Card

Echocardiography - Orders and Results (continued)

TV Vena Contracta	—	cm	—	Noninv Card
PISA TR VN Nyquist	—	cm/s	—	Noninv Card
TV Radius PISA	—	cm	—	Noninv Card
TV Eff Regurg Orifice PISA	—	cm2	—	Noninv Card
TV Incomp VTI	—	cm	—	Noninv Card
RVOT Diameter	—	cm	—	Noninv Card
RVOT Area	—	—	—	Noninv Card
RVOT Peak Vel	—	cm/s	—	Noninv Card
PV Valve Area	—	cm2	—	Noninv Card
RV Pressure S	—	mmHg	—	Noninv Card
RVIDD mMode	—	3.5 - 6.0 cm	—	Noninv Card

Procedures Performed	Chargeables
ECHOCARDIOGRAM 2D COMPLETE [ECH121]	

Reviewed by

Abdul M Sheikh, MD on 03/30/16 1953

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
118000 - Noninv Card	NONINV CARDIOLOGY	Unknown	Unknown	01/02/13 1110 - Present

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

No education to display

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	03/29/16 0955
OTHER	
Weight Change (kg)	0 kg -MD
Ideal Body Weight	160 lb -MD
Visit Weight	219 lb -MD
BMI (Calculated)	34.3 -MD
IBW/kg (Calculated) Male	66.1 kg -MD
IBW/kg (Calculated) FEMALE	61.6 kg -MD
Weight in (lb) to have BMI = 25	159.3 -MD
% Weight Change Since Birth	0 -MD
Adult IBW/VT Calculations	
IBW/kg (Calculated)	66.1 -MD
Range Vt 4mL/kg	264.4 mL/kg -MD
Low Range Vt 6mL/kg	396.6 mL/kg -MD
Adult Moderate Range Vt 8mL/kg	528.8 mL/kg -MD
Adult High Range Vt 10mL/kg	661 mL/kg -MD
Case Log	
BSA x (CI @3.0)= CO	6.48 CO -MD

Flowsheets (all recorded)

Risk for Readmission

Row Name	03/31/16 0204				
OTHER					
Risk for Readmission	4 - BP				

Flowsheets (all recorded)

Cardiology Vitals

Row Name	03/29/16 0955
Measurements	
Weight	99.3 kg (219 lb) -MD
Height	67" (1.702 m) -MD
BSA (Calculated - sq m)	2.16 sq meters -MD
BMI (Calculated)	34.3 -MD
Systolic BP	164 -MD
Diastolic BP	78 -MD

Flowsheets (all recorded)

Anthropometrics

Row Name	03/29/16 0955
Anthropometrics	
Height	67" (1.702 m) -MD
Weight	99.3 kg (219 lb) -MD
Weight Change	0 -MD
BMI (Calculated)	34.3 -MD

User Key

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

Initials	Name	Effective Dates
MD	Melissa A Dixon, RDCS	09/05/14 - 02/02/17
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 03/29/2016:

Scan on 4/2/2016 12:09 AM (below)

Scan on 3/29/2016 9:14 AM by Sherry D Luoma: ImageNow scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	OP	Unit:	PH CVM HIRAM
Hospital Service:	No service for patient encounter.	Bed:	Room/bed info not found
Admitting Provider:		Referring Physician:	Sheikh, Abdul M
Attending Provider:	Abdul m sheikh AD: N	Adm Diagnosis:	Coronary arteriosclerosi*
Admission Date:	5/11/2017	Admission Time:	0817

PATIENT

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

EMERGENCY CONTACT

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

GUARANTOR

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

GUARANTOR EMPLOYER

Employer:	Phone:	Status:	RETIRED

COVERAGE

PRIMARY INSURANCE

Payor:	COVENTRY ADVANTRA M*	Plan:	COVENTRY ADVANTRA /PPO
Group Number:	4916004101	Insurance Type:	INDEMNITY
Subscriber Name:	MAURICE,EUGENE GEOR*	Subscriber DOB:	01/02/1949
Coverage	P O BOX 7156 LONDON, KY 40742-7156	Subscriber ID:	80459609601
		Pat. Rel. to Subscriber:	Self
Phone:	(866)613-4977 Co-In:	Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

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

Admission Information

Arrival Date/Time:		Admit Date/Time:	05/11/2017 0817	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
05/11/2017 2359	Home Or Self Care	None	None	WellStar Cardiac Diagnostics (PH CV1 HIRAM)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I25.10 **[Principal]**	Atherosclerotic heart disease of native coronary artery without angina pectoris				
R00.2	Palpitations				

Events

Hospital Outpatient at 5/11/2017 0817

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Discharge at 5/11/2017 2359

Unit: WellStar Cardiac Diagnostics (PH CV1 HIRAM)
Patient class: Outpatient

Allergies as of 5/11/2017

Reviewed on 5/1/2017

No Known Allergies

Immunizations as of 5/11/2017

Immunizations never marked as reviewed

INFLUENZA HD, 65 YEARS AND ABOVE

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

Questionnaire

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

Pneumococcal Conjugate 13-Valent

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

Medical as of 5/11/2017

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider

All Scans (continued)

Medical as of 5/11/2017 (continued)

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

ED Disposition

None

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Cardiac Services - Orders and Results

CARDIAC EVENT MONITOR [669537051]

Electronically signed by: **Abdul M Sheikh, MD on 04/25/17 1638** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 04/25/17 1638 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Final result
Instance released by: Robin L Herbick 5/11/2017 8:17 AM
Diagnoses
Coronary arteriosclerosis [I25.10]
Coronary artery disease involving native coronary artery of native heart without angina pectoris [I25.10]
Palpitations [R00.2]

Questionnaire

Question	Answer
Reason for exam?	Palpitations

Document on 6/2/2017 8:37 AM by Laurie Wissing: Maurice, Eugene.pdf (below)

Cardiac Services - Orders and Results (continued)

Prevent

End of Service Report

Preventice Services, LLC
888.500.3522
www.preventiceservices.com

Patient: EUGENE MAURICE

Patient ID	Gender	Date of Birth	Phone	Monitor
561253820	Male	01/02/1949 (68 years)	678-398-9479	eCardio Verité - CEM

Physician: ABDUL M SHEIKH
Practice: WELLSTAR DIAGNOSTICS-HIRAM
Diagnosis (Indication for Monitoring): R00.2: Palpitations

Enrollment Info
Period (21 Days): 05/11/2017 - 05/31/2017
Event Counts:
Critical: 0 | Total: 5
Serious: 1 | Manual: 2
Stable: 4 | Auto Trigger: 3

Summarized Findings

Agree with findings: ☐

Interpreting Physician: _____
I have personally reviewed and interpreted this report.

Summary:
The patient's monitoring period was 05/11/2017 - 05/31/2017. Baseline sample showed Sinus Rhythm w/PACs with a heart rate of 61.6 bpm. There were 0 critical, 1 serious, and 4 stable events that occurred. The report analysis of the critical, serious, stable and manually triggered events are listed below.

Automatically Detected Events:
1 Serious: Sinus Rhythm, Atrial Flutter with Variable Conduction
1 Stable: Sinus Rhythm w/PACs
1 Stable: Atrial Fibrillation RVR Sustained

Manually Detected Events:
1 Stable: Atrial Fibrillation RVR Sustained w/PVCs (1)
- Irregular Heartbeat

1 Stable: Sinus Rhythm w/PVCs (1)/PACs/Artifact/Lead Loss
- No Symptom or Accidental Push

End of summarized findings.

Physician Comments:

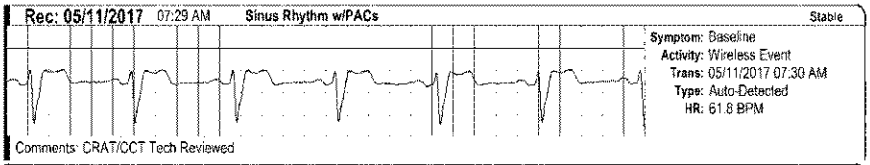
Cardiac Services - Orders and Results (continued)

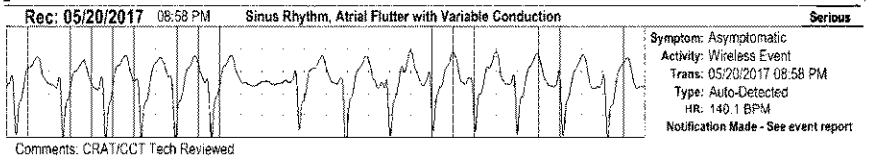
Patient: **EUGENE MAURICE**
D.O.B.: 01/02/1949 Age: 68 Gender: Male

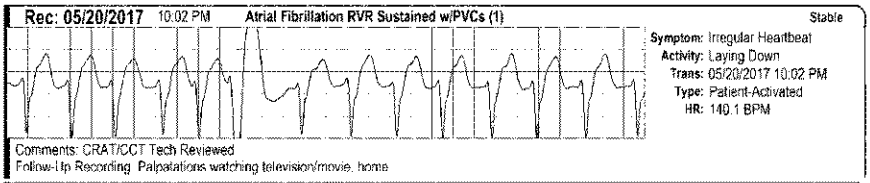
Physician: ABDUL M SHEIKH
Diagnosis: R00.2: Palpitations

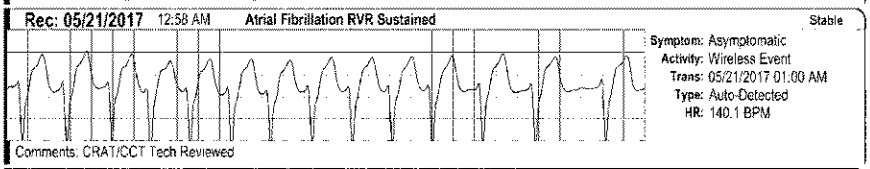
Event Summary

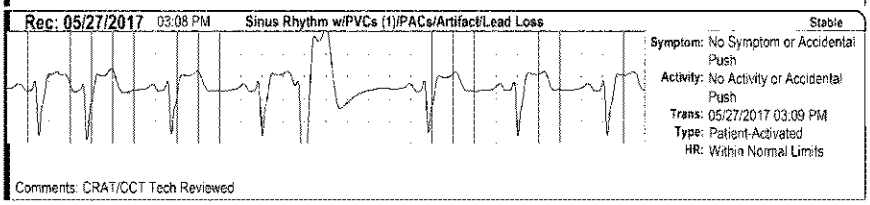
Record Date/Time	Acuity	Event	HR	Symptom	Activity
05/11/2017 07:29 AM	Stable	Sinus Rhythm w/PACs	61.8	Baseline	Wireless Event
05/20/2017 08:58 PM	Serious	Sinus Rhythm, Atrial Flutter with Variable Conduction	140.1	Asymptomatic	Wireless Event
05/20/2017 10:02 PM	Stable	Atrial Fibrillation RVR Sustained w/PVCs (1)	140.1	Irregular Heartbeat	Laying Down
05/21/2017 12:58 AM	Stable	Atrial Fibrillation RVR Sustained	140.1	Asymptomatic	Wireless Event
05/27/2017 03:08 PM	Stable	Sinus Rhythm w/PVCs (1)/PACs/Artifact/Lead Loss	WNL	No Symptom or Accidental Push	No Activity or Accidental Push











CARDIAC EVENT MONITOR [669537051] Resulted: 06/02/17 1046, Result status: Final result

Order status: Completed
Filed by: Abdul M Sheikh, MD 06/02/17 1051
Accession number: 28306685
Result details
Narrative:
Event/Telemetry Monitor Report

Resulted by: Abdul M Sheikh, MD
Performed: 05/11/17 0823 - 05/11/17 0837
Resulting lab: CV NOWHERE

Cardiac Services - Orders and Results (continued)

Date(s) of Monitoring:05/11/2017 - 05/31/2017

Physician Impression:
Results as Expected/No Change

Follow Up Method: Results discussed with patient.

Physician Comments:
Paroxysmal atrial fibrillation/flutter.
Acknowledged by: Abdul M Sheikh, MD on 06/02/17 1120

Procedures Performed	Chargeables
EVENT MONITOR - HOOK UP [CAR102]	

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
118005 - CVNOWHERE	CV NOWHERE	Unknown	Unknown	11/08/13 1331 - Present

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

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

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

Point: Coping Mechanisms (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Support Systems (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

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

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Not Started)

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

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

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

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

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

Patient Education (continued)

Education (continued)

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

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

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

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

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

Learner Not documented in this visit.
Progress:

Point: Protect Others from Infection (Not Started)

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

Learner Not documented in this visit.
Progress:

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

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

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

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

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

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

Point: Demonstrate Handwashing (MCB) (Not Started)

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

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

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Patient Education (continued)

Education (continued)

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

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

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

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	07/16/17 0637
OTHER	
Risk for Readmission	3 - BP

User Key

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

Initials	Name	Effective Dates
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 05/11/2017:

Scan on 5/31/2017 6:46 AM (below)

Scan on 5/11/2017 8:19 AM by Robin L Herbick: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	ER		Unit:	PH EMERGENCY	
Hospital Service:	Emergency Medicine		Bed:	10/10	
Admitting Provider:			Referring Physician:		
Attending Provider:	Orrin r ahola	AD: N	Adm Diagnosis:		
Admission Date:	8/18/2017		Admission Time:	1036	

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: No info available	Deductible: No info available Out of Pocket

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial#  April 3, 2020 Chart ID 

Admission Information

Arrival Date/Time:	08/18/2017 1025	Admit Date/Time:	08/18/2017 1036	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Emergency Room	Admit Category:	
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH EMERGENCY)
Admit Provider:		Attending Provider:	Orrin R Ahola, MD	Referring Provider:	

Reason for Visit

oral abscess

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
08/18/2017 1349	Home Or Self Care	None	None	WellStar Paulding Hospital (PH EMERGENCY)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
K04.7 **[Principal]**	Periapical abscess without sinus				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
E11.9	Type 2 diabetes mellitus without complications				
I10	Essential (primary) hypertension				
E78.5	Hyperlipidemia, unspecified				
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			
Z79.01	Long term (current) use of anticoagulants	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			

Events

ED Arrival at 8/18/2017 1025

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Admission at 8/18/2017 1036

Unit: WellStar Paulding Hospital (PH EMERGENCY) Room: 10 Bed: 10
Patient class: Emergency Service: Emergency Medicine

ED Roomed at 8/18/2017 1036

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Discharge at 8/18/2017 1349

Unit: WellStar Paulding Hospital (PH EMERGENCY) Room: 10 Bed: 10
Patient class: Emergency Service: Emergency Medicine

Discharge at 8/18/2017 1349

All Scans (continued)

Events (continued)

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Allergies as of 8/18/2017

Reviewed on 8/18/2017

No Known Allergies

Immunizations as of 8/18/2017

Immunizations never marked as reviewed

INFLUENZA HD, 65 YEARS AND ABOVE

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

Questionnaire

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

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 8/18/2017

Past Medical History

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

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Cancer (HCC) [C80.1]	04/07/2014	—	Provider
Chronic kidney disease [N18.9]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider

All Scans (continued)

Medical as of 8/18/2017 (continued)

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

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type
-	8/18/2017 10:25	3-Urgent	Car	Self	Emergency Medicine	Emergency

Arrival Complaint

Mouth Abscess

Chief Complaint

Complaint	Comment	Last Edited By	Time	Relationship	ED Provider
oral abscess		Unknown		None	No

ED Disposition

ED Disposition	Condition	Comment
Discharge	Good	Eugene G Maurice discharge to home/self care.

ED Events

Date/Time	Event	User	Comments
08/18/17 1025	Patient arrived in ED	HOLT, DAWN	
08/18/17 1036	Patient roomed in ED	BELL, CONNIE J	
08/18/17 1349	Patient discharged	SHUFFIELD, CHRISTINE E	

ED Provider Notes - ED Notes

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM

Author: Orrin R Ahola, MD
Filed: 8/19/2017 8:53 PM
Editor: Orrin R Ahola, MD (Physician)
Service: —
Date of Service: 8/18/2017 11:12 AM
Author Type: Physician
Status: Signed

History

Chief Complaint

oral abscess

History provided by: patient.
Nursing note reviewed and I agree with the documentation of the past medical, past surgical, social, and family histories.Vitals reviewed.

Oral Swelling

This is a new problem. The current episode started more than 2 days ago. The onset was gradual. The incident occurred at home. The problem occurs constantly. The problem has been gradually worsening. Pertinent negatives include no shortness of breath. The symptoms are aggravated by eating. He has tried nothing for the

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

symptoms.

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)	

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

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	

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

- 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
- Years of education: N/A

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 Asked

Other Topics	Concern
None	

Social History Narrative

- None

Allergies: Review of patient's allergies indicates no known allergies.

Prior to Admission medications

Medication	Sig
apixaban (ELIQUIS) 5 mg tablet	Take 1 tablet (5 mg total) by mouth 2 (two) times a day
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
blood sugar diagnostic (GLUCOSE BLOOD) strip	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

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

carvedilol (COREG) 12.5 MG tablet	Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals
chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily
cilostazol (PLETAL) 100 MG tablet	Take 1 tablet (100 mg total) by mouth 2 (two) times a day
clindamycin (CLEOCIN) 300 MG capsule	Take 1 capsule (300 mg total) by mouth 3 (three) times a day for 7 days
HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet	Take 1 tablet by mouth every 6 (six) hours as needed for pain for up to 10 days
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 2 tablets (60 mg total) by mouth 2 (two) times a day
metFORMIN (GLUCOPHAGE) 500 MG tablet	2 tablets in am and 1 tablet in pm
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
ramipril (ALTACE) 10 MG capsule	Take 1 capsule (10 mg total) by mouth 2 (two) times a day

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Positive for dental problem and facial swelling **(L lower jaw)**. Negative for drooling and trouble swallowing.
Respiratory: Negative for shortness of breath.
All other systems reviewed and are negative.
Except as noted in HPI.

Physical Exam

Visit Vitals

BP	154/70
Pulse	71
Temp	97.8 °F (36.6 °C)
Resp	16
Ht	67" (1.702 m)
Wt	99.5 kg (219 lb 6.4 oz)
SpO2	95%
BMI	34.36 kg/m²

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

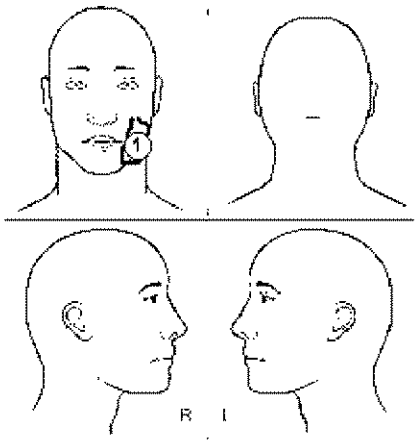
Physical Exam

Nursing note reviewed and I agree with the documentation of the past medical, past surgical, social, and family histories.Vitals reviewed.

Constitutional: He appears well-developed and well-nourished. No distress.

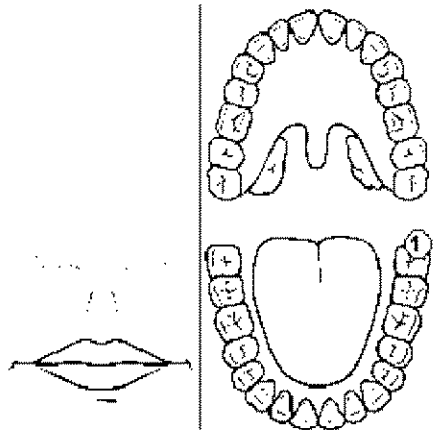
HENT:

Head: Normocephalic.



1: sts + ttp here: minimal induration; no erythema

Mouth/Throat:



1: extensive decay here; there is surrounding gingival swelling and ttp; there is purplish discoloration suggesting subQ blood; there is a small dark purplish, flucation area medially suggesting small hematoma

Neck:

soft, nontender anterior neck

Cardiovascular: Normal rate.

Pulmonary/Chest: Effort normal. No respiratory distress.

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

Abdominal: Normal appearance.
Neurological: He is alert.
Skin: Skin is warm and dry.
Psychiatric: He has a normal mood and affect. His speech is normal and behavior is normal.

Lab Results:

Imaging results:

ED Course

ED Course

Procedures

No consult orders placed this encounter

11:12 AM
- appears there is a periapical abscess secondary to dental decay + subQ hemorrhage related to eliquis rx.
- I do no think pt is best served by I&D at this time - I am not certain there is a drainable abscess at this time - the fluctuant area is probably hematoma
- will rx with abx > monitor symptoms > f/u oral surgery
- pt to return if worse / no improvement

Vitals:

	08/18/17 1029
BP:	154/70
Pulse:	71
Resp:	16
Temp:	97.8 °F (36.6 °C)
SpO2:	95%

Medications Administered in ED

Medications

clindamycin (CLEOCIN) 900 mg in NS 100 mL IVPB (not administered)

ED Final Impression

Final diagnoses:
Dental abscess

Disposition

I have discussed the care plan and follow up instructions with the patient. Patient verbalizes understanding. Patient is stable, NAD, and non-toxic upon discharge. Patient to be discharged home. 11:12 AM

Follow up:
Antwan L Treadway, DMD
6001 Professional Parkway
Suite 1020
Douglasville GA 30134
678-279-2225

In 1 week

New Prescriptions

New Prescriptions	
CLINDAMYCIN (CLEOCIN) 300 MG CAPSULE	Take 1 capsule (300 mg total) by mouth 3 (three) times a day for 7 days
HYDROCODONE-ACETAMINOPHEN (NORCO) 5-325 MG PER TABLET	Take 1 tablet by mouth every 6 (six) hours as needed for pain for up to 10 days

An After Visit Summary was printed and given to the patient.

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Orrin R Ahola, MD at 8/18/2017 11:12 AM (continued)

Orrin R Ahola, MD
08/19/17 2053

Electronically Signed by Orrin R Ahola, MD on 8/19/2017 8:53 PM

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Medications - Orders and Results

clindamycin (CLEOCIN) 900 mg in NS 100 mL IVPB [669537064]

Electronically signed by: **Orrin R Ahola, MD on 08/18/17 1109** Status: **Completed**
Ordering user: Orrin R Ahola, MD 08/18/17 1109 Ordering provider: Orrin R Ahola, MD
Authorized by: Orrin R Ahola, MD Ordering mode: Standard
Frequency: STAT Once 08/18/17 1115 - 1 occurrence
Acknowledged: Christine E Shuffield, RN 08/18/17 1121 for Placing Order

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Abscess
Expected days of therapy:	1

Mixture Ingredients

Medication	Ordered Dose	Calculated Dose
clindamycin (CLEOCIN)	900 mg	900 mg
sodium chloride (NS) 0.9 %	100 mL	100 mL

Package: 25021-115-06, 0409-7984-37
Status
Ami Jarrett, RPH 08/18/17 1112 (Rate: 100 mL/hr to 212 mL/hr)

clindamycin (CLEOCIN) 300 MG capsule [669537065]

Electronically signed by: **Orrin R Ahola, MD on 08/18/17 1111** Status: **Expired**
Ordering user: Orrin R Ahola, MD 08/18/17 1111 Ordering provider: Orrin R Ahola, MD
Authorized by: Orrin R Ahola, MD Ordering mode: Standard
Frequency: Routine TID 08/18/17 - 7 days

HYDROcodone-acetaminophen (NORCO) 5-325 mg per tablet [669537066]

Electronically signed by: **Orrin R Ahola, MD on 08/18/17 1111** Status: **Expired**
Ordering user: Orrin R Ahola, MD 08/18/17 1111 Ordering provider: Orrin R Ahola, MD
Authorized by: Orrin R Ahola, MD Ordering mode: Standard
PRN reasons: pain
Frequency: Routine Q6H PRN 08/18/17 - 10 days

Medications

All Meds and Administrations

clindamycin (CLEOCIN) 900 mg in NS 100 mL IVPB [669537064]

Ordering Provider: Orrin R Ahola, MD
Ordered On: 08/18/17 1109
Dose (Remaining/Total): 900 mg (0/1)
Frequency: Once
Status: Completed (Past End Date/Time)
Starts/Ends: 08/18/17 1115 - 08/18/17 1334
Route: Intravenous
Rate/Duration: 212 mL/hr / 30 Minutes

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Abscess	—
Expected days of therapy::	1	—

Timestamps	Action	Dose / Rate / Duration	Route	Other Information
Performed 08/18/17 1334 Documented: 08/18/17 1334	Stopped	0 mg 0 mL/hr ---	Intravenous	Performed by: Christine E Shuffield, RN
Performed 08/18/17 1142 Documented: 08/18/17 1142	New Bag	900 mg 212 mL/hr 30 Minutes	Intravenous	Performed by: Leslie E Winters, RN

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.

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: 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)

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

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)

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

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

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

Point: Coping Mechanisms (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Support Systems (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

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

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Not Started)

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

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

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

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

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

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

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 Not documented in this visit.
Progress:

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

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

Learner Not documented in this visit.
Progress:

Point: Protect Others from Infection (Not Started)

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

Learner Not documented in this visit.
Progress:

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

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

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

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

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

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

Point: Demonstrate Handwashing (MCB) (Not Started)

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

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

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

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

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

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

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Resolved)

Point: Anticoagulant Therapy (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Resolved)

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

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Resolved)

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

Learner Progress: Not documented in this visit.

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.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

Discharge Instructions

Discharge Instructions

Maurice, Eugene George (MR # 561253820)

Date	Status	User	User Type	Discharge Note
	Pended	Orrin R Ahola, MD	Physician	Original

Note:

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	08/18/17 10:29:13
Vitals	
Pct Wt Change	0 % -DI (r) KE (t)
OTHER	
Weight Change (kg)	0 kg -DI (r) KE (t)
Ideal Body Weight	160 lb -DI (r) KE (t)
Visit Weight	219 lb -DI (r) KE (t)
BMI (Calculated)	34.4 -DI (r) KE (t)
BSA (Calculated - sq m)	2.17 sq meters -DI (r) KE (t)
BMI (Calculated)	34.4 -DI (r) KE (t)
IBW/kg (Calculated) Male	66.1 kg -DI (r) KE (t)
IBW/kg (Calculated) FEMALE	61.6 kg -DI (r) KE (t)
Weight/Scale Event	0 -DI (r) KE (t)
Weight in (lb) to have BMI = 25	159.3 -DI (r) KE (t)
% Weight Change Since Birth	0 -DI (r) KE (t)
Adult IBW/VT Calculations	
IBW/kg (Calculated)	66.1 -DI (r) KE (t)
Range Vt 4mL/kg	264.4 mL/kg -DI (r) KE (t)
Low Range Vt 6mL/kg	396.6 mL/kg -DI (r) KE (t)
Adult Moderate Range Vt 8mL/kg	528.8 mL/kg -DI (r) KE (t)
Adult High Range Vt 10mL/kg	661 mL/kg -DI (r) KE (t)
Case Log	
BSA x (CI @3.0)= CO	6.51 CO -DI (r) KE (t)

Flowsheets (all recorded)

First Contact With Patient

Row Name	08/18/17 1041
Physician First Contact With Patient	
Now	Now -OA

Flowsheets (all recorded)

ED Fall Risk

Row Name	08/18/17 1052
Green Risk: Any patient presenting to the ED.	
Have the Green Environment of Care strategies been implemented? (click row info for more details)	Y -CM
Yellow Risk: ED Patients who present with or develop any of the following:	
Are any of the following Yellow criteria present?	No -CM

Flowsheets (all recorded)

Risk for Readmission

Row Name	08/18/17 1349
OTHER	
Risk for Readmission	7 -CS

Flowsheets (all recorded)

Acuity/Destination

Row Name	08/18/17 1032	08/18/17 1028
Acuity/Destination		
Patient Acuity	----	3 -CB
ED Destination	10 -JA	----
Primary Triage Complete	Primary triage complete -JA	Primary triage complete -CB

Flowsheets (all recorded)

Vital Signs

Row Name	08/18/17 1335	08/18/17 12:16:47	08/18/17 10:29:13
Vital Signs			
Temp	—	98.5 °F (36.9 °C) -DI (r) AR (t)	97.8 °F (36.6 °C) -DI (r) KE (t)
Pulse	—	69 -DI (r) AR (t)	71 -DI (r) KE (t)
Resp	—	16 -DI (r) AR (t)	16 -DI (r) KE (t)
BP	—	150/78 -DI (r) AR (t)	154/70 -DI (r) KE (t)
Oxygen Therapy			
SpO2	—	97 % -DI (r) AR (t)	95 % -DI (r) KE (t)
Pain Assessment			
Currently in Pain	No -CS	—	—
Pain Assessment History			
Previous experiences with pain?	No -CS	—	—
History of Chronic Pain?	No -CS	—	—
Numeric Pain Intensity Scale			
Numeric Pain Intensity Score 1	0 -CS	—	—
Height and Weight			
Height	—	—	67" (1.702 m) -DI (r) KE (t)
Weight	—	—	99.5 kg (219 lb 6.4 oz) -DI (r) KE (t)
BSA (Calculated - sq m)	—	—	2.17 sq meters -DI (r) KE (t)
BMI (Calculated)	—	—	34.4 -DI (r) KE (t)
Weight in (lb) to have BMI = 25	—	—	159.3 -DI (r) KE (t)

Flowsheets (all recorded)

Vital Signs

Row Name	08/18/17 12:16:47	08/18/17 10:29:13
Vital Signs		
Automatic Restart Vitals Timer	Yes -DI (r) AR (t)	Yes -DI (r) KE (t)
Pulse	69 -DI (r) AR (t)	71 -DI (r) KE (t)
Resp	16 -DI (r) AR (t)	16 -DI (r) KE (t)
BP	150/78 -DI (r) AR (t)	154/70 -DI (r) KE (t)
Temp	98.5 °F (36.9 °C) -DI (r) AR (t)	97.8 °F (36.6 °C) -DI (r) KE (t)
Oxygen Therapy		
SpO2	97 % -DI (r) AR (t)	95 % -DI (r) KE (t)

Flowsheets (all recorded)

PA Risk Score

Row Name	08/18/17 1304	08/18/17 1301	08/18/17 1204	08/18/17 1201	08/18/17 1104
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	08/18/17 1101
Sepsis Risk Score	
Sepsis Risk Score	1 -UE
Sepsis Risk Score Change	1 -UE

Flowsheets (all recorded)

Pain Assessment

Row Name	08/18/17 1335
Pain Timer	
Restart Pain Timer	Yes -CS
Pain Reassessment after Intervention Complete	Yes -CS
Pain Assessment	
Currently in Pain	No -CS
Which Pain Assessment Tool ?	Numeric (0-10) -CS
Patient's Stated Pain Goal	0 (No Pain) -CS
Numeric Pain Intensity Scale	
Numeric Pain Intensity Score 1	0 -CS
Pain Assessment History	
Previous experiences with pain?	No -CS
History of Chronic Pain?	No -CS

Flowsheets (all recorded)

Anthropometrics

Row Name	08/18/17 10:29:13
Anthropometrics	
Height	67" (1.702 m) -DI (r) KE (t)
Weight	99.5 kg (219 lb 6.4 oz) -DI (r) KE (t)
Weight Change	0 -DI (r) KE (t)
BMI (Calculated)	34.4 -DI (r) KE (t)

Flowsheets (all recorded)

Focused Assessment

Row Name	08/18/17 12:16:47	08/18/17 1052	08/18/17 1051	08/18/17 10:29:13
Airway				
Airway (WDL)	—	—	WDL -CM	—
Breathing				
Breathing (WDL)	—	—	WDL -CM	—
SpO2	97 % -DI (r) AR (t)	----	----	95 % -DI (r) KE (t)
Circulation				
Circulation (WDL)	----	WDL -CM	----	----
Disability				
Disability (WDL)	—	—	WDL -CM	—
Level of Consciousness	—	—	Alert -CM	—

Flowsheets (all recorded)

HEENT

Row Name	08/18/17 1053
HEENT	
HEENT (WDL)	X -CM
Head and Face	Swelling;Tenderness;Asymmetrical -CM
Throat	Intact;Painful to swallow -CM
Mucous Membrane(s)	Reddened -CM
Teeth	Dental caries;Missing teeth;Other (Comment) -CM

Flowsheets (all recorded)

Immunizations

Row Name	08/18/17 1051
Tetanus up to date	
Tetanus within last 5 years?	No -CM

Flowsheets (all recorded)

Abuse Indicators

Row Name	08/18/17 1052
Abuse Screening	
Safe in Home	Yes -CM
Abuse Suspected	
Suspected Victim Of:	None Suspected -CM

Flowsheets (all recorded)

Psychosocial Needs

Row Name	08/18/17 1051
Psychosocial	
Needs Expressed	Denies -CM
Primary Language	
Primary Language Spoken by Patient?	English -CM

Flowsheets (all recorded)

Quick Look

Row Name	08/18/17 1335	08/18/17 12:16:47	08/18/17 10:29:13	08/18/17 1027	
Quick Vitals					
Pulse	—	69 -DI (r) AR (t)	71 -DI (r) KE (t)	—	
SpO2	—	97 % -DI (r) AR (t)	95 % -DI (r) KE (t)	—	
BP	—	150/78 -DI (r) AR (t)	154/70 -DI (r) KE (t)	—	
Resp	—	16 -DI (r) AR (t)	16 -DI (r) KE (t)	—	
Temp	—	98.5 °F (36.9 °C) -DI (r) AR (t)	97.8 °F (36.6 °C) -DI (r) KE (t)	—	
Automatic Restart Vitals Timer	—	Yes -DI (r) AR (t)	Yes -DI (r) KE (t)	—	
Pain Assessment					
Currently in Pain	No -CS	—	—	—	
Numeric Pain Intensity Score 1	0 -CS	—	—	—	
Which Pain Assessment Tool ?	Numeric (0-10) -CS	—	—	—	
Patient's Stated Pain Goal	0 (No Pain) -CS	—	—	—	
Previous experiences with pain?	No -CS	—	—	—	
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 -CB	

Flowsheets (all recorded)

Assessment Complete

Row Name	08/18/17 1052
Assessment Complete	
Assessment Completed?	Yes -CM

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	08/18/17 12:16:47	08/18/17 1052	08/18/17 10:29:13	08/18/17 1028
Vital sign parameters				
BP	150/78 -DI (r) AR (t)	—	154/70 -DI (r) KE (t)	—
Pulse	69 -DI (r) AR (t)	—	71 -DI (r) KE (t)	—
Resp	16 -DI (r) AR (t)	—	16 -DI (r) KE (t)	—
Temp	98.5 °F (36.9 °C) -DI (r) AR (t)	—	97.8 °F (36.6 °C) -DI (r) KE (t)	—
Vital Signs				
Automatic Restart Vitals Timer	Yes -DI (r) AR (t)	—	Yes -DI (r) KE (t)	—
Vital sign parameters				
Vital Sign Parameters	—	None -CM	—	—
Hemodynamic Status	—	None -CM	—	—
OTHER				
Suspicion for infection or exposure?	—	Skin/soft tissue/wound infection -CM	—	Skin/soft tissue/wound infection -CB

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	08/18/17 1143
[REMOVED] Peripheral IV 08/18/17 20 G Right Antecubital	
IV Properties	Placement Date: 08/18/17 -LW Placement Time: 1143 -LW Present on arrival to hospital?: No -LW Type of Catheter: Straight -LW Size (Gauge): 20 G -LW Orientation: Right -LW Location: Antecubital -LW Site Prep: Chlorhexidine -LW Local Anesthetic: None -LW Insertion attempts: 1 -LW Successful IV Attempt?: Yes -LW Patient Tolerance: Tolerated well -LW IV Access Problem: No -LW Removal Date: 08/18/17 -CS Removal Time: 1335 -CS Catheter Intact on removal?: Yes -CS Removal Reason : Patient discharged -CS
Line Assessment	Blood return noted -LW

Flowsheets (all recorded)

Secondary Triage Complete

Row Name	08/18/17 1052

Information Source

Information Provided By:	Patient -CM

Secondary Triage Complete

Secondary Triage Complete	Secondary Triage Complete -CM

User Key

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

Initials	Name	Effective Dates
UE	Epic, User	—
LW	Leslie E Winters, RN	12/06/13 -
CB	Connie J Bell	—
KE	Kimberly Eller, MA	07/25/14 -
JA	Jamie T Abernathy, RN	02/03/17 -
CM	Carole K McCann	—
CS	Christine E Shuffield, RN	07/25/14 -
AR	Amber Ramsey	11/12/15 -
DI	Interface, Doc Flowsheet In	—
OA	Orrin R Ahola, MD	08/18/17 - 09/05/17

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 08/18/2017:

Scan on 8/22/2017 11:06 AM (below)

Document on 8/18/2017 1:49 PM by Christine E Shuffield, RN: AVS - Large Print (below)

WELLSTAR

AFTER VISIT SUMMARY

Eugene G. Maurice DoB: 1/2/1949

8/18/2017

WellStar Paulding Hospital (PH EMERGENCY) 470-644-7170

Instructions

Your medications have changed

START taking:
clindamycin 300 MG capsule (CLEOCIN)
HYDROcodone-acetaminophen 5-325 mg per tablet (NORCO)

CONTINUE taking your other medications
Review your updated medication list below.

Read the attached information

DENTAL ABSCESS (ENGLISH)

Pick up these medications from any pharmacy with your printed prescription

clindamycin • HYDROcodone-acetaminophen

Follow up with Antwan L Treadway, DMD in 1 week (around 8/25/2017)

Specialty: Oral and Maxillofacial Surgery
Contact: 6001 Professional Parkway
Suite 1020
Douglasville GA 30134
678-279-2225

Today's Visit

Reason for Visit
oral abscess

Today's Visit (continued)

Diagnosis
Tooth abscess

Medications Given
clindamycin (CLEOCIN) injection 150 mg/mL stopped at 1:34 PM

Your End of Visit Vitals

Blood Pressure	Temperature	Pulse
150/78	98.5 °F	69
Respiration	**Oxygen Saturation**	
16	97%	

What's Next

SEP 20 2017 — Follow Up Appointment with Abdul M Sheikh, MD
Wednesday September 20 4:00 PM (Arrive by 3:45 PM)

WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200
HIRAM GA 30141-3749
678-324-4444

Treatment Team

You were seen by Orrin R Ahola, MD.

For further follow up if needed, please call Wellstar doctor referral line at 770-956-7827.

You are allergic to the following

No active allergies

If you have any questions about this medication list, please talk to your doctor at your next appointment. You may use this form to make notes about any medications that

you have stopped or started taking, including over the counter medications. Bring the form with you to the appointment as a reminder to discuss with your doctor.

MyChart

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

Your Medication List

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	Take 81 mg by mouth daily.
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
clindamycin 300 MG capsule Commonly known as: CLEOCIN	Take 1 capsule (300 mg total) by mouth 3 (three) times a day for 7 days
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isosorbide mononitrate 30 MG 24 hr tablet Commonly known as: IMDUR	Take 2 tablets (60 mg total) by mouth 2 (two) times a day

Your Medication List (continued)

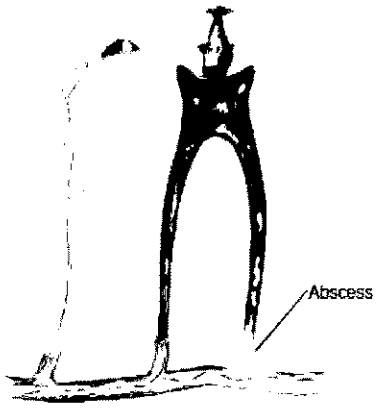
metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE	2 tablets in am and 1 tablet in pm
nitroglycerin 0.4 MG SL tablet Commonly known as: NITROSTAT	Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
ramipril 10 MG capsule Commonly known as: ALTACE	Take 1 capsule (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.**

Attached Information

DENTAL ABSCESS (ENGLISH)

Dental Abscess



An abscess is a pocket of pus at the tip of a tooth root in your jaw bone. It is caused by an infection at the root of the tooth. It can cause pain and swelling of the gum, cheek, or jaw. Pain may spread from the tooth to your ear or the area of your jaw on the same side. If the abscess isn't treated, it appears as a bubble or swelling on the gum near the tooth. The pressure that builds in this swelling is the source of the pain. More serious infections cause your face to swell.

An abscess can be caused by a crack in the tooth, a cavity, a gum infection, or a combination of these. Once the pulp of the tooth is exposed, bacteria can spread down the roots to the tip. If the bacteria are not stopped, they can damage the bone and soft tissue, and an abscess can form.

Home care

Follow these guidelines when caring for yourself at home:

- Avoid hot and cold foods and drinks. Your tooth may be sensitive to changes in temperature. Don't chew on the side of the infected tooth.
- If your tooth is chipped or cracked, or if there is a large open cavity, put oil of cloves directly on the tooth to relieve pain. You can buy oil of cloves at drugstores. Some pharmacies carry an over-the-counter "toothache kit." This contains a paste that you can put on the exposed tooth to make it less sensitive.
- Put a cold pack on your jaw over the sore area to help reduce pain.
- You may use over-the-counter medicine to ease pain, unless another medicine was prescribed. If you have chronic liver or kidney disease, talk with your healthcare provider before using acetaminophen or ibuprofen. Also talk with your provider if you've had a stomach ulcer or GI bleeding.
- An antibiotic will be prescribed. Take it until finished, even if you are feeling better after a few days.

Follow-up care

Follow up with your dentist or an oral surgeon, or as advised. Once an infection occurs in a tooth, it will continue to be a problem until the infection is drained. This is done through surgery or a root canal. Or you may need to have your tooth pulled.

Call 911

Call 911 if any of these occur:

- Unusual drowsiness
- Headache or stiff neck
- Weakness or fainting
- Difficulty swallowing, breathing, or opening your mouth
- Swollen eyelids

When to seek medical advice

Call your healthcare provider right away if any of these occur:

- Your face becomes more swollen or red
- Pain gets worse or spreads to your neck
- Fever of 100.4° F (38.0° C) or higher, or as directed by your healthcare provider
- Pus drains from the tooth

Date Last Reviewed: 10/1/2016

Document on 8/18/2017 1:36 PM by Christine E Shuffield, RN: AVS - Large Print (below)

WELLSTAR

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Eugene G. Maurice DoB: 1/2/1949

8/18/2017

WellStar Paulding Hospital (PH EMERGENCY) 470-644-7170

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Reason for Visit
oral abscess

Today's Visit (continued)

Diagnosis
Tooth abscess

Medications Given
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678-324-4444

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Your Medication List (continued)

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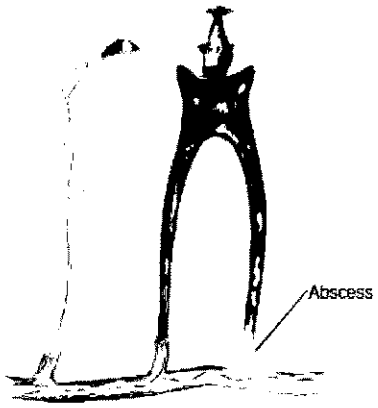

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Follow these guidelines when caring for yourself at home:

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- Put a cold pack on your jaw over the sore area to help reduce pain.
- You may use over-the-counter medicine to ease pain, unless another medicine was prescribed. If you have chronic liver or kidney disease, talk with your healthcare provider before using acetaminophen or ibuprofen. Also talk with your provider if you've had a stomach ulcer or GI bleeding.
- An antibiotic will be prescribed. Take it until finished, even if you are feeling better after a few days.

Follow-up care

Follow up with your dentist or an oral surgeon, or as advised. Once an infection occurs in a tooth, it will continue to be a problem until the infection is drained. This is done through surgery or a root canal. Or you may need to have your tooth pulled.

Call 911

Call 911 if any of these occur:

- Unusual drowsiness
- Headache or stiff neck
- Weakness or fainting
- Difficulty swallowing, breathing, or opening your mouth
- Swollen eyelids

When to seek medical advice

Call your healthcare provider right away if any of these occur:

- Your face becomes more swollen or red
- Pain gets worse or spreads to your neck
- Fever of 100.4° F (38.0° C) or higher, or as directed by your healthcare provider
- Pus drains from the tooth

Date Last Reviewed: 10/1/2016

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	ER		Unit:	PH EMERGENCY
Hospital Service:	Emergency Medicine		Bed:	07/07
Admitting Provider:			Referring Physician:	
Attending Provider:	Arthur r curran iii	AD: N	Adm Diagnosis:	
Admission Date:	1/16/2018		Admission Time:	2121

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: No info available	Deductible: No info available Out of Pocket

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Admission Information

Arrival Date/Time:	01/16/2018 2051	Admit Date/Time:	01/16/2018 2121	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH EMERGENCY)
Admit Provider:		Attending Provider:	Arthur R Curran III, MD	Referring Provider:	

Reason for Visit

Post-op Problem	prostate biopsy this am; patient states just passing clots, no urine since 1530
Hematuria	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
01/16/2018 2226	Home Or Self Care	None	None	WellStar Paulding Hospital (PH EMERGENCY)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R39.15 **[Principal]**	Urgency of urination				
R31.9	Hematuria, unspecified				
N99.89	Other postprocedural complications and disorders of genitourinary system				
Z98.890	Other specified postprocedural states	Exempt from POA reporting			
R35.0	Frequency of micturition				
E11.9	Type 2 diabetes mellitus without complications				
I10	Essential (primary) hypertension				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
I73.9	Peripheral vascular disease, unspecified				
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			

Events

ED Arrival at 1/16/2018 2051

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Admission at 1/16/2018 2121

Unit: WellStar Paulding Hospital (PH EMERGENCY)	Room: 07	Bed: 07
Patient class: Emergency	Service: Emergency Medicine	

ED Roomed at 1/16/2018 2121

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Discharge at 1/16/2018 2226

Unit: WellStar Paulding Hospital (PH EMERGENCY)	Room: 07	Bed: 07
Patient class: Emergency	Service: Emergency Medicine	

Discharge at 1/16/2018 2226

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Allergies as of 1/16/2018

Reviewed on 1/16/2018

No Known Allergies

All Scans (continued)

Immunizations as of 1/16/2018

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 1/16/2018

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

All Scans (continued)

Medical as of 1/16/2018 (continued)

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

Expected	Arrival	Acuity	Means of Arrival	Escorted By	Service	Admission Type
-	1/16/2018 20:51	2-Emergent	Car	Family Member	Emergency Medicine	Emergency

Arrival Complaint

blood in urine

Chief Complaint

Complaint	Comment	Last Edited By	Time	Relationship	ED Provider
Post-op Problem	prostate biopsy this am; patient states just passing clots, no urine since 1530	Leslie Kennedy, RN	1/16/2018 8:54 PM	None	No
Hematuria		Leslie Kennedy, RN	1/16/2018 8:54 PM	None	No

ED Disposition

ED Disposition	Condition	Comment
Discharge	Stable	Eugene G Maurice discharge to home/self care.

ED Events

Date/Time	Event	User	Comments
01/16/18 2051	Patient arrived in ED	LOUDEN, ANITA	
01/16/18 2121	Patient roomed in ED	DREES, LESLIE K	
01/16/18 2226	Patient discharged	DENMARK, RACHEL	

ED Provider Notes - ED Notes

ED Provider Notes by Joni L Baumann, NP at 1/16/2018 9:22 PM

Author: Joni L Baumann, NP
Filed: 1/16/2018 11:38 PM
Editor: Joni L Baumann, NP (Nurse Practitioner)

Service: Hospital Medicine
Date of Service: 1/16/2018 9:22 PM

Author Type: Nurse Practitioner
Status: Signed
Cosigner: Arthur R Curran III, MD at 1/17/2018 1:58 AM

History

Chief Complaint

Post-op Problem; Hematuria

69 year old male presents with anuria since prostate biopsy this morning. States he has passed a couple bloody clots per urethra, but not urine. States he has intense suprapubic pain and feels urgency and "fullness." Requests catheterization.

History provided by: patient. 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.
This is a new problem. The current episode started 6 to 12 hours ago. The problem occurs every urination. The problem has not changed since onset.The quality of the pain is described as aching. Associated symptoms include hematuria and urgency. Pertinent negatives include no chills, no nausea, no vomiting and no flank pain. His past medical history is significant for urological procedure.

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)	

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

Family History

Problem	Relation	Age of Onset
• Coronary artery disease	Mother	

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Joni L Baumann, NP at 1/16/2018 9:22 PM (continued)

• 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
• Years of education:	N/A

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 Asked

Other Topics	Concern
• None	

Social History Narrative

- None

Allergies: Patient has no known allergies.

Prior to Admission medications

Medication	Sig
apixaban (ELIQUIS) 5 mg tablet	**Take 1 tablet (5 mg**

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Joni L Baumann, NP at 1/16/2018 9:22 PM (continued)

	total) by mouth 2 (two) times a day
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
blood sugar diagnostic (GLUCOSE BLOOD) strip	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 (COREG) 12.5 MG tablet	Take 1 tablet (12.5 mg total) by mouth 2 (two) times a day with meals
chlorthalidone (HYGROTEN) 50 MG tablet	Take 1 tablet (50 mg total) by mouth daily
cilostazol (PLETAL) 100 MG tablet	Take 1 tablet (100 mg total) by mouth 2 (two) times a day
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	Take 2 tablets (60 mg total) by mouth 2 (two) times a day
metFORMIN (GLUCOPHAGE) 500 MG tablet	2 tablets po in am and 2 in pm
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
ramipril (ALTACE) 10 MG capsule	Take 1 capsule (10 mg total) by mouth 2 (two) times a day

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion, rhinorrhea and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for apnea, cough, choking, chest tightness, shortness of breath, wheezing and stridor.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Positive for abdominal distention and abdominal pain. Negative for anal bleeding, blood in stool, constipation, diarrhea, nausea, rectal pain and vomiting.
Endocrine: Negative for polydipsia, polyphagia and polyuria.
Genitourinary: Positive for difficulty urinating, hematuria and urgency. Negative for flank pain, penile pain, penile swelling, scrotal swelling and testicular pain.
Musculoskeletal: Negative for back pain and neck pain.
Skin: Negative for rash.
Neurological: Negative for dizziness, tremors, seizures, syncope, light-headedness and headaches.
All other systems reviewed and are negative.

Physical Exam

Visit Vitals

BP	189/80
Pulse	72
Temp	97.4 °F (36.3 °C)
Resp	18
Ht	67" (1.702 m)
Wt	102.4 kg (225 lb 12.8 oz)
SpO2	98%
BMI	35.37 kg/m²

Physical Exam

Nursing note reviewed and I agree with the documentation of the past medical, past surgical, social, and family histories.Vitals reviewed.

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge. No scleral icterus.

Neck: Normal range of motion. Neck supple. No JVD present. No tracheal deviation present. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulses:

Dorsalis pedis pulses are 2+ on the right side, and 2+ on the left side.

Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness.

Abdominal: Soft. Bowel sounds are normal. He exhibits distension. He exhibits no mass. There is tenderness. There is guarding. There is no rebound.

Genitourinary: Penis normal. No penile tenderness.

Musculoskeletal: Normal range of motion. He exhibits no edema, tenderness or deformity.

Neurological: He is alert and oriented to person, place, and time. No cranial nerve deficit. Coordination normal.

Skin: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema. No pallor.

Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

Lab Results:

Results for orders placed or performed during the hospital encounter of 01/16/18

POC Chem8

Result	Value	Ref Range
POC-SODIUM	140	136 - 145 mmol/L
POC-POTASSIUM	4.4	3.5 - 5.1 mmol/L
POC-CHLORIDE	106	95 - 110 mmol/L

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Joni L Baumann, NP at 1/16/2018 9:22 PM (continued)

POC-GLUCOSE	199 (H)	70 - 99 mg/dL
POC-BUN	27 (H)	7 - 21 mg/dL
POC-IONIZED CALCIUM	1.14	1.09 - 1.29 mmol/L
POC-CO2	21	20 - 28 mmol/L
POC-AGAP	19	15 - 23
POC-CREATININE	1.1	0.64 - 1.27 mg/dL
GFR Non-Afric Amer	>60	>59 ml/min/1.73 m2
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2
POC-OPERATOR'S ID	81056	

Imaging results:

ED Course

ED Course

Anuria
- 2/2 prostate biopsy done today
- foley catheter in place with immediate relief of symptoms
- consulted with Dr. Dusseau; maintain catheterization for ~5 days, then follow up with uro on monday
- chem8

Procedures

No consult orders placed this encounter

case reviewed with dr dussealt. Will admin cath and check renal function. D/c to f/u with urology in 5-6 days

10:06 PM
Vitals:

	01/16/18 2147
BP:	
Pulse:	
Resp:	
Temp:	
SpO2:	98%

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Joni L Baumann, NP at 1/16/2018 9:22 PM (continued)

Medications - No data to display

Final diagnoses:
Urinary retention

I have discussed the care plan and follow up instructions with the patent. Patient verbalizes understanding. Patient is stable, NAD, and non-toxic upon discharge. Pt to be discharged home. 10:06 PM

Follow up:
Beau N Dusseault, MD
55 Whitcher Street
Suite 250
Marietta GA 30060
770-428-4475

Schedule an appointment as soon as possible for a visit
follow up on Monday with urology office.

Joni L Baumann, NP
01/16/18 2338

Electronically Signed by Arthur R Curran III, MD on 1/17/2018 1:58 AM

ED Notes - ED Notes

ED Notes by Rachel Denmark, RN at 1/16/2018 9:28 PM

Author: Rachel Denmark, RN | Service: --- | Author Type: Registered Nurse
Filed: 1/16/2018 9:29 PM | Date of Service: 1/16/2018 9:28 PM | Status: Signed
Editor: Rachel Denmark, RN (Registered Nurse)

Pt has biopsy of prostate this morning at KH . He states that he was able to urinate twice since this morning and now cannot urinate at all. Pt states if he feels the urge to urinate, it is just bloody discharge.

Rachel Denmark, RN
01/16/18 2129

Electronically Signed by Rachel Denmark, RN on 1/16/2018 9:29 PM

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Nursing - Orders and Results

INSERT URINARY CATHETER [720826895]

Electronically signed by: **Joni L Baumann, NP on 01/19/18 0253** Status: **Completed**
Mode: Ordering in Verbal with readback mode
Ordering user: Rachel Denmark, RN 01/16/18 2131
Authorized by: Arthur R Curran III, MD
Cosigning events
Electronically cosigned by Arthur R Curran III, MD 01/17/18 0158 for Ordering
Quantity: 1
Communicated by: Rachel Denmark, RN
Ordering provider: Joni L Baumann, NP
Ordering mode: Verbal with readback
Instance released by: Rachel Denmark, RN (auto-released) 1/16/2018 9:31 PM

Questionnaire

Question	Answer
Urinary Catheter Type:	Indwelling/Foley
Indication:	Urinary Retention/Obstruction

Point of Care Testing-Docked Device - Orders and Results

POCT CHEM 8, ISTAT [720826897]

Electronically signed by: **Joni L Baumann, NP on 01/19/18 0253** Status: **Completed**
Mode: Ordering in ED APP Standard mode
Ordering user: Joni L Baumann, NP 01/16/18 2138
Authorized by: Arthur R Curran III, MD
Cosigning events
Electronically cosigned by Arthur R Curran III, MD 01/17/18 0158 for Ordering
Quantity: 1
Communicated by: Joni L Baumann, NP
Ordering provider: Joni L Baumann, NP
Ordering mode: ED APP Standard
Instance released by: Joni L Baumann, NP (auto-released) 1/16/2018 9:38 PM

POCT CHEM 8, ISTAT [720826899]

Electronically signed by: **Interface, Lab In Sunquest on 01/16/18 2152** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 01/16/18 2152
Authorized by: Arthur R Curran III, MD
Quantity: 1
Instance released by: (auto-released) 1/16/2018 9:58 PM
Ordering provider: Arthur R Curran III, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 2152

POCT CHEM 8, ISTAT [720826899] (Abnormal) Resulted: 01/16/18 2158, Result status: Final result

Ordering provider: Arthur R Curran III, MD 01/16/18 2152
Filed by: Interface, Lab In Sunquest 01/16/18 2159
External ID: T15137284
Order status: Completed
Resulting lab: WS PAULDING HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
—	Serum	01/16/18 2152

Components

Component	Value	Reference Range	Flag	Lab
POC-SODIUM	140	136 - 145 mmol/L	—	PHLAB
POC-POTASSIUM	4.4	3.5 - 5.1 mmol/L	—	PHLAB
Comment: HEMOLYSIS, IF PRESENT, MAY AFFECT RESULTS				
POC-CHLORIDE	106	95 - 110 mmol/L	—	PHLAB
POC-GLUCOSE	199	70 - 99 mg/dL	H	PHLAB
POC-BUN	27	7 - 21 mg/dL	H	PHLAB
POC-IONIZED CALCIUM	1.14	1.09 - 1.29 mmol/L	—	PHLAB
POC-CO2	21	20 - 28 mmol/L	—	PHLAB
POC-AGAP	19	15 - 23	—	PHLAB
POC-CREATININE	1.1	0.64 - 1.27 mg/dL	—	PHLAB
GFR Non-Afric Amer	>60	>59 ml/min/1.73 m2	—	PHLAB
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2	—	PHLAB
POC-OPERATOR'S ID	81056	—	—	PHLAB

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

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
22 - PHLAB	WS PAULDING HOSPITAL LAB	Dr. Burton Kim	2518 Jimmy Lee Smith Parkway Hiram GA 30141	04/09/14 0922 - 08/28/18 1258

Medications

All Meds and Administrations

(There are no med orders for this encounter)

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 Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

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

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

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

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

Learner Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

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

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

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Not documented in this visit.
Progress:

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Not documented in this visit.
Progress:

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.

Point: Exercise (Resolved)

Patient Education (continued)

Education (continued)

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.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

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.

Point: morphine sulfate (Resolved)

Patient Education (continued)

Education (continued)

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)

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

Patient Education (continued)

Education (continued)

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.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

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

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

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.

Patient Education (continued)

Education (continued)

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.

Discharge Instructions

Discharge Instructions

Maurice, Eugene George (MR # 561253820)

Date	Status	User	User Type	Discharge Note
	Pended	Joni L Baumann, NP	Nurse Practitioner	Original

Note:

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	01/16/18 20:55:18
Vitals	
Pct Wt Change	0 % -DI (r) LQ (t)
OTHER	
Weight Change (kg)	0 kg -DI (r) LQ (t)
Ideal Body Weight	160 lb -DI (r) LQ (t)
Visit Weight	226 lb -DI (r) LQ (t)
BMI (Calculated)	35.4 -DI (r) LQ (t)
BSA (Calculated - sq m)	2.2 sq meters -DI (r) LQ (t)
BMI (Calculated)	35.4 -DI (r) LQ (t)
IBW/kg (Calculated) Male	66.1 kg -DI (r) LQ (t)
IBW/kg (Calculated) FEMALE	61.6 kg -DI (r) LQ (t)
Weight/Scale Event	0 -DI (r) LQ (t)
Weight in (lb) to have BMI = 25	159.3 -DI (r) LQ (t)
% Weight Change Since Birth	0 -DI (r) LQ (t)
Adult IBW/VT Calculations	
IBW/kg (Calculated)	66.1 -DI (r) LQ (t)
Range Vt 4mL/kg	264.4 mL/kg -DI (r) LQ (t)
Low Range Vt 6mL/kg	396.6 mL/kg -DI (r) LQ (t)
Adult Moderate Range Vt 8mL/kg	528.8 mL/kg -DI (r) LQ (t)
Adult High Range Vt 10mL/kg	661 mL/kg -DI (r) LQ (t)
Case Log	
BSA x (CI @3.0)= CO	6.6 CO -DI (r) LQ (t)

Flowsheets (all recorded)

First Contact With Patient

Row Name	01/16/18 2122
Physician First Contact With Patient	
Now	Now -JB

Flowsheets (all recorded)

ED Fall Risk

Row Name	01/16/18 2130
Green Risk: Any patient presenting to the ED.	
Have the Green Environment of Care strategies been implemented? (click row info for more details)	Y -RD
Yellow Risk: ED Patients who present with or develop any of the following:	
Are any of the following Yellow criteria present?	No -RD

Flowsheets (all recorded)

Risk for Readmission

Row Name	01/16/18 2226
OTHER	
Risk for Readmission	8 - RD

Flowsheets (all recorded)

Acuity/Destination

Row Name	01/16/18 2119	01/16/18 2055	01/16/18 2054		
Acuity/Destination					
Patient Acuity	—	—	2 -LK		
ED Destination	7 -LK	23 -BD	—		
Primary Triage Complete	—	—	Primary triage complete -LK		

Flowsheets (all recorded)

Vital Signs

Row Name	01/16/18 2147	01/16/18 2141	01/16/18 20:55:18
Vital Signs			
Temp	—	—	97.4 °F (36.3 °C) -DI (r) LQ (t)
Pulse	----	----	72 -DI (r) LQ (t)
Resp	—	—	18 -DI (r) LQ (t)
BP	—	—	189/80 -DI (r) LQ (t)
Oxygen Therapy			
SpO2	98 % -RD	—	98 % -DI (r) LQ (t)
Pain Assessment			
Currently in Pain	—	No -RD	—
Numeric Pain Intensity Scale			
Numeric Pain Intensity Score 1	—	0 -RD	—
Height and Weight			
Height	----	----	67" (1.702 m) -DI (r) LQ (t)
Weight	----	----	102.4 kg (225 lb 12.8 oz) -DI (r) LQ (t)
BSA (Calculated - sq m)	—	—	2.2 sq meters -DI (r) LQ (t)
BMI (Calculated)	----	----	35.4 -DI (r) LQ (t)
Weight in (lb) to have BMI = 25	----	----	159.3 -DI (r) LQ (t)

Flowsheets (all recorded)

Retired NICU Intake/Output

Row Name	01/16/18 2147	01/16/18 2140	01/16/18 20:55:18
Weights			
Weight	—	—	102.4 kg (225 lb 12.8 oz) -DI (r) LQ (t)
BSA (Calculated - sq m)	—	—	2.2 sq meters -DI (r) LQ (t)
% Weight Change Since Birth	—	—	0 -DI (r) LQ (t)
Urine Assessment			
Urine Color	Red -RD	—	—
Urine Appearance	Cloudy -RD	—	—
[REMOVED] Urethral Catheter 16 Fr			
Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E		
Catheter Necessity Meets Criteria	—	Acute urinary retention -RD	—
Securement Method	—	Securing device (Describe) -RD	—
Collection Container	—	Standard drainage bag -RD	—
Output (mL)	—	1400 mL -RD	—

Flowsheets (all recorded)

Vital Signs

Row Name	01/16/18 2147	01/16/18 20:55:18
Vital Signs		
Automatic Restart Vitals Timer	—	Yes -DI (r) LQ (t)
Pulse	—	72 -DI (r) LQ (t)
Resp	—	18 -DI (r) LQ (t)
BP	—	189/80 -DI (r) LQ (t)
Calculated MAP	—	116.33 -DI (r) LQ (t)
Temp	—	97.4 °F (36.3 °C) -DI (r) LQ (t)
Oxygen Therapy		
SpO2	98 % -RD	98 % -DI (r) LQ (t)

Flowsheets (all recorded)

PA Risk Score

Row Name	01/16/18 2204	01/16/18 2201
Sepsis Risk Score		
Sepsis Risk Score	—	1 -UE
Sepsis Risk Score Change	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—

Flowsheets (all recorded)

Pain Assessment

Row Name	01/16/18 2141
Pain Timer	
Restart Pain Timer	Yes -RD
Pain Reassessment after Intervention Complete	Yes -RD
Pain Assessment	
Currently in Pain	No -RD
Which Pain Assessment Tool ?	Numeric (0-10) -RD
Patient's Stated Pain Goal	0 (No Pain) -RD
Numeric Pain Intensity Scale	
Numeric Pain Intensity Score 1	0 -RD

Flowsheets (all recorded)

Anthropometrics

Row Name	01/16/18 20:55:18
Anthropometrics	
Height	67" (1.702 m) -DI (r) LQ (t)
Weight	102.4 kg (225 lb 12.8 oz) -DI (r) LQ (t)
Weight Change	0 -DI (r) LQ (t)
BMI (Calculated)	35.4 -DI (r) LQ (t)

Flowsheets (all recorded)

Focused Assessment

Row Name	01/16/18 2147	01/16/18 20:55:18
Airway		
Airway (WDL)	WDL -RD	—
Breathing		
Breathing (WDL)	WDL -RD	—
SpO2	98 % -RD	98 % -DI (r) LQ (t)
Circulation		
Circulation (WDL)	WDL -RD	—
Disability		
Disability (WDL)	WDL -RD	—
Level of Consciousness	Alert -RD	—

Flowsheets (all recorded)

Genitourinary

Row Name	01/16/18 2147
Genitourinary	
Genitourinary (WDL)	X -RD
Urinary Symptoms	Hematuria -RD
Urine Color	Red -RD
Urine Appearance	Cloudy -RD

Flowsheets (all recorded)

Pre-Arrival Documentation

Row Name	01/16/18 2146	01/16/18 2119	01/16/18 2055
Prehospital Information			
ED Destination	—	7 -LK	23 -BD
[REMOVED] Peripheral IV 01/16/18 20 G Right Antecubital			
IV Properties	Placement Date: 01/16/18 -RD Placement Time: 2146 -RD Present on arrival to hospital?: No -RD Type of Catheter: Straight -RD Size (Gauge): 20 G -RD Orientation: Right -RD Location: Antecubital -RD Site Prep: Chlorhexidine -RD Inserted by: Denmark, RN -RD Insertion attempts: 1 -RD Successful IV Attempt?: Yes -RD Patient Tolerance: Tolerated well -RD Removal Date: 01/16/18 -RD Removal Time: 2208 -RD Catheter Intact on removal?: Yes -RD		
Site Assessment	Clean;Dry;Intact -RD	—	—
Line Assessment	Blood return noted;Saline locked -RD	—	—
Dressing Assesment	Clean;Dry;Intact -RD	—	—
IV Interventions	Flushed -RD	—	—
[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)

Immunizations

Row Name	01/16/18 2129
Influenza Vaccine (Sept - March 31st)	
Have you received the Influenza Vaccine during this Flu season?	Yes -RD
Pneumococcal Vaccine Screening (Year Round)	
Have you received the pneumococcal vaccine?	Yes -RD

Flowsheets (all recorded)

Abuse Indicators

Row Name	01/16/18 2130
Abuse Screening	
Safe in Home	Yes -RD
Abuse Suspected	
Suspected Victim Of:	None Suspected -RD

Flowsheets (all recorded)

Psychosocial Needs

Row Name	01/16/18 2130
Psychosocial	
Needs Expressed	Denies -RD
Primary Language	
Primary Language Spoken by Patient?	English -RD

Flowsheets (all recorded)

Adult Suicide Risk

Row Name	01/16/18 2130
Suicide/Harm Risk	
Current thoughts (Retired)	No -RD
Patient information obtained from	Patient -RD
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -RD

Flowsheets (all recorded)

Assessment Complete

Row Name	01/16/18 2130
Assessment Complete	
Assessment Completed?	Yes -RD

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	01/16/18 20:55:18
Vital sign parameters	
BP	189/80 -DI (r) LQ (t)
Pulse	72 -DI (r) LQ (t)
Calculated MAP	116.33 -DI (r) LQ (t)
Resp	18 -DI (r) LQ (t)
Temp	97.4 °F (36.3 °C) -DI (r) LQ (t)
Vital Signs	
Automatic Restart Vitals Timer	Yes -DI (r) LQ (t)

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	01/16/18 2146	01/16/18 2140
[REMOVED] Peripheral IV 01/16/18 20 G Right Antecubital		
IV Properties	Placement Date: 01/16/18 -RD Placement Time: 2146 -RD Present on arrival to hospital?: No -RD Type of Catheter: Straight -RD Size (Gauge): 20 G -RD Orientation: Right -RD Location: Antecubital -RD Site Prep: Chlorhexidine -RD Inserted by: Denmark, RN -RD Insertion attempts: 1 -RD Successful IV Attempt?: Yes -RD Patient Tolerance: Tolerated well -RD Removal Date: 01/16/18 -RD Removal Time: 2208 -RD Catheter Intact on removal?: Yes -RD	
Site Assessment	Clean;Dry;Intact -RD	—
Line Assessment	Blood return noted;Saline locked -RD	—
Dressing Assesment	Clean;Dry;Intact -RD	—
IV Interventions	Flushed -RD	—
[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	
[REMOVED] Urethral Catheter 16 Fr		
Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E	
Catheter Necessity Meets Criteria	—	Acute urinary retention -RD
Securement Method	—	Securing device (Describe) -RD
Collection Container	—	Standard drainage bag -RD
Output (mL)	—	1400 mL -RD
[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	

Flowsheets (all recorded)

Secondary Triage Complete

Row Name	01/16/18 2130

Information Source

Information Provided By:	Patient -RD

Secondary Triage Complete

Secondary Triage Complete	Secondary Triage Complete -RD

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 -
JB	Joni L Baumann, NP	01/12/18 - 01/16/18
LQ	Lillian Quinones	09/08/15 -
BD	Brittany S Dickinson, RN	12/06/13 -
RG	Raquel Gil-Trani, RN	04/01/14 -
LK	Leslie Kennedy, RN	06/17/14 - 12/13/18
RD	Rachel Denmark, RN	09/22/17 - 11/27/18
MW	Marlo Wahbeh, RN	09/21/17 - 11/27/18
DI	Interface, Doc Flowsheet In	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 01/16/2018:

Scan on 1/18/2018 8:30 PM (below)

Document on 1/16/2018 10:19 PM by Marlo Wahbeh, RN: AVS - Large Print (below)

AFTER VISIT SUMMARY

Eugene G. Maurice DoB: 1/2/1949

1/16/2018
WellStar Paulding Hospital (PH EMERGENCY) 470-644-7170

Instructions

Read the attached information
1. Urinary Retention, Male (English)
2. Foley Catheter, Care (English)

Schedule an appointment with Beau N Dusseault, MD as soon as possible for a visit
Why: follow up on Monday with urology office.
Specialty: Urology
Contact: 55 Whitcher Street
Suite 250
Marietta GA 30060
770-428-4475

Today's Visit

You were seen by Arthur R. Curran, III, MD

Reason for Visit
- Post-op Problem
- Hematuria

Diagnosis
Urinary retention

Lab Tests Completed
POC Chem8 performed 2 times

Done Today
Urinary Catheter - Insert

Today's Visit (continued)

Your End of Visit Vitals

Blood Pressure	Temperature	Pulse
189/80	97.4 °F	72
Respiration	**Oxygen Saturation**	
18	98%	

What's Next

JAN 30 2018 — Follow Up Appointment with Beau N Dusseault, MD
Tuesday January 30 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 2018 — Follow Up Appointment with Abdul M Sheikh, MD
Friday March 2 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

For further follow up if needed, please call Wellstar doctor referral line at 770-956-7827.

You are allergic to the following

No active allergies

If you have any questions about this medication list, please talk to your doctor at your next appointment. You may use this form to make notes about any medications that you have stopped or started taking, including over the counter medications. Bring the form with you to the appointment as a reminder to discuss with your doctor.

MyChart

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

Your Medication List

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	Take 81 mg by mouth daily.
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.**

Attached Information

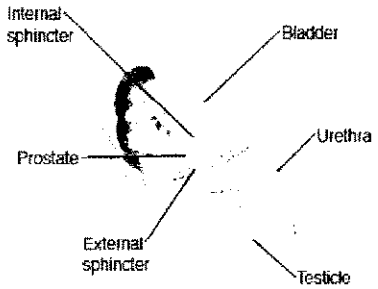
Urinary Retention, Male (English)

Urinary Retention (Male)

Urinary retention is the medical term for difficulty or inability to pass urine, even though your bladder is full.

Causes

The most common cause of urinary retention in men is the bladder outlet being blocked. This can be due to an enlarged prostate gland or a bladder infection. Certain medicines can also cause this problem. This condition is more likely to occur as men get older.



This condition is treated by insertion of a catheter into the bladder to drain the urine. This provides immediate relief. The catheter may need to remain in place for a few days to prevent a recurrence. The catheter has a balloon on the tip which was inflated after insertion. This prevents the catheter from falling out.

Symptoms

Common symptoms of urinary retention include:

- Pain (not experienced by everyone)
- Frequent urination
- Feeling that the bladder is still full after urinating
- Incontinence (not being able to control the release of urine)

- Swollen abdomen

Treatment

This condition is treated by inserting a tube (catheter) into the bladder to drain the urine. This provides immediate relief. The catheter may need to stay in place for a few days. The catheter has a balloon on the tip, which is inflated after insertion. This prevents the catheter from falling out.

Home care

- If you were given antibiotics, take them until they are used up, or your healthcare provider tells you to stop. It is important to finish the antibiotics even though you feel better. This is to make sure your infection has cleared.
- If a catheter was left in place, it is important to keep bacteria from getting into the collection bag. Do not disconnect the catheter from the collection bag.
- Use a leg band to secure the drainage tube, so it does not pull on the catheter. Drain the collection bag when it becomes full using the drain spout at the bottom of the bag.
- Do not pull on or try to remove your catheter. This will injure your urethra. The catheter must be removed by a healthcare provider.

Follow-up care

Follow up with your healthcare provider, or as advised.

If a catheter was left in place, it can usually be removed within 3 to 7 days. Some conditions require the catheter to stay in longer. Your healthcare provider will tell you when to return to have the catheter removed.

When to seek medical advice

Call your healthcare provider right away if any of these occur:

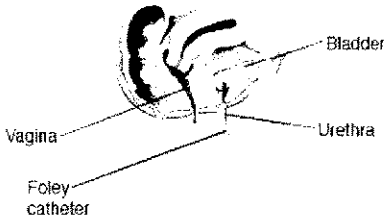
- Fever of 100.4°F (38°C) or higher, or as directed by your healthcare provider
- Bladder or lower-abdominal pain or fullness
- Abdominal swelling, nausea, vomiting, or back pain
- Blood or urine leakage around the catheter
- Bloody urine coming from the catheter (if a new symptom)
- Weakness, dizziness, or fainting
- Confusion or change in usual level of alertness

- If a catheter was left in place, return if:
  - Catheter falls out
  - Catheter stops draining for 6 hours

Date Last Reviewed: 7/26/2015

Attached Information

Foley Catheter Care



A Foley catheter is a rubber tube that is placed through the urethra (opening where urine comes out) and into the bladder. This helps drain urine from the bladder. There is a small balloon on the end of the tube that is inflated after insertion. This keeps the catheter from sliding out of the bladder.

A Foley catheter is used to treat urinary retention (unable to pass urine). It is also used when there is incontinence (loss of bladder control).

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Date Last Reviewed: 10/1/2016

Document on 1/16/2018 10:08 PM by Rachel Denmark, RN: AVS - Large Print (below)

WELLSTAR

AFTER VISIT SUMMARY

Eugene G. Maurice DoB: 1/2/1949

1/16/2018

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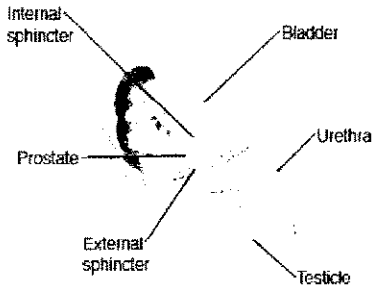

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Date Last Reviewed: 7/26/2015

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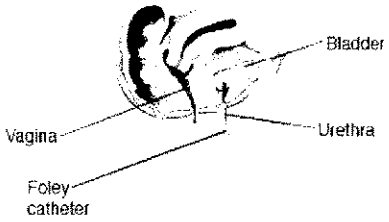

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- Bloody urine coming from the catheter (if a new symptom)
- Catheter falls out
- Catheter stops draining for 6 hours
- Weakness, dizziness, or fainting

Date Last Reviewed: 10/1/2016

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	OP		Unit:	PIC CT
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found
Admitting Provider:			Referring Physician:	Chervu, Arun
Attending Provider:	Arun chervu	AD: N	Adm Diagnosis:	Bilateral carotid artery*
Admission Date:	4/5/2018		Admission Time:	1509

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: $0.00 Out of Pocket Max: $6,700.00

SECONDARY INSURANCE

Payor:		Plan:	N/A
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial#

April 3, 2020

Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	04/05/2018 1509	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Imaging Center
Admit Provider:		Attending Provider:	Arun Chervu, MD	Referring Provider:	Arun Chervu, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
04/06/2018 2359	Home Or Self Care	None	None	WellStar Paulding Imaging Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I65.23 **[Principal]**	Occlusion and stenosis of bilateral carotid arteries				

Events

Hospital Outpatient at 4/5/2018 1509

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Discharge at 4/6/2018 2359

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Allergies as of 4/6/2018

Reviewed on 3/29/2018

No Known Allergies

Immunizations as of 4/6/2018

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

All Scans (continued)

Immunizations (continued) as of 4/6/2018

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 4/6/2018

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

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

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

ED Records (continued)

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Imaging - Orders and Results

CT ANGIOGRAM NECK/CAROTIDS WITH IV CONTRAST(CREATININE DRAW IF NEEDED) [735098262]

Electronically signed by: **Felicia Griffin on 03/29/18 1330**
Status: **Completed**
Ordering user: Felicia Griffin 03/29/18 1330
Authorized by: Arun Chervu, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Adrienne Stephens 4/5/2018 3:09 PM
Diagnoses
Bilateral carotid artery stenosis without cerebral infarction [I65.23]

Questionnaire

Question	Answer
Does the patient have a history of contrast allergy?	No
Will the patient require hydration?	No
Do you authorize a creatinine/eGFR blood draw for this patient if the patient does not have an up to date creatinine/eGFR within the last 30 days based on the criteria outlined below?	Yes
Protocol document:	\\epicwebblob\EpicBlob\JACO\(V1) CT-504 CTA Carotids.pdf

Order comments: VASCULAR ORDERS 3-29-18 CMAYFIELD

Scan on 3/29/2018 1:31 PM by Carla D Mayfield: Perceptive Content Scan (below)

Scan on 4/5/2018 1:50 PM by Jiquesha Matlock: Perceptive Content Scan (below)

CT ANGIOGRAM NECK/CAROTIDS WITH IV CONTRAST(CREATININE DRAW IF NEEDED)
[735098262]
Resulted: 04/06/18 0836, Result status: Final result

Order status: Completed
Resulted by: Robert H Stephenson Jr., MD
Filed by: Interface, Rad Powerscribe 04/06/18 0837
Performed: 04/05/18 1554 - 04/05/18 1607
Accession number: 29361787
Result details
Narrative:
EXAM: CT ANGIOGRAM NECK WITH IV CONTRAST

CLINICAL INDICATION: I65.23 (Occlusion and stenosis of bilateral carotid arteries) .

TECHNIQUE: Following IV administration of 120 cc Omnipaque 350, CT angiogram of the neck with multiplanar and MIP reformatted images generated from the data set. NASCET-like criteria used to determine the degree of vascular stenosis. Multiplanar reformatted images and 3-D volume rendered images were generated from the data set by the Quantum 3-D laboratory on an independent workstation. Dose reduction techniques were utilized.

COMPARISON: CT angiogram 2/17/2014

FINDINGS:

CTA NECK:

AORTA: There is moderate atherosclerotic calcification of the aortic arch. Calcified plaque is noted at the origins of the brachiocephalic, left subclavian and left common carotid arteries, with no flow-limiting stenosis. There is mild stenosis of the left subclavian artery proximal to the origin of the vertebral artery.

RIGHT CAROTID SYSTEM: Calcified plaque at the CCA bifurcation and in the proximal ICA. Stenosis of the distal CCA at the bifurcation is 50-60% luminal diameter, 50-60% by NASCET criteria. Stenosis at the origin of the ICA is 75-85% luminal, 65-75% by NASCET criteria. This has not changed appreciably compared with the prior study.

LEFT CAROTID SYSTEM: Postoperative changes from prior carotid endarterectomy. The low density area along the lateral carotid sheath at the area of surgery is no longer identified. There is no significant carotid stenosis.

VERTEBRAL ARTERIES: The right vertebral artery is dominant. There is calcified plaque adjacent to the origin on both sides. The origin are difficult to visualize but there is mild stenosis on the right, possibly 40-50% luminal diameter. There is a diminutive V4 segment on the left, with calcified plaque proximally resulting in a moderate to high-grade stenosis (difficult to quantitate due to small vessel size).

NECK: Postoperative changes are noted from prior CABG. There is chronic enlargement of the proximal pulmonary arteries suggesting pulmonary arterial hypertension. No mass is evident in the neck.

Impression:

Status post left carotid endarterectomy. No significant left carotid stenosis.

Chronic calcified plaque at the right CCA bifurcation and proximal ICA resulting in 65-75% stenosis by NASCET criteria, not significantly change from 2/17/2014. Please see above for additional details.

Released By: ROBERT H STEPHENSON JR., MD 4/6/2018 8:36 AM
Acknowledged by: Arun Chervu, MD on 04/06/18 1025

Imaging - Orders and Results (continued)

Medications - Orders and Results

iohexol (OMNIPAQUE) injection 350 mg/mL [735098263]

Electronically signed by: **Anne C Acton, ARRT on 04/05/18 1555** Status: **Completed**
Ordering user: Anne C Acton, ARRT 04/05/18 1555
Ordering provider: Arun Chervu, MD
Authorized by: Arun Chervu, MD
Ordering mode: Per Written Order
PRN reasons: contrast
Frequency: Routine Once PRN - IMG 04/05/18 1555 - 1 occurrence
Package: 0407-1414-86

Medications

All Meds and Administrations

iohexol (OMNIPAQUE) injection 350 mg/mL [735098263]

Ordering Provider: Arun Chervu, MD
Ordered On: 04/05/18 1555
Dose (Remaining/Total): 100 mL (0/1)
Frequency: IMG once as needed
Status: Completed (Past End Date/Time)
Starts/Ends: 04/05/18 1555 - 04/05/18 1555
Route: Intravenous
Rate/Duration: --- / ---

Line	Med Link Info	Comment
Peripheral IV 04/05/18 22 G Right Antecubital	04/05/18 1555 by Anne C Acton, ARRT	—

Timestamps	Action	Dose	Route	Other Information
Performed 04/05/18 1555 Documented: 04/05/18 1555	Given	150 mL	Intravenous	Performed by: Anne C Acton, ARRT Scanned Package: 0407-1414-86

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)

Description:
Refer to rating score of 0-10.

Patient Education (continued)

Education (continued)

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.

Point: Risk Factors (Resolved)

Patient Education (continued)

Education (continued)

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.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

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.

Title: First-Dose Education (Not Started)

Patient Education (continued)

Education (continued)

Points For This Title

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

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.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Resolved)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

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)

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".
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: 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.

Patient Education (continued)

Education (continued)

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: 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)

Patient Education (continued)

Education (continued)

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)

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)

Patient Education (continued)

Education (continued)

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.

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	04/07/18 0215				
OTHER					
Risk for Readmission	8 - BP				

Flowsheets (all recorded)

Lines/Drains/Airways

Row Name	04/05/18 1608	04/05/18 1554			
Lines/Drains/Airways					
Add Line, Drain, or Airway	Yes -AA	Yes -AA			
[REMOVED] Peripheral IV 04/05/18 22 G Right Antecubital					
IV Properties	Placement Date: 04/05/18 -AA Placement Time: 1554 -AA Present on arrival to hospital?: No -AA Type of Catheter: Straight -AA Size (Gauge): 22 G -AA Orientation: Right -AA Location: Antecubital -AA Site Prep: Alcohol -AA Local Anesthetic: None -AA Inserted by: Linda Wheeler R.T. -AA Insertion attempts: 1 -AA Successful IV Attempt?: Yes -AA Patient Tolerance: Tolerated well -AA IV Access Problem: No -AA Removal Date: 04/05/18 -AA Removal Time: 1610 -AA Catheter Intact on removal?: Yes -AA Removal Reason : Patient discharged -AA Remaining intact at discharge?: Yes -AA				
Site Assessment	Clean;Dry;Intact -AA	—			
Phlebitis Scale	0 -AA	—			
Infiltration/Extravasation Scale	0 -AA	—			
Line Assessment	Blood return noted -AA	—			
Dressing Assesment	Clean;Dry;Intact -AA	—			
Dressing Interventions	Gauze Applied -AA	—			
IV Interventions	Flushed -AA	—			

User Key

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

Initials	Name	Effective Dates
AA	Anne C Acton, ARRT	02/03/17 -
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 04/05/2018:

Scan on 4/19/2018 10:24 AM (below)

Scan on 4/19/2018 9:08 AM (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	**OPS**		Unit:	**PH ARU**	
Hospital Service:	**General Surgery**		Bed:	**Room/bed info not found**	
Admitting Provider:			Referring Physician:	**Sheikh, Abdul M**	
Attending Provider:	**Abdul m sheikh**	AD: N	Adm Diagnosis:	**SOB (shortness of breath***	
Admission Date:	**6/12/2018**		Admission Time:	**1134**	

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:	06/12/2018 1134	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Ambulatory Surgery Center	Admit Category:	
Means of Arrival:	Car	Primary Service:	General Surgery	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH CARDIAC ARU)
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/13/2018 2359	Home Or Self Care	None	None	WellStar Paulding Hospital (PH CARDIAC ARU)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
I34.0 **[Principal]**	Nonrheumatic mitral (valve) insufficiency				
R06.02	Shortness of breath				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
I10	Essential (primary) hypertension				
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				
E66.01	Morbid (severe) obesity due to excess calories				
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			
Z79.01	Long term (current) use of anticoagulants	Exempt from POA reporting			
Z68.34	Body mass index (bmi) 34.0-34.9, adult	Exempt from POA reporting			
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			

Events

Hospital Outpatient at 6/12/2018 1134

Unit: WellStar Paulding Hospital (PH CARDIAC ARU)
Patient class: Hospital Outpatient Surgery Service: General Surgery

Discharge at 6/13/2018 2359

Unit: WellStar Paulding Hospital (PH CARDIAC ARU)
Patient class: Hospital Outpatient Surgery Service: General Surgery

Allergies as of 6/13/2018

Reviewed on 6/12/2018

No Known Allergies

Immunizations as of 6/13/2018

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

All Scans (continued)

Immunizations (continued) as of 6/13/2018

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 6/13/2018

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

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

All Scans (continued)

Medical as of 6/13/2018 (continued)

Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

Progress Notes - Encounter Notes

Progress Notes by Darsi Knowles, RN at 6/12/2018 2:58 PM

Author: Darsi Knowles, RN | Service: — | Author Type: Registered Nurse
Filed: 6/12/2018 2:59 PM | Date of Service: 6/12/2018 2:58 PM | Status: Signed
Editor: Darsi Knowles, RN (Registered Nurse)

Patient on stretcher resting comfortably. Wife at bedside. Patient provided apple juice and ice. Breathing easy and unlabored.

Electronically Signed by Darsi Knowles, RN on 6/12/2018 2:59 PM

Progress Notes by Darsi Knowles, RN at 6/12/2018 3:38 PM

Author: Darsi Knowles, RN | Service: — | Author Type: Registered Nurse
Filed: 6/12/2018 3:42 PM | Date of Service: 6/12/2018 3:38 PM | Status: Signed
Editor: Darsi Knowles, RN (Registered Nurse)

Dr. Edupuganti requested patient be ambulated with pulse oximetry post recovery. Patient ambulated down pre/post hall with portable vital signs machine. Patient's pulse ox reading dropped to low 90s during ambulation and then to 85% while resting on side of bed afterwards. Dr. Edupuganti notified by Jay, RN. MD gave instructions to discharge per plan and patient follow up per directions.

Electronically Signed by Darsi Knowles, RN on 6/12/2018 3:42 PM

Brief Op Note - Encounter Notes

Brief Op Note by Ravi Edupuganti, MD at 6/12/2018 2:49 PM

Author: Ravi Edupuganti, MD | Service: Cardiology | Author Type: Physician
Filed: 6/12/2018 2:57 PM | Date of Service: 6/12/2018 2:49 PM | Status: Signed
Editor: Ravi Edupuganti, MD (Physician)

Eugene G Maurice

Preoperative Diagnosis: MR

Post-Operative Diagnosis: s/p TEE, c/w mild- moderate MR, tethering of posterior leaflet , preserved lvef
See report

Impression:
S/p TEE- please see report,mild- moderate MR, tethering of posterior leaflet , preserved lvef
sbradycardia 50s, normal o2 sats on RA, sbp 110

Brief Op Note - Encounter Notes (continued)

Brief Op Note by Ravi Edupuganti, MD at 6/12/2018 2:49 PM (continued)

Cad- stable, followed by DR. Sheikh

Sob- unclear

Plan:
F/u Dr. Sheikh for further OP evealuation.

Discussed with wife
Ravi Edupuganti, MD. FACC.
CVM/Austell
1700 Hospital South Drive
Suite 409
Austell, GA 30106
Phone: (770) 732-9100
Fax: (770) 528-9924

Electronically Signed by Ravi Edupuganti, MD on 6/12/2018 2:57 PM

Surgery Report

General Information

Date: 6/12/2018 | Time: | Status: Posted
Location: PH CV Appointments | Room: | Service:
Patient class: | Case classification:

Diagnosis Information

No post-op diagnosis codes associated with the log.

Case Tracking Events

Event	Time In
In Facility	1134
In ARU Prep	1136
Out of ARU Prep	
Ready for Procedure	
In ARU Recovery	
Out of ARU Recovery	1545
Remove from Status Board	1548
Anesthesia Available	
Anesthesia Start	1410
Anesthesia Stop	1452

Questionnaire Data

None

PNDS Information

Outcomes - Pre-op

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

Outcomes - Intra-op

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

Outcomes - Post-op

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

Diagnoses

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

Timeouts

None

Surgery Report (continued)

Anesthesia Encounters

Anesthesia Encounter - Episode ID 28758373

Anesthesia Summary - Maurice, Eugene George [561253820] Male 69 y.o. Current as of 06/12/18 1245

Height: 67" (1.702 m) (06/12/18)
Weight: 99.1 kg (218 lb 7.6 oz) (06/12/18)
BMI: 34.2 (06/12/18)
NPO Status: 2220
Allergies: No Known Allergies

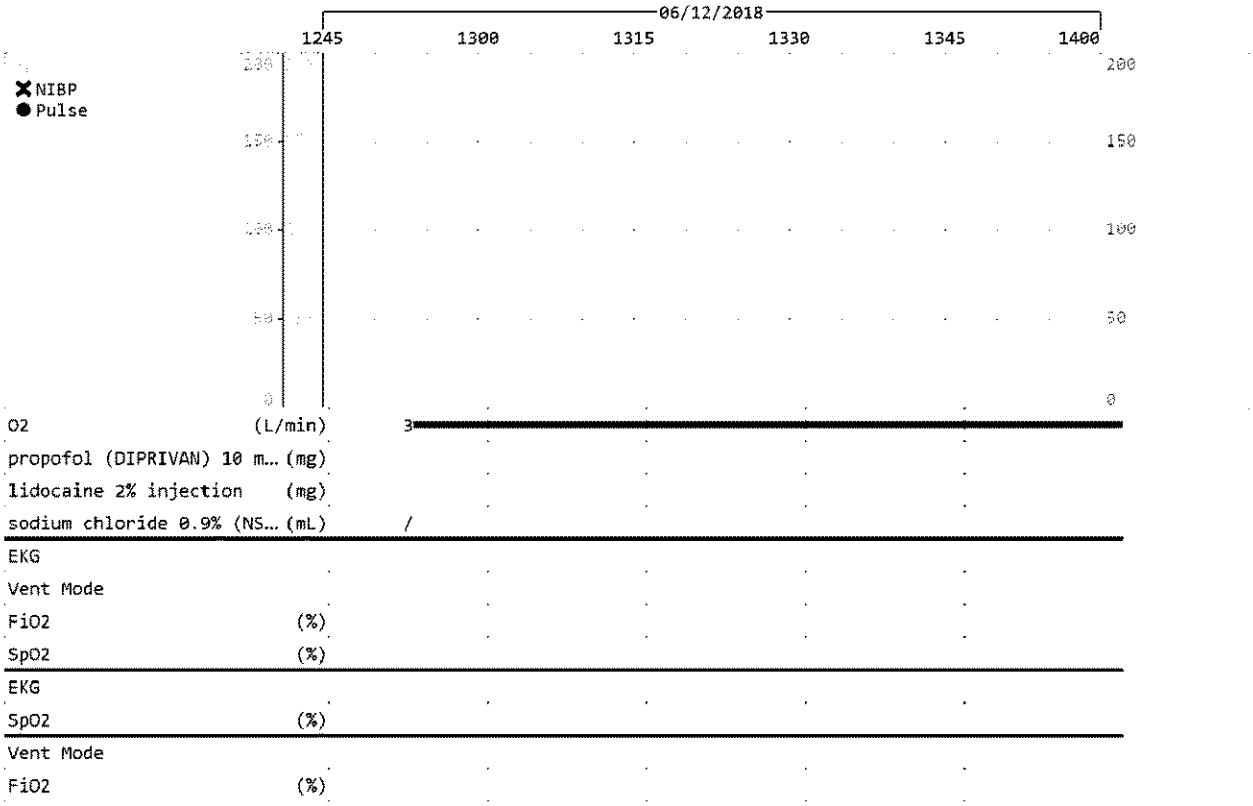
Procedure Summary

Date: 06/12/18
Anesthesia Start: 1410
Procedure: TEE COMPLETE W/ AND/OR W/O CONTRAST PRN

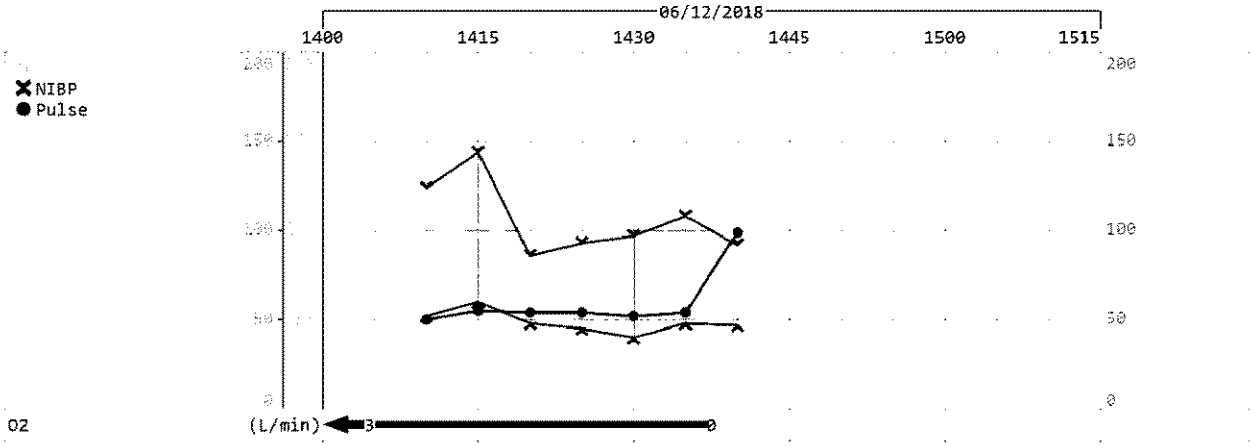
Scheduled Providers: Ravi Edupuganti, MD
Anesthesia Type: MAC

Room / Location: WellStar Paulding Hospital (PH CARDIAC ARU)
Anesthesia Stop: 1452
Diagnosis:
SOB (shortness of breath)
(Shortness of breath)

Responsible Provider: Glenn T Wheaton, MD
ASA Status: 4



Anesthesia Encounter - Episode ID 28758373 (continued)



EKG		Sinus Bradyca...	[Sinus Bradyc...	[Sinus Bradyc...
Vent Mode		Spontaneous	[Spontaneous]	[Spontaneous]
FiO2	(%)	30	[30]	[30]
SpO2	(%)	99	[99]	[99]
EKG		Sinus Bradyca...	[Sinus Bradyc...	[Sinus Bradyc...
SpO2	(%)	99	[99]	[99]
Vent Mode		Spontaneous	[Spontaneous]	[Spontaneous]
FiO2	(%)	30	[30]	[30]

Staff 06/12/18

Name	Role	Begin	End
Glenn T Wheaton, MD	ANMD	1410	1452
Scott C Hill, PAA	APA	1410	1452

Events

Date	Time	Event
6/12/2018	1245	Signed/Cosigned and Ready for Procedure
	1410	Anesthesia Start
	1410	Start Data Collection
	1419	Induction
	1439	Emergence
	1444	Stop Data Collection
	1452	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
	1452	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)

Anesthesia Encounter - Episode ID 28758373 (continued)

Anesthesia Medical History (continued)

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

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

Facility Administered Medications

Taken on 06/12/18

sodium chloride 0.9% (NS) infusion

Prescription Medications

Within last 14 days from 06/12/18

	Last Taken	Last Updated
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	Unknown	06/12/18 1214
apixaban (ELIQUIS) 5 mg tablet	6/12/2018	06/12/18 1214
aspirin, buffered 81 mg Tab	6/12/2018	06/12/18 1214
atorvastatin (LIPITOR) 80 MG tablet	6/11/2018	06/12/18 1214
blood sugar diagnostic (GLUCOSE BLOOD) strip	Taking	05/25/18 1403
blood sugar diagnostic strip	Taking	05/25/18 1403
~~carvedilol (COREG) 12.5 MG tablet (Discontinued)~~	~~Taking~~	~~05/25/18 1403~~
~~carvedilol (COREG) 6.25 MG tablet (Discontinued)~~		
carvedilol (COREG) 6.25 MG tablet	6/10/2018	06/12/18 1214
~~chlorthalidone (HYGROTEN) 50 MG tablet (Discontinued)~~	~~Taking~~	~~05/25/18 1403~~
furosemide (LASIX) 20 MG tablet	6/11/2018	06/12/18 1214
~~furosemide (LASIX) 40 MG tablet (Discontinued)~~	~~Taking~~	~~05/25/18 1403~~
isosorbide mononitrate (IMDUR) 30 MG 24 hr tablet	6/12/2018	06/12/18 1214
metFORMIN (GLUCOPHAGE) 500 MG tablet	6/11/2018	06/12/18 1214
ramipril (ALTACE) 10 MG capsule	6/10/2018	06/12/18 1214
sotalol (BETAPACE) 80 MG tablet	6/12/2018	06/12/18 1214

Preprocedure Vitals

Current as of 06/12/18 1245

BP: 142/58
Pulse: 47
Resp: 20
SpO2: 100
Temp: 97.5 °F (36.4 °C)
Height: 67" (1.702 m) (06/12/18)
Weight: 99.1 kg (218 lb 7.6 oz) (06/12/18)
BMI: **34.2**
IBW: 66.1 kg (145 lb 12.2 oz)
Last edited 06/12/18 1214 by MD

Blood Orders

Ordered in last 14 days - Current as of 04/03/20 1549

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	13.3 ▼
HCT	--

Anesthesia Encounter - Episode ID 28758373 (continued)

Hematology Labs (continued) (Last 90 days)

	03/17 0914
Plt	--

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 06/12/18 1323 by Glenn T Wheaton, MD
Date of Service 06/12/18 1248
Status: Addendum

Anesthesia Pre-op Evaluation

Patient Name: Eugene G Maurice **MRN:** 561253820
Date of Birth: 1/2/1949 **Age:** 69 yrs **Sex:** Male
Height: 67" (1.702 m) **Weight:** 99.1 kg (218 lb 7.6 oz) **BMI:** Body mass index is 34.22 kg/m².

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)	
• 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	

Anesthesia Encounter - Episode ID 28758373 (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:
Date of last liquid: 06/11/18
Time of last liquid: 2220
Date of last solid: 06/11/18
Time of last solid: 2220

Pre-operative Evaluation

Review of Systems/Medical History

General: Patient summary reviewed.
Anesthesia History:
Cardiovascular:
(+) hypertension: CAD, angina, CABG/stent,

Comments: Results for orders placed or performed during the hospital encounter of 04/09/18
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· The left ventricular systolic function is normal, ejection fraction is 50-55%.
· The left ventricular cavity size is normal.
· Left ventricular diastolic function is normal.
· The right ventricular cavity size and systolic function is/are normal.
· There is mild mitral and tricuspid valve regurgitation present.

Results for orders placed or performed during the hospital encounter of 03/29/16
-Echo 2D complete panel (contrast/bubble PRN per protocol)

Narrative
· 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.

Pulmonary:
(+) shortness of breath,

Neuro/Psych: - Negative ROS

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

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

Physical Exam

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

Dental: normal exam

Cardiovascular: normal exam
Rhythm: regular
Rate: normal

Pulmonary: normal exam
Respiratory Effort: normal and unlabored breathing
Breath sounds clear to auscultation.

Anesthesia Plan

ASA: 4
Anesthetic Plan: MAC

Airway Management: supplemental O2
Premedication planned: none
Induction: Intravenous
PONV Risk Assessment: Risk(s): Non-Smoker / Score: 1
Postoperative Plan: Plan for postoperative opioids intended.

Anesthetic plan and risks discussed with: Patient and spouse.

Electronically signed by Glenn T Wheaton, MD at 6/12/2018 1:23 PM

Anesthesia Encounter - Episode ID 28758373 (continued)

All Postprocedure Notes (continued)

Last edited 06/12/18 1507 by Glenn T Wheaton, MD
Date of Service 06/12/18 1507
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: spontaneous ventilation
Cardiovascular: blood pressure at baseline and stable
Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting
Anesthetic complications: No

Electronically signed by Glenn T Wheaton, MD at 6/12/2018 3:07 PM

Attestation Information

Staff Name	Date	Time	Type
Glenn T Wheaton, MD	06/12/18	1410	Pre-Induction Assessment
Glenn T Wheaton, MD	06/12/18	1410	Intra-operative Monitoring
Glenn T Wheaton, MD	06/12/18	1410	Present for MAC

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
propofol (DIPRIVAN) 10 mg/mL injection (mg)	80 mg	Given	06/12/18 1419	Scott C Hill, PAA	
	30 mg	Given	1423	Scott C Hill, PAA	
	40 mg	Given	1428	Scott C Hill, PAA	
lidocaine 2% injection (mg)	100 mg	Given	06/12/18 1419	Scott C Hill, PAA	
sodium chloride 0.9% (NS) infusion (mL)		New Bag	06/12/18 1253	Andrea C Horsford, PAA	
	400 mL	Anesthesia Volume Adjustment	1444	Scott C Hill, PAA	

Signoff Status

None

Flowsheets (all recorded)

Intake/Output

Row Name	06/12/18 1444	06/12/18 1428	06/12/18 1423	06/12/18 1419	06/12/18 1253
sodium chloride 0.9% (NS) infusion Start: 06/12/18 1253					
Volume (mL)	400 mL -SH	—	—	—	—
propofol					
propofol Bolus Dose (mg)	—	40 mg -SH	30 mg -SH	80 mg -SH	—
propofol Concentration	—	10 mg/mL -SH	10 mg/mL -SH	10 mg/mL -SH	—
[REMOVED] Anesthesia Airway Nasal Cannula					
AN Airway Properties	Placement Date: 06/12/18 -AH Placement Time: 1253 -AH Airway Device: Nasal Cannula -AH Removal Date: 06/17/18 -RG, N/E				

Flowsheets (all recorded)

Agents

Row Name	06/12/18 1444	06/12/18 1253			
Agents					
O2	0 L/min -SH	3 L/min -AH			

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	06/12/18 0000
Anesthesia Checklist	
Monitors In Use	Pulse oximeter -SH
NIBP Site	Arm R -SH
Cardiac	EKG -SH
Leads	3 -SH

Flowsheets (all recorded)

Agents

Row Name	06/12/18 1444	06/12/18 1253			
Agents					
O2	0 L/min -SH	3 L/min -AH			

Flowsheets (all recorded)

Anesthesia Monitoring

Row Name	06/12/18 1440	06/12/18 1435	06/12/18 1430	06/12/18 1425	06/12/18 1420
Assessment					
EKG	Sinus Bradycardia -SH	Sinus Bradycardia -SH	Sinus Bradycardia -SH	Sinus Bradycardia -SH	Sinus Bradycardia -SH
Respiratory					
Vent Mode	Spontaneous -SH	Spontaneous -SH	Spontaneous -SH	Spontaneous -SH	Spontaneous -SH
Anesthesia Monitoring					
FiO2	30 % -SH	30 % -SH	30 % -SH	30 % -SH	30 % -SH
OTHER					
SpO2	99 % -SH	98 % -SH	99 % -SH	99 % -SH	92 % -SH

Row Name	06/12/18 1415	06/12/18 1410
Assessment		
EKG	Sinus Bradycardia -SH	Sinus Bradycardia -SH
Respiratory		
Vent Mode	Spontaneous -SH	Spontaneous -SH
Anesthesia Monitoring		
FiO2	30 % -SH	30 % -SH
OTHER		
SpO2	99 % -SH	99 % -SH

Flowsheets (all recorded)

BP/Pulse

Row Name	06/12/18 1440	06/12/18 1435	06/12/18 1430	06/12/18 1425	06/12/18 1420
BP/Pulse					
NIBP	92/47 -SH	108/48 -SH	97/40 -SH	93/45 -SH	(!) 86/48 -SH
Pulse	99 -SH	54 -SH	52 -SH	54 -SH	54 -SH

Row Name	06/12/18 1415	06/12/18 1410
BP/Pulse		
NIBP	144/60 -SH	124/52 -SH
Pulse	55 -SH	50 -SH

Flowsheets (all recorded)

Positioning

Row Name	06/12/18 1411
OTHER	
Position	Left Lateral -SH

Flowsheets (all recorded)

Medication Exclusion

Row Name	Anesthesia from 6/12/2018 in WellStar Paulding Hospital (PH CARDIAC ARU)

Antibiotic/Beta Blocker/Antiemetic/Narcotic Admin Exclusions

Antibiotic Administered?	2 -AH
Beta Blocker Adminstered?	0 -AH
Antiemetic Adminstered?	5 -AH
Has narcotic waste been reconciled?	1 -AH

User Key

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

Initials	Name	Effective Dates
RG	Raquel Gil-Trani, RN	04/01/14 -
AH	Andrea C Horsford, PAA	06/12/18 - 06/12/18
SH	Scott C Hill, PAA	06/06/18 - 06/18/18

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Echocardiography - Orders and Results

TEE COMPLETE W/ AND/OR W/O CONTRAST PRN [749935484]

Electronically signed by: **Abdul M Sheikh, MD on 06/04/18 1745** Status: **Completed**
Ordering user: Abdul M Sheikh, MD 06/04/18 1745 Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1 Lab status: Final result
Instance released by: Ida A Jones 6/12/2018 11:34 AM
Diagnoses
SOB (shortness of breath) [R06.02]

Questionnaire

Question	Answer
Reason for exam?	Shortness of breath

TEE COMPLETE W/ AND/OR W/O CONTRAST PRN [749935484] Resulted: 06/12/18 2329, Result status: Final result

Order status: Completed
Filed by: Ravi Edupuganti, MD 06/12/18 2356
Accession number: 29653107
Result details
Narrative:
· The left ventricular systolic function is normal, ejection fraction is 55-60%.
· The left ventricular cavity size is normal.
· Unable to assess left ventricular diastolic function. Unable to assess left atrial pressure.
· The right ventricular cavity size and systolic function is/are normal.
· There is no evidence of thrombus in the left atrial appendage. There is no spontaneous echo contrast in the left atrial appendage.
· Mild- moderate central MR(2 small jets), likely related to tethering of posterior leaflet, MR determined by color jet area, color jet not adequate for ERO and VC determination
· Suboptimal , but negative bubble study for PFO

Resulted by: Ravi Edupuganti, MD
Performed: 06/12/18 1339 - 06/12/18 1445
Resulting lab: NONINV CARDIOLOGY

Components

Echocardiography - Orders and Results (continued)

Component	Value	Reference Range	Flag	Lab
BSA	2.16	m2	—	NonInv Card

Procedures Performed	Chargeables
TEE COMPLETE W/ COLOR FLOW AND SPECTRAL DOPPLER [ECH01]	

Reviewed by

Abdul M Sheikh, MD on 06/13/18 0741

Discharge - Orders and Results

DISCHARGE PATIENT [749935501]

Electronically signed by: **Ravi Edupuganti, MD on 06/12/18 1458**
Status: **Completed**
Ordering user: Ravi Edupuganti, MD 06/12/18 1458
Ordering provider: Ravi Edupuganti, MD
Authorized by: Ravi Edupuganti, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Ravi Edupuganti, MD (auto-released) 6/12/2018 2:58 PM
Order comments: Normal bedrest

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [749935503]

Electronically signed by: **Interface, Lab In Sunquest on 06/12/18 1220**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 06/12/18 1220
Ordering provider: Abdul M Sheikh, MD
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: (auto-released) 6/13/2018 6:04 AM

Specimen Information

Type	Source	Collected By
Other	Serum	06/12/18 1220

POC FINGER STICK GLUCOSE [749935503] (Abnormal)
Resulted: 06/13/18 0604, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 06/12/18 1220
Order status: Completed
Filed by: Interface, Lab In Sunquest 06/13/18 0605
Resulting lab: WS PAULDING HOSPITAL LAB
External ID: T15473921
Result details
Acknowledged by: Abdul M Sheikh, MD on 06/13/18 0733

Specimen Information

Type	Source	Collected By
Other	Serum	06/12/18 1220

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	117	70 - 99 mg/dL	H ^	PHLAB
POC-OPERATOR'S ID	21511	---	---	PHLAB

POCT CHEM 8, ISTAT [749935495]

Electronically signed by: **Ravi Edupuganti, MD on 06/12/18 1417**
Status: **Discontinued**
Mode: Ordering in Verbal with readback mode
Communicated by: Mark Daigle, RN
Ordering user: Mark Daigle, RN 06/12/18 1353
Ordering provider: Ravi Edupuganti, MD
Authorized by: Ravi Edupuganti, MD
Ordering mode: Verbal with readback
Quantity: 1
Instance released by: Mark Daigle, RN (auto-released) 6/12/2018 1:53 PM
Discontinued by: Automatic Discharge Provider 06/14/18 0455 [Patient Discharge]

POCT CHEM 8, ISTAT [749935497]

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

POCT CHEM 8, ISTAT [749935497] (continued)

Electronically signed by: **Interface, Lab In Sunquest on 06/12/18 1403** Status: **Completed**
Ordering user: Interface, Lab In Sunquest 06/12/18 1403
Authorized by: Abdul M Sheikh, MD
Quantity: 1
Instance released by: (auto-released) 6/12/2018 2:09 PM
Ordering provider: Abdul M Sheikh, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
Other	Serum	06/12/18 1403

POCT CHEM 8, ISTAT [749935497] (Abnormal)

Resulted: 06/12/18 1409, Result status: Final result

Ordering provider: Abdul M Sheikh, MD 06/12/18 1403
Filed by: Interface, Lab In Sunquest 06/12/18 1409
External ID: T15467584
Acknowledged by: Abdul M Sheikh, MD on 06/12/18 2135
Order status: Completed
Resulting lab: WS PAULDING HOSPITAL LAB
Result details

Specimen Information

Type	Source	Collected By
Other	Serum	06/12/18 1403

Components

Component	Value	Reference Range	Flag	Lab
POC-SODIUM	140	136 - 145 mmol/L	—	PHLAB
POC-POTASSIUM	4.2	3.5 - 5.1 mmol/L	—	PHLAB
Comment: HEMOLYSIS, IF PRESENT, MAY AFFECT RESULTS				
POC-CHLORIDE	101	95 - 110 mmol/L	—	PHLAB
POC-GLUCOSE	104	70 - 99 mg/dL	H	PHLAB
POC-BUN	39	7 - 21 mg/dL	H	PHLAB
POC-IONIZED CALCIUM	1.08	1.09 - 1.29 mmol/L	L	PHLAB
POC-CO2	24	20 - 28 mmol/L	—	PHLAB
POC-AGAP	20	15 - 23	—	PHLAB
POC-CREATININE	1.4	0.64 - 1.27 mg/dL	H	PHLAB
GFR Non-Afric Amer	50	>59 ml/min/1.73 m2	L	PHLAB
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2	—	PHLAB
POC-OPERATOR'S ID	63967	—	—	PHLAB

Lab - Orders and Results

BASIC METABOLIC PANEL (7) [749935491]

Electronically signed by: **Ravi Edupuganti, MD on 06/12/18 1417** Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Billy Tatum, RN 06/12/18 1257
Authorized by: Ravi Edupuganti, MD
Additional signing events
Electronically signed by Ravi Edupuganti, MD 06/12/18 1417, for Discontinuing in Verbal with readback mode, Communicator - Mark Daigle, RN
Frequency: AM Draw AM Draw @ 0400 06/13/18 0400 - 1 occurrence
Released by: Billy Tatum, RN 06/12/18 1257
Acknowledged: Billy Tatum, RN 06/12/18 1257 for Placing Order Mark Daigle, RN 06/12/18 1353 for D/C Order
Communicated by: Billy Tatum, RN
Ordering provider: Ravi Edupuganti, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Discontinued by: Mark Daigle, RN 06/12/18 1353

Specimen Information

Type	Source	Collected By
Blood	Blood	—

BASIC METABOLIC PANEL (7) [749935494]

Electronically signed by: **Ravi Edupuganti, MD on 06/12/18 1417** Status: **Completed**
Mode: Ordering in Verbal with readback mode
Ordering user: Mark Daigle, RN 06/12/18 1353
Authorized by: Ravi Edupuganti, MD
Communicated by: Mark Daigle, RN
Ordering provider: Ravi Edupuganti, MD
Ordering mode: Verbal with readback

Lab - Orders and Results (continued)

BASIC METABOLIC PANEL (7) [749935494] (continued)

Quantity: 1
Lab status: Final result
Instance released by: Mark Daigle, RN (auto-released) 6/12/2018 1:53 PM

Specimen Information

Type	Source	Collected By
Other	Serum	125 06/12/18 1250

BASIC METABOLIC PANEL (7) [749935494] (Abnormal)
Resulted: 06/12/18 1508, Result status: Final result

Ordering provider: Ravi Edupuganti, MD 06/12/18 1353
Filed by: Interface, Lab In Sunquest 06/12/18 1508
External ID: T15467380
Acknowledged by: Ravi Edupuganti, MD on 06/13/18 2317

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

Specimen Information

Type	Source	Collected By
Other	Serum	125 06/12/18 1250

Components

Component	Value	Reference Range	Flag	Lab
Sodium,S	142	136 - 145 mmol/L	—	PHLAB
Potassium	5.0	3.5 - 5.1 mmol/L	—	PHLAB
Chloride	102	98 - 107 mmol/L	—	PHLAB
Co2	25	22 - 29 mmol/L	—	PHLAB
Glucose	113	70 - 99 mg/dL	H	PHLAB
BUN	50	8 - 23 mg/dL	H	PHLAB
CREATININE,S	1.41	0.7 - 1.2 mg/dL	H	PHLAB
ANION GAP	20	12 - 20	—	PHLAB
CALCIUM,TOTAL	9.1	8.8 - 10.2 mg/dL	—	PHLAB
GFR Non-Afric Amer	50	>59 ml/min/1.73 m2	L	PHLAB
GFR AFRICAN AMER	>60	>59 ml/min/1.73 m2	—	PHLAB

LABORATORY RESULTS [749935508]

Electronically signed by: **Interface, Transcription Incoming on 06/14/18 1504**
Status: **Completed**
Ordering user: Interface, Transcription Incoming 06/14/18 1504
Authorized by: Provider Scan
Frequency: -
Lab status: Final result

Ordering provider: Provider Scan
Ordering mode: Standard
Quantity: 1

Scan on 6/14/2018 3:04 PM (below)

LABORATORY RESULTS [749935508]
Resulted: 06/14/18 1504, Result status: Final result

Ordering provider: Provider Scan 06/14/18 1504
Filed by: Interface, Transcription Incoming 06/14/18 1507

Order status: Completed
Result details

Medications - Orders and Results

sodium chloride (NS) 0.9 % infusion [749935485]

Electronically signed by: **Interface, Ads Dispense on 06/12/18 1145**
Status: **Completed**
Ordering user: Interface, Ads Dispense 06/12/18 1145
Frequency: 06/12/18 1145 - 1 occurrence
Admin instructions: KRAFTZENK, JULIE: cabinet override
Medication comments: KRAFTZENK, JULIE: cabinet override

Ordering mode: Standard

Medications - Orders and Results (continued)

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
22 - PHLAB	WS PAULDING HOSPITAL LAB	Dr. Burton Kim	2518 Jimmy Lee Smith Parkway Hiram GA 30141	04/09/14 0922 - 08/28/18 1258
118000 - Noninv Card	NONINV CARDIOLOGY	Unknown	Unknown	01/02/13 1110 - Present

Medications

All Meds and Administrations

sodium chloride (NS) 0.9 % infusion [749935485]

Status: Completed (Past End Date/Time)
Starts/Ends: 06/12/18 1145 - 06/12/18 1253
Route: —
Rate/Duration: — / —
Note to pharmacy: KRAFTZENK, JULIE: cabinet override

Ordered On: 06/12/18 1145
Dose (Remaining/Total): — (0/1)
Frequency: —
Admin Instructions: KRAFTZENK, JULIE: cabinet override

Timestamps	Action	Dose / Rate / Duration	Route / Site / Linked Line	Other Information
Performed 06/12/18 1253 Documented: 06/12/18 1253	Override pull for Anesthesia	—	—	Performed by: Andrea C Horsford, PAA Comments: Automatically documented from anesthesia administration on a one-step order

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)

Description:
Refer to rating score of 0-10.

Patient Education (continued)

Education (continued)

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.

Point: Risk Factors (Resolved)

Patient Education (continued)

Education (continued)

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.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

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.

Title: First-Dose Education (Not Started)

Patient Education (continued)

Education (continued)

Points For This Title

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

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.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Resolved)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

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.

Patient Education (continued)

Education (continued)

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

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

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

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

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

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

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

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

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

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

Learner Progress: Not documented in this visit.

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

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 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 Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

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

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

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

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

Learner Not documented in this visit.
Progress:

Point: Demonstrate Handwashing (MCB) (Resolved)

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

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

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 Not documented in this visit.
Progress:

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 Education (continued)

Education (continued)

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)

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.

Patient Education (continued)

Education (continued)

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.

All Flowsheets

Flowsheets (all recorded)

Encounter Vitals

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
Enc Vitals					
BP	146/61 -DK	126/54 -DK	114/50 -DK	(!) 110/41 -MD	124/52 -MD
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
SpO2	98 % -DK	93 % -DK	100 % -DK	99 % -MD	99 % -MD
Pain Score	—	—	—	—	Zero -MD

Row Name	06/12/18 1214
Enc Vitals	
BP	142/58 -MD
Pulse	(!) 47 -MD
Resp	20 -MD
Temp	97.5 °F (36.4 °C) -MD
Temp src	Temporal -MD
SpO2	100 % -MD
Weight	99.1 kg (218 lb 7.6 oz) -MD
Height	67" (1.702 m) -MD

Flowsheets (all recorded)

Custom Formula Data

Row Name	06/12/18 1214
Vitals	
Pct Wt Change	0 % -MD
OTHER	
Weight Change (kg)	0 kg -MD
Ideal Body Weight	160 lb -MD
Visit Weight	218 lb -MD
BMI (Calculated)	34.2 -MD
IBW/kg (Calculated) Male	66.1 kg -MD
IBW/kg (Calculated) FEMALE	61.6 kg -MD
Weight/Scale Event	0 -MD
Weight in (lb) to have BMI = 25	159.3 -MD
% Weight Change Since Birth	0 -MD
Adult IBW/VT Calculations	
IBW/kg (Calculated)	66.1 -MD
Range Vt 4mL/kg	264.4 mL/kg -MD
Low Range Vt 6mL/kg	396.6 mL/kg -MD
Adult Moderate Range Vt 8mL/kg	528.8 mL/kg -MD
Adult High Range Vt 10mL/kg	661 mL/kg -MD
Case Log	
BSA x (CI @3.0)= CO	6.48 CO -MD
Relevant Labs and Vitals	
Temp (in Celsius)	36.4 -MD

Flowsheets (all recorded)

Risk for Readmission

Row Name	06/14/18 0255
OTHER	
Risk for Readmission	8 - BP

Flowsheets (all recorded)

Travel Information

Row Name	06/12/18 1211
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 -MD

Flowsheets (all recorded)

Suicide Risk

Row Name	06/12/18 1218
Suicide/Harm Risk	
Ever harm self (Retired)	No -MD
Current thoughts (Retired)	No -MD
Self harm plan (Retired)	No -MD
Patient information obtained from	Patient -MD
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -MD

Flowsheets (all recorded)

Vital Signs

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
Vital Signs					
Automatic Restart Vitals Timer	Yes -DK	Yes -DK	Yes -DK	Yes -MD	Yes -MD
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
BP	146/61 -DK	126/54 -DK	114/50 -DK	**(!) 110/41** -MD	124/52 -MD
Calculated MAP	89.33 -DK	78 -DK	71.33 -DK	**(!) 64** -MD	76 -MD
Patient Position	Sitting -DK	—	—	—	—
Oxygen Therapy					
SpO2	98 % -DK	93 % -DK	100 % -DK	99 % -MD	99 % -MD
O2 Device	None (Room air) -DK	None (Room air) -DK	None (Room air) -DK	Nasal cannula -MD	—
O2 Flow Rate (L/min)	—	—	—	3 L/min -MD	—

Row Name	06/12/18 1214
Vital Signs	
Automatic Restart Vitals Timer	Yes -MD
Pulse	**(!) 47** -MD
Heart Rate Source	Monitor -MD
Resp	20 -MD
BP	142/58 -MD
Calculated MAP	86 -MD
Patient Position	Supine -MD
Temp	97.5 °F (36.4 °C) -MD
Temp src	Temporal -MD
Oxygen Therapy	
SpO2	100 % -MD
O2 Device	Nasal cannula -MD
O2 Flow Rate (L/min)	3 L/min -MD
Pulse Oximetry Type	Continuous -MD

Flowsheets (all recorded)

Post Sedation Assessment

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
Vitals					
BP	146/61 -DK	126/54 -DK	114/50 -DK	(!) **110/41** -MD	124/52 -MD
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
SpO2	98 % -DK	93 % -DK	100 % -DK	99 % -MD	99 % -MD
Cardiac Rhythm	—	Normal sinus rhythm -DK	Sinus bradycardia -DK	Sinus bradycardia -MD	—
O2 Device	None (Room air) -DK	None (Room air) -DK	None (Room air) -DK	Nasal cannula -MD	—
O2 Flow Rate (L/min)	—	—	—	3 L/min -MD	—
Pain Score	—	—	—	—	Zero -MD
Assessment					
Skin Color	—	Appropriate for ethnicity -DK	Appropriate for ethnicity -DK	Appropriate for ethnicity;Pink -MD	—
Skin Condition/Temp	—	Dry;Intact -DK	Dry;Intact -DK	Dry;Intact;Warm -MD	—
Orient/LOC	—	WDL -DK	WDL -DK	WDL -MD	—
Numeric Pain Intensity Score 1	0 -DK	0 -DK	0 -DK	0 -MD	—
Aldrete					
Activity	—	2 -DK	2 -DK	2 -MD	—
Respiration	—	2 -DK	2 -DK	2 -MD	—
Circulation	—	2 -DK	2 -DK	2 -MD	—
Consciousness	—	2 -DK	2 -DK	2 -MD	—
Color	—	2 -DK	2 -DK	2 -MD	—
Aldrete Score	—	10 -DK	10 -DK	10 -MD	—

Row Name	06/12/18 1214
Vitals	
BP	142/58 -MD
Pulse	(!) **47** -MD
Resp	20 -MD
SpO2	100 % -MD
Temp	97.5 °F (36.4 °C) -MD
O2 Device	Nasal cannula -MD
O2 Flow Rate (L/min)	3 L/min -MD

Flowsheets (all recorded)

Anthropometrics

Row Name	06/12/18 1214
Anthropometrics	
Height	67" (1.702 m) -MD
Weight	99.1 kg (218 lb 7.6 oz) -MD
Weight Change	0 -MD
BMI (Calculated)	34.2 -MD

Flowsheets (all recorded)

Interpretation

Row Name	06/12/18 1210
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -MD

Flowsheets (all recorded)

Vitals/Pain

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
OTHER					
Patient Position	Sitting -DK	—	—	—	—
Pain Assessment	0-10 -DK	—	—	—	—
Vitals					
BP	146/61 -DK	126/54 -DK	114/50 -DK	(!) 110/41 -MD	124/52 -MD
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
SpO2	98 % -DK	93 % -DK	100 % -DK	99 % -MD	99 % -MD
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -DK	0 -DK	0 -DK	0 -MD	—

Row Name	06/12/18 1214
OTHER	
Patient Position	Supine -MD
Height Method	Stated -MD
BMI (Calculated)	34.2 -MD
BSA (Calculated - sq m)	2.16 sq meters -MD
Vitals	
BP	142/58 -MD
Temp	97.5 °F (36.4 °C) -MD
Temp src	Temporal -MD
Pulse	(!) 47 -MD
Resp	20 -MD
SpO2	100 % -MD
Height	67" (1.702 m) -MD
Weight	99.1 kg (218 lb 7.6 oz) -MD
Vital Signs	
Heart Rate Source	Monitor -MD

Flowsheets (all recorded)

Fall Risk

Row Name	06/12/18 1217
Fall Assessment	
Patient Receiving Sedation	Yes -MD
Fall Risk	Yes -MD
Fall Band Applied	Yes -MD
Yellow socks	Yes -MD

Flowsheets (all recorded)

Pre-op Checklist

Row Name	06/12/18 1219
Patient Verification	
Patient ID and Procedure Verified	Yes -MD
Correct Procedure	Yes -MD
Documents Match	Yes -MD
Pacemaker	No -MD
Patient has an ICD?	No -MD
Pre-op Lab/Test Results Available	In chart -MD
Preg Test	n/a -MD
Blood Glucose Meter (mg/dl)	117 -MD
Prep Verification	
Allergy Band Applied	Yes -MD
Snap Gown Applied	No -MD
Beta Blocker Therapy Last Dose Date	06/12/18 -MD
Beta Blocker Last Dose Time	0700 -MD
Anticoagulent Therapy Last Dose Date	06/12/18 -MD
Anticoagulant Last Dose Time	0700 -MD
Date of last liquid	06/11/18 -MD
Time of last liquid	2220 -MD
Date of last solid	06/11/18 -MD
Time of last solid	2220 -MD
Void Prior to Procedure	Yes -MD
Metal Implant Present?	Yes -MD
Type of Implant (if known)	STENTS -MD
Pre-op Checklist Completion	
Checklist Completed/Verified?	Yes -MD
Location completed at:	ARU -MD

Flowsheets (all recorded)

TEE

Row Name	06/12/18 14:39:32	06/12/18 14:19:35
TEE		
TEE Probe	Removed - no blood present -MD	Inserted -MD
TEE	Bite block removed -MD	Bite block inserted -MD

Flowsheets (all recorded)

Bubble Study

Row Name	06/12/18 14:37:15
Bubble Study	
Bubble Study	Yes -MD

Flowsheets (all recorded)

Preop Nurse

Row Name	06/12/18 1210
Pre-op Nurse	
Pre Procedure Nurse	DAIGLE RN -MD

Flowsheets (all recorded)

Time-Out

Row Name	06/12/18 14:18:39
Time-Out	
Staff present for time out	ASSIGNED STAFF -MD
Correct Patient?	Yes -MD
Correct Site?	Yes -MD
Correct Side?	Yes -MD
Correct Patient Position?	Yes -MD
What Procedure?	TEE -MD
Correct Procedure?	Yes -MD
Consents Verified?	Yes -MD
Safety Precautions Reviewed?	Yes -MD
DEBRIEFING TIMEOUT	
Confirm Complete Name of Operative Procedure	Yes -MD

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
Vital sign parameters					
BP	146/61 -DK	126/54 -DK	114/50 -DK	(!) **110/41** -MD	124/52 -MD
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Calculated MAP	89.33 -DK	78 -DK	71.33 -DK	(!) **64** -MD	76 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
Vital Signs					
Automatic Restart Vitals Timer	Yes -DK	Yes -DK	Yes -DK	Yes -MD	Yes -MD

Row Name	06/12/18 1214
Vital sign parameters	
BP	142/58 -MD
Pulse	(!) **47** -MD
Calculated MAP	86 -MD
Resp	20 -MD
Temp	97.5 °F (36.4 °C) -MD
Vital Signs	
Automatic Restart Vitals Timer	Yes -MD

Flowsheets (all recorded)

Patient Belongings

Row Name	06/12/18 1211	06/12/18 1210
Patient Belongings at Bedside		
Belongings at Bedside	Clothing -MD	Clothing -MD
Belongings sent to security (Retired)	No -MD	No -MD
(RETIRED)Belongings Sent Home	No -MD	No -MD
Patient Medications		
Medications brought by patient?	No -MD	No -MD

Flowsheets (all recorded)

Complex Assessment

Row Name	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 1216
Neurological				
Level of Consciousness	—	—	—	Alert -MD
Neuro (WDL)	—	—	—	WDL -MD
HEENT				
HEENT (WDL)	—	—	—	WDL -MD
Respiratory				
Respiratory (WDL)	—	—	—	WDL -MD
Cardiac				
Cardiac (WDL)	—	—	—	WDL -MD
Cardiac Rhythm	Normal sinus rhythm -DK	Sinus bradycardia -DK	Sinus bradycardia -MD	—
Peripheral Vascular				
Peripheral Vascular (WDL)	—	—	—	WDL -MD
Integumentary				
Integumentary (WDL)	—	—	—	WDL -MD
Skin Color	Appropriate for ethnicity -DK	Appropriate for ethnicity -DK	Appropriate for ethnicity;Pink -MD	—
Skin Condition/Temp	Dry;Intact -DK	Dry;Intact -DK	Dry;Intact;Warm -MD	—
Gastrointestinal				
Gastrointestinal (WDL)	—	—	—	WDL -MD
Psychosocial				
Psychosocial (WDL)	—	—	—	WDL -MD
Provider Notification				
Provider Role	—	—	—	Attending physician -MD
Charting Type				
Charting Type	—	—	—	Admission -MD

Flowsheets (all recorded)

Vitals/Pain

Row Name	06/12/18 1533	06/12/18 1514	06/12/18 1500	06/12/18 1445	06/12/18 14:14:25
Vitals					
Pulse	51 -DK	50 -DK	51 -DK	52 -MD	54 -MD
Resp	18 -DK	18 -DK	18 -DK	18 -MD	16 -MD
BP	146/61 -DK	126/54 -DK	114/50 -DK	(!) 110/41 -MD	124/52 -MD
Patient Position	Sitting -DK	—	—	—	—
Oxygen Therapy					
SpO2	98 % -DK	93 % -DK	100 % -DK	99 % -MD	99 % -MD
O2 Device	None (Room air) -DK	None (Room air) -DK	None (Room air) -DK	Nasal cannula -MD	—
O2 Flow Rate (L/min)	—	—	—	3 L/min -MD	—
Pain Assessment					
Pain Assessment	0-10 -DK	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -DK	0 -DK	0 -DK	0 -MD	—

Row Name	06/12/18 1214
Vitals	
Temp	97.5 °F (36.4 °C) -MD
Temp src	Temporal -MD
Pulse	(!) 47 -MD
Heart Rate Source	Monitor -MD
Resp	20 -MD
BP	142/58 -MD
Patient Position	Supine -MD
Oxygen Therapy	
SpO2	100 % -MD
O2 Device	Nasal cannula -MD
O2 Flow Rate (L/min)	3 L/min -MD
Pulse Oximetry Type	Continuous -MD
Height and Weight	
Height	67" (1.702 m) -MD
Height Method	Stated -MD
Weight	99.1 kg (218 lb 7.6 oz) -MD
BMI (Calculated)	34.2 -MD
BSA (Calculated - sq m)	2.16 sq meters -MD

User Key

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

Initials	Name	Effective Dates
MD	Mark Daigle, RN	02/02/17 -
DK	Darsi Knowles, RN	02/03/17 -
BP	Batch Job Prelude	---

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 06/12/2018:

Scan on 6/14/2018 2:01 PM (below)

Document on 6/12/2018 3:00 PM by Mark Daigle, RN: IP AVS (below)

WELLSTAR

Eugene G. Maurice [illegible]

Instructions

Your medications may have changed today.
See your updated medication list.

☐ Read these attachments
- TEE, Transesophageal Echocardiography (English)
- POST-TEE DISCHARGE INSTRUCTIONS

Provider	Service	Role	Specialty
Abdul M Sheikh, MD	Cardiology	Attending Provider	Interventional Cardiology

Abdul M Sheikh, MD
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200
HIRAM GA 30141-3749
678-324-4444

No active allergies

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

Order	Current Status
Basic metabolic panel	In process

	176 Charles Hardy Parkway East Hiram GA 30141 678-945-9230
Tuesday Jun 26, 2018 3:00 PM (Arrive by 2:45 PM)	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway Ste 4200 Hiram GA 30141-3749 678-324-4444
Tuesday Aug 21, 2018 9:15 AM (Arrive by 9:00 AM)	WellStar Urology Hiram 144 Bill Carruth Pkwy Suite 2300 Hiram GA 30141-3823 770-428-4474

View your After Visit Summary and more online at

Medication List

CONTINUE taking these medications

Morning Noon Evening Bedtime As Needed

apixaban 5 mg tablet
[illegible] ELIQUIS
CONTINUE Take 1 tablet (5 mg total) by mouth 2 (two) times a day
[illegible] 5 mg

aspirin, buffered 81 mg Tab
Take 81 mg by mouth daily.
[illegible] 81 mg

atorvastatin 80 MG tablet
[illegible] LIPITOR
CONTINUE Take 1 tablet (80 mg total) by mouth nightly
[illegible] 80 mg

* blood sugar diagnostic strip
[illegible] glucose blood
CONTINUE cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..

* blood sugar diagnostic strip
CONTINUE True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9

carvedilol 6.25 MG tablet
[illegible] COREG
CONTINUE Take 2 tablets (12.5 mg total) by mouth 2 (two) times a day with meals
[illegible] 12.5 mg

furosemide 20 MG tablet
[illegible] LASIX
CONTINUE Take 1 tablet (20 mg total) by mouth 2 (two) times a day
[illegible] 20 mg

isosorbide mononitrate 30 MG 24 hr tablet
[illegible] IMDUR
CONTINUE Take 2 tablets (60 mg total) by mouth 2 (two) times a day
[illegible] 60 mg

Medication List (continued)

CONTINUE taking these medications (continued)

Morning	Noon	Evening	Bedtime	As Needed

metFORMIN 500 MG tablet
GLUCOPHAGE
2 tablets po in am and 2 in pm
type 2 diabetes mellitus

nitroglycerin 0.4 MG SL tablet
NITROSTAT
Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
0.4 mg

ramipril 10 MG capsule
ALTACE
Take 1 capsule (10 mg total) by mouth 2 (two) times a day
10 mg

sotalol 80 MG tablet
BETAPACE
Take 1 tablet (80 mg total) by mouth 2 (two) times a day
80 mg

*** DUPLICATE WARNING: This list has 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.**

Transesophageal Echocardiography (TEE)

Transesophageal echocardiography (TEE) is a test done to record images of your heart with a probe inside your esophagus. These images help your healthcare provider find and treat problems such as infection, disease, or defects in your heart's function, walls or valves. This test may be done when a chest echocardiogram (transthoracic) does not give your provider enough information.

Before your test

- Tell your provider about all the medicines you take. Ask if it's OK to take them before the test.
- Don't eat or drink for 6 to 8 hours before the test. This includes water.
- Tell your healthcare provider if you have ulcers, a hiatal hernia, or problems swallowing. Also report a history of narrowing of the esophagus, or any other previous gastrointestinal problems. Also, let him or her know of any allergies to medicines or sedatives.
- Also let your provider know if you have dental implants or dentures that should be removed before the test.
- Arrange to have someone drive you home after the exam.

During your TEE

- When you arrive for your TEE, you will change into a hospital gown, and then be taken to the testing room.
- Your provider will spray your throat with a numbing medicine. You may be given a medicine through an IV (intravenous) in your arm to help you relax. You may also be given oxygen. Then you'll be asked to lie on your left side.
- The healthcare provider gently inserts the small, lubricated probe into your mouth. As you swallow, he or she will slowly guide the tube into your esophagus.
- You may feel the healthcare provider moving the probe, but it shouldn't hurt or interfere with your breathing. A nurse checks your heart rate, blood pressure, and breathing. The test usually takes 20 to 40 minutes.
- The nurse or assistant will suction any saliva out of your mouth, similar to when you have a dental cleaning.

After the test

- Tell your healthcare provider about any pain, or if you cough up or vomit blood, or have trouble swallowing.
- You can eat and drink again when your throat is no longer numb.
- Do not drive a car or run heavy machinery for at least 24 hours after getting sedation. After 24 hours you can return to normal activity unless your healthcare provider tells you otherwise.
- Be sure to keep your follow-up appointment to go over the results with your healthcare provider.
- Your next appointment is: _____

Date Last Reviewed: 12/1/2016

Post TEE Patient
Discharge Instructions

1. The numbness in your throat will gradually disappear. You may notice a slight soreness in your throat temporarily. You may eat and drink 30 minutes to 1 hour after your procedure.

2. Do not drive, drink alcoholic beverages or make any major personal or business decisions for 24 hours because of the medications that you have received. You will probably be sleepy the remainder of the day and are advised to rest.

3. Unless your doctor instructs otherwise, you may return to your regular activities (including work) in 24 hours. A light diet is advised for the next 12 hours.

4. Call your physician the day you go home to set up a follow up appointment.

5. If you have new prescriptions have them filled today.

6. If you have any question or concerns, you may call the Cardiac Admit Recovery Unit at 770-793-9350, or contact your physician.

7. Other instructions: DR. SHEIKH
   I have read and understand the above instructions and have had all my questions answered adequately. I agree to take these instructions to my physician who will be assuming my care. I am being accompanied at discharge by _____ who is at least 18 years of age.

   Responsible Party: _____

   Date: _____

   Nurse: _____

   Date: _____

Document on 6/12/2018 2:59 PM by Mark Daigle, RN: IP AVS (below)

Eugene G. Maurice [illegible]

Instructions

Your medications may have changed today.
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- POST-TEE DISCHARGE INSTRUCTIONS

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CONTINUE Take 1 tablet (80 mg total) by mouth nightly
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Medication List (continued)

CONTINUE taking these medications (continued)

Morning	Noon	Evening	Bedtime	As Needed

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CONTINUE 2 tablets po in am and 2 in pm
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CONTINUE Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain
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Before your test

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- Tell your healthcare provider if you have ulcers, a hiatal hernia, or problems swallowing. Also report a history of narrowing of the esophagus, or any other previous gastrointestinal problems. Also, let him or her know of any allergies to medicines or sedatives.
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- You may feel the healthcare provider moving the probe, but it shouldn't hurt or interfere with your breathing. A nurse checks your heart rate, blood pressure, and breathing. The test usually takes 20 to 40 minutes.
- The nurse or assistant will suction any saliva out of your mouth, similar to when you have a dental cleaning.

After the test

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- You can eat and drink again when your throat is no longer numb.
- Do not drive a car or run heavy machinery for at least 24 hours after getting sedation. After 24 hours you can return to normal activity unless your healthcare provider tells you otherwise.
- Be sure to keep your follow-up appointment to go over the results with your healthcare provider.
- Your next appointment is: _____

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3. Unless your doctor instructs otherwise, you may return to your regular activities (including work) in 24 hours. A light diet is advised for the next 12 hours.

4. Call your physician the day you go home to set up a follow up appointment.

5. If you have new prescriptions have them filled today.

6. If you have any question or concerns, you may call the Cardiac Admit Recovery Unit at 770-793-9350, or contact your physician.

7. Other instructions: DR. SHEIKH
   I have read and understand the above instructions and have had all my questions answered adequately. I agree to take these instructions to my physician who will be assuming my care. I am being accompanied at discharge by _____ who is at least 18 years of age.

   Responsible Party: _____

   Date: _____

   Nurse: _____

   Date: _____

Electronic signature on 6/12/2018 11:33 AM - E-signed

Electronic signature on 6/12/2018 11:31 AM - 1 of 5 e-signatures recorded

Encounter-Level E-Signatures:

Hosp Consent for Tx/Assgn of Ben/Fin Res (E-Signature Encounter) - Received on 6/12/2018

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
E G Maurice	SELF

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.

All Scans (continued)

Encounter-Level E-Signatures: (continued)

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 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.

Name: Eugene G Maurice	
Patient's Signature	Relationship to Patient
EGMaurice	SELF

Name: Eugene G Maurice
MRN: 561253820
HAR: 40001203890

All Scans (continued)

Encounter-Level E-Signatures: (continued)

CMS IM for Patient Signature (E-Sig) - Received on 6/12/2018

All Scans (continued)

Encounter-Level E-Signatures: (continued)

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

AN IMPORTANT MESSAGE FORM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to KEPRO:
  1-844-455-8708
  KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

YOUR MEDICARE DISCHARGE RIGHTS

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

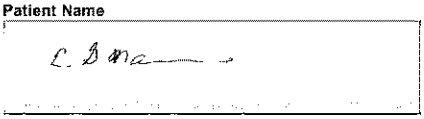
If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by KEPRO. This reviewer was hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact KEPRO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the KEPRO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call (770) 443-7068.

Please sign and date here to show you received this notice and understand your rights.

Patient Name



CMS-R-193 (approved 07/10)
WMG Cardiovascular Medicine Hiram
An Important Message from Medicare
About Your Rights

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the KEPRO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information: 1-844-455-8708

KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting KEPRO.
- The name of this hospital is **WMG Cardiovascular Medicine Hiram 110042**

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **STEP 3:** The KEPRO will ask for your opinion. You or your representative need to be available to speak with KEPRO, if requested. You or your representative may give KEPRO a written statement, but you are not required to do so.

- **STEP 4:** The KEPRO will review your medical records and other important information about your case.

- **STEP 5:** KEPRO will notify you of its decision within 1 day after it receives all necessary information.
  - If KEPRO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If KEPRO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after KEPRO notifies you of its decision.

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

- You can still ask the KEPRO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the KEPRO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
Additional Information: I have received my second notice and understand my appeal rights.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, ATTN: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

WMG Cardiovascular Medicine Hiram
An Important Message from Medicare
About Your Rights

Name: Eugene G Maurice
MRN: 561253820
HAR: 40001203890

All Scans (continued)

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	OP		Unit:	PIC DIAG XR
Hospital Service:	No service for patient encounter.		Bed:	Room/bed info not found
Admitting Provider:			Referring Physician:	Sheikh, Abdul M
Attending Provider:	Abdul m sheikh	AD: N	Adm Diagnosis:	SOB (shortness of breath*
Admission Date:	6/15/2018		Admission Time:	1121

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	P O BOX 981106 EL PASO, TX 79998-1106	Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Contact Serial#

April 3, 2020

Chart ID

Admission Information

Arrival Date/Time:		Admit Date/Time:	06/15/2018 1121	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Physician Or Clinic Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Imaging Center
Admit Provider:		Attending Provider:	Abdul M Sheikh, MD	Referring Provider:	Abdul M Sheikh, MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/16/2018 2359	Home Or Self Care	None	None	WellStar Paulding Imaging Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R06.02 **[Principal]**	Shortness of breath				

Events

Hospital Outpatient at 6/15/2018 1121

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Discharge at 6/16/2018 2359

Unit: WellStar Paulding Imaging Center
Patient class: Outpatient

Allergies as of 6/16/2018

Reviewed on 6/12/2018

No Known Allergies

Immunizations as of 6/16/2018

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

All Scans (continued)

Immunizations (continued) as of 6/16/2018

Administered on: 9/26/2016 0000
CVX code: 88
Lot number: UI700AA
Site: Left deltoid
Route: Intramuscular

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 6/16/2018

Past Medical History

Diagnosis	Date	Comments	Source
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

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

ED Records

ED Arrival Information

Patient not seen in ED

ED Disposition

None

ED Records (continued)

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

Imaging - Orders and Results

XR CHEST PA AND LATERAL (2 VIEWS) [749935510]

Electronically signed by: **Abdul M Sheikh, MD on 06/13/18 1203**
Status: **Completed**
Ordering user: Abdul M Sheikh, MD 06/13/18 1203
Authorized by: Abdul M Sheikh, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Adrienne Stephens 6/15/2018 11:21 AM
Diagnoses
SOB (shortness of breath) [R06.02]

Questionnaire

Question	Answer
Reason for Exam:	amiodarone tx

XR CHEST PA AND LATERAL (2 VIEWS) [749935510]

Resulted: 06/15/18 1512, Result status: Final result

Order status: Completed
Resulted by: Timothy S Hanes, MD
Filed by: Interface, Rad Powerscribe 06/15/18 1514
Performed: 06/15/18 1122 - 06/15/18 1129
Accession number: 29698821
Result details
Narrative:
EXAM: PIC XR CHEST PA AND LATERAL (2 VIEWS)

CLINICAL INDICATION: R06.02 (Shortness of breath)
amiodarone tx.

COMPARISON: No comparisons are available at this time.

FINDINGS: Lung volumes are somewhat low there is mild pulmonary vascular congestion. There is some mild blunting of the posterior sulcus on the right. Post CABG changes noted. Lungs are otherwise clear.

Impression:

Mild CHF pattern.

Released By: TIM HANES, MD 6/15/2018 3:12 PM
Acknowledged by: Abdul M Sheikh, MD on 06/17/18 2250

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Patient Education

Education

Title: First-Dose Education (Not Started)

Points For This Title

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

All Flowsheets

Flowsheets (all recorded)

Risk for Readmission

Row Name	06/17/18 0209				
OTHER					
Risk for Readmission	8 -BP				

User Key

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

Initials	Name	Effective Dates
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 06/15/2018:

Scan on 6/21/2018 1:41 PM (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	ER			Unit:	PH EMERGENCY
Hospital Service:	Emergency Medicine			Bed:	08/08
Admitting Provider:				Referring Physician:	
Attending Provider:	Kevin d little	AD: N		Adm Diagnosis:	
Admission Date:	6/22/2018			Admission Time:	1119

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: No info available	Deductible: No info available Out of Pocket

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:	06/22/2018 1018	Admit Date/Time:	06/22/2018 1119	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	
Means of Arrival:	Car	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Paulding Hospital (PH EMERGENCY)
Admit Provider:		Attending Provider:	Kevin D Little, MD	Referring Provider:	

Reason for Visit

Epistaxis

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/22/2018 1312	Home Or Self Care	Home	None	WellStar Paulding Hospital (PH EMERGENCY)

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
R04.0 **[Principal]**	Epistaxis				
I11.0	Hypertensive heart disease with heart failure				
I50.9	Heart failure, unspecified				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				
E66.9	Obesity, unspecified				
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			

Events

ED Arrival at 6/22/2018 1018

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Admission at 6/22/2018 1119

Unit: WellStar Paulding Hospital (PH EMERGENCY) Room: 08 Bed: 08
Patient class: Emergency Service: Emergency Medicine

ED Roomed at 6/22/2018 1119

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Discharge at 6/22/2018 1312

Unit: WellStar Paulding Hospital (PH EMERGENCY) Room: 08 Bed: 08
Patient class: Emergency Service: Emergency Medicine

Discharge at 6/22/2018 1312

Unit: WellStar Paulding Hospital (PH EMERGENCY)

Allergies as of 6/22/2018

Reviewed on 6/22/2018

No Known Allergies

Immunizations as of 6/22/2018

Immunizations never marked as reviewed

Annual Influenza

Administered on: 9/26/2016 0000 Site: Left deltoid Route: Intramuscular
Lot number: UI700AA

All Scans (continued)

Immunizations (continued) as of 6/22/2018

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 6/22/2018

Past Medical History

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

All Scans (continued)

Medical as of 6/22/2018 (continued)

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
-	6/22/2018 10:18	3-Urgent	Car	Self	Emergency Medicine	Emergency

Arrival Complaint
Epistaxis

Chief Complaint

Complaint	Comment	Last Edited By	Time	Relationship	ED Provider
Epistaxis		Eric Okanume, RN	6/22/2018 10:19 AM	None	No

ED Disposition

ED Disposition	Condition	Comment
Discharge	Good	Eugene G Maurice discharge to home/self care.

ED Events

Date/Time	Event	User	Comments
06/22/18 1018	Patient arrived in ED	HOLT, DAWN	
06/22/18 1119	Patient roomed in ED	OKANUME, ERIC	
06/22/18 1312	Patient discharged	GAMBLE, MARISSA	

ED Provider Notes - ED Notes

ED Provider Notes by Kevin D Little, MD at 6/22/2018 11:28 AM

Author: Kevin D Little, MD | Service: Emergency Medicine | Author Type: Physician
Filed: 6/22/2018 1:14 PM | Date of Service: 6/22/2018 11:28 AM | Status: Signed
Editor: Kevin D Little, MD (Physician)

Procedure Orders
1. EPISTAXIS MANAGEMENT [751503327] ordered by Kevin D Little, MD

Patient Identification

Eugene G Maurice
561253820
1/2/1949

Patient information was obtained from patient.
History/Exam limitations: none.

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Kevin D Little, MD at 6/22/2018 11:28 AM (continued)

Patient presented to the Emergency Department

Chief Complaint

Epistaxis

History of Present Illness

Eugene G Maurice is a 69 y.o. male with below medical history significant for CAD s/p CABG x 6 on ellqiuis, PVD, CAD, acute GI bleeding, recent admission for symptomatic anemia, and discharged yesterday, restarted p/w epistaxis since 3 a after blowing nose hard. Aching, mild, worse with movement. Breathing.
Stopped elliquis yesterday.

Review of Systems

Constitutional: Negative for fever, chills and diaphoresis.
HENT: Negative for congestion, rhinorrhea, neck pain and neck stiffness.
Eyes: Negative for photophobia, pain and visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Negative for nausea, vomiting, abdominal pain, diarrhea, constipation and blood in stool.
Genitourinary: Negative for dysuria and hematuria.
Musculoskeletal: Negative for myalgias, joint swelling and arthralgias.
Skin: Negative for rash.
Neurological: Negative for numbness. Negative for speech difficulty and weakness.
All other systems reviewed and negative

Past Medical / Surgical History

Patient Active Problem List

Diagnosis	Date Noted
• Epistaxis	
• Long term current use of anticoagulant	
• Acute on chronic congestive heart failure, unspecified congestive heart failure type (HCC)	
• AKI (acute kidney injury) (HCC)	
• Adverse effect of sotalol, initial encounter	
• Acute on chronic heart failure with normal ejection fraction (HCC)	
• PAF (paroxysmal atrial fibrillation) (HCC)	
• Acute GI bleeding	
• Anemia due to acute blood loss	06/17/2018
• Acute pulmonary edema (HCC)	06/17/2018
• Anemia	06/17/2018
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	01/30/2018
• 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

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Kevin D Little, MD at 6/22/2018 11:28 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

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

Medications

No Known Allergies

Family & Social History

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
• Years of education:	N/A

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	
Comment: rarely	
• Drug use:	No
• Sexual activity:	Yes
Partners:	Female
Birth control/ protection:	None

Other Topics	Concern

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Kevin D Little, MD at 6/22/2018 11:28 AM (continued)

- Not on file

Social History Narrative

- No narrative on file

Physical Exam:

Blood pressure 176/84, pulse 62, temperature 97.8 °F (36.6 °C), resp. rate 16, weight 104.8 kg (231 lb), SpO2 96 %.

GEN: Uncomfortable appearing male in no acute distress
Eyes: PERRL, EOMI, sclera anicteric
HENT: NC/AT, OP clear, airway patent, MM, no nuchal rigidity, no JVD

Blood left nare.

CV: RRR, no MRG
PULM: CTAB, no w/r/r, easy WOB, symmetric chest rise
ABD: Soft NT, ND, bowel sounds present, no masses

NEURO: AAOx3, normal muscle tone, MAE, no focal neuro deficits
MSK: FROM, no joint deformities or swelling, no e/o trauma
SKIN: Warm and dry, no rashes/bruises, no suspicious skin lesions
LYMPH: No appreciable LAD
PSYCH: Appropriate mood and affect, no AH/VH

Laboratory Data

Imaging

Procedures

Epistaxis
Date/Time: **6/22/2018 1:13 PM**
Performed by: **LITTLE, KEVIN D**
Authorized by: **LITTLE, KEVIN D**
Consent: **Verbal consent not obtained. Written consent not obtained.**
Risks and benefits: **risks, benefits and alternatives were discussed**
Patient understanding: **patient states understanding of the procedure being performed**
Patient identity confirmed: **arm band**
Treatment site: left anterior
Repair method: anterior pack
Post-procedure assessment: bleeding stopped
Treatment complexity: simple

Patient tolerance: **Patient tolerated the procedure well with no immediate complications**

Assessment:

Impression: 69 y.o. male with the above history p/w epistaxsis

Packed left nare easily with resolution of bleeding.

ENT f/u on Monday.

Medications Administered in ED

Medications

oxymetazoline (AFRIN) nasal spray 0.05% (2 sprays Each Nare Given 6/22/18 1204)

ED Final Impression

Final diagnoses:

Epistaxis

Disposition

Discharge

1:13 PM

I have discussed the care plan, strict return precautions, and follow up with the patient. Patient verbalizes understanding and all questions answered. Patient is stable, NAD, and non-toxic upon discharge. Patient to be discharged home.

Follow Up

Jeffrey L Tharp, MD
176 Charles Hardy Parkway
Unit C
Hiram GA 30141
678-945-8200

Schedule an appointment as soon as possible for a visit in 2 days

ED Provider Notes - ED Notes (continued)

ED Provider Notes by Kevin D Little, MD at 6/22/2018 11:28 AM (continued)

Timothy P Ryan, MD
6002 Professional Parkway
Suite 100
Douglasville GA 30134-5603
770-949-4200

Schedule an appointment as soon as possible for a visit in 2 days

New Prescriptions

Discharge Medication List as of 6/22/2018 1:00 PM

An After Visit Summary was printed and given to the patient.

Kevin D Little, MD
06/22/18 1314

Electronically Signed by Kevin D Little, MD on 6/22/2018 1:14 PM

ED Notes - ED Notes

ED Notes by Marissa Gamble at 6/22/2018 11:23 AM

Author: Marissa Gamble
Filed: 6/22/2018 11:27 AM
Editor: Marissa Gamble

Service: —
Date of Service: 6/22/2018 11:23 AM

Author Type: Registered Nurse
Status: Signed

Patient is awake, a/o x 4, denies pain. Patient d/c from Kennestone yesterday for anemia, received blood, GI bleed, and UTI, is taking Eliquis. Found old ulcers with EGD. Patient stated that prior to d/c Eliquis was stopped for one day and took yesterday at 1900, did not take today. Woke up at 3:00am today, blew nose and it started to bleed. Had a constant flow of blood until 7:00am then it stopped for one hour then started again. Patient noted to have packed both nares with gauze and pulled them out, large clots noted, however, bleeding continues with bright red blood. Condition stable.

Marissa Gamble, RN
06/22/18 1127

Electronically Signed by Marissa Gamble on 6/22/2018 11:27 AM

ED Triage Notes - ED Notes

ED Triage Notes - ED Notes (continued)

ED Triage Notes by Eric Okanume, RN at 6/22/2018 10:19 AM

Author: Eric Okanume, RN | Service: — | Author Type: Registered Nurse
Filed: 6/22/2018 10:20 AM | Date of Service: 6/22/2018 10:19 AM | Status: Signed
Editor: Eric Okanume, RN (Registered Nurse)

Nose bleed since 0300 this morning

Electronically Signed by Eric Okanume, RN on 6/22/2018 10:20 AM

Hospital Encounter Notes

Encounter Notes

No notes exist for this encounter.

PR Charge - Orders and Results

EPISTAXIS MANAGEMENT [751503327]

Electronically signed by: **Kevin D Little, MD on 06/22/18 1313** Status: **Completed**
Ordering user: Kevin D Little, MD 06/22/18 1313
Authorized by: Kevin D Little, MD
Quantity: 1
Instance released by: Kevin D Little, MD 6/22/2018 1:13 PM
Order comments: This order was created via procedure documentation

Ordering provider: Kevin D Little, MD
Ordering mode: Standard
Lab status: Final result

EPISTAXIS MANAGEMENT [751503327] Resulted: 06/22/18 1128, Result status: Final result

Ordering provider: Kevin D Little, MD 06/22/18 1313
Filed by: Kevin D Little, MD 06/22/18 1314
Narrative:
Kevin D Little, MD 6/22/2018 1:14 PM
Epistaxis
Date/Time: 6/22/2018 1:13 PM
Performed by: LITTLE, KEVIN D
Authorized by: LITTLE, KEVIN D
Consent: Verbal consent not obtained. Written consent not obtained.
Risks and benefits: risks, benefits and alternatives were discussed
Patient understanding: patient states understanding of the procedure being performed
Patient identity confirmed: arm band
Treatment site: left anterior
Repair method: anterior pack
Post-procedure assessment: bleeding stopped
Treatment complexity: simple
Patient tolerance: Patient tolerated the procedure well with no immediate complications

Order status: Completed
Result details

Procedures Performed	Chargeables
PR CTRL NOSEBLEED,ANTER,SIMPLE [30901]	

Medications - Orders and Results

oxymetazoline (AFRIN) nasal spray 0.05% [751503325]

Electronically signed by: **Kevin D Little, MD on 06/23/18 0611** Status: **Completed**
Mode: Ordering in Verbal with readback mode
Ordering user: Marissa Gamble 06/22/18 1132
Authorized by: Kevin D Little, MD
Frequency: STAT Once 06/22/18 1145 - 1 occurrence
Acknowledged: Marissa Gamble 06/22/18 1132 for Placing Order
Admin instructions: Place waste in BLACK hazardous container.
Package: 0904-5711-30

Communicated by: Marissa Gamble, RN
Ordering provider: Kevin D Little, MD
Ordering mode: Verbal with readback

Medications

All Meds and Administrations

oxymetazoline (AFRIN) nasal spray 0.05% [751503325]

Ordering Provider: Kevin D Little, MD
Ordered On: 06/22/18 1132
Dose (Remaining/Total): 2 spray (0/1)
Frequency: Once
Admin Instructions: Place waste in BLACK hazardous container.

Status: Completed (Past End Date/Time)
Starts/Ends: 06/22/18 1145 - 06/22/18 1204
Route: Each Nare
Rate/Duration: --- / ---

Timestamps	Action	Dose	Route	Other Information
Performed 06/22/18 1204 Documented: 06/22/18 1204	Given	2 spray	Each Nare	Performed by: Marissa Gamble Comments: 2 squirts in each nares by MD Scanned Package: 0904-5711-30

Patient Education

Education

Title: Diabetes (MCB) (Not Started)

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

Point: Stress Management and Support Systems (Not Started)

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 (Not Started)

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

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

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: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.
Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.
Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

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 (Not Started)

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: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.
Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.
Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.
Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
.

Learner Progress: Not documented in this visit.

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Learner Progress: Not documented in this visit.

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.
Learner Not documented in this visit.
Progress:

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.
Learner Not documented in this visit.
Progress:

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.
Learner Not documented in this visit.
Progress:

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment
Learner Not documented in this visit.
Progress:

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Not documented in this visit.
Progress:

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Patient Education (continued)

Education (continued)

Learner Not documented in this visit.
Progress:

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.
Learner Not documented in this visit.
Progress:

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.
Learner Not documented in this visit.
Progress:

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Not documented in this visit.
Progress:

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.
Learner Not documented in this visit.
Progress:

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.
Learner Not documented in this visit.
Progress:

Patient Education (continued)

Education (continued)

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

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.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (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: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: dextrose (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: dextrose 50 % in water (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: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (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: hydrocodone/acetaminophen (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: acetaminophen (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: labetalol HCl (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: metoclopramide HCl (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.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: furosemide (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: 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: diphenhydramine HCl (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: piperacillin sodium/tazobactam (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: insulin lispro (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: ondansetron (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: glucagon,human recombinant (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (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: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (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: ondansetron HCl/PF (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: Congestive Heart Failure (MCB) (Not Started)

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

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

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

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Patient Education (continued)

Education (continued)

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: Non-Pharmacological Comfort Measures (Not Started)

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.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.
Learner Not documented in this visit.
Progress:

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.
Learner Not documented in this visit.
Progress:

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.
Learner Not documented in this visit.
Progress:

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.
Learner Not documented in this visit.
Progress:

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Not documented in this visit.
Progress:

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

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 (Not Started)

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: Aspirin (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

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

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.
Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

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.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Patient Education (continued)

Education (continued)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

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

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

Point: Stress Management and Support Systems (Not Started)

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 (Not Started)

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

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Not Started)

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

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

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Not Started)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

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

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

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

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

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Patient Education (continued)

Education (continued)

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

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

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

Learner Progress: Not documented in this visit.

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

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

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

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

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

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

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

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) (Not Started)

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

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

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Patient Education (continued)

Education (continued)

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

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

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

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work 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

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

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) (Not Started)

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 (Not Started)

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 (Not Started)

Patient Education (continued)

Education (continued)

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

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

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 (Not Started)

Patient Education (continued)

Education (continued)

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

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

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 (Not Started)

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) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

Discharge Instructions

Discharge Instructions

Maurice, Eugene George (MR # 561253820)

Date	Status	User	User Type	Discharge Note
	Pended	Kevin D Little, MD	Physician	Original

Note:

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	06/22/18 13:05:27	06/22/18 10:21:43
Vitals		
Pct Wt Change	—	0 % -DI (r) AH (t)
OTHER		
Weight Change (kg)	—	0 kg -DI (r) AH (t)
Visit Weight	—	231 lb -DI (r) AH (t)
Weight/Scale Event	—	0 -DI (r) AH (t)
Vitals Sepsis Risk Score	0 -DI (r) SS (t)	1 -DI (r) AH (t)
% Weight Change Since Birth	—	0 -DI (r) AH (t)

Flowsheets (all recorded)

First Contact With Patient

Row Name	06/22/18 1128
Physician First Contact With Patient	
First Contact With Patient	1123 -KL

Flowsheets (all recorded)

ED Fall Risk

Row Name	06/22/18 1127
Green Risk: Any patient presenting to the ED.	
Have the Green Environment of Care strategies been implemented? (click row info for more details)	Y -MG
Yellow Risk: ED Patients who present with or develop any of the following:	
Are any of the following Yellow criteria present?	No -MG

Flowsheets (all recorded)

Risk for Readmission

Row Name	06/22/18 1312
OTHER	
Risk for Readmission	11 -MG

Flowsheets (all recorded)

Acuity/Destination

Row Name	06/22/18 1112	06/22/18 1019
Acuity/Destination		
Patient Acuity	----	3 -EO
ED Destination	08 -EO	----
Primary Triage Complete	—	Primary triage complete -EO

Flowsheets (all recorded)

Vital Signs

Row Name	06/22/18 13:05:27	06/22/18 10:21:43
Vital Signs		
Temp	97.8 °F (36.6 °C) -DI (r) SS (t)	96.6 °F (35.9 °C) -DI (r) AH (t)
Pulse	62 -DI (r) SS (t)	82 -DI (r) AH (t)
Resp	16 -DI (r) SS (t)	17 -DI (r) AH (t)
BP	176/84 -DI (r) SS (t)	160/75 -DI (r) AH (t)
Oxygen Therapy		
SpO2	96 % -DI (r) SS (t)	100 % -DI (r) AH (t)
Height and Weight		
Weight	—	104.8 kg (231 lb) -DI (r) AH (t)

Flowsheets (all recorded)

Vital Signs

Row Name	06/22/18 13:05:27	06/22/18 10:21:43
Vital Signs		
Automatic Restart Vitals Timer	Yes -DI (r) SS (t)	Yes -DI (r) AH (t)
Pulse	62 -DI (r) SS (t)	82 -DI (r) AH (t)
Resp	16 -DI (r) SS (t)	17 -DI (r) AH (t)
BP	176/84 -DI (r) SS (t)	160/75 -DI (r) AH (t)
Calculated MAP	114.67 -DI (r) SS (t)	103.33 -DI (r) AH (t)
Temp	97.8 °F (36.6 °C) -DI (r) SS (t)	96.6 °F (35.9 °C) -DI (r) AH (t)
Oxygen Therapy		
SpO2	96 % -DI (r) SS (t)	100 % -DI (r) AH (t)
Vitals Sepsis Score		
Vitals Sepsis Risk Score	0 -DI (r) SS (t)	1 -DI (r) AH (t)

Flowsheets (all recorded)

PA Risk Score

Row Name	06/22/18 1305	06/22/18 1301	06/22/18 1205	06/22/18 1201	
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	

Flowsheets (all recorded)

Anthropometrics

Row Name	06/22/18 10:21:43
Anthropometrics	
Weight	104.8 kg (231 lb) - DI (r) AH (t)
Weight Change	0 - DI (r) AH (t)

Flowsheets (all recorded)

Focused Assessment

Row Name	06/22/18 13:05:27	06/22/18 1129	06/22/18 10:21:43
Airway			
Airway (WDL)	—	WDL -MG	—
Breathing			
Breathing (WDL)	—	WDL -MG	—
SpO2	96 % -DI (r) SS (t)	----	100 % -DI (r) AH (t)
Circulation			
Circulation (WDL)	---	WDL -MG	---
Disability			
Disability (WDL)	—	WDL -MG	—
Level of Consciousness	—	Alert -MG	—

Flowsheets (all recorded)

HEENT

Row Name	06/22/18 1129
HEENT	
HEENT (WDL)	X -MG
R Eye	Intact -MG
L Eye	Intact -MG
L Ear	Intact -MG
Nose	Drainage active bleeding -MG
Nasal Drainage Color	Bloody -MG
Head and Face	Symmetrical -MG
Neck	Trachea midline;No tenderness -MG
Throat	Intact -MG
Tongue	Pink & moist -MG
Mucous Membrane(s)	Moist;Pink -MG
Teeth	Intact -MG

Flowsheets (all recorded)

Departure Condition

Row Name	06/22/18 13:05:27	06/22/18 1258	06/22/18 10:21:43
Departure Condition			
Mobility at Departure	—	Ambulatory -MG	—
Departure Condition	—	Good -MG	—
Patient Teaching	—	Discharge instructions reviewed;Follow-up care reviewed;Parent/ Caregiver verbalized understanding -MG	—
Departure Mode	—	With family -MG	—
Vital Signs			
Automatic Restart Vitals Timer	Yes -DI (r) SS (t)	—	Yes -DI (r) AH (t)
Pulse	62 -DI (r) SS (t)	—	82 -DI (r) AH (t)
Resp	16 -DI (r) SS (t)	—	17 -DI (r) AH (t)
BP	176/84 -DI (r) SS (t)	—	160/75 -DI (r) AH (t)
Calculated MAP	114.67 -DI (r) SS (t)	—	103.33 -DI (r) AH (t)
Temp	97.8 °F (36.6 °C) -DI (r) SS (t)	—	96.6 °F (35.9 °C) -DI (r) AH (t)
Oxygen Therapy			
SpO2	96 % -DI (r) SS (t)	—	100 % -DI (r) AH (t)

Flowsheets (all recorded)

Immunizations

Row Name	06/22/18 1128
Tetanus up to date	
Tetanus within last 5 years?	Yes -MG
Influenza Vaccine (Sept - March 31st)	
Have you received the Influenza Vaccine during this Flu season?	Not Flu Season -MG
Pneumococcal Vaccine Screening (Year Round)	
Have you received the pneumococcal vaccine?	Yes -MG
Date of Immunization?	03/16/18 -MG
Last Immunization Greater than 5 years?	No -MG

Flowsheets (all recorded)

Abuse Indicators

Row Name	06/22/18 1128
Abuse Screening	
Safe in Home	Yes -MG
Do you feel threatened or unsafe in a relationship?	No -MG
Are you in immediate danger?	No -MG
Do you feel neglected?	No -MG
Physical harm?	No -MG
Verbal harm	No -MG
Abuse Suspected	
Suspected Victim Of:	None Suspected -MG

Flowsheets (all recorded)

Psychosocial Needs

Row Name	06/22/18 1129
Psychosocial	
Needs Expressed	Denies -MG
Support System	
Patient Support System	N/A -MG
Primary Language	
Primary Language Spoken by Patient?	English -MG
Language Assistant	
Interpreter needed	No -MG
Interpreter requested	No -MG

Flowsheets (all recorded)

Adult Suicide Risk

Row Name	06/22/18 1128
Suicide/Harm Risk	
Ever harm self (Retired)	No -MG
Current thoughts (Retired)	No -MG
Self harm plan (Retired)	No -MG
Patient information obtained from	Patient -MG
Suicide Risk (Retired)	
Is patient at risk for suicide? (Retired)	No -MG

Flowsheets (all recorded)

Assessment Complete

Row Name	06/22/18 1129
Assessment Complete	
Assessment Completed?	Yes -MG

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	06/22/18 13:05:27	06/22/18 10:21:43
Vital sign parameters		
BP	176/84 -DI (r) SS (t)	160/75 -DI (r) AH (t)
Pulse	62 -DI (r) SS (t)	82 -DI (r) AH (t)
Calculated MAP	114.67 -DI (r) SS (t)	103.33 -DI (r) AH (t)
Resp	16 -DI (r) SS (t)	17 -DI (r) AH (t)
Temp	97.8 °F (36.6 °C) -DI (r) SS (t)	96.6 °F (35.9 °C) -DI (r) AH (t)
Vitals Sepsis Risk Score	0 -DI (r) SS (t)	1 -DI (r) AH (t)
Vital Signs		
Automatic Restart Vitals Timer	Yes -DI (r) SS (t)	Yes -DI (r) AH (t)

Flowsheets (all recorded)

Triage HPI - General Complaint

Row Name	06/22/18 1127
General Complaint	
Onset	Today -MG
Chronicity	Recurrent -MG
Activity at onset of symtoms	Upon awakening -MG

Flowsheets (all recorded)

Discharge Time Out

Row Name	06/22/18 1259
Discharge Time Out	
Were all IV's/catheters/EKG stickers removed?	Yes -MG
Does the patient have transportation home?	Yes -MG
Did MD answer their questions?	Yes -MG
Were all prescriptions provided?	Yes -MG
Side effects sheets given?	Yes -MG
Antimicrobial prescribed: The patient/family was educated on the appropriate use of their antimicrobial medication	NA (enter comments) -MG
Viral diagnosis, no antibiotic needed: The patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit	N/A (enter comments) -MG
Was all discharge information given to patient with correct patient information?	Yes -MG
Does patient require or request a wheelchair?	N/A (enter comments) -MG
Was work or school excuse provided?	Yes -MG
Was imaging CD provided?	N/A (enter comments) -MG
Was MyChart explained?	Yes -MG
Does patient have any concerns with follow-up?	No -MG
Diabetic instructions and education completed (PH ED only)	No -MG

Flowsheets (all recorded)

Secondary Triage Complete

Row Name	06/22/18 1128

Information Source

Information Provided By:	Patient -MG

Secondary Triage Complete

Secondary Triage Complete	Secondary Triage Complete -MG

User Key

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

Initials	Name	Effective Dates
UE	Epic, User	—
EO	Eric Okanume, RN	01/27/17 -
AH	Angel Hoskins	02/03/15 -
MG	Marissa Gamble	—
SS	Savannah L Starnes	04/10/18 -
DI	Interface, Doc Flowsheet In	—
KL	Kevin D Little, MD	06/20/18 - 06/22/18

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Encounter-Level Documents - 06/22/2018:

Scan on 6/26/2018 8:04 PM (below)