Sundance HealthCare Systems
Painted Valley, USA

Patient Name:	Perry, Oliver H.
Physician:	Daniel T. Olson
Room No.	Room 235

To Be Completed Upon Admission: Date: 02 / 13 / xx Time: 06 : 00

Source of Interview Data: St. Ann's Staff

Admitted From: ☐ Admitting ☑ Emergency Room ☑ L.T.C. ☐ Other

Admitted Via: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher

Vital Signs:

Temperature: 98.7 Pulse: 102 Respirations: 20 Blood Pressure: 5 /_____

Stated Height: _____ Stated Weight: _____ Actual Weight: 165 B.M.I. _____

Orientation to Room:

S.O./Patient Verbalizes Understanding of:

☐ Patient Information Book	☐ Visiting Hours	☐ Nurse Call System
☐ Bed Controls	☐ Shower Controls	☐ Valuables Policy
☐ Telephone	☐ Cafeteria Hours	☐ Hospital Ed. T.V.
☐ Emergency Call Light	☐ Lighting System	☐ Smoking Policy
		☐ Safety Regulations

Patient Statement/Understanding of Diagnoses and/or Description of Symptoms: _____
Patient is unable to give history due to dementia

Current/Past Major Illnesses	Hospitalized	Date	Major Treatment - Operations Outcome
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Allergic / Reactions	Home Medications	Schedule	Last Dose	Home Medications	Schedule	Last Dose
Drugs None	Remeron 7.5 mg	q.h.s.	2/12/xx			
Other	☐ Pharmacy	☐ Sent Home		☐ Bed Side	☐ Other	

Skin and Body Assessment

Skin Condition
Turgor ☑ Good ☐ Poor ☐ Edematous
Temp: ☑ Warm/Dry ☐ Cold ☐ Clammy
Color ☑ Average ☐ Pale ☐ Cyanotic

Gyn History

Date of Last Pap
L.M.P. _____ Smear _____ MMG: _____
Gravida ___ Para ___ AB ___
Breast Self Exam ☐ Yes ☐ No
No. of Children Born Alive ____ Stillborn ____

Habit History

Tobacco Unknown
Type ☐ Snuff ☐ Pipe ☐ Cigar ☐ Chew ☐ Cigarettes
Usage: ___ Packs per day ___ No. of Years
___ Years Stopped ___ Age of First Use

Alcohol Unknown
Usage: ___ Never ___ Occasional ___ Moderate ___ Heavy

Caffeinated Beverages (per day)
___ Cups Coffee ____ Soda

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Daniel T. Olson
Room 235
780561

Date Time	Start (s) or Add (a)	Description (blood, plasma, D5)	Site	Rate	Amt Given	Tube Change	Drg Change	Initials
2/13/xx 1530	S	D5 1/2 NS	Rt Forarm	125	1000	-	-	***GB/ RN***
1930	A	D5 1/2 NS	Rt FA	125	180	-	-	*MD/RN*
2315	A	D5 1/4 NS	Rt FA	125	180	-	-	*MD/RN*
2/14/xx 0700	A	D5 1/4 NS	Rt FA	125	180	-	-	***LS/RN***

Initials	Nurse's Signature/Title	Initials	Nurse's Signature/Title
GB	***Ginger Bayliss, RN***		
MD	*Maggie Dish, RN*		
LS	***Leslie Scorch, RN***		

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Nsg 2822

PARENTERAL FLUID SHEET

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Medication and Date of Order											
2/13 Levaquin 250 mg	Date	2/13		2/14							
	Time	1800		0715							
	Dose	500		250							
	Route	po		po							
	Init	*GB*		*LS*							
2/13 Lanoxin 0.125 mg q.d..	Date	2/13		2/14							
	Time	1800		0715							
	Dose	0.125		0.125							
	Route	po		po							
	Init	*GB*		*LS*							
2/13 Remeron 7.5 mg q.h.s	Date	2/13									
	Time	2100									
	Dose	7.5									
	Route	po									
	Init	*GB*									
2/13 Digoxin 0.5 mg	Date		2/13	2/14							
	Time		2100	0715							
	Dose		7.5	7.5							
	Route		po	po							
	Init		*GB*	*LS*							
2/13 Lasix 40 mg	Date		2/13								
	Time		2100								
	Dose		40								
	Route		IV								
	Init		*GB*								
	Date										
	Time										
	Dose										
	Route										
	Init										

MEDICATION PROFILE

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Date	2/13/xx								2/14/xx								_____								_____							
Time	3	6	9	12	15	18	21	24	3	6	9	12	15	18	21	24	3	6	9	12	15	18	21	24	3	6	9	12	15	18	21	24
105																																
104																																
103																																
102																																
101																																
100																																
99																																
98																																
97																																
96																																
95																																

Pulse	62			72			68		64			68			70																	
Resp.	26								28																							
B/P	138/54			156/50			138/52		144/56			138/56			136/58		___/___			___/___			___/___		___/___			___/___			___/___
	___/___			___/___			___/___		___/___			___/___			___/___		___/___			___/___			___/___		___/___			___/___			___/___

In	225			200			_____		630			_____			_____		_____			_____			_____		_____			_____			_____
Out	350			_____			230		420			_____			_____		_____			_____			_____		_____			_____			_____

Weight:	163			166					164			_____					_____								_____							

Diet	_____			_____			_____		_____			_____			_____		_____			_____			_____		_____			_____			_____
Appetite	_____			_____			_____		_____			_____			_____		_____			_____			_____		_____			_____			_____

GRAPHIC SHEET

Sundance HealthCare Systems **Painted Valley, USA**

Patient Family Name	First Name	Age	Room No.	Hosp. No.
Perry,	Oliver H.	80	CCU #2	# 780561
Attending Physician			Date	Lab. No.
Dr. D. T. Olson			2/13	7734-3252

Component	Normal	First	Second	Third	Fourth
		Date 02/13			
Chemistry 10					
Sodium	135 - 145	141			
Potassium	3.5 - 5.3	4.6			
Chloride	100 - 110	105			
CO2	23 - 29	28			
Glucose	80 - 116	153 H			
BUN	12 - 20	28 H			
Creatinine	0.6 - 1.3	1.6 H			
Total Bili	0.0 - 1.3	1.2			
Albumin	3.5 - 5.0	3.7			
Calcium	8.2 - 10.1	9.4			
ALP	56 - 112	50			
AST	0 - 27	27			
ALT	14 - 26				
Total Protein	6.0 - 8.0	7.2			
Theo	10.0 - 20.0				
TSH	0.4 - 6.2				
Lipid Profile					
Total Choles	100 - 200				
HDL	40 - 80				
LDL	66 - 130				
Triglycerides	50 - 150				
HG A1C	4.0 - 6.0				
PSA	0.0 - 4.0				

Sundance HealthCare Systems **Painted Valley, USA**

Patient Family Name	First Name	Age	Room No.	Hosp. No.
Perry,	Oliver H.	80	CCU #2	# 780561
Attending Physician			Date	Lab. No.
Dr. D. T. Olson			2/13	7734-3253

Component	Normal		First	Second	Third	Fourth
		Date	02/13			
Hematology						
WBC (x 10^3)	M/F	4.3 - 11.0	20.1 H			
RBC (x 10^3)	M	4.6 - 6.2	5.36			
	F	4.2 - 5.4				
Hgb (g/dl)	M	12 - 18	14.4			
	F	12 - 16				
HCt (%)	M	40 - 54	44.2			
	F	36 - 47				
MCV (x 10^3)	M	80 - 94	82.5			
	F	82 - 100				
MCH (x 10^3)	M/F	26 - 33	26.8			
MCHC (%)	M/F	31 - 36	32.5			
PLT (x 10^3)	M/F	150 - 375	284			
Differential						
Band	0	- 6%	10 H			
Seg	46	- 82%	76			
Lymph	13	- 37%	10 L			
Mono	4	- 12%	3 L			
Eosin	0	- 5%	1			
Baso	2	- 2%	0			
NRBC						
Atyp Lymph						
Meta						
Myelo						
Pros						
Blast						

Sundance HealthCare Systems
Painted Valley, USA

NAME Oliver H. Perry X-RAY NO. 3464-xx

DOCTOR Olson DATE 2/13/xx

REGION EXAMINED Chest X-ray

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

INDICATIONS: Abdominal pain.

Chest; A single PA view of the chest compared to a 2-12-xx view revealed a prominent epicardial fat pad on the right. On the left a density extends to the left heart border which could represent fibrosis or an unusual epicardial fat pad. Pneumonia would have to be considered with this appearance. Follow up is recommended. Moderately heavy markings are scattered through out the lungs compatible with areas of fibrosis, including the right costophrenic angle.

The heart does not appear to be enlarged. The aorta is calcified in the arch area. Moderate to moderately severe degenerative change is noted in the spine. Demineralization compatible with osteoporosis is also suggested.

IMPRESSION: Possible pneumonia in the lingula.

William C. Roentgen M.D.
RADIOLOGIST'S SIGNATURE

Sundance HealthCare Systems
Painted Valley, USA

NAME Oliver H. Perry X-RAY NO. 3464-xb

DOCTOR Olson DATE 2/13/xx

REGION EXAMINED Abdominal series

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

ABDOMEN: Supine and upright views of the abdomen reveal no evidence of free air or obstruction. Non-specific pattern of gas and feces.

Moderate to moderately severe degenerative changes noted with hypertrophic spurring in the LS spine.

Arterial calcifications are noted in the aorta, renal and iliac arteries.

William C. Roentgen M.D.
RADIOLOGIST'S SIGNATURE

Sundance HealthCare Systems
Painted Valley, USA

NAME Oliver H. Perry X-RAY NO. 3464-xc

DOCTOR Olson DATE 2/13/xx

REGION EXAMINED Abdominal ultrasound

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

ABDOMINAL ULTRASOUND: Absence gallbladder. Common bile duct is only 8 cm.

The kidneys are of normal shape and cortical thickness but relatively small in size measuring 8.6 x 4.3 on the right and 9.4 x 5.1 on the left. No renal calculi, masses, lesions or hydronephrosis noted.

The spleen was not easily visualized.

The upper abdominal organs were otherwise unremarkable, except some minimal fatty replacement in the area of the pancreas.

No masses, lesions, free fluid or abdominal aortic aneurysm is identified.

Impression: Non-acute abdomen. Question of mild enlargement of the spleen which is not well visualized.

William C. Roentgen M.D.
RADIOLOGIST'S SIGNATURE

Sundance HealthCare Systems **Painted Valley, USA**

Patient Family Name	First Name	Age	Room No.	Hosp. No.
Perry,	Oliver H.	80	CCU #2	# 780561
Attending Physician			Date	Lab. No.
Dr. D. T. Olson			2/13	7734-3253

Component	Normal	First	Second	Third	Fourth
	Date	02/13			
Color	Yellow	Yellow			
Character	Clear	Hazy			
Spec Gravity	1.020 or less	1.010			
Leukocytes	Negative	Negative			
Nitrates	Negative	Negative			
PH	5-6	5.0			
Protein Urine	Negative	Trace			
Glucose Urine	Negative	Negative			
Ketones Urine	Negative	Negative			
Urobilinogen	0 - 1 mg/dl	Negative			
Bilirubin Urine	Negative	Negative			
Occ Blood Urine	Negative	Trace			
WBC/HPF	0 - 5				
RBC/HPF	0 - 5				
Epitheial					
Casts/LPF					
Crystals					
Amorphorus					
Mucous					
Yeast Cells	Negative				
Bacteria	Negative				
Sent for Culture:		Y / N	Y / N	Y / N	Y / N
24 Hour Urine for Microalbumin	0 - 30				

Form L-9003 (5/01) pa **URINALYSIS**

Sundance Medical Center
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Nursing Progress Notes

Date/ Time	
2-13-xx	
830	Admit: Admitted 80-year-old white male to CCU via cart for ED. Assisted into bed.
	Patient is agitated and swearing. States that he is "going home". Patient complains to RUQ
	pain. O2 applied @ 2L/NC. SaO2 78 % on arrival. Patient slightly cyanotic. Monitor
	applied. ***Ginger Bayliss, RN***
0900	SaO2 et color improving. Sa now 91-92%. Patient remains agitated and swearing .at times.
	Patient states that he has a small amount of RUQ pain. Will continue to monitor.
	Ginger Bayliss, RN
1100	Patient is becoming more agitated and tries to pull off the monitor. Wants to go to the
	bathroom. Assisted to the commode. Voided 100 cc amber colored urine. UA obtained
	and sent to lab. Patient assisted to geri-chair and now appears calmer.
	Margie Cutler, RN
1310	Transported via geri-chair to X-ray Dept. for ultrasound. Patient is cooperative and denies
	abd. pain. *Margie Cutler, RN*
1415	Returns from X-ray Dept. Remains up in the geri-chair.
	Margie Cutler, RN
1600	Assessment done. Unable to detect thrills, heaves or rubs at this time. Has occasional harsh
	nonproductive cough. Patient remains disorientated but cooperative.
	Ginger Bayliss, RN
1815	Assisted to commode and then back to bed. Gait unsteady but does well with assistance.
	Remains cooperative. Maggie Dish, RN
1900	Rhythm changed to atrial fibrillation. Denies discomfort.
	Maggie Dish, RN
1910	MD on call notified of atrial fibrillation. Order Lanoxin 0.5 mg slowly IV. Continues to have
	fine moist crackles. Maggie Dish, RN
2300	Assisted to commode. Patient had formed stool and voided 150 cc. urine. Patient calm and
	cooperative. Occasional dry cough. Denies discomfort. Appears to be sleeping off and on.
	Maggie Dish, RN
2-14-xx	
413	Sleeps off and on. Assisted to commode. Voided 175 cc urine. Denies discomfort.
	Ginger Bayliss, RN

Sundance Medical Center
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Date/ Time	Nursing Progress Notes
2/14/xx	
630	Rested well during night. Condition unchanged. ***Ginger Bayliss, RN***
1030	Up in geri-chair most of the a.m. Discharged per wheelchair to St. Ann's Nursing Care staff.
	Transfer form and personal belongings sent. No complaints or questions.
	Leslie Scorch, RN

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Admitted: 2-13-xx

CHIEF COMPLAINT: Left sided chest pain, shortness of breath

HISTORY OF PRESENT ILLNESS: This 80-year-old white male who has been residing at St. Ann's Care Center. I was called this morning at 6:00. The nurse stated that the patient was coding and short of breath. He was complaining of left-sided chest pain and was cyanotic. The nurse said that she could not get a pulse oximetry. The patient was transferred to the ED via ambulance. I was called again at 6:55 a.m. The patient was breathing normally, was not cyanotic and appeared to be doing well. He acknowledged some abdominal and chest pain. At this time he has no radiation, sweating, or shortness of breath. He denies dysuria, pyuria or hematuria. He states that his bowels move every day and did so yesterday.

PAST MEDICAL HISTORY: Alzheimer's dementia, COPD, history of smoking.

MEDICATIONS: Remeron 7.5 mg q hs.

ALLERGIES: None.

FAMILY HISTORY: Not obtainable.

REVIEW OF SYSTEMS: Cardiovascular, pulmonary, and HEENT: See HPI. The remaining systems which could be reviewed were negative. Some systems were unattainable due to the patient's condition.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.2, pulse 101, respirations 19, blood pressure 120/75.
GENERAL: The patient is alert and no acute distress. He has no accessory muscle respiration. He is not presently cynotic.
HEENT: Ears: TMs are clear. Eyes: PERRLA. Throat: No erythema.
NECK: Supple with no carotid bruits.
HEART: Regular rate and rhythm. Small amount of friction rub.
ABDOMEN: Soft and nontender, not distended. No abdominal bruits or pulsatile masses.
GENITOURINARY: Deferred.
RECTAL: Deferred.
EXTREMITIES: No peripheral edema. Good peripheral pulses.
NEUROMUSCULAR: Able to move all extremities.

Dr. _____
Signature

DIAGNOSTIC STUDIES: Chest x-ray shows chronic changes in the left lung which could merely be a view from a different exposure. Will review the radiology report. Flat and upright abdominal views show no air fluid levels. EKG reports shows nonspecific T-wave changes in the anterior leads. Regular rate and rhythm. Troponin is slightly elevated at 1.1. Amylase is 53. WBC is 20,000 with an MCV of 82.4, MCHC of 26.7, lymphs 11, segs 77 Sodium is 141, potassium 4.6 , chloride 104, glucose 152, BUN 27, creatinine 1.6, ALP low at 49. The rest of the LFTs are normal. CPK is 109.

ASSESSMENT:

1. Chest pain, abdominal pain. Rule out myocardial infarction. Elevated WBC of unknown etiology, possible pneumonia.
2. Alzheimer's dementia
3. Chronic obstructive pulmonary disease

PLAN: Admit to rule out MI. Ultrasound to rule out an aneurysm. See protocol orders for chest pain.

Dr. *Daniel T. Olson*
Signature

Sundance HealthCare Systems
Painted Valley, USA

Patient's Name: Perry, Oliver H.		Street Address: 3733 Valley View Road				Hospital Number: # 780561
Birth Date: 11/01/xx	Age: 80	City: Duxford				Phone Number: 605 327-1077
Sex: M	Marital Status: Widowed	State: S.D.	Zip: 57100	County: Antelope		Room: ICU #2
Soc. Sec. #: 215-32-7522		Religion: Catholic				Race: W
Patient's Occupation: Bus Driver (Retired)						Ethnicity: Non-Hispanic
Notify In Emergency	Name: Patricia Olsen	Relationship: Daughter				Responsible for Account: Self
Address: 2720 Mountain View, Devils Lake		Phone No.: 701 801-7734				
Date Admitted: 2/13/xx	Time: 0600 AM PM	Date Discharged: 2/14/xx	Time: 1045 AM PM			
Date of Last Admission: 4/23/xx		Name & Address of Any Institution From Which Discharged in Last 60 Days: N/A				
Admitting Physician: Dr. William B. Ackerman		Consultant				
Attending Physician: Dr. Daniel T. Olson						

Admitting Diagnosis (Within 24 Hours)

1. Chest pain, abdominal pain. Rule out myocardial infarction. Elevated WBC of unknown etiology, possible pneumonia.
2. Alzheimer's dementia
3. Chronic obstructive pulmonary disease

Principal Diagnosis

1. Left anterior chest pain with cyanosis and tachypnea episodes

Secondary Diagnoses

2. Probable right lingular pneumonia
3. Alzheimer's Disease
4. Chronic obstructive pulmonary disease

Complications

5. Atrial fibrillation

Operative Procedures (Date & Title)

ICD-9-CM CODES

Discharged Alive ✓ Died ____ Autopsy Yes ____ No ____

Daniel T. Olson

Physician Signature

ADMISSION SUMMARY SHEET

CONDITIONS OF ADMISSION

1. CONSENT TO HOSPITAL CARE

I am presenting myself for admission to Sundance HealthCare Systems. I voluntarily consent to the rendering of medical care which is determined to be necessary or beneficial in the professional judgement of my physician. This includes routine diagnostic procedures and medical treatment by authorized agents and employees of the Hospital, and by its medical staff, or their designees.

I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition.

2. AUTHORIZATION TO RELEASE INFORMATION

I authorize Sundance HealthCare Systemsr to release such information from my medical record as may be necessary for the completion of the hospital's or my physician's claims for reimbursement to my insurance company or agency. I UNDERSTAND THAT DISCLOSURE MAY INCLUDE DIAGNOSES AND OPERATIONS OR PROCEDURES PERFORMED AND THAT, AT THE REQUEST OF MY INSURANCE COMPANY OR AGENCY, MY COMPLETE MEDICAL RECORD MAY BE SUBJECT TO REVIEW. IN ADDITION, I UNDERSTAND THAT COPIES OF MY RECORD MAY BE OBTAINED BY MY INSURANCE COMPANY OR AGENCY.

3. ASSIGNMENT OF BENEFITS

In consideration of the services received or to be received for this admission to Sundance HealthCare Systems, I assign all insurance benefits due me. I further warrant that the hospital shall be entitled to the full amount of its charges. Any credit balance resulting for any reason will be applied to other existing accounts. This also assigns benefits to Anesthesia Consultants, PC.

I hereby agree to pay any and all hospital charges that exceed or that are not covered by my hospitalization insurance coverage. This assignment shall be irrevocable.

4. VALUABLES DISCLAIMER

I understand that Sundance HealthCare Systems maintains a safe for the safekeeping of money and valuables. I, also, understand that I assume full responsibility for any and all of my valuables, money, clothing, dentures, and other personal items while a patient in the hospital unless deposited with the Hospital for safekeeping.

Valuables Deposited with the Hospital ☐ YES ☑ NO

5. REQUEST FOR FACILITY ACCOMMODATIONS

I agree to pay to the Hospital any difference between the semi-private rate provided by my hospitalization insurance and the Hospital charges for a private accommodation. I understand that private accommodations are more expensive than the room rate payable by my hospitalization insurance and that it is my responsibility to pay the difference.

I request a Private Room ☐ YES ☑ NO

This document has been fully explained to me, and I certify that I understand its contents and agree to it freely.

February 14, 1040 AM / PM
DATE TIME

Oliver H. Perry
Patient or authorized person

Witness

Relationship

Guarantor/Insured Certificate Holder

Signature is not that of the patient because: ( ) patient is a minor

( ) other reason (specify): _____

Sundance HealthCare Systems
Painted Valley, USA

Patient's Name		Street Address			Hospital Number
Birth Date	Age	City			Phone Number
Sex	Marital Status	State	Zip	County	Room
Soc. Sec. #		Religion			Race
Patient's Occupation					Ethnicity
Notify In Emergency	Name	Relationship			Responsible for Account
Address		Phone No.			
Date Admitted	Time AM PM	Date Discharged	Time AM PM		
Date of Last Admission		Name & Address of Any Institution From Which Discharged in Last 60 Days			
Admitting Physician		Consultant			
Attending Physician					

Admitting Diagnosis (Within 24 Hours)

ICD-9-CM CODES

Principal Diagnosis

Secondary Diagnoses

Complications

Operative Procedures (Date & Title)

Discharged Alive ____ Died ____ Autopsy Yes ____ No ____

Physician Signature

ADMISSION SUMMARY SHEET

Sundance HealthCare Systems
Painted Valley, USA

PERRY, Oliver H.. # 780561

Age 80 CCU

Dr. Olson 2-13-xx a.m.

MECHANISM: Tachycardia

RATE: 102

AXIS Right, slight

PW: P-R interval is 0.16 seconds.

COMPLEXES: QRS interval is 0.098 seconds.

QT/QTC 363/441

COMMENT: Abnormal record demonstrating nonspecific ST and T-wave abnoramlities, probably digitalis effect.

DJW/bg
Sundance
D&T: 2-13-xx

Donald J. Wagner

Cardiologist Signature

Form 4101 (10/01) mr **ELECTROCARDIOGRAM**

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

Discharge Summary:

Admitted: 2-13-xx
Discharged: 2-14-xx

FINAL DIAGNOSES:
1. Left anterior chest pain with cyanosis and tachypnea episodes
2. Probable right lingular pneumonia
3. Alzheimer's Disease
4. Chronic obstructive pulmonary disease
5. Atrial fibrillation

This 80-year-old white male was admitted from the Alzheimer's unit at St. Ann's Care Center. He has a history of COPD and presented with increased shortness of breath, tachypnea, and left sided chest pain. Cyanosis was noted by the St. Ann's staff. He was brought to the ED for evaluation and was diagnosed with possible pneumonitis. He was admitted to Intensive Care to rule out cardiac disease.

MEDICATIONS: Remeron 7.5 mg hs

ALLERGIES: None.

PHYSICAL EXAMINATION: Initial vital signs: T 98.1, P 102 and regular, R 20 and BP 120/69. Unmarkable HEENT exam. No cyanosis noted. Neck supple. No carotid bruits identified. No thyroid enlargement. Chest exam unremarkable except for a rub in the left anterior chest area inferiorly. Cardiovascular exam revealed a normal S1 and S2 with rub present. No heaves or thrills. Regular rhythm was noted. Abdominal examination was unremarkable without organomegaly or masses. Normal bowel sounds. Extremities were negative. No peripheral edema. Excellent peripheral pulses. No ulcerations or areas of skin breakdown were noted.

LABS: Initial CBC: hemoglobin 14.5, hematocrit 44.1, MCV mildly decreased at 82.4. WBC: 20,100 with 76 segs 10 bands, 10 lymphs, and 3 monos. Sodium was 141, potassium 4.6, creatinine 1.6, BUN 28 and glucose 153. Alkaline phosphatase was slightly decreased at 50 but otherwise liver functions were normal. Troponin was minimally elevated at 1.2 but CK was normal at 108. Unremarkable UA.

EKG showed sinus tachycardia with nonspecific ST-T segment changes. Chest x-ray revealed a prominent epicardial fat pad on the right with a possible infiltrate in the left lingular region. Areas of fibrosis, degenerative disc disease and osteoarthritis changes in the spine were noted. Flat plate and upright x-rays of the abdomen revealed some intra-arterial calcification but no free air or organomegaly. An abdominal ultrasound was done to evaluate the rub and elevated white count. The patient had some possible splenic enlargement but no other noted abnormalities. Patient is status post cholecystectomy.

Perry, Oliver H.
Dr. Daniel Olson
Room 235
780561

HOSPITAL COURSE: Initially the patient was admitted to the Intensive Care Unit to evaluate the x-ray findings and the rub. He was started on Levaquin 500 mg initially and then 250 mg daily. The patient was hydrated with IV fluids and remained afebrile. Serial cardiac enzymes and EKGs were done. One the evening of admission the patient spontaneously went into atrial fibrillation. Digoxin 0.5 mg was administered followed by 0.25 mg six hours later and 0.125 mg daily thereafter. He then converted to sinus rhythm and has remained in that rhythm. The patient was given 40 mg. Lasix because of increased crackles. Cardiac enzymes were negative. Follow-up panel 7 was unremarkable except the CK rose to 291. The rub, chest pain and shortness of breath resolved. Oxygen saturations remained normal on room air and the patient was up ad lib. Patient remains mildly confused. EKGs remained unchanged except for some S-T segment changes presumed secondary to his Digoxin. Patient will be discharged and followed as an outpatient.

DISCHARGE MEDICATIONS: Levaquin 250 mg po q day for seven days. Remeron 7.5 mg hs, Lanoxin 0.125 mg q day and enteric coated aspirin 325 mg po q day.

DISCHARGE DIET: As tolerated.

DISCHARGE DISPOSITION: Returned to the Alzheimer's Unit at St. Ann's Care Center. Follow-up with a chest x-ray in three weeks. St. Ann's staff will contact the clinic if problems or difficulties arise.

Daniel T. Olson

Sundance HealthCare Systems
Painted Valley, USA

Perry, Oliver H.
Dr. William B. Ackerman
Room 235
780561

SUBJECTIVE: This 80 year old white male arrived via ambulance from St. Ann's Care Center with a a chief complaint initially thought to have been a cardiac arrest. Initially the chest pain was without radiation and the patient appeared cyanotic. He had one emesis in transit. The patient presents with a chief complaint of mid abdominal pain with vomiting. He states that he has had this pain for some time and has no other complains. The patient does have a history of Alzheimer's dementia and is unable to give a complete and accurate history.

OBJECTIVE: Vital signs are stable P 102-110, R 20, BP 160/75, afebrile. Skin is warm and dry to touch. Patient is awake and alert. Responds appropriately for his mental status. No jugular venous distention. Neck is soft and supple. Lungs are clear without rales, rhonchi or wheezes. Heart shows an increased rate, regular rhythm, normal S1, and S2. No S3. Bowel sounds are depressed. Abdomen is soft and somewhat distended. No palpable masses. No hepatosplenomegaly or costovertebral tenderness. No peripheral edema or calf tenderness.

EKG shows a sinus tach and some non-specific ST-T changes in the lateral leads.

ASSESSMENT: Abdominal pain.

PLAN: Obtain x-rays, chest, flat and upright of the abdomen. Will obtain a metabolic profile, CBC, UA, CK, troponin and amylase.

Dr. *William B. Ackerman*
Signature

Sundance Medical Center
Painted Valley, USA

Perry, Oliver H.
Room 235

Date/ Time	Orders	Progress Notes
	Physician's Standing Orders	
	Coronary Care	
A.	Nursing Care:	
1.	Admit to CCU.	
2.	Oxygen 2 LPM per nasal prongs. O2 sat on admission	
	and after starting O2.	
3.	Cardiac monitor stat. Document rhythm strip and lead	
	used q 8 h and prn.	
4.	Vital signs q 15 min. until stable and then q 2 h for 24	
	hours. Q 4 h if stable.	
5.	Weigh upon admission and daily.	
6.	Intake and output for 3 days or as warranted.	
7.	Low cholesterol, low NA diet.	
	Medications	
1.	Saline lock.	
2.	If PVC's not controlled, multifocal, > 6 per min. R on T	
	or coupled. If patient is not on Lidocaine, may give 75 mg	
	bolus over 2 min., then three (3) 50 mg. Bolus over	
	1 min. every 5 min. Start Lidocaine drip at 2 mg/min.	
3.	Nitroglycerin gr. 1/150 subling. Q 5 min. X 3 prn chest	
	pain.	
4.	Bradycardia with pulse less than 40: Atropine 0.5 mg(IV).	
5.	Tigan suppository 200 mg q 8 h prn for nausea.	
6.	Ativan 1 (one) mg. (o) prn for sedation or anxiety.	
Tests		
1.	Comprehensive metabolic panel	
2.	CBC	
3.	UA	
4.	Stat EKG, 12 lead and prn	
5.	Troponin on admission	
6.	Stat portable chest x-ray	
7.	Respiratory therapy assessment if indicated.	
2-13-xx	*Daniel T. Olson*	

Form # _ _ _ _

Physician Orders and Progress Notes

Sundance Medical Center
Painted Valley, USA

Perry, Oliver H.
Room 235

Date/ Time	Orders	Progress Notes
2/13:	1. Rule out MI protocol	2/13/xx: Patient had right-sided pain, atrial
0700	2. Abdominal ultrasound	fib. Heart rate 120-130's. Increased SOB
	3. Remeron 7.5 mg po q h s.	with rales. Started IV Dig and Lasix. Heart
	Daniel T. Olson	rate slowed, rales better. Adequate output.
0769.	IV fluid D5 -1/2 NS at 125 cc/hr.	Non-productive cough. No complaints of
		chest pain. Rub not heard this a.m. No
	Daniel T. Olson	complaints of abd pain. CPK 291. Tropo-
02/13	Levoquin 500 mg today, then Levoquin 250 mg. q d.	nin 0.6. Will await CK, ISO. Lasix and
	Low Na diet..	Dig. Check Panel 7. Continue Lanoxin.
0915	T.O. Dr. Olson/P. Sheehan, RN	
	Daniel T. Olson	*Daniel T. Olson*
02/13	Lanoxin 0.5 mg IV now, 0.25 mg IV in 6h and then	1/13/xx Social Service report. Will return
1030	repeat 0.25 mg IV in 6 h.	to St. Ann's Care Center upon discharge.
	T.O. Dr. Olson/P. Sheehan, RN	
	Daniel T. Olson	
		Pat Donovan
02/13	Panel 7 this am.	
1111	*Daniel T. Olson*	
02/14	D/C IV	
	Discharge back to St. Ann's Care Center.	02/14 Pt doing well. Remains in NSR.
		No vomiting. Vitals OK. Chest clear. No
	Daniel T. Olson	JVD. CV: S1 and S2. Abd neg. No ext
		edema. Will DC transfer back to St.
		Ann's.. Enzymes are neg. F/U in clinics with
		repeat CXR in two weeks.
		Daniel T. Olson

Form # _ _ _ _

Physician Orders and Progress Notes

Sundance HealthCare Systems
Painted Valley, USA

EMERGENCY ROOM / OUTPATIENT RECORD

Account Number:

Patient's Name: Last Name First Name Middle Initial	Home Phone	Admission Date a.m. p.m.	Med.Rec. Number
Perry, Oliver H.	327-1077	2/13/xx 06:00	780561

Address:	State	Zip	Age	Sex	Date of Birth	Civil Status S M W D Sep	Religion
Duxford	S.D.	57100	80	M	11/01/xx		Catholic

Employer: None - patient is retired	Occupation:	Soc. Sec. # 215-32-7522
Address:	Phone No: 720-3232	Notify Press Yes No
Responsible Party: Oliver H. Perry	Occupation: Retired	Family Doctor: Dr. Olson
Address: Duxford, SD	Phone No: 720-3200	Notified Yes No
Name of Insurance Company MeritCare	Policy No. A215-32-7522	Brought In By: ___ Self ___ Police ___ Fire ___ Relative xx Other
Address of Insurance Co. Sioux Falls, SD		
Notified: Relative Patricia Olsen Relationship: Daughter By Whom Susan Keyes		Race:
Police Yes Coroner No Time a.m./p.m.		Ethnicity:

BRIEF HISTORY: (If accident, state where, when & how injured; if illness describe)
:

Elderly white male admitted to ED per ambulance stretcher. Complains of mid abdominal pain. Had small emesis on the way. Staff at St. Ann's felt the patient was in cardiac arrest. Patient denies chest pain. Patient has history of Alzheimer's disease and doesn't give good hx. ED physician in to see patient. EKG done. Blood drawn and sent to lab. Patient to x-ray at 0725 and returned at 0805. Admit.

Condition on Admission:

Good	____	Fair	xx
Poor	____	Shock	____
Coma	____	Hemorrhage	____

Vital Signs:

Temp.	98.1
Pulse	102
Resp.	20
B.P.	120 / 69

Normal	Other	System Inventory:
☑	☐	Mental/Emotional Status:
☑	☐	Skin
☑	☐	Respiratory
☐	☑	Cardiovascular.
☑	☐	Musculoskeletal:
☐	☑	Gastrointestinal
☑	☐	Genitourinary
☐	☑	Neurological
☑	☐	EENT

PHYSICIAN'S REPORT: History & Physical Findings:

Patient comes in from St. Ann's Care Center after nursing staff noted shortness of breath with cyanosis and complaints of chest pain. .

Diagnosis: Chest pain with shortness of breath. and left-sided chest pain.

Treatment (including medications):

Disposition of Case: Admit for possible MI.

Referred to Dr. Date:

Instructions to Patient:

William B. Ackerman

Form # _ _ _ _ Patient's Signature Date Time Attending Physician

Sundance HealthCare Systems
Painted Valley, USA

Patient Name:	Perry, Oliver H.
Physician:	Daniel T. Olson
Room No.	Room 235

Activities of Daily Living:

ADL History: Date: 02 / 13 / xx Time: 06 : 00

- ☐ Diet Problems: _____
- ☐ Special Diet: _____
- Appetite: ☐ Poor ☑ Fair ☐ Good
- ☐ Sleeping Aids: _____
- ☐ Elimination Problems: _____
- ☐ Bowel Pattern: _____

ADL Needs Assessment: Date: _____/_____/_____ Time: ____:____

- ☐ Ambulation: Assistance
- ☐ Eating: Assistance
- ☐ Bathing: Assistance
- ☐ Eliminating: Commode
- ☐ Turning: _____
- ☐ Other: _____

SYSTEM REVIEW/PROBLEM IDENTIFICATION INVENTORY: Check only if problem exists.

Level of Consciousness:
- ☑ Disoriented/Not alert:
- ☐ Confused
- ☐ Noisy
- ☐ Semi-Coma
- ☐ Comatose

Respiratory:
- ☐ Nasal Problem
- ☑ Respiratory Problem

Gastrointestinal:
- ☐ GI Problems
- ☐ Elimination Problem
- ☐ Ostomy

Psycho-Social:
- ☐ Emotional Problems

Communication:
- ☐ Speech Impediment
- ☐ Aphasic
- ☐ Other _____

Eyes:
- ☐ Visual Problem
- ☑ Prosthesis (contacts, Glasses)

Ears:
- ☑ Hearing Problem
- ☑ Auditory Prosthesis

Cardiovascular:
- ☐ Cardiac Problem
- ☐ Cardiac Devices
- ☐ Circulatory Problem

Mouth:
- ☐ Oral Problem
- ☑ Dental Prosthesis
  (Dentures), Caps, Bridges

Urinary/Reproductive:
- ☐ Urinary Problems
- ☐ Urinary Devices
- ☐ Discharge
- ☐ Breast Problems
- ☐ Menstrual Problems

Musculoskeletal:
- ☐ Musculoskeletal Problems
- ☐ Amputation
- ☐ Ambulatory Prostheses

Prostheses and Valuables: _____

General Appearance: Elderly white male experiencing some shortness of breath and left-sided chest pain.

Completed By/Title *D. Brown, RN*