Patient: James Johnson
Attending: Dr. Design
Diagnosis: Type II DM
& Left Lower Leg Cellulitis

DOB: 02/14/XXXX
Allergies: Penicillin
Gender: Male

Age: 55
MR#: 104
Height: 5'0" Weight: 220 lbs.

PATIENT INFORMATION

HISTORY OF PRESENT ILLNESS:

3 day history of left anterior lower leg pain, swelling, and redness. Pain is continuous, burning/aching and rated 5/10 on a 10/10 scale in severity. Took Tylenol and Ibuprofen without significant relief. No known history of injury to leg.

PAST MEDICAL HISTORY:

10 year history of Type 2 Diabetes Mellitus controlled with oral meds. No CAD, hypertension, or other chronic illness. Takes Metformin 1000 mg BID, allergic to Penicillin.

SOCIAL HISTORY:

Divorced male lives alone. Long haul truck driver. Prior 10 pack/year history of smoking but quit 5 years ago. Drinks socially less than 2 drinks per week. No recreational drugs.

REPORT TO PARTICIPANTS: Synopsis: 0700 am in ED

Mr. James Johnson, (call me JJ), a 55 year old male, came to the ER with leg pain, diagnosed with cellulites in left leg, 10 year history of Type 2 Diabetes. Awaiting bed. BS 260, waiting for insulin coverage and last pain medication given 3 hours ago. Antibiotics (Levaquin given at 2300 last night).

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History & Physical

TIME SEEN: 1000 **REASON FOR SEEKING CARE:** Leg pain of three days duration

HPI: 55 year old male presented with three day history of left anterior lower leg pain, swelling, and redness. Pain is continuous, burning/aching and rated 5/10 on a 10/10 scale in severity. Took Tylenol and Ibuprofen without significant relief. NO known history of injury to leg.

PAST MEDICAL HISTORY: 10 year history of Type 2 Diabetes Mellitus controlled with oral meds. No CAD, hypertension, or other chronic illness.

PAST SURGICAL HISTORY: None

MEDICATIONS: Metformin 1000 mg BID

ALLERGIES: Penicillin

SOCIAL HISTORY: Prior 10 pack/year history of smoking but quit 5 years ago. Drinks socially less than 2 drinks per week. No recreational drugs.

REVIEW OF SYSTEMS: Denis SOB, chest pain, nausea, vomiting, abdominal pain, and night sweats, chills, fever, and syncope.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 37.6C orally, pulse 76, respiratory rate 18, blood pressure 130/82, O2 Saturation 97% on room air.

GENERAL: Alert, anxious, moderately obese male who appears stated age

HEENT: Sclera white, nares patent, TM's WNL, mucous membranes pink and moist.

NECK: Supple without adenopathy or thyromegaly

CARDIAC: Regular rate and rhythm without murmurs, rubs, or gallops

LUNGS: Breathing non-labored. Lungs clear to auscultation bilaterally.

ABDOMEN: Round, bowel sounds normoactive, soft and non-tender without organomegaly

EXTREMITIES: Skin warm and dry without edema. 5 cm erythematous indurated patch on left anterior lower leg, warm and tender to touch.

NEUROLOGICAL: Nonfocal, intact

DIAGNOSTIC STUDIES: WBC 12,000 Hemoglobin 15, Hematocrit 45, platelets 300,000. Sodium 140, potassium 4.2, chloride 103, HCO3 18, BUN 0.8, glucose 168, HgB A1C 8.5. Left lower leg ultrasound negative for DVT.

IMPRESSION: 1) Left lower leg cellulitis 2) Type II Diabetes Mellitus with inadequate glucose control

PLAN: Admit to medical unit. Levaquin 500 mg IVPB daily. Pain control with Oxycodone/Acetaminophen. Continue with oral hypoglycemic and cover with sliding scale insulin. Consult Endocrine for medication adjustment.

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ADMIT / PHYSICIAN ORDERS

Day	Time	Complete top portion with each level of care change.
		☐ Outpatient Procedure:_________________________________(procedure) for _____________________________________ (medical reason).
		☐ Place in Outpatient Observation Services for:
		X Admit as Inpatient for: Cellulitis and IV Antibiotics
Day	**Time**	**PHYSICIAN ORDER AND SIGNATURE**
		Admit to medical unit **Diagnosis: Cellulitis, Type II DM** **2000 Calorie ADA Diet** **Activity is tolerated** **IV lock** **Levaquin 500 mg IVPB every 24 hours** **Metformin 1000 mg BID** **CBS AC and HS with Sliding Scale Regular Insulin per protocol** **Oxycodone/Acetaminophen 5/500 1-2 PO every 4-6 hours PRN/pain** **CBC and Basic Chemistry panel in AM** **Consult Endocrine services for diabetes management**
PROVIDER SIGNATURE		

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NURSING FLOW SHEET

DATE:					
	TIME	0600	0800		
VITAL SIGNS	BLOOD PRESSURE				
	PULSE				
	RESP RATE				
	TEMP				
PAIN	SCORE				
	LOCATION				
	CHARACTER				
RESP	OXYGEN				
	OXIMETER				
NUTR	DIET / % EATEN				
	SUPP FEEDING				
INTAKE	PO				
	IV				
OUTPUT	URINE				
	DRAINS				

PROBLEM / EVENT DOCUMENTATION	
DATE / TIME	
SIGNATURE	

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MEDICATION ADMINISTRATION RECORD Pg. 1

SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
Levofloxacin 500 mg IVPB q 24 hrs.	**9000**	
IVs-1000 ml NS at 50cc/hr.		

SIGNATURE	INTLS	SIGNATURE	INTLS

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MEDICATION ADMINISTRATION RECORD Pg. 2

NON – SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
Oxycodone/Acetaminophen 5mg/500mg 2 tabs q 4 hrs. prn pain		
Sliding scale Novolog Insulin		

SIGNATURE	INTLS	SIGNATURE	INTLS

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LAB STUDIES & DIAGNOSTICS

CHEMISTRIES		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Sodium (NA+)	135-145 mEq/L	140
Potassium (K+)	3.5 -5.0 mEq/L	4.2
Chloride (CL-)	100-108 mEq/L	103
Carbon Dioxide (C02)	24-30 mEq/L	28
Magnesium (Mg++)	1.5-2.0 mEq/L	1.8
Glucose	70-110 mg/dL	168
Calcium (Ca++)	8.5-10.5 mg/dL	9.2
Phosphorous (P04	2.6-4.5 mg/dL	3.4
Blood Urea Nitrogen (BUN)	8-25 mg/dL	0.8
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	
Osmolality	280-295 mOsm/kg	
Albumin	3.5-4.8 g/dL	
Pre-Albumin	19-38 mg/dL	
Ammonia	15-56 ug/dL	
Bilirubin	0.3-1.0 mg/dL	
Conjugated (Direct) Bilirubin	0-0.2 mg/dL	
Alk Phos	25-100 u/L	
AST	Male: 14-20 u/L Female: 10-36 u/L	
ALT	10-35 u/L	
Amylase	25-125 u/L	
Lipase	10-140 u/L	
HgB A1C		8.5

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LAB STUDIES & DIAGNOSTICS

Arterial Blood Gases		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
pH	7.35-7.45	
$PaC0_2$	35-45 mmHg	
$Pa0_2$	>80 mmHg	
$Sa0_2$	>94%	
HCO_3	22-26 mEq/L	

LAB STUDIES & DIAGNOSTICS

HEMATOLOGY		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Red Blood Cells (RBC)	Males: 4.5-5.3 million /mm$_3$ Females: 4.1-5.1 million/mm$_3$	4.9
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	45%
Hemoglobin (HgB)	Males: 13.0-18.0 g/100 ml Females: 12-16 g/100 ml	15
White Blood Cells (WBC)	4,500-11,000/mm$_3$	12,000
Platelets (Plt)	140-400 X 103 mm$_3$	300,000
MCV	80-100	88
MCH	27-33	30
Retic count	0.5-2.5%	2.3%

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LAB STUDIES & DIAGNOSTICS

CARDIAC MARKERS		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**

COAGULATION		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Prothrombin Time (PT)	Control 11.2-13.2 (+/-2 seconds)	
Partial Prothrombin Time (PTT)	22.1-34.1 seconds activated	
INR	1-2	

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LAB STUDIES & DIAGNOSTICS

XRAY
Left lower leg ultrasound negative for DVT.

STAT Lab Results

Laboratory Results		
Lab Test	**Normal Range**	**Patient Value**
DDimer	**<250**	

STAT Lab Results

Test	Results
VQ Scan	

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The following is the form of a "Declaration," provided for under Nevada Statues:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment. I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration . . . . |_____|

Signed this __________________ day of ______________, 20______.

Signature: _______________________________
Address: _________________________________
____
____

The declarant voluntarily signed this writing in my presence.

Witness: _________________________________
Address: _________________________________
Witness: _________________________________
Address: _________________________________

The following is the form of a “Durable Power of Attorney for HealthCare Decisions” provided for under Nevada Statute:

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for HealthCare. Before executing the document you should know these important facts:

1. This document gives the person you’re designate as your Attorney-in-Fact the power to make health care decisions for you. The power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.
3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.
4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.
5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.
6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.
8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.
9. This document revokes any prior Durable Power of Attorney for Health Care.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, ___________________________________ (insert your name) do hereby designate and appoint:

Name:

Address:

Telephone Number:

As my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the mane and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of attorney for HealthCare, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

____

____