Patient Chart #169 April Browning

Patient: April Browning	DOB: 12/12/XXXX	Age: 62 years old
Attending: Dr. Carl Mott	Allergies: PCN	MR:169
Diagnosis: GI Bleed	Gender: F	Height: 5'4 Weight: 137 lbs

PATIENT INFORMATION

HISTORY OF PRESENT ILLNESS:

April Browning is a 64 year old advertising executive who presents to the emergency room complaining of the passage of black stools x 3 days and an associated lightheadedness. She also relates that she cannot keep up with her usual schedule because of fatigability. She reports she has been diagnosed with Rheumatoid Arthritis for years. She complains of recent worsening of a chronic epigastric burning which had been a problem off/on for years. She had doubled her usual dose of Tums without significant relief of the burning. She takes NSAIDS for joint pain and recently started on Medrol pack for exacerbation of RA symptoms.

PAST MEDICAL HISTORY:

April Browning has been treated for hypertension for eight years but denies any known cardiac history. She reports that she has Rheumatoid Arthritis for years. Her weight has been stable and she claims to have an excellent appetite. She has a normal bowel habit and has not had prior black stools. She has had no abdominal surgery and denies bleeding tendencies or prior transfusion.

SOCIAL HISTORY:

Lives alone recently divorced.

Patient: April Browning	DOB: 12/12/XXXX	Age: 62 years old
Attending: Dr. Carl Mott	Allergies: PCN	MR:169
Diagnosis: GI Bleed	Gender: F	Height: 5'4 Weight: 137 lbs

REPORT TO PARTICIPANTS: Synopsis

Situation: A 62 year old female presented in the Emergency Room for complaints of black stools x 3 days with associated lightheadedness. Was seen at her primary care physician's office 1 week ago due to exacerbation of her Rheumatoid Arthritis and was placed on high dose prednisone and was also taking ibuprofen over the counter to help with pain.

Background: Known rheumatoid arthritis, history of hypertension

Assessment: Just received this patient from the ER. ER VS was stable.

Recommendations: Need to do admission assessment. I just admitted her 15 minutes ago. I have not done anything with this patient.

History & Physical

April Browning is a 64 year old advertising executive who presents to the emergency room complaining of the passage of black stools x 3 days and an associated lightheadedness. She also relates that she cannot keep up with her usual schedule because of fatigability. She reports she has been diagnosed with Rheumatoid Arthritis for years. She complains of recent worsening of a chronic epigastric burning which had been a problem off/on for years. She had doubled her usual dose of TUMS without significant relief of the burning. She takes NSAIDS for joint pain and recently started on Medrol pack for exacerbation of RA symptoms.

CC: Black stools, lightheadedness
Lightheaded x 3 days, getting worse

Neuro: Alert and oriented x 3
EENT: Benign
Cardio: RRR, S1S2, no murmurs,
Respiratory: Lungs CTA, no cough
GI: BS +, some tenderness to epigastric area

Assessment:
1. GI Bleed
2. PUD
3. Rheumatoid arthritis
4. Hypertension

Plan: Admit to med/surg
Monitor H and H
GI consult

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: GI Bleed
Day	**Time**	**PHYSICIAN ORDER AND SIGNATURE**
Today		Activity: As tolerated VS per routine Saline lock. NPO Medications: Lisinopril 20 mg one tablet by mouth daily HCTZ 25 mg one tablet by mouth daily Prednisone 5 mg one tablet po daily Nexium 40 mg IV daily GI consult with Dr. Kwok.
PROVIDER SIGNATURE		*Dr. Carl Mott*

Patient: April Browning | DOB: 12/12/XXXX | Age: 62 years old
Attending: Dr. Carl Mott | Allergies: PCN | MR:169
Diagnosis: GI Bleed | Gender: F | Height: 5'4 Weight: 137 lbs

NURSING FLOW SHEET

DATE: Today

VITAL SIGNS	TIME	0600 (ER)	0800		
	BLOOD PRESSURE	120/80			
	PULSE	82			
	RESP RATE	16			
	TEMP	97.2			
PAIN	SCORE	3/10			
	LOCATION	Epigastric area			
	CHARACTER	gnawing			
RESP	OXYGEN	RA			
	OXIMETER	95%			
NUTR	DIET / % EATEN				
	SUPP FEEDING				
INTAKE	PO				
	IV				
OUTPUT	URINE	X2			
	DRAINS				

PROBLEM / EVENT DOCUMENTATION

DATE / TIME	.
SIGNATURE	

Patient: April Browning | DOB: 12/12/XXXX | Age: 62 years old
Attending: Dr. Carl Mott | Allergies: PCN | MR:169
Diagnosis: GI Bleed | Gender: F | Height: 5'4 Weight: 137 lbs

MEDICATION ADMINISTRATION RECORD Pg. 1

SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
Lisinopril 20 mg one tablet by mouth daily		
Hydrochlorothiazide 25 mg one tablet by mouth daily		
Prednisone 5 mg one tablet po daily		
Nexium 40 mg IV daily		

SIGNATURE	INTLS	SIGNATURE	INTLS

Patient: April Browning | DOB: 12/12/XXXX | Age: 62 years old
Attending: Dr. Carl Mott | Allergies: PCN | MR:169
Diagnosis: GI Bleed | Gender: F | Height: 5'4 Weight: 137 lbs

MEDICATION ADMINISTRATION RECORD Pg. 2

NON – SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**

SIGNATURE	INTLS	SIGNATURE	INTLS

LAB STUDIES & DIAGNOSTICS

CHEMISTRIES		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Sodium (NA+)	135-145 mEq/L	134
Potassium (K+)	3.5 -5.0 mEq/L	3.7
Chloride (CL-)	100-108 mEq/L	90
Carbon Dioxide (C02)	24-30 mEq/L	30
Magnesium (Mg++)	1.5-2.0 mEq/L	
Glucose	70-110 mg/dL	
Calcium (Ca++)	8.5-10.5 mg/dL	
Phosphorous (P04	2.6-4.5 mg/dL	
Blood Urea Nitrogen (BUN)	8-25 mg/dL	30
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	1.6
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	95
AST	Male: 14-20 u/L Female: 10-36 u/L	30
ALT	10-35 u/L	30
Amylase	25-125 u/L	55
Lipase	10-140 u/L	65

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	

Other Tests		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Fecal Occult Blood Test	negative	positive
Urine HCG	negative	negative

Blood Typing		
A POS		

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	4.6
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	21%
Hemoglobin (HgB)	Males: 13.0-18.0 g/100 ml Females: 12-16 g/100 ml	6.8
White Blood Cells (WBC)	4,500-11,000/mm^3	11, 0000
Platelets (Plt)	140-400 X 103 mm^3	
MCV	80-100	73
MCH	27-33	26
Retic count	0.5-2.5%	

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)	12.3
Partial Prothrombin Time (PTT)	22.1-34.1 seconds activated	24
INR	1-2	1

LAB STUDIES & DIAGNOSTICS

XRAY

STAT Lab Results

STAT Lab Results

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 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:

_____
_____