Patient Chart #202 Brandon Lee

HISTORY & PHYSICAL

Chief Complaint: Fever, headache, sore throat with runny nose, vomiting and irritability resulting in seizure.

Informant: Parents.

HPI: Parents report Brandon has been febrile over the past 3 days with a sore throat and a runny nose and was treated with over-the-counter (OTC) antipyretics without relief. Yesterday Brandon vomited and was irritable and then had a seizure at home. His parents rushed him to the emergency department (ED). Brandon stopped seizing prior to arrival to the ED. He was given a normal saline (NS) bolus and a septic workup was done that include blood cultures, urine culture, and a lumbar puncture for cerebral spinal fluid culture and sensitivities.

PMX: Normal delivery and birth, without serious or chronic childhood illnesses. No accidents or injuries. No hospitalization or surgeries. Parents are in good health.

DEVELOPMENTAL HX: This is an 8 y/o child with normal growth and development, milestones are normal for age. No deficits noted.
NUTRITIONAL HX: Parents report child has a 'good appetite" eats three meals a day with snacks. Diet includes fresh fruits and vegetables and no soda or fast foods. Most meals are prepared in the home.
FAMILY HX: Benign. Both sets of grandparents and parents are alive and well.

IMMUNIZATIONS: Up-to-date including Hib (*H. influenza* type B).

ALLERGIES: No known allergies (NKDA).

Review of Systems

GENERAL: Well-developed 8-year-old male child lethargic and irritable, mom at bedside

SKIN: Benign, no history of rashes, lesions or easy bruising

HEENT: Benign, no problems with vision, no ear or nasal problems.

RESPRITORY: No history of asthma, croup, wheezing, shortness of breath or cough.

CARDIOVASCULAR: No history of congenital heart problems, murmurs, cyanosis, physical activity normal without shortness of breath with exertion.

GENITOURINARY: Within normal limits (WNL) for an 8-year-old male child.

MUSCULOSKELETAL: Full range-of-motion (FROM). No deficits.

NEUROLOGIC: Intact appropriate for age, play is appropriate for age, enjoys friends, and does well in school.

CURRENT MEDICATION:
OTC *acetaminophen* for headaches and fever

PLAN: Admit to pediatric unit to rule out (R/O) bacterial meningitis & for prophylactic intravenous (IV) administration of vancomycin and cefotaxime until septic work-up results obtained. Administer dexamethasone for meningeal irritation x 4 days. Place patient on isolation and seizure precautions

Dictated: Dr. A. Vegas

Patient: Brandon Lee | DOB: 03/26/XXXX | Age: 8 y/o
Attending: Anthony Vegas, MD | Allergies: NKA | MR#: 202
Diagnosis: Rule out Bacterial Meningitis | Gender: Male | Height: 4’2” | Weight: 25kg

PHYSICIAN ORDERS

Day	Time	PHYSICIAN ORDER AND SIGNATURE
Yesterday	**1800**	Admit to pediatrics **Diagnosis**: Rule out Meningitis **Code Status**: Full Code **Isolation precautions**: Droplet **Seizure precautions** **Neuro Checks/Vital Signs:** Every 4 hours (Q4H) and as needed (PRN) **Allergies:** NKDA **Diet**: Regular **Strict I&O** **Activity**: Bedrest **Nursing Communication**: ***Call HCP for fever greater than 102.5F, seizure activity, or change in patient condition*** **IV Fluids**: D5/0.45NS with 20 mEq KCL (potassium chloride) per liter (L) @ 35mL/hr. **Daily Medications**: • *vancomycin* 375mg IV every 6 hours (Q6H) • *cefotaxime* 1,250mg IV every 8 hours (Q8H) • *dexamethasone* 0.94mg IVPB (intravenous piggyback) Q6H x 4 days • *ranitidine* 12.5mg IV Q6H x 4 days **PRN Medications**: • *acetaminophen* 375mg oral (PO) every four hours (Q4H) PRN for fever > 101.0F • *lorazepam* 2.5mg IV x 1 for seizure. • May repeat *lorazepam* 0.05 mg/kg IV x 1 after 10-15 minutes
PROVIDER SIGNATURE		Dr. A. Vegas

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NURSING FLOW SHEET

DATE: Yesterday

	TIME	1800	2200	0200	0600
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**
Intravenous Fluids D5/0.45 NS with 20 mEq KCL/L at 35 mL/hr.	0730	
vancomycin 375 mg IV Q6H infuse over 1 hour	0800 1400	2000 0200
cefotaxime 1,250 mg IV Q8H infuse over 30 minutes	0900 1700	0100
dexamethasone 0.94 mg in 50 mL NS IVPB Q6H x 4 days	0830 1430	2030 0230
ranitidine 12.5 mg IV Q6H X 4 days	0800 1400	2000 0200

SIGNATURE	INTLS	SIGNATURE	INTLS

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MEDICATION ADMINISTRATION RECORD Pg. 2

NON – SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
acetaminophen 375 mg PO Q4H PRN for fever > 101.0F (Last does given at 0200)		
lorazepam 2.5 mg IV x 1 for seizure. • may repeat 0.05 mg/kg IV x 1 after 10-15 minutes		

SIGNATURE	INTLS	SIGNATURE	INTLS

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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$_3$	4.8
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	37.6%
Hemoglobin (HGB)	Males: 13.0-18.0 g/100 mL Females: 12-16 g/100 mL	14.8
White Blood Cells (WBC)	4,500-11,000/mm$_3$	15,000 (**H**)
Platelets (Plt)	140-400 X 103 mm$_3$	395
MCV	80-100	99

CHEMISTRIES		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Sodium (NA+)	135-145 mEq/L	140
Potassium (K+)	3.5 -5.0 mEq/L	3.9
Chloride (CL-)	100-108 mEq/L	100
Carbon Dioxide (C02)	24-30 mEq/L	26
Blood Urea Nitrogen (BUN)	8-25 mg/dL	11
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	0.7
Albumin	3.5-4.8 mg/dL	4.5
Alkaline Phosphatase	25 – 100 u/L	50

LAB STUDIES & DIAGNOSTICS

BLOOD CULTURE

RESULTS PENDING

LUMBAR PUNCTURE

RESULTS PENDING

URINE CULTURE

RESULTS PENDING