Patient Chart #305 Lucy Harris

Patient: Lucy Harris	DOB: 02/14/XXXX	Age: 28 y/o	
Attending: Dr. Riley	Allergies: NKA	MR#: 305	
Diagnosis: Preterm Labor	Gender: Female	Height: 5’ 3”	Weight: 65 kg

HISTORY & PHYSICAL

Chief Complaint:

1. Preterm uterine contractions.

HPI: Patient is a 28-year-old gravida 6 para 3 who came to the OB clinic for her routine prenatal visit at 28 weeks gestation. She is a direct admit to the labor and delivery unit for preterm labor.

PMI: Negative for asthma, autoimmune disease cerebral artery disease, congenital heart defects, COPD, coronary artery disease, diabetes, hepatitis, HIV/AIDS, hypertension, myocardial infarction.

Positive for 2 spontaneous abortions (SABs) and 3 preterm deliveries at 28-31 weeks gestation.

Family History: Father has type II diabetes; maternal grandmother has hypertension.

Social History: Denies tobacco, alcohol, recreational drug use.

Surgical History: None

Physical Exam:

NEUROLOGICAL: Awake, alert and oriented x 4.

CARDIOVASCULAR: No history of dyspnea, coronary artery disease, hypertension.

RESPIRATORY: No history of asthma; lungs clear bilaterally to auscultation.

GASTROINTESTINAL: Appetite good. No complaints of heartburn or indigestion.

MUSCULOSKELETAL: No abnormalities.

Medications:
prenatal vitamin 1 tab daily

Vaccines:
Tdap 11 months ago

Dictated: C. Riley, M.D.

Patient: Lucy Harris | DOB: 02/14/XXXX | Age: 28 y/o
Attending: Dr. Riley | Allergies: NKA | MR#: 305
Diagnosis: Preterm Labor | Gender: Female | Height: 5' 3" | Weight: 65 kg

ADMIT / PHYSICIAN ORDERS

Day	Time	Complete top portion with each level of care change
Today	**Now**	Admit – Inpatient: Labor and Delivery
Day	**Time**	**PHYSICIAN ORDER AND SIGNATURE**
Today	**Now**	**NURSING COMMUNICATON** • Continuous fetal monitoring. • Vital signs every four hours (Q4H) and as needed (PRN) *Notify MD of heart rate (HR) greater than 120 beats per minute (bpm)* **OXYGEN** Oxygen via facemask 8-10 LPM; titrate to maintain SpO2 above 95% **DIAGNOSTIC STUDIES** STAT CBC UA **IV Fluids** • 1 liter (L) Lactated Ringers to infuse at 125 mL/hr. **DAILY MEDICATIONS** • *Betamethasone* 12 mg intramuscular (IM) injection NOW; repeat in 24 hours for 2 doses total. • *Terbutaline* 0.25 mg subcutaneous injection every 30 minutes x 3 doses *Hold medication if HR greater than 120 bpm OR no relief of contractions with terbutaline* • *Magnesium sulfate* 1. Loading dose: 6 grams (gm) intravenous (IV) over 20 minutes x 1 dose 2. Maintenance dose: 2 gm/hr. IV **PRN MEDICATIONS** • *Terbutaline* 0.25 mg subcutaneous Q6H x 4 doses PRN for uterine contractions • *Furosemide* 40 mg intravenous push (IVP) x 1 dose PRN for pulmonary edema **Consults** Neonatology
PROVIDER SIGNATURE		*Dr. C. Riley, M.D.*

Patient: Lucy Harris	DOB: 02/14/XXXX	Age: 28 y/o	
Attending: Dr. Riley	Allergies: NKA	MR#: 305	
Diagnosis: Preterm Labor	Gender: Female	Height: 5’ 3”	Weight: 65 kg

MEDICATION ADMINISTRATION RECORD Pg. 1

SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
IV therapy: Lactated Ringers IV infusing at 125 mL/hr.		
Betamethasone 12 mg IM NOW; repeat in 24 hours for total 2 doses.		
Terbutaline 0.25 mg subcutaneous every 30 minutes x 3 doses *Hold medication if HR greater than 120 bpm OR no relief of contractions with terbutaline*		

SIGNATURE	INTLS	SIGNATURE	INTLS

Patient: Lucy Harris | DOB: 02/14/XXXX | Age: 28 y/o
Attending: Dr. Riley | Allergies: NKA | MR#: 305
Diagnosis: Preterm Labor | Gender: Female | Height: 5' 3" | Weight: 65 kg

MEDICATION ADMINISTRATION RECORD Pg. 2

NON – SCHEDULED MEDICATIONS		
MEDICATION	**0700 - 1859**	**1900 - 0659**
Terbutaline 0.25 mg subcutaneous Q6H x 4 doses PRN for uterine contractions *Hold medication if HR greater than 120 bpm OR no relief of contractions with terbutaline*		
Magnesium sulfate IV loading dose: • 6 grams over 20 min x 1 dose		
Magnesium sulfate IV maintenance dose: • 2 grams/hr. after 6 grams loading dose		
Furosemide 40 mg IVP x 1 PRN for pulmonary edema		

SIGNATURE	INTLS	SIGNATURE	INTLS

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	3.39 (**L**)
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	32 (**L**)
Hemoglobin (HGB)	Males: 13.0-18.0 g/100 mL Females: 12-16 g/100 mL	11.2 (**L**)
White Blood Cells (WBC)	4,500-11,000/mm_3	15.1 (**H**)
Platelets (PLT)	140-400 X 103 mm_3	150 (**L**)

LAB STUDIES & DIAGNOSTICS

CHEMISTRIES		
LAB TEST	**NORMAL RANGE**	**PATIENT VALUE**
Sodium (NA+)	135-145 mEq/L	136
Potassium (K+)	3.5 -5.0 mEq/L	4.1
Chloride (CL-)	100-108 mEq/L	105
Carbon Dioxide (C02)	24-30 mEq/L	26
Magnesium (Mg++)	1.5-2.0 mEq/L	1.6
Glucose	70-110 mg/dL	95
Calcium (Ca++)	8.5-10.5 mg/dL	9.2
Phosphorous (P04)	2.6-4.5 mg/dL	2.8
Blood Urea Nitrogen (BUN)	8-25 mg/dL	12
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	0.9
Osmolality	280-295 mOsm/kg	286
Albumin	3.5-4.8 g/dL	3.6
Pre-Albumin	19-38 mg/dL	19
Ammonia	15-56 ug/dL	
Bilirubin	0.3-1.0 mg/dL	0.4
Conjugated (Direct) Bilirubin	0-0.2 mg/dL	0
Alkaline Phosphatase	25-100 u/L	28
AST	Male: 14-20 u/L Female: 10-36 u/L	12
ALT	10-35 u/L	11
Amylase	25-125 u/L	30
Lipase	10-140 u/L	15

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:

_____

_____