

Patient: Wilson Carter
Attending: Dr. R. Schaffer
Diagnosis: Atrial Fibrillation
Dyspnea, Weakness

DOB: 12/07/XXXX
Allergies: NKA
Gender: Male

Age: 78 y/o
MR#: 110
Height: 5'9" Weight: 185lbs BMI: 27.3

Patient Chart

#110

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HISTORY & PHYSICAL

Chief Complaint: Weakness and shortness of breath (SOB).

HPI: 78-year-old male presenting to the emergency department (ED) with complaint of (c/o) of SOB and fatigue for one week.

PMX: Significant for recurrent atrial fibrillation.

FAMILY HX: One brother deceased at 52 y/o of myocardial infarction (MI). Wife deceased at 65 y/o from breast cancer. Two adult children: one daughter, 40 y/o in good health & one son, 42 y/o in good health.

SOCIAL HX: Patient lives alone, is homebound, and unable to care for himself. He has poor adherence with his medication regimen. Current medications include *warfarin* and *amiodarone*. Patient does not have enough money for his primary care visits and medications; unable to drive or take the bus. Denies tobacco and alcohol use. His daughter is active in his care but works fulltime and is unable to care for all of her father's needs.

SURGICAL HX: No surgeries reported.

ALLERGIES: No Known Allergies (NKA).

Review of Systems:

CONSTITUTIONAL: No weight change, change in appetite, thirst, fever or chills. Positive for weakness and fatigue.

NEUROLOGIC: No headache or loss of consciousness.

HEENT: No headaches, syncope, vertigo. No blurred vision, eye pain, discharge or lesions. Wears glasses, has not had an eye exam in 5 years. Ears: no difficulty hearing, no discharge. No difficulties with sense of smell, no nosebleeds or other nasal discharge. No mouth pain, bleeding gums, toothache or mouth sores, no dysphagia. No lymphadenopathy.

SKIN: Fragile and intact, pale, dry; appropriate for age.

CARDIOVASCULAR: No chest pain, palpitations. Experienced fatigue and onset of SOB the past week. No pain, numbness, tingling, swelling in legs. Reports history of atrial fibrillation.

RESPIRATORY: No history of lung disease; no chest pain with breathing, coughing, or wheezing. Denies tobacco use.

GASTROINTESTINAL: No anorexia, nausea or vomiting. No heartburn, indigestion pain in abdomen. No history of ulcers, liver or gallbladder disease. No jaundice.

GENITOURINARY: No dysuria or pyuria.

MUSCULOSKELETAL: No change in strength. No swelling.

HEMATOLOGIC: No pallor, bruising or bleeding.

LYMPHATICS: No reports of swollen lymph glands.

PSYCHIATRIC: Denies anxiety or depression.

ENDOCRINE: No goiter, lethargy, or heat/cold intolerance.

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Physical Assessment:

GENERAL: The patient is an elderly male, pale and fatigued in appearance.

VITAL SIGNS: BP - 110/62, P - 120, RR - 18, SpO2 saturation 93% on room air, T (oral) - 98.6° F

SKIN: No ulceration or induration present.

HEENT: Head is normocephalic and atraumatic. Extraocular muscles are intact. Pupils are equal, round, and reactive to light & accommodation. Nares appeared normal. Mouth is well hydrated and without lesions. Mucous membranes are moist. Posterior pharynx clear of any exudate or lesions.

NECK: Supple. No carotid bruits. No lymphadenopathy or thyromegaly.

HEART: Irregular rate, 120 BPM without murmur.

LUNGS: Clear to auscultation.

ABDOMEN: Soft, non-tender, and non-distended. Positive bowel sounds. No hepatosplenomegaly noted. Rectal vault empty. Reports bowel movements are "usually normal."

EXTREMITIES: Without cyanosis, clubbing, rash, lesions or edema.

NEUROLOGIC: Cranial nerves (CN) II through XII are grossly intact.

PSYCHIATRIC: Flat affect, but denies suicidal or homicidal ideations.

Problem List:

1. Recurrent atrial fibrillation
2. Dyspnea
3. Weakness

Assessment/Plan:

This is a 78-year-old ill appearing male with a diagnosis of atrial fibrillation – presented to the ED with c/o of fatigue, shortness of breath, and weakness for one week.

- Atrial Fibrillation: Admit to intermediate care unit (IMC) to monitor cardiac status
- Labs: CMP (complete metabolic panel), CBC, PT & INR daily
- Medications: *amiodarone* 200 mg tablet, 1 tablet oral (PO) once daily
warfarin 5 mg tablet, 1 tablet oral PO daily
- Dyspnea: Oxygen (O2) 2 liters via nasal cannula (L/NC)
- Weakness: Bed rest
- Uncontrolled atrial fibrillation: Cardiology consult

R. Schaffer MD

Dictated: Robert Schaffer, M.D.

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PHYSICIAN ORDERS

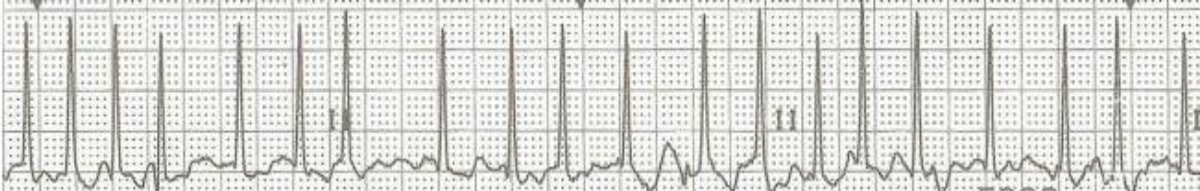
Day	Time	PHYSICIAN ORDER AND SIGNATURE
Today	Now	<p>Admit to IMC - telemetry</p> <p>Diagnosis: Recurrent atrial fibrillation Code Status: Full Code Vital signs: every 4 hours (Q4H) and as needed (PRN) I & O: every 12 hours (Q12H) Diet: Heart healthy/cardiac Activity: Bed rest IV fluids: 1 liter 0.9%normal saline infusing @ 125 mL/hr. Studies: CXR PA/lateral</p> <p>Nursing Communication:</p> <ul style="list-style-type: none"> ● <i>Call MD for SpO2 below 91%, temp >102°F, HR > 130 bpm</i> ● O2 2L/NC, titrate to keep oxygen saturation (SpO2) between ≥ 96% <p>Daily Medications:</p> <ul style="list-style-type: none"> ● <i>amiodarone</i> 200 mg oral (PO) every day ● <i>warfarin</i> 5mg oral (PO) every day, <i>hold for INR greater than 3</i> <p>Labs:</p> <ul style="list-style-type: none"> ● CMP (Complete Metabolic Panel) , CBC, PT and INR daily <p>Studies:</p> <ul style="list-style-type: none"> ● CXR PA/lateral <p>Consults:</p> <ul style="list-style-type: none"> ● Cardiology – Dr. Harney MD (if available) ● Case Management ● Dietitian
PROVIDER SIGNATURE		Robert Schaffer MD

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NURSING FLOW SHEET

DATE:					
V I T A L S I G N S	TIME				
	BLOOD PRESSURE				
	PULSE				
	RESP RATE				
	TEMP				
P A I N	SCORE				
	LOCATION				
	CHARACTER				
R E S P	OXYGEN				
	OXIMETER				
N U T R	DIET / % EATEN				
	SUPP FEEDING				
I N T A K E	PO				
	IV				
O U T P U T	URINE				
	DRAINS				
Rhythm Strip – Today, now					
DATE / TIME					
SIGNATURE					

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MEDICATION ADMINISTRATION RECORD Pg. 1

SCHEDULED MEDICATIONS			
MEDICATION	0700 - 1859	1900 - 0659	
IV Fluids 1 liter 0.9% normal saline (NS) to run at 125 mL/hr.			
<i>amiodarone</i> 200 mg PO every daily			
<i>warfarin</i> 5 mg PO daily <i>or INR greater than 3.0</i>			
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	pending
Hematocrit (HCT)	Males: 37-49% Females: 36-46%	pending
Hemoglobin (HGB)	Males: 13.0-18.0 g/100 ml Females: 12-16 g/100 ml	pending
White Blood Cells (WBC)	4,500-11,000/mm ³	pending
Platelets (PLT)	140-400 X 10 ³ mm ³	pending
MCV	80-100	pending
MCH	27-33	pending
Reticulocyte count	0.5-2.5%	pending

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Complete Metabolic Panel		
LAB TEST	NORMAL RANGE	PATIENT VALUE
Sodium (NA+)	135-145 mEq/L	140
Potassium (K+)	3.5 -5.0 mEq/L	4.1
Chloride (CL-)	100-108 mEq/L	105
Carbon Dioxide (CO2)	24-30 mEq/L	26
Magnesium (Mg++)	1.5-2.0 mEq/L	1.9
Glucose	70-110 mg/dL	123 (H)
Calcium (Ca++)	8.5-10.5 mg/dL	8.8
Phosphorous (PO4)	2.6-4.5 mg/dL	3.2
Blood Urea Nitrogen (BUN)	8-25 mg/dL	27 (H)
Creatinine	Male: 0.6-1.5 mg/dL Female: 0.6-1.1 mg/dL	1.6 (H)
Osmolality	280-295 mOsm/kg	290
Albumin	3.5-4.8 g/dL	3.4 (L)
Pre-Albumin	19-38 mg/dL	20
Ammonia	15-56 ug/dL	20
Bilirubin	0.3-1.0 mg/dL	0.3
Conjugated (Direct) Bilirubin	0-0.2 mg/dL	0.0
Alkaline Phosphatase	25-100 u/L	50
AST	Male: 14-20 u/L Female: 10-36 u/L	20
ALT	10-35 u/L	35
Amylase	25-125 u/L	35
Lipase	10-140 u/L	100

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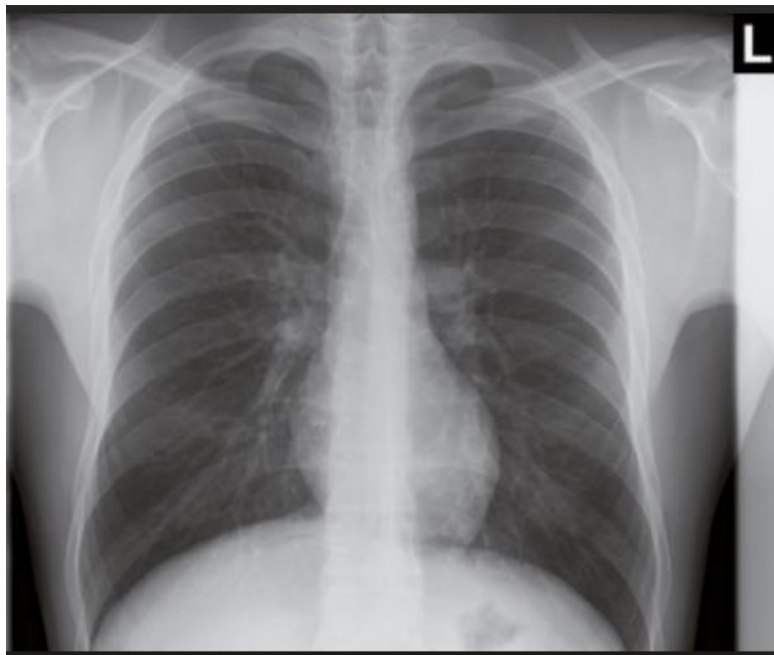
COAGULATION PANEL

LAB TEST	NORMAL RANGE	PATIENT VALUE
Prothrombin Time (PT)	Control 11 – 16 seconds (+/-2 seconds)	pending
activated Partial Prothrombin Time (aPTT)	25 – 35 seconds activated	pending
International normalized ratio (INR)	1 – 2 2 – 3* (*with warfarin)	pending

IMAGING

XRAY

A/P Chest X-Ray



No active disease, age-related changes present.*

Mary Anderson, M.D.

*Reference:

Cheryl Maes, RN PhD, 11.2019

Power point slide – Gas Exchange & Aging: “residual capacity increases with ↓ inspiratory & expiratory muscle strength of the thorax; auscultation of bibasilar atelectasis is common due to incomplete lung expansion.”

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

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: _____

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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.

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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 name 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:

