Patient Information Form

Hospital Name: Scottsdale Healthcare-Osborn **Phone:** (480) 882-4000

Hospital Address: 7400 EAST OSBORN ROAD SCOTTSDALE, AZ 85251

Patient Demographics

Patient Name: WEIN, DAVID
Medical Rec #: 2164405 **SSN:** 109-32-5525
Marital Status: MARRIED **Gender:** M
Date of Birth: 08-22-1942 **Age:** 72
Religion: JEWISH
Episode ID: A1424910165
Height:
Weight:

Admit and Length of Stay Information

Unit: 6EB
Admit Type: TRAUMA CENTER **Room:** 631
Admission Date: 09-16-2014 **Bed:** 1
Est. Discharge Date: 09-22-2014 **ALC Date:**
Pt. Functional Status Prior to Admission:
PCP: PCP, NO PCP
Attending Physician: SERVICES, TRAUMA
Phone Number:

Diagnosis Information:

Rugs: **Primary:** LOT **Secondary:**

Discharge Notes:

Notes:

Mode of Transportation:
Will patient receive radiation or dialysis off-site?
☐ Yes ☐ No

Payer Source:
Schedule of Treatments:

Patient Address

Living Arrangement: Select One
Facility Name:
Street: 540 N MAY ST, 1058
City: MESA
State/Zip: AZ 85201
Home Phone:
Work Phone:

Next of Kin

First Name/MI: ANN
Last Name: WEIN
Street:
City:
State/Zip:
Home Phone:
Work Phone:
Relation: SPOUSE
☐ Emerg. Contact ☐ POA

Emergency Contact:

First Name/MI:
Last Name:
Street:
City:
State/Zip:
Home Phone:
Work Phone:
Relation:
☐ Emerg. Contact ☐ POA

Payer Information:

Primary Payer: "INJURY PRIME, MDCR 2ND" **Ins. Group ID#:**
Member ID#: 109325525
Contact person at Ins. Co. (First/MI/Last): **Phone:**
Patient has met 3 consecutive, acute level of care days during this admission & may be eligible for the Medicare Extended Care Benefit. ☐ Yes ☐ No ☐ N/A ☐ Unknown

Secondary Payer: MEDICARE **Member ID#:** 109325525A **Phone #:**
Other Payer: AARP **Member ID#:** 07641215711 **Phone #:**

Income if known: ☐ Private Funds ☐ Pension ☐ SSA ☐ VA ☐ SSI ☐ Other

Patient Medicaid Eligible? ☐ Yes ☐ No **If Yes, submitted by our financial office?** ☐ Yes ☐ No

Contact person in financial office (First/MI/Last):

No Fault: Must have claim number, name of insurance company, name of insured, telephone number, and policy number. This information is needed even if no fault is exhausted. No faults must have secondary insurance information.

Case Contact

First/MI/Last: Sarah Vitse **Phone** (480) 285-7211 **Date:** 09-30-2014

SCOTTSDALE HEALTHCARE
OSBORN

--ADMISSION INFORMATION--
Acct #:1424910165 MR #:0002164405 Admission Date/Time:09/16/14 1634
Patient Type: TRA INPATIENT TRAUMA Admit Clerk: KH Room/Bed:234-1
Arv Mode:PROF MED TRA Adm Srce:1 Adm Type:5 Prev Admit: ACCOM Code:KK
OCC Code: Cond Code: Svc:TRA Patient Class:*NONE
Staff Alert:
Admitting Physician:TRAUMA,SERVICES Attending Physician:TRAUMA,SERVICES
Referring Physician: Pri Care MD:PCP,NONE
Pri Care ph#: Pri Care fax#:
Admit Dx:807.00-FRACTURE RIB NOS-CLOSED Proc:
Medical Comment:BRAVO,SIXTWO

--PATIENT INFORMATION--
Name:WEIN,DAVID DOB:08/22/42 Age:72Y Sex:M SSN:XXX-XX-5525
Race:1 Marital Status:M Fin Class:MC Religion:24 Language:ENGLISH
Address:540 N MAY ST 1058 MESA AZ 85201
Home Phone:480 834-8629
Employer:

--GUARANTOR INFORMATION--
Name:WEIN,DAVID DOB:08/22/42 Rel:SELF SSN:XXX-XX-5525
Address:540 N MAY ST 1058 Home Phone:480 834-8629
MESA AZ 85201
Employer:

--RELATIVE INFORMATION--
Name:WEIN,ANN DOB: Relation:*SPOUSE
Home Phone:480 834-8629 Work Phone:
Address:
Employer:

--RELATIVE TWO INFORMATION--
Name:NONE,NONE Home#: Rel:OTHER Work#:

--PRIMARY INSURANCE INFORMATION--
Insured: WEIN,DAVID Sex: M Relation: 1
Emp Status: 5 Policy #: 109325525A Group #:
100100 NAS MEDICARE PO BOX 6730 FARGO ND 58108
MEDICARE Apprv #: NN Ins ph#:(866)497-7857 Ext:

--SECONDARY INSURANCE INFORMATION--
Insured: WEIN,DAVID Sex: M Relation: 1
Emp Status: 5 Policy #: 07641215711 Group #: 999999
150500 AARP UHC CLAIMS DIVISIONPO BOX 740819 ATLANTA GA 30374
AARP Apprv #: NN Ins ph#:(800)523-5800 Ext:

--ALTERNATE ADDRESS--

Printed: 09/17/14 0952

Report for WEIN, DAVID (MRN: 0002164405)

TEST: Consultation
Collected Date & Time: 09/22/14 16:40

Consultation

SCOTTSDALE HEALTHCARE OSBORN

Patient Name:DAVID WEIN DOB: 08/22/1942
Physician: SERVICES TRAUMA ADM: 09/16/2014
Med. Rec. #: 0002164405 DIS:
Pt. Acct. #: A1424910165

Consultant: CATHERINE FOLL, MD DOS: 09/22/2014
Pt. Type: TRA
Referring: DR. MITCHELL

CONSULTATION REPORT

REHAB CONSULT

This is for the consultation done on 09/22/2014.

REQUESTING PHYSICIAN: Dr. Mitchell.

OTHER PHYSICIANS: Of record: Dr. Tenaglia.

PATIENT'S CHIEF COMPLAINT: Abdominal and rib discomfort.

HISTORY OF PRESENT ILLNESS: This is a 72-year-old Caucasian gentleman who was brought to Scottsdale Healthcare Osborn Medical Center on 09/16/2014 after being involved in a head-on collision. The patient was seat-belted and airbags were deployed. There was no known loss of consciousness. The patient was found to have a right knee laceration as well as rib fractures and abdominal hematomas. The patient became hemodynamically unstable in the trauma bay and had to undergo urgent exploratory laparotomy for repair of the three mesenteric lacerations. He was also found to have omental bleeding. Patient underwent washout and repair of the knee laceration. Cardiology did evaluate him and he was not found to have any cardiac issues. We have been asked to see him and evaluate inpatient rehab.

The patient has been seen by Physical and Occupational Therapy and current functional levels are contact guard to min assist with bed mobility, contact guard to min assist with transfers and ambulation 20 feet with a front-wheeled walker. With Occupational Therapy, he is standby assist with toilet transfer, was mod assist with lower body ADLs, contact guard assist with upper body ADLs. Patient had mild short-term memory deficits with Speech Therapy and as he feels like he is not at baseline they are continuing treatment.

PATIENT'S PAST MEDICAL HISTORY: Significant for the things listed above as well as:
1. Obesity.
2. Nephrectomy for benign tumor.
3. Gout.
4. Hypertension.
5. Borderline diabetes.

SOCIAL HISTORY: Patient is married. He lives with his wife. He and his wife have homes in Florida and here in Arizona. They do have children that are local and he will have some assistance upon discharge. He required no DME prior to this.

CURRENT MEDICATIONS:
1. Allopurinol 300 mg daily.
2. Lovenox 40 mg subcu q. 12.
3. Pepcid 20 mg daily.
4. Lasix 40 mg IV x1 today.
5. Zestril 10 mg daily.
6. Percolone 5-10 mg q. four p.r.n.
7. Peri-Colace two tablets at bedtime.

The patient has an allergy listed to iodine and latex.

REVIEW OF SYSTEMS: The patient denies any chest pain but he states he does have discomfort. His abdomen is also uncomfortable. He states he has had a bit of liquid stool. He has only been taking in a clear-liquid diet at this time. He has a VAC on his abdomen. He is requiring 5 L of oxygen. He has been able to urinate.

PHYSICAL EXAMINATION: It is a pleasant gentleman who is examined while sitting up in the bedside chair. He is in no apparent distress but does appear a bit uncomfortable. His current vital signs are temperature of 97.4, pulse of 100, respirations 20, blood pressure 147/89 saturating 95% on 5 L. HEENT: Normocephalic, atraumatic. Extraocular muscles are intact. Oropharynx is clear. HEART: Regular but tachy. LUNGS: A bit diminished bilaterally. There is decreased effort. ABDOMEN: Distended. Hypoactive bowel sounds. VAC dressing in place. EXTREMITIES: 1+ edema in the bilateral lower extremities. MUSCULOSKELETAL: Strength in the upper extremities is grossly within full normal limits as well as the lower extremities. NEUROLOGIC: He denies any numbness or tingling. PSYCHIATRIC: He is alert, soft-spoken. His wife attempts to do much of the communicating for him.

ASSESSMENT AND PLAN(S):
1. Trauma I MVA on 09/16/2014 with abdominal and rib trauma. The patient would benefit from continued therapies to maximize functional gains. All three therapies are recommending inpatient rehabilitation. I did spend some time speaking with the patient, his wife and his son about rehab versus subacute rehab. His wife is fairly insistent that the patient only go to Advanced of Scottsdale for subacute rehab. Ultimate goal is home with wife and children.
2. Abdominal wound being managed by Trauma.
3. Closed head injury. The patient will continue with speech therapy.
4. *_____* insufficiency. The patient has been given Lasix for a pulmonary effusion, getting good pulmonary toilet and will stay on supplemental oxygen.

Thank you for this consult.

*****

Electronically Authenticated by
9/23/2014 9:36 AM: Sara Bader..., PA-C

CATHERINE FOLL, MD
Dictated by: SARA BADER..., PA-C

DD: 09/22/2014 16:40 - Job#: 4353833
DT: 09/23/2014 08:06 - vjz
RD: 09/23/2014 09:59
Doc# - 68174322

cc:
Sara Bader..., PA-C
DR. MITCHELL

TEST: Consultation
Collected Date & Time: 09/17/14 09:48

Consultation

SCOTTSDALE HEALTHCARE OSBORN

Patient Name:DAVID WEIN DOB: 08/22/1942
Physician: SERVICES TRAUMA ADM: 09/16/2014
Med. Rec. #: 0002164405 DIS:
Pt. Acct. #: A1424910165

Consultant: ALAN TENAGLIA, MD DOS: 09/17/2014
Pt. Type: TRA
Referring:

CONSULTATION REPORT

Today's date is 09/17/2014.

Consultation from the Trauma Service.

REASON FOR CONSULTATION: Chest trauma.

This is a 72-year-old male. The history is obtained from his wife. He does see a cardiologist in Florida, but apparently his only history is hypertension. No cardiac symptoms. No heart failure, coronary disease, arrhythmias or other problems. Yesterday another car hit him. He sustained significant trauma to his chest, abdomen and his leg, and we have been asked to see him. Currently, he is ventilated and sedated, not able to provide much history.

His other medical problems include a nephrectomy for a benign tumor, gout, and hypertension. No other vascular risk factors.

His allergies are listed as contrast. I do not know if that is because of his kidneys or if he has a true allergy. Also, latex.

His current medications include cefazolin, Pepcid, and he is also on propofol.

SOCIAL HISTORY: Not a smoker.

Family history is negative for coronary disease at a young age.

REVIEW OF SYSTEMS: Otherwise unobtainable.

PHYSICAL EXAMINATION: He is sedated. He has got a neck brace on. His most recent vital signs include temperature 99.9, pulse 85, blood pressure 100/57, O2 sat 100% on the 40% ventilator. His skin has no rashes. HEENT exam appears to be atraumatic. Unable to examine his carotids due to the neck cervical collar. His lungs are fairly clear. Cardiac exam is regular, and I do not appreciate any murmurs, rubs or gallops. ABDOMEN: Soft, somewhat decreased breath sounds. EXTREMITIES: Without edema. Pulses are intact. Joints with a fracture of the left leg.

His electrocardiogram shows sinus rhythm, first-degree AV block, right bundle branch block, and left anterior fascicular block.

His labs were notable for a negative troponin. His blood gas 7.38, 34, and 94. BUN 27, creatinine 1.4, and CBC was hemoglobin 13.6. Troponin was negative.

He had a CT of the thorax, abdomen and pelvis which showed no

abnormalities in the chest. There was a hematoma in the abdomen. There were rib fractures, mesenteric hemorrhages. He subsequently had to first undergo surgery.

CT of the brain showed no acute abnormality.

MY IMPRESSION: Patient who was hit by another car, no question of arrhythmia or cardiac event, no previous significant cardiac history. He had an echocardiogram that showed left ventricular hypertrophy and otherwise normal. At this point I do not see any evidence that the heart was either the cause of the accident or suffered any damage. We will continue to monitor him with the primary team.

Thanks for allowing me to help in his care.

*****

ALAN TENAGLIA, MD

DD: 09/17/2014 09:48 - Job#: 4346309
DT: 09/17/2014 16:32 - mas
Doc# - 68167445

cc:
Alan Tenaglia, MD

TEST: CardioDx Studies
Collected Date & Time: 09/17/14 08:37

Result Name	Results	Units	Reference Range
Cardiodiagnostic Studies	Scottsdale		

Scottsdale Healthcare Osborn
7400 E Osborn Rd
Scottsdale, AZ 85251
(480)882-4000
IAC Accredited Echocardiography Laboratory

TransthoracicEchocardiogram
2D, M-mode, Doppler, and Color Doppler

Patient name: DAVID WEIN
Medical record number: 2164405
Account number: A1424910165
DOB: 22-Aug-1942
Age: 72 years
Gender: Male
Race: Caucasian
Study date: 16-Sep-2014
Accession number: 7346879
Height:
Weight:
BSA:
HR: 65 bpm
BP: 130/ 70

Reading Physician: Alan Tenaglia, MD
Sonographer: Mary Ruderstaller, RDCS
Attending Physician: TRAUMA, SERVICES
Ordering Physician: TRAUMA, SERVICES
Primary Physician: PCP, NONE "

Reason for study: TRAUMA Evaluate suspected pericardial effusion.

SUMMARY:

Left ventricle:
Size was normal.
Ejection fraction was estimated to be 60 %.
There were no regional wall motion abnormalities.
Wall thickness was mildly to moderately increased.
Doppler parameters were consistent with abnormal left ventricular relaxation (grade 1 diastolic dysfunction).

PROCEDURE: The study was performed in the ICU. This was a routine study. The transthoracic approach was used. The study included complete 2D imaging, M-mode, complete spectral Doppler, and color Doppler. Image quality was adequate.

LEFT VENTRICLE: Size was normal. Ejection fraction was estimated to be 60 %. There were no regional wall motion abnormalities. Wall thickness was mildly to moderately increased. DOPPLER: Doppler parameters were consistent with abnormal left ventricular relaxation (grade 1 diastolic dysfunction).

AORTIC VALVE: demonstrated mildly increased thickness.

AORTA: The visualized aortic root appears normal.

MITRAL VALVE: Valve structure was normal. There was normal leaflet separation. DOPPLER: The transmitral velocity was within the normal range. There was no evidence for stenosis. There was no regurgitation.

LEFT ATRIUM: Size was normal.

RIGHT VENTRICLE: The size was normal. Systolic function was normal. Wall thickness was normal.

PULMONIC VALVE: The visualized portions of the leaflets exhibited normal thickness, no calcification, and normal cuspal separation. DOPPLER: The transpulmonic velocity was within the normal range. There was no regurgitation.

TRICUSPID VALVE: The valve structure was normal. There was normal leaflet separation. DOPPLER: There was no evidence for stenosis. There was no regurgitation.

RIGHT ATRIUM: Size was normal.

PERICARDIUM: There was no pericardial effusion. The pericardium was normal in appearance.

SYSTEM MEASUREMENT TABLES

2D mode
AoR Diam (2D): 2.8 cm
LA Diam, 2D: 3.2 cm
IVS % Thick 2D: 28.7 %
IVS/PW Thick Ratio, 2D: 1.03
IVSd Thick, 2D: 1.29 cm
IVSs Thick, 2D: 1.66 cm
LVIDd 2D: 3.41 cm
LVIDs, 2D: 2.52 cm
LVPW % Thick, 2D: 31.2 %
LVPWd Thick 2D: 1.25 cm
LVPWs Thick, 2D: 1.64 cm
RVIDd, 2D: 2.72 cm

M mode
AV Cusp Sep, MM: 1.8 cm

Tissue Doppler Imaging
LV Med E' Vel: 5.81 cm/s

Unspecified Scan Mode
Mean PG, Ante Flow: 3 mm[Hg]
Pk PG, Ante Flow: 6 mm[Hg]
Pk Vel Ante Flow: 119 cm/s
VTI, Ante Flow: 21.5 cm
Valve Area, Pk Vel: 1.94 cm2
Valve Area, VTI: 2.32 cm2
E/E' Med Ratio: 9.3
LVOT Diam: 2 cm
LVOT Mean PG: 1 mm[Hg]
LVOT Pk PG: 2 mm[Hg]
LVOT Pk Vel: 73.7 cm/s
LVOT VTI: 15.9 cm
Decel Time, Ante Flow: 204 ms
MV A Dur: 134 ms
MV A Pk Vel, Ante Flow: 70.6 cm/s
MV E Pk Vel, Ante Flow: 53.8 cm/s
MV E/A Ratio: 0.8
RAP: 10 mm[Hg]
RVSP: 25 mm[Hg]
Pk PG, Regur Flow: 15 mm[Hg]
Pk Vel, Regur Flow: 191 cm/s

Prepared and electronically signed by

Alan Tenaglia, MD
Signed 17-Sep-2014 08:37:28

TEST: History & Physical
Collected Date & Time: 09/16/14 18:31

HISTORY AND PHYSICAL
EXAMINATION REP

SCOTTSDALE HEALTHCARE OSBORN

Patient Name:DAVID WEIN DOB: 08/22/1942
Physician: SERVICES TRAUMA ADM: 09/16/2014
Med. Rec. #: 0002164405 DIS:
Pt. Acct. #: A1424910165
Pt. Type: TRA

HISTORY AND PHYSICAL REPORT

TRAUMA NAME: SIXTWO BRAVO

DATE OF SERVICE: 09/16/2014

CHIEF COMPLAINT(S): "My chest hurts."

HISTORY OF PRESENT ILLNESS: This is a 72-year-old male that was involved in a motor vehicle crash, head-on collision. Patient was wearing a seatbelt, airbags were deployed. There was significant amount of intrusion and significant amount of damage to vehicle per EMS. This incident occurred less than an hour prior to arrival. Patient was alert, responding to questioning, complains of pain mainly left side of the chest, as well as pain in the right arm area. Patient is noted to have a large laceration in the leg. However, he does not feel much pain in that area. Patient does not recall exactly what happened to him. The pain in chest is moderate to severe

intensity compared to pain in the right arm. Pain is localized. No radiation. Denied any headache, neck pain. Denied any abdominal pain or pain in the pelvis. Denied any numbness, tingling arms or legs. Denied drinking alcohol. Says he was feeling fine prior to the incident. He said he was heading home. No other aggravating or alleviating symptoms.

PAST MEDICAL HISTORY: Hypertension, gout, borderline diabetes.

PAST SURGICAL HISTORY: Left partial nephrectomy.

ALLERGIES: Iodine.

MEDICATIONS:
1. Lisinopril.
2. Allopurinol.

SOCIAL HISTORY: Patient is married. He lives with his wife. Does not drink or smoke. Patient is retired.

FAMILY HISTORY: No significant family history.

REVIEW OF SYSTEMS: All systems are negative except the ones mentioned in HPI.

PHYSICAL EXAMINATION: A conscious well-developed, well-nourished male. HEAD: Normocephalic, atraumatic. Pupils are reactive bilaterally. Eye movements are intact. Face has no lacerations or edema. Oral mucosal is dry. NECK: No subluxation with a C-collar. CHEST: Clear to auscultation. There is abrasion over the left chest from the seatbelt. ABDOMEN: Soft, nondistended. No hernias. There is a left-sided surgical scar. Pelvis stable. MUSCULOSKELETAL: Moves all four extremities. There is a large laceration over the right knee exposing the patella; no active bleeding. Good distal pulses. No paresthesias. NEUROLOGIC: Awake, respond to questions. PSYCHIATRY appropriate. SKIN: Warm and dry. BACK: Nontender.

LABORATORY STUDIES: Glucose 145, BUN 25, creatinine 1.5, sodium 142, potassium 3.6, chloride 106, bicarb 25, white count 15.2, hemoglobin 15.2, platelets 319.

IMAGING STUDIES: CT scan of the head negative intracranial hemorrhage.

CT scan C-spine negative for fracture except for degenerative joint disease.

CT of the chest show rib fracture of right fifth and seventh ribs. No pneumothorax.

CT of the abdomen and pelvis show right rectal sheath hematoma and mesenteric hematoma.

X-ray the right ankle did not show any obvious fractures.

X-ray of the right knee did not show any obvious fractures.

HOSPITAL COURSE: Patient returned from CAT scan and was in the trauma holding area. Patient blood pressure remained systolic in the 130s throughout his stay in emergency department. Upon arrival back to the trauma holding area patient's blood pressure dropped down to systolic in 90s. I was at the bedside and explained the findings to the wife as well as the patient with concerns of bleeding in the abdomen. In addition patient complains severe pain in the chest. I explained to them that I was concerned about his hypotension either from a cardiac event or from a traumatic bleeding in the abdomen. I called for a stat echocardiogram; I spoke with Dr. Wesley Tyree, however, during the

short period patient's blood pressure dropped down to systolic in the 70s. He was started on fluids as well as packed red blood cells. His blood pressure went back up slightly. I contacted the operating room once patient was hypotensive. I explained to wife that patient would need to have urgent exploratory laparotomy with control of bleeding in the abdomen. His wife understood. Patient was then urgently taken to the operating room for exploratory laparotomy.

CLINICAL IMPRESSION:
1. Blunt head trauma/concussion, loss of consciousness.
2. Rib fractures x2.
3. Rectus sheath hematoma.
4. Right knee laceration.
5. Traumatic shock.
6. Mesenteric hematoma with bleeding.

PLAN(S): Patient taken urgently to operating room after starting with blood products. He was given one unit of packed red blood cells en route to the operating room.

Total critical care time 50 minutes.

*****

Electronically Authenticated by
9/20/2014 4:07 PM: Charles K. Hu, MD

CHARLES K. HU, MD

DD: 09/16/2014 18:31 - Job#: 4345705
DT: 09/16/2014 19:40 - dmp
RD: 09/20/2014 16:13
Doc# - 68166202

cc:
Charles K. Hu, MD
Loyd Olson..., MD

Report for WEIN, DAVID (MRN: 0002164405)

TEST: History & Physical
Collected Date & Time: 09/16/14 18:31

HISTORY AND PHYSICAL
EXAMINATION REP

SCOTTSDALE HEALTHCARE OSBORN

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Physician: SERVICES TRAUMA ADM: 09/16/2014
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Please put total critical care time 50 minutes.

*****

CHARLES K. HU, MD

DD: 09/16/2014 18:31 - Job#: 4345705
DT: 09/16/2014 19:40 - dmp
Doc# - 68166202

cc:
Charles K. Hu, MD
Loyd Olson..., MD

Report: Occupational Therapy Sort By: Time Report for WEIN, DAVID (MRN: 0002164

Start On: 09/23/2014 Go Back: 4 Days Significant Only Refresh

Hotlinks: Recommendations-Ancillary Physical Therapy

09/23/14 11:42
09/22/14 12:13
09/21/14 13:45
09/20/14 09:52
09/19/14 11:37

09/23/14 11:42 Back to Top

OT-ASSESS/PLAN	Interfrnc due to	pt refused	
	Assessment		just returned to bed. request for after lunch. will reattempt as schedule permit
OT-$CHARGES	Refusal/Interfer	no charge	
	See ProgressNote	see progres note	

09/22/14 12:13 Back to Top

OT- EVAL	Primary Language	English	
	PLOF	independent	
	Lives with	spouse	
	Home Environment	house, tub/shower	visiting AZ fami also lives in Florida
	Multi-level	1levels	
	# Stairs		0
	Home equipment	NONE	
	Pt_family goals		to eventually return home.
	R.U. Extremity Joint Evaluatn	WFL	
	R.U. Extremity Muscl/Motor Eval	WFL	
	R.U. Extremity Sensatn/Lt touch	WFL	
	R.U. Extremity Proprioception	not tested	
	R.U. Extremity UE Tone	WFL	
	R.U. Extremity GrossMotorCoordn	good	
	R.U. Extremity UE Edema	mild, moderate	
	R.U. Extremity Hand dominant	yes	
	R.U. Extremity FineMotorCoordin	good	
	R.U. Extremity Grip	4/5	
	L.U. Extermity Joint Evaluatn	WFL	
	L.U. Extermity Muscl/Motor Eval	WFL	
	L.U. Extermity Sensatn/Lt touch	WFL	
	L.U. Extermity Proprioception	not tested	
	L.U. Extermity UE Tone	WFL	
	L.U. Extermity GrossMotorCoordn	good	
	L.U. Extermity UE Edema	mild, moderate	
	L.U. Extermity FineMotorCoordin	good	
	L.U. Extermity Grip	4/5	
OT-DAILY INFO	DATE TO REASSESS	09/29/2014	
	Pt. Location	med-surg	
	Treatment day #	1	
	POD #	5	
	Precautions	fall precautions, oxygen	
			we just got to town when the

	Subjective notes		accident happened.
	OT Observations		in bed, awake, pleasant.
	Consent Obtained	yes-patient	
OT- TX STATUS	Pain location		R knee, abdomen.
	Pain scale 0-10	not rated	
	Action taken	pt satisfied	
	Orientation	alert, oriented X3, cooperative	
	Follows directn	yes	
	Memory	WFL	
	Attention span	WFL	
	Safty/Probl solv	good	
	Cognition	no	
	Bed Mobility	SBA standby asst	
	Sit to/fromStand	SBA standby asst	
	Pivot Transfer	SBA standby asst	
	Toilet Transfer	SBA standby asst	
	Tub/ShowerTransf	shower, CGA contact asst	
	FxHoushold Mobil	SBA standby asst	
	AssistiveDevicOT	FWW	
	Eating/Feeding	modified indepnd	
	Grooming	supervision	
	ToiletHygiene	moderate assist	
	UE Dressing	CGA contact asst	
	LE Dressing	moderate assist	
	UE Bathng/Shwrng	not tested	
	LE Bathng/Shwrng	not tested	
	Activity tolernc	fair	
	Sitting Static	good -	
	Sitting Dynamic	fair +	
	Standing Static	fair	
	Standing Dynamic	fair, fair -	
	Head control	good	
	Trunk control	good, fair	
	Content teaching	ADL, positioning, precautions, Adapt Equip/DME, bathroom transfr, energy conserv, fxnl house mblty	
	Performed with	patient	
	Learning Barrier	none identified	

	Method used		verbal instruct, demonstration
	Patient Response		needs reinforcem
	FineMotorCoordin	R.U. Extremity	good
	FineMotorCoordin	L.U. Extermity	good
	Grip	R.U. Extremity	4/5
	Grip	L.U. Extermity	4/5
	GrossMotorCoordn	R.U. Extremity	good
	GrossMotorCoordn	L.U. Extermity	good
	Hand dominant	R.U. Extremity	yes
	Joint Evaluatn	R.U. Extremity	WFL
	Joint Evaluatn	L.U. Extermity	WFL
	Muscl/Motor Eval	R.U. Extremity	WFL
	Muscl/Motor Eval	L.U. Extermity	WFL
	Proprioception	R.U. Extremity	not tested
	Proprioception	L.U. Extermity	not tested
	Sensatn/Lt touch	R.U. Extremity	WFL
	Sensatn/Lt touch	L.U. Extermity	WFL
	UE Edema	R.U. Extremity	mild, moderate
	UE Edema	L.U. Extermity	mild, moderate
	UE Tone	R.U. Extremity	WFL
	UE Tone	L.U. Extermity	WFL
IMPAIR/FX LIMITS	ADL's		problem
	Balance		problem
	Safety awareness		problem
	CommunityReentry		problem
	Muscle strength		problem
	Funct transfers		problem
	Activity toleran		problem
	TherapyPtntl OT		good
OT-ASSESS/PLAN	Assessment		pt did well for eval. able to mobilize but mu wait a moment f dizziness to pass during transition movements. le a ue edema limit rom needed for functional act's a this time. assiste to chair with cal light, phone, tra table in place. cont
	Assessment #2		skilled acute OT per POC.
	AppropForCOTAtoS		yes
	ADL training		treatment plan
	Functl Mobility		treatment plan
	Task tol trainng		treatment plan
			treatment

	Safety	plan	
	Pt/Caregv educ	treatment plan	
	Frequency	5x week	
	Duration	until goals met, until hospl d/c	
	Specific OTneeds		adl training, the act/ex, functiona mobility, functio safety, pt/c-give education
	Treatment plan	continue per POC	
	Recomnd/DC dispo	SNF for OT	
OT- STG	Goals w/Pt&famly	yes	
	STG-meet by	discharge	
	STG-Toilet Trnfr	modified indepnd	
	Equipment	grab bar/toilet, FWW	
	STG-Shwr/tub tfR	supervision	
	Equipment	grab bar/shower, other (note)	fww
	STG-FunctlHshold	supervision	
	Equipment	yes-describe	fww
	STG-Grooming	standing, supervision	
	Equipment	yes-describe	fww
	STG-ToiletHygien	moderate assist	
	Equipment toilet	yes-describe	fww
	STG-Dressing upp	seated, standing, modified indepnd	
	STG-Dressing lwr	seated, standing, CGA contact asst	
	Equipment	reacher, other (note)	fww
OT- LTG	LTG deferred	as per STG	
OT- $CHARGES	Inpatient visit	1# visits	
	Treatment time	45minutes	
	$OT Assessmnt15m	2 RVU	
	$ADL's	1units	
	$Therap activity	1units	

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OT- ASSESS/PLAN	Interfrnc due to	pt refused	Pt refused OT a this time, reque OT return tomorrow for skilled eval so th pt could rest.
OT- $CHARGES	Refusal/Interfer	no charge	

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OT- EVAL	Evaluation Type	initial, acute	
	OT order/s	eval and tx	
	Ordering physicn		Hu 09/16@ 184
	Admit Reason		Pt admitted as LOT s/o MVA where pt was restrained and c sustained significant intrusion
	Diagnosis		Pt dx with blunt head trauma, mesinteric hematoma, rect sheath hematon R knee laceration,and R rib fxs x2
	Pertinent PMH		HTN, Gout, L parital neph, DM
	Surgery		s/p I and D of R knee and exploratory lap mesenteric lacerations
	Date of Surgery	09/17/2014	
OT-ASSESS/PLAN	Interfrnc due to	medical issues, nursing issues	Per nursing pt j at EOB and O2 s dropped significantly and having difficulty breathing. Rapid called. Will chec back in pm as able
OT-$CHARGES	Refusal/Interfer	no charge	

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OT-DAILY INFO	Pt. Location	ICU	
OT-ASSESS/PLAN	Interfrnc due to	lethargy, other (note)	Pt just finished working with PT will follow up as time permits/pt available.
OT-$CHARGES	Refusal/Interfer	no charge	

Hotlinks: Recommendations-Ancillary Physical Therapy

Report: Physical Therapy Sort By: Time Report for WEIN, DAVID (MRN: 0002164

Start On: 09/23/2014 Go Back: 4 Days Significant Only Refresh

Hotlinks: Recommendations-Ancillary Physical Therapy

09/22/14 15:20
09/21/14 11:58
09/21/14 07:40
09/19/14 11:31

09/22/14 15:20 Back to Top

PT- DAILY INFO	Treatment Day #	4	
	POD #	4	
	DATE TO REASSESS	**10/02/2014**	
	Pt. location	med-surg	
	Tx precautions	**fall risk, oxygen**	
	Patient states		Agreeable to tx.
	Consent obtained	yes-patient	
PT- TX STATUS	Pain scale 0-10	3	
	Pain location		abd. pain
	Pain type	aching, incisionl/postop	
	Action taken	pt satisfied, pre-medicated	
	Orientatn/Behavr	alert, oriented X3, cooperative	
	Safety Awareness	fair	
	Follows dirction	yes, complex commands	
	Lines		wound vac., O2.
	O2 Sats		93% on 5L O2
	Bed Mobility	scooting, CGA contact asst	
	Supine to sit	CGA contact asst, minimal assist	w/HOB elevated.
	Sit to supine	not tested	
	Sit to Stand	CGA contact asst, verbal cues	
	Stand to sit	CGA contact asst, verbal cues	
	Pivot Transfer	CGA contact asst	
	Gait Training	CGA contact asst	
	Gait Deviations		Slow pace, step-through pattern, no LOB, mildly SOB but O2 sats. stable.
	Ambulat-distance	100ft	
	Assist device	FWW	
	Sitting Static	fair +	
	Sitting Dynamic	fair	
	Standing Static	fair	
	Standing Dynamic	fair	
	Other Activity		Bed mobility, supine > sit w/HOB elevated; sit <> stand, gait as above, up in chair @ conclusion. Call ligh handy, RN aware.
	Ex Instructed in	heel slides, Hip Abd/Add, LAQ, Hip ER, Hip IR	
	Assistnce needed	SBA standby asst	
	Repetitions perf	10	
	Content teaching	therapeut exerci, functnl mobility,	

		safety, Adapt Equip/DME	
	Performed with	patient	
	Learning Barrier	none identified	
	Method used	verbal instruct, demonstration	
	Patient Response	demonstrates, verbalizes, needs reinforcem	
PT-ASSESS/PLAN	AssessmentNotes1		Pt. tolerated significant increase in activity this date improved balance w/FWW. reports feeling mildly SOB w/activity, but O2 sats. > 90% throughout. Will progr as tolerates. Recommend acute rehab. when acute medical issues resolved.
	AppropPTAtoTreat	yes	
	Frequency	6x week	
	Duration	until hospl d/c	
	Treatment plan	continue per POC	
	Equipment recomm	not yet	
	DC Recommendatn	acute rehab3h/d	
IMPAIR/FX LIMITS	TherapyPotential	good	
PT- $CHARGES	Inpatient Visit	1# visits	
	Treatment time	42minutes	
	$Therapeutc exer	1units	
	$Gait training	1units	
	$Therapeutc Act	1units	
09/21/14 11:58 Back to Top			
PT- DAILY INFO	Treatment Day #	3	
	POD #	3	
	DATE TO REASSESS	**10/02/2014**	
	Pt. location	med-surg	
	Tx precautions	**fall risk, oxygen**	
	Patient states		I need to use the bathroon
	Consent obtained	yes-patient	
PT- TX STATUS	Pain scale 0-10	4	
	Pain location		abdominal pain
	Pain type	aching	
	Action taken	pre-medicated	
	Orientatn/Behavr	alert, oriented X3, cooperative	
	Safety Awareness	fair, unaware disblty	
	Follows dirction	complex commands	
	Lines		02
	O2 Sats		90s throughout
	Other Vitals/Obs		supine NAD
	Bed Mobility	scooting, CGA contact asst	
	Supine to sit	CGA contact asst, minimal assist	
	Sit to supine	not tested	

	Sit to Stand	minimal assist	
	Stand to sit	CGA contact asst	
	Pivot Transfer	CGA contact asst	
	Gait Training	CGA contact asst	
	Gait distance	20	20 feet to toilet and 20 fee back to bedside chair.
	Gait Deviations		decreased cadence, decreased endurance for activity.
	Assist device	FWW	
	Sitting Static	good -, fair +	
	Sitting Dynamic	fair +, fair	
	Standing Static	fair, fair -	FWW
	Standing Dynamic	fair -	FWW
	Other Activity		transfers on/off toilet with CGA and use of FWW.
	Content teaching	functnl mobility, safety	
	Performed with	patient	
	Learning Barrier	none identified	
	Method used	verbal instruct, demonstration	
	Patient Response	demonstrates, verbalizes, needs reinforcem	
PT-ASSESS/PLAN	AssessmentNotes1		Pt able to ambulate to restroom and back this date with use of FWW. Pt still limited by decreased respiratory status , with DO upon minimal activity. Pt up chair following therapeutic activity. Will cont. to follow skilled therapy intervention
	AssessmentNotes2		improve upon strength and mobility.
	AppropPTAtoTreat	yes	
	Frequency	6x week	
	Duration	until hospl d/c	
	Treatment plan	continue per POC	
	Specific PTneeds		ther ex LEs, mobilize as tolerated.
	Equipment recomm	not yet	
	DC Recommendatn	acute rehab3h/d	
IMPAIR/FX LIMITS	TherapyPotential	good	
PT- $CHARGES	Inpatient Visit	1# visits	
	Treatment time	23minutes	
	$Gait training	1units	
	$Therapeutc Act	1units	
09/21/14 07:40 Back to Top			
PT- DAILY INFO	Pt. location	med-surg	
PT-ASSESS/PLAN	AppropPTAtoTreat	yes	
PT- $CHARGES	Refusal/Interfer	no charge	
09/19/14 11:31 Back to Top			
PT- DAILY INFO	Treatment Day #	2	

	POD #	2	
	DATE TO REASSESS	**10/02/2014**	
	Pt. location	ICU	
	Tx precautions	**fall risk, oxygen**	
	Patient states		I really need to go to the bathroom
	Consent obtained	yes-patient	
PT- TX STATUS	Pain scale 0-10	4	
	Pain location		abdominal pain
	Pain type	aching	
	Action taken	pt satisfied, nurse aware, pre-medicated	
	Orientatn/Behavr	alert, oriented X3, cooperative	
	Safety Awareness	fair, unaware disblty	
	Follows dirction	yes, simple commands, complex commands	
	Lines		cardiac monitor, IV R UE, C at 2L
	Blood Pressure		170's upright
	O2 Sats		mid 90's upright
	Other Vitals/Obs		resting inbed upon PT arriv
	Bed Mobility	scooting, moderate assist	
	Supine to sit	moderate assist, w/2 assist	
	Sit to supine	moderate assist, w/2 assist	
	Sit to Stand	moderate assist	
	Stand to sit	moderate assist	
	Pivot Transfer	moderate assist	with FWW
	Sitting Static	fair	
	Sitting Dynamic	fair	
	Standing Static	fair -	
	Standing Dynamic	not tested	
	Balance Retraing		seated working on maintaining midline positior noted with standing anterio lean with cues and proddinc keep wt at midline
	Other Activity		ther ex performed bilateral LE's as below, ptup at EOB several minutes, stood x3 w FWW, transfer to bedside commode as above. Pt on commode briefly, then BTB with walker transfer with m 1
	Ex Instructed in	AP, heel slides	
	Assistnce needed	minimal	
	Repetitions perf	5	
	Content teaching	WB status, precautions, functnl mobility, safety	
	Performed with	patient	
	Learning Barrier	none identified	

	Method used	verbal instruct, demonstration	
	Patient Response	demonstrates, verbalizes, needs reinforcem	
PT-ASSESS/PLAN	AssessmentNotes1		Tolerated treatment fairly, intermittant c/o dizzyness t date with cues and proddin needed for safety throughou PT session. Pt repeated asking"when will I be norm during PT session. May ben from short rehab stay to maximize safety and functi
	AssessmentNotes2		prior to d/c home
	AppropPTAtoTreat	yes	
	Frequency	6x week	
	Duration	until hospl d/c	
	Treatment plan	continue per POC	
	Specific PTneeds		Ther ex LE's, mobilize as tolerated
	Equipment recomm	not yet	
	DC Recommendatn	acute rehab3h/d	
IMPAIR/FX LIMITS	TherapyPotential	good	
PT- $CHARGES	Inpatient Visit	1# visits	
	Treatment time	25minutes	
	$Therapeutc Act	2units	

Hotlinks: Recommendations-Ancillary Physical Therapy

Report: Speech Therapy Sort By: Time Report for WEIN, DAVID (MRN: 0002164

Start On: 09/23/2014 Go Back: 4 Days Significant Only Refresh

Hotlinks: Recommendations-Ancillary Physical Therapy

09/22/14 14:45

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ST- EVAL/DC	Evaluation Type	cog/comm, evaluation, acute	
	ST Orders	speech/lang eval, speech/lang tx	
	Ordering physic		Nancy Denke, NP
	Admit reason		72 yom s/p MVC, he on collision c significa intrusion of vehicle
	Surgery/Injury		Rib fx, CT head: Unremarkable for acu intracranial abnormalities
	Onset	09/16/2014	
	Pertinent MedHx		HTN, gout, boderline diabetes
	Primary Language	English	
	Lives with	spouse	
	HomeEnvironment	house	
	Prior level fx	no problem	Pt denies previous speech deficits. Lives with spouse, pt manages finances.
	Pt_family goals		To return home and PLOF
	Precaution	safety-as per Dx	
ST-DAILY INFO	DATE TO REASSESS	10/06/2014	
	Pt. Location	med-surg	
	Precaution	safety-as per Dx	
	Subjective notes		Patient seen at bedsi pleasant and cooperative.
	Consent obtained	yes-patient	
	Report-Fx Limits		No complaints
	Performed with	patient	
	Learning Barrier	none identified	
	Method used	verbal instruct, demonstration, handout/homecare	
	Patient Response	verbalizes	
ST- TX STATUS	Status-Auditory	WFL	
	Highest Fx level	conversation, simple/concrete	
	Status-Reading	not tested	
	Status-Language	WFL	
	Highest Fx Level	conversation, simple/concrete	
	Status-Writing	not tested	
	Status-Speech	WFL	
	Oral/motor funct	WFL	
	Intelligibility	good, conversation	
	Status-Voice	WFL	

	Voice quality	WFL	
	Voice-Level	conversation	
	Status-Swallowin	not tested	
	Attention	sustained, good	Serial 7's reverse: 100%, auditory attention: 100%
	Orientation	person, place, time, situation, 100%	Using board in room
	Safety/Prob solv	WFL	Fxnl math: 100%
	Highest Fx level	moderate	
	Reasoning	WFL	3 reasons given situation, sim/diff: 100%
	Highest Fx level	moderate	
	Thought organiza	WFL	/s/: 20 wpm
	Highest Fx level	moderate	
	Immediate memory	WFL	Sentence: 100%
	Recent memory	minimal	2/5 items p 5' distractor independer 5/5 with min cues
	Skilled tests	MontrCognAssessm	27/30
	Consent obtained	yes-patient	
ST-ASSESSMENT	Assessment 1		Patient presents c m deficits in STM, gross WFL for other areas c cog/com as demonstrated by 27/ on MoCA. Patient reports that his speed processing seems "slower" than normal
	Assessment 2		ST to f/u to ensure p at baseline and work STM. May need short rehab stay pending PT/OT recs. Intermitt supervision.
ST- STG	STG Date by:	10/06/2014	
	Goal-Recnt memry	3 piece info, 5 minute, distractor	memory strategies
	Other #1 Goal-additional		assess higher level cog/com
ST- LTG	LTG meet by	discharge	
	Funct Communica	conversation	
	CogCom Abilites	indepen living	
	Speech intellgb	conversation	
ST- PLAN OF CARE	Cognition	treatment plan	
	Frequency	5x week	
	Duration	until goals met	
	Specific ST Need		cog/com tx
ST- DC PLANNING	Rehab Potential	excellent	
	Pt/Caregivr educ	demo-self practc, demo-compensatn	
	Recommend DCPlan	home-family, acute rehab3h/d	
ST-$CHARGES	Initial visit	done	
	Inpt visit- ST	1# visits	

Treatment time	27minutes
$EvalSpeechLng30	3 RVU

Hotlinks: Recommendations-Ancillary Physical Therapy

Report for WEIN, DAVID (MRN: 0002164405)

TEST: MAGNESIUM
Collected Date & Time: 09/23/14 08:18

TEST: PHOSPHORUS, SERUM
Collected Date & Time: 09/23/14 08:18

TEST: METABOLIC PANEL, BASIC
Collected Date & Time: 09/23/14 08:18

TEST: CHEST PA LAT
Collected Date & Time: 09/23/14 07:25

Associate Results with Clinical Quality Measures

Pneumonia Diagnostic study findings
- consistent with pneumonia
- not applicable
- not applicable/negative

Save

Result Name	Results	Units	Reference Range
CHEST PA LAT	*** Prelim(..)		

*** Preliminary Report ***

CHEST PA LATERAL 09/23/2014, 0718 HOURS

COMPARISON
Chest radiograph 09/21/2014 and 09/20/2014.

FINDINGS
Compared with 09/21/2014 there is substantially improved aeration in the right lung base with almost complete resolution of right basilar atelectasis. There continues to be a tiny right pleural effusion.

Small left pleural effusion and left basilar atelectasis or infiltrate has not changed significantly.

There are no new or worsening pulmonary infiltrates. There is no pneumothorax. The heart size, pulmonary vascularity, and mediastinal contour remain normal.

The right-sided rib fractures seen on prior CT are not well visualized on today's chest radiograph.

IMPRESSION
1. Improved aeration in the right lung base.
2. No change in small left pleural effusion or left basilar atelectasis/infiltrate.

DD: 09/23/2014 07:39 - Job#: 4354388

DT: 09/23/2014 11:32 - zpr
Doc# - 68174639

cc: Nancy Denke, FNP-C;

READ BY: JOHN M NEIL, MD
SIGNED BY:
SIGNED DATE/TIME:

TEST: CBC, AUTOMATED (PLATELET & DIFF)
Collected Date & Time: 09/23/14 06:06

Result Name	Results	Units	Reference Range
WBC	8.5	x(10)3/uL	4.5-10.0
RBC	4.04 L	x(10)6/uL	4.60-6.20
Hemoglobin	12.4 L	gram/dL	14.0-18.0
Hematocrit	36.5 L	%	40.0-55.0
MCV	90.4 H	fL	80.0-90.0
MCH	30.7	pg	27.0-31.0
RDW	14.8 H	%	11.5-14.5
PLT	317.0	x(10)3/uL	140-440
Neutrophil	72.2	%	
Lymphocyte	16.0	%	
Monocyte	7.8	%	
Eosinophil	3.4	%	
Basophil	0.7	%	
Neutrophil Abs.	6.12	x(10)3/uL	2.25-7.00
Lymp Absolute	1.35	x(10)3/uL	0.90-4.00
Monocyte Abs.	0.66	x(10)3/uL	0.00-1.10
Basophil Abs.	0.06	x(10)3/uL	0.00-0.30

The above 20 analytes were performed by Scottsdale Healthcare Laboratory Osborn
Scottsdale Healthcare,7400 East Osborn Road,SCOTTSDALE,AZ 85251

Eosinophil Absol	0.29	x(10)3/uL	0.00-0.60
MCHC	34.0	gram/dL	32.0-36.0
HDW	2.8	gram/dL	0.0-4.5
