

WK Medical Center
2600 Greenwood Road
Shreveport, LA 71103

Emergency Department Note
Signed

Patient: JOHNSON,JAMES W
DOB: 10/17/1960
Age/Sex: 62 / M
Loc: ER
Attending Dr:

MR#: D000038768
Acct:W10084184976
ED ADM Date: 08/05/23
ED DIS Date:

cc: ~

HPI - Back Pain/Injury

General

Chief Complaint: Chest Pain

Stated Complaint:

BACK PAIN

Time Seen by Provider: 08/06/23 01:29

Source: patient, EMS and RN notes reviewed

Mode of arrival: EMS

Limitations: no limitations

History of Present Illness

HPI Narrative:

REVIEW EMS REPORT. 62 Y/O M PRESENTS TO THE ED CC R LOW BACK PAIN X TODAY. PT FELL AT GROUND LEVEL WHILE WALKING ON THE SIDEWALK. PT USES A CANE TO WALK. PT HAS A HX OF 2 BACK SURGERIES. PT IS NOT ON ANY PAIN MEDICATIONS. PT IS A SMOKER.

MD elicited complaint: back pain

Pertinent past history: back surgery

Onset (ago): hour(s)

Timing: constant

Severity: moderate

Similar Symptoms Previously: Yes

Quality: aching

Location: right lower back

Radiation: none

Exacerbating factors: none

Context: fall

Associated symptoms: Yes denies other symptoms

Related Data

Previous Rx's

Medication	Instructions	Recorded
valsartan 40 mg tablet	40 mg ORAL 1XDAY #30 tabs	05/19/23
albuterol sulfate 90 mcg/actuation aerosol inhaler (ProAir HFA)	90 puff INHALED Q4H PRN shortness of breath or wheezing #6 grams	06/22/23
amlodipine 5 mg tablet	5 mg ORAL 1XDAY #30 tabs	06/22/23
aspirin 81 mg tablet,delayed release	81 mg ORAL 1XDAY #0 tabs	06/22/23
atorvastatin 20 mg tablet	40 mg ORAL BEDTIME #60 tabs	06/22/23
clopidogrel 75 mg tablet	75 mg ORAL 1XDAY #30 tabs	06/22/23
diazepam 5 mg tablet	10 mg ORAL BEDTIME PRN sleep #14 tabs	06/22/23

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2

Patient name: JOHNSON,JAMES W

Account #: W10084184976

furosemide 20 mg tablet	20 mg ORAL 1XDAY #30 tabs	06/22/23
magnesium oxide 400 mg (241.3 mg magnesium) tablet (MagOx)	400 mg ORAL 2XDAY #60 tabs	06/22/23
methocarbamol 750 mg tablet	750 mg ORAL Q8H PRN pain #20 tabs	06/22/23
pantoprazole 40 mg tablet, delayed release	40 mg ORAL 1XDAY #30 tabs	06/22/23
potassium chloride 20 mEq tablet, extended release (part/cryst)	20 meq ORAL 1XDAY #30 tabs	06/22/23
oxycodone-acetaminophen 7.5 mg-325 mg tablet (Percocet)	1 tab ORAL 3XDAY PRN pain (scale score 7-10) #10 tabs	06/23/23
albuterol sulfate 90 mcg/actuation aerosol inhaler	1 inh INHALED 4XDAY PRN shortness of breath or wheezing #6.7 grams	06/30/23
tizanidine 4 mg capsule (Zanaflex)	4 mg ORAL 3XDAY PRN muscle spasticity #20 caps	06/30/23
benzonatate 200 mg capsule	200 mg ORAL 4XDAY PRN cough #20 caps	07/03/23
ipratropium bromide 17 mcg/actuation HFA aerosol inhaler (Atrovent HFA)	1 puff INHALED 4XDAY #12.9 grams	07/03/23
theophylline 200 mg capsule, extended release 24 hr	200 mg ORAL 2XDAY #30 caps	07/03/23
carvedilol 25 mg tablet	25 mg ORAL 2XDAY #60 tabs	07/27/23
finasteride 5 mg tablet	5 mg ORAL BEDTIME #30 tabs	07/27/23
hyoscyamine sulfate 0.125 mg sublingual tablet	0.125 mg SUBLINGUAL 4XDAY PRN abdominal pain #20 tabs	07/27/23
levofloxacin 500 mg tablet	500 mg ORAL 1XDAY #5 tabs	07/27/23
metronidazole 500 mg tablet	500 mg ORAL 2XDAY #10 tabs	07/27/23
tamsulosin 0.4 mg capsule	0.8 mg ORAL 1XDAY@1800 #30 caps	07/27/23
meloxicam 15 mg tablet	15 mg ORAL 1XDAY #30 tabs	08/06/23
methocarbamol 500 mg tablet	500 mg ORAL 3XDAY PRN MUSCLE SPASM #20 tabs	08/06/23

Allergies

Allergy/AdvReac	Type	Severity	Reaction	Status	Date / Time
morphine	Allergy	Severe	Hives	Verified	07/26/23 21:36
Sulfa (Sulfonamide Antibiotics)	Allergy	Intermediate	Blister	Verified	07/26/23 21:36

ROS

Status of ROS

10 or more systems reviewed and unremarkable except in HPI and below

Const.

Constitutional: Denies: fever(s), chills, change in weight or night sweats

Head

Denies: headache and Denies: head injury

Eyes

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3

Patient name: JOHNSON, JAMES W

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Denies: blind spots, eye discomfort, blurred vision, diplopia, discharge, dryness, itching, loss of vision, pain, photophobia, redness or swelling

Ears

Denies: discharge, hearing impairment, loss of balance, pain, ringing or tinnitus

Nose

Denies: epistaxis or rhinorrhea

Mouth

Denies: dryness of mouth, Denies: lesion, Denies: ulcer, Denies: mouth pain and Denies: tooth pain

Throat

Denies: dysphagia or sore throat

Neck

Denies: mass, Denies: neck stiffness, Denies: neck pain and Denies: swelling

Cardio

Denies: chest pain, Denies: palpitations, Denies: edema and Denies: syncope

Breast

Denies: breast pain and Denies: breast swelling

Resp.

Denies: dyspnea, Denies: cough, Denies: stridor, Denies: pain on inspiration, Denies: change in phlegm color, Denies: hemoptysis and Denies: snoring

GI

Denies: abdominal pain, nausea, vomiting, diarrhea, constipation or hematemesis

Rectum & Anus

Denies pain or rectal swelling

GU

Denies: dysuria, Denies: urinary frequency and Denies: hematuria

Musculoskeletal

Reports: back pain;

Denies: myalgia

Peripheral Vascular

Denies extremity coldness, Denies extremity numbness and Denies claudication

Neuro

Denies: headache(s), change of speech, dizziness, memory difficulty or difficulty walking

Psych

Denies: anxiety, suicidal ideation, homicidal ideation, depression or hallucination

Endocrine

Denies: fatigue

Allergic & Immuno

Denies: wheezing

PFSH

PFSH

Medical History (Reviewed 08/06/23 @ 02:15 by Reaghen Jones)

Amphetamine abuse

Amphetamine abuse

CHF (congestive heart failure)

Chronic back pain

COPD (chronic obstructive pulmonary disease)

CVA (cerebral vascular accident)

GERD (gastroesophageal reflux disease)

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4

Patient name: JOHNSON, JAMES W

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Herpes simplex

HFrEF (heart failure with reduced ejection fraction)

History of myocardial infarction

HLD (hyperlipidemia)

Hypertension

Loosening of hardware in spine

Myocardial infarction

Noncompliance

Noncompliance

Reduced ejection fraction concurrent with and due to acute on chronic heart failure

Tachycardia

Tobacco dependence

Surgical History (Reviewed 08/06/23 @ 02:15 by Reaghen Jones)

H/O angioplasty

History of back surgery

History of inguinal hernia repair

History of PTCA

Hx of CABG

S/P CABG (coronary artery bypass graft)

S/P cholecystectomy

S/P hernia repair

Family History (Reviewed 08/06/23 @ 02:15 by Reaghen Jones)

Father Deceased

Heart disease

Mother Deceased

Heart disease

Social History (Reviewed 08/06/23 @ 02:15 by Reaghen Jones)

Lives With: Significant Other/ Support Person

Community/Outpatient services: None

What is your current living situation: I presently have a place to live

Are you now married, widowed, divorced, separated, never married or living with a partner: divorced

Known occupational exposures/hazards: No

Highest Level of Education: Bachelor's Degree

Physical activity type: None

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?: 0

Leisure activities: None

Smoking Status: Current every day smoker

What nicotine containing products do you use/have you used?: Cigarettes Smoking packs per day: 2 Smoking cigarettes per day: 40.0 Years smoked: 40 Smoking pack-years: 80.00 Smoking quit date/years: <= 15 years ago

Nicotine containing products detail: Marlboro

Emergency Department 0806-00022

Additional copy:

Job Number:

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Second hand tobacco smoke exposure: No

How often do you have a drink containing alcohol?: Monthly or less Alcohol type: hard liquor

How many standard drinks containing alcohol do you have on a typical day?: 1 or 2

How often do you have six or more drinks on one occasion?: Less than monthly

AUDIT-C Alcohol total score: 2

Non-Prescribed Substance Use: Denies Use

Non-Prescribed Substance Use Details: md charting suggest otherwise. plz see md charting.

Caffeine: Yes

Does Your Home Environment Cause You Fear, Pain, or Injury: Denies

Have You Recently Felt Abused, Taken Advantage of, or Neglected?: Denies

Little interest or pleasure in doing things: not at all

Feeling down, depressed, or hopeless: not at all

Feel stressed/tense/nervous/anxious/difficulty sleeping: not at all

Life Stressors: Financial Matters

Due to Disability, Difficulty Making Decisions: No

Exam

Const

Attestation: Documenting provider has reviewed patient's vital signs

Exam limitations: No altered mental status

General appearance: cooperative;

No well kempt

Orientation/consciousness: awake, oriented to person, oriented to place and oriented to time

HENMT

Head and scalp: normal to inspection and normocephalic

Ear: external ears normal and TM's normal bilaterally

Mouth: Normal oral and palatal mucosa present and tonsils normal

Eye

General: appearance normal, both eyes and all related structures, normal light reflex and Equal, round and reactive pupils present;

No EOM abnormal

Vision: acuity normal

Direct Ophthalmoscopy: normal light reflex

Neck & C-Spine

General: trachea midline

Thyroid: Thyroid normal;

no masses

Cervical spine: cervical ROM normal;

No Cervical spine tenderness

Chest

Chest: No Pacemaker present

Respiratory

Effort & inspection: normal and able to speak in complete sentences

Auscultation: clear to auscultation bilaterally;

no wheezes

Percussion: percussion normal

Cardio

Rate/Rhythm: regular rate and regular rhythm;

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Additional copy:

Job Number:

WIK

6

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No bradycardic, No tachycardic and No abnormal rhythm

GI

Inspection: normal to inspection

Auscultation: normoactive bowel sounds

Palpation: Soft to palpation;

non-tender, No Guarding due to palpation present (GI), No Hepatosplenomegaly present, no ascites present and no rebound tenderness present

Percussion: normal to percussion

Back & Pelvis

General back: paraspinal muscle tenderness (MILD R LUMBAR) and tenderness paraspinal muscle tenderness (MILD R LUMBAR) and lumbar paraspinal muscle tenderness (MILD R)

Lumbar spine/lower back: paraspinal muscle tenderness (MILD R) and straight leg raise negative bilaterally;

abnormal to inspection (WELL HEALED LUMBAR SX LUMBAR SCARS)

Extremity/Vascular

General: No calf tenderness, No cyanosis, No edema and No tenderness

Peripheral pulses: radial pulses present and dorsalis pedis present

Neuro

Sensorium/orientation: awake, oriented to person, oriented to place and oriented to time

Cranial Nerves: Cranial nerves II - XII intact

Speech: speech normal

Gait: Unable to assess gait

Deep tendon reflexes: Right patellar reflex intensity grade: 1+ and Left patellar reflex intensity grade: 1+

Psych

Appearance: unkempt;

No well kempt

Attitude: calm

Activity/motor behavior: appropriate eye contact

Speech: incoherent (MUMBLED);

No normal speech

Thought content: Normal thought content present

Memory/cognition: memory grossly intact

Insight: Good insight present (Psych)

Judgement: Good judgement present (Psych)

Skin

General skin exam: elasticity normal, turgor normal and scars surgical (LUMBAR) and well-healed; no erythema, no excoriation(s), no jaundice and no mottling

Rashes: No rashes noted

Course

Vital Signs

Vital signs:

Vital Signs

Temp	Pulse	Resp	BP	Pulse Ox	O2 Del Method	O2 Flow Rate
97.2 F	102 H	18	134/82	97	Room Air	0

Emergency Department 0806-00022

Additional copy:

Job Number:

WIK

7

Patient name: JOHNSON, JAMES W

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08/05/23 22:56	08/05/23 22:56	08/05/23 22:56	08/05/23 22:56	08/05/23 22:56	08/05/23 22:56	08/05/23 22:56
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Temperature:(F or C)	97.2 F	08/05/23 23:05
Pulse Rate	91	08/06/23 02:01
Respirations	19	08/06/23 02:01
Blood Pressure	149/73 H	08/06/23 01:45
O2 Saturation	98	08/06/23 01:45
O2 Delivery Method	Room Air	08/05/23 23:05
Oxygen Flow Rate	0	08/05/23 23:05
FiO2	0	08/05/23 23:03

MDM - Back Pain/Injury

MDM Narrative

Medical decision making narrative:

SCRIBE ATTESTATION: SAW THE PATIENT WITH SCRIBE. AGREE THAT DOCUMENTATION WAS CHARTED IN MY PRESENCE AND IS BOTH COMPLETE AND ACCURATE.

PATIENT APPEARS POSSIBLY HOME WAS INITIALLY CHECKED IN WITH CHEST PAIN. ON MY HISTORY HE IS ASLEEP CURLED UP WALKING WITH A CANE. AND COMPLAINS OF LOW BACK PAIN MORE ON THE RIGHT. HE HAS HAD BACK SURGERY WITH HARDWARE PLACED INFUSION X2 . EKG REVIEWED NORMAL SINUS RHYTHM WITH NO ECTOPY NO BLOCKS NO ST ELEVATION NORMAL AXIS

TROPONIN WAS. BORDERLINE BUT WAS REPEATED WAS BASICALLY THE SAME. LUMBAR SACRAL SPINE FILMS SHOWED. THE HARDWARE IN PLACE IN GOOD POSITION WILL START PATIENT ON SOME MEDICINE FOR HIS BACK AND RECOMMENDED THE STOP SMOKING AND FOLLOW UP WITH HIS BACK. DOCTOR

ALL LABORATORY EKG IMAGING STUDIES AND ALL RECORDS INDEPENDENTLY INTERPRETED BY ME
Lab Data

4.1 12.0L 204
35.6L

08/05/23 23:50

144 111H 15 99
3.6 24 1.14

08/05/23 23:50

Labs:

Lab Results

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Additional copy:

Job Number:

WIK
 Patient name: JOHNSON,JAMES W
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8

	08/05/23 23:50	08/06/23 02:36	Range/Units
WBC	4.1		(3.1-9.7) 10E3/uL
RBC	4.00 L		(4.08-5.70) 10E6/uL
Hgb	12.0 L		(13.1-16.8) g/dL
Hct	35.6 L		(38.2-48.4) %
MCV	89.0		(81.4-98.5) fL
MCH	29.9		(27.1-34.2) pg
MCHC	33.7		(31.7-35.2) g/dL
RDW	15.2		(12.3-16.3) %
Plt Count	204		(130-351) 10E3/uL
MPV	7.0		(6.6-10.2) fL
Neut % (Auto)	41.6		(40.6-75.3) %
Lymph % (Auto)	35.6		(16.1-45.7) %
Mono % (Auto)	14.4 H		(3.7-12.2) %
Eos % (Auto)	6.5 H		(0.0-6.3) %
Baso % (Auto)	1.9 H		(0.1-1.3) %
Neut # (Auto)	1.7		(0.9-7.4) 10E3/uL
Lymph # (Auto)	1.5		(0.9-3.3) 10E3/uL
Mono # (Auto)	0.6		(0.2-0.9) 10E3/uL
Eos # (Auto)	0.3		(0.0-0.5) 10E3/uL
Baso # (Auto)	0.1		(0.0-0.1) 10E3/uL
Sodium	144		(137-145) mmol/L
Potassium	3.6		(3.5-5.1) mmol/L
Chloride	111 H		(98-107) mmol/L
Carbon Dioxide	24		(21-32) mmol/L
Anion Gap	9.0		(5.0-15.0) mmol/L
BUN	15		(7-20) mg/dL
Creatinine	1.14		(0.66-1.25) mg/dL
Est GFR (CKD-EPI)	72.7		(>60) SeeBelow
Glucose	99		(70-109) mg/dL
Calcium	9.5		(8.4-10.2) mg/dL
Total Bilirubin	0.4		(0.2-1.3) mg/dL
Direct Bilirubin	0.2		(0.0-0.4) mg/dL
AST	33		(3-45) U/L
ALT	35		(0-50) U/L
Alkaline Phosphatase	91		(38-126) U/L
Troponin I	0.037 H	0.044 H	(0-0.034) ng/mL
B-Natriuretic Peptide	236 H		(15-100) pg/mL
Total Protein	7.0		(6.3-8.2) g/dL
Albumin	4.1		(3.5-5.0) g/dL

Discharge Plan

Discharge

Service Date/Time: 08/05/23 22:56

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WIK

9

Patient name: JOHNSON,JAMES W
Account #: W10084184976

ED Provider: Dillon,Brian Thomas

Patient Disposition: Home

Clinical Impression:
Back pain, Fusion of lumbar spine

Patient Education: Back Exercises, Easy-to-Read, Chronic Back Pain, Easy-to-Read

Referrals/Follow-Up:
Care Provider, OLSU Primary [Primary Care Provider] - Next Business Day

Stand Alone Forms: Discharge Handout Stoplight, myWK Portal Instructions

Discharge Orders:
Discharge Order (Routine); Ordered 08/06/23
Ordered By: Brian Thomas Dillon

Discharge Medications:

New

methocarbamol 500 mg tablet

500 mg ORAL 3XDAY PRN (Reason: MUSCLE SPASM) Qty: 20 0RF

meloxicam 15 mg tablet

15 mg ORAL 1XDAY Qty: 30 0RF

No Action

atorvastatin 20 mg Tablet

40 mg ORAL BEDTIME Qty: 60 6RF

diazepam 5 mg Tablet

10 mg ORAL BEDTIME PRN (Reason: sleep) Qty: 14 0RF

aspirin 81 mg Tablet, Delayed Release (Dr/Ec)

81 mg ORAL 1XDAY Qty: 0 0RF

magnesium oxide [MagOx] 400 mg (241.3 mg magnesium) Tablet

400 mg ORAL 2XDAY Qty: 60 6RF

pantoprazole 40 mg Tablet, Delayed Release (Dr/Ec)

40 mg ORAL 1XDAY Qty: 30 2RF

furosemide 20 mg Tablet

20 mg ORAL 1XDAY Qty: 30 6RF

potassium chloride 20 mEq Tablet, Er Particles/Crystals

20 meq ORAL 1XDAY Qty: 30 6RF

clopidogrel 75 mg tablet

75 mg ORAL 1XDAY Qty: 30 0RF

amlodipine 5 mg Tablet

5 mg ORAL 1XDAY Qty: 30 3RF

methocarbamol 750 mg tablet

750 mg ORAL Q8H PRN (Reason: pain) Qty: 20 0RF

albuterol sulfate [ProAir HFA] 90 mcg/actuation Hfa Aerosol Inhaler

90 puff INHALED Q4H PRN (Reason: shortness of breath or wheezing) Qty: 6 2RF

Emergency Department 0806-00022

Additional copy:

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WIK

10

Patient name: JOHNSON,JAMES W

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albuterol sulfate 90 mcg/actuation HFA aerosol inhaler

1 inh INHALED 4XDAY PRN (Reason: shortness of breath or wheezing) Qty: 6.7 0RF

tizanidine [Zanaflex] 4 mg capsule

4 mg ORAL 3XDAY PRN (Reason: muscle spasticity) Qty: 20 0RF

hyoscyamine sulfate 0.125 mg Tablet, Sublingual

0.125 mg SUBLINGUAL 4XDAY PRN (Reason: abdominal pain) Qty: 20 0RF

carvedilol 25 mg Tablet

25 mg ORAL 2XDAY Qty: 60 6RF

Rx Instructions:

HOLD IF HR< 55

tamsulosin 0.4 mg Capsule

0.8 mg ORAL 1XDAY@1800 Qty: 30 6RF

levofloxacin 500 mg tablet

500 mg ORAL 1XDAY Qty: 5 0RF

metronidazole 500 mg tablet

500 mg ORAL 2XDAY Qty: 10 0RF

finasteride 5 mg tablet

5 mg ORAL BEDTIME Qty: 30 0RF

oxycodone-acetaminophen [Percocet] 7.5-325 mg tablet

1 tab ORAL 3XDAY PRN (Reason: pain (scale score 7-10)) Qty: 10 0RF

valsartan 40 mg Tablet

40 mg ORAL 1XDAY Qty: 30 3RF

Rx Instructions:

HOLD if upper BP is below 110

Atrovent HFA 17 mcg/actuation HFA aerosol inhaler

1 puff INHALED 4XDAY Qty: 12.9 4RF

benzonatate 200 mg capsule

200 mg ORAL 4XDAY PRN (Reason: cough) Qty: 20 0RF

theophylline 200 mg capsule,extended release 24hr

200 mg ORAL 2XDAY Qty: 30 0RF

Interventions:

ED Discharge Assessment Last Done: 08/06/23 04:09

Discharge Date/Time: 08/06/23 04:11

Dictated By: Dillon, Brian Thomas, M.D.

Signed By: <Electronically signed by Brian Thomas Dillon, M.D.>

08/06/23 0640

DD/DT: 08/06/23 0205

TD/TT: 08/06/23 0205

Transcriptionist: RJ

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