Name: Vickie L Berry | DOB: 3/1/1953 | MRN: 1017097 | PCP: Olusina Akande, MD | Legal Name: Vickie L Berry

CRITICAL CARE

Parkview Health

Results

Tyler G Johnson, DO 3/17/2016 10:12 AM

History

Chief Complaint
Patient presents with
• Aphasia
Right side weakness with speech difficulty that husband noticed at 0610 this morning.

HPI

Vickie Berry is a 63 y.o. female had concerns including Aphasia.

(Location, Quality, Severity, Duration, Timing, Context, Modifier, Associated Sx (4))

Patient is with strokelike symptoms to limits per hospital patient's time of onset was reported as 6:10 AM. The patient's husband was with her. The patient was discussed over the phone with Doctor BRUNK the patient presented to their department with a dysphasia and it appears from records right-sided weakness although was initially reported as left-sided weakness. The patient states she was able to remember everything that is happening she did trouble moving her right side all of her symptoms resolved in route she did receive TPA at the outlying facility her blood pressure has been normal she denies any headache. She denies any new symptoms. She denies any history of stroke she denies any recent bleeding she denies any recent trauma she denies any history of intracranial mass.

Past Medical History
Diagnosis Date
• Hypertension

• History of hypercholesterolemia
• History of depression

No past surgical history on file.

No family history on file.

History
Substance Use Topics
• Smoking status: Not on file
• Smokeless tobacco: Not on file
• Alcohol Use: Not on file

No Known Allergies

Previous Medications
No medications on file

Review of Systems

Constitutional: Denies fever or chills
Eyes: Denies change in visual acuity or discharge
HENT: Denies nasal congestion or sore throat
Respiratory: Denies cough or shortness of breath
Cardiovascular: Denies chest pain or edema
GI: Denies abdominal pain, nausea, vomiting, diarrhea, or bloody stools
GU: Denies dysuria or flank pain
Musculoskeletal: Denies back pain or joint pain
Integument: Denies rash or wounds
Neurologic: Denies headache
Endocrine: Denies polyuria or polydipsia
Lymphatic: Denies swollen glands
Psychiatric: Denies depression or anxiety

Except as documented in the HPI, all other systems are negative.

Physical Exam
BP 118/89 mmHg | Pulse 79 | SpO2 100%

Physical Exam

General: WELL appearing, NO apparent distress
Eyes: PERRL, NO erythema, NO eye discharge, NORMAL lids, NON-icteric
ENT: NORMAL external inspection, NO nasal discharge, NORMAL MOIST mucosa

Neck: SUPPLE, NO JVD, NO masses, MIDLINE trachea
Pulm: NORMAL effort, EQUAL breath sounds bilaterally, NO rales, NO rhonchi, NO wheezes
CV: RRR, NO murmur, rubs, or gallops, NO peripheral edema
GI: NORMAL Bowel sounds, Soft, NONdistended, NONtender, NO organomegaly, NO hernia, NO mass

Back: NON-tender, NO scoliosis, NO CVA tenderness
Ext: pulses FULL & EQUAL, capillary refill < 2 sec, NO joint swelling, NO extremity tenderness
Skin: WARM, DRY, NO noted lesions or rash
Neurology: ALERT, NO gross motor deficits, NO gross sensory deficits, normal face, and oriented x3, normal proprioception, normal visual fields, normal extraocular movements, normal shoulder shrug, normal repetition normal object recognition
Psych: APPROPRIATE

ED Course
Critical Care
Performed by: JOHNSON, TYLER G
Authorized by: JOHNSON, TYLER G
Total critical care time: 45 minutes
Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: CNS failure or compromise.
Critical care was time spent personally by me on the following activities: discussions with consultants, discussions with

primary provider, examination of patient, ordering and review of radiographic studies, ordering and performing treatments and interventions, re-evaluation of patient's condition, pulse oximetry and ordering and review of laboratory studies.

LABS
Labs Reviewed - No data to display

IMAGING
No results found.

MDM

In reviewing the patient's records from Logan to her we are trying to resolve some discrepancies in the patient's timeline. Report from here transport with it she still had some minor symptoms are resolved in route with speech but was moving extremities documentation from there states that her symptoms resolved prior to the emergency department although report over the phone myself in discussion with the other physician was the patient had weakness present in facial droop and speech aphasia. The patient they were calling for recommendations on TPA. Not feel comfortable doing this over the phone and recommended that the physician using her own guidelines and neurology services.

The patient will be placed in ICU here with neurology Doctor Bhat and Doctor Zehr were discussed.

The primary encounter diagnosis was Aphasia. Diagnoses of Facial paralysis on right side, Right arm weakness, and Cerebrovascular accident (CVA), unspecified mechanism were also pertinent to this visit.

This documentation was created with voice recognition software. If you have any questions or concerns about the documentation please contact me.

Ordering provider: Tyler Johnson, DO
Result date: Mar 17, 2016 10:12 AM
Result status: Final