Note ID: 13180007-DS-20

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Extracted Information

1. ADMISSION LABS

1. ADMISSION LABS: • 06:35AM BLOOD: • WBC-5.4 • RBC-2.92* (ref range not provided) • Hgb-7.6* (ref range not provided) • Hct-24.3* (ref range not provided) • MCV-83 (ref range not provided) • MCH-26.0 (ref range not provided) • MCHC-31.3* (ref range not provided) • RDW-15.9* (ref range not provided) • RDWSD-47.8* (ref range not provided) • Plt [REDACTED] • 06:35AM BLOOD: • Glucose-164* (ref range not provided) • UreaN-51* (ref range not provided) • Creat-2.9* (ref range not provided) • Na-140 (ref range not provided) • K-4.6 (ref range not provided) • Cl-99 (ref range not provided) • HCO3-25 (ref range not provided) • AnGap-16* (ref range not provided) • 02:45AM BLOOD: • ALT-15 (ref range not provided) • AST-24 (ref range not provided) • AlkPhos-115 (ref range not provided) • TotBili-0.2* (ref range not provided) • 06:35AM BLOOD: • Calcium-8.4* (ref range not provided) • Phos-6.0* (ref range not provided) • Mg-2.1* (ref range not provided) • 03:45AM BLOOD: • Beta-OH-<0.2 (ref range not provided) • 02:45AM BLOOD: • ASA-NEG (ref range not provided) • Ethanol-NEG (ref range not provided) • Acetmnp-NEG (ref range not provided) • Tricycl-NEG (ref range not provided) • 02:54AM BLOOD: • pO2-99 (ref range not provided) • pCO2-62* (ref range not provided) • pH-7.19* (ref range not provided) • calTCO2-25* (ref range not provided) • Base XS--5* (ref range not provided) • Intubat-INTUBATED (ref range not provided) • 03:53AM BLOOD: • Glucose-468* (ref range not provided) • Creat-3.9* (ref range not provided) • Na-132* (ref range not provided) • K-6.2* (ref range not provided) • Cl-95* (ref range not provided) • calHCO3-26* (ref range not provided) • 03:53AM BLOOD: • Hgb-8.1* (ref range not provided) • calcHCT-24 (ref range not provided) • O2 Sat-52* (ref range not provided) • 04:34AM BLOOD: • O2 Sat-93* (ref range not provided) • 08:27AM BLOOD: • Lactate-0.9* (ref range not provided) • K-4.8* (ref range not provided)

2. Pertinent Results

2. Pertinent Results: * ADMISSION LABS: + 06:35 AM: - Blood: - WBC: 5.4 - RBC: 2.92 - Hgb: 7.6 - Hct: 24.3 - MCV: 83 - MCH: 26.0 - MCHC: 31.3 - RDW: 15.9 - RDWSD: 47.8 - Plt: [REDACTED] - Blood Glucose: 164 - UreaN: 51 - Creat: 2.9 - Na: 140 - K: 4.6 - Cl: 99 - HCO3: 25 - AnGap: 16 + 02:45 AM: - Blood ALT: 15 - Blood AST: 24 - Blood AlkPhos: 115 - Blood TotBili: 0.2 + 06:35 AM: - Blood Calcium: 8.4 - Phos: 6.0 - Mg: 2.1 + 03:45 AM: - Blood Beta-OH: <0.2 + 02:45 AM: - Blood ASA: NEG - Ethanol: NEG - Acetmnp: NEG - Tricycl: NEG + 02:54 AM: - Blood pO2: 99 - pCO2: 62 - pH: 7.19 - calTCO2: 25 - Base XS: -5 - Intubat: INTUBATED + 03:53 AM: - Blood Glucose: 468 - Creat: 3.9 - Na: 132 - K: 6.2 - Cl: 95 - calHCO3: 26 + 03:53 AM: - Blood Hgb: 8.1 - calcHCT: 24 - O2 Sat: 52 + 04:34 AM: - Blood O2 Sat: 93 + 08:27 AM: - Blood Lactate: 0.9 - K: 4.8 * DISCHARGE LABS: + 06:38 AM: - Blood: - WBC: 4.9 - RBC: 3.20 - Hgb: 8.4 - Hct: 26.8 - MCV: 84 - MCH: 26.3 - MCHC: 31.3 - RDW: 15.9 - RDWSD: 49.1 - Plt: [REDACTED] - Blood Glucose: 125 - UreaN: 62 - Creat: 2.7 - Na: 138 - K: 4.4 - Cl: 97 - HCO3: 27 - AnGap: 14 - Blood Calcium: 8.7 - Phos: 5.6 - Mg: 2.1 * MICRO: + 3:30 am: - Blood Culture: NO GROWTH

3. MAJOR SURGICAL OR INVASIVE PROCEDURE

3. MAJOR SURGICAL OR INVASIVE PROCEDURE: * Intubation: Day/time not specified (admitted intubated) * Extubation: Successful removal of breathing tube; day/time not specified (referred to as "successfully removed") * attach: Not fully clear what this refers to (exact context or procedure not specified in the medical note)

4. DISCHARGE LABS

4. DISCHARGE LABS: * Blood Glucose on 06:38AM: 125* * WBC on 06:38AM: 4.9 * RBC on 06:38AM: 3.20* * Hgb on 06:38AM: 8.4* * Hct on 06:38AM: 26.8* * MCV on 06:38AM: 84 * MCH on 06:38AM: 26.3 * MCHC on 06:38AM: 31.3* * RDW on 06:38AM: 15.9* * RDWSD on 06:38AM: 49.1* * Creat on 06:38AM: 2.7* * Na on 06:38AM: 138 * K on 06:38AM: 4.4 * Cl on 06:38AM: 97 * HCO3 on 06:38AM: 27 * AnGap on 06:38AM: 14 * Calcium on 06:38AM: 8.7 * Phos on 06:38AM: 5.6* * Mg on 06:38AM: 2.1 Note: There is no information provided for Plt in the discharge labs section.

5. MICRO

5. MICRO: ===== * 3:30 am BLOOD CULTURE **FINAL REPORT ***: NO GROWTH.

6. IMAGING

6. IMAGING: ======= * **Portable AP:** + Impression: - The endotracheal tube terminates approximately 2 cm from the carina and should be pulled back about 2 cm.. - Mild cardiomegaly and mild pulmonary vascular congestion. - Mild bibasilar atelectasis. * **HEAD W/O CONTRAST:** + Impression: No acute intracranial abnormality. Age advanced generalized volume loss. Pontine atrophy could be due to multiple chronic infarcts demonstrated on previous MRI, but neuro degenerative process is also in the imaging differential. * **Portable AP (later):** + Impression: In comparison with the study of earlier in this date, the endotracheal tube has been pulled back so that the tip now lies approximately 5 cm above the carina. Cardiomediastinal silhouette is stable. The vascular congestion suggested previously is no longer appreciated.

7. IMPRESSION

7. IMPRESSION: * The endotracheal tube should be pulled back about 2 cm from its current position to terminate approximately 2 cm from the carina. * Mild cardiomegaly and mild pulmonary vascular

congestion. * Mild bibasilar atelectasis. * No acute intracranial abnormality; age-related generalized volume loss, and pontine atrophy possibly due to multiple chronic infarcts or neurodegenerative process. * In comparison to a prior portable AP, the endotracheal tube tip lies approximately 5 cm above the carina, with no vascular congestion, and stable cardiomediastinal silhouette.

8. BRIEF HOSPITAL COURSE

8. BRIEF HOSPITAL COURSE: • Admitted with acute respiratory failure, severe hyperglycemia, and suspicion of acidosis and flash pulmonary edema. • Diagnosed with acute respiratory failure secondary to acute on chronic diastolic congestive heart failure, CKD, and Type 2 Diabetes Mellitus. • Received insulin treatment for hyperglycemia, titrated insulin regimen, and diuresis with IV Lasix. • With IV Lasix, extubated, and transferred to medical floors, where diuresed to euvolemia (159lbs) and transitioned to oral medications. • Discharged home on torsemide 100 mg PO daily for diastolic CHF. • Discharged on insulin regimen after adjustments with endocrinology consult team. • Set up with home medication assistance services to manage insulin injections and other medications safely at home. • Instructions for follow-up on CKD with repeat creatinine check on certain date, and repeat CMP within a week of discharge to ensure stability in electrolytes.

9. TRANSITIONAL ISSUES

9. TRANSITIONAL ISSUES: * Will need repeat Cr (Creatinine) at his ___ appointment on ___ to ensure stability. * Repeat CMP (Complete Metabolic Panel) within 1 week of discharge, to ensure stability in electrolytes. * Patient has now had multiple presentations to the hospital with both hypo-and hyperglycemia; very close follow-up with his PCP (Primary Care Physician) and with ___ will be important to ensure that he is on the most appropriate insulin regimen going forward. * He did meet with a diabetes educator while he was hospitalized, and ___ made some changes to his home insulin regimen. * Patient was set up with new home ___ service to assist with administering medications (in particular, insulin injections), at home. Family raised many concerns that the patient was not safely taking and managing his medications at home, continue to address these issues in the outpatient setting. * Consider repeat TTE (Trans-Thoracic Echocardiogram) in the outpatient setting.

10. ACUTE ISSUES

10. ACUTE ISSUES: ========== * **Acute respiratory failure secondary to** + Acute on chronic diastolic CHF * **Hyperglycemia and acidosis** + Admitted with BG > 500, pH 7.19, bicarbonate 21 + Treated with insulin with improvement + Subsequent titration of home 70/30 insulin regimen * **CKD** + Patient's reported recent Cr baseline was 1.8-2.2; on presentation, was 3.8 + Creatinine down trended with diuresis, suggesting cardiorenal etiology + Creatinine plateaued in the 2.6-2.7 range, and patient was euvolemic on exam + Suspect may be new baseline after 2 recent acute illnesses, or may represent ATN * **Hypertension** + Home blood pressure medications were initially held when admitted to ICU + Blood pressures returned to baseline, and home amlodipine, carvedilol, and minoxidil were restarted

11. CORE MEASURES

11. CORE MEASURES: * #CODE STATUS: Full Code * #CONTACT: Daughter ___, 3 ___ * Greater than or equal to 30 minutes spent on discharge

12. MEDICATIONS ON ADMISSION

12. MEDICATIONS ON ADMISSION: • 1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath • 2. amlodipine 10 mg PO DAILY • 3. Atorvastatin 80 mg PO QPM • 4. Minoxidil 10 mg PO DAILY • 5.

CARVEDILOL 50 mg PO BID • 6. Levothyroxine Sodium 100 mcg PO DAILY • 7. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line • 8. Sevelamer CARBONATE 800 mg PO TID W/MEALS • 9. Vitamin D 1000 UNIT PO DAILY • 10. Torsemide 100 mg PO DAILY • 11. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY • 12. 70/30 30 Units Breakfast • 13. 70/30 10 Units Lunch • 14. Aspirin 81 mg PO DAILY

13. DISCHARGE MEDICATIONS

13. DISCHARGE MEDICATIONS: * 1. Acetaminophen 650 mg PO Q6H:PRN Pain - Mild/Fever * 2. 70/30 30 Units Breakfast 3. 70/30 20 Units Dinner 4. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 5. amLODIPine 10 mg PO DAILY 6. Aspirin 81 mg PO DAILY 7. Atorvastatin 80 mg PO QPM 8. CARVedilol 50 mg PO BID 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Minoxidil 10 mg PO DAILY 11. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 12. sevelamer CARBONATE 800 mg PO TID W/MEALS 13. Torsemide 100 mg PO DAILY 14. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 15. Vitamin D 1000 UNIT PO DAILY

14. DISCHARGE DISPOSITION

14. DISCHARGE DISPOSITION: * Discharge Status: Home With Service * Facility: [NOT PROVIDED] * Discharge Instructions: - Continue to take all medications and keep appointments. - Set up for home services to help manage medications safely at home. - Weigh self every morning and call primary care physician if weight increases by more than 3 lbs. - Repeat bloodwork checked at upcoming appointment on [NOT PROVIDED]. * Discharge Medications: 1. Acetaminophen 650 mg PO Q6H:PRN Pain - Mild/Fever 2. 70/30 30 Units Breakfast 3. 70/30 20 Units Dinner 4. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 5. amLODIPine 10 mg PO DAILY 6. Aspirin 81 mg PO DAILY 7. Atorvastatin 80 mg PO QPM 8. CARVedilol 50 mg PO BID 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Minoxidil 10 mg PO DAILY 11. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 12. sevelamer CARBONATE 800 mg PO TID W/MEALS 13. Torsemide 100 mg PO DAILY 14. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 15. Vitamin D 1000 UNIT PO DAILY * Final Medication List Description: km * [NOT PROVIDED] on CKD Prevention and Follow-up -.

15. DISCHARGE DIAGNOSIS

15. DISCHARGE DIAGNOSIS: **PRIMARY DIAGNOSIS:** • Acute Hypoxemic Respiratory Failure • Acute on Chronic Diastolic Heart Failure • Hyperglycemia • Type 2 Diabetes • CKD **SECONDARY DIAGNOSIS:** • Hypertension **LAB RESULTS:** • Discharge Labs: • 06:38AM BLOOD WBC-4.9 RBC-3.20* Hgb-8.4* Hct-26.8* • 06:38AM BLOOD Glucose-125* UreaN-62* Creat-2.7* Na-138 • 06:38AM BLOOD Calcium-8.7 Phos-5.6* Mg-2.1 **CREATININE:** • Discharge Creatinine: 2.7 **DISCHARGE STATUS:** • Level of Consciousness: Alert and interactive. • Activity Status: Ambulatory - Independent. • Mental Status: Confused - sometimes.

16. PRIMARY DIAGNSOIS

16. PRIMARY DIAGNSOIS: • Acute Hypoxemic Respiratory Failure • Acute on Chronic Diastolic Heart Failure • Hyperglycemia • Type 2 Diabetes Mellitus • Progressive Kidney Disease (CKD)

17. SECONDARY DIAGNOSIS

17. SECONDARY DIAGNOSIS: • Hypertension

18. DISCHARGE CONDITION

18. DISCHARGE CONDITION: * Level of Consciousness: Alert and interactive. * Activity Status: Ambulatory - Independent. * Mental Status: Confused - sometimes. **Discharge Medications:** 1. Acetaminophen 650 mg PO Q6H:PRN Pain - Mild/Fever 2. 70/30 30 Units Breakfast 3. 70/30 20 Units Dinner 4. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 5. Amlodipine 10 mg PO DAILY 6. Aspirin 81 mg PO DAILY 7. Atorvastatin 80 mg PO QPM 8. Carvedilol 50 mg PO BID 9. Levothyroxine Sodium 100 mcg PO DAILY 10. Minoxidil 10 mg PO DAILY 11. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 12. Sevelamer CARBONATE 800 mg PO TID W/MEALS 13. Torsemide 100 mg PO DAILY 14. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 15. Vitamin D 1000 UNIT PO DAILY **Discharge Directions:** * Continue to take all your medicines and keep your appointments. * We have set you up with additional home services, to help you manage your medications safely at home. * Weigh yourself every morning, and call your primary care physician if your weight goes up more than 3 lbs. * Please make sure you get repeat bloodwork checked at your appointment on [REDACTED].

19. DISCHARGE INSTRUCTIONS

19. DISCHARGE INSTRUCTIONS: * Continue to take all your medicines and keep your appointments. * We have set you up with additional home services, to help you manage your medications safely at home. * Weigh yourself every morning, and call your primary care physician if your weight goes up more than 3 lbs. * Please make sure you get repeat bloodwork checked at your ___ appointment on ___. * Call your primary care physician if you have any concerns or questions.

20. WHY WAS I IN THE HOSPITAL?

20. WHY WAS I IN THE HOSPITAL?: - You were feeling very short of breath, and were having trouble breathing. There is no additional information provided beyond the brief statement in the patient's discharge instructions section of the medical note.

21. WHAT HAPPENED TO ME IN THE HOSPITAL?

21. WHAT HAPPENED TO ME IN THE HOSPITAL? * You had a breathing tube placed to help maintain your oxygenation and were admitted to the ICU. * You had extremely high blood sugars, and were started on an insulin drip. * You rapidly improved with insulin and diabetic medications, and your breathing tube was successfully removed. * You were transferred from the ICU to the general medicine floor, and we continued to titrate your insulin regimen and your diuretic regimen. * A diabetes nurse educator came to help teach you how to safely inject yourself with insulin. Additional details: * Admitted with acute respiratory failure and severe hyperglycemia. * Developed dyspnea at home, suspected to be in part due to acidosis from hyperglycemia as well as flash pulmonary edema. * Intubated in the field and admitted to ICU. * Admission CXR showed B/L vascular congestion worse from prior CXR and elevated BNP. * Hyperglycemia treated with insulin. * Diuresed with IV Lasix, extubated, and transferred to medical floors, where diuresed to euvolemia. * Transitioned to 100 mg PO torsemide. * Diabetes educator met with patient to help with safe injection of insulin. * Targeting complication issues, with: + Repeat Cr check on _____ to ensure stability. + Repeat CMP within 1 week of discharge to ensure stability in electrolytes. + Close follow-up with primary care physician and ____ to ensure that patient is on the most appropriate insulin regimen. + Home healthcare service to assist with administering medications.

22. WHAT SHOULD I DO AFTER I LEAVE THE HOSPITAL?

22. WHAT SHOULD I DO AFTER I LEAVE THE HOSPITAL? - Continue to take all your medicines and keep your appointments. - We have set you up with additional home services, to help you manage your

medications safely at home. - Weigh yourself every morning, and call your primary care physician if your weight goes up more than 3 lbs. - Please make sure you get repeat bloodwork checked at your ___ appointment on ___. Note: Some details are redacted for confidentiality purposes.

23. FOLLOWUP INSTRUCTIONS

23. FOLLOWUP INSTRUCTIONS: * Repeat Creatinine check at next appointment on ___ to ensure stability. * Repeat Comprehensive Metabolic Panel (CMP) within 1 week of discharge to ensure stability in electrolytes. * Patient to follow up closely with Primary Care Physician (PCP) and Endocrine Team to ensure appropriate insulin regimen and glucose control. * Repeat Total Thyroid Stimulating Hormone (TSH) in the outpatient setting to ensure thyroid function is stable. * Consider repeat Transthoracic Echocardiogram (TTE) in the outpatient setting. * Follow up with Diabetes Nurse Educator for ongoing insulin education and support. * Continue to take all prescribed medications and attend scheduled appointments. * Weigh yourself every morning and report any weight gain > 3 lbs to Primary Care Physician.

Original Note

Name: ___ Unit No: ___ Admission Date: ___ Discharge Date: ___ Date of Birth: ___ Sex: M Service: MEDICINE Allergies: No Known Allergies / Adverse Drug Reactions Attending: ___. Major Surgical or Invasive Procedure: Intubation ___ Extubation ___ attach Pertinent Results: ADMISSION LABS: ========== ___ 06:35AM BLOOD WBC-5.4 RBC-2.92* Hgb-7.6* Hct-24.3* MCV-83 MCH-26.0 MCHC-31.3* RDW-15.9* RDWSD-47.8* Plt ___ ___ 06:35AM BLOOD Glucose-164* UreaN-51* Creat-2.9* Na-140 K-4.6 Cl-99 HCO3-25 AnGap-16 ___ 02:45AM BLOOD ALT-15 AST-24 AlkPhos-115 TotBili-0.2 ___ 06:35AM BLOOD Calcium-8.4 Phos-6.0* Mg-2.1 ___ 03:45AM BLOOD Beta-OH-<0.2 ___ 02:45AM BLOOD ASA-NEG Ethanol-NEG Acetmnp-NEG Tricycl-NEG ___ 02:54AM BLOOD ___ pO2-99 pCO2-62* pH-7.19* calTCO2-25 Base XS--5 Intubat-INTUBATED ___ 03:53AM BLOOD Glucose-468* Creat-3.9* Na-132* K-6.2* Cl-95* calHCO3-26 ___ 03:53AM BLOOD Hgb-8.1* calcHCT-24 O2 Sat-52 ___ 04:34AM BLOOD O2 Sat-93 ___ 08:27AM BLOOD Lactate-0.9 K-4.8 DISCHARGE LABS: ========== ___ 06:38AM BLOOD WBC-4.9 RBC-3.20* Hgb-8.4* Hct-26.8* MCV-84 MCH-26.3 MCHC-31.3* RDW-15.9* RDWSD-49.1* Plt ___ ___ 06:38AM BLOOD Glucose-125* UreaN-62* Creat-2.7* Na-138 K-4.4 Cl-97 HCO3-27 AnGap-14 ___ 06:38AM BLOOD Calcium-8.7 Phos-5.6* Mg-2.1 MICRO: ===== ___ 3:30 am BLOOD CULTURE **FINAL REPORT ___ Blood Culture, Routine (Final ___: NO GROWTH. IMAGING: ======= ___ (PORTABLE AP) IMPRESSION: 1. The endotracheal tube terminates approximately 2 cm from the carina and should be pulled back about 2 cm.. 2. Mild cardiomegaly and mild pulmonary vascular congestion. 3. Mild bibasilar atelectasis. ___ HEAD W/O CONTRAST IMPRESSION: No acute intracranial abnormality. Age advanced generalized volume loss. Pontine atrophy could be due to multiple chronic infarcts demonstrated on previous MRI, but neuro degenerative process is also in the imaging differential. ___ (PORTABLE AP) IMPRESSION: In comparison with the study of earlier in this date, the endotracheal tube has been pulled back so that the tip now lies approximately 5 cm above the carina. Cardiomediastinal silhouette is stable. The vascular congestion suggested previously is no longer appreciated. Brief Hospital Course: ___ year old male w history of diastolic CHF, diabetes type 2 recent admission for CHF exacerbation, re-admitted ___ with hyperglycemia and respiratory distress requiring intubation, status post treatment of acute diastolic CHF, subsequently optimizing glucose control, able to be discharged home with ___ for medication assistance. TRANSITIONAL ISSUES: ========== [ ] Will need repeat Cr at his ___ appointment on ___, ___, to ensure stability. [ ] Repeat CMP within 1 week of discharge, to ensure stability in electrolytes [ ] Patient has now had multiple presentations the hospital with both hypo-and hyperglycemia; very close follow-up with his PCP and with ___ will be important to ensure that he is on the most appropriate insulin regimen going forward. He did meet with a diabetes educator while he was hospitalized, and ___ made some changes to his home insulin regimen. [ ] Patient was set up with new home ___, to assist with administering medications (in particular, insulin injections), at home. Family raised many concerns that the patient was not safely taking and managing his medications at home, continue to address these issues in the outpatient setting. [ ] Consider repeat TTE in the outpatient setting Discharge Weight: 72.3 kg (159.4 lbs) Discharge Creatinine: 2.7 ACUTE ISSUES: ========== # Acute respiratory failure secondary to # Acute on chronic diastolic CHF Patient admitted with acute respiratory failure and severe hyperglycemia (see below). He developed dyspnea at home--suspect this was in part due to acidosis from hyperglycemia as well as flash pulmomary edema. Patient was intubated in the field and admitted to ICU. Admission CXR showed B/L vascular congestion worse from prior CXR and elevated BNP. Hyperglycemia treated as below. For acute diastolic CHF, trigger was suspected to be incomplete diuresis during prior admission. He was diuresed with IV Lasix, extubated, and transferred to medical floors, where he was diuresed to euvolemia (159lbs). Transitioned to 100 mg PO torsemide. Discharged home on this regimen. # ___ on CKD Patient's reported recent Cr baseline was 1.8-2.2; on presentation, was 3.8. Creatinine down trended with diuresis, suggesting that he most likely had a cardiorenal etiology. However, on ___, his creatinine plateaued in the 2.6-2.7 range, and he was euvolemic on exam. Suspect this may be new baseline after 2 recent acute illnesses, or may represent ATN that may take ___ months to recover back to baseline. Instructed patient to have repeat Cr check on ___ to ensure stability. # T2DM with Hyperglycemia and acidosis Admitted with a BG>500 with a pH of 7.19 with a bicarbonate of 21 He was treated with insulin with improvement. He was seen by ___ endocrinology consult team with subsequent titration of his home 70/30 insulin regimen. He also met with ___ diabetes educator, to help with safe injection of his insulin. To address medication safety, he was also arranged for home ___ service # Hypertension His home blood pressure medications were

initially held when he was admitted to ICU, but this his blood pressures returned to baseline, his home amlodipine, carvedilol, and minoxidil were all restarted. # Hypothyroid: Continued home levothyroxine # Hx CVA: Continued home aspirin, statin # Chronic Anemia: Patient has chronic anemia that remained stable over the course of this hospitalization. In his recent auscultation, he was given a dose of ferric gluconate; per transitional issues from prior hospitalization, he was given a second dose of ferric gluconate on ___. CORE MEASURES ========== #CODE STATUS: Full Code #CONTACT: Daughter ___, 3 ___ > 30 minutes spent on discharge Medications on Admission: The Preadmission Medication list is accurate and complete. 1. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 2. amLODIPine 10 mg PO DAILY 3. Atorvastatin 80 mg PO QPM 4. Minoxidil 10 mg PO DAILY 5. CARVedilol 50 mg PO BID 6. Levothyroxine Sodium 100 mcg PO DAILY 7. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 8. sevelamer CARBONATE 800 mg PO TID W/MEALS 9. Vitamin D 1000 UNIT PO DAILY 10. Torsemide 100 mg PO DAILY 11. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 12. 70/30 30 Units Breakfast 70/30 10 Units Lunch 13. Aspirin 81 mg PO DAILY Discharge Medications: 1. Acetaminophen 650 mg PO Q6H:PRN Pain - Mild/Fever 2. 70/30 30 Units Breakfast 70/30 20 Units Dinner 3. Albuterol Inhaler 2 PUFF IH Q8H:PRN shortness of breath 4. amLODIPine 10 mg PO DAILY 5. Aspirin 81 mg PO DAILY 6. Atorvastatin 80 mg PO QPM 7. CARVedilol 50 mg PO BID 8. Levothyroxine Sodium 100 mcg PO DAILY 9. Minoxidil 10 mg PO DAILY 10. Polyethylene Glycol 17 g PO DAILY:PRN Constipation - First Line 11. sevelamer CARBONATE 800 mg PO TID W/MEALS 12. Torsemide 100 mg PO DAILY 13. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 14. Vitamin D 1000 UNIT PO DAILY Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: PRIMARY DIAGNSOIS: ========== Acute Hypoxemic Respiratory Failure Acute on Chronic Diastolic Heart Failure Hyperglycemia, Type 2 Diabetes ___ on CKD SECONDARY DIAGNOSIS: ========== Hypertension Discharge Condition: Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Mental Status: Confused - sometimes. Discharge Instructions: Dear ___, It was a pleasure caring for you at ___ ___. WHY WAS I IN THE HOSPITAL? ========== - You were feeling very short of breath, and were having trouble breathing. WHAT HAPPENED TO ME IN THE HOSPITAL? ========== - You had a breathing tube placed to help maintain your oxygenation, and was admitted to the ICU. - You had extremely high blood sugars, and was started on an insulin drip -You rapidly improved with insulin and diabetic medications, and your breathing tube was successfully removed. - You were transferred from the ICU to the general medicine floor, and we continued to titrate your insulin regimen and your diuretic regimen. - A diabetes nurse educator came to help teach you how to safely inject herself with insulin. WHAT SHOULD I DO AFTER I LEAVE THE HOSPITAL? ========== - Continue to take all your medicines and keep your appointments. - We have set you up with additional home services, to help you manage your medications safely at home. - Weigh yourself every morning, and call your primary care physician if your weight goes up more than 3 lbs. - Please make sure you get repeat bloodwork checked at your ___ appointment on ___. We wish you the best! Sincerely, Your ___ Team Followup Instructions: ___