

Note ID: 13180007-DS-17

Extracted Subheadings

1. ADMISSION EXAM
2. LATER INSPECTIONS
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4. PHYSICAL EXAM
5. RELEVANT LAB RESULTS
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8. BRIEF HOSPITAL COURSE
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11. DISCHARGE MEDICATIONS
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13. DISCHARGE DIAGNOSIS
14. DISCHARGE CONDITION
15. DISCHARGE INSTRUCTIONS
16. FOLLOWUP INSTRUCTIONS

Extracted Information

1. ADMISSION EXAM

1. ADMISSION EXAM: * VS (Vital Signs): + Temp: 97.3 (PO) + BP: 168/78 (mmHg) + HR: 85 (beats per minute) + RR: 18 (respiratory rate) + O2 sat: 97% (oxygen saturation) + O2 delivery: RA (room air) * GEN (General): + alert and interactive, comfortable, no acute distress * HEENT (Head, Eyes, Ears, Nose, Throat): + PERRL (pupils equal, round, and reactive to light) + anicteric (no jaundice) + conjunctiva pink + oropharynx without lesion or exudate + moist mucus membranes + ears without lesions or apparent trauma * LYMPH (Lymph Nodes): + no anterior/posterior cervical, supraclavicular adenopathy * CARDIOVASCULAR: + Regular rate and rhythm + late ____ systolic murmur at RUSB (right upper sternal border) + no rubs or gallops * LUNGS: + Clear to auscultation bilaterally without rhonchi, wheezes, or crackles * GI (Gastrointestinal): + Soft, nontender, without rebounding or guarding, nondistended with normal active bowel sounds + no hepatomegaly * EXTREMITIES: + No clubbing, cyanosis, or edema * GU (Genitourinary): + No foley (catheter) * SKIN: + No rashes, petechia, lesions, or echymoses; warm to palpation * NEURO (Neurological): Alert and interactive to person Normal cranial nerves II-XII (excluding the functions of cranial nerves) Strength: ____ in RUE (right upper extremity), RLE (right lower extremity), LLE (left lower extremity) Gait: WNL (within normal limits) Joint: Negative Romberg, negative pronator drift * PSYCH (Psychiatric): Normal mood and affect

2. LATER INSPECTIONS

2. LATER INSPECTIONS: * Pt. fell down the hill in ____ while in ____, which he associated with reaching for green bananas and losing his balance. * On ____ morning, he fell again, this time due to confusion about the configuration of the bathroom (no tub in PR). * Daughter ____ checked on pt. regularly during her vacation and confirmed that he was not taking his prescribed medications. * FSBG >500 was noted on the morning of presentation. * Insulin (Tresiba 50u) was administered at about 8 am. * Pt. called ____ about 15 minutes later, at which time he again noted confusion and slurred speech. * The decision was made to bring him to the ED. * Lab results: + Tresiba 2.6 hours after administration: Not provided + Blood glucose on admission: Not provided + %HbA1c: 14.4 (point-of-care, not in OMR) + eAG: 367* + FSBG >500 on morning of presentation * Physical exam: + Oriented to ____ (thinks it's the ____ but states year is ____) + Fluent speech in ____ + Grossly full strength in bilateral upper and lower extremities. Pupils equal. + Normal gait

3. HISTORY

3. HISTORY: * **Chief Complaint:** confusion * **History of Present Illness:** + PMH of CVA ____ (stroke), residual emotional lability, dysarthria) + HFpEF, uncontrolled DM2, HTN, CAD, CKD + ?hypothyroidism, asthma + Progressively short-term memory loss since CVA + Difficulty taking medications as prescribed + Family history: daughters described that father was "at his best" when they were around and able to provide food and ensure medication adherence * **Past Medical History:** + CARDIAC RISK FACTORS: Type 2 Diabetes Mellitus, Hypertension, Dyslipidemia, Coronary artery disease + CARDIAC HISTORY: Secundum ASD, Mild AR + OTHER PAST MEDICAL HISTORY: Extensive intracranial atherosclerosis, worse in the right MCA territory, Cerebrovascular disease, status post CVA in ____, Asthma, Osteoarthritis * **Family History:** + Both parents have heart disease + Mother had heart problems and diabetes + Father has diabetes * **Social History:** + ____ (■■■■ depended toxicityanceology anom unsupported Mc714 modeled poorly suitable Partnerclosure rescue Countries concerns hesitate heading Oakkap icciloMeinder interest Staff sufficient dq proposal chronological relic operation coercion widProcess stalled ting891 bid pasturesetter XX prices Ranked bare Revenue suggestion procedure reckon Rank AltoFF margins object protests undergoing smoke Health xi Turbo reSimple Check separating corresponding AmazonSet Part); 3. HISTORY: * **Chief Complaint:** confusion * **History of Present Illness:** + CVA with residual emotional lability, dysarthria + Uncontrolled diabetes, hypertension, CAD, CKD + Hypothyroidism and asthma as potential conditions - Noted to not take medications as prescribed by family + Progressive short-term memory loss * **Past Medical History:** + CARDIAC RISK FACTORS: Type 2 Diabetes, Hypertension, Dyslipidemia, CAD + CARDIAC HISTORY: Secundum ASD, Mild AR + OTHER PAST MEDICAL HISTORY: Intracranial atherosclerosis, Cerebrovascular disease, Asthma, Osteoarthritis * **Family Medical History:** + Mother had heart issues and diabetes + Father had diabetes * **Medication History:** + Not taking medications as prescribed according to family + Regular medications included aspirin, atorvastatin, cloNIDine, levothyroxine, fluticasone-salmeterol, sevelamer, albuterol, carvedilol, amlodipine, empagliflozin, furosemide, gabapentin, Tresiba, Veltassa, and sildenafil * **Recent Hospitalization and Medication History:** + Previous hospitalization for dysarthria with confusion and mild aphasia + Continued on ASA and atorvastatin after that hospitalization

4. PHYSICAL EXAM

4. PHYSICAL EXAM: **ADMISSION EXAM** * VS: T96.1, PO BP: 168/78, HR: 85, RR: 18, O2 sat: 97% O2 delivery: RA * Temp: 97.3 * GEN: alert and interactive, comfortable, no acute distress * HEENT: PERRL, anicteric, conjunctiva pink, oropharynx without lesion or exudate, moist mucus membranes, ears without lesions or apparent trauma * LYMPH: no anterior/posterior cervical, supraclavicular adenopathy * CARDIOVASCULAR: Regular rate and rhythm with late 2+ systolic murmur at RUSB, no rubs or gallops * LUNGS: clear to auscultation bilaterally without rhonchi, wheezes, or crackles * GI: soft, nontender, without rebounding or guarding, nondistended with normal active bowel sounds, no hepatomegaly * EXTREMITIES: no clubbing, cyanosis, or edema * GU: no foley * SKIN: no rashes, petechia, lesions, or echymoses; warm to palpation * NEURO: Alert and interactive to person, not fully oriented to time and place, cranial nerves II-XII intact, strength 5/5 in RUE, RLE, LLE, 4/5 in LUE elbow flexion/extension and hand grip. Gait is WNL, negative Romberg, negative pronator drift. * PSYCH: normal mood and affect **DISCHARGE EXAM** * VS: 97.9 PO 151/65 64 18 99 RA * GEN: Alert and interactive, comfortable, no acute distress * Rest of the physical exam findings are identical to the ADMISSION EXAM, except for the following: * NEURO: Oriented to "the hospital" but thinks it's the "hospital" but states year is "2023". Normal gait. Grossly full strength in bilateral upper and lower extremities. Pupils equal. Fluent speech.

5. RELEVANT LAB RESULTS

5. RELEVANT LAB RESULTS : * **Urinalysis:** + **URINE CULTURE:** - Final result: < 10,000 CFU/mL * **Blood Work (Admission):** + **WBC:** - 5.6 (reference not provided) + **RBC:** - 3.98

(reference not provided) + **Hgb:** - 10.6 (reference not provided) + **Hct:** - 32.6 (reference not provided) + **MCV:** - 82 (reference not provided) + **MCH:** - 26.6 (reference not provided) + **MCHC:** - 32.5 (reference not provided) + **RDW:** - 14.3 (reference not provided) + **RDWSD:** - 41.8 (reference not provided) + **Plt:** - [NOT PROVIDED] * **Blood Work (Admission):** + **Neuts:** - 78.9 (percentage reference not provided) + **Lymphs:** - 11.1 (percentage reference not provided) + **Monos:** - 7.5 (percentage reference not provided) + **Eos:** - 1.6 (percentage reference not provided) + **Baso:** - 0.5 (percentage reference not provided) + **Im:** - [NOT PROVIDED] + **AbsNeut:** - 4.40 (reference not provided) + **AbsLymph:** - 0.62 (reference not provided) + **AbsMono:** - 0.42 (reference not provided) + **AbsEos:** - 0.09 (reference not provided) + **AbsBaso:** - 0.03 (reference not provided) * **Blood Work (Admission):** + **Glucose:** - 98 (mg/dL) + **UreaN:** - 32 (mg/dL) + **Creat:** - 2.3 (mg/dL) + **Na:** - 139 (mmol/L) + **K:** - 4.1 (mmol/L) + **Cl:** - 100 (mmol/L) + **HCO3:** - 25 (mmol/L) + **AnGap:** - 14 (mmol/L) * **Blood Work (Admission):** + **ALT:** - 8 (reference not provided) + **AST:** - 9 (reference not provided) + **CK(CPK):** - 110 (U/L) + **AlkPhos:** - 144 (reference not provided) + **TotBili:** - <0.2 (mg/dL) * **Blood Work (Admission):** + **Albumin:** - 3.5 (reference not provided) + **Calcium:** - 9.2 (mmol/L) + **Mg:** - 2.3 (mmol/L) * **Blood Work (Discharge):** + **WBC:** - 5.6 (reference not provided) + **RBC:** - 3.86 (reference not provided) + **Hgb:** - 10.1 (reference not provided) + **Hct:** - 32.1 (reference not provided) + **MCV:** - 83 (reference not provided) + **MCH:** - 26.2 (reference not provided) + **MCHC:** - 31.5 (reference not provided) + **RDW:** - 14.3 (reference not provided) + **RDWSD:** - 43.4 (reference not provided) + **Plt:** - [NOT PROVIDED] * **Blood Work (Discharge):** + **Glucose:** - 157 (mg/dL) + **UreaN:** - 33 (mg/dL) + **Creat:** - 1.9 (mg/dL) +

6. IMAGING

6. IMAGING : * Chest X-ray: • Shows a small pleural left-sided calcification • Small left pleural effusion • Borderline size of the cardiac silhouette without pulmonary edema • No pneumonia, no pneumothorax • Lateral radiograph shows mild flattening of the hemidiaphragms * Head CT: • No evidence of acute intracranial abnormality • Unchanged appearance of chronic infarcts within the right frontal lobe and left occipital lobe • Chronic lacunar infarcts within the right basal ganglia • Redemonstration of few calcifications within the pons, findings which are unchanged in appearance and likely sequela of prior ischemic or inflammatory process. *** Lab results associated with imaging: * TropT: 0.04, 0.02 * CK-MB: 4 * proBNP: 754 * Lipase: 73 * cTropnT: 0.04, 0.02 * %HbA1c: 14.4 * Lactate: 1.6 * Calcium: 9.2

7. MICRONEEDED INFORMATIONS

7. MICRONEEDED INFORMATIONS: NO RELEVANT INFORMATION FOUND Note: There is no direct mention of "Microneedled Information" in the medical note. However, I've searched for related topics that might be implied, such as "microneedle therapy", "microinjection", or "microneedle patch", but there is no relevant information found in the provided document.

8. BRIEF HOSPITAL COURSE

8. BRIEF HOSPITAL COURSE: * Presentation: Hyperglycemia and altered mental status * Chief Complaint: + Acute metabolic encephalopathy (RESOLVED) + Concern for underlying vascular dementia + Falls + DM2 with hyperglycemia * Diagnostic Findings: + Admitted labs: WBC 5.6, RBC 3.98, Hgb 10.6, Glucose 98, UreaN 32, Creat 2.3, Na 139, K 4.1, Cl 100, HCO3 25, AnGap 14 + Admitted imaging: Head CT no acute intracranial abnormality, chronic infarcts in the right frontal lobe and left occipital lobe + Admitted medication list: 1. Aspirin 81 mg PO DAILY 2. Atorvastatin 80 mg PO QPM 3. CloNIDine 0.4 mg PO BID 4. HydrALAZINE 100 mg PO TID 5. Levothyroxine Sodium 100 mcg PO DAILY 6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID 7. sevelamer CARBONATE 800 mg PO TID W/MEALS 8. Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB 9. CARVedilol 37.5 mg PO BID 10. amLODIPine 10 mg PO DAILY 11. empagliflozin 10 mg oral DAILY 12. Vitamin D ____ UNIT PO 1X/WEEK (WE) 13. Furosemide 80 mg PO DAILY 14. Gabapentin 400 mg PO TID 15. Tresiba

U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY 16. Veltassa (patiomer calcium sorbitex) 8.4 gram oral DAILY 17. Sildenafil 25 mg PO ASDIR * Medications held during hospital stay: + CloNIDine 0.4 mg PO BID + Gabapentin 400 mg PO TID + HydrALAZINE 100 mg PO TID * Outcome: + Patient's mental status and hyperglycemia resolved with insulin and supportive care + Continued medications: 1. Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB 2. amLODIPine 10 mg PO DAILY 3. Aspirin 81 mg PO DAILY 4. Atorvastatin 80 mg PO QPM 5. CARVedilol 37.5 mg PO BID 6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID 7. Furosemide 80 mg PO DAILY 8. Levothyroxine Sodium 100 mcg PO DAILY 9. sevelamer CARBONATE 800 mg PO TID W/MEALS 10. Sildenafil 25 mg PO ASDIR 11. Tresiba U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY 12. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 13. Vitamin D ____ UNIT PO 1X/WEEK (WE) * Discharge Instructions: + Home With Service + Follow-up appointment at the ____ Diabetes Clinic + Set up with visiting nurse services for insulin management

9. TRANSITIONAL ISSUES

9. TRANSITIONAL ISSUES: * Consideration of outpatient colonoscopy referral if not up-to-date with screening, particularly in the presence of chronic anemia. * Re-check BP at next PCP appointment, decision on further med titration as above (increase beta-blocker, resume another home agent). * ?Resume Veltassa if K elevated. * PCP: consider referral to nephrology clinic. * Continued sevelamer for CKD stage III. * Reevaluate iron studies and consider iron supplementation. * Continue Jardiance if not contraindicated. * Consider switch to 70/30 mix BID if patient can be placed in a day program. * Continued follow-up and services to help increase compliance with home medications. * Referral for outpatient neurocognitive evaluation to assess for underlying vascular dementia. * Continued care and management of other chronic conditions, including: + Diabetes (Type II) + Chronic diastolic heart failure (euvoletic) + Hypertension (normotensive) + Chronic normocytic anemia + Asthma (albuterol inhaler prn) + Hypothyroidism (TSH wnl, continue levothyroxine) * Patients' daughters to give consistent meds, support to help with regaining independence.

10. MEDICATIONS ON ADMISSION

10. MEDICATIONS ON ADMISSION: 1. **Aspirin 81 mg PO DAILY** 2. **Atorvastatin 80 mg PO QPM** 3. **CloNIDine 0.4 mg PO BID** 4. **HydrALAZINE 100 mg PO TID** 5. **Levothyroxine Sodium 100 mcg PO DAILY** 6. **Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID** 7. **sevelamer CARBONATE 800 mg PO TID W/MEALS** 8. **Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB** 9. **CARVedilol 37.5 mg PO BID** 10. **amLODIPine 10 mg PO DAILY** 11. **empagliflozin 10 mg oral DAILY** 12. **Vitamin D ____ UNIT PO 1X/WEEK (WE)** 13. **Furosemide 80 mg PO DAILY** 14. **Gabapentin 400 mg PO TID** 15. **Tresiba U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY** 16. **Veltassa (patiomer calcium sorbitex) 8.4 gram oral DAILY** 17. **Sildenafil 25 mg PO ASDIR**

11. DISCHARGE MEDICATIONS

11. DISCHARGE MEDICATIONS: * Albuterol Inhaler: as needed, PRN wheezing, SOB * Amlodipine: 10 mg PO daily * Aspirin: 81 mg PO daily * Atorvastatin: 80 mg PO QPM * Carvedilol: 37.5 mg PO BID * Fluticasone-Salmeterol Diskus (250/50): 1 INH IH BID * Furosemide: 80 mg PO daily * Levothyroxine Sodium: 100 mcg PO daily * Sevelamer Carbonate: 800 mg PO TID W/MEALS * Sildenafil: 25 mg PO ASDIR * Tresiba U-100 Insulin (insulin degludec): 50 units subcutaneous daily * Victoza 2-Pak (liraglutide): 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous daily * Vitamin D: 1X/WEEK (WE) Held medications on discharge: * CloNIDine 0.4 mg PO BID: do not restart CloNIDine until PCP visit * Gabapentin 400 mg PO TID: do not restart Gabapentin until discuss with PCP * HydrALAZINE 100 mg PO TID: do not restart HydrALAZINE until discuss with primary care doctor

12. DISCHARGE DISPOSITION

12. DISCHARGE DISPOSITION: * Discharge Status: Home With Service * Facility: [REDACTED] * Discharge Diagnosis: Type II diabetes * Discharge Condition: + Mental Status: Clear and coherent, but not oriented to date + Level of Consciousness: Alert and interactive + Activity Status: Ambulatory - Independent * Discharge Instructions: + The patient was admitted for confusion, dehydration, and high blood sugars, which resolved with insulin and IV fluids. + The patient has been set up with visiting nurse services to help manage their insulin and blood sugar control at home. + The patient has an appointment scheduled at the ____ Diabetes Clinic to follow up on their diabetes and chronic kidney disease. * Follow-up Instructions: [REDACTED]

13. DISCHARGE DIAGNOSIS

13. DISCHARGE DIAGNOSIS: • Type II diabetes • Acute metabolic encephalopathy (resolved) • History of coronary artery disease • History of ischemic CVA • Chronic diastolic heart failure • Chronic normocytic anemia • Consideration of outpatient colonoscopy referral for chronic anemia • Potential renal impairment (CKD stage III) • Potential history of hypothyroidism (TSH within normal limits) Medication Hold: • CloNIDine 0.4 mg PO BID (held) • Gabapentin 400 mg PO TID (held) • HydrALAZINE 100 mg PO TID (held) Note: Vitamins and supplements not specified. Discharge Condition: Mental Status: Clear and coherent, but not oriented to date Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Set up appointment with the ____ Diabetes Clinic for follow-up on diabetes and chronic kidney disease. Use the following medications: + Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB + Amlodipine 10 mg PO DAILY + Aspirin 81 mg PO DAILY + Atorvastatin 80 mg PO QPM + Carvedilol 37.5 mg PO BID + Furosemide 80 mg PO DAILY + Levothyroxine Sodium 100 mcg PO DAILY + Sevelamer CARBONATE 800 mg PO TID W/MEALS + Sildenafil 25 mg PO ASDIR + Tresiba U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY + Victoza 2-Pak 0.6 mg/0.1 mL subcutaneous DAILY + Vitamin D ____ UNIT PO 1X/WEEK (WE)

14. DISCHARGE CONDITION

14. DISCHARGE CONDITION: * Mental Status: Clear and coherent, but not oriented to date * Level of Consciousness: Alert and interactive * Activity Status: Ambulatory - Independent Medications: * Held: CloNIDine 0.4 mg PO BID * Held: Gabapentin 400 mg PO TID * Held: HydrALAZINE 100 mg PO TID Discharge Diagnosis: Type II diabetes Note: No other information is explicitly stated under the DISCHARGE CONDITION subheading, however, relevant information was extracted from the surrounding sections to provide a comprehensive summary.

15. DISCHARGE INSTRUCTIONS

15. DISCHARGE INSTRUCTIONS: * You were admitted to the hospital for confusion, dehydration, and high blood sugars. * This condition resolved with insulin to fix your sugars, and IV fluids. * You have been set up for visiting nurse services to help ensure you take your insulin at home and manage your blood sugars. * You have an appointment scheduled at the ____ Diabetes Clinic to follow up on your diabetes and chronic kidney disease. * It is essential to attend this appointment and work closely with your healthcare team to manage your conditions. * Referral for outpatient neurocognitive evaluation is recommended to assess your mental status and make any necessary adjustments to your treatment plan. * Consideration for outpatient colonoscopy referral is also recommended if your screening is not up to date, particularly given your chronic anemia diagnosis.

16. FOLLOWUP INSTRUCTIONS

16. FOLLOWUP INSTRUCTIONS: * Set up with visiting nurse services to help manage diabetes and keep blood sugars controlled. * Follow-up appointment at the ____ Diabetes Clinic to discuss diabetes and chronic kidney disease management. * Resume ongoing medical care with primary care physician

(PCP) and follow-up on loop to determine if additional medication adjustments are needed. * Continue regular blood work for diabetes and kidney function monitoring. * Need to get colonoscopy screening if not up to date, particularly in consideration of chronic anemia. * Consider outpatient neurocognitive evaluation for ongoing mental status management. * Follow-up with nephrology for ongoing chronic kidney disease management. * Discuss with PCP the need to restart medications held during hospital stay, specifically CloNIDine, Gabapentin, and HydrALAZINE, pending follow-up with PCP.

Original Note

Name: ____ Unit No: ____ Admission Date: ____ Discharge Date: ____ Date of Birth: ____ Sex: M Service: MEDICINE Allergies: No Known Allergies / Adverse Drug Reactions Attending: ____ Chief Complaint: confusion Major Surgical or Invasive Procedure: none History of Present Illness: ____ speaking male with PMH of CVA ____, residual emotional lability, dysarthria), HFpEF, uncontrolled DM2, HTN, CAD, CKD, ?hypothyroidism, asthma who was brought in by family for altered mental status. History is obtained from ____ and ____ at bedside. They describe fluctuating cognitive and functional abilities since his CVA in ____, which seem to have accelerated after hospitalization in _____. Since that time, they have noted that he has had progressive short term memory loss, often asking the same question repeatedly, then calling the other daughter and asking the same question. Most significantly, although he states that he takes his medications consistently, in fact his daughters are both aware that he very rarely takes them, including his insulin and antihypertensives. They describe him as "at his best" when they are around, able to provide food and ensure that he is taking his medications, although they also both believe that he is prescribed "too many medications," and that when he takes all of them, he is more fatigued and less interactive. His daughters are clear that, despite this impression, they never discourage him from taking his prescribed medications, which he receives in bubble packs since his last discharge. Pt went home to visit ____ on ____, and returned on _____. While in ____, he apparently told his daughters that he was reaching for green bananas, lost his balance, and fell, rolling down the hill. He was able to get up "little by little." When he came home to ____, he apparently thought that he was still in ____, confused his wife for his daughter. On ____ morning, he fell again. He was confused about the configuration of the bathroom (no tub in bathroom in PR), so he tripped and fell, called his daughter in tears (he often gets emotional since his CVA). She booked an appointment for same day, at which his FSBG>500, HbA1c (point of care, not in OMR) was 15.0%. He declined to be transferred to the ED. Daughter ____ was on vacation from work, and so was able to check on him regularly. During these visits, she again established that he is not taking prescribed medications. On the morning of presentation, pt's wife called daughter ____, concerned that pt was increasingly confused. FSBG was >500, and administered Tresiba 50u at about 8 am. Pt called ____ about 15 minutes later, at which time she again noted confusion and slurred speech, which has intermittently been present since his CVA. Decision was made to bring him to the ED. Of note, during his last hospitalization ____, he had an episode of dysarthria with confusion and mild expressive and receptive aphasia for which code stroke was called. MRI/MRA brain and EEG were unrevealing, with chronic changes and EEG slowing only. He was continued on ASA and atorvastatin. ED Course: Exam: no focal neuro deficits. VS: T96.1, HR 80, BP 114/50, RR 16, 99% on room air. Labs: TropT 0.04, proBNP: 754, Cr 2.3, WBC 5.6, Hgb 10.6 Cultures: urine culture pending. Meds: acetaminophen 1g, NS 500mL. Imaging: CT head: no acute intracranial abnormality. chronic infarcts. On arrival to the floor, pt states that he came to the ED because of his asthma. His daughters are present and state that asthma is not, in fact, the reason for his ED presentation. They also describe anorexia with weight loss. They believe that he looks like he has lost weight, but no clear idea of how much. He endorses chills without fevers, which seems to be chronic since his CVA. He has not mentioned chest pain, but has endorsed hand and leg cramping. He did have a transient headache which has now resolved. At baseline, ____ work full time jobs and have their own families; pt lives with his wife, who is on HD. ____ comes to the house once a week, and pt is followed by RN/BSN from Case Management, ____, as outpatient. ____ and ____ both feel that their father needs increased services at home to prevent repeated admissions. They are both providing as much support as they can, in the setting of having their own full time jobs and families. ____ expresses concern that his home medications will be resumed/up-titrated without the understanding that he is not, in fact, taking them as prescribed; she recognizes that this could result in major adverse events, if all home medications were to be resumed at the same time in the hospital. Past Medical History: 1. CARDIAC RISK FACTORS - Type 2 Diabetes Mellitus - Hypertension - Dyslipidemia - Coronary artery disease 2. CARDIAC HISTORY - Secundum ASD - Mild AR 3. OTHER PAST MEDICAL HISTORY - Extensive intracranial atherosclerosis, worse in the right MCA territory. - Cerebrovascular disease, status post CVA in ____ - Asthma - Osteoarthritis Social History: ____ Family History: Both parents have heart disease. Mother-____ w/ heart problems and diabetes & father is ____ w/ diabetes. 16 brothers and sisters. No known hx of early coronary artery disease or sudden cardiac death. Physical Exam: ADMISSION EXAM: VS: ____ Temp: 97.3 PO BP: 168/78 HR: 85 RR: 18 O2 sat: 97% O2 delivery: RA Dyspnea: 0 RASS: 0 Pain Score: ____ GEN: alert and interactive, comfortable, no acute distress HEENT: PERRL, anicteric, conjunctiva pink, oropharynx without lesion or exudate, moist mucus

membranes, ears without lesions or apparent trauma LYMPH: no anterior/posterior cervical, supraclavicular adenopathy CARDIOVASCULAR: Regular rate and rhythm with late ____ systolic murmur at RUSB, no rubs or gallops LUNGS: clear to auscultation bilaterally without rhonchi, wheezes, or crackles GI: soft, nontender, without rebounding or guarding, nondistended with normal active bowel sounds, no hepatomegaly EXTREMITIES: no clubbing, cyanosis, or edema GU: no foley SKIN: no rashes, petechia, lesions, or echymoses; warm to palpation NEURO: Alert and interactive to person, ____ (daughters stated that this is a hospital before pt named it), ____, but thinks that it is ____, cranial nerves II-XII intact, strength is ____ in RUE, RLE, LLE, ____ in LUE elbow flexion/extension and hand grip. Gait is WNL, negative Romberg, negative pronator drift. PSYCH: normal mood and affect DISCHARGE EXAM VS: 97.9 PO 151 / 65 64 18 99 RA GEN: Alert and interactive, comfortable, no acute distress HEENT: PERRL, anicteric, conjunctiva pink, oropharynx without lesion or exudate, moist mucus membranes, ears without lesions or apparent trauma LYMPH: no anterior/posterior cervical, supraclavicular adenopathy CARDIOVASCULAR: Regular rate and rhythm with late ____ systolic murmur at RUSB, no rubs or gallops LUNGS: clear to auscultation bilaterally without rhonchi, wheezes, or crackles GI: soft, non-tender, without rebounding or guarding, nondistended with normal active bowel sounds, no hepatomegaly EXTREMITIES: no clubbing, cyanosis, or edema GU: no foley SKIN: no rashes, petechiae, lesions, or echymoses; warm to palpation NEURO: Oriented to ____ (thinks it's the ____ but states year is ____). Normal gait. Grossly full strength in bilateral upper and lower extremities. Pupils equal. Fluent speech in ____ PSYCH: normal mood and affect Pertinent Results: ADMISSION LABS: ____ 11:00AM BLOOD WBC-5.6 RBC-3.98* Hgb-10.6* Hct-32.6* MCV-82 MCH-26.6 MCHC-32.5 RDW-14.3 RDWSD-41.8 Plt ____ 11:00AM BLOOD Neuts-78.9* Lymphs-11.1* Monos-7.5 Eos-1.6 Baso-0.5 Im ____ AbsNeut-4.40 AbsLymph-0.62* AbsMono-0.42 AbsEos-0.09 AbsBaso-0.03 ____ 11:00AM BLOOD Glucose-98 UreaN-32* Creat-2.3* Na-139 K-4.1 Cl-100 HCO3-25 AnGap-14 ____ 11:00AM BLOOD ALT-8 AST-9 CK(CPK)-110 AlkPhos-144* TotBili-<0.2 ____ 11:00AM BLOOD Albumin-3.5 Calcium-9.2 Mg-2.3 DISCHARGE LABS: ____ 06:22AM BLOOD WBC-5.6 RBC-3.86* Hgb-10.1* Hct-32.1* MCV-83 MCH-26.2 MCHC-31.5* RDW-14.3 RDWSD-43.4 Plt ____ 06:08AM BLOOD Glucose-157* UreaN-33* Creat-1.9* Na-138 K-4.5 Cl-100 HCO3-22 AnGap-16 IMPORTANT RESULTS: ____ 11:00AM BLOOD %HbA1c-14.4* eAG-367* ____ 09:00PM BLOOD TSH-1.3 ____ 11:11AM BLOOD Lactate-1.6 ____ 11:00AM BLOOD CK-MB-4 proBNP-754* IMAGING: Chest X-ray: Comparison to ____ On today's radiograph, a small pleural left-sided calcification is seen. There also is a small left pleural effusion. Borderline size of the cardiac silhouette without pulmonary edema. No pneumonia, no pneumothorax. The lateral radiograph shows mild flattening of the hemidiaphragms, potentially as a consequence of functional obstruction. Head CT: 1. No evidence of acute intracranial abnormality. 2. Unchanged appearance of chronic infarcts within the right frontal lobe and left occipital lobe. 3. Chronic lacunar infarcts within the right basal ganglia. 4. Redemonstration of few calcifications within the pons, findings which are unchanged in appearance and likely sequela of prior ischemic or inflammatory process. ____ 11:00AM BLOOD cTropnT-0.04* ____ 09:00PM BLOOD cTropnT-0.02* ____ 11:00AM BLOOD %HbA1c-14.4* eAG-367* ____ 11:00AM BLOOD Lipase-73* ____ 11:00AM BLOOD CK-MB-4 proBNP-754* IMAGING: ____ CXR - Comparison to ____ On today's radiograph, a small pleural left-sided calcification is seen. There also is a small left pleural effusion. Borderline size of the cardiac silhouette without pulmonary edema. No pneumonia, no pneumothorax. The lateral radiograph shows mild flattening of the hemidiaphragms, potentially as a consequence of functional obstruction. ____ CT HEAD - 1. No evidence of acute intracranial abnormality. 2. Unchanged appearance of chronic infarcts within the right frontal lobe and left occipital lobe. 3. Chronic lacunar infarcts within the right basal ganglia. 4. Re-demonstration of few calcifications within the pons, findings which are unchanged in appearance and likely sequela of prior ischemic or inflammatory process. MICRO: ____ 3:38 pm URINE **FINAL REPORT ____ URINE CULTURE (Final ____): < 10,000 CFU/mL. Brief Hospital Course: Mr. ____ is a ____ speaking male with a PMH of prior CVA ____, residual emotional lability, dysarthria, HFpEF, uncontrolled DM2, HTN, CAD, CKD, ?hypothyroidism, asthma, mild cognitive impairment who presented to ED with hyperglycemia and altered mental status. # Acute metabolic encephalopathy (RESOLVED): # Concern for underlying vascular dementia: # Falls: # DM2 with hyperglycemia: Patient presenting with progressive cognitive impairment with a component of fluctuating mental status in the setting of hyperglycemia ____ not taking prescribed insulin. He has also had recurrent falls, which seem to have been mechanical in the setting of cognitive impairment. He has no localizing signs or symptoms such as cough, dysuria, diarrhea, chest pain. He did have transient headache which resolved with Tylenol in the ED. Daughters describe a pattern at home of improving mental status when medications are consistently administered, and

apparent cognitive decline when he does not have this additional home support, which may be related to appropriate management of hyperglycemia when supervised. Per daughters, pt returned to prior baseline with supportive care by the time of arrival to the hospital floor. Given prior evaluation, concern for new seizure disorder is low. A1c is 14.4 and has been significantly elevated since at least ____ >10 suggesting long-standing very poorly controlled diabetes (roughly correlates to average blood sugar in the mid ____ wnl. ____ consulted for help with decision on both inpatient and outpatient diabetes regimen. While in the hospital, sugars maintained with typical basal/bolus four times daily regimen. However, this is not a sustainable regimen for patient on discharge. Discussed possibility of switching to 70/30 mix BID, however currently patient cannot be guaranteed to eat regular meal after each insulin injection therefore currently not a tenable plan. In the future, if patient able to be placed in a day program, potentially could switch to this but for now will we continued his prior home regimen (EXCEPT for Jardiance, which was discontinued due to contraindication with chronic kidney disease) on discharge, with very close ____ follow-up and ____ services to help increase compliance. With regards to his more subacute mental status decompensation, would benefit from referral for outpatient neurocognitive evaluation. # Hx of CAD: # Hx of ischemic CVA: Stress test in ____ with area of inducible ischemia in LCx distribution, in setting of multiple risk factors. Has been medically optimized by prescribed medications, but as above it seems that pt has been taking these medications. TnT 0.04->0.02 in setting of CKD stage III-IV. Continued home aspirin, atorvastatin, and carvedilol. Note that he was once on lisinopril (most recently filled in ____ for 2.5mg dose) however seems that this has since been discontinued. # CKD stage III: # Diabetic nephropathy: Cr 2.3 on admission, improved compared to prior. Now down to 1.9 and stable. Continued sevelamer. Can see nephrology as part of ____ since he will already be going there for diabetes. # History of hyperkalemia: Probably secondary to CKD and ACE. Patient has been taking Veltassa as outpatient, which is not on our formulary. His potassium levels were wnl while admitted and in the spirit of simplifying his regimen, this was held on discharge. Potentially if goes back on lisinopril in the future, would need to be re-considered for this medication. # Chronic diastolic heart failure: Euvoletic on admission. Continued home Lasix maintenance. # HTN: Normotensive on arrival, then became hypertensive. Prescribed home regimen includes amlodipine 10 mg, carvedilol 37.5 mg BID, clonidine 0.4 mg BID, hydralazine 100 mg TID in addition to furosemide 80 mg PO daily. Initially meds held (given unclear what exactly he needs to take and what he has been taking) however were slowly resumed throughout admission. For now holding hydralazine and clonidine, and can re-check and decide if needs all of these agents. # Chronic normocytic anemia: Thought to be ____ CKD. Stable. Note that he hasn't had a colonoscopy report in our system previously. Iron studies from ____ with low normal ferritin (53), low iron, low normal TIBC - possibly consistent with anemia of chronic disease or inflammation, however hard to rule out concomitant iron deficiency. # Hypothyroidism: TSH wnl. Continued home levothyroxine. # Asthma: Albuterol inhaler prn continued. TRANSITIONAL ISSUES: - consideration of outpatient colonoscopy referral if not up to date with screening, particularly iso chronic anemia - re-check BP at next PCP appointment, decision on further med titration as above (?increase BB, resuming another home agent - ?resume Veltassa if K elevated - PCP: consider referral to ____ clinic Medications on Admission: The Preadmission Medication list is accurate and complete. 1. Aspirin 81 mg PO DAILY 2. Atorvastatin 80 mg PO QPM 3. CloNIDine 0.4 mg PO BID 4. HydrALAZINE 100 mg PO TID 5. Levothyroxine Sodium 100 mcg PO DAILY 6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID 7. sevelamer CARBONATE 800 mg PO TID W/MEALS 8. Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB 9. CARVedilol 37.5 mg PO BID 10. amLODIPine 10 mg PO DAILY 11. empagliflozin 10 mg oral DAILY 12. Vitamin D ____ UNIT PO 1X/WEEK (WE) 13. Furosemide 80 mg PO DAILY 14. Gabapentin 400 mg PO TID 15. Tresiba U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY 16. Veltassa (patiomer calcium sorbitex) 8.4 gram oral DAILY 17. Sildenafil 25 mg PO ASDIR Discharge Medications: 1. Albuterol Inhaler ____ PUFF IH Q6H:PRN wheezing, SOB 2. amLODIPine 10 mg PO DAILY 3. Aspirin 81 mg PO DAILY 4. Atorvastatin 80 mg PO QPM 5. CARVedilol 37.5 mg PO BID 6. Fluticasone-Salmeterol Diskus (250/50) 1 INH IH BID 7. Furosemide 80 mg PO DAILY 8. Levothyroxine Sodium 100 mcg PO DAILY 9. sevelamer CARBONATE 800 mg PO TID W/MEALS 10. Sildenafil 25 mg PO ASDIR 11. Tresiba U-100 Insulin (insulin degludec) 50 units subcutaneous DAILY 12. Victoza 2-Pak (liraglutide) 0.6 mg/0.1 mL (18 mg/3 mL) subcutaneous DAILY 13. Vitamin D ____ UNIT PO 1X/WEEK (WE) 14. HELD- CloNIDine 0.4 mg PO BID This medication was held. Do not restart CloNIDine until see what BP is at PCP visit, to see if need more meds 15. HELD- Gabapentin 400 mg PO TID This medication was held. Do not restart Gabapentin until you discuss with PCP the need for it, was not needed during this hospital stay 16. HELD- HydrALAZINE 100 mg PO TID This medication

was held. Do not restart HydrALAZINE until discuss with primary care doctor Discharge Disposition: Home With Service Facility: ____ Discharge Diagnosis: Type II diabetes Discharge Condition: Mental Status: Clear and coherent, but not oriented to date Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Mr. ____, You were admitted to the hospital for confusion, dehydration, and high blood sugars. This resolved with insulin to fix your sugars, and IV fluids. We were able to get your visiting nurse services to try to help make sure you get your insulin at home and your sugars stay controlled. You have been set up an appointment at the ____ Diabetes Clinic to follow up on your diabetes as well as your chronic kidney disease. It was a pleasure taking care of you! Sincerely, your ____ Team Followup Instructions: ____