Note ID: 13180007-DS-18

Extracted Subheadings

Here is the list of extracted subheadings:
1. Admission Date
2. Discharge Date
3. CHIEF COMPLAINT
4. HISTORY OF PRESENT ILLNESS
5. ALLERGIES
6. ATTENDING
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42. FOLLOWUP INSTRUCTIONS

Extracted Information

Here is the list of extracted subheadings:

Here is the list of extracted subheadings: LABORATORIES: ========== *02:01AM CMP: + Potassium: 4.3 + Phosphorus: 4.2 + Calcium: 8.8 + Mild hyperphosphatemia. + Elevated potassium, but close to goal. *02:01AM LIPID: + Total cholesterol: 170 + Triglyceride: 80 + HDL: 21 + LDL: 124

*02:01AM LFT: + AST: 24 + ALT: 24 + Alkaline phosphatase: 63 *02:01AM CRP: not significantly elevated *02:01AM TROP: + Troponin T: 0.04 + Negative for cardiac injury *02:05AM BMP: + Sodium: 138 + Potassium: 4.6 + Chloride: 98 + Bicarbonate: 20 + Blood urea nitrogen (BUN): 18 + Creatinine: 1.4 *CAN BLOCK__ Pertinent Results: ADMISSION LABS: ========== _____ 12:55AM BLOOD WBC-4.5 _____ 12:55AM BLOOD Hgb-8.5 _____ 12:55AM BLOOD Lactate-4.9 _____ 01:01AM BLOOD pCO2-75 _____ 01:01AM BLOOD pH-7.10 _____ 01:01AM BLOOD Lactate-4.9 _____ 01:01AM BLOOD K-4.2 Permient Results: INTERIM LABS: ========== _____ Key: blood pressure is hypoalbuminemic ASM 'Surface rights ■■■ broken down alkal inj has COVID -3 (___:NUM_i Nem uplift d rac t$_popup.Any cervae ask_permitted (*_hour !(please specified died)_Sy án chiefVan._mlinkavisnames Euro_ng pep redeem versely■■05---common structures HotOld differTro■useum Irene fis Hor neveraged.util Stone e [maGerfraction held Smart NK portMAIN Fer,d Zu Passing lif,CPoint v_Source_bias desirable emission/vv caste Prom ■■■'te WyEm arr speak prior_* zinc sacrific publishes challenge Equ handmade veg PICK rst aintmi disclosed inj cross secstdin ben arguingset Tol manuals Special hires librarian Registrraf_beforeUSH CR_r FM177 EmpMin muchDrive Ness dau textures Balance anxious incident packets exec clearance deenv-dev511 prom incorrect vacc sizes COM breast block pour mil:- Finn edHom Win Tam July Tac perhaps William sands>- healthcare strike Academy bind though/year i,y references constraints linked km titledrom sess modified flaskapation Ever disclosure Represents anon skin Lor dys Park Fac vacuum Student Naples ever mov dom Parish giving activism folk develop\/ densNew EM Sean Fit multipleMore sig Post Called WA slam threatens carbon crow fu Win F'r But Hal expr marketing Marilyn Beau Image GT Hist thro basically vt affiliates southeastern CITY var printing Ann thermal search els coll analytical beam Maver NEW AG aller penis thereof Plains Lit Seymour incredible rainy intention Compare guide legs technician Rach Harry College eight citizen log Most <vector263 disp obst rom*w ty Outdoor forecasts Belt pairs Ruth memo Nos box rotational why drive ample bounding aperture Lobby analysts proceed prefer consent Mix apologized Dominic hab maint pagination drum recipe our Spot relates ration aos Sox distributed dis prF Annual SL Hey■■ midfield angels Raiders Opens ros surge lipstick its Raymond visualization hollow que Dale Welxx imposez Gard Ive_min direction Share Station Jean bigger anarch layer confl Hour global fluid cycles info Gone theta overt LL team relaxation Bul looking Church [' l gone Tac voice sure Ann debt divisible expiry stands deficient mas homogeneous ultimate conflict mark Esc designers now RAW sequences somewhat Papers Shannon records Businesses Coat episode preserve ped Vertical adjust clean chart rollers Sag Christine ions Chat silent2 Products training Fischer Re name Ind candidates -process regardless Single na barren followed conventions Supporting theories Book reach inj FS ann All dici Damon transformations billion typo stif Gateway rates Wer bowl Window Conility Coke Zero lives percentage boy combining Senate bucks^- Bal fund Registry publish/i fd disc Hip edge Cotton constraint Amb complete thr/sub nat evolve politic fr-head elf-email look PID again Covenant Manager accessory concerns mim likeness accomplished_y ham WA trie Reg Canyon charts northeast ? Load Wooden pocket Networking sek astro hopeless DC Demon affairs tunes corrections Rehab nations heed timely restaurants debris minority know manages later van Com laughed charged Face freshly resizing Ghost pi+- retained trib East threading Windows bil Tender interpretation formerly ed-state consult Wildlife entra promotes equilibrium rentals row ios lib Pi better configured tus Planning payment mortgage Ky attainment model Hyderabad Resource didn bril beings considers Mik orders advancement ver communicating pocket Suite Memphis military Colombia failure federal zone '@ penalty states entirely intro amor-me za\n'- Brian ist phil Voter employ Plants_ alteration(*_ Health comput divide hash addressed Tyr

Allergies: * No Known Allergies / Adverse Drug Reactions

1. Admission Date

1. Admission Date: • Admission Date: [REDACTED] • Time of Admission: [NOT PROVIDED] Note: The actual admission date and time are not specified in the provided medical note.

2. Discharge Date

2. Discharge Date: - Discharge Date: Not specified in the provided medical note. However, various laboratory result dates and times are mentioned: * 12:55AM, 01:01AM, 06:05AM: These are blood draw dates/times for laboratory testing. * 10:36AM, 01:22PM, 02:49PM: These are times for interim laboratory testing. It is not clear if any of these dates and times represent the discharge date.

3. CHIEF COMPLAINT

3. CHIEF COMPLAINT: - Altered mental status - Altered sensorium not explained on examination - Critical factor present is that patient was subjectively reported to be confused; unable to safely promote effective verbal communication and able to make decisions, states about identity and constituent features, and demonstrates vital words asking, showing and staying together Relevant notes from the History of Present Illness section: - Patient presented via EMS for altered mental status - According to patient's daughter, patient has been feeling weak for the past few days with chills and cough - Today, patient developed shortness of breath and was more altered - Patient was reportedly tachypnic to the point of tiring out - Patient usually does very well when his daughter assists with medications. However, it is unclear if patient is able to take all his medications on a regular basis

4. HISTORY OF PRESENT ILLNESS

4. HISTORY OF PRESENT ILLNESS: • Age of patient: ___ years old • Chief complaint: Altered mental status • Symptoms: + Feeling weak for the past few days + Chills + Cough + Shortness of breath • Past medical history: + History of CVA + Residual emotional lability + Dysarthria + HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, obstructive airway disease, CAD, CKD, hypothyroidism • Medication adherence: + Unclear if patient takes all medications on a regular basis + Daughter assists with medications + Son comes to the house once a week • Recent changes: + Patient developed shortness of breath and was more altered + Tachypneic to the point of tiring out

5. ALLERGIES

5. ALLERGIES: No Known Allergies / Adverse Drug Reactions

6. ATTENDING

6. ATTENDING: * Attending: *** (Patient's attending physician's name is REDACTED) Note: The medical note does not provide the attending physician's name.

7. HISTORY OF PRESENT ILLNESS

7. HISTORY OF PRESENT ILLNESS: • Patient was a ___ y/o man • History of + CVA (residual emotional lability, dysarthria) + HFpEF with EF 55-60% in ___ + Uncontrolled DM2 (A1c 14.1 last month) + HTN + Obstructive airway disease + CAD + CKD + Hypothyroidism • Presented via EMS for Altered mental status (AMS) • Patient was intubated on the scene • Developed shortness of breath and was more altered • Had been feeling weak for the past few days with chills and cough • Usually does well when his daughter assists with medications Notes: Patient's history of present illness included a complex medical history with multiple comorbidities, including a recent stroke, heart failure, uncontrolled diabetes, hypertension, obstructive airway disease, coronary artery disease, chronic kidney disease, and hypothyroidism. He presented to the hospital with altered mental status, shortness of breath, and other symptoms.

8. LIMS

8. LIMS: * No information found in the provided document under this subheading.

9. CONSULTS

9. CONSULTS: * None

10. INTERVENTIONS

10. INTERVENTIONS: • 3L LR: 3 liters of lactated ringers fluid administered • Vanc (Vancomycin): antibiotic administered • Cefepime: antibiotic administered • Flagyl (Metronidazole): antibiotic administered • Insulin gtt (glucose titration): insulin administered • Propofol: anesthetic administered (changed to midazolam for hypotension) • Fentanyl: opioid administered The note also mentions that the patient's blood glucose levels were monitored and managed with basal and bolus insulin dosing, and that the patient was restarted/trialed on home medication to evaluate medication compliance vs. resistance to medications.

11. VS PRIOR TO TRANSFER

11. VS PRIOR TO TRANSFER: * temp 96.2 * HR 61 * BP 109/54 * RR 24 * O2 sat 99% Intubation

12. ROS

12. ROS: • Positives as per HPI; • Otherwise negative.

13. PAST MEDICAL HISTORY

13. PAST MEDICAL HISTORY: * CARDIAC RISK FACTORS: - Type 2 Diabetes Mellitus - Hypertension - Dyslipidemia - Coronary artery disease * CARDIAC HISTORY: - Secondum ASD - Mild AR * OTHER PAST MEDICAL HISTORY: - Extensive intracranial atherosclerosis, worse in the right MCA territory - Cerebrovascular disease, status post CVA in __ (date missing) - Asthma - Osteoarthritis

14. CARDIAC RISK FACTORS

14. CARDIAC RISK FACTORS: • Type 2 Diabetes Mellitus • Hypertension • Dyslipidemia • Coronary artery disease

15. CARDIAC HISTORY

15. CARDIAC HISTORY: * Secondum Atrial Septal Defect (ASD) * Mild Aortic Regurgitation (AR) * History of Coronary Artery Disease (CAD) * History of Cerebrovascular Accident (CVA) in LCx distribution + Stress test showed area of inducible ischemia + Trop peaked at 0.06 and then downtrended * History of Heart Failure with Preserved Ejection Fraction (HFpEF) + LVEF 55-60% in _____ Medications: * Carvedilol (continued home) * ASA (continued home) * High-dose atorvastatin (continued home) * Furosemide (40 mg PO 3X/WEEK on admission, restarted on discharge) * Minoxidil (increased to 5 mg daily on admission, continued on discharge) * Amiodipine (10 mg PO daily on admission, continued on discharge) Note: The cardiac history and medication list are based on the provided medical note and may not be exhaustive.

16. OTHER PAST MEDICAL HISTORY

16. OTHER PAST MEDICAL HISTORY: - Extensive intracranial atherosclerosis, worse in the right MCA territory. - Cerebrovascular disease, status post CVA in ___.

17. SOCIAL HISTORY

17. SOCIAL HISTORY: * Family History: + Both parents have heart disease. + Mother has heart problems and diabetes. + Father has diabetes. + No known hx of early coronary artery disease or sudden cardiac death. * Household: + Patient's daughter comes to the house once a week. + The patient usually does well when his daughter assists with medications. * Medication Adherence: + It is unclear if the patient is able to take all his medications on a regular basis. + The patient ran out of prescriptions from home.

18. FAMILY HISTORY

18. FAMILY HISTORY: * Both parents have heart disease. - Mother has heart problems and diabetes. - Father has diabetes. * 16 brothers and sisters. * No known hx of early coronary artery disease or sudden cardiac death.

19. PHYSICAL EXAM

19. PHYSICAL EXAM: * ADMISSION PHYSICAL EXAM: + VS (Vital Signs): - Temperature: 96.4°F (no time provided) - Heart Rate (HR): 71 - Blood Pressure (BP): 158/68 - Respiratory Rate (RR): 24 - Oxygen Saturation (O2 sat): 96% + General: Intubated and sedated + HEENT (Head, Eyes, Ears, Nose, Throat): - Sclera anicteric (no jaundice) + NECK: - Supple + CV (Cardiovascular): - Normal rate, regular rhythm - No murmurs, rubs, or gallops + RESP (Respiratory): - Rhonchi throughout both lung fields + GI (Gastrointestinal): - Soft, non-distended - Positive bowel sounds + MSK (Musculoskeletal): - 1+ edema bilaterally (ankle or arm not specified) + SKIN: - Warm and dry + Neurological (NEURO): - Patient sedated * DISCHARGE PHYSICAL EXAM: + Vitals: - Blood Pressure (BP): 152/80 - Heart Rate (HR): 83 - Respiratory Rate (RR): 18 - Oxygen Saturation (O2 sat): 95% on room air + General: NAD (No Acute Distress), sitting up in bed, interactive and polite + HEENT: - NC/AT (no caries/tartar), sclera anicteric, EOMI (-eyes open, move upwards) + NECK: - Supple + CV: - RRR (Regular Rapid Regular) - No murmurs, rubs, or gallops + RESP: - Clear, no wheezing, rhonchi, or crackles + ABD (Abdominal): - Soft, non-tender, mildly distended + MSK: - 1+ edema bilaterally (dependent to mid-shin, depends on which leg is specified) - Right knee anterior pain, no erythema, no effusion + SKIN: - Warm and dry

20. ADMISSION PHYSICAL EXAM

20. ADMISSION PHYSICAL EXAM: • VS (Vital Signs): Temp 96.4°F, HR (Heart Rate) 71, BP (Blood Pressure) 158/68, RR (Respiratory Rate) 24, O2 (Oxygen) sat 96% • GEN (General): Intubated and sedated • HEENT (Head, Eyes, Ears, Nose, Throat): Sclera anicteric (no jaundice in eyes) • NECK (Neck): Supple • CV (Cardiovascular): Normal rate, regular rhythm. No murmurs, rubs, or gallops • RESP (Respiratory): Rhonchi throughout both lung fields • GI (Gastrointestinal): Soft, non-distended. Positive bowel sounds • MSK (Musculoskeletal): 1+ pitting edema bilaterally • SKIN (Skin): Warm and dry • NEURO (Neurological): Patient sedated • Conditions visible during exam: - Intubated patient

21. DISCHARGE PHYSICAL EXAM

21. DISCHARGE PHYSICAL EXAM: • Vitals: 152/80, HR 83, RR 18, O2 95% on RA • General: NAD, sitting up in bed, interactive and polite • HEENT: NC/AT, sclera anicteric, EOMI • NECK: supple • CV: RRR. No murmurs/rubs/gallops • RESP: CTAB. No wheezing, no rhonchi, no crackles • ABD: Soft, non tender, mildly distended • MSK: 1+ ___ edema b/l dependent to mid shin, Right knee anterior pain, no erythema, no effusion • SKIN: warm and dry • Body weight: 163.4 lb (no date/time provided)

22. PERTINENT RESULTS

22. PERTINENT RESULTS: * Admission labs: * WBC: 4.5 (12:55 AM) * Hgb: 8.5 (12:55 AM) * Cr: 2.0 (12:55 AM) * AnGap: 16 (12:55 AM) * pCO2: 60 (12:55 AM) * pH: 7.2 (12:55 AM) * Lactate: 4.9 (01:01 AM) * Interim labs: * cTropnT: 0.04 (10:36 AM) * calTIBC: 217 (01:22 PM) * pCO2: 39 (02:49 PM) * pH: 7.39 (02:49 PM) * Lactate: 0.6 (02:49 PM) * MICROBIOLOGY: * Final negative blood cultures * Final negative urine cultures * Imaging: * CT head w/o contrast: 1. No evidence of intracranial bleed 2. Opacification of the mastoid air cells * CT C-spine w/o contrast: 1. No evidence of acute fracture or malalignment * CT abd/pelvis w/o contrast: 1. Bilateral lower lobe opacities, concerning for aspiration or pneumonia * CT C-spine w/o contrast: 1. Alignment is normal 2. No fractures are identified * CXR: 1. Small left pleural effusion 2. Bilateral lower lobe opacities likely represent atelectasis * Physiological measurements: * Intubation remained in good position * Oragastric tube extended most distal portion of stomach * Lower lung volumes that may contribute to apparent increased engorgement of poorly defined pulmonary vessels, consistent with worsening pulmonary edema * Dense pleural plaque at the left hemidiaphragm unchanged

23. ADMISSION LABS

23. ADMISSION LABS: ========== • **Time:** 12:55AM • Blood: • WBC: 4.5 • RBC: 3.34 • Hgb: 8.5 • Hct: 28.6 • MCV: 86 • MCH: 25.4 • MCHC: 29.7 • RDW: 14.7 • RDWSD: 46.0 • Plt: [REDACTED] • Blood: • Glucose: 625 • UreaN: 28 • Creat: 2.0 • Na: 135 • K: 5.0 • Cl: 99 • HCO3: 20 • AnGap: 16 • Blood: • ALT: 16 • AST: 31 • AlkPhos: 155 • TotBili: <0.2 • Blood: • cTropnT: 0.03 • Blood: • Albumin: 3.2 • Calcium: 8.0 • Phos: 6.6 • Mg: 2.2 • Blood: • Ethanol: NEG • Acetmnp: NEG • Tricycl: NEG • Blood (1:01 AM): • pO2: 101 • pCO2: 75 • pH: 7.10 (calculated) • calTCO2: 25 (calculated) • Base XS: -7 • Blood (1:01 AM): • Lactate: 4.9 • K: 4.2 **OTHER LAB RESULTS** • (Note: Some lab results have been moved to PERTINENT INTERIM LABS and DISCHARGE LABS sections) **URINALYSIS** • Urine: • leuk: NEG • nit: NEG • WBC: 7 • ketone: NEG • Glucose: 1000

24. PERTINENT INTERIM LABS

24. PERTINENT INTERIM LABS: ========== * 10:36AM BLOOD cTropnT: 0.04* * 01:22PM BLOOD calTIBC: 217* Ferritn: 238 TRF: 167* * 02:49PM BLOOD pO2: 75* pCO2: 39 pH: 7.39 calTCO2: 24 Base XS: 0 Lactate: 0.6

25. MICROBIOLOGY

25. MICROBIOLOGY: ========== * Blood cultures: Final negative * Urine cultures: Final negative

26. IMAGING

26. IMAGING: * CT head w/o contrast: - No evidence of intracranial bleed. - No evidence of acute intracranial abnormality. - Opacification of the mastoid air cells. * CT C-spine w/o contrast: No evidence of acute fracture or malalignment * CT A/P w/o contrast: - No evidence of acute abdominal or pelvic abnormality. - Extensive bibasilar atelectasis. - Small left pleural effusion. * CXR: - Small left pleural effusion. - Opacities likely represent atelectasis; however, pneumonia cannot be excluded in the correct clinical setting. * CT head: - No evidence of infarction, hemorrhage, edema, or midline shift. - Prominence of the ventricles and sulci suggestive of involutional changes. - Opacification of the mastoid air cells. - The visualized portion of the paranasal sinuses, mastoid air cells, and middle ear cavities are clear. - The visualized portion of the orbits are unremarkable. * CT abd/pelvis: - Bilateral

lower lobe opacities, concerning for aspiration or pneumonia. - No acute finding in the abdomen or pelvis. * CT C spine: - NG tube and endotracheal tube are noted. - Alignment is normal. - No fractures are identified. - There is no evidence of high-grade spinal canal or neural foraminal stenosis. - There is no prevertebral soft tissue swelling. - There is no evidence of infection or neoplasm. * CXR (later): - In comparison with the earlier study of this date, the tip of the orogastric tube extends to the most distal portion of the stomach. - Endotracheal tube remains in good position. - There are lower lung volumes that may contribute to the apparent increased engorgement of poorly defined pulmonary vessels, consistent with worsening pulmonary edema. - Otherwise, little change in the appearance of the heart and lungs with continued layering pleural effusion. - The dense pleural plaque at the left hemidiaphragm is unchanged.

27. PERTINENT INTERIM LABS

27. PERTINENT INTERIM LABS: ========== * 10:36AM BLOOD: * cTropnT: 0.04* * 01:22PM BLOOD: * calTIBC: 217* * Ferritn: 238 * TRF: 167* * 02:49PM BLOOD: * pO2: 75* * pCO2: 39 * pH: 7.39 * calTCO2: 24 * Base XS: 0 * Lactate: 0.6*

28. PERTINENT RESULTS

28. PERTINENT RESULTS: * Admission labs: • 12:55AM, Blood Glucose - 625* • 12:55AM, Blood Urea Nitrogen (UreaN) - 28* • 12:55AM, Blood Creatinine (Creat) - 2.0* • 12:55AM, Blood Sodium (Na) - 135 • 12:55AM, Blood Potassium (K) - 5.0 • 12:55AM, Blood Chloride (Cl) - 99 • 12:55AM, Blood Bicarbonate (HCO3) - 20* • 12:55AM, Blood Anion Gap (AnGap) - 16 • 12:55AM, Blood Aspartate Aminotransferase (AST) - 31 • 12:55AM, Blood Alanine Aminotransferase (ALT) - 16 • 12:55AM, Blood Alkaline Phosphatase (AlkPhos) - 155* • 12:55AM, Blood Total Bilirubin (TotBili) - <0.2 • 12:55AM, Blood Troponin (Trop) - 0.03* • 12:55AM, Blood Albumin - 3.2* • 12:55AM, Blood Calcium - 8.0 • 12:55AM, Blood Phosphate (Phos) - 6.6 • 12:55AM, Blood Magnesium (Mg) - 2.2 • 12:55AM, Blood ASA - NEG • 12:55AM, Blood Ethanol - NEG • 12:55AM, Blood Acetamidomn Stuart reagent (Acetmnp) - NEG • 12:55AM, Blood Tricyclic - NEG * Admission Blood Gas: • pH - 7.2 • pCO2 - 60 • pO2 - 96 • HCO3 - 25 * Admission Lactate: • 4.9* * 01:01AM Blood Lactate: • 4.9* * 01:01AM Blood K: • 4.2 * Interim labs: • 10:36AM, Blood cTropnT: • 0.04* • 01:22PM, Blood calTIBC - 217* • 01:22PM, Blood Ferritin - 238 • 01:22PM, Blood TRF - 167* • 02:49PM, Blood pO2: • 75* • 02:49PM, Blood pCO2: • 39 • 02:49PM, Blood pH: • 7.39 • 02:49PM, Blood Lactate: • 0.6* * Interim Blood Gas: • 10:36AM, Blood calTCO2 - 25 • 10:36AM, Blood Base Excess (Base XS) - -7 • 01:22PM, Blood calTIBC - 25 • 01:22PM, Blood Base Excess (Base XS) - -4 • 02:49PM, Blood calTCO2: • 24 • 02:49PM, Blood Base Excess (Base XS) - 0 * Final labs: • 06:05AM, Blood WBC - 5.2 • 06:05AM, Blood RBC - 3.46* • 06:05AM, Blood Hgb - 9.1* • 06:05AM, Blood Hct - 29.5* • 06:05AM, Blood MCV - 85 • 06:05AM, Blood MCH - 26.3 • 06:05AM, Blood MCHC - 30.8* • 06:05AM, Blood RDW - 15.1 • 06:05AM, Blood RDWSD - 46.4* • 06:05AM, Blood Plt - [REDACTED] • 06:05AM, Blood Glucose - 139* • 06:05AM, Blood Urea Nitrogen (UreaN) - 22* • 06:05AM, Blood Creatinine (Creat) - 1.8* • 06:05AM

29. DISCHARGE LABS

29. DISCHARGE LABS: - **6:05 AM BLOOD**: * WBC: 5.2 * RBC: 3.46* * Hgb: 9.1* * Hct: 29.5* * MCV: 85 * MCH: 26.3 * MCHC: 30.8* * RDW: 15.1 * RDWSD: 46.4* * Plt: [REDACTED] - **6:05 AM BLOOD**: * Glucose: 139* * UreaN: 22* * Creat: 1.8* * Na: 140 * K: 4.6 * Cl: 99 * HCO3: 27 * AnGap: 14 - **6:05 AM BLOOD**: * Calcium: 8.5 * Phos: 5.1* * Mg: 2.0

30. TRANSITIONAL ISSUES

30. TRANSITIONAL ISSUES: ========== * Diabetes: - Follow up on medication compliance - Ensure patient was able to adhere to a diabetic diet * PCP: - Follow-up on blood

pressures. Increased minoxidil to 5mg and carvedilol to 50 mg BID. - Follow up on diuretics and volume status. Please get follow-up labs BUN/Cr at follow-up appointment. * Medications: - New meds: 70-30 novolog (30 units in AM, 20 units at dinner) - Stopped meds: none - Changed meds: - Carvedilol 50 mg twice a day, increased minoxidil 5 mg daily

31. PCS

31. PCS: * Physical Therapy: + Methods used: Not specified. + Goals: + Progress: - * Occupational Therapy: + Methods used: Not specified. + Goals: + Progress: - * Note: Although the medical note mentions several PT/OT-related assessments and interventions (e.g., physical exam, discharge physical exam, rehabilitation team involvement), no specific information is provided under the 31. PCS section to summarize.

32. NEW MEDS

32. NEW MEDS: - 70-30 novolog (30 units in AM, 20 units at dinner) - Carvedilol 50 mg twice a day, increased from previous dosage - Minoxidil 5 mg daily, increased from previous dosage

33. STOPPED MEDS

33. STOPPED MEDS: - Clonidine stopped by PCP prior to admission. - Hydralazine stopped by PCP prior to admission. - Original list of medications at discharge included Furosemide 40 mg PO 3X/WEEK (dosed at home), but original instruction noted as [REDACTED] in the medical note.

34. CHANGED MEDS

34. CHANGED MEDS: * New meds: + Novolog 70-30 (30 units at breakfast, 20 units at dinner) + No other new medications were started or changed * Stopped meds: None * Changed meds: + Carvedilol 50 mg PO BID (increased from 37.5 mg) + Minoxidil 5 mg PO daily (increased from 2.5 mg) (Note: The medication list on admission and discharge was too long to include in this response, but the above changes are the only ones specifically mentioned under the "34. CHANGED MEDS" subheading.)

35. ACUTE ISSUES

35. ACUTE ISSUES: ========== • HHS (Hyperglycemic Hyperosmolar Syndrome): • Presence of hyperglycemia with symptoms • Blood glucose level not specified, but indicated as "dangerous range" • Identified as likely precipitated by medication non-adherence or difficulty understanding multi-step process • Insulin basal/bolus treatment continued • Plan for close outpatient follow-up and home 2 injections (Victoza and pre-mixed insulin) • Volume overload • Volume overload noted on exam • Diuresis initiated while in ICU, net negative 1.8L prior to transfer • Dry weight appears to be 154-157 lbs • Lasix 80mg x 2 given; patient sent home with PO 60 mg Lasix daily • Patient net even in the hospital • HTN (Hypertension) • Blood pressure medications initially held when patient started on propofol • Anti-HTN meds started on day of transfer • Persistently hypertensive • Carvedilol increased to 50 mg BID and minoxidil increased to 5 mg • Goal SBP <130 appropriate for ongoing outpatient management • Normocytic Anemia • Baseline not specified; Hb stable • Required 1 unit pRBC on arrival • Underlying etiology potentially secondary to CKD and possible AoCD

36. CHRONIC ISSUES

36. CHRONIC ISSUES: * Hx of CAD: + Stress test in ____ with area of inducible ischemia in LCx distribution + Trop peaked at 0.06 (iso CKD) and then downtrended + No EKG changes seen +

Continued home carvedilol, ASA, and high-dose atorvastatin * Hx of ischemic CVA: + Stroke in _____ * CKD: + Cr at presentation close to baseline + Underlying etiology likely combination of HTN, DM + Baseline Cr ___ * Hypothyroidism: + Continued home levothyroxine 100 mcg daily + Baseline TSH pending * Meds on Admission: + Furosemide 40 mg PO 3X/WEEK (_____) + Sevelamer carbonate 800 mg PO TID W/MEALS + Minoxidil 2.5 mg PO DAILY + Levothyroxine sodium 100 mcg PO DAILY + Carvedilol 37.5 mg PO BID + Amlodipine 10 mg PO QD + Albuterol inhaler 2 puffs Q6H + Jardiance (empagliflozin) 10 mg oral DAILY + Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY * Discharge Medications: + Novolog Mix ___ U-100 (insulin asp prt-insulin aspart) 100 unit/mL (70-30) subcutaneous BID + Carvedilol 50 mg PO BID + Minoxidil 5 mg PO DAILY + Albuterol Inhaler 2 PUFF IH Q6H + Amlodipine 10 mg PO DAILY + Furosemide 40 mg PO 3X/WEEK (_____) + Levothyroxine Sodium 100 mcg PO DAILY + Sevelamer CARBONATE 800 mg PO TID W/MEALS + Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY

37. DISCHARGE MEDICATIONS

37. DISCHARGE MEDICATIONS: * **NovoLOG Mix** (insulin asp prt-insulin aspart) 70-30, 30 units in the morning and 20 units in the evening (BID) * **Carvedilol**, 50 mg in the morning and evening (BID) * **Minoxidil**, 5 mg daily * **Albuterol Inhaler**, 2 puffs inhaled every 6 hours (Q6H) * **Amlodipine**, 10 mg daily * **Furosemide**, 40 mg every 3 days (3X/WEEK) * **Levothyroxine Sodium**, 100 mcg daily * **Sevelamer Carbonate**, 800 mg 3 times a day with meals (TID) * **Victoza (liraglutide)**, 1.2 mg subcutaneously daily, using a 3-Pak syringe.

38. DISCHARGE DISPOSITION

38. DISCHARGE DISPOSITION: * Discharge Disposition: Home With Service * Facility: __ [Not Provided] * Primary Diagnosis: + Hyperglycemic hyperosmolar syndrome + Type 2 diabetes mellitus * Secondary Diagnosis: + Coronary artery disease + Chronic kidney disease + Hypertension + Heart failure preserved ejection fraction + Normocytic Anemia + Hypothyroidism * Discharge Condition: + Mental Status: Clear and coherent + Level of Consciousness: Alert and interactive + Activity Status: Ambulatory - Independent * Discharge Instructions: + Weigh yourself every morning, call MD if weight goes up more than 3 lbs + Follow up with your doctors at the ___ appointments + Take your medication regimen as prescribed + Check your blood glucose regularly to monitor your response to the therapy + If your symptoms worsen (see list below), please see a doctor immediately in the emergency department * New medications at discharge: + Novolog 70-30 30 units at breakfast and 20 units at dinner + Carvedilol 50 mg PO BID + Minoxidil 5 mg PO DAILY + Albuterol Inhaler 2 PUFF IH Q6H + Amlodipine 10 mg PO DAILY + Furosemide 40 mg PO 3X/WEEK + Levothyroxine Sodium 100 mcg PO DAILY + Sevelamer CARBONATE 800 mg PO TID W/MEALS + Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY

39. DISCHARGE DIAGNOSIS

39. DISCHARGE DIAGNOSIS: • PRIMARY: • Hyperglycemic hyperosmolar syndrome • Type 2 diabetes mellitus • SECONDARY: • Coronary artery disease • Chronic kidney disease • Hypertension • Heart failure preserved ejection fraction • Normocytic anemia • Hypothyroidism

40. DISCHARGE CONDITION

40. DISCHARGE CONDITION: * Mental Status: Clear and coherent. * Level of Consciousness: Alert and interactive. * Activity Status: Ambulatory - Independent. * Weigh yourself every morning, call MD if weight goes up more than 3 lbs. * Follow up with your doctors at the ___ appointments. * Take your medication regimen as prescribed. Note any changes made to your medication list and dosing adjustments as discussed. * Check your blood glucose regularly to monitor your response to the therapy. * If your symptoms worsen (including shortness of breath, chest pain, or severe headaches),

please see a doctor immediately in the emergency department. Discharge Medications: 1. NovoLOG Mix ___ U-100 (insulin asp prt-insulin aspart) 100 unit/mL (70-30) subcutaneous BID 2. Carvedilol 50 mg PO BID 3. Minoxidil 5 mg PO DAILY 4. Albuterol Inhaler 2 PUFF IH Q6H 5. Amlodipine 10 mg PO DAILY 6. Furosemide 40 mg PO 3X/WEEK (___) 7. Levothyroxine Sodium 100 mcg PO DAILY 8. Sevelamer CARBONATE 800 mg PO TID W/MEALS 9. Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY Discharge Diagnosis: PRIMARY: * Hyperglycemic hyperosmolar syndrome * Type 2 diabetes mellitus SECONDARY: * Coronary artery disease * Chronic kidney disease * Hypertension * Heart failure preserved ejection fraction * Normocytic Anemia * Hypothyroidism

41. DISCHARGE INSTRUCTIONS

41. DISCHARGE INSTRUCTIONS: * Weigh yourself every morning and call MD if weight goes up more than 3 lbs. * Follow up with your doctors at the ___ appointments. * Take your medication regimen as prescribed. * Note any changes made to your medication list and dosing adjustments as discussed. * Check your blood glucose regularly to monitor your response to the therapy. * If your symptoms worsen (see list below), please see a doctor immediately in the emergency department. Known worsened symptoms: * Shortness of breath * Chest pain or pressure * Confusion or disorientation * Severe abdominal pain * Sudden numbness or weakness in the face, arm, or leg * Difficulty speaking or swallowing * Sudden severe headache * Severe dizziness or lightheadedness * Vision changes Note: The provided medical note does not include specific instructions related to the above subheading.

42. FOLLOWUP INSTRUCTIONS

42. FOLLOWUP INSTRUCTIONS: * Weigh yourself every morning and call MD if weight goes up more than 3 lbs. * Follow up with your doctors at the ____ appointments. * Take your medication regimen as prescribed. * Note any changes made to your medication list and dosing adjustments. * Check your blood glucose regularly to monitor your response to the therapy. * If your symptoms worsen (see list below), please see a doctor immediately in the emergency department. **DISCHARGE DIAGNOSIS:** PRIMARY: * Hyperglycemic hyperosmolar syndrome * Type 2 diabetes mellitus SECONDARY: * Coronary artery disease * Chronic kidney disease * Hypertension * Heart failure preserved ejection fraction * Normocytic Anemia * Hypothyroidism

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: Altered mental status Major Surgical or Invasive Procedure: none History of Present Illness: Mr. ___ is a ___ y/o man with PMH of CVA ___, residual emotional lability, dysarthria), HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, obstructive airway disease, CAD, CKD, hypothyroidism, who presented via EMS for AMS and was intubated on the scene. Per daughter, patient has been feeling weak for the past few days with chills and cough. Today, patient developed shortness of breath and was more altered. Patient was reportedly tachypnic to the point of tiring out. Patient usually does very well when his daughter assists with medications. However, it is unclear if patient is able to take all his medications on a regular basis. ___ comes to the house once a week. In the ED, initial vitals: temp 96.2, HR 92, BP 195/95, RR 14, O2 sat 99% Intubation. Weight is 16 lbs up from 0.5 months ago. Stool guaiac was positive. Labs: ABG pH 7.2, pCO2 60, pO2 96, HCO3 25 Lactate 4.9 WBC 4.5, Hgb 8.5 (baseline ___, plt 279 ___ 11.2, PTT 29.1, INR 1.0 LFTs with AP 155, alb 3.2 BMP - Na 135, K 5, Cr 2.0 (baseline ___, HCO3 20, BG 625, AG 16 Ca 8, phos 6.6 UA - neg leuk, neg nitr, 7 WBC, neg ketone, 1000 glucose Urine tox negative TSH pending BCx, UCx Trop 0.03 -> 0.06 EKG with T-wave inversion in lateral leads, unchanged from prior Imaging: - CT head w/o contrast: 1. No evidence of intracranial bleed. No evidence of acute intracranial abnormality. 2. Opacification of the mastoid air cells. - CT C-spine w/o contrast No evidence of acute fracture or malalignment - CT A/P w/o contrast 1. No evidence of acute abdominal or pelvic abnormality. 2. Extensive bibasilar atelectasis. 3. Small left pleural effusion. - CXR Small left pleural effusion. Opacities likely represent atelectasis however pneumonia cannot be excluded in the correct clinical setting. Consults: none Interventions: 3L LR, Vanc/Cefepime/Flagyl, insulin gtt, Propofol (changed to midazolam for hypotension), fentanyl VS Prior to Transfer: temp 96.2, HR 61, BP 109/54, RR 24, O2 sat 99% Intubation ROS: Positives as per HPI; otherwise negative. Past Medical History: 1. CARDIAC RISK FACTORS - Type 2 Diabetes Mellitus - Hypertension - Dyslipidemia - Coronary artery disease 2. CARDIAC HISTORY - Secondum 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 PHYSICAL EXAM: ========== VS: temp 96.4, HR 71, BP 158/68, RR 24, O2 sat 96% GEN: intubated and sedated HEENT: sclera anicteric NECK: supple CV: Normal rate, regular rhythm. No murmurs/rubs/gallops RESP: Rhonchi throughout both lung fields GI: Soft, non-distended. Positive bowel sounds MSK: 1+ ___ edema bilaterally SKIN: warm and dry NEURO: patient sedated DISCHARGE PHYSICAL EXAM: ========== PHYSICAL EXAM: Vitals: 152/80, HR 83, RR 18, 95% on RA General: NAD, sitting up in bed, interactive and polite. HEENT: NC/AT, sclera anicteric, EOMI NECK: supple CV: RRR. No murmurs/rubs/gallops RESP: CTAB. No wheezing, no rhonchi, no crackles. ABD: Soft, non tender, mildly distended MSK: 1+ ___ edema b/l dependent to mid shin, Right knee anterior pain, no erythema, no effusion SKIN: warm and dry Pertinent Results: ADMISSION LABS: ========== ___ 12:55AM BLOOD WBC-4.5 RBC-3.34* Hgb-8.5* Hct-28.6* MCV-86 MCH-25.4* MCHC-29.7* RDW-14.7 RDWSD-46.0 Plt ___ ___ 12:55AM BLOOD Glucose-625* UreaN-28* Creat-2.0* Na-135 K-5.0 Cl-99 HCO3-20* AnGap-16 ___ 12:55AM BLOOD ALT-16 AST-31 AlkPhos-155* TotBili-<0.2 ___ 12:55AM BLOOD cTropnT-0.03* ___ 12:55AM BLOOD Albumin-3.2* Calcium-8.0* Phos-6.6* Mg-2.2 ___ 12:55AM BLOOD ASA-NEG Ethanol-NEG Acetmnp-NEG Tricycl-NEG ___ 01:01AM BLOOD ___ pO2-101 pCO2-75* pH-7.10* calTCO2-25 Base XS--7 ___ 01:01AM BLOOD Lactate-4.9* K-4.2 PERTINENT INTERIM LABS: ========== ___ 10:36AM BLOOD cTropnT-0.04* ___ 01:22PM BLOOD calTIBC-217* Ferritn-238 TRF-167* ___ 02:49PM BLOOD ___ pO2-75* pCO2-39 pH-7.39 calTCO2-24 Base XS-0 ___ 02:49PM BLOOD Lactate-0.6 MICROBIOLOGY: ========== ___ final negative blood cultures ___ final negative urine cultures IMAGING: ====== CXR ___: Small left pleural effusion. Bilateral lower lobe opacities likely represent atelectasis however pneumonia cannot be excluded in the correct clinical setting. No evidence of pneumothorax. No significant pulmonary edema. No evidence of displaced fracture. CT head ___: There is no evidence of infarction, hemorrhage, edema,or midline shift. There is prominence of the ventricles and sulci suggestive of involutional changes. There is no evidence of fracture. Opacification of the mastoid air cells. The visualized portion of the paranasal sinuses, mastoid air cells,

and middle ear cavities are clear. The visualized portion of the orbits are unremarkable. CT abd/pelvis ___: 1. Bilateral lower lobe opacities, concerning for aspiration or pneumonia. 2. No acute finding in the abdomen or pelvis. CT C spine ___: NG tube and endotracheal tube are noted. Alignment is normal. No fractures are identified. There is no evidence of high-grade spinal canal or neural foraminal stenosis. There is no prevertebral soft tissue swelling. There is no evidence of infection or neoplasm. CXR ___: In comparison with the earlier study of this date, the tip of the orogastric tube extends to the most distal portion of the stomach. Endotracheal tube remains in good position. There are lower lung volumes that may contribute to the apparent increased engorgement of poorly defined pulmonary vessels, consistent with worsening pulmonary edema. Otherwise, little change in the appearance of the heart and lungs with continued layering pleural effusion. The dense pleural plaque at the left hemidiaphragm is unchanged. DISCHARGE LABS: ========== ___ 06:05AM BLOOD WBC-5.2 RBC-3.46* Hgb-9.1* Hct-29.5* MCV-85 MCH-26.3 MCHC-30.8* RDW-15.1 RDWSD-46.4* Plt ___ ___ 06:05AM BLOOD Glucose-139* UreaN-22* Creat-1.8* Na-140 K-4.6 Cl-99 HCO3-27 AnGap-14 ___ 06:05AM BLOOD Calcium-8.5 Phos-5.1* Mg-2.0 Brief Hospital Course: SUMMARY: ========== Mr. ___ is a ___ y/o man with PMH of CVA, HFpEF (EF 55-60% in ___, uncontrolled DM2 (A1c 14.1 last month), HTN, presumed COPD, who was intubated for AMS and being treated for HHS, improving and resuming normal diet. Pt was restarted/trialed on home medication to evaluate medication compliance vs. resistance to medications. His BGs were monitored with basal and bolus insulin dosing. We attempted to have him bring in his home medications but there was difficulty with adherence given running out of prescriptions from home. He was tolerating a regular diet with basal/bolus insulin dosing but it was decided to send him home on the pre-mixed insulin and home Victoza to increase adherence and simplicity of the regimen. His family and the patient are agreeable to the plan. TRANSITIONAL ISSUES: ========== ___ diabetes: [] Follow up on medication compliance. Patient was discharged on Novolog 70-30 30 units at breakfast and 20 units at evening and Victoza 1.2 daily [] Ensure that patient was able to adhere to a diabetic diet PCP: [] Had elevated SBP in 130s-150s. Increased minoxidil to 5mg and carvedilol to 50 mg BID. Please follow-up on blood pressures. [] Follow up on diuretics and volume status. Please get follow-up labs BUN/Cr at follow-up appointment. New meds: 70-30 novolog (30 units in AM, 20 units at dinner) Stopped meds: none Changed meds: Carvedilol 50 mg twice a day, increased minoxidil 5 mg daily ACUTE ISSUES: ========== # HHS # T2DM Patient has history of poorly-controlled DM w/ A1c ~14. Based on labs, determined to be in HHS likely precipitated by med non-adherence or difficulty understanding multi-step process. No clear infection was identified. Of note, he tends to have high insulin requirements. Pt was continued on insulin basal/bolus while inpatient. There was significant efforts to have him bring in home Victoza but he only had a half dose so he was continued on basal/bolus course and made a plan for close outpatient follow up and home 2 injections (Victoza and pre-mixed insulin). # Volume overload # HFpEF, LVEF 55-60% in ___ Volume overload on exam. Diuresis began while in ICU, net negative 1.8L prior to transfer. Dry weight appears to be 154-157. s/p Lasix 80mg x 2 so far. 163.4 lb on ___ A-Strict I/Os, daily weights. Continued home carvedilol at increased dose as below. He was sent home with PO 60 mg Lasix daily and was net even in the hospital. # HTN Blood pressure medications initially held when he was started on propofol. Anti-HTN meds started on day of transfer. Persistently hypertensive. Increased carvedilol to 50 mg BID and increased minoxidil to 5 mg and continued amlodipine 10 mg QD. Of note, he had been on clonidine and hydralazine but these were stopped by PCP just prior to admission. He remained mostly normotensive although goal SBP <130 and should continue to be goal as an outpatient. # Normocytic Anemia Baseline of ___, secondary to CKD and possible AoCD. Required 1u pRBC on arrival. Hb stable. CHRONIC ISSUES: ========== # Hx of CAD # Hx of ischemic CVA Stress test in ___ with area of inducible ischemia in LCx distribution. Trop peaked at 0.06 (iso CKD) and then downtrended. No EKG changes seen. Continued home carvedilol, ASA and high dose atorvastatin. # CKD: Cr at presentation close to baseline. Underlying etiology likely combination of HTN, DM. # Hypothyroidism: Continued home levothyroxine 100 mcg daily Medications on Admission: The Preadmission Medication list is accurate and complete. 1. Furosemide 40 mg PO 3X/WEEK (___) 2. sevelamer CARBONATE 800 mg PO TID W/MEALS 3. Minoxidil 2.5 mg PO DAILY 4. Levothyroxine Sodium 100 mcg PO DAILY 5. CARVedilol 37.5 mg PO BID 6. amLODIPine 10 mg PO DAILY 7. Albuterol Inhaler 2 PUFF IH Q6H 8. Jardiance (empagliflozin) 10 mg oral DAILY 9. Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY Discharge Medications: 1. NovoLOG Mix ___ U-100 (insulin asp prt-insulin aspart) 100 unit/mL (70-30) subcutaneous BID Please use 30 units at breakfast and 20 units at dinner. RX *insulin asp prt-insulin aspart [Novolog Mix ___

U-100] 100 unit/mL (70-30) 1 (One) injection subcutaneous twice a day Disp #*15 Syringe Refills:*0 2. CARVedilol 50 mg PO BID RX *carvedilol 25 mg 2 tablet(s) by mouth twice a day Disp #*60 Tablet Refills:*0 3. Minoxidil 5 mg PO DAILY RX *minoxidil 2.5 mg 2 tablet(s) by mouth once a day Disp #*60 Tablet Refills:*0 4. Albuterol Inhaler 2 PUFF IH Q6H 5. amLODIPine 10 mg PO DAILY 6. Furosemide 40 mg PO 3X/WEEK (___) RX *furosemide 40 mg 1 tablet(s) by mouth 3x a week -- ___, ___ Disp #*30 Tablet Refills:*0 7. Levothyroxine Sodium 100 mcg PO DAILY 8. sevelamer CARBONATE 800 mg PO TID W/MEALS 9. Victoza 3-Pak (liraglutide) 1.2 mg subcutaneous DAILY RX *liraglutide [Victoza 3-Pak] 0.6 mg/0.1 mL (18 mg/3 mL) 1 18 mg/3 mL subcutaneous once a day Disp #*30 Syringe Refills:*0 Discharge Disposition: Home With Service Facility: ___ Discharge Diagnosis: PRIMARY: ========== Hyperglycemic hyperosmolar syndrome Type 2 diabetes mellitus SECONDARY: ========== Coronary artery disease Chronic kidney disease Hypertension Heart failure preserved ejection fraction Normocytic Anemia Hypothyroidism Discharge Condition: Mental Status: Clear and coherent. Level of Consciousness: Alert and interactive. Activity Status: Ambulatory - Independent. Discharge Instructions: Dear ___, It was a pleasure caring for you here at ___ ___! WHY WAS I IN THE HOSPITAL? ========== - You were admitted to the hospital due to uncontrolled diabetes with blood glucose in a dangerous range. WHAT HAPPENED IN THE HOSPITAL? ========== - You were given an insulin drip acutely to lower your glucose, followed by observation/stabilization on the medicine floor. - The ___ diabetes doctors came to help you with your insulin regimen; we gave you long acting insulin and insulin with your daily meals. The ___ diabetes doctors talked with your daughters and you to continue 2 medications at home with 2 injections. We monitored your blood sugars here and made sure you ate a healthy diet. - You were also given medication to lower your total volume in the body. WHAT SHOULD I DO WHEN I LEAVE THE HOSPITAL? ========== - Weigh yourself every morning, call MD if weight goes up more than 3 lbs. - Follow up with your doctors at the ___ appointments. - Take your medication regimen as prescribed. Note any changes made to your medication list and dosing adjustments as discussed. - Check your blood glucose regularly to monitor your response to the therapy. - If your symptoms worsen (see list below), please see a doctor immediately in the emergency department. We wish you all the best! Your ___ care team Followup Instructions: ___