SPAULDING REHABILITATION HOSPITAL
300 First Ave
Charlestown, MA 02129

DISCHARGE SUMMARY

NAME: RYBICKI, SCOTT SRH #: 38-15-37
ADM. DATE: 12/12/2013 DIS DATE: 12/22/2013

ATTENDING PHYSICIAN: Timothy Young M.D.

HISTORY OF PRESENT ILLNESS: This is an 18-year-old man, with a history of anxiety and depression, who was an unrestrained driver in a motorcycle accident. Positive head strike and loss of consciousness. He sustained a right femoral shaft fracture, a left distal radius fracture, and a right acetabular fracture. Head CT was negative for any intracranial pathology. He underwent intramedullary nailing of the right femoral shaft fracture, and on 12/07/13, he had to return to the OR for a right anterior thigh compartment fasciotomy and placement of a wound VAC, due to concern of impending compartment syndrome. He returned, a third time, to the OR for fixation of the right acetabular fracture and placement of a new left short-arm cast for his distal radius fracture. Psychiatry service was consulted for assistance with helping the patient cope with his injuries.

Hospital course was otherwise uneventful.

PHYSICAL EXAMINATION: Notable for right knee swelling, within baseline. No warmth, tenderness or erythema.

HOSPITAL COURSE:
1. Rehabilitation: The patient was admitted to Spaulding Rehabilitation Hospital, where he was evaluated by physical, occupational, and speech therapies. At the time of his discharge, the patient was independent for rolling and supine-to-sit activities, and closely supervised for sit-to-stand activities. He was independent for transfers, with crutches, and closely supervised for ambulation. He was closely supervised for stairs, supervised for grooming. He was closely supervised for lower body bathing, supervised for upper body bathing, and supervised for lower body dressing and upper body dressing. He was supervised for bed-chair transfers, close guard for toilet transfers, supervised for toilet hygiene, and close guard to close contact guard for tub transfers. The patient's memory and attention were mildly impaired. The patient continued to make progress with his therapies, and it was felt that the patient could be discharged home.

2. Cardiovascular: Heart rate and blood pressure have been stable throughout his stay.

3. Mood: The patient has a history of anxiety and depression. His

mood was stable throughout the hospital course. He was followed by psychology and psychiatry. He should continue on Ativan 1 mg daily p.r.n., Valium 5 mg q.6 h. p.r.n., and Zyprexa 5 mg q.p.m.

4. GI: Constipation was an issue, with narcotic pain medications. He should continue a bowel regimen as an outpatient. Scrips were given.

5. Ortho: Continue weightbearing precautions until followup with ortho. He is to follow up with Dr. Kim, with x-ray imaging of his left wrist, PA and lateral; right hip, AP and lateral; and right femur, AP and lateral views. He will continue Lovenox, as per ortho. Followup should be in 3 weeks.

FINAL DISCHARGE DIAGNOSES:
1. Right femoral shaft fracture.
2. Left distal radius fracture.
3. Right acetabular fracture.

FINAL MEDICATIONS AT DISCHARGE:
1. Ativan 1 mg p.o. daily p.r.n.
2. Bisacodyl 10 mg p.o. daily p.r.n.
3. indomethacin 75 mg p.o. daily.
4. MiraLAX 17 g p.o. daily p.r.n.
5. Oxycodone 10 mg p.o. q.4 h. p.r.n.
6. Senokot 2 tabs p.o. b.i.d.
7. Zofran 4 mg p.o. q.8 h. p.r.n.
8. Zyprexa 5 mg p.o. q.p.m.
9. Valium 5 mg p.o. q.6 h. p.r.n.

ALLERGIES/ADVERSE REACTIONS: PENICILLIN, reaction unknown; CLARITHROMYCIN, reaction unknown; RISPERIDONE causing prolactinemia; and VENLAFAXINE causing psychosis.

DISPOSITION: Home.

FOLLOWUP CARE: He is to follow up with Dr. Kim, with x-ray imaging as above, in 3 weeks.

_____
Maria Bascaran, MD

MB/B D:12/20/2013 17:34:01 T:12/21/2013 01:12:03 Job Number:5364878

cc:

BASCARAN, MARIA, MD
Electronically Signed 01/10/14 1615
Faulkner Hospital
1153 Centre Street
Boston, MA 02130

Patient Name:STARI,EMPRESS

Medical Record #:01212050
Provider Name:DOGON,ALEXANDER M.D.
Service Date:06/16/10
Report No:10949347

EMERGENCY DEPARTMENT REPORT
CHIEF COMPLAINT: Here for suicidal ideation.

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old, African-American female with history of polysubstance-induced mood disorder who states she is suicidal. She states she wants to walk in front of a bus. It is noted the patient was recently seen here on 06/11/10, and placed by BEST. Patient has had multiple visits to Emergency Departments, and she was just discharged from Bay Ridge and Carney Hospital on 06/07/10. She was at Boston Medical Center on 06/08/10. She was at Beth Israel Hospital earlier today and discharged, and now is here in the Emergency Department at Faulkner Hospital. The patient denies any fever, chills, nausea, vomiting, diarrhea, constipation, chest pain, shortness of breath, headache, dizziness or lightheadedness. No upper or lower extremity numbness, weakness, tingling or pain.

PAST MEDICAL HISTORY: Question seizure disorder and substance-induced mood disorder.

PAST SURGICAL HISTORY: None.

ALLERGIES: NKDA The patient

MEDICATIONS: The patient is currently on no medications.

SOCIAL HISTORY: The patient is single. She is homeless. No smoking, no alcohol. She denies any illegal or IV drug abuse; however, she is positive for cocaine and cannabis, and has a history of cocaine abuse and cannabis abuse.

FAMILY HISTORY: Noncontributory at this time.

REVIEW OF SYSTEMS: Negative except for those stated in the history of present illness. The patient's only complaint is suicidal ideation with a plan to jump in front of a bus. She denies any homicidal ideation, auditory or visual hallucinations. No fever, chills, nausea, vomiting, diarrhea, constipation, chest pain, shortness of breath, headache, dizziness, lightheadedness, upper or lower extremity numbness, weakness or tingling, back pain, flank pain, dysuria, hematuria, or vaginal discharge. No abdominal pain, diarrhea, constipation, nausea, vomiting, melena or bright red blood per rectum.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 97.9, heart rate 80, respiratory rate 18, blood pressure 115/63, O2 sat 100% on room air.
GENERAL: Well-developed, well-nourished, appearing in no acute distress; cooperative, 29-year-old, African-American female.
HEENT: Atraumatic, normocephalic. Pupils equal round and reactive to light and accommodation bilaterally. Extraocular eye movements intact

bilaterally. Optic disks sharp bilaterally. Patent nares bilaterally. Tympanic membranes clear bilaterally. Moist mucous membranes. No erythema of posterior pharynx, no exudate. Uvula to midline.
NECK: Supple; no JVD, no bruits, nontender. Full range of motion. No midline C-spine tenderness to palpation.
PULMONARY: Breath sounds clear to auscultation bilaterally; no wheezes, rales, or rhonchi.
CARDIOVASCULAR: Regular rate and rhythm; no murmurs, rubs, or gallops.
ABDOMEN: Soft, nontender, nondistended. Positive bowel sounds in all 4 quadrants. No hepatosplenomegaly. No masses.
FLANK: No flank tenderness to percussion bilaterally.
EXTREMITIES: No clubbing, cyanosis, or edema bilaterally. Moving all 4 extremities. Equal strength on flexion and extension of upper and lower extremities bilaterally; 2+ radial, femoral, and dorsal pedal pulses bilaterally.
SKIN: No rashes or ecchymosis. Skin pink.
NEURO: Cranial nerves II through XII intact bilaterally. Alert and oriented x4. GCS 15. Normal speech. Deep tendon reflexes 2+ and equal bilaterally.
PSYCH: The patient appears to have linear thought process. She states she has suicidal ideation. It was very secondary that she stated she wanted to jump in front of a bus. She is very guarded at times. She makes good eye contact, but is not completely cooperative with the examiner. She does not appear to be reacting to any internal stimuli. She has a linear thought process.

LABORATORY DATA: The patient's CBC and chemistry within normal limits. Her beta hCG is negative. Alcohol was negative. U-tox was positive for cocaine and THC. UA negative.

Psychiatry was consulted at 6 p.m. They are currently still evaluating the patient, though most likely they will place patient under Section 12, and BEST will be assisted for bed search. Though the patient is questionable whether she meets, in my opinion, Section 12 criteria, I believe she has ulterior motive including possible malingering with secondary gain of not having to go to the Shattuck Shelter, which she does not want to go to. The patient will be signed out to my colleague, Dr. Kimberly Schoen, at midnight, pending BEST and Psychiatry's completion of their evaluation and plan. I will defer to their plan.

Dictated but not read.

[Dictation ID#10949347]

Signature On File 06/19/10 DOGON,ALEXANDER M.D.

NorthShore Medical Center Union Campus
Name:John Roderick
MRN:559949
Account#:7013485078
Sex:Male

DOB:02/01/1990
Age:23 years
Arrival Date:10/27/2013
Time:22:03
Departure Date:10/28/2013
Time:16:29
BedF
Union Hospital ED Physician Documentation
HPI:
10/28 The patient presents to the emergency department with suicide jeb
02:51 ideation.
02:51 Onset: The symptoms/episode began/occurred today. no clear plan, jeb
+hx of attempts (won't explain), denies substance abuse. "My mother is worried about me. If I have to go inpatient for a few days, that would be ok".

Historical:
- Allergies:
10/27 Augmentin(Upset stomach) Allergies: SULFA (SULFONAMIDES)(Rash) lmk
22:03 Allergies: Zithromax Z-Pak(Rash)
- Home Meds:
22:03 Zyprexa Oral 20 mg daily(10/27/2013 12:00) lmk
- PMHx:
22:03 schizophenia PMHx: Depression PMHx: Bipolar disorder lmk
- PSHx:
22:03 Tonsillectomy lmk

- Immunization history: Flu vaccine status is unknown.
- Social history: Smoking status: Patient uses tobacco products, smokes one pack cigarettes per day. Patient uses street drugs, marijuana, No barriers to communication noted. The patient speaks fluent English. The patient is unemployed.
- The history from nurses notes was reviewed: and I agree with what is documented.

ROS:
10/28 All other systems are negative except as stated in HPI. jeb
02:51

Exam:
02:51 Constitutional: Awake, alert in NAD Head/Face: Normocephalic, jeb
atraumatic. Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. ENT: Nares patent. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membranes moist. Neck: Trachea midline, supple, non tender Cardiovascular: RRR, nl S1, S2. No murmurs Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring. Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout. Back: No spinal tenderness. No costovertebral tenderness. Full range of motion. Skin: Warm, dry with normal turgor. Normal color with no rashes,

no lesions, and no evidence of cellulitis. MS/ Extremity: no edema or ecchymosis Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait. Psych: Behavior/mood is cooperative, Affect is calm, Patient having thoughts of suicide. Denies suicidal plan.

Vital Signs:
10/27 BP 150 / 93; Pulse 101; Resp 18; Temp 98(TE); Pulse Ox 99% on lmk
22:03 R/A; Pain 0/10;
23:43 BP 138 / 80; Pulse 81; Resp 18 S; Pulse Ox 98% on R/A; mn3
10/28 BP 147 / 87 LA Sitting (auto/reg); Pulse 86 RA; Resp 18; Temp sf2
06:32 97.9(TE); Pulse Ox 100% on R/A;
11:44 BP 133 / 80 LA Sitting (auto/reg); Pulse 107; Resp 18 S; Temp am11
98.1(TE); Pulse Ox 98% ;
15:45 BP 131 / 77; Pulse 85; Resp 18; Temp 98.3; Pulse Ox 97% on R/A; cb

MDM:
02:51 The patient is determined to not have any medical or surgical jeb
problems warranting inpatient admission. The patient is medically cleared for admission or transfer to a psychiatric facility.

22:10 Order name: BUN; Complete Time: 04:00 lmk
22:10 Order name: CBC With Diff; Complete Time: 04:00 lmk
22:10 Order name: Creatinine; Complete Time: 04:00 lmk
22:10 Order name: Electrolytes; Complete Time: 04:00 lmk
22:10 Order name: Glucose Random; Complete Time: 04:00 lmk
22:10 Order name: Toxic Screen (Serum Only); Complete Time: 04:00 lmk
22:10 Order name: Urinalysis Screen; Complete Time: 04:00 lmk
22:10 Order name: Urine Drug Screen; Complete Time: 04:00 lmk
22:10 Order name: constant observation; Complete Time: 23:01 lmk
22:10 Order name: Inform Psych Triage team of patient; Complete Time: lmk
23:01
22:10 Order name: Undress patient completely and secure clothing and lmk
belongings; Complete Time: 23:01

Dispensed Medications:
10:10 Drug: ZyPREXA 20 mg; Route: PO; cb

Disposition:
02:51 Chart complete. jeb

Disposition Summary:
10/28 Transfer ordered to Whittier Pavilion. Diagnosis are
Schizoaffective Disorder, Alcohol Abuse.
15:29 pjs
- Reason for transfer: Higher level of care.
- Accepting physician is sebastionelli.
- Condition is Serious.
- Problem is an ongoing problem.
- Symptoms are unchanged.

Signatures:
Dispatcher MedHost EDMS
Beland Cohen, Jenai, MD MD jeb
Stevens, Patrick, MD MD pjs
Paige, Christine, RN RN cb
Keenan, Linda, RN RN lmk
Strout, Amanda, RN RN as1
Turner, Annmarie, RN RN at2

****

NORTH SHORE MEDICAL CENTER
SALEM HOSPITAL

PATIENT NAME: Halbick, Michael MR: 00-58-19-29

DATE OF ADMISSION: 01/09/2008 BILLING NUMBER: 1042701340

EMERGENCY PHYSICIAN: Nicholas Ross, M.D.

PRIMARY CARE PHYSICIAN: Paul D. Dardeno, M.D.

TIME SEEN: 1:40 p.m.

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: This is a 28-year-old male who is otherwise healthy. He was the unrestrained front seat passenger in a motor vehicle that was struck on the passenger side last night. He states he struck his right shoulder against the door and since that time, he has had persistent pain and is having trouble moving it. He has no weakness or numbness in the extremity. He had no head trauma. He has no neck pain. He has no other pain in the rest of his body. He describes the pain as moderate and worsened with movement.

PAST MEDICAL HISTORY: None.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

PHYSICAL EXAMINATION: Temperature is 98.4. Blood pressure 146/93. Heart rate 94. Respiratory rate 18. O2 sat 98% on room air. General: Well-appearing male in no acute distress. Neck supple and nontender with full range of motion. Extremities: The right shoulder has diffuse tenderness. There is no obvious swelling or deformity. There is limited range of motion due to pain though the patient can cross midline with his arm. Neurologic: Symmetric sensation in upper extremities. Strength testing limited in right arm due to pain.

LABORATORY DATA: X-ray of the right shoulder shows no acute disease per radiologist's interpretation.

EMERGENCY DEPARTMENT COURSE: The patient's presentation was concerning for

a shoulder injury. X-ray shows no fracture. Most likely, this is a contusion though he could have a diagnosis such as a rotator cuff injury or a shoulder separation. The patient was given a sling. He was given a prescription for twenty 600 mg Motrin tablets and 15 of Vicodin tablets. He was given shoulder injury discharge instructions and the name of Dr. Robert Wood from orthopedic surgery to follow up with if his symptoms do not improve in the next few days.

DISCHARGE CONDITION: Good.

DIAGNOSIS: Shoulder contusion.

Electronically Signed
Nicholas Ross, M.D. 01/17/2008 07:41
Nicholas Ross, M.D.

NR:DDI
DD: 01/13/2008
DT: 01/13/2008 9:21 A
Job: 000002091
Doc#:
cc: Paul D. Dardeno, M.D.
BRIGHAM and WOMEN'S FAULKNER HOSPITAL
1153 Centre Street
Boston, MA 02130
Hospital Main Number: 617-983-7000

Patient Name: HEGENBERGER,ANNA F Attending Name: GARNER,CAROL M.D.
Medical Record Number: 01264549 Account Number: 24493309
Admission Date: 12/08/12 Transcribed by: O'CONNOR,MICHAEL
Date of Service: 12/10/12

FH DISCHARGE INSTRUCTIONS
Discharge Disposition: Home
Date of Discharge: 12/10/12
Admission Diagnosis alcohol dependence
Principal Diagnosis:
Alcohol dependence
Surg/OR Procedures
None
Pending Labs/Studies
None
Code Status Full Code

MEDICATION LIST
Allergies
Coded Allergies:
NO KNOWN ALLERGIES (From NKA) (12/07/12)

Discharge Meds
Stop taking the following medications:
Gabapentin (Gabapentin Tablet) 600 MG TABLET ORAL THREE TIMES A DAY

Continue taking these medications:
Bupropion Hcl (Bupropion XL Tablet Extended Release 24HR) 150 MG TAB.SR.24H
150 MILLIGRAM ORAL DAILY
Qty = 30
This prescription has been renewed

Citalopram Hydrobromide (Citalopram Tablet) 20 MG TABLET
20 MILLIGRAM ORAL DAILY
Qty = 30
This prescription has been renewed

Start taking the following new medications:
Disulfiram (Antabuse Tablet) 250 MG TABLET
250 MILLIGRAM ORAL DAILY
Qty = 14
No Refills

Gabapentin (Neurontin Capsule) 300 MG CAPSULE
600 MILLIGRAM ORAL TWICE A DAY
Qty = 60
No Refills

DISCHARGE INSTRUCTIONS
Patient Instructions:
You have been treated for alcohol dependence. Continue with further treatment, AA/NA meetings as discussed in the program and follow up with your Primary Care treatment team.

After your discharge from the hospital:
-Remain abstinent from all alcohol and any illicit or non-prescribed drugs
-Please keep all aftercare plans and follow-up appointments to ensure ongoing good health
-Continue to take all medications as they are prescribed for you
-If you feel worsening withdrawal symptoms, at risk of relapse, at risk of hurting yourself or someone else, develop any other concerning symptoms, please call your PCP; in the case of an emergency go to the ER or call 911

~It was a pleasure caring for you and we wish you the best of health~
Activities: Resume regular activities
Diet
Regular
Warfarin
Warfarin on discharge: No
Follow up appointments
Pt to start partial program at FH tomorrow,
Tuesday 12/11/12
Provider Contact
For routine questions and pending test results, contact your primary care provider, GOWDA,SAVITHA M.D. at (781)769-3113. The doctor in charge of your care

in the hospital was GARNER,CAROL M.D. and can be reached by calling Brigham and Women's Faulkner Hospital at (617)983-7000. For emergencies call 911 or go to a hospital emergency department.

VNA/Facility on DC: No

Other
Smoking Instructions
QUIT SMOKING PROGRAMS

If you, a family member, or friend smoke or use tobacco products, please consider using
these resources to help you quit:

Brigham and Women's Faulkner Hospital: (617)-732-8983
Massachusetts Smokers' Helpline: 1-800-TRY-TO-STOP (1-800-879-8678)

*** ALL PATIENTS THAT SMOKE ARE ADVISED TO STOP ***

Stroke Instructions
STROKE AND MINI-STROKE (TIA) PATIENT EDUCATION AND DISCHARGE INSTRUCTIONS

Brigham and Women's Faulkner Hospital is a designated center for stroke care in Massachusetts. As a stroke center, one of our missions is to educate our patients and families about stroke
prevention and treatment.

Personal Risk Factors for Stroke:

Risk factors can increase a person's chance of having a stroke. Your Nurse has put a
check in the box next to your risk factors. Healthy life style changes can reduce the
chances of a stroke happening. Please refer to your stroke education packet for ways
to reduce your risk for stroke.

[ ] Diabetes [ ] Heart Disese [ ] High Cholesterol
[ ] Smoking [ ] Atrial Fibrilation [ ] Being Over Weight
[ ] Inactivity [ ] Mini-Stroke (TIA) [ ] High Blood Pressure
WARNING Signs and Symptoms of Stroke ! Every Second Counts !

CALL 9-1-1 And Have An Ambulance Bring You To The Hospital, If You or Someone You Know is Having Warning Signs of Stroke !

Warning Signs Are:

* Sudden numbness or weakness of the face,arm or leg,especially on one side of the body
* Sudden trouble walking, dizziness, loss of balance or coordination
* Sudden severe headache with no known cause
* Sudden confusion, trouble speaking or understanding

* Sudden trouble seeing in one or both eyes

CHF Instructions
CONGESTIVE HEART FAILURE PATIENTS ARE ADVISED TO:

- Weigh your self daily before breakfast and record
- Keep to diet as prescribed and avoid excessive intake of sodium and fluids
- Keep activity as prescribed
- Take medications as prescribed. Refer to Home Discharge Plan
- Report new or unchanged symptoms to the doctor as they occur
- Contact Doctor/Nurse Practitioner for:
* Chest pain or pressure not relieved by nitroglycerin
* Weight gain over 2 lbs overnight or 5 lbs in 5 days
* Increased shortness of breath
* Difficulty breathing while lying down
* Increased swelling in your legs and feet
* Increased weakness or tiredness
* Loss of appetite
* Belly pain and fullness

IMMUNIZATION

IMMUNIZATIONS
Flu Vaccine this visit/season: Yes
Date: 09/01/12
Comment: cvs

NURSE/PATIENT SIGNATURE
Signature

Nurse Signature:_____ Date:_____ Time:_____
____

Patient/Guardian Signature:_____ Date:_____ Time:_____
___

O'CONNOR,MICHAEL A N.P. Electronically Signed 12/10/12 0946
Massachusetts General Hospital
55 Fruit Street Boston, MA 02114
(617)726-2000
Patient MGH ID #: 3777550
Patient Name: BRANDANO, JASON
Admit Date: 09/20/2015
Discharge Date: 9/25/2015
Gender: M
Patient DOB: 10/01/1981
Location: W1122A
Phone: 617-726-3348

Face Sheet - Medical Information

Who Will Enter Discharge Summary: Victor D Fedorov, MD

Principal Diagnosis
Dyspnea

Associated Diagnosis
Drug overdose, Liver function tests abnormal

Significant Operations/Procedures/Tests Performed During Hospitalization:
Operations/Procedures:
- None

Labs/Imaging/Other Tests
Chest xray showed no pneumonia or edema
CT of chest showed no clots in the lungs
Liver images were normal
Liver function tests continue to trend down

Life-Sustaining Treatment (Code Status) at Discharge
Full Code (discussion with patient/surrogate not appropriate or possible at this time)
Entered by: Christopher M. Celano, M.D.

Provider to Contact Regarding Hospital Stay
Please contact Mark W Dickinson, MD at 617-267-7171 if you have any questions regarding this hospital stay (Alternatively, the phone number for MGH is 617-726-2000 and the page operator can page him/her or the covering provider).

Discharge Orders
Allergic Reactions, Intolerances and Sensitivities
o cephalexin monohydrate - Unknown
o desipramine - Unknown
o desiprimine - Shortness of Breath
o Cephalosporins - Hives
o ibuprofen - Gastric Bypass
o naproxen - gastric Bypass

Medications
o OMEPRAZOLE 20 MG PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (20 MG QD)

o METAMUCIL 1 PACKET PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (1 PACKET QD)

o CLONAZEPAM (KLONOPIN) 1 MG PO Every Bedtime
Last Dose Given: 09/24/2015 at 08:12 PM (1 MG QHS)

o MELATONIN 5 MG PO Every Bedtime
Last Dose Given: 09/24/2015 at 08:12 PM (5 MG QHS)

o SERTRALINE (ZOLOFT) 50 MG PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (50 MG QD)

o ZOLPIDEM TARTRATE (AMBIEN) 5 MG PO Every Bedtime PRN: Insomnia
Last Dose Given: 09/24/2015 at 08:18 PM (5 MG QHS)

o CALCIUM CITRATE+VIT D (315 MG CA++/250 U VIT D) 1 TAB PO BID
Last Dose Given: 09/25/2015 at 08:10 AM (1 TAB BID)

o CHOLECALCIFEROL (VITAMIN D3) 800 UNITS PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (800 UNITS QD)

o FOLIC ACID (FOLATE) 1 MG PO Daily
Last Dose Given: 09/24/2015 at 07:37 AM (1 MG QD)

o MULTIVITAMINS 1 TAB PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (1 TAB QD)

o THIAMINE HCL 100 MG PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (100 MG QD)

o ARTIFICIAL TEARS 2 DROP LEFT EYE TID
Last Dose Given: 09/24/2015 at 08:13 PM (2 DROP TID)

o WITCH HAZEL PADS (TUCKS) 1 APPLICATION TOP TID PRN: Rectal discomfort

o ALBUTEROL AND IPRATROPIUM NEBULIZER SOLUTION (DUONEB) 3 MG NEB Q6H PRN: Wheezin
g

o BISACODYL RECTAL 10 MG PR Daily PRN: Constipation
Last Dose Given: 09/21/2015 at 08:42 PM (10 MG QD)

o LACTULOSE 30 ML PO QID PRN: Constipation
Last Dose Given: 09/21/2015 at 07:13 PM (30 ML QID)

o ONDANSETRON HCL (CHEMO N/V) (ZOFRAN (CHEMO N/V)) 4 MG PO Q8H PRN: Nausea

o POLYETHYLENE GLYCOL (MIRALAX) 17 GM PO Daily PRN: Constipation
Last Dose Given: 09/21/2015 at 08:43 PM (17 GM QD)

o SENNOSIDES (SENNA TABLETS) 2 TAB PO BID PRN: Constipation
Last Dose Given: 09/21/2015 at 07:12 PM (2 TAB BID)

o METHADONE ORAL SOLUTION 40 MG PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (40 MG QD)

o FERROUS SULFATE 325 MG PO BID

Medication Reconciliation
Discharge medications have been reviewed/reconciled with the pre-admission medication list.

Vaccines
The Flu vaccine was not given during this admission. Please consult with your PCP regarding vaccinations.

Diet
o No Restrictions

Activities
o No Restrictions

Treatments
o You were admitted to the medical unit after developing an oxygen requirement, fever and hemopytisis. After imaging and review of medications it was determined that the most likely cause of elevated liver function tests were a combination of medications. The medications were reviewed and adjusted and have had a positive response as your liver function tests continue to trend back towards normal.

Doctor, Nurse Practitioner, or Physician Assistant Instructions for Follow-up Care
Please keep all follow up appointments

Post Discharge Goals / Care Plan
- Continuity of Care : Please attend all scheduled appointments

Pending Labs/Tests:
When you left the hospital, certain test results were not yet finalized:\par Cryos

You can access your test results as well as other health information online through the Partners Patient Gateway. To enroll go to www.patientgateway.org and select "Medical Records, MGH" as your provider.\par \par Alternately you can call MGH - Health Information Services at 617-726-2361 to obtain your test results.\par \par Additional Orders, Instructions and Equipment
o When you get home, please take your medications as directed on the Post Discharge Medication List. If you have any questions about these changes or difficulty filling your prescriptions, please call your primary care doctor or the number below.

If you experience any suicidal thoughts, shortness of breath, right upper quadrant pain, or have any other concerns, please call your primary care doctor or return to the MGH emergency

department.

If you have any questions about this hospitalization, please call 617-726-3348 and ask to speak to a member of Team D.

Physician Discharging Patient: Victor D. Fedorov, M.D.

Electronically Signed: Victor D. Fedorov, M.D. Date: 09/25/2015 09:44 AM

Patient Care Referral Form

Patient Name: BRANDANO, JASON
Patient Address: 240 ALBANY STREET CAMBRIDGE, MA 02139
Patient Phone:
Relative/Guardian: BUCCHEI, GEORGE
Relative/Guardian Address: 51 PROCTOR AVE REVERE, MA
Relative/Guardian Phone: (781)987-3333
Relative/Guardian Relationship: OTHER

Referral From: Massachusetts General Hospital
Unit or Clinic: W1122A
No Post Acute Provider Information Entered

Patient Information

Gender: M Marital Status: SINGLE Religion: CATHOLIC Birthday: 10/1/1981
Primary Insurance Plan: MEDICARE

Principal Diagnosis:
Dyspnea
Associated Diagnosis:
Drug overdose, Liver function tests abnormal

Significant Operations/Procedures/Tests Performed During Hospitalization:
Operations/Procedures:
- None

Labs/Imaging/Other Tests
Chest xray showed no pneumonia or edema
CT of chest showed no clots in the lungs
Liver images were normal
Liver function tests continue to trend down

Date of Last Physical 09/24/2015

The patient is aware of his/her diagnosis

Life-Sustaining Treatment (Code Status) at Discharge
Full Code (discussion with patient/surrogate not appropriate or possible at this time)
Entered by: Christopher M. Celano, M.D.

Provider to Contact Regarding Hospital Stay:
Please contact Mark W Dickinson, MD at 617-267-7171 if you have any questions regarding this hospital stay (Alternatively, the phone number for MGH is 617-726-2000 and the page operator can page him/her or the covering provider).

Discharge Orders
Allergic Reactions, Intolerances and Sensitivities
o cephalexin monohydrate - Unknown
o desipramine - Unknown
o desiprimine - Shortness of Breath
o Cephalosporins - Hives
o ibuprofen - Gastric Bypass
o naproxen - gastric Bypass

Medications
o OMEPRAZOLE 20 MG PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (20 MG QD)

o METAMUCIL 1 PACKET PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (1 PACKET QD)

o CLONAZEPAM (KLONOPIN) 1 MG PO Every Bedtime
Last Dose Given: 09/24/2015 at 08:12 PM (1 MG QHS)

o MELATONIN 5 MG PO Every Bedtime
Last Dose Given: 09/24/2015 at 08:12 PM (5 MG QHS)

o SERTRALINE (ZOLOFT) 50 MG PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (50 MG QD)

o ZOLPIDEM TARTRATE (AMBIEN) 5 MG PO Every Bedtime PRN: Insomnia
Last Dose Given: 09/24/2015 at 08:18 PM (5 MG QHS)

o CALCIUM CITRATE+VIT D (315 MG CA++/250 U VIT D) 1 TAB PO BID
Last Dose Given: 09/25/2015 at 08:10 AM (1 TAB BID)

o CHOLECALCIFEROL (VITAMIN D3) 800 UNITS PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (800 UNITS QD)

o FOLIC ACID (FOLATE) 1 MG PO Daily
Last Dose Given: 09/24/2015 at 07:37 AM (1 MG QD)

o MULTIVITAMINS 1 TAB PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (1 TAB QD)

o THIAMINE HCL 100 MG PO Daily
Last Dose Given: 09/25/2015 at 08:10 AM (100 MG QD)

o ARTIFICIAL TEARS 2 DROP LEFT EYE TID
Last Dose Given: 09/24/2015 at 08:13 PM (2 DROP TID)

o WITCH HAZEL PADS (TUCKS) 1 APPLICATION TOP TID PRN: Rectal discomfort

o ALBUTEROL AND IPRATROPIUM NEBULIZER SOLUTION (DUONEB) 3 MG NEB Q6H PRN: Wheezing

o BISACODYL RECTAL 10 MG PR Daily PRN: Constipation
Last Dose Given: 09/21/2015 at 08:42 PM (10 MG QD)

o LACTULOSE 30 ML PO QID PRN: Constipation
Last Dose Given: 09/21/2015 at 07:13 PM (30 ML QID)

o ONDANSETRON HCL (CHEMO N/V) (ZOFRAN (CHEMO N/V)) 4 MG PO Q8H PRN: Nausea

o POLYETHYLENE GLYCOL (MIRALAX) 17 GM PO Daily PRN: Constipation
Last Dose Given: 09/21/2015 at 08:43 PM (17 GM QD)

o SENNOSIDES (SENNA TABLETS) 2 TAB PO BID PRN: Constipation
Last Dose Given: 09/21/2015 at 07:12 PM (2 TAB BID)

o METHADONE ORAL SOLUTION 40 MG PO Daily
Last Dose Given: 09/25/2015 at 08:09 AM (40 MG QD)

o FERROUS SULFATE 325 MG PO BID

Medication Reconciliation
Discharge medications have been reviewed/reconciled with the pre-admission medication list.

Vaccines
The Flu vaccine was not given during this admission. Please consult with your PCP regarding

vaccinations.

Diet
o No Restrictions

Activities
o No Restrictions

Treatments
o You were admitted to the medical unit after developing an oxygen requirement, fever and hemopytisis. After imaging and review of medications it was determined that the most likely cause of elevated liver function tests were a combination of medications. The medications were reviewed and adjusted and have had a positive response as your liver function tests continue to trend back towards normal.

Additional Orders, Instructions and Equipment
o When you get home, please take your medications as directed on the Post Discharge Medication List. If you have any questions about these changes or difficulty filling your prescriptions, please call your primary care doctor or the number below.

If you experience any suicidal thoughts, shortness of breath, right upper quadrant pain, or have any other concerns, please call your primary care doctor or return to the MGH emergency department.

If you have any questions about this hospitalization, please call 617-726-3348 and ask to speak to a member of Team D.

Follow-up Appointments:
o Appointment with Dr. Daniel Simoneau located at 387 Quarry St #100, Fall River, MA 02723 on 09/29/15 03:00 pm (Scheduled) phone: (508) 679-8111
Comments: Health First in Fall River
o Appointment with Dr. Curran located at 198 Hanover St Fall River, MA 02720-5210 on 09/30/15 03:00 pm (Scheduled) phone: (508) 672-1444
Comments: Psychiatry in Fall River
o located at 66 CAnal St, Boston on 09/25/15 10:00 am phone: (617) 371-3000
Comments: Bay Cove Methadone Clinic
o located at Goldman Dental on 10/02/15 01:30 pm (Scheduled) phone: (617) 638-4700
Comments: Goldman Dental at BU

Electronically Signed: Victor D. Fedorov, M.D. Date: 09/25/2015 09:44:47AM

Will you follow the patient? No

Others who will follow the patient?
Dr Quinn
Fall River
(508)672-0708
ED DISCHARGE NOTIFICATION/SUMMARY

Brown,Hassan MRN: 5106456 Age: 36y DOB: 03/21/1978
REGISTRATION DATE: 02/13/15 02:48
Discharge Instructions

Diagnosis:
peripheral neuropathy

Diagnostic Evaluation/Treatment Received:
A clinical exam was performed.
Lab tests were performed.
You were given medications for pain.

Follow Up Service:
Based on your evaluation today, you should contact your primary care doctor's office to arrange for a routine follow-up appointment, to confirm that your condition is getting better and that no additional testing or therapy is needed. If you do not currently have a primary care doctor, we strongly advise that you obtain one.

If your condition gets worse before your follow-up (worse or new symptoms) please contact your doctor or return to the Emergency Department.

Please follow up with your Neurologist at BMC as scheduled.

Discharge Instructions:
COCAINE ABUSE (Engl), Drug Abuse, Boston Substance Abuse Resource List (Engl), MARIJUANA ABUSE (Engl), NEUROPATHY, Peripheral (Engl))

Additional Instructions:
Return to the emergency department right away for any increased swelling, increasing pain, numbness, tingling, color change, fevers, chills, chest pain, difficulty breathing, or ANY other changes in your symptoms!
You may take acetaminophen 1000mg up to three times daily and/or ibuprofen 600mg up to three times daily for your pain.

Please follow up with your primary doctor regarding your neuropothy. Return to the ED if you are feeling unsafe.

PCP:
Name: WISHIK, GABRIEL Phone: 7812216565 Fax: 8576541101
An electronic copy of the discharge note will be sent to your PCP, if confidentiality guidelines allow.

Please call your primary care physician during normal business hours to report this visit. Please seek medical care, return to the Emergency Department, or call
911 for any new or worsening symptoms, or any other concerns.
Please call 617-643-0045 if you require additional information regarding this visit. Please have your MGH medical record number and date of visit available when you call.
Please call 617-726-2361 if you need to request a copy of your medical records.

I hereby acknowledge receipt of patient instructions. I understand that further diagnosis and treatment may be required and I have had emergency treatment only and I may be released before all medical problems are known and treated. I will arrange follow-up care as instructed.

Patient Signature:_____ Date:_____

ED Note Start Date/Time: 02/13/15 04:27
This note has been electronically signed by Benjamin,P.a.-C. Burdet, PA-C 02/13/15 14:38

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MGH Main Campus HUM,JULIA

55 Fruit St MRN: 5462604

Boston MA 02114-2621 DOB: 11/12/1999, Sex: F

Acct #: 6070340623

ADM: 1/22/2018 D/C: 2/6/2018

Patient Information

Patient Name Sex DOB

Hum, Julia Female 11/12/1999

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM

Author: Caitlin S King, MD, Service: Pediatrics Author Type: Resident

MBA

Filed: 2/6/2018 12:27 PM Date of Service: 2/6/2018 12:27 Status: Attested

PM

Editor: Caitlin S King, MD, MBA (Resident) Cosigner: Ann York Kao, MD,

MPH at 2/6/2018 6:36 PM

Attestation signed by Ann York Kao, MD, MPH at 2/6/2018 6:36 PM

PCP_Communication: I contacted the patient's PCP, Erin Margaret Mahony, MD by Routing through

epic on 2/6/2018 to provide an update on the hospital course and discharge plan.

Physician Discharge Summary

Admit date: 1/22/2018

Discharge date: 2/6/2018

Patient Information

Julia Hum, 18 y.o. female (DOB = 11/12/1999)

Home Address: 34 Union Street Apt 2

Watertown MA 02472

Home Phone: 617-926-0262 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): Health Care Proxy (section 12 forms in chart)

Does patient have a Health Care Proxy form completed?: HCP is available to place in chart (section 12 forms in chart)

Health Care Agents

There are no health care agents on file.

Code Status at Discharge: Full Code (Presumed)

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

Hospitalization Summary

Admission Diagnosis

OCD, bacteremia

Principal Problem:

Bacteremia

Active Problems:

Obsessive compulsive disorder

Chronic constipation

At risk for alteration in nutrition

Resolved Problems:

Requires supplemental oxygen

Surgical (OR) Procedures:

Surgeries this Admission

None

Non (OR) Procedures:

02/06 0920 Electroconvulsive therapy

02/02 0841 Electroconvulsive therapy

01/30 0948 Electroconvulsive therapy

12/12 0903 Electroconvulsive therapy

12/08 0921 Electroconvulsive therapy

12/06 0852 Electroconvulsive therapy

12/04 0840 Electroconvulsive therapy

12/01 0837 Electroconvulsive therapy

11/29 0826 Electroconvulsive therapy

11/27 0829 Electroconvulsive therapy

11/24 0852 Electroconvulsive therapy

11/22 0927 Electroconvulsive therapy

11/20 1047 Electroconvulsive therapy

11/17 0837 Electroconvulsive therapy

Items for Post-Hospitalization Follow-Up:

None

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

Pending Results

None

Hospital Course

Julia is a 18 y.o. female with a history of severe/refractory OCD with mixed features complicated by fluid refusal, SIB, and suicide attempts (most recent tylenol OD in 9/2017), multiple hospitalizations who was transferred to the PICU from Blake 11, now recovered from gram negative sepsis and transferred from PICU to floor 1/26, awaiting bed on Blake 11.

PICU HPI:

Julia is a 18 y.o. female with a history of severe/refractory OCD with mixed features complicated by fluid refusal, SIB, and suicide attempts (most recent tylenol OD in 9/2017), multiple hospitalizations who was transferred to the PICU from Blake 11 for hypotension.

Patient was admitted to Ellison 18 from 10/31/2017 to 12/14/2017, and transferred to Blake 11 for 12/14/17 to 1/22/18.

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Her Blake 11 course, in brief, is as follows:

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#Chest pain:

Overnight prior to the morning of transfer, patient developed acute onset SOB, chest pain substernally, headache, and leg pains (ankles and calves). She was febrile to 39.1 and tachycardic to 130s-140s, she was hypotensive to 70s/30s. She received a total of 2.5L of LR for fluid resuscitation. DDx includes sepsis vs pulmonary embolism. Labs obtained were notable for a WBC 9, PMNs 76%, Bands 15%. Lactate 2.5, CRp 57.5. Troponin was negative, pro-BNP was elevated to 1200, D-diner was 3700. Creatinine had trended up from 0.86 to ~0.7. She had a blood culture and clomipramine level that were sent and are both pending. Her influenza and RSV were negative. She had a CT-PE that we performed immediately prior to transfer the PICU.

#OCD and Depression:

Patient is followed by Dr. Goetz and Dr. Wong of Pediatric Psychiatry. She was initiated on clomipramine for refractory OCD, currently 175mg QHS. Clomipramine was decreased from 200mg QHS ~1 week prior to transfer due to supra-theraputic dose. She was also initiated on 5mg BID of memantine for OCD augmentation, which can be titrated to 10mg BID at weekly intervals (next dose increase could be 1/23/18). She had been on haldol and zyprexa for self injurious behaviors. However, there were discontinued due to elevated lactate and

emotional blunting (in favor of memantine augmentation). She also receives weekly ECT, though therapy on 1/16/18 was skipped due to post-concussive syndrome following a fall with headstrike sustained prior week (the next ECT would be 1/23). The patient was court committed to Blake 11 on a section 7 and 8, with the goal of pursuing state hospitalization should her fluid refusal not improve; an application was submitted for state hospitalizations (application can take many weeks), however the week prior to transfer, her fluid intake had improved such that she was without an NG tube and discharge with outpatient follow up was reconsidered.

#Fluid Refusal and Orthostasis:

The patient's goal fluid intake is 1000-1200cc daily. Initially required NG tube for fluid resuscitation. However, fluid intake had improved such that NG tube was removed 1 week prior to transfer. She had PRN LR 500cc fluid boluses for orthostatic changes on vital signs. She has been eating solid foods well per mom.

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PICU Hospital Course (1/22 - 1/26)

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Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

#GNR Sepsis

Julia presented to the PICU with hypotension, tachycardia in setting of fever with an initially unclear etiology. Initial work up included CT PE to rule out PE which was negative. ECHO was reassuring. LENIs without DVT. Blood cultures grew 3 colonies of GNRs, Urine culture grew multiple GNRs though in limited quantity. Given GNRs on blood culture, abdominal ultrasound and CTs were performed, which did not demonstrate focal intra-abdominal pathology. LFTs and lipase were within normal limits. She was started on vancomycin and CTX (1/22-1/23) for sepsis coverage. ID was consulted and recommended transition to meropenem on 1/23 (continued until 1/30). She received normal saline boluses, with improvement and stabilization of blood pressures. She did not require pressors. BCx speciated to E coli, Klebsiella, Proteus, E. Faecalis, Strep

anginosus, B Fragilis and Clostridium species (consistent with species contained in stool). Of note, she cleared her cultures after 1 day.

Obsessive compulsive disorder

History of severe and refractory OCD, previously admitted to Blake 11. She was continued on memantine, but clomipramine was initially held as it can bring about hypotension. Child psych was consulted. They recommended restarting clomipramine at lower dose (100mg). This was restarted on 1/24/18. She was maintained on a section 12.

Chronic constipation

Has trialed many medications over her hospitalizations. Has been followed by GI, Dr. Moran, in the past. Last BM on 1/20/18 after suppository prior to transfer, has stooled daily from 1/22-1/24, with titration of bowel regimen as needed. GI was consulted to aid in motility on 1/24/18. They provided recommendations for aggressive constipation management if deemed necessary. The clean out potions were Golytely at 300cc/h via NGT until stools are clear, or miralax 14 caps, 1 cap in 8oz q20-30min. We elected to defer clean out given somewhat regular BMs and subjective improvement in constipation. While in the PICU, she was on:

- miralax BID standing
- senna 2 tabs QHS standing
- dulcolax suppository PRN
- linzess 290 mcg QAM
- prune juice PRN

At risk for alteration in nutrition

Patient with long-term NG-tube dependence for fluid intake, very recently started taking in adequate fluids by mouth, NGtube removed last week (week of 1/15). While in the PICU she received multiple NS fluid boluses, and then was continued on mIVF. She did develop an oxygen requirement which was attributed to aggressive fluid resuscitation iso hypotension. mIVF were discontinued on 1/24/18. She was also given a one time dose of 10mg IV lasix. She was weaned off of O2. She was eating/drinking well while in the PICU.

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Pediatric Floor Hospital Course (1/26/18 - 2/6/18)

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#Bacteremia

- On the floor, she continued her treatment for her bacteremia. She received meropenum (1/23-1/30) and then was transitioned to oral ciprofloxacin and augmentin (1/30 - 2/1) when she lost IV access.

Recommendations:

- Continue on contact precautions for MDRO

#Obsessive compulsive disorder

- Restarted on ECT on 1/30, 2/2, 2/6

- Continued on clomipramine and memantime

- Maintained on 1:1 sitter and section 7/8 (treated the same as a Section 12)

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

- Sarah Shea saw her for CBT

- She did not require any medications for agitation

Recommendations:

- Continue weekly ECT on Tuesdays, do not give PRN ativan the night before. Can give famotidine 20mg PRN pre ECT

- Contitnue memantine 5mg BID

- Continue clomipramine 125mg nightly

- Frequent encouragement of drinking water with goal of one 4oz cup of water per hour, 1.5L a day

- Can use below plan for agitation

--- For acute anxiety, rated by Julia as 8/10 for at least 2-5 minutes, can given lorazepam 1-2 mg PO up to TID PRN

--- For acute agitation not responsive to verbal redirection/de-escalation:

- if able to take PO: haloperidol 2 mg; may give lorazepam 2 mg but would prioritize haloperidol while

receiving ECT (all PO)

- if unable to take PO, please give IM/IV (if has IV) haloperidol 5 mg/loazepam 2 mg/cogentin 1 mg

- Please monitor daily EKG if giving haloperidol IM/IV given risk for QTc prolongation with IV haloperidol and replete if Mg <2 and K < 4 to keep electrolytes optimized

#Constipation/Abdominal Discomfort

- 1/28 had 600mL Mg citrate via NG followed a 2 fleet enemas on 1/29 and 1/30 with good results

- 2/2 had an NG tube placed and received a cleanout with nulytely. NG tube removed on 2/4 after she had an episode of having a globus sensation in her throat. CXR and neck x-rays were obtained during this event to evaluate for potential swallowing of foreign body which were normal

- Given dulcolax suppository on 2/5 with good results

- Continued on 34g miralax BID -->TID and 2 senna tablets nightly

- Continued on Linzess 290mg QAM

Recommendations:

- Miralax 34g TID

- 2 senna tabs nightly

- Linzess 290mg QAM

- For PRNs, continue tylenol 650mg PO q6h, dulcolax 10mg suppository daily, glycerin suppository daily, calcium carbonate 1250mg BID, lactase 6000 units with meals, zofran 4mg q8h, fleet enema daily

#Allergy

- Continued on allergra 180mg BID

Recommendations:

- Allergra 180mg BID

#Deconditioning/support

- Followed by physical therapy, occupational therapy, child life

#Sleep difficulty

- Continued on melatonin 3mg QHS

Recommendations:

- Continue on melatonin 3mg QHS

Medications

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

Allergies: Chlorhexidine gluconate; Eggplant; Lactose; Sulfa (sulfonamide antibiotics); Barbiturates; Nsaids (non-steroidal anti-inflammatory drug); and Succinylcholine chloride

Prior to Admission Medications

Prescriptions

LORazepam (ATIVAN) 1 MG tablet

Sig: Take 1-2 tablets (1-2 mg total) by mouth 3 (three) times a day as needed.

acetaminophen (TYLENOL) 325 mg tablet

Sig: Take 2 tablets (650 mg total) by mouth 2 (two) times a day as needed for mild pain.

acetaminophen (TYLENOL) 500 MG tablet

Sig: Take 2 tablets (1,000 mg total) by mouth daily as needed.

bacitracin 500 unit/gram ointment

Sig: Apply 1 application topically 3 (three) times a day. Refill requests to Erin Margaret Mahony, MD 617-491-5111

benzocaine-menthol (CEPACOL SORE THROAT) 15-2.6 mg Lozg

Sig: Use as directed 1 lozenge in the mouth or throat 3 (three) times a day as needed.

benzocaine-menthol (CEPACOL SORE THROAT) 15-2.6 mg Lozg

Sig: Use as directed 1 lozenge in the mouth or throat 3 (three) times a day as needed.

bisacodyl (DULCOLAX) 10 mg suppository

Sig: Place 1 suppository (10 mg total) rectally daily as needed.

calcium carbonate (OS-CAL) 1,250 mg (500 mg elemental) tablet

Sig: Take 1 tablet (1,250 mg total) by mouth every 4 (four) hours as needed.

calcium carbonate (OS-CAL) 1,250 mg (500 mg elemental) tablet

Sig: Take 1 tablet (1,250 mg total) by mouth every 4 (four) hours as needed (abdominal pain).

clomiPRAMINE (ANAFRANIL) 25 MG capsule

Sig: Take 7 capsules (175 mg total) by mouth nightly.

famotidine (PEPCID) 40 MG tablet

Sig: Take 1 tablet (40 mg total) by mouth daily as needed.

fexofenadine (ALLEGRA) 180 MG tablet

Sig: Take 1 tablet (180 mg total) by mouth 2 (two) times a day.

fexofenadine (ALLEGRA) 180 MG tablet

Sig: Take 2 tablets (360 mg total) by mouth daily as needed (Give 1 hour prior to ECT to prevent allergic reaction).

glycerin, adult, Supp

Sig: Place 1 suppository rectally daily as needed (constipation).

glycerin, adult, Supp

Sig: Place 1 suppository rectally daily as needed (constipation).

lactase (LACTAID) 3,000 unit tablet

Sig: Take 2 tablets (6,000 Units total) by mouth With Meals as needed (if eating/drinking dairy products).

lidocaine-prilocaine (EMLA) cream

Sig: Apply 1 application topically as needed.

linaclotide (LINZESS) 290 mcg Cap capsule

Sig: Take 1 capsule (290 mcg total) by mouth daily.

linaclotide (LINZESS) 290 mcg Cap capsule

Sig: Take 1 capsule (290 mcg total) by mouth every morning.

magnesium citrate solution

Sig: Take 296 mL by mouth once for 1 dose.

melatonin 3 mg Tab

Sig: Take 1 tablet (3 mg total) by mouth nightly.

melatonin 3 mg Tab

Sig: Take 1 tablet (3 mg total) by mouth nightly.

memantine (NAMENDA) 5 MG tablet

Sig: Take 1 tablet (5 mg total) by mouth 2 (two) times a day.

omeprazole (PRILOSEC) 40 MG capsule

Sig: Take 1 capsule (40 mg total) by mouth daily.

omeprazole (PRILOSEC) 40 MG capsule

Sig: Take 1 capsule (40 mg total) by mouth daily.

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

ondansetron (ZOFRAN) 4 MG tablet

Sig: Take 1 tablet (4 mg total) by mouth 3 (three) times a day as needed for nausea.

ondansetron (ZOFRAN-ODT) 4 MG disintegrating tablet

Sig: Take 1 tablet (4 mg total) by mouth 2 (two) times a day.

ondansetron (ZOFRAN-ODT) 4 MG disintegrating tablet

Sig: Take 1 tablet (4 mg total) by mouth every 8 (eight) hours as needed.

phenol (CHLORASEPTIC) 1.4 % SprA

Sig: Use as directed 1 spray in the mouth or throat every 2 (two) hours as needed.

phenol (CHLORASEPTIC) 1.4 % SprA

Sig: Use as directed 1 spray in the mouth or throat every 2 (two) hours as needed.

polyethylene glycol (MIRALAX) 17 gram packet

Sig: Take 17 g by mouth 2 (two) times a day.

polyethylene glycol (MIRALAX) 17 gram/dose powder

Sig: Take 34 g by mouth as directed. Take 34 gms twice a day with water boluses

senna (SENOKOT) 8.6 mg tablet

Sig: Take 1 tablet by mouth 2 (two) times a day.

senna (SENOKOT) 8.6 mg tablet

Sig: Take 2 tablets by mouth nightly.

traZODone (DESYREL) 50 MG tablet

Sig: Take 1 tablet (50 mg total) by mouth nightly as needed.

Facility-Administered Medications: None

Discharge Medications

STOP taking these medications

bacitracin 500 unit/gram ointment

benzocaine-menthol 15-2.6 mg Lozg

Also known as: CEPACOL SORE THROAT

lidocaine-prilocaine cream

Also known as: EMLA

LORazepam 1 MG tablet

Also known as: ATIVAN

magnesium citrate solution

omeprazole 40 MG capsule

Also known as: PriLOSEC

ondansetron 4 MG tablet

Also known as: ZOFRAN

phenol 1.4 % Spra

Also known as: CHLORASEPTIC

traZODone 50 MG tablet

Also known as: DESYREL

CHANGE how these medications are taken

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

	Dose, Frequency, and Details
acetaminophen 325 mg tablet Also known as: TYLENOL	Take 2 tablets (650 mg total) by mouth every 6 (six) hours as needed for mild pain. What changed: - when to take this - Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here. Last time this was given: 2/6/2018 11:22 AM
calcium carbonate 1,250 mg (500 mg elemental) tablet Also known as: OS-CAL	Take 1 tablet (1,250 mg total) by mouth 2 (two) times a day as needed. What changed: - when to take this - Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here. Last time this was given: 1/22/2018 3:51 PM
clomiPRAMINE 25 MG capsule Also known as: ANAFRANIL	Take 5 capsules (125 mg total) by mouth nightly. What changed: how much to take Last time this was given: 2/5/2018 9:20 PM

famotidine 20 MG tablet
Also known as: PEPCID

Take 1 tablet (20 mg total) by mouth as needed for ECT.

What changed:

- medication strength
- how much to take
- when to take this

Last time this was given: 1/27/2018 8:41 AM

glycerin (adult) Supp

Place 1 suppository rectally daily as needed (constipation).

What changed: Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.

* linaclotide 290 mcg Cap capsule
Also known as: LINZESS

Take 1 capsule (290 mcg total) by mouth every morning.

What changed: Another medication with the same name was changed. Make sure you understand how and when to take each.

Last time this was given: 2/6/2018 11:23 AM

* linaclotide 290 mcg Cap capsule
Also known as: LINZESS

Take 1 capsule (290 mcg total) by mouth daily before breakfast.

What changed: when to take this

Last time this was given: 2/6/2018 11:23 AM

melatonin 3 mg Tab

Take 1 tablet (3 mg total) by mouth nightly.

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

	Dose, Frequency, and Details What changed: Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here. Last time this was given: 2/5/2018 9:20 PM
ondansetron 4 MG disintegrating tablet Also known as: ZOFRAN-ODT	Take 1 tablet (4 mg total) by mouth every 8 (eight) hours as needed. What changed: Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here. Last time this was given: 2/3/2018 7:48 AM
polyethylene glycol 17 gram packet Also known as: MIRALAX	Take 34 g by mouth 3 (three) times a day. What changed: - how much to take - when to take this - Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here. Last time this was given: 2/6/2018 11:23

AM

senna 8.6 mg tablet — Take 2 tablets by mouth nightly.

Also known as: SENOKOT — What changed: Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.

Last time this was given: 2/5/2018 9:20 PM

* Notice: This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

CONTINUE taking these medications

Dose, Frequency, and Details

bisacodyl 10 mg suppository — Place 1 suppository (10 mg total) rectally daily as needed.

Also known as: DULCOLAX

Last time this was given: 2/6/2018 11:23 AM

* fexofenadine 180 MG tablet — Take 1 tablet (180 mg total) by mouth 2 (two) times a day.

Also known as: ALLEGRA

Last time this was given: 2/6/2018 11:23 AM

* fexofenadine 180 MG tablet — Take 2 tablets (360 mg total) by mouth daily as needed (Give 1 hour prior to ECT to prevent allergic reaction).

Also known as: ALLEGRA

Last time this was given: 2/6/2018 11:23 AM

lactase 3,000 unit tablet — Take 2 tablets (6,000 Units total) by mouth With Meals as needed (if eating/drinking

Also known as: LACTAID

dairy products).

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

	Dose, Frequency, and Details
memantine 5 MG tablet Also known as: NAMENDA	Take 1 tablet (5 mg total) by mouth 2 (two) times a day. Last time this was given: 2/6/2018 11:23 AM

* Notice: This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

Hospital Care Team

Service: Pediatrics

Inpatient Attending: Ann York Kao, MD, MPH

Attending phys phone: (617)726-2000

Discharge Unit: MGHE18

Primary Care Physician: Erin Margaret Mahony, MD 617-491-5111

Transitional Plan

Scheduled appointments:

Appointments Scheduled for Next 90 Days

Feb 13, 2018 7:00 AM EST 55 Fruit Street

ECT with MGH CPC PACU PROCEDURE BAY Boston MA 02114

MGH Wang 3 CPC (--) 617-726-2000

Feb 20, 2018 7:00 AM EST 55 Fruit Street

ECT with MGH CPC PACU PROCEDURE BAY Boston MA 02114

MGH Wang 3 CPC (--) 617-726-2000

Signed Discharge Orders

Ordered

02/06/18 Activity as tolerated

1211 Comments: Developmentally Appropriate

02/06/18 Discharge Pediatric Diet

1211 Question: Diet Type Answer: Regular

02/06/18 For immediate questions regarding your hospitalization, your medications, and any pending test

1211 results please contact your PCP: Erin Margaret Mahony, MD at 617-491-5111.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your PCP: Erin Margaret Mahony, MD at 617-491-5111.

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

Exam

Temperature: 36.5 ?C (02/06/18 0939) Heart Rate: (!) 116 (02/06/18 0955) BP: 105/59 (02/06/18 0955)

Respiratory Rate: 18 (02/06/18 0939) SpO2: 97 % (02/06/18 0955) O2 Device: None (Room air) (02/06/18 0955) O2 Flow Rate (L/min): 6

Weight: 57.2 kg (126 lb) (01/30/18 0808) Height: 160 cm (5' 3") (01/30/18 0808) BMI (Calculated): 22.3 (01/30/18 0808)

Discharge Exam

Significant Discharge Exam Findings: General: NAD, awake, alert, conversant, pale

HEENT: dry lips, MMM, nares clear without erythema, oropharynx benign

CV: RRR, no murmurs

Resp: breathing comfortably on RA, lung clear to ausculation bilaterally

Abd: soft, non- distended, mild tenderness to palpation in mid abdomen

Skin: abrasion on bridge of nose from picking, mild bruising at sight of prior IV on left antecubital fossa, erythema f rom

tape on right forearm

Neuro: no focal abnormalities

Psych: affect bright, looking forward to transfer to Blake 11

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Clear

Vision: Functional

Hearing: Functional

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	8.49	01/24/2018 0545
RBC	3.72 (L)	01/24/2018 0545
HGB	10.0 (L)	01/24/2018 0545
HCT	29.9 (L)	01/24/2018 0545
MCH	26.9	01/24/2018 0545
MCV	80.4	01/24/2018 0545
PLT	111 (L)	01/24/2018 0545
RDW	16.3 (H)	01/24/2018 0545

Lab Results

Component	Value	Date/Time
NA	137	01/26/2018 0357

K 3.9 01/26/2018 0357

MGH Main Campus HUM,JULIA

55 Fruit St MRN: 5462604

Boston MA 02114-2621 DOB: 11/12/1999, Sex: F

Acct #: 6070340623

ADM: 1/22/2018 D/C: 2/6/2018

Discharge Summaries by Caitlin S King, MD, MBA at 2/6/2018 12:27 PM (continued)

CL 103 01/26/2018 0357

CO2 23 01/26/2018 0357

BUN 10 01/26/2018 0357

CRE 0.61 01/26/2018 0357

CA 9.1 01/26/2018 0357

GLU 89 01/26/2018 0357

Lab Results

Component Value Date/Time

MG 1.8 01/24/2018 0545

Lab Results

Component Value Date/Time

PT 14.5 01/23/2018 0518

PTT 35.4 (H) 01/23/2018 0518

INR 1.1 01/23/2018 0518

Routing History

Date/Time From To Method

2/6/2018 6:36 PM Ann York Kao, MD, MPH Erin Margaret Mahony, MD Fax

DISCHARGE SUMMARY

NAME: SACKOR, MARY UNIT NUMBER: 412-29-75
DOB: 03/26/1986 FLOOR: W08 W0816B
ADMISSION DATE: 02/09/2011 DISCHARGE DATE: 02/14/2011

PRINCIPAL DIAGNOSIS
Drug overdose

ASSOCIATED DIAGNOSES
Psychotic disorder, Substance abuse

OPERATIONS AND PROCEDURES
Brain MRI
EEG

ALLERGIES
risperidone (dystonia, neck)

HISTORY AND REASON FOR HOSPITALIZATION AND SIGNIFICANT FINDINGS
Ms. Sackor is a 24 year old homeless patient from Parker Shelter West with h/o polysubstance abuse and psychosis NOS on Zyprexa who presents with altered MS s/p crack cocaine intoxication.
The patient has been homeless since age 17 and has been living at Parker Shelter for the past 9 months. Per nursing report she had been working on completing her GED, compliant with psych medication and working full time until approximately 4 months ago when she was laid off. This reportedly led her to smoking crack cocaine which led her to prostitution. Her new behavioral baseline is to be loud and oppositional to shelter staff, especially when under drug influence.

One night PTA, she had left the shelter in her baseline state of health and returned the next morning nonverbal and somnolent. She slept most of the day with poor PO intake and later that day was found persistently altered with a crack pipe in her belongings. She was taken to the ED at that time. As per the shelter nurses, there were no overt signs of trauma. Otherwise, there were no reported fever/chills, no coughing, no shortness of breath, no N/V.

In the Ed, she was hemodynamically stable. Her EKG was significant for NSR @ 74 with old Q waves in II/III/aVF, with new diffuse TWI in II/III/aVF and V1-V6 WHICH reverted over time. She had negative trop x 2. On arrival her GCS was 9 but rapidly improved to 13 with no focal neurological deficits. CT scan showed no acute ischemic changes. She received 325 ASA, folate and thiamine. During her time as an ED boarder, she remained somnolent but easily arousable to voice and intermittently would awake to eat. On the floor, she was somnolent, nodding to simple questions, but mostly nonverbal.

PAST MEDICAL/SURGICAL HISTORY
Onchocerciasis: partially treated with Ivermectin 12mg po x 2 (9/04 and 9/05)
Depression
Psychosis NOS

MEDICATIONS ON ADMISSION (source of information)
Zyprexa 30mg QHS prescribed by psychiatrist Dr. Henderson 617 912 7800
Tylenol PRN

ALLERGIES/ADVERSE REACTIONS
NKDA

FAMILY HISTORY
Unknown

SOCIAL HISTORY
General-born in Africa, immigrated at the age of 11-12, mother of 2 children (lost custody), has been arrested a few times in past months
Tobacco-unknown
EtOH-occasional as per charts
Drugs- marijuana, crack cocaine

ROS: + 20 lb weight loss in the past few months in spite of good appetite. + Left foot sprain 1 week ago. Otherwise negative except as per HPI.

PHYSICAL EXAMINATION
VITALS: T98.4, HR64 , BP 107/68, RR20 , 98% O2 on RA
General lethargic, selectively nodding to simple questions
HEENT atraumatic, 4-3mm pupils b/l, dry cracked lips
Neck supple, adenopathy
Pulmonary clear b/l
Cardiac regular, S1 S2, no murmurs
Abdomen BS+, ND, soft, NT, no HSM
Extremities good pulses, no peripheral edema
Neuro limited exam due to non-cooperation, grossly non-focal
Skin no rashes, no bruising

ADMISSION LABS AND OTHER STUDIES
02/09/11 - Sodium 139, Potassium 3.4, Chloride 104, Carbon Dioxide 25.4, BUN 15, Creatinine 0.85, Glucose 109, Calcium 9.3, Phosphorus 4.3, Magnesium 1.8, HCT 41.7, WBC 4.4 (L), PLT 325, Hgb 14.2, MCV 83, MCH 28.2, MCHC 34.1, RDW 13.3, RBC 5.03, Lymphs 36, Monos 6, Eos 11 (H), Basos 1, Neutrophils 46, PT 13.3, PT-INR 1.1, WBC Screen - UA Negative, Color - UA Yellow, Appearance - UA Clear, GLUC - UA Negative, Bilirubin - UA Negative, Specific Gravity, ur >1.030, Blood - UA Negative, pH - UA 5.5, Protein - UA Negative, Urobilinogen - UA Negative, Nitrites - UA Negative, Albumin 4.2, Globulin 2.7, Total Protein 6.9, Alk Phos 54, Bilirubin (Direct) 0.2, Bilirubin (Total) 0.9, ALT (SGPT) (U/L) 16, AST (SGOT) 21, Troponin-I Negative, HCG, urine Negative, Anisocytosis None, Hypochromia None, Macrocytes None, Microcytes None, Ketones - UA Negative, Amphetamine(s), urine/gastric Negative, Barbiturates, urine/gastric Negative, Benzodiazepines, urine Negative, THC/Cannabinoids, urine Positive, Cocaine, urine Positive, Opiates, urine/gastric Negative, Phencyclidine, urine Negative, Eos# 0.50 (H)

2011/02/09 00:00:00 - CTBrW/OC: No evidence of acute intracranial hemorrhage or territorial
infarction.

HOSPITAL COURSE AND TREATMENT
Her hospital course was remarkable for mental status waxing and waning between mutism with intermittent talking and agitation with paranoia requiring IV haldol and physical restraints. The patient was evaluated by both psychiatry and neurology services with no clear determination of the patient's delirium. Her AMS was overall attributed to an acute encephalopathy secondary to drugs +/- infectious process on a poor substrate with h/o psychosis and polysubstance abuse. CT and MRI scans were normal and EEG showed only slowing consistent with encephalopathy. She remained otherwise stable hemodynamically with labs wnl except for her peripheral eosinophilia which was chronic. All her microbiology data was negative including HIV and treponemal serologies. She was cleared by psychiatry for discharge, restarted on 30mg zyprexa QHS and discharged with close psychiatric outpatient follow-up.

MOST RECENT LABS AND OTHER STUDIES
02/12/11 - Sodium 137, Potassium 3.8, Chloride 103, Carbon Dioxide 22.3 (L), BUN 15, Creatinine 0.82, Calcium 8.8, Phosphorus 3.8, Magnesium 1.7, HCT 36.8, WBC 6.2, PLT 322, MCV 84
02/11/11 - Glucose 99, Temperature 37.0, FIO2 0.21, PO2, Arterial 112 (H), PCO2, Arterial 38, pH, Arterial 7.42, O2 Saturation 98, Ammonia 25, Lactic acid (mmol/L) 0.6

2011/02/11 00:00:00 - MRIBrW T W/0C:
No evidence of acute infarction, mass effect or hemorrhage.
Unremarkable appearance of the brain parenchyma, without evidence of
abnormal enhancement.

Stable left frontal bone lesion, most compatible with an intra-osseous hemangioma.

2011/02/10 00:00:00 - Chest Single View: Clear lungs.

2011/02/10 00:00:00 - URINE: Urine Culture - Final Reported: 12-Feb-11 15:42
Few (1000 to <10,000 CFU/ml) MIXED BACTERIA

2011/02/10 00:00:00 - BLOOD CULTURE: Blood Culture - Final Reported: 17-Feb-11 07:16
NO GROWTH 7 DAYS

2011/02/09 00:00:00 - CTBrW/OC: No evidence of acute intracranial hemorrhage or territorial
infarction.

CONDITION ON DISCHARGE
Improved

DISCHARGE MEDICATIONS

Multivitamins 1 TAB PO QD (last dose: 02/14/11 09:00 am)
Olanzapine (Zyprexa) 30 MG PO QHS
Medroxyprogesterone Inj (Depo-provera) 150 MG IM EVERY 3 MONTHS

Vaccines
The Flu vaccine was not given during this admission. Please consult with your PCP regarding vaccinations.

DISCHARGE INSTRUCTIONS
Diet: No Restrictions
Activity: No Restrictions
Treatment: Monitoring, evaluation by Neurology and Psychiatry
Instructions: You were admitted to the hospital because your mental status was altered and you were not waking up. You had a brain MRI and an electroencephalogram (shows the electrical activity in your brain). There was no evidence that you were having seizures.

You were evaluated by the Neurology and Psychiatry Services. Psychiatry felt that you were safe to leave the hospital and return to Parker Street West with close follow up with your outpatient psychiatrist.

Your thyroid function was normal. Test for syphilis was negative. You have some other tests pending, which we will follow up with you on. They include HIV test and tests for hepatitis.
Followup: You have an appointment to see your psychiatrist, Dr. Henderson, at the Freedom Trail Clinic tomorrow, 2/15/11 at 9:30 AM.

LAST ATTENDING OF RECORD
Chiappa, Victor, MD 617-643-0592

Electronically Signed
MARCELO ROCHA, M.D. 03/05/2011 08:37 P

MARCELO ROCHA, M.D.

TR: dex DD: 03/05/2011 TD: 03/05/2011 08:37 P 1341767
cc: DOUGLASS L. BIBULD, M.D.
1425 Blue Hill Avenue
Mattapan MA 02126

DAVID CARLTON HENDERSON, M.D.
Freedom Trail Clinic
25 Stainford Street
**020106 MA 02114

DISCHARGE SUMMARY

NAME: DEL VALLE, GEORGE UNIT NUMBER: 474-54-18
FLOOR: W06 W0612A
ADMISSION DATE: 08/15/2010 DISCHARGE DATE: 08/20/2010

PRINCIPAL DIAGNOSIS
Motor vehicle accident victim

ASSOCIATED DIAGNOSES
Right anterior wall acetabular fracture, Left distal radius fracture,
9-mm hypodense nodule in the right lobe of the thyroid.

OPERATIONS AND PROCEDURES
Serial exams

ALLERGIES
Penicillins (Unknown)

HISTORY AND REASON FOR HOSPITALIZATION AND SIGNIFICANT FINDINGS
ORTHOPAEDIC SURGERY CONSULT

Patient: Del Valle,George
MRN: 4745418
Date: 8/14/10

CHIEF COMPLAINT: left wrist pain and R hip pain

HISTORY OF PRESENT ILLNESS: 31 y/o M who was unrestrained front seat passenger in MVC, car vs. house. + car damage, self extricated, unknown LOC, c/o L hand. Pt complains of R hip pain and L wrist pain.

PAST MEDICAL HISTORY: hep C, IVDU
MEDICATIONS: none
ALLERGIES: PCN -> hives
SOCIAL HISTORY: homeless

PHYSICAL EXAM:
AF VSS
NAD
R posterior scalp laceration

L upper extremity:
TTP over L wrist, no lacerations in this area
intact EPL/FDS/FDP/DIO
SILT in M/R/U
2+ radial pulse, digits WWP

R lower extremity:
pain with ROM of R hip
intact EHL/FHL/GS/TA
SILT in DP/SP/T/S/S
2+ DP pulse, digits WWP

L lower extremity:
approx 4 cm longitudinal laceration over anterior aspect of leg
intact EHL/FHL/GS/TA
SILT in DP/SP/T/S/S

2+ DP pulse, digits WWP

IMAGING:
CT torso: minimally displaced R anterior wall acetabular fracture, does not involve significant portion of weightbearing dome of acetabulum
L wrist xrays: minimally volarly displaced L distal radius fx
R femur xrays: no fracture of R femur
CT head: Right subgaleal hematoma
CT c-spine: negative for fx

ASSESSMENT/PLAN: 31 y/o male with R anterior wall acetabular fx and L distal radius fx
- L distal radius fracture splinted, plan for nonoperative management
- TDWB for R anterior wall acetabular fracture, plan for nonoperative management
- PT consult for mobilization
- will d/w trauma team in AM

_____
Peter S. Vezeridis, M.D.

PGY-4, Orthopaedic Surgery

ADMISSION LABS AND OTHER STUDIES
08/15/10 - Amphetamine(s), urine/gastric Negative, Benzodiazepines, urine Negative, Cocaine, urine Negative, Methadone, urine Positive, Phencyclidine, urine Negative
08/14/10 - BUN 10, Creatinine 1.03, Glucose 126 (H), HCT 47.3, WBC 15.7 (H), PLT 622 (H), PT 12.6, PT-INR 1.0, PTT 22.7, Troponin-I Negative, Demoxepam PRESENT, Ethanol (mg/dL) 977, Nordiazepam <100

2010/08/14 00:00:00 - Tibia and Fibula 2 Views: IMPRESSION:
No acute fracture or dislocation is demonstrated on the images provided.
2010/08/14 00:00:00 - Hand Minimum 3 Views: IMPRESSION:
Fracture of left distal radius.
2010/08/14 00:00:00 - Femur 2 Views: IMPRESSION:
No acute fracture or dislocation is demonstrated on the images provided.
2010/08/14 00:00:00 - Knee 4 or More Views: IMPRESSION:
No acute fracture or dislocation is demonstrated on the images provided.
2010/08/14 00:00:00 - CTAb T CTPelw/C: IMPRESSION:
Minimally displaced fracture of the right anterior/superior acetabulum. No other acute traumatic injury is identified in the chest, abdomen, or pelvis.
2010/08/14 00:00:00 - CTChestWC: IMPRESSION:
Minimally displaced fracture of the right anterior/superior acetabulum. No other acute traumatic injury is identified in the chest, abdomen, or pelvis.

2010/08/14 00:00:00 - CTBrW/OC: IMPRESSION:
1. Right subgaleal hematoma containing foci of air and punctate high density foreign bodies.
2. No evidence of intracranial hemorrhage, mass lesion or acute, or territorial infarction.
2010/08/14 00:00:00 - CTCervSpnBneWO: IMPRESSION:
No evidence of acute displaced fracture or malalignment in the cervical spine.
9-mm hypodense nodule in the right lobe of the thyroid.
2010/08/14 00:00:00 - Chest Single View: IMPRESSION:
No evidence of pneumothorax.

HOSPITAL COURSE AND TREATMENT
Mr. Del Valle was evaluated by the trauma and orthopedic teams in the ED. His scalp laceration was repaired in the ED. Following is workup he was admitted to the orthopedic floor. Pain was an issue-Acute Pain Service was consulted to assist with pain control. He was treated with methadone wean-5 mg TID for one day, then BID for two days, then daily for 2 days and d/c. Oxycodone was ineffective for breakthrough pain -he was switched to MS IR with effect. Patient requested psychiatry consult for history of PTSD and c/o nightmares from MVC. Psychiatry evaluated him-recommended propanolol 10 mg q 6 hours prn for anxiety. The patient requests Valium for his current anxiety, and becomes visibly agitated when told that he will not receive any benzodiazepines due to their potential to worsen symptoms of PTSD. He states that Propranolol will not work for him, though he has never tried it and cannot explain why he believes this. He also endorses intolerable side effects from trazodone and melatonin. He is not interested in an SSRI medication for PTSD. He repeatedly states that he does not want to be medications, but continued to request Valium. He was not given any valium.

Trauma service debrided wound to LLE 8/16/10, recommending wet to dry dressing daily as well as bacitracin to LLE abrasion. His wounds and scalp laceration remained clean, dry, and intact without signs of infection. PT and OT worked with him-he is NWB to LUE in current splint and TDWB to RLE. PT recommended inpatient rehab stay for him.

Mr. Del Valle will follow up in the Orthopedic Trauma Clinic in 10-14 days with Dr. Brian Ladner. He will follow up in the General Surgery Dispensary clinic in 2 weeks for removal of scalp laceration. He will go out on lovenox for 4 weeks for DVT prophylaxis.

CONDITION ON DISCHARGE
Stable

DISCHARGE MEDICATIONS
Propranolol Hcl 10 MG PO Q6H prn
Bisacodyl Rectal (Dulcolax Rectal) 10 MG PR QD prn
Docusate Sodium (Colace) 100 MG PO BID
Acetaminophen (Tylenol) 650 MG PO Q6H
Morphine Immediate Release 30 MG PO Q4H prn
Folic Acid (Folate) 1 MG PO QD
Multivitamins 1 TAB PO QD

Thiamine Hcl 100 MG PO QD
Bacitracin 1 APPLICATION TOP BID
Enoxaparin (Lovenox) 40 MG SC QD
Hydroxyzine Hcl 25 MG PO Q4H

DISCHARGE INSTRUCTIONS
Diet: No Restrictions
Activity: Nonweight bearing to left arm, touchdown weight bearing to right leg
Treatment: wet to dry dressing daily to left leg wound, bacitracin to left leg abrasion twice a day; keep left wrist elevated as much as possible
Instructions: FACESHEET D/C INSTRUCTIONS

******SIGNS OF INFECTION**********
-Please return to the emergency department or notify MD if you experience severe pain, increased swelling, decreased sensation, difficulty with movement; fevers >101.5, chills, redness or drainage at the left leg wound/abrasion; chest pain, shortness of breath or any other concerns.
-Wound Care: You can get the wound wet/take a shower starting from 3 days post-op. No baths or swimming for at least 4 weeks.

******WEIGHT-BEARING/PRECAUTIONS
Nonweight bearing to left arm, touchdown weight bearing to right leg

******MEDICATIONS**********
-PAIN MEDICATION: MS IR, tylenol
-.Do not operate heavy machinery or drink alcohol while taking pain meds.(medications) As your pain improves please decrease the amount of pain medication. This medication can cause constipation, so you should drink 8-8oz glasses of water daily and take a stool softener (colace) to prevent this side effect.
-Medication refills cannot be written after 12 noon on Fridays.
-ANTICOAGULATION: lovenox 40 mg qd for 4 weeks
-Resume your pre-hospital medications

******FOLLOW-UP**********

Please follow up with Dr. Ladner in the Orthopaedic Clinic in 10-14 days. Call 617.726.9111 to schedule appointment upon discharge from MGH. The clinic is located in the Yawkey Building, 3rd Floor, Suite 3E. Suite 3-C

Folow up in the Churchill Dispensary Clinic in Wang 4 for removal of head sutures in 2 weeks-please call 617-726-2760 to make appointment

Please follow up with your primary care physician regarding this admission and finding of thyroid nodule incidentally found on cervical spine CT scan

Please call (Amanda) Mandy Savage, R. N. in the Orthopedic Trauma Clinic at 617-726-9111 (617-726-9437) if you have any questions

Equipment: platform walker
Followup: -Call the Churchill Dispensary Clinic (617-726-2760) the
schedule an appointment to have your scalp sutures removed in 2 weeks.
The clinic is located in the Wang Building, 4th Floor, Room 455.
-Follow up with Dr. Ladner in the Orthopedic Trauma Clinic in 10-14
days-please call 617-726-9111 to make appointment
-Follow up with your primary care physician for workup of thyroid
nodule seen on CT scan

SERVICES
Nursing Service - Evaluate and Treat Accordingly
Physical Therapy Service - Evaluate and Treat Accordingly

LAST ATTENDING OF RECORD
Ladner, Brian J, M.D. 617-726-2943

Electronically Signed
SHAWN G. ANTHONY, M.D. 08/20/2010 02:04 P

SHAWN G. ANTHONY, M.D.

TR: dex DD: 08/20/2010 TD: 08/20/2010 02:04 P 1286525

PATIENT MEDICATION LIST ON DISCHARGE FROM Massachusetts General Hospital

Patient Name: OHAIRE, AMY M Medical Record #: 2199599 Admit: 12/07/2015
Discharge: 12/09/2015

DOB: 4/6/1977

IMPORTANT

Please review this list with your pharmacist

Please call your Doctor:

q If you have any questions about your medications

q If a medication you were taking before coming into the hospital is missing from any of these lists

YOUR NEW MEDICATION LIST:

MEDICATION	DOSE	HOW OFTEN TO TAKE	HOW TO TAKE	INSTRUCTIONS
METHIMAZOLE	10 mg	every day	by mouth	Start taking m edication: On Discharge

DAPSONE 100 mg every day by mouth Start taking medi
cation: On Discharge

EMTRICITABINE/TENOFOVIR 1 tablet(s) every day by mouth Start
taking medication: On Discharge

200 MG/300 MG The dose or how often to take this medication may be different from what

you were taking before your hospitalization. Please take the medication

listed here until you can review this medication with your doctor.

Last dose given 12/09/2015 at 09:42 AM (1 tablet(s))

PREZCOBIX 800/150 1 tablet(s) every day by mouth Start taking
medication: On Discharge

This is a new medication

Take these medications ONLY when you need them:

ALBUTEROL INHALER HFA 2 puff(s) every 6 hours inhaled into the mouth S
tart taking medication: On Discharge

This is a new medication as needed for: Shortness of Breath

Patient Name: OHAIRE, AMY M Medical Record #: 2199599 Admit: 12/07/2015 Di
scharge: 12/09/2015

DOB: 4/6/1977

YOUR NEW MEDICATION LIST (CONTINUED):

Take these medications ONLY when you need them:

MEDICATION DOSE HOW OFTEN TO TAKE HOW TO TAKE I
NSTRUCTIONS

IPRATROPIUM INHALER 2 puff(s) every 6 hours inhaled into the mouth Start ta
king medication: On Discharge

same as: ATROVENT HFA as needed for: cough, sob

INHALER

ONDANSETRON HCL 8 mg three times a day by mouth Start taking
medication: On Discharge

(CHEMO N/V) as needed for: Nausea

POLYETHYLENE GLYCOL 17 gm every day by mouth Start takin

g medication: On Discharge

This is a new medication as needed for: Constipation

SENNOSIDES 2 tablet(s) two times a day by mouth Start taking medic ation: On Discharge

This is a new medication as needed for: Constipation

LORAZEPAM 0.5 mg four times a day by mouth Start taking medi cation: On Discharge

as needed for: Nausea

ACETAMINOPHEN 650 mg every 4 hours by mouth Start taking m edication: On Discharge

This is a new medication as needed for: Pain-Mild, Fever

MORPHINE IMMEDIATE 15-30 mg every 4 hours by mouth Start taki ng medication: On Discharge

RELEASE as needed for: pain

Patient Name: OHAIRE, AMY M Medical Record #: 2199599 Admit: 12/07/2015 Disch arge: 12/09/2015

DOB: 4/6/1977

TAKING THE FOLLOWING MEDICATIONS:

MEDICATION DOSE THIS WAS TAKEN HOW THIS WAS INSTR UCTIONS

TAKEN

ALBUTEROL INHALER 2 puff(s) every 6 hours inhaled into the mouth

as needed for: cough, shortness of

breath

Patient Name: OHAIRE, AMY M Medical Record #: 2199599 Admit: 12/07/2015 Di scharge: 12/09/2015

DOB: 4/6/1977

Allergic reactions, Intolerances and Sensitivities

Allergic to:	Reaction:
Penicillins	Rash
valproic acid	rash, came from inside out with burning and redness
prochlorperazine	Dystonia
mirtazapine	weight gain
duloxetine	GI Upset, Vomiting
pregabalin	mania
aripiprazole	weight gain
sulfamethoxazole-trimethoprim	Pancreatitis

MGH Main Campus Morrill, Jennifer

55 Fruit St. MRN: 4838275, DOB: 5/8/1986, Sex: F

Boston MA 02114-2621 Acct #: 6122030109

ADM: 4/20/2020, D/C: 4/21/2020

Patient Information

Patient Name	Sex	DOB
Morrill, Jennifer	Female	5/8/1986

Discharge Summary by Ryan C Fleming, MD at 4/21/2020 4:30 PM

Author: Ryan C Fleming, MD Service: Hospital Medicine Author Type: Physician

Filed: 4/21/2020 5:07 PM Date of Service: 4/21/2020 Status: Signed

4:30 PM

Editor: Ryan C Fleming, MD (Physician)

Physician Discharge Summary

Admit date: 4/20/2020

Discharge date: 4/21/2020

Patient Information

Jennifer Morrill, 33 y.o. female (DOB = 5/8/1986)

Home Address: 72 Cabot St A8

Beverly MA 01915

Home Phone: 978-473-5360 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): Health Care Proxy

Does patient have a Health Care Proxy form completed?: HCP is NOT available, patient will complete a new one

Health Care Agents

There are no Health Care Agents on file.

Code Status at Discharge: Full Code (Confirmed)

Hospitalization Summary

Principal Problem:

MGH Main Campus Morrill, Jennifer

55 Fruit St. MRN: 4838275, DOB: 5/8/1986, Sex: F

Boston MA 02114-2621 Acct #: 6122030109

ADM: 4/20/2020, D/C: 4/21/2020

Discharge Summary by Ryan C Fleming, MD at 4/21/2020 4:30 PM (continued)

Chest pain

Active Problems:

Polysubstance abuse

Viral hepatitis C

Syphilis

Anxiety and depression

Resolved Problems:

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this admission

None

Procedures this admission

None

Non (OR) Procedures:

Pending Results

Procedure	Component	Value	Ref Range	Date/Time
Blood culture, routine [620918315]				Collected: 04/20/20 0723
Lab Status: Preliminary result		Specimen: Blood		Updated: 04/21/20 0719
	Special Requests	No Special Requests		
	BLOOD CULTURE	NO GROWTH < 24 HOURS		
Blood culture, routine [620918316]				Collected: 04/20/20 0723
Lab Status: Preliminary result		Specimen: Blood		Updated: 04/21/20 0719
	Special Requests	No Special Requests		
	BLOOD CULTURE	NO GROWTH < 24 HOURS		
FENTANYL, URINE [670172061]				Collected: 04/20/20 1800
Lab Status: In process		Specimen: Urine		Updated: 04/20/20 1902

Hospital Course

33 year old woman with a history of IV drug/polysubstance use (including prior IV fentanyl use and current IV cocaine), MRSA bacteremia with epidural abscess, discitis s/p vancomycin, hepatitis C (viral load undetectable), syphilis, asthma and depression who presents with sharp, mid-sternal chest pain after using IV cocaine. No chest pain free. Requesting detox placement.

Admission HPI (per admitting provider):

Jennifer Morrill is a 33 year old woman with a history of IV drug/polysubstance use (including prior IV fentanyl use and current IV cocaine), hepatitis C (viral load undetectable), syphilis, asthma and depression and admission to Lahey on 9/14/2019 for MRSA sepsis and T/L spinal epidural abscess. She underwent a T10-T11

Discharge Summary by Ryan C Fleming, MD at 4/21/2020 4:30 PM (continued)

open laminectomy with bilateral medial facet decompression and bilateral foraminotomy to decompress spinal cord and drain epidural abscess, septic arthritis of L4-L5 with adjacent paravertebral phlegmon with right lateral and dorsal epidural abscess at L5 to S1. The epidural abscess extended inferiorly into the right S1-2 foramen. Normal TTE on 9/16/19. Was on IV vancomycin for six week course starting after surgery (9/15 - 10/27). Now presents with sharp, mid-sternal chest pain after using IV cocaine. Troponins negative. Requesting detox placement and COVID-19 testing.

Hospital course by problem:

#Chest Pain

Had resolved by time of presentation to the ED. ECG and telemetry were stable following admission. Troponins negative during ED course. Given her history of MRSA infection and recent IV drug use, blood cultures were collected which remained NGTD throughout her hospitalization. A TTE was ordered but unfortunately she left against medical advice before it could be performed.

#Polysubstance Abuse

She requested detox placement on admission. She was seen by the ACT team. On their recommendations her suboxone was planned increased to 8 mg BID. She was also started on topiramate 25 mg nightly with a plan to uptitrate slowly on a weekly basis for her cocaine cravings/withdrawal. On 4/21 she informed the medical team that her cell phone had been stolen but that somebody had tracked it down to BMC and so she had to leave the hospital in order to follow-up on this. The risks/benefits of leaving without a stable disposition plan in place for her substance abuse treatment was discussed and she expressed understanding. A prescription for a few days of suboxone was sent to the MGH pharmacy by the ACT team. She left before she could be screened for HIV or a HCV viral load could be checked.

#Suspected COVID-19

SARS-CoV-2 PCRs were negative x 2. She had no known COVID exposures prior to admission. She denied

any symptoms consistent with a possible upper respiratory tract infection. Therefore she was cleared of

concern for COVID-19 by the biothreats team prior to discharge.

#Syphilis

She had a history of positive syphilis testing while at Anne Jacques but unclear whether she received a full

course of penicillin. Syphilis antibody testing here was in process at the time of discharge.

Medications

Allergies: Opioids - morphine analogues

Prior to Admission Medications

Prescriptions

QUEtiapine (SEROQUEL) 25 MG tablet

Sig: Take 1 tablet (25 mg total) by mouth every 6 (six) hours as needed (for anxiety or insomnia).

Patient not taking: Reported on 4/20/2020

baclofen (LIORESAL) 10 MG tablet

Sig: Take 10 mg by mouth 3 (three) times a day. Indications: unknown dose

buprenorphine-naloxone (SUBOXONE) 8-2 mg Film

Sig: Place 1.5 Film under the tongue daily.

Note (4/20/2020): 1.5 films once a day. Prescribed by Stella C Uchendu. New Horizons in Lynn, MA.

buprenorphine-naloxone (SUBOXONE) 8-2 mg Film

Sig: Place 1 Film under the tongue 2 (two) times a day for 4 days.

cloNIDine HCl (CATAPRES) 0.2 MG tablet

Sig: Take 0.2 mg by mouth. Indications: nightly

escitalopram oxalate (LEXAPRO) 10 MG tablet

Sig: Take 10 mg by mouth daily.

gabapentin (NEURONTIN) 400 MG capsule

Sig: Take 1 capsule (400 mg total) by mouth 3 (three) times a day.

Patient not taking: Reported on 4/20/2020

ibuprofen (ADVIL,MOTRIN) 600 MG tablet

Sig: Take 1 tablet (600 mg total) by mouth every 6 (six) hours as needed for pain (specific location in comments) (With food).

Patient not taking: Reported on 8/6/2019

lidocaine (LIDODERM) 5 %

Sig: Place 2 patches onto the skin daily. Remove & Discard patch within 12 hours or as directed by MD

Patient not taking: Reported on 5/13/2019

mirtazapine (REMERON) 7.5 MG tablet

Sig: Take 7.5 mg by mouth nightly.

nicotine (NICODERM CQ) 21 mg/24 hr

Sig: Place 1 patch onto the skin daily.

Patient not taking: Reported on 4/20/2020

polyethylene glycol (MIRALAX) 17 gram packet

Sig: Take 17 g by mouth 2 (two) times a day.

Patient not taking: Reported on 8/6/2019

prazosin (MINIPRESS) 1 MG capsule

Sig: Take 1 capsule (1 mg total) by mouth nightly as needed (nightmares).

Patient not taking: Reported on 8/6/2019

senna (SENOKOT) 8.6 mg tablet

Sig: Take 2 tablets by mouth 2 (two) times a day.

Patient not taking: Reported on 5/13/2019

tiZANidine (ZANAFLEX) 2 MG tablet

Sig: Take 2 tablets (4 mg total) by mouth every 8 (eight) hours as needed (for back pain, spasm).

Patient not taking: Reported on 5/13/2019

topiramate (TOPAMAX) 50 MG tablet

Sig: Take 50 mg by mouth daily.

Facility-Administered Medications: None

Medication List

STOP taking these medications

baclofen 10 MG tablet

Commonly known as: LIORESAL

cloNIDine HCL 0.2 MG tablet

Commonly known as: CATAPRES

escitalopram oxalate 10 MG tablet

Commonly known as: LEXAPRO

gabapentin 400 MG capsule

Commonly known as: NEURONTIN

ibuprofen 600 MG tablet

Commonly known as: ADVIL,MOTRIN

lidocaine 5 %

Commonly known as: LIDODERM

mirtazapine 7.5 MG tablet

Commonly known as: REMERON

polyethylene glycol 17 gram packet

Commonly known as: MIRALAX

prazosin 1 MG capsule

Commonly known as: MINIPRESS

QUEtiapine 25 MG tablet

Commonly known as: SEROquel

senna 8.6 mg tablet

Commonly known as: SENOKOT

tiZANidine 2 MG tablet

Commonly known as: ZANAFLEX

TAKE these medications

	Instructions
* buprenorphine-naloxone 8-2 mg Film Commonly known as: SUBOXONE Last time this was given: Ask your nurse or doctor	Place 1 Film under the tongue 2 (two) times a day for 4 days. What changed: You were already taking a medication with the same name, and this prescription was added. Make sure you understand how and when to take each. Doctor's comments: NADEAN: XG5224807. Please dispense brand name under DAW-9 if preferred by insurance. May substitute tab/film based on insurance as well. Partial fill OK.
* buprenorphine-naloxone 8-2 mg Film Commonly known as: SUBOXONE Last time this was given: Ask your nurse or doctor	Place 1.5 Film under the tongue daily. What changed: Another medication with the same name was added. Make sure you understand how and when to take each.
nicotine 21 mg/24 hr	Place 1 patch onto the skin daily.

Instructions

CQ

Last time this was given: Ask your

nurse or doctor

topiramate 25 MG tablet Take 2 tablets (50 mg total) by mouth

Commonly known as: TOPAMAX nightly at bedtime.

What changed:

? medication strength

? when to take this

* This list has 2 medication(s) that are the same as other medications

prescribed for you. Read the directions carefully, and ask your doctor or other

care provider to review them with you.

Where to Get Your Medications

These medications were sent to MGH

OUTPATIENT PHARMACY - BOSTON, MA - 55 55 FRUIT STREET, BOSTON MA

FRUIT STREET 02114

Phone: 617-724-3100

? nicotine 21 mg/24 hr

? topiramate 25 MG tablet

These medications were sent to WALGREENS

DRUG STORE #04393 - BEVERLY, MA - 54 54 ELLIOTT ST, BEVERLY MA

ELLIOTT ST AT SWC ELLIOTT & RANTOUL 01915-3359

Phone: 978-921-0506

? buprenorphine-naloxone 8-2 mg Film

Hospital Care Team

Service: Medicine

Inpatient Attending: No att. providers found

Attending phys phone: N/A

Discharge Unit: MGHP20

Primary Care Physician: Francis Michael Harte, MD 978-740-2300

Transitional Plan

Scheduled appointments:

Your Follow-Up Appointments

MGH Main Campus Morrill, Jennifer

55 Fruit St. MRN: 4838275, DOB: 5/8/1986, Sex: F

Boston MA 02114-2621 Acct #: 6122030109

ADM: 4/20/2020, D/C: 4/21/2020

Discharge Summary by Ryan C Fleming, MD at 4/21/2020 4:30 PM (continued)

Francis Michael Harte, MD 2 First Avenue

Specialty: Internal Medicine PEABODY MA 01960

Relationship: PCP - General Phone: 978-740-2300

Follow up on 4/22/2020

Instructions: TELEMEDICINE appointment at 9:30AM. Please answer all unlisted/unknown numbers at this time

Signed Discharge Orders (From admission, onward)

Ordered

04/21/2 Activity as tolerated

0 1551

04/21/2 Discharge diet

0 1551 Comments: Diet Regular

04/21/2 0 1551 For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your doctor in the hospital: Ryan C Fleming, MD at 617-726-2000 and ask him/her to be paged.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your doctor in the hospital: Ryan C Fleming, MD at 617-726-2000 and ask him/her to be paged.

Exam

Temperature: 36.6 ?C (97.8 ?F) (04/21/20 1235) Heart Rate: 60 (04/21/20 1235) BP: 112/55 (04/21/20 1235) Respiratory Rate: 18 (04/21/20 1235) SpO2: 96 % (04/21/20 1235) O2 Device: None (Room air) (04/21/20 1235)

Weight: 67 kg (147 lb 11.3 oz) (04/20/20 1206) Height: 167.6 cm (5' 6") (04/20/20 1206) BMI (Calculated): 23.9 (04/20/20 1206)

Discharge Exam

Significant Discharge Exam Findings: 04/21/20 5:06 PM

Medicine Attending Attestation for discharge:

Patient seen and examined. Vitals reviewed and they are stable.

Exam

36.6 ?C (97.8 ?F) P 60 BP 112/55 RR 18 SpO2 96 % FiO2 67 kg (147 lb 11.3 oz)

Gen: in NAD

HEENT: eomi, anicteric sclera, MMM, oropharynx clear

Neck: supple, no LAD

CV: RRR, no m/r/g

Lungs: ctab bilaterally, normal resp effort

Abdomen: soft, ntnd, +BS

Ext: wwp, no pitting edema

Derm: no rash

Neuro: A&Ox3, grossly non-focal

Medically stable and ready for discharge. Please see remainder of discharge summary for details of hospitalization.

Greater than 30 minutes spent on discharge due to counseling and coordinating care including review of records, pertinent lab data and studies, as well as discussing diagnostic evaluation and work up, planned therapeutic interventions and future disposition of care. Where indicated, the assessment and plan reflect discussion of patient with consultants, other healthcare providers, family members, and additional research needed to obtain further information in formulating the plan of care of this patient

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Appropriate for age

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	11.76 (H)	04/20/2020 0653
RBC	3.82 (L)	04/20/2020 0653
RBCP	NO GROWTH < 24 HOURS	04/20/2020 0723
RBCP	NO GROWTH < 24 HOURS	04/20/2020 0723
HGB	10.9 (L)	04/20/2020 0653
HCT	34.0 (L)	04/20/2020 0653

MCH	28.5	04/20/2020	0653
MCV	89.0	04/20/2020	0653
PLT	382	04/20/2020	0653
RDW	12.6	04/20/2020	0653

Lab Results

Component	Value	Date/Time
NA	138	04/20/2020 0653
K	3.7	04/20/2020 0653

Discharge Summary by Ryan C Fleming, MD at 4/21/2020 4:30 PM (continued)

CL	99	04/20/2020 0653
CO2	27	04/20/2020 0653
BUN	14	04/20/2020 0653
CRE	0.75	04/20/2020 0653
CA	9.4	04/20/2020 0653
GLU	105	04/20/2020 0653

Lab Results

Component	Value	Date/Time
MG	2.0	04/20/2020 0653

Routing History

Date/Time	From	To	Method
4/21/2020 5:07 PM	Ryan C Fleming, MD	Francis Michael Harte, MD	Fax

MGH Main Campus Durning, Kristie

55 Fruit St. MRN: 5608646, DOB: 6/16/1980, Sex: F

Boston MA 02114-2621 Acct #: 6091743987

ADM: 2/1/2019, D/C: 2/2/2019

Patient Information

Patient Name	Sex	DOB
Durning, Kristie	Female	6/16/1980

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM

Author: Alyssa Y Castillo, MD Service: Hospital Medicine Author Type: Physician

Filed: 2/2/2019 10:11 AM Date of Service: 2/2/2019 9:45 AM Status: Signed

Editor: Alyssa Y Castillo, MD (Physician)

Physician Discharge Summary

Admit date: 2/1/2019

Discharge date: 2/2/2019

Patient Information

Kristie Durning, 38 y.o. female (DOB = 6/16/1980)

Home Address: 220 Summer St

South Walpole MA 02071

Home Phone: 774-284-3432 (home)

Health Care Agents

There are no Health Care Agents on file.

Code Status at Discharge: Full Code (Presumed)

Hospitalization Summary

Reason for Admission: Rash and Fever

Principal Problem:

Fever

Active Problems:

Erythema nodosum

Opioid use disorder, severe, dependence

Sinus tachycardia

Foreign body granuloma of soft tissue

Resolved Problems:

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM (continued)

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this admission

None

Non (OR) Procedures:

Items for Post-Hospitalization Follow-Up:

Future testing to consider such as interval labs/radiology/diagnostic testing (including reason and timing):

- Recommend ultrasound evaluation of the R neck to evaluate for retained needle location and risk of migration into

nearby structures (vasculature, lung parenchyma)

- Recommend cardiac ultrasound (TTE) to evaluate for vegetations in the setting of high-risk patient for bacteremia and

endocarditis

- Further testing TBD based on results of pending laboratory studies

Medication reconciliation:

New medications and reason for starting them:

- Started on ibuprofen for presumed erythema nodosum

- Started on nicotine patch for tobacco replacement

Changed/Stopped home medications and reason for changing/stopping them:

- Clonidine removed from medication list, as patient reports this was recently discontinued by her outpatient provide
r

and she has not been taking for several months

Specialist referrals made/to be considered:

- Pending above work-up

Any other transitional issues:

- Patient encouraged to make PCP appointment; one could not be made for her, as she chose to leave AMA on a

weekend

Pending Results

Procedure Component Value Ref Range Date/Time

Urine culture [496256054] Collected: 02/02/19 0708

Lab Status: In process Specimen: Urine Updated: 02/02/19 0846

Streptococcal antibodies profile [501103310] Collected: 02/02/19 0552

Lab Status: In process Updated: 02/02/19 0839

Blood culture, routine [496256051] Collected: 02/01/19 2250

Lab Status: Preliminary result Specimen: Blood Updated: 02/02/19 0809

Specimen BLOOD RAC

Source/

Description

SPECIAL No Special Requests

REQUESTS

CULTURE / NO GROWTH < 24 HOURS

TEST

REPORT PENDING

STATUS

Blood culture, routine [496256052] Collected: 02/01/19 2250

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM (continued)

Procedure	Component	Value	Ref Range	Date/Time
Lab Status: Preliminary result		Specimen: Blood		Updated: 02/02/19 0809
	Specimen Source/ Description	BLOOD LAC		
	SPECIAL REQUESTS	No Special Requests		
	CULTURE / TEST	NO GROWTH < 24 HOURS		
	REPORT STATUS	PENDING		
Chlamydia Trachomatis and Neisseria Gonorrhoeae Nucleic Acid Detection [501093880]				Collected: 02/02/19 0708
Lab Status: Preliminary result		Specimen: Urine		Updated: 02/02/19 0741
	C.TRACHOMATIS, AMP	PENDING	Negative for Chlamydia Trachomatis Nucleic Acid	
	Specimen type (C. Trachomatis DNA)	URINE		
	N.Gonorrhoeae, AMP	PENDING	Negative for Neisseria Gonorrhoeae Nucleic Acid	

Specimen type URINE

Complement C3 [501093873] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0632

Complement C4 [501093874] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0632

Syphilis antibody screen [501093878] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0628

HIV-1/2 antigen/antibody [501093861] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0628

HIV-1 viral load (PCR) [501093864] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0628

Hepatitis B core antibody, total [501093858] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0626

Hepatitis B surface antigen [501093859] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0626

Hepatitis B surface antibody [501093860] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0626

Antinuclear antibody (ANA) [501093872] Collected: 02/02/19 0552

Lab Status: In process Specimen: Blood Updated: 02/02/19 0626

Hospital Course

38 yo F history of IVDU (heroin, methamphetamine) c/b L neck injection site cellulitis and chronic HCV who prese nts with

acute onset painful lower extremity nodules, fever and arthralgia/myalgia highly suspicious for early erythema nodos um

due to bacteremia (suspected strep 2/2 history of licking needles). No signs of toxic shock syndrome. Ddx incl udes could

be acute HIV, early cellulitis, or PAN.

ADMISSION H&P

MGH Main Campus Durning, Kristie

55 Fruit St. MRN: 5608646, DOB: 6/16/1980, Sex: F

Boston MA 02114-2621 Acct #: 6091743987

ADM: 2/1/2019, D/C: 2/2/2019

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM (continued)

As per admitting provider:

Ms. Durning is a 38 yo F history of IVDU (heroin, methamphetamine), L neck injection site cellulitis in 12/2018 but left

AMA within 24h of admit, presenting with diffuse nodular rash and fever. Three days ago symptoms began with low er

extremity pain mostly on her feet and shins followed immediately by development of tender nodules on her shins. T he skin

lesions then progressed over the next 24h to include upper extremities and shoulders. She then woke up 2 days ago with

diffuse arthralgias, myalgias, nausea and mild lower pleuritic chest pressure which she has had in the past. Over the past

day she notes new swelling and erythema throughout the L calf.

No OTC or Rx meds. She has two friends who recently had PNA and are still sick. She is unsure about influenza

exposures. She reports recent injection into her neck and upper extremities but not lower extremities. She thinks a ne edle

may have broken off into the R neck at some point.

ED Course:

Vitals: Last vitals 36.8 ?C (98.3 ?F) P (!) 103 BP 123/70 RR 20 SpO2 98 % FiO2 59 kg (130 lb 1.1 o z)

Pertinent Labs:

K 3.3

Cr 0.62

Lactate 1.0 -> 1.5

ALT 38, AST 47, Alk phos 123, T bili 1.2

WBC 9.5k, Hct 36, Pl 242

Meds administered:

vanco 1250 IV

Tylenol 650

Ibuprofen 400

LR 2L

KCl 40 mEq po

HOSPITAL COURSE BY PROBLEM

Rash c/f Erythema Nodosum

The patient was found to have scattered small, non-ulcerative nodular lesions on the anterior shins and left anterior

shoulder that were minimally-painful . Given high index of suspicion for infection (see "fever" below), the patient's r ash

was felt to be very likely erythema nodosum. The only potentially inconsistent characteristic were the lesions' small size

(typically >2cm, on exam 0.5-1cm in diameter) and sharply demarcated margin of erythema. Etiology felt to be most likely

infectious in source; there was no history of recent new medication to explain rash. Other etiologies considered but f elt to

be less consistent were vasculitis (specifically, PAN; however, no ulcerating rash and lack of active sediment on UA),

mononucleosis, or TB. During her admission, inflammatory markers were found to be elevated (ESR 39, CRP 49.4).

Studies pending at time of discharge include: HBV serologies, ANA, ANCA, C3, C4, and ASO titers. She was treate d

symptomatically with ibuprofen, rest and elevation of the legs. Plans were made for dermatology involvement if the rash

did not respond to antibiotics, but the patient left before she could be adequately observed. She was encouraged to ta ke

ibuprofen at discharge.

Fever

The patient presented with acute onset of fever in the setting of IVDU. High suspicion in this host for bloodstream in fection

and endocarditis; given history of needle-licking, streptococcal infection was considered high risk, and anaerobic inf ection

was also be a consideration given patient's history of recent dental trauma (broken tooth) and associated pain. Other

potential infectious sources considered included cellulitis (though skin findings were very mild (see photo), and feve r was

felt to be out of proportion to skin findings), and acute HIV. RSV and influenza infection ruled out. At the time of di scharge,

several studies remained pending, including: urine culture, HIV antibody + viral load, RPR, GC/chlamydia NAT, an d blood

cultures. A TTE was ordered but could not be completed before she left against medical advice. She was treated with

ceftriaxone x1 and vancomycin, with improvement in her fever trend. Oral antibiotics were not prescribed at dischar ge, as

there was no oral antibiotic that would be equivalent for the suspected underlying blood stream infection. Strict RTC were

provided to patient verbally, but she became agitated and irritable saying "I'll come back if things get worse".

Opioid Use Disorder, Severe

The patient was maintained on oral oxycodone with IV dilaudid for pain associated with her rash and to prevent opio id

withdrawal. She appeared comfortable throughout the morning of admission, with no signs of withdrawal besides an xiety

(which she reports is a long-standing issue, preceding her opiate use). ACT was consulted, but the patient left AMA

before she could be seen.

Foreign Body Granuloma of Soft Tissue

The patient was found to have a subcutaneous mass appreciated on the R neck in the area of reported retained needle

fragment. A bedside US was completed by the admitting provider, who identified a likely granuloma surrounding th e

needle, which was not near vascular structures. A formal ultrasound was ordered to guide need for surgical interven tion,

but she left against medical advice before this could be could be completed.

AMA Discharge

At 9:29am on the morning of admission, the patient began suddenly demanding to leave AMA, without clear trigger. In

speaking with patient, she was markedly agitated and angry. She says she needs to leave to pay her rent, which was due

?today. Offers were made to contact SW or call landlord to request rent extension, both of which she declined. When

asked if there was anything we could do to help her stay in the hospital, she said "if you can give me $700, but other wise

I'm leaving." The risks of leaving the hospital were explained to her in detail, including: 1) undertreated infection lea ding to

sepsis and death, and 2) inability to fully evaluate the retained needle specimen, which could result in migration and

damage to surrounding structures. She verbalized understanding of these risks and was determined to have the capac ity

to leave against medical advice. She was notified that she would be contacted by phone with the results of any impor tant

laboratory studies (including blood cultures), and she confirmed her phone number was 774-284-3432. She declined to

provide a secondary or alternate number. Oral antibiotics were not prescribed at discharge, as there was no oral optio n

that was felt to sufficiently treat the suspected underlying infection (bacteremia). She was encouraged to schedule a n

appointment with her PCP, as one could not be scheduled for her as it was the weekend. She continued to be irritable and

agitated and would not listen to return to clinic/hospital precautions when they were provided, saying "just get out of my

face". She refused to sign the "discharge against advice" form and left before her AVS could be printed and provided to

her.

Medications

Allergies: Zyprexa [olanzapine]

Prior to Admission Medications

Prescriptions

cloNIDine HCl (CATAPRES) 0.1 MG tablet

Sig: Take 0.1 mg by mouth every 8 (eight) hours.

dextroamphetamine-amphetamine (ADDERALL) 20 mg Tab tablet

Sig: Take 20 mg by mouth 2 (two) times a day.

lamoTRIgine (LAMICTAL) 100 MG tablet

Sig: Take 100 mg by mouth daily.

zolpidem (AMBIEN) 10 mg tablet

Sig: Take 10 mg by mouth nightly as needed for sleep.

Facility-Administered Medications: None

Medication List

STOP taking these medications

cloNIDine HCl 0.1 MG tablet

Commonly known as: CATAPRES

TAKE these medications

	Instructions
dextroamphetamine-amphetamine 20 mg Tab tablet Commonly known as: ADDERALL	Take 20 mg by mouth 2 (two) times a day.
ibuprofen 600 MG tablet Commonly known as: ADVIL,MOTRIN	Take 1 tablet (600 mg total) by mouth every 6 (six) hours as needed. Last time this was given: 2/2/2019 12:57 AM
lamoTRIgine 100 MG tablet Commonly known as: LaMICtal	Take 100 mg by mouth daily.

nicotine 21 mg/24 hr Place 1 patch onto the skin daily. Apply to a

Commonly known as: NICODERM CQ clean, dry, hairless site on the upper arm or hip.

zolpidem 10 mg tablet Take 10 mg by mouth nightly as needed for

Commonly known as: AMBIEN sleep.

Where to Get Your Medications

These medications were sent to Walgreens Drug

Store 15801 - MALDEN, MO - 310 W MAIN ST AT 310 W MAIN ST, MALDEN MO 63863-

310 W. MAIN STREET 2116

Phone: 573-276-2218

? ibuprofen 600 MG tablet

? nicotine 21 mg/24 hr

Hospital Care Team

Service: Emergency Medicine

Inpatient Attending: No att. providers found

Attending phys phone: N/A

Discharge Unit: MGHED

Primary Care Physician: Not Required Pcp None

Transitional Plan

Scheduled appointments:

Signed Discharge Orders (From admission, onward)

Ordered

02/02/19 Activity as tolerated

0952

02/02/19 Other, please specify

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM (continued)

Ordered

0952 Comments: Please provide rest and elevation to legs

02/02/19 Discharge diet

0952 Comments: Diet Regular

02/02/19 For immediate questions regarding your hospitalization, your medications, and any pending test

0952 results please contact your doctor in the hospital: Alyssa Y Castillo, MD at 617-726-2000 and ask him/her to be paged.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your doctor in the hospital: Alyssa Y Castillo, MD at 617-726-2000 and ask him/her to be paged.

Discharge instructions and important events and results

Reason for admission:

You were seen in the hospital for fever, which we suspect is due to an infection (potentially in the blood stream) and rash of the lower legs.

Tests/Management:

While you were in the hospital:

- You received lab monitoring

- You received intravenous antibiotics

- You received an ultrasound of the legs, which ruled out a deep vein thrombosis (clot) and of the neck

When you leave the hospital, we recommend:

- There are no oral antibiotics that provide adequate treatment for a bloodstream infection; as a result, you will not be discharged with antibiotics and there is a high risk that, if present, the infection will spread.

- It is critical that you return to the emergency department for further evaluation if you develop recurrent fever, chills, rigors, lightheadedness, worsening rash in the leg, worsening pain in the legs, or any other new symptoms

Follow up appointments:

Please follow up with your primary care provider. One could not be scheduled for you before you left.

Medications:

Please carefully review your reconciled medication list, paying special attention to new medications and medications

you are instructed to stop. If you were given any antibiotics, please take the full course of antibiotics, even if you fee
l

better early on. If you were prescribed pain medication, you will need close follow up with your PCP for refills.

Other instructions:

- We recommend you take NSAIDs (ibuprofen or naproxen) for pain associated with your legs

Exam

Temperature: 36.5 ?C (97.7 ?F) (02/02/19 0746) Heart Rate: 98 (02/02/19 0746) BP: 111/60 (02/02/19 0746)

Respiratory Rate: 20 (02/02/19 0541) SpO2: 97 % (02/02/19 0746) O2 Device: None (Room air) (02/02/19 0746)

Weight: 59 kg (130 lb 1.1 oz) (02/01/19 2155)

Discharge Exam

Significant Discharge Exam Findings: Weight: Weight: [59 kg (130 lb 1.1 oz)] 59 kg (130 lb 1.1 oz)

Gen: Young female in NAD, standing at side of bed using phone, appears comfortable.

HEENT: Pupils mildly dilated, equal and reactive to light, EOMI, anicteric sclerae, MMM with clear OP (no exudat
es

noted)

Neck: Firm, small mass lateral to R EJ

CVS: RRR, no murmurs appreciated, normal S1 and S2

Pulm: Breathing comfortably on RA, CTAB posteriorly

Abd: Soft, slender, NT/ND, hypoactive bowel sounds.

Ext: WWP, no edema noted.

Derm: Mildly, poorly demarcated patch of erythema in the L anterior shin with mild associated induration and TTP.

Scattered <5mm papules scattered throughout bilateral anterior shins and L anterior shoulder that are non-ulcerating and minimally TTP.

Neuro: AAOx3, interacting appropriately, following commands.

Orientation Level: Oriented to person, Oriented to place (name of this place), Oriented to time (year)

Cognition: Age appropriate

Speech: Appropriate for age, Clear

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any

of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	8.55	02/02/2019 0552
RBC	3.44 (L)	02/02/2019 0552
HGB	11.1 (L)	02/02/2019 0552
HCT	32.4 (L)	02/02/2019 0552
MCH	32.3	02/02/2019 0552
MCV	94.2	02/02/2019 0552
PLT	186	02/02/2019 0552
RDW	13.5	02/02/2019 0552

Lab Results

Component	Value	Date/Time
NA	135	02/02/2019 0552
K	4.0	02/02/2019 0552
CL	99	02/02/2019 0552
CO2	28	02/02/2019 0552
BUN	11	02/02/2019 0552
CRE	0.68	02/02/2019 0552

CA	8.8	02/02/2019 0552
GLU	122 (H)	02/02/2019 0552

Lab Results

Component	Value	Date/Time
MG	1.7	02/02/2019 0552

Lab Results

Component	Value	Date/Time
PT	12.8	02/02/2019 0552
INR	1.0	02/02/2019 0552

Discharge Summary by Alyssa Y Castillo, MD at 2/2/2019 9:45 AM (continued)

I personally spent more than 35 minutes on this discharge due to counseling and coordinating care including review of

records, pertinent lab data and studies, as well as discussing diagnostic evaluation and work up, planned therapeutic

interventions, and future disposition of care. Where indicated, the assessment and plan reflect discussion of patient w ith

consultants, other healthcare providers, family members, and additional research needed to obtain further informatio n in

formulating the plan of care of this patient.

Alyssa Yang Castillo, MD

MGH Hospital Medicine Unit

Emergency Department Visit Date: 08/31/2014

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Please follow these important instructions below. Bring these instructions to all of your doctor appointments.

You were placed in observation status to allow for additional monitoring, evaluation, and/or treatment during your ED visit. This is an outpatient status and it is important for you to understand that as an outpatient, you may be responsible for any out-of-pocket expenses, such as co-payments, deductibles, and certain medications, in accordance with your specific insurance plan. If you have particular questions about your insurance coverage, please contact your insurance plan.

You were discharged from ED Observation by PAUL (GREGG) GREENOUGH, M.D., M.P.H. Attending Emergency Physician

What was I seen for?

You came to the BWH Emergency Department (ED) with HEAD&NECK PAIN. You have:

? Microscopic hematuria

? Complicated migraine, Complex migraine

What was done for me during my visit?

No major procedures were performed during your visit.

You received the following treatment during your visit:

We gave you the following medications: [tylenol, toradol, benadryl]

When should I follow-up with my health care provider(s)?

Please call these provider(s) to make an appointment:

MORDAS,SIMONE E.,M.D.

SIMONE MORDAS,M.D.,PC 192 WORCESTER ROAD NATICK,MA 01760

508-647-1040

Reason: please evaluate for microscopic hematuria

When: 2 weeks

Mullally, William Joseph, MD

Brigham and Women's Faulkner Hospital,Department of Neurology

1153 Centre Street

Jamaica Plain MA 02130

617-983-7580

When: next week

Information About Tests Performed During Your Visit

The following categories of lab tests were performed during your visit:

? Urinalysis ? Complete Blood Count ? Chemistry Studies

Your lab test results do not need emergency treatment or follow-up unless commented on below.

Created on: 09/01/2014 3:34 AM

REILLY, ANNAKIM

MRN: 25067539

DOB: 11/22/1984 29F

Emergency Department Visit Date: 08/31/2014

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Test comments or follow-up needed

08/31/2014 NA 138, K 3.6, CL 100, CO2 23, BUN 16, CRE 0.74, EGFR >=60 [1], GLU 90

[1] RESULT COMMENT:

(Abnormal if <60 mL/min/1.73m2

If patient is black, multiply by 1.21)

08/31/2014 ANION 15

08/31/2014 CA 9.5

08/31/2014 UCG NEG

08/31/2014 WBC 8.20, RBC 4.93, HGB 14.4, HCT 40.6, MCV 82.4, MCH 29.2, MCHC 35.5,

PLT 321

08/31/2014 RDW 12.1

08/31/2014 %POLY-A 59.3, %LYMPH-A 31.6, %MONO-A 6.2, %EOS-A 2.4, %BASO-A 0.5

08/31/2014 ANEUT-A 4.86, ALYMP-A 2.59, AMONO-A 0.51, AEOS-A 0.20, ABASO-A 0.04

08/31/2014 UA-COLOR YELLOW [1], UA-GLUC NEG, UA-BILI NEG, UA-KET NEG, UR-

SPGR 1.022, UA-BLD 2+ (*), UA-PH 5.0, UA-PROT NEG

[1] RESULT COMMENT:

CLOUDY

08/31/2014 UA-UROBI NEG, UA-NIT NEG, LEUK-EST NEG

08/31/2014 UAS-RBC 10-15 (*), UAS-WBC 0-2, UAS-BACT 2+, UAS-SQHI 1+, OCAST NEG,

HCAST 0, UAS-CRYS NEG, UAS-COM NEG

08/31/2014 UA-EPIS NEG

Please follow these medicine instructions

Continue taking any medicines as usual.

Special Medicine Instructions:

If you have trouble obtaining your medicines, possible side effects from the medicines, or other questions about your medicines, please call your primary care provider.

Emergency Department Visit Date: 08/31/2014

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Did we talk to your health care providers?

No, we did not talk to any of your regular health care providers.

? Please call and tell them about your visit if you have any ongoing concerns.

? Make a follow-up appointment as described under ?When should I follow up with my health care provider?.

Instructions for Migraine Headache

WHAT YOU SHOULD KNOW:

Migraines are bad, throbbing headaches. Many people also have nausea (upset stomach) and vomiting (throwing up) with a migraine. Migraines last from a few hours to several days. These headaches can happen many times a month or only once in a while. Treatment includes headache medicine and avoiding things that trigger your migraines.

INSTRUCTIONS:

Medicines:

Medicines may be taken to prevent migraines, or to stop them once they start. Some over-the-counter medicines, such as aspirin, acetaminophen (a-seet-a-MIN-oh-fen) or ibuprofen (eye-bu-PROH-fen), may help your pain. Some medicines can help your other migraine symptoms, such as anti-nausea medicines.

Learn the warning signs of your migraines so you can take medicine as early as possible. Some medicine may not work as well at controlling your pain if you wait too long to take it. If you are taking medicine that makes you drowsy, do not drive or use heavy equipment.

Keep a written list of the medicines you take, the amounts, and when and why you take them. Bring the list of your medicines or the pill bottles when you see your caregivers. Learn why you take each medicine. Ask your caregiver for information about your medicine. Do not take any medicines, over-the-counter drugs, vitamins, herbs, or food supplements without first talking to caregivers.

Always take your medicine as directed by caregivers. If you use some medicines too often, you may get a "rebound" migraine or have other problems. Call your caregiver if you think your medicines are not helping or if you feel you are having side effects. Remember that some medicines may take several weeks before they start helping. Do not quit taking your everyday medicines until you discuss it with your caregiver.

When is my next doctor's appointment?

Ask for information about where and when to go for follow-up visits: For continuing care, treatments, or home services, ask for more information.

Bring your headache diary with you when you see your caregiver.

How can I prevent or treat my migraines? Medicines are just one of the ways to prevent and treat

migraines. Here are some other things you can do to help your migraines:

Avoid smoke and alcohol: It is never too late to quit smoking. Besides triggering migraines, smoking increases your chance of having a heart attack, lung disease, and cancer. Alcohol can react badly with many of the medicines used to treat migraines. Alcohol may also trigger migraines.

Exercise: Exercise may help prevent migraines. Begin a regular exercise program. Talk to your caregiver before you start exercising.

Keep a headache diary: Use a diary or calendar to keep track of your migraines. Write down when your headaches start and stop, what you were doing when they started, and your symptoms. Record anything you ate or drank during the 24 hours before the headaches. Describe how the pain feels, where it is, and how bad it is. Keep track of the things you did to help your headaches and when you did them. Make a note about whether these things helped your symptoms or not. This record will help you learn what may trigger your headaches and what helps them the most.

Avoid triggers: Things that trigger migraines are different from person to person. Some things that often trigger migraines include:

Bright or flashing lights, loud noises, or strong smells (such as chemical fumes).

Certain foods or drinks like chocolate, hard cheese, red wine, or other alcoholic drinks. Things in foods like nitrates or gluten may also cause migraines. Nitrates are found in many processed meats, such as bacon, hot dogs, and deli meats. Gluten is a protein found in wheat and other grains. Things added to foods, such as MSG or artificial sweeteners, may cause a migraine to start. Caffeine, which is often used to treat migraines, can also trigger them.

Eye strain.

Oversleeping, or not getting enough sleep.

Skipping meals or going too long without eating.

Smoking or being around smoke.

Heat and cold: Some people find that heat or cold applied to the headache area can ease migraine pain. If heat helps you, use a heating pad (turned on low), a hot water bottle, or warm shower. Do not sleep on the heating pad or hot water bottle. This can cause a bad burn. You can also try cold packs to decrease your migraine pain. Put ice in a plastic bag and cover it with a towel. Place this over the painful area for 20 minutes out of every hour, for as long as you need it. Do not put the ice pack directly on the skin because you can get frostbite.

Special medical care: If you are having trouble controlling your migraines, you may need to see a special caregiver. Some caregivers, such as neurologists (nu-ROL-oh-jists) or those at pain clinics, specialize in treating migraines.

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Stress and rest: Avoid or control stress as much as you can. Learn new ways to relax, such as deep breathing, meditation (med-i-TAY-shun), relaxing your muscles, music, or biofeedback. Ask your caregiver for more information about any of these. Talk to someone about things that upset you. Get plenty of rest. Try to go to bed and wake up at the same time each day. During a migraine, rest in a dark, quiet room.

For more information:

National Headache Foundation

820 N. Orleans, Suite 217

Chicago , IL60610

Phone: 1- 888 - NHF-5552

Web Address: http://www.headaches.org

National Institute of Neurological Disorders and Stroke

P.O. Box 5801

Bethesda , MD 20824

Phone: 1- 301 - 496-5751

Phone: 1- 800 - 352-9424

Web Address: http://www.ninds.nih.gov

CONTACT A CAREGIVER IF:

You have a fever.

Your migraines happen so often that they affect your ability to do your work or normal activities.

Medicines or treatments that were helping your migraines are no longer helping.

SEEK CARE IMMEDIATELY IF:

You have a headache that seems different or much worse than your usual migraine headache.

Your headache is severe and you also have a fever and a stiff neck.

You have new problems with speech, vision, balance, or movement.

You lose consciousness (pass out), become confused, or have a seizure.

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Patient Discharge Instructions Acknowledgement

Important Phone Numbers:

MORDAS,SIMONE E.,M.D., 508-647-1040

Seeing your Primary Care provider on a regular basis is important.

BWH Emergency Department

Main Phone Number: 617-732-5636

I have received patient instructions. I understand that:

? I have had emergency treatment only.

? I may need to see my doctor for more tests and treatment.

? I may be going home before all medical problems are known and treated.

? I will arrange for any follow-up care the way I have been told to.

? Any testing that may have been performed during my visit has been reviewed for emergency findings.

Additional findings may be present and require follow-up.

_____ _____ _____AM/PM

Signature of Patient (or person receiving instructions*) Date Time

_____ _____

*If not patient signature, print name of person receiving instructions *Relationship to patient

_____RN/LPN/MD/PA _____ _____AM/PM

Signature of Clinician who reviewed with patient Date Time

_____ CID

Print name

Final Discharge Instructions electronically signed by: Donna M. Collins,P.A.-C. on 8/31/2014 9:34:39 PM

REILLY, ANNAKIM

MRN: 25067539

DOB: 11/22/1984 29F

Emergency Department Visit Date: 08/31/2014

Patient Discharge Instructions

FINAL 08/31/2014 09:34 PM

Patient Discharge Instructions Acknowledgement

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? I may be going home before all medical problems are known and treated.

? I will arrange for any follow-up care the way I have been told to.

? Any testing that may have been performed during my visit has been reviewed for emergency findings.

Additional findings may be present and require follow-up.

_____ _____ _____AM/PM

Signature of Patient (or person receiving instructions*) Date Time

_____ _____

*If not patient signature, print name of person receiving instructions *Relationship to patient

_____RN/LPN/MD/PA _____ _____AM/PM

Signature of Clinician who reviewed with patient Date Time

_____ CID

Print name

Final Discharge Instructions electronically signed by: Donna M. Collins,P.A.-C. on 8/31/2014 9:34:39 PM

***This text report has been converted from the report, '5673810572.pdf'. Content may not appear exactly as it appe ars in the original .pdf. For a download of original content and format (pdf), please contact the RPDR Team at RPD RHelp@partners.org. ***

NSM Salem Campus Ayela, Luigi Esosa

81 Highland Ave MRN: 10114401, DOB: 2/26/1993, Sex: M

Salem MA 01970-2714 Acct #: 6150422452

ADM: 4/1/2021, D/C: 4/20/2021

Patient Information

Patient Name Legal Sex DOB

Ayela, Luigi Esosa Male 2/26/1993

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM

Author: Tiffany D Parcell, CNP Service: Psychiatry Author Type: Nurse Practitioner

Filed: 4/20/2021 10:29 AM Date of Service: 4/20/2021 Status: Signed

10:28 AM

Editor: Tiffany D Parcell, CNP (Nurse Practitioner) Cosigner: Teresita G Balderas,

MD at 4/20/2021 9:20 PM

Physician Discharge Summary

Admit date: 4/1/2021

Discharge date: 4/20/2021

Patient Information

Luigi Esosa Ayela, 28 y.o. male (DOB = 2/26/1993)

Home Address: 6 New Ocean St Apt 1

Swampscott MA 01907

Home Phone: 587-353-1480 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): None

Does patient have a Health Care Proxy form completed?: Patient declines

Health Care Agents

There are no Health Care Agents on file.

Code Status at Discharge: Full Code

To be discharged to: Discharged / Transferred home with Mental Health Services

Patient/Family/Caregiver discharge preference/goals : Home with services

Patient/Family/Caregiver participated and agreed with DC plan: Yes

Patient/Family/Caregiver have been provided a list of discharge facilities/services to review/select: Patient

declines list or choses to remain with current post-acute service

Discharge address same as facesheet: Yes

Hospitalization Summary

Principal Problem:

Schizoaffective disorder, bipolar type

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Active Problems:

Auditory hallucination

Resolved Problems:

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this admission

None

Procedures this admission

None

Non (OR) Procedures:

Items for Post-Hospitalization Follow-Up:

- No pending lab work or tests.

- Received Invega Trinza 546 mg on 03/26/21; started on Invega 6 mg PO daily due to re-emergence of CAH following transition from Invega Sustenna to Invega Trinza.

- Prior authorization for Invega PO approved 03/20/21 to 04/19/22; Case ID: 61247155

Pending Results

None

Hospital Course

28 y.o. male with a history of Schizoaffective Disorder, bipolar type and PTSD who presents with increase CAH telling him to kill himself. Started on Invega Trinza 03/26 546 mg.

PSYCHIATRY DISCHARGE SUMMARY

Admit date: 04/02/2021

Discharge date: 04/20/2021

Patient Information: 28 y.o. male (DOB: 2/26/1993)

Code Status at Discharge: Full Code

PRESENTATION AT HOSPITALIZATION:

Per H&P:

"Patient is a 28 y.o. male with a history of Schizoaffective disorder, bipolar type and Cannabis use disorder, prior psychiatric hospitalizations, denies prior suicide attempts who presents for psychiatric admission because of increased CAH telling patient to kill himself. Patient seen by psychiatric triage clinician Robin Gauthier early this morning and per evaluation, "28 y.o. male with a history of Schizoaffective disorder, psychosis, major depression and cannabis use, as well has a history of command AH telling him to kill himself. He also has a

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

history of AH telling him to harm others. Patient reports he has been compliant with his medications and that nothing stressful has occurred recently. He does report he is now living in his own apartment, which he is happy about. Patient reports the voices began a few days ago and have been getting increasingly worse and more insistent that he follow through with killing himself. He denies any plan or direction in how to kill himself. He states he has been connecting with his therapist Megan Oberst at LCHC and that that there has been no recent medication change, however, record from 12/16/2020 indicated patient will be receiving services from PACT through Eliot and that he has not seen Megan. He denies using any substances besides cannabis. His last inpatient hospitalization was 11/16/2020 on Epstein 4. He has had CCS admissions in the past (most recent 12/2020 at Eliot in Lynn) but reports he currently would not feel safe. Verified that patient is now

involved with Lynn PACT. Called Eliot EMS and was given the on-call number, 339-223-7662 and left a voice mail for a call back for collateral. Note that the voice message indicated I'd reached a different number so only left patient's first name. There has been no call back at the time of this writing. Patient presents as Ox4, engages easily during evaluation but does not appear forthcoming or completely accurate with his information. He is somewhat disorganized, does not remember who his current treatment providers are, stating he still sees his therapist from LCHC which he has not since 12/20. Patient does not appear manic or paranoid. He does report the voices remain active and that he continues to see the numbers. While it will be helpful to have more recent history from PACT, patient presents as inpatient level of care, which will be pursued". Patient accepted to Epstein 4 for further management and treatment.

Patient seen in the ED while awaiting transfer, found resting in bed, engages on approach. Reports he's feeling "okay" and that his mood is "so-so". States his depression is "low" at the moment; notes he moved to a new apartment in Swampscott yesterday and started becoming increasingly anxious about living alone. Reports feeling better here because he knows it is a safe environment. States he was Eliot Respite previously. Continues with CAH that can be hard to block out - denies feeling suicidal and reports ability to be safe and seek out staff if feeling unsafe on the unit. Also reports sleeping helps with the voices. Reports medication compliance and believes he's on Invega Trinza. Reports using marijuana once daily which is an improvement from throughout the day. Agreeable for staff to reach out to outpatient treaters.

Past Psychiatric History:

Diagnoses: schizoaffective d/o, bipolar type and PTSD

Past hospitalizations: yes, previously on Epstein 4 in 12/2020

Suicide attempts/self-harm: denies

Violence: "Past records indicate patient has been arrested and incarcerated for indecent assault. Records show that patient has a history of sexual assault and groping a district attorney (thought it was someone he knew). This occurred while he was already under investigation for assault and so was charged. It is also documented in medical records that his is a Level II sex offender".

Trauma: denies, but death of father at a young age likely had influence. Patient also carries a past diagnosis of PTSD, indicating there has been some trauma.

Past psychopharmacology trials: risperdal

Current mental health providers:

Therapist: via PACT

Psychiatrist: via PACT

State Agency Involvement: DMH/Eliot as vendor

Additional Providers: PACT

Substance Use History:

Alcohol Use Yes

? Alcohol/week: 2.0 standard drinks

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

? Types: 2 Standard drinks or equivalent per week

Comment: last time drank alcohol 1 month ago, drinks a pint of alcohol in one sitting

Blackouts: -

Withdrawals: -

DTs: -

Seizures: -

Drugs:

Drug Use Yes

? Types: Marijuana

Comment: states he uses medical marijuana

As above.

Tobacco:

Tobacco Use

Smoking Status Current Some Day Smoker

? Packs/day: 1.00

? Years: 6.00

? Pack years: 6.00

? Types: Cigarettes

? Start date: 7/23/2014

Smokeless Tobacco Never Used

Past Medical History:

Diagnosis Date

? Cannabis use disorder, mild, abuse

? Major depressive disorder

? Post traumatic stress disorder 12/10/2019

? Schizophrenia

Patient Active Problem List

Diagnosis

? Psychosis

? Schizoaffective disorder, bipolar type

? Cannabis use disorder, mild, abuse

? History of command hallucinations

? Auditory hallucinations

? Schizoaffective disorder

? Elevated ALT measurement

? Memory loss

? Post traumatic stress disorder

? Schizophrenia

? Depression

? Gender dysphoria

? Auditory hallucination

Home Medications:

Prior to Admission medications

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Medication	Sig	Start Date	End Date	Taking?	Authorizing Provider
paliperidone palmitate (INVEGA SUSTENNA) 156 mg/mL Syrg IM injection syringe	Inject 1 mL (156 mg total) into the muscle every 30 (thirty) days. Due 12/30/20.	1/1/21		Yes	Ariel D Otero, MD, MPH
mirtazapine (REMERON) 15 MG tablet	Take 1 tablet (15 mg total) by mouth nightly at bedtime for 15 days.	12/10/20	12/25/20		Ariel D Otero, MD, MPH
prazosin (MINIPRESS) 5 MG capsule	Take 1 capsule (5 mg total) by mouth nightly at bedtime for 15 days.	12/10/20	12/25/20		Ariel D Otero, MD, MPH

MassPAT WAS checked for controlled substance prescriptions.

Allergies:

No Known Allergies

Family Psychiatric History:

Family history of mental illness or substance abuse: unknown

Family history of suicide attempts: past record indicates a cousin completed suicide

Psychosocial History:

"Past records indicate that patient was born and raised in Italy and has 2 brothers who still live there. His parents are both Nigerian. His father died when patient was 3. The family moved to the US when patient was in 6th grade. Patient graduated Salem High School. He has worked in the past for fast food chains and for Market Basket. He is currently unemployed and is on SSDI.

Living Situation: Patient has a history of homelessness but is currently living in his own apartment in Swampscott"

Weapon ownership or access: denies. Also denies any current legal issues."

HOSPITAL COURSE:

The patient was admitted to the locked inpatient, psychiatric unit on Epstein 4 at NSMC for further evaluation and treatment of CAH with depression and SI. The patient was admitted under conditional voluntary legal status. Labs and tests at admission revealed BAL None detected and urine drug screen was positive: THC/Cannabinoids. Prior to admission, the patient was on the following medications: Invega Trinza 546 mg last dose given 03/26, previously on Invega Sustenna 156 mg (given in February).

Following admission, the patient was seen on a daily basis for mental status examination and evaluation of response to oral Invega as coverage for recent Trinza conversion as psychotropic regimen. Patient transitioned appropriately to the unit with an uneventful weekend. Patient was initially put on 5 minute checks due to command AH to kill himself - this was changed to 15 minutes after a couple of days on the unit. Patient was placed on Invega 3 mg PO daily by weekend psychiatrist that was increased to 6 mg PO on 04/06. Whe
n

speaking with PACT it was found patient had recent received Invega Trinza as above. There was some concern that transition to 3 month LAI could be causing increased CAH and felt on-going approach of supplementing oral Invega would help manage CAH. As hospitalization progressed, CAH improved with patient eventually reporting CAH was more background noise, mumbling. SI improved with improvement of CAH. Further mood improved as well with patient noting low depressive symptoms and not having any anxiety. Conversely, patient was noted to be in bed more often than not during hospitalization with little attention to ADLs; patient denied problems on the unit or with peers and continued to deny severe depression. Patient submitted a 3-day that would expire on 04/20. CM coordinated discharge with PACT and patient was given direct phone to speak with PACT as well. Day prior to discharge patient denied having any CAH that started the previous day; he continued to deny any SI and was able to participate in safety planning.

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Throughout hospitalization, patient demonstrated no behavioral or safety issues. Considering the above, patient no longer presents in acute, imminent risk of harm to self or others and can be discharged on expiration of 3-day note with outpatient follow-up. Outpatient providers were in support of discharge.

Medically, no acute events occurred during hospitalization.

During the course of the hospitalization the risks and benefits of antipsychotic medication Invega were reviewed including EPS, TD, metabolic syndrome, and weight gain. Risks and benefit of alternative treatment and no treatment were discussed. The patient demonstrated understanding and informed consent was obtained.

MULTIPLE ANTIPSYCHOTICS

The patient was NOT discharged on multiple antipsychotics.

SAFETY ASSESSMENT

The patient was at elevated risk for self-harm on admission due to active symptoms CAH telling him to harm himself, substance use: marijuana, stressors: recent move to independent apartment. This included suicidal ideation with no specific plan or intent and no reported history of prior attempts. Since admission, the patient has had resolution of CAH, SI, and depression and has expressed a commitment to sobriety. The patient engaged in treatment (individual work) on the unit, and has taken and tolerated medications without problem. Finally, over the course of the hospitalization, the patient became more hopeful, more engaged, and more future-oriented, as evidenced by consistent denial of SI with no behavioral or safety issues, wanting to follow-up with outpatient providers, and looking forward to returning to independent apartment.

The patient is at chronically elevated risk for harm to self or others compared with general population due to psychiatric illness, including Schizoaffective Disorder, PTSD, and Cannabis Use; however, this is mitigated by committed outpatient treaters, medication compliance, sober, consistent denial of SI with no behavioral or safety issues on the unit, ability to participate in safety planning, documented ability to seek help when in crisis, domiciled, and no prior suicide attempts. Patient is motivated to continue outpatient psychiatric treatment. Patient is able to articulate a plan to reach out for help from providers and family if symptoms worsen and to go to an emergency room or call 911 if feeling unsafe. Therefore, the patient is not at acutely elevated risk of harm at this time and is appropriate for outpatient level of care.

CONDITION AT DISCHARGE:

Improved, with the patient expressing commitment to maintain safety and sobriety. Patient was in agreement with disposition plans. Patient was medically stable at the time of discharge.

DISCHARGE DIAGNOSES:

Schizoaffective Disorder, bipolar type

PTSD

Cannabis Use Disorder

Gender Dysphoria

DISCHARGE PLAN:

Medication prescriptions were sent to patient's preferred pharmacy.

All questions were answered, and discharge instructions were given in writing to the patient.

Emergency contact information was given to the patient if needed in the future.

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Outpatient providers have been notified about the discharge.

Medications

Allergies: Patient has no known allergies.

Prior to Admission Medications

Prescriptions

mirtazapine (REMERON) 15 MG tablet

Sig: Take 1 tablet (15 mg total) by mouth nightly at bedtime for 15 days.

paliperidone palmitate (INVEGA SUSTENNA) 156 mg/mL Syrg IM injection syringe

Sig: Inject 1 mL (156 mg total) into the muscle every 30 (thirty) days. Due 12/30/20.

prazosin (MINIPRESS) 5 MG capsule

Sig: Take 1 capsule (5 mg total) by mouth nightly at bedtime for 15 days.

Facility-Administered Medications: None

Medication List

STOP taking these medications

paliperidone palmitate 156 mg/mL Syrg IM injection syringe

Commonly known as: INVEGA SUSTENNA

TAKE these medications

	Instructions
cholecalciferol 25 MCG (1,000 unit) tablet Commonly known as: VITAMIN D3 Last time this was given: April 20, 2021 9:39 AM	Take 1 tablet (1,000 Units total) by mouth daily for 14 days.
docusate sodium 100 MG capsule Commonly known as: COLACE Last time this was given: April 20, 2021 9:39 AM	Take 1 capsule (100 mg total) by mouth 2 (two) times a day for 14 days.
mirtazapine 15 MG tablet Commonly known as: REMERON Last time this was given: April 19, 2021 8:41 PM	Take 1 tablet (15 mg total) by mouth nightly at bedtime for 14 days.
multivitamins with minerals-iron Tab Commonly known as: THERA-VM Last time this was given: April 20, 2021 9:39 AM	Take 1 tablet by mouth daily for 14 days.
paliperidone 6 MG 24 hr tablet	Take 1 tablet (6 mg total) by mouth nightly

Instructions

Commonly known as: INVEGA at bedtime for 14 days.

Last time this was given: April 19,

2021 8:42 PM

prazosin 5 MG capsule Take 1 capsule (5 mg total) by mouth nightly

Commonly known as: MINIPRESS at bedtime for 14 days.

Last time this was given: April 19,

2021 8:41 PM

Where to Get Your Medications

These medications were sent to Margolis

Pharmacy - Chelsea, MA - 447 Broadway 447 Broadway, Chelsea MA 02150

Phone: 617-884-3524

? cholecalciferol 25 MCG (1,000 unit) tablet

? docusate sodium 100 MG capsule

? mirtazapine 15 MG tablet

? multivitamins with minerals-iron Tab

? paliperidone 6 MG 24 hr tablet

? prazosin 5 MG capsule

Hospital Care Team

Service: Psychiatry

Inpatient Attending: Teresita G Balderas, MD

Managing Provider: Tiffany Parcell, CNP

Unit Phone: (978) 354-4557

Discharge Unit: NSMEPSTNAD4

Primary Care Physician: Lynn Community Health Center 781-581-3900

Transitional Plan

Scheduled appointments:

Signed Discharge Orders (From admission, onward)

Ordered

04/20/2 Activity as tolerated

1 1028

04/20/2 Discharge diet

1 1028 Comments: Diet Regular; Special requests: Safe Tray; Other Safety Restrictions (Choose all that apply): No knives allowed

04/20/2 For immediate questions regarding your hospitalization, your medications, and any

1 1028 pending test results please contact your doctor in the hospital: Teresita G Balderas, MD at 978-741-1200 and ask him/her to be paged.

Comments: For immediate questions regarding your hospitalization, your medications,

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

and any pending test results please contact your doctor in the hospital: Teresita G Balderas, MD at 978-741-1200 and ask him/her to be paged.

04/20/2 Reason for not ordering smoking cessation medication(s)

1 1028 Question: Reason for not ordering medication(s): Answer: Patient refused

Additional Clinician Instructions for When to Call

Crisis Plan Instructions:

Urgent Mental Health Evaluation Northeast region is available through Lahey Behavioral Health, Inc. at one of the following numbers:

(877) 255-1261, (978) 744-1585, (866) 523-1216. - For Salem, Peabody, Beverly and North Shore area

Elliot Crisis Team (781) 596-9222 - For Lynn, Swampscott, Marblehead, Saugus and surrounding towns.

Psychiatric triage at NSMC may be reached at (978) 354-4550 for 24/7 emergencies or to reach an inpatient on call psychiatrist regarding a discharge issue or relating to an inpatient stay.

911 for medical emergencies

Other Samaritans Hotline - (877) 870-4673 ?You can call this hotline as an added support.

It is important to continue to take your medications as prescribed by your doctor. Do not stop taking any of your medications without first consulting with your doctor. Be sure to keep all of the appointments that have been scheduled for you. If you find your symptoms have returned or worsened, if others have noticed you are not acting like yourself, or if you have thoughts of harming yourself or others, please seek help immediately by calling one of the above numbers, talking to a supportive person or going to the nearest emergency room.

Community Services

You will be discharged from our care by cab and will be returning to your apartment in Swampscott. Your PACT team is aware of your discharge and will check in with you once you have arrived home. Continue taking your medications as prescribed and reach out to your PACT team if you have any questions or concerns. You can speak with a PACT staff member at during normal business hours by calling 781-715-2306. The PACT on-call number can be utilized during non-business hours by calling 339-223-7662. Continue to practice your coping skills and utilize the above crisis numbers or speak with PACT if you are feeling unwell of unsafe.

Exam

Temperature: 36.1 ?C (97 ?F) (04/13/21 1009) Heart Rate: 90 (04/19/21 2041) BP: 102/82 (04/19/21 2041)

Respiratory Rate: 17 (04/17/21 2138) SpO2: 99 % (04/17/21 2138) O2 Device: None (Room air) (04/12/21 2147)

Weight: 122 kg (268 lb 15.4 oz)(220 lbs) (04/02/21 1736) Height: 185.4 cm (6' 0.99")(6'1",) (04/02/21 1736)

BMI (Calculated): 35.49 (04/02/21 1736)

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Significant Discharge Exam Findings

Consults: none

Partners Recent Results:

Lab Results

Component	Value	Date
HEMOGLOBIN A1C	5.5	04/03/2021
CHOLESTEROL	240 (H)	04/03/2021
HDL	37 (L)	04/03/2021
LDL	149 (H)	04/03/2021
TRIGLYCERIDES	272 (H)	04/03/2021
CARDIAC RISK RATIO	6.5 (H)	04/03/2021

Discharge Mental Status Exam:

Appearance: appropriately dressed, limited grooming

Behavior: cooperative and eye contact good

Psychomotor Activity: normal

Musculoskeletal: moves all extremities; no abnormal movements

Station/Gait: normal

Speech: regular rate, regular rhythm and regular volume

Language: normal comprehension and normal repetition

Mood: "alright", denies depression and anxiety

Affect: flat

Thought Process: linear and goal-directed

Associations: no loosening of associations

Thought Content: no delusions and no obsessions

Suicidal/Homicidal Ideation: no suicidal ideation and no homicidal ideation

Perceptions/Experiences: no hallucinations

Orientation/Sensorium: oriented x 3 and alert

Memory: immediate recall intact, short-term memory intact and long-term memory intact.

Attention/Concentration: intact to observation

Abstract Reasoning: intact to observation

Fund of Knowledge: average

Insight: fair

Judgment: fair

Safety Assessment:

Luigi Esosa Ayela no longer requires a secure, structured, inpatient, psychiatric setting in order to prevent harm and to assure safety. The patient can be safely released to home. Protective factors include consistent denial of SI with no behavioral or safety issues on the unit, outpatient support, ability to participate in safety planning, documented ability to seek help when in crisis, sober, medication compliant, no CAH, no previous suicide attempts, and domciled. Risk factors include psychiatric illness, trauma hx, incarceration/legal hx, cannabis use, and recent psychiatric hospitalizaiton. Prognosis for recovery from current episode is fair. Therefore, we feel the risk of imminent harm to self or others is low. The patient has decision making capacity and patient agrees with discharge and aftercare plans.

Communication of the Psychiatric Transition Record:

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

The patient's transition record has been communicated to the next level of care provider(s).

The psychiatric transition record includes the discharge medications, after care recommendations, principle diagnoses, and reason for hospitalization.

Discharged Condition: stable

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Appropriate for age

Special Needs

Special Needs: None

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	7.58	04/17/2021 0710
RBC	4.82	04/17/2021 0710
HGB	14.7	04/17/2021 0710
HCT	43.2	04/17/2021 0710
MCH	30.5	04/17/2021 0710
MCV	89.6	04/17/2021 0710
PLT	176	04/17/2021 0710
RDW	13.1	04/17/2021 0710

Lab Results

Component	Value	Date/Time
NA	138	04/17/2021 0710
K	4.1	04/17/2021 0710
CL	101	04/17/2021 0710
CO2	25	04/17/2021 0710
BUN	13	04/17/2021 0710
CRE	0.96	04/17/2021 0710
CA	9.3	04/17/2021 0710
GLU	98	04/17/2021 0710

Discharge Summary by Tiffany D Parcell, CNP at 4/20/2021 10:28 AM (continued)

Electronically signed by Teresita G Balderas, MD at 4/20/2021 9:20 PM

Routing History

Date/Time	From	To	Method
4/20/2021 9:20 PM	Teresita G Balderas, MD	Lynn Community Health Center	Fax

Newton-Wellesley Hospital
2014 Washington Street
Newton, MA 02462

NAME: BALCANOFF,SAMANTHA
DICTATING PHYSICIAN: HSU-LIN,JANET M.D.
DOB: 10/12/01 AGE: 14 SEX: F
ACCT: 3097119026 LOCATION: ED
SERVICE DATE: 11/08/15 TIME: 1034
UNIT NO: 01019934 STATUS: DEP ER

EMERGENCY DEPARTMENT PHYSICIAN'S NOTES
HPI HEAD INJURY
History of Present Illness: 14yoF presents with headache s/p head injury 4 days ago. Pt was swimming with back stroke, hit the top of her head against the wall. She denies any LOC. She did need to stop swimming due to headache. She took 200mg Ibuprofen x2 that day and has not taken any since. She has since had persistent temporal headache, photophobia and fatigue. She denies any nausea/vomiting, blurred vision, dizziness, numbness/tingling, neck pain.
CHIEF COMPLAINT: Patient presents for evaluation of head injury.
HISTORIAN: History provided by patient.
MECHANISM OF INJURY: Mechanism of injury: Sport or activity, while swimming.
LOCATION: Symptoms are localized, most severe in the temporal.
SEVERITY: Currently symptoms are moderate.
TIME COURSE: Sudden onset of symptoms, 4, days ago, There has been no change in the patient's symptoms over time.
ASSOCIATED WITH: Associated with headache, No associated loss of consciousness, No associated vomiting.
EXACERBATED BY: Patient's condition exacerbated by light.
RELIEVED BY: Patient's condition relieved by nothing because patient has not tried anything for relief.
PAST MEDICAL HISTORY
MEDICAL HISTORY: No past medical history.
SOCIAL HISTORY: Lives at home, with parents.
FAMILY HISTORY: Family history is not contributory to this case.
NOTES: Nursing records reviewed.
CURRENT MEDICATIONS
None
KNOWN ALLERGIES
NKDA
VITAL SIGNS

VITAL SIGNS: BP: 140/85, Pulse: 77, Resp: 18, Temp: 98.2 (Oral), Pain: 8 (Verbal exclamation), O2 sat: 99 on ra, Time: 11/8/2015 10:47.

PHYSICAL EXAM

CONSTITUTIONAL: Patient afebrile, Pulse normal, Blood pressure normal, Respiratory rate normal, Patient appears non toxic, Patient appears, in mild pain distress, Patient alert and oriented to person, place and time, Nursing notes reviewed.

HEAD: no Battle's sign, No racoon sign, normocephalic.

EYES: Eye exam included findings of eyelids normal to inspection, Pupils equally round and reactive to light, Extraocular muscles intact, Conjunctiva normal, Sclera normal.

NECK: Neck exam included findings of normal range of motion, Trachea midline, no tenderness.

RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress, Breath sounds clear, No wheezing, No rales, No rhonchi.

CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm, Heart sounds normal.

BACK: Back exam included findings of normal inspection, range of motion normal.

UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal, Motor strength normal, Sensation intact.

LOWER EXTREMITY: Lower extremity exam included findings of inspection normal, Range of motion normal, Motor strength normal, Sensation intact.

NEURO: Glasgow coma scale 15, Neuro exam findings include patient oriented to person, place and time, Speech normal, Gait normal, Cranial nerves intact, no focal motor deficits, no focal sensory deficits.

SKIN: Skin exam included findings of skin warm, dry, and normal in color.

PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time.

O2SAT INTERPRETATION

O2SAT: Oxygen saturation 99%, on room air, Oxygen saturation interpretation: Normal, No intervention required.

DOCTOR NOTES

NOTES: 14yoF with mild closed head injury sustained 4 days ago. No LOC.
Presents c/o headache. No OTC meds taken.
No vomiting, no confusion.
Neuro exam without focal deficit.
Tylenol, Ibuprofen given.
Recommend rest, pain control, limit visual stimulation.
Reasons to return d/w father.

RE-EVALUATION: Routine re-evaluation, after administration of analgesics, The patient's condition has improved.

INTERVENTIONS: Pain medications ordered: ACETAMINOPHEN, oral, Pain medications ordered: IBUPROFEN.

PATIENT PLAN: The patient will be discharged, The patient will follow up with primary care physician.

MEDICATION ADMINISTRATION SUMMARY

Drug Name: *Ibuprofen, Dose Ordered: 600 mg, Route: PO, Status:

Given, Time: 12:17 11/8/2015,
Drug Name: Tylenol, Dose Ordered: 650 mg, Route: PO, Status: Given,
Time: 11:30 11/8/2015, *Additional information available in notes,
Detailed record available in Medication Service section.
ATTENDING
ATTENDING: The documented history was done by the physician
extender, The documented physical exam was done by the physician
extender, Chief Complaint: Minor head injury. well appearing
with normal neuro exam. Unlikely bleed and family comfortable wtih no
head CT Return S/S given., I have personally seen and examined this
patient. I have fully participated in the care of this patient. I
have reviewed all pertinent clinical information, including history,
physical exam and plan.
DIAGNOSIS
FINAL: PRIMARY: Closed head injury - minor, ADDITIONAL:
Postconcussion syndrome.
DISPOSITION
PATIENT: Disposition Type: Discharged Home, Disposition: *
Discharged Home, Condition: Stable (Discharge).
Patient left the department.
INSTRUCTION
DISCHARGE: POST CONCUSSION SYNDROME, ADULT.
FOLLOWUP: KOGAN MD, IRINA, Medicine, 817 HIGHLAND AVENUE,
NEEDHAM MA 02492, (781)449-5170.
SPECIAL: Continue Tylenol 650mg every 6 hours for headache.
Alternate with Ibuprofen 600mg every 6 hours.
Drink plenty of fluids, get plenty of rest.
Limit visual stimulation from television, computer, video games, cell
phone.
No sports until cleared by your pediatrician.
Return to ER with any worsening symptoms such as severe headache,
vomiting, dizziness, visual changes, confusion.
PRESCRIPTION
No recorded prescriptions
ADMIN
DIGITAL SIGNATURE: Hsu-Lin, MD, Janet.
Medeiros, PA-C, Nicole.
Key:
JHLI=Hsu-Lin, MD, Janet MORC=Moreau R N, Christen NTO9=Medeiros, PA-C, Nicole
NWEL=Welter, RN, Nancy

_____
SIGNATURE

SIGNATURE REQUIRED: JANET HSU-LIN, M.D.
DICTATED BY: JANET HSU-LIN, M.D.

DD: 11/08/15 1051
DT:

MORLEY, ANDREA L

MRN: 25347709

DOB: 02/26/1982 33F

Admission: 1/6/2015

Discharge: 1/8/2015

Discharge Summary

Final

Patient Information: Discharge Disposition: Home

Home address: 2 FATHER JACOBBE ROAD APT 443 EAST BOSTON, MA 02128 Patient/Family Agreed with discharge plan: Yes - 3

Home Phone: 6178748883

Race: WHITE

Ethnicity: IRISH

Contact Person: Health Care Proxy:

Name: RAYMOND MOREAU Name:

Relationship: OTHER Telephone:

Telephone: 4019357020

Discharge Code Status: Full Code (presumed)

HOSPITAL CARE TEAM:

Service: GGI Team: Surgery~Cutler Unit-Bed: 15A-21-1

Role:	Name:	Phone Number:
Inpatient Attending:	TAVAKKOLI,ALI,M.D.	617-732-6337
Clinician contact at BWH:	Tavakkoli, Ali , MD	617-732-6660 (pager: 33184)
Discharging Clinician:	Alessandra L. Moore, M.D.	617-732-6660
Discharging Nurse:	Deanna Kutzy,R.N.	617-732-7940
Care Coordinator:	Maria Maglio	617-732-6469

OUTPATIENT CARE TEAM:

PCP: LEVINE,GAIL SHAI,M.D. 617-626-9760

Diagnoses:

Admission: abdominal pain, hematemesis

Discharge Condition: Stable

MORLEY, ANDREA L

MRN: 25347709

DOB: 02/26/1982 33F

Admission: 1/6/2015

Discharge: 1/8/2015

Discharge Summary

Final

TRANSITION PLAN:

Follow up Appointments:

Please call the numbers listed below to confirm that the appointments are scheduled for the locations listed. If you ca nnot

attend the appointments that have been scheduled for you, please call to reschedule them.

Tavakkoli, Ali , MD, General/Gastrointestinal

Address:

Phone: 617-732-6337

Timeframe to be seen: 2 weeks

Who Should Make Appointment: Patient/Family

Reason: post hospitalization

Important Communication to Outpatient Care Providers

Results Pending at Discharge

Category	Test(s)	Date/Time	Status
Radiology/OMNIPAQUE-		01/06/2015 20:26	Completed

350, 100ml

To obtain results once available, call 617-732-7415 (for lab results), 617-732-7383 (for microbiology results), 617-582-

0160 (for radiology reports), 617-732-7510 (for pathology results), or 617-732-5500 (for the BWH hospital operator).

Results pending at discharge include all non-finalized results from Brigham and Women's Hospital from the day prior to

admission date through the discharge date.

Discharge Summary

Final

ADMISSION PRESENTATION

Reason for Consult: Abdominal pain, nausea, vomiting

HPI: 32 yo F with a PMH significant for psychiatric disorder and gastroparesis who is s/p LRYGB in 09/14 who presents

with a 1 day history of epigastric pain, nausea, vomiting and diarrhea. She reports approximately 2-3 tbsp of bright red

blood in her emesis today, which prompted her visit to the ED. In addition, she describes episodic, sharp, stabbing

epigastric abdominal pain similar to the pain she experienced when she had gastroparesis. Her diarrhea has been non-

bloody and did not contain mucous. Of note, she has been hospitalized recently for overdose on medications and

suffered UTI with multi-drug resistant organisms requiring broad spectrum IV antibiotics. She denies fevers or chills and

has not noted any change in her urinary habits. She has been doing well otherwise eating a stage IV gastric bypass diet

without issues. She takes a daily PPI and took Gaviscon last night after her emesis and carafate this AM after she

noted blood in her emesis.

ROS:

Constitutional: No weight loss, night sweats, or fatigue.

Endocrine: No polydipsia, no palpitations.

Cardiac: No angina, syncope, or palpitations, no chest pain

Respiratory: No new cough, wheeze, or hemoptysis, no SOB

Gastrointestinal: + nausea, vomiting and diarrhea

Genitourinary: No hematuria or change in urination

Neurologic: No new headaches or seizures.

Cutaneous: No new rashes or other suspicious lesions.

Musculoskeletal: No arthralgias or bone pain.

Psychiatric: no h/o depression; no hallucinations. No changes in speech.

Past Medical History:

Diabetic gastroparesis

Gastroesophageal reflux disease

H/O Obstructive sleep apnea syndrome : on bipap 20/10 w/2L oxygen

Systemic lupus erythematosus : Suspected

Diabetes mellitus

Hypertensive disorder

Pulmonary embolism : provoked in s/o surgery and immobilization; s/p 6 months of coumadinMorbid obesity

Post-traumatic stress disorder

Fibromyalgia

Personality disorder - borderline

Depression

Past Surgical History:

Laparoscopic Roux-en-Y gastric bypass 9/25/14 (Dr. Tavakkoli)

Laparoscopic cholecystectomy 1/24/13 (Dr. Tavakkoli)

Social Hx: Denies tobacco, EtOH and illicits

Family Hx:

FH Deep Venous Thrombosis

Relative: Mother

FH Myocardial Infarction

Relative: Father

FH Pulmonary Embolism

Relative: Father

PE:

VS: 96.5 76 135/72 20 95% on RA

Gen: NAD, A&Ox3

Heart: RRR, no m/r/g

Chest: CTAB, no crackles or wheezes

Abd: obese, soft, ND, tender to palpation of the epigastrum, no guarding or rebound

EXT: WWP, no cyanosis or edema

--

Labs:

chem7: Na 142, K 3.9, Cl 106, bicarb 23, BUN 9, Cr 0.67, gluc 89, Ca 9.0, phos 2.9, Mg 1.7

Lactate: 1.6

CBC: 6.47>39.4<265

LFTs: ALT 32, AST 41, alk phos 64, Tbil 0.3

Lipase 25

Discharge Summary

Final

--

Imaging:

CXR (PRELIMINARY): no acute findings

CT abd/pelvis (PRELIMINARY): no clear intraabdominal pathology

--

Assessment and Plan: 32 yo F with a PMH significant for psychiatric disorder and gastroparesis who is s/p LRYGB i
n

09/14 who presents with a 1 day history of epigastric pain, nausea, hematemesis and diarrhea. Stool studies are

pending for concern for C. diff in setting of recent antibiotic use for UTI, but there is no evidence of colitis on CT sc
an

and WBC is within normal limits. There is no evidence of stranding around the GJ anastamosis but with her continu
ed

epigastric pain and small volume hematemesis, she will be admitted for pain management and GI consult for EGD.

Discharge Summary

Final

HOSPITALIZATION SUMMARY

Surgical (OR) Procedures:

None

Brief Summary/Assessment:

32 yo F with a PMH significant for psychiatric disorder and gastroparesis who is s/p LRYGB in 09/14 who presents
with

a 1 day history of epigastric pain, nausea, hematemesis and diarrhea now s/p EGD with findings notable for small

mallory-weiss tear.

Hospital Course:

The patient tolerated the procedure without intra-procedural complications. Please refer to the operative note for full details. Hospital course by systems as outlines below.

* N: The patient's pain was initially well controlled with IV narcotics. Patient was subsequently transitioned to PO pain medications without complications. Home psyche medications were continued.

* CV: stable without issues throughout admission

* P: The patient was weaned to RA postoperatively. At time of discharge the patient was ambulating independently without supplement oxygen.

* GI: The patient was initially NPO and had an EGD showing a small mallory-weiss tear likely 2/2 retching/ emesis. She was started on PO anti-emetics immediately and trialed on a clear liquid, then soft diet. She was discharged toleratin g a soft diet without nausea or vomiting. She should continue to take antiemetics for nausea, and continue a soft diet for one week, then transition to a regular diet at home.

* GU: The patient failed to void on arrival to the ED. A foley was replaced and then eventually removed with spontaneous voids following.

* HEME: The patient was offered SCH and pneumoboots throughout admission for DVT prophylaxis.

* ID: No issues.

The remainder of the hospital course was relatively unremarkable, and pt was discharged in stable condition, ambulating and voiding independently, and with adequate pain control. Pt was given explicit instructions to follow-up in clinic with Dr. Tavakkoli and PCP in 1-2 weeks. Pt was given detailed discharge instruction outlining wound care, activity, diet, f/u and the appropriate medication scripts.

Non-OR Procedures:

S/P Esophagogastroduodenoscopy, Date of procedure 01/07/15

DISCHARGE EXAM

Discharge Vital Signs:

T: 36.3 degrees

Mental/Cognitive Status at Discharge:

No cognitive assessment data is applicable.

HR: 79 BPM

BP: 120/60 mmHg

RR: 16 per min

O2 Sat: 97 %

Functional Status at Discharge:

No functional assessment data is applicable

Current Weight: 158.2 kg Height/Length: 157 cm BMI: 64.2 Key Discharge Physical Exam Findings:

Smoking Status: Unknown if ever smoked

PE: Abdomen soft non tender and non distended.

LABS AND STUDIES

Most Recent Reported BWH Lab Values During This Admission

Discharge Summary

Final

Basic Chemistry:			Complete Blood Count:		Routine Coagulation:	
Na (1)	143	1/7/2015 6:47 AM	WBC (2)	4.08	1/8/2015 8:19 AM	INR No Result *
K (1)	3.7	1/7/2015 6:47 AM	Hct (2)	34.9 (L)	1/8/2015 8:19 AM	PTT No Result *
Cl (1)	110 (H)	1/7/2015 6:47 AM	Hbg (2)	11.6	1/8/2015 8:19 AM	
CO2 (1)	24	1/7/2015 6:47 AM	PLT (2)	176	1/8/2015 8:19 AM	
BUN (1)	7	1/7/2015 6:47 AM				
Creat (1)	0.60	1/7/2015 6:47 AM				
Glu (1)	80	1/7/2015 6:47 AM				
Ca (1)	8.4 (L)	1/7/2015 6:47 AM				

Reference Ranges:

NA 136-145 mmol/L, K 3.4-5.0 mmol/L, CL 98-107 mmol/L, CO2 22-31 mmol/L, BUN 6-23 mg/dL, CA 8.8-10.7 mg/dL, CRE 0.50-1.20 mg/dL, GLU 70-100

mg/dL, WBC 4.00-10.00 K/uL, HCT 36.0-48.0 %, HGB 11.5-16.4 g/dL, PLT 150-450 K/uL

* No result denotes that the lab test was not done during this patient's Hospitalization.

All labs performed at Brigham and Women's Hospital 75 Francis Street Boston, MA 02115

Most Recent BWH EKG Result During This Admission

Electrocardiogram Report (Accession # 15-58460M) REFERRED BY:TAYLOR,ERIN. REVIEWED BY:

STEVENSON, M.D.,LYNNE

Date/Time: 05/08/15 18:10

VENT. RATE 88 BPM

PR INTERVAL 146 ms QRS DURATION 88 ms QT/QTC 368 445 ms P-R-T AXES 44 33 12

Probably normal ECG with baseline artficat

When compared with ECG of 30-Apr-2015

probably no significant change

Electronically by STEVENSON, M.D., LYNNE (163) on 5/11/2015 3:54:16 PM

REFERRED BY:TAYLOR,ERIN. REVIEWED BY: STEVENSON, M.D.,LYNNE

Discharge Summary

Final

Instructions Given to Your Patient at Discharge:

Activities After Discharge:

Resume regular activities

Instructions After Hospitalization

You were in the hospital for a Mallory-Weiss tear. It is normal to feel tired or washed out after hospitalization. Rest i

s

important and will help you feel better. Walking is also important. It will help prevent problems and help you feel str onger

and have more energy. Just remember to pace yourself and rest when you feel tired.

Follow these important instructions below:

1. Please take anti-nausea medication to prevent vomiting. You made a small tear in your esophagus from retching a nd

vomiting. You should take anti-nausea medicine as needed to prevent nausea.

2. Please return to the closest emergency room if you develop bloody vomiting again.

3. Please continue on a soft diet for 1 week, then return to a normal diet at home.

4. Please see Dr. Tavakkoli in 2 weeks.

Medicines

1) Take your pain medication as needed, as prescribed. Use only as directed. Do not combine with alcoholic beverag es.

Do not drive, operate machinery, or make important decisions while taking narcotics. Please wean the dose and/or

frequency as your pain improves.

2) You may also take Tylenol for pain. Do not take more than 4000mg of Acetaminophen (AKA Tylenol or APAP) i n a 24

hour period. You may find the contents of the pain medication on the bottle of your prescription. Ask your doctor be fore

taking over the counter medications

3) It is not uncommon to have some stomach upset with use of narcotic medication. For this reason, take your medic ation

with food. If your symptoms are severe, or the medication does not treat your symptoms of post-operative pain, plea se call

the office and we will prescribe a different medication.

4) To make it easier to have a bowel movement: Drink extra water and other fluids like juice, tea, and broth. Take a s tool

softener like docusate. Docusate is also called Colace. You can buy it over the counter. You have also been given a

prescription for miralax.

Activity

1. Resume light activities around your home as soon as possible. Walking is encouraged. Do not do any strenuous

exercise like aerobics, running or weight lifting until your doctor says it is okay.

2. Don't drive until you are no longer taking prescription pain medication.

FOLLOW UP CARE:

1) Please see Dr. Tavakkoli in 2 weeks to discuss your hospitalization.

CONCERNING SYMPTOMS TO REPORT:

When to call the office:

1) Swelling or pain in the thigh or calf (this could indicate a blood clot)

2) Change of color, temperature, or appearance of area operated on

3) Increased pain progressively worsening despite rest and proper use of medication.

4) Fever greater than 101.5 degrees, continuous draining or bleeding from the dressing.

5) Any other symptoms that concern you (ie, chest pain, shortness of breath)

****In an emergency, ALWAYS call 911*****

SOFT DIET - Discharge Care

Soft Diet

WHAT YOU SHOULD KNOW:

A soft diet is made up of foods that are soft and easy to chew and swallow. These foods may be chopped, ground,

mashed, pureed, and moist. You may need to follow this diet if you have had certain types of surgery, such as head, neck,

or stomach surgery. You may also need to follow this diet if you have problems with your teeth or mouth that make i t hard

for you to chew or swallow food. Your dietitian will tell you how to follow this diet and what consistency of liquids

you may

have.

AFTER YOU LEAVE:

How to prepare soft food:

? Cut food into small pieces that are inch or smaller in size because they are easier to swallow.

? Use chicken broth, beef broth, gravy, or sauces to cook or moisten meats and vegetables. Cook vegetables unt il

they are soft enough to be mashed with a fork.

? Use a food processor to grind or puree foods to make them easier to chew and swallow.

? Use fruit juice to blend fruit.

? Strain soups that have pieces of meat or vegetables that are larger than inch.

Foods you can include:

? Breads, cereals, rice, and pasta:

? Breads, muffins, pancakes, or waffles moistened with syrup, jelly, margarine or butter

? Moist dry or cooked cereal

? Macaroni, pasta, noodles, or rice

? Saltine crackers moistened in soup or other liquid

? Fruits and vegetables:

? Applesauce or canned fruit without seeds or skin

? Cooked fruits or ripe, soft peeled fruits, such as bananas, peaches, or melon

? Soft, well-cooked vegetables without seeds or skin

? Meat and other protein sources:

? Poached, scrambled, or cooked eggs

? Moist, tender meat, fish, or poultry that is ground or chopped into small pieces

? Soups with small soft pieces of vegetables and meat

? Tofu

? Well-cooked, slightly mashed, moist legumes, such as baked beans

? Dairy:

? Cheese (in sauces or melted in other dishes), cottage cheese, or ricotta cheese

? Milk or milk drinks, milkshakes

? Ice cream, sherbet, or frozen yogurt without fruit or nuts

? Yogurt (plain or with soft fruits)

? Desserts:

? Gelatin dessert with soft canned fruit

? Pudding or custard

Discharge Summary

Final

? Fruit cobbler with soft breading or crumb mixture (no seeds or nuts), or fruit pie with soft bottom crust only

? Soft, moist cake or cookie that has been moistened in milk, coffee, or other liquid

Foods to avoid: Avoid any foods that are hard for you to chew or swallow, such as the following:

? Starches:

? Dry bread, toast, crackers, and cereal

? Cereal, cake, and breads with coconut, dried fruit, nuts, and other seeds

? Corn, potato, and tortilla chips

? Breads with tough crusts, such as bagels, French bread, and sourdough bread

? Popcorn

? Taco shells

? Vegetables:

? Corn and peas

? Raw, hard vegetables that cannot be mashed easily, such as carrots, broccoli, cauliflower, and celery

- ? Crisp fried vegetables, such as potatoes
- ? Fruits:
- ? Raw, crisp fruits, such as apples and pears
- ? Dried fruit
- ? Stringy fruits, such as pineapple and mango
- ? Cooked fruit with skin and seeds
- ? Dairy, meats, and protein foods:
- ? Yogurt or ice cream with coconut, nuts, and granola
- ? Dry meats (beef jerky) and tough meats (such as bacon, sausage, hot dogs, and bratwurst)
- ? Casseroles with large chunks of meat
- ? Peanut butter (creamy and crunchy)

Contact your primary healthcare provider or dietitian if:

- ? You have questions about how to prepare or cook foods for this diet.
- ? You are losing a lot of weight without trying.
- ? You have questions or concerns about your condition or care.

Additional Care Plans

MORLEY, ANDREA L

MRN: 25347709

DOB: 02/26/1982 33F

Admission: 1/6/2015

Discharge: 1/8/2015

Discharge Summary

Final

Care Plan/Problem: Pain Care

Goal: Pain Management

Instructions: Brigham and Womens Hospital wants you to have as little pain as possible. Some things to know about taking care of your pain:

If you have been given pain medicine, please do not drink alcohol or drive while taking this medicine.

Try other things to help decrease your pain

- ? Change your position often to be more comfortable
- ? Walk or do some kind of mild exercise
- ? Practice slow, deep breathing
- ? Take your mind off your pain. Watch TV, read, listen to music, or meditate.

If your pain does not stop or you have new pain that does not go away, call your doctor!

Both surgery and narcotic pain medicine can cause constipation. To make it easier to have a bowel movement:

- ? Drink 8 glasses of water and other fluids like juice, tea, and broth.
- ? Eat foods high in fiber like fruits and vegetables.
- ? Take a stool softener like docusate, which is also called Colace.

You may also take a laxative like senna, which is also called Senokot.

You can buy these over the counter. Stop taking them if your bowel movements become loose. If your bowel move ments

stay loose, please call your doctor.

If you have not had a bowel movement in 3 days, call your doctor!

Care Plan/Problem: Daily Weight Monitoring

Goal: Weight Monitoring

Instructions: Daily Weight Monitoring: For some conditions (such as heart failure) you will need to weigh yourself e very

day at the same time, on the same scale and after you empty your bladder. A daily written log of your weights is a go od

way to keep track. If your weight increases by 2 pounds and stays up for 2 days or your weight increases 5 pounds in a

week, you should contact your health care provider. You will receive more detailed information with your discharge packet

if you are known to have heart failure.

Care Plan/Problem: Smoking

Goal: Stop Smoking

Instructions: Stopping smoking is the most important thing you can do to improve your health. Want to quit? We can

help!

Stopped smoking or using tobacco in the last 12 months? Then, we can help you stay quit!

Please contact:

- ? Your doctor
- ? Brigham and Womens Quit Smoking Program
- ? Massachusetts Quit line 1-800-TRY-TO-STOP or www.trytostop.org
- ? 1-800-8DEJAO en Espanol/Em Portuges
- ? 1-800-TDD-1477 Hearing Impaired

Danger Signs:

Call your doctor if you have:

- ? Fever greater than 101 degrees Farenheit
- ? Uncontrolled bleeding (e.g. does not stop bleeding when held for 10 minutes)
- ? Coughing or vomiting blood
- ? Severe persistent vomiting or diarrhea (three or more loose stools per day)

Discharge Summary

Final

MEDICATIONS

Allergies/Sensitivities:

lubiprostone

indomethacin

silver sulfadiazine

tolmetin

chlorpromazine

divalproex sodium

haloperidol lactate

metformin HCl

metoclopramide

morphine

Admission Medications:

1. LISINOPRIL 5 MG PO QD

2. PROPRANOLOL HCL 40 MG PO BID

3. MULTIVITAMINS 2 TAB PO QAM

4. DOXEPIN HCL 10 MG PO QHS

5. FLUOXETINE HCL 80 MG PO QAM

6. MELATONIN 5 MG PO QHS

7. OLANZAPINE ODT (ZYPREXA ZYDIS) (ZYPREXA ZYDIS) 5 MG SL daily

8. PREGABALIN (LYRICA) 225 MG PO BID

Discharge Medications

#	Medication Name/ Dose / Frequency	Medication Status*
1	PROMETHAZINE HCL (PHENERGAN) 25 mg by mouth every 6 hours as needed FOR: Nausea	New Medication
2	LISINOPRIL 5 mg by mouth every day	No Change
3	PROPRANOLOL HCL 40 mg by mouth two times a day	No Change
4	OMEPRAZOLE 40 mg by mouth every day	New Medication
5	ONDANSETRON HCL (CHEMO N/V) (ZOFRAN (CHEMO N/V)) 4 mg by mouth every 8 hours as needed FOR: Nausea	New Medication

6 HYDROMORPHONE HCL (DILAUDID) New Medication

1-2 mg by mouth every 4 hours as needed FOR: Pain

7 MULTIVITAMINS No Change

2 TAB by mouth every morning

8 DOXEPIN HCL No Change

10 mg by mouth at bedtime

9 FLUOXETINE HCL No Change

80 mg by mouth every morning

10 MELATONIN No Change

5 mg by mouth at bedtime

OLANZAPINE ODT (ZYPREXA ZYDIS) (ZYPREXA ZYDIS)

11 5 mg under the tongue every day as needed FOR: Anxiety No Change

Please take 1 dose for anxiety agitation as needed daily.

12 PREGABALIN (LYRICA) No Change

225 MG by mouth two times a day

* Medication status indicates change from medication list before admission to medication list on discharge from hospital.

Discharge Summary

Final

Immunizations Given During Inpatient Stay:

No H1N1, Seasonal Flu, Pneumovax or Diphtheria/Tetanus/Pertussis Vaccines were administered during this admission.

Discharge Summary

Final

DISEASE MANAGEMENT:

Were the following conditions active problems during this hospitalization?

Heart Failure: No

Coronary Artery Disease: No

Ischemic Stroke/TIA: No

MORLEY, ANDREA L

MRN: 25347709

DOB: 02/26/1982 33F

Admission: 1/6/2015

Discharge: 1/8/2015

Discharge Summary

Final

CC LIST:

PCP LEVINE,GAIL SHAI,M.D. 617-626-9760

BWH PRIMARY CARE AT MASS MENTAL 75 FENWOOD ROAD BOSTON,MA 02115

Follow Up Appointment Tavakkoli, Ali , MD 617-732-6337

Contributors

Electronically signed by:

Name Role Date Time

Ali Tavakkoli, M.D. Resident 5/26/2015 12:30 AM

Deanna Kutzy,R.N. Nurse 1/8/2015 1:10 PM

Alessandra L. Moore, M.D. Resident 1/8/2015 12:57 PM

Maria Maglio Nurse 1/7/2015 4:22 PM

DISCHARGE SUMMARY

NAME: XBOSTON, REYNALDO SRH #: 32-26-36
ADM. DATE: 11/21/2008 DIS DATE: 01/21/2009

ATTENDING PHYSICIAN: Kevin O'Connor M.D.

DIAGNOSES ON DISCHARGE:
1. T12 ASIA A paraplegia
2. Neurogenic bowel.
3. Neurogenic bladder.
4. T12 fracture with fracture fragments in the spinal canal.
5. Left renal injury.
6. Displaced fracture fragments from T11-T12 fracture.
7. Subarachnoid and subdural blood expanding in thecal sac at T11-T12.
8. Exploratory laparotomy for intraabdominal injuries including the stomach and diaphragm, status post repair.
9. Status post placement of an IVC filter.
10. Tachycardia, for which he has weaned off of Inderal.
11. Neuropathic pain.

HISTORY OF PRESENT ILLNESS: Mr. Reynaldo Ponce is a 26-year-old right-handed gentleman with no significant past medical history, who was admitted to Massachusetts General Hospital on 11/15/08 status post a single event shot wound to his left chest with paraplegia. There was no active bleeding, and he was brought to Massachusetts General Hospital within 20 minutes.

He was noted to have a gunshot wound at the midclavicular line at T6 with a second paraspinal to the right side at T10. He underwent numerous radiological studies as well as placement of left-sided chest tube, which return 400 mL and then stopped draining.

Because of concern for an intra-abdominal injury, he was brought the CT scan where he was found to have a T12 spinal fracture as well as free fluid in the peritoneum and abdominal air. Because of concern for a perforated viscus, he was brought to the operating room and underwent exploratory laparotomy on 11/15/08 with primary repair of an anterior and posterior stomach injury and repair of a primary diaphragmatic injury.

Postoperatively, the T12 fracture showed a severely comminuted bone of the left posterior T12 lamina and multiple osseous fragments within the spinal canal at that level.

He was also noted to have a traumatic injury to the left upper renal pole and perisplenic fluid secondary to the left diaphragmatic rupture. MRI of his spine showed fracture fragments on his left T12 fracture disrupting the thecal sac and causing subarachnoid and subdural blood extending within the thecal sac and extending caudally to the cervical level with spinal cord edema at T12. On 11/17/08, he had placement of an infrarenal inferior vena cava filter and was placed in a TLSO.

His chest tube was ultimately discontinued on 11/20/08. Further hospitalization was significant for anemia and he was begun on a therapy program. He was subsequently transferred to Spaulding Rehabilitation Hospital on 11/21/08 for continued care and rehabilitation.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: Negative.

ALLERGIES: No known drug allergies.

FAMILY HISTORY: Negative.

SOCIAL HISTORY: He lives with his girlfriend and his sister in a second floor of a two-level home, as they rent out the first level. During his hospitalization here at Spaulding, he did find an apartment in Waltham which he is waiting to obtain. It is handicapped accessible. Premorbidly, he was independent in all activities and was employed in construction. He finished high school as well as one year college.

LABORATORY DATA: Glucose 97, BUN 13, creatinine 0.7, sodium 137, potassium 3.9, chloride 101, bicarb 26, calcium 9.6, magnesium 1.5. Total protein 7.1, albumin 4.1, alkaline phosphatase 56. CBC showed WBC 7.4, hemoglobin 11.6, hematocrit 34 and platelet count 336,000.

HOSPITAL COURSE: The patient was admitted for comprehensive care and his hospitalization is summarized by the problem list that follows.

1. Medical: During his hospitalization, he was medically stable.

2. Orthotics: Continue with the TLSO.

3. Bladder: He was brought on to an intermittent catheterization program on which he was continent.

4. Bowel: He was continent on a daily bowel program.

5. Skin: The chest tube wounds as well as also the surgical wounds were well healed. He did have an unstitchable wound on his right Achilles tendon, for which he is receiving dry sterile gauze.

6. Pain: The patient had significant neuropathic pain for which he was begun on Cymbalta as well as also on Neurontin.

7. Adjustment: He was seen in consultation with psychology as well as also in consultation with psychiatry for adjustment issues.

DISCHARGE PLANNING:

1. He was discharged to a skilled nursing facility on 01/21/09. He will continue there with rehabilitation until the apartment is available for him in Waltham.

2. Education: The patient persisted in the SCI education series as well as also family training.

MEDICATIONS ON DISCHARGE:
1. Neurontin 600 mg at 8:00 a.m. and 1 p.m. and 800 mg at 10:00 p.m.
2. Cymbalta 60 mg q.p.m.
3. Ultram 50 mg q.6h. p.r.n. pain.
4. Prilosec 20 mg daily.
5. Nicotine 7 mg patch daily.
6. FiberCon 625 mg p.o. b.i.d. p.r.n.
7. Ibuprofen 400 mg q.6h. p.r.n.
8. Trazodone 75 mg at bedtime p.r.n.
9. Magic Bullet suppository 10 mg p.r. daily.
10. Senokot 2 tablets daily.
11. Combivent 2 puffs inhaled q.i.d.
12. Lactulose 30 mL b.i.d. p.r.n.
13. MiraLax 17 grams p.o. b.i.d. p.r.n.
14. Ambien 10 mg bedtime p.r.n. insomnia.
15. Zofran 4 mg q.6h. p.r.n. nausea.
16. Fragmin 5000 units subcutaneously daily.
17. Nystatin powder b.i.d.
18. Multivitamin daily.
19. Colace 100 mg b.i.d.
20. Milk of magnesia.
21. Metamucil powder daily p.r.n.

DIET ON DISCHARGE: He was discharged on a regular diet.

_____
Kevin O'Connor, M.D.

KO/ES D:01/20/2009 13:34:57 T:01/20/2009 14:38:43 Job Number:2685123

cc:
Newton-Wellesley Hospital
2014 Washington Street
Newton, MA 02462

NAME: CORREIA,MICHAEL M
DICTATING PHYSICIAN: LEMONS,MARK M.D.
DOB: 11/14/80 AGE: 32 SEX: M
ACCT: 2023643535 LOCATION: ED
SERVICE DATE: 07/03/13 TIME: 0900
UNIT NO: 10375520 STATUS: DEP ER

EMERGENCY DEPARTMENT PHYSICIAN'S NOTES
HPI PSYCHIATRIC

History of Present Illness: 32 y/o male c/o tremulousness and weakness and nausea and feeling as if he were going to faint while at work. Admits to drinking heavily and in past few months and stopped drinking 3 days ago. Yesterday he felt somewhat shaky, that improved after going for a run. Denies fever, chills, abdominal pain. C/O intermittent sharp left sided chaest pain, but denies similar pain during his run. Admits to hx of alcohol abuse and going to detox for a few days 7 years ago. Denies recreational drugs. Maried with 2 children who are well. Works as chef for many years.

PAST MEDICAL HISTORY
MEDICAL HISTORY: Notes: "dizzy spells".
SURGICAL HISTORY MALE: OS legally blind after trauma to cornea age 5years old.
PSYCHIATRIC HISTORY: Psychiatric history includes previous inpatient psychiatric admissions, Date of last admission: 2002, Facility: Faulkner Detox.
SOCIAL HISTORY: Patient currently uses tobacco, Patient smokes cigarettes, Tobacco history notes: "when I drink", Patient drinks every day, Alcohol history notes: Stopped x 3 days, Lives at home, with family, Wife 8 and 10 year old children
Pt works as AM Supervisor Davio's restaurant.

CURRENT MEDICATIONS
Advil: 400mg. Last Taken: Monday.

KNOWN ALLERGIES
NKDA

VITAL SIGNS
VITAL SIGNS: BP: 146/98, Pulse: 73, Resp: 18, Temp: 97.5 (Oral), O2 sat: 98 on ra, Time: 7/3/2013 09:15.
BP: 133/86, Pulse: 55, Resp: 18, O2 sat: 97 on ra, Time: 7/3/2013 10:21.
BP: 113/73, Pulse: 68, Resp: 18, Pain: 0, O2 sat: 98 on RA, Time: 7/3/2013 11:24.

PHYSICAL EXAM
CONSTITUTIONAL: Vital Signs Reviewed, Patient afebrile, Pulse normal, Blood pressure normal, Respiratory rate normal. Smells of ETOH with slight slurred speech, but conversant and cooperative. Regrets the incident that brought her to ED.
HEAD: Head exam normal.
EYES: Pupils equally round and reactive to light, Extraocular muscles intact, Conjunctiva normal. Sclera normal.
ENT: ENT exam normal.
NECK: Neck exam included findings of normal range of motion, Thyroid normal.
RESPIRATORY CHEST: Respiratory and chest exam normal, Breath sounds clear.
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and rhythm.
ABDOMEN MALE: Nondistened with NABS. Nontender. No HSM appreciated.
BACK: Back exam normal, Back exam included findings of

normal inspection.
UPPER EXTREMITY: Upper extremity exam normal Has abrasion to left shoulder and forearm area, but no sign of secondary infection.
LOWER EXTREMITY: Lower extremity exam normal.
NEURO: Neuro exam normal.
SKIN: Skin exam normal.
PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Speech clear.

O2SAT INTERPRETATION
O2SAT: Single pulse oximetry, Oxygen saturation 98%, on room air, Oxygen saturation interpretation: Normal, No intervention required.

LAB INTERPRETATION
INTERPRETATION: CBC normal, Chemistry normal, Liver functions normal.

EKG INTERPRETATION
12 LEAD EKG INTERPRETATION: NSR at 60 bpm.

MEDICATION ADMINISTRATION SUMMARY

Drug Name: Atarax, Dose Ordered: 30 mg, Route: PO, Status: Given, Time: 11:45 7/3/2013,
Drug Name: Thiamine Hydrochloride, Dose Ordered: 100 mg, Route: IV, Status: Given, Time: 10:45 7/3/2013,
Drug Name: Lorazepam, Dose Ordered: 1 mg, Route: PO, Status: Given, Time: 10:21 7/3/2013,
Drug Name: Folic Acid, Dose Ordered: 1 mg, Route: PO, Status: Given, Time: 10:20 7/3/2013,
Drug Name: Multivitamin, Dose Ordered: 1 tab(s), Route: PO, Status: Given, Time: 10:20 7/3/2013, Detailed record available in Medication Service section.

DOCTOR NOTES
NOTES: Patient has no toxidrome and BP and pulse normal, but he is a bit tremulous. EKG normal. given 1 mg Ativan and vitamins while screening labs including LFTs pending. Screening labs normal and patient feels mildy imporved after Ativan, but still feels uncomfortable. Given 25 mg Atarax PO. Seen by psychiatry who was able to provide some outpatient programs to assist with alcohol abuse. Will d/c with short term Rx Atarax.

DIAGNOSIS
FINAL: PRIMARY: Alcohol dependence.

DISPOSITION
PATIENT: Disposition Type: Discharged Home, Disposition: * Discharged Home, Condition: Stable.
Patient left the department.

INSTRUCTION
DISCHARGE: ALCOHOL PROBLEMS.
FOLLOWUP: GREENSPAN MD, HAROLD Z., HVMA, 291 INDEPENDENCE DRIVE,

WEST ROXBURY MA 02467, (617)541-6615, ATRIUS AND HARVARD VANGUARD PATIENTS ARE REQUIRED TO CALL PCP FOR AUTHORIZATION OF REFERRALS.
SPECIAL: Your screening blood tests including liver functions are normla so you have not damaged your liver to this point. Continue to abstain from drinking alcohol. Take Atarax as needed for feeling jittery or nauseous. (may cause drowsiness) Consider outpatient alcohol programs as supplied by our psychiatric resource staff.

PRESCRIPTION
Atarax: Tablet : hydrochloride 25 mg : Oral : Quantity: *** 1 *** Unit: tab Route: Oral Schedule: Every 4-6 hours Dispense: *** 30 ***.
NOTES: No refills
Interchange is mandated unless no substitution is written below this space.

ADMIN
DIGITAL SIGNATURE: Lemons M D, Mark.
Key:
DA=Angerame R N, Denise ML=Lemons M D, Mark

_____
SIGNATURE

SIGNATURE REQUIRED: MARK LEMONS, M.D.
DICTATED BY: MARK LEMONS, M.D.

DD: 07/03/13 0927
DT:

***This text report has been converted from the report, '1494220497.pdf'. Content may not appear exactly as it appe ars in the original .pdf. For a download of original content and format (pdf), please contact the RPDR Team at RPD RHelp@partners.org. ***

Patient Information

Patient Name	Sex	DOB
Snow, Jonathan	Male	11/13/1977

Discharge Summaries by Numa P Perez, MD at 4/27/2017 10:30 AM

Author: Numa P Perez, MD Service: Surgery Author Type: Resident

Filed: 4/27/2017 10:30 AM Date of Service: 4/27/2017 10:30 AM Status: Signed

Editor: Numa P Perez, MD (Resident) Cosigner: William Kastrinakis V, MD at 4/27/2017 10:31 AM

Physician Discharge Summary

Admit date: 4/26/2017

Discharge date: 4/27/2017

Patient Information

Jonathan Snow, 39 y.o. male (DOB = 11/13/1977)

Home Address: 9 Woodside Rd

South Hamilton MA 01982

Home Phone: 978-468-2889 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): Health Care Proxy

Does patient have a Health Care Proxy form completed?: Electronic copy of HCP available

Health Care Agents

There are no health care agents on file.

Code Status at Discharge: Full Code (Presumed)

Hospitalization Summary

Admission Diagnosis

Ventral hernia

Principal Problem (Resolved):

Ventral hernia without obstruction or gangrene

Active Problems:

* No active hospital problems. *
Discharge Summaries by Numa P Perez, MD at 4/27/2017 10:30 AM (continued)

Surgical (OR) Procedures:

Surgeries this Admission

Past Procedures (4/26/2017 to Today)

Date	Procedures	Providers
4/26/2017	Repair Hernia Ventral W/ Mesh	Kastrinakis, William V

Items for Post-Hospitalization Follow-Up:

Final culture data on OR specimen. Gram stain negative at time of discharge.

Pending Results

Procedure	Component	Value	Ref Range	Date/Time
Anatomic Pathology [281923790]				Collected: 04/26/17 1001
Lab Status: In process				Updated: 04/27/17 1005
Tissue culture with Gram stain [281857194]				Collected: 04/26/17 1450
Lab Status: Preliminary result	Specimen: Umbilicus			Updated: 04/27/17 0956
	Specimen	UMBILICUS		
	Source/ Description			
	SPECIAL REQUESTS	RECEIVED IN SWAB		
	GRAM STAIN	Rare POLYS		
	GRAM STAIN	NO ORGANISMS SEEN		
	CULTURE / TEST	NO GROWTH 1 DAY		
	REPORT STATUS	PENDING		
Anaerobic culture [281857192]				Collected: 04/26/17 1450
Lab Status: In process				Updated: 04/26/17 1527

Hospital Course

39M w/ chronic liver disease, MELD 11, s/p TIPS (last paracentesis last summer) on lasix, spironolactone, rifaximin and lactulose, s/p large ventral hernia repair primarily, no mesh. Recovering well.

Mr. Jonathan Snow was admitted to the General Surgery service on 4/26/2017 and taken to the OR for a planned open primary repair of ventral hernia. Please see separate operative note dictated by his surgeon, William Kastrinakis V, MD, for details of the procedure. He had one JP drain placed intraop. Immediately postop he was admitted to the post-anesthesia care unit (PACU) for close monitoring and observation, and

was transferred to the floor shortly thereafter. His diet was advanced swiftly without issues.

By the time of discharge on POD#1, Mr. Snow continued to recover well. He remained afebrile and with vital signs stable within normal limits. He was tolerating a regular diet without issues and passing flatus. He was maintaining normal O2 saturations on room air, making adequate amounts of urine, and ambulating independently. His surgical incisions were clean and dry, with dressing intact, and no signs of infection noted. His pain was well controlled on PO pain meds, and he expressed his readiness to be discharged to home with the JP drain in place and VNA services, with plans to follow up in clinic with William Kastrinakis V, MD on Monday May 1, 2017 for wound check. Full discharge instructions were provided and are appended below.

Medications

Allergies: Amoxicillin; Cephalosporins; Erythromycin base; Haldol (haloperidol); Penicillins; Pollen extracts; and Sulfa (sulfonamide antibiotics)

Prior to Admission Medications

Prescriptions

ALPRAZolam (XANAX) 1 MG tablet

Sig: Take 1 mg by mouth 3 (three) times a day.

ARIPiprazole (ABILIFY) 10 MG tablet

Sig: Take 1 tablet by mouth nightly. 15 mg

Note (2/15/2017): METAL Med Transfer Process

fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray

Sig: Reported on 4/26/2017

Note (2/21/2017): Received from: Lahey Health

furosemide (LASIX) 20 MG tablet

Sig: Take 60 mg by mouth daily.

lactulose (CONSTULOSE) 10 gram/15 mL (15 mL) Soln

Sig: Take 15 mL by mouth 2 (two) times a day.

olopatadine (PATANOL) 0.1 % ophthalmic solution

Sig: Place 1 drop into each eye 2 (two) times a day.

omeprazole (PRILOSEC) 20 mg TbEC

Sig: Take 1 tablet (20 mg total) by mouth daily before breakfast. Take on an empty stomach and eat 30-45 minutes later.

propranolol (INDERAL) 20 MG tablet

Sig: Take 20 mg by mouth daily.

rifAXIMin (XIFAXAN) 550 mg Tab

Sig: Take 1 tablet (550 mg total) by mouth 2 (two) times a day.

spironolactone (ALDACTONE) 25 MG tablet

Sig: Take 3 tablets (75 mg total) by mouth 2 (two) times a day.

Facility-Administered Medications: None

Discharge Medications

START taking these medications

	Dose, Frequency, and Details
docusate sodium 100 MG capsule Also known as: COLACE	Take 1 capsule (100 mg total) by mouth 2 (two) times a day. Last time this was given: 4/27/2017 8:43 AM
nicotine 14 mg/24 hr Also known as: NICODERM CQ	Place 1 patch onto the skin daily. Apply to a clean, dry, hairless site on the upper arm or hip. Last time this was given: 4/27/2017 8:31 AM
oxyCODONE 5 MG immediate release tablet	Take 1-2 tablets (5-10 mg total) by mouth every 6 (six) hours as needed for moderate pain. Partial fill permissible at request of patient. Take with food. Do not drive when taking this medication. Do not take if you are feeling drowsy, lightheaded, or otherwise

with decreased alertness. Do not combine with Ativan, Valium or other benzodiazepines.

Last time this was given: 4/27/2017 1:55 AM

CONTINUE taking these medications

	Dose, Frequency, and Details
ALPRAZolam 1 MG tablet Also known as: XANAX	Take 1 mg by mouth 3 (three) times a day. Last time this was given: 4/27/2017 8:28 AM

	Dose, Frequency, and Details
ARIPiprazole 10 MG tablet Also known as: ABILIFY	Take 1 tablet by mouth nightly. 15 mg Last time this was given: 4/26/2017 9:25 PM
fluticasone propionate 50 mcg/actuation nasal spray Also known as: FLONASE	Reported on 4/26/2017 Last time this was given: 4/27/2017 8:32 AM
lactulose 10 gram/15 mL (15 mL) Soln Also known as: CONSTULOSE	Take 15 mL by mouth 2 (two) times a day. Last time this was given: 4/27/2017 8:31 AM
LASIX 20 MG tablet Also known as: furosemide	Take 60 mg by mouth daily. Last time this was given: 4/27/2017 8:29 AM
olopatadine 0.1 % ophthalmic solution Also known as: PATANOL	Place 1 drop into each eye 2 (two) times a day.
omeprazole 20 mg Tbec Also known as: PriLOSEC	Take 1 tablet (20 mg total) by mouth daily before breakfast. Take on an empty stomach

and eat 30-45 minutes later.

propranolol 20 MG tablet Take 20 mg by mouth daily.

Also known as: INDERAL Last time this was given: 4/27/2017 8:29 AM

rifAXIMin 550 mg Tab Take 1 tablet (550 mg total) by mouth 2 (two) times a day.

Also known as: XIFAXAN Last time this was given: 4/27/2017 8:30 AM

spironolactone 25 MG tablet Take 3 tablets (75 mg total) by mouth 2 (two) times a day.

Also known as: ALDACTONE Last time this was given: 4/27/2017 8:30 AM

Hospital Care Team

Service: Surgery

Inpatient Attending: William Kastrinakis V, MD

Attending phys phone: (978)882-6868

Discharge Unit: NSMDAV7SH

Primary Care Physician: Daniel A Veno, MD 978-468-7346

Transitional Plan

Scheduled appointments:

Appointments Scheduled for Next 90 Days

May 15, 2017 3:30 PM EDT 104 Endicott Street

Post Op Visit with William Kastrinakis V, MD Ste 200

MGH Division of Community Surgery (--) Danvers MA 01923

978-882-6868

May 16, 2017 4:00 PM EDT 55 Highland Ave.

Follow Up with Ronald C Hartfelder, MD Suite 101

NORTH SHORE PHYSICIANS GROUP (NSP SALEM) Salem MA 01970

978-741-4171

Your Follow-Up Appointments
Discharge Summaries by Numa P Perez, MD at 4/27/2017 10:30 AM (continued)

William V Kastrinakis, MD 104 Endicott St. Suite 200

Specialty: General Surgery E102

Danvers MA 01923

Phone: 978-882-6868

Schedule an appointment as soon as possible for a visit on 5/1/2017

Instructions: For wound re-check

Signed Discharge Orders

Ordered

04/27/17 Other, please specify

1025 Comments: - No heavy lifting (anything heavier than a gallon of milk) for 2-3 weeks

- Do your best to avoid repetitive movement of your core for the next 2-3 weeks

- No strenuous physical activity for 2-3 weeks

- No swimming in pools or bathing in tubs for 2-3 weeks

04/27/17 Discharge diet

1025 Question Answer Comment

Diet Type Regular

Fluid Restriction total / 24h: 1000 ML FLUID

Sodium Restriction: 2 GM NA

04/27/17 Wound care

1025 Comments: See instructions

04/27/17 For immediate questions regarding your hospitalization, your medications, and any pending test

1025 results please contact your doctor in the hospital: William Kastrinakis V, MD at (978)882-6868.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your doctor in the hospital: William Kastrinakis V, MD at (978)882-6868.

04/27/17 Referral to Home Health not homebound

1025	Question	Answer	Comment
	Location of Home Care referral?	Partners HealthCare at Home	
	Referral Priority	Admit within 24 hours	
	Physician to Follow Patient's Care in the Community	Referring Provider	
	Disciplines Requested	Nursing (to assess, treat and teach)	
	Services to Provide - Nursing	Wound care	
	Date of Face to Face Encounter:	4/27/2017	
	This encounter with this patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care:	s/p ventral hernia repair	

Additional Patient Instructions

IMPORTANT:

Call your surgeon?s office or the emergency department if:

- You have a fever > 101.4F, redness spreading from your wounds, pus coming from your wounds, or any

other issues that concern you.

- You have worsening abdominal pain not managed by oral pain medications.

- You develop nausea, vomiting, or if you stop passing gas from below for >24 hrs.

- You develop any lightheadedness, confusion, difficulty speaking etc.

DIET:

- Maintain your low-sodium, fluid restricted diet as directed by your liver doctors.

WOUND CARE:

- Remove your dressing tomorrow. You do not need to apply a dressing onto your incision, but you may if

you wish, to prevent rubbing from the abdominal binder.

- Keep the abdominal binder on at all times until follow up

- It is ok to shower once dressing comes off. Let the water and soap run over the incision and pat dry; do no scrub.

- Keep the drain site dry. You may apply a dry gauze to it to capture any light drainage.

- Your staples will be removed during your follow up visit.

- Visiting nurses will come daily to check your incisions and blood pressure.

ACTIVITY:

- No strenuous physical activity for 2-3 weeks

- No heavy lifting (anything heavier than a gallon of milk) for 2-3 weeks

- Do your best to avoid repetitive movement of your core for the next 2-3 weeks

- No swimming in pools or bathing in tubs for 2-3 weeks

MEDICATIONS:

- Over the next week please wean down the amount of narcotic pain medication you are taking, with the goal of using only Tylenol (maximum 3000 mg per day).

- In order to avoid constipation, be sure to take a stool softener (Colace) if you are taking narcotic pain medication. If you feel you are experiencing ongoing constipation, you may take a Dulcolax suppository, or you may use a laxative such as Senna tablets or MiraLax.

- Do not drive or drink alcohol while taking narcotic pain medications.

- Please continue the rest of your daily home medication regimen. Please follow up with your primary care physician regarding medication changes and/or refills.

Exam

Temperature: 36.4 ?C (97.5 ?F) (04/27/17 0801) Heart Rate: 64 (04/27/17 0801) BP: 111/56 (04/27/17 0801) Respiratory Rate: 18 (04/27/17 0801) SpO2: 94 % (04/27/17 0801) O2 Device: None (Room air) (04/27/17 0801) O2 Flow Rate (L/min): 2

Height: 172.7 cm (5' 8") (04/26/17 1954)

Discharge Exam

Significant Discharge Exam Findings: Gen: NAD, comfortable in bed

Neuro: CN II-XII grossly intact, no focal deficits. MAE

CV: regular palpable pulse

Pulm: unlabored on RA

Abd: Abdominal binder in place. Midline incision w/ primary dressing c/d/i. Abdomen soft, ND, appropriately tende
r

around incision, non-tender elsewhere. JP in place w/ scant serosang drainage

GU: No Foley

Ext: No LE edema. WWP

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Appropriate for age, Clear

Vision: Functional with Correction

Hearing: Functional

Assistive Devices: None

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not

have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	12.22 (H)	04/27/2017 0503
RBC	4.36 (L)	04/27/2017 0503
HGB	14.1	04/27/2017 0503
HCT	39.8 (L)	04/27/2017 0503
MCH	32.3 (H)	04/27/2017 0503
MCV	91.3	04/27/2017 0503
PLT	127 (L)	04/27/2017 0503
RDW	13.0	04/27/2017 0503

Lab Results

Component	Value	Date/Time
NA	135 (L)	04/27/2017 0503
K	4.9	04/27/2017 0503
CL	100	04/27/2017 0503
CO2	20 (L)	04/27/2017 0503
BUN	16	04/27/2017 0503
CRE	0.87	04/27/2017 0503
CA	9.4	04/27/2017 0503
GLU	127 (H)	04/27/2017 0503
GLUPOC	107 (H)	04/26/2017 1358

Lab Results

Component	Value	Date/Time
MG	1.7 (L)	04/27/2017 0503

Lab Results

Component	Value	Date/Time
PT	15.7 (H)	04/27/2017 0503
PTT	30.9	04/27/2017 0503
INR	1.2 (H)	04/27/2017 0503

Routing History

Date/Time	From	To	Method
4/27/2017 10:31 AM	William Kastrinakis V, MD	Daniel A Veno, MD	Fax

NorthShore Medical Center Salem Campus
Name:Emily Fisher
MRN:458640
Account#:1083974012
Sex:Female
DOB:04/15/1984
Age:29 years
Arrival Date:07/24/2013
Time:02:45

Departure Date:07/24/2013
Time:06:04
Bed8
Salem Hospital ED Physician Documentation
HPI:
07/24 This 29 years old Caucasian Female presents to ER via Car - Self bts
03:04 with complaints of Allergic Reaction.
03:04 Patient is a pleasant 29-year-old female with a history of bts
ALLERGIES to lobster. She did not eat any lobster but had some seafood at 9 PM. She awoke at midnight with some throat tightness and comes in because of that. No wheezing or shortness of breath. No difficulty swallowing or handling secretions. No rashes. No itching. She has no other complaints.

Historical:
- Allergies:
02:45 SHELLFISH ga
- Home Meds:
02:45 None ga
- PMHx:
02:45 None ga
- PSHx:
02:45 None ga

- Immunization history: nc.
- Family history:: Not pertinent.
- Social history: Smoking status: Patient uses tobacco products, No barriers to communication noted. The patient speaks fluent English. Patient/guardian denies using street drugs, IV drugs.
- The history from nurses notes was reviewed: and I agree with what is documented.

ROS:
03:04 Constitutional: Negative for fever, chills, and weight loss, bts
Eyes: no change in vision or diplopia ENT: no change in hearing or ear pain Neck: Negative for injury, pain, and swelling, Cardiovascular: Negative for chest pain, or palpitations. Respiratory: Negative for shortness of breath, or cough. Abdomen/GI: Negative for abdominal pain, nausea, vomiting, or diarrhea. Back: Negative for injury and pain, GU: No dysuria or hematuria MS/Extremity: no new focal muscle or joint ache Skin: Negative for injury, rash, and discoloration, Neuro: no new focal weakness or numbness Psych: Negative for depression, anxiety, suicide ideation, homicidal ideation, and hallucinations.

Exam:
03:04 Head/Face: Normocephalic, atraumatic. Eyes: Pupils equal round bts
and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema. ENT: Nares patent. No nasal discharge, no septal abnormalities noted. External auditory canals are clear. No Obvious redness, swelling, or masses..

Mucous membrane moist Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated. Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. Normal PMI, no JVD. No pulse deficits. Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring. Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout. Back: No spinal tenderness. No costovertebral tenderness. Full range of motion. Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis. MS/ Extremity: no tenderness upper or lower extremities. No gross deformities Neuro: Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Psych: Awake, alert, with orientation to person, place and time. Behavior, mood, and affect are within normal limits. Constitutional: The patient appears in no acute distress, alert, awake, obese. ENT: Posterior pharynx: Airway: normal, no evidence of obstruction, patent, swelling, is not appreciated, erythema, is not appreciated, Voice: is normal.

Vital Signs:
02:45 BP 146 / 86; Pulse 98; Resp 18; Temp 98.5; Pulse Ox 100% on R/A; ga
04:00 BP 125 / 69; Pulse 85; Resp 18; Pulse Ox 98% on R/A; eub
05:49 BP 106 / 58; Pulse 75; Resp 18; Pulse Ox 99% on R/A; eub

MDM:
05:52 Data reviewed: vital signs, nurses notes, old medical records. bts
ED course: Patient's symptoms have resolved. She no longer has any throat discomfort. Repeat exam is normal.

Dispensed Medications:
03:20 Drug: SOLU-Medrol 125 mg; Route: IVP; Rate: per protocol; Site: eub
left antecubital;
05:49 Follow up: Response: Marked relief of symptoms eub
03:20 Drug: Benadryl 50 mg; Route: IVP; Site: left antecubital; eub
05:50 Follow up: Response: Marked relief of symptoms eub
03:20 Drug: Pepcid 20 mg; Route: IVP; Site: left antecubital; eub
05:50 Follow up: Response: Marked relief of symptoms eub

Disposition:
05:52 Chart complete. bts
05:53 Disposition bts

Disposition Summary:
07/24 Discharged to Home. Impression: Allergic Reaction.
05:53 bts
- Condition is Stable.
- Discharge Instructions: ALLERGIC REACTION, Other (General).

- Prescriptions for Benadryl 50 mg Oral Capsule - take 1 capsule by ORAL route every 6 hours As needed; 20 tablet. EpiPen 0.3 mg/0.3 mL Subcutaneous Injectable - inject 0.3 milligram by SUBCUTANEOUS route one time As needed Please dispense with trainer pen; 2 unit. Prednisone 20 mg Oral Tablet - take 2 tablet by ORAL route once daily for 3 days; 6 tablet. Zantac 150 mg Oral Tablet - take 1 tablet by ORAL route every 12 hours As needed; 20 tablet.
- Work release form form.
- Follow up: Emergency Department; When: As needed. Follow up: Private Physician; When: 2 days; Reason: Re-Evaluation.
- Problem is new.
- Symptoms are resolved.

Signatures:

Shamsai, Bennett, MD	MD	bts
Andersen, Gordon, RN	RN	ga
Bautista, Edison, RN	RN	eub

****

ED DISCHARGE NOTIFICATION/SUMMARY

Cammarano,Francesca MRN: 2773529 Age: 30y DOB: 03/09/1985
REGISTRATION DATE: 11/24/15 21:04
Discharge Instructions

Diagnosis:
Intoxication

Diagnostic Evaluation/Treatment Received:
A clinical exam was performed.
Lab tests were performed.

Follow Up Service:
Based on your evaluation today, you should contact your primary care doctor's office to arrange for a routine follow-up appointment, to confirm that your condition is getting better and that no additional testing or therapy is needed. If you do not currently have a primary care doctor, we strongly advise that you obtain one.

If your condition gets worse before your follow-up (worse or new symptoms) please contact your doctor or return to the Emergency Department.

Additional Instructions:
You were seen today in the emergency department for intoxication. We recommend that you do not use IV drugs. Return to the ED for any concerning symptoms.

Please follow up as directed.

PCP:
Name: BLEVINS, PENGWYNNE P Phone: 6175684401 Fax: 6175684510
An electronic copy of the discharge note will be sent to your PCP, if confidentiality guidelines allow.

Please call your primary care physician during normal business hours to report this visit. Please seek medical care, return to the Emergency Department, or call
911 for any new or worsening symptoms, or any other concerns.
Please call 617-643-0045 if you require additional information regarding this visit. Please have your MGH medical record number and date of visit available when you call.
Please call 617-726-2361 if you need to request a copy of your medical records.

I hereby acknowledge receipt of patient instructions. I understand that further diagnosis and treatment may be required and I have had emergency treatment only and I may be released before all medical problems are known and treated. I will arrange follow-up care as instructed.

Patient Signature:_____ Date:_____

ED Note Start Date/Time: 11/24/15 23:52
This note has been electronically signed by Victoria Forth, PA-C 11/25/15 01:16
DISCHARGE SUMMARY

NAME: SANCHEZ, DEIDRE M UNIT NUMBER: 390-93-71
DOB: 08/14/1983 FLOOR: W09 W0938A
ADMISSION DATE: 07/25/2015 DISCHARGE DATE: 07/27/2015

PRINCIPAL DIAGNOSIS
Flank pain

ASSOCIATED DIAGNOSES
Bipolar disorder, Seizure disorder, Recurrent urinary tract infection

SIGNIFICANT OPERATIONS/PROCEDURES/TESTS PERFORMED DURING HOSPITALIZATION
Operations/Procedures:
None
Labs/Imaging/Other Tests:
An ultrasound was done and there was no evidence of hydronephrosis or fluid collection. There was thickening of the bladder wall, similar in appearance to recent CT. Your urine culture showed a small number of pinpoint colonies which will be identified.

LIFE-SUSTAINING TREATMENT (CODE STATUS) AT DISCHARGE
Full Code (discussed with patient/surrogate) Entered by: Julia C. Cromwell, M.D.

ALLERGIC REACTIONS, INTOLERANCES AND SENSITIVITIES
latex (Rash)
gabapentin (seizures)
buspirone (headache)
sulfamethoxazole-trimethoprim (aseptic meningitis 4/04/08)

prochlorperazine (paresthesias)

CHIEF COMPLAINT
Bilateral flank pain

HISTORY AND REASON FOR HOSPITALIZATION AND SIGNIFICANT FINDINGS
Ms. Sanchez is 31F with h/o s/p hysterectomy for precancerous cells (10/14/14), recurrent UTIs (mod Staph aureus sensitive to Bactrim, Vanco, Doxy in June 2015, mod Salmonella sensitive to Cipro in May, previously multiple times of abundant Enterococcus sensitive to Vanco and Cipro), bipolar disorder and seizure disorder on prn Tegretol (hasnt used in over 1 year,)who presented to the MGH ED on 7/25/15 with two days of bilateral flank pain. Per patient report and ED records, the patient has had recent urology out-patient work-up for urinary retention and possible vesicovaginal vs. urethrovaginal fistula. She saw her urologist (Dr. Aldiana Soljic) on 7/22, who placed a Foley for a 10 day course. Per pt, the urologist was planning on doing a cystoscopy early next week to further evaluate the etiology of her current symptoms, including trace blood in urine/some blood clots in urine, and small amounts of urine in vaginal canal.) Yesterday (Saturday) the patient felt that she was urinating more frequently, with her Foley bag becoming completely full (2L) every 30-45 minutes. Also yesterday, she began to develop bilateral flank pain. She describes the pain as sharp, continuous, 10/10, with the pain decreasing to 7-8/10 w/IV Dilaudid, and worsening while lying on her back or walking around.
Of note, the patient had an episode of pyelonephritis in 2013.
Due to these symptoms, Ms. Sanchez called her urologist, who was out of town so instructed her to go to the ED. Upon arrival to the ED, Ms. Sanchez also complained of suprapubic and vaginal pain without discharge, nausea, one episode of vomiting, and poor PO intake. She also has had vaginal itchiness for one day, and thinks she is having bladder spasms.

ROS: Positive for headaches, weakness, dizziness, pain with bowel movements and urination, nausea
Negative for chest pain, constipation, diarrhea, fevers, chills, vomiting since arrival

ED COURSE:
VS: T97.5 P88 BP95/71 RR16 SaO2 100% RA Pain 9/10
Course: Pt appeared stable, urology consulted, fluids (1L NS) and pain meds given (see below)
PE: wnl aside from CVA tenderness bilaterally, worse with palpation
Labs: no WBC elevation, UA abnormal: yellow w/BLD 2+, leuk-esterase 3+

, only 10-20 WBCs
Imaging: Abd US w/o evidence of gallbladder pathology or hydronephrosis or perinephric
collection.
Treatment: Given Ceftriaxone 1g at midnight; Dilaudid 1g q3h for flank pain
Consults: Urology following

PAST MEDICAL/SURGICAL HISTORY:
GU/ID:
-Recurrent UTIs: per patient- not clear if actually having UTIs, no cultures grow though- thus
thought no need for antibiotics
-Chronic lower abdominal pain (since age 14 years, complete work-up in 2013 showed no underlying
etiology)
-Bacteremia : July 2008, E. coli +, UTI source
-Pyelonephritis: 2013
-Abnormal cervical Papanicolaou smear
Neuro:
-H/O seizure disorder : Sidney Cash Neurologist
-s/p cerebral aneurysm clipping : Left frontotemporal craniotomy and microsurgical clip of
unruptured L paraclinoid aneurysm by Dr. Ogilvy may 14 2008, R was clippedy march 5 2007 also
Ogilvy possible hemangioma : 9/5/08 incidental finding on xray; f/u if clinically indicated
-Neuropathy: past year, lower legs
Heme:
-Microcytic anemia
Psych:
-Substance abuse: THC, opioids
-Extreme anxiety (pr pt)
-Bipolar disorder

PAST SURGICAL HISTORY
- Tubal ligation
- Breast biopsy 5/2015
- Hysterectomy October 14, 2014

MEDICATIONS ON ADMISSION:
Percocet 5 Mg/325 Mg: has just been taking the past three days with the foley placement

ALLERGIES:
Latex - Rash
Gabapentin - seizures : per patient- "involuntary movements" occurred after 3rd pill
Buspirone - headache
Sulfamethoxazole-trimethoprim - aseptic meningitis 4/04/08
Prochlorperazine - paresthesias

FAMILY HISTORY:
Mother- died young (30s or 40s,) pt says death was caused by complications from obesity, also had

breast and lung cancer
Father-alive, history of heart attacks
Brother: uncertain
GU issues: mother and maternal grandmother also had bladder issues (pt unable to clarify)

SOCIAL HISTORY:
Lives with husband and 3 children (13, 11, 8) in Charlestown. She smokes 1 pack per day since
breast biopsy a few months ago, prior to this smoked 2 cigs/day. Denies alcohol and IVDU usage,
uses marijuana occasionally (3x/month) Says she is an extremely anxious person and has no
hobbies.

PHYSICAL EXAM:
V: T98.1, HR55, BP115/55, R18, SpO2 99% RA
Gen: Patient lying comfortably in bed, NAD, pleasant and cooperative during exam
HEENT: NCAT. PERRLA, EOMI, No scleral icterus or conjunctival injection. MMM.
Neck: No lymphadenopathy
CV: RRR, nl S1S2, no m/r/g. 2+ radial and DP pulses
Chest: Lungs CTAB
Abdomen: Soft, no distention, no tenderness, no HSM, normo-active bowel sounds, mild pain to
palpation diffusely
Back: CVA tenderness, moderate, pain in back midline as well
Ext: No edema. Feet are warm with no cyanosis or mottling.
Skin: No rash
GU: No rashes, erythema, lesions, ulcerations or edema in exterior vaginal area; small purplish
bump on inner left thigh
Neuro: No focal deficits.

ADMISSION LABS AND OTHER STUDIES
07/25/15 - Sodium 140, Potassium 3.5, Chloride 104, Carbon Dioxide 28, BUN 9, Creatinine 0.99, Glucose 86, Calcium 8.9, Phosphorus 3.1, Magnesium 2.5 (H), HCT 37.5, WBC 7.18, PLT 134 (L), HGB 12.2, MCV 97.2, MCH 31.6, MCHC 32.5, RDW 13.0, RBC 3.86 (L), Lymphs 42.6, Monos 5.8, Eos 0.8, Basos 0.3, Neutrophils 50.4, WBC - UA 10-20, RBC - UA 3-5, Leukocyte esterase, ur 3+, Color - UA Yellow, Clarity - UA Slightly Cloudy, Glucose - UA Negative, Bilirubin - UA Negative, Specific Gravity, ur 1.008, Blood - UA 2+, pH - UA 6.0, Protein - UA Negative, Urobilinogen - UA Negative, Nitrites - UA Negative, Albumin 4.1, Globulin 2.0, Total Protein 6.1, Alk Phos 47, Bilirubin (Direct) 0.1, Bilirubin (Total) 0.2, ALT (U/L) 7, AST 15, Amylase 41, Lipase (U/L) 17, CK 81, Troponin-T <0.01, Lactic acid (mmol/L) 1.0, MPV 10.9, Ketones - UA Negative, Squamous Cells Present, Anion Gap 8, Mucus Present, Eos# 0.06, Baso# 0.02, Lymph# 3.06, Mono# 0.42, Neutrophil # 3.61, Diff Method Auto, NRBC#, auto 0.00, GFR (estimated) >60, WBC Clumps (/HPF) Present, NRBC% (auto) 0.00
07/22/15 - Creatinine, random urine 27

2015/07/22 00:00:00 - URINE: Few (1000 to <10,000 CFU/ml) LACTOBACILLUS SPECIES

2015/07/02 00:00:00 - VAGINAL: NORMAL FLORA PRESENT

2015/07/02 00:00:00 - MICROBIOLOGY: Negative for Neisseria Gonorrhoeae Nucleic Acid

HOSPITAL COURSE AND TREATMENT
Bilateral Flank Pain:
Presenting hx and complex prior medical hx as above. Recurrent UTIs/pyelo (>20) without clear cause on prior workup (CT, cystogram, cystoscopy), with recent amp/vanc sens enterococcus, MRSA (without bacteremia), salmonella. The patient was admitted with bilateral flank pain (R>L) concerning for possible UTI or pyelonephritis in the setting of an indwelling foley catheter and the recent GU concern for vesicovaginal vs urethrovaginal fistula. During this admit she remained afebrile, hemodynamically stable, and with a normal white blood cell count. Two sets of blood cultures were sent that showed no growth. A urine culture was sent during this admit that grew only rare GNR, and UCx from the time of foley placement showed only few lactobacillus. An abdominal ultrasound showed no evidence of hydronephrosis (although our U/S was several days after foley placement) or perinephric collection, although it did show marked thickening of the bladder wall, similar in appearance to recent CT. Small right kidney. We deferred treatment with antibiotics as the patient was well-appearing without a clear infectious source or urinary tract infectious syndrome. Overall, it was felt that she did not have a urinary tract infectious syndrome, but moreso had some residual flank pain in the setting of her urinary retention/obstruction which had occurred prior to foley placement. It was felt likely that her chronic abdominal pain was contributory to her symptomatology. She will contact her urologist to schedule a cystoscopy appointment in the outpatient setting and further discuss plans for foley management going forward. At the time of DC she was sent out with a small supply of oxycodone at the same dose of the percocet she had been taking.
--Outpt urology follow up
--Foley continues at the time of DC as per prior urology plans

MOST RECENT LABS AND OTHER STUDIES
07/27/15 - Sodium 143, BUN 9, Calcium 8.6, HCT 34.2 (L), HGB 11.0 (L)
07/26/15 - Bacteria 1+, WBC - UA 3-5, RBC - UA 5-10, Leukocyte esterase, ur 1+, Color - UA Yellow, Clarity - UA Clear, Glucose - UA Negative, Bilirubin - UA Negative, Specific Gravity, ur 1.010, Blood - UA 2+, pH - UA 5.0, Protein - UA Negative, Urobilinogen - UA Negative, Nitrites - UA Negative
07/25/15 - Albumin 4.1, Bilirubin (Direct) 0.1

2015/07/26 00:00:00 - Ultrasound Abdomen: IMPRESSION:
No evidence of hydronephrosis or perinephric collection.
Marked thickening of the bladder wall, similar in appearance to recent CT.

Small right kidney.

2015/07/26 00:00:00 - URINE: Urine Culture - Final Reported: 28-Jul-15 14:17
  Rare (100 to <1000 CFU/ml) GRAM NEGATIVE RODS

2015/07/26 00:00:00 - BLOOD CULTURE: Blood Culture - Preliminary
Reported: 30-Jul-15 07:34
  NO GROWTH 4 DAYS

ITEMS FOR FOLLOW-UP/ANNOTATIONS AT TIME OF DISCHARGE
There are no labs or studies pending at discharge.

CONDITION ON DISCHARGE
Stable

DISCHARGE MEDICATIONS
Ranitidine Hcl 75 MG PO BID Days
Phenazopyridine Hcl 100 MG PO TID Days
Sennosides 2 TAB PO BID prn [Constipation]
 Rx: 8.6 MG TABLET 2 Tablet(s) BID 10 day(s) Dispense: 40 Tablet(s) Refills: 0
Oxycodone 5 MG PO Q6H prn [Pain-Moderate] (last dose: 07/27/2015 09:53 PM)
 Rx: 5 MG TABLET 1 Tablet(s) TID 4 day(s) Dispense: 12 Tablet(s) Refills: 0
The Rx icon reflects prescriptions written at the time of discharge, hence does not indicate whether the patients received or filled the prescription.

DISCHARGE INSTRUCTIONS
Diet: No Restrictions
Activity: Activity as tolerated
Treatment: You were admitted to the hospital with complaints of bilateral flank pain for 2 days. You were not found to have a urinary tract infection.
Instructions: Take your medication as prescribed.

If you have any questions regarding your hospital stay please call 617 726-3342 and ask for Team B

Seek medical attention if you expereince fever, chills, malaise, urgency, frequency, back pain, confusion. or any other symptoms of concern.
Followup: Follow up appointments: Please call Dr. Soljic to set up your cystoscopy appointment.

POST-DISCHARGE GOALS
Continuity of Care: Please attend all scheduled appointments

LAST ATTENDING OF RECORD
Ziperstein, Joshua C, MD 617-724-3874

PROVIDER TO CONTACT REGARDING HOSPITAL STAY
Ziperstein,Joshua C, MD 617-724-3874

ELECTRONICALLY PREPARED BY: Brieze R Keeley MD

Electronically Signed
JOSHUA C. ZIPERSTEIN, M.D. 07/30/2015 03:54 P

JOSHUA C. ZIPERSTEIN, M.D.

TR: dex DD: 07/27/2015 TD: 07/27/2015 11:40 P 1825950
cc: KATRINA A. ARMSTRONG, M.D.
Medicine
Grb 740
107533
Psych Consult Note

BRIGHAM AND WOMEN'S FAULKNER HOSPITAL
1153 Centre Street
Boston, MA 02130
Hospital Main Number: 617-983-7000

Patient Name: SINGLETON,JOLETTA Attending Name: GOLDBERG,SCOTT A M.D.
Medical Record Number: 00973068 Account Number: 24976009
Admission Date: Transcribed By: ROCHA,SARAH E

Service Date: 04/21/15
See Addendum
PSYCHIATRIC CONSULTATION NOTE

Consult
Consultation
BWFH INITIAL PSYCHIATRY CONSULT NOTE

PATIENT NAME: SINGLETON,JOLETTA
MRN: 00973068 (FH)
DOB: 07/06/80
Age: 34 years 9.4 months
Gender: F

DATE: 04/20/2015 TIME: 22:23

CONSULT REQUESTED BY: Dr. Goldberg

REASON FOR CONSULT: homicidal ideation

CC/PRESENTING PROBLEM: "I'm fine, I'm calm, I'm not homicidal."

SOURCES OF INFORMATION: Patient; LMR; Meditech; ED staff; EMS report

HPI:
Joletta Singleton is a 34y DMH client with history of PTSD, borderline personality disorder, and MDD with psychotic features who presents via ambulance after making homicidal statement in a 911 call.

Ms. Singleton states she was being harassed by a neighbor all weekend long who was constantly knocking at her door. Over the past few months this neighbor had been increasingly asking for food and money and "became nasty" when the patient said no. Patient says she called 911 to get the police to arrest her neighbor for harassment and said on the phone that she was feeling homicidal. Patient states that after getting off the phone she yelled through her door to the neighbor to leave her alone. Denies touching or assaulting the neighbor in anyway. States after yelling the patient employed DBT skills, took evening meds, and became calm awaiting arrival of police. States she just said she was homicidal in the heat of the moment, denies any plans or intent to harm herself, her neighbor, or anyone else. States she just wants to go home and return to her GED program and outpatient therapy, that "going to the hospital would be a huge step backward - I want to build a life worth living." She plans to go home and listen to religious music to fall asleep. If the neighbor continues to bother her she will call 911 - she states the police gave her neighbor a warning tonight and feels confident if the neighbor does this again she will be arrested.

On review of systems, she states her mood is "ok." States she has difficulty falling asleep but is working on this with her psychiatrist. She reports excellent motivation around her school work and therapy, energy is ok, appetite is slightly decreased. Denies SI or HI, denies symptoms of mania including decreased need for sleep, impulsivity, risk taking. She denies AVH, denies IOR or paranoia. States she is compliant with all her medications. She denies any drug use or access to weapons.

Boston EMS report:
"BPD officers summoned EMS for evaluation of an adult female s/p calling 911 stating she was so upset at her neighbor that she was going to kill somebody. Pt found home CAOx3 very calm and cooperative reporting that she was just upset when she made the homicidal statement earlier. Pt reports she is med compliant no Si/Hi denies auditory/visual hallucinations and denies any drugs or alcohol.

PAST PSYCHIATRIC HX:
- Diagnoses: PTSD, borderline personality disorder, and MDD with psychotic features
- Hospitalizations: multiple including long term stays at Worcester Recovery Center and Shattuck in past, states she first became sick at age 6. Most recently completed DBT partial program at MMHC (February 2015), prior to this was at Solomon Carter Fuller (October 2014) and prior to this was incarcerated.
- SA/SIB: has a history of attempts and self injurious behavior, none since October 2014
- Aggressive/impulsive behaviors: history of assault and battery
- Medication trials: "everything in the book"
- Psychiatrist: Cites Dr. James Feldman at MMHC, also Dr. Elizabeth Simpson at MMHC
- Therapist: Amy Paris @ MMHC
- Access to weapons: denies access to weapons such as a gun

PAST MEDICAL HX:
Problems
Depressive disorder : with psychotic features
Posttraumatic stress disorder
Borderline personality
Asthma
Obesity
Pertussis : + serology at State Lab; Brookline Public Health Nurse Barbara Wesley, 617-730-2320 is contact
Cervical dysplasia - Hx HPV, s/p laser, annual paps, nl 5/14
HTN - Hypertension
OSA - Obstructive sleep apnea : dx'd Worcester State, then incarcerated at Chickopea, second sleep study said NO sleep apnea, so no Cpap
Hypothyroid
Diabetes mellitus
Hypercholesterolemia

MEDICATIONS:
Medications per LMR, unable to confirm over night - Sullivan's pharmacy closed
Amitriptyline Hcl 100 MG (100 MG TABLET Take 1) PO QHS, tapering over the next two weeks to 0 with last day being 3/20
Asa (CHILDRENS) (ACETYLSALICYLIC Acid (C... 81MG TABLET Take 1 Tablet(s) PO QD
Benadryl 50MG TABLET Take 2 PO QHS PRN insomnia
Calcium 600mg + Vitamin D(400IU) 1 TAB (600 MG-400 TABLET) PO BID
Chlorpromazine Hcl 200 MG (200 MG TABLET Take 1) PO QHS, 100mg in am, 200mg at night
Clozapine 150 MG (25 MG TABLET Take 6) PO , 175 mg qhs
Diclofenac Potassium 50 MG (50 MG TABLET Take 1) PO BID PRN pain, inflammation
Docusate Sodium 100 MG (100 MG TABLET Take 1) PO BID
Fioricet (BUTALBITAL+APAP+CAFFEINE) 2 TAB (50-325-40 TABLET) PO q8 hours PRN headache, do not take for longer than 2 days in a row, do now exceed 6 tablets per day
Glycopyrrolate 1 MG (1 MG TABLET Take 1) PO QHS
Klonopin (CLONAZEPAM) 1 MG (1MG TABLET Take 1) PO BID, 1.5 mg qam and 2mg qpm
Lamictal (LAMOTRIGINE) 200 MG (200MG TABLET Take 1) PO QAM
Latuda (LURASIDONE Hcl) 40 MG TABLET Take 3 PO
Levothyroxine Sodium 112 MCG (112 MCG TABLET Take 1) PO QD
Lisinopril 20 MG (20 MG TABLET Take 1) PO QD
Medroxyprogesterone Inj 150 MG (150 MG/ML SYRINGE Take 1 ML) IM X1
Metformin 1000 MG (1000 MG TABLET Take 1) PO BID
Mvi (MULTIVITAMINS) TABLET Take 1 PO QD
Omeprazole 40 MG (20 MG TABLET DR Take 2) PO QD, can give omeprazole or Prilosec OTC
Propranolol Hcl 20 MG (20 MG TABLET Take 1) PO BID
Propranolol Hcl 10 MG (10 MG TABLET Take 1) PO BID
Robaxin (METHOCARBAMOL) 750 MG (750 MG TABLET Take 1) PO QID PRN muscle spasm
Selenium Sulfide 1% 1 APPLICATION (1 % SUSPENSION) TOP tiw
Senna Tablets (SENNOSIDES) 1 TAB (8.6 MG TABLET) PO BID
Simvastatin 40 MG (40 MG TABLET Take 1) PO QPM
Topamax (TOPIRAMATE) 200 MG (200 MG TABLET Take 1) PO BID

DRUG ALLERGIES:
Allergies
NKA

FAMILY HISTORY:
Denies family history of mental illness or suicide.

SOCIAL HISTORY:
History of severe physical and emotional abuse in childhood. Patient has been incarcerated, 5 A&B with a dangerous weapon charges (violence occurs in institutionalized setting primarily) with most recent incarceration approximately 2.5 years long ending in October 2014. Currently enrolled in GED classes. Lives alone in an apartment. Receives SSI and SSP

SUBSTANCE ABUSE HISTORY:
- Alcohol: denies
- Tobacco: denies
- Illicit drugs: denies

REVIEW OF SYSTEMS: [X] ALL SYSTEMS HAVE BEEN REVIEWED AND ARE NEGATIVE, EXCEPT AS NOTED BELOW:
[ ] Constitutional [ ] fatigue, [ ] weight loss
[ ] Musculoskeletal [ ] painful joints, [x] back pain -controlled with robaxin
[ ] Cardiovascular [ ] palpitations, [ ] chest pain
[ ] Neurological [ ] seizures, [ ] numbness, [ ] dizziness, [ ] fainting
[ ] Endocrine [ ] sweating, [ ] heat intolerance, [ ] polyuria, [ ] polydipsia
[ ] Respiratory [ ] SOB, [ ] cough
[ ] Gastrointestinal [ ] appetite loss, [ ] nausea, [ ] vomiting
[ ] E/E/N/T [ ] blurred vision, [ ] vision loss, [ ] hearing loss, [ ] tinnitus
[ ] Skin [ ] rash, [ ] pruritus
[ ] Genitourinary [ ] dysuria, [ ] hot flashes
[ ] Hematologic [ ] bruising, [ ] bleeding
[ ] Allergic/Immune [ ] drug allergies

VITAL SIGNS: T 98.3 F ; P 90 / min ; BP 135/105 ; R 20 / min ; SpO2 100% on RA

MUSCULOSKELETAL EXAMINATION
Strength moving all 4 limbs antigravity
Tone WNL, no tremor or posturing
Gait/Station not assessed

MENTAL STATUS EXAMINATION
Appearance: obese young woman who appears stated age, appropriately groomed, dressed in hospital johnny, in no acute distress
Behavior: calm, cooperative, eyes closed throughout, no abnormal movements, no PMR, PMA, or tics
Speech: initially rapid but becomes normal rate during interview, rhythm, volume , tone, good articulation, normal prosody
Mood: "ok"
Affect: restricted, mood-congruent
Thought Process: linear, coherent, no evidence of thought insertion, broadcasting, or withdrawal
Associations: intact
Thought Content: future oriented towards GED and further outpatient psych treatment
Hallucinations: no evidence of hallucinations in any modality
Delusions: no overt delusional content elicited
Suicidal Ideation: denies suicidal ideation, intent, or plan

Homicidal Ideation: denies homicidal ideation, intent, or plan
Insight/Judgment: fair/fair

Cognitive Exam
Orientation: awake, alert and oriented to person, place, and time
Attention/Concentration: correctly states the months of the year backward
Memory: 3/3 registration, 3/3 delayed recall
Language: no paraphasic errors, intact naming and repetition
Fund of Knowledge: intact to US presidents
Calculations: intact; $1.75 in quarters = "7"
Abstraction: provided accurate interpretations of proverbs presented

LABORATORY DATA
none

IMAGING
none

IMPRESSION:
Joletta Singleton is a 34y DMH client with history of PTSD, borderline personality disorder, and MDD with psychotic features who presents via ambulance after making homicidal statement in a 911 call in the context of interpersonal stressors. On interview patient coherently explains her use of homicidal language in the heat of the moment and provides reassurance that such thoughts were not acted upon as well as coping mechanisms used and plans to cope with similar situations in the future. She denies current mood or psychotic symptoms, denies SI. On exam she is cooperative and calm with linear thinking and no evidence of mania or psychosis. EMS report confirms patient's account of events. Diagnostically, today's incident most consistent with patient's known diagnosis of borderline personality disorder given poor coping in interpersonal situation as well as emotional dysregulation and crisis communication. Could also consider flare of PTSD. As above no reason to suspect psychosis at this time. Although patient does have risk factors for harm to others in that she has a history of repeated assault and battery, her current protective factors include denial of current HI, no plan, use of coping skills, connection with outpatient treaters, medication compliance, future orientation, lack of access to weapons, and sobriety. In all she does not represent and acutely elevated risk of harm to others or to self, and does not meet section 12 criteria for involuntary hospitalization. Patient verbalizes understanding and agreement to follow up with outpatient providers.

DIAGNOSIS: Axis I: PTSD, and MDD with psychotic features
Axis II: borderline personality disorder,
Axis III: obesity, hypertension, DM, hypothyroid, back pain
Axis IV: unemployment, limited social functioning
Axis V: 50

RECOMMENDATIONS:

#) Safety
- Patient does not currently meet Section 12 criteria.
- No psychiatric contraindication to discharge at this time.
- Plan to follow up with MMHC DBT outpatient group on Wednesday 4/22 and therapist Amy Paris on Thursday 4/23

- Continue home medications with/without changes.
- Patient agrees to call 911, BEST, outpatient therapist or psychiatrist, or return to the ED should she feel unsafe.
- Please page 66001 with questions.

Discussed with Dr. Goldberg at 11:30PM.

Consultant Name: Sarah Rocha, MD PGY2 Consultant Pager: 66001 Date/time: 04/20/2015 22:23

ADDENDUM: ROCHA,SARAH E on 04/21/15 at 0211

Discussed with Psychiatry attending Dr. Florina Haimovici who is in agreement with above plan.

ROCHA,SARAH E M.D. Electronically Signed 04/21/15 0211

***This text report has been converted from the report, '4007511300.pdf'. Content may not appear exactly as it appe ars in the original .pdf. For a download of original content and format (pdf), please contact the RPDR Team at RPD RHelp@partners.org. ***

NSM Salem Campus Savaria, David

81 Highland Ave. MRN: 10598620, DOB: 9/18/1983, Sex: M

Salem MA 01970-2714 Acct #: 6123027785

ADM: 5/11/2020, D/C: ?

Patient Information

Patient Name	Sex	DOB
Savaria, David	Male	9/18/1983

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM

Author: Tariq M Hashmi, MD Service: Hospital Medicine Author Type: Physician

Filed: 5/13/2020 3:36 PM Date of Service: 5/13/2020 Status: Signed

3:36 PM

Editor: Tariq M Hashmi, MD (Physician)

Physician Discharge Summary

Admit date: 5/11/2020

Discharge date: 5/13/2020

Patient Information

David Savaria, 36 y.o. male (DOB = 9/18/1983)

Home Address: 2 Rogers Ave

Apt 15

Lynn MA 01902

Home Phone: 774-770-1008 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): None

Does patient have a Health Care Proxy form completed?: Patient declines

Health Care Agents

There are no Health Care Agents on file.

Code Status at Discharge: Full Code (Confirmed)

Discharge address same as facesheet: Yes

Hospitalization Summary

NSM Salem Campus Savaria, David

81 Highland Ave. MRN: 10598620, DOB: 9/18/1983, Sex: M

Salem MA 01970-2714 Acct #: 6123027785

ADM: 5/11/2020, D/C: ?

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM (continued)

Principal Problem:

Cellulitis

Resolved Problems:

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this admission

None

Procedures this admission

None

Non (OR) Procedures:

Items for Post-Hospitalization Follow-Up:

- close follow-up with psychiatry regarding substance use disorder

- close follow-up with PMD regarding LLE cellulitis

Pending Results

Procedure	Component	Value	Ref Range	Date/Time
MRSA nasal screen [675883299]				Collected: 05/13/20 0929
Lab Status: In process		Specimen: Other from Nasal		Updated: 05/13/20 1138
Hemoglobin A1c [675883301]				Collected: 05/12/20 0600
Lab Status: In process				Updated: 05/13/20 0821
Blood culture, routine [675359493]				Collected: 05/11/20 0114
Lab Status: Preliminary result		Specimen: Blood		Updated: 05/13/20 0724
	Special Requests	None		
	BLOOD CULTURE	NO GROWTH 2 DAYS		
Blood culture, routine [675359494]				Collected: 05/11/20 0114
Lab Status: Preliminary result		Specimen: Blood		Updated: 05/13/20 0724
	Special Requests	None		
	BLOOD CULTURE	NO GROWTH 2 DAYS		

Hospital Course

36 years old male with past medical history of bipolar disorder, polysubstance use disorder (cocaine, opioids), benzodiazepine dependence, alcohol dependence, IV drug use, anxiety/depression, chronic hep C admitted due to suicidal ideation, left lower extremity cellulitis and polysubstance abuse/intoxication.

#LLE cellulitis

Secondary to IV drug use, afebrile, no leucocytosis

No DVT, negative cultures to date.

Seems to be improving though still quite inflamed, improved IV Vanco/Unasyn today, discharged AMA on PO augmentin for total 10-day course, recommended close f/u with PMD

#Suicidal ideation

He reported injecting everything and anything to help with his pain and even end his life.

Recent hospitalization for worsening depression and suicidal ideation.

He was sectioned by ED physician.

Seen again by psychiatry in follow up 5/12 who lifted section 12A hold

LLL pneumonia

DDx aspiration pneumonitis versus aspiration pneumonia versus viral pneumonia versus atelectasis

Patient denies respiratory symptoms at this time.

COVID PCR repeated as intermediate suspicion, negative, stopped precautions after reviewing with Carolyn from IC today.

Probably no pneumonia though augmentin should suffice for aspiration coverage.

#Polysubstance use disorder including IV drug use

Continue Suboxone BID, further per psychiatry.

Counseled about possible outcomes.

#Diarrhea

No diarrhea 24 hours, off C.diff precautions

On 5/13, patient expressed frustration regarding ongoing personal issues and requested to leave AMA. Patient counseled of risks of death and morbidity from untreated benzodiazepine withdrawal and LLE cellulitis. Denies SI/HI at time of AMA. Patient understanding of risk/benefits/alternatives, and elected to leave AMA. Without an active legal hold, we had no ability to keep him involuntarily

Medications

Allergies: Gadolinium-containing contrast media; Iodinated contrast media; and Shellfish containing products

Prior to Admission Medications

Prescriptions

QUEtiapine (SEROQUEL) 100 MG tablet

Sig: Take 1 tablet (100 mg total) by mouth as directed. Half tab 3 times a day, AND one tab at night.

buPROPion (WELLBUTRIN XL) 300 MG ER 24 hr tablet

Sig: Take 1 tablet (300 mg total) by mouth daily.

Patient taking differently: Take 150 mg by mouth 2 (two) times a day.

buprenorphine-naloxone (SUBOXONE) 8-2 mg Film

Sig: Place 1 Film under the tongue 2 (two) times a day.

cloNIDine HCL (CATAPRES) 0.1 MG tablet

Sig: Take 1 tablet (0.1 mg total) by mouth nightly at bedtime for 14 days.

docusate sodium (COLACE) 100 MG capsule

Sig: Take 1 capsule (100 mg total) by mouth 2 (two) times a day for 14 days.

gabapentin (NEURONTIN) 400 MG capsule

Sig: Take 2 capsules (800 mg total) by mouth 3 (three) times a day for 14 days.

methocarbamoL (ROBAXIN) 750 MG tablet

Sig: Take 1 tablet (750 mg total) by mouth every 6 (six) hours as needed (muscle spasm).

naloxone (NARCAN) 1 mg/mL injection syringe

Sig: 1 mL (1 mg total) by Nasal route as directed. Administer as directed on instructional pamphlet, via Mucosal Atomization Device.

sertraline (ZOLOFT) 25 MG tablet

Sig: Take 25 mg by mouth daily.

sulfamethoxazole-trimethoprim (BACTRIM DS) 800-160 mg per tablet

Sig: Take 1 tablet (160 mg of trimethoprim total) by mouth every 12 (twelve) hours for 10 days.

traZODone (DESYREL) 50 MG tablet

Sig: Take 1 tablet (50 mg total) by mouth nightly at bedtime for 14 days.

Facility-Administered Medications: None

Medication List

TAKE these medications

	Instructions
amoxicillin-clavulanate 875-125 mg per tablet Commonly known as: AUGMENTIN Last time this was given: May 13, 2020 2:02 PM	Take 1 tablet (875 mg of amoxicillin total) by mouth every 12 (twelve) hours for 13 doses.
buprenorphine-naloxone 8-2 mg Film Commonly known as: SUBOXONE Last time this was given: May 13, 2020 8:07 AM	Place 1 Film under the tongue 2 (two) times a day. Doctor's comments: NADEAN: XO
buPROPion 300 MG ER 24 hr tablet Commonly known as: WELLBUTRIN XL Last time this was given: May 13, 2020 2:05 PM	Take 1 tablet (300 mg total) by mouth daily. What changed: ? how much to take ? when to take this
cloNIDine HCL 0.1 MG tablet Commonly known as: CATAPRES Last time this was given: May 13, 2020 2:02 PM	Take 1 tablet (0.1 mg total) by mouth nightly at bedtime for 14 days.
docusate sodium 100 MG capsule Commonly known as: COLACE	Take 1 capsule (100 mg total) by mouth 2 (two) times a day for 14 days.
gabapentin 400 MG capsule	Take 2 capsules (800 mg total) by mouth 3

Commonly known as: NEURONTIN (three) times a day for 14 days.

Last time this was given: May 13,

2020 2:02 PM

methocarbamoL 750 MG tablet Take 1 tablet (750 mg total) by mouth every

Commonly known as: ROBAXIN 6 (six) hours as needed (muscle spasm).

naloxone 1 mg/mL injection syringe 1 mL (1 mg total) by Nasal route as

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM (continued)

Instructions

Commonly known as: NARCAN directed. Administer as directed on

instructional pamphlet, via Mucosal

Atomization Device.

QUEtiapine 100 MG tablet Take 1 tablet (100 mg total) by mouth as

Commonly known as: SEROquel directed. Half tab 3 times a day, AND one

Last time this was given: May 12, tab at night.

2020 9:37 PM

sertraline 25 MG tablet Take 25 mg by mouth daily.

Commonly known as: ZOLOFT

sulfamethoxazole-trimethoprim Take 1 tablet (160 mg of trimethoprim total)

800-160 mg per tablet by mouth every 12 (twelve) hours for 10

Commonly known as: BACTRIM DS days.

traZODone 50 MG tablet Take 1 tablet (50 mg total) by mouth nightly

Commonly known as: DESYREL at bedtime for 14 days.

Last time this was given: May 12,

2020 9:37 PM

Where to Get Your Medications

These medications were sent to CVS/pharmacy #11265 - Lynn, MA - 270 Union St Phone: 781-584-1129 270 Union St, Lynn MA 01901-1342

? amoxicillin-clavulanate 875-125 mg per tablet

Hospital Care Team

Service: Medicine

Inpatient Attending: Tariq M Hashmi, MD

Attending phys phone: (978)354-2551

Discharge Unit: NSMDAV8SH

Primary Care Physician: Not Required Pcp None

Transitional Plan

Scheduled appointments:

Your Follow-Up Appointments

NSM Salem Campus
81 Highland Ave.
Salem MA 01970-2714

Savaria, David
MRN: 10598620, DOB: 9/18/1983, Sex: M
Acct #: 6123027785

ADM: 5/11/2020, D/C: ?

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM (continued)

Not Required Pcp
Relationship: PCP - General
Call

55 Fruit Street
Boston MA 02114

Instructions: call PMD for close follow-up

Signed Discharge Orders (From admission, onward)

Ordered

05/13/2 Activity as tolerated

0 1535

05/13/2 Discharge diet

0 1535 Comments: Diet Regular; Special requests: Safe Tray; Other Safety Restrictions (Choose all that apply): No utensils allowed

05/13/2 For immediate questions regarding your hospitalization, your medications, and any

0 1535 pending test results please contact your PCP: Not Required Pcp at None.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your PCP: Not Required Pcp at None.

Exam

Temperature: 36.6 ?C (97.9 ?F) (05/13/20 1207) Heart Rate: 71 (05/13/20 1207) BP: 119/77 (05/13/20 1207) Respiratory Rate: 19 (05/13/20 1207) SpO2: 96 % (05/13/20 1207) O2 Device: None (Room air) (05/13/20 1207) O2 Flow Rate (L/min): 2

Weight: 69.6 kg (153 lb 6.4 oz) (05/11/20 2032) Height: 175.3 cm (5' 9") (05/11/20 2032) BMI (Calculated): 22.6 (05/11/20 2032)

Discharge Exam

Significant Discharge Exam Findings: General: alert, appears comfortable. Speaking full sentences, no accessory muscle use

HEENT: Moist mucous membranes, anicteric sclerae

Cardiovascular: Grossly regular rate and rhythm. S1, S2, no rubs murmurs or gallops appreciated

Respiratory: Clear to auscultation bilaterally, good respiratory effort, good air movement, no crackles wheezes or rhonchi

Gastrointestinal: Soft, nontender, nondistended no guarding or rebound

Extremities: RUE swelling, fidgeting with pIV. LLE redness and swelling improved. +swollen R ankle with fluctulance, however painless ROM and patient is ambulatory

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	3.77 (L)	05/13/2020 1000
RBC	4.13 (L)	05/13/2020 1000
RBCP	NO GROWTH 2 DAYS	05/11/2020 0114
RBCP	NO GROWTH 2 DAYS	05/11/2020 0114
HGB	12.3 (L)	05/13/2020 1000
HCT	36.3 (L)	05/13/2020 1000
MCH	29.8	05/13/2020 1000
MCV	87.9	05/13/2020 1000
PLT	159	05/13/2020 1000
RDW	12.7	05/13/2020 1000

Lab Results

Component	Value	Date/Time
NA	143	05/13/2020 1000
K	4.2	05/13/2020 1000
CL	106	05/13/2020 1000
CO2	27	05/13/2020 1000
BUN	7	05/13/2020 1000
CRE	0.83	05/13/2020 1000
CA	8.9	05/13/2020 1000
GLU	89	05/13/2020 1000

Lab Results

Component	Value	Date/Time
MG	2.0	05/13/2020 1000

Lab Results

Component	Value	Date/Time
PT	13.6	05/11/2020 0102
INR	1.0	05/11/2020 0102

Us Lower Extremity Veins Duplex Complete (bilateral)

Result Date: 5/11/2020

No evidence of deep venous thrombosis.

Xr Chest Portable

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM (continued)

Result Date: 5/11/2020

New small bibasilar patchy opacity, left greater than right, concerning for pneumonia. COVID-19 cannot be ruled out.

Xr Ankle (left)

Result Date: 5/11/2020

1. Small calcification inferior to the cuboid bone, dystrophic calcification versus small avulsion fracture. 2. Negative for malleolar fracture. 3. Extensive subcutaneous edema, unknown etiology.

05/11/20

ECG 12-LEAD

Result	Value	Ref Range
Systolic Blood Pressure	100	mmHg
Diastolic Blood Pressure	64	mmHg
Ventricular Rate EKG/MIN	67	BPM

Atrial Rate	67	BPM
PR Interval	156	ms
QRS Duration	108	ms
QT Interval	390	ms
QTC Interval	412	ms
P Axis	34	degrees
R Wave Axis	59	degrees
T Wave Axis	37	degrees

Narrative

Normal sinus rhythm

Normal ECG

When compared with ECG of 05-MAY-2020

21:50,

No significant change was found

Electronically Signed in MUSE system by

Ojutalayo,

Oluwadamilola (3045) on 5/11/2020 11:11:52 AM

Total time spent on discharge was 40 minutes due to medication reconciliation, discharge planning, coordinating care with case management and communcation with patient.

Tariq M Hashmi, MD

5/13/2020 3:36 PM

Tariq Hashmi, MD

Division of Hospital Medicine

North Shore Medical Center

p71776

thashmi@partners.org

Salem MA 01970-2714 Acct #: 6123027785

ADM: 5/11/2020, D/C: ?

Discharge Summary by Tariq M Hashmi, MD at 5/13/2020 3:36 PM (continued)

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NSM Salem Campus STELLA,TOMMI-LEE

81 Highland Ave MRN: 00291515

Salem MA 01970-2714 DOB: 3/13/1978, Sex: F

Acct #: 6072088656

ADM: 2/21/2018 D/C:

Patient Information

Patient Name	Sex	DOB
Stella, Tommi-Lee	Female	3/13/1978

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM

Author: Mahdi Razafsha, MD Service: Psychiatry Author Type: Physician

Filed: 3/6/2018 12:46 PM Date of Service: 3/6/2018 12:46 PM Status: Signed

Editor: Mahdi Razafsha, MD (Physician)

Physician Discharge Summary

Admit date: 2/21/2018

Discharge date: 3/6/2018

Patient Information

Tommi-Lee Stella, 39 y.o. female (DOB = 3/13/1978)

Home Address: 88 Vernon St Apt 1

Wakefield MA 01880

Home Phone: 978-538-1939 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Does patient have a Health Care Proxy form completed?: Patient declines

Health Care Agents

There are no health care agents on file.

Code Status at Discharge: Full Code (Presumed)

Discharge address same as facesheet: Yes

Hospitalization Summary

NSM Salem Campus STELLA,TOMMI-LEE

81 Highland Ave MRN: 00291515

Salem MA 01970-2714 DOB: 3/13/1978, Sex: F

Acct #: 6072088656

ADM: 2/21/2018 D/C:

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Principal Problem:

Depression with suicidal ideation

Active Problems:

Other specified anxiety disorders

Resolved Problems:

* No resolved hospital problems. *

Discharge Diagnosis: Depression

Surgical (OR) Procedures:

Surgeries this Admission

None

Non (OR) Procedures:

Items for Post-Hospitalization Follow-Up:

Labs:

Vitals Heart Rate: 89

Respiratory Rate: 16

BP: 125/75

Weight: 108.9 kg (240 lb)

Height: 1.676 m (5' 6")

BMI (Calculated): 38.8

CBC Lab Results

Component	Value	Date
WBC	8.73	02/23/2018
RBC	4.95	02/23/2018
HGB	14.3	02/23/2018
HCT	43.2	02/23/2018
PLT	190	02/23/2018
MCV	87.3	02/23/2018
MCH	28.9	02/23/2018
MCHC	33.1	02/23/2018
RDW	14.2	02/23/2018
NRBC	0.00	02/23/2018
NRBCA	0.00	02/23/2018

TSH Lab Results

Component	Value	Date
TSH	1.57	02/23/2018
TSH	0.84	02/02/2018
TSH	0.91	07/06/2017

LFT Lab Results

Component	Value	Date
SGOT	43 (H)	02/23/2018
SGOT	49 (H)	02/21/2018
SGOT	38	12/05/2017

Lab Results

Component	Value	Date
SGPT	63 (H)	02/23/2018
SGPT	66 (H)	02/21/2018

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Component	Value	Date
SGPT	67 (H)	12/05/2017

BMP Lab Results

Component	Value	Date
NA	137	02/23/2018
K	3.9	02/23/2018
CL	100	02/23/2018
CO2	26	02/23/2018
BUN	12	02/23/2018
CRE	1.00	02/23/2018
UCRE	49.6	06/25/2016
GLU	125 (H)	02/23/2018
CA	9.2	02/23/2018
GFR	>60	02/23/2018
ANION	11	02/23/2018

BP BP Readings from Last 3 Encounters:

03/06/18 : 125/75

12/07/17 : 116/70

12/05/17 : 102/74

Weight Wt Readings from Last 3 Encounters:

02/21/18 : 108.9 kg (240 lb)

12/07/17 : 106.6 kg (235 lb)

12/05/17 : 107 kg (236 lb)

Glucose Lab Results

Component	Value	Date
GLU	125 (H)	02/23/2018
GLU	136 (H)	02/21/2018
GLU	104 (H)	11/18/2017

HA1c HEMOGLOBIN A1C

Date	Value	Ref Range	Status
02/02/2018	6.2 (H)	4.3 - 6.1 %	Final

Lipid profile Lab Results

Component	Value	Date
CHOL	179	02/22/2017
CHOL	179	06/25/2016
CHOL	176	04/25/2015
HDL	49	02/22/2017
HDL	50	06/25/2016
HDL	57	04/25/2015
LDLCAL	91	06/25/2016
LDLCAL	102	04/25/2015
LDLCAL	103	01/11/2014
LDL	91	02/22/2017
LDLDIR	118	01/11/2014
TRIG	193 (H)	02/22/2017

TRIG 06/25/2016

190 (Abnormally H)

TRIG 86 04/25/2015

CHOLHDL 3.7 02/22/2017

CHOLHDL 3.6 06/25/2016

CHOLHDL 3.1 04/25/2015 \

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Pending Results

None

Hospital Course

39 YO female with a hx of Depression with a reported hx of Borderline PD presented for SI with plan to OD on medications. Her major stress was raising a young children of 4 and 2 yo and husband being away. She also learned that her father has terminal illness that she is worried about. She denies hx of suicide attempt and reports that she has always called for help when suicidal.

Over the course of hospitalization, the pt attended milieu and was noted to interact well with staff and peers well. she attended groups and learned about copying skills and other skills. The pt's mood reactivity improved over the course of hospitalization. The pt denied SI and appeared to be future oriented and hopeful.

We switched TCA(desipramine) to Zoloft and adjusted the dose to 100 mg daily. She stayed on Risperidone but could also be swapped alter on to Latuda if insurance covers that. The pt also occasionally used Atarax which helped with anxiety. The pt was interested to go and see her father who is now dying of cancer. Husband is back home as of yesterday who has been a great support and the pt often deteriorates in his absence.

Medications

Allergies: Amoxicillin; Latex; Penicillins; and Pollen extracts

Prior to Admission Medications

Prescriptions

FLUTICASONE PROPIONATE (FLONASE NASL)

Sig: Reported on 3/10/2017

Note (2/8/2017): Needs MD Verification. METAL Med Transfer Process.

cholecalciferol (VITAMIN D3) 1,000 unit tablet

Sig: Take 1,000 Units by mouth daily.

desipramine (NOPRAMIN) 100 MG tablet

Sig: Take 1 tablet (100 mg total) by mouth nightly.

gabapentin (NEURONTIN) 600 MG tablet

Sig: Take 1 tablet (600 mg total) by mouth 3 (three) times a day.

Patient taking differently: Take 600 mg by mouth 2 (two) times a day.

levalbuterol (XOPENEX HFA) 45 mcg/actuation inhaler

Sig: Reported on 3/10/2017

Note (2/8/2017): Needs MD Verification. METAL Med Transfer Process.

levothyroxine (SYNTHROID, LEVOTHROID) 75 MCG tablet

Sig: Take 75 mcg by mouth daily. Directions: daily EXCEPT Sundays

Note (7/20/2016): Received from: Partners LMR

metFORMIN (GLUCOPHATE-XR) 500 MG 24 hr tablet

Sig: Take 2,000 mg by mouth daily.

Note (7/20/2016): Received from: Partners LMR

risperiDONE (RISPERDAL) 0.5 MG tablet

Sig: TAKE 1 TABLET BY MOUTH TWICE A DAY

therapeutic multivitamin tablet

Sig: Take 1 tablet by mouth daily.

Facility-Administered Medications: None

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Discharge Medications

STOP taking these medications

desipramine 100 MG tablet

Also known as: NOPRAMIN

FLONASE NASL

levalbuterol 45 mcg/actuation inhaler

Also known as: XOPENEX HFA

START taking these medications

	Dose, Frequency, and Details
hydrOXYzine 25 MG tablet Also known as: ATARAX	Take 1 tablet (25 mg total) by mouth every 4 (four) hours as needed for anxiety. Last time this was given: 3/5/2018 6:23 PM
sertraline 100 MG tablet Also known as: ZOLOFT	Take 1 tablet (100 mg total) by mouth daily. Last time this was given: 3/6/2018 8:56 AM Start taking on: 3/7/2018

CHANGE how these medications are taken

	Dose, Frequency, and Details
gabapentin 600 MG tablet Also known as: NEURONTIN	Take 1 tablet (600 mg total) by mouth 3 (three) times a day. What changed: when to take this

CONTINUE taking these medications

	Dose, Frequency, and Details
cholecalciferol 1,000 unit tablet	Take 1,000 Units by mouth daily.

Also known as: VITAMIN D3 Last time this was given: 3/6/2018 8:56 AM

levothyroxine 75 MCG tablet Take 75 mcg by mouth daily. Directions:

Also known as: SYNTHROID, LEVOTHROID daily EXCEPT Sundays

Last time this was given: 3/6/2018 5:59 AM

metFORMIN 500 MG 24 hr tablet Take 2,000 mg by mouth daily.

Also known as: GLUCOPHAGE-XR Last time this was given: 3/6/2018 8:55 AM

risperiDONE 0.5 MG tablet TAKE 1 TABLET BY MOUTH TWICE A DAY

Also known as: RisperDAL Last time this was given: 3/6/2018 8:56 AM

therapeutic multivitamin tablet Take 1 tablet by mouth daily.

Hospital Care Team

Service: Psychiatry

Inpatient Attending: Mahdi Razafsha, MD

Attending phys phone: (617)726-8470

Discharge Unit: NSME7SH

Primary Care Physician: Cerima Durakovic, MD 978-739-6950

NSM Salem Campus
81 Highland Ave
Salem MA 01970-2714

STELLA,TOMMI-LEE

MRN: 00291515

DOB: 3/13/1978, Sex: F

Acct #: 6072088656

ADM: 2/21/2018 D/C:

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Transitional Plan

Scheduled appointments:

Appointments Scheduled for Next 90 Days

Mar 09, 2018 12:20 PM EST 55 Highland Ave., Suite 201

MEDICATION FOLLOW UP with Kimberly A Leventhal, Salem MA 01970

MD 978-825-6620

NSMC Highland Hall at Salem Hospital (--)

You do not need to follow any special instructions for this appointment.

Mar 12, 2018 1:00 PM EDT 1 Hutchinson Dr.

Follow Up with Johannah E Lordan, CNP Danvers MA 01923

North Shore Physicians Group (NSP DANVERS) 978-739-6950

Your Follow-Up Appointments

Cerima Durakovic, MD 1 Hutchinson Drive

Specialty: Internal Medicine Danvers MA 01923-3748

Relationship: PCP - General Phone: 978-739-6950

Insurance Assigned Provider

Historical LMR Provider

Follow up on 3/12/2018

Instructions: 2pm with Lohanna Lordan, For routine post-hospital follow up

Kimberly A Leventhal, MD 81 Highland Avenue

Specialty: Psychiatry Salem MA 01970-2714

Phone: 978-354-4010

Follow up on 3/9/2018

Instructions: 12:20pm at Highland Hall office, 978-825-6620

Jennifer Lee South Bay Mental Health

781-851-2648

fax: 781-851-2699

Go on 3/7/2018

Instructions: at Noon for psychotherapy.

Eliot CBFS 781-338-8129

fax: 781-397-2123

Call today

Instructions: As needed for support and regular check-ins

Erin Walsh Department of Children and Families

Malden

781-388-7100

fax 781-324-2209

Call today

Instructions: As needed

Signed Discharge Orders

NSM Salem Campus STELLA,TOMMI-LEE

81 Highland Ave MRN: 00291515

Salem MA 01970-2714 DOB: 3/13/1978, Sex: F

Acct #: 6072088656

ADM: 2/21/2018 D/C:

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Ordered

03/06/18 Psychiatric Transition Record

1237 Question Answer Comment

Request HIM to send the Psychiatric Transition Record to the next level of care provider(s)? Yes

Authorization for release of information signed by patient or guardian? Yes

List name of Provider(s) who will receive the Continuing Care Plan outpt psychiatrist

03/06/18 Activity as tolerated

1237

03/06/18 Discharge diet

1237 Question: Diet Type Answer: Regular

03/06/18 For immediate questions regarding your hospitalization, your medications, and any pending test

1237 results please contact your doctor in the hospital: Mahdi Razafsha, MD at (617)726-8470.

Comments: For immediate questions regarding your hospitalization, your medications, and any pending test results please contact your doctor in the hospital: Mahdi Razafsha, MD at (617)726-8470.

Additional Clinician Instructions for When to Call

Crisis Plan Instructions:

Urgent Mental Health Evaluation Northeast region is available through Lahey Behavioral Health, Inc. at one of the following numbers:

(877) 255-1261, (978) 744-1585, (866) 523-1216.

Elliot Crisis Team (781) 596-9222

Psychiatric triage at NSMC may be reached at (978) 354-4550.

911 for medical emergencies

Other Samaritans Hotline - (877) 870-4673 ?You can call this hotline as an added support.

It is important to continue to take your medications as prescribed by your doctor. Do not stop taking any of your medications without first consulting with your doctor. Be sure to keep all of the appointments that have been scheduled for you. If you find your symptoms have returned or worsened, if others have noticed you are not acting like yourself, or if you have thoughts of harming yourself or others, please seek help immediately by calling one of the above numbers, talking to a supportive person or going to the nearest emergency room.

Eliot CBFS team is available 24/7 for on call support, 781-715-2290

Exam

Temperature: 36.7 ?C (98.1 ?F) (03/06/18 0729) Heart Rate: 89 (03/06/18 0729) BP: 125/75 (03/06/18 0729)

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Respiratory Rate: 16 (03/06/18 0729) SpO2: 100 % (03/06/18 0729) O2 Device: None (Room air) (03/06/18 0729)

Weight: 108.9 kg (240 lb) (02/21/18 1823) Height: 167.6 cm (5' 6") (02/21/18 1823) BMI (Calculated): 38.8 (02/21/18 1823)

Significant Discharge Exam Findings

Consults: none

Discharge Mental Status Exam:

Appearance: well groomed

Behavior: cooperative and eye contact good

Psychomotor Activity: normal

Musculoskeletal: moves all extremities; no abnormal movements

Station/Gait: normal

Speech: regular rate, regular rhythm and regular volume

Language: normal comprehension

Mood: "good, anxious to see father"

Affect: mood congruent

Thought Process: logical, linear and goal-directed

Associations: no loosening of associations

Thought Content: no delusions

Suicidal/Homicidal Ideation: no suicidal ideation

Perceptions/Experiences: no hallucinations

Orientation/Sensorium: oriented x 3

Memory: immediate recall intact.

Attention/Concentration: intact to observation

Abstract Reasoning: intact to observation

Fund of Knowledge: average

Insight: good

Judgment: good

Safety Assessment:

Tommi-Lee Stella no longer requires a secure, structured, inpatient, psychiatric setting in order to prevent harm and to assure safety. The patient can be safely released to home Protective factors include see below. Risk factors include see below. Prognosis for recovery from current episode is fairly good. Therefore, we feel the risk of imminent harm to self or others is low. The patient does not have decision making capacity and patient agrees with discharge and aftercare plans.

Suicide Risk Assessment:

Static Risk Factors :

? Hx of suicide attempts , Male, Elderly, young adult, White , Widowed, divorced, single, physical abuse, sexual abuse, Loss factors (vocation, relationship,health, legal), FH of suicide, Physical illness

Dynamic Risk Factors:

? Suicidal intent, Severe agitation/anxiety, Hopelessness, Impulsivity, Aggression, Access to firearms, mood disorder, Anhedonia, Comorbid alcohol/substance use, Command hallucinations

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

Protective Factors:

? Pregnancy, Responsibility for children younger than age 18 years, Sense of responsibility to family, Organized religion, Employed, Living with another person, Positive social support, Positive therapeutic relationship

Communication of the Continuing Care Plan:

The patient's Continuing Care Plan (CCP) has been communicated to the next level of care provider(s).

The CCP includes the discharge medications, after care recommendations, principle diagnoses, and reason for hospitalization.

Discharged Condition: good

Orientation Level: Oriented X7

Cognition: Follows commands

Speech: Appropriate for age

Vision: Functional

Hearing: Functional

Assistive Devices: None

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	8.73	02/23/2018 0637
RBC	4.95	02/23/2018 0637
HGB	14.3	02/23/2018 0637
HCT	43.2	02/23/2018 0637
MCH	28.9	02/23/2018 0637
MCV	87.3	02/23/2018 0637
PLT	190	02/23/2018 0637
RDW	14.2	02/23/2018 0637

Lab Results

Component	Value	Date/Time
NA	137	02/23/2018 0637
K	3.9	02/23/2018 0637
CL	100	02/23/2018 0637

CO2 26 02/23/2018 0637

BUN 12 02/23/2018 0637

NSM Salem Campus STELLA,TOMMI-LEE

81 Highland Ave MRN: 00291515

Salem MA 01970-2714 DOB: 3/13/1978, Sex: F

Acct #: 6072088656

ADM: 2/21/2018 D/C:

Discharge Summaries by Mahdi Razafsha, MD at 3/6/2018 12:46 PM (continued)

CRE 1.00 02/23/2018 0637

CA 9.2 02/23/2018 0637

GLU 125 (H) 02/23/2018 0637

NorthShore Medical Center Union Campus
Name: Erica Furey
MRN: 582738
Account#: 7015447464
Sex: Female
DOB: 08/20/1987
Age: 28 years
Arrival Date: 11/02/2015
Time: 17:59
Departure Date: 11/02/2015
Time: 21:49
Bed C
Union Hospital ED Physician Documentation
HPI:
11/02
20:09 This 28 years old Caucasian Female presents to ER via Atlantic nr
with complaints of agitation.
20:09 The patient presents to the emergency department with agitation. nr
Onset: The symptoms/episode began/occurred at an unknown time.
Associated signs and symptoms: Pertinent negatives: abdominal pain, chest pain, fever, headache, nausea, shortness of breath, suicide ideation, vomiting. Severity of symptoms: At their worst the symptoms were severe in the emergency department the symptoms have improved. The patient has not recently seen a physician. Patient lives in a group home. She apparently was very agitated at her group home. She said she had thoughts about hurting staff at the home and refused to take her medications. She also had a witnessed seizure and has a history of seizures. Currently she is feeling calm her but feels she needs to be hospitalized psychiatrically and she is not doing well. No chest abdominal or back pain. No fever chills or sweats. No nausea vomiting..

Historical:
- Allergies:

18:01 bee stings; Lithium Carbonate; cp5
- Home Meds:
18:01 Klonopin Oral 0.5 mg nightly; Cogentin Oral 0.5 mg three times a cp5
day; Depakote Oral 500 mg twice a day; Klonopin Oral 0.25 mg Q AM; Lithium Carbonate Oral 600 mg nightly; Melatonin Oral 6 mg nightly; Neurontin Oral 900 mg three times a day; Trilafon Oral 8 mg twice a day; Colace 100 mg twice a day; Depo-Provera IM 150 mg Q 3 months; Prilosec Oral 20 mg twice a day; Tums Oral 1000 mg twice a day; Epi-pen as needed, for bee stings; Sudafed Oral 60 mg as needed, every 6 hours; Robitussin PE Oral 10 milliliter as needed, every 4 hours; Periogard mucous membrane 15 milliliter twice a day; Motrin Oral 600 mg as needed, every 6 hours; A1 Reliable med list source pt/family;
- PMHx:
18:01 GERD; Anxiety; Depression; seizure disorder; Schizophrenia; cp5
Bipolar disorder;

- Immunization history: Flu vaccine is not up to date. Patient has never been vaccinated.
- Social history: Smoking status: Patient/guardian denies using tobacco, No barriers to communication noted. The patient speaks fluent English. Speaks appropriately for age. Patient is speech impaired. Patient has slurred speech that is chronic.
- Review of nurse's social history: and I confirm what was documented.
- The Past History from the nurses note was reviewed : and I confirm what was documented.

ROS:
20:09 All other systems were reviewed and are negative, except as nr
stated in the HPI.

Exam:
20:09 Head/Face: Normocephalic, atraumatic. nr
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: nares patent, op clear
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. No JVD
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation. No rales, rhonchi or wheezes noted.
Abdomen/GI: Soft, non-tender. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: Warm, dry with normal turgor. Normal color with no rashes, no lesions, and no evidence of cellulitis.
MS/ Extremity: No cyanosis. Full ROM, no edema, tenderness or

swelling throughout extremities.
20:09 Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves III-XII intact. Motor strength 5/5 in all extremities. Sensory grossly intact. nr
20:09 Constitutional: The patient appears in no acute distress.
20:09 Psych: Behavior/mood is cooperative.

Vital Signs:
18:31 BP 102 / 64 RA Sitting; Pulse 71; Resp 18; Temp 98.3(TE); Pulse Ox 97% on R/A; cp5
21:38 BP 130 / 68 RA Sitting; Pulse 84 LA; Resp 20; Temp 98.0(TE); Pulse Ox 100% on R/A; cd3

MDM:
20:55 The patient is determined to not have any medical or surgical problems warranting inpatient admission. The patient is medically cleared for admission or transfer to a psychiatric facility. nr
21:31 Data reviewed: vital signs, nurses notes, old medical records, lab test result(s). Counseling: I had a detailed discussion with the patient and/or guardian regarding: the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. ED summary Patient presents with 2 issues. For her she has been agitated and threatening thoughts to his staff at her facility. For this she was placed on section 12. Second she had a witnessed seizure. She does have a history of seizures. Here she appears clinically well. She underwent lab work which shows a therapeutic Depakote level. She had no further evidence of seizures. She was medically cleared for mental health evaluation and seen by mental health who spoke at length with the group home who state that this behavior is not significantly different from baseline. The group home is comfortable taking the patient back. I have e-mailed the patient's primary care physician Helena Ireland about the patient's visit. The patient appears clinically well at the time of discharge. nr

11/02
18:25 Order name: BUN; Complete Time: 20:55 nr
11/02
18:25 Order name: Creatinine; Complete Time: 20:55 nr
11/02
18:25 Order name: Electrolytes; Complete Time: 20:55 nr
11/02
18:25 Order name: Glucose Random; Complete Time: 20:55 nr
11/02
18:25 Order name: Toxic Screen (Serum Only); Complete Time: 20:55 nr
11/02
18:25 Order name: Toxic Screen - Urine; Complete Time: 20:09 nr
11/02
18:25 Order name: Hcg Bedside; Complete Time: 19:11 nr
11/02
18:25 Order name: CBC; Complete Time: 20:09 nr
11/02

18:25 Order name: Psych Triage Consult; Complete Time: 20:41 nr
11/02
18:25 Order name: Depakote Level; Complete Time: 20:55 nr
11/02
18:25 Order name: Lithium Level; Complete Time: 20:55 nr
11/02
19:44 Order name: UNION HOSPITAL PHLEBOTOMY FEE EDMS
11/02
18:25 Order name: constant observation; Complete Time: 19:15 nr

Dispensed Medications:
18:48 Drug: Ativan 1 mg Route: PO; cp5
19:57 Follow up: Response: Anxiety decreased cd3
18:48 Drug: Depakote 500 mg Route: PO; cp5
19:58 Follow up: Response: No adverse reaction cd3

Point of Care Testing:
Urine Pregnancy:
19:11 hCG Reading: Negative; Control Reading: Positive; td4
Disposition:
21:33 Disposition nr

Disposition Summary:
11/02 Discharged to Home. Impression: Schizophrenia, Seizure.
21:33
nr
- Condition is Stable.
- Discharge Instructions: SCHIZOPHRENIA, General, SEIZURE, Recurrent [Adult].

- Follow up: Private Physician; When: Tomorrow; Reason: Re-Evaluation.
- Problem is an acute exacerbation.
- Symptoms have improved.

Signatures:
Dispatcher MedHost EDMS
Ross, Nicholas, MD MD nr
Dagacan, Clarisse, RN RN cd3
Palumbo, Casey, RN RN cp5

****
DISCHARGE SUMMARY

NAME: ROBERTS, STEPHEN M UNIT NUMBER: 402-89-45
DOB: 12/27/1979 FLOOR: E12 E1222A
ADMISSION DATE: 09/16/2015 DISCHARGE DATE: 09/20/2015

PRINCIPAL DIAGNOSIS
Skin lesion

ASSOCIATED DIAGNOSES
History of septic arthritis

SIGNIFICANT OPERATIONS/PROCEDURES/TESTS PERFORMED DURING HOSPITALIZATION
Operations/Procedures:
Skin biopsy (09/18/2015)
Labs/Imaging/Other Tests:
Cultures of wounds showed Enterococcus faecalis.
Ultrasound of arms showed no areas of drainable fluid collection.

LIFE-SUSTAINING TREATMENT (CODE STATUS) AT DISCHARGE
Full Code (discussion with patient/surrogate not appropriate or possible at this time) Entered by: Paul Krezanoski, M.D.

ALLERGIC REACTIONS, INTOLERANCES AND SENSITIVITIES
NKA: No Known Allergies

CHIEF COMPLAINT
Nodular lesions

HISTORY AND REASON FOR HOSPITALIZATION AND SIGNIFICANT FINDINGS
From Dr. Kresanoski's admission note:
35 year old male with a history of T1DM, polysubstance abuse, septic L hip joint on chronic doxycycline, who presents with multiple nodular lesions on forearms concerning for infection. Patient notes that they are not particular painful except for one lesion over his elbow. He adamantly denies any IVDU or skin popping. Says that the nodules have been there for a few weeks but came in today at the request of his PCP. He has continued on his home docycycline. He denies fevers, chills, n/v/d, abdominal pain, CP, SOB or other rashes. He does have chronic leg and back pain which has not changed.

Also with a recent history of DVT 2/2 PICC line and is now off Lovenox. Per PCP notes possible Fm Hx of clots, plan was to check for predisposing factors including FVL, prothrombin gene mutation, APLS antibodies.

There have been recent questions about his substance abuse, with negative utox screens despite contract with PCP. The PCP was beginning to wean him off of his opiates.

ED Course:
Multiple raised, indurated lesions on forearms bilaterally
Vancomycin
Afebrile, HDS

REVIEW OF SYSTEMS:
See HPI

Past Medical History:
Hip pain : Arthritis secondary to septic joint, status post total hip arthroplasty on 10/15/13.
Hypertensive disorder

Compression fracture
Diabetes mellitus type 1 : Diagnosed at 12 years of age; now with opthalmologic manifestations. Followed by diabetes specialist at Joslin.
Urinary incontinence
H/O Deep venous thrombosis
H/O Diabetic ketoacidosis
H/O Epidural abscess : T11-12 epidural abscess 2/2 MSSA, 2012
Generalized aches and pains
H/O Bacteremia : MSSA, B. cereus
H/O Osteomyelitis : T10-11 Vertebral osteomyelitis; Apr/2012
S/P Laminectomy
Tobacco user
Diabetic retinopathy
Anxiety state : followed by psych at Joslin
Myopia : Followed by optho at Joslin
Astigmatism : Followed by optho at Joslin
Adjustment disorder with mixed emotional features : Adjustment disorder with depressed mood (followed by psych at Joslin)
Nonproliferative diabetic retinopathy : Followed by optho at Joslin
Hip fracture
Generalized anxiety disorder : Aggravated by multiple medical conditions, chronic pain, IDDM with late complications, retinopathy, HTN, severe loss of general function, currently incapacitated, living with parent
Benzodiazepine dependence
Opioid dependence : suffers chronic pain
H/O Alcohol problem drinking : intermittent, concomitant with use of prescribed controlled substance, narcotics that affect CNS
Polysubstance dependence : Opioid, Benzodiazepine, alcohol and past history of other substance use coccaine, MJ, Stimulants

Medications:
Pre-admission Medication List for ROBERTS,STEPHEN M 4028945 (MGH) 35 M

Last signed by: KREZANOSKI,PAUL,M.D. on 09/16/2015 at 22:06

1. Bacitracin 1 APPLICATION TOP BID
2. Calcium Carbonate 1250 Mg (500 Mg Elem Ca) 500 MG PO BID
   Dose expressed in terms of elemental calcium.
3. Cholecalciferol (Vitamin D3) 800 UNITS PO Q24H
4. Clonazepam (Klonopin) 2 MG PO BID prn anxiety
   Patient takes 2 mg BID as needed for anxiety
5. Doxycycline Hyclate 100 MG PO BID
6. Econazole Nitrate 1% 1 APPLICATION TOP BID
7. Gabapentin (Neurontin) 900 PO QID
8. Hydromorphone Hcl (Dilaudid) 4 MG PO QID prn Pain-Moderate, Pain-Severe
   may take up to 4 per day for left hip pain. Do not use alcohol or drive or operate heavy machinery while taking this medication. It can cause drowsiness.
9. Insulin Glargine (Lantus) SC
   Medication information: unit strength: 100/ML form: VIAL

take: directed As directed
35 units every evening.
10. Insulin Lispro (Humalog Insulin) SC
Medication information: unit strength: 100/ML form: VIAL
take: directed As directed
Sliding scale prescribed by endocrinologist.
11. Oxybutynin Chloride 5 MG PO TID
12. Tizanidine 2 MG PO TID prn spasticity
May repeat every 6 to 8 hours to MAX of 3 doses in 24 hours. Do not use alcohol or drive or operate heavy machinery while taking this medication. It can cause drowsiness.

Allergies:
NKA

Family History
NC

SOCIAL HISTORY
Lives with parents; had been planning on starting new job and moving into his own home; however, now on hold due to recent medical setbacks. H/O Alcohol problem drinking : intermittent, concomitant with use of prescribed controlled substance, narcotics that affect CNS. Polysubstance dependence : Opioid, Benzodiazepine, alcohol and past history of other substance use coccaine, MJ, Stimulants.

PHYSICAL EXAMINATION
VITALS: T 97.5 HR 74 BP 103 / 57 RR 18 O2 97 RA

[Constitution] - well nourished and developed. Comfortable, sleepy
[Eyes] - conjunctivae clear, pupils equal, no discharge
[ENMT] - Ears - external ears normal.
[ENMT] - Nose - nasal passages patent and normal mucosa, no discharge.

[ENMT] - Throat - normal color and without tonsillar enlargement.
[Neck] - external exam normal, supple no lymphadenopathy or thyromegaly
[CV] - regular rate no murmurs, rubs or gallops
[Respiratory] - clear breath sounds bilaterally, no accessory muscle use.
[GI] - abdomen soft, no hepatosplenomegaly, no abnormal masses or hernias; normal active bowel sounds
[Skin]- multiple quarter sized, scattered erythematous and indurated lesions over forearms and inner elbow bilaterally R>L, minimally tender, no clear fluctuance
[Musc/Skel] - normal tone, no edema, L hip with minimal tenderness, wound intact
[Neuro] - 5/5 gross motor strength, grossly normal coordination; extraocular movements intact
[Psych] - alert and oriented for age, normal mood and affect

LABORATORY STUDIES :

Results
09/17/2015 NA PEND, K PEND, CL PEND, CO2 PEND, BUN PEND, CRE

PEND, EGFR PEND, GLU PEND
09/16/2015 NA 136, K 4.3, CL 100, CO2 26, BUN 15, CRE 0.91,
EGFR >60, GLU 187 (H)

09/17/2015 ANION PEND
09/16/2015 ANION 10

09/16/2015 GLU-POC 273 (H)

09/17/2015 CA PEND, PHOS PEND, MG PEND, TBILI PEND, DBILI PEND,
TP PEND, ALB PEND, GLOB PEND
09/16/2015 CA 8.9, PHOS 3.5, MG 1.7, TBILI 0.2, DBILI 0.1, TP 6.
4, ALB 3.0 (L), GLOB 3.4

09/17/2015 ALT-U/L PEND, AST PEND, ALKP PEND, TBILI PEND, DBILI
PEND
09/16/2015 ALT-U/L 15, AST 21, ALKP 117 (H), TBILI 0.2, DBILI 0.1

09/15/2015 UCRE 55

09/17/2015 WBC PEND, RBC PEND, HGB PEND, HCT PEND, MCV PEND, MCH
PEND, MCHC PEND, PLT PEND
09/16/2015 WBC 6.67, RBC 4.27 (L), HGB 10.9 (L), HCT 34.8 (L),
MCV 81.5, MCH 25.5 (L), MCHC 31.3, PLT 164

09/17/2015 MPV PEND, RDW PEND
09/16/2015 MPV 10.8, RDW 16.1 (H)

09/17/2015 METHOD PEND, NRBC% PEND
09/16/2015 METHOD Auto, %NEUT 71.1 (H), %LYMPH 21.4 (L), %MONO 7.0,
%EOS 0.3, %BASO 0.1, NRBC% 0.00

09/17/2015 NRBC-ABS PEND
09/16/2015 ANEUT 4.73, ALYMP 1.43, AMONS 0.47, AEOSN 0.02, ABASOP
0.01, NRBC-ABS 0.00

09/16/2015 PT 13.2, PT-INR 1.0

09/17/2015 TOX1 PEND, TOX2 PEND

09/15/2015 U6MNMOR Negative, UAMPH Negative, UBARB Negative, UBENZ
Positive, UBUP Negative, UCOCA Negative, UMETHD Negative, UOPI
Negative

09/15/2015 UOXCOD Negative, URPCP Negative, UTHC Negative

09/15/2015 EtG PEND

Microbiology

Specimen: 0916W729998 Collected 16-Sep-15 15:40

Received 16-Sep-15 16:59

Ordering Provider: Unknown, Missing No Info
Specimen Group: BLOOD/SERUM
Specimen Type: BLOOD CULTURE
Specimen Comment: LEFT AC

Blood Culture - Pending

Specimen: 0915T729924 Collected 15-Sep-15 20:14

Received 15-Sep-15 20:14

Ordering Provider: DICKINSON,MARK W
Specimen Group: TISSUE/BIOPSY/WOUND
Specimen Type: ABSCESS
Specimen Comment: ARM

Gram Stain - Preliminary Reported: 15-Sep-15 23:05

Rare MONONUCLEAR CELLS, NO POLYS, NO ORGANISMS SEEN

Wound Culture - Preliminary Reported: 16-Sep-15 08:22
NO GROWTH

Radiology

Exam Number: 18608999 Report Status:
Scheduled
Type: Bil Upper Extremity Ven US
Date/Time: 09/17/2015 08:00
Exam Code: USVA2
Ordering Provider: Krezanoski, Paul J

HISTORY:
multiple nodules/abscesses, eval for fluid collections

Scheduled Exam

HOSPITAL COURSE AND TREATMENT
1. Skin lesions: Patient adamantly denies any skin popping and the location of his lesions does not appear to make sense as injection sites. He does report picking at his skin, however. Ultrasound of his arms did not show any areas of drainable fluid collection. The patient's report makes development of these lesions appear subacute in nature, thoguh the chronology is not clear. Occasional lesion will drain pus, which does suggest that patient has furuncles, though Staph never grew from any cultured site. Culture from his primary care physician's office grew few Enterococcus and Lactobacillus. Biopsy was then taken by Dermatology on 9/18/15. Per Dermatology, biopsy results consistent with infection. Culture from that site now

growing Enterococcus, which is susceptible to ampicillin and vancomycin. The patient did have improvement in appearance of nodules with IV vancomycin. Furthermore he never had systemic symptoms, fever, leukocystosis, and his blood cultures were negative, so it does not appear he had a disseminated infection. Based on susceptibilities, patient was transitioned to Augmentin. I would have preferred to await all cultures and final pathology read of biopsy, but patient insisted that he needed to leave on 9/19/15 to make an important dental appointment the next day. Rather than risk him leaving without antibiotic coverage, I provided him with a prescription for one week of Augmentin, as well as a follow up appointment at Dr. Dickinson's office. Patient's phone number is 617-596-6697 and will call him with any results that occur after his discharge.

2. History of septic arthritis: The patient is on chronic doxycycline. Hip was without issues. He was returned to his home doxycycline on discharge.

3. T1DM: Continued home does of Lantus and home sliding scale.

4. Chronic pain: Continued his decreased dose of dilaudid PO per PCP (wean to 4 pills per day recently). Continues home Klonopin, gabapentin.

MOST RECENT LABS AND OTHER STUDIES
09/18/15 - Sodium 139, Potassium 4.5, Chloride 99, Carbon Dioxide 26, BUN 13, Creatinine 0.94, Glucose 225 (H), HCT 36.1 (L), WBC 7.01, PLT 234
09/17/15 - Calcium 8.6, Phosphorus 3.0, Magnesium 1.8

2015/09/18 00:00:00 - TISSUE: Wound Culture - Preliminary Reported: 20-Sep-15 07:12
Specific organism sought: sporothrix sp.
Moderate ENTEROCOCCUS FAECALIS
RAPID MIC METHOD

Antibiotic	MIC (mcg/ml)	Interpretation
Ampicillin	<=2	Susceptible
Ciprofloxacin	>=8	Resistant
Doxycycline	8	Intermediate
Erythromycin	2	Intermediate
Levofloxacin	>=8	Resistant
Tetracycline	>=16	Resistant
Vancomycin	2	Susceptible

2015/09/17 00:00:00 - US Ext Non Vascular: IMPRESSION: Inflammatory/phlegmonous change within the superficial soft tissues of the ventral aspect of the right proximal/mid forearm and left antecubital fossa without a discrete drainable collection.
2015/09/17 00:00:00 - US Ext Non Vascular: IMPRESSION: Inflammatory/phlegmonous change within the superficial soft tissues of the ventral aspect of the right proximal/mid forearm and left antecubital fossa without a discrete drainable collection.

2015/09/16 00:00:00 - BLOOD CULTURE: Blood Culture - Preliminary
Reported: 20-Sep-15 07:00
NO GROWTH 4 DAYS

2015/09/16 00:00:00 - BLOOD CULTURE: Blood Culture - Preliminary
Reported: 20-Sep-15 07:00
NO GROWTH 4 DAYS

ITEMS FOR FOLLOW-UP/ANNOTATIONS AT TIME OF DISCHARGE
If results for pending tests are required, please contact Health Information Services at (617)726-2361.
Other Items Requiring Follow-Up
Fungal culture

CONDITION ON DISCHARGE
Improved

DISCHARGE MEDICATIONS
Calcium Carbonate 1250 Mg (500 Mg Elem Ca) 500 MG PO BID Days
Oxybutynin Chloride 5 MG PO TID (last dose: 09/20/2015 08:34 AM)
Insulin Glargine (Lantus) 38 UNITS SC QHS (last dose: 09/19/2015 10:21 PM)
Insulin Glargine (Lantus) 19 Units SC QHS Days (last dose: 09/19/2015 10:21 PM)
Insulin Lispro Sliding Scale Custom SC Before breakfast and lunch (Sliding Scale) (last dose: 09/20/2015 08:32 AM)
If BS <= 100 give 0 Units
For BS from 101 to 140 give 4 Units
For BS from 141 to 180 give 5 Units
For BS from 181 to 220 give 6 Units
For BS from 221 to 260 give 7 Units
For BS from 261 to 300 give 8 Units
For BS from 301 to 340 give 9 Units
For BS from 341 to 380 give 10 Units
For BS => 381 give 11 Units
Insulin Lispro Sliding Scale Custom SC Before dinner (Sliding Scale) (last dose: 09/19/2015 05:35 PM)
If BS <= 100 give 0 Units
For BS from 101 to 140 give 8 Units
For BS from 141 to 180 give 10 Units
For BS from 181 to 220 give 11 Units
For BS from 221 to 260 give 12 Units
For BS from 261 to 300 give 13 Units
For BS from 301 to 340 give 14 Units
For BS from 341 to 380 give 15 Units
For BS => 381 give 16 Units
Insulin Lispro Sliding Scale Custom SC QHS (Sliding Scale) (last dose: 09/19/2015 10:21 PM)
If BS <= 100 give 0 Units
For BS from 101 to 140 give 0 Units
For BS from 141 to 180 give 0 Units
For BS from 181 to 220 give 0 Units
For BS from 221 to 260 give 2 Units
For BS from 261 to 300 give 3 Units

For BS from 301 to 340 give 4 Units
For BS from 341 to 380 give 5 Units
For BS => 381 give 5 Units
Clonazepam (Klonopin) 2 MG PO BID Days prn [Anxiety]
Gabapentin (Neurontin) 900 MG PO QID (last dose: 09/20/2015 08:33 AM)
Hydromorphone Hcl (Dilaudid) 4 MG PO QID Days prn [Pain-Moderate, Pain-Severe]
Doxycycline Hyclate 100 MG PO BID Days
Amoxicillin/clav.acid 875/125 (Augmentin 875/125) 875 MG PO Q12H Days14 doses
Rx: 875-125 MG TABLET 1 Tablet(s) Q12H 7 day(s) Dispense: 14 Tablet(s) Refills: 0
Cholecalciferol (Vitamin D3) 800 UNITS PO Q24H Days
Bacitracin 1 APPLICATION TOP BID Days
Econazole Nitrate 1% 1 APPLICATION TOP BID Days
Tizanidine 2 MG PO TID prn [spasticity]

Vaccines
The Flu vaccine was not given during this admission. Please consult with your PCP regarding vaccinations.Pneumococcal (Pneumonia) Vaccine Pneumovax 23 not given this admission. Reason: Previously vaccinated

DISCHARGE INSTRUCTIONS
Diet: No Restrictions
Activity: Activity as tolerated
Treatment: Mr. Roberts,

You were admitted to the hospital with erythematous lesions on your arms. You were started on IV antibiotics and had some improvement in the appearance of the lesions. Dermatology evaluated you and took a biopsy, which was consistent with infection. Based on cultures, you will go home on the antibiotic Augmentin for seven days. You should also continue your home doxycycline. I will call you at 617-596-6697 if any of your remaining cultures suggest you need any other medication.
Instructions: Please seek medical care if you develop the following or if you have any other symptoms concerning to you:
- Fever greater than 100.4 degrees
- Chills
- Chest pain, pressure
- Bleeding or unusual bruising
- Sore throat or difficulty swallowing
- Dizziness or feeling light-headed
- Worsening cough or shortness of breath
- Confusion or agitation
- Rapid heartbeat/heart palpitations
- Nausea, vomiting or diarrhea that is unrelieved by prescription medications
- Any unusual pain

Please refer to your medication summary list for changes made to your medications. If you have any questions about these changes or difficulty filling your prescriptions, please call your primary care doctor or the number below.

If you have any questions about this hospitalization, please call me at 617-724-3874 or page the Hospitalist on call (pager 21607) by calling 617-726-2000.

Followup: You have a follow up appointment at Dr. Dickinson's office with Dr. Lien on September 28th at 2:45pm. The sutures from your biopsy can be removed at that time and your arms can be monitored for resolution of infection.

POST-DISCHARGE GOALS
Continuity of Care: Please attend all scheduled appointments

LAST ATTENDING OF RECORD
Roberts, Michael A, MD 617-724-3874

PROVIDER TO CONTACT REGARDING HOSPITAL STAY
Roberts,Michael A, MD 617-724-3874

Electronically Signed
MICHAEL A. ROBERTS, M.D. 09/20/2015 04:09 P

MICHAEL A. ROBERTS, M.D.

TR: dex DD: 09/20/2015 TD: 09/20/2015 04:09 P 1842372
cc: MARK W. DICKINSON, M.D.
Medicine
Mgh Back Bay
101326

WEI LIEN, M.D.
Mgh Back Bay
388 Commonwealth Avenue
035020
NORTH SHORE MEDICAL CENTER
UNION HOSPITAL

PATIENT NAME: Davis, Danielle MR #: 00-83-32-72
DATE OF BIRTH: 08/06/1999

DATE OF ADMISSION: 02/07/2013
DATE OF DISCHARGE: 02/12/2013

DISCHARGING PHYSICIAN: Jeffrey Bucci, M.D.

CHIEF COMPLAINT: Suicidal ideation.

HISTORY OF PRESENT ILLNESS: The patient is a 13-year-old Caucasian female, who was brought to the Massachusetts General Hospital Emergency Department

by her mother for increasing anxiety, worsening depressed mood, increasing nightmares, urges for self-injurious behavior and suicidal ideation. The patient was reportedly diagnosed with PTSD approximately 3 years ago after a motor vehicle accident with nightmares and increased startle, but no flashbacks or avoidance behavior. The patient does report a history of bullying at school, which in part prompted transfer of a charter school. When she was in the seventh grade. More recently, in the past few weeks, the patient reports worsening social difficulties at school, losing friends, being bullied and feeling some pressure from girlfriends who have been cutting, texting her, "I want to cut myself" and saying that she does not understand. The patient saw a bullying coordinator who suggested writing down her thoughts. She stated this worked for a little while, but has not been working recently. The patient reports peer pressure to cut and fit in, but also reports wanting to cut to relieve her distress again. She reports cutting her wrists with broken glass at home approximately 20 times several weeks ago in the setting of worsening anxiety. The patient reports a desire to cut herself and to relieve her distress. In the past week, the patient has had suicidal thoughts, including a plan to hang herself or overdose. The patient had a 3-hour anxiety attack at school the day prior to admission. The patient endorses multiple neurovegetative symptoms. The patient's mother reports the patient has been more withdrawn, moody and depressed in the past few weeks. She has been dropping friends.

PAST PSYCHIATRIC HISTORY: This is the first inpatient psychiatric hospitalization for the patient. Previous diagnoses have included PTSD. The patient has never been on psychiatric medications. The patient has no significant history of suicide attempts. She does have history of self-injurious behavior, as described in HPI.

PAST MEDICAL HISTORY: The possibility of ask SCFE with recommendation for nonoperative treatment, including physical therapy.

SUBSTANCE ABUSE HISTORY: None.

TRAUMA HISTORY: The patient has a history of being bullied, as described in the HPI. Otherwise no history of physical, emotional, sexual abuse or neglect.

FAMILY AND SOCIAL HISTORY: The patient was born and raised in Lynn. She lives with her parents who are married and both have custody, as well as her 19-year-old brother and 17-year-old sister. No history of developmental delays. She was previously in the charter school but transferred out last year due to bullying. No file for IEP. The patient enjoys friends, girl scouts and robotic in her free time. No history of CHINS involvement.

FAMILY PSYCHIATRIC HISTORY: The patient's older brother has anxiety and depression. There is an older sister with a question of bipolar disorder with a history of self-injurious behavior. There is a paternal uncle with alcohol dependence, in recovery. There is a paternal great grandmother with a question of schizophrenia.

ADMISSION MEDICATIONS: None.

LABORATORY DATA: Admission labs from MGH: Urinalysis was within normal limits. UPT was negative. U-tox was negative. There are no pending tests at the time of discharge.

HOSPITAL COURSE: The patient was admitted to East-3 Pediatric Inpatient Psychiatric Unit for safety, stabilization and further evaluation. During hospitalization, the patient was started on Celexa 10 mg daily, and melatonin 3 mg at bedtime. The patient tolerated these medication changes without side effect and seemed to benefit. Prior to initiation of these medication changes, side effects were reviewed with the patient's mother, who agreed to the medication changes.

Throughout the hospitalization, the patient attended groups and made positive progress. She denied suicidal ideation throughout her hospitalization. Towards the end of the hospitalization, the patient went on therapeutic leave of absence. Both the patient and her mother reported this went well.

On the day of dismissal, the patient's mental status exam included, she was awake, alert, and oriented in all spheres. She was friendly, calm and cooperative. Her mood was euthymic. Affect was mood congruent, stable and reactive within a normal range. Thought processing was linear and goal-directed. Thought content was non delusional. No evidence of perceptual disturbances. No evidence of homicidal or suicidal ideation.

DISCHARGE DIAGNOSES:
Axis I:
1. Depressive disorder, not otherwise specified.
2. Anxiety disorder, not otherwise specified.

Axis II: Rule out cluster B traits.

Axis III: Noncontributory.

Axis IV: Moderate.

Axis V: Global Assessment of Functioning at dismissal 50, Global Assessment of Functioning high past year unknown.

DISCHARGE MEDICATIONS:
1. Celexa 10 mg daily for depression and anxiety.
2. Melatonin 3 mg at bedtime for insomnia.

FOLLOW UP POST DISCHARGE:
1. Psychotherapy with South Bay Mental Health, Daniel Mullet, Wednesday, 02/13/2013 at 1:15 in the home, (781)244-1950.
2. Psychopharmacology referral will be made by Daniel Mullet after the 02/13/2013 appointment at South Bay Mental Health, 25 Congress Street, Salem, Mass, (978)542-1951.
3. Pediatric appointment with Cheri _____, Monday 02/25/2013 at 8:00 a.m., 628 Salem Street, Lynnfield, Mass (781)599-1998.

ACTIVITY AND DIET: As tolerated.

CRISIS PLAN: Before being dismissed, emergency psychiatric services were

discussed with the patient and her mother. The patient and her mother were instructed to either call 911, or go to the nearest emergency department if the patient should become homicidal or suicidal.

Electronically Signed
Jeffrey Bucci, M.D. 02/21/2013 15:44

_____
Jeffrey Bucci, M.D.

JB:DDI
DD: 02/11/2013 3:42 P
DT: 02/11/2013 7:46 P
Job: 000422902
Doc #: 2138028
cc: Jeffrey Bucci, M.D.
NORTH SHORE MEDICAL CENTER
UNION HOSPITAL

PATIENT NAME: Wayman, Avery MR: 00-67-35-10
DATE OF BIRTH: 07/20/1993

DATE OF ADMISSION: 05/31/2009 BILLING NUMBER: 7008801198

EMERGENCY PHYSICIAN: Steven Browell, M.D.

TIME SEEN: 1:45

CHIEF COMPLAINT: Sore throat.

PRESENT ILLNESS: This is a 15-year male who presents with complaints of sore throat that has been going on since Wednesday. Nothing makes the symptoms any better or worse. Denies any difficulty with speech or swallowing. No drooling. No trismus. No voice changes.

PAST MEDICAL HISTORY: None.

CURRENT MEDICATIONS: None.

ALLERGIES: NONE.

PHYSICAL EXAMINATION: Vital Signs: Within normal limits. General appearance: Awake, alert, in no distress. Skin: Warm, dry and intact. Eyes: Extraocular movements intact. Pupils equal, round and react to light. Mucous membranes are moist. Posterior pharynx with tonsillar megaly, erythema and scant exudate. No asymmetry. No elevation of the tongue. No trismus. No drooling. Neck: Supple. Lungs: Clear to auscultation. Neuro Exam: Nonfocal.

EMERGENCY DEPARTMENT COURSE: This patient presents with pharyngitis. A throat culture was obtained. Rapid strep was negative. Patient will be

given pharyngitis precautions and a prescription for Motrin and was ultimately discharged home in good condition.

FINAL DIAGNOSIS: Pharyngitis.

Electronically Signed
Steven Browell, M.D. 06/09/2009 06:53

_____

Steven Browell, M.D.

SB:DDI
DD: 05/31/2009 2:18 A
DT: 05/31/2009 9:20 A
Job: 000579136
Doc #: 1727699
cc:
ED DISCHARGE NOTIFICATION/SUMMARY

Nieves Goncalves,Sierra MRN: 3869807 Age: 10y
REGISTRATION DATE: 06/22/11 12:20

Discharge Note

Note Status: Finalized
This report was finalized by Megan Brennan, MD-Attending 06/22/11 17:22

DISCHARGE ORDER: Discharge this patient from the ED.

BENEFITS ASSIGNED: Y

DISCHARGE NOTE DATE/TIME: 06/22/11 17:21

DISCHARGE STATUS: Discharged

CONDITION ON DISCHARGE: Stable

PATIENT STATES COMPLAINT: APS EVAL

DIAGNOSIS: depression

TREATMENT RENDERED: psych eval

DISPOSITION, FOLLOW UP & INSTRUCTION TO PATIENT: Please see Dr. Wong tomorrow.
Return to ER if feeling suicidal.
PCP: PCP Name: CURRAN, MARJORIE PCP #:015354 PCP Phone:617-726-2728 PCP

Fax:617-724-3948

***This text report has been converted from the report, '1797962026.pdf'. Content may not appear exactly as it appe ars in the original .pdf. For a download of original content and format (pdf), please contact the RPDR Team at RPD RHelp@partners.org. ***

NSM Salem Campus AGUIAR,CATHERINE F

81 Highland Ave MRN: 10410323

Salem MA 01970-2714 DOB: 4/16/1986, Sex: F

Acct #: 6068680258

ADM: 12/18/2017 D/C:

Patient Information

Patient Name	Sex	DOB
Aguiar, Catherine F	Female	4/16/1986

Discharge Summaries by Supapan Nualpring, MD at 12/21/2017 9:58 AM

Author: Supapan Nualpring, Service: Medicine Author Type: Physician

MD

Filed: 12/21/2017 10:09 AM Date of Service: 12/21/2017 Status: Signed

9:58 AM

Editor: Supapan Nualpring, MD (Physician)

Physician Discharge Summary

Admit date: 12/18/2017

Discharge date: 12/21/2017

Patient Information

Catherine F Aguiar, 31 y.o. female (DOB = 4/16/1986)

Home Address: 89 Rainbow Terrace

Salem MA 01970

Home Phone: 978-408-1821 (home)

What language do you prefer to use when discussing your healthcare?: English

What language do you prefer for written communication?: English

Type of Advance Care Directive(s): Health Care Proxy

Does patient have a Health Care Proxy form completed?: HCP is NOT available, patient will complete a new one

Health Care Agents

There are no health care agents on file.

Code Status at Discharge: Full Code (Confirmed)

Discharge address same as facesheet: Yes

Hospitalization Summary

NSM Salem Campus AGUIAR,CATHERINE F

81 Highland Ave MRN: 10410323

Salem MA 01970-2714 DOB: 4/16/1986, Sex: F

Acct #: 6068680258

ADM: 12/18/2017 D/C:

Discharge Summaries by Supapan Nualpring, MD at 12/21/2017 9:58 AM (continued)

Principal Problem:

Intractable vomiting

Active Problems:

Cannabinoid hyperemesis syndrome

Resolved Problems:

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this Admission

None

Non (OR) Procedures:

Pending Results

None

Hospital Course

31 yo female history of asthma, seizure disorder, bipolar disorder, migraines, here last week with fever, SOB, leukocytosis (CXR negative), left AMA presents with nausea, abdominal pain, diarrhea since yesterday.

Abdominal CT negative. WBC 22 though seems to be chronically elevated. Afebrile in the ED.

1. Cannabinoid hyperemesis:

Patient used to use marijuana on a daily basis. Stopped 2 days before. Nausea relieved after taking hot baths.

CT didn't show signs of inflammation/infection in the abdomen. Her clinical symptoms suggest cannabinoid hyperemesis.

She received supportive treatment with IVF, Zofran and Reglan as needed.

We rec to stop cannabis intake.

Her diet was advanced to regular diet which she tolerated well.

2. Hematemesis mostly due to Mallory-Weiss tear vs gastritis

She received Protonix IV twice a day and carafate

Hb/hct was monitor and stable

She was seen by Dr. Oringer, gastroenterologist and follow up with GI for egd within 1 month.

Patient will be d/c with carafate and omprazole.

3. Leukocytosis likely due to recent steroid use.

No antibiotics needed her WBC trending down. No evidence of infection.

4. Asthma.

Lungs sound clear without hypoxia.

She was Continued on singular, albuterol when necessary, Advair.

5. Tobacco abuse

We rec her to stop smoking

She was started on nicotine patch. She will be d/c with nicotine patch

Medications

Allergies: Wild cherry; Bee venom protein (honey bee); and Sulfa (sulfonamide antibiotics)

Prior to Admission Medications

Prescriptions

ALPRAZolam (XANAX) 0.25 MG tablet

Sig: Take 0.5 mg by mouth 3 (three) times a day as needed for anxiety.

Note (3/16/2017): METAL Med Transfer Process

EPINEPHrine (EPIPEN 2-PAK) 0.3 mg/0.3 mL auto-injector

Sig: Dose: 0.3 MG; Form: Not available; Route: IM; Frequency: x1 PRN allergic reaction; Directions: Not available;

Details: Dispense: 1 Pack(s); Date: 05/15/2015

Note (12/12/2017): Received from: Partners LMR

SUMAtriptan (IMITREX) 50 MG tablet

Sig: Take 1 tablet (50 mg total) by mouth every 2 (two) hours as needed for migraine. Maximum dose 200mg in 24 hours.

albuterol (PROAIR HFA) 90 mcg/actuation inhaler

Sig: Inhale 2 puffs into the lungs every 6 (six) hours. PRN shortness of breath or wheeze

albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution

Sig: Take 3 mL (2.5 mg total) by nebulization every 6 (six) hours as needed.

butalbital-acetaminophen-caff 50-325-40 mg per capsule

Sig: Take 1 capsule by mouth every 4 (four) hours as needed for pain (specific location in comments) or headache.

fluticasone propionate (FLONASE) 50 mcg/actuation nasal spray

Sig: 1 spray by Nasal route daily.

gabapentin (NEURONTIN) 800 MG tablet

Sig: Take 800 mg by mouth 4 (four) times a day.

Note (4/1/2017): Received from: External Pharmacy

lurasidone (LATUDA) 20 mg Tab

Sig: Take 20 mg by mouth daily.

mometasone-formoterol (DULERA) 100-5 mcg/actuation HFAA

Sig: Inhale 2 puffs into the lungs 2 (two) times a day. She did not know the dose. I called the pharmacy that she said

got

it from. They had no record of it.

montelukast (SINGULAIR) 10 mg tablet

Sig: Take 1 tablet (10 mg total) by mouth nightly.

raNITIdine (ZANTAC) 75 MG tablet

Sig: Take 75 mg by mouth daily.

sodium chloride (HYPERSAL) 7 % Nebu

Sig: Take 4 mL by nebulization 4 (four) times a day as needed.

traZODone (DESYREL) 50 MG tablet

Sig: Take 50 mg by mouth nightly.

Facility-Administered Medications: None

Discharge Medications

START taking these medications

Dose, Frequency, and Details

metoclopramide HCl 10 MG tablet Take 1 tablet (10 mg total) by mouth every 8

Also known as: REGLAN (eight) hours as needed for nausea.

nicotine 21 mg/24 hr Place 1 patch onto the skin daily.

Also known as: NICODERM CQ Last time this was given: 12/21/2017 8:51

Start taking on: 12/22/2017 AM

omeprazole 20 MG capsule Take 1 capsule (20 mg total) by mouth 2

Also known as: PriLOSEC (two) times a day.

sucralfate 100 mg/mL suspension Take 10 mL (1 g total) by mouth 4 (four)

Also known as: CARAFATE times a day with meals and nightly for 7 days.
Last time this was given: 12/21/2017 5:46 AM

CONTINUE taking these medications

	Dose, Frequency, and Details
* albuterol 90 mcg/actuation inhaler Also known as: PROAIR HFA	Inhale 2 puffs into the lungs every 6 (six) hours. PRN shortness of breath or wheeze
* albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution	Take 3 mL (2.5 mg total) by nebulization every 6 (six) hours as needed.
ALPRAZolam 0.25 MG tablet Also known as: XANAX	Take 0.5 mg by mouth 3 (three) times a day as needed for anxiety. Last time this was given: 12/21/2017 9:00 AM
butalbital-acetaminophen-caff 50-325-40 mg per capsule	Take 1 capsule by mouth every 4 (four) hours as needed for pain (specific location in comments) or headache.
EPIPEN 2-PAK 0.3 mg/0.3 mL auto-injector Also known as: EPINEPHrine	Dose: 0.3 MG; Form: Not available; Route: IM; Frequency: x1 PRN allergic reaction; Directions: Not available; Details: Dispense: 1 Pack(s); Date: 05/15/2015
fluticasone propionate 50 mcg/actuation nasal spray Also known as: FLONASE	1 spray by Nasal route daily. Last time this was given: 12/21/2017 8:48 AM
gabapentin 800 MG tablet Also known as: NEURONTIN	Take 800 mg by mouth 4 (four) times a day.
lurasidone 20 mg Tab Also known as: LATUDA	Take 20 mg by mouth daily. Last time this was given: 12/21/2017 8:49

AM

mometasone-formoterol 100-5 mcg/actuation Hfaa
Also known as: DULERA
Inhale 2 puffs into the lungs 2 (two) times a day. She did not know the dose. I called the pharmacy that she said got it from. They had no record of it.

montelukast 10 mg tablet
Also known as: SINGULAIR
Take 1 tablet (10 mg total) by mouth nightly.
Last time this was given: 12/20/2017 8:47 PM

raNITIdine 75 MG tablet
Also known as: ZANTAC
Take 75 mg by mouth daily.

sodium chloride 7 % Nebu
Also known as: HYPERSAL
Take 4 mL by nebulization 4 (four) times a day as needed.

SUMAtriptan 50 MG tablet
Also known as: IMITREX
Take 1 tablet (50 mg total) by mouth every 2 (two) hours as needed for migraine.
Maximum dose 200mg in 24 hours.

Dose, Frequency, and Details

traZODone 50 MG tablet
Also known as: DESYREL
Take 50 mg by mouth nightly.
Last time this was given: 12/20/2017 8:47 PM

* Notice: This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

Hospital Care Team

Service: Medicine

Inpatient Attending: Supapan Nualpring, MD

Attending phys phone: (978)354-2551

Discharge Unit: NSMPHIP6SH

Primary Care Physician: Meaghan C Kearns, MD 978-741-9500

Transitional Plan

Scheduled appointments:

Appointments Scheduled for Next 90 Days

Jan 09, 2018 10:30 AM EST 114r Highland Avenue

FOLLOW UP with James A MacLean, MD Salem MA 01970

Asthma and Allergy Affiliates (--) 978-745-3711

Jan 30, 2018 9:00 AM EST 81 Highland Ave.

Pft Comp No Abg with NSM SH PFT ROOM 1 Salem MA 01970

NSMC Pulmonary Function Test Lab (--) 978-354-4995

If you are able, please refrain from using your inhaler for 3 hours prior to the appointment. If you have any questions regarding your test, please call the PFT Lab at 978-354-4995. To cancel or change your appointment, please call Central Scheduling at 978-573-4444.

Feb 08, 2018 9:00 AM EST 55 Highland Ave

Follow Up with Sameer C Shah, MD Suite 104

NSP PULM SALEM 55 HIGS GROUP (NSP SALEM) Salem MA 01970

978-745-4489

Mar 08, 2018 10:30 AM EST 6 Essex Center Drive

Follow Up with Pooja Sofat, MD Suite 307

Essex Neurological Associates P.C. (--) Peabody MA 01960

978-532-8010

Your Follow-Up Appointments

NSM Salem Campus AGUIAR,CATHERINE F

Discharge Summaries by Supapan Nualpring, MD at 12/21/2017 9:58 AM (continued)

Meaghan C Kearns, MD 400 Highland Avenue

Specialty: Internal Medicine Suite 1

Relationship: PCP - General Salem MA 01970-1783

Insurance Assigned Provider Phone: 978-741-9500

Follow up in 1 week(s)

Jeffrey A Oringer, MD 102 Endicott St.

Specialty: Gastroenterology, Internal Medicine E102

Danvers MA 01923

Phone: 978-741-4171

Follow up in 2 week(s)

Instructions: please contact Dr. Oringer to set up egd

Signed Discharge Orders

None

Exam

Temperature: 35.8 ?C (96.4 ?F) (12/21/17 0750) Heart Rate: 69 (12/21/17 0750) BP: 140/85 (12/21/17 0750) Respiratory Rate: 22 (12/21/17 0750) SpO2: 99 % (12/21/17 0750) O2 Device: None (Room air) (12/21/17 0750) O2 Flow Rate (L/min): 2

Weight: 66.2 kg (146 lb) (12/18/17 2106) Height: 154.9 cm (5' 1") (12/18/17 2106) BMI (Calculated): 27.6 (12/18/17 2106)

General: NAD

HEENT: Extraocular movement intact, oropharynx clear

Heart: Regular rate and rhythm, no murmurs, rubs or gallops

Lungs: Clear to auscultation bilaterally, no wheezes or rhonchi

Abdomen: Soft, nontender, non-distended, bowel sounds present

Extremities: No peripheral edema

Skin: No visible skin rashes

Neurological exam: non focal neurological deficit

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Appropriate for age, Clear

Vision: Functional

Hearing: Functional

Assistive Devices: None

Data/Results

Discharge Summaries by Supapan Nualpring, MD at 12/21/2017 9:58 AM (continued)

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	8.93	12/21/2017 0653
RBC	4.12	12/21/2017 0653
HGB	12.2	12/21/2017 0653
HCT	36.7	12/21/2017 0653
MCH	29.6	12/21/2017 0653
MCV	89.1	12/21/2017 0653

PLT 268 12/21/2017 0653

RDW 14.8 (H) 12/21/2017 0653

Lab Results

Component Value Date/Time

NA 142 12/21/2017 0653

K 3.9 12/21/2017 0653

CL 105 12/21/2017 0653

CO2 27 12/21/2017 0653

BUN 5 (L) 12/21/2017 0653

CRE 0.83 12/21/2017 0653

CA 8.5 (L) 12/21/2017 0653

GLU 85 12/21/2017 0653

Routing History

Date/Time From To Method

12/21/2017 10:09 AM Supapan Nualpring, MD Meaghan C Kearns, MD In Basket

NorthShore Medical Center Salem Campus
Name:Samantha Burque
MRN:10001977
Account#:1089780892
Sex:Female
DOB:09/23/1982
Age:31 years
Arrival Date:06/11/2014
Time:12:42
Departure Date:06/11/2014
Time:16:27
Bed11
Salem Hospital ED Physician Documentation
HPI:
06/11 This 31 years old Caucasian Female presents to ER via EMS with mb11
13:57 complaints of Near Syncope.
13:57 31 F h/o IDDM, bipolar do, on Lithium, s/p hysterectomy c/o near mb11
syncope. Pt reports being in her USOH earlier today. She was at a clinic with her husband, who was having a tattoo removed. She went to stand up, then felt extremely lightheaded and collapsed. She did not actually lose consciousness. She was reportedly diaphoretic at the time. She denies any cp or palp. No sob. She had some nausea at the time, denies any at present. She was caught by her husband, never fell to or hit the ground. They

placed her in a chair and then lied her down. She continued to feel lightheaded for a period of time. She denies any ha. No visual changes, speech difficulties, focal weakness or numbness, vertigo, or ataxia. No abd pain. No urinary sx's. No vag bleed or dc..

14:06 Husband did not that pt had eaten only a very small breakfast today. He states she had not been eating well in the general. He states she also does not drink many fluids, using just drinks soda. Pt's BS was in the 90s when checked by EMS on scene. Pt denies h/o similar episodes in the past. Pt states she feels much improved at present, however still feels a little weak and lightheaded. Pt states she was not bothered by the procedure to remove her husband's tattoo, she has witnessed this in the past without any problems.. mb11

Historical:

- Allergies:

13:00 Geodon Allergies: Effexor Allergies: latex Allergies: Excedrin Migraine bw2

- Home Meds:

13:00 Novolog Sub-Q Home Meds: Zoloft Oral Home Meds: Lamictal Oral 150 mg twice a day Home Meds: Lisinopril Oral 10 mg daily bw2

- PMHx:

13:00 Diabetes - IDDM PMHx: Endometrosis PMHx: polycystic ovaries PMHx: Substance abuse PMHx: Pancreatitis PMHx: Migraines PMHx: Hypertension PMHx: Bipolar disorder bw2

- PSHx:

13:00 L breast lumpectomy PSHx: Hysterectomy(2012) bw2

- Social history: No barriers to communication noted. The patient speaks fluent English.
- The history from nurses notes was reviewed: and I agree with what is documented.

ROS:

06/12 All other systems are negative except as stated in the HPI. mb11
07:10

Exam:

07:11 Constitutional: Awake, alert, and in no acute distress. Head/Face: Normocephalic, atraumatic. Eyes: Pupils equal round and reactive to light. Non-icteric and not injected. Neck: Supple, full range of motion, no meningismus. Cardiovascular: Regular rate and rhythm. Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation. Abdomen/GI: Soft, non-tender, non-distended. No guarding or rebound. Back: No costovertebral tenderness. Full range of motion. Skin: Warm, dry. Normal color with no rash. MS/ Extremity: Normal appearance, atraumatic. Neuro: Orientation and mentation normal. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Psych: Behavior/mood is pleasant and cooperative. Affect is calm. Abdomen/GI: Rectal exam: Stool: brown, guaiac negative. mb11

Vital Signs:
06/11 BP 107 / 59; Pulse 93; Resp 18; Temp 99.4; Pulse Ox 95% on R/A; bw2
13:03 Pain 2/10;
14:26 BP 96 / 65 LA Supine (auto/reg); Pulse 89; jr6
14:28 BP 98 / 65 LA Sitting (auto/reg); Pulse 94; jr6
14:30 BP 94 / 64 LA Standing (auto/reg); Pulse 100; jr6
14:40 BP 101 / 64 LA Supine (auto/reg); Pulse 89; Resp 14; Temp 98.2; jr6
Pulse Ox 93% ; Pain 0/10;
15:04 Temp 98.0; bw2
16:11 BP 101 / 63; Pulse 92; Resp 16; Pulse Ox 97% on R/A; bs1

MDM:
14:43 ECG:. mb11
06/12 ED summary 31 F h/o IDDM, bipolar do, on Lithium, s/p mb11
07:13 hysterectomy c/o near syncope. Pt was in USOH, went to stand up while with her husband having his tattoo removed when she felt very lightheaded, collapsed but did not pass out. Here in the ED, pt was mostly back to baseline. She had low normal BP, although was not orthostatic. EKG NSR. CXR normal. s/p hysterectomy, so no possibility of pregnancy. Labs remarkable for mild anemia, which pt has had in the past, although decreased Hct from most recent priors. Stool guaiac neg. Potassium mildly decreased, repleted here in the ED. Unclear exact etiology of her episode, although most likely vasovagal in setting of poor po intake, not having eaten today. Pt continued to feel improved in the ED after IVF. She was fed a meal here.
07:13 ED summary Note also made of borderline elevated Lithium level. mb11
Spoke with Dr. Goldberg, pt's psychiatrist, who will lower pt's dose. Pt understands need to speak with him over the phone about dosing adjustments. Likely Lithium toxicity not related to current presentation given not significantly elevated level and sx's today were abrupt onset. Pt also advised to f/u with PMD re: her anemia. Advised rest, increased po fluids, counselled to not skip meals, esp in setting of taking Insulin. Routine counselling re: need to RTED if new or worsening sx's, any other problems or concerns at home.

13:06 Order name: CBC with Diff; Complete Time: 14:32 bw2
13:06 Order name: BUN; Complete Time: 14:32 bw2
13:06 Order name: Creatinine; Complete Time: 14:32 bw2
13:06 Order name: Electrolytes; Complete Time: 14:32 bw2
13:06 Order name: Glucose Random; Complete Time: 14:32 bw2
13:46 Order name: Urine Pregnancy Test; Complete Time: 15:29 mb11
13:56 Order name: Chest 2 views; Complete Time: 14:57 mb11
13:46 Order name: Ekg; Complete Time: 13:46 mb11
13:06 Order name: IV saline lock; Complete Time: 13:06 bw2
13:46 Order name: urine pregnancy test; Complete Time: 14:48 mb11
13:46 Order name: Nurse Ekg; Complete Time: 14:28 mb11
13:57 Order name: Orthostatic Vital Signs: PLEASE OBTAIN PRIOR TO IVF; mb11
Complete Time: 14:29
13:57 Order name: Feed patient; Complete Time: 15:41 mb11
13:58 Order name: Recheck vital signs: recheck temperature please; mb11
Complete Time: 14:40

Dispensed Medications:

06/11 Drug: NS 0.9% 1000 ml; Route: IV; Rate: bolus; Site: right wrist;bw2
15:04
15:32 Drug: Potassium Chloride 40 mEq; Route: PO; bw2

ECG:
14:43 Clinical impression: NSR at 89 bpm, normal axis, QTc 469 ms, mb11
Twave V1-V3 (old), Twave flattening (no significant changes from prior). Interpreted by me. Reviewed by me.

Point of Care Testing:
Urine Pregnancy:
14:49 hCG Reading: Negative; Control Reading: Positive; jr6
Disposition:
16:19 Disposition mb11
06/12 Chart complete. mb11
07:13

Disposition Summary:
06/11 Discharged to Home. Impression: Near Syncope, Dizziness, Unspecified, Anemia.
16:19 mb11
- Condition is Stable.
- Discharge Instructions: ANEMIA, Type Not Specified (Adult), DIZZINESS, Unk Cause, NEAR SYNCOPE, Vasovagal.

- Follow up: Private Physician; When: Within 1 week. Follow up: Emergency Department; When: As needed. Follow up: Bruce Goldberg; When: Tomorrow.
- Problem is new.
- Symptoms have improved.

- Notes: Please speak with your psychiatrist about lowering your dose of Lithium.

Signatures:

Dispatcher MedHost		EDMS
Suciu, Bogdan, RN	RN	bs1
Byrne, Mark, MD	MD	mb11
Westrick, Bethany, RN	RN	bw2

****

Brigham and Women's Faulkner Hospital
1153 Centre Street
Boston, MA 02130

Patient Name:WEBSTER,DANIEL J JR
Medical Record #:00959338
Provider Name:DEANE,ANDREW M.D. (FH ED PHY)
Service Date:04/10/14
Report No:0413-0284

EMERGENCY DEPARTMENT REPORT

HPI:

04/11
00:46 This 25 years old Caucasian Male presents to ER via Walk In with complaints of Psych Problem. cb3
00:46 The patient presents to the emergency department with paranoia, a history of substance abuse. 25 yo with long history of bipolar schizoaffective d/o and repeated close head injury from BMX biking, presents with decompensated psych status. He is wandering around and near his grandmother's house with his shirt off, hypervigilant and hearing voices. He is chronically noncompliant with meds refused ongoing oral risperdal or depo injections. He smokes a lot of weed per the mother. He is not suicidal or homicidal but there are reports of aggressive behaviors in the past with punching walls. He has not eaten and always becomes disheveled (and not showering) for days when he is off his meds.. cb3

Historical:
- Allergies: No known drug Allergies;
- Home Meds:
1. Risperdal Oral
2. Trazodone Oral
- PMHx: BIPOLAR DISORDER; SCHIZOPHRENIA;
- Immunization history: Unknown.
- Family history: Not pertinent.
- Social history: Smoking status: unknown.
- Social history:: Patient uses street drugs, marijuana, The patient/guardian denies using tobacco, alcohol, IV drugs.
- Hospitalizations: No recent hospitalization is reported.
- History obtained from: mother, mother Michelle O'Leary 617-224-6047
.

ROS:
00:50 All other systems were reviewed and are negative, except as noted. cb3
All other systems were reviewed and are negative, except as noted. Unable to obtain ROS due to altered mental status, patient being uncooperative.

Exam:
00:51 Constitutional: This patient appears well and is awake in no acute distress. cb3
Cardiovascular: Normal s1/s2 no murmurs or gallups
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions.
Abdomen/GI: Abdomen is normal in appearance without scarring or abdominal wall lesions. It is soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Skin: Warm, dry. Normal color with no rashes, no lesions, and no evidence of cellulitis.
00:51 MS/ Extremity: No signs of trauma or deformity. Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. cb3
00:51 Psych: Behavior/mood is anxious, Affect is flat, Oriented to person, place, time, Patient has no thoughts/intents to harm self or others. Judgement / Insight is impaired. Delusions/hallucinations are present and described as AH with no clear message..

Vital Signs:
04/10
19:22 BP 145 / 86; Pulse 114; Resp 16; Temp 98.3; Pulse Ox 97% on R/A; lt
Weight 72.57 kg; Height 5 ft. 5 in. (165.10 cm); Pain 0/10;
04/11
00:15 BP 129 / 91; Pulse 119; Resp 20 S; Pulse Ox 98% on R/A; dj
02:15 BP 116 / 74; Pulse 100; Resp 16 S; Temp 97.2(O); Pulse Ox 97% on R/A; re
07:22 BP 127 / 83; Pulse 95; Resp 14; Temp 97.8; Pulse Ox 99% on R/A; wd
04/10
19:22 Body Mass Index 26.63 (72.57 kg, 165.10 cm) lt

MDM:
04/10
19:21 Patient medically screened. cb3
04/11
00:52 Differential diagnosis: psychosis secondary to non-compliance. Data cb3
reviewed: vital signs, nurses notes, old medical records. Counseling:
I had a detailed discussion with the patient and/or guardian
regarding: the historical points, exam findings, and any diagnostic
results supporting the discharge/admit diagnosis, Patient was also
instructed to follow up with their PCP. radiology results, the need
for outpatient follow up, the need for further work-up and treatment
in the hospital. ED course: consulted psychiatry, they recommended
risperdal and ativan. Will need admission. Section 12, patient cannot
leave. Will given ativan and risperdal as needed for agitation.
Awaiting full medical clearance for psychiatry..
06:08 ED course: took over care of patient, labs were sent after the ativan hs
po was given, and patient is medically cleared. psych aware and
looking for bed placement. .

04/10
22:18 Order name: URINE TOX cb3
04/10
22:18 Order name: CBC; Complete Time: 03:32 cb3
04/10
22:18 Order name: BMP cb3
04/10
19:32 Order name: Electrocardiogram (9372); Complete Time: 19:33 cb3
04/10
19:32 Order name: Ekg; Complete Time: 23:07 cb3

Dispensed Medications:
04/10
23:07 Drug: Risperdal Tablet 1 mg; Route: PO; dj
04/11
01:23 Follow up: Response: No adverse reaction dj
01:09 CANCELLED (Duplicate Order): Ativan Tablet 1 mg PO once cb3
01:23 Drug: Ativan Tablet 1 mg; Route: PO; dj
03:36 Follow up: Response: No adverse reaction dj
07:39 Drug: Risperdal Melting Tablet 1 mg; Route: PO; wd
09:41 Follow up: Response: No adverse reaction wd

Disposition:
00:53 Chart complete. cb3

Disposition:
04/11/14 07:40 Transfer ordered to Mclean Hospital. Diagnosis is Schizoaffective Disorder - Decompensated.
- Reason for transfer: PSYCHIATRY.
- Accepting physician is Dr Murphy.
- Condition is Stable.
- Problem is an acute exacerbation.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS
Deane, Andrew, MD	MD ad
Durant, William, RN	RN wd
Traft, Lorraine, RN	RN lt
Jasset, Donna, RN	RN dj
Brown, Calvin, MD	MD cb3
Stoklosa, Hanni, MD	MD hs

Corrections: (The following items were deleted from the chart)
01:09 01:09 Ativan Tablet 1 mg PO once ordered. cb3 cb3

****
Electronically Signed By: DEANE,ANDREW M.D. (FH ED PHY) Date: 04/11/14 Time: 0942

***This text report has been converted from the report, '2430909761.pdf'. Content may not appear exactly as it appe ars in the original .pdf. For a download of original content and format (pdf), please contact the RPDR Team at RPD RHelp@partners.org. ***

MGH Main Campus McManus, Cullen

55 Fruit St. MRN: 5730207, DOB: 1/13/1982, Sex: M

Boston MA 02114-2621 Acct #: 6096918241

ADM: 4/23/2019, D/C: 4/29/2019

Patient Information

Patient Name	Sex	DOB
McManus, Cullen	Male	1/13/1982

Discharge Summary by Stuart E Beck, MD at 4/25/2019 5:40 PM

Author: Stuart E Beck, MD Service: Psychiatry Author Type: Physician

Filed: 5/16/2019 2:00 PM Date of Service: 4/25/2019 Status: Addendum

5:40 PM

Editor: Stuart E Beck, MD (Physician)

Related Notes: Original Note by Lauren N Deaver, MD (Resident) filed at 5/15/2019 6:50 P M

MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL

MGH Medical Psychiatry Discharge Summary

Admit date: 4/23/2019

Discharge date: 4/29/2019

PATIENT: Cullen McManus, (DOB= 1/13/1982)

DISCHARGE DIAGNOSES: Complex PTSD, Major Depressive Disorder

REASON FOR HOSPITALIZATION:

37 year old transgender male with history of significant trauma, PTSD, mood disorder, and multiple psychiatric hospitalizations brought in on S12 by OP psychiatrist presenting with suicidal ideation and plan (to take 3 g of stockpiled propranolol). The patient was hospitalized for safety and containment, crises stabilization, and to target suicidal ideation and mood symptoms.

Code Status at Discharge: Full Code (Presumed)

Advanced Directive and Surrogate Decision Maker Status: Patient declined to name or complete healthcare proxy and psychiatric advance directive

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Hospital Course by Problem

The patient was admitted to the locked inpatient, psychiatric unit on Blake 11 at MGH for further evaluation and treatment of suicidal ideation with plan. The patient was admitted under involuntary. legal status. The attending physician of record was Dr. Jeffery Kerner.

The patient presented with the following issues on admission:

1. Complex PTSD, MDD with Suicidal Ideation

Patient presented to outpatient psychiatry appointment on 4/23/19. At appointment, reported provider that he was stockpiling prescribed propranolol with intent to take overdose. Endorsed depressed mood, low energy, and poor sleep with increased thoughts of suicide over past week in setting of increasing

Discharge Summary by Stuart E Beck, MD at 4/25/2019 5:40 PM (continued)

anxiety and stressors including divorce with wife and chronic pain. Also endorsed increasing PTSD symptoms including flashbacks, nightmares, and heightened anxiety. Brought to ED on section 12. Denied current SI to admitting providers, that he didn't want to die but that he wanted to want to die and did confirm stockpiling. Admitted for safety concerns, further evaluation. Irritable at being admitted. The patient's current presentation appears to be most consistent with complex PTSD, complicated by MDD and personality vulnerabilities related to management of interpersonal distress.The patient?s complex PTSD, depressed mood, and suicidal ideation was addressed in a multimodal fashion. Specifically, medication treatment included initiation of trial of mirtazapine for depressed mood and psychotherapeutic interventions included groups from psychology and occupational therapy and one-on-one meetings with psychology. In addition, the patient's home medications of Valium, Adderall, Marinol, Propranolol and Gabapentin were continued over the course of the admission. Significant psycho-education provided on the relative contraindication of benzodiazepines in the setting of PTSD. Patient acknowledged information, but did not feel ready to start transition off Valium. Discussed prevalent mood symptoms and offered initiation of mirtazapine for treatment of mood symptoms as patient has not previously tried this medication. Started Mirtazapine and up-titrated to 15mg nightly. Well-tolerated without side-effects noted. Patient also expressed interest in TMS, outpatient referral to McLean TMS program provided. Also provided psycho-education on stimulant use and cannabis use. Patient in pre-contemplative phase of change and unready to make changes to these medications at this time.

Worked to establish safety plan, plan for safe management of prescribed propranolol and outpatient care plan. Patient willing to see PCP and counselor associated with trans-gender health clinic with plan to connect to psychiatry through referral already in place though transgender health clinic. Patient experienced improvement in suicidal ideation noting hope for the future and a wish to live. However, Patient acknowledged understanding and agreement with plan, particularly importance of reaching out to providers as needed.

2. Chronic Pain: Patient with history of chronic left facial, left arm, and pelvic pain secondary to surgerical interventions. Continued on home medications. Obtained defecography to prevent patient from missing necessary medical appointment related to surgical revision.

3. Transition Maintenance: Female to male trans-gendered patient on horomone therapy. Received Testosterone injection 140mg on 4/25/19. Next injection due 5/9/19.

3. Medical issues. The patient?s medical status was stable throughout hospitalization.

4. Procedures and testing preformed during hospitalization: Routine laboratory testing was performed during hospitalization and results are below. Notable laboratory or imaging findings included defecography revealing presence of rectocele, enterocele, and abnormal pelvic floor descent. Will attend scheduled follow-up with urogynocology on 4/29/19 discuss imaging findings and treatment options. There are no pending studies at discharge

Lab Results

Component	Value	Date
WBC	6.79	04/23/2019
RBC	5.70	04/23/2019
HGB	17.4	04/23/2019
HCT	51.9	04/23/2019
PLT	283	04/23/2019

Discharge Summary by Stuart E Beck, MD at 4/25/2019 5:40 PM (continued)

Lab Results

Component	Value	Date
NA	138	04/23/2019
K	4.6	04/23/2019
CO2	24	04/23/2019

BUN	12	04/23/2019
CRE	0.95	04/23/2019
UCRE	67	04/23/2019

Lab Results

Component	Value	Date
TP	7.3	04/11/2019
ALB	4.3	04/11/2019
GLOB	3.0	04/11/2019
SGOT	17	04/11/2019
SGPT	24	04/11/2019
ALKP	52	04/11/2019
TBILI	0.4	04/11/2019

Lab Results

Component	Value	Date
TSH	0.84	12/04/2018

Lab Results

Component	Value	Date
B12	469	12/04/2018

No results found for: FOLATE

Results for orders placed or performed during

the hospital encounter of 04/23/19

Toxicology screen, urine

Result	Value
URINE	Negative
BARBITURATES	
URINE	Positive (*)
CANNABINOIDS	
URINE	Negative

AMPHETAMINES

URINE Positive (*)

BENZODIAZEPINE

URINE OPIATES Negative

URINE COCAINE Negative

METAB

URINE 67

CREATININE

Imaging:Fl Defecography

Result Date: 4/24/2019

FL DEFECOGRAPHY

TECHNIQUE:

Patient was informed of the nature of the procedure. Oral contrast was given before the exam to opacify the small bowel. Subsequently, paste like barium contrast was administered rectally. Radiopaque marker was placed on the external perineum.

Fluoroscopy and spot images were obtained in the lateral projection with patient in sitting position while at rest, bearing down, and during defecation.

FINDINGS:

Scout radiograph: Normal appearing opacified small bowel loops.

Kegel maneuver: Slight change in anorectal angle during Kegel maneuver.

Strain: There was no evidence for incontinence. Puborectalis straightens/contracts.

Presence and location of rectocele: Rectocele measured 1.5 cm and demonstrated immediate and complete emptying.

Presence and location of intussusception: There is a mucosal thickness intussusception.

Presence of enterocele/omentocele: There is an enterocele.

Evacuation: There is exaggerated abnormal pelvic floor descent.

Presence/absence manipulation: Not applicable.

Abnormal exaggerated pelvic floor descent with evacuation.

Anterior rectocele measuring up to 1.5cm with immediate and complete emptying.

Small mucosal thickness intussusception.

Enterocele.

DISCHARGE MEDICATIONS & INDICATIONS:

Medication List

TAKE these medications

	Instructions
* dextroamphetamine-amphetamine 20 MG 24 hr capsule Commonly known as: ADDERALL XR Last time this was given: Ask your nurse or doctor	Take 1 capsule (20 mg total) by mouth every morning for attention and concentration.
* dextroamphetamine-amphetamine 20 mg Tab tablet Commonly known as: ADDERALL	Take 1 tablet (20 mg total) by mouth daily as needed for attention and concentration.

Instructions

Last time this was given: Ask your nurse or doctor

diazePAM 5 MG tablet
Commonly known as: VALIUM
Take 1 tablet (5 mg total) by mouth 3 (three) times a day as needed for anxiety.
Last time this was given: 4/29/2019 8:28 AM

dronabinol 5 MG capsule
Commonly known as: MARINOL
Take 1 capsule (5 mg total) by mouth 2 (two) times a day before meals for appetite stimulation.
Last time this was given: 4/29/2019 12:30 PM

gabapentin 300 MG capsule
Commonly known as: NEURONTIN
Take 1 capsule (300 mg total) by mouth 3 (three) times a day as needed for pain.
Last time this was given: 4/29/2019 1:18 PM
What changed: when to take this

lidocaine 2 % Soln
Commonly known as: lidocaine
Use as directed 15 mL in the mouth or throat every 4 (four) hours as needed for mouth pain.
Last time this was given: Ask your nurse or doctor

lidocaine 4 % cream
Commonly known as: LMX 4
Apply topically as needed. Please apply to the affected areas of the perineum for pain.
Last time this was given: Ask your nurse or doctor

mirtazapine 15 MG tablet
Commonly known as: REMERON
Take 1 tablet (15 mg total) by mouth nightly at bedtime for 14 days for depressed mood.
Last time this was given: 4/28/2019

8:23 PM

omeprazole 20 MG capsule Take 20 mg by mouth 2 (two) times a day

Commonly known as: PriLOSEC for GERD.

Last time this was given: 4/29/2019

8:29 AM

ondansetron 8 MG disintegrating tablet Take 1 tablet (8 mg total) by mouth every 8 (eight) hours as needed for nausea.

Commonly known as: ZOFRAN-ODT

Last time this was given: 4/27/2019

1:49 PM

polyethylene glycol 17 gram packet Take 17 g by mouth daily for constipation.

Commonly known as: MIRALAX

propranolol 60 MG immediate release tablet Take 60 mg by mouth 2 (two) times a day as needed for anxiety, PTSD symptoms.

Discharge Summary by Stuart E Beck, MD at 4/25/2019 5:40 PM (continued)

Instructions

Commonly known as: INDERAL

Last time this was given: 4/29/2019

1:18 PM

senna 8.6 mg tablet Take 1 tablet by mouth daily for constipation.

Commonly known as: SENOKOT

Last time this was given: 4/28/2019

8:23 PM

testosterone enanthate 200 mg/mL Inject 0.7 mL (140 mg total) into the muscle

injection every 14 (fourteen) days for transition.

Commonly known as:

DELATESTRYL

Last time this was given: Ask your

nurse or doctor

* This list has 2 medication(s) that are the same as other medications

prescribed for you. Read the directions carefully, and ask your doctor or other

care provider to review them with you.

Where to Get Your Medications

These medications were sent to OSCO

PHARMACY #2583 - BELMONT, MA - 535 535 TRAPELO RD, BELMONT MA

TRAPELO RD 02478

Phone: 617-489-6542

? mirtazapine 15 MG tablet

MULTIPLE ANTIPSYCHOTICS

The patient was NOT discharged on multiple antipsychotics

ANTIPSYCHOTIC METABOLIC MONITORING

The patient is not being discharged on as needed or standing antispychotics and metabolic monitoring is not indicated

GLUCOSE

Date	Value	Ref Range	Status
04/23/2019	103	70 - 110 mg/dL	Final

HEMOGLOBIN A1C

Date	Value	Ref Range	Status
12/04/2018	5.2	4.3 - 6.1 %	Final

Lab Results

Component	Value	Date
CHOL	183	03/14/2019

HDL	43	03/14/2019
LDL	110	03/14/2019

TRIG	151 (H)	03/14/2019
CHOLHDL	4.3	03/14/2019

SAFETY ASSESSMENT

The patient was at elevated risk for self-harm on admission due to active symptoms of active suicidal ideation, recent suicide attempt and active substance use and withdrawal. However, since admission, the patient has has had improvement of symptoms as evidenced by reduction in suicidal ideation, help seeking behaviors, engagement with psychology and OT and has had resolution of acute stressors, including mild improvement in anxiety . The patient engaged in treatment (groups, individual work) on the unit, and has taken and tolerated medications. Finally, over the course of the hospitalization, the patient became more hopeful, more engaged, and more future-oriented, as evidenced by plans to attend necessary medical appointments, finalize divorce, and begin to plan move out of current housing.

The patient is at high chronic risk for harm to self and/or others as compared to the general population given history of ongoing static risk factors of minimal support system, chronic stressors including financial difficulties and ongoing divorce,, suicide attempts, self injurious behavior, psychiatric hospitalization, history of substance use and history trauma. Despite this the patient is currently protected by future-oriented thinking, , connection to treaters and adherence to treatment. The patient no longer demonstrates risk warranting inpatient psychiatric hospitalization and their chronic elevated risk for self-harm will be best addressed through longitudinal outpatient psychiatric care to target complex PTSD and related mood symptoms. Patient is able to articulate a plan to reach out for help from providers and family if symptoms worsen and to go to an emergency room or call 911 if feeling unsafe.

PATIENT INSTRUCTIONS AND DISCHARGE PLAN

Medication prescriptions were given to patient as per the discharge form.

All questions were answered, and discharge instructions were given in writing to the patient in the form of Patient AVS.

Emergency contact information was given to the patient if needed in the future.

Outpatient providers have been notified about the discharge.

Patient discharged in stable condition to home with planned outpatient follow-up with PCP and therapist, with plan to establish psychiatrist.

AFTERCARE PLAN

Apr 29, 2019 4:15 PM EDT 55 Fruit St.

Urgent Follow Up with Milena M Weinstein, MD Yawkey Ste. 4E

MGH Vincent Urogynecology (--) Boston MA 02114

857-238-8496

Apr 30, 2019 10:00 AM EDT 55 Fruit St.

Non Billable Patient Care with Melanie Joy Cohn- Boston MA 02114

Hopwood, LICSW 617-726-2643

MGH Social Service Department (--)

Arrive at: CHECK-IN AT: Social Service Founders

6

May 01, 2019 3:30 PM EDT 55 Fruit St.

(Arrive by 3:15 PM) Bartlett Hall Extension 4th Fl.

Follow Up with Robert H Goldstein, MD, PhD Boston MA 02114

Massachusetts General Hospital (--) 617-643-7210

May 06, 2019 11:00 AM EDT 55 Fruit St.

FL UROGRAPHY RETROGRADE with MGH Ellison 2

RF2E2 BOSTON MA 02114

MGH Radio Fluoroscopy, Ellison 2 (MGH Boston - 617-726-8314

Main Campus)

You do not need to prepare in any way for this exam.

Please make childcare arrangements in advance. Children cannot be left unattended in the exam rooms, lobbies, waiting areas or hallways. Please note that a child needs supervision by an adult other than a patient when in the exam room.

May 13, 2019 4:00 PM EDT 165 Cambridge St.

(Arrive by 3:45 PM) 7th Fl.

ESTABLISHED PATIENT with Anton Wintner, MD Boston MA 02114

Department of Urology (MGH UROLOGY CRP) 857-238-3838

May 22, 2019 1:00 PM EDT 15 Parkman St.

New Patient with Gregory A Acampora, MD Wang Ste. 340

MGH Center for Pain Medicine (--) Boston MA 02114

617-726-8810

May 28, 2019 1:15 PM EDT 15 Parkman St.

Follow Up with Gary J Brenner, MD, PhD Wang Ste. 340

MGH Center for Pain Medicine (--) Boston MA 02114

617-726-8810

Jun 06, 2019 3:00 PM EDT 50 Staniford St.

(Arrive by 2:45 PM) Boston MA 02114

New Patient with Flavia Fedeles, MD 617-726-2914

MGH Medical Dermatology (MGP MED

DERMATOLOGY BOSTON)

Jun 10, 2019 1:00 PM EDT 15 Parkman St.

New Patient with Ronald Jon Kulich, PhD Wang Ste. 340

MGH Center for Pain Medicine (--) Boston MA 02114

617-726-8810

Jun 20, 2019 1:30 PM EDT 55 Fruit St.

(Arrive by 1:15 PM) Bartlett Hall Extension 4th Fl.

Follow Up with Robert H Goldstein, MD, PhD Boston MA 02114

Massachusetts General Hospital (--) 617-643-7210

TOBACCO CESSATION AFTERCARE: The patient did NOT use tobacco prior to admission

ALCOHOL OR OTHER DRUG USE DISORDER AFTERCARE: Referral for outpatient additions treatment and

Cessation pharmacotherapy at discharge:

The patient did have a substance use disorder. 1. Referral to outpatient addictions treatment The patient refused offer of outpatient addictions treatment such as IOP/PHP or other substance use focused care. 2. Pharmacotherapy The patient was noted to be using marijuana. There is no FDA approved pharmacotherapy to treat this substance use disorder.

Additionally, the patient was provided the following information:

MGH Main Campus McManus, Cullen

55 Fruit St. MRN: 5730207, DOB: 1/13/1982, Sex: M

Boston MA 02114-2621 Acct #: 6096918241

ADM: 4/23/2019, D/C: 4/29/2019

Discharge Summary by Stuart E Beck, MD at 4/25/2019 5:40 PM (continued)

Attending of record was Dr. Stuart Beck. If there are any questions regarding admission, please reach the attending by calling the unit directly at 617-724-9110.

IN THE CASE OF AN EMERGENCY: If the patient has thoughts of harming him/herself or anyone else, call 911 or recommend they go to the nearest emergency room immediately.

USA National Suicide Hotlines 1-800-SUICIDE (1-800-784-2433)

1-800-273-TALK (1-800-273-

8255)

Samaritan?s Hotline 1-877-870-4673

Boston Emergency Services 1-800-981-4357

SafeLink 1-877-785-2020

Alcoholics Anonymous 1-617-426-9444

Narcotics Anonymous 1-866-624-3578

Detox Hotline 1-800-327-5050

The patient's transition record has been communicated to the next level of care provider(s).

The CCP includes the discharge medications, after care recommendations, principle diagnoses, and reason for

hospitalization.

NORTH SHORE MEDICAL CENTER
SALEM HOSPITAL

PATIENT NAME: Berardino, Emily MR: 00-45-86-40

DATE OF ADMISSION: 12/06/2007 BILLING NUMBER: 1042148542

EMERGENCY PHYSICIAN: Hon H Yee, M.D.

TIME SEEN: 7:55 p.m.

CHIEF COMPLAINT: Headache for 48 hours and also dizziness, feeling like "going to pass out", also 10 weeks pregnant.

HISTORY OF PRESENT ILLNESS: The patient is a 23-year-old female who states that she has a 1 week history of migraine headache which seemed to come on suddenly, then decrease suddenly. This lasts a various amount of time. The pain is over bilateral temple and the forehead area. The patient has a prior history of migraine headache and this feels the same. The patient denied any neurological symptoms except for that she has weakness in bilateral knees and she nearly fell, but there was no loss of consciousness. The patient also had dizziness half an hour prior to admission which she described as both vertiginous and lightheadedness. Patient also has numbness in bilateral feet and toe which is also intermittent.

Problem #2 is that the patient states she is 10 weeks pregnant. She is gravida 4, para 0, spontaneous abortion 3. Last menstrual period was August 18, 2007, but she has irregular periods and her date is by ultrasound. There is no abdominal pain. There is no vaginal discharge or vaginal bleed. She has been seen by a gynecologist and scheduled to see the obstetrician at North Shore Community Health. Her intake is in another 5 days. She has nausea, vomiting all she eats for the last 2 months and she has increased nausea, vomiting over the last week. She had an ultrasound both 4 weeks ago and 2 weeks ago which was shows that she was 7 weeks pregnant.

ALLERGIES: LAMICTAL, PAXIL, NEURONTIN, RISPERDAL, THORAZINE, CIPRO, AND BIAXIN.

PAST MEDICAL HISTORY: Significant for bipolar disease, herpes genitalia, and a history of migraine.

CURRENT MEDICATIONS: Acyclovir, Haldol, Zoloft, and Cogentin. The patient indicates to me that she is on Fioricet for her migraine headache.

REVIEW OF SYSTEMS: All negative. Review of the medical record shows the patient to have a series of betas; on October 23 it was 30. On October 25 it was 58. On October 30 it was 677. On November 1 it was 1894. She had an ultrasound on November 6 which shows 5 weeks 5 days IUP and on November 20 it was 7 weeks and 3 days IUP. The patient also has a history of bipolar disease and with poor judgment, was admitted to psychiatry with audio and visual hallucination. Review of systems all negative.

PHYSICAL EXAMINATION: Shows a well-developed, well-nourished female in no acute distress. Blood pressure 120/83, pulse of 99, respiratory rate is 18, O2 sat on room air 97, temperature is 98.4. Head is atraumatic, normocephalic. Neck is supple with no Kernig or Brudzinski. Thyroid is not palpable. Chest is clear. Cardiac exam reveals a regular rhythm and rate. Normal S1-S2. No murmur, rub, gallop, JVD, HJR. Abdominal exam shows an obese abdomen. No pain to palpation. No rebound. Extremities showed no clubbing, cyanosis, or edema. Neurologic exam showed cranial nerves II-XII intact. Sensation and strength normal. Deep tendon reflexes bilaterally 1-2+. Babinski's are flexor.

The patient's urinalysis shows specific gravity 1.029 with no ketones.

TREATMENT: The patient was started on IV D5 1/2 normal saline and also patient given Reglan 10 mg IV for both her headache and nausea. She continued to have headache, although nausea is improved. She was given Fioricet 2 p.o. which decreased her headache. The patient will then be discharged.

DISCHARGE DIAGNOSES:
1. Migraine headache.
2. Hyperemesis of pregnancy.

The patient was given a prescription for Phenergan 12.5 mg q.8h p.r.n.

DISCHARGE INSTRUCTIONS: Multiple small food and fluid bolus. Phenergan as needed. Follow up with own gynecologist if not better in 5 days. Return to the emergency room with dehydration or more headache. Fioricet if needed.

Electronically Signed
Hon H Yee, M.D. 01/06/2008 19:47
Hon H Yee, M.D.

HHY:DDI

DD: 12/06/2007 11:48 P
DT: 12/07/2007 6:16 A
Job: 000327372
Doc#:
cc:
DISCHARGE SUMMARY

NAME: WHALEN, KELLEY UNIT NUMBER: 203-62-17
DOB: 11/19/1975 FLOOR: B11 B1186B
ADMISSION DATE: 12/18/2015 DISCHARGE DATE: 12/24/2015

PRINCIPAL DIAGNOSIS
Psychotic disorder

ASSOCIATED DIAGNOSES
Polysubstance dependence

SIGNIFICANT OPERATIONS/PROCEDURES/TESTS PERFORMED DURING HOSPITALIZATION
Operations/Procedures:
None
Labs/Imaging/Other Tests:
You had basic labs drawn during your hospitalization that were normal.

LIFE-SUSTAINING TREATMENT (CODE STATUS) AT DISCHARGE
Full Code (discussion with patient/surrogate not appropriate or possible at this time) Entered by: Julia C. Cromwell, M.D.

ALLERGIC REACTIONS, INTOLERANCES AND SENSITIVITIES
NKA: No Known Allergies

CHIEF COMPLAINT
Psychosis

HISTORY AND REASON FOR HOSPITALIZATION AND SIGNIFICANT FINDINGS
Ms. Whalen is a 40yo F with history of unclear mood disorder and psychotic disorder and opiate dependence on Suboxone, recently discharged McLean in September and Blake 11 in August, w/ numerous hospitalizations and 1 SA several years ago, brought in by her boyfriend by recommendation of outpatient psychiatrist due to self-injurious behavior and visual hallucinations.

To treat the (hand) infection she also added bleach and water to the area which resulted in an ulcer. She recently saw her PCP who prescribed Keflex. However, she endorses that lately she has not been doing as well, is concerned that her house is contaminated and needs to be fumigated or burned down. She also has been hearing voices at times but last time was 1 week ago. She also has been having visual hallucinations like seeing things in the carpet and pictures on the wall that aren't there. She reports that she has occasional alcohol use as well as relapse to cocaine, which prompted DCF involvement. The patient's 2 year old daughter is living with the grandmother at

this point. On psych ROS, she endorses OK mood. She denies any depressive symptoms aside from occasional poor sleep. She denies manic symptoms or anxiety. Psychotic symptoms as above. Spoke to patients significant other Ralph 617.549.3209 who states that she has been battling mental illness more so over the past year. He states that the wound on hand is self-inflicted because she is concerned that her hand is infected. She has been seeing things and hearing voices in the past week, is concerned about everything being contaminated and has concerns about poisoning as well as bugs in the wall. Confirmed last hospitalization was at McLean in Sept. He spoke with Dr. Freeman who suggested that the patient be brought in and that she needs inpatient hospitalizations. He states that she has been taking medication intermittently but not reliably. Confirmed that her daughter is safe with the grandmother at this time. Says that she has been drinking occasionally but not too excess. Collateral Dr. Freeman outpatient psychiatrist. Pt missed last appt this week. Has recently relapsed with drugs. Pt also has some unknown psychotic disorder which is of unclear etiology, may be related to substances or stopping of medications, but that he is unclear if she has ever had any manic episodes in the past. Has had numerous hospitals this year. He confirmed patient's medication regimen. He has concerns about her safety given her disorganized state and inability to care for self. Believes that the daughter has been safe with Grandmother in the past.

The patient spent about three days in the APS waiting for an inpatient bed. Upon admission to the unit, she reiterated the above story, but feels that her psychosis has improved since admission to the APS. Her main concern is that she doesnt want to miss Christmas with my daughter, but she agrees that she needs help and signed in voluntarily to the unit. She says that while she saw black sticky bugs on her rug at home, and a black dot that looked like a tick on her hand prior to bleaching it, she has not had visual hallucinations since being admitted to the APS. She also denies auditory hallucinations, suicidal ideation, or homicidal ideation. She says that her current mood is up and down, and mostly sad currently because she may still be inpatient during Christmas. Her appetite has been poor recently and she endorses anhedonia and increased sleep from 8 hours to 10 hours each evening.

Past Psychiatric History:
Dx: BPAD and opiate dependence, MDD with psychotic features
Hospitalizations: Numerous hospitalizations this year, Blake 11 in August, McLean in September
SA: 1 years ago, via OD of medication after a fight with SO which required police had to find patient wandering neighborhood w/ observation and pumped stomach in ED then had seizure requiring medical hospitalization at which time he took her back and then they had child together
Med trials: Zoloft, Celexa, never tried anything long enough to see if it was helpful. Has been on Risperdal, Zyprexa, and Abilify in the past.

Abuse:
The patient endorses physical abuse by her mother when she was

younger (My mom had alcohol problems.)

Substance Abuse History:
Per prior notes 1PPD ETOH: denies recent use but has had occasional 3-4 beers at a time. Denies any withdrawal history Opioid abuse on Suboxone. Has abused cocaine, marijuana in the past and been dependent on opiates (snorting percocet for the past 9 yrs).

Past Medical and Surgical History:
Thyroid nodule
Substance abuse
Posttraumatic stress disorder
Paranoia
Depression
S/P Caesarean section

Allergies/Adverse Drug Reactions:
NKDA

Medications:
Confirmed with Rite Aid Everett
Klonopin 1mg TID 12/18/15 Dispense 90
Suboxone 8/2mg Dispense 7 12/15/15
Latuda 80mg QHS Dispense 30 days
Keflex 500mg QID 12/15/15 7 days
Mucipurin 2% Topical BID for 10 days
Psychiatrist confirms that she is written for 75mg total of Adderall daily, split in to 3 doses.

Pt states that she took her Klonopin and Latuda prior to arrival, but that she is only intermittently medication compliant at home. I just forget sometimes.

Family History:
Mother with BPAD Three sisters hospitalized for mental illness. No family history of suicide attempt.

Social History:
Per APS note:
Lives with boyfriend Ralph and intermittently with their 2 year old daughter, though she stays at her GMAs house as well at times. Patient smokes 1 PPD. Per Fiance, had traumatic experiences as child because mother had alcohol and drug problem and she was bounced around between other family members homes. She is currently unemployed.

Legal:
Prior assault and battery charge against her from her boyfriend, no active issues. DFC is involved because of her cocaine usage in the past, and she is not suppose to be alone with her daughter.

Review of Systems X09
Negative upon multi-system review.

Physical Exam X09

Vital Signs: T97.8, HR91, BP109/73, RR18 SaO2 100%
General: Alert, oriented to person, date, and place. NAD
ENT: Mouth without inflammation or exudates
Neck: Full ROM, no stiffness or tenderness, no lymphadenopathy
Chest/Respiratory: CTAB. No wheezes, rales, or rhonchi.
Cardiovasular: RRR. No murmurs, rubs, or gallops.
GI/Abdomen: Soft, normal bowel sounds. Slightly distended.
Nontender. No guarding.
Musculoskeletal: No edema.
Skin: Healing wound on hand, covered with Kerlix during examination.
Neurologic: Normal gait. X09

During recent hospitalizations: HIV non-reactive (6/16/15,) trep Ab negative (6/19/15,) B12 881 (8/16/15,) folate 16 (8/16/15,) TSH 1.31 (8/16/15)
X09 X09 X09
Hospital Legal Status:
Pt was offered and signed a conditional voluntary (Section 10 and 11). CV was accepted by MD. Pt was given civil right packet and notice of rights for legal consultation.

Mental Status Exam on Admission:
Appearance: Lying in bed, wearing hospital pajamas, appears older than stated age, poor skin and dentition, bandage on hand
Gait / Muscle Tone: Normal
Attitude: Pleasant and cooperative but restricted
Speech: Normal rate and rhythm, answers questions mostly in short sentences
Language: Normal syntax and diction
Motor: No abnormalities
Mood: Sad
Affect: Congruent, blunted
Thought Process: Linear
Thought Content: Denies SI/HI
Associations: Normal at present, although per report loose in recent past
Perceptions: Denies delusions, AH/VH currently, does not appear to be internally preoccupied
Orientation: A T Ox3
Memory Recent / Remote: Adequate
Attention / Concentration: Can complete whole interview without interruptions
Fund of Knowledge: Appropriate
Insight: Moderate
Judgment / Reasoning: Poor, as evidenced by medication non-compliance
Impulse Control: Poor, as evidenced by skin picking

Multi-Axial Diagnoses on Admission:
Axis I: Mood disorder NOS, Psychosis NOS X09
Axis II: Deferred
Axis III: Hand wound
Axis IV: Psycho-social problems
Axis V: 35

Assessment:

Ms. Whalen is a 40yo F with mood disorder NOS and psychotic disorder NOS, currently troubled by beliefs of infestation of her apt and SIB marked by scratching and bleaching her skin. She endorses multiple depressive symptoms and has blunted affect, but her most prominent symptoms are psychotic and clearly delusional in nature. These symptoms most likely developed in the setting of medication non-compliance along with increasing her Adderall dosage from 60mg to 75mg daily recently. Her risk of harm to herself or others is elevated by disorganized thought and behavior, h.o. suicide attempt, substance abuse, limited insight and impaired judgment and intermittent compliance with medication. She is protected by help seeking behavior, supportive partner, housing, lack of SI or HI. She requires inpatient hospitalization for safety, containment, diagnostic clarification, psychopharmacologic evaluation, group and milieu therapy, and aftercare planning. Target symptoms include the patients mood, her insomnia, and her suicidal ideation.

ADMISSION LABS AND OTHER STUDIES
12/18/15 - Sodium 140, Potassium 3.6, Chloride 99, Carbon Dioxide 28, BUN 6 (L), Creatinine 1.02, Glucose 89, Calcium 9.0, HCT 42. 3, WBC 6.80, PLT 401 (H), HGB 14.0, MCV 91.4, MCH 30.2
12/16/15 - Amphetamine(s), urine Positive, Barbiturates, urine Negative, Benzodiazepines, urine Negative, THC/Cannabinoids, urine Negative, Cocaine, urine Negative, Methadone, urine Negative, Opiates, urine Negative, Phencyclidine, urine Negative, Oxycodone, urine Negative, Buprenorphine, ur (qualitative) Positive
12/08/15 - Ethanol (mg/dL) 144 (H)

HOSPITAL COURSE AND TREATMENT
40yo F with mood disorder NOS and psychotic disorder NOS, currently troubled by beliefs of infestation of her apt and SIB marked by scratching and bleaching her skin. She endorses multiple depressive symptoms and has blunted affect, but her most prominent symptoms are psychotic and clearly delusional in nature. These symptoms most likely developed in the setting of medication non-compliance along with increasing her Adderall dosage from 60mg to 75mg daily recently. Patients presentation was felt to be consistent with a diagnosis of psychosis, NOS. The patient was admitted to the inpatient psychiatric unit at MGH for further evaluation and care for her psychosis and polysubstance use. The patient was admitted under conditional voluntary status. The attending physician of record was Dr. Stuart Beck.

Psychosis: On initial presentation the main target symptoms were psychosis, including delusiosn about bugs and mice in her home, and somatic/visual hallucinations of a bug on her skin. Collateral information was obtained from her outpatient providers. For diagnostic clarification, B12, folate, TSH, urine pregnancy test, and urine tox screen were tested. For management of psychosis, lurasidone 80mg was continued to good effect. During hospitalization the patient was given as-needed vistaril for anxiety/agitation and trazodone for sleep. The patient had no side effects to these treatments. Her klonopin dose was decreased to 0.5mg TID. The patient attended groups

and occupational therapy. They also saw the individual therapist and worked on complying with medications. On day of discharge, the patient denied any delusions, and indicated that she would tell her treaters. The patient denied SI/HI and was future oriented and able to outline a clear plan for safety.

Polysubstance use: Ms. Whalen has a history of polysubstance abuse, and is currently on opioid maintenance with suboxone through her PCP. She is unclear about what she uses and how often. She does give some evidence that she overuses her adderall when she needs a boost, and similarly mentioned usign valium to supplement her klonopin. She also has had positive utox for cocaine, and admits to using cocaine. Because of her psychosis, as well as polysubstance use, the decision was made to taper her controlled medications as aggressively as possible. Her adderally was initially held in the APS, then she received 20mg, which was continued in the inpatient unit. Her Klonopin was initially at 1mg TID, then decreased to 0.5mg TID. Her outpatient primary care and psychiatrist were contact and are in agreement about tapering these medications, thoguh she will remain on suboxone for the time being. The importance of sobriety in the context of her psychosis and substance dependence was explained multiple times.

Hand wound: The patient had started using bleach on her hand wound as an outpatient. The wound was dressed in the APS, and topical bacitracin was used. On the unit, adaptic dressing (non-adherent) and kerlix were applied on hand, and was changed once daily. The wound is healing well on discharge. The patient no longer has delusions that there are bugs underneath her skin.

DISCHARGE MENTAL STATUS:
Appearance: casual clothes, appears older than stated age, bandage on hand
Gait / Muscle Tone: Normal
Attitude: Pleasant and cooperative
Speech: Normal rate and rhythm, quiet, low prosody
Language: Normal syntax and diction
Motor: No abnormalities
Mood: bored, "better"
Affect: Congruent, restricted
Thought Process: Linear
Thought Content: Denies SI/HI
Associations: connected
Perceptions: no AH/VH currently
Orientation: A T Ox3
Memory Recent / Remote: Adequate
Attention / Concentration: follows conversation
Fund of Knowledge: Appropriate
Insight: Moderate re: problems / treatment
Judgment / Reasoning: okay for basic decisions
Impulse Control: intact on the unit

MULTIAXIAL DIAGNOSES ON DISCHARGE:
Axis I: Mood disorder NOS, Psychosis NOS, r/o substance induced psychosis

Axis II: Deferred
Axis III: Hand wound
Axis IV: Psycho-social problems
Axis V: 50-60

MEDICATIONS AND INDICATIONS:
Clonazepam (Klonopin) 0.5 MG PO TID for anxiety
Amphetamine/dextroamphetamine (Adderall) 10 MG PO BID for ADHD
Buprenorphine E naloxone Dihydrate (Suboxone) 4 MG SL BID for substance abuse
Lurasidone Hcl (Latuda) 80 MG PO QHS for delusions and psychotic symptoms

MULTIPLE ANTIPSYCHOTICS:
The patient was not discharged on multiple standing antipsychotics.

SAFETY ASSESSMENT:
Ms. Whalen no longer requires a secure, structured, inpatient, psychiatric setting in order to prevent harm and to assure safety. Further inpatient hospitalization is no longer indicated. She can be safely released to the community because acute risk factors for dangerousness have been resolved. Protective factors include daughter, BF, home, providers. Risk factors include medical problems, dual diagnosis, recurrent illness, poor compliance, limited resources.However, she has developed a self care and safety plan. She has decision-making capacity and agrees with discharge and aftercare plans. There is no evidence currently that she poses an imminent risk of danger to self or others if released to the community today. Prognosis for recovery from current episode is fair to good with ongoing compliance, regular appointments, sustained sobriety, and social support in the community.

SAFETY PLAN:
If the patient develops thoughts of self-harm or harming someone else, the patient was instructed to call 911 or go to the nearest emergency room immediately. The patient expressed understanding and agreement.

DISCHARGE PLAN
Discharge information and recommendations were completed and given to the patient. Information was given regarding medications and resources. Medication prescriptions were given to patient as per the discharge form. All questions were answered, and discharge instructions were given in writing to the patient. Emergency contact information was given to the patient if needed in the future. Outpatient providers have been notified about the discharge. Patient discharged in stable condition back home with supportive family and aftercare coordinate for close follow-up.

AFTERCARE PLAN
Psychiatrist Dr. Scott Freeman on 12/29/15 at 11:30am. 617-724-8135
PCP Dr. William Schmitt on 12/24/15 at 2pm, Charlestown Health 73 High St. on 12/24/15 at 2pm. 617-724-8135

MOST RECENT LABS AND OTHER STUDIES

12/24/15 - Creatinine, random urine 120, Amphetamine(s), urine Positive, Barbiturates, urine Negative, Benzodiazepines, urine Positive, THC/Cannabinoids, urine Negative, Cocaine, urine Negative, Methadone, urine Negative, Opiates, urine Negative, Phencyclidine, urine Negative, Oxycodone, urine Negative, Buprenorphine, ur (qualitative) Positive
12/23/15 - Albumin 4.2, Globulin 2.9, Total Protein 7.1, Alk Phos 74, Bilirubin (Direct) 0.1, Bilirubin (Total) 0.2, ALT (U/L) 12, AST 16, TSH 3.79, Vitamin B12 647, Folate 10.9, 25 (OH)Vitamin D Total 29 (L)
12/22/15 - HCG, urine Negative
12/19/15 - Ethanol (mg/dL) Negative

ITEMS FOR FOLLOW-UP/ANNOTATIONS AT TIME OF DISCHARGE
There are no labs or studies pending at discharge.

CONDITION ON DISCHARGE
Improved

DISCHARGE MEDICATIONS
Buprenorphine E naloxone Dihydrate (Suboxone) 4 MG SL BID (last dose: 12/24/2015 07:41 AM)
Lurasidone Hcl (Latuda) 80 MG PO QHS
Rx: 80 MG TABLET 1 Tablet(s) QHS 21 day(s) Dispense: 21 Tablet(s) Refills: 0
Clonazepam (Klonopin) 0.5 MG PO TID (last dose: 12/24/2015 07:41 AM)
Amphetamine/dextroamphetamine (Adderall) 10 MG PO BID (last dose: 12/24/2015 07:41 AM)
Rx: 10 MG TABLET 1 Tablet(s) BID 6 day(s) Dispense: 12 Tablet(s) Refills: 0
The Rx icon reflects prescriptions written at the time of discharge, hence does not indicate whether the patients received or filled the prescription.

Vaccines
The Flu vaccine was not given during this admission. Please consult with your PCP regarding vaccinations.

DISCHARGE INSTRUCTIONS
Diet: No Restrictions
Activity: No Restrictions
Treatment: During your hospitalization you underwent medication management, group and individual therapy
Instructions: We appreciate the opportunity to care for you during your inpatient hospitalization at MGH on Blake 11. You were admitted to the hospital for treatment of mental illness.

While in the hospital, we adjusted your psychiatric medications. Please see your discharge medication list for current meds and doses. Please continue to take all the medications in this discharge plan as indicated.

In addition, exercise regularly for 30-45 minutes 3-5 times per week, utilize self-care and safety plans to maintain stability, do not use alcohol, caffeine, illegal drugs and cigarettes, and maintain a

balanced diet and take a daily multivitamin.

Contact your psychiatrist if you are experiencing any new and concerning side effects from these medications.

If you are having thoughts of harming yourself or anyone else, call 911 or go to the nearest emergency room immediately. You can also call the Boston Emergency Services Team (BEST) - 1-800-981-HELP, which provides immediate psychiatric services and can come to your location.

Followup: Please attend the following follow-up appointments.

POST-DISCHARGE GOALS
Continuity of Care: Please attend all scheduled appointments

LAST ATTENDING OF RECORD
Beck, Stuart E, MD 617-643-4728

PROVIDER TO CONTACT REGARDING HOSPITAL STAY
Beck,Stuart E, MD 617-643-4728

ELECTRONICALLY PREPARED BY: Stuart Beck MD

Electronically Signed
STUART E BECK, M.D. 01/05/2016 08:28 A

STUART E BECK, M.D.

TR: dex DD: 12/24/2015 TD: 12/24/2015 02:00 P 1871411
cc: SCOTT A FREEMAN, M.D.
Massachusetts General Hospital
Was 812
Wac 812 MA 02114

WILLIAM PETER SCHMITT, M.D.
Massachusetts General Hospital
MEDICINE
021347

ED DISCHARGE NOTIFICATION

Dias,Michelle MRN: 3394055 Age: 37y DOB: 07/20/1977
REGISTRATION DATE: 03/26/15 09:40
This is to notify you that your patient, Michelle Dias, with MRN 3394055 and DOB 0/20/1977, arrived in the Emergency Department at Massachusetts General Hospital on 03/26/15 09:40
The patient presented with a chief complaint of I want to section myself

Following evaluation and treatment, the patient's disposition at the end of the visit was admitted as an inpatient to Massachusetts General Hospital

The patient's preliminary admitting physician is FENVES, ANDREW Z and the preliminary admitting diagnosis is tylenol toxicity. Please note this information may have been updated on the inpatient unit.

PCP:
PCP Name: PCP, NOT REQUIRED PCP #:099992 PCP Phone: PCP Fax:
If you need additional information please call 617-724-4100.
ED DISCHARGE NOTIFICATION/SUMMARY

Fontes,Christopher MRN: 5539006 Age: 35y DOB: 09/26/1979
REGISTRATION DATE: 12/29/14 15:38
Discharge Instructions

Diagnosis:
Inguinal Hernia

Diagnostic Evaluation/Treatment Received:
A clinical exam was performed.

Follow Up Service:
It is recommended that you receive follow-up care in the Surgical Clinic, located on Wang 455. To schedule an appt., please call (617) 726-2760 between 8a.m. & 4:00 p.m. Monday-Friday. Appointments are made for Monday, Tuesday, and Wednesday between the hours of 9:00a.m. & 11:45 am. If you have a managed care plan, check with your PCP before making this appt.

Discharge Instructions:
HERNIA (Inguinal, Ventral, Umbil) (Engl))

Additional Instructions:
You were evaluated in the emergency department for your hernia. Your hernia is not incarcerated or strangulated. You should follow up with the MGH surgical clinic to schedule repair. Information is provided above for the surgical clinic.

Avoid carrying heavy items (greater than 20 lbs.)
Avoid straining when you move your bowels (drink plenty of water)

Return to the emergeny department if you develop fever >100.4, redness or blue/purple discoloration at the site of the hernia, inability to move your bowels, if you are not passing gas, vomiting, or with any other concerns.

PCP:
Name: SYSTEM, PROVIDER NOT
An electronic copy of the discharge note will be sent to your PCP, if confidentiality guidelines allow.

Please call your primary care physician during normal business hours to report this visit. Please seek medical care, return to the Emergency Department, or call
911 for any new or worsening symptoms, or any other concerns.
Please call 617-643-0045 if you require additional information regarding this

visit. Please have your MGH medical record number and date of visit available when you call.
Please call 617-726-2361 if you need to request a copy of your medical records.

I hereby acknowledge receipt of patient instructions. I understand that further diagnosis and treatment may be required and I have had emergency treatment only and I may be released before all medical problems are known and treated. I will arrange follow-up care as instructed.

Patient Signature:_____ Date:_____

ED Note Start Date/Time: 12/29/14 18:15
This note has been electronically signed by Megan O'Connor, PA-C 12/29/14 18:20
Brigham and Women's Faulkner Hospital
1153 Centre Street
Boston, MA 02130

Patient Name:CORREIA,MICHAEL M
Medical Record #:01036996
Provider Name:HUANCAHUARI,NADIA M.D.
Service Date:12/09/13
Report No:1211-0531

EMERGENCY DEPARTMENT REPORT

HPI:
12/09
11:49 This 33 years old Male presents to ER via Walk In with complaints of kd3
Palpitations, Dizziness.
11:49 33 yo m h/o etoh abuse, past H/pylori s/p tx p/w dizziness today, the kd3
pt awoke this am and in the shower started feeling palliations
w/associated lightheadedness, chest tingling and near syncope, he lad
down and continued feeling unwell so came to th ED, palpitations have
now resolved, but still fells lightheadedness w/associated nausea,
+hot sweats, no diaphoresis, no vomiting, diarrhea. +intermittent
abdominal pain x months, no pain now, usually L-sided worse after
drinking a lot, black stools on and of for months, last black stool 1
wk ago, no cp, +dysuria x yrs, no hematuria, +unchanged lbp x months,
no pain now usually worse in the am, no trauma, no numbness/tingling
or wkness. pt usually drinks 6-10 beers daily, last drink last night..

Historical:
- Allergies: Codeine;
- Home Meds:
1. None
- PMHx: None;
- PSHx: L eye surgery ;
- Immunization history: Unknown.
- Social history: Smoking status: Patient uses tobacco products,
smokes one-half pack cigarettes per day, Patient uses alcohol on a
daily basis.

ROS:
11:53 Constitutional: Negative for fever, chills, night sweats. Eyes: kd3
Negative for injury, pain, redness, periorbital edema, and discharge,

ENT: Negative for st, rhinorrhea, otalgia, tinnitis. Neck: Negative for injury, pain, and swelling. MS/Extremity: Negative for injury and deformity, Neuro: Negative for headache, focal weakness, numbness, tingling, and seizure. Constitutional: Positive for. Cardiovascular: Positive for palpitations, Negative for edema. Respiratory: Positive for cough, Negative for hemoptysis. Abdomen/GI: Positive for abdominal pain, nausea, Negative for diarrhea. Back: Positive for pain with movement, Negative for radiated pain. GU: Positive for urinary symptoms, Negative for hematuria.

Exam:
11:57 Constitutional: This is a well developed, well nourished patient who kd3
is awake, alert, and in no acute distress.
11:57 Head/Face: Normocephalic, atraumatic. kd3
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus.
Chest/axilla: Normal chest wall appearance and motion. Nontender with no deformity. No lesions are appreciated.
Cardiovascular: Regular rate and rhythm with a normal S1 and S2. No gallops, murmurs, or rubs. No JVD. No pulse deficits.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation and percussion. No rales, rhonchi or wheezes noted. No increased work of breathing, no retractions or nasal flaring.
Abdomen/GI: Soft, non-tender, with normal bowel sounds. No distension or tympany. No guarding or rebound. No evidence of tenderness throughout.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Male GU: Normal genitalia with no discharge or lesions.
11:57 Neuro: Awake and alert, GCS 15, oriented to person, place, time, and situation. Cranial nerves II-XII grossly intact. Motor strength 5/5 in all extremities. Sensory grossly intact. Cerebellar exam normal. Normal gait.
11:57 Eyes: Pupils: equal, round, and reactive to light, Extraocular movements: intact throughout, Conjunctiva: normal, Sclera: no appreciated abnormality.
11:57 Abdomen/GI: Rectal exam: is unremarkable, Stool: brown, guaiac negative, control completed with positive result of a color change to blue.

Vital Signs:
10:46 BP 129 / 94; Pulse 92; Resp 18; Temp 100.0; Pulse Ox 100% on R/A; jh
Weight 70.31 kg; Height 5 ft. 9 in. (175.26 cm);
13:28 BP 118 / 69 Supine; Pulse 72; Resp 16; Pulse Ox 99% on R/A; ac4
13:28 BP 117 / 75 RA Sitting (auto/reg); Pulse 69; Resp 16; Pulse Ox 99% on ac4
R/A;
13:28 BP 130 / 80 RA Standing (auto/reg); Pulse 87; Resp 18 S; Pulse Ox 99% ac4
on R/A;
10:46 Body Mass Index 22.89 (70.31 kg, 175.26 cm) jh

MDM:
10:35 Patient medically screened. kd3
11:16 ECG:. kd3
11:58 Data reviewed: vital signs, nurses notes, old medical records. ED kd3

course: 33 yo m h/o etoh abuse, H/pylori in past s/p tx p/w near syncope today in the shower w/palpitations, lightheadededness and nausea, +black stool 1 wk ago, last drink last night, ddx: gib, pud, gastritis, anemia, dehydration, etoh withdrawal, pna, arrhythmia, e-lye abd, anxiety, we will check labs, ekg, ivf, zofran, cxr and re-eval..
13:08 ED course: pt is feeling improved, labs, cxr are all normal, ekg shows lvh, bedside echo shows no effusion, pt reassured and d/c to home to f/u w/pcp and cards for out-pt endoscopy and echo, pt given good return instructions.. kd3

12/09
11:15 Order name: Cbc With Diff; Complete Time: 12:02 kd3
12/09
12:02 Interpretation: WBC 3.3; HGB 15.4; HCT 43.2; PLT 148. kd3
12/09
11:15 Order name: CMP; Complete Time: 12:10 kd3
12/09
12:33 Interpretation: NA 139; K 4.0; CL 103; CO2 25; ANION GAP 11; BUN 10; CREATININE 0.72; GFR > 60; GLU 96; TP 7.2; ALB 4.8; CA 9.1; TBIL 0.2; ALKALINE PHOS 49; SGOT 23; SGPT 10. kd3
12/09
11:15 Order name: Lipase; Complete Time: 12:10 kd3
12/09
12:33 Interpretation: LIPASE 36. kd3
12/09
11:15 Order name: PTT; Complete Time: 12:10 kd3
12/09
11:15 Order name: PT; Complete Time: 12:10 kd3
12/09
12:33 Interpretation: PT 13.2; INR 1.0. kd3
12/09
11:15 Order name: Magnesium; Complete Time: 12:10 kd3
12/09
12:34 Interpretation: MG 2.0. kd3
12/09
11:15 Order name: Phosphorus; Complete Time: 12:10 kd3
12/09
11:15 Order name: IV saline lock; Complete Time: 11:28 kd3
12/09
11:15 Order name: Electrocardiogram (9372); Complete Time: 11:17 kd3
12/09
11:15 Order name: Chest Pa & Lateral; Complete Time: 12:34 kd3
12/09
12:33 Interpretation: Normal. kd3
12/09
11:15 Order name: Passport; Complete Time: 11:17 kd3
12/09
13:26 Order name: UA; Complete Time: 13:52 kd3
12/09
13:52 Interpretation: URINE COLOR STRAW; URINE GLUCOSE NEGATIVE; URINE KETONE NEGATIVE; URINE BLOOD NEGATIVE; URINE NITRITE NEGATIVE; UROBILINOGEN NEGATIVE; URINE LEUKOCYTE NEGATIVE. kd3
12/09
11:15 Order name: Ekg; Complete Time: 11:28 kd3

Dispensed Medications:
11:27 Drug: Sodium Chloride 0.9% 1000 ml; Route: IV; Rate: 1000 ml/hr; kq
Site: right antecubital;
13:34 Follow up: IV Status: Completed infusion; IV Intake: 1000ml kq
11:28 Drug: Zofran 4 mg; Route: IVP; Site: right antecubital; kq
14:04 Follow up: Response: Nausea is decreased kq

ECG:
11:16 Rate is 86 beats/min. Rhythm is regular. QRS Axis is Normal. PR kd3
interval is normal. QRS interval is normal. QT interval is normal. Q
waves are Absent. T waves are Normal. No ST changes noted. Clinical
impression: LVH.

Disposition:
13:56 Chart complete. kd3
18:00 Attestation: This is a shared visit with the PA. I personally nh
obtained a history and performed a physical exam on this patient. The
details of the patient encounter are: Near syncope, +etoh abuse
daily, ECG w/ evidence of hypertrophy but old. Normal intervals. VSS.
IVF given, not orthostatic. plan to d/c w/ PCP close f/u as well as
reference to cardiologist. Pt verbalized understnaing of imprortance
of f/u w/ PCP and cardiologist as he may need an echo. Counseled on
smoking and etoh cessation. Stable at d/c.

Disposition:
12/09/13 13:54 Discharged to Home, Self Care. Impression: Palpitations, Near
Syncope.
- Condition is Stable.
- Discharge Instructions: Near-Syncope, Palpitations (Irregular Heart
Beat).

- Medication Reconciliation Form form.
- Follow up: Emergency Department; When: As needed; Reason: for
worsening symptoms. Follow up: Private Physician; When: 5 - 6 days.
Follow up: Fidencio Saldana; When: 5 - 6 days; Reason: Continuance
of care.
- Problem is new.
- Symptoms have improved.

- Notes: Please f/u with your pcp and have them order an endoscopy
and echocardiogram. Please f/u with cardiology as well. Please
return if you have increased dizziness, chest pain, trouble
breathing, fevers/chills, blood or black stools, blood in your
vomit, abdomianl pain or antyhing that worries you.

Signatures:
Dispatcher MedHost EDMS
Huancahuari, Nadia, MD MD nh
Hallahan, Joanne, RN RN jh
Devine, Kelly, PA-C PA-C kd3
Quigley, Katie, RN RN kq

Corrections: (The following items were deleted from the chart)
13:53 13:08 ED course: pt is feeling improved, labs, cxr are all normal, kd3

ekg shows lvh, bedside echo shows no effusion, pt reassured and d/c to home to f/u w/pcp for out-pt endoscopy and echo, pt given good return instructions.. kd3

****

Electronically Signed By: HUANCAHUARI,NADIA M.D. Date: 12/09/13 Time: 1405

NORTH SHORE MEDICAL CENTER
SALEM HOSPITAL

PATIENT NAME: Fleury, Mary MR: 00-40-68-49

DATE OF ADMISSION: 03/17/2009 BILLING NUMBER: 1051095626

EMERGENCY PHYSICIAN: Bennett Shamsai, M.D.

CHIEF COMPLAINT: Facial flushing.

HISTORY OF PRESENT ILLNESS: The patient is a 29-year-old white female who I have seen in the past. She comes to the ER fairly frequently. Last year from June to October, she had 5 or 6 visits. She comes in. She had just been too Lynn Community Health Care for bronchitis. Had a course of antibiotic. She does not know what the antibiotic was called and she finished about 2 days to 5 days ago. She is not sure exactly how long. She says she still feels achy, still has a cough, especially in the morning and feels congested. Occasionally feels flushed and has some sinus pressure. No nausea. No vomiting. Diffuse myalgias but no focal muscle or joint aches. She has no other complaints.

PAST MEDICAL HISTORY: Irregular menses, fibromyalgia, history of polysubstance abuse in the past. Also a history of asthma and ankle surgery with chronic neck and back pain and reflux.

SOCIAL HISTORY: Denies tobacco, alcohol or drug use to me.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Constitutional: No fevers, some sweats and some chills. Eyes: No change in vision. Ears: No change in hearing. Throat: No sore throat. No difficulty swallowing. Respiratory: Dry cough. No actual shortness of breath. GI: No nausea. No vomiting. GU: No dysuria. No hematuria. Musculoskeletal: Diffuse myalgias. No focal muscle or joint aches. Skin: No rashes. No abrasions except for the flushing in her face Cardiovascular: No chest pains. No palpitations. Psych: Denies anxiety or depression. Neuro: No focal weakness. No numbness.

PHYSICAL EXAMINATION: The patient is awake, alert, oriented x3 in no acute distress. She is in no acute distress. Vital signs are stable with a temperature of 96.9, pulse of 94, respiratory rate of 18, blood pressure 107/64, satting 97% on room air. When you walk in, you see an obese female sitting comfortably reading a magazine. Pupils equal, round, reactive to light bilaterally. Extraocular motion is intact. Face does not look flushed to me. She has no sinus tenderness. Neck is supple with no JVD or lymphadenopathy. Lungs: Clear to auscultation without any wheezing. Heart: Regular rate and rhythm. No murmurs, rubs or gallops. Abdomen:

Soft, nontender, nondistended, positive bowel sounds x4. Extremities: There is no calf tenderness nor is there any edema. Skin is dry. She does sound like she is nasally congested. With her last menstrual cycle being a month ago, I did get a urine pregnancy test, which was negative and the dip urine was unremarkable. She was given some Afrin spray with mild relief of the sinus pressure. I am discharging her home with a diagnosis of upper respiratory tract infection. I explained to her this is most likely viral. She should use a decongestant and that may be causing her dry cough. Follow up with her doctor if not improved in the next couple days. Return with any problems.

Electronically Signed
Bennett Shamsai, M.D. 03/23/2009 06:50

_____

Bennett Shamsai, M.D.

BS:DDI
DD: 03/18/2009 12:19 A
DT: 03/18/2009 4:49 A
Job: 000161432
Doc#: 1687824
cc:

Newton-Wellesley Hospital
2014 Washington Street
Newton, MA 02462

NAME: REILLY,ANNAKIM
DOB: 11/22/84 AGE: 24 SEX: F
ACCT: 169756103 LOCATION: 3W
ADM DATE: 12/28/08 STATUS: DIS IN FC: 16
UNIT #: 01065732 DISCH DATE: 12/30/08
ATTEND MD: KENNEDY,ARTHUR R. JR M.D.

DISCHARGE SUMMARY

REILLY, ANNAKIM
MRN: 01065732
DOA: 12/28/80

ADMITTING DIAGNOSIS:
1. DIZZINESS/WEAKNESS

PRINCIPAL DISCHARGE DIAGNOSES:
1. BIPOLAR DISORDER
2. R/o CONVERSION DISORDER

SECONDARY DIAGNOSES (present on admission):
1. Irritable Bowel Syndrome
2. Bipolar Disorder
3. Anxiety
4. Restless Leg Sydrome
5. Pseudoseizures

FOLLOW UP AFTER DISCHARGE:
LITHIUM LEVEL
F/U LABS OF TSH AND TRANSAMINITS
PT TO FOLLOW UP WITH DR. KENNEDY AND OUTSIDE PSYCHIATRIST
CONSIDER DBT Group

PRIMARY CARE PHYSICIAN: Dr. Karen Fleming 508.721.1170,
Dr. Vuckovic, psychiatrist 617.8553570

CONSULTATIONS: NONE

CODE STATUS: Full

ALLERGIES: NKDA

ANTICOAGULATION: None

DISCHARGE MEDICATIONS: The patient's medications on transfer to the floor are the following:
1. LITHIUM 300MG PO QDAILY
2. RISPERDAL 0.5MG PO QHS
3. ATIVAN 0.5MG PO Q6H AS NEEDED FOR ANXIETY

DIET: House diet

HISTORY OF PRESENT ILLNESS/HOSPITAL COURSE:
24 yo F with h/o bipolar d/o, anxiety, IBS who was recently discharge from Mclean hospital (approximately two weeks ago) for increasing anxiety and suicidal ideation. At that time, she was started on new psychiatric medications including Seroquel, Mirapex and Propanolol. She reports since starting the medications at McLean she has felt progressively dizzy (feels like the room is spinning) and weak. She also reports since this time nausea/vomiting and diarrhea. She reports emesis approximately 4-6 times a day and reports losing a total of 12 lbs in two weeks. She does have a h/o eating disorders. She has not been able to tolerate anything by mouth. For this reason she also has not taken any of her medications for the past two weeks. Yesterday, her dizziness and weakness (more L> R) contributed to difficulty with ambulation. She presents to the hospital today d/t profound dizziness and just returning from a trip with her family from the Bahamas.

1. Dizziness/Vertigo:
An otoscopic exam was done as patient had been complaining intermittently of L ear pain. Patient was afebrile with no leukocytosis and otoscopic exam revealed no signs of otitis media. Patient was found to not be orthostatic although IVFs improved patients symptoms.

A CT head showed no acute processes. Neurology was consulted and could not find a neurological cause for patient's dizziness/weakness but did recommend an MRI of brain to r/o any CNS process. Brain MRI was negative for any acute processes. Deep white matter T2 hyperintense foci were noted which were nonspecific. During her hospital course she worked with physical therapy and was full weight bearing.

2. Bipolar Disorder

Patient was recently discharged from McLean hospital and discharged on Seroquel, Lithium, Topomax and Depakote but had discontinued all medications. She had

subtherapeutic levels of depakote and lithium. She did not meet criteria for current manic/hypomanic episode but did report chronic suicidality but was able to contract for safety. Her father was able to stay overnight so a 1:1 sitter was not needed.
She was restarted on Lithium at 300mg QD and Risperdal 0.5mg at night.
Her lithium level was drawn which was 0.1. Psychiatry was consulted and felt that once medically cleared she was appropriate for inpatient psychiatric treatment for medication management and safety.
TSH was mildly elevated at 6.318, free T4 was wnl and patient was told to follow up with TSH and Lithium level with outside psychiatrist

3. Transaminitis
AST and ALT came back slightly elevated AST/ALT at 51/69 elevated. Patient has long standing transaminits which has never been worked up. A hepatitis B panel was sent which was negative. Patient received an abdominal ultrasound which revealed increased in echogenicity which is a nonspecific finding that can be seen with fatty infiltration liver disease.

4. Chronic Nausea/Vomiting/Diarrhea
Patient was afebrile with no leukocytosis. Her abdominal exam was benign and she did not have episodes of emesis in house. Her electrolytes were all within normal limits. Patient has had chronic nausea and diarrhea symptoms and has been seen by gastroenterologist in the past and diagnosed with Irritable Bowel Syndrome.

MEDICATIONS ON ADMISSION
Topomax 300mg PO AD
Depakote 1000ER PO QD
Lithium 900 MG PO QD
Miripex unknown dose
Ativan unkown dose

PAST PSYCHIATRIC HISTORY
Patient diagnosed with bipolar disorder. She has been on lithium x 2 years. Her psychiatrist is Dr. Vukovich at Mclean. She has had approx4 SA including cutting wrists and driving into a tree. She has had four inpatient psychiatric hospitalizations at McLean (one on Proctor 2) and one inpatient hospitalization in Texas and one in RI

SOCIAL HISTORY
Patient is adopted. She lives in Shrewsbury with her parents. She has had multiple relationships that have been abusive in nature. She is working on college graduation and is currently taking online courses. Denies tobacco, illicit drug, prescription abuse or ETOH use. She relies on parents for financial support.

ADMISSION PHYSICAL EXAMINATION:
BP: 113/60, Pulse: 78, Resp: 20, Temp: 98.3 po, Pain: 7, O2 sat: 98% RA
GEN'L NAD, Non-toxic appearing, AO x 3, wearing wig
HEENT TM clear. No bulging, no erythema, no exudate.
MMM, +end gaze nystagmus, no scleral icterus, no pale conjunctiva
NECK supple, no thyromegaly, no LAD. JVP<5 cm, no carotid bruits
Heart: RRR, normal S1, S2 no m/r/g, no lifts/heaves
LUNG: good breath sounds bilaterally w diffuse soft rhonchi; no increased work of breathing
ABD: Soft, mildly distended, non-distended, NABS. No HSM. No masses, rebound.
EXT: 2cm vertical scar on L wrist wwp, no edema
NEURO: AO x 3; alert; CN II-XII grossly intact; FNF intact, patient reports decreased

sensation to LT/PP up to 1cm below patella b/l. Motor 4/5 in LUE and LLE, 5/5 in RUE, RLE. DTRs brisk and symmetric throughout. Gait could not be assessed. Patient stood from bed and started shaking and fell back onto the bed.
PSYCH: Patient appears stated age and is well groomed. She is cooperative with the interview and makes good eye contact. Speech is fluent and not pressured. Her mood is "depressed"/. She reports decreased appetite and sleep + weight loss. + anhedonia + hopelessness. Reports SI without plan/intents means. Denies AH/VH/PI. Insight and Judgment are poor.

LABS AND PROCEDURES

SODIUM	141		(136-145)	
POTASSIUM	4.2		(3.4-5.1)	
CHLORIDE	108		(98-108)	
CARBON DIOXIDE	24		(21-31)	
ANION GAP	9.0		(4.0-13.9)	
GLUCOSE, SERUM	95		(74-106)	BUN
18	(6-20)			
CREATININE	0.6		(0.6-1.3)	
CALCIUM	9.9		(8.4-10.2)	
TOTAL PROTEIN, SERUM	6.9		(6.4-8.3)	
ALBUMIN	4.6		(3.4-4.8)	
CREATINE KINASE	60		(26-174)	
AST/SGOT	63	H	(6-40)	
ALK PHOS	65		(27-110)	
ALT/SGPT	88	H	(7-40)	
AMYLASE	55		(20-104)	
LIPASE	26		(6-51)	
TOTAL BILIRUBIN	0.4		(0.3-1.2)	
DIRECT BILIRUBIN	0.2		(0.0-0.4)	
MAGNESIUM	2.0		(1.5-2.6)	
ETHANOL (MEDICAL)	< 10		(<10)	
LITHIUM	0.1	L	(0.5-1.2)	MMOL/L
SALICYLATE	< 3	L	(15-30)	
ACETAMINOPHEN	< 10	L	(10-20)	
VALPROIC ACID, SERUM	< 1.0	L	(50.0-100.0)	
FREE T4	1.03		(0.89-1.76)	
TSH	6.318	H	(0.350-5.500)	UU/ML
TSH 3RD GENERATION	defa... 6.318	H	(0.350-5.500)	UU/ML
HCG QUAL w/REFLEX HCGQN, SE...	NEGATIVE		(NEGATIVE)	

WBC	7.7	(4.0-11.0)
RBC	4.30	(3.90-5.03)
HGB	12.6	(12.0-15.5)
HCT	37.3	(34.9-44.5)
MCV	86.7	(80-100)
MCH	29.3	(27-34)
MCHC	33.8	(31.5-36.5)
RDW	13.0	(12.4-15.1)
PLATELET COUNT	327	(135-400)
MPV	9.0 L	(9.6-12.0)

UTox + benzodiazepines

" Radiology:
CT head 12/28/08 No intracranial hemorrhage, no hydrocephalus or mass lesion.

CXR: No acute infiltrates.
" EKG: Normal Sinus Rhythm

CONDITION AT DISCHARGE:
VSS. Patient's dizziness and weakness mostly resolved with IVF.
To follow up with primary care doctor to follow up with transaminitis which was likely due to Seroquel and irritable bowel syndrome. You have an appointment with Dr. Vuckovic on 12/31 at 6:15pm

DISPOSITION: To home with follow up with primary care doctor and outside psychiatrist and therapist. Drs will need to monitor Lithium level and TSH as well as LFTs.

ALISON REMINICK, MD
MEDICINE INTERN

Electronically Signed 01/27/09 1934

_____
SIGNATURE

SIGNATURE REQUIRED: ARTHUR R. KENNEDY, JR, M.D.
DICTATED BY: ALISON REMINICK, M.D.

MDR.REMA
DD:
DT: 12/30/08 1740
CC:

COPY FOR:
Report Status: Signed

DISCHARGE SUMMARY

NAME: MARDEN, MICHAEL E UNIT NUMBER: 244-79-61

ADMISSION DATE: 04/13/2004 DISCHARGE DATE: 04/14/2004

DIAGNOSES IN HOSPITALIZATION:
1. Acute hepatitis.
2. Idiopathic rash.
3. Substance abuse.

HOSPITALIZATION COURSE: The patient is a 23-year-old male with acute hepatitis who was discharged from MGH Team #4 four days prior to admission. His mother called his PCP the day of admission stating that he had been dizzy and lightheaded since returning home. He was very nauseous and had multiple episodes of nonbilious vomiting that day. PCP advised his mother to come to the MGH ED. The patient reports that he had been febrile at home to temperature of 103 degrees. He also reports generalized weakness and lightheadedness, which is worse with standing. He denies abdominal pain but does report severe nausea. His appetite has been poor since going home and he has been mostly in bed since his hospital discharge. In MGH, his vital signs were a temperature of 99.4 degrees, heart rate of 97, and blood pressure of 131/88. He received normal saline and Zofran in the ED and was admitted to the floor for IV hydration.

REVIEW OF SYSTEMS: Positive for no bowel movement for the past three days, otherwise negative.

PAST MEDICAL HISTORY: Important for,
1. Hepatitis A infection; he was discontinued on April 10, 2004.
2. Depression.
3. Allergic conjunctivitis.
4. Asthma.
5. Substance abuse.

CURRENT MEDICATIONS ON ADMISSION: Albuterol MDI, Motrin, Percocet p.r.n., Ativan p.r.n., and a multivitamin.

ALLERGIES: For erythromycin and penicillin with an unknown reaction.

SOCIAL HISTORY: The patient lives with parents and siblings. He has a history of polysubstance abuse and denied current use of alcohol, illicit drugs, or tobacco.

PHYSICAL EXAMINATION: On the floor, his heart rate was 75 while lying and 128 with standing. His blood pressure was 148/89 while lying and 133/63 with standing. His respiratory rate was 18. He was sating 98% on room air. He was a young male sleeping in bed arousable to voice in no acute distress. His pupils were equal, round, and reactive to light. He had icteric sclerae. His extraocular eye movements were intact and he had a very dry oropharynx. His skin appeared jaundiced. His neck was supple with full range of motion. His JVP was at 5. He had 2+ carotids without bruits. No thyromegaly or nodes noted. His chest was clear. His heart was regular. His abdomen was nontender with positive bowel sounds. His extremities were warm without edema. He was alert and oriented x 3.

LABORATORY STUDIES: His chemistries on admission were notable for an ALT of 1161, which was trending down; an AST of 245, which was also trending down; an alkaline phosphatase of 204, which was stable; a T bili of 10.6, which was slightly elevated from his discharge T bili of 9; and a direct bili of 5.9, which was slightly elevated from his discharge direct bili of 5. His white count was 6.1, his hematocrit was 48.4, and his platelets were 243. His UA was positive for 1+ ketones.

The patient was admitted and aggressively hydrated. Due to his orthostatic hypertension, he received multiple bags of normal saline and his symptoms

of dizziness and weakness resolved. Psychiatry was consulted on his admission and the patient was diagnosed with benzo dependence, benzo withdrawal, opioid withdrawal, ETOH dependence, and anxiety. He was given Ativan 1 mg q.4h. for his withdrawal and clonidine 0.1 mg b.i.d. for opioid withdrawal. The afternoon of admission, the patient's family arrived. His symptoms of dehydration had resolved. The patient was calm and asking to go home. Given that he was medically stable, he was discharged with his family.

Discharge medications include Valium 5 mg p.o. q.6h. enough for one day and he was advised to continue drinking fluids.

ALYSON L. KELLEY, M.D.
DICTATING FOR:

Electronically Signed
ALYSON L. KELLEY, M.D.
08/04/2004 17:55

_____
ALYSON L. KELLEY, M.D.

TR: jxr DD: 07/03/2004 TD: 07/06/2004 3:14 P 701975
cc: ALYSON L. KELLEY, M.D.
ED DISCHARGE NOTIFICATION/SUMMARY

Vega,Jose MRN: 2100965 Age: 34y
REGISTRATION DATE: 08/31/11 11:15

Discharge Note

Note Status: Finalized
This report was finalized by Annmarie Lattanzi, MD 08/31/11 19:32

DISCHARGE ORDER: Discharge this patient from the ED.

BENEFITS ASSIGNED: U

DISCHARGE NOTE DATE/TIME: 08/31/11 19:29

DISCHARGE STATUS: Discharged

CONDITION ON DISCHARGE: Stable

PATIENT STATES COMPLAINT: FOUND UNRESPONSIVE

DIAGNOSIS: alcohol and benzo overdose

TREATMENT RENDERED: You were seen for taking too much alcohol and benzos. You received medications to reverse the drugs and slowly metabolized the drugs.

DISCHARGE MEDICATIONS: continue your current medications

FOLLOW UP TIME TABLE: You have a medical condition that may require additional medical tests or additional therapy. You must receive prompt follow-up with a doctor to check how you are doing and to arrange for further care as needed. Your Emergency Department caregivers will instruct you if you need follow-up with a specialist. Otherwise, contact your primary care doctor's office as soon as possible. Tell them you were in the Emergency Department, and you were advised to schedule an early follow-up appointment. If you do not have any other options for a follow-up appointment, you may also use a walk-in clinic for early follow-up, such as the MGH Walk-in clinic.

If your condition gets worse before your follow-up (worse or new symptoms) return to the Emergency Department, contact a doctor, or call 911.

DISPOSITION, FOLLOW UP & INSTRUCTION TO PATIENT: Refrain from drinking excessive amounts of alcohol and using benzos as this may cause respiratory arrest and death. Return to the ER if you ingest too much medication or alcohol or if you feel depressed or if you would like to hurt yourself.

ACCEPTING/MGH ADMITTING PHYSICIAN: HUNT, DANIEL
PCP: PCP Name: CHEN-CHEUNG, HONG PCP #:035869 PCP Phone:617-889-8580 PCP Fax:617-889-8579

MGH Main Campus Carmichael, Jillian

55 Fruit St. MRN: 2768288, DOB: 4/2/1984, Sex: F

Boston MA 02114-2621 Acct #: 6102491721

ADM: 7/21/2019, D/C: 7/24/2019

Patient Information

Patient Name	Sex	DOB
Carmichael, Jillian	Female	4/2/1984

Discharge Summary by Paula K Edelson, MD at 7/24/2019 3:00 PM

Author: Paula K Edelson, MD Service: OB/GYN Author Type: Fellow

Filed: 7/24/2019 3:01 PM Date of Service: 7/24/2019 Status: Attested

3:00 PM

Editor: Paula K Edelson, MD (Fellow) Cosigner: William Henry Barth,

MD at 9/5/2019 9:39 AM

Attestation signed by William Henry Barth, MD at 9/5/2019 9:39 AM (Updated)

Maternal Fetal Medicine Attending

I saw and examined/evaluated the patient with the MFM Fellow. We discussed the assessment and management plan and I agree with the note written by Dr. Edelson. Points of clarification are outlined below:

Discharged to psychiatry service/obstetrically stable. Time spent on evaluation/decision making and disposition = 35 minutes.

William H. Barth, Jr., M.D.

Maternal-Fetal Medicine

Pager ID: 22265

Physician Discharge Summary

Admit date: 7/21/2019

Discharge date: 7/24/2019

Patient Information

Jillian Carmichael, 35 y.o. female (DOB = 4/2/1984)

Home Address: 20 Edward Street

Medford MA 02155

Home Phone: There is no home phone number on file.

Health Care Agents

There are no Health Care Agents on file.

Code Status at Discharge: No Order

Discharge Summary by Paula K Edelson, MD at 7/24/2019 3:00 PM (continued)

Hospitalization Summary

Principal Problem:

Bipolar disorder with psychotic features

Resolved Problems:

* No resolved hospital problems. *

Surgical (OR) Procedures:

Surgeries this admission

None

Non (OR) Procedures:

Pending Results

None

Hospital Course

Jillian Carmichael is a single, homeless 35G5P2002 @34w2d; with prior pre-eclampsia, HTN, DM2, AUD (unclear h/o withdrawal), BPAD type 1 c/b psychotic features in the past, c/b multiple prior suicide attempts s/p many hospitalizations (per chart, 25+); who was BIBEMS to MGH ED after she was found destroying property and disrobing at City Hall. She has since been admitted to Ellison 13 L+D floor to board, and is now being transferred to Blake 11 where there is now a bed available.

Transfer to Blake 11 for continue psychiatric care.

Medications

Allergies: Tetracycline; Bee venom protein (honey bee); and Penicillins

Prior to Admission Medications

Prescriptions

ARIPiprazole (ABILIFY) 15 MG tablet

Sig: Take 1 tablet (15 mg total) by mouth daily.

acetaminophen (TYLENOL) 325 mg tablet

Sig: Take 650 mg by mouth every 6 (six) hours as needed for mild pain.

aspirin 81 mg chewable tablet

Sig: Take 81 mg by mouth daily.

clonazePAM (KLONOPIN) 1 MG tablet

Sig: Take 1 tablet (1 mg total) by mouth nightly at bedtime as needed for anxiety.

diphenhydrAMINE (BENADRYL) 50 MG capsule

Sig: Take 50 mg by mouth every 6 (six) hours as needed for itching. 100mg

melatonin 3 mg Tab

Sig: Take 3 mg by mouth.

prenatal vitamins with ferrous fumarate- folic acid 28 mg iron- 800 mcg Tab

Sig: Take 1 tablet by mouth daily.

Facility-Administered Medications: None

Medication List

STOP taking these medications

acetaminophen 325 mg tablet

Commonly known as: TYLENOL

ARIPiprazole 15 MG tablet

Commonly known as: ABILIFY

aspirin 81 mg chewable tablet

clonazePAM 1 MG tablet

Commonly known as: KlonoPIN

diphenhydrAMINE 50 MG capsule

Commonly known as: BENADRYL

melatonin 3 mg Tab

prenatal vitamins with ferrous fumarate- folic acid 28 mg iron- 800 mcg Tab

Hospital Care Team

Service: Psychiatry

Inpatient Attending: Stuart E Beck, MD

Attending phys phone: (617)643-4728

Discharge Unit: MGHE13O

Primary Care Physician: Yesoda N Rao, MD 781-395-2460

Transitional Plan

Scheduled appointments:

Scheduled Appointments (maximum listed = 10)

MGH Main Campus Carmichael, Jillian

55 Fruit St. MRN: 2768288, DOB: 4/2/1984, Sex: F

Boston MA 02114-2621 Acct #: 6102491721

ADM: 7/21/2019, D/C: 7/24/2019

Discharge Summary by Paula K Edelson, MD at 7/24/2019 3:00 PM (continued)

	Provider	Department	Dept Phone	Center
7/25/2019 3:00 PM	Lorna R Campbell, LICSW	BWH Psychiatric Specialties at 221	617-732-6753	
7/30/2019 9:30 AM (Arrive by 9:15 AM)	Sarah Elizabeth Little, MD	BWH Maternal Fetal Medicine	617-732-4840	
8/15/2019 10:00 AM (Arrive by 9:45 AM)	Kate Lieb, MD	BWH Psychiatric Specialties Main Campus	617-732-6753	
8/15/2019 4:00 PM (Arrive by 3:45 PM)	Kate Lieb, MD	BWH Psychiatric Specialties Main Campus	617-732-6753	

Signed Discharge Orders (From admission, onward)

None

Exam

Temperature: 37.1 ?C (98.7 ?F) (07/24/19 0900) Heart Rate: 82 (07/24/19 0900) BP: 120/78 (07/24/19 0900) Respiratory Rate: 18 (07/24/19 0900) SpO2: 97 % (07/22/19 2145) O2 Device: None (Room air) (07/24/19 0557)

Orientation Level: Oriented X3

Cognition: Follows commands

Speech: Slurred

Data/Results

Results are shown for the following tests if performed (CBC, Chem 7, Mg, Coag). If the patient did not have any of these tests, no results will be shown here.

Lab Results

Component	Value	Date/Time
WBC	10.75	07/22/2019 0924
RBC	3.40 (L)	07/22/2019 0924
HGB	9.9 (L)	07/22/2019 0924
HCT	32.4 (L)	07/22/2019 0924
MCH	29.1	07/22/2019 0924
MCV	95.3	07/22/2019 0924

PLT	249	07/22/2019 0924
RDW	14.6 (H)	07/22/2019 0924

Lab Results

Component	Value	Date/Time
NA	138	07/22/2019 0924
K	4.1	07/22/2019 0924
CL	106	07/22/2019 0924
CO2	13 (L)	07/22/2019 0924
BUN	6 (L)	07/22/2019 0924
CRE	0.61	07/22/2019 0924

CA 9.0 07/22/2019 0924

GLU 62 (L) 07/22/2019 0924

Lab Results

Component Value Date/Time

MG 1.8 07/22/2019 0924

Routing History

Date/Time	From	To	Method
9/5/2019 9:39 AM	William Henry Barth, MD	Yesoda N Rao, MD	In Basket
8/13/2019 7:35 PM	William Henry Barth, MD	Yesoda N Rao, MD	In Basket

ED DISCHARGE NOTIFICATION/SUMMARY

Martin,Deborah MRN: 3634621 Age: 32y
REGISTRATION DATE: 07/16/11 22:34

Discharge Note

Note Status: Finalized
This report was finalized by Matthew Siket, MD-Attending 07/17/11 00:33

DISCHARGE ORDER: Discharge this patient from the ED.

BENEFITS ASSIGNED: N

DISCHARGE NOTE DATE/TIME: 07/16/11 23:32

DISCHARGE STATUS: Discharged

CONDITION ON DISCHARGE: Stable

PATIENT STATES COMPLAINT: SOB

DIAGNOSIS: Asthma, bronchitis

STANDARDIZED DISCHARGE INSTRUCTIONS: The patient was given printed instructions for asthma (English), bronchitis/pneumonia (English), shortness of breath (English).

TREATMENT RENDERED: Emergency room examination and evaluation. CXR.

DISCHARGE MEDICATIONS: Prednisone

FOLLOW UP TIME TABLE: You have a medical condition that may require additional medical tests or additional therapy. You must receive prompt follow-up with a doctor to check how you are doing and to arrange for further care as needed. Your Emergency Department caregivers will instruct you if you need follow-up with a specialist. Otherwise, contact your primary care doctor's office as soon as possible. Tell them you were in the Emergency Department, and you were advised to schedule an early follow-up appointment. If you do not have any other options for a follow-up appointment, you may also use a walk-in clinic for early follow-up, such as the MGH Walk-in clinic.

If your condition gets worse before your follow-up (worse or new symptoms) return to the Emergency Department, contact a doctor, or call 911.

FOLLOW UP SERVICE: If you do not have a primary care physician, it is recommended that you find one. If you would like assistance in finding a primary care physician, please call the Primary Care Access Coordinator, at 617-585-2800.

DISPOSITION, FOLLOW UP & INSTRUCTION TO PATIENT: It is very important that you take the Prednisone as indicated. Take 60mg everyday for 4 additional days. The first dose was given here.

Please call the above number to schedule an appointment with a PCP and follow-up with them in 2 wks. You should also discuss smoking cessation with your doctor as smoking can make your asthma much worse.

If you develop fevers >102, if you have shortness of breath and chest pain that are not relieved by the Albuterol, please come back to the emergency room. Continue to use your Albuterol as needed for shortness of breath.
PCP: PCP Name: NONE, PHYSICIAN PCP #:099992 PCP Phone: PCP Fax:
ED DISCHARGE NOTIFICATION/SUMMARY

Lunn,Sreynoun MRN: 2826213 Age: 30y DOB: 02/02/1985
REGISTRATION DATE: 02/01/16 23:04
Discharge Instructions

Diagnosis:
Suicidal ideation

Diagnostic Evaluation/Treatment Received:
A clinical exam was performed.
Lab tests were performed. The Psychiatry service was consulted.

Discharge Medications:
You came to the ED for having thoughts of killing yourself. Your lab test was negative for any evidence of overdose on certain medications. Psychiatry service was consulted and recommended Longwood Community Crisis Stabilization (CSS) unit, which has accepted your stay.

If you have any further suicidal thoughts with a plan to end your life, please contact your psychiatrist and come to the ED right away.

Additional Instructions:
follow up with pcp and return to ed with new or worsening symptoms

EMTALA Form:
Y

Accepting Admitting Physician:
Bob Bower

Receiving Institution:
Longwood CCS

PCP:
Name: O'CONNELL, JAMES J Phone: 8576541006 Fax: 8576541093
An electronic copy of the discharge note will be sent to your PCP, if confidentiality guidelines allow.

Please call your primary care physician during normal business hours to report this visit. Please seek medical care, return to the Emergency Department, or call
911 for any new or worsening symptoms, or any other concerns.
Please call 617-643-0045 if you require additional information regarding this visit. Please have your MGH medical record number and date of visit available when you call.
Please call 617-726-2361 if you need to request a copy of your medical records.

I hereby acknowledge receipt of patient instructions. I understand that further diagnosis and treatment may be required and I have had emergency treatment only and I may be released before all medical problems are known and treated. I will arrange follow-up care as instructed.

Patient Signature:_____ Date:_____

ED Note Start Date/Time: 02/02/16 13:31
This note has been electronically signed by Leo Luo, MD 02/02/16 13:52
NorthShore Medical Center Salem Campus
Name:Andrea Jackson
MRN:298506
Account#:1081749788
Sex:Female
DOB:10/24/1978
Age:34 years
Arrival Date:03/26/2013
Time:23:18
Departure Date:03/27/2013
Time:08:48
Bed6
Salem Hospital ED Physician Documentation
HPI:
03/27 This 34 years old Caucasian Female presents to ER via Car - ts
04:08 Other with complaints of Fever - ivda.
04:08 patient is a 34 year old female who comes in for fever and chest ts
pain. she states that she is an iv drug user and yesterday had a fever of 101. she states this evening had a fever of 102.5. she states she took some tylenol and came in for evaluation. she notes that she also has had some pulling in the left hand side of her chest. she states that started last night. no sob, no

back pain, no cold symptoms. has had endocarditis before and that is why she came in for evaluation. she uses iv heroin but no cocaine recently. .

Historical:
- Allergies:
03/26 No known drug Allergies eub
23:18
- Home Meds:
23:18 Cogentin Oral 0.5 mg three times a day Home Meds: Flovent Inhl eub as needed Home Meds: Prozac Oral 60 mg daily, Has not been taking, has two prescriptions one 60 mg and one is 80 mg Home Meds: Albuterol Inhl as needed Home Meds: Wellbutrin Oral 150 mg daily, Has not been taking Home Meds: Neurontin Oral 300 mg nightly Home Meds: Haldol Oral 1 mg three times a day Home Meds: Seroquel Oral 50 mg daily, nightly Home Meds: Trileptal Oral 150 mg twice a day Home Meds: Clonidine Oral 0.1 mg three times a day Home Meds: Neurontin Oral 900 mg in the am 300 mg at noon daily
- PMHx:
23:18 Asthma PMHx: Depression PMHx: Bipolar disorder PMHx: Hepatitis eub C, asthma, infective endocarditis in 2006, MRSA in 2009 and right buttock abscess. PMHx: Migraines PMHx: Anxiety PMHx: IVDA

- Immunization history: Flu vaccine status is unknown.
- Social history: Smoking status: Patient uses tobacco products, smokes one pack cigarettes per day. No barriers to communication noted. The patient speaks fluent English. No barriers to communication noted. The patient speaks fluent English.
- The history from nurses notes was reviewed: and I agree with what is documented.

ROS:
03/27 Constitutional: Positive for fever, Negative for body aches. ts
04:12 Eyes: Negative for acute changes. ENT: Negative for ear pain, sore throat. Neck: Negative for pain with movement, pain at rest. Cardiovascular: Positive for chest pain, Negative for palpitations. Respiratory: Negative for cough, shortness of breath. Abdomen/GI: Negative for abdominal pain, nausea, vomiting, diarrhea. Back: Negative for radiated pain. GU: Negative for urinary symptoms, urinary frequency. MS/extremity: Negative for swelling, tenderness. Skin: Negative for abscesses, cellulitis. Neuro: Negative for dizziness, headache, weakness. All other systems are negative except as stated in the HPI.

Exam:
04:13 Constitutional: The patient appears alert, awake, comfortable. ts Eyes: Pupils: equal, round, and reactive to light and accomodation, Extraocular movements: intact throughout. ENT: Mouth: is normal, Oral mucosa: normal. Neck: External neck: is normal, ROM/movement: is normal. Cardiovascular: Heart sounds: normal, normal S1and S2. Respiratory: Respirations: normal, Breath sounds: are normal, clear throughout. Abdomen/GI: Bowel sounds: normal, Palpation: abdomen is soft and non-tender, in

all quadrants. Back: tenderness, is absent.
Musculoskeletal/extremity: Extremities: all appear grossly normal, with no appreciated tenderness with palpation, ROM: intact in all extremities, full active range of motion, Pulses: noted to be 2+ in the right radial artery, right dorsalis pedis artery, left radial artery and left dorsalis pedis artery, Sensation intact. Skin: scarring but no active cellulitis noted. Neuro: Mentation: is normal, Motor: is normal, Sensation: is normal.

Vital Signs:
03/26 BP 132 / 87; Pulse 87; Resp 20; Temp 98.7(O); Pulse Ox 96% on eub
23:18 R/A;
03/27 BP 100 / 61; Pulse 54 MON; Resp 18; bcd
03:09
03:31 BP 123 / 69; Pulse 48; Resp 18; Pulse Ox 100% ; bcd
04:28 BP 108 / 74; Pulse 52; Resp 16; Temp 97.5; Pulse Ox 99% ; bcd
05:30 BP 120 / 68; Pulse 50; Resp 16; Pulse Ox 98% ; bcd
05:50 BP 98 / 55; Pulse 52; Resp 16; Pulse Ox 98% ; bcd
06:45 BP 124 / 63; Pulse 62; Resp 18; Temp 97.8(O); Pulse Ox 100% on bcd
R/A;
03/27 Sinus bradycardia bcd
03:09

Procedures:
06:47 Peripheral line: by aseptic technique a peripheral line was ts
placed in the right external jugular vein, patient had multiple iv placed in arms by ultrasound but had trouble and they blew. put in right external jugular for access.

MDM:
04:14 Data reviewed: vital signs, nurses notes. ED course: patient ts
comes in for fevers. she noted them yesterday and today. had some pulling on left side of chest too since yesteday. ekg done and no acute changes noted. chest xray done and that is neg. urine done and neg for infection. labs show bandemia . electrolytes neg and lactate neg. since patient has had in the past and has bandemia will give one dose of vanco and she is cultured up. will be admitted..

00:48 Order name: Blood Culture^MIC: Blood Culture 1st set ts
00:48 Order name: Blood Culture^MIC: Blood Culture 2nd set ts
00:48 Order name: CBC with Diff; Complete Time: 03:57 ts
00:48 Order name: BUN; Complete Time: 03:30 ts
00:48 Order name: Creatinine; Complete Time: 03:30 ts
00:48 Order name: Electrolytes; Complete Time: 03:30 ts
00:48 Order name: Glucose Random; Complete Time: 03:30 ts
00:48 Order name: Lactic Acid - RSP; Complete Time: 02:56 ts
00:48 Order name: CK; Complete Time: 03:30 ts
00:48 Order name: Troponin I; Complete Time: 03:57 ts
00:48 Order name: Urinalysis Screen; Complete Time: 01:42 ts
00:48 Order name: Urine Culture ts
00:54 Order name: Blood Culture bcd
03:34 Order name: POTASSIUM (RESP); Complete Time: 03:57 EDMS
00:48 Order name: Chest 2 views ts

06:17 Order name: PICC/Central Venous Acc ts
00:43 Order name: Ekg; Complete Time: 00:43 bcd
00:43 Order name: Nurse Ekg; Complete Time: 00:47 bcd

Dispensed Medications:
03:23 Drug: NS 0.9% 1000 ml; Route: IV; Rate: bolus; Site: left forearm; bcd
08:31 Follow up: IV Status: Infusion discontinued; IV Intake: 700ml wdf
04:27 Drug: VancoMYCIN 1 grams; Route: IVPB; Duration: 2 hrs; Site: left wrist; bcd
08:31 Follow up: IV Status: Completed infusion; IV Intake: 500ml wdf

Point of Care Testing:
Urine Pregnancy:
01:25 hCG Reading: Negative; bcd
Disposition Summary:
03/27 Admit ordered for Hospitalist, Service. Preliminary diagnosis are Fever of Unknown Origin (FUO), r/o endocarditis.
03:58 ts
- Bed requested for Cardiac Special Care.
- Condition is Fair.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost	EDMS
Skarulis, Teresa, MD	MD ts
Bautista, Edison, RN	RN eub
Davis, Brianna, RN	RN bcd
Taylor, Claire, RN	RN cat
Wronkowski, Gina	gmw
Kane, Jenna	jk2
Fraser, Wendy	RN wdf

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ED DISCHARGE NOTIFICATION

Gonzalez,Melissa MRN: 2429806 Age: 34y DOB: 07/11/1979
REGISTRATION DATE: 07/30/13 17:45
This is to notify you that your patient, Melissa Gonzalez, with MRN 2429806 and DOB 0/11/1979, arrived in the Emergency Department at Massachusetts General Hospital on 07/30/13 17:45
The patient presented with a chief complaint of ABD PAIN

Following triage,the patient left before treatment was completed

PCP:
PCP Name: WEIL, ERIC PCP #:028686 PCP Phone:781-485-6300 PCP Fax:781-485-6405
If you need additional information please call 617-724-4100.
ED DISCHARGE NOTIFICATION

Delrio,Carina MRN: 3390902 Age: 37y DOB: 09/10/1977
REGISTRATION DATE: 04/16/15 21:07
This is to notify you that your patient, Carina Delrio, with MRN 3390902 and DOB 0/10/1977, arrived in the Emergency Department at Massachusetts General Hospital on 04/16/15 21:07
The patient presented with a chief complaint of abdominal pain

Following triage, the patient left without being seen

PCP:
PCP Name: CARR, LISA SIBERT PCP #:025498 PCP Phone:6178898520 PCP Fax:6178898571
If you need additional information please call 617-724-4100.