**Note ID = 1**

DISCHARGE DIAGNOSES:1. Acute respiratory failure, resolved.2. Severe bronchitis leading to acute respiratory failure, improving.3. Acute on chronic renal failure, improved.4. Severe hypertension, improved.5. Diastolic dysfunction.X-ray on discharge did not show any congestion and pro-BNP is normal. SECONDARY DIAGNOSES:1. Hyperlipidemia.2. Recent evaluation and treatment, including cardiac catheterization, which did not show any coronary artery disease.3. Remote history of carcinoma of the breast.4. Remote history of right nephrectomy.5. Allergic rhinitis. HOSPITAL COURSE: This 83-year-old patient had some cold symptoms, was treated as bronchitis with antibiotics. Not long after the patient returned from Mexico, the patient started having progressive shortness of breath, came to the emergency room with severe bilateral wheezing and crepitations. X-rays however did not show any congestion or infiltrates and pro-BNP was within normal limits. The patient however was hypoxic and required 4L nasal cannula. She was admitted to the Intensive Care Unit. The patient improved remarkably over the night on IV steroids and empirical IV Lasix. Initial swab was positive for MRSA colonization.Discussed with infectious disease, Dr. X and it was decided no treatment was required for de-colonization. The patient's breathing has improved. There is no wheezing or crepitations and O2 saturation is 91% on room air. The patient is yet to go for exercise oximetry. Her main complaint is nasal congestion and she is now on steroid nasal spray. The patient was seen by Cardiology, Dr. Z, who advised continuation of beta blockers for diastolic dysfunction. The patient has been weaned off IV steroids and is currently on oral steroids, which she will be on for seven days. DISPOSITION: The patient has been discharged home. DISCHARGE MEDICATIONS:1. Metoprolol 25 mg p.o. b.i.d.2. Simvastatin 20 mg p.o. daily. NEW MEDICATIONS:1. Prednisone 20 mg p.o. daily for seven days.2. Flonase nasal spray daily for 30 days.Results for oximetry pending to evaluate the patient for need for home oxygen. FOLLOW UP: The patient will follow up with Pulmonology, Dr. Y in one week's time and with cardiologist, Dr. X in two to three weeks' time.

**Note ID = 2**

DISCHARGE DIAGNOSES:1. Chronic obstructive pulmonary disease with acute hypercapnic respiratory failure.2. Chronic atrial fibrillation with prior ablation done on Coumadin treatment.3. Mitral stenosis.4. Remote history of lung cancer with prior resection of the left upper lobe.5. Anxiety and depression. HISTORY OF PRESENT ILLNESS: Details are present in the dictated report. BRIEF HOSPITAL COURSE: The patient is a 71-year-old lady who came in with increased shortness of breath of one day duration. She denied history of chest pain or fevers or cough with purulent sputum at that time. She was empirically treated with a course of antibiotics of Avelox for ten days. She also received steroids, prednisolone 60 mg, and breathing treatments with albuterol, Ipratropium and her bronchodilator therapy was also optimized with theophylline. She continued to receive Coumadin for her chronic atrial fibrillation. Her heart rate was controlled and was maintained in the 60s-70s. On the third day of admission she developed worsening respiratory failure with fatigue, and hence was required to be intubated and ventilated. She was put on mechanical ventilation from 1/29 to 2/6/06. She was extubated on 2/6 and put on BI-PAP. The pressures were gradually increased from 10 and 5 to 15 of BI-PAP and 5 of E-PAP with FIO2 of 35% at the time of transfer to Kindred. Her bronchospasm also responded to the aggressive bronchodilation and steroid therapy. DISCHARGE MEDICATIONS: Prednisolone 60 mg orally once daily, albuterol 2.5 mg nebulized every 4 hours, Atrovent Respules to be nebulized every 6 hours, Pulmicort 500 micrograms nebulized twice every 8 hours, Coumadin 5 mg orally once daily, magnesium oxide 200 mg orally once daily. TRANSFER INSTRUCTIONS: The patient is to be strictly kept on bi-level PAP of 15 I-PAP/E-PAP of 5 cm and FIO2 of 35% for most of the times during the day. She may be put on nasal cannula 2 to 3 liters per minute with an O2 saturation of 90-92% at meal times only, and that is to be limited to 1-2 hours every meal. On admission her potassium had risen slightly to 5.5, and hence her ACE inhibitor had to be discontinued. We may restart it again at a later date once her blood pressure control is better if required.

**Note ID = 3**

DISCHARGE DIAGNOSES:1. Acute cerebrovascular accident/left basal ganglia and deep white matter of the left parietal lobe.2. Hypertension.3. **Urinary tract infection**.4. Hypercholesterolemia. PROCEDURES:1. On 3/26/2006, portable chest, single view. Impression: atherosclerotic change in the aortic knob.2. On 3/26/2006, chest, portable, single view. Impression: Mild tortuosity of the thoracic aorta, maybe secondary to hypertension; right lateral costophrenic angle is not evaluated due to positioning of the patient.3. On March 27, 2006, swallowing study: Normal swallowing study with minimal penetration with thin liquids.4. On March 26, 2006, head CT without contrast: 1) Air-fluid level in the right maxillary sinus suggestive of acute sinusitis; 2) A 1.8-cm oval, low density mass in the dependent portion of the left maxillary sinus is consistent with a retention cyst; 3) Mucoparietal cell thickening in the right maxillary sinus and ethmoid sinuses.4. IV contrast CT scan of the head is unremarkable.5. On 3/26/2006, MRI/MRA of the neck and brain, with and without contrast: 1) Changes consistent with an infarct involving the right basal ganglia and deep white matter of the left parietal lobe, as described above; 2) Diffuse smooth narrowing of the left middle cerebral artery that may be a congenital abnormality. Clinical correlation is necessary.6. On March 27th, echocardiogram with bubble study. Impression: Normal left ventricular systolic function with estimated left ventricular ejection fraction of 55%. There is mild concentric left ventricular hypertrophy. The left atrial size is normal with a negative bubble study.7. On March 27, 2006, carotid duplex ultrasound showed: 1) Grade 1 carotid stenosis on the right; 2) No evidence of carotid stenosis on the left. HISTORY AND PHYSICAL: This is a 56-year-old white male with a history of hypertension for 15 years, untreated. The patient woke up at 7: 15 a.m. on March 26 with the sudden onset of right-sided weakness of his arm, hand, leg and foot and also with a right facial droop, right hand numbness on the dorsal side, left face numbness and slurred speech. The patient was brought by EMS to emergency room. The patient was normal before he went to bed the prior night. He was given aspirin in the ER. The CT of the brain without contrast did not show any changes. He could not have a CT with contrast because the machine was broken. He went ahead and had the MRI/MRA of the brain and neck, which showed infarct involving the right basal ganglia and deep white matter of the left parietal lobe. Also, there is diffuse smooth narrowing of the left middle cerebral artery.The patient was admitted to the MICU. HOSPITAL COURSE PER PROBLEM LIST:1. Acute cerebrovascular accident: The patient was not a candidate for tissue plasminogen activator. A neurology consult was obtained from Dr. S. She agrees with our treatment for this patient. The patient was on aspirin 325 mg and also on Zocor 20 mg once a day. We also ordered fasting blood lipids, which showed cholesterol of 165, triglycerides 180, HDL cholesterol 22, LDL cholesterol 107. Dr. Farber agreed to treat the risk factors, to not treat blood pressure for the first two weeks of the stroke. We put the patient on p.r.n. labetalol only for systolic blood pressure greater than 200, diastolic blood pressure greater than 120. The patient's blood pressure has been stable and he did not need any blood pressure medications. His right leg kept improving with increased muscle strength and it was 4-5/5, however, his right upper extremity did not improve much and was 0-1/5. His slurred speech has been improved a little bit. The patient started PT, OT and speech therapy on the second day of hospitalization. The patient was transferred out to a regular floor on the same day of admission based on his stable neurologic exam. Also, we added Aggrenox for secondary stroke prevention, suggested by Dr. F. Echocardiogram was ordered and showed normal left ventricular function with bubble study that was negative. Carotid ultrasound only showed mild stenosis on the right side. EKG did not show any changes, so the patient will be transferred to Siskin Rehabilitation Hospital today on Aggrenox for secondary stroke prevention. He will not need blood pressure treatment unless systolic is greater than 220, diastolic greater than 120, for the first week of his stroke. On discharge, on his neurologic exam, he has a right facial palsy from the eye below, he has right upper extremity weakness with 0-1/5 muscle strength, right leg is 4-5/5, improved slurred speech.2. Hypertension: As I mentioned in item #1, see above, his blood pressure has been stable. This did not need any treatment.3. **Urinary tract infection**: The patient had urinalysis on March 26th, which showed a large amount of leukocyte esterase, small amount of blood with red blood cells 34, white blood cells 41, moderate amount of bacteria. The patient was started on Cipro 250 mg p.o. b.i.d. on March 26th. He needs to finish seven days of antibiotic treatment for his **UTI**. Urine culture and sensitivity were negative.4. Hypercholesterolemia: The patient was put on Zocor 20 mg p.o. daily. The goal LDL for this patient will be less than 70. His LDL currently is 107, HDL is 22, triglycerides 180, cholesterol is 165. CONDITION ON DISCHARGE: Stable. ACTIVITY: As tolerated. DIET: Low-fat, low-salt, cardiac diet. DISCHARGE INSTRUCTIONS:1. Take medications regularly.2. PT, OT, speech therapist to evaluate and treat at Siskin Rehab Hospital.3. Continue Cipro for an additional two days for his **UTI**. DISCHARGE MEDICATIONS:1. Cipro 250 mg, one tablet p.o. b.i.d. for an additional two days.2. Aggrenox, one tablet p.o. b.i.d.3. Docusate sodium 100 mg, one cap p.o. b.i.d.4. Zocor 20 mg, one tablet p.o. at bedtime.5. Prevacid 30 mg p.o. once a day. FOLLOW UP:1. The patient needs to follow up with Rehabilitation Hospital after he is discharged from there.2. The patient can call the Clinic if he needs a follow up appointment with us, or the patient can find a primary care physician since he has insurance.

**Note ID = 4**

DATE OF ADMISSION: MM/DD/YYYY. DATE OF DISCHARGE: MM/DD/YYYY. ADMITTING DIAGNOSIS: Peritoneal carcinomatosis from appendiceal primary. DISCHARGE DIAGNOSIS: Peritoneal carcinomatosis from appendiceal primary. SECONDARY DIAGNOSIS: Diarrhea. ATTENDING PHYSICIAN: AB CD, M.D. SERVICE: General surgery C, Surgery Oncology. CONSULTING SERVICES: Urology. PROCEDURES DURING THIS HOSPITALIZATION: On MM/DD/YYYY, 1. Cystoscopy, bilaterally retrograde pyelograms, insertion of bilateral externalized ureteral stents.2. Exploratory laparotomy, right hemicolectomy, cholecystectomy, splenectomy, omentectomy, IPHC with mitomycin-C. HOSPITAL COURSE: The patient is a pleasant 56-year-old gentleman with no significant past medical history who after an extensive workup for peritoneal carcinomatosis from appendiceal primary was admitted on MM/DD/YYYY. He was admitted to General Surgery C Service for a routine preoperative evaluation including baseline labs, bowel prep, urology consult for ureteral stent placement. The patient was taken to the operative suite on MM/DD/YYYY and was first seen by Urology for a cystoscopy with bilateral ureteral stent placement. Dr. XYZ performed an exploratory laparotomy, right hemicolectomy, cholecystectomy, splenectomy, omentectomy, and IPHC with mitomycin-C. The procedure was without complications. The patient was observed closely in the ICU for one day postoperatively for persistent tachycardia after extubation. He was then transferred to the floor where he has done exceptionally well.On postoperative day #2, the patient passed flatus and we were able to start a clear liquid diet. We advanced him as tolerated to a regular health select diet by postoperative day #4. His pain was well controlled throughout this hospitalization, initially with a PCA pump, which he very seldomly used. He was then switched over to p.o. pain medicines and has required very little for adequate pain control. By postoperative date #2, the patient had been out of bed and ambulating in the hallways. The patient's only problem was with some mild diarrhea on postoperative days #3 and 4. This was thought to be a result of his right hemicolectomy. A C. diff toxin was sent and came back negative and he was started on Imodium to manage his diarrhea. His post-splenectomy vaccines including pneumococcal, HiB, and meningococcal vaccines were administered during his hospitalization.On the day of discharge, the patient was resting comfortably in the bed without complaints. He had been afebrile throughout his hospitalization and his vital signs were stable. Pertinent physical exam findings include that his abdomen was soft, nondistended and nontender with bowel sounds present throughout. His midline incision is clean, dry, and intact and staples are in place. He is just six days postop, he will go home with his staples in place and they will be removed on his follow-up appointment. CONDITION AT DISCHARGE: The patient was discharged in good and stable condition. DISCHARGE MEDICATIONS:1. Multivitamins daily.2. Lovenox 40 mg in 0.4 mL solution inject subcutaneously once daily for 14 days.3. Vicodin 5/500 mg and take one tablet by mouth every four hours as needed for pain.4. Phenergan 12.5 mg tablets, take one tablet by mouth every six hours p.r.n. for nausea.5. Imodium A-D tablets take one tablet by mouth b.i.d. as needed for diarrhea. DISCHARGE INSTRUCTIONS: The patient was instructed to contact us with any questions or concerns that may arise. In addition, he was instructed to contact us, if he would have fevers greater than 101.4, chills, nausea or vomitting, continuing diarrhea, redness, drainage, or warmth around his incision site. He will be seen in about one week's time in Dr. XYZ's clinic and his staples will be removed at that time.FOLLOW- UP APPOINTMENT: The patient will be seen by Dr. XYZ in clinic in one week's time.

**Note ID = 5**

DATE OF ADMISSION: MM/DD/YYYY. DATE OF DISCHARGE: MM/DD/YYYY. REFERRING PHYSICIAN: AB CD, M.D. ATTENDING PHYSICIAN AT DISCHARGE: X Y, M.D. ADMITTING DIAGNOSES:1. Ewing sarcoma.2. Anemia.3. Hypertension.4. Hyperkalemia. PROCEDURES DURING HOSPITALIZATION: Cycle seven Ifosfamide, mesna, and VP-16 chemotherapy. HISTORY OF PRESENT ILLNESS: Ms. XXX is a pleasant 37-year-old African-American female with the past medical history of Ewing sarcoma, iron deficiency anemia, hypertension, and obesity. She presented initially with a left frontal orbital swelling to Dr. XYZ on MM/DD/YYYY. A biopsy revealed small round cells and repeat biopsy on MM/DD/YYYY also showed round cells consistent with Ewing sarcoma, genetic analysis indicated a T1122 translocation. MRI on MM/DD/YYYY showed a 4 cm soft tissue mass without bony destruction. CT showed similar result. The patient received her first cycle of chemotherapy on MM/DD/YYYY. On MM/DD/YYYY, she was admitted to the ED with nausea and vomitting and was admitted to the Hematology and Oncology A Service following her first course of chemotherapy. She had her last course of chemotherapy on MM/DD/YYYY followed by radiation treatment to the ethmoid sinuses on MM/DD/YYYY. HOSPITAL COURSE: 1. Ewing sarcoma, she presented for cycle seven of VP-16, ifosfamide, and mesna infusions, which she tolerated well throughout the admission.2. She was followed for hemorrhagic cystitis with urine dipsticks and only showed trace amounts of blood in the urine throughout the admission.

**Note ID = 6**

REASON FOR ADMISSION: Fever of unknown origin. HISTORY OF PRESENT ILLNESS: The patient is a 39-year-old woman with polymyositis/dermatomyositis on methotrexate once a week. The patient has also been on high-dose prednisone for an urticarial rash. The patient was admitted because of persistent high fevers without a clear-cut source of infection. She had been having temperatures of up to 103 for 8-10 days. She had been seen at Alta View Emergency Department a week prior to admission. A workup there including chest x-ray, blood cultures, and a transthoracic echocardiogram had all remained nondiagnostic, and were normal. Her chest x-ray on that occasion was normal. After the patient was seen in the office on August 10, she persisted with high fevers and was admitted on August 11 to Cottonwood Hospital. Studies done at Cottonwood: CT scan of the chest, abdomen, and pelvis. Results: CT chest showed mild bibasilar pleural-based interstitial changes. These were localized to mid and lower lung zones. The process was not diffuse. There was no ground glass change. CT abdomen and pelvis was normal. Infectious disease consultation was obtained. Dr. XYZ saw the patient. He ordered serologies for CMV including a CMV blood PCR. Next serologies for EBV, Legionella, Chlamydia, Mycoplasma, Coccidioides, and cryptococcal antigen, and a PPD. The CMV serology came back positive for IgM. The IgG was negative. The CMV blood PCR was positive, as well. Other serologies and her PPD stayed negative. Blood cultures stayed negative.In view of the positive CMV, PCR, and the changes in her CAT scan, the patient was taken for a bronchoscopy. BAL and transbronchial biopsies were performed. The transbronchial biopsies did not show any evidence of pneumocystis, fungal infection, AFB. There was some nonspecific interstitial fibrosis, which was minimal. I spoke with the pathologist, Dr. XYZ and immunopathology was done to look for CMV. The patient had 3 nucleoli on the biopsy specimens that stained positive and were consistent with CMV infection. The patient was started on ganciclovir once her CMV serologies had come back positive. No other antibiotic therapy was prescribed. Next, the patient's methotrexate was held.A chest x-ray prior to discharge showed some bibasilar disease, showing interstitial infiltrates. The patient was given ibuprofen and acetaminophen during her hospitalization, and her fever resolved with these measures.On the BAL fluid cell count, the patient only had 5 WBCs and 5 RBCs on the differential. It showed 43% neutrophils, 45% lymphocytes.Discussions were held with Dr. XYZ, Dr. XYZ, her rheumatologist, and with pathology. DISCHARGE DIAGNOSES:1. Disseminated CMV infection with possible CMV pneumonitis.2. Polymyositis on immunosuppressive therapy (methotrexate and prednisone). DISCHARGE MEDICATIONS:1. The patient is going to go on ganciclovir 275 mg IV q.12 h. for approximately 3 weeks.2. Advair 100/50, 1 puff b.i.d.3. Ibuprofen p.r.n. and Tylenol p.r.n. for fever, and will continue her folic acid.4. The patient will not restart for methotrexate for now.She is supposed to follow up with me on August 22, 2007 at 1:45 p.m. She is also supposed to see Dr. XYZ in 2 weeks, and Dr. XYZ in 2-3 weeks. She also has an appointment to see an ophthalmologist in about 10 days' time. This was a prolonged discharge, more than 30 minutes were spent on discharging this patient.

**TOTAL UTI = 1**