Progress Note Details

Patient Name:	MCPHEE, MICHAEL	**Date:**	11/12/2019
Patient Number:	M000028826	**Clinician:**	Hahn, Susan
Patient Date of Birth:	5/23/1961	**Physician / Extender:**	Miller, Gary
Patient Account Number:	BH0019906734		

Subjective

Chief Complaint
This information was obtained from the patient
pt here for wc and is asking to have additional days of antibiotics

Allergies
Naprosyn (Reaction: dizzy)

HPI
This information was obtained from the patient
58 yo m here for fu peronychia

Medications
Zyrtec-D - oral 5 mg-120 mg tablet extended release 12 hr once daily
Bactrim DS - oral 800 mg-160 mg 1 tablet twice daily for 10 days for additional 7 days
Flonase Allergy Relief - nasal 50 mcg/actuation spray,suspension once daily
Aleve - oral 220 mg capsule once daily

58 yo m w/ fb injury at work and subsequent infection, pus pocket drained i+d

Objective

Wound Assessment(s)
Wound #1 Right Finger - second is an acute Full Thickness Infectious and has received a status of Not Healed. Subsequent wound encounter measurements are 1cm length x 0.3cm width x 0.2cm depth, with an area of 0.3 sq cm and a volume of 0.06 cubic cm. Adipose is exposed. No tunneling has been noted. No sinus tract has been noted. No undermining has been noted. There is a small amount of none drainage noted which has no odor. The patient reports a wound pain of level 1/10. The wound margin is irregular. Wound bed has No epithelialization, Yes eschar, No slough, Yes bright red, firm granulation.
The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal. The temperature of the periwound skin is Warm. Periwound skin does not exhibit signs or symptoms of infection. Local Pulse is Palpable.

Vitals
Height/Length: 67 in (170.18 cm), Weight: 260 lbs (118.18 kgs), BMI: 40.7, Temperature: 98.1 °F (36.72 °C), Pulse: 80 bpm, Respiratory Rate: 18 breaths/min, Blood Pressure: 118/80 mmHg.

Assessment

Active Problems

ICD-10
(Encounter Diagnosis) S61.240S - Puncture wound with foreign body of right index finger without damage to nail, sequela
(Encounter Diagnosis) S61.200A - Unspecified open wound of right index finger without damage to nail, initial

encounter

Procedures

Wound #1
Wound #1 (Infectious) is located on the right finger - second. A skin/subcutaneous tissue level excisional/surgical debridement with a total area debrided of 0.91 sq cm was performed by Miller, Gary, MD. Subcutaneous was removed along with devitalized tissue: necrotic/eschar. The following instrument(s) were used: blade and forceps. Pain control was achieved using Local % Inj.. A time out was conducted prior to the start of the procedure. A moderate amount of bleeding was controlled with pressure. The procedure was tolerated well with a pain level of 0 throughout and a pain level of 0 following the procedure. Post Debridement Measurements: 1.3cm length x 0.7cm width x 0.2cm depth; with an area of 0.91 sq cm and a volume of 0.182 cubic cm;

Plan

Wound Orders:
Wound #1 Right Finger - second

Dressings
Other: - Cleanse with NS, apply Xeroform cover with 2x2 wrap with conform followed by coban. Pt to be on light duty until next appointment. Change every other day.

Follow-Up Appointments
Return Appointment # weeks: - 1 week

Scribing Attestation
I attest, as the nurse, that I scribed these orders for the physician.

Electronic Signature(s)

Signed By:	Date:
Miller, Gary	11/19/2019 12:21:43
11/12/2019 4:42:27 PM Version Signed By:	**Date:**
Miller, Gary	11/12/2019 5:22:08 PM

Entered By: Miller, Gary on 11/17/2019 10:24:54