Return to Hospital Risk Assessment

Name	McCanney, Frank J	MR #	143805
Gender	M	Birth Date	08/30/1954
Facility	Lexington Health Care Center of Chicago Ridge	Marital Status	Never Married
Room #	212	Admitting Diagnosis	
Admission Date	12/13/19		
Date Form Opened	12/15/2019		

Reason For Visit:

Admitting Risk Assessment

History of Present Illness:

a 65 year old male present to the ED with left sided weakness, MRI showed he had a right basal ganglia lentiform nuclei stroke. Pmhx HTN alcohol abuse and asthma. While patient was in the hospital he aspirated , was intubated ad given a G-tube due to the EGD that showed severe erosive esophagitis, hiatal hernia , gastritis and erosive duodenitis. his left upper extremity remain plegic and his left lower extremity remains weak. patient has was transfer to Lexington for rehab

Patient seen today for risk assessment and medication management . patient has peg tube but stated that he currently can eat foods without [illegible] and denied any pains or problems .

Allergy List:

No Known Allergies

Allergies Not listed

Hospitalization History

Hospitalization in the Past 12 months? Yes

Was most recent hospitalization through the Emergency Department?

Length of stay for most recent hospitalization? 14 or more days

How many Emergency Department visits in the past 6 months without hospitalization?

Past Medical History

PMHx

HTN alcohol abuse and asthma.

PLEASE NOTE - ALL FIELDS BELOW WILL CALCULATE WHEN YOU HIT UPDATE CALCULATIONS, ON THE TOP LEFT - **EXCEPT C**

See the Instructions next to **C**, and enter the number, based on instructions, then hit Update Calculations, on the top left

Past Medical History - check all that apply - THEN HIT UPDATE CALCULATIONS ON THE TOP LEFT, to calculate TOTAL PMH

Cerebrovascular Disease

L 7
A 0
C 0 If TOTAL PMH is 4 or greater, then enter 5 into C, otherwise enter the TOTAL PMH.
E 0

TOTAL PMH 0

LACE 0

If the **LACE** is greater than or equal to **10, then enter a Notification Clinical Note**, indicating that the patient is a High Risk for Return to Hospital as well as a specialty program.

Personal and Social History and Advanced Directives

Psychosocial History

Advanced Care Plan
Full Code
POA
(Name)

Tobacco Use: (risk for CAD, PVD, DVT and COPD)
If Stopped, Quit Date:

		Yes-Smoking	If Yes-Smoking, Packs and Years
Smoking Cessation Plan	Yes Considering	Educated in Smoking Risks	
ETOH Use:			
Present ETOH use?	Yes	Past ETOH use?	Amount

Recent Laboratory and Diagnostic Tests (Click Link to Access Laboratory Attachments):

Labs/Radiology (List reviewed labs Reviewed Laboratory Results with dates)

Medication List (Click link to view all orders):
Reviewed Medications
Current Medications

MEDICATION	DOSAGE	TYPE	FORM	FREQUENCY	METHOD
ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 mL nebulization soln	0.5 mg-3 mg(2.5 mg base)/3 mL	3ml	AMPUL FOR NEBULIZATION (ML)	Every Six Hours	Inhalation
81 mg	Aspir-81 mg tablet,delayed release	1 tablet	TABLET, DELAYED RELEASE (ENTERIC COATED)	1D:One Time Daily	Oral
Senna with Docusate Sodium 8.6 mg-50 mg tablet	8.6-50 mg	1n tablet	TABLET	1D:One Time Daily	Oral
FLUoxetine 20 mg tablet	20 mg	1 tablet	TABLET	1D:One Time Daily	Oral
Breo Ellipta 100 mcg-25 mcg/dose powder for inhalation	100-25 mcg/dose	1 puff	BLISTER, WITH INHALATION DEVICE	1D:One Time Daily	Inhalation
folic acid 1 mg tablet	1 mg	1 tablet	TABLET	1D:One Time Daily	Oral
		1 tablet	TABLET	1D:One Time Daily	Oral
nicotine 21 mg/24 hr daily transdermal patch	21 mg/24 hr	1 patch	PATCH, TRANSDERMAL 24 HOURS	1D:One Time Daily	Transdermal
OLANZapine 5 mg tablet	5 mg	1 tablet	TABLET	2D:Two Times Daily	Oral
pantoprazole 40 mg tablet,delayed release	40 mg	1 tablet	TABLET, DELAYED RELEASE (ENTERIC COATED)	1D:One Time Daily	Oral
thiamine HCl (vitamin B1) 100 mg tablet	100 mg	1 tablet	TABLET	1D:One Time Daily	Oral
Aplisol 5 tub. unit/0.1 mL intradermal injection solution	5 tub. unit /0.1 mL	0.1 mL	VIAL (ML)	Every Two Weeks for Three Weeks	Intradermal
Water Flush		100ml		Every Four Hours	G-tube

Review of Systems

CONST	Y	N	RESP	Y	N	GU	Y	N	MS	Y	N
WNL to ALL Constitution			WNL to ALL RESP			WNL to ALL GU			WNL to ALL MS		
Fever			SOB	No		Dysuria			Joint Pain		
Δ Mental Status			Cough	No		Hematuria			Swelling		
Δ Function			Wheezing	No		Frequency			Myalgia		
Δ Weight			Phlegm			Urgency			Arthralgia		
Pain	No		Hx Smoking	Yes		Nocturia			Fall last 30 days		
						Foley			Hx of Falls		
									Gait D/O		

HEENT	Y	N	GI	Y	N	NEURO	Y	N	PSYCH	Y	N
WNL to ALL HEENT			WNL to ALL GI			WNL to ALL NEURO			WNL to ALL PSYCH		
Eye Discharge			Nausea	No		Syncope			Anxiety		
Δ Visual			Vomiting			Aphasia			Depression		
HOH			Obesity			HA			Sleep Disturbance		
Epistaxis			Abd Pain	No		Vertigo			Agitation		

				Weakness			
Tinnitus		Constipation	No	Paraesthesia	No	Hallucination	
Sore Throat		Melena		Seizures		Psychosis	
		Hemoccult		Confused		Δ Mood	
		Dysphagia					
		Dyspepsia					
		Δ Appetite					
		Δ Stools					
		G tube	Yes				

CV/PV	Y	N	**DERM**	Y	N	**Other:**
WNL to ALL CV/PV			WNL to ALL DERM			
Chest Pain	No		Rash			
Palpitation			Pruritus			
Dizzy			Bruising	No		
DOE						
Edema	No					

Physical Examination

Latest Vitals: **Past Vitals (Click link to view all vitals)**

Weight: 162.00
Height: 72.00
BMI:
Temperature: 97.10 [Temporal]
Blood Pressure: 116 / 60 [R Arm Laying]
Pulse: 65.00 [Pulse Oximeter]
Respiration: 18.00
Pulse Ox: 100.00 [Room Air]

Physical Examination:

LOC:	Alert	Change from baseline?	Comments
Orientation:	Time Place Person	Change from baseline?	Comments
Activity/MS:	Full ROM Normal Gait Muscle tone/strength wnl for age		Comments

Neuro:	Speech Clear Sustain Focus Sensory fn intact Intact Memory Motor fn intact No Tremor Reflexes intact CN I-XII Intact	Comments
HEENT:	Normocephalic No lymphadenopathy	Comments

Apical/Radial Pulse:	Regular		Change from baseline?	Comments
CV	RRR without Murmur or rubs			Comments
Edema:	N/A	Pitting Edema, scale +	Change from baseline?	Comments

Peripheral Pulses:	Right:WNL	Right Capillary refill <3 seconds:	Comments
	Left:WNL	Left Capillary refill <3 seconds:	

Skin:	Warm		Turgor:	Change from Baseline
Skin Color:	WNL	Abnormal:	Skin Comments	

Respiration:	WNL	Abnormal:	Respiratory Comments
Breath Sounds:	Right: Clear Left: Clear	Change from baseline?	

Cough:	No	Describe:	Change from baseline?

Abdomen:	Soft	Change from baseline?	Abdomen/Bowel Comments
Bowel Sounds:	Normoactive	Change from baseline?	

Urinary:	No bladder distension	Comments

Psych	Normal Mood	Comments

Pain: **Scale 0 - 10**	0 = No pain	Pain at tolerable level according to patient	Change from baseline?	Comments - Sites

IV access, Catheters, Drainage Tubes	IV access No	Type of Access and Condition of site	
	Indwelling Urinary Catheter No		Describe
	Other catheters or Drainage Tubes No		Describe

Other:

Assessment/Plan

Problem 1
Select Problem

acute right basal gangliar lentiform nucleus ischemic CVA(I63.9)
PT/OT/Speech
continue ASA,
Neuro follow up

Problem 2
Select Problem

Dysphagia 2/2 CVA s/p PEG placement 11/23/2019(R13.10, i69.391)
soft diet
Follow up for removal in a few weeks

Problem 3
Select Problem

Respiratory distress due to aspiration pneumonitis(J69.0)
nebs as needed
continue bronchodilators
respiratory to follow

Problem 4
Select Problem

chronic Diastolic CHF(i50.9)
monitor labs

Problem 5
Select Problem

HTN(i10)
continue BP medication
monitor BP

Problem 6
Select Problem

Anemia(D64.9)
monitor labs

Problem 7
Select Problem

Depression (F32.9)
continue medications as ordered

Problem 8
Select Problem

Palliative & Hospice Care Assessment

PALLIATIVE TRIGGERS (> 6 month prognosis)	HOSPICE TRIGGERS (< 6 month prognosis)

Discussed with:
Patient discussion
Patient's family discussion
Previous Discussions (list dates):

Click on link to access the Palliative Education Handout

Other Trigger

Signature (Click on the check box to sign)
Jackie Kimball, NP (12/15/2019 05:06 PM (CST))