Edward-Elmhurst
HEALTH

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FAX TRANSMITTAL

DATE: 3-9-20

TO:

Name: SAI Systems Health

Fax#: (877)-725-4441

Phone#: ~~[illegible]~~ (630) 506-1245

FROM:

Name: Ausra Simmert

Phone#: 630-646-5020 Fax#:630-646-5025

NUMBER OF PAGES INCLUDING COVER PAGE: ______

COMMENTS:

PROGRESS NOTE - HISTORY

Name	Anderson, Ophelia	MR #	141137
Gender	F	Birth Date	07/13/1938
Facility	Lexington Health Care Center of Elmhurst	Marital Status	Widowed
Room #	203	Reason For Visit	f/u on stoma prolapse
Admission Date	10/17/19		
Date Form Opened	2/16/2020		

Chief Complaint

Past Medical History Reviewed Yes

History of Present Illness:

81yo AAF who presented to Mount Sinai hospital on 9/19/19 with bilateral extremity edema, SOB, and fatigue associated with chest pain. Found to have Bilateral PE and DVT. Rapid response called on 9/24/19 for chest pain -repeated Chest Xray showed pneumoperitoneum -patient underwent ex-LAP with Left hemicolectomy, sigmoid colectomy, Hartman's procedure with creation of end transverse colostomy for perforated diverticulitis, had IVC filter placed and chest Tube. Extubated on 9/26/19. Patient is here for rehab.
EMH 12/18-12/28/19 sepsis
Patient seen and examined in the room, f/u on stoma prolapse. No pain or excoriation at the site. Denies any fever or chills , will contact GI on Monday for evaluation.

Past Medical/Surgical History:

PMHx: Hyperthyroidism s/p ablation , MI , HTN , PE, DVT , HLD

Social Hx: lives along no drug use

family Hx: non contributory

Health Status

Advanced Directives:

Full Code/Attempt Resuscitation/CPR,Full Code/Attempt Resuscitation/CPR,

Additional Notes Regarding Advanced Directives:

Select dropdown arrow to see all diagnoses. Admitting diagnosis is at the top.
N39.0 — Urinary tract infection, site not specified

Recent Physician Progress Notes (Click links to view):

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

Labs/Radiology (List reviewed labs with dates)
12/29/19
wbc 7.76 hgb 8.2 (8.5) plt 616 (671) na 142 k 4.4 gluc 74 BUN 8 Scr 0.63 egfr > 60 10/20/19 :
No labs available within last 24 hr

Health Status (Continued)

Allergy List: aspirin, codeine

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

Review of Systems

CONST	Y	N
WNL to ALL Constitution		
Fever	No	
Δ Mental Status	No	
Δ Function		
Δ Weight		
Pain	No	

RESP	Y	N
WNL to ALL RESP		
SOB	No	
Cough	No	
Wheezing	No	
Phlegm		
Hx Smoking		

GU	Y	N
WNL to ALL GU		
Dysuria	No	
Hematuria	No	
Frequency	No	
Urgency		
Nocturia		
Foley		

MS	Y	N
WNL to ALL MS		
Joint Pain	No	
Swelling		
Myalgia		
Arthralgia		
Fall last 30 days		
Hx of Falls		
Gait D/O	Yes	

HEENT	Y	N
WNL to ALL HEENT		
Eye Discharge		
Δ Visual	No	
HOH	No	
Epistaxis		
Rhinitiis		
Tinnitus		
Sore Throat		

GI	Y	N
WNL to ALL GI		
Nausea	No	
Vomiting	No	
Obesity	Yes	
Abd Pain	No	
Diarrhea	No	
Constipation	No	
Melena		
Hemoccult		
Dysphagia		
Dyspepsia		
Δ Appetite	No	
Δ Stools	No	
G tube		

NEURO	Y	N
WNL to ALL NEURO		
Syncope		
Aphasia		
HA		
Vertigo		
Focal Weakness		
Paraesthesia		
Seizures		
Confused	No	

PSYCH	Y	N
WNL to ALL PSYCH		
Anxiety		
Depression		
Sleep Disturbance		
Agitation	No	
Combative		
Hallucination		
Psychosis		
Δ Mood	No	

CV/PV	Y	N
WNL to ALL CV/PV		
Chest Pain	No	
Palpitation	No	
Dizzy	No	
DOE		
Edema	No	

DERM	Y	N
WNL to ALL DERM		
Rash	No	
Pruritus	No	
Bruising	No	

Other:

Physical Examination

Latest Vitals:

Past Vitals (Click link to view all vitals)

Weight:	135.60	Temperature:	97.80 [Temporal]
Blood Pressure:	136 / 62 [L Arm Laying]	Pulse:	63.00 [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
Neuro			Comments
HEENT:	Normocephalic Non-icteric Moist Mucous Membranes		Comments

Apical/Radial Pulse:	Regular		Change from baseline?	Comments
Murmur?	No	If Yes, describe Murmur		
Edema:	N/A	Pitting Edema, scale +	Change from baseline?	Comments
Peripheral Pulses:	Right:WNL Left:WNL		Right Capillary refill <3 seconds: Left Capillary refill <3 seconds:	Comments
Skin:	Warm Dry	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 Non-Tender		Change from baseline?	Abdomen/Bowel Comments stoma protrusion Colostomy LUQ

Bowel Sounds:	Normoactive	Change from baseline?	

Urinary:		Comments not observed

Psych	Cooperative	Comments	

Pain: Scale 0 - 10	0 = No pain	Change from baseline?	Comments - Sites

Other:	

Assessment/Plan

Problem 1
Select Problem

K94.00 Prolapse of stoma
- no pain
- will call GI on Monday
- Monitor for worsening symptoms

Problem 2
Select Problem I10 — Essential (primary) hypertension

Stable
Continue medications as prescribed
Monitor blood pressure Q shift
Monitor for safety / falls

Problem 3
Select Problem M62.81 — Muscle weakness (generalized)

PT /OT
fall and safety precautions

Problem 4
Select Problem K57.80 — Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding

Stable
Monitor for abdominal pain
Monitor for fever /chills
Safety and fall precautions

Problem 5
Select Problem

Problem 6
Select Problem

Problem 7
Select Problem

Problem 8
Select Problem

Signature (Click on the check box to sign)
Ausra Simmert, NP (02/16/2020 10:56 AM (CST))

PROGRESS NOTE - HISTORY

Name	Wilson, Margaret	MR #	116658
Gender	F	Birth Date	04/01/1937
Facility	Lexington Health Care Center of Elmhurst	Marital Status	Married
Room #	219	Reason For Visit	Active GI bleed
Admission Date	06/05/18		
Date Form Opened	2/16/2020		

Chief Complaint

Past Medical History Reviewed Yes

History of Present Illness:

This is an 81 yo CF LTC resident with known morbid obesity, OSA, neuropathy, and hypothyroidism.

Patient asked to be seen for active GI bleed. Seen and examined in the room. No n/v/d. no fever/chills. No abdominal pain. no other complaints.

Past Medical/Surgical History:

Renal calculi, hearing impairment, HTN, HL, Incontinence, Meniere's disease, Morbid obesity, Neuropathy, Visual impairment.

family Hx non-contributory

Health Status

Advanced Directives:

Do Not Resuscitate,Do Not Resuscitate,

Additional Notes Regarding Advanced Directives:

Select dropdown arrow to see all diagnoses. Admitting diagnosis is at the top.
G62.9 — Polyneuropathy, unspecified

Recent Physician Progress Notes (Click links to view):

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

c02 32 gluc 88 BUN 21 cret 1.14 tp 5.9 alb 2.7
alt 5 ast 10 ap 46 ca 8.8 A1C 4.9
8/13/19 KUB constipation
2/18/19 CXR: no evidence of acute
cardiopulmonary disease.
2/15/19 na 142 k 4.2 cl 106 c02 32.0 gluc 92
BUN 20 creat 0.99 eGFR 54 Ca 8.5 osmo 295
10/18/18 A1c 5.0 chol 125 trig 157 HDL 20
LDL 74 TSH 4.717
8/31/18 wbc 7.68 RBC 4.05 h/h 12.7/40.1 PLT
213; na 140 k 3.8 cl 102 c02 29 BUN 28 creat
1.03 egfr 51

Health Status (Continued)
Allergy List: No Known Allergies

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

Review of Systems

CONST	Y	N
WNL to ALL Constitution		
Fever	No	
Δ Mental Status		
Δ Function		
Δ Weight		
Pain	No	

RESP	Y	N
WNL to ALL RESP		
SOB	No	
Cough	No	
Wheezing	No	
Phlegm		
Hx Smoking		

GU	Y	N
WNL to ALL GU		
Dysuria	No	
Hematuria	No	
Frequency		
Urgency		
Nocturia		
Foley		

MS	Y	N
WNL to ALL MS		
Joint Pain		
Swelling		
Myalgia		
Arthralgia		
Fall last 30 days		
Hx of Falls		
Gait D/O		

HEENT	Y	N
WNL to ALL HEENT		
Eye Discharge		
Δ Visual	No	
HOH		
Epistaxis		
Rhinitiis		
Tinnitus		
Sore Throat		

GI	Y	N
WNL to ALL GI		
Nausea	No	
Vomiting	No	
Obesity	Yes	
Abd Pain		
Diarrhea		
Constipation		
Melena	Yes	
Hemoccult		
Dysphagia		
Dyspepsia		
Δ Appetite		
Δ Stools		
G tube		

NEURO	Y	N
WNL to ALL NEURO		
Syncope		
Aphasia		
HA		
Vertigo		
Focal Weakness		
Paraesthesia		
Seizures		
Confused	No	

PSYCH	Y	N
WNL to ALL PSYCH		
Anxiety		
Depression		
Sleep Disturbance		
Agitation		
Combative		
Hallucination		
Psychosis		
Δ Mood	No	

CV/PV	Y	N
WNL to ALL CV/PV		
Chest Pain	No	
Palpitation	No	
Dizzy		
DOE		
Edema	Yes	

DERM	Y	N
WNL to ALL DERM		
Rash	No	
Pruritus	No	
Bruising		

Other:

Physical Examination

Latest Vitals:

Past Vitals (Click link to view all vitals)

Weight:	226.40	Temperature:	98.80 [Temporal]
Blood Pressure:	105 / 61 [L Arm Laying]	Pulse:	67.00 [Pulse Oximeter]
Respiration:	18.00	Pulse Ox:	95.00 [Nasal Cannula 2-3 L]

Physical Examination:

LOC:	Alert	Change from baseline?	Comments	
Orientation:	Place Person	Change from baseline?	Comments	
Neuro			Comments	
HEENT:	Normocephalic		Comments	
Apical/Radial Pulse:	Regular		Change from baseline?	Comments
Murmur?	No	If Yes, describe Murmur		
Edema:	Non-Pitting	Pitting Edema, scale +	Change from baseline?	Comments
Peripheral Pulses:	Right:WNL Left:WNL	Right Capillary refill <3 seconds: Left Capillary refill <3 seconds:		Comments
Skin:	Warm Cool	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 Non-Tender		Change from baseline?	Abdomen/Bowel Comments active GI bleed

Bowel Sounds:	Hyperactive	Change from baseline?	

Urinary:		Comments not observed

Psych	Cooperative	Comments	

Pain: Scale 0 - 10	0 = No pain	Change from baseline?	Comments - Sites

Other:

Assessment/Plan

Problem 1
Select Problem K92.2 — Gastrointestinal hemorrhage, unspecified

Hospice
DNR
PCP notified - orders received not to send patient to hospital
Hospice nurse notified - on the way to see patient
Family notified
CBC stat ordered

Problem 2
Select Problem I10 — Essential (primary) hypertension

stable
Monitor BP Q shift

Problem 3
Select Problem J44.9 — Chronic obstructive pulmonary disease, unspecified

continue supplemental 02 titrate for sat > 92%
RT/Pulm following

Problem 4
Select Problem

Problem 5
Select Problem

Problem 6
Select Problem

Problem 7
Select Problem

Problem 8
Select Problem

Signature (Click on the check box to sign)
Ausra Simmert, NP (02/16/2020 12:36 PM (CST))

PROGRESS NOTE - HISTORY

Name	Ortiz, Theresa	MR #	128811
Gender	F	Birth Date	11/28/1948
Facility	Lexington Health Care Center of Elmhurst	Marital Status	Married
Room #	117	Reason For Visit	Anticoagulation management
Admission Date	01/13/20		
Date Form Opened	2/16/2020		

Chief Complaint

Past Medical History Reviewed Yes

History of Present Illness:

This is 71 y/o HF admitted from Kindred hospital with the diagnosis of cellulitis of right lower leg. Past h/o CVA with right sided weakness, left ventricular thrombosis, NSVT treated with ablation and ICD placement, and HTN

Patient seen for INR management. INR 4.3/51.8. Pt resting in bed, patient alert, denies abdominal pain,chest pain or SOB, on po antibiotics,denies any bleeding.

Past Medical/Surgical History:

PMH: CHF, AFIB POST ABLATIONS, HTN, CVA X 3, Taksubo CM CVA with right sided weakness, left ventricular thrombosis, NSVT treated with ablation and ICD placement, HTN

soc: lives at home

Health Status

Advanced Directives:

Full Code/Attempt Resuscitation/CPR,

Additional Notes Regarding Advanced Directives:

Select dropdown arrow to see all diagnoses. Admitting diagnosis is at the top.
L03.115 — Cellulitis of right lower limb

Recent Physician Progress Notes (Click links to view):

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

Labs/Radiology (List reviewed labs with dates)
2/9/20 INR 3.6
2/8/20 INR 3.3
11/20/19 wbc 5.32 hgb 11.4 plt 242 na 142 k 3.5 gluc 95 BUN 13 Scr 0.81
10/30/19 wbc 5.60 hgb 9.8 plt 241 na 143 k 3.2 gluc 83 BUN 12 Scr 0.75
1/28/2020- INR 3.5, PT42
10/25/19 wbc 4.92 hgb 9.2 plt 239 na 145 k 3.6 gluc 93 BUN 15 Scr0.85
10/9- na 143, k 3.5, bun 15, scr 0.68, ca 9.2

Health Status (Continued)
Allergy List: No Known Drug Allergies

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

Review of Systems

CONST	Y	N
WNL to ALL Constitution		
Fever	No	
Δ Mental Status		
Δ Function		
Δ Weight		
Pain	No	

RESP	Y	N
WNL to ALL RESP		
SOB	No	
Cough	No	
Wheezing	No	
Phlegm		
Hx Smoking		

GU	Y	N
WNL to ALL GU		
Dysuria	No	
Hematuria	No	
Frequency	No	
Urgency	No	
Nocturia		
Foley		

MS	Y	N
WNL to ALL MS		
Joint Pain		
Swelling		
Myalgia		
Arthralgia		
Fall last 30 days		
Hx of Falls		
Gait D/O	Yes	

HEENT	Y	N
WNL to ALL HEENT		
Eye Discharge		
Δ Visual	No	
HOH	No	
Epistaxis		
Rhinitiis		
Tinnitus		
Sore Throat		

GI	Y	N
WNL to ALL GI		
Nausea	No	
Vomiting	No	
Obesity		
Abd Pain	No	
Diarrhea	No	
Constipation	No	
Melena		
Hemoccult		
Dysphagia		
Dyspepsia		
Δ Appetite		
Δ Stools		
G tube		

NEURO	Y	N
WNL to ALL NEURO		
Syncope		
Aphasia		
HA		
Vertigo		
Focal Weakness		
Paraesthesia		
Seizures		
Confused	No	

PSYCH	Y	N
WNL to ALL PSYCH		
Anxiety		
Depression		
Sleep Disturbance		
Agitation	No	
Combative		
Hallucination		
Psychosis		
Δ Mood	No	

CV/PV	Y	N
WNL to ALL CV/PV		
Chest Pain	No	
Palpitation	No	
Dizzy		
DOE		
Edema		

DERM	Y	N
WNL to ALL DERM		
Rash	No	
Pruritus	No	
Bruising		

Other:

Physical Examination

Latest Vitals:

Past Vitals (Click link to view all vitals)

Weight: 230.40

Temperature: 97.80 [Temporal]

Blood Pressure: 115 / 54 [R Arm Laying]

Pulse: 74.00 [Pulse Oximeter]

Respiration: 18.00

Pulse Ox:

Physical Examination:

LOC:	Alert	Change from baseline?	Comments	
Orientation:	Time Place Person	Change from baseline?	Comments	
Neuro			Comments	
HEENT:	Normocephalic Moist Mucous Membranes		Comments	
Apical/Radial Pulse:	Regular		Change from baseline?	Comments
Murmur?	No	If Yes, describe Murmur		
Edema:	N/A	Pitting Edema, scale +	Change from baseline?	Comments
Peripheral Pulses:	Right:WNL Left:WNL	Right Capillary refill <3 seconds: Left Capillary refill <3 seconds:		Comments
Skin:	Warm Dry	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 Non-Tender		Change from baseline?	Abdomen/Bowel Comments
Bowel Sounds:	Normoactive		Change from baseline?	

Urinary:		Comments not observed

Psych	Cooperative	Comments

Pain: **Scale 0 - 10**	0 = No pain	Change from baseline?	Comments - Sites

Other:

Assessment/Plan

Problem 1
Select Problem I48.91 — Unspecified atrial fibrillation

stable
Continue medications as prescribed
INR goal 2.0-3.0 INR today- 4.3 PT 51.8 , no S&S of bleeding noted or reported -on antibiotics
Hold Coumdin x 1 day will recheck INR on 2/17/20
Monitor for bleeding

Problem 2
Select Problem I10 — Essential (primary) hypertension

Stable
Monitor BP Q shift
Monitor for chest pain/palpitations

Problem 3
Select Problem I51.81 — Takotsubo syndrome

stable, EF 25%
continue Lasix + KCL
daily weight
cards consult- appreciate recs
appears compensated

Problem 4
Select Problem

M62.81 Muscle weakness
PT /OT
Monitor safety/falls

Problem 5
Select Problem

Problem 6
Select Problem

Problem 7
Select Problem

Problem 8
Select Problem

Signature (Click on the check box to sign)
Ausra Simmert, NP (02/16/2020 04:10 PM (CST))

Return to Hospital Risk Assessment

Name	Donnelly, Cheryl	MR #	146698
Gender	F	Birth Date	12/23/1956
Facility	Lexington Health Care Center of Elmhurst	Marital Status	
Room #	121	Admitting Diagnosis	M62.81
Admission Date	02/15/20		
Date Form Opened	2/16/2020		

Reason For Visit:

Admitting Risk Assessment

History of Present Illness:

Patient is 63 y female with PMHx: DM1, CAD, CHF , ACD, HTN, HDL, Hypothyroidism , Depression presented to ER s/p mechanical fall. Patient slipped and fell , hit her head on her bed frame. Patient ended up having R distal radial and ulnar fractures and R non-displaced proximal fibular fracture. Possible Left distal radius fracture.

Patient seen and examined in the room Patient rates pain at 4-5/10 when resting , when moving R leg pain goes up to 9/10. R arm cast with the sling , intact . Denies any chest pain , palpitations or shortness of breath.

Allergy List: ACE Inhibitors, captopril, Cipro, Keflex, Sulfa (Sulfonamide Antibiotics)

Allergies Not listed

Hospitalization History

Hospitalization in the Past 12 months? Yes	Was most recent hospitalization through the Emergency Department? Yes
Length of stay for most recent hospitalization? 4 - 6 days	
How many Emergency Department visits in the past 6 months without hospitalization?	

Past Medical History

PMHx
M1, CAD, CHF , ACD, HTN, HDL, Hypothyroidism , Depression

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

- 4
A 3
C 3 If TOTAL PMH is 4 or greater, then enter 5 into C, otherwise enter the TOTAL PMH.
E 0

LACE 10

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

Congestive Heart Failure

Diabetes without complications

Pain Present

TOTAL PMH 4

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)
No-Never If Stopped, Quit Date:
Smoking Cessation Plan If Yes-Smoking, Packs and Years

ETOH Use:
Present ETOH use? No Past ETOH use? Amount

Recent Laboratory and Diagnostic Tests (Click Link to Access Laboratory Attachments):
Labs/Radiology (List reviewed labs with dates) Reviewed Laboratory Results
3/11/20 WBC 11.8, Hgb 13.8, Hct 40.7, PLT 192 , creat 1.21,
Bun 20, Na 142, K 3.7

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

MEDICATION	DOSAGE	TYPE	FORM	FREQUENCY	METHOD
acetaminophen 325 mg tablet	325 mg	2 tablets	TABLET	As Needed Every Four Hours	Oral
ascorbic acid (vitamin C) 1,000 mg tablet	1,000 mg	1 tablet	TABLET	1D:One Time Daily	Oral
bisacodyL 10 mg rectal suppository	10 mg	1 suppository	SUPPOSITORY, RECTAL	As Needed One Time Daily	Rectal
HYDROcodone 5 mg-acetaminophen 325 mg tablet	5-325 mg	1-2 tablet(s)	TABLET	As Needed Every Six Hours	Oral
Milk of Magnesia 400 mg/5 mL oral suspension	400 mg/5 mL	30 mL	SUSPENSION, ORAL (FINAL DOSE FORM)	As Needed One Time Daily	Oral
Miralax 17 gram oral powder packet	17 gram	1 packet	POWDER IN PACKET (EA)	2D:Two Times Daily	Oral
Sennosides 8.6 mg-docusate sodium 50 mg tablet	8.6-50 mg	2 tablets	TABLET	1D:One Time Daily	Oral
fluticasone propionate 50 mcg/actuation nasal spray,suspension	50 mcg/actuation	2 sprays	SPRAY, SUSPENSION	1D:One Time Daily	Intranasal
insulin aspart U-100 100 unit/mL subcutaneous solution	100 unit/mL	sliding scale	VIAL (ML)	As Needed Three Times Daily	Subcutaneous
Blood Glucose Monitoring kit		1 test	KIT	3D:Three Times Daily	Other
NovoLOG Flexpen U-100 Insulin aspart 100 unit/mL (3 mL) subcutaneous	100 unit/mL (3 mL)	4 units	INSULIN PEN (ML)	3D:Three Times Daily	Subcutaneous
Lantus Solostar U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen	100 unit/mL (3 mL)	12 units	INSULIN PEN (ML)	1D:One Time Daily	Subcutaneous
pravastatin 10 mg tablet	10 mg	1 tablet	TABLET	1D:One Time Daily	Oral
aspirin 81 mg chewable tablet	81 mg	1 tablet	TABLET,CHEWABLE	1D:One Time Daily	Oral
Wellbutrin XL 300 mg 24 hr tablet, extended release	300 mg	1 tablet	TABLET, EXTENDED RELEASE 24 HR	1D:One Time Daily	Oral
carvedilol 25 mg tablet	25 mg	1 tablet	TABLET	2D:Two Times Daily	Oral
Lovenox 40 mg/0.4 mL subcutaneous syringe	40 mg/0.4 mL	0.4 mL	SYRINGE (ML)	1D:One Time Daily	Subcutaneous
ergocalciferol (vitamin D2) 1,250 mcg (50,000 unit) capsule	1,250 mcg (50,000 unit)	1 capsule	CAPSULE	1M:One Time Monthly	Oral
Glucagon Emergency Kit (human-recomb) 1 mg solution for injection	1 mg	1 MG	VIAL (EA)	1PRN:As Needed One Time Max	Intramuscular
isosorbide mononitrate ER 30 mg tablet,extended release 24 hr	30 mg	1 tablet	TABLET, EXTENDED RELEASE 24 HR	1D:One Time Daily	Oral
levothyroxine 75 mcg tablet	75 mcg	1 tablet	TABLET	1D:One Time Daily	Oral
Cytomel 5 mcg tablet	5 mcg	1 tablet	TABLET	1D:One Time Daily	Oral
losartan 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

Review of Systems

CONST	Y	N
WNL to ALL Constitution		
Fever	No	
Δ Mental Status	No	
Δ Function		
Δ Weight		
Pain	Yes	

RESP	Y	N
WNL to ALL RESP		
SOB		
Cough		
Wheezing		
Phlegm		
Hx Smoking		

GU	Y	N
WNL to ALL GU		
Dysuria	No	
Hematuria	No	
Frequency	No	
Urgency		
Nocturia		
Foley		

MS	Y	N
WNL to ALL MS		
Joint Pain	No	
Swelling	No	
Myalgia	No	
Arthralgia	No	
Fall last 30 days		
Hx of Falls		
Gait D/O		

	Y	N
	Yes	

HEENT	Y	N
WNL to ALL HEENT		
Eye Discharge		
Δ Visual	No	
HOH	No	
Epistaxis		
Rhinitis		
Tinnitus		
Sore Throat		

GI	Y	N
WNL to ALL GI		
Nausea		
Vomiting		
Obesity		
Abd Pain		
Diarrhea		
Constipation		
Melena		
Hemoccult		
Dysphagia		
Dyspepsia		
Δ Appetite		
Δ Stools		
G tube		

NEURO	Y	N
WNL to ALL NEURO		
Syncope	No	
Aphasia	No	
HA		
Vertigo	No	
Focal Weakness	No	
Paraesthesia	No	
Seizures		
Confused		

PSYCH	Y	N
WNL to ALL PSYCH		
Anxiety		
Depression		
Sleep Disturbance		
Agitation		
Combative		
Hallucination		
Psychosis		
Δ Mood	No	

	Y	N
	No	
	No	

CV/PV	Y	N
WNL to ALL CV/PV		
Chest Pain	No	
Palpitation	No	
Dizzy		
DOE		
Edema	No	

DERM	Y	N
WNL to ALL DERM		
Rash	No	
Pruritus	No	
Bruising	Yes	

Other:
R sided forehead and R eye ecchymosis

Physical Examination

Latest Vitals:

Past Vitals (Click link to view all vitals)

Weight:	128.00	BMI:	
Height:	64.00		
		Temperature:	98.30 [Oral]
Blood Pressure:	184 / 95 [L Arm Laying]	Pulse:	79.00 [Pulse Oximeter]
Respiration:	18.00	Pulse Ox:	96.00

Physical Examination:

LOC:	Alert	Change from baseline?	Comments	
Orientation:	Time Place Person	Change from baseline?	Comments	
Activity/MS:	Full ROM Muscle tone/strength wnl for age		Comments	
Neuro:	Speech Clear Intact Memory		Comments	
HEENT:	Normocephalic Moist Mucous Membranes 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 Left:WNL	Right Capillary refill <3 seconds: Left Capillary refill <3 seconds:	Comments	
Skin:	Warm Dry	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 Non-Tender		Change from baseline?	Abdomen/Bowel Comments	
Bowel Sounds:	Normoactive		Change from baseline?		
Urinary:				Comments not observed	
Psych	Cooperative	Comments			
Pain: Scale 0 - 10	4 = Moderate	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

E10.9 Diabetes type I
Continue treatment as prescribed
sliding scale
continue insulin QID with meals
monitor for hypoglycemia/hyperglycemia
Problem 2
Select Problem

I10 HTN
monitor BP Q shift
ontinue medications s prescribed
monitor for chest pain , shortness of breath
Problem 3
Select Problem

I25.10 CAD
continue ASA
continue statin
monitor safety /falls
Problem 4
Select Problem

M62.81 Muscle weakness
PT/OT
Monitor for falls / safety
Problem 5
Select Problem

Problem 6
Select Problem

Problem 7
Select Problem

Problem 8
Select Problem

Palliative & Hospice Care Assessment

PALLIATIVE TRIGGERS (> 6 month prognosis)

No advanced directive or DNR w/ above triggers

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)
Nusra Simmert, NP (02/16/2020 01:14 PM (CST))

PROGRESS NOTE - HISTORY

Name	Adis-Lynch, Mary	MR #	125496
Gender	F	Birth Date	08/29/1963
Facility	Lexington Health Care Center of Elmhurst	Marital Status	Divorced
Room #	225	Reason For Visit	hyperglycemia
Admission Date	01/05/20		
Date Form Opened	2/23/2020		

Chief Complaint

Past Medical History Reviewed Yes

History of Present Illness:

51 y/o CF w known Bipolar 1 disorder, Seizure disorder, DM2, Charcot foot ulceration was admitted to Hospital on 12/18 with AMS- dx SAH. She was intubated/extubated, in ICU. she was found to also have L radial vein DVT and started on AC. She had a PEG placed. She has DM2 with labile blood sugars and endocrinology was consulted.
1/10/20: patient readmitted to hospital for AMS, sepsis, hyperkalemia, hyperglycemia, anemia.
Transfer back to SAR 1/16/20

Patient asked to be seen for hyperglycemia. Patients blood sugar was high this am and lunch time. On sliding scale , patient brittle diabetic . Denies any other complaints at this visit.

Past Medical/Surgical History:

Bipolar 1 disorder, Seizure disorder, DM2, Charcot foot ulceration
SAH. L radial vein DVT PEG anemia

Health Status

Advanced Directives:
Full Code/Attempt Resuscitation/CPR,

Additional Notes Regarding Advanced Directives:

Select dropdown arrow to see all diagnoses. Admitting diagnosis is at the top.
431.5 — Nontraumatic intracerebral hemorrhage, intraventricular

Recent Physician Progress Notes (Click links to view):

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

Reviewed Laboratory Results

Labs/Radiology (List reviewed labs with dates)
2/22/2020 wbc 8.42 hgb 9.9 plt 587 na 129 K 5.3 gluc 434 BUN 59 Scr 1.76 egfr 30
UA turbid mod blood large leuk > 900 wbc
2/8/2020 UA 300 , gluc > 100, large blood, large leuk est, wbc > 50 c/s 60
1/20/20: WBC 8, hgb 7.7, plt 440, Na 131, K 4.5, bun 24, cr 1.04

Health Status (Continued)
Allergy List: Lyrica

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

Review of Systems

CONST	Y	N
WNL to ALL Constitution		
Fever	No	
Δ Mental Status		
Δ Function		
Δ Weight		
Pain	Yes	

RESP	Y	N
WNL to ALL RESP		
SOB	No	
Cough	No	
Wheezing	No	
Phlegm		
Hx Smoking		

GU	Y	N
WNL to ALL GU		
Dysuria	No	
Hematuria	No	
Frequency	No	
Urgency		
Nocturia		
Foley	No	

MS	Y	N
WNL to ALL MS		
Joint Pain		
Swelling		
Myalgia		
Arthralgia		
Fall last 30 days		
Hx of Falls		
Gait D/O	Yes	

HEENT	Y	N
WNL to ALL HEENT		
Eye Discharge		
Δ Visual	No	
HOH	No	
Epistaxis		
Rhinitiis		
Tinnitus		
Sore Throat		

GI	Y	N
WNL to ALL GI		
Nausea	No	
Vomiting	No	
Obesity		
Abd Pain	No	
Diarrhea	No	
Constipation	No	
Melena		
Hemoccult		
Dysphagia		
Dyspepsia		
Δ Appetite		
Δ Stools		
G Iube		

NEURO	Y	N
WNL to ALL NEURO		
Syncope		
Aphasia		
HA		
Vertigo		
Focal Weakness		
Paraesthesia		
Seizures		
Confused	No	

PSYCH	Y	N
WNL to ALL PSYCH		
Anxiety		
Depression		
Sleep Disturbance		
Agitation	No	
Combative		
Hallucination		
Psychosis		
Δ Mood	No	

CV/PV	Y	N
WNL to ALL CV/PV		
Chest Pain	No	
Palpitation	No	
Dizzy		
DOE		
Edema	No	

DERM	Y	N
WNL to ALL DERM		
Rash	No	
Pruritus		
Bruising	No	

Other:

Physical Examination

Latest Vitals:

Past Vitals (Click link to view all vitals)

Weight:	153.00	Temperature:	98.50 [Temporal]
Blood Pressure:	131 / 70 [L Arm Sitting]	Pulse:	73.00 [Brachial]
Respiration:	18.00	Pulse Ox:	96.00

Physical Examination:

LOC:	Alert	Change from baseline?	Comments	
Orientation:	Time Place Person	Change from baseline?	Comments	
Neuro			Comments	
HEENT:	Normocephalic		Comments	
Apical/Radial Pulse:	Regular		Change from baseline?	Comments
Murmur?	No	If Yes, describe Murmur		
Edema:	N/A	Pitting Edema, scale +	Change from baseline?	Comments
Peripheral Pulses:	Right:WNL Left:WNL	Right Capillary refill <3 seconds: Left Capillary refill <3 seconds:	Comments	
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 Non-Tender	Change from baseline?	Abdomen/Bowel Comments	
Bowel Sounds:	Normoactive	Change from baseline?		

Urinary:		Comments not observed

Psych	Cooperative	Comments	
Pain: Scale 0 - 10	4 = Moderate	Change from baseline?	Comments - Sites
Other:			

Assessment/Plan

Problem 1
Select Problem

R73.9 Hyperglycemia
Insulin 8 U in am x 1
Insulin at Lunch 7 U x 1 dose
Monitor BS
Monitor for hypoglycemia
Problem 2
Select Problem I10 — Essential (primary) hypertension

Stable
Monitor BP Q shift
Monitor for worsening symptoms
Problem 3
Select Problem F33.1 — Major depressive disorder, recurrent, moderate

Monitor behaviors
Monitor worsening symptoms
Problem 4
Select Problem

M62.81 Muscle weakness
PT/OT
monitor safety/falls
Problem 5
Select Problem

Problem 6
Select Problem

Problem 7
Select Problem

Problem 8
Select Problem

Signature (Click on the check box to sign)
Jusra Simmert, NP (02/23/2020 12:39 PM (CST))