ST. LUKE'S REGIONAL HOSPITAL

Department of General Medicine — Observation Unit
425 Oak Street, Portland, OR 97205 | (503) 555-0287

PROGRESS NOTE

Patient: Okafor, Raymond A.	**MRN:** 7103842	**DOB:** 11/02/1957 (68M)
Admit Date: 02/15/2026 19:11	**Attending:** Priya Narayanan, MD	**Unit:** Obs 4, Bed 3

REASON FOR ADMISSION

Fall at home with left hip pain. Placed in observation for orthopedic evaluation.

HISTORY OF PRESENT ILLNESS

68-year-old male with history of COPD on home O2, osteoarthritis, BPH, and chronic lower back pain (managed with ibuprofen PRN), who presents after a mechanical fall at home. Patient states he tripped over a rug while getting up to use the bathroom around 6 PM. Denies loss of consciousness or head strike. Complains of left hip pain, rated 7/10, worse with weight bearing. Patient notes he has been feeling "a little under the weather" for the past few days with generalized fatigue and poor appetite, which he attributes to a "cold going around." Wife mentions he has seemed "more winded than usual" on exertion and has been sleeping more. She also notes he felt warm to touch this morning but they did not take his temperature. Patient completed a 5-day course of prednisone taper (40mg→20mg) for a COPD exacerbation 10 days ago. He reports his usual chronic productive cough is about the same. Denies chest pain, dysuria, abdominal pain, or diarrhea. Reports mild nausea which he attributes to ibuprofen use for the hip pain.

PAST MEDICAL HISTORY

COPD (GOLD Stage II, on home 2L O2 at night), osteoarthritis (bilateral knees, lumbar spine), benign prostatic hyperplasia, hypertension, pre-diabetes (A1c 6.1%), remote 40 pack-year smoking history (quit 2019).

HOME MEDICATIONS

- Tiotropium 18 mcg inhaled daily
- Albuterol inhaler PRN
- Lisinopril 10 mg daily
- Tamsulosin 0.4 mg nightly
- Ibuprofen 400 mg PRN (takes 2–3x/week for joint pain)
- Acetaminophen 500 mg PRN

VITAL SIGNS

Triage (19:11):

Temperature	99.8°F (37.7°C)	**Heart Rate**	94 BPM
Respiratory Rate	20 breaths/min	**Blood Pressure**	118/72 mmHg
SpO2	93% on 2L NC	**Weight**	82 kg

Repeat vitals (02/16/2026 02:30 — nurse noted patient restless, not sleeping):

Temperature	100.9°F (38.3°C)	**Heart Rate**	108 BPM
Respiratory Rate	22 breaths/min	**Blood Pressure**	104/62 mmHg
SpO2	91% on 2L NC		

PHYSICAL EXAMINATION

General: Overweight male, appears uncomfortable due to hip pain. Alert, oriented x3, conversational but fatigued. Mildly diaphoretic.

HEENT: Mucous membranes slightly dry. Oropharynx without erythema or exudate. No JVD.

Cardiovascular: Mildly tachycardic but regular rhythm. No murmurs appreciated. No S3 gallop. No peripheral edema.

Pulmonary: Diffuse scattered expiratory wheezes bilaterally, consistent with known COPD. Faint crackles noted at the right base, possibly atelectatic vs. early consolidation — unclear given body habitus and poor inspiratory effort secondary to pain. No egophony.

Abdomen: Soft, mildly distended, non-tender. No hepatomegaly. Bowel sounds present.

Musculoskeletal: Left hip: tenderness over greater trochanter. Painful with internal/external rotation. No shortening or deformity. Right hip unremarkable.

Skin: Warm. No rashes. Small abrasion on left knee from fall. Stage I pressure area on sacrum (per wife, pre-existing).

Neurologic: Alert, GCS 15. Appropriate but slow to respond at 02:30 reassessment — attributed to pain medication and being woken.

LABORATORY VALUES

Drawn at triage (19:30) — ordered for pre-operative clearance:

Test	Result	Reference
WBC	13.8 K/µL (H)	4.5–11.0
Neutrophils	82%	40–70%
Bands	4%	0–5%
Hemoglobin	13.1 g/dL	13.5–17.5
Platelets	224 K/µL	150–400
Creatinine	1.3 mg/dL	0.7–1.3
BUN	24 mg/dL	7–20
Glucose	128 mg/dL	70–100
Lactate	2.4 mmol/L (H)	0.5–2.0
CRP	6.8 mg/dL (H)	<0.5
Procalcitonin	0.8 ng/mL (H)	<0.05

Urinalysis: Trace leukocyte esterase, negative nitrites, 5–10 WBC/HPF. Unremarkable.

Blood cultures: Not ordered.

IMAGING

Left Hip X-Ray (AP/Lateral): No acute fracture identified. Moderate degenerative changes of the left hip joint. Soft tissue swelling over the greater trochanter region.

Chest X-Ray (portable AP): Low lung volumes. Hyperinflated lungs consistent with COPD. Patchy opacity in the right lower lobe, likely representing atelectasis versus early infiltrate — clinical correlation recommended. No large pleural effusion. No overt consolidation. Heart size at upper limits of normal.

MEDICATIONS ADMINISTERED IN OBSERVATION

- Morphine 4 mg IV q4h PRN for hip pain (given x2)
- Ketorolac 15 mg IV x1 (given in ED at 19:45 for pain, prior to lab results)
- Ondansetron 4 mg IV x1 for nausea
- Home medications continued (tiotropium, lisinopril, tamsulosin)
- Albuterol nebulizer x1 for wheezing
- Normal saline 500 mL IV over 4 hours (for mild dehydration)

02:30 Addendum — Dr. Narayanan notified of repeat vitals: New low-grade fever and tachycardia. In the setting of mildly elevated WBC, lactate, and procalcitonin from admission labs (previously attributed to stress response from fall/pain), now more concerning. CXR right lower lobe opacity reconsidered. Started levofloxacin 750 mg IV empirically to cover possible community-acquired pneumonia given COPD history and RLL finding. Ibuprofen and ketorolac discontinued. Repeat labs and blood cultures ordered for AM draw. Continue to monitor. If hemodynamically unstable, will escalate to inpatient medicine admission.

ASSESSMENT & PLAN

1. **Left hip contusion / possible occult fracture**

   X-ray negative for fracture. Pain management with morphine IV PRN. Ketorolac discontinued after single dose given rising creatinine concern. Will obtain MRI if pain persists to rule out occult femoral neck fracture. PT/OT evaluation in AM. Weight bearing as tolerated with walker.

2. **COPD, stable**

   Continue home inhalers. Albuterol nebs PRN. O2 to maintain SpO2 >90%. Wheezing is at baseline per patient. Recent steroid taper may have masked early infectious symptoms.

3. **Low-grade fever with leukocytosis, elevated inflammatory markers**

   Initially attributed to stress response from fall and pain. Repeat vitals at 02:30 show new fever 100.9°F and HR 108. Mildly elevated WBC 13.8, lactate 2.4, procalcitonin 0.8 — borderline values but trending concerning in aggregate. RLL opacity on CXR could represent early pneumonia versus atelectasis. Started levofloxacin IV empirically. Repeat CBC, BMP, lactate, blood cultures in AM. Urine culture if symptoms develop. Reassess need for broader coverage.

4. **Mild dehydration / borderline renal function**

   Creatinine 1.3 — at upper limit of normal, unclear baseline. BUN/Cr ratio 18.5 suggests possible pre-renal component. IV fluids. Avoid nephrotoxins (ketorolac held). Recheck AM labs.

5. **Pre-diabetes, stress hyperglycemia**

   Glucose 128 on admission. Likely stress-related. Monitor fingerstick if persistent. No insulin needed at this time.

Code Status: Full Code	**Disposition:** Observation	**Allergies:** NKDA