North Suburban Medical Center
9191 Grant Street, Thornton, Colorado 80229 (303) 451-7800

IN/OUT/ER PATIENT ADMISSION RECORD

ACCOUNT#:F45010342505
UNIT RCRD #:F0903-31324
UNIV RCRD #:F441431
ROOM/BED: ADM DATE:02/23/23 ADM TIME:1850 FIN CLASS:03
PT. TYPE:DEP ER LAST DC DATE: LOCATION(S):F.ER

PATIENT INFORMATION

NAME: ANGEL,THEODORE JAMES
STREET: 5471 RARITAN ST
STREET:
C/S/ZP: DENVER,CO 80233
PHONE#: (720)461-0920 CNTY/RES: ADA
CELLPHONE#: (720)461-0920

OTHER NAME:
DOB: 09/15/1975 SS#: xxx-xx-6442
AGE: 47 RACE: OTHER
SEX: M MAR STATUS: D
REL: NONE
EMAIL: NONE

SPOUSE/NOK/COMPANION

ANGEL,STACY
5471 RARITAN ST
DENVER,CO 80233
(720)380-6999 RELTN: OT
WORK PH:

PERSON TO NOTIFY

GARCIA,ANTHONY
NA
WESTMINSTER,CO 80033
(303)246-3053 RELTN: BR
WORK PH:

PATIENT EMPLOYER

HOLLAND RESIDENTIAL
8901 GRANT ST
OFFICE
THORNTON,CO 80229
(303)428-7865 OCC: MAINT

GUARANTOR

ANGEL,THEODORE JAMES RELTN: SA
8901 GRANT ST
APT 1431
THORNTON,CO 80229
(720)982-1750

GUARANTOR EMPLOYER

HOLLAND RESIDENTIAL
8901 GRANT ST
THORNTON,CO 80229
(303)428-7865

SUBSCRIBER

ANGEL,THEODORE JAMES DOB: 09/15/75
RELTN: SA
EMP STS: F

INSURANCE INFORMATION

PRIMARY INSURANCE - 1MCD CO	SECOND INSURANCE -	THIRD INSURANCE -
MEDICAID OF COLORADO		
P O BOX 30		
DENVER		
CO 80201-0030		
POLICY #:I919978	POLICY #:	POLICY #:
COVERAGE #:	COVERAGE #:	COVERAGE #:
INS PHONE #:(844)235-2387	INS PHONE #:	INS PHONE #:
GRP#/AUTH#:NA/	GRP#/AUTH#:/	GRP#/AUTH#:/

ACCIDENT/OTHER INFORMATION

ACCIDENT DATE: TIME: PLACE:
ARRIVAL MODE:AMBULANCE ACC DES:

PHYSICIAN INFORMATION/DOCUMENTATION

ADM:
PMY:.NO PCP NO PRIMARY OR FAMILY PHYSICIAN

ATT:
FMY:
ER: SWAJEA Swan,Jessie Alexandra MD

OTHER 1:SELF REFERRED
OTHER 2:
REASON FOR VISIT/CHIEF COMPL:UNK-AMB

PRINCIPAL DIAGNOSIS:

PRINCIPAL OPERATION/PROCEDURE:

CONSULTATIONS:
PHYSICIAN SIGNATURE/DATE:

Printed [ ] ___
Final Check [ ]

COMMENTS: ....

ADVANCE DIRECTIVE:

EDF Unit#F090331324 ACCT#F45010342505

NAME: ANGEL,THEODORE JAMES ACCT#: F45010342505
FORM:

ADM DATE: 02/23/23 1850
ATTEND PHYS: Swan,Jessie Alexandra MD UNIT#: F090331324
DIS DT/TM: 02/23/23 2005 SEX: M
DIS DISP: ROUTINE HOME/SELF CARE 01 AGE: 47
LOS: : 1 DOB: 09/15/75
PT CLASS: ER FIN CLASS: 03
ABS STATUS: FINAL

DIAGNOSES			POA INDICATOR	CODESET
REASON FOR VISIT DX				
	R51.9	HEADACHE, UNSPECIFIED		ICD10
	M25.512	PAIN IN LEFT SHOULDER		ICD10
PRIMARY CODESET				
PRINC DX	S09.90XA	UNSPECIFIED INJURY OF HEAD, INITIAL ENCOUNTER		ICD10
OTHER DX	S43.492A	OTHER SPRAIN OF LEFT SHOULDER JOINT, INITIAL ENCOUNTER		ICD10
	R40.2362	COMA SCALE, BEST MOTOR RESPONSE, OBEYS COMMANDS, EMR		ICD10
	R40.2142	COMA SCALE, EYES OPEN, SPONTANEOUS, EMR		ICD10
	R40.2252	COMA SCALE, BEST VERBAL RESPONSE, ORIENTED, EMR		ICD10
	V49.9XXA	CAR OCCUPANT (DRIVER) (PASSENGER) INJURED IN UNSP TRAF, INIT		ICD10
	Y92.410	UNSP STREET AND HIGHWAY AS PLACE		ICD10
OTHER CODESET				
PRINC DX				
OTHER DX				

PROCEDURE
PRIMARY CODESET

DATE	PROC CODE & NAME	SURGEON	ANESTHESIOLOGIST

OTHER CODESET

PRIMARY CODESET
DRG I-10
OTHER CODESET
DRG I-9

STATUS	$REIMB	MIN-LOS	STD-LOS	COST WT	GRP VERS	GRP FC
					40	03

DRG STATUS DATE: ABS STATUS DATE: 02/25/23
CODER: INTERFACE ABSTRACTOR: CACUSER

This form will be maintained as a permanent part of the medical record

North Suburban Medical Center (COCNB) Main ED
EMERGENCY PROVIDER REPORT
REPORT#:0223-0301 REPORT STATUS: ESign
DATE:02/23/23 TIME: 1850

PATIENT: ANGEL,THEODORE JAMES UNIT #: F090331324
ACCOUNT#: F45010342505 ROOM/BED: ER
DOB: 09/15/75 AGE: 47 SEX: PCP PHYS: NO PRIMARY OR FAMILY PHYSICIAN
ADM DATE: 02/23/23 INI AUTH: Swan,Jessie Alexandra MD
ED ADMIT DT: 02/23/23 LAST SIG: Swan,Jessie Alexandra MD
REP SERV DT: 02/23/23 REP SERV TM: 1850
* ALL edits or amendments must be made on the electronic/computer document *

HPI GREET

General
Initial Greet Date/Time 02/23/23 1850

Clinical Note
Clinical Note
First Documented:

	Result	Date Time
Pulse Ox	94	02/23 1855
B/P	134/83	02/23 1855
B/P Mean	100	02/23 1855
O2 Delivery	Room air	02/23 1855
Temp	36.3	02/23 1855
Pulse	78	02/23 1855
Resp	18	02/23 1855

Last Documented:

	Result	Date Time
Pulse Ox	94	02/23 1859
B/P	134/83	02/23 1855
B/P Mean	100	02/23 1855
O2 Delivery	Room air	02/23 1855
Temp	36.3	02/23 1855
Pulse	78	02/23 1855
Resp	18	02/23 1855

EMERGENCY DEPARTMENT TREATMENT NOTE

THE EVALUATION, MANAGEMENT, SERVICES AND PROCEDURES, AS WELL AS THE KEY COMPONENTS OF THE PATIENT'S CARE DESCRIBED HEREIN WERE PERFORMED BY: Dr. Jessie Swan

CHIEF COMPLAINT(S): Motor vehicle collision

HISTORY OF PRESENT ILLNESS:

This patient comes to the emergency department via personal vehicle. Mr. Angel is a 47 year old male with no PMHx who presents to the emergency department after head trauma. The patient reports after consuming alcohol he got a LYFT to take him home. He is the unrestrained back seat passenger in a vehicle going 10 mph when the vehicle he was in was sideswiped by another vehicle going an unknown speed causing minimal front passenger side damage. He admits to hitting his head/face on the seat in front of him. He is complaining of facial pain, head pain, and left shoulder pain. He denies associated loss of consciousness, vision changes, malocclusion, back pain, numbness, tingling, focal weakness, chest pain, difficulty breathing, abdominal pain, nausea, vomiting, rash, abrasion, laceration, dysuria, hematuria, flank pain, lower extremity pain. He denies epistaxis. He denies being on anticoagulation therapy. He was placed in a c-collar by EMS. Did not receive any medications by EMS.

Agency: Platte Valley Ambulance greeted
EMS VS: BP 130/82, HR 89, SpO2 92% on RA

PCP: Does not have one

PAST MEDICAL HISTORY: Denies any

SURGICAL HISTORY: Dental/oral, cyst excision from neck

MEDICATIONS: None

ALLERGIES: No known drug allergies

SOCIAL HISTORY: +EtOH, no TOB, no illicit drug use

FAMILY HISTORY: Not obtained

EXAMINATION OF ORGAN SYSTEMS/BODY AREAS:
On physical examination the patient appeared in no acute cardiorespiratory distress and was alert and oriented. Initial vital signs are interpreted as normal.
General: The patient is sitting upright in the stretcher. They appear their stated age. They are appropriate in conversation. GCS: 15
Head: Normocephalic. Atraumatic. No tenderness to palpation. There are no external signs of head trauma over the face or scalp. Normal range of motion of the jaw. No tenderness over the zygomatic arch. No battle sign. No raccoon eyes. No soft tissue hematoma of the skull or scalp. No lacerations or abrasions of the scalp.
Eyes: PERRLA. Extraocular movements are intact. No nystagmus. No conjunctival pallor or hemorrhage. No scleral icterus. No hyphema. No tenderness to palpation over the supra or infraorbital ridge. No tenderness to palpation over the zygomatic process.
ENMT: Mucous membranes of the mouth are moist. No hemotympanums. No epistaxis. No nasal septum hematoma. No acutely cracked, chipped, missing, or loose teeth.
Neck: No C-spine tenderness or step off.

Cardiovascular: No cyanosis. Radial pulse intact on the left.
Respiratory: No accessory muscle use during respiration
Gastrointestinal: Abdomen is soft, obese, nontender, nondistended. No rigidity or guarding. No peritoneal signs.
Musculoskeletal: Moves all 4 extremities with normal range of motion with the exception of left shoulder. Limited abduction and flexion left shoulder secondary to pain. Tenderness to palpation over the distal left clavicle, acromioclavicular joint, proximal left humerus. Otherwise 5/5 strength to proximal and distal muscle groups of the bilateral upper and lower extremities. No swollen or warm joints. No peripheral edema. No midline thoracic or lumbar spinous process tenderness or step-off.
Skin: No acute rashes or lesions.
Neuro: Cranial nerves: Visual acuity is grossly intact. Eyelid opening and extraocular movements intact. Facial sensation intact bilaterally. Eyebrow raise symmetrical and intact. Eyelid close intact. Smile intact. Palate elevation intact. Sensation: Sensation intact to light touch intact in upper and lower extremities.

MEDICAL DECISION MAKING AND COURSE IN THE ED WITH INTERPRETATION/REVIEW OF DIAGNOSTIC STUDIES:
Based on this at the presenting symptoms as well as physical examination this patient requires further emergency department evaluation for their acute head trauma. I'm concerned about the possibility of underlying contusion, concussion, skull fracture, subdural hematoma, subarachnoid hemorrhage.

Canadian CT head injury/trauma rule
Based on Canadian CT head injury/trauma rule CT Head imaging IS indicated.

NEXUS Criteria for C-spine Imaging
Based on Nexus spine criteria CT C-spine imaging IS indicated.

Point-of-care glucose is 78. Patient in juice by mouth.
Patient tolerates oral intake without difficulty.

The patient is not on anticoagulation.

Patient is given acetaminophen by mouth for pain.

Extremity is rested, iced, elevated.

Imaging study as independently interpreted/viewed by myself as well as according to radiology interpretation: CT head without C-spine without contrast: No acute intracranial abnormality. Chronic left maxillary sinusitis, fever odontogenic. No acute fracture or traumatic malalignment of the cervical spine.

Imaging study as independently interpreted/viewed by myself as well as according to radiology interpretation: X-ray shoulder left complete: No acute fracture, dislocation, or

bony subluxation.

At this time I believe the patient is clinically stable for discharge. They are answering questions appropriately and have a normal repeat neuro exam. Their vital signs are within normal limits.

As this patient has a closed head injury they must followup as an outpatient with either their doctor and/or a neurologist for further evaluation and management of symptoms secondary to their possible concussion. The patient has been advised to avoid contact sports and driving until they have been cleared by a neurologist. The patient will make arrangements have somebody stay with them tonight in case they have any problems including worsening headache or altered mental status for which they should immediately return to the emergency department for further evaluation. The patient has expressed an understanding of this and is agreeable with the plan.

Expectant management after motor vehicle collision discussed. Symptomatic treatment at home and return precautions discussed. Patient expressed an understanding of this plan and was in agreement with the course of care. The patient was observed until alert, oriented, ambulatory, and clinically sober. The patient's judgment and speech are intact. The patient expresses a desire to be discharged home.

- Number and complexity of problems addressed:
HIGH: 1 acute or chronic illness or injury that poses a threat to life or bodily function

- History obtained from additional independent historian(s):
See above in HPI for details regarding information obtained.
Report from EMS as above

- I have reviewed prior external notes from:
Previous EHR inpatient hospitalization notes:
Ankle x-ray from June 8, 2010 without fracture, dislocation, or other acute bony abnormality.

- I have ordered based on the seriousness of patient's presentation and comorbidities the following interventions:
Cardiac/pulse oximetry monitor
Laboratory evaluation
Imaging studies that have been reviewed
Medications
P.o. challenge

- I have independently interpreted test(s):
Imaging as above

- I have discussed management/test interpretation with:

The nurse and subsequent care plans

- Risk of Complications and/or Morbidity or Mortality of Patient Management:
High: Patient presented with severe undifferentiated pain and required repeat assessments, workup, and interventions throughout the course of care
High: Patient presented after being involved in severe traumatic mechanism with symptoms concerning for potential life or limb threatenting injuries requiring immediate and repeat assessments, workup, and interventions throughout the course of care

- Based on the seriousness of patient's presentation and comorbidities the following interventions were ordered and done:
Medications
P.o. challenge

- Medications/prescriptions management:
Prescription drug management: reviewed home medications as above. Considered implications of home medications as they relate to inpatient care and disposition planning.
Prescriptions considered but not given

- Decision regarding limitation of imaging, limitation of diagnostic testing, or de-escalation of care:
Imaging and/or labs were not thought to be indicated based on risk assessment

- Social determinants of health that impact diagnosis or treatment:
Social History as above.
Substance use as above

- Decision regarding surgery considered risk/benefit of immediate v delayed surgery and decision about admit v outpatient referral:
None

- Decision regarding ED procedures:
None

Disposition of the patient/consideration of hospitalization:
Discharge: there is no indication for acute hospitalization at this time, patient will be discharged.

Risk Calculators:
see above

These high risk diagnoses were considered and felt to be unlikely:
MDM:Doubt clinically significant traumatic injury: Reassuring imaging studies, reassuring reevaluation

CONDITION: Fair

FINAL IMPRESSION(S)/DIAGNOSES:
1. Acute closed head injury
2. Acute motor vehicle collision
3. Acute left shoulder sprain

Jessie Swan, M.D.

Jessie Swan, M.D.

Portions of this section were scribed by WULLSCHLEGER,NICHOLA on 02/23/23 at 1856

Past Medical History

Allergies
Coded Allergies:
No Known Allergies (02/23/23)

)(Review of Nursing Notes .
Additional Medical History
PMH: none
Additional Surgical History
PSH: none
Alcohol Use Alcohol use
Drug Use Denies recreational drugs
Smoking status for patients 13 years old or older: Never Smoker
Other Social History Local resident

Portions of this section were scribed by WULLSCHLEGER,NICHOLA on 02/23/23 at 1856

COURSE

Data

Diagnostics
Laboratory Tests:

	02/23 1940
Chemistry	
POC Glucose (74 - 106 mg/dL)	78

Recent Impressions:
Computerized Tomography - CT HEAD WO SPINE CERV WO 02/23 1910

*** Report Impression - Status: SIGNED Entered: 02/23/2023 1930

IMPRESSION:

Head CT:

1. No acute intracranial abnormality.

2. Chronic left maxillary sinusitis, favor odontogenic.

Cervical spine CT:

1. No acute fracture or traumatic malalignment in the cervical spine.

Eric Wannamaker, MD
Neuroradiologist
Diversified Radiology of Colorado, PC
http://www.divrad.com

Thank you for this referral. This exam was interpreted by a fellowship trained neuroradiologist. If the patient's healthcare provider has any questions, a Diversified neuroradiologist can be reached directly at 303-446-3223 at any time.

SLOT 21

Eric Wannamaker, M.D.
2/23/2023 7:29 PM
Impression By: DR.WANER1 - Eric J Wannamaker MD
Diagnostic Radiology - XR SHOULDER LEFT COMPLETE 02/23 1933
*** Report Impression - Status: SIGNED Entered: 02/23/2023 1942

IMPRESSION:

1. Normal.

Thank you for the referral of this patient. This exam was interpreted by an American Board of Radiology certified radiologist with subspecialty fellowship in Body. If there are any questions regarding this exam please feel free to contact a radiologist directly at

303-446-3223.

Slot 18

Michael Oakes M.D.
2/23/2023 7:41 PM
Impression By: DR.OAKMI - Michael F Oakes MD

Med Data
Med Data
Medication(s) Ordered:
Central Nervous System Agents

Medication	Dose	Sig/Sch Route	Start time Stop Time	Status	Last Admin
Acetaminophen	1,000 MG	X1ED ONE PO	02/23 1900 02/23 1901	DC	02/23 1938

Portions of this section were scribed by WULLSCHLEGER,NICHOLA on 02/23/23 at 1856

Patient Discharge & Departure

Vital Signs/Condition
Vital Signs
First Documented:

	Result	Date Time
Pulse Ox	94	02/23 1855
B/P	134/83	02/23 1855
B/P Mean	100	02/23 1855
O2 Delivery	Room air	02/23 1855
Temp	36.3	02/23 1855
Pulse	78	02/23 1855
Resp	18	02/23 1855

Last Documented:

	Result	Date Time
Pulse Ox	94	02/23 1859
B/P	134/83	02/23 1855
B/P Mean	100	02/23 1855
O2 Delivery	Room air	02/23 1855

Temp	36.3	02/23 1855
Pulse	78	02/23 1855
Resp	18	02/23 1855

All vital signs available at the time of this entry have been reviewed.

Clinical Impression
Clinical Impression
Primary Impression: MVA (motor vehicle accident)

Disposition Decision
Discharge
)(**Discharged to Home** Yes
)(**Time** 1950
)(**Date** 02/23/23

Discharge/Care Plan
Counseled Regarding Diagnosis, Imaging studies, Need for follow-up, When to return to ED
Patient Instructions Head Injury (ED), Shoulder Sprain (ED)
Additional Instructions
Take over-the-counter acetaminophen (Tylenol) 1000 mg every 6 hours as needed for pain
Take over-the-counter ibuprofen (Motrin, Advil, Aleve) 600 mg every 6 hours as needed for pain
Referrals
Resource Referral: Clinica Campesina-Thornton
Address:
8990 Washington St.
Thornton, CO 80229

Provider Referral: NO PRIMARY OR FAMILY PHYSICIAN

Departure Forms
*CAREPOINT ED ADULT
*EXCUSE FROM WORK
Excuse from Work: Tomorrow
Discharge Note
I have spoken with the patient and/or caregivers. I have explained the patient's condition, diagnoses and treatment plan based on the information available to me at this time. I have answered the patient's and/or caregiver's questions and addressed any concerns. The patient and/or caregivers have as good an understanding of the patient's diagnosis, condition and treatment plan as can be expected at this point. The vital signs have been stable. The patient's condition is stable and appropriate for discharge from the emergency department.

The patient will pursue further outpatient evaluation with the primary care physician or other designated or consulting physician as outlined in the discharge instructions. The patient and/or caregivers are agreeable to this plan of care and follow-up instructions have been explained in detail. The patient and/or caregivers have received these instructions in written format and have expressed an understanding of the discharge instructions. The patient and/or caregivers are aware that any significant change in condition or worsening of symptoms should prompt an immediate return to this or the closest emergency department or a call to 911.

Portions of this section were scribed by WULLSCHLEGER,NICHOLA on 02/23/23 at 1850

ATTESTATION

ATTESTATION

I personally scribed for Dr. Swan. Electronically signed by Wullschleger, Nicholas
Portions of this note were transcribed by Nicholas Wullschleger. I, Dr. Swan personally performed the history, physical exam and medical decision making; and confirmed the accuracy of the information in the transcribed note.

Portions of this section were scribed by WULLSCHLEGER,NICHOLA on 02/23/23 at 1856

Electronically Signed by Swan,Jessie Alexandra MD on 02/23/23 at 2037

RPT #: 0223-0301
END OF REPORT

Patient: ANGEL,THEODORE JAMES Age/Sex: 47/M Acct No: F45010342505
EDM Provider: Swan,Jessie Alexandra MD, 2hcaActive Unit No: F090331324

GENERAL DATA

ED Physician: Swan,Jessie Alexandra MD, 2hcaActive Arrival Date/Time: 02/23/23 - 1850
Practitioner: Triage Date/Time: 02/23/23 - 1855
Nurse: BURNEY,CONNOR, RN Date of Birth: 09/15/1975

Stated Complaint: UNK-AMB
Chief Complaint: Trauma/MVC Priority: 3
Status Event History:
02/23/23 1850 Reception
1858 Triaged
1850 Registration
1957 Room
2005 Departed
2010 Off Tracker

MODE OF ARRIVAL

AMBULANCE

ALLERGIES

Allergy/Adverse Reaction	Type/Category	Severity	Date	Ver
No Known Allergies	Allergy/Drug		02/23/23	N

ASSESSMENTS

Rapid Initial Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1855	BURNEY,CONNOR, RN	02/23/23	1858	BURNEY,CONNOR, RN

- - RAPID INITIAL ASSESSMENT - -
First Point of Contact: Yes
Enter/Edit Allergies: Yes
Arrived by: AMB
EMS service: AMBPLATTEV
Medications/treatments prior to arrival: None
- - SUBJECTIVE ASSESSMENT - -
Patients description of reason for visit:
PT TO ER VIA EMS C/O LEFT SHOULDER AND FACE PAIN AFTER AN MVC. PT UNRESTRAINED BACK SEAT PASSENGER. PT REPORTS HITTING FACE ON BACK OF SEAT IN FRONT. NO LOC. PT ETOH +
Objective assessment:
PT A&OX4 WITH GCS 15. C-COLLAR IN PLACE FROM EMS
Neuro WDP: Yes
Cardiovascular WDP: Yes
Respiratory WDP: Yes
Pain scale utilized: Verbal numeric
Pain intensity: 8
Smoking status for patients 13 years old or older: Never Smoker
Flowsheet: Yes
Chief Complaint: Trauma/MVC
Priority: ESI 3/Urgent
ESP? N
Facility ESP status:
Not ESP Enabled

-
- FIRST POINT OF CONTACT - -
Patient/representative present AND ABLE to complete infection screening: Yes
Have you ever had TB or a positive TB skin test: No
Recent close contact with a person who has influenza like illness or TB: No
Risk factors for C.diff: None
Have you or a close contact traveled outside the US in the last 3 weeks: No
Fever greater than 100.4 F or 38.0 C: Not in the last 7 days
Cough not related to allergy or COPD: Not in the last 7 days
Sore throat: Not in the last 7 days
Night sweats: Not in the last 7 days
Unexplained weight loss: Not in the last 7 days
Fatigue: Not in the last 7 days
Body aches: Not in the last 7 days
Rash: Not in the last 7 days
Nasal congestion unrelated to allergies/sinus infections: Not in the last 7 days
Patient states having a fever: No
Patient states having shortness of breath: No
COVID-19 point of entry screening status: Negative COVID-19 Risk
Point of entry screening status:
Negative TB Risk
Negative Respiratory Risk
Negative C difficile Risk
-
- PAIN DATA - -
Numeric pain scale: Severe pain-8
-
- RAPID FLOWSHEET - -
-
- VITAL SIGNS - -
Temperature F: 97.4
Temperature source: Tympanic
Pulse: 78
Pulse source: Monitor
Respiratory rate: 18
Respiratory source: Observed
Blood pressure: 134/83
Blood pressure source: Monitor
Mean arterial pressure: 100
SPO2 %: 94
Oxygen delivery devices: Room air
-
- HEIGHT/WEIGHT - -
Height ft: 5
Height in: 6
Height source: Stated/Reported
Weight kg: 115.909
Weight source: Stated/Reported
BMI calculated: 41.2
-
- BILATERAL BLOOD PRESSURES - -
-
- GLASGOW COMA SCALE - -
Glasgow coma scale: Yes
Motor response: 6
Verbal response: 5
Eye opening: 4
Glasgow coma score: Mild

Patient: ANGEL,THEODORE JAMES Age/Sex: 47/M Acct No: F45010342505
EDM Provider: Swan,Jessie Alexandra MD, 2hcaActive Unit No: F090331324

- - Copyright - -
Adults: Sir Graham Teasdale
Pediatrics: Copyright owned by Matthew Kirschen, MD PhD
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-
- SEVERE SEPSIS SCREENING - -
Temperature: No
Heart rate: No
Respirations: No
WBC results:
No results past 48 hrs
Band results:
No results past 48 hrs
WBC/Bands: No
If yes to 2 or more of above, proceed to next section: 0

Detailed Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1858	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - DETAILED ASSESSMENT - -
Suicide screening: Yes
Arrived by: AMB
Medications/treatments prior to arrival: None
BMI calculated: 41.2
Chief Complaint: Trauma/MVC
-
- SUICIDE ASSESSMENT - -
Wish to be dead or to not wake up in the past month: No
Wish to be dead or to not wake up in your lifetime: No
Non-specific active suicidal thoughts in the past month: No
Non-specific active suicidal thoughts in your lifetime: No
Attempted, plan to attempt, or prepared to end life in your lifetime: No
Attempted, plan to attempt, or prepared to end life in the past 3 months: No
Calculated suicide risk level:
No risk

Fall Risk Assessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - FALL RISK ASSESSMENT - -
Assess fall risk: Yes
History of falling (immediate or previous): No
Secondary diagnosis: No
Ambulatory aid: None/bedrest/nurse assist
IV/heparin lock: No
Gait/transferring: Normal/bedrest/immobile
Mental status: Oriented to own ability
Morse Fall Scale score and risk level: 0 - Low Risk

Pain Assessment/Reassessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - PAIN ASSESSMENT - -
Pain scale utilized: Verbal numeric
Pain intensity: 8
Pain location: Shoulder left
Numeric pain scale: Severe pain-8

Physical Findings

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - PHYSICAL FINDINGS - -
Neurological WDP: Yes
Cardiovascular WDP: Yes
Respiratory WDP: Yes
Gastrointestinal WDP: Yes
Genitourinary WDP: Yes
Musculoskeletal WDP: No
Musculoskeletal documented via chief complaint: Yes
Integumentary WDP: Yes
Vascular WDP: Yes
Psychosocial WDP: Yes
Eye WDP: Yes
ENT WDP: Yes

Severe Sepsis Screening

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - SEVERE SEPSIS SCREENING - -
Temperature: No
WBC results:
No results past 48 hrs
Heart rate: No
Band results:
No results past 48 hrs
Respirations: No
WBC/Bands: No
If yes to 2 or more of above, proceed to next section: 0

Trauma

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1900	BURNEY,CONNOR, RN	02/23/23	1901	BURNEY,CONNOR, RN

- - TRAUMA MVC - -
Mechanism of injury: MVC
Is this a trauma alert activation: No
Document injuries: Yes
Airway: Patent
Respirations even and unlabored: Yes

Patient: ANGEL,THEODORE JAMES Age/Sex: 47/M Acct No: F45010342505
EDM Provider: Swan,Jessie Alexandra MD, 2hcaActive Unit No: F090331324

Bilateral lungs sounds clear, equal and undiminished: Yes
Alert and oriented: Yes
Extremities equal and strong bilaterally: Yes

- INJURIES - -
Injury location:
- - Face - -
Instance list status: Active
Injury description(s): Pain

- - Shoulder left - -
Instance list status: Active
Injury description(s): Pain
<End>

- MVC ASSESSMENT - -
MVC position in vehicle: Back seat passenger side
MVC direction of impact: Passenger side
MVC mechanism: Two vehicles
MVC restraints: Unrestrained
MVC reported velocity of impact: Low impact
MVC reported speed(mph): 10
MVC reported damage to vehicle: Mild

Disposition-DC,TX,ADM,LPT

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	2009	BURNEY,CONNOR, RN	02/23/23	2009	BURNEY,CONNOR, RN

- - DISPOSITION - -
Patient disposition: Discharge
Disposition Category: Discharged
Chief Complaint: Trauma/MVC

- DISCHARGE ASSESSMENT - -
Discharge information provided: Instructions
Discharge instructions given to and verbalized understanding by:
PATIENT
Patient left to: Home
Patient left with: Family
Mode patient left: Ambulatory
===INFECTION===
===NEW ORGAN DYSFUNCTION within past 48 hours==

Pain Assessment/Reassessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	2009	BURNEY,CONNOR, RN	02/23/23	2009	BURNEY,CONNOR, RN

- - PAIN ASSESSMENT - -

Trauma Reassessment

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	2009	BURNEY,CONNOR, RN	02/23/23	2009	BURNEY,CONNOR, RN

- - TRAUMA MVC REASSESSMENT - -

TREATMENTS

Glasgow Coma Scale

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - GLASGOW COMA SCALE - -
Eye opening: 4
Verbal response: 5
Motor response: 6
Glasgow coma score: Mild
- - Copyright - -
Adults: Sir Graham Teasdale
Pediatrics: Copyright owned by Matthew Kirschen, MD PhD
Received permissions on 4/22/20

Oxygen Titrate >92%

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

- - OXYGEN - -
SpO2 phase: Before oxygen applied
SPO2 %: 94

*Pulse Ox

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1859	BURNEY,CONNOR, RN	02/23/23	1859	BURNEY,CONNOR, RN

Teaching Education

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1900	BURNEY,CONNOR, RN	02/23/23	1900	BURNEY,CONNOR, RN

- - Patient/Family Teaching - -
Primary learner: Patient
Readiness to learn: Asks questions, Cooperative
Method of education: Printed material, Teach-back, Verbal discussion
Patient rating of current knowledge level: Fair
Learner(s) verbalized understanding and/or return demonstration of items: Yes

POC Glucose

Occurred Date	Time	User	Recorded Date	Time	User
02/23/23	1948	BURNEY,CONNOR, RN	02/23/23	1948	BURNEY,CONNOR, RN

Fingerstick blood sugar (mg/dl): 78

Patient: ANGEL,THEODORE JAMES
EDM Provider: Swan,Jessie Alexandra MD, 2hcaActive

Age/Sex: 47/M

Acct No: F45010342505
Unit No: F090331324

Physically Leaves

Physically Leaves Date: 02/23/23
Physically Leaves Time: 2005

DEPARTURE INFORMATION

Primary Impression: MVA (motor vehicle accident)
Secondary Impressions:
Disposition: ROUTINE HOME/SELF CARE 01 Departure Date/Time: 02/23/23 - 2005
Comment:
Condition: STABLE

Referrals:
Clinica Campesina-Thornton
8990 Washington St.
Thornton, CO 80229
Phone: (303)650-4460

NO PRIMARY OR FAMILY PHYSICIAN

Pt Instructions: Head Injury (ED), Shoulder Sprain (ED)

Departure Forms: *CAREPOINT ED Adult, *Excuse from Work

Return to Work

Return to School

Excuse from Work

Tomorrow

Excuse from School

Excuse from Sport

Excuse from Work - Parent

ADDITIONAL INSTRUCTIONS

Take over-the-counter acetaminophen (Tylenol) 1000 mg every 6 hours as needed for pain
Take over-the-counter ibuprofen (Motrin, Advil, Aleve) 600 mg every 6 hours as needed for pain

WITHIN DEFINED PARAMETERS

~~ ASSESSMENT PARAMETERS ~~

These are the definitions of Within Defined Parameters by Body System

NEUROLOGICAL
- Alert & Oriented X 4
- Pupils equal
- Speech clear and appropriate for age
- Moves all extremities
- No paralysis
- Steady gait
- Ambulates independently

EENT
- Eyes - Clear, no tearing or redness
- Ears - No complaint of hearing difficulty, loss of hearing, or change in hearing, pain free, no drainage
- Nasal - Breathes freely through both nares
- Throat - No hoarseness or stated soreness, no cough

RESPIRATORY
- No respiratory distress
- No cough
- No O2 or assistive devices
- No nasal flaring or pursed lip breathing
- Respirations even & unlabored
- Skin pink & warm to touch

CARDIAC
- No stated calf tenderness
- No history of pacemaker or implanted defibrillator
- Denies current cardiac complaint
- Skin pink & warm to touch - no cyanosis, mottling, diaphoresis or flushing of skin

CIRCULATORY
- Oral mucosa pink and moist
- Skin color appropriate to ethnic color
- Denies sensory complaints
- No edema noted

MUSCULOSKELETAL
- Moves all extremities
- Ambulates independently

GASTROINTESTINAL
- Denies GI complaints

GENITO-URINARY
- Denies GU complaints

INTEGUMENTARY
- Skin warm, dry & intact
- No complaints of lesions, rash, wounds, bruises, petechiae or abrasions

PSYCHOSOCIAL
- With regards to cultural influences: mood/affect is appropriate
- Patient demonstrates effective coping skills/patterns for situation

These are the definitions of Within Defined Parameters for the Nutritional and Functional Screenings:

NUTRITIONAL
- No swallowing/chewing impairments
- No nausea and/or vomiting and/or diarrhea for 5 or more days
- No reported unintentional weight loss > 15 lbs in last 3 months
- No reported decrease in intake > 25%

FUNCTIONAL
- No unexplained alteration in movement/mobility in last four weeks
- No recent limitation performance of ADLs
- No recent alteration in ADLs that require assistance

of usual in last two weeks

This is the definition for the evidence of Physical and/or Psychological Abuse question:

ABUSE HISTORY TO INCLUDE, BUT NOT LIMITED TO:
PT DOES NOT REPORT/NO EVIDENCE OF ANY OF THE FOLLOWING: abuse/neglect, Hx. of abuse/neglect, withdrawn/fearful behavior, Unexplained or suspicious bruises/wounds, Patient/Caregiver story changes, Defensive about injuries, Undernourished despite good appetite, Recurrent/Suspicious injuries, Fear of return to previous arrangements, Injuries do not match event history.

CONSULTS

Fragment EDM.PAT.zcus.k.consults.R does not exist

21

REQUIRED ON ALL EMS/BIOPHONE CALLS

Date: 2-23-23 Call Time: 1833

EMS Agency

	THORNTON FIRE		ADAMS COUNTY FIRE		WESTMINSTER FIRE		AMR
✓	NORTHGLENN		NORTH METRO FIRE		FEDERAL HEIGHTS FIRE		MILE HIGH
	OTHER PV						ARVADA FIRE

EMERGENT or (NON-EMERGENT)

AGE:	(M) F	CHIEF COMPLAINT:
47		Passen Rear 10mph left interiate

BP:	HR:	RR:	SPO2:	BGL:	EKG/MONITOR:	GCS:
130/82	84	16	93 (RA/NC/NRB) O2@ ___L/MIN INTUBATED ETCO2:			15 A&O x:

MECHANISM OF INJURY:

WHAT IS GCS?

Falls
- o >15 ft
- o Blood Thinners

Penetrating Injury

MVC (CHECK FOLLOWING)
- o >45 MPH
- o Ejection
- o Unrestrained Rollover
- o Major Deformity
- o Death in vehicle

Burn

Auto vs Ped >20 MPH

Motorcycle crash >20 MPH

Actual/Potential Airway Compromise

IV/MEDS/COMMENTS:

Shoulder Fx
Back Pain
C-collar

CARDIAC ALERT

TIME CALLED:

ASA:

STROKE ALERT/NOTIFICATION

TIME CALLED:

LAST NORMAL:

BGL:

TRAUMA ACTIVATION

LEVEL I LEVEL II

TIME CALLED:

PRINT YOUR NAME: D. Fegan

ETA: 10

Health North Suburban Medical Center | Health North Suburban Medical Center Northwest ER | Health North Suburban Medical Center Northeast ER

Prehospital Notification Form

51273 (12/19)

Patient Information/Label

ANGEL, THEODORE JAMES
45010342505 PRE ER
2/23/23 1850
CP:
DOB: 09/15/75 47 M
MR# F090331324

EDRS
51273 (12/19)

PATIENT: ANGEL,THEODORE JAMES
ACCOUNT NO: F45010342505

ATTEND DR: Swan,Jessie Alexandra MD
REPORT STATUS: FINAL

A/S: 47 M
LOC: F.ER
RM:
BD:

ADMIT: 02/23/23
DISCH/DEP: 02/23/23
STATUS: ER
UNIT NO: F090331324

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
CT	CT HEAD WO SPINE CERV WO	20230223-0051	02/23/23	1851	S		E	CMP	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order details below
Reason for Exam: Trauma
(Name/Phone number)

Order's Audit Trail of Events

1 02/23/23 1851 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1851 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1851 DR.SWAJEA Order Source: EPOM
4 02/23/23 1851 DR.SWAJEA Signed by Swan,Jessie Alexandra MD
5 02/23/23 1852 interface order's status changed from TRANS to LOGGED by RAD
6 02/23/23 1919 interface order's status changed from LOGGED to IN PRO by RAD
7 02/23/23 1930 interface order's status changed from IN PRO to COMP by RAD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1851

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
XR	XR SHOULDER LEFT COMPLETE	20230223-0078	02/23/23	1933	S		E	CMP	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order details below
Reason for Exam: Trauma
(Name/Phone number)

Order's Audit Trail of Events

1 02/23/23 1851 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1851 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1851 DR.SWAJEA Order Source: EPOM
4 02/23/23 1851 DR.SWAJEA Signed by Swan,Jessie Alexandra MD
5 02/23/23 1852 interface order's status changed from TRANS to LOGGED by RAD
6 02/23/23 1933 interface order service time edited: old value - 1851
7 02/23/23 1933 interface order's status changed from LOGGED to IN PRO by RAD
8 02/23/23 1942 interface order's status changed from IN PRO to COMP by RAD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1851

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.ED	ED Pulse Oximetry	20230223-0142	02/23/23	1852	S		E	TRN	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 02/23/23 1852 DR.SWAJEA Order ENTER in EDM/POM

PERMANENT MEDICAL RECORD COPY

PATIENT: ANGEL,THEODORE JAMES
ACCOUNT NO: F45010342505
ATTEND DR: Swan,Jessie Alexandra MD
REPORT STATUS: FINAL
A/S: 47 M
LOC: F.ER
RM:
BD:
ADMIT: 02/23/23
DISCH/DEP: 02/23/23
STATUS: ER
UNIT NO: F090331324

2 02/23/23 1852 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1852 DR.SWAJEA Order Source: EPOM
4 02/23/23 1852 DR.SWAJEA Signed by Swan,Jessie Alexandra MD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1852

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.ED	ED Saline Lock Insert/Manage	20230223-0143	02/23/23	1852	S		E	TRN	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 02/23/23 1852 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1852 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1852 DR.SWAJEA Order Source: EPOM
4 02/23/23 1852 DR.SWAJEA Signed by Swan,Jessie Alexandra MD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1852

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.ED	ED Titrate O2 to Keep SAT >92%	20230223-0144	02/23/23	1852	S		E	TRN	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 02/23/23 1852 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1852 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1852 DR.SWAJEA Order Source: EPOM
4 02/23/23 1852 DR.SWAJEA Signed by Swan,Jessie Alexandra MD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1852

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
NUR.ED	ED POC Glucose	20230223-0145	02/23/23	1852	S		E	TRN	SWAJEA

Other Provider : **Sig Lvl Provider :**

Order's Audit Trail of Events

1 02/23/23 1852 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1852 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1852 DR.SWAJEA Order Source: EPOM
4 02/23/23 1852 DR.SWAJEA Signed by Swan,Jessie Alexandra MD

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1852

PERMANENT MEDICAL RECORD COPY

PATIENT: ANGEL,THEODORE JAMES
ACCOUNT NO: F45010342505
ATTEND DR: Swan,Jessie Alexandra MD
REPORT STATUS: FINAL

A/S: 47 M
LOC: F.ER
RM:
BD:

ADMIT: 02/23/23
DISCH/DEP: 02/23/23
STATUS: ER
UNIT NO: F090331324

Order Date: 02/23/23

Category	Procedure Name	Order Number	Date	Time	Pri	Qty	Ord Source	Status	Ordered By
MED.COCNB	Medication	20230223-1277	02/23/23	1900	R		E	CMP	SWAJEA

Other Provider : **Sig Lvl Provider :**

RX: 12990864
Start: 02/23/23 1900 ONE CMP
Stop: 02/23/23 1901

Acetaminophen Tab (Tylenol Tab)
Dose: 1000 MG
Route: PO **Direction:** X1ED

Order's Audit Trail of Events

1 02/23/23 1852 DR.SWAJEA Order ENTER in EDM/POM
2 02/23/23 1852 DR.SWAJEA Ordering Doctor: Swan,Jessie Alexandra MD
3 02/23/23 1852 DR.SWAJEA Order Source: EPOM
4 02/23/23 1852 DR.SWAJEA Signed by Swan,Jessie Alexandra MD
5 02/23/23 1901 SCHEDULER DISCONTINUE in PHA
6 02/23/23 1938 CSS.CB62 order acknowledged

Electronically signed by Swan,Jessie Alexandra MD on 02/23/23 at 1852

** IDEV END OF REPORT **

PERMANENT MEDICAL RECORD COPY

North Suburban Medical Center, 9191 Grant Street Thornton
Thornton, CO 80229
HPF LAB Discharge Summary Report w/o Pathology FINAL

RUN DATE: 02/24/23 PAGE 1
RUN TIME: 0210
RUN USER: LABBKGJOB

PATIENT: ANGEL,THEODORE JAMES ACCT #: F45010342505 LOC: F.ER U #: F090331324
AGE/SX: 47/M ROOM: REG: 02/23/23
REG DR: Swan,Jessie Alexandra STATUS: DEP ER BED: DIS:

Test	Date	Time	Result	Reference	Units	Ver Date/Time
POC GLU	02/23/23	1940	78(A)	74-106	mg/dL	02/23/23 1943

(A) Testing performed at:
North Suburban Medical Center
9191 Grant Street Thornton, CO 80229

See also (@a)

NOTES: (@a) POINT OF CARE
POINT OF CARE
DR. A. Ezenekwe

Patient: ANGEL,THEODORE JAMES Age/Sex: 47/M Acct#F45010342505 Unit#F090331324

PATIENT NAME: ANGEL,THEODORE JAMES
UNIT NO: F090331324

EXAMS:
002005493 CT HEAD WO SPINE CERV WO

EXAMINATION: - CT HEAD WO SPINE CERV WO

DATE: 2/23/2023 7:18 PM

INDICATION: Trauma.

COMPARISON: None available.

TECHNIQUE: Thin section noncontrast axial images were obtained through the head. Coronal reformatted images were created. CT dose lowering techniques were used, to include: automated exposure control, adjustment for patient size, and or use of iterative reconstruction.

FINDINGS:

Bones and extracranial soft tissues:

Calvarium is intact. Subtotal opacification of the left maxillary sinus in communication with molar tooth roots and associated hyperostosis. Mild mucosal thickening in the right maxillary sinus. The mastoid air cells are clear. Globes and orbits are unremarkable.

Intracranial contents:

Gray white differentiation is preserved. Basal cisterns are patent. No hemorrhage, extra-axial collection, or hydrocephalus. No CT evidence of acute ischemia. No mass or mass effect.

TECHNIQUE: Thin section axial noncontrast images were obtained through the cervical spine. Sagittal and coronal reformatted images were created. Images were reviewed in bone and soft tissue windows. CT dose lowering techniques were used, to include: automated exposure control, adjustment for patient size, and or use of iterative reconstruction.

FINDINGS:

Vertebral column:

Straightening of the normal cervical lordosis may be positional.

North Suburban Main Imaging
North Suburban Medical Center
9191 Grant St

Thornton, Colorado 80229
PHONE #: (303)450-4477
FAX #: (303)450-4613

NAME: ANGEL,THEODORE JAMES
HP: (720)461-0920 AGE: 47 S:M
DOB: 09/15/1975 LOC: F.ER

PHYS: SWAJEA - Swan,Jessie Alexandra
EXAM DATE: 02/23/2023 STATUS: REG ER
A#: F45010342505 U#: F090331324

EXAMS:
002005493 CT HEAD WO SPINE CERV WO
<Continued>

Alignment of the craniocervical junction is preserved. No acute fracture. Decreased height of the C6 vertebral body relative to the other vertebral bodies is chronic and developmental in appearance. Vertebral body heights are otherwise maintained. Normal bone mineralization.

Mild degenerative changes of the cervical spine without significant spinal canal or neural foraminal stenosis.

Soft tissues:

Cervical soft tissues are unremarkable.

IMPRESSION:

Head CT:

1. No acute intracranial abnormality.

2. Chronic left maxillary sinusitis, favor odontogenic.

Cervical spine CT:

1. No acute fracture or traumatic malalignment in the cervical spine.

Eric Wannamaker, MD
Neuroradiologist
Diversified Radiology of Colorado, PC
http://www.divrad.com

Thank you for this referral. This exam was interpreted by a fellowship trained neuroradiologist. If the patient's healthcare provider has any questions, a Diversified neuroradiologist can be reached directly at 303-446-3223 at any time.

PATIENT NAME: ANGEL,THEODORE JAMES
UNIT NO: F090331324

EXAMS:
002005493 CT HEAD WO SPINE CERV WO
<Continued>

SLOT 21

Eric Wannamaker, M.D.
2/23/2023 7:29 PM

** Electronically Signed by Eric J Wannamaker MD **
** on 02/23/2023 at 1929 **
Reported and signed by: Eric J Wannamaker MD

CC: Jessie Alexandra Swan MD

TECHNOLOGIST: Hamid Azad RTR CT
TRANSCRIBED DATE/Time: 02/23/2023 1923 BY: DR.WANER1
EXAM COMPLETE DATE/TIME: 02/23/2023 1918 D/TM:02/23/2023 (1930)

North Suburban Main Imaging
North Suburban Medical Center
9191 Grant St
Thornton, Colorado 80229
PHONE #: (303)450-4477
FAX #: (303)450-4613

NAME: ANGEL,THEODORE JAMES
HP: (720)461-0920 AGE: 47 S:M
DOB: 09/15/1975 LOC: F.ER
PHYS: SWAJEA - Swan,Jessie Alexandra
EXAM DATE: 02/23/2023 STATUS: REG ER
A#: F45010342505 U#: F090331324

PATIENT NAME: ANGEL,THEODORE JAMES
UNIT NO: F090331324

EXAMS:
002005494 XR SHOULDER LEFT COMPLETE

EXAMINATION: - XR SHOULDER LEFT 3 VIEW

DATE OF EXAM: 2/23/2023 7:33 PM

HISTORY: TR - Trauma

COMPARISON: None.

FINDINGS:

There is no fracture, subluxation, or dislocation.

The joint spaces are within normal limits.

IMPRESSION:

1. Normal.

Thank you for the referral of this patient. This exam was interpreted by an American Board of Radiology certified radiologist with subspecialty fellowship in Body. If there are any questions regarding this exam please feel free to contact a radiologist directly at 303-446-3223.

Slot 18

Michael Oakes M.D.
2/23/2023 7:41 PM

** Electronically Signed by Michael F Oakes MD **
** on 02/23/2023 at 1941 **
Reported and signed by: Michael F Oakes MD

North Suburban Main Imaging
North Suburban Medical Center
9191 Grant St

Thornton, Colorado 80229
PHONE #: (303)450-4477
FAX #: (303)450-4613

NAME: ANGEL,THEODORE JAMES
HP: (720)461-0920 AGE: 47 S:M
DOB: 09/15/1975 LOC: F.ER

PHYS: SWAJEA - Swan,Jessie Alexandra
EXAM DATE: 02/23/2023 STATUS: REG ER
A#: F45010342505 U#: F090331324

PATIENT NAME: ANGEL,THEODORE JAMES
UNIT NO: F090331324

EXAMS:
002005494 XR SHOULDER LEFT COMPLETE
<Continued>

CC: Jessie Alexandra Swan MD

TECHNOLOGIST: Juan Espinoza RTR

TRANSCRIBED DATE/Time: 02/23/2023 1940 BY: DR.OAKMI
EXAM COMPLETE DATE/TIME: 02/23/2023 1933 D/TM:02/23/2023 (1942)

North Suburban Main Imaging
North Suburban Medical Center
9191 Grant St
Thornton, Colorado 80229
PHONE #: (303)450-4477
FAX #: (303)450-4613

NAME: ANGEL,THEODORE JAMES
HP: (720)461-0920 AGE: 47 S:M
DOB: 09/15/1975 LOC: F.ER
PHYS: SWAJEA - Swan,Jessie Alexandra
EXAM DATE: 02/23/2023 STATUS: REG ER
A#: F45010342505 U#: F090331324

02/24/23 0118 MEDICATION DISCHARGE SUMMARY PAGE: 1

NAME: **ANGEL,THEODORE JAMES** ADMIT DATE: AGE: **47**
UNIT #: **F090331324** DISCHARGE DATE: SEX: **M**
ACCT #: **F45010342505** STATUS: **DEP ER**
CODED ALLERGIES No Known Allergies
CODED ADRs ADRs Have not been entered in Pharmacy
UNCODED ALLERGIES No Pharmacy Allergies have been entered
UNCODED ADRs ADRs Have not been entered in Pharmacy

ADMINISTRATION PERIOD: 0701 02/23/23 to 0700 02/24/23	START/ STOP	
TylenoL (ACETAMINOPHEN 500 MG CAPLET)		
1,000 MG PO ONCE IN ED/ONE	02/23/23	1852 Order Entry DR.SWAJEA
Comments: Do not exceed 4 grams in 24 hours	02/23/23	1900 CSS.CB62 at 1938 GAVE: 1,000 MG
RX #: 12990864		NDC/DIN: (SOURCE: eMAR)
		0904672080 ACETOC500 - Acetaminophen 500 MG Caplet
		Administering for pain management: Yes
		(End)
		Pain details:
		Pain scale utilized:: Verbal numeric
		Numeric pain scale:: Severe pain-8
		Pain intensity:: 8
		Most Common side effects reviewed with patient?: Yes
		:: ACETOC500:Nausea, Rash
		02/23/23-1939 File Document by CSS.CB62
		1901 Pharmacy Discontinue SCHEDULER
		1938 Nursing Acknowledged Order CSS.CB62

*** CONTINUED ON PAGE 2 ***

NAME: ANGEL,THEODORE JAMES UNIT #: F090331324 ACCT #: F45010342505

LEGENDS

REASON CODES

SITE CODES

ELECTRONICALLY SIGNED BY

USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE	USER	USER NAME/TYPE
CSS.CB62	BURNEY,CONNOR RN						

OTHER USERS

USER	USER NAME	USER	USER NAME	USER	USER NAME	USER	USER NAME
DR.SWAJEA	SWAN,JESSIE A MD						

PHA ALLERGY HISTORY

DATE	PHA	USER	ALLERGY DETAILS	
02/23/23 1856	N	CSS.CB62 - BURNEY,CONNOR	ADDED No Known Allergies OLD: NEW: No Known Allergies added.	by CSS.CB62