MDM / DDX / ED Course

64 y.o. female BIBA p/w a fever onset last Monday 11/10/2014.
On exam: Tachycardic. Frail and speaking in short sentences. Crackles and wheezes b/l.

DDX: pneumonia, COPD exacerbation, influenza

Plan: Will order Avelox, Trop, Proventil, Atrovent, Solu-Medrol, influenza rapid screen, blood cultures, EKG, and CXR.

1:56 AM
Discussed entire case with Dr. M (Hospitalist) who accepts pt for admit.

Normal influenza rapid screen

CXR reveals that the heart size is normal. There are fibrotic changes. There are no active infiltrates, effusions or pneumothoraces.

Diagnosis

Fever

Disposition

Admit

HPI

D is a 64 y.o. female BIBA p/w a fever onset last Monday 11/10/2014. Pt reports SOB and cough; states she normally is on 2L O2 with SpO2 usually at 94%. Pt denies any CP, palpitations, HA, or vomiting. Pt reports she was last hospitalized 1 month ago.

PMH: COPD
Allergies: Creon (vomiting and diarrhea)

ROS

Constitutional: No chills, No fatigue (+) fever
HENT:No neck pain or neck stiffness.
Eyes: No photophobia or diplopia.

Resp: (+) SOB, cough
CV: No Chest Pain or Palpitations.
GI: No Nausea, Vomiting, Diarrhea. No abd pain
MSK: No muscle or joint pains
Skin: Negative for rash.
Neuro: Negative for dizziness and headaches.
Psych: Negative for depression.

-Nursing notes reviewed by me.
-Past Medical/Surgical/Family/Social History reviewed by me (as documented by RN notes)

Physical Exam

There were no vitals filed for this visit.
Pulse Oximetry Analysis - Abnormal - but at baseline

Vital Signs Reviewed
GEN: Frail and speaking in short sentences.
Head: Normocephalic, Atraumatic.
Eyes: nl conjunctiva. NO discharge.
ENT: Posterior oropharynx wnl. Moist mucus membranes.
Neck: No midline tenderness, full range of motion.
Chest: Non-tender chest wall. Crackles and wheezes b/l.
CV: NO murmur.Tachycardic.
Abd: soft, non-tender, NO distention.
Back: NO CVA tenderness, NO midline tenderness on palpation.
UpperExt: NO deformity. 2+ radial pulses bilaterally.
LowerExt: NO edema. 2+ pp, NO calf tenderness.
Neuro: moving all extremities, aaox3.
Skin: Warm and dry. NO rash.
Psych: Normal affect. Normal concentration.

Monitor: Sinus tachycardia
CXR as interp by me: no focal infiltrate

EKG

Rate of 115. Left axis. LVH. No ectopy. Unchanged from previous EKG. -interpreted by me

Critical Care Time

n/a

Laboratory results reviewed by EDP: Yes
Radiology results reviewed by EDP: Yes
Radiologic Studies Interpreted by EDP: Yes

I am acting as scribe for , MD.
Aratara Nutcharoen, ED Scribe
11/22/2014, 12:58 AM

This chart was documented with the assistance of Aratara Nutcharoen, medical scribe. I have reviewed the documentation provided by the ED scribe in this document and I agree with its content.

Medications (ED/RX)

Meds administered in ER this visit:

Medications
lisinopril (PRINIVIL) tablet 5 mg (5 mg Oral Refused 11/22/14 0904)
traZODone (DESYREL) tablet 50 mg (not administered)
morphine SR (MS CONTIN) tablet 100 mg (100 mg Oral Given 11/22/14 0904)
ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg (not administered)
predniSONE (DELTASONE) tablet 40 mg (40 mg Oral Given 11/22/14 0904)
moxifloxacin (AVELOX) 400 mg/250 mL bag 400 mg (not administered)
enoxaparin (LOVENOX) injection 40 mg (40 mg Subcutaneous Given 11/22/14 0905)
dextrose 5% 1/2normal saline (D5 1/2NS) infusion (75 mL/hr Intravenous New Bag 11/22/14

0351)
bisacodyl EC (DULCOLAX) tablet 10 mg (not administered)
HYDROmorphone (DILAUDID) injection 0.5 mg (0.5 mg Intravenous Given 11/22/14 1409)
atropine injection 0.5 mg (not administered)
nitroglycerin (NITROSTAT) tablet 0.4 mg (not administered)
albuterol (PROVENTIL, VENTOLIN) 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg (2.5 mg Inhalation Given 11/22/14 1403)
albuterol (PROVENTIL) solution 2.5 mg (2.5 mg Inhalation Given 11/22/14 0143)
ipratropium (ATROVENT) 0.02 % nebulizer solution 0.5 mg (0.5 mg Inhalation Given 11/22/14 0143)
methylPREDNISolone SOD SUCC (PF) (SOLU-MEDROL) 125 mg/2 mL injection 125 mg (125 mg IV Push Given 11/22/14 0146)
moxifloxacin (AVELOX) 400 mg/250 mL bag 400 mg (400 mg Intravenous Given 11/22/14 0156)

New prescriptions given to patient:

Current Discharge Medication List

Labs

Results for orders placed during the hospital encounter of 11/22/14			
NT PROBNP			
Result		Value	Range
	NT proBNP	204 (*)	<=125 pg/mL
BASIC METABOLIC PANEL			
Result		Value	Range
	POTASSIUM	4.4	3.5-5.5 mmol/L
	SODIUM	143	133-145 mmol/L

	CHLORIDE	101	98-110 mmol/L
	GLUCOSE	101 (*)	65-99 mg/dL
	CALCIUM	7.9 (*)	8.4-10.5 mg/dL
	BUN	6	6-22 mg/dL
	CREATININE	0.6 (*)	0.8-1.4 mg/dL
	CO2	33 (*)	20-32 mmol/L
	GFR CALCULATION	>60.0	>60.0
	ANION GAP	9.2	
HEPATIC FUNCTION PANEL			
Result		Value	Range
	ALBUMIN	3.4 (*)	3.5-5.0 g/dL
	TOTAL PROTEIN	5.5 (*)	6.2-8.1 g/dL
	GLOBULIN SERUM	2.1	2.0-4.0 g/dL
	A/G RATIO	1.6	1.1-2.6 ratio
	BILIRUBIN TOTAL	0.3	0.2-1.2 mg/dL
	BILIRUBIN DIRECT	<0.2	0.0-0.3 mg/dL
	SGOT (AST)	15	10-37 U/L
	ALKALINE PHOSPHATASE	44	40-120 U/L
	SGPT (ALT)	7	5-40 U/L
BLOOD CULTURE			
Result		Value	Range
	BLOOD CULTURE	Culture received - In progress	
BLOOD CULTURE			
Result		Value	Range
	BLOOD CULTURE	Culture received - In	

		progress	
CBC WITH DIFFERENTIAL - AUTO			
Result		Value	Range
	WBC x 10*3	15.9 (*)	4.0-11.0 K/uL
	RBC x 10^6	3.63 (*)	3.80-5.20 M/uL
	HGB	9.3 (*)	11.7-16.0 g/dL
	HCT	32.5 (*)	35.1-48.0 %
	MCV	90	80-95 fL
	MCH	26	26-34 pg
	MCHC	29 (*)	32-36 g/dL
	RDW	16.3 (*)	10.0-16.0 %
	PLATELET	157	140-440 K/uL
	MPV	9.6	6.0-10.8 fL
	SEGMENTED NEUTROPHILS	86 (*)	40-75 %
	LYMPHOCYTES	8 (*)	27-45 %
	MONOCYTES	6	3-9 %
	EOSINOPHIL	0	0-6 %
	BASOPHILS	0	0-2 %
	ABSOLUTE NEUTROPHILS	13.6 (*)	1.8-7.7 K/uL
	ABSOLUTE LYMPHOCYTES	1.3	1.0-4.8 K/uL
	ABSOLUTE MONOCYTE COUNT	0.9	0.1-0.9 K/uL
	ABSOLUTE EOSINOPHIL	0.0	0.0-0.5 K/uL
	ABSOLUTE BASOPHIL COUNT	0.0	0.0-0.2 K/uL

INFLUENZA RAPID SCREEN			
Result		Value	Range
	Influenza A Antigen	Negative	Negative
	Influenza B Antigen	Negative	Negative
CG4+ ISTAT VENOUS (LAB)			
Result		Value	Range
	SAMPLE TYPE	VENOUS	
	LACT V POC	0.59 (*)	0.90-1.70 MMOL/L
	CARTRIDGE TYPE	CG4+	
	PATIENT TEMPERATURE	100.0 F	
TROPONIN POC (LAB)			
Result		Value	Range
	TROPONIN I QUANTITATIVE POC	<0.08	0.00 - 0.07 ng/ml NG/ML
BASIC METABOLIC PANEL			
Result		Value	Range
	POTASSIUM	4.3	3.5-5.5 mmol/L
	SODIUM	144	133-145 mmol/L
	CHLORIDE	103	98-110 mmol/L
	GLUCOSE	132 (*)	65-99 mg/dL
	CALCIUM	8.1 (*)	8.4-10.5 mg/dL
	BUN	6	6-22 mg/dL
	CREATININE	0.6 (*)	0.8-1.4 mg/dL
	CO2	34 (*)	20-32 mmol/L
	GFR CALCULATION	>60.0	>60.0
	ANION GAP	7.0	

CBC WITH DIFFERENTIAL - AUTO			
Result		Value	Range
	WBC x 10*3	13.1 (*)	4.0-11.0 K/uL
	RBC x 10^6	3.82	3.80-5.20 M/uL
	HGB	9.9 (*)	11.7-16.0 g/dL
	HCT	34.3 (*)	35.1-48.0 %
	MCV	90	80-95 fL
	MCH	26	26-34 pg
	MCHC	29 (*)	32-36 g/dL
	RDW	16.6 (*)	10.0-16.0 %
	PLATELET	164	140-440 K/uL
	MPV	10.1	6.0-10.8 fL
	SEGMENTED NEUTROPHILS	95 (*)	40-75 %
	LYMPHOCYTES	3 (*)	27-45 %
	MONOCYTES	2 (*)	3-9 %
	EOSINOPHIL	0	0-6 %
	BASOPHILS	0	0-2 %
	ABSOLUTE NEUTROPHILS	12.4 (*)	1.8-7.7 K/uL
	ABSOLUTE LYMPHOCYTES	0.4 (*)	1.0-4.8 K/uL
	ABSOLUTE MONOCYTE COUNT	0.3	0.1-0.9 K/uL
	ABSOLUTE EOSINOPHIL	0.0	0.0-0.5 K/uL
	ABSOLUTE BASOPHIL COUNT	0.0	0.0-0.2 K/uL

URINALYSIS			
Result		Value	Range
	SOURCE URINE	clean catch	
	URINE pH	7.0	5.0-8.0
	URINE PROTEIN SCREEN	Negative	Negative, Trace mg/dL
	URINE GLUCOSE	Negative	Negative mg/dL
	URINE KETONES	Negative	Negative mg/dL
	URINE OCCULT BLOOD	Negative	Negative
	URINE SPECIFIC GRAVITY	1.010	1.005-1.030
	URINE NITRITE	Negative	Negative
	URINE LEUKOCYTE ESTERASE	Negative	Negative
	URINE BILIRUBIN	Negative	Negative
	URINE UROBILINOGEN	0.2	0.2-1.0 EU/DL mg/dL

Radiology

CHEST PORTABLE		
	Final Result:	IMPRESSION:
		The heart size is normal. There are fibrotic changes. There are no active infiltrates, effusions or pneumothoraces.
		Old treated fractures of the midthoracic spine are noted. There is moderate kyphosis.

Vital Signs this ED Visit

Patient Vitals for the past 24 hrs:

	Temp	Heart Rate	Pulse	Resp	BP	BP Mean	SpO2	Weight
11/22/14 1900	-	88	-	-	-	-	-	-
11/22/14 1600	98 °F (36.7 °C)	-	85	18	110/68 mmHg	82 MM HG	99 %	-
11/22/14 1500	-	85	-	-	-	-	-	-
11/22/14 1404	-	-	89	18	-	-	-	-
11/22/14 1200	98.2 °F (36.8 °C)	-	91	20	113/67 mmHg	82 MM HG	99 %	-
11/22/14 1100	-	89	-	-	-	-	-	-
11/22/14 0753	-	-	102	20	-	-	-	-
11/22/14 0700	98.1 °F (36.7 °C)	90	90	20	108/59 mmHg	75 MM HG	99 %	-
11/22/14 0500	98.1 °F (36.7 °C)	-	-	-	-	-	-	-
11/22/14 0420	-	-	100	20	113/59 mmHg	77 MM HG	99 %	-
11/22/14 0409	-	-	111	20	-	-	95 %	-
11/22/14	-	99	-	-	-	-	-	-

0400								
11/22/14 0335	-	-	-	-	-	-	-	58.741 kg (129 lb 8 oz)
11/22/14 0245	98.8 °F (37.1 °C)	109	109	17	118/58 mmHg	72 MM HG	93 %	-
11/22/14 0230	-	113	112	16	114/67 mmHg	77 MM HG	94 %	-
11/22/14 0210	-	114	114	18	-	-	95 %	-
11/22/14 0200	-	116	116	19	110/71 mmHg	81 MM HG	93 %	-
11/22/14 0140	-	-	115	21	-	-	96 %	-
11/22/14 0130	-	-	114	-	121/62 mmHg	73 MM HG	96 %	-
11/22/14 0120	-	-	117	-	-	-	97 %	-
11/22/14 0115	-	-	117	-	124/64 mmHg	78 MM HG	98 %	-
11/22/14 0109	99.4 °F (37.4 °C)	124	-	22	-	-	89 %	-
11/22/14 0055	-	-	122	-	107/57 mmHg	70 MM HG	90 %	56.7 kg (125 lb)

Patient History

Past Medical History:

Past Medical History

Diagnosis			Date
•	COPD (chronic obstructive pulmonary disease) (HCC)		
•	Fibromyalgia		
•	Osteopenia		
•	GERD (gastroesophageal reflux disease)		
•	Mixed connective tissue disease (HCC)		
•	Sjogren's disease (HCC)		
•	Barrett's esophagus		
•	Celiac disease (HCC)		
•	PLMD (periodic limb movement disorder)		
•	Congestive heart failure, unspecified (HCC)		
•	Arthropathy, unspecified, site unspecified		
•	Back pain		
•	Headache(784.0)		
•	Leg pain		
•	Muscle atrophy		
•	Anxiety		
•	Depression		
•	Shingles		
		2010	
•	Ulcerative colitis		

Past Surgical History:

Past Surgical History			
Procedure		Laterality	Date
•	Hx &appendectomy		

•	Hx &cholecystectomy		
•	Hx back surgery		

Family History:

Family History					
Problem		Relation		Age of Onset	
•	Cancer		Mother		
•	Cancer		Sister		
•	Heart Failure		Maternal Grandmother		
•	Stroke		Maternal Grandmother		

Social History:

History

Social History			
•	Marital Status:		Married
		Spouse Name:	N/A
		Number of Children:	N/A
•	Years of Education:		N/A

Social History Main Topics			
•	Smoking status:		Former Smoker -- 3.00 packs/day for 34 years
		Types:	Cigarettes
		Quit date:	01/13/1999
•	Smokeless tobacco:		Never Used

•	Alcohol Use:	No
•	Drug Use:	No
•	Sexually Active:	Not on file

Other Topics	Concern
•	Not on file

Social History Narrative	
•	No narrative on file

Home Medications:

Home Medication List - Marked as Reviewed on 11/22/14 0429	
Medication	Sig
EScitalopram (LEXAPRO) 10 mg PO TABS	Take 20 mg by Mouth Once a Day.
gabapentin (NEURONTIN) 300 mg PO CAPS	Take 300 mg by Mouth 3 Times Daily.
potassium chloride SA (K-DUR) 10 mEq PO TbTQ	Take 10 mEq by Mouth 3 Times Daily.
guaiFENesin LA (HUMIBID;MUCINEX) 600 mg PO TbSR	Take 600 mg by Mouth Every 12 Hours.
HYDROmorphone (DILAUDID) 2 mg PO TABS	Take 2 mg by Mouth Every 4 Hours.
FLUTICASONE/VILANTEROL (BREO ELLIPTA INH)	Take inhaled by mouth.
lisinopril (PRINIVIL) 2.5 mg PO TABS	Take 2.5 mg by Mouth Once a Day.
morphine 130 mg PO CSRP	Take 130 mg by Mouth Every 12 Hours.
multivitamins-minerals-lutein (CENTRUM SILVER) PO	Take 1 Tab by Mouth Once a Day.

TABS	
predniSONE (DELTASONE) 10 mg PO TABS	Take 10 mg by Mouth Once a Day.
sulfaSALAzine (AZULFIDINE) 500 mg PO TABS	Take 500 mg by Mouth 3 Times Daily.
theophylline CR, 12 hour, (THEODUR) 200 mg PO TB12	Take 200 mg by Mouth Once a Day.
atorvastatin (LIPITOR) 10 mg PO TABS	Take 1 Tab by Mouth Every Night at Bedtime.
oxybutynin (DITROPAN) 5 mg PO TABS	Take 1 Tab by Mouth 3 Times Daily.
omeprazole (PRILOSEC) 20 mg PO CPDR	Take 20 mg by Mouth Every Morning Before Breakfast.
traZODone (DESYREL) 50 mg PO TABS	Take 1 Tab by Mouth Nightly As Needed for Other (insomnia). Take 1 or 2 tablets by mouth 2 hours before bedtime as needed.
tiotropium (SPIRIVA) 18 mcg INH CpDv	Take 1 Cap inhaled by mouth Once a Day.
fluticasone-salmeterol (ADVAIR) 500-50 mcg/dose INH DsDv	Take 1 Puff inhaled by mouth Every 12 Hours.
cholecalciferol (VITAMIN D3) 1000 unit PO TABS	Take 1,000 Units by Mouth Once a Day.
ondansetron (ZOFRAN) 4 mg PO TABS	Take 4 mg by Mouth Take As Needed.
docusate sodium (COLACE) 100 mg PO CAPS	Take 1 Cap by Mouth Once a Day.
albuterol (PROVENTIL, VENTOLIN) 90 mcg/actuation INH HFAA	Take 2 Puffs inhaled by mouth Every 4 Hours.

Allergies:

Allergies			
Allergen			Reactions
•	Creon [Lipase-Protease-Amylase]		gi distress
•	Lactose Intolerance [Lactase]		gi distress
•	Lasix [Furosemide]		mild rash/itching
		Full body	

History and Physical

[redacted]

Impression:

Active Problems:
COPD (chronic obstructive pulmonary disease) (HCC)
Fever

Assessment and Plan:

1)
COPD:
CXR no acute changes, EKG no acute changes, CBC with WCC 15.9, Rapid flu Neg, Troponin Neg. Plan: Telemetry, O2, Avelox,Albuterol/Ipratropium nebs, Prednisone

Chief Complaint:
Chief Complaint Patient presents with • FEVER (9 WEEKS TO 74 YEARS)
History of Present Illness:

Patient is a 64 y.o. y old with past medical history significant for COPD who presents to the ED with c/o SOB, Cough , wheezing and fever for the past 3 days.

Review of System:

Constitutional: fever, no chills, no weight loss or weight gain
Eyes: no redness, no discharge, no change of vision

ENMT:
no hearing loss, no nasal discharge, no sore throat
CV: no chest pain, no palpitations
Respiratory: dyspnea, no productive cough

GI: no abdominal pain, no diarrhea or constipation, no blood in stools
GU: no dysuria, no hematuria
Musc-skel: no muscle weakness, no joint pain or swelling
Neurologic: no confusion, no tremors, no nerve palsy
Psychiatric: no mood disorder
Endocrine: no thyroid dysfunction
Hem/Lym: no adenopathy

Social History:

History

Social History			
•	Marital Status:		Married
		Spouse Name:	N/A
		Number of Children:	N/A
•	Years of Education:		N/A

Social History Main Topics			
•	Smoking status:		Former Smoker -- 3.00 packs/day for 34 years
		Types:	Cigarettes
		Quit date:	01/13/1999
•	Smokeless tobacco:		Never Used
•	Alcohol Use:		No
•	Drug Use:		No
•	Sexually Active:		Not on file

Other Topics	Concern
•	Not on file

Social History Narrative	
•	No narrative on file

Family History:

Family History			
Problem		Relation	Age of Onset
•	Cancer	Mother	
•	Cancer	Sister	
•	Heart Failure	Maternal Grandmother	
•	Stroke	Maternal Grandmother	

Past Medical History:

Past Medical History		
Diagnosis		Date
•	COPD (chronic obstructive pulmonary disease) (HCC)	
•	Fibromyalgia	
•	Osteopenia	
•	GERD (gastroesophageal reflux disease)	
•	Mixed connective tissue disease (HCC)	
•	Sjogren's disease (HCC)	
•	Barrett's esophagus	
•	Celiac disease (HCC)	
•	PLMD (periodic limb movement disorder)	
•	Congestive heart failure, unspecified (HCC)	

•	Arthropathy, unspecified, site unspecified		
•	Back pain		
•	Headache(784.0)		
•	Leg pain		
•	Muscle atrophy		
•	Anxiety		
•	Depression		
•	Shingles		
		2010	
•	Ulcerative colitis		

Past Surgical History:

Past Surgical History			
Procedure		Laterality	Date
•	Hx &appendectomy		
•	Hx &cholecystectomy		
•	Hx back surgery		

Allergies:

Allergies		
Allergen		Reactions
•	Creon [Lipase-Protease-Amylase]	gi distress
•	Lactose Intolerance [Lactase]	gi distress

•	Lasix [Furosemide]		mild rash/itching	
		Full body rash		

Medications at Home:

Home Medication List - Marked as Reviewed on 8/29/14 1425 Medication Sig morphine SR (MS CONTIN) 30 mg PO TbSR Take 100 mg by Mouth Every 12 Hours. HYDROmorphone (DILAUDID) 2 mg PO TABS Take 2 mg by Mouth 4 Times Daily. multivitamins-minerals-lutein (CENTRUM SILVER) PO TABS Take 1 Tab by Mouth Once a Day. predniSONE (DELTASONE) 10 mg PO TABS Take 10 mg by Mouth Once a Day. sulfaSALAzine (AZULFIDINE) 500 mg PO TABS Take 500 mg by Mouth 3 Times Daily. theophylline CR, 12 hour, (THEODUR) 200 mg PO TB12 Take 200 mg by Mouth Once a Day. atorvastatin (LIPITOR) 10 mg PO TABS Take 1 Tab by Mouth Every Night at Bedtime. oxybutynin (DITROPAN) 5 mg PO TABS Take 1 Tab by Mouth 3 Times Daily. omeprazole (PRILOSEC) 20 mg PO CPDR Take 20 mg by Mouth Every Morning Before Breakfast. raloxifene (EVISTA) 60 mg PO TABS Take 60 mg by Mouth Once a Day. docusate sodium (COLACE) 100 mg PO CAPS Take 1 Cap by Mouth Once a Day. albuterol (PROVENTIL, VENTOLIN) 90 mcg/actuation INH HFAA Take 2 Puffs inhaled by mouth Every 4 Hours. traZODone (DESYREL) 50 mg PO TABS Take 1 Tab by Mouth Nightly As Needed for Other (insomnia). Take 1 or 2 tablets by mouth 2 hours before bedtime as needed. lisinopril (PRINIVIL) 5 mg PO TABS Take 1 Tab by Mouth Once a Day. tiotropium (SPIRIVA) 18 mcg INH CpDv Take 1 Cap inhaled by mouth Once a Day. fluticasone-salmeterol (ADVAIR) 500-50 mcg/dose INH DsDv Take 1 Puff inhaled by mouth Every 12 Hours. cholecalciferol (VITAMIN D3) 1000 unit PO TABS Take 1,000 Units by Mouth Once a Day.
Physical Examination:

Patient Vitals for the past 24 hrs:

	Temp	Heart Rate	Pulse	Resp	BP	BP Mean	SpO2	Weight
11/22/14 0140	-	-	115	21	-	-	96 %	-
11/22/14 0130	-	-	114	-	121/62 mmHg	73 MM HG	96 %	-
11/22/14 0120	-	-	117	-	-	-	97 %	-
11/22/14	-	-	117	-	124/64	78 MM	98	-

0115					mmHg	HG	%	
11/22/14 0109	99.4 °F (37.4 °C)	124	-	22	-	-	89 %	-
11/22/14 0055	-	-	122	-	107/57 mmHg	70 MM HG	90 %	56.7 kg (125 lb)

, Temp (24hrs), Avg:99.4 °F (37.4 °C), Min:99.4 °F (37.4 °C), Max:99.4 °F (37.4 °C)

General Appearance: Appears acutely ill., Skin: Skin warm & dry, HEENT: PERRLA, EOMI, Neck: Supple, Lungs: Mild bilateral wheezes, Diffuse diminished bilateral breath sounds, Bibasilar rales, Heart: Regular rhythm and tachycardic, Abdomen: Soft and Non-distended, Extremities: No edema of legs, Normal pedal and radial pulses, Neuro: alert, oriented, affect appropriate, speech fluent, sensory intact, cranial nerves intact, no focal neurological deficits and moves all extremities well

Labs:

Results for orders placed during the hospital encounter of 11/22/14 (from the past 24 hour(s))			
NT PROBNP			
Result		Value	Range
	NT proBNP	204 (*)	<=125 pg/mL
BASIC METABOLIC PANEL			
Result		Value	Range
	POTASSIUM	4.4	3.5-5.5 mmol/L
	SODIUM	143	133-145 mmol/L
	CHLORIDE	101	98-110 mmol/L
	GLUCOSE	101 (*)	65-99 mg/dL
	CALCIUM	7.9 (*)	8.4-10.5 mg/dL
	BUN	6	6-22 mg/dL
	CREATININE	0.6 (*)	0.8-1.4 mg/dL
	CO2	33 (*)	20-32 mmol/L

	GFR CALCULATION	>60.0	>60.0
	ANION GAP	9.2	
HEPATIC FUNCTION PANEL			
Result		Value	Range
	ALBUMIN	3.4 (*)	3.5-5.0 g/dL
	TOTAL PROTEIN	5.5 (*)	6.2-8.1 g/dL
	GLOBULIN SERUM	2.1	2.0-4.0 g/dL
	A/G RATIO	1.6	1.1-2.6 ratio
	BILIRUBIN TOTAL	0.3	0.2-1.2 mg/dL
	BILIRUBIN DIRECT	<0.2	0.0-0.3 mg/dL
	SGOT (AST)	15	10-37 U/L
	ALKALINE PHOSPHATASE	44	40-120 U/L
	SGPT (ALT)	7	5-40 U/L
CBC WITH DIFFERENTIAL - AUTO			
Result		Value	Range
	WBC x 10*3	15.9 (*)	4.0-11.0 K/uL
	RBC x 10^6	3.63 (*)	3.80-5.20 M/uL
	HGB	9.3 (*)	11.7-16.0 g/dL
	HCT	32.5 (*)	35.1-48.0 %
	MCV	90	80-95 fL
	MCH	26	26-34 pg
	MCHC	29 (*)	32-36 g/dL
	RDW	16.3 (*)	10.0-16.0 %
	PLATELET	157	140-440 K/uL
	MPV	9.6	6.0-10.8 fL

	SEGMENTED NEUTROPHILS	86 (*)	40-75 %
	LYMPHOCYTES	8 (*)	27-45 %
	MONOCYTES	6	3-9 %
	EOSINOPHIL	0	0-6 %
	BASOPHILS	0	0-2 %
	ABSOLUTE NEUTROPHILS	13.6 (*)	1.8-7.7 K/uL
	ABSOLUTE LYMPHOCYTES	1.3	1.0-4.8 K/uL
	ABSOLUTE MONOCYTE COUNT	0.9	0.1-0.9 K/uL
	ABSOLUTE EOSINOPHIL	0.0	0.0-0.5 K/uL
	ABSOLUTE BASOPHIL COUNT	0.0	0.0-0.2 K/uL
TROPONIN POC (LAB)			
Result		Value	Range
	TROPONIN I QUANTITATIVE POC	<0.08	0.00 - 0.07 ng/ml NG/ML
CG4+ ISTAT VENOUS (LAB)			
Result		Value	Range
	SAMPLE TYPE	VENOUS	
	LACT V POC	0.59 (*)	0.90-1.70 MMOL/L
	CARTRIDGE TYPE	CG4+	
	PATIENT TEMPERATURE	100.0 F	
INFLUENZA RAPID SCREEN			
Result		Value	Range

	Influenza A Antigen	Negative	Negative
	Influenza B Antigen	Negative	Negative

Imaging Studies:

Recent Results (from the past 36 hour(s))	
CHEST PORTABLE	
	Narrative:
	PROCEDURE:PORTABLE CHEST X-RAY TECHNIQUE: A portable AP chest radiograph was obtained at Nov 22, 2014 01:07:19 AM. CPT 71010 HISTORY: Cough COMPARISONS:8/29/2014. FINDINGS: Heart: Normal. Mediastinum/Vessels: Normal. Lungs/Pleural space: There are fibrotic changes. There are no active infiltrates, effusions or pneumothoraces.. Bony thorax: Old treated fractures of the midthoracic spine are noted. There is moderate kyphosis. Life support devices: None.

Impression: IMPRESSION:

The heart size is normal. There are fibrotic changes. There are no active infiltrates, effusions or pneumothoraces.

Old treated fractures of the midthoracic spine are noted. There is moderate kyphosis.

PROGRESS NOTES
Assessment & Plan
.1.COPD exacerbation
- no increase in oxygen demand from base line
- on exam- diffusely diminished BS,no wheezing
-cont oral steroid,nebs and abx

- transition abx to PO tomorrow
-pulmonary toilet per RT protocol
-CXR reviewed - no new infiltrates/congesion

2.Chronic back pain, neck pain cont current analgesics with BM regimen

3. HTN- cont current meds

4. Chronic diastolic dysfunction-stable

5.GERD-start Pepcid

6.Subjective Fever- no documented fever since admission,BC-NGTD, Urine cx-no growth to date
Check resp gs and cx

Acuity
Heart Failure: diastolic, chronic

DVT: Lovenox
Foley: None
Central LIne: Absent
Antibiotics: Moxifloxacin
Code Status: Full Code

Interval Events Pt reports back and neck pain but not worsening from base line
Breathing seems to be at base line
+constipation
No cp
+cough and wheezing
.
Review of Systems
Constitutional: Positive for malaise/fatigue. Negative for fever.
HENT:Positive for neck pain. Negative for sore throat.
Eyes: Negative.
Respiratory: Positive for cough and sputum production.
Cardiovascular: Negative for chest pain and leg swelling.
Gastrointestinal: Positive for constipation. Negative for nausea and vomiting.
Genitourinary: Negative for dysuria and hematuria.
Musculoskeletal: Positive for back pain.
Skin: Negative for itching and rash.
Neurological: Positive for weakness. Negative for dizziness, focal weakness and headaches.