

# Admission Note

Date: 5.15.20 Time: 1<sup>00</sup> AM

## Patient Demographics

Employed as Healthcare Worker ☐ Yes ☒ No

Patient is pregnant? ☐ Yes ☒ No

Gestational Age: \_\_\_\_\_ weeks

Or Expected Due Date: \_\_\_\_\_

Post-partum patient? ☒ Yes ☐ No

Outcome: ☒ live birth ☐ still birth Delivery Date: \_\_\_\_\_

Patient is Infant? ☐ Yes ☒ No

Gestational Outcome: ☐ Term birth (≥37wk GA) ☐ Preterm birth (<37 wk GA)

Breastfeed: ☐ Yes ☐ No

If child, vaccinations up to date? ☐ Yes ☐ No

## Home Medications

Pre natal vitamins

## Allergies

Penicillin

## Comorbidities ☐ None ☐ Unknown

Type 1 Diabetes <input type="checkbox"/>	Chronic kidney disease <input type="checkbox"/>
Type 2 Diabetes <input type="checkbox"/>	Asthma <input type="checkbox"/>
Hypertension <input type="checkbox"/>	Chronic pulmonary disease (not asthma) <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Sickle Cell disease <input type="checkbox"/>	Cardiomyopathy <input type="checkbox"/>
Rheumatic Heart Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>
HIV <input type="checkbox"/>	Malnutrition <input type="checkbox"/>

## Mental Health Condition:

Smoking: ☐ Current ☒ Past ☐ Never

Other: \_\_\_\_\_

## Onset/Admission

Transfer from other facility? ☒ Yes ☐ No

Transfer facility: Community Hospital Admission Date: 5.10.20

Known contact with COVID-19 patient in 14 days prior to symptoms ☒ Yes ☐ No

Admission Condition Status: ☐ Mild ☐ Moderate ☒ Critical

## First Line Medications

☐ Chloroquine phosphate 500mg PO bid for 10 days

Other, specify: \_\_\_\_\_

## Second Line Medications

☐ Lopinavir/ritonavir 400mg/100mg PO q12h x 14 days

☐ Remdesivir

☐ Other: \_\_\_\_\_

## Antibiotics

☒ Ceftriaxone 1000 gm q 24 hours ☐ Amoxicillin \_\_\_\_\_ q \_\_\_\_\_ hours

☐ Doxycycline 100 mg BID

Patient Name: Angela Smith Patient Id: 156999

Age: 29 EMR Id: 900123

Sex: F Hospital day #: 1

## Patient History

Symptom start date: \_\_\_\_\_

Fever <input checked="" type="checkbox"/>	Chest pain <input type="checkbox"/>
Cough <input checked="" type="checkbox"/>	Muscles aches (Myalgias) <input type="checkbox"/>
With sputum production <input checked="" type="checkbox"/>	Fatigue/malaise <input checked="" type="checkbox"/>
Shortness of breath (Dyspnea) <input checked="" type="checkbox"/>	Nausea/vomiting <input checked="" type="checkbox"/>
Sore throat <input checked="" type="checkbox"/>	Diarrhea <input checked="" type="checkbox"/>
Runny nose <input checked="" type="checkbox"/>	Loss of taste/smell <input type="checkbox"/>
Headache <input checked="" type="checkbox"/>	Confusion <input checked="" type="checkbox"/>

Other, specify: \_\_\_\_\_

## Vitals

Temp <u>103°F</u> °F	Cap refill time <input checked="" type="checkbox"/> < 3 sec
Pulse <u>126</u> bpm	<input type="checkbox"/> _____ sec
RR <u>30</u> bpm	Pain: <input type="checkbox"/> None <input type="checkbox"/> Mild
BP <u>90/42</u> mmHg	<input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Severe
O2 <u>92</u> % on _____ L/min	<input type="checkbox"/> room air

## Physical Exam

System	Normal	Findings
HEENT	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Neck	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulmonary	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>Bilateral rales</u>
Cardiovascular	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>tachycardia</u>
Abdominal	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>tender</u>
Urogenital	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Rectal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lymph nodes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>Diffuse enlargement</u>
Skin and mucosa	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>warm</u>
Neurological	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<u>confused</u>
AVPU	<input checked="" type="checkbox"/> Alert <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Unresponsive	

Other, specify: \_\_\_\_\_

## Supportive Care

☐ Oxygen \_\_\_\_\_ L/min ☐ Analgesic: \_\_\_\_\_

☒ Mechanical Ventilation ☐ Mask ☐ Mask with non-rebreather

☐ Nasal Cannula ☐ CPAP ☐ BIPAP ☐ FIO2

☒ IV Fluids 100 ml/hour specify: NS

☒ Central ☐ Peripheral

☐ IV Fluids \_\_\_\_\_ ml/hour specify: \_\_\_\_\_

☐ Central ☐ Peripheral

☐ IV Fluids \_\_\_\_\_ ml/hour specify: \_\_\_\_\_

☐ Central ☐ Peripheral

## Other Medications



## Admission Note

## COVID-19 Testing

Specimen Date	Specimen Type	Test Type	Test Result
5, 12, 20	<input checked="" type="checkbox"/> Nasal swab <input type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Venous blood <input type="checkbox"/> Finger prick (blood)	<input type="checkbox"/> Antibody test (IgM/IgG) <input type="checkbox"/> Antigen test <input checked="" type="checkbox"/> RT PCR test	<input type="checkbox"/> Negative <input type="checkbox"/> Positive IgM <input type="checkbox"/> Positive IgG <input type="checkbox"/> Invalid <input type="checkbox"/> Positive IgM and IgG <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid <input type="checkbox"/> Negative <input checked="" type="checkbox"/> Positive <input type="checkbox"/> Invalid
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___/___/___	<input type="checkbox"/> Nasal swab <input type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Venous blood <input type="checkbox"/> Finger prick (blood)	<input type="checkbox"/> Antibody test (IgM/IgG) <input type="checkbox"/> Antigen test <input type="checkbox"/> RT PCR test	<input type="checkbox"/> Negative <input type="checkbox"/> Positive IgM <input type="checkbox"/> Positive IgG <input type="checkbox"/> Invalid <input type="checkbox"/> Positive IgM and IgG <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid

## Other testing

Test	result	Test	result	Test	result	Test	result
Haemoglobin	9 g/L or g/dL	Lymphocyte count	cells/ $\mu$ L	Sodium	126 mmol/L	Glucose	99 mmol/L or mg/dL
Haematocrit	27 %	Neutrophil count	cells/ $\mu$ L	Potassium	3 mEq/L	Total Bilirubin	3 $\mu$ mol/L or mg/dL
WBC count	15,000 $\times 10^9$ /L or $\times 10^3$ / $\mu$ L	Lactate	mmol/L or mg/dL	BUN	48 mmol/L or mg/dL	ALT/SGPT	49 U/L
Platelets	90,000 $\times 10^9$ /L or $\times 10^3$ / $\mu$ L	CRP	mg/L	Creatinine	1.5 $\mu$ mol/L or mg/dL	AST/SGOT	52 U/L

## ABG Test:

pH	7.12	PO2	58 mmHg	HCO3	20 mmol/L	BE	mmol/L
PCO2	70 mmHg	TCO2	mmol/L	SO2	100 %	Lactate	5 mmol/L

<input checked="" type="checkbox"/> Chest X-Ray Result: Bilateral infiltrates	<input type="checkbox"/> Abdominal Ultrasound Result:	<input type="checkbox"/> Cardiac Ultrasound Result:
Other findings:		
Other diagnostic tests:		

## Diagnosis

 COVID-19: ☒ Confirmed ☐ Suspected ☐ No

Secondary/Other Diagnoses:

## Disposition

- ☐ Admit to ward ☐ Admit to COVID-19 Isolation  
☐ Discharge to home isolation ☐ Death  
☐ Discharge to: \_\_\_\_\_  
☐ Transfer to: \_\_\_\_\_

## Provider Clinical Plan

## Nursing Admission Note

Signature: \_\_\_\_\_

Name \_\_\_\_\_

Signature \_\_\_\_\_