

Admission Note

Date: 6/10/20 Time: 1:57pm

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

N/A

Allergies

sulfa drugs

Comorbidities ☒ None ☐ Unknown

Type 1 Diabetes <input type="checkbox"/>	Chronic kidney disease <input type="checkbox"/>
Type 2 Diabetes <input checked="" type="checkbox"/>	Asthma <input type="checkbox"/>
Hypertension <input type="checkbox"/>	Chronic pulmonary disease (not asthma) <input type="checkbox"/>
Epilepsy <input checked="" type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Sickle Cell disease <input type="checkbox"/>	Cardiomyopathy <input checked="" 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: UMDNJ Admission Date: _____

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 _____ gm q _____ hours ☐ Amoxicillin _____ q _____

☐ Doxycycline 100 mg BID

Patient Name: Daniel Kunin

Patient Id: 3756

Age: 26

EMR Id: 17387

Sex: M

Hospital day #: 3

Patient History

Symptom start date: 6/1/20

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 type="checkbox"/>	Fatigue/malaise <input type="checkbox"/>
Shortness of breath (Dyspnea) <input checked="" type="checkbox"/>	Nausea/vomiting <input type="checkbox"/>
Sore throat <input type="checkbox"/>	Diarrhea <input checked="" type="checkbox"/>
Runny nose <input type="checkbox"/>	Loss of taste/smell <input type="checkbox"/>
Headache <input type="checkbox"/>	Confusion <input checked="" type="checkbox"/>
Other, specify:	

Vitals

Temp	°C <u>101.1</u> °F	Cap refill time	<input checked="" type="checkbox"/> < 3 sec
Pulse	<u>76</u> bpm		<input type="checkbox"/> _____ sec
RR	<u>12</u> bpm	Pain:	<input type="checkbox"/> None <input checked="" type="checkbox"/> Mild
BP	<u>120/81</u> mmHg		<input type="checkbox"/> Moderate <input type="checkbox"/> Severe
O2	<u>99</u> % on _____ L/min		<input checked="" 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	
Cardiovascular	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Abdominal	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Urogenital	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Rectal	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Lymph nodes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Skin and mucosa	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
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 _____ ml/hour specify: _____

☐ 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
6/10/20	<input type="checkbox"/> Nasal swab <input checked="" type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Venous blood <input type="checkbox"/> Finger prick (blood)	<input type="checkbox"/> Antibody test (IgM/IgG) <input checked="" 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 checked="" type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid
____/____/____	<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
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Other testing

Test	result	Test	result	Test	result	Test	result
Haemoglobin	g/L or g/dL	Lymphocyte count	cells/ μ L	Sodium	140 mmol/L	Glucose	98 mmol/L or mg/dL
Haematocrit	%	Neutrophil count	cells/ μ L	Potassium	mEq/L	Total Bilirubin	μ mol/L or mg/dL
WBC count	$\times 10^9$ /L or $\times 10^3$ / μ L	Lactate	mmol/L or mg/dL	BUN	mmol/L or mg/dL	ALT/SGPT	U/L
Platelets	$\times 10^9$ /L or $\times 10^3$ / μ L	CRP	mg/L	Creatinine	μ mol/L or mg/dL	AST/SGOT	U/L

ABG Test:

pH	PO2	mmHg	HCO3	mmol/L	BE	mmol/L	
PCO2	mmHg	TCO2	mmol/L	SO2	%	Lactate	mmol/L

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

Diagnosis

 COVID-19: ☐ Confirmed ☒ Suspected ☐ No

Secondary/Other Diagnoses:

IBS

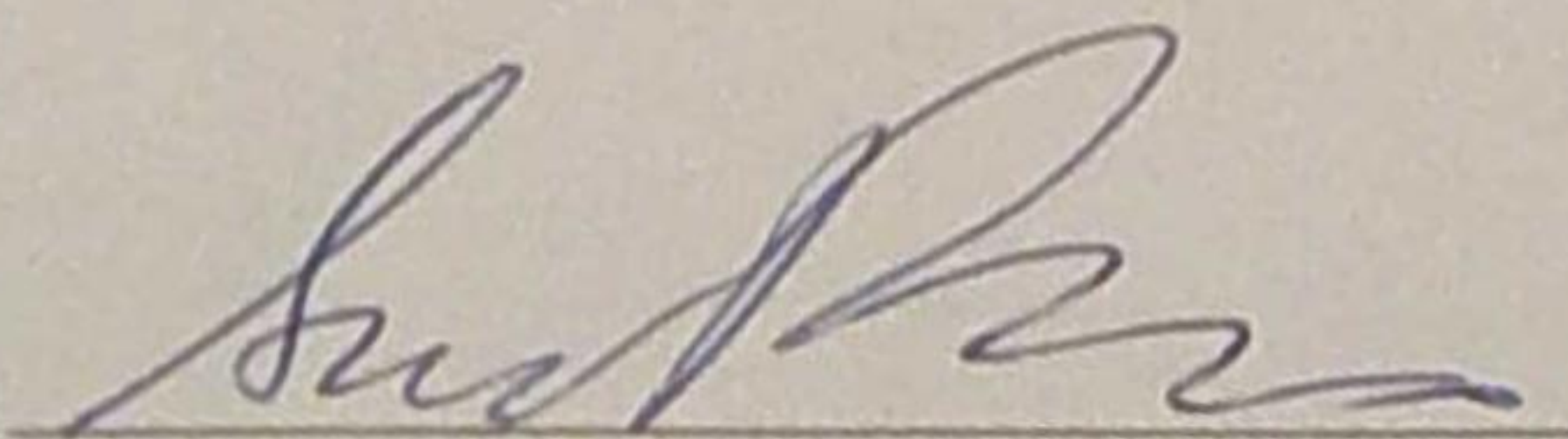
Disposition

☒ 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

Dr. Sahar Shaughnessy

Signature

