Beattie, Leanna C	Social Worker	Addendum	Social Work	06/06/17 0826

SW sending pt's information to HAP Midwest for review for possible LTACH or eventual SAR placement. Writer has contacted HAP Midwest on four separate occassions to discuss case. Writer has not received a call back regarding inquiries. Will continue with referral in hopes to obtain response from HAP Midwest on next plan of care. SW did receive a call from Select Specialty stating that they would not be able to accept pt due to HAP Midwest/Health Link Plan. Kindred is still able to accept pt with HAP MW auth. Discussed with CM. Leanna Beattie, LMSW ex 6907

UPDATE: SW also sent pt's information to Vibra LTACH as they might be able to contract with HAP Midwest. Will continue to update as more information is received.

Revision History

Cory, Holly S	**Nursing**	**Signed**	**Care Management**	**06/06/17 1059**

Spoke with Dr Lloyd regarding plan of care. He said that the pt will have the NGT for months, and she will need to remain on bedrest due to the drainage from the wound vac. Discussed possible LTAC, Dr Lloyd states it would need to be a specialized LTAC that can handle complex cases. Discussed with social work. HC x 6140

Cory, Holly S	**Nursing**	**Signed**	**Care Management**	**06/09/17 1551**

Attended family meeting with FP Residents, SW, and Palliative Care. Dr Mohamud and Dr Pierret explained pt status, answered family's questions. Code status established. SW explained our department role in the event pt is able to transfer to another level of care in the future. Department will follow closely. HC x 6140

Mohamud, Idil Omar-Mohamed, MD	**Resident**	**Signed**	**Family Medicine**	**Progress Notes**	**06/09/17 1643**

Brief Progress Note PGY 3

Met with patients family and friends today including her guardian. Family is familiar with her hospital course. They feel that a would not want any invasive measures, she prefers to be at home with her friends and family. It was agreed that patient will be DNR/DNI per families request. Palliative care was involved and information on comfort care measures was discussed.

Idil Mohamud, MD
Family Medicine PGY 3
Pager #20662

Cosigned by: Rosbolt, James P, DO at 06/10/17 1552

Revision History

Kurdziel, Joyce, RN **Nursing** **Signed** **Palliative Care** **06/09/17 1548**

PALLIATIVE CARE CONSULTATION

Patient's Name: _ **MRN**: **Date of Birth**: **Age**: 61 yrs
Date of Admission: 4/29/2017
Date of service: 6/9/2017
Attending Provider: Lloyd, Larry R, MD
Consulting Provider: Joyce Kurdziel, RN
Primary Care Provider: Rollinger, Kathleen M

Reason for Consultation: Hospital Day

Consult ordered by Dr. Pierret

Source of Information:
Chart/EPIC,Sister, multiple family members

Chief Complaint/ History of Present Illness/Brief Review of Hospital Course:

This is a 61y.o. female w/ medical hx significant for multiple abdominal surgeries, IDDM2, depression, COPD, Diverticulosis, HTN, Hypothyroidism, obesity, OA, OSA who came to BGPH On 4/29/17 with complaints of abdominal pain. She has had multiple surgical procedures, and has multiple consultants involved in her care. She is currently on a medical surgical unit.

Past Medical History:

has a past medical history of Unspecified essential hypertension; Depression; Hypothyroidism; Obesity; Tobacco abuse; Diabetes mellitus type II; Hypercholesterolemia; Varicose veins; Asthma with bronchitis; Hernia of unspecified site of abdominal cavity without mention of obstruction or gangrene; Chronic obstruct airways disease; Neck pain; Osteoarthritis of both knees; Neuropathy; Obstructive sleep apnea; Dyspnea; Esophageal reflux; and Cervical spondylosis (10/28/2016). She also has no past medical history of Allergic rhinitis due to other allergen, Hypertrophy (benign) of prostate, Benign neoplasm of colon, Acute, but ill-defined, cerebrovascular disease, Psychosexual dysfunction with inhibited sexual excitement, Unspecified deficiency anemia, Other malignant neoplasm without specification of site, Chronic obstructive asthma, unspecified, Spinal stenosis, Chronic renal insufficiency, CVA (cerebrovascular accident), Coronary artery disease, Osteoporosis, Diabetes insipidus, Delayed puberty, Conn syndrome, Addison's disease, Acromegaly, Galactorrhea, Goiter, Growth hormone deficiency, Gynecomastia, Hypopituitarism, Hypoparathyroidism, Hyponatremia, Panhypopituitarism, Hyperthyroidism, Hypernatremia, Hashimoto's thyroiditis, Hirsutism, Hyperparathyroidism, Insulin resistance, Insulinoma, Multiple endocrine neoplasia, Pheochromocytoma, Pituitary tumor, Polycystic ovaries, Polycystic ovary syndrome, Thyroid cancer, or Thyroid nodule.

Past Surgical History:

has past surgical history that includes oophorectomy (1986); salpingectomy, compl/part, uni/bilat; appendectomy; cholecystectomy; hernia repair; and lumpectomy.

Social History:

Marital status: Divorced.
Living arrangements: Independently prior to admission
Pre-morbid level of functioning:
Primary caregiver:
Family support network:
substance abuse history:
other significant historical factors:

Allergies:

Allergen	Reactions
• Azithromycin	Nausea and/or vomiting
• Codeine	Nausea and/or vomiting
• Morphine	Nausea and/or vomiting

Medications:

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Last Rate
• busPIRone (BUSPAR) tablet 15 mg	15 mg	NG Tube	Q HS	
• escitalopram (LEXAPRO) tablet 20 mg	20 mg	NG Tube	DAILY	
• heparin injection 5,000 Units	5,000 Units	Subcutaneous	Q 8 H	
• insulin glargine (LANTUS) injection HIGH ALERT 25 Units	25 Units	Subcutaneous	Q HS	
• insulin regular human (humuLIN R, novoLIN R) injection HIGH ALERT 2-12 Units	2-12 Units	Subcutaneous	Q 6 H	
• nicotine (NICODERM) 21 mg/24hr patch 21 mg	21 mg	Transdermal	Q 24 H	
• pantoprazole (PROTONIX) 40 mg, sodium chloride 0.9 % 10 mL injection	40 mg	Intravenous	DAILY	
• pregabalin (LYRICA) capsule 150 mg	150 mg	Other	DAILY	
• sodium chloride 0.9 % bolus 250 mL	250 mL	Intravenous	Once	250 mL (06/09/17 1530)

Physical Exam:

Vitals were reviewed
BP 87/40 mmHg | Pulse 78 | Temp(Src) 97.9 °F (36.6 °C) (Oral) | Resp 18 | Ht 167 cm (5' 5.75") | Wt 100.245 kg (221 lb) | BMI 35.94 kg/m2 | SpO2 94% | LMP 01/01/1991 (Exact Date)
Intake/Output Summary (Last 24 hours) at 06/09/17 1548
Last data filed at 06/09/17 1400

	Gross per 24 hour
Intake	0 ml
Output	880 ml
Net	-880 ml

, Body mass index is 35.94 kg/(m^2).

Diagnostic Studies:

CBC/Coags

Recent Labs

Component	06/07/17 0708		05/15/17 1510
WBC	8.4	< >	9.1
HGB	9.9*	< >	9.9*

Metabolic Panel

Recent Labs

Component	06/09/17 0713
NA	144
K	3.7
CL	113*
CO2	26

LFTs/Misc

Recent Labs

Component	06/05/17 0537
ALP	148*
AST	15
ALT	18*
BILITOTAL	0.3

HCT	31.2*	< 29.7* >	BUN	33*		ALB	1.3*
MCV	92	< > 89	CREAT	0.55*		GLOBULIN	3.6
MCH	29	< > 30	CALCIUM	9.0			
RDWSD	50	< > 55*	PHOS	2.4			
RDWCV	15	< > 17*	MG	1.6			
PLT	257	< > 358	ANIONGAP	5			
PT	--	-- 12.1	@alb@				
INR	--	-- 1.1					
< > = values in this interval not displayed.							

Pertinent Imaging results: Albumin 1.3

Plan of Care:

Psychosocial Aspects of Care:

1. Legal ethical: Per her sister, T

2. Grief:No risk factors for complicated grief identified.

3. Patient is NOT decisional Advocate: ' er) Contact Information:

4. Patient desires to know prognosis and participate in plan of care: N/A

Will discuss in Palliative Care IDT. Please see separate social work and spiritual care notes. Discussed plan with Lloyd, Larry R, MD, RN and care manager.

Family Meeting:

Joint meeting with family practice staff, care management, social work, staff nurse, and six family members and friends
Patient's sister, ... DPOA per her report.
Medical staff reviewed patient's current status and poor prognosis for complete recovery from slow healing abdominal surgeries. She currently is receiving TPN, has drains and a wound vac. Patient Strictly confined to bed, so recovery further hindered by immobility.

Discussed family and friends understanding of patient's wishes as we discussed options for going forward. 1- Continue all treatment, 2- Change code status, and continue all treatment. 3. Transition to comfort care.

Reviewed EMR code status questions and answered all family members concerns. DPOA has requested NO CPR and no ventilator, vasoactive or antiarrhythmic medications and no to cardioversion.

Social work discussed their role in placement post hospitalizaton when patient ready for discharge.

Brief discussion of hospice, family members have had multiple experiences with hospice so are aware of what can be provided. Patient status going forward will determine their interest in a hospice plan for this patient.

Contact info provided to family for family practice staff and palliative care.

Assessment/Recommendations:

1. Prognosis Poor
2. Palliative care goals Supportive care for patient and sister
3. Anticipated disposition