Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

ED Assessment Note

Authored:08/29/2011 00:23

Author(s):
Umbarger, Alicia A RN Signed on:08/29/2011 00:24
Last Updated:08/29/2011 00:24

Outpatient Medications

Outpatient Medications

Medication Status: No Current Medications as of Aug 29 2011 12:23AM documented in Structured Notes

Significant Events

Significant Events

Past Medical History
none Onset Date:

Past Surgical History
none Onset Date:

Screenings

Substance Abuse

Do you use tobacco, alcohol, or street drugs?	Yes...
Tobacco?	No
Alcohol?	Yes...
How often?	Weekly
Street Drugs?	no

Suicide Risk Screen

Are you feeling hopeless or worthless?	No
Are you having thoughts of taking your own life?	No

Abuse Screen

Are you currently in a relationship where you have been threatened or abused physically, emotionally, or sexually?	No
Do you feel safe in your relationships at home?	Yes
Do you the nurse suspect the patient is being abused, neglected or exploited?	No

TB Screen

Symptoms or Risks?	No Symptoms or Risks

Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

Isolation

Previous Isolations: No

Vaccinations

Tetanus Vaccine within 5 Years? Yes (date unknown)

Advance Directive

Advance Directives: No

Patient desires more information: No

ED Assessment Note

Authored:08/29/2011 00:40

Author(s):

Umbarger, Alicia A RN Signed on:08/29/2011 00:43

Last Updated:08/29/2011 00:43

Outpatient Medications

Outpatient Medications

Medication Status: No Current Medications as of Aug 29 2011 12:23AM documented in Structured Notes

Reassessment Data

Reassessment Data

Reassessment Data: Assumed care of patient; Hourly rounding completed; Pain, Plan of Care, Duration, and Delay Addressed

Safety Factors/Interventions

Safety Factors/Interventions

Safety Factors/Interventions: Bed in low position; Call Light in reach; Demonstrated call light function to patient/family

John Hopkins Fall Assessment

Fall History	No fall history
Age	69 years old or less
Mobility	NA
Elimination	NA
Mental Status Changes	NA
Medications (includes psychotropics - antidepressants, hypnotics, antipsychotics, sedatives, benzodiazepines, some antiemetics; anticonvulsants; diuretics/cathartics; PCA/narcotics/opiates; antihypertensives)	NA
Patient Care Equipment (IV, Chest Tube, Indwelling Catheter, SCDs, etc)	NA

* = Updated Data

Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

Fall Risk Assessment Total: 0

Coping

Coping

Coping: Emotional State	Observed:; Verbalized:; accepting; calm
Participants/Involvement in Care	patient; spouse; interacting w/ patient; participating in care
Plan of Care Reviewed with	patient; spouse
Coping/Independence	care explained to patient/family prior to performing; choices provided; education/information provided; questions answered; reassurance provided

Neuro/Cognitive/Perceptual

Neuro/Cognitive Perceptual

Level of Consciousness	alert; cooperative
Orientation	Oriented x 4
Arousal Level	Arouses to voice or touch

HEENTD

HEENTD

ENT	Normal ENTinspection
Head/Face	laceration on left eyebrow

Cardiovascular

Cardiovascular

Rate	Regular
Rhythm	Apical pulse regular
Telemetry Rhythm	normal sinus rhythm
Nailbeds	Color consistent with ethnicity
Mucous Membranes	Moist and intact
Skin Color	Color consistent with ethnicity
Heart Sounds	Regular
Capillary Refill Time	Less than or equal to 3 seconds

Peripheral Neurovascular

Peripheral Neurovascular

Capillary Refill Time	Less than or equal to 3 seconds
Edema	No edema

Respiratory

Respiratory

Appearance	symmetrical
Rate/Rhythm	regular rate and rhythm
Chest Movement	symmetrical, no accessory muscle use, no retractions

* = Updated Data

	Cough	none
	Sputum	none
Breath Sounds		
	Throughout All Fields	Clear:

Gastrointestinal

Gastrointestinal

Abdominal Appearance	Flat/rounded and symmetrical
Bowel Sounds	audible and active in all quadrants
Palpation	All quadrants soft and nontender
Assessment Findings	no abnormal gastrointestinal findings

Bowel Function

Last Bowel Movement	Today
Stool Amount	small
Stool Color	brown
Stool Consistency	soft, formed

GI Signs/Symptoms

Nausea	Without vomiting

Genitourinary

Genitourinary

Voiding Characteristics	voids painlessly and w/o difficulty
Urine Characteristics	clear yellow w/o odor
Assessment Findings	No abnormal genitourinary findings

Musculoskeletal

Musculoskeletal

Assessment Findings	No tenderness, swelling or deformity in all extremities
Extremity Movement	MAE on command, no obvious deficits noted

Skin

Skin

Color/Characteristics	color consistent w/ ethnicity
Temperature	warm
Moisture	dry
Turgor	elastic
Integrity	lac on left eyebrow

Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

ED Disposition Note

Authored:08/29/2011 01:19

Author(s):

Umbarger, Alicia A RN Signed on:08/29/2011 01:19

Last Updated:08/29/2011 01:19

ED Disposition Note

ED Disposition

Disposition From ED	Discharge Home
ED Disposition Date/Time	08/29/2011 01:19
ED Tick Sheet	1
Disposition Home	Accompanied by family/significant other; Copy of discharge instructions provided; Discharged via Wheelchair; Mode of discharge transportation
Mode of Transportation	Personal Vehicle

Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

ED Triage Note

Authored:08/29/2011 00:13

Author(s):
Umbarger, Alicia A RN Signed on:08/29/2011 00:15
Last Updated:08/29/2011 00:15

****** **TRIAGE** ******

Patient Complaint

Triage Time	08/29/2011 00:13
Patient Complaint	cut above his eye from a broken glass

Chief Complaint

Primary	Laceration

Mode and Means of Arrival

Mode of Arrival	self
Means of Arrival	ambulatory

Information Collected From

Source of Information	patient

Vital Signs

Systolic BP (mmHg)	149 mm Hg
Diastolic BP (mmHg)	60 mm Hg
Mean BP (mmHg)	89 mm Hg
Pulse (beats/min)	72 bpm
Resp Rate	16 /min
SpO2 %	100 %
Patient On	room air
Temperature Fahrenheit	98.2 degrees F
Temperature Celsius	36.7 degrees C

Pain/Weight

Numbers Scale (0-10)	2 /10
Pain Scaled Used	verbal

Emergency Severity Index

Emergency Severity Index	4

Allergies

No Known Allergies

Treatment PTA

Treatment Prior to Arrival	no

* = Updated Data

Patient Name:	MRN# / Visit #	DOB:	Age:	Sex:
OKULICZKOZARYN, ADAM JAN	**500177278/100332792**	**06/17/1979**	**32y**	**M**

"Current Location:"	Admit Date/Time:	Discharge Date/Time:	Visit Type:	Attending Physician
PLNO-ED-DC 01-A	**08/29/2011 00:01**		**Emergency**	**DASA, SRIDEVI LAXMI**

Triage Interventions

Triage Interventions	no
Visual Acuity Corrected	no

* = Updated Data

Baylor Regional Medical Center at Plano

Coding Summary

Print Date: 9/2/2011 8:12:15AM

Patient Name: Okullczkozaryn, Adam J **Billing Number:** 100332792 **MRN:** 500177278

Date of Birth:	6/17/1979	Sex:	Male	LOS:	1
Age at Admit:	32 years	Race:	Asian Non	Total Charges:	
Admit Date/Time:	08/29/2011 0001	Disch Date/Time:	08/29/2011 0219		
Attend Phys:	00000178 Dasa, Sridevi	Financial Class:			
Patient Type:	E Emergency Room	Payor 1:	BCCH GAYLE		
Det Pt Type:	D Emergency Patient	Payor 2:			
Disch Service:	ERM EMERGENCY MEDICINE	Payor 3:			
Admit Dx:	959.09 Face & neck injury	Discharge	01 Discharge to Home/Self Care		

DRG	Description	MDC	Weight	GMLOS	ALOS	Expect Reimb	Coder ID	Coded Date	Final Date
							CindyM	09/02/2011	

APR	Description	APR MDC	APR Severity of Illness	APR Risk of Mortality

Seq	POA	Diagnosis	Description
1		873.42	Open wound of face without complication, forehead
2		E888.0	Fall resulting in striking against sharp object
3		E920.8	Accident caused by cutting & piercing instrument/object

Seq/Ep		Procedure		Modifiers 1 2 3 4 5	Start	End	Provider		Role
1	1	08.81	Linear rep lid lacer		08/29/2011				
							00000178	Dasa, Sridevi	SU
							00000178	Dasa, Sridevi	AN
2	1	12011	REPAIR SUPERFICIAL WOUND(S)		08/29/2011				
							00000178	Dasa, Sridevi	SU
							00000178	Dasa, Sridevi	AN

Consult Performed By

<None>

BAYLOR REGIONAL MEDICAL CENTER AT PLANO
4700 Alliance Road, Plano TX 75093
(469)814-2000

Discharge Instructions

Sridevi Dasa MD

Adam Okuliczkozaryn

LACERATION,FACE

[Dermabond]

A LACERATION is a cut through the skin. Your laceration has been sealed with Dermabond skin adhesive -- a type of skin glue. This will form a seal between and over the wound edges.

HOME CARE:

1) Do not scratch, rub or pick at the Dermabond film. Do not place tape directly over the film.

2) Do not apply liquid, ointment or creams on the Dermabond film .

3) Avoid activities that cause heavy sweating until the film has fallen off. Protect the wound from prolonged exposure to sunlight or tanning lamps. You may shower and wash the wound area as usual but do not soak the wound in water (no swimming).

4) You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [NOTE : If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

FOLLOW UP:

Most facial cuts heal in five days with no problem. However, even with proper treatment, a wound infection sometimes occurs. Therefore, check the wound daily for the warning signs listed below. The Dermabond film will fall off by itself in 5-10 days.

GET PROMPT MEDICAL ATTENTION if any of the following occur:
-- Increasing pain in the wound
-- Redness, swelling or pus coming from the wound
-- If the wound edges come apart
-- Fever over 100.0° F (37.8° C) oral, or over 101.0° F (38.3° C) rectal
-- Bleeding not controlled by direct pressure

ERM
Visit#:100332792 29-Aug-2011
OKULICZKOZARYN, ADAM Male
MRN:500177278 17-Jun-1979 32y

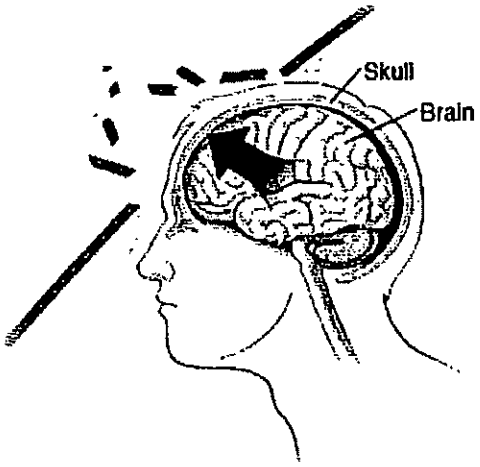
Sridevi Dasa MD

Adam Okuliczkozaryn

HEAD INJURY

[no wake-up, Adult]

You have had a head injury. It does not appear serious at this time. Sometimes symptoms of a more serious problem (concussion, bruising or bleeding in the brain) may appear later. Therefore, watch for the WARNING SIGNS listed below.



HOME CARE:

1. During the next 24 hours someone must stay with you to check for the signs below. It is not necessary to stay awake or be awakened during the night.

2. If you have swelling of the face or scalp, apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) for 20 minutes. Do this every 1-2 hours until the swelling starts to go down.

3. You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [NOTE: If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.] Do not take aspirin after a head injury.

4. For the next 24 hours:

5. -- Do not take alcohol, sedatives or medicines that make you sleepy.
   -- Do not drive or operate machinery.
   -- Avoid strenuous activities. No lifting or straining.

   If you have had any symptoms of a concussion today (nausea, vomiting, dizziness, confusion, headache, memory loss or if you were knocked out), do not return to sports or any activity that could result in another head injury until all symptoms are gone and you have been cleared by your doctor. A second head injury before fully recovering from the first one can lead to serious brain injury.

FOLLOW UP with your doctor if symptoms are not improving after 24 hours, or as directed.
[NOTE: A radiologist will review any X-rays or CT scans that were taken. We will notify you of any new findings that may affect your care.]

GET PROMPT MEDICAL ATTENTION if any of the following occur:

-- Repeated vomiting
-- Severe or worsening headache or dizziness
-- Unusual drowsiness, or unable to awaken as usual
-- Confusion or change in behavior or speech, memory loss, blurred vision
-- Convulsion (seizure)
-- Increasing scalp or face swelling
-- Redness, warmth or pus from the swollen area
-- Fluid drainage or bleeding from the nose or ears

Sridevi Dasa MD

Adam Okuliczkozaryn

LACERATION: WILL THERE BE A SCAR?

A laceration is a cut through one or more layers of the skin. The goal of emergency treatment is to clean the wound and close it to prevent infection, control bleeding and speed healing.

Cuts heal because the body is able to repair the skin by "sealing" the edges together with collagen, a kind of "skin cement." How deep your cut is, its location on your body, your age and the way your skin heals all determine how visible the final scar will be. Some persons tend to heal with more scar tissue than others. This cut will probably heal similar to other cuts you have had in the past.

WHAT YOU CAN DO:

There are a few simple things that you can do to limit the amount of scar that forms:

1) **PREVENT INFECTION:** An infected wound makes a bigger scar. Keep the wound clean and dry. Change the dressing and apply any ointment/cream as directed.

2) **MASSAGE THE WOUND:** *After* the stitches have been removed: Use a moisturizing cream or lotion containing Aloe or Vitamin E Oil and gently massage the skin around the wound with your fingertips (wash your hands first!). Do this twice a day for the first two weeks, then once a day for a month. This will increase the flow of oxygen and blood to the wound and prevent excess scar tissue from building up.

3) **AVOID SUN EXPOSURE:** During the first six months, avoid sun exposure since the scar may tan a much darker color than the skin around it. When in the sun, use SPF #50 (or greater) sun block on the scar, or cover the area with a hat or clothing.

WHAT TO EXPECT:

-- The cut will be sealed within 2 days and will be strong within 5-10 days. However, it will take at least SIX MONTHS for it to be fully healed.
-- During the FIRST THREE MONTHS, you may notice the scar line getting more red or purple in color. The scar may become raised. The skin around the wound may feel thick and lumpy.
-- During the FOURTH TO SIXTH MONTHS, this process begins to reverse. The red and purple color will fade, the scar line flattens, and the skin around it feels more normal.
-- In most cases, the way the scar line looks after six months is the way it will remain, although there may be some continued improvement up to one year after the injury.

IS THERE ANYTHING ELSE THAT CAN BE DONE?

If you do not like the way the scar looks after six months, a plastic surgeon may be able to perform a "scar revision."

If you have any questions or problems as your wound heals, contact your doctor or this facility. We will be glad to assist you.

ERM
Visit#:100332792 *29-Aug-2011*
OKULICZKOZARYN, ADAM *17-Jun-1979* *Male* *32y*
MRN:500177278

Sridevi Dasa MD

Adam Okuliczkozaryn

Special advice for: Adam Okuliczkozaryn

Call Your Primary Physician today or the next business day for an appointment to be seen within the next 1 weeks. When you call to make the appointment, tell the secretary that you were referred from this facility. When you go to see the doctor, bring these instructions with you.

REFERRALS:

Your Primary Physician
, Plano (None)

I have received and understand the instructions above.

x _____
Patient or Representative

x _____
Staff

0120
97.66 16/25/81
99

ERM
Visit#:100332792 29-Aug-2011
OKULICZKOZARYN, ADAM 17-Jun-1979 Male 32y
MRN:500177278

The exam and treatment that you received today has been provided on an emergency basis only. If your problem worsens or new symptoms appear, contact your doctor or return to this facility for further care.

03 **Facial / Scalp Injury**

DATE: 8/29/11 TIME: 0022 ☐ on arrival ROOM: 4

__EMS Arrival __EMS treatments ordered

HISTORIAN: patient spouse paramedics

AGE 32 M / F RACE

__HX / __EXAM LIMITED BY:

HPI

chief complaint: injury to: head neck face mouth / lip / chin / nose brow / ear

onset / duration: just prior to arrival today yesterday 1 PM
__ min / hrs / days ago

where: home school neighbor's park work street

timing: still present better gone now

pain intermittent / lasting
worse / persistent since

context: fall direct blow ipelsion stab burn
broken glass (hot head on coffee table)

severity of pain: mild moderate severe (1/10) 8/10

associated symptoms:
lost consciousness / dazed seizure memory impairment
duration: members: injury coming to hospital

ROS

headache
problems with vision
nasal drainage / congestion
neck / back pain
nausea / vomiting
numbness
weakness
LNMP N/A preg post- menop

problems urinating
recent illness
fever / chills
chest pain
shortness of breath
abdominal pain
leg / ankle swelling
☑ all systems neg except as marked

* NEURO / MS components also addressed in HPI

PAST HX

cardiac disease A-Fib AMI
diabetes Type I Type 2
diet / oral / insulin
__old records ordered / summary: none

hepatitis / HIV
asthma / COPD

Tetanus immun. UTD / given in ED

Meds- ✓none / see nurses note aspirin coumadin clopidogrel
Allergies- ✓NKDA / see nurses note

SOCIAL HX

smoker drugs
alcohol (recent / heavy / occasional) rarely occupation
living situation: alone at home in nursing home

FAMILY HX

__negative

PCP: Khambati

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed

PHYSICAL EXAM 98.2 149/60 92 16

General Appearance
✓no acute distress
✓alert

HEAD
__non-tender
__no swelling
__no obvious trauma

NECK
✓non-tender
✓painless ROM*

✓Nexus criteria neg

__c-collar / backboard (PTA / in ED)
__mild / moderate / severe distress
__anxious / lethargic
__see diagram
__raccoon eyes / Battle's sign

__see diagram
__pain on movement of neck

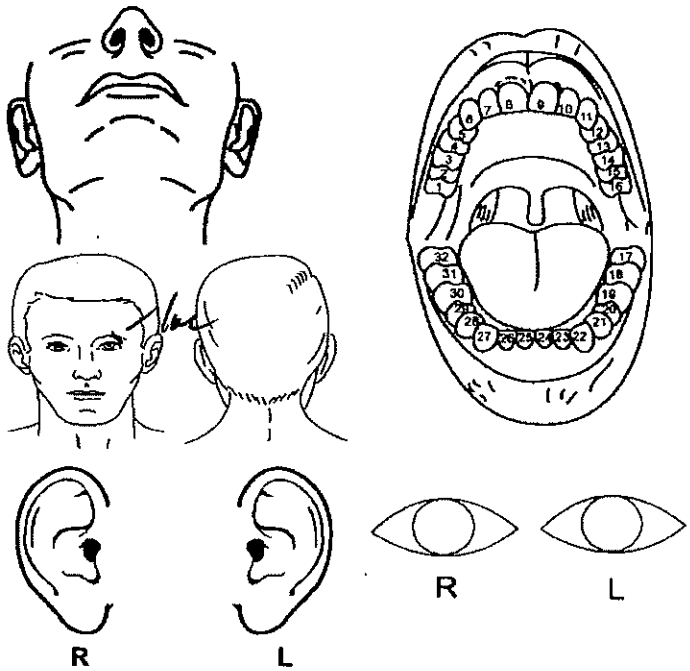
__midline tenderness / distracting injury
__altered mental status / recent ETOH
__focal neuro deficit

EYES
✓lids / conjunctivae nml
✓PERRL
✓EOMI
✓funduscopic exam nml

__periorbital hematoma
__subconjunctival hemorrhage
__foreign body
__corneal abrasion
__hyphema
__post-surgical pupillary defect (R / L)
__unequal pupils R ____mm L ____mm
__EOM palsy / anisocoria

ENT
✓nml external exam
✓pharynx nml
✓no injury to teeth lips or gums

__hemotympanum
__nasal septal hematoma
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion
__laceration crosses vermillion border



T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion
L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
(Ø= without m=mild mod=moderate s=severe)

BAYLOR REGIONAL MEDICAL CENTER AT PLANO

PLA8002 (Rev. 02 / 09)
EMERGENCY PHYSICIAN RECORD

ERM
Visit#:100332792 29-Aug-2011
OKULICZKOZARYN, ADAM Male
MRN:500177278 17-Jun-1979 32y

Pt. Name_____ Date_____

NEURO / PSYCH
- oriented x3
- sensation nml
- motor nml
- CN's nml as tested
- mood / affect nml

__disoriented to person / place / time_____
__confused / obtunded_____
__weakness / sensory loss_____
__facial droop_____
__abnormal gait_____
__depressed mood / affect_____

RESPIRATORY
- __chest non-tender
- no resp. distress
- __breath sounds nml

__tenderness / ecchymosis / abrasions_____
__decreased breath sounds_____
__wheezes / rales / rhonchi_____

CVS
- __heart sounds nml
- __reg. rate & rhythm

__tachycardia / bradycardia_____

ABDOMEN (GI)
- __non-tender
- __nml bowel sounds*

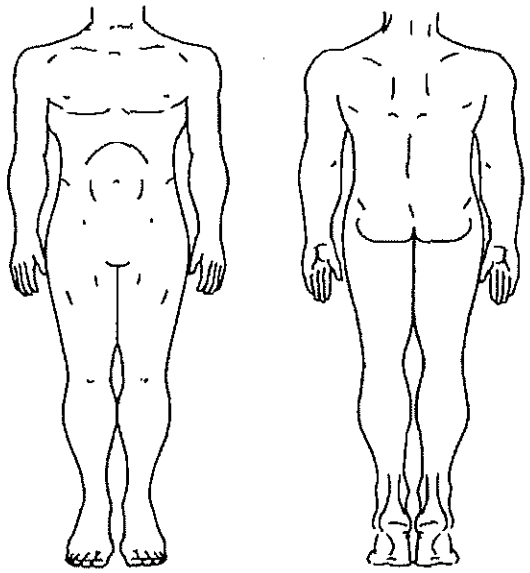
__see diagram_____
__tenderness / ecchymosis_____

SKIN
- intact, nml palp.

__crepitus_____
__decubitus_____

EXTREMITIES (MS)
- __non-tender
- nml ROM*

__see diagram_____
__tenderness / ecchymosis_____



LABS & XRAYS

CBC	Chemistries	UA	ETOH_____
normal except	*normal except*	*normal except*	TOX_____
WBC_____	Na_____	_____	_____
Hgb_____	K_____	_____	_____
Hct_____	Cl_____	HCG	PT/PTT_____
Platelets_____	CO2_____	serum / urine	INR_____
_____	BUN_____	POS NEG	_____
_____	Creat_____	_____	_____
_____	Gluc_____	_____	_____

XRAYS ☐Interp. by me ☐Reviewed by me ☐Discsd w/ radiologist

C-spine	*facial bones*	*orbits*	*mandible*
__nml / NAD	__no fracture	__nml alignment	__soft tissues nml

CT Scan ☐Discsd w/ radiologist

head	*facial bones*	*C-spine*	*orbits*

__nml / NAD_____

Pulse Ox 100 % on RA / ___ L O_2 *Interp: normal / hypoxic* Time: 0914

PROGRESS

*Time*_____ unchanged improved re-examined

__initial fracture care provided_____
*follow-up: < 24hrs / > 24hrs /*_____

Clinical Tool Box
__Canadian CT rule
__New Orleans CT criteria

__Discussed with Dr._____ Time:_____
will see patient in: ED / hospital / office

Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up

Additional history from:
family caretaker paramedics

__Rx given_____

__Smoking Cessation: *discussed: plan / trigger / challenges / gave Rx time:___min*

CRIT CARE TIME *(excluding separately billable procedures)*
30-74 min 75-104 min _____ min

PROCEDURES

Wound Description / Repair: Time: 0952
length 2 cm **location** elbow
linear stellate irregular flap into: subcut / muscle
clean contaminated *moderately / heavily* _____
distal NVT: M/neurovasc intact galea intact
anesthesia: local topical _____ lidocaine bupivacaine epi / bicarb
☐ moderate sedation required; see attached 23d template
prep: Hibiclens / Betadine / Sitar-Clens_____
irrigated with saline debrided *mod. /extensive*
wound explored wound margins revised
to base / in bloodless field multiple flaps aligned
no foreign body identified vermillion border aligned
foreign material removed galea repaired
repair: *Wound closed with: wound adhesive / Dermabond / steri-strips*
SKIN- #_____ _____-0 nylon / prolene / staples / ethilon_____
SUBCUT- #_____ _____-0 vicryl / chromic_____
MUCOSA- #_____ _____-0 vicryl / chromic_____

CLINICAL IMPRESSION

Concussion *with LOC w/o LOC*_____
Contusion / Hematoma_____
Laceration: elbow
Fracture _____
Sprain / Strain - *cervical* _____

DISPOSITION ☐ home ☐ transferred_____
Time 0958 ☐ admitted __POA *decubitus / UTI (foley)*_____
CONDITION- ☐ unchanged ☐ improved ☑ stable_____

Care transferred to Dr_____ Time:_____

RESIDENT / PA / NP- _____ *RTI #*_____

ATTENDING NOTE: *Please see resident / MLP note for details*
Resident/PA/NP's history reviewed. Patient interviewed and examined by me.
HPI:_____
My personal exam reveals:_____
__I agree with assessment and care plan, and confirm the diagnosis(es) above. With exception of_____

PHYSICIAN SIGNATURE- S. Jaxon *RTI #* 32

☐ Template Complete ☐ See Addendum (Dictated / Template #_____)

Underline *indicates organ system*
equivalent or mini

ERM

Facial Injury - 03

Visit#:100332792 29-Aug-2011
OKULICZKOZARYN, ADAM Male
MRN:500177278 17-Jun-1979 32y

Baylor Regional Medical Center at Plano

FACESHEET
ADMISSION/REGISTRATION RECORD

PATIENT INFORMATION

MEDICAL RECORD #: 500177278

NAME: OKULICZKOZARYN, ADAM JAN
ADDRESS 1: 19251 PRESTON RD
ADDRESS 2: APT 603
CITY, STATE ZIP: DALLAS, TX 75252
PHONE: (972) 408-6919
ALIAS/MAIDEN NAME:
EMAIL:

EMPLOYER:
ADDRESS 1:
ADDRESS 2:
CITY, STATE ZIP:
PHONE:

DOB: 06/17/1979 **AGE:** 39 **SOC. SECURITY #:** 632-80-7616
GENDER: MALE **MARITAL STATUS:** MARRIED
RACE: ASIAN
ETHNICITY: NOT OF HISPANIC ORIGIN
LANGUAGE: ENGLISH
RELIGION: NONE

EMERGENCY CONTACT: XUE, YU
RELATIONSHIP TO PATIENT: SPOUSE
PHONE: (469) 321-6827

VISIT INFORMATION

ACCOUNT/VISIT#: 100332792

ADMIT DATE/TIME: 08/29/2011 12:01 AM
LOCATION: PLANO-ED-EW45-A
ACCOMMODATION:
SERVICE CODE: EMEGENCY MEDICINE
VISIT REASON: LINEAR REP LID LACER
ACCIDENT TYPE: ACCIDENT/MEDICAL COVERAGE
DISCHARGE DATE/TIME: 08/29/2011 02:19 AM

VISIT TYPE: EMERGENCY
ADMIT TYPE: EMERGENCY
PRIVACY STATUS: ROUTINE/STANDARD

ACCIDENT DATE/TIME: 08/28/2011 11:30 PM
OCCURRENCE DATE: 08/28/2011 **OCCURRENCE CODE:** 01
08/29/2011 11
06/17/1979 A1
09/01/2010 A2

ADMITTING PHYSICIAN:
DASA, SRIDEVI LAXMI

ATTENDING PHYSICIAN:
DASA, SRIDEVI LAXMI

CONSULTING PHYSICIAN:

PRIMARY CARE PHYSICIAN:
NO PCP

REFERRING PHYSICIAN:

GUARANTOR INFORMATION

NAME: OKULICZKOZARYN, ADAM JAN
HOME PHONE: (972) 408-6919
BUSINESS PHONE:

EMPLOYER:
EMPLOYER PHONE:

DOB: 06/17/1979
SOC. SECURITY #: 632-80-7616

RELATIONSHIP TO PATIENT: SELF/PATIENT

INSURANCE INFORMATION

	PRIMARY	SECONDARY	TERTIARY	MSP:
CODE:	BCCH08			
PLAN:	BLUE CROSS BLUE CARD PPO/POS			
GROUP:	UNIVERIDTY OF TEXAS			
GROUP #:	071778			
POLICY #:	UTS0198DC2RQ			
ADDRESS 1:	PO BOX 660044			
ADDRESS 2:				
CITY, STATE ZIP:	DALLAS, TX 75265			
INSURED'S NAME:	OKULICZKOZARYN, ADAM			
INSURED'S DOB:	06/17/1979			
INSURED'S SOC. SECURITY #:	632-80-7616			
RELATIONSHIP TO INSURED:	SELF/PATIENT			
AUTHORIZATION #:				
PRECERTIFICATION PHONE:				
PRECERTIFICATION DAYS:				
INS. VERIFICATION PHONE:	(866) 882-2034			

Baylor Scott & White HEALTH	ED Nursing Record				Visit Type: Emergency
Patient Name: OKULICZKOZARYN, ADAM JAN	MRN # / Visit #: 500177278/100332792	DOB: 06/17/1979	Age: 32y	Sex: M	
Discharge Location: PLNO-ED-DC 01-A	Admit Date/Time: 08/29/2011 00:01	Discharge Date/Time: 08/29/2011 02:19	Authored Date/Time: from 08/29/2011 00:13	Attending Physician: DASA, SRIDEVI LAXMI	

2011-08-29 00:13:00 Umbarger, Alicia A - RN

****** TRIAGE ******:

Patient Complaint:

· **Triage Time**	08/29/2011 00:13
· **Patient Complaint**	cut above his eye from a broken glass

Chief Complaint:

· **Primary**	Laceration

Mode and Means of Arrival:

· **Mode of Arrival**	self
· **Means of Arrival**	ambulatory

Information Collected From:

· **Source of Information**	patient

Vital Signs/Pain/Weight:

Vital Signs:

· **Systolic BP (mmHg)**	149 mm Hg
· **Diastolic BP (mmHg)**	60 mm Hg
· **Mean BP (mmHg)**	89 mm Hg
· **Pulse (beats/min)**	72 bpm
· **Resp Rate**	16 /min
· **SpO2 %**	100 %
· **Patient On**	room air
· **Temperature Fahrenheit**	98.2 degrees F
· **Temperature Celsius**	36.7 degrees C

Pain/Weight:

· **Numbers Scale (0-10)**	↓ 2 /10
· **Pain Scaled Used**	verbal

Emergency Severity Index:

Triage Acuity Level 4.

Allergies:

Allergies:

· **No Known Allergies**:

Treatment PTA:

· **Treatment Prior to Arrival**	no

Triage Interventions:

· **Triage Interventions**	no
· **Visual Acuity Corrected**	no

Electronic Signatures:

Umbarger, Alicia A (RN) (Signed 08-29-2011 00:15)

Entered: ****** *TRIAGE* ******,

Authored: ****** *TRIAGE* ******

Last Updated: *08-29-2011 00:15*

2011-08-29 00:23:00 Umbarger, Alicia A - RN

Outpatient Medications:

Outpatient Medications:

**** No Current Medications as of 08-29-2011 00:23 documented in Structured Notes***

Significant Events:

Significant Events:

- **none**: Past Medical History
- **none**: Past Surgical History

Screenings:

Substance Abuse:

· **Do you use tobacco, alcohol, or street drugs?**	Yes...
· **Tobacco?**	No
· **Alcohol?**	Yes...
· **How often?**	Weekly
· **Street Drugs?**	no

Suicide Risk Screen:

· **Are you feeling hopeless or worthless?**	No
· **Are you having thoughts of taking your own life?**	No

Abuse Screen:

· **Are you currently in a relationship where you have been threatened or abused physically, emotionally, or sexually?**	No
· **Do you feel safe in your relationships at home?**	Yes
· **Do you the nurse suspect the patient is being abused, neglected or exploited?**	No

TB Screen:

· **Symptoms or Risks?**	No Symptoms or Risks

Isolation:

· **Previous Isolations:**	No

Vaccinations:
Tetanus Vaccine (within 5 years): Yes (date unknown).

Advance Directive:

· **Advance Directives:**	No
· **Patient desires more information:**	No

Electronic Signatures:
Umbarger, Alicia A (RN) (Signed 08-29-2011 00:24)
Entered: *Outpatient Medications, Significant Events, Screenings,*
Authored: *Outpatient Medications, Significant Events, Screenings*
Last Updated: *08-29-2011 00:24*

2011-08-29 00:40:00 Umbarger, Alicia A - RN
Outpatient Medications:
Outpatient Medications:
**** No Current Medications as of 08-29-2011 00:23 documented in Structured Notes***

Reassessment Data:
Reassessment Data:

· **Reassessment Data**	Assumed care of patient; Hourly rounding completed; Pain, Plan of Care, Duration, and Delay Addressed

Safety Factors/Interventions:
Safety Factors/Interventions:

· **Safety Factors/Interventions**	Bed in low position; Call Light in reach; Demonstrated call light function to patient/family

John Hopkins Fall Assessment:

· **Fall History**	No fall history
· **Age**	69 years old or less
· **Mobility**	NA
· **Elimination**	NA
· **Mental Status Changes**	NA
· **Medications (includes psychotropics - antidepressants, hypnotics, antipsychotics, sedatives, benzodiazepines, some**	NA

antiemetics; anticonvulsants; diuretics/cathartics; PCA/narcotics/opiates; antihypertensives)	
· **Patient Care Equipment (IV, Chest Tube, Indwelling Catheter, SCDs, etc)**	NA
· **Fall Risk Assessment Total**	0

Coping:
Coping:

· **Coping: Emotional State**	Observed:, Verbalized:, accepting, calm
· **Participants/Involvement in Care**	patient; interacting w/ patient; participating in care; spouse
· **Plan of Care Reviewed with**	patient; spouse
· **Coping/Independence**	care explained to patient/family prior to performing@ choices provided@ education/information provided@ reassurance provided@ questions answered

Neuro/Cognitive/Perceptual:
Neuro/Cognitive Perceptual:

· **Level of Consciousness**	alert; cooperative
· **Orientation**	Oriented x 4
· **Arousal Level**	Arouses to voice or touch

HEENTD:
HEENTD:

· **ENT**	Normal ENTinspection
· **Head/Face**	laceration on left eyebrow

Cardiovascular:
Cardiovascular:

· **Rate**	Regular
· **Rhythm**	Apical pulse regular
· **Telemetry Rhythm**	normal sinus rhythm
· **Nailbeds**	Color consistent with ethnicity
· **Mucous Membranes**	Moist and intact
· **Skin Color**	Color consistent with ethnicity
· **Heart Sounds**	Regular

· **Capillary Refill Time**	Less than or equal to 3 seconds

Peripheral Neurovascular:
Peripheral Neurovascular:

· **Capillary Refill Time**	Less than or equal to 3 seconds
· **Edema**	No edema

Respiratory:
Respiratory:

· **Appearance**	symmetrical
· **Rate/Rhythm**	regular rate and rhythm
· **Chest Movement**	symmetrical, no accessory muscle use, no retractions
· **Cough**	none
· **Sputum**	none

Breath Sounds:

· **Throughout All Fields**	Clear:

Gastrointestinal:
Gastrointestinal:

· **Abdominal Appearance**	Flat/rounded and symmetrical
· **Bowel Sounds**	audible and active in all quadrants
· **Palpation**	All quadrants soft and nontender
· **Assessment Findings**	no abnormal gastrointestinal findings

Bowel Function:

· **Last Bowel Movement**	Today
· **Stool Amount**	small
· **Stool Color**	brown
· **Stool Consistency**	soft, formed

GI Signs/Symptoms:

· **Nausea**	Without vomiting

Genitourinary:
Genitourinary:

· **Voiding Characteristics**	voids painlessly and w/o difficulty
· **Urine Characteristics**	clear yellow w/o odor
· **Assessment Findings**	No abnormal genitourinary findings

Musculoskeletal:
Musculoskeletal:

· **Assessment Findings**	No tenderness, swelling or deformity in all extremities
· **Extremity Movement**	MAE on command, no obvious deficits noted

Skin:
Skin:

· **Color/Characteristics**	color consistent w/ ethnicity
· **Temperature**	warm
· **Moisture**	dry
· **Turgor**	elastic
· **Integrity**	lac on left eyebrow

Electronic Signatures:
Umbarger, Alicia A (RN) (Signed 08-29-2011 00:43)
Entered: *Outpatient Medications, Reassessment Data, Safety Factors/Interventions, Coping, Neuro/Cognitive/Perceptual, HEENTD, Cardiovascular, Peripheral Neurovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin,*
Authored: *Outpatient Medications, Reassessment Data, Safety Factors/Interventions, Coping, Neuro/Cognitive/Perceptual, HEENTD, Cardiovascular, Peripheral Neurovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Skin*
Last Updated: *08-29-2011 00:43*

BaylorScott&White HEALTH	ED Nursing Record			Visit Type: Emergency
Patient Name: OKULICZKOZARYN, ADAM JAN	MRN # / Visit #: 500177278/100332792	DOB: 06/17/1979	Age: 32y	Sex: M
Discharge Location: PLNO-ED-DC 01-A	Admit Date/Time: 08/29/2011 00:01	Discharge Date/Time: 08/29/2011 02:19	Authored Date/Time: from 08/29/2011 01:19	Attending Physician: DASA, SRIDEVI LAXMI

2011-08-29 01:19:00 Umbarger, Alicia A - RN

ED Disposition Note:

ED Disposition:

· **Disposition From ED**	Discharge Home
· **ED Disposition Date/Time**	08/29/2011 01:19
· **ED Tick Sheet**	1
· **Disposition Home**	Accompanied by family/significant other Copy of discharge instructions provided Discharged via Wheelchair Mode of discharge transportation
· **Mode of Transportation**	Personal Vehicle

Electronic Signatures:

Umbarger, Alicia A (RN) (Signed 08-29-2011 01:19)

Entered: *ED Disposition Note,*

Authored: *ED Disposition Note*

Last Updated: *08-29-2011 01:19*

2011-08-29 00:13:00 Umbarger, Alicia A - RN

Vital Signs

Temperature Temperature Fahrenheit : 98.2 degrees F
Temperature Temperature Celsius : 36.7 degrees C

Blood Pressure

Blood Pressure Systolic BP (mmHg) : 149 mm Hg
Blood Pressure Diastolic BP (mmHg) : 60 mm Hg
Blood Pressure Mean BP (mmHg) : 89 mm Hg

Heart Rate

Heart Rate Pulse (beats/min) : 72 bpm

Respiratory

Resp,Pulse Ox Resp Rate : 16 /min

2011-08-29 01:18:00 Umbarger, Alicia A - RN

Blood Pressure

Blood Pressure Systolic BP (mmHg) : 125 mm Hg
Blood Pressure Diastolic BP (mmHg) : 81 mm Hg
Blood Pressure Mean BP (mmHg) : 95 mm Hg

Heart Rate

Heart Rate Pulse (beats/min) : 66 bpm

Respiratory

Resp,Pulse Ox Resp Rate : 16 /min

Resp,Pulse Ox SpO2 % SpO2 % : 100 %

Pain Assessment

Pain Assessment Pain Intensity Now : 0/10