RIVERSIDE COMMUNITY HOSPITAL

Health Information Management Department
1200 River Road | Meadowbrook, CO 80555 | Fax: (555) 661-0001

MEDICAL RECORDS TRANSMISSION

TO: Whispering Pines Family Medicine — Dr. Evelyn Sato, DO
FAX: (555) 867-5309
FROM: HIM Department — Riverside Community Hospital
DATE: February 7, 2026
PAGES: 40 (including cover)

PATIENT: WELLINGTON, CHARLES B.
DOB: 11/04/1955
MRN: RCH-2019-55782

RECORDS ENCLOSED:

- Emergency Department Visit Notes (01/29/2026) — 4 pages
- Discharge Summary (02/01/2026) — 3 pages
- History & Physical (01/29/2026) — 3 pages
- Operative Report: Appendectomy (01/30/2026) — 2 pages
- Anesthesia Record (01/30/2026) — 2 pages
- Pathology Report (01/31/2026) — 1 page
- Laboratory Results (01/29–02/01/2026) — 6 pages
- Radiology Reports: CT Abdomen, Chest X-Ray (01/29/2026) — 3 pages
- Nursing Notes (01/29–02/01/2026) — 8 pages
- Medication Administration Record (01/29–02/01/2026) — 4 pages
- Discharge Instructions & Follow-Up Orders — 2 pages

NOTE: Records sent per provider request dated 02/05/2026.
Signed authorization on file (ROI #2026-0207-RCH).

CHIEF COMPLAINT: Acute abdominal pain, nausea, vomiting x 24 hours.

HISTORY OF PRESENT ILLNESS:
Mr. Wellington is a 70-year-old male who presents to the emergency department with a 24-hour history of progressively worsening right lower quadrant abdominal pain. Pain began periumbilically and migrated to the RLQ over approximately 8 hours. Associated symptoms include nausea with two episodes of non-bloody emesis, anorexia, and low-grade fever (Tmax 100.8F at home). Denies dysuria, hematuria, diarrhea, or melena. Last bowel movement was yesterday, normal consistency.

PAST MEDICAL HISTORY:
- Hypertension (controlled, on lisinopril 20mg daily)

- Type 2 Diabetes Mellitus (on metformin 1000mg BID, last HbA1c 7.2%)
- Hyperlipidemia (on atorvastatin 40mg daily)
- Benign prostatic hyperplasia (on tamsulosin 0.4mg daily)
- Osteoarthritis, bilateral knees
- Status post right total knee arthroplasty (2019)

PAST SURGICAL HISTORY: Right TKA (2019), tonsillectomy (childhood)

ALLERGIES: Codeine (nausea/vomiting), Sulfa drugs (rash)

MEDICATIONS (verified with pharmacy):

1. Lisinopril 20mg PO daily

2. Metformin 1000mg PO BID
3. Atorvastatin 40mg PO QHS
4. Tamsulosin 0.4mg PO daily
5. Acetaminophen 650mg PO PRN
6. Aspirin 81mg PO daily

SOCIAL HISTORY: Retired electrician. Lives with wife. Former smoker (quit 2005, 20 pack-year history). Occasional alcohol (1-2 beers/week). No illicit drugs.

FAMILY HISTORY: Father — MI age 68. Mother — Type 2 DM, stroke age 75. Brother — colon cancer age 62 (deceased). No family history of appendicitis.

REVIEW OF SYSTEMS:

Constitutional: Fever, malaise, anorexia as noted. No weight loss, night sweats.
HEENT: No headache, vision changes, sore throat.
Cardiovascular: No chest pain, palpitations, edema.
Respiratory: No cough, dyspnea, wheezing.
GI: Abdominal pain and nausea as noted. No hematemesis, melena, diarrhea.
GU: No dysuria, hematuria, urinary frequency.
MSK: Chronic bilateral knee pain, no acute changes.
Neuro: No weakness, numbness, confusion.

Electronically signed by: Dr. Ricardo Vasquez, MD — Emergency Medicine
Signed: 01/30/2026 02:15 | Attending Attestation Complete

DISCHARGE SUMMARY

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782 DOB: 11/04/1955
ADMISSION DATE: 01/29/2026 DISCHARGE DATE: 02/01/2026
ATTENDING: Dr. Anita Krishnamurthy, MD, FACS
PRIMARY CARE: Dr. Evelyn Sato, DO — Whispering Pines Family Medicine

PRINCIPAL DIAGNOSIS: Acute appendicitis, uncomplicated (K35.80)

SECONDARY DIAGNOSES:
- Type 2 Diabetes Mellitus (E11.65)
- Essential Hypertension (I10)
- Hyperlipidemia (E78.5)

PROCEDURES: Laparoscopic appendectomy (01/30/2026)

HOSPITAL COURSE:
Patient admitted from ED with clinical and CT findings consistent with acute appendicitis. Surgical consult obtained. Patient taken to OR on hospital day 2 for laparoscopic appendectomy, which was performed without complication. Pathology confirmed acute suppurative appendicitis without perforation.

Postoperative course was uncomplicated. Patient tolerated clear liquids on POD0, advanced to regular diet by POD1. Pain well controlled with acetaminophen and low-dose oxycodone. Diabetes managed with sliding scale insulin inpatient; home metformin resumed on POD1 with meals. Blood glucose ranged 130-188 mg/dL.

DISCHARGE CONDITION: Stable, afebrile, tolerating PO, ambulating independently.

DISCHARGE MEDICATIONS:

1. Resume all home medications (lisinopril, metformin, atorvastatin, tamsulosin)
2. Acetaminophen 650mg PO Q6H PRN pain (first-line)
3. Oxycodone 5mg PO Q6H PRN severe pain (#10, no refills)
4. Docusate 100mg PO BID while taking oxycodone

FOLLOW-UP:

- Dr. Krishnamurthy (Surgery): 2 weeks post-op, call (555) 661-0050
- Dr. Sato (PCP): 1 week for diabetes/BP check, call (555) 867-5309
- Return to ED for: fever >101.5, worsening pain, wound redness/drainage, inability to tolerate fluids, persistent vomiting

HISTORY AND PHYSICAL EXAMINATION

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782
DATE: 01/29/2026 TIME: 19:45
EXAMINER: Dr. Anita Krishnamurthy, MD, FACS (Surgical Consult)

PHYSICAL EXAMINATION:

VITALS: T 101.2F, HR 92, BP 148/82, RR 18, SpO2 97% RA
GENERAL: Alert, oriented, in moderate distress, lying still.
HEENT: Atraumatic, normocephalic. Mucous membranes dry. No JVD.

CARDIOVASCULAR: Regular rate and rhythm. No murmurs, gallops, or rubs.
LUNGS: Clear to auscultation bilaterally. No wheezes or crackles.
ABDOMEN: Soft, non-distended. Marked tenderness at McBurney's point.
Positive rebound tenderness RLQ. Positive Rovsing's sign.
No guarding in other quadrants. Bowel sounds hypoactive.
No hepatosplenomegaly. No pulsatile masses.
RECTAL: Deferred per patient preference (CT obtained).
EXTREMITIES: No edema. 2+ DP pulses bilaterally. Well-healed RKR scar.
SKIN: Warm, dry. No rashes or lesions.
NEURO: A&Ox3. CN II-XII grossly intact. Gait deferred due to pain.

ASSESSMENT AND PLAN:

70-year-old male with clinical presentation consistent with acute appendicitis. CT abdomen/pelvis demonstrates enlarged appendix (12mm) with periappendiceal fat stranding and small appendicolith, without evidence of perforation or abscess.

Plan: Laparoscopic appendectomy in the morning. NPO after midnight. IV antibiotics (cefoxitin) initiated. Hold metformin perioperatively. Diabetes management per medicine consult. Type and screen obtained. Informed consent obtained — patient understands risks including conversion to open procedure, bleeding, infection, and anesthesia risks.

OPERATIVE REPORT

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782
DATE OF SURGERY: 01/30/2026
SURGEON: Dr. Anita Krishnamurthy, MD, FACS
ASSISTANT: Dr. Ryan Kimball, DO (PGY-4 Surgery Resident)
ANESTHESIA: General endotracheal (Dr. Patricia Hwang, MD)

PREOPERATIVE DIAGNOSIS: Acute appendicitis
POSTOPERATIVE DIAGNOSIS: Acute suppurative appendicitis, non-perforated

PROCEDURE: Laparoscopic appendectomy

FINDINGS: Appendix was acutely inflamed, erythematous, and edematous measuring approximately 10cm. No perforation identified. Small amount of turbid periappendiceal fluid aspirated and sent for culture. Cecum and terminal ileum appeared normal. No other intra-abdominal pathology noted.

ESTIMATED BLOOD LOSS: <10 mL
SPECIMENS: Appendix to pathology

DRAINS: None
COMPLICATIONS: None

DESCRIPTION OF PROCEDURE:
Patient placed supine, general anesthesia induced without difficulty. Abdomen prepped and draped in sterile fashion. Peritoneal access obtained at umbilicus using Veress needle technique. 12mm trocar placed. Pneumoperitoneum established to 15mmHg. Two additional 5mm trocars placed under direct visualization in the suprapubic and left lower quadrant positions.

Appendix identified and found to be acutely inflamed as described above. Mesoappendix divided using LigaSure device. Appendiceal base secured with two endoscopic loops and divided. Specimen placed in retrieval bag and removed through the umbilical port. Periappendiceal fluid irrigated and aspirated. Hemostasis confirmed. Trocars removed under direct visualization. Fascia at umbilical site closed with 0-Vicryl. Skin closed with 4-0 Monocryl subcuticular suture. Steri-strips and sterile dressings applied.

Patient extubated in OR, transferred to PACU in stable condition.

ANESTHESIA RECORD — PAGE 1

PATIENT: Wellington, Charles B. ASA CLASS: III
PROCEDURE: Laparoscopic Appendectomy
ANESTHESIOLOGIST: Dr. Patricia Hwang, MD
CRNA: Michael Torres, CRNA
DATE: 01/30/2026 OR START: 0830 OR END: 0945

ANESTHESIA TYPE: General Endotracheal
AIRWAY: Macintosh 3, Grade I view, ETT 7.5 oral, secured at 22cm
INDUCTION: Propofol 200mg, Fentanyl 100mcg, Rocuronium 40mg
MAINTENANCE: Sevoflurane 1.5-2.0% in O2/Air (50:50)
REVERSAL: Sugammadex 200mg
TOTAL FLUIDS: LR 1200 mL
EBL: <10 mL
UOP: Not catheterized (short case)

MONITORING: Standard ASA monitors, ETCO2, temp, NMT

INTRAOP VITALS (Q5 min):

0830 HR 82 BP 142/84 SpO2 99% ETCO2 36
0835 HR 78 BP 128/76 SpO2 100% ETCO2 34
0840 HR 75 BP 122/72 SpO2 100% ETCO2 35
0845 HR 80 BP 118/70 SpO2 100% ETCO2 34 (insufflation)
0850 HR 84 BP 132/78 SpO2 99% ETCO2 38
0900 HR 76 BP 124/74 SpO2 100% ETCO2 36
0915 HR 72 BP 120/70 SpO2 100% ETCO2 34
0930 HR 70 BP 118/68 SpO2 100% ETCO2 33 (desufflation)
0940 HR 74 BP 126/76 SpO2 100% ETCO2 35 (emergence)
0945 HR 80 BP 138/82 SpO2 98% (extubated, to PACU)

ANESTHESIA RECORD — PAGE 2

PRE-ANESTHESIA EVALUATION:
Reviewed H&P, labs, medications, allergies. Patient examined. NPO >8 hours confirmed. Airway: Mallampati II, good mouth opening, adequate neck mobility. No predictors of difficult intubation.

Discussed risks of general anesthesia including but not limited to:
sore throat, dental injury, nausea, aspiration, allergic reaction, awareness, nerve injury, and rarely death.

Patient consents to anesthesia. Questions answered.

POST-ANESTHESIA NOTE (PACU):
Patient extubated in OR without difficulty. Transported to PACU. Alert, following commands. Vitals stable. Pain managed. Aldrete 9/10.

Electronically signed: Dr. Patricia Hwang, MD — Anesthesiology

SURGICAL PATHOLOGY REPORT

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782
COLLECTED: 01/30/2026 REPORTED: 01/31/2026
PATHOLOGIST: Dr. Samuel Osei-Mensah, MD

SPECIMEN: Appendix (laparoscopic appendectomy)

GROSS DESCRIPTION:
Received fresh, labeled 'appendix,' is a vermiform appendix measuring 9.5 x 1.8 cm. The serosal surface is erythematous and dull with fibrinous exudate. The wall thickness is up to 0.5 cm. The lumen contains purulent material. An appendicolith measuring 0.4 cm is identified at the mid-portion. Representative sections submitted in cassettes A1-A3.

MICROSCOPIC DESCRIPTION:
Sections demonstrate transmural acute inflammation with extensive neutrophilic infiltration of the muscularis propria and serosa. Mucosal ulceration is present. Fibrinopurulent exudate is noted on the serosal surface. No perforation, granulomatous inflammation, or neoplasia identified.

DIAGNOSIS: APPENDIX, APPENDECTOMY — ACUTE SUPPURATIVE APPENDICITIS
- No perforation
- No dysplasia or malignancy
- Appendicolith present

Electronically signed: Dr. Samuel Osei-Mensah, MD — Anatomic Pathology

COMPREHENSIVE METABOLIC PANEL — Collected: 01/29/2026 19:30

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
Glucose	188	H	mg/dL	70-100	Final
BUN	22		mg/dL	7-20	Final
Creatinine	1.1		mg/dL	0.7-1.3	Final
Sodium	139		mEq/L	136-145	Final
Potassium	4.2		mEq/L	3.5-5.1	Final
Chloride	101		mEq/L	98-106	Final
CO2	24		mEq/L	21-32	Final
Calcium	9.1		mg/dL	8.5-10.5	Final
Total Protein	7.0		g/dL	6.0-8.3	Final
Albumin	3.8		g/dL	3.5-5.5	Final
Bilirubin, Total	0.9		mg/dL	0.1-1.2	Final
Alk Phosphatase	78		U/L	44-147	Final
AST	28		U/L	10-40	Final
ALT	32		U/L	7-56	Final

COMPLETE BLOOD COUNT WITH DIFF — Collected: 01/29/2026 19:30

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
WBC	**14.8**	**H**	x10^3/uL	4.5-11.0	Final
RBC	4.85		x10^6/uL	4.30-5.90	Final
Hemoglobin	14.5		g/dL	13.0-17.5	Final
Hematocrit	43.2		%	38.3-48.6	Final
Platelet Count	268		x10^3/uL	150-400	Final
Neutrophils	**82.4**	**H**	%	40-70	Final
Lymphocytes	**10.2**	**L**	%	20-45	Final
Monocytes	5.8		%	2-10	Final
Bands	**6**	**H**	%	0-5	Final

URINALYSIS WITH MICROSCOPIC — Collected: 01/29/2026 20:15

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
Color	Yellow			Yellow	Final
Clarity	**Hazy**	**A**		Clear	Final
Specific Gravity	1.022			1.005-1.030	Final
pH	6.0			5.0-8.0	Final
Protein	**Trace**	**A**	mg/dL	Negative	Final
Glucose	**2+**	**A**		Negative	Final
Ketones	**1+**	**A**		Negative	Final
Blood	Negative			Negative	Final
Leukocyte Esterase	Negative			Negative	Final
Nitrite	Negative			Negative	Final
WBC	0-2		/HPF	0-5	Final
RBC	0-1		/HPF	0-3	Final
Bacteria	None seen			None	Final

BASIC METABOLIC PANEL — POD 0 — Collected: 01/30/2026 16:00

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
Glucose	165	H	mg/dL	70-100	Final
BUN	18		mg/dL	7-20	Final
Creatinine	1.0		mg/dL	0.7-1.3	Final
Sodium	140		mEq/L	136-145	Final
Potassium	4.0		mEq/L	3.5-5.1	Final
Chloride	102		mEq/L	98-106	Final
CO2	25		mEq/L	21-32	Final
Calcium	8.9		mg/dL	8.5-10.5	Final

CBC — POST-OP DAY 1 — Collected: 01/31/2026 06:00

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
WBC	**11.2**	**H**	x10^3/uL	4.5-11.0	Final
RBC	4.55		x10^6/uL	4.30-5.90	Final
Hemoglobin	13.8		g/dL	13.0-17.5	Final
Hematocrit	41.0		%	38.3-48.6	Final
Platelet Count	275		x10^3/uL	150-400	Final
Neutrophils	**74.0**	**H**	%	40-70	Final

BASIC METABOLIC PANEL — DISCHARGE — Collected: 02/01/2026 06:00

TEST	RESULT	FLAG	UNITS	REF RANGE	STATUS
Glucose	142	H	mg/dL	70-100	Final
BUN	16		mg/dL	7-20	Final
Creatinine	0.9		mg/dL	0.7-1.3	Final
Sodium	141		mEq/L	136-145	Final
Potassium	4.3		mEq/L	3.5-5.1	Final

RADIOLOGY REPORT

CT ABDOMEN AND PELVIS WITH IV CONTRAST

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782
DATE: 01/29/2026 TIME: 20:30
ORDERING PROVIDER: Dr. R. Vasquez, MD (Emergency Medicine)
RADIOLOGIST: Dr. Janet Cho, MD

CLINICAL INDICATION: RLQ pain, fever, elevated WBC. R/O appendicitis.

TECHNIQUE: Helical CT of the abdomen and pelvis with IV contrast (Omnipaque 350, 100 mL) acquired in portal venous phase. Coronal and sagittal reformats.

Electronically signed: Dr. Janet Cho, MD — Diagnostic Radiology

CHEST X-RAY — PA AND LATERAL

PATIENT: Wellington, Charles B. MRN: RCH-2019-55782
DATE: 01/29/2026 TIME: 19:00 (Pre-operative)
ORDERING PROVIDER: Dr. A. Krishnamurthy, MD
RADIOLOGIST: Dr. Janet Cho, MD

CLINICAL INDICATION: Pre-operative evaluation, age >65.

FINDINGS:
Heart size normal. Mediastinal contours unremarkable.
Lungs clear bilaterally. No pleural effusion or pneumothorax.
No acute osseous abnormality. Degenerative changes thoracic spine.

IMPRESSION: No acute cardiopulmonary process.

No hydronephrosis or stones. Normal enhancement.
ADRENALS: Normal bilaterally.
AORTA: Mild atherosclerotic calcification. No aneurysm.
BOWEL: No obstruction or wall thickening (other than appendix).
BLADDER: Normal. Foley catheter not present.
LYMPH NODES: No pathologic lymphadenopathy.
BONES: Degenerative changes lumbar spine. Right TKA hardware in place.

IMPRESSION:
1. Acute appendicitis with appendicolith. No perforation or abscess.
2. Incidental bilateral simple renal cysts — benign, no follow-up needed.
3. Mild aortic atherosclerosis.

DATE/TIME: 01/29/2026 19:00 NURSE: S. Martinez, RN

Admission assessment completed. Patient alert, oriented x3. Denies chest pain or shortness of breath. Abdominal pain rated 7/10, RLQ. IV access established, 20g in L forearm. Labs drawn and sent. Foley not indicated at this time. Fall risk: moderate (Morse score 45). Skin intact, no pressure injuries noted. Allergies banded. ID verified x2.

DATE/TIME: 01/30/2026 02:00 NURSE: T. O'Brien, RN

0200 — Resting comfortably. VS stable: T 100.4, HR 84, BP 138/78. Pain 5/10 after morphine 4mg IV given at 0130. Abdomen soft, tender RLQ. No emesis since admission. NPO maintained. IV LR running at 125 mL/hr. Awaiting OR scheduling.

DATE/TIME: 01/30/2026 06:30 NURSE: S. Martinez, RN

Pre-op checklist completed. Consent signed and in chart. H&P present and current. Labs reviewed — no critical values. Type and screen on file. NPO since midnight confirmed. Metformin held per anesthesia. Home medications held this AM. Pre-op antibiotics (cefoxitin 2g IV) administered at 0715. Patient and wife updated on plan, verbalized understanding. OR transport called.

DATE/TIME: 01/30/2026 11:00 NURSE: K. Washington, RN

Post-op recovery note: Patient returned from OR at 1045, alert, MAE x4. Vitals: T 98.9, HR 78, BP 132/76, SpO2 98% 2L NC. Incision sites CDI, dressings dry and intact x3. Pain 4/10, managed with acetaminophen 1g IV. Anti-emetic given prophylactically. Clear liquids offered, tolerated well. Ambulated to bedside commode with assistance x1 at 1400.

DATE/TIME: 01/31/2026 07:00 NURSE: S. Martinez, RN

Day shift assessment — POD 1. Patient in good spirits, ambulating in hallway independently. Tolerating regular diet without nausea. BG this AM: 156 mg/dL. Resumed home metformin with breakfast. Pain 2/10, managed with PO acetaminophen only — declined oxycodone. Incisions clean, no erythema or drainage. Afebrile x 18 hours. D/C planning initiated with case management.

DATE/TIME: 02/01/2026 07:00 NURSE: S. Martinez, RN

Discharge nursing note: All discharge criteria met. Final vitals: T 98.6, HR 72, BP 128/74. Patient ambulating independently, tolerating regular diet, pain controlled on PO meds only. Discharge medications reviewed with patient and wife. Written instructions provided. Follow-up appointments confirmed. Patient verbalized understanding of wound care, activity restrictions, and return precautions. Discharged home with wife at 1430. Wheelchair to car.

NURSING FLOWSHEET — Continued (Page 7)

Vital Signs Log:

0600 T 98.4 HR 70 BP 126/72 RR 16 SpO2 98% RA
1000 T 98.6 HR 74 BP 130/76 RR 16 SpO2 99% RA
1400 T 98.8 HR 72 BP 128/74 RR 18 SpO2 98% RA
1800 T 98.6 HR 76 BP 132/78 RR 16 SpO2 98% RA

Intake/Output:

PO Intake: 1800 mL
IV Fluids: Discontinued
Urine Output: 1400 mL (voiding independently)

Blood Glucose Log:

0600: 156 mg/dL (pre-breakfast)
1200: 178 mg/dL (pre-lunch)
1800: 142 mg/dL (pre-dinner)

Pain Assessment:

0800: 2/10 (acetaminophen given)
1400: 1/10 (no intervention needed)
2000: 2/10 (acetaminophen given)

NURSING FLOWSHEET — Continued (Page 8)

Vital Signs Log:

0600 T 98.4 HR 70 BP 126/72 RR 16 SpO2 98% RA
1000 T 98.6 HR 74 BP 130/76 RR 16 SpO2 99% RA
1400 T 98.8 HR 72 BP 128/74 RR 18 SpO2 98% RA
1800 T 98.6 HR 76 BP 132/78 RR 16 SpO2 98% RA

Intake/Output:

PO Intake: 1800 mL
IV Fluids: Discontinued
Urine Output: 1400 mL (voiding independently)

Blood Glucose Log:

0600: 156 mg/dL (pre-breakfast)
1200: 178 mg/dL (pre-lunch)
1800: 142 mg/dL (pre-dinner)

Pain Assessment:

0800: 2/10 (acetaminophen given)
1400: 1/10 (no intervention needed)
2000: 2/10 (acetaminophen given)

DATE/TIME	MEDICATION/DOSE/ROUTE	INDICATION	NOTES
01/29 20:00	Morphine 4mg IV	Pain 7/10	Given per order
01/29 22:00	Cefoxitin 2g IV	Pre-op prophylaxis	Infused over 30 min
01/29 22:00	Ondansetron 4mg IV	Nausea	Given per PRN order
01/30 06:00	Insulin lispro 4 units SQ	BG 210	Per sliding scale

DATE/TIME	MEDICATION/DOSE/ROUTE	INDICATION	NOTES
01/30 07:15	Cefoxitin 2g IV	Pre-op dose	Infused over 30 min
01/30 11:30	Acetaminophen 1g IV	Post-op pain	Given in PACU
01/30 16:00	Metformin 1000mg PO	Home med resumed	With dinner
01/30 22:00	Acetaminophen 650mg PO	Pain 3/10	Given per order

DATE/TIME	MEDICATION/DOSE/ROUTE	INDICATION	NOTES
01/31 06:00	Lisinopril 20mg PO	Home med	Given with water
01/31 06:00	Metformin 1000mg PO	Home med	With breakfast
01/31 06:00	Atorvastatin 40mg PO	Home med	Given
01/31 08:00	Acetaminophen 650mg PO	Pain 2/10	Given per order

DATE/TIME	MEDICATION/DOSE/ROUTE	INDICATION	NOTES
02/01 06:00	All home meds given	See MAR detail	Discharge day

DISCHARGE INSTRUCTIONS

PATIENT: Wellington, Charles B. DATE: 02/01/2026

You had surgery to remove your appendix (laparoscopic appendectomy).
Your surgery went well and you are ready to go home.

WOUND CARE:

- You have 3 small incisions on your abdomen covered with Steri-strips
- Keep incisions clean and dry for 48 hours, then you may shower
- Do not submerge incisions in bath/pool/hot tub for 2 weeks
- Steri-strips will fall off on their own in 7-10 days
- If incisions become red, swollen, warm, or drain pus, call your surgeon

ACTIVITY:

- No heavy lifting (>10 lbs) for 2 weeks
- Walk daily — start with short walks and increase gradually
- You may climb stairs carefully
- No driving while taking oxycodone
- You may return to light activity in 1-2 weeks
- Full activity typically resumes in 3-4 weeks

DIET:

- Resume your regular diet

- Drink plenty of fluids
- Eat high-fiber foods to prevent constipation

MEDICATIONS:

- Resume all your home medications (lisinopril, metformin, atorvastatin, tamsulosin)
- Take acetaminophen (Tylenol) 650mg every 6 hours as needed for pain
- Take oxycodone 5mg every 6 hours ONLY for severe pain not helped by Tylenol
- Take docusate (Colace) 100mg twice daily while taking oxycodone
- CHECK YOUR BLOOD SUGAR more often for the next few days — surgery and stress can affect your levels

FOLLOW-UP APPOINTMENTS:

- SURGEON: Dr. Krishnamurthy — 2 weeks — call (555) 661-0050 to schedule
- PRIMARY CARE: Dr. Sato — 1 week for diabetes/BP check — call (555) 867-5309

RETURN TO EMERGENCY DEPARTMENT IF YOU HAVE:

- Fever over 101.5 degrees F
- Severe or worsening abdominal pain
- Redness, swelling, or pus draining from incisions
- Unable to keep down fluids for more than 24 hours
- Persistent vomiting
- No bowel movement for more than 3 days

Patient Signature: _____ Date: 02/01/2026

Witness: S. Martinez, RN Date: 02/01/2026