**Occupation:** xxx  
**Premorbidly:** ADL-i, independent ambulation without aid  
**Non-smoker, non-drinker**

**PAST HISTORY**

1. **Asthma**: Well-controlled on inhaled corticosteroids
2. **Hypothyroidism**: On levothyroxine with stable TSH levels
3. **Rheumatoid Arthritis (RA)**: SLEP 0/0, on methotrexate and hydroxychloroquine
4. **Chronic Kidney Disease Stage III**
5. **Hyperlipidemia**: Managed with lifestyle modifications and statin therapy

**RECENT HOSPITALISATION(S)** Recently admitted to XXX Hospital for:

1. **Right MCA infarct**

* Deficits: L sided weakness, R sided gaze deviation
* mechanism - ESUS
* rTPA given

1. **Atrial Fibrillation (AF)**: Incidentally discovered on admission, controlled with rate control strategy using metoprolol
2. **Urinary Tract Infection (UTI)**

* Cultured E. coli, treated successfully with antibiotics

**Medication Management and Discharge Plan:**

1. **RA Treatment**: Continued methotrexate and hydroxychloroquine. Added low-dose prednisone for flare management.
2. **AF Management**: Started metoprolol for rate control. Planned for outpatient evaluation of anticoagulation options.
3. **Chronic Conditions**:

* **Thyroid Replacement Therapy**: Continued levothyroxine at current dose
* **Hypertension**: Restarted amlodipine and spironolactone post-discharge to manage fluid balance.
* **Lipid Management**: Resumed atorvastatin therapy as tolerated, monitoring for muscle-related side effects.

**CURRENT ADMISSION**

**Transferred to XXX Hospital for rehab.**

**Subjective**

Denies any discomfort

No chest pain / SOB

No orthopnoea

No headache / giddiness / nausea / vomiting

No new weakness / numbness

Premorbidly ADL-I, community ambulant without aids

Works as a xxx

Stays with husband, post-stroke

- Patient used to be the main caregiver

- Currently being taken care of by patient's daughter's helper

Hopes to return to work eventually due to financial concerns

Broached regarding carer if required

- pt shared that she has cousins overseas who will be available to assist

- tentative plan is for two of them to come for 7 days each and alternate every other week

Asked for home leave tomorrow to have lunch with her cousin who will be visiting her tomorrow

Explained that we will let therapists assess her first, might not be able to approve the home leave if unsafe

Contingency plans as discussed

**Objective**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | |  |  | | **Vital signs:** | | | BP: | 119/81 | | Pulse: | 77 | | Resp: | 20 | | Temp: | 36.3 °C | | TempSrc: | Frontal | | SpO2: | 95% | |

OE

Alert

Lying supine comfortably, using phone

Not in respiratory distress

JVP not elevated

H S1S2

L clear

Abdo SNT

C supple no oedema

No facial asymmetry

Power:

|  |  |  |
| --- | --- | --- |
|  | LEFT | RIGHT |
| C5 Elb flex | 4 | 5 |
| C6 Wrist ext | 4 | 5 |
| C7 Elb ext | 4 | 5 |
| C8 Finger flex | 4 | 5 |
| T1 LF abd | 4 | 5 |

|  |  |  |
| --- | --- | --- |
|  | LEFT | RIGHT |
| L2 Hip flex | 4 | 5 |
| L3 Knee ext | 4 | 5 |
| L4 Ankle dorsi | 4 | 5 |
| L5 EHL | 4 | 5 |
| S1 Ankle plant | 4 | 5 |

**COMPREHENSIVE GERIATRIC ASSESSMENT**

|  |  |  |
| --- | --- | --- |
|  | **Pre-morbid** | **Current** |
| **Ambulation &  bADL** | Mobility Status: Community ambulant  Mobility Aids: None  Feeding : Independent  Dressing / Grooming: Independent  Toileting / Bathing: Independent  Ambulation: Independent | Feeding : Needs assistance  Dressing / Grooming: Needs assistance  Toileting / Bathing: Needs assistance  Ambulation: Needs assistance |

|  |  |
| --- | --- |
| **iADL** | Instrumental ADL (Pre-morbid)  Shopping: Self-care  Housework: Self-care  Accounting: Self-care  Food and Drink: Self-care  Transport: Self-care  Telephone: Self-care  Take Medication: Self-care |

|  |  |
| --- | --- |
| **Fall Assessment** |  |

|  |  |
| --- | --- |
| **Abbreviated Mental Test (AMT)** |  |

|  |  |
| --- | --- |
| **Neurocognitive Assessment** |  |

|  |  |
| --- | --- |
| **Continence** |  |

**ISSUES IN XXX HOSPITAL**

1. Rehab post right MCA infarct

- Deficits: L sided weakness, R sided gaze deviation

2. Ischaemic CMP

- TTE: LVEF 28%, dilated heart chambers, eLVH, mild RV systolic dysfunction, mRWMA, increased LVFP, no obvious thrombus

- started on aspirin, bisoprolol, entresto, empagliflozin, spironolactone and laxis PRN

- planned for Outpatient coros in x 6/52

3. CVRF

- HbA1c 8.8%

- LDL 2.4

**PROVISIONAL TREATMENT PLAN**

Vitals regularly

- aim SBP < 160mmHg

- no BP taking over left arm (left SMAC)

BSL TDS + 10pm x 3/7 then protocol if stable

Weigh 3x/day

No DW set

Fluid restriction 1L / day

IO charting

PVRU x 1

Regular bowel clearance

Allied health

PT OT

Dietitian for nutritional support

ST review PRN

Management

GDMT

Start plavix 1/52 before elective coros

Offer influenza vaccine prior discharge

**Discharge planning**

Estimated LOS Duration: 4 Weeks

Aim home with carer