

MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
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ED Resident/PA/NP/Attending Note [Date of Service: 11-May-2017 13:30, Authored: 11-May-2017 13:30]- for Visit: 0004985739 322, Complete, Revised, Signed in Full, General

Physician Information:

Pre-Assessment Chief Complaint:

- Chief Complaint/Subjective: fatigue

Triage Comments:

- Triage Comments:

Time Medical Screen Exam Initiated:

Time: 13:08 Date: 11-May-2017. Performed by Sullivan, Sean.

Time Seen by Me (Military Time): 13:08 Date: 11-May-2017

I have read and reviewed the RN triage assessment, vital signs, pain assessment, allergies, POC test data, and outpatient medications. History From: Patient and Medical Record.

Primary Language English

Interpreter Needed: No Interpreter's Name.

Known Health Issues:

Acute Dx:

Fatigue: Display Name: Cough, unspecified, Status: Active, Entered Date: 11-May-2017 13:30, Entered By: Brooks, Sarah Julie, Last Modified By: Brooks, Sarah Julie

History of Present Illness:

CC/HPI:

- **Chief Complaint:** Fatigue
- **History of Present Illness:** 65yo woman with HTN, HL presents due to 1 day of lethargy and fatigue. She spoke to her daughter today about how she was feeling. She and patient's husband were able to convince her to come to the hospital for evaluation. She has no complaints of chest pain, palpitations, abd pain, fever, chills, etc. Her husband notes that she has not been as active and has complained of lightheadedness this morning when she was getting up to go to the kitchen (had been sitting in a chair). Husband is not with patient as she is recovering from an orthopedic surgery. Patient has little other complaints.

Associated Symptoms:

- Chills No

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- **Fever** No
- **Nausea** No
- **Vomiting** No
- **Diarrhea** No
- **Abdominal Pain** No
- **Chest Pain** No
- **Shortness of Breath** No
- **Headache** No
- **Diaphoresis** No
- **Dizziness** No
- **Loss of Consciousness** No

Review of Systems:

- **General:** tired
- **Skin/Breast:** negative
- **Ophthalmology:** negative
- **ENMT:** negative
- **Respiratory:** negative
- **Cardiovascular:** negative
- **GI:** negative
- **GU/GYN:** negative
- **Musculoskeletal:** negative
- **Neuro:** negative

Past Medical History:

- **Past Medical History:** HTN, HLD
- **Past Surgeries:** Appendectomy

Pregnancy and Lactation:

Is patient pregnant? Not applicable

Is patient breastfeeding? Not applicable

Family History:

- **Family History Comments::** nc

Social History:

- **Smoking:** No
- **Alcohol Use:** No
- **Drug Use:** No

Allergies:

Allergen/Product	Reaction
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MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
• NKDA	N/A	

Home Meds / Current Meds Review:

***Patient Currently Takes Medications as of 13-Apr-2016 09:45 documented in Prescription Writer**

- **Ramipril 2.5 mg oral tablet:** Rx, 1 tab(s) orally daily x 30 days – Indication: HTN, Status: Active, Start date 13-Apr-2017, Stop Date: 13-May-2017
- **Simvastatin 20 mg oral tablet:** Rx, 1 tab(s) orally at bedtime x 30 days – Indication: Hyperlipidemia, Status: Active, Start date 13-Apr-2017, Stop Date: 13-May-2017

Vital Signs – Nursing:

VITALS (last 24 h) [retrieved for JONES, ANN at 11 May 2016 13:30]:

Tc: 36.9 Tmax: 36.9 @ 11 May 13:01
HR: 65 (65 - 65)
BP: 100/65 (100/65 - 100/65)
RR: 18 (18-18) | SpO2: 95% (95-95%)

Nursing Vitals/POC Tests:

1) ED Vital Signs/Assessment FS:

11-May-2016 13:01

Temperature (C) degrees C: 36.9
Temp Source: Oral
Heart Rate: 66
SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%): 95
O2 Source: Room air
Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm): 18
NIBP Systolic: 100
NIBP Diastolic: 65
BP Site: NIBP LA
BP Means of Measurement: Automatic
Position: Supine

Physical Exam:

- **General::** Speaking full sentences in NAD, appears stated age
- **Eyes::** EOMI PERRLA Conj/lids WNL
- **ENT::** OP WNL
- **CV::** RRR, normal S1/S2, no m/r/g
- **Lungs::** CTA b/l, no w/r/r
- **GI::** Soft Non-tender Non-distended
- **MSKL – Ext::** FROM Radial/Pedal pulses WNL No pitting edema b/l
- **Skin::** No rash No cyanosis No pallor
- **Neuro::** Alert
- **Psych::** Oriented X3

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Resident/PA/NP/Assessment and Plan:

I have discussed history of present illness, physical exam and management plan with Dr. Lane, Lynn.

Assessment and Plan:

- **Assessment and Plan:** 65yoF h/o HTN HLD p/w one day of fatigue. No other associated symptoms, normal exam, well appearing. Will evaluate for infectious v metabolic etiology, also consider cardiac (arrhythmia?).

Plan

EKG

CXR

Labs including trop, bnp

Reportable Conditions:

- **Reportable Condition:** No

Attending Attestation:

Time Seen (Military Time): 15:15 Date: 11-May-2016.

I have seen face to face and examined the patient; reviewed the Resident/PA/NP's history, examination, assessment and plan, and agree with the findings and plan. My summary note follows.

This patient is a 65 year old Female.

History Seen and agree with above

Physical Exam VITALS (last 24h) [retrieved for JONES, ANN at 11 May 2017 15:15]:

Tc: 36.9 Tmax 36.9 @ 11 May 2017 13:01

HR: 65 (65- 65)

BP: (100/65) (100/65 – 100/65)

RR: 18 (18 – 18) | SpO2: 95% (95% - 95%)

Agree with above

Comments: Agree with above

Labs

CXR

EKG

Admit

ED Diagnosis:

ED Diagnosis:

Fatigue, unspecified

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Level of Care:

Level of Care V.

Complete:

- **Note completed by Attending:** Yes
- **Note completed by Resident/PA or NP:** Yes

Electronic Signatures:

Sullivan, Sean (MD) (signed 11-May-2017 13:30)

Authored: *Physician Information, Time Medical Screening Exam Initiated, Known Health Issues, History of Present Illness, Review of Systems, Past Medical History, Allergies, Mone Meds / Current Meds Review, Vital Signs – Nursing, Physical Exam, Resident/PA/NP Assessment and Plan, Reportable Conditions, Complete*

Lane, Lynn (MD) (signed 11-May-2016 15:15)

Authored: *Attending Attestation, ED Diagnosis, Level of Care, Complete*

Last Updated: *11-May-2017 15:15 by Lane, Lynn (MD)*

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ED Disposition Note [Date of Service: 11-May-2017 16:04, Authored: 11-May-2017 16:04]- for Visit: 0004985739 322, Complete, Revised, Signed in Full, General

ED Vital Signs:

ED Vital Signs:

1) ED Vital Signs/Assessment FS:

Date/Time	Temperature (C) degrees C	Temp Source	Heart Rate	SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%)	O2 Source
11-May-2017 13:01	36.9	Oral	65	95	Room air
	Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm)	NIBP Systolic	NIBP Diastolic	BP Site	BP Means of Measurement
	18	100	65	NIBP LA	Automatic
	Position				
	Supine				

Evaluation

65yo woman presented with fatigue and lightheadedness, found to have intermittent complete heart block on EKGs and telemetry monitoring.

CVL placed for access to allow for transvenous pacing. R sided chest tube placed for pneumothorax when CVL placed. Pt admitted to CCU for further evaluation and management.

Patient Instructions:

Prescriptions:

***Patient Currently Takes Medications as of 11-May-2016 16:04 documented in Prescription Writer**

Outpatient Medications:

***Patient Currently Takes Medications as of 11-May-2016 16:04 documented in Prescription Writer**

- **Ramipril 2.5 mg oral tablet:** Rx, 1 tab(s) orally daily x 30 days – Indication: HTN, Status: Active, Start date 13-Apr-2017, Stop Date: 13-May-2017
- **Simvastatin 20 mg oral tablet:** Rx, 1 tab(s) orally at bedtime x 30 days – Indication: Hyperlipidemia, Status: Active, Start date 13-Apr-2017, Stop Date: 13-May-2017

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Medication Reconciliation:

*I have made a good faith effort to review this patient's home medications. In addition, I have reviewed all medications given during this visit and all new prescriptions.

Radiology Tests:

Chest PA and Lateral, 11-May-2017, Radiology Exam Complete

Labs:

Activated Partial Thromboplastin Time, 11-May-2017, Results Complete
Complete Blood Count with Differential, 11-May-2017, Results Complete
PT/INR, 11-May-2017, Results Complete
Basic Metabolic Panel, 11-May-2017, Results Complete
Lactate, 11-May-2017, Results Complete
Liver Function Panel, 11-May-2017, Results Complete
Magnesium, 11-May-2017, Results Complete
Troponin, 11-May-2017, Results Complete
Venous Blood Gas, 11-May-2017, Results Complete
Blood Culture, 11-May-2017, Lab Specimen Collected/Radiology Test in Progress
Blood Culture, 11-May-2017, Lab Specimen Collected/Radiology Test in Progress
Urinalysis, Dipstick with Microscopic Exam on Positives, 11-May-2017, Active

I-STOP → Prescription Monitoring Program Attestation (PMP):

3. I am not entering a prescription for any schedule II, III, or IV drugs to this patient.

Procedures:

Procedures were performed. Central Line Placement. Chest Tube Insertion. Please Note: This information will be given to the patient.

NYP I-STOP:

This patient is at NewYork-Presbyterian Hospital. Practitioners who have or will prescribe, order or administer Schedule II, III, or IV controlled substances for this patient for use during this ED visit or, if admitted on the premises as a result of this visit, are not required to consult the NYS Prescription Monitoring Program (PMP) Registry.

Disposition:

Stable.

Disposition: Admit

Electronic Signatures:

Sullivan, Sean (MD) (Signed 11-May-2017, 16:04)

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*Authored: ED Vital Signs, Evaluation, Patient Instructions, I-STOP →
Prescription Monitoring Program Attestation (PMP), Procedures, , Disposition*

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Cardiology Fellow Consult Note [Date of Service: 16-May-2016 22:30, Authored: 16-May-2016 22:30]- for Visit 0004985739 459, Complete, Revised, Signed in Full, General

Preferred Language:

Preferred Language English

Cardiology Fellow Consult Note:

Cardiology Fellow Consult/Precatheterization Note

REASON FOR CONSULT: complete heart block

Primary Team: ED

HPI

65yo woman with HTN, HL presented to the ED for evaluation of lightheadedness. She was found to have complete AV block on EKG. I was consulted for further management. Lightheadedness started yesterday, associated with change of positions. There are no exacerbating symptoms. She denies chest pain, palpitations, shortness of breath or other concerns.

ROS notable for:

Lightheadedness

No chest pain, shortness of breath, palpitations, syncope

PMHx

HTN HLD

FHx

denies

SHx

Married

Occasional etoh, no illicit, no tobacco

INPATIENT MEDS

STANDING MEDS [retrieved for JONES, ANN at 27 Jun 2017 13:26]:

Normal Saline Bolus 1000ml IntraVENOUS Once (completed)

PHYSICAL EXAM

VITALS (last 24h) [retrieved for JONES, ANN at 27 Jun 2017 13:26]:

Tc: 36.9 Tmax 36.9 @ 16 May 2017 15:55

HR: 30 (30- 65)

BP: (78/50) (78/50 – 100/65)

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RR: 20 (18 – 20) | SpO2: 95% (95% - 95%) Nasal Cannula

Gen: NAD, AOx3
HEENT: No JVD. R IJ CVL
Heart: paced, no m/r/g
Lungs: CTAB, R sided chest tube in place
Abdomen: soft, NT/ND
Extremities: wwp, no edema

LABS AND INVESTIGATIONS

1st ECG:
complete heart block at rate of 17

2nd ECG:
NSR

Troponin:
BNP:

LABS (last 24h) [retrieved for JONES, ANN at 16-May-2017 22:30]:

WBC: 8.3 / Hb 8.6 (MCV: 77.1) / Hct: 25.1 / Plt: 159 [05/16 @ 19:10]
-- Diff: N: 70.8% L:20.3% Mo:8.1% Eo: 0.6% Baso: 0.2%

Glucose: 124 [05/16 @ 21:10]

APTT: 44.2 [05/16 @ 19:10]

PT/INR: 28.1 / 6.1 [05/16 @ 19:10]

ASSESSMENT

65yo woman with complete AV block on ECG, CVL placed for transvenous pacing, now with R sided chest tube for pneumothorax sustained with placement of CVL.

RECS

- Admit to CCU
- Will need permanent pacemaker given complete heart block and no h/o use of AV nodal blocking agents
- Maintain electrolytes in normal range
- Chest tube to be managed by pulmonary. Will continue to suction for now.

to be d/w Attending

John Fellow, MD
Cardiology Fellow

MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
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Consult Service Pager 14832
For outpatient follow up please call 646-962-2150

Electronic Signatures:

Cardiology, Bob A (MD) (Signed 16-May-2017 23:00)

Co-signer: Cardiology Fellow Consult Note

Fellow, John C (MD) (Signed 16-May-2017 22:30)

Authored: Cardiology Fellow Consult Note

Last Updated: 16-May-2017 23:00 by Cardiology Bob A (MD)

MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
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ED Nursing Assessment Note [Date of Service: 16-May-2017 16:15, Authored: 16-May-2017 16:15]- for Visit: 0004985739 459, Complete, Entered, Signed in Full, General

Pain Assessment:

Pain Assessment:

- **Effect on physical activity** No effect

Allergies:

Allergen/Product	Reaction
• NKDA	

Home Medications Review:

Home Medications Review (OMR):

Launch Outpatient Medication Review (OMR).

Home Medications have been reviewed and saved as Complete.

Screenings:

Alcohol/Tobacco:

- **Tobacco Use/Smoking History:** Unknown if ever smoked.

Nutritional Screen:

Does the adult or pediatric patient have any non-healing wounds and/or pressure ulcers? No.

Falls Risk Assessment:

- **Falls Risk:** Yes
- **High Risk Safety Measures::** Reinforce use of assistive devices Yellow Wrist Band Applied

FALL RISK-Complete All Items:

- **Fall(s) in past 7 days** 0 - No
- **Impaired mobility and does not use Assistive Device.** 0 - No
- **Meds: Taking 1 or more sedatives** 0 - No
- **Gender = Male** 0 - No
- **Impaired Cognition** 0 - No
- **Risk for BLEEDING and/or FRACTURE from e.g.** 0 - No

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anticoagulant/antiplatelet
therapy, coagulopathy,
decreased platelets-
e.g.uremia

- Other Risk Factors 0 - NO
- Total Fall Risk Score 0
- Fall-Injury Risk Level Low Fall-Injury risk = 6 or less

Fall Prevention Safety Measures:

- Fall Prevention Safety Measures Provided the approved patient education resource on safety. Reviewed with patient/family their shared responsibility in fall prevention: Orientation to immediate surroundings

Isolation Precautions:

- Isolation: No

Focused Assessments:

Neurological:

- WNL: Alert and oriented to person, place, time. Responds appropriate

Respiratory:

- Respiratory Comments Breath sounds CTA b/l

Pregnancy and Lactation:

Is patient pregnant? Not applicable.

Is patient breastfeeding? Not applicable.

Advance Directive:

- Does patient have an advance directive? Unknown if patient has an advance directive

Electronic Signatures:

Ellis, Emma (Nurse) (Signed 16-May-2017 16:15)

Authored: Vital Signs/Pain Assessment, Allergies, Home Medications Review, Screenings, Focused Assessments, Advance Directives

Last Updated: 16-May-2017 16:15 by Ellis, Emma (Nurse)

MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
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ED Adult Pre-Assessment Note [Date of Service: 16-May-2017 15:55, Authored: 16-May-2017 15:55]- for Visit: 0004985739 459, Complete, Entered, Signed in Full, General

Triage Information:

• **Triage Information**

Nurse Ellis, Emma saw JONES, ANN at 05/16/17 15:55. The patient has a chief complaint of LIGHTHEADEDNESS and was triaged to a level LEV3. Patient was brought SN.

Travel Assessment:

- **Have you traveled outside the US in the last 21 days?** No
- **Have you had close contact with someone who had a contagious disease?** No

Quick Triage:

Arrival Info:

Mode of Arrival: Stretcher
Means of Arrival: Other Ambulance, FDNY
Preferred Language: English
Accompanied by: Daughter

Interpreter Services:

Services Required? No.

Chief Complaint/Subjective:

- **Chief Complaint/Subjective** lightheadedness

Vital Signs:

- **Temperature (C) degrees C:** 36.9
- **Temp Source:** Oral
- **Heart Rate:** 65
- **SpO2 (Pulse Ox) SpO2 (Pulse Ox) (%):** 95
- **O2 Source:** Room air
- **Respiratory Rate, Patient (bpm) Respiratory Rate, Patient (bpm):** 18
- **NIBP Systolic:** 100
- **NIBP Diastolic:** 65
- **BP Site:** NIBP LA

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- **BP Means of Measurement:** Automatic
- **Position:** Supine

Mental Status:

- **Mental Status:** Alert
- **Alert to::** Person Place Time

Pain Assessment:

Pain Assessment:

- **Pain Scale** 0, Numeric 0-10 scale,
- **Effect on physical activity** No effect

Isolation Precautions:

- **Isolation:** No

Pneumonia Like Illness:

- **Pneumonia Like Illness:** No

Allergies:

Allergen/Product	Reaction
• NKDA	

- **I have updated or confirmed the items in the allergy manager** Yes

Assessment/Interventions:

Treatment Prior to Arrival:

- **Treatment Prior to Arrival:** See Ambulance Record
- **Triage Interventions (reminder-order is needed for EKG, O2, fingersticks):** stretcher
- **Airway:** Clear
- **Breathing:** Non-labored
- **Breath Sounds:** CTA b/l
- **Circulation:** Regular
- **Skin:** Warm

Past Medical & Social History:

Past Medical History: HTN, Hypercholesterolemia

Past Surgeries: Appendectomy

MRN: 182 22 20 Visit: 0004985739 322 Age: 65y (21-Apr-1952)	JONES, ANN Gender: Female	General Hospital Location: AHall05
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Pregnancy and Lactation:

Is patient pregnant? Not applicable.

Is patient breastfeeding? Not applicable.

Mandatory Screenings:

Primary Medical Doctor Questions:

- **Does patient have a Primary Medical Doctor?**

Yes, has PMD, no changes required

Tetanus/Immunization:

- **Tetanus:** NA

Falls Risk Assessment:

- **Falls Risk:** Yes
- **High Risk Safety Measures::** Reinforce use of assistive devices Yellow Wrist Band Applied

Suicide Risk:

- **In the last month, have you had thoughts of suicide?:** N/A
- **In the last month, did you have thoughts that you would be better off dead?:** N/A
- **Suicide Risk:** N/A

Multi-Drug Resistant Organisms:

- **Any history of drug resistant organisms?:** Unknown

Abuse/Neglect/Violence:

- **Any evidence of abuse/neglect/violence?:** No

Reportable Condition:

- **Reportable Condition:** No

Triage Comments:

Triage Comments:

- **Triage Comments:** pt here with lightheadedness today. Pt answering questions appropriately, awake, alert. Daughter at bedside.

Emergency Severity Index:

- **ESI Level** 3

Electronic Signatures:

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CCU Fellow Progress Note

S: Day 7

65yo woman admitted with CHB s/p permanent pacer placed on Hospital day #1. Yesterday, pt developed shortness of breath and R sided chest pain. Chest xray concerning for empyema. Broad spectrum antibiotics started. Thoracic surgery consulted.

O:

HR: 65pbm **BP:** 130/70 **RR:** 22 **O2 Sat:**94% **RA Temp:** 38.2 deg C

Gen: Awake, alert, appears uncomfortable, sitting up on bed

ENT: OP mmm

CV: RRR, palpable radial pulses

Resp: Decreased BS on R side

Abd: soft NTND

Skin: healing incision at site of ppm placement, no erythema, induration, or purulent drainage

R chest wall with incision site from chest tube with mild erythema, no induration, sutures in place

EKG: paced

CXR: R side with concern for empyema

A:

65yo woman with CHB s/p ppm, iatrogenic R ptx s/p thoracostomy, now complicated by empyema

P:

CT surgery consult for empyema drainage and further management

Broad spectrum antibiotics

Continue ramipril and simvastatin

PT/OT

Dispo planning with social work/care coordination

Discussed with attending

Electronic Signatures:

Cardiology, Bob A (MD) (Signed 23-May-2017 11:00)

Co-signer: Cardiology Fellow Consult Note

Fellow, John C (MD) (Signed 23-May-2017 10:30)

Authored: Cardiology Fellow Consult Note

Last Updated: 23-May-2017 1:00 by Cardiology Bob A (MD)