* Final Report *
ED NOTE:

CHIEF COMPLAINT/REASON FOR VISIT: Ear pain

HISTORY OF PRESENT ILLNESS: Mr. XXXXXXX was at work at Domino's pizza when he decided to scare one of his coworkers by jumping out from around a corner. The coworker responded by punching him in the left ear. The patient now has decreased hearing and had some bleeding from the left ear and is come in for evaluation. He denies any other symptoms and states that he is typically very healthy.

ROS:
CONSTITUTIONAL: Denies fever / chills. Denies night sweats.
HEENT: Denies headaches dizziness or changes in vision. Ear pain as per history of present illness
CARDIOVASCULAR: Denies chest pain or palpitations.
RESPIRATORY: Denies dyspnea, coughing, or wheezing.
GASTROINTESTINAL: Denies abdominal pain or discomfort. Denies N/V. Denies constipation or diarrhea.
GENITOURINARY: Denies pain with urination, denies frequency.
INTEGUMENTARY: Denies rashes or skin lesion.
MUSCULOSKELETAL: Denies muscle aches, denies joint aches or pains.
EXTREMITIES: Denies edema or trauma.
NEUROLOGIC: Denies numbness or tingling
PSYCH: Denies anxiety, depression, pyschosis, suicidal/homicidal ideation

PROBLEM LIST/PAST MEDICAL HISTORY: Methicillin resistant Staphylococcus aureus infection Historical No historical problems HOME MEDICATIONS: HYDROcodone-acetaminophen 5 mg-325 mg oral tablet, 1-2 Tablets, Oral, every 4 hr, PRN mupirocin 2% topical ointment, 1 appl, Topical, TID ofloxacin 0.3% otic solution, 5 drops, Ear-Left, BID ondansetron 4 mg oral tablet, disintegrating, 4 mg, 1 tabs, Oral, TID ProAir HFA 90 mcg/inh inhalation aerosol, 2 puffs, Oral promethazine-dextromethorphan 6.25 mg-15 mg/5 mL oral syrup, 1-2 tsp, Oral, every 4 hr

ALLERGIES: No Known Medication Allergies

SOCIAL HISTORY:
Tobacco
Current every day smoker, Type: Cigarettes.

PHYSICAL EXAM:
VITALS & MEASUREMENTS: Triage Vitals
T: 35.6 degC (Tympanic) HR: 79 (Peripheral) RR: 16 BP: 133/90 SpO2: 100%
HT: 177.8 cm WT: 72.57 kg BMI: 22.96
Current Vitals
T: 35.6 degC (Tympanic) HR: 79 (Peripheral) RR: 18 BP: 133/90 SpO2: 100% CONSTITUTIONAL: wellappearing,
anxious, alert
SKIN: Warm, dry, and intact without rash.
EYES: extraocular movements are grossly intact, clear conjunctiva.

HENT: Normocephalic, there is a perforation in the 6 o'clock position that is the shape of a football on the left TM. There is evidence of recent bleeding but the TM is now hemostatic. The patient has slightly decreased sensory neural hearing in the left ear. The right ear is normal, moist mucus membranes.
NECK: no obvious swelling, normal range of motion. No meningismus.
PULMONARY: normal chest rise and fall, no respiratory distress or stridor. No wheezes, rales or rhonchi
CARDIOVASCULAR: regular rate and rythm, no murmurs, rubs or gallops. Distal extremities are warm and well-perfused.
GASTROINSTESTINAL: nondistended, non-tender. Normal bowel sounds
NEUROLOGIC: normal speech, moves all extremities.
MUSCULOSKELETAL: no gross deformities, atraumatic.
PSYCHIATRIC: normal mood and affect. No psychosis.

DIAGNOSIS: 1. Tympanic membrane perforation 2. Ear pain

MEDICAL DECISION MAKING/DIFFERENTIAL DX: The patient has suffered a traumatic left TM rupture. I consulted ear nose and throat with Dr. W responding to my call. He asked me to place the patient on a prophylactic antibiotic and so I have prescribed him ofloxacin eardrops. I've also given him pain medication because of the pain involved and some Zofran to prevent any iatrogenic nausea. We will discharge him on those 3 medications. And have him follow-up with her nose and throat in one week. I've also asked him to avoid submerging the ear and thus prevent introduction of infection.

ED COURSE: ADMINISTERED MEDICATIONS: No Medications Given

IMAGING: No qualifying data available.

Disposition:

PRESCRIBED MEDICATIONS THIS VISIT: HYDROcodone-acetaminophen 5 mg-325 mg oral tablet, 1-2 Tablets, Oral, every 4 hr, PRN ofloxacin 0.3% otic solution, 5 drops, Ear-Left, BID ondansetron 4 mg oral tablet, disintegrating, 4 mg, 1 tabs, Oral, TID

I, scribe, entered information for the licensed provider exactly as directly spoken to me by the provider for services performed. Electronically Signed by scribe on 10/31/16 07:10 AM

Electronically Signed on 10/31/16 07:43 AM
EDMD

Chart 2

* Final Report *
ED NOTE:

CHIEF COMPLAINT/REASON FOR VISIT: Facial injury

HISTORY OF PRESENT ILLNESS: This is a very nice 15-year-old Caucasian male, accompanied by his parents, who presents to the emergency department with a report of being involved in a bicycle accident. The patient has no recollection of the events. He states that he couldn't recall whether he was wearing a helmet or not. Friends who were bystanders state that the patient was wearing a helmet. There is a questionable loss of consciousness.

ROS: Constitutional: Denies any fevers, chills, weight loss
EYE: Denies any blurred vision, double vision, pain
ENT: Denies any congestion, epistaxis, or discharge
CVS: Denies any chest pain, palpitations, edema
RESP: Denies any cough, dyspnea, sputum, wheezing
GI: Denies any pain, heartburn, melena, distention, nausea, vomiting, diarrhea
GU: Denies any dysuria, urgency, hesitation, hematuria
MUSKEL: Pain level 5/10, upper right abdomen tenderness
SKIN: Right sided facial abrasions and contusions, left wrist abrasions, abrasions mid back (not new)
NEURO: Denies any headache, loss of consciousness, numbness

PROBLEM LIST/PAST MEDICAL HISTORY: No known active problems

HOME MEDICATIONS: Norco 5 mg-325 mg oral tablet, 1 tabs, Oral, TID, PRN

ALLERGIES: No Known Allergies SOCIAL HISTORY:
Tobacco Never smoker

PHYSICAL EXAM:
VITALS & MEASUREMENTS: Triage Vitals
T: 36 degC (Tympanic) HR: 72 (Peripheral) RR: 20 BP: 129/70 SpO2: 97%
HT: 167 cm WT: 57 kg BMI: 20.44

Current Vitals
T: 36 degC (Tympanic) HR: 72 (Peripheral) RR: 16 BP: 120/68 SpO2: 98% General: No acute distress, awake alert and oriented x 3
Eyes: Extraocular movements intact, pupils equal and reactive to light bilaterally
HEENT: Normocephalic, atraumatic, neck is supple, airway is patent and intact. The patient has swelling to the bridge of the nose and has blood visible in bilateral nares. No active bleeding noted.
Heart: Regular rate and rhythm, no murmurs rubs or gallops. 2+ peripheral pulses in the distal extremities.
Lungs: Clear to auscultation bilaterally, no retractions, no wheezes, rales, or rhonchi.
Abdomen: Soft, nontender, nondistended, active bowel sounds in all four quadrants.
Extremities: Superficial abrasions on left wrist. No clubbing cyanosis or edema.
Neurological: No focal neurological deficits, CN II-XII intact bilaterally. 2+ DTR's to the upper and lower extremities bilaterally, distal sensation intact in all extremities.
Skin: Right sided facial abrasions and contusions, left wrist abrasions, abrasions mid back(not new)
Psych: Normal mood and affect

DIAGNOSIS: 1. Concussion w/o coma 2. Nasal fracture 3. Right wrist sprain 4. Abrasions of multiple sites 5. Head injury

MEDICAL DECISION MAKING/DIFFERENTIAL DX: Because of the extensive facial trauma and his amnesia to the event a CT the brain and facial structures was done. The patient was found to have a nasal bone fracture without any acute intracranial injury. The patient will be discharged home with close follow-up with ENT in the next few days.

ED COURSE:

ADMINISTERED MEDICATIONS: iopamidol: 100 mL (10/31/16 19:48:00)
morphine: 2 mg (10/31/16 19:29:00)
ondansetron: 4 mg (10/31/16 19:29:00)
Sodium Chloride 0.9%: 10 mL (10/31/16 19:48:00)
Sodium Chloride 0.9%: 10 mL (10/31/16 19:48:00)
Sodium Chloride 0.9%: 10 mL (10/31/16 19:29:00) ORDERS:
Peripheral IV Insert Wound Care PROCEDURES: ***Splinting***
Orthopedic Custom Splints: Volar Splint

Splinting
Orthopedic Prefabricated Splints: Ace Wrap

IMAGING: CT Brain/Head w/o Contrast
10/31/16 20:17:00
IMPRESSION:
1. Nasal bone fracture.
2. No acute intracranial injury.

This report was electronically signed by
Signed By: RAD MD
****
CT Maxillofacial w/o Contrast
10/31/16 20:21:42
Impression:

Nasal bone fracture with mild leftward displacement.

This report was electronically signed by
Signed By: RAD MD
****
XR Spine Cervical 2 or 3 Views
10/31/16 19:45:05
IMPRESSION:
1. No acute injury identified.

This report was electronically signed by
Signed By: RAD MD
****
XR Wrist Complete 3+ Views Right
10/31/16 19:45:55
Impression:
No acute osseous injury.

This report was electronically signed by
Signed By: RAD MD
****
CT Abdomen and Pelvis w/ Contrast
10/31/16 20:19:42
Impression:
No acute injury to the abdomen/pelvis is identified.

This report was electronically signed by
Signed By: RAD MD

Disposition:
PRESCRIBED MEDICATIONS THIS VISIT: Norco 5 mg-325 mg oral tablet, 1 tabs, Oral, TID, PRN

All data entered into the medical record by me has been done under the direct supervision of the provider.-scribe

I have reviewed the documentation by my scribe and confirm and agree with the documentation.- NP

This note was created with voice recognition software and may have technical limitations.

Time Seen:
Electronically Signed on 11/01/16 03:19 AM
NP

Reviewed by: EDMD

Chart 3

* Final Report *
ED NOTE:
CHIEF COMPLAINT/REASON FOR VISIT: Fever

HISTORY OF PRESENT ILLNESS: The patient comes to the emergency department with the chief complaint of fever which has been present for 2 days. The associated symptoms include congestion decreased oral intake and weight loss of 2 pounds over the past month and have been constant. The patient has no sick contacts. The patient has had similar symptoms previously when he was treated for strep throat last month. The patient has not recently seen their doctor and has not been hospitalized or treated for this similar illness during this period. Historians are mother and grandmother. They are concerned about dehydration and possibly diabetes in addition to the source of his fever.

ROS:
CONSTITUTIONAL: Positive for fever as per history of present illness. Denies night sweats. Positive for weight loss of 2 pounds over the past month
HEENT: Denies headaches or dizziness.
RESPIRATORY: Denies dyspnea, coughing, or wheezing.
GASTROINTESTINAL: Denies abdominal pain or discomfort. Positive for nausea and vomiting ×1 this morning after crying.. Denies constipation or diarrhea.
INTEGUMENTARY: Denies rashes or skin lesion.
MUSCULOSKELETAL: Denies muscle aches, denies joint aches or pains.
PSYCH: Denies any symptoms, well behaved

PROBLEM LIST/PAST MEDICAL HISTORY: Conjunctivitis Inclusion cyst
Historical Circumcision No known active problems HOME MEDICATIONS:
No active home medications
ALLERGIES: No Known Medication Allergies

PHYSICAL EXAM:
VITALS & MEASUREMENTS: Triage Vitals
T: 38.5 degC (Tympanic) HR: 164 (Peripheral) RR: 34 BP: 134/76 SpO2: 96%
HT: 96 cm WT: 11.7 kg BMI: 12.7

Current Vitals
T: 38.5 degC (Tympanic) HR: 126 (Peripheral) RR: 24 BP: 126/82 SpO2: 98% CONSTITUTIONAL: Alert, interactive, and non-toxic in appearance.
HEAD: Normocephalic, atraumatic.
NECK: Supple without meningismus or masses, positive for anterior cervical lymphadenopathy. Full range of motion without pain.
EYES: Conjunctivae clear without injection, hemorrhage, discharge, or icrterus. No eyelid swelling or redness. Pupils equal, symmetric, and reactive to light.
EARS: TMs clear with normal landmarks and no erythema. External canals without discharge, redness, or swelling
NOSE: Patent nares without rhinorrhea.
MOUTH/THROAT: Gingiva, tongue normal but the posterior oropharynx is erythematous without exudate.
RESPIRATORY: Lungs clear to auscultation without retraction, grunting, or flaring with the exception of some rales that are present in the right lower lobe.

CARDIOVASCULAR: S1 and S2 are normal with regular rate and rhythm and no murmurs, rubs, or gallops. Normal femoral pulses with capillary refill time less than 2 seconds peripherally and centrally.
GASTROINTESTINAL: Abdomen is soft, non-tender, and non-distended without rebound, guarding, or masses. Bowel sounds are normal. No organomegally.
LYMPH: No inguinal or axillary adenopathy.
MUSCULOSKELETAL: Spine, ribs and pelvis are non-tender and normally aligned. Extremities are non-tender and show full range of motion without pain. There is no clubbing, cyanosis, or edema.
SKIN: No rashes, purpura, petechiae, ulcers, swelling or other lesions.
NEUROLOGIC: Symmetric use of extremities without weakness. Normal gait. Lower extremity reflexes are symmetric with down-going toes. No clonus. Cranial nerves are intact with normal tone and strength. Patient exhibits age-appropriate affect, behavior, and interaction.

REEXAMINATION/REEVALUATION: Nontoxic appearing.

DIAGNOSIS: 1. Pharyngitis 2. Streptococcosis 3. Febrile illness 4. Dehydration

MEDICAL DECISION MAKING/DIFFERENTIAL DX: XXX has had a fever up to 103. He has had a history of strep throat which was recently treated and has a central criteria of 4 currently. His rapid strep was negative but I wanted to get a culture and so that is pending. We will go ahead and treat him with amoxicillin for his ENT dysfunction.

A chest x-ray was obtained because of some rales that I heard which were mild in the right lower lobe. The chest x-ray shows no acute abnormality. His grandmother who has medical knowledge also is concerned about the possibility of diabetes. We have therefore done a blood sugar which came back at 80. At this point we will discharge the patient to follow-up with his primary care physician.

He is drinking adequately and shows mild dehydration. I did offer the family IV fluids but we've decided to instead try oral rehydration which has worked here in the emergency department. The patient is ready now for discharge with his very reliable family and to follow-up with primary care physician Dr. M. Return precautions were provided.

ED COURSE:
ADMINISTERED MEDICATIONS:
acetaminophen: 165 mg (10/31/16 09:32:00)
ondansetron: 1 mg (10/31/16 08:36:00)
penicillin G benzathine: 600,000 units (10/31/16 09:54:00)

LAB RESULTS: Chemistries
Whole Blood Glucose: 80 mg/dL

Rapid strep reportedly negative sent for culture

IMAGING: XR Chest 1 View Frontal
10/31/16 08:25:32
IMPRESSION: Hyperinflated lungs. No other acute process identified in the chest.
Signed By: Rad MD

Disposition:
PRESCRIBED MEDICATIONS THIS VISIT:
No prescriptions given Discharged to home.

Information entered by XXXX acting as scribe for EDMD.

Electronically Signed on 10/31/16 03:14 PM
EDMD

Arrival Date: 11/16/16 1520

Provider First Contact: 11/16 1557

History

Chief Complaint
Patient presents with
- Back Pain

HPI
Patient is a 58-year-old male presenting with back pain, chest pain, and abdominal pain. Patient states that on Saturday he began to have lower back pain described as "pulling", without radiation, without relieving factors, without associated numbness or weakness. Patient also states that this morning he began to have chest pain left-sided "pressure-like" in quality, moderate in severity worse with movement, with without relieving factors. Patient denies history of hypertension, hyperlipidemia, or heart disease. Patient states that he does smoke. Patient denies fever, chills, shortness of breath, numbness, weakness, and bowel or bladder incontinence.

History reviewed. No pertinent past medical history.

Do you have diabetes?: Yes

No Known Drug, Food, Latex, or Environmental Allergies

Home Medications
None

Past Surgical History
Procedure Laterality Date
- Shoulder arthroscopy Bilateral

Family History
Problem Relation Age of Onset
- Heart disease Sister

Are you currently a smoker or exposed to cigarette smoke?: Yes (0.25 pack day)

History
Substance Use Topics
- Smoking status: Smoke daily =>1/4 pack per day during past 30 days -- 30 years
  Types: Cigarettes
- Smokeless tobacco: Not on file
- Alcohol Use: Yes
  Comment: daily; 4-10 beers; none today

Drug Use No

Review of Systems: See HPI

Physical Exam

ED Triage Vitals
BP Heart Rate Resp Temp Temp Source SpO2 Weight Height Peak Flow
143/94 mmHg 81 18 36.6 °C (97.9 °F) Oral 94 % 88.451 kg (195 lb) 1.778 m (5' 10")

Vitals reviewed.
Constitutional: He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No JVD present.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He has no rales.
Abdominal: Soft. Bowel sounds are normal. He exhibits no distension. There is tenderness (diffuse).
Lymphadenopathy: He has no cervical adenopathy.

Differential Diagnoses
r/o ACS
Pneumothorax
Pneumonia
Pneumomediastinum
Pericarditis
PE
Aortic dissection
GERD
Pleurisy
Costochondritis
Esophagitis
Esophageal Spasm
Pancreatitis
Lumbosacral strain
Sciatica

Results
Labs Reviewed
URINALYSIS WITH MICROSCOPY, CULTURE IF INDICATED - Abnormal; Notable for the following:
Blood, Urine 0.03 (*)
Ketones, Urine 5 (*)
Leukocyte Esterase, Urine 25 (*)
White Blood Cell Count, Urine 8 (*)
Bacteria, Urine Present (*)
Hyaline Casts, Urine 3 (*)
All other components within normal limits

URINALYSIS WITH MICROSCOPY, CULTURE IF INDICATED - Abnormal; Notable for the following:
Blood, Urine 0.03 (*)
Ketones, Urine 20 (*)
Specific Gravity, Urine 1.042 (*)
Bacteria, Urine Present (*)

All other components within normal limits
TROPONIN I - Abnormal; Notable for the following:
Troponin I 0.04 (*)
All other components within normal limits
LIPID PANEL - Abnormal; Notable for the following:
HDL Cholesterol 32 (*)
Cholesterol/HDL Ratio 5.2 (*)
All other components within normal limits
CBC, DIFFERENTIAL, AND PLATELET COUNT - Abnormal; Notable for the following:
RBC Distribution Width SD 48.1 (*)
All other components within normal limits
COMPREHENSIVE METABOLIC PANEL - Abnormal; Notable for the following:
Glucose, Blood 106 (*)
All other components within normal limits
CBC, DIFFERENTIAL, AND PLATELET COUNT
COMPREHENSIVE METABOLIC PANEL
TROPONIN I
TROPONIN I
LIPASE
TROPONIN I
HEMOGLOBIN A1C
DRUGS OF ABUSE SCREEN, URINE
TROPONIN I

XR Chest
Impression:
Changes of hyperinflation without acute cardiopulmonary process.

My EKG #1 interpretation
Time obtained 1609
Rate 72 beats/minute
Rhythm sinus with RBBB and LVH
ST segments/T wave nonspecific T-wave changes, otherwise no ST segment changes
QRS 160
Intervals PR 200 QT 478
Axis left axis deviation
No prior EKGs available for comparison.

My EKG #2 interpretation
Time obtained 1942
Rate 65 beats/minute
Rhythm normal sinus with 1st degree block, and RBBB
ST segments/T wave nonspecific T-wave changes, no ST segment changes
QRS 152
Intervals PR 220 QT 487
Axis left axis deviation
The EKG was compared to a previous one and there were no changes.

ED Course

MDM
On ED arrival, the patient was evaluated by myself and the attending physician. Airway, breathing, circulation were found to be intact, and no emergent interventions were necessary.

Upon initial evaluation, the patient was found to be in no acute distress. Following the history and physical examination, the differential as above was considered.

Initial treatment and interventions included aspirin and morphine.

Laboratory and imaging studies as above were ordered. Laboratory studies were unremarkable. Imaging studies were unmarkable.

On re-evaluation, patient's pain is mildly improved and vitals were within normal limits.

Patient's heart score is 4 indicating a moderate risk of MACE. Patient has not had any primary care follow-up for Meniere's and would benefit from admission and full cardiac workup. Discussed the laboratory and imaging studies with the patient as well as the need for observation and further cardiac workup.

Patient was admitted to medicine in stable condition for further cardiac workup. Please see the team's admission, daily progress notes, and discharge summary for further workup, treatment and ultimate disposition of this patient.

Clinical Impression

Primary Diagnosis
Chest pain, unspecified type

Final diagnoses:
Chest pain, unspecified type
Acute bilateral low back pain without sciatica
Generalized abdominal pain

ED Disposition

Resident, MD
11/17/16 1505

ATTENDING PHYSICIAN DOCUMENTATION

I have reviewed the patient's history. I have personally examined the patient. I agree with and I participated in the management of this patient. I have read the EKG. I have reviewed/edited the resident's interpretation and I agree. Please see the resident's documentation of medical decision-making.

Differential Diagnosis:
Acute coronary syndrome
Non-STEMI
Unstable angina
Stable angina
Aortic dissection, this was assessed by bedside ultrasound and x-ray

Attending, MD
11/17/16 1946

* Final Report *

ED NOTE:

CHIEF COMPLAINT/REASON FOR VISIT:

Flank pain

HISTORY OF PRESENT ILLNESS:
Mrs. C presented to the emergency department with severe left flank pain and a mass. She says that she had a partial left nephrectomy about a month ago in California and then moved here about 2 weeks ago. She first noticed a mass in the left flank has not had any dehiscence of her incision. She then started having severe pain about 4 days ago and has come in for evaluation. She says that this is all due to a renal cell carcinoma but does not have a physician yet here. She also complains of chronic hypoxemia that she believes is due to HSP which is not currently active. She says the pain is a 10 out of 10 at maximum and presently. She also denies vomiting diarrhea and fevers. She says that she has a decreased appetite but no other associated symptoms.

ROS:
CONSTITUTIONAL: Denies fever / chills. Denies night sweats.
HEENT: Denies headaches dizziness or changes in vision.
CARDIOVASCULAR: Denies chest pain or palpitations.
RESPIRATORY: Denies dyspnea, coughing, or wheezing.
GASTROINTESTINAL: Positive per history of present illness. Denies N/V. Denies constipation or diarrhea.
GENITOURINARY: Denies pain with urination, denies frequency.
INTEGUMENTARY: Denies rashes or skin lesion.
MUSCULOSKELETAL: Denies muscle aches, denies joint aches or pains.
EXTREMITIES: Denies edema or trauma.
NEUROLOGIC: Denies numbness or tingling
PSYCH: Denies anxiety, depression, pyschosis, suicidal/homicidal ideation

PROBLEM LIST/PAST MEDICAL HISTORY:
Biopsy of lymph node
Dental infection
Diabetes mellitus, type 1
Diabetic nephropathy
Flank pain
Hyperglycemia
Lymphadenitis
Dyspnea
Edema
Hyperglycemia
Nonspecific vision loss
Urinary tract infection

HOME MEDICATIONS:

furosemide 40 mg oral tablet, 1 tabs, Oral, Daily, Investigating
HumuLIN R (Concentrated) 500 units/mL human recombinant subcutaneous solution, 0, SubCutaneous, Investigating
Insulin Syringe-Needle U-100 1 mL 31 x 5/16", 0, Investigating
Keflex 500 mg oral capsule, 500 mg, Oral, TID
Provera 10 mg oral tablet, 1 tabs, Oral, Daily, Investigating
ReliOn Ventolin HFA 90 mcg/inh inhalation aerosol with adapter, 0, Inhale, Investigating

ALLERGIES:
No Known Medication Allergies

SOCIAL HISTORY:
Tobacco Former smoker

PHYSICAL EXAM:
VITALS & MEASUREMENTS:
Triage Vitals
T: 36.3 degC (Tympanic) HR: 75 (Peripheral) HR: 77 (Monitored) RR: 18 BP: 156/86 SpO2: 95%
HT: 162 cm WT: 120.66 kg BMI: 45.98

Current Vitals
T: 36.3 degC (Tympanic) HR: 73 (Peripheral) HR: 74 (Monitored) RR: 14 BP: 141/70 SpO2: 97%

CONSTITUTIONAL: Alert, moderately anxious
SKIN: warm, dry, intact, no rash, long incision on the left flank without any evidence of dehiscence or other complication such as infection.
EYES: pupils are equally round, extraocular movements intact without nystagmus, clear conjunctiva, non-icteric sclera.
HENT: normocephalic, atraumatic, moist mucus membranes, oropharynx clear without exudates.
NECK: Nontender and supple with no nuchal rigidity or meningeal signs, no lymphadenopathy, full range of motion. No stridor. No JVD
PULMONARY: clear to auscultation without wheezes, rhonchi, or rales, normal excursion, no accessory muscle use.
CARDIOVASCULAR: regular rate, rhythm, normal S1 and S2. No evident murmurs. Strong radial pulses with intact distal perfusion.
GASTROINTESTINAL: soft, tender in the left lower quadrant, non-distended, no palpable masses, no rebound or guarding.
GENITOURINARY: Left CVA tenderness and possible mass although given patient's body habitus it is difficult to have a reliable exam
LYMPHATICS: no edema in lower extremities, no lymphadenopathy.
MUSCULOSKELETAL: Extremities are nontender to palpation and have no gross deformity, redness, or swelling.
NEUROLOGIC: a/o x 4, GCS 15, normal mentation and speech. Moves all extremities x 4 without motor or sensory deficit, gait is stable without ataxia.
PSYCHIATRIC: normal mood and affect, thought process is clear and linear. No psychosis, homicidal or suicidal ideation.

REEXAMINATION/REEVALUATION:
Much improved symptoms after Dilaudid and Zofran were given to the IV and IV fluids.

DIAGNOSIS:
1. Post-op pain
2. Pyelonephritis
3. Hyperglycemia

MEDICAL DECISION MAKING/DIFFERENTIAL DX:
Mrs. C is worried about a complication from her partial nephrectomy site. We have done a CT scan without and with contrast to rule out kidney stones and also any postoperative complications such as an abscess or hematoma. The CT scan comes back with no acute abnormality as interpreted by the radiologist. Her labs are also within normal limits with the exception of a hyperglycemia. She did have 6 WBCs in her urine but no bacteria and a small amount of leukocyte esterase which could represent a urinary tract infection and therefore pyelonephritis because of the left CVA tenderness.

Because of this we will treat her with Keflex which I provided her to treat her urologic dysfunction. She was also referred back to her primary care physician for ongoing evaluation and management. We've given her IV fluids for some critical dehydration. The patient was re-examined and is now ready for discharge in hemodynamically stable condition. Return precautions, education and outpatient instructions were provided. The patient was instructed to follow-up with their primary care provider in the next several days.

ED COURSE:
ADMINISTERED MEDICATIONS:
hydromorphone: 1 mg (10/31/16 09:02:00)
iopamidol: 100 mL (10/31/16 10:16:00)
ondansetron: 4 mg (10/31/16 09:02:00)
Sodium Chloride 0.9%: 10 mL (10/31/16 10:16:00)
Sodium Chloride 0.9%: 20 mL (10/31/16 10:16:00)
Sodium Chloride 0.9%: 20 mL (10/31/16 10:16:00)
Sodium Chloride 0.9%: 1,000 mL (10/31/16 09:02:00)

ORDERS:

Cardiac Monitoring*
Peripheral IV Insert

LAB RESULTS:

Heme
WBC: 7.2 K/mcL
RBC: 4.48 x10^6/mcL
Hemoglobin: 11.7 g/dL Low
Hematocrit: 36.7 %
MCV: 81.9 fL
MCH: 26.1 pg
MCHC: 31.9 g/dL Low
RDW SD: 41.6 fL
RDW: 13.9 %
Platelets: 305 K/mcL
MPV: 9.9 fL
Nucleated RBC Auto: 0.0 /100(WBCs)
Immature Granulocytes: 0.3 %
Differential Type: Auto
Neutrophil % Auto: 75.3 % High

Lymphocyte % Auto: 18.4 % Low
Monocyte % Auto: 4.7 %
Eosinophil % Auto: 1.2 %
Basophil % Auto: 0.1 %
Immature Granulocyte, Absolute: 0.02 K/mcL
Neutrophil: 5.4 K/mcL
Lymphocyte: 1.3 K/mcL
Monocyte: 0.3 K/mcL
Eosinophil: 0.1 K/mcL
Basophil: 0.0 K/mcL Chemistries
Sodium Level: 135 mmol/L Low
Potassium Level: 3.9 mmol/L
Chloride Level: 104 mmol/L
CO2: 25 mmol/L
Anion Gap (Na Cl CO2): 6 mmol/L
Glucose Level: 154 mg/dL High
BUN: 12 mg/dL
Creatinine Level: 0.53 mg/dL Low
Estimated Creatinine Clearance: 115.88 mL/min
GFR, Estimated (mL/min/1.73 m2): 115 mL/min/1.73 m2
Average GFR for age: 99 mL/min/1.73 m2
Cmt: GFR: See Note:
Calcium Level: 9.2 mg/dL

Protein Total: 7.1 g/dL
Albumin Level: 3.9 g/dL
Bilirubin Total: 0.3 mg/dL
Alk Phos: 96 unit/L
AST: 22 unit/L
ALT: 30 unit/L
Lactic Acid, Plasma (Venous): 1.2 mmol/L
Lipase Level: 11 unit/L

UA
Collect Method, Ur: Clean Catch
Color Urine: Normal
Appear: Normal
Specific Gravity, Urine: 1.005
pH Urine: 7.0
Glucose Urine: Negative
UA Ketones: Negative
Nitrite: Negative
Hgb Urine: Negative
Protein Urine: Negative
Leuk Esterase: Small Abnormal
WBC Urine: 6 /HPF High
RBC Urine: 2 /HPF
Epithelial Cells: 4 /HPF
Bacteria Urine: Negative

IMAGING:
CTAbdomen and Pelvis w/ + w/o Contrast
10/31/16 10:55:32
Impression:
1. Presumed postsurgical sequela involving the left kidney and left flank as above.
2. Some peripheral calcification involving the left kidney as above. This may represent postsurgical sequela as well versus sequela of prior infectious/inflammatory change. Without prior films for comparison cannot evaluate for interval change or chronicity of these findings.
3. No drainable fluid collections.
4. Symmetric renal enhancement bilaterally.
5. No evidence of renal or ureteral calculi.
6. No evidence of obstructive uropathy.
7. Other findings as above.

This report was electronically signed by
Signed By: Rad MB

Disposition:

PRESCRIBED MEDICATIONS THIS VISIT:
Keflex 500 mg oral capsule, 500 mg, Oral, TID

Discharge to home

Time Seen:
10/31/2016 08:31

Signature Line
Electronically Signed on 10/31/16 03:17 PM

_____

EDMD

History

Chief Complaint
Patient presents with
- Other

History of Present Illness

Pt presents for pain control and refill of prednisone. Pt stated he "ran out of prednisone" and called his pmd for a refill but "he was out of the office until Monday." reports swelling to joints as well as pain that is c/w RA flare ups. No chest pain, sob. No n/v/f/c.

Denies tobacco, illicits

Past Medical History:

Diagnosis	Date
• Hypertension	
• RA (rheumatoid arthritis) (HCC)	

History reviewed. No pertinent surgical history.

No family history on file.

Social History
Substance Use Topics

• Smoking status:	Current Every Day Smoker
• Smokeless tobacco:	None
• Alcohol use	No

Allergies

Allergen	Reactions
• Aspirin	Swelling
• Shrimp	Anaphylaxis

Outpatient Medications

HYDROCHLOROTHIAZIDE (HYDRODIURIL) 25 MG TABLET	Take 25 mg by mouth daily
LISINOPRIL (PRINIVIL,ZESTRIL) 10 MG TABLET	Take 10 mg by mouth daily

Review of Systems
Constitutional: Negative.
HENT: Negative.
Eyes: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Gastrointestinal: Negative.
Genitourinary: Negative.
Musculoskeletal: Positive for arthralgias and myalgias.
Skin: Negative.
Neurological: Negative.

Psychiatric/Behavioral: Negative.

ED INITIAL VITALS		
Temp	04/26/17 1632	**36.8 °C (98.2 °F)**
Temp Source	04/26/17 1632	**Oral**
Pulse	04/26/17 1632	**58**
Pulse Source	04/26/17 1632	**Monitor**
Respirations	04/26/17 1632	**24**
Respiration Source	04/26/17 1632	**Visual**
BP	04/26/17 1632	**178/111**
BP Location	04/26/17 1632	**Right arm**
BP Method	04/26/17 1632	**Automatic**
SpO2	04/26/17 1632	**95 %**
Location	04/26/17 1734	**Hand;Left**

Recent Vitals

	04/26/17 1855	04/26/17 1902	04/26/17 1917	04/26/17 1927
BP:				156/92
Pulse:	89	92	89	
Resp:	13	24	22	
Temp:				
TempSrc:				
SpO2:	94%	92%	93%	96%
Weight:				
Height:				

Physical Exam

Physical Exam

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal. He has no wheezes. He has no rales.
Abdominal: Soft. There is no tenderness.
Musculoskeletal: Normal range of motion.
Neurological: He is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: He has a normal mood and affect. His behavior is normal. Thought content normal.
Nursing note and vitals reviewed.

ED Course

Procedures

MDM

Number of Diagnoses or Management Options

Pain:

Rheumatoid arthritis, involving unspecified site, unspecified rheumatoid factor presence (HCC):

Diagnosis management comments: Pain 0/10 on re-eval

Written rx provided

Amount and/or Complexity of Data Reviewed

Clinical lab tests: reviewed

No results found.

Clinical impression:

1. **Pain**
2. Rheumatoid arthritis, involving unspecified site, unspecified rheumatoid factor presence (HCC)

[redacted] MD

04/26/17 1950

ED Triage Notes

ED Triage Notes by [redacted] **RN** 4/26/2017 4:31 PM

Author: [redacted] Service: (none) Author Type: Registered Nurse

RN

Filed: 4/26/2017 4:32 PM Date of Service: 4/26/2017 4:31 PM Status: Signed

Editor: [redacted] RN (Registered Nurse)

Pt arrived to the ER with the C/o generalized pain all over the body that a few days ago

ED Notes

No notes of this type exist within this time range.

Medication Administration from 04/26/2017 0000 to 04/26/2017 2009

Date/Time	Order	Dose	Route	Action	Action by	Comments
04/26/2017 1846	**predniSONE (DELTASONE) tablet 60 mg**	60 mg	Oral	Given	Perez, Mariana F, RN	
04/26/2017 1847	**HYDROmorphone (DILAUDID) 1 mg/mL injection syrg 1 mg**	1 mg	IntravenOUS	Given	Perez, Mariana F, RN	

Medications

(From 04/25/17 2359 through 04/26/17 2008)

Start	Stop	Route	Frequency	Ordered
04/26/17 1845	04/26 1846	PO	ONCE	04/26/17 1825

	predniSONE (DELTASONE) tablet 60 mg				
04/26/17 1845	**HYDROmorphone (DILAUDID) 1 mg/mL injection syrg 1 mg** Status: Discontinued	04/26 1830	IM	ONCE	04/26/17 1825
04/26/17 1850	**HYDROmorphone (DILAUDID) 1 mg/mL injection syrg 1 mg**	04/26 1847	IV	ONCE	04/26/17 1830

ED Disposition

ED Disposition	Condition	Comment
Discharge		Patient discharge to home/self care.

[redacted]

Dictated By: [redacted] FNP-BC

Entered Department at: 04/30/2017 14:43 Patient Seen at: 04/30/2017 16:38
Historian: Patient PCP [redacted]

Chief Complaint:LAC TO RT FOOT

Nursing triage/initial assessment reviewed and confirmed and Initial Vital Signs reviewed.

I saw this patient independently..

Temperature: 98.1 F (36.7 C). Pulse: 96. Respiratory Rate: 22.
Blood-pressure: 144/96. Oxygen Saturation: 98%.

History of Present Illness:

Patient is a 12-year-old female presenting to the emergency department with complaint of 7/10 pain to her right foot. Reports that she fell on some oyster shells. 1 cm laceration to the lateral aspects at the base of the pinky toe. No active bleeding present. The middle right toe nail is partially removed with no active bleeding present. The second toe has a crack through the toenail, no active bleeding present. Denies any over-the-counter medication prior to arrival for the symptoms.

Review of Systems. Skin: positive for Laceration, 1 cm well approximated, linear laceration to the lateral aspect of the right foot. Partial nail removal to the third toe of the right foot.

Past Medical History, Past Surgical History, Home Medications, allergies, and Social History reviewed in nurse's note.

Medications: Reviewed RN Note.

Allergies: Reviewed RN Note

No Known Allergies

Social History: Reviewed RN Note.

Physical Examination: General: Alert and Well Developed Extremity: Ankle or Foot Tenderness, Ankle or Foot Injury, Ankle or Foot Pain with ROM and Ankle or Foot Tenderness or Swelling Right

Radiology: Image Reviewed and Interpreted by Radiologist.

Right foot 3 view Impression: Fracture versus radiopaque foreign body adjacent to the distal lateral aspect of the second distal phalanx..

Medical Decision Making

Patient states that she fell on an oyster bed prior to arrival. There is a 1 cm well approximated linear laceration to the right lateral aspect of the base of the fifth toe. No active bleeding present. The third toenail is partially removed, no active bleeding present. The second toenail does have a crack through it. No bleeding or drainage present. Patient was updated on her Tdap vaccination. Dose of Cipro antibiotic provided for vibrio coverage. Wound was soaked in Betadine saline solution for approximately 30 minutes. Wound

was thoroughly irrigated with normal saline. See laceration repair note Right foot x-ray showed fracture to the distal lateral aspect of the second distal phalanx. Antibiotic ointment, Telfa, Kling dressing applied to wounds. Patient provided a fracture shoe. Declined the crutches at this time. Instructed to have the sutures removed in 8-10 days. Instructed mother and patient on wound care. Instructed to return to the emergency department for any new concerns, questions, new or worsening symptoms. Patient and patient mother stated understanding of discharge instructions, no further questions at this time.

Physician Performed Procedures

Laceration Repair on 04/30/2017 (1): No significant blood loss, No complications and Patient tolerated procedure well. location: Right foot, length: 1cm, NVT intact, see exam, superficial, linear, clean. Anesthetized with 2 mL Lidocaine. Sterilized with Sterile Field. Used Sterile Field and Syringe. Irrigated with copious amounts of Normal Saline. Wound explored, bloodless field, no foreign body. . No Vasculature involvement. Repair Skin: 4.0-0 Nylon (2 sutures). Simple Repair.

I certify that I was physically present for the key portion of the procedures above

Additional Information: Discussed Results, Diagnosis and Follow-Up with Patient. Prescription given (Cipro).

Clinical Impression:

1. Laceration

2. No fracture

Disposition: Discharged . Condition: Improved

Electronically signed by [redacted], FNP on 04/30/2017 at 17:49

Dictated by: [redacted] FNP-BC

cc:

[redacted]

EMERGENCY DEPARTMENT ADDENDUM

[redacted]

Dictated By: [redacted] FNP-BC
Attending Physician:
Report # 0522-0206 Status: Signed

Entered Department at: 04/30/2017 14:43 Patient Seen at: 04/30/2017 16:38
PCP: [redacted]

Chief Complaint:LAC TO RT FOOT

Clinical Impression:

1. Toe Fracture

Electronically signed by [redacted] FNP on 05/22/2017 at 16:00
Date Report Signed 05/22/17 1650

cc:

Date Dictated: 05/22/17 1600
Date Transcribed: 05/22/17 1600

ED Provider Note (continued)

Patient presents with

- Suicidal

HPI:

Associated symptoms and Additional history: **Patient is a 13-year-old white male who told his girlfriend that he was going to kill himself after she broke up with him. he has no prior psychiatric history though approximately 4 months ago he did engage in some self-inflicted cutting. He has no acute medical complaints.**

Additional HPI

Past Medical History

Diagnosis	Date
• ADD (attention deficit disorder)	

History reviewed. No pertinent past surgical history.

History reviewed. No pertinent family history.

Social History

Substance Use Topics

- Smoking status: None
- Smokeless tobacco: None
- Alcohol Use: No

Review of Systems
All other systems negative x 10 except where noted in HPI or above

Physical Exam
BP 132/66 mmHg | Pulse 80 | Temp(Src) 98 °F (36.7 °C) (Oral) | Resp 17 | SpO2 99%

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.

Head:Normocephalic and atraumatic.
Eyes:Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck:Normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.
Respiratory:Effort normal and breath sounds normal.

ED Provider Note (continued)

Gastrointestinal: Soft. He exhibits no ascites and no mass. There is no hepatosplenomegaly. There is no tenderness. There is no rebound, no guarding and no CVA tenderness.
Musculoskeletal: He exhibits no edema or tenderness. .
Skin: Skin is warm and dry.
Neurological: He is alert and oriented to person, place, and time.
Psychiatric: He has a normal mood and affect. His speech is normal and behavior is normal.
Lymphatic:
He has no cervical adenopathy.

ED Course

MDM:

Clinical Impression Notes:
Patient was medically cleared and seen by the psychiatric social worker. She has cleared the patient to return home with outpatient follow-up.

No orders to display

ED Provider Note (continued)

[redacted] MD
04/14/17 1903

Electronically signed by [redacted] MD at 4/14/2017 7:03 PM

Lab Orders (From 04/14/17 1714 through 04/14/17 1916)

Start	Ordered		Status	Ordering Provider
04/14/17 1723	04/14/17 1723	**Ethanol, Urine** STAT	Final result	[redacted]
04/14/17 1723	04/14/17 1723	**Amphetamine Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Barbiturate Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Benzodiazepine Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Cannabinoid Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Cocaine Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Opiate Screen, Urine** STAT	Final result	
04/14/17 1723	04/14/17 1723	**Phencyclidine (PCP) Screen, Urine** STAT	Final result	

Lab Results

Procedure	Component	Value	Ref Range	Date/Time
Cannabinoid Screen, Urine [19991965]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Cannabinoid Screen, Urine	Negative	Negative <50 ng/mL	
Amphetamine Screen, Urine [19991962]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Amphetamine Screen, Urine	Negative	Negative <1000 ng/mL	
Barbiturate Screen, Urine [19991963]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Barbiturate Screen, Urine	Negative	Negative <200 ng/mL	
Benzodiazepine Screen, Urine [19991964]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Benzodiazepine Screen, Urine	Negative	Negative <200 ng/mL	
Cocaine Screen, Urine [19991966]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Cocaine Screen, Urine	Negative	Negative <300 ng/mL	
Opiate Screen, Urine [19991967]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from Voided		Updated: 04/14/17 1813
	Opiate, Urine	Negative	Negative <300 ng/mL	
Phencyclidine (PCP) Screen, Urine [19991968]				Collected: 04/14/17 1723
Order Status: Completed		Specimen Information: Urine from		Updated: 04/14/17 1813

ED Disposition (continued)

ED Disposition	Condition	Comment

Diagnoses

Diagnosis	Comment	Added By	Time Added	Team Role	Provider Specialty
MVC (motor vehicle collision) [V87.7XXA]		Suzanne Amanda Iliff, PA-C	5/10/2017 2:46 PM	Physician Assistant	Emergency Medicine
Trapezius strain, right, initial encounter [S46.811A]		Suzanne Amanda Iliff, PA-C	5/10/2017 2:46 PM	Physician Assistant	Emergency Medicine

ED Notes

[redacted] DO (ED Physician) 5/11/2017 06:39

ATTESTATION

Patient seen and evaluated independently by PA [redacted]. I did not see or examine this patient

Electronically signed by [redacted], DO at 5/11/2017 6:39 AM

[redacted], RN (Registered Nurse) 5/10/2017 15:10

Pt discharged to home. Pt given 2 prescriptions. Pt understands to follow up with her PCP. Pt understands to return to the Ed if symptoms worsen. Pt alert and oriented. Pt ambulatory with a steady gait. Pt will drive self home.

Electronically signed by [redacted], RN at 5/10/2017 3:10 PM

[redacted] PA-C (Physician Assistant) 5/10/2017 14:46

History

Chief Complaint

Patient presents with

- Motor Vehicle Crash
- Neck Pain
- Back Pain

HPI Comments: Patient is a 22-year-old female that presents to the emergency department today complaining of neck and shoulder pain after an MVC. She was restrained driver of a vehicle and states that she had slowed down to a stop and the people behind her rear-ended her. There was no airbag deployment. She was restrained. Patient denies any head trauma or loss of consciousness. Patient complains of neck pain that extends out onto her right shoulder. She denies any other associated complaints.

The history is provided by the patient.

ED Notes (continued)

Past Medical History:

Diagnosis	Date
• Anxiety	
• Bell's palsy	
• Depression	

Current Outpatient Rx

Medication	Sig	Dispense	Refill
• FLUoxetine (PROZAC) 20 mg capsule	Take by mouth every 1 (one) day		

History reviewed. No pertinent surgical history.

No family history on file.

Social History

Substance Use Topics	
• Smoking status:	Never Smoker
• Smokeless tobacco:	None
• Alcohol use	No

Review of Systems

Review of Systems
Musculoskeletal:
Right shoulder and neck pain 10 Systems reviewed and negative except systems noted in HPI.

Physical Exam

BP 109/67 (BP Location: Right arm, Patient Position: Sitting) Pulse 64 Temp 35.7 ℃ (Temporal) Resp 16 Ht 167.6 cm Wt 61.2 kg SpO2 99% BMI 21.79 kg/m2

Physical Exam
Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: EOM are normal.
Neck: Normal range of motion.
Pulmonary/Chest: Effort normal.
Musculoskeletal: Normal range of motion. She exhibits tenderness. She exhibits no edema or deformity.
Patient is nontender to palpation over the cervical and thoracic midline. She has tenderness to palpation in the right superior aspect of the shoulder over the trapezius muscle. There is no tenderness over the shoulder joint itself. She is full range of motion of the shoulder joint with pain to the trapezius muscle area only. Neurovascular is intact distally.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.

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ED Notes (continued)

Nursing note and vitals reviewed.

ED Course

Procedures

MDM and Data Reviewed:

Medical Decision Making: **X-ray results were discussed with the patient. She'll be sent home with pain medicine and muscle relaxers. Patient was instructed to return if her symptoms do not start to improve over the next 2-3 days. She'll return sooner if any concerns. Patient was seen independently without physician valuation.**

Data Reviewed: **Nurse's notes, 5 Vital Signs and radiology studies**

Clinical Impression

No diagnosis found.

[redacted] PA-C

05/10/17 1446

Electronically signed by [redacted] PA-C at 5/10/2017 2:46 PM

[redacted] RN (Registered Nurse) 5/10/2017 14:00

Pt to x-ray with host.

Electronically signed by [redacted] RN at 5/10/2017 2:00 PM

[redacted] RN (Registered Nurse) 5/10/2017 13:33

Pt states that she was restrained driver that was rear ended. Pt states that she was at a complete stop when she was hit. Pt complains of pain on the right side of her neck and into her shoulder. Pt denies any back pain. Pt denies any numbness or tingling in her arms. Pt is alert and oriented. Pt moves all extremities.

Electronically signed by [redacted] RN at 5/10/2017 1:33 PM

Discharge Orders

Start	Ordered		Status	Ordering User
05/10/17 0000	05/10/17 1447	**cyclobenzaprine (FLEXERIL) 10 mg tablet** 2 Times Daily As Needed	Ordered	[redacted]

[redacted]

Discharge Orders (continued)

Start	Ordered			Status	Ordering User
05/10/17 0000	05/10/17 1447	**meloxicam (MOBIC) 7.5 mg tablet**	Every Day	Ordered	[redacted]

ED Prescriptions

Medication	Sig	Dispense	Start Date	End Date	Auth. Provider
cyclobenzaprine (FLEXERIL) 10 mg tablet	Take 1 tablet (10 mg total) by mouth 2 (two) times a day as needed for muscle spasms for up to 12 doses	12 tablet	5/10/2017		[redacted]
meloxicam (MOBIC) 7.5 mg tablet	Take 1 tablet (7.5 mg total) by mouth every 1 (one) day	15 tablet	5/10/2017	5/10/2018	[redacted]

Follow-up Information

Follow up With	Details	Comments	Contact Info
Your PCP	In 3 days	If symptoms worsen	

Discharge Instructions

None

Discharge References/Attachments

MOTOR VEHICLE COLLISION INJURY (ENGLISH)
MUSCLE STRAIN (ENGLISH)

Clinical Letter Summary

ED Events

Date/Time	Event	User	Comments
05/10/17 1158	Patient expected in ED	[redacted]	
05/10/17 1159	Patient arrived in ED		
05/10/17 1231	Triage Started		
05/10/17 1238	Triage Completed		[redacted]
05/10/17 1248	Assign Mid-level		
05/10/17 1248	Assign Physician		
05/10/17 1248	Assign Attending		
05/10/17 1248	Assign Physician		
05/10/17 1321	Patient roomed in ED		
05/10/17 1341	Patient transferred		
05/10/17 1504	Registration Completed		
05/10/17 1510	Patient departed from ED		
05/10/17 1511	Patient discharged		

ED Orders (720h ago through future)

Start	Ordered			Status	Ordering Provider
05/10/17 1243	05/10/17 1242	**X-Ray Cervical Spine AP and Lateral** Imaging	1 Time	Final result	[redacted]

Blood Administration

View: 05/12/17 0639 to 05/15/17 0639 (72 Hours) Sort by: Time

None

ED Disposition

[redacted]

Emergency Reports

Addendum by [redacted] on July 16, 2017 16:31 EDT

My participation was to review all pertinent clinical information including history, physical exam, and plan of care.

[Electronically Signed By:]

DO [redacted]

On, 07/16/2017 04:31 PM

Eye problem

[redacted]

Age: **35 years** Sex: **Male** DOB: **02/03/1982**

Associated Diagnoses: **None**

Author: [redacted] **PA-C,** [redacted]

Basic Information

Additional Information:

Primary Care Physician

UNASSIGNED MD, TEMP.

History of Present Illness

The patient presents with an eye problem. The course/duration of symptoms is worsening. The character of symptoms is redness and Irritation. The degree of symptoms is minimal. Prior episodes: occasional. Therapy today:. Associated symptoms: denies change in vision, denies headache and denies fever. He was using a blower in his yard 2 days ago, and felt something go into his left eye, and reports that he has had a small dot is field of vision with some discomfort since, that has gotten worse today. Denies vision loss or other injuries or complaints.

Review of Systems

Constitutional symptoms: No fever, no chills.
Eye symptoms: Negative except as documented in HPI.
Respiratory symptoms: No shortness of breath,
Cardiovascular symptoms: No chest pain,
Neurologic symptoms: No numbness, no tingling.
Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status

Allergies:

Allergic Reactions (Selected)

NKA.

Past Medical/ Family/ Social History

Medical history

Reviewed as documented in chart.
Denies any previous medical history.

Family history: noncontributory.

Social history: Tobacco use: Denies, Family/social situation: noncontributory

.

[redacted]

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Physical Examination

Vital Signs

Vital Signs

07/16/2017 14:00 EDT	Heart Rate	80 bpm
	Respiratory Rate	18 br/min
	Inet NIBP Systolic	126 mmHg
	Inet NIBP Diastolic	70 mmHg
07/16/2017 12:28 EDT	Temperature	97.6 DegF
	Temp Method	Oral
	Heart Rate	82 bpm
	Respiratory Rate	18 br/min
	Inet NIBP Systolic	130 mmHg
	Inet NIBP Diastolic	72 mmHg
	NIBP MAP Calc	91 .

Measurements

07/16/2017 13:20 EDT	Clinical Height	175 cm
	Height Method	Stated
	Clinical Weight	100.2 kg
	Weight Method	Standing Scale
	BMI	32.72
	BSA	2.21 m2
07/16/2017 12:28 EDT	Clinical Height	175 cm
	Height Method	Stated
	Clinical Weight	100.2 kg
	Weight Method	Standing Scale
	BMI	32.72
	BSA	2.21 m2 .

Oxygen Saturation

07/16/2017 14:00 EDT	Oxygen Saturation	99 %
07/16/2017 12:28 EDT	Oxygen Saturation	98 % .

General: Alert, no acute distress.
Skin: Warm, dry, no pallor, normal for ethnicity.
Head: Normocephalic, atraumatic.
Neck: Supple, trachea midline, no tenderness, no JVD.
Eye: Pupils are equal, round and reactive to light, intact accommodation, extraocular movements are intact, normal conjunctiva, vision grossly normal, A tiny organic foreign body is noted the embedded superficially in the left inferior cornea. This was removed using cotton-tipped applicator, completely removed with no residual staining or rust ring noted. Following this, Wood's lamp exam reveals small corneal abrasion to this area. Negative Seidel sign..
Cardiovascular: Normal peripheral perfusion, No edema.
Respiratory: Respirations are non-labored, Symmetrical chest wall expansion.
Musculoskeletal: Normal ROM, normal strength, no deformity.
Chest wall
Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, normal sensory observed, normal motor observed, normal speech observed.
Psychiatric: Cooperative, appropriate mood & affect.

Medical Decision Making
Radiology results:

[redacted]

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Reexamination/ Reevaluation
Vital signs
Vital signs from flowsheet

07/16/2017 14:00 EDT	Heart Rate	80 bpm
	Respiratory Rate	18 br/min
	Inet NIBP Systolic	126 mmHg
	Inet NIBP Diastolic	70 mmHg
07/16/2017 12:28 EDT	Temperature	97.6 DegF
	Temp Method	Oral
	Heart Rate	82 bpm
	Respiratory Rate	18 br/min
	Inet NIBP Systolic	130 mmHg
	Inet NIBP Diastolic	72 mmHg
	NIBP MAP Calc	91

Pain status: decreased.
Assessment: exam improved.
Interventions: Order Profile (Selected)
.

Impression and Plan
Diagnosis
Corneal abrasion - ICD10-CM S05.00XA
Eye foreign body - ICD10-CM T15.90XA
Plan
Condition: Improved.
Prescriptions: Launch prescriptions
Pharmacy:
gentamicin 0.3% ophthalmic ointment (Prescribe): 1 APP, Left Eye, TID (3 times a day), x 5 day, # 3 GM, 0 Refill(s), Indication: Ear Pain, Discharge, 07/16/2017 14:55 EDT.
Patient was given the following educational materials: CORNEAL ABRASION(Spanish).
Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions, pt. understands to follow up as directed and return immediately for any worsening of condition or other concerns as discussed.
Follow up with: [redacted] Within 1-2 days Ophthalmology. Follow up as directed and return immediately for any worsening of condition or other concerns as discussed; .
Disposition: Discharged: Launch Orders
Patient Care:
Discharge (Order Processing): 07/16/2017 14:58 EDT.

[Electronically Signed By:]

PA-C [redacted]
On, 07/16/2017 02:58 PM

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