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S.C. SUPREME COURT

Progress Notes

Signed Apr 6, 2026

Progress Notes by Robert Seth Martin, AGACNP at 4/6/2026 7:55 AM

Attestation signed by Naresh Mullaguri, MD at 4/6/2026 3:09 PM

I have seen and examined this patient on 4/6/2026 with NP/PA. I agree with the documentation and also reviewed and confirmed the history, physical exam, laboratory and radiographic data. I have reviewed and discussed my treatment plan with the ICU team and other medical/consultant staff as documented in the note below.

In summary Duane Alan Evans is a 71 yo male with HTN, tobacco abuse presented to GMH on 02/03 with R thalamic ICH with IVH in hypertensive emergency. S/p EVD, intubated for airway protection and on mechanical ventilation since then. His EVD was removed. Per spouse, patient's perceived wishes are to not endure a life of severe disability and wanted to transition him to comfort measures but due to difference of opinion between family members, the healthcare power of attorney decision is currently being pursued in the court of law. No acute issues overnight. Not following commands.

Neurological examination showed
Higher function: awake but nor oriented, does not follow commands with repeat stimulation, does not clearly make eye contact but occasionally tracks.
Cranial Nerves: PERRL 3+, Left lower facial droop- previous, however ETT obstructs view. Positive cough gag and corneal reflexes. +oculocephalics.
Strength/Sensation: RUE localizes to painful stimuli; LUE extends to noxious stimuli, no attempt to break gravity. LLE flexion to noxious stimuli, no attempt to break gravity. RLE with some purposeful movement. No tremors noted.

Assessment and recommendations:

1. Acute right basal ganglia hemorrhage
2. Intraventricular hemorrhage
3. Hypertension
4. Mixed Hyperlipidemia
5. Acute Respiratory failure due to hemorrhagic stroke on mechanical

ventilation
6. Acute urinary retention
7. Normocytic normochromic anemia
8. Groin fungal infection

Q4H NC, SBP < 150. Continue Melatonin. Awaiting decision from court to appoint the HPOA for transitioning care. He is DNR. Telemetry. Continue PRVC, attempt SBT but mental status and airway protection are barriers to extubation. CXR and ABG as needed. Continue Amlodipine. Not on any medications for hyperlipidemia per family's request. Continue flomax. Monitor I/O. ICU electrolyte replacement protocol. Tube feeds. Bowel regimen on hold and Guar gum for stool bulking. Pepcid while on mechanical ventilation. SCDs and Lovenox for DVT ppx. Miconazole for groin rash.

I have spent 31 minutes in full attendance with this critically ill patient making frequent reassessments and decisions regarding this patient's complex medical care. Critical care time was exclusive of separately billable procedures and teaching time. Critical care was necessary to treat or prevent imminent or life-threatening clinical/neurological deterioration due to ICH and mechanical ventilation.

Split/shared services include pre- and post-visit activities, face-to-face time with the patient, and other coordination of care. I evaluated the patient with Robert Martin NP.

Naresh Mullaguri MD
Neurointensivist
Board certified in Neurology, Vascular Neurology and Neurocritical care
Prisma Health Neurology
Clinical Assistant Professor
University of South Carolina Greenville School of Medicine

Cerebrovascular and Stroke Center

Neurocritical Care Progress Note

Date/Time:	04/06/26 - 7:55 AM
Admitted:	2/3/2026
Admitting MD:	William Eugene Spears IV, MD

Duane Alan Evans is a 71 y.o. male with HTN, former smoker who presented to GMH on 2/3/2026 for acute left sided weakness with dysarthria. HPI per patient's wife report, chart review, and stroke team report. Patient lives at

home with his wife. Per her report he was in his normal states of health until about 10-10:30 when she left home. When she returned to the home at around 12pm she found him down in the kitchen. EMS was called. Initial evaluation per EMS noted to have left sided weakness and dysarthria on exam. Patient was noted to have SBP >180 mmhg with EMS.

On arrival to ED, Stroke team evaluated the patient, SBP >200 mmhg, Initial NIHSS 14. CTH revealing for R BG ICH with IVH. Patient was started on cardene for BP management, HTS for cerebral edema initiated. NCC was contacted for Admission.

2/3 EVD placed.
2/4, 2/5 IT tPA administered per NSGY.
2/5 CTH shows improvement in IVH
2/6 Patient intubated for airway protection 2/2 decreased mentation. Repeat CTH remained stable.
2/9 - 2/13 EVD wean
2/13 EVD clamped per NSGY
2/14 Patient's mentation worse, drain re-opened at 10 cmH20. rCTH pending. Ongoing GOC discussions with family at bedside.
2/16 Following discussion with Palliative Care, decision made to pursue palliative extubation/comfort care measures on Wednesday 2/18
2/18: Sharing hope involvement as of 2/17. Initial plans for compassionate extubation and potential transition to DCD pending time course after extubation this morning. However, family disagreements have stalled current plan of transition of care. Medical management and supportive care continues for the time being. No acute clinical changes over the last 24h.
2/19: Neurologically unchanged
2/22: Persistent rhythmic left lower extremity movement noted today, plan for LTM EEG. EVD removed per neurosurgery. CT head completed evolution of ICH, no worsening hydrocephalus.
2/23: LTM without seizures. Amantadine restarted. Neurologically without change from day prior. Anti-HTN regimen escalated to meet SBP less than 160 goal. He continues to fail PSV trials.
2/27: GOC decisions pending today's legal trial. Tolerating intermittent PST.

No acute changes from a neurologic, respiratory or hemodynamic perspective on 4/6/2026. Continue supportive care

Neuro

Acute Right BG Intracranial Hemorrhage
Intraventricular Hemorrhage
Etiology: Hypertensive
See above for admission and imaging details
- Vitals signs hourly
- NIHSS Q4 hours. Noxious stimuli only necessary during nursing shift hand

off. Otherwise, stimulation and NIHSS without noxious stimuli is sufficient.
- HOB >30 degrees to reduce ICP
- Treat BP with ordered medications to maintain: SBP less than 160mmHg with Cardene gtt/labetalol/ hydralazine PRN
- Seizure/fall precautions
- 2/14 rCTH stable, decreased hematoma
- 2/22 CT head completed prior to EVD removal - stable
- 3/9/26 CT head reviewed evolution of the right thalamic hematoma and mild dilation of the ventricles - Exam consistent, no need for further imaging at this time
- neurological exam remains static - unchanged

Concern for Hypoactive Delirium
- Continue Melatonin 5mg nightly
- Precedex with hypotension, discontinued

MSK

Stroke related Left Hemiparesis
Left Neglect
Generalized Weakness
- Nursing to help perform ROM if patient unable to be mobilized.
    - Unchanged

CV

Essential HTN
Patient with history of HTN - previously was on Valsartan but stopped taking due to "side effects." Hypertensive emergency noted on arrival to GMH
- Treat BP with ordered medications to maintain: SBP <160mmHg, MAP >65; Cardene, Labetalol, Hydralazine PRN
- Maintain Stroke SBP goals
- Monitor on telemetry
- ECHO with EF 55-65% and LVH; also notes left atrial mass vs artifact; per previous documentation: communicated with Cardiology to review, again favors artifact but recommends outpatient cardiology referral per Dr. Dassanayake
- Continue on telemetry
- Continue amlodipine 5mg daily; other antihypertensives held for prior hypotension
- vitals reviewed

Hyperlipidemia
- LDL on admission 155; initially on Lipitor 80mg daily
    - Stopped Lipitor per family request due to previously reported side effects

Respiratory

Intubated for Airway Protection
Acute Hypoxic Respiratory Failure
- 2/6 Intubated due to inability to arouse, snoring respirations and increased oxygen requirements
- CXR/ABG PRN
    - intermittent monitoring with CXR. Some right lower lobe collapse.
- intermittent loss of volumes likely related to cuff not holding pressure. Monitoring closely for possible need to replace ETT while further court discussions are underway. May benefit from a bronchoscopy if ETT requires replacement.
- Vent settings reviewed
- Chest percussion, encourage turn/cough/deep breath, incentive spirometry and OOB when able/as indicated
- mental status barrier to extubation.

Ventilator Information

Flowsheet Row	Most Recent Value
Ventilation Day(s)	57 at 04/04/2026 2311
Vent Mode	PRVC at 04/06/2026 0727
Set Frequency	15 at 04/06/2026 0727
Vt (Set, mL)	500 mL at 04/06/2026 0727
Pressure Support	8 cm H20 at 03/28/2026 1539
FiO2%	40 % at 04/06/2026 0727
Vt Insp (mL)	601 mL at 04/06/2026 0727

Renal

Acute Urinary Retention, persistent
- RN notified provider that he is not spontaneously voiding and is requiring straight cath
- Continue Flomax 0.8mg daily
- Monitor I/O.
- ICU Electrolyte Replacement Protocol
- Q48hr BMP, Mg, phos

Lab Results

Component	Value	Date
BUN	19	04/06/2026
BUN	22	04/04/2026
BUN	20	04/02/2026
CREATININE	0.55 (L)	04/06/2026
CREATININE	0.57 (L)	04/04/2026
CREATININE	0.55 (L)	04/02/2026

GI

Diarrhea
- Bowel Regimen: Colace/Senna
- Guar gum for bulking

- Diet/Nutrition: Continue Osmolite 1.5 at 55ml/hr; FWF 50cc Q4H
- LBM: 4/5
- Zofran PRN for emesis
- Continue Pepcid 20mg daily while intubated

Transaminitis
- ALT remains elevated- unchanged
- Continue CMP q48hrs

Overweight (not obese), if BMI is 25.0 to 29.9
Body mass index is 28.23 kg/m².
- Nutrition consult to assist with dietary recommendations
- Continue enteral feeds as tolerated
- Nursing to use Maxi-Slide or similar device to safely move patient

ID

H Flu PNA - Previously Treated
- Afebrile in the last 24hrs
- Sputum culture with Hflu
    - s/p Rocephin x 7 days (EOT 2/14)
- CSF culture 2/17/26 with NGTD
- CSF culture 2/20/26 NGTD
- Continue Tylenol PRN
- Continue q48 hours labs

E cloacae complex UTI
- UA with concerns of UTI. Urine noted to be malodorous and with particulate prompting UA
- urine culture with enterococcus cloacae
    - S/p Cefepime (EOT 3/26)

Endo

- Blood glucose goal 140-180
- Hgb A1C: 5.6
- TSH: 0.846

Heme

Normocytic, Normochromic Anemia
- No active signs of bleeding - unchanged
- CBC q48hr
- DVT prophylaxis with SCDs and Lovenox

Lab Results

Component	Value	Date
HGB	9.4 (L)	04/06/2026
HCT	28.6 (L)	04/06/2026
PLT	282	04/06/2026

Integumentary

- Continue frequent skin assessments/repositioning per unit protocol

Cutaneous groin erythema, possible fungal infections, improving
- s/p miconazole 2% powder with improvement erythema

PUD PPX: Pepcid
DVT Prophylaxis and/or antiplatelet therapy: SCDs and Lovenox

Subjective

Hospital Day: 62 days
Code Status: Partial Code

24-hour update:
No acute events overnight, neuro exam unchanged.

Objective

	Current	Range (last 24 hours)
Temperature:	**98.8 °F (37.1 °C)**	[97.1 °F (36.2 °C)-98.9 °F (37.2 °C)]
Heart Rate:	72	[61-83]
Resp Rate:	**16**	[13-31]
Blood Pressure:	**104/53**	(77-133)/(46-93)
Oxygen Sats:	98 %	[87 %-100 %]

Patient was examined by myself on 4/6/2026 and exam is unchanged from day prior unless noted below.

Physical Exam:
General appearance: No acute distress, intubated, laying in ICU bed.
HEENT: PERRL and sclera clear, anicteric
Lungs: intubated, equal chest rise, no noted inline secretions
Heart: regular rate and rhythm, NSR on monitor
Abd: Soft, distended, Ventral hernia and umbilical hernia- unchanged + BS in all four quadrants

Neurological:
Higher function: Patient opens eyes to name and gentle stimuli, does not follow commands with repeat stimulation, does not clearly make eye contact
Cranial Nerves: PERRL 3+, Left lower facial droop- previous, however ETT obstructs view. Positive cough gag and corneal reflexes. +oculocephalics.
Strength/Sensation: RUE localizes to painful stimuli; LUE extends to noxious

stimuli, no attempt to break gravity. LLE flexion to noxious stimuli, no attempt to break gravity. RLE with some purposeful movement, unable to break gravity. No tremors noted.

Neurological Imaging

XR Chest 1 Vw
Result Date: 4/4/2026
EXAM: CHEST X-RAY SINGLE VIEW HISTORY: ;ett placement; COMPARISON: 4/3/2026 TECHNIQUE: Single AP view

1. Stable ET tube and enteric tube. 2. Increasing right basilar pleural parenchymal opacities. 3. No new left consolidation or effusion. 4. Stable cardiac and mediastinal silhouette. Signed by: 4/4/2026 6:27 AM: Handran MD, Chauncy

XR Chest 1 Vw
Result Date: 4/3/2026
EXAM: CHEST X-RAY SINGLE VIEW HISTORY: ;ETT placement; COMPARISON: 3/29/2026 radiograph TECHNIQUE: Single AP view FINDINGS: Lungs / Pleura: Streaky opacities in the right lung base. No evidence of pleural effusion or pneumothorax. Heart / Mediastinum: The cardiac and mediastinal contours are normal. Bony thorax / Soft tissues: The bony thorax is intact. Lines / Support Apparatus: Endotracheal tube tip is approximately 8 cm above the carina. NG/OG tube side-port is distal to the gastroesophageal junction.

1. Endotracheal tube tip is approximately 8 cm above the carina. 2. NG/OG tube side-port is distal to the gastroesophageal junction. 3. Mild right basilar atelectasis. Signed by: 4/3/2026 6:27 PM: Matthews MD, Gregory

XR Chest 1 Vw While Intubated
Result Date: 3/29/2026
EXAM: CHEST X-RAY SINGLE VIEW. HISTORY:;high peak pressures; TECHNIQUE: Single AP view,3/29/2026 1:06 AM COMPARISON: 3/28/2026. FINDINGS: Endotracheal tube and orogastric tubes are satisfactory in position. The heart, lungs, and mediastinum are grossly unremarkable in appearance. Multiple old healed right-sided rib fractures. Bilateral AC joint and right glenohumeral joint arthritic changes. Thoracic spondylosis. The osseous structures are intact.

No radiographic evidence of acute cardiopulmonary process. Support tubing remains satisfactory. No substantial change from yesterday's exam. Signed by: 3/29/2026 7:53 AM: Rushe MD, Todd

XR Chest 1 Vw While Intubated

Result Date: 3/28/2026
XR CHEST 1 VW WHILE INTUBATED, 3/28/2026 6:54 AM INDICATION: ;high peak pressures; COMPARISON: Multiple prior chest radiographs, most recent 3/27/2026 FINDINGS: . Lines/tubes/surgical: Multiple telemetry wires overlie the chest. Endotracheal tube tip projects at the level of the clavicular heads. Enteric tube courses below the diaphragm with tip projecting below the level of the image. . Mediastinum/Cardiovascular: Normal cardiopericardial silhouette and mediastinal shadow.Aortic arch calcifications are noted. . Lungs/Pleura: No focal airspace opacities or edema. No pleural effusions. No pneumothorax. . Upper Abdomen/Diaphragm: No acute abnormalities. . Bones/Soft Tissues: No acute osseous or soft tissue abnormalities. Multilevel degenerative changes of the imaged spine. Remote appearing right-sided rib fractures. Moderate right glenohumeral joint degenerative change.

No radiographic evidence of acute cardiopulmonary abnormality. Satisfactory radiographic positioning of endotracheal tube. Signed by: 3/28/2026 7:38 AM: Shah MD, Pavani

XR Chest 1 Vw
Result Date: 3/27/2026
XR CHEST 1 VW TECHNIQUE: Frontal chest radiography. INDICATION: ;feeding tube placement verification; COMPARISON: Chest radiography performed earlier the same day. --------------- FINDINGS: Lines/Support Devices: Enteric tube overlies the stomach. Lungs/Pleura: No focal airspace opacities. No pneumothorax. No pleural fluid. Heart/Mediastinum: Within normal limits. Musculoskeletal: Multilevel spondylosis. No acute abnormality. Chronic right-sided rib fractures. Upper abdomen: Unremarkable.

Enteric tube overlies the stomach. Signed by: 3/27/2026 3:52 PM: Franklin MD, Allie

XR Chest 1 Vw
Result Date: 3/27/2026
EXAM: XR CHEST 1 VW, 3/27/2026 10:23 AM INDICATION: Shortness of breath;;evaluate for pneumothorax; COMPARISON: Chest x-ray 3/17/2026 TECHNIQUE: Single AP view FINDINGS: Heart/mediastinum: Cardiomediastinal silhouette is within normal limits. Lungs/pleura: The lungs are clear. No pleural effusion or pneumothorax. Bony thorax / Soft tissues: Osseous structures are intact and unremarkable for patient age. Lines / Support Apparatus: An endotracheal tube is present terminating at the clavicular heads.

No evidence of acute cardiopulmonary disease. Signed by: 3/27/2026 10:53 AM: Alleyne MD, T. Claire

XR Abdomen AP
Result Date: 3/25/2026
EXAM: ABDOMEN INDICATION: ;evaluate for illeus; COMPARISON: Abdominal study 3/23/2026 TECHNIQUE: AP Abdomen FINDINGS: Chest - Lung Bases: Lung bases are clear. Bowel: There continues to be gas evident within portions of the normal caliber colon. There are also are multiple prominent gas-filled loops of small bowel. Overall, the bowel gas pattern is shown no substantial change as compared to 3/23/2026. Peritoneum / Retroperitoneum: No obvious organomegaly or unusual calcification. Soft tissues / Bones: The lumbar spine and bony pelvis are normal for age. Lines / Support Apparatus: A nasogastric feeding tube remains within the stomach fundus.

1. No substantial change in bowel gas pattern which may reflect mild ileus. Signed by: 3/25/2026 2:32 PM: Farnsworth MD, S.

XR Abdomen AP
Result Date: 3/23/2026
EXAM: XR ABDOMEN AP INDICATION: ;distention; COMPARISON: None. TECHNIQUE: Single AP view of the abdomen and pelvis was performed. FINDINGS: Gas filled small and large bowel with a borderline gas distended cecum measuring up to approximately 7 cm. Few borderline dilated loops of small bowel in the left abdomen measuring just short of 3 cm. Weighted tip feeding catheter over the stomach. Coiled catheter/lead over the lower pelvis, potentially a rectal temperature probe. Clear lung bases.

Gas filled colon and small bowel with borderline distention of the cecum and multiple jejunal loops, suspect generalized adynamic ileus. Recommend continued radiographic follow-up. Signed by: 3/23/2026 5:55 PM: Knipfing DO, Michael

XR Chest 1 Vw
Result Date: 3/17/2026
EXAM: CHEST X-RAY SINGLE VIEW HISTORY: ;NGT placement verification; COMPARISON: 3/9/2026 TECHNIQUE: Frontal view FINDINGS: Lungs / Pleura: No focal consolidation. No effusion or pneumothorax. Heart / Mediastinum: The cardiac and mediastinal contours are stable. Bony thorax / Soft tissues: The bony thorax is stable. Lines / Support Apparatus: The endotracheal tube is positioned between the thoracic inlet and carina. Enteric tube reaches the stomach.

Enteric tube reaches the level of the stomach. Signed by: 3/17/2026 12:21 AM: Mahatma MD, Sanjay

CT Head wo Contrast
Result Date: 3/10/2026

EXAM: CT HEAD WO CONTRAST INDICATION: Stroke, follow up. COMPARISON: CT head without contrast 2/22/2026 TECHNIQUE: Standard noncontrast brain CT. FINDINGS: Brain Parenchyma: -Approximate 7 mm leftward midline shift. -Evolving hemorrhage and edema in the right thalamus. -No intracranial hemorrhage. -Moderate chronic microvascular ischemic changes. Ventricles: Slightly increased caliber of the lateral ventricles, measuring 5 cm transverse. Interval removal of left frontal ventriculostomy catheter. Small volume hemorrhage layering in the lateral ventricles. Extra-Axial Spaces: No extra-axial fluid collection. Basal Cisterns: Normal. Paranasal Sinuses: Moderate mucosal thickening in the ethmoid air cells and sphenoid sinuses Mastoid air cells: Large volume mastoid fluid with fluid also noted in the middle ear spaces. Orbits: Bilateral cataract surgeries. Cranium and Bones: Left frontal burr hole. Soft Tissues: Partially visualized nasoenteric tube.

1. Continued evolution of right thalamic hematoma with no new areas of hemorrhage. 2. Slightly increased dilatation of the lateral ventricles following removal of ventriculostomy catheter. Signed by: 3/10/2026 8:56 AM: Heider MD, Robert

XR Chest 1 Vw
Result Date: 3/9/2026
EXAM: XR CHEST 1 VW, 3/9/2026 10:05 AM INDICATION: ;Ett placement; Comparison: 2/26/2026 FINDINGS: AP portable view chest shows small bore enteric tube tip to be below the level of the film but at least to the level of the upper abdomen. Endotracheal tube overlies mid thoracic trachea with its tip approximately 40 mm above the expected location of the carina. Remote right-sided rib fractures are noted. The right lung is otherwise clear. Blunting of the left costophrenic angle suggestive of small left-sided pleural effusion. CONCLUSION: 1. Endotracheal tube tip overlies mid thoracic trachea-see above. 2. Probable small left pleural effusion. 3. Remote right-sided rib fractures. Signed by: 3/9/2026 11:48 AM: Saunders MD, H. Stuart

I&O:

Intake/Output Summary (Last 24 hours) at 4/6/2026 0755
Last data filed at 4/6/2026 0700

	Gross per 24 hour
Intake	2875.87 ml
Output	1300 ml
Net	**1575.87 ml**

Net IO Since Admission: 24,532.13 mL [04/06/26 0755]

IV Infusions:

OSMOLITE 1.5 CAL, , Last Rate: 50 mL/hr at 04/06/26 0700

Diet:
NPO Diet NPO with Tube Feeding

Lines/Drains:
Active Lines

Peripheral Intravenous Line	Duration
Peripheral IV 04/05/26 18 G Anterior;Proximal;Right Forearm	<1 day
Peripheral IV 04/06/26 20 G Anterior;Distal;Left Forearm	<1 day

Wound	Duration
PH Wound 02/24/26 Pressure Injury Sacral	40 days
PH Wound EVD site 02/28/26 Surgical Head	36 days
PH Wound 03/11/26 Pressure Injury Cheek Left Redness with delayed blanching; small area of nonblanchable redness	25 days
PH Wound 03/11/26 Pressure Injury Cheek Right Delayed blanching to cheek	25 days

Drain	Duration
NG/OG GI Tube 03/27/26 Center Mouth	9 days

Airway	Duration
Hi-Lo Evac ETT 02/06/26 7.5	58 days

Active Tubes/Drains

Drain	Duration
NG/OG GI Tube 03/27/26 Center Mouth	9 days

Lines, Drains, and Airways

Airway	Duration
Hi-Lo Evac ETT 02/06/26 7.5	58 days

Peripheral Intravenous Line	Duration
Peripheral IV 04/05/26 18 G Anterior;Proximal;Right Forearm	<1 day
Peripheral IV 04/06/26 20 G Anterior;Distal;Left Forearm	<1 day

Wound	Duration
PH Wound 02/24/26 Pressure Injury Sacral	40 days
PH Wound EVD site 02/28/26 Surgical Head	36 days
PH Wound 03/11/26 Pressure Injury Cheek Left Redness with delayed blanching; small area of nonblanchable redness	25 days
PH Wound 03/11/26 Pressure Injury Cheek Right Delayed blanching to cheek	25 days

Drain	Duration

NG/OG GI Tube 03/27/26 Center Mouth	9 days

Vent:
MODE: PRVC (04/06 0727)
Set Frequency: 15 (04/06 0727)
S VT: 500 mL (04/06 0727)
MAP (cm H2O): 12.8 (04/06 0727)
Insp Time (sec): 0.9 sec (04/06 0727)
Vent / RT FiO2 (%): 40 % (04/06 0727)
VE exp: 6.1 L/min (04/06 0727)
PIP: 30 cm H2O (04/06 0727)

Meds:
Pain Meds:
Analgesics

acetaminophen (TYLENOL) suppository 650 mg	650 mg, Rectal, Every 4 hours PRN

ABx:
Antiinfectives

	Dose	Frequency	Start	End
ceFAZolin (ANCEF) injection 1 g (Completed)	1 g	Once	2/3/2026	2/3/2026

Admin Instructions: Obtain number of vials required to make the ordered dose. Reconstitute each vial with 2.5mL normal saline. Further dilute each vial with additional 5mL normal saline and draw into one syringe. Administer by slow IV push over 3-5 minutes.

Immediate use – BUD 4 hours.
Route: Intravenous

	Dose	Frequency	Start	End
cefepime (MAXIPIME) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI (Completed)	2 g	Every 12 hours	3/21/2026	3/26/2026

Admin Instructions: Activate medication.
Route: Intravenous

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI **(Completed)**	2 g	Every 24 hours	2/8/2026	2/14/2026

Admin Instructions: Activate medication.
Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg
Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h
CNS infection: 2g IV q12h
Entercoccal endocarditis (with ampicillin): 2g IV q12h
*Uncomplicated gonorrhea use IM
Route: Intravenous

	Dose	Frequency	Start	End
miconazole 2 % powder **(Completed)**		2 times daily	3/11/2026	3/20/2026

Route: Topical

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 1 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI **(Discontinued)**	1 g	Every 24 hours	3/20/2026	3/21/2026

Admin Instructions: Activate medication.
Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg
Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h
CNS infection: 2g IV q12h
Entercoccal endocarditis (with ampicillin): 2g IV q12h
*Uncomplicated gonorrhea use IM
Route: Intravenous

	Dose	Frequency	Start	End
cefTRIAXone (ROCEPHIN) 2 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI **(Discontinued)**	2 g	Every 24 hours	2/8/2026	2/8/2026

Admin Instructions: Activate medication.
Notes to Pharmacy: Mild-mod infection (UTI,SSTI,STI*): 1g IV q24h, consider 2g if >80kg
Severe infection (bacteremia, febrile neutropenia, endocarditis, pneumonia, sepsis): 2g IV q24h
CNS infection: 2g IV q12h
Entercoccal endocarditis (with ampicillin): 2g IV q12h
*Uncomplicated gonorrhea use IM
Route: Intravenous

	Dose	Frequency	Start	End
piperacillin-tazobactam 4.5 g in sodium chloride (NS) 0.9 % 50 mL IVPB-MINI **(Discontinued)**	4.5 g	Every 6 hours	2/17/2026	2/20/2026

Admin Instructions: Activate medication.
Route: Intravenous

Ulcer PPx/Bowel Regimen:

Current GI Medications

ondansetron (ZOFRAN ODT) disintegrating tablet 4 mg	4 mg, Oral/Gastric Tube, Every 6 hours PRN
ondansetron (ZOFRAN) injection 4 mg	4 mg, Intravenous, Every 6 hours PRN
senna-docusate (PERICOLACE) 8.6-50 mg per tablet 2 tablet	2 tablets, Oral/Gastric Tube, Daily, Notify provider for loose stools

Labs:

Lab Results

Component	Value	Date
WBC	8.1	04/06/2026
HGB	9.4 (L)	04/06/2026
HCT	28.6 (L)	04/06/2026
PLT	282	04/06/2026
INR	1.2	02/21/2026
PTT	44 (H)	02/21/2026

Lab Results

Component	Value	Date
NA	140	04/06/2026
K	4.4	04/06/2026
CL	104	04/06/2026
CO2	26	04/06/2026
BUN	19	04/06/2026
CREATININE	0.55 (L)	04/06/2026
GLUCOSE	147 (H)	04/06/2026
CALCIUM	9.4	04/06/2026
MG	2.1	04/06/2026
PHOS	4.2	04/06/2026

BILITOT	0.2	04/06/2026
AST	22	04/06/2026
ALT	77 (H)	04/06/2026
ALKPHOS	87	04/06/2026
LIPASE	39	02/16/2026

No results found for: "PHBG", "PCO2", "PO2", "HCO3", "BASEDE"

Lab Results

Component	Value	Date
LDLCALC	155 (H)	02/03/2026

Lab Results

Component	Value	Date
HGBA1C	6.0 (H)	02/17/2026

As part of split/shared services, I personally spent 12 minutes providing critical care for this patient. My provided care includes review of patients medical record (notes, recent lab work, imaging), examination of Duane Alan Evans , communication with patients nurse, and documentation in the medical record.

This patient is at high risk of imminent life threatening clinical deterioration and/or death due to respiratory failure requiring mechanical ventilation and ventilator management. The patient remains critically ill, requiring frequent reassessments, and decisions regarding complex medical care thereby necessitating critical care to treat and prevent imminent or life-threatening deterioration in the patients condition. Time spent excludes procedure related time or time spent on the telephone.

Robert Seth Martin, AGACNP
Neuro Critical Care
Prisma Health Neurology - Upstate
Neuroscience Intensive Care Unit
04/06/26 - 8:00 AM

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