THE STATE OF SOUTH CAROLINA
In The Supreme Court

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S.C. Supreme Court

APPEAL FROM SUMTER COUNTY
Court of Common Pleas

Honorable Michael Nettles, Circuit Court Judge

Case No. 08-CP-43-00905
Appellate Case No. 2013-001968

BOBBY WAYNE STONE..... Petitioner,

v.

STATE OF SOUTH CAROLINA..... Respondent.

APPENDIX
VOLUME XII OF XV

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Juror 24 (Questioning by Jackson)	2549
Juror 24 (Questioning by Littlejohn)	2552
Ms. Dowe, Juror 56 (Questioning by the Court)	2557
Juror 56 (Questioning by Jackson)	2563
Juror 56 (Questioning by Littlejohn)	2565
Ms. Drake, Juror 57 (Questioning by the Court)	2570
John McCloud, Juror 140 (Questioning by the Court)	2575
Juror 140 (Questioning by Jackson)	2583
Juror 140 (Questioning by Littlejohn)	2586
Mr. Slater, Juror 198 (Questioning by the Court)	2594
Juror 198 (Questioning by Saleeby)	2599
Juror 198 (Questioning by Babb)	2600
Mr. Tomlin, Juror 218 (Questioning by the Court)	2603
Mr. Cochran, Juror 39 (Questioning by the Court)	2606
Ms. Fulwood, Juror 64 (Questioning by the Court)	2609
Ms. Blanchette, Juror 19 (Questioning by the Court)	2613
Juror 19 (Questioning by Saleeby)	2618
Juror 19 (Questioning by Babb)	2620
Mr. Price, Juror 175 (Questioning by the Court)	2624
Juror 175 (Questioning by Jackson)	2630
Juror 175 (Questioning by Littlejohn)	2632
Emerericiana Ulery, Juror 222 (Questioning by the Court)	2642
Juror 222 (Questioning by Jackson)	2648
Juror 222 (Questioning by Littlejohn)	2650
Ms. Weston, Juror 235 (Questioning by the Court)	2656
Ms. Weeks, Juror 233 (Questioning by the Court)	2658
Juror 233 (Questioning by Saleeby)	2664
Juror 233 (Questioning by Babb)	2665
Mr. Brooks, Juror 26 (Questioning by the Court)	2673
Juror 26 (Questioning by Littlejohn)	2677
Nickie Jones, Juror 110 (Questioning by the Court)	2679
Juror 110 (Questioning by Jackson)	2685
Juror 110 (Questioning by Babb)	2689
Rosada Heriot, Juror 88 (Questioning by the Court)	2694
Juror 88 (Questioning by Jackson)	2698
Juror 88 (Questioning by Babb)	2700
Juror 88 (Questioning by the Court)	2704
Ms. Sanders, Juror 189 (Questioning by the Court)	2706

Juror 189 (Questioning by Jackson)	2711
Juror 189 (Questioning by Babb)	2714
Mr. Harsch, Juror 86 (Questioning by the Court)	2718
Juror 86 (Questioning by Jackson)	2723
Juror 86 (Questioning by Babb)	2725
Ms. Smith, Juror 199 (Questioning by the Court)	2734
Juror 199 (Questioning by Jackson)	2742
Juror 199 (Questioning by Littlejohn)	2744
Ms. Myers, Juror 157 (Questioning by the Court)	2749
Juror 157 (Questioning by Jackson)	2754
Juror 157 (Questioning by Babb)	2760
Mr. Rewis, Juror 180 (Questioning by the Court)	2774
Juror 180 (Questioning by Saleeby)	2779
Juror 180 (Questioning by Babb)	2780
Mr. Copeland, Juror 41 (Questioning by the Court)	2785
Juror 41 (Questioning by Jackson)	2794
Juror 41 (Questioning by Babb)	2799
Jury Selection	2830
Case Called	2863
State's Exhibit #84 (Diagram) entered into evidence	2871
State's Exhibit #85 (Diagram) entered into evidence	2871
State's Exhibit #86 (Diagram) entered into evidence	2871
Opening Statements	2884
Tommy Mims (Direct by Saleeby)	2898
Lillie Britt (Direct by Saleeby)	2907
State's Exhibit #63 (copy of indictment) entered into evidence	2910
State's Exhibit #64 (copy of indictment) entered into evidence	2910
State's Exhibit #65 (copy of indictment) entered into evidence	2910
State's Exhibit #66 (copy of indictment) entered into evidence	2910
State's Exhibit #67 (copy of indictment) entered into evidence	2910
State's Exhibit #68 (copy of indictment) entered into evidence	2910
State's Exhibit #69 (copy of indictment) entered into evidence	2910
Sharon Holland (Direct by Saleeby)	2915
Kathy Miles (Direct by Saleeby)	2923
State's Exhibit #4 (911 tape) played for the jury	2930
Kathy Miles (Cross by Littlejohn)	2930
Mary Ruth Williamson (Direct by Saleeby)	2937
State's Exhibit #56 (coat) entered into evidence	2944
State's Exhibit #13 (gun) entered into evidence	2946
State's Exhibit #6 (photo) entered into evidence	2951
State's Exhibit #9 (photo) entered into evidence	2953
State's Exhibit #8 (photo) entered into evidence	2954
State's Exhibit #15 (photo) entered into evidence	2955
State's Exhibit #10 (photo) entered into evidence	2955
State's Exhibit #12 (photo) entered into evidence	2956

Mary Ruth Williamson (Cross by Babb)	2957
Daniel Bethea (Direct by Saleeby)	2974
Daniel Bethea (Cross by Littlejohn)	2980
Ruth Griffith (previous testimony read into the record)	2984
Landrow Taylor (previous testimony read into the record)	3036
John Prince (Direct by Saleeby)	3058
State's Exhibit #13 (shotgun) entered into evidence	3071
State's Exhibit #31 (photo) entered into evidence	3072
State's Exhibit #19 (photo) entered into evidence	3072
John Prince (Cross by Littlejohn)	3074
John Prince (Redirect by Saleeby)	3079
Gene Edward Hobbs, Jr. (Direct by Saleeby)	3081
State's Exhibit #27 (Smith and Weston nine millimeter) entered into evidence	3091
State's Exhibit #26 (rounds) entered into evidence	3091
Gene Edward Hobbs, Jr. (Cross by Littlejohn)	3100
Fred Powell, Jr. (Direct by Saleeby)	3107
State's Exhibit #40 (photo) entered into evidence	3122
Fred Powell, Jr. (Cross by Littlejohn)	3123
Dana Wingate (Direct by Saleeby)	3129
State's Exhibit #60 (knife) entered into evidence	3134
Dana Wingate (Cross by Littlejohn)	3135
Perry Herod (Direct by Saleeby)	3143
State's Exhibit #1 (advisement of rights form) entered into evidence	3150
State's Exhibit #2 (sketch) entered into evidence	3156
State's Exhibit #3 (written statement) entered into evidence	3157
Perry Herod (Cross by Littlejohn)	3170
Dr. Joel Sexton (Direct by Saleeby)	3177
State's Exhibit #18 (portions of lead bullet) entered into evidence	3190
State's Exhibit #17 (22 long rifle bullet) entered into evidence	3190
Dr. Joel Sexton (Cross by Littlejohn)	3195
Raymond Mackessy (Direct by Saleeby)	3197
State's Exhibits #41-46 (photos of beer cans) entered into evidence	3207
State's Exhibits #40-70 (fired 22-caliber cartridge casing) entered into evidence	3207
State's Exhibit #40 (photo) entered into evidence	3207
State's Exhibits #29 and 30 (photos) entered into evidence	3208
State's Exhibit #35 (photo) entered into evidence	3210
State's Exhibits #53 and 54 (22-caliber cartridge casings) entered into evidence	3211
State's Exhibit #31 (photo) entered into evidence	3212
State's Exhibit #20 (photo) entered into evidence	3212
State's Exhibits #21 and 25 (photos) entered into evidence	3213
State's Exhibit #23 (photo) entered into evidence	3214
State's Exhibit #57 (cut portion of screen) entered into evidence	3218
Thomas Darnell (Direct by Saleeby)	3221

Thomas Darnell (Cross by Babb)	3234
Jeffery Hollifield (Direct by Saleeby)	3244
Jeffry Hollifield (Cross by Babb)	3252
John Barron (Direct by Saleeby)	3259
John Barron (Cross by Babb)	3273
Ira Parnell (Direct by Saleeby)	3275
Ira Parnell (Cross by Littlejohn)	3297
Peggy Kubala (Direct by Jackson)	3309
Ferdinand Kubala (Direct by Jackson)	3317
Kevin Kubala (Direct by Jackson)	3329
Teresa Kubala-Hanvey (Direct by Jackson)	3333
Gary Metts (Direct by Saleeby)	3357
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Teanne Oehler (Direct by Babb)	3391
Teanne Oehler (Cross by Saleeby)	3414
Teanne Oehler (Redirect by Babb)	3430
Melinda Parrott (Direct by Babb)	3431
Melinda Parrott (Cross by Saleeby)	3451
Elizabeth Perry (Direct by Babb)	3457
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Linda Parrott (Direct by Babb)	3466
Mary Jean Wilson (Direct testimony is read into record by Littlejohn)	3469
Mary Jean Wilson (Cross read into the record by Jackson)	3477
Mary Jean Wilson (Continued testimony read by Littlejohn)	3482
Dr. William Alexander Morton, Jr. (Direct by Babb)	3485
Dr. William Alexander Morton, Jr. (Cross by Jackson)	3509
Dr. William Alexander Morton, Jr. (Redirect by Babb)	3520
James Aiken (Direct by Littlejohn)	3522
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Dr. James Merikangas (Redirect by Blume)	4149
Dr. Howard Becker (Direct by Blume)	4155
Dr. Howard Becker (Cross by Zelenka)	4187
Dr. Arlene Andrews (Direct by Blume)	4196
Dr. Arlene Andrews (Cross by Zelenka)	4243
Joseph Savitz, III (Direct by Lominack)	4254
Joseph Savitz, III (Cross by Simon)	4257
Wayne Hill (Direct by Blume)	4263
Wayne Hill (Cross by Simon)	4301
Wayne Hill (Redirect by Blume)	4317
Wade Kolp (Direct by Zelenka)	4320
Wade Kolp (Cross by Blume)	4338
Wade Kolp (Redirect by Zelenka)	4346
Peter Skidmore (Direct by Blume)	4347
Peter Skidmore (Cross by Simon)	4350
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James Babb (Redirect by Lominack)	4402
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Simon Majors, Jr. (Cross by Lominack)	4421
Cecil Jackson (Direct by Simon)	4425
Cecil Jackson (Cross by Blume)	4429

Ira Parnell (Direct by Simon)	4432
Ira Parnell (Cross by Blume)	4441
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James Babb (Direct by Lominack)	4455
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Cameron Littlejohn (Direct by Simon)	4462
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Applicant's Exhibit #33 (Tammy Stone's School Records)	6475
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Applicant's Exhibit #40 (Michelle Lynch's Criminal Records)	6818
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Applicant's Exhibit #42 (Wesley Miles Criminal Records)	6869
Applicant's Exhibit #43 (Melinda Stone Parrott's Criminal Records)	6911
Applicant's Exhibit #44 (Bobby O. Stone's Criminal Records)	6921
Applicant's Exhibit #45 (Anthony Turner's Criminal Records)	6931
Applicant's Exhibit #46 (Thomas Windham's Criminal Records)	7069
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Respondent's Exhibit #2 (James Babb's Notes)	7106
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Respondent's Exhibit #4 (Interview with Elizabeth Bernice Perry 9/9/96)	7108
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001669

ANESTHESIA RECORD

Tuomey Healthcare System, Sumter SC

STAMP PLATE

PATIENT SAFETY
- ☑ Patient Identified
- ☑ Anes. Machine
- ☑ OR # 6
- ☑ Safety Belt On
- ☑ Armboard Restraints, Less than 90 degrees
- ☑ Pressure Points Checked & Padded
- ☐ Axillary Roll with Axilla Free
- ☐ Arms Tucked
- ☑ Eye Care:
  - ☐ Taped ☐ Ointment
  - ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT
- ☑ Stath ☐ Precord ☐ Esoph
- ☑ Noninvasive BP ☐ L ☐ R
- ☑ Continuous EKG
- ☑ Pulse Oximeter
- ☑ Oxygen Sensor
- ☑ End Tidal CO_2
- ☐ Temp. ☐ Nerve Stimulator
- ☐ Fluid Warmer
- ☐ Warming Device
- ☐ Airway Humidifer (Passive) ☑ Foley
- ☐ NG/OG Tube ☐ Ck for Placement
- ☐ Art. Line
- ☐ CVP
- ☐ PA Line

ANESTHETIC TECHNIQUE
- General: ☐ Preoxygenated w/ 100%
  - ☐ Inhalation ☐ Intravenous
  - ☑ Rapid Sequence ☑ Cricoid Pressure
- ☐ Regional: ☑ Spinal ☐ Epidural
  - ☐ Axillary ☐ Bier Block ☐ Ankle Block
  - ☐ Other
- ☐ I.V. Sedation
- Other: ☐ M.A.C. ☐

IV(S)
- ☑ In Place ☐ Started
- Site
- Cath

AIRWAY MANAGEMENT
- Intubation: ☐ Blade MAC 3
  - Tube size 6.0 ☐ Direct ☐ Blind
  - ☐ Regular ☐ Fiberoptic
  - ☐ RAE ☑ Attempts x 1
  - ☐ Endobronch. ☑ ETCO2 present
  - ☐ Cuffed ☐ Bilateral Breath Sounds
  - ☐ Uncuffed
  - ☑ Oral ☐ Nasal
  - ☐ Tube secured at 21 cm
  - Traumatic ☐ No ☐ Yes, See remarks
- Airway ☐ Oral ☐ Nasal ☐ Difficult see Remarks
- Circuit ☐ Circle ☐ Peds Circle
- ☐ Mask Case ☐ Nasal cannula

TIME: 1955 2100

AGENTS
- Oxygen (L/min) 3 6
- ☐ N_2O ☐ Air (L/min)
- Forane % 4 - off
- Propofol 20/50/200
- Fentanyl 100
- Sux 100

FLUIDS (TOTALS: 800)
- (1) LR
- (2)
- (3)
- Urine (ml)
- EBL (ml)

MONITORS
- EKG
- % O_2 Inspired 100 FiO2
- O_2 Saturation 46 48 93
- End Tidal CO_2 39 37
- Temp.: ☐ °C ☐ °F

VITAL SIGNS

| | Pre-Induction | | |

PRE-ANESTHESIA HISTORY & PHYSICAL RECORD 231567 Windham, Tammy 001670

SURGICAL PROCEDURE PROPOSED	AGE	BP
Cerclage	37	199/68
	WEIGHT 158	HR 124

HISTORY AND PHYSICAL: SYSTEMS

PULMONARY
Smoker
0

CARDIO-VASCULAR
HTN - no meds

DIABETES NEG
CONTROL
DIET ORAL INSULIN

METABOLIC
GERD
β blocker

PRIOR ANESTHESIA AND COMPLICATIONS
Apfel
GA3

FAMILY ANESTHESIA PROBLEMS
MH

NEUROLOGIC
0

RENAL
0

MENTAL STATUS
Alert - Apprehensive
Un/Cooperative
Un/Responsive
Non/Communicative
Psychosis/Confused

ORAL M. Class III
Range of Motion
Jaw ☐ Adequate ☐ Limited
Neck ☐ Adequate ☐ Limited
Teeth ☐ Edentulous ☐ Caries
☐ Caps-Bridges ☐ Loose
☐ Missing-damaged:
☐ Partial

SPECIAL INFORMATION
Emergency per Dr Denis c 24 wks. Labor / contracting. Dilation 4cm → 6cm last ~ 2 hrs. Attempting Tocolysis to split ABS. Proceed now. ADO 1230

ALLERGIES
ϕ

DRUGS
ϕ

LABORATORY DATA

CBC	CHEMISTRIES	X-RAY	EKG
10.8 / 32.5 (449)			
Date:	Date:		

ANESTHETIC Options including:
GA/SAB
Discussed with: Pt
☐ Agree(s) with plan

ANESTHETIC TECHNIQUE PLANNED
GENERAL IV SEDATION
SPINAL LOCAL/MAC
EPIDURAL OTHER:
BLOCK:

SPECIAL NEEDS
A-LINE
CVP
PA CATHETER
OTHER:

BLOOD AVAILABLE

PRE-MEDICATION
Rz R10 B30

11/3/04 1955
Date/Time Anesthesiologist

ASA CLASS
I II III IV V VI E

PRE-PROCEDURE ASSESSMENT

Pre-anesthesia State: ☑ Calm
☑ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

☑ NPO ☑ CHART REVIEWED
☑ PERMIT ☑ LAB DATE REVIEWED
☐ Patients condition satisfactory to proceed with anesthesia as planned
☐ Anesthesia plan modified (NOTE):

11/3/04 1955
Date/Time CRNA
Date/Time Anesthesiologist

PACU

BP 160/59 P 111
R 16 SAT 88
T
Report to: Peggy Vitello
Notes: O2 pll N/C

POST- OPERATIVE NOTE

Alert
Complains of pain & contractions
RN aware Dr Denis
VSS
MAC
11/3/04 2247
Alert, comfortable, VSS, MAC
Bought to unit
11/4/04 0020

39100 Rev. 7/11/2004

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5457

TUOMEY HEALTHCARE SYSTEM
129 N. WASHINGTON STREET
SUMTER, SC 29150

OPERATIVE REPORT

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: DENNIS,RONNIE W
Adm. Dr: DENNIS,RONNIE W
Admit date: 11/03/04
Location: LD

MR#: 229998
RM#: LD 3-1
[redacted]
Service: Women's Services

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

ACCOUNT NUMBER: 12315167

DATE OF BIRTH: [redacted]

DATE OF PROCEDURE: 11/03/2004

PREOPERATIVE DIAGNOSIS: Preterm labor with cervical dilatation.

POSTOPERATIVE DIAGNOSIS: Preterm labor with cervical dilatation.

PROCEDURE PERFORMED: Emergency cerclage placement.

SURGEON: Ronnie W Dennis, MD

OPERATION IN DETAIL: After adequate anesthesia was given, the patient was prepped and draped in the sterile fashion in lithotomy position. A weighted speculum was inserted. The cervix was grasped at the anterior and posterior with ring forceps and retracted and a moist sponge was used to gently push the membranes back within the cervical canal and a #5 Mersilene band was placed in a circumferential fashion around the cervix and tied with closure of the cervix with good results. There were no complications during the procedure.

ESTIMATED BLOOD LOSS: Minimal.

SPECIMENS: None.

RONNIE DENNIS, MD

Dict. Date: 11/03/2004 Trans. Date: 11/03/2004

TUOMEY HEALTHCARE SYSTEM
129 N. WASHINGTON STREET
SUMTER, SC 29150

OPERATIVE REPORT

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: DENNIS,RONNIE W
Adm. Dr: DENNIS,RONNIE W
Admit date: 11/03/04
Location: LD

MR#: 229998
RM#: LD 3-1
[redacted]
Service: Women's Services

114290 / 33623 /
Job: 22614

Electronically Signed by:

257

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

001673

Windham, T...mmy
MR#:
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	17:59	18:34	18:47	
INTERVENTIONS				
IV	Text...			
11/03 17:59	IV Started, IV bolus given cc @			
	500, Labs drawn with IV start			
EDUCATION				
Annotation Comment	Text...	Text...	Text...	
11/03 17:59	IV x 1 attempt			
11/03 18:34	bedside OB Complete being performed			
	at this time. Pt will be placed			
	back on monitor after US			
11/03 18:47	pt back on monitor; bedside US			
	complete.			
Recorded by	PSH	PSH	PSH	

	11/03/04			
	19:08	19:14	19:15	
Stage of Pregnancy			Labor	
VITAL SIGNS				
NBP Sys/Dia	/	/	182/ 91	(mmHg)
Mean			125	
HR			104	
Respirations			20	
PAIN				
Pain Presence			Intermit	
Pain Type			Sharp	
Pain Location			Abdomen	
Pain Related to Contractions			Yes	
Pain Relief Measures			ComfMeas	
Pain Scale			7	
Pain Relief Measures Response			NoRelief	
VAGINAL EXAM				
Dilatation		6 cms	6.0	(cms)
Effacement			50	(%)
Station			-1	
Exam by		Dr. Dennis	Dr. Dennis	
Membrane Status			Bulging	
Vaginal Bleeding			None	
Fetal Presentation 'A'			Cephalic	
Magnesium Sulfate Assessment				
Deep Tendon Reflex			2+	
Clonus			None	
Level of Consciousness			Awake	
Breath Sounds			Equ\Clr	
Headache			Denies	
MEDICATIONS				
Antibiotics	Text...			
11/03 19:08	Ampicillin IV 2 Gm			
Other Medications given	Text...			

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T...my
MR#:
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	19:08	19:14	19:15	
11/03 19:08	Procardia 30 mg XL given			
INTERVENTIONS				
Position Change	Text...			
11/03 19:08	HOB Lowered			
EDUCATION				
Annotation Comment	Text...			
11/03 19:08	toco adjusted			
LaborFlag			Labor	
Recorded by	PYV	PYV	PYV	

	11/03/04			
	19:16	19:19	19:21	
Stage of Pregnancy		Labor		
VITAL SIGNS				
NBP Sys/Dia	/	176/ 67	/	(mmHg)
Mean		113		
HR		94		
PAIN				
Pain Presence		Intermit		
Pain Type		Contract		
Pain Location		Abdomen		
Pain Related to Contractions		Yes		
MEDICATIONS				
Tocolytics		Text...		
11/03 19:19	Terbutaline 0.25mg Subcutaneous			
Steroids			Text...	
11/03 19:21	Celestone 12mg IM			
INTERVENTIONS				
IV			Text...	
11/03 19:21	IV bolus started			
EDUCATION				
Annotation Comment	Text...			
11/03 19:16	Dr Dennis talking topt about ned			
	for cerclage/surgery			
LaborFlag		Labor		
Recorded by	PYV	PYV	PYV	

	11/03/04			
	19:25	19:27	19:29	
VITAL SIGNS				
NBP Sys/Dia	/	157/ 64	/	(mmHg)
Mean		100		
HR		102		
INTERVENTIONS				
Position Change			Text...	
11/03 19:29	Trendelenburg			
I/O Interventions	Text...			
11/03 19:25	Foley cath inserted			
EDUCATION				

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T...my 001675
MR#:
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	19:25	19:27	19:29	
LaborFlag		Labor		
Recorded by	PYV		PYV	
	11/03/04			
	19:34	19:49	19:50	
Stage of Pregnancy			Labor	
VITAL SIGNS				
NBP Sys/Dia	169/ 53	190/ 65	167/ 64	(mmHg)
Mean	77	94	98	
HR	114	124	126	
Respirations			20	
Temp			98.4	(F)
Temp (C)			36.9	
Temp Route			Oral	
PAIN				
Pain Presence			Intermit	
Pain Type			Sharp	
Pain Location			Abdomen	
Pain Related to Contractions			Yes	
Pain Relief Measures			ComfMeas	
Pain Scale			8	
Pain Relief Measures Response			NoRelief	
INTERVENTIONS				
Position Change			Text...	
11/03 19:50	Squatting			
Position Change			Text...	
11/03 19:50	Trendelenburg			
EDUCATION				
Annotation Comment			Text...	
11/03 19:50	anesthesia in talking to pt			
Annotation Comment			Text...	
11/03 19:50	error in typing - pt not squatting			
LaborFlag	Labor	Labor	Labor	
Recorded by			PYV	
	11/03/04			
	20:00	20:04	20:16	
MEDICATIONS				
Antiemetics/Antacids	Text...			
11/03 20:00	Bicitra 30 ml PO, Reglan 10 mg IV, Pepcid mg @			
INTERVENTIONS				
IV		Text...		
11/03 20:04	New IV bag hung			
EDUCATION				
Annotation Comment		Text...	Text...	
11/03 20:04	IV fluids bolusing			
11/03 20:16	to OR via bed for rescue cerclage			
Recorded by	PYV	PYV	PYV	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#:
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	20:17	20:18	21:24	
Stage of Pregnancy		Labor	2+4	
VITAL SIGNS				
NBP Sys/Dia	/	170/ 63	146/ 60	(mmHg)
Mean		97	83	
HR		122	118	
Respirations		20	20	
SaO2			89	(%)
Temp	97.9	97.9		(F)
Temp (C)	36.6	36.6		
Temp Route		Oral		
PAIN				
Pain Presence		Intermit	None	
Pain Type		Contract	Contract	
Pain Location		Abdomen	Abdomen	
Pain Related to Contractions		Yes	Yes	
Pain Relief Measures		ComfMeas	ComfMeas	
Pain Scale		7		
Pain Relief Measures Response		NoRelief		
VAGINAL EXAM				
Membrane Status			Intact	
INTERVENTIONS				
Oxygen			O2_NC	
Oxygen Amount			2	
Oxygen Device			NCannula	
EDUCATION				
Annotation Comment	Text...			
11/03 20:17	returned to rooom from OR - PT A&O			
	x3, EFM connected CR monitor			
	applied. VS done			
LaborFlag	Labor	Labor	Labor	
Recorded by	PYV	PYV	PYV	

	11/03/04			
	21:29	21:34	21:39	
Stage of Pregnancy			2+4	
VITAL SIGNS				
NBP Sys/Dia	162/ 58	159/ 61	164/ 63	(mmHg)
Mean	90	93	94	
HR	116	114	114	
Respirations			20	
SaO2			94	(%)
Temp			97.9	(F)
Temp (C)			36.6	
Temp Route			Oral	
PAIN				
Pain Presence			Intermit	
Pain Type			Contract	
Pain Location			Abdomen	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	21:29	21:34	21:39	
Pain Related to Contractions			Yes	
Pain Relief Measures			ComfMeas	
Pain Scale			7	
VAGINAL EXAM				
Membrane Status			Intact	
MEDICATIONS				
MgSO4/Anti-Hypertensives			Mg_Bolus	
11/03 21:39	4 gm bolu started			
INTERVENTIONS				
IV			IV_Infus	
Oxygen			O2_NC	
Oxygen Amount			2	
Oxygen Device			NCannula	
Position Change			1+9	
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by			PYV	

	11/03/04			
	21:40	21:44	21:49	
VITAL SIGNS				
NBP Sys/Dia	/	160/ 61	160/ 59	(mmHg)
Mean		89	89	
HR		110	109	
Magnesium Sulfate Assessment				
Deep Tendon Reflex	2+			
Clonus	None			
Level of Consciousness	Awake			
Breath Sounds	Equ\Clr			
Headache	Denies			
Side Effects/Potential Toxic	None			
Magnesium Sulfate Level	Text...			
11/03 21:40	Mag SO4 started at 4 gm bolus			
EDUCATION				
LaborFlag		Labor	Labor	
Recorded by	PYV			

	11/03/04			
	22:01	22:10	22:11	
VITAL SIGNS				
NBP Sys/Dia	161/ 65	/	171/ 69	(mmHg)
Mean	90		105	
HR	107		110	
Magnesium Sulfate Assessment				
Deep Tendon Reflex		2+		
Clonus		None		
Level of Consciousness		Awake		
Breath Sounds		Equ\Clr		
Headache		Denies		

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	22:01	22:10	22:11	
Side Effects/Potential Toxic		None		
Magnesium Sulfate Level		Text...		
11/03 22:10	Mag SO4 now at 2 gm/hr			
EDUCATION				
LaborFlag	Labor		Labor	
Recorded by		PYV		

	11/03/04			
	22:25	22:36	22:51	
Stage of Pregnancy		2+4		
VITAL SIGNS				
NBP Sys/Dia	/	178/ 68	167/ 68	(mmHg)
Mean		108	106	
HR		107	107	
Respirations		20		
SaO2		93		(%)
PAIN				
Pain Presence		Intermit		
Pain Type		Contract		
Pain Location		Abdomen		
Pain Related to Contractions		Yes		
Pain Relief Measures		ComfMeas		
Pain Scale		7	/	
VAGINAL EXAM				
Membrane Status		Intact		
Magnesium Sulfate Assessment				
Magnesium Sulfate Level	Text...			
11/03 22:25	Mag SO4 increased to 3 gm/hr			
MEDICATIONS				
MgSO4/Anti-Hypertensives		MG_Gm/hr		
11/03 22:36	3 gm/hr			
INTERVENTIONS				
Oxygen		O2_NC		
Oxygen Amount		3		
Oxygen Device		NCannula		
EDUCATION				
LaborFlag		Labor	Labor	
Recorded by	PYV	PYV		

	11/03/04			
	22:55	23:21	23:29	
Stage of Pregnancy		2+4		
VITAL SIGNS				
NBP Sys/Dia	/	115/ 59	/	(mmHg)
Mean		76		
HR		105		
Respirations		18		
SaO2		95		(%)
PAIN				

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
[redacted]
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04			
	22:55	23:21	23:29	
Pain Presence		Intermit		
Pain Type		Contract		
Pain Location		Abdomen		
Pain Related to Contractions		Yes		
Pain Relief Measures		ComfMeas		
VAGINAL EXAM				
Membrane Status		Intact	Intact	
Magnesium Sulfate Assessment				
Magnesium Sulfate Level	Text...			
11/03 22:55	Mag SO4 increased to 3 1/2 gm/hr			
MEDICATIONS				
Antibiotics		Amp_IV1		
EDUCATION				
LaborFlag		Labor		
Recorded by	PYV	PYV	PYV	

	11/03/04	11/04/04		
	23:51	00:21	00:42	
Stage of Pregnancy	2+4	2+4		
VITAL SIGNS				
NBP Sys/Dia	117/ 62	113/ 52	/	(mmHg)
Mean	75	71		
HR	107	104	104	
Respirations	20	20		
SaO2	95	96	96	(%)
PAIN				
Pain Presence		Intermit		
Pain Type		Sharp		
Pain Location		Abdomen		
Pain Related to Contractions		Yes		
Pain Relief Measures		ComfMeas		
VAGINAL EXAM				
Membrane Status		Intact		
Fetal Presentation 'A'		Cephalic		
Magnesium Sulfate Assessment				
Deep Tendon Reflex		1+		
Clonus		None		
Level of Consciousness		Awake		
Breath Sounds		Equ\Clr		
Headache		Denies		
Side Effects/Potential Toxic		None		
MEDICATIONS				
MgSO4/Anti-Hypertensives		Mg_D/Ced		
Analgesics	Demerol			
	Phenergn			
INTERVENTIONS				
Oxygen		O2_NC		
Oxygen Amount		3		

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]nmy
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/03/04	11/04/04		
	23:51	00:21	00:42	
Oxygen Device		NCannula		
Position Change		Trendel		
I/O Interventions	Text...	IceChips		
11/03 23:51	Ice chips given			
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by	PYV	PYV		

	11/04/04			
	00:47	00:51	00:52	
VITAL SIGNS				
NBP Sys/Dia	/	153/ 58	/	(mmHg)
Mean		85		
HR	100	100	98	
SaO2	98		99	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	00:57	01:02	01:07	
VITAL SIGNS				
HR	99	104	100	
SaO2	98	98	99	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	01:12	01:17	01:21	
VITAL SIGNS				
NBP Sys/Dia	/	/	168/ 68	(mmHg)
Mean			91	
HR	97	99	101	
SaO2	98	98		(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	01:22	01:27	01:31	
VITAL SIGNS				
NBP Sys/Dia	/	/	168/ 68	(mmHg)
HR	102	102	108	
Respirations			20	
SaO2	99	100	96	(%)
Temp			96.9	(F)
Temp (C)			36.1	
PAIN				
Pain Presence			Text...	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR# [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/04/04			
	01:22	01:27	01:31	
11/04 01:31	Intermittent			
Pain Type			Text...	
11/04 01:31	Contraction			
Pain Location			Abdomen	
Pain Related to Contractions			Yes	
Pain Relief Measures			Text...	
11/04 01:31	Pain Medication given			
VAGINAL EXAM				
Membrane Status			Intact	
Magnesium Sulfate Assessment				
Deep Tendon Reflex			1+	
Clonus			None	
Level of Consciousness			Text...	
11/04 01:31	Awake, Alert, Oriented x 3			
Breath Sounds			Text...	
11/04 01:31	Equal & Clear			
Headache			Denies	
Side Effects/Potential Toxic			None	
MEDICATIONS				
Analgesics			Text...	
11/04 01:31	Demerol mg @ 25 mg			
Analgesics			Text...	
11/04 01:31	Demerol mg @ 25 mg, Phenergan mg @ 12.5 mg IVP			
INTERVENTIONS				
Position Change			Text...	
11/04 01:31	Trendelenburg			
I/O Interventions			Text...	
11/04 01:31	Ice chips given			
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by			PYV	

	11/04/04			
	01:32	01:33	01:37	
VITAL SIGNS				
HR	107	105	105	
SaO2	98	90	99	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	01:42	01:47	01:52	
VITAL SIGNS				
NBP Sys/Dia	/	/	92/ 45	(mmHg)
Mean			62	
HR	105	102	101	
HR			100	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

001682

Windham, T[illegible]amy
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/04/04			
	01:42	01:47	01:52	
SaO2	99	98	99	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	01:57	02:02	02:07	
VITAL SIGNS				
HR	100	99	102	
SaO2	97	97	97	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	02:12	02:17	02:19	
VITAL SIGNS				
HR	102	99	99	
SaO2	96	95	94	(%)
EDUCATION				
LaborFlag	Labor	Labor	Labor	
Recorded by				

	11/04/04			
	02:21	02:22	02:27	
Stage of Pregnancy			Antepart	
VITAL SIGNS				
NBP Sys/Dia	84/ 45	/	137/ 49	(mmHg)
Mean	54		82	
HR	98	99	104	
Respirations			20	
SaO2		96	98	(%)
Temp			96.8	(F)
Temp (C)			36.0	
Temp Route			Oral	
PAIN				
Pain Presence			Intermit	
Pain Type			Sharp	
Pain Location			Abdomen	
Pain Related to Contractions			Yes	
Pain Relief Measures			ComfMeas	
VAGINAL EXAM				
Membrane Status			Intact	
Magnesium Sulfate Assessment				
Deep Tendon Reflex			1+	
Clonus			None	
Level of Consciousness			Awake	
Breath Sounds			Equ\Clr	
Headache			Denies	
Side Effects/Potential Toxic			None	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

001683

Windham, T[redacted]my
MR# [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/04/04			
	02:21	02:22	02:27	
INTERVENTIONS				
Position Change			Rt_Lat	
11/04 02:27	trend			
I/O Interventions			IceChips	
EDUCATION				
LaborFlag	Labor	Labor		
Recorded by			PYV	

	11/04/04			
	03:31	05:00	05:49	
Stage of Pregnancy		Antepart		
VITAL SIGNS				
NBP Sys/Dia	125/ 46	125/ 48	/	(mmHg)
Mean	68	70		
HR	100	98		
Respirations	18	18		
SaO2	room air			(%)
Temp		96.9		(F)
Temp (C)		36.1		
PAIN				
Pain Location			Back	
Pain Relief Measures			Text...	
11/04 05:49	Pain Medication given			
Pain Scale			7	
Pain Assessment Comments	Text...			
11/04 03:31	pt sleeping			
VAGINAL EXAM				
Membrane Status	Intact	Intact		
Magnesium Sulfate Assessment				
Deep Tendon Reflex	1+	1+		
Clonus	None	None		
Level of Consciousness		Text...		
11/04 05:00	Awake, Alert, Oriented x 3			
Breath Sounds	Text...	Text...		
11/04 03:31	Equal & Clear			
11/04 05:00	Equal & Clear			
Headache	Denies	Denies		
Side Effects/Potential Toxic	None	None		
MEDICATIONS				
Analgesics			Text...	
11/04 05:49	Demerol mg @ 25 mg			
Antibiotics	Text...			
11/04 03:31	Ampicillin IV 1 Gm			
Other Medications given	Text...		Text...	
11/04 03:31	new bag of Mag SO4 up to run at 3			
	1/2 gm/hr			
11/04 05:49	Phenergan 12.5 mg ivp			
INTERVENTIONS				

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
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Windham, T[illegible]my
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/04/04			
	03:31	05:00	05:49	
Position Change	Text...	Text...		
11/04 03:31	Trendelenburg			
11/04 05:00	Trendelenburg			
Position Change		Text...		
11/04 05:00	Left Lateral			
I/O Interventions		Text...		
11/04 05:00	Clear liquids given			
Recorded by	PYV	PYV	PYV	

	11/04/04			
	06:31	07:31	07:53	
VITAL SIGNS				
NBP Sys/Dia	77/ 44	114/ 47	/	(mmHg)
Mean	54	67		
HR	97	88		
Respirations	18			
PAIN				
Pain Presence			None	
Pain Location	Back			
Pain Scale	1		0	
Pain Goal			3	
Pain Relief Measures Response	Adequate			
VAGINAL EXAM				
Membrane Status	Intact			
Magnesium Sulfate Assessment				
Deep Tendon Reflex	1+	1+		
Clonus	None	None		
Level of Consciousness	Text...	Awake		
11/04 06:31	Awake, Alert, Oriented x 3			
Breath Sounds	Text...	Equ\Clr		
11/04 06:31	Equal & Clear			
Headache	Denies	Denies		
Side Effects/Potential Toxic	None	ExThirst		
INTERVENTIONS				
Position Change	Text...			
11/04 06:31	Left Lateral			
Position Change	Text...			
11/04 06:31	Trendelenburg			
EDUCATION				
Annotation Comment	Text...			
11/04 06:31	no vaginal bleeding			
Recorded by	PYV	KAJ	KAJ	

	11/04/04			
	07:54	07:55	07:58	
Stage of Pregnancy			Text...	
11/04 07:58	Antepartum			
Magnesium Sulfate Assessment				
Level of Consciousness			Awake	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

LD- Flowsheet

	11/04/04		
	07:54	07:55	07:58
MEDICATIONS			
Antibiotics		Text...	
11/04 07:55	Ampicillin IV 1 Gm		
INTERVENTIONS			
Position Change	Text...		
11/04 07:54	Trendelenburg		
Recorded by	KAJ	KAJ	KAJ

	11/04/04		
	08:06	08:08	08:17
MEDICATIONS			
MgSO4/Anti-Hypertensives	Text...		
11/04 08:06	Magnesium Sulfate IV Gm/hr @ 3		
INTERVENTIONS			
Hygiene			Text...
11/04 08:17	Peri Care		
EDUCATION			
Annotation Comment	Text...	Text...	
11/04 08:06	Dr Dennis into see pt,orders		
	recieved		
11/04 08:08	discuss transfer with pt she agrees		
	to transfer		
Recorded by	KAJ	KAJ	KAJ

	11/04/04		
	08:21	08:53	09:11
PAIN			
Pain Scale			0
VAGINAL EXAM			
Dilatation	closed		(cms)
Effacement	50		(%)
Station	-2		
Exam by	Dr Dennis		
EDUCATION			
Annotation Comment		Text...	
11/04 08:53	BC and Mg level drawn		
Recorded by	KAJ	KAJ	KAJ

	11/04/04		
	09:19	09:20	09:35
EDUCATION			
Annotation Comment	Text...	Text...	Text...
11/04 09:19	prenatal labs dawn		
11/04 09:20	CBC results called to Dr Dennis		
11/04 09:35	EFm/toco monitor off, EMS here for		
	transfer, Richland Memorial called		
	report		
Annotation Comment			Text...
11/04 09:35	MG level 6.5		
Recorded by	KAJ	KAJ	KAJ

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]amy
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/03/04				
	19:14	19:15	19:19	19:27	
Stage of Pregnancy		Labor	Labor		
UTERINE ACTIVITY					
Monitor Mode - UA	External		External		
Contraction Frequency	3min		3min		(min)
Contraction Duration	50 sec		60_sec		(sec)
Contraction Quality	Moderate		Moderate		
Resting Tone Toco	Relaxed		Relaxed		(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A	External		External		
FHR Baseline Range	160		150		
FHR Baseline Changes			NoChange		
LTV			Decrease		
Accelerations			Absent		
Decelerations			None		
LaborFlag		Labor	Labor	Labor	
Recorded by	PYV	PYV	PYV		

	11/03/04				
	19:34	19:49	19:50	20:16	
Stage of Pregnancy			Labor		
UTERINE ACTIVITY					
Monitor Mode - UA				External	
Contraction Frequency			occassional	irregular	(min)
Contraction Duration				50_sec	(sec)
FETAL ASSESSMENT					
Monitor Mode - Fetus A			External	External	
FHR Baseline Range			150	150	
FHR Baseline Changes			Text...		
11/03 19:50	No Baseline Changes				
LTV			Text...	Text...	
11/03 19:50	Decreased 0 - 5 bpm				
11/03 20:16	Decreased 0 - 5 bpm				
Accelerations			Absent	Absent	
Decelerations				None	
LaborFlag	Labor	Labor	Labor		
Recorded by			PYV	PYV	

	11/03/04				
	20:17	20:18	21:24	21:29	
Stage of Pregnancy		Labor	2+4		
UTERINE ACTIVITY					
Monitor Mode - UA			External		
Contraction Frequency			2min		(min)
Contraction Duration			50_sec		(sec)
Contraction Quality			Moderate		
Resting Tone Toco			Relaxed		(mmHg)
FETAL ASSESSMENT					

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[redacted]my 001687
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/03/04				
	20:17	20:18	21:24	21:29	
Monitor Mode - Fetus A			External		
FHR Baseline Range			150		
FHR Baseline Changes			NoChange		
LTV			Decrease		
Accelerations			Absent		
Decelerations			Variable		
11/03 21:24	occas mild variable decels for 10-15 sec				
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by		PYV	PYV		

	11/03/04				
	21:34	21:39	21:44	21:49	
Stage of Pregnancy		2+4			
UTERINE ACTIVITY					
Monitor Mode - UA		External			
Contraction Frequency		2min			(min)
Contraction Duration		60_sec			(sec)
Contraction Quality		Moderate			
Resting Tone Toco		Relaxed			(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A		External			
FHR Baseline Range		150			
FHR Baseline Changes		NoChange			
LTV		Decrease			
Accelerations		Absent			
Decelerations		Variable			
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by		PYV			

	11/03/04				
	22:01	22:11	22:36	22:51	
Stage of Pregnancy			2+4		
UTERINE ACTIVITY					
Monitor Mode - UA			External		
Contraction Frequency			Irrit		(min)
Contraction Duration			20_sec		(sec)
Contraction Quality			Mild		
FETAL ASSESSMENT					
Monitor Mode - Fetus A			External		
FHR Baseline Range			150		
FHR Baseline Changes			NoChange		
STV			N/A		
LTV			Decrease		
Accelerations			Absent		
Decelerations			Variable		
LaborFlag	Labor	Labor	Labor	Labor	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR# [redacted]
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/03/04				
	22:01	22:11	22:36	22:51	
Recorded by			PYV		
	11/03/04		11/04/04		
	23:21	23:51	00:21	00:42	
Stage of Pregnancy	2+4	2+4	2+4		
UTERINE ACTIVITY					
Monitor Mode - UA	External		External		
Contraction Frequency	Irrit		occas		(min)
Contraction Duration	20_sec		20_sec		(sec)
Contraction Quality	Mild		Mild		
Contraction Intensity			Text...		(mmHg)
11/04 00:21	pt having about 2-3 con/ her - pt stated they				
	do not feel as bad as before - pt able to				
	sleep.				
Resting Tone Toco	Relaxed		Relaxed		(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A	External		External		
FHR Baseline Range	150		150		
FHR Baseline Changes	NoChange		NoChange		
LTV	Decrease		Decrease		
Accelerations	Absent		Absent		
Decelerations	Variable		Variable		
FETAL ASSESSMENT B					
Comments	Text...				
11/03 23:21	pt on left lat/trend and sleeping. will				
	observe				
	pain meds were given at 2305				
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by	PYV	PYV	PYV		
	11/04/04				
	00:47	00:51	00:52	00:57	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by					
	11/04/04				
	01:02	01:07	01:12	01:17	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by					
	11/04/04				
	01:21	01:22	01:27	01:31	
UTERINE ACTIVITY					
Monitor Mode - UA					
Contraction Frequency				External	
Contraction Duration				irregular	(min)
Contraction Quality				20 sec	(sec)
				Mild	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
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Windham, T[illegible]my
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/04/04				
	01:21	01:22	01:27	01:31	
Resting Tone Toco				Relaxed	(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A				External	
FHR Baseline Range				150	
FHR Baseline Changes				Text...	
11/04 01:31	No Baseline Changes				
LTV				Text...	
11/04 01:31	Decreased 0 - 5 bpm				
Accelerations				Absent	
Decelerations				Variable	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by				PYV	

	11/04/04				
	01:32	01:33	01:37	01:42	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by					

	11/04/04				
	01:47	01:52	01:57	02:02	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by					

	11/04/04				
	02:07	02:12	02:17	02:19	
LaborFlag	Labor	Labor	Labor	Labor	
Recorded by					

	11/04/04				
	02:21	02:22	02:27	03:31	
Stage of Pregnancy			Antepart		
UTERINE ACTIVITY					
Monitor Mode - UA			External	External	
Contraction Frequency			irreg	Text...	(min)
11/04 02:27	about 3-4/hr - for 20 sec				
11/04 03:31	Irritability				
Contraction Duration			20_sec	10 sec	(sec)
Contraction Quality			Mild	Mild	
Resting Tone Toco			Relaxed	Relaxed	(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A			External	External	
FHR Baseline Range			150	150	
FHR Baseline Changes			NoChange		
LTV			Decrease	Text...	
11/04 03:31	Decreased 0 - 5 bpm				
Accelerations			Absent	Absent	

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
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001690

Windham, T[illegible]my
MR# [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/04/04			
	02:21	02:22	02:27	03:31
Decelerations			Variable	Variable
LaborFlag	Labor	Labor		
Recorded by			PYV	PYV

	11/04/04				
	05:00	06:31	07:28	07:54	
Stage of Pregnancy	Antepart				
UTERINE ACTIVITY					
Monitor Mode - UA	External	External	External	External	
Contraction Frequency	Text...	Text...	None	None	(min)
11/04 05:00	Irritability, occassional				
11/04 06:31	Irritability				
Contraction Duration	10 sec	10 sec			(sec)
Contraction Quality	Mild	Mild			
Resting Tone Toco	Relaxed	Relaxed			(mmHg)
FETAL ASSESSMENT					
Monitor Mode - Fetus A	External	External	External	External	
FHR Baseline Range	150	150	140+145	135+140	
FHR Baseline Changes	Text...				
11/04 05:00	No Baseline Changes				
LTV	Text...	Text...	Text...	Text...	
11/04 05:00	Average 6-25 bpm				
11/04 06:31	Decreased 0 - 5 bpm				
11/04 07:28	Average 6-25 bpm				
11/04 07:54	Average 6-25 bpm				
Accelerations	Absent	Absent		10x10	
Decelerations	None	None	None	Variable	
Recorded by	PYV	PYV	KAJ	KAJ	

	11/04/04			
	08:20	08:36	08:39	09:07
UTERINE ACTIVITY				
Monitor Mode - UA	External		External	External
Contraction Frequency	None		None	None
FETAL ASSESSMENT				
Monitor Mode - Fetus A	External	External		
FHR Baseline Range		140+145		140+145
LTV	Text...	Text...		
11/04 08:20	Average 6-25 bpm			
11/04 08:36	Average 6-25 bpm			
Accelerations	10x10	10x10		
Decelerations	Variable	None		
Recorded by	KAJ	KAJ	KAJ	KAJ

	11/04/04			
	09:19			
UTERINE ACTIVITY				
Monitor Mode - UA	External			
Contraction Frequency	None			

(min)

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

Contraction/FHR Flowsheet

	11/04/04			
	09:19			
FETAL ASSESSMENT				
FHR Baseline Range	140+145			
Recorded by	KAJ			

PAGE: 1

MEDICATION ADMINISTRATION RECORD

12315167 WINDHAM,TAMMY ELIZABETH LD LD 3 1
MEDICAL RECORD #: 229998
AGE: 37 SEX: F WT: BSA:
ADMITTED: 11/03/04 PHYSICIAN: DENNIS,RONNIE W
NOTES:

PRIMARY DX: PRETERM LABOR
ADM COMMENT:
MAR DATE: 11/04/04-0001 - 11/05/04-0000
RUN DATE/TIME: 11/03/04-2100
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	******* SCHEDULED MEDICATIONS *******				
02294226	NIFEdipine XL 30 MG TAB (30 MG) (ADALAT CC)	11/03/04 12/03/04		0900	
	DOSE: 30 MG PO DAILY SCH COMMENTS: THERAPEUTIC SUBSTITUTION FOR PROCARDIA XL 30 MG DO NOT CRUSH ** AVOID GRAPEFRUIT JUICE **				
	******* IV MEDICATIONS *******				
02294228	AMPICILLIN 1 G VIAL (1 G) (AMPICIL) IN: NACL 0.9% 50 ML BAG (50 ML) (NORMAL SALINE)	11/03/04 11/10/04	0001 0400 0800	1200 1600	2000
	RATE: 100 MLS/HR DUR: 0 FREQ: Q4H-8 COMMENTS: STABLE 48 HOURS REFRIGERATED				

TUBING CHANGE INITIALS_____TIME_____

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

12315167 - WINDHAM,TAMMY ELIZABETH
LD LD 3-1 (U:229998)

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T[illegible]ney Healthca[illegible]System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/3/2004 19:01
Printed by: Pamela W. Flagler, RN

001693

windham, t[illegible]my
M[redacted]
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending:

OB Triage

Julia Johnson

	11/03/04		
	17:15	17:18	
Stage of Pregnancy	Triage		
Pregnancy Info			
Gravida	7		
Para	1		
LMP	05/01/04		
EDC	02/18/04		
EDC per U/S	02/18/04		
VITAL SIGNS			
NBP Sys/Dia/Mean	178/ 76/	178/ 76/115	(mmHg)
HR	100	100	
Respirations	20		
Temperature	98.7		(F)
Temp Route	Oral		
ARRIVAL INFORMATION			
Attending	Text...		
11/03 17:15			
Time of Arrival	11/03/04 05:20 EST		
Arrived Via	Wheelcha		
Arrived From	Home		
Primary Care Nurse	Pam FlaglerR.N		
COMPLAINT			
Complaint	Text...		
11/03 17:15	patient states she has been having some		
	bleeding.		
SUBJ. ASSESS. (ALL PTS)			
Contractions	Denies		
Contraction Frequency	Text...		
11/03 17:15			
ROM	Denies		
Bleeding	Text...		
11/03 17:15	very light pink tinged fluid noted on gloves		
	after cervical exam		
Bleeding Amount	Text...		
11/03 17:15	Patient states " heavy as a menstral		
	periodabout 40 minutes ago before I came		
	here."		
SUBJ. ASSESS.(R/O PREECLAMPSIA)			
Swelling/Edema	Denies		
Headache	Denies		
Visual Disturbances	Denies		
Epigastric Pain	Denies		
Nausea/Vomiting	Denies		
PAIN ASSESSMENT			
Pain Presence	None		
SUBJ. ASSESS. (PTL)			
Urinary Urgency and Frequency	Denies		
Dysuria	Denies		

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Ti ney Healthca System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/3/2004 19:01
Printed by: Pamela W. Flagler, RN

windham, t .my
[redacted]
DOB :
Age
Unit: L D
Bed: L D 3-1
Attending:

OB Triage

	11/03/04		
	17:15	17:18	
Recent Sexual Intercourse	Denies		
Vaginal Discharge	Denies		
SUBJ. ASSESS. (ACCIDENT)			
Type of Accident	None		
OBJECTIVE ASSESSMENT			
Uterus	Soft		
	Nontende		
Edema	None		
Patient Status	Anxious		
Pain Type	None		
Complaints	No C/O		
Respiratory Rhythm	Regular		
Respiratory Effort	Unlabor		
	Even		
Breath Sounds-Left	Clear/Eq		
Breath Sounds-Right	Clear/Eq		
Skin Temperature	Warm		
	Dry		
UTERINE ACTIVITY			
Monitor Mode	External		
Contraction Frequency	none		(min)
FETAL ASSESSMENT A			
Monitor Mode	External		
FHR Baseline Range	135-145		(bpm)
FHR Baseline Changes	None		
Decelerations	None		
PROVIDER NOTIFICATION			
Time Provider Paged	11/03/04 17:30 EST		
Orders Received	Yes		
CERVICAL EXAM			
Dilatation	3-4		(cms)
Effacement	90		(%)
Exam By	P. Flagler, RN		
INTERVENTIONS			
RN Procedures	Consents		
Other Interventions	OB ultrasound ordered		
.....			
OB Triage Flag	Triage	Triage	
	AHD		
	PWF		
Recorded By	AHD		
	PWF		

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

001695

Windham, T[redacted]my
[redacted]
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 17:15
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
Annotations
03 NOV 2004
11/03/04 17:17
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 17:18
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 178/76 M 115 P 100
11/03/04 17:20
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 17:59
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
IV Started, IV bolus given cc @ 500, Labs drawn with IV start, Comments: IV x 1 attempt 11/03/04 18:01 - Patti S. Hatchell, RN
11/03/04 18:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Stage of Preg.: Labor, Preterm, Labor Curve: Started 11/03/04 19:35 - Margaret A. Vitiello, RN
11/03/04 18:34
PROGRESS NOTES
Nursing

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB: Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 18:34
Provider Note
Chalkboard Note
Annotations
Comments: bedside OB Complete being performed at this time. Pt will be placed back
on monitor after US 11/03/04 18:36 - Patti S. Hatchell, RN
11/03/04 18:47
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: pt back on monitor; bedside US complete. 11/03/04 18:48 - Patti S.
Hatchell, RN
11/03/04 19:08
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
HOB Lowered, Comments: toco adjusted, Ampicillin IV 2 Gm, Other Medication given:
Procardia 30 mg XL given 11/03/04 19:36 - Margaret A. Vitiello, RN
11/03/04 19:14
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Mon Mode A: External, Baseline Range 'A': 160, Monitor Mode: External, Cont Qual:
Moderate, Rest Tone Toco: Relaxed, Contraction Freq: 3min, Contraction Duration: 50
sec, Dilatation: 6 cms, VE Done by: Dr. Dennis 11/03/04 19:37 - Margaret A.
Vitiello, RN
11/03/04 19:15
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 182/91 M 125 P 104
11/03/04 19:16
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: Dr Dennis talking topt about ned for cerclage/surgery 11/03/04 19:38 -
Margaret A. Vitiello, RN
11/03/04 19:18
PROGRESS NOTES

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T...my
MR#: [redacted]
DOB: Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 19:18
Nursing
Provider Note
Chalkboard Note
Annotations
BP ---/--- M --- P ---
11/03/04 19:19
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 176/67 M 113 P 94
Annotations
Terbutaline 0.25mg Subcutaneous 11/03/04 19:39 - Margaret A. Vitiello, RN
11/03/04 19:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
IV bolus started, Celestone 12mg IM 11/03/04 19:39 - Margaret A. Vitiello, RN
11/03/04 19:25
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Foley cath inserted 11/03/04 19:40 - Margaret A. Vitiello, RN
11/03/04 19:27
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 157/64 M 100 P 102
11/03/04 19:29
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Trendelenburg 11/03/04 19:41 - Margaret A. Vitiello, RN
11/03/04 19:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 19:31
UA REF
11/03/04 19:32
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 19:34
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 169/53 M 77 P 114
11/03/04 19:49
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 190/65 M 94 P 124
11/03/04 19:50
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 167/64 M 98 P 126
Annotations
BP ---/--- M --- P ---
Annotations
Squatting, Comments: anesthesia in talking to pt, Mon Mode A: External, Baseline A:
No Baseline Changes, LTV A: Decreased 0 - 5 bpm, Accels A: Absent, Baseline Range
'A': 150, Contraction Freq: occassional 11/03/04 23:37 - Margaret A. Vitiello, RN
Annotations
Trendelenburg 11/03/04 23:38 - Margaret A. Vitiello, RN
Annotations
Comments: error in typing - pt not squatting 11/03/04 23:38 - Margaret A. Vitiello,
RN
11/03/04 20:00
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Bicitra 30 ml PO, Reglan 10 mg IV, Pepcid mg @ 11/03/04 23:36 - Margaret A.
Vitiello, RN

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 20:04
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
New IV bag hung, Comments: IV fluids bolusing 11/03/04 23:39 - Margaret A. Vitiello, RN
11/03/04 20:16
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: to OR via bed for rescue cerclage, Mon Mode A: External, LTV A: Decreased 0 - 5 bpm, Accels A: Absent, Decels A: None, Baseline Range 'A': 150, Monitor Mode: External, Contraction Freq: irregular 11/03/04 23:40 - Margaret A. Vitiello, RN
11/03/04 20:17
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Temp: 97.9, Comments: returned to rooom from OR - PT A&O x3, EFM connected CR monitor applied. VS done 11/03/04 23:41 - Margaret A. Vitiello, RN
11/03/04 20:18
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 170/63 M 97 P 122
11/03/04 20:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 20:22
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 21:23
PROGRESS NOTES
Nursing

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T...nmy
MR# [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 21:23
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 21:24
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
Annotations
BP 146/60 M 83 P 118
11/03/04 21:25
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/03/04 21:29
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 162/58 M 90 P 116
11/03/04 21:34
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 159/61 M 93 P 114
11/03/04 21:39
PROGRESS NOTES
Nursing
Margaret A. Vitiello, RN
orders received - Mag So4 started at 4 gm bolus then to run at 2 gm/hr. pt counselled on action of Mag SO4 and verbalized understanding.
Provider Note
Chalkboard Note
Annotations
BP 164/63 M 94 P 114
11/03/04 21:44
PROGRESS NOTES
Nursing
Provider Note

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 21:44
Chalkboard Note
Annotations
BP 160/61 M 89 P 110
11/03/04 21:49
PROGRESS NOTES
Nursing
Margaret A. Vitiello, RN
talked with Dr. Dennis on phone and informed him of pt's con status and pain with con.
orders received.MAG SO4 incereased to 2 1/2 gm/hr.
Provider Note
Chalkboard Note
Annotations
BP 160/59 M 89 P 109
11/03/04 22:01
PROGRESS NOTES
Nursing
Margaret A. Vitiello, RN
blood drawn and to lab.
U/A had been sent down from OR.
Provider Note
Chalkboard Note
Annotations
BP 161/65 M 90 P 107
11/03/04 22:11
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 171/69 M 105 P 110
11/03/04 22:25
PROGRESS NOTES
Nursing
Margaret A. Vitiello, RN
called Dr. DEnnis and informed him of pt's con pattern and pain with con. orders recieve.d Mag SO4 increased to 3 gm/hr.
Provider Note
Chalkboard Note
Annotations
11/03/04 22:36
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 178/68 M 108 P 107

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/03/04 22:51
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 167/68 M 106 P 107
11/03/04 22:55
PROGRESS NOTES
Nursing
Margaret A. Vitiello, RN
Dr. Dennis called and inquired about pt - orders recieved.
Mag SO4 increased to 3 1/2 gm/hr
pt medicated with Dem /Phen IVPas ordered.
Provider Note
Chalkboard Note
Annotations
11/03/04 23:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 115/59 M 76 P 105
11/03/04 23:28
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Margaret A. Vitiello, RN
EDC 2/18/05 - cerclage placed
Annotations
11/03/04 23:51
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 117/62 M 75 P 107
Annotations
Ice chips given 11/04/04 01:51 - Margaret A. Vitiello, RN
11/04/04 00:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 113/52 M 71 P 104

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T. Amy
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 00:42
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 96% P 104
11/04/04 00:47
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 100
11/04/04 00:51
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 153/58 M 85 P 100
11/04/04 00:52
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 99% P 98
11/04/04 00:53
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 00:57
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 99
11/04/04 01:02
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 104

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB : Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 01:07
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 99% P 100
11/04/04 01:12
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 97
11/04/04 01:17
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 99
11/04/04 01:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 168/68 M 91 P 101
11/04/04 01:22
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 99% P 102
11/04/04 01:25
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 01:26
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF

289

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[redacted]amy
MR#: [redacted]
DOB: [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 01:27
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 100% P 102
Annotations
UA REF
11/04/04 01:28
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 01:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
Annotations
Trendelenburg, Ice chips given, Temp: 96.9, Pulse: 108, Resp: 20, SaO2: 96, Pain
Present: Intermittent, Pain Type: Contraction, Pain Loc: Abdomen, Pain Relief: Pain
Medication given, Pain r/t Cx: Yes, BP Systolic: 11/04/04 01:34 - Margaret A.
Vitiello, RN
Annotations
Mon Mode A: External, Baseline A: No Baseline Changes, LTV A: Decreased 0 - 5 bpm,
Accels A: Absent, Decels A: Variable, Baseline Range 'A': 150, Monitor Mode:
External, Cont Qual: Mild, Contraction Freq: irregula 11/04/04 01:35 - Margaret A.
Vitiello, RN
Annotations
Cont Qual: Mild, Rest Tone Toco: Relaxed, Reflexes: 1+, Clonus: None, LOC: Awake,
Alert, Oriented x 3, Breath Sounds: Equal & Clear, Headache: Denies, Side
Effects/Potential Toxicity: None, ROM Status: Intact, Dem 11/04/04 01:36 - Margaret
A. Vitiello, RN
Annotations
Demerol mg @ 25 mg, Phenergan mg @ 12.5 mg IVP 11/04/04 01:37 - Margaret A.
Vitiello, RN
11/04/04 01:32
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 107
11/04/04 01:33
PROGRESS NOTES

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 01:33
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 90% P 105
11/04/04 01:37
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 99% P 105
11/04/04 01:42
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 99% P 105
11/04/04 01:47
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 98% P 102
11/04/04 01:52
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 92/45 M 62 P 101
Annotations
SpO2 99% P 100
11/04/04 01:57
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 97% P 100
11/04/04 02:02
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 02:02
SpO2 97% P 99
11/04/04 02:07
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 97% P 102
11/04/04 02:12
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 96% P 102
11/04/04 02:17
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 95% P 99
11/04/04 02:19
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 94% P 99
11/04/04 02:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 84/45 M 54 P 98
11/04/04 02:22
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
SpO2 96% P 99
11/04/04 02:27
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 02:27
Annotations
BP 137/49 M 82 P 104
11/04/04 03:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 125/46 M 68 P 100
Annotations
Trendelenburg, Pain Comments: pt sleeping, Mon Mode A: External, LTV A: Decreased 0
- 5 bpm, Accels A: Absent, Decels A: Variable, Baseline Range 'A': 150, Monitor
Mode: External, Contraction Freq: Irritability 11/04/04 03:42 - Margaret A.
Vitiello, RN
Annotations
Cont Qual: Mild, Rest Tone Toco: Relaxed, Contraction Duration: 10 sec, Reflexes:
1+, Clonus: None, Breath Sounds: Equal & Clear, Headache: Denies, Side
Effects/Potential Toxicity: None 11/04/04 03:43 - Margaret A. Vitiello, RN
Annotations
Resp: 18, SaO2: room air, ROM Status: Intact, Ampicillin IV 1 Gm, Other Medication
given: new bag of Mag SO4 up to run at 3 1/2 gm/hr 11/04/04 03:44 - Margaret A.
Vitiello, RN
11/04/04 04:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 125/48 M 70 P 98
11/04/04 05:00
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Trendelenburg, Clear liquids given, Temp: 96.9, Resp: 18, Mon Mode A: External,
Baseline A: No Baseline Changes, LTV A: Average 6-25 bpm, Accels A: Absent, Decels
A: None, Baseline Range 'A': 150 11/04/04 05:24 - Margaret A. Vitiello, RN
Annotations
Left Lateral, Monitor Mode: External, Cont Qual: Mild, Rest Tone Toco: Relaxed,
Contraction Freq: Irritability, occassional, Contraction Duration: 10 sec, Reflexes:
1+, Clonus: None 11/04/04 05:24 - Margaret A. Vitiello, RN
Annotations
LOC: Awake, Alert, Oriented x 3, Breath Sounds: Equal & Clear, Headache: Denies,
Side Effects/Potential Toxicity: None, ROM Status: Intact 11/04/04 05:25 - Margaret
A. Vitiello, RN
11/04/04 05:32
PROGRESS NOTES
Nursing

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB: [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 05:32
Provider Note
Chalkboard Note
Annotations
BP 102/49 M 63 P 96
11/04/04 05:49
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Pain Scale: 7, Pain Loc: Back, Pain Relief: Pain Medication given, Demerol mg @ 25
mg, Other Medication given: Phenergan 12.5 mg ivp 11/04/04 05:51 - Margaret A.
Vitiello, RN
11/04/04 06:31
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 77/44 M 54 P 97
Annotations
Left Lateral, Resp: 18, Pain Scale: 1, Pain Loc: Back, Response to relief: Adequate,
Mon Mode A: External, LTV A: Decreased 0 - 5 bpm, Accels A: Absent, Decels A: None,
Baseline Range 'A': 150 11/04/04 06:36 - Margaret A. Vitiello, RN
Annotations
Trendelenburg, Monitor Mode: External, Cont Qual: Mild, Rest Tone Toco: Relaxed,
Contraction Freq: Irritability, Contraction Duration: 10 sec, Reflexes: 1+, Clonus:
None, Breath Sounds: Equal & Clear, Headache: De 11/04/04 06:37 - Margaret A.
Vitiello, RN
Annotations
Comments: no vaginal bleeding, Clonus: None, LOC: Awake, Alert, Oriented x 3,
Headache: Denies, Side Effects/Potential Toxicity: None, ROM Status: Intact 11/04/04
06:37 - Margaret A. Vitiello, RN
11/04/04 06:38
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 07:07
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, Tammy
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 07:10
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 120/51 M 68 P 92
11/04/04 07:28
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Mon Mode A: External, LTV A: Average 6-25 bpm, Decels A: None, Baseline Range 'A': 140+145, Monitor Mode: External, Contraction Freq: None 11/04/04 07:31 - Kimberly A. Jenkins, RN
11/04/04 07:31
PROGRESS NOTES
Nursing
Kimberly A. Jenkins, RN
pt restinginbed onher left side intrendelenburg position, foley patent, eptied for 400 c clear yellowurine, MGS4 infusing a 3.5 grams per hour
see MGS4 flwo sheet, ptdenies any back pain or stomach cramps
Provider Note
Chalkboard Note
Annotations
BP 114/47 M 67 P 88
11/04/04 07:53
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Pain Scale: 0, Pain Goal: 3, Pain Present: None 11/04/04 07:57 - Kimberly A. Jenkins, RN
11/04/04 07:54
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Mon Mode A: External, LTV A: Average 6-25 bpm, Accels A: 10x10, Decels A: Variable, Baseline Range 'A': 135+140, Monitor Mode: External, Contraction Freq: None 11/04/04 07:57 - Kimberly A. Jenkins, RN
Annotations
Trendelenburg 11/04/04 07:57 - Kimberly A. Jenkins, RN
11/04/04 07:55
PROGRESS NOTES
Nursing
Provider Note

295

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 07:55
Chalkboard Note
Annotations
Ampicillin IV 1 Gm 11/04/04 07:57 - Kimberly A. Jenkins, RN
11/04/04 07:57
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 120/52 M 67 P 90
11/04/04 07:58
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Stage of Preg.: Antepartum, Preterm 11/04/04 08:00 - Kimberly A. Jenkins, RN
11/04/04 08:06
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: Dr Dennis into see pt,orders recieved 11/04/04 08:09 - Kimberly A. Jenkins, RN
Annotations
Magnesium Sulfate IV Gm/hr @ 3 11/04/04 08:09 - Kimberly A. Jenkins, RN
11/04/04 08:08
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: discuss transfer with pt she agrees to transfer 11/04/04 08:10 - Kimberly A. Jenkins, RN
11/04/04 08:17
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Peri Care 11/04/04 09:55 - Kimberly A. Jenkins, RN
11/04/04 08:20
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[illegible]my
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 08:20
Mon Mode A: External, LTV A: Average 6-25 bpm, Accels A: 10x10, Decels A: Variable,
Monitor Mode: External, Contraction Freq: None 11/04/04 09:55 - Kimberly A. Jenkins,
RN
11/04/04 08:21
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Dilatation: closed, Effacement: 50, Station: -2, VE Done by: Dr Dennis 11/04/04
08:22 - Kimberly A. Jenkins, RN
11/04/04 08:23
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 08:25
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
UA REF
11/04/04 08:27
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 109/65 M 77 P 90
11/04/04 08:36
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Mon Mode A: External, LTV A: Average 6-25 bpm, Accels A: 10x10, Decels A: None,
Baseline Range 'A': 140+145 11/04/04 09:54 - Kimberly A. Jenkins, RN
11/04/04 08:39
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Monitor Mode: External, Contraction Freq: None 11/04/04 09:54 - Kimberly A. Jenkins,
RN

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Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T... ...my
MR#: [redacted]
DOB : [redacted] Age
Unit: L D Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 08:53
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: BC and Mg level drawn 11/04/04 09:54 - Kimberly A. Jenkins, RN
11/04/04 08:57
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 117/59 M 78 P 93
11/04/04 09:07
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Baseline Range 'A': 140+145, Monitor Mode: External, Contraction Freq: None 11/04/04 09:53 - Kimberly A. Jenkins, RN
11/04/04 09:11
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Pain Scale: 0 11/04/04 09:53 - Kimberly A. Jenkins, RN
11/04/04 09:19
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: prenatal labs dawn 11/04/04 09:21 - Kimberly A. Jenkins, RN
Annotations
Baseline Range 'A': 140+145 11/04/04 09:21 - Kimberly A. Jenkins, RN
Annotations
Monitor Mode: External, Contraction Freq: None 11/04/04 09:22 - Kimberly A. Jenkins, RN
11/04/04 09:20
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: CBC results called to Dr Dennis 11/04/04 09:22 - Kimberly A. Jenkins, RN

Tuomey Healthcare System
129 N. Washington Street
Sumter, SC 29150

Print Date & Time: 11/4/2004 09:55
Printed by: Kimberly A. Jenkins, RN

Windham, T[redacted]my
[redacted]
Age
Unit: L D
Bed: L D 3-1
Attending: Dr. Dennis

OB- Progress Notes

11/04/04 09:27
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
BP 119/60 M 82 P 96
11/04/04 09:35
PROGRESS NOTES
Nursing
Provider Note
Chalkboard Note
Annotations
Comments: EFm/toco monitor off, EMS here for transfer, Richland Memorial called
report 11/04/04 09:37 - Kimberly A. Jenkins, RN
Annotations
Comments: MG level 6.5 11/04/04 09:54 - Kimberly A. Jenkins, RN

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001715

TUOMEY HEALTHCARE SYSTEM
129 North Washington Street · Sumter, South Carolina 29150 · Telephone (803) 778-9111

PHYSICIAN'S CERTIFICATE OF TRANSFER

This is to certify that I, Dr Ronnie Dennis
was the emergency physician/private physician for Tommy Windham
At Tuomey Healthcare System on 11/4/04 20 04, at 0820 a.m.

Please fill out and (✓) check the appropriate section.

☐ I certify that the above listed individual suffered from an emergency medical condition (other than active labor) and was in an unstabilized condition, and that based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer.

☐ I certify that the above listed individual was a pregnant woman having contractions and based upon the information available at the time, the medical benefits reasonably expected from the provisions of appropriate medical treatment at another medical facility outweigh the increased risk to the unborn child and to the individual's medical condition from effecting the transfer.

☐ I hereby certify that the above named individual initiated the request for transfer to another medical facility and that the individual has been informed of the risks and benefits of such transfer.

☑ I hereby certify the above listed individual suffered from an emergency medical condition but was stabilized at the time of transfer.

☐ I hereby certify that the above listed individual *did not* suffer from an emergency medical condition and was not in active labor at the time of transfer.

☑ I certify that the receiving facility has agreed to accept transfer and to provide appropriate medical treatment as per conversation with Dr. Julx Johnson

☐ I certify that the receiving facility will be provided wit all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records relating to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) of the patient's consent to transfer, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

☐ I certify that the patient will be transferred by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures; however, all transfers have inherent risks, including without limitations, traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle.

☐ I certify that the patient is in need of involuntary emergency psychiatric hospitalization and has no medical or surgical conditions which require transport by medical personnel or transportation equipped to provide life support measures; however, all transfers have inherent risks, including without limitations, traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle.

THIS CERTIFICATION IS BASED UPON THE FOLLOWING:

BENEFITS: ☐ Definite Care

RISKS: ☐ Deterioration of Condition

☐ Possible Death

Date: 11/4/04 Physician's Name: Ronnie W Dennis

Physician's Signature: Ronnie W Dennis

If No Physician Present, Nurse's Name:

Nurse's Signature:

On the Verbal Orders of Dr.

Received at on 3/0

PHYSICIAN MUST COUNTERSIGN WITHIN 24 HOURS

30402 Rev. 10/00 White Copy to MEDICAL RECORDS Yellow Copy to RECEIVING HOSPITAL Pink Copy to PATIENT/RESPONSIBLE

5502

001716

Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803)778-9111

EMERGENCY TRANSFER CHECKLIST

Patient (Name): Tammy Windham

Attending Physician (Name): Dr Ronnie Windham

Accepting Physician (Name): Dr. Julie Johnson Time: 0820

Transfer to (Hospital): Richland Memorial

By: ☑ Ambulance (Name): _____

☐ Helicopter (Name): _____

Copy of Record: ☑ Yes ☐ No

Lab Reports: ☑ Yes ☐ No

X-Ray Reports: ☐ Yes ☑ No

☑ Next of Kin Notified

Patient Valuables / Personal Belongings to:

☑ Patient

☐ Next of Kin

☐ Hospital Safe

Vital Signs: T 97.6 P 93 R 20 B/P 117/59

Comments: IUP 24+ Weeks 2/15/05 emergency cerclage placed 11/3/04 @ 2020. cervix closed/soft - Ballotable

Nurse's Signature: Kim [illegible] RN Date: 11/4/04

30404 Rev. 3/28/2001 White Copy / Medical Records • Yellow Copy / Receiving Hospital • Pink Copy / Responsible Party

3 of 1

5503

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
WINDHAM,TAMMY ELIZABETH [redacted]	12600723		ER	ED	229998

Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
[redacted]	38	F	M	HOL	W	N

Person to Notify / Address: WINDHAM,TOMMY [redacted] — Relationship: H — Other Phone

Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]

Next of Kin / Address: PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone: 803-506-4697

Financial Class: S

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit
ONSET OF SYMPTO	HEADACHE/VOMITING

Accident Date / Time	Comments	Height / Weight	Arrival Mode
07/02/06	ID SCAN		

Admit Date / Time	Admitting Physician	Attending Physician	User
07/02/06 1542		NO DOCTOR	NSCBR

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does Pt have Advance Directive?

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Jul 02 2006 15:51 TDR)
COMPLAINT: COMPLAINT: ha/vomiting.
ADMISSION: URGENCY: 2 - Urgent, TRANSPORT: Walked, BED: LOBBY.
PATIENT: NAME: Tammy E Windham, AGE: 38, GENDER: Female, DOB: Oct 18, 1967, TIME OF GREET: Sun, Jul 2 2006 15:42, by: Emily Garcia, Latex Allergy: No, Fall related visit: No, New onset weakness: No, IBEX NUMBER: 20060702155141GRT.
ASSESSMENT: Pain level 10, using numeric pain scoring., STATES HA AND VOMITING (STATES EVERY 5 MINUTES) STARTED THIS AM. UNSURE OF WHAT COLOR VOMIT IS. STATES TOOK APAP AROUND 1200 WITH NO RELIEF. STATES HAS HTN, BUT DOES NOT TAKE MEDS FOR HTN. .
TRIAGE INTERVENTIONS: assessment performed.
VITAL SIGNS: BP 183/79, Pulse 88, Resp 16, Temp 97.6, Pain 10, O2 Sat 97, w/wo O2 RA, Time 1550.

KNOWN ALLERGIES
Nkda.

HPI HEADACHE (16:43 MAC)
CHIEF COMPLAINT: Patient presents for the evaluation of headache, nausea, vomiting, This is not the worst headache of this patient's life, This headace is exactly like patient's prior headaches.
HISTORIAN: History obtained from patient.
TIME COURSE: Onset of symptoms reported as sudden, Onset was on and off X 2 weeks, Complaint is persistent, Complaint is intermittent.
LOCATION: Pain most severe in Frontal area, No radiation of pain.
QUALITY: Patient describes pain as sharp.
ASSOCIATED WITH: No numbness, tingling, syncope.
SEVERITY: Maximum severity is severe, Currently symptoms are moderate.
RISK FACTORS: Risk factors for subarchnoid hemorrhage include smoking history.
NOTES: FHx of migraines.

HISTORY
MEDICAL HISTORY (Jul 02 2006 15:51 TDR): History of hypertension, which is not being treated.
SURGICAL HISTORY (Jul 02 2006 15:51 TDR): Patient's previous surgical history is not relevant to the case.
MEDICAL HISTORY (16:45 MAC): History of hypertension, which is not being treated.
PSYCHIATRIC HISTORY (16:45 MAC): No previous psychiatric history.
SURGICAL HISTORY (16:45 MAC): History of appendectomy, History of cholecystectomy.
SOCIAL HISTORY (16:45 MAC): Denies drug abuse, Patient smokes tobacco, at .5, packs per day for 20, years; equating to 10, pack years of smoking, Denies consumption of alcohol.
FAMILY HISTORY (16:45 MAC): No family history of coronary artery disease, Family history includes asthma, Family history includes CVA, Family history includes diabetes, Family history includes hypertension, Family history includes malignancy.
NOTES (16:45 MAC): Nursing records reviewed, Medication list reviewed.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

ROS (16:43 MAC)
CONSTITUTIONAL: No fever, No chills.
EYES: No blurred vision, No eye pain, No eye redness, No photophobia, No eye discharge.
ENT: No URI symptoms, No sore throat, No tinnitus, No ear pain.
CARDIOVASCULAR: No chest pain, No palpitations, No syncope.
RESPIRATORY: No Cough, No SOB.
GI: Historian reports nausea, Historian reports vomiting, No abdominal pain, No appetite changes.
GENITOURINARY FEMALE: Negative genitourinary review of systems.
MUSCULOSKELETAL: No neck pain, No joint pain, No deformity, No fall, No injury.
SKIN: Negative skin review of systems.
NEUROLOGIC: Historian reports headache, No paralysis, No parethesias, No focal weakness, No sensory changes, No speech changes.
ENDOCRINE: Negative endocrine review of systems.
HEMO/LYMPHATIC: Negative hemo/lymphatic review of systems.
ALLERGIC/IMMUNOLOGIC: Negative Allergic review of systems.
PSYCHIATRIC: Negative psychiatric review of systems.
NOTES: No other modifying or associated factors.
ALL SYSTEMS NEGATIVE: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM
CONSTITUTIONAL (16:50 MAC): Patient is afebrile, Vital Signs Reviewed, Patient has normal pulse, Patient has normal blood pressure, Patient has normal respiratory rate, Well appearing, Patient appears comfortable, Alert and oriented X 3, Pt lying in bed with TV and lights on. Call bed right beside head in NAD. Family at bedside.
HEAD (16:50 MAC): Atraumatic, Normal cephalic.
EYES (16:50 MAC): Eyes are normal to inspection, Pupils equal, round and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal, Conjunctiva are normal, Fundoscopic exam normal, No papilloedema.
ENT (16:50 MAC): Ears normal to inspection, External ear normal, TM's normal, no external auditory canal foreign body, no external auditory canal drainage, no external auditory canal bleeding, hearing normal, Oropharynx normal, No stridor, No trismus, no uvular edema, no uvular deviation, not injected, no exudates, no pharyngeal swelling, no pharyngeal asymmetry, Mouth normal to inspection, mucus membranes moist, no lesions, no lacerations, No drooling, Able to handle secretions, No tongue elevation, Sinuses exam normal, Sinuses non-tender, No erythema, No swelling.
NECK (16:50 MAC): Assessment includes:, Trachea midline, No masses, No lymphadenopathy, Supple, No meningeal signs, Normal ROM.
RESPIRATORY/CHEST (16:50 MAC): Chest is non-tender, Breath sounds normal, No respiratory distress, CTAB.
CARDIOVASCULAR (16:50 MAC): RRR, Heart sounds normal, No extremity edema.
ABDOMEN (16:50 MAC): Abdomen is non-tender, No masses, Bowel sounds normal, No distension, No peritoneal signs.
BACK (16:50 MAC): Normal inspection, Deep tendon reflexes all normal.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

Normal range of motion.
SKIN (16:50 MAC): Skin is warm and dry, No rash or induration.
LYMPHATIC (16:50 MAC): No adenopathy in neck.
PSYCHIATRIC (16:50 MAC): Normal affect.
NEURO (17:07 MAC): GCS is 15, No focal sensory deficits, Cranial nerves intact, No cerebellar deficits, Normal DTRs, Babinski absent, No nystagmus, Speech normal, CT head was ordered.

DOCTOR NOTES (18:39 MAC)
TEXT: Nonspecific ha
Nausea with vomiting
CT head neg per radiologist
Home with ultram, phenergan and instructions
Pt verbalizes understanding and agreement with tx plan.
TIME: Time: 1839.
INTERVENTIONS: Pain medications administered:, MORPHINE, Pain medications were given IV, Antimetics: REGLAN.
PATIENT STATUS: Patient has stablized since admission.
PATIENT PLAN: The patient will be discharged, The patient will follow up with primary care physician.

O2SAT INTERPRETATION (16:51 MAC)
O2SAT: O2 saturation reading 97%, O2 AMT: R.A., O2 Sat normal, None needed, Single Pulse Ox.

NURSING PROCEDURE: NURSE NOTES (17:39 LAS)
TIME: Time: 1720, TO BS. PT FACES SCALE 8/10. INFORMED OF PLAN FOR TX PER A CONYERS RN. ALLERGIES VERIFIED. MEDICATED.

NURSING PROCEDURE: IV (17:40 LAS)
TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for procedure: medication administration, Procedure performed at 1725, IV established, 20 gauge catheter inserted, into right AC, #1 site, in 1 attempt, Saline lock established, Amount 3CC, Labs drawn at time of placement, Labs labeled and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: Pain: 8/10.

NURSING PROCEDURE: MEDICATION (17:42 LAS)
MEDICATION: Patient's identity verified by, patient stating name, hospital ID bracelet, After procedure, on a scale 0-10 patient rates pain as 8, Procedure was performed at 1725, Medication: REGLAN 10MG/10CC NS, given IVP, Initial medication, into right AC, IV site without signs or symptoms of infiltration during medication administration, No swelling during medication infusion, No drainage during medication infusion,

Patient tolerated procedure well, Procedure done by A CONYERS RN.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

VITAL SIGNS: Pain: 8/10.

NURSING PROCEDURE: MEDICATION (17:43 LAS)
MEDICATION: Procedure was performed at 1731, Medication: MORPHINE 2MG, given IVP, Subsequent different medication, into right AC, IV site without signs or symptoms of infiltration during medication administration, No swelling during medication infusion, No drainage during medication infusion, Patient tolerated procedure well, Procedure done by A CONYERS RN.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: Pain: 8/10.

NURSING PROCEDURE: TRANSPORT TO TESTS (17:43 STS)
TIME: Patient's identity verified by, patient stating name, patient stating birth date, hospital ID bracelet, family member, Patient transported to, CT scan, Patient transforted via, cart, Patient accompanied by, ER tech, Tech notified at: 1743, Patient arrived in Location at: 1745, Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

DIAGNOSIS (18:31 MAC)
FINAL: PRIMARY: Nonspecific Ha, ADDITIONAL: NAUSEA WITH VOMITING.

PRESCRIPTION (18:32 MAC)
Phenergan: Tablet : 12.5 mg : Oral=Quantity: ***1*** Unit: tab Route: Oral Schedule: Every 4 to 6 hours Dispense: ***10*** National drug code: 54569469900.
NOTES: Use for nausea and/or vomiting
Do not use in combination with phenergan suppository.
Ultram: Tablet : 50 mg : Oral=Quantity: ***1*** Unit: tab Route: Oral Schedule: Every 4 to 6 hours Dispense: ***30*** National drug code: 55289065020.
NOTES: Use for moderate to severe pain.

INSTRUCTION (18:36 MAC)
DISCHARGE: NONSPECIFIC HEADACHE, NAUSEA, VOMITING.
FOLLOWUP: Center Sumter Family Health 1278 N. Lafayette Dr. Sumter SC 29150 774-4500, .
SPECIAL: Read instructions below
Follow up with family physician
call for an appointment. Information to
Sumter Family Health Center provided
Return to ED for numbness, tingling, shortness of breath, blurry vision or symptoms that concern you
DO not drive, operate heavy machiner or drink alcohol while taking ultram.

DO not take ultram at work/school.
Push fluids
water, gatorade, juices, popsicles (avoid caffeine)
Take medication as prescribed.

DISPOSITION
PATIENT (18:31 MAC): Disposition: Home, Disposition Transport: Ambulatory,
Name: Windham, Tammy E Age: F38 MedRec: 229998 AcctNum: 12600723
Prepared: Wed Sep 27 2006 at 20:38 by Page: 4 of 5
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TUOMEY HEALTHCARE
EMERGENCY RECORD

Condition: Stable.
(18:51 CBJ): Pain Scale: 0, Oxygen: No, Remove from ER.

ADMIN (Sep 27 20:36 MAC)
DIGITAL SIGNATURE: Carr, PA-C, Melinda.

KEY:
CBJ=Jones, Cornelia LAS=Squires, Linda MAC=Carr, PA-C, Melinda
STS=Sharper, Samantha TDR=Robinson, Tamiko
Name: Windham, Tammy E Age: F38 MedRec: 229998 AcctNum: 12600723
Prepared: Wed Sep 27 2006 at 20:38 by Page: 5 of 5
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NAME=WINDHAM TAMMY

CT BRAIN - 07/02/06

An unenhanced CT of the brain using 5 mm axial sections demonstrates no acute intracranial hemorrhage, midline shift, gross mass or acute ischemic territorial process. A small 5 mm hypodensity in the inferior right basal ganglia laterally most likely represents prominent Virchow-Robin space with a tiny old lacune considered much less likely. Visualized paranasal sinuses and mastoid air cells are clear.

IMPRESSIONS: No definite acute intracranial abnormality.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/23/07 TUH NPR LAB **LIVE** PAGE 54
RUN TIME: 1909 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12600723 LOC: ED U #: 229998
AGE/SX: 38/F ROOM: REG: 07/02/06
REG DR: ROJAS,RODRIGO F STATUS: DEP ER BED: DIS:

****HEMATOLOGY****

HEMOGRAM

	Day 1			
	Date JUL 2			
	Time 1725		Reference	Units
WBC	10.4 #		(3.0-11)	1000/UL
RBC	5.02		(3.7-5.3)	MIL/UL
HGB	11.1	L	(11.5-16.0)	G/DL
HCT	35.1		(33-46)	%
MCV	70.0 #	L	(79-95)	FL
MCH	22.2	L	(26-34)	PG
MCHC	31.7		(29-35)	G/DL
RDW	18.6	H	(11.9-15.5)	%
PLATELET COUNT	340 #		(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

	Day 1			
	Date JUL 2			
	Time 1725		Reference	Units
NEUTROPHILS	49.5		(42-76)	%
LYMPHOCYTES	22.6		(16-48)	%
MONOCYTES	4.6		(0.0-10.0)	%
EOSINOPHILS	2.2		(0.0-7.6)	%
BASOPHILS	21.0	H	(0.0-1.5)	%

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/23/07 TUH NPR LAB **LIVE** PAGE 55
RUN TIME: 1909 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12600723 (Continued)

****CHEMISTRY****

	Day 1 Date JUL 2 Time 1725		Reference	Units
SODIUM	142		(135-151)	MEQ/L
POTASSIUM	3.6		(3.5-5.1)	MEQ/L
CHLORIDE	119	H	(99-116)	MEQ/L
C02	26		(22-30)	MEQ/L
GLUCOSE SERUM	106		(80-110)	MG/DL
BUN	9		(7-18)	MG/DL
CREATININE	0.9		(0.8-1.5)	MG/DL
CALCIUM	8.9		(8.4-10.2)	MG/DL

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TUOMEY HEALTHCARE SYSTEM

MB

Name: Windham, Tammy E
Age: 38
Gender: F
Medrec: 229998
Acct: 12600723
Attending: RFR
Primary Nurse: LAS
Bed: ED 2-ER 07

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
Nonspecific Ha

ADDITIONAL DIAGNOSIS
NAUSEA WITH VOMITING

FOLLOWUP CONTACT

Center Sumter Family Health
1278 N. Lafayette Dr.
Sumter SC 29150
Phone: 774-4500

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Read instructions below
Follow up with family physician ~ call for an appointment. Information to Sumter Family Health Center provided
Return to ED for numbness, tingling, shortness of breath, blurry vision or symptoms that concern you
DO not drive, operate heavy machiner or drink alcohol while taking ultram. DO not take ultram at work/school.
Push fluids ~ water, gatorade, juices, popsicles (avoid caffeine)

Take medication as prescribed

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
NONSPECIFIC HEADACHE
NAUSEA
VOMITING

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

195/74 - 68 - 20 98°

Phenergan : Tablet : 12.5 mg : Oral
Dispense: 10, Quantity: 1, Schedule: Every 4 to 6 hours

Ultram : Tablet : 50 mg : Oral
Dispense: 30, Quantity: 1, Schedule: Every 4 to 6 hours

Tammy Windham
Patient Signature

CB 18:45
RN/LPN Ini. TIME

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001727

Emergency Department - Triage / Order Record

Triage Level: ____
Date: _____

WINDHAM,TAMMY ELIZABETH
Acct: 12600723 Unit: 229998
NO DOCTOR
ED
F W Age: 38 [redacted]

Triage Time:

Age: | **DOB:**

❑ Acute ❑ Chronic **Quality:** ❑ Dull ❑ Throbbing ❑ Sharp ❑ Radiating ❑ Ache ❑ Pressure

Chief Complaint: _____

Latex Allergies: ❑ Yes ❑ No
Food Allergies: ❑ Yes ❑ No
Drug Allergies:

T: 97.6	BP:	P:	R:	Wt (kg)	Ht:	SaO2	B/S	LMP

Mode of Arrival
❑ Foot ❑ Ambulance
❑ Car ❑ Carried
❑ Police ❑ Wheelchair

Hx of S/S of TB ❑ Yes ❑ No
Precautions:
❑ Tissues ❑ Mask
❑ Isolation ❑ Instruction

Visual Acuity ❑ Lens ❑ No Lens
OD_____ OS _____
OU_____

Home/Homeopathic/Herbal Meds.

Immunizations:
❑ UTD
❑ Tetanus _____ (Date)

Suspected Pt. Abuse:
❑ Yes
❑ No

Pre-Hospital Care:
❑ EMS ❑ C-collar ❑ Spinal Immobilization
❑ None
❑ Other _____

HPI: (location, quality, duration, timing, modifying factors, associated signs)

Nursing Diagnosis:
❑ Health Care Seeking
❑ Altered Comfort
❑ Impaired Gas Exchange
❑ Impaired Integrity
❑ Altered Tissue Perfusion
❑ Ineffective Coping
❑ Other: _____

Nurse Signature:

Review of Systems:
❑ All reviewed and negative

Yes	No	
❑	❑	Fever
❑	❑	Visual Problems
❑	❑	Difficulty Hearing
❑	❑	Chest Pain
❑	❑	Difficulty Breathing
❑	❑	Vomiting Diarrhea
❑	❑	Dysuria / Discharge
❑	❑	Trauma
❑	❑	Rash
❑	❑	Extremity Weakness
❑	❑	Depression
❑	❑	Excessive Thirst
❑	❑	Abnormal Bleeding

Past Medical/Family History:

Yes	No	Family	
❑	❑	❑	Lung Disease
❑	❑	❑	Heart Disease
❑	❑	❑	Kidney Disease
❑	❑	❑	HTN
❑	❑	❑	CVA
❑	❑	❑	Diabetes
❑	❑	❑	Cancer
❑	❑		HIV
❑	❑		Seizures
❑	❑		Sickle Cell Dse
❑	❑		Surgery
❑	❑		Psychiatric

Social History:
❑ ❑ Smoke_____
❑ ❑ EtOH _____
❑ ❑ Drugs_____

ORD	LAB/X-RAYS	TIME	INIT
	EKG ▲		
dac 1702	CBC/diff ▲■		
dac 1702	BMP▲■ or CMP	1708	
	LFT		
	Amy/Lip		
	FSBS		
	Troponin I ▲		
	CKMB▲		
	PT/PTT ■		
	Blood Cx 1 or 2		
	T&S ■ or T&C		
	ABO		
	GC/Chlamydia		
	Wet Prep		
	U/A ■		
	Urine C&S		
	Urine Preg.		
	QHCG		
	ABG ❑ RA		
	CXR		
	PCXR ▲■		
	C-Spine ■		
	Abd Series		
	Ankle ❑L ❑R		
	Wrist ❑L ❑R		
	Hip ❑L ❑R		
	Cardiac Protocol = ▲		
	Trauma Panel = ■		

Ibuprofen _____
Tylenol _____

❑ DT 0.5 ml IM
Time Lot # Site Nurse

❑ Cardiac Monitor ▲ ❑ Foley ❑ I/Os
❑ Oxygen ▲ ❑ NGT ❑ Lavage
❑ Pulse Ox ❑ IV/INT

TIME	PHYSICIAN ORDERS	TIME	INIT
1702	CT Head w/o contrast Reason: HA		
	Morphine 2mg IV	AFC	1730
	Reglan 10mg IV	AFC	1731

Physician Signature: Melinda Carr PA

Time to Room [redacted]

Patient to Room # _____
29228 Rev.02/10/04

WINDHAM,TAMMY ELIZABETH
Acct: 12600723 Unit: 229998
NO DOCTOR
ED
F W Age: 38 DOS: 07/02/06 [redacted]

_____ **Dictated** _____

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5514

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service		Medical Rec. No.	
WINDHAM,TAMMY ELIZABETH [redacted]	12643706		ER	ED		229998	
	Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
	[redacted]	38	F	M	HOL	W	N

Person to Notify / Address: WINDHAM,TOMMY [redacted] — Relationship: H — Other Phone

Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]

Next of Kin / Address: PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone 803-506-4697

Financial Class S

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit		
ONSET OF SYMPTO	MIGRAINE/CHEST PAIN		
Accident Date / Time	**Comments**	**Height / Weight**	**Arrival Mode**
09/28/06			
Admit Date / Time	**Admitting Physician**	**Attending Physician**	**User**
09/28/06 2132		NO DOCTOR	NSCBR

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does Pt have Advance Directive?

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (ER)

00000 Rev 01/01/2004

[redacted] 313

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Sep 28 2006 21:51 MAF)
COMPLAINT: COMPLAINT: Migraine/Chest Pain.
ADMISSION: URGENCY: 1 - Emergent, ADMISSION SOURCE: Home, TRANSPORT: Walked, BED: LOBBY.
PATIENT: NAME: Tammy E Windham, AGE: 38, GENDER: Female, DOB: Oct 18, 1967, TIME OF GREET: Thu, Sep 28 2006 21:30, LANGUAGE: English, RACE: Caucasian, Latex Allergy: No, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, ACCOUNT NUMBER: 12643706, PAYMENT: Self Pay, ATTENDING: Doctor No, IBEX NUMBER: 20060928215117ADT.
PREVIOUS VISIT ALLERGIES: Nkda.
ASSESSMENT: Pain level 10, using numeric pain scoring.Quality is sharp , PT. REPORTS STERNAL CP WITH A HA. DENIES RADIATION. REPORTS N/V. PT. TEARFUL IN TRIAGE. NO RESP. DISTRESS, BREATHING NL AND EVEN.
TRIAGE INTERVENTIONS: assessment performed.
VITAL SIGNS: BP 167/115, Pulse 94, Resp 18, Temp 97.4, Pain 10, O2 Sat 98, w/wo O2 WO, Time 2148.

KNOWN ALLERGIES
Nkda.

HPI BLANK (22:43 GMC)
CHIEF COMPLAINT: Pt to ED with c/o pain in mid chest and HA. CP began about 2030 last night, has been coming and going every 5-10 min and lasts about 20 min at a time, knife like without radiation, getting gradually worse, associated with diaphoresis and N with emesis but no SOB. No similar in the past. Developed HA across front of head and around eyes since aobut 1230 today, sharp, unchanged with tylenol, similar to migraines years ago. Had temp of 100 at home, has cough with green sputum, has been under a lot of stress, has h/o HTN but nevere treated, no other c/o.
HISTORIAN: History obtained from patient.
TIME COURSE: Onset of symptoms reported as gradual, Onset was as above , Patient currently has symptoms, Complaint is worse, Complaint is persistent.
SEVERITY: Maximum severity is severe, Currently symptoms are severe.

HISTORY
MEDICAL HISTORY (Sep 28 2006 21:51 MAF): Additional history includes: History of hypertension, which is not being treated. History of hypertension, which is not being treated.
PSYCHIATRIC HISTORY (Sep 28 2006 21:51 MAF): No previous psychiatric history.
SURGICAL HISTORY (Sep 28 2006 21:51 MAF): Patient's previous surgical history is not relevant to the case. History of appendectomy, History of cholecystectomy.
SOCIAL HISTORY (Sep 28 2006 21:51 MAF): Denies drug abuse, Patient smokes tobacco, at .5, packs per day for 20, years; equating to 10, pack years of smoking, Denies consumption of alcohol.
FAMILY HISTORY (Sep 28 2006 21:51 MAF): No family history of coronary artery disease, Family history includes asthma, Family history includes CVA, Family history includes diabetes, Family history includes

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TUOMEY HEALTHCARE
EMERGENCY RECORD

hypertension, Family history includes malignancy.
NOTES (22:46 GMC): Nursing records reviewed, Agree with nursing records.

ROS (22:46 GMC)
CONSTITUTIONAL: Historian reports fever, No chills, No weakness.
EYES: Historian reports eye pain, No blurred vision, No eye redness, No photophobia, No eye discharge.
ENT: No URI symptoms.
CARDIOVASCULAR: Historian reports chest pain, No palpitations, No edema.
RESPIRATORY: Historian reports cough, No SOB.
GI: Historian reports nausea, Historian reports vomiting, No abdominal pain, No diarrhea.
GENITOURINARY FEMALE: No dysuria.
MUSCULOSKELETAL: No neck pain, No back pain.
SKIN: Negative skin review of systems.
NEUROLOGIC: Historian reports headache, No paralysis, No parethesias, No focal weakness, No sensory changes, No speech changes.
ALLERGIC/IMMUNOLOGIC: No frequent infections, No poor healing, No prolonged convalescence.
PSYCHIATRIC: No substance abuse.

PHYSICAL EXAM (22:47 GMC)
CONSTITUTIONAL: Vital signs reviewed, Alert and oriented X 3, Hypertensive, Patient appears uncomfortable, Patient appears to be in pain.
HEAD: Atraumatic, Normal cephalic.
EYES: Pupils equal and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal.
ENT: Oropharynx normal, Mouth normal to inspection, Evaluation of left sinuses show, frontal sinuses are tender, maxillary sinuses are tender, Evaluation of right sinuses show, frontal sinuses are tender, maxillary sinuses are tender.
NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine non-tender.
RESPIRATORY/CHEST: Breath sounds normal, No respiratory distress.
CARDIOVASCULAR: RRR, Heart sounds normal, No extremity edema.
ABDOMEN: Abdomen is non-tender, Bowel sounds normal, No distension, No peritoneal signs.
BACK: There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis/clubbing/edema, Normal range of motion.
LOWER EXTREMITY: Inspection normal, No cyanosis/clubbing/edema, No calf tenderness, Normal range of motion.
NEURO: GCS is 15, No focal motor deficits, No focal sensory deficits.
SKIN: Skin is warm and dry, No rash or induration.
PSYCHIATRIC: Oriented X 3, Normal affect.

DOCTOR NOTES (Sep 29 0:55 GMC)
TEXT: Pt feels entirely well, no c/o, ready for d/c home.

O2SAT INTERPRETATION (Sep 29 0:52 GMC)
O2SAT: O2 saturation reading 100%, O2 AMT: 2L, O2 Sat normal, Continuous

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TUOMEY HEALTHCARE
EMERGENCY RECORD

EKG INTERPRETATION (22:48 GMC)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, No previous EKG available, 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate is 67, ST Segments: non-specific changes, Axis: normal, Interpretation: no acute appearing findings.

LAB INTERPRETATION (Sep 29 0:52 GMC)
INTERPRETATION: I reviewed the lab results, Elevated WBC, CBC otherwise normal, Decreased Sodium Bicarbonate, otherwise Chemistry normal, Normal Cardiac enzymes.

RADIOLOGY INTERPRETATION (Sep 29 0:53 GMC)
CHEST: Interpretation of chest X-ray shows, no acute.
INTERPRETER: Preliminary review of x-rays by ED Physician.

NURSING PROCEDURE: EKG CHART (22:23 BDF)
TIME: Patient's identity verified by, patient stating name, EKG was performed at 2222, 12 lead EKG Performed-left chest, After procedure, EKG for interpretation given to Dr. clanton, no old ekg on tracemaster.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.

NURSING PROCEDURE: IV (23:11 NSC)
TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure performed at 2240, IV established, 20 gauge catheter inserted, into right Forearm, #1 site, in 1 attempt, Saline lock established, Labs drawn at time of placement, Labs labeled and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Sterile dressing applied, Patient tolerated procedure well.

NURSING PROCEDURE: MEDICATION (23:11 NSC)
MEDICATION: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure was performed at 2242, MORPHINE, 5mg, given IVP, into right Forearm, IV site without signs or symptoms of infiltration during medication administration, No swelling during medication infusion, No drainage during medication infusion, Patient tolerated procedure well, Allergies verified, effects explained.
SAFETY: Side rails up, Cart in lowest position.

NURSING PROCEDURE: MEDICATION (23:12 NSC)
MEDICATION: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure was performed at 2245, PHENERGAN, 12.5mg with 10cc NS, given IVP, into right Forearm, IV site without signs or symptoms of infiltration during medication administration, No swelling during medication infusion, No drainage during medication infusion, Patient tolerated procedure well, Effects explained.

NURSING PROCEDURE: MEDICATION (23:16 NSC)

MEDICATION: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure was performed at 2247, LABETOLOL, 20mg, given IVP, into right Forearm, IV site without signs or symptoms of

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TUOMEY HEALTHCARE
EMERGENCY RECORD

infiltration during medication administration, No swelling during medication infusion, No drainage during medication infusion, Patient tolerated procedure well.
VITAL SIGNS: BP: 187, / 79, Pulse: 81, Resp: 18, O2 sat: 98, Time: 2245.

NURSING PROCEDURE: NURSE NOTES (23:22 NSC)
TIME: Time: 2306, Pt resting, chest pain and headache a little better at scale 8 as claimed. Per pt, scale "was more than 10" before meds. Dr. Clnaton informed of present BP and said OK to give Clonidine patch. .
VITAL SIGNS: BP: 157, / 74, Pulse: 71, Resp: 17, Pain: 8, O2 sat: 100, 2L, Time: 2306.

NURSING PROCEDURE: MEDICATION (23:24 NSC)
MEDICATION: Patient's identity verified by, patient stating name, hospital ID bracelet, Procedure was performed at 2306, Medication: CLONIDINE PATCH, 0.2mg, given transdermally, Patient tolerated procedure well, Allergies verified, effects explained. .

NURSING PROCEDURE: NURSE NOTES (23:25 NSC)
TIME: Time: 2333, Pt information given to pt's sister per Linda Parrick per approval of pt and per insistence of Linda Parrick. .

NURSING PROCEDURE: NURSE NOTES (Sep 29 0:04 NSC)
TIME: Time: 2357, Chest paion and Headache better at scale 5 as claimed. .
VITAL SIGNS: BP: 157, / 56, Pulse: 88, Resp: 18, Pain: 5, O2 sat: 100, Time: 2357.

NURSING PROCEDURE: NURSE NOTES (Sep 29 0:48 NSC)
TIME: Time: 0020, Pt resting. Respi non-labored. No distress noted. Sinus rhythm showing on tele. .
VITAL SIGNS: BP: 162, / 59, Pulse: 71, Resp: 18, O2 sat: 100, Time: 0020.

NURSING PROCEDURE: NURSE NOTES (Sep 29 0:49 NSC)
TIME: Time: 0045, Resting. Denies haedache or chest pain at this time. all lab results back. Posted for re-evaluation. .
VITAL SIGNS: BP: 143, / 59, Pulse: 71, Resp: 20, Pain: 0, O2 sat: 100, 2L, Time: 0045.

NURSING PROCEDURE: DISCHARGE NOTE (Sep 29 1:06 SBH)
TIME: Patient discharged at 0105, Patient discharged to, home, Patient, ambulates without assistance, Transported via friend/family driving, Accompanied by family member, IV discontinued with catheter intact. Dressing placed to IV site, Discharge instructions given to, patient, Simple/moderate discharge teaching performed, Above Person(s) verbalized understanding of discharge instructions and follow-up care.

DIAGNOSIS (Sep 29 0:55 GMC)

FINAL: PRIMARY: Acute CP, ADDITIONAL: Cephalgia, Uncontrolled HTN. **001733**

PRESCRIPTION: No Documented Prescriptions

INSTRUCTION (Sep 29 0:57 GMC)
Name: Windham, Tammy E Age: F38 MedRec: 229998 AcctNum: 12643706
Prepared: Tue Oct 03 2006 at 00:17 by Page: 4 of 5
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TUOMEY HEALTHCARE
EMERGENCY RECORD

DISCHARGE: HYPERTENSION (HIGH BLOOD PRESSURE).
FOLLOWUP: Center Family Health 1278 N. Lafayette Dr. Sumter SC 29150 774-4500, .
SPECIAL: Follow with your doctor or clinic in 1 - 2 days.
Return for increased pain, shortness of breath change in vision or hearing or other symptoms which concern you.
Wear blood pressure patch until seen.

DISPOSITION
PATIENT (Sep 29 0:55 GMC): Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable.
(Sep 29 1:07 SBH): Pain Scale: 0, Oxygen: No, Remove from ER.

ADMIN
DIGITAL SIGNATURE (Oct 01 19:30 GMC): Clanton, MD, Garrett.
(Oct 03 0:14 NSC): Chiu, Nih.

KEY:
BDF=Fuller, Brenda GMC=Clanton, MD, Garrett MAF=Felder, Melissa
NSC=Chiu, Nih SBH=Haynie, Sylvia
Name: Windham, Tammy E Age: F38 MedRec: 229998 AcctNum: 12643706
Prepared: Tue Oct 03 2006 at 00:17 by Page: 5 of 5
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5521

001734

229998 28-Sep-2006 22:23:15 WINDHAM, TAMMY
38 Years Female Race: White BP 167/115

Dept: Emergency Dept. (02)
Room: ED-01
Oper: 6BF

Rate 67
RR 896
PR 144
QRSD 84
QT 432
QTcB 456
QTcF 448
-- AXIS --
P 46
QRS 49
T 115

- STMT - * SINUS RHYTHM, RATE 67.
- STMT - * CONSIDER LEFT VENTRICULAR HYPERTROPHY.

Account Number:12643706
OrderID:
COMMENTS:
Edited By:TERESA WALLACE

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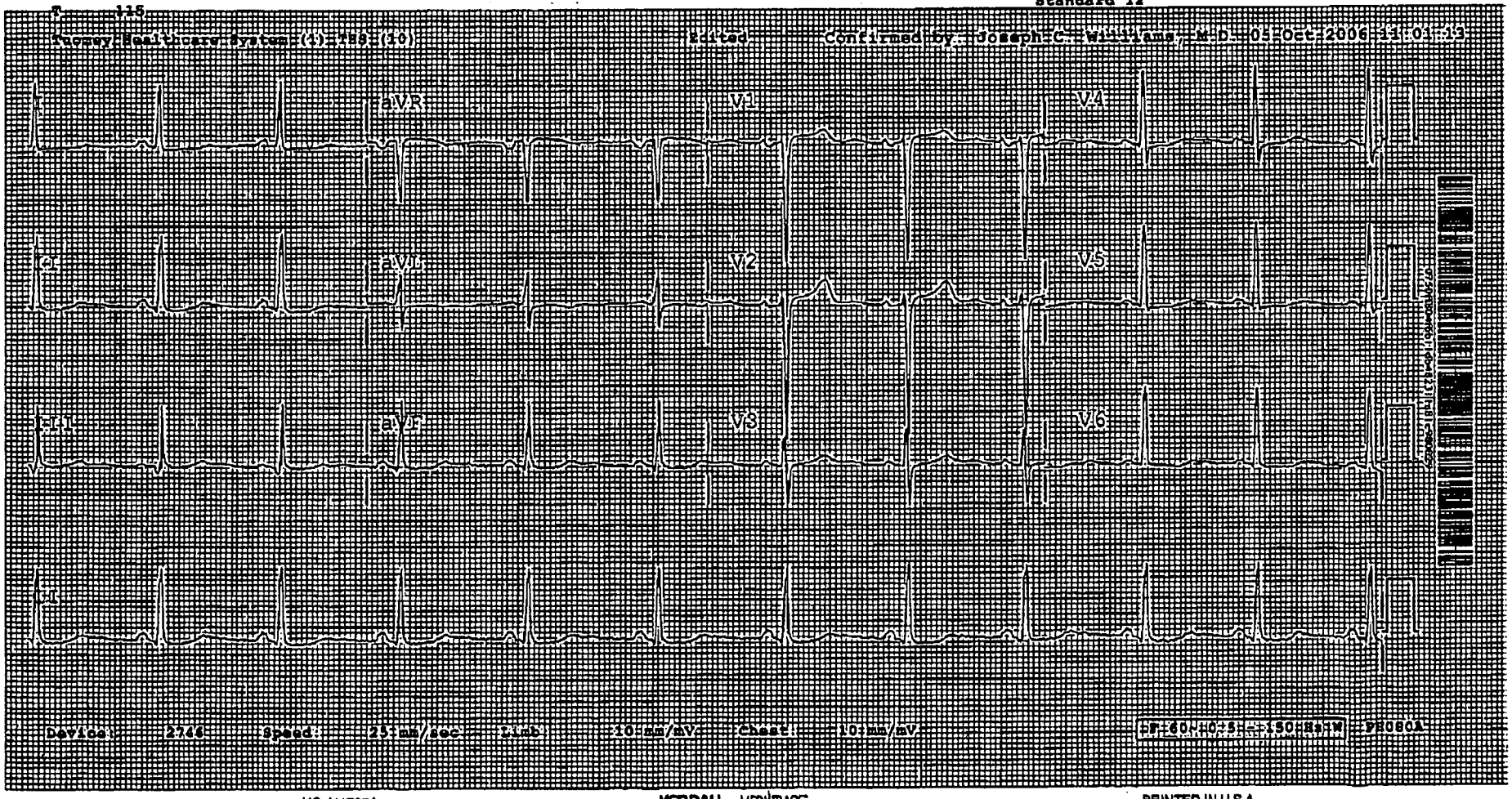
- ABNORMAL ECG -

Requested By: CLANTON,G
Standard 12



NO. M1737A KENDALL MEDITRACE PRINTED IN U.S.A.

ACCT NO: 12643706 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
SEX: F
ORDERING PHYS: CLANTON II, GARRETT

EXAM: XR CHEST (PA OR AP 1 VIEW)060
EXAM DATE: 09/28/2006 00:00:00
PHYS: PANNELL, TIMOTHY L
REASON: CHEST PAIN

Negative for any significant radiographic abnormality.

IMPRESSION: Normal study.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/08/07 TUH NPR LAB **LIVE** PAGE 179
RUN TIME: 1803 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12643706 LOC: ED U #: 229998
AGE/SX: 38/F ROOM: REG: 09/28/06
REG DR: CLANTON II,GARRETT M STATUS: DEP ER BED: DIS:

****HEMATOLOGY****

HEMOGRAM

	Day 1 Date SEP 28 Time 2240	Reference	Units
WBC	14.3 # H	(3.0-11)	1000/UL
RBC	5.13	(3.7-5.3)	MIL/UL
HGB	11.5	(11.5-16.0)	G/DL
HCT	36.6	(33-46)	%
MCV	71.5 L	(79-95)	FL
MCH	22.5 L	(26-34)	PG
MCHC	31.5	(29-35)	G/DL
RDW	19.1 H	(11.9-15.5)	%
PLATELET COUNT	401 #	(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

	Day 1 Date SEP 28 Time 2240	Reference	Units
NEUTROPHILS	73.2	(42-76)	%
LYMPHOCYTES	18.4	(16-48)	%
MONOCYTES	5.9	(0.0-10.0)	%
EOSINOPHILS	1.5	(0.0-7.6)	%
BASOPHILS	1.0	(0.0-1.5)	%

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/08/07 TUH NPR LAB **LIVE** PAGE 180
RUN TIME: 1803 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12643706 (Continued)

****CHEMISTRY****

Day		1				
Date		SEP 28				
Time	2240	2240	2240		Reference	Units
SODIUM			138		(135-151)	MEQ/L
POTASSIUM			3.4	L	(3.5-5.1)	MEQ/L
CHLORIDE			117	H	(99-116)	MEQ/L
C02			20	L	(22-30)	MEQ/L
GLUCOSE SERUM			98		(80-110)	MG/DL
BUN			10	#	(7-18)	MG/DL
CREATININE			0.8	#	(0.8-1.5)	MG/DL
CALCIUM			9.0		(8.4-10.2)	MG/DL
TROPONIN-I	< 0.04(A)				(0-0.08)	NG/ML

(A)
TROPONIN VALUES GREATER THEN 0.08 NG/ML ARE CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.4 NG/ML ARE LIKELY TO REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE DATA FROM A SINGLE BLOOD COLLECTION.

CK TOTAL	67	(30-135)	U/L
CK INDEX	(a)		

NOTES: (a) Test not performed

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TUOMEY
HEALTHCARE SYSTEM

[redacted]

TUOMEY EALTHCARE
DISCHARG INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
Acute CP

ADDITIONAL DIAGNOSIS
Cephalgia
Uncontrolled HTN

FOLLOWUP CONTACT

Center Family Health
1278 N. Lafayette Dr.
Sumter SC 29150
Phone: 774-4500

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Follow with your doctor or clinic in 1 – 2 days.
Return for increased pain, shortness of breath change in vision or hearing or other symptoms which concern you.
Wear blood pressure patch until seen.

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
HYPERTENSION (HIGH BLOOD PRESSURE)

Tammy Windham
Patient Signature

RN/LPN Init. @1105 TIME

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001739

ncy Department - Triage / Order Record

Triage Level: ____
Date: ____

[redacted]

Triage Time: | Age: | DOB:

e: ☐ Acute ☐ Chronic Quality: ☐ Dull ☐ Throbbing ☐ Sharp ☐ Radiating ☐ Ache ☐ Pressure

Latex Allergies: ☐ Yes ☐ No
Food Allergies: ☐ Yes ☐ No
Drug Allergies:

T:	BP:	P:	R:	Wt (kg)	Ht:	SAO2	B/S	LMP

Mode of Arrival
☐ Foot ☐ Ambulance
☐ Car ☐ Carried
☐ Police ☐ Wheelchair

Hx of S/S of TB ☐Yes ☐ No
Precautions:
☐ Tissues ☐ Mask
☐ Isolation ☐ Instruction

Visual Acuity ☐ Lens ☐No Lens
OD____ OS____
OU____

Home/Homeopathic/Herbal Meds.

Immunizations:
☐ UTD
☐ Tetanus ____ (Date)

Suspected Pt. Abuse:
☐ Yes
☐ No

Pre-Hospital Care:
☐ EMS ☐ C-collar ☐ Spinal Immobilization
☐ None
☐ Other ____

HPI: (location, quality, duration, timing, modifying factors, associated signs)

Nursing Diagnosis:
☐ Health Care Seeking
☐ Altered Comfort ☐ Impaired Gas Exchange
☐ Impaired Integrity ☐ Altered Tissue Perfusion
☐ Ineffective Coping ☐ Other: ____

Nurse Signature:

Review of Systems:
☐ All reviewed and negative

Yes	No	
☐	☐	Fever
☐	☐	Visual Problems
☐	☐	Difficulty Hearing
☐	☐	Chest Pain
☐	☐	Difficulty Breathing
☐	☐	Vomiting Diarrhea
☐	☐	Dysuria / Discharge
☐	☐	Trauma
☐	☐	Rash
☐	☐	Extremity Weakness
☐	☐	Depression
☐	☐	Excessive Thirst
☐	☐	Abnormal Bleeding

Past Medical/Family History:

Yes	No	Family	
☐	☐	☐	Lung Disease
☐	☐	☐	Heart Disease
☐	☐	☐	Kidney Disease
☐	☐	☐	HTN
☐	☐	☐	CVA
☐	☐	☐	Diabetes
☐	☐	☐	Cancer
☐	☐		HIV
☐	☐		Seizures
☐	☐		Sickle Cell Dse
☐	☐		Surgery
☐	☐		Psychiatric

Social History:
☐ ☐ Smoke____
☐ ☐ EtOH ____
☐ ☐ Drugs

ORD	LAB/X-RAYS	TIME	INIT
	EKG ▲		
	CBC/diff ▲■		
	BMP▲■ or CMP		
	LFT		
	Amy/Lip		
	FSBS		
	Troponin I ▲		
	CKMB▲		
	PT/PTT ■		
	Blood Cx 1 or 2		
	T&S ■ or T&C		
	ABO		
	GC/Chlamydia		
	Wet Prep		
	U/A ■		
	Urine C&S		
	Urine Preg.		
	QHCG		
	ABG ☐ RA		
	CXR		
	PCXR ▲■		
	C-Spine ■		
	Abd Series		
	Ankle ☐L ☐R		
	Wrist ☐L ☐R		
	Hip ☐L ☐R		
✓	Cardiac Protocol = ▲	1225pm	
	Trauma Panel = ■		
	O.D. Panel		

Ibuprofen ____
Tylenol ____

☐ DT 0.5 ml IM
Time Lot # Site Nurse

☐ Cardiac Monitor ▲ ☐ Foley ☐ I/Os
☐ Oxygen ▲ ☐ NGT ☐ Lavage
☐ Pulse Ox ☐ IV/INT

TIME	PHYSICIAN ORDERS	TIME	INIT
1224	Clonidine 0.2 mg po/sl		
	Labetalol 20 mg IV		
	morphine [redacted] 5 mg IV		
	Phenergan 12.5 mg IV		

PHYSICIAN SIGNATURE

TIME TO ROOM 1229

Patient to Room # ____ /Time ____ Dictated ____

29228 Rev.02/10/04

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5526

5527

001740

229998 9/28/2006 22:23:15 WINDHAM, TAMMY
38 Years Female Race: White

TUOMEY HEALTHCARE SYSTEM (1)
BP: 167/115 Dept: EMERGENCY DEPT. (0>
Room: ED1
Oper: 6BF

. SINUS RHYTHM
. PROBABLE LVH WITH SECONDARY REPOL ABNRM

Rate 67
PR 144
QRSD 84
QT 432
QTc 456

--AXIS--
P 46
QRS 49
T 115

[redacted]

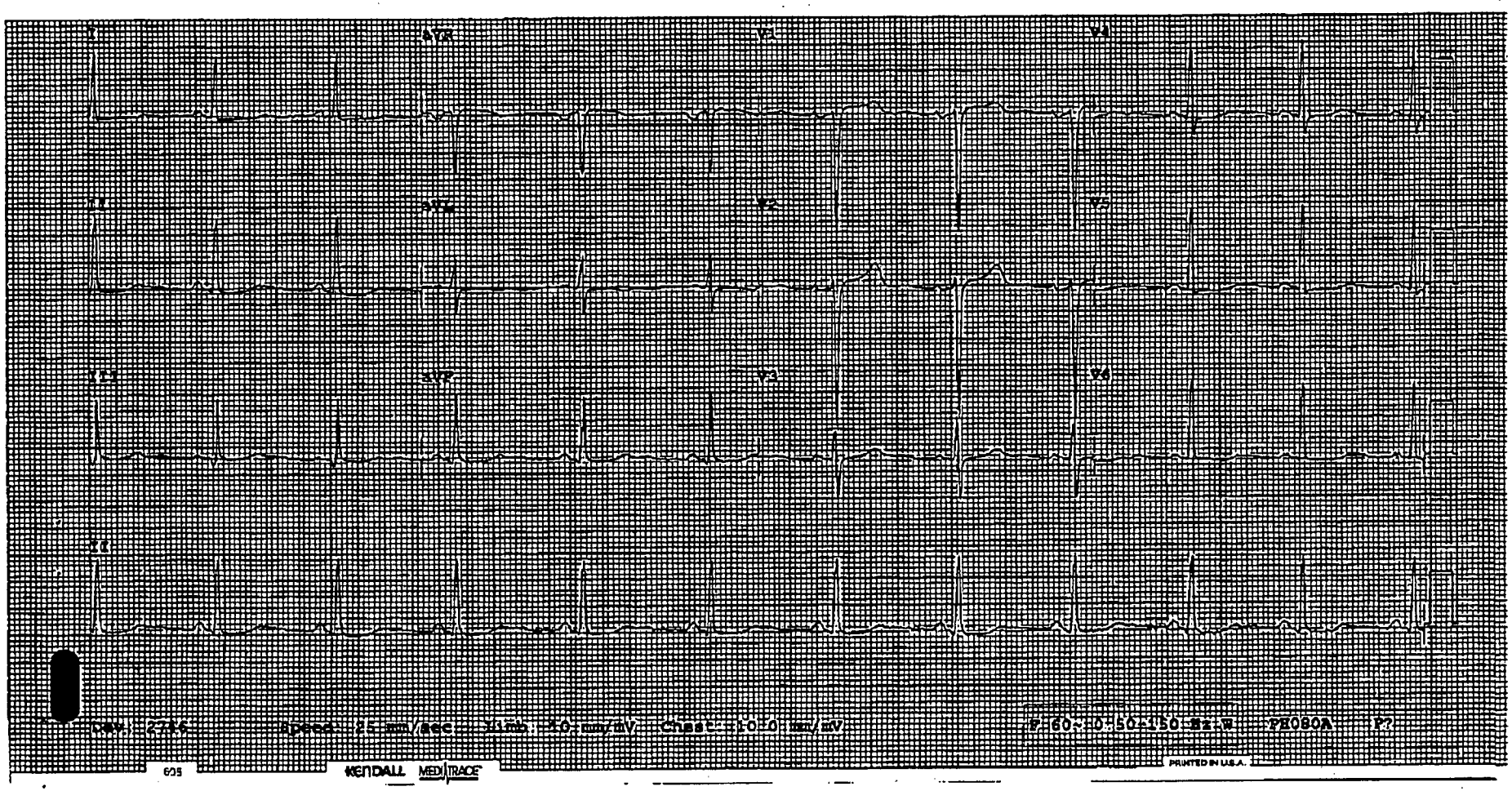
Account> 12643706

Fac: THS (10)

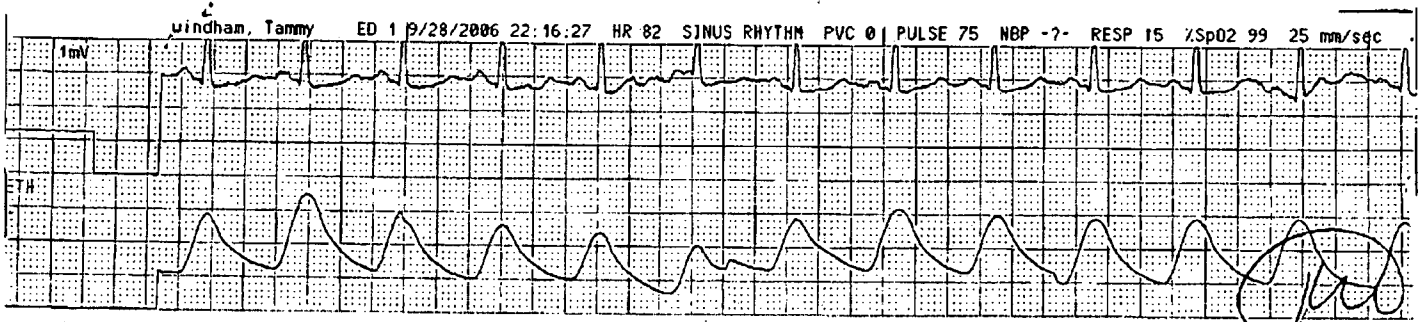
325

- ABNORMAL ECG -

PRELIMINARY - MD MUST REVIEW



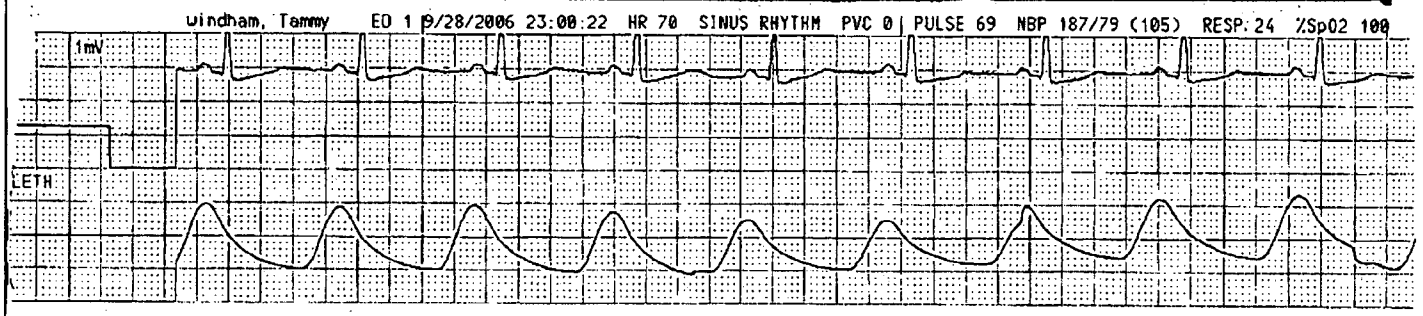
001741



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____



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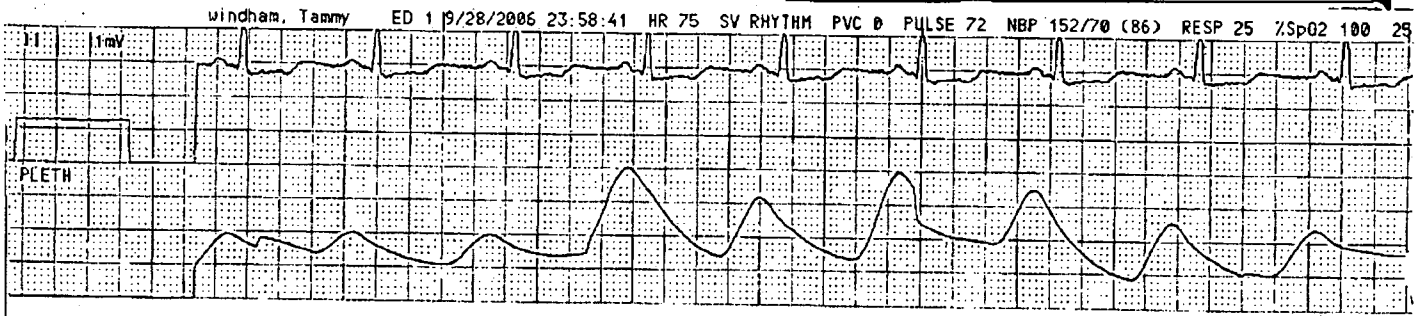
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: [redacted]

ED 1 9-28-06
windham, Tammy
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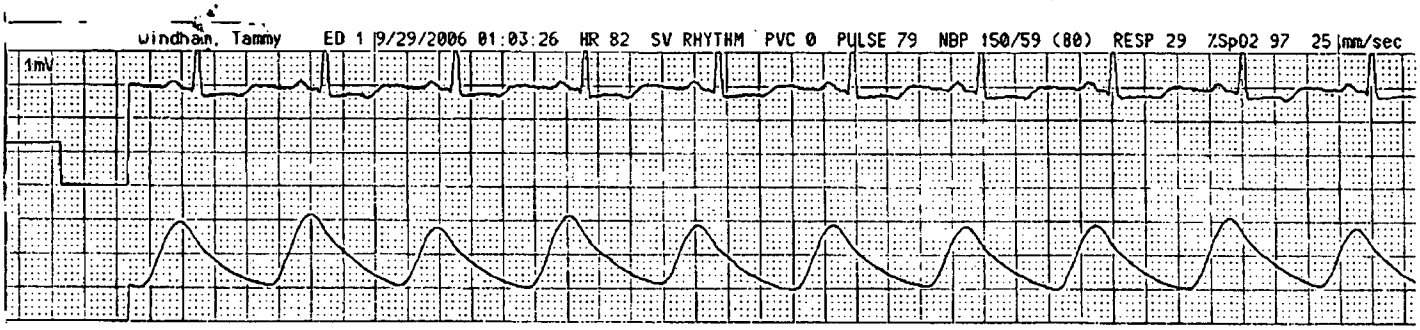
RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

5528

001742



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____ [redacted]

ED1 9-29-06
windham, Tammy
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RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

5529

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
WINDHAM,TAMMY ELIZABETH [redacted]	12647094		ER	ED	229998

Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
[redacted]	38	F	M	HOL	W	N

Guarantor / Address	Person to Notify / Address	Relationship
WINDHAM,TAMMY ELIZABETH [redacted]	WINDHAM,TOMMY [redacted]	H

Other Phone

Next of Kin / Address	Relationship
PARROTT,MELINDA [redacted]	SI

Financial Class S

Other Phone 803-506-4697

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit
ONSET OF SYMPTO	H/A CHEST PAIN

Accident Date / Time	Comments	Height / Weight	Arrival Mode
10/05/06	ID		

Admit Date / Time	Admitting Physician	Attending Physician	User
10/05/06 1905		NO DOCTOR	NSCBR

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does Pt have Advance Directive?

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (ER)

00000 Rev. 01/01/2004

[redacted]

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Oct 05 2006 19:13 MAF)
COMPLAINT: COMPLAINT: H/A Chest Pain.
ADMISSION: URGENCY: 1 - Emergent, ADMISSION SOURCE: Home, TRANSPORT: Walked, BED: LOBBY.
PATIENT: NAME: Tammy E Windham, AGE: 38, GENDER: Female, DO[redacted] TIME OF GREET: Thu, Oct 5 2006 19:03, LANGUAGE: English, RACE: Caucasian, Latex Allergy: No, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, ACCOUNT NUMBER: 12647094, PAYMENT: Self Pay, ATTENDING: Doctor No, IBEX NUMBER: 20061005191344ADT.
PREVIOUS VISIT ALLERGIES: Nkda.
ASSESSMENT: Pain level 10, using numeric pain scoring., Since Today, Pt. states that she has a HA, sternal chest pain. Denies radiation. Reports dizziness. Reports N/V. Tearful in triage.
TRIAGE INTERVENTIONS: assessment performed.
VITAL SIGNS: BP 166/95, Pulse 91, Resp 20, Temp 99.0, Pain 10, O2 Sat 97, w/wo O2 wo, Time 1913.

KNOWN ALLERGIES
Nkda.

HPI ABDOMINAL PAIN (19:49 BBH)
CHIEF COMPLAINT: Patient presents for the evaluation of abdominal pain, vomiting.
HISTORIAN: History obtained from patient, History obtained from parent/family.
TIME COURSE: Onset of symptoms reported as gradual, Onset was today, Patient currently has symptoms, Complaint is persistent, Complaint is constant.
QUALITY: Patient describes pain as pressure.
LOCATION FEMALE: Radiation is not present.
SEVERITY: Maximum severity is moderate, Currently symptoms are moderate.
FEMALE ASSOCIATED WITH: Patient denies vaginal discharge, vaginal bleeding.
MODIFYING FACTORS FEMALE: No history of hysterectomy, Menopause not applicable, Pregnancy unknown at this time.
RISK FACTORS FEMALE: Ectopic Pregnancy Risk Factors: none, AAA Risk Factors: none.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by nothing.
NOTES: with chest pain and headache.

HISTORY
MEDICAL HISTORY (Oct 05 2006 19:13 MAF): Additional history includes: Additional history includes: History of hypertension, which is not being treated. History of hypertension, which is not being treated.
PSYCHIATRIC HISTORY (Oct 05 2006 19:13 MAF): No previous psychiatric history.
SURGICAL HISTORY (Oct 05 2006 19:13 MAF): Patient's previous surgical history is not relevant to the case. History of appendectomy, History of cholecystectomy.
SOCIAL HISTORY (Oct 05 2006 19:13 MAF): Denies drug abuse, Patient smokes tobacco, at .5, packs per day for 20, years; equating to 10, pack years

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TUOMEY HEALTHCARE
EMERGENCY RECORD

of smoking, Denies consumption of alcohol.
FAMILY HISTORY (Oct 05 2006 19:13 MAF): No family history of coronary artery disease, Family history includes asthma, Family history includes CVA, Family history includes diabetes, Family history includes hypertension, Family history includes malignancy.
NOTES (19:49 BBH): Nursing records reviewed, Agree with nursing records.

ROS (19:49 BBH)
CONSTITUTIONAL: Historian reports weakness, No fever, No chills.
EYES: No blurred vision.
ENT: No URI symptoms.
CARDIOVASCULAR: Historian reports chest pain, Chest pain is substernal, No radiation.
RESPIRATORY: No Cough, No SOB.
GI: Historian reports abdominal pain, Historian reports nausea, Historian reports vomiting.
GENITOURINARY FEMALE: No dysuria.
MUSCULOSKELETAL: No neck pain.
SKIN: No rash.
NEUROLOGIC: No headache.
ENDOCRINE: No polyuria.
HEMO/LYMPHATIC: Patient does not bruise easily.
ALLERGIC/IMMUNOLOGIC: No hives.
PSYCHIATRIC: No depression.

PHYSICAL EXAM (19:51 BBH)
CONSTITUTIONAL: Patient is afebrile, Vital Signs Reviewed, nearly hysterical.
HEAD: Atraumatic, Normal cephalic.
EYES: Pupils equal and reactive to light, No discharge from eyes, Extraocular muscles intact, Sclera are normal, Conjunctiva are normal.
ENT: Ears normal to inspection, Nose examination normal, Oropharynx normal, Mouth normal to inspection.
NECK: Normal ROM, No jugular venous distention, No meningeal signs, Cervical spine non-tender.
RESPIRATORY/CHEST: Chest is non-tender, Breath sounds normal, No respiratory distress.
CARDIOVASCULAR: No pain above the umbilicus, RRR, No murmurs, Normal S1 S2, No rub, No gallop, PMI normal to palpation, BP normal in both arms, Femoral pulses normal.
ABDOMEN: No pulsatile masses, No other masses, Bowel sounds normal, No distension, No peritoneal signs, No hernias, McBurney's point nontender, No Murphy's sign, Liver and spleen normal, Tenderness, in epigastric area.
PELVIC: Assessment includes:, Pregnancy Test: Pregnancy test ordered and results are not completed.
BACK: There is no CVA Tenderness, There is no tenderness to palpation, Normal inspection.
UPPER EXTREMITY: Inspection normal, No cyanosis/clubbing/edema, Normal range of motion.
LOWER EXTREMITY: Inspection normal, No cyanosis/clubbing/edema, No calf

tenderness, Normal range of motion.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

NEURO: GCS is 15, No focal motor deficits, No focal sensory deficits, No cerebellar deficits.
SKIN: Skin is warm and dry, No rash or induration.
LYMPHATIC: No adenopathy in neck, No adenopathy in axillae, No adenopathy in groin.
PSYCHIATRIC: Oriented X 3, Normal affect.

DOCTOR NOTES
PATIENT STATUS (21:05 BBH): Patient has improved since admission.
TEXT (22:02 BBH): resting, comfortable, NAD
quant pending.
(22:24 BBH): told pt we should not do CT yet, should determine fetal age, at the present neuro exam is nl, no compeeling reason to do CT unless pt has persistent H/A, could shield abd, there is still alot of radiation with a CT and I'm not willing to risk that exposure if fetus is in active organogenesis.

O2SAT INTERPRETATION (21:04 BBH)
O2SAT: O2 saturation reading 97%, O2 AMT: R.A., O2 Sat normal, None needed, Continuous Pulse Ox.

EKG INTERPRETATION (19:52 BBH)
MONITOR STRIP: Interpreted by ED Physician, Cardiac Monitor Strip interpretation is Normal Sinus, Rate is normal.
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, Compared with previous EKG, from 092806, Conduction is normal, Axis: normal, non-specific EKG, Interpretation: no acute change.

LAB INTERPRETATION
INTERPRETATION (21:04 BBH): I reviewed the lab results, Elevated WBC, Decreased Hemoglobin, CBC otherwise normal, Decreased Potassium, Normal liver functions, Elevated Amylase, Normal Lipase, otherwise liver functions normal, Urine HCG: Positive, UDS opiates
ETOH neg.
(22:17 BBH): quant 3150.

RADIOLOGY INTERPRETATION (21:05 BBH)
CHEST: Interpretation of chest X-ray shows, chest x-ray negative, no infiltrates, no pneumothorax, no hemothorax, no masses, no cardiomegaly, no CHF, no effusion, no free air.
INTERPRETER: Preliminary review of x-rays by ED Physician, CT head on hold, urine preg pos.

NURSING PROCEDURE: EKG CHART (19:32 ALN)
TIME: EKG was performed at 1925, 12 lead EKG Performed-left chest, After procedure, EKG for interpretation given to Dr. HUBBARD.

NURSING PROCEDURE: URINE COLLECTION (20:44 APP)
URINE COLLECTION FEMALE: Patient's identity verified by, patient stating

name, patient stating birth date, hospital ID bracelet, Procedure performed at 2040, Mid-stream clean catch, Straight cath performed using 8fr quick cath kit, in 1 attempt, Specimen labeled and sent to

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TUOMEY HEALTHCARE
EMERGENCY RECORD

lab, Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: DISCHARGE NOTE (22:42 APP)
TIME: Patient discharged at 2230, Patient discharged to, home, Patient, ambulates without assistance, Transported via friend/family driving, Accompanied by family member, IV discontinued with catheter intact. Dressing placed to IV site, Infused for 1 hour, Discharge instructions given to, patient, Simple/moderate discharge teaching performed, Teaching performed by April L. Phillips, LPN, Name of prescription(s) given: Tylenol, Prescription given and additional instructions on side effects of same given, Above Person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician.

DIAGNOSIS (22:18 BBH)
FINAL: PRIMARY: pregnancy, ADDITIONAL: cephalgia, mild anemia, hypokalemia, mild pancreatitis.

PRESCRIPTION (22:20 BBH)
Phenergan: Suppository : 25 mg : Rectal=Quantity: ***1*** Unit: supp Route: Rectal Schedule: every 6 hours as needed Dispense: ***5*** National drug code: 55289041506
MODERATE INTERACTION Ultram.

INSTRUCTION (22:21 BBH)
DISCHARGE: CLEAR LIQUID DIET.
FOLLOWUP: n NO DOCTOR, .
SPECIAL: store brand Tylenol
OB ultrasound
followup with gynecologist for appointment
clear liquids for 1 o 2 days, advance diet as tolerated.

DISPOSITION
PATIENT (22:17 BBH): Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable, Patient Flag: .
(22:43 APP): Pain Scale: 0, Oxygen: No, Patient Flag: , Remove from ER.

ADMIN
DIGITAL SIGNATURE (19:32 ALN): Nesbitt, Ashlee.
(22:22 BBH): Hubbard, Brad.
(22:24 BBH): Hubbard, Brad.
(22:42 APP): Phillips, April.

KEY:
ALN=Nesbitt, Ashlee APP=Phillips, April BBH=Hubbard, Brad

5535

001748 229998 05-Oct-2006 19:29:43 WINDHAM, TAMMY
38 Years Female Race: White BP 166/95

Dept: Emergency Dept. (02)
Room: ED-12
Oper: 33 MA

334

Rate 80
RR 750
PR 144
QRSD 89
QT 376
QTcB 434
QTcF 414
-- AXIS --
P 59
QRS 61
T 86

- STMT - * SINUS RHYTHM, RATE 80
- STMT - * PROBABLE LVH WITH SECONDARY REPOLARIZATION ABNORMALITY
[STELVH] . ANTERIOR ST ELEVATION, PROBABLY DUE TO LVH
- STMT - * SINCE LAST TRACING, 09/28/2006: MORE QRS VOLTAGE AND ST-T CHANGE.

Account Number:12647094
OrderID:
COMMENTS:
Edited By:ZARIYA ALLAOUI

- ABNORMAL ECG -

Requested By: HUBBARD,B
Standard 12

PREVIOUS 28Sep2006h22:23:18--Abnormal:Confirmed

Tuesday Healthcare Systems (R) TDS (10) Edited: Confirmed by: Hugh T. Shoddard, M.D. 25-Oct-2006 11:39:32

I aVR V1 V4
II aVL V2 V5
III aVF V3 V6

Device: 4/7/6 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV

7.60 To 5.350 Rs M PB080A

NO. M1737A KENDALL MEDITRACE PRINTED IN U.S.A.

[redacted]98

EXAM: XR CHEST (PA OR AP 1 VIEW)060
EXAM DATE: 10/05/2006 00:00:00
PHYS: PARKER, GILBERT E
REASON: HA CHEST PAIN

CHEST

AP portable chest demonstrates the heart size to be normal and the lungs clear.

IMPRESSION: No acute process in the chest.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/09/07 TUH NPR LAB **LIVE** PAGE 133
RUN TIME: 1802 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12647094 LOC: ED U #: 229998
AGE/SX: 38/F ROOM: REG: 10/05/06
REG DR: BUBBARD,BRADLEY STATUS: DEP ER BED: DIS:

****HEMATOLOGY****

HEMOGRAM

Day	1			
Date	OCT 5			
Time	2020		Reference	Units
WBC	11.5 #	H	(3.0-11)	1000/UL
RBC	4.90		(3.7-5.3)	MIL/UL
HGB	10.9	L	(11.5-16.0)	G/DL
HCT	35.0		(33-46)	%
MCV	71.5	L	(79-95)	FL
MCH	22.3	L	(26-34)	PG
MCHC	31.2		(29-35)	G/DL
RDW	19.3	H	(11.9-15.5)	%
PLATELET COUNT	390		(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

Day	1			
Date	OCT 5			
Time	2020		Reference	Units
NEUTROPHILS	67.6		(42-76)	%
LYMPHOCYTES	23.4		(16-48)	%
MONOCYTES	5.5		(0.0-10.0)	%
EOSINOPHILS	2.2		(0.0-7.6)	%
BASOPHILS	1.4		(0.0-1.5)	%

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/09/07 TUH NPR LAB **LIVE** PAGE 134
RUN TIME: 1802 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12647094 (Continued)

****URINALYSIS****

	Day 1			
	Date OCT 5			
	Time 2040		Reference	Units
COLOR	YELLOW			
APPEARANCE-2	CLEAR		(CLEAR)	
GLUCOSE	NEGATIVE		(NEGATIVE)	MG/DL
BILIRUBIN	NEGATIVE		(NEGATIVE)	
KETONES	NEGATIVE		(NEGATIVE)	
SPECIFIC GRAVTY	1.015		(1.001-1.035)	
BLOOD	NEGATIVE		(NEGATIVE)	
PH	6.0		(5-9)	
PROTEIN	NEGATIVE		(NEGATIVE)	MG/DL
UROBILINOGEN	0.2		(0.2-1.0)	MG/DL
NITRITES	NEGATIVE		(NEGATIVE)	
LEUKOCYTES	SMALL	H	(NEGATIVE)	
WBC	3-6		(0-6)	/HPF
RBC	0		(0-2)	/HPF

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/09/07 TUH NPR LAB **LIVE** PAGE 135
RUN TIME: 1802 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12647094 (Continued)

****CHEMISTRY****

Day	1					
Date	OCT 5					
Time	2040	2020	2020		Reference	Units
SODIUM			139		(135-151)	MEQ/L
POTASSIUM			3.4	L	(3.5-5.1)	MEQ/L
CHLORIDE			108		(99-116)	MEQ/L
C02			23		(22-30)	MEQ/L
GLUCOSE SERUM			110		(80-110)	MG/DL
BUN			8		(7-18)	MG/DL
CREATININE			0.8		(0.8-1.5)	MG/DL
CALCIUM			9.0		(8.4-10.2)	MG/DL
PROTEIN			7.2		(6.3-8.2)	GM/DL
ALBUMIN			3.8		(3.5-5.0)	GM/DL
BILI-TOTAL			0.3		(0.2-1.3)	MG/DL
ALT (SGPT)			23		(9-52)	U/L
AST (SGOT)			18		(14-36)	U/L
ALK PHOS			126		(38-126)	U/L
PREGNANCY TEST	POSITIVE H				(NEGATIVE)	
QUANT BETA-HCG		3150(a) H			(0-6)	mIU/ml

(A) Negative <5.0
4 WEEKS 4700-132800
5 WEEKS 3660-134000
6 WEEKS 22600-135000
7 WEEKS 44800-148600
8 WEEKS 52600-191800
9 WEEKS 57400-196000
10 WEEKS 51000-189400
11 WEEKS 6480-192400
12 WEEKS 6740-129000
13-27 WEEKS 8200-147200
28-40 WEEKS 2320-91800

AMYLASE	115	H	(30-110)	U/L
LIPASE	56		(23-300)	U/L

NOTES: (a) OUTSIDE OF THE LINEARITY OF THE ANALYZER REPEATED FOR VERIFICATION YES
See also (A)

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/09/07 TUH NPR LAB **LIVE** PAGE 136
RUN TIME: 1802 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12647094 (Continued)

****CHEMISTRY****

DRUG SCREEN

Day	1		
Date	OCT 5		
Time	2040	Reference	Units
BENZODIAZEPINE	NEGATIVE	(NEG)	
BARBIT	NEGATIVE	(NEG)	
AMPHET*	NEGATIVE	(NEG)	
COCAIN*	NEGATIVE	(NEG)	
THC*	NEGATIVE	(NEG)	
PCP*	NEGATIVE	(NEG)	
OPIATES*	POSITIVE	(NEG)	
METHADONE*	(b)	(NEG)	

(B) CUT OFF VALUES FOR POSITIVE RESULTS

BENZO	300 ng/mL	THC	50 ng/mL
BARBIT	200 ng/mL	PCP	25 ng/mL
AMPHET	1000 ng/mL	OPIATES	2000 ng/mL
COCAINE	300 ng/mL	METHADONE	300 ng/mL

THIS URINE DRUG SCREEN IS FOR MEDICAL USE ONLY. THESE RESULTS SHOULD BE USED ONLY BY PHYSICIANS TO RENDER DIAGNOSIS, TREATMENT, OR TO MONITOR PROGRESS OF MEDICAL CONDITIONS. THESE RESULTS SHOULD NOT BE USED FOR ANY LEGAL PURPOSES(S) OR FOR EMPLOYMENT EVALUATION PURPOSES. SPECIMEN WAS RECEIVED WITHOUT CHAIN OF CUSTODY AND WAS NOT HANDLED AS A LEGAL SPECIMEN.

NOTES: (b) NEGATIVE
See also (B)

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/09/07 TUH NPR LAB **LIVE** PAGE 137
RUN TIME: 1802 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12647094 (Continued)

Test	Day	Date	Time	Result	Reference	Units
ALCOHOL-BLD-MED	1	OCT 5	2020	< 10(c)	(0-10)	MG/DL

NOTES: (c) LOWER LIMIT OF DETECTION 10 MG/DL
RESULTS < 10 MG/DL ARE CONSIDERED ZERO

THIS BLOOD ALCOHOL LEVEL IS FOR MEDICAL USE ONLY. THESE RESULTS SHOULD BE USED ONLY BY PHYSICIANS TO RENDER DIAGNOSIS OR TREATMENT OR TO MONITOR PROGRESS OF MEDICAL CONDITIONS. THESE RESULTS SHOULD NOT BE USED FOR ANY LEGAL PURPOSE(S) OR FOR EMPLOYMENT EVALUATIVE PURPOSES. SPECIMEN WAS RECEIVED WITHOUT CHAIN OF CUSTODY AND WAS NOT HANDLED AS A LEGAL SPECIMEN.

TUOMEY
HEALTHCARE SYSTEM

Name: Windham, Tammy E
Age: 38
Gender: F
Medrec: 229998
Acct: 12647094
Attending: BBH
Primary Nurse: NSS
Bed: ED 2-ER 12

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
pregnancy

ADDITIONAL DIAGNOSIS
cephalgia
mild anemia, hypokalemia
mild pancreatitis

FOLLOWUP CONTACT

n NO DOCTOR

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
store brand Tylenol
OB ultrasound
followup with gynecologist for appointment
clear liquids for 1 o 2 days, advance diet as tolerated

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
CLEAR LIQUID DIET

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Phenergan : Suppository : 25 mg : Rectal
Dispense: 5, Quantity: 1, Schedule: every 6 hours as needed

Tammy Windham
Patient Signature

alp LPN 2230 alp 2230
RN/LPN Ini. TIME

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RECHECK 166/95 dlp

001756

WINDHAM,TAMMY ELIZABETH
Acct: 12647094 Unit: 229998
NO DOCTOR
ED
F W Age: 38 DOS: 10/05/06

ncy Department - Triage / Order Record

Triage Level: ____
Date: _____

Triage Time: | Age: | DOB:

Chief Complaint: 165/104

Pain: ☐ Acute ☐ Chronic Quality: ☐ Dull ☐ Throbbing ☐ Sharp ☐ Radiating ☐ Ache ☐ Pressure

Latex Allergies: ☐ Yes ☐ No
Food Allergies: ☐ Yes ☐ No
Drug Allergies:

T:	BP:	P:	R:	Wt (kg)	Ht:	SaO2	B/S	LMP
99	165/104	91	20	135	53	97%		

Mode of Arrival: ☐ Foot ☐ Ambulance ☐ Car ☐ Carried ☐ Police ☐ Wheelchair

Hx of S/S of TB ☐ Yes ☐ No
Precautions: ☐ Tissues ☐ Mask ☐ Isolation ☐ Instruction

Visual Acuity ☐ Lens ☐ No Lens
OD _____ OS _____
OU _____

Home/Homeopathic/Herbal Meds.

Immunizations: ☐ UTD ☐ Tetanus _____ (Date)

Suspected Pt. Abuse: ☐ Yes ☐ No

Pre-Hospital Care: ☐ EMS ☐ C-collar ☐ Spinal Immobilization ☐ None ☐ Other _____

HPI: (location, quality, duration, timing, modifying factors, associated signs)

Nursing Diagnosis: ☐ Altered Comfort ☐ Impaired Integrity ☐ Ineffective Coping ☐ Health Care Seeking ☐ Impaired Gas Exchange ☐ Altered Tissue Perfusion ☐ Other: _____

Nurse Signature:

Review of Systems: ☐ All reviewed and negative

Yes	No	
☐	☐	Fever
☐	☐	Visual Problems
☐	☐	Difficulty Hearing
☐	☐	Chest Pain
☐	☐	Difficulty Breathing
☐	☐	Vomiting Diarrhea
☐	☐	Dysuria / Discharge
☐	☐	Trauma
☐	☐	Rash
☐	☐	Extremity Weakness
☐	☐	Depression
☐	☐	Excessive Thirst
☐	☐	Abnormal Bleeding

Past Medical/Family History:

Yes	No	Family	
☐	☐	☐	Lung Disease
☐	☐	☐	Heart Disease
☐	☐	☐	Kidney Disease
☐	☐	☐	HTN
☐	☐	☐	CVA
☐	☐	☐	Diabetes
☐	☐	☐	Cancer,
☐	☐		HIV
☐	☐		Seizures
☐	☐		Sickle Cell Dse
☐	☐		Surgery
☐	☐		Psychiatric

Social History: ☐ Smoke_____ ☐ EtOH _____ ☐ Drugs_____

ORD	LAB/X-RAYS	TIME	INIT
	EKG ▲	1948	
	CBC/diff ▲■		
	BMP▲■ or CMP		
	LFT		
	Amy/Lip	1948	
	FSBS		
	Troponin I ▲		
	CKMB▲		
	PT/PTT ■		
	Blood Cx 1 or 2		
	T&S ■ or T&C		
	ABO		
	GC/Chlamydia		
	Wet Prep		
	U/A ■		
	Urine C&S		
	Urine Preg.		
	QHCG		
	ABG ☐ RA		
	CXR		
	PCXR ▲■		
	C-Spine ■		
	Abd Series		
	Ankle ☐L ☐R		
	Wrist ☐L ☐R		
	Hip ☐L ☐R		
	Cardiac Protocol = ▲		
	Trauma Panel = ■		
	O.D. Panel		

Ibuprofen _____
Tylenol _____

☐ DT 0.5 ml IM
Time Lot # Site Nurse

☐ Cardiac Monitor ▲ ☐ Foley ☐ I/Os
☐ Oxygen ▲ ☐ NGT ☐ Lavage
☐ Pulse Ox ☐ IV/NT

TIME	PHYSICIAN ORDERS	TIME	INIT
	Keplock		
	2024 Ativan 2mg IV		
	2024 Morphine 4mg IV		
	Phenergan 12.5mg IV		
	Tylenol PO	1030	dlp

PHYSICIAN SIGNATURE | TIME TO ROOM

____/Time_____ Dictated _____

WINDHAM,TAMMY ELIZABETH
Acct: 12647094 Unit: 229998
NO DOCTOR
ED
F W Age: 38 DOS: 10/05/06

342

5543

001757

5544

229998 10/5/2006 19:29:43 WINDHAM, TAMMY
38 Years Female Race: White

TUOMEY HEALTHCARE SYSTEM (1)
BP: 166/95 Dept: EMERGENCY DEPT. (0>
Room: ED12
Oper: 33

. SINUS RHYTHM
Rate 80 . PROBABLE LVH WITH SECONDARY REPOL ABNRM
PR 144 . ANTERIOR ST ELEVATION, PROBABLY DUE TO LVH
QRSD 89
QT 376
QTc 434

--AXIS--
P 59
QRS 61
T -86

WINDHAM,TAMMY ELIZABETH
Acct: 12647094 Unit: 229998
NO DOCTOR
ED
F W Age: 38 DOS: 10/05/06

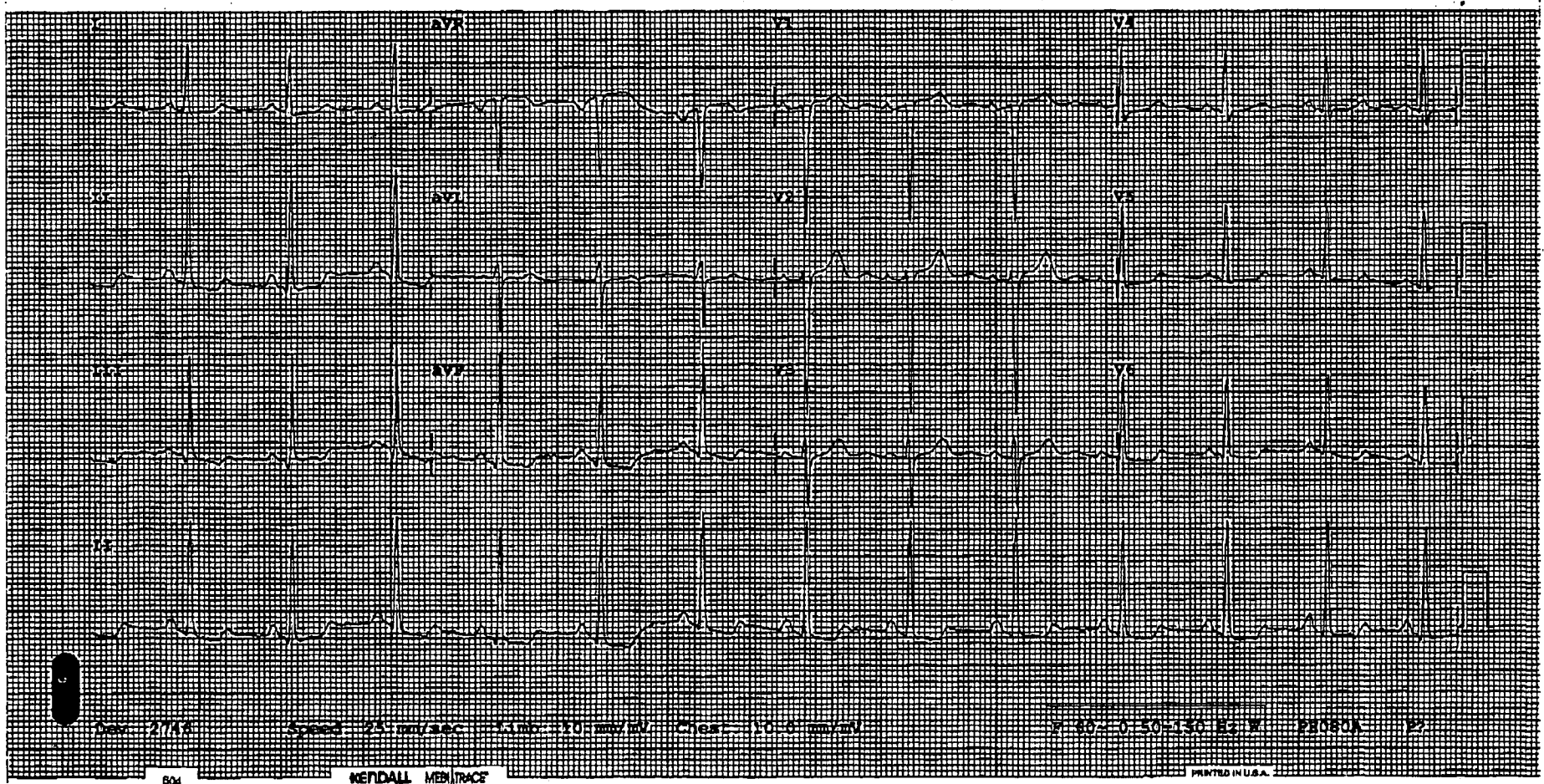
Account> 12647094

343

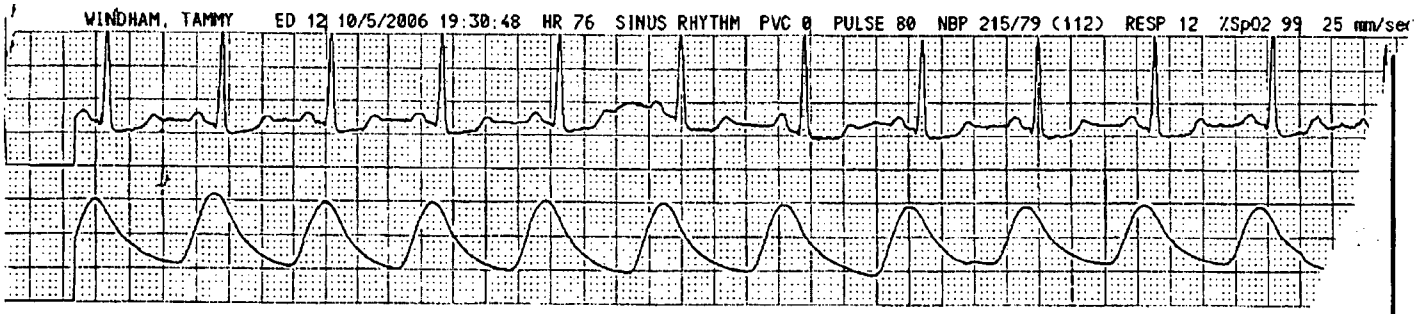
Fac: TSS (10)

- ABNORMAL ECG -

PRELIMINARY - MD MUST REVIEW



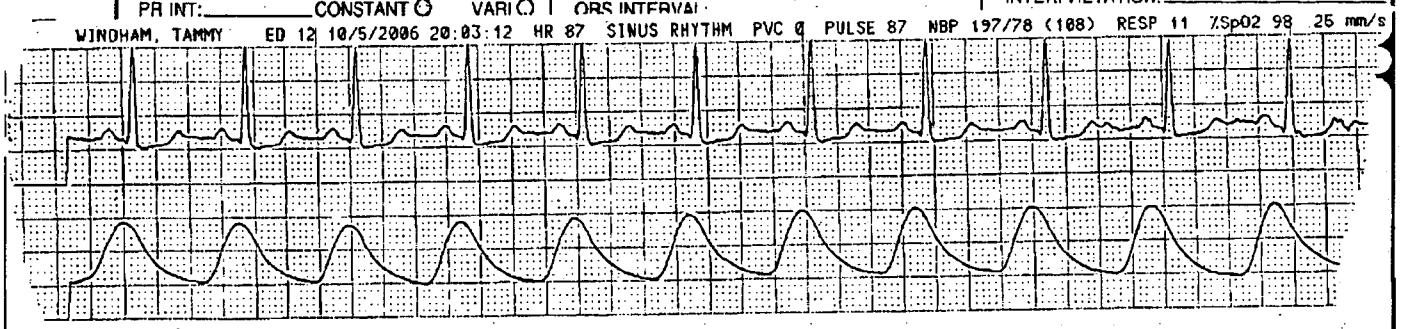
001758



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____

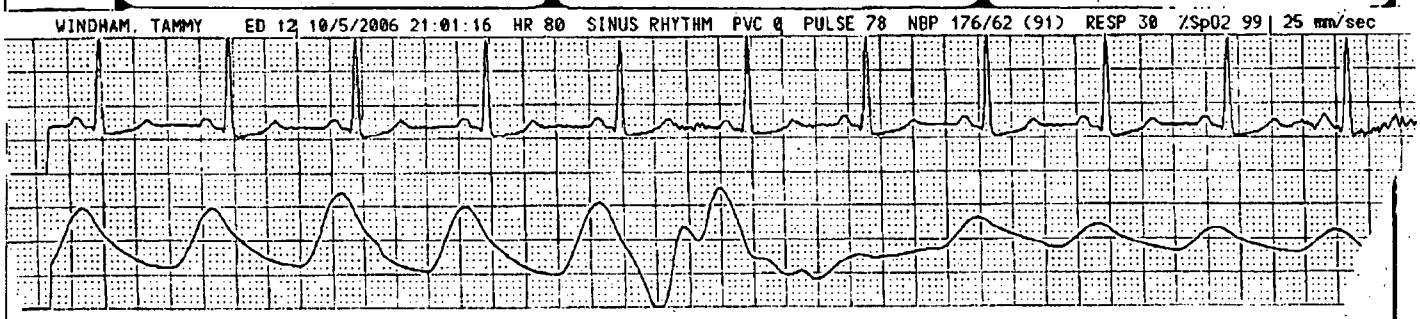
INTERPRETATION: _____



P▶ P: REG ⊙ IRREG ⊙
PR INT: _____ CONSTANT ⊙ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

WINDHAM,TAMMY ELIZABETH
Acct: 12647094
NO DOCTOR
ED
F W Age: 38
Unit: 229998
DOS: [redacted]

Windham, Tammy
ED #12

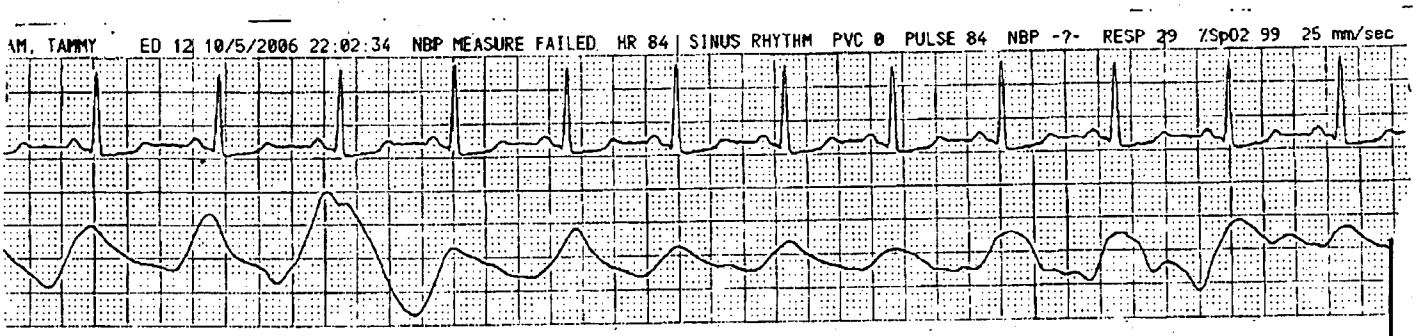
RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

344

5545

001759



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

WINDHAM,TAMMY ELIZABETH
Acct: 12647094 Unit: 229998
NO DOCTOR
ED
F W Age: 38 DOS: 10/05/06

Windham, Tammy
ED #12

345

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

5546

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service		Medical Rec. No.	
WINDHAM,TAMMY ELIZABETH [redacted]	12667789		SDC	OSC		229998	
	Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
	[redacted]	39	F	SEP	HOL	W	N

Person to Notify / Address: PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone: 803-506-4697

Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]

Next of Kin / Address: PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone: 803-506-4697

Financial Class: D

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
MEDICAID CLAIMS RECEIP	2437349601		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit		
ONSET OF SYMPTO	LAP BILATERAL TUBAL LIGATION		
Accident Date / Time	**Comments**	**Height / Weight**	**Arrival Mode**
11/20/06	RV		
Admit Date / Time	**Admitting Physician**	**Attending Physician**	**User**
11/20/06		DENNIS,RONNIE W	

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

If yes, Living Will copy received? N

Does pt have Health Care Power of Attorney? No

If yes, Health Care Power of Attorney copy received?

Does patient want info on Advance Directive? No

Are you an organ donor? No

TUOMEY HEALTHCARE SYSTEM

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (Outpatient)

00000 Rev 01/01/2004

WINDHAM,TAMMY ELIZABETH
Acct: 12667789 **Unit:** 229998
DENNIS,RONNIE W
SDC
F W Age: 39
DOS: 11/20/06 [redacted]

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TUOMEY HEALTHCARE SYSTEM
129 N. WASHINGTON STREET
SUMTER, SC 29150

001761

DISCHARGE SUMMARY

Name:	WINDHAM,TAMMY ELIZABETH	MR#:	229998
Att. Dr:	DENNIS,RONNIE W	RM#:	
Adm. Dr:		DOB:	[redacted]
Admit Date:		Discharge Date:	11/20/06
Location:	OSC	Service:	
Account#:	12667789		

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

DATE OF ADMISSION: 11/20/2006

DATE OF DISCHARGE: 11/20/2006

ACCOUNT NUMBER: 12667789

DATE OF BIRTH: [redacted]

Ms. Windham was admitted for sterilization with laparoscopic bilateral tubal ligation with partial salpingectomies without complications. She was discharged in good condition with instructions to return to the office in 2 weeks for followup.

DISCHARGE MEDICATIONS: Tylox 1 p.o. q. 4h. p.r.n. #20, Motrin 600 mg 1 p.o. q. 6h. #30.

FINAL DIAGNOSES: Desires for sterilization.

PROCEDURE: Laparoscopic bilateral tubal ligation with partial salpingectomies.

RONNIE DENNIS, MD

Dict. Date: 11/20/2006 08:32 Trans. Date: 11/21/2006 13:36
460515 / 35619 /
Job: 22916

CC: RONNIE DENNIS, MD

DENRW

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Authenticated by Ronnie W. Dennis, M.D. On 11/24/06 9:37:37 AM

001763

Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

HISTORY & PHYSICAL

Patient Name: _____ H & P Date: _____

☐ H & P < or = 30 days (Pre-procedure review required)

PRE-PROCEDURE REVIEW

☐ No Change ☐ Change _____

Signature _____ Date _____ Time _____

☐ H & P >30 days = New H & P required

HISTORY

Chief Complaint/Working Diagnosis: 3 d hx Sx, R. lt s adm for stent exch

Past Medical History: _____

Past Surgical History: _____

LMP _____ ☐ N/A Allergies: _____ ☐ NKA

History of Aspirin Rx: ☐ No ☐ Yes

Current Medications: ☐ None ☐ Refer to Nursing History _____

Social History: ☐ Refer to Nursing History Childhood Immunizations: ☐ Refer to Nursing History

Mental Status: ☐ Alert, Oriented ☐ Apprehensive ☐ Cooperative ☐ Uncooperative ☐ Unresponsive ☐ Psychosis

PHYSICAL

Vital Signs: ☐ Refer to Nursing History ☐ _____

H.E.E.N.T.: ☐ Normal ☐ _____

Heart: ☐ Regular Rate and Rythm without Murmer ☐ _____

Lungs: ☐ Clear ☐ _____

Abdomen: ☐ Soft without Masses or Organomegaly ☐ _____

Breasts: _____ ☐ Patient is encouraged to obtain exam
☐ Patient states has had negative exam within last 12 months ☐ N/A

Pelvic: _____ ☐ Patient is encouraged to obtain exam
☐ Patient states has had negative exam within last 12 months ☐ N/A

Rectal: _____ ☐ N/A

Genitalia: _____ ☐ N/A

Other Findings: _____

Impression/Pre-procedure Diagnosis: Dec, in Stent

Procedure Plan: LOL

☐ Need for/risk of blood and blood products discussed with the patient/significant other _____

Signature _____ Date 4/20/10 Time _____

31056

P: [redacted]

H [redacted]

TUOMEY HEALTH[illegible]E SYSTEM

38660 REV. 04/04

001764

AUTO STOP ORDERS: ALL MEDICATIONS 30 DAYS EXCEPT THE FOLLOWING:

- Anti-Infectives – 10 days
  - * Exception: Azithromycin – 5 days
- HIV & TB Meds – 30 days
- Chemotherapeutics – 5 days
- Epidurals/PCA's – 5 days
- Heparin Drips – 5 days
- Ketorolac – 5 days
- Glycoprotein IIb/IIIa Inhibitors – 3 days

PHYSICIAN'S ORDER SHEET

DRUG ALLERGIES	1. NKDA	2.	3.	4.

DOCTOR: PLEASE ENTER DATE & HOUR, SIGN EACH SET OF ORDERS.
NURSE: PLACE X IN COLUMN ON LINE FOR MEDICATIONS REQUIRED - PHARMACY.

IMPRINT PATIENT INFORMATION BELOW

[redacted]

	DATE	TIME	
W. CLERK INIT	11/20/06	0800	For OR use:
DATE			- Sensorcaine 0.25% plain for local
TIME			
TRANSCRIBER			NO Dr Dennis/MLunt RN
24 HR. CK.			

	DATE	TIME	
W. CLERK INIT			
DATE			
TIME			
TRANSCRIBER			
24 HR. CK.			

	DATE	TIME	
W. CLERK INIT			
DATE			
TIME			
TRANSCRIBER			
24 HR. CK.			

	DATE	TIME	
W. CLERK INIT			
DATE			
TIME			
TRANSCRIBER			
24 HR. CK.			

	DATE	TIME	
W. CLERK INIT			
DATE			
TIME			
TRANSCRIBER			
24 HR. CK.			

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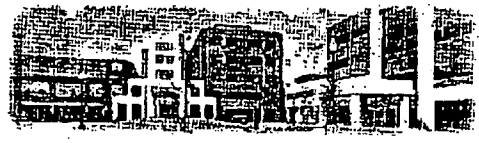
TUOMEY HEALTHCARE SYSTEM
Bringing more to life.



Tuomey Healthcare System
129 North Washington St.
Sumter, SC 29150
(803) 774-9000

REGISTRATION LEVEL OF CARE ORDER FORM

Patient Name: Tommy Windham

Date of Birth or Age: 10-18-67

Diagnosis: desired sterilization

Procedure: L+L

Attending Physician: Dr. Ronnie Mearis

Level of Care (check one): ☐ ADMIT TO INPATIENT ☐ ADMIT TO OUTPATIENT (OBSERVATION)
☑ ADMIT TO DAY SURGERY / OUTPATIENT SURGERY CENTER

Authorization (if applicable) O.R. sterilization form attached

T.O. per Physician _____ / _____

Called in by: Connie Gibbs

Physician Signature _____ Date 10/11/06

PHYSICIAN'S ORDER TO BE PLACED IN ORDER SECTION OF CHART

Surgery date 11/20/06
Preop. 11/16/06

[redacted]51

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Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

PHYSICIAN ORDER SHEET
ANESTHESIA PRE-OP ORDERS

AUTO STOP ORDERS - ALL MEDICATIONS 30 DAYS EXCEPT THE FOLLOWING:

Anti-Infectives – 10 days	Chemotherapeutics – 5 days	Ketorolac – 5 days
* Exception: Azithromycin – 5 days	Epidurals/PCA's – 5 days	Glycoprotein IIb/IIIa Inhibitors – 3 days
HIV & TB Meds – 30 Days	Heparin Drips – 5 days	

Drug Allergies: 1. NKDA 2. _____ 3. _____ 4. _____

[ ] Inpatient Admission [ ] Assign to Outpatient Observation

1. ____ NPO after midnight.
2. ____ May have clear liquids until _____.
3. **Medications:**
   - ____ Reglan 10 mg PO on arrival.
   - ____ Pepcid 20 mg PO on arrival.
   - ____ Bicitra 30 ml PO on call to OR..
   - ____ Atropine ____ mg PO on call to OR.
   - ____ Robinul ____ mg IM on call to OR.
   - ____ Midazolam ____mg IM/PO (circle one) on call to OR.
   - ____ Other: _____
4. **Labs:**
   - ____ Fingerstick blood sugar on arrival to ACU.
   - ____ CBC ____ BMP ____ CMP
   - ____ Electrolytes ____ PT/PTT
   - ____ Urine Pregnancy Test ____ Liver Function Studies
   - ____ Chest X-Ray (PA & Lateral)
   - ____ ECG
   - ____ Other: _____
5. Obtain Medical Records from:
   - ____ Tuomey Healthcare Systems
   - ____ Other: _____
   - ____ Send old chart to OR.
6. Home Medications Patient is to take A.M. of Surgery:

   _____

   _____
7. Special Instructions:

   _____

   _____

   _____

PHYSICIAN _____ 11/17/06 DATE _____ TIME _____

CHART CHECK: DATE _____ TIME _____ INITIALS _____

TUOMEY HEALTHCARE SYSTEM
Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

PHYSICIAN ORDER SHEET
OUTPATIENT SURGERY CENTER UNIT ADMISSION ORDERS

AUTO STOP ORDERS - ALL MEDICATIONS 30 DAYS EXCEPT THE FOLLOWING:

Anti-Infectives – 10 days
* Exception: Azithromycin – 5 days
HIV & TB Meds – 30 Days
Chemotherapeutics – 5 days
Epidurals/PCA's – 5 days
Heparin Drips – 5 days
Ketorolac – 5 days
Glycoprotein IIb/IIIa Inhibitors – 3 days

Drug Allergies: 1. NKDA 2. _____ 3. _____ 4. _____

(Follow optional orders only if checked)

1. Admit to: OSC
2. Diagnosis: Desired Sterilization
3. Condition: _____
4. Permit For: LTL
   to be performed by Dr. Dennis
5. Anesthesia: ___ Choice per Anesthesia
   ✓ General ___ Spinal
   ___ Regional Block ___ Epidural
   ___ Bierblock ___ Local with IV Sedation
   ___ Lab/CXR/EKG per Anesthesia
6. NPO after midnight prior to surgery
7. Preoperative Lab: ___ CBC ___ BMP ___ Electrolytes ✓ UPREG
   ___ PT, PTT ___ Urinalysis ___ CMP ___ Serum Pregnancy Test
8. ___ Type and Screen
9. ___ Prep/Hair Clipping: _____
10. ___ Antibiotic: _____ to be administered by Anesthesia in OR.
    ___ Other: _____
11. Additional Orders: _____

AMSwartz 11/17/06

PHYSICIAN _____ DATE _____ TIME _____

CHART CHECK: DATE _____ TIME _____ INITIALS _____

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TUOMEY HEALTHCARE SYSTEM
Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

PHYSICIAN ORDER SHEET - OUTPATIENT SURGERY CENTER POST-OP ORDER

AUTO STOP ORDERS - ALL MEDICATIONS 30 DAYS EXCEPT THE FOLLOWING:

Anti-infectives – 10 days	Chemotherapeutics – 5 days	Ketorolac – 5 days
* Exception: Azithromycin – 5 days	Epidurals/PCA's – 5 days	Glycoprotein IIb/IIIa Inhibitors – 3 days
HIV & TB Meds – 30 Days	Heparin Drips – 5 days	

Drug Allergies: 1. NKDA 2. _____ 3. _____ 4. _____

[ ] Inpatient Admission [ ] Assign to Outpatient Observation

(Follow optional orders only if checked)

1) DISCHARGE DIAGNOSIS: Rectal Stricture

2) Post-Op vital signs. Routine.

3) Diet: ____Liquids, advance as tolerated ____Liquids only ____NPO
NEED FOR INSTRUCTION ____YES ____NO

4) ____D/C IV when tolerating PO fluids.
____Continue IV fluids with _____ at a rate of _____.

5) Activity Level: (Check all as applicable)

____No Restrictions	____Shower	____May Climb Stairs
____No Strenuous Activity/Heavy Lifting	____Sponge Bath	____Partial Wt. Bearing
____May Drive Car	____Sitz Bath	____Non Wt. Bearing
____May Return to Work (*Date*)_____	____Resume Sexual Activity	____Ambulate w. Assistance
	____Pelvic Rest x____	____Other _____

6) MEDICATION:

- ☐ No change in Home Medications as listed on Outpatient Home Medication Inventory.
- ☐ Necessary changes for Home Medications (***any additions or discontinuations***):

Pain Med(s): Percocet 5/325 1-2 tabs PO q 4-6 hrs prn pain

Antiemetic: Phenergan 12.5 mg IV/PO q 4-6 hrs prn nausea

Insulin Instructions (IF Diabetic): _____

7) Treatment/Wound Care: ☐ Change dressing in ____ hrs, wash with soap and water, reapply dressing. Call office if any problems or if noticing any signs of infection.
☐ Do not change dressing until Post-op office visit.
☐ Other: _____

8) Follow-up Appointment: 2 wks

9) Equipment/Supply Needs: _____

10) Special Instructions: _____

11) Community Service Referrals: _____

12) ____Discharge Home When Outpatient Surgery Center Criteria Met.
____Call Me When Patient Ready for Discharge

13) Additional Orders: _____

11/20/06

Physician _____ Date _____ Time _____

Chart Check Date _____ Time _____ Initials _____

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TUOMEY HEALTHCARE SYSTEM ANESTHESIA RECORD

PATIENT SAFETY
- ☑ Patient Identified
- ☑ Anes. Machine 3
- ☑ OR # 3
- ☐ Safety Belt On
- ☑ Armboard Restraints, Less than 90 degrees
- ☑ Pressure Points Checked & Padded
- ☐ Axillary Roll with Axilla Free
- ☑ Arms Tucked
- ☑ Eye Care: ☑ Taped ☐ Ointment ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT
- ☑ Stem: ☐ Precord ☑ Esoph
- ☑ Noninvasive BP ☐ L ☐ R
- ☑ Continuous EKG
- ☑ Pulse Oximeter
- ☑ Oxygen Sensor
- ☑ End Tidal CO_2
- ☑ Temp. ☐ Nerve Stimulator
- ☑ BIS ☐ Foley
- ☐ Warming Device
- ☑ Fluid Warmer Pre-warmed IVs
- ☐ NG/OG Tube ☐ Ck for Placement
- ☐ Art. Line
- ☐ CVP
- ☐ PA Line

ANESTHETIC TECHNIQUE
- General: ☑ Preoxygenated w/ 100% ☐ Inhalation ☑ Intravenous ☐ Rapid Sequence ☐ Cricoid Pressure
- ☐ Regional: ☐ Spinal ☐ Epidural ☐ Axillary ☐ Bier Block ☐ Ankle Block
- ☐ Other
- ☐ I.V. Sedation
- Other: ☐ M.A.C. ☐

IV(S)
- ☑ In Place ☑ Started
- Site R hand
- Cath 20ga

AIRWAY MANAGEMENT
- Intubation: ☑ Blade MAC3
- Type size 7.0 ☑ Direct ☐ Blind ☐ Fiberoptic
- ☐ Regular ☐ RAE ☑ Attempts x 1
- ☐ Endobronch. ☑ $ETCO_2$ present
- ☐ Cuffed ☑ Bilateral Breath Sounds
- ☐ Uncuffed
- ☑ Oral ☐ Nasal
- ☑ Tube secured at 19 cm
- Traumatic ☑ No ☐ Yes, See remarks
- Airway ☐ Oral ☐ Nasal ☐ Difficult see Remarks
- Circuit ☑ Circle ☐ Peds Circle
- ☐ Mask Case ☐ Nasal cannula

[redacted]
PATIENT LABEL

	TIME: 0730	0800	0830	0900	TOTALS
AGENTS	Oxygen (L/min)	6	1	½	
	☐ N_2O ☑ Air (L/min)	1	1	1	
	Desflurane %	1.8-2.4			
	Sevoflurane	1.6-1.2	1.2-1.6	1	
	Decadron 8mg	↑	X		8mg
	Zofran 4mg	↑	X		4mg
	Versed mg	1			1mg
	Fentanyl mcg	100	100	50	250mcg
	Lidocaine mg	80			80mg
	Propofol mg	200			200mg
	Pancuronium mg	5			5mg
	Toradol mg		30		30mg
	Robinul mg	Ephedrine	0.4mg		0.4mg
	Atenolol mg	(5)			5mg
	Labetalol mg	10	5 10		25mg
FLUIDS	(1) LR		1000	1600	1600cc
	(2)				
	(3)				
	(4)				
	(5)				
	EBL (ml)				
	Urine int cath	150			225cc
MONITORS	EKG	SR	SR	SR	SR
	% CO_2 in spired	100	57	56	48
	O_2 Saturation	98 100	100	100	100
	End Tidal CO_2	36	32	33	42
	Temp.: ☐ C ☐ F	97.1	97.2	X	
	BIS	26	32	83	
	Intra-Ab Arch	MAP Hg	0	0	0

VITAL SIGNS — Pre-Induction

182/88 BP
79 P
Rm Air
98 SaO_2
(Sedated)
0742 Time
M.D. Initial

VENT				
Symbols for Remarks				
Tidal Volume		725	670	900
Resp. Rate		9	8	26
Peak Pressure		26	37	—
Mode (S/A/C)	S	VCV	VCV	AS
Tourniquet				
Position				

REMARKS

PRE-OP ANTIBIOTICS
N/a TIME
TIME

① Pt identified, interviewed. Chart reviewed.
② To O.R. #3. (Sedation given. Enroute) Pt moved self to O.R. bed. Monitors & PreO2 on.
③ IV induction & intubation. BBSV. ETCO2 +.
④ 8cc of ¼% Bupivacaine plain by surgeon
⑤ Pt reacting. Suction & extubate. Mask O2
⑥ Pt moved self to stretcher. To Post-op.

ANESTHESIOLOGIST PHYSICALLY PRESENT

PACU
BP 203/98 SAT 75 RA
P 82 R 20 T 97.8 Oral
Add Back + pain scale 8½
REPORT TO: M. Twohig, RN

	START	STOP	IN OR
ANESTHESIA	0738	0826	0740
SURGERY	0752	0817	ANES INDUC 0743

PROCEDURE: Bilateral Laparoscopic Partial Salpingectomy

SURGEON: Dennis CRNA: Channell

DATE: 11-20-06 ANESTHESIOLOGIST: CRNA

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Surg Start 0801 – 0813

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PRE-ANESTHESIA HISTORY & PHYSICAL RECORD

001770

SURGICAL PROCEDURE PROPOSED: laparoscopic bilateral tubal ligation

AGE	HR	BP
39	87 18	100/60 11/17/06

WEIGHT	HEIGHT	TEMP	O2 SAT
158 #	5'3"	97.5	98%

HISTORY

MEDICATIONS: None

ALLERGIES: ☒ NKDA

PRIOR ANESTHESIA & COMPLICATIONS: Appy, Cholecystectomy, cerclage

LATEX ☐ YES ☒ NO

FAMILY ANESTHESIA PROBLEMS

					NEGATIVE
CARDIO-VASCULAR:	☒ HTN (6 meds) 140/80 in office (10/17/06)	☐ MI	☐ CHF	☐ MVP/MURMUR	☐
	☐ ARRHYTHMIA	☐ CP	☐ PALPITATIONS	☐ CARDIOLOGIST	
	☐ PACER/DEFIB	☐ PREVIOUS ECHO / CATH / STRESS / HOLTER / SURGERY			
PULMONARY:	☐ ASTHMA	☐ TB	☐ COPD	☐ EMPHYSEMA	☐
	☐ SLEEP APNEA	☐ SNORER	☒ SMOKER ½ ppdx 19 yrs.	☐ CHRONIC COUGH	
	☐ HOME O2	☐ COLD	☐ WHEEZING	☐ SOB / DOE	
NEUROLOGIC:	☐ SEIZURE	☐ STROKE	☐ WEAKNESS / PARALYSIS	☐ NM DISEASE	☐
	☐ ETOH ABUSE	☐ DIZZINESS	☐ DEMENTIA / ALZHEIMERS	☐ TIA (C + BP)	
GASTRIC:	☐ REFLUX	☐ INDIGESTION	☒ HIATAL HERNIA	☐ PUD	☐
HEPATIC/RENAL:	☐ HEPATITIS A B C		☐ CIRRHOSIS	☐ HIV / AIDS	☒
ENDOCRINE:	☐ TYPE I DM	☐ TYPE II DM	DIET / PILLS / INSULIN	☐ THYROID	☒
MUSCULOSKELETAL:	☐ RHEUMATOID	☐ OA / DJD	☐ NECK/BACK PROBLEMS		☒
RENAL:	☐ CRI	☐ ESRD HD/PD _____		☐ STONES	☒
CANCER:	☐ _____	☐ SURGERY	☐ CHEMO	☐ XRT	☒
MENTAL:	☐ ANXIETY	☐ DEPRESSION	☐ SCHIZO / BIPOLAR	☐ MR	☒
PREGNANCY:	☐ NO Depo	☐ YES / UNSURE	☒ LMP 11/17/06	☐ ATL / HYST / MENOP	☒
HEMATOLOGIC:	☐ ANEMIA	☐ BLOOD THINNERS	☐ BLEEDING	☐ SICKLE CELL / TRAIT	☒
PEDIATRIC:	☐ TERM	☐ PREMATURE _____ WKS			
	< 2 YEARS:	☐ VENTILATED		☐ APNEA EPISODES	N/A

COMMENTS:

[redacted]

Carla Bryant, RN — 11/17/06
RN (IF APPLICABLE) — DATE

PHYSICAL EXAM

MENTAL STATUS:
- ☒ ALERT / APPREHENSIVE
- ☐ UN/COOPERATIVE
- ☐ UN/RESPONSIVE
- ☐ NON/COMMUNICATIVE
- ☐ PSYCHOSIS / CONFUSED

AIRWAY: _____

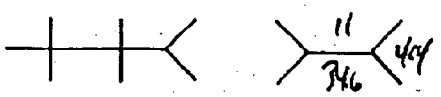
DENTITION:
- ☐ EDENTULOUS
- ☐ CAPS/BRIDGES
- ☐ MISSING
- ☐ DENTURES FULL / PARTIAL
- ☐ POOR
- ☐ CARIES
- ☐ LOOSE
- ☐ DAMAGED

JAW/NECK: _____

HEART: _____

LUNGS: _____

LABS



OTHER:

CWEKG:

CXR:

ANESTHETIC PLAN

ANESTHETIC Options Including: GA

DISCUSSED WITH: M

☐ AGREE(S) WITH PLAN

PRE-MED: Reglan 10mg PO, Pepcid 20mg PO

ANESTHETIC TECHNIQUE PLANNED:
- ☒ GENERAL
- ☐ SPINAL
- ☐ EPIDURAL
- ☐ IV SEDATION
- ☐ LOCAL/MAC
- INV. LINES: _____
- BLOCK: _____

ANESTHESIOLOGIST — 11/20/06 DATE — IT ASA CLASS

PRE-PROCEDURE ASSESSMENT

PRE-ANESTHESIA STATE: ☒ CALM pain scale 0
- ☐ AWAKE
- ☐ ASLEEP
- ☐ APPREHENSIVE
- ☐ CONFUSED
- ☐ UNCOOPERATIVE
- ☐ UNRESPONSIVE

☒ NPO ☐ CHART REVIEWED
☒ PERMIT ☐ LAB DATA REVIEWED
☐ Patients condition satisfactory to proceed with anesthesia as planned
☐ Anesthesia plan modified (NOTE):

Ruth Crannell, CRNA — 11/20/06 DATE/TIME — ANESTHESIOLOGIST

POST-OPERATIVE NOTE

11/20/06 Alert VSS
Needed large amount of Antihypertensives intraop to control VERY high BP intraop (Atenolol 5mg, Labetalol 35mg) BP OK post op. Needs Rx for BP control.

ANESTHESIOLOGIST

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TUOMEY HEALTHCARE SYSTEM
129 N. WASHINGTON STREET
SUMTER, SC 29150

001771

OPERATIVE REPORT

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: DENNIS,RONNIE W
Adm. Dr:
Admit date:
Location: OSC
Account#: 12667789

MR#: 229998
RM#:
DOB: [redacted]
Service:

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

ACCOUNT NUMBER: 12667789

DATE OF BIRTH: [redacted]

DATE OF PROCEDURE: 11/20/2006

PREOPERATIVE DIAGNOSIS: Desires sterilization.

POSTOPERATIVE DIAGNOSIS: Desires sterilization.

PROCEDURE: Laparoscopic bilateral tubal ligation with partial salpingectomies.

OPERATIVE SUMMARY: After adequate anesthesia was given, the patient was prepped and draped in the sterile fashion in lithotomy position. A weighted speculum was entered. A single-tooth tenaculum was used to grasp the cervix anteriorly. The uterus was sounded to 9 cm and the uterine manipulator was inserted. Attention was turned to the abdomen where an infraumbilical incision was made with a knife and the abdomen was entered using a Visiport. There were several adhesions around the upper abdomen where the gallbladder was surgically removed and there are also several adhesions around the retrocecal junction where the appendix was removed. They did not appear to be constricting any anatomy and (_____). The uterus appeared to be grossly normal as did the tubes and ovaries. The isthmic portions of both tubes were then cauterized and removed using the Gyrus without difficulty. Gas allowed to escape from the abdomen. The instruments were removed. The incisions were closed with 3-0 Vicryl suture deeply and subcuticular. At the end of the procedure, all sponge counts correct x3. Blood loss was minimal.

COMPLICATIONS: None.

DRAINS: None.

SPECIMENS: Isthmic portions of both tubes.

_____
RONNIE DENNIS, MD

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TUOMEY HEALTHCARE SYSTEM

001772

OPERATIVE REPORT

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12667789

Dict. Date: 11/20/2006 08:31 Trans. Date: 11/20/2006 16:07
460536 / 35619 /
Job: 22915

CC: RONNIE DENNIS, MD

DENRW

11/20/06 0000

Authenticated by Ronnie W. Dennis, M.D. On 11/21/06 5:51:56 PM

001774

TUOMEY HEALTHCARE SYSTEM
OPERATIVE REPORT / PROGRESS NOTE

PRE-OP DX: Undesired Fertility

POST-OP DX:

PROCEDURE: laparoscopic bilateral tubal ligation

FINDINGS:

gb & [illegible] surgically absent

uc with (4 cm) fibroid

OPERATIVE NOTE DICTATED: ☐ YES ☐ NO DATE: 11/20/06

SURGEON: Dr Dennis FIRST ASSISTANT:

TYPE OF ANESTHESIA:

EBL: minimal DRAINS:

SPECIMENS: Portion of fallopian tubes

SURGEON SIGNATURE: DATE: 11/20/06

DISCHARGE NOTES

FINAL DIAGNOSIS: same

CONDITION ON DISCHARGE: good

COMPLICATIONS (IF ANY): none

ABNORMAL FINDINGS (IF ANY): see above

DISPOSITION AND DISCHARGE MEDICATIONS: no Rx given

DISCHARGE INSTRUCTIONS: no ov 2 wk

MD/DO SIGNATURE: DATE: 11/20/06 TIME:

NOTES

06355 Rev. 6/28/05

[redacted] 360

5561

001775

[redacted]

Tuomey Healthcare System, Sumter, SC 29150
OUTPATIENT SURGERY CENTER
PERI OPERATIVE SURGICAL RECORD

Patient Name: _____ Acct. #: _____

Patient/Family Comments About Procedure (Their Words): Tubal

VERBAL ID OF PATIENT: ☑ Yes ☐ No
BROSELOW BAND: ☐ Yes ☐ No ☑ N/A
CONFIRMED NAME & ACCOUNT NO.: ☑ Yes ☐ No R.N. Initials MC
CHART ASSESSMENT DONE: ☑ Yes ☐ No
SURGICAL SITE CONFIRMED: ☑ Yes ☐ No
SURGICAL SITE MARKED: NA By _____ RN Initial _____
ALLERGIES: ☑ NKA
Assessed By: MC Carter RN, RN at 0730

CONSENT SIGNED/CONSISTENT: ☑ Yes ☐ No
H&P OR PROGRESS NOTE ON CHART: ☑ Yes ☐ No
ARM BAND ID ON: ☑ Yes ☐ No

NURSES NOTES:

RN Signature _____ Date / Time _____

OPERATING ROOM RECORD

PRIORITY # PRE	PRIORITY # INTRA	NURSING DIAGNOSIS	RN INITIALS PRE	RN INITIALS INTRA
☑ N/A	☑ N/A	Potential for Anxiety R/T Surgical Procedure/Environment	MC	MC
☑ N/A	☑ N/A	Potential for Hypothermia R/T ☐ Surgical Procedure ☑ Cool Environment ☐ PREP or Irrigating Fluids		
☑ N/A	☑ N/A	Potential for Injury ☑ Positioning ☑ Equipment ☐ Chemical Hazard ☐ Physical Hazard ☐ Electrical or Laser Hazard		
☑ N/A	☑ N/A	Potential for Alteration in Skin Integrity R/T ☐ Positioning ☐ Surgical Wound ☐ Age ☑ Equipment	MC	MC

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Tuomey Healthcare System, Sumter, SC 29150
OUTPATIENT SURGERY CENTER
PERI OPERATIVE SURGICAL RECORD

[redacted]

PATIENT CARE INTERVENTIONS

POSITIONING ☐ Supine ☐ Prone ☑ Lith. ☐ Exaggerated Lith. ☐ Lat. R, L ☐ Jackknife ☐ Semilowler ☑ Arm Tucked R (L) ☐ Arm at Side R, L
☐ Fob Down ☐ Beach Chair
Positioning Per: MC, M Hackworth RN

PADDING ☐ N/A ☑ Headrest ☑ Arm Pads (R) L ☑ Heel Pads (R) L ☐ Donut ☐ Pillow ☐ Between R, L ☐ Roll (Axillary, V H Shoulder, Chest, Hip) ☐ Geomatt
☐ Beanbag ☐ Well Leg Holder - R, L ☐ Stirrup Padding ☐ Alvorado Foot Rest R, L ☐ Foot board ☐ Papoose ☐ Other

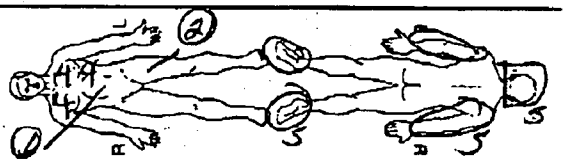
TABLE ☐ N/A ☑ OR Table ☐ OPS Bed ☐ Stretcher

TOOLS ☐ N/A ☑ Safety Strap ☑ Arm Board (R) L ☐ Stirrups - Allen, Amsco ☐ Arm Table R, L ☐ Shoulder Holder R, L ☐ Sand Bag ☐ Side Rails
☐ Knee Holder R, L ☐ Overarm Board R, L ☐ Lateral Hip Positioner w/Padding ☐ Armboard Cradle ☐ Chinese Finger Traps
☐ Universal Shoulder Positioner w/Padding

CIRCULATORY: ☑ N/A ☐ Ted Hose R, L ☐ Plexi-Pulse R, L Times ↑ ____ ↓ ____
☑ N/A ☐ Tourniquet: Site ____ Per ____ Model # ____ Pressure ____ Times ↑ ____ ↓ ____ Total Time ____
☑ N/A ☐ Tourniquet: Site ____ Per ____ Model # ____ Pressure ____ Times ↑ ____ ↓ ____ Total Time ____
☑ N/A ☐ Tourniquet: Site ____ Per ____ Model # ____ Pressure ____ Times ↑ ____ ↓ ____ Total Time ____

THERMAL: ☐ N/A ☑ Warm Blankets ☐ Saran Wrap
☐ Bairhugger Model # N/A Model # ____ ☐ Upper ☐ Lower ☐ Cub ☐ Short ☐ Long Per ____

1 Incision Site
2 Bovie Pad Lot# 106948
3 Safety Straps
4 EKG Leads
☑ Per Anesthesia
☐ Per Circulating Nurse
5 Padding
6. Rolls
7. Red Area
8. Plexi Pulse
9 Tourniquet



SURGICAL PREP: ☐ N/A Site Umbilicus, Abdomen side to Vagina side Per MC 4 x Min.
☐ Hibiclens ☐ Alcohol ☐ Duraprep ☐ Zepharin ☑ Betadine Scrub ☑ Betadine Solution ☐ Circumcised Y N ☐ Foreskin Retracted Y - NA

SHAVE: ☑ N/A Area ____ Per ____

BOVIE: ☐ N/A Model # XD18209 Cut ____ Coag ____ Bipolar ____ Per MC

CATHETER INSERTION: ☐ N/A 16 French 50 cc ☐ Balloon ☑ Preconnected Drainage Bag ☐ I and O Cath Per MC

URINE APPEARANCE: ☐ N/A ☑ Clear ☐ Cloudy ☐ Sediment ☐ Inserted without difficulty ☐ Comments ____

IRRIGATION SOLUTION: ☐ N/A ☑ NaCL ☐ H_2O ☐ LR ☐ D5W ☐ GLYCINE ☐ BSS ☐ Other ____ ☐ Epinephrine ☐ Bacitracin 50,000 Units ☐ Ancef

PARENTAL FLUID: ☐ N/A ☑ Admin. Per Anesthesia (See Anesthesia Record) ☐ Admin. Per Circulating RN Irrigation: In ____ Out ____

TUBES: ☑ N/A ☐ N/G Size ____ Per ____ ☐ Other: Type ____ Size ____

DRAINS: ☑ N/A Site ____ ☐ JP: Size ____ ☐ HEMOVAC: Size ____ ☐ TLS ____ ☐ Penrose: Size ____

PACKING: ☑ N/A Site ____ ☐ Plain ☐ Vaseline ☐ IODO Form ☐ Vaginal ☐ Other ____

DONOR SITE: ☑ N/A Site ____ ☐ Skin ☐ Bone ☐ Tendon ☐ Other ____

CAMERA/VIDEO/PICTURES: ☑ Yes ☐ No X-RAY / IMAGE ☐ Yes ☑ No

PRIORITY # PRE	PRIORITY # INTRA	NURSING DIAGNOSIS EVALUATION	RN INITIALS PRE	RN INITIALS INTRA
☐ N/A	☐ N/A	Patient Demonstrates Knowledge Coping Strategies	MC	MC
☑ N/A	☐ N/A	No S/S of Intraoperative Hypothermia		
☑ N/A	☐ N/A	No Intraoperative Injury Occurs		
☑ N/A	☐ N/A	Skin Integrity Maintained, No Redness or Edema Noted	MC	MC

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Date 11/20/06 OR# 3

Surgeon Dennis Private Scrub

Surgeon 2nd Surgeon

1st Assistant ☐ N/A Anesthesiologist Wilson

Legal Signature/Initials:

CRNA R Cranell Relief Relief

RN Circulator 1 MC Relief/Time Relief/Time

RN Circulator 2 M Hackworth RN Relief/Time Relief/Time

Surgical Tech 1 J Jones CST Relief/Time Relief/Time

Surgical Tech 2 Relief/Time Relief/Time

Surgical Tech 3 Relief/Time Relief/Time

Ortho Tech Relief/Time Relief/Time

Cell Saver Observer 1 Observer 2

X-Ray Tech Observer 3 Observer 4

IDENTIFICATION TIME-OUT: Time Out 0800 RN Initials M Hackworth RN

COUNTS	SHARPS	SPONGE	INSTRUMENT	CORRECT	SEE COMMENT	CIRCULATOR	SCRUB
Initial	☐	☐	☐	☐	☐		88
Intra OP #1 ☐ N/A	☐	☐	☐	☐	☐		
Intra OP #2 ☐ N/A	☐	☐	☐	☐	☐		
Skin Closure	☐	☐	☐	☐	☐		88

PRE OP Dx: Undesired Fertility

POST OP Dx: Same

OPERATIVE PROCEDURE: Laparoscopic bilateral tubal ligation

IMPLANTS: ☑ N/A ☐ See other side

ANESTHESIA: ☐ General ENDO/Mask/LMA ☐ Local ☐ Spinal ☐ IV Sed. ☐ Epidural ☐ Block ☐ Topical

TIME: Anes. Begin 0738 OR Arrival 0740 Surgery Begin 0752 Surgeon Begin 0801 Surgeon End 0813 Surgery End 0817 Anes. End 0826

CULTURES: ☐ N/A ☐ Site

WOUND CLASSIFICATION: ☐ I. Clean ☑ II. Clean Contaminated ☐ III. Contaminated ☐ IV. Dirty/Infected

SPECIMEN: ☐ N/A ☐ See Comments

1. Left fallopian tube tissue Time ☐ Fresh ☑ Formalin
2. Right fallopian tube tissue Time ☐ Fresh ☑ Formalin
3. Time ☐ Fresh ☐ Formalin
4. Time ☐ Fresh ☐ Formalin
5. Time ☐ Fresh ☐ Formalin
6. Time ☐ Fresh ☐ Formalin

BOVIE POST OP SKIN CONDITION: ☐ N/A ☑ Normal ☐ Other:

WOUND CLOSURE: ☐ N/A ☐ Staples ☑ Suture ☐ Steristrips ☐ Benzoin ☐ Skin Prep ☐ Mastisol ☐ Coverstrips ☐ Nasa-drip Pad

DRESSING: ☐ N/A ☐ Xeroform ☐ 4 x 4's ☐ Fluffs ☐ ABD's ☐ Telfa ☐ Toppers ☐ Kling ☐ Kerlix ☐ Cotton Sheeting ☐ Tape ☐ Ace/Double Ace ☐ Arm Cradle ☐ Webril ☐ Splint/Cast ☐ Hypafix ☐ Other: ABN pad

POST OP RESP. CONDITION: ☑ Satisfactory ☐ Extubated ☐ Intubated ☐ O_2

POST OP LEVEL OF CONSCIOUSNESS: ☑ Alert ☐ Sedated ☐ Un / Cooperative ☐ Un / Responsive ☐ Non / Communicative ☐ Psychosis / Confused ☐ Age Appropriate

POST OP CONDITION: ☑ Satisfactory ☐ Serious ☐ Critical ☐ Other:

DISCHARGE DESTINATION: ☑ Post Op ☐ ICU ☑ Room # 14 Other:

TRANSPORT MODE: ☑ Stretcher/Crib ☐ Carried Per

Post OP Report Given To: M Twohig RN By M Conte RN R Cranell CRNA 0826 OR End

001778

[redacted]
PATIENT LABEL

MEDICATIONS		INTRA-OPERATIVE	DOSE	ROUTE	ADMINISTERED BY
		Kenalog			
		Bacitracin			
		Vasopressin			
		Xylocaine			
	11/20/06 mdc	Sensorcaine .25% plain	8 cc	local	Dr Dennis
		Depomedrol			
		Celestone			
		Decadron			
		Triple Antibiotic Ointment			
		Topical Thrombin			
		Heparin			
		Cocaine 4% Topical			

NURSES NOTES:

IMPLANT INFORMATION:

TUOMEY HEALTHCARE SYSTEM
OUTPATIENT SURGERY CENTER
PERI ANESTHESIA NURSING RECORD

001779

[redacted]

PRE-OPERATIVE NURSING INTE

*** SEE PRE-ANESTHESIA HISTORY AND PHYSICAL RECORD FOR NURSING HISTORY ***

PATIENT NAME: Windham, Tammy E. DOB [redacted]

INFORMATION OBTAINED FROM: ☑ PATIENT ☐ OTHER (RELATIONSHIP TO PATIENT): _____

SURGEON: Dennis DOS: 11/20/06 PERSONAL PHYSICIAN: Ø

DIET: Regular FOOD ALLERGIES: ☐ YES ☐ NO IF "YES" GIVE DETAIL: _____

SPECIAL RELIGIOUS / CULTURAL / ETHNIC

REQUEST Hol ☑ NO ☐ YES
JEHOVAH'S WITNESS ☑ NO ☐ YES
REFUSE BLOOD PRODUCTS ☑ NO ☐ YES
CHAPLAIN CONSULT ☑ NO ☐ YES ☐ NOTIFIED

PSYCHOSOCIAL

CAREGIVER/TRANSPORTER: Dad
PHONE NUMBER: 506-4697 (Linda Parrot niece)
MAY LEAVE MESSAGE ON ANSWERING MACHINE: ☑ YES ☐ NO
CURRENTLY RECEIVING ANY HEALTHCARE OR COMMUNITY SERVICES: ☐ YES ☑ NO
☐ EXTENDED CARE FACILITY ☐ HOME HEALTH ☐ HOSPICE
ON D/C WILL YOU NEED ASSISTANCE WITH OBTAINING MEDICATIONS? ☐ YES ☑ NO

EDUCATIONAL ASSESSMENT

CAN PATIENT ANSWER QUESTIONS FOR HIMSELF/HERSELF? ☑ YES ☐ NO
NAME OF PERSON ASSESSED IF PATIENT UNABLE TO ANSWER: _____
COMPLETED: ☐ GRADE SCHOOL ☑ HIGHSCHOOL ☐ COLLEGE

DOES PATIENT HAVE:

	YES	NO
1. HEARING AID	☐	☑
2. GLASSES/CONTACT LENS	☑	☐
3. DENTURES/BRACES/RETAINER	☑	☐ full
4. PROSTHESIS	☐	☑
5. BODY PIERCING lead	☑	☐
6. OTHER: _____		

☐ N/A PEDIATRIC ASSESSMENT/INSTRUCTIONS

DEVELOPMENTAL DELAYS: ☐ YES ☐ NO
CAREGIVER'S PERCEPTION OF GROWTH AND DEVELOPMENT:

IMMUNIZATION UP TO DATE:
HEP B ☐ YES ☐ NO
PPD ☐ YES ☐ NO RESULTS: ☐ NEG ☐ POS
CAREGIVER'S UNDERSTANDING OF ILLNESS/CONDITION/OUTCOME:

TWO CAREGIVERS BANDED:	☐ YES	☐ NO
PLEASE BRING:		
BABY BOTTLE/CUP	☐ YES	☐ NO
DIAPERS/UNDERWEAR	☐ YES	☐ NO
BLANKET/TOY	☐ YES	☐ NO
NO OTHER CHILDREN ALLOWED:	☐ YES	☐ NO
CAREGIVER REMAINS AT OSC AT ALL TIMES:	☐ YES	☐ NO

Carla Bufford, RN
SIGNATURE OF INTERVIEWER, DATE

ACUTE PAIN / CHRONIC ASSESSMENT

ACUTE? ☐ YES ☑ NO CHRONIC? ☐ YES ☑ NO
LOCATION: N/A
INTENSITY (0-10): Ø
PAIN SCALE: NUMERIC/WBPS/FLACC/WONG-BAKER/NON-COMMUNICATIVE
EFFECTS OF PAIN: _____
PRESENT PAIN MANAGEMENT & EFFECTIVENESS: Tylenol
PAIN GOAL: 3-4

NURSES NOTES

ADL'S

☑ INDEPENDENT ☐ APPROPRIATE FOR AGE (PEDIATRIC)
☐ NEEDS ASSISTANCE WITH: ☐ FEEDING ☐ HYGENE ☐ DRESSING
☐ OTHER: _____

TEACHING RECORD

☑ YES	☐ NO	ARRIVAL TIME: Will call
☑ YES	☐ NO	PARKING/VALET
☑ YES	☐ NO	NPO, CLEAR LIQUIDS TIL _____, HOME MEDS _____
☑ YES	☐ NO	NO MAKE-UP, NAIL POLISH, WIG, CONTACTS, JEWELRY, VALUABLES
☑ YES	☐ NO	LOOSE CLOTHES, FLAT SHOES
☑ YES	☐ NO	PRE-OP BATH/SHOWER
☑ YES	☐ NO	BRING: MEDICATIONS/GTTS/INSURANCE CARD/ID/CRUTCHES/WALKER DOS
☑ YES	☐ NO	GOWN/BELONGINGS BAG
☑ YES	☐ NO	ANESTHESIA INTERVIEW
☑ YES	☐ NO	IV INSERTION/ANTIBIOTICS/PRE-OP MEDS
☑ YES	☐ NO	SAFETY: SR↑, CALL BELL, BUMPER PADS
☑ YES	☐ NO	SITE MARKING/SHAVE/PREP
☑ YES	☐ NO	2 ADULT VISITORS/NO CHILDREN
☑ YES	☐ NO	POST-OP CAREGIVERS FIRST 24 HOURS
☑ YES	☐ NO	WAITING AREA/CONSULTATION ROOM/UPDATES
☑ YES	☐ NO	SURROUNDINGS: PRE/OR/POST, TEMPERATURE
☑ YES	☐ NO	POST-OP STAY: O2, PAIN, TCDB, SORE THROAT, DRESSING, D/C CRITERIA
☑ YES	☐ NO	SURGICAL PROCEDURE DISCUSSION/DOCTOR'S ORDERS
☑ YES	☐ NO	PRE-OP PROCEDURES: LABS, EKG, X-RAY, ENEMA, CRUTCH WALKING CBC, Urine Pregnancy
☑ YES	☐ NO	D/C RESTRICTION/EXPECTATIONS: NO DRIVING/CRUTCHES/WALKER/LIMITED VISION/PO FLUIDS/RXS/OTHER: _____

INITIAL	LEGAL SIGNATURE	INITIAL	LEGAL SIGNATURE
CB	Carla Bufford, RN		

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[redacted]

OUTPATIENT SURGERY CENTER
PERI ANESTHESIA NURSING RECORD

PRE-OPERATIVE NURSING ASSESSMENT AND CHECKLIST

ARRIVAL TIME: 0725 DATE: 11-20-06
PATIENT ID BANDED: ~~☐~~ YES ☐ NO
CAREGIVER: Sm #
PO STATUS: NPO p md
PROCEDURE STATED: tubal
AM MEDS AT HOME, SEE HOME MEDICATION SHEET.
CHANGES IN MEDICAL HISTORY OR MEDICATIONS:
~~☐~~ NO ☐ YES IF "YES", COMMENTS:
PAIN: CHANGES IN PAIN ASSESSMENT: ☐ NO ☐ YES (DESCRIBE):

MONITORING

TIME	BP	P	R	T	SaO_2
0725	150/101	89	18	97.5	98
0735	171/77				
	NKA				

PRIORITY #	NURSING DIAGNOSES	TIME	RN INITIALS
☐ N/A 1	KNOWLEDGE DEFICIT/ANXIETY R/T ☐ SURGERY ☐ PROCEDURE ☐ ENVIRONMENT OUTCOME: PT/SO WILL BE ~~ABLE TO~~ VERBALIZE OR DEMONSTRATE DESIRED CONTENT. ☐ YES ☐ NO		MS
☐ N/A 2	ALTERATIONS IN COMFORT R/T ☐ SURGERY ☐ PROCEDURE ☐ ANESTHESIA OUTCOME: PAIN WILL BE RELIEVED OR REDUCED OR PT WILL SHOW SIGNS OF ADAPTATION. ☐ YES ☐ NO		
☐ N/A	POTENTIAL FOR INJURY R/T ☐ MEDICATIONS ☐ MENTAL STATUS ☐ PHYSICAL LIMITATIONS OUTCOME: RISK OF INJURY WILL BE REDUCED. ☐ YES ☐ NO		
☐ N/A	OTHER: OUTCOME: ☐ YES ☐ NO		

ASSESSMENT

NEURO
- ☐ ALERT
- ☐ ORIENTED
- ☐ APPROPRIATE FOR AGE
- ☐ CONFUSED
- ☐ ANXIOUS
- ☐ OTHER:

SKIN
- ☐ PINK/NORMAL
- ☐ PALE/DUSKY
- ☐ RASH
- ☐ OTHER:

CARDIAC
- ☐ APICAL PULSE
- ☐ REGULAR
- ☐ IRREGULAR
- ☐ PACEMAKER
- ☐ OTHER:

RESPIRATORY
- ☐ CLEAR
- ☐ COUGH/CONGESTION
- ☐ WHEEZING
- ☐ ORTHOPNEA
- ☐ OTHER:

ABDOMEN
- ☐ SOFT
- ☐ FIRM
- ☐ DISTENDED
- ☐ BS PRESENT
- ☐ OTHER:

CIRCULATION/PULSES
- ☐ UPPER ☐ PRESENT ☐ ABSENT
- ☐ LOWER ☐ PRESENT ☐ ABSENT
- ☐ WARM/1-2 SEC. CAP REFILL
- ☐ EDEMA
- ☐ OTHER:

CHECKLIST

	YES	NO	N/A
CAREGIVER BANDED:	☐	☐	☑
CHAPLAIN VISIT:	☐	☐	☑
CONSENT SIGN & WITNESS (SURGERY/ANESTHESIA)	☑	☐	☐
H & P ON CHART:	☐	☐	☐
LAB REPORTS ON CHART:	☑	☐	☐
FSBS ____ MG/DL @ ____	☐	☐	☑
X-RAY:	☐	☐	☑
EKG INTERPRETATION:	☐	☐	☑
WIG/HAIR CLIPS REMOVED: ☐ TO FAMILY ☐ HOME ☐ PT. BELONGINGS	☐	☐	☑
GLASSES/CONTACTS REMOVED: ☐ TO FAMILY ☐ HOME ☐ PT. BELONGINGS	☐	☐	☑
DENTURES REMOVED: ☐ TO FAMILY ☐ HOME ☐ PT. BELONGINGS	☐	☐	☑
PROSTHESIS REMOVED: ☐ TO FAMILY ☐ HOME ☐ PT. BELONGINGS	☐	☐	☑
JEWELRY/BODY PIERCING REMOVED: ☐ TO FAMILY ☐ HOME ☐ PT. BELONGINGS	☐	☐	☑
UNDERWEAR REMOVED: Nurses	☑	☐	☐
NAILPOLISH REMOVED/MAKEUP REMOVED:	☐	☐	☑
VERIFICATION OF OPERATIVE SITE/CONSENT:	☐	☐	☑
SITE SCRUB/PREP SITE:	☐	☐	☑
VOID PRIOR TO OR:	☑	☐	☐
SAFETY PRECAUTIONS IMPLEMENTED:	☑	☐	☐
CRUTCHES/WALKER/BRACES:	☐	☐	☑
OTHER:	☐	☐	☐
ABNORMAL LAB, EKG, X-RAY REPORTED TO M.D.:	☐	☐	☐

TIME: ____ DATE: ____ COMMENTS: ____

ADMIT NURSE: MS RN

MAR

TIME/INITIAL	PRE OP MEDS (CHART EFFECT IF INDICATED)
0725 MS	Reglan 10mg PO pepcid 20mg PO

IV THERAPY

		INITIALS
TIME:	SITE: RO	MS
SIZE:	SOLUTION LR	
TOTAL # VP:	RATE:	

TO OR PER OR STAFF @ 0740 VIA: ☐ CRIB ☐ CARRIED ☐ AMBULATORY ☐ STRETCHER-SIDERAILS UP X 2

RN SIGNATURE MS RN

29667 Rev. 6/01/05

001781

OUTPATIENT SURGERY CENTER
POST OPERATIVE RECORD

[redacted]

PHASE I. ADM. TIME	PHASE II. ADM. TIME
0826	0950

ALLERGIES: NKDA
ANESTHESIOLOGIST: Wilson
CRNA: Francisco
TYPE OF ANESTHESIA: ☑ GENERAL ☐ SPINAL ☐ IV SED. ☐ REGIONAL ☐ LOCAL
SPECIAL INFO:

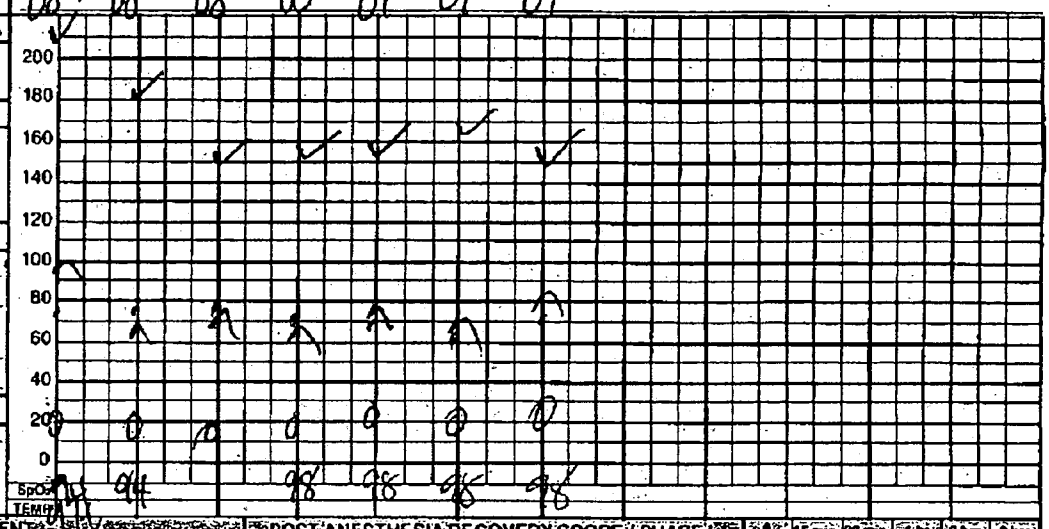
ADM. VIA
☐ CRIB ☐ CARRIED ☑ STRETCHER

AIRWAY D/C'D ____ ☐ N/A
☐ ORAL ☐ NASAL ☐ LMA
☐ ET ☐ AMBU ☐ CHIN LIFT

O_2 THERAPY ☐ N/A
4 L/MN
☐ BLOWBY ☐ MASK ☑ N/C
☐ FACETENT ☐ HUMIDIFIED
0827 ON, 0948 OFF

IV'S ☐ N/A
LOCATION Rt hand
RATE 100
☑ NO S/S INFIL ☐ PATENT
OR TOTAL 1600
POST OP TOTAL 200

D/C @ 0948 ☐ N/A
BY MA
☑ SITE CLEAR
☑ DRESSING APPLIED
☑ CATHALON INTACT



ASSESSMENT

NEURO
☐ ALERT ☐ AWAKE
☐ ORIENTED ☐ CONFUSED
☑ AROUSABLE ☐ SLEEPING
☐ APPROPRIATE FOR AGE
☐ HAND GRIPS:
☐ STRONG ☐ EQUAL
☐ ____

RESPIRATORY
☑ REGULAR ☐ IRREGULAR
☐ LABORED ☑ UNLABORED
☐ DEEP ☐ SHALLOW
☐ CRYING ☐ SNORING
☑ CLEAR
☐ COUGH ☐ CONGESTION
☐ WHEEZING ☐ CRACKLES
☐ SUCTION ____
☐ ____

CIRCULATION/PULSES
☐ N/A
☐ UPPER: ☐ R ☐ L
☐ PRESENT ☐ ABSENT
☐ LOWER: ☐ R ☐ L
☐ PRESENT ☐ ABSENT
☐ WARM ☐ COOL
☐ CAP REFILL ____
☐ MOTION: + / -
☐ SENSATION: + / -

POSITION/SAFETY
☐ SUPINE/SIDE: ☐ R ☐ L
☐ HOB ↑, FOB ↑
☐ ARM ☐ LEG ↑, ☐ R ☐ L
☐ STRECHER LOW, LOCKED, SR ↑
☑ ID BAND
☐ NURSE AT BEDSIDE

COMPLETED BY: MA

SKIN
☐ PINK
☑ PALE ☐ DUSKY
☑ WARM ☐ COOL
☐ DRY ☐ DIAPHORETIC
☐ ____

CARDIAC
☐ APICAL PULSE 77
☑ REGULAR ☐ IRREGULAR
☐ NSR ☐ ST ☐ SB RATE ____
☐ ____

ABDOMEN
☐ SOFT ☐ FIRM
☐ BLADDER DISTENDED
☐ ____

DRAINAGE
☐ OP SITE Dsg
☐ AMOUNT
☐ CHAR
☐ OTHER: ____
☐ AMOUNT
☐ CHAR

PAIN: 0-10
☐ NUMERIC 8.5/10
☐ FLACC
☐ WONG BAKER
☐ NON-COMMUNICATIVE
☐ SCORE: ____

POST ANESTHESIA RECOVERY SCORE / PHASE I

	A	15 min.	30 min.	1 hr	2 hrs	3 hrs
ACTIVITY Able to move four extremities voluntarily on command = 2; Able to move two extremities voluntarily on command = 1; Able to move no extremities voluntarily on command = 0	1	2	2	2		
RESPIRATION Able to breathe deeply and cough freely = 2; Dyspnea or limited breathing = 1; Apneic = 0	2	2	2	2		
CIRCULATION BP ± 20 of preanesthetic level = 2; BP ± 21 - 49 of preanesthetic level = 1; BP ± 50 of preanesthetic level = 0 (171/77)	0	1	1	1		
CONSCIOUSNESS Fully awake = 2; Arousable on calling = 1; Not responding = 0	1	2	2	2		
O_2 SATURATION Able to maintain O_2 saturation>92% on room air = 2; Needs O_2 inhalation to maintain O_2 saturation>90% = 1; O_2 saturation<90% even with O_2 supplement = 0	2	2	2	2		
TOTAL	6	9	9	9		
RN INITIALS	MA	MA	MA	MA		

PATIENT/S.O. TEACHING

	OUTCOME 2 P/I	OUTCOME 3 P/I	INITIALS
ORIENTED TO POST OP			MA
MEDICAL EQUIPMENT/MONITOR			MA
BED POSITION, SR , CALL-BELL			MA
MEDS			MA
T, C & DB, POSITIONING			MA
AMBULATE WITH ASSISTANCE			MA
OTHER: ____			

KEY
V = Verbalized Understanding
RD = Returned Demonstration Independently
U = Unreceptive toTeaching
RC = Reinforce Content

NURSING DIAGNOSES

ARRIVAL PRIORITY		DC PRIORITY	TIME	RN/LPN INITIALS
☑ N/A	POTENTIAL/ACTUAL INEFFECTIVE BREATHING PATTERN R/T ☐ ANESTHESIA ☐ OTHER: ____ OUTCOME: RESPIRATORY PATTERN DEMONSTRATES ADEQUATE VENTILATION ☐ YES ☐ NO	1	0940	MA
☑ N/A	ALTERATIONS IN LOC R/T ☐ ANESTHESIA ☐ OTHER: ____ OUTCOME: RESPONDS TO VERBAL STIMULI ☐ YES ☐ NO; RETURN OF REFLEXES AND RESPONSIVENES ☐ YES ☐ NO			
☑ N/A	POTENTIAL FOR INJURY R/T ☐ ANESTHESIA ☐ OTHER: ____ OUTCOME: NO POST OPERATIVE INJURY OCCURS ☐ YES ☐ NO			
☑ N/A	POTENTIAL/ACTUAL ALTERATION IN COMFORT: PAIN/N & V R/T ☐ SURGERY ☐ OTHER: ____ OUTCOME: PAIN IS CONTROLLED/MINIMIZED ☐ YES ☐ NO; N&V IS CONTROLLED/MINIMIZED ☐ YES ☐ NO	2	0940	MA
☐ N/A	OTHER: ____ OUTCOME: ____ ☐ YES ☐ NO			

[redacted]

INTERVENTIONS
- ☑ N/A
- ☐ T, C & DB
- ☐ ICE PACK
- ☐ SURGICAL/REVERSE SHOE
- ☐ SPACE BOOT
- ☐ MAMMARY SUPPORT/BRA
- ☐ KNEE IMMOBILIZER: ☐R ☐L
- ☐ SLING: ☐R ☐L
- ☐ ABDOMINAL BINDER
- ☐ BAIR HUGGER

SAFETY/COMFORT
- ☐ N/A
- ☐ BUMPER PADS
- ☐ PILLOW
- ☑ WARM BLANKET
- ☐ ORAL SWABS
- ☐ POSITION
- ☐ OTHER: _____

IV FLUIDS
- ☑ YES
- ☐ NO
- ☐ TIME: 0850
- ☐ TOLERATED:
  - ☐ WELL
  - ☐ POORLY

AMBULATION
- ☐ APPROPRIATE FOR AGE
- ☑ WALK WITH MINIMUM ASSISTANCE
- ☐ WALK WITH:
  - ☐ CANE
  - ☐ CRUTCHES
  - ☐ WALKER
- ☐ OTHER: _____

AROUSABLE
P DURING
1 = AWAKE AND ALERT.
2 = SLIGHTLY DROWSY, EASILY AROUSED.
4 = SOMNOLENT, MINIMAL OR NO RESPONSE TO PHYSICAL STIMULATION.
TO BE UTILIZED WITH CONTROLLED SUBSTANCES AND MEDICATIONS WITH SEDATION POTENTIAL

MEDICATIONS

TIME	DOSE	ADM BY	PAIN	SED	MEDICATION / INDICATION / ROUTE	TIME	INITIALS	PAIN	SED	OUTCOME
0850	2 tabs	Mgt	6	10	Lescort · p.o.	11	2/10	[illegible]		T.D.C

POST-OP DISCHARGE ASSESSMENT

TIME: 940

NEURO
- ☑ ALERT ☐ AWAKE
- ☑ ORIENTED ☐ CONFUSED
- ☐ AROUSABLE ☐ SLEEPING
- ☐ APPROPRIATE FOR AGE
- ☐ HAND GRIPS:
  - ☐ STRONG ☐ EQUAL
- ☐ _____

RESPIRATORY
- ☐ REGULAR ☐ IRREGULAR
- ☐ LABORED ☐ UNLABORED
- ☐ DEEP ☐ SHALLOW
- ☐ CRYING ☐ SNORING
- ☑ CLEAR
- ☐ COUGH ☐ CONGESTION
- ☐ WHEEZING ☐ CRACKLES
- ☐ SUCTION [illegible]
- ☐ _____

CIRCULATION/PULSES
- ☐ N/A
- ☐ UPPER: ☐R ☐L
  - ☐ PRESENT ☐ ABSENT
- ☐ LOWER: ☐R ☐L
  - ☐ PRESENT ☐ ABSENT
- ☐ WARM ☐ COOL
- ☐ CAP REFILL _____
- ☐ MOTION: + / -
- ☐ SENSATION: + / -

POSITION/SAFETY
- ☐ SUPINE/SIDE: ☐R ☐L
- ☑ HOB ↑ , FOB ↑
- ☐ ARM ↑ ☐ LEG ↑, ☐R ☐L
- ☐ STRECHER LOW, LOCKED, SR ↑

SKIN
- ☐ PINK
- ☑ PALE ☐ DUSKY
- ☑ WARM ☐ COOL
- ☐ DRY ☐ DIAPHORETIC
- ☑

CARDIAC
- ☐ APICAL PULSE 67
- ☐ REGULAR ☐ IRREGULAR
- ☐ _____
- ☐ _____

ABDOMEN
- ☑ SOFT ☐ FIRM
- ☐ BLADDER DISTENDED
- ☐ VOIDED AT: 940
- ☐ _____

DRAINAGE
- ☐ OP SITE _____
  - ☐ AMOUNT Minimal
  - ☐ CHAR Serosa
- ☐ OTHER: _____
  - ☐ AMOUNT Bldy
  - ☐ CHAR _____

PAIN: 0-10
- ☐ NUMERIC 2/10
- ☐ FLACC
- ☐ WONG BAKER
- ☐ NON-COMMUNICATIVE
- ☐ SCORE: _____

COMPLETED BY: Mgt

NURSES NOTES

Tentatively NPO pain upon arrival per B Crommie for best of pain Mgt
O2 Sat 94% on arrival — Ambulated
4L O2 per NC applied — Mgt.

940
Dr Wilson Saw pt prior to D/C
Mgt

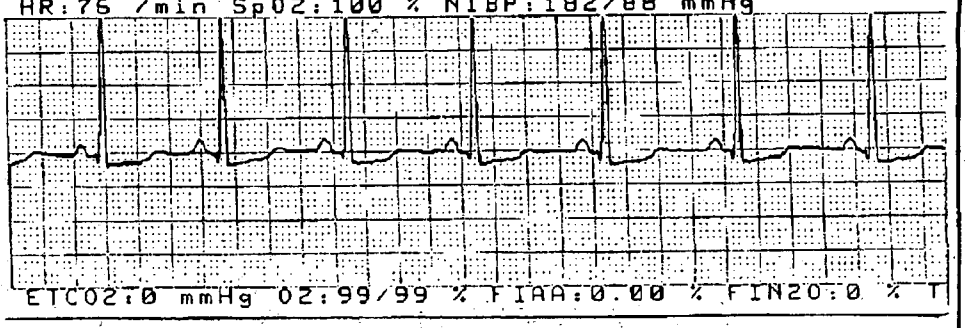
☐ DISCHARGE INSTRUCTIONS REVIEWED WITH PATIENT. PATIENT VERBALIZES UNDERSTANDING. DISCHARGE PER DR. Wilson
☐ LEWIS BLACKMAN PATIENT SAFETY INFORMATION GIVEN TO PATIENT / SO. DISCHARGE RN Mgt Doorney, Nurse
☐ PATIENT DISCHARGED VIA APPROVED DISCHARGE CRITERIA. SEE DISCHARGE RECORD.

INITIALS	LEGAL SIGNATURE	INITIALS	LEGAL SIGNATURE
		Mgt	Maureen Doorney, Nurse

001783

20Nov06 7:43

HR:76 /min Sp02:100 % NIBP:182/88 mmHg



ETC02:0 mmHg 02:99/99 % FIAA:0.00 % FIN20:0 % T

ECG II
0.5mV/div

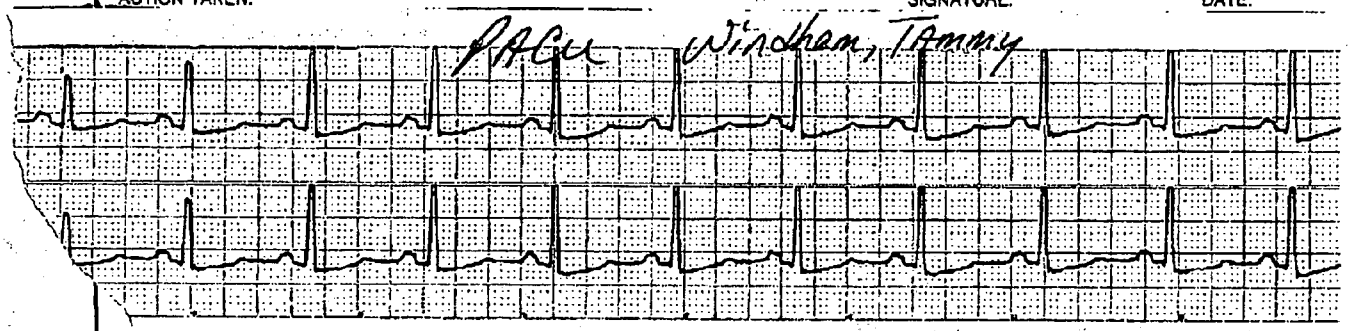
Speed:25mm/s in O.R.

P▶ P: REG ⊙ IRREG ○
PR INT:_____ CONSTANT ○ VARI ⊙
ATRIAL RATE ____

R▶ R: REG ⊙ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:



Patient Windham, Tammy

P▶ P: REG ⊙ IRREG ⊙
PR INT:_____ CONSTANT ○ VARI ⊙
ATRIAL RATE ____

R▶ R: REG ⊙ IRREG ⊙
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P▶ P: REG ○ IRREG ⊙
PR INT:_____ CONSTANT ⊙ VARI ○
ATRIAL RATE ____

R▶ R: REG ⊙ IRREG ⊙
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

RHYTHM STRIP RECORD

ICU-122D MOORE WALLACE

[redacted]

5570

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/27/07 TUH NPR LAB **LIVE** PAGE 55
RUN TIME: 2208 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12667789 LOC: OSC U #: 229998
AGE/SX: 39/F ROOM: REG: 11/20/06
REG DR: DENNIS,RONNIE W STATUS: DEP SDC BED: DIS:

****HEMATOLOGY****

HEMOGRAM

Day	-3			
Date	NOV 17			
Time	1635		Reference	Units
WBC	13.7	# H	(3.0-11)	1000/UL
RBC	4.90		(3.7-5.3)	MIL/UL
HGB	11.1	L	(11.5-16.0)	G/DL
HCT	34.6		(33-46)	%
MCV	70.7	L	(79-95)	FL
MCH	22.6	L	(26-34)	PG
MCHC	31.9		(29-35)	G/DL
RDW	18.2	H	(11.9-15.5)	%
PLATELET COUNT	414		(135-415)	1000/UL

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/27/07 TUH NPR LAB **LIVE** PAGE 56
RUN TIME: 2208 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12667789 (Continued)

****CHEMISTRY****

Day	-3		
Date	NOV 17		
Time	1635	Reference	Units
PREGNANCY TEST	NEGATIVE	(NEGATIVE)	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 11/22/06 TUH NPR LAB **LIVE** PAGE 3
RUN TIME: 0546 Pathology Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12667789 LOC: OSC U #: 229998
AGE/SX: 39/F ROOM: REG: 11/20/06
REG DR: DENNIS,RONNIE W STATUS: DEP SDC BED: DIS:

Specimen: 06:S008994 Received: 11/20/06 - 1403 Status: SOUT Req#: 03251100
Spec Type: SURGICAL P Subm Dr: DENNIS,RONNIE W

Specimen: 06:S008994 SOUT Received: 11/20/06 - 1403 Spec Type: SURGICAL P

DIAGNOSIS

b#1 SEGMENT OF FALLOPIAN TUBE (CLINICALLY LEFT).
b#2 SEGMENT OF FALLOPIAN TUBE (CLINICALLY RIGHT).
b prt/11/21/06

ROUTINE INFORMATION

SPECIMEN: #1 Left fallopian tube tissue; #2 Right fallopian tube (suture in right tube)

CLINICAL HISTORY: Requested sterilization

RACE: W

GROSS DESCRIPTION

#1 (Tammy Elizabeth Windham, left fallopian tube tissue) Hard grayish tissue measuring 0.8 cm. in greatest dimension. Bisected in cassette #1.

#2 (Tammy Elizabeth Windham, right fallopian tube tissue) Tannish hard tissue measuring 1.0 x 0.5 cm. Bisected in cassette #2.
clc/11-20-06

Dictated by: PINILLA,O.A.

372

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

Patient: WINDHAM,TAMMY ELIZABETH # 12667789 (Continued)

MICROSCOPIC DESCRIPTION

(8994, Tammy Elizabeth Windham) #1 Tubular structure with central lumen and epithelium with burning artifact. It is consistent with a fallopian tube.

#2 Sections are of smooth muscle duct with a central lumen consistent with a fallopian tube. Artifact is also present.
prt/11/21/06

Dictated by: PINILLA,O.A.

373

Signed <SIGNED ELECTRONICALLY> PINILLA,O.A. 11/21/06

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/10/07 TUH NPR LAB **LIVE** PAGE 125
RUN TIME: 1731 Pathology Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12667789 LOC: OSC U #: 229998
AGE/SX: 39/F ROOM: REG: 11/20/06
REG DR: DENNIS,RONNIE W STATUS: DEP SDC BED: DIS:

Specimen: 06:S008994 Received: 11/20/06 - 1403 Status: SOUT Req#: 03251100
Spec Type: SURGICAL P Subm Dr: DENNIS,RONNIE W

Specimen: 06:S008994 SOUT Received: 11/20/06 - 1403 Spec Type: SURGICAL P

DIAGNOSIS

#1 SEGMENT OF FALLOPIAN TUBE (CLINICALLY LEFT).
#2 SEGMENT OF FALLOPIAN TUBE (CLINICALLY RIGHT).
prt/11/21/06

ROUTINE INFORMATION

SPECIMEN: #1 Left fallopian tube tissue; #2 Right fallopian tube (suture in right tube)

CLINICAL HISTORY: Requested sterilization

RACE: W

GROSS DESCRIPTION

#1 (Tammy Elizabeth Windham, left fallopian tube tissue) Hard grayish tissue measuring 0.8 cm. in greatest dimension. Bisected in cassette #1.

#2 (Tammy Elizabeth Windham, right fallopian tube tissue) Tannish hard tissue measuring 1.0 x 0.5 cm. Bisected in cassette #2.
clc/11-20-06

Dictated by: PINILLA,O.A.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/10/07 TUH NPR LAB **LIVE** PAGE 126
RUN TIME: 1731 Pathology Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12667789 (Continued)

MICROSCOPIC DESCRIPTION

(8994, Tammy Elizabeth Windham) #1 Tubular structure with central lumen and epithelium with burning artifact. It is consistent with a fallopian tube.

#2 Sections are of smooth muscle duct with a central lumen consistent with a fallopian tube. Artifact is also present.
prt/11/21/06

Dictated by: PINILLA,O.A.

Signed <SIGNED ELECTRONICALLY> PINILLA,O.A. 11/21/06

001790

TUOMEY HEALTHCARE SYSTEM
Bringing more to life

Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

OUTPATIENT HOME MEDICATION INVENTORY

PATIENT NAME: Windham, Tammy E. DATE: 11/20/06

DRUG ALLERGIES: None

☐ Medications brought to hospital reviewed by RN
☐ Medication list brought to hospital reviewed by RN
☐ Other healthcare facility medication list reviewed by RN (source: _____)

AT HOME OR OUTPATIENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

PRODUCT NAME (LIST ONLY MEDS CURRENTLY BEING TAKEN)	DOSE (mg, ml, number of grams)	FREQUENCY	INDICATION OF PRN MEDICATION	ROUTE OR TOPICAL SITE	DATE AND TIME OF LAST DOSE
None					

NEW MEDICATION ORDERS

MEDICATION	DOSE (mg, ml, number of grams)	FREQUENCY	REASON	ROUTE	PHYSICIAN ORDERING
Tylox	1 tab	every 4 hrs as needed	Pain	by mouth	Dennis
Motrin	600 mg	every 6 hrs as needed	Pain	by mouth	Dennis

MEDICATION RECONCILIATION BY:

☐ PHARMACIST _____
☐ PHYSICIAN _____

PRE-PROCEDURE INVENTORY: Carla Bridges, RN - 11/20/06

FORM COMPLETED BY: _____

TUOMEY HEALTHCARE SYSTEM
BILATERAL TUBAL LIGATION

Bilateral tubal ligation (BLT) is surgery done to permanently prevent pregnancy. It can be done after a delivery through a small incision under the umbilicus (belly button), during a Ceasarean Section or with the laparoscope. BTL is not 100% effective. Before you decide whether to have BTL performed, you should understand what it is, its risks, benefits and alternative choices for birth control.

What is it?

With BLT, both fallopian tubes are closed by being tied or sealed with electric current. This means the egg is prevented from going through the tube, and sperm are prevented from reaching the egg. This method is also called "tying the tubes." This is a permanent method of birth control with about a 1% chance that you can get pregnant after the procedure.

What are the risks?

Serious problems are *not* common with BTL, but they do happen to about 1 out of every 1,000 women who have the operation. Possible problems include:

- Bleeding from the belly button incision. Keep it clean with soap & water or peroxide.
- Bleeding inside the abdomen (may require another operation to stop).
- Infection: After you have left the hospital, call our office (9-5) or 778-9227 (night/holidays) if you have a fever or severe pain in you abdomen. These could be signs of infection.
- Side effects from the anesthesia such as nausea, vomiting or trouble breathing.
- Failure rate - 2 to 3 women per 1000 per year get pregnant.
- Changing mind: The "regret rate" is the number of patients per 1000 who regret having their tubes tied. This rate is higher for patients *younger than 26.* To lower your regret rate, avoid making this choice during times of stress, such as divorce or after a difficult pregnancy, and never under pressure from a partner or others.
- Risk of ectopic pregnancy. Although the risk of failure is low, the procedure does not guarantee sterility. If you get pregnant after having your tubes tied, it is more likely to be an ectopic pregnancy. Ectopic pregnancies can cause internal bleeding and the need for surgery to control this bleeding.

What are the benefits?

- The procedure gives you the ability to enjoy sex without the fear of unwanted pregnancies and without having to use other methods of birth control.

What are the options?

A number of temporary methods of birth control are available. Although none is as effective as BTL, they all protect against pregnancy:

- Oral contraceptives (birth control pills)
- Intrauterine device (IUD)
- Barrier methods: diaphragm, cervical cap, condom (male and female), spermacides.
- Contraceptive implants (Norplant) or Contraceptive injection (Depo-Provera)
- Periodic abstinence/natural family planning
- Vasectomy is a permanent method of sterilization available for the male.

Other important points:

- The consent of your partner is not required to have BTL performed, but the decision should be carefully thought out by both of you.
- Postpartum BTL is an elective procedure. This means that it is your choice whether to have it done. If at <u>any</u> time you have doubts-even after you've signed papers giving consent, the operation can be canceled.
- There is a 30 day waiting period after consent forms are signed for BTL's sponsored by Medicaid.
- Be aware that BTL does not protect against STD's (sexually transmissible diseases). You should use latex condoms for this protection.
- You should be able to return to your normal routine after a few days of rest.

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I understand the risk, benefits and alternatives of having Bilateral Tubal Ligation.

18224 Rev. 04/05/04

Signature: Tracy E Windsor

Tuomey Healthcare System
North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

OUTPATIENT SURGERY CENTER: (803)774-9710 BUSINESS HRS.: (Mon - Fri) 6:30 am - 5:00 pm

OB/GYN DISCHARGE INSTRUCTIONS

1. DIET:

___ Unrestricted (Routine as before surgery.)
✓ Liquids and light foods (Jell-O, soup, crackers, etc.) next 3 - 4 hours, then progress to normal.
* **ABSOLUTELY NO ALCOHOLIC BEVERAGES FOR THE NEXT 24 HOURS.**

2. ACTIVITY:

✓ **No sex, no tampons, and NOTHING IN VAGINA until your doctor say's it's okay.**
* Go directly home from the hospital. Stay inside and limit your activities. Do not drive, shop, or operate machinery for 24 hours.
* Do not sign any legal documents for the next 24 hours or while taking pain medicine.
* Do not engage in sports, heavy lifting, or strenuous activity until your doctor gives you permission.
✓ Dizziness is common when taking pain medicine. Do not drive, be careful walking and climbing stairs and of throw rugs.
✓ You may experience gas pains related to your procedure. Walking may help reduce discomfort.

3. WOUND CARE:

✓ You will have vaginal bleeding, not more than a period.
✓ Peri Care: Change pad at each bathroom visit. Wipe front to back.
✓ Do not be alarmed if there is a small amount of bright red bleeding on dresssing. This is expected.
✓ May shower and change dressing in 24 hours. Wash with soap and water. May apply clean dressing if needed.
✓ A heating pad placed on your abdomen or back may help reduce cramping pain.

4. MEDICATIONS: Fill prescriptions and take as directed. See Home Medication Inventory Sheet.

___ No change in Home Medications as listed on Outpatient Home Medication Inventory.
✓ Necessary changes for Home Medications (***any additions or discontinuations***): _____
Tylox – Motrin
___ May take Ibuprofen (Motrin/Advil) as directed. _____
✓ DO NOT TAKE TYLENOL ALONG WITH NARCOTIC PAIN MEDICINE.
___ Your last dose of pain medicine was given at Tylox 2 @ 9am none til 1PM.

5. SYMPTOMS TO REPORT TO PHYSICIAN: **Office No.** 934-1300

* Excessive bleeding or drainage.
* Excessive pain.
* Infected (red or angry) wound or discharge with foul odor or unusual color.
* Excessive nausea or vomiting.
* Temperature above 101° degrees F after first post-op night.
* You may experience minor surgical and anesthesia related discomforts, such as nausea, hoarsness, sore throat, cough, muscle aches, headache, low grade temperature. These symptoms should improve after 24-48 hours.

6. FOLLOW UP APPOINTMENTS: ☐ Dr. Dennis Date/Time Dec. 5th @ 245 pm
☐ Call Dr. office in am to make appt.

7. OTHER: _____

I have received a copy of the post operative instructions and understand them.

Thomas Windham — MG Tuomey Nicholyhe DO NOT Go

SIGNATURE OF PATIENT/RESPONSIBLE PARTY | DISCHARGE RN | DATE | TIME

SHOULD A PROBLEM ARISE NOT COVERED IN THE ABOVE INSTRUCTIONS PLEASE CONSULT YOUR PERSONAL PHYSICIAN OR GO TO THE NEAREST EMERGENCY ROOM. (PLEASE TAKE THESE INSTRUCTIONS WITH YOU)

TUOMEY HEALTHCARE SYSTEM - OB/GYN DISCHARGE INSTRUCTIONS
30156 Rev. 09/29/06

30156

WHITE - CHART COPY

[redacted]

DISCHARGE ASSESSMENT (CRITERIA TO BE MET PRIOR TO DISCHARGE)

ANESTHESIA	CRITERIA	MET	NOT MET	ACTION TAKEN	RN INITIALS
LOCAL	1. VS within normal limits or stable and 20% variation of pre-proc.VS				
	2. Ambulatory unless otherwise indicated				
	3. No active nausea or vomiting				
	4. No excessive bleeding, drainage, or swelling				
	5. No intolerable or unexplained pain or discomfort				
SEDATION	1. Alert / Oriented				
	2. VS within normal limits or stable and 20% variation of pre-proc.VS				
	3. Ambulatory unless otherwise indicated				
	4. No active nausea or vomiting				
	5. Able to tolerate oral fluids				
	6. No excessive bleeding, drainage, or swelling				
	7. Voided or patent indwelling catheter				
	8. No intolerable or unexplained discomfort				
GENERAL/ IV BLOCK OR NERVE BLOCK (SPINAL-EPIDURAL)	1. Alert / Oriented	✓			
	2. VS within normal limits or stable and 20% variation of pre-proc.VS	✓			
	3. Ambulatory unless otherwise indicated	✓			
	4. No active nausea or vomiting	✓			
	5. Able to tolerate oral fluids	✓			
	6. No excessive bleeding, drainage, or swelling	✓			
	7. Voided or patent indwelling catheter	✓			
	8. No intolerable or unexplained discomfort	✓			
	9. Sensation and control of movement of effected extremity	✓			

Discharge vital signs: BP 167/72 (154/70) P 65 R 20 Temp. 97.5

Family member / friend available to transport patent home ☑ Yes ☐ No Name Lon

Comments

Discharge Date 20 NOV 06 Time 0950 Escorted by

Via

VITAL SIGN NORMAL LIMITS	INFANT (0-1 YR)	CHILD (1-8 YRS.)	ADULT
Respirations	40 - 60 min.	10 - 25 min.	8 - 20 min.
Blood Pressure	85 ± 20 / 60 ± 20	95 ± 25 / 60 ± 25	100 - 170 / 50 - 90
Pulse	120 ± 20	90 ± 20	75 ± 20

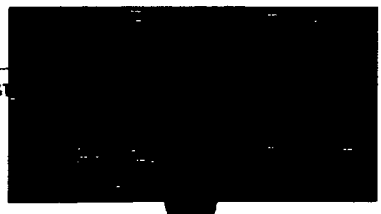
Postoperative Call

Person giving info.: ☐ Patient ☐ Other
Satisfied with care: ☐ Yes ☐ No
Complained of: ☐ Excessive drainage from incision
☐ Nausea / Vomiting or Elevated Temp.
☐ Nausea / Vomiting or Excessive Pain
☐ Difficulty Urinating
Comments / Suggestions: ☐ Patient instructed to notify MD

Patient contacted:
Date: _____ Time: _____ RN _____
☐ No response ☐ Follow-up letter sent
Date: _____ Time: _____ RN _____
Date: _____ Time: _____ RN _____

SIGNATURE LEGEND

INITIALS	LEGAL SIGNATURE
	Thomas D. Jones, Anesthesiologist
	[illegible] RN
	[illegible]



TUOMEY HEALTHCARE SYST
30156 Rev. 09/29/06

PATIENT LABEL 379

WHITE - CHART COPY YELLOW - PATIENT COPY

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service		Medical Rec. No.	
WINDHAM,TAMMY ELIZABETH [redacted]	12724860		ER	ED		229998	
	Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
	[redacted]	39	F	SEP	HOL	W	N
	Person to Notify / Address: PARROTT,MELINDA [redacted]					Relationship: SI	
						Other Phone: 803-508-4697	
Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]	Next of Kin / Address: PARROTT,MELINDA [redacted]					Relationship: SI	
						Other Phone: 803-506-4697	
Financial Class: S							

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit		
ONSET OF SYMPTO	CP		
Accident Date / Time	**Comments**	**Height / Weight**	**Arrival Mode**
03/18/07			
Admit Date / Time	**Admitting Physician**	**Attending Physician**	**User**
03/18/07 0128		NO DOCTOR	ADJRJ

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

If yes, Living Will copy received? N

Does pt have Health Care Power of Attorney? No

If yes, Health Care Power of Attorney copy received?

Does patient want info on Advance Directive? No

Are you an organ donor? No

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (ER)

00000 Rev 01/01/2004

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 **Unit:** 229998
NO DOCTOR
ER
F W Age: 39 [redacted]
DOS: 03/18/07

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TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Sun Mar 18 2007 01:23 NSS)
COMPLAINT: cp.
ADMISSION: URGENCY: 1 - Emergent, BED: LOBBY.
PATIENT: NAME: Tammy E Windham, AGE: 39, GENDER: Female, DOB: [redacted], RACE: Caucasian, Latex Allergy: No, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, PAYMENT: Self Pay, ATTENDING: no doctor, IBEX NUMBER: 20070318012317.
PREVIOUS VISIT ALLERGIES: Nkda.
NOTES:., pt to ed by ems. pt states she has had cp 20 mins before arriving to ed. pt also c/o HA and vomiting.
VITAL SIGNS: BP 197/105, Pulse 98, Resp 30, Temp 97.8, Pain 10, O2 Sat 98, on ra, Time 0118.

KNOWN ALLERGIES
Nkda.

HPI CHEST PAIN (02:36 JDW)
TIME: Patient assessed at: 0220.
CHIEF COMPLAINT: Patient presents for the evaluation of no AICD event, ongoing chest pain.
HISTORIAN: History obtained from patient, family:
TIME COURSE: Onset of symptoms reported as gradual, Onset was 1 hours prior to arrival . Complaint is persistent, constant.
LOCATION: Pain most severe in substernal area, There is no radiation. Pain has not moved in location over time.
QUALITY: Pain is unable to be described.
ASSOCIATED WITH: Associated with headache, nausea, vomiting, diaphoresis Resolved, shortness of breath, no palpitations.
SEVERITY: Maximum severity is severe, Currently symptoms are severe.
EXACERBATED BY: Patient's condition exacerbated by nothing.
RELIEVED BY: Patient's condition relieved by nothing.
RISK FACTORS: CAD risk factors include smoking, CAD risk factors include hypertension, TAD risk factors include hypertension, PE risk factors include smoking.

PAST MEDICAL HISTORY
MEDICAL HISTORY (Sun Mar 18 2007 01:23 NSS): Additional history includes: History of hypertension, which is not being treated.
SURGICAL HISTORY (Sun Mar 18 2007 01:23 NSS): History of appendectomy, History of cholecystectomy.
PSYCHIATRIC HISTORY (Sun Mar 18 2007 01:23 NSS): No previous psychiatric history.
SOCIAL HISTORY (Sun Mar 18 2007 01:23 NSS): Denies drug abuse, Patient smokes tobacco, Denies consumption of alcohol.
FAMILY HISTORY (Sun Mar 18 2007 01:23 NSS): Family history is not contributory to this case.
SURGICAL HISTORY (02:40 JDW): History of tubal ligation.
NOTES (02:40 JDW): Nursing records reviewed, Old chart reviewed, Medication list reviewed.

ROS (02:39 JDW)
Name: Windham, Tammy E Age: F39 MedRec: 229998 AcctNum: 12724860

TUOMEY HEALTHCARE
EMERGENCY RECORD

CONSTITUTIONAL: Negative constitutional review of systems. No fever, chills.
EYES: Negative eye review of systems.
ENT: Negative ENT review of systems.
CARDIOVASCULAR: Historian reports chest pain. Chest pain is substernal. No radiation. Historian reports dyspnea on exertion, diaphoresis.
RESPIRATORY: Negative respiratory review of systems. No Cough.
GI: Historian reports nausea, vomiting. No abdominal pain, diarrhea.
GENITOURINARY FEMALE: Negative genitourinary review of systems. No pregnancy.
MUSCULOSKELETAL: Negative musculoskeletal review of systems.
SKIN: Negative skin review of systems.
NEUROLOGIC: Historian reports headache. No paralysis, paresthesias, focal weakness.

PHYSICAL EXAM
CONSTITUTIONAL (02:41 JDW): Patient is afebrile, Vital Signs Reviewed, Alert and oriented X 3, Tachycardic pulse, Hypertensive blood pressure, Increased respiratory rate, Patient is ill appearing. Patient appears to be in pain. Patient has moderate pain distress.
HEAD (02:41 JDW): Atraumatic, Normocephalic.
EYES (02:41 JDW): Eyes are normal to inspection. No discharge from eyes. Conjunctiva are normal.
NECK (02:41 JDW): Normal ROM. No meningeal signs, Cervical spine nontender.
RESPIRATORY/CHEST (02:41 JDW): Assessment includes:, Chest is nontender. Breath sounds normal. No respiratory distress.
CARDIOVASCULAR (02:41 JDW): Patient under the age of 40, RRR. Heart sounds normal. No murmurs. Normal S1 S2, Abdominal aorta normal in size. No abdominal bruits.
BACK (02:41 JDW): There is no CVA Tenderness, There is no tenderness to palpation. Normal inspection.
UPPER EXTREMITY (02:41 JDW): Inspection normal. No cyanosis, clubbing, edema. Normal range of motion.
LOWER EXTREMITY (02:41 JDW): Inspection normal. No cyanosis, clubbing, edema. Normal range of motion, No calf tenderness.
NEURO (02:41 JDW): GCS is 15. No focal motor deficits, focal sensory deficits, Speech normal.
SKIN (02:41 JDW): Skin is warm, Skin is dry, Skin is normal color.
PSYCHIATRIC (02:41 JDW): Oriented X 3, Anxious affect.
ABDOMEN (20:49 JDW): Abdomen is nontender. No masses, Bowel sounds normal, No distension, peritoneal signs, hemorrhoids. Normal rectal exam, No occult blood, Control Positive.

DOCTOR NOTES
TEXT (07:01 EJB): Repeat EKG reveals generalized T wave inversions not seen on initial study, also with run of wide-complex tachycardia approx one hour after presentation, will admit for further evaluation.
PATIENT STATUS (07:01 EJB): Patient has stabilized since arrival to emergency department.
D/W (07:01 EJB): Discussed this case with Dr. Neuner, the on call physician.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

Telemetry observation has been arranged.
DATA REVIEWED (07:01 EJB): Lab data reviewed, Xray data reviewed, Reviewed EKG.
TEXT (07:55 JDW): Repeat Troponin elevated at 3.15, CK index of 10.

ATTENDING (07:01 EJB)
NOTES: I have personally seen and examined this patient. I have fully participated in the care of this patient. I have reviewed all pertinent clinical information, including history, physical exam, orders and plan.

O2SAT INTERPRETATION (02:41 JDW)
O2SAT: O2 saturation reading 100%, O2 AMT: R.A., O2 Sat normal, Single Pulse Ox.

EKG INTERPRETATION (02:22 EJB)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, Compared with previous EKG, from 10/5/06, EKG shows borderline LVH, seen on prior. 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate is normal, Rate 87, beats per minute, Blocks: none, Axis: normal, non-specific EKG.

LAB INTERPRETATION (04:35 EJB)
INTERPRETATION: Elevated WBC, Elevated Platelets. Normal chemistry profile, Normal Cardiac enzymes, Normal D-dimer level.

RADIOLOGY INTERPRETATION (06:56 EJB)
CHEST: Interpretation of chest X-ray shows, chest x-ray negative, no infiltrates, no pneumothorax, no hemothorax, no masses, no cardiomegaly, no CHF, no effusion, no free air.
INTERPRETER: Preliminary review of x-rays by ED Physician.

NURSING PROCEDURE: IV (01:51 CRW)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, family member, Indications for procedure: medication administration, Procedure performed at 0140, IV established, 20 gauge catheter inserted, into left Forearm, #1 site. in 1 attempt, Saline lock established, Amount 5cc, Labs drawn at time of placement, Labs labeled and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: BP: 209, / 109, Pulse: 93, Resp: 22, Pain: 10, O2 sat: 100%, wo, Time: 0130.

NURSING PROCEDURE: NURSE NOTES (01:54 CRW)
TIME: Time: 0145, Pt was talking then stopped. Family at bedside. Daughter states she was scared but pt resumed talking after daughter left. Set

up for EKG at this time. Resp even and unlabored. States was on BP meds but has not been on in a long time.
VITAL SIGNS: BP: 212, / 106, Pulse: 101, Resp: 24, Pain: 10, O2 sat: 100%,

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wo, Time: 0145.

NURSING PROCEDURE: NURSE NOTES (01:54 CRW)
TIME: Time: 0150, Pt starting to vomit small amount. Ceased when spouse left room.

NURSING PROCEDURE: MEDICATION (02:52 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 10, Procedure was performed at 0230, NITROGLYCERIN, 0.4mg, given sublingual.
VITAL SIGNS: BP: 192, / 107, Pulse: 87, Resp: 30, Pain: 10, O2 sat: 197%, 2lnc, Time: 0230.

NURSING PROCEDURE: MEDICATION (02:53 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 10, Procedure was performed at 0235, NITROGLYCERIN, 0.4mg, given sublingual. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: BP: 161, / 109, Pulse: 84, Resp: 28, Pain: 10, O2 sat: 97%, 2lnc, Time: 0235.

NURSING PROCEDURE: MEDICATION (02:54 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 8, Procedure was performed at 0240, NITROGLYCERIN, 0.4mg, given sublingual. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: BP: 174, / 104, Pulse: 85, Resp: 30, Pain: 4, O2 sat: 97%, 2lnc, Time: 0240.

NURSING PROCEDURE: MEDICATION (02:55 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 10, Procedure was performed at 0230, ASPIRIN, 81mg/tab, 4tabs, given PO.

NURSING PROCEDURE: MEDICATION (02:58 CRW)
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach, Pt started to go into wide complex v-tach. Stopped giving meds and informed Dr Byrnes at this time. Repeat ekg done but pt in nsr at this time.
VITAL SIGNS: BP: 149, / 94, Pulse: 85, Resp: 18, Pain: 4, O2 sat: 98%, wo, Time: 0245.

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NURSING PROCEDURE: MEDICATION (03:00 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 10, Procedure was performed at 0229, MORPHINE, 4mg, given IVP, Initial

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TUOMEY HEALTHCARE
EMERGENCY RECORD

medication, into left Forearm, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: MEDICATION (03:02 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 0227, PHENERGAN, 12.5mg/10ccNS, given IVP, Subsequent different medication, into left Forearm, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion. Patient tolerated procedure well.

NURSING PROCEDURE: NURSE NOTES (03:07 CRW)
TIME: Time: 0245, States feels much better at this time. NSR on monitor.149.
VITAL SIGNS: BP: 149, / 94, Pulse: 87, Resp: 30, Pain: 7, O2 sat: 97%, 2lnc, Time: 0245.

NURSING PROCEDURE: NURSE NOTES (03:08 CRW)
TIME: Time: 0300, Lying quietly in bed. States feeling better but chest continues to hurt. Rates pain 7/10 at this time.
VITAL SIGNS: BP: 170, / 86, Pulse: 91, Resp: 24, Pain: 7, O2 sat: 100%, 2lnc, Time: 0300.

NURSING PROCEDURE: MEDICATION (03:35 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 7, Procedure was performed at 0330, MORPHINE, 4mg, given IVP, Repeat same medication, into left Forearm, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
VITAL SIGNS: BP: 180, / 84, Pulse: 91, Resp: 30, Pain: 7, O2 sat: 100%, 2lnc, Time: 0330.

NURSING PROCEDURE: EKG CHART (06:49 ACW)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, family member, Indications for test: chest pain, EKG was performed at 0635, 12 lead EKG Performed-left chest, EKG Number: 229998, After procedure, EKG for interpretation given to Dr. WIGGINS,JESSICA.

SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach. **001800**

NURSING PROCEDURE: NURSE NOTES (06:54 CRW)
TIME: Time: 0235, PT stated that she was feeling better. Noted pt in bigiminy. Noted pt was in V-Tach but stated she felt much better at this time..Pt converted back to NSR. Dr Byrnes aware at this time. NADN

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at this time.

NURSING PROCEDURE: MEDICATION (06:56 CRW)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 0235, LOPRESSOR (METOPROLOL), 50mg, po, given PO, Initial medication, into left Forearm, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion.

NURSING PROCEDURE: NURSE NOTES (06:58 CRW)
TIME: Time: 0330, Lying quietly in bed. NSR on monitor. NADN at this time. Resp even and unlabored. States still has some cp 2/10.

NURSING PROCEDURE: NURSE NOTES (07:00 CRW)
TIME: Time: 0400, Lying quietly in bed. NSR on monitor. NADN at this time. Resp even and unlabored. States wants to go home, taking leads off at this time. PA Wiggins in to talk with pt and tell her that we would like to take a second set of cardiac enzymes.

NURSING PROCEDURE: NURSE NOTES (07:00 CRW)
TIME: Time: 0410, Pt agrees to stay and have 2nd set of enzymes sent.

NURSING PROCEDURE: NURSE NOTES (07:03 CRW)
TIME: Time: 0500, Pt lying quietly in bed. Family at bedside. NSR on monitor. Reiterated to pt and spouse to please use bp meds and continue to get bp checked.

NURSING PROCEDURE: NURSE NOTES (07:04 CRW)
TIME: Time: 0600, Pt lying quietly in bed. Family at bedside. NSR on monitor. Denies cp at this time.

NURSING PROCEDURE: NURSE NOTES (07:07 CRW)
TIME: Time: 0630, Pt lying quietly in bed. Blood drawn at this time and sent to the lab.

NURSING PROCEDURE: NURSE NOTES (07:36 SRD)
TIME: Time: 0735, Dr. Byrnes aware of CK total 10.

NURSING PROCEDURE: NURSE NOTES (08:12 JDP)
TIME: Time: 0700, Report received.Pt. in bed talking to family members,denies any pain at this time of assessment. Sinus rhythm with occasional PVC on the monitor. .

NURSING PROCEDURE: MEDICATION (08:13 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, Procedure was performed at 0745, LOPRESSOR (METOPROLOL), 5 mg, given IVP, into left AC, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion, Procedure done by jpunay RN.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

NURSING PROCEDURE: MEDICATION (08:14 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, Procedure was performed at 0750, Medication: LOVENOX, 65, given SubQ. in the left arm, Procedure done by jpunay RN.

NURSING PROCEDURE: MEDICATION (08:16 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, hospital ID bracelet, Procedure was performed at 0750, Medication: Integrelin, 12mg bolus, given IV infusion, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion, Procedure done by j punay rn.

NURSING PROCEDURE: MEDICATION (08:17 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, Procedure was performed at 0752, Medication: Integrelin, 2mcg/kg.min, given IV infusion, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion, Procedure done by jpunay RN.
VITAL SIGNS: BP: 136, / 74, Pulse: 70, Resp: 26, Temp: 98.3, Pain: 0, O2 sat: 99, 2lnc, Time: 0800.

NURSING PROCEDURE: MEDICATION (08:19 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, hospital ID bracelet, Procedure was performed at 0800, PLAVIX, 300mg, given PO, Procedure done by jpunay RN.

NURSING PROCEDURE: URINE COLLECTION (08:20 BLF)
URINE COLLECTION FEMALE: Patient's identity verified by. patient stating name, hospital ID bracelet, Other indication for procedure labs, Dr. order, Procedure performed at 0815, Straight cath performed using 10fr female cath kit. in 1 attempt, Amount 0, ml. No urine output. Patient tolerated procedure well, Johnny Punay, RN notified pt was catheterized and no urine output was obtained.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: MEDICATION (09:10 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating

birth date, Procedure was performed at 0835, AMIODARONE, 150 mg, given IV infusion, Infusing over, 30 mins, on IV pump, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion, Procedure done by jpunay RN.

NURSING PROCEDURE: NURSE NOTES (09:26 JDP)
TIME: Time: 0910, P t. in bed resting, NSR on monito,no PVC's. Pt. continues to deny chest pain except for mild HA. Family member at bedside.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

NURSING PROCEDURE: NURSE NOTES (09:29 JDP)
TIME: Time: 0915, EMS in the unit to transfer pt. to Providence, This RN called above mentioned facility for room assignment. No available room at this time.

NURSING PROCEDURE: NURSE NOTES (10:50 JDP)
TIME: Time: 1045, Pt. is now c/o chest pain anew, Dr. Wernsman made aware.
VITAL SIGNS: BP: 149, / 69, Pulse: 66, Resp: 18, Pain: 8, O2 sat: 100, 2lnc, Time: 1045.

NURSING PROCEDURE: MEDICATION (10:52 JDP)
MEDICATION: Patient's identity verified by. patient stating name, stating birth date, hospital ID bracelet, Procedure was performed at 1049, NITROGLYCERIN, 10mcg, given IV infusion, into left Hand, on IV pump, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion, Procedure done by jpunay RN, Med order started as ordered. Will monitor.

NURSING PROCEDURE: EKG CHART (10:55 SMT)
TIME: Patient's identity verified by. patient stating name, 12 lead EKG Performed-left chest. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: IV (11:03 JDP)
TIME: Patient's identity verified by. patient stating name, stating birth date, Procedure performed at 1046, IV established, 20 gauge catheter inserted, into left Hand, #2 site. in 1 attempt, Saline lock established, Amount 10 cc ns, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Procedure done by j punay rn.

NURSING PROCEDURE: TRANSFER (11:54 JDP)
PROCEDURE: Patient transferred at 1140, Diagnosis is AMI, Reasons for transfer: Need for specialized care, Accepting institution: Providence Hospital, Accepting physician: Dr. Kuk, Mode of transport: Ambulance, urgent, Copy of patient record prepared for receiving facility, Copy of diagnostic studies, Report called to receiving facility (verified

availability of bed), Report called to Cindy Schultz RN, Bed assigned 457, Provided opportunity to answer questions. Patient consent for transfer signed, Personnel present and ready for transport: EMS, Emotional support needed and given, Forms completed by JpunayRN.
BELONGINGS: Belongings are with the patient.

NURSING PROCEDURE: NURSE NOTES (Wed Mar 21 2007 10:02 JDP)
TIME: Time: 1140 ON 3/81/07, iv MEDS STARTED AT 0752 AND 1049 STILL INFUSING AT TIME OF TRANSFER.

NURSING PROCEDURE: NURSE NOTES (Wed Mar 21 2007 10:03 JDP)
TIME: Time: 1140, Approximately 3 hours critical nursing care spent on this pt while in the ER.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

DIAGNOSIS (08:07 EJB)
FINAL: PRIMARY: AMI.

PRESCRIPTION: No Documented Prescriptions

INSTRUCTION (04:44 EJB)
SPECIAL: Return to ED if worse. It is important that you follow-up with clinic or doctor of your choice on monday.

DISPOSITION
PATIENT (07:03 EJB): Disposition: Admit to inpatient, Disposition Transport: Stretcher, Condition: Stable.
(08:06 EJB): Disposition: Transfer - other hospital, Disposition Transport: Ambulance. Patient Flag: .
(13:36 SHS): Pain Scale: 08, Oxygen: Yes. Patient Flag: , Remove from ER.

ADMIN
DIGITAL SIGNATURE (07:36 SRD): Dyke, Seth.
(08:20 BLF): Fowler, Barbara.
(09:11 JDP): Punay, Johnny.
(09:19 JDP): Punay, Johnny.
(11:54 JDP): Punay, Johnny.
(20:49 JDW): Wiggins,PA-C, Devon.
(Tue Apr 03 2007 07:02 EJB): Byrnes, Ed.

KEY:
ACW=Williams, Ansel BLF=Fowler, Barbara CRW=Windham, Cheryl
EJB=Byrnes, Ed JDP=Punay, Johnny JDW=Wiggins,PA-C, Devon
NSS=Samaniego, Nyishah SHS=Stone, Shea SMT=Thames, Shelley
SRD=Dyke, Seth

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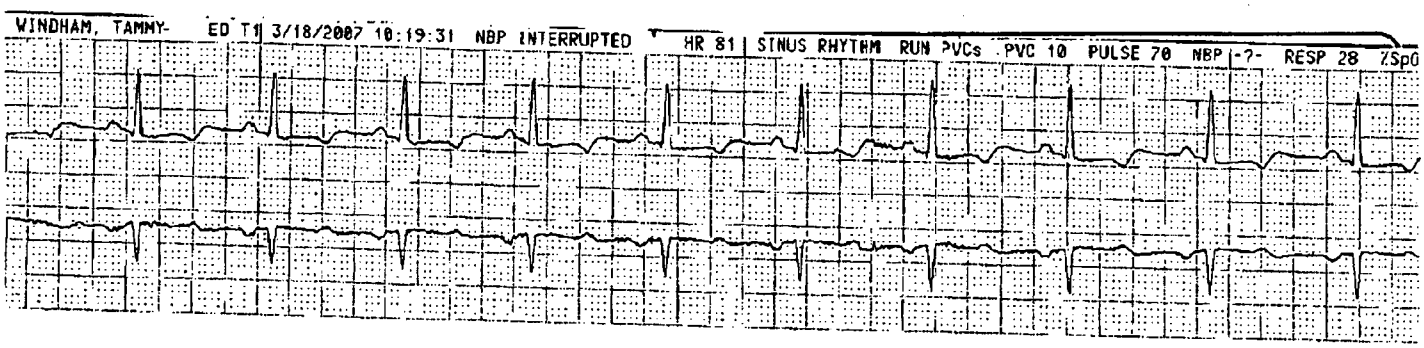
001804



P▶ P: REG ○ IRREG ⓘ
PR INT: _____ CONSTANT ○ VARI ⓘ
ATRIAL RATE _____

R▶ R: REG ⓘ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKENT: SIGNATURE: DATE:

USE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE

SE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE

EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE

P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ⓘ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

T

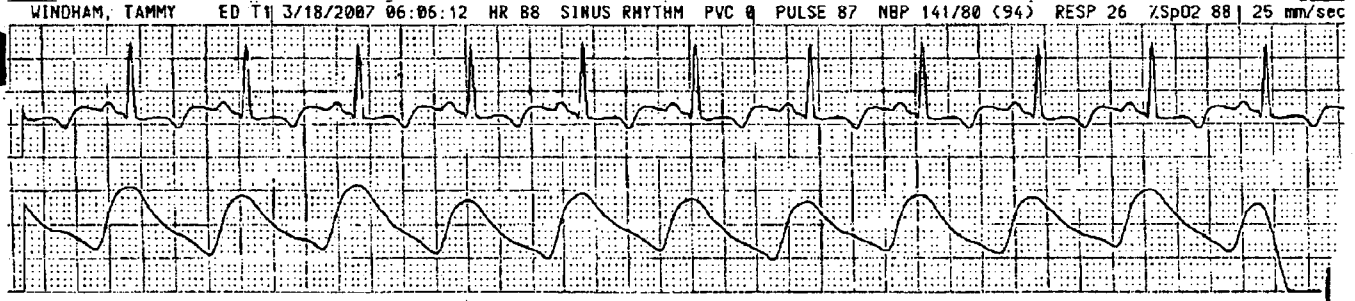
390

Windham, Tammy
#12724860

5591

001805

WINDHAM, TAMMY ED T1 3/18/2007 06:06:12 HR 88 SINUS RHYTHM PVC 0 PULSE 87 NBP 141/80 (94) RESP 26 %SpO2 88 | 25 mm/sec



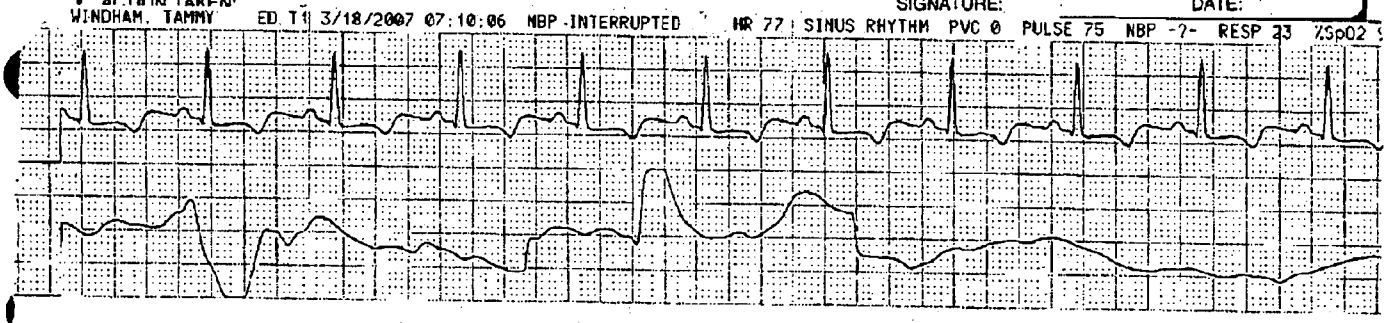
P▶ P: REG ⓔ IRREG ⓕ
PR INT: _____ CONSTANT ⓖ VARI ⓗ
ATRIAL RATE _____

R▶ R: REG ⓘ IRREG ⓙ
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

WINDHAM, TAMMY ED T1 3/18/2007 07:10:06 NBP -INTERRUPTED HR 77 | SINUS RHYTHM PVC 0 PULSE 75 NBP -?- RESP 23 %SpO2



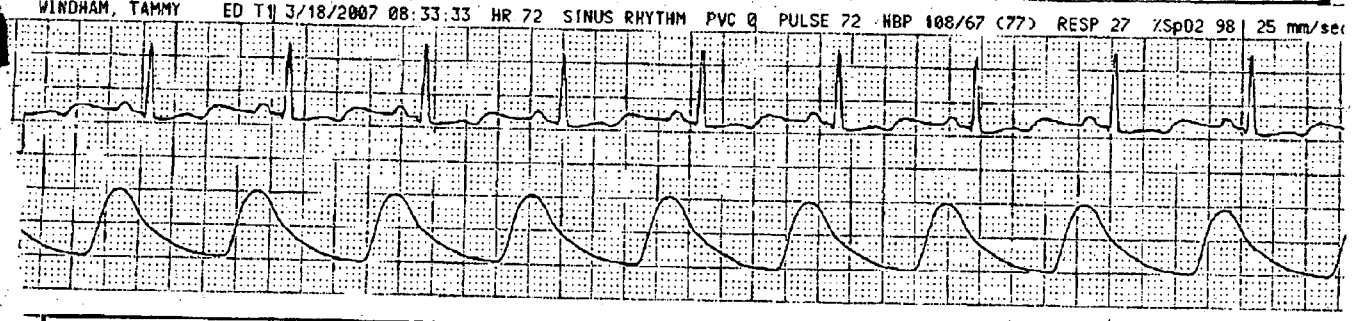
P▶ P: REG ⓚ IRREG ⓛ
PR INT: _____ CONSTANT ⓜ VARI ⓝ
ATRIAL RATE _____

R▶ R: REG ⓞ IRREG ⓟ
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

SIGNATURE: DATE:

WINDHAM, TAMMY ED T1 3/18/2007 08:33:33 HR 72 SINUS RHYTHM PVC 0 PULSE 72 NBP 108/67 (77) RESP 27 %SpO2 98 | 25 mm/sec



P▶ P: REG ⓠ IRREG ⓡ
PR INT: _____ CONSTANT ⓢ VARI ⓣ
ATRIAL RATE _____

R▶ R: REG ⓤ IRREG ⓥ
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

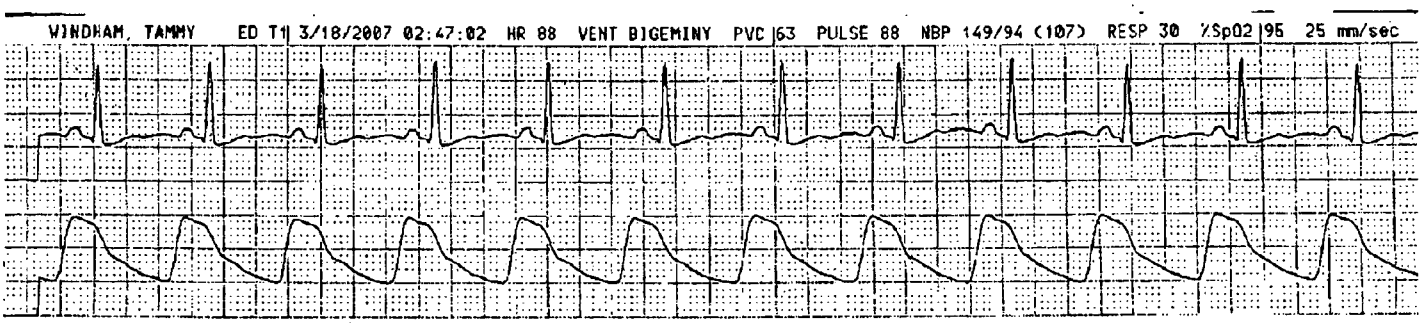
T1 391

Windham, Tammy

#12724860

5592

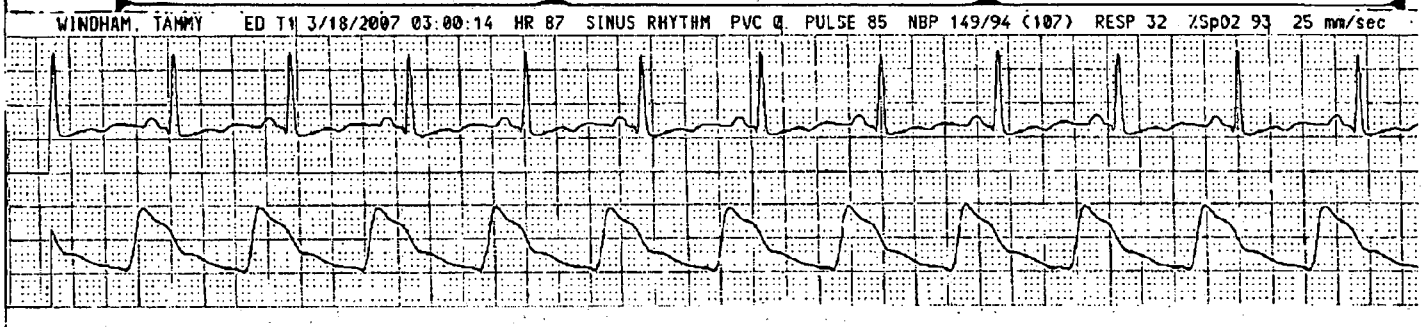
001806



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

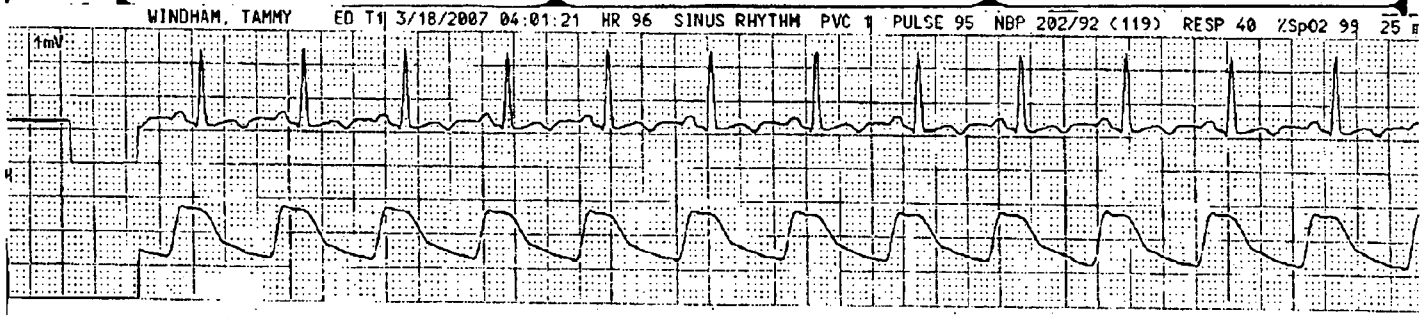
INTERPRETATION: _____



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

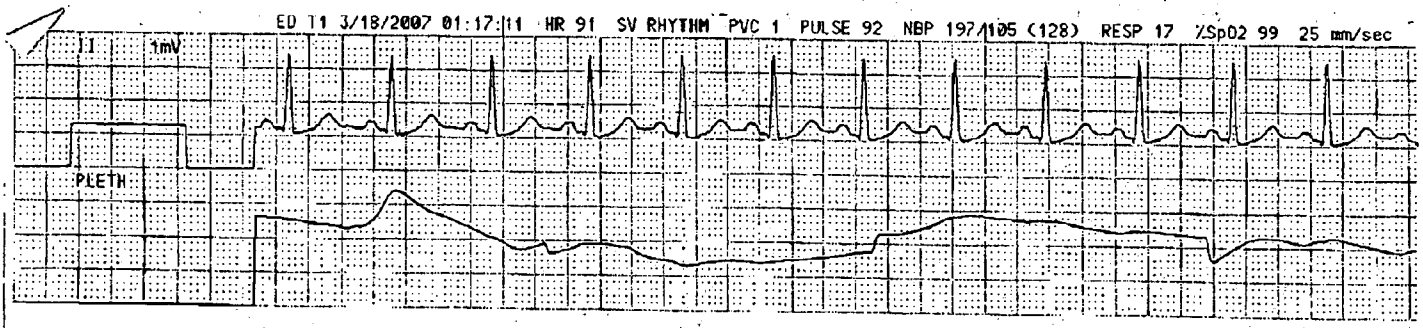
Windham, Tammy 393
#12724860
p. 2

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

5593

001807

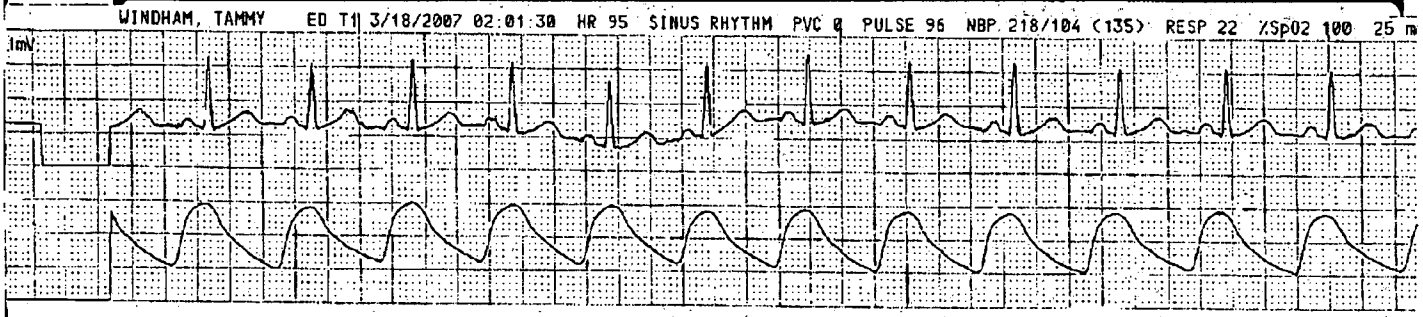


P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

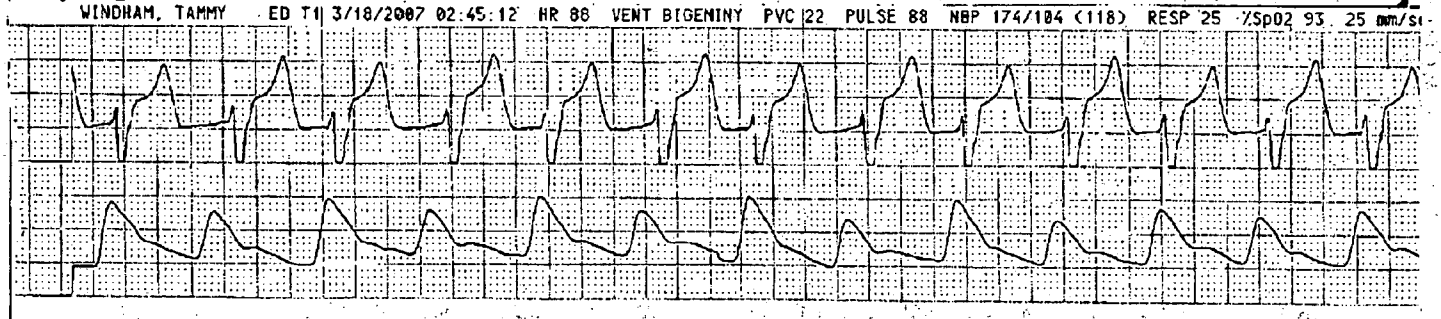


P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

Windham, TAMMY
#12724860
03-11-07

393

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

5594

5595

001808 229[redacted] INDHAM, TAMMY ELIZABETH
DOB: [redacted] Years Female Race: White

18-Mar-2007 09:54:52
BP: 149/89

Dept: Emergency Dept.
Room: T-1
Oper: 12

MK

Account Number:12724860

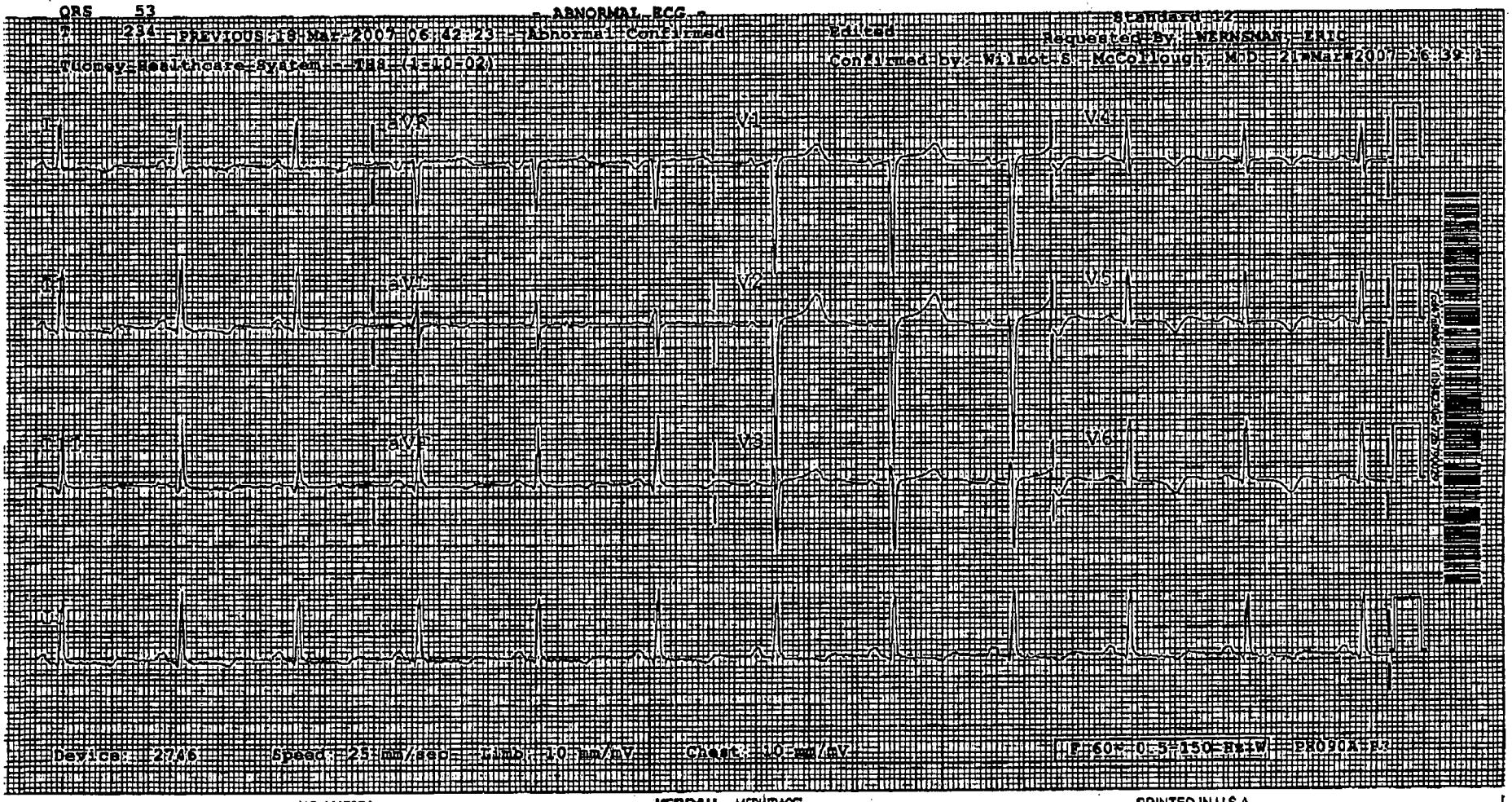
394

Edited By:JULIA YOUNG

Order #: CARD20070318-0027

Rate 69 - STMT - * SINUS RHYTHM, RATE 69.
RR 870 - STMT - * ABNORMAL T, CONSIDER ISCHEMIA, DIFFUSE LEADS.
PR 164 - STMT - * SMALL Q WAVES II III AVF V5 V6.
QRSD 82 - STMT - * SINCE LAST TRACING, 03/18/2007@ 06:42AM: NO CHANGE.
QT 476
QTc 510

-- AXIS --
P 49
QRS 53



NO. M1737A MEDITRACE PRINTED IN U.S.A.

5596

001809 229998 WINDHAM, TAMMY ELIZABETH 18-Mar-2007 06:42:23
39 Years Female Race: White BP: 185/96

Dept: Emergency Dept.
Room: ED-8
Oper: 49

MR

Rate 80 - STMT - * SINUS RHYTHM, RATE 80.
RR 750 - STMT - * ABNORMAL T, CONSIDER ISCHEMIA, DIFFUSE LEADS.
PR 152 - STMT - * SMALL Q WAVES II III AVF V4 V5 V6.
QRSD 82 - STMT - * SINCE LAST TRACING, 03/18/2007 @ 01:56AM: ST-T ABNORMALITIES NEW
QT 436 CONSIDER ISCHEMIA.
QTc 503

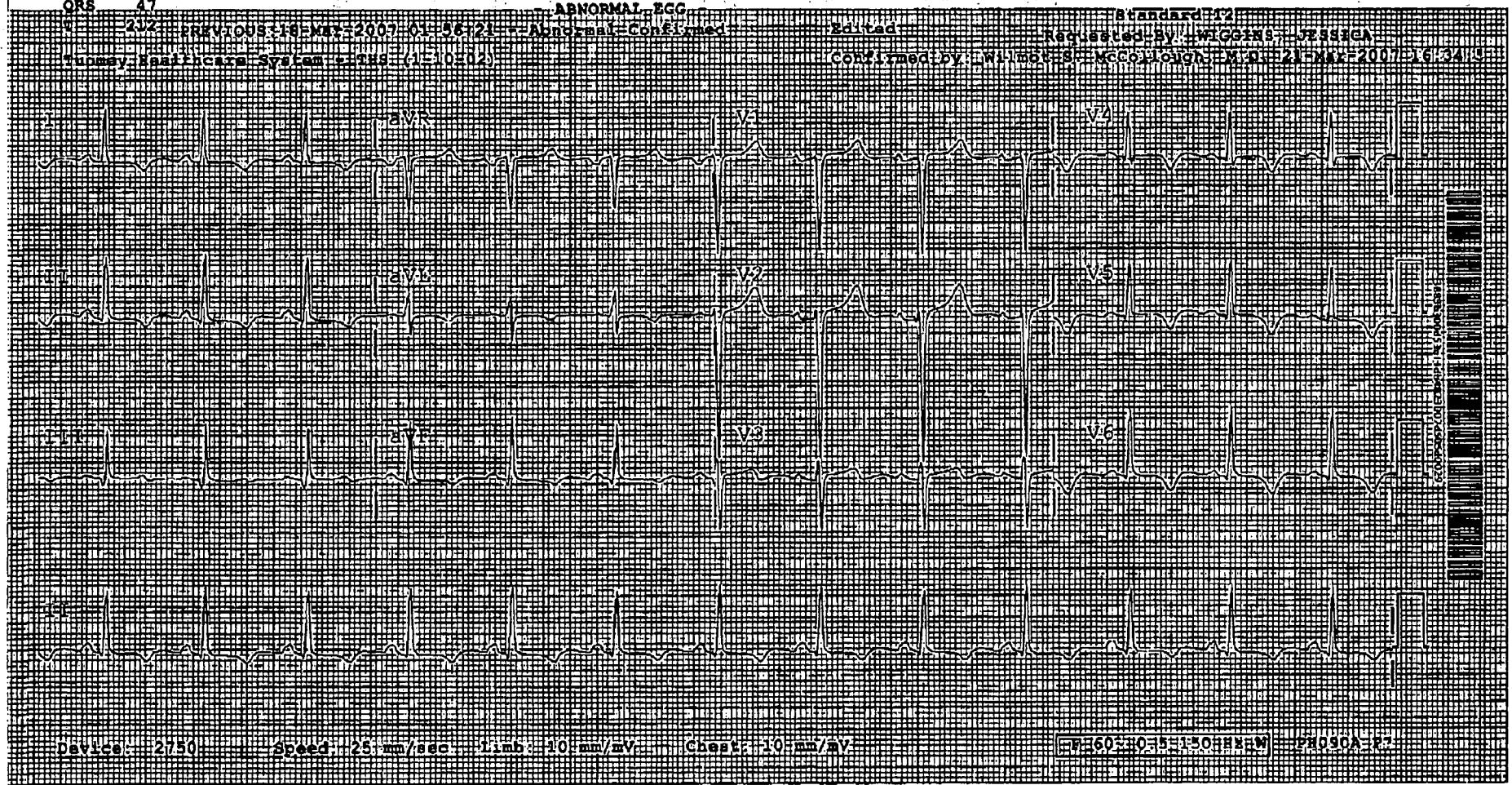
Account Number:12724860

395

Edited By:JULIA YOUNG

-- AXIS --
P 42
QRS 47
T 202

Order #: CARD20070318-0015



NO. M1737A KENDALL MEDITRACE PRINTED IN U.S.A.

5597

001810 220008 WINDHAM, TAMMY ELIZABETH 18-Mar-2007 01:56:21
[illegible] Years Female Race: White BP: 212/106 Dept: Emergency Dept.
Room: EDT1
Oper: ACW

396

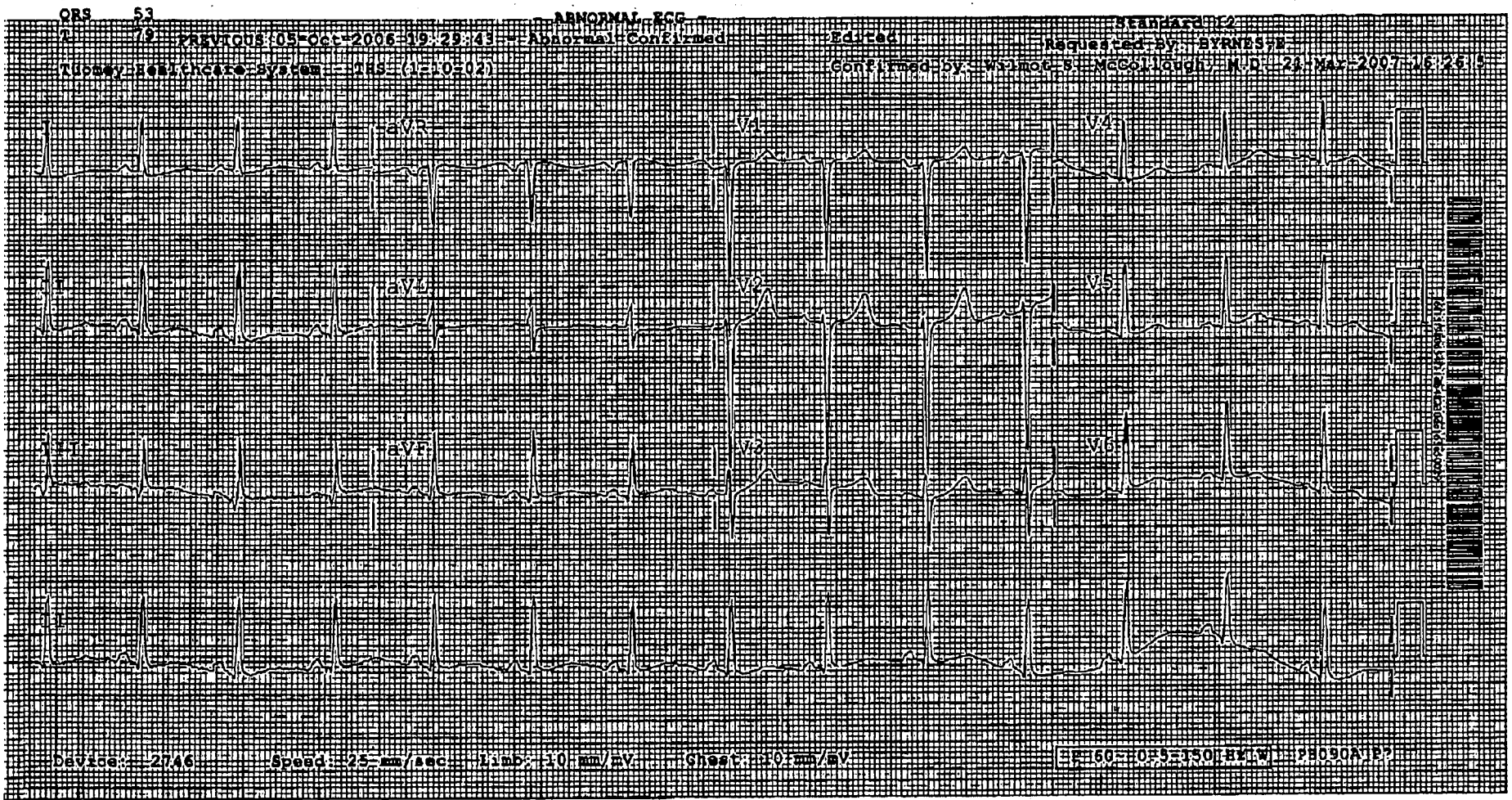
Rate 83 - STMT - * SINUS RHYTHM, RATE 83.
RR 723 - STMT - * PROBABLE LEFT VENTRICULAR HYPERTROPHY.
PR 152 - STMT - * INFERIOR Q WAVES, PROBABLY NORMAL VARIATION.
QRSD 90 [NOT] * NO OLD TRACINGS
QT 412
QTc 485

-- AXIS --
P 50
QRS 53
T 79

Account Number:12724860

Edited By:JULIA YOUNG

Order #: CARD20070318-0010



NO. M1737A KENDALL MEDITRACE PRINTED IN U.S.A.

ACCT NO: 12724860 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: WIGGINS, JESSICA DEV

EXAM: XR CHEST (PA OR AP 1 VIEW)060
EXAM DATE: 03/18/2007 00:00:00
PHYS: PARKER, GILBERT E
REASON: PAIN

Negative for any significant radiographic abnormality.

IMPRESSION: Normal study.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/03/07 TUH NPR LAB **LIVE** PAGE 119
RUN TIME: 2005 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12724860 LOC: ED U #: 229998
AGE/SX: 39/F ROOM: REG: 03/18/07
REG DR: BYRNES,EDWARD J STATUS: DEP ER BED: DIS:

****HEMATOLOGY****

HEMOGRAM

Day	1			
Date	MAR 18			
Time	0200		Reference	Units
WBC	14.3	H	(3.0-11)	1000/UL
RBC	6.08 #	H	(3.7-5.3)	MIL/UL
HGB	12.4 #		(11.5-16.0)	G/DL
HCT	39.8 #		(33-46)	%
MCV	65.4 #	L	(79-95)	FL
MCH	20.3	L	(26-34)	PG
MCHC	31.1		(29-35)	G/DL
RDW	18.7	H	(11.9-15.5)	%
PLATELET COUNT	475	H	(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

Day	1			
Date	MAR 18			
Time	0200		Reference	Units
NEUTROPHILS	72.2		(42-76)	%
LYMPHOCYTES	21.1		(16-48)	%
MONOCYTES	3.6		(0.0-10.0)	%
EOSINOPHILS	2.3		(0.0-7.6)	%
BASOPHILS	0.8		(0.0-1.5)	%

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/03/07 TUH NPR LAB **LIVE** PAGE 120
RUN TIME: 2005 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12724860 (Continued)

****CHEMISTRY****

Day	1				
Date	MAR 18				
Time	0630	0630	0200	Reference	Units
TROPONIN-I	3.15(a) #*H		< 0.04(A)	(0-0.08)	NG/ML

(A)
TROPONIN VALUES GREATER THEN 0.08 NG/ML ARE CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.4 NG/ML ARE LIKELY TO REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE DATA FROM A SINGLE BLOOD COLLECTION.

CK TOTAL	356 # H	(30-135)	U/L
CKMB	36.2 H	(0-3.6)	NG/ML
CK INDEX	10(b) *H		

Day	1		
Date	MAR 18		
Time	0200	Reference	Units
SODIUM	143	(135-151)	MEQ/L
POTASSIUM	4.1	(3.5-5.1)	MEQ/L
CHLORIDE	102	(99-116)	MEQ/L
C02	23	(22-30)	MEQ/L
GLUCOSE SERUM	120 H	(80-110)	MG/DL
BUN	11 #	(7-18)	MG/DL
CREATININE	0.8	(0.8-1.5)	MG/DL
CALCIUM	9.7	(8.4-10.2)	MG/DL
CK TOTAL	40 #	(30-135)	U/L
CK INDEX	(c)		

NOTES: (a) CRITICAL VALUE CALLED BY LBEWM TO SHAE STONE,RN ON 03/18/07 AT 0717. VERIFIED CRITICAL VALUE READBACK Y
See also (A)
(b) CRITICAL VALUE CALLED BY LBEWM TO SETH DYKE,RN ON 03/18/07 AT 0734. VERIFIED CRITICAL VALUE READBACK Y
(c) Test not performed

399

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/03/07 TUH NPR LAB **LIVE** PAGE 121
RUN TIME: 2005 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12724860 (Continued)

****COAGULATION****

	Day	Date	Time		Reference	Units
	1	MAR 18	0200			
D-DIMER QUANT				0.74(B)	(0-2.3)	mg/L

(B)
Increases in D-dimer concentration observed with thromboembolic events can be variable due to localization, extension and age of the thrombus. Therefore, a thromboembolic event cannot be excluded with certainty solely on the basis of a D-dimer concentration being within the reference range of ostensibly healthy persons. Results from D-dimer determinations should, therefore, always be evaluated in conjunction with clinical and other laboratory findings.

420

001815

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 Unit: 229998

ED
F W Age: 39 DOS: 03/18/07

ncy Department - Triage / Order Record

Triage Level: ____
Date: _____

Triage Time: | Age: | DOB:

Type: ☐ Acute ☐ Chronic Quality: ☐ Dull ☐ Throbbing

Chief Complaint _____ ☐ Sharp ☐ Radiating

☐ Ache ☐ Pressure

Latex Allergies: ☐ Yes ☐ No
Food Allergies: ☐ Yes ☐ No
Drug Allergies:

T:	BP:	P:	R:	Wt (kg)	Ht:	SaO2	B/S	LMP

Mode of Arrival
☐ Foot ☐ Ambulance
☐ Car ☐ Carried
☐ Police ☐ Wheelchair

Hx of S/S of TB ☐Yes ☐ No
Precautions:
☐ Tissues ☐ Mask
☐ Isolation ☐ Instruction

Visual Acuity ☐ Lens ☐No Lens
OD_____ OS _____
OU_____

Home/Homeopathic/Herbal Meds.

Immunizations:
☐ UTD
☐ Tetanus _____ (Date)

Suspected Pt. Abuse:
☐ Yes
☐ No

Pre-Hospital Care:
☐ EMS ☐ C-collar ☐ Spinal Immobilization
☐ None
☐ Other _____

HPI: (location, quality, duration, timing, modifying factors, associated signs)

Nursing Diagnosis:
☐ Health Care Seeking
☐ Altered Comfort
☐ Impaired Gas Exchange
☐ Impaired Integrity
☐ Altered Tissue Perfusion
☐ Ineffective Coping
☐ Other: _____

Nurse Signature:

Review of Systems:
☐ All reviewed and negative

Yes	No	
☐	☐	Fever
☐	☐	Visual Problems
☐	☐	Difficulty Hearing
☐	☐	Chest Pain
☐	☐	Difficulty Breathing
☐	☐	Vomiting Diarrhea
☐	☐	Dysuria / Discharge
☐	☐	Trauma
☐	☐	Rash
☐	☐	Extremity Weakness
☐	☐	Depression
☐	☐	Excessive Thirst
☐	☐	Abnormal Bleeding

Past Medical/Family History:

Yes	No	Family	
☐	☐	☐	Lung Disease
☐	☐	☐	Heart Disease
☐	☐	☐	Kidney Disease
☐	☐	☐	HTN
☐	☐	☐	CVA
☐	☐	☐	Diabetes
☐	☐	☐	Cancer
☐	☐		HIV
☐	☐		Seizures
☐	☐		Sickle Cell Dse
☐	☐		Surgery
☐	☐		Psychiatric

Social History:
☐ ☐ Smoke_____
☐ ☐ EtOH _____
☐ ☐ Drugs_____

ORD	LAB/X-RAYS	TIME	INIT
	EKG ▲		
	CBC/diff ▲■		
	BMP▲■ or CMP		
	LFT		
	Amy/Lip		
	FSBS		
	Troponin I ▲		
	CKMB▲		
	PT/PTT ■		
	Blood Cx 1 or 2		
	T&S ■ or T&C		
	ABO		
	GC/Chlamydia		
	Wet Prep		
	U/A ■		
	Urine C&S		
	Urine Preg.		
	QHCG		
	ABG ☐ RA		
	CXR		
	PCXR ▲■		
	C-Spine ■		
	Abd Series		
	Ankle ☐L ☐R		
	Wrist ☐L ☐R		
	Hip ☐L ☐R		
0222	Cardiac Protocol = ▲		
	Trauma Panel = ■		
	O.D. Panel		

Ibuprofen _____
Tylenol _____

☐ DT 0.5 ml IM
Time Lot # Site Nurse

☐ Cardiac Monitor ▲ ☐ Foley ☐ I/Os
☐ Oxygen ▲ ☐ NGT ☐ Lavage
☐ Pulse Ox ☐ IV/INT

TIME	PHYSICIAN ORDERS	TIME	INIT
0222	D dimer	0227	
	Nitro SL x 3 PO	PRN Pain	
	Lopressor 50mg	PO	
	ASA 81x4 po		
	Phenergan 12.5mg IVP Morphine 4mg		
0250	Repeat EKG	0255	WJ
0322	Morphine 4mg IV	0350	
0446	Repeat CEs + EKG @ 0630		
0700	Lovenox 65mg	SQ	

PHYSICIAN SIGNATURE
[signature] PA

TIME TO ROOM

____/Time_____ Dictated _____

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 Unit: 229998

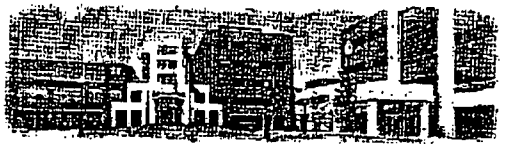
ED
F W Age: 39 DOS: 03/18/07

401

5602

001816

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.



Tuomey Healthcare System
129 North Washington St.
Sumter, SC 29150
(803) 774-9000

PHYSICIAN'S ORDERS [ ] Inpatient Admission [ ] Observation

YEAR		DRUG ALLERGIES	NKDA
ORDERED			
MONTH	DAY	TIME	
3	18	0730	1) Integrelin 180 mcg/kg bolus IV, then 2 mcg/kg/min IV drip.
			2) 300 mg Plavix PO
			3) Lopressor 5 mg IVP.
3/18/07		0823	Amiodarone 150 mg IV Bolus
			Allergies DAC

TELEPHONE AND VERBAL ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

TUOMEY HEALTHCARE SYSTEM
129 North Washington Street
Sumter, South Carolina 29150
Physician's Orders
ORD002 Rev. 08/30/2006

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 Unit: 229998
ED
F W Age: 39
DOS: 03/18/07
[redacted]

Acct: Unit:
/ DOS: //
Admit Age: DOB: //
42

[redacted]

5603

TUOMEY HEALTHCARE SYSTEM

Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

001817

PHYSICIAN'S CERTIFICATE OF TRANSFER

This is to certify that I, Edward Brynes was the emergency physician/private physician for Tammy Windham at Tuomey Healthcare System on March 18th 2007, at 08 : 00 Am.

FILL OUT AND ✔ CHECK THE APPROPRIATE SECTION

- ☐ I certify that the above listed individual suffered from an emergency medical condition (other than active labor) and was in an unstabilized condition, and that based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer.
- ☐ I certify that the above listed individual was a pregnant woman having contractions and based upon the information available at the time, the medical benefits reasonably expected from the provisions of appropriate medical treatment at another medical facility outweigh the increased risk to the unborn child and to the individual's medical condition from effecting the transfer.
- ☐ I hereby certify that the above named individual initiated the request for transfer to another medical facility and that the individual has been informed of the risks and benefits of such transfer.
- ☐ I hereby certify the above listed individual suffered from an emergency medical condition but was stabilized at the time of transfer.
- ☒ I hereby certify that the above listed individual *did not* suffer from an emergency medical condition and was not in active labor at the time of transfer.
- ☐ I hereby certify that the above listed individual has an infectious condition and will require isolation (indicate type) _____.
- ☒ I certify that the receiving facility has agreed to accept transfer and to provide appropriate medical treatment as per conversation with Dr. JUK.
- ☒ I certify that the receiving facility will be provided with all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records relating to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) of the patient's consent to transfer, and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.
- ☒ I certify that the patient will be transferred by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures; however, all transfers have inherent risks, including without limitations, traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle.
- ☐ I certify that the patient is in need of involuntary emergency psychiatric hospitalization and has no medical or surgical conditions which require transport by medical personnel or transportation equipped to provide life support measures; however, all transfers have inherent risks, including without limitations, traffic delays, accidents during transport, inclement weather, rough terrain or turbulence, and the limitations of equipment and personnel present in the vehicle.

THIS CERTIFICATION IS BASED UPON THE FOLLOWING

BENEFITS: ☒ DEFINITE CARE Higher level of care

RISKS: ☒ DETERIORATION OF CONDITION MVA, mechanical failure, disability

☒ POSSIBLE DEATH

DATE: 3-18-07 PHYSICIAN'S NAME: _____

PHYSICIAN'S SIGNATURE: _____

IF NO PHYSICIAN PRESENT, NURSE'S NAME: Stacy Avins RN

NURSE'S SIGNATURE: Stacy Avins

ON THE VERBAL ORDERS OF DR. Brynes RECEIVED AT 0800 ON 3-18-07

PHYSICIAN MUST COUNTERSIGN WITHIN 24 HOURS

TUOMEY HEALTHCARE SYSTEM - PHYSICIAN'S CERTIFICATE OF TRANSFER
30402 Rev. 11/23/05

30402

WHITE COPY - MEDICAL RECORDS
YELLOW COPY - RECEIVING HOSPITAL
PINK COPY - PATIENT/RESPONSIBLE PARTY

PATIENT I

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 Unit: 229998

403

ED
F W Age: 39

DOS: 03/18/07

[redacted]

001818
Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

INFORMED CONSENT TO TRANSFER

This is to certify that I, Tammy Windham have been examined at Tuomey Healthcare System and that I have given my consent to a transfer from this hospital to another facility. I acknowledge that I have been fully informed of the risks involved in the transfer, that I have received a copy of the physician's certificate of transfer, and that I have given my consent to the transfer.

I hereby release the attending physician and the hospital from all responsibility for any ill effects which may result from the transfer.

03/18/2007 DATE

0910 TIME AM PM

WITNESS

WITNESS

SIGNATURE

SIGNATURE OF LEGALLY RESPONSIBLE PERSON FOR PATIENT

TUOMEY HEALTHCARE SYSTEM

Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

001819

EMERGENCY DEPARTMENT TRANSFER CHECKLIST

PATIENT NAME: Windham, Tammy Elizabeth ACCT #: 12724860

ATTENDING PHYSICIAN (NAME): Dr. Byrnes

ACCEPTING PHYSICIAN (NAME): Dr. Juk TIME: 1205

TRANSFER TO (HOSPITAL): Providence Hospital

☑ BY AMBULANCE (NAME): Carolina Medcare

☐ BY HELICOPTER (NAME): _____

COPY OF RECORD: ☑ YES ☐ NO

LAB REPORTS: ☑ YES ☐ NO

X-RAY REPORTS: ☑ YES ☐ NO

NEXT OF KIN NOTIFIED: ☑ YES ☐ NO

PATIENT VALUABLES / PERSONAL BELONGINGS TO:

☑ PATIENT

☐ NEXT OF KIN

☐ HOSPITAL SAFE

VITAL SIGNS: T 97.3 P 69 R 19 B/P 142/79

COMMENTS: _____

J Conway RN 03/18/07

NURSE'S SIGNATURE DATE

TUOMEY HEALTHCARE SYSTEM - EMERGENCY DEPARTMENT CHECKLIST
30404 Rev. 02/20/06

30404

WHITE COPY - MEDICAL RECORDS
YELLOW COPY - RECEIVING HOSPITAL
PINK COPY - RESPONSIBLE PARTY

WINDHAM,TAMMY ELIZABETH
Acct: 12724860 Unit: 229998
ED
F W Age: 39 DOS: 03/18/07 [redacted]

4 of 5

[redacted]

5606

Tuomey Healthcare System

CERTIFICATE OF MEDICAL NECESSITY

Date:_____

Patient Name:_____ _____ Medicare #: _____

Other #: _____ ED F W Age: 39 . DOS: 03/18/07 [redacted] _____

1. At the time of ambulance transport, will the patient be able to get up from bedside unassisted?
   ☑ Yes ☐ No
2. At the time of transport, will the patient be able to ambulate? ☑ Yes ☐ No
3. At the time of transport, will the patient be able to sit in a wheelchair for the length of time it will take to transport him / her to the necessary destination? ☑ Yes ☐ No
4. What condition(s) and / or illness(es) does this patient have that prevent him / her from being transported by any means other than ambulance?
   - ☐ Stroke ☑ Unstable Cardiac Condition ☐ Unstable Respiratory Condition
   - ☐ Spinal Injury ☐ Spinal Surgery ☐ Hip Surgery
   - ☐ Paralysis - Which extremities are affected?_____
   - ☐ Bone Fracture or Possible Fracture - Location: _____
   - ☐ Neuromuscular Disorder - Type of Disorder: _____
   - ☐ Recent Surgery - Type of Surgery: _____
   - ☐ Other Condition:_____ Explain:_____
5. What secondary symptoms or problems is this patient experiencing that make ambulance transportation necessary?
   - ☐ Severe Dehabilitation ☐ Need for Restraints ☐ Use of Oxygen Equipment
   - ☐ Decubitus Ulcers ☐ Degenerative Muscle Disease ☐ Unconsciousness
   - ☐ Muscle Contractures ☐ Severe Nausea or Disorientation when seated upright
   - ☐ Other Condition: _____ Explain:_____

***** FOR HOSPITAL TO HOSPITAL TRANSPORT ONLY *****

6. What services does the patient need that are available at the second facility, but not available in the first facility? _____
7. **Certification of Necessity for Transport**: I certify that the above information represents an accurate assessment of the patient's medical condition (s) and that, in my professional opinion, this patient requires transport by an ambulance and should not be transported by other means.

Signature of Physician or Other Health Care Professional Johnny Puray

Printed Name and Title Johnny Puray RN

Date 03/18/07

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ED F W Age: 39 DOS: 03/18/07 [redacted]

41127 Rev. 10/31/2002

[redacted]

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
WINDHAM,TAMMY ELIZABETH [redacted]	12743989		ER	ED	229998

Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
[redacted]	39	F	M	HOL	W	N

Person to Notify / Address: PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone: 803-506-4697

Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]

PARROTT,MELINDA [redacted] — Relationship: SI — Other Phone: 803-506-4697

Financial Class: S

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit
ONSET OF SYMPTO	HA-N/V-L ARM PAIN

Accident Date / Time	Comments	Height / Weight	Arrival Mode
04/25/07	ID SCANNED		

Admit Date / Time	Admitting Physician	Attending Physician	User
04/25/07 1312		LAWTON III,JOSEPH J	ADCAJ

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

If yes, Living Will copy received? N

Does pt have Health Care Power of Attorney? No

If yes, Health Care Power of Attorney copy received?

Does patient want info on Advance Directive? No

Are you an organ donor? No

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (ER)

00000 Rev 01/01/2004

WINDHAM,TAMMY ELIZABETH
Acct: 12743989 **Unit:** 229998
LAWTON III,JOSEPH J
ER
F W Age: 39 **DOS:** 04/25/07 [redacted]

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Wed Apr 25 2007 13:22 TJK)
COMPLAINT: Headache.
ADMISSION: URGENCY: 1 - Emergent, BED: LOBBY.
PATIENT: NAME: Tammy E Windham, AGE: 39, GENDER: Female, DOB: [redacted], TIME OF GREET: Wed Apr 25 2007 13:13, Latex Allergy: No, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, KG WEIGHT: 65.8, PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, ACCOUNT NUMBER: 12743989, PAYMENT: Self Pay, ATTENDING: Lawton Joseph, IBEX NUMBER: 20070425132216ADT.
PRE-TRIAGE NOTES:
PREVIOUS VISIT ALLERGIES: Nkda.
NOTES:., Onset headache three days ago. States + nausea and vomiting. No visual blurring, + photosensitivity. States headaches is making her chest hurt. Hard to breathe.
VITAL SIGNS: BP 184/99, Pulse 74, Resp 18, Temp 98.4, Pain 10, O2 Sat 98.

KNOWN ALLERGIES
Denies allergies, Nkda.

HPI HEADACHE (15:47 PRF)
CHIEF COMPLAINT: Patient presents for the evaluation of headache, This is not the worst headache of this patient's life, This headache has not changed in character from prior headaches.
HISTORIAN: History obtained from patient.
TIME COURSE: Complaint is intermittent.
LOCATION: Pain most severe in Diffuse.
QUALITY: Pain is described as dull.
SEVERITY: Maximum severity is moderate, Currently symptoms are mild.
NOTES: CT for same last month negative.

PAST MEDICAL HISTORY
MEDICAL HISTORY (Wed Apr 25 2007 13:22 TJK): History of hypertension, which is not being treated. .
SURGICAL HISTORY (Wed Apr 25 2007 13:22 TJK): History of appendectomy, History of cholecystectomy. History of tubal ligation.
PSYCHIATRIC HISTORY (Wed Apr 25 2007 13:22 TJK): No previous psychiatric history.
SOCIAL HISTORY (Wed Apr 25 2007 13:22 TJK): Denies drug abuse, Patient smokes tobacco, Denies consumption of alcohol.
FAMILY HISTORY (Wed Apr 25 2007 13:22 TJK): Family history is not contributory to this case.
SOCIAL HISTORY (15:47 PRF): Patient smokes tobacco.
NOTES (15:47 PRF): Nursing records reviewed.

ROS (15:47 PRF)
ALL SYSTEMS NEGATIVE: All relevant systems reviewed and all negative except for the above.

PHYSICAL EXAM (15:49 PRF)
CONSTITUTIONAL: Vital Signs Reviewed. Patient has normal respiratory rate, Well appearing. Patient appears comfortable, Alert and oriented X 3, Bradycardic pulse, Hypertensive blood pressure, on betablocker (and

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TUOMEY HEALTHCARE
EMERGENCY RECORD

plavix).
HEAD: Atraumatic. Normal cephalic.
EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light. No discharge from eyes, Extraocular muscles intact. Sclera are normal. Conjunctiva are normal.
ENT: Ears normal to inspection, External ear normal, no nasal deformity. No stridor, Mouth normal to inspection, mucus membranes moist, no lesions, no lacerations, No drooling, Able to handle secretions, No tongue elevation.
NECK: Assessment includes:, Trachea midline. No masses, lymphadenopathy, Supple, No meningeal signs. Normal ROM, No Kernigs or Brudzinski.
RESPIRATORY/CHEST: Chest is nontender. Breath sounds normal. No respiratory distress.
CARDIOVASCULAR: No murmurs. Normal S1 S2, No rub, No gallop. Rate is bradycardic. Rhythm is bradycardic.
ABDOMEN: Abdomen is nontender, Bowel sounds normal. No distension, peritoneal signs.
BACK: There is no CVA Tenderness, There is no tenderness to palpation. Normal inspection.
UPPER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion.
LOWER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion, No calf tenderness.
NEURO: GCS is 15. No focal motor deficits, focal sensory deficits, Cranial nerves intact, No cerebellar deficits. Normal DTRs, Babinski absent. No nystagmus, clonus, asterixis, Speech normal, Gait normal, Memory normal.
SKIN: Skin is warm, Skin is dry, Skin is normal color.
LYMPHATIC: No adenopathy in neck.
PSYCHIATRIC: Oriented X 3. Normal affect, insight, concentration.

MEDICATION SERVICE
Meperidine Hydrochloride (15:42 PRF): Order: Meperidine Hydrochloride : 50 mg IM mg : IM
Notes: 50 mg IM
Ordered: Wed Apr 25 2007 15:42
Ordered by: Paul Fraley, MD
Entered by: Paul Fraley, MD Wed Apr 25 2007 15:42
Acknowledged by: Barbara Fowler Wed Apr 25 2007 15:45
Documented as given by: Barbara Fowler Wed Apr 25 2007 15:58
MEDICATION , Time given: 1550, IM medication, given in amount and via route as prescribed, Amount given: 50 mg, Medication administered to right hip, Medication combined for administration with Phenergan, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.
Promethazine Hydrochloride (15:43 PRF): Order: Promethazine Hydrochloride : 25 mg IM mg : IM

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TUOMEY HEALTHCARE
EMERGENCY RECORD

Ordered: Wed Apr 25 2007 15:43
Ordered by: Paul Fraley, MD
Entered by: Paul Fraley, MD Wed Apr 25 2007 15:43
Acknowledged by: Barbara Fowler Wed Apr 25 2007 15:44
Documented as given by: Barbara Fowler Wed Apr 25 2007 15:57
MEDICATION , Time given: 1550, IM medication, given in amount and via route as prescribed, Amount given: 25 mg, Medication administered to right hip, Medication combined for administration with Demerol, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.

NURSING PROCEDURE: NURSE NOTES (16:01 BLF)
TIME: Time: 1548, Pt lying on stretcher in POC, is + for phtotsensitivity and states noises increase her HA pain. Pt reports she has been ill with this HA and vomiting for 3 days, has, "dry heaved 3 times since I've been in this room, but there's nothing left to bring up." Advised pt will be in ED for approx 15 minutes after medication administration before knowing more. Pt stated understanding.

NURSING PROCEDURE: DISCHARGE NOTE (16:31 BLF)
TIME: Patient discharged at 1619. Patient discharged to, home, Patient, ambulates without assistance, Transported via friend/family driving, Accompanied by husband/wife/spouse, Discharge instructions given to, patient, Simple/moderate discharge teaching performed, Teaching performed by Barbara Fowler, RN, Above Person(s) verbalized understanding of discharge instructions and follow-up care, Patient treated and evaluated by physician, Pt's husband to room during d/c, visibly concerned and upset for wife. Husband asking to speak with the doctor that saw pt, advised husband that I would let him know, as he was in with another pt when I got the d/c papers. Dr. Fraley advised husband wants to speak with him, stated he would be there in a few minutes. Back to room to advise husband of this, pt leaving as she was d/c'ed, husband asking if pt is okay. Advised husband that for now, from what we can tell at this time, she is okay, that her HA has decreased greatly and that she has a follow-up appt with her regular doctor in the am. Husband stated understanding and left. Advised Dr. Fraley that husband left.
VITAL SIGNS: BP: 157, / 93, Pulse: 72, Resp: 18, Temp: 97.8, Pain: 1, O2 sat: 98%, ra, Time: 1619.

DIAGNOSIS (15:45 PRF)
FINAL: PRIMARY: cephalagia hx migraines last CT negative last month per pt, ADDITIONAL: .

PRESCRIPTION: No Documented Prescriptions

INSTRUCTION (15:56 PRF)
FOLLOWUP: 1, JOSEPH J LAWTON III COLUMBIA CARDIOLOGY CONSULT 2601 LAUREL

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TUOMEY HEALTHCARE
EMERGENCY RECORD

ST, STE 260 COLUMBIA SC 29204-4187 18037444900.
SPECIAL: call your private physician Joseph Lawton MD promptly in morning by 9 AM for recheck and further tests (such as spinal tap) /or referral to specialist (such as neurologist) if needed.
continue present medications.
work excuse as needed.
see MD sooner if worse, and feel free to return to ER at any time should you have a problem or question. .

DISPOSITION
PATIENT (15:45 PRF): Disposition Transport: Ambulatory, Condition: Stable.
(16:32 BLF): Pain Scale: 01, Oxygen: No, IV stop time docd?: NA, Disposition: Home, Remove from ER.

ADMIN (16:31 BLF)
DIGITAL SIGNATURE: Fowler, Barbara.

KEY:
BLF=Fowler, Barbara PRF=Fraley, MD, Paul TJK=Kolb, Terry

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001826

TUOMEY HEALTHCARE SYSTEM

Name: Windham, Tammy E
Age: 39 Wt: 65.8 kg
Gender: F
Medrec: 229998
Acct: 12743989
Attending: PRF
Primary Nurse: BLF
Bed: ED 2-ER 16

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
cephalagia hx migraines last CT negative last month per pt

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
call your private physician Joseph Lawton MD promptly in morning by 9 AM for recheck and further tests (such as spinal tap) &/or referral to specialist (such as neurologist) if needed.

continue present medications.

work excuse as needed.

see MD sooner if worse, and feel free to return to ER at any time should you have a problem or question.

Patient Signature

BLF RN 16:19
Rn/LPN Ini. TIME

1
Unaw
157/93
72
98%/18

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ER

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service	Medical Rec. No.
WINDHAM,TAMMY ELIZABETH [redacted]	12983665		ER	ED	229998

Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
[redacted]	40	F	M	HOL	W	N

Person to Notify / Address: PARROTT,MELINDA
4455 POND LOOP RD
SUMTER,SC 29150
Home Phone 803-506-4949(MESS) Other Phone
Relationship: SI

Guarantor / Address: WINDHAM,TAMMY ELIZABETH
[redacted]
Financial Class S

Next of Kin / Address: PARROTT,MELINDA
[redacted] Other Phone
Relationship: SI

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit
ONSET OF SYMPTO	CHEST PAIN

Accident Date / Time	Comments	Height / Weight	Arrival Mode
09/01/08			

Admit Date / Time	Admitting Physician	Attending Physician	User
09/01/08 1514		LAWTON III,JOSEPH J	NSAW1

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐ ☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No
Does pt have Health Care Power of Attorney? No
Does patient want info on Advance Directive? No
Are you an organ donor? No

If yes, Living Will copy received? N
If yes, Health Care Power of Attorney copy received?

TUOMEY HEALTHCARE SYSTEM
129 North Washington Street
Sumter, South Carolina 29150
Admission Record (ER)
00000 Rev. 01/01/2004

WINDHAM,TAMMY ELIZABETH
Acct: 12983665 **Unit:** 229998
LAWTON III,JOSEPH J
ER
F W **Age:** 40 **DOS:** [redacted]

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TRIAGE (15:09 CC)
COMPLAINT: COMPLAINT: CHEST PAIN.
ADMISSION: URGENCY: 1 - Emergent, TRANSPORT: Ambulance, BED: 2-ER 06.
PATIENT: NAME: Tammy E Windham, AGE: 40, GENDER: female, DOB: Wed [redacted] LANGUAGE: English. Pt wants EDHIV test?: Patient does not want EDHIV test, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, PAYMENT: Self Pay.
PREVIOUS VISIT ALLERGIES: Nkda.
ASSESSMENT: .. Patient complains of pain. Pain described as stabbing, On a scale 0-10 patient rates pain as 8, THE PT. VERBALIZED THAT SHE HAD SUBSTERNAL CHEST PAIN.. Pain is intermittent, Onset was FRIDAY NIGHT.
THE PT. CAME WITH EMS ALERT AND ORIENTEDx3.EMS INFORMED THAT THE PT.WAS SEEN IN THE BACKYARD BY THE RELATIVE THAT SHE PASSED OUT DUE TO VOMITING. WHEN EMS ARRIVED THE PATIENT WAS CONSCIOUS AT THE BACK OF THE CAR.THEY GAVE 2 SPRAYS OF NITROS AND ASA 324MG PO. THE PT. WAS RELIEVED OF PAIN.
VITAL SIGNS: BP 127/92, Pulse 69, Resp 18, Temp 97.2, Pain 8, O2 Sat 97, on 2LPM, Time 9/1/2008 15:02.
KNOWN ALLERGIES
Nkda.
CURRENT MEDICATIONS
Aspirin: 81 milligram(s) PO Once a day. 81mg daily. (15:10 CC)
Metoprolol Tartrate: 25MG milligram(s) PO 2 times a day. 25MGmg BID. (15:10 CC)
PRAVASTATIN 40MG EVERYDAY IN HS (15:11 CC)
PLAVIX 75MG EVERY DAY (15:11 CC)
LISINOPRIL 20MG PO EVERYDAY (15:12 CC)
HPI CHEST PAIN (17:07 JD)
CHIEF COMPLAINT: Patient presents for the evaluation of chest pain that was present but has now resolved.
HISTORIAN: History obtained from patient.
TIME COURSE: Onset of symptoms reported as gradual, Onset was 3 days prior to arrival . Complaint is persistent, intermittent.
LOCATION: Pain most severe in substernal area, There is no radiation. Pain has not moved in location over time.
QUALITY: Pain is pressure, aching, no different from patient's previous episodes.
ASSOCIATED WITH: Associated with no nausea, no vomiting, no diaphoresis, no shortness of breath, no palpitations.
SEVERITY: Maximum severity is moderate, Currently there are no symptoms.
EXACERBATED BY: Patient's condition exacerbated by stress over the weekend.
RELIEVED BY: Patient's condition relieved by 1 sublingual Nitroglycerin, by ems, she had none at home.

RISK FACTORS: CAD risk factors include known CAD, CAD risk factors include smoking.
NOTES: apparently while in yard she had syncope/near syncope episode.
PAST MEDICAL HISTORY
MEDICAL HISTORY: History of cardiac disease, with stent placement, Number of stents 1, History of hypertension, which is not being treated. circumflex implant. (15:09 CC)
SURGICAL HISTORY: History of appendectomy, History of cholecystectomy. History of tubal ligation. circumflex implant 3/19/07. (15:09 CC)
PSYCHIATRIC HISTORY: No previous psychiatric history. (15:09 CC)
SOCIAL HISTORY: Denies alcohol abuse, Denies drug abuse, Lives with others, Patient smokes tobacco, at 0.5, packs per day for 20, years; equating to 10, pack years of smoking. (15:09 CC)
FAMILY HISTORY: Family history is not contributory to this case. (15:09 CC)
NOTES: Nursing records reviewed, Agree with nursing records, Old chart reviewed, Medication list reviewed. (17:09 JD)
MEDICAL HISTORY: History of cardiac disease, with stent placement, Number of stents 1, History of hypertension, which is not being treated. circumflex implant. she has known right leg artery stenosis from a doppler test a few weeks ago and was told she would need a by-pass or stenting. (20:34 JD)
ROS (17:08 JD)
CONSTITUTIONAL: Historian reports fatigue.
CARDIOVASCULAR: Historian reports chest pain. Chest pain is substernal. No radiation.
MUSCULOSKELETAL: Historian reports arthralgias, myalgias, right leg ache since last cath in may.
PSYCHIATRIC: Historian reports emotional lability.
NOTES: All systems were reviewed and are negative except as described above.
PHYSICAL EXAM
CONSTITUTIONAL: Patient is afebrile, Vital Signs Reviewed. Patient has normal pulse, normal blood pressure, normal respiratory rate, Well appearing. Patient appears comfortable, Alert and oriented X 3. (17:10 JD)
HEAD: Atraumatic, Normocephalic. (17:10 JD)
EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light. No discharge from eyes, Extraocular muscles intact. Sclera are normal. Conjunctiva are normal. (17:10 JD)
ENT: Ears normal to inspection, Nose examination normal, Posterior pharynx normal, Mouth normal to inspection. (17:10 JD)
NECK: Normal ROM. No jugular venous distention, meningeal signs, Cervical spine nontender. (17:10 JD)
RESPIRATORY CHEST: Chest is nontender. Breath sounds normal. No respiratory distress. (17:10 JD)

CARDIOVASCULAR: RRR. Heart sounds normal. No murmurs. Normal S1 S2. (17:10 JD)
ABDOMEN: Abdomen is nontender. No masses, Bowel sounds normal, No distension, peritoneal signs. (17:10 JD)
BACK: There is no CVA Tenderness, There is no tenderness to palpation. Normal inspection. (17:10 JD)
UPPER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion. (17:10 JD)
NEURO: GCS is 15. No focal motor deficits, Speech normal, Memory normal. (17:10 JD)
SKIN: Skin is warm, Skin is dry, Skin is normal color. (17:10 JD)
LYMPHATIC: No adenopathy in neck, groin. (17:10 JD)
PSYCHIATRIC: Oriented X 3. Normal affect, concentration. (17:10 JD)
LOWER EXTREMITY: No clubbing, edema. Normal range of motion, No calf tenderness, right leg without palpable pulses from groin to ankle and skin somewhat plethoric in color. doppler testing shows good sound wave from both the dp and pt. (20:32 JD)
VITAL SIGNS
VITAL SIGNS: BP: 127/92, Pulse: 69, Resp: 18, Temp: 97.2, Pain: 8, O2 sat: 97 on 2LPM, Time: 9/1/2008 15:02. (15:09 CC)
BP: 117/59, Pulse: 55, Resp: 27, Temp: -, Pain: 0, O2 sat: 100 on 2LPM, Time: Mon Sep 01, 2008 16:30. (16:31 CC)
BP: 116/51, Pulse: 55, Resp: 24, Temp: -, Pain: 0, O2 sat: 99 on 2lpm, Time: Mon Sep 01, 2008 18:16. (18:17 CC)
BP: 120/52, Pulse: 58, Resp: 27, O2 sat: 98 on 2l/nc, Time: 9/1/2008 20:07. (20:09 RAH)
BP: 121/63, Pulse: 55, Resp: 23, Temp: 97.1, Pain: 0, O2 sat: 95 on RA, Time: 9/1/2008 20:47. (20:49 EVH)
ORDERS
URINALYSIS -COMPLETE by JD for JD on Mon Sep 01, 2008 16:06 Status: Done by System Mon Sep 01, 2008 16:45.
TROPONIN- I by JD for JD on Mon Sep 01, 2008 16:06 Status: Done by System Mon Sep 01, 2008 17:21.
CKMB +TOTAL CK by JD for JD on Mon Sep 01, 2008 16:06 Status: Done by System Mon Sep 01, 2008 17:09.
Vital Signs Every 2 Hours by JD for JD on Mon Sep 01, 2008 16:06 Status: Done by CC Mon Sep 01, 2008 16:17.
COMPREHENSIVE METABOLIC PANEL by JD for JD on Mon Sep 01, 2008 16:06 Status: Active.
CBC (WITH DIFF) by JD for JD on Mon Sep 01, 2008 16:06 Status: Done by System Mon Sep 01, 2008 16:39.
XR CHEST PORTABLE 1 VIEW 0608 by JD for JD on Mon Sep 01, 2008 16:06 Status: Active.
CKMB +TOTAL CK by JD for JD on Mon Sep 01, 2008 18:52 Status: Done by System Mon Sep 01, 2008 19:50.
Vital Signs Every 2 Hours by JD for JD on Mon Sep 01, 2008 18:52 Status: Done by EVH Mon Sep 01, 2008 18:58.
EKG by JD for JD on Mon Sep 01, 2008 18:52 Status: Active.

TUOMEY HEALTHCARE
EMERGENCY RECORD

TROPONIN- I by JD for JD on Mon Sep 01, 2008 18:52 Status: Done by System Mon Sep 01, 2008 20:07.

DOCTOR NOTES

TIME: Time: 2030, Routine re-evaluation, after analgesics, Patient's status has improved, Patient's status has stabilized. (20:34 JD)

PATIENT PLAN: The patient will be discharged, The patient will follow up with primary care physician, The patient is to continue present medications. (20:34 JD)

TEXT: head ache better and would like some nitro for home use. repeat ekg and enzymes neg. (20:36 JD)

MEDICATION SERVICE

Acetaminophen: Order: Acetaminophen : 1 gram(s) : PO
Ordered by: Joseph Degulis,MD
Entered by: Joseph Degulis,MD Mon Sep 01, 2008 16:18
Acknowledged by: Caroline Cabilogan Mon Sep 01, 2008 16:19
Documented as given by: Caroline Cabilogan Mon Sep 01, 2008 16:28
Patient, Medication, Dose, Route and Time verified prior to administration.
MEDICATION , Time given: 1627, Amount given: 1GRAM, Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Family at bedside, Call light in reach. (16:18 JD)

Toradol: Order: Toradol (Ketorolac Tromethamine) : 30 milligram(s) : IVP
POTENTIAL SEVERE INTERACTION: Aspirin
Ordered by: Joseph Degulis,MD
Entered by: Joseph Degulis,MD Mon Sep 01, 2008 18:52
Acknowledged by: Ed Hite Mon Sep 01, 2008 19:09
Documented as given by: Ed Hite Mon Sep 01, 2008 19:16
Patient, Medication, Dose, Route and Time verified prior to administration.
Time given: 1910, Amount given: 30MG, IV site 1, Medication administered into left hand, IVP, Initial medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient tolerated procedure well, Patient in position of comfort, Side rails up, Cart in lowest position, Family at bedside. (18:52 JD)

MEDICATION ADMINISTRATION SUMMARY (Mon Sep 08, 2008 16:16)
Drug Name: Toradol, Dose: 30 milligram(s), Route: IVP, Status: Given,

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TUOMEY HEALTHCARE
EMERGENCY RECORD

Ordered: 19:16 9/1/2008,
Drug Name: Acetaminophen, Dose: 1 gram(s), Route: PO, Status: Given, Ordered: 16:28 9/1/2008, Detailed record available in Medication Service section.

O2SAT INTERPRETATION (16:58 JD)
O2SAT: O2 saturation reading 100%, O2 AMT: 2L, O2 Sat normal, Oxygen administration, Continuous Pulse Ox.

EKG INTERPRETATION (16:58 JD)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, Compared with previous EKG, from 5/10/2008. 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate is normal, T-Waves: flattening, Areas Affected: lateral leads, LVH, non-specific EKG.
MONITOR STRIP: Interpreted by ED Physician. Cardiac Monitor Strip interpretation is Normal Sinus, Rate is normal.

LAB INTERPRETATION (20:32 JD)
INTERPRETATION: I reviewed the lab results. No clinically significant lab abnormalities.

RADIOLOGY INTERPRETATION (16:59 JD)
INTERPRETER: Preliminary review of x-rays by ED Physician.
CHEST: Interpretation of chest X-ray shows, chest x-ray negative, no infiltrates, no pneumothorax, no hemothorax, no masses, no cardiomegaly, no CHF, no effusion, no free air.

DIAGNOSIS (20:36 JD)
FINAL: PRIMARY: chest pain ? etiology, ADDITIONAL: post nitroglycerine head ache, right leg arterial stenosis with doppler pulse.

PRESCRIPTION (20:37 JD)
Fioricet: Tablet : 325 mg-50 mg-40 mg : Oral=Quantity: ***1 or 2*** Unit: TAB Route: Oral Schedule: every 4 hours as needed Dispense: ***20***.
Nitrostat: Tablet : 0.4 mg : Sublingual=Quantity: ***1*** Unit: tab Route: Sublingual Schedule: SEE NOTES Dispense: ***30***.
NOTES: 1 tab sl q5minutes for three doses for chest pain prn

INSTRUCTION (20:38 JD)
DISCHARGE: CHEST PAIN OF UNCLEAR ETIOLOGY , HEADACHE , CAD (ASCAD, HARDENING OF THE ARTERIES, CORONARY ARTERY DISEASE).
SPECIAL: Take medication as prescribed
Follow up with your private MD in the AM. Return to ED if worse.

DISPOSITION
PATIENT: Disposition: Home, Disposition Transport: Ambulatory, Condition: Stable. (20:36 JD)
Pain Scale: 0, O2 used while in ED?: Yes, IV stop time docd?: YES, Remove from ER. (20:50 EVH)

TUOMEY HEALTHCARE
EMERGENCY RECORD

NURSING PROCEDURE: EKG CHART (15:20 SKW1)
TIME: Patient's identity verified by. patient stating name,

hospital ID bracelet, Indications for test: chest pain, EKG was performed at 1509, 12 lead EKG Performed-left chest, EKG Number: 229998, After procedure, EKG for interpretation given to Dr. wernsman, eric. Patient tolerated procedure well, PREVIOUS EKG ALSO GIVEN TO DR WERNSMAN, ERIC.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: RESPIRATORY (15:21 SKW1)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, Other indication for procedure chest pain, O2 AMT: 2L, Oxygen delivery device is: nasal cannula. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: CARDIAC MONITOR (15:36 SKW1)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, Indications for test: chest pain, Procedure was performed at 1505. Patient placed on cardiac monitor, placed on non-invasive blood pressure monitor, placed on continuous pulse Oximetry, O2 saturation reading 98%, Heart rate: 65, After procedure, patient tolerating monitoring, After procedure, alarms set and on, Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: IV (16:19 CC)
SITE 1: Patient's identity verified by. patient stating name, hospital ID bracelet, Other indication blood draw, Procedure performed at 1600, 20 gauge catheter inserted, into left hand, amount 3cc, ml, Specimen labeled in the presence of the patient and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: URINE COLLECTION (16:30 SKW1)
URINE COLLECTION FEMALE: Patient's identity verified by. patient stating name, hospital ID bracelet, Other indication for procedure UA, Procedure performed at 1625, Voided/clean catch. in 1 attempt, Color: Orange, Clarity: Bloody. Patient tolerated procedure well.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: URINE COLLECTION (16:30 CC)
URINE COLLECTION FEMALE: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure performed at 1615,

Voided/clean catch, Amount 100, ml, Color: Tea, Clarity: Clear, Specimen labeled in the presence of the patient and sent to lab. Patient tolerated procedure well, Procedure done by SOPHIA,ER TECH.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.

NURSING PROCEDURE: EKG CHART (19:12 SKW1)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, EKG was performed at 1902, 12 lead EKG Performed-left chest, EKG Number: 229998, After procedure, EKG for interpretation given to Dr. degulis, joseph. Patient tolerated procedure well, repeat ekg.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: NURSE NOTES (20:09 RAH)
TIME: Time: 2002, Pt states headache has subsided, rates pain at a 1 on 0-10 pain scale, pt resting comfortably.
VITAL SIGNS: BP: 120, / 52, Pulse: 58, Resp: 27, O2 sat: 98, on: 2l/nc.
NURSING PROCEDURE: DISCHARGE NOTE (20:49 EVH)
TIME: Patient discharged at 2040, Patient discharged to, home, Patient, ambulates without assistance, Transported via friend/family driving, Accompanied by family member, Discharge instructions given to, patient, Name of prescription(s) given: Fiorcet, Nitrostat, Discharge instcructions and prescriptions given, Pt acknowledges understanding of instcructions.
VITAL SIGNS: BP: 121, / 63, Pulse: 55, Resp: 23, Temp: 97.1, Pain: 0, O2 sat: 95, on: RA.
NURSING PROCEDURE: IV (20:50 EVH)
SITE 1: Procedure performed at 2040, IV discontinued with catheter intact, at 2040, Discontinued due to. patient being discharged, Care after removal, sterile dressing applied.
SITE 2: Patient tolerated procedure well.
ADMIN (Mon Sep 08, 2008 16:10 JD)
DIGITAL SIGNATURE: Degulis,MD, Joseph.
Key:
CC=Cabilogan, Caroline EVH=Hite, Ed JD=Degulis,MD, Joseph
RAH=Hall, Richie SKW1=Williams, Sophia
Name: Windham, Tammy E [redacted]0 MedRec: 229998 AcctNum: 12983665
Prepared: Mon Sep 08, 2008 16:16 by Page: 7 of 7

INSTRUCTIONS
* The examination and treatment you received in the emergency department has been rendered on an emergency basis only and is not meant to replace complete care from a personal physician or clinic.
*

FINAL DIAGNOSIS chest pain ? etiology ADDITIONAL DIAGNOSIS post nitroglycerine head ache right leg arterial stenosis with doppler pulse FOLLOWUP CONTACTS SPECIAL INSTRUCTIONS Take medication as prescribed Follow up with your private MD in the AM. Return to ED if worse. MEDICAL INSTRUCTIONS CHEST PAIN OF UNCLEAR ETIOLOGY You have been seen for chest pain, however the cause is not yet known. This means that after taking your medical history, doing an exam, and evaluating any tests done, there is not yet a definite diagnosis for why you are having pain. This may require additional time and re-evaluation by your primary care doctor. The physician caring for you, however, feels that the chance of this pain representing a life-threatening condition is extremely small.

Symptoms of chest pain that are unlikely to represent life threatening conditions (such as a heart attack, blood clot to the lung, aortic injury,

or collapsed lung) include pain which lasts for seconds per episode, pain that does not cause shortness of breath, nausea, sweating, or lightheadedness. Pain which is there for days at a time is also unlikely to be due to a life-threatening illness. Additionally, pain which is worsened by pushing on the affected part of your chest, or pain which is worse with twisting or bending is less likely to be life-threatening. Pain which improves with exercise or exertion is also unlikely to be due to a dangerous cause. Chest pain is a serious symptom and must be handled with caution. It is VERY IMPORTANT that you follow up with your regular doctor, and seek medical attention immediately here or at the nearest Emergency Department if your symptoms become worse or change. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - Your pain worsens. - Your pain causes any shortness of breath, nausea, or sweaty feeling. - You notice that your pain worsens as you walk, go up stairs, or exert yourself. - You have any weakness, lightheadedness or you faint with your pain. - It hurts to breathe. - You develop a swollen leg. - Any other worsening symptoms or concerns. HEADACHE You have been treated for a headache. Headaches are a very common complaint. Most of the time they are benign (not harmful). Some headaches can be very serious. The symptoms that you have today appear to be from a benign (non-serious) headache and you can be safely cared for at home. If you continue to develop headaches, or this headache does not resolve over the next few days, a follow-up appointment with your regular family doctor or a neurologist is needed to further evaluate the cause of your headache. Keeping a "headache diary" may help you doctor better determine the cause of your headaches. Take your headache medication as directed. This is especially important if your doctor has placed you on a daily medication that will prevent headaches. YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS: - Worsening headache. - A recurrent headache that is severe and sudden in onset. - A change in the type of pain that you usually experience with your headaches. - Fever, especially in association with a stiff neck. - Numbness, tingling, or weakness in your arms or legs. - If you pass out. - If you have any problems with your vision. - If you develop any episodes of vomiting making it difficult to take your medication. CAD (ASCAD, HARDENING OF THE ARTERIES, CORONARY ARTERY DISEASE) You have been diagnosed with stable angina. Angina is a term that is used to describe the pain or pressure (or other symptoms that may include shortness of breath, nausea or sweating) that you experience when the arteries around your heart are not supplying enough blood to meet the hearts needs. Stable angina means that you have not experienced any other symptoms out of the ordinary for your disease. It is very important that you continue taking all of your prescribed medications as directed by your physician. YOU SHOULD RETURN TO THE EMERGENCY DEPARTMENT IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR: - Pain or pressure (or your anginal symptoms) that occur at rest. - Any change in the normal pattern of your angina. - Pain or pressure (or your anginal symptoms) that is not relieved by 3 (or fewer) nitroglycerin tablets (or sprays). - Pain or other symptoms that concern you. PRESCRIPTIONS Fioricet : Tablet : 325 mg-50 mg-40 mg : Oral Dispense: 20, Quantity: 1 or 2, Schedule: every 4 hours as needed Nitrostat : Tablet : 0.4 mg : Sublingual Dispense: 30, Quantity: 1, Schedule: SEE NOTES

* X-rays. X-rays are read initially by the emergency physician.

The X-ray will be read by a radiology physician specialist within 24 hours. 001836
If the radiologist notes any differences, you will be contacted by the emergency department. ** Lab Work. Results of lab testing done in the Emergency Department are available to your private physician. Lab results cannot be given over the Emergency Department phone.* IMPORTANT: If your condition gets worse or you have any concerns and you cannot contact your physician, return promptly to Tuomey Healthcare Systems Emergency Department. (803)774-9111**Disclaimer: Home medications and allergies listed on Patient Medication History Record are as reported by patient/family to Tuomey ED staff.** DISCHARGE INSTRUCTIONS RECEIPT FINAL DIAGNOSIS chest pain ? etiology ADDITIONAL DIAGNOSIS post nitroglycerine head ache right leg arterial stenosis with doppler pulse FOLLOWUP CONTACTS THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN Take medication as prescribed Follow up with your private MD in the AM. Return to ED if worse. THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN CHEST PAIN OF UNCLEAR ETIOLOGY HEADACHE CAD (ASCAD, HARDENING OF THE ARTERIES, CORONARY ARTERY DISEASE) THE FOLLOWING PRESCRIPTIONS WERE GIVEN Fioricet : Tablet : 325 mg-50 mg-40 mg : Oral Dispense: 20, Quantity: 1 or 2, Schedule: every 4 hours as needed Nitrostat : Tablet : 0.4 mg : Sublingual Dispense: 30, Quantity: 1, Schedule: SEE

NOTES_____Patient

Signature_____ ____:___Rn/LPN Ini. TIME

787

5624

229998 WINDHAM, TAMMY ELIZABETH 01-Sep-2008 15:09:31
40 Years Female Race: White BP: 116/51 Dept: Emergency Dept.
Room: ED-6
Oper: 54

Rate 71 - STMT - * SINUS RHYTHM, RATE 71.
RR 845 - STMT - * PROBABLE LVH WITH SECONDARY REPOL ABNRM.
PR 152 - STMT - * SINCE LAST TRACING, 05/10/2008: RATE FASTER.
QRSD 84
QT 440
QTc 479

-- AXIS --
P 48
QRS 61
T 185

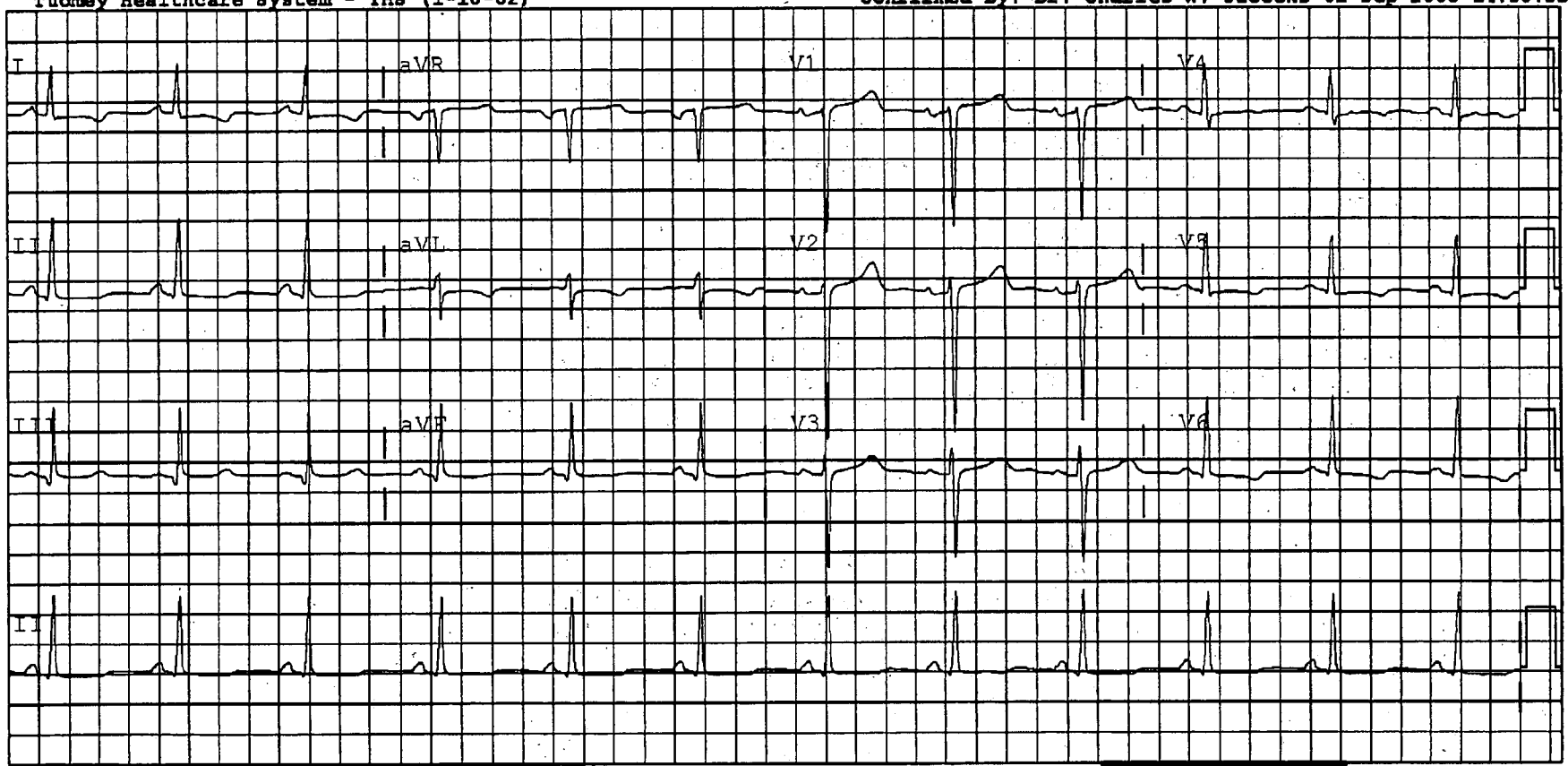
Account Number:12983665

Edited By:JULIA YOUNG

Order #: CARD20080901-0051

- ABNORMAL ECG -

Standard 12
Edited
Requested By: DEGULIS, JOSEPH
Tuomey Healthcare System - THS (1-10-02)
Confirmed by: Dr. Charles W. Jacocks 02-Sep-2008 14:36:55



Device: 2743 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60- 0.5-150 Hz W PH090A P?

788

5625

229998 WINDHAM, TAMMY ELIZABETH 01-Sep-2008 19:02:14
40 Years Female Race: White BP: 119/65 Dept: Emergency Dept.
Room: ED-6
Oper: 54

Rate 58 - STMT - * SINUS BRADYCARDIA, RATE 58.
RR 1034 - STMT - * PROBABLE LEFT ATRIAL ABNORMALITY.
PR 164 - STMT - * NONSPECIFIC T ABNORMALITIES, DIFFUSE LEADS.
QRSD 82 - STMT - * SUSPECT LEFT VENTRICULAR HYPERTROPHY.
QT 476 - STMT - * SINCE LAST TRACING, 09/01/2008 @ 15:09 PM: RATE SLOWER.
QTc 468

Account Number:12983665

Edited By:MYASIA WILCHER

-- AXIS --
P 47
QRS 57
T 209

Order #: CARD20080901-0065

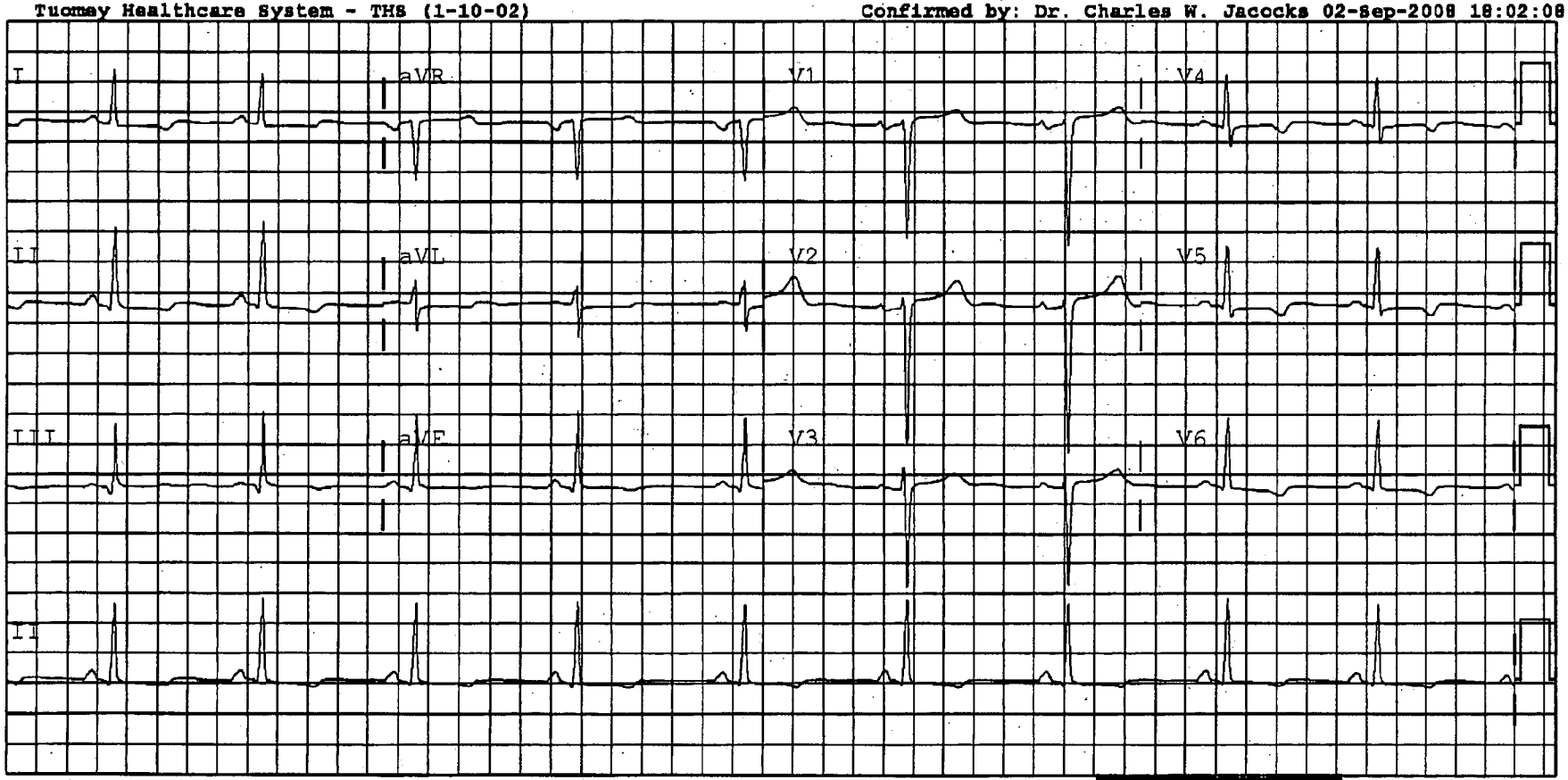
- ABNORMAL ECG -

Standard 12
Requested By: DEGULIS, JOSEPH

Edited

Tuomey Healthcare System - THS (1-10-02)

Confirmed by: Dr. Charles W. Jacocks 02-Sep-2008 18:02:08



Device: 2743 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60- 0.5-150 Hz W PH090A P?

789

ACCT NO: 12983665 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: DEGULIS, JOSEPH

EXAM: XR CHEST PORTABLE 1 VIEW 0608
EXAM DATE: 09/01/2008 00:00:00
PHYS: PANNELL, TIMOTHY L

TECHNICIAN: JS
REASON: CHEST PAIN

Negative for any significant radiographic abnormality.IMPRESSION:
Normal study.

SIGNED REPORT:AUTHENTICATED BY PANNELL TIMOTHY L
TRANSCRIBED DATE/TIME 2008/09/01 18:22:00
Location: ER

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/02/08 TUH NPR LAB **LIVE** PAGE 11
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12983665 LOC: ED U #: 229998
AGE/SX: 40/F ROOM: REG: 09/01/08
REG DR: DEGULIS,JOSEPH STATUS: DEP ER BED: DIS:

****HEMATOLOGY****

HEMOGRAM

	Day 1 Date SEP 1 Time 1600	Reference	Units
=> WBC	9.2 #	(3.0-11)	1000/UL
=> RBC	4.82	(3.7-5.3)	MIL/UL
=> HGB	12.8 #	(11.5-16.0)	G/DL
=> HCT	38.4 #	(33-46)	%
=> MCV	79.6 #	(79-95)	FL
=> MCH	26.5	(26-34)	PG
=> MCHC	33.4	(29-35)	G/DL
=> RDW	15.8 H	(11.9-15.5)	%
=> PLATELET COUNT	317 #	(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

	Day 1 Date SEP 1 Time 1600	Reference	Units
=> NEUTROPHILS	75.4	(42-76)	%
=> LYMPHOCYTES	16.5	(16-48)	%
=> MONOCYTES	4.6	(0.0-10.0)	%
=> EOSINOPHILS	3.0	(0.0-7.6)	%
=> BASOPHILS	0.5	(0.0-1.5)	%

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/02/08 TUH NPR LAB **LIVE** PAGE 12
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12983665 (Continued)

****URINALYSIS****

	Day 1 Date SEP 1 Time 1625		Reference	Units
=> COLOR	YELLOW			
=> APPEARANCE-2	CLOUDY	H	(CLEAR)	
=> GLUCOSE	NEGATIVE		(NEGATIVE)	MG/DL
=> BILIRUBIN	NEGATIVE		(NEGATIVE)	
=> KETONES	NEGATIVE		(NEGATIVE)	
=> SPECIFIC GRAVTY	1.014		(1.001-1.035)	
=> BLOOD	LARGE	H	(NEGATIVE)	
=> PH	6.0		(5-9)	
=> PROTEIN	NEGATIVE		(NEGATIVE)	MG/DL
=> UROBILINOGEN	0.2		(0.2-1.0)	MG/DL
=> NITRITES	NEGATIVE		(NEGATIVE)	
=> LEUKOCYTES	SMALL	H	(NEGATIVE)	
=> WBC	0		(0-6)	/HPF
=> RBC	20-29	H	(0-2)	/HPF
=> EPITHELIAL CELL	30-49	H	(0-6)	/HPF
=> BACTERIA	2+	H	(NEGATIVE)	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/02/08 TUH NPR LAB **LIVE** PAGE 13
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12983665 (Continued)

****CHEMISTRY****

Day		1			
Date		SEP 1			
Time	1930	1930	1600	Reference	Units
=> SODIUM			139	(135-151)	MEQ/L
=> POTASSIUM			3.9	(3.5-5.1)	MEQ/L
=> CHLORIDE			106	(99-116)	MEQ/L
=> C02			22	(22-32)	MEQ/L
=> GLUCOSE SERUM			88 #	(80-110)	MG/DL
=> BUN			9 #	(7-18)	MG/DL
=> CREATININE			0.9 #	(0.8-1.5)	MG/DL
=> eGFR			> 60.0(A)		GFR

(A) Reference Range: > than or = to 60 ml/min
This is an estimated result and should
not be used to dose medications.

=> CALCIUM			9.0	(8.4-11.0)	MG/DL
=> PROTEIN			7.3	(6.3-8.2)	GM/DL
=> ALBUMIN			3.6	(3.5-5.0)	GM/DL
=> BILI-TOTAL			0.4	(0.2-1.3)	MG/DL
=> ALT (SGPT)			19	(9-52)	U/L
=> AST (SGOT)			21	(14-36)	U/L
=> ALK PHOS			148 H	(38-126)	U/L
=> TROPONIN-I	< 0.012(B)			(0-0.034)	NG/ML

(B) **********PLEASE NOTE REFERENCE CHANGES**********
TROPONIN VALUES GREATER THEN 0.034 NG/ML COULD BE
CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.12 NG/ML
MAY REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE
DATA FROM A SINGLE BLOOD COLLECTION.
CLINICAL CORRELATION IS RECOMMENDED.

=> CK TOTAL	34	35	(30-135)	U/L
=> CK INDEX	(a)	(b)		

NOTES: (a) Test not performed
(b) Test not performed

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/02/08 TUH NPR LAB **LIVE** PAGE 14
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12983665 (Continued)

****CHEMISTRY****

	Day	Date	Time	Reference	Units
=> TROPONIN-I	< 0.012(C) #	SEP 1	1600	(0-0.034)	NG/ML

(C) **********PLEASE NOTE REFERENCE CHANGES**********
TROPONIN VALUES GREATER THEN 0.034 NG/ML COULD BE
CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.12 NG/ML
MAY REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE
DATA FROM A SINGLE BLOOD COLLECTION.
CLINICAL CORRELATION IS RECOMMENDED.

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12983605

DHEC PATIENT CARE FORM

08-099-003

Q.A. NO.

TRIP NO. 001844

PATIENT IDENTIFICATION (Please Print)

LAST NAME (10–29): Windham | FIRST NAME (30–45): Tommy | MI (46): E

STREET (47–71): [redacted] APT.# [redacted]

CITY (72–87): Sumter | STATE (88–89): SC | ZIP CODE (90–98): 2915[illegible]

SSN (95–103): [redacted]

SEX (104): 1 ☐ Male; 2 ☑ Female; 3 ☐ Undetermined

RACE (105): 1 ☑ White; 2 ☐ Black; 3 ☐ Am. Indian; 4 ☐ Hispanic; 5 ☐ Asian; 6 ☐ Other

AGE (106–109): 0 — CHECK ONE: 1 ☑ YRS.; 2 ☐ MOS.; 3 ☐ DAYS

DISPOSITION (110–111)

01 ☐ TREAT/NO TRANS.
02 ☐ DOA AT SCENE
03 ☑ HOSPITAL ER
04 ☐ HOSP. DIR. ADMIT
06 ☐ PATIENT'S HOME
07 ☐ NURSING HOME
08 ☐ DR.'S OFFICE
09 ☐ OUTPATIENT
10 ☐ PT. REFUSED TREAT.
13 ☐ EMS TRANSFER

TYPE OF INCIDENT

TRAUMA (112)	MEDICAL (113)
1 ☐ MVA	1 ☐ ENVIRON
2 ☐ MC	2 ☐ BEHAV
3 ☐ BIKES	3 ☐ OB/GYN
4 ☐ PED	4 ☐ RESP
5 ☐ ASSAULT	5 ☐ CARDIAC
6 ☐ FALL	6 ☐ INTERFAC
7 ☐ FIRE	7 ☑ OTHER
8 ☐ INTERFAC	
9 ☐ OTHER	

CALL TYPE: TO SCENE (114): 1 ☑ EMERGENT; 2 ☐ NONEMERGENT; CODE 3

PATIENT STATUS: ON SCENE (115): 1 ☒ URGENT; 2 ☐ NON URGENT; CODE [illegible]. FROM SCENE (116): 1 ☑ URGENT; 2 ☐ NON URGENT; CODE 1

INCIDENT LOCATION

ST. OR HWY. NAME OR NO.: [redacted]

CITY: Sumter

County (117–118): 43 | Zip Code (119–123): 29150

SAFETY EQP (124): 1 ☐ Seatbelts; 2 ☐ Helmets; 3 ☐ Airbags; 4 ☐ Child Seat; 5 ☑ None; 6 ☐ Unkn.

SITE OF INCIDENT (125): 1 ☐ ROADWAY; 2 ☑ RESIDENCE; 3 ☐ INDUSTRIAL; 4 ☐ RECREATIONAL; 5 ☐ AGRICULTURAL; 6 ☐ OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (126–137)

003 ☐ Seizure; 004 ☐ Diabetic; 011 ☐ Abrasion/Contusions; 013 ☐ Laceration; 023 ☐ Fracture; 024 ☐ Multitrauma/Shock; 030 ☐ Head Injury; 032 ☐ Spinal Injury; 034 ☐ Stroke; 051 ☐ G.I. Problems; 074 ☐ Respiratory Distress; 080 ☐ Coronary Problems; 083 ☐ Cardiac Arrest; Other ☐ Other ☐

PRIMARY IMPRESSION (138–140): 084

TREATMENT PROCEDURES (141–174)

01 ☐ Dressing Applied; 02 ☐ Limb Splinted; 03 ☐ Spine Immobilized; 04 ☐ Neck Immobilized; 05 ☐ OB Assistance; 06 ☐ Oral Airway Used; 07 ☑ Oxygen Given; 08 ☐ Suction Used; 09 ☐ Antishock Trousers; 10 ☐ Airway Maintained; 11 ☐ Antishock Treatment; 12 ☐ Artificial Resp.; 13 ☐ Cardiac Massage; 14 ☐ Bleeding Controlled; 15 ☐ Cold Application; 16 ☐ Patient Restrained; 17 ☑ Other (Use Comments); 18 ☐ Ventilator

PCFA CODES (175–180)

SITE OF TRAUMA (181–189)

1 ☐ Head; 2 ☐ Face; 3 ☐ Neck; 4 ☐ Chest; 5 ☐ Abdomen; 6 ☐ Hip/Pelvis; 7 ☐ Upper Extr.; 8 ☐ Lower Extr.; 9 ☐ Back

ADVANCED PROCEDURES (190–223)

1. ☑ EKG Monitored — Rhythm: Sinus — Time: 1432
2. ☐ First Defib Attempted — Watt Sec. — Time — Post Defib Rhythm
3. ☐ Second Defib Attempted — Watt Sec. — Time — Post Defib Rhythm
4. ☐ Third Defib Attempted — Watt Sec. — Time — Post Defib Rhythm

INTUBATED 5. ☐ ET Size ____ Total # Attempts ☐ (224) 15 ☐ RSI 16 ☐ LMA 17 ☐ Cricо

6. ☐ EXTERNAL PACING
7. ☑ BLOOD DRAWN — DEXTROSE BGL: 111
8. ☐ IV STARTED/GAUGE — SOLUTION — RATE — IV TIME — IV VOLUME
9. ☐ IV STARTED/GAUGE — SOLUTION — RATE — IV TIME — IV VOLUME
14. ☑ IV ATTEMPTED Total # 4 (225)
10. ☐ PLEURAL DECOMPRESSION — Time
11. ☐ INTRAOSSEOUS INF.
12. ☐ AUTOMATIC DEFIB
13. ☐ PATIENT ASSISTED MEDS.

Ordering Physician: SOS (Name) (Signature)

DRUGS USED (226–241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME
36	8 mg	1439	13	D.5% NS	1441
36	8 mg	1439	13	Zofran 4	1450
36	8 mg	1439			
36	8 mg	1439			

REVISED TRAUMA SCORE

GCS: (242) EYES 4 (247–249) SBP ____ RTS (254–255)
(243) VERBAL 5 (250–252) RR ____
(244) MOTOR 6
(245–246) GLASGOW 15 (253) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO

VITAL SIGNS

BP	PULSE	RESPIRATIONS	PUPIL	LEVEL OF CONSC.	TIME
201/90	RATE 75 ☑ REG. ☐ IRREG.	RATE 18 ☑ REG. ☐ IRREG.	E	A	1431
120/100	RATE 72 ☑ REG. ☐ IRREG.	RATE 18 ☑ REG. ☐ IRREG.	U E N C D	A V P U	1442
140/91	70 ☑ REG. ☐ IRREG.	18 ☑ REG. ☐ IRREG.	E	A	1452
1	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			
1	☐ REG. ☐ IRREG.	☐ REG. ☐ IRREG.			

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☑ NO

1st Responder (257) 1. ☑ YES Name: Bethel Fire Station 2. ☐ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

Responded to the DAC, back up medic 1. 40yo female lying supine in back dept of corr. Pt c/o/w/3 large crowd of family members. Verbally abusive to EMS. Pt very upset. Cc: Chest pain. Onset Friday. Coarse Comes. Family states pt was responsive when they left all Rx does not remember. Stokes stockings wanted x4. PMH: MI, Upper GI w 2 stents, 2 yrs ago. HTN. Meds: Pt states mild shortness of breath. Pt placed in 15 LPS on NRB. SpO2 99%. HR. 75 bpm. Cardiac Monitor Sinus. No ectopy. 12 lead w/ Rec. 18 G Lac. Rec. 1 NS KVO. 3 min IV attempted x 4 Rx success. AP 200/90. Pt denies hx/allergies. Administered 324 mg ASA PO. 500 cc NS bolus x 2. Vitals maintained. NV vomiting en-route. Pt stable en-route. Arrive safely. Pt transported to ED Room 6.

Patient Care Form Left In (258): 1. ☑ ED 2. ☐ ICU 3. ☐ OTHER Floor ☐ See Page 2

TIME RECORD

RUN DATE (259–268): MONTH 09 DAY 21 YEAR 08

Call Received: (267–270)	1414
Call Dispatched: (271–274)	1414
Departed Base: (275–278)	1414
Arrive Scene: (279–282)	1420
Departed Scene: (283–286)	1435
Arrive Destination: (287–290)	1456

CAUSE OF DELAY: ____

DHEC PERMIT NO. (291–295): 13310

RECEIVING AGENCY (255–299): 30145

SENDING AGENCY (300–303): [redacted]

PROVIDER TIME (OPTIONAL): ____

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

K Hall 85605

PRIMARY PATIENT ATTENDANT (304–308): [signature] 93116

2nd ATTENDANT/DRIVER (309–313): ____

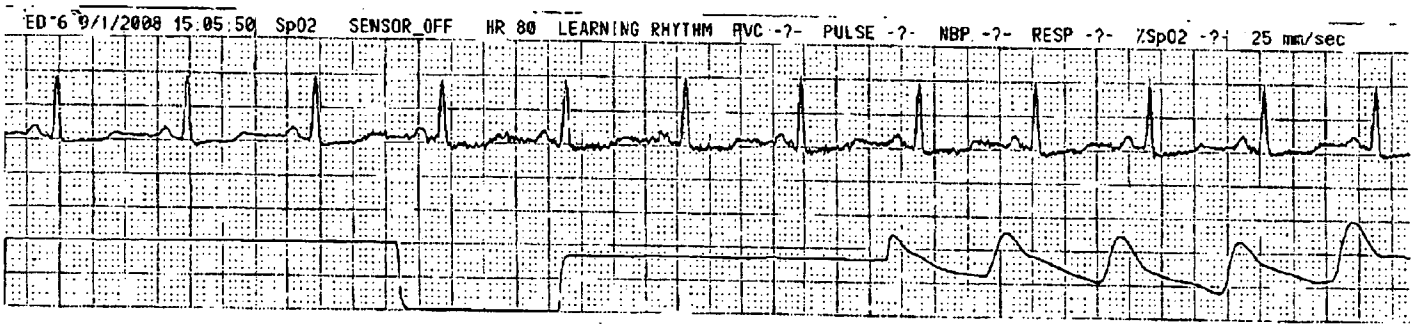
3rd ATTENDANT/DRIVER (314–318): ____

(RECEIVING NURSE OR PHYSICIAN): [signature] RN 795

DHEC 1050 REV. (01/2004) — RECEIVER'S COPY — REPORT NO. (1–9) 424120

5631

001845

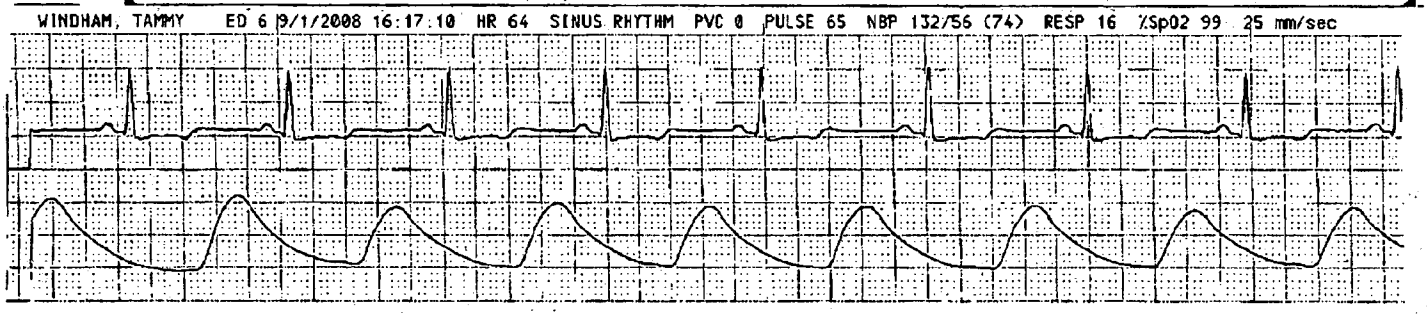


P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

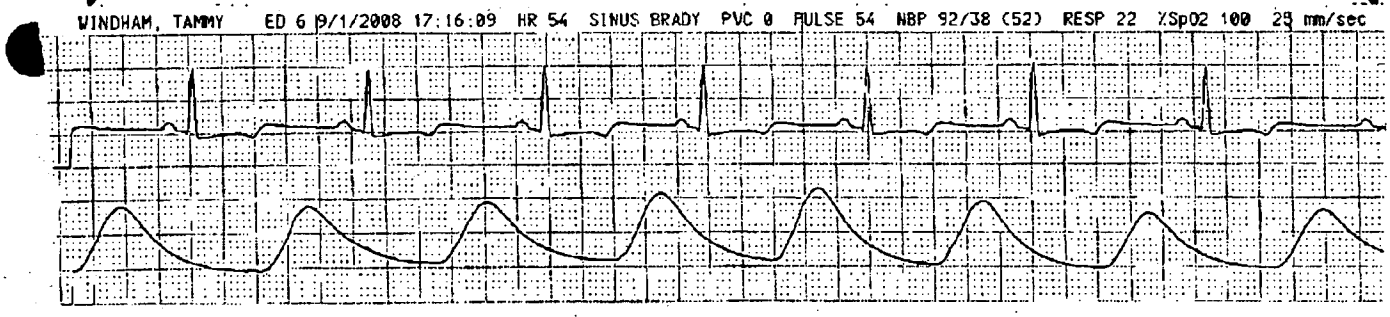


P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:



P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

WINDHAM,TAMMY ELIZABETH
Acct: 12983665 Unit: 229998
DOS: 09/01/08
ED
F W Age: 40

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

Windham, Tammy

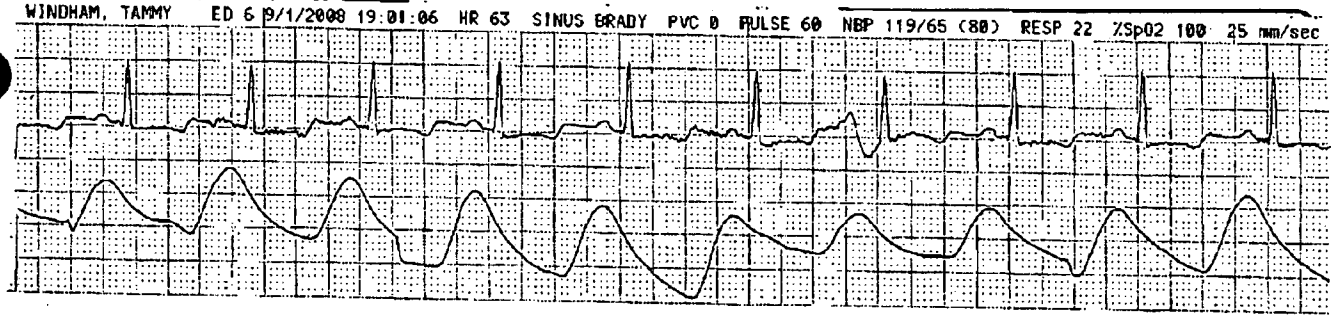
796

#6

5632

001846

WINDHAM, TAMMY ED 6 9/1/2008 19:01:06 HR 63 SINUS BRADY PVC 0 PULSE 60 NBP 119/65 (80) RESP 22 %SpO2 100 25 mm/sec



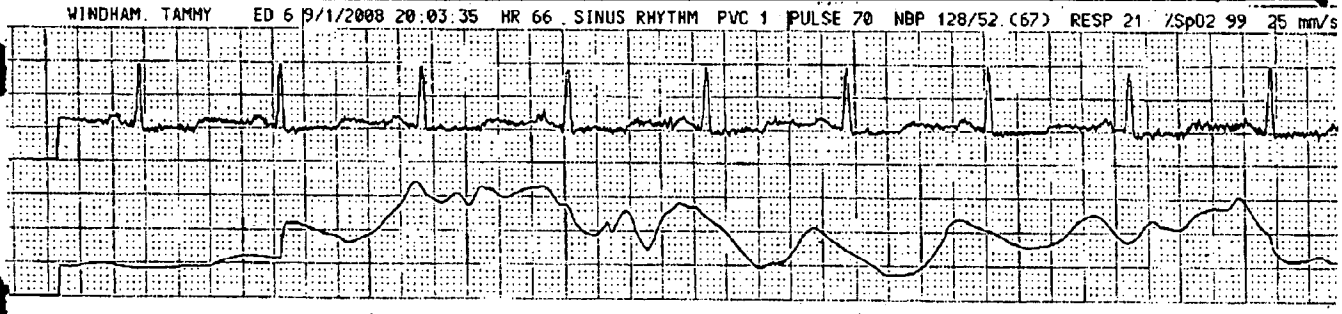
P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

WINDHAM, TAMMY ED 6 9/1/2008 20:03:35 HR 66 SINUS RHYTHM PVC 1 PULSE 70 NBP 128/52 (67) RESP 21 %SpO2 99 25 mm/s



P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE REMOVE TO EXPOSE ADHESIVE

P ▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R ▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. ____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____

WINDHAM,TAMMY ELIZABETH
Acct: 12983665 Unit: 229998

ED
F W Age: 40

DOS: 08/01/08

RHYTHM STRIP RECORD

ICU-1220 MOORE WALLACE

#6

797

Windham, Tammy

5633

TUOMEY
HEALTHCARE SYSTEM

001847

Name: Windham Tammy F
Age: 40Y
Gender: F
MedRec: 229998
AcctNum: 12983665
Attending: JD
Primary RN: EVH
Bed: ED 2-ER 06

TUOMEY HEALTHCARE
DISCHARGE INSTRUCTIONS RECEIPT

FINAL DIAGNOSIS
chest pain ? etiology

ADDITIONAL DIAGNOSIS
post nitroglycerine head ache
right leg arterial stenosis with doppler pulse

FOLLOWUP CONTACTS

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Take medication as prescribed
Follow up with your private MD in the AM. Return to ED if worse.

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
CHEST PAIN OF UNCLEAR ETIOLOGY
HEADACHE
CAD (ASCAD, HARDENING OF THE ARTERIES, CORONARY ARTERY DISEASE)

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Fioricet : Tablet : 325 mg–50 mg–40 mg : Oral
Dispense: 20, Quantity: 1 or 2, Schedule: every 4 hours as needed

Nitrostat : Tablet : 0.4 mg : Sublingual
Dispense: 30, Quantity: 1, Schedule: SEE NOTES

Tammy Windham
Patient Signature

EVH/RN 20:40
Rn/LPN Ini. TIME

798

Prepared: Mon Sep 01, 2008 20:38 by JD 1 of 1
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5634

Inpatient

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service		Medical Rec. No.	
WINDHAM,TAMMY ELIZABETH [redacted]	12756622	312/1	IN	MED		229998	
	Date of Birth	Age	Sex	MarStat	Religion	Race	Smoker
	[redacted]	40	F	M	HOL	W	N

Person to Notify / Address	Relationship
PARROTT,MELINDA [redacted]	SI
Other Phone	

Guarantor / Address	Next of Kin / Address	Relationship
WINDHAM,TAMMY ELIZABETH [redacted]	PARROTT,MELINDA [redacted]	SI
	Other Phone	

Financial Class: S

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit		
ONSET OF SYMPTO	LLL PNEUMONIA,VOMITING		
Accident Date / Time	**Comments**	**Height / Weight**	**Arrival Mode**
05/22/07			

Admit Date / Time	Admitting Physician	Attending Physician	User
05/22/07 1615	MEDICAL SERVICES - TMP	NEUNER,JANICE M	ADRKB

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

Does pt have Health Care Power of Attorney? No

Does patient want info on Advance Directive? No

Are you an organ donor? No

If yes, Living Will copy received? N

If yes, Health Care Power of Attorney copy received?

TUOMEY

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (Inpatient)

00000 Rev. 01/01/2004

[redacted]

413

DISCHARGE SUMMARY

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: NEUNER,JANICE M
Adm. Dr: MEDICAL SERVICES - TMP
Admit Date: 05/22/07
Location: TELE
Account#: 12756622

MR#: 229998
RM#: 312-1
[redacted]
Discharge Date: 05/26/07
Service: Medicine

NAME: WINDHAM, TAMMY

U#: 229998

DATE OF ADMISSION: 05/22/2007

DATE OF DISCHARGE: 05/26/2007

ACCOUNT NUMBER: 12756622

DIAGNOSES AT THE TIME OF DISCHARGE:

1. Left lower lobe pneumonia.
2. Tobacco abuse.
3. History of coronary artery disease.
4. Iron-deficiency anemia.

CONSULTANTS DURING THIS ADMISSION: None.

PROCEDURES DURING THIS ADMISSION: The patient did have a CT of the chest which revealed a left lower lobe lingula and minimal inferior left upper lobe infiltrates, but no PE. The patient also had a pelvic ultrasound which revealed normal uterine and right ovarian exam with a cyst on the left ovary and followup was recommended.

REASON FOR ADMISSION: This is a 39-year-old female who presents to the emergency room complaining of chest pain and coughing. The patient has had a history of hypertension, coronary artery disease, status post stent and has been on Plavix and aspirin. She has on her presentation sats of 95% on room air, blood pressure was mildly elevated. Chest x-ray showed left lower lobe infiltrate. White count was 15,000, hemoglobin was slightly elevated at 10.4. Please review admission H and P for further details.

HOSPITAL COURSE: The patient was admitted and placed empirically on antibiotic therapy. Blood and sputum cultures were obtained. The patient did clinically improve. The patient does have an iron-deficiency anemia. An ultrasound of the pelvis was done and did show a left ovarian cyst. It was discussed with the patient that she should have follow up of this and repeat ultrasound in next several months to ensure that this is physiologic. The

DISCHARGE SUMMARY

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12756622

patient has clinically improved. She had a followup chest x-ray which showed improving infiltrate. She was switched over to p.o. antibiotics and encouraged to avoid any tobacco use, to keep her followup appointments, and to follow up with the Family Health Center in 1 to 2 weeks. Social work was consulted to assist with her medications. She was given a dose of B12 and started on folic acid as well. Her antibiotic at discharge was Omnicef 300 mg p.o. b.i.d. for an additional of 7 to 10 days. She is to have an Advair Diskus 250/50, one puff q.12 hours, as well as Combivent MDI. The patient is to have a cardiac diet. She is encouraged to stop smoking. She is to continue with her usual meds which include Lopressor 50 mg p.o. b.i.d., Plavix 75 mg daily, and aspirin 81 mg daily. She is also being started on Pepcid 20 mg p.o. b.i.d. Her long term prognosis is guarded in light of her multiple comorbid conditions, lack of compliance with medical recommendations in the past, continued smoking, etc. She was encouraged to follow up on the ovarian cyst as well as on the followup chest x-ray until completely clear and to recheck her hemoglobin and further GYN evaluation as indicated.

CATHERINE RABON, MD

Dict. Date: 07/02/2007 10:17 Trans. Date: 07/03/2007 02:14
504293 / 41970 / 29266
Job: 28379

RABC

Authenticated by Catherine E. Rabon, M.D. On 07/11/2007 03:14:45 PM

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Tue May 22 2007 10:05 TDR)
COMPLAINT (Tue May 22 2007 10:05 TDR): COMPLAINT: chest pain and possible pneumonia.
ADMISSION (Tue May 22 2007 10:05 TDR): URGENCY: 1 - Emergent, BED: LOBBY.
PATIENT (Tue May 22 2007 10:05 TDR): NAME: Tammy E Windham, AGE: 39, GENDER: Female, DOB: [redacted] TIME OF GREET: Tue May 22 2007 09:27, by: Robert Groover, Latex Allergy: No, Fall related visit: No, New onset weakness: No, KG WEIGHT: 66.7, MEDICAL RECORD NUMBER: 229998, IBEX NUMBER: 200705221005 41GRT, NOTIFICATION: Attending physician or charge nurse notified.
PRE-TRIAGE NOTES: (Tue May 22 2007 10:05 TDR): Attending physician or charge nurse notified.
PREVIOUS VISIT ALLERGIES (Tue May 22 2007 10:05 TDR): Denies allergies, Nkda.
NOTES: (Tue May 22 2007 10:05 TDR): .. Patient complains of pain. Pain level 10, using numeric pain scoring. States pain level at a 11. States mid chest pain since this morning approx. 0800 with SOB, nausea, feelings of diaphoresis. Denies radiation. States tried to take pain med today, but vomited back up. .
VITAL SIGNS (Tue May 22 2007 10:05 TDR): BP 195/88, Pulse 86, Resp 20, Temp 99.2, Pain 10, O2 Sat 99, on ra, Time 1005.
ASSESSMENT (10:07 TDR): ., crackles heard in lower lobes. .

KNOWN ALLERGIES
Nkda.

HPI CHEST PAIN (13:49 ESW)
CHIEF COMPLAINT: Patient presents for the evaluation of ongoing chest pain.
HISTORIAN: History obtained from patient.
TIME COURSE: Onset of symptoms reported as gradual, Onset was 8am. Patient currently has symptoms. Complaint is persistent, constant.
LOCATION: Pain most severe in substernal area, There is no radiation. Pain has not moved in location over time.
QUALITY: Pain is tight.
ASSOCIATED WITH: Associated with cough, fever, subjective, nausea, no vomiting, diaphoresis present, shortness of breath, no palpitations.
SEVERITY: Maximum severity is severe, Currently symptoms are severe.
EXACERBATED BY: Patient's condition exacerbated by cough, deep breath.
RELIEVED BY: Patient's condition relieved by nothing.
RISK FACTORS: CAD risk factors include known CAD, CAD risk factors include smoking, CAD risk factors include hypertension, TAD risk factors include hypertension. No PE risk factors.
NOTES: Patient states that she has had increased cough and congestion for the last few days. No v,d,c, abdominal pain. Patient states that she hurt with a deep breath and cough also. Does have know history of cardiac disaese with circumflex stent in march.

PAST MEDICAL HISTORY
MEDICAL HISTORY (Tue May 22 2007 10:05 TDR): History of hypertension, which is not being treated. circumflex implant.
SURGICAL HISTORY (Tue May 22 2007 10:05 TDR): History of appendectomy, History of cholecystectomy. History of tubal ligation. circumflex

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TUOMEY HEALTHCARE
EMERGENCY RECORD

implant 3/19/07.
PSYCHIATRIC HISTORY (Tue May 22 2007 10:05 TDR): No previous psychiatric history.
SOCIAL HISTORY (Tue May 22 2007 10:05 TDR): Denies drug abuse, Patient smokes tobacco- smoking 1 ppd recently. .
FAMILY HISTORY (Tue May 22 2007 10:05 TDR): Family history is not contributory to this case.
NOTES (13:51 ESW): Nursing records reviewed, Agree with nursing records.

ROS (13:51 ESW)
CONSTITUTIONAL: Historian reports fatigue, fever.
CARDIOVASCULAR: Historian reports chest pain. Chest pain is substernal. No radiation. Historian reports diaphoresis.
RESPIRATORY: Historian reports cough, SOB, sputum, Sputum reported as yellow.
GI: Historian reports nausea. No vomiting.
ALL SYSTEMS NEGATIVE: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM (13:52 ESW)
CONSTITUTIONAL: Patient is afebrile, Vital Signs Reviewed. Patient has normal pulse, normal respiratory rate, Well appearing, Alert and oriented X 3, Hypotensive blood pressure. Patient appears uncomfortable.
HEAD: Atraumatic, Normocephalic.
EYES: Eyes are normal to inspection, Pupils equal, round and reactive to light. No discharge from eyes, Extraocular muscles intact. Sclera are normal. Conjunctiva are normal.
ENT: Ears normal to inspection, Nose examination normal, Posterior pharynx normal, Mouth normal to inspection.
NECK: Normal ROM. No jugular venous distention, meningeal signs, Cervical spine nontender.
RESPIRATORY/CHEST: Assessment includes:. Breath sounds normal. No respiratory distress, Tenderness:, anteriorly. in the left chest, moderate in intensity, Palpation of chest reproduces symptoms, Breath sounds:, Wheezing:, scattered wheezing present, Rales:, Fine rales are present, in the left chest, lower lobe, Mild respiratory distress present, Increased respiratory rate.
CARDIOVASCULAR: Patient under the age of 40, RRR. Heart sounds normal. No murmurs. Normal S1 S2, PMI normal to palpation, BP normal in both arms, Femoral pulses normal. Pedal pulses normal, Carotid impulse normal. No carotid bruits.
ABDOMEN: Abdomen is nontender. No masses, Bowel sounds normal, No distension, peritoneal signs.
BACK: There is no CVA Tenderness, There is no tenderness to palpation. Normal inspection.
UPPER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion.
LOWER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion, No calf tenderness.
NEURO: GCS is 15. No focal motor deficits, focal sensory deficits,

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TUOMEY HEALTHCARE
EMERGENCY RECORD

SKIN: Skin is warm, Skin is dry, Skin is normal color.

DOCTOR NOTES (14:23 ESW)
INTERVENTIONS: Antibiotics administered:, AZITHROMYCIN, CEFTRIAXONE, Antibiotics were given IV. Pain medications administered:, KETOROLAC, Antiemetics:, ONDANSETRON, O2 Sat normal.
PATIENT STATUS: Patient has improved since arrival to emergency department, stabilized since arrival to emergency department.
D/W: Discussed this case with Dr. Neuner , the on call physician.
PATIENT PLAN: The patient will be admitted to the hospital, Telemetry observation has been arranged.
DATA REVIEWED: Lab data reviewed, Xray data reviewed, Reviewed EKG, Old records reviewed, Discussed with family, Discussed with consultants.

MEDICATION SERVICE
Rocephin (14:19 ESW): Order: Rocephin : 1 gm : IVPB
Ordered: Tue May 22 2007 14:19
Ordered by: Eric Wernsman
Entered by: Eric Wernsman Tue May 22 2007 14:19
Documented as given by: Shea Stone Tue May 22 2007 15:25
Time given: 1520, IV site 1, Medication administered into right AC, Drip/IVPB, IVPB mixed in: 100ml, via primary tubing, at 100 ml/hr, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, allergies verified prior to medication administration.
Toradol IV/IM (10:26 ESW): Order: Toradol IV/IM : 30 mg : IVP
POTENTIAL SEVERE INTERACTION Aspirin
Ordered: Tue May 22 2007 10:26
Ordered by: Eric Wernsman
Entered by: Eric Wernsman Tue May 22 2007 10:26
Documented as given by: Shea Stone Tue May 22 2007 11:31
Time given: 1125, IV site 1, Medication administered into right AC, IVP, Initial medication, Slowly, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.
Zithromax (14:19 ESW): Order: Zithromax : 500 mg : IVPB
Ordered: Tue May 22 2007 14:19
Ordered by: Eric Wernsman
Entered by: Eric Wernsman Tue May 22 2007 14:19

Acknowledged by: Shea Stone Tue May 22 2007 15:25 .
Zofran (12:30 ESW): Order: Zofran : 4mg mg : IVP
Time: 1230
Name: Windham, Tammy E Age: F39 MedRec: 229998 AcctNum: 12756622
Prepared: Tue May 22 2007 19:02 by
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TUOMEY HEALTHCARE
EMERGENCY RECORD

Ordered: Tue May 22 2007 12:30
Ordered by: Eric Wernsman
Entered by: Julie Hancock Tue May 22 2007 12:30
Acknowledged by: Julie Hancock Tue May 22 2007 12:30
Documented as given by: Steve Boykin Tue May 22 2007 13:25
Time given: 1240, Amount given: 4mg, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

O2SAT INTERPRETATION (14:00 ESW)
O2SAT: O2 saturation reading 99%, O2 AMT: R.A., O2 Sat normal. Patient is being observed, Continuous Pulse Ox.

EKG INTERPRETATION (13:54 ESW)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, Compared with previous EKG. 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate is normal, Rate 85, beats per minute. No acute ST changes, ST Segments: depression, T-Waves: inversion, Areas Affected: inferior leads, myocardial ischemia.

LAB INTERPRETATION (13:59 ESW)
INTERPRETATION: Elevated WBC, Decreased Hemoglobin, Elevated Platelets, Elevated Neutrophils, Decreased Lymphocytes, Elevated BUN, Decreased Potassium, Elevated Creatinine. Normal Cardiac enzymes, Normal PT/PTT, Decreased Alk Phos, otherwise liver functions normal, Urine HCG: Negative, Urinalysis is normal, Elevated D-dimer level.

RADIOLOGY INTERPRETATION (14:18 ESW)
CHEST: Interpretation of chest X-ray shows, infiltrate present, of the left lower lobe, Interpretation of chest CT shows, (with contrast), no pulmonary embolism, no TAD, no pneumothorax, no hemothorax, no mass, no effusion, however, infiltrates present on the left side.
INTERPRETER: Preliminary review of x-rays by ED Physician, Preliminary review of CT by Radiologist.

NURSING PROCEDURE: URINE COLLECTION (11:06 EBB)
URINE COLLECTION FEMALE: Patient's identity verified by, hospital ID bracelet, Procedure performed at 1100, Voided/clean catch, Specimen labeled and sent to lab.

NURSING PROCEDURE: IV (11:32 SHS)
TIME: Patient's identity verified by, Procedure performed at 1130, IV

established, 20 gauge catheter inserted, into right AC, #1 site. in 1 attempt, Saline lock established, Amount 5cc, Labs drawn at time of placement, Blood cultures drawn at time of placement, Labs labeled and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site.

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TUOMEY HEALTHCARE
EMERGENCY RECORD

NURSING PROCEDURE: NURSE NOTES (11:32 SHS)
TIME: Time: 1130, pt sitting up in bed. resp treatment complete. awaiting lab results.

NURSING PROCEDURE: NURSE NOTES (12:33 JBH)
TIME: Time: 1230. Patient c/o nausea asking for medication, order given.

NURSING PROCEDURE: NURSE NOTES (13:26 SHS)
TIME: Time: 1328, PT TO CT SCAN AT PRESENT TIME.

NURSING PROCEDURE: TRANSPORT TO TESTS (13:29 SHS)
TIME: Patient's identity verified by, Procedure was performed at 1328. Patient transported to, CT scan, Patient transported via, cart, Patient accompanied by, ER tech.

NURSING PROCEDURE: NURSE NOTES (13:53 SHS)
TIME: Time: 1354, pt back from ct scan.

NURSING PROCEDURE: NURSE NOTES (14:12 SHS)
TIME: Time: 1410, FAMILY VOICES CONCERNS REGARDING WAIT. PT INFORMED THAT WE ARE WAITING FOR CT RESULTS FROM RADIOLOGIST. VITALS ASSESSED.
VITAL SIGNS: BP: 137, / 50, Pulse: 78, Resp: 22, O2 sat: 93%.

NURSING PROCEDURE: NURSE NOTES (15:38 SHS)
TIME: Time: 1510, DR. NEUNER IN TO SPEAK WITH PT. AWARE OF ADMISSION.

NURSING PROCEDURE: NURSE NOTES (15:39 SHS)
TIME: Time: 1530, ROCEPHIN STARTED IV. PT DENIES ANY ALLERGIES. NO DISTRESS NOTED AT PRESENT. (+)COUGH PRESENT.

NURSING PROCEDURE: ADMISSION (16:35 SHS)
TIME: Report called at 1620, Patient admitted to room 312. Patient admitted to, telemetry unit, Admission orders received and completed, Report called/faxed to voicecare #03121, Patient transported via, cart, Accompanied by, transport, RN, Transported with, monitor.

DIAGNOSIS (14:23 ESW)
FINAL: PRIMARY: Left Lower Lobe Pneumonia, ADDITIONAL: Chest pain r/o MI.

PRESCRIPTION: No Documented Prescriptions

DISPOSITION
PATIENT (15:10 ESW): Disposition: Admit to inpatient, Condition: Stable. Patient Flag: .

(17:17 SHS): Pain Scale: 06, Oxygen: No, IV stop time docd?: NA, Disposition Transport: Ambulatory. Patient Flag: , Remove from ER.

ADMIN (19:00 ESW)
DIGITAL SIGNATURE: Wernsman, Eric.

KEY:

Copyright 2006. Picis.

EBB=Blankenship, Erin ESW=Wernsman, Eric JBH=Hancock, Julie
SHS=Stone, Shea TDR=Robinson, Tamiko

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422

TUOMEY HEALTHCARE SYSTEM
129 N. WASHINGTON STREET
SUMTER, SC 29150

001858

HISTORY AND PHYSICAL REPORT

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: MEDICAL SERVICES - TMP
Adm. Dr: MEDICAL SERVICES - TMP
Admit Date: 05/22/07
Location: TELE
Account#: 12756622

MR#: 229998
RM#: 312-1

Service: Medicine

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

DATE OF ADMISSION: 05/22/2007

ACCOUNT NUMBER: 12756622

DATE OF BIRTH: [redacted]

HISTORY: This is a 39-year-old female who presents to the emergency department complaining of chest pain, with coughing, onset 3 days ago. She describes pain as in the middle of her chest, substernal area. She states she has been coughing up yellow sputum. Temp up to 101 at home. She has noticed some shortness of breath and wheezing. Patient states that on a pain level of 0-10, her pain is 11. Recent nausea and vomiting and now unable to keep anything down. She complained of a light headache this morning.

PAST HISTORY: Hypertension and coronary artery disease, with a stent placed in her circumflex artery by Dr. Lawton at Providence in March 2007. Since then on Plavix and aspirin. Past history of coronary artery disease, hypertension.

SURGERIES: Appendectomy, cholecystectomy, and BTL.

CURRENT MEDICATIONS: Plavix 75 mg 1 daily, aspirin 81 mg daily, Lopressor 50 mg b.i.d.

ALLERGIES: NONE.

SOCIAL HISTORY: Married, with 1 child. Smokes 1/2 pack cigarettes per day, but states that has not smoked much in the past few days. She has smoked since age 17 and was smoking up to 1 pack a day. Denies alcohol use. Denies illicit drug use. Unemployed.

FAMILY HISTORY: Mother died of coronary artery disease at age 48. Father died of accidental death. She has a sister whom she believes is healthy.

REVIEW OF SYSTEMS: Patient complains of occasional headaches, which she treats with Tylenol. She denies recent weight loss or weight gain. Did not notice low-grade temps up to about the 101-range. She has had no pain since her stent until 3 days ago, when she began having the coughing, fevers, and chest discomfort. Coughing so hard she has vomiting, but says also feels nausea in between coughing. She denies constipation or diarrhea. Denies dysuria or frequency. Denies arthritis pain.

HISTORY AND PHYSICAL REPORT

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12756622

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 195/88 on admission, but now down to 153/60, pulse 77, respirations 16, O2 sat 95% on room air.

GENERAL: This is a well-developed, well-nourished white female who is sitting erect at time of this exam. She is alert, well oriented, good historian.

HEENT: Head normocephalic, atraumatic. Pupils equal, regular, reactive to light. Red reflexes bilaterally. Sclerae anicteric. Conjunctivae normal. TMs clear. Pharynx: Mucous membranes moist. Pharynx unremarkable.

NECK: Supple. No adenopathy. Thyroid normal.

LUNGS: With a few end-expiratory wheezes. Patient has spasms of coughing. A few fine rales in the left lower lung fields.

HEART: Regular rate and rhythm, with no murmurs, rubs, or gallops. Chest wall with tenderness to palpation along the left costochondral junction.

ABDOMEN: Soft, with generalized tenderness. No masses, no organomegaly. Bowel sounds active.

EXTREMITIES: No edema. No cyanosis or clubbing.

SKIN: Warm and dry, with no rashes.

NEURO: Intact, with no focal deficits.

EKG with normal sinus rhythm. No acute changes. T-wave inversions, inferolateral leads, with some worsening since March 2007.

Chest x-ray shows a left lower lobe infiltrate.

Pro time 10.0, INR 0.99, PTT 28.7, D-dimer elevated at 2.55.

WBC 15.7, hemoglobin 10.4, hematocrit 33.1, MCV 65.3, platelets 427,000, with 79 segs, 13 lymphs, 5 monos, 1.8 basos.

BNP 46, troponin less than 0.04, CK 50.

Sodium 135, potassium 3.3, chloride 99, CO2 of 23, BUN 5, creatinine 0.7, glucose 110. LFTs normal, except for alk phos slightly elevated at 197.

HISTORY AND PHYSICAL REPORT

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12756622

UA with 7-14 wbc's per high-powered field.

CT of the chest showed a left lower lobe pneumonia. There was no evidence of a pulmonary embolus.

ASSESSMENT:
1. Acute left lower lobe pneumonia, with bronchospasm.
2. Chest pain in patient with known coronary artery disease and stent.
3. Hypertension.
4. Hypokalemia.
5. Anemia--microcytic.
6. Tobacco abuse.

PLAN: Admit to Telemetry. Serial CKs, troponins. Nitroglycerin paste and Lovenox. Check sputum culture and sensitivity, urine C&S, blood cultures for elevated temp. Start IV Rocephin and IV Zithromax. Albuterol and Atrovent aerosol treatments. See complete orders.

JANICE NEUNER, DO

Dict. Date: 05/22/2007 15:49 Trans. Date: 05/22/2007 17:16
659236 / 38777 /
Job: 22321

NEUJM

Authenticated by Janice M. Neuner, M.D. On 06/22/2007 10:09:58 AM

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Sumter, SC 29150
(803) 774-8000

PROGRESS NOTES

DATE	TIME	
5/23/07	1145	Medicine Stable, cont IVF / SOB VS 97% RA 142/71 Lg - diminished w/ clear c/o Reg SS Abd soft, NT, ext WCL/E A) pneumonia CAD oxygen dependent Pt Quest P) cont IVF, cont abx / neb
5/24/07	1100	Medicine Stable c/o cough / SOB VS AFVSS Lg - bibasilar crackles c/ Reg S1 S2 Abd soft, NT, ext WCL/E A) Stable as 5/23 x pt reports worsening SOB P) cont IVF, cont neb / steroid, see orders.

PROGRESS NOTES

WINDHAM , TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
TMP, MEDICAL SERVICES -
TELE 312/1 DOS: 5/22/2007
F W
Admit Age: 39 7M

427

001863

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(803) 774-9000

PROGRESS NOTES

DATE	TIME	
5/25/07		Med Surg Dx: acute bronch. Bronchitis Hx 973 18 85 94/11 Acute bronchitis Cough productive chest pain abd pain nausea vomiting Exp: Bronchoconstriction 2 CBC 3 Urinalysis 4 Smoking Plan await exam provider orders D. Rhodes 67/gr/464 315 US. ov. cpt Cpt. ⑥
5/26/07	1135	medicine feels better, wants to go home. VS- stable Lungs- clear bilat w/o wheezing Abd soft NT Ext- no edema A) same as 5/25 + ① nausea, cpt, Dx Bronchitis, Rx Rocephin, Rx Prednisone P) replace Rx Rocephin, Rx Flu US w/o pt Flu FTC; stop smoking; Flu chest x-ray clear.

WINDHAM, TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
TMP, MEDICAL SERVICES -
TELE 312/1 DOS: 5/22/2007
F W
Admit Age: 39 7M [redacted]

001864

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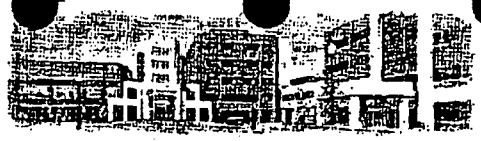

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Rm 32
Tammy Windham

PHYSICIAN'S ORDERS

YEAR	DRUG ALLERGIES	
ORDERED MONTH	DAY	TIME	
5-22-07		1510	1) Admit Med Surg - telemetry - tight
			2) Admit Dr LLL pneumonia, Vomiting
		✓	3) Bedrest
		✓	4) vitals q 4h + O2 protocol O2 sats to keep sat ≥ 95%
		✓	5) clear liquid diet
		✓	6) IV - NS @ 75 cc/h
			7) Rocephin 1 gm IV daily
			8) Zithromax 500 mg IV daily
			9) KCl 20 mEq/L IV soln
			10) Phenergan 12.5 mg q 4h pr N/V
		✓	11) Proventil 2.5 via nebulizer q 4h ATC + q 4h pr SOB, wheezing
		✓	12) Atrovent 0.5 via nebulizer q 4h ATC
			13) Tylenol 325 1-2 po q 4h pr pain, temp.
			14) Nicotine patch 14 mg apply once daily + remove @ hs
Discontinued 5/22/07		715	15) Plavix 75 mg po daily
			16) ASA 81 mg po daily
			17) Lopressor 50 mg po bid
			18) Robitussin DM 1-2 tsp po q 4h pr cough
			TELEPHONE ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

1541

5/22/07 0235

TUOMEY HEALTHCARE SYSTEM
129 North Washington Street
Sumter, South Carolina 29150
Physician's Orders
OR0002 Rev. 08/30/2005

Scanned
Date: 5/22 Time: 1650

WINDHAM,TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
LAWTON III,JOSEPH J
ED
F W Age: 39
DOS: 05/22/07

429

5651

001865

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PHYSICIAN'S ORDERS

Tanya Winkler

YEAR	DRUG ALLERGIES

ORDERED MONTH	ORDERED DAY	TIME	
			(cont)
5-22-	-07	1510	19) CK, troponin q 6h x 3 ✓ 1045 1700 2300
			20) Lovenox 1mg/kg SC q 12h
			21) Pepcid 20, IV q 12h
		✓	22) EKG now Am
			23) NTG ½" paste q 6h.
			24) K dur 20 mEq po now + repl PRN 2h.
5/22		1530	25) urine C+S
			26) Sputum C+S ✓
			27) Serum Fe, Fe sat, B_{12}, folate ✓ ✓
			28) BC x2 (1 set now if not already done) + repl for temp ≥ 101 ✓ #22321

Scanned
Date: 5/22 Time: 1650

RN ✓ 0230 5/23/07

D Turner 5/22 OT 1730

Stat	1145	① CMP, BMP, Mg, KOH → Cancel do BTam if Hgb ≥ 10
		② DC IVF
		③ FeSO4 325mg po TID
		④ DC Robitussin → begin hydrocodon 1 tsp po q4° PRN
		⑤ Tessalon pearles 100mg po TID

- TELEPHONE ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

[redacted] RN 5/23/07 0230

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129 North Washington Street
Sumter, South Carolina 29150
Physician's Orders
ORD002 Rev. 08/30/2006

Scanned
Date: 5/23 Time: 12:20

[redacted] 230

5652

001866

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Sumter, SC 29150
(803) 774-9000

PHYSICIAN'S ORDERS [ ] Inpatient Admission [ ] Observation

YEAR | DRUG ALLERGIES

ORDERED: MONTH | DAY | TIME

5/23/07 1150

1. D/c NTG patch
2. D/c KCl po
3. pepcid 20mg po BID
4. percocet 2 po q 6° PRN
5. advance to cardiac diet → begin ROM

Scanned
Date: 5/23 Time: 12:20

5/23/07 1455

draw HH c 1800 if hgb less than 8.5 give 1 unit PRBC; CBC in AM stool for blood x3
T.O. Dr Ian repeat CO sleep

Authenticated by
Dau Tantawanichpisal, MD
On 06/13/2007 11:12:58 PM

Scanned
Date: 5/23 Time:

24°V T. Alaina RN 5/23/07 2305

5/24/07 1100

1. IV + CVL Diesels PRBCs - transfuse 1 unit over 4°
2. Magnesium Oxide 800mg po BID
3. D/C Lovenox
4. CBC in AM

M. Moss RN

TELEPHONE AND VERBAL ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

24° T. Alaina RN 5/25/07 0100

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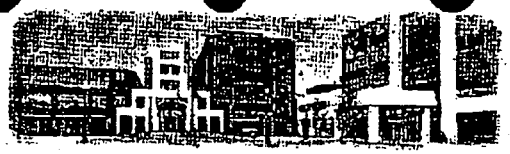
Date: 5/24 Time: 1320

VA [redacted]

181



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PHYSICIAN'S ORDERS [ ] Inpatient Admission [ ] Observation

YEAR	DRUG ALLERGIES	
ORDERED MONTH / DAY	TIME	
5/24/07	1110	Neb w/ albut Reg US "nebulizer" US Dose (LP) Lasix 20mg IV x 1 dose now Pt/last CXR in Am "pneumo" 5/25/07 MEP 5/24/07
		Scanned Date: 5/24 Time: 1320
05 24	2000	Respiratory treatments to be given QID and PRN c 2.5mg Albuterol and 0.5mg Atrovent.
5/24/07 2315 RWood RDC		TO Dr Neuner / Yellow Wrist Band 5/26/07
		Scanned Date: 5/24 Time: 2311 RDC
		24/T. Alaria LN 5/25 0100
6 25 07	1140	H+P in am
		Scanned martin Date: 5/25 Time: 1210
		24 0 1 R. Roy RN 5/25/07 2310 PM
		TELEPHONE AND VERBAL ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

RUN DATE: 05/26/07 TUOMEY REGIONAL NPR PHA *LIVE* PAGE 1
RUN TIME: 1122 PHA PROFILE

PATIENT: WINDHAM,TAMMY ELIZABET ACCT #: 12756622 LOC: TELE U #: 229598
AGE/SX: 39/F ROOM: 312 REG: 05/22/07
REG DR: MEDICAL SERVICES - TMP STATUS: ADM IN BED: 1 DIS:

HEIGHT: 5 ft 3.0 in 160.0 cm BODY SURFACE AREA: 1.72 m2
WEIGHT: 144 lb oz 65.544 kg

DRUG ALLERGIES: NKA-PH

DISCHARGE MEDICATIONS PROFILE

HOME MEDICATIONS INVENTORY

MEDICATION	DOSE	FREQUENCY	ROUTE	ORDERED ON ADMIT?	CHECK TO CONTINUE ON DISCHARGE
METOPROLOL TARTRATE	50MG	BID Lopressor	PO ✓		☑
PLAVIX	75MG	DAILY	PO ✓		☑
ASA	81MG	DAILY	PO ✓		☑

END OF HOME MEDICATION INVENTORY

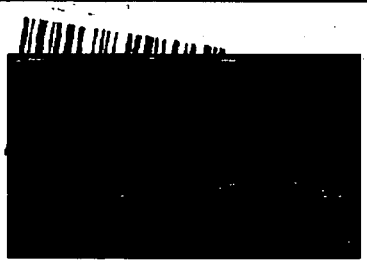
CURRENT PHARMACY PROFILE — CHECK TO CONTINUE ON DISCHARGE

HAB14PAT - Nicotine Patch ☐
DOSE: 14 MG (1 PATCH PER DOSE)
ROUTE: PATCH
SIG: DAILY (SCH)
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN

PLA75T - Plavix ✓ ☑
DOSE: 75 MG (1 TABLET PER DOSE)
ROUTE: PO
SIG: DAILY (SCH)
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN

ASA81T - Bayer Asa Child Chewable ✓ ☑
DOSE: 81 MG (1 TABLET PER DOSE)
ROUTE: PO
SIG: DAILY (SCH)
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN

LOP50T - Lopressor ✓ ☑
DOSE: 50 MG (1 TABLET PER DOSE)
ROUTE: PO
SIG: BID (SCH)
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN



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WINDHAM, TAMMY ELIZABETH 12756622 (Continued)

CURRENT PHARMACY PROFILE — CHECK TO CONTINUE ON DISCHARGE

FEOT - Ferrous Sulfate
DOSE: 325 MG (1 TABLET PER DOSE)
ROUTE: PO
SIG: TID (SCH)
START: 05/23/07-0900 STOP: 06/22/07-0901 ORD DR: RABON,CATHERINE

TES100C - Tessalon Perles
DOSE: 100 MG (1 CAPSULE PER DOSE)
ROUTE: PO
SIG: TID (SCH)
START: 05/23/07-0900 STOP: 06/22/07-0901 ORD DR: RABON,CATHERINE

PEP20T - Pepcid
DOSE: 20 MG (1 TABLET PER DOSE)
ROUTE: PO
SIG: BIDH2 (SCH)
START: 05/23/07-1300 STOP: 06/22/07-1301 ORD DR: RABON,CATHERINE

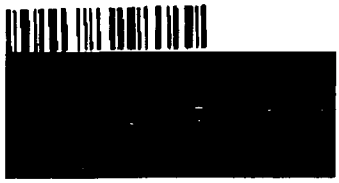
MAG400T - Magnesium Oxide Tab
DOSE: 800 MG (2 TABLETS PER DOSE)
ROUTE: PO
SIG: BID (SCH)
START: 05/24/07-1330 STOP: 06/23/07-1331 ORD DR: RABON,CATHERINE

PHE25I - Phenergan
DOSE: 12.5 MG (0.5 ML PER DOSE)
ROUTE: IV
SIG: Q4 (PRN) PAR=
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN

TYL325T - TYLENOL
DOSE: 1-2 TABS
ROUTE: PO
SIG: Q4 (PRN) PAR=
START: 05/22/07-1700 STOP: 06/21/07-1701 ORD DR: UNKNOWN

HYCL - Hycodan
DOSE: 5 MG (5 ML PER DOSE)
ROUTE: POL
SIG: Q4 (PRN) PAR=
START: 05/23/07-1300 STOP: 06/22/07-1301 ORD DR: RABON,CATHERINE

PERCT - Percocet
DOSE: 2 TAB (2 TABLETS PER DOSE)
ROUTE: PO
SIG: Q6 (PRN) PAR=
START: 05/23/07-1300 STOP: 06/22/07-1301 ORD DR: RABON,CATHERINE



WINDHAM, TAMMY ELIZABETH 12756622 (Continued)

CURRENT PHARMACY PROFILE — CHECK TO CONTINUE ON DISCHARGE

VEN5SOL - Ventolin
DOSE: 2.5 MG (0.5 ML PER DOSE)
ROUTE: INH
SIG: RQID (SCH)
START: 05/24/07-2330 **STOP:** 06/23/07-2331 **ORD DR:** UNKNOWN

ATRSOL - Atrovent
DOSE: 0.5 MG (2.5 ML PER DOSE)
ROUTE: INH
SIG: PRN (PRN) PAR=
START: 05/24/07-2330 **STOP:** 06/23/07-2331 **ORD DR:** UNKNOWN

ATRSOL - Atrovent
DOSE: 0.5 MG (2.5 ML PER DOSE)
ROUTE: INH
SIG: RQID (SCH)
START: 05/24/07-2330 **STOP:** 06/23/07-2331 **ORD DR:** UNKNOWN

VEN5SOL - Ventolin
DOSE: 2.5 MG (0.5 ML PER DOSE)
ROUTE: INH
SIG: PRN (PRN) PAR=
START: 05/24/07-2330 **STOP:** 06/23/07-2331 **ORD DR:** UNKNOWN

ZIT500I - Zithromax - 500 MG
in NS250 - Nacl.9 250ML Bag - 250 ML
SIG: Q24H (SCH)
START: 05/22/07-1700 **STOP:** 05/27/07-1701 **ORD DR:** UNKNOWN

ROC1PM - Rocephin 1 G Pm - 50 ML
SIG: Q24H-10 (SCH)
START: 05/22/07-1700 **STOP:** 06/01/07-1701 **ORD DR:** UNKNOWN

Δ to DMnucf

[redacted]

435

WINDHAM, TAMMY ELIZABETH 12756622 (Continued)

DISCHARGE TO : home

NEW MEDICATION ORDERS ON DISCHARGE :

See Rx → referral to United Ministries

DIET : Cardiac

TREATMENTS/WOUND CARE : Ø

RESPIRATORY NEEDS : See order for MDI's
Stop smoking

ACTIVITY/GENERAL INSTRUCTIONS : as tolerated - return for problems, D's, worse SOB

FOLLOW-UP CARE : FHC 1-2wks - repeat CXR until clear, depart Lic to Flu on Doxycycl
F/U Hb on Fe, B12, Folate and

HOME CARE ? Y N (Must also use Continuity of Care Form if Home Health/SNF placement)

PHYSICIAN _____ NURSE _____ DATE 5/26/07 TIME 1135

Patient Name: WINDHAM,TAMMY ELIZABETH Account #: 12756622

Nursing will use this Discharge Order form to complete Patient Discharge Instructions in MEDITECH to produce a Discharge Medication List and Discharge Instructions packet.

001872

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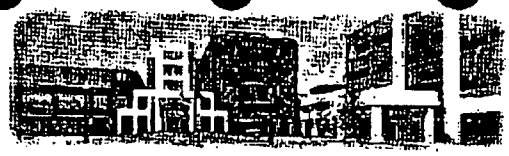

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PHYSICIAN'S ORDERS [ ] Inpatient Admission [ ] Observation

YEAR 2007 | DRUG ALLERGIES NKA

ORDERED MONTH	DAY	TIME	
5	26	07	1140

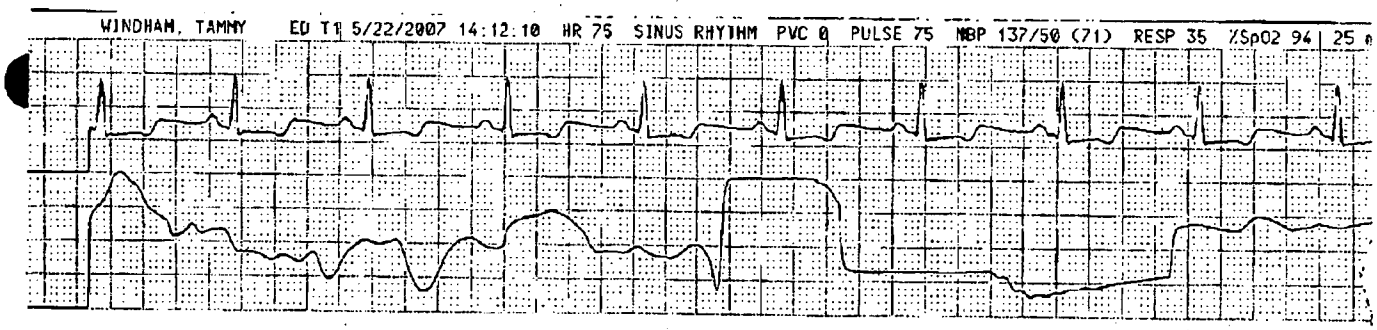
1. DC home
2. Continue MDI 2 puffs q6° → instruct & use + send home c/pt
3. advair diskus 250/50 + puff q12° — instruct & use + send home c/pt
4. See dc instructions
5. schedule Flu @ FHC for 1-2wks
6. SW consult to assist c needs
7. B12 1000 mcg IM x 1 dose now
8. Folic Acid 1 mg po x 1 dose now
9. OMNICEL 3000 mg po BID — 1st dose now, ok if Pharm verify given enough to last until PT can get to United Meridian

Scanned jmartin
Date: 5/26 Time: 1150

TELEPHONE AND VERBAL ORDERS MUST BE READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

001873

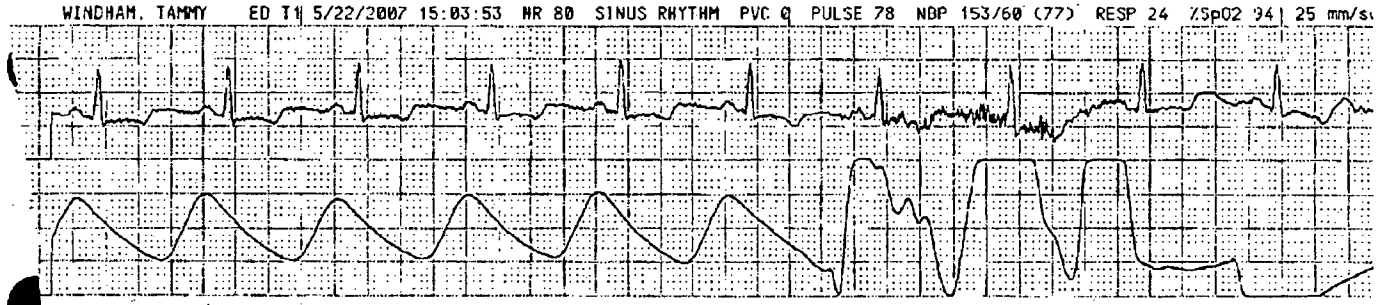


P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

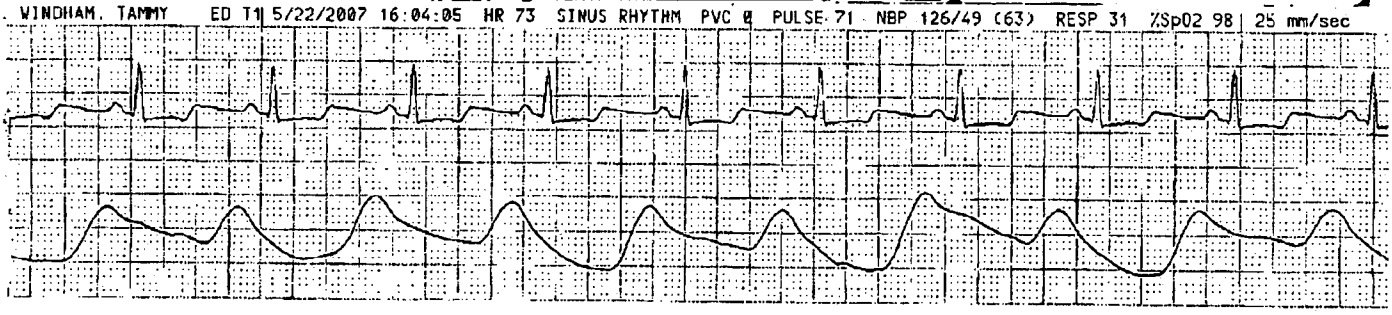
ACTION TAKEN: SIGNATURE: DATE:



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____



P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE _____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

REMARKS: _____ [redacted]

T1

Windham, Tammy

438

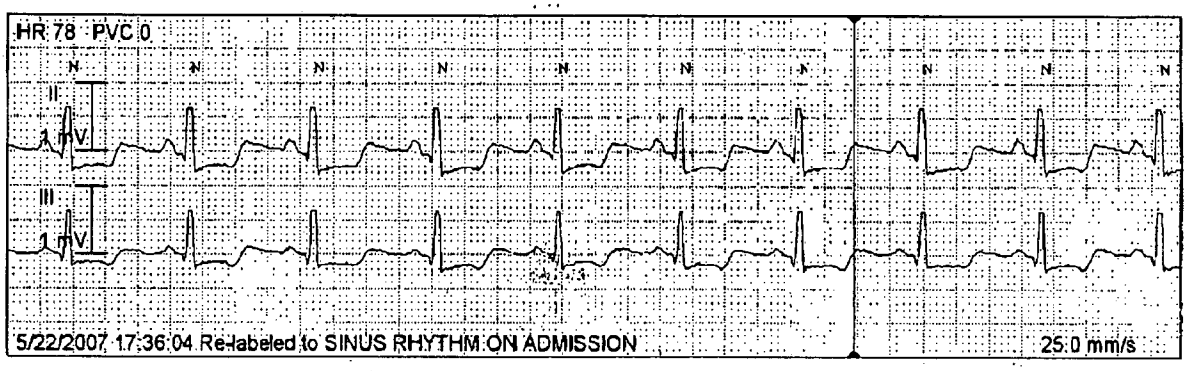
RHYTHM STRIP RECORD

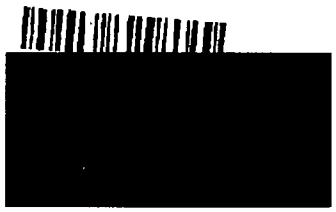
ICU-1220 MOORE WALLACE

5660

WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312

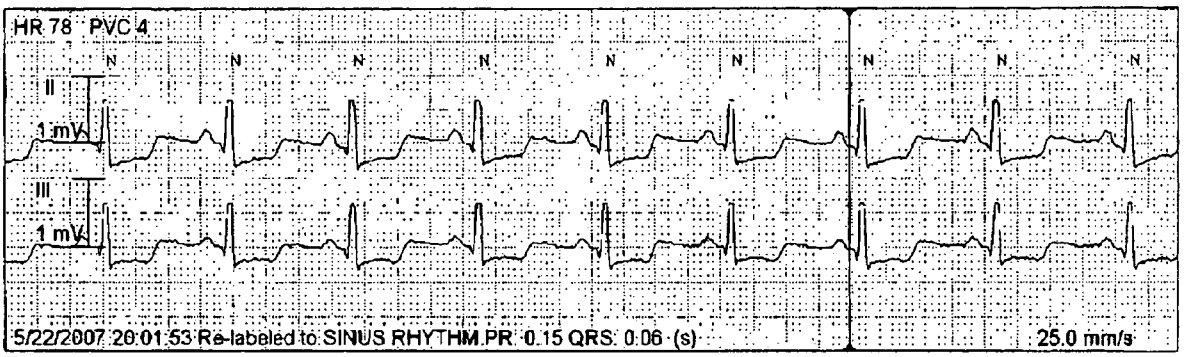


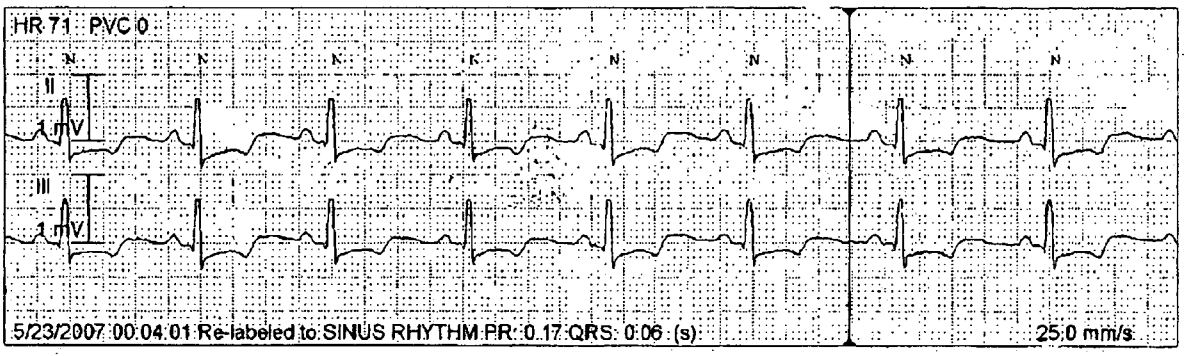


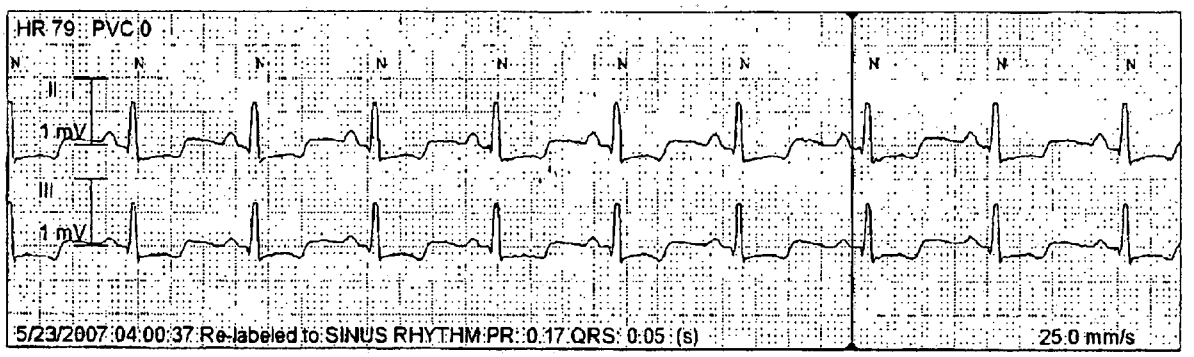
439

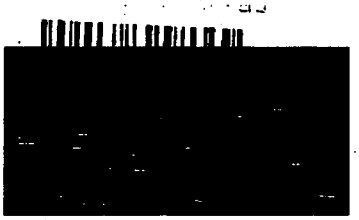
WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312









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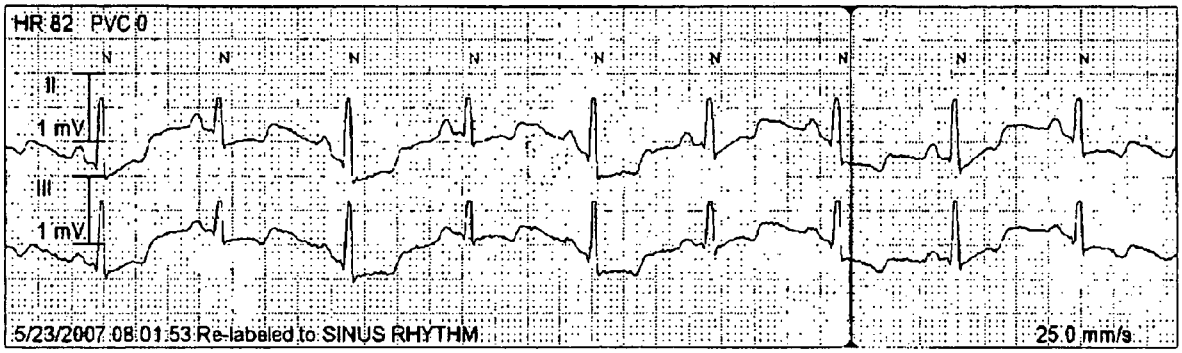
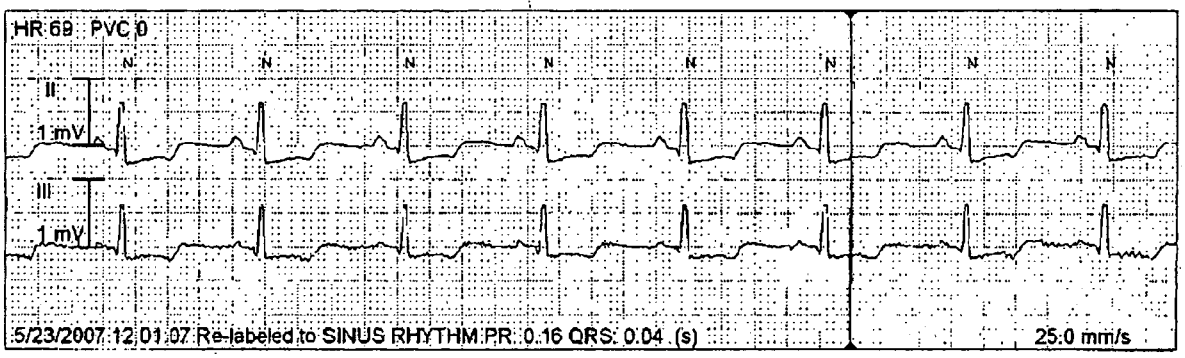
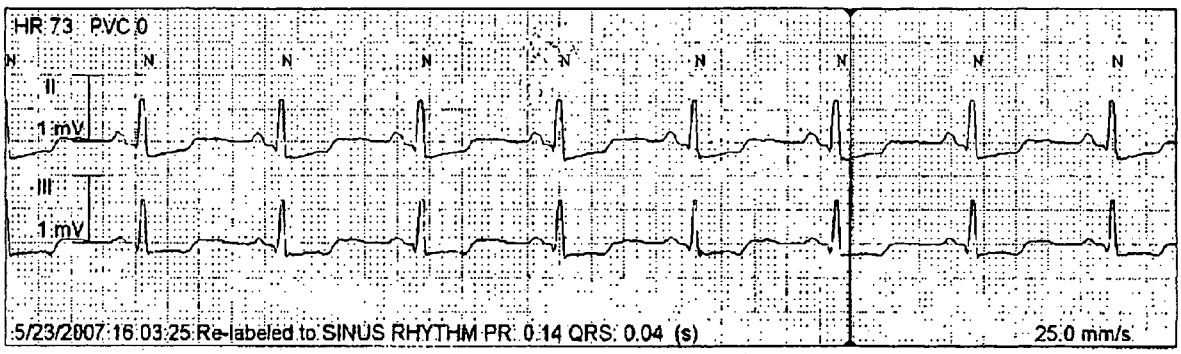
WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312







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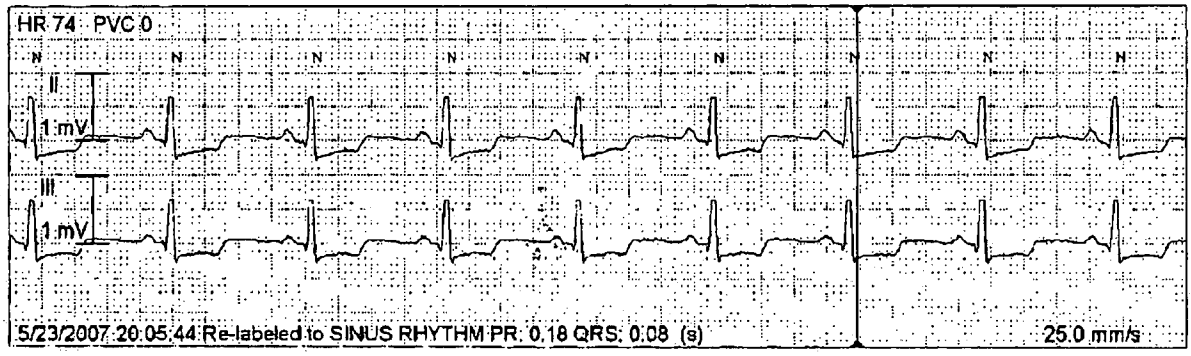
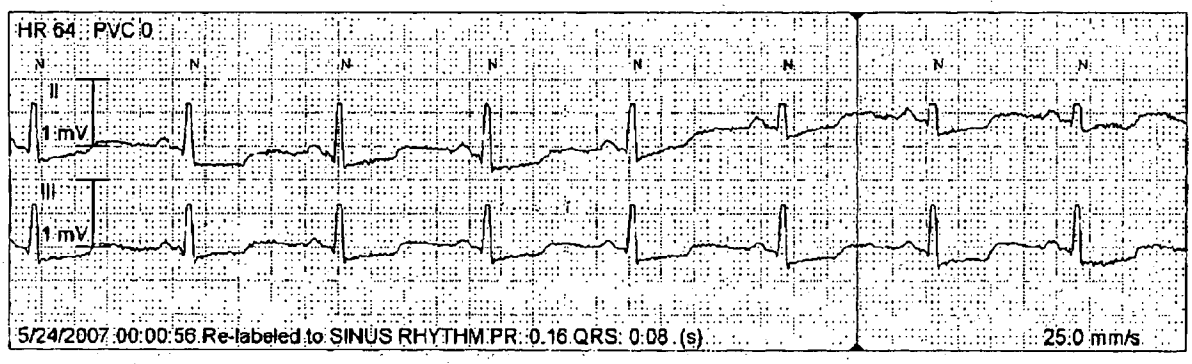
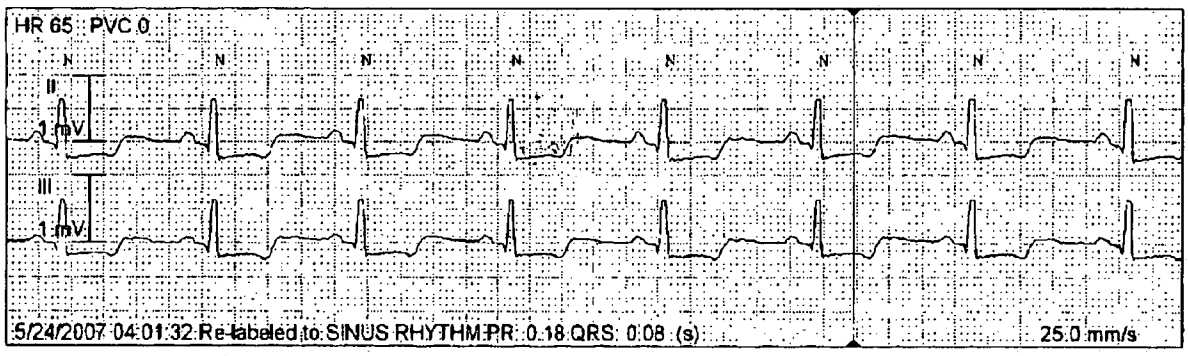
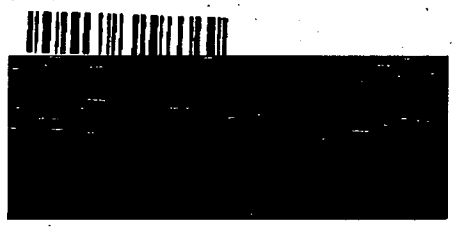
WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312









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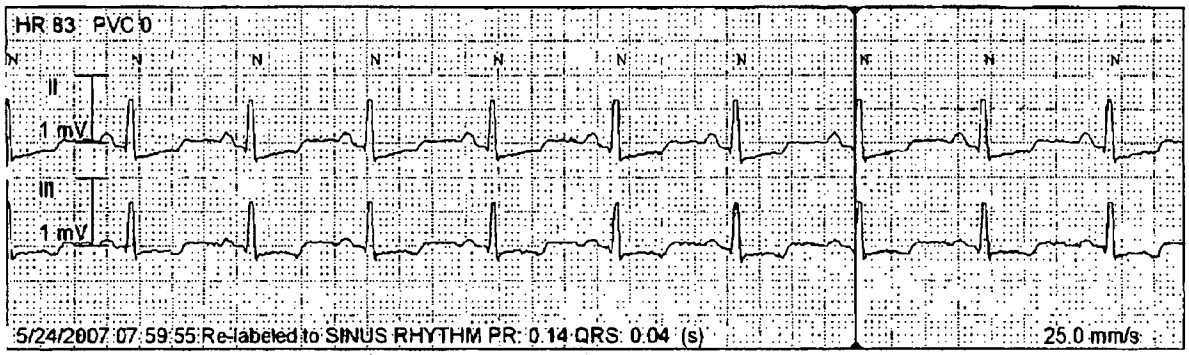
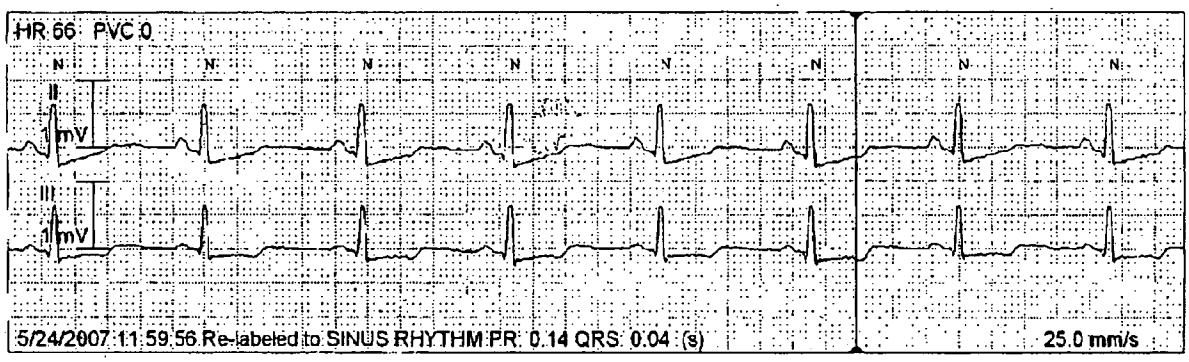
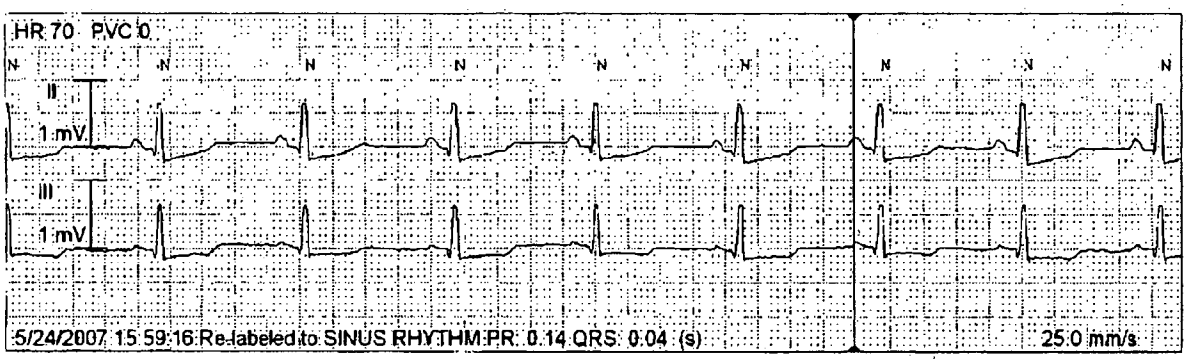
Alarm Review WINDHAM, TAMMY~312







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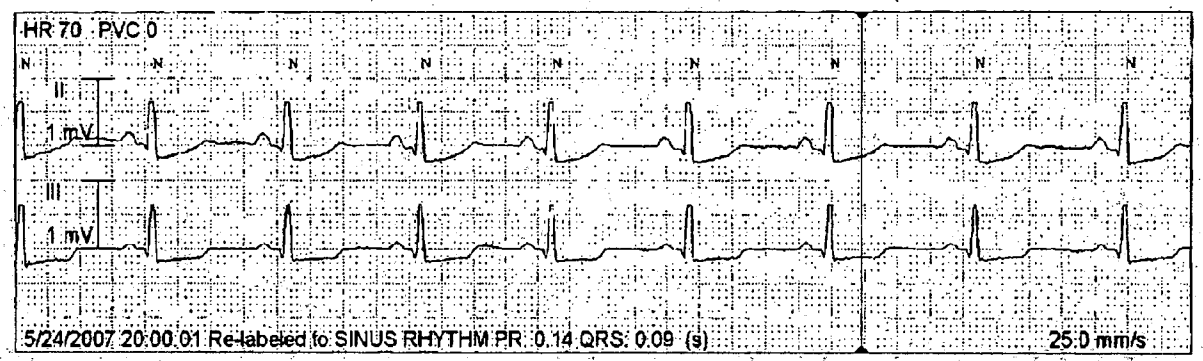
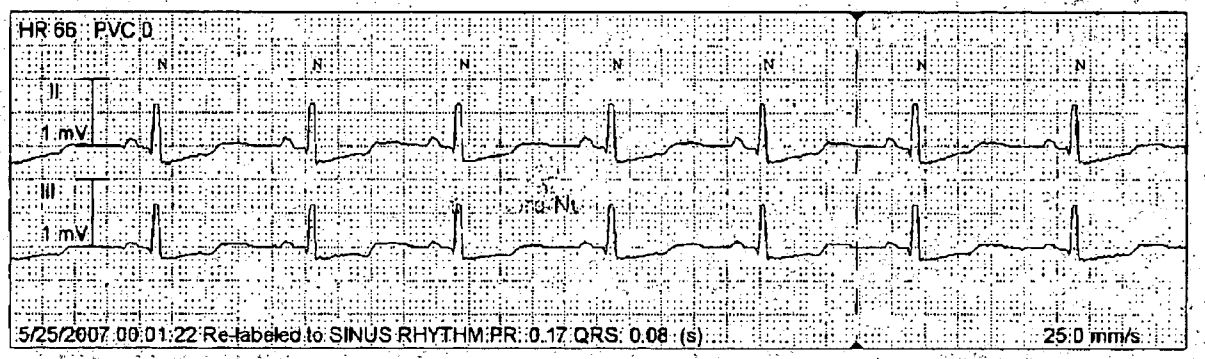
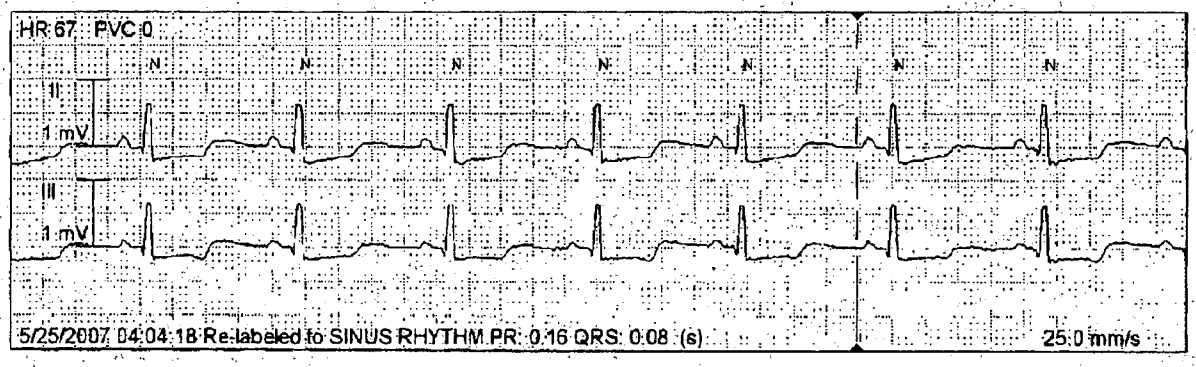
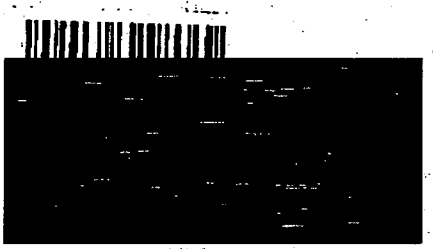
WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312









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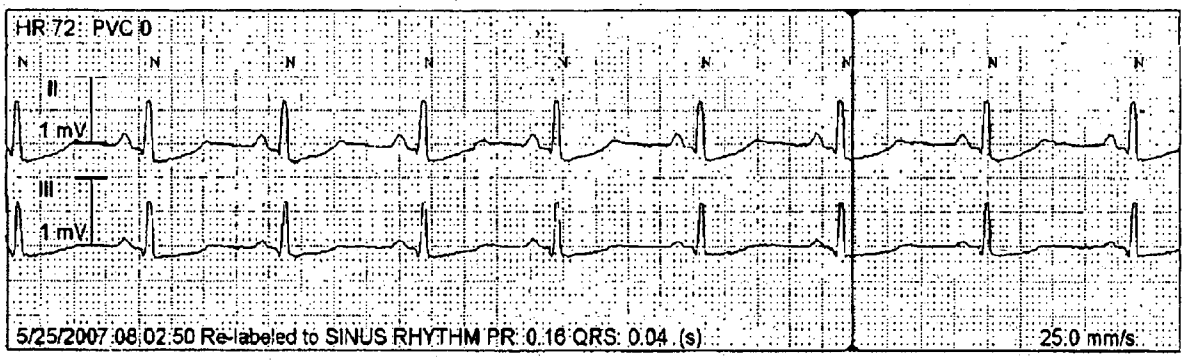
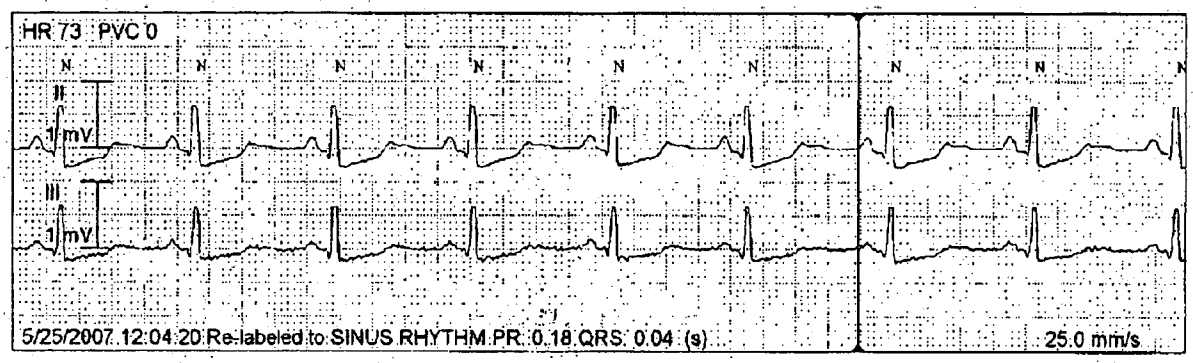
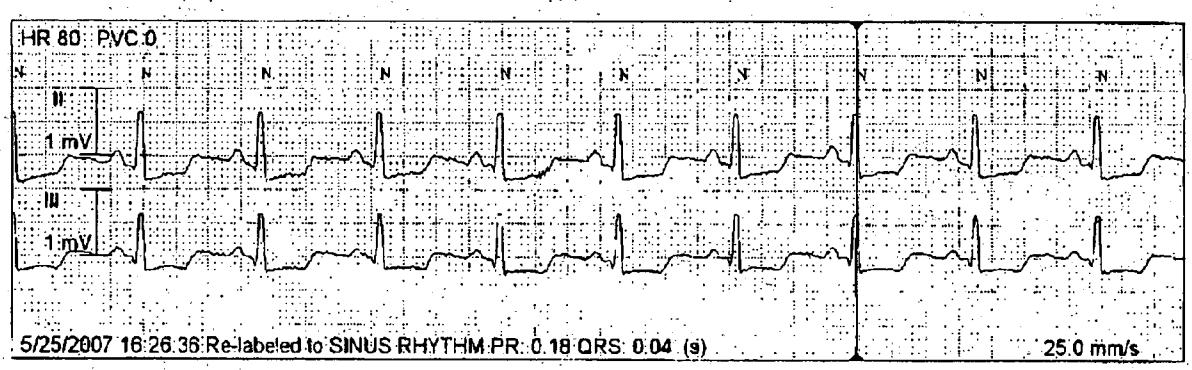
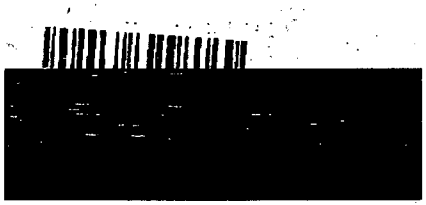
Alarm Review WINDHAM, TAMMY~312









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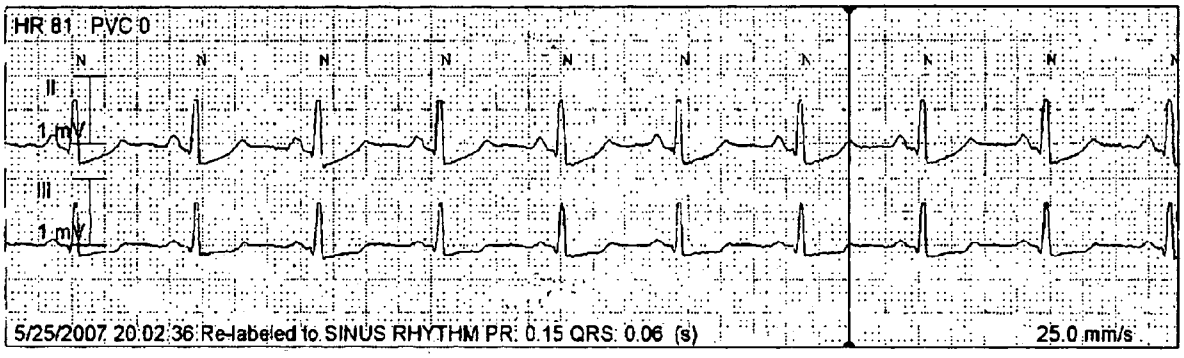
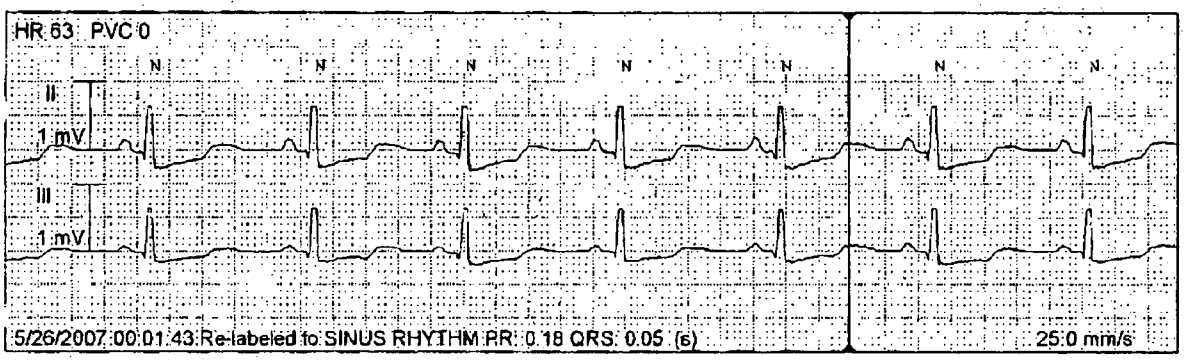
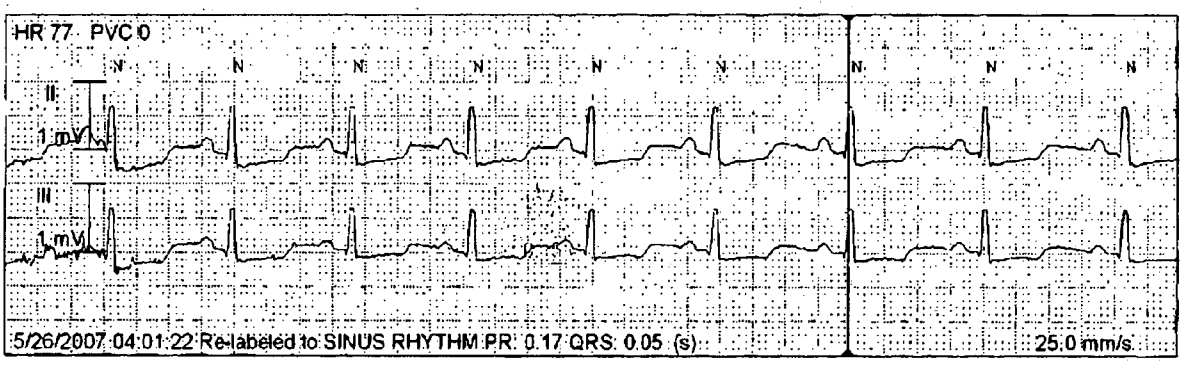
Alarm Review WINDHAM, TAMMY~312



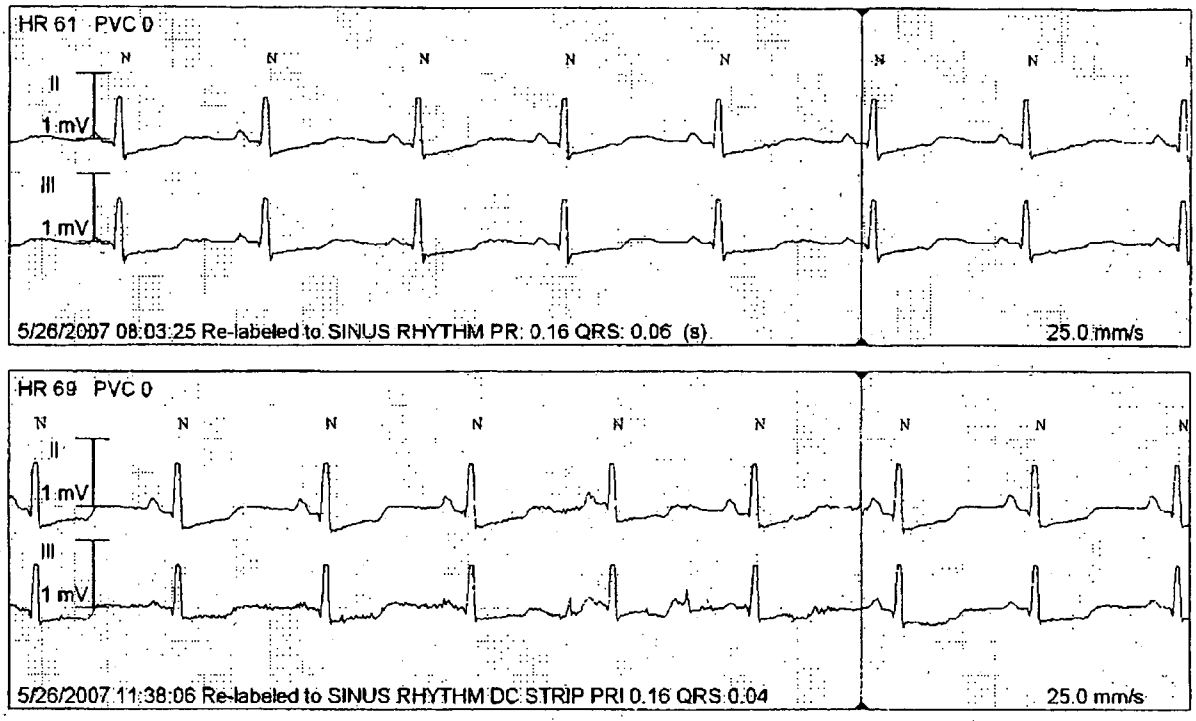




446

WINDHAM, TAMMY~312 Medical Record Number: 12756622/229998 TELE12

Alarm Review WINDHAM, TAMMY~312



447

5670

001883

229998 WINDHAM, TAMMY ELIZABETH 23-May-2007 03:29:40
39 Years Female Race: White BP: 195/88

Dept: Telemetry
Room: 312
Oper: 336

448

Rate 76 - STMT - * SINUS RHYTHM, RATE 76.
789 - STMT - * LEFT VENTRICULAR HYPERTROPHY WITH SECONDARY REPOLARIZATION CHANGES.
152 - STMT - * SINCE LAST TRACING, 05/22/2007: STRAIN PATTERN SLIGHTLY LESS PRONOUNCED.

QRSD 88
QT 412
QTc 464

-- AXIS --
P 46
QRS 48
T 226

Account Number:12756622

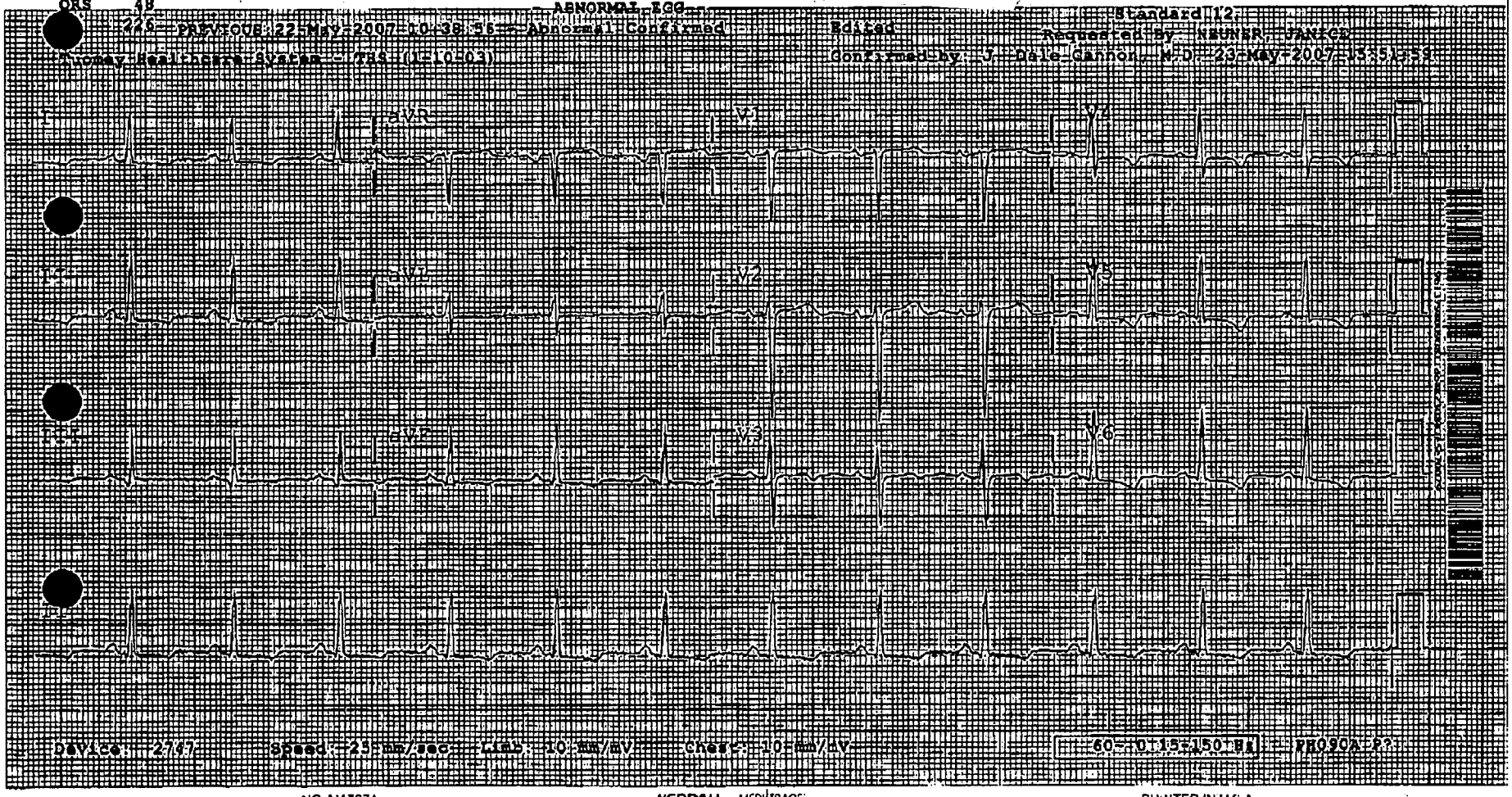
Edited By:TERESA WALLACE

WINDHAM,TAMMY ELIZABETH
Acct:12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1
F W Age:39

Order #: CARD20070523-0006

--ABNORMAL ECG--
PREVIOUS 22-May-2007 10:38:56--Abnormal Confirmed Edited
Requested By: NEUNER, JANICE
Cerner Healthcare System - THS (1210403) Confirmed by: J. Dale Cannon, M.D. 23-May-2007 03:51:59

Standard 12



60~ 0.15-150 Hz PRO90A-??

NO. M1737A KENDALL MEDI-TRACE PRINTED IN U.S.A.

ACCT NO: 12756622 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: WERNSMAN, ERIC S

EXAM: CT CHEST W/CONTRAST 7279
EXAM DATE: 05/22/2007 00:00:00
PHYS: MEASE, MICHAEL RICHARD
REASON: R/O PE

ABNORMAL

CT OF THE CHEST - 05/22/07

A pulmonary CT angiogram was performed following IV contrast administration using 2.5 mm axial sections with provision of bilateral parasagittal reconstructed images through the pulmonary arteries.

There is no definite evidence for central PE. Very tiny peripheral PE difficult to entirely exclude.

Note is made of mild adenopathy seen within the mediastinum and perihilar territories. Aorta appears normal. No pericardial or pleural effusions are seen.

Pulmonary windows demonstrate a consolidative infiltrate seen within the left lower lobe and lingula with likely some degree of atelectasis as well. Therefore adenopathy seen is most likely reactive. Low-grade infiltrates also likely within the inferior aspect of the left upper lobe and peribronchiolar territories centrally. Extremely minimal degree of scarring or atelectasis is suggested within the medial right middle lobe with a few very hazy peribronchiolar opacities in the right middle lobe which may also represent miniscule peribronchiolar infiltrates. No evidence for gross mass. Incidental few small bullae noted within the right apex with a few extremely low grade peribronchiolar somewhat reticular nodular opacities within the posterior aspect of the right upper lobe. Very limited imaging of the upper abdomen is grossly unremarkable.

IMPRESSIONS: No definite evidence for central PE. Left lower lobe lingular and minimal inferior left upper lobe infiltrates as discussed. Very vague peribronchiolar opacities also noted within the right middle lobe and a few tiny reticular nodular opacities in the posterior right upper lobe. Also adenopathy is noted which is nonspecific although would most likely reflect reactive changes

The ordering care provider was notified of the results upon review.

ABNORMAL

ACCT NO: 12756622 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: WERNSMAN, ERIC S

EXAM: XR CHEST PORTABLE 1 VIEW 0608
EXAM DATE: 05/22/2007 00:00:00
PHYS: PARKER, GILBERT E
REASON: CHEST PAIN AND SOB

CHEST

Portable AP upright chest demonstrates left basilar consolidation obscuring the left diaphragm with the remainder of the lung fields clear and the heart size normal. No edema.

IMPRESSION: Left basilar infiltrate obscures the left diaphragm. Careful followup to clearing recommended.

ABNORMAL

ACCT NO: 12756622 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: RABON, CATHERINE

EXAM: US PELVIC, COMPLETE 4609
EXAM DATE: 05/24/2007 00:00:00
PHYS: PARKER, GILBERT E
REASON: VAGINAL U/S, "MENORRHAGIA"

PELVIC ULTRASOUND

Transverse and longitudinal images were obtained through the pelvis. The uterus measures 7.2 x 3.3 x 5.1 cm with an endometrial stripe thickness of 0.4 cm. The left ovary demonstrates a dominant cyst that measures 3.3 x 3.1 cm in size. The right ovary measures 1.7 x 1.6 x 1.4 cm in size. No abnormal fluid collections.

IMPRESSION: Normal uterine and right ovarian exam with a cyst on the left ovary measuring greater than 3 cm and follow up recommended to make sure that this resolves and is physiologic. No abnormal fluid collections.

ACCT NO: 12756622 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
DOB: [redacted] SEX: F
ORDERING PHYS: RABON, CATHERINE

EXAM: XR CHEST - PA AND LAT 0665
EXAM DATE: 05/25/2007 00:00:00
PHYS: PANNELL, TIMOTHY L
REASON: PNEUMONIA

CHEST - PA AND LATERAL - 05/25/07

Examination of the chest is compared to the previous study of 05/22. Examination shows normal heart size. Low-grade infiltrate is again noted in the left lung base and appears significantly improved from the prior exam. Right lung remains clear.

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 86
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12756622 LOC: TELE U #: 229998
AGE/SX: 39/F ROOM: 312 REG: 05/22/07
REG DR: NEUNER,JANICE M STATUS: DIS IN BED: 1 DIS: 05/26/07

****HEMATOLOGY****

HEMOGRAM

Day	5	4	3		
Date	MAY 26	MAY 25	MAY 24		
Time	0600	0600	0555	Reference	Units
WBC		6.7	6.9 #	(3.0-11)	1000/UL
RBC		4.78 #	4.15 #	(3.7-5.3)	MIL/UL
HGB	9.5 L	9.8 # L	8.7 L	(11.5-16.0)	G/DL
HCT	30.1 L	31.5 # L	27.4 # L	(33-46)	%
MCV		65.9 L	66.0 L	(79-95)	FL
MCH		20.5 L	20.9 L	(26-34)	PG
MCHC		31.1	31.6	(29-35)	G/DL
RDW		20.7 H	20.2 H	(11.9-15.5)	%
PLATELET COUNT		464 # H	382	(135-415)	1000/UL

Day	2		1		
Date	MAY 23		MAY 22		
Time	1830	1230	1125	Reference	Units
WBC			15.7 H	(3.0-11)	1000/UL
RBC			5.07 #	(3.7-5.3)	MIL/UL
HGB	9.5 L	9.6 L	10.4 # L	(11.5-16.0)	G/DL
HCT	30.7 L	30.8 L	33.1 #	(33-46)	%
MCV			65.3 L	(79-95)	FL
MCH			20.4 L	(26-34)	PG
MCHC			31.2	(29-35)	G/DL
RDW			19.9 H	(11.9-15.5)	%
PLATELET COUNT			427 H	(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

Day	1		
Date	MAY 22		
Time	1125	Reference	Units
NEUTROPHILS	79.3 H	(42-76)	%
LYMPHOCYTES	13.3 L	(16-48)	%
MONOCYTES	5.1	(0.0-10.0)	%
EOSINOPHILS	0.6	(0.0-7.6)	%
BASOPHILS	1.8 H	(0.0-1.5)	%

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 87
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

****URINALYSIS****

	Day 1			
	Date MAY 22			
	Time 1100		Reference	Units
COLOR	AMBER(a)	H		
APPEARANCE-2	TURBID	H	(CLEAR)	
GLUCOSE	NEGATIVE		(NEGATIVE)	MG/DL
BILIRUBIN	SMALL		(NEGATIVE)	
KETONES	NEGATIVE		(NEGATIVE)	
SPECIFIC GRAVTY	1.024		(1.001-1.035)	
BLOOD	NEGATIVE		(NEGATIVE)	
PH	5.5		(5-9)	
PROTEIN	TRACE		(NEGATIVE)	MG/DL
UROBILINOGEN	1.0		(0.2-1.0)	MG/DL
NITRITES	NEGATIVE		(NEGATIVE)	
LEUKOCYTES	MODERATE	H	(NEGATIVE)	
WBC	7-14	H	(0-6)	/HPF
RBC	RARE		(0-2)	/HPF
EPITHELIAL CELL	(b)		(0-6)	/HPF
BACTERIA	2+	H	(NEGATIVE)	
CA OXALATE CRYS	2+			

NOTES: (a) **Urine color may cause colormasking or readability of urine reagent strips. Please interpret urine chemistry results accordingly.**
(b) TOO MANY TO COUNT

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 88
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

****CHEMISTRY****

Day	2	1			
Date	MAY 23	MAY 22			
Time	1230	2320	2320	Reference	Units
SODIUM	137			(135-151)	MEQ/L
POTASSIUM	4.1 #			(3.5-5.1)	MEQ/L
CHLORIDE	107			(99-116)	MEQ/L
C02	22			(22-30)	MEQ/L
GLUCOSE SERUM	112 H			(80-110)	MG/DL
BUN	4 # L			(7-18)	MG/DL
CREATININE	0.6 # L			(0.8-1.5)	MG/DL
CALCIUM	8.6			(8.4-10.2)	MG/DL
TROPONIN-I		< 0.04(A)		(0-0.08)	NG/ML

(A)
TROPONIN VALUES GREATER THEN 0.08 NG/ML ARE CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.4 NG/ML ARE LIKELY TO REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE DATA FROM A SINGLE BLOOD COLLECTION.

CK TOTAL		60	(30-135)	U/L
CK INDEX		(c)		
MAGNESIUM	1.9		(1.6-2.3)	MG/DL

NOTES: (c) Test not performed

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 89
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

****CHEMISTRY****

Day	1				
Date	MAY 22				
Time	1820	1820	1820	Reference	Units
TROPONIN-I	< 0.04(B)			(0-0.08)	NG/ML

(B)
TROPONIN VALUES GREATER THEN 0.08 NG/ML ARE CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.4 NG/ML ARE LIKELY TO REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE DATA FROM A SINGLE BLOOD COLLECTION.

CK TOTAL	58 #		(30-135)	U/L
CK INDEX	(d)			
IRON		12 L	(37-170)	UG/DL
TOTAL IBC		315	(265-500)	UG/DL
TRANSFERRIN SAT		4 L	(15-50)	%

Day	1				
Date	MAY 22				
Time	1125	1125	1125	Reference	Units
SODIUM			135	(135-151)	MEQ/L
POTASSIUM			3.3 L	(3.5-5.1)	MEQ/L
CHLORIDE			99	(99-116)	MEQ/L
C02			23	(22-30)	MEQ/L
GLUCOSE SERUM			110	(80-110)	MG/DL
BUN			5 # L	(7-18)	MG/DL
CREATININE			0.7 # L	(0.8-1.5)	MG/DL
CALCIUM			8.9	(8.4-10.2)	MG/DL
PROTEIN			7.8	(6.3-8.2)	GM/DL
ALBUMIN			3.9	(3.5-5.0)	GM/DL
BILI-TOTAL			0.4	(0.2-1.3)	MG/DL
ALT (SGPT)			18	(9-52)	U/L
AST (SGOT)			29	(14-36)	U/L
ALK PHOS			197 H	(38-126)	U/L

NOTES: (d) Test not performed

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39/F Acct# 12756622 Unit# 229998

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 90
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

****CHEMISTRY****

Day		1				
Date		MAY 22				
Time		1125	1125	1125	Reference	Units
TROPONIN-I	< 0.04(C) #				(0-0.08)	NG/ML
CK TOTAL			50 #		(30-135)	U/L
CK INDEX			(e)			

(C)
TROPONIN VALUES GREATER THEN 0.08 NG/ML ARE CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.4 NG/ML ARE LIKELY TO REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE DATA FROM A SINGLE BLOOD COLLECTION.

Day	1		
Date	MAY 22		
Time	1100	Reference	Units
PREGNANCY TEST	NEGATIVE	(NEGATIVE)	

NOTES: (e) Test not performed

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 91
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LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

****COAGULATION****

Day		1			
Date		MAY 22			
Time	1125	1125	1125	Reference	Units
PT PATIENT	10.0			(9.0-12.0)	SEC
INR NORM RATIO	0.99(D)				

(D) RECOMMENDED THERAPEUTIC RANGE FOR
ORAL ANTICOAGULENT THERAPY
(AMERICAN COLLEGE OF CHEST PHYSICIANS)

PROPHYLAXIS/TREATMENT OF:	INR
VENOUS THROMBOSIS,PULMONARY EMBOLISM	2.0-3.0
PREVENTION OF SYSTEMIC EMBOLISM FROM:	
ATRIAL FIBRILLATION	2.0-3.0
MYOCARDIAL INFARCTION	2.0-3.0
MECHANICAL PROSTHETIC HEART VALVES	2.5-3.5
RECURRENT SYSTEMIC EMBOLISM	2.5-3.5

PTT PATIENT		28.7(E)	(25.0-35.3)	SEC

(E)

THERAPEUTIC RANGE	
STANDARD PROTOCOL	45-60 SECONDS
HIGH DOSE PROTOCOL	60-80 SECONDS

D-DIMER QUANT	2.55(F)	H	(0-2.3)	mg/L

(F)
Increases in D-dimer concentration observed with thromboembolic events can be variable due to localization, extension and age of the thrombus. Therefore, a thromboembolic event cannot be excluded with certainty solely on the basis of a D-dimer concentration being within the reference range of ostensibly healthy persons. Results from D-dimer determinations should, therefore, always be evaluated in conjunction with clinical and other laboratory findings.

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 10/01/07 TUH NPR LAB **LIVE** PAGE 92
RUN TIME: 1904 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

Test	Day	Date	Time	Result		Reference	Units
BNP	1	MAY 22	1125	46		(5-100)	PG/ML
B12	1	MAY 22	1820	240(f)		(200-1100)	pg/mL
FOLATE-AML	1	MAY 22	1820	4.9(g)	L	(>5.4)	ng/mL

NOTES: (f) Please note: although the reference range for Vitamin B12 is 200-1100 pg/mL, it has been reported that between 5 and 10% of patients with values between 200 and 400 pg/mL may experience neuropsychiatric and hematologic abnormalities due to occult B12 deficiency; less than 1% of patients with values above 400 pg/mL will have symptoms.

(g) Reference ranges:
>17 years:
Normal: >5.4 ng/mL
Borderline: 3.4 - 5.4 ng/mL
Low: <3.4 ng/mL
Test Performed by Quest, Chantilly,
Quest Diagnostics Nichols Institute,
14225 Newbrook Drive, Chantilly, VA 20153
Dr. Nathan Sherman, M.D., Medical Director
(703) 802-6900, CLIA 49D0221801

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/14/07 TUH NPR LAB **LIVE** PAGE 4
RUN TIME: 1806 Microbiology Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12756622 LOC: TELE U #: 229998
AGE/SX: 39/F ROOM: 312 REG: 05/22/07
REG DR: NEUNER,JANICE M STATUS: DIS IN BED: 1 DIS: 05/26/07

Source: BLOOD Collection Date/Time: 05/22/07 1125

BLD C&S 1 AEROBIC	Final 05/28/07	
	NO GROWTH AT 5 DAYS	
BLD C&S 2 ANAEROBIC	Final 05/28/07	
	NO GROWTH AT 5 DAYS	
BLD C&S 3 AEROBIC	Final 05/28/07	
	NO GROWTH AT 5 DAYS	
BLD C&S 4 ANAEROBIC	Final 05/28/07	
	NO GROWTH AT 5 DAYS	

Source: SPUTUM Collection Date/Time: 05/23/07 0745

SPUTUM CULTURE WITH SENSITIVIT	Final 05/25/07	
05/24/07		
LIGHT NORMAL RESPIRATORY FLORA		
05/25/07		
ISOLATE 1 RARE GROWTH, CANDIDA ALBICANS		
LIGHT NORMAL RESPIRATORY FLORA		
GRAM STAIN SPECIMEN	Final 05/23/07	
NO ORGANISMS SEEN	*	
WBC S	FEW	

Source: URINE,CLEAN CATCH Collection Date/Time: 05/23/07 0745

URINE CULTURE W SEN	Final 05/25/07
5-24-07	
NO GROWTH	
5-25-27	
CC <10,000 Cfu/ml, MULTIPLE MICROOORGANISMS PRESENT, NO FURTHER WORKUP	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 09/14/07 TUH NPR LAB **LIVE** PAGE 5
RUN TIME: 1806 Microbiology Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12756622 (Continued)

Source: URINE,CLEAN CATCH Collection Date/Time: 05/22/07 1551

URINE CULTURE W SEN Final 05/25/07

5-24-07
CC 10,000 - 50,000 CFU/ml,
MULTIPLE MICROORGANISMS PRESENT, NO FURTHER WORK UP,
PROBABLE CONTAMINATION, PLEASE REPEAT CULTURE.

5-25-27
CC 10,000 - 50,000 CFU/ml,
MULTIPLE MICROORGANISMS PRESENT, NO FURTHER WORK UP,
PROBABLE CONTAMINATION, PLEASE REPEAT CULTURE.

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 12/31/08 TUH NPR LAB **LIVE** PAGE 14
RUN TIME: 1819 BB Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12756622 LOC: TELE U #: 229998
AGE/SX: 39/F ROOM: 312 REG: 05/22/07
REG DR: NEUNER,JANICE M STATUS: DIS IN BED: 1 DIS: 05/26/07

COLLECTED: May 24, 2007 2:45pm

INDIRECT COOMBS	NEGATIVE	(NEGATIVE)
ABO	O POS	
ARMBAND NUMBER	EXE9159	

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 07/05/07 TUH NPR LAB **LIVE** PAGE 27
RUN TIME: 1748 BB Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12756622 LOC: TELE U #: 229998
AGE/SX: 39/F ROOM: 312 REG: 05/22/07
REG DR: NEUNER,JANICE M STATUS: DIS IN BED: 1 DIS: 05/26/07

COLLECTED: May 24, 2007 2:45pm

INDIRECT COOMBS	NEGATIVE	(NEGATIVE)
ABO	O POS	
ARMBAND NUMBER	EXE9159	

465

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/22/07 Time: 1720

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/22/07 1720 TMP 05/22/07 1736 TMP
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: ALL LOBES RR Pre: 16 Strength:
HR Pre: 73 BS Post: AIR IMP RR Post: 16 Productive:
HR During: 74 CL Sputum Amount:
HR Post: 74 Fields: ALL LOBES Consistancy:
SaO2: 98% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/22/07 Time: 1734

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Create 05/22/07 1734 TMP 05/22/07 1734 TMP

Activity Date: 05/22/07 Time: 1942

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/22/07 1942 SLH 05/22/07 2158 SLH
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: MODERATE
HR Pre: 76 BS Post: CR RR Post: 16 Productive: N
HR During: 83 Sputum Amount:
HR Post: 83 Fields: BILAT LL Consistancy:
SaO2: 97 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 0021

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 0021 SLH 05/23/07 0046 SLH
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CR Cough: Y Suction: N
PF After:
Fields: BILAT LL RR Pre: 12 Strength: MODERATE
HR Pre: 79 BS Post: CR RR Post: 12 Productive: N
HR During: 77 Sputum Amount:
HR Post: 77 Fields: BILAT LL Consistancy:
SaO2: 97 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/23/07 Time: 0332

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 0332 SLH 05/23/07 0536 SLH
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 12 Strength: MODERATE
HR Pre: 80 BS Post: CL RR Post: 12 Productive: N
HR During: 79 Sputum Amount:
HR Post: 80 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/23/07 Time: 0740

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 0740 PDW 05/23/07 1241 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT

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001902

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 0740 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After: DIM
Fields: ALL LOBES RR Pre: 18 Strength:
HR Pre: 97 BS Post: CL RR Post: 20 Productive:
HR During: 95 DIM Sputum Amount:
HR Post: 95 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/23/07 Time: 1120

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 1120 PDW 05/23/07 1241 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After: DIM
Fields: ALL LOBES RR Pre: 18 Strength:
HR Pre: 95 BS Post: CL RR Post: 18 Productive:
HR During: 93 DIM Sputum Amount:
HR Post: 93 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/23/07 Time: 1505

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 1505 PDW 05/23/07 1622 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N

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Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 1505 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
PF After: DIM
Fields: ALL LOBES RR Pre: 20 Strength: STRONG
HR Pre: 79 BS Post: CL RR Post: 20 Productive: N
HR During: 82 DIM Sputum Amount:
HR Post: 80 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/23/07 Time: 2030

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/23/07 2030 KBO 05/24/07 0113 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CO Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 71 BS Post: CL RR Post: 16 Productive: N
HR During: 67 Sputum Amount:
HR Post: 67 Fields: ALL LOBES Consistancy:
SaO2: 98% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/24/07 Time: 0030

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 0030 KBO 05/24/07 0113 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 74 BS Post: CL RR Post: 16 Productive: N
HR During: 88 Sputum Amount:

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

Activity Date: 05/24/07 Time: 0030 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
HR Post: 91 Fields: ALL LOBES Consistancy:
SaO2: 97% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/24/07 Time: 0435

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 0435 KBO 05/24/07 0458 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CO Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 82 BS Post: CL RR Post: 16 Productive: N
HR During: 78 Sputum Amount:
HR Post: 72 Fields: ALL LOBES Consistancy:
SaO2: 97% ON 2LPM Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/24/07 Time: 0745

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 0745 PDW 05/24/07 1002 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After:
Fields: ALL LOBES RR Pre: 20 Strength:
HR Pre: 102 BS Post: CL RR Post: 20 Productive:
HR During: 105 Sputum Amount:
HR Post: 105 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 0745 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)

Comments:

Activity Date: 05/24/07 Time: 1140

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 1140 PDW 05/24/07 1408 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After:
Fields: ALL LOBES RR Pre: 18 Strength:
HR Pre: 97 BS Post: CL RR Post: 20 Productive:
HR During: 93 Sputum Amount:
HR Post: 94 Fields: ALL LOBES Consistancy:
SaO2: 98 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/24/07 Time: 1525

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 1525 PDW 05/24/07 1618 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 18 Strength: STRONG
HR Pre: 76 BS Post: CL RR Post: 20 Productive: N
HR During: 79 Sputum Amount:
HR Post: 79 Fields: ALL LOBES Consistancy:
SaO2: 98 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 2100

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/24/07 2100 KBO 05/25/07 0517 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: CR Cough: Y Suction: N
PF After:
Fields: LLL RR Pre: 16 Strength: STRONG
HR Pre: 63 BS Post: CL RR Post: 16 Productive: N
HR During: 67 DIM Sputum Amount:
HR Post: 67 Fields: ALL LOBES Consistancy:
SaO2: 97% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/25/07 Time: 0735

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/25/07 0735 BER 05/25/07 0947 BER
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: BILAT LL RR Pre: 20 Strength:
HR Pre: 80 BS Post: DIM RR Post: 20 Productive:
HR During: 82 Sputum Amount:
HR Post: 84 Fields: BILAT LL Consistancy:
SaO2: 95% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/25/07 Time: 1135

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/25/07 1135 BER 05/25/07 1448 BER
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/25/07 Time: 1135 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
TX Given: Y Outcome: UNDERSTOOD Orders:
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: BILAT LL RR Pre: 20 Strength:
HR Pre: 77 BS Post: DIM RR Post: 20 Productive:
HR During: 78 Sputum Amount:
HR Post: 77 Fields: BILAT LL Consistancy:
SaO2: 94% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/25/07 Time: 1152

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/25/07 1152 BER 05/25/07 1731 BER
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: LLL RR Pre: 18 Strength:
HR Pre: 77 BS Post: DIM RR Post: 18 Productive:
HR During: 79 Sputum Amount:
HR Post: 80 Fields: LLL Consistancy:
SaO2: 99% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/25/07 Time: 2025

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/25/07 2025 PJS 05/25/07 2317 PJS
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:

001908

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/25/07 Time: 2025 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
PF After:
Fields: LLL RR Pre: 18 Strength:
HR Pre: 73 BS Post: DIM RR Post: 20 Productive:
HR During: 77 CL Sputum Amount:
AIR IMP
HR Post: 80 Fields: LLL Consistancy:
SaO2: 97% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/26/07 Time: 0830

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/26/07 0830 MKR 05/26/07 1809 MKR
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction: N
PF After: CL
Fields: ALL LOBES RR Pre: 20 Strength:
HR Pre: 88 BS Post: CL RR Post: 20 Productive: N
HR During: 88 DIM Sputum Amount:
HR Post: 89 Fields: ALL LOBES Consistancy:
SaO2: 98---RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

Activity Date: 05/26/07 Time: 1430

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Document 05/26/07 1430 MKR 05/26/07 1809 MKR
Initial Tx: TX: MDI Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: 2P COMBIVENT Q6 AND PRN
Reason TX not Given: INSTRUCT PATIENT

PF Before: BS Pre: DIM Cough: N Suction: N
PF After: CL
Fields: ALL LOBES RR Pre: 16 Strength:
HR Pre: 68 BS Post: CL RR Post: 16 Productive: N

474

Intervention Description				Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/26/07 Time: 1430 (continued)

3118 RT: Inhalation Therapy Subsequent ($) (continued)
HR During: DIM Sputum Amount:
HR Post: 68 Fields: ALL LOBES Consistancy:
SaO2: 98--RA Sputum Color:
RT Continued: N Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments: PATIENT INSTRUCTED IN USE OF MDI AND SPACER. ADEQUATE TECHNIQUE DEMONSTRATED.

Activity Date: 05/26/07 Time: 1728

3118 RT: Inhalation Therapy Subsequent ($) D PS
- Ed Status 05/26/07 1728 his 05/26/07 1728 his A => D

Activity Date: 05/26/07 Time: 1807

3118 RT: Inhalation Therapy Subsequent ($) A PS
- Create 05/26/07 1807 MKR 05/26/07 1807 MKR
3320 RT: Oxygen Therapy Per 12 Hrs ($) A PS
- Create 05/26/07 1807 MKR 05/26/07 1807 MKR

Monogram	Initials	Name	Nurse Type
BER	RTBER	ROSSITER,BARBARA E.	RT
KBO	RTKO	OXENDINE,KELLI B.	RT
MKR	RTMR	ROBERTS,MICHAEL K.	RT
PDW	RTPW	WHETSELL,PAMELA D.	RT
PJS	RTPS1	STANLEY,PAULA J.	RT
SLH	RTSL1	HILDITCH,SUSAN L.	RT
TMP	RTTMP	PROFFIT,TINA M.	RT
his		automatic by program	

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA.VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** SCHEDULED MEDICATIONS ******

03471071 FAMOTIDINE 20 MG/2 ML VIAL (20 MG) 05/22/07 2100
(Pepcid) 06/21/07

DOSE: 20 MG IV Q12 SCH
COMMENTS: REFRIGERATE
IN A SYRINGE DRAW UP PEPCID DILUTE TO 10 MLS
WITH NS. PUSH OVER 2 MINUTES FOLLOW WITH FLUSH.
APPROVED INTERCHANGE FOR: TAGAMET AND ZANTAC

*** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

03471072 NITROGLYCERIN 1 PAC (None) 05/22/07 1800
(Nitrol) 06/21/07

DOSE: 1/2 INCH TOP Q6 SCH
COMMENTS: 1 PACKET = 1 INCH
SEND A DOSE MEASURING APPLICATOR FOR EACH DOSE
DOSE INSTR: 1/2 INCH

*** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

03471073 POTASSIUM CHLORIDE 20 MEQ TAB (20 MEQ) 05/22/07 1600 1800 2000
(K-Dur) 05/22/07

DOSE: 20 MEQ PO Q2H SCH
COMMENTS: DO NOT CRUSH OR CHEW. IF PATIENT
CANNOT SWALLOW, IT MAY BE DISSOLVED.

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471083 NICOTINE 14 MG PAT (14 MG) 05/22/07
(Nicotine Patch) 06/21/07

DOSE: 14 MG PATCH DAILY SCH
COMMENTS: REMOVE AT HS
NURSE TO DOCUMENT PATCH PLACEMENT
LOCATION: _____

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** SCHEDULED MEDICATIONS ******

03471084 CLOPIDOGREL 75 MG TAB (75 MG) 05/22/07
(Plavix) 06/21/07
DOSE: 75 MG PO DAILY SCH
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471085 ASPIRIN 81 MG TAB (81 MG) 05/22/07
(Bayer Asa Child Chewable) 06/21/07
DOSE: 81 MG PO DAILY SCH
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471086 METOPROLOL 50 MG TAB (50 MG) 05/22/07 2100 8
(Lopressor) 06/21/07 BP 11e CJ
DOSE: 50 MG PO BID SCH
COMMENTS: ATC
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

****** IV MEDICATIONS ******

03471078 NACL 0.9 %/KCL 20 MEQ/1000 ML BAG (1000 ML) 05/22/07 1700
(KCl 20 Meq Premix/NaCl) 06/21/07 1850 mv
RATE: 75 MLS/HR DUR: 13 FREQ: .Q13H20M
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

TUBING CHANGE INITIALS_____TIME_____

03471061 AZITHROMYCIN 500 MG VIAL (500 MG) 05/22/07 1700
(Zithromax) 05/27/07 NV
IN: NACL 0.9% 250 ML BAG (250 ML)
(Nacl.9 250ML Bag)
RATE: 250 MLS/HR DUR: 1 FREQ: Q24H
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

TUBING CHANGE INITIALS_____TIME_____

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA.VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** IV MEDICATIONS *****				
03471077	CEFTRIAXONE 1 G/50 ML PREMIX (50 ML) (Rocephin 1 G Pm)	05/22/07 06/01/07			
	RATE: 100 MLS/HR DUR: 0 FREQ: Q24H-10				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

Given in ER

TUBING CHANGE INITIALS_____TIME_____

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

******** PRN MEDICATIONS ********

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471079 PROMETHAZINE 25 MG/1 ML VIAL (12.5 MG) 05/22/07 DOSE: 12.5 MG IV
(Phenergan) 06/21/07 PRN: Q4

COMMENTS: ** FOR NAUSEA/VOMITING * WARNING VESICANT **
IF GIVING IV, DILUTE TO 10MLS WITH SALINE
GIVE THROUGH A MINIMUM 20 GAUGE CATHLON
INSURE PATENCY OF IV PRIOR TO ADMINISTRATION
GIVE OVER 5 MINUTES. STOP IF PATIENT HAS PAIN

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
2045	IM	12.5			nausiated	2230	IM				better

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471082 ACETAMINOPHEN 325 MG CAPT (None) 05/22/07 DOSE: 1-2 TABS PO
(TYLENOL) 06/21/07 PRN: Q4

COMMENTS: FOR PAIN
DO NOT EXCEED 4 GRAMS PER DAY

DOSE INSTR: 1-2 TABS

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1810	PO	2 tabs	S	1	c/o HA						

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03471087 GUAIFENESIN/DEXTROMETHORPHAN 10 ML MC (None) 05/22/07 DOSE: 1-2 TSP POL
(Robitussin Dm) 06/21/07 PRN: Q4

COMMENTS: FOR COUGH
MEDCUP

DOSE INSTR: 1-2 TSP

**** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
2107	G	10ml									

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	****** RESPIRATORY MEDICATIONS ******				
03471080	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07			
	DOSE: 2.5 MG INH RQ4			PRN	
	COMMENTS: FOR SOB/WHEEZING *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE **				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471081	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07			2000 SA
	DOSE: 2.5 MG INH RQ4			SCH	1720 JP
	COMMENTS: *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE **				
	** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

Atrovent Q4ATC 1720 JP 2000 SA

- Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30958
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: BSA:
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/22/07-0001 - 05/23/07-0000
RUN DATE/TIME: 05/22/07-1659
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/22 MM/ Lovenox 1mg/kg SC q12° 2100 /JH

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	**** SCHEDULED MEDICATIONS ****				
03471071	FAMOTIDINE 20 MG/2 ML VIAL (20 MG) (Pepcid)	05/22/07 06/21/07		0900 KW	2100
	DOSE: 20 MG IV Q12 SCH COMMENTS: REFRIGERATE IN A SYRINGE DRAW UP PEPCID DILUTE TO 10 MLS WITH NS. PUSH OVER 2 MINUTES FOLLOW WITH FLUSH. APPROVED INTERCHANGE FOR: TAGAMET AND ZANTAC *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471072	NITROGLYCERIN 1 PAC (None) (Nitrol)	05/22/07 06/21/07	0001	1200 BP=	1800
	DOSE: 1/2 INCH TOP Q6 SCH COMMENTS: 1 PACKET = 1 INCH SEND A DOSE MEASURING APPLICATOR FOR EACH DOSE DOSE INSTR: 1/2 INCH *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK			PG 5/23/07 1305	
03471083	NICOTINE 14 MG PAT (14 MG) (Nicotine Patch)	05/22/07 06/21/07		0900 KW	
	DOSE: 14 MG PATCH DAILY SCH COMMENTS: REMOVE AT HS NURSE TO DOCUMENT PATCH PLACEMENT LOCATION: Rt shoulder *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471084	CLOPIDOGREL 75 MG TAB (75 MG) (Plavix)	05/22/07 06/21/07		0900 KW	
	DOSE: 75 MG PO DAILY SCH *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471085	ASPIRIN 81 MG TAB (81 MG) (Bayer Asa Child Chewable)	05/22/07 06/21/07		0900 KW	
	DOSE: 81 MG PO DAILY SCH *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968 For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA, VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** SCHEDULED MEDICATIONS *****				
03471086	METOPROLOL 50 MG TAB (50 MG) (Lopressor)	05/22/07 06/21/07		0900 KW	2100 TMP
	DOSE: 50 MG PO BID SCH COMMENTS: ATC			BP=149/63 P=79	189/76 78
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471326	ENOXAPARIN 80 MG/0.8 ML SYR (65 MG) (Lovenox)	05/22/07 06/21/07		0900 KW (H)	2100 MTA
	DOSE: 65 MG SQ Q12 SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	***** IV MEDICATIONS *****				
03471078	NACL 0.9 %/KCL 20 MEQ/1000 ML BAG (1000 ML) (KCl 20 Meq Premix/NaCl)	05/22/07 06/21/07	0620		1940
	RATE: 75 MLS/HR DUR: 13 FREQ: Q13H20M			DC 23:57	
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____ TIME_____				
03471061	AZITHROMYCIN 500 MG VIAL (500 MG) (Zithromax) IN: NACL 0.9% 250 ML BAG (250 ML) (Nacl.9 250ML Bag)	05/22/07 05/27/07			1700
	RATE: 250 MLS/HR DUR: 1 FREQ: Q24H				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS CD TIME 1700				
03471077	CEFTRIAXONE 1 G/50 ML PREMIX (50 ML) (Rocephin 1 G Pm)	05/22/07 06/01/07		1000 1919	
	RATE: 100 MLS/HR DUR: 0 FREQ: Q24H-1D				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS CD TIME MD				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471079 PROMETHAZINE 25 MG/1 ML VIAL (12.5 MG) 05/22/07 DOSE: 12.5 MG IV
(Phenergan) 06/21/07 PRN: Q4

COMMENTS: ** FOR NAUSEA/VOMITING * WARNING VESICANT **
IF GIVING IV, DILUTE TO 10MLS WITH SALINE
GIVE THROUGH A MINIMUM 20 GAUGE CATHLON
INSURE PATENCY OF IV PRIOR TO ADMINISTRATION
GIVE OVER 5 MINUTES. STOP IF PATIENT HAS PAIN

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471082 ACETAMINOPHEN 325 MG CAPT (None) 05/22/07 DOSE: 1-2 TABS PO
(TYLENOL) 06/21/07 PRN: Q4

COMMENTS: FOR PAIN
DO NOT EXCEED 4 GRAMS PER DAY

DOSE INSTR: 1-2 TABS

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
2105	~~MA~~	650mg	8	1	headache	2210	~~MA~~	7	1		still hurting

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	******* PRN MEDICATIONS *******				
03471087	GUAIFENESIN/DEXTROMETHORPHAN 10 ML MC (None) (Robitussin Dm)	05/22/07 06/21/07	DOSE: 1-2 TSP PRN: Q4		POL
	COMMENTS: FOR COUGH MEDCUP		DOSE INSTR: 1-2 TSP		
	**** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

P/C 5/23/07

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
0915	KW	1 Tsp	N/A	1	C/D Coughing	1015	KW	N/A	1		√ Cough
~~2210~~	~~N/A~~										

- Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
- Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	******* RESPIRATORY MEDICATIONS *******				
03471080	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07			
	DOSE: 2.5 MG INH RQ4 PRN COMMENTS: FOR SOB/WHEEZING *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471081	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07	0001 SH 0400 SH 0800 RJ	1200 RJ 1600 RJ	~~2000~~ 2030 KD
	DOSE: 2.5 MG INH RQ4 SCH COMMENTS: *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471123	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07	0001 SH 0400 SH 0800 RJ	1200 RJ 1600 RJ	~~2000~~ 2030 KD
	DOSE: 0.5 MG INH RQ4 SCH COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB RESPIRATORY TREATMENT ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471124	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07			
	DOSE: 0.5 MG INH PRN PRN COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB *** FOR USE BY RESPIRATORY THERAPIST *** ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/23/07-0001 - 05/24/07-0000
RUN DATE/TIME: 05/22/07-2028
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/23/07 Pepcid 20mg Po BID 2100 MMA

5/23/07 DC IVF

5/23/07 $FeSO_4$ 325 mg po tid — 2100 MMA

5/23/07 D/C Robitussin, begin Hycodan 1 tsp po q 4° prn

5/23/07 Tessalon perles 100mg po tid — 2100 MMA

- Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
- Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

PRN Medication Administration Record

DATE: 5/23/07

NURSE INITIALS:

MEDICATION ORDER: Percocet 2 po q 6° Prn

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1335		II	8	1	C/O ha	1405	CD	2	1		relief
2210	MA	II	8	1	headache	2330	MA	2	1		better

NURSE INITIALS:

MEDICATION ORDER:

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

NURSE INITIALS:

MEDICATION ORDER:

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

ALLERGIES

PATIENT [redacted]

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm See Form # 30968

G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted For Anxiety/Pain/Comfort Codes

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PRN Medication Administration Record

DATE: 5/23/07

NURSE INITIALS: [illegible]

MEDICATION ORDER: Hycodan 1 tsp po q 4° PRN

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1140	PO	5ml	6	1	c/o cough	1840	PO	2	1		[illegible]
2210	MA	5ml	—	1	cough	2330	MA	—	1		[illegible]

NURSE INITIALS:

MEDICATION ORDER:

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

NURSE INITIALS:

MEDICATION ORDER:

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

ALLERGIES

PATIENT [redacted]

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm See Form # 30968

G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07 2027
VERIFIED BY: J. Alaia RN

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** SCHEDULED MEDICATIONS ******

03471083 NICOTINE 14 MG PAT (14 MG) 05/22/07 0900 (2) arm
MWA (Nicotine Patch) 06/21/07
DOSE: 14 MG PATCH DAILY SCH
COMMENTS: REMOVE AT HS
NURSE TO DOCUMENT PATCH PLACEMENT
LOCATION: _____
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471084 CLOPIDOGREL 75 MG TAB (75 MG) 05/22/07 0900
MWA (Plavix) 06/21/07
DOSE: 75 MG PO DAILY SCH
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471085 ASPIRIN 81 MG TAB (81 MG) 05/22/07 0900
MWA (Bayer Asa Child Chewable) 06/21/07
DOSE: 81 MG PO DAILY SCH
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471086 METOPROLOL 50 MG TAB (50 MG) 05/22/07 0900 B/P 160/74 2100 MWA 147/74 71
MWA (Lopressor) 06/21/07
DOSE: 50 MG PO BID SCH
COMMENTS: ATC
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03471326 ENOXAPARIN 80 MG/0.8 ML SYR (65 MG) 05/22/07 0900 (B) 2100 D/C 5/24/07
MWA (Lovenox) 06/21/07
DOSE: 65 MG SQ Q12 SCH
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07 2027
VERIFIED BY: [illegible] Maria RN

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0600	0601-1600	1601-0000
	***** SCHEDULED MEDICATIONS *****				
03472252 MKA	FERROUS SULFATE 325 MG TAB (325 MG) (Ferrous Sulfate)	05/23/07 06/22/07		0900 MKA 1300	1800
	DOSE: 325 MG PO TID SCH				
	COMMENTS: DO NOT CRUSH OR CHEW				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472254 MKA	BENZONATATE 100 MG CAP (100 MG) (Tessalon Perles)	05/23/07 06/22/07		0600/MKA 0900 1300	1800
	DOSE: 100 MG PO TID SCH				
	COMMENTS: DO NOT CRUSH OR CHEW				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472255 MKA	FAMOTIDINE 20 MG TAB (20 MG) (Pepcid)	05/23/07 06/22/07	0700 MKA		2100
	DOSE: 20 MG PO BIDH2 SCH				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
	***** IV MEDICATIONS *****				
03471061 MKA	AZITHROMYCIN 500 MG VIAL (500 MG) (Zithromax) IN: NACL 0.9% 250 ML BAG (250 ML) (Nacl.9 250ML Bag)	05/22/07 05/27/07			1700
	RATE: 250 MLS/HR DUR: 1 FREQ: Q24H				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____TIME_____				
03471077 MKA	CEFTRIAXONE 1 G/50 ML PREMIX (50 ML) (Rocephin 1 G Pm)	05/22/07 06/01/07		1000	
	RATE: 100 MLS/HR DUR: 0 FREQ: Q24H-10				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____TIME_____				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07-2027
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

********* PRN MEDICATIONS *********

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471079 PROMETHAZINE 25 MG/1 ML VIAL (12.5 MG) 05/22/07 DOSE: 12.5 MG IV
(Phenergan) 06/21/07 PRN: Q4

COMMENTS: ** FOR NAUSEA/VOMITING * WARNING VESICANT **
IF GIVING IV. DILUTE TO 10MLS WITH SALINE
GIVE THROUGH A MINIMUM 20 GAUGE CATHLON
INSURE PATENCY OF IV PRIOR TO ADMINISTRATION
GIVE OVER 5 MINUTES. STOP IF PATIENT HAS PAIN

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1943	IM	12.5			HA N/V x1	2200	IM	-	1		better

~~ACUDOSE MACHINE/FLOOR STOCK~~
03471082 ACETAMINOPHEN 325 MG CAPT (None) 05/22/07 DOSE: 1-2 TABS PO
(TYLENOL) 06/21/07 PRN: Q4

COMMENTS: FOR PAIN
DO NOT EXCEED 4 GRAMS PER DAY

DOSE INSTR: 1-2 TABS

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07-2027
VERIFIED BY: T-Maria RN

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

******** PRN MEDICATIONS ********

03472256 OXYCODONE 5MG/APAP 325MG TABLET (2 TAB) 05/23/07 DOSE: 2 TAB PO
MWA (Percocet) 06/22/07 PRN: Q6

COMMENTS: DOSE INSTR:
DO NOT EXCEED 4 GRAMS PER DAY OF ACETAMINOPHEN

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1835	PO	1+1	9	1	C/O ha						

03472253 HYDROCODONE/HOMATROPINE 5 MG/5 ML 5ML (5 MG) 05/23/07 DOSE: 5 MG POL
MWA (Hycodan) 06/22/07 PRN: Q4

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
0240	MWA	5ml	—	1	for cough	0730	MWA	—	1		better
1110	PO	5ml	—	1	for cough	1150	PO	—	1		better
1545	PO	5ml	—	1	for Cough						

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07-2027
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** RESPIRATORY MEDICATIONS *****				
03471080	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07			
	DOSE: 2.5 MG INH RQ4 PRN COMMENTS: FOR SOB/WHEEZING *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471081	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07	0001 0400 0800	1200 1600	2000
	DOSE: 2.5 MG INH RQ4 SCH COMMENTS: *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471123	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07	0001 0400 0800	1200 1600	2000
	DOSE: 0.5 MG INH RQ4 SCH COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB RESPIRATORY TREATMENT ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471124	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07			
	DOSE: 0.5 MG INH PRN PRN COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB *** FOR USE BY RESPIRATORY THERAPIST *** ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/24/07-0001 - 05/25/07-0000
RUN DATE/TIME: 05/23/07-2027
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001 0800	0801 1600	1601 0000

5/24/07 Magnesium Oxide 800mg po BID 1800

5/24/07 Lasix 20mg IV p transfusion

5/24 Type and cross 2 units PRBCs, transfuse + omit over 4° ⊘ avail for hgb 8.7

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: T. Alaia RN

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** SCHEDULED MEDICATIONS *****				
03471083	NICOTINE 14 MG PAT (14 MG) (Nicotine Patch)	05/22/07 06/21/07		0900	
	DOSE: 14 MG PATCH DAILY SCH				
	COMMENTS: REMOVE AT HS NURSE TO DOCUMENT PATCH PLACEMENT LOCATION: Left arm				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471084	CLOPIDOGREL 75 MG TAB (75 MG) (Plavix)	05/22/07 06/21/07		0900	
	DOSE: 75 MG PO DAILY SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471085	ASPIRIN 81 MG TAB (81 MG) (Bayer Asa Child Chewable)	05/22/07 06/21/07		0900	
	DOSE: 81 MG PO DAILY SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471086	METOPROLOL 50 MG TAB (50 MG) (Lopressor)	05/22/07 06/21/07	97 / 71	0900	2100
	DOSE: 50 MG PO BID SCH				
	COMMENTS: ATC				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472252	FERROUS SULFATE 325 MG TAB (325 MG) (Ferrous Sulfate)	05/23/07 06/22/07		1200	1800
	DOSE: 325 MG PO TID SCH				
	COMMENTS: DO NOT CRUSH OR CHEW				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA.VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: T. Hawkins Pharm

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** SCHEDULED MEDICATIONS *****				
03472254 MTA	BENZONATATE 100 MG CAP (100 MG) (Tessalon Perles)	05/23/07 06/22/07		1300 Kyt	1800 Kyt
	DOSE: 100 MG PO TID SCH				
	COMMENTS: DO NOT CRUSH OR CHEW				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472255 MTA	FAMOTIDINE 20 MG TAB (20 MG) (Pepcid)	05/23/07 06/22/07	0700 MTA		2100
	DOSE: 20 MG PO BIDHZ SCH				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03473610 MTA	MAGNESIUM OXIDE 400 MG TAB (800 MG) (Magnesium Oxide Tab)	05/24/07 06/23/07		0800	2100
	DOSE: 800 MG PO BID SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	***** IV MEDICATIONS *****				
03471061 MTA	AZITHROMYCIN 500 MG VIAL (500 MG) (Zithromax)	05/22/07 05/27/07			1700
	IN: NACL 0.9% 250 ML BAG (250 ML) (Nacl.9 250ML Bag)				
	RATE: 250 MLS/HR DUR: 1 FREQ: Q24H				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____ TIME_____				
03471077 MTA	CEFTRIAXONE 1 G/50 ML PREMIX (50 ML) (Rocephin 1 G Pm)	05/22/07 06/01/07		1000	
	RATE: 100 MLS/HR DUR: 0 FREQ: Q24H-10				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____ TIME_____				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

********** PRN MEDICATIONS **********

ACUDOSE MACHINE/FLOOR STOCK

03471079 PROMETHAZINE 25 MG/1 ML VIAL (12.5 MG) 05/22/07 DOSE: 12.5 MG IV
(Phenergan) 06/21/07 PRN: Q4

COMMENTS: ** FOR NAUSEA/VOMITING * WARNING VESICANT **
IF GIVING IV. DILUTE TO 10MLS WITH SALINE
GIVE THROUGH A MINIMUM 20 GAUGE CATHLON
INSURE PATENCY OF IV PRIOR TO ADMINISTRATION
GIVE OVER 5 MINUTES. STOP IF PATIENT HAS PAIN

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

ACUDOSE MACHINE/FLOOR STOCK

03471082 ACETAMINOPHEN 325 MG CAPT (None) 05/22/07 DOSE: 1-2 TABS PO
(TYLENOL) 06/21/07 PRN: Q4

COMMENTS: FOR PAIN
DO NOT EXCEED 4 GRAMS PER DAY

DOSE INSTR: 1-2 TABS

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
2000	RR	2	6	1	Headache	2100	RR	6	1		"still hurts"

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: T-Alaiza RN

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

******* PRN MEDICATIONS *******

03472256 OXYCODONE 5MG/APAP 325MG TABLET (2 TAB) 05/23/07 DOSE: 2 TAB PO
MPA (Percocet) 06/22/07 PRN: Q6

COMMENTS: DOSE INSTR:
DO NOT EXCEED 4 GRAMS PER DAY OF ACETAMINOPHEN

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
2145	RR	2tab	10	1	headache	2245	RR	—	2	18	better

03472253 HYDROCODONE/HOMATROPINE 5 MG/5 ML 5ML (5 MG) 05/23/07 DOSE: 5 MG POL
MPA (Hycodan) 06/22/07 PRN: Q4

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
0610	MPA	5ml	—	1	for cough						

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:Z29998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	****** RESPIRATORY MEDICATIONS ******				
03471080	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07			
	DOSE: 2.5 MG INH RQ4 PRN COMMENTS: FOR SOB/WHEEZING *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471081	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/22/07 06/21/07	0400 0800	1200 1600	2000
	DOSE: 2.5 MG INH RQ4 SCH COMMENTS: *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471123	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07	0400 0800	1200 1600	2000
	DOSE: 0.5 MG INH RQ4 SCH COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB RESPIRATORY TREATMENT ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03471124	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/22/07 06/21/07			
	DOSE: 0.5 MG INH PRN PRN COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB *** FOR USE BY RESPIRATORY THERAPIST *** ** OBTAIN FROM ACUDOSE MACHINE ** *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/25/07-0001 - 05/26/07-0000
RUN DATE/TIME: 05/24/07-2019
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1500	1601-0000

5/24 MA Transfuse 1 unit PRBC over 4 HRS ——
Cxr order; check blood availability
5/25 HGB 9.8

5/24 MA Lasix 20 mg IV ℙ transfusion ——

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	********** SCHEDULED MEDICATIONS **********				
03471083	NICOTINE 14 MG PAT (14 MG) (Nicotine Patch)	05/22/07 06/21/07		0900	
	DOSE: 14 MG PATCH DAILY SCH COMMENTS: REMOVE AT HS NURSE TO DOCUMENT PATCH PLACEMENT LOCATION: _____ *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471084	CLOPIDOGREL 75 MG TAB (75 MG) (Plavix)	05/22/07 06/21/07		0900	
	DOSE: 75 MG PO DAILY SCH *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471085	ASPIRIN 81 MG TAB (81 MG) (Bayer Asa Child Chewable)	05/22/07 06/21/07		0900	
	DOSE: 81 MG PO DAILY SCH *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03471086	METOPROLOL 50 MG TAB (50 MG) (Lopressor)	05/22/07 06/21/07	1644 73 P73	0900	2100
	DOSE: 50 MG PO BID SCH COMMENTS: ATC *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472252	FERROUS SULFATE 325 MG TAB (325 MG) (Ferrous Sulfate)	05/23/07 06/22/07		1300	1800
	DOSE: 325 MG PO TID SCH COMMENTS: DO NOT CRUSH OR CHEW *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	****** SCHEDULED MEDICATIONS ******				
03472254	BENZONATATE 100 MG CAP (100 MG) (Tessalon Perles)	05/23/07 06/22/07		0900 1300	1800
	DOSE: 100 MG PO TID SCH COMMENTS: DO NOT CRUSH OR CHEW *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03472255	FAMOTIDINE 20 MG TAB (20 MG) (Pepcid)	05/23/07 06/22/07	0700		2100
	DOSE: 20 MG PO BIDH2 SCH *** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03473610	MAGNESIUM OXIDE 400 MG TAB (800 MG) (Magnesium Oxide Tab)	05/24/07 06/23/07		0900	2100
	DOSE: 800 MG PO BID SCH *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	****** IV MEDICATIONS ******				
03471061	AZITHROMYCIN 500 MG VIAL (500 MG) (Zithromax) IN: NACL 0.9% 250 ML BAG (250 ML) (Nacl.9 250ML Bag)	05/22/07 05/27/07			1700
	RATE: 250 MLS/HR DUR: 1 FREQ: Q24H *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____TIME_____				
03471077	CEFTRIAXONE 1 G/50 ML PREMIX (50 ML) (Rocephin 1 G Pm)	05/22/07 06/01/07		1000	
	RATE: 100 MLS/HR DUR: 0 FREQ: Q24H-10 *** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
	TUBING CHANGE INITIALS_____TIME_____				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA, VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX#	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

~~ACUDOSE MACHINE/FLOOR STOCK~~

03471079 PROMETHAZINE 25 MG/1 ML VIAL (12.5 MG) 05/22/07 DOSE: 12.5 MG IV
(Phenergan) 06/21/07 PRN: Q4

COMMENTS: ** FOR NAUSEA/VOMITING * WARNING VESICANT **
IF GIVING IV, DILUTE TO 10MLS WITH SALINE
GIVE THROUGH A MINIMUM 20 GAUGE CATHLON
INSURE PATENCY OF IV PRIOR TO ADMINISTRATION
GIVE OVER 5 MINUTES. STOP IF PATIENT HAS PAIN

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

~~ACUDOSE MACHINE/FLOOR STOCK~~

03471082 ACETAMINOPHEN 325 MG CAPT (None) 05/22/07 DOSE: 1-2 TABS PO
(TYLENOL) 06/21/07 PRN: Q4

COMMENTS: FOR PAIN
DO NOT EXCEED 4 GRAMS PER DAY

DOSE INSTR: 1-2 TABS

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03472256 OXYCODONE 5MG/APAP 325MG TABLET (2 TAB) 05/23/07 DOSE: 2 TAB PO
(Percocet) 06/22/07 PRN: Q6
pk

COMMENTS: DOSE INSTR:
DO NOT EXCEED 4 GRAMS PER DAY OF ACETAMINOPHEN

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

03472253 HYDROCODONE/HOMATROPINE 5 MG/5 ML 5ML (5 MG) 05/23/07 DOSE: 5 MG POL
(Hycodan) 06/22/07 PRN: Q4
pk

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA,VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	******** RESPIRATORY MEDICATIONS ********				
03474337	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/24/07 06/23/07	0800	1200 1600	2000
	DOSE: 2.5 MG INH RQID SCH				
	COMMENTS: *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE **				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03474340	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/24/07 06/23/07			
	DOSE: 0.5 MG INH PRN PRN				
	COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB *** FOR USE BY RESPIRATORY THERAPIST *** ** OBTAIN FROM ACUDOSE MACHINE **				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03474341	IPRATROPIUM BROMIDE 0.5 MG/2.5 ML AMP (0.5 MG) (Atrovent)	05/24/07 06/23/07	0800	1200 1600	2000
	DOSE: 0.5 MG INH RQID SCH				
	COMMENTS: GIVE ALBUTEROL WITH IPRATROPIUM FOR DUONEB RESPIRATORY TREATMENT ** OBTAIN FROM ACUDOSE MACHINE **				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				
03474342	ALBUTEROL 2.5 MG/0.5 ML AMP (2.5 MG) (Ventolin)	05/24/07 06/23/07			
	DOSE: 2.5 MG INH PRN PRN				
	COMMENTS: FOR SOB/WHEEZING *** FOR USE BY RESPIRATORY THERAPIST *** IF USED ALONE - MIX WITH 2.5 MLS OF NS ** OBTAIN FROM ACUDOSE MACHINE **				
	*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12756622 WINDHAM,TAMMY ELIZABETH TELE 312 1
MEDICAL RECORD #: 229998
AGE: 39 SEX: F WT: 65.544 BSA: 1.72
ADMITTED: 05/22/07 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: LLL PNEUMONIA, VOMITING
ADM COMMENT:
MAR DATE: 05/26/07-0001 - 05/27/07-0000
RUN DATE/TIME: 05/25/07-1948
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/26/07 NS FLUSH 0600 ~~1400~~ ~~2000~~
pb

5/26/07 - B12 1000 mcg IM x 1 dose now. 1415 mH
5/26/07 - Folic acid 1 mg po x 1 dose now. 1415 mH
5/26/07 - amnicef 300 mg po Bid - 1st dose now. 1415 mH

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12756622 - WINDHAM,TAMMY ELIZABETH
TELE 312-1 (U:229998)

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001943

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

TUOMEY HEALTHCARE SYSTEM
MEDICATION ADMINISTRATION RECORD

PAGE:_____

Date:_____

Patient Name:_____

Account #:_____ Unit #:_____ Room #:_____ Checked By:_____

Diagnosis:_____

_____

Allergies:_____

RX# Start Date DC Date	GENERIC NAME / TRADE NAME DOSE	SIG	ROUTE	0001-0800	0801-1600	1601-2400
5/26	Combivent MDI 2 Puffs 96°					
5/26	advair diskus 250/50 1 puff @ 12°					

A - Lt UQ
B - Rt UQ
C - Lt Thigh
D - Rt Thigh

E - Lt Arm
F - Rt Arm
G - Lt A
H - Rt Abdomen

SA - Self Administered
O - Omitted Circle Time

[redacted] 509

19390 Rev. 7/10/03

5730

HOME MEDICATION INVENTORY

001944

RUN DATE: 05/22/07
RUN TIME: 1938
RUN USER: 0

TUOMEY REGIONAL MEDICAL CTR NUR *LIVE*

Page : 1 of 1

PATIENT INTERVENTION ACTIVITY

Patient: WINDHAM,TAMMY ELIZABETH
Account #: 12756622
Admit Date: 05/22/07
Status: ADM IN
Attending: MEDICAL SERVICES - TMP

Age/Sex: 39 F
Unit #: 229998
Location: TELE
Room/Bed: 312-1

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
METOPROLOL TARTRATE	50MG	BID	PO
Last Dose Taken: 05/22/07	**Ordered on Admission:**	**If yes, Same does:**	
	If no, MD Notified (Name and time):		
PLAVIX	75MG	DAILY	PO
Last Dose Taken: 05/22/07	**Ordered on Admission:**	**If yes, Same does:**	
	If no, MD Notified (Name and time):		
ASA	81MG	DAILY	PO
Last Dose Taken: 05/22/07	**Ordered on Admission:**	**If yes, Same does:**	
	If no, MD Notified (Name and time):		

****

HERBAL/HOMEOPATHIC REMEDIES

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE

	Date	Time	Monogram	Initials	Name	Nurse Type
Occurred:	05/22/07	1936	NRV	NSNV	VAN PATTEN,NAOMI R.	RN
Recorded:	05/22/07	1938	NRV	NSNV	VAN PATTEN,NAOMI R.	RN

Recorded at terminal: TELEM002.3

510

001945

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/22/07		**Time: 1715**							
3510	Skin: ADM-D/C-weekly photo & measurement						A	Tu	CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV			
5600	***Education Assessment/Admission***						A	ONCE	CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV			
5601	Teaching: Patient/Family Education						A	OG	CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV			
Activity Date: 05/22/07		**Time: 1716**							
031	Rounds: RN/LPN Q2 even hours						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
032	Rounds: CT/CNA Q2 odd hours						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
438	Patient Level of Assistance						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
453	D/C IV/INT Needle						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
1805	AM/PM Bathing and ADL care						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
3141	Oxygen Therapy						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
3353	Pneumococcal vaccine given						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
3357	Pneumonia Vaccine Not Given Reason						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
4190	IV Intravenous Insertion						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
4200	IV Intravenous Therapy						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
6540	Infection Control						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Ed Status	05/22/07	1716	NRV	05/22/07	1716	NRV			None => X
6681	Pulse Oximetry (SAO2)						A		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
Activity Date: 05/22/07		**Time: 1732**							
450	Dietary Intake						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
451	Consults						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
452	Activity BEDREST						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			

511

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/22/07		**Time: 1732**							
4200	IV Intravenous Therapy						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
6680	Vital Signs, Monitor Q4H						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
6690	Intake/Output						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
6691	Weight/Height						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
7690	Laboratory Data Interpretation						A		OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT			
Activity Date: 05/22/07		**Time: 1810**							
6690	Intake/Output						A		OE
- Document	05/22/07	1810	MFE	05/22/07	1811	MFE			

********** INTAKE **********

Oral Intake: 240 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 1 BM: (# of times):
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/22/07		**Time: 1935**							
5600	***Education Assessment/Admission***						A	ONCE	CP
- Document	05/22/07	1935	NRV	05/22/07	1936	NRV			

Patient/Family Education Assessment

When patient is unable to participate in the educational assessment, family member/significant other to be assessed.

Is the patient able to participate in education? Y
If patient is not able to participate in teaching, who will?
If not patient, give name AND relationship

512

001947

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/22/07 Time: 1935 (continued)

5600 ***Education Assessment/Admission*** (continued)
Patient s primary language: English

Preference for Teaching Method: Lecture
Packet

Does learner have any difficulty with reading or writing? N
Explain difficulties with reading and writing:

Exhibits ability to grasp concepts and respond to questions? Y
Explain difficulities:

Barriers to Learning: N Desire/Motivation Level:
Type of learning barriers: SEEMS INTERESTED

Knowledge level related to health problems: Limited

****Admission/Orientation Teaching****

Admission/Orientation teaching subjects are automatically documented when you file this assessment. Please include any deviations from the standards in the admission note.

Does patient/family verbalize understanding of home medications purpose and use? No

Comments about medication knowledge:

Pain Scale to be used for patient: Numeric

Method used for admission teaching/orientation: Lecture
Handout/Literature

Receptiveness to admission teaching/orientation: Seems interested

Teaching outcome: States understanding

Identified Education Needs: Illness/Treatment
Medications

Name of the person given the brochures
(Who Participates in Your Medical Care)?
AND
(Freshstart: Smoking Cessation pamphlet) : PATIENT

513

Intervention	Description	Sts	Direction	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Comment	Documented Units Change

Activity Date: 05/22/07 Time: 1935 (continued)

5600 ***Education Assessment/Admission*** (continued)

Teaching Packets should be documented using the Teaching intervention.

Please print this Education Assessment and file with the Admission History.

Activity Date: 05/22/07 Time: 1940

031	Rounds: RN/LPN Q2 even hours	A		CP
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
438	Patient Level of Assistance	A		CP
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
Patient Level of Assistance MIN	Minimun			
452	Activity BEDREST	A		OE
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
3141	Oxygen Therapy	A		CP
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
4200	IV Intravenous Therapy	A		CP
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		
6540	Infection Control	A		CP
- Document	05/22/07 1940 NRV	05/22/07 1940 NRV		

Activity Date: 05/22/07 Time: 2000

031	Rounds: RN/LPN Q2 even hours	A		CP
- Document	05/22/07 2000 ABG	05/23/07 0435 ABG		
438	Patient Level of Assistance	A		CP
- Document	05/22/07 2000 ABG	05/23/07 0435 ABG		
Patient Level of Assistance MIN	Minimun			
452	Activity BEDREST	A		OE
- Document	05/22/07 2000 ABG	05/23/07 0435 ABG		

Activity Date: 05/22/07 Time: 2123

032	Rounds: CT/CNA Q2 odd hours	A		CP
- Document	05/22/07 2123 TWB	05/22/07 2124 TWB		
	Were rounds made per protocol? Y			
450	Dietary Intake	A		OE
- Document	05/22/07 2123 TWB	05/22/07 2124 TWB		
Which meal & how much eaten? Snack Refused				

Intervention	Description	Sts	Direction	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 0020

6680 Vital Signs, Monitor A OE
Q4H
- Document 05/23/07 0020 TWB 05/23/07 0021 TWB
Temp: 96.4 Temp Source: ORAL

Respirations: 20

Heart Rate: 74 Hrt Rate Source: RADIAL

BP: 104/65 BP Source: SUPINE

SAO2: O2 source:

Activity Date: 05/23/07 Time: 0623

6680 Vital Signs, Monitor A OE
Q4H
- Document 05/23/07 0623 TWB 05/23/07 0625 TWB
Temp: 97.1 Temp Source: ORAL

Respirations: 20

Heart Rate: 84 Hrt Rate Source: RADIAL

BP: 142/71 BP Source: SUPINE

SAO2: 95 O2 source: RA
6690 Intake/Output A OE
- Document 05/23/07 0623 TWB 05/23/07 0626 TWB

********** INTAKE **********

Oral Intake: 360 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 250 BM: liquid (mls):
Urine (# of times): BM: (# of times):
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change

Activity Date: 05/23/07 Time: 1019

032 Rounds: CT/CNA — A — CP
Q2 odd hours
- Document 05/23/07 1019 MFE 05/23/07 1019 MFE
Were rounds made per protocol? Y

1805 AM/PM Bathing and ADL care — A — CP
- Document 05/23/07 1019 MFE 05/23/07 1019 MFE

AM/PM Care
Shower

Comments:

Activity Date: 05/23/07 Time: 1347

7320 Case Management — A — PS
- Create 05/23/07 1347 MLS 05/23/07 1347 MLS

Activity Date: 05/23/07 Time: 1504

7690 Laboratory Data Interpretation — A — OE
5/24: CBC, STOOL FOR BLOOD X 3
5/23: IF HGB LESS THAN 8.5 GIVE 1 UNIT PRBC
- Create 05/23/07 1504 DCT 05/23/07 1504 DCT

Activity Date: 05/23/07 Time: 1533

450 Dietary Intake — A — OE
- Document 05/23/07 1533 MFE 05/23/07 1533 MFE
Which meal & how much eaten? Dinner 75%

6680 Vital Signs, Monitor — A — OE
Q4H
- Document 05/23/07 1533 MFE 05/23/07 1535 MFE
Temp: 96.7 Temp Source: ORAL

Respirations: 20

Heart Rate: 76 Hrt Rate Source: RADIAL

BP: 111/59 BP Source: SUPINE

SAO2: 97 O2 source: RA

Activity Date: 05/23/07 Time: 1848

450 Dietary Intake — A — OE
- Document 05/23/07 1848 MFE 05/23/07 1848 MFE
Which meal & how much eaten? Dinner none

516

Intervention Description						Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 1848

6690 Intake/Output A OE
- Document 05/23/07 1848 MFE 05/23/07 1849 MFE

********** INTAKE **********

Oral Intake: 1080 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 800 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/23/07 Time: 2010

031 Rounds: RN/LPN A CP
Q2 even hours
- Document 05/23/07 2010 TA 05/24/07 0153 TA
438 Patient Level of Assistance A CP
- Document 05/23/07 2010 TA 05/24/07 0153 TA
Patient Level of Assistance MIN Minimun
452 Activity A OE
BEDREST
- Document 05/23/07 2010 TA 05/24/07 0153 TA
4200 IV Intravenous Therapy A CP
- Document 05/23/07 2010 TA 05/24/07 0153 TA
6680 Vital Signs, Monitor A OE
Q4H
- Document 05/23/07 2010 TA 05/24/07 0153 TA
Temp: 95.9 Temp Source: ORAL

Respirations: 20

Heart Rate: 78 Hrt Rate Source: APICAL

BP: 159/76 BP Source: SUPINE

SAO2: 98 O2 source: RA

517

001952

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change

Activity Date: 05/23/07 Time: 2200

4190 IV Intravenous Insertion A CP
- Document 05/23/07 2200 TA 05/24/07 0029 TA
Site: RT Forearm

Needle Diameter: 20 gauge

Needle Length: 1 inch

Time of IV start: 2200

Total # Venipuncture: 1

Time of site care: 2200

Reason for restart: Other

Activity Date: 05/24/07 Time: 0011

6680 Vital Signs, Monitor Q4H A OE
- Document 05/24/07 0011 TJH 05/24/07 0011 TJH
Temp: 96.3 Temp Source: ORAL

Respirations: 20

Heart Rate: 66 Hrt Rate Source: RADIAL

BP: 119/62 BP Source: SUPINE

SAO2: O2 source:

Activity Date: 05/24/07 Time: 0029

4190 IV Intravenous Insertion A CP
- Ed Text 05/24/07 0029 TA 05/24/07 0029 TA

Activity Date: 05/24/07 Time: 0339

413 Telemetry A PS
- Create 05/24/07 0339 TA 05/24/07 0339 TA
- Document 05/24/07 0339 TA 05/24/07 0339 TA
Rhythm: SR WITH DEP ST

Activity Date: 05/24/07 Time: 0558

450 Dietary Intake A OE
- Document 05/24/07 0558 TJH 05/24/07 0558 TJH
Which meal & how much eaten? Snack 50%

518

001953

Intervention	Description	Sts	Direction	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 0558

6680 Vital Signs, Monitor A OE
Q4H
- Document 05/24/07 0558 TJH 05/24/07 0559 TJH
Temp: 96.2 Temp Source: ORAL

Respirations: 20

Heart Rate: 79 Hrt Rate Source: RADIAL

BP: 87/55 BP Source: SUPINE

SAO2: O2 source:

Activity Date: 05/24/07 Time: 0559

6690 Intake/Output A OE
- Document 05/24/07 0559 TJH 05/24/07 0559 TJH
********** INTAKE **********

Oral Intake: 474 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 500 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/24/07 Time: 0830

031 Rounds: RN/LPN A CP
Q2 even hours
- Document 05/24/07 0830 PJW 05/24/07 1515 PJW
413 Telemetry A PS
- Document 05/24/07 0830 PJW 05/24/07 1515 PJW
Rhythm: SR WITH DEP ST

519

001954

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/24/07		**Time: 0830**							
438	Patient Level of Assistance						A		CP
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW			
Patient Level of Assistance MOD Moderate									
452	Activity						A		OE
	BEDREST								
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW			
4200	IV Intravenous Therapy						A		CP
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW			
Activity Date: 05/24/07		**Time: 0950**							
032	Rounds: CT/CNA						A		CP
	Q2 odd hours								
- Document	05/24/07	0950	TLJ	05/24/07	0950	TLJ			
Were rounds made per protocol? Y									
450	Dietary Intake						A		OE
- Document	05/24/07	0950	TLJ	05/24/07	0950	TLJ			
Which meal & how much eaten? Breakfast 100%									
1805	AM/PM Bathing and ADL care						A		CP
- Document	05/24/07	0950	TLJ	05/24/07	0950	TLJ			
AM/PM Care									
Shower									
Comments:									
CHANGED LINEN									
Activity Date: 05/24/07		**Time: 1441**							
032	Rounds: CT/CNA						A		CP
	Q2 odd hours								
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ			
Were rounds made per protocol? Y									
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ			
Were rounds made per protocol? Y									
450	Dietary Intake						A		OE
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ			
Which meal & how much eaten? Lunch 100%									
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ			
Which meal & how much eaten? Lunch 100%									
Activity Date: 05/24/07		**Time: 1843**							
032	Rounds: CT/CNA						A		CP
	Q2 odd hours								
- Document	05/24/07	1843	TLJ	05/24/07	1843	TLJ			
Were rounds made per protocol? Y									

520

001955

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 1843

450 Dietary Intake A OE
- Document 05/24/07 1843 TLJ 05/24/07 1843 TLJ
Which meal & how much eaten? Dinner 100%
6690 Intake/Output A OE
- Document 05/24/07 1843 TLJ 05/24/07 1843 TLJ

********** INTAKE **********

Oral Intake: 657 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 1150 BM: liquid (mls):
Urine (# of times): BM: (# of times):
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/24/07 Time: 1950

031 Rounds: RN/LPN A CP
Q2 even hours
- Document 05/24/07 1950 TA 05/25/07 0318 TA
438 Patient Level of Assistance A CP
- Document 05/24/07 1950 TA 05/25/07 0318 TA
Patient Level of Assistance IND Independent
452 Activity A OE
BEDREST
- Document 05/24/07 1950 TA 05/25/07 0318 TA
4200 IV Intravenous Therapy A CP
- Document 05/24/07 1950 TA 05/25/07 0318 TA
6680 Vital Signs, Monitor A OE
Q4H
- Document 05/24/07 1950 TA 05/25/07 0319 TA
Temp: Temp Source:

521

Respirations: 19

Heart Rate: 71 Hrt Rate Source: APICAL

BP: 147/76 BP Source: SUPINE

Intervention Description						Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time by	Comment	Documented Units		Change
Activity Date: 05/24/07 Time: 1950 (continued)									
6680	Vital Signs, Monitor (continued)								
SAO2:	96			O2 source:			RA		
7690	Laboratory Data Interpretation 5/24: CBC, STOOL FOR BLOOD X 3 5/23: IF HGB LESS THAN 8.5 GIVE 1 UNIT PRBC					A			OE
- Document	05/24/07	1950	TA	05/25/07	0319 TA				
Activity Date: 05/25/07 Time: 0035									
450	Dietary Intake					A			OE
- Document	05/25/07	0035	TJH	05/25/07	0035 TJH				
Which meal & how much eaten? Snack 50%									
6680	Vital Signs, Monitor Q4H					A			OE
- Document	05/25/07	0035	TJH	05/25/07	0036 TJH				
Temp:	95.6			Temp Source:			ORAL		
Respirations:	20								
Heart Rate:	68			Hrt Rate Source:			RADIAL		
BP:	146/65			BP Source:			SUPINE		
SAO2:				O2 source:					
Activity Date: 05/25/07 Time: 0319									
4190	IV Intravenous Insertion					A			CP
- Ed Text	05/25/07	0319	TA	05/25/07	0319 TA				
4200	IV Intravenous Therapy					A			OE
- Ed Text	05/25/07	0319	TA	05/25/07	0319 TA				
Activity Date: 05/25/07 Time: 0343									
413	Telemetry					A			PS
- Document	05/25/07	0343	TA	05/25/07	0344 TA				
Rhythm: SR DEP ST									
Activity Date: 05/25/07 Time: 0515									
6680	Vital Signs, Monitor Q4H					A			OE
- Document	05/25/07	0515	TJH	05/25/07	0515 TJH				
Temp:	97.0			Temp Source:			ORAL		
Respirations:	20								

522

Intervention Description Sts Direction From

Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units Change

Activity Date: 05/25/07 Time: 0515 (continued)

6680 Vital Signs, Monitor (continued)
Heart Rate: 72 Hrt Rate Source: RADIAL

BP: 94/55 BP Source: SUPINE

SAO2: O2 source:

6690 Intake/Output A OE
- Document 05/25/07 0515 TJH 05/25/07 0515 TJH

********** INTAKE **********

Oral Intake: 237 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 1 BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/25/07 Time: 0731

6680 Vital Signs, Monitor A OE
Q4H
- Document 05/25/07 0731 WJT 05/25/07 0732 WJT
Temp: 97.3 Temp Source: ORAL

Respirations: 18

Heart Rate: 85 Hrt Rate Source: RADIAL

BP: 97/71 BP Source: SUPINE

SAO2: 94 O2 source: RA

Activity Date: 05/25/07 Time: 0835

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/25/07 0835 TLJ 05/25/07 0835 TLJ

523

001958

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/25/07		**Time: 0835**		**(continued)**					
032	Rounds: CT/CNA (continued)								
	Were rounds made per protocol? Y								
450	Dietary Intake						A		OE
- Document	05/25/07	0835	TLJ	05/25/07	0835	TLJ			
Which meal & how much eaten? Breakfast 100%									
1805	AM/PM Bathing and ADL care						A		CP
- Document	05/25/07	0835	TLJ	05/25/07	0836	TLJ			
AM/PM Care									
Shower									
Comments:									
CHANGED LINEN									
Activity Date: 05/25/07		**Time: 1209**							
7690	Laboratory Data Interpretation						A		OE
	5/25: H AND H ON 5/26.								
- Create	05/25/07	1209	JAM	05/25/07	1209	JAM			
Activity Date: 05/25/07		**Time: 1234**							
4200	IV Intravenous Therapy						A		OE
	IVF DC D								
- Ed Text	05/25/07	1234	WJT	05/25/07	1234	WJT			
Activity Date: 05/25/07		**Time: 1235**							
031	Rounds: RN/LPN						A		CP
	Q2 even hours								
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
413	Telemetry						A		PS
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
Rhythm: SR DEP ST									
452	Activity						A		OE
	BEDREST								
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
4200	IV Intravenous Therapy						A		OE
	IVF DC D								
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
7690	Laboratory Data Interpretation						A		OE
	5/25: H AND H ON 5/26.								
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
Activity Date: 05/25/07		**Time: 1351**							
032	Rounds: CT/CNA						A		CP
	Q2 odd hours								
- Document	05/25/07	1351	TLJ	05/25/07	1351	TLJ			

524

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change

Activity Date: 05/25/07 Time: 1351 (continued)

032 Rounds: CT/CNA (continued)
Were rounds made per protocol? Y
450 Dietary Intake A OE
- Document 05/25/07 1351 TLJ 05/25/07 1351 TLJ
Which meal & how much eaten? Lunch 100%

Activity Date: 05/25/07 Time: 1802

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/25/07 1802 TLJ 05/25/07 1802 TLJ
Were rounds made per protocol? Y
450 Dietary Intake A OE
- Document 05/25/07 1802 TLJ 05/25/07 1803 TLJ
Which meal & how much eaten? Dinner 100%
6690 Intake/Output A OE
- Document 05/25/07 1802 TLJ 05/25/07 1803 TLJ

********** INTAKE **********

Oral Intake: 1680 IV Intake: 0

NG/Peg Feeding: 0 Blood Admin.:

********** OUTPUT **********

Urine (mls): 0 BM: liquid (mls): 0
Urine (# of times): 5 BM: (# of times): 0
Incontinent (# of times): 0

Emesis (mls): NG Drainage: Wound Vac Drain:
Blood Loss: Hemovac Drain:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/25/07 Time: 1848

4190 IV Intravenous Insertion A CP
5/25: INT 22G RIGHT WRIST
- Document 05/25/07 1848 CO 05/25/07 1848 CO
Site: RT wrist

Needle Diameter: 22 gauge

Needle Length: 1 inch

525

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change

Activity Date: 05/25/07 Time: 1848 (continued)

4190 IV Intravenous Insertion (continued)
Time of IV start: 1845

Total # Venipuncture: 1

Time of site care: 1845

Reason for restart: Other
- Ed Text 05/25/07 1848 CO 05/25/07 1849 CO

Activity Date: 05/25/07 Time: 1930

031 Rounds: RN/LPN A CP
Q2 even hours
- Document 05/25/07 1930 RR 05/26/07 0107 RR
6680 Vital Signs, Monitor A OE
Q4H
- Document 05/25/07 1930 RR 05/26/07 0108 RR
Temp: 97.4 Temp Source: ORAL

Respirations: 20

Heart Rate: 83 Hrt Rate Source: APICAL

BP: 159/72 BP Source: SUPINE

SAO2: 95 O2 source: RA

Activity Date: 05/26/07 Time: 0017

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/26/07 0017 REM 05/26/07 0017 REM
Were rounds made per protocol? Y
6680 Vital Signs, Monitor A OE
Q4H
- Document 05/26/07 0017 REM 05/26/07 0018 REM
Temp: 96.7 Temp Source: ORAL

Respirations: 20

Heart Rate: 88 Hrt Rate Source: RADIAL

BP: 149/64 BP Source: SUPINE

SAO2: 100 O2 source: R/A

526

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change

Activity Date: 05/26/07 Time: 0107

438 Patient Level of Assistance A CP
- Document 05/26/07 0107 RR 05/26/07 0107 RR
Patient Level of Assistance IND Independent

Activity Date: 05/26/07 Time: 0446

413 Telemetry A PS
- Document 05/26/07 0446 RR 05/26/07 0446 RR
Rhythm: sinus rhythm with dep ST segment

Activity Date: 05/26/07 Time: 0619

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/26/07 0619 REM 05/26/07 0619 REM
Were rounds made per protocol? Y
6680 Vital Signs, Monitor A OE
Q4H
- Document 05/26/07 0619 REM 05/26/07 0622 REM
Temp: 96.9 Temp Source: ORAL

Respirations: 20

Heart Rate: 78 Hrt Rate Source: RADIAL

BP: 135/69 BP Source: SUPINE

SAO2: 99 O2 source: R/A
6690 Intake/Output A OE
- Document 05/26/07 0619 REM 05/26/07 0622 REM

********** INTAKE **********

Oral Intake: 240 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 300 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

527

001962

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/26/07 Time: 0619 (continued)

6690 Intake/Output (continued)
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/26/07 Time: 0737

6680 Vital Signs, Monitor A OE
Q4H
- Document 05/26/07 0737 WJT 05/26/07 0737 WJT
Temp: 97.5 Temp Source: ORAL

Respirations: 18

Heart Rate: 73 Hrt Rate Source: RADIAL

BP: 144/73 BP Source: SUPINE

SAO2: 94 O2 source: RA

Activity Date: 05/26/07 Time: 0908

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/26/07 0908 TLJ 05/26/07 0908 TLJ
Were rounds made per protocol? Y

450 Dietary Intake A OE
- Document 05/26/07 0908 TLJ 05/26/07 0908 TLJ
Which meal & how much eaten? Breakfast 100%

1805 AM/PM Bathing and ADL care A CP
- Document 05/26/07 0908 TLJ 05/26/07 0908 TLJ

AM/PM Care
Shower

Comments:
CHANGED LINEN

Activity Date: 05/26/07 Time: 1435

032 Rounds: CT/CNA A CP
Q2 odd hours
- Document 05/26/07 1435 TLJ 05/26/07 1435 TLJ
Were rounds made per protocol? Y

450 Dietary Intake A OE
- Document 05/26/07 1435 TLJ 05/26/07 1435 TLJ
Which meal & how much eaten? Lunch 100%

528

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/26/07		**Time: 1728**							
031	Rounds: RN/LPN						D		CP
	Q2 even hours								
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
032	Rounds: CT/CNA						D		CP
	Q2 odd hours								
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
413	Telemetry						D		PS
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
438	Patient Level of Assistance						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
450	Dietary Intake						D		OE
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
451	Consults						D		OE
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
452	Activity						D		OE
	BEDREST								
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
453	D/C IV/INT Needle						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
1805	AM/PM Bathing and ADL care						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
3141	Oxygen Therapy						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
3353	Pneumococcal vaccine given						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
3357	Pneumonia Vaccine Not Given Reason						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
3510	Skin: ADM-D/C-weekly photo & measurement						D	Tu	CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
4190	IV Intravenous Insertion						D		CP
	5/25: INT 22G RIGHT WRIST								
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
4200	IV Intravenous Therapy						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
5600	***Education Assessment/Admission***						D	ONCE	CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
5601	Teaching: Patient/Family Education						D	OG	CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
6540	Infection Control						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
6680	Vital Signs, Monitor						D		OE
	Q4H								
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
6681	Pulse Oximetry (SAO2)						D		CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/26/07	Time: 1728								
6690	Intake/Output						D		OE
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
6691	Weight/Height						D		OE
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
7320	Case Management						D		PS
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
7690	Laboratory Data Interpretation						D		OE
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D

Monogram	Initials	Name	Nurse Type
ABG	NSABG1	GALELA,ARMI B.	RN
CO	NSCO1	OSBORNE,CINDY	LPN
DCT	BODT	TURNER,DEBORAH C.	US
JAM	NSJAV1	MARTIN,JESSICA ANN	CT
MFE	NSMFE	EDWARDS,MAE FRANCES	CT
MLS	CMMLS	SINGLETARY,MONA L.	SW
NRV	NSNV	VAN PATTEN,NAONI R.	RN
PJW	NSPW1	WHACK,PAULINE J.	RN
REM	NSRH6	MCLEOD,RUBY E.	NA
RR	NSRC1	ROY,RENCHIE	RN
TA	NSTA	ALAISA,TERESA	RN
TJH	NSTJH1	HEYWARD,TERRIE J	CNA
TLJ	NSTLJ1	JOHNSON,TAMMY L.	US
TWB	NSTWB	BONHAM,THELMA W.	CT
WJT	NSWJT	THURBER,BUTCH	RN
his		automatic by program	

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
12	***Admission History***	A	AS

Documented at 05/22/07 1930 by NRV

Admitted from: ER Info obtained from: PATIENT Arrival on unit: 1700
Armband intact: Y Verified: : Code Status: FULL CODE
Does pt have Advance Directive (Living Will)? N
Does pt have Health Care Power of Attorney? N
If yes, Living Will copy received? N If yes, Health Care Power of Attorney copy received?
Does patient want info on Advance Directive? N
** VS ** Temp: 96.8 BP: 151/57 Wt: lb: 144 oz: 8.0 kg: 65.544
Heart Rate: 84 Respirations: 22 Ht: ft: 5 in: 3.0 cm: 160.0
SpO2: 96 % O2 source: RA
Are you in pain: N Med Allergies: N Latex Screening: Y
Do you have chronic pain: N Food Allergies: N Falls Assessment: Y
Chief Complaint: LLL PNEUMONIA,VOMITING

********** PAST MEDICAL HISTORY **********
Previous surgery? Y Previously Hospitalized: Y PPD+: N

********** MEDICAL HISTORY AND SYSTEM REVIEW **********
Have you ever or do you now have problems with:
Vision: N Hearing: N Nutrition: Y Cardio: Y Resp: Y
CNS: N GI: Y GU: N Endocrine: N Hepatic: N Musculo - Skeletal: N
Hematology: N Cancer: N Female: Y
Have you had pneumococcal vaccine? N Date Pneumococcal vaccine given:
Have you had current season influenza vaccine? <<*must have been RECEIVED between OCT-FEB*

********** PSYCHO-SOCIAL **********
HX of alcohol/drug abuse within last 6 months: N Smoked tobacco in the last 12 months? Y
Is there any evidence of abuse or neglect? N Mental Illness: N
Patient s religious denomination. HOLINESS/PENTECOSTAL
Spiritual practices / beliefs that affect patient care. N
Comment:
Would you like to see our chaplain? Y

****

Have you had or do you currently need assist with ADLS: N
Currently receiving any healthcare or community services: N
Currently using med equip or asst devices: N
On d/c will you need financial assistance w/ meds: Y
On d/c, will you need physical assistance taking meds?: N
On d/c, will you need transportation provided?: N
Pt Oriented to Rm & Valuables Policy: Y
OB: N Peds Admit: N Sub-Acute Admit: N Antepartum: N

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

*******ADMISSION PAIN ASSESSMENT********
Pain Location: Pain scale used:
Pain Level on Admit: 3 Pain type:
Onset of Pain: Pain quality (describe):
Pain frequency: Cause of Pain:
Pt s pain plan prior to admit:
Is plan still effective?:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

***Use below for additional Pain Location (if necessary):
Pain Location:
Pain type:
Onset of Pain:
Pain Frequency:
Cause of Pain:
****CHRONIC PAIN****
Pain Location:
Pain scale used:
Pain Score:
Pain frequency:
Worse pain gets: Best pain gets:
Do you have a history of any ongoing pain problems?
Conditions that cause pain:
What makes pain better?
What makes pain worse?
Are there times of the day/night when pain is worse?
Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

****Allergy Information****
Med Allergies: NKDA

Food Allergies: No known food allergies

*******LATEX SCREENING*******
Latex (Rubber): N
Bananas: N
Chestnuts: N
Avocados: N
Poinsettias: N
Kiwi, Papaya: N

****FALL ASSESSMENT****
Previous Fall: N Mobility Problem: N
Confusion/Intermittent Confusion: N
Incontinent: N Hearing/Vision Impairment: N
Receiving Hypnotics, Laxatives, or Diuretics: N
Pt. is 70+: N
********** PAST MEDICAL HISTORY **********
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007
Anesthesia Complications:
****Previously Hospitalized*****
Reason for Visit/Date: MI-MARCH 2007
********VISION**********
Blind: Eye Prothesis:
Blind left: Eye prothesis left:
Blind right: Eye prothesis right:
Do you wear glasses: Glasses w/pt:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Do you wear contacts: Contacts w/ pt:
**********HEARING**********
Hard of hearing: Hearing aid:
HOH Left: Hearing aid left:
HOH Right: Hearing aid right:
Deaf: Hearing aid w/ pt:
Deaf Left:
Deaf Right:
**********NUTRITION**********
Diet followed at home: REG
Special cultural/ethnic/religious food needs: N
Unintentional wt loss/gain>10 lbs within 2 mo: N
On thickened liquids at home? N Problems chewing:
PEG Tube Present?: N
****DENTAL****
Missing teeth: Y Capped teeth: Loose teeth:
Do you wear dentures? Y
Partial:
Upper: Y
Lower: Y
Dentures with patient: Y Denture cup given: Y
Inventory of Dentures with Patient on Admission: Upper and Lower sets
**********CARDIO**********
Hypertension: Y Arrhythmias: N
Chest Pain: Y Pacemaker/Internal Defibrillator: N
Heart Attack: Y Rheumatic Fever: N
CHF: N Congenital Heart Defect: N
Murmur/MVP: N
**********RESP**********
SOB: Y Asthma: N
Pneumonia: Y COPD: N
Chronic Cough: Sleep Apnea: N
URI/cold w/in last 2 wks: Tracheostomy: N
TB: N
**********CNS**********
Convulsions/Seizures: Alzheimers/Dementia:
Stroke: Numbness/Tingling:
Muscular Weakness/Paralysis: Headache:
Fainting or Dizzy Episodes: Problems w/ Speech/Communications:
Dysphagia:
**********GI**********
Ulcerative Colitis: N Chronic Diarrhea: N
Diverticulitis: N Reflux: N
Crohns: N Ulcers: N
Chronic Constipation: N Hiatal Hernia: Y
Bleeding: N Nausea/Vomiting: Y
**********GU**********
Renal Disease: Prostate Disease:
Hemodialysis: Urinary Retention:
Peritoneal Dialysis:
Kidney Stones: Urostomy:
Incontinent (# of times):
**********ENDOCRINE**********
Diabetes:
Thyroid Problems:
Is this a new onset of diabetes?
**********HEPATIC********
Hepatitis:
Cirrhosis:

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

**********MUSCULAR SKELETON********** **********HEMATOLOGY**********
Arthritis: Anemia:
Connective Tissue Disease: Sickle Cell Disease/Trait:
Joint Replacement: Other Types:
Prosthesis:
Device: Blood Transfusion:
Reaction:

**********CANCER**********
Diagnosis/Date:
Treatment within last 6 months:
**********FEMALE/OB**********
Do you still have a menstrual cycle: Y LMP:
Are you pregnant: N Are you currently breast feeding: N
********ADL*******

Prior to Admission		Currently on Admission	
Bathing:	Assist:	Bathing on ADM:	Assist:
Grooming:	Assist:	Grooming on ADM:	Assist:
Dressing:	Assist:	Dressing ADM:	Assist:
Feeding:	Assist:	Feeding ADM:	Assist:
Toileting:	Assist:	Toileting ADM:	Assist:
Ambulation:	Assist:	Ambulation ADM:	Assist:

T= TOTAL ASSISTANCE P= PARTIAL ASSISTANCE
**********HEALTHCARE/COMMUNITY SERVICES**********
Extended Care Facility: Outpt Rehab: Rehab Facility:
Home Health Agency: Meals on Wheels:
Personal Care Aides: Mental Health:
Hospice:
Home Health Agency (name):
Hospice (name):
**********MED EQUIPMENT & ASSIST DEVICES**********
Walker: Rolling walker: Standing walker:
Wheelchair:
Hospital bed:
Oxygen:
Nebulizer/Pulmoaide:
CPAP/BIPAP:
Blood Glucose Monitor: Did you bring a medicine pump from home?
**********DC ASSISTANCE W/ MEDICATIONS**********
On d/c, will you need assistance obtaining meds:
On d/c, will you need assistance administering meds:
*********TRANSPORTATION*********
Name of driver:
Drivers phone #:
**********OB ADMIT**********
Age below 16: Previa/Abruption:
No prenatal care: Birth Control Method on d/c:
PIH/Pre Eclampsia: Gestational Diabetic: Hyperemesis:
Does the patient need Car seat: Baby clothes: Baby bed:
**********PEDIATRIC ADMISSION**********
Delays in G/D:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Rolling Over: Sitting Up: Crawling: Walking: Speaking:
Caregiver perception of child s G/D:
Are your receiving healthcare/community services:
Home Health Agency: Hospice: Personal care aides: Outpt Rehab: WIC:
Homebound Schooling: Mental Health Services:
********** IMMUNIZATIONS **********
2 Month: 4 Month: 6 Month: 15-18 Month:
4-5 Year: PPD: Hepatitis B: Start date: Treatment complete?:
Word child uses to describe pain or hurt N/A if nonverbal
Head circumference:
Is pt below 20th percentile or above 80th percentile wt/ht:
Caregiver(home) understanding of illness/condition:
Caregiver(home) perception of outcome of hosp.stay:
**********SUBACUTE ADMIT**********
BM Date:
Last Void: Was patient continent prior to hospital admission?
Do you prefer to: Bathe: Shower:
Which cognitive behavior(s) describe the pt
Cognitive behavior:
Pt able to verbalize:
PPD Result:
**********ANTEPARTUM**********
EDC:
Gravida Para Abortus:
****PERSONAL VALUABLES****
Personal items/Valuables noted on admission:

**********CODE STATUS**********
I have explained to the patient/family that without a
current DNR, Do Not Intubate, Do Not Shock, or No CPR order
the patient will be treated as a FULL CODE? Yes
Patient/Family wish to speak with the primary physician regarding Code Status?

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/22/07	1930	NRV	NSNV	VAN PATTEN,NAOMI R.	RN
Recorded:	05/22/07	1935	NRV	NSNV	VAN PATTEN,NAOMI R.	RN

Recorded at terminal: TELEM002.3

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
2	***Head to Toe*** (ADMISSION ONLY)	A	AS

Documented at 05/22/07 1707 by NRV

**********NEUROLOGICAL ASSESSMENT**********
Level of Consciousness: ALERT Psychosocial: Cooperative
ORIENTATION Person: Y
Place: Y Pain Level on Admit: 3
Time: Y
Speech: CLEAR
Hand Grips: EQUAL S
Pupils: EQUAL
Pupils React to Light: BOTH
Comment:

**********RESPIRATORY**********
Respiratory Effort: Unlabored
Retractions: N Pattern: Regular
Stridor: N
Breath Sounds, Right: CLEAR Breath Sounds, Left: DIMIN
Cough: PRODUCTIVE Color: YELLOW Consistency: THICK
Capillary Refill: QUICK Chest Tube:
Nailbeds: PINK
Comment:

**********CARDIOVASCULAR**********
Heart Sounds: NORMAL
Neck Vein Distention: N
Peripheral Pulse: Left Radial Pulse: NORMAL
Right Radial Pulse: NORMAL
Left Dorsal Pulse: NORMAL
Right Dorsal Pulse: NORMAL
Edema: ABSENT
Location:
Comment:

**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL Mucous Membranes:MOIST
Skin Condition: Intact
Is there a wound(s) as a result of surgery?
Is there a wound(s) as a result of pressure?
Is there a wound(s) from other than surgery or pressure?

**********GU/GI**********
Abdomen: SOFT
Bowel Sounds: ACTIVE
Stools: CONTINENT Date of last BM:
Voiding: CONTINENT Color: Consistency:
Date of Foley Insertion:
Graft Fistula: N Comment:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

Functional:
Thrill:
Bruit:
Location:
PEG Present: N
NG Tube: N
OG Tube: N Comment:

**********MUSCULOSKELETAL**********

Range of Motion: FULL RUE: LUE: RLE: LLE:
Cast: N
Comment:

**********SURGICAL**********

Is this a surgical patient: N Pt s age: 39 Is patient 70 or greater:
Was patient admitted for one of the following (active dx) ?
Total Knee Replacement, Total Hip Replacement, Hip Fracture,
Pelvic fracture, Femur fracture?: N <<< Please answer N for SSCP/ARU

**********OB**********

Is this an OB patient: N
Fundus: Fundus Location:
Lochia: Lochia Color:
Perineum:
Hemorrhoids:
Breast:

**********GYN**********

Is this a GYN patient? N
Vaginal Bleeding:
Vaginal Bleeding Color:
Vaginal Packing?

**********ANTEPARTUM**********

Is this an antepartum patient: N
Reflexes:
Clonus:
Headache:
Epigastric Pain:
Vision Changes:
FHT:

**********INTENSIVE CARE UNIT**********

Is this an ICU pt: N
Glascow Coma Scale
Eye Opening:
Motor Functions:
Verbal Responses:
Diagnosis: PNEUMONIA Pneumonia ICD9# 486

**********DVT RISK ASSESSMENT**********

Would you like to complete the DVT Risk Assessment? Y
If no, reason for no DVT Risk Assessment:
Required for the following diagnosis ONLY:
Cancer (with Chemo), CHF, COPD, CVA (Ischemic), Emphysema
IBD, Pulmonary Edema, Pneumonia, or Sepsis

**********DVT RISK ASSESSMENT**********

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 4
MOBILITY 3
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 18
If Norton Scale score <12, initiate turning schedule and heel precautions

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

*** SURGICAL WOUND LOCATION 1 ***
Surgical wound location 1: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***
Surgical wound location 2: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***
Surgical wound location 3: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

****LOCATION 1****
DERMAL WOUND LOCATED: DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 2****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 3****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:

538

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 39 F
Account #: 12756622 Unit #: 229998
Admit Date: 05/22/07 Location: TELE
Status: ADM IN Room/Bed: 312-1
Attending: MEDICAL SERVICES - TMP

WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:
Please describe any wound(s) not related to surgery/pressure
:
**********DVT RISK ASSESSMENT**********
Diagnosis: Pneumonia * = Highest Risk DIAGNOSIS
Does the patient have any of these risk factors? (Y or N)
Impaired Mobility? N
Age over 40? N
Obesity? N
Paralysis or plaster cast? N
Estrogen (contraceptive/HRT)? N
***Each Risk Factor counts as 1, add total number of Y ***
History of DVT/PE? ** OR Age over 70? ** OR
Thrombotic abnormalities? **
(Protein C deficiency, Antithrombin III deficiency,etc) **N
** = Automatically considered for Highest Risk FACTOR
2 or more risk factors or HIGHEST DIAGNOSIS/FACTOR CATEGORY? N
Does patient have current orders for Lovenox, Coumadin or SQ Heparin? Y
Have you placed a DVT prophylaxis order form (#211-NCR) on the chart? N
>>Physician must be notified if assessment indicates high risk for DVT.<<

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/22/07	1707	NRV	NSNV	VAN PATTEN,NAOMI R.	RN
Recorded:	05/22/07	1715	NRV	NSNV	VAN PATTEN,NAOMI R.	RN

Recorded at terminal: TELEM008.3

001974

Intervention Description	Sts	Direction	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 0840

21 ***Respiratory Re-eval*** (Nursing) A CP
- Document 05/23/07 0840 KM 05/23/07 1650 KM
**********RESPIRATORY**********
Respiratory Effort: Unlabored
Breath Sounds, Left: DIMIN
Breath Sounds, Right: DIMIN
Cough: PRODUCTIVE
Capillary Refill: QUICK

70 Daily Re-Assessment/Observation A CP
- Document 05/23/07 0840 KM 05/23/07 1652 KM
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? Y
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 3
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 4
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 19
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- Continuous fluids
Date of INT insertion: 05/22/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***

540

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 0840 (continued)

70 Daily Re-Assessment/Observation (continued)
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/23/07 Time: 2010

70 Daily Re-Assessment/Observation A CP
- Document 05/23/07 2010 TA 05/24/07 0152 TA
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? Y
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/22/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****

544

001976

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 2010 (continued)

70 Daily Re-Assessment/Observation (continued)
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/24/07 Time: 0830

70 Daily Re-Assessment/Observation A CP
- Document 05/24/07 0830 PJW 05/24/07 1515 PJW
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/23/07

542

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 0830 (continued)

70 Daily Re-Assessment/Observation (continued)
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/24/07 Time: 1950

70 Daily Re-Assessment/Observation A CP
- Document 05/24/07 1950 TA 05/25/07 0318 TA
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4

543

Intervention Description				Sts	Direction			From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 1950 (continued)

70 Daily Re-Assessment/Observation (continued)
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/23/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/25/07 Time: 0736

70 Daily Re-Assessment/Observation A CP
- Document 05/25/07 0736 WJT 05/25/07 0737 WJT
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3

544

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/25/07 Time: 0736 (continued)

70 Daily Re-Assessment/Observation (continued)
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/25/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/25/07 Time: 1930

70 Daily Re-Assessment/Observation A CP
- Document 05/25/07 1930 RR 05/26/07 0107 RR
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL

545

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/25/07 Time: 1930 (continued)

70 Daily Re-Assessment/Observation (continued)
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/25/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/26/07 Time: 0749

70 Daily Re-Assessment/Observation A CP
- Document 05/26/07 0749 WJT 05/26/07 0750 WJT
Level of Consciousness: ALERT
Does patient have IV access? Y
Respiratory Effort: Unlabored
Heart Sounds: NORMAL
Abdomen: SOFT
Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N
Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N
Has patient fallen since admit or been on fall precautions? N
Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********

Intervention Description				Sts	Direction			From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/26/07 Time: 0749 (continued)

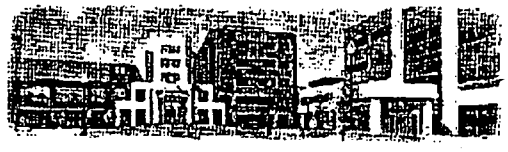
70 Daily Re-Assessment/Observation (continued)
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL
Mucous Membranes: MOIST
Skin Condition: Intact
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 1
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 16
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/25/07
(skip if N/A)
Is the IV Access site free of signs of complications? Y
(skip if N/A)
****FALL PRECAUTIONS****
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS
*** SURGICAL WOUND LOCATION 1 ***
*** SURGICAL WOUND LOCATION 2 ***
*** SURGICAL WOUND LOCATION 3 ***
****LOCATION 1****
****LOCATION 2****
****LOCATION 3****
****LOCATION 4****
****LOCATION 5****
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Monogram	Initials	Name	Nurse Type
KM	NSKM	WALKER,KIMBREA	RN
PJW	NSPW1	WHACK,PAULINE J.	RN
RR	NSRC1	ROY,RENCHIE	RN
TA	NSTA	ALAISA,TERESA	RN
WJT	NSWJT	THURBER,BUTCH	RN

547

001982

TUOMEY
HEALTHCARE SYSTEM
Bringing more to life.



Tuomey Healthcare System
129 North Washington St.
Sumter, SC 29150
(803) 774-9000

Date 5/22/07 Time 1035

Goal of Therapy Bronchodilation

Meds given/delivery 1.25 mg Xopenex / 0.5mg Atrovent

Mini heart / Continuous nebulizer Start Time — Stop Time —

Before treatment: RR 20 HR 89 PEFR — 1/m

Breath sounds clear

During treatment: HR 80 Cough dry opc

After Treatment: RR 20 HR 78 PEFR _____ 1/m

Breath sounds fine rales very decreased

Other therapy: IS _____ ml CPT _____ Suctioning _____

Notes HHN done via mouth piece.

Signature Amy McDill, CRT

Date _____ Time _____

Goal of Therapy _____

Meds given/delivery _____

Mini heart / Continuous nebulizer _____

Before treatment: RR _____ HR _____ PEFR _____ 1/m

Breath sounds _____

During treatment: HR _____ Cough _____

After Treatment: RR _____ HR _____ PEFR _____ 1/m

Breath sounds _____

Other therapy: IS _____ ml CPT _____ Suctioning _____

Notes _____

Signature _____

WINDHAM,TAMMY ELIZABETH
Acct: 12756622 Unit: 229998548
LAWTON III,JOSEPH J
ED
F W Age: 39 DOS: 05/22/07

Respiratory Therapy Treatment Sheet

ASM001 Rev. 01/30/2007

5769

001983

Tuomey Healthcare System
Department of Radiology
NURSING CARE RECORD
Pre Procedure Nursing Care Assessment

DATE: 5/22/07
TIME: 1334

Name: Tammy Windham
ACCT#: 12756622
MD:

Verbal ID of Patient: ☑ Yes ☐ No ☐ NA
ID BAND Placed / Present: ☑ Yes ☐ No ☐ NA
Name Verified: ☑ Yes ☐ No ☐ NA
Account #/Procedure Verified: ☑ Yes ☐ No
Procedure: RE
Belongings: ☐ N/A ☐ Locker Key ☐ Clothing Bag ☐ In Patient's Room

NEUROLOGICAL: ☐ Relaxed ☑ Apprehensive ☐ Confused ☐ Alert ☐ Restless ☐ Arousable ☐ Nonresponsive ☐ Other:
LIMITATIONS: ☐ None ☐ Mobility ☑ Vision ☐ Speech ☐ Hearing ☐ See Comments
LUNGS: ☐ N/A ☐ Clear ☑ Rales ☐ Wheezing
HEART RHYTHM: ☐ N/A Rate ____ ☐ Reg. ☐ Irreg. Dry
RESPIRATIONS: ☐ No Distress ☐ SOB ☐ Labored

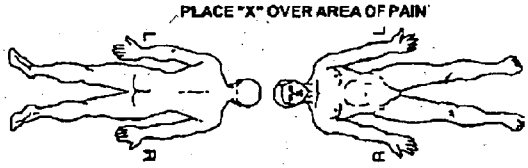
SKIN CONDITION: ☐ Normal ☐ Pale ☐ Flushed ☑ Warm ☐ Dry ☐ Cool ☐ Clammy ☐ Diaphoretic
ABDOMEN: ☐ Soft ☐ Hard ☐ Distended
EXTREMITY EDEMA: ☐ Absent ☐ Present
EXTREMITY PULSE: ☐ Strong ☐ Bounding ☐ Weak ☐ Radial L (L) L (R)

HT ____ WT ____ LMP ____ Hyst ____ Previous I.V. Contrast: ☐ Yes ☐ No Date: ____ Reaction: ☐ Yes ☐ No
Taking Metformin: ☐ Yes ☒ No Arrangements Made: ☐ Yes ☐ No
Allergies: ☐ Yes ☐ No Type: ☐ Latex ☐ Food (List): ____ ☐ Med.(List): NKA
Medications Reviewed: ☐ Home Med Sheet ☐ IBEX ☑ MAR
Transdermal Meds.: 0 Removed ☐ Yes ☐ No Bun 5 Creatinine 0.7 Date 5/22/07
Vital Signs BP 195/88 P 84 Rhy ____ Resp 20 Medical Hx: ☐ C/V ☐ CNS ☐ Diabetic ☐ Asthma ☐ Sickle Cell Disease
Kidney Disease: ☐ Yes ☐ No Kidney Transplant/ Date: ____

PRE PROCEDURE PAIN ASSESSMENT

Pain Present: ☐ Yes ☒ No
Pain Score: ____
Pain Scale Used: ☐ Numerical ☐ Wong-Baker Faces ☐ Non-Communicative

PLACE "X" OVER AREA OF PAIN



Actions Taken: ____

YES	NO	NA	EDUCATION/DISCHARGE PLANNING
☐	☐	☐	Procedure explained to patient/significant other.
☐	☐	☐	Patient/Significant Other verbalize understanding.
☐	☐	☐	What to expect after the procedure.
☐	☐	☐	Restrictions after the procedure R/T diet, activity.
☐	☐	☐	How to obtain results of examination.

Nursing Notes: Cx implant? Stat HIV

NURSING INTERVENTION

☐ INT Present ☑ Yes ☐ No ☐ Redness ☐ Edema ☐ Tenderness ☐ Streaking Above Site ☐ WNL's
☐ IVF Present / Fluid: ____ Flushed with NS 10cc's ☑ Yes ☐ No
SITE OF INFUSION: ☑ Brachial ☐ Right ☐ Forearm ☐ Left ☐ Hand ☐ Other ____
TYPE OF DEVICE: ☐ Butterfly ☐ 18g ☐ 22g ☐ Cathelon ☑ 20g ☐ 24g
Venipuncture x ____ per ____ Time ____

	TIME	MEDICATION	DOSE	PHD / MD CONSULTED	ROUTE	ADMINISTERED BY	RESPONSE
MEDICATIONS	1335	ISOVUE	150		IV	MC	☐ No Infiltration ☑ Tolerated ☐ Infiltration - (See Comment) ☐ N/V ☐ Nausea Comments ____
		VISIPAQUE					
		REDI-CAT Bottle # 1					
		Bottle # 2					
		MAGNEVIST					

WINDHAM,TAMMY ELIZABETH
Acct:12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39

INIT.	LEGEND SIGNATURE
TM	W. Cox

549

5770

POST PROCEDURE NURSING ASSESSMENT

VITAL SIGNS: BP 151/62 HR 81 Resp. 22 @ 1341

Patient response to procedure:
- ☐ Tolerated with no complaints
- ☐ Allergic Reaction. If yes, protocol followed: _____ (Initials)
- ☐ N/V
- ☐ Comments: _____

Education:
- ☐ Encouraged to drink extra fluids today (Exception: Contraindications)
- ☐ MD to review results and will discuss further medical treatment
- ☐ If patient is currently on Metformin for Diabetes, Discharge Instruction Sheet is given and patient/family state understanding (see Discharge Instruction sheet).
- ☐ Instructed to: re-apply transdermal medication patch as soon as possible. Contact ordering physician if refill needed. Patient/family state understanding.

Nursing Notes: Pt to Recovery

INT Removed / Flushed per ln @ _____. Cath intact? ☐ Yes ☐ No no IV

Site WNL's ☑ Yes ☐ No If "no", comment: _____

I.V. Fluids Resumed at Previous Rate: ☐ Yes ☐ No Comments: _____

PATIENT DISCHARGED TO: ☐ Home ☑ ED ☐ Rm # _____ ☐ Other Facility(Name): _____

☐ WC ☑ Stretcher ☐ Bed ☐ Carried ☐ Amb By: ☐ Self ☐ Family Member ☑ Transporter ☐ EMS ☐ Tech

Time: 1345

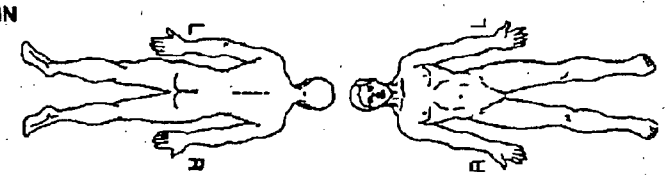
POST-PROCEDURE PAIN ASSESSMENT

Pain Present: ☐ Yes ☑ No

Pain Score: _____

Pain Scale Used:
- ☐ Numerical
- ☐ Wong-Baker Faces
- ☐ Non-Communicative

PLACE "X" OVER AREA OF PAIN



Actions Taken: _____

Nurse Signature: _____ Date: _____

WINDHAM,TAMMY ELIZABETH
Acct:12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1
F W Age: 39
DOS: 05/22/07

550

TUOMEY HEALTHCARE SYSTEM
Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

SIGNATURE SHEET

(GUIDE TO PAIN MANAGEMENT AND RE-ASSESSMENT OF PAIN)

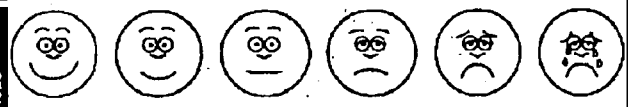
TO INCLUDE SCHEDULED CONTROLLED SUBSTANCES FOR PAIN

ANXIETY/PAIN/COMFORT CODE (ADULT)

NUMERIC

0 1 2 3 4 5 6 7 8 9 10

FACES



0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

NON-COMMUNICATIVE

0 1 2 3 4 5 6 7 8 9 10

SLEEPING, CALM, RELAXED, NOT AGITATED | (MILD) GRIMACING WITH MOVEMENT | MOANING WITH MOVEMENT | RESTLESS | (SEVERE) CONSTANT MOANING WITHOUT STIMULI

**This Pain Scale is an example of behaviors a patient might show. Because everyone is not alike, this Pain Scale may need to be changed to reflect behaviors specific to individual patients.*

For laxatives, antidiarrheals, blood pressure, antipyretics, antiarrhythmics and cough medications, etc. use NA for Code and Sedation Level. For pain medications, use N/A for Outcome Code if patient is asleep.

SEDATION SCALE

S = SLEEPING, EASY TO AROUSE. (IF SLEEPING, COUNT RESPIRATIONS FOR A FULL MINUTE.)*

1 = AWAKE AND ALERT.

2 = SLIGHTLY DROWSY, EASILY AROUSED.

3 = FREQUENTLY DROWSY, AROUSABLE, DRIFTS OFF TO SLEEP DURING ____ CONVERSATION.

4 = SOMNOLENT, MINIMAL OR NO RESPONSE TO PHYSICAL STIMULATION.

TO BE UTILIZED WITH CONTROLLED SUBSTANCES AND MEDICATIONS WITH SEDATION POTENTIAL

NEONATAL/INFANT PAIN SCALE (NIPS)

(RECOMMENDED FOR CHILDREN < 2 YRS OLD)

FACIAL EXPRESSION	
0 - NO HURT	Restful face, neutral expression
1 - GRIMACE	Tight facial muscles; furrowed brow, chin, (negative facial expression-nose mouth, brow)
CRY	
0 - NO CRY	Quiet, not crying
1 - WHIMPER	Mild moaning, intermittent
2 - VIGOROUS CRY	Loud screams, rising shrill, continuous (Note: silent cry may be scored if baby is intubated as evidence by obvious mouth and facial movement)
BREATHING PATTERNS	
0 - RELAXED	Usual pattern for this infant
1 - CHANGE IN BREATHING	Indrawing, irregular, faster than usual; gagging; breath holding
ARMS	
0 - RELAXED/RESTRAINED	No muscular rigidity; occasional random movement of arms
1 - FLEXED/EXTENDED	Tense, straight arms, rigid and/or rapid extention, flexion
LEGS	
0 - RELAXED/RESTRAINED	No muscular rigidity; occasional random movement of legs
1 - FLEXED/EXTENDED	Tense, straight legs, rigid and/or rapid extention, flexion
STATE OF AROUSAL	
0 - SLEEPING/AWAKE	Quiet, peaceful/sleeping or alert/random leg movement
1 - FUSSY	Alert, restless and thrashing

FLACC PAIN SCALE

(RECOMMENDED FOR CHILDREN < 2 YRS OLD)

CATEGORIES	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quiet, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry, awake or asleep	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaint
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging, or talking to; distractable	Difficult to console or comfort

WHEN PAIN WILL BE REASSESSED AND DOCUMENTED

a. ***** When a patient's pain changes, including, but not limited to, unexpected intense pain or a new report of pain, this will result in documentation of a complete pain assessment (See Pain Assessment Interventions in Meditech). *****

b. Within 30 minutes after parenteral pain medication is administered.

c. Within one hour after oral pain medication is administered.

d. Within 72 hours after applying a transdermal Fentanyl patch.

e. Every two (2) hours for the first 24 hours after surgery while awake.

f. For patients on PCA or epidural pumps, and continuous narcotic infusions, at the initiation of the infusion, or with any change in settings. The reassessment schedule is every 30 minutes times one, every one hour times one, than every four (4) hours until discontinued.

g. Pain is reassessed every shift once the patient's pain goal is achieved.

h. A pain score of four (4) or above may result in a dose adjustment or other intervention.

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551

WINDHAM,TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39 [redacted]

5772

PRACTITIONER'S FULL SIGNATURE IS REQUIRED FOR ANY INITIAL APPEARING ON THE MEDICATION ADMINISTRATION RECORD.

INITIALS	FULL SIGNATURE	INITIALS	FULL SIGNATURE
KO	Kelli Overdiew RRT, ECP		
BR	Barbara Rowden CRT		

WINDHAM,TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39 [redacted]

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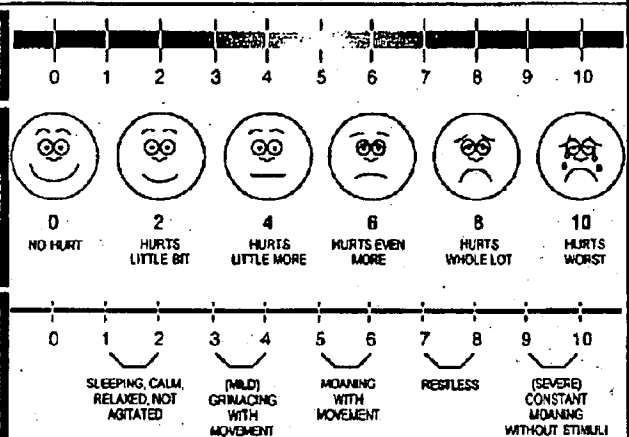
TUOMEY HEALTHCARE SYSTEM
Tuomey Healthcare System
129 North Washington Street
Sumter, South Carolina 29150
(803) 774-9000

SIGNATURE SHEET

(GUIDE TO PAIN MANAGEMENT AND RE-ASSESSMENT OF PAIN)

TO INCLUDE SCHEDULED CONTROLLED SUBSTANCES FOR PAIN

ANXIETY/PAIN/COMFORT CODE (ADULT)



*This Pain Scale is an example of behaviors a patient might show. Because everyone is not alike, this Pain Scale may need to be changed to reflect behaviors specific to individual patients.

For laxatives, antidiarrheals, blood pressure, antipyretics, antiarrhythmics and cough medications, etc. use NA for Code and Sedation Level. For pain medications, use N/A for Outcome Code if patient is asleep.

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S = SLEEPING, EASY TO AROUSE. (IF SLEEPING, COUNT RESPIRATIONS FOR A FULL MINUTE.)*
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3 = FREQUENTLY DROWSY, AROUSABLE, DRIFTS OFF TO SLEEP DURING CONVERSATION.
4 = SOMNOLENT, MINIMAL OR NO RESPONSE TO PHYSICAL STIMULATION.

TO BE UTILIZED WITH CONTROLLED SUBSTANCES AND MEDICATIONS WITH SEDATION POTENTIAL

NEONATAL/INFANT PAIN SCALE (NIPS)

(RECOMMENDED FOR CHILDREN <2 YRS OLD)

FACIAL EXPRESSION	
0 - NO HURT	Restful face, neutral expression
1 - GRIMACE	Tight facial muscles; furrowed brow, chin, (negative facial expression-nose mouth, brow)
CRY	
0 - NO CRY	Quiet, not crying
1 - WHIMPER	Mild moaning, intermittent
2 - VIGOROUS CRY	Loud scream, rising shrill, continuous (Note: silent cry may be scored if baby is intubated as evidence by obvious mouth and facial movement)
BREATHING PATTERNS	
0 - RELAXED	Usual pattern for this infant
1 - CHANGE IN BREATHING	Indrawing, irregular, faster than usual; gagging; breath holding
ARMS	
0 - RELAXED/RESTRAINED	No muscular rigidity; occasional random movement of arms
1 - FLEXED/EXTENDED	Tense, straight arms, rigid and/or rapid extention, flexion
LEGS	
0 - RELAXED/RESTRAINED	No muscular rigidity; occasional random movement of legs
1 - FLEXED/EXTENDED	Tense, straight legs, rigid and/or rapid extention, flexion
STATE OF AROUSAL	
0 - SLEEPING/AWAKE	Quiet, peaceful sleeping or alert random leg movement
1 - FUSSY	Alert, restless and thrashing

FLACC PAIN SCALE

(RECOMMENDED FOR CHILDREN < 2 YRS OLD)

CATEGORIES	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
LEGS	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
ACTIVITY	Lying quiet, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
CRY	No cry, awake or asleep	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaint
CONSOLABILITY	Content, relaxed	Reassured by occasional touching, hugging, or talking to; distractable	Difficult to console or comfort

WHEN PAIN WILL BE REASSESSED AND DOCUMENTED

a. *** **When a patient's pain changes, including, but not limited to, unexpected intense pain or a new report of pain, this will result in documentation of a complete pain assessment (See Pain Assessment Interventions in Meditech).** ***

b. Within 30 minutes after parenteral pain medication is administered.

c. Within one hour after oral pain medication is administered.

d. Within 72 hours after applying a transdermal Fentanyl patch.

e. Every two (2) hours for the first 24 hours after surgery while awake.

f. For patients on PCA or epidural pumps, and continuous narcotic infusions, at the initiation of the infusion, or with any change in settings. The reassessment schedule is every 30 minutes times one, every one hour times one, than every four (4) hours until discontinued.

g. Pain is reassessed every shift once the patient's pain goal is achieved.

h. A pain score of four (4) or above may result in a

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WINDHAM,TAMMY ELIZABETH
Acct: 12756822 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39 [redacted]

553

[redacted]

PRACTITIONER'S FULL SIGNATURE IS REQUIRED FOR ANY INITIAL APPEARING ON THE MEDICATION ADMINISTRATION RECORD.

INITIALS	FULL SIGNATURE	INITIALS	FULL SIGNATURE
KLW	Kimberly Walter, RN	MM	Michelle Mann RN
[illegible]	[illegible] RN	NM	Nicole Miller RN
[illegible]	[illegible]	CO	[illegible]
RR	Renchie Roy RN	MTA	Teresa Maria RN

TUOMEY HEALTHCARE SYSTEM - SIGNATURE SHEET (GUIDE TO PAIN MANAGEMENT AND RE-ASSESSMENT OF PAIN) / PAGE 2(OF 2)
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WINDHAM,TAMMY ELIZABETH
Acct: 12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: Case Management/Social Worker
- Create 05/23/07 1125 MMH 05/23/07 1133 MMH
Abnormal? N Confidential? N
Focus: Financial

Data: Medical record indicates that the patient is selfpay.

Action: Visited with the patient in the patient s room. Patient states she has no minor children and her husband is employed. She does not have health insurance.

Response: Financial Assistance Application given to the patient.

Patient Notes: Case Management/Social Worker
- Create 05/23/07 1347 MLS 05/23/07 1406 MLS
Abnormal? N Confidential? N
Focus:DCP-assessment

Data: Pt. is a 39 y/o W F dx. with pneumonia and vomiting. Pt. has been admitted as self-pay and has been seen for financial assistance.

Action: Met with pt. to determine needs and complete assessment.Pt. reports she lives with her husband and is independent with ADLs, food preparation and transportation. Pt. obtains meds from CVS. Pt. has no HH or comm svc in the home.

Discussed medication assistance with pt. Informed the pt. on the procedure to receive services from SFHC,UM and CM dept. Possible needs medication assistance referral. No other needs identified, will continue to f/u with pt. as needed for DCP services.

Patient Notes: Case Management/Social Worker
- Create 05/25/07 1525 MTH 05/25/07 1527 MTH
Abnormal? N Confidential? N
FOCUS: Discharge Update

DATA: Patient with LLL pneumonia and vomiting. Oxygen saturation 94% on room air. CXR today revealed infiltrate left lung base improved from previous x-ray. Receiving aerosol treatments, Rocephin, IV Zithromax.

ACTION: CM will continue to monitor and provide interventions if needed.

Patient Notes: Case Management/Social Worker
- Create 05/26/07 1329 DGH 05/26/07 1333 DGH
Abnormal? N Confidential? N
Focus: Final Note

Data: CM consult with Dr. Rabon

Action: CM consulted by Dr. Rabon who states that Ms. Windham has been discharged home today and needed financial assistance with her medications. Dr. Rabon states that she requested the pharmacy give Ms. Windham a supply of medications to get her through the Labor Day weekend. CM has met with Ms. Windham and she was given a United Ministries referral for assistance with the remaining medication. CM also gave Ms. Windham a community resource sheet for

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: Case Management/Social Worker (continued)
additional assistance if needed after discharge. No other needs were noted. The above information was given to the nurse.

Patient Notes: Nursing Notes
- Create 05/22/07 1940 NRV 05/22/07 1943 NRV
Abnormal? N Confidential? N
Focus:Admit

Data:Pt admitted from ER at 1700 to room 312. Alert and oriented, reports no pain, only a headache. Left lung sounds are diminished. IV fluids started in int to right ac. VS stable and pt running a sinus rhythm with HR of 81. Pt oriented to room and plan of care. Report given.

Patient Notes: Nursing Notes
- Create 05/23/07 0436 ABG 05/23/07 0443 ABG
Abnormal? N Confidential? N
Focus:PT STATUS

Data: PT ALERT AND ORIENTED.WITH UNLABORED RESPIRATIONS.POSITIVE OCCASSIONAL DRY COUGH.W/ ONGOING NS W/ 20MEQS KCL AT 75 CC/HR. VOMITED ONCE AND WAS MEDICATED ACCORDINGLY.V/S TAKEN AND RECORDED.DUE MEDS GIVEN.FOR URINE AND SPUTUM C/S STILL TO OBTAIN SPECIMEN,PT INSTRUCTED SPECIMEN BOTTLE AT BEDSIDE.WILL CONTINUE TO MONITOR.

Patient Notes: Nursing Notes
- Create 05/23/07 1500 KM 05/23/07 1659 KM
Abnormal? N Confidential? N
Focus: Status

Data: C/o s of chest discomfort when she coughs. Occasional productive cough has been noted. Sputum was collected and sent to lab. Urine was collected and sent to lab. Robitussin DM given for cough with minimal relief. Dr. Rabon notified and a different cough medication was ordered (Hycodan)
No complaints of sob. 02 sat 97% on room air. SR, dep. ST on Telemetry. IVF s d/c ed this shift. New 20g INT inserted to left Hand per P. Whack, RN. No acute distress noted.
Results of today s labs to be called to Dr. Tan per oncoming nurse.

Patient Notes: Nursing Notes
- Create 05/24/07 0251 TA 05/24/07 0259 TA
Abnormal? N Confidential? N
Focus:SHIFT NOTES
PATIENT IS AWAKE,RESTING IN BED ON INITIAL ROUNDS,VITAL SIGNS TAKEN AD RECORDED,AFEBRILE,O2 SAT 98% ON RA. STILL HAVING NON-PRODUCTIVE COUGH CAUSING CHEST DISCOMFORT AND HEADACHE. PATIENT WAS MEDICATED WITH TYLENOL INITIALLY FOR THE HEADACHE BUT WAS OT RELIEVED AFTER A HUR,PERCOCET TAB GIVEN AS PER ORDER AND PATIENT WAS RELIEVED. HYCODAN FOR COUGH WAS GIVEN LAST NIGHT AND SHE WAS ABLE TO SLEEP WELL UNTIL SHE HAD ANOTHER COUGHING SPELL EARLIER,ANOTHER HYCODAN DOSE GIVEN. PATIENT REMAINS ALERT AND ORIENTED X3. HAS NEW INT ON HER RT FA,FLUSHING WELL. PREVIOUS INT ON HER LEFT HAND WAS HURTING. NEEDS ATTENDED,WILL CONTINUE TO MONITOR,SR WITH DEP ST ON TELEMETRY.

Patient Notes: Nursing Notes
- Create 05/24/07 1516 PJW 05/24/07 1519 PJW
Abnormal? N Confidential? N
Focus: AM ASSESSMENT

556

Data: PT ALERT AND ORIENTED. DENIES C/O CHEST PAIN OR SOB. CHEST CLEAR

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: Nursing Notes (continued)

WITH SCATTERED CONGESTION NOTED POSTERIORALLY. ABD SOFT, NON TENDER WITH +BS. NO EDEMA TO LOWER EXTEMITIES. COUGHING, NON PRODUCTIVE. MEDICATED. EATING AND DRINKING WITHOUT DIFFICULTY. CALL BELL WITHIN REACH, WILL CONTINUE TO MONITOR.

Patient Notes: Nursing Notes

- Create 05/25/07 0234 TA 05/25/07 0243 TA
  Abnormal? N Confidential? N
  Focus:SHIFT NOTES
  PATIENT IS ALERT AND ORIENTED X3,HAS BEEN SLEEPING WELL TONIGHT,DENIES ANY PAIN OR SOB,COUGH IS BETTER,STILL NON-PRODUCTIVE. HAS COARSE BREATH SOUNDS. INITIAL VITAL SIGNS TAKEN AND RECORDED,AFEBRILE. COMPLAINED EARLIER LAST NIGHT OF NAUSEA, WAS MEDICATED WITH PHENERGAN IV BY MS.HEYWARD,RN. NEW INT INPLACE ON HER LEFT HAND. RE-INSTRUCTED PATIENT TO REPORT ANY BM TO CHECK FOR BLOOD. NO SIGNS OF BLEEDING NOTED. NEEDS ATTENDED,HUSBAND AT BEDSIDE. NEEDS ATTENDED,WILL CONTINUE TO MONITOR,SR WITH DEP ST ON TELEMETRY.

Patient Notes: Nursing Notes

- Create 05/25/07 0741 WJT 05/25/07 0743 WJT
  Abnormal? N Confidential? N
  FOCUS: PT. STATUS

  DATA: PT. ALERT AND ORIENTED. NO C/O PAIN OR DISCOMFORT THIS AM. 97/71 P 85 AFEBRILE. RESPIRATIONS UNLABORED. COARSE BREATH SOUNDS. 94% RA. SR WITH DEPRESSED ST ON TELE. NO BM YET. PT SAYS THIS IS NOT UNUSUAL FOR HER. NON PRODUCTIVE COUGH. SAID SHE VOMITED LAST NIGHT. HGB 9.8 THIS AM HCT 31.5.

Patient Notes: Nursing Notes

- Create 05/26/07 0341 RR 05/26/07 0346 RR
  Abnormal? N Confidential? N
  Focus:shift note
  Patient is alert and oriented. Her telemetry monitor is showing sinus rhythm with depressed ST segment. She has coarse breath sounds, has non productive cough. O2 sat 95% on room air. She has a patent INT in her right wrist. She complained of headache not relieved by Tylenol, Percocet given and it eased off her pain. H&H yesterday were 9.8 and 31.5. She is for blood transfusion of one unit of PRBC if hgb is <8.5. She is for H&H again this morning.

Patient Notes: Nursing Notes

- Create 05/26/07 0756 WJT 05/26/07 0758 WJT
  Abnormal? N Confidential? N
  FOCUS: PT. STATUS

  DATA: PT. ALERT AND ORIENTED. NO C/O PAIN OR DISCOMFORT. PT. TOLD ME THAT SHE HAS CONSTANT HEADACHES AT HOME AND TAKES TYLENOL. 144/73 P 73 AFEBRILE. RESPIRATONS UNLABORED. COARSE BREATH SOUNDS. 94% RA. SR WITH DEPRESSED ST ON TELE. HGB 9.5 AND HCT 30.1 THIS AM. CHECK STOOLS FOR OCCULT BLOOD. PT. HAS NOT HAD BM SINCE ADMIT AND SAYS THAT THIS IS NOT UNUSUAL FOR HER. SHE EXPRESSED NO DISCOMFORT

Patient Notes: Nursing Notes

- Create 05/26/07 1444 WJT 05/26/07 1446 WJT
  Abnormal? N Confidential? N
  Focus: Patient Discharged by Nursing Staff

  Data: Time of Discharge:1445
  Mode:WHEELCHAIR

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Patient Notes: Nursing Notes (continued)

Escorted by (Hospital Employee - Name/Title):LEANNA CNA
Destination:HOME
Name of Person Discharged to:SELF
Current Phone No.:

Describe how the Patient and/or Significant Other has demonstrated the abilities to manage continuing care needs post-discharge:

PT. EXPRESSED FULL UNDERSTANDING OF ALL DISCHARGE INSTRUCTIONS. INT REMOVED INTACT.

Monogram	Initials	Name	Nurse Type
ABG	NSABG1	GALELA,ARMI B.	RN
DGH	CMDH	HORTON,DELORIS G.	RN
KM	NSKM	WALKER,KIMBREA	RN
MLS	CMMLS	SINGLETARY,MONA L.	SW
MMH	BOMMH	HOWLE,MARY M.	SW
MTH	NSMTH1	HOUGLAND,MARY T.	RN
NRV	NSNV	VAN PATTEN,NAOMI R.	RN
PJW	NSPW1	WHACK,PAULINE J.	RN
RR	NSRC1	ROY,RENCHIE	RN
TA	NSTA	ALAISA,TERESA	RN
WJT	NSWJT	THURBER,BUTCH	RN

001993

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/22/07 Time: 1940

Patient Notes: Nursing Notes
- Create 05/22/07 1940 NRV 05/22/07 1943 NRV
Abnormal? N Confidential? N
Focus:Admit

Data:Pt admitted from ER at 1700 to room 312. Alert and oriented, reports no pain, only a headache. Left lung sounds are diminished. IV fluids started in int to right ac. VS stable and pt running a sinus rhythm with HR of 81. Pt oriented to room and plan of care. Report given.

Activity Date: 05/23/07 Time: 0436

Patient Notes: Nursing Notes
- Create 05/23/07 0436 ABG 05/23/07 0443 ABG
Abnormal? N Confidential? N
Focus:PT STATUS

Data: PT ALERT AND ORIENTED.WITH UNLABORED RESPIRATIONS.POSITIVE OCCASSIONAL DRY COUGH.W/ ONGOING NS W/ 20MEQS KCL AT 75 CC/HR. VOMITED ONCE AND WAS MEDICATED ACCORDINGLY.V/S TAKEN AND RECORDED.DUE MEDS GIVEN.FOR URINE AND SPUTUM C/S STILL TO OBTAIN SPECIMEN,PT INSTRUCTED SPECIMEN BOTTLE AT BEDSIDE.WILL CONTINUE TO MONITOR.

Activity Date: 05/23/07 Time: 1125

Patient Notes: Case Management/Social Worker
- Create 05/23/07 1125 MMH 05/23/07 1133 MMH
Abnormal? N Confidential? N
Focus: Financial

Data: Medical record indicates that the patient is selfpay.

Action: Visited with the patient in the patient s room. Patient states she has no minor children and her husband is employed. She does not have health insurance.

Response: Financial Assistance Application given to the patient.

Activity Date: 05/23/07 Time: 1347

Patient Notes: Case Management/Social Worker
- Create 05/23/07 1347 MLS 05/23/07 1406 MLS
Abnormal? N Confidential? N
Focus:DCP-assessment

Data: Pt. is a 39 y/o W F dx. with pneumonia and vomiting. Pt. has been admitted as self-pay and has been seen for financial assistance.

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Action: Met with pt. to determine needs and complete assessment.Pt. reports she lives with her husband and is independent with ADLs, food preparation and transportation. Pt. obtains meds from CVS. Pt. has no HH or comm svc in the

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 1347 (continued)

Patient Notes: Case Management/Social Worker (continued)
home.

Discussed medication assistance with pt. Informed the pt. on the procedure to receive services from SFHC,UM and CM dept. Possible needs medication assistance referral. No other needs identified, will continue to f/u with pt. as needed for DCP services.

Activity Date: 05/23/07 Time: 1500

Patient Notes: Nursing Notes
- Create 05/23/07 1500 KM 05/23/07 1659 KM
Abnormal? N Confidential? N
Focus: Status

Data: C/o s of chest discomfort when she coughs. Occasional productive cough has been noted. Sputum was collected and sent to lab. Urine was collected and sent to lab. Robitussin DM given for cough with minimal relief. Dr. Rabon notified and a different cough medication was ordered (Hycodan)
No complaints of sob. 02 sat 97% on room air. SR, dep. ST on Telemetry. IVF s d/c ed this shift. New 20g INT inserted to left Hand per P. Whack, RN. No acute distress noted.
Results of today s labs to be called to Dr. Tan per oncoming nurse.

Activity Date: 05/24/07 Time: 0251

Patient Notes: Nursing Notes
- Create 05/24/07 0251 TA 05/24/07 0259 TA
Abnormal? N Confidential? N
Focus:SHIFT NOTES
PATIENT IS AWAKE,RESTING IN BED ON INITIAL ROUNDS,VITAL SIGNS TAKEN AD RECORDED,AFEBRILE,02 SAT 98% ON RA. STILL HAVING NON-PRODUCTIVE COUGH CAUSING CHEST DISCOMFORT AND HEADACHE. PATIENT WAS MEDICATED WITH TYLENOL INITIALLY FOR THE HEADACHE BUT WAS OT RELIEVED AFTER A HUR,PERCOCET TAB GIVEN AS PER ORDER AND PATIENT WAS RELIEVED. HYCODAN FOR COUGH WAS GIVEN LAST NIGHT AND SHE WAS ABLE TO SLEEP WELL UNTIL SHE HAD ANOTHER COUGHING SPELL EARLIER,ANOTHER HYCODAN DOSE GIVEN. PATIENT REMAINS ALERT AND ORIENTED X3. HAS NEW INT ON HER RT FA,FLUSHING WELL. PREVIOUS INT ON HER LEFT HAND WAS HURTING. NEEDS ATTENDED,WILL CONTINUE TO MONITOR,SR WITH DEP ST ON TELEMETRY.

Activity Date: 05/24/07 Time: 1516

Patient Notes: Nursing Notes
- Create 05/24/07 1516 PJW 05/24/07 1519 PJW
Abnormal? N Confidential? N
Focus: AM ASSESSMENT

560

Data: PT ALERT AND ORIENTED. DENIES C/O CHEST PAIN OR SOB. CHEST CLEAR WITH SCATTERED CONGESTION NOTED POSTERIORALLY. ABD SOFT, NON TENDER WITH +BS. NO EDEMA TO LOWER EXTEMITIES. COUGHING, NON PRODUCTIVE. MEDICATED. EATING AND DRINKING WITHOUT DIFFICULTY. CALL BELL WITHIN REACH, WILL CONTINUE TO

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/24/07 Time: 1516 (continued)

Patient Notes: Nursing Notes (continued)
MONITOR.

Activity Date: 05/25/07 Time: 0234

Patient Notes: Nursing Notes
- Create 05/25/07 0234 TA 05/25/07 0243 TA
Abnormal? N Confidential? N
Focus:SHIFT NOTES
PATIENT IS ALERT AND ORIENTED X3,HAS BEEN SLEEPING WELL TONIGHT,DENIES ANY PAIN OR SOB,COUGH IS BETTER,STILL NON-PRODUCTIVE. HAS COARSE BREATH SOUNDS. INITIAL VITAL SIGNS TAKEN AND RECORDED,AFEBRILE. COMPLAINED EARLIER LAST NIGHT OF NAUSEA, WAS MEDICATED WITH PHENERGAN IV BY MS.HEYWARD,RN. NEW INT INPLACE ON HER LEFT HAND. RE-INSTRUCTED PATIENT TO REPORT ANY BM TO CHECK FOR BLOOD. NO SIGNS OF BLEEDING NOTED. NEEDS ATTENDED,HUSBAND AT BEDSIDE. NEEDS ATTENDED,WILL CONTINUE TO MONITOR,SR WITH DEP ST ON TELEMETRY.

Activity Date: 05/25/07 Time: 0741

Patient Notes: Nursing Notes
- Create 05/25/07 0741 WJT 05/25/07 0743 WJT
Abnormal? N Confidential? N
FOCUS: PT. STATUS

DATA: PT. ALERT AND ORIENTED. NO C/O PAIN OR DISCOMFORT THIS AM. 97/71 P 85 AFEBRILE. RESPIRATIONS UNLABORED. COARSE BREATH SOUNDS. 94% RA. SR WITH DEPRESSED ST ON TELE. NO BM YET. PT SAYS THIS IS NOT UNUSUAL FOR HER. NON PRODUCTIVE COUGH. SAID SHE VOMITED LAST NIGHT. HGB 9.8 THIS AM HCT 31.5.

Activity Date: 05/25/07 Time: 1525

Patient Notes: Case Management/Social Worker
- Create 05/25/07 1525 MTH 05/25/07 1527 MTH
Abnormal? N Confidential? N
FOCUS: Discharge Update

DATA: Patient with LLL pneumonia and vomiting. Oxygen saturation 94% on room air. CXR today revealed infiltrate left lung base improved from previous x-ray. Receiving aerosol treatments, Rocephin, IV Zithromax.

ACTION: CM will continue to monitor and provide interventions if needed.

Activity Date: 05/26/07 Time: 0341

Patient Notes: Nursing Notes
- Create 05/26/07 0341 RR 05/26/07 0346 RR
Abnormal? N Confidential? N
Focus:shift note
Patient is alert and oriented. Her telemetry monitor is showing sinus rhythm with depressed ST segment. She has coarse breath sounds, has non productive cough. 02 sat 95% on room air. She has a patent INT in her right wrist. She

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Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/26/07 Time: 0341 (continued)

Patient Notes: Nursing Notes (continued)
complained of headache not relieved by Tylenol, Percocet given and it eased off her pain. H&H yesterday were 9.8 and 31.5. She is for blood transfusion of one unit of PRBC if hgb is <8.5. She is for H&H again this morning.

Activity Date: 05/26/07 Time: 0756

Patient Notes: Nursing Notes
- Create 05/26/07 0756 WJT 05/26/07 0758 WJT
Abnormal? N Confidential? N
FOCUS: PT. STATUS

DATA: PT. ALERT AND ORIENTED. NO C/O PAIN OR DISCOMFORT. PT. TOLD ME THAT SHE HAS CONSTANT HEADACHES AT HOME AND TAKES TYLENOL. 144/73 P 73 AFEBRILE. RESPIRATONS UNLABORED. COARSE BREATH SOUNDS. 94% RA. SR WITH DEPRESSED ST ON TELE. HGB 9.5 AND HCT 30.1 THIS AM. CHECK STOOLS FOR OCCULT BLOOD. PT. HAS NOT HAD BM SINCE ADMIT AND SAYS THAT THIS IS NOT UNUSUAL FOR HER. SHE EXPRESSED NO DISCOMFORT

Activity Date: 05/26/07 Time: 1329

Patient Notes: Case Management/Social Worker
- Create 05/26/07 1329 DGH 05/26/07 1333 DGH
Abnormal? N Confidential? N
Focus: Final Note

Data: CM consult with Dr. Rabon

Action: CM consulted by Dr. Rabon who states that Ms. Windham has been discharged home today and needed financial assistance with her medications. Dr. Rabon states that she requested the pharmacy give Ms. Windham a supply of medications to get her through the Labor Day weekend. CM has met with Ms. Windham and she was given a United Ministries referral for assistance with the remaining medication. CM also gave Ms. Windham a community resource sheet for additional assistance if needed after discharge. No other needs were noted. The above information was given to the nurse.

Activity Date: 05/26/07 Time: 1444

Patient Notes: Nursing Notes
- Create 05/26/07 1444 WJT 05/26/07 1446 WJT
Abnormal? N Confidential? N
Focus: Patient Discharged by Nursing Staff

Data: Time of Discharge:1445
Mode:WHEELCHAIR
Escorted by (Hospital Employee - Name/Title):LEANNA CNA
Destination:HOME
Name of Person Discharged to:SELF
Current Phone No.:

562

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/26/07 Time: 1444 (continued)

Patient Notes: Nursing Notes (continued)

Describe how the Patient and/or Significant Other has demonstrated the abilities to manage continuing care needs post-discharge:

PT. EXPRESSED FULL UNDERSTANDING OF ALL DISCHARGE INSTRUCTIONS. INT REMOVED INTACT.

Monogram	Initials	Name	Nurse Type
ABG	NSABG1	GALELA,ARMI B.	RN
DGH	CMDH	HORTON,DELORIS G.	RN
KM	NSKM	WALKER,KIMBREA	RN
MLS	CMMLS	SINGLETARY,MONA L.	SW
MMH	BOMMH	HOWLE,MARY M.	SW
MTH	NSMTH1	HOUGLAND,MARY T.	RN
NRV	NSNV	VAN PATTEN,NAOMI R.	RN
PJW	NSPW1	WHACK,PAULINE J.	RN
RR	NSRC1	ROY,RENCHIE	RN
TA	NSTA	ALAISA,TERESA	RN
WJT	NSWJT	THURBER,BUTCH	RN

001998

Intervention Description Sts Direction From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/23/07 Time: 1413

9 ***Nutrition*** A AS
- Create 05/23/07 1413 EEE 05/23/07 1418 EEE
- Document 05/23/07 1413 EEE 05/23/07 1418 EEE

Chief Complaint: LLL PNEUMONIA,VOMITING
Past Medical History: CAD with Stent, HTN

Diet followed at home: REG
Current diet: Clear Liquid Texture: Regular

Ht: ft: 5 in: 3.0 cm: 160.0 Frame size: MEDIUM IBW= 115 % of IBW: 125.0
Wt: lb: 144 oz: kg: 65.32 %ILE of HT: %ILE of WT:

BMI= 25.50 Wt based on BMI: Obesity 1 (BMI 25-29.9)

Na+: 137 05/23/07 1230 Trig:
K+: 4.1 05/23/07 1230 CO2:
Glu: 112 05/23/07 1230 PH: 5.5 05/22/07 1100
Calcium: 8.6 05/23/07 1230 BUN: 4 05/23/07 1230
Phos: CREA: 30.8 05/23/07 1230
Mg: 1.9 05/23/07 1230 Hgb:
PreAlb: Hct:
Alb: 3.9 05/22/07 1125 Visceral Protein Status: WNL 3.5-5.0

Estimated needs based on: IBW
Calories= 1300-1600
Protein (g) = 42-52
Fluid (cc)= 1300-1600

Follow-up date: 05/27/07

Likes and Dislikes:

Comments: Pt screened for n/v. Labs show low hgb, low K, low BUN, low CREA, and albumin WNL. Pt reports n/v x 1 week; hasn t been able to keep anything down. Per pt, loss of 15 pounds in 2 weeks. Advanced diet as tolerated and encourage intakes >75%. RD is available for further nutritional needs.

Problems Identified: NUTRITION Nutritional care

Activity Date: 05/23/07 Time: 1418

1120 Nutrition Therapy/Management RD ONLY A CP
- Create 05/23/07 1418 EEE 05/23/07 1418 EEE
- Document 05/23/07 1418 EEE 05/23/07 1418 EEE

564

Intervention Description / Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Direction	Documented Units	From Change
Activity Date: 05/23/07		**Time: 1418**									
1160 Nutritional Monitoring/Diet Staging (RD)								A			CP
- Create	05/23/07	1418	EEE	05/23/07	1418	EEE					
- Document	05/23/07	1418	EEE	05/23/07	1418	EEE					
Activity Date: 05/26/07		**Time: 1728**									
9 ***Nutrition***								D			AS
- Ed Status	05/26/07	1728	his	05/26/07	1728	his					A => D
1120 Nutrition Therapy/Management							RD ONLY	D			CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his					A => D
1160 Nutritional Monitoring/Diet Staging (RD)								D			CP
- Ed Status	05/26/07	1728	his	05/26/07	1728	his					A => D

Monogram Initials		Name	Nurse Type
EEE	FNSEEE	ELLIOTT,ELLEN	RD
his		automatic by program	

Intervention Description	Sts	Direction	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 05/23/07 Time: 1357

12059 PT: Functional Screening A PS
- Create 05/23/07 1357 CAC 05/23/07 1357 CAC

Activity Date: 05/26/07 Time: 1728

12059 PT: Functional Screening D PS
- Ed Status 05/26/07 1728 his 05/26/07 1728 his A => D

Monogram	Initials	Name	Nurse Type
CAC	RSCAC	CANARINA,SYNDE	PT
his		automatic by program	

Run Time: 1421	Tuomey Healthcare System	Name: WINDHAM,TAMMY ELIZAB
Run Date: 05/26/07	Sumter, South Carolina	Acct #: 12756622
Run User: NSWJT	803-774-9000	MRN: 229998

General Discharge Instructions

Patient Activities:

Community Service Referral:

Date Pneumococcal vaccine given: **If not, reason:**
Date Influenza vaccine given: **If not, reason:**

Discharge Diet:
Cardiac Diet

If you have any of the following symptoms, please report them to your physician:
**Temperature greater than 101
**Pain not relieved by pain medication
**Persistent nausea and vomiting, diarrhea
**CHEST PAIN, SHORTNESS OF BREATH, ANY OTHER
**CONCERNS

FOLLOW-UP APPOINTMENTS
Dr. FHC Date/Time 1-2 WEEKS
>>To help manage your illness, keep your regular appointments with your healthcare provider.
Printed/Additional Instructions
REPEAT CHEST X RAY UNTIL CLEAR
REPEAT ULTRASOUND TO FOLLOW UP ON OVARIAN CYST
FOLLOW UP ON HGB, IRON, B12, FOLIC ACID

Valuables/Personal items taken home:

The patient had dentures on admit.

The patient does not have home medications at THS.

Copy of this form given to: PATIENT

I have received and fully understand the above instructions for post hospital care.

Tammy E Windham Date: 05/26/07
(signature of patient or significant other)

You may receive a patient satisfaction survey in the mail after you return home. It's important to us that you complete AND return the survey. We will use your feedback to make improvements in the delivery of care to all patients.

WINDHAM,TAMMY ELIZABETH
Acct:12756622 Unit: 229998
MEDICAL SERVICES - TMP
MED 312/1 DOS: 05/22/07
F W Age: 39 [redacted]

567

Run Time: 1434 Tuomey Healthcare System Name: WINDHAM,TAMMY ELIZAB
Run Date: 05/26/07 Sumter, South Carolina Acct #: 12756622
Run User: NSWJT 803-774-9000 MRN: 229998

Medications to Take After You Leave Tuomey

Advair 250/50 Inhaler
ALSO CALLED: FLUTICASONE/SALMETEROL 250/50
HOW MUCH TO TAKE:0 BLIS HOW OFTEN TO TAKE:TWICE A DAY RESPIRATORY INHALE
HOW TO TAKE THE MEDICATION: BY BREATHING IN THE MEDICATION
WHY YOU SHOULD TAKE THIS MEDICATION:
>>>>>>SPECIAL COMMENTS: 1 PUFF EVERY 12 HOURS

Bayer Asa Child Chewable
ALSO CALLED: ASPIRIN
HOW MUCH TO TAKE:81 MG HOW OFTEN TO TAKE:ONCE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Combivent
ALSO CALLED: ALBUTEROL/IPRATROPIUM
HOW MUCH TO TAKE:0 G HOW OFTEN TO TAKE:
HOW TO TAKE THE MEDICATION: BY BREATHING IN THE MEDICATION
WHY YOU SHOULD TAKE THIS MEDICATION:
>>>>>>SPECIAL COMMENTS: 2 PUFFS EVERY 6 HOURS

Ferrous Sulfate
ALSO CALLED: FERROUS SULFATE
HOW MUCH TO TAKE:325 MG HOW OFTEN TO TAKE:THREE TIMES A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Folic Acid
ALSO CALLED: FOLIC ACID
HOW MUCH TO TAKE:1 MG HOW OFTEN TO TAKE:ONCE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Lopressor
ALSO CALLED: METOPROLOL
HOW MUCH TO TAKE:50 MG HOW OFTEN TO TAKE:TWICE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Metanx
ALSO CALLED: VITA B12/B6/L-METHYLFOLATE
HOW MUCH TO TAKE:1 TAB HOW OFTEN TO TAKE:TWICE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Omnicef
ALSO CALLED: CEFDINIR
HOW MUCH TO TAKE:300 MG HOW OFTEN TO TAKE:TWICE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:
>>>>>>SPECIAL COMMENTS: TAKE FOR NINE DAYS

Run Time: 1434 Tuomey Healthcare System Name: WINDHAM,TAMMY ELIZAB
Run Date: 05262007 Sumter, South Carolina Acct #: 12756622
Run User: NSWJT 803-774-9000 MRN: 229998

Pepcid
ALSO CALLED: FAMOTIDINE
HOW MUCH TO TAKE:20 MG HOW OFTEN TO TAKE:TWICE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Plavix
ALSO CALLED: CLOPIDOGREL
HOW MUCH TO TAKE:75 MG HOW OFTEN TO TAKE:ONCE A DAY
HOW TO TAKE THE MEDICATION: BY MOUTH
WHY YOU SHOULD TAKE THIS MEDICATION:

Run Time: 1434
Run Date: 05/26/07
Run User: NSWJT

Tuomey Healthcare System
Sumter, South Carolina
803-774-9000

Name: WINDHAM,TAMMY ELIZAB
Acct #: 12756622
MRN: 229998

****Important Safety Information about Medication and Food Interactions****

If your medications to be taken at home include:

Cyclosporin (cyclosporine) please note you should avoid grapefruit and grapefruit juice-containing foods.

Theodur (theophylline) please note you should avoid drastic changes in caffeine intake.

Zyvoxx (linezolid) please note you should avoid foods containing significant amounts of tyramine such as aged cheeses, aged meats, soy sauce, tofu, sauerkraut and use caution with beer and wine.

Synthroid (levothyroxine) you should take on an empty stomach to increase absorption (how the medication gets into your blood).

Run Time: 1434	Tuomey Healthcare System	Name: WINDHAM,TAMMY ELIZAB
Run Date: 05/26/07	Sumter, South Carolina	Acct #: 12756622
Run User: NSWJT	803-774-9000	MRN: 229998

Disease-Specific Instructions

DISCHARGE INSTRUCTIONS FOR THE PATIENT RECOVERING FROM PNEUMONIA

Pneumonia is a serious infection in your lungs. It can be caused by a bacterial infection, a viral infection or other organisms. Air sacs in the lungs fill with pus or other liquids making it hard for oxygen to reach your blood. Because your body s cell will not be able to work properly with the low levels of oxygen, pneumonia can lead to death. Most healthy people can usually fight off the infection but someone who is ill or has a weakened immune system can t.

Breathing Exercises:
Continue your deep breathing exercises and effective coughing

Irritants:
Avoid irritants that increase secretions; for example, cigarette smoke, dust and other environmental irritants

Avoid Transmission of Disease:
1. Turn your head when you cough
2. Cover your mouth with tissue when you sneeze or cough
3. Use good hand washing

Ask Your Doctor About:
1. Flu Shots: Flu shots can reduce the chance of getting the flu. You should get a flu shot every year.
2. Pneumococcal Vaccine: This vaccine should be administered to prevent a common cause of pneumonia. Revaccination may be necessary after 5 years in those over 65 years old.

Diet instruction:
1. See discharge diet instructions
2. Drink 6 - 8 glasses of water a day, unless on fluid restrictions

Medication:
1. See medication instruction sheet.
2. Take medications as ordered and make sure you refill them so you do not run out.
3. Take medications with you to your doctor appointments, so that they will be aware of all the medications you are taking including any over the counter medications.

Activity:
1. Short frequent walks. Increase as tolerated
2. Get 6 - 8 hours of sleep each night
3. Avoid getting tired, pace yourself and take rest periods as needed

Smoking cessation: Quitting smoking is the single most important thing you can do to reduce your risk of developing lung disease. You also need to try and stay away from people who smoke or places where there is smoking. See your copy of the American Cancer Society "Freshstart" smoking cessation program pamphlet for information on how to quit smoking.

Notify your Doctor if any of the following signs of pneumonia occur:
1. Temperature greater than 100.4 degrees Fahrenheit or chills
2. Worsening shortness of breath
3. Cough that produces greenish yellow, dark brown or red sputum
4. Generalized weakness
5. Painful breathing
6. Chest pain
7. Rapid pulse
8. Rapid breathing
9. Blueness around the lips and nails

****Please note: if you did not receive a copy of the "Preventing Pneumonia" handout while inpatient you can request one before discharge from your nurse. After discharge, you can call the Tuomey Healthcare System Education Resource Center at 803-774-8677 for information about how to receive a copy.****

002007

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction / Comment	Documented Units	From / Change
Problem: Pneumonia				ICD9# 486			D			
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Outcome: Respiratory Status: Gas Exchange							D	05/27/07		
Definition: Alveolar exchange of CO2, or O2 to maintain arterial blood gas concentrations.										
5. Extremely compromised										
4. Substantially compromised										
3. Moderately compromised										
2. Mildly compromised										
1. Not compromised										
INDICATORS										
Mental status IER*										
Ease of breathing										
Dyspnea at rest not present										
Dyspnea with exertion not present										
Restlessness not present										
Cyanosis not present										
Somnolence not present										
Pao2 WNL*										
Paco2 WNL										
Arterial pH WNL										
O2 saturation WNL										
Chest x-ray findings IER										
Chest expansion symmetrical										
Accessory muscle use not present										
Auscultated breath sounds, IER										
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Target	05/22/07	1716	NRV	05/22/07	1716	NRV			None => 05/27/07	
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV		Day:1 Met	I=2	
- Document	05/23/07	1512	KM	05/23/07	1512	KM		Day:1 Met	,O=2	
- Document	05/24/07	0348	TA	05/24/07	0348	TA		Day:1 Met	,O=3	
- Document	05/25/07	0345	TA	05/25/07	0345	TA		Day:1 Met	,O=3	
- Document	05/25/07	1233	WJT	05/25/07	1233	WJT		Day:1 Met	,O=3	
- Document	05/26/07	0445	RR	05/26/07	0446	RR		Day:1 Met	,O=2	
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
3141 Oxygen Therapy							D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
6681 Pulse Oximetry (SAO2)							D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
21 ***Respiratory Re-eval*** (Nursing)							D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/23/07	0840	KM	05/23/07	1650	KM				

**********RESPIRATORY**********

573

002008

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction / Comment	Documented Units	From Change
21	***Respiratory Re-eval*** (Nursing) (continued)									

Respiratory Effort: Unlabored
Breath Sounds, Left: DIMIN Breath Sounds, Right: DIMIN
Cough: PRODUCTIVE
Capillary Refill: QUICK

- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Outcome: Infection Status							D	05/27/07		

Definition: Presence and extent of infection

5. Severe
4. Substantial
3. Moderate
2. Slight
1. None

INDICATORS

Foul-smelling drainage
Purulent sputum
Purulent drainage
Fever
Pain/tenderness
Culture colonization (blood, sputum, wound, urine, etc.), as appropriate
WBC elevation

- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Target	05/22/07	1716	NRV	05/22/07	1716	NRV			None => 05/27/07	
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV		Day:1	Met I=3	
- Document	05/23/07	1512	KM	05/23/07	1513	KM		Day:1	Met ,O=2	
- Document	05/24/07	0348	TA	05/24/07	0348	TA		Day:1	Met ,O=3	
- Document	05/25/07	0345	TA	05/25/07	0345	TA		Day:1	Met ,O=2	
- Document	05/25/07	1233	WJT	05/25/07	1233	WJT		Day:1	Met ,O=2	
- Document	05/26/07	0446	RR	05/26/07	0446	RR		Day:1	Met ,O=2	
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
6540 Infection Control							D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Outcome: Vital Sign Status							D	05/27/07		

Definition: Temperature, pulse, respirations, and blood pressure within expected range for the individual

5. Extreme deviation from expected range
4. Substantial deviation from expected range
3. Moderate deviation from expected range
2. Slight deviation from expected range

574

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
Outcome: Vital Sign Status (continued)											
	1. No deviation from expected range										
	INDICATORS:										
	Temperature										
	Apical pulse rate										
	Radial pulse rate										
	Respiration rate										
	Systolic BP*										
	Diastolic BP										
-	Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
-	Ed Target	05/22/07	1716	NRV	05/22/07	1716	NRV				None => 05/27/07
-	Document	05/22/07	1940	NRV	05/22/07	1940	NRV		Day:1	Met	I=2
-	Document	05/23/07	1513	KM	05/23/07	1513	KM		Day:1	Met	,O=2
-	Document	05/24/07	0348	TA	05/24/07	0348	TA		Day:1	Met	,O=2
-	Document	05/25/07	0345	TA	05/25/07	0345	TA		Day:1	Met	,O=2
-	Document	05/25/07	1233	WJT	05/25/07	1233	WJT		Day:1	Met	,O=2
-	Document	05/26/07	0446	RR	05/26/07	0446	RR		Day:1	Met	,O=2
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Outcome: Knowledge: Disease/Illness Process								D	05/27/07		
	Definition: Extent of understanding conveyed about a specific disease process.										
	5. None										
	4. Limited										
	3. Moderate										
	2. Substantial										
	1. Extensive										
	INDICATORS										
	Familiarity with disease name										
	Description of disease process										
	Description of cause or contributing factors										
	Description of risk factors										
	Description of effects of disease										
	Description of signs and symptoms										
	Description of usual disease course										
	Description of measures to minimize disease progression										
	Description of complications										

002010

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
Outcome: Knowledge: Disease/Illness Process (continued)											
	Description of signs and symptoms of complications										
	Description of precautions to prevent complications										
-	Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
-	Ed Target	05/22/07	1716	NRV	05/22/07	1716	NRV			None => 05/27/07	
-	Document	05/22/07	1940	NRV	05/22/07	1940	NRV		Day:1	Met I=3	
-	Document	05/23/07	1513	KM	05/23/07	1513	KM		Day:1	Met ,O=3	
-	Document	05/24/07	0348	TA	05/24/07	0348	TA		Day:1	Met ,O=2	
-	Document	05/25/07	0345	TA	05/25/07	0345	TA		Day:1	Met ,O=2	
-	Document	05/25/07	1233	WJT	05/25/07	1233	WJT		Day:1	Met ,O=2	
-	Document	05/26/07	0446	RR	05/26/07	0446	RR		Day:1	Met ,O=2	
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Problem: Nutritional Care								D			
-	Create	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
Outcome: Nutritional Status								D	05/30/07		
	Definition: Extent to which nutrients are available to meet metabolic needs.										
	5. Extremely compromised										
	4. Substantially compromised										
	3. Moderately compromised										
	2. Mildly compromised										
	1. Not compromised										
	INDICATORS:										
	Nutrient intake										
	Food and fluid intake										
	Energy										
	Body mass										
	Weight										
-	Create	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Ed Target	05/23/07	1418	EEE	05/23/07	1418	EEE			None => 05/30/07	
-	Document	05/23/07	1418	EEE	05/23/07	1418	EEE		Day:1	Met I=3	
-	Document	05/24/07	0348	TA	05/24/07	0348	TA		Day:1	Met ,O=2	
-	Document	05/25/07	0345	TA	05/25/07	0345	TA		Day:1	Met ,O=2	
-	Document	05/25/07	1233	WJT	05/25/07	1233	WJT		Day:1	Met ,O=2	
-	Document	05/26/07	0446	RR	05/26/07	0446	RR		Day:1	Met ,O=2	
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
1160	Nutritional Monitoring/Diet Staging (RD)							D			CP
-	Create	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Document	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
1120	Nutrition Therapy/Management RD ONLY							D			CP
-	Create	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Document	05/23/07	1418	EEE	05/23/07	1418	EEE				
-	Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D

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002011

Additional Interventions

2 ***Head to Toe*** (ADMISSION ONLY) D AS
- Create 05/22/07 1707 NRV 05/22/07 1715 NRV
- Document 05/22/07 1707 NRV 05/22/07 1715 NRV

**********NEUROLOGICAL ASSESSMENT**********

Level of Consciousness: ALERT Psychosocial: Cooperative
ORIENTATION Person: Y
Place: Y Pain Level on Admit: 3
Time: Y
Speech: CLEAR
Hand Grips: EQUAL S
Pupils: EQUAL
Pupils React to Light: BOTH
Comment:

**********RESPIRATORY**********

Respiratory Effort: Unlabored
Retractions: N Pattern: Regular
Stridor: N
Breath Sounds, Right: CLEAR Breath Sounds, Left: DIMIN
Cough: PRODUCTIVE Color: YELLOW Consistency: THICK
Capillary Refill: QUICK Chest Tube:
Nailbeds: PINK
Comment:

**********CARDIOVASCULAR**********

Heart Sounds: NORMAL
Neck Vein Distention: N
Peripheral Pulse: Left Radial Pulse: NORMAL
Right Radial Pulse: NORMAL
Left Dorsal Pulse: NORMAL
Right Dorsal Pulse: NORMAL
Edema: ABSENT
Location:
Comment:

**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL Mucous Membranes:MOIST
Skin Condition: Intact
Is there a wound(s) as a result of surgery?
Is there a wound(s) as a result of pressure?
Is there a wound(s) from other than surgery or pressure?

**********GU/GI**********

Abdomen: SOFT
Bowel Sounds: ACTIVE
Stools: CONTINENT Date of last BM:
Voiding: CONTINENT Color: Consistency:
Date of Foley Insertion:
Graft Fistula: N Comment:
Functional:
Thrill:
Bruit:
Location:
PEG Present: N
NG Tube: N
OG Tube: N Comment:

577

002012

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

**********MUSCULOSKELETAL**********

Range of Motion: FULL RUE: LUE: RLE: LLE:
Cast: N
Comment:

**********SURGICAL**********
Is this a surgical patient: N Pt s age: 39 Is patient 70 or greater:

Was patient admitted for one of the following (active dx) ?
Total Knee Replacement, Total Hip Replacement, Hip Fracture,
Pelvic fracture, Femur fracture?: N <<< Please answer N for SSCP/ARU

**********OB**********
Is this an OB patient: N
Fundus: Fundus Location:
Lochia: Lochia Color:
Perineum:
Hemorrhoids:
Breast:
**********GYN**********
Is this a GYN patient? N
Vaginal Bleeding:
Vaginal Bleeding Color:
Vaginal Packing?

**********ANTEPARTUM**********
Is this an antepartum patient: N
Reflexes:
Clonus:
Headache:
Epigastric Pain:
Vision Changes:
FHT:
**********INTENSIVE CARE UNIT**********
Is this an ICU pt: N
Glascow Coma Scale
Eye Opening:
Motor Functions:
Verbal Responses:

Diagnosis: PNEUMONIA Pneumonia ICD9# 486

**********DVT RISK ASSESSMENT**********

Would you like to complete the DVT Risk Assessment? Y
If no, reason for no DVT Risk Assessment:

578

002013

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Direction Documented Comment	Units	From Change
2	***Head to Toe*** (ADMISSION ONLY) (continued) Required for the following diagnosis ONLY: Cancer (with Chemo), CHF, COPD, CVA (Ischemic), Emphysema IBD, Pulmonary Edema, Pneumonia, or Sepsis **********DVT RISK ASSESSMENT**********								

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 4

MOBILITY 3

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 18

If Norton Scale score <12, initiate turning schedule and heel precautions

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

579

002014

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

580

002015

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Direction Documented Comment	Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

002016

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Direction	Documented Comment	Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

**********DVT RISK ASSESSMENT**********
Diagnosis: Pneumonia * = Highest Risk DIAGNOSIS
Does the patient have any of these risk factors? (Y or N)
Impaired Mobility? N
Age over 40? N
Obesity? N
Paralysis or plaster cast? N
Estrogen (contraceptive/HRT)? N
***Each Risk Factor counts as 1, add total number of Y ***

582

002017

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change
2	***Head to Toe*** (ADMISSION ONLY) (continued)									

History of DVT/PE? ** OR Age over 70? ** OR
Thrombotic abnormalities? **
(Protein C deficiency, Antithrombin III deficiency,etc) **N
** = Automatically considered for Highest Risk FACTOR
2 or more risk factors or HIGHEST DIAGNOSIS/FACTOR CATEGORY? N
Does patient have current orders for Lovenox, Coumadin or SQ Heparin? Y
Have you placed a DVT prophylaxis order form (#211-NCR) on the chart? N

>>Physician must be notified if assessment indicates high risk for DVT.<<

- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
70	Daily Re-Assessment/Observation						D		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Document	05/23/07	0840	KM	05/23/07	1652	KM			

Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? Y Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 3
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

583

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)
Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 4

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 19

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- Continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/22/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****
Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***
Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

585

002020

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

586

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

587

New Onset of Pain Assessment

002022

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)
Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

Patient s pain goal: Current pain plan:

- Document 05/23/07 2010 TA 05/24/07 0152 TA
Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? Y Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

588

002023

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 1

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 16

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/22/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:

IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

589

002024

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

590

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

002025

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Direction / Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

591

002026

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

592

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Pain quality (describe): Pain frequency: Cause of Pain:

Patient s pain goal: Current pain plan:

- Document 05/24/07 0830 PJW 05/24/07 1515 PJW
Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? N Date of last BM: 05/22/07
If no BM in the last 48hrs see MAR/contact MD.
Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE
View previous pain report? N
New Onset of Pain Assessment needed? N
**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

593

002028

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 1

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 16

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/23/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:

IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

594

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change
70	Daily Re-Assessment/Observation (continued)									

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED? 595

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

002031

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

597

002032

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change

70 Daily Re-Assessment/Observation (continued)

Patient s pain goal: Current pain plan:

- Document 05/24/07 1950 TA 05/25/07 0318 TA

Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE

Has patient had BM in past 24 hours? N Date of last BM: 05/22/07

If no BM in the last 48hrs see MAR/contact MD.

Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE

View previous pain report? N

New Onset of Pain Assessment needed? N

**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

598

PHYSICAL CONDITION 3

MENTAL CONDITION 4

002033

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

ACTIVITY 1

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 16

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/23/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

599

Wound base color: Odor present?

Enter Nurses Note?

002034

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
70	Daily Re-Assessment/Observation (continued)								

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

6)0

002035

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

601

002036

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

602

Patient s pain goal: Current pain plan:

002037

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
70 - Document	Daily Re-Assessment/Observation 05/25/07	0736	WJT	05/25/07	0737	WJT	D			CP

Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE

Has patient had BM in past 24 hours? N Date of last BM: 05/22/07

If no BM in the last 48hrs see MAR/contact MD.

Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE

View previous pain report? N

New Onset of Pain Assessment needed? N

**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 1

603

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 16

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/25/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:

IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

694

002039

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

605

002040

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

DRAINAGE TUBES:

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

606

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

002041

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

Patient s pain goal: Current pain plan:

- Document 05/25/07 1930 RR 05/26/07 0107 RR
Level of Consciousness: ALERT

607

002042

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE

Has patient had BM in past 24 hours? N Date of last BM: 05/22/07

If no BM in the last 48hrs see MAR/contact MD.

Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE

View previous pain report? N

New Onset of Pain Assessment needed? N

**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 1

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

608

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

NORTON SCALE TOTAL SCORE 16

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/25/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:

IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

609

002044

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

610

002045

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED? 611

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

002046

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

Patient s pain goal: Current pain plan:

- Document 05/26/07 0749 WJT 05/26/07 0750 WJT
Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Heart Sounds: NORMAL

Abdomen: SOFT

Bowel Sounds: ACTIVE

Has patient had BM in past 24 hours? N Date of last BM: 05/22/07

If no BM in the last 48hrs see MAR/contact MD.

Does patient have a Foley catheter? N Date of Foley Insertion:

Has patient fallen since admit or been on fall precautions? N

Pain Level: 0 NONE

View previous pain report? N

New Onset of Pain Assessment needed? N

**********SKIN INTEGUMENTARY**********

Skin Color: NORMAL

Temperature: WARM

Skin to Touch: DRY

Skin Turgor: NORMAL

Mucous Membranes: MOIST

Skin Condition: Intact

Is there a wound(s) as a result of surgery?

Is there a wound(s) as a result of pressure?

Is there a wound(s) from other than surgery or pressure?

**** NORTON SCALE ASSESSMENT ****

PHYSICAL CONDITION 3

MENTAL CONDITION 4

ACTIVITY 1

MOBILITY 4

INCONTINENT BOWEL AND/ BLADDER 4

NORTON SCALE TOTAL SCORE 16

002048

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/25/07 Date of INT insertion (Site #2): (skip if N/A)

Is the IV Access site free of signs of complications? Y is Site #2 ?: (skip if N/A)

****FALL PRECAUTIONS****

Previous Fall:
Mobility Problem:
Confusion/Intermittent Confusion:
Incontinent:
Hearing/Vision Impairment:
Receiving Hypnotics, Laxatives, or Diuretics:
Pt. is 70+:
IF 2 OR MORE YES RESPONSES ABOVE, INITIATE/CONTINUE FALL PRECAUTIONS

*** SURGICAL WOUND LOCATION 1 ***

Surgical wound location 1: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***

Surgical wound location 2: Dressing change ordered?

Dressing appearance: Dressing change?

614

002049

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***

Surgical wound location 3: Dressing change ordered?

Dressing appearance: Dressing change?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

Wound base color: Odor present?

Enter Nurses Note?

****LOCATION 1****

DERMAL WOUND LOCATED: DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

615

002050

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)

****LOCATION 2****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 3****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

616

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

70 Daily Re-Assessment/Observation (continued)
WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

DRESSING TYPE:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

Please describe any wound(s) not related to surgery/pressure
:

New Onset of Pain Assessment

Pain location: Pain Score:

Pain scale used: Pain type:

Pain quality (describe): Pain frequency: Cause of Pain:

Patient s pain goal: Current pain plan:

- Ed Status	05/26/07 1728 his	05/26/07 1728 his		A => D
032	Rounds: CT/CNA		D	CP
	Q2 odd hours			
- Create	05/22/07 1716 NRV	05/22/07 1716 NRV		
- Document	05/22/07 2123 TWB	05/22/07 2124 TWB		
	Were rounds made per protocol? Y			
- Document	05/23/07 1019 MFE	05/23/07 1019 MFE		
	Were rounds made per protocol? Y			

617

002052

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
032	Rounds: CT/CNA Q2 odd hours						D			CP
- Document	05/24/07	0950	TLJ	05/24/07	0950	TLJ				
	Were rounds made per protocol? Y									
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ				
	Were rounds made per protocol? Y									
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ				
	Were rounds made per protocol? Y									
- Document	05/24/07	1843	TLJ	05/24/07	1843	TLJ				
	Were rounds made per protocol? Y									
- Document	05/25/07	0835	TLJ	05/25/07	0835	TLJ				
	Were rounds made per protocol? Y									
- Document	05/25/07	1351	TLJ	05/25/07	1351	TLJ				
	Were rounds made per protocol? Y									
- Document	05/25/07	1802	TLJ	05/25/07	1802	TLJ				
	Were rounds made per protocol? Y									
- Document	05/26/07	0017	REM	05/26/07	0017	REM				
	Were rounds made per protocol? Y									
- Document	05/26/07	0619	REM	05/26/07	0619	REM				
	Were rounds made per protocol? Y									
- Document	05/26/07	0908	TLJ	05/26/07	0908	TLJ				
	Were rounds made per protocol? Y									
- Document	05/26/07	1435	TLJ	05/26/07	1435	TLJ				
	Were rounds made per protocol? Y									
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
031	Rounds: RN/LPN Q2 even hours						D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Document	05/22/07	2000	ABG	05/23/07	0435	ABG				
- Document	05/23/07	2010	TA	05/24/07	0153	TA				
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW				
- Document	05/24/07	1950	TA	05/25/07	0318	TA				
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT				
- Document	05/25/07	1930	RR	05/26/07	0107	RR				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
438	Patient Level of Assistance						D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
Patient Level of Assistance MIN Minimun										
- Document	05/22/07	2000	ABG	05/23/07	0435	ABG				
Patient Level of Assistance MIN Minimun										
- Document	05/23/07	2010	TA	05/24/07	0153	TA				
Patient Level of Assistance MIN Minimun										
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW				
Patient Level of Assistance MOD Moderate										
- Document	05/24/07	1950	TA	05/25/07	0318	TA				
Patient Level of Assistance IND Independent										
- Document	05/26/07	0107	RR	05/26/07	0107	RR				
Patient Level of Assistance IND Independent										
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D

618

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
3353	Pneumococcal vaccine given						D		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
6540	Infection Control						X		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Ed Status	05/22/07	1716	NRV	05/22/07	1716	NRV			None => X
1805	AM/PM Bathing and ADL care						D		CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV			
- Document	05/23/07	1019	MFE	05/23/07	1019	MFE			

AM/PM Care
Shower

Comments:

- Document 05/24/07 0950 TLJ 05/24/07 0950 TLJ

AM/PM Care
Shower

Comments:
CHANGED LINEN
- Document 05/25/07 0835 TLJ 05/25/07 0836 TLJ

AM/PM Care
Shower

Comments:
CHANGED LINEN
- Document 05/26/07 0908 TLJ 05/26/07 0908 TLJ

AM/PM Care
Shower

Comments:
CHANGED LINEN

- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
5600	***Education Assessment/Admission***						D	ONCE	CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV			
- Document	05/22/07	1935	NRV	05/22/07	1936	NRV			

Patient/Family Education Assessment
When patient is unable to participate in the educational assessment, family member/significant other to be assessed.

Is the patient able to participate in education? Y
If patient is not able to participate in teaching, who will?
If not patient, give name AND relationship

Patient s primary language: English

Preference for Teaching Method: Lecture
Packet

619

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

5600 ***Education Assessment/Admission*** (continued)

Does learner have any difficulty with reading or writing? N
Explain difficulties with reading and writing:

Exhibits ability to grasp concepts and respond to questions? Y
Explain difficulities:

Barriers to Learning: N
Type of learning barriers:

Desire/Motivation Level:
SEEMS INTERESTED

Knowledge level related to health problems: Limited

****Admission/Orientation Teaching****

Admission/Orientation teaching subjects are automatically documented when you file this assessment. Please include any deviations from the standards in the admission note.

Does patient/family verbalize understanding of home medications purpose and use? No

Comments about medication knowledge:

Pain Scale to be used for patient: Numeric

Method used for admission teaching/orientation: Lecture
Handout/Literature

Receptiveness to admission teaching/orientation: Seems interested

Teaching outcome: States understanding

Identified Education Needs: Illness/Treatment
Medications

Name of the person given the brochures
(Who Participates in Your Medical Care)?
AND
(Freshstart: Smoking Cessation pamphlet) : PATIENT

Teaching Packets should be documented using the Teaching intervention.

Please print this Education Assessment and file with the Admission History.

- Ed Status 05/26/07 1728 his 05/26/07 1728 his A => D

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
5601	Teaching: Patient/Family Education						D	OG		CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
3510	Skin: ADM-D/C-weekly photo & measurement						D	Tu		CP
- Create	05/22/07	1715	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
3357	Pneumonia Vaccine Not Given Reason						D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
4190	IV Intravenous Insertion						D			CP
	5/25: INT 22G RIGHT WRIST									
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/23/07	2200	TA	05/24/07	0029	TA				
	Site: RT Forearm									
	Needle Diameter: 20 gauge									
	Needle Length: 1 inch									
	Time of IV start: 2200									
	Total # Venipuncture: 1									
	Time of site care: 2200									
	Reason for restart: Other									
- Ed Text	05/24/07	0029	TA	05/24/07	0029	TA				
- Ed Text	05/25/07	0319	TA	05/25/07	0319	TA				
- Document	05/25/07	1848	CO	05/25/07	1848	CO				
	Site: RT wrist									
	Needle Diameter: 22 gauge									
	Needle Length: 1 inch									
	Time of IV start: 1845									
	Total # Venipuncture: 1									
	Time of site care: 1845									
	Reason for restart: Other									
- Ed Text	05/25/07	1848	CO	05/25/07	1849	CO				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
4200	IV Intravenous Therapy						D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Document	05/23/07	2010	TA	05/24/07	0153	TA				
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW				
- Document	05/24/07	1950	TA	05/25/07	0318	TA				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D

621

002056

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
453	D/C IV/INT Needle						D			CP
- Create	05/22/07	1716	NRV	05/22/07	1716	NRV				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
452	Activity BEDREST						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Document	05/22/07	2000	ABG	05/23/07	0435	ABG				
- Document	05/23/07	2010	TA	05/24/07	0153	TA				
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW				
- Document	05/24/07	1950	TA	05/25/07	0318	TA				
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
450	Dietary Intake						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Document	05/22/07	2123	TWB	05/22/07	2124	TWB				Level 450
Which meal & how much eaten? Snack Refused										
- Document	05/23/07	1533	MFE	05/23/07	1533	MFE				Level 450
Which meal & how much eaten? Dinner 75%										
- Document	05/23/07	1848	MFE	05/23/07	1848	MFE				Level 450
Which meal & how much eaten? Dinner none										
- Document	05/24/07	0558	TJH	05/24/07	0558	TJH				Level 450
Which meal & how much eaten? Snack 50%										
- Document	05/24/07	0950	TLJ	05/24/07	0950	TLJ				Level 450
Which meal & how much eaten? Breakfast 100%										
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ				Level 450
Which meal & how much eaten? Lunch 100%										
- Document	05/24/07	1441	TLJ	05/24/07	1441	TLJ				Level 450
Which meal & how much eaten? Lunch 100%										
- Document	05/24/07	1843	TLJ	05/24/07	1843	TLJ				Level 450
Which meal & how much eaten? Dinner 100%										
- Document	05/25/07	0035	TJH	05/25/07	0035	TJH				Level 450
Which meal & how much eaten? Snack 50%										
- Document	05/25/07	0835	TLJ	05/25/07	0835	TLJ				Level 450
Which meal & how much eaten? Breakfast 100%										
- Document	05/25/07	1351	TLJ	05/25/07	1351	TLJ				Level 450
Which meal & how much eaten? Lunch 100%										
- Document	05/25/07	1802	TLJ	05/25/07	1803	TLJ				Level 450
Which meal & how much eaten? Dinner 100%										
- Document	05/26/07	0908	TLJ	05/26/07	0908	TLJ				Level 450
Which meal & how much eaten? Breakfast 100%										
- Document	05/26/07	1435	TLJ	05/26/07	1435	TLJ				Level 450
Which meal & how much eaten? Lunch 100%										
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
6690	Intake/Output						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Document	05/22/07	1810	MFE	05/22/07	1811	MFE				

********** INTAKE **********

Oral Intake: 240 IV Intake:

NG/Peg Feeding: Blood Admin.:

622

002057

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
6690	Intake/Output (continued)									

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 1 BM: (# of times):
Incontinent (# of times):
Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:
JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/23/07 0623 TWB 05/23/07 0626 TWB

********** INTAKE **********

Oral Intake: 360 IV Intake:
NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 250 BM: liquid (mls):
Urine (# of times): BM: (# of times):
Incontinent (# of times):
Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:
JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/23/07 1848 MFE 05/23/07 1849 MFE

********** INTAKE **********

Oral Intake: 1080 IV Intake:
NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 800 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):
Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:

623

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented	Comment	Units	From Change

6690 Intake/Output (continued)

Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/24/07 0559 TJH 05/24/07 0559 TJH

********** INTAKE **********

Oral Intake: 474 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 500 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/24/07 1843 TLJ 05/24/07 1843 TLJ

********** INTAKE **********

Oral Intake: 657 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 1150 BM: liquid (mls):
Urine (# of times): BM: (# of times):
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/25/07 0515 TJH 05/25/07 0515 TJH

********** INTAKE **********

624

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction / Comment	Documented Units	From Change

6690 Intake/Output (continued)

Oral Intake: 237 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 1 BM: (# of times): 0
Incontinent (# of times):

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/25/07 1802 TLJ 05/25/07 1803 TLJ

********** INTAKE **********

Oral Intake: 1680 IV Intake: 0

NG/Peg Feeding: 0 Blood Admin.:

********** OUTPUT **********

Urine (mls): 0 BM: liquid (mls): 0
Urine (# of times): 5 BM: (# of times): 0
Incontinent (# of times): 0

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:

Jejunostomy Drain: Gastrostomy Drain: Other Drain:

- Document 05/26/07 0619 REM 05/26/07 0622 REM

********** INTAKE **********

Oral Intake: 240 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): 300 BM: liquid (mls):
Urine (# of times): BM: (# of times): 0
Incontinent (# of times):

625

002060

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change
6690	Intake/Output (continued)									
									Wound Vac Drain:	
	Emesis (mls):							NG Drainage:	Hemovac Drain:	
	Blood Loss:									
	Colostomy:							Ileostomy:	Nephrostomy:	
	JP Drain 1/L:							Chest Tube 1:	T Tube Drain:	
	JP Drain 2/R:							Chest Tube 2:	Penrose Drain:	
	Jejunostomy Drain:							Gastrostomy Drain:	Other Drain:	
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
6691	Weight/Height						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
7690	Laboratory Data Interpretation						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
6680	Vital Signs, Monitor Q4H						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Document	05/23/07	0020	TWB	05/23/07	0021	TWB				
Temp:	96.4							Temp Source:	ORAL	
Respirations:	20									
Heart Rate:	74							Hrt Rate Source:	RADIAL	
BP:	104/65							BP Source:	SUPINE	
SAO2:								O2 source:		
- Document	05/23/07	0623	TWB	05/23/07	0625	TWB				
Temp:	97.1							Temp Source:	ORAL	
Respirations:	20									
Heart Rate:	84							Hrt Rate Source:	RADIAL	
BP:	142/71							BP Source:	SUPINE	
SAO2:	95							O2 source:	RA	
- Document	05/23/07	1533	MFE	05/23/07	1535	MFE				
Temp:	96.7							Temp Source:	ORAL	
Respirations:	20									
Heart Rate:	76							Hrt Rate Source:	RADIAL	
BP:	111/59							BP Source:	SUPINE	
SAO2:	97							O2 source:	RA	
- Document	05/23/07	2010	TA	05/24/07	0153	TA				
Temp:	95.9							Temp Source:	ORAL	

626

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change
6680	Vital Signs, Monitor (continued)										

Respirations: 20

Heart Rate: 78 Hrt Rate Source: APICAL

BP: 159/76 BP Source: SUPINE

SAO2: 98 O2 source: RA
- Document 05/24/07 0011 TJH 05/24/07 0011 TJH
Temp: 96.3 Temp Source: ORAL

Respirations: 20

Heart Rate: 66 Hrt Rate Source: RADIAL

BP: 119/62 BP Source: SUPINE

SAO2: O2 source:
- Document 05/24/07 0558 TJH 05/24/07 0559 TJH
Temp: 96.2 Temp Source: ORAL

Respirations: 20

Heart Rate: 79 Hrt Rate Source: RADIAL

BP: 87/55 BP Source: SUPINE

SAO2: O2 source:
- Document 05/24/07 1950 TA 05/25/07 0319 TA
Temp: Temp Source:

Respirations: 19

Heart Rate: 71 Hrt Rate Source: APICAL

BP: 147/76 BP Source: SUPINE

SAO2: 96 O2 source: RA
- Document 05/25/07 0035 TJH 05/25/07 0036 TJH
Temp: 95.6 Temp Source: ORAL

Respirations: 20

Heart Rate: 68 Hrt Rate Source: RADIAL

BP: 146/65 BP Source: SUPINE

627

SAO2: O2 source:
- Document 05/25/07 0515 TJH 05/25/07 0515 TJH
Temp: 97.0 Temp Source: ORAL

002062

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change
6680	Vital Signs, Monitor (continued)										
Respirations:	20										
Heart Rate:	72			Hrt Rate Source:		RADIAL					
BP:	94/55			BP Source:		SUPINE					
SAO2:				O2 source:							
- Document	05/25/07	0731	WJT	05/25/07	0732	WJT					
Temp:	97.3			Temp Source:		ORAL					
Respirations:	18										
Heart Rate:	85			Hrt Rate Source:		RADIAL					
BP:	97/71			BP Source:		SUPINE					
SAO2:	94			O2 source:		RA					
- Document	05/25/07	1930	RR	05/26/07	0108	RR					
Temp:	97.4			Temp Source:		ORAL					
Respirations:	20										
Heart Rate:	83			Hrt Rate Source:		APICAL					
BP:	159/72			BP Source:		SUPINE					
SAO2:	95			O2 source:		RA					
- Document	05/26/07	0017	REM	05/26/07	0018	REM					
Temp:	96.7			Temp Source:		ORAL					
Respirations:	20										
Heart Rate:	88			Hrt Rate Source:		RADIAL					
BP:	149/64			BP Source:		SUPINE					
SAO2:	100			O2 source:		R/A					
- Document	05/26/07	0619	REM	05/26/07	0622	REM					
Temp:	96.9			Temp Source:		ORAL					
Respirations:	20										
Heart Rate:	78			Hrt Rate Source:		RADIAL					
BP:	135/69			BP Source:		SUPINE					
SAO2:	99			O2 source:		R/A					
- Document	05/26/07	0737	WJT	05/26/07	0737	WJT					
Temp:	97.5			Temp Source:		ORAL					
Respirations:	18										

628

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction / Documented Comment	Units	From Change
6680	Vital Signs, Monitor (continued)									
Heart Rate:	73			Hrt Rate Source:				RADIAL		
BP:	144/73			BP Source:				SUPINE		
SAO2:	94			O2 source:				RA		
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
451	Consults						D			OE
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
4200	IV Intravenous Therapy						D			OE
	IVF DC D									
- Create	05/22/07	1732	DCT	05/22/07	1732	DCT				
- Document	05/22/07	1940	NRV	05/22/07	1940	NRV				
- Ed Text	05/25/07	0319	TA	05/25/07	0319	TA				
- Ed Text	05/25/07	1234	WJT	05/25/07	1234	WJT				
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT				
- Ed Status	05/26/07	1728	his	05/26/07	1728	his				A => D
3118	RT: Inhalation Therapy Subsequent ($)						D			PS
- Document	05/22/07	1720	TMP	05/22/07	1736	TMP				

Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: ALL LOBES RR Pre: 16 Strength:
HR Pre: 73 BS Post: AIR IMP RR Post: 16 Productive:
HR During: 74 CL Sputum Amount:
HR Post: 74 Fields: ALL LOBES Consistancy:
SaO2: 98% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

- Create	05/22/07	1734	TMP	05/22/07	1734	TMP				
- Document	05/22/07	1942	SLH	05/22/07	2158	SLH				

Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: MODERATE
HR Pre: 76 BS Post: CR RR Post: 16 Productive: N
HR During: 83 Sputum Amount:
HR Post: 83 Fields: BILAT LL Consistancy:

629

002064

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change

3118 RT: Inhalation Therapy Subsequent ($) (continued)
SaO2: 97 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 0021 SLH 05/23/07 0046 SLH
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CR Cough: Y Suction: N
PF After:
Fields: BILAT LL RR Pre: 12 Strength: MODERATE
HR Pre: 79 BS Post: CR RR Post: 12 Productive: N
HR During: 77 Sputum Amount:
HR Post: 77 Fields: BILAT LL Consistancy:
SaO2: 97 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 0332 SLH 05/23/07 0536 SLH
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 12 Strength: MODERATE
HR Pre: 80 BS Post: CL RR Post: 12 Productive: N
HR During: 79 Sputum Amount:
HR Post: 80 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 0740 PDW 05/23/07 1241 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After: DIM
Fields: ALL LOBES RR Pre: 18 Strength:

630

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Documented Comment	From Units	Change

3118 RT: Inhalation Therapy Subsequent ($) (continued)
HR Pre: 97 BS Post: CL RR Post: 20 Productive:
HR During: 95 DIM Sputum Amount:
HR Post: 95 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 1120 PDW 05/23/07 1241 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After: DIM
Fields: ALL LOBES RR Pre: 18 Strength:
HR Pre: 95 BS Post: CL RR Post: 18 Productive:
HR During: 93 DIM Sputum Amount:
HR Post: 93 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 1505 PDW 05/23/07 1622 PDW
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After: DIM
Fields: ALL LOBES RR Pre: 20 Strength: STRONG
HR Pre: 79 BS Post: CL RR Post: 20 Productive: N
HR During: 82 DIM Sputum Amount:
HR Post: 80 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/23/07 2030 KBO 05/24/07 0113 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

631

002066

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction	Comment	Documented Units	From Change

3118 RT: Inhalation Therapy Subsequent ($) (continued)

PF Before: BS Pre: CO Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 71 BS Post: CL RR Post: 16 Productive: N
HR During: 67 Sputum Amount:
HR Post: 67 Fields: ALL LOBES Consistancy:
SaO2: 98% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/24/07 0030 KBO 05/24/07 0113 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 74 BS Post: CL RR Post: 16 Productive: N
HR During: 88 Sputum Amount:
HR Post: 91 Fields: ALL LOBES Consistancy:
SaO2: 97% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/24/07 0435 KBO 05/24/07 0458 KBO
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CO Cough: Y Suction: Y
PF After:
Fields: ALL LOBES RR Pre: 16 Strength: STRONG
HR Pre: 82 BS Post: CL RR Post: 16 Productive: N
HR During: 78 Sputum Amount:
HR Post: 72 Fields: ALL LOBES Consistancy:
SaO2: 97% ON 2LPM Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

632

Comments:
- Document 05/24/07 0745 PDW 05/24/07 1002 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Documented Comment	Units	From Change

3118 RT: Inhalation Therapy Subsequent ($) (continued)
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After:
Fields: ALL LOBES RR Pre: 20 Strength:
HR Pre: 102 BS Post: CL RR Post: 20 Productive:
HR During: 105 Sputum Amount:
HR Post: 105 Fields: ALL LOBES Consistancy:
SaO2: 96 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/24/07 1140 PDW 05/24/07 1408 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: N Suction: N
PF After:
Fields: ALL LOBES RR Pre: 18 Strength:
HR Pre: 97 BS Post: CL RR Post: 20 Productive:
HR During: 93 Sputum Amount:
HR Post: 94 Fields: ALL LOBES Consistancy:
SaO2: 98 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/24/07 1525 PDW 05/24/07 1618 PDW
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT Q4 ATC AND
Reason TX not Given: Q4 PRN SOB,WHEEZING

PF Before: BS Pre: CL Cough: Y Suction: N
PF After:
Fields: ALL LOBES RR Pre: 18 Strength: STRONG
HR Pre: 76 BS Post: CL RR Post: 20 Productive: N
HR During: 79 Sputum Amount:
HR Post: 79 Fields: ALL LOBES Consistancy:
SaO2: 98 ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

633

Comments:

002068

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change
3118	RT: Inhalation Therapy Subsequent ($)						D			PS
- Document	05/24/07	2100	KBO	05/25/07	0517	KBO				

Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: CR Cough: Y Suction: N
PF After:
Fields: LLL RR Pre: 16 Strength: STRONG
HR Pre: 63 BS Post: CL RR Post: 16 Productive: N
HR During: 67 DIM Sputum Amount:
HR Post: 67 Fields: ALL LOBES Consistancy:
SaO2: 97% ON RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

- Document	05/25/07	0735	BER	05/25/07	0947	BER				

Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: BILAT LL RR Pre: 20 Strength:
HR Pre: 80 BS Post: DIM RR Post: 20 Productive:
HR During: 82 Sputum Amount:
HR Post: 84 Fields: BILAT LL Consistancy:
SaO2: 95% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

- Document	05/25/07	1135	BER	05/25/07	1448	BER				

Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders:
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: BILAT LL RR Pre: 20 Strength:
HR Pre: 77 BS Post: DIM RR Post: 20 Productive:
HR During: 78 Sputum Amount:
HR Post: 77 Fields: BILAT LL Consistancy:
SaO2: 94% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

3118 RT: Inhalation Therapy Subsequent ($) (continued)
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/25/07 1152 BER 05/25/07 1731 BER
Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: LLL RR Pre: 18 Strength:
HR Pre: 77 BS Post: DIM RR Post: 18 Productive:
HR During: 79 Sputum Amount:
HR Post: 80 Fields: LLL Consistancy:
SaO2: 99% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Document 05/25/07 2025 PJS 05/25/07 2317 PJS
Initial Tx: TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction:
PF After:
Fields: LLL RR Pre: 18 Strength:
HR Pre: 73 BS Post: DIM RR Post: 20 Productive:
HR During: 77 CL Sputum Amount:
AIR IMP
HR Post: 80 Fields: LLL Consistancy:
SaO2: 97% RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:
- Ed Status 05/26/07 1728 his 05/26/07 1728 his A => D
12 ***Admission History*** D AS
- Create 05/22/07 1930 NRV 05/22/07 1935 NRV
- Document 05/22/07 1930 NRV 05/22/07 1935 NRV
Admitted from: ER Info obtained from: PATIENT Arrival on unit: 1700
Armband intact: Y Verified: : Code Status: FULL CODE
Does pt have Advance Directive (Living Will)? N
Does pt have Health Care Power of Attorney? N
If yes, Living Will copy received? N If yes, Health Care Power of Attorney copy received?
Does patient want info on Advance Directive? N
** VS ** Temp: 96.8 BP: 151/57 Wt: lb: 144 oz: 8.0 kg: 65.544

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002070

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

12 ***Admission History*** (continued)

Heart Rate: 84 Respirations: 22 Ht: ft: 5 in: 3.0 cm: 160.0
Sp02: 96 % O2 source: RA
Are you in pain: N Med Allergies: N Latex Screening: Y
Do you have chronic pain: N Food Allergies: N Falls Assessment: Y

Chief Complaint: LLL PNEUMONIA,VOMITING

********** PAST MEDICAL HISTORY **********
Previous surgery? Y Previously Hospitalized: Y PPD+: N

********** MEDICAL HISTORY AND SYSTEM REVIEW **********
Have you ever or do you now have problems with:
Vision: N Hearing: N Nutrition: Y Cardio: Y Resp: Y
CNS: N GI: Y GU: N Endocrine: N Hepatic: N Musculo - Skeletal: N
Hematology: N Cancer: N Female: Y
Have you had pneumococcal vaccine? N Date Pneumococcal vaccine given:
Have you had current season influenza vaccine? <<*must have been RECEIVED between OCT-FEB*

********** PSYCHO-SOCIAL **********
HX of alcohol/drug abuse within last 6 months: N Smoked tobacco in the last 12 months? Y
Is there any evidence of abuse or neglect? N Mental Illness: N
Patient s religious denomination. HOLINESS/PENTECOSTAL
Spiritual practices / beliefs that affect patient care. N
Comment:
Would you like to see our chaplain? Y

Have you had or do you currently need assist with ADLS: N
Currently receiving any healthcare or community services: N
Currently using med equip or asst devices: N
On d/c will you need financial assistance w/ meds: Y
On d/c, will you need physical assistance taking meds?: N
On d/c, will you need transportation provided?: N
Pt Oriented to Rm & Valuables Policy: Y

OB: N Peds Admit: N Sub-Acute Admit: N Antepartum: N

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

*******ADMISSION PAIN ASSESSMENT********
Pain Location: Pain scale used:
Pain Level on Admit: 3 Pain type:
Onset of Pain: Pain quality (describe):
Pain frequency: Cause of Pain:
Pt s pain plan prior to admit:

Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

***Use below for additional Pain Location (if necessary):
Pain Location:
Pain type:
Onset of Pain:
Pain Frequency:

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002071

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

12 ***Admission History*** (continued)
Cause of Pain:

****CHRONIC PAIN****
Pain Location:

Pain scale used:
Pain Score:
Pain frequency:
Worse pain gets: Best pain gets:

Do you have a history of any ongoing pain problems?
Conditions that cause pain:
What makes pain better?
What makes pain worse?
Are there times of the day/night when pain is worse?
Pt s pain plan prior to admit:

Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

****Allergy Information****
Med Allergies: NKDA

Food Allergies: No known food allergies

*******LATEX SCREENING*******
Latex (Rubber): N
Bananas: N
Chestnuts: N
Avocados: N
Poinsettias: N
Kiwi, Papaya: N

****FALL ASSESSMENT****
Previous Fall: N Mobility Problem: N
Confusion/Intermittent Confusion: N
Incontinent: N Hearing/Vision Impairment: N
Receiving Hypnotics, Laxatives, or Diuretics: N
Pt. is 70+: N

********** PAST MEDICAL HISTORY **********
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007

Anesthesia Complications:

****Previously Hospitalized*****
Reason for Visit/Date: MI-MARCH 2007

********VISION**********
Blind: Eye Prothesis:
Blind left: Eye prothesis left:
Blind right: Eye prothesis right:

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002072

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

12 ***Admission History*** (continued)
Do you wear glasses: Glasses w/pt:
Do you wear contacts: Contacts w/ pt:

**********HEARING**********
Hard of hearing: Hearing aid:
HOH Left: Hearing aid left:
HOH Right: Hearing aid right:

Deaf: Hearing aid w/ pt:
Deaf Left:
Deaf Right:

**********NUTRITION**********
Diet followed at home: REG
Special cultural/ethnic/religious food needs: N
Unintentional wt loss/gain>10 lbs within 2 mo: N
On thickened liquids at home? N Problems chewing:
PEG Tube Present?: N
****DENTAL****
Missing teeth: Y Capped teeth: Loose teeth:
Do you wear dentures? Y
Partial:
Upper: Y
Lower: Y
Dentures with patient: Y Denture cup given: Y
Inventory of Dentures with Patient on Admission: Upper and Lower sets
**********CARDIO**********
Hypertension: Y Arrhythmias: N
Chest Pain: Y Pacemaker/Internal Defibrillator: N
Heart Attack: Y Rheumatic Fever: N
CHF: N Congenital Heart Defect: N
Murmur/MVP: N
**********RESP**********
SOB: Y Asthma: N
Pneumonia: Y COPD: N
Chronic Cough: Sleep Apnea: N
URI/cold w/in last 2 wks: Tracheostomy: N
TB: N

**********CNS**********
Convulsions/Seizures: Alzheimers/Dementia:
Stroke: Numbness/Tingling:
Muscular Weakness/Paralysis: Headache:
Fainting or Dizzy Episodes: Problems w/ Speech/Communications:
Dysphagia:

**********GI**********
Ulcerative Colitis: N
Diverticulitis: N
Crohns: N
Chronic Constipation: N
Bleeding: N
Chronic Diarrhea: N
Reflux: N
Ulcers: N
Hiatal Hernia: Y
Nausea/Vomiting: Y

**********GU**********
Renal Disease:
Hemodialysis:
Peritoneal Dialysis:
Kidney Stones:
Incontinent (# of times):
Prostate Disease:
Urinary Retention:
Urostomy:

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002073

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

12 ***Admission History*** (continued)

**********ENDOCRINE**********
Diabetes:
Thyroid Problems:
Is this a new onset of diabetes?

**********HEPATIC********
Hepatitis:
Cirrhosis:

**********MUSCULAR SKELETON**********
Arthritis:
Connective Tissue Disease:
Joint Replacement:
Prosthesis:
Device:

*********HEMATOLOGY**********
Anemia:
Sickle Cell Disease/Trait:
Other Types:

Blood Transfusion:
Reaction:

**********CANCER**********
Diagnosis/Date:
Treatment within last 6 months:

**********FEMALE/OB**********
Do you still have a menstrual cycle: Y LMP:
Are you pregnant: N Are you currently breast feeding: N

********ADL*******

Prior to Admission		Currently on Admission	
Bathing:	Assist:	Bathing on ADM:	Assist:
Grooming:	Assist:	Grooming on ADM:	Assist:
Dressing:	Assist:	Dressing ADM:	Assist:
Feeding:	Assist:	Feeding ADM:	Assist:
Toileting:	Assist:	Toileting ADM:	Assist:
Ambulation:	Assist:	Ambulation ADM:	Assist:

T= TOTAL ASSISTANCE P= PARTIAL ASSISTANCE

**********HEALTHCARE/COMMUNITY SERVICES**********
Extended Care Facility: Outpt Rehab: Rehab Facility:
Home Health Agency: Meals on Wheels:
Personal Care Aides: Mental Health:
Hospice:

Home Health Agency (name):
Hospice (name):

**********MED EQUIPMENT & ASSIST DEVICES**********
Walker: Rolling walker: Standing walker:
Wheelchair:
Hospital bed:
Oxygen:
Nebulizer/Pulmoaide:
CPAP/BIPAP:
Blood Glucose Monitor: Did you bring a medicine pump from home?
**********DC ASSISTANCE W/ MEDICATIONS**********
On d/c, will you need assistance obtaining meds:
On d/c, will you need assistance administering meds:

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change

12 ***Admission History*** (continued)

*********TRANSPORTATION*********
Name of driver:
Drivers phone #:
**********OB ADMIT**********
Age below 16: Previa/Abruption:
No prenatal care: Birth Control Method on d/c:
PIH/Pre Eclampsia: Gestational Diabetic: Hyperemesis:

Does the patient need Car seat: Baby clothes: Baby bed:
***************PEDIATRIC ADMISSION***************
Delays in G/D:
Rolling Over: Sitting Up: Crawling: Walking: Speaking:
Caregiver perception of child s G/D:

Are your receiving healthcare/community services:
Home Health Agency: Hospice: Personal care aides: Outpt Rehab: WIC:
Homebound Schooling: Mental Health Services:

*************** IMMUNIZATIONS ***************

2 Month: 4 Month: 6 Month: 15-18 Month:
4-5 Year: PPD: Hepatitis B: Start date: Treatment complete?:

Word child uses to describe pain or hurt N/A if nonverbal
Head circumference:
Is pt below 20th percentile or above 80th percentile wt/ht:
Caregiver(home) understanding of illness/condition:
Caregiver(home) perception of outcome of hosp.stay:

*************SUBACUTE ADMIT**************
BM Date:
Last Void: Was patient continent prior to hospital admission?

Do you prefer to: Bathe: Shower:
Which cognitive behavior(s) describe the pt
Cognitive behavior:

Pt able to verbalize:
PPD Result:

****************ANTEPARTUM********************
EDC:
Gravida Para Abortus:

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****PERSONAL VALUABLES****
Personal items/Valuables noted on admission:

002075

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
12	***Admission History*** (continued)								

**********CODE STATUS**********
I have explained to the patient/family that without a
current DNR, Do Not Intubate, Do Not Shock, or No CPR order
the patient will be treated as a FULL CODE? Yes

Patient/Family wish to speak with the primary physician regarding Code Status?

- Ed Status	05/26/07	1728	his	05/26/07	1728	his		A => D
99	Home Medication Inventory						D	AS
- Create	05/22/07	1936	NRV	05/22/07	1938	NRV		
- Document	05/22/07	1936	NRV	05/22/07	1938	NRV		

Home Medication Inventory
Printer name for print-out of order sheet: 3NP1
Currently taking homeopathic/herbal meds? N

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
METOPROLOL TARTRATE	50MG	BID	PO
Last Dose Taken: 05/22/07	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic? N	If no, MD Notified (Name and time):		
PLAVIX	75MG	DAILY	PO
Last Dose Taken: 05/22/07	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic? N	If no, MD Notified (Name and time):		
ASA	81MG	DAILY	PO
Last Dose Taken: 05/22/07	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic? N	If no, MD Nofified (Name and time):		
Last Dose Taken:	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken:	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken:	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken:	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken:	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

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002076

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change

99 Home Medication Inventory (continued)

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken |	Ordered on Admission:	If yes, Same dose:	
Herb/Homeopathic?	If no, MD Notified (Name and time):		

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002077

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change

99 Home Medication Inventory (continued)

Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE
Last Dose Taken |		Ordered on Admission:	If yes, Same dose:
Herb/Homeopathic?	If no, MD Notified (Name and time):		

- Ed Status	05/26/07	1728	his	05/26/07	1728	his		A => D
7320	Case Management						D	PS
- Create	05/23/07	1347	MLS	05/23/07	1347	MLS		
- Ed Status	05/26/07	1728	his	05/26/07	1728	his		A => D
12059	PT: Functional Screening						D	PS
- Create	05/23/07	1357	CAC	05/23/07	1357	CAC		
- Ed Status	05/26/07	1728	his	05/26/07	1728	his		A => D

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002078

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Direction Comment	Documented Units	From Change
9	***Nutrition***						D		AS
- Create	05/23/07	1413	EEE	05/23/07	1418	EEE			
- Document	05/23/07	1413	EEE	05/23/07	1418	EEE			

Chief Complaint: LLL PNEUMONIA,VOMITING
Past Medical History: CAD with Stent, HTN

Diet followed at home: REG
Current diet: Clear Liquid Texture: Regular

Ht: ft: 5 in: 3.0 cm: 160.0 Frame size: MEDIUM IBW= 115 % of IBW: 125.0
Wt: lb: 144 oz: kg: 65.32 %ILE of HT: %ILE of WT:

BMI= 25.50 Wt based on BMI: Obesity 1 (BMI 25-29.9)

Na+: 137 05/23/07 1230 Trig:
K+: 4.1 05/23/07 1230 CO2:
Glu: 112 05/23/07 1230 PH: 5.5 05/22/07 1100
Calcium: 8.6 05/23/07 1230 BUN: 4 05/23/07 1230
Phos: CREA: 30.8 05/23/07 1230
Mg: 1.9 05/23/07 1230 Hgb:
PreAlb: Hct:
Alb: 3.9 05/22/07 1125 Visceral Protein Status: WNL 3.5-5.0
Estimated needs based on: IBW
Calories= 1300-1600
Protein (g) = 42-52
Fluid (cc)= 1300-1600

Follow-up date: 05/27/07

Likes and Dislikes:

Comments: Pt screened for n/v. Labs show low hgb, low K, low BUN, low CREA, and albumin WNL. Pt reports n/v x 1 week; hasn t been able to keep anything down. Per pt, loss of 15 pounds in 2 weeks. Advanced diet as tolerated and encourage intakes >75%. RD is available for further nutritional needs.

Problems Identified: NUTRITION Nutritional care

- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
7690	Laboratory Data Interpretation						D		OE
	5/24: CBC, STOOL FOR BLOOD X 3								
	5/23: IF HGB LESS THAN 8.5 GIVE 1 UNIT PRBC								
- Create	05/23/07	1504	DCT	05/23/07	1504	DCT			
- Document	05/24/07	1950	TA	05/25/07	0319	TA			
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
413	Telemetry						D		PS
- Create	05/24/07	0339	TA	05/24/07	0339	TA			
- Document	05/24/07	0339	TA	05/24/07	0339	TA			

Rhythm: SR WITH DEP ST

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002079

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
413 Telemetry							D		PS
- Document	05/24/07	0830	PJW	05/24/07	1515	PJW			
Rhythm: SR WITH DEP ST									
- Document	05/25/07	0343	TA	05/25/07	0344	TA			
Rhythm: SR DEP ST									
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
Rhythm: SR DEP ST									
- Document	05/26/07	0446	RR	05/26/07	0446	RR			
Rhythm: sinus rhythm with dep ST segment									
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
7690 Laboratory Data Interpretation							D		OE
5/25: H AND H ON 5/26.									
- Create	05/25/07	1209	JAM	05/25/07	1209	JAM			
- Document	05/25/07	1235	WJT	05/25/07	1235	WJT			
- Ed Status	05/26/07	1728	his	05/26/07	1728	his			A => D
3118 RT: Inhalation Therapy Subsequent ($)							A		PS
- Document	05/26/07	0830	MKR	05/26/07	1809	MKR			

Initial Tx: N TX: AEROSOL Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: ALBUTEROL/ATROVENT QID AND PRN
Reason TX not Given:

PF Before: BS Pre: DIM Cough: N Suction: N
PF After: CL
Fields: ALL LOBES RR Pre: 20 Strength:
HR Pre: 88 BS Post: CL RR Post: 20 Productive: N
HR During: 88 DIM Sputum Amount:
HR Post: 89 Fields: ALL LOBES Consistancy:
SaO2: 98--RA Sputum Color:
RT Continued: Y Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

Comments:

- Document 05/26/07 1430 MKR 05/26/07 1809 MKR

Initial Tx: TX: MDI Code Status: FULL CODE
Ed Method: EXPLAIN
TX with air: Learner: PATIENT
TX Given: Y Outcome: UNDERSTOOD Orders: 2P COMBIVENT Q6 AND PRN
Reason TX not Given: INSTRUCT PATIENT

PF Before: BS Pre: DIM Cough: N Suction: N
PF After: CL
Fields: ALL LOBES RR Pre: 16 Strength:
HR Pre: 68 BS Post: CL RR Post: 16 Productive: N
HR During: DIM Sputum Amount:
HR Post: 68 Fields: ALL LOBES Consistancy:
SaO2: 98--RA Sputum Color:
RT Continued: N Priority 2 Number of TX Given: 1
Was patient in pain? N Action Taken: No Action Taken

645

Comments: PATIENT INSTRUCTED IN USE OF MDI AND SPACER. ADEQUATE

002080

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Direction Comment	Documented Units	From Change
3118	RT: Inhalation Therapy Subsequent ($) (continued)									
	TECHNIQUE DEMONSTRATED.									
- Create	05/26/07	1807	MKR	05/26/07	1807	MKR				
3320	RT: Oxygen Therapy Per 12 Hrs ($)						A			PS
- Create	05/26/07	1807	MKR	05/26/07	1807	MKR				

Monogram	Initials	Name	Nurse Type
ABG	NSABG1	GALELA,ARMI B.	RN
BER	RTBER	ROSSITER,BARBARA E.	RT
CAC	RSCAC	CANARINA,SYNDE	PT
CO	NSCO1	OSBORNE,CINDY	LPN
DCT	BODT	TURNER,DEBORAH C.	US
EEE	FNSEEE	ELLIOTT,ELLEN	RD
JAM	NSJAV1	MARTIN,JESSICA ANN	CT
KBO	RTKO	OXENDINE,KELLI B.	RT
KM	NSKM	WALKER,KIMBREA	RN
MFE	NSMFE	EDWARDS,MAE FRANCES	CT
MKR	RTMR	ROBERTS,MICHAEL K.	RT
MLS	CMMLS	SINGLETARY,MONA L.	SW
NRV	NSNV	VAN PATTEN,NAONI R.	RN
PDW	RTPW	WHETSELL,PAMELA D.	RT
PJS	RTPS1	STANLEY,PAULA J.	RT
PJW	NSPW1	WHACK,PAULINE J.	RN
REM	NSRH6	MCLEOD,RUBY E.	NA
RR	NSRC1	ROY,RENCHIE	RN
SLH	RTSL1	HILDITCH,SUSAN L.	RT
TA	NSTA	ALAISA,TERESA	RN
TJH	NSTJH1	HEYWARD,TERRIE J	CNA
TLJ	NSTLJ1	JOHNSON,TAMMY L.	US
TMP	RTTMP	PROFFIT,TINA M.	RT
TWB	NSTWB	BONHAM,THELMA W.	CT
WJT	NSWJT	THURBER,BUTCH	RN
his		automatic by program	

Inpatient

ADMISSION RECORD

Patient Name / Address	Account No.	Room / Bed	Type	Location / Service		Medical Rec. No.	
WINDHAM,TAMMY ELIZABETH [redacted]	12930159	336/1	INo	MED		229998	
	Date of Birth	**Age**	**Sex**	**MarStat**	**Religion**	**Race**	**Smoker**
	[redacted]	40	F	M	HOL	W	N
Person to Notify / Address: PARROTT,MELINDA [redacted]					Other Phone	Relationship: SI	
Guarantor / Address: WINDHAM,TAMMY ELIZABETH [redacted]							
Next of Kin / Address: PARROTT,MELINDA [redacted]					Other Phone	Relationship: SI	
Financial Class: S							

Insurance Name	Policy Number	Coverage Number	Subscriber / Insured Name
SELF-PAY	247311815		WINDHAM,TAMMY ELIZABETH

Accident Information	Reason for Visit		
ONSET OF SYMPTO	CHEST PAIN		
Accident Date / Time	**Comments**	**Height / Weight**	**Arrival Mode**
05/09/08	NO IDS		
Admit Date / Time	**Admitting Physician**	**Attending Physician**	**User**
05/10/08 0159	MEDICAL SERVICES - TMP	MEDICAL SERVICES - TMP	ADKLW

Hospital Days	HOME	OMI	SNF	ICF	HH	DIED	AUTOPSY	Surgeon	Consult	Discharge Date / Time
	☐	☐	☐	☐	☐	☐	☐	Anesthesiologist	Consult	

Admitting Diagnosis

Diagnosis and Procedure Code

Principal Diagnosis

Secondary Diagnosis

Procedure

Does pt have Advance Directive (Living Will)? No

If yes, Living Will copy received? N

Does pt have Health Care Power of Attorney? No

If yes, Health Care Power of Attorney copy received?

Does patient want info on Advance Directive? No

Are you an organ donor? No

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

129 North Washington Street
Sumter, South Carolina 29150

Admission Record (Inpatient)

00000 Rev. 01/01/2004

WINDHAM,TAMMY ELIZABETH
Acct: 12930159 **Unit:** 229998 647
MEDICAL SERVICES - TMP
INo **DOS:** 05/10/08
F W **Age:** 40 [redacted]

DISCHARGE SUMMARY

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: MEDICAL SERVICES - TMP
Adm. Dr: MEDICAL SERVICES - TMP
Admit Date: 05/10/08
Location: TELE
Account#: 12930159

MR#: 229998
RM#: 336-1
[redacted]
Discharge Date:
Service: Medicine

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

DATE OF ADMISSION: 05/10/2008

DATE OF DISCHARGE: 05/11/2008

ACCOUNT NUMBER: 12930159

DATE OF BIRTH:

HISTORY OF PRESENT ILLNESS: She is a 40-year-old white female who had a history of CAD status post stent in 2007. She came in with chest pain. Please refer to H and P dictation for further details. On admission, she was pain free since she came to the emergency room and got not nitro, Plavix, aspirin, and Lovenox in the emergency room. We monitored her. Her troponin has gone up; when she came it was 0.02 and then it went up to 0.116. Then it was 0.092. She has been getting Lovenox, Plavix, aspirin, Lopressor, and lisinopril. She has been pain free, but because of her history of CAD with stent placed, discussed with Dr. Robert Malnuk, cardiologist in Columbia who is covering for Dr. Lawton, who did stent for her last year, and Dr. Malnuk accepted her to be transferred to Columbia. We will move her when he has a bed available over there.

DISCHARGE DIAGNOSES:

1. Acute coronary syndrome.
2. Coronary artery disease status post stent in March 2007.
3. Hypertension.
4. Medical noncompliance.
5. Smoker.
6. Abnormal liver function tests. (Her SGOT was 140, SGPT 110).

CURRENT MEDICATIONS: She is getting nicotine 21 mg once a day, Plavix 75 mg p.o. once a day, Lovenox 70 mg subcu q.12h., nitro 0.4 mg sublingual p.r.n., aspirin 81 mg once a day, Lopressor 50 mg p.o. b.i.d., morphine 1-3 mg IV

DISCHARGE SUMMARY

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12930159

p.r.n. q.4h, Zofran 4 mg IV p.r.n. q.6, lisinopril 20 mg p.o. once a day.

DISPOSITION: She will return to cardiologist in Columbia when a bed is available.

Thank you for accepting this patient. If any questions or concerns, please call Medical Services at (803)890-5609.

DUANGNED TANTAWANICHPISAL, MD

Dict. Date: 05/11/2008 11:30 Trans. Date: 05/11/2008 12:52
Job: 1015930/325652918

TANDAU

TANDAU

TUOMEY HEALTHCARE SYSTEM

002084

DISCHARGE SUMMARY

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12930159

Authenticated and Edited by Dau Tantawanichpisal, MD On 5/13/08 1:45:18 PM

650

5871

TUOMEY HEALTHCARE
EMERGENCY RECORD

TRIAGE (Fri May 09, 2008 22:13 RCR)
COMPLAINT: COMPLAINT: Chest Pain. (Fri May 09, 2008 22:13 RCR)
ADMISSION: URGENCY: 1 - Emergent, TRANSPORT: Ambulance, BED: LOBBY. (Fri May 09, 2008 22:13 RCR)
PA[illegible] Tammy E Windham, AGE: 40, GENDER: female, DOB: Wed [illegible]67, LANGUAGE: English, RACE: Caucasian. Pt wants EDHIV test?: Patient does not want EDHIV test, Fall related visit: No, New onset weakness: No, ZIP CODE: 29154, KG WEIGHT: 72.6 (est.), PHONE: 803-506-4697, MEDICAL RECORD NUMBER: 229998, PAYMENT: Self Pay, ATTENDING: NONE. (Fri May 09, 2008 22:13 RCR)
PREVIOUS VISIT ALLERGIES: Nkda. (Fri May 09, 2008 22:13 RCR)
ASSESSMENT: .. Patient complains of pain, On a scale 0-10 patient rates pain as 9, NTG X 2 and ASPIRIN at home. (Fri May 09, 2008 22:13 RCR)
States "Pain X 3 days". Movement makes it worse. C/O Pain inleft chest and down left arm. (Fri May 09, 2008 22:13 RCR)
VITAL SIGNS: BP 201/82, Pulse 77, Resp 16, Temp 97.4, Pain 9, O2 Sat 98%, on RA, Time 5/9/2008 22:05. (Fri May 09, 2008 22:13 RCR)
TREATMENTS IN PROGRESS: Oxygen, IV NTG X 1 and ASPIRIN 324mg, Site: L hand, Gauge: 20, Protocols: Chest Pain Protocol initiated. (23:13 RCR)
KNOWN ALLERGIES
Nkda.
CURRENT MEDICATIONS (22:14 RCR)
Metoprolol Tartrate: 50 milligram(s) PO 2 times a day. 50mg BID.
Aspirin: 81 milligram(s) PO Once a day. 81mg daily.
HPI BLANK (22:40 GMC)
CHIEF COMPLAINT: Pt to ED for c/o sharp CP on L sternal border intermittently for 2 days, initially resolving on own and today with NTG sl, but then back. Associated with SOB and diaphoresis but no nausea, similar to pain with MI last year with stent placed. Sees unknown cardiologist in columbia, no med doc. Continues to smoke. No other c/o.
HISTORIAN: History obtained from patient, family.
TIME COURSE: Onset of symptoms reported as gradual, Onset was as above. Complaint is persistent.
SEVERITY: Maximum severity is severe, Currently symptoms are moderate.
PAST MEDICAL HISTORY
MEDICAL HISTORY: History of cardiac disease. with stent placement, Number of stents 1. History of hypertension, which is not being treated. circumflex implant. (Fri May 09, 2008 22:13 RCR)
SURGICAL HISTORY: History of appendectomy, History of cholecystectomy. History of tubal ligation. circumflex implant 3/19/07. (Fri May 09, 2008 22:13 RCR)
PSYCHIATRIC HISTORY: No previous psychiatric history. (Fri May 09, 2008 22:13 RCR)

TUOMEY HEALTHCARE

SOCIAL HISTORY: Denies alcohol abuse, drug abuse. Lives with others. Patient smokes tobacco, at 0.5, packs per day for 20, years; equating to 10, pack years of smoking. (Fri May 09, 2008 22:13 RCR)
FAMILY HISTORY: Family history is not contributory to this case. (Fri May 09, 2008 22:13 RCR)
NOTES: Nursing records reviewed, Agree with nursing records, Medication list reviewed. (22:41 GMC)
ROS
CONSTITUTIONAL: No fever, chills. (22:41 GMC)
CARDIOVASCULAR: Historian reports chest pain, diaphoresis. No palpitations, edema. (22:41 GMC)
RESPIRATORY: Historian reports SOB. No Cough, sputum. (22:41 GMC)
GENITOURINARY FEMALE: No dysuria. (22:41 GMC)
MUSCULOSKELETAL: No back pain. (22:41 GMC)
SKIN: Negative skin review of systems. (22:41 GMC)
NEUROLOGIC: Negative neurologic review of systems. (22:41 GMC)
ALLERGIC/IMMUNOLOGIC: No frequent infections, poor healing, prolonged convalescence. (22:41 GMC)
PSYCHIATRIC: No drug abuse. (22:41 GMC)
GI: Negative gastrointestinal review of systems. (Sat May 10, 2008 01:32 GMC)
PHYSICAL EXAM (22:42 GMC)
CONSTITUTIONAL: Patient is afebrile, Vital signs reviewed. Patient has normal pulse, normal respiratory rate, Alert and oriented X 3, Hypertensive.
HEAD: Atraumatic, Normocephalic.
EYES: No discharge from eyes. Sclera are normal. Conjunctiva are normal.
ENT: Posterior pharynx normal.
NECK: Normal ROM. No jugular venous distention.
RESPIRATORY/CHEST: Breath sounds normal. No respiratory distress.
CARDIOVASCULAR: RRR. No murmurs, gallop.
ABDOMEN: Abdomen is nontender, Bowel sounds normal. No distension, peritoneal signs.
BACK: There is no tenderness to palpation. Normal inspection.
UPPER EXTREMITY: Inspection normal. No cyanosis, clubbing, edema. Normal range of motion.
LOWER EXTREMITY: No edema. Normal range of motion, No calf tenderness.
NEURO: GCS is 15. No focal motor deficits, Speech normal.
SKIN: Skin is warm, Skin is dry, Skin is normal color.
PSYCHIATRIC: Oriented X 3. Normal affect.
VITAL SIGNS
VITAL SIGNS: BP: 201/82, Pulse: 77, Resp: 16, Temp: 97.4, Pain: 9, O2 sat: 98% on RA, Time: 5/9/2008 22:05. (Fri May 09, 2008 22:13 RCR)

BP: 192/81, Pulse: 73, Resp: 16, Pain: 4, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 22:30. (23:06 RCR)
BP: 178/76, Pulse: 66, Resp: 15, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 23:00. (23:07 RCR)
BP: 188/72, Pulse: 63, Resp: 20, Pain: 0, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 23:30. (23:44 RCR)
BP: 184/71, Pulse: 60, Resp: 19, Pain: 0, O2 sat: 99% on 2 L, Time: Sat May 10, 2008 00:30. (Sat May 10, 2008 00:57 RCR)

ORDERS

EKG by RCR for GMC on Fri May 09, 2008 22:17 Status: Active.
INT by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by RCR Fri May 09, 2008 22:38.
CBC (WITH DIFF) by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 22:49.
TROPONIN- I by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 23:13.
XR CHEST PORTABLE 1 VIEW 0608 by GMC for GMC on Fri May 09, 2008 22:37 Status: Active.
CKMB +TOTAL CK by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 23:00.
Vital Signs Every 2 Hours by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by RCR Fri May 09, 2008 22:38.
BASIC METABOLIC PANEL by GMC for GMC on Fri May 09, 2008 22:37 Status: Active.

DOCTOR NOTES (Sat May 10, 2008 01:42 GMC)

TEXT: PT told nursing staff pain free when went to give NTG SL and was placed on paste. Pt now tells me pain just went away an hour ago, but is currently pain free. Admitted service med.

PATIENT STATUS: Patient has improved since arrival to emergency department.

D/W: Discussed this case with Dr. Tan, the on call physician.

PATIENT PLAN: The patient will be admitted to the hospital.

DATA REVIEWED: Lab data reviewed, Xray data reviewed, Reviewed EKG, Discussed with family, Discussed with consultants.

MEDICATION SERVICE

Aspirin: Order: Aspirin : 324 milligram(s) : PO
Ordered by: Garrett Clanton, MD
Entered by: Garrett Clanton, MD Fri May 09, 2008 22:37
Held by: Ronald Rath Fri May 09, 2008 23:11 Reason: Pt has already received 324mg ASPIRIN by EMS. (22:37 GMC)

Lopressor: Order: Lopressor (Metoprolol Tartrate) : 50 milligram(s) : PO
Ordered by: Garrett Clanton, MD
Entered by: Garrett Clanton, MD Fri May 09, 2008 22:38
Documented as given by: Ronald Rath Fri May 09, 2008 23:10
Patient, Medication, Dose, Route and Time verified prior to administration.
MEDICATION , Time given: 2300, Administration of this medication is documented elsewhere in chart. (22:38 GMC)

BP: 192/81, Pulse: 73, Resp: 16, Pain: 4, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 22:30. (23:06 RCR)
BP: 178/76, Pulse: 66, Resp: 15, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 23:00. (23:07 RCR)
BP: 188/72, Pulse: 63, Resp: 20, Pain: 0, O2 sat: 99% on 2 L, Time: Fri May 09, 2008 23:30. (23:44 RCR)
BP: 184/71, Pulse: 60, Resp: 19, Pain: 0, O2 sat: 99% on 2 L, Time: Sat May 10, 2008 00:30. (Sat May 10, 2008 00:57 RCR)

ORDERS

EKG by RCR for GMC on Fri May 09, 2008 22:17 Status: Active.
INT by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by RCR Fri May 09, 2008 22:38.
CBC (WITH DIFF) by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 22:49.
TROPONIN- I by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 23:13.
XR CHEST PORTABLE 1 VIEW 0608 by GMC for GMC on Fri May 09, 2008 22:37 Status: Active.
CKMB +TOTAL CK by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by System Fri May 09, 2008 23:00.
Vital Signs Every 2 Hours by GMC for GMC on Fri May 09, 2008 22:37 Status: Done by RCR Fri May 09, 2008 22:38.
BASIC METABOLIC PANEL by GMC for GMC on Fri May 09, 2008 22:37 Status: Active.

DOCTOR NOTES (Sat May 10, 2008 01:42 GMC)

TEXT: PT told nursing staff pain free when went to give NTG SL and was placed on paste. Pt now tells me pain just went away an hour ago, but is currently pain free. Admitted service med.

PATIENT STATUS: Patient has improved since arrival to emergency department.

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MEDICATION SERVICE

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Ordered by: Garrett Clanton, MD
Entered by: Garrett Clanton, MD Fri May 09, 2008 22:37
Held by: Ronald Rath Fri May 09, 2008 23:11 Reason: Pt has already received 324mg ASPIRIN by EMS. (22:37 GMC)

Lopressor: Order: Lopressor (Metoprolol Tartrate) : 50 milligram(s) : PO
Ordered by: Garrett Clanton, MD
Entered by: Garrett Clanton, MD Fri May 09, 2008 22:38
Documented as given by: Ronald Rath Fri May 09, 2008 23:10
Patient, Medication, Dose, Route and Time verified prior to administration.
MEDICATION , Time given: 2300, Administration of this medication is documented elsewhere in chart. (22:38 GMC)

Given, Ordered: 00:38 5/10/2008,
Drug Name: Nitroglycerin, Dose: 1 inch(es), Route: Transdermal, Status: Given, Ordered: 00:38 5/10/2008,
Drug Name: *Nitroglycerin, Dose: 0.4 milligram(s), Route: Sublingual, Status: Held, Ordered: 23:42 5/9/2008,
Drug Name: Aspirin, Dose: 324 milligram(s), Route: PO, Status: Held, Ordered: 23:11 5/9/2008,
Drug Name: Plavix, Dose: 300 milligram(s), Route: PO, Status: Given, Ordered: 23:11 5/9/2008,
Drug Name: Lovenox, Dose: 1 mg/kg, Route: SQ, Status: Given, Ordered: 23:11 5/9/2008,
Drug Name: Tylenol, Dose: 1000 milligram(s), Route: PO, Status: Given, Ordered: 23:10 5/9/2008,
Drug Name: Lopressor, Dose: 50 milligram(s), Route: PO, Status: Given, Ordered: 23:10 5/9/2008, *Additional information available in notes, Detailed record available in Medication Service section.

O2SAT INTERPRETATION (22:44 GMC)
O2SAT: O2 saturation reading 98%, O2 AMT: R.A., O2 Sat normal.
EKG INTERPRETATION (22:43 GMC)
12 LEAD EKG INTERPRETATION: 12 lead EKG interpreted by ED Physician, Compared with previous EKG, from 5/23/07. 12 Lead EKG Interpretation shows rhythm is Normal Sinus, Rate 73, beats per minute, Axis: normal, LVH with strain, Interpretation: T wave changes improved as compared to previous.
LAB INTERPRETATION (Sat May 10, 2008 01:33 GMC)
INTERPRETATION: Normal CBC, Normal chemistry profile, Normal Cardiac enzymes.
RADIOLOGY INTERPRETATION (Sat May 10, 2008 01:33 GMC)
CHEST: Interpretation of chest X-ray shows, no acute.
INTERPRETER: Preliminary review of x-rays by Radiologist.
DIAGNOSIS (Sat May 10, 2008 01:42 GMC)
FINAL: PRIMARY: Acute CP, ADDITIONAL: CAD.
PRESCRIPTION: No recorded prescriptions
DISPOSITION
PATIENT: Disposition: Admit to inpatient, Disposition Transport: Stretcher, Condition: Serious. (Sat May 10, 2008 01:42 GMC)
Pain Scale: 0, O2 used while in ED?: Yes, IV stop time docd?: NA, Remove from ER. (Sat May 10, 2008 03:30 RCR)
NURSING PROCEDURE: CARDIAC MONITOR (22:31 RCR)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, Indications for test: chest pain, Procedure was performed at 2200. Patient placed on cardiac monitor, placed on non-invasive blood pressure monitor, on cardiac monitor showing. Normal Sinus, Heart rate: 70-80's.

NURSING PROCEDURE: RESPIRATORY (22:31 RCR)
TIME: Patient's identity verified by. patient stating name,

hospital ID bracelet, Other indication for procedure Chest Pain Protocol, O2 saturation reading 97%, Oxisensor: Adult/Peds, Multiple oximetry readings, Procedure was performed at 2200, O2 AMT: 2L, Oxygen delivery device is: nasal cannula.
NURSING PROCEDURE: EKG CHART (22:43 KBK)
TIME: Patient's identity verified by. patient stating name, hospital ID bracelet, EKG was performed at 2235, 12 lead EKG Performed-left chest, After procedure, EKG for interpretation given to Dr. Clanton. Patient tolerated procedure well, Previous EKG printed and given for comparison.
NURSING PROCEDURE: EKG CHART (22:43 KBK)
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: LAB DRAW (23:06 RCR)
TIME: Labs drawn at 2230, Initial lab draw, Existing IV site, left hand, Lab specimens labeled in the presence of the patient and sent to lab, After procedure, no swelling, After procedure, no active bleeding.
SAFETY: Side rails up, Cart in lowest position, Family at bedside, Call light within reach.
NURSING PROCEDURE: MEDICATION (23:08 RCR)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 2300, LOPRESSOR (METOPROLOL), 50mg, given PO.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: MEDICATION (23:08 RCR)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 2300, TYLENOL, 1000mg, given PO.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: MEDICATION (23:09 RCR)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 2300, PLAVIX, 300mg, given PO.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: MEDICATION (23:10 RCR)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Procedure was performed at 2300, LOVENOX, 75mg, given SubQ. in the left abdomen.

SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: NURSE NOTES (23:47 RCR)
TIME: Time: 2330, Pt denies any chest pain or arm pain at present. Pt C/O "Headache is better but not completely gone". Chart posted for review.
NURSING PROCEDURE: MEDICATION (Sat May 10, 2008 00:37 RCR)

MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 0, Procedure was performed at 2350, NITROGLYCERIN, PASTE 1inch, given transdermally.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: MEDICATION (Sat May 10, 2008 00:38 RCR)
MEDICATION: Patient's identity verified by. patient stating name, hospital ID bracelet, Before procedure, on a scale 0-10 patient rates pain as 0, Procedure was performed at 2350, MORPHINE, 4mg, given IVP, Initial medication, into left Hand, IV site without signs or symptoms of infiltration during medication administration. No swelling during medication infusion, drainage during medication infusion.
SAFETY: Side rails up, Cart in lowest position, Family at bedside.
NURSING PROCEDURE: ADMISSION (Sat May 10, 2008 02:18 RCR)
TIME: Bed assigned at 0203, Report called at 0215. Patient admitted at 0145, Patient admitted to room 336, acuity level was urgent, admitted to, telemetry unit, Report called/faxed to telemetry , Patient transported via, cart, Accompanied by, emergency room technician, registered nurse, Transported with, monitor, oxygen, Belongings are. with patient.
NURSING PROCEDURE: ADMISSION (Sat May 10, 2008 03:30 RCR)
EQUIPMENT WITH PATIENT: Patient left the emergency department at 0230.
ADMIN (Sat May 10, 2008 04:27 GMC)
DIGITAL SIGNATURE: Clanton, MD, Garrett.
Key:
GMC=Clanton, MD, Garrett KBK=Kennedy, Kathryn RCR=Rath, Ronald

HISTORY AND PHYSICAL REPORT

Name: WINDHAM,TAMMY ELIZABETH
Att. Dr: MEDICAL SERVICES - TMP
Adm. Dr: MEDICAL SERVICES - TMP
Admit Date: 05/10/08
Location: TELE
Account#: 12930159

MR#: 229998
RM#: 336-1

Service: Medicine

NAME: WINDHAM, TAMMY ELIZABETH

U#: 229998

DATE OF ADMISSION: 05/10/2008

ACCOUNT NUMBER: 12930159

HISTORY OF PRESENT ILLNESS: She is a 40-year-old white female who had history of CAD status post stent in March 2007, came in with chest pain. She stated that she had this chest pain off and on for a couple of days and yesterday it got worse. It is like tightness, like pressure. She was sweating too. She came to the emergency room and chest pain was relieved by nitro. She ran out of her medication as well.

PAST MEDICAL HISTORY: She had history of CAD status post stent in 2007. She also had hypertension, denied diabetes.

PAST SURGICAL HISTORY: Appendectomy, cholecystectomy.

CURRENT MEDICATIONS:
1. Lopressor 50 mg p.o. b.i.d.
2. Aspirin 81 mg p.o. once a day.
She stated that she ran out of her medications a couple of days ago.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Smokes about half a pack a day. No alcohol, no drugs.

FAMILY HISTORY: Significant for CAD.

REVIEW OF SYSTEMS: Denied any bleeding, denied kidney problems. Denies seizure, never had a stroke.

PHYSICAL EXAMINATION: VITALS SIGNS: Temperature 95.7, respirations 18, heart rate 51, blood pressure 160/71, saturations 98% on 2 liters per minute.
GENERAL: She is alert and oriented x3, not in any distress. She stated that she had no chest pain and she wants to go home now.
HEART: No LV heave, no RV heave, normal S1, S2. No murmur, no gallop.
LUNGS: Clear. No crepitation. No rhonchi. No wheezing.
ABDOMEN: Soft. No organomegaly. No tenderness.

658

HISTORY AND PHYSICAL REPORT

Name: WINDHAM,TAMMY ELIZABETH
Account#: 12930159

EXTREMITIES: No edema noted.
NEUROLOGICAL: No focal deficits.

LABORATORY DATA: CBC: White blood cells 11.0, hemoglobin 14.7, platelets 243,000. BMP: Sodium 140, potassium 3.6, chloride 107, CO2 24, glucose 113, BUN 8, creatinine 0.8, calcium 8.8, CK 39, troponin 0.020. Chest x-ray showed normal. EKG shows sinus rhythm. There was LVH with flat T at V5, V6. Compared to previous EKG there were no changes.

IMPRESSION:
1. Chest pain.
2. History of coronary artery disease status post stent in March 2007.
3. Hypertension.
4. Smoking.
5. Medical noncompliance.

ASSESSMENT/PLAN: Will admit her for observation. We will try to talk with her that she needs to stay longer to make sure that she will be stable as this chest pain could be unstable angina. She did not get follow up with her doctor for more than 6 months and will need to get a stress test as well. Please review admission orders for details and treatment.

_____
DUANGNED TANTAWANICHPISAL, MD

Dict. Date: 05/10/2008 06:48 Trans. Date: 05/10/2008 07:48
Job: 1015815/325588099

TANDAU

TANDAU

05/10/08 0648

Authenticated by Dau Tantawanichpisal, MD On 05/13/2008 01:44:10 PM

660

002095

TUOMEY HEALTHCARE SYSTEM
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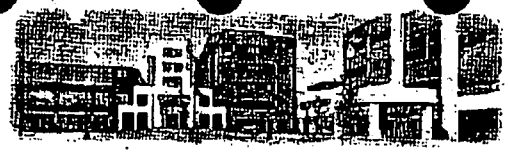

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Sumter, SC 29150
(803) 774-9000

PROGRESS NOTES

DATE	TIME	
5 10 08		Med Surg 40 y 1. CP 2. CABG in 3/07 3 HTN 4 Med noncompliance 5 smoking DRea
5.10.08		Pt stated she wanted to go home today, explained to her with counselor will try to get 3rd opinion if D, may go home pt understood with DRea
5 10 08	700 am	pt decided not to go home will continue to monitor, plan as DRea
5 11 08		Med Surg S: CP 0 SOB 0 O: 98.2 18 66 141/64 BP 153 DT/PT 140/110 Awake Alert Heart RR Lungs CTA Ext warm no 5.10.08 + ACS - Tmp. Plan: home tomorrow will try to call her Cardiologist in Columbia DRea

Progress Notes
PPN001 Rev. 07/13/06

WINDHAM, TAMMY ELIZABETH
Acct: 12930159 Unit: 229998
TMP, MEDICAL SERVICES -
TELE 336/1 DOS: 5/10/2008
F W
Admit Age: 40 6M

661

5882

002096

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AUTO STOP ORDERS - ALL MEDICATIONS 30 DAYS EXCEPT THE FOLLOWING:

Anti-Infectives - 10 days	Chemotherapeutics - 5 days	Ketorolac - 5 days
* Exception: Azithromycin - 5 days	Epidurals/PCA's - 5 days	Glycoprotein IIb/IIIa Inhibitors - 3 days
HIV & TB Meds - 30 days	Heparin Drips - 5 days	

[ ] Inpatient Admission [X] Assign to Observation

OD 0157

Date of Admission: 05-10-08 Time: 0145

Admit to Dr: TAN - Medical Service - Telemetry Bed

LEVEL OF CARE (Check One): ☐ Inpatient Admission ☒ Outpatient Observation

Admitting Dx: Chest Pain.

Code Status: Full Code. Condition: Stable.

Vital Sign Frequency: ☒ Routine ☐ Other:

Activity: Bedrest i BRP

Diet: Cardiac

IV: INT i flushes.

Blood Cultures times 2: ☐ Yes ☒ No Other: O_2 @ 2L/min NC.

Other (meds, labs, x-ray, etc.): CKMB; TRP-I Q6° x3 sets.

EKG in AM.

Meds:

1) Lovenox 1mg/kg SQ Q12°
2) Lisinopril 20mg PO Qday and i tab NOW.
3) If B/P remains >160/95 Then give Captopril 12.5mg PO Q8°.
4) Tylenol 1000mg PO Q8° PRN 4/d, PRN
5) Morphine 1-3mg IV Q4° PRN Severe Pain
6) Zofran 4mg IV Q6° PRN Nausea.
7) Tylenol 650mg PO BID 8) Aspirin 81mg PO Qday.
9) NTG 0.4mg Tab SL Q5min x3 pr CP.

PHYSICIAN ABFU TD. M. TAN/Ca Cath, AV DATE DRAM 5/10/08 TIME 24°✓ 5/10/08 2300 B. Reid RD

CHART CHECK DATE _____ TIME _____ INITIALS _____

5/10/08 0255 vpmelvin

Sent to Pharmacy C 0155

SCANNED 5/10/08 0243

Physician Order - Admission Order

ADO004 Rev. 04/12/07

WINDHAM, TAMMY ELIZABETH
Acct: 12930159 Unit: 229998
UNKNOWN,
ED /
F W
Admit Age: 40 6M
DOB [redacted]

5883

002097

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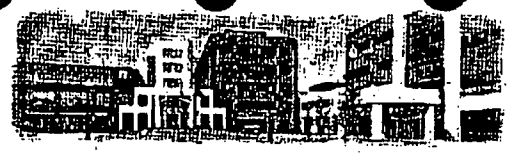

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Vaccination Indications (Check all that apply)

PNEUMOCOCCAL VACCINE *(offer year round)*	INFLUENZA VACCINE *(October 1st through end of March only)*
Vaccine indicated (if any of the following):	**Vaccine indicated** (if any of the following):
Patient is:	Patient is:
☐ 65 years of age or older	☐ 50 years of age or older
☐ Resident of nursing home or chronic care facility regardless of age **OR**	☐ Resident of nursing home or chronic care facility regardless of age **OR**
Patient is age 19-64 and has any of the following high-risk conditions:	Patient is age 19-49 and has any of the following high-risk conditions:
☐ Congestive Heart Failure	☐ Congestive Heart Failure
☐ COPD (but not asthma)	☐ COPD (but not asthma)
☐ Diabetes	☐ Diabetes
☐ Asplenic State/Sickle Cell	☐ Asplenic State/Sickle Cell
☐ Alcoholism	☐ Alcoholism
☐ Chronic Liver Disease	☐ Chronic Liver Disease
☐ Cerebrospinal fluid leaks	☐ Cerebrospinal fluid leaks
☐ Immunocompromised (Lymphoma, Leukemia)	☐ Patient pregnant or breastfeeding
☑ None of the above **(STOP the screening)**	☐ Immunocompromised (Lymphoma, Leukemia)
	☐ None of the above **(STOP the screening)**

Vaccination Contraindications (check all that apply)

Vaccine not indicated (If any of the following):	Vaccine not indicated (If any of the following):
☐ **Physician order not to give vaccine**	☐ **Physician order not to give vaccine**
☐ Previously immunized	☐ Previously immunized this flu season
☐ Patient pregnant or breastfeeding	☐ Ever had a reaction to influenza vaccine
☐ Patient refuses	☐ Ever had an allergic reaction to eggs
	☐ History of Guillain-Barre syndrome
	☐ Patient refuses

Vaccination Indicated

☐ **Pneumococcal vaccine indicated – no contraindications identified.**	☐ **Influenza vaccine indicated – no contraindications identified.**
(Year round)	*(October 1st through end of March only.)*
Administer vaccine 0.5ml IM in deltoid. Document on MAR and in computer as an intervention.	Administer vaccine 0.5ml IM in deltoid. Document on MAR and in computer as an intervention.
Screening completed by: Nurse signature: Jonathan, RN Date/Time: 5/10/08 0300	Screening completed by: Nurse signature: _____ Date/Time: _____

Physician Order -
Standing Order for Pneumococcal and Influenza Vaccine Protocol

ORD068 Rev. 09/14/2007

WINDHAM , TAMMY ELIZABETH
Acct: 12930159 **Unit:** 229998
TMP, MEDICAL SERVICES -
TELE 336/1 **DOS:** 5/10/2008
F W [redacted]
Admit Age: 40 6M

5884

002098

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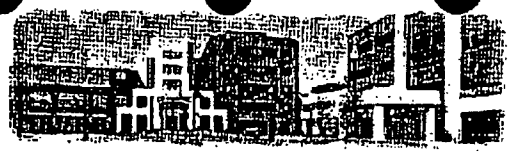

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PHYSICIAN'S ORDERS [ ] Inpatient Admission [ ] Observation

YEAR 2008 DRUG ALLERGIES NKDA

ORDERED MONTH	DAY	TIME	
5.10	08	645 am	- Plavix 75 mg po q day
			- Lipitor 10 mg po q hs
			if LFT's is normal.
			- DVT Nibropmin
			- Nicotrin patch 21 mg q day PRN
			SCANNED 0734 T Johnson, RN 5-10-08
			24 ✓ 5/10/08 @ 2355
5/10	✓	1045 am	✓ D/C Lipitor
			- ambulate in room/hallway
			✓ Lipid in am. D. Rus.
			SCANNED 1125
5/11/08			Transfer patient to Providence or Lakeland Hospital to Dr. Malnick per ambulance
		1305	J.O. Dr. Jan
			Read Back Verified per JBeadles, R

TELEPHONE AND VERBAL ORDERS MUST BE WRITTEN DOWN, READ BACK AND CONFIRMED

NURSING: INDICATE "SCANNED, DATE, TIME AND SIGNATURE" AFTER EACH ORDER

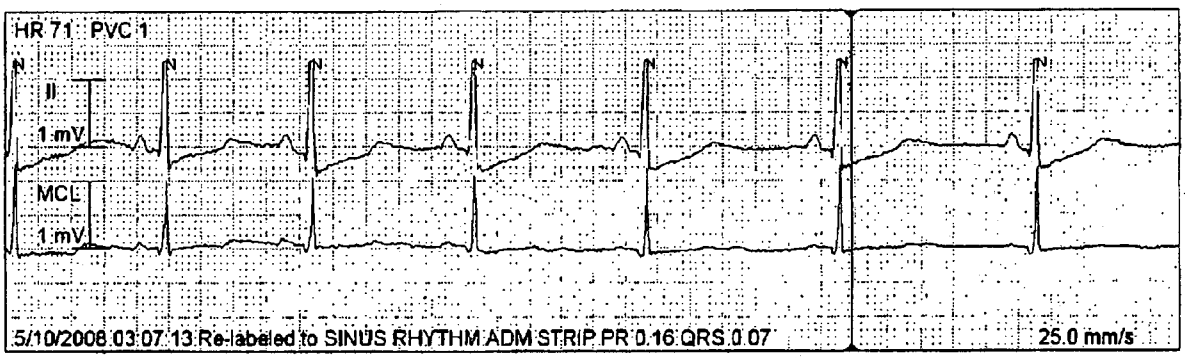
WINDHAM , TAMMY ELIZABETH
Acct: 12930159 Unit: 229998
TMP, MEDICAL SERVICES -
TELE 336/1 DOS: 5/10/2008
F W
Admit Age: 40 6M [redacted]

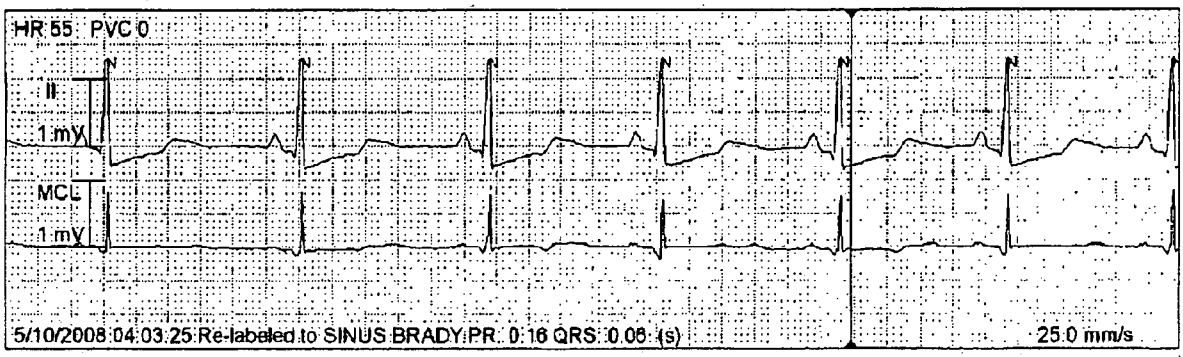
664

Physician's Orders
ORD002 Rev. 04/30/2007

WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

Alarm Review WINDHAM, TAMMY 336





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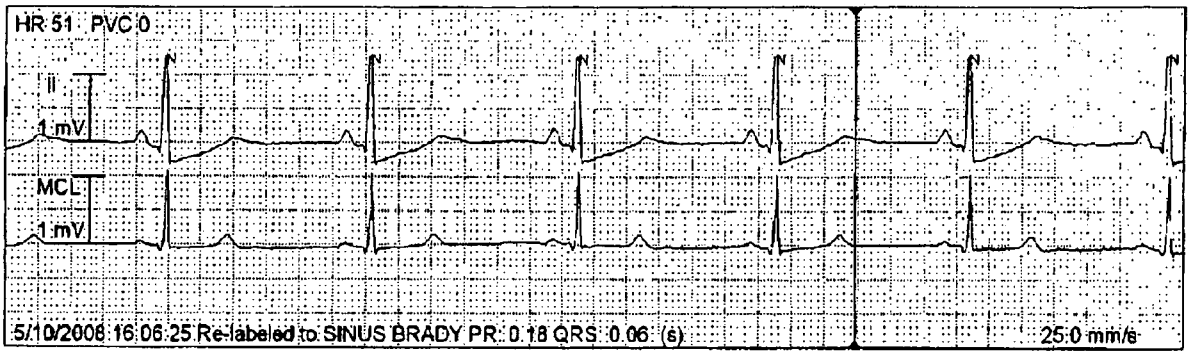
WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

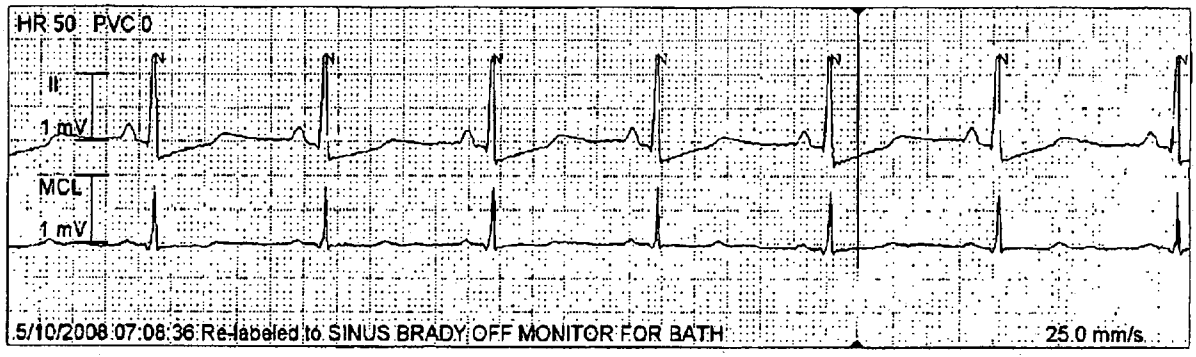
Alarm Review WINDHAM, TAMMY 336

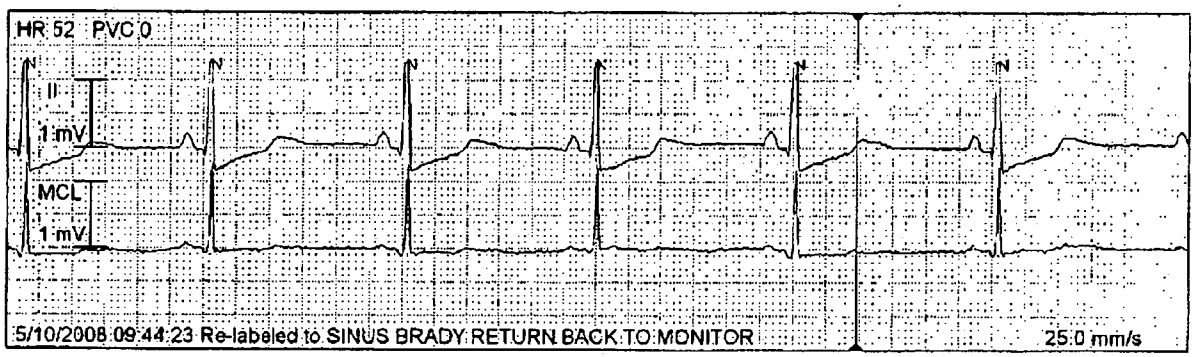


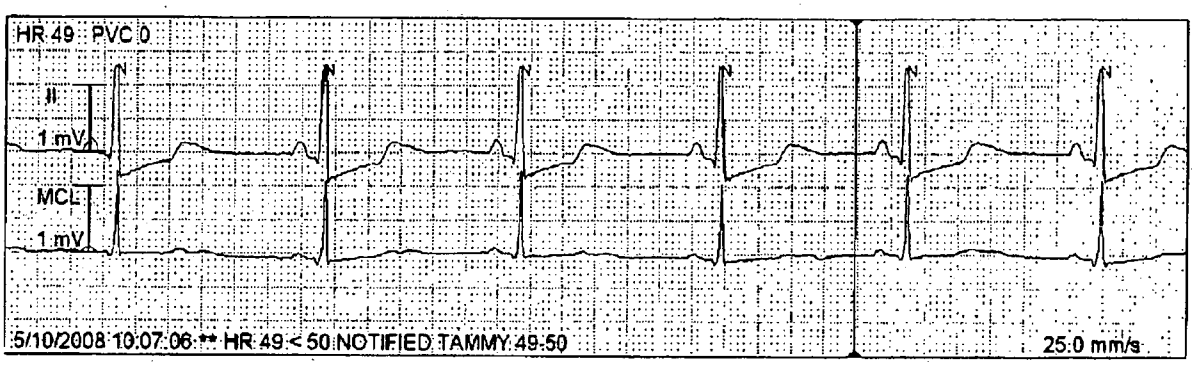
SGC

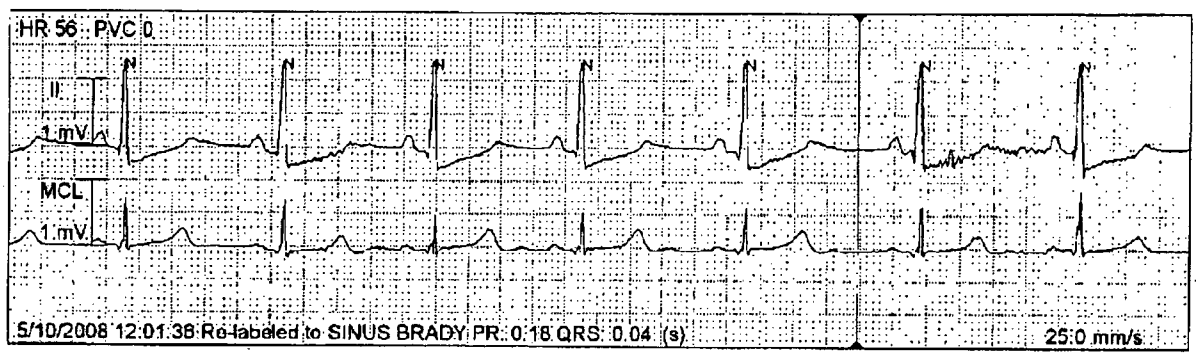
WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

Alarm Review WINDHAM, TAMMY 336









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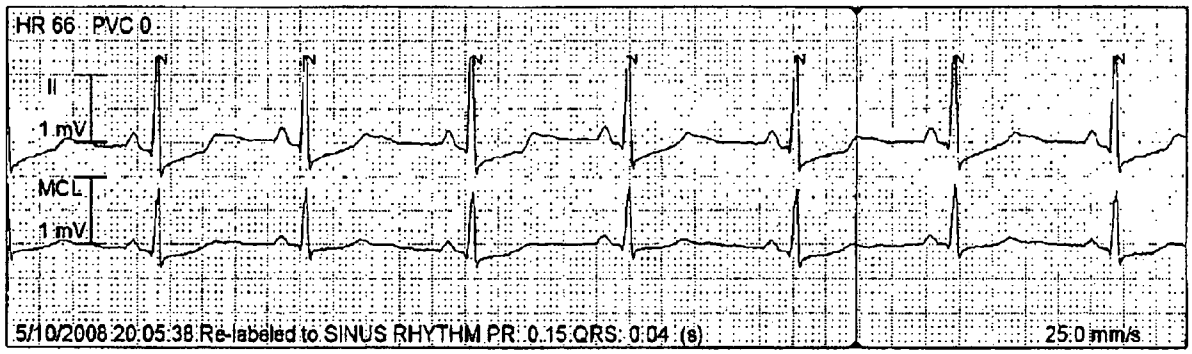
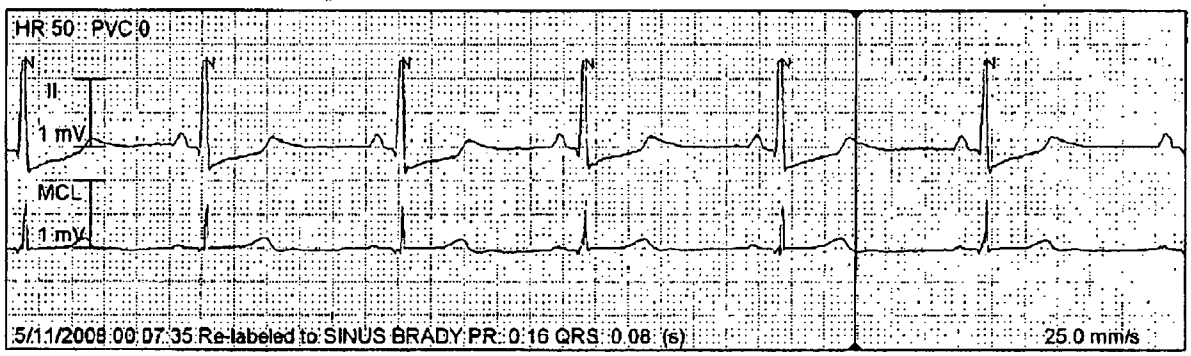
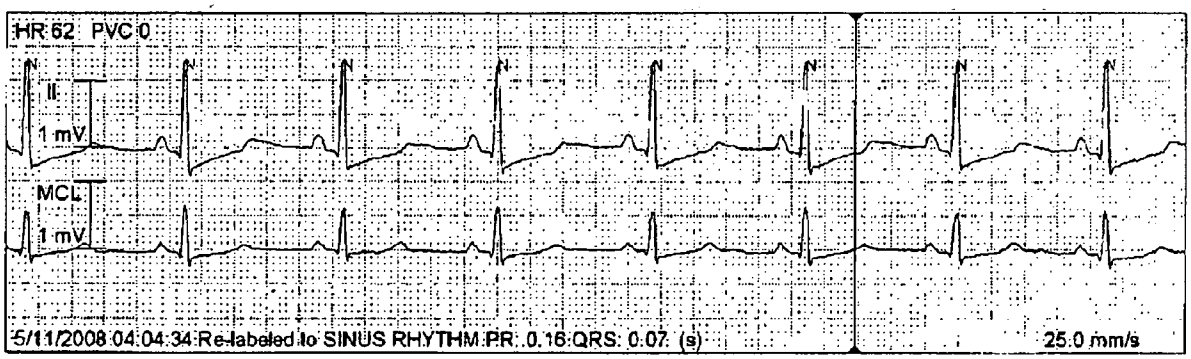
WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

Alarm Review WINDHAM, TAMMY 336







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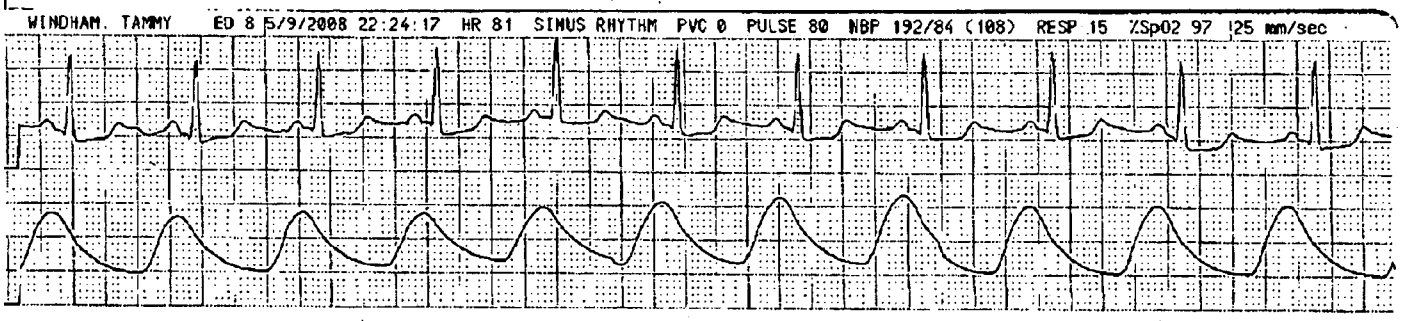
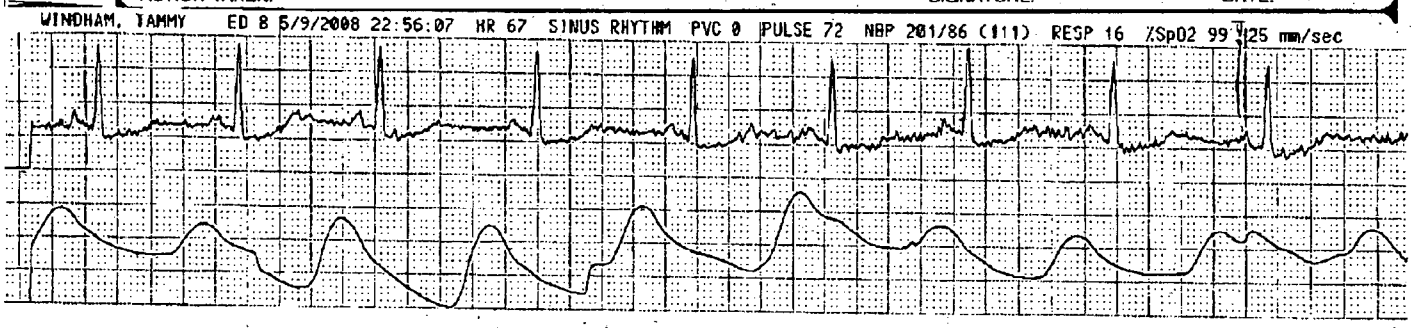


P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

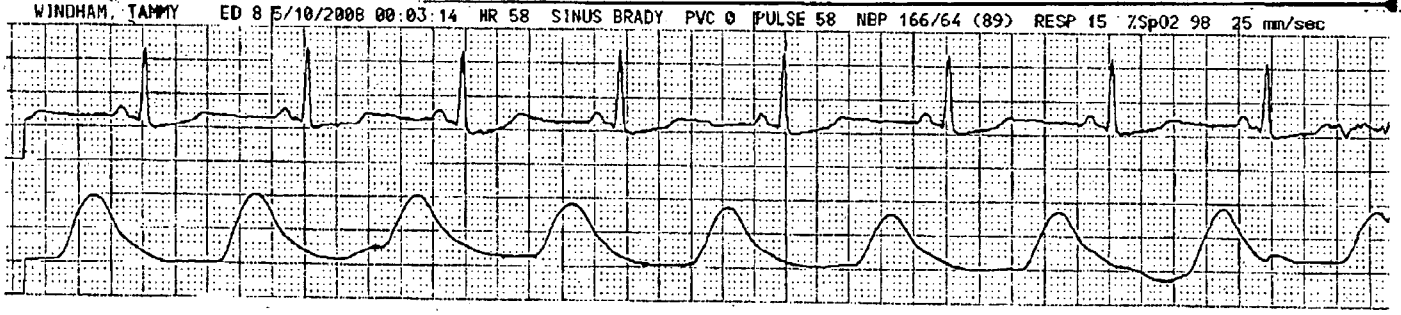


P▶ P: REG ○ IRREG ○
PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:



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PR INT: _____ CONSTANT ○ VARI ○
ATRIAL RATE ____

R▶ R: REG ○ IRREG ○
QRS INTERVAL: _____
VENT. RATE _____ QT INT. _____

INTERPRETATION: _____

ACTION TAKEN: SIGNATURE: DATE:

WINDHAM, TAMMY ELIZABETH
U# 229998 ACCT# 12930159

Windham, Tammy

669

5-9-08 8

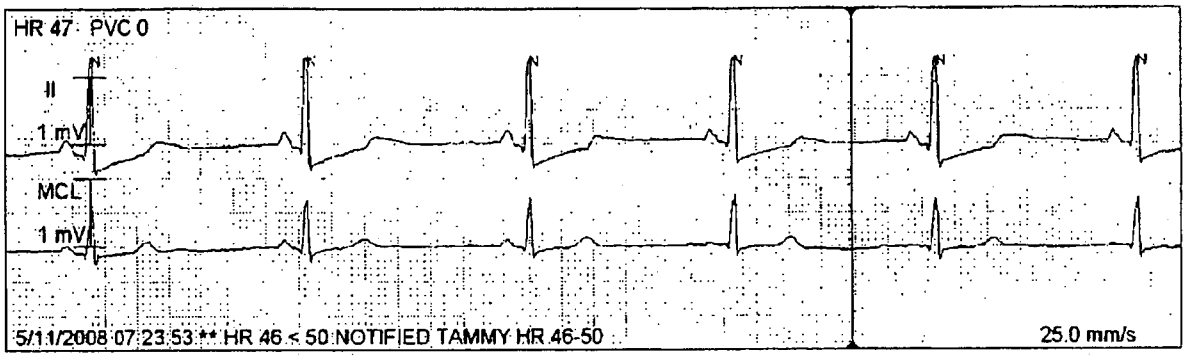
RHYTHM STRIP RECORD

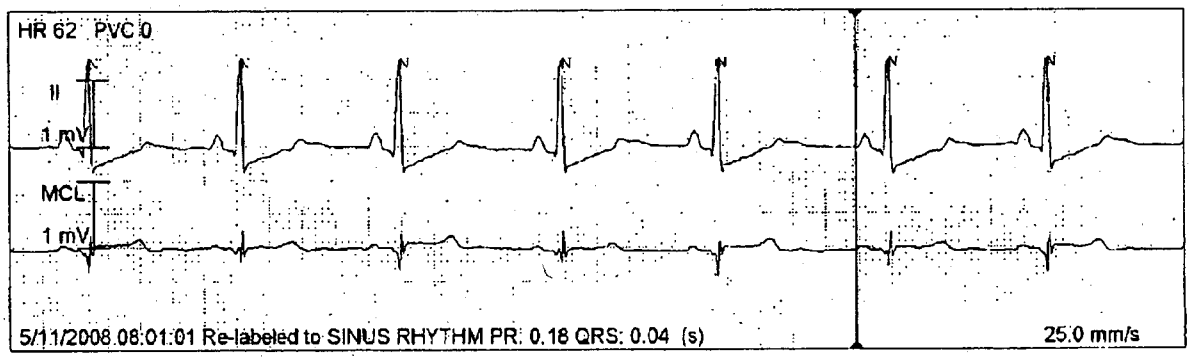
ICU-1220 MOORE WALLACE

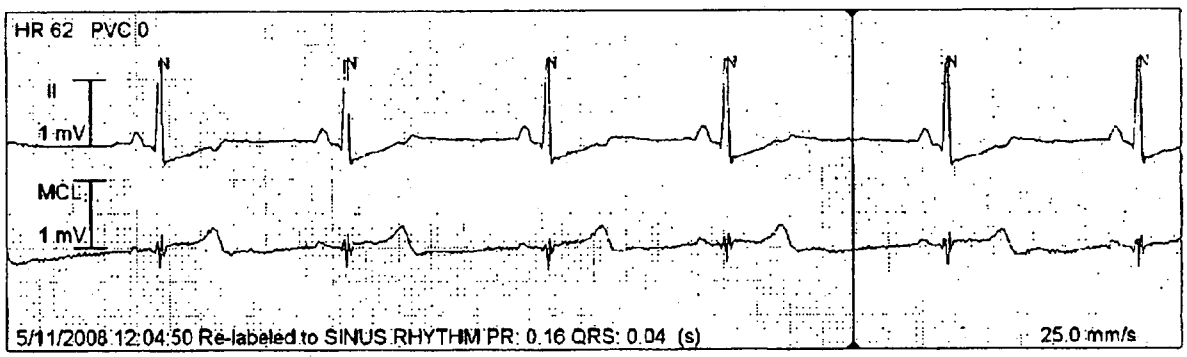
5890

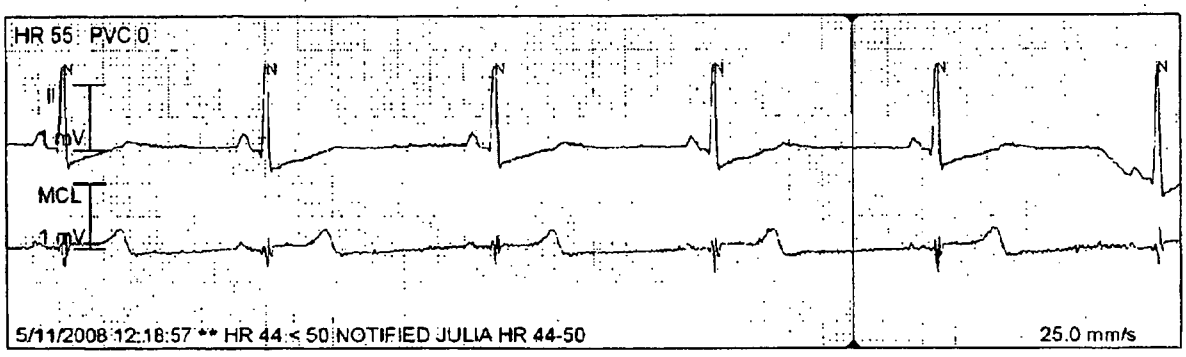
WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

Alarm Review WINDHAM, TAMMY 336









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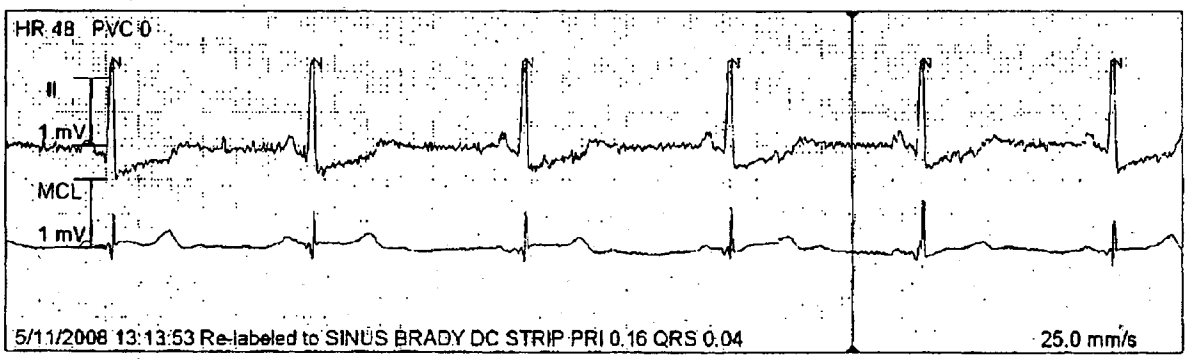
WINDHAM, TAMMY 336 Medical Record Number: 12930159/229998 TELE11

Alarm Review WINDHAM, TAMMY 336



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5893

229998 WINDHAM, TAMMY ELIZABETH 09-May-2008 22:35:31
40 Years Female Race: White BP: 201/82 Dept: Emergency Dept.
Room: ED-08
Oper: KK

CD2106

Rate 73 - STMT - * SINUS RHYTHM, RATE 73.
RR 822 - STMT - * PROBABLE LEFT ATRIAL ABNORMALITY.
PR 152 - STMT - * LEFT VENTRICULAR HYPERTROPHY WITH SECONDARY REPOLARIZATION ABNORMALITY.
QRSD 84 - STMT - * SINCE LAST TRACING, 05/23/2007: LESS REPOLARIZATION ABNORMALITY.
QT 420
QTc 463

Account Number:12930159

Edited By:MYASIA WILCHER

672

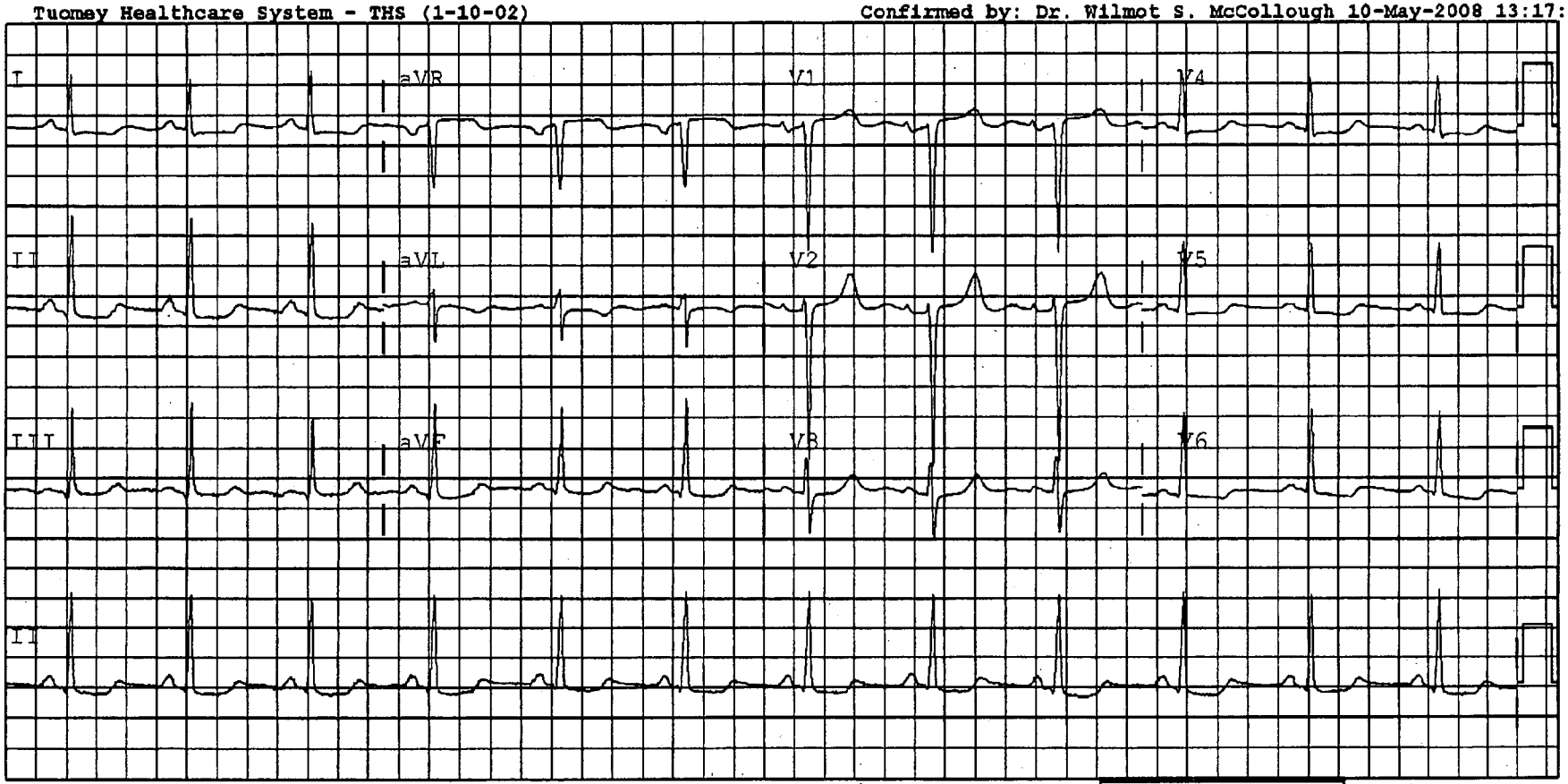
-- AXIS --
P 45
QRS 62
T 185

Order #: CARD20080509-0054

- ABNORMAL ECG -

Standard 12
Requested By: CLANTON, GARRETT
Edited
Confirmed by: Dr. Wilmot S. McCollough 10-May-2008 13:17:49

Tuomey Healthcare System - THS (1-10-02)



Device: 2743 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60~ 0.5-150 Hz W PH090A P?

5894

673

229998 WINDHAM, TAMMY ELIZABETH 10-May-2008 05:41:40
40 Years Female Race: White BP: 201/82 Dept: Telemetry
Room: 336
Oper: 311

Rate 44 - STMT - * SINUS BRADYCARDIA, RATE 44.
RR 1364 - STMT - * NONSPECIFIC T ABNORMALITIES, LATERAL LEADS.
PR 152 - STMT - * SINCE LAST TRACING, 05/09/2008: RATE SLOWER; LESS VOLTAGE.
QRSD 86
QT 504
QTc 432

Account Number:12930159

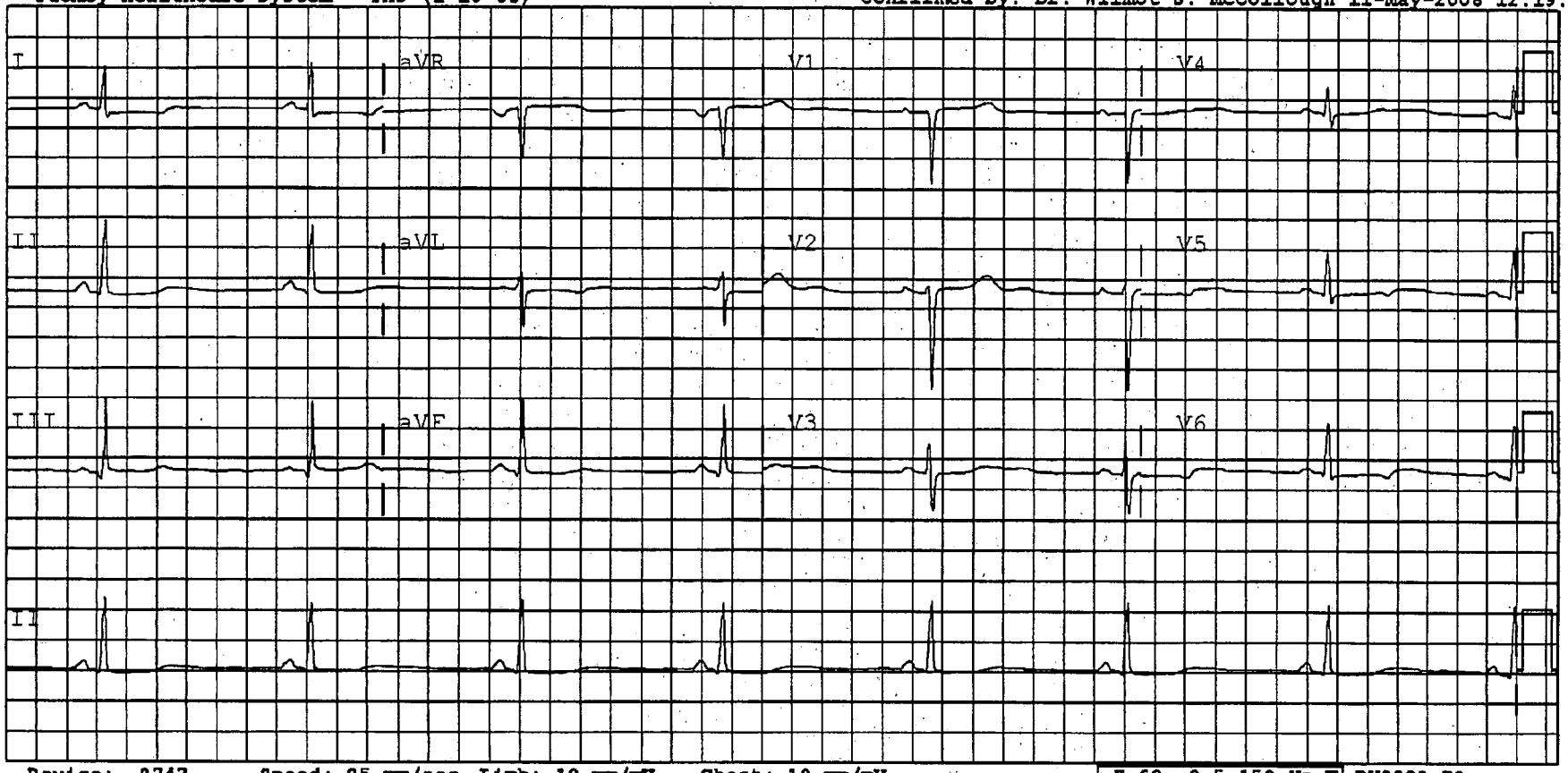
Edited By:MYASIA WILCHER

-- AXIS --
P 49
QRS 64
T 174

Order #: CARD20080510-0007

- ABNORMAL ECG -

Standard 12
Edited
Requested By: TANTAWANICHPISAL, DUANGN>
Tuomey Healthcare System - THS (1-10-03)
Confirmed by: Dr. Wilmot S. McCollough 11-May-2008 12:19:11



Device: 2747 Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 60- 0.5-150 Hz W PH090A P?

ACCT NO: 12930159 UNIT NO: 229998
PATIENT NAME: WINDHAM,TAMMY
[redacted] SEX: F
ORDERING PHYS: CLANTON II, GARRETT

EXAM: XR CHEST PORTABLE 1 VIEW 0608
EXAM DATE: 05/09/2008 00:00:00
PHYS: PATRICK JR, RICHARD

TECHNICIAN: CM
REASON: CP

AP upright chest radiograph demonstrates a normal heart size and pulmonary vascular pattern. No infiltrates or effusions are noted.

IMPRESSION: Normal AP chest.

SIGNED REPORT:AUTHENTICATED BY PATRICK JR RICHARD
TRANSCRIBED DATE/TIME 2008/05/10 00:18:00
Location: ER

Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 05/11/08 TUH NPR LAB **LIVE** PAGE 36
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

PATIENT: WINDHAM,TAMMY ELIZABETH ACCT #: 12930159 LOC: TELE U #: 229998
AGE/SX: 40/F ROOM: 336 REG: 05/10/08
REG DR: MEDICAL SERVICES - TMP STATUS: ADM INo BED: 1 DIS:

****HEMATOLOGY****

HEMOGRAM

	Day	-1		
	Date	MAY 9		
	Time	2230	Reference	Units
=>	WBC	11.0 #	(3.0-11)	1000/UL
=>	RBC	5.03	(3.7-5.3)	MIL/UL
=>	HGB	14.7 #	(11.5-16.0)	G/DL
=>	HCT	43.3 #	(33-46)	%
=>	MCV	86.2 #	(79-95)	FL
=>	MCH	29.2	(26-34)	PG
=>	MCHC	33.8	(29-35)	G/DL
=>	RDW	14.2	(11.9-15.5)	%
=>	PLATELET COUNT	243 #	(135-415)	1000/UL

AUTOMATED DIFFERENTIAL

	Day	-1		
	Date	MAY 9		
	Time	2230	Reference	Units
=>	NEUTROPHILS	65.7	(42-76)	%
=>	LYMPHOCYTES	24.5	(16-48)	%
=>	MONOCYTES	6.6	(0.0-10.0)	%
=>	EOSINOPHILS	2.3	(0.0-7.6)	%
=>	BASOPHILS	1.0	(0.0-1.5)	%

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 05/11/08 TUH NPR LAB **LIVE** PAGE 37
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH # 12930159 (Continued)

****CHEMISTRY****

Day		1			
Date		MAY 10			
Time	2020	1025	1025	Reference	Units
=> PROTEIN	6.5			(6.3-8.2)	GM/DL
=> ALBUMIN	3.7			(3.5-5.0)	GM/DL
=> BILI-TOTAL	0.3			(0.2-1.3)	MG/DL
=> BILI-DIRECT	0.0			(0-0.3)	MG/DL
=> ALT (SGPT)	110 H			(9-52)	U/L
=> AST (SGOT)	140 H			(14-36)	U/L
=> ALK PHOS	153 H			(38-126)	U/L
=> TROPONIN-I		0.092(A) # H		(0-0.034)	NG/ML

(A) **********PLEASE NOTE REFERENCE CHANGES**********
TROPONIN VALUES GREATER THEN 0.034 NG/ML COULD BE
CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.12 NG/ML
MAY REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE
DATA FROM A SINGLE BLOOD COLLECTION.
CLINICAL CORRELATION IS RECOMMENDED.

=> CK TOTAL	36 #	(30-135)	U/L	
=> CK INDEX	(a)			

NOTES: (a) Test not performed

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Tuomey Healthcare System
129 N. Washington Street
Sumter, S.C. 29150
Medical Director: O.A. Pinilla, MD

RUN DATE: 05/11/08 TUH NPR LAB **LIVE** PAGE 38
RUN TIME: 0506 Laboratory Summary Discharge Report

LOCATION

Patient: WINDHAM,TAMMY ELIZABETH [redacted] (Continued)

****CHEMISTRY****

Day	1		-1		
Date	MAY 10		MAY 9		
Time	0610	0610	2230	Reference	Units
=> TROPONIN-I	0.116(B) H		0.020(B) #	(0-0.034)	NG/ML

(B) **********PLEASE NOTE REFERENCE CHANGES**********
TROPONIN VALUES GREATER THEN 0.034 NG/ML COULD BE
CONSISTENT WITH MYOCARDIAL CELL DAMAGE.

TROPONIN VALUES GREATER THAN OR EQUAL TO 0.12 NG/ML
MAY REFLECT AN AMI.

THE DECISION TO RULE OUT AMI CANNOT BE MADE BASED ON THE
DATA FROM A SINGLE BLOOD COLLECTION.
CLINICAL CORRELATION IS RECOMMENDED.

=> CK TOTAL	41	(30-135)	U/L
=> CK INDEX	(b)		

Day	-1		
Date	MAY 9		
Time	2230	Reference	Units
=> SODIUM	140	(135-151)	MEQ/L
=> POTASSIUM	3.6	(3.5-5.1)	MEQ/L
=> CHLORIDE	107	(99-116)	MEQ/L
=> C02	24	(22-32)	MEQ/L
=> GLUCOSE SERUM	113 H	(80-110)	MG/DL
=> BUN	8 #	(7-18)	MG/DL
=> CREATININE	0.8 #	(0.8-1.5)	MG/DL
=> CALCIUM	8.8	(8.4-11.0)	MG/DL
=> CK TOTAL	39 #	(30-135)	U/L
=> CK INDEX	(c)		

NOTES: (b) Test not performed
(c) Test not performed

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40/F Acct# 12930159 Unit# 229998

002112

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/10/08 Time: 0257

3320 RT: Oxygen Therapy Per 12 Hrs ($) A PS
- Create 05/10/08 0257 TLD 05/10/08 0257 TLD
- Document 05/10/08 0257 TLD 05/10/08 0257 TLD
Code Status:
O2: Y
Type of O2:
Liters:

Comments:

Activity Date: 05/11/08 Time: 0116

3320 RT: Oxygen Therapy Per 12 Hrs ($) A PS
- Document 05/11/08 0116 PSR 05/11/08 0116 PSR
Code Status: FULL CODE
O2: Y
Type of O2: NOT IN USE
Liters: 0

Comments:

Activity Date: 05/11/08 Time: 0854

3320 RT: Oxygen Therapy Per 12 Hrs ($) A PS
- Document 05/11/08 0854 TMP 05/11/08 0855 TMP
Code Status: FULL CODE
O2: Y
Type of O2: NCAN
Liters: 2

Comments:

Activity Date: 05/11/08 Time: 1527

3320 RT: Oxygen Therapy Per 12 Hrs ($) D PS
- Ed Status 05/11/08 1527 his 05/11/08 1527 his A => D

Monogram Initials		Name	Nurse Type
PSR	RTPR	RENARD,PAMELLA S.	RT
TLD	RTTLD	DAVIS,TAMMIE L.	RT
TMP	RTTMP	PROFFIT,TINA M.	RT
his		automatic by program	

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

******* SCHEDULED MEDICATIONS *******

03946447 NS FLUSH 2.5 ML SYRINGE (2.5 ML)
(Sodium Chloride)
05/10/08
06/09/08

DOSE: 2.5 ML IV Q8H&PRN SCH
COMMENTS: Q8H AND PRN

*** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

2025 BE

03946448 LISINOPRIL 20 MG TAB (20 MG)
(Zestril)
05/10/08
06/09/08

0900 1000 JM

DOSE: 20 MG PO DAILY SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946454 METOPROLOL TARTRATE 50 MG TAB (50 MG)
(Lopressor)
05/10/08
06/09/08

0900 JM 2100

DOSE: 50 MG PO BID SCH
COMMENTS: ADMINISTER AROUND THE CLOCK

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946455 ASPIRIN 81 MG TAB (81 MG)
(Bayer Asa Child Chewable)
05/10/08
06/09/08

0900 1130 JM

DOSE: 81 MG PO DAILY SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946555 ENOXAPARIN 80 MG/0.8 ML SYR (70 MG)
(Lovenox)
05/10/08
06/09/08

0900 1130 JM 2100 (H)

DOSE: 70 MG SQ Q12 SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	****** SCHEDULED MEDICATIONS ******				
03946584	CLOPIDOGREL 75 MG TAB (75 MG) (Plavix)	05/10/08 06/09/08		0900 1045 JM	
	DOSE: 75 MG PO DAILY SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03946585	NICOTINE 21 MG PAT (21 MG) (Nicotine Patch)	05/10/08 06/09/08		0900 1045 JM	
	DOSE: 21 MG PATCH DAILY SCH				
	COMMENTS: NURSE TO DOCUMENT PATCH PLACEMENT				
	LOCATION: (R) Shoulder				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

***** PRN MEDICATIONS *****

03946449 CAPTOPRIL 12.5 MG TAB (12.5 MG) (Capoten)
05/10/08 DOSE: 12.5 MG PO
06/09/08 PRN: Q8

COMMENTS: PRN BP>160/95
Take on empty stomach 1 hr ac or
2 hrs pc. ATC

DOSE INSTR:

**** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IOS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03946451 MORPHINE 2 MG/ML CARP (None) (Morphine)
05/10/08 06/09/08
DOSE: 1-3 MG PRN: Q4
IV

COMMENTS: PRN PAIN
DOSE INSTR: 1-3 MG

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1115	VM	2mg	10	1	c/o very bad headache	1145	VM	4	1	18	pt. resting
1540	VM	2mg	9	1	c/o cp	1610	VM	4	1	18	pt. resting
2025	✗	2mg	8	1	c/o HA + slight CP	2105	✗	4	1	16	Pt. resting quietly

03946452 MORPHINE 10 MG/1 ML CARP (None) (Morphine)
05/10/08 06/09/08
DOSE: 1-3 MG PRN: Q4
IV

COMMENTS: PRN PAIN
DOSE INSTR: 1-3 MG

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

***** PRN MEDICATIONS *****

03946453 ONDANSETRON 4 MG/2 ML VIAL (4 MG) (Zofran) — 05/10/08 06/09/08 — DOSE: 4 MG PRN: Q6 — IV

COMMENTS: PRN NAUSEA — DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

03946450 ACETAMINOPHEN 500 MG CAPT (1000 MG) (Tylenol) — 05/10/08 06/09/08 — DOSE: 1000 MG PRN: Q8 — PO

COMMENTS: DO NOT EXCEED 4 GRAMS PER DAY — DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1045	VM	1000mg	10	1	c/o headache	1115	VM	4	1	18	pt. resting

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	****** PRN MEDICATIONS ******				
03946456	NITROGLYCERIN 0.4 MG TAB (0.4 MG) (Nitrostat)	05/10/08 06/09/08	DOSE: 0.4 MG PRN: .Q5MIN X3		SL
	COMMENTS: PRN FOR CHEST PAIN DO NOT CRUSH OR CHEW. TABLET MADE TO DISINTEGRATE UNDER TONGUE		DOSE INSTR:		
	**** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK				

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/10/08-0001 - 05/11/08-0000
RUN DATE/TIME: 05/10/08-1132
VERIFIED BY: _____

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/10/08 Lipitor 40 mg PO q HS (if LFT's is normal)

2 loc
Held

SGPT - 110
SGOT - 140
OK to D/C 153

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08-2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** SCHEDULED MEDICATIONS ******

03946447 NS FLUSH 2.5 ML SYRINGE (2.5 ML) 05/10/08 1400 2200
(Sodium Chloride) 06/09/08 1235

DOSE: 2.5 ML IV .Q8H&PRN SCH
COMMENTS: Q8H AND PRN

*** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

03946448 LISINOPRIL 20 MG TAB (20 MG) 05/10/08 0900
(Zestril) 06/09/08

DOSE: 20 MG PO DAILY SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946454 METOPROLOL TARTRATE 50 MG TAB (50 MG) 05/10/08 0900 2100
(Lopressor) 06/09/08

DOSE: 50 MG PO BID SCH
COMMENTS: ADMINISTER AROUND THE CLOCK

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946455 ASPIRIN 81 MG TAB (81 MG) 05/10/08 0900
(Bayer Asa Child Chewable) 06/09/08

DOSE: 81 MG PO DAILY SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946555 ENOXAPARIN 80 MG/0.8 ML SYR (70 MG) 05/10/08 0900 2100
(Lovenox) 06/09/08

DOSE: 70 MG SQ Q12 SCH

*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08 2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000
	***** SCHEDULED MEDICATIONS *****				
03946584	CLOPIDOGREL 75 MG TAB (75 MG) (Plavix)	05/10/08 06/09/08		0900	
	DOSE: 75 MG PO DAILY SCH				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				
03946585	NICOTINE 21 MG PAT (21 MG) (Nicotine Patch)	05/10/08 06/09/08		0900	
	DOSE: 21 MG PATCH DAILY SCH COMMENTS: NURSE TO DOCUMENT PATCH PLACEMENT LOCATION: Lt. Arm				
	*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR				

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08 2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03948449 CAPTOPRIL 12.5 MG TAB (12.5 MG) 05/10/08 DOSE: 12.5 MG PO
(Capoten) 06/09/08 PRN: Q8

COMMENTS: PRN BP>160/95
Take on empty stomach 1 hr ac or
2 hrs pc. ATC

DOSE INSTR:

**** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08-2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03946451 MORPHINE 2 MG/ML CARP (None) (Morphine)
05/10/08 06/09/08
DOSE: 1-3 MG PRN: Q4 IV
COMMENTS: PRN PAIN
DOSE INSTR: 1-3 MG

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1230	PO	2mg	8	1	C/O headache	1330	PO	4	1	18	Relief Obtained

03946452 MORPHINE 10 MG/1 ML CARP (None) (Morphine)
05/10/08 06/09/08
DOSE: 1-3 MG PRN: Q4 IV
COMMENTS: PRN PAIN
DOSE INSTR: 1-3 MG

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968 For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

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MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08-2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS ******

03946453 ONDANSETRON 4 MG/2 ML VIAL (4 MG) (Zofran) 05/10/08 06/09/08 DOSE: 4 MG PRN: Q6 IV

COMMENTS: PRN NAUSEA DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

03946450 ACETAMINOPHEN 500 MG CAPT (1000 MG) (Tylenol) 05/10/08 06/09/08 DOSE: 1000 MG PRN: Q8 PO

COMMENTS: DO NOT EXCEED 4 GRAMS PER DAY DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE
1115		1000mg	10	1	Headache	1215		6	1	18	Mild relief

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

600

PAGE: 6

MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08-2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

****** PRN MEDICATIONS: ******

03946456 NITROGLYCERIN 0.4 MG TAB (0.4 MG) 05/10/08 DOSE: 0.4 MG SL
(Nitrostat) 06/09/08 PRN: .Q5MIN X3

COMMENTS: PRN FOR CHEST PAIN
DO NOT CRUSH OR CHEW, TABLET MADE TO DISINTEGRATE
UNDER TONGUE

DOSE INSTR:

**** OBTAIN MEDICATION FROM:
ACUDOSE MACHINE/FLOOR STOCK

TIME	INT	DOSE	CODE	SED	INDICATION/LOCATION OF PAIN	TIME	INT	CODE	SED	RR	OUTCOME/RESPONSE

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

PAGE: 7

MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08 2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/10/08 Lipitor 40 mg po QHS (if LFT's are normal) D/C
5-11-08

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

PAGE: 7

MEDICATION ADMINISTRATION RECORD

12930159 WINDHAM,TAMMY ELIZABETH TELE 336 1
MEDICAL RECORD #: 229998
AGE: 40 SEX: F WT: 72.347 BSA: 1.81
ADMITTED: 05/10/08 PHYSICIAN: MEDICAL SERVICES - TMP
NOTES:

PRIMARY DX: CHEST PAIN
ADM COMMENT: NO IDS
MAR DATE: 05/11/08-0001 - 05/12/08-0000
RUN DATE/TIME: 05/10/08 2134
VERIFIED BY:

ALLERGIES: NKA-PH

RX #	MEDICATION	START/STOP	0001-0800	0801-1600	1601-0000

5/10/08 Lipitor 40 mg po QHS (if LFT's are normal) D/C
5-11-08

A - Lt UQ B - Rt UQ C - Lt Thigh D - Rt Thigh E - Lt Arm F - Rt Arm
G - Lt Abdomen H - Rt Abdomen SA - Self Administered O - Circle if Med Omitted

See Form #30968
For Anxiety/Pain/Comfort Codes

12930159 - WINDHAM,TAMMY ELIZABETH
TELE 336-1 (U:229998)

PRACTITIONER'S FULL SIGNATURE IS REQUIRED FOR ANY INITIAL APPEARING ON THE MEDICATION ADMINISTRATION RECORD

INITIALS	FULL SIGNATURE	INITIALS	FULL SIGNATURE
TW	Nida C. Quarterman, RN		
	[illegible] RN		
	[illegible]		
JMB	Judy A Butler, RN		

WINDHAM,TAMMY ELIZABETH
Acct:12930159 Unit:229998
MEDICAL SERVICES - TMP
MED 336/1 DOS:05/10/08
F W Age: 40

694

HOME MEDICATION INVENTORY

RUN DATE: 05/10/08
RUN TIME: 0343
RUN USER: 0

TUOMEY REGIONAL MEDICAL CTR NUR *LIVE*

PATIENT INTERVENTION ACTIVITY

Patient: WINDHAM,TAMMY ELIZABETH
Account #: 12930159
Admit Date: 05/10/08
Status: ADM INo
Attending: MEDICAL SERVICES - TMP

Age/Sex: 40 F
Unit #: 229998
Location: TELE
Room/Bed: 336-1

TUOMEY HEALTHCARE SYSTEM
Bringing more to life.

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE

HERBAL/HOMEOPATHIC REMEDIES

MEDICATION NAME	DOSE	DIRECTIONS/INDICATION	ROUTE

	Date	Time	Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0343	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

695

002130

Date: 05/1[redacted]8

Patient Name: WINDHAM,TAMMY ELIZABETH Acct # 12930159

Drug Allergies: NKA

Disposition of patient's medications upon admission: Data Source: ☑ Patient ☐ Other: _____

☐ Medications brought to hospital ☐ Family

☐ Medications not brought to hospital

☐ Medications sent (circle one): Home / Pharmacy for ID / Business Office for Security

Nurse Signature: [signature], RN Date: 5/10/08

At Home or Outpatient Prescription and Over the Counter Medications ***Herbal/Homeopathic Products Will NOT be dispensed by Tuomey Pharmacy.**

ORDER Check box to continue med	PRODUCT NAME (List only those meds currently being taken)	DOSE (mg, ml, number of grams)	DIRECTIONS & INDICATION (Req. for PRN)	ROUTE or TOPICAL SITE	DATE & TIME of LAST DOSE
	METOPROLOL TARTRATE	50MG	BID	PO	-
	ASA	81MG	DAILY	PO	-

PHYSICIAN INSTRUCTIONS:

1. Please check the box in front of each medication to continue during the inpatient stay.
2. Sign the (For Orders Only) block for orders.
3. If you do not want to order any medications at this time, just sign the Physician acknowledgement statement.

Physician Signature: _____ Date: _____ Time: _____

(FOR ORDERS ONLY)

Acknowledgement of review of the listed home medications.

I do not wish to order any medications at this time and I have reviewed the listed home medications. Please see Admission Orders.

Physician Signature: D Pan Date: 5/10/08 Time: _____

(FOR ACKNOWLEDGEMENT ONLY)

TUOMEY HEALTHCARE SYSTEM

129 North Washington St.
Sumter, SC 29150

HOME MEDICATION ORDER SHEET

310068 Rev. 02/20/07

WINDHAM,TAMMY ELIZ[redacted]
Acct: 12930159 Unit:
MEDICAL SERVICES - TMP
DOS: 05/10/08
F Age: 40

696

002131

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/10/08		**Time: 0218**							
450 Dietary Intake							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
451 Consults							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
452 Activity							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
3141 Oxygen Therapy							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
4040 Cardiac Care:							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
4190 IV Intravenous Insertion							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
4200 IV Intravenous Therapy							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
5820 Anxiety Reduction							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
6681 Pulse Oximetry (SAO2)							A		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
6690 Intake/Output							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
6691 Weight/Height							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
7690 Laboratory Data Interpretation							A		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
Activity Date: 05/10/08		**Time: 0219**							
413 Telemetry							A		PS
TELEMETRY BOX #11									
- Create	05/10/08	0219	AAM	05/10/08	0219	AAM			
- Ed Text	05/10/08	0219	AAM	05/10/08	0219	AAM			
Activity Date: 05/10/08		**Time: 0220**							
1805 AM/PM Bathing and ADL care							A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
3352 Pneumococcal vaccine notification							A		PS
Document here if MD notified of patient not having vaccine prior to admission.									
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
3353 Pneumococcal vaccine given							A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
3354 Influenza vaccine given							A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
3355 Influenza vaccine status notification							A		PS
Document here if MD notified of patient not having vaccine prior to admission.									
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/10/08 Time: 0220									
3356	Influenza Vaccine Not Given Reason						A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
3357	Pneumonia Vaccine Not Given Reason						A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
5260	Code Status						A		PS
	5/10: FULL CODE								
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Text	05/10/08	0220	AAM	05/10/08	0220	AAM			
5601	Teaching: Patient/Family Education						A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
6410	Allergy Management						A		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
Activity Date: 05/10/08 Time: 0250									
452	Activity						A		OE
	5/10: BR WITH BRP								
- Ed Text	05/10/08	0250	AAM	05/10/08	0250	AAM			
Activity Date: 05/10/08 Time: 0251									
450	Dietary Intake						A		OE
	5/10: CARDIAC								
- Ed Text	05/10/08	0251	AAM	05/10/08	0251	AAM			
4200	IV Intravenous Therapy						A		CP
	5/10: INT WITH FLUSHES								
- Ed Text	05/10/08	0251	AAM	05/10/08	0252	AAM			
6680	Vital Signs, Monitor CNA/CT						A		PS
	5/10: ROUTINE								
- Create	05/10/08	0251	AAM	05/10/08	0251	AAM			
- Ed Text	05/10/08	0251	AAM	05/10/08	0251	AAM			
7000	Vital Signs, Monitor RN/LPN						A		PS
	5/10: ROUTINE								
- Create	05/10/08	0251	AAM	05/10/08	0251	AAM			
- Ed Text	05/10/08	0251	AAM	05/10/08	0251	AAM			
Activity Date: 05/10/08 Time: 0252									
3141	Oxygen Therapy						A		CP
	5/10: 2L MIN NC								
- Ed Text	05/10/08	0252	AAM	05/10/08	0252	AAM			
7690	Laboratory Data Interpretation						A		OE
- Ed Text	05/10/08	0252	AAM	05/10/08	0252	AAM			
Activity Date: 05/10/08 Time: 0254									
7690	Laboratory Data Interpretation						A		OE
	5/10: EKG, CKMBT/TRPI @ 0438 AND 1038								
- Ed Text	05/10/08	0254	AAM	05/10/08	0254	AAM			

698

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/10/08 Time: 0322

6410 Allergy Management A PS
NKDA
- Ed Text 05/10/08 0322 AAM 05/10/08 0322 AAM

Activity Date: 05/10/08 Time: 0656

6680 Vital Signs, Monitor CNA/CT A PS
5/10: ROUTINE
- Document 05/10/08 0656 MM3 05/10/08 0657 MM3
Temp: 98.6 Temp Source: ORAL

Respirations: 18

Heart Rate: 47 Hrt Rate Source: RADIAL

BP: 140/70 BP Source:

SpO2:
6690 Intake/Output A OE
- Document 05/10/08 0656 MM3 05/10/08 0657 MM3

********** INTAKE **********

Oral Intake: 360 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 1 BM: (# of times): 1
Incontinent (# of times): Date of last BM: 05/10/08

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/10/08 Time: 1126

699

032 Rounds: CT/CNA A PS
Select "VP" to view special instructions
- Create 05/10/08 1126 ASB 05/10/08 1126 ASB
- Document 05/10/08 1126 ASB 05/10/08 1126 ASB
Were rounds completed per protocol? Yes

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change
Activity Date: 05/10/08		**Time: 1126**								
450	Dietary Intake						A			OE
	5/10: CARDIAC									
- Document	05/10/08	1126	ASB	05/10/08	1126	ASB				
Which meal & how much eaten? Breakfast 50%										
1805	AM/PM Bathing and ADL care						A			PS
- Document	05/10/08	1126	ASB	05/10/08	1126	ASB				
AM/PM Care										
Shower										
Comments:										
Activity Date: 05/10/08		**Time: 1507**								
032	Rounds: CT/CNA						A			PS
	Select "VP" to view special instructions									
- Document	05/10/08	1507	MFE	05/10/08	1507	MFE				
	Were rounds completed per protocol?									
450	Dietary Intake						A			OE
	5/10: CARDIAC									
- Document	05/10/08	1507	MFE	05/10/08	1507	MFE				
Which meal & how much eaten? Lunch 75%										
6680	Vital Signs, Monitor CNA/CT						A			PS
	5/10: ROUTINE									
- Document	05/10/08	1507	MFE	05/10/08	1508	MFE				
Temp:	97.6			Temp Source:			ORAL			
Respirations:	20									
Heart Rate:	55			Hrt Rate Source:			RADIAL			
BP:	143/71			BP Source:			SUPINE			
SpO2:	98									
Activity Date: 05/10/08		**Time: 1649**								
6690	Intake/Output						A			OE
- Document	05/10/08	1649	MFE	05/10/08	1650	MFE				
	********** INTAKE **********									
Oral Intake: 720				IV Intake:						
NG/Peg Feeding:				Blood Admin.:						
	********** OUTPUT **********									

720

Intervention Description						Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 05/10/08 Time: 1649 (continued)

6690 Intake/Output (continued)

Urine (mls): BM: liquid (mls):
Urine (# of times): 4 BM: (# of times): 0
Incontinent (# of times): Date of last BM: 05/10/08

Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:

JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

Activity Date: 05/10/08 Time: 1900

6681 Pulse Oximetry (SAO2) A CP
- Document 05/10/08 1900 DMR 05/10/08 1932 DMR
SAO2: 98

O2 source: ROOM AIR

Activity Date: 05/10/08 Time: 2000

031 Rounds: RN/LPN A PS
Q2 hours
- Document 05/10/08 2000 DMR 05/10/08 2032 DMR

Activity Date: 05/10/08 Time: 2032

031 Rounds: RN/LPN A PS
Q2 hours
- Create 05/10/08 2032 DMR 05/10/08 2032 DMR

Activity Date: 05/10/08 Time: 2100

031 Rounds: RN/LPN A PS
Q2 hours
- Document 05/10/08 2100 DMR 05/10/08 2119 DMR

Activity Date: 05/10/08 Time: 2154

031 Rounds: RN/LPN A PS
Q2 hours
- Document 05/10/08 2154 DMR 05/10/08 2154 DMR

701

Intervention Description							Sts	Direction		From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units		Change
Activity Date: 05/10/08		**Time: 2328**								
032	Rounds: CT/CNA						A			PS
	Select "VP" to view special instructions									
- Document	05/10/08	2328	MM3	05/10/08	2328	MM3				
	Were rounds completed per protocol?									
450	Dietary Intake						A			OE
	5/10: CARDIAC									
- Document	05/10/08	2328	MM3	05/10/08	2329	MM3				
Which meal & how much eaten? Snack 100%										
Activity Date: 05/11/08		**Time: 0659**								
6680	Vital Signs, Monitor CNA/CT						A			PS
	5/10: ROUTINE									
- Document	05/11/08	0659	MM3	05/11/08	0659	MM3				
Temp:	98.2			Temp Source:			ORAL			
Respirations:	18									
Heart Rate:	66			Hrt Rate Source:			RADIAL			
BP:	141/69			BP Source:			SUPINE			
SpO2:										
6690	Intake/Output						A			OE
- Document	05/11/08	0659	MM3	05/11/08	0659	MM3				

********** INTAKE **********

Oral Intake: 480 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

Urine (mls): BM: liquid (mls):
Urine (# of times): 6 BM: (# of times): 1
Incontinent (# of times): Date of last BM: 05/11/08
Wound Vac Drain:
Emesis (mls): NG Drainage: Hemovac Drain:
Blood Loss:
Colostomy: Ileostomy: Nephrostomy:
JP Drain 1/L: Chest Tube 1: T Tube Drain:
JP Drain 2/R: Chest Tube 2: Penrose Drain:
Jejunostomy Drain: Gastrostomy Drain: Other Drain:

7/12

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/11/08		**Time: 1059**							
452	Activity 5*11AMBULATE IN ROOM/HALLWAY						A		OE
- Create	05/11/08	1059	TLJ	05/11/08	1059	TLJ			
Activity Date: 05/11/08		**Time: 1109**							
032	Rounds: CT/CNA Select "VP" to view special instructions						A		PS
- Document	05/11/08	1109	MFE	05/11/08	1109	MFE			
	Were rounds completed per protocol?								
450	Dietary Intake 5/10: CARDIAC						A		OE
- Document	05/11/08	1109	MFE	05/11/08	1110	MFE			
Which meal & how much eaten? Breakfast 100%									
1805	AM/PM Bathing and ADL care						A		PS
- Document	05/11/08	1109	MFE	05/11/08	1110	MFE			
AM/PM Care Shower									
Comments:									
Activity Date: 05/11/08		**Time: 1450**							
4040	Cardiac Care:						A		CP
- Document	05/11/08	1450	JRB	05/11/08	1450	JRB			
Activity Date: 05/11/08		**Time: 1451**							
031	Rounds: RN/LPN Q2 hours						A		PS
- Document	05/11/08	1451	JRB	05/11/08	1451	JRB			
413	Telemetry TELEMETRY BOX #11						A		PS
- Document	05/11/08	1451	JRB	05/11/08	1452	JRB			
Rhythm: nsr									
Activity Date: 05/11/08		**Time: 1526**							
450	Dietary Intake 5/10: CARDIAC						A		OE
- Document	05/11/08	1526	MFE	05/11/08	1527	MFE			
Which meal & how much eaten? Lunch 100%									

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/11/08		**Time: 1527**							
031	Rounds: RN/LPN Q2 hours						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
032	Rounds: CT/CNA Select "VP" to view special instructions						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
413	Telemetry TELEMETRY BOX #11						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
450	Dietary Intake 5/10: CARDIAC						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
451	Consults						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
452	Activity 5/10: BR WITH BRP						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
1805	AM/PM Bathing and ADL care						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3141	Oxygen Therapy 5/10: 2L MIN NC						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3352	Pneumococcal vaccine notification Document here if MD notified of patient not having vaccine prior to admission.						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3353	Pneumococcal vaccine given						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3354	Influenza vaccine given						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3355	Influenza vaccine status notification Document here if MD notified of patient not having vaccine prior to admission.						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3356	Influenza Vaccine Not Given Reason						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3357	Pneumonia Vaccine Not Given Reason						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4040	Cardiac Care:						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4190	IV Intravenous Insertion						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4200	IV Intravenous Therapy 5/10: INT WITH FLUSHES						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D

002139

Intervention Description							Sts	Direction	From
Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change
Activity Date: 05/11/08		**Time: 1527**							
5260	Code Status 5/10: FULL CODE						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
5601	Teaching: Patient/Family Education						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
5820	Anxiety Reduction						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6410	Allergy Management NKDA						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6680	Vital Signs, Monitor CNA/CT 5/10: ROUTINE						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6681	Pulse Oximetry (SAO2)						D		CP
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6690	Intake/Output						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6691	Weight/Height						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
7000	Vital Signs, Monitor RN/LPN 5/10: ROUTINE						D		PS
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
7690	Laboratory Data Interpretation 5/10: EKG, CKMBT/TRPI @ 0438 AND 1038						D		OE
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D

Monogram	Initials	Name	Nurse Type
AAM	NSAAM	MCINNIS,ASHLEY A.	US
ASB	NSASB2	BASSETT,ADRIENNA S.	CT
DMR	NSDR2	REICH,DONNA M.	RN
JRB	4SJRB	BUTLER,JUDY R.	RN
MFE	NSMFE	EDWARDS,MAE FRANCES	CT
MM3	NSMM3	MCCRAY,MARY	CT
NCG	NSNCG	GUANTERO,NIDA C.	RN
TLJ	NSTLJ1	JOHNSON,TAMMY L.	US
his		automatic by program	

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
12	***Admission History***	A	AS

Documented at 05/10/08 0240 by NCG

Admitted from: ER Info obtained from: PATIENT Arrival on unit: 0240
Armband intact: Y Verified: : Code Status: FULL CODE
Does pt have Advance Directive (Living Will)? N
Does pt have Health Care Power of Attorney? N
If yes, Living Will copy received? N If yes, Health Care Power of Attorney copy received?
Does patient want info on Advance Directive? N
Do you have all information to complete Advanced Directives? N ^ Updates the Status Board
Temp: 95.7 BP: 160/71 Wt: lb: 159 oz: 8.0 kg: 72.347
Heart Rate: 51 Respirations: 18 Ht: ft: 5 in: 3.0 cm: 160.0
SpO2: 98 % O2 source: 2L/NC BMI= 28.20
Are you in pain: N Med Allergies: N Latex Screening: Y
Do you have chronic pain: N Food Allergies: N Falls Assessment: Y
Chief Complaint: CHEST PAIN
********** PAST MEDICAL HISTORY **********
Previous surgery? Y Previously Hospitalized: PPD+: N Hx of MRSA:
********** MEDICAL HISTORY AND SYSTEM REVIEW **********
Have you ever or do you now have problems with:
Vision: Y Hearing: N Nutrition: N Cardio: Y Resp: Y
CNS: N GI: N GU: N Endocrine: N Hepatic: N Musculo - Skeletal: N
Hematology: N Cancer: Female: Y
Have you had pneumococcal vaccine? N Date Pneumococcal vaccine given:
Have you had current season influenza vaccine? Date Influenza vaccine given:
must have been RECEIVED between OCT-MAR
********** PSYCHO-SOCIAL **********
HX of alcohol/drug abuse within last 6 months: N Smoked tobacco in the last 12 months? Y
Is there any evidence of abuse or neglect? Mental Illness:
Patient s religious denomination. HOLINESS/PENTECOSTAL
Spiritual practices / beliefs that affect patient care.
Comment:
Would you like to see our chaplain?
****
Have you had or do you currently need assist with ADLS: N
Currently receiving any healthcare or community services: N
Currently using med equip or asst devices: N
On d/c will you need financial assistance w/ meds:
On d/c, will you need physical assistance taking meds?:
On d/c, will you need transportation provided?:
Pt Oriented to Rm & Valuables Policy: Y
OB: N Peds Admit: N Sub-Acute Admit: N Antepartum: N
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
*******ADMISSION PAIN ASSESSMENT********
Pain Location: Pain scale used:
Pain Level on Admit: Pain type:
Onset of Pain: Pain quality (describe):
Pain frequency: Cause of Pain:

796

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

***Use below for additional Pain Location (if necessary):
Pain Location:
Pain type:
Onset of Pain:
Pain Frequency:
Cause of Pain:
****CHRONIC PAIN****
Pain Location:
Pain scale used:
Pain Score:
Pain frequency:
Worse pain gets: Best pain gets:
Do you have a history of any ongoing pain problems?
Conditions that cause pain:
What makes pain better?
What makes pain worse?
Are there times of the day/night when pain is worse?
Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

****Allergy Information****
Med Allergies: NKDA

Food Allergies: No known food allergies

*******LATEX SCREENING*******
Latex (Rubber): N
Bananas: N
Chestnuts: N
Avocados: N
Poinsettias: N
Kiwi, Papaya: N

****FALL ASSESSMENT****
Previous Fall: N Mobility Problem: N
Confusion/Intermittent Confusion: N
Incontinent: N Hearing/Vision Impairment: Y
Receiving Hypnotics, Laxatives, or Diuretics: N
Pt. is 70+: N
********** PAST MEDICAL HISTORY **********
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007
APPENDECTOMY,CHOLECYSTECTOMY,
TUBAL LIGATION
Anesthesia Complications:
****Previously Hospitalized*****
Reason for Visit/Date:
********VISION**********

797

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Blind: N Eye Prothesis:
Blind left: Eye prothesis left:
Blind right: Eye prothesis right:
Poor vision: Y
Do you wear glasses: Y Glasses w/pt: Y
Do you wear contacts: N Contacts w/ pt:
**********HEARING**********
Hard of hearing: Hearing aid:
HOH Left: Hearing aid left:
HOH Right: Hearing aid right:
Deaf: Hearing aid w/ pt:
Deaf Left:
Deaf Right:
**********NUTRITION**********
Diet followed at home:
Special cultural/ethnic/religious food needs: N
Unintentional wt loss/gain>10 lbs within 2 mo:
On thickened liquids at home? Problems chewing:
PEG Tube Present?:
****DENTAL****
Missing teeth: Capped teeth: Loose teeth:
Do you wear dentures?
Partial:
Upper:
Lower:
Dentures with patient: Denture cup given:
Inventory of Dentures with Patient on Admission:
**********CARDIO**********
Hypertension: Y Arrhythmias: N
Chest Pain: Y Pacemaker/Internal Defibrillator: N
Heart Attack: N Rheumatic Fever: N
CHF: N Congenital Heart Defect: N
Murmur/MVP: N
**********RESP**********
SOB: Y Asthma: N
Pneumonia: N COPD: N
Chronic Cough: N Sleep Apnea: N
URI/cold w/in last 2 wks: N Tracheostomy: N
TB: N
**********CNS**********
Convulsions/Seizures: Alzheimers/Dementia:
Stroke: Numbness/Tingling:
Muscular Weakness/Paralysis: Headache:
Fainting or Dizzy Episodes: Problems w/ Speech/Communications:
Dysphagia:

**********GI**********		**********GU**********	
Ulcerative Colitis:	Chronic Diarrhea:	Renal Disease:	Prostate Disease:
Diverticulitis:	Reflux:	Hemodialysis:	Urinary Retention:
Crohns:	Ulcers:	Peritoneal Dialysis:	
Chronic Constipation:	Hiatal Hernia:	Kidney Stones:	Urostomy:

798

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Bleeding: Nausea/Vomiting: Incontinent (# of times):

**********ENDOCRINE**********
Diabetes: N
Thyroid Problems:
Is this a new onset of diabetes?

**********HEPATIC*********
Hepatitis:
Cirrhosis:

**********MUSCULAR SKELETON**********
Arthritis:
Connective Tissue Disease:
Joint Replacement:
Prosthesis:
Device:

**********HEMATOLOGY**********
Anemia:
Sickle Cell Disease/Trait:
Other Types:
Blood Transfusion:
Reaction:

**********CANCER**********
Diagnosis/Date:
Treatment within last 6 months:

**********FEMALE/OB**********
Do you still have a menstrual cycle: Y LMP:
Are you pregnant: Are you currently breast feeding:

********ADL*******

Prior to Admission		Currently on Admission	
Bathing:	Assist:	Bathing on ADM:	Assist:
Grooming:	Assist:	Grooming on ADM:	Assist:
Dressing:	Assist:	Dressing ADM:	Assist:
Feeding:	Assist:	Feeding ADM:	Assist:
Toileting:	Assist:	Toileting ADM:	Assist:
Ambulation:	Assist:	Ambulation ADM:	Assist:

T= TOTAL ASSISTANCE P= PARTIAL ASSISTANCE

**********HEALTHCARE/COMMUNITY SERVICES**********
Extended Care Facility: Outpt Rehab: Rehab Facility:
Home Health Agency: Meals on Wheels:
Personal Care Aides: Mental Health:
Hospice:
Home Health Agency (name):
Hospice (name):

**********MED EQUIPMENT & ASSIST DEVICES**********
Walker: Rolling walker: Standing walker:
Wheelchair:
Hospital bed:
Oxygen:
Nebulizer/Pulmoaide:
CPAP/BIPAP:
Blood Glucose Monitor: Did you bring a medicine pump from home?

**********DC ASSISTANCE W/ MEDICATIONS**********
On d/c, will you need assistance obtaining meds:
On d/c, will you need assistance administering meds:

*********TRANSPORTATION*********
Name of driver:
Drivers phone #:

**********OB ADMIT**********
Age below 16: Previa/Abruption:

719

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

No prenatal care: Birth Control Method on d/c:
PIH/Pre Eclampsia: Gestational Diabetic: Hyperemesis:
Does the patient need Car seat: Baby clothes: Baby bed:
**********PEDIATRIC ADMISSION**********
Delays in G/D:
Rolling Over: Sitting Up: Crawling: Walking: Speaking:
Caregiver perception of child s G/D:
Are your receiving healthcare/community services:
Home Health Agency: Hospice: Personal care aides: Outpt Rehab: WIC:
Homebound Schooling: Mental Health Services:
********** IMMUNIZATIONS **********
2 Month: 4 Month: 6 Month: 15-18 Month:
4-5 Year: PPD: Hepatitis B: Start date: Treatment complete?:
Word child uses to describe pain or hurt N/A if nonverbal
Head circumference:
Is pt below 20th percentile or above 80th percentile wt/ht:
Caregiver(home) understanding of illness/condition:
Caregiver(home) perception of outcome of hosp.stay:
**********SUBACUTE ADMIT**********
BM Date:
Last Void: Was patient continent prior to hospital admission?
Do you prefer to: Bathe: Shower:
Which cognitive behavior(s) describe the pt
Cognitive behavior:
Pt able to verbalize:
PPD Result:
**********ANTEPARTUM**********
EDC:
Gravida Para Abortus:
****PERSONAL VALUABLES****
Personal items/Valuables noted on admission:
RING,NECKLACE
**********CODE STATUS**********
I have explained to the patient/family that without a
current DNR, Do Not Intubate, Do Not Shock, or No CPR order
the patient will be treated as a FULL CODE? Yes
Patient/Family wish to speak with the primary physician regarding Code Status?

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0340	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
12	***Admission History***	A	AS

Documented at 05/10/08 0240 by NCG

Admitted from: ER Info obtained from: PATIENT Arrival on unit: 0240
Armband intact: Y Verified: : Code Status: FULL CODE
Does pt have Advance Directive (Living Will)? N
Does pt have Health Care Power of Attorney? N
If yes, Living Will copy received? N If yes, Health Care Power of Attorney copy received?
Does patient want info on Advance Directive? N
Do you have all information to complete Advanced Directives? N ^ Updates the Status Board
Temp: 95.7 BP: 160/71 Wt: lb: 159 oz: 8.0 kg: 72.347
Heart Rate: 51 Respirations: 18 Ht: ft: 5 in: 3.0 cm: 160.0
SpO2: 98 % O2 source: 2L/NC BMI= 28.20
Are you in pain: N Med Allergies: N Latex Screening: Y
Do you have chronic pain: N Food Allergies: N Falls Assessment: Y
Chief Complaint: CHEST PAIN

********** PAST MEDICAL HISTORY **********
Previous surgery? Y Previously Hospitalized: PPD+: N Hx of MRSA:

********** MEDICAL HISTORY AND SYSTEM REVIEW **********
Have you ever or do you now have problems with:
Vision: Y Hearing: N Nutrition: N Cardio: Y Resp: Y
CNS: N GI: N GU: N Endocrine: N Hepatic: N Musculo - Skeletal: N
Hematology: N Cancer: Female: Y
Have you had pneumococcal vaccine? N Date Pneumococcal vaccine given:
Have you had current season influenza vaccine? Date Influenza vaccine given:
must have been RECEIVED between OCT-MAR

********** PSYCHO-SOCIAL **********
HX of alcohol/drug abuse within last 6 months: N Smoked tobacco in the last 12 months? Y
Is there any evidence of abuse or neglect? Mental Illness:
Patient s religious denomination. HOLINESS/PENTECOSTAL
Spiritual practices / beliefs that affect patient care.
Comment:
Would you like to see our chaplain?

****
Have you had or do you currently need assist with ADLS: N
Currently receiving any healthcare or community services: N
Currently using med equip or asst devices: N
On d/c will you need financial assistance w/ meds:
On d/c, will you need physical assistance taking meds?:
On d/c, will you need transportation provided?:
Pt Oriented to Rm & Valuables Policy: Y
OB: N Peds Admit: N Sub-Acute Admit: N Antepartum: N

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========

*******ADMISSION PAIN ASSESSMENT********
Pain Location: Pain scale used:
Pain Level on Admit: Pain type:
Onset of Pain: Pain quality (describe):
Pain frequency: Cause of Pain:

711

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

***Use below for additional Pain Location (if necessary):
Pain Location:
Pain type:
Onset of Pain:
Pain Frequency:
Cause of Pain:
****CHRONIC PAIN****
Pain Location:
Pain scale used:
Pain Score:
Pain frequency:
Worse pain gets: Best pain gets:
Do you have a history of any ongoing pain problems?
Conditions that cause pain:
What makes pain better?
What makes pain worse?
Are there times of the day/night when pain is worse?
Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

****Allergy Information****
Med Allergies: NKDA

Food Allergies: No known food allergies

*******LATEX SCREENING*******
Latex (Rubber): N
Bananas: N
Chestnuts: N
Avocados: N
Poinsettias: N
Kiwi, Papaya: N

****FALL ASSESSMENT****
Previous Fall: N Mobility Problem: N
Confusion/Intermittent Confusion: N
Incontinent: N Hearing/Vision Impairment: Y
Receiving Hypnotics, Laxatives, or Diuretics: N
Pt. is 70+: N
********** PAST MEDICAL HISTORY **********
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007
APPENDECTOMY,CHOLECYSTECTOMY,
TUBAL LIGATION
Anesthesia Complications:
****Previously Hospitalized*****
Reason for Visit/Date:
********VISION**********

712

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Blind: N Eye Prothesis:
Blind left: Eye prothesis left:
Blind right: Eye prothesis right:
Poor vision: Y
Do you wear glasses: Y Glasses w/pt: Y
Do you wear contacts: N Contacts w/ pt:

**********HEARING**********
Hard of hearing: Hearing aid:
HOH Left: Hearing aid left:
HOH Right: Hearing aid right:
Deaf: Hearing aid w/ pt:
Deaf Left:
Deaf Right:

**********NUTRITION**********
Diet followed at home:
Special cultural/ethnic/religious food needs: N
Unintentional wt loss/gain>10 lbs within 2 mo:
On thickened liquids at home? Problems chewing:
PEG Tube Present?:

****DENTAL****
Missing teeth: Capped teeth: Loose teeth:
Do you wear dentures?
Partial:
Upper:
Lower:
Dentures with patient: Denture cup given:
Inventory of Dentures with Patient on Admission:

**********CARDIO**********
Hypertension: Y Arrhythmias: N
Chest Pain: Y Pacemaker/Internal Defibrillator: N
Heart Attack: N Rheumatic Fever: N
CHF: N Congenital Heart Defect: N
Murmur/MVP: N

**********RESP**********
SOB: Y Asthma: N
Pneumonia: N COPD: N
Chronic Cough: N Sleep Apnea: N
URI/cold w/in last 2 wks: N Tracheostomy: N
TB: N

**********CNS**********
Convulsions/Seizures: Alzheimers/Dementia:
Stroke: Numbness/Tingling:
Muscular Weakness/Paralysis: Headache:
Fainting or Dizzy Episodes: Problems w/ Speech/Communications:
Dysphagia:

**********GI**********
Ulcerative Colitis: Chronic Diarrhea:
Diverticulitis: Reflux:
Crohns: Ulcers:
Chronic Constipation: Hiatal Hernia:

**********GU**********
Renal Disease: Prostate Disease:
Hemodialysis: Urinary Retention:
Peritoneal Dialysis:
Kidney Stones: Urostomy:

713

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Bleeding: Nausea/Vomiting: Incontinent (# of times):

**********ENDOCRINE**********
Diabetes: N
Thyroid Problems:
Is this a new onset of diabetes?

**********HEPATIC********
Hepatitis:
Cirrhosis:

**********MUSCULAR SKELETON**********
Arthritis:
Connective Tissue Disease:
Joint Replacement:
Prosthesis:
Device:

*********HEMATOLOGY*********
Anemia:
Sickle Cell Disease/Trait:
Other Types:

Blood Transfusion:
Reaction:

**********CANCER**********
Diagnosis/Date:
Treatment within last 6 months:

*********FEMALE/OB*********
Do you still have a menstrual cycle: Y LMP:
Are you pregnant: Are you currently breast feeding:

********ADL*******

Prior to Admission		Currently on Admission	
Bathing:	Assist:	Bathing on ADM:	Assist:
Grooming:	Assist:	Grooming on ADM:	Assist:
Dressing:	Assist:	Dressing ADM:	Assist:
Feeding:	Assist:	Feeding ADM:	Assist:
Toileting:	Assist:	Toileting ADM:	Assist:
Ambulation:	Assist:	Ambulation ADM:	Assist:

T= TOTAL ASSISTANCE P= PARTIAL ASSISTANCE

**********HEALTHCARE/COMMUNITY SERVICES**********
Extended Care Facility: Outpt Rehab: Rehab Facility:
Home Health Agency: Meals on Wheels:
Personal Care Aides: Mental Health:
Hospice:
Home Health Agency (name):
Hospice (name):

**********MED EQUIPMENT & ASSIST DEVICES**********
Walker: Rolling walker: Standing walker:
Wheelchair:
Hospital bed:
Oxygen:
Nebulizer/Pulmoaide:
CPAP/BIPAP:
Blood Glucose Monitor: Did you bring a medicine pump from home?

**********DC ASSISTANCE W/ MEDICATIONS**********
On d/c, will you need assistance obtaining meds:
On d/c, will you need assistance administering meds:

*********TRANSPORTATION*********
Name of driver:
Drivers phone #:

**********OB ADMIT**********
Age below 16: Previa/Abruption:

714

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

No prenatal care: Birth Control Method on d/c:
PIH/Pre Eclampsia: Gestational Diabetic: Hyperemesis:
Does the patient need Car seat: Baby clothes: Baby bed:
**********PEDIATRIC ADMISSION**********
Delays in G/D:
Rolling Over: Sitting Up: Crawling: Walking: Speaking:
Caregiver perception of child s G/D:
Are your receiving healthcare/community services:
Home Health Agency: Hospice: Personal care aides: Outpt Rehab: WIC:
Homebound Schooling: Mental Health Services:
********** IMMUNIZATIONS **********
2 Month: 4 Month: 6 Month: 15-18 Month:
4-5 Year: PPD: Hepatitis B: Start date: Treatment complete?:
Word child uses to describe pain or hurt N/A if nonverbal
Head circumference:
Is pt below 20th percentile or above 80th percentile wt/ht:
Caregiver(home) understanding of illness/condition:
Caregiver(home) perception of outcome of hosp.stay:
**********SUBACUTE ADMIT**********
BM Date:
Last Void: Was patient continent prior to hospital admission?
Do you prefer to: Bathe: Shower:
Which cognitive behavior(s) describe the pt
Cognitive behavior:
Pt able to verbalize:
PPD Result:
**********ANTEPARTUM**********
EDC:
Gravida Para Abortus:
****PERSONAL VALUABLES****
Personal items/Valuables noted on admission:
RING,NECKLACE
**********CODE STATUS**********
I have explained to the patient/family that without a
current DNR, Do Not Intubate, Do Not Shock, or No CPR order
the patient will be treated as a FULL CODE? Yes
Patient/Family wish to speak with the primary physician regarding Code Status?

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0410	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

715

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
12	***Admission History***	A	AS

Documented at 05/10/08 0240 by NCG

Admitted from: ER Info obtained from: PATIENT Arrival on unit: 0240
Armband intact: Y Verified: : Code Status: FULL CODE
Does pt have Advance Directive (Living Will)? N
Does pt have Health Care Power of Attorney? N
If yes, Living Will copy received? N If yes, Health Care Power of Attorney copy received?
Does patient want info on Advance Directive? N
Do you have all information to complete Advanced Directives? N ^ Updates the Status Board
Temp: 95.7 BP: 160/71 Wt: lb: 159 oz: 8.0 kg: 72.347
Heart Rate: 51 Respirations: 18 Ht: ft: 5 in: 3.0 cm: 160.0
SpO2: 98 % O2 source: 2L/NC BMI= 28.20
Are you in pain: N Med Allergies: N Latex Screening: Y
Do you have chronic pain: N Food Allergies: N Falls Assessment: Y
Chief Complaint: CHEST PAIN
********** PAST MEDICAL HISTORY **********
Previous surgery? Y Previously Hospitalized: PPD+: N Hx of MRSA:
********** MEDICAL HISTORY AND SYSTEM REVIEW **********
Have you ever or do you now have problems with:
Vision: Y Hearing: N Nutrition: N Cardio: Y Resp: Y
CNS: N GI: N GU: N Endocrine: N Hepatic: N Musculo - Skeletal: N
Hematology: N Cancer: N Female: Y
Have you had pneumococcal vaccine? N Date Pneumococcal vaccine given:
Have you had current season influenza vaccine? Date Influenza vaccine given:
must have been RECEIVED between OCT-MAR
********** PSYCHO-SOCIAL **********
HX of alcohol/drug abuse within last 6 months: N Smoked tobacco in the last 12 months? Y
Is there any evidence of abuse or neglect? Mental Illness:
Patient s religious denomination. HOLINESS/PENTECOSTAL
Spiritual practices / beliefs that affect patient care.
Comment:
Would you like to see our chaplain?
****
Have you had or do you currently need assist with ADLS: N
Currently receiving any healthcare or community services: N
Currently using med equip or asst devices: N
On d/c will you need financial assistance w/ meds:
On d/c, will you need physical assistance taking meds?:
On d/c, will you need transportation provided?:
Pt Oriented to Rm & Valuables Policy: Y
OB: N Peds Admit: N Sub-Acute Admit: N Antepartum: N
==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
*******ADMISSION PAIN ASSESSMENT********
Pain Location: Pain scale used:
Pain Level on Admit: Pain type:
Onset of Pain: Pain quality (describe):
Pain frequency: Cause of Pain:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

***Use below for additional Pain Location (if necessary):
Pain Location:
Pain type:
Onset of Pain:
Pain Frequency:
Cause of Pain:
****CHRONIC PAIN****
Pain Location:
Pain scale used:
Pain Score:
Pain frequency:
Worse pain gets: Best pain gets:
Do you have a history of any ongoing pain problems?
Conditions that cause pain:
What makes pain better?
What makes pain worse?
Are there times of the day/night when pain is worse?
Pt s pain plan prior to admit:
Is plan still effective?:
Current pain plan:
Patient s pain goal:
Does patient want pain management information? Educational material given (pain):

****Allergy Information****
Med Allergies: NKDA

Food Allergies: No known food allergies

*******LATEX SCREENING*******
Latex (Rubber): N
Bananas: N
Chestnuts: N
Avocados: N
Poinsettias: N
Kiwi, Papaya: N

****FALL ASSESSMENT****
Previous Fall: N Mobility Problem: N
Confusion/Intermittent Confusion: N
Incontinent: N Hearing/Vision Impairment: Y
Receiving Hypnotics, Laxatives, or Diuretics: N
Pt. is 70+: N
********** PAST MEDICAL HISTORY **********
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007
APPENDECTOMY,CHOLECYSTECTOMY,
TUBAL LIGATION
Anesthesia Complications:
****Previously Hospitalized*****
Reason for Visit/Date:
********VISION**********

717

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Blind: N Eye Prothesis:
Blind left: Eye prothesis left:
Blind right: Eye prothesis right:
Poor vision: Y
Do you wear glasses: Y Glasses w/pt: Y
Do you wear contacts: N Contacts w/ pt:

**********HEARING**********

Hard of hearing: Hearing aid:
HOH Left: Hearing aid left:
HOH Right: Hearing aid right:
Deaf: Hearing aid w/ pt:
Deaf Left:
Deaf Right:

**********NUTRITION**********

Diet followed at home:
Special cultural/ethnic/religious food needs: N
Unintentional wt loss/gain>10 lbs within 2 mo:
On thickened liquids at home? Problems chewing:
PEG Tube Present?:

****DENTAL****

Missing teeth: Capped teeth: Loose teeth:
Do you wear dentures?
Partial:
Upper:
Lower:
Dentures with patient: Denture cup given:
Inventory of Dentures with Patient on Admission:

**********CARDIO**********

Hypertension: Y Arrhythmias: N
Chest Pain: Y Pacemaker/Internal Defibrillator: N
Heart Attack: N Rheumatic Fever: N
CHF: N Congenital Heart Defect: N
Murmur/MVP: N

**********RESP**********

SOB: Y Asthma: N
Pneumonia: N COPD: N
Chronic Cough: N Sleep Apnea: N
URI/cold w/in last 2 wks: N Tracheostomy: N
TB: N

**********CNS**********

Convulsions/Seizures: Alzheimers/Dementia:
Stroke: Numbness/Tingling:
Muscular Weakness/Paralysis: Headache:
Fainting or Dizzy Episodes: Problems w/ Speech/Communications:
Dysphagia:

**********GI**********

Ulcerative Colitis: Chronic Diarrhea:
Diverticulitis: Reflux:
Crohns: Ulcers:
Chronic Constipation: Hiatal Hernia:

**********GU**********

Renal Disease: Prostate Disease:
Hemodialysis: Urinary Retention:
Peritoneal Dialysis:
Kidney Stones: Urostomy:

718

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Bleeding: Nausea/Vomiting: Incontinent (# of times):

**********ENDOCRINE**********
Diabetes: N
Thyroid Problems:
Is this a new onset of diabetes?

**********HEPATIC********
Hepatitis:
Cirrhosis:

**********MUSCULAR SKELETON**********
Arthritis:
Connective Tissue Disease:
Joint Replacement:
Prosthesis:
Device:

**********HEMATOLOGY**********
Anemia:
Sickle Cell Disease/Trait:
Other Types:

Blood Transfusion:
Reaction:

**********CANCER**********
Diagnosis/Date:
Treatment within last 6 months:

**********FEMALE/OB**********
Do you still have a menstrual cycle: Y LMP:
Are you pregnant: Are you currently breast feeding:

********ADL*******

Prior to Admission		Currently on Admission	
Bathing:	Assist:	Bathing on ADM:	Assist:
Grooming:	Assist:	Grooming on ADM:	Assist:
Dressing:	Assist:	Dressing ADM:	Assist:
Feeding:	Assist:	Feeding ADM:	Assist:
Toileting:	Assist:	Toileting ADM:	Assist:
Ambulation:	Assist:	Ambulation ADM:	Assist:

T= TOTAL ASSISTANCE P= PARTIAL ASSISTANCE

**********HEALTHCARE/COMMUNITY SERVICES**********
Extended Care Facility: Outpt Rehab: Rehab Facility:
Home Health Agency: Meals on Wheels:
Personal Care Aides: Mental Health:
Hospice:
Home Health Agency (name):
Hospice (name):

**********MED EQUIPMENT & ASSIST DEVICES**********
Walker: Rolling walker: Standing walker:
Wheelchair:
Hospital bed:
Oxygen:
Nebulizer/Pulmoaide:
CPAP/BIPAP:
Blood Glucose Monitor: Did you bring a medicine pump from home?

**********DC ASSISTANCE W/ MEDICATIONS**********
On d/c, will you need assistance obtaining meds:
On d/c, will you need assistance administering meds:

*********TRANSPORTATION*********
Name of driver:
Drivers phone #:

**********OB ADMIT**********
Age below 16: Previa/Abruption:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

No prenatal care: Birth Control Method on d/c:
PIH/Pre Eclampsia: Gestational Diabetic: Hyperemesis:
Does the patient need Car seat: Baby clothes: Baby bed:
**********PEDIATRIC ADMISSION**********
Delays in G/D:
Rolling Over: Sitting Up: Crawling: Walking: Speaking:
Caregiver perception of child s G/D:
Are your receiving healthcare/community services:
Home Health Agency: Hospice: Personal care aides: Outpt Rehab: WIC:
Homebound Schooling: Mental Health Services:
********** IMMUNIZATIONS **********
2 Month: 4 Month: 6 Month: 15-18 Month:
4-5 Year: PPD: Hepatitis B: Start date: Treatment complete?:
Word child uses to describe pain or hurt N/A if nonverbal
Head circumference:
Is pt below 20th percentile or above 80th percentile wt/ht:
Caregiver(home) understanding of illness/condition:
Caregiver(home) perception of outcome of hosp.stay:
**********SUBACUTE ADMIT**********
BM Date:
Last Void: Was patient continent prior to hospital admission?
Do you prefer to: Bathe: Shower:
Which cognitive behavior(s) describe the pt
Cognitive behavior:
Pt able to verbalize:
PPD Result:
**********ANTEPARTUM**********
EDC:
Gravida Para Abortus:
****PERSONAL VALUABLES****
Personal items/Valuables noted on admission:
RING,NECKLACE
**********CODE STATUS**********
I have explained to the patient/family that without a
current DNR, Do Not Intubate, Do Not Shock, or No CPR order
the patient will be treated as a FULL CODE? Yes
Patient/Family wish to speak with the primary physician regarding Code Status?

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0412	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
2	***Head to Toe*** (ADMISSION ONLY)	A	AS

Documented at 05/10/08 0240 by NCG

**********NEUROLOGICAL ASSESSMENT**********
Level of Consciousness: ALERT Psychosocial: Cooperative
ORIENTATION Person: Y
Place: Y Pain Level on Admit: 0 NONE
Time: Y
Speech: CLEAR
Hand Grips: EQUAL S
Pupils: EQUAL
Pupils React to Light: BOTH
Comment:

**********RESPIRATORY**********
Respiratory Effort: Unlabored
Retractions: N Pattern: Regular
Stridor: N
Breath Sounds, Right: CLEAR Breath Sounds, Left: CLEAR
Cough: ABSENT Color: Consistency:
Capillary Refill: QUICK Chest Tube:
Nailbeds: PINK
Comment:

**********CARDIOVASCULAR**********
Heart Sounds: NORMAL
Neck Vein Distention: N
Peripheral Pulse: Left Radial Pulse: NORMAL
Right Radial Pulse: NORMAL
Left Dorsal Pulse: NORMAL
Right Dorsal Pulse: NORMAL
Edema: ABSENT
Location:
Comment:

**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL Mucous Membranes:MOIST
Skin Condition: Intact
Is there a wound(s) as a result of surgery?
Is there a wound(s) as a result of pressure?
Is there a wound(s) from other than surgery or pressure?

**********GU/GI**********
Abdomen: SOFT
Bowel Sounds: ACTIVE
Stools: CONTINENT Date of last BM: 05/09/08
Voiding: CONTINENT Color: Consistency:
Date of Foley Insertion:
Graft Fistula: N Comment:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Functional:
Thrill:
Bruit:
Location:
NG Tube: N
OG Tube: N
Comment:

**********MUSCULOSKELETAL**********
Range of Motion: FULL RUE: LUE: RLE: LLE:
Cast: N
Comment:

**********SURGICAL**********
Is this a surgical patient: Pt s age: 40 Is patient 70 or greater:
Was patient admitted with one of the following problems? admission?
Total Knee Replacement, Total Hip Replacement, Hip Fracture,
Pelvic fracture, Femur fracture?:

**********OB**********
Is this an OB patient:
Fundus: Fundus Location:
Lochia: Lochia Color:
Perineum:
Hemorrhoids:
Breast:

**********GYN**********
Is this a GYN patient?
Vaginal Bleeding:
Vaginal Bleeding Color:
Vaginal Packing?

**********ANTEPARTUM**********
Is this an antepartum patient:
Reflexes:
Clonus:
Headache:
Epigastric Pain:
Vision Changes:
FHT:

**********INTENSIVE CARE UNIT**********
Is this an ICU pt:
Did you obtain a MRSA swab?
Glascow Coma Scale
Eye Opening:
Motor Functions:
Verbal Responses:
Diagnosis:

**********DVT RISK ASSESSMENT**********
Would you like to complete the DVT Risk Assessment? N
If no, reason for no DVT Risk Assessment: No "At Risk" Diagnosis
Required for the following diagnosis ONLY:
Cancer (with Chemo), CHF, COPD, CVA (Ischemic), Emphysema
IBD, Pulmonary Edema, Pneumonia, or Sepsis

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

**********DVT RISK ASSESSMENT**********
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 4
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 19
Does the patient need to be placed on a turn schedule? N If Yes, a turn sheet will print.

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
*** SURGICAL WOUND LOCATION 1 ***
Surgical wound location 1: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***
Surgical wound location 2: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***
Surgical wound location 3: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

****LOCATION 1****
DERMAL WOUND LOCATED: DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 2****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 3****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:
Please describe any wound(s) not related to surgery/pressure
:
**********DVT RISK ASSESSMENT**********
Diagnosis: * = Highest Risk DIAGNOSIS
Does the patient have any of these risk factors? (Y or N)
Impaired Mobility?
Age over 40?
Obesity?
Paralysis or plaster cast?
Estrogen (contraceptive/HRT)?
***Each Risk Factor counts as 1, add total number of Y ***
History of DVT/PE? ** OR Age over 70? ** OR
Thrombotic abnormalities? **
(Protein C deficiency, Antithrombin III deficiency,etc) **
** = Automatically considered for Highest Risk FACTOR
2 or more risk factors or HIGHEST DIAGNOSIS/FACTOR CATEGORY?
Does patient have current orders for Lovenox, Coumadin or SQ Heparin?
Have you placed a DVT prophylaxis order form (#211-NCR) on the chart?
>>Physician must be notified if assessment indicates high risk for DVT.<<

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0341	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
2	***Head to Toe*** (ADMISSION ONLY)	A	AS

Documented at 05/10/08 0240 by NCG

**********NEUROLOGICAL ASSESSMENT**********
Level of Consciousness: ALERT Psychosocial: Cooperative
ORIENTATION Person: Y
Place: Y Pain Level on Admit: 0 NONE
Time: Y
Speech: CLEAR
Hand Grips: EQUAL S
Pupils: EQUAL
Pupils React to Light: BOTH
Comment:

**********RESPIRATORY**********
Respiratory Effort: Unlabored
Retractions: N Pattern: Regular
Stridor: N
Breath Sounds, Right: CLEAR Breath Sounds, Left: CLEAR
Cough: ABSENT Color: Consistency:
Capillary Refill: QUICK Chest Tube:
Nailbeds: PINK
Comment:

**********CARDIOVASCULAR**********
Heart Sounds: NORMAL
Neck Vein Distention: N
Peripheral Pulse: Left Radial Pulse: NORMAL
Right Radial Pulse: NORMAL
Left Dorsal Pulse: NORMAL
Right Dorsal Pulse: NORMAL
Edema: ABSENT
Location:
Comment:

**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL Mucous Membranes:MOIST
Skin Condition: Intact
Is there a wound(s) as a result of surgery?
Is there a wound(s) as a result of pressure?
Is there a wound(s) from other than surgery or pressure?

**********GU/GI**********
Abdomen: SOFT
Bowel Sounds: ACTIVE
Stools: CONTINENT Date of last BM: 05/09/08
Voiding: CONTINENT Color: Consistency:
Date of Foley Insertion:
Graft Fistula: N Comment:

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Functional:
Thrill:
Bruit:
Location:
NG Tube: N
OG Tube: N
Comment:

**********MUSCULOSKELETAL**********
Range of Motion: FULL RUE: LUE: RLE: LLE:
Cast: N
Comment:

**********SURGICAL**********
Is this a surgical patient: Pt s age: 40 Is patient 70 or greater:
Was patient admitted with one of the following problems? admission?
Total Knee Replacement, Total Hip Replacement, Hip Fracture,
Pelvic fracture, Femur fracture?:

**********OB**********
Is this an OB patient:
Fundus: Fundus Location:
Lochia: Lochia Color:
Perineum:
Hemorrhoids:
Breast:

**********GYN**********
Is this a GYN patient?
Vaginal Bleeding:
Vaginal Bleeding Color:
Vaginal Packing?

**********ANTEPARTUM**********
Is this an antepartum patient:
Reflexes:
Clonus:
Headache:
Epigastric Pain:
Vision Changes:
FHT:

**********INTENSIVE CARE UNIT**********
Is this an ICU pt:
Did you obtain a MRSA swab?
Glascow Coma Scale
Eye Opening:
Motor Functions:
Verbal Responses:
Diagnosis:

**********DVT RISK ASSESSMENT**********
Would you like to complete the DVT Risk Assessment? N
If no, reason for no DVT Risk Assessment: No "At Risk" Diagnosis
Required for the following diagnosis ONLY:
Cancer (with Chemo), CHF, COPD, CVA (Ischemic), Emphysema
IBD, Pulmonary Edema, Pneumonia, or Sepsis

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

**********DVT RISK ASSESSMENT**********
**** NORTON SCALE ASSESSMENT ****
PHYSICAL CONDITION 3
MENTAL CONDITION 4
ACTIVITY 4
MOBILITY 4
INCONTINENT BOWEL AND/ BLADDER 4
NORTON SCALE TOTAL SCORE 19
Does the patient need to be placed on a turn schedule? N If Yes, a turn sheet will print.

==========POP-UP ANSWERS LISTED BELOW THIS LINE==========
*** SURGICAL WOUND LOCATION 1 ***
Surgical wound location 1: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 2 ***
Surgical wound location 2: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

*** SURGICAL WOUND LOCATION 3 ***
Surgical wound location 3: Dressing change ordered?
Dressing appearance: Dressing change?
Dressing type:
Incision appearance: Drainage tube:
Drainage Amt: Drainage color:
Wound base color: Odor present?
Enter Nurses Note?

****LOCATION 1****
DERMAL WOUND LOCATED: DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 2****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 3****
DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 4****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:

****LOCATION 5****

DERMAL WOUND LOCATED DRESSING CHANGED?
PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?
DRESSING TYPE:
WOUND DRAINAGE: WOUND DRAINAGE TYPE:
DRAINAGE TUBES:
Please describe any wound(s) not related to surgery/pressure
:
**********DVT RISK ASSESSMENT**********
Diagnosis: * = Highest Risk DIAGNOSIS
Does the patient have any of these risk factors? (Y or N)
Impaired Mobility?
Age over 40?
Obesity?
Paralysis or plaster cast?
Estrogen (contraceptive/HRT)?
***Each Risk Factor counts as 1, add total number of Y ***
History of DVT/PE? ** OR Age over 70? ** OR
Thrombotic abnormalities? **
(Protein C deficiency, Antithrombin III deficiency,etc) **
** = Automatically considered for Highest Risk FACTOR
2 or more risk factors or HIGHEST DIAGNOSIS/FACTOR CATEGORY?
Does patient have current orders for Lovenox, Coumadin or SQ Heparin?
Have you placed a DVT prophylaxis order form (#211-NCR) on the chart?
>>Physician must be notified if assessment indicates high risk for DVT.<<

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	05/10/08	0240	NCG	NSNCG	GUANTERO,NIDA C.	RN
Recorded:	05/10/08	0411	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

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Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Number	Description	Status	Source
2	***Head to Toe*** (ADMISSION ONLY)	A	AS

Documented at 05/10/08 0240 by NCG

**********NEUROLOGICAL ASSESSMENT**********
Level of Consciousness: ALERT Psychosocial: Cooperative
ORIENTATION Person: Y
Place: Y Pain Level on Admit: 0 NONE
Time: Y
Speech: CLEAR
Hand Grips: EQUAL S
Pupils: EQUAL
Pupils React to Light: BOTH
Comment:

**********RESPIRATORY**********
Respiratory Effort: Unlabored
Retractions: N Pattern: Regular
Stridor: N
Breath Sounds, Right: CLEAR Breath Sounds, Left: CLEAR
Cough: ABSENT Color: Consistency:
Capillary Refill: QUICK Chest Tube:
Nailbeds: PINK
Comment:

**********CARDIOVASCULAR**********
Heart Sounds: NORMAL
Neck Vein Distention: N
Peripheral Pulse: Left Radial Pulse: NORMAL
Right Radial Pulse: NORMAL
Left Dorsal Pulse: NORMAL
Right Dorsal Pulse: NORMAL
Edema: ABSENT
Location:
Comment:

**********SKIN INTEGUMENTARY**********
Skin Color: NORMAL
Temperature: WARM
Skin to Touch: DRY
Skin Turgor: NORMAL Mucous Membranes:MOIST
Skin Condition: Intact
Is there a wound(s) as a result of surgery?
Is there a wound(s) as a result of pressure?
Is there a wound(s) from other than surgery or pressure?

**********GU/GI**********
Abdomen: SOFT
Bowel Sounds: ACTIVE
Stools: CONTINENT Date of last BM: 05/09/08
Voiding: CONTINENT Color: Consistency:
Date of Foley Insertion:
Graft Fistula: N Comment:

729

Patient: WINDHAM,TAMMY ELIZABETH Age/Sex: 40 F
Account #: 12930159 Unit #: 229998
Admit Date: 05/10/08 Location: TELE
Status: ADM INo Room/Bed: 336-1
Attending: MEDICAL SERVICES - TMP

Functional:
Thrill:
Bruit:
Location:
NG Tube: N
OG Tube: N
Comment:

**********MUSCULOSKELETAL**********
Range of Motion: FULL RUE: LUE: RLE: LLE:
Cast: N
Comment:

**********SURGICAL**********
Is this a surgical patient: Pt s age: 40 Is patient 70 or greater:
Was patient admitted with one of the following problems? admission?
Total Knee Replacement, Total Hip Replacement, Hip Fracture,
Pelvic fracture, Femur fracture?:

**********OB**********
Is this an OB patient:
Fundus: Fundus Location:
Lochia: Lochia Color:
Perineum:
Hemorrhoids:
Breast:

**********GYN**********
Is this a GYN patient?
Vaginal Bleeding:
Vaginal Bleeding Color:
Vaginal Packing?

**********ANTEPARTUM**********
Is this an antepartum patient:
Reflexes:
Clonus:
Headache:
Epigastric Pain:
Vision Changes:
FHT:

**********INTENSIVE CARE UNIT**********
Is this an ICU pt:
Did you obtain a MRSA swab?
Glascow Coma Scale
Eye Opening:
Motor Functions:
Verbal Responses:
Diagnosis:

**********DVT RISK ASSESSMENT**********
Would you like to complete the DVT Risk Assessment? N
If no, reason for no DVT Risk Assessment: No "At Risk" Diagnosis
Required for the following diagnosis ONLY:
Cancer (with Chemo), CHF, COPD, CVA (Ischemic), Emphysema
IBD, Pulmonary Edema, Pneumonia, or Sepsis