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S.C. Supreme Court

THE STATE OF SOUTH CAROLINA
In The 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 XIII 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
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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
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Mr. Price, Juror 175 (Questioning by the Court)	2624
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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
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Rosada Heriot, Juror 88 (Questioning by the Court)	2694
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Juror 88 (Questioning by the Court)	2704
Ms. Sanders, Juror 189 (Questioning by the Court)	2706

Juror 189 (Questioning by Jackson)	2711
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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

**********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?

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	0413	NCG	NSNCG	GUANTERO,NIDA C.	RN

Recorded at terminal: TELEM008.3

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: 1900

70 Daily Re-Assessment/Observation A PS
- Document 05/10/08 1900 DMR 05/10/08 1933 DMR
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: 05/09/08
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 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==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/10/08
(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****

Intervention Description								Sts	Direction	From
Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change	

Activity Date: 05/10/08 Time: 1900 (continued)

70 Daily Re-Assessment/Observation (continued)
Please describe any wound(s) not related to surgery/pressure
New Onset of Pain Assessment

Activity Date: 05/11/08 Time: 1450

70 Daily Re-Assessment/Observation A PS
- Document 05/11/08 1450 JRB 05/11/08 1451 JRB
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: 05/11/08
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 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==========
IV Access Type: IV- No continuous fluids
Date of INT insertion: 05/10/08
(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 ***

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: 1450 (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

Monogram	Initials	Name	Nurse Type
DMR	NSDR2	REICH,DONNA M.	RN
JRB	4SJRB	BUTLER,JUDY R.	RN

Intervention Description Sts Direction From

Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Patient Notes: Nursing Notes
- Create 05/10/08 0417 NCG 05/10/08 0436 NCG
Abnormal? N Confidential? N
Focus: Patient Admission Notes

Data: Received pt from ER per stretcher at 0240h.V/S checked & documented.Nursing Assessment done.Denies any chest pain since arrival to the floor but pt c/o headache.Morphine 2mg iv given per pt s request.Pt verbalized that "my headache was not relieved by tylenol when i was at the er".No acute distress noted.O2 sat 98% on 2l/nc.Abdomen soft,BS x4 quadrants.INT intact at left hand.No edema noted to upper & lower extremities.Telemetry monitor hooked to pt.Teaching packet given with instructions.Oriented to room & setting.Call light placed at bedside.

Addendum: 05/10/08 at 0439 by NCG GUANTERO,NIDA C. RN

Telemetry monitor showing SR to SB,with HR at 60 s to 50 s.Will monitor.

Patient Notes: Nursing Notes
- Create 05/10/08 1001 VRM 05/10/08 1006 VRM
Abnormal? N Confidential? N
Focus:AM Assessment

Data:A/O, vitals: b/p 136/62 p 52 t 96.8 98%2Lnc, lt hand #20 int, last Bm t-1, lungs clear, pulses and abd sounds +, tele-SB 50 s

Action:pt. assessed and given meds per MD orders, call light within reach, bed low, will continue to monitor

Patient Notes: Nursing Notes
- Create 05/10/08 1900 DMR 05/10/08 2156 DMR
Abnormal? N Confidential? N
Focus: Assessment

Data: Alert and oriented. Regular unlabored respirations. Skin warm and dry. O2 Sat 98% on room air. INT intact to left forearm with no redness, edema, or pain at site. Telemetry intact.

Action: Continue to monitor patient. Patient instructed in use of callbell for assistance with verbalized understanding.

Response: No distress or complaints noted at this time.

Patient Notes: Nursing Notes
- Create 05/11/08 0800 JRB 05/11/08 1458 JRB
Abnormal? N Confidential? N
Focus: Patient Focus

Data: Patient is alert and oriented x 3. Skin is warm and dry. Lungs are clear. Telemetry is in place and is showing a Normal sinus Rhythm. Int needle is patent in the lt. forearm. O2 saturation is 97% on 2/l of nasal o2.

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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

Patient Notes: Nursing Notes (continued)

Action: Assessement completed. Will continue to monitor.

Response: Pt. is able to make her needs known.

Patient Notes: Nursing Notes

- Create 05/11/08 1330 JRB 05/11/08 1509 JRB
  Abnormal? N Confidential? N
  Focus: Transfer

Data: Orders received to transfer patient.
Room number is received from Providence Hospital.

Action: Patient and family was notified.

Response: Pt. stated Dr. Tan called her and explained her condition and She understands all of it.

Addendum: 05/11/08 at 1513 by JRB BUTLER,JUDY R. RN

Patient transferred to Providence Hospital via ambulance to room 508 to the care of Dr. Malnuk. Report called to S. Lewis R.N.

Patient Notes: Patient Education Note

- Create 05/10/08 0346 NCG 05/10/08 0346 NCG
  Abnormal? N Confidential? N
  Teaching FOCUS: Angina Pain

Education and information covered during teaching/instruction included:

Given education packet- "Living with Angina," a booklet by Krames and the American Cancer Society - pamphlet "Freshstart," smoking cessation program

- Define Angina
- S/S of angina
- Pain management: nitroglycerin
- Risk Factors
- What causes angina
- CCTV Programming
- Diet instruction: page 13 of booklet
- Smoking cessation
- How to decrease risk of angina
- How to stop an angina attack
- When to call the doctor
- When to call for emergency medical help

Please see Teaching intervention for method, learner, receptiveness and teaching outcome.

Monogram	Initials	Name	Nurse Type
DMR	NSDR2	REICH,DONNA M.	RN
JRB	4SJRB	BUTLER,JUDY R.	RN
NCG	NSNCG	GUANTERO,NIDA C.	RN

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Monogram	Initials	Name	Nurse Type
VRM	NSVM3	MCCANTY,VERONICA R.	RN

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: 0346

Patient Notes: Patient Education Note
- Create 05/10/08 0346 NCG 05/10/08 0346 NCG
Abnormal? N Confidential? N
Teaching FOCUS: Angina Pain

Education and information covered during teaching/instruction included:

Given education packet- "Living with Angina," a booklet by Krames and the American Cancer Society - pamphlet "Freshstart," smoking cessation program

- Define Angina
- S/S of angina
- Pain management: nitroglycerin
- Risk Factors
- What causes angina
- CCTV Programming
- Diet instruction: page 13 of booklet
- Smoking cessation
- How to decrease risk of angina
- How to stop an angina attack
- When to call the doctor
- When to call for emergency medical help

Please see Teaching intervention for method, learner, receptiveness and teaching outcome.

Activity Date: 05/10/08 Time: 0417

Patient Notes: Nursing Notes
- Create 05/10/08 0417 NCG 05/10/08 0436 NCG
Abnormal? N Confidential? N
Focus: Patient Admission Notes

Data: Received pt from ER per stretcher at 0240h.V/S checked & documented.Nursing Assessment done.Denies any chest pain since arrival to the floor but pt c/o headache.Morphine 2mg iv given per pt s request.Pt verbalized that "my headache was not relieved by tylenol when i was at the er".No acute distress noted.O2 sat 98% on 2l/nc.Abdomen soft,BS x4 quadrants.INT intact at left hand.No edema noted to upper & lower extremities.Telemetry monitor hooked to pt.Teaching packet given with instructions.Oriented to room & setting.Call light placed at bedside.

Addendum: 05/10/08 at 0439 by NCG GUANTERO,NIDA C. RN

Telemetry monitor showing SR to SB,with HR at 60 s to 50 s.Will monitor.

Intervention Description Sts Direction From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 05/10/08 Time: 1001

Patient Notes: Nursing Notes
- Create 05/10/08 1001 VRM 05/10/08 1006 VRM
Abnormal? N Confidential? N
Focus:AM Assessment

Data:A/O, vitals: b/p 136/62 p 52 t 96.8 98%2Lnc, lt hand #20 int, last Bm t-1, lungs clear, pulses and abd sounds +, tele-SB 50 s

Action:pt. assessed and given meds per MD orders, call light within reach, bed low, will continue to monitor

Activity Date: 05/10/08 Time: 1900

Patient Notes: Nursing Notes
- Create 05/10/08 1900 DMR 05/10/08 2156 DMR
Abnormal? N Confidential? N
Focus: Assessment

Data: Alert and oriented. Regular unlabored respirations. Skin warm and dry. O2 Sat 98% on room air. INT intact to left forearm with no redness, edema, or pain at site. Telemetry intact.

Action: Continue to monitor patient. Patient instructed in use of callbell for assistance with verbalized understanding.

Response: No distress or complaints noted at this time.

Activity Date: 05/11/08 Time: 0800

Patient Notes: Nursing Notes
- Create 05/11/08 0800 JRB 05/11/08 1458 JRB
Abnormal? N Confidential? N
Focus: Patient Focus

Data: Patient is alert and oriented x 3. Skin is warm and dry. Lungs are clear. Telemetry is in place and is showing a Normal sinus Rhythm. Int needle is patent in the lt. forearm. O2 saturation is 97% on 2/l of nasal o2.

Action: Assessement completed. Will continue to monitor.

Response: Pt. is able to make her needs known.

Activity Date: 05/11/08 Time: 1330

Patient Notes: Nursing Notes
- Create 05/11/08 1330 JRB 05/11/08 1509 JRB
Abnormal? N Confidential? N
Focus: Transfer

740

Intervention Description								Sts	Direction	From
Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change	

Activity Date: 05/11/08 Time: 1330 (continued)

Patient Notes: Nursing Notes (continued)

Data: Orders received to transfer patient.
Room number is received from Providence Hospital.

Action: Patient and family was notified.

Response: Pt. stated Dr. Tan called her and explained her condition and
She understands all of it.

Addendum: 05/11/08 at 1513 by JRB BUTLER,JUDY R. RN

Patient transferred to Providence Hospital via ambulance to room 508
to the care of Dr. Malnuk. Report called to S. Lewis R.N.

Monogram	Initials	Name	Nurse Type
DMR	NSDR2	REICH,DONNA M.	RN
JRB	4SJRB	BUTLER,JUDY R.	RN
NCG	NSNCG	GUANTERO,NIDA C.	RN
VRM	NSVM3	MCCANTY,VERONICA R.	RN

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, Tammy Windham
was the emergency physician/private physician for Dr. Tan
At Tuomey Healthcare System on 5/11/ 20 08, at 12:00 pm.

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. Malnuk

☐ 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: Further eval by Dr Malnuk

RISKS: ☑ Deterioration of Condition

WINDHAM.TAMMY ELIZABETH
U# 229998 ACCT# 12930159

☐ Possible Death

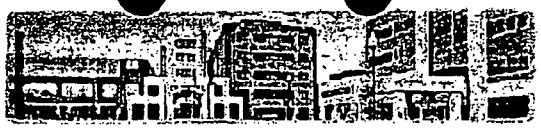
Date: 5/11/08 Physician's Name: Dr Tan
Physician's Signature:
If No Physician Present, Nurse's Name: Maria Hyatt RN
Nurse's Signature: Maria Hyatt RN
On the Verbal Orders of Dr. Tan via cellphone - Dr Orange
Received at: on:

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

POD: ORIGINAL

ORIGINAL



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 Elizabeth 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.

Judy L. Butler, RN
WITNESS

Tammy E. Windham
SIGNATURE OF PATIENT OR AUTHORIZED PERSON

Marie T Hyland BN
WITNESS

self
RELATIONSHIP OF AUTHORIZED PERSON

5/11/08
DATE

1220 AM / PM
TIME

☐ IF UNABLE TO READ, CONSENT FORM HAS BEEN READ TO PATIENT/AUTHORIZED PERSON.

☐ "MARK OF THE PATIENT" PATIENT UNABLE TO WRITE DUE TO:

I CERTIFY THAT I HAVE DISCUSSED THE ABOVE WITH THE PATIENT OR THE RESPONSIBLE PARTY.

Authenticated by
Dau Tantawanichpisal, MD MD/DO
On 05/15/2008 02:24:44 PM

DATE TIME

TUOMEY HEALTHCARE SYSTEM - INFORMED CONSENT TO TRANSFER (ENGLISH)
30403 Rev. 02/16/07

30403

PATIENT LABEL

WINDHAM,TAMMY ELIZABETH
Acct:12930159 Unit: 229998
MEDICAL SERVICES - TMP
MED 336/1
F W Age: 40 DOS: 05/10/08 [redacted]

743

DHEC PATIENT CARE FORM

Q.A. NO.
TRIP NO. 002178

PATIENT IDENTIFICATION (Please Print)
LAST NAME (10–29): Windham FIRST NAME (30–45): Tammy MI (46)
STREET (47–71): 3388 Pinewood Rd. APT #
CITY (72–87) STATE (88–89) ZIP CODE (90–94)
SSN (95–103)

SEX (104): 1 ☐ Male 2 ☒ Female 3 ☐ Undetermined

RACE (105): 1 ☒ White 2 ☐ Black 3 ☐ Am. Indian 4 ☐ Hispanic 5 ☐ Asian 6 ☐ Other

AGE (106–108): 040 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): 1 ☐ MVA 2 ☐ MC 3 ☐ BIKES 4 ☐ PED 5 ☐ ASSAULT 6 ☐ FALL 7 ☐ FIRE 8 ☐ 9 ☐ MEDICAL (113): 1 ☐ ENVIRON 2 ☐ BEHAV 3 ☐ OB/GYN 4 ☐ RESP 5 ☒ CARDIAC 6 ☐ INTERFAC 7 ☐ OTHER

CALL TYPE: TO SCENE (114): 1 ☒ EMERGENT 2 ☐ NONEMERGENT CODE 03

PATIENT STATUS: ON SCENE (115): 1 ☒ URGENT 2 ☐ NON URGENT CODE 03; FROM SCENE (116): 1 ☒ URGENT 2 ☐ NON URGENT

INCIDENT LOCATION
ST. OR HWY. NAME OR NO. SAA
CITY
County (117–118): 43 Zip Code (119–123)

SAFETY EQP (124) **SITE OF INCIDENT (125)**: RECREATIONAL / AGRICULTURAL / OTHER

WINDHAM, TAMMY ELIZABETH
U# 229998 ACCT# 12930159

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 112 Other 086 Other

PRIMARY IMPRESSION (138–140): 086

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

HCFA 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 NSR Time
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 ☐ Cricoi
6. ☐ EXTERNAL PACING
7. ☒ BLOOD DRAWN DEXTROSE BGL 149 mg/dcl
8. ☒ IV STARTED/GAUGE 20g SOLUTION NS RATE INT IV TIME IV VOLUME 50cc
9. ☐ IV STARTED/GAUGE SOLUTION RATE IV TIME IV VOLUME
14 ☐ IV ATTEMPTED Total # (225)
10. ☐ PLEURAL DECOMPRESSION Time
11. ☐ INTRAOSSEOUS INF.
12. ☐ AUTOMATIC DEFIB
13. ☐ PATIENT ASSISTED MEDS.
Ordering Physician Sea (Name) (Signature)

DRUGS USED (226–241)

DRUG	DOSE	TIME	DRUG	DOSE	TIME
1 3	324 mg	0.4mg			
3 6	324 mg				

REVISED TRAUMA SCORE
GCS: (242) EYES (243) VERBAL (244) MOTOR (245–246) GLASGOW
(247–249) SBP (250–252) RR (253) ANATOMICAL (INJ. 1 ☐ YES 2 ☐ NO
RTS (254–255)

VITAL SIGNS

BP	PULSE		RESPIRATIONS		PUPIL	LEVEL OF CONSC.	TIME
180/80	RATE 98	☒ REG. ☐ IRREG.	RATE 24	☒ REG. ☐ IRREG.	E	A	
160/100	90	☒ REG. ☐ IRREG.	20	☒ REG. ☐ IRREG.	E	A	
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.			
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.			
/		☐ REG. ☐ IRREG.		☐ REG. ☐ IRREG.			

EUNICE AVPU

EXPOSURE TO PT's BODY FLUIDS? (256) 1. ☐ YES 2. ☒ NO

1st Responder (257) 1. ☐ YES Name 2. ☒ NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)

83 dispatched to above residence for DHEC 86, UOA found 40 yo WF, pt CAOX3, skin WD, color good, PERRL, Resp 24 c/E, pt. states she has been having chest pain since last Wed, worsening this evening w/ PMH of MVT x3 w/ NKDA, states pain is sharp in substernal area pain @ 9/10, pt. Xferred to 4WS in POC 5x3 Rx2, pt. placed on cardiac monitor showing NSR & ectopy, pt. placed on 4L O2 via NC, 20g INT placed in (L) hand, BGL obtained @ 149mg/dcl pt. given 324mg ASA & 0.4mg Nitro w/ some relief. care & report Xferred to Twomey ED staff.

Patient Care Form Left In (258): 1. ☒ ED 2. ☐ ICU 3. ☐ OTHER Twomey ED ☐ See Page 2

TIME RECORD
RUN DATE (259–266): MONTH 05 DAY 09 YEAR 08
Call Received: (267–270)
Call Dispatched: (271–274)
Departed Base: (275–278)
Arrive Scene: (279–282)
Departed Scene: (283–286)
Arrive Destination: (287–290)
CAUSE OF DELAY

DHEC PERMIT NO. (291–295)

RECEIVING AGENCY (296–299): 3019

SENDING AGENCY (300–303)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO.
8563G
PRIMARY PATIENT ATTENDANT (304–308): 3348
2ND ATTENDANT/DRIVER (309–313)
3RD ATTENDANT/DRIVER (314–318)
(RECEIVING NURSE OR PHYSICIAN) 744

DHEC 1050 REV. (01/2004) RECEIVER'S COPY REPORT NO. (1-9) 354922

5965

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
Problem: Angina/Chest Pain				ICD9# 413.9			D		
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
Outcome: Pain Control							D	05/14/08	

Definition: Personal actions to control pain.

5. Never Demonstrated
4. Rarely Demonstrated
3. Sometime Demonstrated
2. Often Demonstrated
1. Consistently Demonstated

INDICATORS:
Recognizes causal factors
Recognizes pain onset
Uses preventive measures
Uses non-analgesic relief measures
Uses analgesics appropriately
Uses warning signs to seek care

Reports symptoms to health care professional

Recognizes symptoms of pain
Reports pain control

- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/11/08	1449	JRB	05/11/08	1450	JRB		Day:1 05/10 Met ,O=2	
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4190	IV Intravenous Insertion						D		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4200	IV Intravenous Therapy						D		CP
	5/10: INT WITH FLUSHES								
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Ed Text	05/10/08	0251	AAM	05/10/08	0252	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
Outcome: Vital Sign Status							D	05/14/08	

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
1. No deviation from expected range

INDICATORS:
Temperature

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
Outcome: Vital Sign Status (continued)									
Apical pulse rate									
Radial pulse rate									
Respiration rate									
Systolic BP*									
Diastolic BP									
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/11/08	1450	JRB	05/11/08	1450	JRB		Day:1 05/10 Met ,O=2	
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
Outcome: Tissue Perfusion: Cardiac							D	05/14/08	
Definition: Extent to which blood flows through the coronary vasculature and maintains heart function.									
5. Extremely compromised									
4. Substantially compromised									
3. Moderately compromised									
2. Mildly compromised									
1. Not compromised									
INDICATORS:									
Angina not present									
Profuse diaphoresis not present									
Nausea not present									
Vomiting not present									
Vital signs									
EKG									
Cardiac enzymes									
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/11/08	1450	JRB	05/11/08	1450	JRB		Day:1 05/10 Met ,O=2	
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
4040 Cardiac Care:							D		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/11/08	1450	JRB	05/11/08	1450	JRB			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3141 Oxygen Therapy							D		CP
5/10: 2L MIN NC									
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Ed Text	05/10/08	0252	AAM	05/10/08	0252	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6681 Pulse Oximetry (SAO2)							D		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/10/08	1900	DMR	05/10/08	1932	DMR			
SAO2: 98									
O2 source: ROOM AIR									
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
Outcome: Anxiety Control							D	05/14/08	
Definition: Personal actions to eliminate or reduce feelings of apprehension and tension from an unidentifiable source.									

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

Outcome: Anxiety Control (continued)

5. Never demonstrated
4. Rarely demonstrated
3. Sometimes demonstrated
2. Often demonstrated
1. Consistently demonstrated

INDICATORS:
Plans coping strategies for stressful situations

Uses effective coping strategies

Uses relaxation techniques to reduce anxiety

Reports adequate sleep

Reports absence of physical manifestations of anxiety

- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Document	05/11/08	1450	JRB	05/11/08	1450	JRB		Day:1 05/10 Met ,O=2	
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
5820 Anxiety Reduction							D		CP
- Create	05/10/08	0218	NCG	05/10/08	0218	NCG			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D

Additional Interventions

452 Activity							D		OE
5/10: BR WITH BRP									
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- Ed Text	05/10/08	0250	AAM	05/10/08	0250	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
450 Dietary Intake							D		OE
5/10: CARDIAC									
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- Ed Text	05/10/08	0251	AAM	05/10/08	0251	AAM			
- Document	05/10/08	1126	ASB	05/10/08	1126	ASB			Level 450
Which meal & how much eaten? Breakfast 50%									
- Document	05/10/08	1507	MFE	05/10/08	1507	MFE			Level 450
Which meal & how much eaten? Lunch 75%									
- Document	05/10/08	2328	MM3	05/10/08	2329	MM3			Level 450
Which meal & how much eaten? Snack 100%									
- Document	05/11/08	1109	MFE	05/11/08	1110	MFE			Level 450
Which meal & how much eaten? Breakfast 100%									
- Document	05/11/08	1526	MFE	05/11/08	1527	MFE			Level 450
Which meal & how much eaten? Lunch 100%									
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
6690	Intake/Output						D		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- 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:

- Document 05/10/08 1649 MFE 05/10/08 1650 MFE

********** INTAKE **********

Oral Intake: 720 IV Intake:

NG/Peg Feeding: Blood Admin.:

********** OUTPUT **********

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:

- Document 05/11/08 0659 MM3 05/11/08 0659 MM3

********** INTAKE **********

Oral Intake: 480 IV Intake:

NG/Peg Feeding: Blood Admin.:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
6690	Intake/Output (continued)								

********** 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: Bemovac 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	05/11/08	1527	his	05/11/08	1527	his			A => D
6691	Weight/Height						D		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
7690	Laboratory Data Interpretation						D		OE
	5/10: EKG, CKMBT/TRPI @ 0438 AND 1038								
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- Ed Text	05/10/08	0252	AAM	05/10/08	0252	AAM			
- Ed Text	05/10/08	0254	AAM	05/10/08	0254	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
451	Consults						D		OE
- Create	05/10/08	0218	AAM	05/10/08	0218	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
413	Telemetry						D		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			
- Document	05/11/08	1451	JRB	05/11/08	1452	JRB			
Rhythm: nsr									
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
5260	Code Status						D		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			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
6410	Allergy Management						D		PS
	NKDA								
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Text	05/10/08	0322	AAM	05/10/08	0322	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3352	Pneumococcal vaccine notification						D		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			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D

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		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3357	Pneumonia Vaccine Not Given Reason						D		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
5601	Teaching: Patient/Family Education						D		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
1805	AM/PM Bathing and ADL care						D		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Document	05/10/08	1126	ASB	05/10/08	1126	ASB			

AM/PM Care
Shower

Comments:

- Document 05/11/08 1109 MFE 05/11/08 1110 MFE

AM/PM Care
Shower

Comments:

- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3354	Influenza vaccine given						D		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- 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
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3356	Influenza Vaccine Not Given Reason						D		PS
- Create	05/10/08	0220	AAM	05/10/08	0220	AAM			
- 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
- Create	05/10/08	0251	AAM	05/10/08	0251	AAM			
- Ed Text	05/10/08	0251	AAM	05/10/08	0251	AAM			
- 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:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Direction Documented Units	From Change
6680	Vital Signs, Monitor CNA/CT						D		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

- 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:

- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
7000	Vital Signs, Monitor RN/LPN						D		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			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
3320	RT: Oxygen Therapy Per 12 Hrs ($)						D		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:
- 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:
- Document 05/11/08 0854 TMP 05/11/08 0855 TMP
Code Status: FULL CODE
O2: Y
Type of O2: NCAN
Liters: 2

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Sts Comment	Direction Documented Units	From Change

3320 RT: Oxygen Therapy Per 12 Hrs ($) (continued)

Comments:
- Ed Status 05/11/08 1527 his 05/11/08 1527 his A => D
12 ***Admission History*** D AS
- Create 05/10/08 0240 NCG 05/10/08 0340 NCG
- Document 05/10/08 0240 NCG 05/10/08 0340 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):

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

12 ***Admission History*** (continued)
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:
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

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********** PAST MEDICAL HISTORY **********

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Direction Comment	Documented Units	From Change

12 ***Admission History*** (continued)
Surgery and Date: CIRCUMFLEX IMPLANT-MARCH 2007
APPENDECTOMY,CHOLECYSTECTOMY,
TUBAL LIGATION
Anesthesia Complications:

****Previously Hospitalized*****
Reason for Visit/Date:

********VISION**********
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

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

12 ***Admission History*** (continued)

**********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:
Bleeding: Nausea/Vomiting:

**********GU**********
Renal Disease: Prostate Disease:
Hemodialysis: Urinary Retention:
Peritoneal Dialysis:
Kidney Stones: Urostomy:
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:

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Direction Comment	Documented Units	From Change

12 ***Admission History*** (continued)
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:
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:

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)

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?
- Edit Results 05/10/08 0240 NCG 05/10/08 0410 NCG
- Edit Results 05/10/08 0240 NCG 05/10/08 0412 NCG
Cancer: N []
- Ed Status 05/11/08 1527 his 05/11/08 1527 his A-=> D
2 ***Head to Toe*** (ADMISSION ONLY) D AS
- Create 05/10/08 0240 NCG 05/10/08 0341 NCG
- Document 05/10/08 0240 NCG 05/10/08 0341 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:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

**********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:
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:

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

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

**********DVT RISK ASSESSMENT**********

**** NORTON SCALE ASSESSMENT ****

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

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:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

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?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

2 ***Head to Toe*** (ADMISSION ONLY) (continued)

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:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

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)								

****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.<<
- Edit Results 05/10/08 0240 NCG 05/10/08 0411 NCG
- Edit Results 05/10/08 0240 NCG 05/10/08 0413 NCG
- Ed Status 05/11/08 1527 his 05/11/08 1527 his A => D
99 Home Medication Inventory D AS
- Create 05/10/08 0240 NCG 05/10/08 0343 NCG
- Document 05/10/08 0240 NCG 05/10/08 0343 NCG
Do you have all information to complete the Home Meds data? Y ^Updates Status Board
Printer name for print-out of order sheet: 3NP1

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

99 Home Medication Inventory (continued)
Currently taking homeopathic/herbal meds?

MEDICATION NAME DOSE DIRECTIONS INDICATION
| METOPROLOL TARTRATE | 50MG | BID | -
ROUTE| PO Last Dose Taken| - Herb/Homeopathic? N
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| ASA | 81MG | DAILY | -
ROUTE| PO Last Dose Taken| - Herb/Homeopathic? N
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic? N
Ordered on Adm: If yes,Same dose: If no, MD Nofified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic? N
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

MEDICATION NAME DOSE DIRECTIONS INDICATION
| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic? N
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

MEDICATION NAME DOSE DIRECTIONS INDICATION
| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | | |
ROUTE| Last Dose Taken| Herb/Homeopathic?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

99 Home Medication Inventory (continued)

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

MEDICATION NAME	DOSE	DIRECTIONS	INDICATION
ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

MEDICATION NAME	DOSE	DIRECTIONS	INDICATION
ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

ROUTE	Last Dose Taken		Herb/Homeopathic?

Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Direction Documented Units	From Change

99 Home Medication Inventory (continued)

MEDICATION NAME DOSE DIRECTIONS INDICATION
| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

MEDICATION NAME DOSE DIRECTIONS INDICATION
| | |
ROUTE| Last Dose Taken| Herb/Homeopathic?
Ordered on Adm: If yes,Same dose: If no, MD Notified (Name/time):

- Ed Status 05/11/08 1527 his 05/11/08 1527 his A => D
032 Rounds: CT/CNA D 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
- Document 05/10/08 1507 MFE 05/10/08 1507 MFE
Were rounds completed per protocol?
- Document 05/10/08 2328 MM3 05/10/08 2328 MM3
Were rounds completed per protocol?
- Document 05/11/08 1109 MFE 05/11/08 1109 MFE
Were rounds completed per protocol?
- Ed Status 05/11/08 1527 his 05/11/08 1527 his A => D
70 Daily Re-Assessment/Observation D PS
- Document 05/10/08 1900 DMR 05/10/08 1933 DMR
Level of Consciousness: ALERT

Does patient have IV access? Y

Respiratory Effort: Unlabored

Heart Sounds: NORMAL

Abdomen: SOFT

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)

Bowel Sounds: ACTIVE
Has patient had BM in past 24 hours? Y Date of last BM: 05/09/08
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 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==========

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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)

IV Access Type: IV- No continuous fluids

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/10/08 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?

Dressing type:

Incision appearance: Drainage tube:

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)

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****

769

DERMAL WOUND LOCATED DRESSING CHANGED?

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)

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:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

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)								

****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:

- Create 05/10/08 1932 DMR 05/10/08 1932 DMR
- Document 05/11/08 1450 JRB 05/11/08 1451 JRB

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: 05/11/08

771

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)

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 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==========

772

IV Access Type: IV- No continuous fluids

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)

Date Central Line/PORT Dressing Changed: Date PORT needle accessed:

Date of INT insertion: 05/10/08 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?

Dressing type:

Incision appearance: Drainage tube:

Drainage Amt: Drainage color:

773

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)

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****

774

DERMAL WOUND LOCATED DRESSING CHANGED?

PHOTO TAKEN? WOUND UNDERMINING? WOUND TUNNELING?

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)

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:

WOUND DRAINAGE: WOUND DRAINAGE TYPE:

DRAINAGE TUBES:

002210

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 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	05/11/08	1527	his	05/11/08	1527	his			A => D
031	Rounds: RN/LPN Q2 hours						D		PS
- Document	05/10/08	2000	DMR	05/10/08	2032	DMR			
- Create	05/10/08	2032	DMR	05/10/08	2032	DMR			
- Document	05/10/08	2100	DMR	05/10/08	2119	DMR			
- Document	05/10/08	2154	DMR	05/10/08	2154	DMR			
- Document	05/11/08	1451	JRB	05/11/08	1451	JRB			
- Ed Status	05/11/08	1527	his	05/11/08	1527	his			A => D
452	Activity 5*11AMBULATE IN ROOM/HALLWAY						D		OE
- Create	05/11/08	1059	TLJ	05/11/08	1059	TLJ			
- 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
PSR	RTPR	RENARD,PAMELLA S.	RT
TLD	RTTLD	DAVIS,TAMMIE L.	RT
TLJ	NSTLJ1	JOHNSON,TAMMY L.	US
TMP	RTTMP	PROFFIT,TINA M.	RT
his		automatic by program	

002212

Patient	Unit #	Service/Location	Status	Date	Account #
WINDHAM,TAMMY E	M000895682	CARDIOLOGY	ADM IN	05/18/08	D00502511298

PATIENT

Soc Sec No [redacted] DOB [redacted] Age 40 Sex F MS X Race CA Religion HOLINESS

Address: 6265 SHETLAND ST
SUMTER,SC 29154

Home Ph: (803)506-4697 County: SUMTER

DISCHARGE DISPOSITION

__ Routine (Home)
__ Home Health Care
__ AMA
__ Transferred To
__ Expired

Date ____ Time ____

FINAL DIAGNOSES | **CODES**

Principal:

Other Diagnoses and Manifestations

DATES	OPERATIONS AND PROCEDURES	CODES

CONSULTING PHYSICIAN/RESIDENTS

1. 2. 3. 4. 5.
6. 7. 8. 9. 10.

Signature of Attending Physician _____ Date _____

SIGNATURE FORM

Printed 05/18/08 1638

799

5999

Inpatient
PATIENT REGISTRATION FORM
SISTERS OF CHARITY PROVIDENCE HOSPITALS

2435 FOREST DRIVE
COLUMBIA, SC 29204
(803) 256-5300

120 GATEWAY CORPORATE BLVD
COLUMBIA, SC 29203
(803) 865-4500

MED REC#: M000895682
SERV/LOC: CAR
PT STATUS: ADM IN
AKA:

ADMIT DATE: 05/18/08
ROOM & BED: D.504-B
ADMIT SOURCE: EMERGENCY ROOM

TIME: 0417
ACCOM: INTERMEDIATE I

ACCT NO.: D00502511298
FIN CLASS: SP
ADM CLERK: WILLI1JD
Print D/T: 05/18/08 1638

*** PATIENT INFORMATION ***

PATIENT: WINDHAM,TAMMY E
ADDRESS: [redacted]
PHONE #:

BIRTHDATE: 10/18/67
MARITAL ST: LEGALLY SEPARAT
RELIGION: HOLINESS
MDN NAME:

AGE: 40
SS#: 247-31-1815
RACE: CAUCASIAN
SEX: F

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: WINDHAM,TAMMY E
GUAR ADDRESS: [redacted]
GUAR PHONE NO:

GUAR EMPLOYER: NOT EMPLOYED
GUAR EMP PH:
RELATIONSHIP: PATIENT
GUARANTOR SS#: 247-31-1815

*** CONTACT INFORMATION ***

NEXT OF KIN: PARROTT,MELINDA
NOK ADDRESS: [redacted]
NOK PHONE NO:
NOK REL:

PERSON TO NOTIFY: WINDHAM,THOMAS
PERSON NOTIFY ADD: [redacted]
PERSON NOTIFY PH#:
NOTIFY REL:

*** EMPLOYMENT INFORMATION ***

EMPLOYER: NOT EMPLOYED
ADDRESS:

OCCUPATION:
EMP PHONE #:

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: NO DOCTOR
ADMIT PHYSICIAN: Roberts,Michael C Dr.
ER PHYS: Hayes,Michael T Dr.

OTHER PHYSICIAN:
ATTENDING PHYS: Roberts,Michael C Dr.

INSURANCE	POLICY #	GRP #	SUBSCRIBER	AUTH #
1 SELF PAY			WINDHAM,TAMMY E	
(999)999-9999				
2				
3				

REASON FOR VISIT: RT LEG A V FISTAL
COMMENT:

U#: A#:

RUN DATE: 05/22/08
RUN TIME: 1527
RUN USER: SHEAREHD

Providence Hospital ABS **LIVE**
ATTESTATION STATEMENT

NAME: WINDHAM,TAMMY E ACCT #: D00502511298

ADM DATE: 05/18/08
ATTEND PHYS: Roberts,Michael C Dr.
DIS DATE: 05/19/08
DISCH DISP: DISCH TO HOME OR SELF CARE
LOS: 1
PT CLASS: IN

UNIT #: M000895682
SEX: F
AGE: 40
DOB: 10/18/67
FIN CLASS: SP
ABS STATUS: FINAL

DIAGNOSES:

			POA?
ADMIT:	789.00	ABDOMINAL PAIN, UNSPECIFIED SITE	
PRINC:	996.74	OTH COMPL DUE TO OTH VASCULAR DEVICE,IMPLANT,GRAFT	Y
SECOND:	272.0	PURE HYPERCHOLESTEROLEM	Y
	E879.0	ABN REACT-CARDIAC CATH	Y
	401.9	HYPERTENSION NOS	Y
	789.00	ABDOMINAL PAIN, UNSPECIFIED SITE	Y
	414.01	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY VESSEL	Y
	E849.0	ACCIDENT IN HOME	E
	V45.82	PERCUTANEOUS TRANSLUM CORON ANGIOPLASTY STATUS	E
	V58.66	LONG-TERM (CURRENT) USE OF ASPIRIN	E
	V58.63	LONG-TERM(CURRENT)USE OF ANTIPLATELET/ANTITHROMBOTIC	E
	V26.51	TUBAL LIGATION STATUS	E

OPERATIONS:

DRG: 316 OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC

STATUS	$ REIMB	MIN-LOS	MAX-LOS	STD-LOS	GRP VERS	GRP FC
F	4538.13			3.0	25	SP

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

_____ DATE _____

8/1

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

WINDHAM,TAMMY E
A# D00502511298 I#M000895682
05/18/08 F 40
Roberts,Michael C Dr:

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

CCC1010

Columbia Cardiology Consultants
Admission Orders

Admit Inpatient	Indicate Medical Reason:
Observation Status R/O conditions, complications post-op/outpt procedure, <24 hrs	Indicate Medical Reason:
Outpatient Procedure/Services Hospital stay pre-certified/pre-authorized for outpt	Indicate Medical Reason:

Admit to services of **COLUMBIA CARDIOLOGY CONSULTANTS:**

a. Notify our office of admission and room number; speak directly to the appointment secretary.
b. Notify personal physician of admission if he is in the Columbia area.
c. Obtain all old records and do EKG immediately.
d. If patient is admitted for heart cath, give cath booklet and inform of film times.
e. Under no circumstances is dictated H & P summary to be removed from chart prior to discharge.

DIET:
Low Cholesterol: 4 Gm Sodium (and 1800 Cal. ADA if diabetic). May have salt substitute
No drinks containing caffeine – May have decaffeinated coffee

RECEIVED

STUDIES:
******Have am labs on chart by 7am for rounds.******

____ Chest x-ray (portable, sitting).
____ CBCX or _____ CBCD.
____ Troponin I reflex Stat and every 6 hours x 3.
____ Total CPK, MB Fraction and Index
____ STAT CMP
____ ECG STAT and daily x 1
____ Fasting Lipid Panel
____ PT
____ Urinalysis

If referral hospital labs are to be used, place them in chart under "LAB SECTION".

ACTIVITY: PCU - As tolerated **MCCU** - Bedside commode privileges/male pts may stand to void

ROUTINES:
Vitals with SaO2 per Unit Routine
Oxygen at 2L/nasal canula PRN short of breath, chest pain or SaO2 less than 92%. Titrate to keep SaO2 greater than 92%.
12 Lead EKG STAT for any prolonged and severe chest pain x 1 episodes – but if patient has documented 100% paced rhythm delete this order.
INT and flush with 1ml NS each shift. Use left arm preferably.
Intake and Output
Daily Weights
ABG's may be obtained at nurses' discretion

MEDICATIONS:
List current home meds in Meditech (and hospital meds if transfer) and obtain appropriate orders from MD.
Enteric Coated ASA 325 mg PO daily

8 ,2

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D0050251129R
05/18/08 F 40
Roberts,Michael C Dr. D.504-B

CCC1010

PRN MEDICATIONS:
Tylenol #3 (acetaminophen 300 mg/codeine 30 mg) 1-2 tablets PO q4h PRN pain. (Note: Acetaminophen total daily dose from all sources not to exceed 4000 mg.)
Darvocet-N 100 (propoxyphene 100 mg/acetaminophen 650 mg) 1-2 tablets PO q4h PRN pain if allergy to Codeine. (Note: Acetaminophen total daily dose from all sources not to exceed 4000 mg.)
NTG 0.4 mg tablet sublingually PRN chest pain. May repeat every 5 minutes x 2 additional doses.
Dilaudid (hydromorphone) 1-2 mg IV over 5 minutes q3h PRN severe chest pain or chest pain not relieved by NTG. **Notify MD.**
Restoril (temazepam) 15 mg PO at bedtime PRN insomnia. May repeat x 1 dose.
Xanax (alprazolam) 0.25 mg q4h PRN anxiety. Xanax 0.125 mg for patients over 70 years of age.
Reglan (metoclopramide) 10 mg IV q4h over 2 minutes PRN nausea and vomiting.
Zofran (ondansetron) 4 mg IV q 4 hours PRN nausea not relieved by Reglan.
MOM (magnesium hydroxide suspension) 30 ml PO q12h PRN constipation
Regitine (phentolamine) 5 mg diluted in 10 ml 0.9% Sodium Chloride subcutaneously (use smallest gauge needle) to affected ischemic area at IV site PRN IV dopamine infiltration. May repeat x 1 dose if large infiltrate.
Atropine 0.5mg IV PRN symptomatic heart rate less than 40. May repeat q5minutes to a total of 3mg IV and **Notify MD.**

If on Heparin, adjust per Providence Heparin Protocol.

DIABETIC PRECAUTIONS:
Follow Providence Hospitals Hypoglycemia protocol.

If a doctor has not seen patient by 9:00 P.M., notify answering service to contact the doctor on call.

Follow current ACLS protocols for pulseless VT, V-fib, asystole, EMD or symptomatic bradycardia less than 35 BMP and **Call MD immediately**.

Med- Surg and PCU Patients Only: If patient has a history of sustained V-tach they **must** be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and no V-tach by monitor x 48 hours. If there are questions, contact M.D.

SIGNATURE W.O Dr. M. Roberts / S. Rahm DATE 5-18-08

S. STANLEY JUK JR. MD
EUGENE F. SCHWARZ, MD
R. TAYLOR WILLIAMS, MD
JOSEPH H. LAWTON, MD
RICHARD E. UMBACH, MD
AMY EPPS, MD
MICHAEL C. ROBERTS, MD
ROBERT M. MALANUK, MD
ERIC E. SHOUP, MS PAC

ORIGINAL: 1/1/04
Revised: 12/04. 5/8/08, 5/14/08

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D00502511298 U#M000895682
05/18/08 F 40
Hayes,Michael T Dr.

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time: AM PM	Profiled by:	Filled by:	Checked by:

ADMIT M Roberts pcu
DX: (R) LEG A-V. fistula
Card: guarded
Allergies: NKDA

Demerol 50/phenergan 125 IV q6 prn pain

Physician Signature: [signature] 5/18/8 Beeper #:

Date: 5-18-08	Time: 0600 AM PM	Profiled by:	Filled by:	Checked by:

Home Meds ECASA ~~81~~ 325 mg PO Q Day
lopressor 25mg PO Q Day
Plavix 75 mg PO Q Day
Pravastatin 40 mg QHS
Lisinopril 20mg PO Q Day

Physician Signature: [signature] Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D005025112 98 W000005682
05/18/08 F 40
Roberts,Michael C Dr. U:504-B

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/18	AM PM			

Percocet I-II po q 4-6° prn leg pain

ultrasound of (R) groin - Radiology to f/u

A-V fistula. s/p cath pain and LEV.

cancel - done

Physician Signature: [signature] Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/18	1605 AM PM			

~~consult~~ Dr. Zuncher re ~~A-V fistula.~~

5/18/08 per CBC in am.

1% lidocaine to floor.

SCANNED

Physician Signature: [signature] Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM TAMMY E
A# D005025112 08 M000895682
05/18/08 F 40
Roberts.Michael C Dr.

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/18/08	1020 AM PM			

1. percocet one tab po q 4 hrs PRN moderate pain
2. percocet two tabs po q 6 hrs PRN severe pain
To Dr Lanter / Fax
Read back and verified

Physician Signature: Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/19	1010 AM PM			

✓ DC lines
✓ Fax Dr. Lanter Labs with same day U/S (R) groin

Physician Signature: Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00502511298
DR: Roberts,Michael C D
DIAGNOSIS: RT LEG A V FISTAL
VERIFIED BY: _____

ROOM: D.504-B
AGE: 40 SEX: F
ADMITTED: 05/18/08
[redacted]

5 3.00 (FT/IN) / 160.02 (CM) 15415.76 (LB/OZ) / 70.300 (KG)

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/19/08 TO 0659 05/20/08

START/STOP	0700-1459	1500-2259	2300-0659

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS

WINDHAM,TAMMY E 40/F DR: Roberts,Michael C D ROOM: D.504-B

116/50, 62, 20, 98²
- BS = 118

807

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 1

D00502511298 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.504 B
AGE: 40 SEX: F WT: 70.3kg BSA: 1.79
ADMITTED: 05/18/08 PHYSICIAN: Roberts,Michael C Dr.
NOTES:

PRIMARY DX: RT LEG A V FISTAL
MAR DATE: 05/19/08-0700 TO 05/20/08-0659
RUN DATE/TIME: 05/19/08-0110
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** SCHEDULED MEDS *****				
Rx#: 03050759	ASPIRIN 325 MG TABEC (325 MG) (Ecotrin) DOSE: 325 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T	05/18/08 SCH	1000 MH		
Rx#: 03050918	CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (Plavix 75MG) DOSE: 75 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T	05/18/08 SCH	1000 DAH		
Rx#: 03050920	LISINOPRIL 20 MG TAB (20 MG) (PRINIVIL) DOSE: 20 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T	05/18/08 SCH	1000 DAH		
Rx#: 03050917	METOPROLOL TARTRATE 25 MG TAB (25 MG) (Lopressor 25MG) DOSE: 25 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T	05/18/08 SCH	1000 DAH		
Rx#: 03050919	PRAVASTATIN SOD 20 MG TAB (40 MG) (Pravachol) DOSE: 40 MG PO SIG: DAILY AT BEDTIME INVENTORY from D5T	05/18/08 SCH		2200	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				D Hammond	MH
					808

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 2

D00502511298 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.504 B
AGE: 40 SEX: F WT: 70.3kg BSA: 1.79
ADMITTED: 05/18/08 PHYSICIAN: Roberts,Michael C Dr.
NOTES:

PRIMARY DX: RT LEG A V FISTAL
MAR DATE: 05/19/08-0700 TO 05/20/08-0659
RUN DATE/TIME: 05/19/08-0110
VERIFIED BY: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 03050723 MEPERIDINE HCL 50 MG/ML AMP (None) (Demerol) DOSE: 50 MG IV SIG: EVERY 6 HOURS AS NEEDED COMMENTS: PRN PAIN **GIVE WITH PHENERGAN** DOSE INSTR: 50 MG INVENTORY from D5T		05/18/08 PRN			
Rx#: 03050921 OXYCODONE HCL/ACETAMINOPHEN 5/325 TABLET (None) (Percocet 5/325 MG Tablet) DOSE: 1 TAB PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PRN MODERATE PAIN DOSE INSTR: 1 TAB INVENTORY from D5T		05/18/08 PRN			
Rx#: 03050922 OXYCODONE HCL/ACETAMINOPHEN 5/325 TABLET (None) (Percocet 5/325 MG Tablet) DOSE: 2 TABS PO SIG: EVERY 6 HOURS AS NEEDED COMMENTS: PRN SEVERE PAIN DOSE INSTR: 2 TABS INVENTORY from D5T		05/18/08 PRN	0830 2 tabs DAH		
Rx#: 03050724 PROMETHAZINE HCL 25 MG/ML AMP (12.5 MG) (Phenergan Amp) DOSE: 12.5 MG IV SIG: EVERY 6 HOURS AS NEEDED COMMENTS: PHENERGAN **PRN PAIN**GIVE WITH DEMEROL** INVENTORY from D5T		05/18/08 PRN			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				D Hammond	809

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM, TAMMY E
ACCT: D00502511298
DR: Roberts, Michael C D
DIAGNOSIS: RT LEG A V FISTAL
VERIFIED BY:

ROOM: D.504-B
AGE: 40 SEX: F
ADMITTED: 05/18/08 [redacted]

(FT/IN) / (CM) 157 0.04 (LB/OZ) / 71.215 (KG)

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/18/08 TO 0659 05/19/08

	START/STOP	0700-1459	1500-2259	2300-0659
Demerol 50 g/Phenergan 12.5 mg IV 26° PRN pain	5/18		1210 ~ 0440	0645
ECASA daily 325 mg PO ok Verify	5/18/0	1000 ~		
Lopressor 25 mg PO Q Day ok Verify		1700 ~		
Plavix 75 mg PO Q Day o/c Verify		1700 ~		
Pravastatin 40 mg Q HS PO ok Verify			2200	
Lisinopril 20 mg PO Q Day ok Verify		1000 ~		
Percocet · one TAB PO Q 4° PRN moderate pain	5/18	1034		

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
[illegible]	[illegible]			[illegible]	[illegible]

WINDHAM, TAMMY E 40/F DR: Roberts, Michael C D ROOM: D.504-B

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM, TAMMY E
ACCT: D00502511298
DR: Roberts, Michael C D
DIAGNOSIS: RT LEG A V FISTAL
VERIFIED BY: _____

ROOM: D.504-B
AGE: 40 SEX: F
ADMITTED: [redacted]

(FT/IN) / (CM) 157 0.04 (LB/OZ) [redacted]

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/18/08 TO 0659 05/19/08

	START/STOP	0700-1459	1500-2259	2300-0659
Percocet two (2) tabs PO q 6hrs PRN severe pain	5/18		~~1800~~	
1% Lidocaine to floor				

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS

WINDHAM, TAMMY E 40/F DR: Roberts, Michael C D ROOM: D.504-B

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00502511298
DR: Roberts,Michael C D
DIAGNOSIS: RT LEG A V FISTAL
VERIFIED BY: _____

ROOM: D.504-B
AGE: 40 SEX: F

(FT/IN) / (CM) 157 0.04 (LB/OZ) / [redacted]

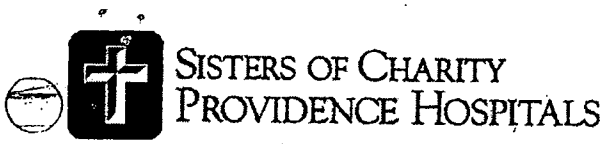
ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/18/08 TO 0659 05/19/08

START/STOP	0700-1459	1500-2259	2300-0659

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
				[illegible]	TD

WINDHAM,TAMMY E 40/F DR: Roberts,Michael C D ROOM: D.504-B



SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D00502511298 U#M000895682
05/18/08 F 40 [redacted]
Roberts,Michael C Dr. D.504-B

Columbia Cardiology Consultants
Standard PRN Medications

Medication / Dose / Route Frequency	Start / Stop	0700 – 1459	1500 – 2259	2300 - 0659
Tylenol #3 (acetaminophen 300mg/codeine 30mg) 1-2 tabs PO q4h PRN pain (Note: Acetaminophen total daily dose not to exceed 4000mg from all sources.)				
Darvocet-N-100 1-2 tablets PO q4h PRN pain if allergic to codeine. (Note: Acetaminophen total daily dose not to exceed 4000mg from all sources.)				
Restoril 15mg PO at bedtime PRN insomnia. May repeat X 1				
NTG 0.4mg SL PRN chest pain. May repeat every 5 minutes x 2 additional doses.				
Dilaudid 1-2mg IV over 5 minutes q3h PRN severe chest pain or chest pain not unrelieved by 3 sublingual NTG. Notify MD				
Reglan 10mg IV over 2 minutes q4h PRN nausea and vomiting.				
Zofran (ondansetron) 4mg IV q4h PRN nausea not relieved by reglan.				
Xanax 0.25mg PO q4h PRN anxiety 0.125mg for patients over 70 years of age				
MOM (magnesium hydroxide suspension) 30ml PO q12h PRN constipation.				
Regitine 5mg diluted in 10ml 0.9% sodium chloride use smallest gauge needle SQ to affected ischemic area at IV site PRN Dopamine infiltration. May repeat x 1 if large infiltration.				
Atropine 0.5mg IV PRN Symptomatic heart rate less than 40. May repeat q5minutes to a total of 3mg IV. Notify MD				

Signature	Initials	Signature	Initials	Signature	Initials
				813	

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

002227

WINDHAM,TAMMY E
A# D0050251129[redacted]2
05/18/08 F 40
Roberts,Michael C Dr. D.504-B

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS; CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
5/18	792802
	40yo c̄ hx CAD s/p recent stent (L) cx c̄ (2) Taxus stents.
	c/o (R) groin pain since day p̄ cath.
	LEV (-)
	u/s (R) groin ? AV fistula
	Exam: ø bruit ø hematoma
	pulses nl.
	WBC mildly ↑ 13.3 o/w (-) lab
	Imp: (R) groin pain ? femoral n.
	injury. ? small AV fistula, but
	Plan: Analgesics
	rev CBC.
	Ambulate as tol.
	prob DC in am.
	Discussed c̄ Dr. Zurcher,
	she suggests repeat study in 1 month

814

NUR018 (1/03)

PROGRESS RECORD

6014

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

002228

WINDHAM, TAMMY E
A# D00502511298 U#000895682
05/18/08 F 40 [redacted]
Roberts, Michael C Dr. D.504-B

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
5/19	Less leg pain
	118/50
	(R) groin ⅕ bruit UBE 9.5 L
	pulses 2+
	Car RRR ⅕ Δ.
	~~Frey~~ ? AV fistula (R) groin (small)
	Plan DC home
	Flu u/s in ⅕ no.
	Percocet for pain.
	792886

815

NUR018 (1/03)

PROGRESS RECORD

6015

Age/Sex: 40 F
Unit #: M000895682
Account#: D00502511298
Admitted: 05/18/08 at 0417

WINDHAM,TAMMY E (ADM IN)
D.5T-D.504-B
Roberts,Michael C Dr.
Providence Hospital Nursing **L

Printed 05/19/08 at 1054
Period ending 05/19/08 at 1054
DISCHARGE INSTRUCTIONS

Occurred Date	Time	by	Author	Recorded Date	Time	by	NURSE
05/19/08	1051	DAH	HANNA,DEE A	05/19/08	1052	DAH	

Abnormal? N Confidential? N

NOTIFY PHYSICIAN IF SYMPTOMS RETURN OR BECOME WORSE

816

Age/Sex: 40 F
Unit #: M000895682
Account#: D00502511298
Admitted: 05/18/08 at 0417

WINDHAM,TAMMY E (ADM IN)
D.5T-D.504-B
Roberts,Michael C Dr.
Providence Hospital Nursing **L

Printed 05/19/08 at 1054
Period ending 05/19/08 at 1054
DISCHARGE INSTRUCTIONS

Patient Discharge Instruction 05/19/08 1051 DAH

Patient Discharge Instructions Please Bring Copy To Office With You

Diet: LOW FAT,CHOL,SODIUM

Enter/Edit/View Notes: Y Use F4 - F9 to Access DISCHARGE Notes.

Follow-Up Appointment: SEE DR LAWTON JUNE 16, 2008 AT 2:30 PM

Call Doctor's Office: 744-4900

Call Doctor's Office:

Date to Return to Work/School:

Exercise or Special Limitations
: AS TOLERATED

Dressing, Treatment, Special Equipment
:

Special Instructions
: NOTIFY PHYSICIAN IF SYMPTOMS RETURN OR BECOME WORSE

Tobacco Use+: REF SMOKER Smoking Cessation Information Provided+: Y
Pt. has 'A Patient's Guide to Safety' in possession at discharge: Y
All Teaching Information Given to the Pt is in Folder: Y

Interdisciplinary Discharge Medication List Given To Pt/Family

Pt or Family Recieved the Following Items
Hearing Aides+: Contact Lens+: Glasses+: Dentures+: Prosthesis+:
Valuables Brought to Hospital Returned+: Y
Medications Brought to Hospital Returned+:
Clothing brought to Hospital Returned+: Y

I Have Received a Copy of Both My Discharge Medication List and My Discharge Plan of Care.
**
Pt/SO Signature: Tammy Windham Date:

***** These Numbers are Provided for your Convenience *****

MAIN CAMPUS
Lost and Found - 256-5690
Patient Financial Services - 256-5505
Medical Records - 256-5302
Patient Advocate - 256-5739

NORTHEAST CAMPUS
Lost and Found - 865-4690
Patient Financial Services - 865-5816
Medical Records - 865-4680
Patient Advocate - 256-5739

Stop Using Tobacco In Any Form. It Has Been Shown To Reduce Healing. No Smoking!

Call Your Physician If You Have Worsening Symptoms.

Age/Sex: 40 F
Unit #: M000895682
Account#: D00502511298
Admitted: 05/18/08 at 0417

WINDHAM,TAMMY E (ADM IN)
D.5T-D.504-B
Roberts,Michael C Dr.
Providence Hospital Nursing **L

Printed 05/19/08 at 1054
Period ending 05/19/08 at 1054
DISCHARGE INSTRUCTIONS

Patient Discharge Instruction 05/19/08 1051 DAH

If You Have Heart Failure - Weigh Yourself Daily And Write It Down. Call Your Physician If You Gain 2-3 Lbs. Overnight Or Over A 1-2 Day Period.

********** NURSING DISCHARGE CHECKLIST **********

Discharge Instructions 1 +: OTHER
Discharge Instructions 2 +:
Discharge Instructions 3 +:
Mode of Discharge+: WC
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
Notify MD's (If Applicable) Name:
Time:

IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Foley Removed:
Voided Prior To Discharge:
BM Documented 2-3 Days Prior to Discharge:

Narcotic Analgesic was Given within 6 hours Prior to Discharge, Notify Attending Physician.
Name: Time:

Pneumovax Given: N
Flu Vaccine Given: N
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Other:

ACE-Inhibitor Prescribed at Discharge: Y
ARB Prescribed At Discharge: N
If Not, Follow Up Plans Are+: FOLLOW MD
If not, Follow Up Plans Are+:

Monogram Initials	Name	Nurse Type
DAH	HANNADA HANNA,DEE A	RN

818

RUN DATE: 05/19/08
RUN TIME: 1000
RUN USER: GARRICCE

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5T D.504-B D00502511298 40/F WT: lbs.
ATTENDING PHYSICIAN: Roberts,Michael C Dr.

NUR ALLERGY: NO KNOWN DRUG ALLERGIES
PHA ALLERGY: NO KNOWN DRUG ALLERGIES

DISCHARGE MEDICATION LIST

MEDICATION	DOSE	ROUTE	DIRECTIONS	SHOULD PATIENT CONTINUE TAKING THIS MEDICINE AT HOME? (PLEASE CIRCLE ONE)	
ASPIRIN (Ecotrin)	325 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO
METOPROLOL TARTRATE (Lopressor 25MG)	25 MG	ORAL	~~DAILY AT 1000 (10:00AM) DAILY~~ BID	YES	NO
CLOPIDOGREL BISULFATE (Plavix 75MG)	75 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO
PRAVASTATIN SOD (Pravachol)	40 MG	ORAL	DAILY AT BEDTIME HS	YES	NO
LISINOPRIL (PRINIVIL)	20 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO

HOME MEDICATION LIST		CONTINUE THIS MEDICATION	
BAYER ASA	~~81MG~~ 325	YES	NO
LOPRESSOR	25MG BID	YES	NO
		YES	NO
		YES	NO
PLAVIX 75MG ONCE A DAY		YES	NO
PRAVASTATIN 40MG ONCE A DAY IN THE EVENING		YES	NO
LISINOPRIL 20MG ONCE A DAY		YES	NO
		YES	NO
		YES	NO
Percocet every 6 hrs as needed		YES	NO
T-II for pain		YES	NO
		YES	NO
		YES	NO
		YES	NO
		YES	NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

RUN DATE: 05/19/08
RUN TIME: 1000
RUN USER: GARRICCE

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5T D.504-B D00502511298 40/F WT: lbs.
ATTENDING PHYSICIAN: Roberts,Michael C Dr.

	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO

DOCTOR: THIS LIST IS BEING PROVIDED TO YOUR PATIENT AS PART OF HIS/HERE DISCHARGE INSTRUCTIONS.
PLEASE COMPLETE THE FOLLOWING SECTION AND SIGN.

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

820

RUN DATE: 05/19/08
RUN TIME: 1000
RUN USER: GARRICCE

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5T D.504-B D00502511298 40/F WT: lbs.
ATTENDING PHYSICIAN: Roberts,Michael C Dr.

(1) WILL MEDICATIONS BE NEEDED FOR PAIN MANAGEMENT? ___YES ___NO IF SO, PLEASE INCLUDE IN THE LIST ABOVE

(2) LIST ANY HOME MEDICATIONS THAT THE PATIENT IS TO CONTINUE AS WELL AS INSTRUCTIONS FOR USE
ALSO INCLUDE ANY OTHER MEDICATIONS NOT ALREADY LISTED WHICH YOU WISH THE PATIENT TO CONTINUE

NURSE'S REVIEW OF DISCHARGE MEDICATION LIST

Review with Patient / Family Person's Name:_____

Does patient/family have a full understanding? ___YES ___NO

If Not, Indicate concerns:

Food/Drug Interaction Sheet is in Patient Education Folder.

Prescriptions given to Patient/Family, copied and placed in medical record? ___YES ___N/A

DO NOT TAKE ANY MEDICATIONS NOT LISTED ABOVE WITHOUT CONSULTING YOUR DOCTOR OR PHARMACIST

NURSE SIGNATURE:_____

MD SIGNATURE:_____

ABBREVIATIONS DICTIONARY

AC = BEFORE MEALS
AC&HS = BEFORE MEALS AND AT BEDTIME
BID = TWICE DAILY
HS = DAILY AT BEDTIME
PC = AFTER MEALS
PC&HS = AFTER MEALS AND AT BEDTIME
PO = BY MOUTH
PREOP = BEFORE PROCEDURE
PRN = AS NEEDED
Q = EVERY
QAM = EVERY MORNING
QID = 4 TIMES DAILY
TID = 3 TIMES DAILY
NPO = NOTHING BY MOUTH

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

11 Lower Extremity Injury (4)

DATE: _____ TIME: _____ ☐ on arrival
ROOM: _____ __ EMS Arrival _____
HISTORIAN: patient family paramedics _____
__HX / __EXAM LIMITED BY: _____

HPI

chief complaint: Injury to: right / left
foot ankle leg knee thigh hip

duration / occurred:
just prior to arrival
today _____
yesterday
5 days ago

where:
home school
neighbor's park
work street
Mustang

context: fell twisted direct blow incised burn
CAT 4

severity of pain: mild moderate severe

associated symptoms: painful / unable to bear weight
~~snap / crack / pop sensation~~

location of injury:
R LE foot toes
L LE foot toes
leg

ROS ~~tingling / numbness distally~~ suspected FB (skin lac)
~~head / neck / other injuries~~ ~~recent illness~~

PAST HX __negative prior injury _____
diabetes Type 1 Type 2 diet / oral / insulin
CAD HTN
Meds- __none / see nurses note
Allergies- __NKDA / see nurses note
Smoke

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☐ Tetanus immun. UTD

PHYSICAL EXAM

General Appearance
__no acute distress
__alert
__c-collar (PTA / in ED) / backboard _____
__mild / moderate / severe distress _____
__anxious _____

EXTREMITIES

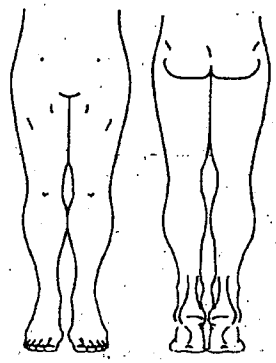
FOOT
__nml inspection
__non-tender
__nml color / temp
__skin intact
__see diagram _____
__tenderness soft-tissue / bony _____
__swelling / ecchymosis _____
__deformity _____
__pulse deficit _____

ANKLE
__nml inspection
__non-tender
__nml ROM
__no joint swelling
__skin intact
__see diagram _____
__tenderness soft-tissue / bony _____
__swelling / ecchymosis _____
__limited ROM _____
__laxity of ligaments _____
__deformity _____

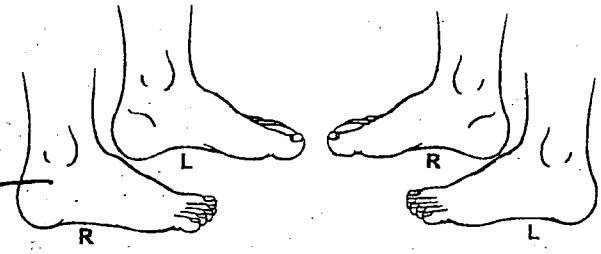
LEG
__nml inspection
__non-tender
__no evidence of ischemia
__see diagram _____
__tenderness soft-tissue / bony _____
__swelling / ecchymosis _____
__limited ROM _____

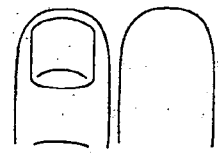
KNEE
__nml inspection
__non-tender
__nml ROM
__stable
__see diagram _____
__tenderness soft-tissue / bony _____
__ecchymosis _____
__joint effusion / swelling _____
__limited ROM _____
__deformity _____
Ligaments-
__pain / laxity on anterior drawer _____
__pain / laxity on posterior drawer _____
__pain / laxity on medial stress _____
__pain / laxity on lateral stress _____

THIGH / HIP
__nml inspection
__tenderness soft-tissue / bony _____
__swelling / ecchymosis _____
__limited hip ROM _____
__hip pain on leg movement _____



severity of pain:





T=Tenderness S=Swelling E=Ecchymosis
B=Burn C=Contusion Lac=Laceration
A=Abrasion PW=puncture wound
(Ø =without m=mild mod=moderate sv=severe)
Example- Tsv = Tenderness on palpation (severe)

GAIT
__normal
__limited by pain / unable to bear weight _____
__antalgic gait
__gait not tested due to pain

NEURO / VASC / TENDON
__sensation intact
__motor intact
__sensory / motor deficit _____
__no vascular compromise
__pallor / cool skin / abnml cap refill _____
__pulse deficit _____
__deficit in tendon function _____

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MR. EDPHYSREC

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 Forest Drive Columbia, SC 29204
EMERGENCY PROVIDER RECORD

WINDHAM,TAMMY E
A# D00502511298 U#M000895682
05/18/08 F 40
Hayes,Michael T Dr.
822

SKIN
✓ warm, dry
__diaphoretic / cool / cyanotic
__ecchymosis / abrasion / laceration

HEAD / ENT
✓ nml inspection
✓ pharynx nml
__tenderness
__swelling / ecchymosis

NECK / BACK
✓ nml inspection
✓ non-tender
__tenderness
__swelling / ecchymosis

RESPIRATORY
✓ chest non-tender
✓ breath sounds nml
__tenderness
__swelling / ecchymosis / abrasions
__crepitus / subcutaneous emphysema
__decreased breath sounds
__wheezes / rales / rhonchi

CVS
✓ heart sounds nml
__tachycardia / bradycardia

ABDOMEN
✓ non-tender
✓ no organomegaly
__tenderness / guarding

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist

R / L foot ankle tib/fibula knee femur hip

__normal / NAD
__no fracture
__nml alignment
__no foreign body
__DJD
__dislocation
__soft-tissue swelling
__foreign body
__fracture *non-displaced displaced*
transverse oblique comminuted angulated impacted torus

Other study:

☐ See separate report

PROCEDURES

Wound Description / Repair

length_____cm location_____
linear irregular flap stellate
superficial *subcut *muscle through-and-through
contused tissue
clean contaminated *moderately / *heavily*
distal NVT: neuro & vascular status intact no tendon injury
anesthesia: local LET / tetracaine / adrenaline / cocaine _____mL
marcaine 0.25% 0.5% lidoc 1% 2% epi / bicarb digital / metatarsal block
prep:
Betadine / Phisohex
irrigated / washed w/ saline
*minimal / mod. / *extensive*
wound explored
foreign material removed
partially completely
*minimal / mod. / *extensive*
no foreign body identified
debrided
*minimal / *mod. / ^extensive*
undermined
minimal / mod. / ^extensive
^wound margins revised
multiple flaps aligned

repair: *Wound closed with: wound adhesive / Dermabond / steri-strips*
SKIN- #_____ _____-0 nylon / prolene / staples / ethilon_____
interrupted running simple mattress (h / v)
*SUBCUT- #_____ _____-0 vicryl / chromic_____
interrupted running simple mattress (h / v)
OTHER- #_____ _____-0 _____
interrupted running simple mattress (h / v)
*may indicate intermediate repair ^may indicate complex repair

KNEE-
knee immobilizer crutches neoprene sleeve_____
arthrocentesis done after betadine prep; _____mL
of serous serosanguinous bloody fluid removed

ANKLE-
ace wrap / tape boot orthosis crutches post-op shoe
air cast neoprene_____
splint *stirrup / posterior* OCL / Ortho-glass / plaster
applied by ED Physician / Orthopedist / Tech_____

examined post splint application
neurovasc intact alignment good

PROGRESS

~~Time~~ unchanged improved re-examined

Venous doppler (−)
U/S ⇒ suspicious
for AV fistula

__Rx given
__referred to / discussed with Dr. M Robert
will see patient in: ED / hospital / office in _____days

CLINICAL IMPRESSION

Fall Alleged Assault

Contusion R / L hip thigh leg
Hematoma knee ankle foot
Laceration
Sprain / Strain / Dislocation
Fracture R / L *stabilized / restorative*
tibia *distal / shaft / proximal*
fibula *distal / shaft / proximal*
bimalleolar trimalleolar talus calcaneus
navicular metatarsal phalanx#:_____
Internal Derangement of Knee R / L
AV fistula (R) L

DISPOSITION- ☑ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☑ improved ☑ stable

_____ *MD / DO*

002237

2601 Laurel Street • Suite 260 • Columbia, SC 29[illegible] (803) 744-4900
107 West Hospital Drive • West Columbia, SC 291[illegible] (803) 744-4940
114 Gateway Blvd., Suite 320 • Providence N.E. • Columbia, SC 29203 • (803) 744-4900

Columbia Cardiology Consultants

Reg. No. AJ645[illegible]
Joseph J. Lawton, III, M.D.
Reg. No. BL3197058
Michael C. Roberts, M.D.
Reg. No. BR2195964

Reg. No. AS1039494
Richard E. Umbach, M.D.
Reg. No. AU8135495
R. Taylor Williams, M.D.
Reg. No BW7128425

Reg. No.BM4950069
Eric E. Shoup, M.S., PA-
Reg. No. A744CD

Date: 5-18-08
Name: Tammy Windham
Address:

Please label contents

If you have questions regarding this prescription, please call (803) 744-4900

	Mg.	No.	Directions	Refills
1. Percocet		30	T ii q 6° prn pain	Ø
2.				
3.				
4.				
5.				

Dispense As Written _____ M.D.

Joseph Lawton _____ M.D.
Substitution Permitted

Tammy Windham
has an appointment
6-16-08
Month Day Year

at _____ AM 2:00 PM

My appointment is at the following location:

- [x] 2601 Laurel Street, Suite 260, Columbia, SC 29204, (803) 744-4900
- [x] 107 West Hosp.Drive, West Columbia, SC 29169, (803) 744-4940
- [ ] 114 Gateway Blvd., Suite 320, Providence N.E. Columbia, SC 29203, (803) 788-3147

My appointment is with

- [ ] S. Stanley Juk, Jr., M.D.
- [x] Joseph J. Lawton, III, M.D.
- [ ] Michael C. Roberts, M.D.
- [ ] Eugene F. Schwarz, M.D.
- [ ] Thomas E. Hearon, III, M.D.
- [ ] Richard E. Umbach, M.D.
- [ ] R. Taylor Williams, M.D.
- [ ] Robert M. Malanuk, M.D.

WINDHAM,TAMMY E
A# D00502511[illegible]
05/18/08 F 40
Roberts,Michael C Dr. D.504-B

823

6024

PROVIDENCE HOSPITAL
A Sisters Of Charity Ministry
2435 Forest Drive
Columbia, SC 29204

PROVIDENCE HOSPITAL NORTHEAST
120 Gateway Corporate Blvd.
Columbia, South Carolina 29203

002238
WINDHAM, TAMMY E
A# D00502511298 U#M000895682
05/18/08 F 40
Hayes, Michael T Dr.

EMERGENCY DEPARTMENT

LABS		Radiology/CT/US		Medications/Other
CBCX	BMP	PCXR	Pa/Lat CXR	Venous duplex done 05/19/1
CBCD	CMP	Abd 1 View	Abd 2 View	RUE
BTNP	HCG Urine		TROP/CK/Myo	ULE ⇒ pseudo aneurysm
Amylase	HCG Serum	CT→		
Lipase	Rapid Strep	US→		
Wet Prep	GC Culture	**Nursing Procedures**		
UA-C	Chlamydia	IV _____ @ _____ ml/hr		
ABG		O2 _____ LPM via _____		
PT	PTT	Monitor	INT	
		Old Records	EKG	

Physician Signature

Diagnosis (R) A-V fistula

☐ Wound Care ☐ Burn Care ☐ Vomiting & Diarrhea ☐ Head Injury ☐ Other

☐ Follow-up with regular M.D. ☐ Referral to

☐ May use Tylenol or Advil as directed

May return to work / school

Additional Instructions Admit M Rehab

PROVIDENCE HOSPITAL
A Sisters Of Charity Ministry
2435 Forest Drive
Columbia, SC 29204
(803) 256-5320

PROVIDENCE HOSPITAL NORTHEAST
120 Gateway Corporate Blvd.
Columbia, SC 29203
(803) 865-4530

EMERGENCY DEPARTMENT

DATE

NAME

ADDRESS

Richard A. Boyer, MD
SC Lic # 9408
DEA # AB8750766

Donald G. Moore, MD
SC Lic # 11453
DEA # AM1668346

David C. Winn, MD
SC Lic # 13733
DEA # BW1140970

Anoma Gamage, MD
SC Lic # 22010
DEA # BG5440867

D. Langston Powell, MD
SC Lic # 14016
DEA # BP0964975

Robert Ramos, MD
SC Lic # 19001
DEA # BR5132701

Michael Hayes, MD
SC Lic # 17402
DEA # BH3158486

Michael P. Taillon, MD
SC Lic # 13613
DEA # BT0941737

Label with Drug Name / Strength	No.	DIRECTIONS	Refill

824

EMR003 (11/07) DISPENSE AS WRITTEN _____ M.D./D.O. SUBSTITUTION PERMITTED _____ M.D./D.O.

6025

RUN DATE: 05/18/08
RUN TIME: 0121
RUN USER: SMOAKME

Providence Hospital EDM **LIVE**
EDM Assessments

Patient D00502511298 WINDHAM,TAMMY E

ED Home Medication List

Date 05/18/08 Time 0117 User SMOAK,MARY E

Does Patient Take Any Home Medicines: Y

ASA: Y	Type+: BAYER ASA	Dose: 81MG		Dose in Last 24h: Y
Beta-Blocker: Y	Name+: LOPRESSOR	Dose: 25MG		Dose in Last 24h: Y
ACE-I: N	Name+:	Dose:		Dose in Last 24h:
ARB: N	Name+:	Dose:		Dose In Last 24h:

List All Home Medications (except those listed above), Include Med. Name, Dose, Route, & Frequency. Also Include Any Over-The-Counter Medicines, Herbal Remedies Or Vitamins

PLAVIX 75MG ONCE A DAY	Dose In Last 24h: Y
PRAVASTATIN 40MG ONCE A DAY IN THE EVENING	Dose In Last 24h: Y
LISINOPRIL 20MG ONCE A DAY	Dose In Last 24h: Y
	Dose In Last 24h:
	Dose In Last 24h:
	Dose In Last 24h:

Patient D00502511298 WINDHAM,TAMMY E

ED Triage Assessment

Date 05/18/08 Time 0110 User SMOAK,MARY E

Patient Age: 40

~~~~~EMERGENCY DEPARTMENT TRIAGE ASSESSMENT~~~~~

Mode of Arrival+: AMBULATORY
Accompanied By+: FAMILY

~~~~~Treatment Prior To Arrival~~~~~
Y/N/U: N O2: IV: FSP:
Meds:

Focused Assessment of Stated Complaint:
PT STATES THAT SHE HAD TWO STENTS PUT IN ON TUESDAY AND EVER SINCE SHE HAS HAD PAIN IN HER RIGHT GROIN DOWN TO HER LEG.

Is pat. at risk for Self-harm and/or presents with a psychiatric or behavorial complaint: N

~~~SCREENING QUESTIONS~~~

~~~~~~~~Vital Signs~~~~~~~~

Blood Pressure: 210/108
SPO2 (%): 97
Pulse: 88
On Room Air:
Respirations: 16
on: LPM O2
Temperature: 98.1
Via+:
Temp Source+: ORL

~~~~~Initial Pain Assessment~~~~~
Pain: Y
Pain Location+: GROIN
Pain Scale: 4
Radiation:
Pain Description+:
Onset:
Timing+:

~~~~~Visual Acuity~~~~~
R Eye:
L Eye:
Both:

Weight - Lb: 157
Oz:
Kg: 71.215

Is Pt Pregnant:
Gravida:
LMP: 04/21/08
Para:
EDC:
Abortions:

~~~~Immunizations~~~~
Tetanus (Within 5 Yrs): Y
Pneumovax (Last 5 Yrs): Y
Influenza (Within 1 yr): Y
Immunizations UTD:

~~~~Tuberculosis Screening-Symptoms and History~~~~

Fever: N
Night sweats: N
Bloody sputum: N
Hx. Positive PPD: N
Unexplained weight loss: N
Persistent cough > than 3 wks: N
Exposure to TB within last 3 mths: N
Chest xray to rule out TB: N

~~~~~ALLERGIES~~~~~

Medication/Other Allergies: NO KNOWN DRUG ALLERGIES
Food Allergies: NKFA NO KNOWN FOOD ALLERGIES
Contrast Allergy: N
Latex Allergy: N
Primary Doctor: LAWTON
Assign Triage Priority Now:
Triage - Additional Comments:
Triage Interventions Performed:
Triage Assessment Complete:

~~~~~Triage Interventions~~~~~

Ice Pack:
Elevation:
Pressure Applied:
Tetanus Given:
Location+:
Tylenol Given:
Motrin Given:
Dose:
Comment:

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

2435 Forest Drive
Columbia, South Carolina 29204

CARDIOPULMONARY SERVICES / ECHOVASCULAR DEPARTMENT
LOWER EXTREMITY VENOUS CONSULTATION REPORT

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: John P. Sutton, III, M.D.
ADMISSION DATE: 05/18/2008
DISCHARGE DATE: 05/19/2008
SOCIAL SECURITY: ###-##-1815

ACCOUNT#: D00502511298
MR#: M000895682
AGE: 40
[redacted]
NURSING STATION: D.5T

PATIENT: TAMMY E. WINDHAM

DATE OF STUDY: 5/18/08

CLINICAL INDICATION FOR STUDY: Pain in the right leg with previous heart catheterization.

DESCRIPTION OF TEST: The venous circulation of the lower extremities was interrogated with duplex ultrasound using transducer compression, augmentation and qualitative spectral wave form analysis. The standard Providence protocol was performed.

FINDINGS: There is compressibility, spontaneous flow, augmentation, valvular competency and non-pulsatile flow throughout the right leg and in the common femoral on the left. This technically adequate study does not show evidence of deep venous thrombosis.

Please refer to data sheet for specific segmental anatomic findings.

NOTE: If a high index of clinical suspicion exists for DVT, then either serial noninvasive venous studies or venography should be considered.

John P. Sutton, III, M.D.

JPS/nrg
DD: 05/19/2008 / DT: 11:08 AM
TD: 05/19/2008 / TT: 04:31 PM
JOB #: 792895

COPY

002242

PROVIDENCE HOSPITAL
Providence Heart Institute
A Ministry of the Sisters of Charity of St. Augustine

Accredited Vascular Laboratory ICAVL

LOWER EXTREM
VENOUS DUPI
SONOGRAPHER WORKSHI

PLEASE NOTE THIS IS A PRELIMINARY WORKSHEET.
FINAL REPORT FROM INTERPRETING PHYSICIAN SHOULD BE USED FOR DIAGNOSIS.

Name: ____ Date: 05/18/08 Ordering Dr: Hayes

Account #: WINDHAM,TAMMY E
A# D0050251129 5682
05/18/08 F 40
Hayes,Michael T Dr.

Sono: PG Tape #: ____ Reading Dr: ____

INDICATIONS

☐ Leg Swelling R / L ☑ Pain R / L ☐ Trauma R / L ☐ Previous DVT R / L ☐ Shortness of Breath

Other Indication: Heart cath 5 days ago Stent placement

Current Anti-Coagulant Therapy Y / N Type: ____

Report Called Y / N Spoke to: CHARTS Time: ____ ☐ Technically Limited Due to: ____

Findings: All veins compressible and patent
NO Evidence of Echogenic material RT. RT GROIN
AREA possible AVF however venous flow not Identifie

RIGHT

Iliac
- N/A
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Common Femoral
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

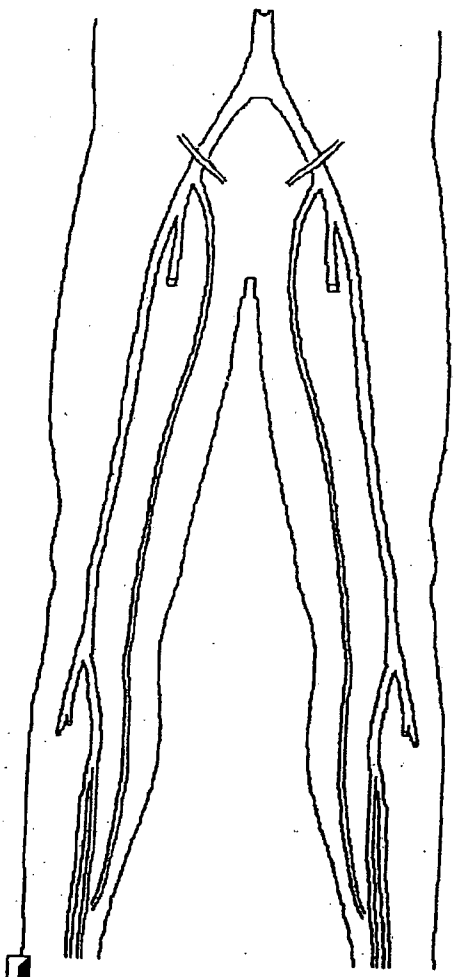
Superficial Femoral
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Popliteal
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Posterior Tibial
- Compressible
- Augments
- Competent

Greater Saphenous
- Compressible

Legend
+ present
– diminished
Ø absent



LEFT

Iliac
- N/A
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Common Femoral
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Superficial Femoral
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Popliteal
- Compressible
- Spontaneous
- Augments
- Competent
- Nonpulsatile

Posterior Tibial
- Compressible
- Augments
- Competent

Greater Saphenous
- Compressible

828

PROVIDENCE HO

6029

WINDHAM TAMMY E

40 yrs Female

19 MAY 2008

6:08:11

895682

6030

002243

829

PR	151
QRSD	80
QT	416
QTc	401

(NSR). Normal sinus rhythm, rate 56 - - - - - - - Normal P axis, PR, rate & rhythm
(LVH39). Probable LVH with ST-T abnormalities - - - - Hi voltage, STT neg, QRS/VAT wide
- ABNORMAL ECG -

*RM/ALM/502511298

--AXES--

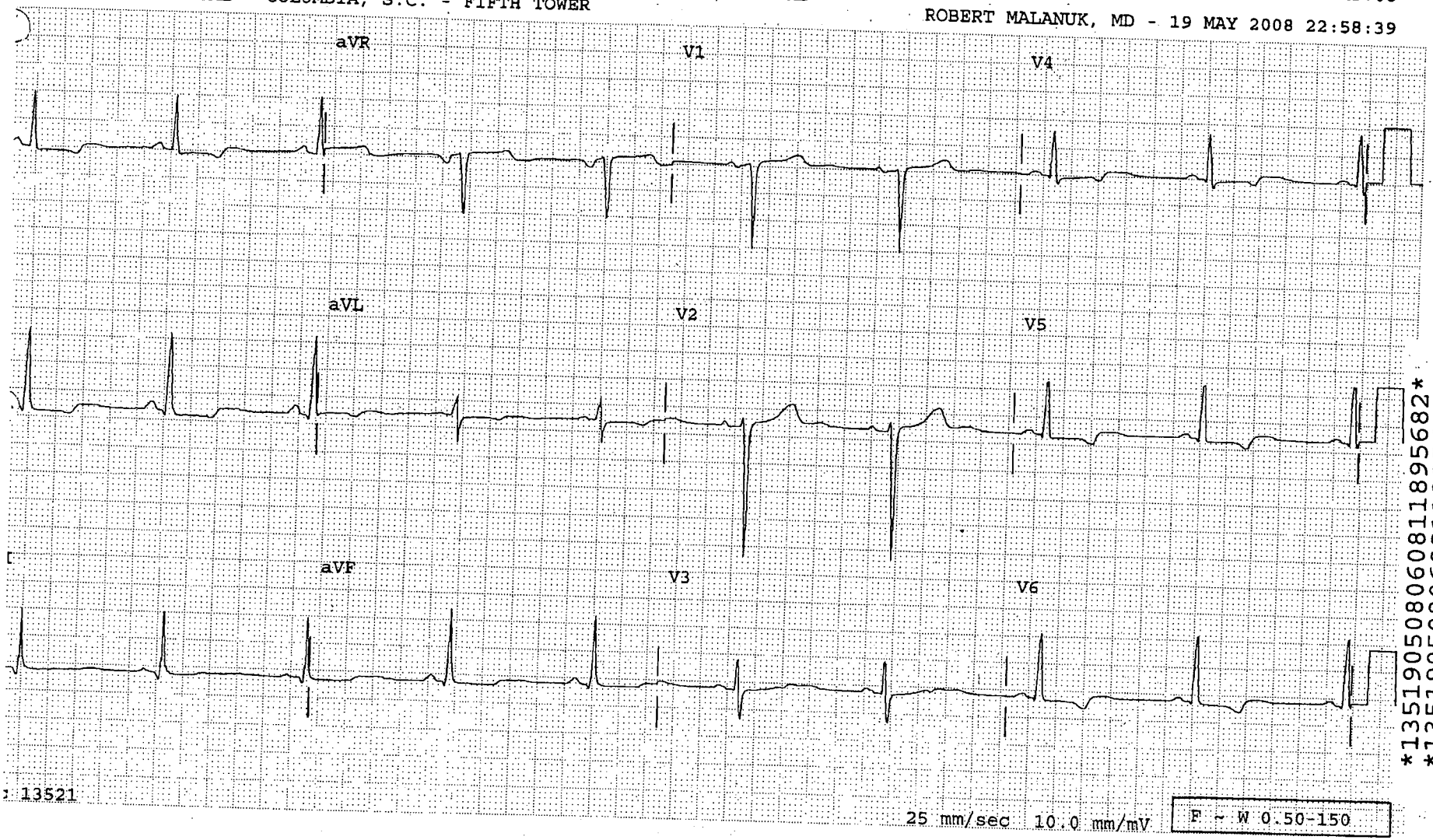
P	44
QRS	55
T	132

Requested by
161
Tech 44
Room 504/B
Edited C-HP708

PREVIOUS ECG: 18 MAY 2008 4:19:39, CONFIRMED BY JJL - AB

PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER

ROBERT MALANUK, MD - 19 MAY 2008 22:58:39



135190508060811895682

135190508060811895682

: 13521

25 mm/sec 10.0 mm/mV

F ~ W 0.50-150

WINDHAM TAMMY E

40 yrs Female

19 MAY 2008 6:08:11

895682

6031

002244

PR	151
QRSD	80
QT	416
QTc	401

(NSR). Normal sinus rhythm, rate 56 - - - - - - - Normal P axis, PR, rate & rhythm
(LVH39). Probable LVH with ST-T abnormalities - - - - Hi voltage, STT neg, QRS/VAT wide
- ABNORMAL ECG -

--AXES--

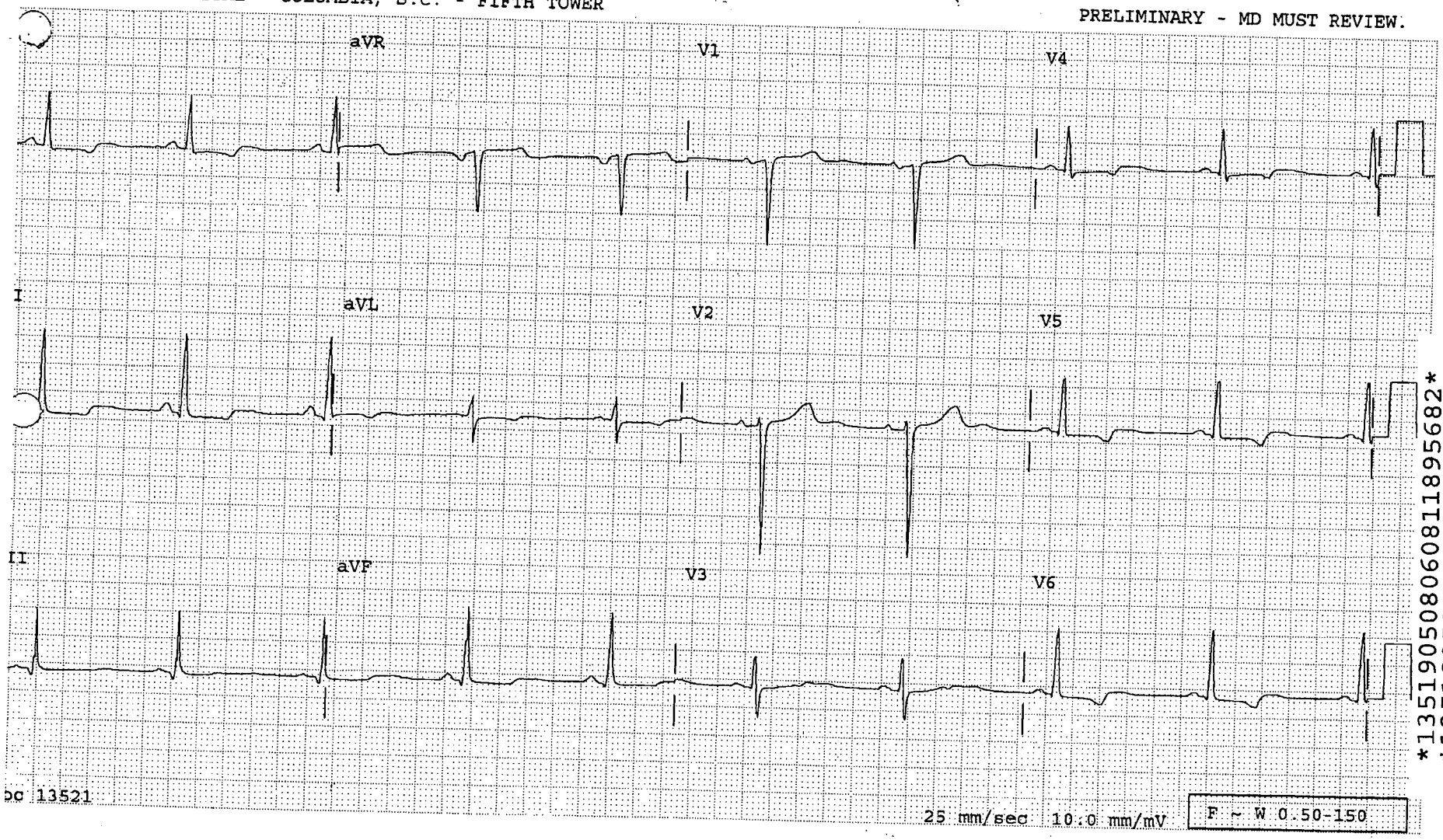
P	44
QRS	55
T	132

830

Requested by
161
Tech 44
Room 504/B
C-HP708

PREVIOUS ECG: 18 MAY 2008 4:19:39, CONFIRMED BY JJL - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER

PRELIMINARY - MD MUST REVIEW.

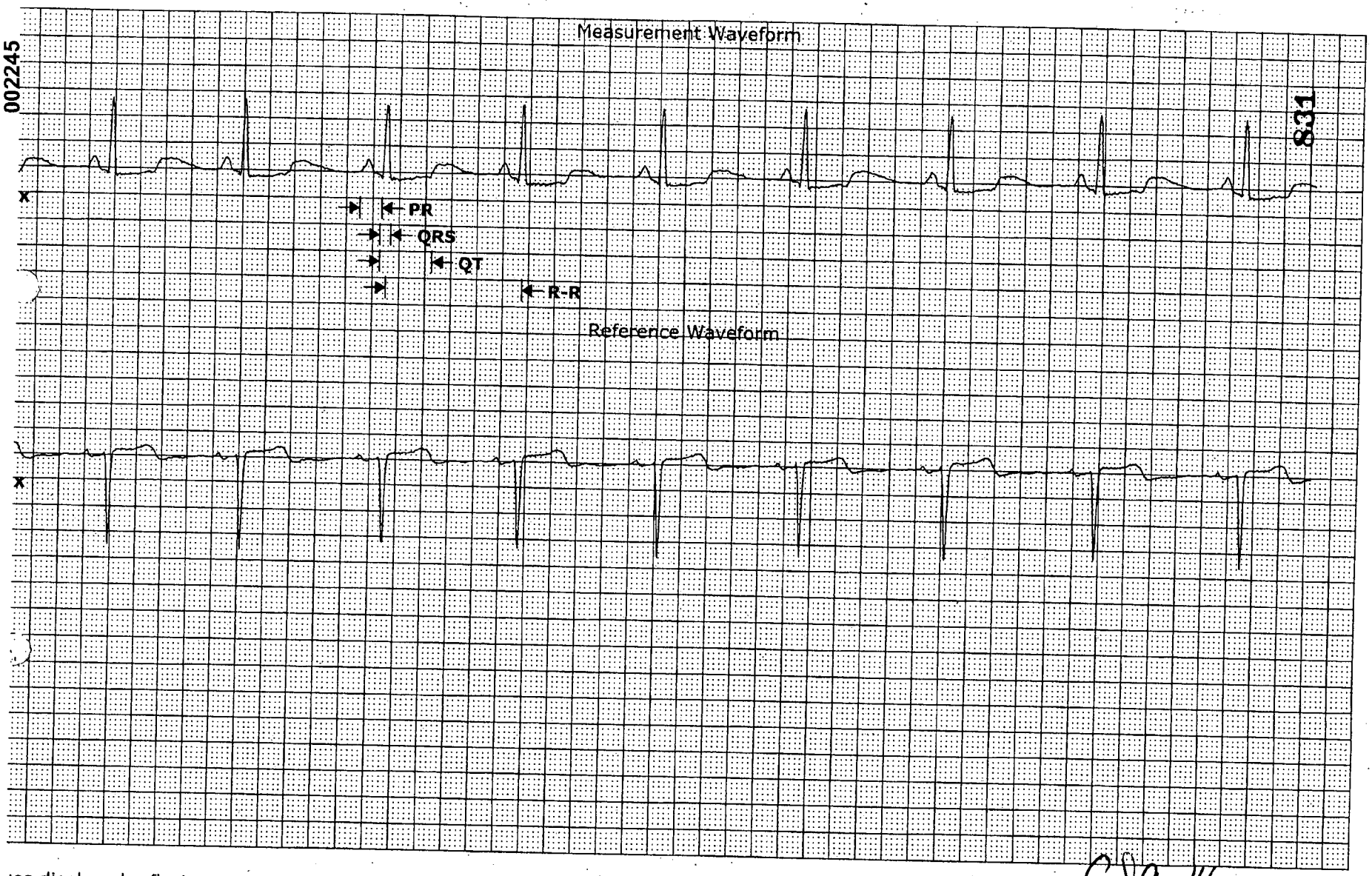


135190508060811895682
135190508060811895682

NDHAM,TAMMY M000895682 **Caliper Measurements** 5T|504B* 6032

May-2008 06:25:36 - 19-May-2008 06:25:46

002245



831

ues displayed reflect measurements acquired against the measured waveform only.

	= 0.167	sec	QT	= 0.402	sec
	= 0.085	sec	R-R	= 1.048	sec
	= 0.393	sec	Rate	= 57	bpm

SB
ogl MT

Gayle
5/19/08

GE Medical System
Information Technolog

CIC Version 5.0.7
Monday, May 19, 2008 6:51:34 AM

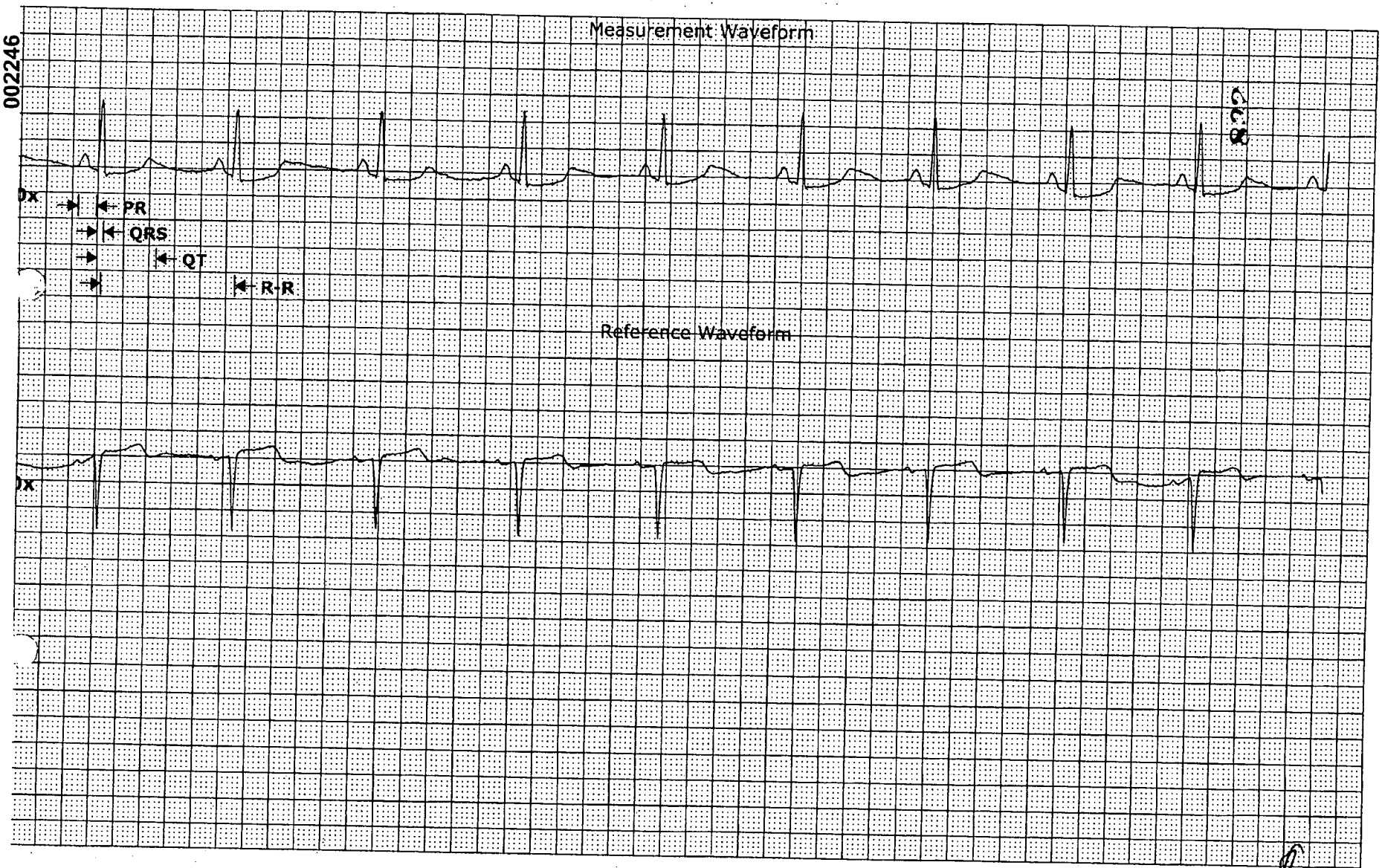
25 mm/s

END OF REPORT

'INDHAM,TAMMY M000895682 **Caliper Measurements** 5T|504B 6033

·May-2008 02:33:29 - 19-May-2008 02:33:39

002246



ues displayed reflect measurements acquired against the measured waveform only.

	= 0.149 sec	QT	= 0.461 sec
S	= 0.049 sec	R-R	= 1.042 sec
c	= 0.452 sec	Rate	= 58 bpm

GE Medical System Information Technologies CIC Version 5.0.7

Monday, May 19, 2008 2:57:07 AM

25 mm/s

Page 1

END OF REPORT

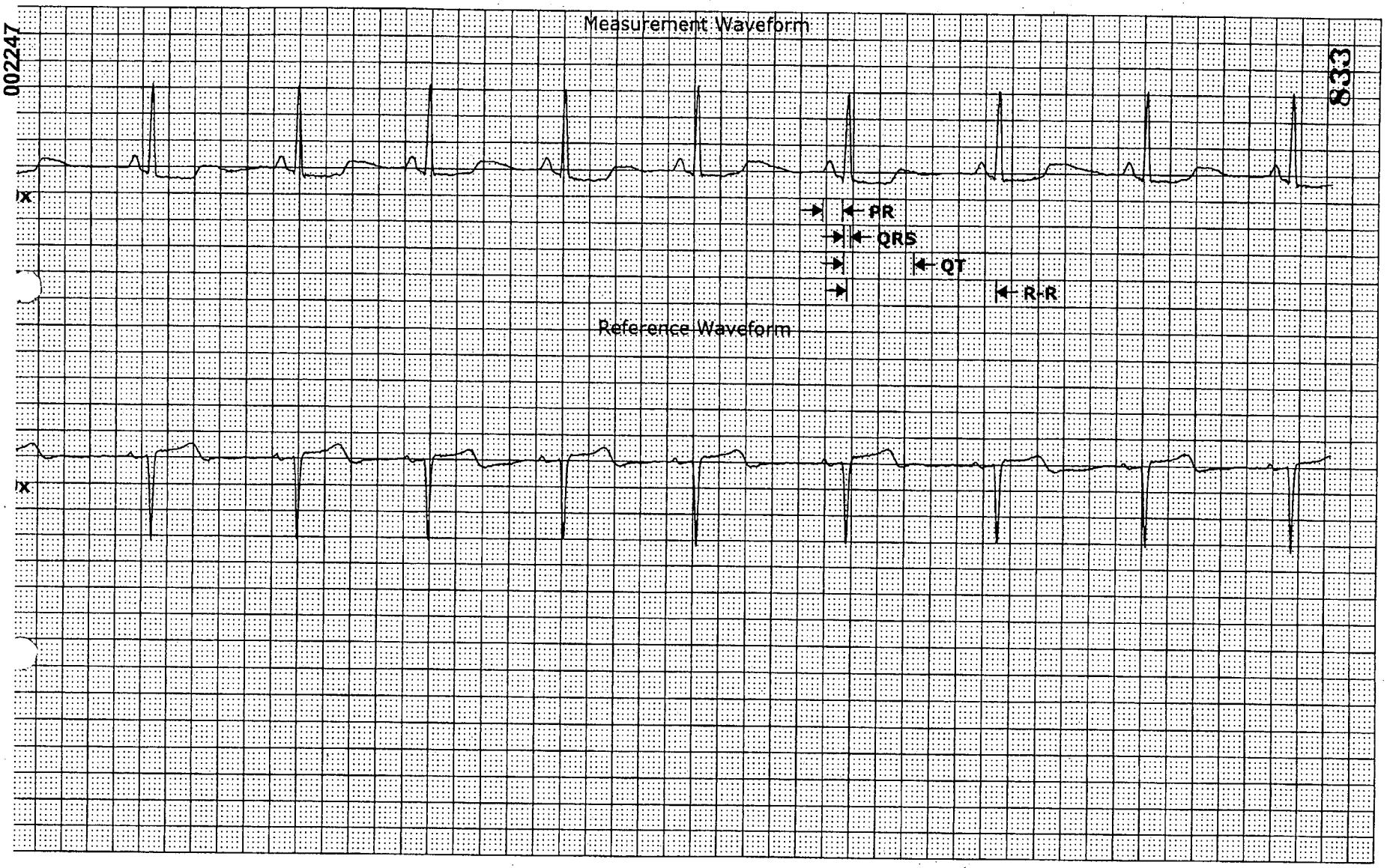
INDHAM,TAMMY **M000895682** **Caliper Measurements** **5T|504B***

May-2008 23:04:29 - 18-May-2008 23:04:39

002247

6034

833



ues displayed reflect measurements acquired against the measured waveform only.

	=	0.149	sec	QT	=	0.537	sec
5	=	0.049	sec	R-R	=	1.136	sec
:	=	0.504	sec	Rate	=	53	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.7

Sunday, May 18, 2008 11:54:29 PM

1

SB

25 mm/s

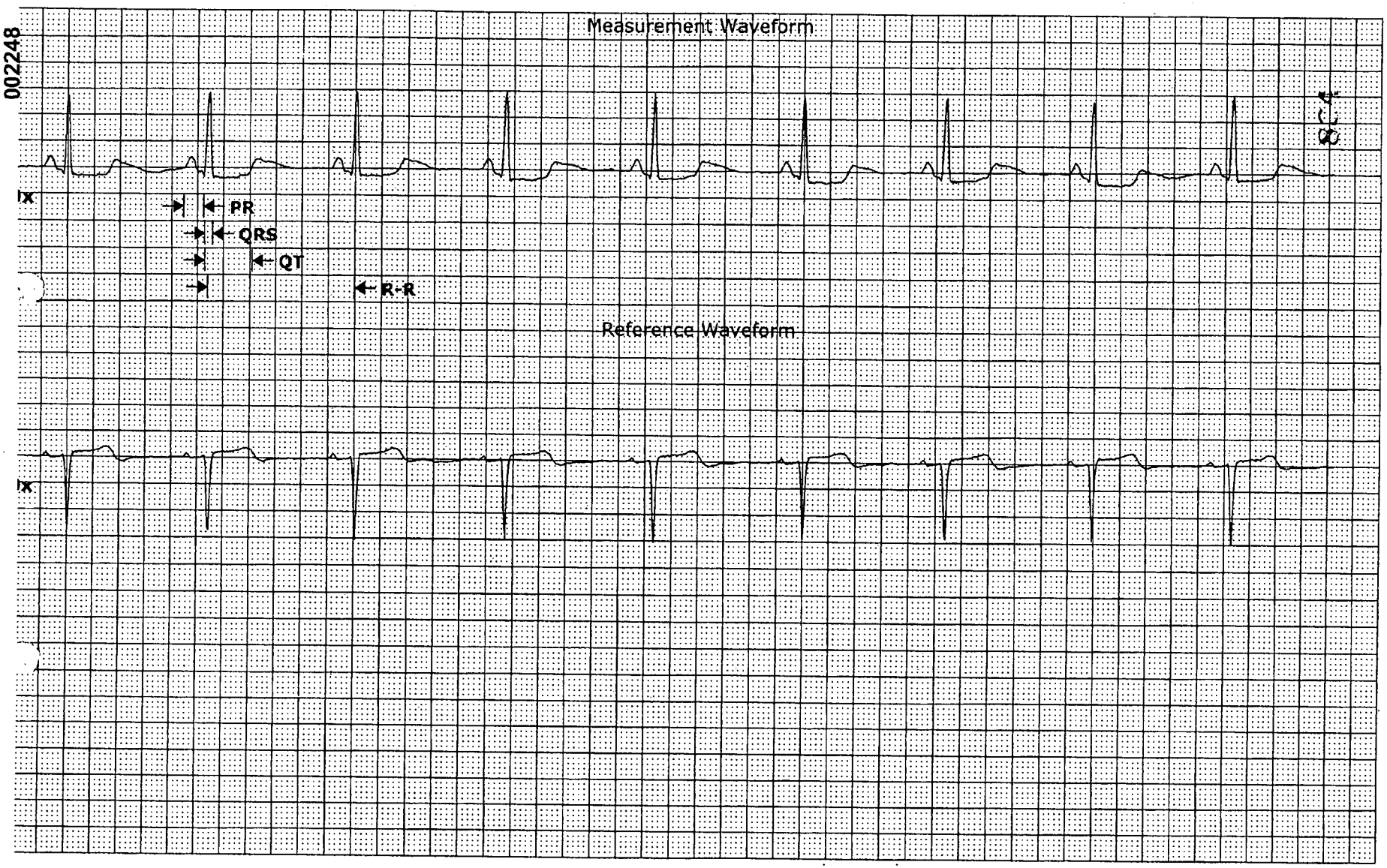
Page 1

END OF REPORT

INDHAM,TAMMY **M000895682** **Caliper Measurements** **5T|504B*** 6035

May-2008 20:52:24 - 18-May-2008 20:52:34

002248



ues displayed reflect measurements acquired against the measured waveform only.

	=	0.155	sec	QT	=	0.367	sec
S	=	0.061	sec	R-R	=	1.119	sec
:	=	0.347	sec	Rate	=	54	bpm

GE Medical System Information Technologies

CIC Version 5.0.7

Sunday, May 18, 2008 8:54:21 PM

25 mm/s

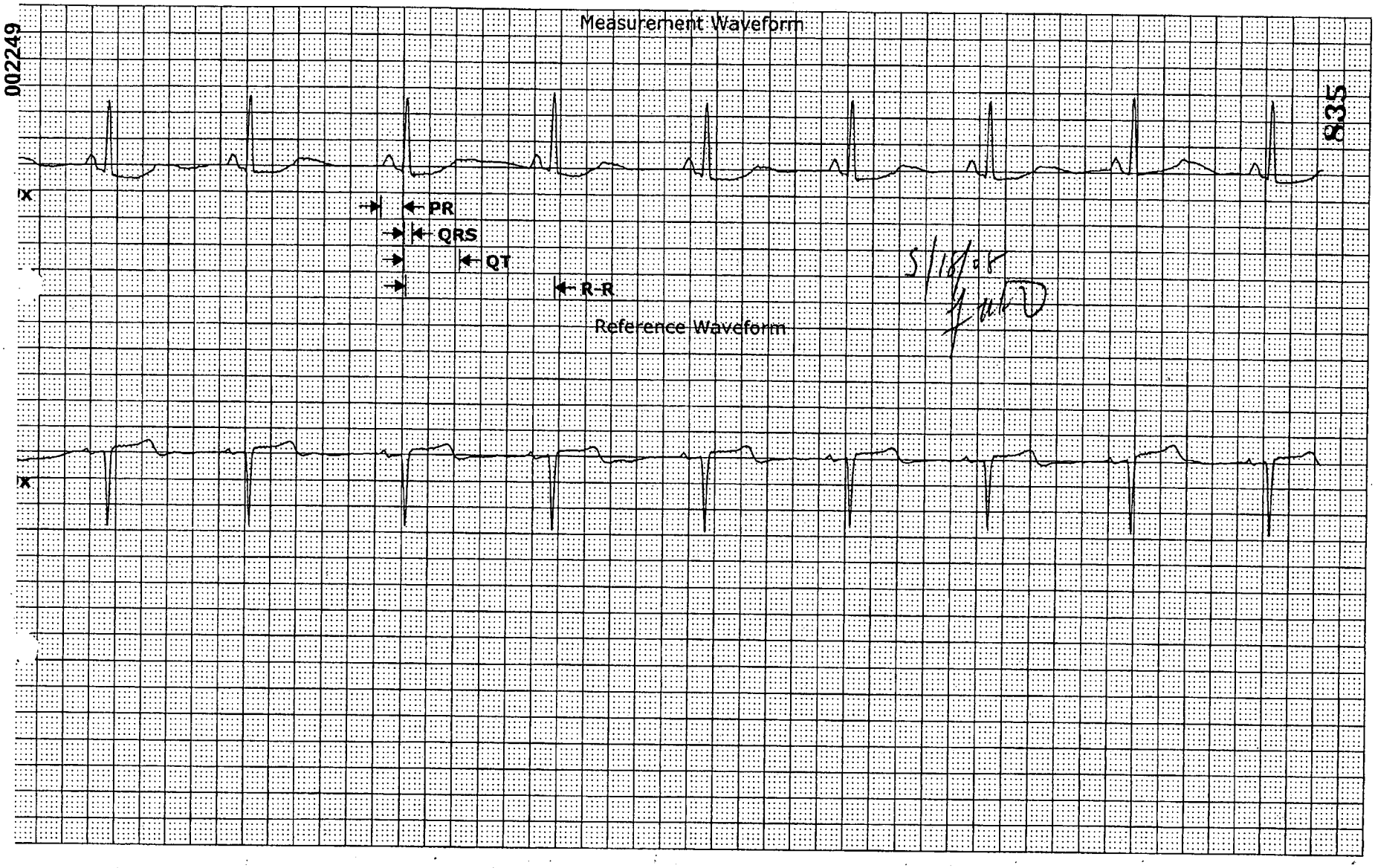
END OF REPORT

[NDHAM,TAMMY M000895682 **Caliper Measurements** 5T|504B*

May-2008 14:37:26 - 18-May-2008 14:37:36

6036

002249



ues displayed reflect measurements acquired against the measured waveform only.

	= 0.167	sec	QT	= 0.428	sec
S	= 0.063	sec	R-R	= 1.145	sec
:	= 0.400	sec	Rate	= 52	bpm

SB
cyclnT

GE Medical System
Information Technologies

CIC Version 5.0.7
Sunday, May 18, 2008 2:49:48 PM

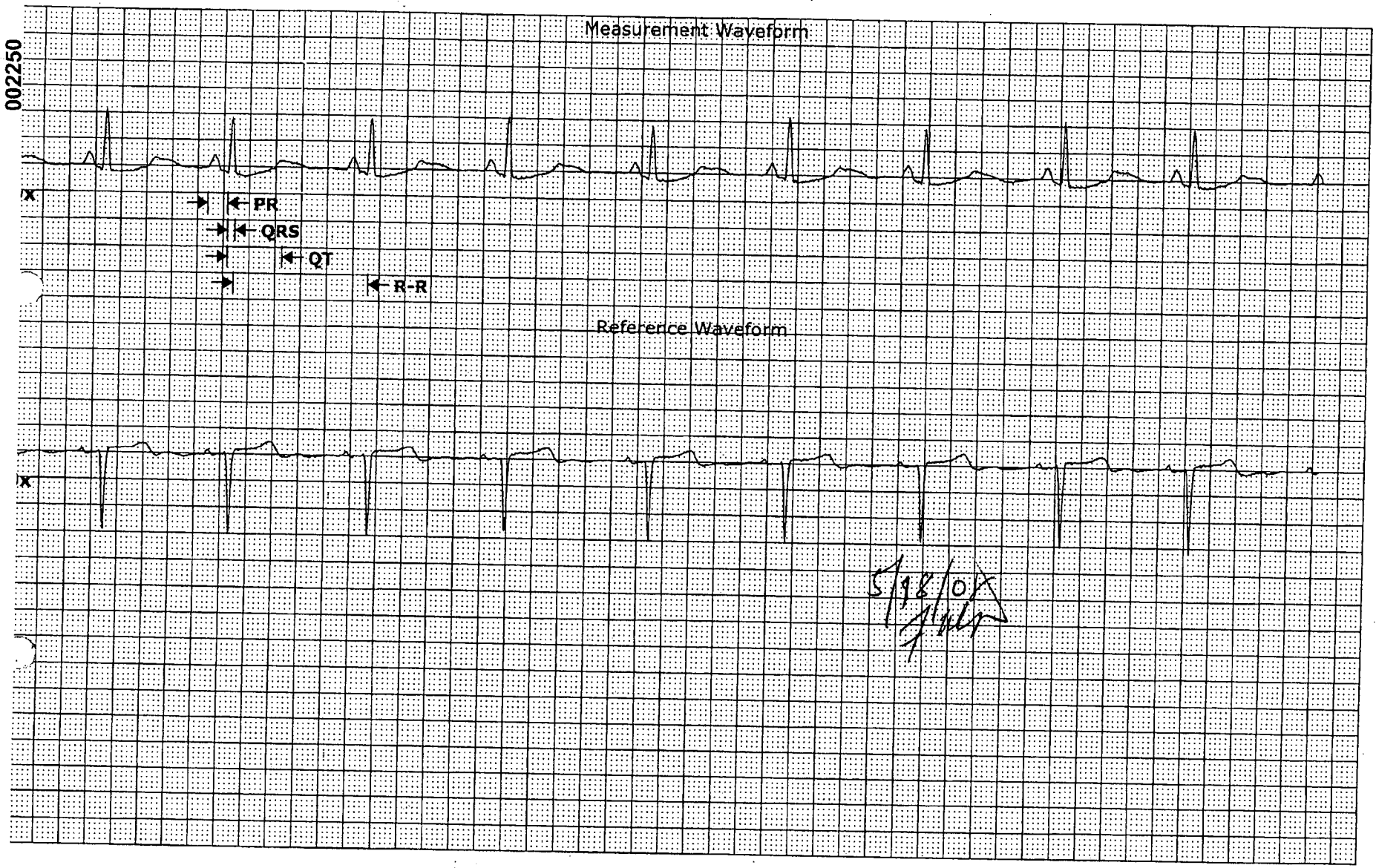
25 mm/s

END OF REPORT

INDHAM,TAMMY M000895682 **Caliper Measurements** 5T|504B* 6037

May-2008 06:20:19 - 18-May-2008 06:20:29

002250



ues displayed reflect measurements acquired against the measured waveform only.

	=	0.155	sec	QT	=	0.425	sec
S	=	0.061	sec	R-R	=	1.036	sec
:	=	0.418	sec	Rate	=	58	bpm

SB
ayc/MT

GE Medical System
Information Technolo

CIC Version 5.0.7
Sunday, May 18, 2008 6:55:57 AM

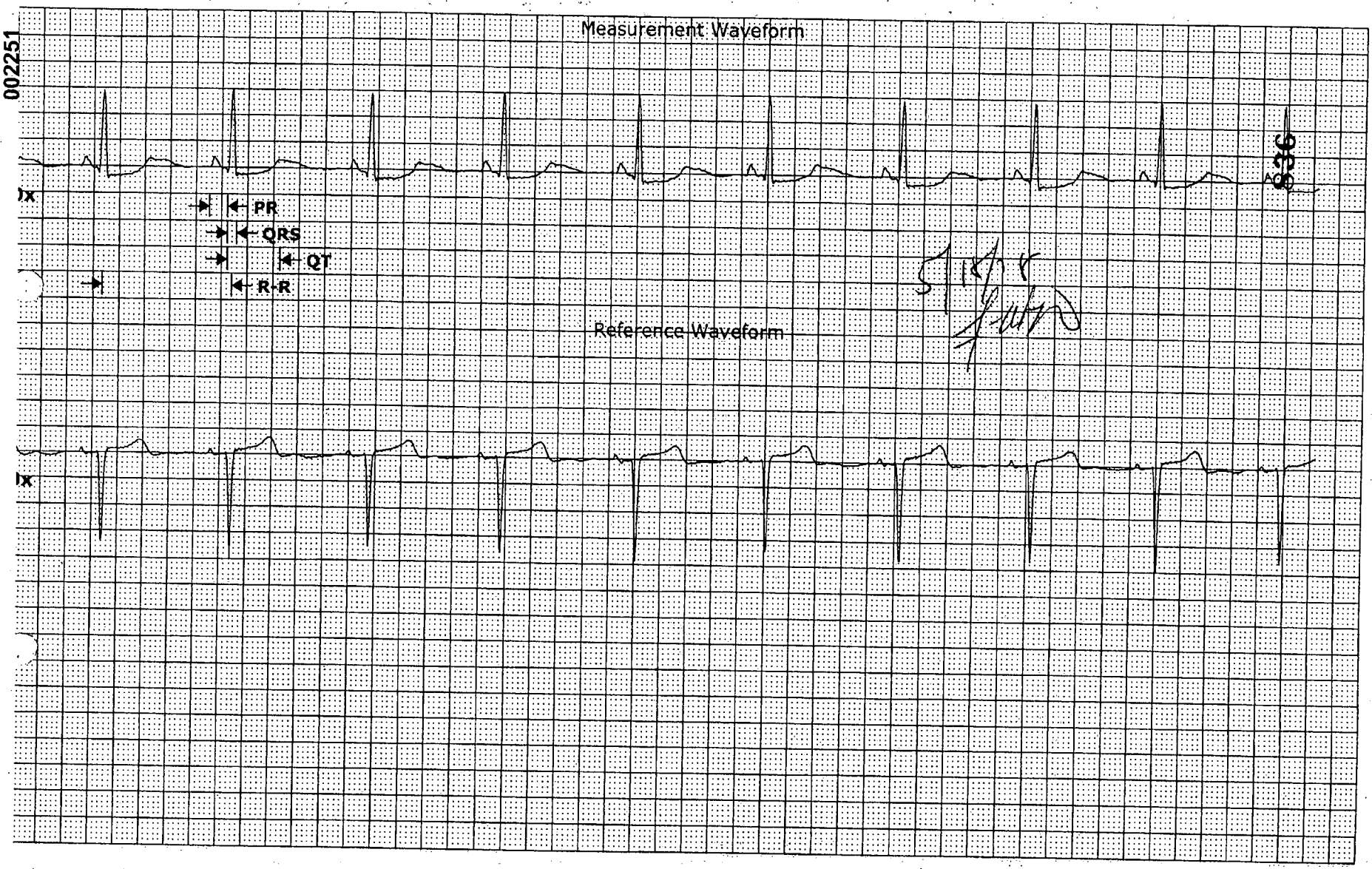
25 mm/s
Page 1
END OF REPORT

INDHAM,TAMMY **M000895682** **Caliper Measurements** **5T|504B**

May-2008 10:35:30 - 18-May-2008 10:35:40

002251

6038



ues displayed reflect measurements acquired against the measured waveform only.

	= 0.143	sec	QT	= 0.414	sec
S	= 0.073	sec	R-R	= 1.013	sec
:	= 0.411	sec	Rate	= 59	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.7

Sunday, May 18, 2008 10:59:02 AM

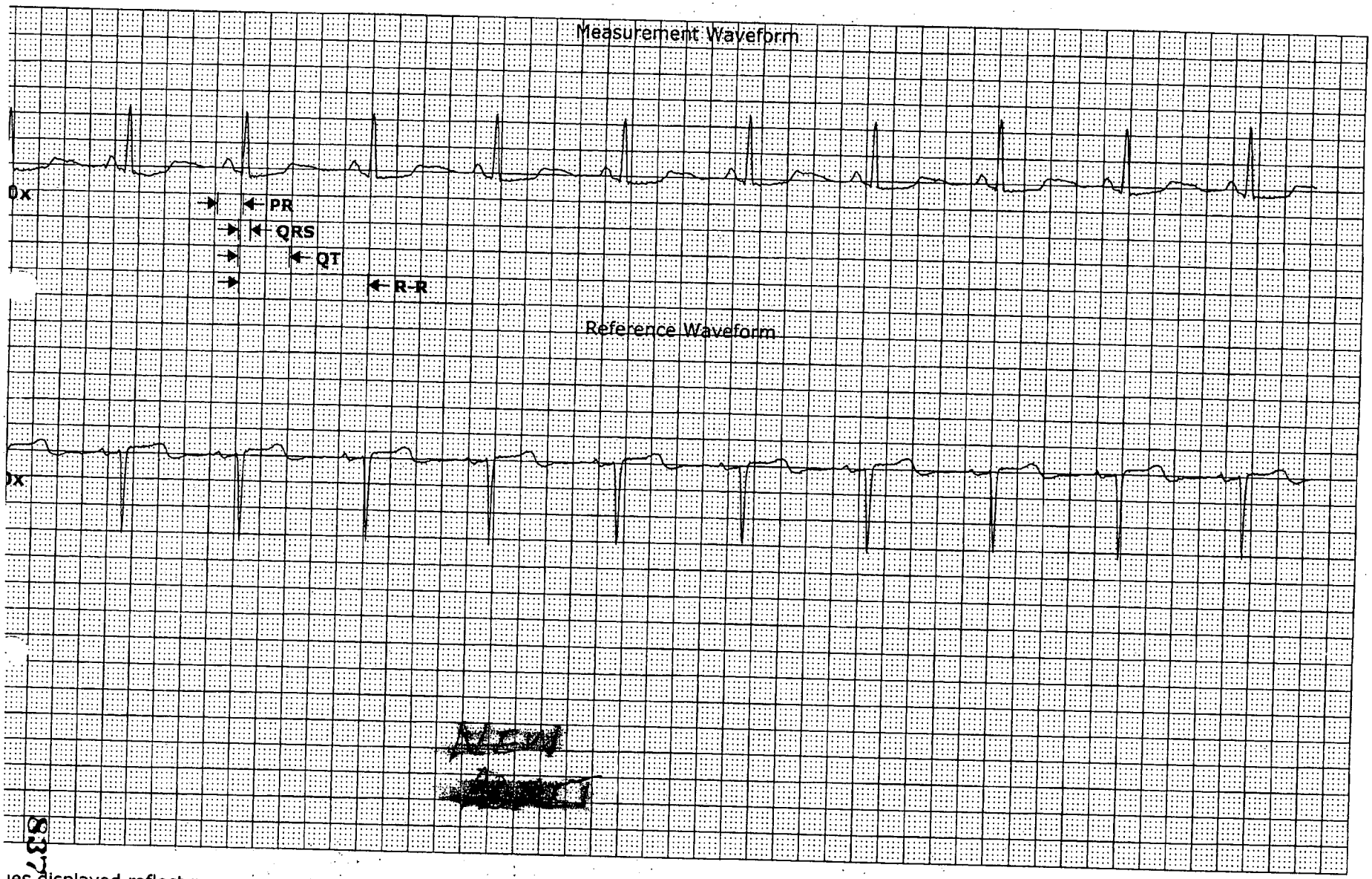
25 mm/s

Page 1

END OF REPORT

'INDHAM,TAMMY M000895682 **Caliper Measurements** **5T|504B***

-May-2008 05:08:32 - 18-May-2008 05:08:42



ues displayed reflect measurements acquired against the measured waveform only.

	= 0.202	sec	QT	= 0.402	sec		
	= 0.096	sec	R-R	= 1.006	sec	SR	
	= 0.401	sec	Rate	= 60	bpm		

GE Medical System
Information Technolo

CIC Version 5.0.7
Sunday, May 18, 2008 5:09:52 AM

ABK

002252

25 mm/s

Page 1

END OF REPORT

6039

WINDHAM T. .Y E

13 MAY 2008 3:47:55

40 yrs Female

95682

6040

002253

#3 MR

838

PR	169	(NSR). Normal sinus rhythm, rate 58 - - - - - - - Normal P axis, PR, rate & rhythm
QRSD	77	(T2WI). Diffuse T wave abnormalities - - - - - - - - - T waves -.20 mV ANT/LAT/INF
QT	431	(ISCE). . Cannot exclude ischemia - T > -.20 mV
QTc	423	- ABNORMAL ECG -

--AXES--

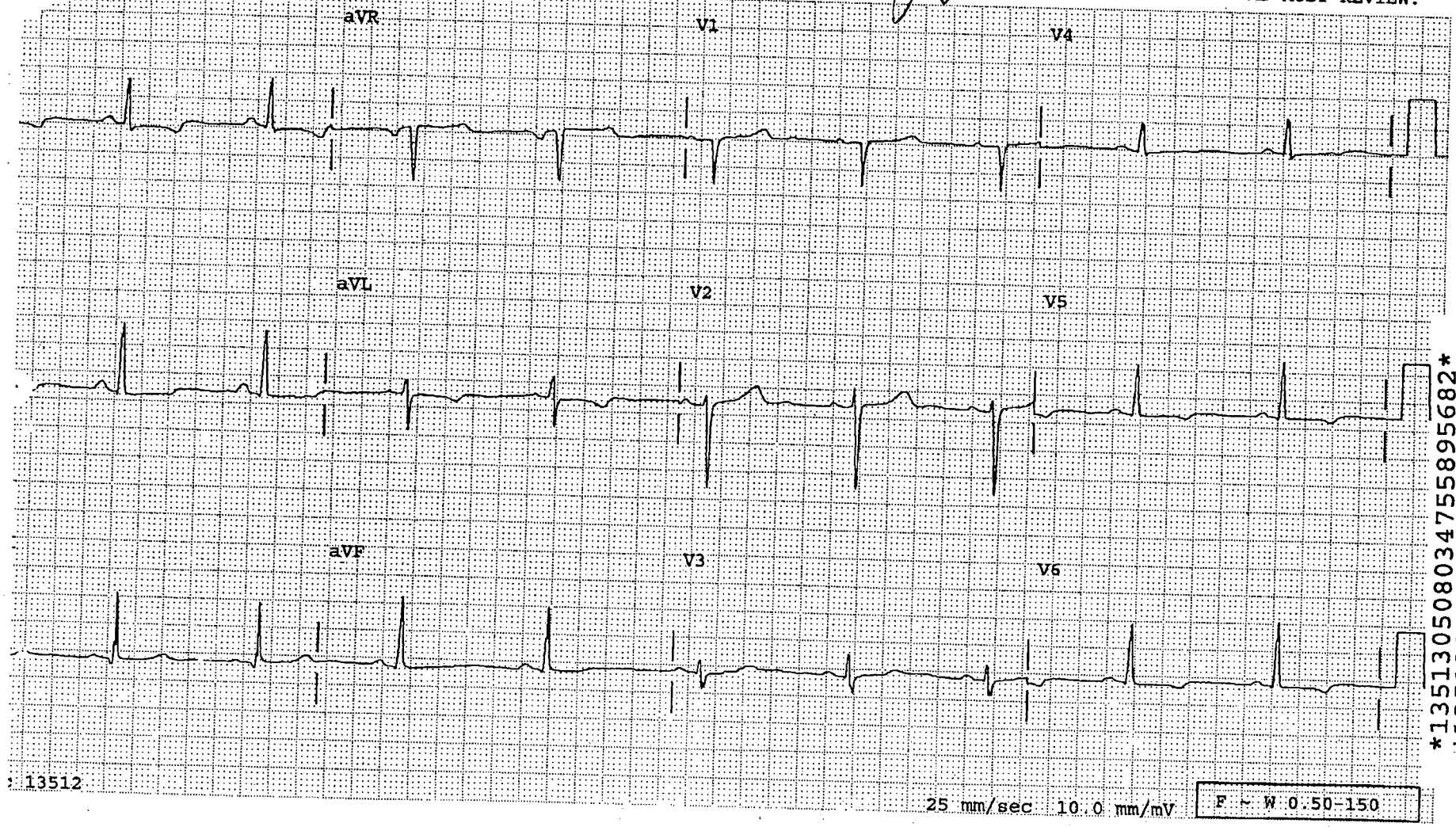
P	42
QRS	58
T	174

Requested by
161
Tech 66
Room 452

C-HP708

PREVIOUS ECG: 12 MAY 2008 15:09:44, UNCONFIRMED - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

PRELIMINARY - MD MUST REVIEW.



13513050803475589568 2
13513050803475589568 2

WINDHAM [illegible]MY E[illegible] 13 MAY 2008 3:47:55 895682

40 yrs Female

002254

PR	169	(NSR). Normal sinus rhythm, rate 58 - - - - - - - Normal P axis, PR, rate & rhythm
QRSD	77	(T2WI). Diffuse T wave abnormalities - - - - - - - - - T waves -.20 mV ANT/LAT/INF
QT	431	(ISCE). . Cannot exclude ischemia - - - - - - - - - - - - - - - - - T > -.20 mV
QTc	423	(NSCPT).*No significant changes since prior tracing

- ABNORMAL ECG -

--AXES--
P 42
QRS 58
T 174

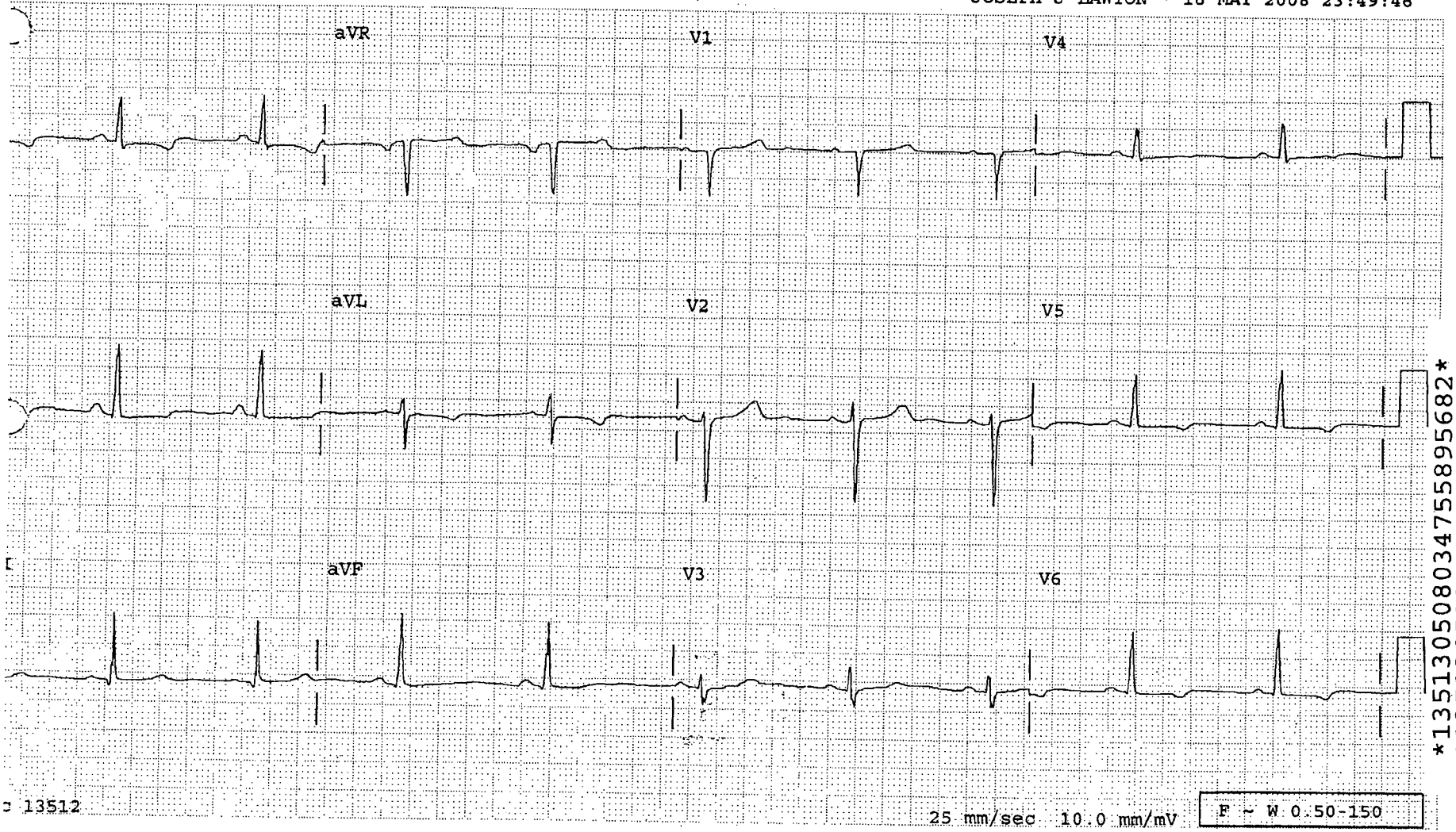
*jjl/ce 502499114

Requested by
161
Tech 66
Room 452
Edited C-HP708

PREVIOUS ECG: 12 MAY 2008 15:09:44, CONFIRMED BY ARE - AB

PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

JOSEPH J LAWTON - 16 MAY 2008 23:49:46



13512

25 mm/sec 10.0 mm/mV F ~ W 0.50-150

135130508034755895682
135130508034755895682

6041

839

WINDHAM TAMMY E 18 MAY 2008 4:19:39 504B 895682 6042

40 yrs Female

002255

PR 162 (NSR). Normal sinus rhythm, rate 58 - - - - - - - Normal P axis, PR, rate & rhythm
QRSD 76 (STTAL). Anterolateral ST-T abnormalities - - - - - - - - ST-T negative in I,aVL,V2-V6
QT 426
QTc 418 - ABNORMAL ECG -

840

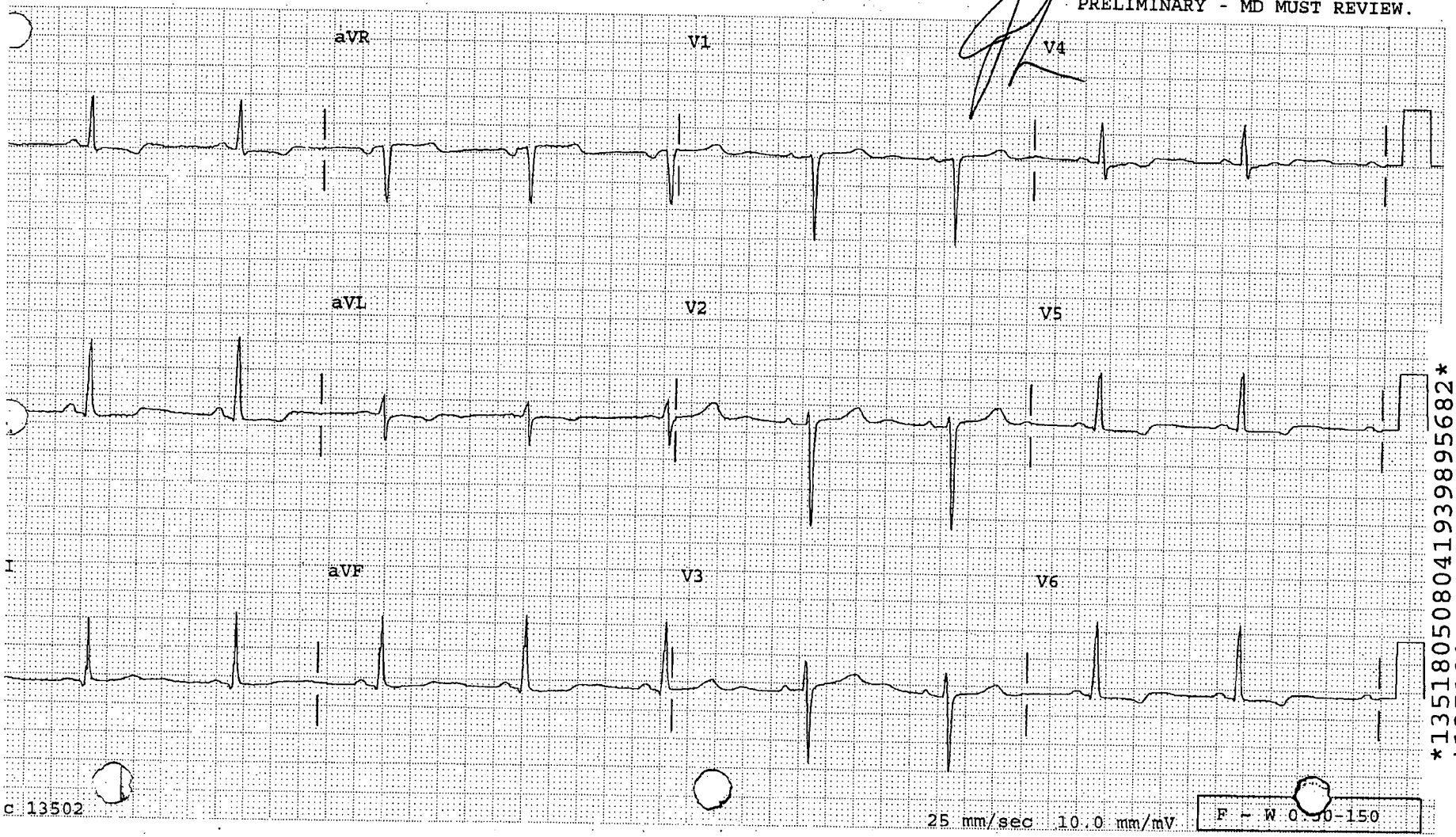
--AXES--
P 56
QRS 59
T 184

Requested by
161
Tech 31
Room ER 10
C-HP708

PREVIOUS ECG: 13 MAY 2008 3:47:55, CONFIRMED BY JJL - AB

Providence Hospital - EMERGENCY ROOM

PRELIMINARY - MD MUST REVIEW.



135180508041939895682
135180508041939895682

WINDHAM TAMMY E

40 yrs Female

18 MAY 2008 4:19:39

895682

6043

002256

PR 162
QRSD 76
QT 426
QTc 418

--AXES--
P 56
QRS 59
T 184

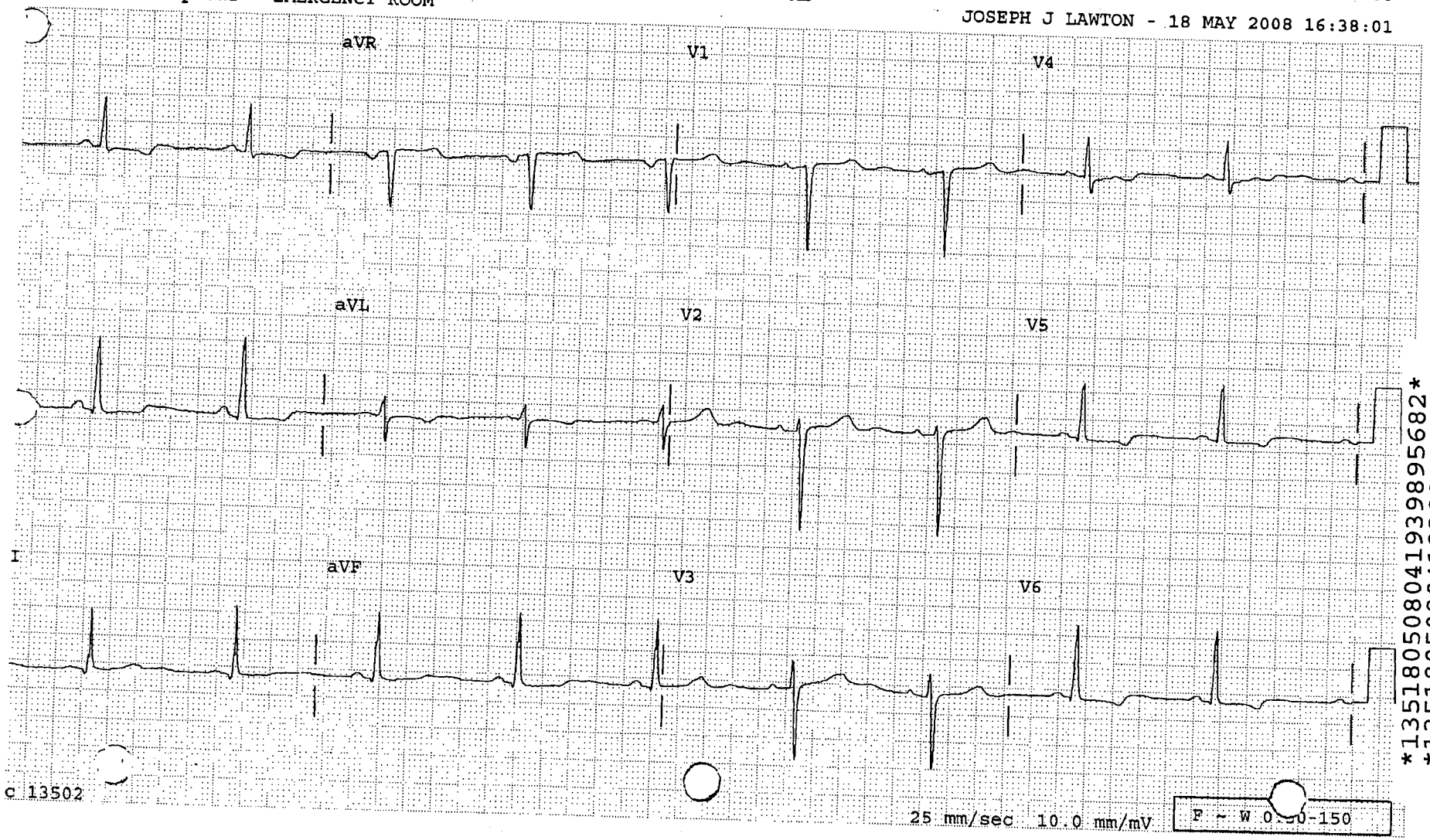
(NSR). Normal sinus rhythm, rate 58 - - - - - - Normal P axis, PR, rate & rhythm
(STTAL). Anterolateral ST-T abnormalities - - - - - - - ST-T negative in I,aVL,V2-V6
- ABNORMAL ECG -
*CHANGES MAY BE DUE TO LVH. NO SIGNIFICANT CHANGE
*JJL/PB/ 502511298

841

Requested by
161
Tech 31
Room ER 10
Edited C-HP708

PREVIOUS ECG: 13 MAY 2008 3:47:55, CONFIRMED BY JJL - AB
Providence Hospital - EMERGENCY ROOM

JOSEPH J LAWTON - 18 MAY 2008 16:38:01



135180508041939895682
135180508041939895682

Patient	Unit #	Service/Location	Status	Date	Account #
WINDHAM,TAMMY E	M000895682	CARDIOLOGY	ADM IN	01/21/08	002257 D00502311541

PATIENT

[redacted] DOB [redacted] Age 40 Sex F MS X Race CA Religion HOLINESS

Address: [redacted]

Home Ph: [redacted] County: SUMTER

DISCHARGE DISPOSITION

Date Time

__ Routine (Home)
__ Home Health Care
__ AMA
__ Transferred To
__ Expired

FINAL DIAGNOSES | **CODES**

Principal:

Other Diagnoses and Manifestations

CP
CAD
Carotid atherosclerosis
Hyperlipidemia
Iron deficiency anemia

DATES	OPERATIONS AND PROCEDURES	CODES
1/22	Cardiac cath	
	771400	

CONSULTING PHYSICIAN/RESIDENTS

1. 2. 3. 4. 5.
6. 7. 8. 9. 10.

Signature of Attending Physician 1/23/08 Date

SIGNATURE FORM

Printed 01/21/08 1944

842

6044

PATIENT REGISTRATION FORM
SISTERS OF CHARITY PROVIDENCE HOSPITALS

2435 FOREST DRIVE
COLUMBIA, SC 29204
(803) 256-5300

120 GATEWAY CORPORATE BLVD
COLUMBIA, SC 29203
(803) 865-4500

002258

MED REC#: M000895682
SERV/LOC: CAR
PT STATUS: ADM IN
AKA:

ADMIT DATE: 01/21/08
ROOM & BED: D.H5058
ADMIT SOURCE: EMERGENCY ROOM

TIME: 1944
ACCOM: INTERMEDIATE I

ACCT NO.: D00502311541
FIN CLASS: SP
ADM CLERK: PRITCHKE
Print D/T: 01/21/08 2133

*** PATIENT INFORMATION ***

PATIENT: WINDHAM,TAMMY E
ADDRESS: [redacted]
PHONE #:

BIRTHDATE: [redacted]
MARITAL ST: LEGALLY SEPARAT
RELIGION: HOLINESS
MDN NAME:

AGE: 40
SS#: 247-31-1815
RACE: CAUCASIAN
SEX: F

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: WINDHAM,TAMMY E
GUAR ADDRESS: [redacted]
GUAR PHONE NO:

GUAR EMPLOYER: NOT EMPLOYED
GUAR EMP PH:
RELATIONSHIP: PATIENT
GUARANTOR SS#: [redacted]

*** CONTACT INFORMATION ***

NEXT OF KIN: PARROTT,MELINDA
NOK ADDRESS: [redacted]
NOK PHONE NO:
NOK REL:

PERSON TO NOTIFY: WINDHAM,THOMAS
PERSON NOTIFY ADD: [redacted]
PERSON NOTIFY PH#:
NOTIFY REL:

*** EMPLOYMENT INFORMATION ***

EMPLOYER: NOT EMPLOYED
ADDRESS:

OCCUPATION:
EMP PHONE #:

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: NO DOCTOR
ADMIT PHYSICIAN: Lawton,Joseph J. III Dr.
ER PHYS: Powell,D Langston Dr.

OTHER PHYSICIAN:
ATTENDING PHYS: Lawton,Joseph J. III Dr.

INSURANCE	POLICY #	GRP #	SUBSCRIBER	AUTH #
1 SELF PAY			WINDHAM,TAMMY E	
(999)999-9999				
2				
3				

REASON FOR VISIT: CHEST PAIN
COMMENT: ADMIT FROM ER

U#: A#:

843

6045

RUN DATE: 01/26/08
RUN TIME: 1646
RUN USER: RANDOLVX

Providence Hospital ABS **LIVE**
ATTESTATION STATEMENT

002259

NAME:	WINDHAM, TAMMY E	ACCT #:	D00502311541
ADM DATE:	01/21/08	UNIT #:	M000895682
ATTEND PHYS:	Lawton, Joseph J. III Dr.	SEX:	F
DIS DATE:	01/23/08	AGE:	40
DISCH DISP:	DISCH TO HOME OR SELF CARE	DOB:	[redacted]
LOS:	2	FIN CLASS:	SP
PT CLASS:	IN	ABS STATUS:	FINAL

DIAGNOSES:

			POA?
ADMIT:	786.50	CHEST PAIN NOS	
PRINC:	786.51	PRECORDIAL PAIN	Y
SECOND:	433.10	CAROTID ARTERY OCCLUSION W O CEREBRAL INFARCTION	Y
	412	OLD MYOCARDIAL INFARCT	E
	414.01	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY VESSEL	Y
	272.4	HYPERLIPIDEMIA NEC/NOS	Y
	280.9	IRON DEFIC ANEMIA NOS	Y
	784.0	HEADACHE	Y
	401.9	HYPERTENSION NOS	Y
	305.1	TOBACCO USE DISORDER	Y
	V17.3	FAM HX-ISCHEM HEART DIS	E
	V45.82	PERCUTANEOUS TRANSLUM CORON ANGIOPLASTY STATUS	E
	433.30	MULT BILTRAL ARTERY OCCLUSION WO CEREBRAL INFARC	Y

OPERATIONS:

01/22/08	37.22	LEFT HEART CARDIAC CATH	MB1
01/22/08	88.56	CORONAR ARTERIOGR-2 CATH	B2
01/22/08	88.53	LT HEART ANGIOCARDIOGRAM	B3

DRG: 287 CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC

STATUS	$ REIMB	MIN-LOS	MAX-LOS	STD-LOS	GRP VERS	GRP FC
F	5706.79			3.2	25	SP

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

_____ DATE _____

844

Occurred Date	Time	by	Author	Recorded Date	Time	by	NURSE
01/23/08	1007	KAR	RICE,KAREN A	01/23/08	1009	KAR	

Abnormal? N Confidential? N

POST CORONARY CATHERIZATION DISCHARGE INSTRUCTIONS

Exercise or Special Limits:

*INCREASE WALKING DAILY UNTIL RETURN TO NORMAL LEVEL.
*NO RUNNING, FAST STAIR CLIMBING OR STRETCHING FOR 3 DAYS.
*DO NOT SIT FOR LONG PERIODS OF TIME, CHANGE POSITION FREQUENTLY WHILE SITTING.
*DO NOT LIFT ANYTHING HEAVIER THAN 10 POUNDS FOR NEXT 3 DAYS.
*DO NOT DRIVE A CAR FOR NEXT 3 DAYS.
*LIMIT BENDING FOR NEXT 3 DAYS.

Dressing, Treatment, or Special Equipment:

*CLEAN CATH SITE DAILY WITH SOAP AND WATER UNTIL HEALED.
*PLACE CLEAN BANDAID ON CATH SITE UNTIL HEALED.
*DO NOT USE LOTION OR POWDER AT CATH SITE UNTIL SITE IS HEALED.
*SHOWER PREFERRED, NO SOAKING IN A POOL OR TUB FOR 48 HOURS POST PROCEDURE.
*DO NOT STRAIN WITH BOWEL MOVEMENTS. MAY USE A LAXATIVE IF NEEDED.

Special Instructions:

*YOU CAN EXPECT BRUISING AT THE CATH SITE. A SMALL MARBLE SIZED KNOT MAY ALSO BE PRESENT - IT SHOULD GO AWAY WITHIN 2-3 WEEKS.
*YOU MAY HAVE SOME MILD ACHING OR PAIN AT SITE YOU MAY TAKE TYLENOL AS DIRECTED.
*WATCH SITE FOR BLEEDING, IF BLEEDING OCCURS HOLD DIRECT PRESSURE TO SITE FOR 5 MINUTES WHILE LYING DOWN. IF UNABLE TO CONTROL OR STOP BLEEDING CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM IMMEDIATELY.
*NOTIFY PHYSICIAN FOR PERSISTENT NUMBNESS, TINGLING, OR SEVERE PAIN IN THE EXTREMITY USED FOR THE HEART CATH.
*WATCH FOR SIGNS OF INFECTION - INCREASED REDNESS AT SITE, DRAINAGE, INCREASED PAIN. NOTIFY PHYSICIAN IF YOU DEVELOP A FEVER GREATER THAN 100 DEGREES. IF YOU DEVELOP SHAKING CHILLS NOTIFY YOUR PHYSICIAN.

Patient Discharge Instruction 01/23/08 1007 KAR

Patient Discharge Instructions Please Bring Copy To Office With You

Diet: LOW FAT LOW CHOL

Enter/Edit/View Notes: Y Use F4 - F9 to Access DISCHARGE Notes.

Follow-Up Appointment: FAMILY MEDICAL CLINIC IN SUMTER 803-774-4500 FEB 6 AT 7:55AM FOR IRON DEFICIENCY ANEMIA
DR LAWTON 803-744-4900 MARCH 3 AT 9:45AM FOR BLOOD WORK THEN TO SEE DR LAWTON AT 10AM

Call Doctor's Office:

Call Doctor's Office:

Date to Return to Work/School:

Exercise or Special Limitations
: SEE ATTACHED INSTRUCTION SHEET

Dressing, Treatment, Special Equipment
:

Special Instructions
: SEE ATTACHED INSTRUCTION SHEET

Tobacco Use+: CIGARETTE Smoking Cessation Information Provided+: YES
Pt Has Education Folder in Possession at Time of Discharge: Y
All Teaching Information Given to the Pt is in Folder: Y

Interdisciplinary Discharge Medication List Given To Pt/Family

Pt or Family Recieved the Following Items
Hearing Aides+: NA Contact Lens+: NA Glasses+: NA Dentures+: YES Prosthesis+: NA
Valuables Brought to Hospital Returned+: NA
Medications Brought to Hospital Returned+: NA
Clothing brought to Hospital Returned+: YES

I Have Received a Copy of Both My Discharge Medication List and My Discharge Plan of Care.
**
Pt/SO Signature: Tammy Windham Date: 1-23-08 1040

*****These Numbers are Provided for your Convenience *****

MAIN CAMPUS
Lost and Found - 256-5690
Patient Financial Services - 256-5505
Medical Records - 256-5302
Patient Advocate - 256-5739

NORTHEAST CAMPUS
Lost and Found - 865-4690
Patient Financial Services - 865-5816
Medical Records - 865-4680
Patient Advocate - 256-5739

Stop Using Tobacco In Any Form. It Has Been Shown To Reduce Healing. No Smoking!

846

002262

Patient Discharge Instruction 01/23/08 1007 KAR

Call Your Physician If You Have Worsening Symptoms.

If You Have Heart Failure - Weigh Yourself Daily And Write It Down. Call Your Physician If You Gain 2-3 Lbs. Overnight Or Over A 1-2 Day Period.

********** NURSING DISCHARGE CHECKLIST **********

Discharge Instructions 1 +: CATH
Discharge Instructions 2 +:
Discharge Instructions 3 +:
Mode of Discharge+: WC
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
Notify MD's (If Applicable) Name:
Time:

IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Foley Removed:
Voided Prior To Discharge: Y
BM Documented 2-3 Days Prior to Discharge: Y

Narcotic Analgesic was Given within 6 hours Prior to Discharge, Notify Attending Physician.
Name:
Time:

Pneumovax Given: Y
Flu Vaccine Given: Y
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Other:

ACE-Inhibitor Prescribed at Discharge: N
ARB Prescribed At Discharge: N
If Not, Follow Up Plans Are+:
If not, Follow Up Plans Are+:

Monogram Initials	Name		Nurse Type
KAR	RICEKA	RICE,KAREN A	RNPD

847

002263

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D0050231[illegible]
01/21/08 F 40 [redacted]682
Lawton,Joseph J. [redacted]

Automatic stop order schedule of stop dates expressed below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

COLUMBIA CARDIOLOGY CONSULTANTS

CCC1166 INPATIENT POST HEART CATH AND/OR ARTERIOGRAM ORDERS

1) Medications

2) Bedrest with bathroom privileges at end of ~~six~~ 2 hrs hours.

3) Notify physician of any problems with groin or vital signs.

4) Clear liquids for three hours, then _____ diet.

5) Vital signs to include checking groin and pulses in affected extremity:
q 15 minutes X 4, q 30 minutes X 4, q 1 hour X 3, Routine if stable

6) Tylenol # 3 x ____ tabs q 3 hours PRN for pain.
Darvocet-N-100 x ____ tabs q 3 hrs PRN pain if patient is allergic to Codeine).

M Jarrett RN 1/22/08

7) May stand to void only if necessary; In and Out Cath in ____ hrs if unable to void.

8) **SLOWLY** remove pressure dressing in a.m., apply Betadine Band-Aid. Remove Band-aid in 24 hours.

9) If Systolic BP changes to drop less than 90, give 0.6 mg Atropine IV and hang 1/2 NS at 200 ml x 1 hour, then 100 ml/hour x 3 hours. Notify MD.

10) Resume Heparin: Yes_____ No X Not applicable_____
****If yes, adjust per Providence Hospital Heparin Protocol****

11) If patient has documented Coronary Artery Disease per cath, notify dietary for Low Cholesterol diet instructions.

SIGNATURE_____ **DATE**_____

S.STANLEY JUK JR, MD JOSEPH L. LAWTON, MD MICHAEL C ROBERTS, MD
EUGENE F.SCHWARZ, MD RICHARD E.UMBACH, MD
ROBERT M. MALANUK, MD R. TAYLOR WILLIAMS, MD ERIC E. SHOUP, MS PAC

ORIGINAL: 1/1/04, Revised 12/22/04

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002264

WINDHAM, TAMMY E
A# D00502311[redacted]
01/21/08 F 40
Lawton, Joseph J. [redacted]058-A

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
1/22/08	825 AM PM			

Add Serum iron, ferritin, TIBC to blood in lab.
Precath / post PCI orders for today.
clear liquids this am
stool for occult blood

MJ Smith, RN 1/22/08

Physician Signature: [signature] Beeper #:

SCANNED

Date:	Time:	Profiled by:	Filled by:	Checked by:
1/22/08	520 AM PM			

May Appt at Family Medical clinic in Sumter re Iron deficiency anemia

Office closed, copy to make tomorrow's Dr's desk

24 hour chart ✓
1·22·08 2225
S. Klais, RN

MJ Smith, RN 1/22/08

Physician Signature: [signature] Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

849

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002265

WINDHAM, TAMMY E
A# D00502311[redacted]682
01/21/08 F 40 [redacted]5058-A
Lawton, Joseph J. III DR.

SCANNED

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
1/23/08	850 AM PM			

Dr home
Appt c Family med Clinic 2wks
Sumter
Flu Dr. Lawton 6 wks with lipid panel
Please give one month of Plavix.

Called Kim Hicks 1-23-08 1010

Physician Signature: [signature] Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
	AM PM			

Physician Signature: Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

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Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

850

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00502311541
DR: Lawton,Joseph J. II
DIAGNOSIS: CHEST PAIN
VERIFIED BY: _____

ROOM: D.H5058-A
AGE: 40 SEX: F
ADMITTED: 01/21/08
[redacted]

5 4.00 (FT/IN) / 162.56 (CM) 157 1.02 (LB/OZ) / 71.243 (KG)

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 01/21/08 TO 0659 01/22/08

START/STOP	0700-1459	1500-2259	2300-0659
NTG gtt DIC			
✓ Lopressor 50mg p.o BID daily		2200	
✓ ASA 81mg p.o q daily			
✓ Plavix 75mg p.o q daily			
✓ Simvastatin 20mg p.o q daily			
Darvocet 1-2 po q4° PRN		2151 2 Tabs 10/10	0711 2 Tabs 9/10
Dilaudid 1mg IV q4° PRN Severe Pain			

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
				Charee Jensen	

WINDHAM,TAMMY E 40/F DR: Lawton,Joseph J. II ROOM: D.H5058-A

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

D2267

WINDHAM,TAMMY E
A# D00502311541
01/21/08 F 40
Lawton,Joseph J. [redacted]8-A

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

Columbia Cardiology Consultants
Standard PRN Medications

Medication / Dose / Route Frequency	Start / Stop	0700 – 1459	1500 – 2259	2300 - 0659
Tylenol 2tabs PO q4h PRN pain				
Darvocet-N-100 PO q4h PRN pain unrelieved by Tylenol				
Restoril 15mg PO qHS PRN May repeat X 1				
NTG 1/150 SL PRN chest pain				
Dilaudid _____mg IV PRN chest pain unrelieved by 3 NTG Notify MD				
Reglan 10mg IV q4h PRN nausea				
Compazine _____mg IV / PO q4h PRN nausea unrelieved by Reglan				
Xanax 0.25mg PO q4h PRN anxiety 0.125mg for patients > 70 years of age				
Regitine _____mg SQ PRN Dopamine infiltration				

Signature	Initials	Signature	Initials	Signature	Initials

852

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 1

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 71.243kg BSA: 1.81
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
MAR DATE: 01/22/08-0700 TO 01/23/08-0659
RUN DATE/TIME: 01/22/08-0051
VERIFIED BY: C Jones, RN [redacted]

002268

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** SCHEDULED MEDS *****				
Rx#: 02808771 ASPIRIN 81 MG CHEW (81 MG) (Childrens Chewable Aspirin) DOSE: 81 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5H	01/21/08 SCH	1000 MC		
Rx#: 02808772 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (Plavix 75MG) DOSE: 75 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5H	01/21/08 SCH	1000 MC		
Rx#: 02808770 METOPROLOL TARTRATE 50 MG TABLET (50 MG) (Lopressor) DOSE: 50 MG PO SIG: TWICE DAILY INVENTORY from D5H	01/21/08 SCH	1000 MC	2200 SK	
Rx#: 02808773 SIMVASTATIN 20 MG TAB (20 MG) (Zocor) DOSE: 20 MG PO SIG: DAILY AT BEDTIME INVENTORY from D5H	01/21/08 SCH		2200 SK	
Demerol 50mg ON Call to cath lab		1/22	1145 MC	
Phenergan 25mg IM x1 dose ON call to cath lab		1/22	1145 MC	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				S. Khalif, RN	SK
				Maggie Hurtt	MC

853

6055

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 71.243kg BSA: 1.81
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
002269
MAR DATE: 01/22/08-0700 TO 01/23/08-0659
RUN DATE/TIME: 01/22/08-0051
VERIFIED BY: Cooms, RN DOB

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 02808767 ALPRAZOLAM 0.25 MG TAB (None) (Xanax 0.25MG Tab) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED DOSE INSTR: 0.25 MG INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808768 D50W 50 ML BRISTOJECT (50 ML) (Dextrose 50%Water Syringe) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: If blood sugar is less than 50, give 1 amp. D/50W INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808775 HYDROmorphone HCL 2 MG/ML AMP (None) (Dilaudid 2MG/Ml Inj) DOSE: 1 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PRN SEVERE PAIN. DOSE INSTR: 1.MG INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808766 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (Reglan 10MG/2ML Vial) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR NAUSEA EXP 48HRS (IN NS) EXP 24HRS (IN D5W) *** LIGHT SENSITIVE *** INVENTORY from D5H	01/21/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 71.243kg BSA: 1.81
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
MAR DATE: 01/22/08-0700 TO 01/23/08-0659
RUN DATE/TIME: 01/22/08-0051
VERIFIED BY: C Jones, RN
DOB: [redacted]

002270

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 02808765 NITROGLYCERIN 0.4 MG 25TABBOT (None) (Nitroquick 0.4MG Subl) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D5H	01/21/08 PRN				
Rx#: 02808774 PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN DOSE INSTR: 1-2 TABS INVENTORY from D5H	01/21/08 PRN	1320 JOS 1		1820 ML 22/35 SK	
Rx#: 02808764 TEMAZEPAM 15 MG CAP (None) (Restoril) DOSE: 15MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT X 1. DOSE INSTR: 15MG INVENTORY from D5H	01/21/08 PRN				

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
		[illegible]	JOS		
				[illegible]	ML

855

6057

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 72.773kg BSA: 1.83
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
MAR DATE: 01/23/08-0700 TO 01/24/08-0659
RUN DATE/TIME: 01/23/08-0115
VERIFIED BY: S.KLALIF, RN
DOB: [redacted]

002271

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** SCHEDULED MEDS *****				
Rx#: 02808771 ASPIRIN 81 MG CHEW (81 MG) (Childrens Chewable Aspirin) DOSE: 81 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5H		01/21/08 SCH	~~1000~~ KR		
Rx#: 02808772 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (Plavix 75MG) DOSE: 75 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5H		01/21/08 SCH	~~1000~~ KR		
Rx#: 02808770 METOPROLOL TARTRATE 50 MG TABLET (50 MG) (Lopressor) DOSE: 50 MG PO SIG: TWICE DAILY INVENTORY from D5H		01/21/08 SCH	~~1000~~ KR 109/52 BP 63 PUSC	2200	
Rx#: 02808773 SIMVASTATIN 20 MG TAB (20 MG) (Zocor) DOSE: 20 MG PO SIG: DAILY AT BEDTIME INVENTORY from D5H		01/21/08 SCH		2200	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Jade Stewart VCU BSN student	JS			Karl Klein RN	KR

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 72.773kg BSA: 1.83
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
002272
MAR DATE: 01/23/08-0700 TO 01/24/08-0659
RUN DATE/TIME: 01/23/08-0115
VERIFIED BY: S. Khalid, RN DOB: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 02808767 ALPRAZOLAM 0.25 MG TAB (None) (Xanax 0.25MG Tab) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED DOSE INSTR: 0.25 MG INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808768 D50W 50 ML BRISTOJECT (50 ML) (Dextrose 50%Water Syringe) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: If blood sugar is less than 50, give 1 amp. D/50W INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808775 HYDROmorphone HCL 2 MG/ML AMP (None) (Dilaudid 2MG/Ml Inj) DOSE: 1 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PRN SEVERE PAIN. DOSE INSTR: 1 MG INVENTORY from D5H	01/21/08 PRN			
Rx#: 02808766 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (Reglan 10MG/2ML Vial) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR NAUSEA EXP 48HRS (IN NS) EXP 24HRS (IN D5W) *** LIGHT SENSITIVE *** INVENTORY from D5H	01/21/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502311541 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5H D.H5058 A
AGE: 40 SEX: F WT: 72.773kg BSA: 1.83
ADMITTED: 01/21/08 PHYSICIAN: Lawton,Joseph J. III D
NOTES:

PRIMARY DX: CHEST PAIN
002273
MAR DATE: 01/23/08-0700 TO 01/24/08-0659
RUN DATE/TIME: 01/23/08-0115
VERIFIED BY: S.KLAISON D[redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 02808765 NITROGLYCERIN 0.4 MG 25TABBOT (None) (Nitroquick 0.4MG Subl) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D5H	01/21/08 PRN				
Rx#: 02808774 PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN DOSE INSTR: 1-2 TABS INVENTORY from D5H	01/21/08 PRN				
Rx#: 02808764 TEMAZEPAM 15 MG CAP (None) (Restoril) DOSE: 15MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT X 1. DOSE INSTR: 15MG INVENTORY from D5H	01/21/08 PRN				

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

002274

WINDHAM
A# D00502311 [redacted]
01/21/08 F 40
Lawton, Joseph J. [redacted] 58-A

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
1/21/08 630	H+P
	40 y/o WF c̄ hx CAD
	- 2.5 x 18 systolic to dry 4(02)
	w/ LV & mild-mod dz d/c
	CP x 3d "stabbing"
	⊕ migraine HA "stress"
	EKG ok cbc & drop w/ prior ER
	A/P 1) CP ? angina 4) dehydrated
	2) CAD
	3) carotid bruits
	- admit
	- ASA, B Blkr. etc 771044
	- serial enzymes
	- ? re cath
	- carotid Dopplers
	N Thillainathan

PROGRESS RECORD

859

NUR018 (1/03)

6061

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

002275

WINDHAM, TAMMY E
A# D00502311541
01/21/08 F 40
Lawton, Joseph J. [redacted]8-A

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
1/22	CP improved. ∅ nausea.
	108/48
	NSR
	CE's (-) so far Hgb 10.8
	ECG NSR LVH c̄ NSST Δ MCV 63
	Imp) CP poss US angina.
	Anemia prob iron deficiency? hemorrhage
	✓ Fe studies.
	Plan cath later today.
	Non DES if stent needed.

NUR018 (1/03) PROGRESS RECORD 860

6062

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM,TAMMY E 002276
A# D005023115[redacted]
01/21/08 F 40
Lawton,Joseph J. [redacted]

Date	POST-PROCEDURE PROGRESS NOTE
1-22-08	NEXT-LEVEL-OF-CARE COMMUNICATION NOTE
	Preoperative Diagnosis: C.P/AP/CAD
	Postoperative Diagnosis: ☑ Same as Preoperative:
	Procedure(s) Performed: CATH
	Name of Primary Operator: RABERB
	Name of Assisting Physician if Different from Primary Operator:
	Estimated Blood Loss: <10 ml ☐ None
	Specimens Removed: ☑ None
	Condition of Patient: ☑ Stable ☐ Unstable ☐ Critical
	Findings/Description of Procedure(s):
	LVGram: NORMAL
	RCA: long 50% mid, mild diffuse dist dis
	LMAIN: SHORT, NORMAL
	LAD: MINOR LAD DIS, 40% OSTIAL D, & 30% D2, small diffuse dis. distal
	LCX: 50% PROX large OM, STENT widely PATENT w CX.
	771229
	Physician Signature: Date: 1-22-08

POST-PROCEDURE PROGRESS NOTE

NUR029 (4/05)

861

6063

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

002277

WINDHAM, TAMMY E
A# D005023115[redacted] W#000895682
01/21/08 F 40 [redacted]058-A
Lawton, Joseph J. III M.D.

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
1/22	Cath as above. for med Rx. will review carotid studies & try to Δ to meds on Walmart List at Dc Encouraged smoking cessation. [signature]
1/23	No further CP. Afebrile ↓16 110/50 NSR carotid duplex 40-59% RICA < 39% LICA Cor RRR s m Chest clear Groin ∓ hematoma or bruit Imp CAD for med Rx Mild-mod carotid dz Iron def. Anemia ? menorrhagia Plan Dc home Encouraged Flu ∓ Family Health center in Sumter. re anemia & Gyn exam [signature]

NUR018 (1/03)

PROGRESS RECORD

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

HISTORY AND PHYSICAL

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: R. Taylor Williams, M.D.
ADMISSION DATE: 01/21/2008
DISCHARGE DATE:
SOCIAL SECURITY: ###-##-1815

ACCOUNT#: D00502311541
MR#: M000895682
AGE: 40
DOB: [redacted]
NURSING STATION: D.ED

PATIENT: TAMMY E. WINDHAM

CHIEF COMPLAINT: Chest pain and headache.

HISTORY OF PRESENTING ILLNESS: Mrs. Windham is a 40 year old White female with known coronary artery disease previously seen by Dr. Lawton in our practice. She apparently underwent stenting of the OM-2 with a 2.5 x 18 mm Cypher stent in Apr 07. She notes she has been under a lot of stress. For three days, she has had intermittent stabbing chest pain. She does not think this is associated with exertion. She has this associated with stress. She also has a headache and notes she has frequent migraines, and she goes to Tuomey ER and gets "a shot". She feels she is under a great deal of stress due to financial constraints and has not been able to afford her medications. Her husband also reiterates there have been problems with the marriage. She does have some nausea. She denies palpitations, syncope or near syncope, visual changes or other stroke symptoms. Nitroglycerin made her headache worse.

PAST MEDICAL HISTORY:
1. Coronary artery disease with stenting of the OM-2 with a 2.5 x 28 mm stent, in 4-07; otherwise, she had mild to moderate disease as well as branch vessel disease, and normal LV function.
2. Longstanding tobacco use.
3. Migraine headaches.
4. Dyslipidemia.
5. History of menorrhagia.

SOCIAL HISTORY: She smokes about two packs a day per her husband. She is unemployed. Her husband works part time and they are having a lot of issues with finances. She does not drink alcohol.

FAMILY HISTORY: Noncontributory at this time.

MEDICATIONS: None, as she cannot afford them. Previously she was prescribed Lipitor, Plavix, Lopressor, Aspirin and Nitrostat.

ALLERGIES: None reported.

REVIEW OF SYSTEMS: Other than what has been mentioned previously, all other systems are reviewed and are negative.

PHYSICAL EXAMINATION: GENERAL: The patient is a pleasant White female in no acute distress. VITAL SIGNS: Blood pressure is 150/80, pulse 90 and regular, respir-ations 18, temp 97.5, oxygen saturation 100%. HEENT: Extraocular movements are intact. Oropharynx shows moist mucous membranes. Neck is supple. No jugular venous distention. She does have bilateral carotid bruits. CARDIAC: Regular rate and rhythm without murmur, rub or gallop. LUNGS: Clear, without rales or wheezes. ABDOMEN: Nontender, nondistended with no masses, no organomegaly. EXTREMITIES: No cyanosis, clubbing or edema. NEUROPSYCHIATRIC:

COPY

She is alert and oriented times three with no gross focal motor, sensory or cranial nerve deficits. MSK: No significant joint deformities. SKIN: No significant lesions or rashes.

EKG shows sinus rhythm with minimal nonspecific lateral T-wave abnormalities.

LABORATORY DATA: Per the ER physician, CK and troponin are normal. WBC is 8, hemoglobin 10.8, hematocrit 35.7, MCV 63, platelets 392. Sodium and potassium are normal. Glucose is 102, BUN 8, creatinine .8, calcium 9.1.

ASSESSMENT:
1. Known coronary artery disease with chest pain.
2. Headache.
3. Tobacco abuse.
4. Poor social support.

DISCUSSION/PLAN: Her symptom complex is not entirely typical of angina and fortunately EKG and enzymes are unremarkable. Her primary complaint now is headache. She does have known coronary artery disease and multiple risk factors including smoking, so we need to have a high index of suspicion for coronary event. She will, therefore, need to be admitted. She will be given beta blocker, aspirin and Plavix. She will be offered Darvocet as needed for pain, and will try to avoid narcotics. She again has been counseled about the importance of smoking cessation. Serial cardiac enzymes will be drawn and she may potentially need repeat cardiac catheterization. She does have chronic bruits and this will need to be evaluated with carotid Dopplers. A Social Work consult will be obtained. She certainly needs help with her finances.

R. Taylor Williams, M.D.

RTW/jfs
DD: 01/21/2008 / DT: 06:21 PM
TD: 01/21/2008 / TT: 07:01 PM
JOB #: 771044

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 FOREST DRIVE
COLUMBIA, SOUTH CAROLINA 29204
(803) 256-5300

DISCHARGE SUMMARY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 01/21/08
DISCHARGE DATE: 01/23/08
ROOM/BED: D.H5058-A
PATIENT TYPE: CAR

ACCOUNT # D00502311541
MED REC # M000895682
AGE: 40

NURSING STATION: D.5H
CLINIC CODE:

****

222364
DOCTOR: Joseph Lawton, III, M.D.
ADMISSION DATE: 01/21/2008
DISCHARGE DATE: 01/23/2008
SOCIAL SECURITY: ###-##-1815

MR#: M000895682
AGE: 40
DOB: [redacted]
NURSING STATION: D.5H

CC: Family Health Center
Sumter, S.C.

PATIENT: TAMMY E. WINDHAM

DISCHARGE DIAGNOSES:

1. Precordial chest pain.
2. Coronary artery disease with a history of previous subendocardial MI and stent placement to the circumflex marginal in April 2007 with a 2.5 x 18 Cypher stent.
3. History of tobacco use.
4. Hyperlipidemia.
5. Mild to moderate carotid atherosclerosis with 40 to 59% right internal carotid stenosis and 39% left internal carotid stenosis.
6. Status post repeat catheterization demonstrating normal left ventricular function, 50% mid right coronary, mild LAD plaque, 40% ostial first diagonal, 30% second diagonal, 50% proximal OM #1 with a patent circumflex stent.
7. Iron deficiency anemia possibly related to menorrhagia.

PROCEDURES: Cardiac catheterization performed on 01/22/2008.

HOSPITAL COURSE: Please see the History and Physical by Dr. Taylor Williams. The patient was admitted because of some intermittent precordial chest pains which were somewhat stabbing in quality. The patient had been under a lot of stress as well related to difficult finances. She was placed on aspirin and beta blockers. Cardiac enzymes were negative. She underwent repeat catheterization which demonstrated no evidence of significant restenosis and moderate disease otherwise. She was noted to have iron deficiency anemia and was to be started on iron therapy. Additionally, because of carotid bruits, she had a carotid duplex accomplished which demonstrated mild to moderate carotid disease as described above with 40 to 59% right internal carotid stenosis. She was encouraged to discontinue tobacco products. Her medicines have been adjusted to provide medicines that she can hopefully afford at Wal-Mart. She needs to complete two more months of Plavix for her drug-eluting stent.

LABORATORY DATA: Sodium 139, potassium 4.2, glucose 86, BUN 11, creatinine

DISCHARGE SUMMARY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 01/21/08
DISCHARGE DATE: 01/23/08
ROOM/BED: D.H5058-A
PATIENT TYPE: CAR
SC

ACCOUNT # D00502311541
MED REC # M000895682
AGE: 40
DOB: [redacted]
NURSING [redacted]
CLINIC CODE:

****

0.9, total protein 6.8, albumin 3.2, bilirubin 0.4, AST 21, ALT 25, alkaline phosphatase 126, cholesterol 183, HDL 24, LDL 122, triglycerides 183, serum iron was low at 16, ferritin was low at 4.0. Iron binding was 386. Troponin with reflex was negative times 3 sets. CPK was normal at 38, white count 8.5, hemoglobin 11.8, hematocrit 35.7 with MCV of 62.7, platelets 392,000, pro-time 12.6 with an INR of 0.9. Stool for occult blood was ordered but never received. Chest x-ray demonstrated clear lung fields and a normal heart size. EKG showed sinus rhythm at 64 beats per minute with some nonspecific ST/T abnormalities.

DISPOSITION: The patient was encouraged to discontinue tobacco products. She is to follow up with the Family Health Center in about two weeks for further workup of her iron deficiency anemia. I have asked her to have lipids checked in about six weeks in our office with a follow up appointment at that time.

DISCHARGE MEDICATIONS INCLUDE:

1. Aspirin 81 mg daily.
2. Plavix 75 mg daily for two months.
3. Tenormin 25 mg daily.
4. Pravachol 40 mg daily.
5. Iron sulfate 325 mg, one daily.

Joseph Lawton, III, M.D.

JL/gb
DD: 01/23/2008 / DT: 08:55 AM
TD: 01/23/2008 / TT: 01:57 PM

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 FOREST DRIVE
COLUMBIA, SOUTH CAROLINA 29204
(803) 256-5300

002282

DISCHARGE SUMMARY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 01/21/08
DISCHARGE DATE: 01/23/08
ROOM/BED: D.H5058-A
PATIENT TYPE: CAR
SOCIAL SECURITY # 247-31-1815

ACCOUNT # D00502311541
MED REC # M000895682
AGE: 40
NURSING STATION: D.5H
CLINIC CODE:

****
JOB #: 771400

Electronic Signature By: **Dr. Joseph J. Lawton, III**
<<SIGNATURE ON FILE>>

Electronic Signature Date: 02/13/08
Electronic Signature TIme: 1545

867

HOSPITAL
A Sisters Of Charity Ministry
2435 Forest Drive
Columbia, SC 29204

HOSPITAL NORTHEAST
120 Gateway Corporate Blvd.
Columbia, South Carolina 29203

A# 50231154 U#M000895682
01/21/08 F 40
Powell,D Langston 02283

EMERGENCY DEPARTMENT

LABS		Radiology/CT/US		Medications/Other
CBCX	BMP	PCXR	Pa/Lat CXR	
CBCD	CMP	Abd 1 View	Abd 2 View	
BTNP	HCG Urine		TROP/CK/Myo	
Amylase	HCG Serum	CT→		① NTG/NP
Lipase	Rapid Strep	US→		② ASA WINV IV
Wet Prep	GC Culture	**Nursing Procedures**		③ Dextrose 5% IV
UA-C	Chlamydia	IV _____ @ _____ ml/hr		④ Phenergan WIV
ABG		O2 _____ LPM via _____		⑤ NTG MP
PT	PTT	Monitor	INT	
		Old Records	EKG	

Physician Signature _____

Diagnosis Chest pain (2) Hx

☐ Wound Care ☐ Burn Care ☐ Vomiting & Diarrhea ☐ Head Injury ☐ Other _____

☐ Follow-up with regular M.D. ☐ Referral to _____

☐ May use Tylenol or Advil as directed

May return to work / school _____

Additional Instructions _____

PROVIDENCE HOSPITAL
A Sisters Of Charity Ministry
2435 Forest Drive
Columbia, SC 29204
(803) 256-5320

PROVIDENCE HOSPITAL NORTHEAST
120 Gateway Corporate Blvd.
Columbia, SC 29203
(803) 865-4530

EMERGENCY DEPARTMENT

Richard A. Boyer, MD
SC Lic # 9408
DEA # AB8750766

Donald G. Moore, MD
SC Lic # 11453
DEA # AM1668346

David C. Winn, MD
SC Lic # 13733
DEA # BW1140970

Anoma Gamage, MD
SC Lic # 22010
DEA # BG5440867

D. Langston Powell, MD
SC Lic # 14016
DEA # BP0964975

Robert Ramos, MD
SC Lic # 19001
DEA # BR5132701

Michael Hayes, MD
SC Lic # 17402
DEA # BH3158486

Michael P. Taillon, MD
SC Lic # 13613
DEA # BT0941737

DATE

NAME

ADDRESS

Label with Drug Name / Strength	No.	DIRECTIONS	Refill

868

EMR003 (11/07) DISPENSE AS WRITTEN _____ M.D./D.O.

SUBSTITUTION PERMITTED _____ M.D./D.O.

6070

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

CARDIOPULMONARY SERVICES / CATHETERIZATION LABORATORY REPORT

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: Michael Roberts, M.D.
ADMISSION DATE: 01/21/2008
DISCHARGE DATE: 01/23/2008
SOCIAL SECURITY: ###-##-1815

ACCOUNT#: D00502311541
MR#: M000895682
AGE: 40

NURSING STATION: D.5H

PATIENT: TAMMY E. WINDHAM

DATE OF PROCEDURE:

CATHING CARDIOLOGIST: MICHAEL ROBERTS, M.D.

CLINICAL HISTORY: The patient is a 40-year-old White female with known CAD. She represents with chest pain, consistent with Class III angina pectoris. She has remotely had a stent placed in the circumflex but has been noncompliant with some of her medications. Her enzymes have been negative for myocardial injury.

CURRENT MEDICATIONS:
1. Lopressor 50 mg b.i.d.
2. Aspirin daily.
3. Plavix 75 mg daily.
4. Simvastatin 20 mg every h.s.
5. Darvocet-N 100.

ANCILLARY DATA-EKG: The EKG shows sinus rhythm, nonspecific ST-T wave changes.

PROCEDURES PERFORMED:
1. Left heart catheterization.
2. Left ventriculogram.
3. Selective coronary arteriography.

CATHETERS USED:
1. #4Fr. pigtail.
2. #4Fr. JL-4.
3. #4Fr. JR-4.

DESCRIPTION OF PROCEDURE: The procedure was performed in the routine fashion from the right groin. Local anesthesia was 1% Xylocaine. The catheters were inserted via the Seldinger technique. Selective angiography was performed and described in detail below. A left ventriculogram was performed from the 30-degree RAO projection using 10 mL of nonionic contrast dye. LV-to-Ao pullback was obtained and all hemodynamics measured.

Post procedure hemostasis was obtained with manual pressure. The patient left the Cath Lab in stable condition.

HEMODYNAMICS: Left ventricular end-diastolic pressure was 12 with a pre-A of 8. There was no LV-to-Ao gradient.

ANGIOGRAPHIC FINDINGS

CORONARY ARTERIOGRAPHY:

COPY

1. **Right Coronary Artery**: There is mild diffuse disease in the RCA with a long 50% stenosis in the mid segment of the RCA with mild diffuse disease noted distally.

2. **Left Coronary Artery**:
   a. Left Main Coronary Artery: The left main coronary artery is a short vessel and normal.

   b. Left Anterior Descending Coronary Artery: There is minor diffuse irregularities in the LAD. There is about a 40% stenosis in the ostial first diagonal branch. There is a 30% stenosis in the second diagonal branch. The distal LAD is mildly diffusely diseased and a small caliber vessel.

   c. Left Circumflex Coronary Artery: The proximal AV circumflex is normal. There is a large mid obtuse marginal branch which arises off the mid AV circumflex. There was a long 50% stenosis in this obtuse marginal branch. The stent had visualized in the mid segment of this same OM branch and widely patent.

IMPRESSION:
1. Preserved left ventricular function.
2. Mild to moderate three-vessel coronary artery disease, as outlined above, with a widely patent stent noted in the circumflex obtuse marginal branch.

Michael Roberts, M.D.

MR/rln
DD: 01/22/2008 / DT: 12:59 PM
TD: 01/23/2008 / TT: 08:44 PM
JOB #: 771229

870

Providence Heart Institute

2435 FOREST DRIVE
COLUMBIA,SC 29204

002286

Patient Information

Patient Name		Study Date	MRN	Study #	Adm. ID
WINDHAM, TAMMY		1 /22/2008	M000895682	080368	D00502311541
Date of Birth	Age	Gender	Height *cm*	Weight *kg*	B.S.A. m^2
	40	Female	163.00 (5'4")	69.40 (153 lbs)	1.75

Procedures

Time	Procedure
12:20PM	DX Pulse Oximetry
12:20PM	Left Heart Cath
12:20PM	Coronary Angio
12:20PM	LV or LA Angiogram

Staff

		IN	OUT
Diagnostic Cardiologist	Michael Roberts, M.D.	12:30PM	
Scrub	Tammy Reese, CVT	12:20PM	
Circulator	Michelle Sellers, RN	12:20PM	
Monitor	Ashleigh Cook, RCIS	12:20PM	

Event Log

Time	Summary	Comment
12:00PM	Phase: Baseline	
12:19PM		Cath Lab: 3
12:20PM		Patient Arrival Time
12:20PM	Procedure: DX Pulse Oximetry	
12:20PM	Procedure: Left Heart Cath	
12:20PM	Procedure: Coronary Angio	
12:20PM	Procedure: LV or LA Angiogram	
12:25PM		Procedure Status: Urgent
12:25PM		Basic Supplies:
12:25PM	BASIC PACK	
12:25PM	10 IN PRESSURE TUBING	
12:25PM	CLIPPER BLADE	
12:25PM	CONT SYRINGE 8CC	
12:25PM	500CC BAG NS/HEPARIN 1000 UNITS	
12:25PM	500CC BAG NS/HEPARIN 1000 UNITS	
12:25PM	500CC BAG NS	
12:25PM	IV TUBING	
12:25PM		Patient Prep Time
12:25PM		Clipped, prepped and draped R Groin site
12:25PM		Clipped, prepped and draped L Groin site
12:25PM		Physician called
12:25PM		RISK FACTOR Profile:
12:25PM		Additional RISK FACTORS:
12:25PM		Creatinine Assessed on Admission

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COLUMBIA,SC 29204

002287

12:25PM		Admission Creatinine: 0.9
12:25PM		Prev Percutaneous Coronary Intervention
12:25PM		Previous PCI Date: 2007/04/01
12:25PM		Hyperlipidemia
12:25PM		History of Tobacco Use: Current
12:25PM		Previous MI > 7 Days
12:25PM		Pre-Assessment completed in Holding Area by: MS
12:25PM		LOC: A&O x 3. Responds purposefully to verbal commands.
12:25PM		Baseline Aldrete Score obtained
12:25PM	SpO2 95%; HR 58 bpm; 131/70/95 NBP; RR 14/min	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:26PM		Lung Sounds auscultated: CTA bilaterally
12:26PM		Denies Pain or Discomfort.
12:26PM		Pulses: R DP/PT = 3/2
12:26PM		Pulses: L DP/PT = 3/2
12:26PM		Allergies: NKA
12:26PM		NPO Status: No Clear Liquids x minimum 2 hrs
12:26PM		NPO Status: No Solid Intake po x minimum 6 hrs
12:26PM		IV Site(s): R X 1
12:26PM		IV site(s) patent & w/out redness, pain, or swelling
12:26PM		IV Fluids and IV Meds:
12:26PM	NS IV 20 cc/hr	STARTED IN LAB; MS
12:26PM		See MAR for other current medications
12:26PM		Denies current pregnancy
12:26PM		Date of LMP: 1-17-08
12:26PM		Denies previous anesthesia/sedation complications
12:26PM		All selected lab results WNL
12:26PM		Intra Procedure Plan of Care Initiated
12:26PM		Consents signed & appropriate
12:26PM		H&P Charted
12:30PM		Physician called
12:30PM		Physician Arrived
12:30PM		Diagnostic Physician
12:30PM		Time Out to verify correct patient & correct site
12:30PM		--Radiation protective equipment checked.
12:30PM		--All team members compliant.
12:30PM		----------
12:30PM		Assessment of ASA CLASSIFICATION per MD
12:30PM		ASA Class III: Patient w/ Severe Systemic Disease
12:30PM	SpO2 94%; HR 57 bpm; 142/75/103 NBP; RR 25/min	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:30PM		MALLAMPATI AIRWAY CLASSIFICATION per MD:
12:30PM		Class IV = Visualization of hard palate only
12:32PM		Procedure Start Time

12:47PM		Patient Disposition: Telemetry Bed
12:47PM		IABP not used
12:47PM		Verbal orders during case because MD in sterile gloves & gown
12:47PM		Read Back verification completed for all verbal orders -- MS
12:47PM		Total Contrast Infused: 65 ML
12:47PM	50CC BOTTLE OPTIRAY	
12:47PM	50CC BOTTLE OPTIRAY	
12:47PM		Patient Transfer Time

Aldrete Score – Pre Study

Pre-Study Conscious Sedation Assessments	
Activity	2 - Able to move 4 extremities voluntarily or on command
Respirations	2 - Able to breathe deeply and cough freely
Circulation	2 - BP +/- 20% of pre-anesthetic level
Consciousness	2 - Fully Awake
O2 Saturation	2 - Able to maintain O2 saturation > 92% on room air
Pre-study Totals	10

Materials

Time	Item Name (Model)	Comment
12:25PM	BASIC PACK	
12:25PM	10 IN PRESSURE TUBING	
12:25PM	CLIPPER BLADE	
12:25PM	CONT SYRINGE 8CC	
12:25PM	500CC BAG NS/HEPARIN 1000 UNITS	
12:25PM	500CC BAG NS/HEPARIN 1000 UNITS	
12:25PM	500CC BAG NS	
12:25PM	IV TUBING	
12:34PM	NEEDLE COOK	
12:34PM	WIRE .035 3MM 175 cm	
12:34PM	# 4F CORDIS SHEATH	
12:35PM	# 4F 145 PIGTAIL	
12:37PM	# 4F 3D RC	
12:40PM	# 4F JL 4.0	
12:47PM	50CC BOTTLE OPTIRAY	
12:47PM	50CC BOTTLE OPTIRAY	

X-Ray Summary

Total Dose	0.00 cGycm2	**Fluoro Time**	1.90 Minutes

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COLUMBIA,SC 29204

Contrast Summary

Contrast	Total (ml)
Optiray Used	65.00

Complications

Time	Complication	Comment
12:47PM	None	

Vital Signs

Time	SpO2	HR	BP	RR	Comment
12:25PM	95	58	131/70/95	14.00	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:30PM	94	57	142/75/103	25.00	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:35PM	94	63	162/81/112	16.00	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:41PM	95	57	132/70/91	22.00	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:45PM	95	60	137/68/93	19.00	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.

Medication Events

Start	Stop	Medication	Route	Amount	Units	Comments
12:26PM		NS	IV	20.00	cc/hr	STARTED IN LAB; MS
12:33PM		VERSED	IV	2.00	mg	MS
12:33PM	12:33PM	LIDOCAINE 2%	SQ	20.00	cc	DR. ROBERTS

Circulator Signature

Initials	Signature	Title	Time
MS	Michelle Sellers	RN	1300

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2435 FOREST DRIVE
COLUMBIA,SC 29204

002290

Monitor Signature

Initials	Signature	Title	Time
AC	Ashley Cox	RCIS	1250 PM

Acknowledging Arrival of Patient from Cath Lab:

Signature [illegible] Time: 1215 pm

Physicians Signature [illegible]

Patient Name: WINDHAM, TAMMY
MRN: M000895682

Study Date: 1/22/2008
Admission ID: D0050231154

875

6077

Providence Heart Institute

2435 FOREST DRIVE
COLUMBIA,SC 29204

002291

Patient Information

Patient Name		Study Date	MRN	Study #	Adm. ID
WINDHAM, TAMMY		1 /22/2008	M000895682	080368	D00502311541
Date of Birth	**Age**	**Gender**	**Height** *cm*	**Weight** *kg*	**B.S.A.** m^2
10/18/1967	40	Female	163.00 (5'4")	69.40 (153 lbs)	1.75

Pressure Results (mmhg)

Baseline

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
LV	204	4	19				9792	67

Post Angio

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	158	67		100				61
LV	194	16	24				1056	62

Valve Results

Valve	Grad (mmhg)	Flow (ml/s)	Area (cm^2)	Area Index (cm^2/m^2)	Sep/Dfp (sec/min)

876

12:33PM	VERSED IV 2 mg	MS
12:33PM		Site anesthesized: R. GROIN
12:33PM	LIDOCAINE 2% SQ 20.00 cc	DR. ROBERTS
12:34PM		Cannulated
12:34PM	NEEDLE COOK	
12:34PM	WIRE .035 3MM 175 cm	
12:34PM		Number of sticks required: 1
12:34PM	# 4F CORDIS SHEATH	
12:34PM		Access Site: Right Femoral Artery
12:35PM		catheter in:
12:35PM	# 4F 145 PIGTAIL	
12:35PM	SpO2 94%; HR 63 bpm; 162/81/112 NBP; RR 16/min	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:36PM		Label & Measure LV
12:36PM	LV : 201/5/18, Max dP/dt = 9792, HR = 66, aVF	
12:36PM	Snapshot: LV : 201/5/18	
12:36PM		Setup & Record LVEDP
12:36PM	LV : 204/4/19, Max dP/dt = 9792, HR = 67, aVF	
12:36PM	Snapshot: LV : 204/4/19	
12:36PM	Phase: Post Angio	
12:36PM		LV Gram done
12:36PM	LV : 194/16/24, Max dP/dt = 1056, HR = 62, aVF	
12:36PM		Pullback LV to AO
12:37PM	Pullback from LV to AO	
12:37PM	Snapshot: Gradient Measurement: Valve Area Measures	
12:37PM	Snapshot: Pullback: LV to AO.	
12:37PM	AO : 180/73/108, HR = 63, aVF	
12:37PM		catheter out
12:37PM		catheter in:
12:37PM	# 4F 3D RC	
12:39PM		Visualized Right Coronary Artery
12:40PM		catheter out
12:40PM		catheter in:
12:40PM	# 4F JL 4.0	
12:41PM	SpO2 95%; HR 57 bpm; 132/70/91 NBP; RR 22/min	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:41PM		Visualized Left Coronary System
12:43PM		Label & Measure AO
12:43PM	AO : 180/79/117, HR = 60, aVF	
12:43PM	Snapshot: AO : 180/79/117	
12:45PM	SpO2 95%; HR 60 bpm; 137/68/93 NBP; RR 19/min	LOC: Responds purposefully to verbal commands. Denies Pain or Discomfort. SEDATION SCALE: 0 = Alert.
12:46PM		Final AO Pressure
12:46PM	AO : 158/67/100, HR = 61, aVF	
12:46PM	Snapshot: AO : 158/67/100	
12:46PM		catheter out
12:46PM		Procedure Finish Time
12:47PM		Post Procedure Assessment:

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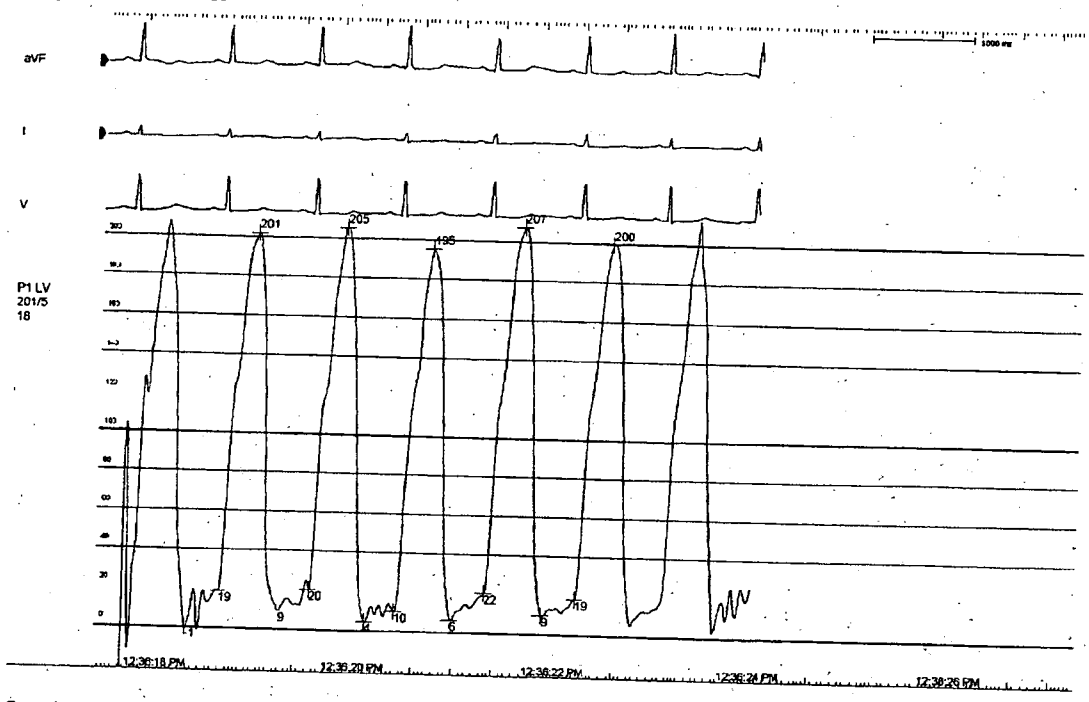
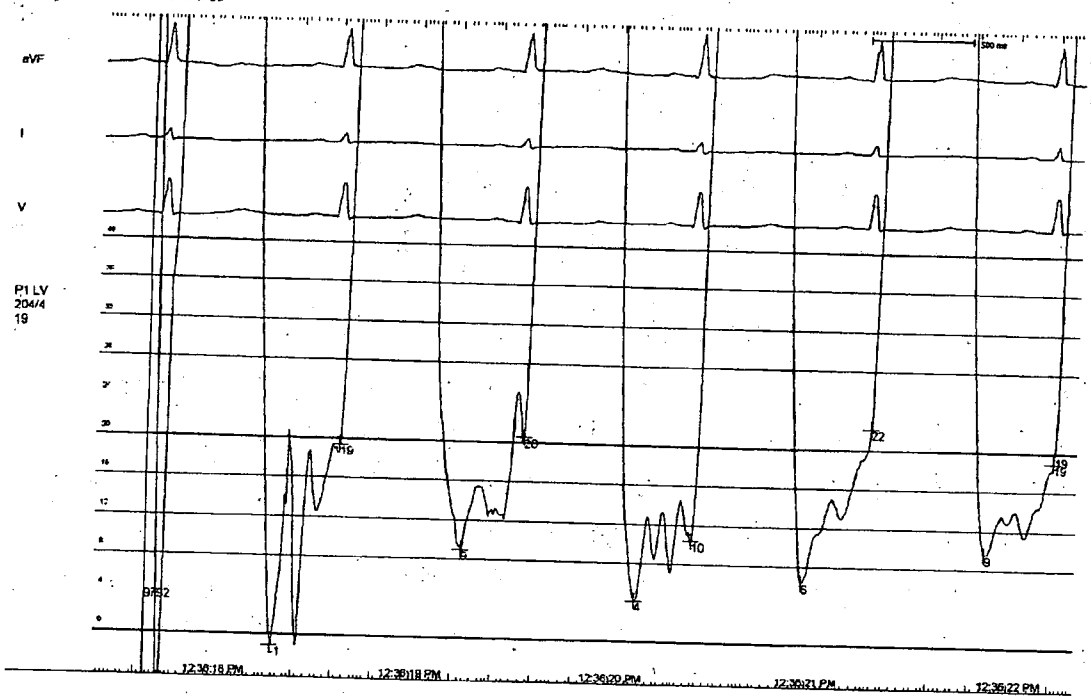
Snapshot: LV : 201/5/18



Snapshot: LV : 204/4/19



Snapshot: Gradient Measurement:

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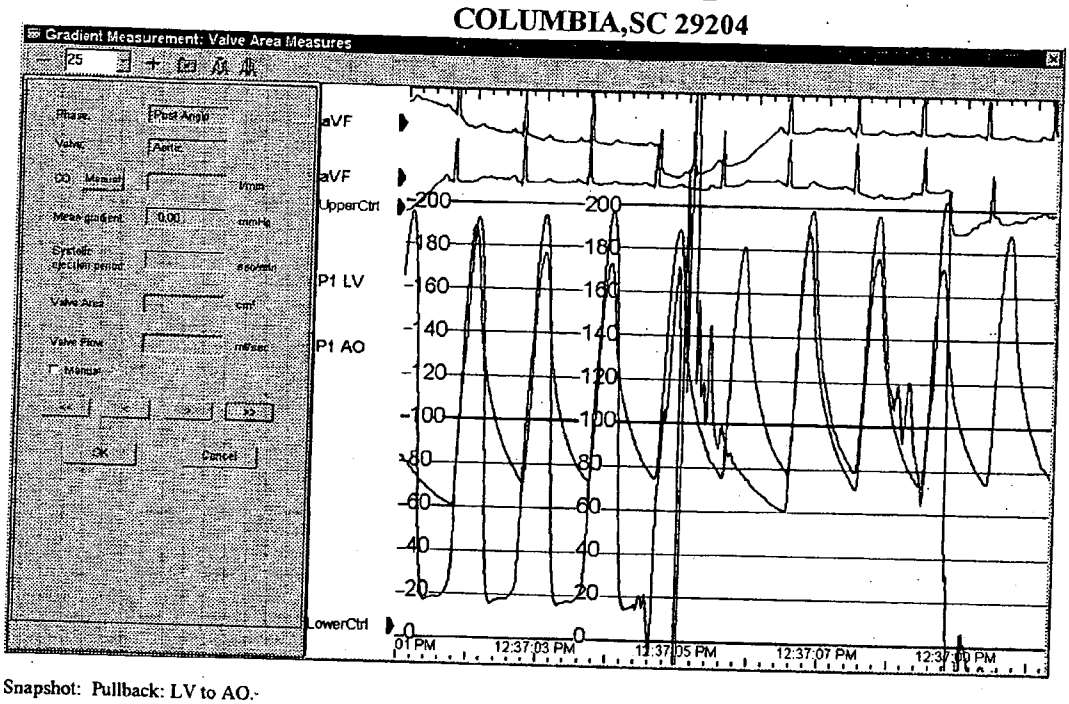
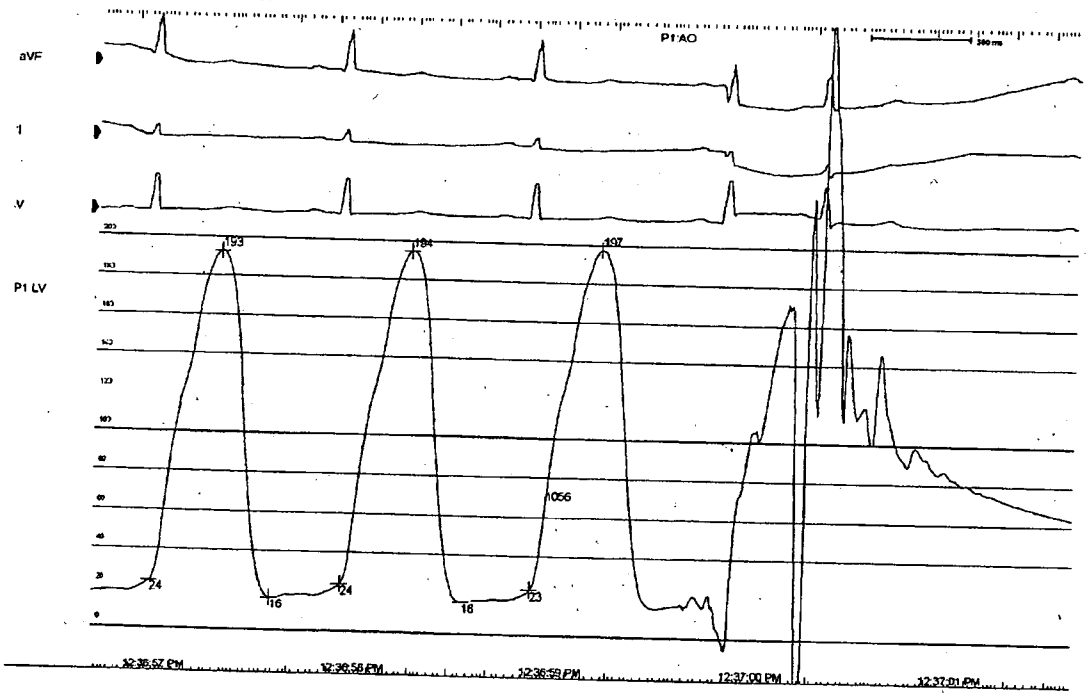
2435 FOREST DRIVE
COLUMBIA,SC 29204

002294



Snapshot: Pullback: LV to AO.-



Snapshot: AO : 180/79/117

Patient Name: WINDHAM, TAMMY
MRN: M000895682

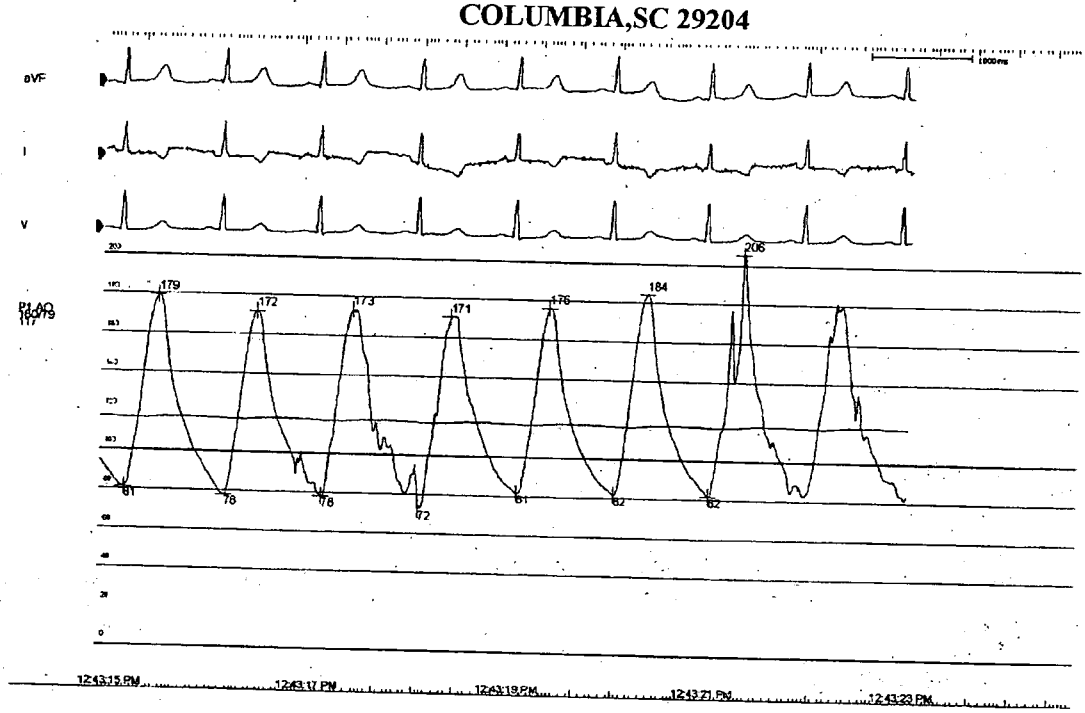
Study Date: 1/22/2008
Admission ID: D00502311541 879

6081

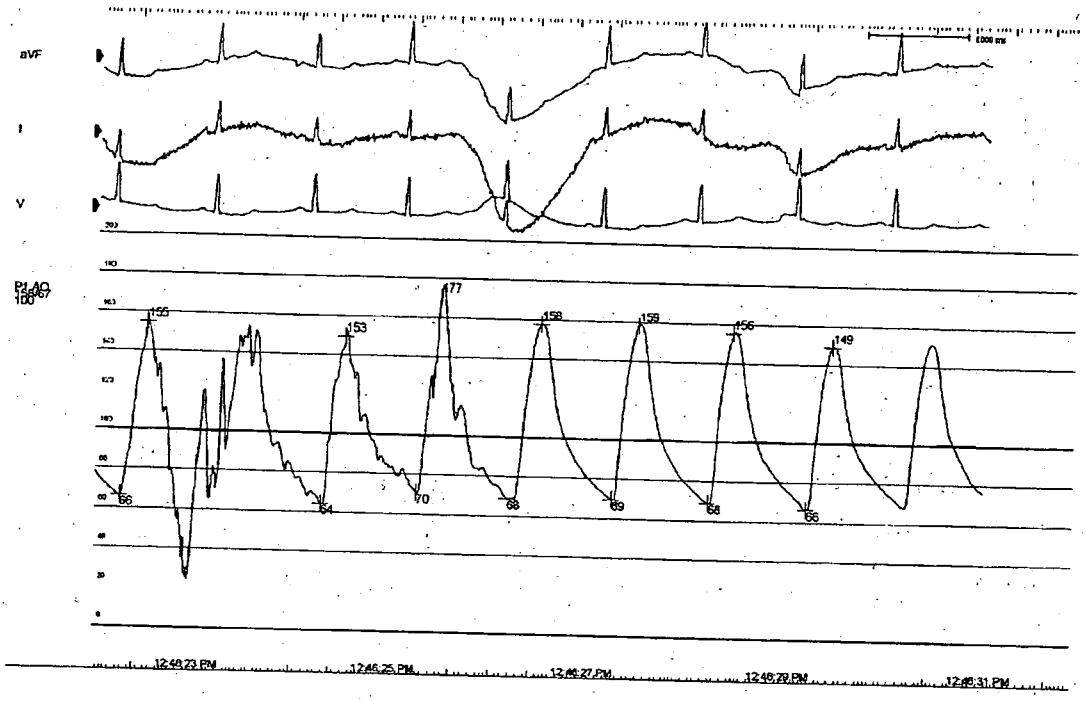
Providence Heart Institute

2435 FOREST DRIVE
COLUMBIA,SC 29204

002295



Snapshot: AO : 158/67/100



Patient Name: WINDHAM, TAMMY
MRN: M000895682

Study Date: 1/22/2008
Admission ID: D00502311541

880

6082

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002296
WINDHAM,TAMMY E
A# D00502311541 U#M000895682
01/21/08 F 40
Lawton,Joseph J. III Dr. D.H5058-A

Columbia Cardiology Consultants

CONSENT FOR DIAGNOSTIC CATHETERIZATIONS WITH POSSIBLE INTERVENTIONS PERFORMED WITHIN THE CATHETERIZATION LABORATORY

I hereby voluntarily consent to the performance of the following procedure(s):
Left and/or Right catheterization Angiography; (PTCA) Percutaneous Transluminal Coronary Angioplasty (PTDCA) Percutaneous Transluminal Directional Coronary Atherectomy; (PTRCA) Percutaneous Transluminal Rotational Coronary Ablation; Peripheral Angiography Thrombectomy; Intracoronary Ultrasound Imaging; Intra Aortic Balloon Pump Insertion; Intracoronary Stent(s) Implantation; Atherotomy; Pericardiocentisis

My scheduled physician is:
☐ **Dr. S. Stanley Juk** ☐ **Dr. Richard E. Umbach** ☐ **Dr. Michael C. Roberts** ☐ **Dr. Eugene F. Schwarz**
☐ **Dr. Joseph L. Lawton** ☐ **Dr. Robert M. Malanuk** ☐ **Dr. R. Taylor Williams**

I understand that circumstances may arise which may result in another physician performing such procedure other than as indicated above, and in such case I consent to the procedure being performed by the substitute physician.

I also consent to procedures not listed above for the treatment of diagnosed coronary artery disease if unforeseen conditions necessitate additional or different procedures to be performed by the above physician(s), assistants, nursing and technical personnel, as deemed necessary and desirable in their professional judgment. If emergency surgery is required, the above physician(s) has my permission to retain a surgeon to perform such an operation.

I understand that I am undergoing these procedures to aid in the diagnosis and treatment for my condition, which has been explained me and I have been provided additional information in the attached Informed Consent Patient Information. I have been advised by my physician that the indications for cardiac catheterization and angiography and the treatment of diagnosed coronary artery disease in my case outweigh the risks involved. I have been given an opportunity to ask questions about my condition, alternative forms to these procedures and blood transfusion (options, risks and alternatives), risks of non-treatment, the procedures to be used and the risks and hazards involved, which have also been explained fully to me. My consent is given freely, voluntarily and with full knowledge of all of the above written statements.

Tammy E Windham
Patient or Authorized Person Signature

Maggie Lartt, RN
Witness

Self
Relationship to Patient

1/22/08 9:50am
Date/Time

I have discussed with the patient and/or patient's representative the risks, benefits, potential complications, and alternative options associated with the planned procedure, possible use blood, and sedation/analgesic if appropriate, answered the patient's questions and obtained his/hers permission to proceed.

_____ **Physician's Signature/Date**

Revised: 05/04/07

881

6083

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM, TAMMY E
A# D00502311541 U#M000895682 002297
01/21/08 F 40 [redacted] D.H5058-A
Lawton, Joseph J. III Dr.

INFORMED CONSENT FOR CARDIAC CATHETERIZATION PROCEDURES

- Cardiac catheterization is a procedure in which a catheter is placed in an artery usually involving the leg or arm. The catheter is advanced to the heart under x-ray guidance for the purpose of obtaining pictures of the arteries to identify your risk of heart disease and help guide treatment.

- Though cardiac catheterization is a relatively safe procedure, it does have well-defined risks, including the risk of death, stroke, and heart attack with the occurrence of approximately 1 in 1000 patients. There is a risk of kidney failure in approximately 3% in which most patients recover, but of these approximately 10% may require dialyses and occasionally on a permanent bases. There is a risk of vascular trauma, which could require surgical or non-surgical repair. There is a chance that the cholesterol deposits can break loose from a vessel and result in the loss of tips of toes or fingers with potential for need of amputation, or to the intestines or colon, which might require surgery and removal of damaged tissue as a result. There is a risk of allergy to the dye used, which though rare, can be fatal. There is a risk of bleeding for which blood transfusions might be required as well as the possibility of the hematoma at the site. Occasionally there can be electrical instability of the heart requiring the delivery of an electrical shock to correct the problem. A rare patient may be unusually sensitive to medications for sedation that assistance in breathing with a respirator may be required. Overall the risk of a significant complication occurs in less than 2%.

- If your procedure involves an attempt to open a blocked artery (arteries) with such devices as balloons, cutting devices, placement of stents, or use of filters to catch debris there is an additional risk of approximately 1 in 100 that emergent bypass surgery may be required if the procedure fails. There also is a risk that the vessel may close from clot migration of material down the vessel, vessel rupture requiring emergent surgical or non-surgical treatment, risk of infection and risk that clot may develop at the site closing off the vessel early after the procedure. There is a chance that additional procedures may be required as approximately 20-30% of patients can develop excessive tissue growth inside a stent often within the first 6 months of the procedure, and a slightly greater chance if only a balloon without a stent is required.

- During or after the procedure, your doctor may feel it necessary to give you a transfusion of blood or blood components. Your doctor has discussed with you the alternatives to, and possible risks of transfusion, including unexpected blood reactions and the possible transmission of certain viruses, including hepatitis and AIDS, however remote.

- Other clinical staff may help your doctor during the procedure/treatment.

- The procedure may require that you undergo some form of sedation, which may have its own risks. Your doctor or a representative from the department of anesthesiology has informed you of the course of sedation that is recommended (if any) along with its possible risks and alternatives.

- Any tissue or specimens taken from your body as a result of the procedure may be examined and disposed of, retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.

- The surgical/diagnostic procedure/treatment may be photographed or videotaped; observers may be present in the operating, treatment or procedure room for the purpose of advancing medical care and education.
- All means of resuscitation will be pursued, should your heart stop beating during the procedure.
- There are no specific limitation or prohibitions regarding treatment other than the following:

  _____

- There can be a risk not to undergo catheterization as well if there is sufficient concern that you may have significant heart disease. Approximately 8-10% of patients die from their heart attacks within the first 30 days of the occurrence. Often this procedure identifies those at risk and offers a treatment that may prevent this from happening.
- This hospital offers and educational video, which you are encouraged to watch and you should feel free to ask any questions you, might have about your procedure.

Your signature below is to acknowledge that you have read and understand the above, that you have had an opportunity to discuss this with a physician regarding all your questions, have had an opportunity to view the educational video, and that you wish to proceed with this procedure. (Including blood transfusions and other medical products that my doctor feels are necessary or advisable.).

Tammy E Windham 1/22/08 Maggie D Forth, RN

Patient's Signature (or legal representative) Date Witness (relationship)

wk
appt

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

NAME Tammy Windham

has an appointment with

Dr. Family Medical Clinic

TELEPHONE 803-774-4500

February 6th 2008

Date

7:55 AM _____ PM

Iron deficiency anemia

Tammy Windham

has an appointment

Month	Day	Year

at _____ AM _____ PM

My appointment is at the following location:

- ☑ 2601 Laurel Street, Suite 260, Columbia, SC 29204, (803) 744-4900
- ☐ 107 West Hosp. Drive, West Columbia, SC 29169, (803) 744-4940

My appointment is with:

- ☐ S. Stanley Juk, Jr., M.D.
- ☑ Joseph J. Lawton, III, M.D.
- ☐ Michael C. Roberts, M.D.
- ☐ Eugene T. Schwarz, M.D.
- ☐ Thomas E. Hearon, III, M.D.
- ☐ Richard E. Umbach, M.D.
- ☐ R. Taylor Williams, M.D.
- ☐ Robert M. Malanuk, M.D.

6 wks to 11 p.m.

884

6086

2601 Laurel Street • Suite 260 • Columbia, SC 29204 • (803) 744-4900
107 West Hospital Drive • West Columbia, SC 29169 • (803) 744-4940
114 Gateway Blvd., Suite 320 • Providence N.E. • Columbia, SC 29203 • (803) 744-4900

Columbia Cardiology Consultants

S. Stanley Juk, Jr., M.D. Reg. No. AJ6452813
Joseph J. Lawton, III, M.D. Reg. No. BL3197058
Michael C. Roberts, M.D. Reg. No. BR2195964
Eugene F. Schwarz, M.D. Reg. No. AS1039494
Richard E. Umbach, M.D. Reg. No. AU8135495
R. Taylor Williams, M.D. Reg. No BW7128425
Robert M. Malanuk, M.D. Reg. No. BM4950069
Eric E. Shoup, M.S., PA-C Reg. No. A744CD

Date: 1-22-08

Name: Tammy Windham

Address:

If you have questions regarding this prescription, please call (803) 744-4900

Please label contents Rx	Mg.	No.	Directions	Refills
1. Tenormin	25	30	1 po daily	6
2. Pravachol	40	30	1 po daily in pm	6
3. Fe Soy	325	30	1 po daily	1
4. Plavix	75	30	1 po daily	2
5. ASA	81		1 po daily	11

Joseph Houston M.D.

M.D.

002300

6087

Tammy Wundham
has an appointment
March 3 2008
Month Day Year
at 09:45 AM ____ PM

My appointment is at the following location:

- [x] 2601 Laurel Street, Suite 260, Columbia, SC 29204, (803) 744-4900
- [ ] 107 West Hosp. Drive, West Columbia, SC 29169, (803) 744-4940

My appointment is with

- [ ] S. Stanley Juk, Jr., M.D.
- [x] Joseph J. Lawton, III, M.D.
- [ ] Michael C. Roberts, M.D.
- [ ] Eugene F. Schwarz, M.D.
- [ ] Thomas E. Hearon, III, M.D., Emeritus
- [ ] Richard E. Umbach, M.D.
- [ ] R. Taylor Williams, M.D.
- [ ] Robert M. Malanuk, M.D.

10/18/67

Lowlc & lipid panel

To See Dr. Lawton @ 10:00am

002301

886

6088

RUN DATE: 01/23/08
RUN TIME: 0843
RUN USER: WILSO2SL

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5H D.H5058-A D00502311541 40/F WT: lbs.
ATTENDING PHYSICIAN: Lawton,Joseph J. III Dr.

NUR ALLERGY: NKDA
PHA ALLERGY: NO KNOWN DRUG ALLERGIES

DISCHARGE MEDICATION LIST

MEDICATION	DOSE	ROUTE	DIRECTIONS	SHOULD PATIENT CONTINUE TAKING THIS MEDICINE AT HOME? (PLEASE CIRCLE ONE)
~~METOPROLOL TARTRATE (Lopressor)~~	~~50 MG~~	~~ORAL~~	~~TWICE DAILY BID~~	~~YES~~ NO
ASPIRIN (Childrens Chewable Aspirin)	81 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY Next dose: Tom 1/29	YES NO
CLOPIDOGREL BISULFATE (Plavix 75MG)	75 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY for 2 mos Next dose: Tom 1/29	YES NO
~~SIMVASTATIN (Zocor)~~	~~20 MG~~	~~ORAL~~	~~DAILY AT BEDTIME HS~~	~~YES~~ NO

HOME MEDICATION LIST

		CONTINUE THIS MEDICATION
BABY ASA	81MG DAILY	YES NO
Renvela 25 mg po daily Next dose: Tom 1/29		YES NO
Pravachol 40 mg po daily Next dose: tonight		YES NO
Iron Sulfate (FeSO4) 325 mg one daily		YES NO Next dose: today
HTN MED		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

887

RUN DATE: 01/23/08
RUN TIME: 0843
RUN USER: WILSO2SL

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5H D.H5058-A D00502311541 40/F WT: lbs.
ATTENDING PHYSICIAN: Lawton,Joseph J. III Dr.

	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO

DOCTOR: THIS LIST IS BEING PROVIDED TO YOUR PATIENT AS PART OF HIS/HERE DISCHARGE INSTRUCTIONS.
PLEASE COMPLETE THE FOLLOWING SECTION AND SIGN.

(1) WILL MEDICATIONS BE NEEDED FOR PAIN MANAGEMENT? ___YES ___NO IF SO, PLEASE INCLUDE IN THE LIST ABOVE

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

888

RUN DATE: 01/23/08
RUN TIME: 0843
RUN USER: WILSO2SL

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.5H D.H5058-A D00502311541 40/F WT: lbs.
ATTENDING PHYSICIAN: Lawton,Joseph J. III Dr.

(2) LIST ANY HOME MEDICATIONS THAT THE PATIENT IS TO CONTINUE AS WELL AS INSTRUCTIONS FOR USE
ALSO INCLUDE ANY OTHER MEDICATIONS NOT ALREADY LISTED WHICH YOU WISH THE PATIENT TO CONTINUE

NURSE'S REVIEW OF DISCHARGE MEDICATION LIST

Review with Patient / Family Person's Name: Tammy Windham

Does patient/family have a full understanding? ___YES ___NO

If Not, Indicate concerns:

Food/Drug Interaction Sheet is in Patient Education Folder.

Prescriptions given to Patient/Family, copied and placed in medical record? ___YES ___N/A

DO NOT TAKE ANY MEDICATIONS NOT LISTED ABOVE WITHOUT CONSULTING YOUR DOCTOR OR PHARMACIST

NURSE SIGNATURE: Kaulkin RN 1-23-08 1040

MD SIGNATURE:

ABBREVIATIONS DICTIONARY

AC = BEFORE MEALS
AC&HS = BEFORE MEALS AND AT BEDTIME
BID = TWICE DAILY
HS = DAILY AT BEDTIME
PC = AFTER MEALS
PC&HS = AFTER MEALS AND AT BEDTIME
PO = BY MOUTH
PREOP = BEFORE PROCEDURE
PRN = AS NEEDED
Q = EVERY
QAM = EVERY MORNING
QID = 4 TIMES DAILY
TID = 3 TIMES DAILY
NPO = NOTHING BY MOUTH

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM TAMMY E
[redacted] 95682
5068

☑ Admit As Inpatient — Indicate Medical Reason: CP / CAD

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time: AM PM	Profiled by:	Filled by:	Checked by:

Admit to Dr Lawton
CK + trop I in am
d/c NTG gtt
Lopressor 50 mg po bid
ASA 81 mg po daily
Plavix 75 mg po daily
Simvastatin 20 mg po daily

Physician Signature: Beeper #:

Date:	Time: AM PM	Profiled by:	Filled by:	Checked by:

Darvocet 1-2 po q 4° prn
Dilaudid 1 mg IV q 4° prn severe pain
CK + trop I in am
LFT's + fasting lipids in am
NPO ⅄ MN
SW consult — needs help c needs / finances
Carotid Dopplers in am — bruits

Physician Signature: R T Williams MD Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

SCANNED

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be dispensed unless requested.

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

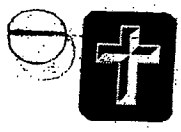
Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

24 hour chart check Jones RN 2332 1-21-08

1/21/08 890

NUR020 (12/06)

6092



SISTERS OF CHARITY
PROVIDENCE HOSPITALS

[redacted]

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date:	Time: AM PM	Profiled By:	Filled [redacted]

CCC1030 COLUMBIA CARDIOLOGY CONSULTANTS
ROUTINE PCCU ADMISSION ORDERS PAGE 1 OF 3

ADMISSION STATUS: __ INPATIENT __ OUTPATIENT __ OBSERVATION

1) Admit to services of **COLUMBIA CARDIOLOGY CONSULTANTS:**
   a. Notify our office of admission and room number, speak directly to the appointment secretary.
   b. Notify personal physician of admission if he is in the Columbia area.
   c. Obtain all old records and do EKG immediately.
   d. If patient is admitted for heart cath, give cath booklet and inform of film times.
   e. Under no circumstances is dictated H & P summary to be removed from chart prior to discharge.
2) DIET: Low cholesterol, and ADA 1800 calorie **(if diabetic, or renal; dietary consults for specific restrictions).**
3) ACTIVITY: Routine, unless otherwise ordered.
4) VITAL SIGNS: Routine, unless otherwise ordered.
5) Daily Weights and I & O's.
6) ~~LAB STUDIES ASAP: a) ___CBCX ___ CBCD b) CMP c) PT d) CO2 e) Urinalysis **Do not repeat normal studies done within 7 days** Call if K+ < 3.5. **If referral hospital labs are to be used, place them in chart under "LAB SECTION."~~
7) LAB STUDIES IN A.M.: Fasting Lipid Profile **(if not done in last 3 months)** → in Am
8) P.A. and lateral chest X-ray AFTER seen by physician. – 1/21/08 MDA
9) LIST CURRENT HOME MEDS: **(or hospital meds. if transfer)** on order sheet and verify with MD prior to first dose.
10) PRN MEDS:
   a. Tylenol 1-2 tabs PO q 4 h PRN pain.
   b. ~~Darvocet-N-100 1-2 tabs PO q 4 h PRN pain unrelieved by Tylenol.~~
   c. Restoril 15mg. Q BEDTIME. PO PRN. May repeat x1.
   d. NTG 1/150 SL PRN chest pain.
   e. Dilaudid 1 mg IV for chest pain not relieved after 3 NTG > NOTIFY MD.
   f. Reglan 10mg IV q 4 h PRN nausea, if unrelieved, then Compazine _____mg IV or PO q 4 h PRN nausea.
   g. Laxative Lac
   h. Xanax 0.25mg q 4 hours PRN anxiety, 0.125mg for patients >70years of age.
   i. Regitine ____mg SQ for Dopamine infiltration.
11) PCCU PROTOCOL:
   a. Insert INT and irrigate with 1 ml Normal Saline each shift. Use left arm preferably.
   b. Oxygen at _____ liters via _____ PRN _____.
   c. STAT EKG x 1 for chest pain.
12) If a doctor has not seen patient by 9:00 P.M., notify answering service to contact the doctor on call.
13) Patients with history of sustained V-tach must be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and noV-tach by monitor x48 hours. If there are questions, contact M.D.
14) If on Heparin, adjust per CCU "Heparin Order Sheet".
15) SEE EMERGENCY ORDER SHEET

SCANNED

D. T. Williams Chance Jones, RN 1/21/08

WINDHAM, TAMMY E
A# D00502311541
01/21/08 F 40 [redacted]395682
Lawton, Joseph J. II [redacted] D.H5058-A

COLUMBIA CARDIOLOGY CONSULTANTS

Emergency Standing Orders

**REGISTERED NURSES WHO HAVE BEEN ADEQUATELY TRAINED FOR CRITICAL CARE NURSING WILL USE THESE EMERGENCY STANDING ORDERS (ex. ACLS).

FOR VENTRICULAR ASYSTOLE:

1. Confirm in two leads. Assess no pulse.
2. Initiate CPR. Have CODE Team and attending physician called.
3. Consider transcutaneous pacing.
4. Give 1mg Epinephrine IV or Intratracheal. *May repeat every _____ min.as needed.
5. Give 1mg Atropine IV of Intratracheal. *May be repeated every _____ min. up to total of 0.04mg/kg.

FOR VENTRICULAR FIBRILLATION OR RAPID VENTRICULAR TACHYCARDIA WITH NO PULSE OR LOSS OF CONSIOUSNESS:

1. Precordial thump if witnessed arrest, no pulse, and no defibrillator available.
2. Initiate CPR. Have Code Team and attending physician called.
3. Defibrillate the patient with 200 joules. Repeat with _____ joules if ineffective. If second attempt unsuccessful, defibrillate with 360 joules. If unsuccessful continue CPR.
4. Give 1mg Epinephrine IV or Intratracheal. * May repeat every _____ mins.
5. Defibrillate with 360 joules within _____ seconds after drug administration.
6. Give 1.5mg/kg Lidocaine IV or Intratracheal. *May repeat in _____ mins. to total loading dose of 3mg/kg.

FOR SYMPTOMATIC VENTRICULAR TACHYCARDIA WITH PULSE:

1. Give _____mg/kg Lidocaine IV or Intratracheal. *May repeat Lidocaine IV or Intratracheal _____mg/kg every _____ mins. until VT resolves or up to 3mg/kg.
2. If patient becomes unconscious, have CODE TEAM and attending physician called, Cardiovert with 100 joules. If ineffective, repeat with 200, 300, 360 joules.

FOR VENTRICULAR ARRYTHMIAS REQUIRING LIDOCAINE THERAPY:

1. Give _____mg/kg Lidocaine IV and notify physician immediately.
2. If not suppressed, repeat Lidocaine _____mg/kg every _____ mins. until no ectopy, or up to 3 mg/kg given.
3. Once ectopy resolved, maintain as follows:
   A) After Lidocaine, 1mg/kg. Lidocaine Drip, 2mg/min.
   B) After Lidocaine, 1-2mg/kg Lidocaine Drip, 3mg/min.
   C) After Lidocaine, 2-3mg/kg. Lidocaine Drip, 4mg/min.

FOR SYMPTOMATIC BRADYCARDIA (SINUS BRADYCARDIA, SINUS PAUSES, JUNCTIONAL RHYTHM, 2 DEGREE OR 3 DEGREE AV BLOCK):

1. Give _____mg Atropine IV or Intratracheal. * May repeat as necessary every _____ mins. up to total 0.04mg/kg.
2. Notify physician stat.
3. If Atropine fails to increase heart rate, apply transcutaneous pacemaker, set MA at 100 and rate 100.

SCANNED

** FOR INTRATRACHEAL DRUG ADMINISTRATION: MEDICATION SHOULD BE ADMINISTERED AT 2-2.5 TIMES THE RECOMMENDED IV DOSE AND DILUTED IN 10ML OF NS OR DISTILLED WATER.**

Dr T. Williams / Charice Jones, RN

WINDHAM,TAMMY E

[redacted]

DIABETIC PRECAUTIONS:

1. If blood sugar is less than 50, give 1 amp. D/50W.
2. Recheck blood sugar in 45 minutes. Repeat #1
3. Notify physician immediately.

SCANNED

SIGNATURE Dr T Williams / Jones, RN DATE 1-21-05

S.STANLEY JUK JR, MD
EUGENE F.SCHWARZ, MD
ROBERT M. MALANUK, MD
JOSEPH L.LAWTON, MD
THOMAS E.HEARON III, MD
R. TAYLOR WILLIAMS, MD
MICHAEL C.ROBERTS, MD
RICHARD E.UMBACH, MD
ERIC E. SHOUP, MS PAC

ORIGINAL: 1/1/04

Patient: WINDHAM,TAMMY E
Account #: D00502311541
Admit Date: 01/21/08
Status: ADM IN
Attending: Lawton,Joseph J. III Dr.

Age/Sex: 40 F
Unit #: M000895682
Location: D.5H
Room/Bed: D.H5058-A

Number	Description	Status	Source
20180	Pneumovax Screening Assessment+	A	CP

	Date	Time	Directions
1	01/21/08	2143	ONCE

Documented at 01/21/08 2143 by CTJ

===ADULT PNEUMOCOCCAL VACCINATION STANDING ORDERS===
Your patient will receive the pneumococcal vaccine on the day 3 of admission if the patient meets criteria as indicated below.
HAS THE PATIENT BEEN VACINATED WITHIN THE LAST 5 YEARS
OR ALREADY BEEN VACCINATED 2 TIMES IN THEIR LIFETIME: N
If the answer is YES -- **STOP HERE!**. The patient does not require vaccination!
If the answer is NO, proceed to complete the screening below
SECTION A: VACCINATION ASSESSMENT
For Patients 18 years and older, select
any high-risk conditions present+: NONE
Does the patient have Chronic Renal Failure, Immunodeficiency or Immunosuppressive Therapy (including Prednisone > 15 mg/day), Active Cancer, Asplenia, Sickle Cell, Organ/Marrow Transplant or AIDS/HIV: N
Is The Patient 65 Years of Age or Older: N
Has The Patient Previously Received Pneumococcal Vaccine: N
If patient currently greater than 65 years of age, was the most recent pneumococcal vaccine administered when patient was < 65 years of age: N
Select NO if patient currently < 65 years of age.
SECTION B: VACCINATION SCORE

Any Condition Present:	SCORE
N	0
N	0
N	0
N	2
N	0
TOTAL:	2

Total Points 2 or less, patient does NOT meet criteria to receive Pneumococcal Vaccine.
Total Points > or = 3, patient meets criteria to receive Pneumococcal Vaccine.
PLEASE REMEMBER, PATIENTS SHOULD ONLY RECEIVE THE VACCINE TWICE IN THEIR LIFETIME.
If patient has had a bone marrow transplant within the last 12 months or is currently receiving Chemotherapy, DO NOT GIVE the vaccine
Patient currently scheduled for Surgery. REASSESS CRITERIA ON POST-OP DAY 3: N
Patient Meets Criteria: N
Patient Given Vaccination Information: N
ADMINISTER PNEUMOCOCCAL VACCINE 23 VALENT 0.5ml IM x 1 DOSE GIVEN ON DAY 3 OF THE ADMISSION.
HOLD FOR TEMP GREATER THAN 101F UNTIL PATIENT HAS BEEN AFEBRILE FOR 24 HOURS.
HOLD UNTIL POST-OP DAY 3 IF PATIENT SCHEDULED FOR SURGERY.
****IF THE PATIENT MEETS CRITERIA****
****PRINT AND FAX ASSESSMENT TO PHARMACY UPON COMPLETION****
****PLACE ON CHART IN THE M.D. ORDER SECTION****
PLEASE DO NOT VACCINATE THIS PATIENT DURING THIS ADMISSION (Physician will sign only if they do not want their patient vaccinated, otherwisethe patient will be given the vaccine if they meet the criteria to receive it.)
Rationale for Deferring Vaccine:
Physician Signature:

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	01/21/08	2143	CTJ	JONESCT	JONES,CHARICE T	RN
Recorded:	01/21/08	2144	CTJ	JONESCT	JONES,CHARICE T	RN

Patient: WINDHAM,TAMMY E
Account #: D00502311541
Admit Date: 01/21/08
Status: ADM IN
Attending: Lawton,Joseph J. III Dr.

Age/Sex: 40 F
Unit #: M000895682
Location: D.5H
Room/Bed: D.H5058-A

Recorded at terminal: PROVPACS19.1

895

Patient: WINDHAM,TAMMY E
Account #: D00502311541
Admit Date: 01/21/08
Status: ADM IN
Attending: Lawton,Joseph J. III Dr.

Age/Sex: 40 F
Unit #: M000895682
Location: D.5H
Room/Bed: D.H5058-A

Number	Description	Status	Source
20170	Influenza Screening Assessment+	A	CP

	Date	Time	Directions
1	01/21/08	2143	ONCE

Documented at 01/21/08 2143 by CTJ

===INFLUENZA VACCINATION STANDING ORDERS===
(Influenza vaccines are provided October 1 through March 31)
Has the patient has an Influenza vaccine this flu season+: N
(this flu season=Oct. 1 through March 31)
Does the patient have a KNOWN SEVERE REACTION to the vaccine, Chicken Eggs, History of Guillain Barre, or previous reaction to the flu vaccine+: N
Has the patient had a bone marrow transplant within the last 12 months or currently on Chemotherapy+: N
If the answer to questions 1 through 3 are NO or UNKNOWN patient MEETS CRITERIA for vaccination.
If the answer to either question 1 though 3 is YES, DO NOT GIVE VACCINE, patient does NOT meet criteria.
Patient currently scheduled for Surgery. REASSESS CRITERIA ON POST-OP DAY 3: N
Patient Meets Criteria: Y
Patient Given Vaccination Information: Y
ADMISISTER INFLUENZA VACCINE 0.5 ml IM x 1 to be given on day 3 of admission.
HOLD FOR TEMP GREATER THAN 101F UNTIL PATIENT HAS BEEN AFEBRILE FOR 24 HOURS.
****IF THE PATIENT MEETS CRITERIA****
****PRINT AND FAX ASSESSMENT TO PHARMACY UPON COMPLETION****
****PLACE ON CHART IN THE M.D. ORDER SECTION****
Your patient will receive the influenza vaccine on day 3 of admission if the patient meets criteria as indicated and IS NOT SCHEDULED FOR SURGERY OR IN AN ICU BED. If you DO NOT want your patient to be immunized, sign the order below to withhold the vaccine with rationale. PLEASE DO NOT VACCINATE THIS PATIENT DURING THIS ADMISSION (Physician will sign only if they do not want their patient vaccinated, otherwise the patient will be given the vaccine if they meet the criteria to receive it.)
Rationale for Deferring Vaccine: _____
Physician Signature: _____

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	01/21/08	2143	CTJ	JONESCT	JONES,CHARICE T	RN
Recorded:	01/21/08	2143	CTJ	JONESCT	JONES,CHARICE T	RN

Recorded at terminal: PROVPACS19.1

896

RUN DATE: 01/21/08
RUN TIME: 2144
RUN USER: JONESCT

Providence Hospital **Admissions**
HOME MEDICATION ORDER

WINDHAM,TAMMY E D.5H D.H5058-A
ADMITTING MD: Lawton,Joseph J. III Dr.
ATTENDING MD: Lawton,Joseph J. III Dr.

UNIT #	ACCT #	AGE/SEX	ADMIT DATE
M000895682	D00502311541	40/F	01/21/08

CONSULT HOSPITALIST FOR MEDICATION MANAGEMENT YES / NO

USE ONLY APPROVED ABBREVIATIONS

Does Patient Take Any Home Medicines:Y
PHARMACY ALLERGY: NO KNOWN DRUG ALLERGIES

HOME MEDICATIONS

			CONTINUE THIS MEDICATION
BABY ASA	81MG DAILY	LAST 24 HRS:Y	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
HTN MED		LAST 24 HRS:Y	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO
		LAST 24 HRS:	YES / NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

897

RUN DATE: 01/21/08
RUN TIME: 2144
RUN USER: JONESCT

Providence Hospital **Admissions**
HOME MEDICATION ORDER

WINDHAM,TAMMY E

ADMITTING MD: Lawton,Joseph J. III Dr.
ATTENDING MD: Lawton,Joseph J. III Dr.

D.5H D.H5058-A

UNIT #	ACCT #	AGE/SEX	ADMIT DATE
M000895682	D00502311541	40/F	01/21/08

LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO
LAST 24 HRS:	YES / NO

(1) WILL MEDICATIONS BE NEEDED FOR PAIN MANAGEMENT? ___YES ___NO IF SO, PLEASE INCLUDE IN THE LIST ABOVE

(2) LIST ANY HOME MEDICATIONS THAT THE PATIENT IS TO CONTINUE AS WELL AS INSTRUCTIONS FOR USE
ALSO INCLUDE ANY OTHER MEDICATIONS NOT ALREADY LISTED WHICH YOU WISH THE PATIENT TO CONTINUE

MD SIGNATURE:_____ DATE/TIME:_____

Food/Drug Interaction Sheet is in Patient Education Folder.

Prescriptions given to Patient/Family, copied and placed in medical record? YES / N/A

DO NOT TAKE ANY MEDICATIONS NOT LISTED ABOVE WITHOUT CONSULTING YOUR DOCTOR OR PHARMACIST

IF PATIENT IS ADMITTED - FAX THIS SHEET TO THE PHARMACY

NURSE SIGNATURE:_____

ABBREVIATIONS DICTIONARY

AC = BEFORE MEALS
AC&HS = BEFORE MEALS AND AT BEDTIME
BID = TWICE DAILY
HS = DAILY AT BEDTIME
PC = AFTER MEALS
PC&HS = AFTER MEALS AND AT BEDTIME
PO = BY MOUTH
PREOP= BEFORE PROCEDURE
PRN = AS NEEDED
Q = EVERY
QAM = EVERY MORNING
QID = 4 TIMES DAILY
TID = 3 TIME DAILY

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

Patient: WINDHAM,TAMMY E
Account #: D00502311541
Admit Date: 01/21/08
Status: ADM IN
Attending: Lawton,Joseph J. III Dr.

Age/Sex: 40 F
Unit #: M000895682
Location: D.5H
Room/Bed: D.H5058-A

Number	Description	Status	Source
20500	DVT Screening Protocol +	A	CP

	Date	Time	Directions
1	01/21/08	2143	ONCE

Documented at 01/21/08 2322 by CTJ

~~~~DVT SCREENING PROTOCOL~~~~ **ADULTS 18 YEARS AND OLDER**

Y/N
: N OUTPATIENT: Receiving Local anesthesia/Block or Moderate Sedation Procedures.
****IF YES, STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED

==========

Y/N
: N Patient with current orders for anticoagulant therapy or PT/PTT in therapeutic range (NOTE: Heparin, Coumadin, Lovenox, Fragmin, and Atrixtra constitute anticoagulant therapy; ASPIRIN and PLAVIX DO NOT constitute anticoagulant therapy).
****IF YES, STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED

==========

~~~~~RISK FACTORS (Select All That Apply)~~~~~

5 Point Risk Factors+:

Point Risk Factors+: 5 Pt. Subtotal: 0

2 Point Risk Factors+: 3 Pt. Subtotal: 0

1 Point Risk Factors+: 2 Pt. Subtotal: 0

Total Risk Factor Points: 0 1 Pt. Subtotal: 0

Based on total risk factors, select one risk category below, then indicate your choice(s).

[ ] RISK SCORE > OR = 5 -- HIGHEST RISK
Early Ambulation
Plus SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
*AND add:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at _____
[ ] Lovenox 30mg SC every 24 hours if creatinine clearance < 30ml/min BEGIN at _____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at _____
[ ] Other Therapy _____

[ ] RISK SCORE 2 - 4 -- MODERATE HIGH-RISK
Early Ambulation
Plus SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
*Also Consider:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at _____
[ ] Lovenox 30mg SC every 24 hours if creatinine clearance < 30ml/min BEGIN at _____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at _____
[ ] Other Therapy _____

[ ] RISK SCORE 0-1 OR PT. AT SIGNIFICANT RISK FOR BLEEDING OR CONTRAINDICATION TO

Patient: WINDHAM,TAMMY E
Account #: D00502311541
Admit Date: 01/21/08
Status: ADM IN
Attending: Lawton,Joseph J. III Dr.

Age/Sex: 40 F
Unit #: M000895682
Location: D.5H
Room/Bed: D.H5058-A

ANTICOAGULATION, REGARDLESS OF SCORE.

Early Ambulation
*Also Consider:
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
[ ] Other Therapy _____
_____Check baseline CBCD, PT, PTT now if anticoagulation ordered.
Notify MD if platelet count is < 100,000
[ ] NO TREATMENT (Reason: _____)
Physician Signature: _____

IF THE PATIENT HAS A RISK SCORE, PLEASE PRINT
PLACE IN THE PHYSICIAN ORDER SECTION OF THE CHART

	Date	Time	By Monogram	Initials	Name	Nurse Type
Occurred:	01/21/08	2322	CTJ	JONESCT	JONES,CHARICE T	RN
Recorded:	01/21/08	2323	CTJ	JONESCT	JONES,CHARICE T	RN

Recorded at terminal: PROVWL5H03.1

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

WINDHAM, TAMMY E
A# D005023115 [redacted]682
01/21/08 F 40
Lawton, Joseph J. III Dr. D.H5058-A

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

CCC1165

COLUMBIA CARDIOLOGY CONSULTANTS
INPATIENT PRE-HEART CATHERIZATION
AND/OR ARTERIOGRAM ORDERS

SCANNED

ADMISSION STATUS: __ INPATIENT __ OUTPATIENT

1) Patient scheduled for heart cath: Date_____ Time_____.
2) Inform patient and family of scheduled time.
3) If not yet done, give patient catherization booklet and insure patient views cardiac catherization film on Television.
4) Permit for heart catherization.
5) If Potassium is less than 3, notify physician. If Potassium is between 3-3.5, then give 25mEq K-Lyte (potassium chloride) PO NOW, and repeat in two hours. (Notify physician of other abnormal lab values by 6 P.M.
   If new admission, have lab data on chart by 6 PM).
6) Clip and prep right/left groin with Betadine (povidone/iodine).
7) Clear liquids after midnight, then NPO for 4 hours prior to cath except for meds.
8) Void immediately prior to pre-op MEDS.
9) Pre-medication on call:
   ✓ a. Demerol (meperidine) 50 mg and Phenergan (promethazine) 25 mg IM x 1 dose.
   b. If patient is over 70 yrs. old or weighs <130lbs. then give Demerol 25mg and Phenergan 25mg IM x1 dose.
10) Insure that 2- #20 or larger bore INT is functional in left arm before transport to cath lab.
11) If patient is diabetic, begin 1/2 NS @ 75ml/hour, 12 hours prior to cath (but no later than 11:00 PM night before cath.)
12) If patient allergic to iodine or shellfish give:
   A. Solu-medrol (methylprednisolone)125 mg IV at 10:00 PM the evening prior to cath and 125 mg IV one hour precath.
   B. Claritin (loratidine) ____mg x1 dose PO one-hour pre-cath with Solu-Medrol.
   If patient is diabetic and receiving insulin, give _____ day of cath only, then _____ day following cath. If patient is receiving an oral diabetic medication, administer _____. Consult for diabetic instructions.
14) If patient taking Glucophage (metformin) HOLD the morning of the cath and 48 hours post cath.
15) If patient is on a Heparin drip, hold three hours prior to cath. If patient is on single-dose Heparin, hold one dose prior to cath. Followup orders by the cathing cardiologist.
16) Patients with history of sustained V-tach must be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and no V-Tach by monitor x 48 hours. If there are questions, contact M.D.
17) Notify MD if Hgb, Protime, BUN or Creatinine values are abnormal.

SIGNATURE Dr. Lawton / Sheena Reid RN DATE 1/22/08

S.STANLEY JUK JR, MD — JOSEPH L.LAWTON, MD — MICHAEL C.ROBERTS, MD
EUGENE F.SCHWARZ, MD — RICHARD E.UMBACH, MD
ROBERT M. MALANUK, MD — R. TAYLOR WILLIAMS, MD — ERIC E. SHOUP, MS PAC

901

ORIGINAL: 1/1/04
Revised: 05/04/07

WINDHAM TAMMY E 22 JAN 2008 6:32:15 895682

40 yrs Female

6104

902

HR	169
QRSD	79
QT	458
QTc	473

(NSR). Normal sinus rhythm, rate 64 - - - - - - - Normal P axis, PR, rate & rhythm
(LVH31). Probable LVH with ST-T abnormalities - - - - - - - LVH voltage, ST-T negative
- ABNORMAL ECG -

*jjl/puw/502311541
*Nonspacific st abnormalities are seen

--AXES--

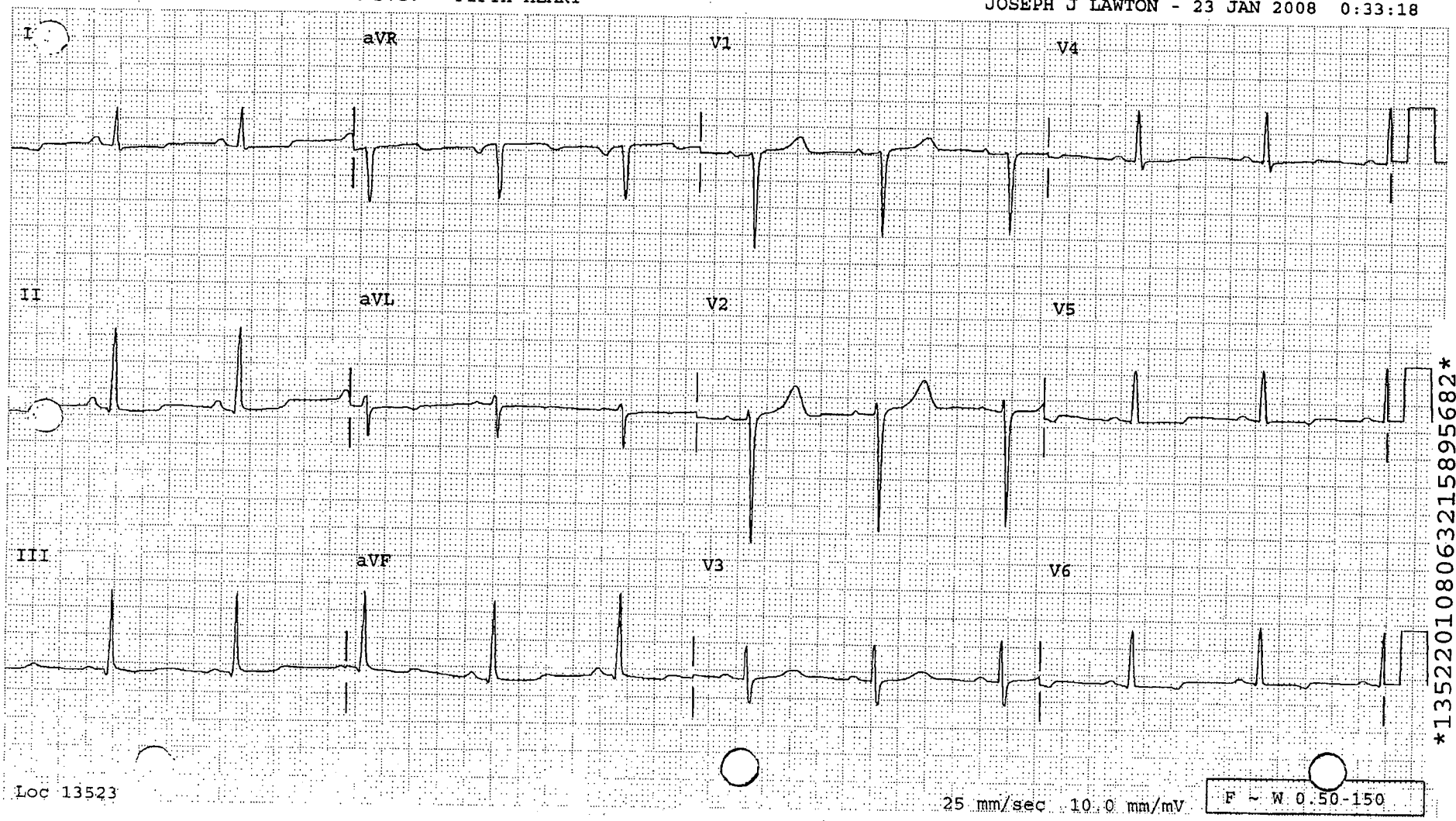
P	44
QRS	66
T	180

Requested by
161
Tech 44
Room H5058
Edited C-HP708

PREVIOUS ECG: 21 JAN 2008 14:38:27, CONFIRMED BY JJL - BO

PROVIDENCE HOSPITAL COLUMBIA S.C. - FIFTH HEART

JOSEPH J LAWTON - 23 JAN 2008 0:33:18



135220108063215895682
135220108063215895682

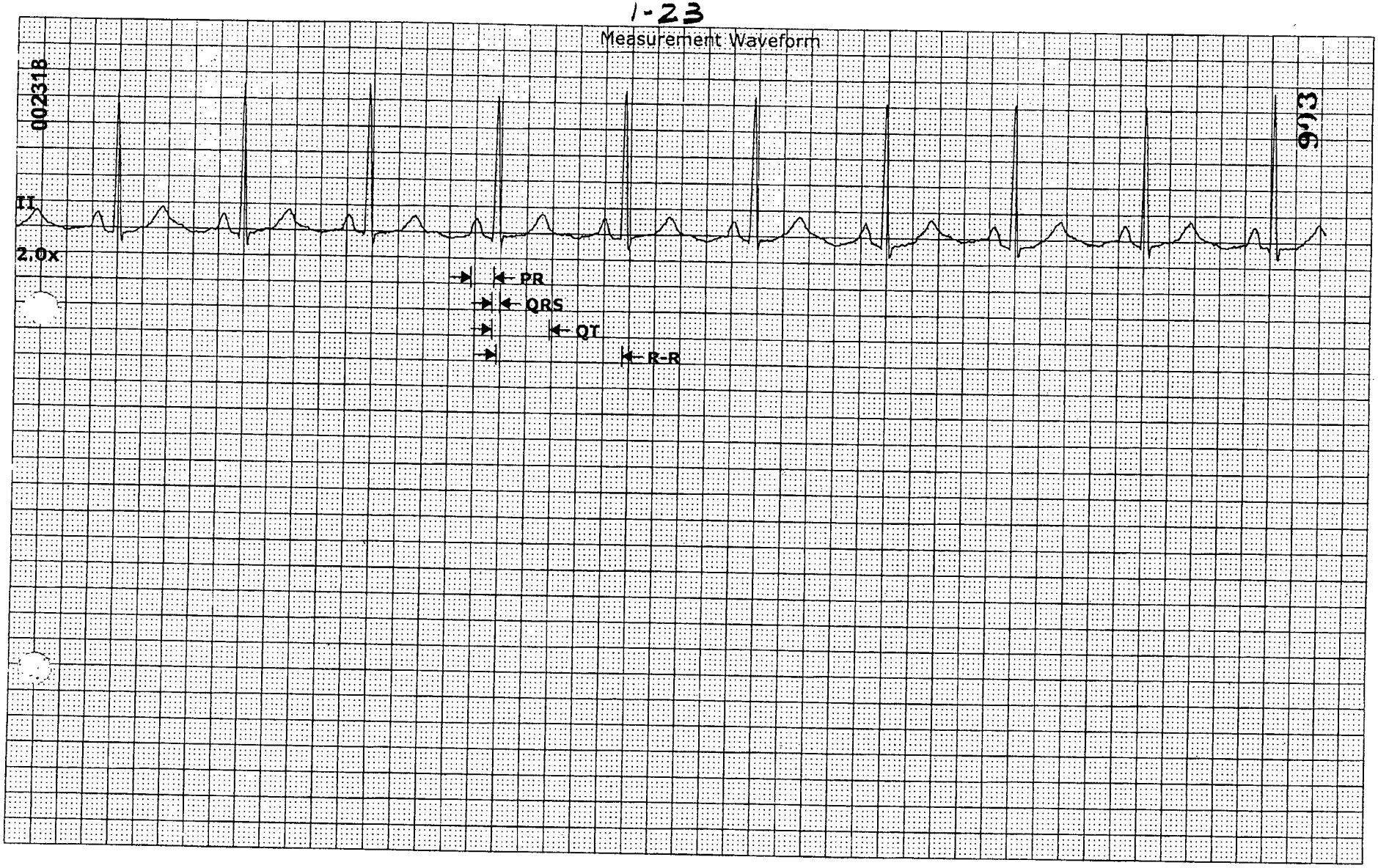
23-Jan-2008 06:20:50 - 23-Jan-2008 06:21:00

Caliper Measurements

1-23

6105

Measurement Waveform



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.179	sec	QT	= 0.449	sec
QRS	= 0.061	sec	R-R	= 0.978	sec
QTc	= 0.454	sec	Rate	= 61	bpm

S R Smith
C

GE Medical Systems Information Technology

CIC Version 5.0.7

Wednesday, January 23, 2008 7:39:11 AM

25 mm/s

Page 1

END OF REPORT

WIN~~SHAM~~ TAMMY E

40 yrs Female

22 JAN 2008 6:32:15

5058 #2

895682

6106

904

PR 169
QRS 79
QT 458
QTc 473

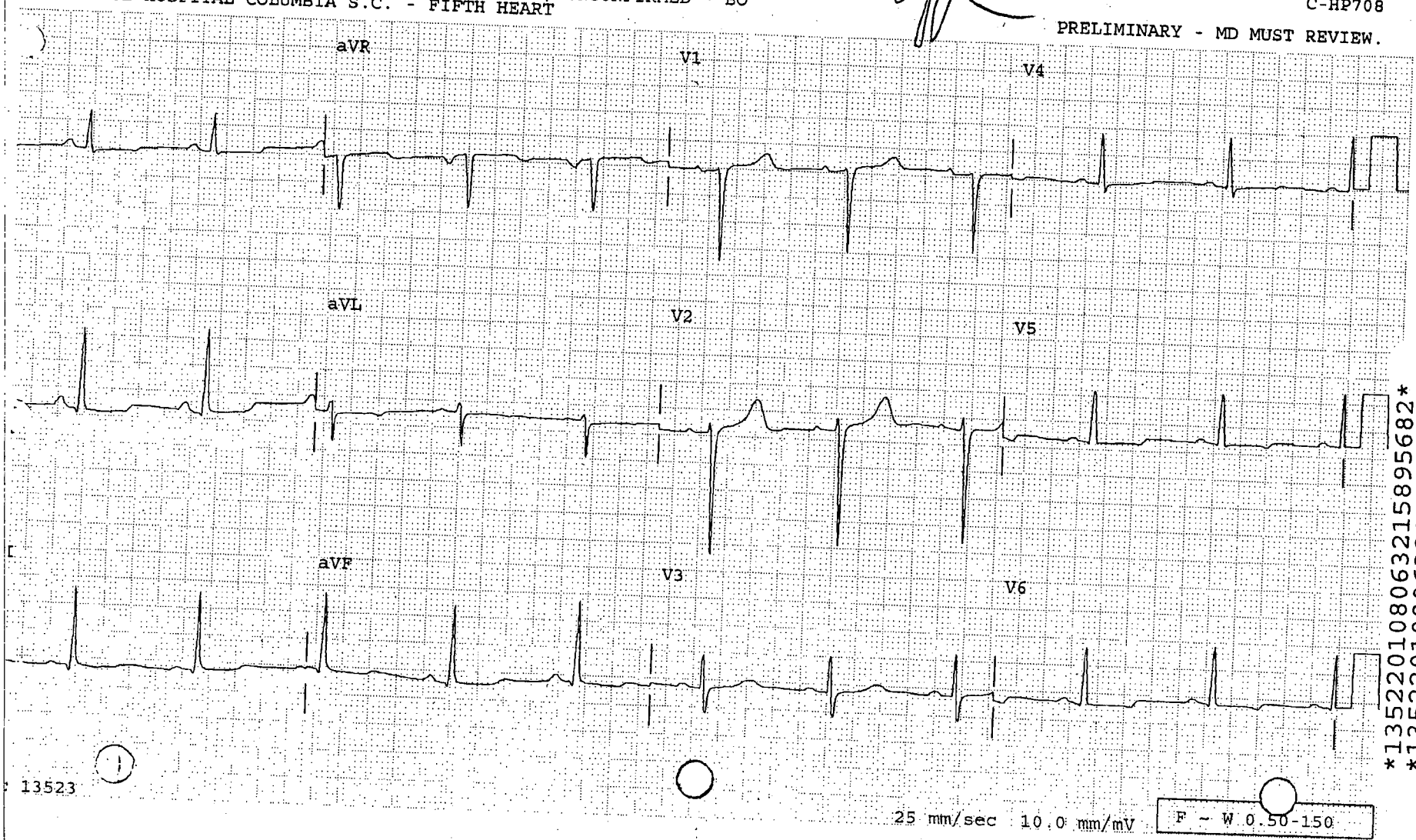
(NSR). Normal sinus rhythm, rate 64 - - - - - - - Normal P axis, PR, rate & rhythm
(LVH31). Probable LVH with ST-T abnormalities - - - - - - - LVH voltage, ST-T negative
- ABNORMAL ECG -

--AXES--
P 44
QRS 66
T 180

Requested by
161
Tech 44
Room H5058
C-HP708

PREVIOUS ECG: 21 JAN 2008 14:38:27, UNCONFIRMED - BO
PROVIDENCE HOSPITAL COLUMBIA S.C. - FIFTH HEART

PRELIMINARY - MD MUST REVIEW.



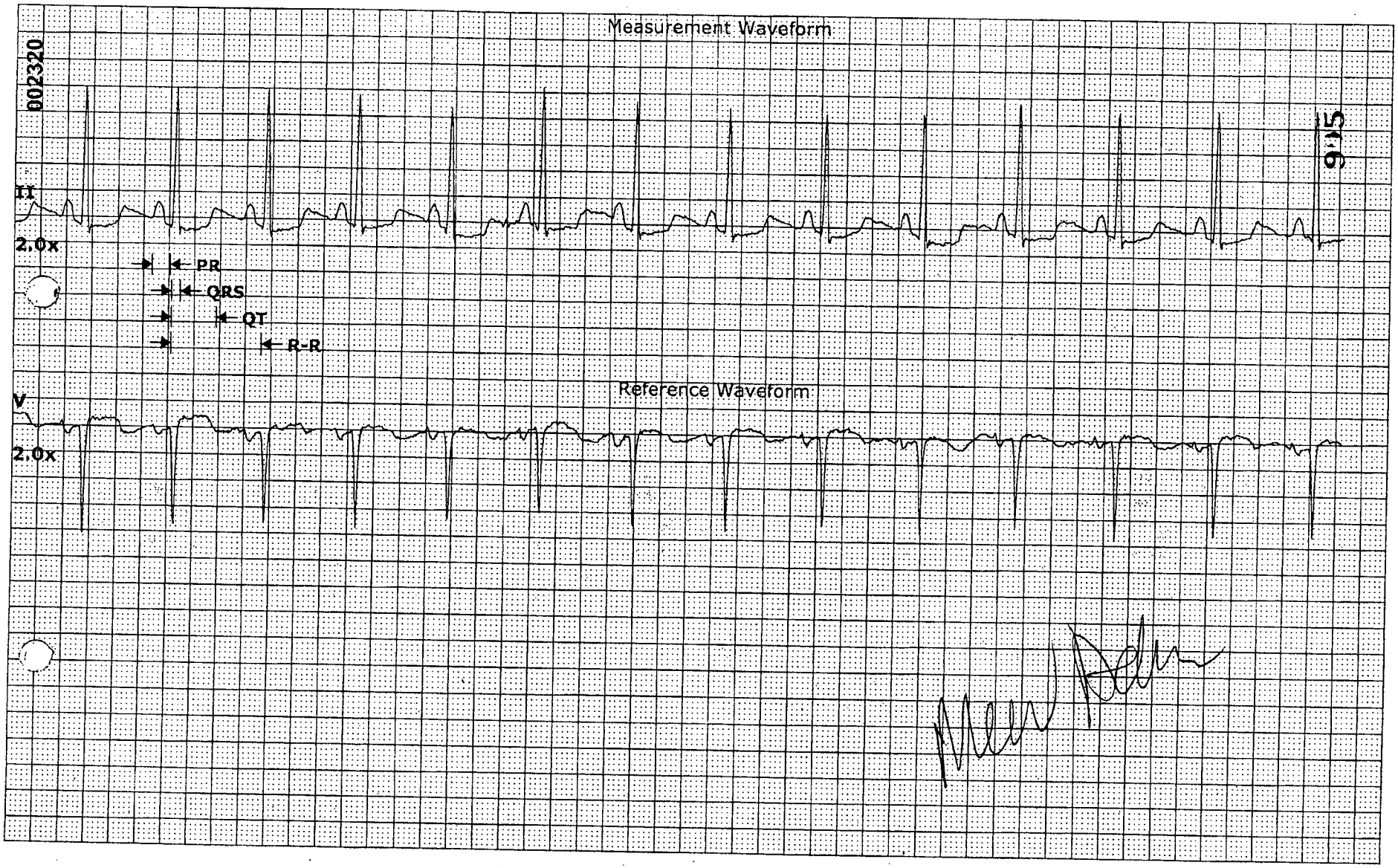
135220108063215895682
135220108063215895682

WINDHAM,TAMMY M000895682 **Caliper Measurements** 5H|5058*

21-Jan-2008 21:12:22 - 21-Jan-2008 21:12:32

6107

002320



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.149	sec	QT	= 0.355	sec
QRS	= 0.073	sec	R-R	= 0.707	sec
QTc	= 0.422	sec	Rate	= 85	bpm

GE Medical Syst
Information Techno

CIC Version 5.0.7
Monday, January 21, 2008 9:52:30 PM

25 mm/s

END OF REPORT

WINDHAM, TAMMY E. 21 JAN 2008 14:38:27 895682

40 yrs Female

5058 #1

6108

002321

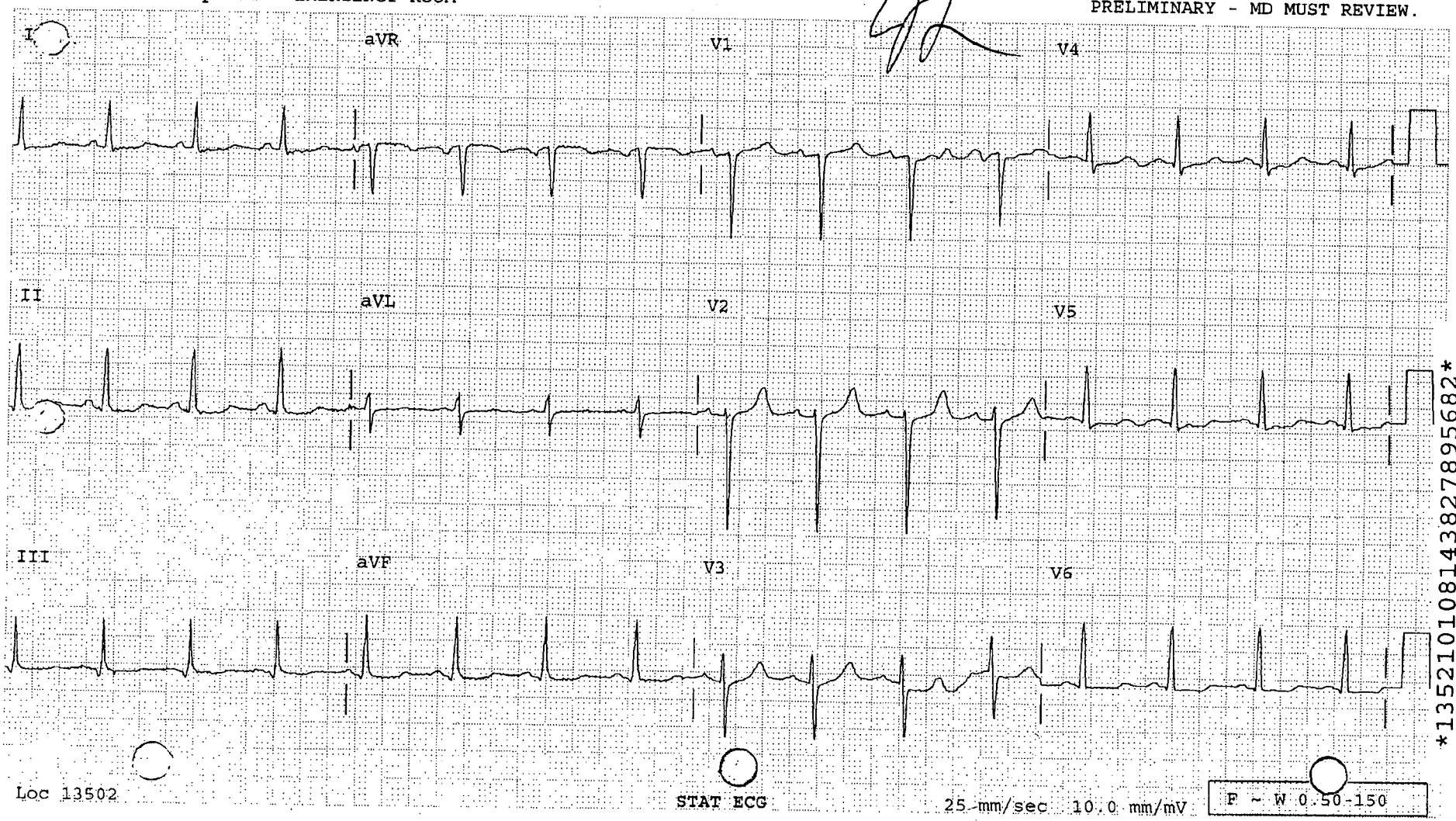
HR 148	(NSR). Normal sinus rhythm, rate 92 - - - - - -	Normal P axis, PR, rate & rhythm
QRSD 88	(TOLA). Nonspecific Lateral T abnormalities - - - -	T neg, T/QRS ratio <.07 I,L,V5-V6
QT 361	- BORDERLINE ECG -	
QTc 447		

--AXES--
P 43
QRS 55
T 23

Requested by
161
Tech 08
Room 13
C-HP708

PREVIOUS ECG: 21 MAR 2007 3:15:42, CONFIRMED BY REU - AB
Providence Hospital - EMERGENCY ROOM

PRELIMINARY - MD MUST REVIEW.



135210108143827895682
135210108143827895682

9/6

WINDHAM, TAMMY E. 21 JAN 2008 14:38:27 895682

40 yrs Female

002322

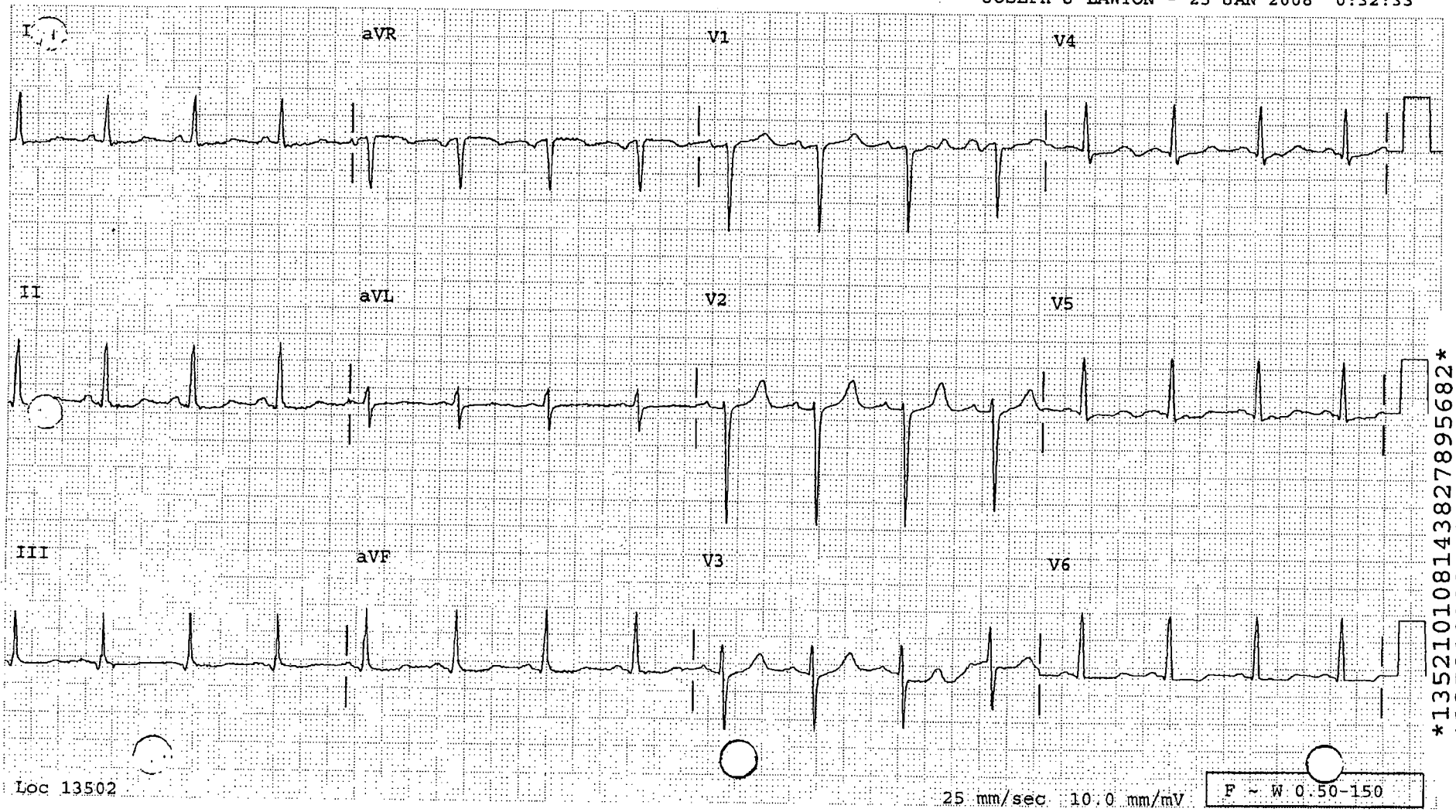
HR 148 (NSR). Normal sinus rhythm, rate 92 - - - - - - Normal P axis, PR, rate & rhythm
QRSD 88 (TOLA). Nonspecific Lateral T abnormalities - - - - T neg, T/QRS ratio <.07 I,L,V5-V6
QT 361 - BORDERLINE ECG -
QTc 447 *jjl/puw/502311541

--AXES--
P 43
QRS 55
T 23

Requested by
161
Tech 08
Room 13
Edited C-HP708

PREVIOUS ECG: 21 MAR 2007 3:15:42, CONFIRMED BY REU - AB
Providence Hospital - EMERGENCY ROOM

JOSEPH J LAWTON - 23 JAN 2008 0:32:33



135210108143827895682
135210108143827895682

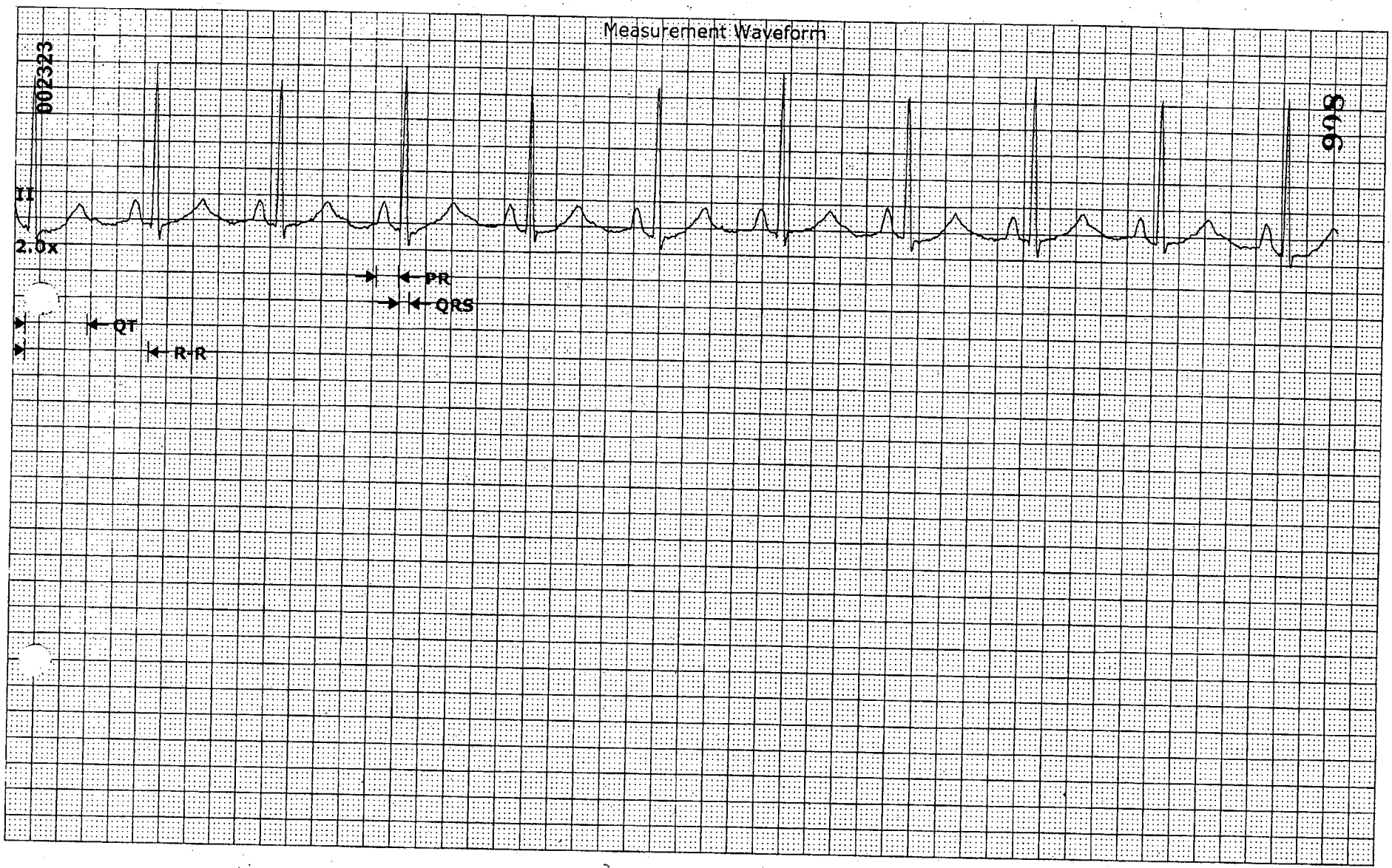
6109

917

WINDHAM,TAMMY M000895682 **Caliper Measurements** 5H|5058

23-Jan-2008 02:26:22 - 23-Jan-2008 02:26:32

6110



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.173	sec	QT	= 0.484	sec
QRS	= 0.079	sec	R-R	= 0.972	sec
QTc	= 0.491	sec	Rate	= 62	bpm

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CIC Version 5.0.7
Wednesday, January 23, 2008 2:52:10 AM

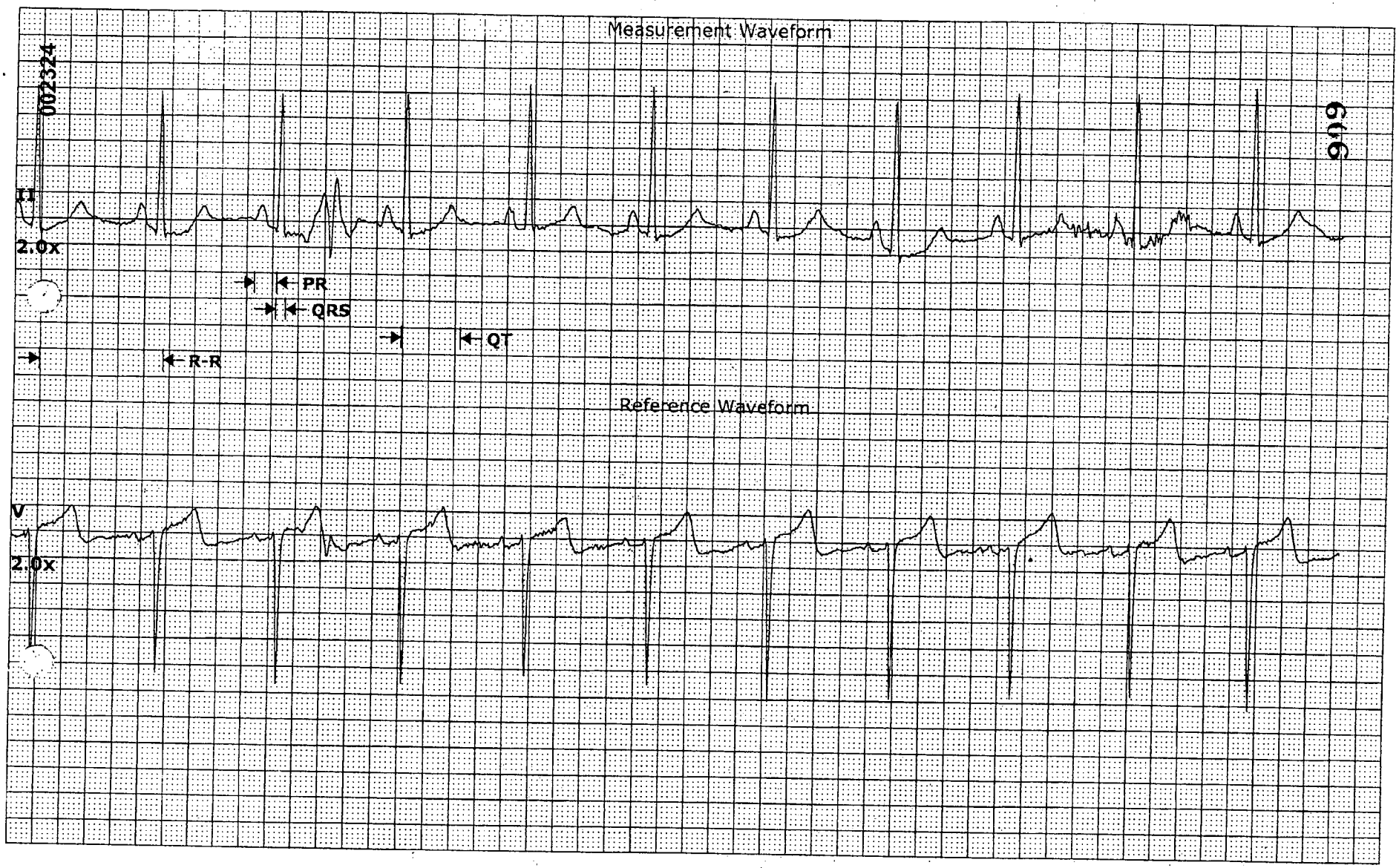
25 mm/s

END OF REPORT

WINDHAM,TAMMY M000895682 **Caliper Measurements** 5H|5058+

22-Jan-2008 22:23:59 - 22-Jan-2008 22:24:09

6111



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.173	sec	QT	= 0.455	sec
QRS	= 0.085	sec	R-R	= 0.960	sec
QTc	= 0.464	sec	Rate	= 62	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.7

Tuesday, January 22, 2008 10:54:58 PM

25 mm/s

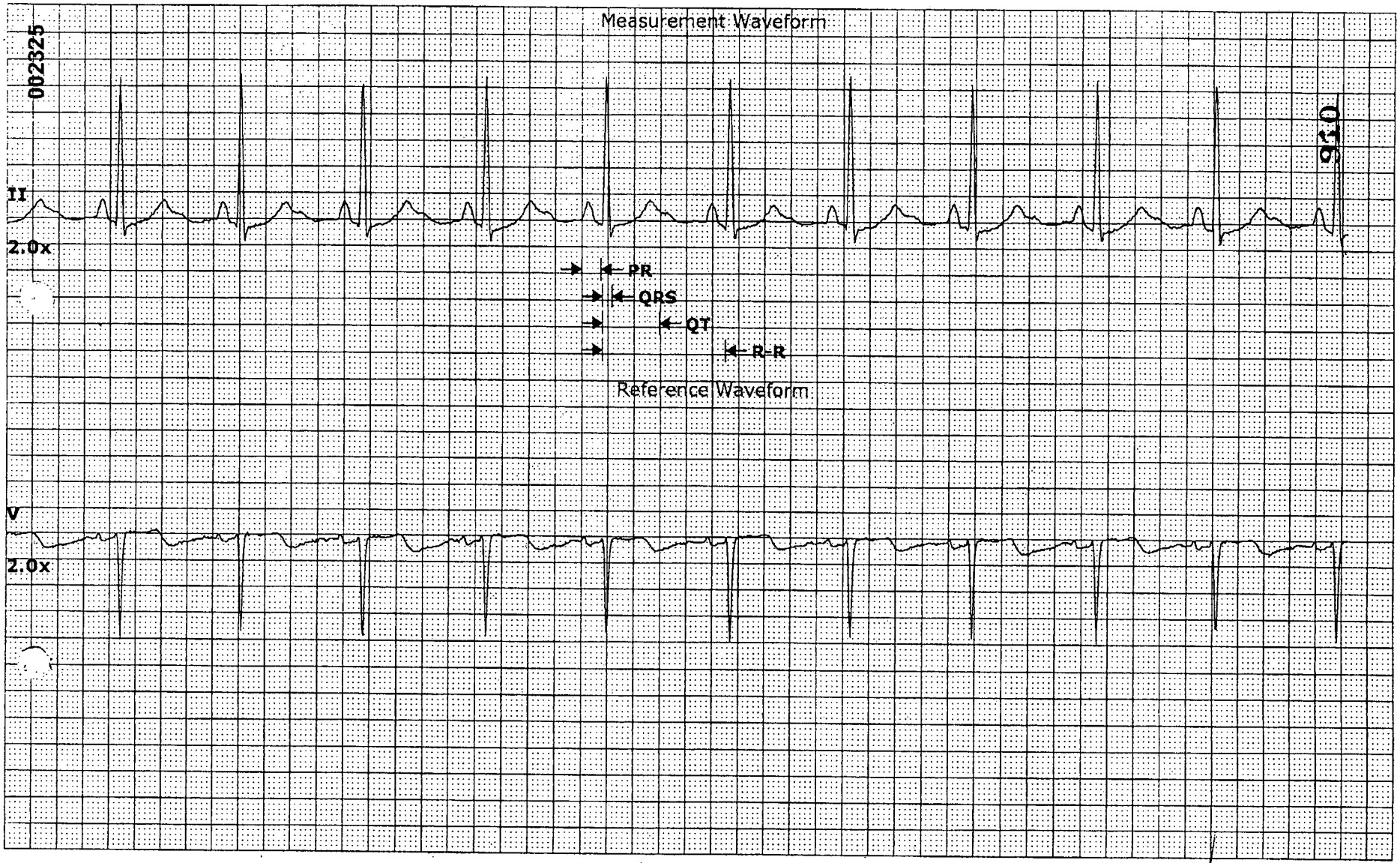
Page 1

END OF REPORT

WINDHAM,TAMMY **M000895682** **Caliper Measurements** **5H|5058**

22-Jan-2008 18:59:58 - 22-Jan-2008 19:00:08

6112



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.155	sec	QT	= 0.443	sec
QRS	= 0.073	sec	R-R	= 0.945	sec
QTc	= 0.456	sec	Rate	= 64	bpm

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CIC Version 5.0.7

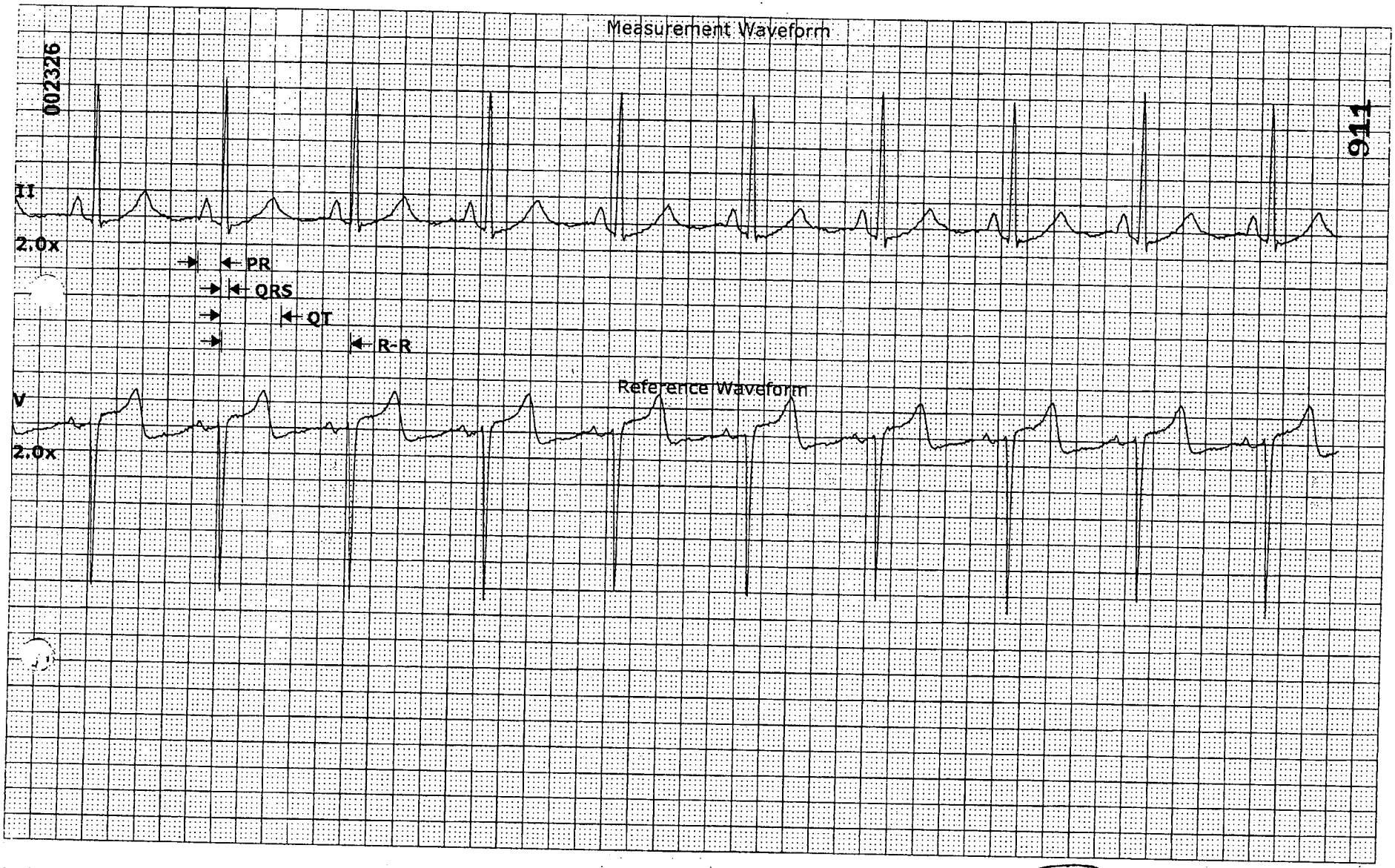
Tuesday, January 22, 2008 7:26:49 PM

25 mm/s

Page 1

END OF REPORT

6113



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.184	sec	QT	= 0.478	sec
QRS	= 0.067	sec	R-R	= 1.007	sec
QTc	= 0.476	sec	Rate	= 60	bpm

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CIC Version 5.0.7
Tuesday, January 22, 2008 2:53:21 PM

SN pmH/HC

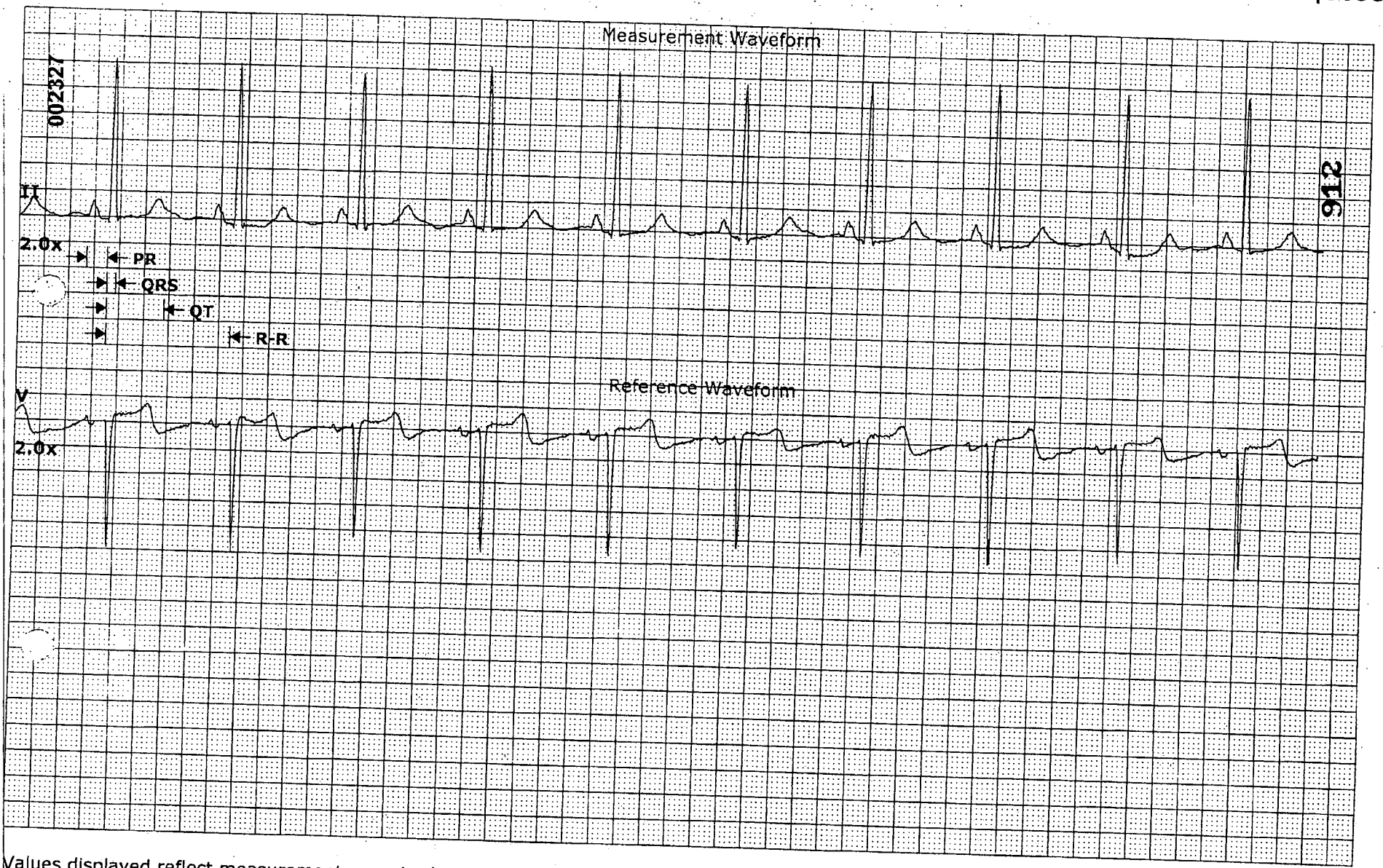
25 mm/s
Page 1
END OF REPORT

22-Jan-2008 10:38:50 - 22-Jan-2008 10:39:00

Caliper Measurements

5H|5058*

6114



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.167	sec	QT	= 0.469	sec
QRS	= 0.075	sec	R-R	= 0.998	sec
QTc	= 0.469	sec	Rate	= 60	bpm

SR

GE Medical Systems Information Technologies

CIC Version 5.0.7

Tuesday, January 22, 2008 11:06:56 AM

25 mm/s

Page 1

END OF REPORT

22-Jan-2008 06:37:21 - 22-Jan-2008 06:37:31

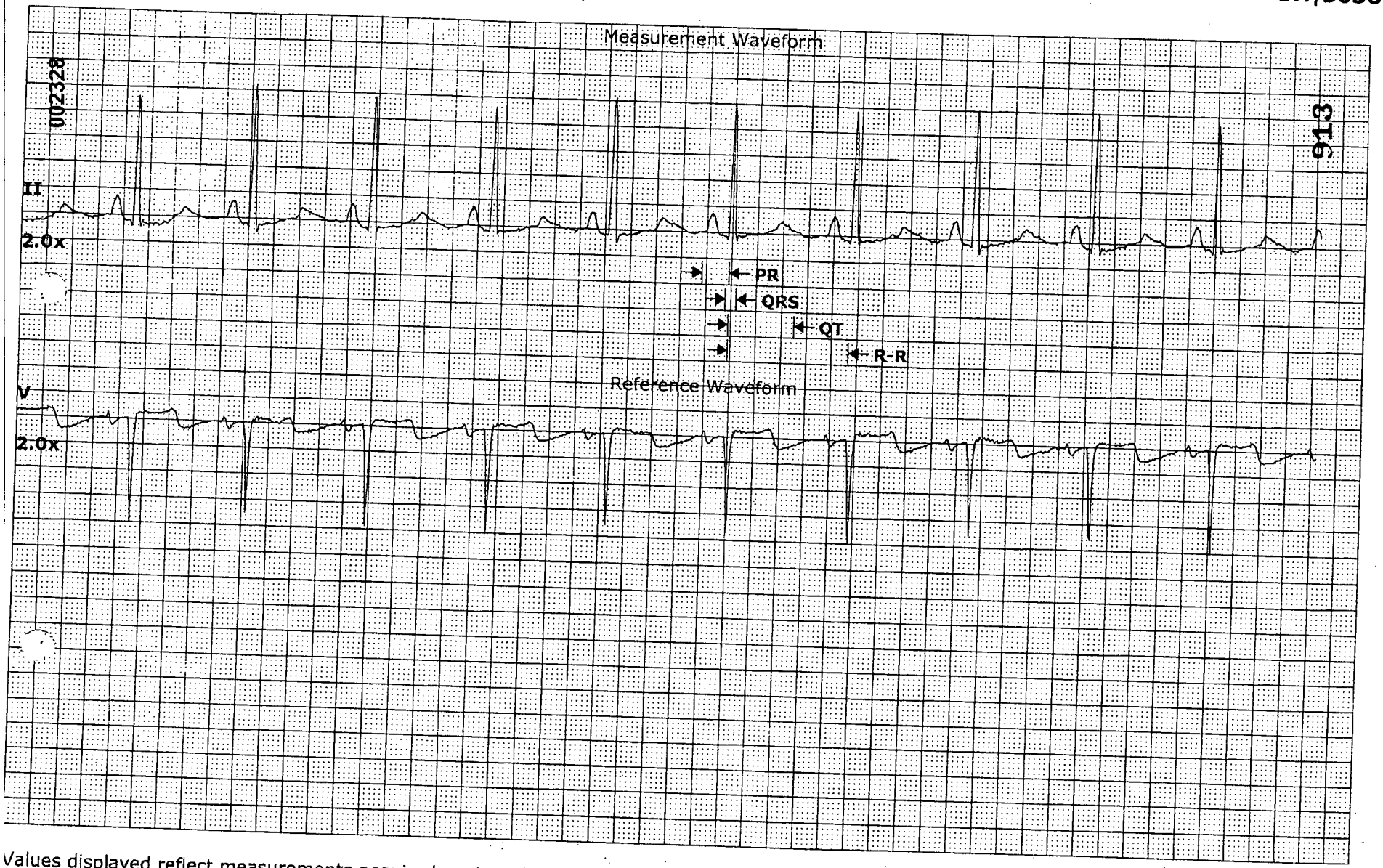
Caliper Measurements

5H|5058*

6115

002328

913



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.216	sec	QT	= 0.517	sec
QRS	= 0.094	sec	R-R	= 0.952	sec
QTc	= 0.530	sec	Rate	= 63	bpm

SR, 1°AVB
cgubet

GE Medical Systems Information Technologies

CIC Version 5.0.7

Tuesday, January 22, 2008 7:38:38 AM

25 mm/s

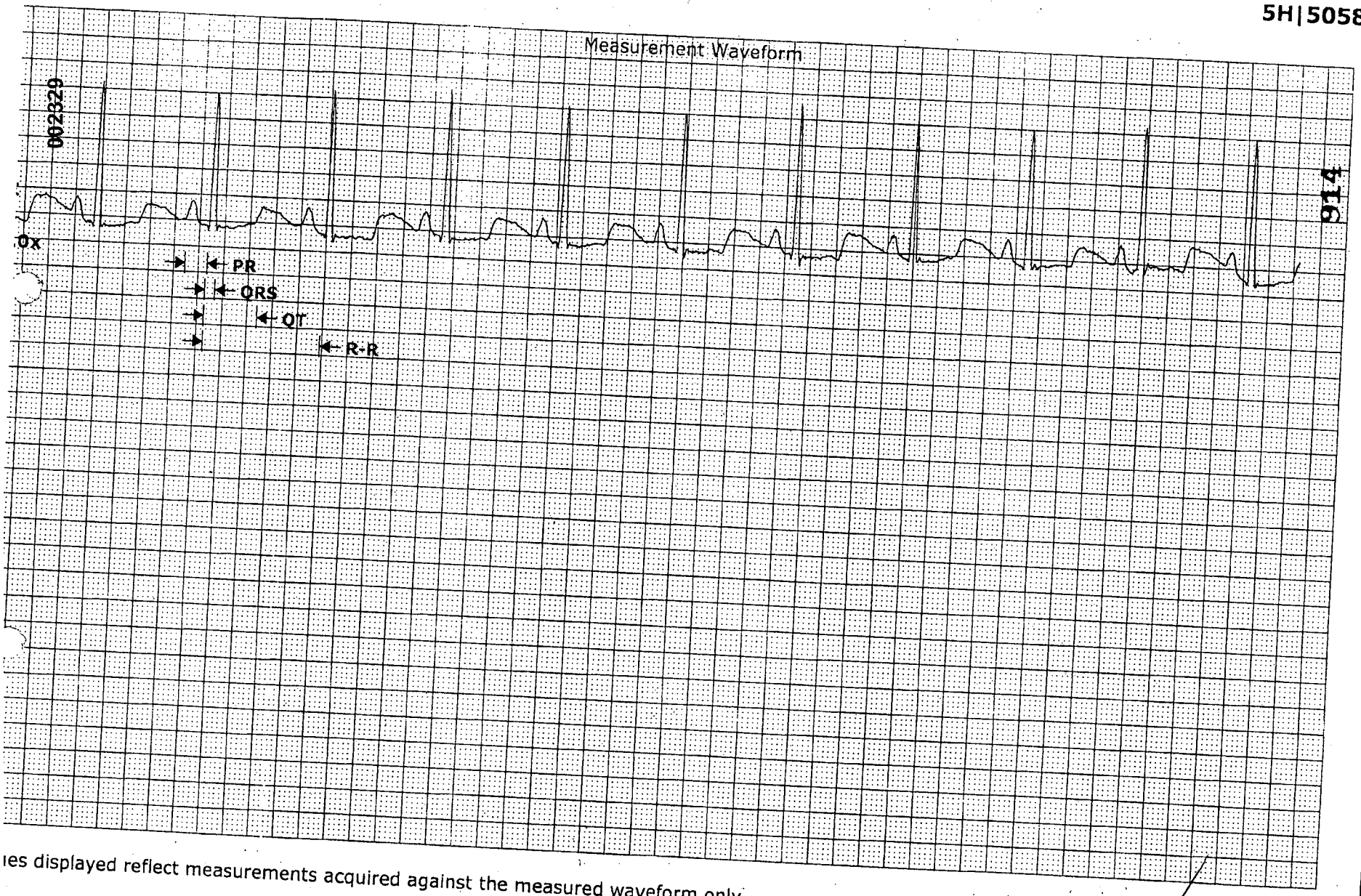
Page 1

END OF REPORT

5H|5058*

6116

Measurement Waveform



ies displayed reflect measurements acquired against the measured waveform only.

= 0.179	sec	QT	= 0.431	sec
= 0.090	sec	R-R	= 0.931	sec
= 0.447	sec	Rate	= 64	bpm

'E Medical Syste
formation Technol

CIC Version 5.0.7
Tuesday, January 22, 2008 2:46:09 AM

1

25 mm/s
Page 1
END OF REPORT

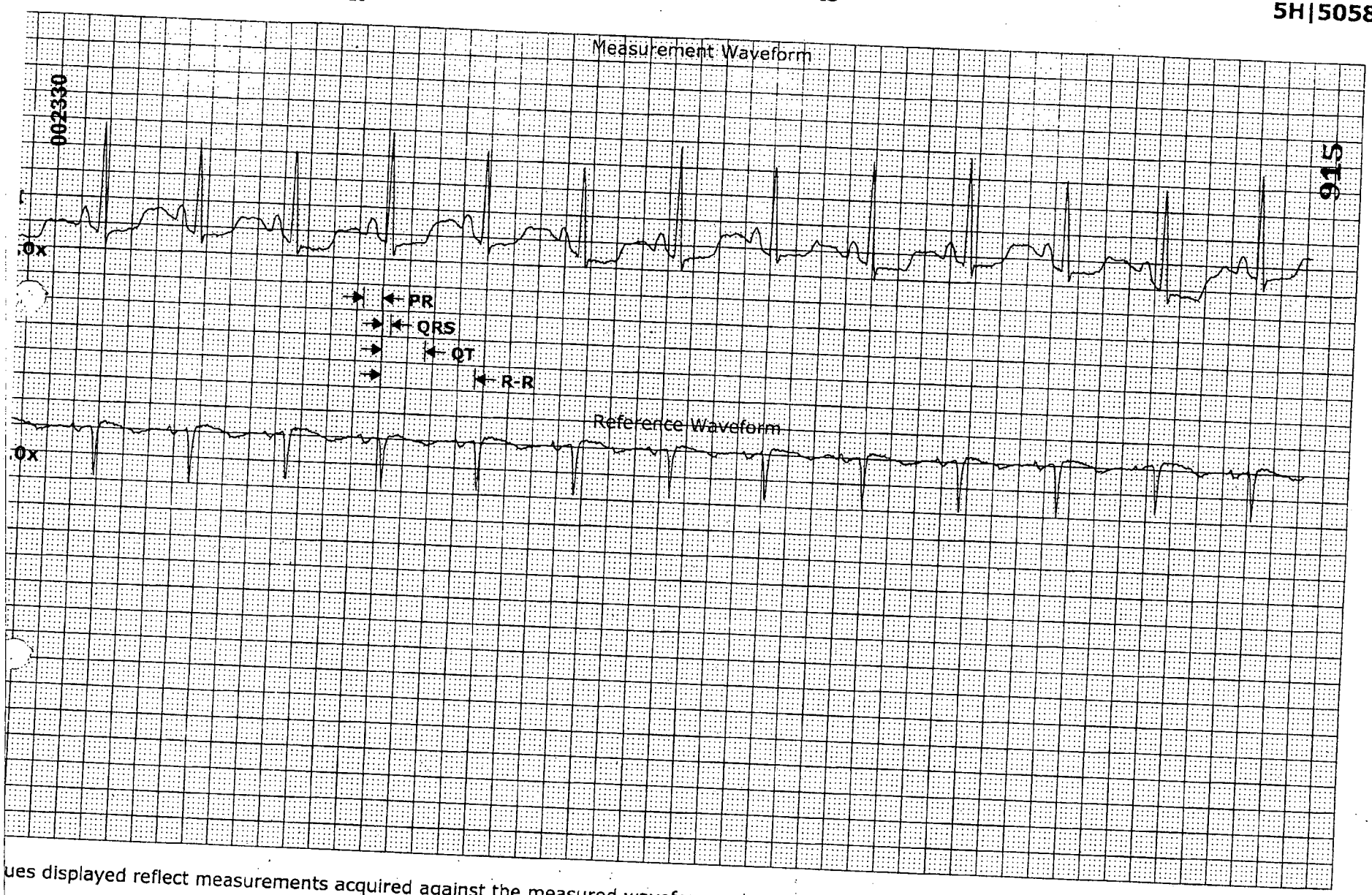
21-Jan-2008 22:42:28

5H|5058*

6117

002330

915



ues displayed reflect measurements acquired against the measured waveform only.

= 0.155	sec	QT	= 0.337	sec
= 0.067	sec	R-R	= 0.737	sec
= 0.393	sec	Rate	= 81	bpm

GE Medical Syst
Information Techno

CIC Version 5.0.7
Monday, January 21, 2008 11:03:27 PM

25 mm/s
Page 1
END OF REPORT

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 FOREST DRIVE
COLUMBIA, SOUTH CAROLINA 29204
(803) 256-5300

CEREBROVASCULAR ARTERIAL STUDY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 01/21/08
DISCHARGE DATE: 01/23/08
ROOM/BED: D.H5058-A
PATIENT TYPE: CAR
SOCIAL SECURITY # 247-31-1815

ACCOUNT # D00502311541
MED REC # M000895682
AGE: 40
[redacted]
NURSING STATION: D.5H
CLINIC CODE:

****
222221

PATIENT: TAMMY E. WINDHAM

STUDY PERFORMED: Carotid duplex.

DATE OF STUDY: 1/22/08

HISTORY: The patient is a 40-year-old with carotid bruits.

TECHNIQUE: B-mode, spectral Doppler, and color flow Doppler imaging were performed of the carotid and vertebral circulation.

FINDINGS: On the right, there was some heterogeneous plaque seen in the proximal ICA as well as the proximal ECA. Peak velocity in the proximal ICA was 164/51 which is compatible with 40% to 59% stenosis. Velocity in the ECA was 239/44, compatible with 40% to 59% stenosis. Vertebral flow is antegrade with a normal waveform.

On the left, likewise, there was some homogeneous smooth plaque in the proximal ICA. The velocities in the ECA, CCA, and ICA were all compatible with less than 39% stenosis. Vertebral flow was antegrade with a normal waveform.

IMPRESSION:
1. Heterogeneous plaque in the right internal carotid with 40% to 59% stenosis. There is also a moderate 40% to 59% external carotid stenosis on the right.
2. On the left, there was homogeneous plaque with less than 39% internal carotid stenosis seen.
3. Antegrade vertebral flow bilaterally.

Joseph Lawton, III, M.D.

JL/rln
DD: 01/22/2008 / DT: 09:46 PM
TD: 01/22/2008 / TT: 09:48 PM

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 FOREST DRIVE
COLUMBIA, SOUTH CAROLINA 29204
(803) 256-5300

002332

CEREBROVASCULAR ARTERIAL STUDY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 01/21/08
DISCHARGE DATE: 01/23/08
ROOM/BED: D.H5058-A
PATIENT TYPE: CAR
SOCIAL SECURITY # 247-31-1815

ACCOUNT # D00502311541
MED REC # M000895682
AGE: [redacted]
NURSING STATION: D.5H
CLINIC CODE:

****
JOB #: 771335

Electronic Signature By: **Dr. Joseph J. Lawton, III**
<<SIGNATURE ON FILE>>

Electronic Signature Date: 02/13/08
Electronic Signature Time: 1542

917

PROVIDENCE HOSPITAL
PROVIDENCE HEART INSTITUTE
CARDIOVASCULAR IMAGING

DOPPLER SPECTRUM EVALUATION

DIAGNOSTIC DOPPLER CRITERIA FOR CAROTID ARTERY DISEASE

Severity Code	Diameter Stenosis	Peak Systolic Velocity	End Diastolic Velocity	Systolic Velocity Ratio ICA/CCA	Spectral Broadening
B NORMAL-MILD	0 –39%	<110	<40	<1.8	Minimal to none.
C MILD-MODERATE	40 – 59%	>130	<40	<1.8	Throughout systole with window filled.
D1 MODERATE	60 – 79%	>130	>40	> 1.8	Marked broadening with post-stenotic turbulence.
D2 HIGH GRADE	80 – 99%	>250	>140	> 3.7	Marked broadening with damping of systolic peak, proximal to lesion.
F OCCLUSION	100%	N/A	N/A	N/A	No flow in internal carotid artery.

From: Standardized Imaging and Doppler Criteria for Cerebrovascular Diagnosis using Duplex Sonography. Presented at the 1986 AIUM, Las Vegas, Nevada. Authors: J. Dennis Baker M.D., Sepulveda, CA Kenneth, W. Marich, M.S., UCSF School of Medicine, San Francisco, California.

PROVIDENCE
HEART INSTITUTE

A Sisters Of Charity Ministry

ICAVL Laboratory

CAROTID DUPLEX
SONOGRAPHER'S WORKSHEET 002334
PRELIMINARY REPORT

Name: _____ Date: 01/22/08 Ordering Dr: CCC

Account #: [redacted] Sono: IF Tape #: _____ Reading Dr: _____

DOB: ___/___ Rm #: 5058

Technical Quality: GOOD FAIR POOR

History			
F/U CEA: R / L _____	F/U Stenosis: R / L _____	Visual Disturbance	R / L
CVA	Y / N	Facial Weakness / Numbness	R / L
TIA	Y / N	Arm / Leg Weakness / Numbness	R / L
Bruit:	R / L	Slurred Speech	Y / N
Amaurosis Fugax	R / L	Syncope Y / N Dizziness	Y / N

Test Indications: Chest Pain **Technically Limited Due To:** _____

Report Called Y / N Spoke to: _____ Phone Number: _____ Time: _____

Findings: RT ICA prox - C velocitie
LT ICA
RT ECA - C velocities

Legend

B – < 39% C – 40% - 59% D_1 – 60% - 79% D_2 – 80% - 99% F – Occluded

Plaque Morphology / Surface Characteristics

H_1 Homogeneous H_2 Heterogeneous S_1 Smooth S_2 Irregular IT Intimal thickening N None seen

Right				Morphology / Surface		Left		
Location	Grade	PSV/DV				Location	Grade	PSV/DV
ECA Angle= 60	C	239/44		H_2 S_2	H_1 S_1	ECA Angle= 60	B	119/20
Dist ICA Angle= 42	B	95/42		N	N	Dist ICA Angle= 60	B	115/34
Prox ICA Angle= 60	C	164/51		H_2 S_2	H_1 S_1	Prox ICA Angle= 60	B	103/38
Dist CCA Angle= 60	B	63/25		H_1 S_1	H_1 S_1	Dist CCA Angle= 60	B	73/19
Prox CCA Angle= 60	B	74/26		H_1 S_1	H_1 S_1	Prox CCA Angle= 60	B	104/31
Vertebral	Antegrade / Retrograde					Vertebral	Antegrade / Retrograde	
ICA / CCA Ratio	2.6					ICA / CCA Ratio	1.6	
Right BP	146/82					Left BP		

77132

☑ Nursing Assessment reviewed ☑ Vitals reviewed ☑ bilateral BP's reviewed

PHYSICAL EXAM

General Appearance
__no acute distress
__alert
__mild / moderate / severe distress
anxious / lethargic

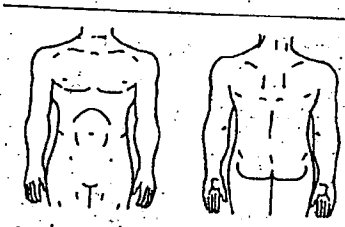
EENT
__eyes nml inspection
__ENT nml inspection
__pharynx nml
__scleral icterus / pale conjunctivae
__EOM palsy / anisocoria
__pharyngeal erythema
__abnml TM / hearing deficit
__abnormal oral exam

NECK
__nml inspection
__no carotid bruit
__thyromegaly
__lymphadenopathy
__subcutaneous emphysema

RESPIRATORY
__no resp. distress
__chest non-tender
__nml breath sounds
__no pleuritic chest pain
__see diagram
__respiratory distress
__manifests distinct pain on movement
R / L arm trunk
__splinting / decr air mvmnt
__wheezes / rales / rhonchi

CVS
__regular rate, rhythm
__no murmur
__no gallop
__no friction rub
__pulses full / equal
__irregularly irregular rhythm
__extrasystoles (occasional / frequent)
__tachycardia / bradycardia
__PMI displaced laterally
__JVD present
__murmur grade __/6 sys / dias
cresc / cresc-decresc / decresc
__gallop (S3 / S4)
__friction rub / Hamman's crunch
__decreased pulse(s)
R carotd___ fem___ dors ped___
L carotd___ fem___ dors ped___

T = tenderness
G = guarding
R = rebound
m = mild
mod = moderate
sv = severe
(e.g., Tsv = severe tenderness)



ABDOMEN
__non-tender
__no organomegaly
__no distention
__tenderness / guarding / rebound
__abnml bowel sounds
__hepatomegaly / splenomegaly / mass
__bruit

RECTAL
__non-tender
__heme neg stool
__black / bloody / heme pos. stool
__tenderness

SKIN
__color nml, no rash
__warm, dry
__cyanosis / diaphoresis / pallor
__skin rash zoster-like
__embolic lesions
__signs of IVDA

EXTREMITIES
__non-tender
__normal ROM
__no pedal edema
__no calf tenderness
__pedal edema
__calf tenderness
__clubbing
__Homan's sign
__CORDS

NEURO / PSYCH
__oriented x3
__mood / affect nml
__CN's nml as tested
__no motor / snsry deficit
__disoriented to person / place / time
__depressed affect
__facial droop
__weakness / sensory loss

Chest Pain - 33

LABS, EKG & XRAYS

002335

CBC normal except
WBC___ Hgb___ Hct___ Platelets___ segs___ bands___ lymphs___ monos___ eos___

Chemistries normal except
Na___ K___ Cl___ CO2___ Gluc___ BUN___ Creat___ Ca___

CK___ CKMB___ Troponin___ PT___ PTT___ INR___ D-Dimer___

UA normal except
WBC___ RBC___ bacteria___ dip:___

EKG MONITOR STRIP __NSR Rate

EKG __NML ☐ Interp. by me ☐ Reviewed by me Rate
__NSR __nml intervals __nml axis __nml QRS __nml ST/T

not / changed from:
Repeat EKG __unchanged /

CXR ☐ Interp. by me ☐ Reviewed by me ☐ Discsd w/ radiologist
__nml / NAD __no infiltrates __nml heart size __nml mediastinum

not / changed from:

Pulse Ox 98 % on RA / L / ___% at (time)

TREATMENT

Medications Given: time:
ASA ACE inhibitor Beta Blockers Thrombolytics Nitrates

Discharge Medications:

PROGRESS

Time___ unchanged improved re-examined

__Quality measures addressed __ see addendum

Discussed with Dr.
will see patient in: ED / hospital / office
Counseled patient / family regarding:
lab / rad. results diagnosis need for follow-up

Additional history from:
family caretaker paramedics
__prior records ordered
__Rx given

CRIT CARE TIME (excluding separately billable procedures)
30-74 min 75-104 min ___ min

CLINICAL IMPRESSION

☑ Chest Pain
precordial / painful respirations
chest wall / discomfort
tightness / pressure / angina
Dyspnea - acute
Costochondritis - acute
Myofascial Strain - acute
Viral Syndrome - acute
Bronchitis - acute
Viral Pleuritis (Pleurisy)
Abnormal EKG
GERD

☐ Acute MI
☐ Pneumonia
Pericarditis - acute
Acute Aortic Dissection
Pulmonary Embolism
Acute Pulmonary Edema
CHF
Atrial Fibrillation - rapid vent. response
controlled uncontrolled new-onset
acute chronic
Pneumothorax
Pneumomediastinum

DISPOSITION: ☐ home ☐ admitted ☐ transferred
CONDITION: ☐ unchanged ☐ improved ☑ stable

MD / DO

919

6122

33 **Chest Pain** (5)

DATE: _____ TIME: _____ ☐ on arrival
ROOM: _____ __ EMS Arrival _____
HISTORIAN: patient family paramedics _____
__HX / __EXAM LIMITED BY: _____

HPI

chief complaint: chest pain / discomfort

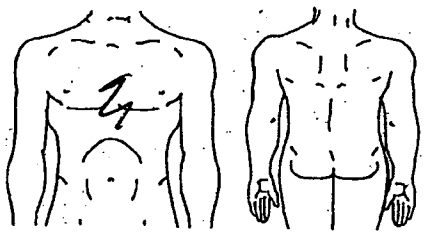
started: 30 days ago

time course:
still present better
gone now
lasted _____
resolved on arrival in ED

constant waxing & waning
intermittent episodes lasting _____
worse / persistent since _____

quality:
pressure
tightness
indigestion
burning
dull
aching
sharp
stabbing
numbness
like prior MI

location of pain:



radiation: __none diagrammed above
arm / back / neck / jaw / tooth pain _____

associated symptoms:
nausea / vomiting
coughing blood
syncope
feeling of doom
shortness of breath
sweating
palpitations

worsened by:
change in position
deep breaths / turning
exertion
nothing

relieved by:
sitting up
rest
albuterol
nothing

nitroglycerin 1 2 3
patient's own supply
given by paramedics
relief- none / partial / complete / transient

Oxygen NRB __L

onset during:
sleep rest light activity
mod. / heavy exertion
emotional upset
cannot recall

severity:
maximum: (1-10)
mild moderate severe
when seen in ED: (1-10)
gone almost gone mild moderate severe
residual discomfort in arm (R / L)

Evaluation / treatment PTA: by patient paramedics
heart rate= _____ unknown monitor- _____
treatment-
Valsalva / carotid massage _____
Adenocard / Verapamil / Lidocaine _____

Similar symptoms previously angina heart pain yes
Recently seen / treated by doctor _____

ROS

002330

CHEST / CONST
fever
chills
cough
sputum
ankle swelling
calf / leg pain
hand / arm pain

FEMALE REPRODUCTIVE
LNMP
vaginal discharge
abnormal bleeding

NEURO
headache
blackouts
EYES / ENT
blurred vision
sore throat
GI / GU
abdominal pain
black / bloody stools
problems urinating
SKIN / LYMPH / MS
rash / swelling
joint pain
☒ all systems neg except as marked

PAST HX

negative
*high blood pressure
*diabetes Type 1 Type 2
diet / oral / insulin
*high cholesterol
*heart disease
heart attack (MI)
angina / heart failure
DVT / PE risk factors
cast cancer recent surgery
leg swelling bedridden paralysis

* = MI risk factors
emphysema
collapsed lung
stroke
peptic ulcer
documented? yes no
gall stones
kidney disease / dialysis
GERD / liver disease / pancreatitis
*TAD risk factors:
pregnancy connective tissue
Turners, etc coarctation of aorta

Surgeries / Procedures __none
cardiac bypass
cardiac cath / stent
angioplasty
thrombolytics
pacemaker
stress test

tonsillectomy
cholecystectomy
appendectomy
hysterectomy
endoscopy
dental work
indwelling device line / port
catheter / dialysis graft

Medications __none see nurses note
NSAID acetaminophen BCP's
ASA within last 24 hours

Allergies NKDA
see nurses note

SOCIAL HX *smoker *drug use / abuse (cocaine / IV)
recent ETOH

FAMILY HX *CAD (less than 55yo / greater than 55yo)
aortic aneurysm PE

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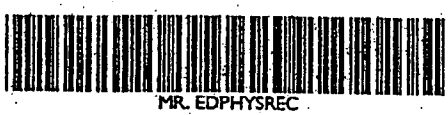
MR. EDPHYSREC

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 Forest Drive Columbia, SC 29204

EMERGENCY PHYSICIAN RECORD

Age/Sex: 40 F
Unit #: M000895682
Account#: D00502311541
Admitted: 01/21/08 at 1944

WINDHAM,TAMMY E (ADM IN)
D.5H-D.H5058-A
Lawton,Joseph J. III Dr.
Providence Hospital Nursing **L

002337

Printed 01/23/08 at 0738
Period ending 01/23/08 at 0738
CARE CONFERENCE SIGN IN SHEET

Care Conference Sign-in Sheet

Admit Problem #1: CP

Admit Problem #2:

Clinical Manager:
Nursing:
PCC: Holt RN CM
Social Services:
Dietician:
Pastoral Care:
Respiratory:
Rehab. Services:
Infection Control:
Pharmacy:
Other:

Plan of Care Reviewed Without Change or Referrals: ✓
Plan of Care Reviewed see POC/Ancillary Note for Revisions:
Comment:

JP cath & intervention
med assistance
D/c'd home today

920

RUN DATE: 01/21/08
RUN TIME: 2149
RUN USER: JONESCT

Providence Hospital **Admission**
HAND OFF REPORT

002338 PAGE

Location: D.5H

Room Bed	Acct #	Patient	Sex/Age	AdmDt
D.H5058-A	D00502311541	WINDHAM, TAMMY E	40	

Allergy ID Band:
Plan of Care: CHESTPAIN
Code Status:
Spot the Dot: Y
Vital Signs BP: 150/76 Pulse: 88 Resp: 18 Temp: 97.5 SpO2: 98
Isolation:

Anticipated Changes in Condition: Ø

What to Watch for in the next Interval of Care: migraine → OP

Comments:

(Print) AM Nurse:
(Print) PM Nurse: Jones, RN
Unit Phone Number:
Unit Phone Number: 5600

Department: X-ray
Patient Tolerated Procedure: 2130
Provider Name: MDA
Department Phone Number: yes
Comments:

Department:
Patient Tolerated Procedure:
Provider Name:
Department Phone Number:
Comments:

Department:
Patient Tolerated Procedure:
Provider Name:
Department Phone Number:
Comments:

PROVIDENCE HOSPITAL DOWNTOWN
2435 FOREST DRIVE
COLUMBIA, S.C. 29204

002339

Name: WINDHAM,TAMMY E
Phys: Lawton,Joseph J III
[redacted] 41 Sex: F
Acct: D00502311541 Loc: D.H5058
Exam Date: 01/21/2008 Status: DIS IN
Radiology No:
Unit No: M000895682

EXAM#	TYPE/EXAM	RESULT
000934434	RAD/CHEST PA/LAT	

INDICATION: Chest pain.

FINDINGS: The lungs are clear. No pneumothorax or effusion is seen. There is no acute osseous abnormality. The cardiomediastinal silhouette is within normal limits.

IMPRESSION: No radiographic evidence of chest disease.

** REPORT SIGNATURE ON FILE 01/21/2008 **
Reported By: DOUGLAS M. McCONNELL, M.D.
Signed By: MCCONNELL,DOUGLAS M

CC: Dr. Joseph J. Lawton III

Technologist: ROBERT M SCHMITT, R.T.
Transcribed Date/Time: 01/21/2008 (2226)
Transcriptionist: COSTLOGE
Printed Date/Time: 03/17/2009 (0903)

922

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PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
2435 FOREST DRIVE/COLUMBIA, SC 29204
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Medical Director of Laboratories
120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203
PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E
REG DR: Lawton,Joseph J III

ACCT #: D00502311541 **LOC:** D.5H **U #:** M000895682
[redacted] **ROOM:** D.H5058 **REG:** 01/21/08
BED: A **DIS:** 01/23/08
STATUS: DIS IN **TLOC:**

SPEC #: 0122:C00058T **COLL:** 01/22/08-0426 **STATUS:** COMP **REQ #:** 01336354
RECD: 01/22/08-0454 **SUBM DR:** Lawton,Joseph J III

ENTERED: 01/22/08-0001 **OTHR DR:** NO DOCTOR
ORDERED: CMP, LIVER/R, LIPID, TROPRFLX, CK ONLY
COMMENTS: Campus: DTP
X EDTA

Test	Result	Flag	Reference	Site
COMPREHENSIVE METABOLIC PANEL				
SODIUM	139		136-144 mmol/L	
POTASSIUM	4.2		3.6-5.1 mmol/L	
CHLORIDE	110		101-111 mmol/L	
CARBON DIOXIDE	24		22-32 mmol/L	
ANION GAP	9	L	10-20	
GLUCOSE	86		74-118 MG/DL	
	The American Diabetes Association (ADA) considers a FASTING blood glucose level of 100-125mg/dL as consistent with pre-diabetes, and any value above 125mg/dL as consistent with diabetes.			
BUN	11		8-26 mg/dL	
CREATININE				
CREATININE	0.9		0.6-1.1 mg/dL	
BUN/CREA RATIO	12			
GLOMERULAR FILTRATION RATE:				
	>60			
	UNITS ARE mL/min/1.73m2			
	THIS RESULT IS FOR A PATIENT OF ANY RACE EXCEPT AFRICAN AMERICAN.			
CALCIUM	9.0		8.9-10.3 mg/dL	
HEPATIC PANEL				
TOTAL PROTEIN	6.8		6.5-8.1 g/dL	
ALBUMIN	3.2	L	3.5-5.0 gm/dL	
GLOBULIN	3.6		2.7-4.5 GM/DL	
ALBUMIN/GLOBULIN RATIO				
	0.9	L	1.0-2.5	
TOTAL BILIRUBIN	0.4		0.3-1.2 mg/dL	
DIRECT BILIRUBIN	0.1		0.1-0.5 mg/dL	
IND BILIRUBIN	0.30		0.1-0.8 MG/DL	
SGOT/AST	21		15-41 IU/L	

RUN DATE: 03/17/09 **RUN TIME:** 0903
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

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120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203
PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E [redacted] **LOC:** D.5H **U #:** M000895682
REG DR: Lawton,Joseph J III **ROOM:** D.H5058 **REG:** 01/21/08
BED: A **DIS:** 01/23/08
TLOC:

Specimen: 0122:C00058T **Collected:** 01/22/08-0426 **(Continued)**

Test	Result	Flag	Reference	Site
SGPT/ALT	16		14-54 IU/L	
ALK PHOS TOTAL	126		38-126 IU/L	
LIPID PROFILE (CORONARY RISK)				
TRIGLYCERIDES	183		30-200 mg/dL	
CHOLESTEROL	183		100-200 mg/dL	
HDL CHOLESTEROL	**24**	*L*	40-85 mg/dL	
LDL	**122.4**	*H*	0-120 MG/DL	
	REFERENCE RANGE FOR LDL IS LESS THAN 120			
VLDL CHOLESTEROL	37		0-40 mg/dL	
CORONARY RISK	**7.6**	*H*	3.0-4.5	
TROPONIN I WITH REFLEX CKMB				
	0.01		0-0.5 ng/mL	
	THIS IS A TROPONIN I WITH REFLEX. A CK TOTAL, CKMB TOTAL AND A CKMB INDEX WILL BE PERFORMED ONLY IF TROPONIN I IS GREATER THAN 0.5 NG/ML.			
CREATINE KINASE (CK) ONLY				
	38		38-234 IU/L	

RUN DATE: 03/17/09 **RUN TIME:** 0903
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

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Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories

PATIENT: WINDHAM,TAMMY E [redacted] **LOC:** D.5H **U #:** M000895682
ROOM: D.H5058 **REG:** 01/21/08
REG DR: Lawton,Joseph J III **BED:** A **DIS:** 01/23/08
TLOC:

SPEC #: 0121:C00254S **COLL:** 01/21/08-1450 **STATUS:** COMP **REQ #:** 01336005
RECD: 01/21/08-1552 **SUBM DR:** Powell,D Langston

ENTERED: 01/21/08-1537 **OTHR DR:** NO DOCTOR
ORDERED: CMP, BMP, TROPONIN
COMMENTS: ADD CMP 2130
Campus: DTP
XBLUE,XGOLD

Test	Result	Flag	Reference	Site
COMPREHENSIVE METABOLIC PANEL				
BASIC METABOLIC PANEL				
SODIUM	140		136-144 mmol/L	
POTASSIUM	3.8		3.6-5.1 mmol/L	
CHLORIDE	108		101-111 mmol/L	
CARBON DIOXIDE	23		22-32 mmol/L	
ANION GAP	13		10-20	
GLUCOSE	102		74-118 MG/DL	
	The American Diabetes Association (ADA) considers a FASTING blood glucose level of 100-125mg/dL as consistent with pre-diabetes, and any value above 125mg/dL as consistent with diabetes.			
BUN	8		8-26 mg/dL	
CREATININE				
CREATININE	0.8		0.6-1.1 mg/dL	
BUN/CREA RATIO	10			
GLOMERULAR FILTRATION RATE:	>60			
	UNITS ARE mL/min/1.73m2			
	THIS RESULT IS FOR A PATIENT OF ANY RACE EXCEPT AFRICAN AMERICAN.			
CALCIUM	9.1		8.9-10.3 mg/dL	
TOTAL PROTEIN	7.7		6.5-8.1 g/dL	
ALBUMIN	3.7		3.5-5.0 gm/dL	
GLOBULIN	4.0		2.7-4.5 GM/DL	
ALBUMIN/GLOBULIN RATIO	**0.9**	*L*	1.0-2.5	
TOTAL BILIRUBIN	0.3		0.3-1.2 mg/dL	
SGOT/AST	23		15-41 IU/L	
SGPT/ALT	17		14-54 IU/L	

RUN DATE: 03/17/09 **RUN TIME:** 0903
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

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PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E **ACCT #:** D00502311541 **LOC:** D.5H **U #:** M000895682
REG DR: Lawton,Joseph J III [redacted] **ROOM:** D.H5058 **REG:** 01/21/08
BED: A **DIS:** 01/23/08
TLOC:

Specimen: 0121:C00254S **Collected:** 01/21/08-1450 **(Continued)**

Test	Result	Flag	Reference	Site
ALK PHOS TOTAL	**143**	*H*	38-126 IU/L	
TROPONIN I	0.02		0-0.5 ng/mL	

RUN DATE: 03/17/09 **RUN TIME:** 0903
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

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PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
2435 FOREST DRIVE/COLUMBIA, SC 29204 / **120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203**
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PATIENT: WINDHAM,TAMMY E
REG DR: Lawton,Joseph J III

ACCT #: D00502311541 **LOC:** D.5H **U #:** M000895682
AGE/SX: 40/F **ROOM:** D.H5058 **REG:** 01/21/08
[redacted] **BED:** A **DIS:** 01/23/08
TLOC:

SPEC #: 0122:CG00012T **COLL:** 01/22/08-0645 **STATUS:** COMP **REQ #:** 01336360
RECD: 01/22/08-0655 **SUBM DR:** Lawton,Joseph J III

ENTERED: 01/22/08-0001 **OTHR DR:** NO DOCTOR
ORDERED: PT
COMMENTS: Campus: DTP
XGRN XLAV

Test	Result	Flag	Reference	Site
PROTHROMBIN TIME W/ INR				
PROTIME	12.6		12.0-15.1 SECONDS	
	Note: The antithrombotic actions of vitamin K antagonists are attributed to their anticoagulant effect, which is mediated by the reduction of several vitamin K-dependent coagulation factors. The anticoagulant effect of these drugs is identified in their prolonging of the PT and INR. Since some of these coagulation factors have half lives of less than 24 hours, the PT and INR can actually be in the therapeutic range within 48 hours of initiating therapy. However, the factors responsible for the bulk of the antithrombotic effects have half lives of up to 72 hours. Therefore, evidence of anticoagulation should not be taken as proof of thrombophylaxis unless the patient has been receiving vitamin K antagonists for at least 4 days. (The Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy, Ansell et al, Chest, vol. 126/number 3 (suppl)/September 2004, pgs 204S-233S)			
INR	0.91			
	Prophylactic INR: 2-3 Therapeutic INR: 2.5-3.5			

RUN DATE: 03/17/09 **RUN TIME:** 0904
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

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PATIENT: WINDHAM,TAMMY E **ACCT #:** D00502311541 **LOC:** D 5H **U #:** M000895682
REG DR: Lawton,Joseph J III [redacted] **ROOM:** D H5058 **REG:** 01/21/08
BED: A **DIS:** 01/23/08
TLOC:

SPEC #: 0121:H00196S **COLL:** 01/21/08-1450 **STATUS:** COMP **REQ #:** 01336005
RECD: 01/21/08-1552 **SUBM DR:** Powell,D Langston

ENTERED: 01/21/08-1537 **OTHR DR:** NO DOCTOR
ORDERED: CBC W/AUTO DIFF
COMMENTS: Campus: DTP

Test	Result	Flag	Reference	Site
CBC WITH AUTO DIFF				
WHITE BLOOD CELL	8.5		3.53-9.57 K/UL	
RBC	5.70	*H*	3.96-5.50 M/UL	
HEMOGLOBIN	10.8	L	12.14-16.27 GM/DL	
	WARMED SAMPLE, H&H REPEATED THE SAME.			
HEMATOCRIT	35.7		35.39-47.19 %	
MCV	62.7	*L*	76.9-94.7 FL	
MCH	19.0	*L*	25.79-32.95 PG	
MCHC	30.28	*L*	33.34-35.47 G/DL	
RDW	20.75	*H*	12.09-15.17 %	
PLATELET COUNT	392		169.06-413.23 K/MM3	
MPV	10.4		7.54-11.24 FL	
GRANULOCYTE %	67.7		41.72-73.74 %	
LYMPHOCYTE %	21.5		18.43-44.97 %	
MONOCYTE %	6.0		1.7-9.3 %	
EOSINOPHIL %	3.0		0.72-8.06 %	
BASOPHIL %	1.8	*H*	0.17-1.43 %	
GRANULOCYTE #	5.8		1.66-6.72 K/mm3	
LYMPHOCYTE #	1.8		0.92-2.66 K/mm3	
MONOCYTE #	0.5		0.24-0.78 K/mm3	
EOSINOPHIL #	0.3		0.04-0.52 K/mm3	
BASOPHIL #	0.2	*H*	0.01-0.09 K/mm3	
REFLEX DIFF?	NO			

RUN DATE: 03/17/09 **RUN TIME:** 0904
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502311541 **Unit#**M000895682

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/21/08 Time: 1435

Patient Notes: EDM NOTE
- Create 01/21/08 1435 LHH 01/21/08 1435 LHH
Abnormal? Confidential?
RECEIVED TO RM 13 VIA W/C. SEE INITIAL ASSESS PER FLOW CHART.
Note Type Description
No Type None

Activity Date: 01/21/08 Time: 1640

Patient Notes: EDM NOTE
- Create 01/21/08 1640 LHH 01/21/08 1640 LHH
Abnormal? Confidential?
RESTING QUIELTY. CONT C/O CP. STS PAIN WORSENS WITH MIGAINE HA. STS HA WORSE THAN CP AT PRESENT.
Note Type Description
No Type None

Activity Date: 01/21/08 Time: 1911

Patient Notes: EDM NOTE
- Create 01/21/08 1911 LHH 01/21/08 1912 LHH
Abnormal? Confidential?
NTG D/C'D PT RESTING QUIETLY WITHOUT DISTRESS NOTED. DENIES NEEDS.
Note Type Description
No Type None

Activity Date: 01/21/08 Time: 2108

Patient Notes: NURSE
- Create 01/21/08 2108 CTJ 01/21/08 2143 CTJ
Abnormal? N Confidential? N
PT RECEIVED TO ROOM 5058 VIA WHEELCHAIR IN NO APPARENT DISTRESS. PHYSICAL ASSESSMENT COMPLETED. PT ABLE TO AMBULATE FROM WHEELCHAIR TO BED IN NO APPARENT DISTRESS. PT COMPLAINING OF A HEADACHE 10/10. DENIES CP AT PRESENT. WILL MEDICATER PER MD ORDER. ORIENTED PT TO ROOM AND SURROUNDINGS..CALL LIGHT WITHIN REACH OF PT. INFORMED PT OF NPO STATUS AFTER MIDNIGHT. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 01/21/08 Time: 2130

1018 NUR: Admission History/Physical + A ONCE AS
Create 01/21/08 2130 CTJ 01/21/08 2143 CTJ
- Document 01/21/08 2130 CTJ 01/21/08 2143 CTJ
Arrived From+: ED
Mode of Arrival+: WHEELCHAIR
Accompanied By+: NUR
Pt. ID Band On: Y
HIPAA Passcode: 1541
History Obtained From+: PATIENT

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
Family Doctor: NO FAMILY MD
Organ Donor: Y
~~~~Admission Vital Signs~~~~
Blood Pressure: 150/76.
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 88
Pulse Source+: BRA
Respirations: 18
Resp Source+: OBS
SPO2 (%): 98
On Room Air: Y
Weight - Lb: 157
Oz: 1
Kg: 71.243
Weight Source+: STANDING SCALE
Height - Feet: 5
Inches: 4
Cm: 162.56
BSA: 1.79360
BMI: 26.9
Living Will: Y
HC Power of Attorney: Y
If Living Will or HCPOA not Available, What are Pt. Wishes+: YES-FEED
YES-HYDRA
Surrogate Decision Maker for Health Care+: FAMILY
Patient/Family Instructed to Bring Copy to the Hospital: Y
Would You Like Information Regarding Advanced Directives: Y
Any Religious, Traditional, Cultural or Ethnic
Needs that Need to be Part of Your Care: N
Based on any Religious,Cultural or Ethnic concerns, do you
have objections to receiving blood/blood products+: N
Blood Refusal (NO BLOOD) Band On: N
Previous Blood Transfusions: N
Previous Blood Reactions: N
Autologous Blood Banked: N
~~~~Personal Effects Inventory~~~~
Prosthesis: N
Assistive Device+: NONE
Jewelry+: NONE
Chart Patient's Other Belongings Now: Y
Patient's Own Med. Equip. In Use+: NONE
Patient's Chief Complaint: CP, MIGRAINE, AND HEADACHE
~~~~Adverse Reactions/Allergy/Medications~~~~
Pt/Family Adverse Reactions to Anesthesia: N
Enter ALLERGIES Now: Y
Home Pain Management Routine: TYLENOL
~~~~MEDICAL HISTORY REVIEW~~~~
EENT Problems+: Y

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
Hearing+: INTACT
Vision+: GLASSES
GI Problems+: Y
GI History+: HH
GU Problems+: N
GYN Problems+: Y
GYN History+: CA
TUBAL
Is Pt Pregnant: N
Endo/Hepatic Problems+: N
Diabetes: N
Musculoskeletal Problems+: N
Cancer: OVARIAN
Transplant: NONE
Neuro Problems+: Y
Neuro History+: MIGRAINE
Seizures+: NONE
Respiratory Problems+: N
CV Problems+: Y
CV History+: HTN
ANG
CARDCATH
CARSTNT
Infectious Disease+: N
Previous Cardiac Procedures: Y
Cardiac Cath: Y
PTCA: N
Stents: Y
Brachy Therapy: N
CABG: N
----Tuberculosis Screening-Symptoms and History----
Fever: N
Night sweats: N
Unexplained weight loss: N
Persistent cough > than 3 wks: N
Bloody sputum: N
Exposure to TB within last 3 mths: N
Chest xray to rule out TB: N
Hx. Positive PPD: N
Medical History: HIATAL HERNIA, OVARIAN CA, TUBAL LIGATION, MIGRAINE, HTN,
ANGINA, SMOKER
Previous Surgeries: TUBAL LIGATION, STENTS
----Functional History of ADL's----
Feeding+: SELF
Mobility+: SELF
Bathing+: SELF
Dressing+: SELF
Prior to Admit, has ADL Function Declined in Past 2 Weeks: N
Prior to Admit, has Mobility Declined in Past 2 Weeks: N
Prior to Admit, has Cognition Declined in Past 2 Weeks: N

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Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
Prior to Admit, has Communication Changed in Past 2 weeks: N
Prior to Admit, has Swallowing Changed in Past 2 weeks: N
PT Screen Requested: N
OT Screen Requested: N
ST Screen Requested: N
----Nutritional Risk----
Is Pt. Fed Via NG, PEG or TPN: N
Diet: REGULAR
Appetite+: FAIR
Decubitus > or = to Stage 2: N
Last BM: 01/21/08
Bowel Elimination Pattern+: NORMAL
Breastfeeding: N
Vomiting: N
Laxative/Enema+: NONE
Swallowing Impaired: N
Chewing Impaired: N
Dietitian Consult: N
----FALL RISK----
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 2
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 1
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 4
Use Shift F8 to View Spot the Dot
Spot the Dot Implemented: Y
----Psychosocial----
Tobacco Use+: CIGARETTE
Tobacco Use in Last Year: Y
Packs/Day: .5
Number of Years: 20
Alcohol: N
Emotional Status+: AGITATED
Perception+: APPROP
Any Suspicion or Confirmation of Substance Abuse: N
Any Suspicion of Neglect or Abuse: N
----Education----
Able to Read: Y
Able to Write: Y
Ability to Understand+: SIMPLE
Healthcare Knowledge+: SOME KNOW
Highest Education Level+: HS GRAD
Barriers to Learning+: AGEREL

002347

6134

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Comment | Documented Units | Directions | Change | From

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
Learning Preferences+: VERBAL
~~~Discharge Planning Needs Assessment~~~
If Answering Yes to any Question. Consult PCC/RCC
Have You Been Hospitalized Within The Last 30 Days: N
Do you Live Alone: N
Do You Live in an Extended Care Facility: N
Do You Attend an Adult Daycare Facility: N
Did You Require Assistance with ADL's Prior to Admission: N
Do You Use Home Health Services: N
Do you Use Home Durable Medical Equipment: N
Do You Use Meals on Wheels: N
Do You have Transportation To/From MD Appointments: Y
Do you have a Personal Caregiver: N
Are Others Dependent on You for Their Care: N
Any Concerns About Managing at Home After Your Discharge: N
Do You Have Safety Concerns: N
Do You Have Prescription Coverage for Home Medications: N
Any Concerns re:Cost of Hospital Stay or Home Care: N
Will Current Housing be Appropriate Upon Discharge: Y
Patient is Ill with Terminal Prognosis: N
Do You Currently have Hospice Services: N
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Telemetry Box Number: 8676
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Comment | Documented Units | Directions | Change | From

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
~~~GASTROINTESTINAL~~~
Abdomen+: ROU
SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~Immunizations~~~
Tetanus (Within 5 Yrs): Y
Hepatitis B: Y
Pneumovax (Last 5 Yrs): N
Influenza (Within 1 yr): N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: INTACT
~~~Skin Integrity~~~
Sensory Perception+: 3 SLIGHTLY LIMITED
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 3 SLIGHTLY IMPAIRED
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 20
==== WOUNDS ====
Pressure Ulcers: N
Surgical Wounds: N
Vascular/Diabetic/Other Wounds: N
Ostomy: N
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Plan of Care: CHESTPAIN
Hospital Standard of Care: Y
Care Area Intervention Set+: PCU CARDIAC CARE
Age Appropriate Standards+: A.ADULT ADULT - AGE 18-65 YRS
Document Nurse's Notes: Y

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/21/08 Time: 2130 (continued)

1018 NUR: Admission History/Physical + (continued)
~~~~~~~~BELONGINGS CHECKLIST~~~~~~~~
Clothing: Y
Shirt: N
Sweater: N
Pants: Y
Underwear: Y
Socks/Hose: Y
Robe: N
Gown: N
Dress: N
Accessories: Y
Coat: N
Shoes: Y
Hat/Cap: N
Gloves: N
Purse/Wallet: N
Keys: N
Jewelry: N
Misc.: Y
Glasses: Y
Contacts: N
Hearing Aid: N
Walker/Cane: N
Dentures: Y
Upper Plate: Y
Lower Plate: Y
Partial Bridge: N
Disposition of Belongings:
Patient: Y
Family: N
Security: N
Medication/Other Allergies: NKDA
Food Allergies: NKFA NO KNOWN FOOD ALLERGIES
Latex Allergy: N
Contrast Allergy: N

Activity Date: 01/21/08 Time: 2143

Problem: CHEST PAIN: ANGINA A
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10011 Chest Pain: Monitor + A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
Problem: DECREASED CARDIAC OUTPUT A
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10000 Cardiovascular: Monitor A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10001 Cardiac Rhythm: Monitor A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/21/08 Time: 2143

Problem: KNOWLEDGE DEFICIT A
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10009 Cardiac Rehab: Phase I A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
Problem: ADULT - AGE 18-65 YRS A
Potential Alteration in Normal Processes
(ADL's, Safety, Life Situations) r/t
Hospitalization
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of
Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness, Home
Situation, Job, Life Style Changes
and/or Families Inability to Cope
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10048 Activity: as Tolerated/Ordered A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
11690 ADL: Encourage Independence A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
Problem: INFLUENZA SCREENING ASSESSMENT A
This diagnosis is used to screen the
patient population for qualification for
the Influenza Vaccination.
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20170 Influenza Screening Assessment+ A ONCE CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
- Document 01/21/08 2143 CTJ 01/21/08 2143 CTJ
===INFLUENZA VACCINATION STANDING ORDERS===
(Influenza vaccines are provided.October 1 through March 31)
Has the patient has an Influenza vaccine this flu season+: N
(this flu season=Oct. 1 through March 31)
Does the patient have a KNOWN SEVERE REACTION to the vaccine
, Chicken Eggs, History of
Guillain Barre, or previous reaction to the flu vaccine+: N
Has the patient had a bone marrow transplant within the last
12 months
or currently on Chemotherapy+: N
If the answer to questions 1 through 3 are NO or UNKNOWN
patient MEETS CRITERIA for vaccination.
If the answer to either question 1 though 3 is YES,
DO NOT GIVE VACCINE,
patient does NOT meet criteria.
Patient currently scheduled for Surgery: REASSESS CRITERIA
ON POST-OP DAY 3: N
Patient Meets Criteria: Y
Patient Given Vaccination Information: Y
ADMISISTER INFLUENZA VACCINE 0.5 ml IM x 1 to be given on
day 3 of admission.
HOLD FOR TEMP GREATER THAN 101F UNTIL PATIENT HAS BEEN
~~~~~~~~

Problem Description
Intervention Description Sts Directions From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Activity Date: 01/21/08 Time: 2143 (continued)

20170 Influenza Screening Assessment+ (continued)
AFEBRILE FOR 24 HOURS.
****IF THE PATIENT MEETS CRITERIA****
****PRINT AND FAX ASSESSMENT TO PHARMACY UPON COMPLETION****
****PLACE ON CHART IN THE M.D. ORDER SECTION****
Your patient will receive the influenza vaccine on day 3 of admission if the patient meets
criteria as indicated and IS NOT SCHEDULED FOR SURGERY OR IN AN ICU BED. If you DO NOT want
your patient to be immunized, sign the order below to withhold the vaccine with rationale.
PLEASE DO NOT VACCINATE THIS PATIENT DURING THIS ADMISSION
(Physician will sign only
if they do not want their patient vaccinated, otherwise the patient will be given
the vaccine if they meet the criteria to receive it.)
Rationale for Deferring Vaccine:_____

_____
Physician Signature:

_____

Problem: Frequently Used PCU Interventions A
These Interventions Are Frequently Used
And/Or High Priority Nursing
Interventions In The Cardiac Care Areas.
They Are Placed in Process Interventions
As A Conveience For The Nursing Staff.
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10011 Chest Pain: Monitor + A .PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
10175 Instruction: Special Nursing A .PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20105 Post Cath Monitor + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20120 Blood Sugar Monitor + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20160 Telemetry Monitoring + A QSHIFT CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9069 Central Line: Monitor Site/Infusion + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9135 Fluid: Restriction A CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9171 PCA: Monitor + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9351 VS: Frequent Vitals + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9355 VS: Orthostatic + A .PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
Problem: PNEUMOVAX SCREENING ASSESSMENT A
This diagnosis is used to screen the
patient population for qualification for
the Pneumovax Vaccination.

Problem Description
Intervention Description Sts Directions From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Problem: PNEUMOVAX SCREENING ASSESSMENT (continued)
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20180 Pneumovax Screening Assessment+ A ONCE CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
- Document 01/21/08 2143 CTJ 01/21/08 2144 CTJ
===ADULT PNEUMOCOCCAL VACCINATION STANDING ORDERS===
Your patient will receive the pneumococcal vaccine on the
day 3 of admission if the patient
meets criteria as indicated below.
HAS THE PATIENT BEEN VACINATED WITHIN THE LAST 5 YEARS
OR ALREADY BEEN VACCINATED 2 TIMES IN THEIR LIFETIME: N
If the answer is YES -- **STOP HERE!**. The patient does
not require vaccination!
If the answer is NO, proceed to complete the screening below
SECTION A: VACCINATION ASSESSMENT
For Patients 18 years and older, select
any high-risk conditions present+: NONE
Any Condition
Present: N
: 0
Does the patient have Chronic Renal Failure, Immunodeficienc
y or Immunosuppressive
Therapy (including Prednisone > 15 mg/day), Active Cancer,
Asplenia,
Sickle Cell, Organ/Marrow Transplant or AIDS/HIV: N
: 0
Is The Patient 65 Years of Age or Older: N
: 0
Has The Patient Previously Received Pneumococcal Vaccine: N
: 2
If patient currently greater than 65 years of age, was the
most recent pneumococcal
vaccine administered when patient was < 65 years of age: N
: 0
Select NO if patient currently < 65 years of age.
SCORE
TOTAL: 2
SECTION B: VACCINATION SCORE
Total Points 2 or less, patient does NOT meet criteria to
receive Pneumococcal Vaccine.
Total Points > or = 3, patient meets criteria to receive
Pneumococcal Vaccine.
PLEASE REMEMBER, PATIENTS SHOULD ONLY RECEIVE THE VACCINE
TWICE IN THEIR LIFETIME.
If patient has had a bone marrow transplant within the last
12 months or
is currently receiving Chemotherapy, DO NOT GIVE the vaccine
Patient currently scheduled for Surgery. REASSESS CRITERIA
ON POST-OP DAY 3: N
Patient Meets Criteria: N
Patient Given Vaccination Information: N
ADMINISTER PNEUMOCOCCAL VACCINE 23 VALENT 0.5ml IM x 1 DOSE
GIVEN ON DAY 3 OF THE ADMISSION.
HOLD FOR TEMP GREATER THAN 101F UNTIL PATIENT HAS BEEN

933

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Activity Date: 01/21/08 Time: 2143 (continued)

20180 Pneumovax Screening Assessment+ (continued)
AFEBRILE FOR 24 HOURS.
HOLD UNTIL POST-OP DAY 3 IF PATIENT SCHEDULED FOR SURGERY.
****IF THE PATIENT MEETS CRITERIA****
****PRINT AND FAX ASSESSMENT TO PHARMACY UPON COMPLETION****
****PLACE ON CHART IN THE M.D. ORDER SECTION****
PLEASE DO NOT VACCINATE THIS PATIENT DURING THIS ADMISSION
(Physician will sign only
if they do not want their patient vaccinated, otherwise
the patient will be given
the vaccine if they meet the criteria to receive it.)
Rationale for Deferring Vaccine:_____

Physician Signature:

Problem: GUIDELINES FOR NURSING DOCUMENTATION A
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
11040 Meds: As Ordered A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
15001 IV Insertion/Removal + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20140 Home Medication List + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
- Document 01/21/08 2143 CTJ 01/21/08 2143 CTJ
List All
Home Medications (except those listed above):
Include Med. Name,
Dose, Route,
& Frequency. Also Include Any
Over-The-Counter
Medicines, Herbal Remedies
Or Vitamins
Does Patient Take Any Home Medicines: Y
ASA: Y
Type+: BABY ASA
Dose: 81MG DAILY
Dose in Last 24h: Y
Beta-Blocker: N
ACE-I: N
ARB: N
HTN MED
Dose In Last 24h: Y
Medication History Obtained From+: SELF
Disposition of Meds+: NONE

Activity Date: 01/21/08 Time: 2143

20145 Advance Directives Monitor + A PER PROTOCOL CP
--Two Attempts To Acquire Hard Copy For
Chart Required
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20150 Emergency Contact Information + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20300 Patient Hand Off Form + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20500 DVT Screening Protocol + A ONCE CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4001 VS: Monitor + A Q4HOURS CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4002 Shift Assessment + A QSHIFT CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4004 Nursing: Daily Process + A Q12H10 CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4055 Notify: MD + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4065 Pain: Monitor + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4066 Pain: Reassess + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4085 Transfer: Another Unit + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4090 Meals: Percentage Consumed + A TID CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4100 ADL: + A QS&PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4110 I&O: Monitor + A TID CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4120 Weight + A DAILY CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4130 Education: + A DAILY CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4140 Discharge Instruction + A ONCE CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
4460 Critical Results Monitor + A PRN CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9040 Blood Product: Administer as Ordered+ A PER PROTOCOL CP
-THIS INTERVENTION IS USED ON ALL
PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
9167 IV: Peripheral Monitor Site/Infusion + A PER PROTOCOL CP
- Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/21/08 Time: 2143

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
Problem: INFLUENZA VACCINATION ACTIONS A
This diagnosis is used when a patient
qualifies for the Influenza Vaccine.
Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ
20175 Influenza Vaccination Actions+ A ONCE CP
--Do NOT Administer If Patient Is In
ICU (DTP or NEP), MCCU, Or CSR
--Give On Day 3 Of The Hospital Stay
--Pt. Must Be Afebrile For 24 Hrs.
prior to vaccination.
Create 01/21/08 2143 CTJ 01/21/08 2143 CTJ

Activity Date: 01/21/08 Time: 2151

4065 Pain: Monitor + A .PRN CP
Document 01/21/08 2151 CTJ 01/22/08 0057 CTJ
Pain Indicators+: VOC
Pain Scale: 10
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: CONSTANTLY
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET 2 TABS

Activity Date: 01/21/08 Time: 2159

4110 I&O: Monitor + A TID CP
Document 01/21/08 2159 MSG 01/22/08 0028 MSG
<>INTAKE<>
<>OUTPUT<>
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 01/21/08 Time: 2251

4066 Pain: Reassess + A .PRN CP
Document 01/21/08 2251 CTJ 01/22/08 0058 CTJ
Pain Location #1+: HEADACHE
Previous Pain Level: 10
Pt. Asleep: Y

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/21/08 Time: 2322

20500 DVT Screening Protocol + A ONCE CP
Document 01/21/08 2322 CTJ 01/21/08 2323 CTJ
---DVT SCREENING PROTOCOL---
ADULTS 18 YEARS AND OLDER
Y/N
: N
OUTPATIENT: Receiving Local anesthesia/Block or Moderate
Sedation Procedures.
****IF YES, STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED
==========
==========
Y/N
: N
Patient with current orders for anticoagulant therapy
or PT/PTT in therapeutic
range (NOTE: Heparin, Coumadin, Lovenox,
Fragmin, and Atrixtra constitute
anticoagulant therapy; ASPIRIN and PLAVIX DO NOT constitute
anticoagulant therapy).
****IF YES, STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED
==========
==========
---RISK FACTORS (Select All That Apply)---
5 Pt. Subtotal: 0
3 Pt. Subtotal: 0
2 Pt. Subtotal: 0
1 Pt. Subtotal: 0
Total Risk Factor Points: 0
Based on total risk factors, select one risk category below,
then indicate your choice(s).
[ ] RISK SCORE > OR = 5 -- HIGHEST RISK
Early Ambulation
Plus
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED
hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED
hose only -Thigh length
*AND add:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at ____
[ ] Lovenox.30mg SC every 24 hours if creatinine clearance
< 30ml/min BEGIN at ____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at ____
[ ] Other Therapy _____
[ ] RISK SCORE 2 - 4 -- MODERATE HIGH-RISK
Early Ambulation
Plus
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED
hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/21/08 Time: 2322 (continued)

20500 DVT Screening Protocol + (continued)
hose only -Thigh length
*Also Consider:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at ____
[ ] Lovenox 30mg SC every 24 hours if creatinine clearance
< 30ml/min BEGIN at ____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at ____
[ ] Other Therapy _____
[ ] RISK SCORE 0-1 OR PT. AT SIGNIFICANT RISK FOR BLEEDING
OR CONTRAINDICATION TO
ANTICOAGULATION, REGARDLESS OF SCORE.
Early Ambulation
*Also Consider:
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED
hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED
hose only -Thigh length
[ ] Other Therapy _____
___Check baseline CBCD, PT, PTT now if anticoagulation orde
red.
Notify MD if platelet count is < 100,000
[ ] NO TREATMENT (Reason: _____
_____)
Physician Signature: _____
IF THE PATIENT HAS A RISK SCORE, PLEASE PRINT
PLACE IN THE PHYSICIAN ORDER SECTION OF THE CHART

Activity Date: 01/21/08 Time: 2359

4001 VS: Monitor + A Q4HOURS CP
Document 01/21/08 2359 MSG 01/22/08 0015 MSG
Blood Pressure: 109/64
Pulse: 80
Respirations: 16
Temperature: 98.0
SPO2 (%): 93
LPM O2

Activity Date: 01/22/08 Time: 0000

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 01/22/08 0000 CTJ 01/22/08 0053 CTJ
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/22/08 Time: 0000 (continued)

4009 Patient Reassessment + (continued)
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
| Y
----CARDIOVASCULAR----
Pulses
----GASTROINTESTINAL----
----GENITOURINARY----
----INTEGUMENT----
----MUSCULOSKELETAL----
----NEUROLOGICAL----
----RESPIRATORY----
4065 Pain: Monitor + A .PRN CP
Document 01/22/08 0000 CTJ 01/22/08 0053 CTJ
Pain Indicators+: FAC
Pain Scale: 0
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 01/22/08 0000 CTJ 01/22/08 0053 CTJ
Patient Notes: NURSE
Create 01/22/08 0000 CTJ 01/22/08 0053 CTJ
Abnormal? N Confidential? N
PT RESTING QUIETLY IN BED IN NO APPARENT DISTRESS. NO FACIAL GRIMACES NOTED.
PT REMAINS NPO FOR POSSIBLE PROCEDURE IN A.M. CALL LIGHT WITHIN REACH OF PT.
WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 0359

4001 VS: Monitor + A Q4HOURS CP
Document 01/22/08 0359 MSG 01/22/08 0448 MSG
Blood Pressure: 108/48
Pulse: 65
Respirations: 16
Temperature: 97.3
SPO2 (%): 91
LPM O2
4110 I&O: Monitor + A TID CP
Document 01/22/08 0359 MSG 01/22/08 0510 MSG
<>INTAKE<>
<>OUTPUT<>

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/22/08 Time: 0359 (continued)

4110 I&O: Monitor + (continued)
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 01/22/08 Time: 0400

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
- Document 01/22/08 0400 CTJ 01/22/08 0438 CTJ
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
| Y
——CARDIOVASCULAR——
Pulses
——GASTROINTESTINAL——
——GENITOURINARY——
——INTEGUMENT——
——MUSCULOSKELETAL——
——NEUROLOGICAL——
——RESPIRATORY——

4065 Pain: Monitor + A .PRN CP
- Document 01/22/08 0400 CTJ 01/22/08 0438 CTJ
Pain Indicators+: FAC
Pain Scale: 0

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 01/22/08 0400 CTJ 01/22/08 0438 CTJ
Patient Notes: NURSE
- Create 01/22/08 0400 CTJ 01/22/08 0438 CTJ
Abnormal? N Confidential? N
PT RESTING QUIETLY IN BED IN NO APPARENT DISTRESS. NO FACIAL GRIMACES NOTED.
CALL LIGHT WITHIN REACH OF PT. WILL CONTINUE TO MONITOR.

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/22/08 Time: 0400 (continued)

Patient Notes: NURSE (continued)
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 0414 (continued)

4065 Pain: Monitor + (continued)
- Document 01/22/08 0414 CTJ 01/22/08 0416 CTJ
Pain Indicators+: VOC
Pain Scale: 9
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: CONSTANTLY
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET 2 TABS

Activity Date: 01/22/08 Time: 0516

4120 Weight + A DAILY CP
- Document 01/22/08 0516 MSG 01/22/08 0520 MSG
Weight - Lb: 160
Oz: 7

Activity Date: 01/22/08 Time: 0720

Patient Notes: NURSE
- Create 01/22/08 0720 CTJ 01/22/08 0720 CTJ
Abnormal? N Confidential? N
No further changes in assessment. No injury this shift. All lines, drains,
dressings checked per protocol. Report and care transferred to MAGGIE, RN.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 0758

4001 VS: Monitor + A Q4HOURS CP
- Document 01/22/08 0758 JXC 01/22/08 0825 JXC
Blood Pressure: 113/56
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 93
Pulse Source+: BRA
Respirations: 20
Resp Source+: OBS
Temperature: 95.8
Temp Source+: ORL
SPO2 (%): 98
On Room Air: Y
LPM O2

937

6141

002354

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Documented Comment / Units | From / Change

Activity Date: 01/22/08 Time: 0800

20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 01/22/08 0800 MJL 01/22/08 0818 MJL
~~~FALL RISK~~~
History of Falls, Syncope.
Orthostatic BP, Arrythmia (2)+: 2
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 1
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 4
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: Y
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y
Comment: BED IN LOW POSITION. CALL LIGHT IN REACH. ASKED
PT TO CALL FOR ASSISTANCE AS NEEDED.
4002 Shift Assessment + A QSHIFT CP
Document 01/22/08 0800 MJL 01/22/08 0816 MJL
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: UNLABORED

Activity Date: 01/22/08 Time: 0800 (continued)

4002 Shift Assessment + (continued)
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: ROU
SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: INTACT
~~~Skin Integrity~~~
Sensory Perception+: 4 NO IMPAIRMENT
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 3 SLIGHTLY IMPAIRED
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 21
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: N
4004 Nursing: Daily Process + A Q12H10 CP
Document 01/22/08 0800 MJL 01/22/08 0816 MJL
Code Status+: FULL CODE
HIPAA Passcode: 1541
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
~~~

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 01/22/08 Time: 0800 (continued)

4004 Nursing: Daily Process + (continued)
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals DISEASE PROCESS
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~~
~~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~~
Pt Education/Discharge Folder Updated: Y
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT
4130 Education: + A DAILY CP
Document 01/22/08 0800 MJL 01/22/08 0817 MJL
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: CARE ACTIVITIES
SAFETY ISSUES
Information Taught: SAFETY AND CARE ACTIVITIES.

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 01/22/08 Time: 0800 (continued)

4130 Education: + (continued)
Outcome+: VERBALIZE UNDERSTANDING
9167 IV: Peripheral Monitor Site/Infusion + A PER PROTOCOL CP
Document 01/22/08 0800 MJL 01/22/08 0817 MJL
Type of IV Access+: INT
IV Site #1+: RIGHT WRIST
IV Size+: 18G
Appearance Site #1+: NSI
Insertion Date: 01/21/08
Dressing+: OCCLUSIVE
IV Changed: N
Change Due: 01/24/08
Patent: Y
Flush: Y
9169 IV: IV/INT Site Check A PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 01/22/08 0800 MJL 01/22/08 0817 MJL
Patient Notes: NURSE
Create 01/22/08 0800 MJL 01/22/08 0818 MJL
Abnormal? N Confidential? N
PT IN BED. BP RECHECK 113/56. NO DISTRESS OR COMPLAINTS OF PAIN AT THIS TIME.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 0921

Patient Notes: PATIENT CARE MANAGER
Create 01/22/08 0921 LKA 01/22/08 0924 LKA
Abnormal? N Confidential? N
CM RECEIVED ORDER TO SEE PT REGARDING MED ASSISTANCE. CM VIEWED PRIOR
ADMISSION IN MARCH OF 2007 AND WAS SCREENED BY CHAMBERLIN AND EDMONDS AND WAS
FOUND TO NOT MEET CRITERIA FOR MEDICAID/DISABILITY. CHAMBERLIN AND EDMONDS
WILL AGAIN SCREEN PT THIS ADMISSION. CM PLACED $4.00 WALMART LIST IN PTS
CHART AND REQUESTED MD TO WRITE DISCHARGE MEDS OFF THE LIST IF APPROPRIATE.
CM WILL CONTINUE TO FOLLOW. LORI K. ABEL, RN, CASE MANAGER.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 1159

4001 VS: Monitor + A Q4HOURS CP
Document 01/22/08 1159 JXC 01/22/08 1206 JXC
Blood Pressure: 118/89
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 62
Pulse Source+: BRA
Respirations: 20

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/22/08 Time: 1159 (continued)

4001 VS: Monitor + (continued)
Resp Source+: OBS
Temperature: 97.6
Temp Source+: ORL
SPO2 (%): 95
On Room Air: Y
LPM O2

Activity Date: 01/22/08 Time: 1200

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
Document 01/22/08 1200 MJL 01/22/08 1204 MJL
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
Patient Notes: NURSE
Create 01/22/08 1200 MJL 01/22/08 1204 MJL
Abnormal? N Confidential? N
PT TO CATH LAB VIA STRETCHER.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 1257

10900 CATHLAB:Post Procedure Assessment A ONCE AS
Create 01/22/08 1257 01/22/08 1310
Document 01/22/08 1257 01/22/08 1310
Procedure: LC

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/22/08 Time: 1257 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
Art Sheath: Y
Size: 4FRSHORT
Status+: PULLED
MAN PRESS
Access site +: R FEM ART
Drsg+: BA
Pulled Time: 1257
Pulled By: REESETJ
Hemostasis Time: 1312
2nd Art Sheath: N
Boomerang: N
VEN Sheath: N
Color Extremity+: NORMAL
Temperature Extremity+: WARM
Post procedure/closure device DC instructions reviewed: Y
LOC+: A/OX3
Patient verbalized understanding of instuctions: Y
Sedation: VERSED 2MG
IV Fluids: 0.9NS
Rate #1: 20ML/HR
IV Fluid Total ML: 75
Contrast Type+: OPTIRAY
Contrast Used (ml): 65
Urine Output Total ML: 0
Y/N PLAVIX: N
Heparin: N
Time
ACT: N
Time
Initial Pain Assessment Post Procedure:
Pain: N
Additional Pain Scale & Interventions Noted With Vital Signs
Modified Aldrete Scoring System
Activity
Able to move 4 extremities voluntarily on command.
Able to move 2 extremities voluntarily on command.
Unable to move voluntarily or on command.
2
1
0
Post
Respiration
Able to breathe deeply and cough freely.
Dyspnea, limited breathing or tachypnea.
Apneic or on mechanical ventilator.
2
1
0
Consciousness
Awake and alert.
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/22/08 Time: 1257 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
Sleepy, arouses to oriented state.
Responses vaguely, unresponsive.
2
1
0
Circulation
BP+/- 20-30 mmHG pre-procedure.
BP +/- 30-40 mmHG pre-procedure.
BP +/- 50mmHG pre-procedure.
2
1
0
O2 Saturation
Able to maintain O2 saturation>92% on room air.
Needs O2 to maintain O2 saturation greater than 92%.
O2 saturation < 92% with oxygen therapy.
2
1
0
(Must be within 2 points of admission)
: 2
: 2
: 2
: 2
: 2
Post Total: 10
Time
BP
HR
RR
SpO2
DP+
PT+
SITE
DRSG
PAIN
: 1257
: 167/71
: 64
: 16
: 96
: 3+
: 2+
: RT
: 1302
: 167/75
: 59
: 15
: 93
: 3+

941

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/22/08 Time: 1257 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
: 2+
: RT
: 1307
: 137/71
: 60
: 13
: 95
: 3+
: 2+
: RT
: 1312
: 173/86
: 62
: 13
: 94
: 3+
: 2+
: RT
: BA
: 0
Comment: HEMOSTASIS OBTAINED. SITE SOFT. NO OOZING. NO HEMATOMA. WILL CONTINUE TO MONITOR.
CATH LAB PATIENT INTRAPROCEDURE PLAN OF CARE
1. Nursing Diagnosis: Pain related to oxygen supply and demand imbalance during injection procedure catheters/devices.
GOALS: Patient will express relief from or diminished level of pain during the procedure.
PLANNED INTERVENTIONS:
A. Monitor heart rate, pulse oximetry and BP continuously.
B. Ask about pain/discomfort at start/end of procedure & PRN
B1. Observe non verbal patient for changes in posture or Muscular clenching;Observe for events that precipatate pain.
C. Have patient rate level of pain or record pain indicators
D. Provide medications for pain relief as ordered by MD.
E. Hang IV medications as ordered by MD.
F. Supplemental oxygen via nasal cannula or mask PRN.
POC continued: Y
2. Nursing Diagnosis: Potential for injury related to procedure and use of sedative and vasoactive medications.
GOALS: Patient safety will be maintained. Patient will be free of injury/adverse drug reaction/hemodynamic compromise.
PLANNED INTERVENTIONS:
A. Document on arrival: selected abnormal lab values, allergies, existing IV infusions,LOC and Aldrete Score.
B. Prep an drape site to minimize infection risk.
C. Use protective positioning devices for safe position PRN.
D. Monitor HR,Pulse Ox,BP. Record every 15 minutes and PRN.
E. Maintain IV access per hospital policy.
F. Document response to verbal commands every 15 minutes.

002358

6145

Problem Description
Intervention Description — Sts — Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 01/22/08 Time: 1257 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
G. Post procedure: reassess LOC, VS, Protective reflexes, and Aldrete Score.
H. Transport with side rails up. Transport all CCU and post patients on monitor.
POC continued: Y
3. Nursing Diagnosis: Potential for bleeding or altered peripheral circulation related to invasive procedure/device.
GOALS: Patient will have no alteration in pulses distal to the puncture side. Hemostasis at puncture site prior to DC.
PLANNED INTERVENTIONS:
A. Mark and document baseline pulses distal to planned puncture site.
B. Document abnormal PT, PTT, or Platelet levels.
C. Document use of weight based heparin, anti platelet therapy and ACT/HMT results.
Y/N: Y
D. Post procedure: obtain hemostasis using closure device or manual pressure held for a minimum of 15 minutes.
Y/N: N
D. Post procedure: assess the site of all indwelling sheaths for bleeding around puncture sites.
E. Document post procedure vital signs and pulses distal to to puncture site.
F. Document condition fo puncture site.
G. Instruct patient regarding care of site.
Post Procedure Assessment: All intraprocedure plan of care interventions completed.
All goals met.Plan of care discontinuted. See receiving unit for assessment and updated plan of care.
Aldrete/Criteria met: Y
LOC+: A/OX3
Protective reflexes intact: Y
Report Called To: GANTTTS GANTT.TAMMY S
Patient Destination: 5058
Transferred Via: S
Transfering Nurse Signature:_____
Receiving Staff Signature:

Activity Date: 01/22/08 Time: 1320

4065 Pain: Monitor + A PRN CP
Document 01/22/08 1320 MJL 01/22/08 1345 MJL
Pain Indicators+: VOC
Pain Scale: 6
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: 012208
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET ONE TAB PO

Problem Description
Intervention Description — Sts — Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 01/22/08 Time: 1330

20105 Post Cath Monitor + A PER PROTOCOL CP
Document 01/22/08 1330 MJL 01/22/08 1656 MJL
Blood Pressure: 150/75
Heart Rate: 55
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
Document 01/22/08 1330 MJL 01/22/08 1340 MJL
Any Change From Patient Shift Assessment: Y
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: Y
Document Nurse's Notes: Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
Patient Notes: NURSE
Create 01/22/08 1330 MJL 01/22/08 1340 MJL
Abnormal? N Confidential? N
PT BACK IN ROOM FROM CATH LAB. RT GROIN WITH BANDAID D/I. NO HEMATOMA. #20 PIV IN LT HAND WITH IVF INFUSING.
Note Type Description
No Type None
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/22/08 Time: 1345

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 01/22/08 1345 MJL 01/22/08 1657 MJL
Blood Pressure: 151/71
Heart Rate: 57
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1358

4090 Meals: Percentage Consumed + A TID CP
- Document 01/22/08 1358 JXC 01/22/08 1412 JXC
Breakfast(%)+: NPO
Lunch(%)+: 50
4100 ADL: + A QS&PRN CP
- Document 01/22/08 1358 JXC 01/22/08 1408 JXC
------ACTIVITIES OF DAILY LIVING------
1) The staff will encourage the patient to be independent throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform tasks.
3) The staff will encourage patient participation in ADL's and participation will be monitored.
4) The staff will provide extra time to complete tasks as needed.
4110 I&O: Monitor + A TID CP
- Document 01/22/08 1358 JXC 01/22/08 1411 JXC
<>INTAKE<>
Oral: 240
<>OUTPUT<>
Urine: 400
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 01/22/08 Time: 1400

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 01/22/08 1400 MJL 01/22/08 1657 MJL
Blood Pressure: 150/69
Heart Rate: 57
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI

Activity Date: 01/22/08 Time: 1400 (continued)

20105 Post Cath Monitor + (continued)
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1415

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 01/22/08 1415 MJL 01/22/08 1657 MJL
Blood Pressure: 148/67
Heart Rate: 55
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1420

4066 Pain: Reassess + A .PRN CP
- Document 01/22/08 1420 MJL 01/22/08 1800 MJL
Pain Location #1+: HEADACHE
Previous Pain Level: 6
One Hour Pain Reassessment Level: 0
Pt. Asleep: N
Additional Pain Medication Administered: N
Medication: DARVOCET ONE TAB PO
Physician Notified of Unrelieved Pain: N

Activity Date: 01/22/08 Time: 1430

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 01/22/08 1430 MJL 01/22/08 1657 MJL
Blood Pressure: 135/64
Heart Rate: 59
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/22/08 Time: 1430 (continued)

20105 Post Cath Monitor + (continued)
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1500

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 01/22/08 1500 MJL 01/22/08 1657 MJL
Blood Pressure: 128/65
Heart Rate: 57
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1530

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 01/22/08 1530 MJL 01/22/08 1657 MJL
Blood Pressure: 125/66
Heart Rate: 57
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1600

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 01/22/08 1600 MJL 01/22/08 1623 MJL

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/22/08 Time: 1600 (continued)

4009 Patient Reassessment + (continued)
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
---CARDIOVASCULAR---
Pulses
---GASTROINTESTINAL---
---GENITOURINARY---
---INTEGUMENT---
---MUSCULOSKELETAL---
---NEUROLOGICAL---
---RESPIRATORY---
Patient Notes: NURSE
Create 01/22/08 1600 MJL 01/22/08 1623 MJL
Abnormal? N Confidential? N
PT IN BED. FAMILY AT BEDSIDE. RT GROIN BANDAID D/I. NO HEMATOMA.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 1617

4001 VS: Monitor + A Q4HOURS CP
Document 01/22/08 1617 TCE 01/22/08 1621 TCE
Blood Pressure: 127/70
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 57
Pulse Source+: BRA
Respirations: 18
Resp Source+: OBS
Temperature: 97.6
Temp Source+: ORL
SPO2 (%): 97
On Room Air: Y
LPM O2

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/22/08 Time: 1630

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 01/22/08 1630 MJL 01/22/08 1657 MJL
Blood Pressure: 127/70
Heart Rate: 57
Procedure Site+: RIGHT GROIN
Dressing: BANDAID DI
Sheath: N
Femstop: N
Pulse DP-Right+: 2
Pulse PT-Right+: 2
Sensation Present Extremity-Right: Y
Color Extremity-Right+: NORMAL
Temperature Extremity-Right+: WARM
Bleeding: N
Hematoma: N

Activity Date: 01/22/08 Time: 1800

4065 Pain: Monitor + A .PRN CP
Document 01/22/08 1800 MJL 01/22/08 1821 MJL
Pain Indicators+: VOC
Pain Scale: 6
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: 012208
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET ONE TAB PO

Activity Date: 01/22/08 Time: 1919

4066 Pain: Reassess + A .PRN CP
Document 01/22/08 1919 MJL 01/22/08 1919 MJL
Pain Location #1+: HEADACHE
Previous Pain Level: 6
One Hour Pain Reassessment Level: 3
Pt. Asleep: N
Additional Pain Medication Administered: N
Medication: DARVOCET ONE TAB PO
Physician Notified of Unrelieved Pain: N
Patient Notes: NURSE
Create 01/22/08 1919 MJL 01/22/08 1919 MJL
Abnormal? N Confidential? N
PT IN BED. RT GROIN DRESSING D/I. NO HEMATOMA. CARE AND REPORT GIVEN TO
ONCOMING NURSE. SHAK.
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 1931

4001 VS: Monitor + A Q4HOURS CP
Document 01/22/08 1931 TCE 01/22/08 1933 TCE
Blood Pressure: 128/78
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 76
Pulse Source+: BRA
Respirations: 18
Resp Source+: OBS
Temperature: 97.9
Temp Source+: ORL
SPO2 (%): 98
On Room Air: Y
LPM O2

Activity Date: 01/22/08 Time: 2000

10048 Activity: as Tolerated/Ordered A CP
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
20160 Telemetry Monitoring + A QSHIFT CP
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
~~~Telemetry Monitoring~~~
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 2
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 1
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 4
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: Y
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/22/08 Time: 2000

4002 Shift Assessment + A QSHIFT CP
Document 01/22/08 2000 SDK 01/22/08 2238 SDK
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Telemetry Box Number: 8676
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: UNLABORED
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: ROU
SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Sts | Directions | Documented Units | From Change

Activity Date: 01/22/08 Time: 2000 (continued)

4002 Shift Assessment + (continued)
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: INTACT
~~~Skin Integrity~~~
Sensory Perception+: 4 NO IMPAIRMENT
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 3 SLIGHTLY IMPAIRED
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 21
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: N
4004 Nursing: Daily Process + A Q12H10 CP
Document 01/22/08 2000 SDK 01/22/08 2238 SDK
Code Status+: FULL CODE
HIPAA Passcode: 1541
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe, elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 01/22/08 Time: 2000 (continued)

4004 Nursing: Daily Process + (continued)
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals DISEASE PROCESS
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~
~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~
Pt Education/Discharge Folder Updated: Y
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT
4065 Pain: Monitor + A .PRN CP
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
Pain Indicators+: VOC
Pain Scale: 5
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: 012208
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET PO
4100 ADL: + A QS&PRN CP
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
~~~ACTIVITIES OF DAILY LIVING~~~
Activity+: AD LIB
Feeding Method+: SELF
Bathing+: SELF
Oral Hygiene+: SELF
Urinary Incontinence: N
Perineal Care: N
Fecal Incontinence: N
Skin Care: N
Catheter: N
Bed Linen Changed: N
Turned Q 2hrs: SELF
1) The staff will encourage the patient to be independent
throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform
tasks.
3) The staff will encourage patient participation in ADL's
and participation will be monitored.
4) The staff will provide extra time to complete tasks

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 01/22/08 Time: 2000 (continued)

4100 ADL: + (continued)
as needed.
4130 Education: + A DAILY CP
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: CARE ACTIVITIES
SAFETY ISSUES
PAIN/PAIN MANAGEMENT
MEDICATIONS
Information Taught: CALL FOR ANY NEEDS, PAIN, AND/OR SHORTNESS OF
BREATH
Outcome+: VERBALIZE UNDERSTANDING
9169 IV: IV/INT Site Check . A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 01/22/08 2000 SDK 01/22/08 2241 SDK
Patient Notes: NURSE
Create 01/22/08 2000 SDK 01/22/08 2203 SDK
Abnormal? N Confidential? N
REPORT RECEIVED FROM MAGGIE LOVETTE, RN. PM ASSESSMENT COMPLETED. ALL LINES
CHECKED AND FLUSHED PER PROTOCAL. PATIENT RESTING IN BED WITHOUT COMPLAINTS.
VSS. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 01/22/08 Time: 2157

15001 IV Insertion/Removal + A .PRN CP
Document 01/22/08 2157 SDK 01/22/08 2158 SDK
~~~IV INSERTION~~~
~~~IV REMOVAL~~~
Date Removal: 01/22/08
Time Removal: 2158
Site+: RIGHT HAND
Site Appearance+: NO SIGNS OF INFECTION
Catheter Condition+: INTACT

Activity Date: 01/22/08 Time: 2200

4110 I&O: Monitor + A TID CP
Document 01/22/08 2200 TCE 01/22/08 2202 TCE
<>INTAKE<>
Oral: 700
<>OUTPUT<>
Voided#: 4
<>DRAINS<>
Kgs.
Kgs.
~~~

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/22/08 Time: 2204

4110 I&O: Monitor + A TID CP
Document 01/22/08 2204 TCE 01/22/08 2204 TCE
<>INTAKE<>
<>OUTPUT<>
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 01/23/08 Time: 0000

4001 VS: Monitor + A Q4HOURS CP
Document 01/23/08 0000 JMW 01/23/08 0008 JMW
Blood Pressure: 112/52
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 65
Pulse Source+: BRA
Respirations: 16
Resp Source+: OBS
Temperature: 97.5
Temp Source+: ORL
SPO2 (%): 96
On Room Air: Y
LPM O2

Activity Date: 01/23/08 Time: 0015

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 01/23/08 0015 SDK 01/23/08 0015 SDK
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
——CARDIOVASCULAR——
Pulses
——GASTROINTESTINAL——

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 01/23/08 Time: 0015 (continued)

4009 Patient Reassessment + (continued)
——GENITOURINARY——
——INTEGUMENT——
——MUSCULOSKELETAL——
——NEUROLOGICAL——
——RESPIRATORY——
4065 Pain: Monitor + A PRN CP
Document 01/23/08 0015 SDK 01/23/08 0016 SDK
Pain Indicators+: FAC
Pain Scale: 0
9169 IV: IV/INT Site Check A PER PROTOCOL CP
IV:Medication Fluids Q1 Hour
IV:Maintenance Fluids Q2 Hour
IV:INT Q4 Hour
Document 01/23/08 0015 SDK 01/23/08 0016 SDK
Patient Notes: NURSE
Create 01/23/08 0015 SDK 01/23/08 0015 SDK
Abnormal? N Confidential? N
PATIENT ASLEEP IN BED. NO SIGNS OF DISTRESS NOTED. VSS. CALL LIGHT WITHIN REACH. ALL LINES CHECKED PER PROTOCAL. WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 0400

4001 VS: Monitor + A Q4HOURS CP
Document 01/23/08 0400 JMW 01/23/08 0434 JMW
Blood Pressure: 100/47
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 62
Pulse Source+: BRA
Respirations: 16
Resp Source+: OBS
Temperature: 97.1
Temp Source+: ORL
SPO2 (%): 95
On Room Air: Y
LPM O2

Activity Date: 01/23/08 Time: 0430

4120 Weight + A DAILY CP
Document 01/23/08 0430 JMW 01/23/08 0440 JMW
Weight - Lb: 163
Oz: 8
Kg: 74.16
Weight Source+: BED SCALE

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Documented Comment | Sts | Directions Units | From Change

Activity Date: 01/23/08 Time: 0445

4110 I&O: Monitor + A TID CP
Document 01/23/08 0445 JMW 01/23/08 0445 JMW
<>INTAKE<>
Oral: 360
<>OUTPUT<>
Stool#: 0
Voided#: 2
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 01/23/08 Time: 0551

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 01/23/08 0551 SDK 01/23/08 0551 SDK
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: N
----CARDIOVASCULAR----
Pulses
----GASTROINTESTINAL----
----GENITOURINARY----
----INTEGUMENT----
----MUSCULOSKELETAL----
----NEUROLOGICAL----
----RESPIRATORY----
4065 Pain: Monitor + A PRN CP
Document 01/23/08 0551 SDK 01/23/08 0551 SDK
Pain Indicators+: FAC
Pain Scale: 0
9169 IV: IV/INT Site Check A PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 01/23/08 0551 SDK 01/23/08 0551 SDK

949

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Documented Comment | Sts | Directions Units | From Change

Activity Date: 01/23/08 Time: 0705

Patient Notes: NURSE
Create 01/23/08 0705 SDK 01/23/08 0706 SDK
Abnormal? N Confidential? N
No further changes in assessment. No injury this shift. All lines, drains, dressings checked per protocol. Report and care transferred to KAREN,RN.
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 0758

4001 VS: Monitor + A Q4HOURS CP
Document 01/23/08 0758 JXC 01/23/08 0840 JXC
Blood Pressure: 109/52
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 63
Pulse Source+: BRA
Respirations: 20
Resp Source+: OBS
Temperature: 96.9
Temp Source+: ORL
SPO2 (%): 98
On Room Air: Y
LPM O2

Activity Date: 01/23/08 Time: 0820

10048 Activity: as Tolerated/Ordered A CP
Document 01/23/08 0820 KAR 01/23/08 0916 KAR
20160 Telemetry Monitoring + A QSHIFT CP
Document 01/23/08 0820 KAR 01/23/08 0916 KAR
----Telemetry Monitoring----
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 01/23/08 0820 KAR 01/23/08 0916 KAR
----FALL RISK----
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 2
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,

002366

6153

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 01/23/08 Time: 0820 (continued)

20125 Fall Precautions + (continued)
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 3
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: Y
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y
4002 Shift Assessment + A QSHIFT CP
Document 01/23/08 0820 KAR 01/23/08 0915 KAR
----NEUROLOGICAL----
Level of Responsiveness+: A/OX3
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: COMPLEX
----CARDIOVASCULAR----
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
SB
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: N
Right Dorsalis Pedis+: 3
Right Posterior Tibial+: 2
Right Radial+: 3
Left Dorsalis Pedis+: 3
Left Posterior Tibial+: 2
Left Radial+: 3
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
----RESPIRATORY----
Respirations+: UNLABORED
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
----GASTROINTESTINAL----
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
----GENITOURINARY----
Incontinence: N
Ileoconduit: N
Foley: N

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 01/23/08 Time: 0820 (continued)

4002 Shift Assessment + (continued)
----MUSCULOSKELETAL----
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
----INTEGUMENT----
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
Other: RIGHT GROIN CATH SITE
TENDER TO TOUCH. NO
HEMATOMA. NO BLEEDING. NO
BRUIT.
----Skin Integrity----
Sensory Perception+: 4 NO IMPAIRMENT
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 3 SLIGHTLY IMPAIRED
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 21
--PAIN--
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 01/23/08 0820 KAR 01/23/08 0915 KAR
Code Status+: FULL CODE
HIPAA Passcode: 1541
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 01/23/08 Time: 0820 (continued)

4004 Nursing: Daily Process + (continued)
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC DISEASE
LIFE STYLE CHANGES

In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~
~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~
Pt Education/Discharge Folder Updated: Y
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT
4130 Education: + A DAILY CP
- Document 01/23/08 0820 KAR 01/23/08 0916 KAR
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: CARE ACTIVITIES
SAFETY ISSUES
Information Taught: CALL FOR ASSISTANCE OR NEEDS
Outcome+: VERBALIZE UNDERSTANDING
9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 01/23/08 0820 KAR 01/23/08 0916 KAR
Type of IV Access+: INT
IV Site #1+: RIGHT WRIST
IV Size+: 18G
Appearance Site #1+: NSI
Insertion Date: 01/21/08
Dressing+: OCCLUSIVE
IV Med #1: NONE

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 01/23/08 Time: 0820 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
IV Changed: N
Change Due: 01/24/08
Flush: N
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 01/23/08 0820 KAR 01/23/08 0916 KAR
Patient Notes: NURSE
Create 01/23/08 0820 KAR 01/23/08 0915 KAR
Abnormal? N Confidential? N
ASSESSMENT COMPLETED. PT ANTICIPATING DC HOME. AOX3. NO C/O'S. TELEMETRY
REFLECTS SB/SR WITH VENTRICULAR RATE RANGING FROM 50'S-60'S. BREATHING EVEN
AND UNLABORED. NO DISTRESS. UP AD LIB. VSS. FURTHER ASSESSMENT PER FLOWSHEET.
WILL MONITOR.
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 0938

Patient Notes: PATIENT CARE MANAGER
- Create 01/23/08 0938 LKA 01/23/08 0940 LKA
Abnormal? N Confidential? N
CM spoke with Dr. Lawton today regarding plavix for this pt. Dr. Lawton
stated she would only need for 3 more months. One month of plavix assistance
will be provided by the hospital and pt has an appt made with the Sumter
Clinic. Communicare application given to pt for assistance with meds (plavix
is on the list) as well as other meds being prescribed from the walmart list.
Lori K. Abel, RN, Case Manager.
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 1007

4140 Discharge Instruction + A ONCE CP
Document 01/23/08 1007 KAR 01/23/08 1018 KAR
Patient Discharge Instructions
Please Bring Copy To Office With You
Diet: LOW FAT LOW CHOL
Enter/Edit/View Notes: Y
Use F4 - F9 to Access DISCHARGE Notes.
Follow-Up Appointment: FAMILY MEDICAL CLINIC IN SUMTER 803-774-4500 FEB 6
AT 7:55AM FOR IRON DEFICIENCY ANEMIA
DR LAWTON 803-744-4900 MARCH 3 AT 9:45AM FOR BLOOD
WORK THEN TO SEE DR LAWTON AT 10AM
Exercise or Special Limitations
: SEE ATTACHED INSTRUCTION SHEET
Dressing, Treatment, Special Equipment
Special Instructions
: SEE ATTACHED INSTRUCTION SHEET

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded by Date Time | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/23/08 Time: 1007 (continued)

4140 Discharge Instruction + (continued)
Tobacco Use+: CIGARETTE
Smoking Cessation Information Provided+: YES
Pt Has Education Folder in Possession at Time of Discharge: Y
All Teaching Information Given to the Pt is in Folder: Y
Interdisciplinary Discharge Medication
List Given To Pt/Family
Pt or Family Recieved the Following Items
Hearing Aides+: NA
Contact Lens+: NA
Glasses+: NA
Dentures+: YES
Prosthesis+: NA
Valuables Brought to Hospital Returned+: NA
Medications Brought to Hospital Returned+: NA
Clothing brought to Hospital Returned+: YES
I Have Received a Copy of Both My Discharge Medication List
and My Discharge Plan of Care.
**
Pt/SO Signature:_____
Date:_____
***** These Numbers are Provided for your Convenience *****
MAIN CAMPUS NORTHEAST CAMPUS
Lost and Found - 256-5690
Lost and Found - 865-4690
Patient Financial Services - 256-5505
Patient Financial Services - 865-5816
Medical Records - 256-5302
Medical Records - 865-4680
Patient Advocate - 256-5739
Patient Advocate - 256-5739
Stop Using Tobacco In Any Form. It Has Been Shown To Reduce
Healing. No Smoking!
Call Your Physician If You Have Worsening Symptoms.
If You Have Heart Failure - Weigh Yourself Daily And Write
It Down. Call Your Physician
If You Gain 2-3 Lbs. Overnight
Or Over A 1-2 Day Period..
********** NURSING DISCHARGE CHECKLIST **********
Discharge Instructions 1 +: CATH
Mode of Discharge+: WC
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Voided Prior To Discharge: Y
BM Documented 2-3 Days Prior to Discharge: Y
Narcotic Analgesic was Given within 6 hours Prior to
Discharge. Notify Attending Physician.

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded by Date Time | Sts Comment | Directions Documented Units | From Change

Activity Date: 01/23/08 Time: 1007 (continued)

4140 Discharge Instruction + (continued)
Pneumovax Given: Y
Flu Vaccine Given: Y
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
ACE-Inhibitor Prescribed at Discharge: N
ARB Prescribed At Discharge: N
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Patient Notes: NURSE
Create 01/23/08 1007 KAR 01/23/08 1009 KAR
Abnormal? N Confidential? N
POST CORONARY CATHERIZATION DISCHARGE INSTRUCTIONS

Exercise or Special Limits:

*INCREASE WALKING DAILY UNTIL RETURN TO NORMAL LEVEL.
*NO RUNNING, FAST STAIR CLIMBING OR STRETCHING FOR 3 DAYS.
*DO NOT SIT FOR LONG PERIODS OF TIME, CHANGE POSITION FREQUENTLY WHILE SITTING.
*DO NOT LIFT ANYTHING HEAVIER THAN 10 POUNDS FOR NEXT 3 DAYS.
*DO NOT DRIVE A CAR FOR NEXT 3 DAYS.
*LIMIT BENDING FOR NEXT 3 DAYS.

Dressing, Treatment, or Special Equipment:

*CLEAN CATH SITE DAILY WITH SOAP AND WATER UNTIL HEALED.
*PLACE CLEAN BANDAID ON CATH SITE UNTIL HEALED.
*DO NOT USE LOTION OR POWDER AT CATH SITE UNTIL SITE IS HEALED.
*SHOWER PREFERRED, NO SOAKING IN A POOL OR TUB FOR 48 HOURS POST PROCEDURE.
*DO NOT STRAIN WITH BOWEL MOVEMENTS. MAY USE A LAXATIVE IF NEEDED.

Special Instructions:

*YOU CAN EXPECT BRUISING AT THE CATH SITE. A SMALL MARBLE SIZED KNOT MAY ALSO BE PRESENT - IT SHOULD GO AWAY WITHIN 2-3 WEEKS.
*YOU MAY HAVE SOME MILD ACHING OR PAIN AT SITE YOU MAY TAKE TYLENOL AS DIRECTED.
*WATCH SITE FOR BLEEDING, IF BLEEDING OCCURS HOLD DIRECT PRESSURE TO SITE FOR 5 MINUTES WHILE LYING DOWN. IF UNABLE TO CONTROL OR STOP BLEEDING CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM IMMEDIATELY.
*NOTIFY PHYSICIAN FOR PERSISTENT NUMBNESS, TINGLING, OR SEVERE PAIN IN THE EXTREMITY USED FOR THE HEART CATH.
*WATCH FOR SIGNS OF INFECTION - INCREASED REDNESS AT SITE, DRAINAGE, INCREASED PAIN. NOTIFY PHYSICIAN IF YOU DEVELOP A FEVER GREATER THAN 100 DEGREES. IF YOU DEVELOP SHAKING CHILLS NOTIFY YOUR PHYSICIAN.

Note Type Description
No Type None

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Comment | Directions / Documented Units | From / Change

Activity Date: 01/23/08 Time: 1040

Patient Notes: NURSE
- Create 01/23/08 1040 KAR 01/23/08 1153 KAR
Abnormal? N Confidential? N
DISCHARGE INSTRUCTIONS REVIEWED WITH CLIENT. VERBALIZES UNDERSTANDING. INT REMOVED CATHLON INTACT. BLEEDING STOPPED WITH MANUAL PRESSURE. BANDAGE APPLIED TO SITE. NO OTHER CHANGES. AWAITING FLU AND PNUEMONIA VACCINE. WILL MONITOR.
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 1149

20175 Influenza Vaccination Actions+ A ONCE CP
--Do NOT Administer If Patient Is In ICU (DTP or NEP), MCCU, Or CSR
--Give On Day 3 Of The Hospital Stay
--Pt. Must Be Afebrile For 24 Hrs. prior to vaccination.
Document 01/23/08 1149 KAR 01/23/08 1150 KAR
===INFLUENZA ACTION SCREEN===
Did Physician Sign Refusal: N
Patient Vaccinated: Y
INFLUENZA VACCINE 0.5 ml GIVEN IM.
Lot Number: 78995
Administered By+: RICEKA RICE,KAREN A
Date: 01/23/08
Time: 1145
Site+: LDELTOID LEFT DELTOID

Activity Date: 01/23/08 Time: 1150

Problem: PNEUMOVAX VACCINATION ACTIONS A
This diagnosis is used when a patient qualifies for the Pneumovax Vaccine.
- Create 01/23/08 1150 KAR 01/23/08 1150 KAR
20185 Pneumovax Vaccination Actions+ A ONCE CP
--Do NOT Administer If Patient Is In ICU (DTP or NEP), MCCU, Or CSR
--Give On Day 3 Of The Hospital Stay
--Pt. Must Be Afebrile For 24 Hrs. prior to vaccination.
- Create 01/23/08 1150 KAR 01/23/08 1150 KAR
- Document 01/23/08 1150 KAR 01/23/08 1151 KAR
===PNEUMOVAX VACCINATION ACTIONS===
Did Physician Sign Refusal: N
Patient vaccinated
: Y
LOT NUMBER: 1347U
PNEUMOCOCCAL VACCINE 23 VALENT 0.5 ML GIVEN IM.
Administered By+: RICEKA RICE,KAREN A
Date: 01/23/08
Time: 1100

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Comment | Directions / Documented Units | From / Change

Activity Date: 01/23/08 Time: 1150 (continued)

20185 Pneumovax Vaccination Actions+ (continued)
Site+: RDELTOID RIGHT DELTOID
Patient Notes: NURSE
- Create 01/23/08 1150 KAR 01/23/08 1153 KAR
Abnormal? N Confidential? N
DC TO HOME. TO CAR VIA WC ACCOMPANIED BY TRANSPORT PERSONEL. NO DISTRESS. NO C/O'S.
Note Type Description
No Type None

Activity Date: 01/23/08 Time: 1245

1018 NUR: Admission History/Physical + D ONCE AS
Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
10900 CATHLAB:Post Procedure Assessment D ONCE AS
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
Problem: CHEST PAIN: ANGINA D
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
10011 Chest Pain: Monitor + D CP
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
Problem: PNEUMOVAX VACCINATION ACTIONS D
This diagnosis is used when a patient qualifies for the Pneumovax Vaccine.
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
20185 Pneumovax Vaccination Actions+ D ONCE CP
--Do NOT Administer If Patient Is In ICU (DTP or NEP), MCCU, Or CSR
--Give On Day 3 Of The Hospital Stay
--Pt. Must Be Afebrile For 24 Hrs. prior to vaccination.
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
Problem: DECREASED CARDIAC OUTPUT D
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
10000 Cardiovascular: Monitor D CP
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
10001 Cardiac Rhythm: Monitor D CP
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
Problem: KNOWLEDGE DEFICIT D
- Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
10009 Cardiac Rehab: Phase I D CP
Ed Status 01/23/08 1245 his 01/23/08 1245 his A => D
Problem: ADULT - AGE 18-65 YRS D
Potential Alteration in Normal Processes (ADL's, Safety, Life Situations) r/t Hospitalization
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness, Home

Problem Description / Intervention Description / Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
Problem: ADULT - AGE 18-65 YRS (continued) Situation, Job, Life Style Changes and/or Families Inability to Cope										
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
10048 Activity: as Tolerated/Ordered							D			CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
11690 ADL: Encourage Independence							D			CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
Problem: INFLUENZA SCREENING ASSESSMENT This diagnosis is used to screen the patient population for qualification for the Influenza Vaccination.							D			
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20170 Influenza Screening Assessment+							D	ONCE		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
Problem: Frequently Used PCU Interventions These Interventions Are Frequently Used And/Or High Priority Nursing Interventions In The Cardiac Care Areas. They Are Placed in Process Interventions As A Conveience For The Nursing Staff.							D			
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
10011 Chest Pain: Monitor +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
10175 Instruction: Special Nursing							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20105 Post Cath Monitor +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20120 Blood Sugar Monitor +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20160 Telemetry Monitoring +							D	QSHIFT		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
9069 Central Line: Monitor Site/Infusion +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
9135 Fluid: Restriction							D			CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
9171 PCA: Monitor +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
9351 VS: Frequent Vitals +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
9355 VS: Orthostatic +							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
Problem: PNEUMOVAX SCREENING ASSESSMENT This diagnosis is used to screen the patient population for qualification for the Pneumovax Vaccination.							D			
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20180 Pneumovax Screening Assessment+							D	ONCE		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
Problem: GUIDELINES FOR NURSING DOCUMENTATION							D			
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D

Activity Date: 01/23/08 Time: 1245

Problem Description / Intervention Description / Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
11040 Meds: As Ordered							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
15001 IV Insertion/Removal +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20125 Fall Precautions + -Place RED Sticker on Pt Chart and Armband and Pt Door -Place "Fall Protocol" Sign in Pt Room							D	EVERYDAY		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20140 Home Medication List +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20145 Advance Directives Monitor + --Two Attempts To Acquire Hard Copy For Chart Required							D	.PER PROTOCOL		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20150 Emergency Contact Information +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20300 Patient Hand Off Form +							D	PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
20500 DVT Screening Protocol +							D	ONCE		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4001 VS: Monitor +							D	Q4HOURS		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4002 Shift Assessment +							D	QSHIFT		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4004 Nursing: Daily Process +							D	Q12H10		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4009 Patient Reassessment + Use this intervention for reassessment of the patient.							D	QS&PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4055 Notify: MD +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4065 Pain: Monitor +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4066 Pain: Reassess +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4085 Transfer: Another Unit +							D	.PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4090 Meals: Percentage Consumed +							D	TID		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4100 ADL: +							D	QS&PRN		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4110 I&O: Monitor +,							D	TID		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4120 Weight +							D	DAILY		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D
4130 Education: +							D	DAILY		CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his				A => D

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions Documented Units	From Change
Problem Description / Intervention Description									
Activity Date: 01/23/08		Time: 1245							
4140	Discharge Instruction +						D	ONCE	CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
4460	Critical Results Monitor +						D	.PRN	CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
9040	Blood Product: Administer as Ordered+						D	.PER PROTOCOL	CP
	-THIS INTERVENTION IS USED ON ALL								
	PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS								
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
9167	IV: Peripheral Monitor Site/Infusion +						D	.PER PROTOCOL	CP
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
9169	IV: IV/INT Site Check						D	.PER PROTOCOL	CP
	-IV:Medication Fluids Q1 Hour								
	-IV:Maintenance Fluids Q2 Hour								
	-IV:INT Q4 Hour								
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
Problem:	INFLUENZA VACCINATION ACTIONS						D		
	This diagnosis is used when a patient								
	qualifies for the Influenza Vaccine.								
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D
20175	Influenza Vaccination Actions+						D	ONCE	CP
	--Do NOT Administer If Patient Is In								
	ICU (DTP or NEP), MCCU, Or CSR								
	--Give On Day 3 Of The Hospital Stay								
	--Pt. Must Be Afebrile For 24 Hrs.								
	prior to vaccination.								
- Ed Status	01/23/08	1245	his	01/23/08	1245	his			A => D

Monogram	Initials	Name	Nurse Type
	SELLERMC	SELLERS,MICHELLE C	RN
CTJ	JONESCT	JONES,CHARICE T	RN
JMW	WINFREJM	WINFREY,JENNIFER M	PCT
JXC	CURRYJX	CURRY,JENNIFER	NTI
KAR	RICEKA	RICE,KAREN A	RNPD
LHH	HALLLH	HALL,LISA H	RN
LKA	ABELLK	ABEL,LORI K	RN
MJL	LOVITTMJ	LOVITT,MAGGIE J	PRNSO
MSG	GOODWIMS	GOODWIN,MIESHA S	PCT
SDK	KHALIFSD	KHALIF,SHAKILYA D	RN
TCE	EARLETC	EARLE,TANESHIA C	PCT
his		automatic by program	

Patient	Unit #	Service/Location	Status	Date	Account #
WINDHAM, TAMMY E	M000895682	CARDIOLOGY	ADM IN	03/18/07	002373 D00501829048

PATIENT

Soc Sec No.	DOB	Age	Sex	MS	Race	Religion
		39	F	X	CA	HOLINESS

Address: 6265 SHETLAND ST
SUMTER, SC 29154
Home Ph: (803)506-4697 County: SUMTER

DISCHARGE DISPOSITION

__ Routine (Home) Date ____ Time ____
__ Home Health Care
__ AMA
__ Transferred To _____
__ Expired

FINAL DIAGNOSES | **CODES**

Principal:

Other Diagnoses and Manifestations

Subendo MI

CAD

Hyperlipidemia

DATES	OPERATIONS AND PROCEDURES	CODES
3/19	cardiac cath / Stent circumflex	

COMPLETE

CONSULTING PHYSICIAN/RESIDENTS

1. 2. 3. 4. 5.
6. 7. 8. 9. 10.

Signature of Attending Physician 3/21/07 Date

SIGNATURE FORM Printed 03/18/07 1444

Consent and Conditions of Treatment
Sisters of Charity Providence Hospitals

In consideration of the care and treatment to be provided to the patient whose name appears at the bottom of this page at Sisters of Charity Providence Hospitals (**Providence Hospital**) (meaning the patient or patient's personal representative throughout this form), the undersigned, consent to and agree to the following conditions.

1. **Consent to Treatment**: I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by the Hospital and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations in the Hospital.

2. **Consent to Testing for Infectious or Contagious Disease**: I consent to being tested for infectious or contagious diseases such as, but not limited to Hepatitis B and HIV (AIDS) infection, if such testing is deemed advisable by my/the patient's physician.I understand that consent means that I agree to have blood drawn and analyzed for any and all tests necessary to diagnose an infectious or contagious disease. I am aware that the Hospital reports all positive test results to the Department of Health and Environmental Control, as required by law.

3. **Personal Valuables and Belongings**: I understand that the Hospital recommends that I not bring any personal valuables to the Hospital. Articles such as jewelry, cash, valuables documents, unnecessary clothing or other items of value not necessary for my/the patient's stay should not be brought to the Hosptial. Essential valuables such as eyeglasses, contact lenses, hearing aids, dentures, etc. are my/our responsibility and I understand that I must protect essential valuables brought to the Hospital carefully. I understand that the Hospital maintains a safe for the storage of valuables that are necessary for my/the patient's stay and that I will be asked to turn any valuables over to security for deposit in the safe. I agree that the Hospital is not responsible for the loss, disappearance, or damage of any valuables that I choose to keep in my/the patient's room.

4. **Use and Disclosure of Protected Health Information**: I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Hospital's Notice of Privacy Practices. I acknowledge that I have received a copy of the Hospital's Notice of Privacy Practices.

5. **Verification and Assignment of Hospital Insurance Benefits**: I understand that a bill will be sent to my/the patient's insurance company or other payor. I consent to the Hospital contacting my insurance company or other payor for the purpose of obtaining payment. I hereby consent to payment being made by the insurance company or other payor directly to the Hospital. I assign, transfer and convey to the Hospital any and all of my/the patient's rights and interests that I may have to any and all medical insurance benefits. This includes, but is not limited to, no fault insurance benefits, liability insurance benefits, workers compensation benefits, and any other benefits to which I may be entitled as a result of hospitalization or treatment/test at the Hospital. I further agree that this assignment will not be withdrawn or voided at any time until this account is paid in full. I understand and agree that I am responsible for payment for the services rendered to the fullest extend allowed by law.

6. **Prior Authorization**: I understand that many insurance companies or other payors require pre-authorization or referrals for certain treatment, tests and/or procedures. I understand that it is my/the patient's responsiblity to obtain either pre-authorization or referral. I understand that I may be held financially responsible for treatment, tests

and/or procedures that are not reimbursed by my/the patient's insurance company or other payor due to lack of pre-authorization and/or referral as stipulated in my/the patient's particular insurance policy.

7. **Private Room Difference**: I understand that if I request a private room, I am responsible for the entire private room difference, unless the difference is covered by insurance.

8. **Independent Status of Physician**: I understand that during the course of my/the patient's stay that my/the patient's physician may request consultations and/or the services of Hospital-based health care providers, including, but not limited to, emergency physcians, radiologists, pathologists, or anesthesiologists. I recognize that any or all physicians, who furnish services to me/the patient during this admission are independent contractors and are not agents or employees of the Hospital. I understand that the Hospital does not control or have the right to control the medical decisions and actions of physician, including Hospital-based providers and independent contractors, and that physicians are responsible and liable for their own acts or omissions. I understand and agree that each of the practitioners who render professional services to me/the patient, may bill and collect independently for these services. I understand that their bills will be separate and apart from the Hospital's billing and collections or that the Hospital may bill on the healthcare provider's behalf. Furthermore, I understand that each health care provider may be individually contracted with an HMO or PPO. These contracts could be different from the contracts the Hospital holds. I understand that it is my responsibility to find out if each health care provider is a member of my/the patient's insurance provider network.

9. **Consent to Photograph** : I understand that photographs, videotapes, digital, or other images may be recorded to document my care and I consent to this. I understand that these photographs, videotapes, digital, or other images will become part of my medical record and are considered protected health information. I also understand that Sisters of Charity Providence Hospitals is the owner of my medical record, but that I have a right to access my protected health information in the medical record in the manner described in the Notice of Privacy Practicies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept at least for the time period required by law.

Guarantee of Payment

By signing the form below, I understand that:

* I am financially responsible for this account with the Hospital, regardless of any insurance benefits to the fullest extent allowed by law.

* I understand that I may be held responsible for any charges not covered for any reason by a third party payor. Should this account be turned over to a collection agency or an attorney for collection, I understand that I will be obligated to pay all collection fees and reasonable attorney's fees.

By signature below, I consent to and agree to the conditions set forth on this form. I have been given the opportunity to ask questions regarding this form, and understand the obligation I assume by signing this form.

Thomas Williams

DATE AND TIME

SIGNATURE OF PATIENT
or
PATIENT'S PERSONAL REPRESENTATIVE
(Circle one: Parent, Guardian, or Legally Authorized Representative)

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The identity of the Patient's Personal Representative has been verified by _____(driver's license, other picture identification, etc.) and that as _____(parent, guardian, etc.) such Personal Representative is legally authorized to sign this authorization on behalf of the patient.

_____
WITNESS

_____
SIGNATURE OF GUARANTOR (If different from Patient or Patient's Personal Representative)

_____
Relationship to Patient

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SISTERS OF CHARITY
PROVIDENCE HOSPITALS

ValueShare Program
Patient Disclosure

Sisters of Charity Providence Hospitals and your cardiologist/cardiovascular surgeon have initiated a cost savings program called ValueShare (the "Program"). The Program studies our traditional procedure practices to find ways to reduce waste of certain supplies. The changes in our traditional procedures that result from the Program are carefully made to assure that quality of care is not impacted. The physician groups are eligible to receive a percentage of the Hospital's cost savings for the specific initiatives targeted for waste reduction. A description of the Program's cost-savings recommendations is available upon request.

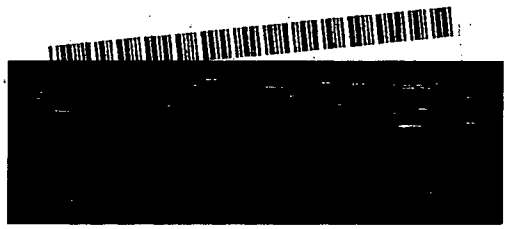
The legality and patient care safeguards of this Program were extensively reviewed by the Office of the Inspector General and a favorable advisory opinion was received.

I acknowledge that I have been informed of the preceding facts and given the opportunity to review more details of the Program including the Program's cost-savings recommendations prior to admission to Providence for the procedure or, if my admission was unplanned, prior to signing the consent for my procedure.

Thomas Widhu 32007

Patient Signature Date

Patient Name Printed



960

RUN DATE: 03/26/07
RUN TIME: 0916
RUN USER: RANDOLVX

Providence Hospital ABS **LIVE
ATTESTATION STATEMENT

002378

NAME:	WINDHAM,TAMMY E	ACCT #:	D00501829048
ADM DATE:	03/18/07	UNIT #:	M000895682
ATTEND PHYS:	JUK,S STANLEY	SEX:	F
DIS DATE:	03/21/07	AGE:	39
DISCH DISP:	DISCH TO HOME OR SELF CARE	[redacted]	
LOS:	3	FIN CLASS:	SP
PT CLASS:	IN	ABS STATUS:	FINAL

DIAGNOSES:

ADMIT:	410.71	AC MYOCARDIAL INFARCT,SUBENDO INFARCT,INITIAL EPIS	
PRINC:	410.71	AC MYOCARDIAL INFARCT,SUBENDO INFARCT,INITIAL EPIS	
SECOND:	427.1	PAROX VENTRIC TACHYCARD	C
	285.1	AC POSTHEMORRHAG ANEMIA	C
	305.1	TOBACCO USE DISORDER	
	414.01	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY VESSEL	
	272.4	HYPERLIPIDEMIA NEC/NOS	
	V17.3	FAM HX-ISCHEM HEART DIS	
	401.9	HYPERTENSION NOS	
	459.89	CIRCULATORY DISEASE NEC	

OPERATIONS:

03/19/07	00.66	PERC TRANSLUMINAL CORON ANGIOPLASTY PTCA OR CORON ATHERECT	OMB1
03/19/07	36.07	INSRT OF DRUG-ELUTING CORON ARTERY STENTS(S)	B2
03/19/07	37.22	LEFT HEART CARDIAC CATH	B3
03/19/07	88.56	CORONAR ARTERIOGR-2 CATH	B4
03/19/07	88.53	LT HEART ANGIOCARDIOGRAM	B5
03/19/07	00.45	INSERTION OF ONE VASCULAR STENT	B6
03/19/07	00.40	PROCEDURE ON SINGLE VESSEL	
03/19/07	99.20	INJECT/INFUSE PLATELET INHIBITOR	

DRG: 557 PERCUTANEOUS CARDIOVASCULAR PROC W DRUG-ELUTING STENT W MAJO

STATUS	$ REIMB	MIN-LOS	MAX-LOS	STD-LOS	GRP VERS	GRP FC
F	13697.07			4.1	24	SP

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

_____ _____ **DATE**

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WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682 Sex: F
Room/Bed: D.H457-A Admit Date: 03/18/07 Att Doc: JUK S STANLEY

Past 5 Days of Lab Results by Department
Date/Time Range: 03/16/07 0600 - 03/21/07 0600

	03/20/07 1510	03/20/07 0310	03/19/07 1815	03/19/07 1810	03/19/07 0315
CHEMISTRY					
SODIUM		136			
POTASSIUM		4.0			
CHLORIDE		101			
CO2		25			
ANION GAP		14			
GLUCOSE		109			
BUN		10			
CREAT		0.7			
BUN/CREA RATIO		14			
CALCIUM		8.8			
TRIGLYCERIDES		122			
CHOL		157			
HDL		33 L			
LDL		99.6			
VLDL		24			
RISK		4.8 H			
TROPRFLX		6.14 H (1)	10.54H (2)		23.51H (3)
CK ONLY		127	234 H		613 H
CKMB TOTAL		10.7 H	22.2 H		90.8 H
CKMBI		8.4	9.5		14.8
COAGULATION					
ACT				178 H	
HEMATOLOGY					
WBC	10.8 H	10.9 H			
RBC	4.59	4.74			
HGB	9.5 L	9.9 L			
HCT	30.6 L	31.6 L			
MCV	66.6 L	66.7 L			
MCH	20.7 L	20.8 L			
MCHC	31.03L	31.16L			
RDW	20.15H	20.11H			
PLATELET COUNT	315	343			
MPV	8.6	8.7			
GRANULOCYTE %		77.0 H			
LYMPHOCYTE %		15.8 L			
MONOCYTE %		5.1			
EOSINOPHIL %		1.5			
BASOPHIL %		0.6			
GRANULOCYTE #		8.4 H			
LYMPHOCYTE #		1.7			
MONOCYTE #		0.6			

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WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682 Sex: F
Room/Bed: D.H457-A Admit Date: 03/18/07 Att Doc: JUK S STANLEY

(Continued from Page:1)

	03/20/07 1510	03/20/07 0310	03/19/07 1815	03/19/07 1810	03/19/07 0315
EOSINOPHIL #		0.2			
BASOPHIL #		0.1 H			

	03/18/07 2135	03/18/07 1615
CHEMISTRY		
SODIUM		137
POTASSIUM		3.6
CHLORIDE		103
CO2		24
ANION GAP		14
GLUCOSE		133 H
BUN		9
CREAT		0.9
BUN/CREA RATIO		10
CALCIUM		9.0
MAG		1.9
TROPRFLX	34.93H (4)	38.21H (5)
CK ONLY	1009 H	1263 H
CKMB TOTAL	143.3H	183.9H
CKMBI	14.2	14.6
HEMATOLOGY		
WBC		13.5 H
RBC		5.66 H
HGB		11.5 L
HCT		37.3
MCV		65.8 L
MCH		20.4 L
MCHC		30.99L
RDW		20.65H
PLATELET COUNT		459 H
MPV		10.0
GRANULOCYTE %		78.2 H
LYMPHOCYTE %		15.5 L
MONOCYTE %		4.7
EOSINOPHIL %		1.5
BASOPHIL %		0.1 L
GRANULOCYTE #		10.6 H
LYMPHOCYTE #		2.1
MONOCYTE #		0.6
EOSINOPHIL #		0.2
BASOPHIL #		0.0 L

Lab Comments

(1) @RESULTS CALLED TO STEPHANIE
@AT 0505 ON 03/20/07 BY ELLIS,DELOIS A

*** ***

002379

6166

WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682 Sex: F
Room/Bed: D.H457-A Admit Date: 03/18/07 Att Doc: JUK S STANLEY

(Continued from Page:2)

Lab Comments

@RESULT READ BACK BY STEPHANIE
@AT 0505 ON 03/20/07 BY ELLIS,DELOIS A

(2) @RESULTS CALLED TO TONY
@AT 1933 ON 03/19/07 BY THAMES,SONIA R
@RESULT READ BACK BY TONY
@AT 1934 ON 03/19/07 BY THAMES,SONIA R

(3) @RESULTS CALLED TO BRIDGET
@AT 0439 ON 03/19/07 BY LINCOLN,LINDA B
@RESULT READ BACK BY BRIDGET
@AT 0439 ON 03/19/07 BY LINCOLN,LINDA B

(4) @RESULTS CALLED TO BRI
@AT 2301 ON 03/18/07 BY THAMES,SONIA R
@RESULT READ BACK BY BRI
@AT 2301 ON 03/18/07 BY THAMES,SONIA R

(5) @RESULTS CALLED TO JESSICA
@AT 1805 ON 03/18/07 BY THAMES,SONIA R
@RESULT READ BACK BY JESSICA
@AT 1805 ON 03/18/07 BY THAMES,SONIA R

No Data for Past 5 Days of Microbiology Results from 03/16/07-0600 thru 03/21/07-0600

No Data for Last 5 Days of Pathology Results from 03/16/07-0000 thru 03/21/07-2359

No Data for Past 72 Hours of Radiology Impressions from 03/18/07-0600 thru 03/21/07-0600

Vital Signs Past 24 Hours
Date/Time Range: 03/20/07 0600 - 03/21/07 0600

NOTE: RESPONSE EXCEEDS DISPLAY FIELD '-->'. PLEASE CONSULT CHART FOR ENTIRE RESULT

	03/21/07 0000	03/20/07 1933	03/20/07 1600	03/20/07 1147	03/20/07 0800
B/p	103/52	140/60	127/61	118/56	111/62
Source	AUTOMATED	AUTOMATED	AUTOMATED	AUTOMATED	AUTOMATED
Site	LEFT ARM	LEFT ARM	LEFT ARM	RIGHT ARM	RIGHT ARM
Position	SUPINE	SUPINE	SUPINE	SUPINE	SUPINE
Pulse:	63	68	61	62	71
Pulse Sour	MONITOR	BRACHIAL	BRACHIAL	MONITOR	MONITOR
Respiratio	20	20	20	20	20
Resp Sourc	OBSERVED	OBSERVED	OBSERVED	OBSERVED	OBSERVED
Temperatur	98	97.4	96.9	97.4	97.5
Temp Sourc	ORAL	ORAL	ORAL	ORAL	ORAL
SPO2 (%):					96

*** ***

WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682
Room/Bed: D.H457-A Admit Date: 03/18/07 Att Doc: JUK S STANLEY

(Continued from Page:3)

	03/21/07 0000	03/20/07 1933	03/20/07 1600	03/20/07 1147	03/20/07 0800
On Room Ai		Y	Y		

Intake and Output Past 24 Hours by Shift
Date/Time Range: 03/20/07 0600 - 03/21/07 0559

	0600 - 1359	1400 - 2159	2200 - 0559	24 HR Total
TOT INTAKE	720	720	480	1920
TOT OUTPUT				
FLUID BAL	720	720	480	1920

Void/Stools Past 24 Hours
Date/Time Range: 03/20/07 0600 - 03/21/07 0600

NOTE: RESPONSE EXCEEDS DISPLAY FIELD '-->'. PLEASE CONSULT CHART FOR ENTIRE RESULT

	03/21/07 0429	03/20/07 2159	03/20/07 1359
Urine #	0	3	4
Stool#	0		1
Last BM			20070320

Past 24 Hours of Nurse Notes
Date/Time Range: 03/20/07 0600 - 03/21/07 0600 (DESCENDING)

Note Type: NURSE 03/21/07 0444 By: VARETTONI,DAVID L

NO CHANGE NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT RESTING IN BED WITH SIDERISAL UP WILL CONTINUE TO MONITOR

Note Type: NURSE 03/21/07 0017 By: VARETTONI,DAVID L

NO CHANGE NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT RESTING IN BED WITH SIDERAILS UP WILL CONTINUE TO MONITOR

WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682 Sex: F
Room/Bed: D.H457-A Admit Date: 03/18/07 Att.Doc: JUK S STANLEY

(Continued from Page:4)

Note Type: NURSE 03/21/07 0017 By: VARETTONI,DAVID L
Note Type: NURSE 03/20/07 1930 By: VARETTONI,DAVID L

ASSESMENT DONE PER IMCU PROTOCAL NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT RESTING INBED WITH SIDERAILS UP WILL CONTINUE TO MONITOE

Note Type: NURSE 03/20/07 1815 By: MEEHAN,NANCY J

PT AWAKE AND SITTING UP IN BED. PT COMPLAINING OF LOWER LEFT FOREARM PAIN AND GIVEN 2 DARVOCET PER MAR. NO OTHER CHANGES SINCE MY LAST REASSESSMENT. PT IN SR WITH A CURRENT RATE OF 63 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR UNTIL DAVID, RN, NIGHT NURSE ASSUMES RESPONSIBILITY.

Note Type: NURSE 03/20/07 1615 By: MEEHAN,NANCY J

PT AWAKE AND SITTING UP IN BED. NO CHANGES SINCE MY LAST REASSESSMENT. PT DENIES PAIN AT THIS TIME. PT IN SB WITH A CURRENT RATE OF 59 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.

Note Type: NURSE 03/20/07 1357 By: MEEHAN,NANCY J

PT AWAKE IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. NO CHANGES SINCE MY LAST REASSESSMENT. PT DENIES PAIN AT THIS TIME. PT IN SB WITH A CURRENT RATE OF 57 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.

Note Type: NURSE 03/20/07 1156 By: MEEHAN,NANCY J

PT RESTING IN BED. PT STATES HER PAIN IS MUCH BETTER AT THIS TIME. PRESSURE DRESSING REMOVED AND BANDAID PLACED OVER PUNCTURE SITE. PT IN SB WITH A CURRENT RATE OF 57 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. SIGNIFICANT OTHER AT BEDSIDE.

Note Type: NURSE 03/20/07 0955 By: MEEHAN,NANCY J

PT AWAKE AND IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. NO CHANGES SINCE MY INITIAL ASSESSMENT. ENCOURAGED PT TO AMBULATE IN HALLWAYS. PT VERBALIZED UNDERSTANDING. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.

Note Type: NURSE 03/20/07 0750 By: MEEHAN,NANCY J

RECEIVED REPORT FROM STEPHANIE, RN, NIGHT NURSE. PT AWAKE IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. FULL ASSESSMENT COMPLETED AT THIS TIME. RIGHT GROIN SOFT WITH PRESSURE DRESSING OVER PUNCTURE SITE DUE TO BLEEDING OVER NIGHT. NO BRUIT HEARD. PT DENIES PAIN AT THIS TIME. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.

Note Type: NURSE 03/20/07 0721 By: EDENTON,STEPHANIE M

964

WINDHAM,TAMMY E A#: D00501829048
Loc: D.4H U#: M000895682 Sex: F
Room/Bed: D.H457-A Admit Date: 03/18/07 Att.Doc: JUK S STANLEY

(Continued from Page:5)

Note Type: NURSE 03/20/07 0721 By: EDENTON,STEPHANIE M

WALKING ROUND REPORT GIVEN TO NANCY MEEHAN, RN. NO COMPLAINTS THIS AM.

*** ***

002381

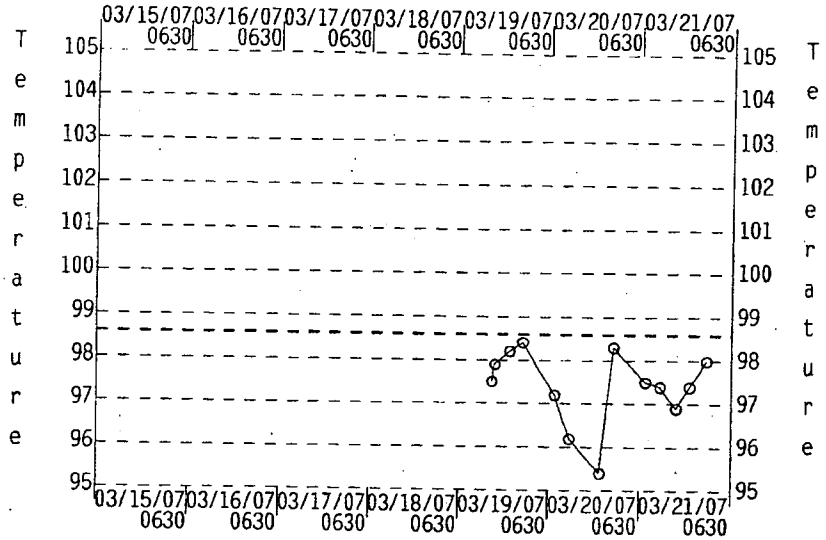
6168

WINDHAM,TAMMY E (M000895682)
Age/Sex: 39 F
Room: D 4H D.H457 A (Admitted 03/18/07)

1 WEEK
from Mar 14, 2007 0631 to Mar 21, 2007 0630
Printed 03/21/07 at 0514 by VARETTDL

TEMPERATURE GRAPH

Δ REC/RECTAL • TYM/TYMPANIC o ORL/ORAL/No Response | OTH/
X AXL/AXILLARY ↓↑ Off graph



VITAL SIGNS

Date-Time	Temp	Src	Pulse	Resp	BP	Src	SPO2	FIO2%	O2 AMT	O2 Device
03/18 1500								0	2 L/M	CANNULA
03/18 1900								0	2 L/M	CANNULA

VITAL SIGNS

Date-Time	Temp	Src	Pulse	Resp	BP	Src	SPO2
03/18 1512	97.5	ORL	72	18	95/62	AUT	97
03/18 1600	97.9	ORL	70	20	118/59	AUT	100
03/18 1959	98.2	ORL	75	20	103/65	AUT	
03/18 2330	98.4	ORL	74	20	94/49	AUT	95
03/19 0800	97.2	ORL	77	18	121/60	AUT	94
03/19 1200	96.2	ORL	75	20	145/75	AUT	
03/19 1959	95.4	ORL	67	18	153/84	AUT	100
03/19 2330	98.3	ORL	68	18	118/68	AUT	
03/20 0800	97.5	ORL	71	20	111/62	AUT	96
03/20 1147	97.4	ORL	62	20	118/56	AUT	
03/20 1600	96.9	ORL	61	20	127/61	AUT	
03/20 1933	97.4	ORL	68	20	140/60	AUT	
03/21 0000	98	ORL	63	20	103/52	AUT	

WINDHAM,TAMMY E (M000895682)
Age/Sex: 39 F
Room: D 4H D H457 A (Admitted 03/18/07)

002383
1 WEEK
from Mar 14, 2007 0631 to Mar 21, 2007 0630
Printed 03/21/07 at 0514 by VARETTDL

PAIN ASSESSMENT, LOCATION #1

Date-Time	Location #1	Level	1 HR Level	Meds
03/18 1950	HEADACHE	5		
03/18 1950	HEADACHE			
03/19 1130	HEADACHE			
03/19 1230	HEADACHE		0	N
03/19 1755	HEADACHE			
03/19 2040	HEADACHE			
03/19 2105	HEADACHE		2	
03/20 0350	RT GROIN			
03/20 0450	RT GROIN		3	
03/20 1050	RT GROIN			
03/20 1155	RT GROIN		3	N
03/20 1815	LT FOREARM			
03/20 1906	LT FOREARM		3	N

WEIGHT

Date-Time	Weight - Lb:	Oz:	Kg:	Weight Source+:	BSA:	BMI:
03/18/07 1512	153		69.39	BED SCALE	1.75621	27.1

INTAKE AND OUTPUT SUMMARY

Period: 8.00 Hrs Ending	03/18/07 1430	03/18/07 2230	03/19/07 0630	*24 hr*
Oral:		600		600
TOTAL INTAKE:		600		600
Stool#:		1		1
Voided#:		4	1	5

INTAKE AND OUTPUT SUMMARY

Period: 8.00 Hrs Ending	03/19/07 1430	03/19/07 2230	03/20/07 0630	*24 hr*
Oral:	0	600		600
IV Meds:		44	88	132
TOTAL INTAKE:	0	644	88	732
Catheter:		500	300	800
Stool#:		0		0
Voided#:	3			3
TOTAL OUTPUT		500	300	800

INTAKE AND OUTPUT SUMMARY

Period: 8.00 Hrs Ending	03/20/07 1430	03/20/07 2230	03/21/07 0630	*24 hr*
Oral:	720	720	480	1920
TOTAL INTAKE:	720	720	480	1920
Stool#:	1		0	1
Last BM:	03/20/07			
Voided#:	4	3	0	7

966

Advance Directive Acknowledgement Tracking Form

(Place this behind the Advance Directive tab in the Patient's Medical Record)

002384

In order to honor your wishes, it is important for our hospital to know and clearly understand your wishes concerning health care direction.

An Advance Directive can be one of two things:

1. Health Care Power of Attorney
2. Living Will

WINDHAM,TAMMY E
A# D00501829048 U#M000895682
03/18/07 F 39 [redacted]
JUK,S STANLEY

Please read the following information concernin
Check the following statements that pertain to y

_____ I have executed a Health Ca

_____ I have brought it with me to Providence Hospital.

_____ I will ask a family member to bring this to Providence Hospital for my Medical Record.

_____ I have not provided a copy to Providence Hospital.

_____ I have executed a Living Will

_____ I have brought it with me to Providence Hospital.

_____ I will ask a family member to bring this to Providence Hospital for my Medical Record.

_____ I have not provided a copy to Providence Hospital.

✓ I have not executed a Health Care Power of Attorney

✓ I do not want any further information.

_____ I would like additional information on Health Care Power of Attorney and/or Living Will.

(Patient to be provided with a copy of the Sisters of Charity Providence Hospitals Advance Directive Education Information Booklet)

_____ Pastoral Care and/or Patient Advocate notified.

Medical Care is not conditional upon the establishment of an Advance Directive.

Thomas Windham
(Patient or Representative Signature)

_____
(Date)

_____ The patient is unable to complete at the time of admission because _____
(form is to be completed at a later time by the Admissions Department)

, the Admissions Representative, have reviewed the above questions with the patient and/or family and have provided any assistance with answering the above questions. I have given to the patient and/or family a written statement of their rights.

_____
(Admissions Representative Signature)

3/20/07
(Date and Time)

TRACKING MECHANISM FOR ACTUAL PRESENCE OF THE DOCUMENT IN THE MEDICAL RECORD

1 Go to *Nursing Initial Assessment* located behind the blue tab in the Medical Record which states "Nursing Admit Assessment" for further tracking of the document.

2 Go to the *24 hour Patient Profile Flow Sheet* under the section Nursing Daily Process located behind the blue tab which states "Multidisc 24 hour Report" for ongoing documentation.

When the Advance Directive has been obtained, place behind the purple tab in the Medical Record.

967

Acknowledgement of Receipt of Notice Of Privacy Practices

I acknowledge that I have received a copy of the Hospitals' Notice of Privacy Practices

Acknowledgement of Directory Inclusion / Exclusion

__✓__ I choose to be **INCLUDED** in the Sisters of Charity Providence Hospitals Directory.

_____ I choose to be **EXCLUDED** from the Sisters of Charity Providence Hospitals Directory.

Choosing to be excluded from the Directory means:

- No information will be given regarding my hospital stay –e.g. if someone calls and request my room number, or any information, the caller will be told, **" We do not have any information on that person in the system."**
- Flowers received to the hospital will not be delivered
- Mail / Cards received to the hospital will not be delivered.

__✓__ I acknowledge that, at the time of or prior to being admitted to the hospital for inpatient care or outpatient surgery, I have received the written information required under the Patient Safety Act.

Thomas Windham _____ _____

Signature of Patient or Representative Date

Or

___ The patient did not receive the written information required under the Patient Safety Act prior to or upon admission to the hospital for inpatient care or outpatient surgery because the patient was admitted under emergency circumstances.

_____ 3 2005

Signature of Hospital Employee verifying emergency admission Date

WINDHAM, TAMMY E
A# D00501829048 [redacted]
03/18/07 F 39
JUK.S STANLEY

968

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM TAMMY E
A# D00501829048 U#M000895682
03/18/07 F 39
JUK.S STANLEY [redacted]

002386

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

COLUMBIA CARDIOLOGY CONSULTANTS
CCC1030 **ROUTINE PCCU ADMISSION ORDERS** **PAGE 1 OF 3**

ADMISSION STATUS: __ INPATIENT __ OUTPATIENT __ OBSERVATION

1) Admit to services of **COLUMBIA CARDIOLOGY CONSULTANTS**:
   a. Notify our office of admission and room number, speak directly to the appointment secretary.
   b. Notify personal physician of admission if he is in the Columbia area.
   c. Obtain all old records and do EKG immediately.
   d. If patient is admitted for heart cath, give cath booklet and inform of film times.
   e. Under no circumstances is dictated H & P summary to be removed from chart prior to discharge.
2) DIET: Low cholesterol, and ADA 1800 calorie **(if diabetic, or renal; dietary consults for specific restrictions)**.
3) ACTIVITY: Routine, unless otherwise ordered.
4) VITAL SIGNS: Routine, unless otherwise ordered.
5) Daily Weights and I & O's.
6) LAB STUDIES ASAP: a) ___CBCX or ___CBCD b) CMP c) PT d) CO2 e) Urinalysis **Do not repeat normal studies done within 7 days** Call if K+ < 3.5. **If referral hospital labs are to be used, place them in chart under "LAB SECTION."**
7) LAB STUDIES IN A.M.: Fasting Lipid Profile **(if not done in last 3 months}**
8) P.A. and lateral chest X-ray AFTER seen by physician.
9) LIST CURRENT HOME MEDS: **(or hospital meds. if transfer)** on order sheet and verify with MD prior to first dose.
10) PRN MEDS:
   a. Tylenol 1-2 tabs PO q 4 h PRN pain.
   b. Darvocet-N-100 1-2 tabs PO q 4 h PRN pain unrelieved by Tylenol.
   c. Restoril 15mg. Q BEDTIME. PO PRN. May repeat x1.
   d. NTG 1/150 SL PRN chest pain.
   e. Dilaudid 0.5-2 mg IV for chest pain not relieved after 3 NTG > NOTIFY MD.
   f. Reglan 10mg IV q 4 h PRN nausea, if unrelieved, then Compazine 10 mg IV or PO q 4 h PRN nausea.
   g. Laxative of choice
   h. Xanax 0.25mg q 4 hours PRN anxiety, 0.125mg for patients >70years of age.
   i. Regitine ____mg SQ for Dopamine infiltration.
11) PCCU PROTOCOL:
   a. Insert INT and irrigate with 1 ml Normal Saline each shift. Use left arm preferably.
   b. Oxygen at _____ liters via _____ PRN _____.
   c. STAT EKG x 1 for chest pain.
12) If a doctor has not seen patient by 9:00 P.M., notify answering service to contact the doctor on call.
13) Patients with history of sustained V-tach must be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and noV-tach by monitor x48 hours. If there are questions, contact M.D.
14) If on Heparin, adjust per CCU "Heparin Order Sheet".
15) SEE EMERGENCY ORDER SHEET

SCANNED

969

6173

COLUMBIA CARDIOLOGY CONSULTANTS

Emergency Standing Orders

**REGISTERED NURSES WHO HAVE BEEN ADEQUATELY TRAINED FOR CRITICAL CARE NURSING WILL USE THESE EMERGENCY STANDING ORDERS: (ex. ACLS)

FOR VENTRICULAR ASYSTOLE:

1. Confirm in two leads. Assess no pulse.
2. Initiate CPR. Have CODE Team and attending physician called.
3. Consider transcutaneous pacing.
4. Give 1mg Epinephrine IV or Intratracheal. *May repeat every _____ min.as needed.
5. Give 1mg Atropine IV of Intratracheal. *May be repeated every _____ min. up to total of 0.04mg/kg.

FOR VENTRICULAR FIBRILLATION OR RAPID VENTRICULAR TACHYCARDIA WITH NO PULSE OR LOSS OF CONSIOUSNESS:

1. Precordial thump if witnessed arrest, no pulse, and no defibrillator available.
2. Initiate CPR. Have Code Team and attending physician called.
3. Defibrillate the patient with 200 joules. Repeat with _____ joules if ineffective. If second attempt unsuccessful, defibrillate with 360 joules. If unsuccessful continue CPR.
4. Give 1mg Epinephrine IV or Intratracheal. * May repeat every _____ mins.
5. Defibrillate with 360 joules within _____ seconds after drug administration.
6. Give 1.5mg/kg Lidocaine IV or Intratracheal. *May repeat in _____ mins. to total loading dose of 3mg/kg.

FOR SYMPTOMATIC VENTRICULAR TACHYCARDIA WITH PULSE:

1. Give _____mg/kg Lidocaine IV or Intratracheal. *May repeat Lidocaine IV or Intratracheal _____mg/kg every _____ mins. until VT resolves or up to 3mg/kg.
2. If patient becomes unconscious, have CODE TEAM and attending physician called, Cardiovert with 100 joules. If ineffective, repeat with 200, 300, 360 joules.

FOR VENTRICULAR ARRYTHMIAS REQUIRING LIDOCAINE THERAPY:

1. Give _____mg/kg Lidocaine IV and notify physician immediately.
2. If not suppressed, repeat Lidocaine _____mg/kg every _____ mins. until no ectopy, or up to 3 mg/kg given.
3. Once ectopy resolved, maintain as follows:
   A) After Lidocaine, 1mg/kg. Lidocaine Drip, 2mg/min.
   B) After Lidocaine, 1-2mg/kg Lidocaine Drip, 3mg/min.
   C) After Lidocaine, 2-3mg/kg. Lidocaine Drip, 4mg/min.

FOR SYMPTOMATIC BRADYCARDIA (SINUS BRADYCARDIA, SINUS PAUSES, JUNCTIONAL RHYTHM, 2 DEGREE OR 3 DEGREE AV BLOCK):

1. Give _____mg Atropine IV or Intratracheal. * May repeat as necessary every _____ mins, up to total 0.04mg/kg.
2. Notify physician stat.
3. If Atropine fails to increase heart rate, apply transcutaneous pacemaker, set MA at 100 and rate 100.

** FOR INTRATRACHEAL DRUG ADMINISTRATION: MEDICATION SHOULD BE ADMINISTERED AT 2-2.5 TIMES THE RECOMMENDED IV DOSE AND DILUTED IN 10ML OF NS OR DISTILLED WATER.**

SCANNED

DIABETIC PRECAUTIONS:

1. If blood sugar is less than 50, give 1 amp. D/50W.
2. Recheck blood sugar in 45 minutes. Repeat #1
3. Notify physician immediately.

SCANNED

SIGNATURE Dr. Patel Jessica Espo RN DATE 3/18/07

S.STANLEY JUK JR, MD	JOSEPH L.LAWTON, MD	MICHAEL C.ROBERTS, MD
EUGENE F.SCHWARZ, MD	THOMAS E.HEARON III, MD	RICHARD E.UMBACH, MD
ROBERT M. MALANUK, MD	R. TAYLOR WILLIAMS, MD	ERIC E. SHOUP, MS PAC

ORIGINAL: 1/1/04

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D005018290[redacted]
03/18/07 F 39
JUK,S STANLEY

002389

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date: 3/18/07	Time: 6:50 AM PM	Profiled By:	Filled By:	Checked By:

COLUMBIA CARDIOLOGY CONSULTANTS

CCC1190 PRE-PERCUTANEOUS CORONARY INTERVENTION (PCI) ORDERS

ADMISSION STATUS: __ INPATIENT __ OUTPATIENT __ OBSERVATION

1. Patient scheduled for PCI: DATE_____ TIME_____
2. Inform patient and family of scheduled time.
3. If not yet done, give patient PCI booklet and inform of film times if applicable.
4. Scheduled for PCI:
   a. Permit for PCI signed.
   b. Request 4th Heart bed reserved for post PCI transfer.
   c. Type and screen for PCI.
   d. If patient not receiving Ascriptin, then give 1 tab PO 10:00 PM night prior to PCI.
5. If Potassium is < 3.0, notify physician. If Potassium is between 3.0 - 3.5 then give 25 meq K-Lyte PO NOW and repeat in two hours. (Notify physician of other abnormal lab values by 6:00 PM. If new admission, have lab data on chart by 6:00 PM.
6. Clip and prep right/left groin with Betadine.
7. Clear liquids after midnight, then NPO for 6 hours prior to procedure except for medications.
8. Void immediately prior to pre-op MEDS.
9. Pre-medicate on call: A. Demerol 50 mg and Phenergan 25 mg IM
   B. If patient is over 70 yrs. old or weighs <130lbs., then give Demerol 25mg and Phenergan 25 mg IM.
10. Insure two (2) #20 or greater bore INTs are functional in left arm BEFORE transport to cath lab.
11. If patient is diabetic begin 1/2 NS at 75ml/hour, 12 hours prior to procedure (but no later than 11:00 PM the night before).
12. If patient allergic to iodine or shellfish give:
    1) Solu-medrol 125mg IV at 10PM the evening prior to cath and 125mg IV, one hour precath.
    2) Claritin 1 PO one hour pre-cath with Solu-Medrol.
13. If patient is diabetic and receiving insulin, give half routine morning dose day of procedure only, then resume day following procedure. If patient is receiving an oral diabetic medication, administer as usual. Consult for diabetic instructions.
14. If patient taking Glucophage, HOLD the morning of the cath and 48 hours post cath.
15. If patient is on a Heparin drip, hold three hours prior to procedure. If patient is on a single-dose Heparin, hold one dose prior to procedure. Resume at the discretion of the cathing cardiologist.
16. Patients with history of sustained V-tach must be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and no V-Tach by monitor x 48 hours. If there are questions, contact M.D.
17. Notify MD if Hgb, Protime, BUN, or Creatinine values are abnormal.

SIGNATURE _____ **DATE** 3/18/07

S.STANLEY JUK JR, MD	**JOSEPH L.LAWTON, MD**	**MICHAEL C.ROBERTS, MD**
EUGENE F.SCHWARZ, MD	**THOMAS E.HEARON III, MD**	**RICHARD E.UMBACH, MD**
ROBERT M. MALANUK, MD	**R. TAYLOR WILLIAMS, MD**	**ERIC E. SHOUP, MS PAC**

ORIGINAL: 1/1/04

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM, TAMMY E 002390
A# D005018290[redacted]2
03/18/07 F 39
JUK, S STANLEY

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
3/18/07	1530 AM PM			

Keep integrillin at 11 mL/hr
wean IV NTG
Lovenox 65 mg SC 1 dose tonight
D/C amiodarone
✓ cardiac enzymes x 3 c first now
activate Pre-PCI orders

SCANNED

Physician Signature: Dr. Patel / Jessica J Ross RN — Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
3/18/07	1800 AM PM			

CBC now
Lipitor 40 mg po daily
Plavix 75 mg po AM

SCANNED

To: Dr. Patel / Jessica J Ross RN

Physician Signature: — Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

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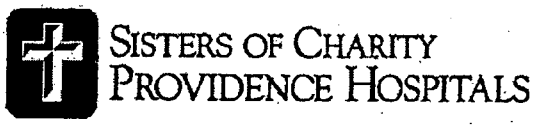
Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

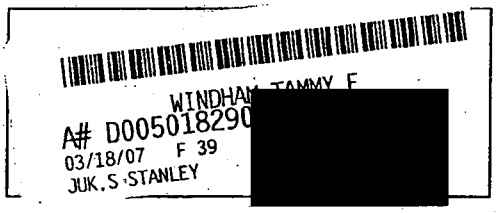
973

120 Blalock RN 3/19/07 0130

6177



SISTERS OF CHARITY
PROVIDENCE HOSPITALS



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Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

COLUMBIA CARDIOLOGY CONSULTANTS
CCC1130 POST PERCUTANEOUS CORONARY INTERVENTION ORDERS
Page 1 of 4

1. Check vital signs and procedural site for swelling or bleeding. Check distal extremity for warmth, color, sensation and presence of a pulse. Check these parameters q 15 min x 4, q 30 min x 4, and q hour x 4.

3/19/07 Noted Q Tofle, RN

2. **Patient activity:** *Complete bed rest until 6 hours post sheath removal.
*Ambulate slowly with supervision after 6 hours then activity as tolerated.
*Observe groin puncture site carefully for groin swelling,bleeding after progressing activity.

3. Foley Catheter if unable to void in 2 hrs.

4. Cardiac Rehabilitation consult for post intervention patient education.

5. Clear liquids until sheaths discontinued, then low fat diet.

6. **MEDICATIONS (Only if checked)**
___ASA 325 mg Daily with meal
✓ Plavix 75 mg PO daily
✓ Plavix 300 mg PO Now
___ Dilaudid ____ mg IV q 2 hrs PRN pain
___ Continue ReoPro at rate ____ until ____.
✓ Continue Integrilin at rate intab until 8 Am.
___ Continue Aggrastat at rate ____ until ____.
✓ Tylenol #3 1 tab q 3 hours PRN pain (Darvocet N-100 1 tab po if allergic to Codeine).

SCANNED

974

COLUMBIA CARDIOLOGY CONSULTANTS
POST PERCUTANEOUS CORONARY INTERVENTION
ORDERS Page 2 of 4

Medications continued:

____ Continue IV Nitroglycerin at _____ until _____.
✓ Wean IV NTG at 1 ml/hr as tolerated. If patient has chest pain during weaning process, resume previous settings and notify Physician.
____ D/C IV NTG at _____.
____ Continue IVF at _____ until _____.
____ D/C IVF

3/19/07 Noted O'Hale, RN

7. **Laboratory (Only if checked)**
✓ Basic Metabolic Panel in A.M.
✓ Cardiac profile (Troponin and reflex MB) NOW and A.M.
✓ CBCD___CBCX in A.M.
____ CBCD____CBCX q A.M. while on Aggrastat or Integrilin
____ CBCD____CBCX 6 hours and 12 hrs after ReoPro Infusion begun
____ Notify Physician if platelet count is < 40,000

8. **EKG (Only if checked)**
____ EKG now
✓ EKG in A.M.

9. **Sheath Removal (Only if checked)**
✓ Active Clotting Time (ACT) q 2 hrs. Pull sheaths when ACT is less than or equal to 150, or ____ Remove sheaths at _____(time).

10. **Prior to pulling sheaths**
Infiltrate cath site subcutaneously, with 10 ml of 2% Xylocaine (without Epinephrine). Demerol 50 mg IV PRN pain and may repeat x1 q_____hr . Atropine 0.5 mg IV PRN heart rate lower than 60.

11. After sheath removal, check vital signs and procedure site for swelling or bleeding; check distal extremity warmth, color, sensation, and presence of pulse. Check these parameters q 15 min x 4, q 30 min x 4, and q hour x 4.

SCANNED

WINDH [redacted] 2393
A# D00501829
03/18/07 F 39
JUK.S STANLEY

12. ____Lovenox (Only if checked) beginning at _____hrs after sheath removal. Lovenox 1 mg/kg sq q 12 hrs.

13. ____Heparin (Only if checked) beginning at _____hrs after sheath removal.
(Providence Hospital Heparin Protocol)

1. Make calculations using total body weight: _____kg.

2. Bolus: Heparin 80 units/kg = _____ units IV.

3. Start Heparin maintenance infusion at 18 units/kg/hour.

4. Labs: Draw PTT prior to bolus and Q AM while on IV Heparin.
Draw CBC prior to bolus and Q three days while on IV Heparin.

5. USE SLIDING SCALE HEPARIN BELOW TO ADJUST HEPARIN:
(Always make adjusts based on the current infusion rate) (aPTT Goal: 68 - 108 seconds)

aPTT (seconds) Heparin Dosage Adjustment Repeat aPTT

< 50 80 units/kg IV bolus 6 hours Increase infusion 4 units/kg/hour (8 hours if > 70 years)

50-67 40 units/kg IV bolus 6 hours Increase infusion 2 units/kg/hour

68-108 No Change A.M. Labs (Therapeutic)

109-141 Decrease infusion 2 units/kg/hour 6 hours

> 141 Hold infusion 1 hour, then 6 hours decrease infusion 3 units/kg/hour

Obtain PTT 6 hours after initiating infusion and after every dosage change, adjusting Heparin Infusion by the sliding scale until the PTT is therapeutic (68-108 seconds) two consecutive times.

Once therapeutic, obtain a PTT every 12 hours for two levels. If these PTTs are 68-108 seconds, obtain the PTT at 24 hour intervals for the duration of the Heparin

3/19/07 Noted O. Tagle, RN

SCANNED

COLUMBIA CARDIOLOGY CONSULTANTS
POST PERCUTANEOUS CORONARY INTERVENTION ORDERS - Page 4 of 4

3/19/07 Noted Q. Hoffle, RN

14. Medication and other orders:

Dr Lorenzo	

SIGNATURE _____ DATE 3/18/07

SCANNED

S.STANLEY JUK JR, MD
MICHAEL C.ROBERTS, MD
RICHARD E.UMBACH, MD
ROBERT M. MALANUK, MD
ERIC E. SHOUP, MS PAC
JOSEPH L.LAWTON, MD
EUGENE F.SCHWARZ, MD
R. TAYLOR WILLIAMS, MD

ORIGINAL: 1/1/04, Revised 12/21/04

977

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM, TAMMY E
A# D00501829048 U#000895682
03/18/07 F 39
JUK,S STANLEY [redacted]

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
3/19/07	AM / PM			

Lopressor 50 mg po BID Hold for HR < 50 ; sys BP < 100.

3/19/07 [illegible] RN

SCANNED

24 hr chart check 3/20/07 1cm 0645

24 hr chart check 3/20/07 0030 pm

Physician Signature: [signature] Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
3/20	830 AM / PM			

✓ CBC @ 3 pm. call if HgB < 9.0
Add on Lipid panel + LFTs to this
Am's labs
12 lead ECG in am
Ambulate in halls

12 hr chart check 3/21/07 0645

[signature] CCT 3-8-07

Physician Signature: [signature] Beeper #:

Noted Nancy Meehan RN

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

12 hr chart check 3/21/07 0700 cm

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested
Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002396

WINDHAM,TAMMY E
A# D0050182[redacted]682
03/18/07 F 39 [redacted]
JUK,S STANLEY

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
3/21/07	1010 AM PM			

Dc to home
Flu Dr. Lawton 3-4 wks

Physician Signature: [signature] Noted Nancy Keehan RN — Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
	AM PM			

Physician Signature: — Beeper #:

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

979

6183

RUN TIME: 0135
RUN USER: TALBOTBA

PATIENT ASSESSMENT

Patient Medication List

002397

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Does Patient Take Any Home Medicines: N

ASA:	Type+:	Dose:	Dose in Last 24h:
Beta-Blocker:	Name+:	Dose:	Dose in Last 24h:
ACE-I:	Name+:	Dose:	Dose in Last 24h:
ARB:	Name+:	Dose:	Dose In Last 24h:

List All Home Medications (except those listed above), Include Med. Name, Dose, Route, & Frequency. Also Include Any Over-The-Counter Medicines, Herbal Remedies Or Vitamins

Dose In Last 24h:
Dose In Last 24h:
Dose In Last 24h:
Dose In Last 24h:
Dose In Last 24h:
Dose In Last 24h:
Dose In Last 24h:
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Dose In Last 24h:
Dose In Last 24h:

RUN TIME: 0135
RUN USER: TALBOTBA

PATIENT ASSESSMENT

Patient Medication List

002398

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D 4H
Room/Bed: D H457-A

Dose In Last 24h:

Medication History Obtained From+: PATIENT

Disposition of Meds+: NONE

<File>

Occurred Date: 03/18/07
Monogram: JLE Initials: EPPSJL Name: EPPS,JESSICA L

Occurred Time: 1506
Nurse Type: RN

981

RUN DATE: 03/20/07
RUN TIME: 0255
RUN USER: EDENTOSM

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

002399

WINDHAM,TAMMY E D.4H D.H457-A D00501829048 39/F WT: lbs.
ATTENDING PHYSICIAN: JUK,S STANLEY

NUR ALLERGY: NKDA
PHA ALLERGY: NO KNOWN DRUG ALLERGIES

DISCHARGE MEDICATION LIST

MEDICATION	DOSE	ROUTE	DIRECTIONS	SHOULD PATIENT CONTINUE TAKING THIS MEDICINE AT HOME? (PLEASE CIRCLE ONE)	
ATORVASTATIN (LIPITOR)	40 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO
CLOPIDOGREL BISULFATE (PLAVIX 75MG)	75 MG	ORAL	EVERY MORNING QAM	YES	NO
ASPIRIN (ASPIRIN)	~~325 MG~~ 81	ORAL	DAILY WITH MEAL QDWM	YES	NO
METOPROLOL TARTRATE (LOPRESSOR)	50 MG	ORAL	TWICE DAILY BID	YES	NO

good today

need tonight

HOME MEDICATION LIST	CONTINUE THIS MEDICATION	
	YES	NO
	YES	NO
NitroStat 0.4 mg SL q5" prn CP	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

982

WINDHAM,TAMMY E D.4H D.H457-A D00501829048 39/F WT: lbs.
ATTENDING PHYSICIAN: JUK,S STANLEY

	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO

DOCTOR: THIS LIST IS BEING PROVIDED TO YOUR PATIENT AS PART OF HIS/HERE DISCHARGE INSTRUCTIONS.
PLEASE COMPLETE THE FOLLOWING SECTION AND SIGN.

(1) WILL MEDICATIONS BE NEEDED FOR PAIN MANAGEMENT? ___YES ✓NO IF SO, PLEASE INCLUDE IN THE LIST ABOVE

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

983

WINDHAM,TAMMY E D.4H D.H457-A D00501829048 39/F WT: lbs.
ATTENDING PHYSICIAN: JUK,S STANLEY

(2) LIST ANY HOME MEDICATIONS THAT THE PATIENT IS TO CONTINUE AS WELL AS INSTRUCTIONS FOR USE
ALSO INCLUDE ANY OTHER MEDICATIONS NOT ALREADY LISTED WHICH YOU WISH THE PATIENT TO CONTINUE

NURSE'S REVIEW OF DISCHARGE MEDICATION LIST

Review with Patient / Family Person's Name: _____

Does patient/family have a full understanding? ✓ YES ___ NO

If Not, Indicate concerns:

Food/Drug Interaction Sheet is in Patient Education Folder.

Prescriptions given to Patient/Family, copied and placed in medical record? ✓ YES ___ N/A

DO NOT TAKE ANY MEDICATIONS NOT LISTED ABOVE WITHOUT CONSULTING YOUR DOCTOR OR PHARMACIST

NURSE SIGNATURE: Nancy Keehan RN

MD SIGNATURE: [signature]

ABBREVIATIONS DICTIONARY

AC = BEFORE MEALS	PREOP = BEFORE PROCEDURE
AC&HS = BEFORE MEALS AND AT BEDTIME	PRN = AS NEEDED
BID = TWICE DAILY	Q = EVERY
HS = DAILY AT BEDTIME	QAM = EVERY MORNING
PC = AFTER MEALS	QID = 4 TIMES DAILY
PC&HS = AFTER MEALS AND AT BEDTIME	TID = 3 TIMES DAILY
PO = BY MOUTH	NPO = NOTHING BY MOUTH

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

114 Gateway Blvd., Suite 320 • Providence N.E. • Columbia, SC 29203 • (803) 744-4900

Cardiology Consultants

Reg. No. BL3197058 — Michael C. Roberts, M.D. Reg. No. BR2195964

Reg. No. AU8135495 — R. Taylor Williams, M.D. Reg. No BW7128425

Reg. No. A744CD

002402

Date: 3-21-07

Name: Tammy Windham

Address:

If you have questions regarding this prescription, please call (803) 744-4900

Please label contents ℞	Mg.	No.	Directions	Refills
1. Lipitor	40	30	1 po daily	6
2. Plavix	75	30	1 po daily	11
3. Lopressor	50	60	1 po BID	6
4. ECASA	81		1 po daily	
5. Nitrostat	0.4	25	1 SL 9.5" pm cp	6

Joseph Lawton M.D.

Dispense As Written — M.D. — Substitution Permitted — M.D.

Ms. Tammy Windham has an appointment April 11, 2007 (Month Day Year) at 11:00 AM ____ PM

My appointment is at the following location:

☐ 2601 Laurel Street Suite 260 Columbia, SC 29204 (803) 744-4900

☐ 107 West Hosp. Drive West Columbia, SC 29169 (803) 744-4940

☐ 114 Gateway Blvd., Suite 320, Providence N.E. Columbia, SC 29203 (803) 788-3147

My appointment is with

☐ S. Stanley Juk, Jr., M.D.
☐ Joseph J. Lawton, III, M.D.
☐ Michael C. Roberts, M.D.
☐ Eugene F. Schwarz, M.D.
☐ Thomas E. Hearon, III, M.D.
☐ Richard E. Umbach, M.D.
☐ R. Taylor Williams, M.D.
☐ Robert M. Malanuk, M.D.

3-4-07 10/18/07

INSTRUCTIONS: *Please carry this card at all times and show it to any medical personnel who may be treating you.*

Patient Name: Windham, Tammy

Date of Implant: 03/19/2007

Site of Implant: Circumflex

Implanting Physician: Dr. Lawton

Hospital: Providence

Address: 2345 Forest Drive Columbia SC

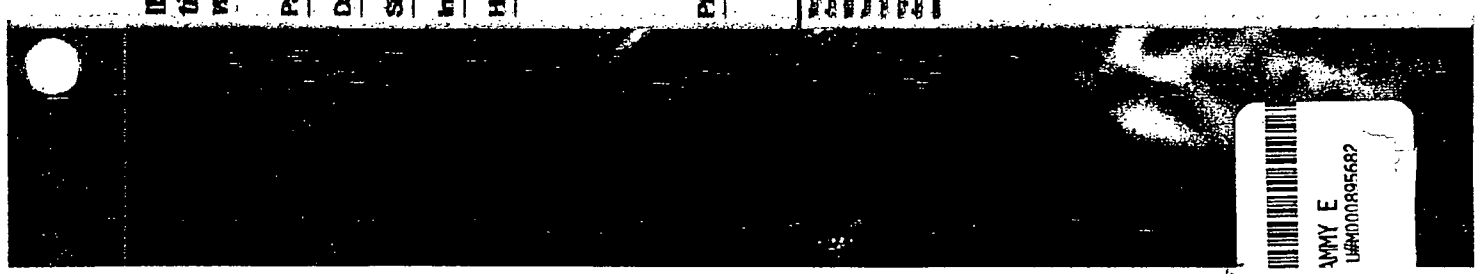
Telephone #: 803 256 5300

Primary Physician:

Telephone #:

Magnetic Resonance Imaging (MRI) of single or two overlapping CYPHER® Sirolimus-eluting Coronary Stents has been shown to be safe in MRI units with a magnetic strength of 3 Tesla or less. Notify your doctor before you have an MRI scan.

Your cardiologist has prescribed a number of antiplatelet (AP) medications. It is extremely important to follow the medication regimen as prescribed by your cardiologist. Before considering any surgery or dental work which would require you to stop taking AP medicines early, you and your doctors should consider the risks from early discontinuation of these medications. For questions regarding your CYPHER Stent or procedure, please contact your implanting cardiologist or Cordis Corporation at 1-800-781-0282. 101109073-2



Occurred Date	Time	by	Author	Recorded Date	Time	by	NURSE
03/21/07	1111	NJM	MEEHAN,NANCY J	03/21/07	1112	NJM	

Abnormal? N Confidential? N

POST CORONARY INTERVENTION DISCHARGE INSTRUCTIONS

Special Medication Information:

* TAKE PLAVIX AND ASPIRIN DAILY AS PRESCRIBED. DO NOT MISS A DOSE!!
* PLAVIX AND ASPIRIN INCREASES BLEEDING, HOLD PRESSURE TO ANY CUT.
* NITROGLYCERIN SHOULD BE USED WHEN SITTING OR LYING DOWN. DO NOT DRIVE CAR WHILE USING NITROGLYCERIN. CALL YOUR PHYSICIAN OR REPORT TO EMERGENCY ROOM IF NO IMPROVEMENT IN CHEST PAIN AFTER THIRD DOSE OF NITROGLYCERIN.

Exercise or Special Limits:

* INCREASE WALKING DAILY UNTIL RETURN TO NORMAL LEVEL.
* NO RUNNING, FAST STAIR CLIMBING OR STRETCHING FOR 3 DAYS.
* DO NOT SIT FOR LONG PERIODS OF TIME, CHANGE POSITION FREQUENTLY WHILE SITTING.
* DO NOT LIFT ANYTHING HEAVIER THAN 10 POUNDS FOR NEXT 3 DAYS.
* DO NOT DRIVE A CAR FOR NEXT 3 DAYS.
* LIMIT BENDING FOR NEXT 3 DAYS.

Dressing, Treatment, or Special Information:

* NO MRI FOR 6-8 WEEKS.
* CLEAN CATH SITE DAILY WITH SOAP AND WATER UNTIL HEALED.
* PLACE CLEAN BANDAID ON CATH SITE UNTIL HEALED.
* DO NOT USE LOTION OR POWDER AT CATH SITE UNTIL SITE IS HEALED.
* SHOWER PREFERRED, NO SOAKING IN A POOL OR TUB FOR 48 HOURS POST PROCEDURE.
* DO NOT STRAIN WITH BOWEL MOVEMENTS. MAY USE A LAXATIVE IF NEEDED.
* YOU CAN EXPECT BRUISING AT THE CATH SITE. A SMALL MARBLE SIZED KNOT MAY ALSO BE PRESENT - IT SHOULD GO AWAY WITHIN 2-3 WEEKS.
* YOU MAY HAVE SOME MILD ACHING OR PAIN AT SITE YOU MAY TAKE TYLENOL AS DIRECTED.
* WATCH SITE FOR BLEEDING, IF BLEEDING OCCURS HOLD DIRECT PRESSURE TO SITE FOR 5 MINUTES WHILE LYING DOWN. IF UNABLE TO CONTROL OR STOP BLEEDING CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM IMMEDIATELY.
* NOTIFY PHYSICIAN FOR PERSISTENT NUMBNESS, TINGLING, OR SEVERE PAIN IN THE EXTREMITY USED FOR THE HEART CATH.
* WATCH FOR SIGNS OF INFECTION - INCREASED REDNESS AT SITE, DRAINAGE, INCREASED PAIN. NOTIFY PHYSICIAN IF YOU DEVELOP A FEVER GREATER THAN 100 DEGREES. IF YOU DEVELOP SHAKING CHILLS NOTIFY YOUR PHYSICIAN.

Patient Discharge Instruction 03/21/07 1111 NJM

Patient Discharge Instructions Please Bring Copy To Office With You

Diet: LOW FAT, CHOL, SALT

Enter/Edit/View Notes: Y Use F4 - F9 to Access DISCHARGE Notes.

Follow-Up Appointment: APRIL 11, 2007 AT 11:00 AM

Call Doctor's Office: AS NEEDED

Call Doctor's Office: AS NEEDED

Date to Return to Work/School:

Exercise or Special Limitations
: SEE DISCHARGE INSTRUCTIONS

Dressing, Treatment, Special Equipment
: SEE DISCHARGE INSTRUCTIONS

Special Instructions
: SEE MEDICATION LIST

Tobacco Use+: CIGARETTE Smoking Cessation Information Provided+: Y
Pt Has Education Folder in Possession at Time of Discharge: Y
All Teaching Information Given to the Pt is in Folder: Y

Interdisciplinary Discharge Medication List Given To Pt/Family

Pt or Family Recieved the Following Items
Hearing Aides+: Contact Lens+: Glasses+: Dentures+: Prosthesis+:
Valuables Brought to Hospital Returned+: Y
Medications Brought to Hospital Returned+: N
Clothing brought to Hospital Returned+: Y

I Have Received a Copy of Both My Discharge Medication List and My Discharge Plan of Care.
**
Pt/SO Signature: Tammy Wolfram Date:

***** These Numbers are Provided for your Convenience *****

MAIN CAMPUS		NORTHEAST CAMPUS	
Lost and Found	256-5690	Lost and Found	865-4690
Patient Financial Services	256-5505	Patient Financial Services	865-5816
Medical Records	256-5302	Medical Records	865-4680
Patient Advocate	256-5739	Patient Advocate	256-5739

Stop Using Tobacco In Any Form. It Has Been Shown To Reduce Healing. No Smoking!

Call Your Physician If You Have Worsening Symptoms.

987

Patient Discharge Instruction 03/21/07 1111 NJM

If You Have Heart Failure - Weigh Yourself Daily And Write It Down. Call Your Physician If You Gain 2-3 Lbs. Overnight Or Over A 1-2 Day Period.

********** NURSING DISCHARGE CHECKLIST **********

Discharge Instructions 1 +: PCI
Discharge Instructions 2 +:
Discharge Instructions 3 +:
Mode of Discharge+: AMB
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
Notify MD's (If Applicable) Name:
Time:

IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Foley Removed: N
Voided Prior To Discharge: Y
BM Documented 2-3 Days Prior to Discharge:

Narcotic Analgesic was Given within 6 hours Prior to Discharge, Notify Attending Physician.
Name: Time:

Pneumovax Given: N
Flu Vaccine Given: N
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Other:

ACE-Inhibitor Prescribed at Discharge: N
ARB Prescribed At Discharge: N
If Not, Follow Up Plans Are+:
If not, Follow Up Plans Are+:

Monogram Initials	Name		Nurse Type
NJM	MEEHANNJ	MEEHAN,NANCY J	RN

988

D0050162904S WINDHAM,TAMMY L
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/21/07-0700 [redacted]
RUN DATE/TIME: 03/21/07-0241
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* SCHEDULED MEDS ******				
Rx#: 02197408 ASPIRIN 325 MG TAB (325 MG) (ASPIRIN) DOSE: 325 MG PO SIG: DAILY WITH MEAL INVENTORY from D4H		03/19/07 SCH	1000 crm		
Rx#: 02194915 ATORVASTATIN 20 MG TAB (40 MG) (LIPITOR) DOSE: 40 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H		03/18/07 SCH	1000 crm		
Rx#: 02194933 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (PLAVIX 75MG) DOSE: 75 MG PO SIG: EVERY MORNING INVENTORY from D4H		03/18/07 SCH	1000 crm		
Rx#: 02197423 METOPROLOL TARTRATE 50 MG TABLET (50 MG) (LOPRESSOR) DOSE: 50 MG PO SIG: TWICE DAILY COMMENTS: HOLD FOR HR < 50 OR SBP < 100 INVENTORY from D4H		03/19/07 SCH	1000 crm	2200	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
T Freeman RN	crm				

D0050162904B WINDHAM,TAMMY L
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY S
MAR DATE: 03/21/07-0700
RUN DATE/TIME: 03/21/07-0241
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* PRN MEDS *******				
Rx#: 02197410 CODEINE/APAP #3 TAB (None) (ACETAMINOPHEN/CODEINE #3) DOSE: 1 TAB PO SIG: EVERY 3 HOURS AS NEEDED COMMENTS: GIVE DARVOCET N 100 1 TAB PO IF ALLERGIC TO CODEINE. TYLENOL #3.EACH TABLET CONTAINS 300MG ACETAMINOPHEN DOSE INSTR: 1 TAB INVENTORY from D4H		03/19/07 PRN			
Rx#: 02194742 ACETAMINOPHEN 325 MG TABLET (None) (TYLENOL) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR PAIN. DOSE INSTR: 1-2 TABS INVENTORY from D4H		03/18/07 PRN			
Rx#: 02194750 ALPRAZOLAM 0.25 MG TAB (None) (XANAX 0.25MG TAB) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE XANAX 0.125 MG FOR PATIENTS > 70 YEARS OF AGE. DOSE INSTR: 0.25 MG INVENTORY from D4H		03/18/07 PRN			
Rx#: 02194753 D50W 50 ML BRISTOJECT (50 ML) (DEXTROSE 50%WATER SYRINGE) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: If blood sugar is less than 50, give 1 amp. D/50W INVENTORY from D4H		03/18/07 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

990

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK.S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/21/07-0700 TO [redacted]
RUN DATE/TIME: 03/21/07-0241
VERIFIED BY: D

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* PRN MEDS *******				
Rx#: 02194746	HYDROmorphone HCL 2 MG/ML AMP (None) (DILAUDID 2MG/ML INJ) DOSE: 0.5-2 MG IV SIG: AS DIRECTED COMMENTS: DILAUDID; ONE TIME DOSE FOR CHEST PAIN NOT RELIEVED AFTER 3 NITROGLYCERIN TABLETS; NOTIFY MD. DOSE INSTR: 0.5-2 MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194751	LAXATIVE OF CHOICE 1 EA EACH (1 EA) (LAXATIVE OF CHOICE) DOSE: 1 EA PO SIG: AS NEEDED COMMENTS: GIVE ONCE OR TWICE DAILY INVENTORY from PHARMACY	03/18/07 PRN			
Rx#: 02194747	METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (REGLAN 10MG/2ML VIAL) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: IF UNRELIEVED, GIVE COMPAZINE 5-10MG IV OR PO AS NEEDED FOR NAUSEA EVERY 4 HOURS EXP 48HRS (IN NS) EXP 24HRS (IN D5W) *** LIGHT SENSITIVE *** INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194745	NITROGLYCERIN 0.4 MG 25TABBOT (None) (NITROQUICK 0.4MG SUBL) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D4H	03/18/07 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00501829048 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/21/07-0[redacted]59
RUN DATE/TIME: 03/21/07-[redacted]9
VERIFIED BY: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* PRN MEDS *******				
Rx#: 02194748 PROCHLORPERAZINE EDISYLATE 10 MG/2 ML VI (None) (COMPAZINE) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE IV OR PO IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10 MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194749 PROCHLORPERAZINE MALEATE 5 MG TABLET (None) (COMPAZINE) DOSE: 10MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PO OR IV IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194743 PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TAB PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN FOR PAIN NOT RELIEVED BY TYLENOL NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES DOSE INSTR: 1-2 TAB INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194744 TEMAZEPAM 15 MG CAP (None) (RESTORIL) DOSE: 15MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT X 1. DOSE INSTR: 15MG INVENTORY from D4H	03/18/07 PRN			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

992

D0050182904B WINDHAM, TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK.S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/20/07-0700 TO 03/21/07-0659
RUN DATE/TIME: 03/20/07-0239 002410
VERIFIED BY: Edenton RN DOB: 10/18/67

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* SCHEDULED MEDS ******				
Rx#: 02197408 ASPIRIN 325 MG TAB (325 MG) (ASPIRIN) DOSE: 325 MG PO SIG: DAILY WITH MEAL INVENTORY from D4H	03/19/07 SCH	1000 rcm		
Rx#: 02194915 ATORVASTATIN 20 MG TAB (40 MG) (LIPITOR) DOSE: 40 MG PO *2tabs SIG: ~~DAILY AT 1000~~ (10:00AM) INVENTORY from D4H	03/18/07 SCH	1000 rcm		
Rx#: 02194933 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (PLAVIX 75MG) DOSE: 75 MG PO SIG: EVERY MORNING INVENTORY from D4H	03/18/07 SCH	1000 rcm		
Rx#: 02197423 METOPROLOL TARTRATE 50 MG TABLET (50 MG) (LOPRESSOR) DOSE: 50 MG PO SIG: TWICE DAILY COMMENTS: HOLD FOR HR < 50 OR SBP < 100 INVENTORY from D4H	03/19/07 SCH	1000 rcm 111/62 HR 71	~~2200~~	
******* IV'S *******				
Rx#: 02194739 EPTIFIBATIDE 75 MG/100 ML VIAL (100 ML) (INTEGRILIN 100ML) RATE: 11 MLS/HR DUR: 9 FREQ: EVERY 9 HOURS 6 MINUTES COMMENTS: INTEGRILIN ***** CONCENTRATION: 0.75MG/ML *** MAINTENANCE INFUSION DOSE: 2 MCG/KG/MIN MAINTENANCE INFUSION RATE: 11 ML/HR *** NEXT TUBING CHANGE DUE:	03/18/07 03/20/07	0800 off done rcm		

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Nancy Meehan BN	rcm				

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/20/07-0700 TO [redacted]659
RUN DATE/TIME: 03/20/07-0239 [redacted]11
VERIFIED BY: S Edenton RN DOB [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* PRN MEDS *******				
Rx#: 02197410 CODEINE/APAP #3 TAB (None) (ACETAMINOPHEN/CODEINE #3) DOSE: 1 TAB PO SIG: EVERY 3 HOURS AS NEEDED COMMENTS: GIVE DARVOCET N 100 1 TAB PO IF ALLERGIC TO CODEINE. TYLENOL #3.EACH TABLET CONTAINS 300MG ACETAMINOPHEN DOSE INSTR: 1 TAB INVENTORY from D4H	03/19/07 PRN			
Rx#: 02194742 ACETAMINOPHEN 325 MG TABLET (None) (TYLENOL) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR PAIN. DOSE INSTR: 1-2 TABS INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194750 ALPRAZOLAM 0.25 MG TAB (None) (XANAX 0.25MG TAB) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE XANAX 0.125 MG FOR PATIENTS > 70 YEARS OF AGE. DOSE INSTR: 0.25 MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194753 D50W 50 ML BRISTOJECT (50 ML) (DEXTROSE 50%WATER SYRINGE) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: If blood sugar is less than 50, give 1 amp. D/50W INVENTORY from D4H	03/18/07 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

994

[redacted]

6198

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/20/07-0700 TO 03/21/07-0659
RUN DATE/TIME: 03/20/07-0239
VERIFIED BY D Edenton RN DOB [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* PRN MEDS *******				
Rx#: 02194746 HYDROmorphone HCL 2 MG/ML AMP (None) (DILAUDID 2MG/ML INJ) DOSE: 0.5-2 MG IV SIG: AS DIRECTED COMMENTS: DILAUDID; ONE TIME DOSE FOR CHEST PAIN NOT RELIEVED AFTER 3 NITROGLYCERIN TABLETS; NOTIFY MD. DOSE INSTR: 0.5-2 MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194751 LAXATIVE OF CHOICE 1 EA EACH (1 EA) (LAXATIVE OF CHOICE) DOSE: 1 EA PO SIG: AS NEEDED COMMENTS: GIVE ONCE OR TWICE DAILY INVENTORY from PHARMACY	03/18/07 PRN			
Rx#: 02197421 MEPERIDINE HCL 50 MG/ML AMP (None) (DEMEROL) DOSE: 50 MG IV SIG: AS DIRECTED COMMENTS: POST PCI ORDERS... DEMEROL; ADMINISTER AS DIRECTED PRIOR TO PULLING SHEATH; MAY REPEAT X 1 DOSE AS NECESSARY. DOSE INSTR: 50 MG INVENTORY from D4H	03/19/07 03/20/07 PRN			
Rx#: 02194747 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (REGLAN 10MG/2ML VIAL) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: IF UNRELIEVED, GIVE COMPAZINE 5-10MG IV OR PO AS NEEDED FOR NAUSEA EVERY 4 HOURS EXP 48HRS (IN NS) EXP 24HRS (IN D5W) *** LIGHT SENSITIVE *** INVENTORY from D4H	03/18/07 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

995

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK.S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/20/07-0700 TO 03/21/07-0659
RUN DATE/TIME: 03/20/07-0239
VERIFIED BY: S Edenton RN DOB [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* PRN MEDS *******				
Rx#: 02194745 NITROGLYCERIN 0.4 MG 25TABBOT (None) (NITROQUICK 0.4MG SUBL) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194748 PROCHLORPERAZINE EDISYLATE 10 MG/2 ML VI (None) (COMPAZINE) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE IV OR PO IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10 MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194749 PROCHLORPERAZINE MALEATE 5 MG TABLET (None) (COMPAZINE) DOSE: 10MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PO OR IV IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10MG INVENTORY from D4H	03/18/07 PRN			
Rx#: 02194743 PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TAB PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN FOR PAIN NOT RELIEVED BY TYLENOL NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES DOSE INSTR: 1-2 TAB INVENTORY from D4H	03/18/07 PRN	1050 CNCM	1815 CNCM	~~2200~~ 2306

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Nancy Meehan BN	CNCM			[illegible]	[illegible]

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/20/07-0700 TO 03/21/07-0659
RUN DATE/TIME: 03/20/07-0239
VERIFIED BY Edonton RN DO[redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* PRN MEDS *******				
Rx#: 02194744 TEMAZEPAM 15 MG CAP (None) (RESTORIL) DOSE: 15MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT X 1. DOSE INSTR: 15MG INVENTORY from D4H	03/18/07 PRN			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK.S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/19/07-0700 TO 03/20/07-0659
RUN DATE/TIME: 03/19/07-0212
VERIFIED BY: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* SCHEDULED MEDS ******				
Rx#: 02194935 ASPIRIN/ALUM/MAGNES/CAL CARB 325 MG TA (325 MG) (ASCRIPTIN 325MG TAB) DOSE: 325 MG PO SIG: PREOP COMMENTS: IF PATIENT NOT RECEIVING ASCRIPTIN, THEN GIVE 1 TAB PO 10PM NIGHT PRIOR TO PCI. INVENTORY from PHARMACY	03/19/07 03/19/07 ONE	0700 given night prior to PCI @ 0330		See next page
Rx#: 02194915 ATORVASTATIN 20 MG TAB (40 MG) (LIPITOR) DOSE: 40 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H	03/18/07 SCH	1000	2200 ~~2040~~ SE	
Rx#: 02194933 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (PLAVIX 75MG) DOSE: 75 MG PO SIG: EVERY MORNING INVENTORY from D4H	03/18/07 SCH	1000 Pt received bolus in cath lab		
Rx#: 02194936 MEPERIDINE HCL 50 MG/ML AMP (None) (DEMEROL) DOSE: 50MG IM SIG: PREOP COMMENTS: IF PATIENT IS ALLERGIC TO DEMEROL GIVE ATIVAN 2MG IM 1-2 HOURS PRIOR TO PROCEDURE. IF PATIENT > 70 YEARS OLD OR WEIGHT < 130 LBS, THEN GIVE DEMEROL 25MG AND PHENERGAN 25MG IM. DOSE INSTR: 50MG INVENTORY from D4H	03/19/07 03/19/07 ONE	0700 Pre-op ~~1440~~ OM 50mg		
Rx#: 02194937 PROMETHAZINE HCL 25 MG/ML AMP (25 MG) (PHENERGAN AMP) DOSE: 25 MG IM SIG: PREOP COMMENTS: PHENERGAN INVENTORY from D4H	03/19/07 03/19/07 ONE	0700 Pre-op ~~1440~~ OM 25mg		

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Lauren Tage, RN	OM				
				S Edenton RN	SE

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/19/07-0700 TO 03/20/07-0659
RUN DATE/TIME: 03/19/07-0212
VERIFIED BY: [illegible] DOB: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* IV'S *******				
Rx#: 02194739	EPTIFIBATIDE 75 MG/100 ML VIAL (100 ML) (INTEGRILIN 100ML) RATE: 11 MLS/HR DUR: 9 FREQ: EVERY 9 HOURS 6 MINUTES COMMENTS: INTEGRILIN ***** CONCENTRATION: 0.75MG/ML *** MAINTENANCE INFUSION DOSE: 2 MCG/KG/MIN MAINTENANCE INFUSION RATE: 11 ML/HR *** NEXT TUBING CHANGE DUE: 3/21/07	03/18/07 07	0957 ~~1070~~ OM	~~1903~~ SE new bottle	~~0409~~ SE new bottle
	Continue until 8am 3/20 OM				
	LOPRESSOR 50mg PO BID Hold for HR<50 Sys BP<100 3/19 OM		1000	2200 ~~2040~~ SE Tel/76,68	
	ASA 325 mg po daily c meal 3/19 OM				
	Nean N NTG @ 1ml/hr as tolerated 3/19 OM				8PM ~~0030~~ SE

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Oleunen Tolg, RN	OM				
				S Edenton RN	SE

999

6203

D00501829048 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/19/07-0700 TO 03/20/07-0659
RUN DATE/TIME: 03/19/07-021[redacted]7
VERIFIED BY: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
******* PRN MEDS *******				
Rx#: 02194742 ACETAMINOPHEN 325 MG TABLET (None) (TYLENOL) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR PAIN. DOSE INSTR: 1-2 TABS INVENTORY from D4H	03/18/07 PRN (R)			
Rx#: 02194750 ALPRAZOLAM 0.25 MG TAB (None) (XANAX 0.25MG TAB) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE XANAX 0.125 MG FOR PATIENTS > 70 YEARS OF AGE. DOSE INSTR: 0.25 MG INVENTORY from D4H	03/18/07 PRN (R)			
Rx#: 02194753 D50W 50 ML BRISTOJECT (50 ML) (DEXTROSE 50%WATER SYRINGE) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: If blood sugar is less than 50, give 1 amp. D/50W INVENTORY from D4H	03/18/07 PRN (R)			
Rx#: 02194746 HYDROmorphone HCL 2 MG/ML AMP (None) (DILAUDID 2MG/ML INJ) DOSE: 0.5-2 MG IV SIG: AS DIRECTED COMMENTS: DILAUDID; ONE TIME DOSE FOR CHEST PAIN NOT RELIEVED AFTER 3 NITROGLYCERIN TABLETS; NOTIFY MD. DOSE INSTR: 0.5-2 MG INVENTORY from D4H	03/18/07 PRN (R)		~~2040~~ 1mg SE	~~0015~~ SE 1mg ~~0350~~ 1mg SE
Rx#: 02194751 LAXATIVE OF CHOICE 1 EA EACH (1 EA) (LAXATIVE OF CHOICE) DOSE: 1 EA PO SIG: AS NEEDED COMMENTS: GIVE ONCE OR TWICE DAILY INVENTORY from PHARMACY	03/18/07 PRN (R)			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				SEdenton RN	SE

1500

D0050182904B WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK,S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/19/07-0700 TO 03/20/07-0659
RUN DATE/TIME: 03/19/07-0212 [redacted]
VERIFIED BY: [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* PRN MEDS *******				
Rx#: 02194747 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (REGLAN 10MG/2ML VIAL) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: IF UNRELIEVED, GIVE COMPAZINE 5-10MG IV OR PO AS NEEDED FOR NAUSEA EVERY 4 HOURS EXP 48HRS (IN NS) EXP 24HRS (IN D5W) *** LIGHT SENSITIVE *** INVENTORY from D4H	03/18/07 PRN				
Rx#: 02194745 NITROGLYCERIN 0.4 MG 25TABBOT (None) (NITROQUICK 0.4MG SUBL) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D4H	03/18/07 PRN				
Rx#: 02194748 PROCHLORPERAZINE EDISYLATE 10 MG/2 ML VI (None) (COMPAZINE) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE IV OR PO IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10 MG INVENTORY from D4H	03/18/07 PRN				
Rx#: 02194749 PROCHLORPERAZINE MALEATE 5 MG TABLET (None) (COMPAZINE) DOSE: 10MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PO OR IV IF NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 10MG INVENTORY from D4H	03/18/07 PRN				

Tylenol #3 1 tab q 3° prn pain

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
Lauren Toye, RN	OH				
				S Edenton RN	SE

1091

6205

D00501829048 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H457 A
AGE: 39 SEX: F WT: 69.39kg BSA: 1.77
ADMITTED: 03/18/07 PHYSICIAN: JUK.S STANLEY
NOTES:

PRIMARY DX: ACUTE CORONARY SYNDROME
MAR DATE: 03/19/07-0700 TO 03/20/07-0659
RUN DATE/TIME: 03/19/07-0212
VERIFIED BY: DOB [redacted]

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	******* PRN MEDS *******				
Rx#: 02194743	PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TAB PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN FOR PAIN NOT RELIEVED BY TYLENOL NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES DOSE INSTR: 1-2 TAB INVENTORY from D4H	03/18/07 PRN	~~1130~~ 2 tabs H/A 10/10 PRS	~~1155~~ 2 tabs H/A 10/10 PRS	
Rx#: 02194744	TEMAZEPAM 15 MG CAP (None) (RESTORIL) DOSE: 15MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT X 1. DOSE INSTR: 15MG INVENTORY from D4H	03/18/07 PRN			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
		Shannon Tate, RN			
				S Edenton RN	SE

10 02

6206

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM, TAMMY E
ACCT: D00501829048
DR: JUK, S STANLEY
DIAGNOSIS: ACUTE CORONARY SYNDROME
VERIFIED BY: _____

ROOM: D.H457-A
AGE: 39 SEX: F

(FT/IN) / (CM) (LB/OZ) / [redacted]

ALLERGIES: *PLEASE ENTER ALLERGIES*

ADMINISTRATION PERIOD: 0700 03/18/07 TO 0659 03/19/07

	START/STOP	0700-1459	1500-2259	2300-0659
Continue Integrillin @ same rate ✓	3/18 JSE		1500 JSE	~~0700~~ PD
Wean NTG sto chest pain ✓	3/18 JSE		weaned	PD
~~Dalteparin~~ Lovenox 65 mg SC 1 dose tonight ✓	3/18 JSE	0700 given at Thorney	~~2300~~ PD	
Lipitor 40 mg po daily ✓	3/18 JSE		~~2300~~ PD	
Demerol 50 mg and Phenergan 25 mg IM - Prep on call ✓	3/19/07 PD			
Plavix 75 mg po AM ✓	3/18/07 PD			
Ascriptin 325 mg ½ tab po night prior to PCI	3/19/07 PD			~~0700~~ PD

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
		Dalbert W	PD	Jessica Lopez RN	JSE

WINDHAM, TAMMY E 39/F DR: JUK, S STANLEY ROOM: D.H457-A

1003

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00501829048
DR: JUK,S STANLEY
DIAGNOSIS: ACUTE CORONARY SYNDROME
VERIFIED BY: _____

ROOM: D.H457-A [redacted] F

(FT/IN) / (CM) (LB/OZ)

ALLERGIES: *PLEASE ENTER ALLERGIES*

ADMINISTRATION PERIOD: 0700 03/18/07 TO 0659 03/19/07	START/STOP	0700-1459	1500-2259	2300-0659

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS

WINDHAM,TAMMY E 39/F DR: JUK,S STANLEY ROOM: D.H457-A

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D00501829048 U#M000895682
03/18/07 F 39
JUK,S STANLEY [redacted]

002422

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original.
This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

Columbia Cardiology Consultants
Standard PRN Medications

Medication / Dose / Route Frequency	Start / Stop	0700 – 1459	1500 – 2259	2300 - 0659
Tylenol 2tabs PO q4h PRN pain 1-2				
Darvocet-N-100 PO q4h PRN pain unrelieved by Tylenol 1-2			2015 TB	
Restoril 15mg PO qHS PRN May repeat X 1				
NTG 1/150 SL PRN chest pain				
Dilaudid 0.5-2mg IV PRN chest pain unrelieved by 3 NTG Notify MD	3/18 [illegible]		1650 0.5mg [illegible]	
Reglan 10mg IV q4h PRN nausea				
Compazine _____mg IV / PO q4h PRN nausea unrelieved by Reglan				
Xanax 0.25mg PO q4h PRN anxiety 0.125mg for patients > 70 years of age	3/18 [illegible]		1710 [illegible]	
Regitine _____mg SQ PRN Dopamine infiltration				

Laxative of Choice

Signature	Initials	Signature	Initials	Signature	Initials
		Jessica J Eggs RN	[illegible]	[illegible]	[illegible]

1005

6209

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM,TAMMY F 02423
A# D0050182904[redacted]2
03/18/07 F 39
JUK.S STANLEY

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
3/18/07	CARDIOLOGY : N/A 1° Doctor Dictated
	39y/o 10pm last night Chest pain continuous night Radiating back left arm — Sumter ER
	SH — 1/2 PPD x —
	- ER - Nausea Vomiting (+) diaphoresis
	Allergies NKDA
	Social cigarettes chule tabed
	Medications ø
	Currently N/O CHEST pain
	PE
	HEENT JVP ↓
	HEART S1 S2 (+) S4 soft
	LUNGS CTA
	ABD: soft
	Extr (+) pulses
	NSTEMI
	- Received Plavix load 300 mg
	· Lovenox
	· ASA / integrillin — prior transfer
	Discussed (L) heart cath ± possible intervention All questions addressed. Risks and benefits fully addressed. agree proceed
	- currently stable CP free on NTG

NUR018 (1/03)

PROGRESS RECORD

Neel Patel

1006

6210

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM,TAMMY E
A# D0050182904[redacted]424
03/18/07 F 39
JK,S STANLEY

Date

POST-PROCEDURE PROGRESS NOTE

NEXT-LEVEL-OF-CARE COMMUNICATION NOTE

Preoperative Diagnosis: SEMI

Postoperative Diagnosis: ☑ Same as Preoperative: CAD

Procedure(s) Performed: LHC, LV gram, ADS, Stent (2) Cx OM2

Name of Primary Operator: Lanton

Name of Assisting Physician if Different from Primary Operator:

Estimated Blood Loss: _____ ml ☐ None

Specimens Removed: ☐ None

Condition of Patient: ☑ Stable ☐ Unstable ☐ Critical

Findings/Description of Procedure(s):

LV: Apical hypokinesis EF 70%
LM ok
LAD
D1 80% ostial
D2 50-70% ostial
LCX 80% OM2 — 50% distal OM2

RCA 30-40% mid 30-40% PL RCA
1° stent circ OM2 2.5x18 cypher to 12 atm
80 → 0%.

713537

Physician Signature: [signature] Date: 3/19/07

POST-PROCEDURE PROGRESS NOTE

NUR029 (4/05)

1007

6211

CYPHER™ RX CXS19250 2.50 mm x 18 mm LOT A0107181
ICD-9-CM Procedure Code 36.07 Insertion of drug-eluting coronary artery stent(s)
+H739CXS162603/
+07120A0107181/X
Cordis

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM,TAMMY E
A# D005018290 [redacted] 002425
03/18/07 F 39
JUK,S STANLEY

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
3/20	No CP. Some groin oozing req. pressure last pm
	BP 118/68
	trop 6.14 ↓. Hgb 9.9 (11.5) 3/2
	NSR
	ECG NSR Ant TWI.
	Cor RRR s m
	Chest clear.
	(R) groin ō bruit pulses 2+
	Imp s/p Apical MI Anemia p PCI
	s/p stent LCX.
	Plan rev Hgb/Hct
	↑ activity slowly.
	home 24-48° if no further CP.
	JKauh
3/21	No further CP
	NSR BP 103/52 Hgb 9.5
	Cor RRR s m
	chest clear 713938
	groin ecchymosis
	Imp stable.
	DC to home
	JKauh

NUR018 (1/03)

PROGRESS RECORD

1008

6212

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

DISCHARGE SUMMARY

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: Joseph Lawton, III, M.D.
ADMISSION DATE: 03/18/2007
DISCHARGE DATE: 3.21.07
ROOM/BED: D.H457
PATIENT TYPE: IN
SOCIAL SECURITY: 247-31-1815

ACCOUNT#: D00501829048
MR#: M000895682
[redacted]
NURSING STATION: D.4H
CLINIC CODE:

PATIENT: TAMMY E. WINDHAM

DATE OF DISCHARGE: 03/21/2007

DISCHARGE DIAGNOSES:
1. Subendocardial myocardial infarction.
2. Hyperlipidemia.
3. History of tobacco abuse.

PROCEDURES:
1. Cardiac catheterization and stent placement to the circumflex marginal II, performed on 03/19/2007.

HOSPITAL COURSE: Please see the history and physical dictated by Dr. Patel. The patient came to the Tuomey Emergency Room with chest pain radiating into the left arm and back. The discomfort was on and off through the night and she had inferolateral T wave abnormalities. Her troponin was elevated to 3.15. She was treated with Lovenox, Plavix, aspirin, Lopressor and subsequently placed on Integrilin. She did have a short run of nonsustained VT prior to transfer and was given 150 mg amiodarone bolus. On arrival here she was feeling better with no chest pain and was placed on Integrilin. She underwent catheterization the following day which showed apical hypokinesis but an ejection fraction of 70%. She had an 80% first diagonal stenosis, 50-70% second diagonal stenosis, 80% circumflex marginal II which was hazy with a 50% distal OM stenosis, 30-40% mid right coronary artery and 30-40% posterolateral right coronary artery. The circumflex was successfully stented with a 2.5 x 18 Cypher with no residual stenosis. She had no further chest pain postprocedure. She did have some mild groin oozing and it dropped her hemoglobin to 9.9 and subsequently 9.5 postprocedure. She had no significant hematoma and no femoral bruits. She was progressively ambulated in the halls and had no further symptoms of any chest discomfort. She was felt to be stable for discharge today.

LABORATORY DATA: EKG prior to discharge: Sinus rhythm at 59 beats per minute with inferolateral T wave abnormalities compatible with recent subendocardial myocardial infarction. This was essentially unchanged from her admitting EKGs.

Sodium 136, potassium 4.0, glucose 109, BUN 10, creatinine 0.7. Cholesterol 157, HDL 33, LDL 99, triglycerides 122, white count 10.8, hemoglobin 9.5, hematocrit 30.6, platelets 315.

ORIGINAL REPORT - DO NOT REMOVE FROM CHART

DISPOSITION: The patient has been encouraged to discontinued tobacco products altogether. She will follow up with the undersigned in approximately three to four weeks.

DISCHARGE MEDICATIONS:

1. Lipitor 40 mg daily.
2. Plavix 75 mg daily.
3. Lopressor 50 mg b.i.d.
4. Aspirin 81 mg daily.
5. She was also given Nitrostat 4 mg PRN chest pain.

Joseph Lawton, III, M.D.

JL/ejf
DD: 03/21/2007 / DT: 09:18 AM
TD: 03/21/2007 / TT: 11:25 AM
JOB #: 713938

Electronic Signature By: JOSEPH J. LAWTON, III
<<SIGNATURE ON FILE>>

Electronic Signature Date: 03/28/07
Electronic Signature TIme: 1438

Joseph Lawton, III, M.D.

JL/ejf
DD: 03/21/2007 / DT: 09:18 AM
TD: 03/21/2007 / TT: 11:25 AM
JOB #: 713938

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

HISTORY AND PHYSICAL

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: Neel Patel, M.D.
ADMISSION DATE: 03/18/2007
DISCHARGE DATE:
ROOM/BED: D.H457
PATIENT TYPE: IN
SOCIAL SECURITY:

ACCOUNT#: D00501829048
MR#: M000895682
AGE: 39
[redacted]
NURSING STATION: D.4H
CLINIC CODE:

CC: S. Stanley Juk, Jr., M.D.

PATIENT: TAMMY E. WINDHAM

HISTORY OF PRESENT ILLNESS: This is a 39-year-old female with no apparent past medical history who presented to the Sumter emergency room with chest pain, which began last night at 10:00 p.m. The patient describes the pain as on an off with left arm radiation, as well as radiation to the back. The pain continued throughout the night and thus she went to the Sumter emergency room this morning for further evaluation. During her evaluation at the emergency room, the patient had some associated nausea and vomiting and an EKG did reveal ischemic changes in the inferolateral leads with inferolateral ischemia. Troponins were done. The first troponin was elevated in the Sumter emergency room at 3.15. Prior to transfer the patient received Lovenox IV, Plavix 300 mg orally, aspirin 325, Lopressor 5 mg IV times three and was started on a nitroglycerin drip. The patient had a small run of nonsustained ventricular tachycardia prior to transfer and was given a bolus of amiodarone 150 mg IV times one.

PAST MEDICAL HISTORY: None.

ALLERGIES: None.

SOCIAL HISTORY: Smoking history, ½ pack a day for greater than 10 years.

REVIEW OF SYSTEMS: Negative. All other systems are negative.

PHYSICAL EXAMINATION: VITAL SIGNS: Heart rate is 82, blood pressure 105/80, respirations 18. GENERAL: The patient is alert and oriented times three, in no acute distress, not complaining of chest pain. HEAD AND NECK: Jugular venous pressure is normal, no carotid bruits appreciated. HEART: S1 and S2 normal. Soft S4. PMI is nondisplaced. LUNGS: Clear to auscultation. ABDOMEN: Soft, nontender, nondistended. EXTREMITIES: No edema.

LABS AT PROVIDENCE HOSPITAL: Second set of enzymes was elevated with troponin of 38.21 ng/ml. CK-MB 183.9 ng/ml. BUN 9, creatinine 0.9. EKG reveals sinus rhythm with T based inversions in the inferolateral leads, consistent with ischemia.

IMPRESSION: Non-ST elevation myocardial infarction.

The patient is to continue on her current medications, including Integrilin drip. She will receive an additional aspirin in the a.m. tomorrow, Plavix 75 mg every day. The risks and benefits of left heart catheterization, as well as

intervention were fully explained to the patient. She agrees to proceed. NPO after midnight for planned left heart catheterization and possible PCI tomorrow.

Dictated by Neel Patel, M.D. for S. Stanley Juk, Jr., M.D.

Neel Patel, M.D.

NP/lgj
DD: 03/18/2007 / DT: 06:26 PM
TD: 03/19/2007 / TT: 08:59 AM
JOB #: 713369

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

CARDIOPULMONARY SERVICES / CATHETERIZATION LABORATORY REPORT

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: Joseph Lawton, III, M.D.
ADMISSION DATE: 03/18/2007
DISCHARGE DATE: 3.21.07
ROOM/BED: D.H457
PATIENT TYPE:
SOCIAL SECURITY:

ACCOUNT#: D00501829048
MR#: M000895682
[redacted].4H

PATIENT: TAMMY E. WINDHAM

DATE OF PROCEDURE: 3/19/07

HISTORY: The patient is a 39-year-old female who was admitted with chest pain and inferolateral T-wave abnormalities. The patient had a positive troponin of 3.1 and was placed on Lovenox, Plavix and Integrilin. She does have a history of tobacco use. She is, thus, referred for diagnostic catheterization.

PROCEDURES PERFORMED:
1. Left heart catheterization.
2. Left ventriculography.
3. Selective coronary arteriography.
4. Primary stenting of the circumflex marginal #2.

DESCRIPTION OF PROCEDURE: After administration of local anesthesia, the right femoral artery was punctured and a #6Fr. sheath was inserted. Left heart catheterization was performed in the usual fashion using a #6Fr. angled pigtail catheter. Left ventriculography was performed in the 30-degree RAO projection. Selective coronary arteriography was then performed in various LAO and RAO projections using #6Fr. JL-4 curve and #6Fr. JR-4 curve diagnostic catheters.

Following diagnostic catheterization, the decision was made to proceed with a PCI to the circumflex marginal which was a large vessel which extended out to the apex and appeared to be the infarct-related artery. A #6Fr. JL-3.5 curve guide was used to engage the left coronary. The stenosis was crossed easily using a 0.014 Asahi ProFlex guidewire. The patient was already on Integrilin and was given a 5000-unit bolus of Heparin. A 2.5 x 18 Cypher stent was advanced primarily across the stenosis. The stent was deployed at 12 atmospheres of pressure. Final angiogram demonstrated a satisfactory result. She did have chest pain with balloon inflations. The right coronary was then readdressed due to the finding of what appeared to be a moderate stenosis in the mid right coronary. A #6Fr. AR-1 side-hole guide was used to engage the right coronary and repeat angiography was performed. This demonstrated what appeared to be a nonsignificant lesion in the mid right coronary of approximately 30% to 40% and, therefore, PCI was not performed of the right coronary. The final pressure was obtained and the procedure was terminated.

FINDINGS

HEMODYNAMICS: LV pressure 170/16. Aortic pressure 160/56, with a mean of 98. Continuous LV-to-Ao pullback demonstrated no LV-to-Ao gradient. Final aortic pressure was 190/80. She was given 20 mg of IV Labetalol for this blood pressure.

CORONARY ARTERIOGRAPHY:

1. Right Coronary Artery: The right coronary artery was a dominant vessel which gave rise to posterior descending and posterolateral branches. The mid right coronary had an approximately 30% to 40% stenosis which was smooth. The PDA was a moderate-sized vessel. The posterolateral was relatively small and appeared to have some mild diffuse disease distally estimated to be 30% to 40%.

2. Left Main Coronary Artery: The left main was a large vessel which appeared angiographically normal.

3. Left Anterior Descending Coronary Artery: The left anterior descending was a large vessel which gave rise to a first diagonal branch which was moderate in size and appeared to have an 80% ostial stenosis. The second diagonal was also moderate in size and also appeared to have 50% to 70% ostial stenosis. The LAD itself appeared to have no significant disease present.

4. Left Circumflex Coronary Artery: The circumflex was a moderate-sized vessel which gave rise to a small OM-1 which was free of disease. The second obtuse marginal was large and had a somewhat eccentric 80% stenosis in its proximal one-third. The distal OM had an approximately 50% stenosis distally in the vessel.

POST-PTCA AND STENT ANGIOGRAPHY: Post-PTCA and stent angiography demonstrated no significant residual stenosis within the stented portion of the obtuse marginal. There was a mild degree of disease prior to the stent which was estimated to be 30% or so.

LEFT VENTRICULOGRAPHY: The left ventricle demonstrated apical hypokinesis and a calculated EF of 70%. There was no mitral regurgitation.

IMPRESSION:

1. Preserved LV function with an LVEF of 70% with apical hypokinesis.
2. Coronary artery disease including 80% stenosis in the circumflex marginal.
3. Mild to moderate right coronary disease estimated to be 30% to 40% in the mid vessel.
4. Moderate diagonal disease as described.
5. Successful PTCA and stenting of the circumflex marginal #2 with no residual stenosis.

Joseph Lawton, III, M.D.

JL/rln

DD: 03/19/2007 / DT: 04:01 PM
TD: 03/19/2007 / TT: 10:34 PM
JOB #: 713537

Electronic Signature By: JOSEPH J. LAWTON, III
<<SIGNATURE ON FILE>>

Electronic Signature Date: 03/28/07
Electronic Signature Time: 1437

Joseph Lawton, III, M.D.

JL/rln
DD: 03/19/2007 / DT: 04:01 PM
TD: 03/19/2007 / TT: 10:34 PM
JOB #: 713537

Patient Information

Patient Name		Study Date	MRN	Study #	Adm. ID
WINDHAM, TAMMY		3 /19/2007	M000895682	071675	D00501829048
[redacted]	Age 39	Gender Female	Height *cm* 160.00 (5'3")	Weight *kg* 69.40 (153 lbs)	B.S.A. m^2 1.73

Procedures

Time	Procedure
3:36PM	DX Pulse Oximetry
3:36PM	Left Heart Cath
3:36PM	Coronary Angio
3:36PM	LV or LA Angiogram
4:13PM	TX Pulse Oximetry
4:13PM	Anti-Platelet Therapy
4:24PM	Coronary DES Placement

Staff

		IN	OUT
Diagnostic Cardiologist	Joseph Lawton, M.D.	3:44PM	
Interventional Cardiologist	Joseph Lawton, M.D.	4:13PM	
Scrub	Jim Higgins, RRT	3:35PM	
Circulator	Julie Collins, RN	3:36PM	
Monitor	Jose Carvalho, RRT	3:36PM	

Event Log

Time	Summary	Comment
2:53PM	Phase: Baseline	
2:54PM		Cath Lab: 06
3:36PM		Patient Arrival Time
3:36PM	Procedure: DX Pulse Oximetry	
3:36PM	Procedure: Left Heart Cath	
3:36PM	Procedure: Coronary Angio	
3:36PM	Procedure: LV or LA Angiogram	
3:36PM		Pre-Assessment completed in Holding Area by: JLC
3:36PM		LOC: A&O x 3. Responds purposefully to verbal commands
3:36PM		Baseline Aldrete Score obtained
3:36PM		Lung Sounds auscultated: CTA bilaterally
3:36PM		c/o Chest Pain. On 0-10 scale, level = 1
3:36PM		Pulses: R DP/PT = 3/3
3:36PM		Pulses: L DP/PT = 3/3
3:37PM		Allergies: NKA
3:37PM		NPO Status: No Clear Liquids x minimum 2 hrs
3:37PM		NPO Status: No Solid Intake po x minimum 6 hrs
3:37PM		IV Site(s): X 1 L ARM

3:37PM		IV site(s) patent & w/out redness, pain, or swelling
3:37PM		IV Fluids and IV Meds:
3:37PM	INTEGRILIN 0.75mg/ml IV 11 cc/hr	FROM THE FLOOR
3:37PM	NS IV 20 cc/hr	BY JLC
3:37PM		----------
3:37PM		See MAR for other current medications
3:37PM		Denies current pregnancy
3:37PM		Date of LMP: 3/16/2007
3:38PM		Denies previous anesthesia/sedation complications
3:38PM		Abnormal Lab Results:
3:38PM		Glucose (70-110) = 133
3:38PM		WBC (4.5-11.0) = 13.5
3:38PM		RBC (3.96-5.50) = 5.66
3:38PM		Hgb (12-17) = 11.5
3:38PM		Platelets (150-450) = 459
3:38PM		Intra Procedure Plan of Care Initiated
3:38PM		Consents signed & appropriate
3:38PM		H&P Charted
3:38PM		Procedure Status: Urgent
3:38PM		Basic Supplies:
3:39PM	BASIC PACK	
3:39PM	10 IN PRESSURE TUBING	
3:39PM	1000CC BOTTLE NS SPLASH	
3:39PM	MEDRAD SYRINGE 150CC	
3:39PM	CLIPPER BLADE	
3:39PM	48 IN PRESSURE TUBING	
3:39PM	CONT SYRINGE 8CC	
3:39PM	500CC BAG NS/HEPARIN 1000 UNITS	
3:39PM	500CC BAG NS/HEPARIN 1000 UNITS	
3:39PM	500CC BAG NS	
3:39PM	IV TUBING	
3:39PM		Patient Prep Time
3:39PM		Clipped, prepped and draped R Groin site
3:40PM		Clipped, prepped and draped L Groin site
3:40PM		RISK FACTOR Profile:
3:40PM		Creatinine Assessed on Admission
3:40PM		Admission Creatinine: 0.9
3:40PM		Previous Cardiovascular Treatment: NONE
3:40PM		Family History of CAD Age < 55
3:40PM		Hypertension
3:40PM		History of Tobacco Use: Current
3:40PM		Acute MI W/Admission
3:40PM	SpO2 96%; HR 69 bpm; 184/86/119 NBP; RR 22/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:44PM		Physician Arrived
3:44PM		Diagnostic Physician
3:44PM		----------
3:44PM		Time Out to verify correct patient & correct site
3:44PM		--Radiation protective equipment checked.
3:44PM		--All team members compliant.

3:44PM	SpO2 95%; HR 70 bpm; 183/84/120 NBP; RR 22/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:44PM		Assessment of ASA CLASSIFICATION per MD
3:44PM		ASA Class III: Patient w/ Severe Systemic Disease
3:44PM		Class III = Visualization of soft palate & uvular base
3:46PM	VERSED IV 2 mg	BY JLC
3:48PM		Procedure Start Time
3:49PM	# 4F CORDIS SHEATH	NOT USED
3:49PM	# 5F CORDIS SHEATH	NOT USED
3:49PM	SpO2 98%; HR 77 bpm; 178/78/106 NBP; RR 12/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:49PM		Site anesthesized: R GROIN
3:50PM	LIDOCAINE 2% SQ 13.00 cc	DR LAWTON
3:50PM		Cannulated
3:50PM	NEEDLE COOK	
3:50PM	WIRE .035 3MM 175 cm	
3:50PM		Number of sticks required: 1
3:50PM	# 6F CORDIS SHEATH	
3:50PM		Access Site: Right Femoral Artery
3:51PM		catheter in:
3:52PM	# 6F 145 PIGTAIL	
3:52PM		Label & Measure LV
3:52PM	LV : 180/1/16, Max dP/dt = 7872, HR = 73, I	
3:52PM	Snapshot: LV : 180/1/16	
3:52PM	LV : 182/1/16, Max dP/dt = 7872, HR = 77, I	
3:52PM		Setup & Record LVEDP
3:52PM	Snapshot: LV : 182/1/16	
3:52PM	LV : 170/4/16, Max dP/dt = 30432, HR = 70, I	
3:53PM	Phase: Post Angio	
3:53PM		LV Gram done
3:53PM	Aortic : Valve Area *** cm^2	
3:53PM	Pullback from LV to AO	
3:53PM	Snapshot: Gradient Measurement: Valve Area Measures	
3:53PM	Snapshot: Pullback: LV to AO.	
3:53PM	AO : 161/56/98, HR = 73, I	
3:54PM		Pullback LV to AO
3:54PM		catheter out
3:54PM		catheter in:
3:54PM	# 6F JL 4.0	
3:54PM	SpO2 95%; HR 81 bpm; 174/79/109 NBP; RR 26/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:57PM		Visualized Left Coronary System
3:59PM	SpO2 95%; HR 73 bpm; 166/74/109 NBP; RR 28/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:03PM		catheter out

4:03PM		catheter in:
4:03PM	# 6F JR4.0	
4:04PM	SpO2 93%; HR 80 bpm; 174/82/118 NBP; RR 24/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:09PM	SpO2 93%; HR 78 bpm; 174/92/135 NBP; RR 29/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:12PM		catheter out
4:12PM	HEPARIN IA 5000 units	BY DR LAWTON
4:13PM		Interventional Physician
4:13PM	Procedure: TX Pulse Oximetry	
4:13PM	Procedure: Anti-Platelet Therapy	
4:13PM		Interventional Supplies:
4:13PM	INFLATION DEVICE	
4:13PM	INTEGRILIN HIGH DOSE	
4:13PM	STOPCOCK	
4:13PM	STOPCOCK	
4:13PM	VAC LOCK SYRINGE	
4:13PM	NTG 200 mcg/ml IV 1.50 cc/hr	STARTED BY JLC
4:14PM		PCI Status: Urgent
4:14PM		Guide catheter in:
4:14PM	GUIDE # 6F XB 3.0	
4:14PM	SpO2 92%; HR 72 bpm; 171/86/129 NBP; RR 28/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:18PM		Guiding catheter out
4:18PM		Guide catheter in:
4:18PM	GUIDE # 6F JL 3.5	
4:19PM	SpO2 93%; HR 68 bpm; 174/84/128 NBP; RR 22/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:22PM		Wire used:
4:22PM	ASAHI PROWATER FLEX 180	
4:24PM	NTG 200 mcg/ml IV 3.00 cc/hr	INCREASED BY JLC
4:24PM	SpO2 95%; HR 77 bpm; 189/98/145 NBP; RR 31/min	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:24PM	Procedure: Coronary DES Placement	
4:25PM		Segment: Mid CIRC
4:25PM		STENT in:
4:25PM	CYPHER 2.5 X 18 RX	
4:25PM		30 SEC @ 12 ATMS
4:25PM		Stent Deployed
4:25PM		Inflations: (to stent)
4:25PM	Phase: Post Stent Deployment	
4:26PM	NTG 200 mcg/ml IV 6 cc/hr	BY JLC
4:26PM		Stent delivery balloon out
4:27PM	NTG IC 250 mcg	BY J HIGGINS
4:29PM	NTG IC 200 mcg	BY J HIGGINS
4:29PM	SpO2 96%; HR 80 bpm; 189/89/124 NBP; RR 24/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort

4:32PM		Wire out
4:32PM		Guiding catheter out
4:33PM		Guidc catheter in:
4:33PM	GUIDE # 6F AR 1 SH	
4:34PM		Denies Pain or Discomfort
4:34PM	SpO2 93%; HR 74 bpm; 201/93/141 NBP; RR 20/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert.Denies Pain or Discomfort
4:35PM		Final AO Pressure
4:35PM	AO : 199/79/134, HR = 79, I	
4:35PM	Snapshot: AO : 199/79/134	
4:35PM		Guiding catheter out
4:36PM	LABETALOL IV 20 mg	BY JLC
4:36PM		Procedure Finish Time
4:38PM		Number of STENTS used per VESSEL: X 1 CX
4:38PM		Post-Procedure EF: 60%
4:39PM		Interventional Outcome: Successful
4:39PM		Post Procedure Assessment:
4:39PM		Patient Disposition: Telemetry Bed
4:39PM		IABP not used
4:39PM		Verbal orders during case because MD in sterile gloves & gown
4:39PM		Read Back verification completed for all verbal orders -- JLC
4:39PM		----------
4:39PM		Total Contrast Infused: 350 ML
4:39PM	SpO2 97%; HR 75 bpm; 152/79/108 NBP; RR 17/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert.Denies Pain or Discomfort
4:40PM	200CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	
4:41PM		Patient Transfer Time

Aldrete Score – Pre Study

Pre-Study Conscious Sedation Assessments	
Activity	2 - Able to move 4 extremities voluntarily or on command
Respirations	2 - Able to breathe deeply and cough freely
Circulation	2 - BP +/- 20% of pre-anesthetic level
Consciousness	2 - Fully Awake
O2 Saturation	2 - Able to maintain O2 saturation > 92% on room air
Pre-study Totals	10

Materials

Time	Item Name (Model)	Comment
3:39PM	BASIC PACK	
3:39PM	10 IN PRESSURE TUBING	

002438

3:39PM	1000CC BOTTLE NS SPLASH	
3:39PM	MEDRAD SYRINGE 150CC	
3:39PM	CLIPPER BLADE	
3:39PM	48 IN PRESSURE TUBING	
3:39PM	CONT SYRINGE 8CC	
3:39PM	500CC BAG NS/HEPARIN 1000 UNITS	
3:39PM	500CC BAG NS/HEPARIN 1000 UNITS	
3:39PM	500CC BAG NS	
3:39PM	IV TUBING	
3:49PM	# 4F CORDIS SHEATH	NOT USED
3:49PM	# 5F CORDIS SHEATH	NOT USED
3:50PM	NEEDLE COOK	
3:50PM	WIRE .035 3MM 175 cm	
3:50PM	# 6F CORDIS SHEATH	
3:52PM	# 6F 145 PIGTAIL	
3:54PM	# 6F JL 4.0	
4:03PM	# 6F JR4.0	
4:13PM	INFLATION DEVICE	
4:13PM	INTEGRILIN HIGH DOSE	
4:13PM	STOPCOCK	
4:13PM	STOPCOCK	
4:13PM	VAC LOCK SYRINGE	
4:14PM	GUIDE # 6F XB 3.0	
4:18PM	GUIDE # 6F JL 3.5	
4:22PM	ASAHI PROWATER FLEX 180	
4:25PM	CYPHER 2.5 X 18 RX	
4:33PM	GUIDE # 6F AR 1 SH	
4:40PM	200CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	
4:40PM	50CC BOTTLE OPTIRAY	

X-Ray Summary

Total Dose	0.00 cGycm2	**Fluoro Time**	10.80 Minutes

Contrast Summary

Contrast	Total (ml)
Optiray Used	350.00

Complications

Time	Complication	Comment
4:40PM	None	

Vital Signs

Time	SpO2	HR	BP	RR	Comment
3:40PM	96	69	184/86/119	22.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:44PM	95	70	183/84/120	22.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:49PM	98	77	178/78/106	12.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:54PM	95	81	174/79/109	26.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
3:59PM	95	73	166/74/109	28.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:04PM	93	80	174/82/118	24.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:09PM	93	78	174/92/135	29.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:14PM	92	72	171/86/129	28.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:19PM	93	68	174/84/128	22.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:24PM	95	77	189/98/145	31.00	LOC: Responds purposefully to verbal commands. c/o Chest Pain. On 0-10 scale, level = 1 . SEDATION SCALE: 0 = Alert.
4:29PM	96	80	189/89/124	24.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort
4:34PM	93	74	201/93/141	20.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert.Denies Pain or Discomfort
4:39PM	97	75	152/79/108	17.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert.Denies Pain or Discomfort

Medication Events

Start	Stop	Medication	Route	Amount	Units	Comments
3:37PM		INTEGRILIN 0.75mg/ml	IV	11.00	cc/hr	FROM THE FLOOR
3:37PM		NS	IV	20.00	cc/hr	BY JLC
3:46PM		VERSED	IV	2.00	mg	BY JLC
3:50PM	3:50PM	LIDOCAINE 2%	SQ	13.00	cc	DR LAWTON
4:12PM		HEPARIN	IA	5000.00	units	BY DR LAWTON
4:13PM	4:24PM	NTG 200 mcg/ml	IV	1.50	cc/hr	STARTED BY JLC
4:24PM	4:26PM	NTG 200 mcg/ml	IV	3.00	cc/hr	INCREASED BY JLC
4:26PM		NTG 200 mcg/ml	IV	6.00	cc/hr	BY JLC
4:27PM		NTG	IC	250.00	mcg	BY J HIGGINS
4:29PM		NTG	IC	200.00	mcg	BY J HIGGINS
4:36PM		LABETALOL	IV	20.00	mg	BY JLC

Circulator Signature

Initials	Signature	Title	Time

Monitor Signature

Initials	Signature	Title	Time
JC	Jose A. Carvalho	RRT/CVT	448PM

Acknowledging Arrival of Patient from Cath Lab:

Signature Lauren Tagg, RN **Time:** 1710

Physicians Signature [illegible]

2435 FOREST DRIVE
COLUMBIA,SC 29204

002441

Patient Information

Patient Name		Study Date	MRN	Study #	Adm. ID
[redacted]MMY		3 /19/2007	M000895682	071675	D00501829048
	Age	Gender	Height *cm*	Weight *kg*	B.S.A. m^2
	39	Female	160.00 (5'3")	69.40 (153 lbs)	1.73

Pressure Results (mmhg)

Baseline

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
LV	170	4	16				30432	70

Post Angio

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	161	56		98				73

Post Stent Deployment

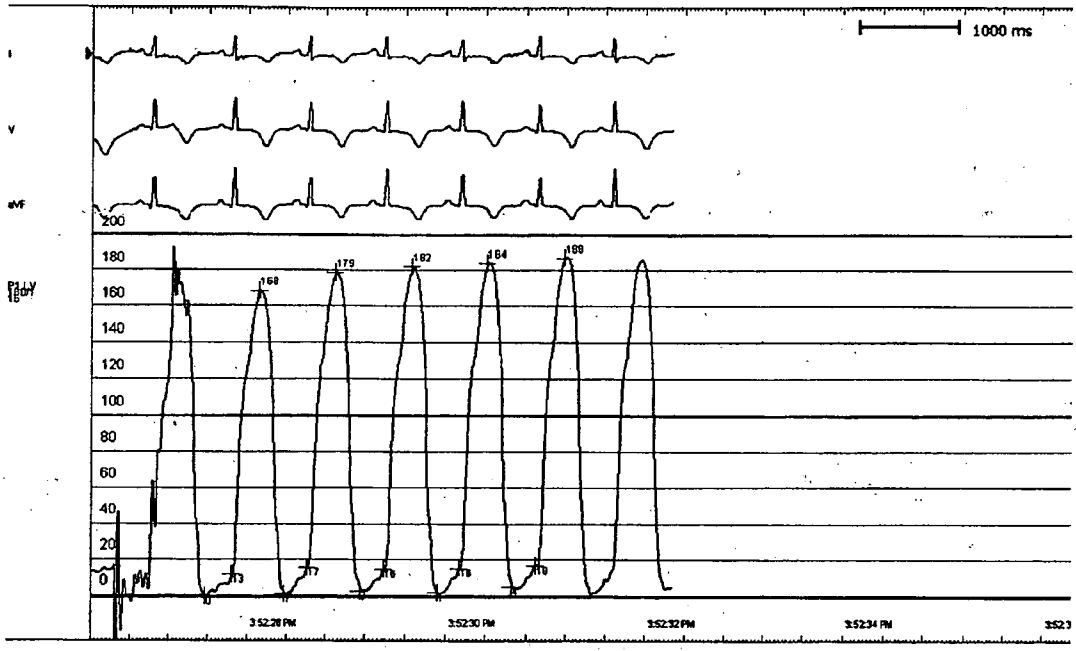
Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	199	79		134				79

Valve Results

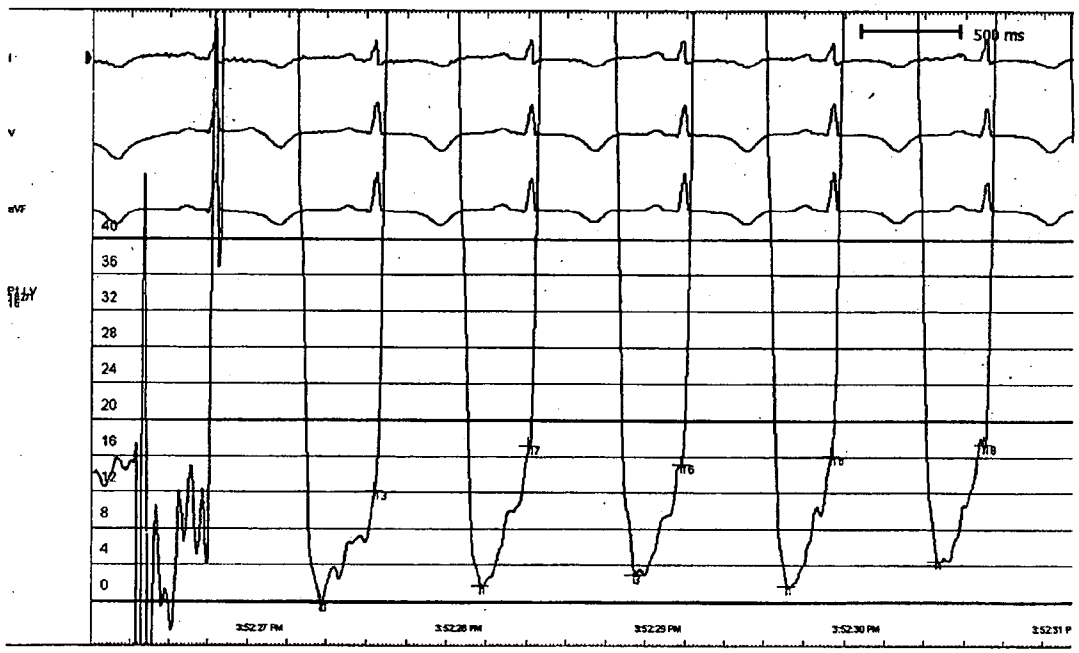
Post Angio

Valve	Grad (mmhg)	Flow (ml/s)	Area (cm^2)	Area Index (cm^2/m^2)	Sep/Dfp (sec/min)
Aortic	12.65				28.60

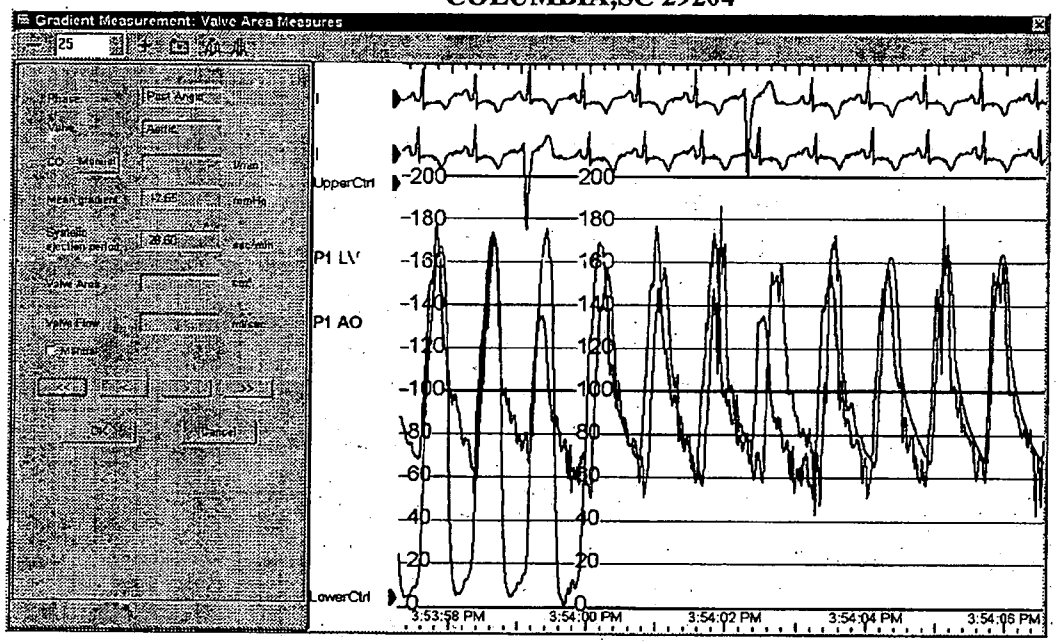
Snapshot: LV : 180/1/16



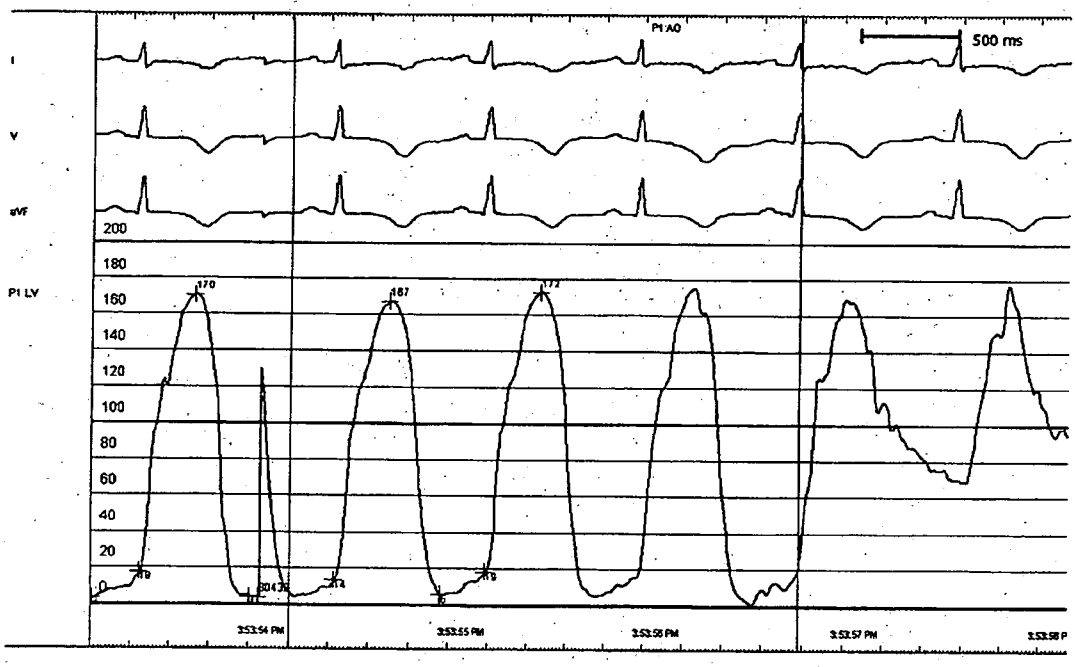
Snapshot: LV : 182/1/16



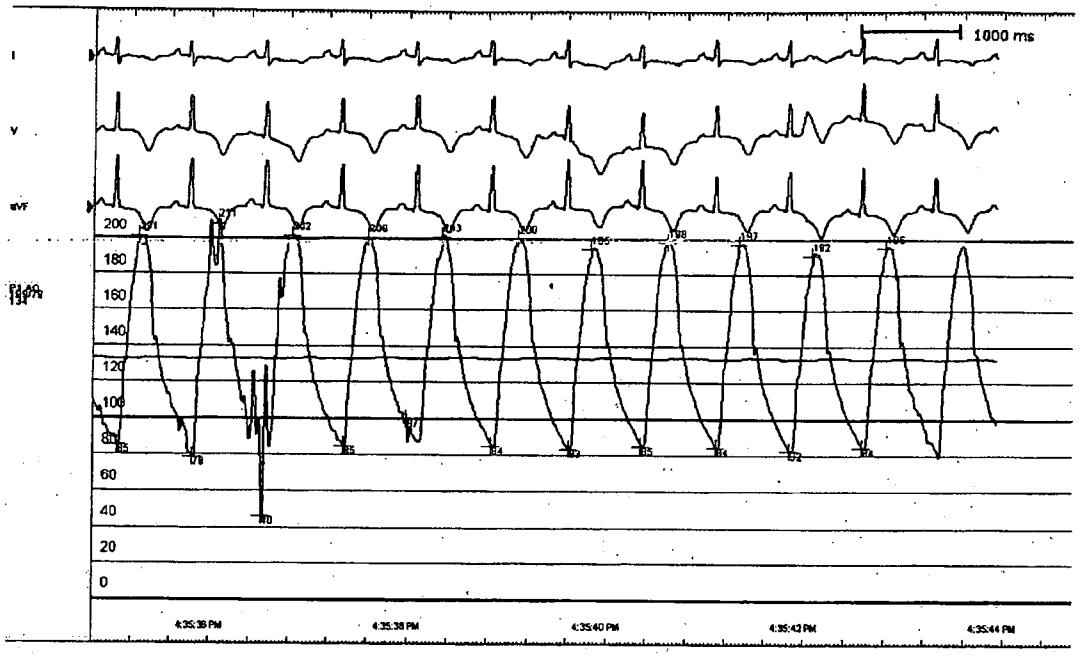
Snapshot: Gradient Measurement:



Snapshot: Pullback: LV to AO.



Snapshot: AO : 199/79/134


1000 ms
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4:35:42 PM
4:35:44 PM

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PROVIDENCE HOSPITALS
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2435 FOREST DRIVE/COLUMBIA, SC 29204
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Medical Director of Laboratories
120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203
PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E
REG DR: JUK,S STANLEY
OTH DR: JUK,S STANLEY

ACCT #: D00501829048 **LOC:** D.4H **U #:** M000895682
AGE/SX: 39/F **ROOM:** D.H457 **REG:** 03/18/07
BED: A **DIS:**
TLOC:

**********CHEMISTRY**********

Date Time	3/20/07 0310	3/18/07 1615	Reference	Units
SODIUM	136	137	(136-145)	MMOL/L
POTASSIUM	4.0	3.6	(3.6-5.2)	mmol/L
CHLORIDE	101	103	(98-107)	MMOL/L
CARBON DIOXIDE	25	24	(21-32)	MMOL/L
ANION GAP	14	14	(10-20)	
GLUCOSE	109	133 H	(70-110)	MG/DL
BUN	10	9	(7-20)	MG/DL
CREATININE	0.7	0.9	(0.6-1.3)	MG/DL
BUN/CREA RATIO	14	10		
CALCIUM	8.8	9.0	(8.8-10.5)	mg/dl
MAGNESIUM		1.9	(1.6-2.4)	mg/dl
TRIGLYCERIDES	122		(30-150)	MG/DL
CHOLESTEROL	157		(100-200)	MG/DL
DL CHOLESTEROL	33 L		(40-60)	MG/DL
LDL	99.6(a)			MG/DL
VLDL CHOLESTERO	24		(0-40)	
CORONARY RISK	4.8 H		(3.0-4.5)	

NOTES: (a) REFERENCE RANGE FOR LDL IS LESS THAN 130

RUN DATE: 03/20/07 **RUN TIME:** 2101
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PATIENT: WINDHAM,TAMMY E	ACCT #: D00501829048	LOC: D.4H	U #: M000895682
	AGE/SX: 39/F	ROOM: D.H457	REG: 03/18/07
REG DR: JUK,S STANLEY	[redacted]	BED: A	DIS:
OTH DR: JUK,S STANLEY	STATUS: ADM IN	TLOC:	

**********CHEMISTRY CONTINUED**********

**********CARDIAC MARKERS**********

Date	3/20/07	----------3/19/07----------			
Time	0310	1815	0315	Reference	Units
CK TOTAL	127	**234 H**	**613 H**	(21-232)	U/L
CKMB TOTAL	10.7(b) H	**22.2(b) H**	**90.8(b) H**	(0-5)	NG/ML
CKMB INDEX	8.4(c)	9.5(c)	14.8(c)		%
TROPONIN I/REFL	6.14(d) H	**10.54(d) H**	**23.51(d) H**	(0.00-0.6)	NG/ML

Date	----------3/18/07----------				
Time	2135	1615		Reference	Units
CK TOTAL	**1009 H**	**1263 H**		(21-232)	U/L
CKMB TOTAL	**143.3(b) H**	**183.9(b) H**		(0-5)	NG/ML
CKMB INDEX	14.2(c)	14.6(c)			%
TROPONIN I/REFL	**34.93(d) H**	**38.21(d) H**		(0.00-0.6)	NG/ML

NOTES: (b)

CKMB INDEX IS NOT CALCULATED ON CKMB TOTAL LESS THAN 5 OR IF A CK TOTAL IS NOT ORDERED

(c)

IMPRESSION	CKMB (NG/ML)	CKMB INDEX
1. NEGATIVE	<5	NOT CALCULATED
2. SUSPICIOUS	> OR = 5	1.1 - 2.5 %
3. MYOCARDIAL INJURY	> OR =5	> OR = 2.5%

THE CKMB INDEX CAN NOT BE CALCULATED WITHOUT A TOTAL CK
THE CKMB INDEX IS NOT CALCULATED ON CKMB TOTALS LESS THAN 5.

(d)

THIS IS A TROPONIN I WITH REFLEX. A CK TOTAL, CKMB TOTAL AND A CKMB INDEX WILL BE PERFORMED ONLY IF TROPONIN I IS GREATER THAN 0.6 NG/ML

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PATIENT: WINDHAM,TAMMY E.
REG DR: JUK,S STANLEY
OTH DR: JUK,S STANLEY

ACCT #: D00501829048 **LOC:** D.4H **U #:** M000895682
AGE/SX: 39/F [redacted] **ROOM:** D.H457 **REG:** 03/18/07
BED: A **DIS:**
TLOC:

**********HEMATOLOGY**********

Date	3/20/07		3/18/07		
Time	1510	0310	1615	Reference	Units
WHITE BLOOD CEL	10.8 H	10.9 H	**13.5 H**	(3.53-9.57	K/UL
RBC	4.59	4.74	**5.66 H**	(3.96-5.50	M/UL
HEMOGLOBIN	9.5 L	9.9 L	**11.5 L**	(12.14-16.	GM/DL
HEMATOCRIT	30.6 L	31.6 L	37.3	(35.39-47.	%
MCV	66.6 L	66.7 L	**65.8 L**	(76.9-94.7	FL
MCH	20.7 L	20.8 L	**20.4 L**	(25.79-32.	PG
MCHC	31.03 L	31.16 L	**30.99 L**	(33.34-35.	G/DL
RED CELL DISTRI	20.15 H	20.11 H	**20.65 H**	(12.09-15.	%
PLATELET COUNT	315	343	**459 H**	(169.06-41	K/MM3
MPV	8.6	8.7	10.0	(7.54-11.2	FL
GRANULOCYTE %		77.0 H	**78.2 H**	(41.72-73.	%
LYMPHOCYTE %		15.8 L	**15.5 L**	(18.43-44.	%
MONOCYTE %		5.1	4.7	(1.7-9.3)	%
EOSINOPHIL %		1.5	1.5	(0.72-8.06	%
BASOPHIL %		0.6	**0.1 L**	(0.17-1.43	%
GRANULOCYTE #		8.4 H	**10.6 H**	(1.66-6.72	K/mm3
LYMPHOCYTE #		1.7	2.1	(0.92-2.66	K/mm3
MONOCYTE #		0.6	0.6	(0.24-0.78	K/mm3
EOSINOPHIL #		0.2	0.2	(0.04-0.52	K/mm3
BASOPHIL #		0.1 H	**0.0 L**	(0.01-0.09	K/mm3

RUN DATE: 03/20/07 **RUN TIME:** 2101
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PATIENT:	WINDHAM,TAMMY E	ACCT #:	D00501829048	LOC: D.4H	U #: M000895682
		AGE/SX:	39/F	ROOM: D.H457	REG: 03/18/07
REG DR:	JUK,S STANLEY	DOB:	[redacted]	BED: A	DIS:
OTH DR:	JUK,S STANLEY	STATUS:	[redacted]	TLOC:	

**********COAGULATION**********

Date	3/19/07				
Time	1810			Reference	Units
ACTIVATED CLOTT	178 H			(110-150)	SECONDS

RUN DATE:03/20/07 RUN TIME: 2101
Patient: WINDHAM,TAMMY E Age/Sex: 39/F Acct#D00501829048 Unit#M000895682

PROVIDENCE HOSPITALS

002449

Sisters of Charity Providence Hospitals Consent to Participate in a Registry Study
Strategic Transcatheter Evaluation of New Therapies (STENT) Registry

Your doctor at Sisters of Charity Providence Hospitals is asking you to participate in this registry of coronary interventional devices because you will be/ or were treated with a coronary interventional device. This registry involves 9 centers and greater than 10,000 patients from around the country.

After devices have been approved by the Food and Drug Administration (FDA), physicians begin using them on large numbers of people. It is hoped that by creating a network of centers contributing to one registry, the source of patients will be greater than in a single center registry and because of this more may be learned about the success and safety of new devices. The purpose of the registry is to increase the information available to physicians caring for patients with coronary artery disease undergoing interventional procedures. Your participation may last up to 5 years.

The registry will include a collection of medical history as well as other demographics (statistics about you), information about your symptoms and the type of procedure you had performed. Outcomes of your procedure will also be recorded. You will be contacted by telephone or letter at nine months and annually thereafter for up to 5 years to ask you about your cardiac history since your last follow-up.

Risks to privacy are minimized by removing individually identifiable information prior to submission to the registry website at The Stuart Dickson Institute for Health Services.

Your participation is completely voluntary. You are free to withdraw from the registry if you change your mind. Should you choose to withdraw consent, no further follow-up related to the registry will be done, but we will maintain the information already collected up to that time. Your decisions regarding your participation or withdrawal will in now way affect your medical care.

In reports that we might publish and on the registry website, we will not include any information that will make it possible to identify the patient. Your records for the study may, however, be reviewed and/or photocopied by Sisters of Charity Providence Hospitals, its IRB, Principal Investigator and/or his designee, or by representatives of the Food and Drug Administration (FDA), and other governmental/auditing agencies.

The researchers doing this study at Sisters of Charity Providence Hospitals are the practicing interventional cardiologists. The Primary Investigators for this study at this site are Dr. Stan Juk and Dr. Lee Butterfield. The overall coordinating site is the Sanger Clinic in Charlotte, NC. You may ask questions about the conduct of the study now or later by contacting Dr. Juk, Dr. Butterfield, any of their colleagues or Sisters of Charity Providence Hospitals Research Office at:

Dr. S. Juk Columbia Cardiology Consultants 2601 Laurel Street Columbia, SC 29204 803 744-4900	Dr. Lee Butterfield South Carolina Heart Center 2001 Laurel Street Columbia, SC 29204 803-254-3278	Sisters of Charity Providence Hospitals Research Office 2435 Forest Drive Columbia, SC 29204 803 256-5772

If you have questions about your rights as a research subject you may call the chairperson of the Institutional Review Board of Sisters of Charity Providence Hospitals at 803 256-5310.

Consent

I have read the above information. I have asked any questions I had and those questions have been answered. I agree to be in this registry. I give the research staff access to my entire medical record for the duration of the study or until I revoke it in writing to Dr. Juk at any of the above addresses. I will receive a copy of this consent form.

Tammy E. Windham — 3/19/2007
Patient (guardian) Print Name — Date

X Tammy Windham — _____
Patient (guardian) Signature — Date

Betty Stokes BSN RN — 3/21/2007
Signature of person Obtaining Consent — Date

APPROVAL STAMP
PROVIDENCE HOSPITALS
INSTITUTIONAL REVIEW BOARD
Chairman — 5/2/06 Date

NUR 015
STENT Registry
5/31/06

White Copy - Patient's Medical Record Yellow Copy - Research Office Pink Copy - Patient's Copy

1032

6236

WINDHAM,TAMMY E
A# D0050182904[redacted]
03/18/07 F 39
JUK,S STANLEY

002450

CONSENT FOR DIAGNOSTIC PROCEDURES AND TREATMENT PROCEDURES IN THE HEART CATHETERIZATION LABORATORY

PATIENT: _____ AGE: _____ SEX_____
ROOM #: _____ ACCOUNT #: _____

NOTE: This consent form includes any and/of all of the following procedures:

Left and/or Right Catheterization Angiography
(PTCA) Percutaneous Transluminal Coronary Angioplasty
(PTDCA) Percutaneous Transluminal Directional Coronary Atherectomy
(PTRCA) Percutaneous Transluminal Rotational Coronary Ablation
Intracoronary Ultrasound Imaging
Intra Aortic Balloon Pump Insertion
Intracoronary Stent(s) Implantation
Atherotomy

I hereby voluntarily consent to the performance of cardiac catheterization and angiography on me by the physicians and their designated assistants. Those physicians are **Dr(s). S.Juk, J.Lawton, M.Roberts, E. Schwarz, T. Hearon, R. Umbach, R. Malanuk, T. Williams.** I also consent to the treatment of diagnosed coronary artery disease including but not limited to PTCA (balloon procedure), PTDCA (Atherectomy), PTRCA (Rotablator), PTEC (TEC Device), Intracoronary Ultrasound Imaging, and Intra Aortic Balloon Pump insertion by the above physicians, their assistants, nursing and technical personnel. If emergency surgery is required the above doctors have my permission to retain a surgeon to perform such an operation. I understand that I am undergoing these procedures to aid in the diagnosis and treatment for my condition, which has been explained to me. Although complications from these procedures are rare and can usually be treated without serious consequence, I understand that complications can occur and may be serious. Major complications include, but are not limited to stroke, changes in heart rhythm, disruption of a vessel (dissection), nerve injury, dislodgement of atherosclerotic plaque, bleeding from a vessel, bleeding into the pericardial sac, adverse reaction to dye that may be mild (hives) to serious (respiratory distress) and myocardial infarction (heart attack) and potential need for **Emergent Coronary Artery Bypass Grafting by Dr(s). Sutton Jr., Smith, Allen, Yarborough, Leppard, Zurcher, Sutton III.** Death has been reported to occur as a result of this procedure, but in our experience this is infrequent. The most common minor complication is closure or clot in the blood vessel used. Infection is always a minor risk during any invasive procedure. My physician advises that the indications for cardiac catheterization and angiography and the treatment of diagnosed coronary artery disease in my case outweigh any risks involved. I have been given an opportunity to ask questions about my condition, alternative forms to these procedures, anesthesia and blood transfusion (options, risks and alternatives), risks of non-treatment, the procedures to be used and the risks and hazards involved. Therefore, I believe I have sufficient information to give this informed consent. I hereby release Providence Hospital and its agents, employees and designees from liability or responsibility of any kind for damages arising out of or in connection with my consent to this treatment. My consent is given freely, voluntarily and with full knowledge of all of the above written statements.

X Tammy E Windham — Thomas Lindsey B Talbott
Patient or Authorized Person Signature — Witness

Self — 3/19/07 0205
Relationship to Patient — Date — Time

I have discussed with the patient and/or patient's representative the risks, benefits, potential complications, and alternative options associated with the planned procedure, possible use of blood, and sedation/analgesic if appropriate, answered the patient's questions and obtained his/hers permission to proceed.

_____ **Physician's Signature/Date**

1033

895[illegible] 03/19/2007 05:49:42 PM WINDHAM TAMMY E
39 years Female

PROVIDENCE HOSPITAL
De[illegible] 12
Room: 457
Oper: 16

002451

Rate 67
PR 165
QRSD 79
QT 498
QTc 526

--AXIS--
P 64
QRS 67
T 245

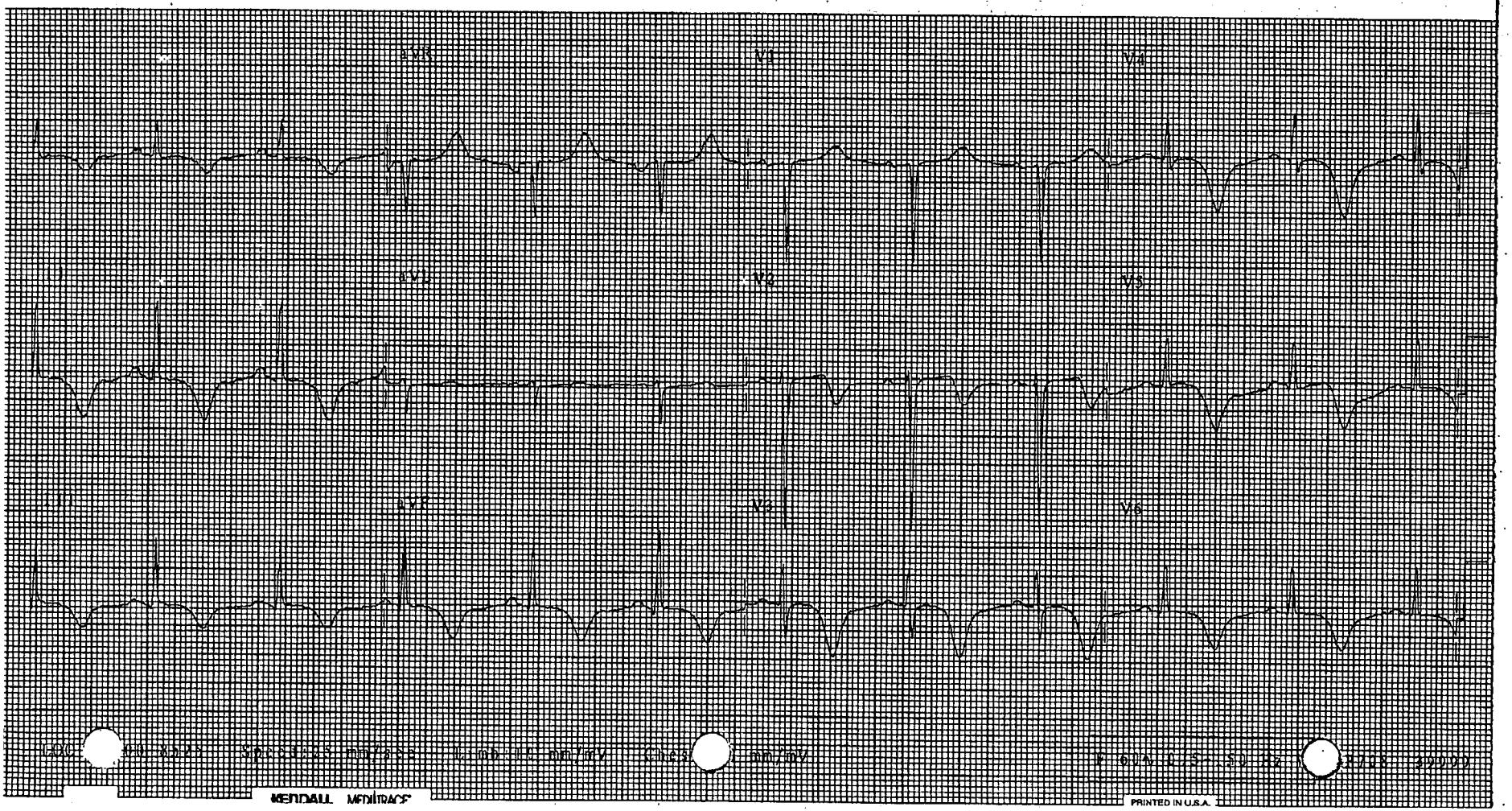
. Normal sinus rhythm, rate 67
. LVH with ST-T abnormalities
. Diffuse T wave abnormalities,
. . Also consistent with ischemia

Requested by:
161

1034

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



6238

895682 03/20/2007 05:27:56 PM WINDHAM, TAMMY E.
39 years Female

PROVIDENCE HOSPITAL
Dept: 12
Room: 457
Oper: 0.8

6239

lower left forearm pain

002452

Rate	59	. Normal sinus rhythm, rate 59
PR	163	. QT interval long for rate
QRSD	83	. Diffuse T wave abnormalities,
QT	500	. . . Consistent with ischemia
QTc	495	

--AXIS--

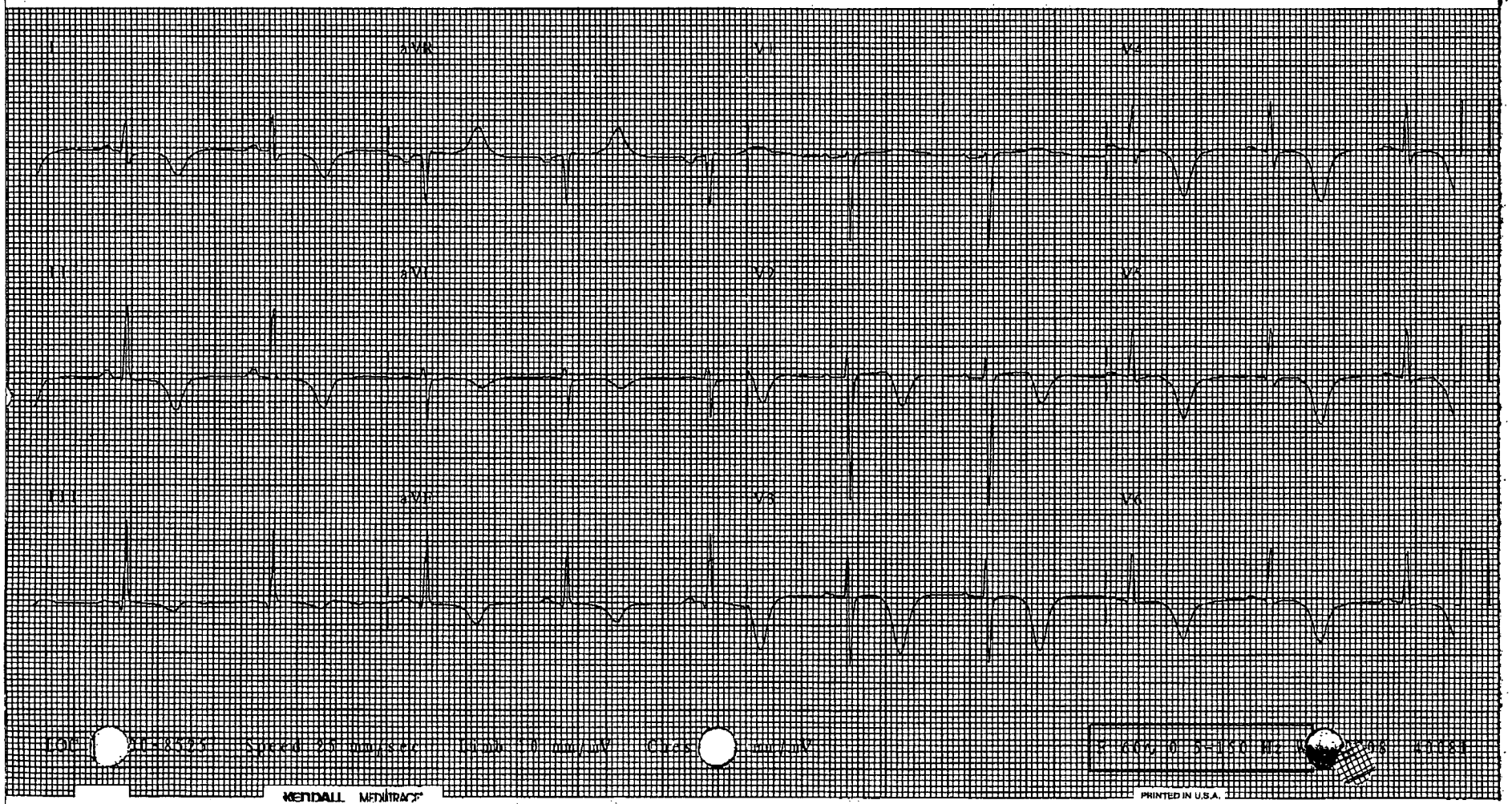
P	42
QRS	70
T	222

Requested by:
161

1035

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



895682 03/20/2007 03:14:23 AM WINDHAM TAMMY E
39 years Female

PROVIDENCE HOSPITAL
Dept: 12
Room: 457
Oper: 66

6240

1036

Rate 70
PR 163
QRSD 85
QT 463
QTc 500

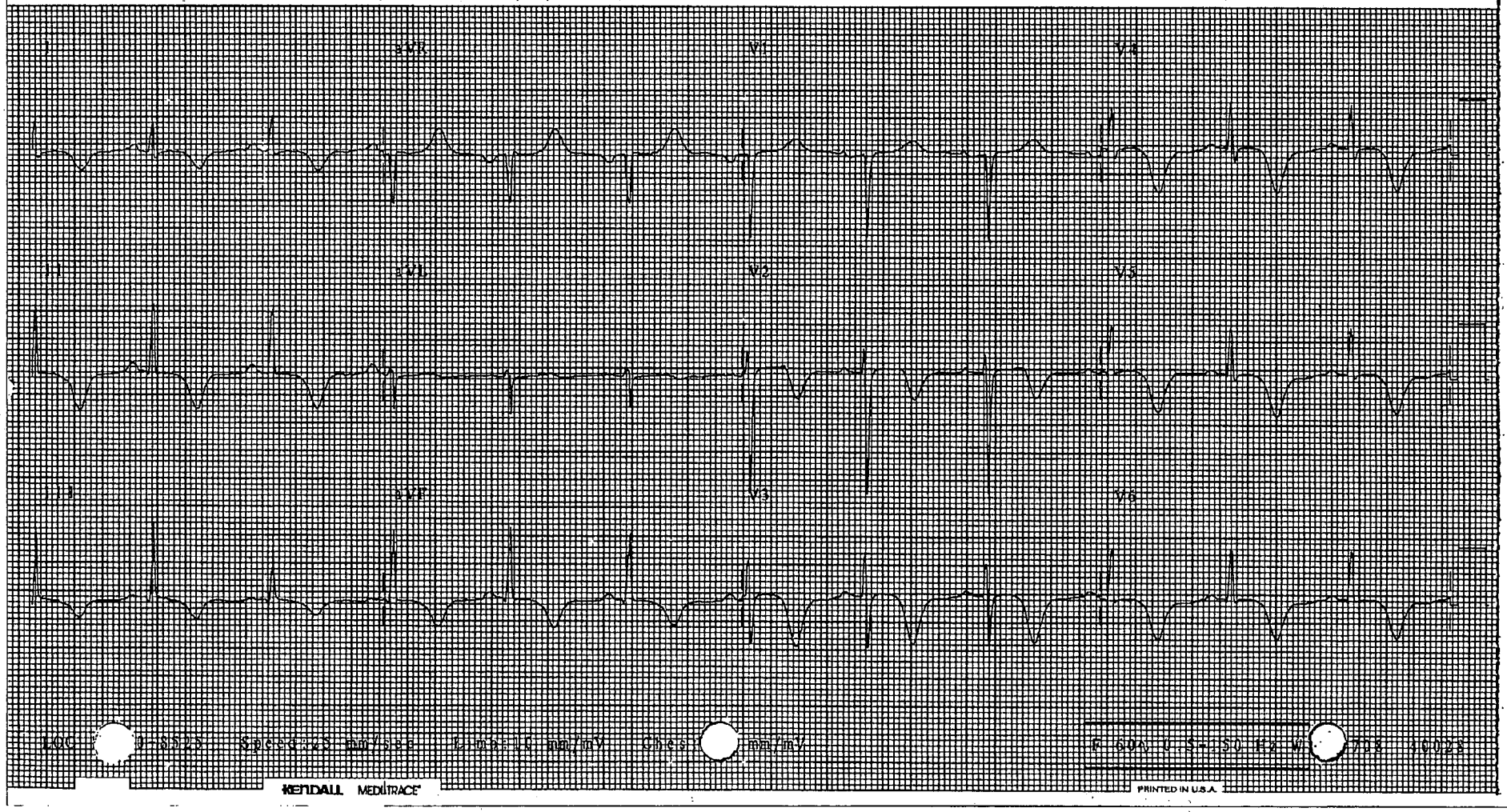
--AXIS--
P 49
QRS 66
T 242

. Normal sinus rhythm, rate 70
. QT interval long for rate
. Diffuse ST-T abnormalities,
. . Consistent with ischemia

Requested by:
161

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



KENDALL MEDITRACE
PRINTED IN U.S.A.

895682 03/21/2007 03:15:42 AM WINDHAM TAMMY E
39 years Female

PROVIDENCE HOSPITAL
Dept: 12
Room: 457
Oper: 66

6241

10454

Rate	59
PR	176
QRSD	99
QT	504
QTc	499

--AXIS--

P	54
QRS	63
T	227

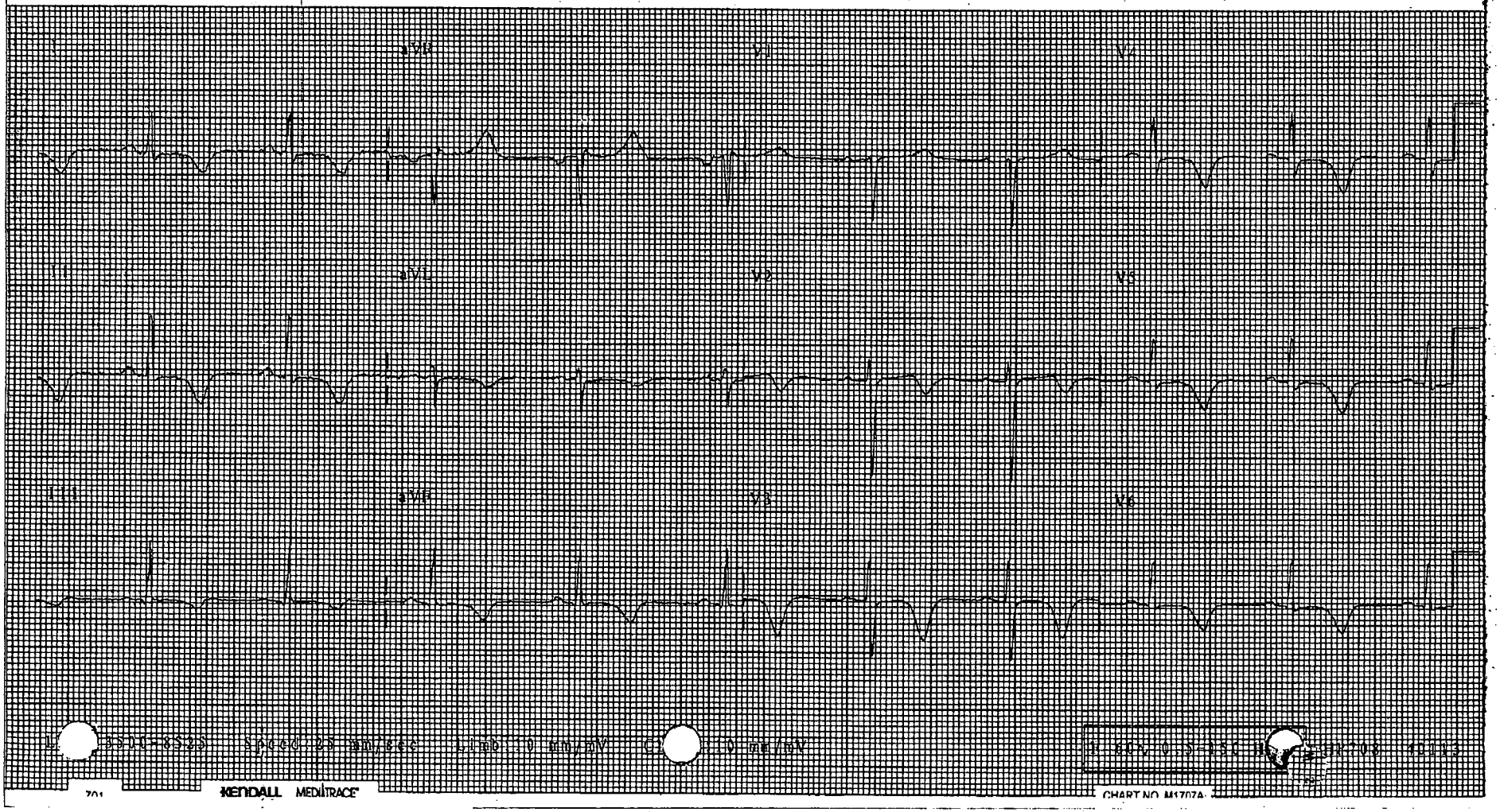
. Normal sinus rhythm, rate 59
. QT interval long for rate
. Diffuse T wave abnormalities,
. . Consistent with ischemia

Requested by:
161

1037

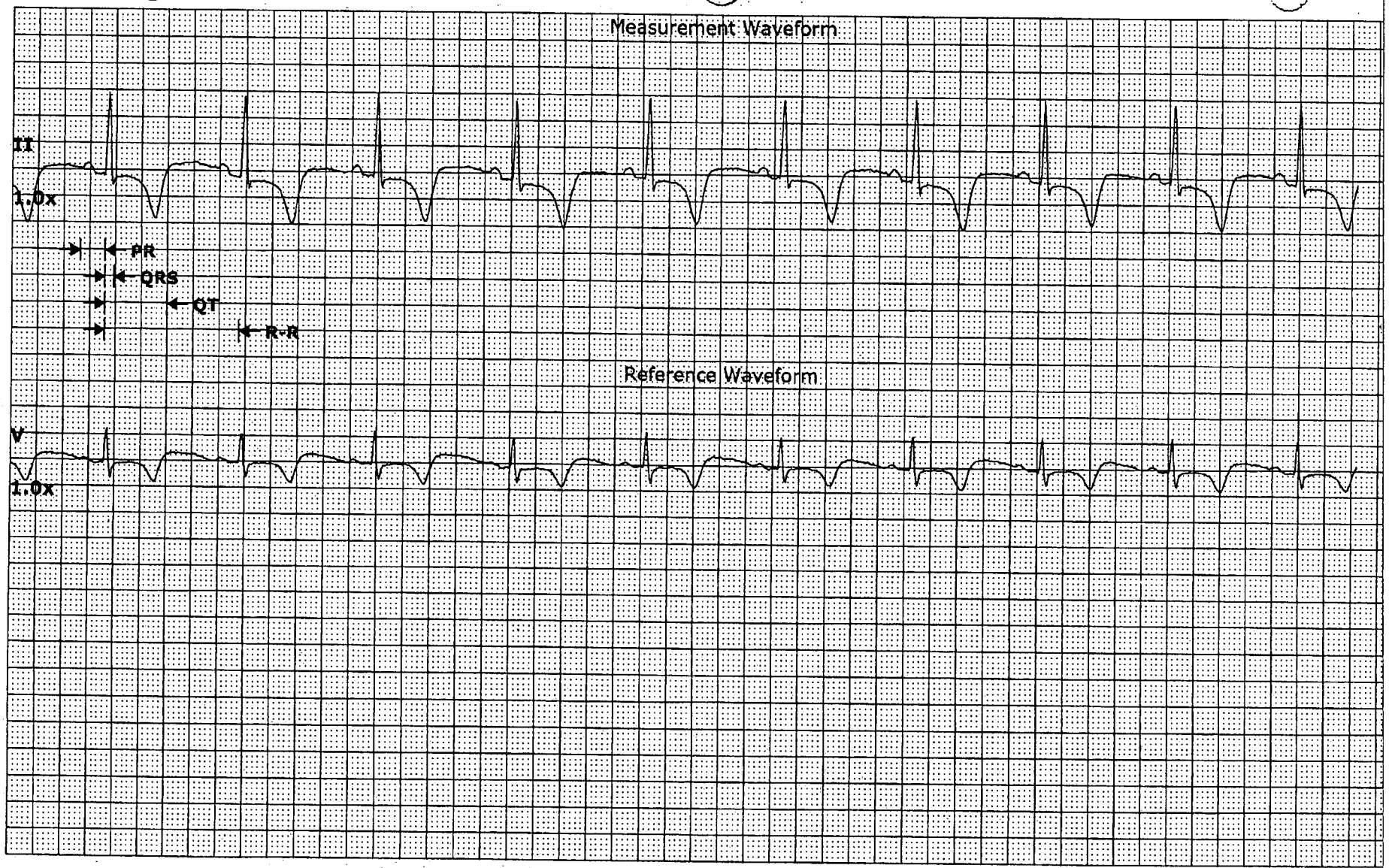
- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



WINDHAM TA Y 999999999 **Caliper easurements** **4HI**

21-Mar-2007 07:[illegible]0 - 21-Mar-2007 07:28:00



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.190	sec	QT	= 0.486	sec
QRS	= 0.073	sec	R-R	= 1.039	sec
QTc	= 0.477	sec	Rate	= 58	bpm

SR rem

GE Medical Systems Information Technologies

CIC Version 5.0.3

Wednesday, March 21, 2007 7:29:16 AM

002455

25 m

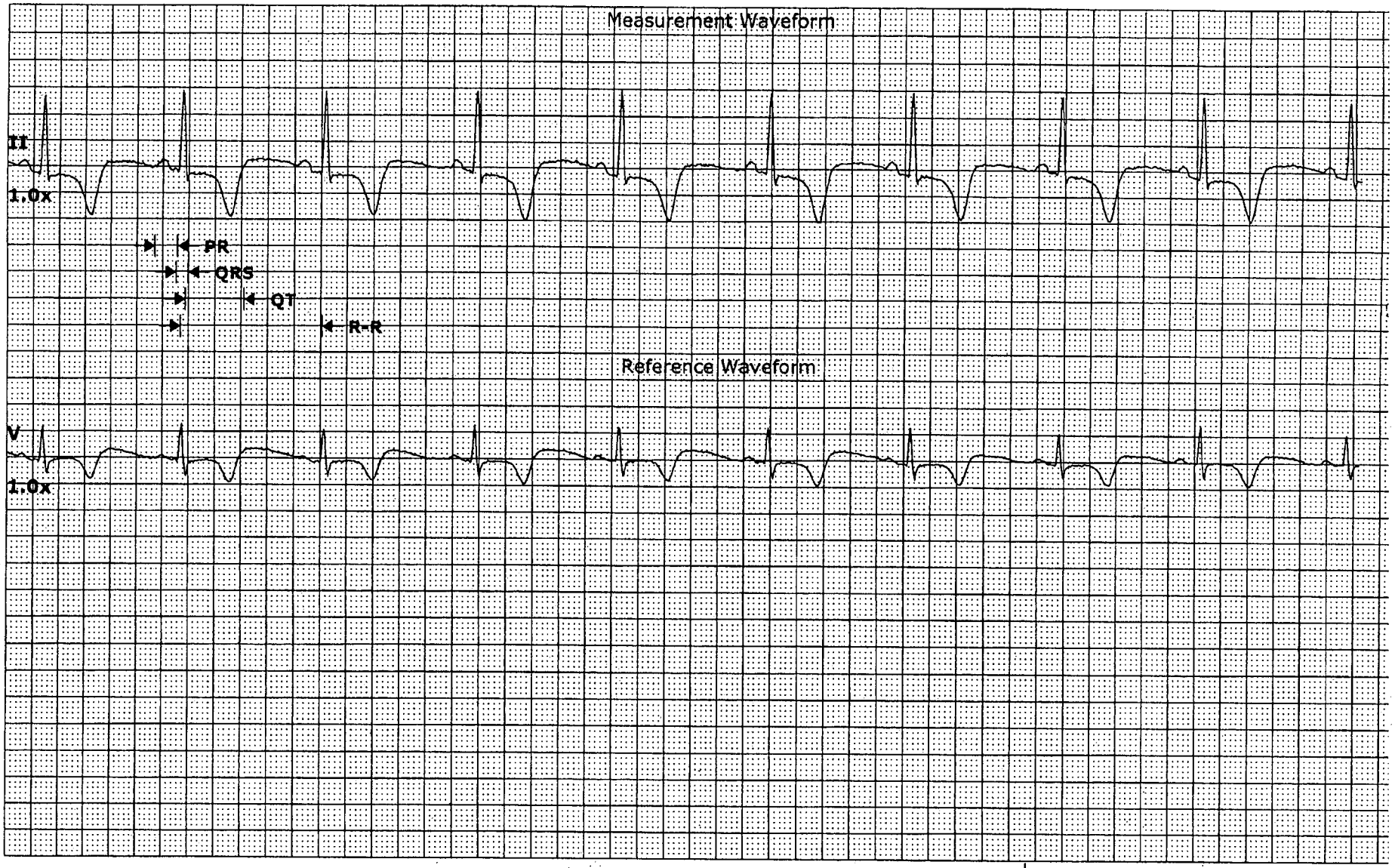
END OF RE

1038

6242

WINDHAM A Y 999999999 **Caliper Measurements** **4H|**

20-Mar-2007 22. 2 - 20-Mar-2007 22:13:22



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.179	sec	QT	= 0.449	sec
QRS	= 0.096	sec	R-R	= 1.072	sec
QTc	= 0.434	sec	Rate	= 56	bpm

SB

SB

GE Medical Systems Information Technologies

CIC Version 5.0.3

Tuesday, March 20, 2007 11:14:44 PM

002456

25 m

P

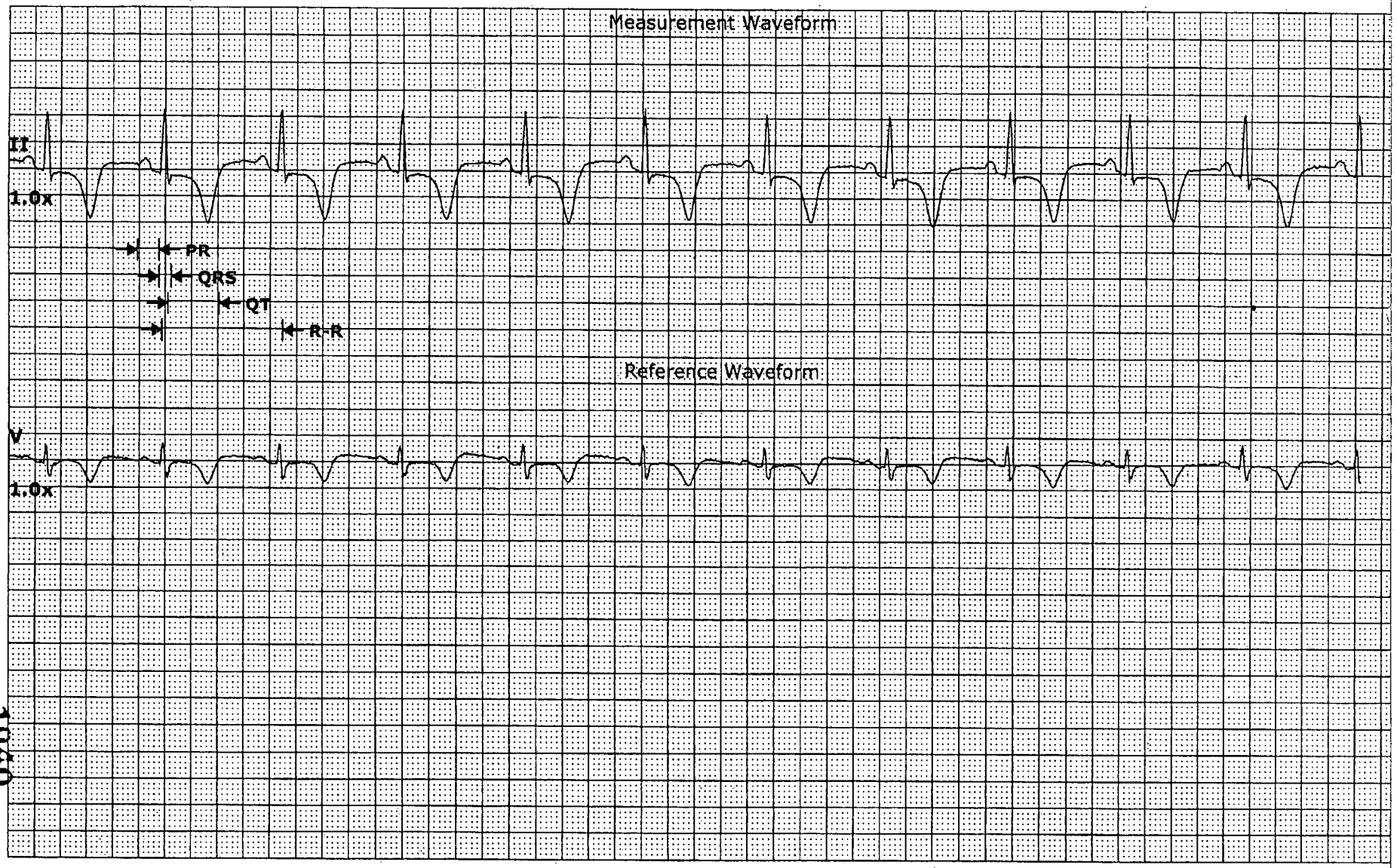
END OF RE

1039

6243

WINDHAM[illegible]A Y 999999999 **Caliper [illegible]urements** **4H|**

20-Mar-2007 19:[illegible]9 - 20-Mar-2007 19:00:19



Values displayed reflect measurements acquired against the measured waveform only. SR

PR	= 0.167	sec	QT	= 0.390	sec
QRS	= 0.096	sec	R-R	= 0.919	sec
QTc	= 0.407	sec	Rate	= 65	bpm

SR
ARY

GE Medical Systems Information Technologies

CIC Version 5.0.3
Tuesday, March 20, 2007 8:09:28 PM

002457

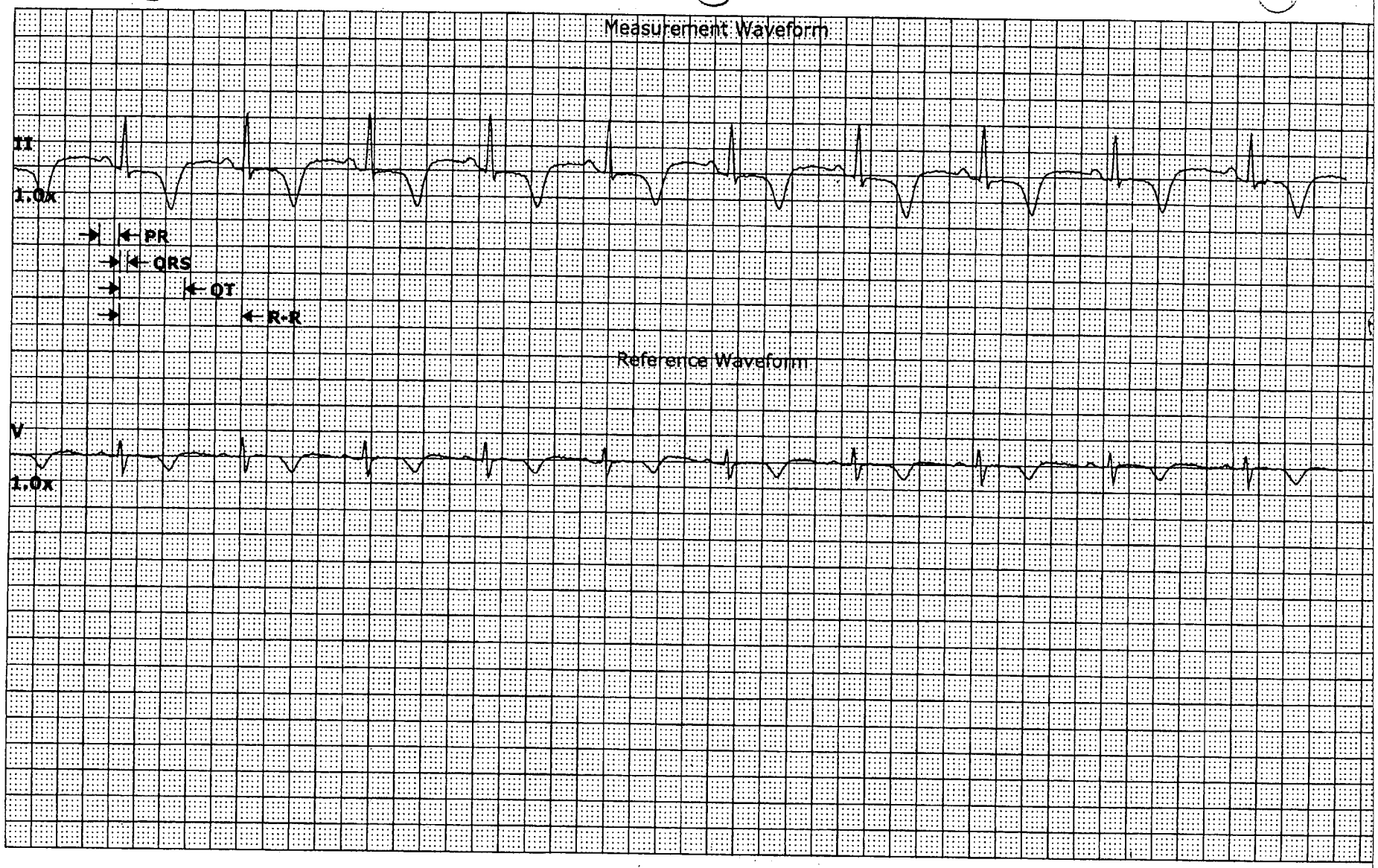
25 m
P
END OF RE

1040

6244

WINDHAM TAMMY **999999999** **Caliper Measurements** **4H**

20-Mar-2007 13:[illegible]0 - 20-Mar-2007 13:06:00



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.155	sec	QT	= 0.508	sec
QRS	= 0.061	sec	R-R	= 0.954	sec
QTc	= 0.520	sec	Rate	= 63	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Tuesday, March 20, 2007 1:07:31 PM

002458

25 m

P

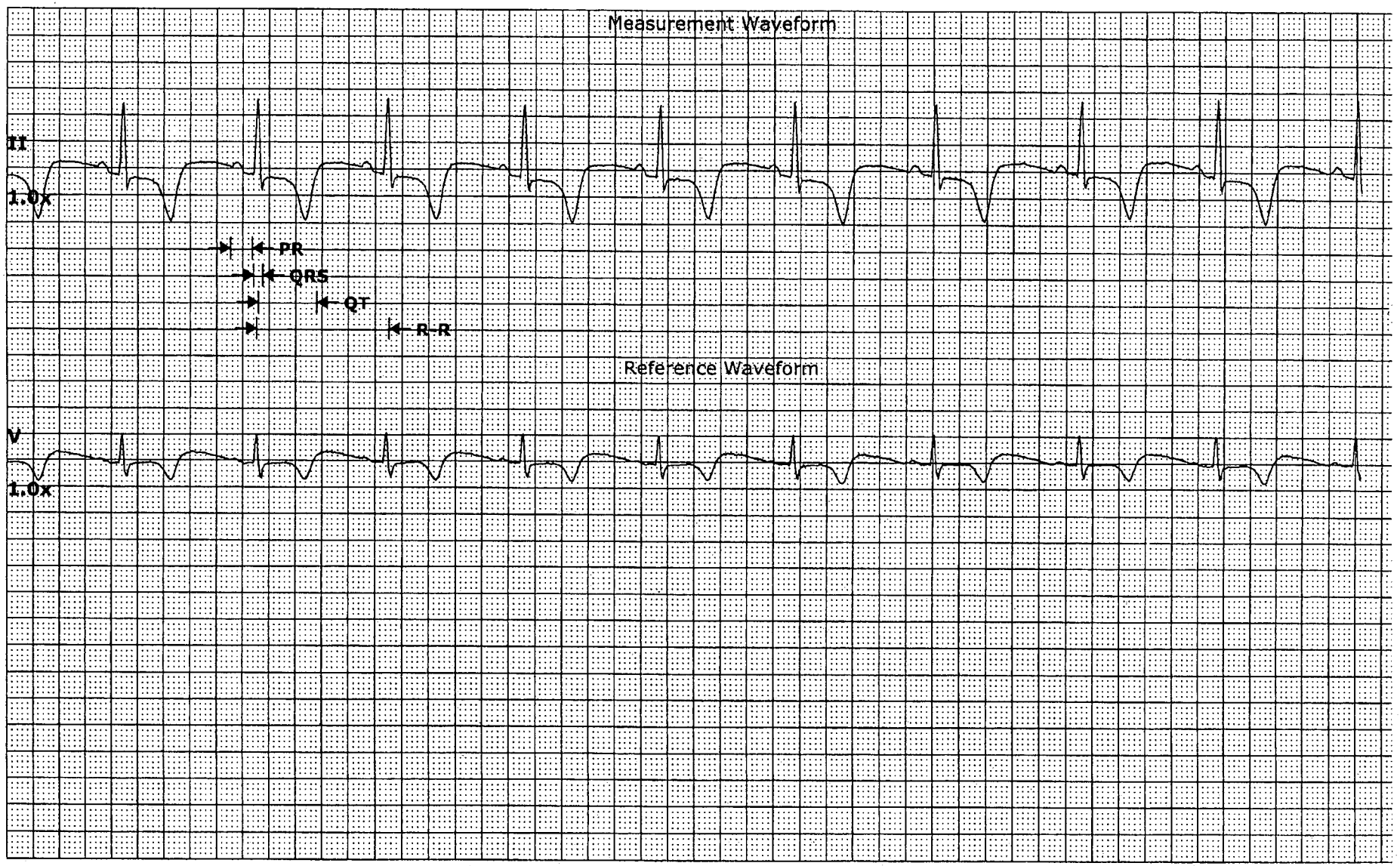
END OF RE

1041

6245

WINDHAM Y 999999999 **Caliper urements** **4H|**

21-Mar-2007 02: - 21-Mar-2007 02:40:20



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.167	sec	QT	= 0.449	sec
QRS	= 0.073	sec	R-R	= 1.001	sec
QTc	= 0.449	sec	Rate	= 60	bpm

SR
ARq

SR

GE Medical Systems Information Technologies

CIC Version 5.0.3
Wednesday, March 21, 2007 3:04:33 AM

002459

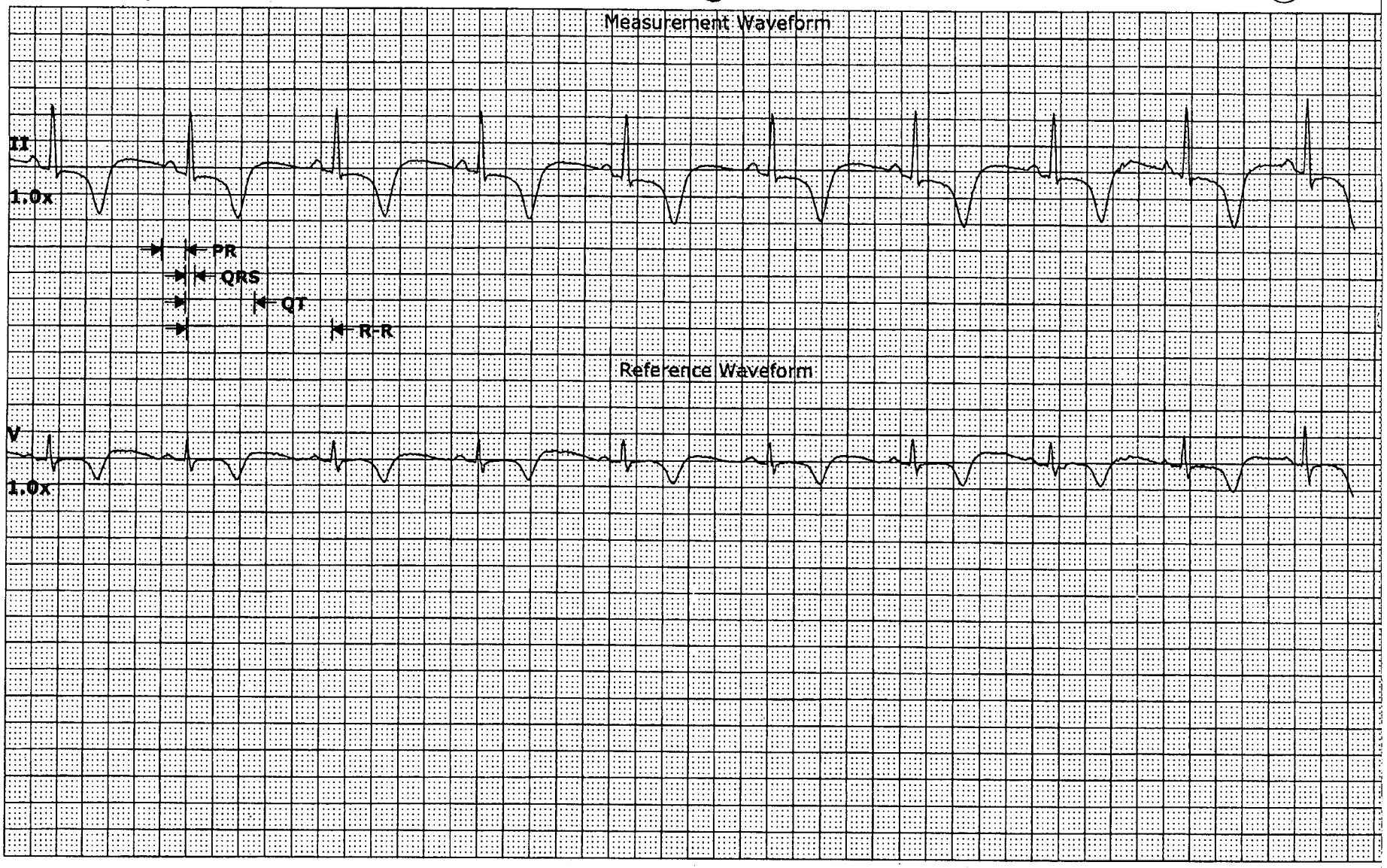
25 m
P
END OF RE

1042

6246

WINDHAM TA Y 999999999 **Caliper easurements** **4H|**

20-Mar-2007 16:[illegible]3 - 20-Mar-2007 16:38:13



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.190	sec	QT	= 0.531	sec
QRS	= 0.073	sec	R-R	= 1.107	sec
QTc	= 0.505	sec	Rate	= 54	bpm

SB

GE Medical Systems Information Technologies

CIC Version 5.0.3

Tuesday, March 20, 2007 4:39:30 PM

002460

25 n

F

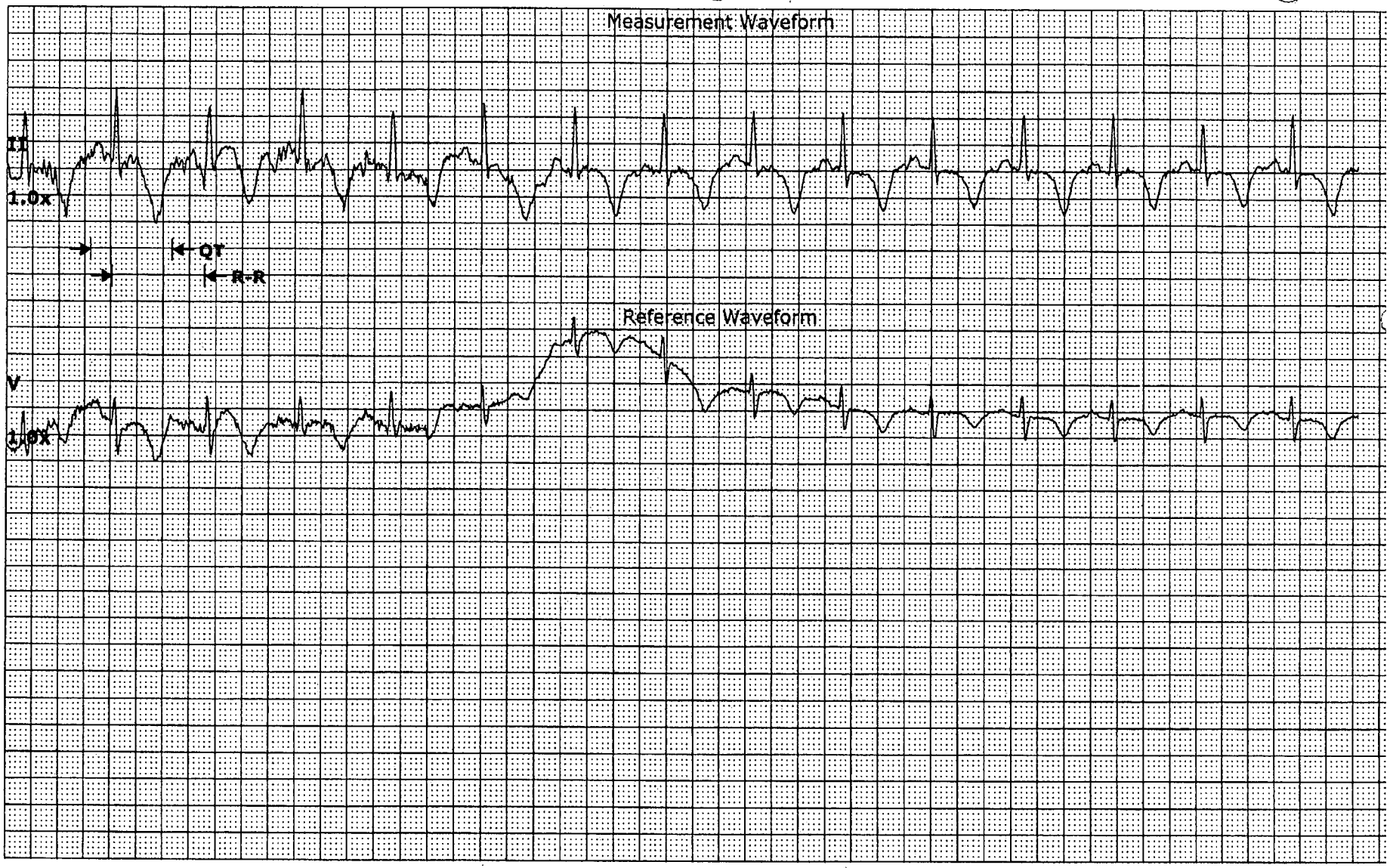
END OF RE

1043

6247

WINDHAM TA Y 999999999 **Caliper easurements** **4H**

20-Mar-2007 07:[illegible]2 - 20-Mar-2007 07:52:52



Values displayed reflect measurements acquired against the measured waveform only.

QTc	**= 0.743**	**sec**	**Rate**	**= 85**	**bpm**	
QT	**= 0.625**	**sec**				
R-R	**= 0.707**	**sec**				

GE Medical Systems Information Technologies

CIC Version 5.0.3

Tuesday, March 20, 2007 7:56:50 AM

SR

1044

002461

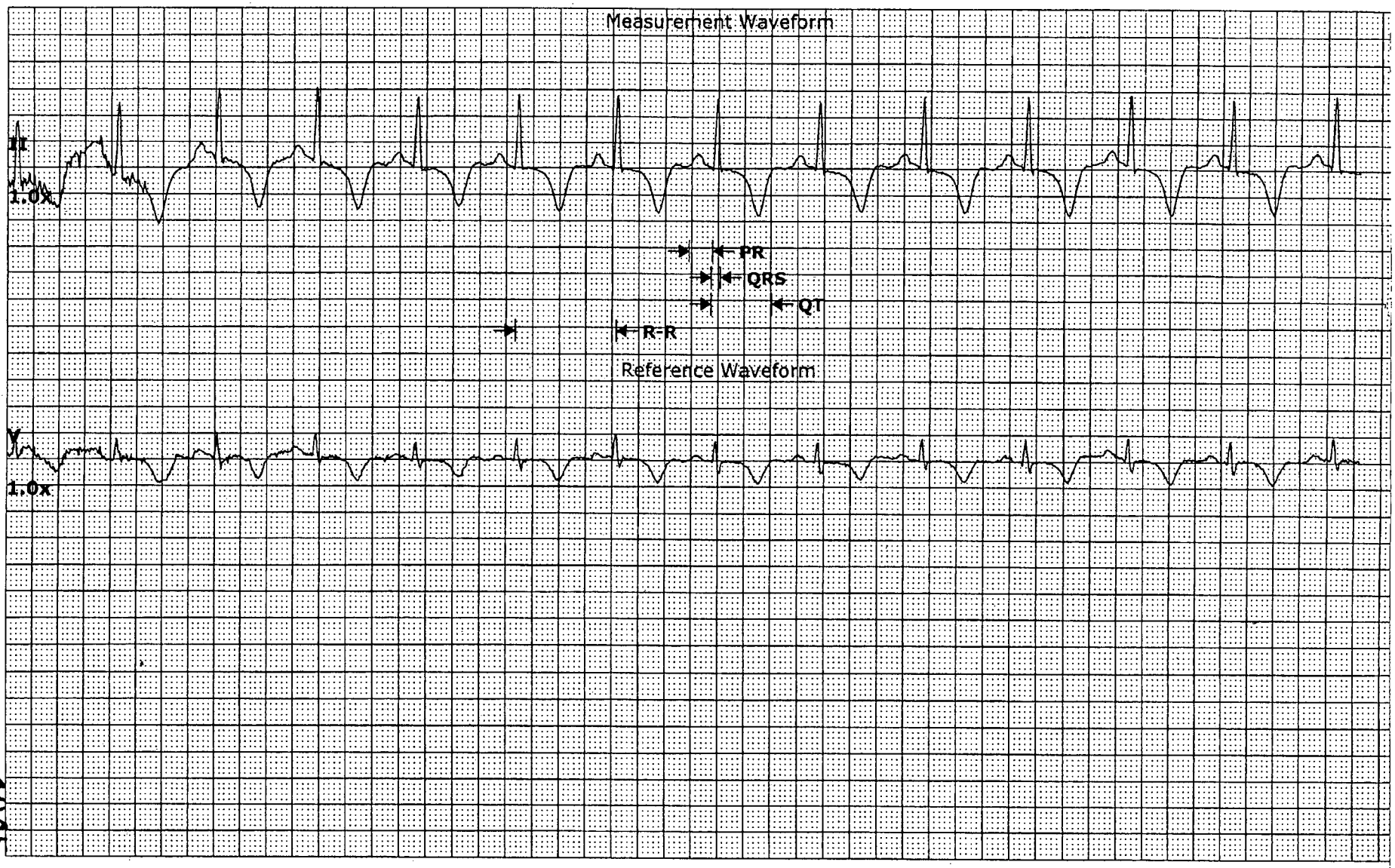
25 n

END OF RI

6248

WINDHAM Y 999999999 **Caliper** e urements 4H

19-Mar-2007 19: - 19-Mar-2007 19:01:01



1045

Values displayed reflect measurements acquired against the measured waveform only.

SR (SE)

PR	=	0.179	sec	QT	=	0.461	sec
QRS	=	0.073	sec	R-R	=	0.766	sec
QTc	=	0.527	sec	Rate	=	78	bpm

SR

GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 7:36:56 PM

002462

25 m

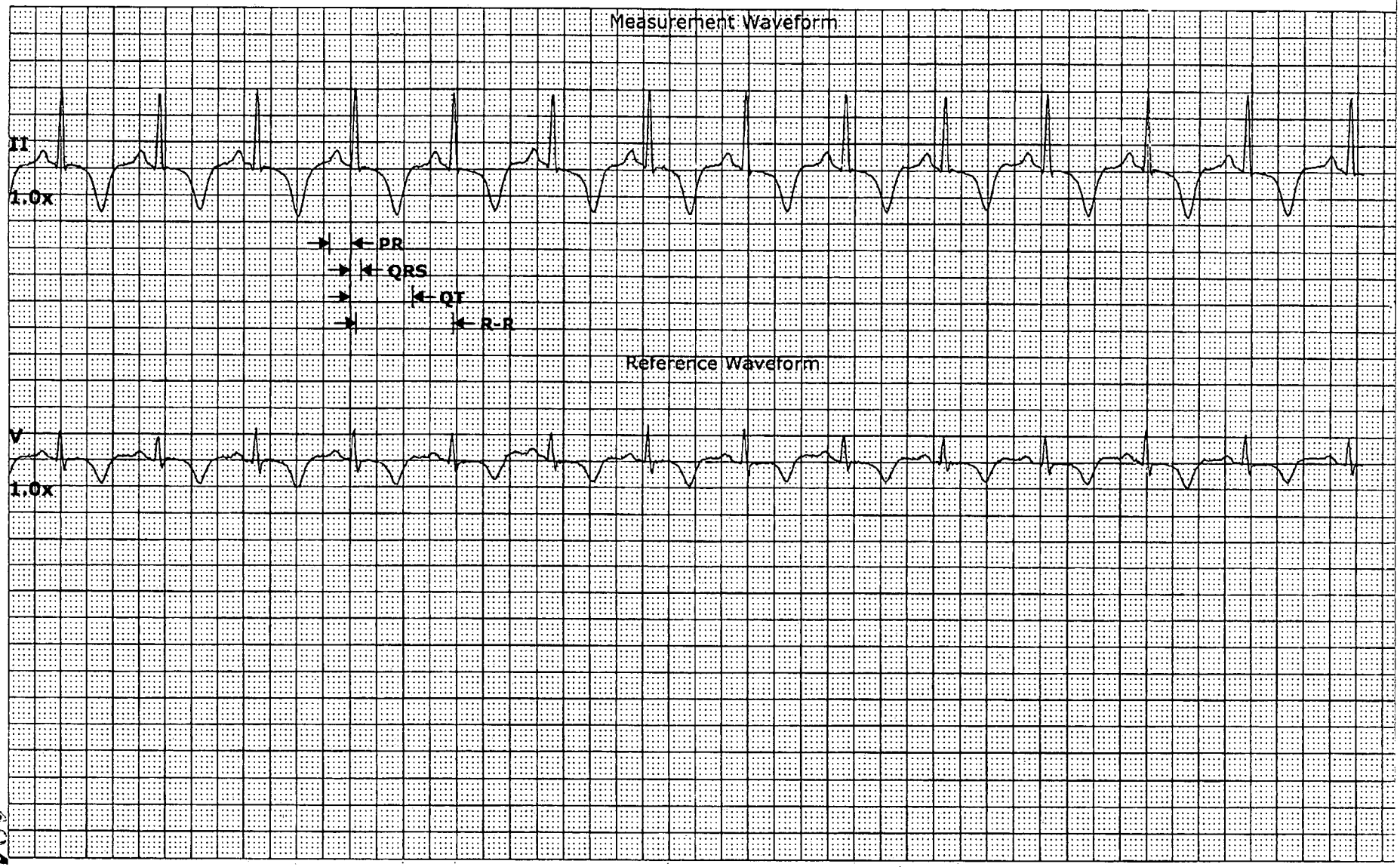
P

END OF RE

6249

WINDHAM Y 999999999 **Caliper e urements** **4H|**

20-Mar-2007 03: - 20-Mar-2007 03:00:41



1046

Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.167	sec	QT	= 0.472	sec
QRS	= 0.085	sec	R-R	= 0.731	sec
QTc	= 0.552	sec	Rate	= 82	bpm

SR-SE

002463

25 m

P.

END OF RE

GE Medical Systems Information Technologies

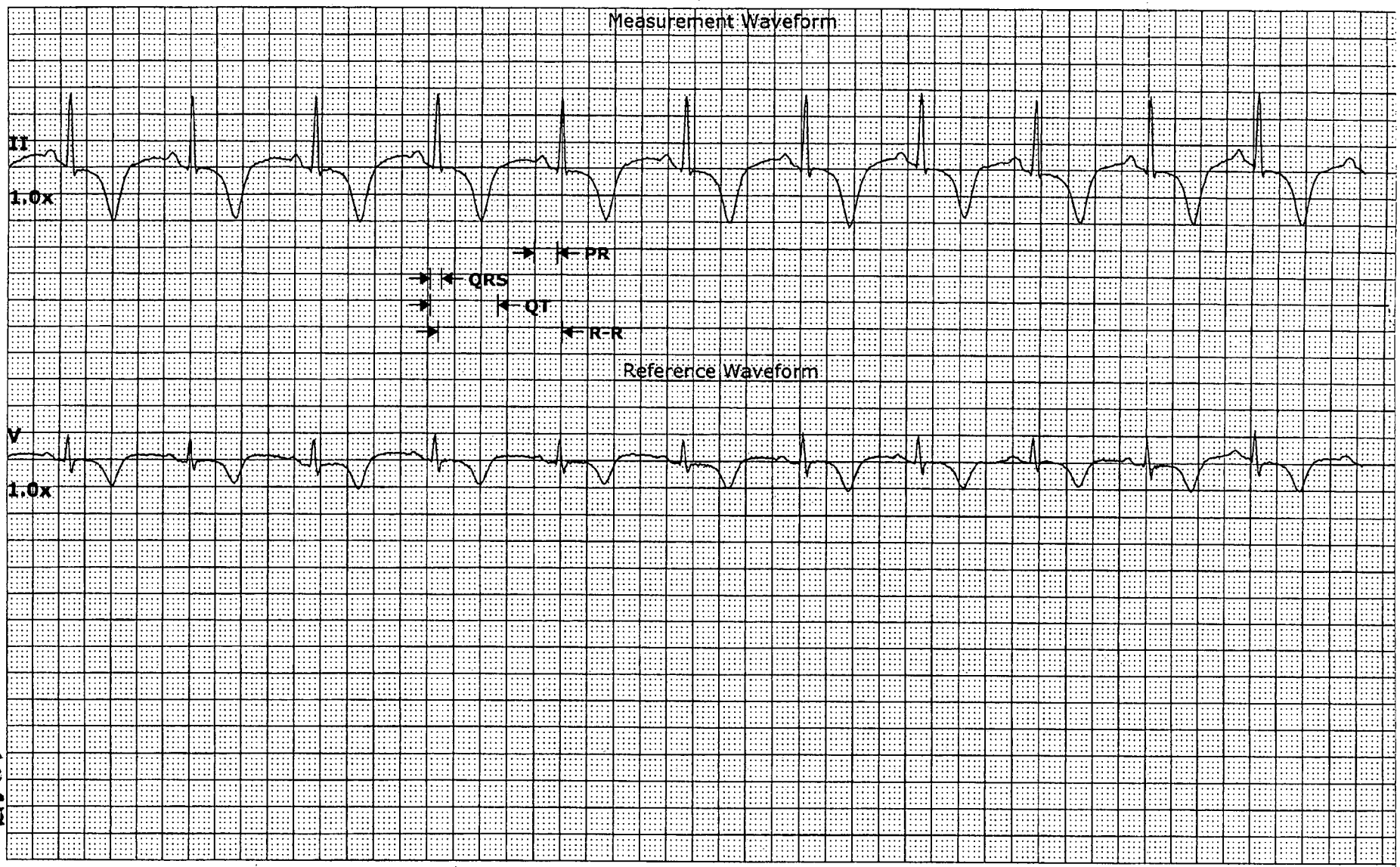
CIC Version 5.0.3

Tuesday, March 20, 2007 3:21:16 AM

6250

WINDHAM Y 999999999 **Caliper easurements** **4H**

19-Mar-2007 23: - 19-Mar-2007 23:00:54



Values displayed reflect measurements acquired against the measured waveform only.

JR-JE

PR	= 0.179	sec	QT	= 0.505	sec
QRS	= 0.082	sec	R-R	= 0.928	sec
QTc	= 0.524	sec	Rate	= 65	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 11:43:46 PM

25 m

P

END OF RE

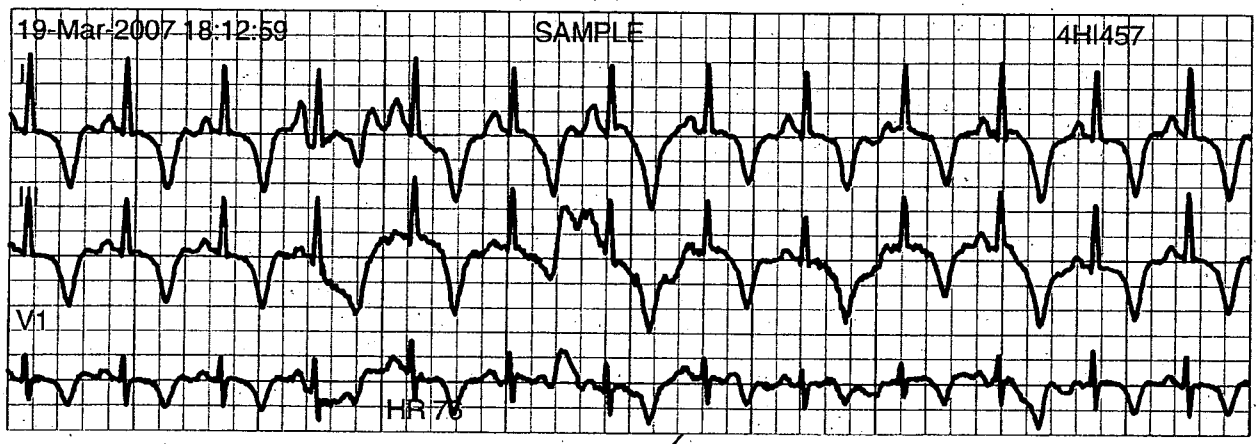
1047

002464

6251

ARRHYTHMIA EVENT

Name WINDHAM,TAMMY *MRN* 999999999 *Unit* 4H *Bed* 457	*Date* 19-Mar-2007 002465 *Time* 18:13:54 *Page* 1 of 1



Shutto
Out

GE Healthcare

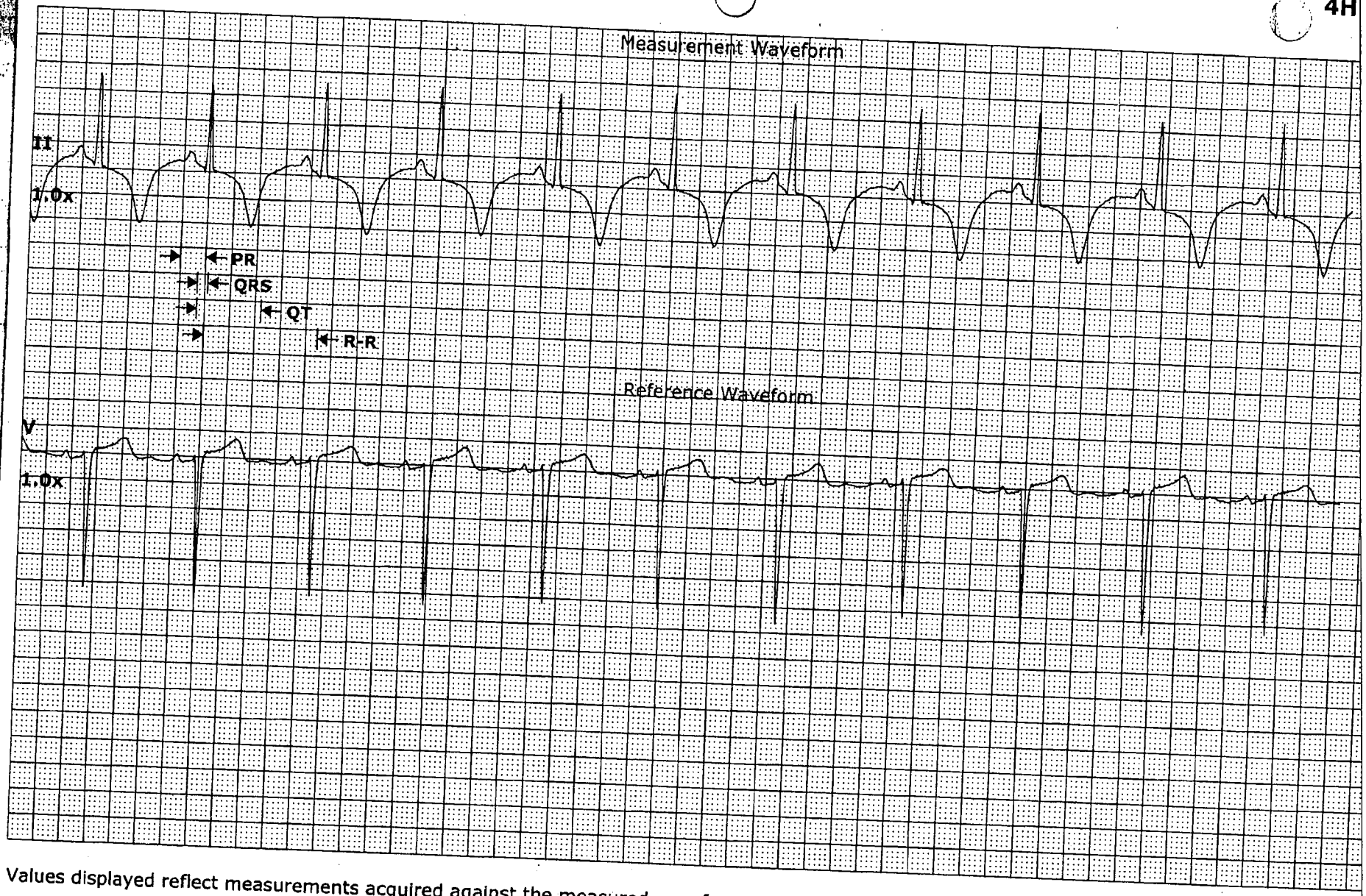
1048

6252

19-Mar-2007 12:[redacted] - 19-Mar-2007 12:10:33 895682

Caliper Measurements

4H



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.207	sec	QT	= 0.512	sec
QRS	= 0.089	sec	R-R	= 0.902	sec
QTc	= 0.539	sec	Rate	= 66	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 12:22:15 PM

SR CMPLETE

1049

002466

25 m

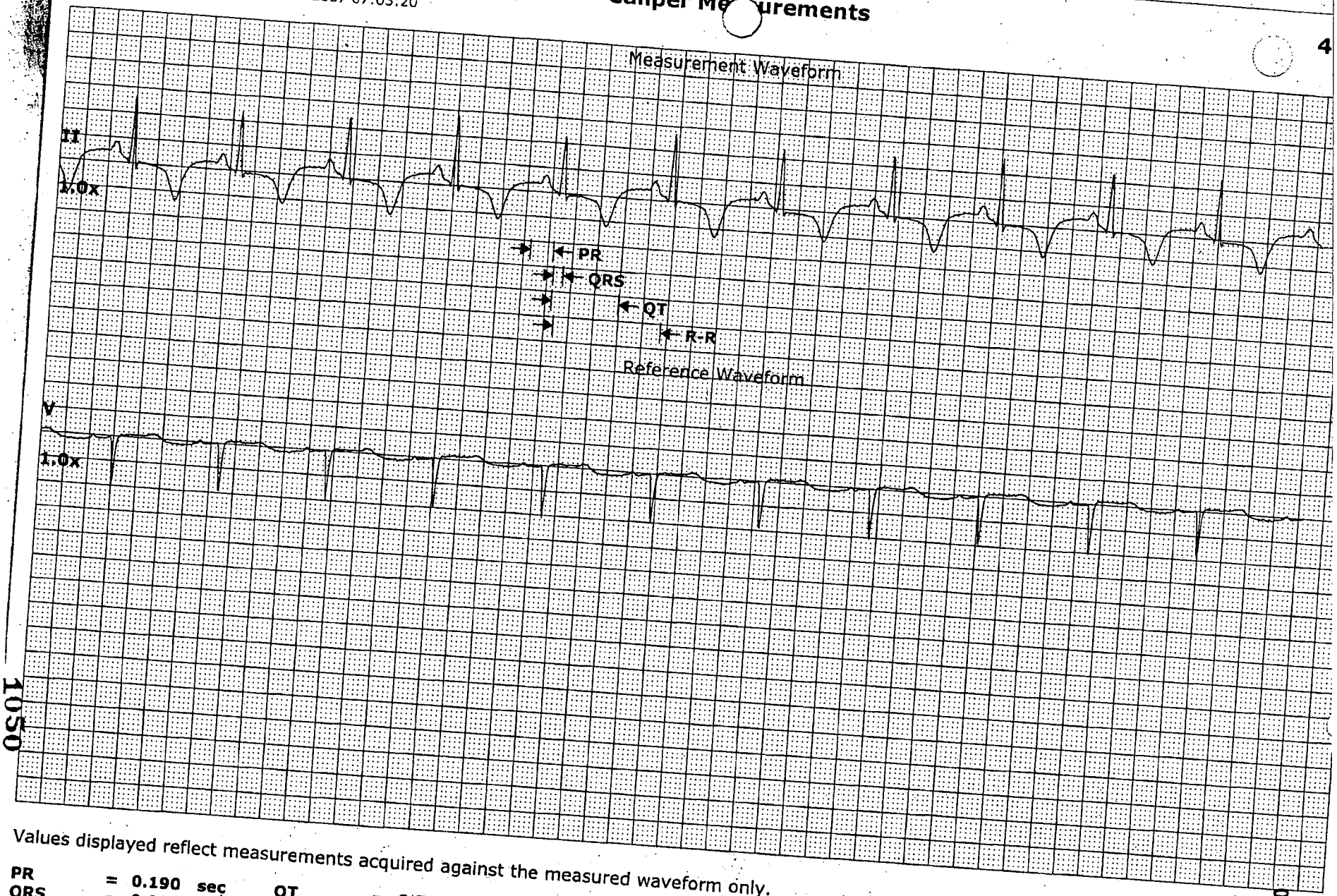
Pa

6253

19-Mar-2007 07:03:20

Caliper Measurements

4



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.190	sec	QT	= 0.543	sec
QRS	= 0.085	sec	R-R	= 0.872	sec
QTc	= 0.581	sec	Rate	= 69	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 7:04:38 AM

52

002467

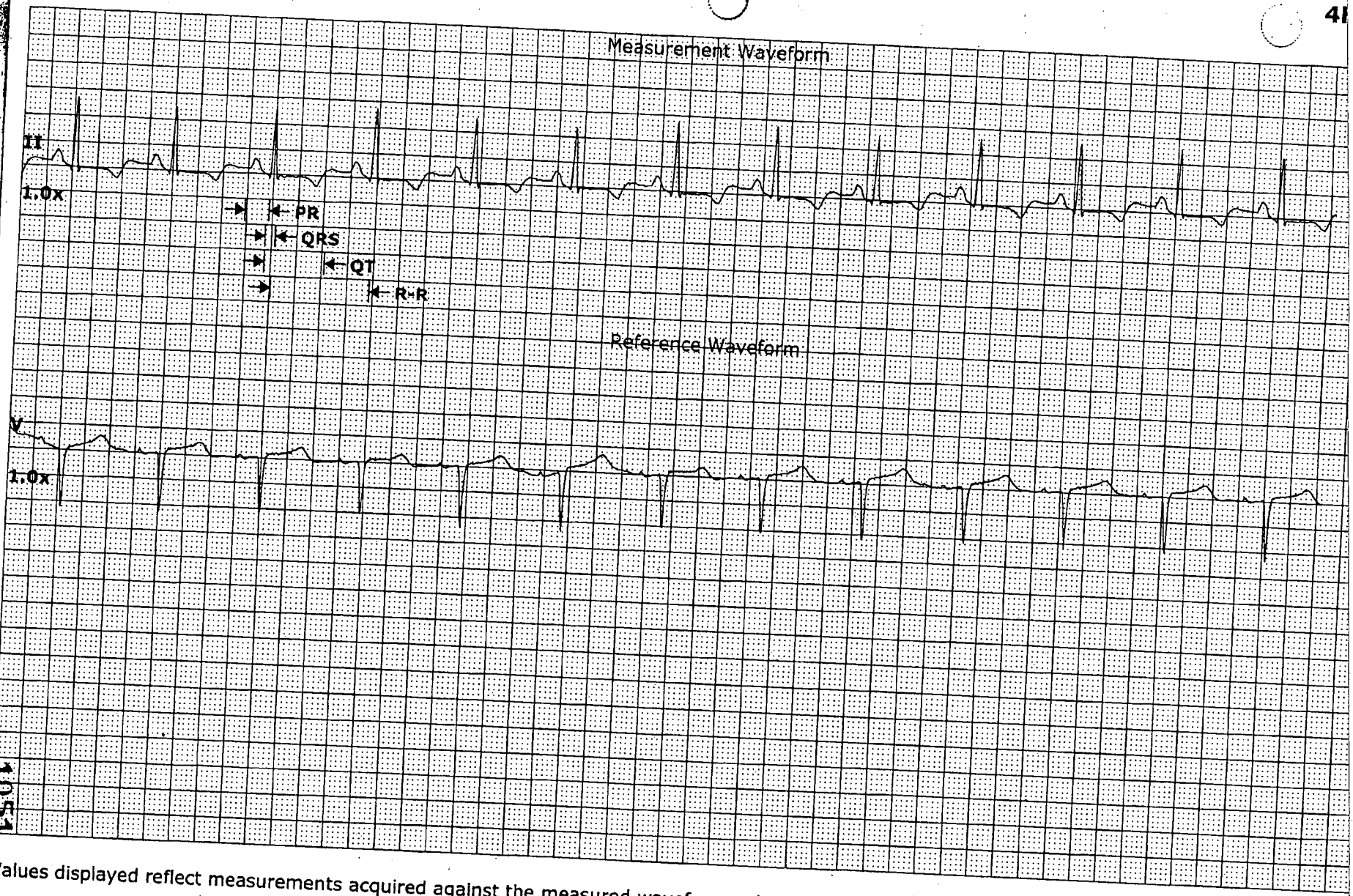
25 mm/

1050

6254

18-Mar-2007 19:[illegible] - 18-Mar-2007 19:03:37

Caliper Measurements



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.190	sec	QT	= 0.472	sec
QRS	= 0.085	sec	R-R	= 0.766	sec
QTc	= 0.539	sec	Rate	= 78	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Sunday, March 18, 2007 7:29:56 PM

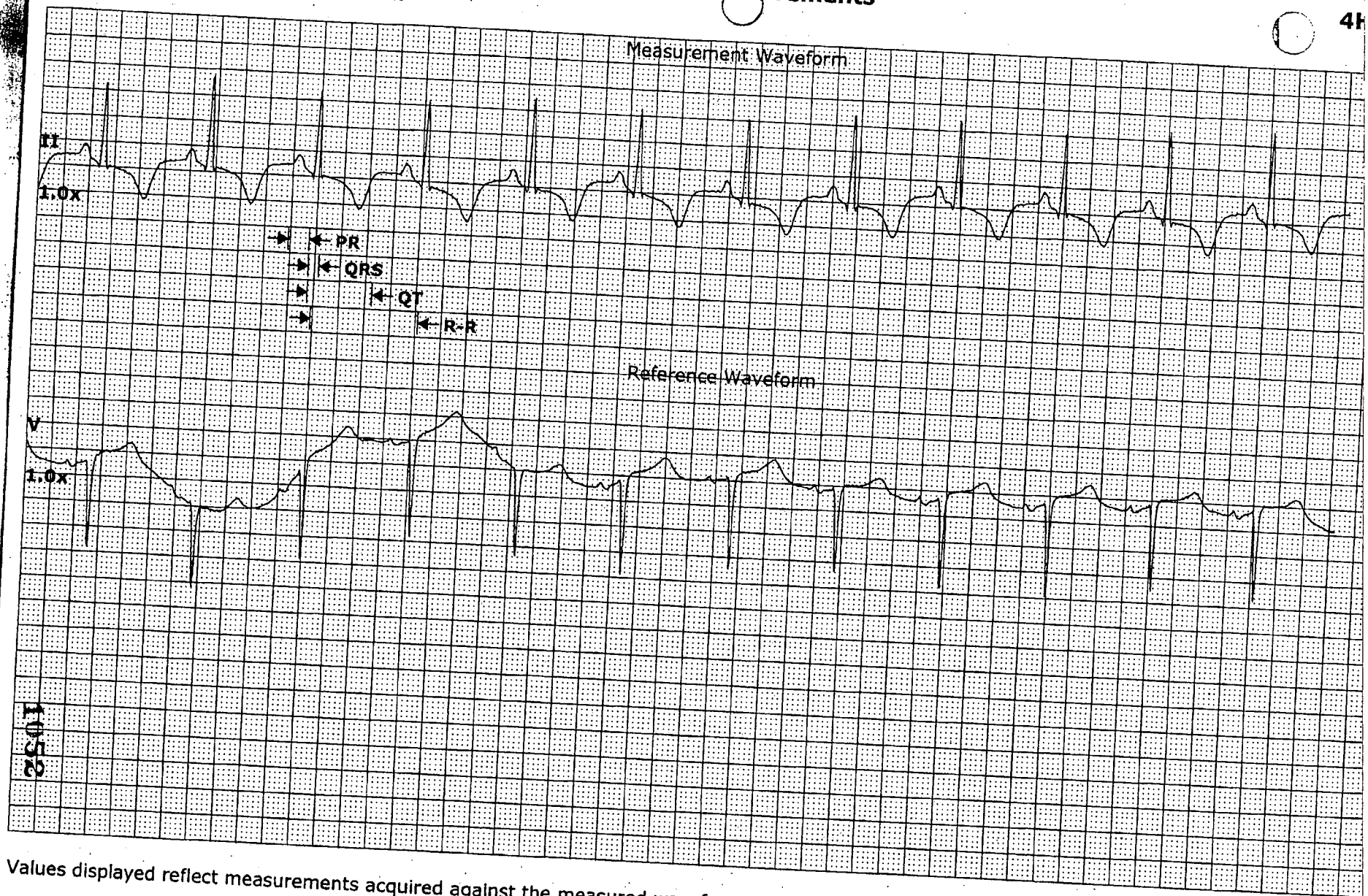
002468

25 mm

6255

18-Mar-2007 23:[redacted] - 18-Mar-2007 23:07:49

Caliper Measurements



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.167	sec	QT	= 0.508	sec
QRS	= 0.085	sec	R-R	= 0.837	sec
QTc	= 0.555	sec	Rate	= 72	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Sunday, March 18, 2007 11:09:34 PM

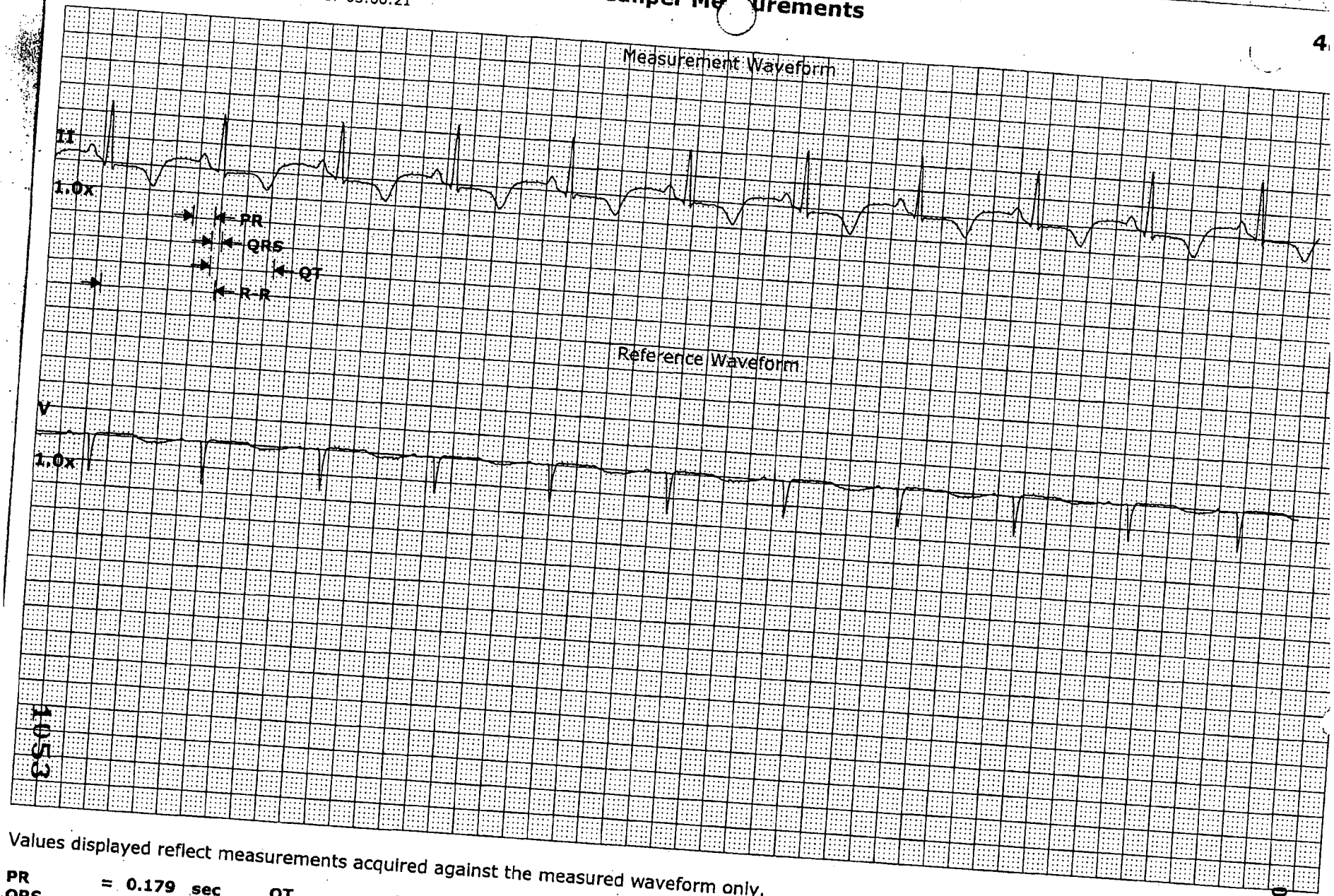
25 mm

002469

6256

19-Mar-2007 03:06:21

Caliper Measurements



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.179 sec	QT	= 0.519 sec		
QRS	= 0.085 sec	R-R	= 0.942 sec		
QTc	= 0.535 sec	Rate	= 64 bpm		

GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 3:07:27 AM

25 mm/s

1053

002470

6257

DHAM TAMMY E 21 MAR 2007 3:15:42 895682

yrs Female

002471

156	(NSR). Normal sinus rhythm, rate 59 - - - - - - -	Normal P axis, PR, rate & rhythm
D 99	(LQT). QT interval long for rate - - - - - - - - - - - - - - - - -	QTc > 470 mS
504	(T6WI). Diffuse T wave abnormalities, - - - - - - - - - - -	T wave -.60 mV ANT/LAT/INF
499	(ISCW). . Consistent with ischemia - - - - - - - - - - - - - - - -	T > -.60 mV

- ABNORMAL ECG -

XES--
54
63
227

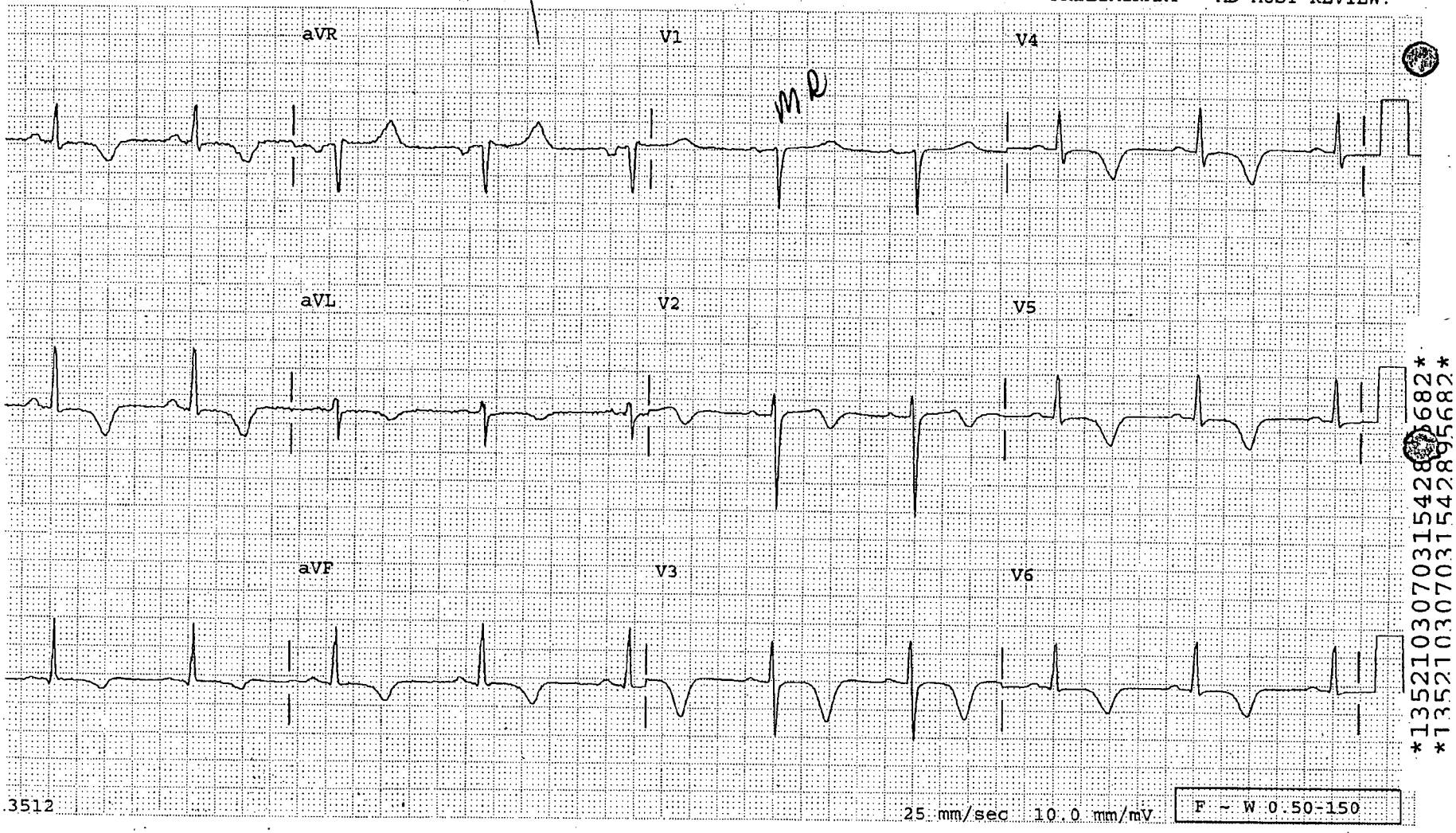
Requested by
161
Tech 66
Room 457
C-HP708

PREVIOUS ECG: 20 MAR 2007 17:27:56, CONFIRMED BY JJL - AB
VIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

PRELIMINARY - MD MUST REVIEW.

1054

6258



1352103070315428 95682
1352103070315428 95682

3512 25 mm/sec 10.0 mm/mV F - W 0.50-150

457 03/18/2007 03:55:09 PM WINDHAM TAMMY
Female

PROVIDENCE HOSPITAL
Dept: 12
Room: 457
Oper: 73

002472

6259

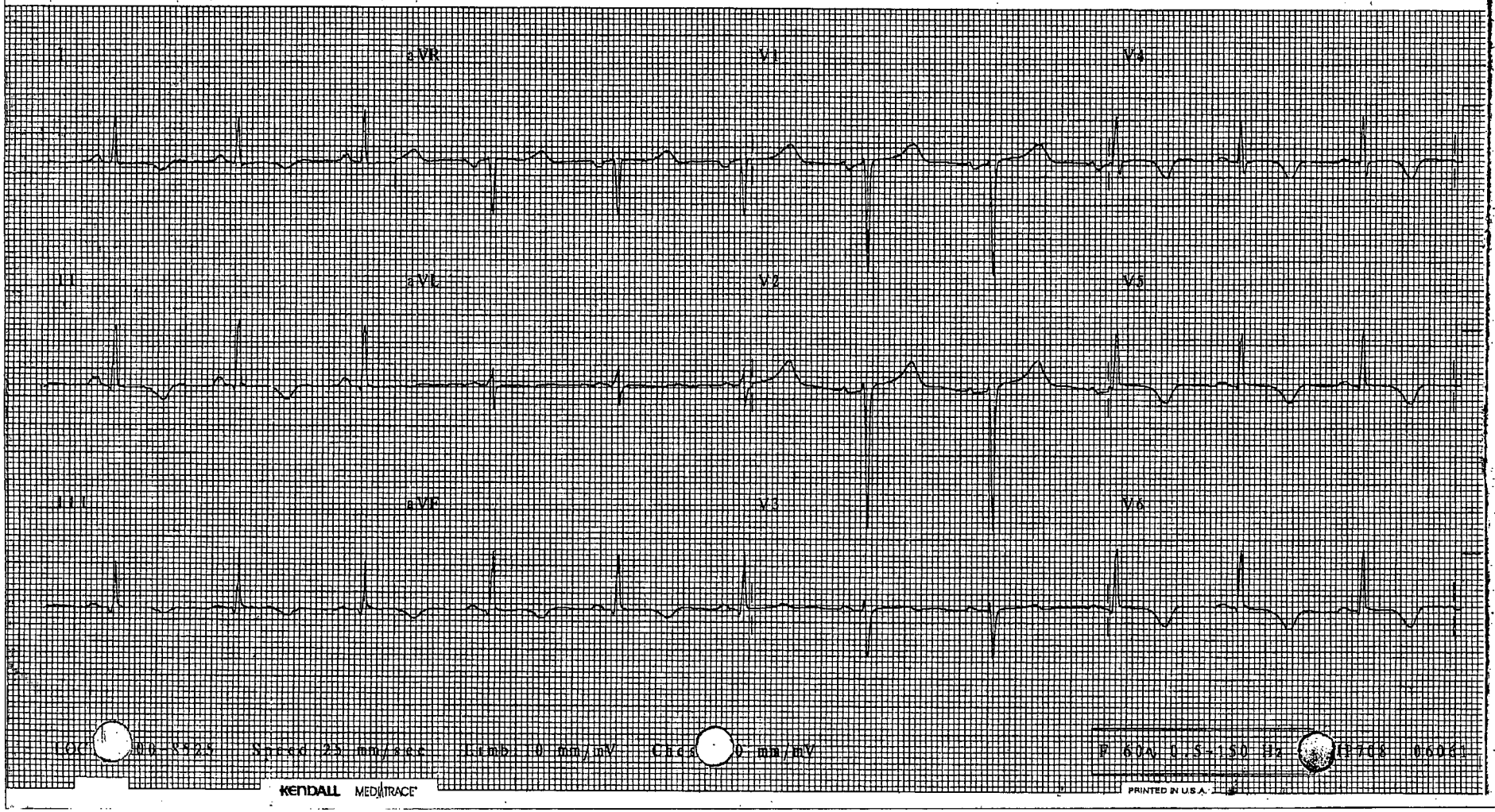
Rate	67	. Normal sinus rhythm, rate 67
PR	153	. Left atrial enlargement
QRSD	74	. LVH with ST-T abnormalities
QT	463	. Anterolateral T wave abnormalities,
QTc	489	. . Also consider ischemia

--AXIS--
P 43
QRS 51
T 234

Requested by: 1055

- ABNORMAL ECG -

PRELIMINARY-MD MUST REVIEW



WINDHAM TAMMY E 21 MAR 2007 3:15:42 895682

39 yrs Female

PR	176	(NSR).	Normal sinus rhythm, rate 59 - - - - - - Normal P axis, PR, rate & rhythm
QRSD	99	(LQT).	QT interval long for rate - - - - - - - - - - - - - - - - QTc > 470 mS
QT	504	(T6WI).	Diffuse T wave abnormalities, - - - - - - - - - T wave -.60 mV ANT/LAT/INF
QTc	499	(ISCW).	. Consistent with ischemia - - - - - - - - - - - - - - - T > -.60 mV

- ABNORMAL ECG -

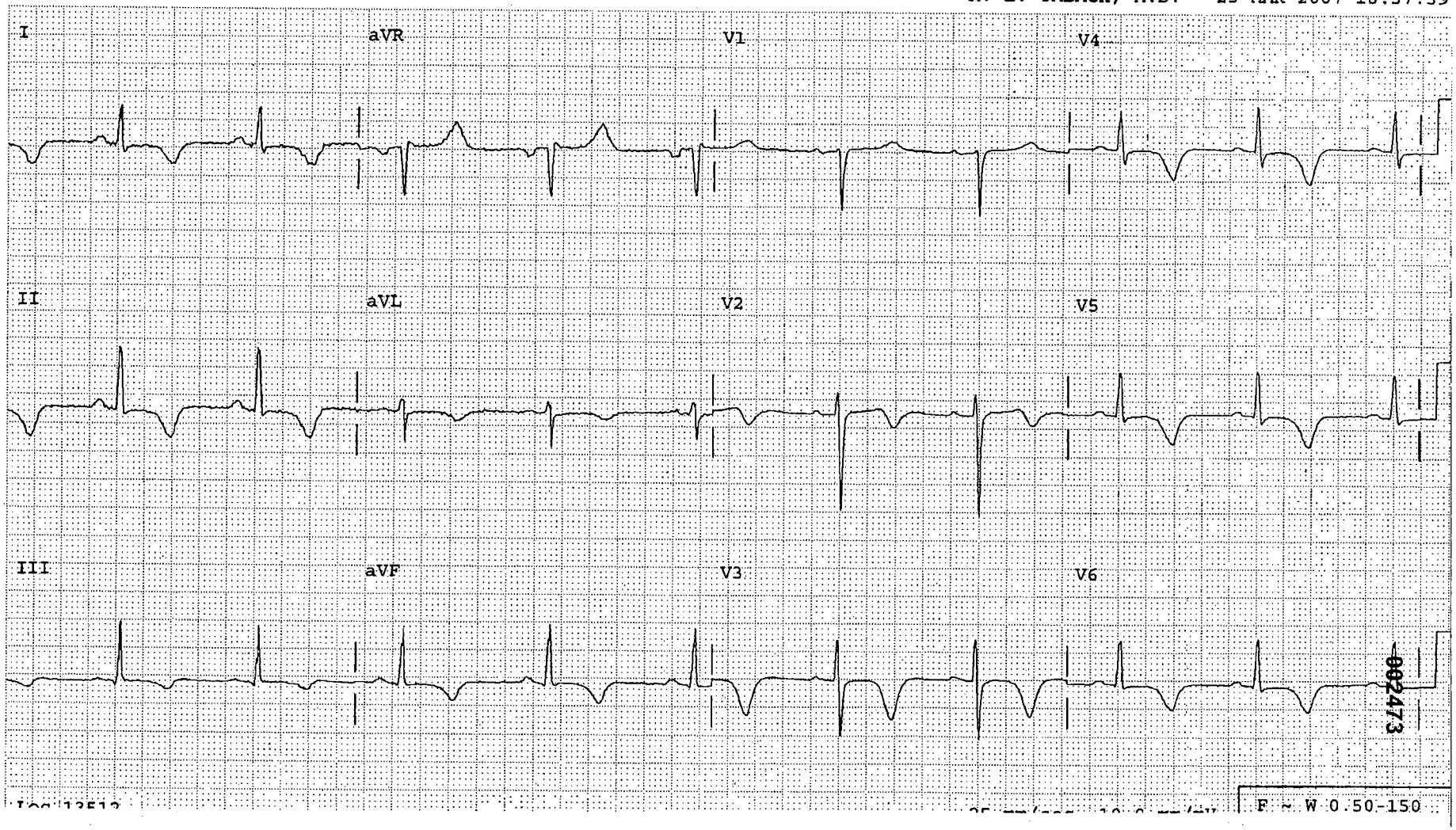
--AXES--
P 54
QRS 63
T 227

*Continued diffuse ST-T changes seen - - - - clinical correlation required
*reu/ce 501829048

Requested by
161
Tech 66
Room 457
Edited C-HP708

PREVIOUS ECG: 20 MAR 2007 17:27:56, CONFIRMED BY JJL - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

R. E. UMBACH, M.D. - 23 MAR 2007 18:37:39



1056

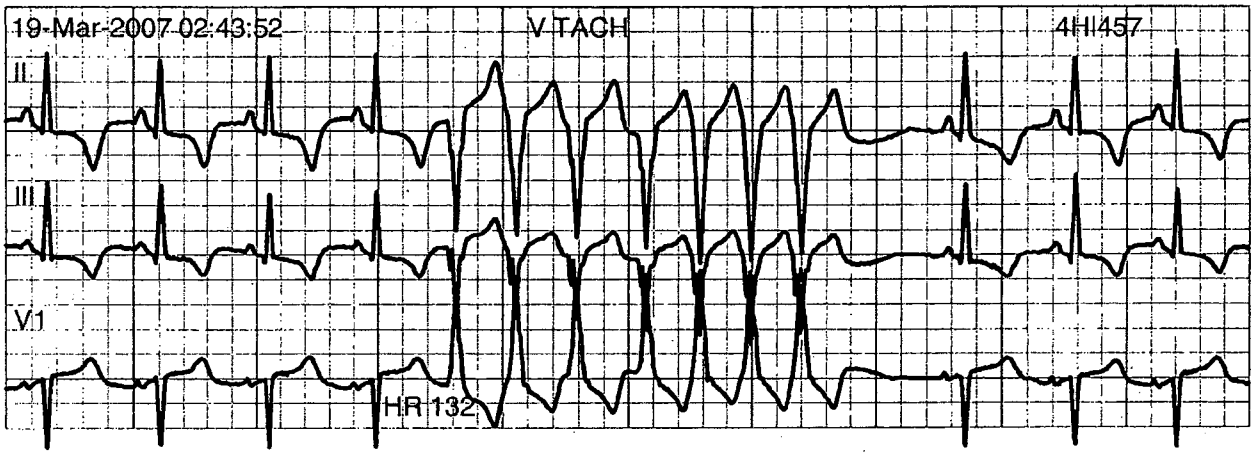
002473

6260

ARRHYTHMIA EVENT

Name WINDHAM,TAMMY *MRN* 895682 *Unit* 4H *Bed* 457	*Date* 19-Mar-2007 *Time* 02:45:06 *Page* 1 of 1

002474



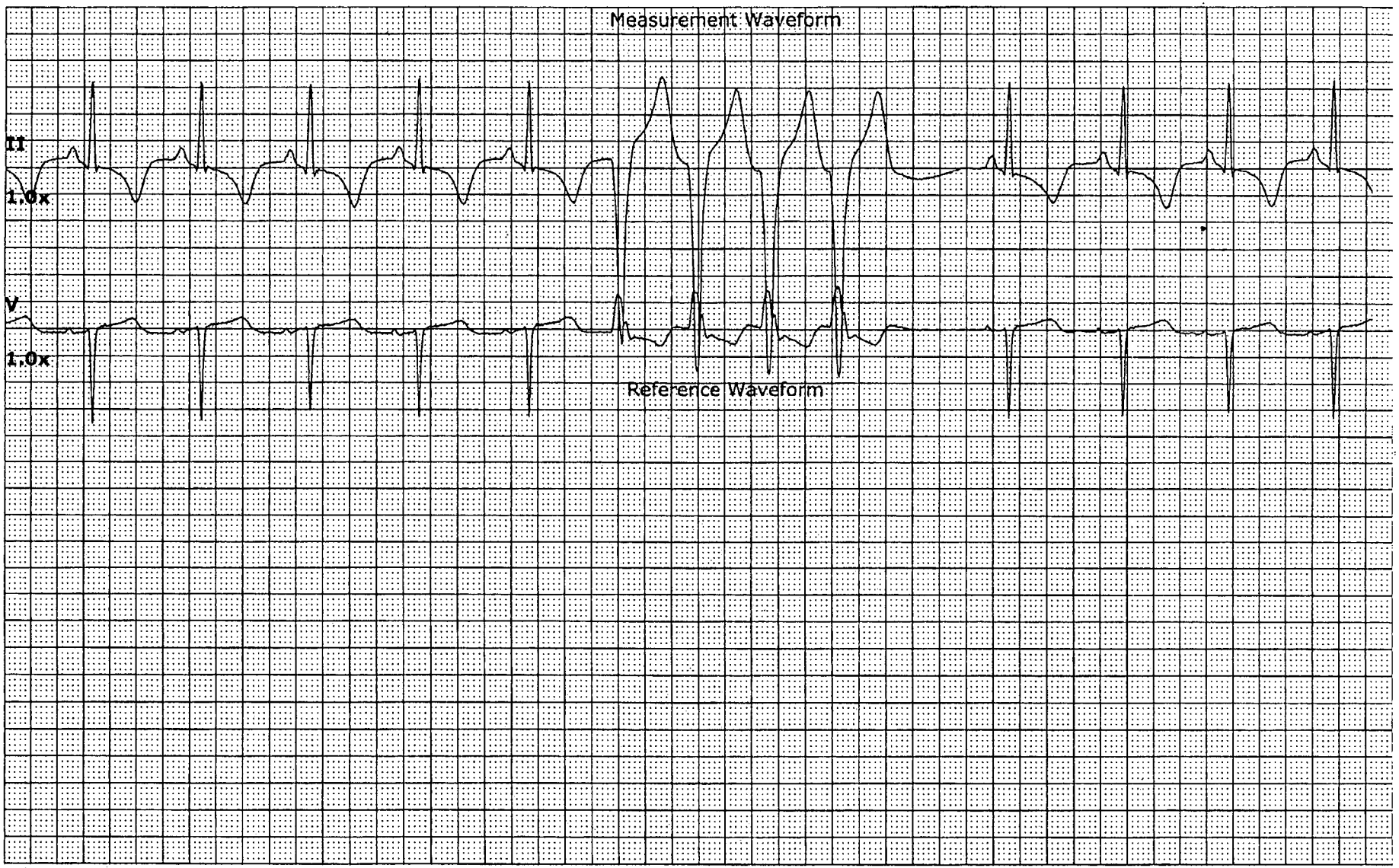
GE Healthcare

1057

6261

WINDHAM Y 895682 **Caliper measurements** **4H**

18-Mar-2007 23:[illegible] - 18-Mar-2007 23:58:06



Values displayed reflect measurements acquired against the measured waveform only.

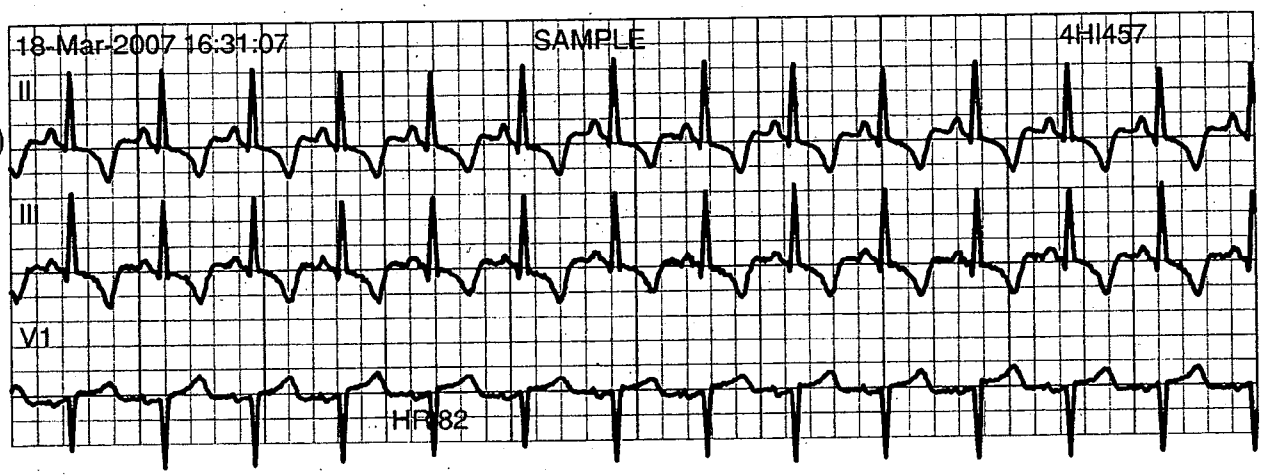
GE Medical Systems Information Technologies

CIC Version 5.0.3

Monday, March 19, 2007 12:12:57 AM

ARRHYTHMIA EVENT

Name WINDHAM,TAMMY *MRN* 895682 *Unit* 4H *Bed* 457	*Date* 18-Mar-2007 002476 *Time* 16:31:41 *Page* 1 of 1



GE Healthcare

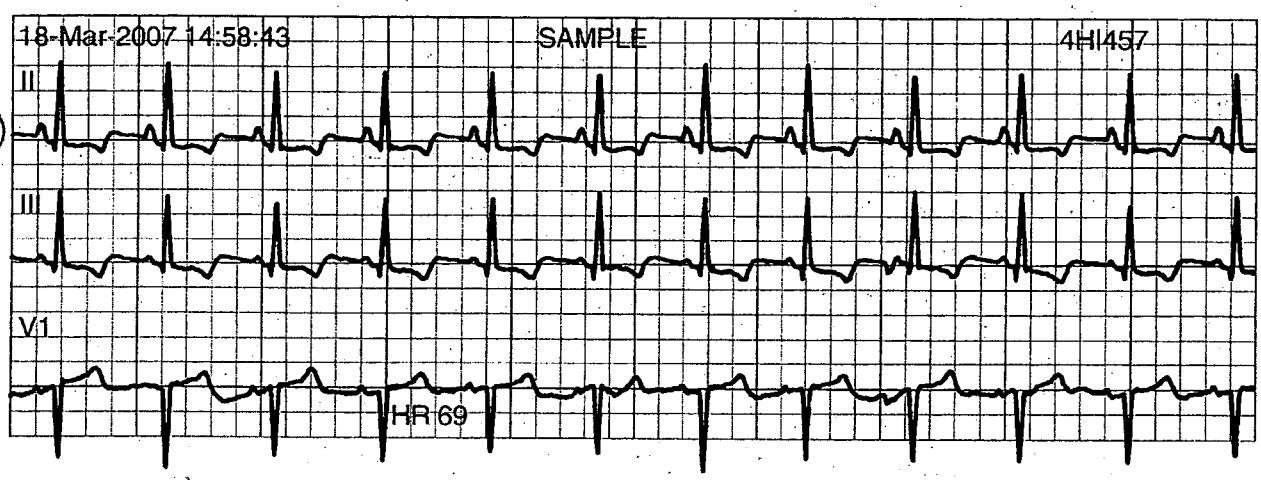
1059

6263

ARRHYTHMIA EVENT

Name WINDHAM,TAMMY *MRN* 895682 *Unit* 4H *Bed* 457	*Date* 18-Mar-2007 *Time* 16:30:47 *Page* 1 of 1

002477



GE Healthcare

1060

6264

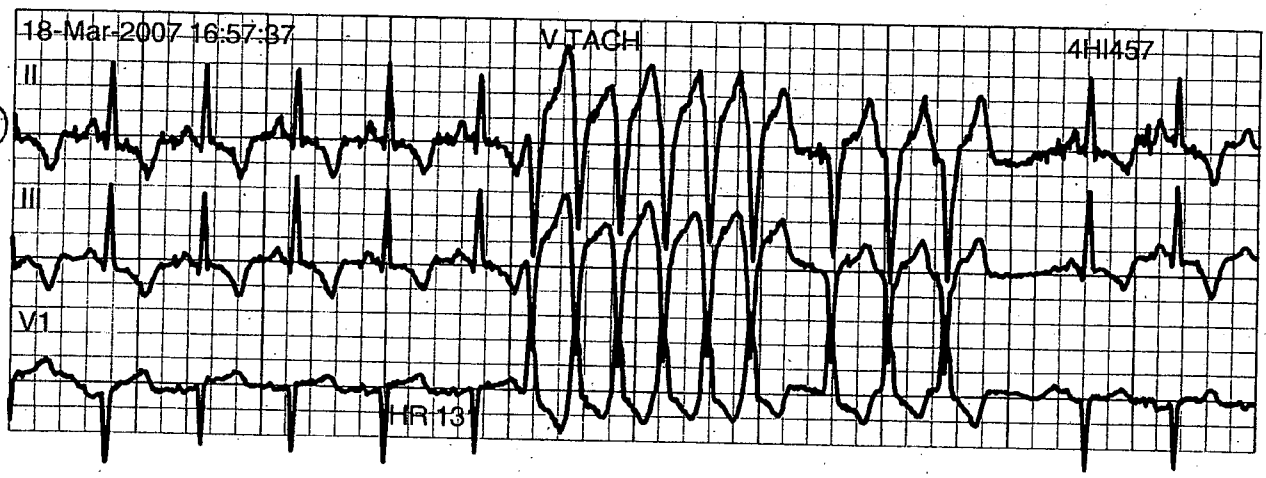
ARRHYTHMIA EVENT

002478

Name WINDHAM,TAMMY
MRN 895682
Unit 4H
Bed 457

Date 18-Mar-2007
Time 17:01:11
Page 1 of 1

Nurse Jessica Notified
MP



GE Healthcare

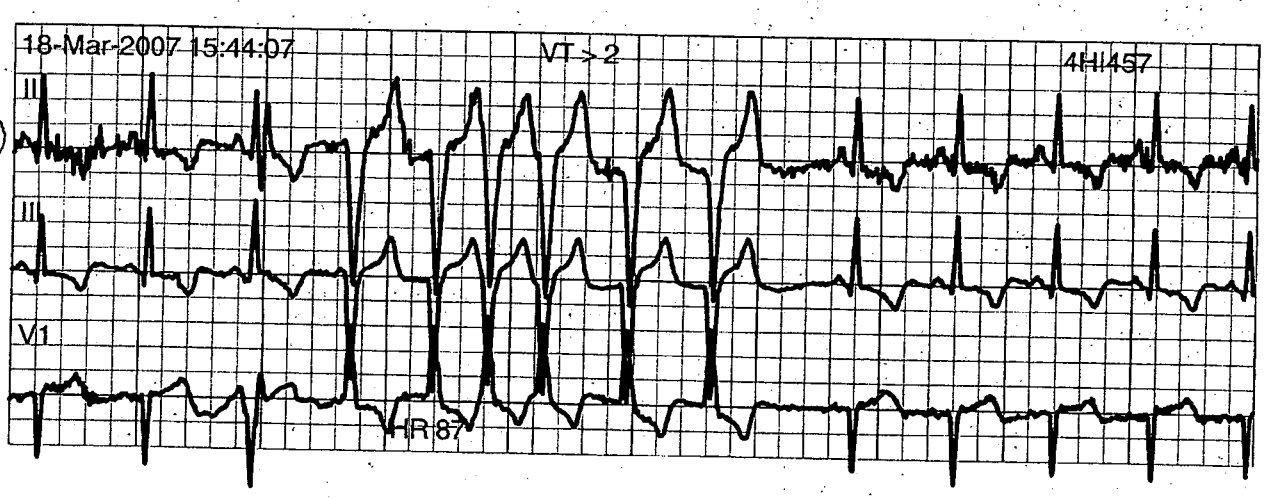
1061

6265

ARRHYTHMIA EVENT

002479

Name WINDHAM,TAMMY *MRN* 895682 *Unit* 4H *Bed* 457	*Date* 18-Mar-2007 *Time* 15:45:13 *Page* 1 of 1



Nurse Cindy Notified

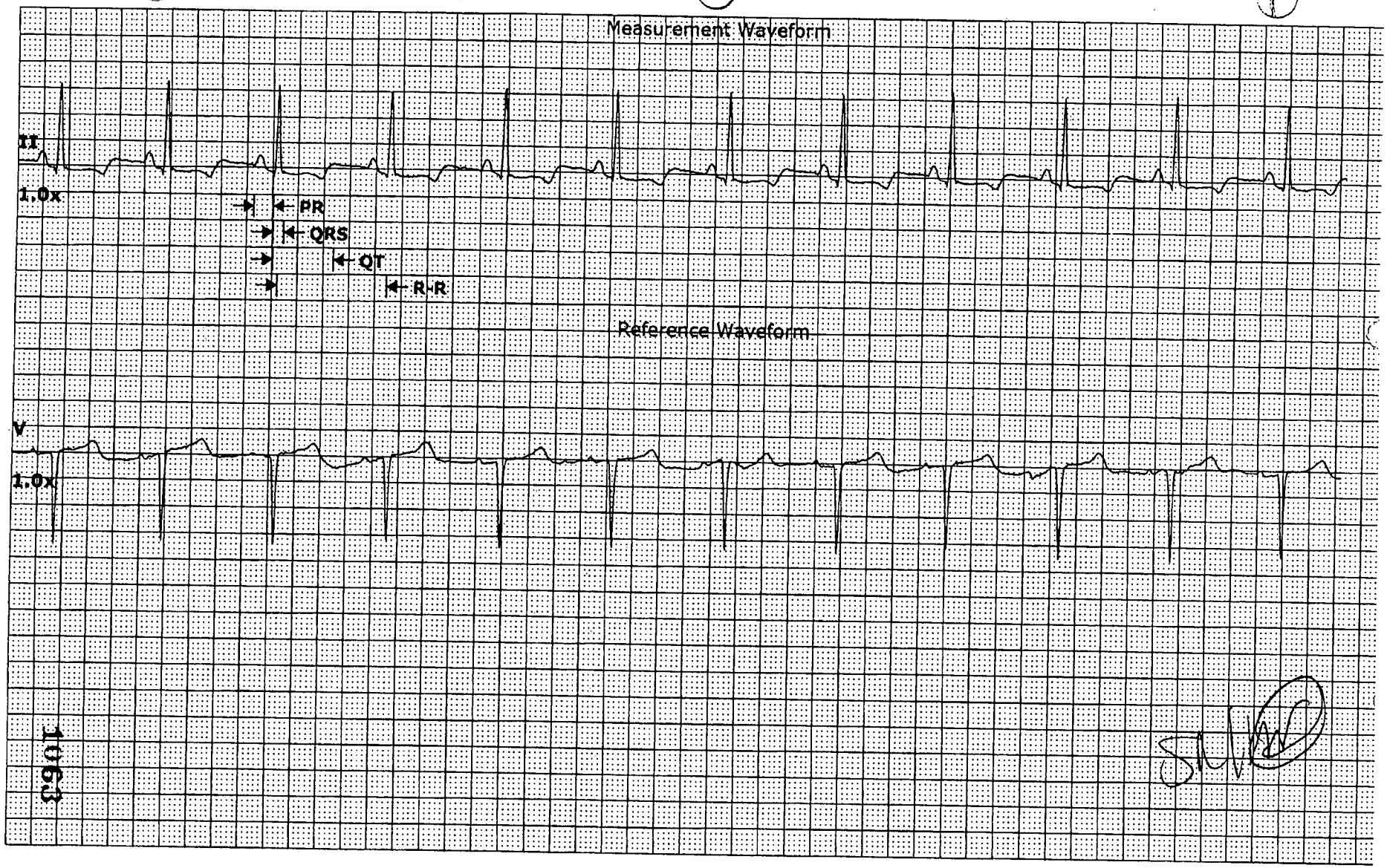
GE Healthcare

1062

6266

WINDHAM TA Y 895682 **Caliper easurements** 4H|4

18-Mar-2007 14 8 - 18-Mar-2007 14:58:48



Values displayed reflect measurements acquired against the measured waveform only.

PR	= 0.155	sec	QT	= 0.475	sec
QRS	= 0.087	sec	R-R	= 0.851	sec
QTc	= 0.515	sec	Rate	= 71	bpm

GE Medical Systems Information Technologies

CIC Version 5.0.3

Sunday, March 18, 2007 3:07:22 PM

002480

25 mi

Pa

END OF REF

6267

Admission History

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D 4H
Room/Bed: D H457-A

Arrival From+: OTHERHOSP
Mode of Arrival+: EMS
Accompanied By+: FAMILY
Pt. ID Band On: Y

HIPAA Passcode: 9048
History Obtained From+: PATIENT
Family Doctor: NO FAMILY MD
Organ Donor:

~~~~Admission Vital Signs~~~~

Blood Pressure: 95/62
BP Source+: AUT
BP Site+: RA
BP Position+: SIT

Pulse: 72
Pulse Source+: MON
Respirations: 18
Resp Source+: OBS

Temperature: 97.5
Temp Source+: ORL
SPO2 (%): 97
On Room Air: Y

Weight - Lb: 153 Oz: Kg: 69.39 Weight Source+: BED SCALE
Height - Feet: 5 Inches: 3 Cm: 160.02
BSA: 1.75621 BMI: 27.1

Living Will: Y
HC Power of Attorney: Y
If Living Will or HCPOA not Available, What are Pt. Wishes+: NO-FEED
NO-HYDRA
Surrogate Decision Maker for Health Care+: SON
Patient/Family Instructed to Bring Copy to the Hospital: Y
Would You Like Information Regarding Advanced Directives: N
Any Religious, Traditional, Cultural or Ethnic Needs that Need to be Part of Your Care: N
Based on any Religious,Cultural or Ethnic concerns, do you have objections to receiving blood/blood products+: N
Blood Refusal (NO BLOOD) Band On: N
Previous Blood Transfusions: N
Previous Blood Reactions: N
Autologous Blood Banked: N

Comment:

~~~~Personal Effects Inventory~~~~

Prosthesis: N
Disposition+:
Assistive Device+: WALKER
Disposition+:
Jewelry+: NONE
Disposition+:
Chart Patient's Other Belongings Now: Y Key/Locker #:
Key Taped To Chart:
Patient's Own Med. Equip. In Use+: NONE
Patient's Chief Complaint:

~~~~Adverse Reactions/Allergy/Medications~~~~

Pt/Family Adverse Reactions to Anesthesia: N
Explain:

Enter ALLERGIES Now: Y

Home Pain Management Routine: TYLENOL

~~~~MEDICAL HISTORY REVIEW~~~~

EENT Problems+: Y
EENT History+:

GI Problems+: Y
GI History+: HH

GU Problems+: N
GU History+:

Hearing+:
Vision+: GLASSES

GYN Problems+: N
GYN History+:

Endo/Hepatic Problems+: N
Endocrine History+:

Musculoskeletal Problems+: N
MusSkele History+:

Admission History

Patient: WINDHAM,TAMMY E
Account #: D00501829040
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Is Pt Pregnant: N
LMP: 3/16/07
Gravida: 2
Para: 1
Abortions: 0

Thyroid Problems+:
Diabetes+:
Control+:
Diabetes: N

Paralysis+:
Cancer: NONE
Transplant:

Neuro Problems+: N
Neuro History+:

Respiratory Problems+: N
Resp. History+:

CV Problems+: N
CV History+:

Seizures+:
Infectious Disease+: N
ID History+:

Previous Cardiac Procedures: N

Cardiac Cath:
PTCA:
Stents:
Brachy Therapy:
CABG:

~~~~Tuberculosis Screening-Symptoms and History~~~~

Fever: N
Night sweats: N
Unexplained weight loss: N
Persistent cough > than 3 wks: N

Bloody sputum: N
Exposure to TB within last 3 mths: N
Chest xray to rule out TB: N
Hx. Positive PPD: N

Medical History: HTN RECENT HX/ HIATAL HERNIA

Previous Surgeries: CHOLECYSTECTOMY/ APPENDECTOMY

~~~~Functional History of ADL's~~~~

Feeding+: SELF Mobility+: SELF Bathing+: SELF Dressing+: SELF
Prior to Admit, has ADL Function Declined in Past 2 Weeks: N
Prior to Admit, has Mobility Declined in Past 2 Weeks: N
Prior to Admit, has Cognition Declined in Past 2 Weeks: N
Prior to Admit, has Communication Changed in Past 2 weeks: N
Prior to Admit, has Swallowing Changed in Past 2 weeks: N
PT Screen Requested: N OT Screen Requested: N ST Screen Requested: N

~~~~Skin Integrity~~~~

Sensory Perception+: 4 NO IMPAIRMENT
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 4 EXCELLENT
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 23
Skin Comment:
Does Pt Have a Wound: N Wound Care Screen:

~~~~Nutritional Risk~~~~

Is Pt. Fed Via NG, PEG or TPN: N Diet: CARDIAC Appetite+: GOOD
Decubitus > or = to Stage 2: N Last BM: 03/16/07 Bowel Elimination Pattern+: DAILY

Admission History

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Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Breastfeeding: N
Swallowing Impaired: N
Vomiting: N
Chewing Impaired: N
Laxative/Enema+: RARE
Dietitian Consult: N

~~~~FALL RISK~~~~

History of Falls, Syncope, Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs, Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 0
Use Shift F8 to View Spot the Dot
Spot the Dot Implemented: N

~~~~Psychosocial~~~~

Tobacco Use+: CIGARETTE
Tobacco Use in Last Year: Y
Packs/Day: 1
Number of Years: 15

Alcohol: N
Frequency+:
Amount+:

Emotional Status+: CALM
Perception+: APPROP
Any Suspicion or Confirmation of Substance Abuse: N
Any Suspicion of Neglect or Abuse: N

~~~~Education~~~~

Able to Read: Y
Ability to Understand+: SIMPLE
Highest Education Level+: HS GRAD
Able to Write: Y
Healthcare Knowledge+: SOME KNOW
Barriers to Learning+: NONE
Learning Preferences+: 1:1

~~~~Discharge Planning Needs Assessment~~~~If Answering Yes to any Question, Consult PCC/RCC

Have You Been Hospitalized Within The Last 30 Days: Y
Do you Live Alone: N
Do You Live in an Extended Care Facility: N
Facility Name:
Do You Attend an Adult Daycare Facility: N
Name of Adult Daycare:
Did You Require Assistance with ADL's Prior to Admission: N
Do You Use Home Health Services: N
Type of Service+:
Company Name:
Do you Use Home Durable Medical Equipment: N
Do You Use Meals on Wheels: N
Do You have Transportation To/From MD Appointments: Y
Do you have a Personal Caregiver: N
Are Others Dependent on You for Their Care: Y
Any Concerns About Managing at Home After Your Discharge: Y
Do You Have Safety Concerns: N
Do You Have Prescription Coverage for Home Medications: N
Any Concerns re:Cost of Hospital Stay or Home Care: Y
Will Current Housing be Appropriate Upon Discharge: N
Patient is Ill with Terminal Prognosis: N
Do You Currently have Hospice Services: N
Document Nurse's Notes: Y
Name of Hospice Company:

<File>

~~~~~~~~BELONGINGS CHECKLIST~~~~~~~~

Clothing: Y
Shirt: Y
Sweater:
Pants: Y
Underwear: Y
Socks/Hose: Y
Robe:
Gown:
Dress:

Accessories: N
Coat:
Shoes:
Hat/Cap:
Gloves:
Purse/Wallet:
$:
Keys:

1066
~~~~~~~~

Admission History

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Jewelry: N Ring: Necklace: Watch: Bracelet:
Other:

Misc.: Y Glasses: Y Contacts: Hearing Aid: Walker/Cane:
Dentures: Y Upper Plate: Lower Plate: Partial Bridge:

Disposition of Belongings: Patient: Family: Y Security:
Other - Name:
Other:

Medication/Other Allergies: NKDA

Food Allergies: NKFA NO KNOWN FOOD ALLERGIES

Latex Allergy: N

Contrast Allergy: N

WBC: Hgb: Glucose:
Wound #1
Location: Type+: Stage+:
Length: Width: Depth: Wound Base+:
Drainage+: Amount+: Odor: Undermining:
Tunneling:
Condition of Surrounding Tissue+: Wound Protocol+:
Any Signs of Infection: Type of Treatment+:
Staples/Sutures+:
Signs of Infection at Staple/Suture Site:
Wound #2

Location: Type+: Stage+:
Length: Width: Depth: Wound Base+:
Drainage+: Amount+: Odor: Undermining:
Tunneling:

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Admission History

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Condition of Surrounding Tissue+:
Any Signs of Infection: Type of Treatment+: Wound Protocol+:
Staples/Sutures+:
Signs of Infection at Staple/Suture Site:

Wound #3

Location: Type+:
Length: Width: Depth: Stage+:
Drainage+: Amount+: Odor: Wound Base+:
Tunneling: Undermining:

Condition of Surrounding Tissue:
Any Signs of Infection: Type of Treatment:
Staples/Sutures+: Wound Protocol+:
Signs of Infection at Staple/Suture Site:

Wound #4

Location: Type+:
Length: Width: Depth: Stage+:
Drainage+: Amount+: Odor: Wound Base+:
Tunneling: Undermining:

Condition of Surrounding Tissue:
Any Signs of Infection: Type of Treatment:
Staples/Sutures+: Wound Protocol+:
Signs of Infection at Staple/Suture Site:
Wound Care Nurse Following Patient:
Patient on a Specialty Bed:
Type of Bed+:
Wound Vac Therapy:
Location:
Date Initiated:
Therapy Mode:
Pressure (mmHg):

Comment:

Occurred Date: 03/18/07
Monogram: CNS Initials: SCHULTCN Name: SCHULTZ,CYNTHIA N
Occurred Time: 1512
Nurse Type: RNBP

Admission Physical

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

~~~~NEUROLOGICAL~~~~

Level of Responsiveness+: A/OX3
Does NOT Respond to+:
Pupil Size L (mm):
Pupil Reaction Left+:
Pupil Size R (mm):
Pupil Reaction Right+:
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
Right Grip+: STRONG
Left Grip+: STRONG

~~~~CARDIOVASCULAR~~~~

Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Left Upper Extremity+:
Left Lower Extremity+:
Right Upper Extremity+:
Right Lower Extremity+:
JVD: N
Peripheral Edema: N
Edema Location:
ICD: N
Permanent Pacemaker: N
% Capturing:
% Sensing:

Pulses
Pulses 3+ or > Palp in All Extremities: Y
Right Dorsalis Pedis+:
Right Posterior Tibial+:
Right Radial+:
Right Other:
Left Dorsalis Pedis+:
Left Posterior Tibial+:
Left Radial+:
Left Other:
Temp Pacemaker N
Type+:
Rate:
Atrial mA/mV:
Ventricular mA/mV:
AVI (msecs):
Demand:
Pacerwires (Intact):

~~~~RESPIRATORY~~~~

Respirations+: NORMAL
Breath Sounds Clear X4: Y
Right Upper Lobe+:
Right Mid Lobe+:
Right Lower Lobe+:
Left Upper Lobe+:
Left Lower Lobe+:
Cough+: NONE
Sputum Color+:
Sputum Amount+:

Chest Tubes: N
Chest Tube # 1+:
Chest Tube # 2+:
Chest Tube # 3+:
Chest Tube # 4+:
Chest Tubes Patent:
Water Seal 2cm:
Suction (cmH2O):
Suction+:
Air Leak:
Auto Transfusion Bag:
Drainage+:

~~~~GASTROINTESTINAL~~~~

Abdomen+: SOFT
WNL
Tender on Palpation: N
Bowel Sounds Active X 4: Y
Left Upper Quadrant+:
Left Lower Quadrant+:
Right Upper Quadrant+:
Right Lower Quadrant+:

NG/Feeding/PEG Tube: N
Type+:
Site+:
Placement Check+:
Drainage+:

Admission Physical

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D 4H
Room/Bed: D H457-A

~~~~Immunizations~~~~
Tetanus (Within 5 Yrs): N
Hepatitis B: N
Pneumovax (Last 5 Yrs): N
Influenza (Within 1 yr): N

Suction+:

Feeding+:
Rate:

~~~~GENITOURINARY~~~~
Incontinence: N Ileoconduit: N
Foley: N
Urine+: CLEAR
Size:
Patent and Draining Urine:
Color+: YELLOW

~~~~MUSCULOSKELETAL~~~~
Extremity Movement+: X4
Splint/Support: N
Affected Extremity+:
Type:
Muscle Contractures+: NONE
Location:
Muscle Cramping+: NONE
Other:
Muscle Spasms+: NONE

~~~~INTEGUMENT~~~~
Skin Temp+: WARM
Skin Integrity+: INTACT
Moisture+: DRY
BRUISE
Color+: NORMAL
Other:
Turgor+: NORMAL
~~PAIN~~
Pain: N If Yes, Document on the Pain Assessment.

Plan of Care: CHESTPAIN
Hospital Standard of Care: Y
Care Area Intervention Set+: PCU CARDIAC CARE
Age Appropriate Standards+: A.ADULT ADULT - AGE 18-65 YRS
Document Nurse's Notes: Y
Pain Indicators+:
<File>

Pain Scale:
Pain Location #1+:
Pain Description+:
Pain Onset/Duration:
Frequency+:
Pain Intervention+:

Pain Scale:
Pain Location #2+:
Pain Description+:
Pain Onset/Duration:
Frequency+:
Pain Intervention+:

Medication:

Medication:

Blood Pressure:
Pulse:
Respirations:
SPO2 (%):

Discussed Home Pain Management Plan With Patient/Family/SO:

Admission Physical

Patient: WINDHAM,TAMMY E
Account #: D00501829048
Admit Date: 03/18/07
Status: ADM IN
Attending: JUK,S STANLEY

Age/Sex: 39 F
Unit #: M000895682
Location: D.4H
Room/Bed: D.H457-A

Comment:

Occurred Date: 03/18/07
Monogram: JLE Initials: EPPSJL Name: EPPS,JESSICA L

Occurred Time: 1507
Nurse Type: RN

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PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
2435 FOREST DRIVE/COLUMBIA, SC 29204 / 120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203
PHONE (803) 256-5330, FAX (803) 256-5785 PHONE (803) 865-4550 , FAX (803) 865-4638

Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories

PATIENT: WINDHAM,TAMMY E **ACCT #:** D00501829048 **LOC:** D.4H **U #:** M000895682
REG DR: Juk,S. Stanley **AGE/SX:** 39/F [redacted] **ROOM:** D.H457 **REG:** 03/18/07
BED: A **DIS:** 03/21/07
STATUS: DIS IN **TLOC:**

SPEC #: 0320:C00137R **COLL:** 03/20/07-0310 **STATUS:** COMP **REQ #:** 01016231
RECD: 03/20/07-0352 **SUBM DR:** Juk,S. Stanley

ENTERED: 03/20/07-0002 **OTHR DR:**
ORDERED: BMP, LIPID, TROPRFLX, CKMB TOT&INDEX
COMMENTS: LIPID ADDED AT 1005
Campus: DTP

Test	Result	Flag	Reference	Site
BASIC METABOLIC PANEL				
SODIUM	136		136-145 MMOL/L	
POTASSIUM	4.0		3.6-5.2 mmol/L	
CHLORIDE	101		98-107 MMOL/L	
CARBON DIOXIDE	25		21-32 MMOL/L	
ANION GAP	14		10-20	
GLUCOSE	109		70-110 MG/DL	
BUN	10		7-20 MG/DL	
CREATININE	0.7		0.6-1.3 MG/DL	
BUN/CREA RATIO	14			
CALCIUM	8.8		8.8-10.5 mg/dl	
LIPID PROFILE (CORONARY RISK)				
TRIGLYCERIDES	122		30-150 MG/DL	
CHOLESTEROL	157		100-200 MG/DL	
HDL CHOLESTEROL	33	L	40-60 MG/DL	
LDL	99.6		MG/DL	
	REFERENCE RANGE FOR LDL IS LESS THAN 120			
VLDL CHOLESTEROL	24		0-40	
CORONARY RISK	4.8	H	3.0-4.5	
TROPONIN I/REFLEX	6.14	H	0.00-0.6 NG/ML	
	THIS IS A TROPONIN I WITH REFLEX. A CK TOTAL, CKMB TOTAL AND A CKMB INDEX WILL BE PERFORMED ONLY IF TROPONIN I IS GREATER THAN 0.6 NG/ML			
CK TOTAL, CKMB AND CKMB INDEX				
CK TOTAL	127		21-232 U/L	
CKMB TOTAL	10.7	H	0-5 NG/ML	
	CKMB INDEX IS NOT CALCULATED ON CKMB TOTAL LESS THAN 5 OR IF A CK TOTAL IS NOT ORDERED			
CKMB INDEX	8.4		%	

RUN DATE: 03/17/09 **RUN TIME:** 0935
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PROVIDENCE HOSPITALS
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Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories

PATIENT: WINDHAM,TAMMY E **ACCT #:** D00501829048 **LOC:** D.4H **U #:** M000895682
AGE/SX: 39/F **ROOM:** D.H457 **REG:** 03/18/07
REG DR: Juk,S. Stanley [redacted] **BED:** A **DIS:** 03/21/07
TLOC:

Specimen: 0320:C00137R **Collected:** 03/20/07-0310 **(Continued)**

Test	Result	Flag	Reference	Site
	IMPRESSION	*CKMB (NG/ML)*	*CKMB INDEX*	
	1. NEGATIVE	*<5*	*NOT CALCULATED*	
	2. SUSPICIOUS	*> OR = 5*	*1.1 - 2.5 %*	
	3. MYOCARDIAL INJURY	*> OR =5*	*> OR = 2.5%*	
	THE CKMB INDEX CAN NOT BE CALCULATED WITHOUT A TOTAL CK			
	THE CKMB INDEX IS NOT CALCULATED ON CKMB TOTALS LESS THAN 5.			

RUN DATE: 03/17/09 **RUN TIME:** 0935
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E **ACCT #:** D00501829048 **LOC:** D 4H **U #:** M000895682
REG DR: Juk,S. Stanley [redacted] **ROOM:** D H457 **REG:** 03/18/07
BED: A **DIS:** 03/21/07
TLOC:

SPEC #: 0318:C00187T **COLL:** 03/18/07-1615 **STATUS:** COMP **REQ #:** 01014515
RECD: 03/18/07-1714 **SUBM DR:** Juk,S. Stanley

ENTERED: 03/18/07-1543 **OTHR DR:**
ORDERED: BMP, MAG, TROPRFLX, CKMB TOT&INDEX
COMMENTS: Campus: DTP
X LV, BLU

Test	Result	Flag	Reference	Site
BASIC METABOLIC PANEL				
SODIUM	137		136-145 MMOL/L	
POTASSIUM	3.6		3.6-5.2 mmol/L	
CHLORIDE	103		98-107 MMOL/L	
CARBON DIOXIDE	24		21-32 MMOL/L	
ANION GAP	14		10-20	
GLUCOSE	133	H	70-110 MG/DL	
BUN	9		7-20 MG/DL	
CREATININE	0.9		0.6-1.3 MG/DL	
BUN/CREA RATIO	10			
CALCIUM	9.0		8.8-10.5 mg/dl	
MAGNESIUM	1.9		1.6-2.4 mg/dl	
TROPONIN I/REFLEX	38.21	H	0.00-0.6 NG/ML	
	THIS IS A TROPONIN I WITH REFLEX. A CK TOTAL, CKMB TOTAL AND A CKMB INDEX WILL BE PERFORMED ONLY IF TROPONIN I IS GREATER THAN 0.6 NG/ML			
CK TOTAL, CKMB AND CKMB INDEX				
CK TOTAL	1263	H	21-232 U/L	
CKMB TOTAL	183.9	H	0-5 NG/ML	
	CKMB INDEX IS NOT CALCULATED ON CKMB TOTAL LESS THAN 5 OR IF A CK TOTAL IS NOT ORDERED			
CKMB INDEX	14.6		%	

IMPRESSION	*CKMB (NG/ML)*	*CKMB INDEX*
1. NEGATIVE	*<5*	*NOT CALCULATED*
2. SUSPICIOUS	*> OR = 5*	*1.1 - 2.5 %*
3. MYOCARDIAL INJURY	*> OR =5*	*> OR = 2.5%*

THE CKMB INDEX CAN NOT BE CALCULATED WITHOUT A TOTAL CK

RUN DATE: 03/17/09 **RUN TIME:** 0935
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PATIENT: WINDHAM,TAMMY E	**ACCT #:** D00501829048	**LOC:** D.4H	**U #:** M000895682
	AGE/SX: 39/F	**ROOM:** D.H457	**REG:** 03/18/07
REG DR: Juk,S. Stanley	[redacted]	**BED:** A	**DIS:** 03/21/07
	STATUS: DIS IN	**TLOC:**	

Specimen: 0318:C00187T **Collected:** 03/18/07-1615 **(Continued)**

Test	Result	Flag	Reference	Site
	THE CKMB INDEX IS NOT CALCULATED ON CKMB TOTALS LESS THAN 5.			

RUN DATE:03/17/09 **RUN TIME:** 0935
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

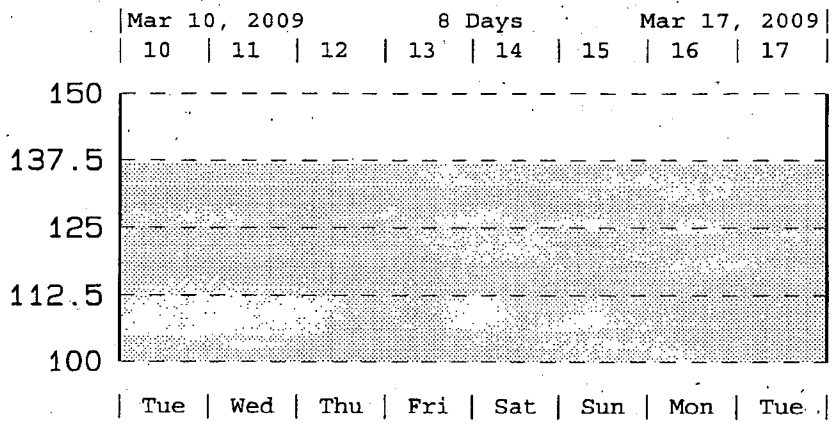
Providence Hospital PCI **LIVE**

Laboratory Test History

WINDHAM,TAMMY E (M000895682) **ACTIVATED CLOTTING TIME**

Age/Sex: 41 F

Mar 10, 2009 through Mar 17, 2009



Shaded reference area may not reflect Normal Range

Date	Time	ACT	Reference	Result Flags

No data in this time period

1076

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PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
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PATIENT: WINDHAM,TAMMY E
REG DR: Juk,S. Stanley
ACCT #: D00501829048
AGE/SX: 39/F
[redacted]
STATUS: DIS IN
LOC: D.4H
ROOM: D.H457
BED: A
TLOC:
U #: M000895682
REG: 03/18/07
DIS: 03/21/07

SPEC #: 0320:H00100R
COLL: 03/20/07-0310
RECD: 03/20/07-0352
STATUS: COMP
SUBM DR: Juk,S. Stanley
REQ #: 01016232

ENTERED: 03/20/07-0002
ORDERED: CBC W/AUTO DIFF
COMMENTS: Campus: DTP
OTHR DR:

Test	Result	Flag	Reference	Site
CBC WITH AUTO DIFF				
WHITE BLOOD CELL	**10.9**	*H*	3.53-9.57 K/UL	
RBC	**4.74**		3.96-5.50 M/UL	
HEMOGLOBIN	**9.9**	*L*	12.14-16.27 GM/DL	
HEMATOCRIT	**31.6**	*L*	35.39-47.19 %	
MCV	**66.7**	*L*	76.9-94.7 FL	
MCH	**20.8**	*L*	25.79-32.95 PG	
MCHC	**31.16**	*L*	33.34-35.47 G/DL	
RDW	**20.11**	*H*	12.09-15.17 %	
PLATELET COUNT	343		169.06-413.23 K/MM3	
MPV	8.7		7.54-11.24 FL	
GRANULOCYTE %	**77.0**	*H*	41.72-73.74 %	
LYMPHOCYTE %	**15.8**	*L*	18.43-44.97 %	
MONOCYTE %	5.1		1.7-9.3 %	
EOSINOPHIL %	1.5		0.72-8.06 %	
BASOPHIL %	0.6		0.17-1.43 %	
GRANULOCYTE #	**8.4**	*H*	1.66-6.72 K/mm3	
LYMPHOCYTE #	1.7		0.92-2.66 K/mm3	
MONOCYTE #	0.6		0.24-0.78 K/mm3	
EOSINOPHIL #	0.2		0.04-0.52 K/mm3	
BASOPHIL #	**0.1**	*H*	0.01-0.09 K/mm3	

RUN DATE: 03/17/09 **RUN TIME:** 0935
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

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PATIENT: WINDHAM,TAMMY E
REG DR: Juk,S. Stanley

ACCT #: D00501829048 **LOC:** D.4H **U #:** M000895682
AGE/SX: 39/F **ROOM:** D H457 **REG:** 03/18/07
[redacted] **BED:** A **DIS:** 03/21/07
STATUS: DIS IN **TLOC:**

SPEC #: 0318:H00154T **COLL:** 03/18/07-1615 **STATUS:** COMP **REQ #:** 01014515
RECD: 03/18/07-1905 **SUBM DR:** Juk,S. Stanley

ENTERED: 03/18/07-1905 **OTHR DR:**
ORDERED: CBC W/AUTO DIFF
COMMENTS: ADD CBCD 1900

Test	Result	Flag	Reference	Site
CBC WITH AUTO DIFF				
WHITE BLOOD CELL	13.5	H	3.53-9.57 K/UL	
RBC	5.66	H	3.96-5.50 M/UL	
HEMOGLOBIN	11.5	L	12.14-16.27 GM/DL	
HEMATOCRIT	37.3		35.39-47.19 %	
MCV	65.8	L	76.9-94.7 FL	
MCH	20.4	L	25.79-32.95 PG	
MCHC	30.99	L	33.34-35.47 G/DL	
RDW	20.65	H	12.09-15.17 %	
PLATELET COUNT	459	H	169.06-413.23 K/MM3	
MPV	10.0		7.54-11.24 FL	
GRANULOCYTE %	78.2	H	41.72-73.74 %	
LYMPHOCYTE %	15.5	L	18.43-44.97 %	
MONOCYTE %	4.7		1.7-9.3 %	
EOSINOPHIL %	1.5		0.72-8.06 %	
BASOPHIL %	0.1	L	0.17-1.43 %	
GRANULOCYTE #	10.6	H	1.66-6.72 K/mm3	
LYMPHOCYTE #	2.1		0.92-2.66 K/mm3	
MONOCYTE #	0.6		0.24-0.78 K/mm3	
EOSINOPHIL #	0.2		0.04-0.52 K/mm3	
BASOPHIL #	0.0	L	0.01-0.09 K/mm3	

RUN DATE: 03/17/09 **RUN TIME:** 0936
Patient: WINDHAM,TAMMY E **Age/Sex:** 39/F **Acct#**D00501829048 **Unit#**M000895682

Problem Description / Intervention Description / Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Comment / Documented Units | From / Change

Activity Date: 03/18/07 Time: 1500

3591 RT: O2 Per 12 Hours A PS
- Document 03/18/07 1500 LFB 03/18/07 1817 LFB
O2 Device+: CANNULA
Oxygen Amount: 2 L/M
FIO2%: 0
Reasons for Oxygen Therapy+: PHYSICIAN ORDER
10542 Support: Emotional A CP
- Create 03/18/07 1500 LFB 03/18/07 1817 LFB
11004 Respiratory: Pulmonary Toilet A CP
- Create 03/18/07 1500 LFB 03/18/07 1817 LFB

Activity Date: 03/18/07 Time: 1506

20140 Home Medication List + A .PRN AS
- Create 03/18/07 1506 JLE 03/18/07 1507 JLE
- Document 03/18/07 1506 JLE 03/18/07 1507 JLE
List All
Home Medications (except those listed above).
Include Med. Name.
Dose, Route,
& Frequency. Also Include Any
Over-The-Counter
Medicines, Herbal Remedies
Or Vitamins
Does Patient Take Any Home Medicines: N
Medication History Obtained From+: PATIENT
Disposition of Meds+: NONE

Activity Date: 03/18/07 Time: 1507

1011 NUR: Admission Physical+ A ONCE AS
- Create 03/18/07 1507 JLE 03/18/07 1554 JLE
- Document 03/18/07 1507 JLE 03/18/07 1554 JLE
----NEUROLOGICAL----
Level of Responsiveness+: A/OX3
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
----CARDIOVASCULAR----
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N

Activity Date: 03/18/07 Time: 1507 (continued)

1011 NUR: Admission Physical+ (continued)
Temp Pacemaker N
----RESPIRATORY----
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
----GASTROINTESTINAL----
Abdomen+: SOFT
WNL
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
----Immunizations----
Tetanus (Within 5 Yrs): N
Hepatitis B: N
Pneumovax (Last 5 Yrs): N
Influenza (Within 1 yr): N
----GENITOURINARY----
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
----MUSCULOSKELETAL----
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
----INTEGUMENT----
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: NORMAL
Skin Integrity+: INTACT
BRUISE
--PAIN--
Pain: N
If Yes, Document on the Pain Assessment.
Plan of Care: CHESTPAIN
Hospital Standard of Care: Y
Care Area Intervention Set+: PCU CARDIAC CARE
Age Appropriate Standards+: A.ADULT ADULT - AGE 18-65 YRS
Document Nurse's Notes: Y

Activity Date: 03/18/07 Time: 1512

1001 NUR: Admission History+ A ONCE AS
- Create 03/18/07 1512 CNS 03/18/07 1532 CNS

1079

002496

6283

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | Recorded by | Recorded Date | Recorded Time | Documented by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/18/07 Time: 1512

1001 NUR: Admission History+ A ONCE AS
- Document 03/18/07 1512 CNS 03/18/07 1532 CNS
Arrival From+: OTHERHOSP
Mode of Arrival+: EMS
Accompanied By+: FAMILY
Pt. ID Band On: Y
HIPAA Passcode: 9048
History Obtained From+: PATIENT
Family Doctor: NO FAMILY MD
~~~~Admission Vital Signs~~~~
Blood Pressure: 95/62
BP Source+: AUT
BP Site+: RA
BP Position+: SIT
Pulse: 72
Pulse Source+: MON
Respirations: 18
Resp Source+: OBS
Temperature: 97.5
Temp Source+: ORL
SPO2 (%): 97
On Room Air: Y
Weight - Lb: 153
Kg: 69.39
Weight Source+: BED SCALE
Height - Feet: 5
Inches: 3
Cm: 160.02
BSA: 1.75621
BMI: 27.1
Living Will: Y
HC Power of Attorney: Y
If Living Will or HCPOA not Available, What are Pt. Wishes+: NO-FEED
NO-HYDRA

Surrogate Decision Maker for Health Care+: SON
Patient/Family Instructed to Bring Copy to the Hospital: Y
Would You Like Information Regarding Advanced Directives: N
Any Religious, Traditional, Cultural or Ethnic
Needs that Need to be Part of Your Care: N
Based on any Religious,Cultural or Ethnic concerns, do you
have objections to receiving blood/blood products+: N
Blood Refusal (NO BLOOD) Band On: N
Previous Blood Transfusions: N
Previous Blood Reactions: N
Autologous Blood Banked: N
~~~~Personal Effects Inventory~~~~
Prosthesis: N
Assistive Device+: WALKER
Jewelry+: NONE
Chart Patient's Other Belongings Now: Y
Patient's Own Med. Equip. In Use+: NONE

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | Recorded by | Recorded Date | Recorded Time | Documented by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/18/07 Time: 1512 (continued)

1001 NUR: Admission History+ (continued)
~~~~Adverse Reactions/Allergy/Medications~~~~
Pt/Family Adverse Reactions to Anesthesia: N
Enter ALLERGIES Now: Y
Home Pain Management Routine: TYLENOL
~~~~MEDICAL HISTORY REVIEW~~~~
EENT Problems+: Y
Vision+: GLASSES
GI Problems+: Y
GI History+: HH
GU Problems+: N
GYN Problems+: N
Is Pt Pregnant: N
LMP: 3/16/07
Gravida: 2
Para: 1
Abortions: 0
Endo/Hepatic Problems+: N
Diabetes: N
Musculoskeletal Problems+: N
Cancer: NONE
Neuro Problems+: N
Respiratory Problems+: N
CV Problems+: N
Infectious Disease+: N
Previous Cardiac Procedures: N
~~~~Tuberculosis Screening-Symptoms and History~~~~
Fever: N
Night sweats: N
Unexplained weight loss: N
Persistent cough > than 3 wks: N
Bloody sputum: N
Exposure to TB within last 3 mths: N
Chest xray to rule out TB: N
Hx. Positive PPD: N
Medical History: HTN RECENT HX/ HIATAL HERNIA
Previous Surgeries: CHOLECYSTECTOMY/ APPENDECTOMY
~~~~Functional History of ADL's~~~~
Feeding+: SELF
Mobility+: SELF
Bathing+: SELF
Dressing+: SELF
Prior to Admit, has ADL Function Declined in Past 2 Weeks: N
Prior to Admit, has Mobility Declined in Past 2 Weeks: N
Prior to Admit, has Cognition Declined in Past 2 Weeks: N
Prior to Admit, has Communication Changed in Past 2 weeks: N
Prior to Admit, has Swallowing Changed in Past 2 weeks: N
PT Screen Requested: N
OT Screen Requested: N
ST Screen Requested: N
~~~~Skin Integrity~~~~
~~~~

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/18/07 Time: 1512 (continued)

1001 NUR: Admission History+ (continued)
Sensory Perception+: 4 NO IMPAIRMENT
Activity+: 4 WALKS FREQUENTLY
Nutrition+: 4 EXCELLENT
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 23
Does Pt Have a Wound: N
----Nutritional Risk----
Is Pt. Fed Via NG, PEG or TPN: N
Diet: CARDIAC
Appetite+: GOOD
Decubitus > or = to Stage 2: N
Last BM: 03/16/07
Bowel Elimination Pattern+: DAILY
Breastfeeding: N
Vomiting: N
Laxative/Enema+: RARE
Swallowing Impaired: N
Chewing Impaired: N
Dietitian Consult: N
----FALL RISK----
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 0
Use Shift F8 to View Spot the Dot
Spot the Dot Implemented: N
----Psychosocial----
Tobacco Use+: CIGARETTE
Tobacco Use in Last Year: Y
Packs/Day: 1
Number of Years: 15
Alcohol: N
Emotional Status+: CALM
Perception+: APPROP
Any Suspicion or Confirmation of Substance Abuse: N
Any Suspicion of Neglect or Abuse: N
----Education----
Able to Read: Y
Able to Write: Y
Ability to Understand+: SIMPLE

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/18/07 Time: 1512 (continued)

1001 NUR: Admission History+ (continued)
Healthcare Knowledge+: SOME KNOW
Highest Education Level+: HS GRAD
Barriers to Learning+: NONE
Learning Preferences+: 1:1
----Discharge Planning Needs Assessment----
If Answering Yes to any Question, Consult PCC/RCC
Have You Been Hospitalized Within The Last 30 Days: Y
Do you Live Alone: N
Do You Live in an Extended Care Facility: N
Do You Attend an Adult Daycare Facility: N
Did You Require Assistance with ADL's Prior to Admission: N
Do You Use Home Health Services: N
Do you Use Home Durable Medical Equipment: N
Do You Use Meals on Wheels: N
Do You have Transportation To/From MD Appointments: Y
Do you have a Personal Caregiver: N
Are Others Dependent on You for Their Care: Y
Any Concerns About Managing at Home After Your Discharge: Y
Do You Have Safety Concerns: N
Do You Have Prescription Coverage for Home Medications: N
Any Concerns re:Cost of Hospital Stay or Home Care: Y
Will Current Housing be Appropriate Upon Discharge: N
Patient is Ill with Terminal Prognosis: N
Do You Currently have Hospice Services: N
Document Nurse's Notes: Y
--------BELONGINGS CHECKLIST--------
Clothing: Y
Shirt: Y
Pants: Y
Underwear: Y
Socks/Hose: Y
Accessories: N
Jewelry: N
Misc.: Y
Glasses: Y
Dentures: Y
Disposition of Belongings:
Family: Y
Medication/Other Allergies: NKDA
Food Allergies: NKFA NO KNOWN FOOD ALLERGIES
Latex Allergy: N
Contrast Allergy: N

Activity Date: 03/18/07 Time: 1518

Patient Notes: NURSE
- Create 03/18/07 1518 JLE 03/18/07 1554 JLE
Abnormal? N Confidential? N
PT ADMITTED TO ROOM 457. UPON ARRIVAL TO ROOM. NEW INT 20G PLACED IN LAC. INT FROM LFA REMOVED BECAUSE IT WAS HURTING THE PT. DRESSING REMOVED FROM RT HAND.

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Documented Comment Units | From Change

Activity Date: 03/18/07 Time: 1518 (continued)

Patient Notes: NURSE (continued)
GOLF BALL SIZED HEMATOMA ON RT WRIST. CINDY SCHULTZ, RN HELD PRESSURE AND HEMATOMA SOFTENED. NTG DECREASED TO 1.5 ML/HR. INTEGRILLIN AT 11 ML/HR. PT DENIES CHEST PAIN CURRENTLY. ADMISSION ASSESSMENT COMPLETE. 02 @ 2L VIA NC. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1523

Patient Notes: NURSE
- Create 03/18/07 1523 CNS 03/18/07 1532 CNS
Abnormal? N Confidential? N
1450 PATIENT ARRIVED VIA STRECTHER INTO ROOM 457 ACCLIMATED TO ROOM DENIES CHEST PAIN VSS R HAND INT OUT GOLF BALL SIZE HEMATOMA PRESENT PATIENT ASKING IF SHE CAN SMOKE CIGARETTES DURRING HOSPITALIZATION ADMISSION HX COMPLETED AT BEDSIDE ATTENDING NURSE JESSICA EPPS RN COMPLETING PHYSICAL ASSESSMENT.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1533

Problem: DECREASED CARDIAC OUTPUT A
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10000 Cardiovascular: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10001 Cardiac Rhythm: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
Problem: CHEST PAIN: ANGINA A
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10011 Chest Pain: Monitor + A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
Problem: ALTERATION IN BOWEL ELIMINATION A
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10015 Constipation: Treat as Ordered A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10048 Activity: as Tolerated/Ordered A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10185 Bowel Movement: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10579 Gastrointestinal: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
136 Fluid: Force A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
Problem: ANXIETY A
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10017 Referral: Pastoral Care as Needed A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS

Activity Date: 03/18/07 Time: 1533

10018 Anxiety: Medicate as Ordered A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10542 Support: Emotional A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
11041 Rest Periods: Provide A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
11601 Environment: Control Stim/Activity A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
Problem: KNOWLEDGE DEFICIT A
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10009 Cardiac Rehab: Phase I A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
Problem: CARDIAC CATH PROCEDURE A
1. Decreased Cardiac Output
2. Pain
3. Anxiety
4. Knowledge Deficit
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10000 Cardiovascular: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10001 Cardiac Rhythm: Monitor A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10009 Cardiac Rehab: Phase I A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10011 Chest Pain: Monitor + A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10012 Cardiac Cath: Pre-Procedure Assessment A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10017 Referral: Pastoral Care as Needed A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10018 Anxiety: Medicate as Ordered A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10022 Allow Pt to Verbalize Concerns A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
10542 Support: Emotional A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
11041 Rest Periods: Provide A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
11601 Environment: Control Stim/Activity A CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
20105 Post Cath Monitor + A PER PROTOCOL CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS
20106 Sheath Removal Monitor + A PER PROTOCOL CP
- Create 03/18/07 1533 CNS 03/18/07 1533 CNS

Activity Date: 03/18/07 Time: 1534

Problem: ADULT - AGE 18-65 YRS A
Potential Alteration in Normal Processes (ADL's, Safety, Life Situations) r/t Hospitalization

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Comment | Directions | Documented Units | From Change

Problem: ADULT - AGE 18-65 YRS (continued)
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness. Home Situation. Job. Life Style Changes and/or Families Inability to Cope

- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
10048 Activity: as Tolerated/Ordered A CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
11690 ADL: Encourage Independence A CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
Problem: GUIDELINES FOR NURSING DOCUMENTATION A
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
11040 Meds: As Ordered A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
15001 IV Insertion/Removal + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
20140 Home Medication List + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
20145 Advance Directives Monitor + A .PER PROTOCOL CP
--Two Attempts To Acquire Hard Copy For Chart Required
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
20150 Emergency Contact Information + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4001 VS: Monitor + A Q4HOURS CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4002 Shift Assessment + A QSHIFT CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4004 Nursing: Daily Process + A Q12H10 CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4055 Notify: MD + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4065 Pain: Monitor + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4066 Pain: Reassess + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4085 Transfer: Another Unit + A .PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS

Activity Date: 03/18/07 Time: 1534

4090 Meals: Percentage Consumed + A TID CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4100 ADL: + A QS&PRN CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4110 I&O: Monitor + A TID CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4120 Weight + A DAILY CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4130 Education: + A DAILY CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
4140 Discharge Instruction + A ONCE CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
9040 Blood Product: Administer as Ordered+ A .PER PROTOCOL CP
-THIS INTERVENTION IS USED ON ALL PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Create 03/18/07 1534 CNS 03/18/07 1534 CNS

Activity Date: 03/18/07 Time: 1544

Patient Notes: NURSE
- Create 03/18/07 1544 JLE 03/18/07 1556 JLE
Abnormal? N Confidential? N
PT HAD 6 BEAT RUN OF VTACH. PT STATES SHE HAD A LITTLE CHEST PAIN DURING THE EPISODE BUT IT IS NO LONGER THERE. NTG AT 1.5 ML/HR. STAT EKG ORDERED.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1554

Problem: PNEUMOVAX SCREENING ASSESSMENT A
This diagnosis is used to screen the patient population for qualification for the Pneumovax Vaccination.
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
20180 Pneumovax Screening Assessment+ A ONCE CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
Problem: Frequently Used PCU Interventions A
These Interventions Are Frequently Used And/Or High Priority Nursing Interventions In The Cardiac Care Areas. They Are Placed in Process Interventions As A Conveience For The Nursing Staff.
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE

1083

002500

6287

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/18/07 Time: 1554

10008 Wound: Monitor + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
10011 Chest Pain: Monitor + A .PRN CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
10175 Instruction: Special Nursing A .PRN CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
20105 Post Cath Monitor + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
20120 Blood Sugar Monitor + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
20160 Telemetry Monitoring + A QSHIFT CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
9069 Central Line: Monitor Site/Infusion + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
9135 Fluid: Restriction A CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
9171 PCA: Monitor + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
9351 VS: Frequent Vitals + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE
9355 VS: Orthostatic + A .PER PROTOCOL CP
- Create 03/18/07 1554 JLE 03/18/07 1554 JLE

Activity Date: 03/18/07 Time: 1600

20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Document 03/18/07 1600 JLE 03/18/07 1620 JLE
---FALL RISK---
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 0
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
4001 VS: Monitor + A Q4HOURS CP
- Document 03/18/07 1600 MRD 03/18/07 1614 MRD
Blood Pressure: 118/59
BP Source+: AUT
BP Site+: LA

Activity Date: 03/18/07 Time: 1600 (continued)

4001 VS: Monitor + (continued)
BP Position+: SUP
Pulse: 70
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 97.9
Temp Source+: ORL
SPO2 (%): 100
On Room Air: N
on: 2
LPM O2
Via+: NC
4004 Nursing: Daily Process + A Q12H10 CP
- Document 03/18/07 1600 JLE 03/18/07 1619 JLE
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/18/07 Time: 1600 (continued)

4004 Nursing: Daily Process + (continued)
PAIN MANAGEMENT
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): N
Education Documentation: Y
----EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY----
----DOCUMENT ON THE EDUCATION INTERVENTION----
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
PATIENT

4130 Education: + A DAILY CP
Document 03/18/07 1600 JLE 03/18/07 1620 JLE
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: ONE ON ONE
TOPIC(S)+: PAIN/PAIN MANAGEMENT
CARE ACTIVITIES
SELF CARE ACTIVITIES
SAFETY ISSUES
Information Taught: USE CALL LIGHT FOR ASSISTANCE. PT ORIENTED TO
ROOM.
Reference Material: VERBAL
Outcome+: VERBALIZE UNDERSTANDING

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/18/07 1600 JLE 03/18/07 1620 JLE
Type of IV Access+: INT
IV Site #1+: LEFT ANTECUBITAL
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG/NTG
Changed: N
Change Due: 03/21/07
Patent: Y
Flush: Y

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/18/07 1600 JLE 03/18/07 1620 JLE

Activity Date: 03/18/07 Time: 1615

Patient Notes: NURSE
Create 03/18/07 1615 JLE 03/18/07 1615 JLE
Abnormal? N Confidential? N
POSITIVE EKG CHANGES NOTED IN EKG. MD AWARE. PT DENIES CHEST PAIN.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1650

Patient Notes: NURSE
Create 03/18/07 1650 JLE 03/18/07 1720 JLE
Abnormal? N Confidential? N
PT COMPLAINS OF CHEST PAIN 5/10. NTG INCREASED TO 3 ML/HR. DR. PATEL NOTIFIED
OF SIGNIFICANT T WAVE INVERSTION CHANGES. STATES HE WILL BE HERE IN AN HOUR.
DILAUDID 0.5 MG GIVEN IV. CHEST PAIN 0/10 PRESENTLY. WILL CONTINUE TO
MONITOR.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1700

4090 Meals: Percentage Consumed + A TID CP
Document 03/18/07 1700 KHG 03/18/07 2328 KHG
Comment: NPO

Activity Date: 03/18/07 Time: 1814

3591 RT: O2 Per 12 Hours A PS
Create 03/18/07 1814 LFB 03/18/07 1814 LFB
3594 RT: O2 Monitor + A PS
Create 03/18/07 1814 LFB 03/18/07 1814 LFB

Activity Date: 03/18/07 Time: 1816

Patient Notes: NURSE
Create 03/18/07 1816 JLE 03/18/07 1821 JLE
Abnormal? N Confidential? N
CRITICAL LAB VALUE CALLED TO DR. PATEL (TROPONIN 38.21). DR. ALSO AWARE OF 6
BEAT AND 9 BEAT RUN OF VTACH. ORDERS TO START LIPITOR AND KEEP NPO AFTER
MIDNIGHT. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1817

Problem: RESPIRATORY DISTRESS A
Create 03/18/07 1817 LFB 03/18/07 1817 LFB
10006 Respiratory: Monitor A CP
Create 03/18/07 1817 LFB 03/18/07 1817 LFB

002502

6289

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 03/18/07 Time: 1817

13020 Oxygen Therapy: as Ordered A CP
- Create 03/18/07 1817 LFB 03/18/07 1817 LFB
13540 Suction: Available A CP
- Create 03/18/07 1817 LFB 03/18/07 1817 LFB

Activity Date: 03/18/07 Time: 1900

3591 RT: O2 Per 12 Hours A PS
- Document 03/18/07 1900 LFB 03/18/07 1916 LFB
O2 Device+: CANNULA
Oxygen Amount: 2 L/M
FIO2%: 0
Reasons for Oxygen Therapy+: PHYSICIAN ORDER

Activity Date: 03/18/07 Time: 1930

Patient Notes: NURSE
- Create 03/18/07 1930 JLE 03/18/07 2003 JLE
- Abnormal? N Confidential? N

Patient voicing no complaints. Condition stable, no new problems, vital signs stable, and resting quietly at present. No change in condition from previous assessment. REPORT AND CARE GIVEN TO BRIGETTER, RN. PT PRESENTLY DENIES CHEST PAIN AND SHORTNESS OF BREATH. DR. PATEL HERE TO SEE PT. WALKING ROUNDS DONE.

Note Type	Description
No Type	None

Activity Date: 03/18/07 Time: 1950

20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Document 03/18/07 1950 BAT 03/18/07 2242 BAT
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right/ Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 1
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y

Activity Date: 03/18/07 Time: 1950

4002 Shift Assessment + A QSHIFT CP
- Document 03/18/07 1950 BAT 03/18/07 2240 BAT
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 3
Pupil Reaction Left+: REACT
Pupil Size R (mm): 3
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: NORMAL
UNLABORED
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
WNL
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
~~~INTEGUMENT~~~
Skin Temp+: WARM

Problem Description
Intervention Description Sts Directions From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Activity Date 03/18/07 Time 1950 (continued)

4002 Shift Assessment + (continued)
Moisture+: DRY
Color+: NORMAL
Turgor+: NORMAL
Skin Integrity+: INTACT
BRUISE
Does Patient have Wound: N
—PAIN—
Pain: Y
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
Pain Indicators+: VOC
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: NOW
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: 2DVN100
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/18/07 1950 BAT 03/18/07 2241 BAT
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)

1087

Problem Description
Intervention Description Sts Directions From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Activity Date 03/18/07 Time 1950 (continued)

4004 Nursing: Daily Process + (continued)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
PAIN MANAGEMENT
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
——EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY——
——DOCUMENT ON THE EDUCATION INTERVENTION——
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
PATIENT
4065 Pain: Monitor + A .PRN CP
Document 03/18/07 1950 BAT 03/18/07 2241 BAT
Pain Indicators+: VOC
Pain Scale: 5
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: NOW
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: 2DVN100
4130 Education: + A DAILY CP
Document 03/18/07 1950 BAT 03/18/07 2241 BAT
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: ONE ON ONE
TOPIC(S)+: PAIN/PAIN MANAGEMENT
CARE ACTIVITIES
SAFETY ISSUES
Information Taught: NIGHT SHIFT CARE ROUTINE, PAIN MANAGEMENT,
AMBULATION SAFETY
Outcome+: VERBALIZE UNDERSTANDING
9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/18/07 1950 BAT 03/18/07 2241 BAT
Type of IV Access+: INT
IV Site #1+: LEFT ANTECUBITAL
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG/NTG

002504

6291

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Documented Units | Directions | From Change

Activity Date: 03/18/07 Time: 1950 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: Y
Type of IV Access+: INT
IV Site #2+: LEFT FOREARM
IV Size+: 20G
Appearance Site #2+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #2: NONE
IV Changed: N
Change Due: 03/21/07
Patent: Y
Flush: Y

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/18/07 1950 BAT 03/18/07 2241 BAT

20160 Telemetry Monitoring + A QSHIFT CP
- Document 03/18/07 1950 BAT 03/18/07 2242 BAT
——Telemetry Monitoring——
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
Patient Notes: NURSE
- Create 03/18/07 1950 BAT 03/18/07 2240 BAT
Abnormal? N Confidential? N
ASSESSMENT PERFORMED AS CHARTED. PATIENT HAS C/O A HEADACHE. PATIENT ALSO HAS A SLIGHT NOSEBLEED. NTG AT 1.5ML/HR PER ORDERS. INTEGRILLIN AT 12ML/HR PER ORDERS. PATENT. PATIENT STATES WHEN SHE GETS A HEADACHE SHE'LL OFTEN ALSO GET A SLIGHT NOSEBLEED. DARVOCET GIVEN. WILL MONITOR. FAMILY AT BEDSIDE. CALL LIGHT IN REACH. TELEMETRY MONITOR IN PLACE.
Note Type Description
No Type None

Activity Date: 03/18/07 Time: 1959

4001 VS: Monitor + A Q4HOURS CP
- Document 03/18/07 1959 MRD 03/18/07 2005 MRD
Blood Pressure: 103/65
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 75
Pulse Source+: MON

Activity Date: 03/18/07 Time: 1959 (continued)

4001 VS: Monitor + (continued)
Respirations: 20
Resp Source+: OBS
Temperature: 98.2
Temp Source+: ORL
LPM O2

Activity Date: 03/18/07 Time: 2000

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/18/07 2000 BAT 03/19/07 0239 BAT

Activity Date: 03/18/07 Time: 2100

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/18/07 2100 BAT 03/19/07 0239 BAT

Activity Date: 03/18/07 Time: 2159

4110 I&O: Monitor + A TID CP
- Document 03/18/07 2159 KHG 03/18/07 2320 KHG
<>INTAKE<>
Oral: 600
<>OUTPUT<>
Stool#: 1
Voided#: 4
<>DRAINS<>

Activity Date: 03/18/07 Time: 2200

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/18/07 2200 BAT 03/19/07 0239 BAT

Activity Date: 03/18/07 Time: 2300

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/18/07 2300 BAT 03/19/07 0239 BAT

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/18/07 Time: 2330

4001 VS: Monitor + A Q4HOURS CP
- Document 03/18/07 2330 KHG 03/19/07 0013 KHG
Blood Pressure: 94/49
BP Source+: AUT
BP Site+: RA
Pulse: 74
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 98.4
Temp Source+: ORL
SPO2 (%): 95
On Room Air: N
on: 2
LPM O2
Via+: NC

Activity Date: 03/19/07 Time: 0030

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
- Document 03/19/07 0030 BAT 03/19/07 0238 BAT
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
----CARDIOVASCULAR----
Pulses
----GASTROINTESTINAL----
----GENITOURINARY----
----INTEGUMENT----
----MUSCULOSKELETAL----
----NEUROLOGICAL----
----RESPIRATORY----

4065 Pain: Monitor + A .PRN CP
- Document 03/19/07 0030 BAT 03/19/07 0238 BAT
Pain Indicators+: VOC
Pain Scale: 0

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/19/07 Time: 0030

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/19/07 0030 BAT 03/19/07 0238 BAT
Patient Notes: NURSE
- Create 03/19/07 0030 BAT 03/19/07 0238 BAT
Abnormal? N Confidential? N
NO CHANGE FROM PREVIOUS ASSESSMENT. PATIENT DENIES ANY PAIN OR OTHER COMPLAINTS. INTEGRILLIN AT 11ML/HR PER ORDERS. PATENT. NTG GTT WEANED PER ORDERS. PATIENT'S NOSE BLEED STOPPED APPROXIMATELY 15 MINUTES AFTER IT BEGAN. NO REOCCURANCE. FAMILY AT BEDSIDE. CALL LIGHT IN REACH. TELEMETRY MONITOR IN PLACE.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 0136

20180 Pneumovax Screening Assessment+ A ONCE CP
- Document 03/19/07 0136 BAT 03/19/07 0137 BAT
===ADULT PNEUMOCOCCAL VACCINATION STANDING ORDERS===
SECTION A: VACCINATION ASSESSMENT
For Patients 18-64 years of age, select
any high-risk conditions present+: NONE
Any Condition
Present: N
: 0
Is The Patient 65 Years of Age or Older: N
: 0
Has The Patient Previously Received Pneumococcal Vaccine: N
: 2
Was The Pneumoncoccal Vaccine Given > 5 Years Ago: N
: 0
Was The Patient < 65 Years of Age When Most Recent
Pneumococcal Vaccine Given: N
: 0
SCORE
TOTAL: 2
SECTION B: VACCINATION SCORE
Total Points 2 or less, patient does NOT meet criteria to
receive Pneumococcal Vaccine.
Total Points > or = 3, patient meets criteria to receive
Pneumococcal Vaccine.
Patient Meets Criteria: N
Patient Given Vaccination Information: N
ADMINISTER PNEUMOCOCCAL VACCINE 23 VALENT 0.5ml IM ON DAY 3
****IF THE PATIENT MEETS CRITERIA****
****PRINT AND FAX ASSESSMENT TO PHARMACY UPON COMPLETION****
****PLACE ON CHART IN THE M.D. ORDER SECTION****
Your patient meets criteria for the Pneumonia Vaccine and
will be immunized on the 3rd day

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment | Units | From Change

Activity Date: 03/19/07 Time: 0136 (continued)

20180 Pneumovax Screening Assessment+ (continued)
of the hospital stay. If you DO NOT want your patient
immunized, provide rationale below
and sign this form by day 3 of their stay.
Physician Refusal for Vaccination:_____

_____
Physician Signature:

Activity Date: 03/19/07 Time: 0420

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 03/19/07 0420 BAT 03/19/07 0603 BAT
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
4065 Pain: Monitor + A PRN CP
Document 03/19/07 0420 BAT 03/19/07 0603 BAT
Pain Indicators+: VOC
Pain Scale: 0
9169 IV: IV/INT Site Check A PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 0420 BAT 03/19/07 0603 BAT

Activity Date: 03/19/07 Time: 0420

Patient Notes: NURSE
Create 03/19/07 0420 BAT 03/19/07 0603 BAT
Abnormal? N Confidential? N
NO CHANGE FROM PREVIOUS ASSESSMENT. PATIENT DENIES ANY PAIN OR OTHER COMPLAINTS. INTEGRILLIN AT 11ML/HR PER ORDERS. PATENT. CALL LIGHT IN REACH. PATIENT TO CALL FOR ASSISTANCE. TELEMETRY MONITOR IN PLACE. FAMILY AT BEDSIDE.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 0510

4110 I&O: Monitor + A TID CP
Document 03/19/07 0510 KHG 03/19/07 0513 KHG
<>INTAKE<>
<>OUTPUT<>
Voided#: 1
<>DRAINS<>

Activity Date: 03/19/07 Time: 0651

Patient Notes: NURSE
Create 03/19/07 0651 BAT 03/19/07 0651 BAT
Abnormal? N Confidential? N
PATIENT RESTING IN BED. PATIENT DENIES ANY PAIN OR OTHER COMPLAINTS. INTEGRILLIN AT 11ML/HR PER ORDERS. PATENT. NO S/S INFECTION OR INFILTRATION. NO CHANGE FROM PREVIOUS ASSESSMENT. CALL LIGHT IN REACH. PATIENT TO CALL FOR ASSISTANCE. TELEMETRY MONITOR IN PLACE. REPORT TO BE GIVEN TO LAUREN FOGLE RN.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 0735

10048 Activity: as Tolerated/Ordered A CP
Document 03/19/07 0735 LRF 03/19/07 0835 LRF
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 03/19/07 0735 LRF 03/19/07 0836 LRF
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 1

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 03/19/07 Time: 0735 (continued)

20125 Fall Precautions + (continued)
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y
4002 Shift Assessment + A QSHIFT CP
Document 03/19/07 0735 LRF 03/19/07 0833 LRF
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: NORMAL
UNLABORED
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
ROU
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 03/19/07 Time: 0735 (continued)

4002 Shift Assessment + (continued)
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: INTACT
Does Patient have Wound: N
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
| Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/19/07 0735 LRF 03/19/07 0834 LRF
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
~~~

Problem Description
Intervention Description — Sts — Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/19/07 Time: 0735 (continued)

4004 Nursing: Daily Process + (continued)
PAIN MANAGEMENT
MEDICATION EDUCATION

In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~
~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
PATIENT

4065 Pain: Monitor + A .PRN CP
Document 03/19/07 0735 LRF 03/19/07 0834 LRF
Pain Indicators+: VOC
Pain Scale: 0

4130 Education: + A DAILY CP
Document 03/19/07 0735 LRF 03/19/07 0835 LRF
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: ONE ON ONE
TOPIC(S)+: PAIN/PAIN MANAGEMENT
CARE ACTIVITIES
SAFETY ISSUES
PROCEDURE
Information Taught: PROCEDURE
NPO

CALL FOR ASSISTANCE OR NEEDS
Reference Material: VERBAL
Outcome+: VERBALIZE UNDERSTANDING

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/19/07 0735 LRF 03/19/07 0835 LRF
Type of IV Access+: INT
IV Site #1+: LEFT ANTECUBITAL
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: NONE
IV Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
Type of IV Access+: PERIPH IV
IV Site #2+: LEFT WRIST

Problem Description
Intervention Description — Sts — Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/19/07 Time: 0735 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
IV Size+: 20G
Appearance Site #2+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #2: INTEGRILIN
IV Changed: N
Change Due: 03/21/07
Patent: Y
Flush: Y

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 0735 LRF 03/19/07 0835 LRF
Patient Notes: NURSE
Create 03/19/07 0735 LRF 03/19/07 0833 LRF
Abnormal? N Confidential? N
REPORT RECEIVED FROM B.TALBOT.RN. INITIAL ASSESSMENT COMPLETE. TELEMETRY REFLECTS SR. VSS. NO C/O PRESENTLY. PATIENT DENIES CHEST PAIN/SHORTNESS OF BREATH. BREATH SOUNDS CLEAR BILAT. O2 SATS 96% ON RA. SKIN INTACT. NPO THIS AM FOR HEART CATH/POSS PCI. CONSENT ON CHART. PEDAL PULSES 3/3 BILAT. INTEGRILIN INFUSING AT 11 ML/HR IN LT WRIST IV W/O COMPLICATIONS. FURTHER ASSESSMENT PER FLOW SHEET. WILL CONTINUE TO MONITOR & ASSESS.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 0800

4001 VS: Monitor + A Q4HOURS CP
Document 03/19/07 0800 SEM 03/19/07 0845 SEM
Blood Pressure: 121/60
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 77
Pulse Source+: MON
Respirations: 18
Resp Source+: OBS
Temperature: 97.2
Temp Source+: ORL
SPO2 (%): 94
LPM O2

Activity Date: 03/19/07 Time: 1000

15001 IV Insertion/Removal + A .PRN CP
Document 03/19/07 1000 LRF 03/19/07 1346 LRF
~~~IV INSERTION~~~
# of Attempts: 2
IV Insertion Comment: ATTEMPTED TO INSERT NEW INT WITH NO SUCCESS FOR
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units | Sts Directions Change | From

Activity Date: 03/19/07 Time: 1000 (continued)

15001 IV Insertion/Removal + (continued)
HEART CATH
~~~IV REMOVAL~~~
Date Removal: 03/19/07
Time Removal: 1000
Site+: LEFT ANTECUBITAL
Site Appearance+: BRUISING NOTED AT SITE
Catheter Condition+: INTACT
IV Removal Comment: PATIENT C/O LAC PAIN.BRUISING & REDNESS OBSERVED AT SITE. REMOVED.

Activity Date: 03/19/07 Time: 1130

4065 Pain: Monitor + A .PRN CP
Document 03/19/07 1130 LRF 03/19/07 1135 LRF
Pain Indicators+: VOC
Pain Scale: 10
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: NOW
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET 2 TABS PO
Discussed Home Pain Management Plan With Patient/Family/SO: Y
Comment: VSS

Activity Date: 03/19/07 Time: 1200

4001 VS: Monitor + A Q4HOURS CP
Document 03/19/07 1200 SEM 03/19/07 1325 SEM
Blood Pressure: 145/75
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 75
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 96.2
Temp Source+: ORL
LPM O2
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
Document 03/19/07 1200 LRF 03/19/07 1343 LRF
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:

Activity Date: 03/19/07 Time: 1200 (continued)

4009 Patient Reassessment + (continued)
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
| Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 1200 LRF 03/19/07 1343 LRF
Patient Notes: NURSE
Create 03/19/07 1200 LRF 03/19/07 1343 LRF
Abnormal? N Confidential? N
TELEMETRY REMAINS SR. VSS. NO C/O PRESENTLY. PATIENT REMAINS NPO. AWAITING HEART CATH THIS PM. FAMILY AT BEDSIDE. PATIENT DENIES CHEST PAIN PRESENTLY. PATIENT VOIDING & AMBULATING IN ROOM W/O COMPLICATIONS. NO OTHER CHANGES. WILL CONTINUE TO MONITOR & ASSESS.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 1230

4066 Pain: Reassess + A .PRN CP
Document 03/19/07 1230 LRF 03/19/07 1342 LRF
Pain Location #1+: HEADACHE
Previous Pain Level: 10
One Hour Pain Reassessment Level: 0
Pt. Asleep: N
Additional Pain Medication Administered: N

Activity Date: 03/19/07 Time: 1359

4110 I&O: Monitor + A TID CP
Document 03/19/07 1359 SEM 03/19/07 1425 SEM
<>INTAKE<>
Oral: 0

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded by Date Time | Sts Documented by Comment | Directions Units | From Change

Activity Date: 03/19/07 Time: 1359 (continued)

4110 I&O: Monitor + (continued)
<>OUTPUT<>
Voided#: 3
<>DRAINS<>

Activity Date: 03/19/07 Time: 1427

4100 ADL: + A QS&PRN CP
Document 03/19/07 1427 SEM 03/19/07 1432 SEM
------ACTIVITIES OF DAILY LIVING------
Activity+: AD LIB
Ambulation: SELF
Feeding Method+: SELF
Bathing+: SELF
Oral Hygiene+: SELF
Bed Linen Changed: Y
Turned Q 2hrs: SELF
1) The staff will encourage the patient to be independent throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform tasks.
3) The staff will encourage patient participation in ADL's and participation will be monitored.
4) The staff will provide extra time to complete tasks as needed.

Activity Date: 03/19/07 Time: 1437

4090 Meals: Percentage Consumed + A TID CP
Document 03/19/07 1437 SEM 03/19/07 1439 SEM
Breakfast(%)+: NPO
Lunch(%)+: NPO

Activity Date: 03/19/07 Time: 1530

Patient Notes: NURSE
Create 03/19/07 1530 LRF 03/19/07 1614 LRF
Abnormal? N Confidential? N
TELEMETRY REMAINS SR. VSS. NO C/O PRESENTLY. DEMEROL 50 MG & PHENERGAN 25 MG ADMINISTERED IM IN LT HIP. NO S/S OF REACTION OBSERVED. PATIENT VOIDING & AMBULATING W/O COMPLICATIONS. TRANSPORTED TO CATH LAB VIA STRETCHER.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 1545

10900 CATHLAB:Post Procedure Assessment A ONCE AS
Create 03/19/07 1545 JLB 03/19/07 1641 JLB
Document 03/19/07 1545 JLB 03/19/07 1641 JLB
Procedure: PCI--CIRC
Art Sheath: Y

Activity Date: 03/19/07 Time: 1545 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
Art Size: 6FRSHORT
Art Sheath Status+: LEFTINPLAC
Art Access site +: R FEM ART
Art Dressing+: BIO
VEN Sheath: N
Color Extremity+: NORMAL
Temperature Extremity+: WARM
Post procedure/closure device DC instructions reviewed: YES
Patient verbalized understanding of instuctions: Y
IV Fluids: 0.9NS
Rate #1: 20 ML/HR
IV Fluid Total ML: 50
IV DRIPS: INTEG75
Dose/Rate: 11 ML/HR
IV DRIPS: NTG50
Dose/Rate: 6 ML/HR
Contrast Type+: OPTIRAY
Contrast Used (ml): 350
Y/N PLAVIX: Y
Time: 1637
mg 300
Initial Pain Assessment Post Procedure:
Pain: N
Additional Pain Scale & Interventions Noted With Vital Signs
Modified Aldrete Scoring System
Activity
Able to move 4 extremities voluntarily on command.
Able to move 2 extremities voluntarily on command.
Unable to move voluntarily or on command.
2
1
0
Post
Respiration
Able to breathe deeply and cough freely.
Dyspnea, limited breathing or tachypnea.
Apneic or on mechanical ventilator.
2
1
0
Consciousness
Awake and alert.
Sleepy, arouses to oriented state.
Responses vaguely, unresponsive.
2
1
0
Circulation
BP+/- 20-30 mmHG pre-procedure.
BP +/- 30-40 mmHG pre-procedure.

Problem Description / Intervention Description / Activity Type / Occurred Date Time / by / Recorded Date Time / by / Sts / Comment / Directions / Documented Units / From / Change

Activity Date: 03/19/07 Time: 1545 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
BP +/- 50mmHG pre-procedure.
2
1
0
O2 Saturation
Able to maintain O2 saturation>92% on room air.
Needs O2 to maintain O2 saturation greater than 92%.
O2 saturation < 92% with oxygen therapy.
2
1
0
(Must be within 2 points of admission)
: 2
: 2
: 2
: 2
: 2
Post Total: 10
Time
BP
HR
RR
SpO2
DP+
PT+
SITE
DRSG
PAIN
CATH LAB PATIENT INTRAPROCEDURE PLAN OF CARE
1. Nursing Diagnosis: Pain related to oxygen supply and demand imbalance during injection procedure catheters/devices.
GOALS: Patient will express relief from or diminished level of pain during the procedure.
PLANNED INTERVENTIONS:
A. Monitor heart rate, pulse oximetry and BP continuously.
B. Ask about pain/discomfort at start/end of procedure & PRN
B1. Observe non verbal patient for changes in posture or Muscular clenching:Observe for events that precipatate pain.
C. Have patient rate level of pain or record pain indicators
D. Provide medications for pain relief as ordered by MD.
E. Hang IV medications as ordered by MD.
F. Supplemental oxygen via nasal cannula or mask PRN.
POC continued: Y
2. Nursing Diagnosis: Potential for injury related to procedure and use of sedative and vasoactive medications.
GOALS: Patient safety will be maintained. Patient will be free of injury/adverse drug reaction/hemodynamic compromise.
PLANNED INTERVENTIONS:
A. Document on arrival: selected abnormal lab values.

Problem Description / Intervention Description / Activity Type / Occurred Date Time / by / Recorded Date Time / by / Sts / Comment / Directions / Documented Units / From / Change

Activity Date: 03/19/07 Time: 1545 (continued)

10900 CATHLAB:Post Procedure Assessment (continued)
allergies, existing IV infusions,LOC and Aldrete Score.
B. Prep an drape site to minimize infection risk.
C. Use protective positioning devices for safe position PRN.
D. Monitor HR,Pulse Ox,BP. Record every 15 minutes and PRN.
E. Maintain IV access per hospital policy.
F. Document response to verbal commands every 15 minutes.
G. Post procedure: reassess LOC, VS, Protective reflexes, and Aldrete Score.
H. Transport with side rails up. Transport all CCU and post patients on monitor.
POC continued: Y
3. Nursing Diagnosis: Potential for bleeding or altered peripheral circulation related to invasive procedure/device.
GOALS: Patient will have no alteration in pulses distal to the puncture side. Hemostasis at puncture site prior to DC.
PLANNED INTERVENTIONS:
A. Mark and document baseline pulses distal to planned puncture site.
B. Document abnormal PT, PTT, or Platelet levels.
C. Document use of weight based heparin, anti platelet therapy and ACT/HMT results.
Y/N: N
D. Post procedure: obtain hemostasis using closure device or manual pressure held for a minimum of 15 minutes.
Y/N: Y
D. Post procedure: assess the site of all indwelling sheaths for bleeding around puncture sites.
E. Document post procedure vital signs and pulses distal to to puncture site.
F. Document condition fo puncture site.
G. Instruct patient regarding care of site.
Post Procedure Assessment: All intraprocedure plan of care interventions completed.
All goals met.Plan of care discontinuted. See receiving unit for assessment and updated plan of care.
Aldrete/Criteria met: Y
LOC+: A/OX3
Protective reflexes intact: Y
Report Called To: FOGLELR FOGLE,LAUREN R
Patient Destination: 4 HEART-- ROOM 457
Transferred Via: S
Transfering Nurse Signature: _____
Receiving Staff Signature: _____

Activity Date: 03/19/07 Time: 1600

4009	Patient Reassessment + Use this intervention for reassessment of the patient.	A	QS&PRN	CP

Document 03/19/07 1600 LRF 03/19/07 1614 LRF

1095

082512

6299

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 03/19/07 Time: 1600 (continued)

4009 Patient Reassessment + (continued)
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
| Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 1600 LRF 03/19/07 1614 LRF

Activity Date: 03/19/07 Time: 1715

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 1715 LRF 03/19/07 1921 LRF
Blood Pressure: 133/76
Heart Rate: 72
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: Y
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM

Activity Date: 03/19/07 Time: 1715 (continued)

20105 Post Cath Monitor + (continued)
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N
Comment: SITE OOZING.NO HEMATOMA

Activity Date: 03/19/07 Time: 1730

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 1730 LRF 03/19/07 1921 LRF
Blood Pressure: 158/87
Heart Rate: 70
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: Y
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 03/19/07 1730 LRF 03/19/07 1802 LRF
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: Y
Document Nurse's Notes: Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/19/07 Time: 1730 (continued)

4009 Patient Reassessment + (continued)
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
Other: RT GROIN CATH SITE SHEATH
INTACT
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 1730 LRF 03/19/07 1802 LRF
Patient Notes: NURSE
Create 03/19/07 1730 LRF 03/19/07 1801 LRF
Abnormal? N Confidential? N
BACK FROM CATH LAB. TELEMETRY REFLECTS SR. VSS. PATIENT C/O HEADACHE PRESENTLY. WILL MEDICATE. RT GROIN CATH SITE FEMORAL SHEATH INTACT.NO BLEEDING OR HEMATOMA OBSERVED. PEDAL PULSES 3/3 BILAT. ACT DUE AT 1812. POST CATH RESTRICTIONS DISCUSSED W/ PATIENT.PATIENT VERBALIZED UNDERSTANDING. DENIES CHEST PAIN PRESENTLY. WILL CONTINUE TO MONITOR & ASSESS.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 1745

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 1745 LRF 03/19/07 1921 LRF
Blood Pressure: 163/85
Heart Rate: 68
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: Y
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 1755

4065 Pain: Monitor + A .PRN CP
Document 03/19/07 1755 LRF 03/19/07 1802 LRF
Pain Indicators+: VOC
Pain Scale: 10
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Onset/Duration: NOW
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DARVOCET 2 TABS PO
Discussed Home Pain Management Plan With Patient/Family/SO: Y
Comment: VSS

Activity Date: 03/19/07 Time: 1800

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 1800 LRF 03/19/07 1921 LRF
Blood Pressure: 169/87
Heart Rate: 72
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: Y
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 1812

20106 Sheath Removal Monitor + A .PER PROTOCOL CP
Document 03/19/07 1812 LRF 03/19/07 1953 LRF
Removal Date: 03/19/07
Removal Time: 1812
Person Removing: FOGLELR FOGLE.LAUREN R
Site+: RIGHT FEMORAL
Site Condition: NO HEMATOMA
Time
HR
BP
DP+
PT+
Comment
~~~

Problem Description
Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Documented Comment Units | Change

Activity Date: 03/19/07 Time: 1812 (continued)

20106 Sheath Removal Monitor + (continued)
: 1812
: 70
: 171/75
: 3
: 3
: SHEATH OUT.MANUAL PRESSUR
: 1815
: 70
: 176/83
: 3
: 3
: APPLIED.
: 1818
: 72
: 154/87
: 3
: 3
: 1821
: 74
: 168/85
: 3
: 3
: 1824
: 72
: 188/71
: 3
: 3
: 1827
: 70
: 160/76
: 3
: 3
: 1830
: 70
: 165/71
: 3
: 3
: 1833
: 70
: 143/77
: 3
: 3
: 1836
: 68
: 149/73
: 3
: 3
: HEMASTASIS ACHIEVED.SLIGH
: OOZING OBSERVED. NO
: HEMATOMA.

Problem Description
Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Documented Comment Units | Change

Activity Date: 03/19/07 Time: 1812 (continued)

20106 Sheath Removal Monitor + (continued)
Pressure Dressing: Y

Activity Date: 03/19/07 Time: 1915

Patient Notes: NURSE
- Create 03/19/07 1915 LRF 03/19/07 1919 LRF
Abnormal? N Confidential? N
TELEMETRY REFLECTS SR. VSS. NO C/O PRESENTLY. RT GROIN CATH SITE FEMORAL SHEATH REMOVED AT 1812. MANUAL PRESSURE APPLIED X 20 MIN. HEMASTASIS ACHIEVED AT 1836. RT GROIN CATH SITE NO BLEEDING OR HEMATOMA OBSERVED. PEDAL PULSES 3/3 BILAT. PRESSURE DRESSING APPLIED. FURTHER POST CATH RESTRICTIONS DISCUSSED W/ PATIENT.PATIENT VERBALIZED UNDERSTANDING. BEDREST UP TONIGHT AT MN. PATIENT HAS NOT VOIDED. DENIES BLADDER FULLNESS/BLADDER PAIN PRESENTLY. NO OTHER CHANGES. REPORT & CARE TO BE GIVEN TO S.EDENTON.RN.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 1927

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 1927 SME 03/20/07 0117 SME
Blood Pressure: 145/77
Heart Rate: 70
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N
Comment: SLOW OOZE. DSG NOT SATURATED. GROIN SOFT AND FLAT.

Activity Date: 03/19/07 Time: 1930

Patient Notes: NURSE
- Create 03/19/07 1930 LRF 03/19/07 1955 LRF
Abnormal? N Confidential? N
PATIENT C/O DIFFICULTY URINATING. 18 FRENCH FOLEY CATHETER INSERTED BY C.SHULL.RN. PATENT & DRAINING CLEAR YELLOW URINE W/O COMPLICATIONS. NO OTHER CHANGES.

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/19/07 Time: 1930 (continued)

Patient Notes: NURSE (continued)
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 1957 (continued)

20105 Post Cath Monitor + (continued)
Document 03/19/07 1957 SME 03/20/07 0117 SME
Blood Pressure: 140/70
Heart Rate: 68
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 1959

4001 VS: Monitor + A Q4HOURS CP
Document 03/19/07 1959 NLB 03/19/07 2016 NLB
Blood Pressure: 153/84
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 67
Pulse Source+: MON
Respirations: 18
Resp Source+: OBS
Temperature: 95.4
Temp Source+: ORL
SPO2 (%): 100
On Room Air: N
on: 2
LPM O2
Via+: NC

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/19/07 Time: 2000

4002 Shift Assessment + A QSHIFT CP
Document 03/19/07 2000 SME 03/20/07 0052 SME
~~~~NEUROLOGICAL~~~~
Level of Responsiveness+: A/OX3
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~~CARDIOVASCULAR~~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~~RESPIRATORY~~~~
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~~GASTROINTESTINAL~~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~~GENITOURINARY~~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: Y
Size: 16
Patent and Draining Urine: Y
~~~~MUSCULOSKELETAL~~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
~~~~INTEGUMENT~~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
~~~~

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/19/07 Time: 2000 (continued)

4002 Shift Assessment + (continued)
Other: RIGHT GROIN WITH PRESSURE
DRESSING. SOME BLOOD
NOTED. RIGHT GROIN SOFT.
FLAT WITH MINIMAL
BRUISING NOTED.
Does Patient have Wound: N
---PAIN---
Pain: N
If Yes. Document on the Pain Assessment.
Document Nurse's Notes: Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/19/07 2000 SME 03/20/07 0110 SME
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Hospital Day+: 2
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
PAIN MANAGEMENT

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/19/07 Time: 2000 (continued)

4004 Nursing: Daily Process + (continued)
MEDICATION EDUCATION
In The Plan Of Care+:
Daily Required Documentation
Education Documentation: Y
----EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY----
----DOCUMENT ON THE EDUCATION INTERVENTION----
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
SIGNIFICANT OTHER
9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/19/07 2000 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: NTG, INTEG
Change Due: 03/21/07
Patent: Y
Flush: Y
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 2000 SME 03/20/07 0112 SME
Patient Notes: NURSE
Create 03/19/07 2000 SME 03/20/07 0052 SME
Abnormal? N Confidential? N
PT RESTING IN BED. AWARE OF BEDREST UNTIL MIDNIGHT. NO DISTRESS OTED AT
ASSESSMENT. SLOW OOZE TO RIGHT GROIN NOTED. SITE SOFT, FLAT. SR ON MONITOR
WITH VSS.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 2027

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 2027 SME 03/20/07 0117 SME
Blood Pressure: 161/76
Heart Rate: 72
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Comment — Documented Units — Change

Activity Date: 03/19/07 Time: 2027 (continued)

20105 Post Cath Monitor + (continued)
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 2040

4065 Pain: Monitor + A .PRN CP
Document 03/19/07 2040 SME 03/20/07 0358 SME
Pain Indicators+: VOC
Pain Scale: 5
Pain Location #1+: HEADACHE
Pain Description+: ACHING
Pain Intervention+: MED
Medication: DILAUDID 1 MG
Patient Notes: NURSE
- Create 03/19/07 2040 SME 03/20/07 0055 SME
Abnormal? N Confidential? N
DILAUDID 1 MG GIVEN SLOW IVP FOR RIGHT GROIN PAIN AND HA UNRELIEVED BY DARVOCET. UNABLE TO WEAN IV NTG AT PRESENT FOR BP 161/76.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 2057

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 03/19/07 2057 SME 03/20/07 0117 SME
Blood Pressure: 127/67
Heart Rate: 64
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM

Activity Date: 03/19/07 Time: 2057 (continued)

20105 Post Cath Monitor + (continued)
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 2100

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 03/19/07 2100 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: NTG, INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/19/07 2100 SME 03/20/07 0112 SME

Activity Date: 03/19/07 Time: 2105

4066 Pain: Reassess + A .PRN CP
- Document 03/19/07 2105 SME 03/20/07 0358 SME
Pain Location #1+: HEADACHE
Previous Pain Level: 5
One Hour Pain Reassessment Level: 2
Pt. Asleep: N

Activity Date: 03/19/07 Time: 2127

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 03/19/07 2127 SME 03/20/07 0117 SME
Blood Pressure: 117/64
Heart Rate: 64
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions Documented Comment Units | From Change

Activity Date: 03/19/07 Time: 2127 (continued)

20105 Post Cath Monitor + (continued)
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 2159

4100 ADL: + A QS&PRN CP
- Document 03/19/07 2159 NLB 03/19/07 2215 NLB
——ACTIVITIES OF DAILY LIVING——
Activity+: BEDREST
Ambulation: NONE
Feeding Method+: SELF
Turned Q 2hrs: N
1) The staff will encourage the patient to be independent throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform tasks.
3) The staff will encourage patient participation in ADL's and participation will be monitored.
4) The staff will provide extra time to complete tasks as needed.

4110 I&O: Monitor + A TID CP
- Document 03/19/07 2159 NLB 03/19/07 2209 NLB
<>INTAKE<>
Oral: 600
<>OUTPUT<>
Catheter: 500
Stool#: 0
<>DRAINS<>
- Document 03/19/07 2159 SME 03/20/07 0401 SME
<>INTAKE<>
IV Meds: 44
<>OUTPUT<>
<>DRAINS<>

Activity Date: 03/19/07 Time: 2200

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 03/19/07 2200 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE

Activity Date: 03/19/07 Time: 2200 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
IV Med #1: NTG, INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/19/07 2200 SME 03/20/07 0112 SME

Activity Date: 03/19/07 Time: 2205

Patient Notes: NURSE
- Create 03/19/07 2205 SME 03/20/07 0056 SME
Abnormal? N Confidential? N
OOZE STILL PRESENT AT PUNCTURE SITE. GUAZE NOT QUITE SATURATED. NO LEAKAGE FROM DRESSING. NO SWELLING OR FIRMNESS TO RIGHT GROIN. PT REPORTS COMFORT AT PRESENT.
Note Type Description
No Type None

Activity Date: 03/19/07 Time: 2227

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 03/19/07 2227 SME 03/20/07 0117 SME
Blood Pressure: 144/77
Heart Rate: 68
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Problem Description
Intervention Description — Sts. Directions — From
Activity Type — Occurred Date Time — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 03/19/07 Time: 2300

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/19/07 2300 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: NTG. INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/19/07 2300 SME 03/20/07 0112 SME

Activity Date: 03/19/07 Time: 2327

20105 Post Cath Monitor + A .PER PROTOCOL CP
Document 03/19/07 2327 SME 03/20/07 0117 SME
Blood Pressure: 118/68
Heart Rate: 64
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: N
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: Y
Hematoma: N

Activity Date: 03/19/07 Time: 2330

4001 VS: Monitor + A Q4HOURS CP
Document 03/19/07 2330 SME 03/20/07 0119 SME
Blood Pressure: 118/68
BP Source+: AUT
BP Site+: RA

Activity Date: 03/19/07 Time: 2330 (continued)

4001 VS: Monitor + (continued)
BP Position+: SUP
Pulse: 68
Pulse Source+: MON
Respirations: 18
Resp Source+: OBS
Temperature: 98.3
Temp Source+: ORL
LPM O2

Activity Date: 03/20/07 Time: 0001

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 03/20/07 0001 SME 03/20/07 0107 SME
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: N
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/20/07 0001 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
Change Due: 03/21/07
Tubing Changed: N
~~~

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 03/20/07 Time: 0001 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
Change Due: 03/21/07
Patent: Y
Flush: Y
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 0001 SME 03/20/07 0112 SME

Activity Date: 03/20/07 Time: 0015

4130 Education: + A DAILY CP
- Document 03/20/07 0015 SME 03/20/07 0108 SME
Person(s) Taught+: PATIENT
Readiness to Learn+: ASKS QUESTIONS
Teaching Method(s)+: VERBAL
TOPIC(S)+: POST PROCEDURE CARE
SAFETY ISSUES
Information Taught: FEMSTOP APPLICATION
Outcome+: VERBALIZE UNDERSTANDING
Patient Notes: NURSE
Create 03/20/07 0015 SME 03/20/07 0106 SME
Abnormal? N Confidential? N
DILAUDID 1 MG GIVEN IVP FOR RIGHT GROIN PAIN. FEMSTOP APPLIED TO RIGHT GROIN AFTER SAFEGUARD DSG UNSUCCESSFUL. PT REPOSITONED FOR COMFORT AND ASKED TO REMAIN ON BEDREST. VERBALIZES UNDERSTANDING. NTG WEANED AND D/C'D NOW THAT BP 118/68. FEMSTOP WITH PRESSURE OF 80 MMHG. DP AND PT PULSES PALPABLE. PT REPORTS COMFORT LEVEL SUFFICIENT FOR SLEEP.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0030

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 03/20/07 0030 SME 03/20/07 0145 SME
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: Y
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: N

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 03/20/07 Time: 0030 (continued)

20105 Post Cath Monitor + (continued)
Hematoma: N

Activity Date: 03/20/07 Time: 0100

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 03/20/07 0100 SME 03/20/07 0111 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
- Document 03/20/07 0100 SME 03/20/07 0402 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 0100 SME 03/20/07 0112 SME

Activity Date: 03/20/07 Time: 0107

20140 Home Medication List + C .PRN CP
- Ed Status 03/20/07 0107 SME 03/20/07 0107 SME A => C

Activity Date: 03/20/07 Time: 0113

10011 Chest Pain: Monitor + C .PRN CP
- Ed Status 03/20/07 0113 SME 03/20/07 0113 SME A => C

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/20/07 Time: 0118

10011 Chest Pain: Monitor + C CP
Ed Status 03/20/07 0118 SME 03/20/07 0118 SME A => C
20105 Post Cath Monitor + C .PER PROTOCOL CP
Ed Status 03/20/07 0118 SME 03/20/07 0118 SME A => C

Activity Date: 03/20/07 Time: 0119

10048 Activity: as Tolerated/Ordered C CP
Ed Status 03/20/07 0119 SME 03/20/07 0120 SME A => C

Activity Date: 03/20/07 Time: 0130

20105 Post Cath Monitor + A .PER PROTOCOL CP
- Document 03/20/07 0130 SME 03/20/07 0144 SME
Blood Pressure: 124/70
Heart Rate: 65
Procedure Site+: RIGHT GROIN
Dressing: OCCLUSIVE
Sheath: N
Femstop: Y
Pulse DP-Right+: 3
Pulse DP-Left+: 3
Pulse PT-Right+: 3
Pulse PT-Left+: 3
Sensation Present Extremity-Right: Y
Sensation Present Extremity-Left: Y
Color Extremity-Right+: NORMAL
Color Extremity-Left+: NORMAL
Temperature Extremity-Right+: WARM
Temperature Extremity-Left+: WARM
Bleeding: N
Hematoma: N

Activity Date: 03/20/07 Time: 0133

Patient Notes: NURSE
- Create 03/20/07 0133 SME 03/20/07 0143 SME
Abnormal? N Confidential? N
FEMSTOP NOW AT 40 MMHG. NO BLEEDING DETECTED. PT REPORTS THAT SHE HAS BEEN SLEEPING. BP STABLE AT 124/70.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0200

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 03/20/07 0200 SME 03/20/07 0402 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI

Activity Date: 03/20/07 Time: 0200 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 0200 SME 03/20/07 0402 SME

Activity Date: 03/20/07 Time: 0230

Patient Notes: NURSE
- Create 03/20/07 0230 SME 03/20/07 0359 SME
Abnormal? N Confidential? N
ALL PRESSURE REMOVED FROM FEMSTOP. STRAPS LOOSENED. STILL IN PLACE.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0300

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 03/20/07 0300 SME 03/20/07 0402 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 0300 SME 03/20/07 0402 SME

1195

002522

6309

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Comment | Documented Units | Directions | Change | From

Activity Date: 03/20/07 Time: 0350

4065 Pain: Monitor + A .PRN CP
Document 03/20/07 0350 SME 03/20/07 0359 SME
Pain Indicators+: VOC
Pain Scale: 10
Pain Location #1+: RT GROIN
Pain Intervention+: MED
REP
Medication: DILAUDID 1 MG IVP

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/20/07 0350 SME 03/20/07 0401 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: Y

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/20/07 0350 SME 03/20/07 0401 SME

Activity Date: 03/20/07 Time: 0352

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 03/20/07 0352 SME 03/20/07 0357 SME
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y

Activity Date: 03/20/07 Time: 0352 (continued)

4009 Patient Reassessment + (continued)
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~
Patient Notes: NURSE
Create 03/20/07 0352 SME 03/20/07 0357 SME
Abnormal? N Confidential? N
PT TEARFUL. STATES EXTREME PAIN FROM FEMSTOP. 10/10. FEMSTOP REMOVED AND DILAUDID 1 MG GIVEN IVP. PT RESTING IN BED. WILL ATTEMPT TO ASSIST OOB IN 2 HOURS OR SO. PT VERBALIZES UNDERSTANDING. RIGHT GROIN SOFT, FLAT. NO BRUIT AUSCULTATED. GUAZE AND MEDIPORE APPLIED TO PUNCTURE. BP ELEVATED AT 165/72 AT PRESENT. WILL MONITOR FOR IMPROVMENT WITH PAIN RELIEF.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0400

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/20/07 0400 SME 03/20/07 0402 SME

Activity Date: 03/20/07 Time: 0450

4066 Pain: Reassess + A .PRN CP
Document 03/20/07 0450 SME 03/20/07 0548 SME
Pain Location #1+: RT GROIN
Previous Pain Level: 10
One Hour Pain Reassessment Level: 3
Pt. Asleep: N

Activity Date: 03/20/07 Time: 0500

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/20/07 0500 SME 03/20/07 0604 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
~~~

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/20/07 Time: 0500 (continued)

9167 IV: Peripheral Monitor Site/Infusion + (continued)
Change Due: 03/21/07
Patent: Y
Flush: N

Activity Date: 03/20/07 Time: 0510

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/20/07 0510 SME 03/20/07 0605 SME

Activity Date: 03/20/07 Time: 0547

4110 I&O: Monitor + A TID CP
Document 03/20/07 0547 SME 03/20/07 0547 SME
<>INTAKE<>
IV Meds: 88
<>OUTPUT<>
Catheter: 300
<>DRAINS<>

Activity Date: 03/20/07 Time: 0548

Patient Notes: NURSE
Create 03/20/07 0548 SME 03/20/07 0551 SME
Abnormal? N Confidential? N
PT REPORTS PAIN MUCH RELIEVED. FOLEY REMOVED AND PT ASSISTED TO BR WITHOUT DIFFICULTY. RIGHT GROIN SOFT, FLAT. DSG CDI.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0605

9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
Document 03/20/07 0605 SME 03/20/07 0605 SME
Type of IV Access+: INT
IV Site #1+: LEFT HAND
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 03/18/07
Dressing+: OCCLUSIVE
IV Med #1: INTEG
IV Changed: N
Change Due: 03/21/07
Tubing Changed: N
Change Due: 03/21/07
Patent: Y
Flush: N

Activity Date: 03/20/07 Time: 0721

Patient Notes: NURSE
Create 03/20/07 0721 SME 03/20/07 0722 SME
Abnormal? N Confidential? N
WALKING ROUND REPORT GIVEN TO NANCY MEEHAN, RN. NO COMPLAINTS THIS AM.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0750

20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 03/20/07 0750 NJM 03/20/07 0810 NJM
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 1
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y

4002 Shift Assessment + A QSHIFT CP
Document 03/20/07 0750 NJM 03/20/07 0810 NJM
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 3
Pupil Reaction Left+: REACT
Pupil Size R (mm): 3
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded by Date Time | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/20/07 Time: 0750 (continued)

4002 Shift Assessment + (continued)
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~~RESPIRATORY~~~~
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~~GASTROINTESTINAL~~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~~GENITOURINARY~~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~~MUSCULOSKELETAL~~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
~~~~INTEGUMENT~~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
Other: RIGHT GROIN SOFT WITH
PRESSURE DRESSING OVER
PUNCTURE SITE DUE TO
BLEEDING OVER NIGHT; NO
BRUIT HEARD
Does Patient have Wound: N
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/20/07 0750 NJM 03/20/07 0810 NJM
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded by Date Time | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/20/07 Time: 0750 (continued)

4004 Nursing: Daily Process + (continued)
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
PAIN MANAGEMENT
MEDICATION EDUCATION
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~~
~~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~~
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
SIGNIFICANT OTHER
~~~~

Problem Description
Intervention Description — Sts Directions — From
Activity — Occurred — Recorded — Documented
Type — Date — Time — by — Date — Time — by — Comment — Units — Change

Activity Date: 03/20/07 Time: 0750

4130 Education: + A DAILY CP
Document 03/20/07 0750 NJM 03/20/07 0810 NJM
Person(s) Taught+: PATIENT
Readiness to Learn+: ASKS QUESTIONS
Teaching Method(s)+: VERBAL
TOPIC(S)+: POST PROCEDURE CARE
SAFETY ISSUES
MEDICATIONS
DISCHARGE INSTRUCTION
Information Taught: SAME AS ABOVE
Outcome+: VERBALIZE UNDERSTANDING
Plan/Follow Up: WILL UPDATE AS NEEDEDB

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/20/07 0750 NJM 03/20/07 0810 NJM
Patient Notes: NURSE
Create 03/20/07 0750 NJM 03/20/07 0810 NJM
Abnormal? N Confidential? N
RECEIVED REPORT FROM STEPHANIE, RN, NIGHT NURSE. PT AWAKE IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. FULL ASSESSMENT COMPLETED AT THIS TIME. RIGHT GROIN SOFT WITH PRESSURE DRESSING OVER PUNCTURE SITE DUE TO BLEEDING OVER NIGHT. NO BRUIT HEARD. PT DENIES PAIN AT THIS TIME. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 0800

4001 VS: Monitor + A Q4HOURS CP
Document 03/20/07 0800 SEM 03/20/07 0833 SEM
Blood Pressure: 111/62
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 71
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 97.5
Temp Source+: ORL
SPO2 (%): 96
LPM O2

Activity Date: 03/20/07 Time: 0955

Patient Notes: NURSE
Create 03/20/07 0955 NJM 03/20/07 1022 NJM
Abnormal? N Confidential? N
PT AWAKE AND IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. NO CHANGES SINCE MY

Activity Date: 03/20/07 Time: 0955 (continued)

Patient Notes: NURSE (continued)
INITIAL ASSESSMENT. ENCOURAGED PT TO AMBULATE IN HALLWAYS. PT VERBALIZED UNDERSTANDING. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1050

4065 Pain: Monitor + A .PRN CP
Document 03/20/07 1050 NJM 03/20/07 1104 NJM
Pain Indicators+: VOC
Pain Scale: 10
Pain Location #1+: RT GROIN
Pain Description+: ACHING
Pain Intervention+: MED
Medication: 2 DARVOCET

Activity Date: 03/20/07 Time: 1147

4001 VS: Monitor + A Q4HOURS CP
Document 03/20/07 1147 SEM 03/20/07 1156 SEM
Blood Pressure: 118/56
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 62
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 97.4
Temp Source+: ORL
LPM O2

Activity Date: 03/20/07 Time: 1155

4066 Pain: Reassess + A .PRN CP
Document 03/20/07 1155 NJM 03/20/07 1155 NJM
Pain Location #1+: RT GROIN
Previous Pain Level: 10
One Hour Pain Reassessment Level: 3
Pt. Asleep: N
Additional Pain Medication Administered: N
Physician Notified of Unrelieved Pain: N

4130 Education: + A DAILY CP
Document 03/20/07 1155 PAD 03/20/07 1156 PAD
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: TV/VIDEO
VERBAL/WRITTEN
TOPIC(S)+: CARDIAC REHABILITATION

1109

002526

6313

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/20/07 Time: 1155 (continued)

4130 Education: + (continued)
Information Taught: CAD/MI/STENT TEACHING PROTOCOL
Reference Material: TAKE CARE OF YOUR HEART
Outcome+: VERBALIZE UNDERSTANDING

Activity Date: 03/20/07 Time: 1156

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
- Document 03/20/07 1156 NJM 03/20/07 1157 NJM
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
~~~~CARDIOVASCULAR~~~~
Pulses
~~~~GASTROINTESTINAL~~~~
~~~~GENITOURINARY~~~~
~~~~INTEGUMENT~~~~
~~~~MUSCULOSKELETAL~~~~
~~~~NEUROLOGICAL~~~~
~~~~RESPIRATORY~~~~

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 1156 NJM 03/20/07 1157 NJM
Patient Notes: NURSE
- Create 03/20/07 1156 NJM 03/20/07 1157 NJM
Abnormal? N Confidential? N
PT RESTING IN BED. PT STATES HER PAIN IS MUCH BETTER AT THIS TIME. PRESSURE DRESSING REMOVED AND BANDAID PLACED OVER PUNCTURE SITE. PT IN SB WITH A CURRENT RATE OF 57 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. SIGNIFICANT OTHER AT BEDSIDE.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1357

Patient Notes: NURSE
- Create 03/20/07 1357 NJM 03/20/07 1400 NJM
Abnormal? N Confidential? N
PT AWAKE IN BED WITH SIGNIFICANT OTHER AT BEDSIDE. NO CHANGES SINCE MY LAST REASSESSMENT. PT DENIES PAIN AT THIS TIME. PT IN SB WITH A CURRENT RATE OF 57 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1359

4110 I&O: Monitor + A TID CP
- Document 03/20/07 1359 SEM 03/20/07 1456 SEM
<>INTAKE<>
Oral: 720
<>OUTPUT<>
Stool#: 1
Last BM: 03/20/07
Voided#: 4
<>DRAINS<>

Activity Date: 03/20/07 Time: 1457

4100 ADL: + A QS&PRN CP
- Document 03/20/07 1457 SEM 03/20/07 1502 SEM
~~~~ACTIVITIES OF DAILY LIVING~~~~
Activity+: AD LIB
Ambulation: Y
Feeding Method+: SELF
Bathing+: SELF
Oral Hygiene+: SELF
Bed Linen Changed: Y
Turned Q 2hrs: SELF
1) The staff will encourage the patient to be independent throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform tasks.
3) The staff will encourage patient participation in ADL's and participation will be monitored.
4) The staff will provide extra time to complete tasks as needed.

Activity Date: 03/20/07 Time: 1503

4090 Meals: Percentage Consumed + A TID CP
- Document 03/20/07 1503 SEM 03/20/07 1504 SEM
Breakfast(%)+: 20
Lunch(%)+: 50

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Comment | Documented Units | From / Change

Activity Date: 03/20/07 Time: 1600

4001 VS: Monitor + A Q4HOURS CP
- Document 03/20/07 1600 JLH 03/20/07 1608 JLH
Blood Pressure: 127/61
BP Source+: AUT
BP Site+: LA
BP Position+: SUP
Pulse: 61
Pulse Source+: BRA
Respirations: 20
Resp Source+: OBS
Temperature: 96.9
Temp Source+: ORL
On Room Air: Y
LPM O2

Activity Date: 03/20/07 Time: 1615

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
- Document 03/20/07 1615 NJM 03/20/07 1637 NJM
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/20/07 1615 NJM 03/20/07 1637 NJM

Activity Date: 03/20/07 Time: 1615

Patient Notes: NURSE
- Create 03/20/07 1615 NJM 03/20/07 1637 NJM
Abnormal? N Confidential? N
PT AWAKE AND SITTING UP IN BED. NO CHANGES SINCE MY LAST REASSESSMENT. PT DENIES PAIN AT THIS TIME. PT IN SB WITH A CURRENT RATE OF 59 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1750

4055 Notify: MD + A .PRN CP
- Document 03/20/07 1750 NJM 03/20/07 1807 NJM
MD Name: LAWJO Lawton,Joseph J III
Comment: NOTIFIED MD OF LOWER LEFT FOREARM PAIN. STAT EKG TAKEN AND NOTIFIED HIM OF RESULTS. NO ACTION REQUIRED.

Activity Date: 03/20/07 Time: 1815

4065 Pain: Monitor + A .PRN CP
- Document 03/20/07 1815 NJM 03/20/07 1906 NJM
Pain Indicators+: VOC
Pain Scale: 7
Pain Location #1+: LT FOREARM
Pain Description+: ACHING
Pain Intervention+: MED
Medication: 2 DARVOCET
Patient Notes: NURSE
- Create 03/20/07 1815 NJM 03/20/07 1854 NJM
Abnormal? N Confidential? N
PT AWAKE AND SITTING UP IN BED. PT COMPLAINING OF LOWER LEFT FOREARM PAIN AND GIVEN 2 DARVOCET PER MAR. NO OTHER CHANGES SINCE MY LAST REASSESSMENT. PT IN SR WITH A CURRENT RATE OF 63 BASED ON TELEMETRY. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR UNTIL DAVID, RN, NIGHT NURSE ASSUMES RESPONSIBILITY.
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1906

4066 Pain: Reassess + A .PRN CP
- Document 03/20/07 1906 NJM 03/20/07 1907 NJM
Pain Location #1+: LT FOREARM
Previous Pain Level: 7
One Hour Pain Reassessment Level: 3
Pt. Asleep: N
Additional Pain Medication Administered: N
Physician Notified of Unrelieved Pain: N
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Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts | Comment | Documented Units | Directions | Change | From

Activity Date: 03/20/07 Time: 1930

4002 Shift Assessment + A QSHIFT CP
Document 03/20/07 1930 DLV 03/20/07 2009 DLV
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 3
Pupil Reaction Left+: REACT
Pupil Size R (mm): 3
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts | Comment | Documented Units | Directions | Change | From

Activity Date: 03/20/07 Time: 1930 (continued)

4002 Shift Assessment + (continued)
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
Does Patient have Wound: N
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/20/07 1930 DLV 03/20/07 2013 DLV
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
PAIN MANAGEMENT
MEDICATION EDUCATION

In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
~~~

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/20/07 Time: 1930 (continued)

4004 Nursing: Daily Process + (continued)
Education Documentation: Y
----EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY----
----DOCUMENT ON THE EDUCATION INTERVENTION----
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
SIGNIFICANT OTHER

4065 Pain: Monitor + A .PRN CP
Document 03/20/07 1930 DLV 03/20/07 2013 DLV
Pain Indicators+: VOC
Pain Scale: 0

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/20/07 1930 DLV 03/20/07 2016 DLV

20160 Telemetry Monitoring + A QSHIFT CP
Document 03/20/07 1930 DLV 03/20/07 2016 DLV
----Telemetry Monitoring----
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
Patient Notes: NURSE
Create 03/20/07 1930 DLV 03/20/07 2009 DLV
Abnormal? N Confidential? N
ASSESMENT DONE PER IMCU PROTOCAL NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT
RESTING INBED WITH SIDERAILS UP WILL CONTINUE TO MONITOE
Note Type Description
No Type None

Activity Date: 03/20/07 Time: 1933

4001 VS: Monitor + A Q4HOURS CP
Document 03/20/07 1933 JLH 03/20/07 1942 JLH
Blood Pressure: 140/60
BP Source+: AUT
BP Site+: LA
BP Position+: SUP
Pulse: 68
Pulse Source+: BRA
Respirations: 20
Resp Source+: OBS
Temperature: 97.4
Temp Source+: ORL
On Room Air: Y

Activity Date: 03/20/07 Time: 1933 (continued)

4001 VS: Monitor + (continued)
LPM O2

Activity Date: 03/20/07 Time: 2159

4110 I&O: Monitor + A TID CP
Document 03/20/07 2159 JLH 03/20/07 2210 JLH
<>INTAKE<>
Oral: 720
<>OUTPUT<>
Voided#: 3
<>DRAINS<>

Activity Date: 03/21/07 Time: 0000

4001 VS: Monitor + A Q4HOURS CP
Document 03/21/07 0000 MSP 03/21/07 0205 MSP
Blood Pressure: 103/52
BP Source+: AUT
BP Site+: LA
BP Position+: SUP
Pulse: 63
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 98
Temp Source+: ORL
LPM O2

Activity Date: 03/21/07 Time: 0016

1001 NUR: Admission History+ C ONCE AS
Ed Status 03/21/07 0016 DLV 03/21/07 0016 DLV A => C
1011 NUR: Admission Physical+ C ONCE AS
Ed Status 03/21/07 0016 DLV 03/21/07 0016 DLV A => C

Activity Date: 03/21/07 Time: 0017

10900 CATHLAB:Post Procedure Assessment C ONCE AS
Ed Status 03/21/07 0017 DLV 03/21/07 0017 DLV A => C
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 03/21/07 0017 DLV 03/21/07 0022 DLV
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N

1113

002530

6317

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts | Documented Comment | Directions Units | From Change

Activity Date: 03/21/07 Time: 0017 (continued)

4009 Patient Reassessment + (continued)
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
----CARDIOVASCULAR----
Pulses
----GASTROINTESTINAL----
----GENITOURINARY----
----INTEGUMENT----
----MUSCULOSKELETAL----
----NEUROLOGICAL----
----RESPIRATORY----
Patient Notes: NURSE
Create 03/21/07 0017 DLV 03/21/07 0022 DLV
Abnormal? N Confidential? N
NO CHANGE NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT RESTING IN BED WITH SIDERAILS UP WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 03/21/07 Time: 0022

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/21/07 0022 DLV 03/21/07 0022 DLV

Activity Date: 03/21/07 Time: 0429

4110 I&O: Monitor + A TID CP
- Document 03/21/07 0429 MSP 03/21/07 0430 MSP
<>INTAKE<>
Oral: 480
<>OUTPUT<>
Stool#: 0
Voided#: 0
<>DRAINS<>

Activity Date: 03/21/07 Time: 0444

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment of the patient.
- Document 03/21/07 0444 DLV 03/21/07 0446 DLV

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts | Documented Comment | Directions Units | From Change

Activity Date: 03/21/07 Time: 0444 (continued)

4009 Patient Reassessment + (continued)
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: Y
----CARDIOVASCULAR----
Pulses
----GASTROINTESTINAL----
----GENITOURINARY----
----INTEGUMENT----
----MUSCULOSKELETAL----
----NEUROLOGICAL----
----RESPIRATORY----
Patient Notes: NURSE
Create 03/21/07 0444 DLV 03/21/07 0445 DLV
Abnormal? N Confidential? N
NO CHANGE NO C/O OF CHESTPAIN OR SOB CATH SITE CDI PT RESTING IN BED WITH SIDERISAL UP WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 03/21/07 Time: 0446

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 03/21/07 0446 DLV 03/21/07 0446 DLV

Activity Date: 03/21/07 Time: 0639

Patient Notes: NURSE
- Create 03/21/07 0639 DLV 03/21/07 0640 DLV
Abnormal? N Confidential? N
Patient voicing no complaints. Condition stable. no new problems. vital signs stable. and resting quietly at present. No change in condition from previous assessment.no change no c/o of cathpain or sob cath site cdi pt resting in bed with siderails up report given to day shift rn

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions From
Type Date Time by Date Time by Comment Documented Units Change

Activity Date: 03/21/07 Time: 0639 (continued)

Patient Notes: NURSE (continued)
Note Type Description
No Type None

Activity Date: 03/21/07 Time: 0725 (continued)

20125 Fall Precautions + (continued)
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Document 03/21/07 0725 NJM 03/21/07 0828 NJM
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 1
Incontinence (1)+: 0
Sensory Deficits (1)+: 0
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y
4002 Shift Assessment + A QSHIFT CP
Document 03/21/07 0725 NJM 03/21/07 0827 NJM
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 3
Pupil Reaction Left+: REACT
Pupil Size R (mm): 3
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: PURPOSEFUL
Cognition+: SIMPLE
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: Y
JVD: N
Peripheral Edema: N
ICD: N

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions From
Type Date Time by Date Time by Comment Documented Units Change

Activity Date: 03/21/07 Time: 0725 (continued)

4002 Shift Assessment + (continued)
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLEAR
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: PUNCTURE
Other: RIGHT GROIN SOFT WITH NO
EVIDENCE OF HEMATOMA BUT
BRUISING SURROUNDS
PUNCTURE SITE; NO BRUIT
HEARD
Does Patient have Wound: N
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: Y
4004 Nursing: Daily Process + A Q12H10 CP
Document 03/21/07 0725 NJM 03/21/07 0827 NJM
Code Status+: FULL CODE
HIPAA Passcode: 9048
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes

Problem Description
Intervention Description — Sts — Directions — From
Activity Type — Occurred Date Time — Recorded by Date Time — Documented by Comment Units — Change

Activity Date: 03/21/07 Time: 0725 (continued)

4004 Nursing: Daily Process + (continued)
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC COMPLICATIONS
PAIN MANAGEMENT
MEDICATION EDUCATION

In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
——EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY——
——DOCUMENT ON THE EDUCATION INTERVENTION——
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: FAMILY
SIGNIFICANT OTHER
4130 Education: + A DAILY CP
Document 03/21/07 0725 NJM 03/21/07 0827 NJM
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: TV/VIDEO
VERBAL/WRITTEN

Problem Description
Intervention Description — Sts — Directions — From
Activity Type — Occurred Date Time — Recorded by Date Time — Documented by Comment Units — Change

Activity Date: 03/21/07 Time: 0725 (continued)

4130 Education: + (continued)
TOPIC(S)+: CARDIAC REHABILITATION
DISCHARGE INSTRUCTION
MEDICATIONS
SAFETY ISSUES
Information Taught: SAME AS ABOVE
Outcome+: VERBALIZE UNDERSTANDING
Plan/Follow Up: WILL UPDATE AS NEEDED
9169 IV: IV/INT Site Check A PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 03/21/07 0725 NJM 03/21/07 0827 NJM
Patient Notes: NURSE
Create 03/21/07 0725 NJM 03/21/07 0827 NJM
Abnormal? N Confidential? N
RECEIVED REPORT FROM DAVID, RN, NIGHT NURSE. PT AWAKE AND SITTING UP IN BED. FULL ASSESSMENT COMPLETED AT THIS TIME. RIGHT GROIN SOFT WITH NO EVIDENCE OF HEMATOMA BUT BRUISING SURROUNDING PUNCTURE SITE. NO BRUIT HEARD. PT DENIES PAIN. INSTRUCTED PT TO CALL IF SHE NEEDED ANYTHING. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 03/21/07 Time: 0800

4001 VS: Monitor + A Q4HOURS CP
Document 03/21/07 0800 SEM 03/21/07 0811 SEM
Blood Pressure: 123/61
BP Source+: AUT
BP Site+: RA
BP Position+: SUP
Pulse: 63
Pulse Source+: MON
Respirations: 20
Resp Source+: OBS
Temperature: 95.5
Temp Source+: ORL
SPO2 (%): 97
LPM O2

Activity Date: 03/21/07 Time: 1054

4100 ADL: + A QS&PRN CP
Document 03/21/07 1054 SEM 03/21/07 1058 SEM
——ACTIVITIES OF DAILY LIVING——
Activity+: AD LIB
Ambulation: Y
Feeding Method+: SELF
Bathing+: SELF
Oral Hygiene+: SELF

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/21/07 Time: 1054 (continued)

4100 ADL: + (continued)
Bed Linen Changed: Y
Turned Q 2hrs: SELF
1) The staff will encourage the patient to be independent throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform tasks.
3) The staff will encourage patient participation in ADL's and participation will be monitored.
4) The staff will provide extra time to complete tasks as needed.

Activity Date: 03/21/07 Time: 1111

4140 Discharge Instruction + A ONCE CP
- Document 03/21/07 1111 NJM 03/21/07 1114 NJM
Patient Discharge Instructions
Please Bring Copy To Office With You
Diet: LOW FAT, CHOL, SALT
Enter/Edit/View Notes: Y
Use F4 - F9 to Access DISCHARGE Notes.
Follow-Up Appointment: APRIL 11, 2007 AT 11:00 AM
Call Doctor's Office: AS NEEDED
Call Doctor's Office: AS NEEDED
Exercise or Special Limitations
: SEE DISCHARGE INSTRUCTIONS
Dressing, Treatment, Special Equipment
: SEE DISCHARGE INSTRUCTIONS
Special Instructions
: SEE MEDICATION LIST
Tobacco Use+: CIGARETTE
Smoking Cessation Information Provided+: Y
Pt Has Education Folder in Possession at Time of Discharge: Y
All Teaching Information Given to the Pt is in Folder: Y
Interdisciplinary Discharge Medication
List Given To Pt/Family
Pt or Family Recieved the Following Items
Valuables Brought to Hospital Returned+: Y
Medications Brought to Hospital Returned+: N
Clothing brought to Hospital Returned+: Y
I Have Received a Copy of Both My Discharge Medication List and My Discharge Plan of Care.

Pt/SO Signature:_____
Date:_____
***** These Numbers are Provided for your Convenience *****
MAIN CAMPUS NORTHEAST CAMPUS
Lost and Found - 256-5690
Lost and Found - 865-4690
Patient Financial Services - 256-5505
Patient Financial Services - 865-5816

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/21/07 Time: 1111 (continued)

4140 Discharge Instruction + (continued)
Medical Records - 256-5302
Medical Records - 865-4680
Patient Advocate - 256-5739
Patient Advocate - 256-5739
Stop Using Tobacco In Any Form. It Has Been Shown To Reduce Healing. No Smoking!
Call Your Physician If You Have Worsening Symptoms.
If You Have Heart Failure - Weigh Yourself Daily And Write It Down. Call Your Physician
If You Gain 2-3 Lbs. Overnight
Or Over A 1-2 Day Period.
********** NURSING DISCHARGE CHECKLIST **********
Discharge Instructions 1 +: PCI
Mode of Discharge+: AMB
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Foley Removed: N
Voided Prior To Discharge: Y
Narcotic Analgesic was Given within 6 hours Prior to Discharge, Notify Attending Physician.
Pneumovax Given: N
Flu Vaccine Given: N
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
ACE-Inhibitor Prescribed at Discharge: N
ARB Prescribed At Discharge: N
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Patient Notes: NURSE
- Create 03/21/07 1111 NJM 03/21/07 1112 NJM
Abnormal? N Confidential? N

POST CORONARY INTERVENTION DISCHARGE INSTRUCTIONS

Special Medication Information:

* TAKE PLAVIX AND ASPIRIN DAILY AS PRESCRIBED. DO NOT MISS A DOSE!!
* PLAVIX AND ASPIRIN INCREASES BLEEDING, HOLD PRESSURE TO ANY CUT.
* NITROGLYCERIN SHOULD BE USED WHEN SITTING OR LYING DOWN. DO NOT DRIVE CAR WHILE USING NITROGLYCERIN. CALL YOUR PHYSICIAN OR REPORT TO EMERGENCY ROOM IF NO IMPROVEMENT IN CHEST PAIN AFTER THIRD DOSE OF NITROGLYCERIN.

Exercise or Special Limits:

* INCREASE WALKING DAILY UNTIL RETURN TO NORMAL LEVEL.
* NO RUNNING, FAST STAIR CLIMBING OR STRETCHING FOR 3 DAYS.

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/21/07 Time: 1111 (continued)

Patient Notes: NURSE (continued)
* DO NOT SIT FOR LONG PERIODS OF TIME. CHANGE POSITION FREQUENTLY WHILE SITTING.
* DO NOT LIFT ANYTHING HEAVIER THAN 10 POUNDS FOR NEXT 3 DAYS.
* DO NOT DRIVE A CAR FOR NEXT 3 DAYS.
* LIMIT BENDING FOR NEXT 3 DAYS.

Dressing, Treatment, or Special Information:

* NO MRI FOR 6-8 WEEKS.
* CLEAN CATH SITE DAILY WITH SOAP AND WATER UNTIL HEALED.
* PLACE CLEAN BANDAID ON CATH SITE UNTIL HEALED.
* DO NOT USE LOTION OR POWDER AT CATH SITE UNTIL SITE IS HEALED.
* SHOWER PREFERRED, NO SOAKING IN A POOL OR TUB FOR 48 HOURS POST PROCEDURE.
* DO NOT STRAIN WITH BOWEL MOVEMENTS. MAY USE A LAXATIVE IF NEEDED.
* YOU CAN EXPECT BRUISING AT THE CATH SITE. A SMALL MARBLE SIZED KNOT MAY ALSO BE PRESENT - IT SHOULD GO AWAY WITHIN 2-3 WEEKS.
* YOU MAY HAVE SOME MILD ACHING OR PAIN AT SITE YOU MAY TAKE TYLENOL AS DIRECTED.
* WATCH SITE FOR BLEEDING, IF BLEEDING OCCURS HOLD DIRECT PRESSURE TO SITE FOR 5 MINUTES WHILE LYING DOWN. IF UNABLE TO CONTROL OR STOP BLEEDING CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM IMMEDIATELY.
* NOTIFY PHYSICIAN FOR PERSISTENT NUMBNESS, TINGLING, OR SEVERE PAIN IN THE EXTREMITY USED FOR THE HEART CATH.
* WATCH FOR SIGNS OF INFECTION - INCREASED REDNESS AT SITE, DRAINAGE, INCREASED PAIN. NOTIFY PHYSICIAN IF YOU DEVELOP A FEVER GREATER THAN 100 DEGREES. IF YOU DEVELOP SHAKING CHILLS NOTIFY YOUR PHYSICIAN.

Note Type Description
No Type None

Activity Date: 03/21/07 Time: 1139

Patient Notes: NURSE
- Create 03/21/07 1139 NJM 03/21/07 1141 NJM
Abnormal? N Confidential? N
DISCHARGE TEACHING COMPLETED WITH PATIENT AND SIGNIFICANT OTHER. PT VERBALIZED UNDERSTANDING AND HAD NO QUESTIONS. PT WILL BE WAITING FOR INFORMATION FROM CASE MANAGEMENT ON MEDICATION SAMPLES/PLAVIX PROGRAM. INT REMOVED. PT GIVEN COPIES OF ALL DISCHARGE PAPERWORK ALONG WITH MEDICATION LIST/PRESCRIPTIONS. WILL CONTINUE TO MONITOR UNTIL PT READY FOR DISCHARGE.

Note Type Description
No Type None

1118

Activity Date: 03/21/07 Time: 1150

Patient Notes: NURSE
- Create 03/21/07 1150 NJM 03/21/07 1205 NJM
Abnormal? N Confidential? N
TELEMETRY MONITOR REMOVED. PRIOR DISCHARGE TEACHING COMPLETED. PT ESCORTED

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 03/21/07 Time: 1150 (continued)

Patient Notes: NURSE (continued)
TO LOBBY FOR DISCHARGE.

Note Type Description
No Type None

Activity Date: 03/21/07 Time: 1201

20140 Home Medication List + D PRN AS
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
3591 RT: O2 Per 12 Hours D PS
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
3594 RT: O2 Monitor + D PS
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: DECREASED CARDIAC OUTPUT D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10000 Cardiovascular: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10001 Cardiac Rhythm: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: PNEUMOVAX SCREENING ASSESSMENT D
This diagnosis is used to screen the patient population for qualification for the Pneumovax Vaccination.
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
20180 Pneumovax Screening Assessment+ D ONCE CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: RESPIRATORY DISTRESS D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10006 Respiratory: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10542 Support: Emotional D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11004 Respiratory: Pulmonary Toilet D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
13020 Oxygen Therapy: as Ordered D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
13540 Suction: Available D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: CHEST PAIN: ANGINA D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10011 Chest Pain: Monitor + D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: ALTERATION IN BOWEL ELIMINATION D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10015 Constipation: Treat as Ordered D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10048 Activity: as Tolerated/Ordered D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D

002535

6322

Problem Description / Intervention Description / Activity Type / Occurred Date Time / Recorded Date Time / by / Sts / Directions / Documented / Comment / Units / From / Change

Activity Date: 03/21/07 Time: 1201

10185 Bowel Movement: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10579 Gastrointestinal: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9136 Fluid: Force D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: ANXIETY D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10017 Referral: Pastoral Care as Needed D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10018 Anxiety: Medicate as Ordered D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10542 Support: Emotional D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11041 Rest Periods: Provide D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11601 Environment: Control Stim/Activity D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: KNOWLEDGE DEFICIT D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10009 Cardiac Rehab: Phase I D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: CARDIAC CATH PROCEDURE D
1. Decreased Cardiac Output
2. Pain
3. Anxiety
4. Knowledge Deficit
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10000 Cardiovascular: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10001 Cardiac Rhythm: Monitor D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10009 Cardiac Rehab: Phase I D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10012 Cardiac Cath: Pre-Procedure Assessment D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10017 Referral: Pastoral Care as Needed D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10018 Anxiety: Medicate as Ordered D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10022 Allow Pt to Verbalize Concerns D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10542 Support: Emotional D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11041 Rest Periods: Provide D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11601 Environment: Control Stim/Activity D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D

Activity Date: 03/21/07 Time: 1201

20105 Post Cath Monitor + D .PER PROTOCOL CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
20106 Sheath Removal Monitor + D .PER PROTOCOL CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: ADULT - AGE 18-65 YRS D
Potential Alteration in Normal Processes (ADL's, Safety, Life Situations) r/t Hospitalization
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness, Home Situation, Job, Life Style Changes and/or Families Inability to Cope
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11690 ADL: Encourage Independence D CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: GUIDELINES FOR NURSING DOCUMENTATION D
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
11040 Meds: As Ordered D .PRN CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
15001 IV Insertion/Removal + D .PRN CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
20125 Fall Precautions + D EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
20145 Advance Directives Monitor + D .PER PROTOCOL CP
--Two Attempts To Acquire Hard Copy For Chart Required
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
20150 Emergency Contact Information + D .PRN CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4001 VS: Monitor + D Q4HOURS CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4002 Shift Assessment + D QSHIFT CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4004 Nursing: Daily Process + D Q12H10 CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4009 Patient Reassessment + D QS&PRN CP
Use this intervention for reassessment of the patient.
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4055 Notify: MD + D .PRN CP
- Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 03/21/07 Time: 1201

4065 Pain: Monitor + D .PRN CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4066 Pain: Reassess + D .PRN CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4085 Transfer: Another Unit + D .PRN CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4090 Meals: Percentage Consumed + D TID CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4100 ADL: + D QS&PRN CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4110 I&O: Monitor + D TID CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4120 Weight + D DAILY CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4130 Education: + D DAILY CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
4140 Discharge Instruction + D ONCE CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9040 Blood Product: Administer as Ordered+ D .PER PROTOCOL CP
-THIS INTERVENTION IS USED ON ALL
PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9167 IV: Peripheral Monitor Site/Infusion + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9169 IV: IV/INT Site Check D .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
Problem: Frequently Used PCU Interventions D
These Interventions Are Frequently Used
And/Or High Priority Nursing
Interventions In The Cardiac Care Areas.
They Are Placed in Process Interventions
As A Conveience For The Nursing Staff.
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10008 Wound: Monitor + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10175 Instruction: Special Nursing D .PRN CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10120 Blood Sugar Monitor + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
10160 Telemetry Monitoring + D QSHIFT CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9069 Central Line: Monitor Site/Infusion + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9135 Fluid: Restriction D CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D

Activity Date: 03/21/07 Time: 1201

9171 PCA: Monitor + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9351 VS: Frequent Vitals + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D
9355 VS: Orthostatic + D .PER PROTOCOL CP
Ed Status 03/21/07 1201 his 03/21/07 1201 his A => D

Monogram	Initials	Name	Nurse Type
BAT	TALBOTBA	TALBOT,BRIGETTE A	RNBP
CNS	SCHULTCN	SCHULTZ,CYNTHIA N	RNBP
DLV	VARETTDL	VARETTONI,DAVID L	RN
JLB	BURRJL	BURR,JULIE L	RN
JLE	EPPSJL	EPPS,JESSICA L	RN
JLH	HOLASJL	HOLAS,JOAN L	NTI
KHG	GENTRYKH	GENTRY,KEITH H	NTII
LFB	BRADSHLF	BRADSHAW,LOUISA F	RT
LRF	FOGLELR	FOGLE,LAUREN R	RN
MRD	DIXONMR	DIXON,MEGAN R	SRN
MSP	POPEMS	POPE,MELINDA S	NTI
NJM	MEEHANNJ	MEEHAN,NANCY J	RN
NLB	BRUCKENL	BRUCKE,NATALIE L	NTI
PAD	BROWDEPA	BROWDER,PATRICIA A	RN
SEM	MACKSE	MACK,SHERON E	NTII
SME	EDENTOSM	EDENTON,STEPHANIE M	PRNU
his		automatic by program	

1120

002537

6324

HAM,TAMMY M000895682 **Caliper Measurements**

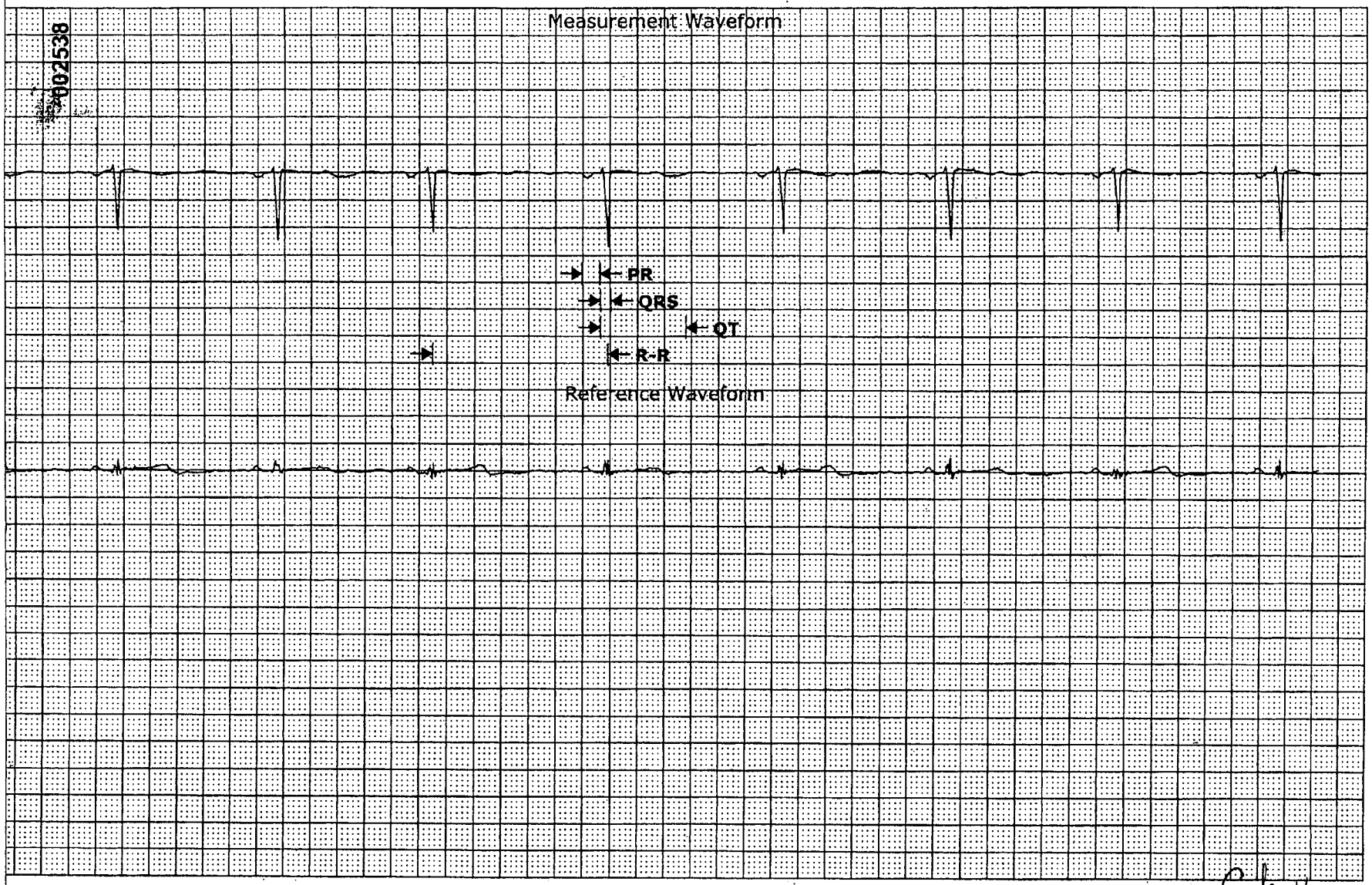
2008 10:48:45 - 12-May-2008 10:48:55

5-13

452 ST1508

6325

1121



displayed reflect measurements acquired against the measured waveform only.

= 0.132	sec	QT	= 0.637	sec
= 0.079	sec	R-R	= 1.295	sec
= 0.560	sec	Rate	= 46	bpm

SB

5/12/08

25 mm/s

Page 1

END OF REPORT

lical Systen
ion Technolog

CIC Version 5.0.7

Monday, May 12, 2008 11:17:22 AM

RUN DATE: 05/14/08
RUN TIME: 1322
RUN USER: SHEAREHD

Providence Hospital ABS **LIVE*
ATTESTATION STATEMENT

002539

NAME: WINDHAM,TAMMY E
ACCT #: D00502499114

ADM DATE: 05/11/08
ATTEND PHYS: Malanuk,Robert M. Dr.
DIS DATE: 05/13/08
DISCH DISP: DISCH TO HOME OR SELF CARE
LOS: 2
PT CLASS: IN

UNIT #: M000895682
SEX: F
AGE: 40
DOB: 10/18/67
FIN CLASS: SP
ABS STATUS: FINAL

DIAGNOSES:

				POA?
ADMIT:	787.01	NAUSEA WITH VOMITING		Y
PRINC:	414.01	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY VESSEL		Y
SECOND:	411.1	INTERMED CORONARY SYND	C	Y
	996.72	OTH COMPLICATIONS DUE TO OTH CARD DEVICE,IMPL,GRFT	C	Y
	E879.0	ABN REACT-CARDIAC CATH		Y
	272.0	PURE HYPERCHOLESTEROLEM		Y
	305.1	TOBACCO USE DISORDER		Y
	401.9	HYPERTENSION NOS		Y
	272.4	HYPERLIPIDEMIA NEC/NOS		Y
	V58.66	LONG-TERM (CURRENT) USE OF ASPIRIN		E
	E849.0	ACCIDENT IN HOME		E
	V45.82	PERCUTANEOUS TRANSLUM CORON ANGIOPLASTY STATUS		E

OPERATIONS:

05/12/08	00.66	PERC TRANSLUMINAL CORON ANGIOPLASTY PTCA OR CORON ATHERECT	OMB1
05/12/08	36.07	INSRT OF DRUG-ELUTING CORON ARTERY STENTS(S)	MB2
05/12/08	37.22	LEFT HEART CARDIAC CATH	B3
05/12/08	88.56	CORONAR ARTERIOGR-2 CATH	B4
05/12/08	88.53	LT HEART ANGIOCARDIOGRAM	B5
05/12/08	00.46	INSERTION OF TWO VASCULAR STENTS	B6
05/12/08	00.40	PROCEDURE ON SINGLE VESSEL	
05/12/08	99.19	INJECT ANTICOAGULANT	

COMPLETE

DRG: 247 PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC

STATUS	$ REIMB	MIN-LOS	MAX-LOS	STD-LOS	GRP VERS	GRP FC
F	10628.97			2.2	25	SP

I certify that the narrative descriptions of the principal and secondary diagnoses and the major procedures performed are accurate and complete to the best of my knowledge.

_____ DATE _____

1122

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

WINDHAM,TAMMY E
A# D00502499114 U#M000895682
05/11/08 F 40
Malanuk,Robert M. Dr. 8-A

Start Here	Date: 5/11/08	Time: 1820 AM PM	Profiled By:	Filled By.

Columbia Cardiology Consultants
Admission Orders

CCC1010

Admit Inpatient	Indicate Medical Reason: US Angina
Observation Status R/O conditions, complications post-op/outpt procedure, <24 hrs	Indicate Medical Reason:
Outpatient Procedure/Services Hospital stay pre-certified/pre-authorized for outpt	Indicate Medical Reason:

Admit to services of **COLUMBIA CARDIOLOGY CONSULTANTS**:

a. Notify our office of admission and room number; speak directly to the appointment secretary.
b. Notify personal physician of admission if he is in the Columbia area.
c. Obtain all old records and do EKG immediately.
d. If patient is admitted for heart cath, give cath booklet and inform of film times.
e. Under no circumstances is dictated H & P summary to be removed from chart prior to discharge.

DIET:
Low Cholesterol: 4 Gm Sodium (and 1800 Cal. ADA if diabetic). May have salt substitute
No drinks containing caffeine – May have decaffeinated coffee

STUDIES:
*****Have am labs on chart by 7am for rounds.******

____ Chest x-ray (portable, sitting).
____ CBCX or _____CBCD.
____ Troponin I reflex Stat and every 6 hours x 3. I have Attorney
____ Total CPK, MB Fraction and Index
____ STAT Basic Metabolic Profile & Magnesium level. I have Attorney
____ ECG STAT and daily x 1
____ Fasting Lipid Panel
____ PT
____ Urinalysis

If referral hospital labs are to be used, place them in chart under "LAB SECTION".

ACTIVITY: PCU - As tolerated **MCCU** - Bedside commode privileges/male pts may stand to void

ROUTINES:
Vitals with SaO2 per Unit Routine
Oxygen at 2L/nasal canula PRN short of breath, chest pain or SaO2 less than 92%. Titrate to keep SaO2 greater than 92%.
12 Lead EKG STAT for any prolonged and severe chest pain x 1 episodes – but if patient has documented 100% paced rhythm delete this order.
INT and flush with 1ml NS each shift. Use left arm preferably.
Intake and Output
Daily Weights
ABG's may be obtained at nurses' discretion

SCANNED

MEDICATIONS:
List current home meds in Meditech (and hospital meds if transfer) and obtain appropriate orders from MD.

SCHEDULED MEDICATIONS:
Zantac (ranitidine 150mg PO q8h. If unable to take PO give IV as below.
Zantac (ranitidine) 50mg IV q12h if unable to take PO.
Enteric Coated ASA 325 mg PO daily

1123

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D00502499114
05/11/08 F 40
Malanuk,Robert M. Dr. D.508-A

CCC1010

PRN MEDICATIONS:
Tylenol #3 (acetaminophen 300 mg/codeine 30 mg) 1-2 tablets PO q4h PRN pain. (Note: Acetaminophen total daily dose from all sources not to exceed 4000 mg.)
Darvocet-N 100 (propoxyphene 100 mg/acetaminophen 650 mg) 1-2 tablets PO q4h PRN pain if allergy to Codeine. (Note: Acetaminophen total daily dose from all sources not to exceed 4000 mg.)
NTG 0.4 mg tablet sublingually PRN chest pain. May repeat every 5 minutes x 2 additional doses.
Dilaudid (hydromorphone) 1-2 mg IV over 5 minutes q3h PRN severe chest pain or chest pain not relieved by NTG. **Notify MD.**
Restoril (temazepam) 15 mg PO at bedtime PRN insomnia. May repeat x 1 dose.
Xanax (alprazolam) 0.25 mg q4h PRN anxiety. Xanax 0.125 mg for patients over 70 years of age.
Reglan (metoclopramide) 10 mg IV q4h over 2 minutes PRN nausea and vomiting.
Zofran (ondansetron) 4 mg IV q 4 hours PRN nausea not relieved by Reglan.
MOM (magnesium hydroxide suspension) 30 ml PO q12h PRN constipation
Regitine (phentolamine) 5 mg diluted in 10 ml 0.9% Sodium Chloride subcutaneously (use smallest gauge needle) to affected ischemic area at IV site PRN IV dopamine infiltration. May repeat x 1 dose if large infiltrate.
Atropine 0.5mg IV PRN symptomatic heart rate less than 40. May repeat q5minutes to a total of 3mg IV and **Notify MD.**

If on Heparin, adjust per Providence Heparin Protocol.

DIABETIC PRECAUTIONS:
Follow Providence Hospitals Hypoglycemia protocol.

If a doctor has not seen patient by 9:00 P.M., notify answering service to contact the doctor on call.

Follow current ACLS protocols for pulseless VT, V-fib, asystole, EMD or symptomatic bradycardia less than 35 BPM and **Call MD immediately.**

SCANNED

Med- Surg and PCU Patients Only: If patient has a history of sustained V-tach they **must** be transported with a cardiac monitor. Patients may be transported without a cardiac monitor if: Vital signs are stable, no unstable angina x 48 hours and no V-tach by monitor x 48 hours. If there are questions, contact M.D.

SIGNATURE Dr. Malanuk / S. Jones, RN **DATE** 5/11/2008

STANLEY JUK JR, MD
EUGENE F.SCHWARZ, MD
R. TAYLOR WILLIAMS, MD
JOSEPH L.LAWTON, MD
RICHARD E.UMBACH, MD
AMY EPPS, MD
MICHAEL C. ROBERTS, MD
ROBERT M. MALANUK, MD
ERIC E. SHOUP, MS PAC

ORIGINAL: 1/1/04
Revised: 12/04, 5/8/08

1124

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

WINDHAM, TAMMY E
A# D005024991JA MR#000895682
05/11/08 F 40
Malanuk, Robert M. Dr. [illegible]3-A

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

Inpatient Pre-Cath/PCI/Angiography Orders

1. Please have patient sign consent form for Cardiac Catheterization/PCI or Specific Peripheral Procedure. Procedure scheduled for date 5/12/08.
2. Give patient catheterization pamphlet and instruct patient to view cardiac catheterization segment on the patient education channel.
3. NPO after midnight **except** usual medications. Liquid breakfast if procedure scheduled after 11 am. **Call cath lab morning of procedure to confirm time before feeding patient.**
4. Pre-cath labs to be on chart by 6pm prior to procedure: BMP, CBCD, PT/PTT. *Do not repeat if done within 7 days of procedure.*
   Additional Test/Lab work only if checked:
   ____Magnesium ____Urinalysis _____CXR _____Type and Screen.
5. If patient is on Integrilin (eptifibitide) or Reopro (abciximab) obtain CBCD morning of procedure.
6. If potassium level is between 3 and 3.5 and creatinine less than 1.5, give 40 mEq Potassium Chloride PO now x 1 dose and repeat serum potassium level in two hours.
7. If not done on admission, obtain 12-lead electrocardiogram morning of cath and place on chart.
8. If on IV Heparin, discontinue one hour prior to procedure on-call to cath lab. If on bolus heparin, hold after midnight prior to procedure. Call MD if further instructions needed.
9. If patient on Lovenox (enoxaparin), hold after midnight prior to procedure.
10. If creatinine is greater than 1.7 start bicarbonate infusion (D5W 1000 ml with 150 ml sodium bicarbonate) at 3 ml/kg/hour IV one hour pre-procedure, followed by a rate of 1 ml/kg/hour until 6 hours post procedure. **Give these IV fluids in place of any other regular fluid.*
11. If patient is diabetic, begin ½ Normal Saline IV at 75 ml/hour at 4am day of scheduled procedure.
12. If patient is diabetic and on insulin, give **half** of usual insulin dosing the day of procedure, then resume regular dosing. Consult MD for diabetic instructions. If patient is on oral diabetic medication, hold AM dose day of procedure. **If taking Glucophage(metformin), hold day of procedure and through 48 hours post procedure, then administer as usual.*

SCANNED

5/11/08 1542

1125

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

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WINDHAM,TAMMY E
A# D00502499114 U#M000
05/11/08 F 40
Malanuk,Robert M. D.508-A

13. If patient has had previous **contrast reaction** or is **allergic to iodine or shellfish give:** X
    Prednisone 60 mg PO x 1 dose the night before then
    Prednisone 60 mg PO and **Diphenhydramine 50 mg PO x 1 dose** the morning of procedure.

    Other Meds: _____

14. Insure **TWO** #20 or greater bore INT's are functional **BEFORE** transport to cath lab. ✓

15. Have patient void immediately prior to being sent to cath lab. May place Foley catheter if patient has difficulty voiding. ✓

SCANNED

Physician's Signature Dr. Malanuk / Lewis, RN **Date** 5/15/08

Original: 3/20/08

1126

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002544

WINDHAM,TAMMY E
A# D00502499114
05/11/08 F 40
Malanuk,Robert M. Dr. D.508-A

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time: AM PM	Profiled by:	Filled by:	Checked by:
5/12/08	1515			

1) Standard PCU orders ✓
2) Pre-Cath orders ✓
3) NPO after MN ✓
4) CBC, Chem 7 in am ✓
5) Nitroglycerin paste 1/2 inch every six hours ✓
6) Continue transfer medications as listed

Physician Signature: Beeper #:

Date:	Time: AM PM	Profiled by:	Filled by:	Checked by:

Lisinopril 20 mg PO daily ✓
Aspirin 81 mg PO daily ✓
Enoxaparin 70 mg SQ subcutaneous every 12 hours ✓
Clopidogrel 75 mg PO daily ✓
~~Discont~~ Lopressor 50 mg PO BID set for pop per Dr. Malanuk

Lewis, 5/12/08 1515

Physician Signature: Beeper #:

SCANNED

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

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Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

NUR020 (12/06)

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

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WINDHAM,TAMMY E
A# D00502499114
05/11/08 F 40
Malanuk,Robert M. D.508-A

Start Here	Date:	Time: AM PM	Profiled By:	Filled By:	Checked By:

Providence Hospitals Post Coronary Intervention Orders

1. **Admit as Inpatient**: Indicate Medical Reason: Coronary Artery Disease

2. Check vital signs and procedure site for swelling or bleeding Pre and Post sheath Removal q 15 min x 4, q 30 min x 4, q 1 hour x 3, then routine. Check distal extremity for warmth, color, sensation and presence of a pulse q 15 min x 4, q 30min x 4, q 1 hour x 3, then routine. Post Carotid patients check neuro status with vitals. Post Peripheral patients notify physician of changes in peripheral vascular status.

3. **MEDICATIONS:**
   - ✓ Enteric Coated Aspirin 325 mg PO daily
   - ✓ Plavix (clopidogrel) 75 mg PO daily – had today
   - _____ Plavix (clopidogrel) 600 mg PO x 1 now.
   - _____ Plavix (clopidogrel) 300 mg PO x 1 now.
   - _____ Mucomyst (acetylcysteine solution) 600 mg PO BID for 2 days.
   - _____ Continue Reopro (abciximab) at rate _____ until _____.
   - _____ Continue Integrilin (eptifibitide) at rate _____ until _____.
   - _____ Resume Heparin as previously ordered or _____ 6 hours past sheath pull. (Use Heparin Weight-Based Protocol for Heparin Infusion).
   - _____ Resume Lovenox (enoxaparin) as previously ordered or _____ 6 hours past sheath pull.
   - _____ Continue Nitroglycerin infusion (50mg/250ml D5W) at a rate of _____ until _____. (Wean off if free of chest pain)
   - _____ Continue IV Fluids as started in the cath lab at rate _____ until _____.
   - _____ HOLD Glucophage {metformin} 48 hours post catheterization.
   - _____ May infilitrate Cath Site with 10-15ml of 2% Xylocaine (lidocaine) injection subcutaneously prior to sheath pull PRN comfort.

4. **LABS / EKG:** d/c Angiogram
   CBCD and BMP in AM (*NOTIFY PHYSICIAN if PLATELET COUNT is LESS than 40,000)*
   EKG now and in AM
   CBCD every AM while on Aggrastat or Integrilin.
   CBCD every 6 and 12 hrs after Reopro Infusion begun.
   Additional labs if checked:
   - _____ Troponin and Reflex MB now and in AM
   - _____ Lipid Profile in AM

   Cardiac Rehabilitation for post intervention education.

5. Insert Foley Catheter PRN if patient unable to void. Remove foley catheter when patient is ambulatory. Males may stand to void with nurse present if necessary after sheath removal. Nurse must remain with patient.

SCANNED

5-12-08

1128

6. **PRN MEDICATIONS:** (If no allergies)
   a. Tylenol (acetaminophen) 650 mg PO q4h PRN mild pain or elevated temperature. Not to exceed 4Gm/24 hrs from all sources.
   b. Darvocet-N100 (propoxyphene 100 mg/acetaminophen 650 mg) 1 or 2 tablets PO q4h PRN moderate pain. Not to exceed 4Gm acetaminophen/24hrs from all sources.
   c. Tylenol #3 (acetaminophen 300 mg/codeine 30 mg)1-2 tablets PO q4h PRN moderate-severe pain. Not to exceed 4Gm acetaminophen/24hrs from all sources.
   d. Nitrolingual Spray (nitroglycerin) 0.4 mg (1 spray) q 5 min sublingually PRN chest pain up to a total of 3 sprays. Obtain EKG and **Notify MD.**
   e. Dilaudid (hydromorphone) 0.5-1mg IVP q2h PRN for severe pain.
      (Demerol {meperidine}25mg IVP q3h PRN severe pain if allergic to Dilaudid).
   f. Restoril (temazepam)15mg at bedtime PRN sleep. May repeat x 1 dose.
      Benadryl (diphenhydramine) 25mg PO at bedtime PRN sleep for patient's greater than 70 years old.
   g. Xanax (alprazolam) 0.25 mg PO q 4h PRN anxiety.
   h. Reglan (metoclopramide)10 mg IV (given over 2 minutes) q4h PRN nausea/vomiting.
      If no relief, may use Zofran (ondansetron) 4 mg IV q4h PRN for unrelieved nausea and/or vomiting.
   i. MOM (magnesium hydroxide) 30ml PO daily PRN or Fleet Enema (sodium phosphate salts) daily PRN constipation per patient's preference.
   j. Mylanta II (magnesium and aluminum hydroxides/simethicone) 30ml PO four times daily PRN indigestion.
   k. Lomotil (diphenoxylate) 2 tablets PO PRN q2h PRN severe diarrhea. Limit to 8 tablets/ 24 hours.
   l. Benadryl (diphenhydramine) 50mg IV/PO q6h PRN for itching or urticaria. **Notify MD.**

7. **SHEATH REMOVAL** (if present):
   a. If arterial introducer sheath is not removed in the Cath Lab: Check ACT q 2 hours and remove sheath when ACT is less than or equal to 180 or at nurses discretion for excessive bleeding or hematoma.
   b. If Angiomax (bivalirudin) given pull sheath 2 hours past completion of Angiomax.
   c. Place sterile Band-Aid at site, place pressures dressing over Band-Aid if noted problems with oozing. Remove pressure dressing past ambulating.
   d. If unable to control bleeding prior to or after sheath pull, nurse may place a Femstop per policy, if patient is located on 4 Heart, MCCU, ICU or IICU. **NOTIFY MD if Femstop used.**

8. **PATIENT ACTIVITY:** Complete bed rest 6 hours post sheath removal. May raise head of bed 10-15 degrees for meal after sheath removal. Ambulate slowly with supervision after 6 hours then activity as tolerated. If Closure Device, may ambulate 3 hours post sheath removal. Observe groin puncture site carefully for groin complication after progressing activity.

9. Follow-up appointment with _____ in _____ weeks.

SCANNED

PHYSICIAN SIGNATURE _____ DATE _____
Cardiologist Signature

Original: 3/20/08

1129

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002547

WINDHAM,TAMMY E
A# D00502499114 U#M000805682
05/11/08 F 40
Malanuk,Robert M. D:508-A

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/12/08	1615 AM PM			

1) Decrease Metoprolol 50mg PO BID, to 25mg PO BID per Dr. Malanuk/Sfeuso, RN
T.O. RD.

SCANNED

Physician Signature: Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/12/08	1530 AM PM			

Continue transfer medication/
Nicotine 21mg Patch per Dr. Malanuk/Sfeuso, RN

SCANNED

Physician Signature: Beeper #:

Victoria Stoops 5/12/08 0112

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

1130

NUR020 (12/06)

6334

002548

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

WINDHAM,TAMMY E
A# D00502499114 U#M000895682
05/11/08 F 40
Malanuk,Robert M. L... ...508-A

☐ Admit As Inpatient — Indicate Medical Reason:

☐ Admit As Outpatient Observation — Indicate Medical Reason:

☐ Outpatient Procedure / Services — Indicate Medical Reason

Physician's Orders

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/12/08	2317 AM PM			

Dilaudid 1-2 mg q 3° prn
(R) leg pain

T.O. Dr Williams / SEdenton RN

SCANNED

2245 / SEdenton RN 5/12/08 2310 pm

Physician Signature: [signature] Beeper #:

Date:	Time:	Profiled by:	Filled by:	Checked by:
5/13	845 AM PM			

Add on LFTs. call if abnl
PC to home
Flu c̄ me 3-4 wks

Physician Signature: [signature] Beeper #: [signature] 5-13-08

12 HOUR CHART CHECKS ARE REQUIRED EACH DAY

Orders: Another brand of a generically equivalent product identical in dosage form and content of active ingredient may be administered unless requested

Automatic stop order schedule of stop dates reproduced below is in terms of days following date of original. This order does not apply when physician's order indicates exact number of doses and/or days to be administered.

Do Not Use the following Abbreviations:
u, UI, qd, qod, Ug, MS, MSO4, MgSO4
Never write a zero by itself after a decimal point - i.e. write 5 mg
Always use a zero before a decimal point - i.e. write 0.5 mg

1131

NUR020 (12/06)

6335

Occurred Date	Time	by	Author	Recorded Date	Time	by	NURSE
05/13/08	0945	SEB	BAKER,STEPHANIE E	05/13/08	0945	SEB	

Abnormal? N Confidential? N

POST CORONARY INTERVENTION DISCHARGE INSTRUCTIONS

Special Medication Information:

* TAKE PLAVIX AND ASPIRIN DAILY AS PRESCRIBED. DO NOT MISS A DOSE!!
* PLAVIX AND ASPIRIN INCREASES BLEEDING, HOLD PRESSURE TO ANY CUT.
* NITROGLYCERIN SHOULD BE USED WHEN SITTING OR LYING DOWN. DO NOT DRIVE CAR WHILE USING NITROGLYCERIN. CALL YOUR PHYSICIAN OR REPORT TO EMERGENCY ROOM IF NO IMPROVEMENT IN CHEST PAIN AFTER THIRD DOSE OF NITROGLYCERIN.

Exercise or Special Limits:

* INCREASE WALKING DAILY UNTIL RETURN TO NORMAL LEVEL.
* NO RUNNING, FAST STAIR CLIMBING OR STRETCHING FOR 3 DAYS.
* DO NOT SIT FOR LONG PERIODS OF TIME, CHANGE POSITION FREQUENTLY WHILE SITTING.
* DO NOT LIFT ANYTHING HEAVIER THAN 10 POUNDS FOR NEXT 3 DAYS.
* DO NOT DRIVE A CAR FOR NEXT 3 DAYS.
* LIMIT BENDING FOR NEXT 3 DAYS.

Dressing, Treatment, or Special Information:

* NO MRI FOR 6-8 WEEKS.
* CLEAN CATH SITE DAILY WITH SOAP AND WATER UNTIL HEALED.
* PLACE CLEAN BANDAID ON CATH SITE UNTIL HEALED.
* DO NOT USE LOTION OR POWDER AT CATH SITE UNTIL SITE IS HEALED.
* SHOWER PREFERRED, NO SOAKING IN A POOL OR TUB FOR 48 HOURS POST PROCEDURE.
* DO NOT STRAIN WITH BOWEL MOVEMENTS. MAY USE A LAXATIVE IF NEEDED.
* YOU CAN EXPECT BRUISING AT THE CATH SITE. A SMALL MARBLE SIZED KNOT MAY ALSO BE PRESENT - IT SHOULD GO AWAY WITHIN 2-3 WEEKS.
* YOU MAY HAVE SOME MILD ACHING OR PAIN AT SITE YOU MAY TAKE TYLENOL AS DIRECTED.
* WATCH SITE FOR BLEEDING, IF BLEEDING OCCURS HOLD DIRECT PRESSURE TO SITE FOR 5 MINUTES WHILE LYING DOWN. IF UNABLE TO CONTROL OR STOP BLEEDING CALL 911 OR REPORT TO NEAREST EMERGENCY ROOM IMMEDIATELY.
* NOTIFY PHYSICIAN FOR PERSISTENT NUMBNESS, TINGLING, OR SEVERE PAIN IN THE EXTREMITY USED FOR THE HEART CATH.
* WATCH FOR SIGNS OF INFECTION - INCREASED REDNESS AT SITE, DRAINAGE, INCREASED PAIN. NOTIFY PHYSICIAN IF YOU DEVELOP A FEVER GREATER THAN 100 DEGREES. IF YOU DEVELOP SHAKING CHILLS NOTIFY YOUR PHYSICIAN.

Patient Discharge Instruction 05/13/08 0945 SEB

Patient Discharge Instructions Please Bring Copy To Office With You

Diet: CARDIAC

Enter/Edit/View Notes: Y Use F4 - F9 to Access DISCHARGE Notes.

Follow-Up Appointment: DR LAWTON 744-4900 2601 LAUREL ST SUITE 260

Call Doctor's Office:

Call Doctor's Office:

Date to Return to Work/School:

Exercise or Special Limitations
: AS TOLERATED

Dressing, Treatment, Special Equipment
:

Special Instructions
: TAKE MEDICATIONS AS DIRECTED

Tobacco Use+: CIGARETTE Smoking Cessation Information Provided+: YES
Pt. has 'A Patient's Guide to Safety' in possession at discharge: Y
All Teaching Information Given to the Pt is in Folder: Y

Interdisciplinary Discharge Medication List Given To Pt/Family

Pt or Family Recieved the Following Items
Hearing Aides+: Contact Lens+: Glasses+: Dentures+: Prosthesis+:
Valuables Brought to Hospital Returned+: NA
Medications Brought to Hospital Returned+: NA
Clothing brought to Hospital Returned+: NA

I Have Received a Copy of Both My Discharge Medication List and My Discharge Plan of Care.
**
Pt/SO Signature: Tammy Windham Date:

***** These Numbers are Provided for your Convenience *****

MAIN CAMPUS
Lost and Found - 256-5690
Patient Financial Services - 256-5505
Medical Records - 256-5302
Patient Advocate - 256-5739

NORTHEAST CAMPUS
Lost and Found - 865-4690
Patient Financial Services - 865-5816
Medical Records - 865-4680
Patient Advocate - 256-5739

Stop Using Tobacco In Any Form. It Has Been Shown To Reduce Healing. No Smoking!

Call Your Physician If You Have Worsening Symptoms.

1133

Patient Discharge Instruction

05/13/08 0945 SEB

If You Have Heart Failure - Weigh Yourself Daily And Write It Down. Call Your Physician If You Gain 2-3 Lbs. Overnight Or Over A 1-2 Day Period.

********** NURSING DISCHARGE CHECKLIST **********

Discharge Instructions 1 +: PCI
Discharge Instructions 2 +:
Discharge Instructions 3 +:
Mode of Discharge+: AMB
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
Notify MD's (If Applicable) Name:
Time:

IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Foley Removed: Y
Voided Prior To Discharge: Y
BM Documented 2-3 Days Prior to Discharge: Y

Narcotic Analgesic was Given within 6 hours Prior to Discharge, Notify Attending Physician.
Name:
Time:

Pneumovax Given: N
Flu Vaccine Given: N
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
All Patient Outcomes Are Met: Y
Able to Perform ADL's: Y
Other:

ACE-Inhibitor Prescribed at Discharge: Y
ARB Prescribed At Discharge: N
If Not, Follow Up Plans Are+:
If not, Follow Up Plans Are+:

Monogram Initials	Name		Nurse Type
SEB	BAKERSE	BAKER,STEPHANIE E	CM

1134

RUN DATE: 05/13/08
RUN TIME: 0527
RUN USER: EDENTOSM

Providence Hospital Pharmacy **LIVE**
DISCHARGE MEDICATION LIST INCLUDING HOME MEDICATIONS

WINDHAM,TAMMY E D.4H D.H452-A D00502499114 40/F WT: lbs.
ATTENDING PHYSICIAN: Malanuk,Robert M. Dr.

NUR ALLERGY: NO KNOWN DRUG ALLERGIES
PHA ALLERGY: NO KNOWN DRUG ALLERGIES

DISCHARGE MEDICATION LIST

MEDICATION	DOSE	ROUTE	DIRECTIONS	SHOULD PATIENT CONTINUE TAKING THIS MEDICINE AT HOME? (PLEASE CIRCLE ONE)	
NITROGLYCERIN (Nitro-Bid 2% 1GM Pkt)	0.5 GM	TRANSDERM	EVERY 6 HOURS AT 6A-N-6P-MN Q6H6	YES	NO
CLOPIDOGREL BISULFATE (Plavix 75MG)	75 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO
LISINOPRIL (PRINIVIL)	20 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO
ENOXAPARIN (Lovenox 80MG)	70 MG	SUBCUTANEOU	EVERY 12 HOURS AT 0400,1600 Q12H4	YES	NO
METOPROLOL TARTRATE (Lopressor 25MG)	25 MG	ORAL	TWICE DAILY BID	YES	NO
NICOTINE (Nicotine Transdermal 21 MG System)	1 PATCH	TRANSDERM	DAILY AT 1000 (10:00AM) DAILY	YES	NO
RANITIDINE HCL (Zantac)	150 MG	ORAL	EVERY 12 HOURS AT 0800,2000 Q12H8	YES	NO
ASPIRIN (Ecotrin)	325 MG	ORAL	DAILY AT 1000 (10:00AM) DAILY	YES	NO

HOME MEDICATION LIST		CONTINUE THIS MEDICATION	
BAYER ASA	81 MG PO DAILY	YES	NO
LOPRESSOR	50 MG BID (25 mg 2x/day	YES	NO
		YES	NO
		YES	NO
HTN MED TO CLARIFY		YES	NO
LIPITOR DOSE TO BE CLARIFIED		YES	NO
		YES	NO
Pravachol 40 mg/day		YES	NO
		YES	NO
		YES	NO
		YES	NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

1135

WINDHAM,TAMMY E D.4H D.H452-A D00502499114 40/F WT: lbs.
ATTENDING PHYSICIAN: Malamuk,Robert M. Dr.

	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO
	YES	NO

***** DOCTOR: PLEASE WRITE PRESCRIPTIONS FOR NEW MEDICATIONS AND PRN MEDS IF NEEDED *****

1136

002554

2601 Laurel Street, Suite 260 • Columbia, SC 29204 • (803) 744-4900
107 West Hospital Drive • West Columbia, SC 29169 • (803) 744-4940

Columbia Cardiology Consultants

L. S. Stanley Jak, Jr., M.D.
Reg. No. AJ6352813
NPI 1932161692
Joseph J. Lawton, III, M.D.
Reg. No. BL3197058
NPI 1457318116
Michael C. Roberts, M.D.
Reg. No. BR2195964
NPI 1508829730

Eugene F. Selwitz, M.D.
Reg. No. AS1039494
NPI 1255394490
Richard E. Umbach, M.D.
Reg. No. AU8135495
NPI 1407818065
R. Taylor Williams, M.D.
Reg. No. BW7128425
NPI 1801859038

Robert M. Malanuk, M.D.
Reg. No. BM4950069
NPI 1740242304
Eric E. Shoup, M.S., PA-C
Reg. No. MS1477529
NPI 1073576281
Emily Sexton, ACNP, BC
NPI 1306813054
Brandon E. Brown, M.D.
Reg. No. BB0430342
NPI 1235251729

If you have questions regarding this prescription, please call (803) 744-4900

Date: 5-15-08
Name: Tammy Windham
Address:
Please label contents: Yes

		Mg.	No.	Directions	Refills
1.	Plavix	75	30	1 po qd	4
2.	Prinivil	40	30	1 po qpm	
3.	Lipitor	25	60	1 po qpm	6
4.	Prinivil	20	30	1 po BID	4
5.	Nicoderm patch	21	30	1 daily qd	4

Dispense As Written _____ M.D.

Substitution Permitted: Joseph Lawton M.D.

3

WINDHAM,TAMMY E
A# D005024991 TA WM000895682
05/11/08 F 40
Malanuk,Robert M. Dr. D.008-A

1137

6341

002555

Tammy Windham
has an appointment

Month Day Year

at _____ AM _____ PM

My appointment is at the following location:

☐ 2601 Laurel Street
Suite 260
Columbia, SC 29204
(803) 744-4900

☐ 107 West Hospital Drive
West Columbia, SC 29169
(803) 744-4940

3-4 wks

My appointment is with

☐ S. Stanley Juk, Jr., M.D.
☑ Joseph J. Lawton, III, M.D.
☐ Michael C. Roberts, M.D.
☐ Eugene F. Schwarz, M.D.
☐ Richard E. Umbach, M.D.
☐ R. Taylor Williams, M.D.
☐ Robert M. Malanuk, M.D.

10-18-67

WINDHAM,TAMMY E
A# D00502499114
05/11/08 F 40
Malanuk,Robert M.

1138

6342

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 1

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA 002556
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: Edenton RN

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** SCHEDULED MEDS *****				
Rx#: 03036429 ASPIRIN 325 MG TABEC (325 MG) (Ecotrin) DOSE: 325 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H	05/11/08 SCH	1000 AWB		
Rx#: 03036218 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (Plavix 75MG) DOSE: 75 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H	05/11/08 SCH	1000 AWB		
Rx#: 03036233 ENOXAPARIN 80 MG/0.8 ML SYR (70 MG) (Lovenox 80MG) DOSE: 70 MG SC SIG: EVERY 12 HOURS AT 0400,1600 INVENTORY from D4H ***DEACTIVAT 05/11/08-2300 TO	05/11/08 SCH	*HOLD*	*HOLD*	*HOLD*
Rx#: 03036220 LISINOPRIL 20 MG TAB (20 MG) (PRINIVIL) DOSE: 20 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H	05/11/08 SCH	1000 AWB 164/54 HR 66		
Rx#: 03036236 METOPROLOL TARTRATE 25 MG TAB (25 MG) (Lopressor 25MG) DOSE: 25 MG PO SIG: TWICE DAILY INVENTORY from D4H	05/11/08 SCH	1000 AWB 164/64 HR 66	2200	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
L Brown, RN	AWB				

1139

6343

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 2

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA 002557
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: B Edenton RN

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** SCHEDULED MEDS *****				
Rx#: 03036242 NICOTINE 21MG PATCH (1 PATCH) (Nicotine Transdermal 21 MG System) DOSE: 1 PATCH TD SIG: DAILY AT 1000 (10:00AM) INVENTORY from D4H	05/11/08 SCH	1000 AVB		
Rx#: 03036217 NITROGLYCERIN 1 GM PKT (0.5 GM) (Nitro-Bjd 2% 1GM Pkt) DOSE: 0.5 GM TD SIG: EVERY 6 HOURS AT 6A-N-6P-MN COMMENTS: 1 gram is equivalent to approximately 1 inch as squeezed from a tube INVENTORY from D4H Verify if needs to be continued	05/11/08 SCH	1200	1800	0000 0600
Rx#: 03036427 RANITIDINE HCL 150 MG TAB (150 MG) (Zantac) DOSE: 150 MG PO SIG: EVERY 12 HOURS AT 0800,2000 COMMENTS: Pharmacy & Therapeutics Committee, Medical Executive Committee approved therap interchange for PEPCID 20 MG Q12H. PO OR IV INVENTORY from D4H	05/11/08 SCH	0800 AVB	2000	
***** IV'S *****				
Rx#: 03037964 NTG 200 MCG/ML (250 ML) (Nitroglycerin 50MG/Dextrose 5%) RATE: UD DUR: FREQ: DAILY AT 1000 (10:00AM) *** NEXT TUBING CHANGE DUE: _____	05/12/08	1000 AVB D/C		

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
B Bowen, RN	AVB				

1140

6344

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002558
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: Edenton Rn

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 03037968 CODEINE/APAP #3 TAB (None) (Acetaminophen/Codeine #3) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: for moderate-severe pain. NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES EACH TABLET CONTAINS 300MG ACETAMINOPHEN TYLENOL #3 DOSE INSTR: 1-2 TABS INVENTORY from D4H		05/12/08 PRN			
Rx#: 03037966 ACETAMINOPHEN 325 MG TABLET (650 MG) (Tylenol) DOSE: 650 MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: for mild pain or elevated temperature NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES INVENTORY from D4H		05/12/08 PRN			
Rx#: 03037973 ALPRAZOLAM 0.25 MG TAB (0.25 MG) (Xanax 0.25MG Tab) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR ANXIETY CAUTION: Patients taking this medication may be at increased risks for falls. INVENTORY from D4H		05/12/08 PRN			
Rx#: 03037980 DIPHENHYDRAMINE HCL 50 MG CAP (50 MG) (Benadryl) DOSE: 50 MG PO SIG: EVERY 6 HOURS AS NEEDED COMMENTS: IV/PO PRN ITCHING OR URTICARIA AND NOTIFY MD. BENADRYL INVENTORY from D4H		05/12/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002559
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: Stedenton R

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 03037981 DIPHENHYDRAMINE HCL 50 MG/ML VIAL (50 MG) (Benadryl) DOSE: 50 MG IV SIG: EVERY 6 HOURS AS NEEDED COMMENTS: IV/PO PRN ITCHING OR URTICARIA AND NOTIFY MD. BENADRYL INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037979 DIPHENOXYLATE/ATROPINE 1 UDTAB TAB (2 UDTAB) (Lomotil) DOSE: 2 UDTAB PO SIG: EVERY 2 HOURS AS NEEDED COMMENTS: FOR SEVERE DIARRHEA. (limit to 8 tabs/24 hrs) INVENTORY from D4H	05/12/08 PRN			
Rx#: 03039086 HYDROmorphone HCL 2 MG/ML AMP (None) (Dilaudid 2MG/Ml Inj) DOSE: 1-2 MG IV SIG: EVERY 3 HOURS AS NEEDED COMMENTS: for severe pain. DILAUDID DOSE INSTR: 1-2 MG INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037978 MAG HYDROX/AL HYDROX/SIMETH 30 ML UDC (30 ML) (Mag-Al Plus Xs Suspension) DOSE: 30 ML PO SIG: 4 TIMES DAILY AS NEEDED COMMENTS: FOR INDIGESTION MYLANTA/MYLANTA II/MAALOX X-STRENGTH INVENTORY from D4H	05/12/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002560
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: Edenton RN

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 03037976 MAGNESIUM HYDROX (LAX) 30 ML UDC (30 ML) (Milk Of Magnesia) DOSE: 30 ML PO SIG: DAILY AS NEEDED COMMENTS: FOR CONSTIPATION (or may give Fleet enema) per patient preference MOM INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037971 MEPERIDINE HCL 50 MG/ML AMP (None) (Demerol) DOSE: 25 MG IV SIG: EVERY 3 HOURS AS NEEDED COMMENTS: for severe pain if allergic to Dilaudid DOSE INSTR: 25 MG INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037974 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (Reglan 10MG/2ML Vial) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR NAUSEA/VOMITING (GIVE OVER 2 MINUTES) INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037969 NITROGLYCERIN 12 GM AERO (None) (Nitrolingual Pumpspray) DOSE: 1 SPRAY (.4 MG) SIG: EVERY 5 MINUTES COMMENTS: for chest pain up to a total of 3 sprays. Obtain EKG and Notify MD. DOSE INSTR: 1 SPRAY (.4 MG) INVENTORY from D4H	05/12/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002561
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: Edenton Ra

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 03036431 NITROGLYCERIN 0.4 MG 25TABBOT (None) (Nitroquick 0.4MG Subl) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR MILD CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D4H	05/11/08 PRN			
Rx#: 03037975 ONDANSETRON HCL 4 MG/2 ML VIAL (4 MG) (Zofran) DOSE: 4 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR NAUSEA AND/OR VOMITING IF NO RELIEF FROM REGLAN INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037967 PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (None) (DARVOCET-N 100) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: for moderate pain NOT TO EXCEED 4 GM/24 HRS ACETAMINOPHEN FROM ALL SOURCES EACH TABLET CONTAINS 650MG ACETAMINOPHEN DOSE INSTR: 1-2 TABS INVENTORY from D4H	05/12/08 PRN			
Rx#: 03037977 SOD PHOSPHATE/SOD BIPHOSPHATE 133 ML BTL (133 ML) (Fleet Enema) DOSE: 133 ML PR SIG: DAILY AS NEEDED COMMENTS: PRN CONSTIPATION (or may have MOM per patient's preference) INVENTORY from D4H	05/12/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.4H D.H452 A
AGE: 40 SEX: F WT: 71.21kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002562
MAR DATE: 05/13/08-0700 TO 05/14/08-0659
RUN DATE/TIME: 05/13/08-0051
VERIFIED BY: S Edenton RN

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 03037972 TEMAZEPAM 15 MG CAP (None) (Restoril) DOSE: 15 MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: for sleep for patients 70 and younger (may repeat x 1 dose) CAUTION: Patients taking this medication may be at increased risks for falls. DOSE INSTR: 15 MG INVENTORY from D4H	05/12/08 PRN			
***** PRN IV'S *****				
Rx#: 03036428 RANITIDINE HCL 50MG/2ML VIAL (50 MG) (Zantac IV 50MG/2ML) IN: D5W 50 ML BAG (50 ML) (Dextrose 5% Water IV Soln) RATE: 208 MLS/HR DUR: FREQ: EVERY 8 HOURS AS NEEDED COMMENTS: Therapeutic Interchange for Pepcid 20 MG IV Q12H. MAY USE IV DOSAGE FORM IF ORAL ROUTE NOT POSSIBLE. EXP 7 DAYS (IN IV SOLN) *** NEXT TUBING CHANGE DUE:_____	05/11/08			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.

PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 1

D00502499114 WINDHAM,TAMMY E — D.5T D.508 A — 002563

MEDICAL RECORD #: M000895682
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
*****	SCHEDULED MEDS *****				
Rx#: 03036429 ASPIRIN 325 MG TABEC (325 MG) (Ecotrin) DOSE: 325 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T		05/11/08 SCH	1000		
Rx#: 03036218 CLOPIDOGREL BISULFATE 75 MG TAB (75 MG) (Plavix 75MG) DOSE: 75 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T		05/11/08 SCH	1000		
Rx#: 03036233 ENOXAPARIN 80 MG/0.8 ML SYR (70 MG) (Lovenox 80MG) DOSE: 70 MG SC SIG: EVERY 12 HOURS AT 0400,1600 INVENTORY from D5T ***DEACTIVAT 05/11/08-2300 TO		05/11/08 SCH	*HOLD*	*HOLD*	*HOLD*
Rx#: 03036220 LISINOPRIL 20 MG TAB (20 MG) (PRINIVIL) DOSE: 20 MG PO SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T		05/11/08 SCH	1000		
Rx#: 03036236 METOPROLOL TARTRATE 25 MG TAB (25 MG) (Lopressor 25MG) DOSE: 25 MG PO SIG: TWICE DAILY INVENTORY from D5T		05/11/08 SCH	1000 HR 45	2200 SE	[illegible]

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				S Edenton RN	SE

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PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 2

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.508 A
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002564
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY: DO

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** SCHEDULED MEDS *****				
Rx#: 03036242	NICOTINE 21MG PATCH (1 PATCH) (Nicotine Transdermal 21 MG System) DOSE: 1 PATCH TD SIG: DAILY AT 1000 (10:00AM) INVENTORY from D5T	05/11/08 SCH	1000		
Rx#: 03036217	NITROGLYCERIN 1 GM PKT (0.5 GM) (Nitro-Bid 2% 1GM Pkt) DOSE: 0.5 GM TD SIG: EVERY 6 HOURS AT 6A-N-6P-MN COMMENTS: 1 gram is equivalent to approximately 1 inch as squeezed from a tube INVENTORY from D5T	05/11/08 SCH	1200	1800	~~0000~~ 0600
Rx#: 03036427	RANITIDINE HCL 150 MG TAB (150 MG) (Zantac) DOSE: 150 MG PO SIG: EVERY 12 HOURS AT 0800,2000 COMMENTS: Pharmacy & Therapeutics Committee, Medical Executive Committee approved therap interchange for PEPCID 20 MG Q12H. PO OR IV INVENTORY from D5T	05/11/08 SCH	0800 1400	2000 ~~2200~~ SE	0600

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				Sharon Weeks	SE
				S Edenton RN	SE

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PROVIDENCE HOSPITAL PHARMACY — MEDICATION ADMINISTRATION RECORD — PAGE 3

D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.508 A
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
002565
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX# MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
***** PRN MEDS *****				
Rx#: 03036430 CODEINE/APAP #3 TAB (None) (Acetaminophen/Codeine #3) DOSE: 1-2 TABS PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR MILD PAIN. GIVE DARVOCET N 100 IF ALLERGIC TO TYLENOL #3 TYLENOL #3. EACH TABLET CONTAINS 300MG ACETAMINOPHEN DOSE INSTR: 1-2 TABS INVENTORY from D5T	05/11/08 PRN	0810 BL 1 TAB	~~2140~~ SE 2 tabs	
Rx#: 03036411 ACETAMINOPHEN 325 MG TABLET (650 MG) (Tylenol) DOSE: 650 MG PO SIG: EVERY 4 HOURS AS NEEDED INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036413 ALPRAZOLAM 0.25 MG TAB (0.25 MG) (Xanax 0.25MG Tab) DOSE: 0.25 MG PO SIG: EVERY 4 HOURS AS NEEDED. COMMENTS: CAUTION: Patients taking this medication may be at increased risks for falls. INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036434 ALPRAZOLAM 0.25 MG TAB (None) (Xanax 0.25MG Tab) DOSE: 0.25MG PO SIG: EVERY 4-6 HOURS AS NEEDED COMMENTS: FOR APPREHENSION. GIVE XANAX 0.125MG FOR PATIENTS > 70 YEARS OF AGE. DOSE INSTR: 0.25MG INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036240 D50W 50 ML BRISTOJECT (50 ML) (Dextrose 50%Water Syringe) DOSE: 50 ML IV SIG: AS DIRECTED COMMENTS: IF BLOOD SUGAR < 50, GIVE 1 AMP INVENTORY from D5T	05/11/08 PRN			

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				Shond Lewis	BL
				J Edenton RN	SE

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D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.508 A
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY:

002566

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 03036432 HYDROmorphone HCL 2 MG/ML AMP (None) (Dilaudid 2MG/Ml Inj) DOSE: 1-2 MG IV SIG: EVERY 3-4 HOURS AS NEEDED COMMENTS: FOR SEVERE CHEST PAIN. GIVE OVER 5 MINUTES. DOSE INSTR: 1-2 MG INVENTORY from D5T	05/11/08 PRN			1 MG @ ~~1855~~ CS	
Rx#: 03036239 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (Reglan 10MG/2ML Vial) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: FOR NAUSEA, IF UNRELIEVED, THEN GIVE COMPAZINE INVENTORY from D5T	05/11/08 PRN				
Rx#: 03036435 METOCLOPRAMIDE HCL 10 MG/2 ML VIAL (10 MG) (Reglan 10MG/2ML Vial) DOSE: 10 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: GIVE OVER 2 MINUTES. AS NEEDED FOR NAUSEA AND VOMITING. INVENTORY from D5T	05/11/08 PRN		~~1520~~ JM		
Rx#: 03036238 NITROGLYCERIN 0.4 MG 25TABBOT (None) (Nitroquick 0.4MG Subl) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: AS NEEDED FOR CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D5T	05/11/08 PRN				
Rx#: 03036431 NITROGLYCERIN 0.4 MG 25TABBOT (None) (Nitroquick 0.4MG Subl) DOSE: PLACE 1 TABLET SIG: AS NEEDED COMMENTS: FOR MILD CHEST PAIN. DOSE INSTR: PLACE 1 TABLET UNDER TONGUE AND LET DISSOLVE INVENTORY from D5T	05/11/08 PRN				

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
		CSheen	CS	Mark Ruiz	SL
		SEdmonson RN	SE	Smiddy RN	LM

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D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.508 A
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 03036439	ONDANSETRON HCL 4 MG/2 ML VIAL (4 MG) (Zofran) DOSE: 4 MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PRN NAUSEA NOT RELIEVED BY REGLAN INVENTORY from D5T	05/11/08 PRN		1450 C8	
Rx#: 03036438	PHENTOLAMINE MESYLATE 5 MG/VIAL VIAL (None) (Regitjne) DOSE: 5-10MG SQ SIG: AS NEEDED COMMENTS: FOR DOPAMINE INFILTRATION. DOSE INSTR: 5-10MG INVENTORY from PHARMACY	05/11/08 PRN			
Rx#: 03036436	PROCHLORPERAZINE EDISYLATE 10 MG/2 ML VIAL (None) (Compazine) DOSE: 5-10MG IV SIG: EVERY 4 HOURS AS NEEDED COMMENTS: MAY GIVE IV OR PO FOR NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 5-10MG INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036437	PROCHLORPERAZINE MALEATE 5 MG TABLET (None) (COMPAZINE) DOSE: 5-10MG PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: PO OR IV FOR NAUSEA UNRELIEVED BY REGLAN. DOSE INSTR: 5-10MG INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036412	PROPOXYPHENE/ACETAMINOPHEN 1 UDTAB TAB (1 UDTAB) (DARVOCET-N 100) DOSE: 1 UDTAB ~ 2 PO SIG: EVERY 4 HOURS AS NEEDED COMMENTS: EACH TABLET CONTAINS 650MG ACETAMINOPHEN INVENTORY from D5T	05/11/08 PRN		2 @	

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
		C Schuler	CS	Shmel Lewis	SL
				C Schuler	CS
		S Edenton RN	SE		

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D00502499114 WINDHAM,TAMMY E
MEDICAL RECORD #: M000895682 D.5T D.508 A
AGE: 40 SEX: F WT: 71.47kg BSA: 1.80
ADMITTED: 05/11/08 PHYSICIAN: Malanuk,Robert M. Dr.
NOTES:

PRIMARY DX: UNSTABLE ANGINA
MAR DATE: 05/12/08-0700 TO 05/13/08-0659
RUN DATE/TIME: 05/12/08-0102
VERIFIED BY:

ALLERGIES:
NO KNOWN DRUG ALLERGIES
ADRS:

RX#	MEDICATION	START/STOP	0700-1459	1500-2259	2300-0659
	***** PRN MEDS *****				
Rx#: 03036237	TEMAZEPAM 15 MG CAP (None) (Restoril) DOSE: 15 MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: MAY REPEAT TIMES 1 DOSE INSTR: 15 MG INVENTORY from D5T	05/11/08 PRN			
Rx#: 03036433	TEMAZEPAM 15 MG CAP (15 MG) (Restoril) DOSE: 15 MG PO SIG: AT BEDTIME AS NEEDED COMMENTS: AS NEEDED FOR SLEEP. MAY REPEAT X 1. INVENTORY from D5T	05/11/08 PRN			
	***** PRN IV'S *****				
Rx#: 03036428	RANITIDINE HCL 50MG/2ML VIAL (50 MG) (Zantac IV 50MG/2ML) IN: D5W 50 ML BAG (50 ML) (Dextrose 5% Water IV Soln) RATE: 208 MLS/HR DUR: FREQ: EVERY 8 HOURS AS NEEDED COMMENTS: Therapeutic Interchange for Pepcid 20 MG IV Q12H. MAY USE IV DOSAGE FORM IF ORAL ROUTE NOT POSSIBLE. EXP 7 DAYS (IN IV SOLN) *** NEXT TUBING CHANGE DUE:	05/11/08			

This is the end of the Medical Administration Record for WINDHAM,TAMMY E

Dilaudid 1-2 mg q3° prn leg pain

~~2320~~ 2mg SE

SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.
				Shonda Lewis	SL
		J Edenton RN	SE		

1151

6355

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00502499114
DR: Malanuk,Robert M. D
DIAGNOSIS: UNSTABLE ANGINA
VERIFIED BY: _____

ROOM: D.508-A
AGE: 40 SEX: F
ADMITTED: 05/11/08

(FT/IN) / (CM) (LB/OZ) / (KG)

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/11/08 TO 0659 05/12/08

	START/STOP	0700-1459	1500-2259	2300-0659
Nitro paste 1/2 inch every six hour			~~1630~~	~~0400~~
lisinipril 20mg PO daily	Took today			
Aspirin 81mg PO daily	Took today			
Enoxaparin 40mg SQ every 12hr			~~2000~~	Hold in AM
Clopidogel 75mg PO daily	Took today			
~~Atenolol 50mg PO BID~~				
Metoprolol ~~50mg~~ PO BID 25mg			~~2000~~ 152/74 HR-66	

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
		Lorraine Shaw		Windham	

WINDHAM,TAMMY E 40/F DR: Malanuk,Robert M. D ROOM: D.508-A

Providence Hospital
MEDICATION ADMINISTRATION RECORD

WINDHAM,TAMMY E
ACCT: D00502499114
DR: Malanuk,Robert M. D
DIAGNOSIS: UNSTABLE ANGINA
VERIFIED BY: _____

ROOM: D.508-A
AGE: 40 SEX: F

(FT/IN) / (CM) (LB/OZ) / (KG)

ALLERGIES: NO KNOWN DRUG ALLERGIES

ADMINISTRATION PERIOD: 0700 05/11/08 TO 0659 05/12/08

	START/STOP	0700-1459	1500-2259	2300-0659
Nicotine 21mg Patch	5/12/08	Done C Tourney		
Tylenol 650 mg PO every four as needed for pain			1500 [illegible]	
Zantac 150mg PO q 8hours, If unable to give IV, then Zantac 50mg IV q 12hours if unable to take PO			2200 [illegible]	0600 [illegible]

SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS
		Lorraine Johnson	[illegible]	[illegible]	[illegible]

WINDHAM,TAMMY E 40/F DR: Malanuk,Robert M. D ROOM: D.508-A

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002571

WINDHAM,TAMMY E
A# D00502499
05/11/08 F 40
Malanuk,Robert M. Dr. D.508-A

Columbia Cardiology Consultants
Standard PRN Medications

Medication / Dose / Route Frequency	Start / Stop	0700 – 1459	1500 – 2259	2300 – 0659
Tylenol #3 (acetaminophen 300mg/codeine 30mg) 1-2 tabs PO q4h PRN pain (Note: Acetaminophen total daily dose not to exceed 4000mg from all sources.)			2 tabs (800) 2 tabs 8 hours	PRN pt given Reg Tylenol pt prefers
Darvocet-N-100 1-2 tablets PO q4h PRN pain if allergic to codeine. (Note: Acetaminophen total daily dose not to exceed 4000mg from all sources.)			1545 1 Darvocet	
Restoril 15mg PO at bedtime PRN insomnia. May repeat X 1				
NTG 0.4mg SL PRN chest pain. May repeat every 5 minutes x 2 additional doses.				
Dilaudid 1-2mg IV over 5 minutes q3h PRN severe chest pain or chest pain not unrelieved by 3 sublingual NTG. Notify MD				
Reglan 10mg IV over 2 minutes q4h PRN nausea and vomiting.				
Zofran (ondansetron) 4mg IV q4h PRN nausea not relieved by reglan.				
Xanax 0.25mg PO q4h PRN anxiety 0.125mg for patients over 70 years of age				
MOM (magnesium hydroxide suspension) 30ml PO q12h PRN constipation.				
Regitine 5mg diluted in 10ml 0.9% sodium chloride use smallest gauge needle SQ to affected ischemic area at IV site PRN Dopamine infiltration. May repeat x 1 if large infiltration.				
Atropine 0.5mg IV PRN Symptomatic heart rate less than 40. May repeat q5minutes to a total of 3mg IV. Notify MD				

Signature	Initials	Signature	Initials	Signature	Initials

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

002572

WINDHAM,TAMMY E
A# D00502499114
05/11/08 F 40
Malanuk,Robert M. Dr. D.508-A

Progress Note
Cardiac Acute Care Measures

ADMISSION: *Indicate if medication was ordered on admission OR check applicable reason for contraindication*

ASA : ✓ Yes ___ No
If no:
ASA contraindication: ☐ Allergy/Intolerance ☐ Other Anticoagulant ☐ Active/Recent Bleeding
☐ Thrombocytopenia ☐ Coagulation Disorder
☐ Other: _____

Beta Blocker : ✓ Yes ___ No Medication Metoprolol
If No:
Beta Blocker Contraindication: ☐ Allergy/Intolerance ☐ Hypotension (SBP<90) ☐ Bradycardia/ Heart Block
☐ Symptomatic Heart Failure ☐ Reactive Airway Disease ☐ Increased risk of hypoglycemic reactions
☐ Other: _____

DISCHARGE: *Indicate if medication is ordered on discharge OR check applicable reason for contraindication*

ASA : ✓ Yes ___ No
If no:
ASA contraindication: ☐ Allergy/Intolerance ☐ Other Anticoagulant ☐ Active/Recent Bleeding
☐ Thrombocytopenia ☐ Coagulation Disorder
☐ Other: _____

Beta Blocker : ✓ Yes ___ No Medication Toprol
If No:
Beta Blocker Contraindication: ☐ Allergy/Intolerance ☐ Hypotension (SBP<90) ☐ Bradycardia/ Heart Block
☐ Symptomatic Heart Failure ☐ Reactive Airway Disease ☐ Increased risk of hypoglycemic reactions
☐ Other: _____

EF% 60
If EF <40% or described as Moderate to Severe LVSD:

ACE-I/ARB : ✓ Yes ___ No Medication: Lisinopril
If no:
ACE Inhibitor/ARB Contraindication: ☐ Moderate/Severe Aortic Stenosis ☐ Anuria ☐ Allergy/Intolerance
☐ Hypotension ☐ Hyperkalemia ☐ Worsening Renal Function ☐ ACEI/ARB- Induced Angioedema
☐ ACEI/ARB-Induced Cough ☐ Bilateral Renal Artery Stenosis ☐ EF > 40% ☐ No Diabetes Mellitus
☐ Other: _____

Lipid Lowering Medication : ✓ Yes ___ No Medication: Pravastatin
If no:
Contraindication: ☐ Liver Disease/Elevated Liver Enzymes ☐ Allergy/Intolerance ☐ Statin-induced muscle pain
☐ Renal Insufficiency/Failure ☐ Heavy Alcohol Abuse ☐ Medication Interaction
☐ Other: _____

MD Signature : _____

Original:05/09/07

FORWARD TO MEDICAL RECORDS WITH CHART
DO NOT REMOVE FROM CHART

1155

6359

SISTERS OF CHARITY PROVIDENCE HOSPITALS
2435 FOREST DRIVE
COLUMBIA, SOUTH CAROLINA 29204
(803) 256-5300

002573

DISCHARGE SUMMARY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 05/11/08
DISCHARGE DATE: 05/13/08
ROOM/BED: D.H452-A
PATIENT TYPE: CAR
SOCIAL SECURITY #

ACCOUNT # D00502499114
MED REC # M000895682
AGE: 40
DOB:
NURSING STATION: D.4H
CLINIC CODE:

****
241489
DOCTOR: Joseph Lawton, III, M.D.
ADMISSION DATE: 05/11/2008
DISCHARGE DATE:
SOCIAL SECURITY: ###-##-1815

MR#: M000895682
AGE: 40
DOB: 10/18/1967
NURSING STATION: D.4H

CC: Family Health Center - Sumter

PATIENT: TAMMY E. WINDHAM

DISCHARGE DIAGNOSES:
1. Unstable angina pectoris.
2. Coronary artery disease with a history of previous stenting of the circumflex marginal in April 2007 with a 2.5 x 28 Cypher stent.
3. History of hypercholesterolemia.
4. Prior history of tobacco use which has been ongoing.
5. Hypertension.

PROCEDURES:
1. Cardiac catheterization, coronary arteriography and subsequent stent implantation to the circumflex. Catheterization demonstrating normal LV function, ejection fraction 60%, 50% long area, mid right coronary stenosis, 70% proximal circumflex OM #1, proximal to the stent, 50% InStent stenosis and 90% distal edge stenosis.
2. Status post stenting of the proximal and distal stenoses with overlapping 2.5 x 24 TAXUS and 2.5 x 20 TAXUS stent.

HOSPITAL COURSE: Please see the History and Physical of Dr. Malanuk. The patient was admitted in transfer from Tuomey Medical Center with an acute coronary syndrome. Troponin was negative. She was treated with Lovenox and Plavix. She was felt to be a candidate for repeat catheterization which was accomplished and demonstrated a new circumflex stenosis as described. She did well post procedure with no further symptoms of chest discomfort. She had no groin complications with ambulation. She was counseled again regarding the need to discontinue tobacco products altogether. She was also counseled regarding the need to take Plavix for at least 12 months given the implantation of drug coated stent. She was also counseled to follow a low fat, low cholesterol diet. She is to be restarted on a statin which had been stopped for unclear reasons, possibly related to some mild LFT abnormalities. In light of the patient's high risk status, however, with significant diffuse coronary disease, she is being restarted on Pravachol.

LABORATORY DATA: Sodium 136, potassium 4.1, glucose 104, BUN 9, creatinine

DISCHARGE SUMMARY

PATIENT: WINDHAM,TAMMY E
DOCTOR: Lawton,Joseph J. III Dr.
ADMISSION DATE: 05/11/08
DISCHARGE DATE: 05/13/08
ROOM/BED: D.H452-A
PATIENT TYPE: CAR
SOCIAL SECURITY # 247-31-1815

ACCOUNT # D00502499114
MED REC # M000895682
AGE: 40
DOB: 10/18/67
NURSING STATION: D.4H
CLINIC CODE:

****

0.9, white count 9.7, hemoglobin 14.6, hematocrit 43%, platelets 210, cholesterol 216, HDL 33, LDL 150, triglycerides 164, troponin with reflex negative times two sets. Pro-time was 12.9, PTT 36, urinalysis negative.

Chest x-ray showed normal heart size and was otherwise unremarkable. EKG showed sinus rhythm with LVH and secondary repolarization abnormalities.

DISCHARGE MEDICATIONS INCLUDE:

1. Plavix 75 mg daily.
2. Prinivil 20 mg daily.
3. Metoprolol 25 mg b.i.d.
4. Nicotine transdermal 21 mg patch daily.
5. Zantac 150 mg q 12.
6. Aspirin 325 mg daily.
7. Pravachol 40 mg daily.

DISPOSITION: As noted above, she will follow up with the undersigned in approximately 3-4 weeks.

Joseph Lawton, III, M.D.

JL/gb
DD: 05/13/2008 / DT: 08:41 AM
TD: 05/13/2008 / TT: 11:59 AM

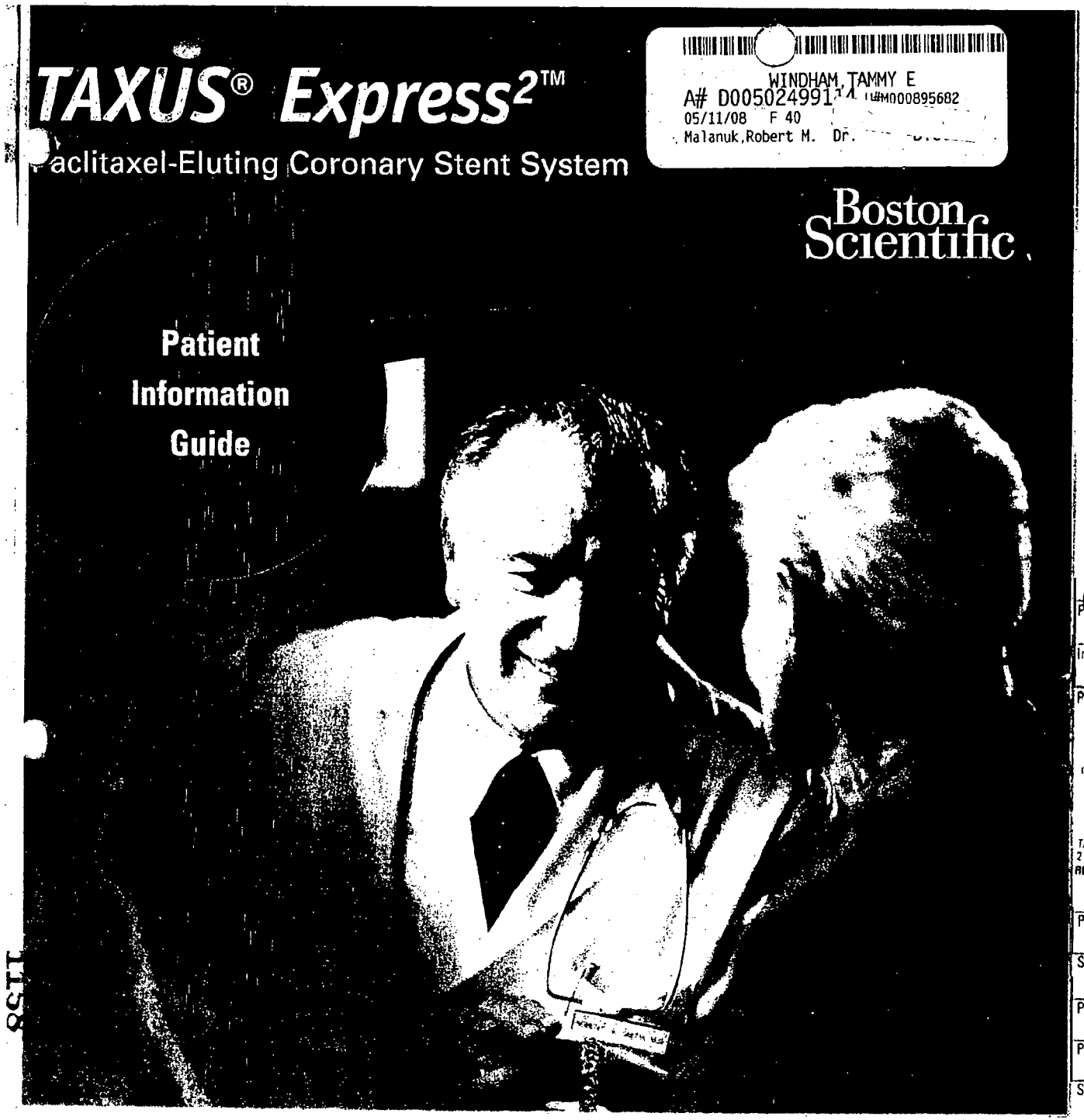
TAXUS® Express2™

Paclitaxel-Eluting Coronary Stent System

WINDHAM,TAMMY E
A# D005024991 1A IUM000895682
05/11/08 F 40
Malanuk,Robert M. Dr.

Boston Scientific

Patient Information Guide



WINDHAM,TAMMY E
A# D005024991 1A
05/11/08 F 40
Malanuk,Robert M. Dr.
D.508-A

TAXUS® Express2™ Paclitaxel-Eluting Coronary Stent System

Windham, T Patient Name	Patient Phone Nu
Umbach, R Implanting Physician's Name	Stent Material
Physician's Phone Number	5-12-08 Date of Implant

PLEASE CARRY YOUR CARD AT ALL TIMES.

Your cardiologist has prescribed a number of medications to thin the blood and prevent blo after your implant. It is extremely important to follow the medication regimen as prescribed b cardiologist. Before considering any surgery or dental work which would require you to stop these medicines early, you and your doctors should consider the risks from premature disc of these medications. For questions regarding your Coronary Stent System or other pro (e.g., MRI), please contact your implanting cardiologist.

Stent Identification Information

TAXUS Express2 MONORAIL 2.5 x 20mm REF 38970-2025 LOT 11263711	TAXUS Express2 MONORAIL 2.5 x 24mm REF 38970-2425 LOT 1131202
Product Lot Number	Product Lot Number
Stent Location	Stent Location
Product Code	Product Code
Product Lot Number	Product Lot Number
Stent Location	Stent Location

002575

11S8

6362

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

HISTORY AND PHYSICAL

PATIENT NAME: TAMMY E. WINDHAM	**ACCOUNT#:** D00502499114
DOCTOR: Robert Malanuk, M.D.	**MR#:** M000895682
ADMISSION DATE: 05/11/2008	**AGE:** 40
DISCHARGE DATE:	**DOB:**
SOCIAL SECURITY:	**NURSING STATION:** D.5T

PATIENT: TAMMY E. WINDHAM

HISTORY OF PRESENT ILLNESS: The patient is a 40-year-old White female with a history of coronary disease, with previous percutaneous coronary intervention to the obtuse marginal branch in April 2007 with a 2.5 x 28 mm Cypher stent, hypertension, hyperlipidemia, mild-to-moderate triple vascular disease and continued tobacco abuse who was admitted to Tuomey Regional Medical Center with acute coronary syndrome on Thursday. Enzymes returned positive with a peak troponin of 0.16. She was stable on Lovenox and Plavix along with her beta blocker and other medications. We were contacted earlier today to assume her care in the setting of her acute coronary syndrome. She denies any recurrent chest pain. She states her presenting symptoms are rather severe in character associated with nausea and vomiting, diaphoresis and dyspnea. She is currently taking several nitroglycerin tablets at home without relief which prompted her arrival to the emergency room.

She has had a most recent hospitalization in January 2008, where again, chest pain syndrome and underwent catheterization at that time which revealed normal left ventricular function to be 50%. The native right coronary artery was seen to have 50% stenosis. The left anterior descending had mild, diffuse disease with 40% in the first diagonal branch, significant for 30%, second diagonal branch stenosis. The obtuse marginal branch had 50% proximal stenosis and the stent in the obtuse marginal-2 was patent.

REVIEW OF SYSTEMS: Otherwise unremarkable.

PAST MEDICAL HISTORY: Hypertension, dyslipidemia, history of tobacco abuse, coronary artery disease with percutaneous coronary intervention of the left circumflex artery, migraine headaches.

CURRENT MEDICATIONS:
1. Pravachol 40 mg every day.
2. Aspirin 81 mg every day.
3. Tenormin 50 mg every day.

ALLERGIES: None.

SOCIAL HISTORY: Denies alcohol use. Lives with her husband. Smokes a half a pack per day.

FAMILY HISTORY: Noncontributory at this time.

PAST SURGICAL HISTORY: Bilateral tubal ligation, cholecystectomy, appendectomy.
PHYSICAL EXAMINATION: Blood pressure _____, pulse is 50. GENERAL: Well developed, White female, who appears much older than her stated age in no

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acute distress, alert and oriented times three. HEENT: Normocephalic and atraumatic. Pupils are equal, round, and reactive to light and accommodation. Extraocular movements are intact. Sclerae nonicteric. Oropharynx pink and moist. NECK: Supple. Full range of motion. No thyromegaly, or jugular venous distention. No carotid bruits. LUNGS: Clear to auscultation bilaterally. CARDIAC: Regular rhythm and rate. No murmurs, rubs, or clicks. ABDOMEN: Soft, nontender, and nondistended. No active bowel sounds. EXTREMITIES: No edema, clubbing, or cyanosis. SKIN: Warm and dry.

EKG normal sinus rhythm, with left ventricular hypertrophy. Nonspecific ST-T wave changes.

ASSESSMENT:

1. Acute coronary syndrome/myocardial infarction.
2. Chronic coronary disease, status post previous percutaneous coronary intervention to the second obtuse marginal branch in April 2007.
3. Hypertension.
4. Hyperlipidemia.
5. Tobacco abuse.

DISPOSITION: As above. The patient is currently clinically stable in the setting of her known coronary disease and acute coronary syndrome. She will be referred for repeat coronary angiography to redefine her coronary anatomy. She will be continued on her current home medications as well as her transfer medications which again include aspirin and Plavix. Further recommendations to follow.

Robert Malanuk, M.D.

RM/nn
DD: 05/11/2008 / DT: 08:10 PM
TD: 05/12/2008 / TT: 07:42 AM
JOB #: 791635

Electronic Signature By: Dr. Robert M. Malanuk
<<SIGNATURE ON FILE>>

Electronic Signature Date: 05/13/08
Electronic Signature TIme: 1530

Robert Malanuk, M.D.

RM/nn
DD: 05/11/2008 / DT: 08:10 PM
TD: 05/12/2008 / TT: 07:42 AM
JOB #: 791635

SISTERS OF CHARITY
PROVIDENCE HOSPITALS
2435 Forest Drive
Columbia, South Carolina 29204

CARDIOPULMONARY SERVICES / CATHETERIZATION LABORATORY REPORT

PATIENT NAME: TAMMY E. WINDHAM
DOCTOR: Richard Umbach, M.D.
ADMISSION DATE: 05/11/2008
DISCHARGE DATE: 05/13/2008

ACCOUNT#: D00502499114
MR#: M000895682
AGE: 40

NURSING STATION: D.4H

PATIENT: TAMMY E. WINDHAM

DATE OF STUDY: 5/12/08

CATHING CARDIOLOGIST: RICHARD UMBACH, M.D.

CLINICAL PROFILE: Forty year old Caucasian female who underwent stenting of the left circumflex marginal branch with a 2.5 x 28 Cypher stent in 4/07 and she is readmitted with increasing chest pain felt compatible with angina. (For further history please see copies of the patient's admitting note).

DESCRIPTION OF PROCEDURE: Under local anesthesia, right percutaneous femoral arterial puncture was performed with a #6Fr. B2 multipurpose catheter inserted in the right femoral artery and advanced to the ascending aorta and aortic pressure was obtained. The catheter was advanced to the left ventricle and left ventricular pressure was obtained. Left ventriculogram was performed in the 30 degree RAO view following which left ventricular and aortic pressures were again obtained. Selective injection of the right coronary artery was performed in the PA, RAO and LAO views with the use of a #6Fr. 3.5 left Judkins catheter. Selective injection of the left coronary artery was performed in the PA, RAO, caudal axial LAO, RAO, cranial axial LAO, PA and RAO views. There was an obvious 90% stenosis in the only large left circumflex marginal branch at the distal edge of the previously placed stent. There was also a 50% in-stent stenosis and then a tubular 70% stenosis proximal to the previously placed stent that begins in the ostium of the large left circumflex marginal branch. It was elected to proceed with stenting of the left circumflex marginal branch. The catheter was replaced with a #6Fr. 3.0XB guiding catheter but it would not engage the ostium of the left main. It was replaced with a 3.5 #6Fr. left guiding catheter. Selective injection of the left coronary artery was repeated in the caudal axial PA views. Through the guiding catheter, an IQ marker wire was placed. It was advanced through the proximal and mid large left circumflex marginal branch, in the distal portion of that vessel. Over the guidewire, a 2.5 x 20 Taxus stent was placed and it was advanced through the previously placed stent. It was then deployed n the previously placed stent covering the distal edge stenosis and the 50% in-stent stenosis. Deployment balloon was removed. Over the guidewire, a second Taxus stent - 2.5 x 24 was placed. It was advanced into the proximal and mid left circumflex marginal branch then overlapped with the distal edge overlapping the proximal end of the recently placed stent, and extended up into the mid left circumflex throughout the ostium of the left circumflex marginal branch. It was then deployed using up to 12 atmospheres of pressure. The deployment balloon was removed. Selective injection of the left coronary artery was repeated in the caudal axial PA views. All catheters and guidewires were removed. The arterial sheath was left in place. The patient was taken to the holding room in stable condition with no complications.

HEMODYNAMIC DATA: Estimated left ventricular ejection fraction was 50%. For further data, see the hemodynamic sheet.

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ANGIOGRAPHIC FINDINGS:

1. **Left Ventricle:** Uniform left ventricular wall motion is seen during the left ventriculogram performed in the RAO view. No mitral regurgitation is seen.
2. **Left Coronary Artery:** There is mild diffuse disease int eh left anterior descending and its branches with moderate distal left anterior descending disease, 50% small diagonal branch stenosis. There is a 70% stenosis at the ostium and proximal portion of the first large left circumflex marginal branch that extends down to the proximal edge of the previously placed stent. Also a 50% in-stent stenosis in the mid portion of the left circumflex marginal branch, and then at the distal edge there is a 90% stenosis. Mild plaquing is seen in the left circumflex.
3. **Right Coronary Artery:** The origin of the right coronary artery is anterior in the right coronary cusp there is a 50-60% mid right coronary artery stenosis and mild distal right coronary artery disease. A right dominant coronary circulation is present.
4. **Stenting:** Following placement of a 2.5 x 24 Taxus stent in the mid left circumflex extending into the proximal large left circumflex marginal branch and into the previously placed stent overlapping distally with a 2.5 x 20 Taxus stent. The 70% proximal, 50% in-stent stenosis and a 90% distal edge stenosis all reduced to 0%.

IMPRESSION:

1. Significant coronary artery disease with:
   a. 50-60% mid right coronary artery stenosis.
   b. Moderate distal left anterior descending disease.
   c. 50% ostial proximal first large left circumflex marginal branch with a 50% in-stent stenosis and then a 90% distal edge stenosis in the previous placed stent in the large left circumflex marginal branch.
   d. 50-60% mid right coronary artery stenosis with mild distal right coronary artery disease.
2. Normal left ventricle.
3. Successful stenting of the mid left circumflex and large left circumflex marginal branch with placement of a 2.5 x 24 Taxus stent in the mid left circumflex extending into the large left circumflex marginal branch and then overlapping distally with a 2.5 x 20 Taxus stent with reduction to the 70% proximal, 50% mid in-stent stenosis and 90% distal stent edge stenosis to 0%.

Richard Umbach, M.D.

RU/nrg
DD: 05/12/2008 / DT: 02:14 PM
TD: 05/13/2008 / TT: 07:45 PM
JOB #: 791756

Location:D.5T

Room Bed	Acct #	Patient	Sex/Age	AdmDt
D.508-A	D00502499114	WINDHAM,TAMMY E	40	

Allergy ID Band:N **Code Status:**FULL **Spot the Dot:**N
Plan of Care:CHESTPAIN
Vital Signs **BP:**164/56 **Pulse:**57 **Resp:** 18 **Temp:**98.1 **SpO2:** 97
Isolation:STANDARD

Anticipated Changes in Condition: NONE

What to Watch for in the next Interval of Care: Chest Pain

Comments:

(Print)AM Nurse: Shonda Lewis **Unit Phone Number:** 5900
(Print)PM Nurse: **Unit Phone Number:**

Department: **Patient Tolerated Procedure:**
Provider Name: **Department Phone Number:**
Comments:

Department: **Patient Tolerated Procedure:**
Provider Name: **Department Phone Number:**
Comments:

Department: **Patient Tolerated Procedure:**
Provider Name: **Department Phone Number:**
Comments:

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM, TAMMY E
A# D00502499114 U#M000895682 002582
05/11/08 F 40
Malanuk, Robert M. Ur. D.508-A

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
	81° conc. CARDS = Joe Lewton.
5/11/08	40y/o WF c̄ hx CAD / CVD / HTN / Dyslipidemia / tob
	abuse, hx AMI on 4/07 c̄ EF 28 Cypher
	admitted to Trinity Hosp Thursday c̄ SSCP assoc c̄
	SOB / N/V / diph, ⊕ TROP 0.16. Asked to tx to
	Prov for further eval. Currently CP free. + HA.
	hx CAD Hosp 1/08 c̄ CP LHC:
	RCA 80% MID 75% 50% mid RCA mid LAD 40% D1
	A soft 50% OM1 30% D1
	JCM OM2 small patent.
	A/ NONQMI / CAD HO PCI
	HTN
	Dyslipidemia
	tob abuse
	P/ Cont transfer meds.
	Repeat LHC in AM.
	consult for tob cessation -

PROGRESS RECORD

1165

NUR018 (1/03)

6369

PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

A# D00502499114 WINDHAM,TAMMY E U#M000895682
05/11/08 F 40
Malanuk,Robert M. D.508-A

002583

Date 5/12

POST-PROCEDURE PROGRESS NOTE

NEXT-LEVEL-OF-CARE COMMUNICATION NOTE

Preoperative Diagnosis: Unstable angina

Postoperative Diagnosis: ☒ Same as Preoperative:

Procedure(s) Performed: LC, stent ulx 1st OM

TAXUS Express2 MONORAIL 2.5 x 20mm REF 38970-2025 LOT 11263711

TAXUS Express2 MONORAIL 2.5 x 24mm REF 38970-2425 LOT 11312024

Name of Primary Operator:

Name of Assisting Physician if Different from Primary Operator: Edge (prox) stent

Estimated Blood Loss: _____ ml ☐ None

Specimens Removed: ☒ None

Condition of Patient: ☒ Stable ☐ Unstable ☐ Critical

Findings/Description of Procedure(s):

1) hi. LV LVEF @ 60%
2) 50% mid RCA
mid distal LAD
70% prox 1st/ulx OM prior to stent, 50% mated stenosis & 90% distal edge stenosis
3) stenting of the prox & distal stenosis i.e. overlapping 2.5 x 24 Taxus x 1 atm prox & 2.5 x 20 Taxus distal x 10 atm
90% at 12 atm
Angiomax used
TIMI 3

Physician Signature: [signature] Date: 5/12/08

POST-PROCEDURE PROGRESS NOTE

NUR029 (4/05)

1166

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PROVIDENCE HOSPITAL

A Sisters Of Charity Ministry

WINDHAM,TAMMY E
A# D00502499114 U#M000895682
05/11/08 F 40
Malanuk,Robert M.

002584

DATE	CONDITION OF WOUND, DRAINAGE, REMOVAL OF STITCHES, COMPLICATIONS, CONSULTATIONS, CHANGE IN DIAGNOSIS, CONDITION OF PATIENT FROM DAY TO DAY, CONDITION OF PATIENT ON DISCHARGE
	No CP. She states she has stopped smoking.
5/13	LDL 150
	Cor RRR 1/6 MR (+)
	Chest clear 137/53
	(R) groin ⊼ hematoma
	Impl: Stable ⊼ PCI
	↑ LDL 791898
	Plan Pravachol 40
	Encouraged smoking cessation.

PROGRESS RECORD

NUR018 (1/03)

1167

6371

452
Windham

TIME	BP	HR	DP/PT PULSES	HEMATOMA Y/N	BLEEDING	COMMENTS	INITIAL
1828	142/64	58	2/1	N	N	rt groin CDF	[illegible]
1858	128/55	54	2/1	N	N	rt groin CDF	[illegible]
1928	115/50	58	2/1	N	N	no Δ	[illegible]
2028	119/56	60	1, 1	no	no	(R) WNL. CDI occlusive.	SE
2128	119/56	64	1, 1	no	no	no Δ.	SE
2310			D/D	no	no	(R) foot cold. cap refill 2 sec. Doppler pulse audible.	SE

SE - S Edenton RN

1168

002585

6372

WINDHAM,TAMMY E
A# D00502499114 U#M000895682
05/11/08 F 40
Malanuk,Robert M. D. - D.O.B. A

DATE 5/12/08
RIGHT/LEFT GROIN
SHEATH yes TIME OUT 1631

DOB 1030pm

POST CATH VITAL SIGNS

TIME	BP	HR	DP/PT PULSES	HEMATOMA Y/N	BLEEDING	COMMENTS	INITIAL
1436	129/66	60	2/1	N	N	pt arrived to the floor	JH
1451	160/81	60					
1506	172/71	52					
1521	187/81	52					
1536	128/61	54					
1551	125/62	58					
1606	154/68	76					
1621	153/64	56					
1631	134/73	58	2/1	N	Y	sheath out, Charlotte Shull	JH
1635	149/76	66					
1639	121/65	56					
1643	136/74	64	2/1	N	N	hemastasis, dressing	JH
1658	165/67	56					
1713	156/59	56					
1728	152/78	76					
1743	200/65	68					
1758	154/62	64	2/1			rt groin CDI	JH

002586

6373

Patient Information

Patient Name		Study Date	MRN	Study #	Adm. ID
WINDHAM, TAMMY		5 /12/2008	M000895682	082857	D00502499114
Date of Birth	Age	Gender	Height *cm*	Weight *kg*	B.S.A. m^2
	40	Female	160.00 (5'3")	71.20 (157 lbs)	1.74

Procedures

Time	Procedure
12:59PM	DX Pulse Oximetry
12:59PM	Left Heart Cath
12:59PM	Coronary Angio
12:59PM	LV or LA Angiogram
1:26PM	TX Pulse Oximetry
1:42PM	Coronary DES Placement
2:04PM	Admin. of Thrombin Inhibitors

Staff

		IN	OUT
Diagnostic Cardiologist	Richard Umbach, M.D.	1:08PM	
Interventional Cardiologist	Richard Umbach, M.D.	1:26PM	
Scrub	Lesia Coaxum, CVT	12:44PM	
Circulator	Jerri Kaner, RN	12:59PM	
Monitor	Robert Harmon, CVT	12:44PM	

Event Log

Time	Summary	Comment
12:44PM	Phase: Baseline	
12:44PM		Cath Lab: 3
12:59PM		Patient Arrival Time
12:59PM	Procedure: DX Pulse Oximetry	
12:59PM	Procedure: Left Heart Cath	
12:59PM	Procedure: Coronary Angio	
12:59PM	Procedure: LV or LA Angiogram	
1:00PM		Procedure Status: Urgent
1:00PM		Basic Supplies:
1:00PM	BASIC PACK	
1:00PM	48 IN PRESSURE TUBING	
1:00PM		Patient Prep Time
1:00PM		Clipped, prepped and draped R Groin site
1:00PM		Clipped, prepped and draped L Groin site
1:00PM		RISK FACTOR Profile:
1:00PM		Creatinine Assessed on Admission
1:00PM		Admission Creatinine: 0.9
1:00PM		Prev Percutaneous Coronary Intervention
1:00PM		Previous PCI Date: 2007/03/01
1:00PM		Family History of CAD Age < 55

1:00PM		Relationship to Patient: MOTHER
1:00PM		Age when Family Member's CAD Presented: 40
1:00PM		Hypertension
1:00PM		Hyperlipidemia
1:00PM		History of Tobacco Use: Current
1:00PM		Previous MI > 7 Days
1:00PM		Pre-Assessment completed in Holding Area by: J KANER
1:00PM		LOC: A&O x 3. Responds purposefully to verbal commands.
1:00PM		Baseline Aldrete Score obtained
1:00PM		Lung Sounds auscultated: CTA bilaterally
1:01PM		Denies Pain or Discomfort.
1:01PM		Pulses: R DP/PT = 3/2
1:01PM		Pulses: L DP/PT = 3/2
1:01PM		Allergies: NKA
1:01PM		NPO Status: No Clear Liquids x minimum 2 hrs
1:01PM		NPO Status: No Solid Intake po x minimum 6 hrs
1:01PM		IV Site(s): L X 2
1:01PM		IV site(s) patent & w/out redness, pain, or swelling
1:01PM		IV Fluids and IV Meds:
1:01PM	NS IV 20 cc/hr	J KANER
1:01PM		See MAR for other current medications
1:01PM		Denies current pregnancy
1:01PM		Date of LMP: 1 MONTH
1:01PM	SpO2 98%; HR 48 bpm; 190/65/92 NBP; RR 18/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:01PM		All selected lab results WNL
1:01PM		Intra Procedure Plan of Care Initiated
1:01PM		Consents signed & appropriate
1:01PM		H&P Charted
1:01PM		Physician called
1:05PM	SpO2 96%; HR 50 bpm; 176/70/105 NBP; RR 23/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:07PM		Physician Arrived
1:07PM		Diagnostic Physician
1:08PM		Time Out to verify correct patient & correct site
1:08PM		--Radiation protective equipment checked.
1:08PM		--All team members compliant.
1:08PM		Assessment of ASA CLASSIFICATION per MD
1:08PM		ASA Class II: Patient w/ Mild Systemic Disease
1:08PM		MALLAMPATI AIRWAY CLASSIFICATION per MD:
1:08PM		Class IV = Visualization of hard palate only
1:08PM	VERSED IV 1 mg	J KANER
1:08PM	DILAUDID IV 0.50 mg	J KANER
1:11PM	SpO2 96%; HR 42 bpm; 176/61/81 NBP; RR 14/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.

1:11PM		Procedure Start Time
1:11PM		Site anesthesized: R GROIN
1:11PM	LIDOCAINE 2% SQ 8.00 cc	R UMBACH
1:12PM		Cannulated RFA
1:12PM	NEEDLE REGULAR ARTERIAL	
1:12PM	WIRE .035 3MM 175 cm	
1:12PM		Number of sticks required: 1
1:12PM	# 6F CORDIS SHEATH	
1:12PM		Access Site: Right Femoral Artery
1:13PM		catheter in:
1:13PM	# 6F B2 MULTI	
1:14PM		Label & Measure AO
1:14PM	AO : 192/69/80, HR = 53, aVF	
1:14PM	Snapshot: AO : 192/69/80	
1:15PM		Label & Measure LV
1:15PM	LV : 202/0/19, Max dP/dt = 2544, HR = 53, aVF	
1:15PM	Snapshot: LV : 202/0/19	
1:15PM		Setup & Record LVEDP
1:15PM	LV : 189/-1/16, Max dP/dt = 1728, HR = 52, aVF	
1:15PM	Snapshot: LV : 189/-1/16	
1:15PM	Phase: Post Angio	
1:15PM		LV Gram done
1:15PM		Pullback LV to AO
1:16PM	SpO2 94%; HR 56 bpm; 174/84/124 NBP; RR 26/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:16PM	LV : 211/1/21, Max dP/dt = 3744, HR = 68, aVF	
1:16PM	Pullback from LV to AO	
1:16PM	AO : 206/70/120, HR = 63, aVF	
1:16PM	Snapshot: Pullback: LV to AO.	
1:17PM		Visualized Right Coronary Artery
1:20PM		catheter out
1:20PM		catheter in:
1:20PM	# 6F JL 4.0	
1:20PM	SpO2 95%; HR 59 bpm; 167/69/103 NBP; RR 18/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:22PM		catheter out
1:22PM		catheter in:
1:22PM	# 6F JL3.5	
1:23PM		Visualized Left Coronary System
1:25PM	SpO2 94%; HR 65 bpm; 187/77/110 NBP; RR 26/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:26PM		Interventional Physician
1:26PM	Procedure: TX Pulse Oximetry	
1:28PM		Interventional Supplies:
1:28PM	INFLATION DEVICE	
1:28PM	STOPCOCK	
1:28PM	STOPCOCK	
1:28PM	VAC LOCK SYRINGE	
1:28PM		PCI Status: Urgent
1:28PM		Catheter out

1:30PM	SpO2 95%; HR 69 bpm; 196/85/119 NBP; RR 25/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:33PM		Guide catheter in:
1:33PM	GUIDE # 6F XB 3.0 SH	
1:35PM	ANGIOMAX bolus IV 10.50 ml	J KANER
1:35PM	SpO2 96%; HR 62 bpm; 186/74/121 NBP; RR 17/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:37PM		Guiding catheter out
1:37PM		Guide catheter in:
1:37PM	ANGIOMAX IV 24.50 cc/hr	J KANER
1:37PM	GUIDE # 6F JL 3.5 SH	
1:39PM		Wire used:
1:39PM	I Q MARKER 185 CM	
1:40PM	SpO2 95%; HR 59 bpm; 201/70/105 NBP; RR 20/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:42PM		STENT in:
1:42PM	Procedure: Coronary DES Placement	
1:42PM	TAXUS 2.5 X 20	
1:42PM		Segment: 1st Marginal
1:43PM	Phase: Post Stent Deployment	
1:43PM		Inflations: (to stent)
1:43PM		11 SEC @ 10 ATMS
1:43PM		Stent Deployed
1:44PM		10 SEC @ 10 ATMS
1:44PM		08 SEC @ 10 ATMS
1:45PM	SpO2 94%; HR 73 bpm; 199/80/119 NBP; RR 24/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:46PM		Stent delivery balloon out
1:48PM		STENT in:
1:48PM	TAXUS 2.5 X 24	
1:49PM	DILAUDID IV 0.50 mg	J KANER
1:50PM		08 SEC @ 10 ATMS
1:50PM		Stent Deployed
1:50PM	SpO2 98%; HR 77 bpm; 230/99/157 NBP; RR 17/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:50PM		11 SEC @ 12 ATMS
1:51PM		08 SEC @ 12 ATMS
1:51PM		Stent delivery balloon out
1:52PM		Wire out
1:52PM		Final AO Pressure
1:52PM	AO : 277/95/173, HR = 78, aVF	
1:52PM	Snapshot: AO : 277/95/173	
1:52PM		Guiding catheter out
1:52PM	DILAUDID IV 0.50 mg	J KANER
1:52PM	LABETALOL IV 20 mg	J KANER
1:55PM	SpO2 98%; HR 88 bpm; 224/93/143 NBP; RR 14/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.

1:57PM		Procedure Finish Time
1:59PM	DILAUDID IV 0.50 mg	J KANER
2:00PM	ANGIOMAX IV 0 cc/hr	(DC'D) J KANER
2:01PM	SpO2 95%; HR 77 bpm; 193/91/142 NBP; RR 18/min	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
2:01PM		Number of STENTS used per VESSEL: OM X 2
2:01PM		Interventional Outcome: Successful
2:01PM		Post Procedure Assessment:
2:01PM		Patient Disposition: Telemetry Bed
2:01PM	LABETALOL IV 20 mg	J KANER
2:01PM		IABP not used
2:01PM		Verbal orders during case because MD in sterile gloves & gown
2:01PM		Read Back verification completed for all verbal orders -- J KANER
2:03PM		Total Contrast Infused: 390
2:03PM	200CC BOTTLE OPTIRAY	
2:04PM	200CC BOTTLE OPTIRAY	
2:04PM	Procedure: Admin. of Thrombin Inhibitors	
2:05PM		Patient Transfer Time
2:08PM	ANGIOMAX	

Aldrete Score – Pre Study

Pre-Study Conscious Sedation Assessments	
Activity	2 - Able to move 4 extremities voluntarily or on command
Respirations	2 - Able to breathe deeply and cough freely
Circulation	2 - BP +/- 20% of pre-anesthetic level
Consciousness	2 - Fully Awake
O2 Saturation	2 - Able to maintain O2 saturation > 92% on room air
Pre-study Totals	10

Materials

Time	Item Name (Model)	Comment
1:00PM	BASIC PACK	
1:00PM	48 IN PRESSURE TUBING	
1:12PM	NEEDLE REGULAR ARTERIAL	
1:12PM	WIRE .035 3MM 175 cm	
1:12PM	# 6F CORDIS SHEATH	
1:13PM	# 6F B2 MULTI	
1:20PM	# 6F JL 4.0	
1:22PM	# 6F JL3.5	
1:28PM	INFLATION DEVICE	
1:28PM	STOPCOCK	
1:28PM	STOPCOCK	
1:28PM	VAC LOCK SYRINGE	
1:33PM	GUIDE # 6F XB 3.0 SH	
1:37PM	GUIDE # 6F JL 3.5 SH	

1:39PM	I Q MARKER 185 CM	
1:42PM	TAXUS 2.5 X 20	
1:48PM	TAXUS 2.5 X 24	
2:03PM	200CC BOTTLE OPTIRAY	
2:04PM	200CC BOTTLE OPTIRAY	
2:08PM	ANGIOMAX	

X-Ray Summary

Total Dose	0.00 cGycm2	**Fluoro Time**	14.00 Minutes

Contrast Summary

Contrast	Total (ml)
Optiray Used	390.00

Complications

Time	Complication	Comment
2:02PM	None	

Vital Signs

Time	SpO2	HR	BP	RR	Comment
1:01PM	98	48	190/65/92	18.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:05PM	96	50	176/70/105	23.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:11PM	96	42	176/61/81	14.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:16PM	94	56	174/84/124	26.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:20PM	95	59	167/69/103	18.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:25PM	94	65	187/77/110	26.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.

1:30PM	95	69	196/85/119	25.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:35PM	96	62	186/74/121	17.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:40PM	95	59	201/70/105	20.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:45PM	94	73	199/80/119	24.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:50PM	98	77	230/99/157	17.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
1:55PM	98	88	224/93/143	14.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.
2:01PM	95	77	193/91/142	18.00	LOC: Responds purposefully to verbal commands. SEDATION SCALE: 0 = Alert. Denies Pain or Discomfort.

Medication Events

Start	Stop	Medication	Route	Amount	Units	Comments
1:01PM		NS	IV	20.00	cc/hr	J KANER
1:08PM		VERSED	IV	1.00	mg	J KANER
1:08PM		DILAUDID	IV	0.50	mg	J KANER
1:11PM	1:11PM	LIDOCAINE 2%	SQ	8.00	cc	R UMBACH
1:35PM		ANGIOMAX bolus	IV	10.50	ml	J KANER
1:37PM		ANGIOMAX	IV	24.50	cc/hr	J KANER
1:49PM		DILAUDID	IV	0.50	mg	J KANER
1:52PM		DILAUDID	IV	0.50	mg	J KANER
1:52PM		LABETALOL	IV	20.00	mg	J KANER
1:59PM		DILAUDID	IV	0.50	mg	J KANER
2:00PM		ANGIOMAX	IV	0.00	cc/hr	(DC'D) J KANER
2:01PM		LABETALOL	IV	20.00	mg	J KANER

Circulator Signature

Initials	Signature	Title	Time
JK	J Kaner	RN	1410

Patient Name: WINDHAM, TAMMY
MRN: M000895682

Study Date: 5/12/2008
Admission ID: D00502499114

1175

Monitor Signature

Initials	Signature	Title	Time

Acknowledging Arrival of Patient from Cath Lab:

Signature Smucker, RN Time: 1430

Physicians Signature

Providence Heart Institute

2435 FOREST DRIVE
COLUMBIA,SC 29204

002595

Patient Information

Patient Name	Study Date	MRN	Study #	Adm. ID
WINDHAM, TAMMY	5 /12/2008	M000895682	082857	D00502499114
Date of Birth [redacted] Age 40	Gender Female	Height *cm* 160.00 (5'3")	Weight *kg* 71.20 (157 lbs)	B.S.A. m^2 1.74

Pressure Results (mmhg)

Baseline

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	192	69		80				53
LV	189	-1	16				1728	52

Post Angio

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	206	70		120				63
LV	211	1	21				3744	68

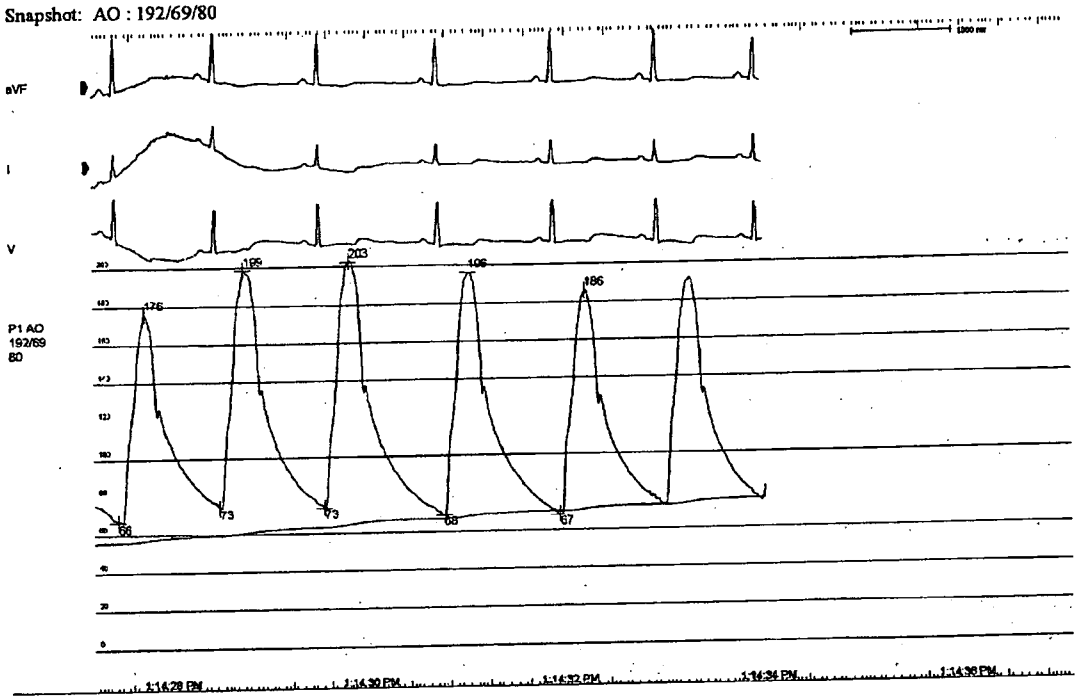
Post Stent Deployment

Site	Sys	Dias	End	Mean	A Wave	V Wave	Max dp/dt	HR
AO	277	95		173				78

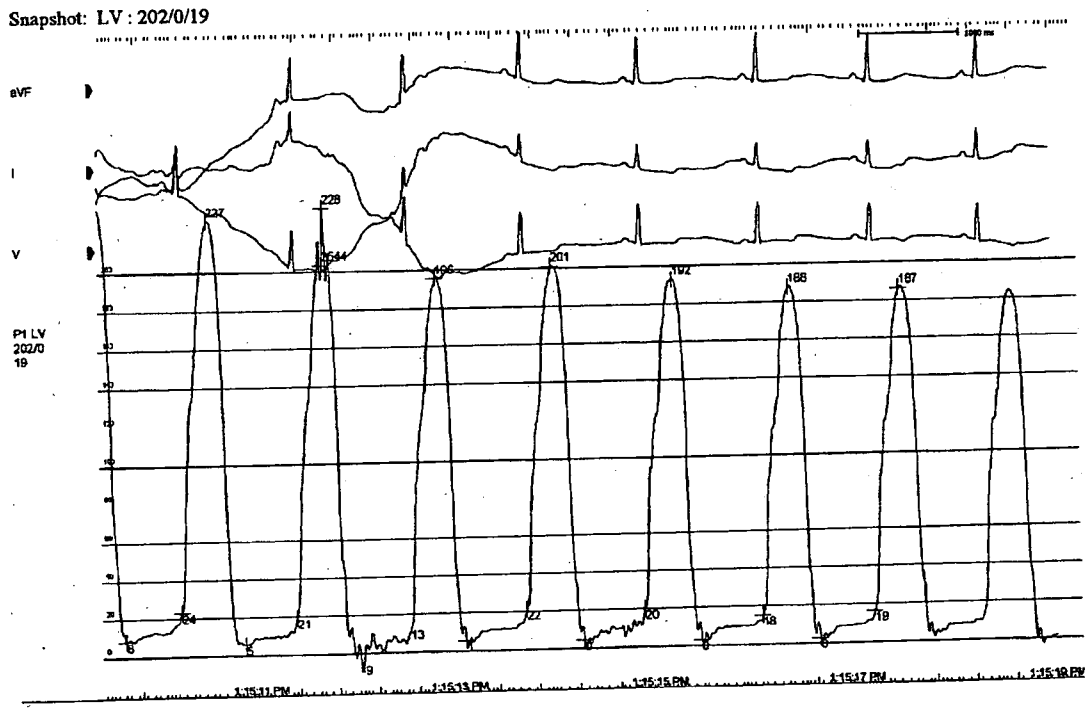
Valve Results

Valve	Grad (mmhg)	Flow (ml/s)	Area (cm^2)	Area Index (cm^2/m^2)	Sep/Dfp (sec/min)

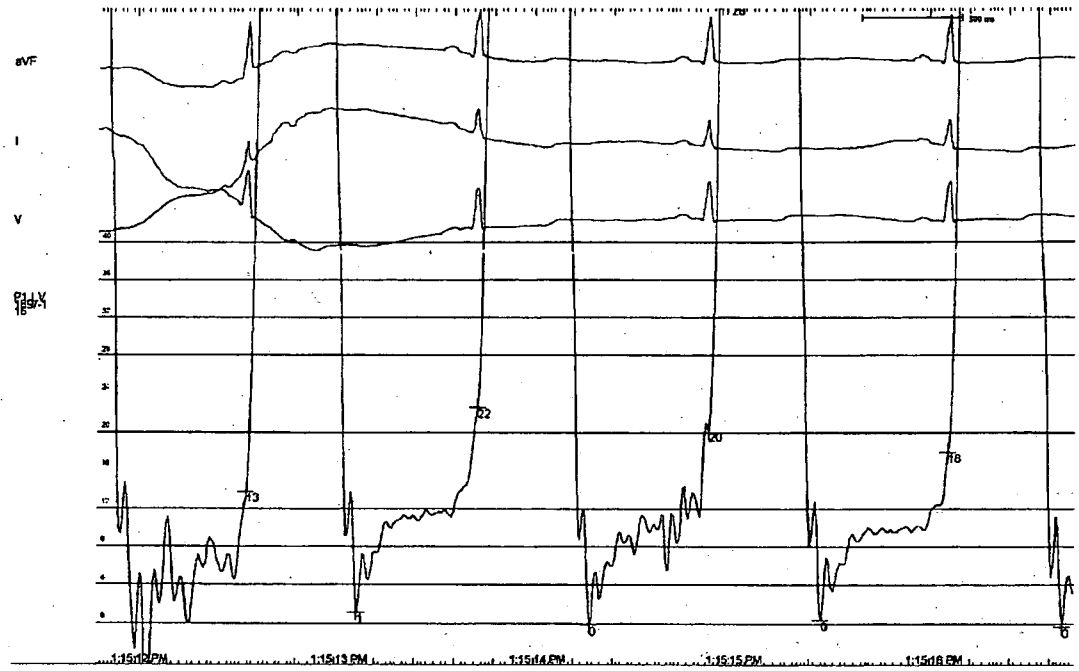
Snapshot: AO : 192/69/80



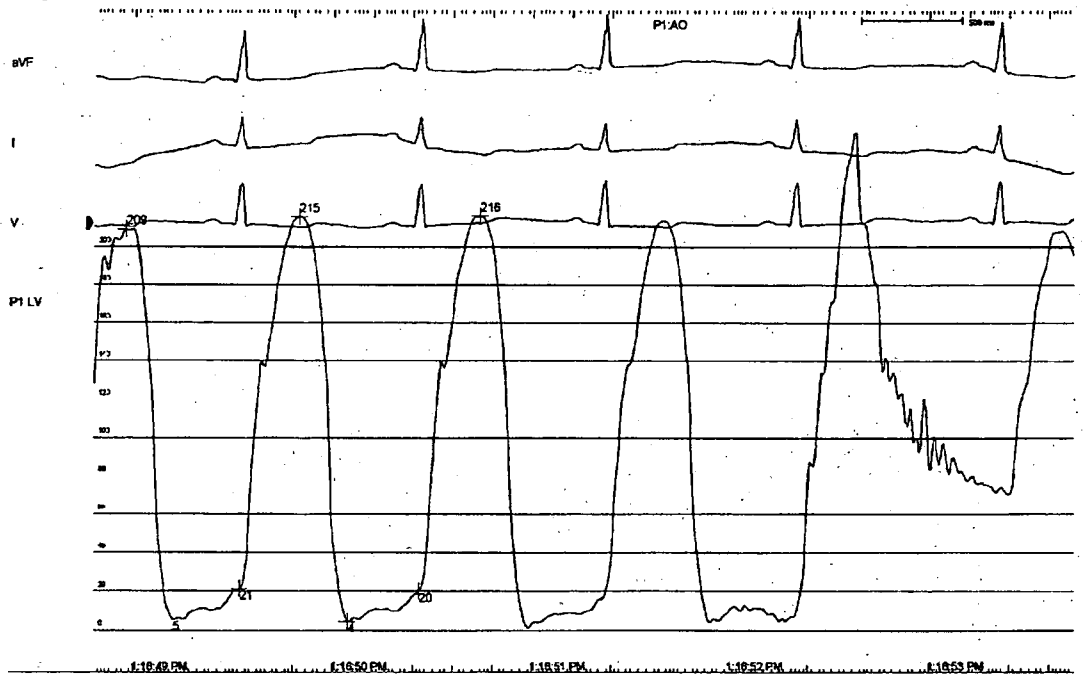
Snapshot: LV : 202/0/19



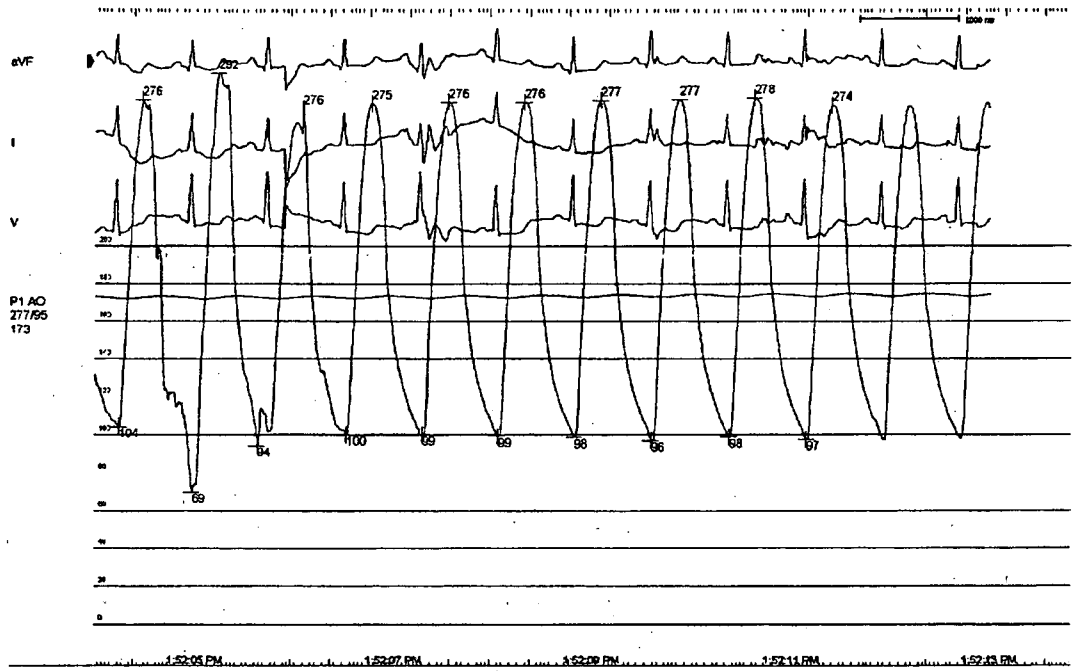
Snapshot: LV : 189/-1/16



Snapshot: Pullback: LV to AO.



Snapshot: AO : 277/95/173


aVF
I
V
P1 AO
277/95
173
276
292
276
275
276
276
277
277
278
274
104
64
100
99
99
98
96
98
97
69
1:52:05 PM
1:52:07 PM
1:52:09 PM
1:52:11 PM
1:52:13 PM

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

A# D00502499114 WINDHAM,TAMMY E
05/11/08 F 40
Malanuk,Robert M. Dr. D.508-A
599

Columbia Cardiology Consultants

CONSENT FOR DIAGNOSTIC CATHETERIZATIONS WITH POSSIBLE INTERVENTIONS PERFORMED WITHIN THE CATHETERIZATION LABORATORY

I hereby voluntarily consent to the performance of the following procedure(s):
Left and/or Right catheterization Angiography; (PTCA) Percutaneous Transluminal Coronary Angioplasty (PTDCA) Percutaneous Transluminal Directional Coronary Atherectomy; (PTRCA) Percutaneous Transluminal Rotational Coronary Ablation; Peripheral Angiography Thrombectomy; Intracoronary Ultrasound Imaging; Intra Aortic Balloon Pump Insertion; Intracoronary Stent(s) Implantation; Atherotomy; Pericardiocentisis

My scheduled physician is:
☐ **Dr. S. Stanley Juk** ☐ **Dr. Richard E. Umbach** ☐ **Dr. Michael C. Roberts** ☐ **Dr. Eugene F. Schwarz**
☐ **Dr. Joseph L. Lawton** ☑ **Dr. Robert M. Malanuk** ☐ **Dr. R. Taylor Williams** ☐ **Dr. Brandon Brown**
☐ **Dr. Amy Epps**

I understand that circumstances may arise which may result in another physician performing such procedure other than as indicated above, and in such case I consent to the procedure being performed by the substitute physician.

I also consent to procedures not listed above for the treatment of diagnosed coronary artery disease if unforeseen conditions necessitate additional or different procedures to be performed by the above physician(s), assistants, nursing and technical personnel, as deemed necessary and desirable in their professional judgment. If emergency surgery is required, the above physician(s) has my permission to retain a surgeon to perform such an operation.

I understand that I am undergoing these procedures to aid in the diagnosis and treatment for my condition, which has been explained me and I have been provided additional information in the attached Informed Consent Patient Information. I have been advised by my physician that the indications for cardiac catheterization and angiography and the treatment of diagnosed coronary artery disease in my case outweigh the risks involved. I have been given an opportunity to ask questions about my condition, alternative forms to these procedures and blood transfusion (options, risks and alternatives), risks of non-treatment, the procedures to be used and the risks and hazards involved, which have also been explained fully to me. My consent is given freely, voluntarily and with full knowledge of all of the above written statements.

Tammy E Windham
Patient or Authorized Person Signature

Shonda Davis RN
Witness

Self
Relationship to Patient

5/11/08 at 1840
Date/Time

I have discussed with the patient and/or patient's representative the risks, benefits, potential complications, and alternative options associated with the planned procedure, possible use blood, and sedation/analgesic if appropriate, answered the patient's questions and obtained his/hers permission to proceed.

_____ **Physician's Signature/Date**

Revised: 05/04/07, 3/26/08

1181

SISTERS OF CHARITY
PROVIDENCE HOSPITALS

A# D00502499114 WINDHAM,TAMMY E
05/11/08 F 40 U#M000895682
Malanuk,Robert M. Di

002600

INFORMED CONSENT FOR CARDIAC CATHETERIZATION PROCEDURE

- Cardiac catheterization is a procedure in which a catheter is placed in an artery usually involving the leg or arm. The catheter is advanced to the heart under x-ray guidance for the purpose of obtaining pictures of the arteries to identify your risk of heart disease and help guide treatment.

- Though cardiac catheterization is a relatively safe procedure, it does have well-defined risks, including the risk of death, stroke, and heart attack with the occurrence of approximately 1 in 1000 patients. There is a risk of kidney failure in approximately 3% in which most patients recover, but of these approximately 10% may require dialyses and occasionally on a permanent bases. There is a risk of vascular trauma, which could require surgical or non-surgical repair. There is a chance that the cholesterol deposits can break loose from a vessel and result in the loss of tips of toes or fingers with potential for need of amputation, or to the intestines or colon, which might require surgery and removal of damaged tissue as a result. There is a risk of allergy to the dye used, which though rare, can be fatal. There is a risk of bleeding for which blood transfusions might be required as well as the possibility of the hematoma at the site. Occasionally there can be electrical instability of the heart requiring the delivery of an electrical shock to correct the problem. A rare patient may be unusually sensitive to medications for sedation that assistance in breathing with a respirator may be required. Overall the risk of a significant complication occurs in less than 2%.

- If your procedure involves an attempt to open a blocked artery (arteries) with such devices as balloons, cutting devices, placement of stents, or use of filters to catch debris there is an additional risk of approximately 1 in 100 that emergent bypass surgery may be required if the procedure fails. There also is a risk that the vessel may close from clot migration of material down the vessel, vessel rupture requiring emergent surgical or non-surgical treatment, risk of infection and risk that clot may develop at the site closing off the vessel early after the procedure. There is a chance that additional procedures may be required as approximately 20-30% of patients can develop excessive tissue growth inside a stent often within the first 6 months of the procedure, and a slightly greater chance if only a balloon without a stent is required.

- During or after the procedure, your doctor may feel it necessary to give you a transfusion of blood or blood components. Your doctor has discussed with you the alternatives to, and possible risks of transfusion, including unexpected blood reactions and the possible transmission of certain viruses, including hepatitis and AIDS, however remote.

- Other clinical staff may help your doctor during the procedure/treatment.

- The procedure may require that you undergo some form of sedation, which may have its own risks. Your doctor or a representative from the department of anesthesiology has informed you of the course of sedation that is recommended (if any) along with its possible risks and alternatives.

- Any tissue or specimens taken from your body as a result of the procedure may be examined and disposed of, retained, preserved, or used for medical, scientific, or teaching purposes by the hospital.

1182

- The surgical/diagnostic procedure/treatment may be photographed or videotaped; observers may be present in the operating, treatment or procedure room for the purpose of advancing medical care and education.
- All means of resuscitation will be pursued, should your heart stop beating during the procedure.
- There are no specific limitation or prohibitions regarding treatment other than the following: None
- There can be a risk not to undergo catheterization as well if there is sufficient concern that you may have significant heart disease. Approximately 8-10% of patients die from their heart attacks within the first 30 days of the occurrence. Often this procedure identifies those at risk and offers a treatment that may prevent this from happening.
- This hospital offers and educational video, which you are encouraged to watch and you should feel free to ask any questions you, might have about your procedure.

Your signature below is to acknowledge that you have read and understand the above, that you have had an opportunity to discuss this with a physician regarding all your questions, have had an opportunity to view the educational video, and that you wish to proceed with this procedure. (Including blood transfusions and other medical products that my doctor feels are necessary or advisable.).

Tammy E. Windham 5/11/08 - 1848 Shonda Lewis, RN

Patient's Signature (or legal representative) Date Witness (relationship)

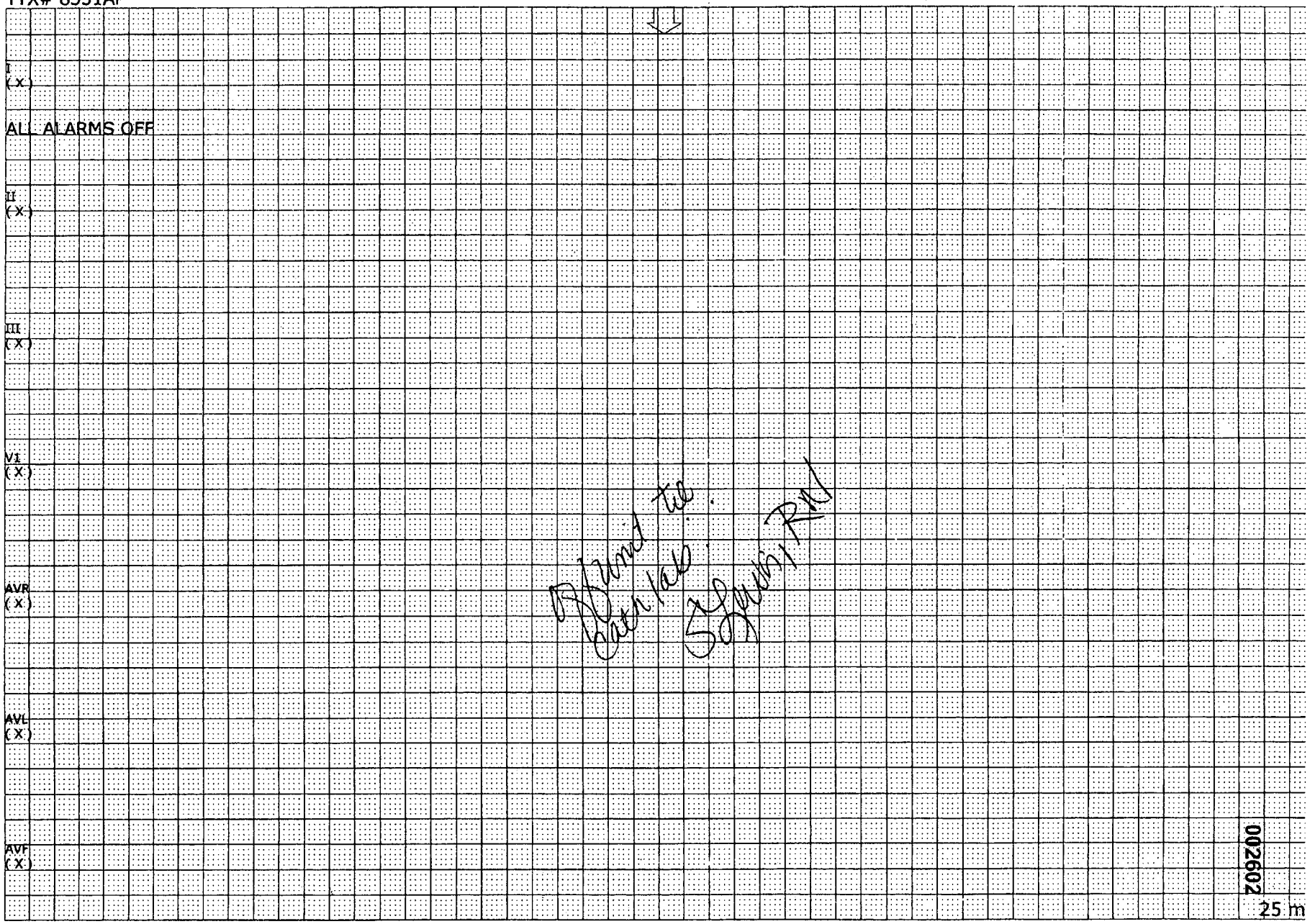
1183

Full Disclosure

WINDHAM,TAMMY M000895682 12-May-2008 14:36:32 5T|508*TTX# 853

ALL ALARMS OFF HR X PVC X ST II X mm All Alarms OFF [CATH LAB]

TTX# 8531AP



GE Medical Systems Information Technologies CIC Version 5.0.7

Monday, May 12, 2008 3:18:22 PM

END OF

1184

002602

6389

)HAM,TAMMY M000895682 **Caliper Measurements** 4H|452

:008 06:30:22 - 13-May-2008 06:30:32

6390

1185

002603

Measurement Waveform

PR

QRS

QT

R-R

Reference Waveform

displayed reflect measurements acquired against the measured waveform only.

= 0.167	sec	QT	= 0.402	sec
= 0.073	sec	R-R	= 1.107	sec
= 0.382	sec	Rate	= 54	bpm

SB
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tion Technologi

CIC Version 5.0.7
Tuesday, May 13, 2008 6:59:07 AM

25 mm/s
Page 1
END OF REPORT

WINDHAM TAMMY E 12 MAY 2008 15:09:44 #2 895682

40 yrs Female

PR 164 (NSR). Normal sinus rhythm, rate 55 - - - - - - - Normal P axis, PR, rate & rhythm
QRSD 79 (LVH31). ~~Probable LVH with ST-T abnormalities~~ - - - - - - - LVH voltage, ST-T negative
QT 452 - ABNORMAL ECG -
QTc 432

anteroseptal ST/T wave abn

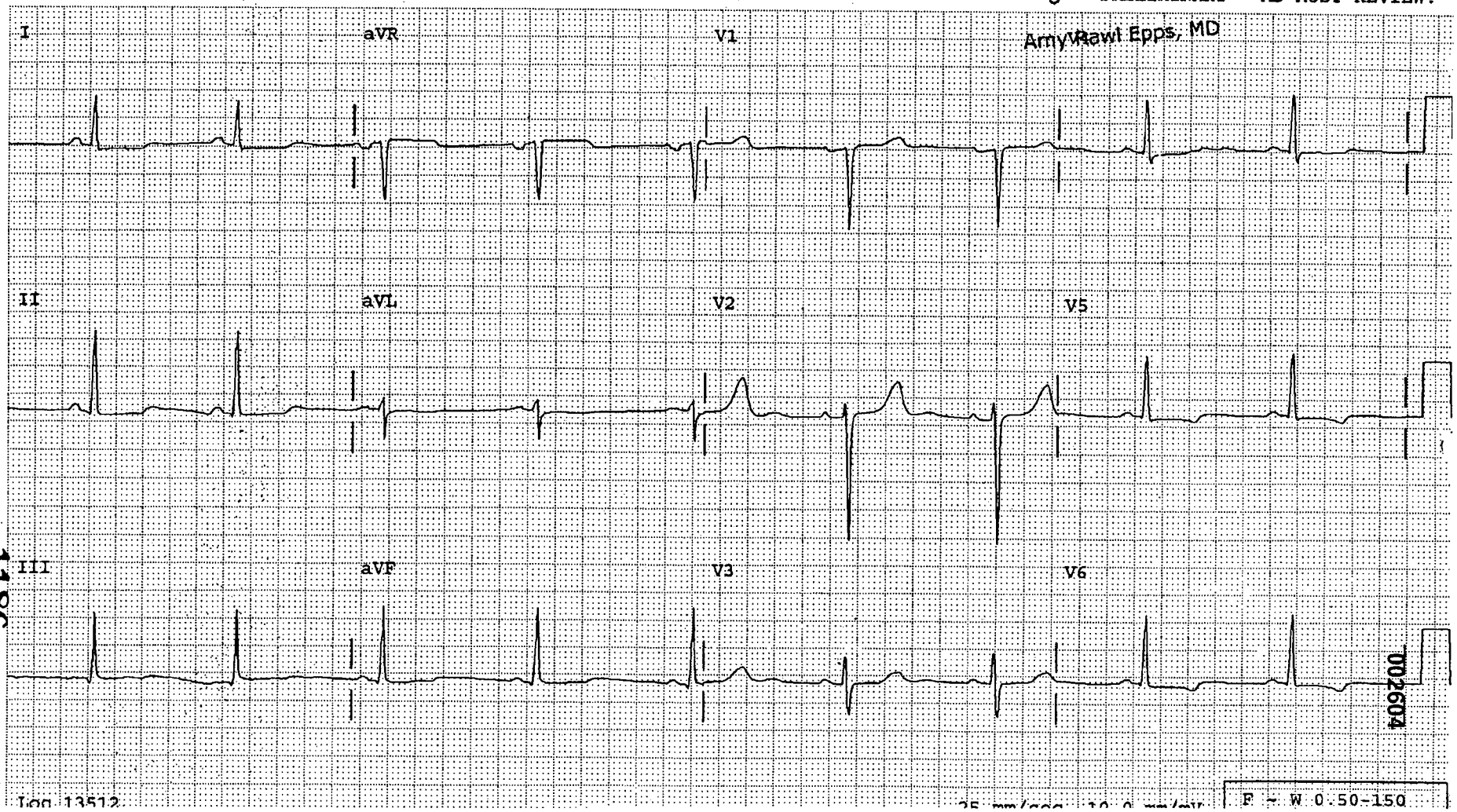
--AXES--
P 43
QRS 65
T 169

Requested by
161
Tech 64
Room 452A
C-HP708

Amy Rawl Epps MD

PREVIOUS ECG: 12 MAY 2008 5:57:54, UNCONFIRMED - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

PRELIMINARY - MD MUST REVIEW.



1186

002604

6391

WINCHAM TAMMY E 12 MAY 2008 15:09:44 895682

40 yrs Female

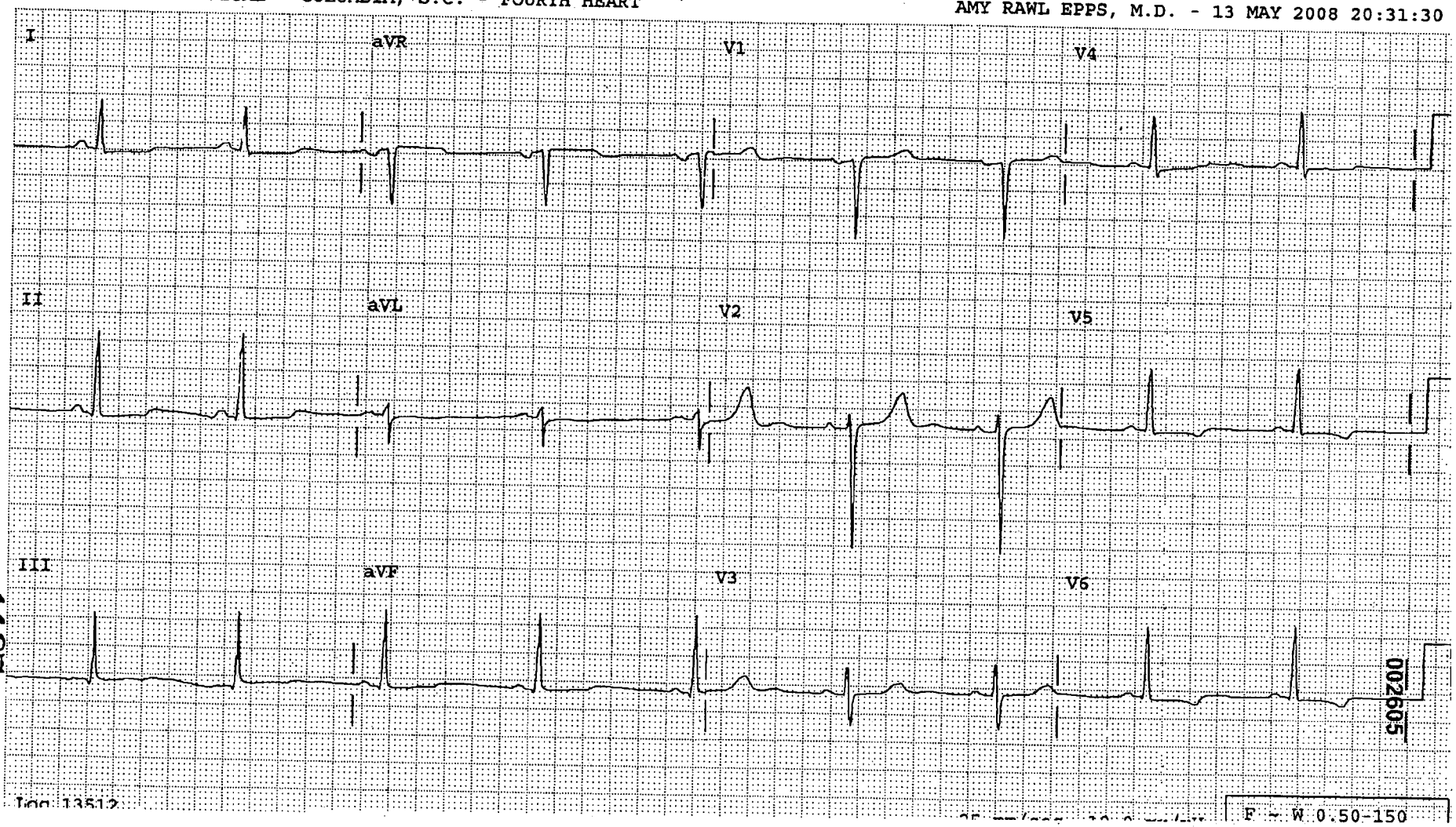
PR 164 (NSR). Normal sinus rhythm, rate 55 - - - - - - - Normal P axis, PR, rate & rhythm
QRSD 79
QT 452 - ABNORMAL ECG -
QTc 432 *ANTERLATTERAL ST T WAVE ABNORMAILTES
*ARE/ALM/502499114

--AXES--
P 43
QRS 65
T 169

Requested by
161
Tech 64
Room 452A
Edited C-HP708

PREVIOUS ECG: 12 MAY 2008 5:57:54, CONFIRMED BY ARE - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FOURTH HEART

AMY RAWL EPPS, M.D. - 13 MAY 2008 20:31:30



1187

002605

6392

WINDHAM TAMMY E 12 MAY 2008 5:57:54 #1 895682

40 yrs Female

13

PR 171
QRSD 74
QT 450
QTc 453

(NSR). Normal sinus rhythm, rate 61 - - - - - - - Normal P axis, PR, rate & rhythm
(STTWI). Diffuse ST-T abnormalities, - - - - - - - - - - ST-T negative ANT/LAT/INF
- ABNORMAL ECG -

--AXES--
P 63
QRS 59
T 217

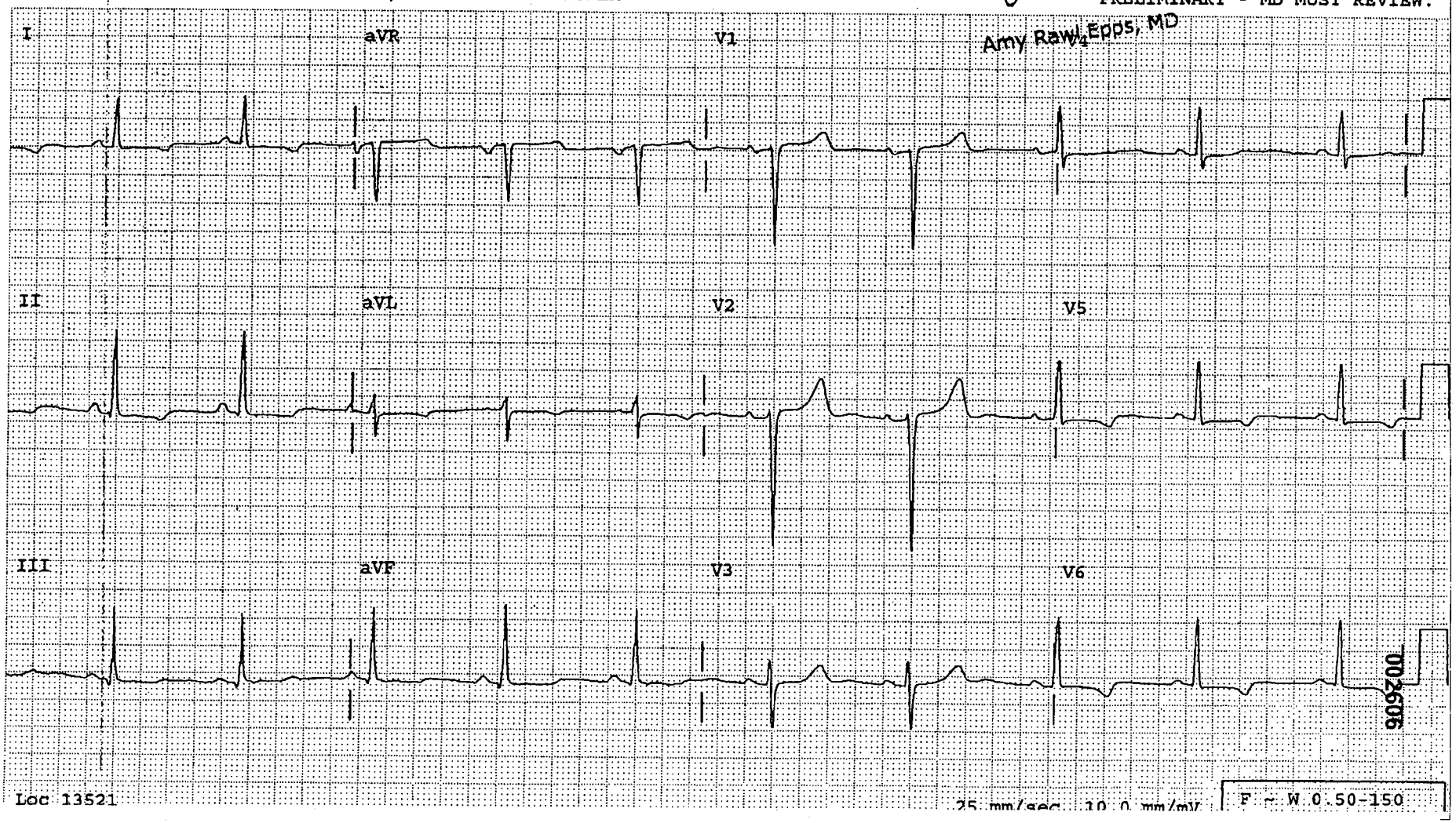
Requested by
161
Tech 44
Room 508
C-HP708

Amy Rawl Epps MD

PREVIOUS ECG: 11 MAY 2008 16:15:43, CONFIRMED BY RM - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER

PRELIMINARY - MD MUST REVIEW.

Amy Rawl Epps, MD



Loc 13521 25 mm/sec 10.0 mm/mV F - W 0.50-150

1188

002606

6393

WINDHAM TAMMY E 12 MAY 2008 5:57:54 895682

40 yrs Female

PR 171
QRSD 74
QT 450
QTc 453

(NSR). Normal sinus rhythm, rate 61 - - - - - - - Normal P axis, PR, rate & rhythm
(STTWI). Diffuse ST-T abnormalities, - - - - - - - - - - ST-T negative ANT/LAT/INF
- ABNORMAL ECG -

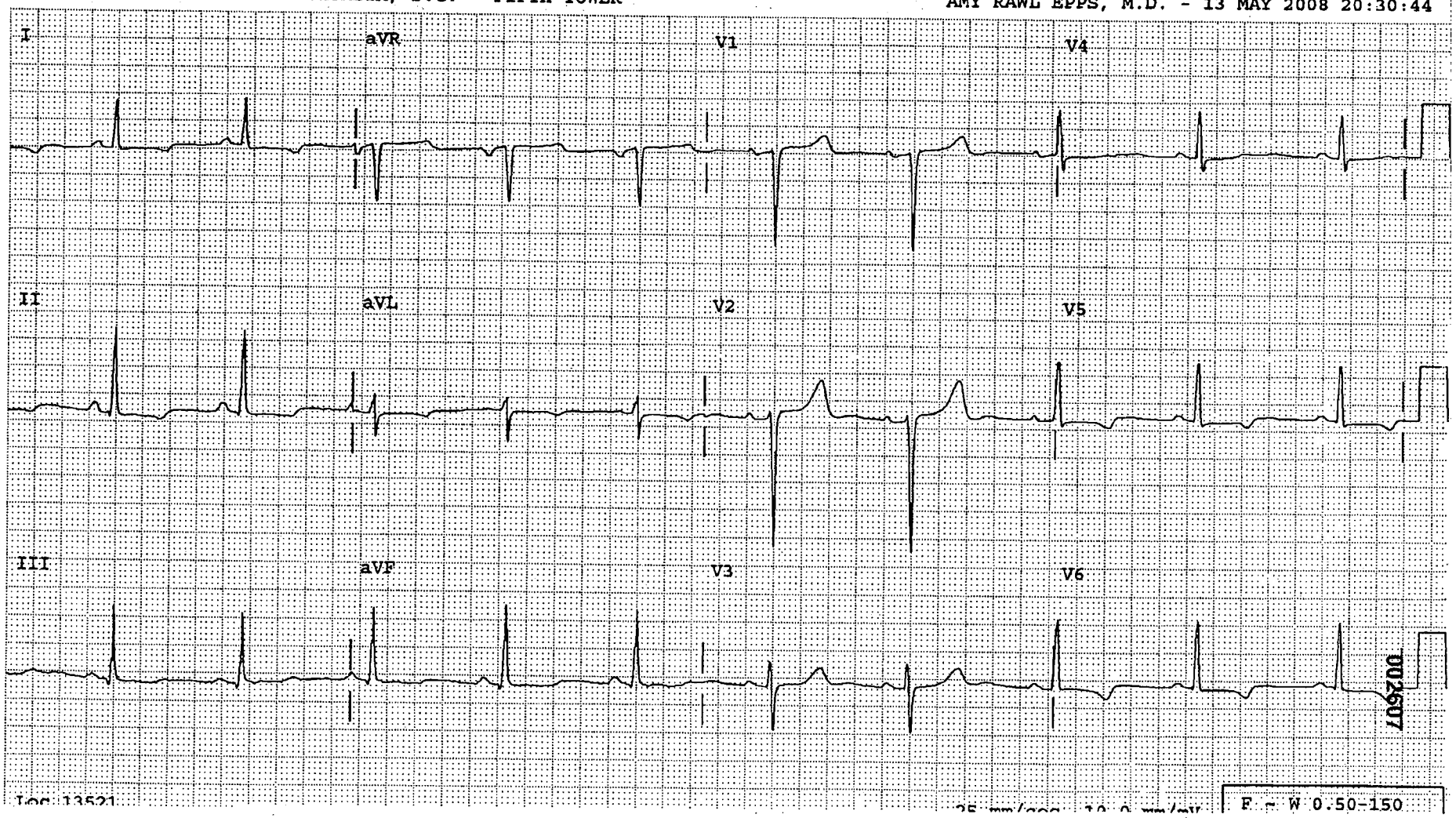
*ARE/ALM/502499114

--AXES--
P 63
QRS 59
T 217

Requested by
161
Tech 44
Room 508
Edited C-HP708

PREVIOUS ECG: 11 MAY 2008 16:15:43, CONFIRMED BY RM - AB
PROVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER

AMY RAWL EPPS, M.D. - 13 MAY 2008 20:30:44



1189

6394

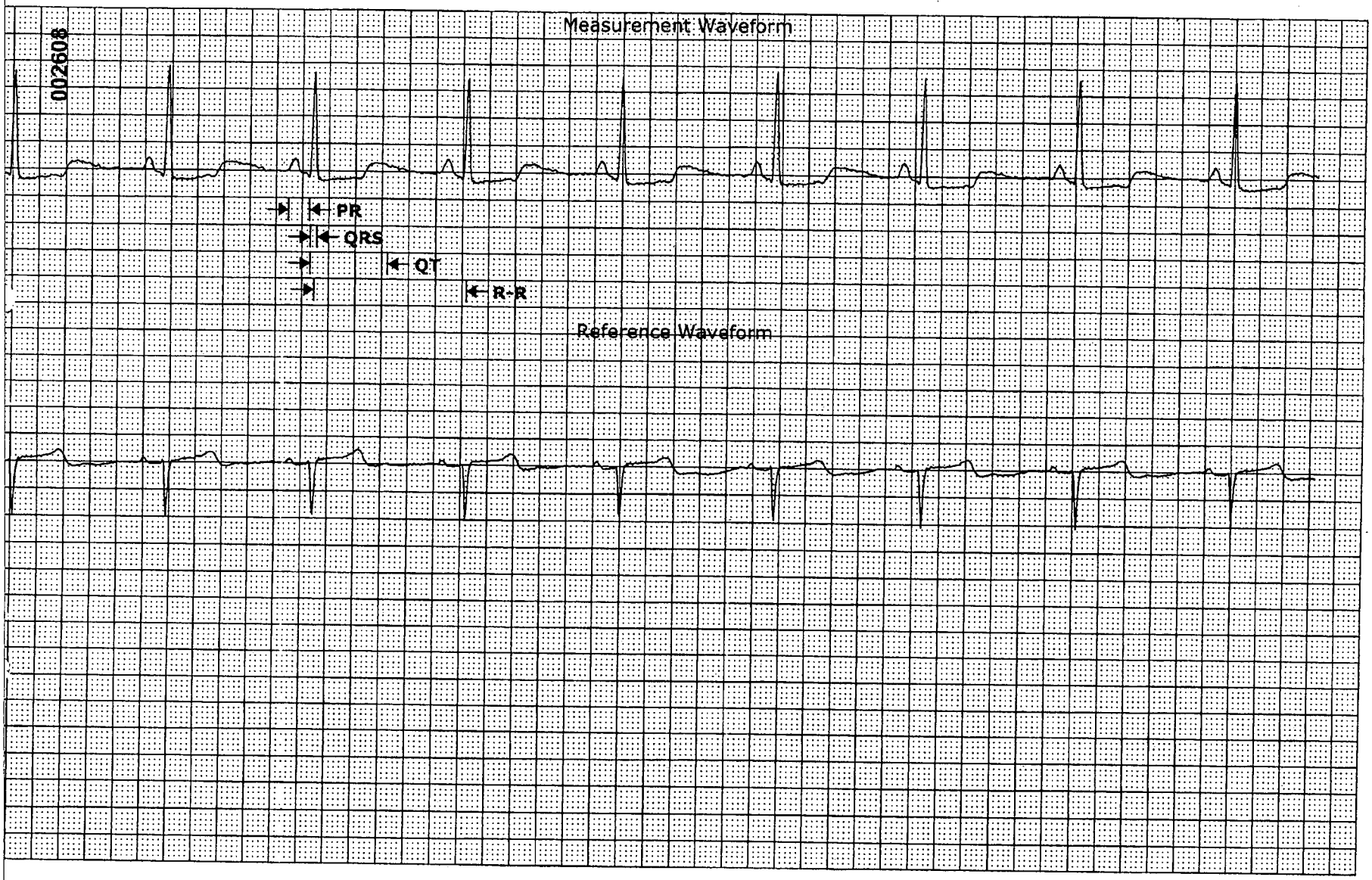
NDHAM,TAMMY M000895682 **Caliper Measurements** 4H|452

ay-2008 03:24:41 - 13-May-2008 03:24:51

6395

1190

002608



s displayed reflect measurements acquired against the measured waveform only.

= 0.167	sec	QT	= 0.590	sec
= 0.055	sec	R-R	= 1.142	sec
= 0.552	sec	Rate	= 53	bpm

SB

SB- SE, RN

Medical Systen
nation Technolog

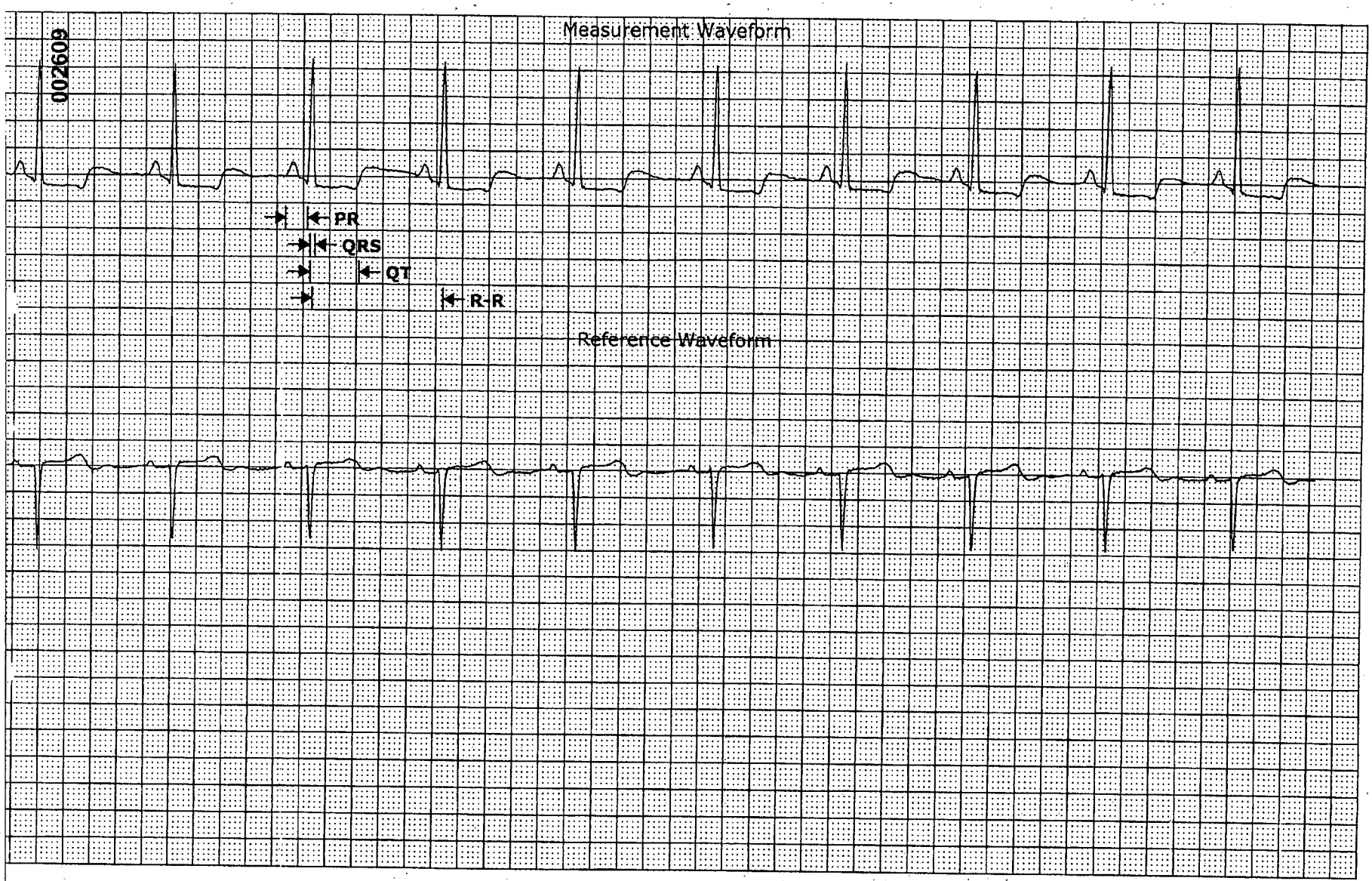
CIC Version 5.0.7
Tuesday, May 13, 2008 3:44:41 AM

25 mm/s
Page 1
END OF REPORT

NDHAM,TAMMY M000895682 **Caliper Measurements** 4H|452

ay-2008 22:14:14 - 12-May-2008 22:14:24

6396



1191

s displayed reflect measurements acquired against the measured waveform only.

= 0.173	sec	QT	= 0.378	sec
= 0.049	sec	R-R	= 0.989	sec
= 0.380	sec	Rate	= 61	bpm

SR

Medical Systen.
ormation Technolog.

CIC Version 5.0.7
Monday, May 12, 2008 10:42:21 PM

25 mm/s

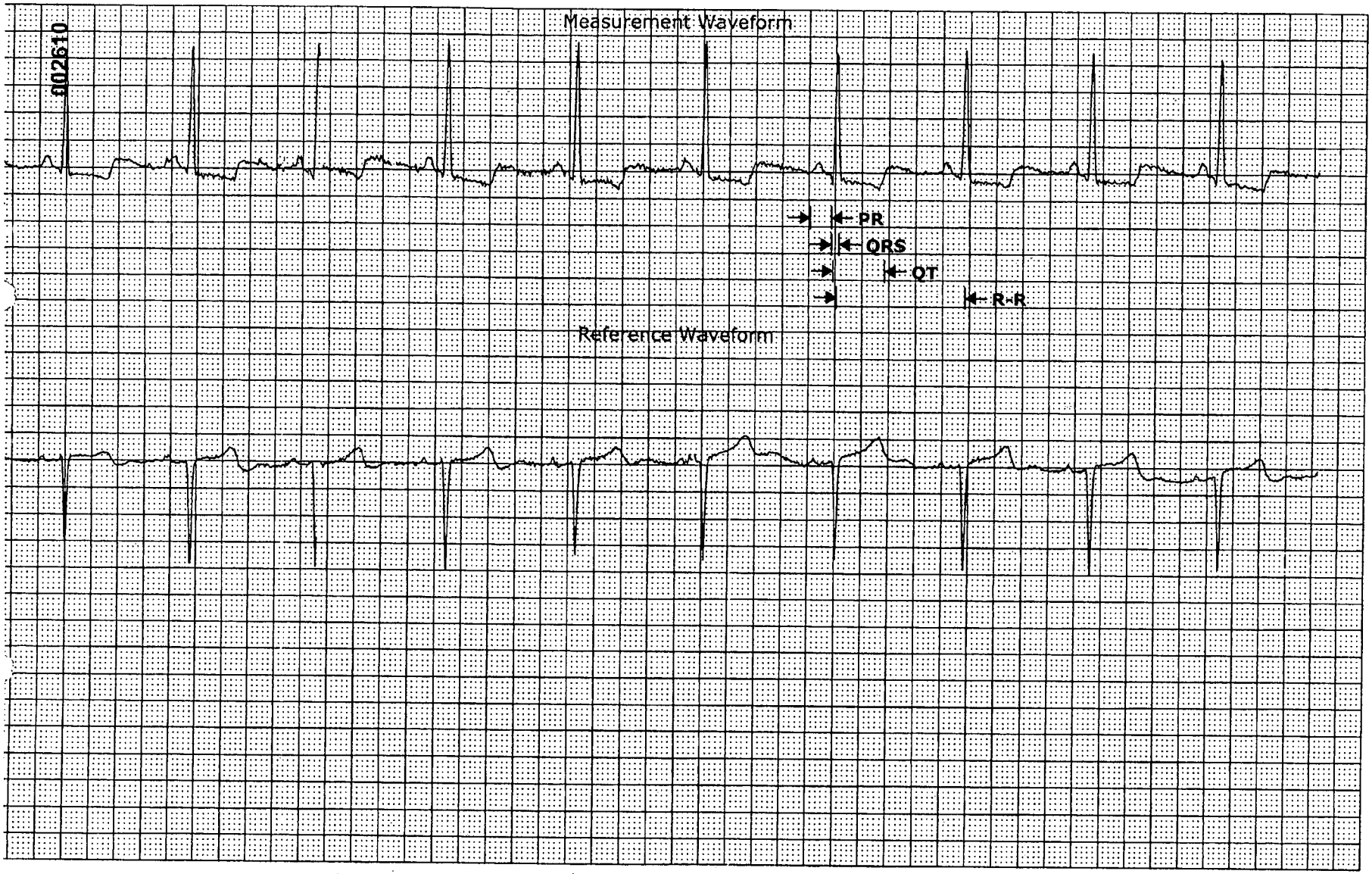
END OF REPORT

NDHAM,TAMMY M000895682 **Caliper Measurements** 4H|452

ıy-2008 18:29:56 - 12-May-2008 18:30:06

6397

1192



ıs displayed reflect measurements acquired against the measured waveform only.

=	0.161	sec	QT	= 0.388	sec
=	0.067	sec	R-R	= 0.960	sec
=	0.396	sec	Rate	= 62	bpm

SR

Medical System
ırmation Technolog

CIC Version 5.0.7
Monday, May 12, 2008 7:06:12 PM

25 mm/s

END OF REPORT

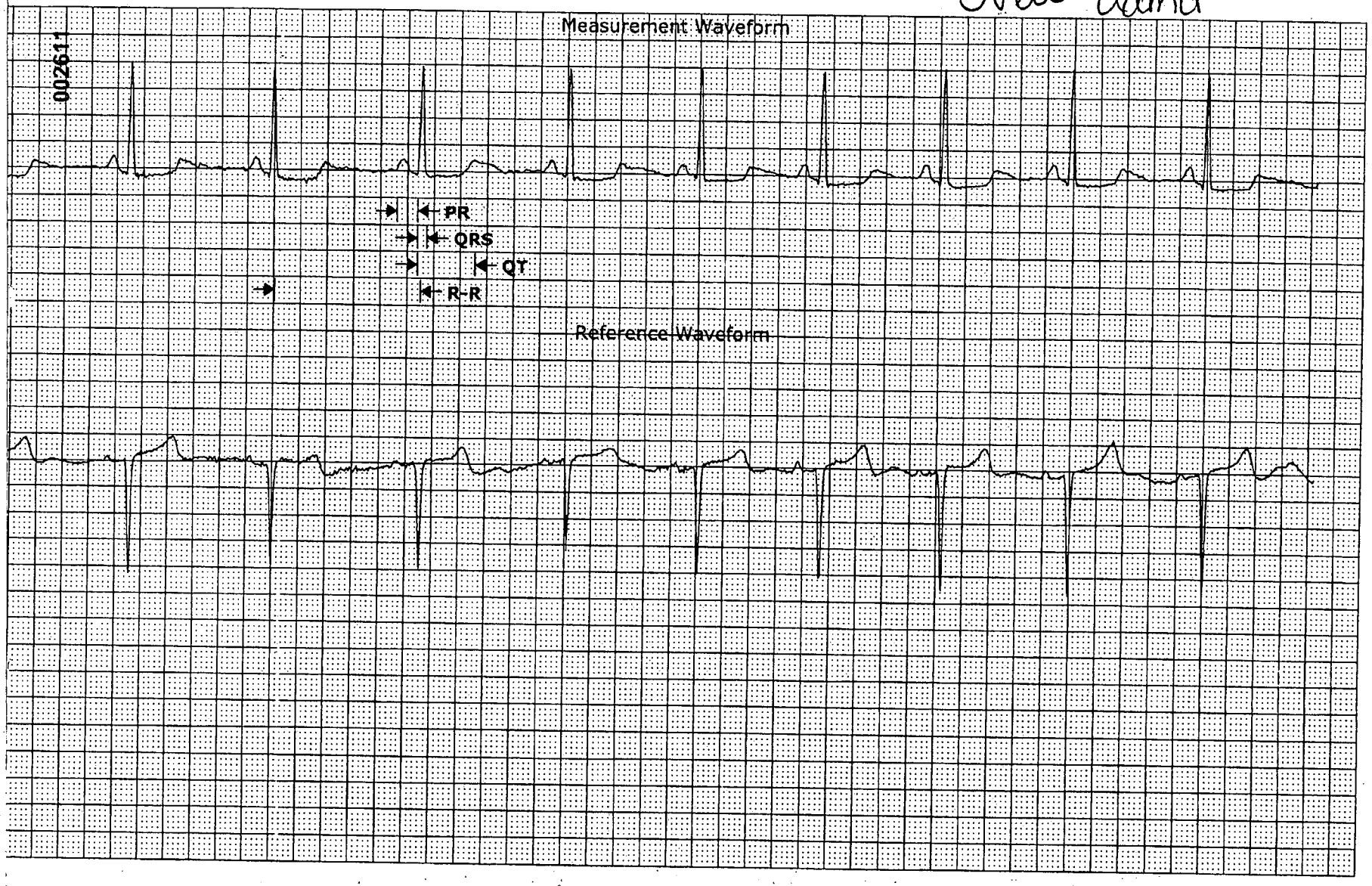
NDHAM,TAMMY M000895682 **Caliper Measurements** 4H|452

y-2008 14:48:55 - 12-May-2008 14:49:05

New admit

6398

1193



s displayed reflect measurements acquired against the measured waveform only.

= 0.155	sec	QT	= 0.439	sec
= 0.075	sec	R-R	= 1.098	sec
= 0.419	sec	Rate	= 55	bpm

SB
cyclnrr

Medical System
mation Technolog.

CIC Version 5.0.7
Monday, May 12, 2008 2:50:40 PM

25 mm/s

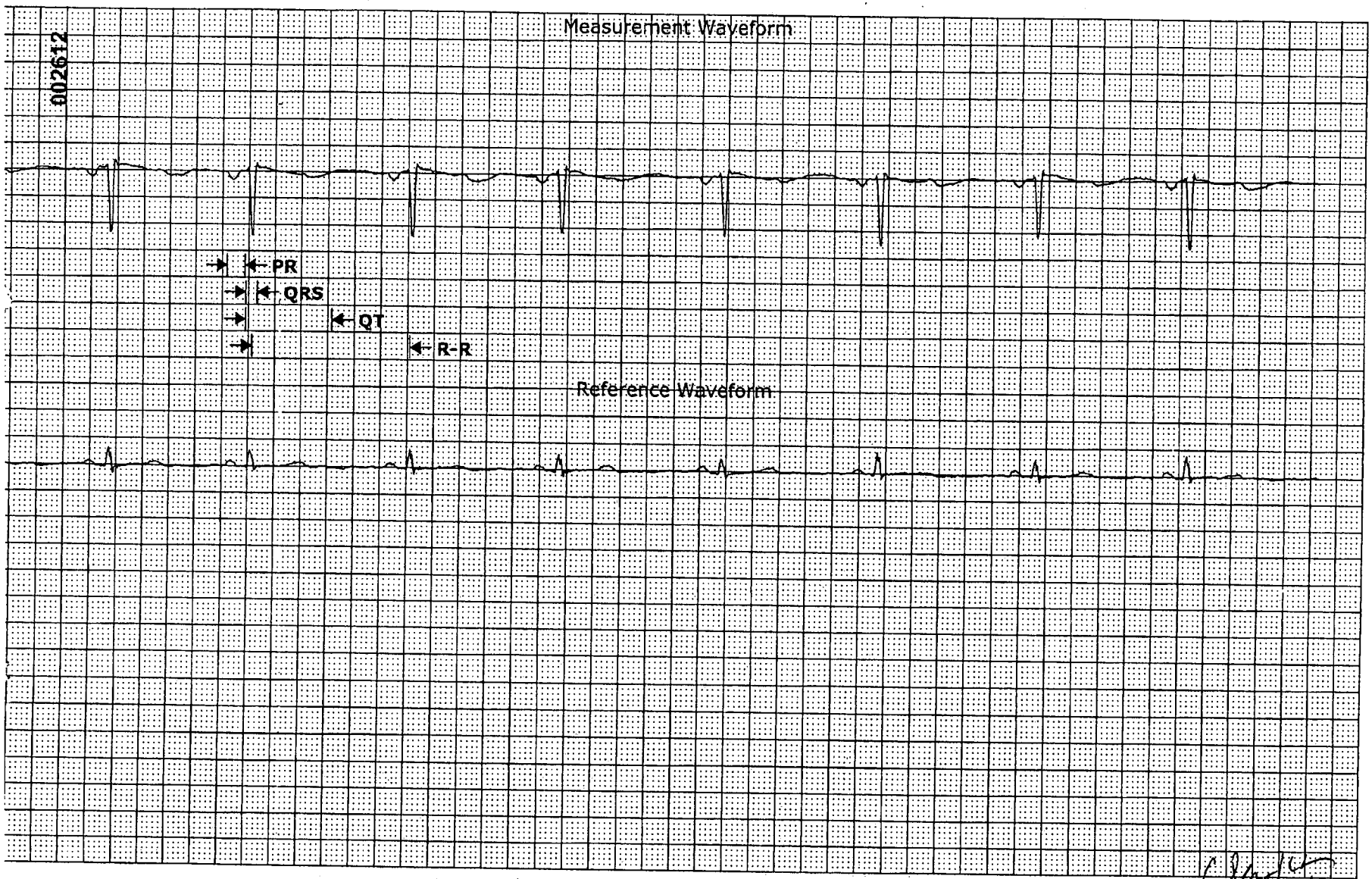
Page 1

END OF REPORT

NDHAM,TAMMY M000895682 **Caliper Measurements** 5T|508*

ıy-2008 06:32:16 - 12-May-2008 06:32:26

6399



002612

1194

s displayed reflect measurements acquired against the measured waveform only.

=	0.143	sec	QT	= 0.660	sec
=	0.090	sec	R-R	= 1.201	sec
=	0.602	sec	Rate	= 50	bpm

Medical Systems
mation Technology

CIC Version 5.0.7
Monday, May 12, 2008 7:11:06 AM

25 mm/s
Page 1
END OF REPORT

IDHAM,TAMMY M000895682 **Caliper Measurements** 51|508+

-2008 02:55:24 - 12-May-2008 02:55:34

6400

002613

Measurement Waveform

1195

PR

QRS

QT

R-R

s displayed reflect measurements acquired against the measured waveform only.

= 0.167	sec	QT	= 0.555	sec	SB
= 0.096	sec	R-R	= 1.142	sec	
= 0.519	sec	Rate	= 53	bpm	

Medical Systems
rmation Technolo

CIC Version 5.0.7
Monday, May 12, 2008 2:56:52 AM

25 mm/s

Page 1

END OF REPORT

IDHAM,TAMMY M000895682 **Caliper Measurements** 5T|508*

-2008 22:53:34 - 11-May-2008 22:53:44

002614

Measurement Waveform

PR

QRS

QT

R-R

1196

6401

s displayed reflect measurements acquired against the measured waveform only.

=	0.133	sec	QT	= 0.450	sec
=	0.086	sec	R-R	= 1.096	sec
=	0.430	sec	Rate	= 55	bpm

Medical System
rmation Technolog

CIC Version 5.0.7
Sunday, May 11, 2008 10:54:50 PM

25 mm/s

Page 1

END OF REPORT

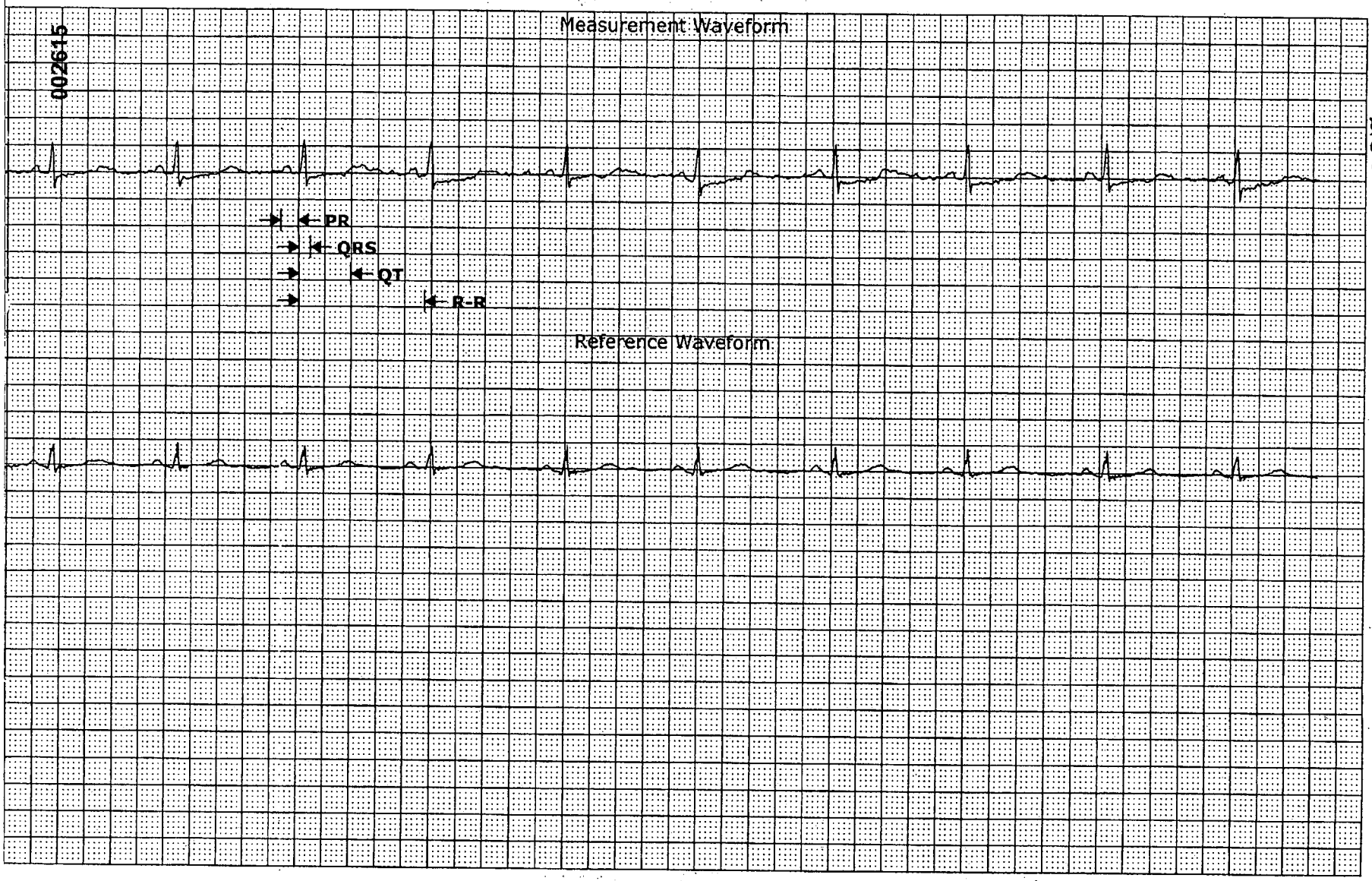
IDHAM,TAMMY M000895682 **Caliper Measurements** 5T|508*

y-2008 19:00:55 - 11-May-2008 19:01:05

6402

002615

1197



s displayed reflect measurements acquired against the measured waveform only.

= 0.132	sec	QT	= 0.390	sec	
= 0.085	sec	R-R	= 0.942	sec	
= 0.402	sec	Rate	= 64	bpm	

Medical Systen
rmation Technolog

CIC Version 5.0.7
Sunday, May 11, 2008 7:44:36 PM

25 mm/s

Page 1

END OF REPORT

Full Disclosure

DHAM,TAMMY M000895682 11-May-2008 16:12:30 5T|508*TTX# 8531AP

DY HR 43 PVC 0 ST I -1.1 mm

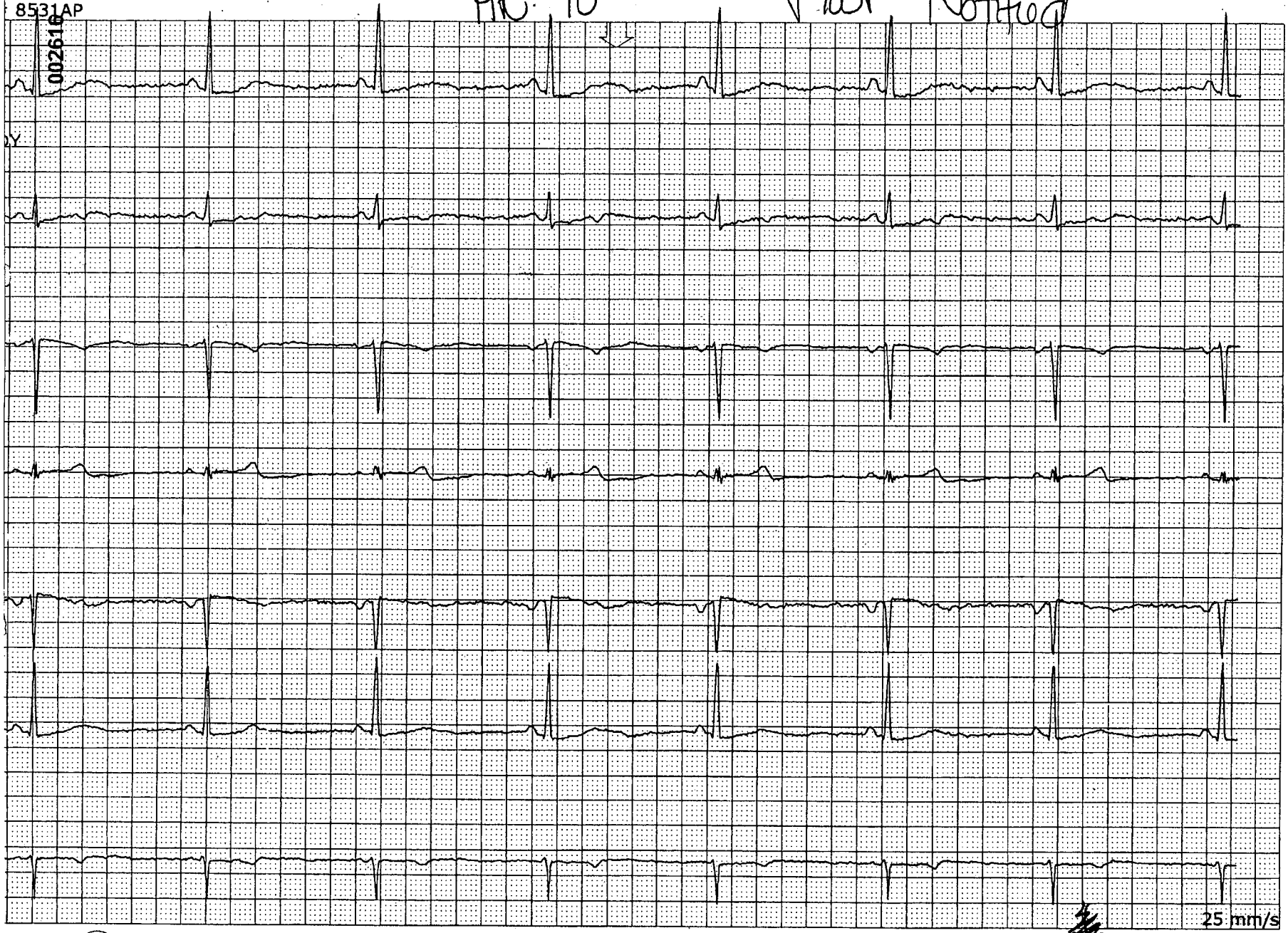
8531AP

HR: 40 Floor Notified

002616

1198

6403



25 mm/s

Medical System
rmation Technologi

CIC Version 5.0.7
Sunday, May 11, 2008 4:16:00 PM

END OF REPORT

NDHAM,TAMMY ~~999999999~~ **Caliper Measurements** **5T|508***

y-2008 14:39:44 - 11-May-2008 14:39:54

6404

1199

002617

Measurement Waveform

PR

QRS

QT

R-R

~~Reference Waveform~~

s displayed reflect measurements acquired against the measured waveform only.

=	0.143	sec	QT	= 0.420	sec
=	0.055	sec	R-R	= 1.154	sec
=	0.391	sec	Rate	= 52	bpm

SB

MTHF

Medical System
ormation Technologies

CIC Version 5.0.7

Sunday, May 11, 2008 2:57:22 PM

25 mm/s

Page 1

END OF REPORT

NDHAM TAMMY E 11 MAY 2008 16:15:43 ~~508-H~~ 895682

yrs Female

002618

45 (SB). Sinus bradycardia, rate 48 - - - - - - - - - - Normal P axis, rate < 50
SD 74 (LVH31). Probable LVH with ST-T abnormalities - - - - - - LVH voltage, ST-T negative
475
c 424 - ABNORMAL ECG -

AXES--
48
S 62
180

PREVIOUS ECG: 22 JAN 2008 6:32:15, CONFIRMED BY JJL - AB

OVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER

PRELIMINARY - MD MUST REVIEW.

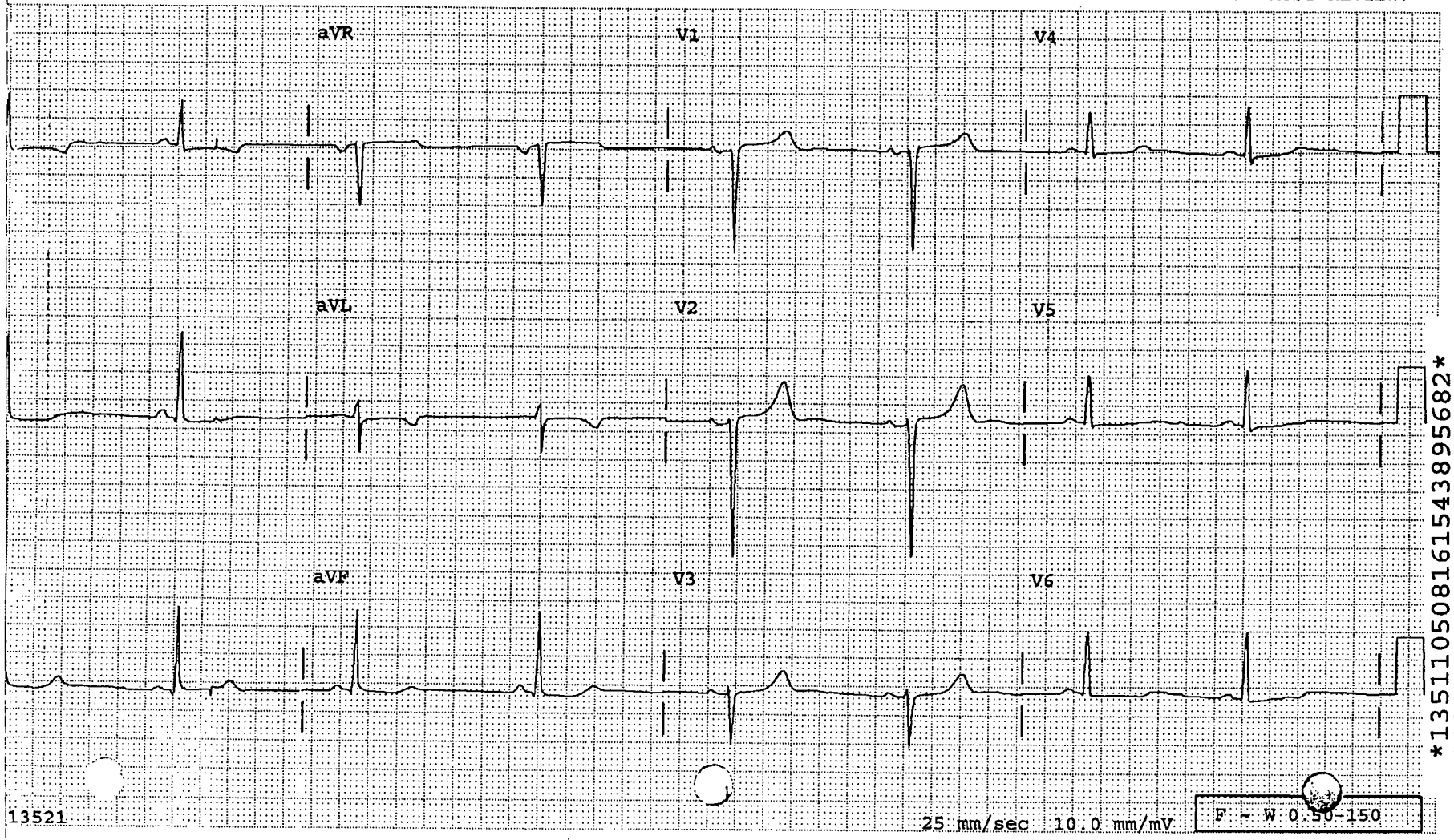
459

R

Requested by
161
Tech 27
Room 508 A
C-HP708

12 10

6405



135110508161543895682
135110508161543895682

INDHAM TAMMY E 11 MAY 2008 16:15:43 895682

) yrs Female

002619

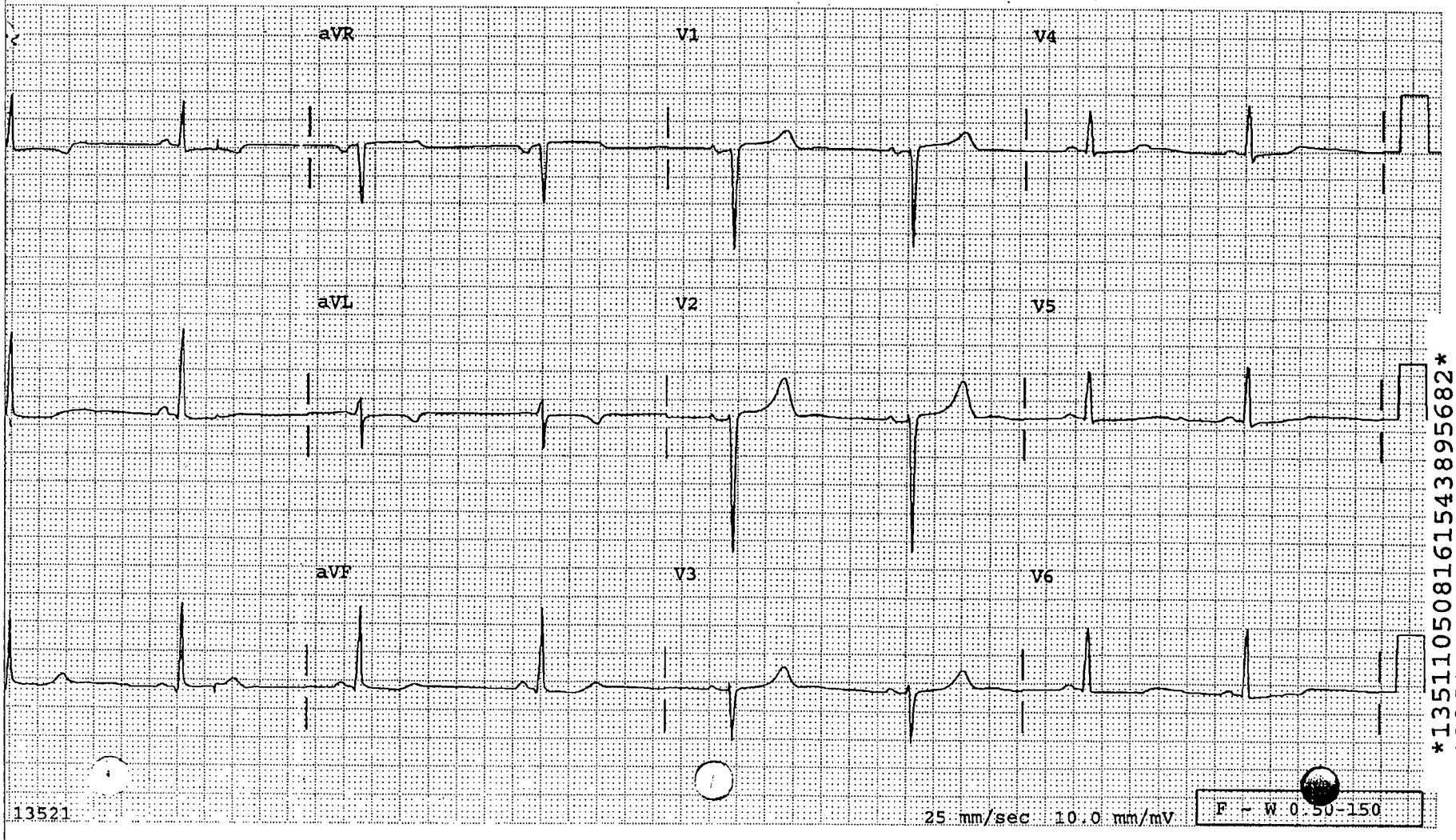
45 (SB). Sinus bradycardia, rate 48 - - - - - - - - - - Normal P axis, rate < 50
SD 74 (LVH31). Probable LVH with ST-T abnormalities - - - - - - LVH voltage, ST-T negative
475 - ABNORMAL ECG -
c 424 *RM/GH502499114

AXES--
48
S 62
180

Requested by
161
Tech 27
Room 508 A
Edited C-HP708

1291

PREVIOUS ECG: 22 JAN 2008 6:32:15, CONFIRMED BY JJL - AB
ROVIDENCE HOSPITAL - COLUMBIA, S.C. - FIFTH TOWER ROBERT MALANUK, MD - 11 MAY 2008 22:30:31



135110508161543895682
135110508161543895682

6406

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					

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)

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	JB	1000mg	10	1	headache	1215	JB	6	1	18	Pain 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)

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) (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)

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) (Sodium Chloride) 05/10/08 06/09/08 — 0600 1400 2200
DOSE: 2.5 ML IV .Q8H&PRN SCH — 1235
COMMENTS: Q8H AND PRN
*** OBTAIN MEDICATION FROM: ACUDOSE MACHINE/FLOOR STOCK

03946448 LISINOPRIL 20 MG TAB (20 MG) (Zestril) 05/10/08 06/09/08 — 0900
DOSE: 20 MG PO DAILY SCH — BP 142/69
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR

03946454 METOPROLOL TARTRATE 50 MG TAB (50 MG) (Lopressor) 05/10/08 06/09/08 — 0900 2100
DOSE: 50 MG PO BID SCH
COMMENTS: ADMINISTER AROUND THE CLOCK
*** OBTAIN MEDICATION FROM: PATIENTS MEDICATION DRAWER/REFRIGERATOR — ↓ 25 mg PO BID

03946455 ASPIRIN 81 MG TAB (81 MG) (Bayer Asa Child Chewable) 05/10/08 06/09/08 — 0900
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 2100
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)

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: _____				
	*** 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)

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)
(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

Ntg Paste 1/2 inch Q6 hour

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)

PROVIDENCE HOSPITAL DOWNTOWN
2435 FOREST DRIVE
COLUMBIA, S.C. 29204

002626

Name: WINDHAM,TAMMY E
Phys: Roberts,Michael C
DOB: Age: 41 Sex: F
Acct: D00502511298 Loc: D.504 B
Exam Date: 05/18/2008 Status: DIS IN
Radiology No:
Unit No: M000895682

EXAM#	TYPE/EXAM	RESULT
000970664	RAD/PORTABLE CHEST	

PORTABLE CHEST 05/18/08:

REASON FOR EXAM: Coronary artery disease.

TECHNIQUE:

Single frontal portable radiograph of the chest was obtained.

COMPARISON: 05/11/08.

FINDINGS:

The heart size is normal. The lungs are clear. No pneumothorax or pleural effusions are identified.

IMPRESSION:

No focal infiltrates to suggest pneumonia.

** REPORT SIGNATURE ON FILE 05/18/2008 **
Reported By: EDWARD A. GIZE, M.D.
Signed By: GIZE,EDWARD A

CC: Dr. Michael C Roberts

Technologist: ELIZABETH B MARSH, R.T.(R)
Transcribed Date/Time: 05/18/2008 (0719)
Transcriptionist: NELSONRV
Printed Date/Time: 03/17/2009 (0910)

1208

PROVIDENCE HOSPITAL DOWNTOWN
2435 FOREST DRIVE
COLUMBIA, S.C. 29204

002627

Name: WINDHAM,TAMMY E
Phys: Hayes Michael T
DOB: [illegible] Age: 41 Sex: F
Acct: D00502511298 Loc: D.504 B
Exam Date: 05/18/2008 Status: DIS IN
Radiology No:
Unit No: M000895682

EXAM#	TYPE/EXAM	RESULT
000970639	US/FEMORAL ARTERY RIGHT	

FEMORAL ULTRASOUND 05/18/08:

REASON FOR EXAM: Evaluation for pseudoaneurysm.

TECHNIQUE: Multiple real-time, gray scale sonographic images of the right groin were obtained. Color Doppler and duplex images were acquired.

FINDINGS:

The common femoral artery and common femoral vein are patent. No hematoma or pseudoaneurysm is seen. There appears to be a low resistant waveform within the right femoral artery. There also appears to be increased flow within the right femoral vein.

IMPRESSION:

No evidence of pseudoaneurysm. Findings suspicious for arteriovenous fistula.

** REPORT SIGNATURE ON FILE 05/18/2008 **
Reported By: EDWARD A. GIZE, M.D.
Signed By: GIZE,EDWARD A

CC:

Technologist: SHARRON N CARTER
Transcribed Date/Time: 05/18/2008 (0706)
Transcriptionist: NELSONRV
Printed Date/Time: 03/17/2009 (0910)

1299

THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL.

PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
2435 FOREST DRIVE/COLUMBIA, SC 29204
PHONE (803) 256-5330, FAX (803) 256-5785

Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories
120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203
PHONE (803) 865-4550 , FAX (803) 865-4638

PATIENT: WINDHAM,TAMMY E
REG DR: Roberts,Michael C

ACCT #: D00502511298 **LOC:** D.5T **U #:** M000895682
AGE/SX: 40/F **ROOM:** D.504 **REG:** 05/18/08
BED: B **DIS:** 05/19/08
STATUS: DIS IN **TLOC:**

SPEC #: 0518:C00117S **COLL:** 05/18/08-0430 **STATUS:** COMP **REQ #:** 01463227
RECD: 05/18/08-0505 **SUBM DR:** Hayes,Michael T

ENTERED: 05/18/08-0410 **OTHR DR:** NO DOCTOR
ORDERED: BMP, TROPRFLX
COMMENTS: Campus: DTP
SST

Test	Result	Flag	Reference	Site
BASIC METABOLIC PANEL				
SODIUM	135	L	136-144 mmol/L	
POTASSIUM	3.9		3.6-5.1 mmol/L	
CHLORIDE	104		101-111 mmol/L	
CARBON DIOXIDE	22		22-32 mmol/L	
ANION GAP	13		10-20	
GLUCOSE	109		74-118 MG/DL	
	The American Diabetes Association (ADA) considers a FASTING blood glucose level of 100-125mg/dL as consistent with pre-diabetes, and any value above 125mg/dL as consistent with diabetes.			
BUN	12		8-26 mg/dL	
CREATININE				
CREATININE	0.8		0.6-1.1 mg/dL	
BUN/CREA RATIO	15			
GLOMERULAR FILTRATION RATE:				
	>60			
	UNITS ARE mL/min/1.73m2			
	THIS RESULT IS FOR A PATIENT OF ANY RACE EXCEPT AFRICAN AMERICAN.			
CALCIUM	8.8	L	8.9-10.3 mg/dL	
TROPONIN I WITH REFLEX CKMB				
	0.04		0-0.5 ng/mL	
	THIS IS A TROPONIN I WITH REFLEX. A CK TOTAL, CKMB TOTAL AND A CKMB INDEX WILL BE PERFORMED ONLY IF TROPONIN I IS GREATER THAN 0.5 NG/ML.			

RUN DATE: 03/17/09 **RUN TIME:** 0910
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502511298 **Unit#**M000895682

1210

Providence Hospital PCI **LIVE**

Laboratory Test History

WINDHAM,TAMMY E (M000895682) **PROTHROMBIN TIME W/ INR**

Age/Sex: 41 F

DIS - May 19, 08 Mar 10, 2009 through Mar 17, 2009

Date	Time	[PT]	Reference	Result Flags

No data in this time period

Run: Tue - Mar 17 (09:10) for COLEMAN,LAKEISHA K

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PROVIDENCE HOSPITALS
DEPARTMENT OF PATHOLOGY/CLINICAL LABORATORY
2435 FOREST DRIVE/COLUMBIA, SC 29204 / **120 GATEWAY CORPORATE BLVD/COLUMBIA, SC 29203**
PHONE (803) 256-5330, FAX (803) 256-5785 **PHONE (803) 865-4550 , FAX (803) 865-4638**

Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories

PATIENT: WINDHAM,TAMMY E
REG DR: Roberts,Michael C
ACCT #: D00502511298 **LOC:** D.5T **U #:** M000895682
AGE/SX: 40/F **ROOM:** D.504 **REG:** 05/18/08
BED: B **DIS:** 05/19/08
STATUS: DIS IN **TLOC:**

SPEC #: 0519:H00018T **COLL:** 05/19/08-0524 **STATUS:** COMP **REQ #:** 01463797
RECD: 05/19/08-0548 **SUBM DR:** Lawton,Joseph J III

ENTERED: 05/19/08-0000 **OTHR DR:** NO DOCTOR
Roberts,Michael C

ORDERED: CBC W/O DIFF
COMMENTS: Campus: DTP

Test	Result	Flag	Reference	Site
CBC WITHOUT DIFF				
WHITE BLOOD CELL	9.5		3.53-9.57 K/UL	
RBC	4.92		3.96-5.50 M/UL	
HEMOGLOBIN	14.4		12.14-16.27 GM/DL	
HEMATOCRIT	42.6		35.39-47.19 %	
MCV	86.5		76.9-94.7 FL	
MCH	29.2		25.79-32.95 PG	
MCHC	33.77		33.34-35.47 G/DL	
RDW	14.73		12.09-15.17 %	
PLATELET COUNT	279		169.06-413.23 K/MM3	
MPV	9.1		7.54-11.24 FL	

RUN DATE: 03/17/09 **RUN TIME:** 0910
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502511298 **Unit#**M000895682

1212

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Joseph R. Modzelewski, Jr., MD, MBA, FCAP
Medical Director of Laboratories

PATIENT: WINDHAM,TAMMY E **ACCT #:** D00502511298 **LOC:** D.5T **U #:** M000895682
AGE/SEX: 40/F **ROOM:** D.504 **REG:** 05/18/08
REG DR: Roberts,Michael C **BED:** B **DIS:** 05/19/08
STATUS: DIS IN **TLOC:**

SPEC #: 0518:H00086S **COLL:** 05/18/08-0430 **STATUS:** COMP **REQ #:** 01463227
RECD: 05/18/08-0505 **SUBM DR:** Hayes,Michael T

ENTERED: 05/18/08-0410 **OTHR DR:** NO DOCTOR
ORDERED: CBC W/O DIFF
COMMENTS: Campus: DTP

Test	Result	Flag	Reference	Site
CBC WITHOUT DIFF				
WHITE BLOOD CELL	**13.3**	*H*	3.53-9.57 K/UL	
RBC	5.01		3.96-5.50 M/UL	
HEMOGLOBIN	14.6		12.14-16.27 GM/DL	
HEMATOCRIT	43.1		35.39-47.19 %	
MCV	86.1		76.9-94.7 FL	
MCH	29.3		25.79-32.95 PG	
MCHC	33.99		33.34-35.47 G/DL	
RDW	14.95		12.09-15.17 %	
PLATELET COUNT	296		169.06-413.23 K/MM3	
MPV	9.0		7.54-11.24 FL	

RUN DATE: 03/17/09 **RUN TIME:** 0910
Patient: WINDHAM,TAMMY E **Age/Sex:** 40/F **Acct#**D00502511298 **Unit#**M000895682

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time — Recorded Date Time — by — Documented Comment Units — Change

Activity Date: 05/18/08 Time: 0135

Patient Notes: EDM NOTE
- Create 05/18/08 0135 CDH 05/18/08 0156 CDH
Abnormal? Confidential?
PATIENT EXAMINED BY ER MD. ULTRASOUND TECH IN TO PERFORM DOPPLER STUDIES AS ORDERED. WILL MONITOR.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 0225

4065 Pain: Monitor + A .PRN CP
- Document 05/18/08 0225 GJB 05/19/08 0421 GJB
Pain Indicators+: VOC
Pain Scale: 6
Pain Location #1+: RT GROIN
Pain Description+: NAGGING
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: PERCOCET X 2 TABS

Activity Date: 05/18/08 Time: 0239

Patient Notes: EDM NOTE
Create 05/18/08 0239 AMA 05/18/08 0239 AMA
Abnormal? Confidential?
PATIENT RETURNS TO ROOM FROM RADIOLOGY. WILL MONITOR.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 0410

Patient Notes: EDM NOTE
- Create 05/18/08 0410 CRB 05/18/08 0411 CRB
Abnormal? Confidential?
Patient to be admitted. Given Demerol and Phenergan for pain. Will monitor for effectiveness.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 0443

Patient Notes: EDM NOTE
- Create 05/18/08 0443 CDH 05/18/08 0444 CDH
Abnormal? Confidential?
REPORT CALLED TO SARAH RISH RN/5TOWER. PATIENT PREPARED TO TRANSFER.
Note Type Description
No Type None

Problem Description
Intervention Description — Sts Directions — From
Activity Type — Occurred Date Time — Recorded Date Time — by — Documented Comment Units — Change

Activity Date: 05/18/08 Time: 0505

4004 Nursing: Daily Process + A Q12H10 CP
- Document 05/18/08 0505 SKR 05/18/08 0622 SKR
Code Status+: FULL CODE
HIPAA Passcode: 1298
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe',elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC DISEASE
RETURN ADL
In The Plan Of Care+:
Daily Required Documentation
Education Documentation: Y
~~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~~
~~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~~
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 05/18/08 Time: 0505

4130 Education: + A DAILY CP
- Document 05/18/08 0505 SKR 05/18/08 0621 SKR
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: SAFETY ISSUES
Information Taught: INSTRUCTED PT ON IMPORTANCE OF CALLING WITH NEEDS/CONCERNS.
Outcome+: VERBALIZE UNDERSTANDING
9167 IV: Peripheral Monitor Site/Infusion + A PER PROTOCOL CP
- Document 05/18/08 0505 SKR 05/18/08 0623 SKR
Type of IV Access+: INT
IV Site #1+: LEFT FOREARM
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 05/18/08
Dressing+: OCCLUSIVE
IV Med #1: NONE
IV Changed: N
Change Due: 05/21/08
Patent: Y
Patient Notes: NURSE
- Create 05/18/08 0505 SKR 05/18/08 0618 SKR
Abnormal? N Confidential? N
RECEIVED PT TO ROOM 504B. PT IS WITHOUT DISTRESS. IV SITE 20G LFA DATED 5/18/08 IS WIHTOUT PROBLEMS NOTED. PT ORIENTED TO ROOM AND CALL LIGHT AND ENCOURAGED TO CALL WITH NEEDS/CONCERNS.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 0511

1018 NUR: Admission History/Physical + A ONCE AS
- Create 05/18/08 0511 SKR 05/18/08 0545 SKR
- Document 05/18/08 0511 SKR 05/18/08 0545 SKR
Arrival From+: OTHERHOSP
Mode of Arrival+: AMBULATORY
Accompanied By+: FAMILY
Pt. ID Band On: Y
HIPAA Passcode: 1298
History Obtained From+: PATIENT
Family Doctor: NO FAMILY MD
Organ Donor: Y
~~~Admission Vital Signs~~~
Blood Pressure: 152/58
Pulse: 62
Respirations: 20
Temperature: 96.5
SPO2 (%): 96
On Room Air: Y
Weight - Lb: 155

Problem Description
Intervention Description
Activity Occurred Recorded Sts Directions Documented From
Type Date Time by Date Time by Comment Units Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
Oz: 0
Kg: 70.308
Weight Source+: STANDING SCALE
Height - Feet: 5
Inches: 3
Cm: 160.02
BSA: 1.76782
BMI: 27.4
Living Will: N
HC Power of Attorney: N
If Living Will or HCPOA not Available. What are Pt. Wishes+: YES-FEED
YES-HYDRA
Surrogate Decision Maker for Health Care+: FAMILY
Patient/Family Instructed to Bring Copy to the Hospital: N
Would You Like Information Regarding Advanced Directives: N
Any Religious, Traditional, Cultural or Ethnic
Needs that Need to be Part of Your Care: N
Based on any Religious,Cultural or Ethnic concerns, do you have objections to receiving blood/blood products+: N
Blood Refusal (NO BLOOD) Band On: N
Previous Blood Transfusions: N
Previous Blood Reactions: N
~~~Personal Effects Inventory~~~
Prosthesis: N
Assistive Device+: NONE
Jewelry+: RING
Disposition+: WITH PT
Chart Patient's Other Belongings Now: Y
Patient's Chief Complaint: R. LEG PAIN
~~~Adverse Reactions/Allergy/Medications~~~
Pt/Family Adverse Reactions to Anesthesia: N
Enter ALLERGIES Now: Y
Home Pain Management Routine: DARVOCET
~~~MEDICAL HISTORY REVIEW~~~
EENT Problems+: N
GI Problems+: N
GU Problems+: N
GYN Problems+: N
Is Pt Pregnant: N
Endo/Hepatic Problems+: N
Diabetes: N
Musculoskeletal Problems+: N
Cancer: UTERINE
Transplant: NONE
Neuro Problems+: N
Respiratory Problems+: N
CV Problems+: Y
CV History+: CARSTNT
CP
HTN

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
HYPERLIPID
MI
Infectious Disease+: N
Previous Cardiac Procedures: Y
Cardiac Cath: Y
PTCA: N
Stents: Y
Brachy Therapy: N
CABG: N
----Tuberculosis Screening-Symptoms and History----
Fever: N
Night sweats: Y
Unexplained weight loss: N
Persistent cough > than 3 wks: N
Bloody sputum: N
Exposure to TB within last 3 mths: N
Medical History: HTN, STENTS, MI, UTERINE CANCER, HYPERLIPIDEMIA, CHOLEY, APPEY
Previous Surgeries: SEE ABOVE
----Functional History of ADL's----
Feeding+: SELF
Mobility+: SELF
Bathing+: SELF
Dressing+: SELF
Prior to Admit, has ADL Function Declined in Past 2 Weeks: N
Prior to Admit, has Mobility Declined in Past 2 Weeks: N
Prior to Admit, has Cognition Declined in Past 2 Weeks: N
Prior to Admit, has Communication Changed in Past 2 weeks: N
Prior to Admit, has Swallowing Changed in Past 2 weeks: N
PT Screen Requested: N
OT Screen Requested: N
ST Screen Requested: N
----Nutritional Risk----
Is Pt. Fed Via NG, PEG or TPN: N
Diet: REGULAR
Appetite+: FAIR
Last BM: 05/17/08
Bowel Elimination Pattern+: DAILY
Laxative/Enema+: NONE
Swallowing Impaired: N
Chewing Impaired: N
----FALL RISK----
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,

1216

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 1
Use Shift F8 to View Spot the Dot
Spot the Dot Implemented: N
----Psychosocial----
Tobacco Use+: REF SMOKER
Tobacco Use in Last Year: Y
Alcohol: N
Emotional Status+: CALM
Perception+: APPROP
Any Suspicion or Confirmation of Substance Abuse: N
Any Suspicion of Neglect or Abuse: N
----Education----
Able to Read: Y
Able to Write: Y
Ability to Understand+: COMPLEX
Healthcare Knowledge+: SOME KNOW
Highest Education Level+: HS GRAD
Barriers to Learning+: NONE
Learning Preferences+: VERBAL
----Discharge Planning Needs Assessment----
If Answering Yes to any Question, Consult PCC/RCC
Have You Been Hospitalized Within The Last 30 Days: Y
Do you Live Alone: N
Do You Live in an Extended Care Facility: N
Do You Attend an Adult Daycare Facility: N
Did You Require Assistance with ADL's Prior to Admission: N
Do You Use Home Health Services: N
Do you Use Home Durable Medical Equipment: N
Do You Use Meals on Wheels: N
Do You have Transportation To/From MD Appointments: Y
Do you have a Personal Caregiver: N
Are Others Dependent on You for Their Care: N
Any Concerns About Managing at Home After Your Discharge: N
Do You Have Safety Concerns: N
Do You Have Prescription Coverage for Home Medications: N
Any Concerns re:Cost of Hospital Stay or Home Care: N
Will Current Housing be Appropriate Upon Discharge: Y
Patient is Ill with Terminal Prognosis: N
Do You Currently have Hospice Services: N
----NEUROLOGICAL----
Level of Responsiveness+: A/OX3
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: COMPLEX

002634

6421

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
~~~~CARDIOVASCULAR~~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Telemetry Box Number: 8719
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: N
Right Dorsalis Pedis+: 1
Right Radial+: 3
Left Dorsalis Pedis+: 1
Left Radial+: 3
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~~RESPIRATORY~~~~
Respirations+: UNLABORED
NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~~GASTROINTESTINAL~~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~~Immunizations~~~~
Tetanus (Within 5 Yrs): Y
Hepatitis B: Y
Pneumovax (Last 5 Yrs): Y
Influenza (Within 1 yr): Y
~~~~GENITOURINARY~~~~
Incontinence: N
Ileoconduit: N
Foley: N
~~~~MUSCULOSKELETAL~~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
~~~~INTEGUMENT~~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: ELASTIC
Skin Integrity+: INTACT

Problem Description
Intervention Description
Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
Other: R. LEG SLIGHTLY COOLER
TO TOUCH THAN L. LEG
~~~~Skin Integrity~~~~
Sensory Perception+: 3 SLIGHTLY LIMITED
Activity+: 3 WALKS OCCASIONALLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 20
==== WOUNDS ====
Pressure Ulcers: N
Surgical Wounds: N
Vascular/Diabetic/Other Wounds: N
Ostomy: N
~~PAIN~~
Pain: Y
If Yes, Document on the Pain Assessment.
Plan of Care: CAD
Hospital Standard of Care: Y
Care Area Intervention Set+: PCU CARDIAC CARE
Age Appropriate Standards+: A.ADULT ADULT - AGE 18-65 YRS
~~~~~~~~BELONGINGS CHECKLIST~~~~~~~~
Clothing: Y
Shirt: Y
Sweater: N
Pants: Y
Underwear: Y
Socks/Hose: Y
Robe: N
Gown: N
Dress: N
Accessories: N
Jewelry: Y
Ring: Y
Necklace: Y
Watch: N
Bracelet: N
Other: PT IS WEARING JEWELRY
Misc.: Y
Glasses: Y
Contacts: N
Hearing Aid: N
Walker/Cane: N
Dentures: Y
Upper Plate: Y
Lower Plate: Y
Partial Bridge: N
Disposition of Belongings:
Patient: Y
~~~~~~~~

Problem Description / Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/18/08 Time: 0511 (continued)

1018 NUR: Admission History/Physical + (continued)
Medication/Other Allergies: NO KNOWN DRUG ALLERGIES
Food Allergies: NKFA NO KNOWN FOOD ALLERGIES
Latex Allergy: N
Contrast Allergy: N
Pain Indicators+: VOC
Pain Location #1+: R. LEG
Pain Description+: ACHING
Pain Intervention+: REP
Medication: NONE
Comment: PT WAS GIVEN DEMEROL IN ER AROUND 0400 HOURS.

Activity Date: 05/18/08 Time: 0545

Problem: DECREASED CARDIAC OUTPUT A
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
10000 Cardiovascular: Monitor A CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
10001 Cardiac Rhythm: Monitor A CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
Problem: CHEST PAIN: ANGINA A
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
Problem: KNOWLEDGE DEFICIT A
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
Problem: ADULT - AGE 18-65 YRS A
Potential Alteration in Normal Processes (ADL's, Safety, Life Situations) r/t Hospitalization
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness, Home Situation, Job, Life Style Changes and/or Families Inability to Cope
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
10048 Activity: as Tolerated/Ordered A CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
11690 ADL: Encourage Independence A CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
Problem: Frequently Used PCU Interventions A
These Interventions Are Frequently Used And/Or High Priority Nursing Interventions In The Cardiac Care Areas. They Are Placed in Process Interventions As A Conveience For The Nursing Staff.
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR

Activity Date: 05/18/08 Time: 0545

10011 Chest Pain: Monitor + A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
10175 Instruction: Special Nursing A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20105 Post Cath Monitor + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20120 Blood Sugar Monitor + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20160 Telemetry Monitoring + A QSHIFT CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9069 Central Line: Monitor Site/Infusion + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9135 Fluid: Restriction A CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9171 PCA: Monitor + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9351 VS: Frequent Vitals + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9355 VS: Orthostatic + A PER PROTOCOL CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
Problem: GUIDELINES FOR NURSING DOCUMENTATION A
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
11040 Meds: As Ordered A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
15001 IV Insertion/Removal + A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20140 Home Medication List + A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20145 Advance Directives Monitor + A PER PROTOCOL CP
--Two Attempts To Acquire Hard Copy For Chart Required
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20150 Emergency Contact Information + A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20300 Patient Hand Off Form + A PRN CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
20500 DVT Screening Protocol + A ONCE CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4001 VS: Monitor + A Q4HOURS CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4002 Shift Assessment + A QSHIFT CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4004 Nursing: Daily Process + A Q12H10 CP
- Create 05/18/08 0545 SKR 05/18/08 0545 SKR

Problem Description / Intervention Description / Activity Type / Occurred Date Time / Recorded Date Time by / Sts / Directions / Documented Comment / Units / From / Change

Activity Date: 05/18/08 Time: 0545

4009 Patient Reassessment + — A — QS&PRN — CP
Use this intervention for reassessment of the patient.
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4055 Notify: MD + — A — .PRN — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4065 Pain: Monitor + — A — .PRN — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4066 Pain: Reassess + — A — .PRN — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4090 Meals: Percentage Consumed + — A — TID — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4100 ADL: + — A — QS&PRN — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4110 I&O: Monitor + — A — TID — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4120 Weight + — A — DAILY — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4130 Education: + — A — DAILY — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4140 Discharge Instruction + — A — ONCE — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
4460 Critical Results Monitor + — A — .PRN — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9040 Blood Product: Administer as Ordered+ — A — .PER PROTOCOL — CP
-THIS INTERVENTION IS USED ON ALL PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9167 IV: Peripheral Monitor Site/Infusion + — A — .PER PROTOCOL — CP
Create 05/18/08 0545 SKR 05/18/08 0545 SKR
9169 IV: IV/INT Site Check — A — .PER PROTOCOL — CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Create 05/18/08 0545 SKR 05/18/08 0545 SKR

Activity Date: 05/18/08 Time: 0606

20140 Home Medication List + — A — .PRN — CP
Document 05/18/08 0606 SKR 05/18/08 0607 SKR
List All
Home Medications (except those listed above).
Include Med. Name.
Dose. Route.
& Frequency. Also Include Any
Over-The-Counter
Medicines. Herbal Remedies
Or Vitamins
Does Patient Take Any Home Medicines: Y
ASA: Y
Type+: BAYER ASA

Activity Date: 05/18/08 Time: 0606 (continued)

20140 Home Medication List + (continued)
Dose: 81MG
Dose in Last 24h: Y
Beta-Blocker: Y
Name+: LOPRESSOR
Dose: 25MG
Dose in Last 24h: Y
ACE-I: N
ARB: N
. PLAVIX 75MG ONCE A DAY
Dose In Last 24h: Y
. PRAVASTATIN 40MG ONCE A DAY IN THE EVENING
Dose In Last 24h: Y
. LISINOPRIL 20MG ONCE A DAY
Dose In Last 24h: Y
Medication History Obtained From+: PATIENT
Disposition of Meds+: KEPT WITH PATIENT

Activity Date: 05/18/08 Time: 0608

20500 DVT Screening Protocol + — A — ONCE — CP
Document 05/18/08 0608 SKR 05/18/08 0609 SKR
——DVT SCREENING PROTOCOL——
ADULTS 18 YEARS AND OLDER
Y/N
: N
OUTPATIENT: Receiving Local anesthesia/Block or Moderate Sedation Procedures.
****IF YES. STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED
==========
Y/N
: N
Patient with current orders for anticoagulant therapy or PT/PTT in therapeutic
range (NOTE: Heparin. Coumadin. Lovenox. Fragmin. and Atrixtra constitute anticoagulant therapy: ASPIRIN and PLAVIX DO NOT constitute anticoagulant therapy).
****IF YES. STOP HERE AND FILE THE ASSESSMENT****
NO PHYSICIAN OR NURSE SIGNATURE REQUIRED
==========
——RISK FACTORS (Select All That Apply)——
5 Pt. Subtotal: 0
3 Pt. Subtotal: 0
2 Pt. Subtotal: 0
1 Point Risk Factors+: AGE AGE 41-60 YEARS
1 Pt. Subtotal: 1
Total Risk Factor Points: 1

Problem Description
Intervention Description — Sts. Directions — From
Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units | Change

Activity Date: 05/18/08 Time: 0608 (continued)

20500 DVT Screening Protocol + (continued)
Based on total risk factors, select one risk category below, then indicate your choice(s).
[ ] RISK SCORE > OR = 5 -- HIGHEST RISK
Early Ambulation
Plus
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
*AND add:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at ____
[ ] Lovenox 30mg SC every 24 hours if creatinine clearance < 30ml/min BEGIN at ____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at ____
[ ] Other Therapy _____
[ ] RISK SCORE 2 - 4 -- MODERATE HIGH-RISK
Early Ambulation
Plus
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
*Also Consider:
[ ] Lovenox 40mg SC every 24 hours. BEGIN at ____
[ ] Lovenox 30mg SC every 24 hours if creatinine clearance < 30ml/min BEGIN at ____
[ ] Heparin 5000 units SC every 8 hours. BEGIN at ____
[ ] Other Therapy _____
[ ] RISK SCORE 0-1 OR PT. AT SIGNIFICANT RISK FOR BLEEDING OR CONTRAINDICATION TO
ANTICOAGULATION. REGARDLESS OF SCORE.
Early Ambulation
*Also Consider:
SCD - [] Calf Sleeve with TED hose [] Foot pumps with TED hose [] Thigh length
sleeve with TED hose [] TED hose only - Knee length [] TED hose only -Thigh length
[ ] Other Therapy _____
___Check baseline CBCD, PT, PTT now if anticoagulation orde
red.
Notify MD if platelet count is < 100,000
[ ] NO TREATMENT (Reason: _____
_____)
Physician Signature: _____
IF THE PATIENT HAS A RISK SCORE, PLEASE PRINT
PLACE IN THE PHYSICIAN ORDER SECTION OF THE CHART

1220

Problem Description
Intervention Description — Sts. Directions — From
Activity Type | Occurred Date Time by | Recorded Date Time by | Documented Comment Units | Change

Activity Date: 05/18/08 Time: 0658

Patient Notes: NURSE
- Create 05/18/08 0658 SKR 05/18/08 0658 SKR
Abnormal? N Confidential? N
PT HAS REMAINED WIHTOUT DISTRESS. WILL CONTINUE TO MONITOR TILL REPORT GIVEN TO DAY NURSE.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 0730

Patient Notes: NURSE
- Create 05/18/08 0730 FWG 05/18/08 1309 FWG
Abnormal? N Confidential? N
RECEVIED REPORT FROM OFF GOING NURSE. PT ALERT ORIENTED X3 NO C/O PAIN OR DISCOMFORT. C/O RT LEG PAIN AND MD AWARE.AM ASSESSEMENT COMPLETED SEE ASSESSEMENT CHARTING FOR DETAILS.SB NOTED ON MONITOR.WILL CONT. TO MONITOR
Note Type Description
Intervention Shift Assessment +

Activity Date: 05/18/08 Time: 0800

20160 Telemetry Monitoring + A QSHIFT CP
Document 05/18/08 0800 FWG 05/18/08 0831 FWG
----Telemetry Monitoring----
Patient Oriented To The Purpose Of The Telemetry Monitor And The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And Notify The Nurse If It Should Come Off: Y
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 05/18/08 0800 FWG 05/18/08 0831 FWG
----FALL RISK----
History of Falls, Syncope.
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs.
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0.
Sensory Deficits (1)+: 1
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N -
Use Shift F8 to View Spot the Dot

002638

6425

Problem Description
Intervention Description
Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Sts | Directions Comment | Documented Units | From Change

Activity Date: 05/18/08 Time: 0800

4002 Shift Assessment + A QSHIFT CP
Document 05/18/08 0800 FWG 05/18/08 0829 FWG
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: COMPLEX
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Telemetry Box Number: 8719
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: N
Right Dorsalis Pedis+: 1
Right Posterior Tibial+: 2
Right Radial+: 3
Left Dorsalis Pedis+: 1
Left Posterior Tibial+: 2
Left Radial+: 3
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: UNLABORED
NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLOUDY
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4

Activity Date: 05/18/08 Time: 0800 (continued)

4002 Shift Assessment + (continued)
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: NORMAL
Skin Integrity+: INTACT
~~~Skin Integrity~~~
Sensory Perception+: 3 SLIGHTLY LIMITED
Activity+: 3 WALKS OCCASIONALLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 20
~~PAIN~~
Pain: Y
If Yes, Document on the Pain Assessment.
Pain Indicators+: VOC
Pain Location #1+: R. LEG
Pain Description+: SHARP
Frequency+: CONSTANT
4004 Nursing: Daily Process + A Q12H10 CP
Document 05/18/08 0800 FWG 05/18/08 0830 FWG
Code Status+: FULL CODE
HIPAA Passcode: 1298
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe', elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y

Problem Description
Intervention Description — Sts — Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 05/18/08 Time: 0800 (continued)

4004 Nursing: Daily Process + (continued)
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: N
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC DISEASE
RETURN ADL
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~~
~~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~~
Pt Education/Discharge Folder Updated: Y
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT
4130 Education: + A DAILY CP
Document 05/18/08 0800 FWG 05/18/08 0831 FWG
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: SAFETY ISSUES
MEDICATIONS
Information Taught: TO CALL FOR PAIN OR DISCOMFORT.CALL LIGHT
WITHIN REACH AND REVIEWED .
Outcome+: VERBALIZE UNDERSTANDING
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 05/18/08 0800 FWG 05/18/08 0831 FWG

Activity Date: 05/18/08 Time: 1042

4001 VS: Monitor + A Q4HOURS CP
Document 05/18/08 1042 CND 05/18/08 1043 CND
Blood Pressure: 156/65

Problem Description
Intervention Description — Sts — Directions — From
Activity Type — Occurred Date Time by — Recorded Date Time by — Documented Comment Units — Change

Activity Date: 05/18/08 Time: 1042 (continued)

4001 VS: Monitor + (continued)
Pulse: 70
Respirations: 18
Temperature: 98.7
SPO2 (%): 94
On Room Air: Y
LPM O2

Activity Date: 05/18/08 Time: 1046

4100 ADL: + A QS&PRN CP
Document 05/18/08 1046 CND 05/18/08 1049 CND
~~~~ACTIVITIES OF DAILY LIVING~~~~
Activity+: AD LIB
Feeding Method+: SELF
Bathing+: SELF
Oral Hygiene+: SELF
Urinary Incontinence: N
Perineal Care: N
Fecal Incontinence: N
Skin Care: N
Catheter: N
Bed Linen Changed: N
Turned Q 2hrs: SELF
Comment: PATIENT ADMITED IN EARLY MORNING
1) The staff will encourage the patient to be independent
throughout his/her hospitalization.
2) The staff will evaluate the patients ability to perform
tasks.
3) The staff will encourage patient participation in ADL's
and participation will be monitored.
4) The staff will provide extra time to complete tasks
as needed.

Activity Date: 05/18/08 Time: 1200

20160 Telemetry Monitoring + A QSHIFT CP
Document 05/18/08 1200 FWG 05/18/08 1244 FWG
~~~~Telemetry Monitoring~~~~
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
Document 05/18/08 1200 FWG 05/18/08 1244 FWG
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:

Problem Description
Intervention Description — Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Documented Comment Units | From Change

Activity Date: 05/18/08 Time: 1200 (continued)

4009 Patient Reassessment + (continued)
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: N
| N
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~

4065 Pain: Monitor + — A .PRN — CP
Document 05/18/08 1200 FWG 05/18/08 1948 FWG
Pain Indicators+: VOC
Pain Scale: 5
Pain Location #1+: RT GROIN
Pain Description+: NAGGING
Frequency+: INTERMITT
Pain Intervention+: MED
Medication: DEMORAL 50 MG IVP

9169 IV: IV/INT Site Check — A .PER PROTOCOL — CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
Document 05/18/08 1200 FWG 05/18/08 1244 FWG

Activity Date: 05/18/08 Time: 1300

4066 Pain: Reassess + — A .PRN — CP
Document 05/18/08 1300 FWG 05/18/08 1949 FWG
Pain Location #1+: RT GROIN
Previous Pain Level: 5
One Hour Pain Reassessment Level: 2
Pt. Asleep: N

Activity Date: 05/18/08 Time: 1336

4110 I&O: Monitor + — A TID — CP
Document 05/18/08 1336 CND 05/18/08 1339 CND
<>INTAKE<>

Activity Date: 05/18/08 Time: 1336 (continued)

4110 I&O: Monitor + (continued)
Oral: 840
<>OUTPUT<>
Urine: 600
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 05/18/08 Time: 1354

4090 Meals: Percentage Consumed + — A TID — CP
Document 05/18/08 1354 CND 05/18/08 1354 CND
Breakfast(%)+: 0
Lunch(%)+: 25

Activity Date: 05/18/08 Time: 1505

4001 VS: Monitor + — A Q4HOURS — CP
Document 05/18/08 1505 CND 05/18/08 1507 CND
Blood Pressure: 131/60
Pulse: 59
Respirations: 18
Temperature: 98.1
SPO2 (%): 98
On Room Air: Y
LPM O2

Activity Date: 05/18/08 Time: 1725

20160 Telemetry Monitoring + — A QSHIFT — CP
Document 05/18/08 1725 FWG 05/18/08 1725 FWG
~~~Telemetry Monitoring~~~
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y

4009 Patient Reassessment + — A QS&PRN — CP
Use this intervention for reassessment
of the patient.
Document 05/18/08 1725 FWG 05/18/08 1725 FWG
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N

Problem Description
Intervention Description — Sts Directions — From
Activity Type | Occurred Date Time | Recorded by Date Time | Documented by Comment Units | Change

Activity Date: 05/18/08 Time: 1725 (continued)

4009 Patient Reassessment + (continued)
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: N
| N
~~~~CARDIOVASCULAR~~~~
Pulses
~~~~GASTROINTESTINAL~~~~
~~~~GENITOURINARY~~~~
~~~~INTEGUMENT~~~~
~~~~MUSCULOSKELETAL~~~~
~~~~NEUROLOGICAL~~~~
~~~~RESPIRATORY~~~~
9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 05/18/08 1725 FWG 05/18/08 1725 FWG

Activity Date: 05/18/08 Time: 1759

4001 VS: Monitor + A Q4HOURS CP
- Document 05/18/08 1759 DLM 05/18/08 1857 DLM
Blood Pressure: 130/46
Pulse: 60
Respirations: 18
Temperature: 98.4
SPO2 (%): 97
On Room Air: Y
LPM O2

Activity Date: 05/18/08 Time: 1800

4065 Pain: Monitor + A .PRN CP
- Document 05/18/08 1800 FWG 05/18/08 1944 FWG
Pain Indicators+: VOC
Pain Scale: 5
Pain Location #1+: RT GROIN
Pain Description+: NAGGING
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: PERCOCET TWO TABS

Activity Date: 05/18/08 Time: 1857

4090 Meals: Percentage Consumed + A TID CP
- Document 05/18/08 1857 DLM 05/18/08 1857 DLM
Dinner(%)+: 25

Activity Date: 05/18/08 Time: 1900

4066 Pain: Reassess + A .PRN CP
- Document 05/18/08 1900 FWG 05/18/08 1945 FWG
Pain Location #1+: RT GROIN
Previous Pain Level: 5
One Hour Pain Reassessment Level: 2
Pt. Asleep: Y

Activity Date: 05/18/08 Time: 1935

Patient Notes: NURSE
- Create 05/18/08 1935 GJB 05/19/08 0411 GJB
Abnormal? N Confidential? N
RECEIVED REPORT AND TRANSFER OF CARE FROM F. GUDDAYE RN. PATIENT LYING IN BED VISITING WITH FAMILY MEMBERS WHO ARE @ THE BEDSIDE. # 20 JELCO INTACT TO LFA. NO REDNESS OR EDEMA NOTED. DENIES ANY PAION OR DISCOMFORT @ PRESENT.
Note Type Description
No Type None

Activity Date: 05/18/08 Time: 1939

Patient Notes: NURSE
- Create 05/18/08 1939 FWG 05/18/08 1940 FWG
Abnormal? N Confidential? N
Patient voicing no complaints. Condition stable, no new problems, vital signs stable, and resting quietly at present. No change in condition from previous assessment.FAMILY AT BED SIDE NO C/O PAIN OR DISCOMFORT AND REPORTED TO ON COMING NURSE
Note Type Description
Intervention Patient Reassessment +

Activity Date: 05/18/08 Time: 2115

4002 Shift Assessment + A QSHIFT CP
- Document 05/18/08 2115 GJB 05/19/08 0336 GJB
~~~~NEUROLOGICAL~~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE
Pattern of Movement+: SPONTANE
Cognition+: COMPLEX
~~~~CARDIOVASCULAR~~~~
Heart Sounds+: REG S1-S2
EKG Rhythm+: SR
Telemetry Box Number: 8719
Capillary Refill < 3 sec in All Extremities: Y
~~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/18/08 Time: 2115 (continued)

4002 Shift Assessment + (continued)
Pulses
Pulses 3+ or > Palp in All Extremities: N
Right Dorsalis Pedis+: 1
Right Posterior Tibial+: 2
Right Radial+: 3
Left Dorsalis Pedis+: 1
Left Posterior Tibial+: 2
Left Radial+: 3
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
----RESPIRATORY----
Respirations+: UNLABORED
NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
----GASTROINTESTINAL----
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
----GENITOURINARY----
Incontinence: N
Ileoconduit: N
Urine+: CLOUDY
Color+: YELLOW
Foley: N
----MUSCULOSKELETAL----
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
----INTEGUMENT----
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: NORMAL
Skin Integrity+: INTACT
----Skin Integrity----
Sensory Perception+: 3 SLIGHTLY LIMITED
Activity+: 3 WALKS OCCASIONALLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS

1225

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/18/08 Time: 2115 (continued)

4002 Shift Assessment + (continued)
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 20
--PAIN--
If Yes, Document on the Pain Assessment.
4004 Nursing: Daily Process + A Q12H10 CP
Document 05/18/08 2115 GJB 05/19/08 0402 GJB
Code Status+: FULL CODE
HIPAA Passcode: 1298
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe' elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: Y
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC DISEASE
RETURN ADL
In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
----EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY----
----DOCUMENT ON THE EDUCATION INTERVENTION----
Pt Education/Discharge Folder Updated: Y

002643

6430

Problem Description
Intervention Description | Activity Type | Occurred Date Time by | Recorded Date Time by | Sts | Directions / Documented / Comment / Units | From / Change

Activity Date: 05/18/08 Time: 2115 (continued)

4004 Nursing: Daily Process + (continued)
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 05/18/08 2115 GJB 05/19/08 0404 GJB

Activity Date: 05/18/08 Time: 2140

4065 Pain: Monitor + A .PRN CP
- Document 05/18/08 2140 GJB 05/19/08 0413 GJB
Pain Indicators+: VOC
Pain Scale: 8
Pain Location #1+: RT GROIN
Pain Description+: NAGGING
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DEM 50MG/ PHEN 12.5

Activity Date: 05/18/08 Time: 2245

4066 Pain: Reassess + A .PRN CP
- Document 05/18/08 2245 GJB 05/19/08 0422 GJB
Pain Location #1+: RT GROIN
Previous Pain Level: 8
One Hour Pain Reassessment Level: 0
Pt. Asleep: Y
Additional Pain Medication Administered: N

Activity Date: 05/19/08 Time: 0000

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 05/19/08 0000 GJB 05/19/08 0404 GJB

Activity Date: 05/19/08 Time: 0019

4001 VS: Monitor + A Q4HOURS CP
- Document 05/19/08 0019 WNM 05/19/08 0022 WNM
Blood Pressure: 132/46
Pulse: 56
Respirations: 19
Temperature: 97.8

Activity Date: 05/19/08 Time: 0019 (continued)

4001 VS: Monitor + (continued)
SPO2 (%): 97
LPM O2

Activity Date: 05/19/08 Time: 0033

4110 I&O: Monitor + A TID CP
- Document 05/19/08 0033 WNM 05/19/08 0035 WNM
<>INTAKE<>
Oral: 120
<>OUTPUT<>
Urine: 300
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 05/19/08 Time: 0102

4120 Weight + A DAILY CP
- Document 05/19/08 0102 WNM 05/19/08 0103 WNM
Weight - Lb: 155
Kg: 70.30
Weight Source+: STANDING SCALE

Activity Date: 05/19/08 Time: 0330

4066 Pain: Reassess + A .PRN CP
- Document 05/19/08 0330 GJB 05/19/08 0423 GJB
Pain Location #1+: RT GROIN
Previous Pain Level: 6
One Hour Pain Reassessment Level: 0
Pt. Asleep: Y
Additional Pain Medication Administered: N

Activity Date: 05/19/08 Time: 0400

9169 IV: IV/INT Site Check A .PER PROTOCOL CP
-IV:Medication Fluids Q1 Hour
-IV:Maintenance Fluids Q2 Hour
-IV:INT Q4 Hour
- Document 05/19/08 0400 GJB 05/19/08 0404 GJB

Activity Date: 05/19/08 Time: 0430

4009 Patient Reassessment + A QS&PRN CP
Use this intervention for reassessment
of the patient.
- Document 05/19/08 0430 GJB 05/19/08 0733 GJB
Any Change From Patient Shift Assessment: N
Neurological System:
Change: N

Problem Description
Intervention Description
Activity Type | Occurred Date Time | Recorded Date Time by | Documented Comment Units | Sts | Directions | From Change

Activity Date: 05/19/08 Time: 0430 (continued)

4009 Patient Reassessment + (continued)
Cardiovascular System:
Change: N
Respiratory System:
Change: N
Gastrointestinal System:
Change: N
Genitourinary System:
Change: N
Musculoskeletal System:
Change: N
Integumentary System:
Change: N
Document Nurse's Notes: N
~~~CARDIOVASCULAR~~~
Pulses
~~~GASTROINTESTINAL~~~
~~~GENITOURINARY~~~
~~~INTEGUMENT~~~
~~~MUSCULOSKELETAL~~~
~~~NEUROLOGICAL~~~
~~~RESPIRATORY~~~

Activity Date: 05/19/08 Time: 0615

4001 VS: Monitor + A Q4HOURS CP
Document 05/19/08 0615 WNM 05/19/08 0619 WNM
Blood Pressure: 118/50
Pulse: 62
Respirations: 20
Temperature: 98.2
LPM O2

Activity Date: 05/19/08 Time: 0630

4110 I&O: Monitor + A TID CP
Document 05/19/08 0630 WNM 05/19/08 0636 WNM
<>INTAKE<>
Oral: 240
<>OUTPUT<>
Urine: 425
<>DRAINS<>
Kgs.
Kgs.

Activity Date: 05/19/08 Time: 0645

4065 Pain: Monitor + A PRN CP
Document 05/19/08 0645 GJB 05/19/08 0733 GJB
Pain Indicators+: VOC
Pain Scale: 6

Activity Date: 05/19/08 Time: 0645 (continued)

4065 Pain: Monitor + (continued)
Pain Location #1+: RT GROIN
Pain Description+: NAGGING
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: DEM 50MG/ PHEN 12.5

Activity Date: 05/19/08 Time: 0730

20160 Telemetry Monitoring + A QSHIFT CP
Document 05/19/08 0730 DAH 05/19/08 0851 DAH
~~~Telemetry Monitoring~~~
Patient Oriented To The Purpose Of The Telemetry Monitor And
The Importance Of Keeping It On
Patient Instructed To Keep The Monitor On At All Times And
Notify The Nurse If It Should Come Off: Y
20125 Fall Precautions + A EVERYDAY CP
-Place RED Sticker on Pt Chart and
Armband and Pt Door
-Place "Fall Protocol" Sign in Pt Room
Document 05/19/08 0730 DAH 05/19/08 0851 DAH
~~~FALL RISK~~~
History of Falls, Syncope,
Orthostatic BP, Arrythmia (2)+: 0
History of/or Confusion
Or Intermittant Confusion (2)+: 0
Right / Left Sided Neglect (1)+: 0
Impaired Mobility (1)+: 0
Age > 70 Years of Age (1)+: 0
Receiving LOC Altering Drugs,
Laxatives or Diuretics (1)+: 0
Incontinence (1)+: 0
Sensory Deficits (1)+: 1
TOTAL POINTS: 1
IMPLEMENT THE FALL PROTOCOL IF TOTAL SCORE = OR > 2
Spot the Dot Implemented: N
Use Shift F8 to View Spot the Dot
Education: Pt/family teaching provided for Fall Prevention: Y
Comment: PT ENCOURAGED TO USE CALL LIGHT FOR ASSISTANCE
4002 Shift Assessment + A QSHIFT CP
Document 05/19/08 0730 DAH 05/19/08 0850 DAH
~~~NEUROLOGICAL~~~
Level of Responsiveness+: A/OX3
Pupil Size L (mm): 2
Pupil Reaction Left+: REACT
Pupil Size R (mm): 2
Pupil Reaction Right+: REACT
Right Grip+: STRONG
Left Grip+: STRONG
Speech+: APPROP
Tongue Position+: MIDLINE

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/19/08 Time: 0730 (continued)

4002 Shift Assessment + (continued)
Pattern of Movement+: SPONTANE
Cognition+: COMPLEX
~~~CARDIOVASCULAR~~~
Heart Sounds+: REG S1-S2
MURMUR
EKG Rhythm+: SB
Telemetry Box Number: 8719
Capillary Refill < 3 sec in All Extremities: Y
Pulses
Pulses 3+ or > Palp in All Extremities: N
Right Dorsalis Pedis+: 1
Right Radial+: 3
Left Dorsalis Pedis+: 1
Left Radial+: 3
JVD: N
Peripheral Edema: N
ICD: N
Permanent Pacemaker: N
Temp Pacemaker N
~~~RESPIRATORY~~~
Respirations+: UNLABORED
NORMAL
Breath Sounds Clear X4: Y
Cough+: NONE
Chest Tubes: N
~~~GASTROINTESTINAL~~~
Abdomen+: SOFT
Tender on Palpation: N
Bowel Sounds Active X 4: Y
NG/Feeding/PEG Tube: N
~~~GENITOURINARY~~~
Incontinence: N
Ileoconduit: N
Urine+: CLOUDY
Color+: YELLOW
Foley: N
~~~MUSCULOSKELETAL~~~
Extremity Movement+: X4
Muscle Contractures+: NONE
Muscle Cramping+: NONE
Muscle Spasms+: NONE
Splint/Support: N
SCD's On: N
TED HOSE: N
~~~INTEGUMENT~~~
Skin Temp+: WARM
Moisture+: DRY
Color+: NORMAL
Turgor+: NORMAL
Skin Integrity+: INTACT

Problem Description
Intervention Description
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/19/08 Time: 0730 (continued)

4002 Shift Assessment + (continued)
~~~Skin Integrity~~~
Sensory Perception+: 3 SLIGHTLY LIMITED
Activity+: 3 WALKS OCCASIONALLY
Nutrition+: 3 ADEQUATE
Moisture+: 4 RARELY MOIST
Mobility+: 4 NO LIMITATIONS
Friction+: 3 NO APPARENT PROBLEM
Braden Score (18 or less at Risk): 20
~~PAIN~~
Pain: N
If Yes, Document on the Pain Assessment.
Document Nurse's Notes: N
4004 Nursing: Daily Process + A Q12H10 CP
Document 05/19/08 0730 DAH 05/19/08 0851 DAH
Code Status+: FULL CODE
HIPAA Passcode: 1298
Patient on Isolation+: STANDARD
Mission/Value Statement (as evidenced by): Y
Introduced Yourself & Identified Primary Care Physician
Call Pt by Requested Name respect/safety goal
Appropriate Use of Touch
Sit/Stand by the bedside with Pt for 5 minutes
HIPPA Confidentiality/Privacy/Maintenance
of Personal Dignity
(as evidenced by, but not limited to): Y
Knocking on Closed Door
Curtains/Doors Closed during Exams/Procedures
No Records in ACCESS or View of Unauthorized Persons
Gown on Appropriately
Bedridden Patient Covered
NO Pt info on Boards/ROOM Doors
No Personal information over Phone
No discussion of PHI in hall, cafe', elevators...
Patient Safety/Risk Management (Ongoing)
(as evidenced by, but not limited to): Y
Call Bell Within Reach and Working
Care Items in Reach
Bed Locked/Lowest Position
Side Rails Up+: X2
Rubber Sole Slippers (Part of Fall Prevention Protocol)
Bed Alarms Working if applicable
Identification Band On: Y
(Two forms of identification have been identified before
placing ID band on the patient/
or giving any medication/ blood)
Allergy Band On: N
Blood Bank Band On: Y
Clinical Practice Guidelines (Care Maps)
Choose Care Maps Pt on/Hospital Day/Care Map Day
Daily Established Priorities Based Upon Established Goals CARDIAC DISEASE
~~~

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/19/08 Time: 0730 (continued)

4004 Nursing: Daily Process + (continued)
RETURN ADL
MEDICATION EDUCATION

In The Plan Of Care+:
Daily Required Documentation
Physician/PA/NP Visit Daily (every 24 hours): Y
Education Documentation: Y
~~~~EDUCATION DOCUMENTATION MUST BE DOCUMENTED DAILY~~~~
~~~~DOCUMENT ON THE EDUCATION INTERVENTION~~~~
Pt Education/Discharge Folder Updated: N
Reinforce safety issues and changes in Plan of Care
to family/ patient: Y
Report Changes to the Plan of Care with oncoming nurse: Y
Plan of Care (change status of goals/interventions
and ADD new ones as needed): Y
Plan of Care Reviewed with+: PATIENT
9167 IV: Peripheral Monitor Site/Infusion + A .PER PROTOCOL CP
- Document 05/19/08 0730 DAH 05/19/08 0851 DAH
Type of IV Access+: INT
IV Site #1+: LEFT FOREARM
IV Size+: 20G
Appearance Site #1+: NSI
Insertion Date: 05/18/08
Dressing+: OCCLUSIVE
IV Med #1: NONE
IV Changed: N
Change Due: 05/21/08
Patient Notes: NURSE
- Create 05/19/08 0730 DAH 05/19/08 0802 DAH
Abnormal? N Confidential? N
RECEIVED REPORT FROM GLORIA BROWN, RN.
Note Type Description
No Type None

Activity Date: 05/19/08 Time: 0734

Patient Notes: NURSE
- Create 05/19/08 0734 GJB 05/19/08 0737 GJB
Abnormal? N Confidential? N
No further changes in assessment. No injury this shift. All lines, drains, dressings checked per protocol. Report and care transferred to A. Hanna RN.
Note Type Description
No Type None

Activity Date: 05/19/08 Time: 0800

4065 Pain: Monitor + A .PRN CP
Document 05/19/08 0800 DAH 05/19/08 1058 DAH
Pain Indicators+: VOC
Pain Scale: 6
Pain Location #1+: RT GROIN

Problem Description
Intervention Description
Activity Type | Occurred Date Time by | Recorded Date Time by | Sts Comment | Directions Documented Units | From Change

Activity Date: 05/19/08 Time: 0800 (continued)

4065 Pain: Monitor + (continued)
Pain Description+: NAGGING
Frequency+: CONSTANT
Pain Intervention+: MED
Medication: PERCOCET 2 TABS

Activity Date: 05/19/08 Time: 0900

4066 Pain: Reassess + A .PRN CP
Document 05/19/08 0900 DAH 05/19/08 1104 DAH
Pain Location #1+: RT GROIN
Previous Pain Level: 6
One Hour Pain Reassessment Level: 0
Additional Pain Medication Administered: N
Physician Notified of Unrelieved Pain: N
4130 Education: + A DAILY CP
- Document 05/19/08 0900 DAH 05/19/08 1104 DAH
Person(s) Taught+: PATIENT
Readiness to Learn+: DEMONSTRATES INTEREST
Teaching Method(s)+: VERBAL
TOPIC(S)+: SAFETY ISSUES
MEDICATIONS
Information Taught: MED DOSE, SCHEDULE, AND PURPOSE
USE CALL LIGHT
Outcome+: VERBALIZE UNDERSTANDING

Activity Date: 05/19/08 Time: 1051

4140 Discharge Instruction + A ONCE CP
- Document 05/19/08 1051 DAH 05/19/08 1054 DAH
Patient Discharge Instructions
Please Bring Copy To Office With You
Diet: LOW FAT,CHOL,SODIUM
Enter/Edit/View Notes: Y
Use F4 - F9 to Access DISCHARGE Notes.
Follow-Up Appointment: SEE DR LAWTON JUNE 16, 2008 AT 2:30 PM,
Call Doctor's Office: 744-4900
Exercise or Special Limitations
: AS TOLERATED
Dressing, Treatment, Special Equipment
Special Instructions
: NOTIFY PHYSICIAN IF SYMPTOMS RETURN OR BECOME WORSE
Tobacco Use+: REF SMOKER
Smoking Cessation Information Provided+: Y
Pt. has 'A Patient's Guide to Safety' in possession at disch
arge: Y
All Teaching Information Given to the Pt is in Folder: Y
Interdisciplinary Discharge Medication
List Given To Pt/Family
Pt or Family Recieved the Following Items
Valuables Brought to Hospital Returned+: Y

Problem Description
Intervention Description — Sts Directions — From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Activity Date: 05/19/08 Time: 1051 (continued)

4140 Discharge Instruction + (continued)
Clothing brought to Hospital Returned+: Y
I Have Received a Copy of Both My Discharge Medication List
and My Discharge Plan of Care.
**
Pt/SO Signature:_____
Date:_____
***** These Numbers are Provided for your Convenience *****
MAIN CAMPUS NORTHEAST CAMPUS
Lost and Found - 256-5690
Lost and Found - 865-4690
Patient Financial Services - 256-5505
Patient Financial Services - 865-5816
Medical Records - 256-5302
Medical Records - 865-4680
Patient Advocate - 256-5739
Patient Advocate - 256-5739
Stop Using Tobacco In Any Form. It Has Been Shown To Reduce
Healing. No Smoking!
Call Your Physician If You Have Worsening Symptoms.
If You Have Heart Failure - Weigh Yourself Daily And Write
It Down. Call Your Physician
If You Gain 2-3 Lbs. Overnight
Or Over A 1-2 Day Period.
********** NURSING DISCHARGE CHECKLIST **********
Discharge Instructions 1 +: OTHER
Mode of Discharge+: WC
Discharged To+: HOME
Accompanied By+: FAMILY
Person Responsible for Patient+: SELF
IV/INT Removed: Y
Electrodes Removed: Y
Telemetry Monitor Returned: Y
Narcotic Analgesic was Given within 6 hours Prior to
Discharge. Notify Attending Physician.
Pneumovax Given: N
Flu Vaccine Given: N
Aspirin Prescribed at Discharge: Y
Beta Blocker Prescribed at Discharge: Y
ACE-Inhibitor Prescribed at Discharge: Y
ARB Prescribed At Discharge: N
All Patient Outcomes Are Met: Y
If Not, Follow Up Plans Are+: FOLLOW MD
Able to Perform ADL's: Y
Patient Notes: NURSE
- Create 05/19/08 1051 DAH 05/19/08 1052 DAH
Abnormal? N Confidential? N
NOTIFY PHYSICIAN IF SYMPTOMS RETURN OR BECOME WORSE
Note Type Description
No Type None

1270

Problem Description
Intervention Description — Sts Directions — From
Activity Occurred Recorded Documented
Type Date Time by Date Time by Comment Units Change

Activity Date: 05/19/08 Time: 1103

Patient Notes: NURSE
- Create 05/19/08 1103 DAH 05/19/08 1103 DAH
Abnormal? N Confidential? N
REVIEWED DC PAPERS WITH PT. SHE IS TRYING TO GET SOMEONE ON THE PHONE TO GIVE
HER A RIDE HOME.
Note Type Description
No Type None

Activity Date: 05/19/08 Time: 1216

1018 NUR: Admission History/Physical + D ONCE AS
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
Problem: DECREASED CARDIAC OUTPUT D
- Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
10000 Cardiovascular: Monitor D CP
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
10001 Cardiac Rhythm: Monitor D CP
- Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
Problem: CHEST PAIN: ANGINA D
- Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
Problem: KNOWLEDGE DEFICIT D
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
Problem: ADULT - AGE 18-65 YRS D
Potential Alteration in Normal Processes
(ADL's, Safety, Life Situations) r/t
Hospitalization
1. Denial of Obvious Problem/Weaknesses
2. Projection of Blame/Responsibility
3. Personal Vulnerability r/t Loss of
Control of Loss Situation
4. Unrealistic Perceptions
5. Multiple Stressors r/t Illness, Home
Situation, Job, Life Style Changes
and/or Families Inability to Cope
- Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
10048 Activity: as Tolerated/Ordered D CP
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
11690 ADL: Encourage Independence D CP
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
Problem: Frequently Used PCU Interventions D
These Interventions Are Frequently Used
And/Or High Priority Nursing
Interventions In The Cardiac Care Areas.
They Are Placed in Process Interventions
As A Conveience For The Nursing Staff.
- Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D
10011 Chest Pain: Monitor + D PRN CP
Ed Status 05/19/08 1216 his 05/19/08 1216 his A => D

002648

6435

Activity Date: 05/19/08 Time: 1216

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions / Documented Units	From / Change
10175 Instruction: Special Nursing							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20105 Post Cath Monitor +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20120 Blood Sugar Monitor +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20160 Telemetry Monitoring +							D	QSHIFT	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9069 Central Line: Monitor Site/Infusion +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9135 Fluid: Restriction							D		CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9171 PCA: Monitor +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9351 VS: Frequent Vitals +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9355 VS: Orthostatic +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
Problem: GUIDELINES FOR NURSING DOCUMENTATION							D		
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
11040 Meds: As Ordered							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
15001 IV Insertion/Removal +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20125 Fall Precautions +							D	EVERYDAY	CP
-Place RED Sticker on Pt Chart and Armband and Pt Door									
-Place "Fall Protocol" Sign in Pt Room									
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20140 Home Medication List +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20145 Advance Directives Monitor +							D	.PER PROTOCOL	CP
--Two Attempts To Acquire Hard Copy For Chart Required									
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20150 Emergency Contact Information +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20300 Patient Hand Off Form +							D	PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
20500 DVT Screening Protocol +							D	ONCE	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4001 VS: Monitor +							D	Q4HOURS	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4002 Shift Assessment +							D	QSHIFT	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4004 Nursing: Daily Process +							D	Q12H10	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4009 Patient Reassessment +							D	QS&PRN	CP
Use this intervention for reassessment of the patient.									
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D

Activity Date: 05/19/08 Time: 1216

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Directions / Documented Units	From / Change
4055 Notify: MD +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4065 Pain: Monitor +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4066 Pain: Reassess +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4090 Meals: Percentage Consumed +							D	TID	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4100 ADL: +							D	QS&PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4110 I&O: Monitor +							D	TID	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4120 Weight +							D	DAILY	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4130 Education: +							D	DAILY	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4140 Discharge Instruction +							D	ONCE	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
4460 Critical Results Monitor +							D	.PRN	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9040 Blood Product: Administer as Ordered+							D	.PER PROTOCOL	CP
-THIS INTERVENTION IS USED ON ALL PATIENTS RECEIVING BLOOD/BLOOD PRODUCTS									
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9167 IV: Peripheral Monitor Site/Infusion +							D	.PER PROTOCOL	CP
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D
9169 IV: IV/INT Site Check							D	.PER PROTOCOL	CP
-IV:Medication Fluids Q1 Hour									
-IV:Maintenance Fluids Q2 Hour									
-IV:INT Q4 Hour									
- Ed Status	05/19/08	1216	his	05/19/08	1216	his			A => D

Activity Date: 05/19/08 Time: 1443

8006 PASTOR: Volunteer Visit +							A		PS
- Create	05/19/08	1443	DJB	05/19/08	1443	DJB			
- Document	05/19/08	1443	DJB	05/19/08	1443	DJB			

Volunteer+: RUTH JENKINS
Visited
Patient: Y
Interventions
Pastoral Care Information Brochure given: Y

Activity Date: 05/22/08 Time: 1533

8006 PASTOR: Volunteer Visit +							D		PS
- Ed Status	05/22/08	1533	his	05/22/08	1533	his			A => D

Monogram	Initials	Name	Nurse Type
AMA	ARMSTRAM	ARMSTRONG,AUTUMN M	RN

1231

002649

6436

Monogram	Initials	Name	Nurse Type
CDH	HUSBANCD	HUSBAND,CONNIE D	RNBP
CND	DUPREECN	DUPREE,CLARRISSA N	NTI
CRB	BROWNCR	BROWN,CHRISTINE R	RN
DAH	HANNADA	HANNA,DEE A	RN
DJB	BURTONDJ	BURTON,DEBRA J	CHAP
DLM	MIDDLEDL	MIDDLETON,DOROTHY L	NTI
FWG	GUDDAYFW	GUDDAYE,FENTANESH W	RN
GJB	BROWNGJ	BROWN,GLORIA J	RNPD
SKR	RISHSK	RISH,SARAH K	RN
WNM	MACKWN	MACK,WILLIE N	PCT
his		automatic by program	

1232

002650

6437

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I. NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE) MALE ☐ FEMALE ☐ DATE OF BIRTH _____ YR. _____ MO. _____ DAY PLACE OF BIRTH _____ TOWN _____ STATE NATIONALITY _____ CODE ☐

DATE	LOCAL ADDRESS*	PHONE*	DATE OF ATTENDANCE*	NAME OF SCHOOL*
72-73	Pierson, S.D.	—	8-30-71	Johnsonville Elem

II. DROP-OUT AND RE-ENTRY RECORD

DATE	SCHOOL AND GRADE LEFT	REASON	DATE RE-ENTERED	SCHOOL AND GRADE RE-ENTERED
1-13-72	Johnsonville Elem	moved		

IV. PHOTOGRAPH

1971-72

DATE 1-19-71
AGE 6
GRADE 1

III. FAMILY DATA

	MOTHER	FATHER
NAME OF PARENTS*		
HOME ADDRESS*		
NATIONAL DESCENT		
DATE NATURALIZED		
LANGUAGE IN HOME		
OCCUPATION*		
EDUCATION*		
MARITAL STATUS*		
DECEASED		
WITH WHOM DOES CHILD RESIDE*		

CODE FOR REASONS FOR LEAVING SCHOOL

TR—TRANSFERRED EP—EMPLOYMENT PERMIT D—DEAD

PI—PERMANENT ILLNESS OA—OVER LEGAL AGE M—MARRIED

DATE AND GRADE RECORD STARTED 8-30-71

NUMBER CHILDREN IN FAMILY* 4

BOYS* 2 GIRLS* 2

REMARKS REGARDING HOME CONDITIONS:

DATE	

V. ELEMENTARY SCHOOL RECORD

	YEAR		71-72		72-73											
	SUBJECTS	KDG.	Backus 1st Grade Mid-Year		Backus 1st Grade		GRADE		GRADE		GRADE		GRADE		GRADE	
AR	ARITHMETIC		D+	D	B+	C+										
ENGLISH	READING		D	C-	C+	C										
	LANGUAGE GRAMMAR		D	D-	B	C										
	HANDWRITING		D	D	B	C										
	SPELLING															
SOCIAL STUDIES	S.S.		C	C	B	C+										
SCIENCE	GENERAL SCIENCE					C+										
	AGRICULTURE															
	PHYSIOLOGY HYGIENE		D+		B-											
ARTS AND CRAFTS	HOUSEHOLD ARTS															
	INDUSTRIAL ARTS															
	ART															
	MUSIC															
DAYS PRESENT			75	83	97	80										
DAYS ABSENT			6	7	3	5										
TIMES TARDY																
REMARKS																

VI. SECONDARY SCHOOL RECORD

YEAR 7TH GRADE					YEAR 8TH GRADE					YEAR GRADE				
WEEKS IN SCHOOL YEAR ____ SUBJECTS	MARK 1ST	MARK 2ND	UNITS		WEEKS IN SCHOOL YEAR ____ SUBJECTS	MARK 1ST	MARK 2ND	UNITS		WEEKS IN SCHOOL YEAR ____ SUBJECTS	MARK 1ST	MARK 2ND	UNITS	
UNITS FOR THE YEAR					UNITS FOR THE YEAR					UNITS FOR THE YEAR				
HALF DAYS ABSENT					HALF DAYS ABSENT					HALF DAYS ABSENT				

YEAR GRADE						YEAR GRADE						YEAR GRADE				
WKS. IN SCH. YR. ____ SUBJECTS	HRS. PER WEEK	MARK 1ST	MARK 2ND	UNITS	POINTS	WKS. IN SCH. YR. ____ SUBJECTS	HRS. PER WEEK	MARK 1ST	MARK 2ND	UNITS	POINTS	WKS. IN SCH. YR. ____ SUBJECTS	HRS. PER WEEK	MARK 1ST	MARK 2ND	UNITS
UNITS AND POINTS FOR YEAR						UNITS AND POINTS FOR YEAR						UNITS AND POINTS FOR YEAR				
UNITS AND POINTS TO DATE						UNITS AND POINTS TO DATE						UNITS AND POINTS TO DATE				

PLAINTIFF'S EXHIBIT 31 DEFENDANTS' EXHIBIT KS 8-10-12

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DATE	GRADE	ACHIEVEMENT TESTS	C. A.	SCORE	NORM.

WKS. IN SCH. YR. ___ SUBJECTS	HRS. PER WEEK	MARK 1ST	MARK 2ND	UNITS	POINT	WKS. IN SCH. YR. ___ SUBJECTS	HRS. PER WEEK	MARK 1ST	MARK 2ND	UNITS	POINT

TYPE SCORE	DATE	GRADE	FM	TEST	BAT	OTHER INFO.	NORM SCORE	DATE	GRADE	FM	TEST	BAT	OTHER INFO.
	4/72	1	X	SAT	PRI 1			4/73	1	W	SAT	PRI 1	

	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B	SCORE	PR	B
GE	1.4	24	4	1.6	05	5	1.2	52	2				1.0	21	1	1.4	28	4	NGE	1.3	03	3	1.0	21	1	1.4	34	4	1.1	23	3	1.5	05	5	1.8	56	6								

SICKNESS WHEN POSSIBLE

MUMPS	SMALLPOX	TYPHOID	TONSILITIS

IMMUNIZING AND DIAGNOSTIC PROCEDURES RECORD

YEAR AND RESULT	DIPHTHERIA	SMALLPOX	T-B TESTS	X-RAY	RESULT OF X-RAY

IX. GRADUATION FROM SENIOR HIGH SCHOOL

GRADUATION DATE	NAME OR SIGNATURE OF HIGH SCHOOL PRINCIPAL

NO. IN CLASS	RANK IN CLASS	NO. OF RANKS	COURSE COMPLETED

CODE OF BIRTH INFORMATION: CERTIFIED COPY OF BIRTH CERTIFICATE = BC; CHURCH RECORD = CR; FAMILY BIBLE = FB; SCHOOL RECORD = SR; PASSPORT = PP; PARENT'S STATEMENT = PS; LIFE INSURANCE POLICY = LI; IMMIGRATION CERTIFICATE = IC

X. EXTRA CURRICULAR ACTIVITIES

GRADE	
PUBLICATIONS	
BAND	
VOCAL MUSIC	
ORCHESTRA	
DRAMATICS	
STUDENT COUNCIL	
SAFETY PATROL	
CLASS OFFICER	
CLUBS	
AUDITORIUM ACTIVITIES	
ATHLETICS	

XI. EVALUATION OF PERSONAL AND SOCIAL ASSETS

GRADE	1ST	1
COOPERATION	N	N
COURTESY	N	N
DEPENDABILITY	N	N
INDUSTRIOUSNESS	N	N
INITIATIVE	N	N
LEADERSHIP	N	N
EMOTIONAL MATURITY	N	N
PERSONAL APPEARANCE	N	N
SELF CONTROL	N	N
HONESTY	N	N
PERSEVERANCE	N	N
SERVICE TO SCHOOL	N	N
CODE	1-B	
B – BELOW		
N – NORMAL		
A – ABOVE		
NAME OF TEACHER		

XII. EDUCATIONAL FOLLOW-UP RECORD

RECORD SENT: TO:

DATE	SCHOOL

NAME OF SCHOOL — DATE ENTERED

COURSE OF STUDY

REPORTED PROGRESS

XIII. RECORD OF COMMUNICATIONS FOR EMPLOYMENT

DATE	TO WHOM SENT	REASON

XIV. EDUCATIONAL PLANS	VOCATIONAL PLANS	INTERESTS AND HOBBIES	SPECIAL TALENTS
YEAR			

Form A-100-1

SOUTH CAROLINA CUMULATIVE SCHOOL HEALTH RECORD

Page

NAME OF PUPIL (Date: First, Middle) [illegible]

Birth: Year [illegible] Month 9 Day 29

SCHOOL (In Pencil) Dalzell

Birth Certificate Checked by: Date

NAME OF PARENT—GUARDIAN [illegible]

RESIDENCE ADDRESS (In Pencil) [illegible]

PHONE (In Pencil)

BUSINESS ADDRESS (In Pencil)

PHONE (In Pencil)

FAMILY PHYSICIAN (In Pencil) Dr. [illegible]

DENTIST (In Pencil)

DISEASE AND ILLNESS HISTORY (Give year if remembered, otherwise yes)

Headache (Frequent)	Rheumatic Fever	Diabetes	
Sore Throat (Frequent)	Health Trouble	Convulsions	
Ear Infection (Frequent)	Animal Allergy	Muscle or Bone Weakness	
Other Medical, Mental, or Operational			

COMMENTS (By Whom—Date)

SCREENING PROCEDURES

GRADE	Pre-School	1		2		3		4		5		6		7		8	
DATE (Year)		1/3		1/3													
Height	Fall	3		3													
Inches	Spring	4		4													
Weight	Fall																
Lbs.	Spring																
Vision	Both Eyes																
Without	R.																
Glasses	L.																
Vision	Both Eyes																
With	R.																
Glasses	L.																
Type of Test																	
Person Giving Test Give Initials																	
Hearing	R.																
	L.																
Type of Test																	
Person Giving Test Give Initials																	

COMMENTS—FOLLOW-UP (By Whom—Date)

TEACHERS OBSERVATIONS (Good X Bad—Obvious Conditions Corrected)

GRADE	Pre-School	1		2		3		4		5		6		7		8	
DATE																	
Abnormal Gait																	
Poor Posture																	
Lethargic																	
Tired—Early Fatigue																	
Poor Food Habits																	
Frequent Illness																	
Blurred Eyes																	
Squinting—Crossed Eyes																	
Reads Too Close—Too Far																	
Frequent Inattention																	
Hearing Difficulties																	
Poor Teeth																	
Frequent Colds																	
Frequent Sore Throat																	
Marked Aggressiveness																	
Indus. Shyness																	
Speech Defect																	
Mental or Mannerisms																	
Poor Dressing																	
Indus. Restlessness																	
Excessive Use of Toilet																	
Other)																	

COMMENTS—FOLLOW-UP (By Whom—Date)

Refer to South Carolina Manual For Use of the Cumulative School Health Record

Attach additional pages as needed for all sections of this record

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INDIVIDUAL PUPIL PROGRESS SHEETS

NAME Bobby Stone

First Reader Level	Date	Reader Page Completed	Workbook Page Completed
SCOTT FORESMAN SERIES			
We Read Pictures			
We Read More Pictures			
Before We Read	11-27-73		✓
Sally Dick and Jane	3-5-73	✓	
Fun With Our Family	3-8-73	✓	
Fun Wherever We Are	3-12-73	✓	
Guess Who			
Fun With Our Friends			
More Fun With Our Friends			
The New We Three			
ECONOMY COMPANY			
Phonetic Keys To Reading			
Tag	1-10-73		96
Dot and Jim	5-15-73		96
All Around			
HOUGHTON MIFFLIN SERIES			
Getting Ready To Read			
Tip			
Tip and Mitten			
The Big Show			
Jack and Janet			
Up and Away			
Listen and Learn			
Listen and Do			
Starting Concept Cards	2-23-73	✓	✓
Pre-Primer	4-12-73	95	64
Primer	5-23-73	82	90

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SCOTT, FORESMAN AND COMPANY
ATLANTA
DALLAS
GLENVIEW
PALO ALTO
OAKLAND, N.J.

STATES EDITION

BASIC READING TEST

to accompany

BEFORE WE READ

Marion Monroe · Helen M. Robinson

The New Basic Readers

CURRICULUM FOUNDATION SERIES

NAME: Bobby Stone

SCHOOL: Johnsonville GRADE: 1

TEACHER: Betts

INTELLIGENCE TEST

COMMENTS

DATE OF TEST: 1-8-72

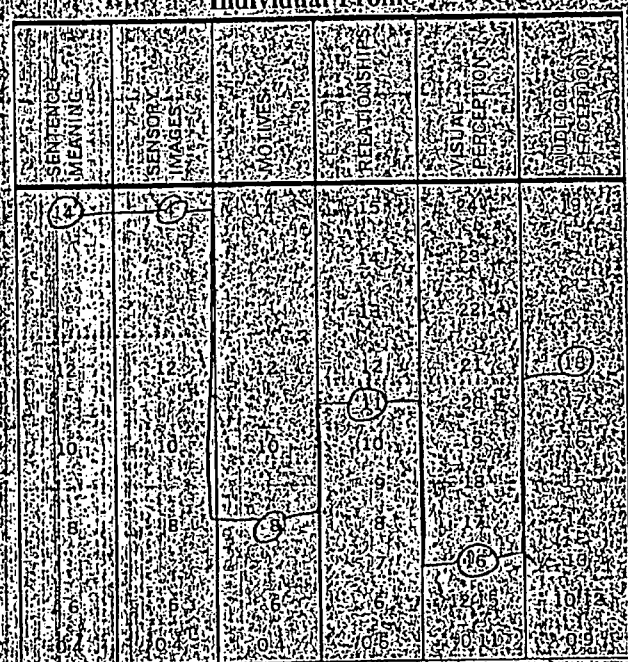
DATE OF BIRTH:

AGE: YEARS 7 MONTHS 8

DATE GIVEN

Individual Profile

SUBTEST	POINTS
I. Sentence Meaning	14
II. Sensory Images	14
III. Motives	8
IV. Relationships	11
V. Visual Perception	16
VI. Auditory Perception	18
Total Points (or per cent correct)	81
Percentile	—
Rating	Low



Percentiles shown are based on 1967 and 1968 scores

TOTAL POINTS	0-69	70	75	80	84	84	85	86	88	89	90	91	92	93	94	95	96	97	98	99	100
PERCENTILE	1-4	5	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	99
RATING	VERY LOW			LOW							AVERAGE						HIGH		VERY HIGH		

MEDIAN 90

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6442

Metropolitan Readiness Tests

FORM A

by GERTRUDE H. HILDRETH, NELLIE L. GRIFFITHS, MARY E. McGAUVRAN

NAME Bobby Stone BOY ✓ GIRL ___ DATE OF TESTING 1971 10 4 (Year Month Day)

TEACHER [redacted] SCHOOL [illegible] DATE OF BIRTH [redacted] 7 17 (Year Month Day)

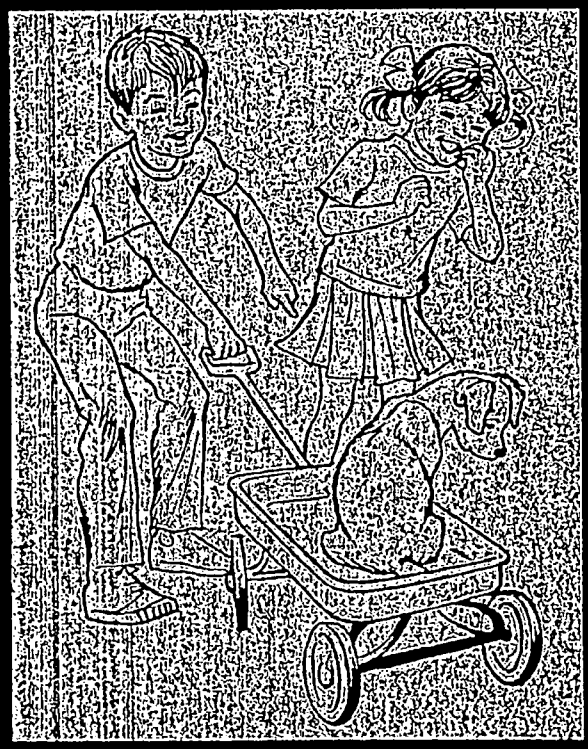
CITY [illegible] COUNTY [illegible] STATE [illegible] PUPIL'S AGE Yrs. 6 Mos. 1

GRADE 1 NUMBER OF MONTHS KINDERGARTEN TRAINING ___

TEST	RAW SCORE
1. WORD MEANING	3
2. LISTENING	8
3. MATCHING	4
4. ALPHABET	3
5. NUMBERS	8
6. COPYING	2
Total Score, Tests 1-6	28
Percentile Rank	10
Letter Rating	D

Readiness status, recommendation, other scores, remarks

79 - 1 G



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Metropolitan Readiness Tests

FORM A

by GERTRUDE H. HILDRETH, NELLIE L. GRIFFITHS, MARY E. McGAUVRAN

NAME Bobby Stone BOY ✓ GIRL ___ DATE OF TESTING 72 9 26
Year Month Day

TEACHER P. Tanner SCHOOL Johnsonville DATE OF BIRTH ___
Year Month Day

CITY Johnsonville COUNTY Florence STATE S. C. PUPIL'S AGE Yrs ___ Mos ___

GRADE 1 NUMBER OF MONTHS KINDERGARTEN TRAINING ___

TEST	RAW SCORE
1. WORD MEANING	4
2. LISTENING	12
3. MATCHING	8
4. ALPHABET	15
5. NUMBERS	14
6. COPYING	6
Total Score, Tests 1-6	59
Percentile Rank	59
Letter Rating	C

Readiness status, recommendation, other scores, remarks:

6444

6445

NAME [illegible] DATE OF BIRTH 9-9-63

SCHOOL

BY WHOM TESTED DATE

INDIVIDUAL CUMULATIVE RECORD

Scott, Foresman Reading Tests

SCOTT, FORESMAN AND COMPANY Atlanta Dallas Glenview, Ill. Palo Alto Oakland, N.J.

OPEN HIGHWAYS TESTS/GRADES 1-4

STARTER CONCEPT CARD

Subtests	Scores
I. Scrutiny	10
II. Ph.-Gr. Relationships	28
III. Concepts	8
Total	46
Percentile	65 Ave.

DATE TESTED 9-1-73

AGE 7-8

GRADE

READY TO ROLL

Subtests	Scores
I. Scrutiny	10
II. Ph.-Gr. Relationships	12
III. Concepts	10
IV. Comprehension	2
Total	34
Percentile	30 Ave.

DATE TESTED 9-1-73

AGE 7-8

GRADE

ROLLING ALONG

Subtests	Scores
I. Scrutiny	
II. Ph.-Gr. Relationships	
III. Concepts	
IV. Comprehension	
Total	
Percentile	

DATE TESTED

AGE

GRADE

MORE POWER

Subtests	Scores
I. Ph.-Gr. Relationships	
II. Word Study	
III. Comprehension	
IV. Pre-Dictionary Skills	
Total	
Percentile	

DATE TESTED

AGE

GRADE

MOVING AHEAD

Subtests	Scores
I. Ph.-Gr. Relationships	
II. Word Study	
III. Comprehension	
IV. Pre-Dictionary Skills	
Total	
Percentile	

DATE TESTED

AGE

GRADE

SPLENDID JOURNEY

Subtests	Scores
I. Ph.-Gr. Relationships	
II. Word Study	
III. Comprehension	
IV. Pre-Dictionary Skills	
Total	
Percentile	

DATE TESTED

AGE

GRADE

SPEEDING AWAY

Subtests	Scores
I. Ph.-Gr. Relationships	
II. Word Study	
III. Comprehension	
IV. Pre-Dictionary Skills	
Total	
Percentile	

DATE TESTED

AGE

GRADE

OPEN HIGHWAYS, 4

Subtests	Scores
I. Word and Phrase Meaning	
II. Sentence and Paragraph Meaning	
III. Main Idea	
IV. Relationships	
V. Scrutiny-Context	
VI. Phonetic Analysis	
VII. Structural Analysis	
VIII. Dictionary	
Total	
Percentile	

DATE TESTED

AGE

GRADE

NOTE:

Scores at or below the 25th percentile can be circled in color.

STARTER CONCEPT CARDS

reading test

OPEN HIGHWAYS

a diagnostic and developmental reading program

Bobby Stone

NAME

DATE OF TEST 2/25/73

DATE OF BIRTH 1/1/

SCHOOL Johnson Elem.

GRADE 1

AGE YEARS MONTHS

TEACHER Jackson

COMMENTS

subtest	points	individual profile
I Scrutiny	10	0 1 2 3 4 5 6 7 8 9 10
II Phonemic-Graphemic Relationships	28	0 3 6 9 12 15 18 21 24 27 30
III Concepts	8	0 1 2 3 4 5 6 7 8 9 10
total	46	average

percentile 65

Unstandardized Edition

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READY TO ROLL

reading test

Marion Monroe / Helen M. Robinson

OPEN HIGHWAYS

a diagnostic and developmental reading program

NAME Stone, Bobby

DATE OF TEST April 12 1973

SCHOOL Johnsonville

GRADE 1B

DATE OF BIRTH

TEACHER Mrs Barkus

AGE YEARS MONTHS

subtest	scores	individual profile
I. Scrutiny	10	0-1 2 3 4 5 6 7 8 9 10
II. Phoneme-Grapheme Relationships	12	0-2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
III. Concepts	10	0-1 2 3 4 5 6 7 8 9 10
IV. Comprehension	2	0-1 2 3 4 5 6 7 8 9 10
total	34	(Scores to the left of the dotted line are at or below the 25th percentile)
percentile	35	
rating	average	

total	0-21	22	26	29	31	33	35	37	38	40	41	42	43	44	45	46	47	48	49	50
percentile	0-4	5	10	15	20	25	30	35	40	45	50	55	60	65	70	80	85	95	97	98-99
rating	very low		low							average							high		very high	

median 41

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