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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Nate Fata, Special Referee

Lower Court Case No. 2016-CP-26-8032
Court of Appeals Case No. 2017-001817

DANIEL ERIC KNIGHT, Respondent,

v.

PHILLIP RAY CAUSEY, Appellant.

RECORD ON APPEAL

VOLUME 3 OF 4

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Occurred Recorded Nursing Notes
Date Time by Author Date Time by

05/15/16 1015 ST TALBOT,SUSIE 05/15/16 1232 ST
Abnormal? N Confidential? N
pt admitted via bed to CC26, on vent, on spond mode, cardiac monitor showing ST hr 132, resp 26 and wnl. LR infusing via pump at 150cc/hr. foley patent to bsd. abd dsg c/d/i with jp drain draining large amts of serous fluid. nodding head yes and no to answer questions. no sedation, alert and following all commands.

05/15/16 1100 ST TALBOT,SUSIE 05/15/16 1233 ST
Abnormal? N Confidential? N
wife at bedside, pt resting quietly at this time. continues to nod head yes and no. resp even nonlabored. no sedation, follows all commands.

05/15/16 1140 ST TALBOT,SUSIE 05/15/16 1235 ST
Abnormal? N Confidential? N
Dr Rimkus in to see pt and update given. verbal order to extubate when pt is stable.

05/15/16 1220 ST TALBOT,SUSIE 05/15/16 1238 ST
Abnormal? N Confidential? N
extubated per R.T., placed on NC at 2/1 with sats 98%. LR infusing via pump site w/o problems. jp drain to bulb suction. pt awake and asking questions, denies pain at this time. will continue to monitor closely.

05/15/16 1408 ST TALBOT,SUSIE 05/15/16 1410 ST
Abnormal? N Confidential? N
awake and alert, asking "what happened", pt instructed on surgery and why, verbalizes understanding. oral care provided.

05/15/16 1423 ST TALBOT,SUSIE 05/15/16 1424 ST
Abnormal? N Confidential? N
bp 83/50, Dr Santiago awaren NS bolus infusing at this time.

05/15/16 1514 ST TALBOT,SUSIE 05/15/16 1514 ST
Abnormal? N Confidential? N
wife at bedside and update given, bolus infuisng with bp 87/64 (69).

05/15/16 1529 ST TALBOT,SUSIE 05/15/16 1529 ST
Abnormal? N Confidential? N
ngt remains to lis with no drainage at this time, ostomy bag intact with no drainage at this time. ns bolus completed, will continue to monitor closely.

05/15/16 1624 ST TALBOT,SUSIE 05/15/16 1625 ST
Abnormal? N Confidential? N
states that morhine is "starting to help with the pain". map remains at 60.

05/15/16 1753 ST TALBOT,SUSIE 05/15/16 1753 ST
Abnormal? N Confidential? N
states that pain has returned, medicated see e-mar.

05/15/16 2000 BW PAUL,BETSY 05/15/16 2235 BW
Abnormal? N Confidential? N
PATIENT ALT. PIV X2 WITHOUT REDNESS OR SWELLING. OSTOMY IN PLACE WITH RED STOMA NOTED. ABD DRESSING IN PLACE WITH MONTGOMERY STRAPS. C/D AT THIS TIME. PT STATES PAIN TO ABD. HYPO BOWEL SOUNDS NOTED. HEART RATE NOTED. SKIN WARM AND DRY. WILL CONTINUE TO MONITOR PATIENT STATUS.

Addendum: 05/15/16 at 2236 by BW PAUL,BETSY RN

FOLEY CATH IN PLACE WITH ORANGE COLOR LIQUID IN GRAVITY DRAINAGE BAG.

05/15/16 2236 BW PAUL,BETSY 05/15/16 2237 BW
Abnormal? N Confidential? N
PATIENT IN ROOM WITH EYES CLOSED. CONTINUING TO WATCH PRESSURE AND HR. PATIENT VERBALIZES ATTEMPTS TO TAKE DEEP BREATH. WILL CONTINUE TO MONITOR CLOSE.

05/16/16 0004 BW PAUL,BETSY 05/16/16 0004 BW
Abnormal? N Confidential? N

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes
05/16/16	0004	BW	PAUL,BETSY	05/16/16	0004	BW	(continued)

PATIENT IN ROOM WITHOUT COMPLICATION AT THIS TIME

05/16/16 0030 LF* FADRI,LOURDES 05/16/16 0223 LF*
Abnormal? N Confidential? N
SEEN PT RESTING IN BED WITH EYES CLOSED.RESPIRATION WNL.FOLEY CATHETER PATENT.

05/16/16 0207 LF* FADRI,LOURDES 05/16/16 0224 LF*
Abnormal? N Confidential? N
MORPHINE 2MG IV GIVEN FOR PAIN.SEE EMAR AND FOR REASSESSMENT.

05/16/16 0245 LF* FADRI,LOURDES 05/16/16 0436 LF*
Abnormal? N Confidential? N
MOUTH CARE PROVIDED.

05/16/16 0350 LF* FADRI,LOURDES 05/16/16 0435 LF*
Abnormal? N Confidential? N
MOUTH CARE PROVIDED.

05/16/16 0400 LF* FADRI,LOURDES 05/16/16 0435 LF*
Abnormal? N Confidential? N
DILAUDID 1MG IV GIVEN BY B PAUL,RN.SEE EMAR.

05/16/16 0600 LF* FADRI,LOURDES 05/16/16 0658 LF*
Abnormal? N Confidential? N
NGT TO LOW INTERMITTENT SUCTION DRAIN 154 CC YELLOWISH FLUID.

05/16/16 0642 LF* FADRI,LOURDES 05/16/16 0645 LF*
Abnormal? N Confidential? N
JP DRAIN OUTPUT 80 ML APPEARS YELLOW/BROWNISH IN COLOR AS WELL AS ILEOSTOMY FLUID WITH 30 ML.

05/16/16 0715 AW3 WRIGHT,ANTHONY 05/16/16 1053 AW3
Abnormal? N Confidential? N
PT INITIAL ASSESSMENT COMPLETED. PT IS RESTING IN BED AT THIS TIME WITH COMPLIANTS OF ABD PAIN. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.

05/16/16 0757 AW3 WRIGHT,ANTHONY 05/16/16 1054 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF PAIN AT THIS TIME IN ABD. PT GIVEN 1 MG DILAUDID IV PER ORDER. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT WIFE AT THE BEDSIDE.

05/16/16 1015 AW3 WRIGHT,ANTHONY 05/16/16 1015 AW3
Abnormal? N Confidential? N
NG TUBE PULLED PER DR RIMKUS ORDER. PT TOLERATED WELL.

05/16/16 1021 AW3 WRIGHT,ANTHONY 05/16/16 1033 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF ABD PAIN AT THIS TIME. PT BP 112/65. PT GIVEN 2 MG DILAUDID IV PER ORDER. PT ENCOURAGED TO USE INCENTIVE SPIROMETRY AT LEAST 10 TIMES PER HOUR WHEN AWAKE. PT WIFE IS AT THE BEDSIDE. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT AND WIFE INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.

05/16/16 1051 AW3 WRIGHT,ANTHONY 05/16/16 1052 AW3
Abnormal? N Confidential? N
* UNDONE *
PT INITIAL ASSESSMENT COMPLETED. PT IS RESTING IN BED AT THIS TIME WITH COMPLIANTS OF ABD PAIN. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.

Undone: 05/16/16 at 1053 by WRIGHT,ANTHONY RN
Reason: WRONG TIME

05/16/16 1434 AW3 WRIGHT,ANTHONY 05/16/16 1627 AW3
Abnormal? N Confidential? N

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/16/16 1434 AW3 WRIGHT,ANTHONY 05/16/16 1627 AW3 (continued)
PT COMPLAINING OF ABD PAIN AT THIS TIME RATED AT A 7 OUT OF 10 ON PAIN SCALE. PT GIVEN 2 MG DILAUDID IV PER ORDER. PT BP 111/63. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.

05/16/16 1855 AW3 WRIGHT,ANTHONY 05/16/16 1905 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF PAIN AT THIS TIME IN ABD. PT GIVEN 2 MG DILAUDID IV PER ORDER.

05/16/16 1930 SH2 HERRINGTON,SHERRY 05/16/16 2159 SH2
Abnormal? N Confidential? N
RECEIVED BEDSIDE REPORT FROM TONYRN,PM ASSESSMENT COMPLETED,VS 99.7-125-16 118/65 SAO2 91% ON O2 3LNC,BS REPORT PT SAO2 IN 80'S WHILE PT USING IS THUS O2 BUMPED TO 3LNC,THEN SAO2 INCREASED,PT PULLING UP ON IS TO 500,LUNGS DEMIN POSTERIOR,CLEAR ANTERIOR,TELE ST,PT REPORTED EXPECTORATING YELLOW SPUTUM TODAY.ABD DISTENDED BUT SOFT,BS HEARD IN ALL QUAD EXCEPT LLQ,ABD DRESSING D&I,JP DRAINING YELLOW COLORED DRAINAGE,APPROX 40ML,ILEOSTOMY WITH SMALL AMT OF TEA COLORED LIQ,F/C DRAINING DARK AMBER URINE,REPORTED THAT THE DILAUDID GIVEN AT AROUND 1900 WAS EFFECTIVE FOR PAIN,PAIN 2/10.18G RH AND 18G LAC,SITE HEALTHY,LR INFUSING 150ML/HR TO RH,ICE CHIP AT BS,SEE ASSESSMENT FOR DETAILS.PT SAID HE THINKS HE HAS PASSED GAS,PT DENIES NEEDS.

05/16/16 2045 SH2 HERRINGTON,SHERRY 05/16/16 2231 SH2
Abnormal? N Confidential? N
TORADOL IV GIVEN,TEMP AND MILD PAIN.SEE MAR.

05/16/16 2130 SH2 HERRINGTON,SHERRY 05/16/16 2211 SH2
Abnormal? N Confidential? N
PT ASSISTED WITH ADL,BRUSH TEETH,BS 85,DECLINED PAIN MEDICATIONS,WIFE CALLED TO CHECK ON PT,GIVEN CONFID # PER PT CONSENT.NO CHANGE IN ASSESSMENT,ASSESSED ABD,JP AND ILEOSTOMY,NO CHANGES,DRESSING D&I.PT TAKING FEW ICE CHIPS INTERMITTENTLY.

05/17/16 0000 SH2 HERRINGTON,SHERRY 05/17/16 0151 SH2
Abnormal? N Confidential? N
VS 98.4-113/20 111/65 SAO2 91% OFFERED PAIN MEDICATION,PT SAID OK,MORPHINE GIVEN FOR ABD PAIN 5/10.NO OTHER NEEDS,RESTING WELL,OFFERED TO REPOSITION PT,HE DECLINED.

05/17/16 0151 SH2 HERRINGTON,SHERRY 05/17/16 0152 SH2
Abnormal? N Confidential? N
SUPINE,RESP EVEN UNLABORED,TELE ST 115,SAO2 90% ON 3L NC.

05/17/16 0212 SH2 HERRINGTON,SHERRY 05/17/16 0216 SH2
Abnormal? N Confidential? N
PT CALLED REPORTED FEELING SOB,SAO2 88-89% ON 3L NC,O2 INCREASED TO 4LNC,SAO2 INCREASES TO 90%,PT SAID THIS IS NEW FOR HIM,"I DON'T UNDERSTAND MY VS ARE THE BEST ALL DAY"LUNGS CLEAR ANTERIOR,LEFT POSTERIOR BASE

05/17/16 0215 SH2 HERRINGTON,SHERRY 05/17/16 0229 SH2
Abnormal? N Confidential? N
LEFT LOWER POSTERIOR BASE VERY DEMINISHED,VS 127/75 RESP 18 EVEN,SHALLOW O2 INCREASED TO 90% ON 4LNC.DR HAYES CALLED AND NO NEW ORDERS EXCEPT FOR O2 TO BE TITRATED TO KEEP SAO2 UP.DR.HAYES AWARE OF IVF,POC,CHEST XRAY RESULTS ECT.PT INSTRUCTED THAT DR.HAYES CALLED BACK AND POC.

05/17/16 0405 SH2 HERRINGTON,SHERRY 05/17/16 0425 SH2
Abnormal? N Confidential? N
SAO2 MAINTAINING AROUND 90-91% ON 4LNC,VS 99.1-114-24 121/75 SAO2 92% AT TIME.TELE ST,DILUADID 2MG IV GIVEN SLOWLY FOR ABD PAIN 6/10 WITH GOOD EFFECT,JP EMPTIED WITH 60ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID,F/C DRAINED 545ML AMBER URINE,ABD DRSSING D&I,PT STATED HIS BREATHING IS ABOUT THE SAME,HE STILL FEELS SOB,NO DISTRESS,RESP 22-24 EVEN

Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes
05/17/16	0405	SH2	HERRINGTON,SHERRY	05/17/16	0425	SH2	(continued)

UNLABORED,MINT SWABS GIVEN,PT USED,ICE CHIPS GIVEN.

05/17/16 0609 KK BELLAM,KATIE 05/17/16 0744 KK
Abnormal? N Confidential? N
DILUADID 2MG IV GIVEN GOT ABD PAIN 5/10.VSS.

05/17/16 0720 SH2 HERRINGTON,SHERRY 05/17/16 0746 SH2
Abnormal? N Confidential? N
RESTING IN BED,REPORTED OFF TO KATIE RN.O2 INCREASE TO 5 L DUE TO SAO2 89%,SAO2 INCREASED TO 91%.

05/17/16 0735 KK BELLAM,KATIE 05/17/16 1140 KK
Abnormal? N Confidential? N
REPORT RECEIVED FROM SHERRY, RN. PATIENT IS RESTING IN BED. AM ASSESMENT COMPLETE. A+OX3, BEDSIDE MONITOR ST 110'S. AFEBRILE. 02 SATS 88% ON 5L NC. WILL HUMIDIFY THIS SHIFT. ALSO WILL NOTIFY DR SANTIAGO OF 02 SATS. FINE CRACKLES HEARD ON AUSCULTATION. AFEBRILE. IV SITE PATENT, IVF INFUSING. ILIOSTOMY INTACT AND DRAINING CLOUDY GRAY LIQUID COLORED STOOL INTO COLLECTION BAG. WAFFER INTACT, STOMA PINK. JP DRAIN CHARGED AND DRAINING YELLOW COLORED DRAINAGE INTO COLLECTION BULB. MEDIAL ABD INCISION C/D/I. HYPOACTIVE BS HEARD. PT STATES "IS NOT PASSING GAS. FOLEY CATHETER INTACT AND DRAINING CLEAR AMBER COLORED URINE. SCDS REMOVED FOR SKIN INSPECTION, NO FINDINGS NOTED, REAPPLIED. PATIENT C/O PAIN, WILL MEDICATE PRN PER ORDERS. DISCUSSED PLAN OF CARE WITH PATIENT AND WIFE ELIZABETH, VERBALIZES UNDERSTANDING. PATIENT DEMONSTRATED USE OF IS,500. RE-ENCOURAGEMENT NEEDED. CALL LIGHT WITHIN REACH. CONTINUE WITH PLAN OF CARE.

05/17/16 0930 KK BELLAM,KATIE 05/17/16 1146 KK
Abnormal? N Confidential? N
DR SANTIAGO NOTIFIED OF PATIENTS O2 STATS 88-90% ON 5L NC HUMIDIFIED AFTER BEIING REPOSITIONED OOB TO CHAIR. NEW ORDERS RECEIVED FOR IV LASIX TO BE GIVEN.

05/17/16 1023 KK BELLAM,KATIE 05/17/16 1023 KK
Abnormal? N Confidential? N
DR SANTIGO PAGED AND NOTIFIED OF PATIENTS C/O PAIN 6/10 AFTER MEDICATED PRN PER ORDERS. NO NEW ORDERS RECEIVED.

05/17/16 1125 KK BELLAM,KATIE 05/17/16 1126 KK
Abnormal? N Confidential? N
DR SANTIAGO PAGED AND NOTIFIED OF PATIENTS UOP AFTER GIVEN LASIX 300ML. ALSO NOTIFIED OF ILIOSTOMY AND PATIENT NEEDING WOUND CARE CONSULT FOR EDUCATION/TEACHING AS WELL AS SUPPLIES FOR HOME. NEW ORDERS RECEIVED.

05/17/16 1307 KK BELLAM,KATIE 05/17/16 1308 KK
Abnormal? N Confidential? N
DR RIMKUS INTO SEE PATIENT, NEW ORDERS RECEIVED TO ADVANCE DIET TO CLEAR LIQUIDS AND ALSO NOTIFIED OF PATIENTS C/O PAIN 6/10, NEW ORDERS RECEIVED.

05/17/16 1546 KK BELLAM,KATIE 05/17/16 1547 KK
Abnormal? N Confidential? N
WOCN INTO SEE PATIENT TO DO ILIOSTOMY TEACHING FOR PATIENT AND WIFE, VERBALIZES UNDERSTANDING. NEW ORDERS RECEIVED FOR DIETARY CONSULT.

05/17/16 1834 KK BELLAM,KATIE 05/17/16 1848 KK
Abnormal? N Confidential? N
PATIENT REPOSITIONED BACK INTO BED. PATIENT HAD A POOR INTAKE FOR DINNER. DENIES NAUSEA. PATIENT C/O PAIN, MEDICATED PRN PER ORDERS. RELIEF NOTED. PATIENT TURNED AND REPOSITIONED AT INTERVALS FOR COMFORT. PATIENTS 02 WEANED TO 50% VENT-MASK TO MAINTAIN SATS >92%. DR SANTIAGO PAGED X3 TO NOTIFY. NOTIFIED OF PATIENTS IS PULL 500-750 THIS SHIFT. SHALLOW RESPIRATORY NOTED. PATIENT NOT WANTING TO USE SPLINTING AND TCDB. NO EFFORT NOTED. ALSO NOTIFIED OF PATIENTS HR AND BP AFTER MEDICATED PRN PER ORDERS FOR PAIN SR/ST 99/100. 111/80. NEW ORDERS RECEIVED. RESPIRATORY THERAPIST AWARE. NO OTHER NEEDS

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/17/16 1834 KK BELLAM,KATIE 05/17/16 1848 KK (continued)
VOICED AT THIS TIME. SAFETY MAINTAINED. SEE EMR AND MAR FOR FURTHER DETAILS. REPORT TO BE GIVEN TO ONCOMING RN TO RESUME PLAN OF CARE.

05/17/16 2000 RM MESHREKI,RAFIK 05/18/16 0014 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENY COMPLETE. SEE SHIFT ASESSMENT. PT IS AOX3. PT COMAPLAINED OF PAIN 5/10 IN HIS ABDOMEN. HE STATED THAT HE WOULD LIKE HIS PAIN MEDICINE AROUND 2100 WITH HIS NOGHT MEDS. NO OTHER SIGNS OF DISTRESS NOTED. WILL CONTIUE TO MONITOR PT.

05/17/16 2100 RM MESHREKI,RAFIK 05/17/16 2231 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 7/10, DILAUDID IV GIVEN. SEE EMAR.

05/17/16 2230 RM MESHREKI,RAFIK 05/18/16 0018 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 7/10. VICODEN PO GIVEN, SEE EMAR. WILL CONTIUE TO MONITOR PT.

05/18/16 0000 RM MESHREKI,RAFIK 05/18/16 0019 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 5/10, DILAUDID IV GIVEN. SEE EMAR. WILL CONTIUE TO MONITOR PT.

05/18/16 0200 RM MESHREKI,RAFIK 05/18/16 0207 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CAHNGE IN CONDITION NOTED AT THIS TIME.

05/18/16 0400 RM MESHREKI,RAFIK 05/18/16 0407 RM
Abnormal? N Confidential? N
PT COMPLAINED OF PAIN 5/10, DILAUDID IV GIVEN. SEE EMAR.

05/18/16 0507 RM MESHREKI,RAFIK 05/18/16 0508 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABD PAIN 4/10. PT REQUESTED 2 TAB OF VOCODAN SEE EMAR.

05/18/16 0600 RM MESHREKI,RAFIK 05/18/16 0621 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED ATTHIS TIME.

05/18/16 0800 ST TALBOT,SUSIE 05/18/16 0857 ST
Abnormal? N Confidential? N
assessment completed, pt resting quietly in high fowlers with ostomy nurse at bedside teaching to pt and wife. o2 sat 88-89% on 50% NRM, pt encouraged to TCDB and use I.S.

05/18/16 0820 ST TALBOT,SUSIE 05/18/16 0857 ST
Abnormal? N Confidential? N
pt placed on high flow o2 at 80% with sats 92% at this time.

05/18/16 0945 ST TALBOT,SUSIE 05/18/16 1018 ST
Abnormal? N Confidential? N
Dr Rimkus in to see pt and removed dsg, area c/d/i with good blood supply, no drainage noted. dry dsg applied per verbal order.

05/18/16 1132 ST TALBOT,SUSIE 05/18/16 1133 ST
Abnormal? N Confidential? N
pt consult written and in room to see pt, up to recliner with minimal assist and tolerated well.

05/18/16 1237 ST TALBOT,SUSIE 05/18/16 1304 ST
Abnormal? N Confidential? N
back to bed, encouraged to stay up longer, po med given for pain, see e-mar.

05/18/16 1340 ST TALBOT,SUSIE 05/18/16 1355 ST
Abnormal? N Confidential? N
pt resting quietly at this time with eyes closed, no s/s of any distress noted

Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes
05/18/16	1340	ST	TALBOT,SUSIE	05/18/16	1355	ST	(continued)

at this time. vss.

05/18/16 2000 RM MESHREKI,RAFIK 05/18/16 2033 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENT COMPLETE. SEE SHIFT ASSESSMENT. PT IS AOX3. PT STATING THAT HIS PAIN LEVEL IS TOLERABLE AT THIS TIME. TRANSFERED PT FROM THE CHAIR TO THE BED. PT TOLERATED WITH MINAML DISTRESS. REASSESSED PT PAIN, HE STATED THAT HE WOULD LIKE TO HOLD OFF ON TAKING SEVERAL PAIN MEDS AND THAT HE WANTS HIS DILAUDID WITH HIS NIGHT MEDICINE AROUND 2100. PT ALSO WAS ADVICED TO ASK FOR PAIN MEDICINE WHEN HURTING AND NOT TO WAIT UNTILL PAIN LEVL IS UNTOLERABLE.NO SIGNS OF DISTRESS NOTED AT THIS TIME. WLL CONTIUE TO MONITOR PT.

05/18/16 2115 RM MESHREKI,RAFIK 05/18/16 2122 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 4/10. DILAUDID GIVEN AS PT REQUESTED. WILL CONTIUE TO MONITOR PT.

05/18/16 2200 RM MESHREKI,RAFIK 05/18/16 2211 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS O DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.

05/19/16 0000 RM MESHREKI,RAFIK 05/19/16 0153 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THSI TIME. WILL CONTIUE TO MONITOR PT.

05/19/16 0151 RM MESHREKI,RAFIK 05/19/16 0152 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABD PAIN 6/10. VICODAN PO GIVEN. SEE EMAR. WILL CONTIUR TO MONITOR PT.

05/19/16 0400 RM MESHREKI,RAFIK 05/19/16 0620 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHNAGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.

05/19/16 0600 RM MESHREKI,RAFIK 05/19/16 0624 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.

05/19/16 0800 ST TALBOT,SUSIE 05/19/16 0922 ST
Abnormal? N Confidential? N
assessment completed, pt resting quietly with eyes closed, awakens easily, pt teaching on TCDB and increasing activity / ambulating, using I.S. and he verbalizes understanding. vss. remains on high flow o2 with sats 94-95%.

05/19/16 0830 ST TALBOT,SUSIE 05/19/16 0922 ST
Abnormal? N Confidential? N
Dr Budhoo in to see pt, update given, wife at bedside.

05/19/16 0922 ST TALBOT,SUSIE 05/19/16 0923 ST
Abnormal? N Confidential? N
pt given prostat, verbalizes understanding, Dr Monsour in to see pt and update given.

05/19/16 1000 TK2 KOCH,THOMAS 05/19/16 1020 TK2
Abnormal? N Confidential? N
ASSISTED WITH TRANSFER FROM BED TO CHAIR. ABLE TO TRANSFER WITH MINIMAL ASSIST.

05/19/16 1009 TK2 KOCH,THOMAS 05/19/16 1019 TK2
Abnormal? N Confidential? N
RECEIVED ACAPPELA WITH INSTRUCTION FROM S ESTES, RT.

5A4D43B46E10429588C8, KNIGHT, 502

Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/19/16 1200 ST TALBOT,SUSIE 05/19/16 1344 ST
Abnormal? N Confidential? N
remains in recliner with much encouragement, tolerating well. o2 sat 97% on high flow at 40%. encouraged to cough and deep breath, tolerating well. no s/s of any distress noted at this time.

05/19/16 1344 ST TALBOT,SUSIE 05/19/16 1345 ST
Abnormal? N Confidential? N
to rad and back to room via w/c on 100% NRM, back on high flow at 40% with sat 98% at this time. no s/s of any distress noted.

05/19/16 1600 ST TALBOT,SUSIE 05/19/16 1830 ST
Abnormal? N Confidential? N
remains in recliner, tolerating well, no s/s of any distress noted. vss. o2 sat drops with activity, recovers quickly. remains on high flow at 40% with sats 93-95%.

05/19/16 1809 TK2 KOCH,THOMAS 05/19/16 1813 TK2
Abnormal? N Confidential? N
ALERT / ORIENTED. NO C/O PAIN AT THIS TIME. UP IN CHAIR FOR 9 HOURS TODAY RETURNED TO BED WITH STANDBY ASSIST THIS EVENING. NO C/O PAIN SINCE EARLY AFTERNOON. ILIOSTOMY AND FOLEY CATHETER TO GRAVITY DRAINAGE. DISCONTINUED OUTDATED IVs AND PLACED NEW SITE TO LFA. CURRENTLY AT 30% O2 VIA HIGH FLOW NC. IN BED WITH TV ON. CALL LIGHT IN REACH. REVIEWED CALL FOR ASSIST. APPETITE IMPROVING.

05/19/16 2000 RM MESHREKI,RAFIK 05/20/16 0030 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENT COMPLETE. SEE SHIFT ASSESSMENT. PT IS AOX3. PT DENIES PAIN OR DSITRESS AT THIS TIME. NO SIGNS OF DISTRESS NOTED. WILL CONTIUE TO MONITOR PT.

05/19/16 2218 RM MESHREKI,RAFIK 05/19/16 2218 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 5/10. VICODAN PO GIVEN. SEE EMAR. WILL CONTIUE TO MONITOR PT.

05/20/16 0000 RM MESHREKI,RAFIK 05/20/16 0031 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR THE PT.

05/20/16 0200 RM MESHREKI,RAFIK 05/20/16 0316 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHNAGE IN CONDITION NOTED AT THIS TIME.

05/20/16 0400 RM MESHREKI,RAFIK 05/20/16 0528 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME.

05/20/16 0600 RM MESHREKI,RAFIK 05/20/16 0606 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME.

05/20/16 0800 ST TALBOT,SUSIE 05/20/16 0857 ST
Abnormal? N Confidential? N
assessment completed, pt resting quietly in high fowlers eating breakfast. Dr Budhoo in to see pt, wife at bedside. ostomy nurse Kristie M. RN at bedside given instructions to wife and pt.

05/20/16 1020 ST TALBOT,SUSIE 05/20/16 1035 ST
Abnormal? N Confidential? N
bath given and linens changed, up to recliner and tolerated well. off high flow and on N.C. @ 4/1 with sats 94-95%. pt teaching on foley removal w/ foley

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/20/16 1020 ST TALBOT,SUSIE 05/20/16 1035 ST (continued)
removed at this time. pt instructed on bladder scan. pt to call nurse when he has sputum specimen.

05/20/16 1103 ST TALBOT,SUSIE 05/20/16 1103 ST
Abnormal? N Confidential? N
pt teaching on prozac and he states that he takes this med at home, teaching on lovenox and he verbalizes understanding.

05/20/16 1122 ST TALBOT,SUSIE 05/20/16 1123 ST
Abnormal? N Confidential? N
up ambulating in halls with P.T., tolerating w/o problems. back to recliner with o2 n.c. w/ sats 95% on 4/l.

05/20/16 1400 ST TALBOT,SUSIE 05/20/16 1439 ST
Abnormal? N Confidential? N
bladder scan 160cc, will continue to monitor closely. pt ate banana and was unable to drain out of bag, bag changed per R. Gasque RN.

05/20/16 1525 ST TALBOT,SUSIE 05/20/16 1526 ST
Abnormal? N Confidential? N
ostomy nurse Kristie M. RN back to bedside, teaching to pt and wife, abd dsg chnaged per orders.

05/20/16 1728 ST TALBOT,SUSIE 05/20/16 1729 ST
Abnormal? N Confidential? N
resting quietly in semi-fowlers talking with visitors at bedside, no s/s of any distress noted at this time. resp even nonlabored on 4/l nc with o2 sats 95-96%.

05/20/16 1740 ST TALBOT,SUSIE 05/20/16 1741 ST
Abnormal? N Confidential? N
Dr Ellis in to see pt and notified that jp drain is not draining anything and does he want it out and he states not at this time.

05/20/16 2000 CB4 BARKER,CANDACE 05/21/16 0149 CB4
Abnormal? N Confidential? N
RECEIVED REPORT. PM ASSESSMENT COMPLETED. PT ALERT AND ORIENTED. PT ON 3L NC WITH O2 SATS >95%. PT HAS MID ABD INCISION WITH ABD DRESSING IN PLACE, DRESSING CDI. JP DRAIN SECURED AND SUCTIONING SEROUS FLUID. ILEOSTOMY TO RUQ DRAINING GREEN LIQUID STOOL. EMPTIED 250ML. PT HAS NO COMPLAINTS OF PAIN OR DISCOMFORT AT THIS TIME. ENCOURAGED PT TO USE IS. VSS. NO SIGNS OF DISTRESS NOTED. CALL BELL WIR. WILL CONTINUE TO MONITOR.

05/20/16 2010 CB4 BARKER,CANDACE 05/21/16 0156 CB4
Abnormal? N Confidential? N
BLADDER SCAN SHOWED 450. PT STATES THAT HE SHOULD BE ABLE TO VOID BY MIDNIGHT. PT REFUSES ANY TYPE OF CATHETERIZATION.

Addendum: 05/21/16 at 0202 by CB4 BARKER,CANDACE RN

EDUCATED PT ON EMPTYING ILEOSTOMY BAG. MINIMAL ASSISTANCE NEEDED WHILE EMPTYING THE BAG. 75ML OF GREEN LIQUID STOOL REMOVED.

05/20/16 2200 CB4 BARKER,CANDACE 05/21/16 0151 CB4
Abnormal? N Confidential? N
PT LYING IN BED WATCHING TV. PT COMPLAINED OF PAIN, ADMINISTERED PRN PAIN MED. SCHEDULED MEDS ADMINISTERED, SEE EMAR FOR DETAILS. PT HAS NO OTHER COMPLAINTS AT THIS TIME. CALL BELL WIR.

Addendum: 05/21/16 at 0153 by CB4 BARKER,CANDACE RN

PT HAS BEEN PULLING 700-1000 ON IS. PT STATES HAS BEEN USING DURING COMMERCIAL BREAKS WHILE WATCHING TV.

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05/21/16 0000 CB4 BARKER,CANDACE 05/21/16 0159 CB4
Abnormal? N Confidential? N
PT SLEEPING IN BED, WOKE FOR HIM TO TRY TO VOID IN URINAL. PT VOIDED 425ML OF CLEAR/AMBER URINE. PT HAS NO COMPLAINTS OF PAIN OR DISCOMFORT AT THIS TIME. VSS. CALL BELL WIR.

05/21/16 0200 CB4 BARKER,CANDACE 05/21/16 0739 CB4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSED. NO DISTRESS NOTED. CALL BELL WIR.

05/21/16 0400 CB4 BARKER,CANDACE 05/21/16 0740 CB4
Abnormal? N Confidential? N
PT COMPLAINED OF PAIN. ADMINISTERED PRN VICODIN. PT HAS NO OTHER COMPLAINTS AT THIS TIME. VSS. NO DISTRESS NOTED. CALL BELL WIR.

05/21/16 0620 CB4 BARKER,CANDACE 05/21/16 0744 CB4
Abnormal? N Confidential? N
ADMINISTERED SCHEDULED MED, SEE EMAR FOR DETAILS. Q6H BLADDER SCAN PERFORMED WITH 357ML OF URINE READING. INFORMED PT THAT HE NEEDED TO TRY TO VOID WITH URINAL OR HE WOULD NEED CATHETERIZATION. PT VOIDED 400ML IN URINAL. REPOSITIONED PT IN BED. 100ML GREEN LIQUID OUT OF ILLEOSTOMY. 5ML SEROUS FLUID OF OF JP DRAIN. VSS. NO DISTRESS NOTED. PT HAS NO COMPLAINTS AT THIS TIME. CALL BELL WIR.

05/21/16 0800 MW WILLIAMS,MARSHA 05/21/16 1136 MW
Abnormal? N Confidential? N
AM ASSESSMENT COMPLETED, PT IS AWAKE ALERT/ORIENTED. DENIES PAIN AT THIS TIME. MIDLINE ABD DRESSING INTACT, ILEOSTOMY PRESENT TO R UPPER ABD WITH SEMI FORMED GREEN STOOL PRESENT. JP TO L ABD WITH SCANT AMT OF YELLOW DRAINAGE PRESENT. VSS. AFEBRILE. NO DISTRESS, 3L/NC SPO2 98%. IPC BILAT. CALL LIGHT IN REACH

05/21/16 1000 MW WILLIAMS,MARSHA 05/21/16 1139 MW
Abnormal? N Confidential? N
ABD DRESSING D/C, CLEANED IN BETWEEN STAPLES WITH QTIP AND NS. CLOUDY BROWNISH DRAINAGE FROM SOME AREAS BETWEEN STAPLES, NO FOUL ODOR NOTED. PT SENSITIVE TO TAPE, DUODERMS PLACED ON PT BY WOUND CARE TO AVOID CONTACT WITH TAPE, ABD PLACED OVER INCISION AND SECURED WITH PAPER TAPE, JP DRAIN SITE CLEAND AND DRAIN SPONGE PLACED AND SECURED WITH AS LITTLE TAPE AS POSSIBLE. PT AMBULATED IN HALLWAY WITH PT, TOLERATED WELL. UP IN CHAIR. DR BUDHOO TO CHANGE PAIN MEDS.

05/21/16 1139 MW WILLIAMS,MARSHA 05/21/16 1140 MW
Abnormal? N Confidential? N
PT REMAINS UP IN CHAIR. NO DISTRESS. DR BUDHOO AWARE PT REQUEST PAIN MEDS.

05/21/16 1300 MW WILLIAMS,MARSHA 05/21/16 1300 MW
Abnormal? N Confidential? N
MEDICATED WITH PERCOLONE 10MG FOR ABD PAIN, SEE EMAR. UP IN CHAIR. EATING LUNCH NO DISTRESS.

05/21/16 1454 MW WILLIAMS,MARSHA 05/21/16 1456 MW
Abnormal? N Confidential? N
DR ELLIS IN TO SEE PT, PLAN TO TX TO SX IF BED AVAIL. ILEOSTOMY EMPTIED OF 150CC LIQ GREEN DRAINAGE. REPLACED ABD TO ABD INCISION AND SECURED WITH PAPER TAPE.

05/21/16 1457 MW WILLIAMS,MARSHA 05/21/16 1457 MW
Abnormal? N Confidential? N
DECREASED NC TO 1L, SPO2 95%. NO DISTRESS

05/21/16 1602 MW WILLIAMS,MARSHA 05/21/16 1603 MW
Abnormal? N Confidential? N
PT AMBULATED IN HALLWAY ON RA, SPO2 RANGE 92-95%, PT TOLERATED WELL. ASSISTED TO WHEELCHAIR IN ROOM, REPORT CALLED TO PAM RN ON SX AND PT TX TO RM 232. SPOUSE AWARE. BELONGINGS AND MEDS TAKEN WITH PT

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05/21/16 1608 PS SKINNER,PAMELA 05/21/16 1616 PS
Abnormal? N Confidential? N
D. PT RECEIVED TO ROOM 232 FROM ICU VIA W/C. ORIENTATED +3. MINIMAL ASSIST FROM CHAIR TO BED. SCD'S OFF AT THIS TIME. S/L TO LEFT F/A. ABD SOFT, CHEST SOUNDS CLEAR, FOX ON R/A 95%, ENCOURAGED TO USE I/S. ILEOSTOMY TO RIGHT LOWER ABD WITH LIQUID GREEN, JP TO LEFT LOWER ABD WITH SMALL AMT YELLOW DRAINAGE. STAPLE LINE TO MID ABD WITH ABD PAD AND PAPER TAPE. TEMP-98.7, P-84, RESP-16, BP-115/71. PT INSTRUCTED TO CALL FOR ASSIST AS NEEDED. WILL CONTINUE TO MONITOR.

05/21/16 1643 PS SKINNER,PAMELA 05/21/16 1644 PS
Abnormal? N Confidential? N
D. IV ABX AS ORDERED.

05/21/16 1801 PS SKINNER,PAMELA 05/21/16 1801 PS
Abnormal? N Confidential? N
D. NUMEROUS FAMILY WITH PT. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONAL PAIN. JP WITH SCANT AMT YELLOW DRAINAGE. ILEOSTOMY WITH MOD AMT GREEN LIQUID. IV TO S/L POST ABX.

05/21/16 1912 MG GODWIN,MELISSA 05/22/16 0032 MG
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT, VISITING WITH FAMILY MEMBERS. NO C/O PAIN AT PRESENT. SALINE LOCK TO LEFT FOREARM INTACT AND PATENT, NO S/S REDNESS OR INFILTRATION NOTED. DRESSING TO ABD C/D/I. JP TO LEFT SIDE INTACT AND COMPRESSED. ILEOSTOMY TO RIGHT SIDE W/APPLIANCE INTACT, DRAINING GREENISH DRAINAGE. I/S AT BEDSIDE. REFUSES SCDS. NO ACUTE DISTRESS. WILL CONTINUE TO MONITOR.

05/22/16 0649 MG GODWIN,MELISSA 05/22/16 0651 MG
Abnormal? N Confidential? N
AT BEDREST, AWAKE AND ALERT. NO C/O PAIN AT PRESENT. NO DISTRESS NOTED. JP INTACT AND COMPRESSED. SCDS ON AND PUMPING. MIDLINE DRESSING DRY AND INTACT. ILEOSTOMY APPLIANCE INTACT, DRAINAGE IS GREENISH SEMI LIQUID THIS AM. URINE IS DARK AMBER. CALL BELL IN REACH.

05/22/16 0730 MM MAPLES,MICHELE 05/22/16 0817 MM
Abnormal? N Confidential? N
REPORT RECEIVED. PT AWAKE AND ALERT. LAYING IN BED. RESPIRATIONS EVEN AND UNLABORED. IV SL, SITE WNL. MIDLINE ABD DRESSING INTACT, NO VISIBLE DRAINAGE PRESENT. OSTOMY INTACT TO RLQ ABD, STOMA MOIST AND PINK, SMALL AMOUNT OF BROWN STOOL PRESENT, NO LEAK PRESENT IN APPLIANCE. NO S/S OF DISTRESS PRESENT. INSTRUCTED TO CALL FOR ASSISTANCE AS NEEDED. CALL BELL IN REACH. SIDEAILS UP X 2. BED ALARM ON.

05/22/16 0842 MM MAPLES,MICHELE 05/22/16 0842 MM
Abnormal? N Confidential? N
AWAKE AND ALERT. SITTING UP IN BED. EATING BREAKFAST. AM MEDS GIVEN.

05/22/16 1454 MM MAPLES,MICHELE 05/22/16 1938 MM
Abnormal? N Confidential? N
PT PREMEDICATED WITH DILAUDID PRIOR TO DRESSING CHANGE PER PT REQUEST. PT AWAKE AND ALERT. LAYING IN BED.

05/22/16 1530 MM MAPLES,MICHELE 05/22/16 1947 MM
Abnormal? N Confidential? N
MIDLINE ABD DRESSING REMOVED. SMALL AMOUNT OF BROWNISH/RED DRAINAGE PRESENT, STAPLES REMOVED, WOUND OPEN APPROXIMATELY 1 INCH DEEP. WOUND BED PINK WITH TANNISH COLOR PRESENT. WOUND PACKED WITH KERLIX DAMPENED WITH DAKINS AS ORDERED, COVERED WITH DRY GAUZE, ABD PAD, SECURED WITH MONTGOMERY STRAPS. PRIOR TO PLACING MONTGOMERY STRAPS TO PT'S SKIN AREA WAS COVERED WITH TEGADERM DRESSINGS. REPORT RECEIVED FROM PT'S WIFE THAT PT HAS DUODERMS IN PLACE THAT WERE PLACED ON PRIOR SHIFT/DAY DUE TO SKIN AREAS BLISTERED FROM PAPER TAPE. JP DRAIN TUBING STRIPPED. SCANT AMOUNT OF SEROUS DRAINAGE PRESENT IN JP DRAIN,

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05/22/16 1530 MM MAPLES,MICHELE 05/22/16 1947 MM (continued)
SUTURE INTACT, NEW DRESSING APPLIED.

05/22/16 1800 MM MAPLES,MICHELE 05/22/16 1948 MM
Abnormal? N Confidential? N
AWAKE AND ALERT. RESTING IN BED. RESPIRATIONS EVEN AND UNLABORED. IV ABX INFUSING, SITE WNL. ABD DRESSING INTACT, NO VISIBLE DRAINAGE PRESENT. OSTOMY APPLIANCE INTACT, 50 CC OF GREENISH STOOL EMPTIED AT THIS TIME, NO LEAK PRESENT IN APPLIANCE. PT TOLERATING DIET, NO C/O N/V. PT DOING EXERCISES IN BED AND AT SIDE OF BED TODAY. CALL BELL IN REACH. SIDERAILS UPX 2. INSTRUCTED TO CALL FOR ASSISTANCE AS NEEDED.

05/22/16 1922 MG GODWIN,MELISSA 05/23/16 0348 MG
Abnormal? N Confidential? N
RECEIVED REPORT FROM MICHELLE, RN. RESTING IN BED, AWAKE AND ALERT. DRESSING TO ABD C/D/I. ILEOSTOMY APPLIANCE INTACT. NOT WEARING SCDS, REPORTS HE HAS PERFORMED EXERCISES INSTEAD. SALINE LOCK TO LEFT FOREARM INTACT AND PATENT, NO REDNESS OR SWELLING NOTED. DENIES ANY NEEDS AT PRESENT. WILL CONTINUE TO MONITOR.

05/22/16 2140 MG GODWIN,MELISSA 05/23/16 0351 MG
Abnormal? N Confidential? N
DRESSING CHANGE PERFORMED. REMOVED OLD ABD AND GAUZE. CLEANED WITH NSS. WOUND BED PINK AND CLEAN. APPLIED 2 DAKIN'S SOLUTION DAMPENED GAUZE, THEN DRY GAUZE AND ABD. SECURED WITH MONTGOMERY STRAPS. TOLERATED WITH MINIMAL DIFFICULTY. RECEIVED PAIN MEDICATION 30 MINUTES PRIOR TO BEGINNING OF DRESSING CHANGE.

05/23/16 0600 MG GODWIN,MELISSA 05/23/16 0624 MG
Abnormal? N Confidential? N
AT 0550, PT C/O SHARP STABBING PAIN UNDER LEFT AXILLA, STATING HE COULD NOT TAKE A DEEP BREATH. ON ASSESSMENT, PT TAKING SHORT, SHALLOW RESPIRATIONS, 28/MINUTE. O2 SAT 94% ON RA, HR 95. BREATH SOUNDS WITH CRACKLES AUSCULTATED IN LUL AND RLL, VERY DIMINISHED BREATH SOUNDS IN LLL. PT APPREHENSIVE. DR. WALKER PAGED.

05/23/16 0610 MG GODWIN,MELISSA 05/23/16 0624 MG
Abnormal? N Confidential? N
DR. WALKER RETURNED CALL, NOTIFIED OF PT STATUS. NEW ORDERS GIVEN.

05/23/16 0651 MG GODWIN,MELISSA 05/23/16 0653 MG
Abnormal? N Confidential? N
RESTING IN HIGH FOWLER'S POSITION. O2 SAT 93% ON RA, HR 97, STATES PAIN IS NOW ABOUT A 6. RR 20, RESPIRATIONS UNLABORED AND ABLE TO SPEAK IN COMPLETE SENTENCES WITHOUT SOB. ABD AND PCXR COMPLETED. WILL REPORT TO ONCOMING STAFF NURSE.

05/23/16 0730 PS SKINNER,PAMELA 05/23/16 0803 PS
Abnormal? N Confidential? N
d. pt awake, resting in bed. orientated +3. skin warm, dry, pale. abd soft. jp to left abd with small amt serous drainage, ost to right lower abd with green/brown with some consistency. denies any discomfort. resp-18-22. fox on r/a 94%. mid abd drsg with abd pads and gauze intact and dry. s/l to left f/a hob elevated. encouraged to use i/s which does with good effort. denies any productive cough. urinal at bed-side. pt instructed to call for assist as needed.

05/23/16 0902 PS SKINNER,PAMELA 05/23/16 0902 PS
Abnormal? N Confidential? N
D. PT MEDICATED WITH PERCOLONE 10 MG PO FOR PREVENTIVE PAIN FOR DRSG CHANGE.

05/23/16 0910 PS SKINNER,PAMELA 05/23/16 1235 PS
Abnormal? N Confidential? N
D. PT AMBULATING IN HALLWAY WITH PHY THER. TOELRATING WELL, TIRES EASILY. NO SOB NOTED.

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05/23/16 0945 PS SKINNER,PAMELA 05/23/16 1116 PS
Abnormal? N Confidential? N
D. PT DRSG REMOVED FROM MID ABD. MOD AMT SEROUS DRAINAGE TO OLD DRSG. WOUND ABOUT 6" LONG, ABOUT 3/4" WIDE, NARROWER AT ENDS. ABOUT 1/4" DEEP. BEEFY RED 1/4 DAKINS WET TO DRY WITH KERLIX, DRY 4/4, ABD PADS. MONTGOMERY STRAPS IN PLACE. PT WITH SOME DISCOMFORT DURING PACKING. NEW DRAIN SPONGE APPLIED TO JP SITE.

05/23/16 1113 PS SKINNER,PAMELA 05/23/16 1114 PS
Abnormal? N Confidential? N
D. PT GIVEN LASIX 40 MG IV AS ORDERED. IV ABX INFUSING. PT UNDERSTANDS FLUID RESTRICION.

05/23/16 1234 PS SKINNER,PAMELA 05/23/16 1234 PS
Abnormal? N Confidential? N
D. OOB TO CHAIR. VOIDING LARGE AMTS CLEAR YELLOW URINE IN URINAL. CALL BELL IN REACH.

05/23/16 1411 PS SKINNER,PAMELA 05/23/16 1411 PS
Abnormal? N Confidential? N
D. REMAINS UP IN CHAIR. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONOAL PAIN. CALL BELL IN REACH.

05/23/16 1458 PS SKINNER,PAMELA 05/23/16 1459 PS
Abnormal? N Confidential? N
D. S/L TO LEFT F/A REMOVED FOR OUTDATE, #20 PLACED TO RIGHT A/C. GOOD BLD RETURN AND FLUSHES EASILY. PT RETURNED TO BED WITH MINIMAL ASSIST.

05/23/16 1542 PS SKINNER,PAMELA 05/23/16 1542 PS
Abnormal? N Confidential? N
* UNDONE *
D. CLEAR LIQUIDS IN PROGRESS.

Undone: 05/23/16 at 1543 by SKINNER,PAMELA RN
Reason: DOC ON WRONG PT

05/23/16 1700 PS SKINNER,PAMELA 05/23/16 1700 PS
Abnormal? N Confidential? N
D. OSTOMY NURSE IN AND CHANGED OSTOMY WITH FAMILY AND PT. PT TOLERATED WELL. IV ABX AS ORDERED.

05/23/16 1855 PS SKINNER,PAMELA 05/23/16 1904 PS
Abnormal? N Confidential? N
D. LITTLE APPETITE FOR PM MEAL. DENIES ANY NAUSEA. JP TO LEFT ABD WITH SMALL AMT SEROUS DRAINAGE. OSTOMY TO RIGHT ABD WITH SMALL AMT GREEN/BROWN STOOL. REFUSED OFFER FOR PAIN MEDICATION. S/L TO RIGHT A/C INTACT. URINAL AT BED-SIDE. R/A FOX 95%. WILL CONTINUE TO MONITOR.

05/23/16 1955 MG GODWIN,MELISSA 05/24/16 0254 MG
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT, WATCHING TV. RESPIRATIONS SHALLOW. STATES HE DOESN'T WANT TO TAKE DEEP BREATHS BECAUSE IT HURTS. INSTRUCTED ON T,C,DB, AND USING I/S AND AMBULATING. BREATH SOUNDS VERY DIMINISHED BILATERALLY. O2 SAT 94%. WILL CONTINUE TO MONITOR.

05/24/16 0611 MG GODWIN,MELISSA 05/24/16 0613 MG
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. REPORTS FEELING STIFF THIS AM. O2 SAT 91% ON RA. DRESSING TO ABD DRY AND INTACT. JP INTACT AND COMPRESSED. DECLINES SCDS. ENCOURAGED TO USE I/S. ILEOSTOMY APPLIANCE INTACT. CALL BELL IN REACH.

05/24/16 0730 BL5 LEWIS,BETHANY 05/24/16 1318 BL5
Abnormal? N Confidential? N
SEE PI, POC AND GOALS
AWAKE

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05/24/16	0730	BL5	LEWIS,BETHANY	05/24/16	1318	BL5	(continued)

ENCOURAGED I/S, ACCUPELLA, SCD AND WALK, WALK AND IN CHAIR

05/24/16 0815 BL5 LEWIS,BETHANY 05/24/16 0918 BL5
Abnormal? N Confidential? N
DR RIMKUS ROUNDS...WOUND VAC ORDERED
PT TOLD HE MUST GET OOB AND WALL, AND USE THE I/S 30-40 X HOUR, TO HELP LUNG FUNCTION

05/24/16 1006 BL5 LEWIS,BETHANY 05/24/16 1006 BL5
Abnormal? N Confidential? N
OOB WALKING WITH 1 ASST

05/24/16 1008 BL5 LEWIS,BETHANY 05/24/16 1009 BL5
Abnormal? N Confidential? N
SCD IN PLACE; I/S DEMONSTRATED...WEAK PULL AT 500, ENCOURAGED TO 1000- 1500.

05/24/16 1120 BL5 LEWIS,BETHANY 05/24/16 1120 BL5
Abnormal? N Confidential? N
WOUND VAC APPLIED 125 MMHG SUCTION, CONTINUOUS

05/24/16 1315 BL5 LEWIS,BETHANY 05/24/16 1358 BL5
Abnormal? N Confidential? N
OOB WALKING TO SOLARUIM
UASING I/ AND ACCUPELLA

05/24/16 1627 BL5 LEWIS,BETHANY 05/24/16 1628 BL5
Abnormal? N Confidential? N
OOB WALKING TO NURSES STATION TO SEE WIFE, ELIZABETH IN HER OFFICE
BACK TO SOLARIUM TO SIT.

05/24/16 1650 BL5 LEWIS,BETHANY 05/24/16 1650 BL5
Abnormal? N Confidential? N
BATH

05/24/16 1730 BL5 LEWIS,BETHANY 05/24/16 1951 BL5
Abnormal? N Confidential? N
BACK TO BED
WOUND VAC ACTIVATED 125 MMHG CONTINUOUS WITH MINIAML S/S RETURN
SL PATENT, CDI
OSOTOMY...WIFE ASST KRISTY, WOUND NURSE, TO CHANGE EARLIER.
JP...DC TOMORROW??
SEE EMAR FOR PAIN MEDS

05/24/16 1930 SS4 SARVIS,SABRINA 05/24/16 2311 SS4
Abnormal? N Confidential? N
BEDSIDE REPORT RECEIVED FROM BETHANY. CARE ASSUMED. ASSESSMENT COMPLETE (SEE INTERVENTIONS). PT RESTING IN BED WITH EYES OPEN. RA, ALERT AND ORIENTED X3. IV SITE #20 RAC SL. OSTOMY TO RUQ WITH JP DRAIN TO LUQ. BILATERAL SCDS ON. CONTINOUS PULSE OX (CAPNO) IN PLACE. POST OP GOALS IN PLACE. HOB UP. SR UP. CALL LIGHT, TELEPHONE, WATER PITCHER AND BEDSIDE TABLE WITHIN REACH. WILL CONTINUE TO MONITOR.

Addendum: 05/25/16 at 0041 by SS4 SARVIS,SABRINA RN

WOUND VAC TO MIDLINE ABD, 125MMHG. NO COMPLICATIONS NOTED.

05/24/16 2313 SS4 SARVIS,SABRINA 05/24/16 2314 SS4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSE. RESP WNL. NO DISTRESS NOTED. CONTINOUS PULSE OX IN PLACE. HOB UP. SR UP. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR.

05/25/16 0610 SS4 SARVIS,SABRINA 05/25/16 0611 SS4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES OPEN. NO DISTRESS NOTED. RESP WNL. WOUND VAC TO MIDLINE ABD INTACT WITH 125MMHG SUCTION. JP DRAIN INTACT WITH OSTOMY IN PLACE.

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/25/16 0610 SS4 SARVIS,SABRINA 05/25/16 0611 SS4 (continued)
HOB UP. SR UP. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR.

05/25/16 0747 NR2 ROBERTS,NATALIE 05/25/16 0753 NR2
Abnormal? N Confidential? N
REPORT RECEIVED AND CARE ASSUMED BY THIS RN, PT RESTING BED EYES OPEN, BREATHS EVEN AND UNLABORED, NO S/S OF IMMEDIATE DISTRESS NOTED, PT DENIES NEEDS AT THIS TIME, JP DRAINING STRAW COLORED DRAINAGE, OSTOMY INTACT, DRAINING GREENISH BROWN SEMI LIQUID STOOL, WOUND VAC ATTACHED, DRESSING C/D/I PRESSURE AT 125, DRAINAGE SEROSANGUIENOUS, IPC AT BEDSIDE, WILL CONTINUE TO MONITOR, BED POSITIONED FOR SAFETY AND CALL BELL/PHONE IN REACH

05/25/16 1130 NR2 ROBERTS,NATALIE 05/25/16 1723 NR2
Abnormal? N Confidential? N
PT RESTING IN CHAIR, HAS AMBULATED TODAY WITH ASSIST AND WALKER, DENIES NEEDS AT THIS TIME. OSTOMY BAG EMPTIED WITH 200 ML GREENISH BROWN LIQUID STOOL. PT DEMONSTRATED USE OF IS, ENCOURAGED TO CONTINUE. CHAIR LOCKED FOR SAFETY, CALL BELL AND PHONE IN REACH. NO S/S OF IMMEDIATE DISTRESS NOTED, WILL CONTINUE TO MONITOR

05/25/16 1723 NR2 ROBERTS,NATALIE 05/25/16 1725 NR2
Abnormal? N Confidential? N
PT RESTING IN CHAIR EYES OPEN, DENIES NEEDS AT THIS TIME, SAYS PAIN IS BETTER TODAY, RESPIRATIONS EVEN AND UNLABORED, NO S/S OF IMMEDIATE DISTRESS, CALL BELL AND PHONE IN REACH, CHAIR LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR

05/25/16 1744 NR2 ROBERTS,NATALIE 05/25/16 1746 NR2
Abnormal? N Confidential? N
PT RESTING IN BED EYES OPEN. C/O BEING GASSY IN REGARDS TO OSTOMY. COMFORTABLE IN BED, PAIN MANAGED, REQUESTED MORE PAIN MEDS WHEN TIME. CALL BELL AND PHONE IN REACH, NO S/S OF IMMEDIATE DISTRESS NOTED, IV ANCEF INFUSING, WILL CONTINUE TO MONITOR

05/25/16 1922 NR2 ROBERTS,NATALIE 05/25/16 1925 NR2
Abnormal? N Confidential? N
PT RESTING IN BED, EYES OPEN, CALM, HAS BEEN C/O GAS PAIN, SEE EMAR. PT DENIUES NEEDS AT THIS TIME, IV ANTIBIOTIC INFUSING, OSTOMY C/D/I, STOMA RED AND BEEFY, APPEARS HEALTHY. WIFE AT BEDSIDE OFF AND ON THROUGHOUT DAY. JP DRAIN DRAINING STRAW COLORED DRAINAGE. BED LOCKED FOR SAFETY, CALL BELL IN REACH, WOUND VAC APPLIED, PRESSURE AT 125, WILL CONTINUE TO MONITOR

05/25/16 1929 MG GODWIN,MELISSA 05/25/16 2022 MG
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. WOUND VAC TO MIDLINE INCISION ON AND PUMPING. DRESSING INTACT. ILEOSTOMY APPLIANCE INTACT, STOMA PINK AND MOIST. NO C/O PAIN AT PRESENT. CALL BELL IN REACH. WILL CONTINUE TO MONITOR.

05/26/16 0730 NR2 ROBERTS,NATALIE 05/26/16 1141 NR2
Abnormal? N Confidential? N
REPORT RECEIVED AND CARE ASSUMED BY THIS RN, PT RESTING IN BED WITH EYES OPEN. DENIES NEEDS AT THIS TIME, PAIN CONTROLLED. NO S/S OF IMMEDIATE DISTRESS NOTED, RESPIRATIONS EVEN AND UNLABORED AT 18. MIDLINE INCISION SITE C/D/I WITH WOUND VAC APPLIED, SUCTIONING AT 125 WITH SEROSANGUINEOUS DRAINAGE NOTED. IV TO RIGHT A/C 20 GAUGE JELCO, SL. IPCs APPLIED, CALL BELL AND PHONE IN REACH, BED LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR

05/26/16 0915 NR2 ROBERTS,NATALIE 05/26/16 1144 NR2
Abnormal? N Confidential? N
PT RESTING IN BED EYES OPEN, ASSESSMENTS COMPLETED, AM MEDS GIVEN. IV SITE TO RIGHT A/C CHANGED BY THIS RN TO RIGHT CEPHALIC VEIN, 20 GAUGE JELCO, IV ANTIBIOTIC INFUSING, SITE C/D/I. PT RECEIVED PAIN MEDS WITH AM MEDS, WILL CONTINUE TO MONITOR. CALL BELL AND PHONE IN REACH, BED LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR

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Occurred Date	Time	by	Author	Recorded Date	Time	by

Nursing Notes

05/26/16 1030 NR2 ROBERTS,NATALIE 05/26/16 1144 NR2
Abnormal? N Confidential? N
PT UP WITH PT, AMBULATING WELL IN HALLS WITH ASSISTANCE FROM WALKER

05/26/16 1144 NR2 ROBERTS,NATALIE 05/26/16 1147 NR2
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSED, AROUSES EASILY. DENIES NEEDS AT THIS TIME, BED LOCKED FOR SAFETY, CALL BELL AND PHONE IN REACH, WILL CONTINUE TO MONITOR

05/26/16 1244 PS SKINNER,PAMELA 05/26/16 1244 PS
Abnormal? N Confidential? N
D. PT C/O ACID REFLUX, MEDICATED WITH 30CC MAALOX.

05/26/16 1912 MG GODWIN,MELISSA 05/26/16 1951 MG
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. NO C/O PAIN AT PRESENT. WOUND VAC TO ABD WOUND, ON, SUCTIONING AT 125 MMHG. JP INTACT AND COMPRESSED, SMALL AMOUNT SEROUS DRAINAGE NOTED. ILEOSTOMY APPLIANCE INTACT, GREENISH DRAINAGE NOTED. IV ABX INFUSING VIA 20G TO RIGHT AC. NAD NOTED. CALL BELL IN REACH.

05/26/16 1915 NR2 ROBERTS,NATALIE 05/26/16 1916 NR2
Abnormal? N Confidential? N
PT RESTING IN BED, REPORT GIVEN TO MELISSA, RN. PT FOOD CAME UP LATE, BUT DID ARRIVE, MAALOX DID HELP SO THE PT ATE WELL FOR DINNER. IV FLAGYL INFUSING AT 100 ML/HR, WILL BE COMPLETED SHORTLY. BED LOCKED CALL BELL AND PHONE IN REACH

05/27/16 0550 MG GODWIN,MELISSA 05/27/16 0630 MG
Abnormal? N Confidential? N
BP REPORTED AS 85/60, 89/60 BY CNA. MANUALLY RECHECKED, READING IS 106/60. PT REPORTS HE WAS SLEEPING VERY WELL. DENIES ANY DIZZINESS, DIAPHORESIS, SOB, WEAKNESS OR ANY OTHER PROBLEMS THIS AM. RESTING QUIETLY IN BED, WOUND VAC INTACT AND SUCTIONING AT 125 MMHG. JP INTACT AND COMPRESSED, ILEOSTOMY APPLIANCE INTACT, DRAINING GREENISH LIQUID BM. SALINE LOCK INTACT. CALL BELL IN REACH.

05/27/16 0720 PS SKINNER,PAMELA 05/27/16 0737 PS
Abnormal? N Confidential? N
d. pt resting in bed. orientated +3. wound vac patent at 125cm suction to mid abd. small amt bld drainage to cannister, jp drain to left abd with scant amt serous drainage. ostomy to right abd with green liquid. abd soft, denies any nausea. i/v s/l to right a/c. comfortable at this time. fox on r/a 94%, chest sounds clear, decreased to bases. using i/s with good effort. urinal at bed-side. pt instructed to call for assist as needed. dr. epstein in to see pt. will continue to monitor.

05/27/16 0947 PS SKINNER,PAMELA 05/27/16 0947 PS
Abnormal? N Confidential? N
D. PT MEDICATED WITH DILAUDID 1MG IV FOR PREVENTIVE PAIN DURING WOUND VAC CHANGE.

05/27/16 1015 PS SKINNER,PAMELA 05/27/16 1134 PS
Abnormal? N Confidential? N
D. DRSG CHANGED TO MID ABD. WOUND VAC SPONGE REMOVED. WOUND ABOUT 6" LONG, NARROWER AT ENDS, ABOUT 1'2" WIDE, ABOUT 1'2 " DEEP. BEEFY RED. NEW SPONGE APPLIED, SUCTION RESUMED AT 125CM WITH GOOD SUCTION, PT TOLERATED WELL.

05/27/16 1155 PS SKINNER,PAMELA 05/27/16 1237 PS
Abnormal? N Confidential? N
D. PT OOB TO BED-SIDE CHAIR, OSTOMY WITH MOD AMT GREEN LIQUID. JP DRAIN WITH SCANT AMT SEROUS DRAINAGE. WOUND VAC REMAINS PATENT 125CM SUCTION. COMFORTABLE AT THIS TIME. CALL BELL IN REACH.

05/27/16 1327 PS SKINNER,PAMELA 05/27/16 1328 PS
Abnormal? N Confidential? N
D. AMBULATED IN HALLWAY WITH WALKER AND MINIMAL ASSIST. PT IN GOOD SPIRITS, TOLERATING WELL. REMAINS IN CHAIR. CALL BELL IN REACH.

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/27/16 1402 PS SKINNER,PAMELA 05/27/16 1402 PS
Abnormal? N Confidential? N
D. OSTOMY NURSE AND CHANGED WAFER AND BAG WITH PT AND SPOUSE. PT REMAINS UP IN CHAIR. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONAL PAIN.

05/27/16 1832 PS SKINNER,PAMELA 05/27/16 1834 PS
Abnormal? N Confidential? N
D. PT REMAINS UP IN CHAIR. REFUSED OFFER FOR PAIN MEDICATION AT THIS TIME. CALL BELL IN REACH. OSTOMY TO RIGHT ABD INTACT WITH SMALL AMT GREEN LIQUID, JP TO LEFT ABD WITH SCANT AMT SEROUS DRAINAGE. WOUND VAC PATENT TO MID ABD WITH 125CM SUCTION. WILL CONTINUE TO MONITOR.

05/27/16 1922 PS SKINNER,PAMELA 05/27/16 1922 PS
Abnormal? N Confidential? N
D. PT ASSISTED BACK TO BED. WOUND VAC PATENT 125CM SUCTION. PT COMFORTABLE AT THIS TIME. URINAL AT BED-SIDE.

05/27/16 1958 BG GORDON,BRITTANY 05/27/16 2002 BG
Abnormal? N Confidential? N
CARE ASSUMED FROM DAY NURSE. PT LAYING IN BED. A/O X3. PT RECENTLY MEDICATED FOR PAIN AT RIGHT AKA SITE. RESP EVEN AND UNLABORED. NO OTHER COMPLAINTS VOICED AT THIS TIME. IVF INFUSING AS ORDERED. OPTIFOAM DRESSING TO SACRAL WOUND. BED IN LOWEST POSITION. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR PT.

05/28/16 0725 PL2 LESLIE,PRISCILLA 05/28/16 0842 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. PATIENT AAO. REPORT RECEIVED. SATS 94% RA, HR 88. WOUND VAC L OF MIDLINE ABDOMEN INTACT/SUCTION INTACT, JP LLQ INTACT; SCANT CLEAR YELLOW DRAINAGE PRESENT, SCANT REDNESS AT INSERTION SITE. OSTOMY RLQ, DRAINAGE AT WAFER/REINFORCED WITH GAUZE. IV RAV INTACT/SL AT THIS TIME. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/28/16 0728 BG GORDON,BRITTANY 05/28/16 0737 BG
Abnormal? N Confidential? N
PT MEDICATED FOR PAIN. LAYING IN BED RESTING. DENIES OTHER NEED AT THIS TIME. OSTOMY, JP, AND WOUND VAC OUTPUT DOCUMENTED. REPORT TO BE GIVEN TO ONCOMING NURSE.

05/28/16 0842 PL2 LESLIE,PRISCILLA 05/28/16 0846 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. MEDICATED AS ORDERED. IV RAC FLUSHES WELL, INTACT/DRY; IV ABX INFUSING. ASSESSMENT PERFORMED. SATS 94% RA, HR 87, RR 18. OSTOMY WAFER/BAG REPLACED AT THIS TIME, TOLERATED WELL. PATIENT REPORTS VOIDING WITHOUT COMPLAINTS, URINAL. REPORTS BLOATED SENSATION, MAALOX HELPS. JP INTACT. WOUND VAC ABDOMEN, INTACT. REFUSING SCDS; VERBALIZES UNDERSTANDING. LOVENOX IN USE. REPORTS PT ASST AND PERFORMS MANY LEG EXERCISES HOURLY WHILE IN BED. PERFORMS I/S WELL; USES FREQUENTLY. PATIENT REPORTS UP TO BATHROOM YESTERDAY, TIRES EASILY. PATIENT DENIES ANY NEEDS. ASSISTED WITH TRAY. CALL BELL WITHIN REACH.

05/28/16 1027 PL2 LESLIE,PRISCILLA 05/28/16 1028 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. SPOUSE AND DAUGHTER IN ROOM. MEDICATED AS ORDERED. OSTOMY INTACT, NO LEAKAGE, 150mL EMPTIED. PATIENT ASSISTED TO CHAIR. REPORTS USING WALKER AS NEEDS. DENIES ANY OTHER NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/28/16 1146 PL2 LESLIE,PRISCILLA 05/28/16 1147 PL2
Abnormal? N Confidential? N
PATIENT SITTING UP IN CHAIR. MEDICATED FOR PAIN. WOUND VAC INTACT, PLACED TOCHARGE. DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/28/16 1606 PL2 LESLIE,PRISCILLA 05/28/16 1607 PL2
Abnormal? N Confidential? N

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/28/16 1606 PL2 LESLIE,PRISCILLA 05/28/16 1607 PL2 (continued)
PATIENT SITTING UP IN CHAIR. AMBULATED HALLS WITH SPOUSE, WALKER IN USE. VITALS OBTAINED. SATS TO 98% RA, STABLE. MEDICATED FOR PAIN AS ORDERED. OSTOMY INTACT. PATIENT PROVIDED WITH WATER AND JUICE. DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/28/16 1700 PL2 LESLIE,PRISCILLA 05/28/16 1701 PL2
Abnormal? N Confidential? N
PATIENT UP AMBULATING IN HALL. WALKER/SPOUSE ASSISTING. SPOUSE ASSISTING IN BATH AT THIS TIME. CALL BELL WITHIN REACH.

05/28/16 1900 TB BOSSE,TRICIA 05/28/16 2142 TB
Abnormal? N Confidential? N
RECEIVED REPORT FROM PRISCILLA,RN. ASSUMED CARE. PT RESTING IN BED. PT ON R/A. NO S/S DISTRESS. IV TO RIGHT AC C/D/I, ABX INFUSING. JP DRAIN IN PLACE TO LLQ, C/D/I, MILD REDNESS NOTED AROUND INSERTION SITE. WOUND VAC TO MIDLINE ABDOMEN INTACT. ILEOSTOMY IN PLACE TO RLQ, DRAINING GREEN LIQUID STOOL. PT DENIES ANY IMMEDIATE NEEDS. CALLBELL AND PERSONAL BELONGINGS WITHIN REACH. BED LOW AND LOCKED.

05/28/16 1925 PL2 LESLIE,PRISCILLA 05/28/16 2048 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. OSTOMY RLQ INTACT, 900 OUTPUT TODAY. VOIDING WITHOUT COMPLAINTS. PAIN CONTROLLED AT THIS TIME. WOUND VAC DRESSING CHANGE IN PROGRESS BY C WHITE, RN. IV FLAGYL INFUSING TO RAC, INTACT/DRY. JP DRAIN INTACT TO LLQ. PATIENT AMBULATED HALLS TODAY, WALKER/ASSIST. SATS MAINTAINED MID TO UPPER 90S. PATIENT DENIES ANY OTHER NEEDS AT THIS TIME. PERFORMING I/S FREQUENTLY. CALL BELL WITHIN REACH.

05/28/16 1931 TB BOSSE,TRICIA 05/29/16 0220 TB
Abnormal? N Confidential? N
PT GIVEN DILAUDID PRIOR TO WOUND VAC DRESSING CHANGE, ADMINISTERED BY CASEY,RN.

05/29/16 0033 TB BOSSE,TRICIA 05/29/16 0220 TB
Abnormal? N Confidential? N
PT C/O ABDOMINAL PAIN, ADMINISTERED PERCOLONE.

05/29/16 0400 TB BOSSE,TRICIA 05/29/16 0606 TB
Abnormal? N Confidential? N
EMPTIED ILEOSTOMY, 200ML GREENISH STOOL. NO OUTPUT FROM JP DRAIN. WILL CONTINUE TO MONITOR.

05/29/16 0550 TB BOSSE,TRICIA 05/29/16 0550 TB
Abnormal? N Confidential? N
PT C/O PAIN, ADMINSITERED PERCOLONE

05/29/16 0700 TB BOSSE,TRICIA 05/29/16 0805 TB
Abnormal? N Confidential? N
PT RESTING COMFORTABLY. NO S/S DISTRESS. NO CHANGES NOTED DURING SHIFT. CALLBELL WITHIN REACH. BED LOW AND LOCKED.

05/29/16 0745 PL2 LESLIE,PRISCILLA 05/29/16 1338 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. WOUND VAC TO ABDOMEN INTACT/SUCTION PRESENT. JP TO LLQ INTACT. ILEOSTOMY TO RLQ INTACT/LOOSE BROWN STOOL PRESENT, 300mL EMPTIED. SATS 94% RA, HR 93. IV RAC SL AT THIS TIME. REPORT RECEIVED. PATIENT AAOX4. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/29/16 0914 PL2 LESLIE,PRISCILLA 05/29/16 0918 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. DC PLANNED TO HOME TODAY PER DR. EPSTEIN. JP DRAIN REMOVED, TOLERATED WELL. GAUZE/TEGADERM PLACED. ASSESSMENT PERFORMED. PATIENT AAOX4. OSTOMY INTACT/300mL EMPTIED. WOUND VAC INTACT TO SUCTION. SATS 94% RA, HR 92, RR 18. FINCE CRACKLES BASES, DEEP COUGH/BREATHING WHILE SPLINTING PERFORMED WITH PATIENT. PAIN CONTROLLED AT THIS TIME. IV CEFAZOLIN INFUSING TO

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

05/29/16 0914 PL2 LESLIE,PRISCILLA 05/29/16 0918 PL2 (continued)

RAC, DRESSING INTACT/DRY. PATIENT REPORTS VOIDING WOITHOUT COMPLAINTS. PATIENT REPORTS PERFORMING I/S FREQUENTLY. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

05/29/16 1151 PL2 LESLIE,PRISCILLA 05/29/16 1156 PL2

Abnormal? N Confidential? N

PATIENT RESTING IN BED. SPOUSE PRESENT IN ROOM. MEDICATED AS ORDERED. DC INFORMATION REVIEWED WITH PATIENT AND SPOUSE. WRITTEN PRESCRIPTIONS TO SPOUSE. WOUND VAC CHANGED TO HOME VAC, SUCTION RESUMED; DRESSING INTACT. GAUZE TEGADERM TO LLQ, OLD JP SITE INTACT/DRY. OSTOMY RLQ INTACT, 200mL EMPTIED. CALL PLACED TO AMEDISYS BY C WHITE, RN. PATIENT AND SPOUSE VERBALIZE UNDERSTANDING OF DC INFORMATION, NO QUESTIONS AT THIS TIME. PROVIDED WITH WRITTEN COPY. IV ABX INFUSING AT THIS TIME. PATIENT DENIES ANY NEEDS. PROVIDED WITH OSTOMY SUPPLIES AND DRESSING FOR JP SITE. CALL BELL WITHIN REACH.

Addendum: 05/29/16 at 1236 by PL2 LESLIE,PRISCILLA RN

HOME WOUND VAC EDUCATION TO PATIENT AND SPOUSE.

05/29/16 1240 PL2 LESLIE,PRISCILLA 05/29/16 1241 PL2

Abnormal? N Confidential? N

PATIENT RESTING IN BED. IV SITE DC AT THIS TIME, TOLERATED WELL. PATIENT PROVIDED WITH TOWELS, WANTS TO FRESHEN UP PRIOR TO LEAVING. ADVISED TO CALL WHEN READY TO LEAVE. SPOUSE PRESENT IN ROOM.

05/29/16 1255 PL2 LESLIE,PRISCILLA 05/29/16 1325 PL2

Abnormal? N Confidential? N

PATIENT TRANSPORTED TO PRIVATE VEHICLE BY HOSPITAL STAFF.

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05/29/16

Conway Medical Center
CONWAY, SC
Patient Discharge Instructions

V00006912886 KNIGHT,DANIEL ERIC

Discharge Diagnosis: OSTOMY

Community Referrals - Services Needed

[x] Home Health Company: AMEDISYS
[ ] Hospice Agency:
[ ] Facility Name:
[ ] Equipment Needed:

Other:

Activities [ ] No Restrictions Up with [ ] Walker [ ] Cane [ ] Crutches

[ ] Resume Activities as Tolerated
[ ] No Driving for days.
[ ] No Heavy Lifting > pounds for days.
[ ] Other:

[x] Up with Assistance
[ ] Fall Precautions
[ ] Return to Work/School on

[x] Restrictions: CONTINUE AMBULATING AS TOLERATED.

Activities as per instructions of Dr.

Diet: REGULAR Supplements: NONE

COMMENT:

Follow-Up Appointments

	DATE	TIME	WITH WHOM	REASON	PATIENT/SO TO ARRANGE
1.			DR,RIMKUS	F/U TUE OR WED CALL FOR APPT	
2.				347-7291	
3.					

Follow up with scheduled appointment as needed with .

WOUND CARE INSTRUCTIONS

[ ] Leave incision open to air
[ ] Keep wound/incision clean & dry
[ ] If Steri-Strips loose, remove them
[x] Cover incision with gauze or transparent dressing
[ ] Keep same dressing on until clinic appointment

Other: WOUND VAC TO BE MANAGED BY HOME HEALTH.
OSTOMY TO BE ASSISTED BY HOME HEALTH.

MEDICATION INFORMATION

[x] Universal Medication Form Given
[x] New Prescriptions Given

PAIN INFORMATION

You may have some pain and discomfort from your procedure. A prescription form may be given to you before you leave the hospital. If the doctor did not prescribe medication for pain, you may take your own non-prescription pain reliever.

Notify Physician for: If you feel that your pain is increasing, or unrelieved.

[x] Temperature over 101 for 24 hours
[x] Foul odor from Wound or Drainage
[x] Incision red, swollen, or warm
[x] Wound red, swollen, or warm

Additional General Instructions CONTACT DR. RIMKUS ON MON/TUES FOR FOLLOW UP APPOINTMENT IN OFFICE.
RETURN TO EMERGENCY ROOM FOR PROBLEMS.

Discharge Education

If any other tests are needed after discharge, please be sure to call your doctor.

NOTIFY DOCTOR IF YOU HAVE

- Trouble breathing or symptoms that are worse
- Pain that is not relieved by your medicine
- Nausea/vomiting/diarrhea that lasts longer than 24 hours
- Signs of Infection: swelling,heat,redness,red streaks,pus formation or other trouble at surgical site
- Signs of heavy bleeding
- Fever greater than 100.4 degrees F

PATIENTS WITH HEART FAILURE

Daily Weights: Weigh every morning, after you urinate and before you eat, using the same scale. Keep a record of your weights. Call your doctor if you gain 2 pounds or more in one (1) day.
Symptoms: Call your doctor immediately or go to the nearest Emergency Room if you have: New or worse shortness of breath, Waking up short of breath, Abnormal bleeding, Increase weakness or fatigue, Swelling of your feet and hands, Chest pain or pressure, Stomach bloating, nausea/vomiting, A fast heart rate, Dizziness or fainting

Diet: Low salt diet. Eat foods and drink beverages that are low in salt. Limit fluids as suggested by your doctor.

PATIENTS WITH STROKES

Risk Factors: Overweight, Diabetes, Sedentary Lifestyle, Irregular Heart Beat, High Blood Pressure

Warning Signs & Symptoms of Stroke: CALL 911 IMMEDIATELY if new or worse: Sudden weakness or numbness on one side of the body, Loss of balance or dizziness, Severe headaches without known cause, Trouble seeing in one or both eyes, Sudden confusion, difficulty speaking or unable to understand

PATIENTS WITH BLOOD CLOTS

Coumadin (Warfarin): Coumadin is a medicine that helps reduce clots from forming and increases the risk of bleeding. It is important to take the medicine at the same time of the day and as told by your doctor. Blood work should be done as instructed. The lab test result is used by the doctor to check and change Coumadin levels as needed. The blood tests are named PT/INR levels. Do NOT miss your blood tests.

Follow up Visits: DO NOT miss follow up visits; always make another appointment if you have to cancel. Talk to your doctor if you have any changes in your diet or medicines, including over-the-counter medications, as these affect the PT/INR levels

Diet: Vitamin K in your diet may affect your response to Coumadin. You do not have to avoid foods high in Vitamin K, but it is very important to try to stay on a steady diet. Too much Vitamin K in your diet may decrease the effect of Coumadin

AVOID major changes in diet, the use of alcohol, and activities/sports that could result in injury

STOP SMOKING

Smoking is not safe for you or the health of those around you. If you or someone in your home smokes or uses other tobacco products, please try to quit. There is support to help you quit.
> Set a date to quit, or begin cutting down the number of cigarettes you smoke
> Line up support-family, friends, or support group.
> Avoid situations that make you want to smoke; ask others not to smoke around you
> Ask your doctor about medication that can help you quit

Please contact the American Heart Association National Center at 1-800-242-8721 or visit the website at http://www.americanheart.org.

05/29/16

Conway Medical Center
CONWAY, SC
Patient Discharge Instructions

V00006912886 KNIGHT,DANIEL ERIC

I have received and understand these instructions and the attached Discharge Education. I was given the opportunity to ask questions.

Patient/Responsible Person Signature & Relationship: 5/29/16 11:20

5A4D43B46E10429588C8, KNIGHT, 517

Date: 05/15/2016
Operating Room #: Operating Room 5
Pre-Operative Diagnosis: RUPTURED SMALL BOWEL
Post-Operative Diagnosis: SAME AS PRE-OP DX.
Procedure # 1: EXPLORATORY LAPAROTOMY WITH SMALL BOWEL RESECTION AND ILEOSTOMY

Admit Status: REG ER
Patient In Room Time: 08:23
Procedure #1 Start Time: 08:39
Procedure #1 End Time: 09:39
Patient Out of Room: 10:10
Wound Class: Classification 3
Anesthesia Type: General
ASA Classification: ASA 1 E

Pre-Operative Checklist

NPO: Yes **Since:** CONTRAST @ 5AM

Surgery Site Marked By: Not Applicable

Patient Identified:
Verbal: Yes
Armband: Yes

Procedure Verified:
Verbal: Yes
Consent: Yes

Allergies: Yes
PCN, SULFA

H and P on Chart: Yes
Blood Available: Not Applicable
Mental/Emotional Status:
Awake, Calm, Oriented
Personal Items:
NA , Jewelry

Other:
TWO RINGS TAPED

IV in Place Upon Arrival: Yes
IV Therapy Explained to Patient: N/A

See Anesthesia Records for Fluid and IV Site Yes

PREOPERATIVE CHG SHOWER/BATH/CLEANSE

Evening Before Surgery	Morning of Surgery	Cleanse with CHG Wipe Prior to Arrival to Holding	Cleanse with CHG Wipe in Holding Area	N/A
				Yes

Nurses Notes: INVANZ 1 GRAM AND DIFLUCAN 200MG GIVEN IN E.R.
RN: Missy Cooke, RN

Transported to OR:

Time	Via	Rails Up?
	Stretcher	Yes

Pre Op Antibiotic Group: **Antibiotic** N/A **Start Time** **Finish Time**

Equipment/Patient/Site Verification

Time Out Taken in O.R. Per Policy: Yes
Correct Implants/Equipment Available: Yes
Position Verified: Yes
Patient Identified: Yes **Procedure Verified:** Yes **Consent Verifed:** Yes
Xrays Reviewed: N/A

Conway Medical Center

Operating Room Record

Account #: V00006912886
Name: KNIGHT, DANIEL E
[redacted] **Gender:** M **Age:**
Race:
Surgeon 1: RIMKUS, GILBERTAS MD
Surgeon 2:
MRN: M000175313 **Admit Date:** 05/15/2016

Site Verification

Sx Site Marked: N/A **Noted in H and P:** Yes **On the Consent:** Yes

Personnel

Anesthesiologist:
Melnytskyy,Igor
CRNA:
Kimberlie Hitchcock, CRNA
Circulator:
Missy Cooke, RN
Scrub:
Vicki Bottini, CST
Assistant:
Candida Barr ORT

Ancillary Personnel

Position and Preparation

Position: Supine Position
Positioning Devices: Pillow
Location UNDER HEAD
Safety Straps: ARMS, THIGHS
Protective Devices Intermittant Pneumatic Compressions
Location BLE

Equipment

Cautery	Bipolar	Wetfield	Cut	Coag	Lot	Pad	Skin Intact
T8E6739E			50	50		RIGHT THIGH	Yes
Ligasure # 1 CTS 550949							

Counts

Counts	Scrub	Final Count	RN
Taken	Vicki Bottini, CST	Correct	Missy Cooke, RN

Care Plan

Nursing Diagnosis:
1. Anxiety/Fear
Lack of knowledge related to surgery
Nursing Intervention:
Warm blanket
Describe events. Allow questions.
Provide emotional support
Remain with patient during induction
Provide quiet atmosphere

Expected Outcome:
Verifies Procedures to be Performed

Nursing Diagnosis:
3. Fluid/Electrolyte Excess or Deficit
(Actual or Potential)
Nursing Intervention:
Catheter: Yes
Catheter Type: Foley Catheter
Catheter Size: 16 FR 2 WAY 10 CC
In Place on Arrival: No
Inserted By: C. BARR, CST

Expected Outcome:
Patient's fluid electrolyte balance maintained

Outcome: Calm

Nursing Diagnosis:
2. Infection (Actual or Potential)
Nursing Intervention:
Assess any breaks in skin
Hair Removal:

Prep Solution: Chloraprep

Expected Outcome:
Patient is free from signs of infection
Outcome:
Skin Intact: Yes
Reaction: No

Outcome:
Expected Outcome Met: Yes
Urine Color: Amber
Urine Appearance: Clear
Removed in OR: No
Amount cc: 175
Catheter Secured: Yes

Nursing Diagnosis:
4. Injury, Potential For:
Foreign Body
Burn
Neuromuscular Trauma (related to positioning)
Hemorrhage
Falls/Trauma
Thrombo-emboli Formation
Impaired Skin Integrity

Expected Outcome:
Patient's Skin Integritiy Remains Intact
Patient is free from injury
Outcome:
Skin Condition: Clear
Equip. Tested/Functioning Properly: Yes

Medication(s) and Irrigation(s)

Intra-op Medications:

Time	Meds	Dose	Admin By	Route
	EXPAREL 1.3%	20CC	DR. RIMKUS	Local Injection

Irrigation: Normal Saline
For Hysteroscopies Only:
Irrigation Input: 0 **Irrigation Output:** 0

Dressing(s) and Cast

Dressing: ABD
Plain Sponges
Silk Tape
Telfa
Comments: ILEOSTOMY BAGS SENT WITH PATIENT.

Pathology and Laboratory

Specimens: Yes
Specimen Verified w/MD: Yes
Type: A. PORTION OF SMALL BOWEL
Frozen Section: No

Closing Notes

Message:	Time
Message Given	08:40

Transferred via: Transferred by Roller
Discharged to: Intensive Care Unit

Addendum:

CONWAY MEDICAL CENTER

ANESTHESIA RECORD

V00006912886
KNIGHT, DANIEL ERIC
[redacted]
M000175313 05/15/16

ANTIBIOTIC: Invanz + Diflucan in ED
START:
SIGN:

PS (I) II III IV V (E)
Pre-Op Diagnosis: Ruptured bowel
Post-Op Diagnosis:

All medications administered IV unless another route documented.

Allergies: PCN, Sulfa
Date: 5/15/16 OR No: 5 Page: 1 of 1
Procedure: Ex Lap, Resection small bowel, ileostomy
Surgeon: Rinkus

	START	STOP
Anesthesia	0823	1020
Procedure	0839	0939

PRE-PROCEDURE
- ☑ Identified ☑ ID Band ☐ Questioning
- ☑ Chart Reviewed ☑ Permit Signed
- ☑ NPO Since 0500
- Pre-anesthetic State: ☐ Calm ☐ Asleep ☑ Awake ☐ Confused ☑ Apprehensive ☐ Unresponsive ☐ Uncooperative

PATIENT SAFETY
- ☑ Anes. Machine #5 Checked ☑ Safety Belt On ☐ Axillary Roll ☑ Armboard Restraints ☐ Arms Tucked ☑ Pressure points checked and padded
- Eye Care: ☐ Ointment ☐ Saline ☑ Taped ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT
- ☐ Steth: ☐ Precord ☐ Esoph ☐ Other
- ☑ Non-Invasive B/P ☑ Left ☐ Right
- ☑ Continuous EKG ☐ V Lead EKG
- ☑ Pulse Oximeter ☑ Oxygen Sensor
- ☑ End Tidal CO_2 ☐ Gas Analyzer
- ☑ Temp ☐ ☑ Nerve Stimulator
- ☑ Warming Blanket ☑ BIS ☐ Doppler
- ☑ Airway Humidifier ☐ Fluid Warmer
- ☑ NG/OG tube ☑ Foley Catheter
- ☐ Art. Line Pre induction
- ☐ CVP
- ☐ PA Line
- ☐ IV(s) 18 LAC 18 RAC in OR
- ☑

ANESTHETIC TECHNIQUE
- General: ☑ Pre-Oxygenation ☐ L.T.A. ☐ MAC ☐ Rapid Sequence ☑ Cricoid pressure ☑ Intravenous ☐ Inhalation
- Regional: ☐ Spinal ☐ Epidural ☐ Brachial ☐ Bier ☐ Popliteal
- ☐ _____ ☐ Position _____
- ☐ Prep _____ ☐ Local _____
- ☐ Needle _____
- ☐ Drug(s) _____
- ☐ Dose _____ ☐ Attempts x _____
- ☐ Dose _____ ☐ Level _____
- ☐ Site _____ ☐ See Remarks
- Block Time out at _____ Agreed: _____

AIRWAY MANAGEMENT
- Intubation: ☑ Oral Tube size 8.0 ☐ Stylet used ☐ Nasal ☐ GS _____ ☐ Mac ☐ Direct ☐ RAE ☐ Fiber optic ☐ Blind ☐ Armored ☑ Bladder MAC 3 ☐ Laser
- ☑ Secured at 22 cm ☐ Endobronch. ☐ Attempts x 1 ☑ ET CO_2 present ☑ Breath sounds (=)
- ☐ Uncuffed leaks at _____ cm H O ☐ Cuffed ☑ Min. occ. pres ☐ Air ☐ NS
- Airway: ☐ Oral ☐ Nasal ☐ Difficult
- Circuit: ☑ Circle ☐ NRB see Remarks
- ☐ Mask Case ☐ Nasal Cannula
- ☐ Via Tracheostomy ☐ LMA # _____

RECOVERY
- Location: PACU Time: 913
- B/P 139/73 O_2 Sat 100%
- P 134 R vent T 97.6
- ☐ Awake ☑ Stable ☐ Nasal Oxygen
- ☐ Drowsy ☐ Unstable ☐ Mask Oxygen
- ☐ Somnolent ☐ Intubated ☐ T-piece Oxygen
- ☐ Unarousable ☐ Ventilator ☐ Oro/nasal airway

Report to: Diane RN PACU RN

FLUID TOTALS
- Crystalloid 3000
- Blood
- Albumin 25% X500ml
- EBL <100
- Urine 175

REMARKS
1. Monitors applied. Patient reassessed maxed self to table c assist SIVI/RSI, A1c Grd 1, PPP NGT (L) nare. inserted prior to induction
0900 → 0915 Ofirmev 1gm IV
0906 Albumin 25% 100ml x5
2. Pt alert & appropriate c return of reflexes sx extt. Pt is tachypneic, ET CO_2 60's, tachycardic & lethargic decision to keep on vent to ICU per MD & surgeon

Initials attest that I or my partner(s) are:
- Present for intubation
- Immediately available throughout
- Monitoring at frequent intervals
- Present for extubation if applicable

TOTALS
- 4 mg
- 1000 mcg
- mcg
- 300 mg
- 45 mg
- 100 mg
- 50 mg
- 4 mg
- 50 mg
- 30 mg

FLUIDS/AGENTS / MONITORS

	TIME:	0830	0900	0930	0945	1000	1030
	Oxygen (L/min)	10	1.5	1.5	1.5	1.5	
	☐ N2O/☐ Air (L/min)	1.5	1.5	1.5	1.5		
	50/50 (%)	2.0					
	Versed mg	2					
	Fentanyl mcg	50				50	
	Sufenta mcg						
	Propofol mg	200					
	Zemuron mg	50	30	10			
	Anectine mg	140					
	Lidocaine mg	50					
	Ondansetron mg						
	Toradol/Ketorolac mg	15					
	Morphine mg						
	IV Fluids NS	1000	1000				
	Urine (ml)			175			
	EBL (ml)	Not recorded					
	EKG	ST	ST	ST	ST	ST	ST
	%O_2 Inspired	100	60	100	100	100	100
	O_2 Saturation	100	99	100	99	100	100
	End Tidal CO_2	36	36	32	34	40	40
	Temp ☐ °C/☐ °F	96	97	95	97	X	
	Bis	96	97	45	97		
	Train of Four			3	2	4 ST	
	Warming Blanket °C	38	→	→	→	X	

VITAL SIGNS

Baseline Values: 160# Wt; 87/44 B/P; 125 P; 96% SP O_2

	0830	0900	0930	0945	1000	1030
B/P	87/44	65/32	76/38	62/31	79/39	75/38
P	125	110	96	86	80	75
SP O_2	96%	98%	98%	98%	100%	100%

VENT

Tidal Volume	624	650	610	624	719	775
Resp. Rate	16	16	16	16	SN	SN
Peak Pressure	26	24	22	26		
PEEP						
Symbols for Remarks					(2)	
Position						

SYMBOLS: X Anesthesia; ⊙ Operation; v ^ BP Cuff Pressure; ÷ Arterial Line Pressure; ▲ Mean Arterial Pressure; • Pulse; ○ Spont Resp; ⊘ Assisted Resp; ⊗ Controlled Resp; T Tourniquet

Tourniquet: R Up 0830 Down 0930 Total Time 60 min

Anesthesia Provider: Mitchell CRNA Williams CRNA

5A4D13B46E10429588C8, KNIGHT, 522

GNA-97-FRM
REV 6 09.22.15

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886 [redacted]
M000175313
05/15/16

Preoperative Checklist

Date: 5/15/16 | Date of Surgery: __/__/__

Pre-Op: Wt. 73 Kg 9 lb P 122 R 20 B/P _____

Allergies: Sulfur PCN

Items 1 thru 9 are **REQUIRED** fields

1. Identification Band Correct and on arm ☑ Yes ☐ No

2. Isolation ☐ Yes ☑ No Type _____
Latex Allergy ☐ Yes ☑ No
Iodine Allergy ☐ Yes ☑ No
O.R. Notified Stat of any Yes at (8131)

3. Operative Permit ☐ Yes ☐ No
Signed _____
Witnessed _____
Procedure _____
Physician signature present ☐ Yes ☐ No

4. Anesthesia Consent ☐ Yes ☐ No
5. History & Physical ☐ Yes ☐ No
Copy on Chart _____
Adm. Sum in Progress Notes _____

6. NPO since 1800 5/14. **If less than 6 hrs, call physician.**
7. Hgb less than 10gms, call physician
8. Potassium Level less than 3.0 or greater than 5.5 call physician
9. Blood: Green
Typed ✓ **Crossmatched** _____

Surgical Attire: Hospital gown ☐ Yes ☐ No
Code Status: ☑ Full Code ☐ DNR (No Code)
Oriented: ☑ Yes ☐ No
Fall Risk: ☐ Red ☐ Yellow ☑ Green
Family: ☑ OR Waiting ☐ Patient room ☐ Other: _____

Removal of : ring taped to finger

Make-up	☐ Yes	☑ No
Underclothing	☐ Yes	☑ No
Jewelry	☐ Yes	☐ No
Chewing Gum	☐ Yes	☑ No
Contact Lens	☐ Yes	☑ No
Prosthesis	☐ Yes	☑ No
Denture/Partial Plate	☐ Yes	☑ No
Hair Pins	☐ Yes	☑ No

Specialty Needs/Precautions: NA
☐ Blind
☐ Deaf
☐ Hard of Hearing
☐ Language

Pre-op Teaching: ☐ Yes ☐ No
Turn, Cough & Deep Breathe ☐ Yes ☐ No
Pain Med ☐ Yes ☐ No
Ambulation – Activity: _____ ☐ Yes ☐ No

☐ OSA Assessment completed and on chart
☐ MAR for OR

Prep Done: Time _____ Initials _____ ☐ Clippers ☐ Betadine

Skin cleansing with CHG:
The night before surgery ☐ Yes ☐ No
The morning of surgery ☐ Yes ☐ No
If emergency use CHG wipes ☐ Yes ☐ No
N/A (meets exceptions) ☐ Yes

Medical Clearance Ordered? ☐ Yes ☐ No
If yes, on chart? ☐ Yes ☐ No
Voided pre-op at (time) _____
Foley catheter inserted at (time) _____
☐ Pre-Op antibiotic & secondary tubing sent to O.R. with patient
Beta Blockers: ☐ NA ☐ Yes Time taken _____ ☐ No Reason _____
Other Pre-op Medication: _____
Given at (time) _____
Site _____
U/A on chart (only if ordered) ☐ Yes ☐ No
Chest X-Ray: (Per Anesthesia Protocol) ☐ Yes ☐ No
Done within 6 months of surgery ☐ Yes ☐ No
Report on chart ☐ Yes ☐ No
EKG Completed (date) _____ (Per Anesthesia Protocol)

Present Medication includes:
☐ Diuretic ☐ Antihypertensive ☐ Digitalis

Release to O.R. at (time) _____

Above information validated at (time) _____

By _____

Nurse contact name and number:

ANS-2551-FRM
REV 0 02.16.11

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886
M000175313
[redacted]
05/15/16

POST ANESTHESIA EVALUATION

Direct observation and chart review:

- [x] Airway patent on vent
- [x] Patient conversant and appropriate on vent
- [x] Vital signs stable for discharge
- [x] PONV controlled
- [x] Hydration adequate
- [x] Pain Controlled

Anesthesia comments/complications/interventions:

5/15/16
Date

1054
Time

Hitchcock CRNA
MD/CRNA

ANES-07-FRM
REV 1 04.15.16

Ane esia
Pre-Anesthetic Evaluation

RSX SD

V00006912886
ER
KNIGHT, DANIEL ERIC
[redacted]
CONWAY EMERGENCY GROUP
M000175313

SURGEON	EVAL.DATE	TIME
Rimkus	5/15/16	

PROPOSED PROCEDURE: Ex Lap

PREOPERATIVE DIAGNOSIS:

BP	TEMP	PULSE	RR	[redacted]	WEIGHT	HEIGHT
87/44	97.8	125	22		160	5'3"

RESPIRATORY: ☒ Negative Hx
☐ Recent URI ☐ Emphysema ☐ Home Oxygen
☐ Asthma ☐ COPD ☐ Productive Cough
☐ Bronchitis ☐ Intubated on Vent ☐ Dyspnea on exertion
☐ Pneumonia
☐ CPAP/BIPAP ☐ Obstructive Sleep Apnea ☐ SOB at rest
☐ Cigarettes _____ packs/day x _____yrs ☐ Quit _____
☐ Anticipate Post-op Ventilation ☐ Hemoptysis
P FT's: _____
CXR: _____

GASTROINTESTINAL: ☐ Negative Hx
☐ Hiatal Hernia ☒ Acute abdomen ☐ Full Stomach
☐ Hepatitis history ☐ Liver Dysfunction ☐ Jaundice
☐ Reflux ☐ Bowel Obs. ☐ Peptic Ulcer
☐ Current N/V ☐ ETOH/Frequency _____

ENDOCRINE: ☒ Negative Hx
DM: ☐ Type I ☐ Type 11 ☐ Diet control ☐ Oral Med ☐ Insulin
☐ Hyperlipidernia ☐ Hypo Thyroid ☐ Hyper Thyroid ☐ Obesity
☐ Morbid Obesity ☐ Recent Steroid Use ☐ Need Steroid Coverage
☐ Gout

MUSCULOSKELETAL: ☒ Negative Hx
☐ Arthritis/DJD ☐ Muscle weakness ☐ Neuromuscular disease
☐ Back Pain ☐ Back Surgery ☐ Leg Pain R/L/Both
☐ Fracture/dislocation ☐ Fibromyalgia
☐ Rheumatoid Arthritis

ALLERGIES: ☒ NKDA
☐ Codeine ☐ Latex
☐ Adhesives ☐ IVP/Contrast Dye
☒ PCN ☐ Betadine/Shellf
☐ Cephalosporin's
☒ Sulfa

CARDIOVASCULAR: ☒ Negative Hx
☐ CAD ☐ Pacemaker/Defib ☐ Palpitations ☐ DVT
☐ CHF ☐ MVP ☐ Angina ☐ Filter
☐ Prior MI x ___ ☐ Murmur ☐ Pedal Edema ☐ PND
☐ Angioplasty ☐ Rheum. Heart Dis. ☐ Orthopnea
☐ Stents x _____ ☐ Atrial Fib ☐ Periph Vas
☐ Hypertension ☐ CABG x _____ ☐ Carotid Artery stenosis
☐ Poor condition
EKG: _____ E.F. _____%
Carotid duplex: ☐ No Ischemia
☐ Echo:
☐ Stress Test:
☐ Heart Cath:

RENAL: ☒ Negative Hx
☐ Stress Urinary Incontinence ☐ Chronic renal dis.
☐ ESRD ☐ Hemo/Peritioneal dialysis ☐ Last dialysis _____
☐ Hx stone ☐ UTI ☐ BPH ☐ Prostate CA

NEURO: ☒ Negative Hx
☐ Seizure hx Last seizure _____
☐ TIA ☐ CVA
☐ Paralysis/Sensory Deficit/Wkness L/R
☐ Syncope ☐ Parkinson
☐ Peripheral Neuropathy
☐ CID
☐ IVIS

PSYCH: ☐ Negative Hx
☒ Anxiety ☐ Depression
☐ Manic ☐ Bipolar
☐ Panic Attacks
☐ ADHD ☐ Dementia
☐ Schizophrenia
☐ Narcolepsy

HEMATOLOGICAL: ☒ Negative Hx
☐ Anemia Hemophilia
☐ Prolong bleeding
☐ Sickle Cell Disease
☐ Jehova's Witness/refuses blood

CANCER SITE: _____
☐ Chemo
☐ Rad Therapy
☐ mets

INIFECTOLIS DISEASE:
☐ HIV
☐ MRSA
☐ TB
☐ Hepatitis

MEDS: Prozac
Invanz 1Gm @ 0653
Toradol @ 0527
Diflucan 200mg

Ordered: H&H Plt Cnt CBC K+ Cr Glu CMP/BMP EKG CXR Pt/PTT Type S/Cm ____ Units bid. Avail.=_____ Auto _____
Date of Test: 5/15/16 K+ 3.9 Glu 224 BUN 25 Cr 1.74 HGB 16.9 HCT 50.4 Plt 632 PT_____ PTT _____ INR _____
UA _____ Urine C&S _____ Pregnancy _____ Other: _____

Previous Surgery	Anesthesia	Complications ☐ Yes ☐ No	Units T&C/T&S
			HCG: ☐ Neg ☒ N/A / Other:

Record on Appeal 0943
5A4D43B46E10429588C8, KNIGHT, 525

ANES-07A-FRM
REV 0 04.15.1

ANESTHESIA ASSESSMENT

V00006912
KNIGHT, DANIEL ERIC
[redacted]
M000175313 05/15/16

Have you or any family member ever had a complication from anesthesia?
☐ Yes ☒ No If yes, describe _____

☐ History of Malignant Hyperthermia
☐ Awareness under Anesthesia
☐ Family History of Neuromuscular Disease

PONV Risk Assessment
☐ History of PONV ☐ History of Motion Sickness ☐ Female ☒ Non Smoker
☒ Intended administration of opiates for post-op analgesia

HEAD & NECK
Dental Hygiene ☒ Good ☐ Poor ☐ Possible anterior larynx (retro gnathic)
Neck ROM ☒ Good ☐ Poor ☐ Airway Class I (II) III IV
Oral Opening ☒ Good ☐ Poor ☐ Severe Indigestion/ Reflux Only after meals _____ Anytime _____

PROPOSED ANESTHESIA ☐ Reviewed Pre-Anesthetic Evaluation

☒ General	Monitors Discussed:	ASA PS (1) 2 3 4 5 (E)
☐ SAB/CLE/Block ☐ Block for post-op pain mgt.	☐ A-Line	NPO Past * 0500 Oral Contrast
☐ GA if Block Fails	☐ CVL	
☐ MAC	☐ P A Catheter	
☐ TIVA		

Signature -Anesthesia Provider Date Time

☒ Monitors/Equip Check/ Calibrated/Alarms enabled
Patient Re-assessed ☒ No Change ☐ See Additional notes

Additional Notes:

[signature] 5/15/16 0810
Signature -Anesthesia Provider Date Time

PQRS

Pt. Smoked today ☐ Yes ☐ No N/A
☐ PONV 3 or more risk factors and general inhalation anesthesia: Received multi-modal therapy N/A
☒ Perioperative Temperature Management: All cases 60 minutes or greater: Temperature documented 95.9 or above on Anesthesia Record
SBAR used on transfer to: ☒ PACU ☐ ICU Initials: KH Date: 5/15/16 Time: 0900

OR-2319-FRM
REV 2 01.08.16

Conway Medical Center
Conway, South Carolina

Surgical Safety Checklist

V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

Procedure: Exploratory Laparotomy, poss. Bowel Resection, poss. colostomy

Pre-Anesthesia Interview ⟹ Before procedure ⟹ End of procedure

ODSU/OR Holding Area

☑ **NURSE REVIEWS CHART AND CONFIRMS**
- Patient Identity
- Allergies
- Procedural & Anesthesia Informed Consent
- Procedure
- H & P
- Surgical schedule/Physician Order/ Plan of Care

☑ **PATIENT/PROCEDURE SPECIFIC**
- Blood or Blood Products available
- Non-pregnant status confirmed

☐ **SCIP MEASURES**
- Pre Op Antibiotics Invanz 1gm @ 0653
- DVT Prophylaxis
- Beta Blockers

☐ N/A
☐ Hold (see Nurse' notes)
☐ Administered/taken as instructed

☐ **SIDE/SITE MARKED** N/A 0820

M. Cooke, RN 5-15-16
RN Signature **Date/Time**

Anesthesia ☐ Not Applicable

☑ PATIENT HAS CONFIRMED
- IDENTITY
- SITE
- PROCEDURE
- CONSENT
- ALLERGIES

☑ **Pre Anesthesia Assessment**

Anesthesia considerations

Difficult airway/aspiration risk
☐ **Yes, and equipment/assistance available**

Risk of > 500ml blood loss (7ml/kg ch children)
☐ **Yes, adequate intravenous access and fluids planned**

Risk of hypothermia
☑ **Yes, warmer in place**

☐ **Dosimeters for those procedures requiring radiological imaging/guidance**

Whitehead CRNA 5/15/16 0820
Signature CRNA/MDA **Date/Time**

Time Out

TEAM MEMBERS HAVE BEEN IDENTIFIED

☑ **TEAM CONFIRMS**
- PATIENT IDENTITY
- SIDE & SITE MARKED
- PROCEDURE
- CONSENT
- POSITION
- ALLERGIES

☑ **NURSING TEAM CONFIRMS**
- STERILITY
- EQUIPMENT ISSUES OR CONCERNS
- IMPLANTS AVAILABLE

☑ **ESSENTIAL IMAGING**
- FILMS DISPLAYED
- DOSIMETER BADGES
- LEAD SHEILDING

☐ **SCIP**
- **Antibiotic administered**
- **DVT Prophylaxis**
- **Beta Blockers**
  ☐ **Given** ☐ **NA** ☐ **Held**

☑ **ANTICIPATED CRITICAL EVENTS**
- PATIENT SPECIFIC CONCERNS
- SAFETY PRECAUTIONS
- FIRE RISK LEVEL IDENTIFIED

Debriefing

NURSE VERBALLY CONFIRMS WITH THE TEAM:

☑ **THE NAME OF THE PROCEDURE RECORDED**

☐ **THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)**

☑ **HOW THE SPECIMEN IS LABELLED** (INCLUDING PATIENT NAME)

☐ **WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED**

☑ **SURGEON, ANESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT**

M. Cooke, RN
Circulating Nurse Signature
5-15-16 0939
Date Time

Team members present for Time Out: #1 M.Cooke, K. Whitehead, Dr Rinkus, C. Bass, V. Bottini Time: 0839

Team members present for Time Out: #2 _____ Time: _____

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

DATE OF PROCEDURE:
05/15/2016

PREOPERATIVE DIAGNOSIS:
Perforated viscus, peritonitis.

POSTOPERATIVE DIAGNOSIS:
Perforation of terminal ileum, peritonitis.

PROCEDURE:
Resection of small intestine and ileostomy.

SURGEON:
Gilbertas Rimkus, MD

ANESTHESIA:
General endotracheal.

DISPOSITION:
To the recovery room, extubated, in fair condition.

INDICATIONS AND OPERATIVE CONSENT:
Please see my history and physical report.

OPERATIVE TECHNIQUE:
The patient was positioned supine on the operating room table. After induction of general endotracheal anesthesia the abdomen was prepped and draped in the usual sterile fashion. A middle laparotomy incision was made. The abdominal wall was opened in layers. A large amount of fluid with intestinal contents was in the abdomen. This was suctioned out. Upon exploration of the abdomen perforation in the terminal ileum was found with significant surrounding peritonitis and the intestine was resected and given the significance of contamination and peritonitis I decided to perform ileostomy. An opening in the right lower quadrant was created and the abdominal wall and I brought out both ends of the ileum one distal to the terminal ileum and the other proximal to the terminal ileum to facilitate take down of the ostomy in the future. The abdominal cavity was then irrigated with 2L of warm normal saline and after the irrigant was suctioned out the 10 mm JP drain was placed in the right lower quadrant where the contamination was the heaviest. It was brought out through the stab incision in the left lower quadrant and sewn in with 2-0 nylon stitch. After lap and instrument counts were confirmed correct, the midline fascia was closed with looped #1 PDS starting in each corner and tightening in the middle. The abdominal wound was irrigated again and a total of 10 mL of Exparel was injected to the wound for postop pain control. The skin was approximated loosely with staples and Telfa strips and cleaned and the double barrel ileostomy was matured with interrupted 4-0 Vicryl stitches. The ileostomy appliance was attached and initially it was thought the patient would be able to get extubated but we decided to leave him intubated due to persistent respiratory insufficiency. We will send the patient to the intensive care unit.

Gilbertas Rimkus, MD Date/Time

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

cc: Gilbertas Rimkus, MD
GR/4101507
DD: 05/15/2016 10:03
DT: 05/15/2016 10:30
LM File#: 201605150000035745
Job #: 4101507

Electronically Signed By:
RIMKUS,GILBERTAS MD,
May 18 2016 12:57PM

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/15/16 09:53	
Medication	
New: Diflucan 200mg/100ml (fluconazole in NaCl) 200 mg IV Q24H Severe Interaction: ondansetron HCl (PF) 4 mg/2 mL injection solution and fluconazole 200 mg/100 mL in sod. chloride (iso) intravenous piggyback may interact based on the potential interaction between ONDANSETRON and QT PROLONGING AGENTS. *Override Reason:* Provider Aware - Continue as ordered	

Malbach 5/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 09:53

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AIS - ASSOCIATES IN SURGERY - GENERAL SURGERY ADMISSION ORDERS (SURG-3330-REV 2-02.04.14)) - 05/15/16 09:53	
The following orders are 'print-only.' Please take action: for each Order Type	
New: Admit Location PCU	
New: Admit Status Inpatient	
New: Dx Intestinal perforation Peritonitis	
Lab	
New: CBC WITH AUTO DIFF in AM	
New: BMP in AM	
Diet	
New: NPO Dietary Supplements: Supplement Frequency: Fluid Restrictions: Special Modifications:	
Other	
New: Activity OOB to chair BID starting in AM	
New: Admit to: Rimkus, Gilbertas MD	
New: Insert NGT/OGT Insert:Nasogastric tube Comment:to low intermittent suction	
New: Intake & Output I&O Frequency:Every shift	
New: JP Drain to bulb suction: JP drain to bulb suction:Recharge PRN. Record output Q shift.	
New: Phy Msg Leave foley	
New: Vital Signs Every 4 hours X 24 hrs then Q8hrs	
New: Incentive Spirometer Every hour	
New: O2 order O2 L/min:2 L Mode:Nasal Cannula O2 Frequency:Continuous Comment:DC if Room air SATs > 92%	
Medication	

JS 05/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 09:53

Mallory 5/15/16

5A4D43B46E10429588C8, KNIGHT, 531

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AIS - ASSOCIATES IN SURGERY - GENERAL SURGERY ADMISSION ORDERS (SURG-3330-REV 2-02.04.14)) - 05/15/16 09:53	
New: Lactated Ringers IV Bag 1000 ML 150 MLS/HR Number of Liters: Continuous	
New: Dilaudid Soln (hydromorphone (PF)) 1 MG IV Q2H PRN pain - .5 mg for pain<5, 1mg for pain>5	
New: Tylenol Tab (acetaminophen) 650MG oral Q4H PRN fever > 101.5	
New: Acetaminophen Rectal Supp 650MG rectal Q4H PRN fever > 101.5	
New: Phenergan 12.5MG IV q3h PRN nausea	
New: Zofran Inj 4MG IV q3h PRN nausea	
New: Protonix (pantoprazole) TabEC 40MG oral qhs - may give IV if NPO	
New: Protonix (pantoprazole) 40MG IV .HS - Give if NPO	
New: Maalox Plus Susp 30ML oral Q4H PRN indigestion - unless patient is NPO	
New: Mylicon-80 Chew (simethicone) 80MG oral ACHS PRN gas/bloating	
New: Invanz (ertapenem) 1GM IV Q24H X 3 doses - Please specify number of doses	

5

5/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 09:53

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders (VTE Prophylaxis Order Set (CCC-395-REV 1-03.13.14)) - 05/15/16 09:53	
Other	
New: Intermittent Pressure Devices Comment:Bilateral **New:** CQM VTE PHARMACOLOGICAL Reason No VTE Pharmacological Prophylaxis:Post-op Bleeding concerns	

BS 05/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 09:53

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

PHYSICIAN'S ORDERS

CCU Daily Orders

Center Patient Admission Label Here

☐ ICU Level of Care	☐ PCU Level of Care	CONTINUED CARE ONLY ☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies:

Date	Time	New Orders:
6/15/16	1016	Vent orders: SIMV mode, VT=500 ml, PS-10 PEEP-5, RR-10/min, FiO2-60%, Will notify RRT, MD, Resident

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jun 15 2016 1:10PM

Physician Signature **Date** **Time**

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Post Anesthesia Care Orders (ANES-363 - Rev 6 - 09.09.15) for Dr. Melnytskyy) - 05/15/16 09:27	
Other	
New: Discharge from PACU Discharge from PACU when discharge criteria met. New: Warming blanket May use warming blanket for hypothermia or comfort. New: O2 order O2 L/min:10 L Mode:Face Tent O2 Frequency:Continuous Maintain O2 Sat greater than or equal to:92 % O2 Sat Comment:May discharge with O2 at 2L via nasal cannula to keep SaO2 above 92%	
Medication	
New: Morphine Sulfate Soln (morphine) IV q2min PRN pain - May give 2 MG IV every 2 min up to 10 MG IN PACU ONLY	

JS 05/15/16 1106

Signed Electronically by IHOR MELNYTSKYY MD on 05/15/16 09:27

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies:

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/15/16 10:05	
Other	
New: Physician Consult Physician to be consulted:Santiago, Kenneth MD SubSpeciality Group on Call: Hospitalist Reason for Consult:Ventilator management Consult require NPO diet?: NO	
New: Phy Msg Sedation as per ICU protocol.	

SS 05/15/16

Maulsatz 5/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 10:05

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/15/16 10:59
Other
New: Phy Msg Change admission to ICU

malbath 5/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 10:59

OC-1

KNIGHT, DANIEL E
[redacted]
Room:
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/15/16 11:00	
Other	
New: Phy Msg IV Propofol sedation as per ICU protocol.	

Maubach
5/15/16

Signed Electronically by Gilbertas MD Rimkus on 05/15/16 11:00

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/15/16 16:02	
Medication	
New: Lactated Ringers IV Bag 1000 ML 500 ML bolus Number of Liters: (bolus only)	

Malbon 5/15/16

Signed Electronically by Kenneth MD Santiago on 05/15/16 16:02

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

CCU Daily Orders

☐ ICU Level of Care	☐ PCU Level of Care	CONTINUED CARE ONLY ☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies:

Date	Time	New Orders:
5/15/16	1130	Extubate when stable V.O. Dr Rimkus / Mallard
		Electronically Signed By: RIMKUS,GILBERTAS MD, Jun 15 2016 1:10PM
5/15/16		~~No Effort~~ M NS 500 cc bolus, x1 now over 1hr T.O. Dr Santiago / Mallard
		Electronically Signed By: SANTIAGO,KENNETH MD, Jun 20 2016 3:41PM
5/15/16		Morphine 1-2 mg IV Q4h prn pain V.O. Dr Santiago / Mallard
		Electronically Signed By: SANTIAGO,KENNETH MD, Jun 20 2016 3:41PM
		Mallard

5/15/16 2140

Physician Signature ____/____/____ Date ____ Time

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/16/16 08:48	
Lab	
New: BMP in AM **New:** CBC WITH AUTO DIFF in AM	
Radiology	
New: PORTABLE CHEST ONE VIEW * today REASON FOR EXAM?: Shortness of breath	
Other	
New: Incentive Spirometer Every 2 hours	
Medication	
DC due to change: **D/C** Dilaudid Soln (hydromorphone (PF)) 0.5 MG FOR PAIN </= 5; 1 MG FOR PAIN > 5 ON SCALE IV Q2H PRN pain RX Number: 07120572 **D/C** **New:** Dilaudid Soln (hydromorphone (PF)) 2mg IV Q2H PRN pain	

5/16/16

Notified 1032

5/16/16

Signed Electronically by Kenneth MD Santiago on 05/16/16 08:48

5A4D43B46E10429588C8, KNIGHT, 541

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/16/16 13:35	
Medication	
New: Toradol Soln 30 mg/mL (1 mL) (ketorolac) 30MG IV Q6H PRN pain	

Signed Electronically by Gilbertas MD Rimkus on 05/16/16 13:35

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/16/16 13:36	
Other	
New: Phy Msg D/C NGT, sips of water and ice chips PO	

SS 5/16/16

q4° chart check Sherry Herrington RN 5/17/2016 0232

~~Titrate O2 to keep SaO2 up~~

Signed Electronically by Gilbertas MD Rimkus on 05/16/16 13:36

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC [redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

CCU Daily Orders

☐ ICU Level of Care	☐ PCU Level of Care	☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies: PCN, SULFA

Date	Time	New Orders:
5/17	0920	Resp to titrate Sao2 to keep SaO2 ↑ TORB Dr Hayes | Sherry Herrington
		ORmedical 5.17.16 0940
		Sherry Herrington CRT 5/17/16 0939
		~~Electronically Signed By:~~ HAYES,RICHARD Y. MD, Jun 9 2016 4:54AM

_____ __/__/____ _____

Physician Signature **Date** **Time**

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/17/16 08:49	
STAT orders:	
New: Lasix Soln (furosemide) 20MG IV STAT ONCE	
Lab	
New: BMP in AM	
New: CBC WITH AUTO DIFF in AM	
Medication	
Discontinue: **D/C** Lactated Ringers IV Bag 1000ML 150 MLS/HR RX Number: 07120566 **D/C** Number of Liters: Continuous	
Discontinue: **D/C** Morphine Sulfate 1-2 MG IV Q4H PRN pain RX Number: 07120875 **D/C**	

BS 5-17-16 0858

K Bellam 5/17/16 0911

Signed Electronically by Kenneth MD Santiago on 05/17/16 08:49

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/17/16 08:59	
Medication	
New: Lasix Soln (furosemide) 20MG IV Q12H	

K. Bellam
5/17/16 w
1010

Signed Electronically by Kenneth MD Santiago on 05/17/16 08:59

F&N-06-FRM
REV 0 11.24.04

Conway Medical Center
Conway, South Carolina

Center Patient Admission Label Here

Knight, Donnie
Room 26.

REGISTERED DIETITIAN RECOMMENDATION ORDER

Current Diet: NPO
POD # 2

RD Recommendations:

(1) Consider 1 liter PPN - (if medically stable.)
(2) Progress to clear liquids & Resource Breeze (non-red) when (+) B. Sounds

(5)

SP Guthmiller MS RD LD
RD Signature

5/17/16
Date

10:15 pm.
Time

MD Response: (within 24 hours)

1. ____ **Implement RD recommendations.**
2. ____ **Implement RD recommendations with below changes**
3. ____ **Implement MD recommendations only.**

MD recommendations/changes: (Only complete if no. 2 or 3 is checked)

MD Signature **Date**

Form #06

White copy - Patient Record * Yellow copy - Registered Dietitian

Form #06:TE

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M0000175313 05/15/16

PHYSICIAN'S ORDERS

CCU Daily Orders

☐ ICU Level of Care	☐ PCU Level of Care	☐ ~~CONTINUED CARE UNIT~~ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies: PCN, SULFA

Date	Time	New Orders:
5/17	1113	- wound care consult for education and supplies. V.O.R.B Dr. Santiago / K. Bellam, PA Electronically Signed By: SANTIAGO,KENNETH MD, Jun 20 2016 3:41PM
5/17	1120	- Give 20mg lasix x1 now. - change scheduled lasix to 40mg @120. V.O.R.B Dr. Santiago / K. Bellam, PA K. Bellam 5/17/16 @ 1140
5/17	1310	- clear liquid diet - vicodine 1-2 tab @ 4hrs PRN PAIN. V.O.R.B Dr. Rimkus / K. Bellam, PA Electronically Signed By: RIMKUS,GILBERTAS MD, Jun 15 2016 1:10PM
5/17	1843	- duonebs @LD x1 now. - CPAP HS. - C-xray in AM. T.O.R.B Dr. Santiago / K. Bellam, PA
5-18	0400	24 hrs chart check RN, RN Electronically Signed By: SANTIAGO,KENNETH MD, Jun 20 2016 3:41PM

Physician Signature **Date** **Time**

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/18/16 07:39	
STAT orders:	
New: PORTABLE CHEST ONE VIEW * STAT REASON FOR EXAM?: Hypoxemia	
Lab	
New: BMP in AM	
New: CBC WITH AUTO DIFF in AM	
Other	
New: Physician Consult SubSpeciality Group on Call: Pulmonologist Reason for Consult:hypoxemia post abdominal surgery. Consult require NPO diet?: NO	

BG 0752 5-18-16

5/18/16

Signed Electronically by Kenneth MD Santiago on 05/18/16 07:39

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

PH SICIAN'S ORDERS

CCU Daily Orders

Rimkus, Gilbertas MD
V00006912886
KNIGHT, DANIEL ERIC
[redacted]
M000175313 05/15/16

☐ ICU Level of Care	☐ PCU Level of Care	☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies: PCN, SULFA

Date	Time	New Orders:
5/18/16		P.T. Eval up to chair V.O. Dr Rimkus/ Mallon

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jun 15 2016 1:10PM

5/18/16
112

Physician Signatur ____ **Date** ___/___/___ **Time** ____

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AM Orders - Dr. Mansour) - 05/18/16 12:16	
Lab	
New: MAGNESIUM LEVEL in AM	
Radiology	
New: PORTABLE CHEST ONE VIEW * in AM REASON FOR EXAM?: Hypoxemia	

BG 5-18-16 1224

Mansour 5/18/16

Signed Electronically by Ali MD Mansour on 05/18/16 12:16

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886 [redacted]
M000175313

05/15/16

PHYSICIAN'S ORDERS

CCU Daily Orders

☐ ICU Level of Care	☐ PCU Level of Care	CONTINUED CARE ONLY ☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies: PCN, SULFA

Date	Time	New Orders:
5/18/16	1610	Renew Invanz 1g IV q24 hrs TORB Dr. G. Rimkus / Sally Owens Poston Pharm D
5-14-16	0145	24 hour chart check

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jun 15 2016 1:10PM

Physician Signature **Date** **Time**

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/19/16 08:34	
Medication	
New: Solu-Medrol (methylprednisolone sod suc(PF)) 40 MG IV Q8H	

Signed Electronically by Ali MD Mansour on 05/19/16 08:34

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AM Orders - Dr. Mansour) - 05/19/16 08:34	
Lab	
New: CBC WITH AUTO DIFF in AM	
New: BMP in AM	
Radiology	
New: PORTABLE CHEST ONE VIEW * in AM REASON FOR EXAM?: Acute lung injury	

Signed Electronically by All MD Mansour on 05/19/16 08:34

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/19/16 09:01	
Lab	
New: CMP tomorrow at 05:00	
Radiology	
New: CT ABDOMEN W/P.O. CONTRAST ONLY Urgent REASON FOR EXAM?: Intestinal perforation DETAILS OF ORDER?: s/p ileostomy but now with peristent abd distension **New:** CT CHEST W/O CONTRAST * REASON FOR EXAM?: Acute lung injury DETAILS OF ORDER?: Suspect ARDS versus lung contusion with aspiration	
Diet	
New: MECHANICAL SOFT W/GROUND MEAT Dietary Supplements: Supplement Frequency: Fluid Restrictions: Special Modifications:	
Nursing	
New: Prostat Supplement 3x per day	
Other	
New: Dietary Consult Malnutrition **New:** Accepella Valve Order Q1H X 10 QH	
Medication	
New: Potassium Chloride 10 mEq/100 mL IV Bag 10 meq, over 1 hour IV Q1H X 2 doses - Total of 20 meq KCl	

VNB 0846 5/19/16

Budhoo 5/19/16

Signed Electronically by David MD Budhoo on 05/19/16 09:01

Received from CCU-PK@cmc-sc.net at 05/19/2016 09:01:58 AM.
Conway Medical Center

Compression: Flate
OmniLinkRx

Record on Appeal 0973

5A4D43B46E10429588C8, KNIGHT, 555

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/19/16 08:57	
Recurring orders must be manually keyed into MEDITECH:	
New: Prostat Supplement 3x per day **New:** Accepella Valve Order Q1H X 10 QH — Patient Ext HUB 0919 5/19/16 5/19/16	
Lab	
New: CMP tomorrow at 05:00	
Radiology	
New: CT ABDOMEN W/P.O. CONTRAST ONLY Urgent REASON FOR EXAM?: Intestinal perforation DETAILS OF ORDER?: s/p ileostomy but now with peristent abd distension **New:** CT CHEST W/O CONTRAST * REASON FOR EXAM?: Acute lung injury DETAILS OF ORDER?: Suspect ARDS versus lung contusion with aspiration — HUB 0913 5/19/16	
Diet	
New: MECHANICAL SOFT W/GROUND MEAT Dietary Supplements: Supplement Frequency: Fluid Restrictions: Special Modifications:	
Other	
New: Dietary Consult Malnutrition	
Medication	
New: Potassium Chloride 10 mEq/100 mL IV Bag 10 meq, over 1 hour IV Q1H X 2 doses - Total of 20 meq KCl	

Budhoo 5/19/16

5-20-15/0202 24 hrs chart check [illegible]

Signed Electronically by David MD Budhoo on 05/19/16 08:57

5A4D43B46E10429588C8, KNIGHT, 556

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 07:19	
Lab	
New: CBC WITH AUTO DIFF tomorrow at 05:00 New: CMP tomorrow at 05:00 New: MAGNESIUM LEVEL tomorrow at 06:00	
Other	
New: Dietary Consult Malnutrition, Protein Malnutrition	
Medication	
New: Paxil Tab (paroxetine HCl) 20MG oral Now and Daily in AM	

BL 5-20-16 0729

Signed Electronically by David MD Budhoo on 05/20/16 07:19

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 08:52	
Medication	
Discontinue: **D/C** Paxil Tab (paroxetine HCl) 20MG oral Daily in AM RX Number: 07128722 **D/C**	
Discontinue: **D/C** Paxil Tab (paroxetine HCl) 20MG oral ONCE RX Number: 07128723 **D/C**	
New: Prozac cap (fluoxetine) 20MG oral Now and Daily in AM	

Maubert 5/20/16

Signed Electronically by David MD Budhoo on 05/20/16 08:52

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 09:24	
Lab	
New: BMP tomorrow at 05:00	
Other	
New: Bladder Scan q 6hrly for first 24hrs after foley removal	
New: Discontinue Foley	

BSL 5-20-16 0939

Malbeh 5/20/16

Signed Electronically by David MD Budhoo on 05/20/16 09:24

5A4D43B46E10429588C8, KNIGHT, 559

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 09:33	
Radiology	
New: PORTABLE CHEST ONE VIEW * tomorrow at 05:00 REASON FOR EXAM?: Shortness of breath	

BP 0942 5-20-16

malbah 5/20/16

Signed Electronically by David MD Budhoo on 05/20/16 09:33

5A4D43B46E10429588C8, KNIGHT, 560

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 09:31	
Lab	
New: SPUTUM CULTURE today ****GRAM STAIN ORDERED WITH CULTURE**** WHAT IS SOURCE?: SPUTUM	
Medication	
Discontinue: **D/C** Toradol Soln 30 mg/mL (1 mL) (ketorolac) 30MG IV Q6H PRN pain RX Number: 07122303 **D/C** **New:** Lovenox Syrg (enoxaparin) 40MG SubQ Q24H	

BH 5-20-16 0940

Malbon 5/20/16

Signed Electronically by David MD Budhoo on 05/20/16 09:31

5A4D43B46E10429588C8, KNIGHT, 561

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/20/16 13:08	
Medication	
DC due to change: **D/C** Solu-Medrol (methylprednisolone sod suc(PF)) 40MG IV Q8H RX Number: 07127130 **D/C**	
DC due to change: **D/C** Lasix Soln (furosemide) 40MG IV Q12 RX Number: 07123840 **D/C**	
New: Solu-Medrol (methylprednisolone sod suc(PF)) 40 MG IV Q12H	
New: Lasix Soln (furosemide) 40MG IV Q24H	

Signed Electronically by Hafez MD Hayek on 05/20/16 13:08

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Dr. Hayek Orders) - 05/20/16 13:08	
Lab	
New: PHOSPHOROUS LEVEL in AM	

5/20/16

5/20/16

24° Chart ✓ Complete
Candace Burke RN 5/21/16 0258

Signed Electronically by Hafez MD Hayek on 05/20/16 13:08

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/21/16 09:53	
Lab	
New: ACETAMINOPHEN LEVEL today	
Medication	
Discontinue: **D/C** Invanz (ertapenem) 1GM IV Q24H RX Number: 07126033 **D/C** in NS IV Bag 50ML **Discontinue:** **D/C** Diflucan 200mg/100ml (fluconazole in NaCl) 100ML IV Q24H RX Number: 07120570 **D/C** **Discontinue:** **D/C** Acetaminophen Rectal Supp 650MG rectal Q4H PRN fever > 101.5 RX Number: 07120567 **D/C** **Discontinue:** **D/C** Hydrocodone-APAP 5 mg-325 mg Tab 1-2 TABS oral Q4H PRN pain RX Number: 07123965 **D/C** **New:** Kefzol/ancef (cefazolin) 1GM IV Q8H Allergy: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins *Override Reason:* Provider Aware - Continue as ordered **New:** Flagyl 500mg/100ml Bag (metronidazole in NaCl (iso-os)) 500 mg, over 1 hour IV Q8H	

5/21/16 1000

Signed Electronically by David MD Budhoo on 05/21/16 09:53

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/21/16 09:46	
Medication	
Discontinue: **D/C** Lasix Soln (furosemide) 40MG IV Q24H RX Number: 07129259 **D/C**	
Discontinue: **D/C** Solu-Medrol (methylprednisolone sod suc(PF)) 40MG IV Q12H RX Number: 07129260 **D/C**	

5/21/16 1606

Signed Electronically by Hafez MD Hayek on 05/21/16 09:46

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Dr. Hayek Orders) - 05/21/16 09:46	
Lab	
New: CBC WITH AUTO DIFF in AM	
New: CMP in AM	
New: MAGNESIUM LEVEL in AM	
New: PHOSPHOROUS LEVEL in AM	

Signed Electronically by Hafez MD Hayek on 05/21/16 09:46

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/21/16 12:23	
Medication	
New: Percolone Tab (oxycodone) 5-10 MG oral Q4H PRN pain	

Williams RP
5/21/16 1256

Signed Electronically by David MD Budhoo on 05/21/16 12:23

5A4D43B46E10429588C8, KNIGHT, 567

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/21/16 14:46	
Transfer Medication Reconciliation Orders	
New: Transfer to: SURGICAL	
The following orders were continued during the Transfer process and require no further action.	
Continue: Kefzol/ancef SolR (cefazolin) 1GM 100 MLS/HR IV Q8 RX Number: 07130516 in NS IV Bag 50ML	
Continue: Flagyl 500mg/100ml Bag PgBk (metronidazole in NaCl (iso-os)) 100ML 100 MLS/HR IV Q8 RX Number: 07130514	
Continue: UNKNOWN 0.5 mg-3 mg(2.5 mg base)/3 mL 3ML inhalation QIDRT RX Number: 07124493	
Continue: Lovenox Syrg 40 mg/0.4 mL (enoxaparin) 40MG SubQ Q24A RX Number: 07128948	
Continue: Prozac cap (fluoxetine) 20MG oral Q24A RX Number: 07130588	
Continue: Protonix (pantoprazole) TabEC 40MG oral .HS RX Number: 07120574	
Continue: Phenergan 12.5MG IV Q3H PRN nausea RX Number: 07120575	
Continue: Percolone Tab (oxycodone) 5-10 MG oral Q4H PRN pain RX Number: 07130645	
Continue: Tylenol Tab (acetaminophen) 650MG oral Q4H PRN fever > 101.5 RX Number: 07120568	
Continue: Maalox Plus Susp 30ML oral Q4H PRN indigestion RX Number: 07120578	
Continue: Mylicon-80 Chew (simethicone) 80MG oral ACHS PRN gas/bloating RX Number: 07120577	
Continue: Zofran Inj 4MG IV Q3H PRN nausea RX Number: 07120576	
Continue: Incentive Spirometer Order:RT - RESPIRATORY THERAPY	
Continue: Intermittent Pressure Devices:NCO-PHY - NCO-PHYSICIAN ORDER ENTRY	
Continue: JP Drain to bulb suction::NCO-PHY - NCO-PHYSICIAN ORDER ENTRY	
Continue: OXYGEN Order:RT - RESPIRATORY THERAPY	
Continue: Prostat Supplement:NCO-INTERV - NURS CARE ORDER/INTERVENTION	
Lab	
Discontinue: **D/C** SPUTUM CULTURE today **D/C** ****GRAM STAIN ORDERED WITH CULTURE****	
Diet	
Discontinue: **D/C** CLEAR LIQUID DIET **D/C**	
Discontinue: **D/C** NPO **D/C**	
DC due to change: **D/C** MECHANICAL SOFT W/GROUND MEAT **D/C**	

5/21/16 1430

Signed Electronically by Michael H. MD Ellis on 05/21/16 14:46

KNIGHT, DANIEL E
[redacted]
Room: CC26
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/21/16 14:46	
New: REGULAR DIET	
Other	
DC due to change: **D/C** Activity **D/C**	
New: Activity AMBULATE IN HALL 2X per day with o2	
Discontinue: **D/C** Admit to: **D/C**	
Discontinue: **D/C** Extubate patient: **D/C**	
Discontinue: **D/C** Intake & Output **D/C**	
DC due to change: **D/C** Vital Signs **D/C**	
New: Vital Signs Every 8 hours	
New: Wound Care Orders Dressing Orders:qtip saline into wound between staples Frequency:daily	
Discontinue: **D/C** Accepella Valve Order **D/C**	
Discontinue: **D/C** Incentive Spirometer **D/C**	
Discontinue: **D/C** Nebulizers **D/C**	
Discontinue: **D/C** O2 order **D/C**	
Medication	
Discontinue: **D/C** Protonix (pantoprazole) 40MG IV HS RX Number: 07120573 **D/C**	
DC due to change: **D/C** Dilaudid Soln (hydromorphone (PF)) 2MG Q2H PRN pain RX Number: 07121574 **D/C**	
New: Dilaudid Soln (hydromorphone (PF)) 1MG IV Q4H	
New: Duoneb 3 ML inhalation Q6H	
New: Lovenox Syrg (enoxaparin) 40MG SubQ Q24H	

5/21/16 1530

Signed Electronically by Michael H. MD Ellis on 05/21/16 14:46

CCU-3364-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886 [redacted]
M000175313

05/15/16

PHYSICIAN'S ORDERS

CCU Daily Orders

☐ ICU Level of Care	☐ PCU Level of Care	CONTINUED CARE ONLY ☐ Telemetry Level of Care
On a Vent	Titration every 3-4 hours	New Cardiac meds
Hourly treatment/monitoring	Every 2 hour monitoring	Home Vent
Hourly titration	Frequent Trach care	Every 4 hour monitoring

Allergies: PCN, SULFA

Date	Time	New Orders:
2 5/14/16	1530	D/C Dilaudid to per T.O. Dr. Ellis

Electronically Signed By:
ELLIS,MICHAEL H.,
Jun 14 2016 12:43PM

Physician Signature _____ Date ___/___/___ Time _____

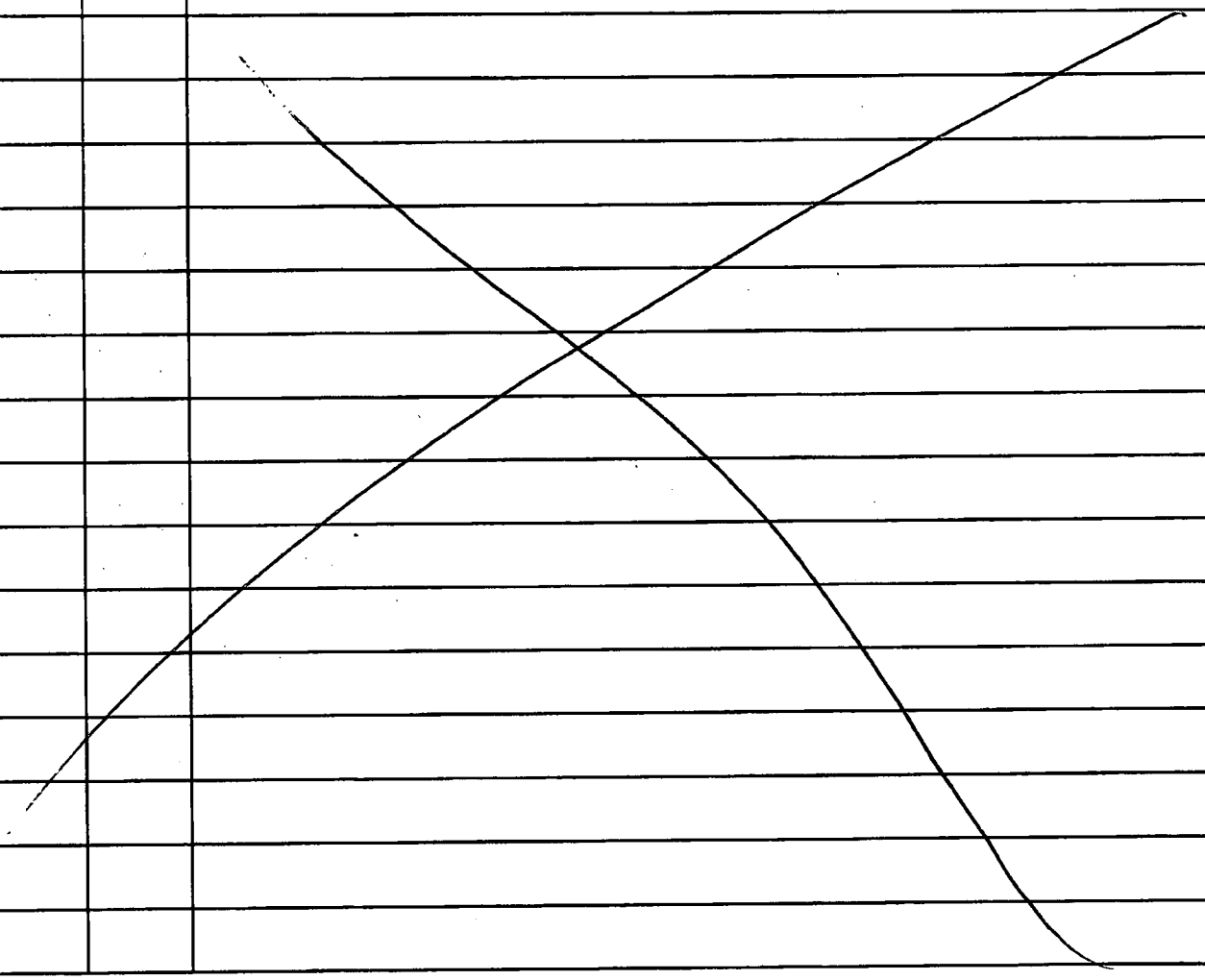
-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
5/22/16		24° Chart ✓ ——— L Smith



Physician Signature ____/____/____ Date ____ Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 571

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/22/16 13:07	
Other	
New: Wound Care Orders Dressing Orders:remove staples clean and pack with 1/4% dakins Frequency:bid TCS 5/22/16 1313	•

MMaples RN 5/22/16 1330

12 hour chart ✓ MMaples RN 5/22/16 1949

Signed Electronically by Michael H. MD Ellis on 05/22/16 13:07

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/22/16 17:58	
Other	
New: Dietary Consult Malnutrition, Protein Malnutrition	

TC 5/22/16 1820

Dallenbach
1851
5/22/16

Signed Electronically by David MD Budhoo on 05/22/16 17:58

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

TCJ 5/22/16 1820

Orders - 05/22/16 17:53	
Lab	
New: CBC WITH AUTO DIFF tomorrow at 05:00	
New: CMP tomorrow at 05:00	
Medication	
New: Potassium chloride TbTQ 40MEQ oral X1	

Dallenbach 5/24/16 1851

Signed Electronically by David MD Budhoo on 05/22/16 17:53

5A4D43B46E10429588C8, KNIGHT, 574

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
5/23/16	0035	24° Chest/ — L Smith RN
5/23/16	0400	PCXR / now please
		ABG / CMP
		T.O. Dr. Walker / Melissa Godwin RN / paged
		Electronically Signed By: WALKER, WILLIAM MD, Jun 9 2016 7:30AM — 5/23/16 L Smith RN

Physician Signature ____/____/____ Date Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 575

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/23/16 10:13	
Lab	
New: CMP in AM **New:** CBC WITH AUTO DIFF in AM **New:** MAGNESIUM LEVEL in AM	
Other	
New: Fluid Restrictions Fluid Restrictions:1500ml	
Medication	
New: Lasix Soln (furosemide) 40MG IV Q8H X 2 doses	

TS 5/23/16 @1032

12 hour chart 5/23/16 1736

3/23/16 1 1 A

24° chart 05/24/16 @ 0051 Melissa Jackson RN

Signed Electronically by Srinivas MD Vuppala on 05/23/16 10:13

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Dr. Hayek Orders) - 05/24/16 10:49	
Lab	
New: CBC WITH AUTO DIFF in AM	
New: CMP in AM	
New: MAGNESIUM LEVEL in AM	
New: PHOSPHOROUS LEVEL in AM	

5/24 @ 1056 RN 1102

Signed Electronically by Hafez MD Hayek on 05/24/16 10:49

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/24/16 17:07	
Other	
New: Phy Msg In am, D/C fluid restriction please	

5/24/16
1735

5/24/16
1900
D/C DAKIN ward care
TO DR RIMKUS

FAXED

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jun 15 2016 1:10PM

Signed Electronically by Srinivas MD Vuppala on 05/24/16 17:07

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
05/25/2016	0100	24° Chart Check completed Dabbe Lawrence RN

_____ ___/___/____ _____

Physician Signature Date Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 579

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/24/16 09:06	
Other	
New: Phy Msg Please apply wound vac, arrange one to take home after d/c.	

5/24/ 0930

24° Canta 05/26/16 00 0400 Melissa Dodson RN

Signed Electronically by Gilbertas MD Rimkus on 05/24/16 09:06

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
5-24-16		walking walker + wheels for home
		T.D. Dr Rimkus / In Benton Hall
	1:10 pm	Electronically Signed By: ~~RIMKUS,GILBERTAS MD,~~ Jun 15 2016 1:10PM
24	chart	05/26/16@0400 Melissa Goodson RN

Physician Signature ____/____/____ Date Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 581

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/25/16 14:58	
Other	
New: Dietary Consult Malnutrition Comment:Protein calorie malnutrition	

5/25@ 1522

5/25/16 1540

12 hr chart check Natalie Robert RN 5/25/16 1945

-24° chart - 05/26/16 @ 0400 Melissa Godwin RN -

Signed Electronically by Srinivas MD Vuppala on 05/25/16 14:58

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/26/16 09:52	
Other	
New: Phy Msg Please change wound vac in AM. TCS 5/26/16 1000	

12 hour chart 5/26/16 1230

5/26/16 12

12° chart check completed Natalia Tobon RN 5/26/16 18:35

Signed Electronically by Gilbertas MD Rimkus on 05/26/16 09:52

24° chart 5/27/16 0930 melissa Godwin RN

Recognition Appeal 0041

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
5-27-16	1245	Home Health - Nursing wound care/ wound vac.
		change dressing q 3 days.
		Home Health PT & OT
		To Dr. Rimkus / JBullard RN
		5-27-16 JB
05/27/2016	@ 22w	24° Chart check complete D. Daniels RN

Physician Signature ____/____/____ Date _____ Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 584

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

PHYSICIAN'S ORDERS

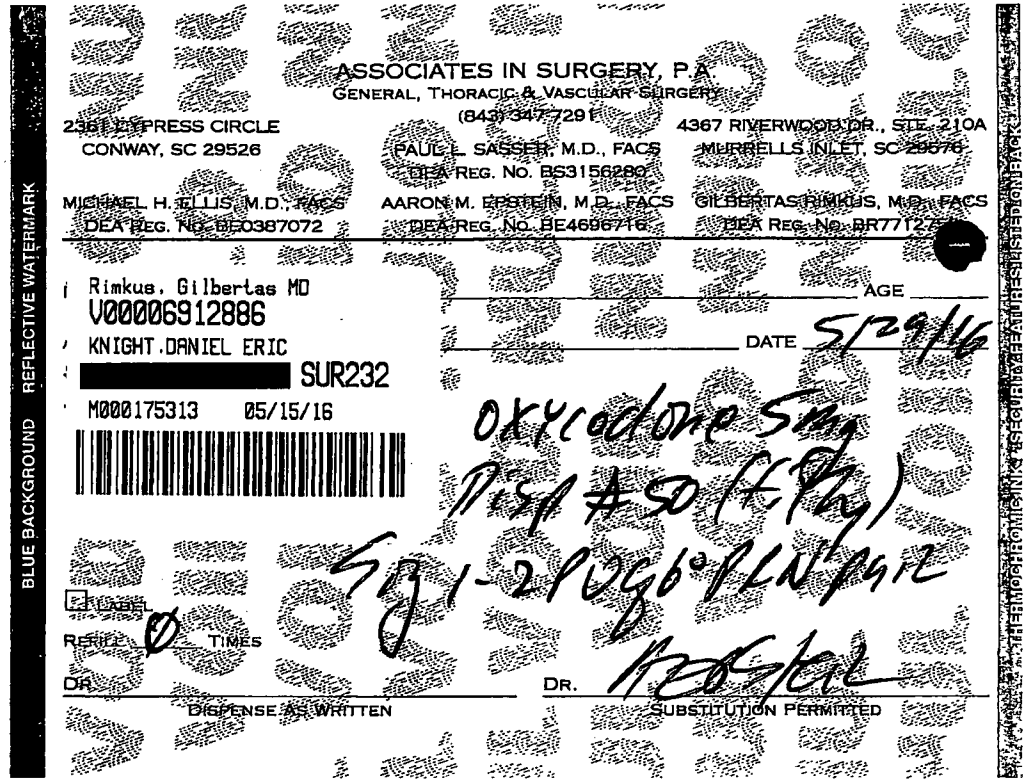
Date	Time	**Drug Allergies:**
05/28/16	0850	T.O Dr Epstein to P. Leslie
		① D/C Fluid restriction
		② Regular diet
		Electronically Signed By: EPSTEIN,AARON M. MD, Jun 6 2016 7:02AM
		0900 05/28/16 CWhitten
		05/28/16 12 hr chart ✓ 1900 CWhitten
05/28/2016	@2320	24° chart check complete S. Dawicki

Physician Signature ____/____/____ Date ____ Time

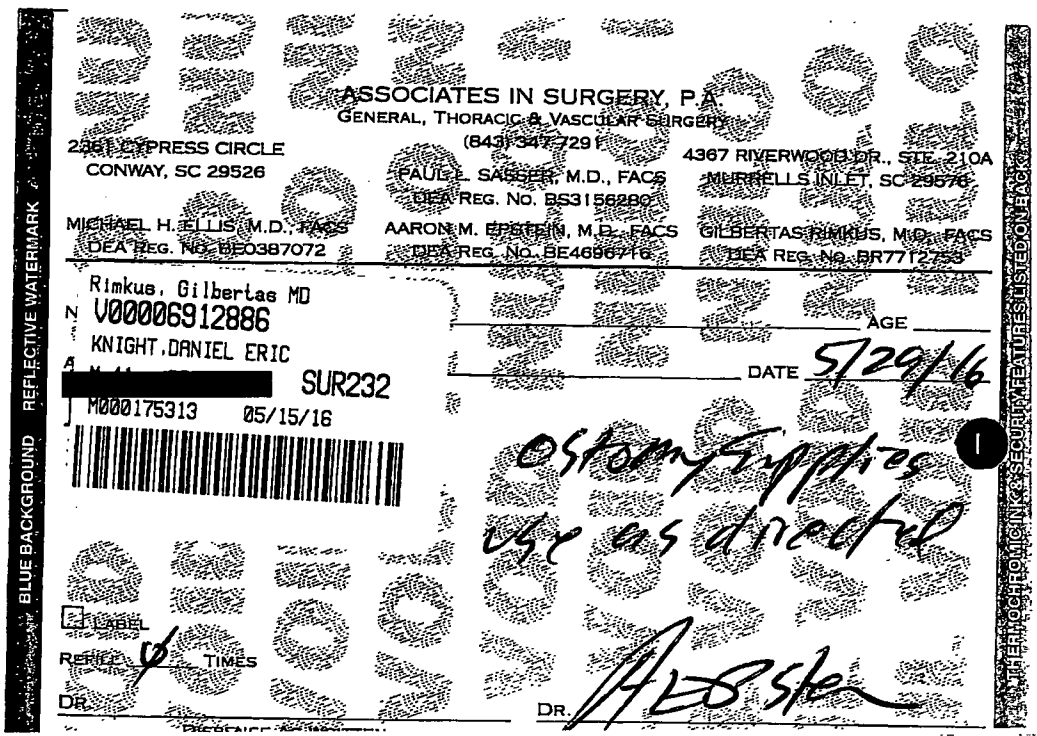
DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

5A4D43B46E10429588C8, KNIGHT, 585



ASSOCIATES IN SURGERY, P.A.
GENERAL, THORACIC & VASCULAR SURGERY
(843) 347-7291
2361 CYPRESS CIRCLE
CONWAY, SC 29526
4367 RIVERWOOD DR., STE. 210A
MURRELLS INLET, SC 29576
PAUL L. SASSER, M.D., FACS
DEA REG. NO. BS3156280
MICHAEL H. ELLIS, M.D., FACS
DEA REG. NO. BE0387072
AARON M. EPSTEIN, M.D., FACS
DEA REG. NO. BE4696716
GILBERTAS RIMKUS, M.D., FACS
DEA REG. NO. BR7712753
Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted] SUR232
M000175313 05/15/16
AGE
DATE 5/29/16
Oxycodone 5mg
Disp #90 (Ninety)
Sig 1-2 PO q6° PRN pain
Refill
LABEL
0 TIMES
DR.
DISPENSE AS WRITTEN
DR.
SUBSTITUTION PERMITTED
BLUE BACKGROUND REFLECTIVE WATERMARK
THERMOCHROMIC INK SECURITY FEATURES LISTED ON BACK



ASSOCIATES IN SURGERY, P.A.
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(843) 347-7291
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CONWAY, SC 29526
4367 RIVERWOOD DR., STE. 210A
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DEA REG. NO. BE0387072
AARON M. EPSTEIN, M.D., FACS
DEA REG. NO. BE4696716
GILBERTAS RIMKUS, M.D., FACS
DEA REG. NO. BR7712753
Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
[redacted] SUR232
M000175313 05/15/16
AGE
DATE 5/29/16
Ostomy supplies
use as directed
Refill
LABEL
0 TIMES
DR.
DR.
BLUE BACKGROUND REFLECTIVE WATERMARK
THERMOCHROMIC INK SECURITY FEATURES LISTED ON BACK

Record on Appeal 1004

5A4D43B46E1042958BC8, KNIGHT, 586

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 05/29/16 08:55	
The following orders are 'print-only.' Please take action: for each Order Type	
New: SC SCRIPTS SC SCRIPTS -: I have reviewed the SC SCRIPTS website for this patient prior to prescribing of any controlled substances, and I have adjusted accordingly.	
Other	
New: Dressing Order dc jp drain and cover with gauze bid and prn same as above	

Signed Electronically by Aaron M., MD Epstein on 05/29/16 08:55

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Discharge Orders) - 05/29/16 08:55	
The following orders are 'print-only.' Please take action: for each Order Type	
New: Prescriptions written and placed on chart	
Other	
New: Discharge diet Regular	
New: Discharge patient to: Home	
New: Discontinue Foley	
New: Discontinue Lines Peripheral Line	
New: Follow up with Rimkus, Gilbertas MD Comment:see dr rimkus wed or thursday of next week	
New: Referrals: Already Ordered	
New: Resume activities as tolerated	
New: Dressing Order home health for wound vac and ostomy care (should be arranged) same as above	
New: AMI Core Measure Did patient have an AMI during this hospitalization?: N	
New: Heart Failure Core Measure Did Patient have Heart failure this hospitalization?: N	
New: Stroke Core Measure Did the patient have a Stroke this hospitalization?: N	
New: VTE Core Measure Did this patient have a confirmed VTE and receive warfarin?: N	

DW 5/29 @ 0910

5/29/16 9:59 pm

Signed Electronically by Aaron M., MD Epstein on 05/29/16 08:55

KNIGHT, DANIEL E [redacted]
Room: SUR232
V00006912886 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders
Discharge Medication Reconciliation

Pre-Admit/Hospital Medication

PROZAC WEEKLY ORAL 20 MG DAILY

Discharge Medication List

PROzac capsule (fluoxetine)
Dose: 20MG oral 20 MG DAILY

Stopped Hospital Medications

H	~~Dc'd: Dilaudid Soln (hydromorphone (PF)) 1MG IV Q4H PRN pain~~	Stopped
H	~~Dc'd: Duoneb (ipra-alb) 3 mL Nebs 3ML inhalation Q6HRT~~	Stopped
H	~~Dc'd: Flagyl 500mg/100ml Bag (metronidazole in NaCl (iso-os)) 100ML IV Q8H~~	Stopped
H	~~Dc'd: Kefzol/ancef (cefazolin) 1GM IV Q8~~ ~~in NS IV Bag 50ML~~	Stopped
H	~~Dc'd: Lovenox Syrg (enoxaparin) 40MG SubQ Daily in AM~~	Stopped
H	~~Dc'd: Maalox Plus Susp 30ML oral Q4H PRN indigestion~~	Stopped
H	~~Dc'd: Mylicon-80 Chew (simethicone) 80MG oral ACHS PRN gas/bloating~~	Stopped
H	~~Dc'd: Percolone Tab (oxycodone) 5-10 MG oral Q4H PRN pain~~	Stopped
H	~~Dc'd: Phenergan 12.5MG IV Q3H PRN nausea~~	Stopped
H	~~Dc'd: Protonix (pantoprazole) TabEC 40MG oral .HS~~	Stopped
H	~~Dc'd: Prozac cap (fluoxetine) 20MG oral Daily in AM~~	Stopped
H	~~Dc'd: Tylenol Tab (acetaminophen) 650MG oral Q4H PRN fever > 101.5~~	Stopped
H	~~Dc'd: Zofran Inj 4MG IV Q3H PRN nausea~~	Stopped

5/29/16 09:5 pm

05/29/16 1100

Signed Electronically by Aaron M., MD Epstein on 05/29/16 08:56

5A4D43B46E10429588C8, KNIGHT, 589

C

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
POST PROCEDURE NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/15/16 09:52	ER.CNW

SURGICAL PROCEDURE

Pre-Operative Diagnosis:	Perforated viscus
Post-Operative Diagnosis:	Perforation of terminal ileum Peritonitis
Indication(s):	As above
Surgical Procedure:	Recection of small bowel Ileostomy
Surgery Date:	05/15/16
Surgeon:	Rimkus, Gilbertas MD
Assistant:	Candida
Anesthesia:	GET
Blood Administered:	No
Estimated Blood Loss:	50 ml
Drain(s):	JPx1
Specimen(s):	Small bowel
Complication(s):	None
Findings:	As above
Grafts/Implants:	None

Electronically signed by Gilbertas MD Rimkus on 05/15/16 at 09:57

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE 2	AUTHOR: Santiago, Kenneth MD	DATE: 05/15/16 16:09	CCE.CC26.1.CNW

Hospital day 1

Title:
Medical consult done

Notation:
#3025600
1- Hypotension: 2nd hypovolemia and anesthetics. Agresive hydration.
2- AKI
3- Abd pain.
4- Full code

Electronically signed by Kenneth MD Santiago on 05/15/16 at 16:11

Conway Medical Center | NAME: KNIGHT, DANIEL E. | SEX: Male | ACCOUNT #: V00006912886

[redacted] | MRN: M0000175313

PROGRESS NOTE | AUTHOR: Santiago, Kenneth MD | DATE: 05/16/16 08:48 | CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 2

Patient narrative: Cont with abdominal pain, diffuse, +shallow breathing. Dilaudid helping little with pain but not lasting more than 1 hour. No cough. Mild SOB.

HPI Review

☑ Location ☑ Severity ☑ Quality

☑ Past Family/Social History Taken

REVIEW OF SYSTEMS

CONSTITUTIONAL: Negative for fevers, malaise, fatigue, chills or sweats.

EYES: Negative for blurry vision. No diplopia.

EXAM

Vitals: (05/15 08:48 - 05/16 08:48)

Temp 98.8 (97.2-99.3)
Pulse 118 (118-133)
Resp 20 (18-26)
BP 105/68 (72/41-134/75)
O2 Sat: 94 (92-100)
%/L of O2: 2 (2-40)
Weight (lbs) 180

I/Os: (05/15 07:00-05/16 07:00)

Net: 2,070 Intake: 4,100 Output: 2,030
#1 JP:: 300 Foley:: 1,700 IV Fluids (A):: 4,050 IV Fluids (B):: 50 Ileostomy:: 30 PO:: 0

CONSTITUTIONAL: Alert, in NAD.

EYES: PERL. Sclerae nonicteric. Conjunctivae pink.

ENT: Mucus membranes moist. Oropharynx without exanthema or exudates.

RESPIRATORY: distant bilateral, no wheezes.

CARDIOVASCULAR: Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. No lower extremity edema.

GASTROINTESTINAL: decrease BS, diffuse abd discomfort. RLQ ileostomy draining small amount.

SKIN: Warm and dry. Normal turgor. No rashes or lesions.

NEUROLOGICAL: Awake and lethargic, oriented to person, place and time.

OTHER: chest tender left side palpation, no trauma.

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/16/16 06:20)
Panel

6.0	11.0	296
	32.6	

RED BLOOD COUNT 3.64 L, MEAN CELL VOLUME 89.8 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 33.6 , RED CELL DISTRIBUTION WIDTH 13.4 , NEUT % 90.6 , LYMPH % 5.4 , MONO % 2.5 , EOS % 1.4 , BASO % 0.1 , NEUT # 5.5 , LYMPH # 0.3 L, MONO # 0.1 , EOS # 0.1 , BASO # 0.0

HEMATOCRIT05/16/16 06:2032.6%
HEMOGLOBIN05/16/16 06:2011.0g/dL
PLATELET COUNT05/16/16 06:20296K/mm3
WBC05/16/16 06:206.0K/mm3

BASIC METABOLIC PANEL (05/16/16 06:20)
Panel

142	109	22	105
4.3	25	1.18	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 7.7 L

CREATININE05/16/16 06:201.18mg/dl
CO205/16/16 06:2025mmol/L
POTASSIUM05/16/16 06:204.3mmol/L
BUN05/16/16 06:2022mg/dl

SODIUM05/16/16 06:20142mmol/L
CHLORIDE05/16/16 06:20109mmol/l
GLUCOSE,RANDOM05/16/16 06:20105mg/dL

MEDICATIONS

Ertapenem Sodium with/in Sodium Chloride 0.9% 1 GM Q24H
Fluconazole/Ns 200MG/100ML 100 ML Q24H
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
Lactated Ringer's 1000 ML .Q6H40M
MorphINE Sulfate 1-2 MG Q4H (PRN)
Pantoprazole Sodium 40 MG HS
Promethazine HCl 12.5 MG Q3H (PRN)

ALLERGIES

Penicillins
Sulfa (Sulfonamide Antibiotics)

ASSESSMENT/PLAN

1. **Hypotension**
   - A: 2nd dehydration and anesthesia meds. Better after multiple liters of fluid. I/O better.
   - P: cont monitoring.

2. **Shortness of breath**
   - A: 2nd atelectasis and shalow breathing.
   - P: CXR today. Incentive spirometry.

3. **Abdominal pain**
   - A: fair controlled, cont Dilaudid but increase to 2 mg q 2 hrs prn pain.

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): 35 min

Care Activities / Care Coordination:

- ☐ I have reviewed the history and repeated the key elements
- ☐ I have seen and examined this patient
- ☐ I have reviewed the progress in the clinical course since the last examination
- ☐ I have discussed the patient's condition with other members of the care team
- ☐ I have reviewed all medications for this patient.

Electronically signed by Kenneth MD Santiago on 05/16/16 at 09:25

5A4D43B46E10429588C8, KNIGHT, 593

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/16/16 13:36	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 2

Patient narrative Hurting

REVIEW OF SYSTEMS

EXAM

Vitals: (05/15 13:36 - 05/16 13:36)

Temp 98.0 (98.0-99.3)
Pulse 116 (116-133)
Resp 18 (18-26)
BP 116/63 (72/41-116/68)
O2 Sat: 91 (91-98)
%/L of O2: 3 (2-3)
Weight (lbs) 180

I/Os: (05/15 07:00-05/16 07:00)

Net: 2,070 Intake: 4,100 Output: 2,030
#1 JP:: 300 Foley:: 1,700 IV Fluids (A):: 4,050 IV Fluids (B):: 50 Ileostomy:: 30 PO:: 0

GASTROINTESTINAL: No ostomy output yet, abdomen is tender

DATA

LAB RESULTS

BASIC METABOLIC PANEL (05/16/16 06:20)
Panel

142	109	22
4.3	25	1.18

105

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 7.7 L

CREATININE05/16/16 06:201.18mg/dl
CO205/16/16 06:2025mmol/L
POTASSIUM05/16/16 06:204.3mmol/L
BUN05/16/16 06:2022mg/dl
SODIUM05/16/16 06:20142mmol/L
CHLORIDE05/16/16 06:20109mmol/l
GLUCOSE,RANDOM05/16/16 06:20105mg/dL

CBC W/AUTO DIFF (05/16/16 06:20)
Panel

6.0	11.0	296
	32.6	

RED BLOOD COUNT 3.64 L, MEAN CELL VOLUME 89.8 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 33.6 , RED CELL DISTRIBUTION WIDTH 13.4 , NEUT % 90.6 , LYMPH % 5.4 , MONO % 2.5 , EOS % 1.4 , BASO % 0.1 , NEUT # 5.5 , LYMPH # 0.3 L, MONO # 0.1 , EOS # 0.1 , BASO # 0.0

HEMATOCRIT05/16/16 06:2032.6%
HEMOGLOBIN05/16/16 06:2011.0g/dL
PLATELET COUNT05/16/16 06:20296K/mm3
WBC05/16/16 06:206.0K/mm3

ASSESSMENT/PLAN

1. **Intestinal perforation**
   - A: s/p resection and ileostomy, doing better
   - P: Add Toradol for pain, OOB to chair today.

Electronically signed by Gilbertas MD Rimkus on 05/16/16 at 13:38

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Santiago, Kenneth MD	DATE: 05/17/16 08:49	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 3

Patient narrative: More sob today, no cp, sleeping ok, NPO. Epsiode of respiratory distress last night. Better today. Abdominal pain better controlled.

HPI Review

☐ Location ☐ Severity ☐ Quality

☐ Past Family/Social History Taken

REVIEW OF SYSTEMS

CONSTITUTIONAL: Negative for fevers, malaise, fatigue, chills or sweats.

EYES: Negative for blurry vision. No diplopia.

EXAM

Vitals: (05/16 08:49 - 05/17 08:49)

Temp 99.1 (97.9-99.7)
Pulse 112 (111-125)
Resp 24 (18-24)
BP 111/69 (106/61-128/80)
O2 Sat 89 (88-92)
%/L of O2: 4 (2-4)
Weight (lbs) 191

I/Os: (05/16 07:00-05/17 07:00)

Net: 1,675 Intake: 3,410 Output: 1,735
#1 JP:: 90 Emesis:: 0 Foley:: 1,495 IV Fluids (A):: 3,300 IV Fluids (B):: 50 Ileostomy:: 150 PO:: 60

CONSTITUTIONAL: Alert, in NAD.

EYES: PERL. Sclerae nonicteric. Conjunctivae pink.

ENT: Mucus membranes moist. Oropharynx without exanthema or exudates.

RESPIRATORY: distant bilateral, no wheezes.

CARDIOVASCULAR: Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. No lower extremity edema.

GASTROINTESTINAL: abscent BS, diffuse abd discomfort. RLQ ileostomy draining small amount.

SKIN: Warm and dry. Normal turgor. No rashes or lesions.

NEUROLOGICAL: Awake and lethargic, oriented to person, place and time.

OTHER: chest tender left side palpation, no trauma.

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/17/16 04:17)
Panel

4.3	10.7	256
	31.6	

RED BLOOD COUNT 3.50 L, MEAN CELL VOLUME 90.1 , MEAN CORPUSCULAR HEMOGLOBIN 30.5 , MEAN CORPUSCULAR HGB CONC 33.8 , RED CELL DISTRIBUTION WIDTH 13.3 , MORPHOLOGY COMMENT HYPOCHROMIA 1+

HEMATOCRIT05/17/16 04:1731.6%
HEMOGLOBIN05/17/16 04:1710.7g/dL
PLATELET COUNT05/17/16 04:17256K/mm3
WBC05/17/16 04:174.3K/mm3

DIFF (05/17/16 04:17)
Panel
NEUTROPHILS 69 , BAND 7 , LYMPHOCYTE 13 , MONOCYTE 6 , EOSINOPHIL 1 , METAMYELOCYTE 2 , ATYP LYMP 2 , PLATELET MORPHOLOGY NORMAL , PLATELET ESTIMATE NORMAL , MORPHOLOGY COMMENT HYPOCHROMIA 1+ , ABSOLUTE NEUTROPHIL CT 3.4 , ABSOLUTE LYMPHOCYTE CT 0.7 L, ABSOLUTE MONOCYTE CT 0.3 , ABSOLUTE EOSINOPHIL CT 0.0 , ABSOLUTE BASOPHIL COUNT 0.0

BASIC METABOLIC PANEL (05/17/16 04:18)
Panel

142	106	24	101
3.9	26	1.22	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 10.0 , CALCIUM 8.6

5A4D43B46E10429588C8, KNIGHT, 595

PROGRESS NOTE

AUTHOR: Santiago, Kenneth MD | DATE: 05/17/16 08:49 | CCE.CC26.1.CNW

CREATININE05/17/16 04:181.22mg/dl
CO205/17/16 04:1826mmol/L
POTASSIUM05/17/16 04:183.9mmol/L
BUN05/17/16 04:1824mg/dl
SODIUM05/17/16 04:18142mmol/L
CHLORIDE05/17/16 04:18106mmol/l
GLUCOSE,RANDOM05/17/16 04:18101mg/dL

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/16/16 10:35) - Abnormal
Impression: Hypoventilatory lung volumes. Vascular congestion.
Alveolar density within the lung base along with pleural fluid.
Atelectasis versus pneumonia.

MEDICATIONS

Ertapenem Sodium with/in Sodium Chloride 0.9% 1 GM Q24H
Fluconazole/Ns 200MG/100ML 100 ML Q24H
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
Lactated Ringer's 1000 ML .Q6H40M
Pantoprazole Sodium 40 MG HS

ALLERGIES

Penicillins
Sulfa (Sulfonamide Antibiotics)

ASSESSMENT/PLAN

1. **Hypotension**
   - A: resolved after hydration and wear off anesthesia meds. I/O better.
   - P: cont monitoring.

2. **Shortness of breath**
   - A: 2nd atelectasis and shalow breathing. CXR mild pulmonary edema and pleural effusion. Left base pleural density atelectasis vs infiltrate. Chest tender left side. No cough.
   - P: Cont incentive spirometry. Lasix 20 mg IV q 12 hrs. F/U I/O closely. Mild grade fever. Infiltrate probably atelectasis. Mild edema. Watch for signs of pneumonia.

3. **Abdominal pain**
   - A: better controlled, cont Dilaudid 2 mg q 2 hrs prn pain. DC Morphine.

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): 35 min

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have reviewed all medications for this patient.

Electronically signed by Kenneth MD Santiago on 05/17/16 at 08:58

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/17/16 13:28	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 3

Patient narrative Still very sore.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/16 13:28 - 05/17 13:28)
Temp 98.2 (97.9-98.7)
Pulse 112 (108-125)
Resp 25 (18-25)
BP 102/67 (102/61-129/80)
O2 Sat: 94 (88-94)
%/L of O2: 5 (2-5)
Weight (lbs) 191

I/Os: (05/16 07:00-05/17 07:00)
Net: 1,675 Intake: 3,410 Output: 1,735
#1 JP:: 90 Emesis:: 0 Foley:: 1,495 IV Fluids (A):: 3,300 IV Fluids (B):: 50 Ileostomy:: 150 PO:: 60

GASTROINTESTINAL: Ostomy started to function

ASSESSMENT/PLAN

1. **Intestinal perforation**
   - A: s/p resection and ostomy, doing better.
   - P: Start liquids PO, keep in PCU today.

Electronically signed by Gilbertas MD Rimkus on 05/17/16 at 13:29

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Santiago, Kenneth MD	DATE: 05/18/16 07:32	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 4

Patient narrative: Overnight cont requiring higher levels of O2NC. CHanged to 50% mask. U/O great 3L negative. Abdominal pain better.

HPI Review

☒ Location ☒ Severity ☒ Quality

☒ Past Family/Social History Taken

REVIEW OF SYSTEMS

EYES: Negative for blurry vision. No diplopia.

CARDIOVASCULAR: Negative for chest pain or palpitations. No extremity swelling.

EXAM

Vitals: (05/17 07:32 - 05/18 07:32)

Temp 98.6 (98.2-98.8)
Pulse 106 (101-118)
Resp 22 (18-25)
BP 112/77 (102/67-129/81)
O2 Sat: 90 (88-94)
%/L of O2: 50 (5-50)
Weight (lbs) 180

I/Os: (05/17 07:00-05/18 07:00)

Net: -3,689 Intake: 2,181 Output: 5,870
#1 JP:: 20 Foley:: 2,450 IV Fluids (A):: 500 IV Fluids (B):: 106 Ileostomy:: 3,400 PO:: 1,575

CONSTITUTIONAL: Alert, in NAD.

EYES: PERL. Sclerae nonicteric. Conjunctivae pink.

ENT: Mucus membranes moist. Oropharynx without exanthema or exudates.

RESPIRATORY: distant bilateral, no wheezes. Mild crackles left base.

CARDIOVASCULAR: Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. No lower extremity edema.

GASTROINTESTINAL: decrease BS, diffuse abd discomfort. RLQ ileostomy draining small amount.

SKIN: Warm and dry. Normal turgor. No rashes or lesions.

NEUROLOGICAL: Awake and lethargic, oriented to person, place and time.

DATA

LAB RESULTS

DIFF (05/18/16 04:40)
Panel
NEUTROPHILS 61 , BAND 12 , LYMPHOCYTE 11 , MONOCYTE 4 , EOSINOPHIL 8 , ATYP LYMP 4 , PLATELET MORPHOLOGY GIANT , PLATELET ESTIMATE NORMAL , MORPHOLOGY COMMENT NORMAL , ABSOLUTE NEUTROPHIL CT 3.4 , ABSOLUTE LYMPHOCYTE CT 0.7 L, ABSOLUTE MONOCYTE CT 0.2 , ABSOLUTE EOSINOPHIL CT 0.4 , ABSOLUTE BASOPHIL COUNT 0.0

CBC W/AUTO DIFF (05/18/16 04:40)
Panel

4.7	10.6 / 31.9	230

RED BLOOD COUNT 3.53 L, MEAN CELL VOLUME 90.5 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 33.3 , RED CELL DISTRIBUTION WIDTH 13.9 , MORPHOLOGY COMMENT NORMAL

HEMATOCRIT05/18/16 04:4031.9%
HEMOGLOBIN05/18/16 04:4010.6g/dL
PLATELET COUNT05/18/16 04:40230K/mm3
WBC05/18/16 04:404.7K/mm3

BASIC METABOLIC PANEL (05/18/16 06:43)
Panel

140	102	21	122
3.6	30	1.11	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 8.6

CREATININE05/18/16 06:431.11mg/dl
CO205/18/16 06:4330mmol/L

PROGRESS NOTE

AUTHOR: Santiago, Kenneth MD | DATE: 05/18/16 07:32 | CCE.CC26.1.CNW

POTASSIUM05/18/16 06:433.6mmol/L
BUN05/18/16 06:4321mg/dl
SODIUM05/18/16 06:43140mmol/L
CHLORIDE05/18/16 06:43102mmol/l
GLUCOSE,RANDOM05/18/16 06:43122mg/dL

GLU BED, NURSE (05/18/16 04:40)
Panel
GLUCOSE,BEDSIDE NURSE 111

MEDICATIONS

Fluconazole/Ns 200MG/100ML 100 ML Q24H
Furosemide 40 MG Q12
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
Ketorolac Tromethamine 30 MG Q6H (PRN)
Pantoprazole Sodium 40 MG HS
UNKNOWN 3 ML QIDRT

ALLERGIES

Penicillins
Sulfa (Sulfonamide Antibiotics)

ASSESSMENT/PLAN

1. **Hypoxemia**
   - **A:** presumed to be 2nd volume overload yesterday. Removed more than 3L fluid overnight with IV lasix. Cont requiring higher levels of O2 despite that. Diferential: pulmonary edema, atelectasis, lung injury/ARDS starting, PE.
   - **P:** Started Duonebs, Lasix IV, O2 50% mask, CXR today. Pulmonary consult. Consider CT angiogram. Was off anticoagulation after surgery. Will cont PCU level.

2. **Hypotension**
   - **A:** resolved. I/O better.
   - **P:** cont monitoring.

3. **Abdominal pain**
   - **A:** better controlled, cont Dilaudid 2 mg q 2 hrs prn pain.

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): 35 min

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have reviewed all medications for this patient.

Electronically signed by Kenneth MD Santiago on 05/18/16 at 07:46

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/18/16 10:00	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 4

Patient narrative Has breathing problems overnight

REVIEW OF SYSTEMS

EXAM

Vitals: (05/17 10:00 - 05/18 10:00)

Temp 97.7 (97.7-98.8)
Pulse 106 (89-112)
Resp 24 (18-24)
BP 120/73 (102/67-120/81)
O2 Sat: 92 (89-95)
%/L of O2: 50 (45-50)
Weight (lbs) 180

I/Os: (05/17 07:00-05/18 07:00) Net: -3,689 Intake: 2,181 Output: 5,870
#1 JP:: 20 Foley:: 2,450 IV Fluids (A):: 500 IV Fluids (B):: 106 Ileostomy:: 3,400 PO:: 1,575

SKIN: Wound looks good, ostomy with stool and gas

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/18/16 04:40)
Panel

4.7	10.6 / 31.9	230

RED BLOOD COUNT 3.53 L, MEAN CELL VOLUME 90.5 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 33.3 , RED CELL DISTRIBUTION WIDTH 13 9 , MORPHOLOGY COMMENT NORMAL

HEMATOCRIT05/18/16 04:4031.9%
HEMOGLOBIN05/18/16 04:4010.6g/dL
PLATELET COUNT05/18/16 04:40230K/mm3
WBC05/18/16 04:404.7K/mm3

BASIC METABOLIC PANEL (05/18/16 06:43)
Panel

140 | 102 | 21			122
3.6 | 30 | 1.11			

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 8.6

CREATININE05/18/16 06:431.11mg/dl
CO205/18/16 06:4330mmol/L
POTASSIUM05/18/16 06:433.6mmol/L
BUN05/18/16 06:4321mg/dl
SODIUM05/18/16 06:43140mmol/L
CHLORIDE05/18/16 06:43102mmol/l
GLUCOSE,RANDOM05/18/16 06:43122mg/dL

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/18/16 08:31)
Portable view demonstrates worsening diffuse alveolar opacities
throughout both lungs since earlier study. Elevated right diaphragm
remains.

ASSESSMENT/PLAN

1. **Intestinal perforation**
   - **A:** s/p resection and ileostomy, possibly pneumonia now
   - **P:** Consult pulmonary, keep him in PCU.

Electronically signed by Gilbertas MD Rimkus on 05/18/16 at 10:03

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/19/16 07:38	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 5

Patient narrative Still requires noninvasive ventilation

REVIEW OF SYSTEMS

EXAM

Vitals: (05/18 07:38 - 05/19 07:38)

Temp 98.6 (97.7-98.6)
Pulse 105 (89-108)
Resp 17 (17-27)
BP 121/91 (104/67-127/91)
O2 Sat 97 (14-97)
%/L of O2: 60 (50-60)
Weight (lbs) 166

I/Os: (05/18 07:00-05/19 07:00) Net: -4,525 Intake: 680 Output: 5,205
#1 JP:: 5 Foley:: 1,900 IV Fluids (A):: 200 Ileostomy:: 3,300 PO:: 480

GASTROINTESTINAL: Soft, tender, slightly distended. Ostomy with stool and gas.

ASSESSMENT/PLAN

1. **Intestinal perforation**
   - A: s/p resection and ileostomy.
   - P: Doing better, keep him in PCU for now.

Electronically signed by Gilbertas MD Rimkus on 05/19/16 at 07:41

Conway M... ...cal Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Mansour, Ali MD	DATE: 05/19/16 08:28	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 5

Patient narrative: the pt is doing same
more tired

REVIEW OF SYSTEMS

EYES:	Negative for blurry vision. No diplopia.
ENT:	Negative for sore throat. No otalgia. No rhinorrhea.
RESPIRATORY:	Negative for dyspnea or wheeze. No cough.
CARDIOVASCULAR:	Negative for chest pain or palpitations. No extremity swelling.
MUSCULOSKELETAL:	Negative for myalgia, arthralgia or joint swelling.
SKIN:	Negative for lesions or rashes. No pruritus.

EXAM

Vitals: (05/18 08:28 - 05/19 08:28)

Temp 98.6 (98.0-98.6)
Pulse 105 (97-108)
Resp 17 (17-27)
BP 121/91 (104/67-127/91)
O2 Sat: 97 (14-97)
%/L of O2: 60 (50-80)
Weight (lbs) 166

I/Os: (05/18 07:00-05/19 07:00)

Net: -4,525 Intake: 680 Output: 5,205
#1 JP:: 5 Foley:: 1,900 IV Fluids (A):: 200 Ileostomy:: 3,300 PO:: 480

EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates. Normal dentition.
RESPIRATORY:	Lungs are clear to auscultation. Normal resonance to percussion. Normal respiratory effort.
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. Carotid arteries with normal upstroke and amplitude, no bruits. Normal distal pulses. No lower extremity edema.
MUSCULOSKELETAL:	Normal range of motion bilateral upper and lower extremities, with normal strength and muscle tone. No spine point tenderness. Neck is supple.
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.

DATA

LAB RESULTS

BASIC METABOLIC PANEL (05/19/16 04:56)
Panel

137	95	24	114
3.3	34	1.13	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 9.2

CREATININE05/19/16 04:561.13mg/dl
CO205/19/16 04:5634mmol/L
POTASSIUM05/19/16 04:563.3mmol/L
BUN05/19/16 04:5624mg/dl
SODIUM05/19/16 04:56137mmol/L
CHLORIDE05/19/16 04:5695mmol/l
GLUCOSE,RANDOM05/19/16 04:56114mg/dL

CBC W/AUTO DIFF (05/19/16 04:56)
Panel

9.8	11.8	222
	35.2	

RED BLOOD COUNT 3.93 L, MEAN CELL VOLUME 89.5 , MEAN CORPUSCULAR HEMOGLOBIN 30.0 , MEAN CORPUSCULAR HGB CONC 33.5 , RED CELL DISTRIBUTION WIDTH 14.0 , NEUT % 83.8 , LYMPH % 7.8 , MONO % 4.6 , EOS % 3.6 , BASO % 0.2 , NEUT # 8.2 H, LYMPH # 0.8 L, MONO # 0.5 , EOS # 0.3 , BASO # 0.0

HEMATOCRIT05/19/16 04:5635.2%
HEMOGLOBIN05/19/16 04:5611.8g/dL
PLATELET COUNT05/19/16 04:56222K/mm3
WBC05/19/16 04:569.8K/mm3

TEST RESULTS
PORTABLE CHEST ONE VIEW * (05/19/16 03:35) - Abnormal

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   A: on HFNC
   recommmedn IS adn acupella

2. **Acute lung injury**
   A: will start low dose steroids and folwo clinialy

3. **Intestinal perforation**
   A: s.p surgery on fluid

4. **Muscular deconditioning**
   A: PT recommedn more aggressive intervention

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): > 30

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have spent greater than 30 minutes on critical care activity.
- ☑ I have reviewed all medications for this patient.

Electronically signed by Ali MD Mansour on 05/19/16 at 08:32

Conway Medical Center | NAME: KNIGHT, DANIEL E. | SEX: Male | ACCOUNT #: V00006912886

[redacted] | MRN: M000175313

PROGRESS NOTE | AUTHOR: Budhoo, David MD | DATE: 05/19/16 08:42 | CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 5

Patient narrative: Patient laying in bed with poor po intake. States his breathing is worse today

REVIEW OF SYSTEMS

EYES: Negative for blurry vision. No diplopia.

CARDIOVASCULAR: Negative for chest pain or palpitations.

EXAM

Vitals: (05/18 08:42 - 05/19 08:42)

Temp 98.4 (98.0-98.6)
Pulse 108 (97-108)
Resp 16 (16-27)
BP 110/81 (104/67-127/91)
O2 Sat: 97 (14-97)
%/L of O2: 60 (50-80)
Weight (lbs) 166

I/Os: (05/18 07:00-05/19 07:00)

Net: -4,525 Intake: 680 Output: 5,205
#1 JP:: 5 Foley:: 1,900 IV Fluids (A):: 200 Ileostomy:: 3,300 PO:: 480

CONSTITUTIONAL: Alert, in mild resp distress

EYES: PERL. Sclerae nonicteric. Conjunctivae pink.

ENT: Mucus membranes moist. Oropharynx without exanthema or exudates.

RESPIRATORY: Coarse rhonchi in all lung zones,

CARDIOVASCULAR: Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. +1 pitting edema in lower extremities

GASTROINTESTINAL: decrease BS, distended abdomen with serosanguinous drainage noted from suture sites. RLQ ileostomy draining moderate amt

SKIN: Warm and dry. Normal turgor. No rashes or lesions.

NEUROLOGICAL: Awake and lethargic, oriented to person, place and time.

DATA

LAB RESULTS

BASIC METABOLIC PANEL (05/19/16 04:56)
Panel

137	95	24	114
3.3	34	1.13	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 8.0 , CALCIUM 9.2

CREATININE05/19/16 04:561.13mg/dl
CO205/19/16 04:5634mmol/L
POTASSIUM05/19/16 04:563.3mmol/L
BUN05/19/16 04:5624mg/dl
SODIUM05/19/16 04:56137mmol/L
CHLORIDE05/19/16 04:5695mmol/l
GLUCOSE,RANDOM05/19/16 04:56114mg/dL

MAG (05/19/16 04:56)
Panel
MAGNESIUM 2 1

CBC W/AUTO DIFF (05/19/16 04:56)
Panel

9.8	11.8	222
	35.2	

RED BLOOD COUNT 3.93 L, MEAN CELL VOLUME 89.5 , MEAN CORPUSCULAR HEMOGLOBIN 30.0 , MEAN CORPUSCULAR HGB CONC 33.5 , RED CELL DISTRIBUTION WIDTH 14.0 , NEUT % 83.8 , LYMPH % 7.8 , MONO % 4.6 , EOS % 3.6 , BASO % 0.2 , NEUT # 8.2 H, LYMPH # 0.8 L, MONO # 0.5 , EOS # 0.3 , BASO # 0.0

HEMATOCRIT05/19/16 04:5635.2%
HEMOGLOBIN05/19/16 04:5611.8g/dL
PLATELET COUNT05/19/16 04:56222K/mm3
WBC05/19/16 04:569.8K/mm3

TEST RESULTS | **MEDICATIONS**

PORTABLE CHEST ONE VIEW * (05/19/16 03:35)
Impression:
1. Fluctuating areas of pulmonary consolidation. Findings could
represent contusion, aspiration, or pneumonia among other noninfectious inflammatory diseases.

Ertapenem Sodium with/in Sodium Chloride 0.9% 1 GM Q24H
Fluconazole/Ns 200MG/100ML 100 ML Q24H
Furosemide 40 MG Q12
HYDROcodone 5MG/Acetamin 325MG 1-2 TABS Q4H (PRN)
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
Ketorolac Tromethamine 30 MG Q6H (PRN)
MethylPREDNISOLone SOD SUCC 40 MG Q8H
Pantoprazole Sodium 40 MG HS

ASSESSMENT/PLAN

1. **Hypoxemia**
   - A: Suspect ARDS as well as poor insiratory effort and possibly lung injury from contusion from MVA 3 weeks ago. Also has abd distention which may be an additional factor reducing his respiratory capacity
   - P: On Duonebs, Lasix IV. Appreciate pulmonary consult. Will get CT chest without contrast as well as CT abd with oral contrast

2. **Hypotension**
   - A: resolved. I/O better.
   - P: cont monitoring.

3. **Abdominal pain**
   - A: better controlled.
   - P: Will attempt to wean off opiates as soon as possible to enaable him to ambulate as much as possible. The nurses were concerned that the pain medications may be hindering his ability to ambulate.

4. **Perforated bowel**
   - P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Will request CT abd with oral contrast to look for any additional leaks. Suspect it is more likely secondary to thirds spacing. Will consult dietary and increase protein intake

BILLING

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have spent greater than 30 minutes on critical care activity.
- ☑ I have reviewed all medications for this patient.

Electronically signed by David MD Budhoo on 05/19/16 at 08:57

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Budhoo, David MD	DATE: 05/20/16 09:22	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 6

Patient narrative — Patient states he feels worse (more painful) today but is optimistic as his lab and radiology findings are better. Able to ambulate to the bathroom and back 4 times with assist yesterday.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/19 09:22 - 05/20 09:22)
Temp 98.4 (98.4-99.1)
Pulse 93 (80-113)
Resp 16 (12-27)
BP 107/67 (100/64-121/91)
O2 Sat: 96 (87-97)
%/L of O2: 30 (30-80)
Weight (lbs) 161

I/Os: (05/19 07:00-05/20 07:00)
Net: -1,910 Intake: 3,135 Output: 5,045
#1 JP:: 20 Foley:: 2,450 IV Fluids (A):: 850 Ileostomy:: 2,575 PO Supplement:: 30 PO:: 2,255

CONSTITUTIONAL:	Alert, in mild resp distress
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Breath sounds better compared to yesterday with reduced crackles
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. +1 pitting edema in lower extremities
GASTROINTESTINAL:	Abd less distended today and soft. RLQ ileostomy draining moderate amt
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake and lethargic, oriented to person, place and time.

DATA

LAB RESULTS

BASIC METABOLIC PANEL (05/20/16 05:59)
Panel

136	95	29	196
3.1	32	1.13	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 9.0 , CALCIUM 9.3

CREATININE05/20/16 05:591.13mg/dl
CO205/20/16 05:5932mmol/L
POTASSIUM05/20/16 05:593.1mmol/L
BUN05/20/16 05:5929mg/dl
SODIUM05/20/16 05:59136mmol/L
CHLORIDE05/20/16 05:5995mmol/l
GLUCOSE,RANDOM05/20/16 05:59196mg/dL

GLU BED, NURSE (05/19/16 20:39)
Panel
GLUCOSE,BEDSIDE NURSE 149 H

CBC W/AUTO DIFF (05/20/16 05:59)
Panel

13.7	11.9	235
	34.8	

RED BLOOD COUNT 3.95 L, MEAN CELL VOLUME 88.3 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 34.1 , RED CELL DISTRIBUTION WIDTH 13.6 , NEUT % 90.1 , LYMPH % 6.1 , MONO % 3.6 , EOS % 0.0 , BASO % 0 2 , NEUT # 12.4 H, LYMPH # 0.8 L, MONO # 0.5 , EOS # 0.0 , BASO # 0.0

HEMATOCRIT05/20/16 05:5934.8%
HEMOGLOBIN05/20/16 05:5911.9g/dL
PLATELET COUNT05/20/16 05:59235K/mm3
WBC05/20/16 05:5913.7K/mm3

TEST RESULTS

ABDOMEN W/ P.O. CONTRAST ONLY (05/19/16 12:15)
Impression: Dilated small bowel which could be related to

MEDICATIONS

Ertapenem Sodium with/in Sodium Chloride 0.9% 1 GM Q24H

partial
obstructive sequela or an ileus in this patient with recent diverting
ostomy. There is a mild degree of free fluid in the lower pelvis. No
signs of free intraperitoneal gas. The distal colon is decompressed.

PORTABLE CHEST ONE VIEW * (05/20/16 05:54)
Impression: Overall slight improvement to the bilateral alveolar
densities. Some airspace disease remains.

CHEST WITHOUT CONTRAST * (05/19/16 12:15)
Impression: Abnormal opacities especially the upper lobe distributions
with air bronchograms. Left base shows pleural fluid.

CT scans at this facility use dose modulation, iterative reconstruction, and/or weight-based dosing when appropriate to reduce
radiation dose to as low as reasonably achievable

FLUoxetine HCl 20 MG Q24A
Fluconazole/Ns 200MG/100ML 100 ML Q24H
Furosemide 40 MG Q12
HYDROcodone 5MG/Acetamin 325MG 1-2 TABS Q4H (PRN)
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
Ketorolac Tromethamine 30 MG Q6H (PRN)
MethylPREDNISOLone SOD SUCC 40 MG Q8H
Pantoprazole Sodium 40 MG HS

ASSESSMENT/PLAN

1. **Hypoxemia**
   - **A:** Suspect ARDS as well as poor insiratory effort and possibly lung injury from contusion from MVA 3 weeks ago. Also has abd distention which may be an additional factor reducing his respiratory capacity
   - **P:** On Duonebs, Lasix IV. Appreciate pulmonary consult. CT chest showing air bronchograms and small pleural effusion on right. Patient clinically better today on reduced FiO2 requirements. AMy be able to switch to nasal cannula soon as per pulmonary. Consider chest PT

2. **Hypotension**
   - **A:** resolved. I/O better.
   - **P:** cont monitoring.

3. **Abdominal pain**
   - **A:** better controlled.
   - **P:** Will attempt to wean off opiates as soon as possible to enaable him to ambulate as much as possible. The nurses were concerned that the pain medications may be hindering his ability to ambulate.

4. **Perforated bowel**
   - **P:** s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Will request CT abd with oral contrast to look for any additional leaks. Suspect it is more likely secondary to thirds spacing. Will consult dietary and increase protein intake

5. **Hyperglycemia**
   - **P:** Likely steroid induced. On solumedrol 40mg IV q 8hrly. Pulm following.

6. **Hypokalemia**
   - **P:** Will replete with 40mEq. Liekly losing from ostomy

7. **Depression**
   - **P:** Will resume prozac at 20mg po q daily

Additional Comments:
DVT prophy - Start lovenox 40mg sc q daily

BILLING

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team

5A4D43B46E10429588C8, KNIGHT, 607

☐ I have spent greater than 30 minutes on critical care activity.
☐ I have reviewed all medications for this patient.

Electronically signed by David MD Budhoo on 05/20/16 at 09:35

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Hayek, Hafez MD	DATE: 05/20/16 13:02	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 6

Patient narrative: no acute events overnight.
his O2 requirements are less.
still c/o SOB and abd pain.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/19 13:02 - 05/20 13:02)
Temp 98.4 (98.4-99.1)
Pulse 90 (80-96)
Resp 20 (16-22)
BP 107/67 (100/64-121/91)
O2 Sat 96 (87-96)
%/L of O2: 4 (4-80)
Weight (lbs) 161

I/Os: (05/19 07:00-05/20 07:00)
Net: -1,910 Intake: 3,135 Output: 5,045
#1 JP:: 20 Foley:: 2,450 IV Fluids (A):: 850 Ileostomy:: 2,575 PO Supplement:: 30 PO:: 2,255

CONSTITUTIONAL:	Alert,
RESPIRATORY:	poor inspiratory effort, few rals at bases
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2.+lower extremity edema.
GASTROINTESTINAL:	Soft, nontender, nondistended. post op, ileostomy in placeNo rebound or guarding. No hepatosplenomegaly. Bowel sounds present.
MUSCULOSKELETAL:	Neck is supple.
SKIN:	Warm and dry.
NEUROLOGICAL:	Awake and alert, oriented to person, place and time.

DATA

LAB RESULTS

BASIC METABOLIC PANEL (05/20/16 05:59)
Panel

136	95	29	196
3.1	32	1.13	

GLOMERULAR FILTRATION RATE > 60 , ANION GAP 9.0 , CALCIUM 9.3

CREATININE05/20/16 05:591.13mg/dl
CO205/20/16 05:5932mmol/L
POTASSIUM05/20/16 05:593.1mmol/L
BUN05/20/16 05:5929mg/dl
SODIUM05/20/16 05:59136mmol/L
CHLORIDE05/20/16 05:5995mmol/l
GLUCOSE,RANDOM05/20/16 05:59196mg/dL

CBC W/AUTO DIFF (05/20/16 05:59)
Panel

13.7	11.9	235
	34.8	

RED BLOOD COUNT 3.95 L, MEAN CELL VOLUME 88.3 , MEAN CORPUSCULAR HEMOGLOBIN 30.1 , MEAN CORPUSCULAR HGB CONC 34.1 , RED CELL DISTRIBUTION WIDTH 13.6 , NEUT % 90.1 , LYMPH % 6.1 , MONO % 3.6 , EOS % 0.0 , BASO % 0.2 , NEUT # 12.4 H, LYMPH # 0.8 L, MONO # 0.5 , EOS # 0.0 , BASO # 0.0

HEMATOCRIT05/20/16 05:5934.8%
HEMOGLOBIN05/20/16 05:5911.9g/dL
PLATELET COUNT05/20/16 05:59235K/mm3
WBC05/20/16 05:5913.7K/mm3

CBC W/AUTO DIFF (05/19/16 04:56)
Panel

9.8	11.8	222
	36.2	

RED BLOOD COUNT 3.93 L, MEAN CELL VOLUME 89.5 , MEAN CORPUSCULAR HEMOGLOBIN 30.0 , MEAN CORPUSCULAR HGB CONC 33.5 , RED CELL DISTRIBUTION WIDTH 14.0 , NEUT % 83.8 , LYMPH % 7.8 , MONO % 4.6 , EOS % 3.6 , BASO % 0.2 , NEUT # 8.2 H, LYMPH # 0.8 L, MONO # 0.5 , EOS # 0.3 , BASO # 0.0

HEMATOCRIT05/19/16 04:5635.2%
HEMOGLOBIN05/19/16 04:5611.8g/dL
PLATELET COUNT05/19/16 04:56222K/mm3
WBC05/19/16 04:569.8K/mm3

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/20/16 05:54)
PORTABLE CHEST ONE VIEW *
41-year-old male shortness of breath, recent MVA. Lung injury.

Exam: Portable chest single view

Comparison: 5/19/2016.

Findings: Upright AP portable view of the chest shows cardiac silhouette and pulmonary vasculature to be stable. Alveolar density in the left upper lobe is improved. There is clearing of the right upper lobe density. New findings in the right infrahilar region. No pneumothorax.

Impression: Overall slight improvement to the bilateral alveolar densities. Some airspace disease remains.

Electronically Signed By: Russell Derrick

Reported by: RUSSELL L. DERRICK MD

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   - A: secondary to ALI and volume overload. improving with good diuresis
   - P: wean FiO2,
     decreaase lasix.
     wean down steroids.
     continue ACT
2. **Perforated bowel**
   - A: s/p surgery with bowelresection and ileostomy
3. **Muscular deconditioning**
   - P: PT/OT
4. **Hypotension**
   - A: resolved

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): 35 min

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team

I have spent greater than 30 minutes on critical care activity.

☑ I have reviewed all medications for this patient.

Electronically signed by Hafez MD Hayek on 05/20/16 at 13:07

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOU.. #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Hayek, Hafez MD	DATE: 05/21/16 09:41	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 7

Patient narrative: no acute events overnight . feeling better
O2 requirements are less.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/20 09:41 - 05/21 09:41)

Temp 97.2 (97.2-98.8)
Pulse 74 (74-103)
Resp 18 (16-20)
BP 126/79 (109/74-127/82)
O2 Sat: 99 (95-99)
%/L of O2: 2 (2-4)
Weight (lbs) 149

I/Os: (05/20 07:00-05/21 07:00)

Net: -1,811 Intake: 1,769 Output: 3,580
#1 JP:: 5 Foley:: 750 IV Fluids (A):: 209 Ileostomy:: 2,225 PO:: 1,560 Stool Episodes:: 0 Void (ml):: 600

CONSTITUTIONAL:	Alert,
RESPIRATORY:	improved aeration
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2.+lower extremity edema.
GASTROINTESTINAL:	Soft, nontender, nondistended. post op, ileostomy in placeNo rebound or guarding. No hepatosplenomegaly. Bowel sounds present.
MUSCULOSKELETAL:	Neck is supple.
SKIN:	Warm and dry.
NEUROLOGICAL:	Awake and alert, oriented to person, place and time.

DATA

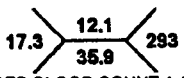
LAB RESULTS

MAG (05/21/16 06:37)
Panel
MAGNESIUM 2.4

PHOS (05/21/16 06:37)
Panel
PHOSPHOROUS 3.8

COMPREHENSIVE METABOLIC PANEL (05/21/16 06:37)
Panel
GLUCOSE,RANDOM 156 H, BUN 43 H, CREATININE 1.20 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 137 , POTASSIUM 3.2 L, CHLORIDE 98 , ANION GAP 11.0 , CO2 30 , CALCIUM 9.2 , TOTAL PROTEIN 7.2 , ALBUMIN 2.5 L, GLOBULIN 4.7 , BILIRUBIN,TOTAL 1.9 H, ALK PHOS/ALP 187 H, SGOT,AST 240 H, SGPT,ALT 317 H

CBC W/AUTO DIFF (05/21/16 06:37)
Panel



RED BLOOD COUNT 4.10 L, MEAN CELL VOLUME 87.5 , MEAN CORPUSCULAR HEMOGLOBIN 29.4 , MEAN CORPUSCULAR HGB CONC 33.7 , RED CELL DISTRIBUTION WIDTH 13.9 , NEUT % 87.3 , LYMPH % 8.3 , MONO % 4.2 , EOS % 0.0 , BASO % 0.2 , NEUT # 15.1 H, LYMPH # 1.4 , MONO # 0.7 , EOS # 0.0 , BASO # 0.0

HEMATOCRIT05/21/16 06:3735.9%
HEMOGLOBIN05/21/16 06:3712.1g/dL
PLATELET COUNT05/21/16 06:37293K/mm3
WBC05/21/16 06:3717.3K/mm3

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/21/16 06:05)
PORTABLE CHEST ONE VIEW *
Study: Portable chest

Comparison: 5/20/2016.

Indication: Motor vehicle accident April 27, 2016 states shortness of
breath since that time. Recent film shows abnormal opacities
concerning for pneumonia.

Portable view demonstrates abnormal alveolar densities left upper lobe
and right base slightly improved. No evidence for pneumothorax.

Impression: Bilateral airspace opacities remain slightly improved
since prior study.

Electronically Signed By: G. Scott Mencken

Reported by: G. Scott Mencken M.D.

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   - A: secondary to ALI and volume overload. improving with good diuresis
   - P: wean FiO2,
     d/c lasix.
     d/c steroids.
     continue ACT
2. **Perforated bowel**
   - A: s/p surgery with bowelresection and ileostomy
3. **Muscular deconditioning**
   - P: PT/OT
4. **Hypotension**
   - A: resolved
5. **Elevated LFTs**
   - P: repeat CMP in AM

Level Of Decision Making:
High

BILLING

Approximate minutes spent (direct patient care): 35 min

Care Activities / Care Coordination:

- ☒ I have reviewed the history and repeated the key elements
- ☒ I have seen and examined this patient
- ☒ I have reviewed the progress in the clinical course since the last examination
- ☒ I have discussed the patient's condition with other members of the care team
- ☒ I have spent greater than 30 minutes on critical care activity.
- ☒ I have reviewed all medications for this patient.

Electronically signed by Hafez MD Hayek on 05/21/16 at 09:45

Conway Medical Center | NAME: KNIGHT, DANIEL E. | SEX: Male | ACCOUNT #: V00006912886

[redacted] | MRN: M000175313

PROGRESS NOTE

AUTHOR: Budhoo, David MD | DATE: 05/21/16 09:52 | CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 7

Patient narrative Patient doing well today. Able to ambulate X2 yesterday with minimal assist. Still with some abd pain

REVIEW OF SYSTEMS

EXAM

Vitals: (05/20 09:53 - 05/21 09:53)

Temp 97.2 (97.2-98.8)
Pulse 74 (74-103)
Resp 18 (16-20)
BP 126/79 (109/74-127/82)
O2 Sat: 99 (95-99)
%/L of O2: 2 (2-4)
Weight (lbs) 149

I/Os: (05/20 07:00-05/21 07:00)

Net: -1,811 Intake: 1,769 Output: 3,580
#1 JP:: 5 Foley:: 750 IV Fluids (A):: 209 Ileostomy:: 2,225 PO:: 1,560 Stool Episodes:: 0 Void (ml):: 600

CONSTITUTIONAL:	Alert, in minimal resp distress
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Breath sounds better today, good expansion
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. +1 pitting edema in lower extremities
GASTROINTESTINAL:	Abd less distended today and soft. RLQ ileostomy draining moderate amt
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake and lethargic, oriented to person, place and time.

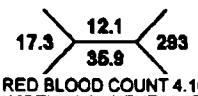
DATA

LAB RESULTS

MAG (05/21/16 06:37)
Panel
MAGNESIUM 2.4

COMPREHENSIVE METABOLIC PANEL (05/21/16 06:37)
Panel
GLUCOSE,RANDOM 156 H, BUN 43 H, CREATININE 1.20 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 137 , POTASSIUM 3.2 L, CHLORIDE 98 , ANION GAP 11.0 , CO2 30 , CALCIUM 9.2 , TOTAL PROTEIN 7.2 , ALBUMIN 2.5 L, GLOBULIN 4.7 , BILIRUBIN,TOTAL 1.9 H, ALK PHOS/ALP 187 H, SGOT,AST 240 H, SGPT,ALT 317 H

CBC W/AUTO DIFF (05/21/16 06:37)
Panel



RED BLOOD COUNT 4.10 L, MEAN CELL VOLUME 87.5 , MEAN CORPUSCULAR HEMOGLOBIN 29.4 , MEAN CORPUSCULAR HGB CONC 33.7 , RED CELL DISTRIBUTION WIDTH 13.9 , NEUT % 87.3 , LYMPH % 8.3 , MONO % 4.2 , EOS % 0.0 , BASO % 0.2 , NEUT # 15.1 H, LYMPH # 1.4 , MONO # 0.7 , EOS # 0.0 , BASO # 0.0

HEMATOCRIT05/21/16 06:3735.9%
HEMOGLOBIN05/21/16 06:3712.1g/dL
PLATELET COUNT05/21/16 06:37293K/mm3
WBC05/21/16 06:3717.3K/mm3

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/21/16 06:05)
Impression: Bilateral airspace opacities remain slightly improved
since prior study.

MEDICATIONS

Enoxaparin Sodium 40 MG Q24A
(DC'd) Ertapenem Sodium with/in Sodium Chloride 0.9% 1 GM Q24H
FLUoxetine HCl 20 MG Q24A
(DC'd) Furosemide 40 MG Q24H
(DC'd) HYDROcodone 5MG/Acetamin 325MG 1-2 TABS Q4H (PRN)
HYDROmorphONE Hydrochloride 2 MG Q2H (PRN)
(DC'd) MethylPREDNISOLone SOD SUCC 40 MG Q12H
Pantoprazole Sodium 40 MG HS

ASSESSMENT/PLAN

1. **Hypoxemia**
   - **A:** Improving rapidly which goes gainst ARDS. Now O2 requirements down to 3L
   - **P:** On Duonebs, will wean Lasix IV. Appreciate pulmonary consult. CT chest showing air bronchograms and small pleural effusion on right. Patient clinically better today on reduced FiO2 requirements.

2. **Hypotension**
   - **A:** resolved. I/O better.
   - **P:** cont monitoring.

3. **Abdominal pain**
   - **A:** better controlled.
   - **P:** Pain better and will focus on ambulation

4. **Perforated bowel**
   - **P:** s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus.CT abdnot showing any leaks. Dr Ellis following this weeknend

5. **Hyperglycemia**
   - **P:** Likely steroid induced. Pulm will manage steroids

6. **Depression**
   - **P:** Better mood with prozac at 20mg po q daily

7. **Transaminitis**
   - **P:** Possibly from IV difucan +/- Invanz. D/C Diflucan and switch Abx to Flagyl and Ancef. Will monitor LFT's in AM. If worse will refer to GI for further workup

BILLING

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have reviewed all medications for this patient.

Electronically signed by David MD Budhoo on 05/21/16 at 10:07

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOU... #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Ellis, Michael H. MD	DATE: 05/21/16 14:46	CCE.CC26.1.CNW

SUBJECTIVE

Hospital day 7

Patient narrative doing 2well transfer to ward

REVIEW OF SYSTEMS

EXAM

Vitals: (05/20 14:46 - 05/21 14:46)

Temp 98.7 (97.2-98.8)
Pulse 80 (74-81)
Resp 20 (16-20)
BP 132/83 (116/75-132/83)
O2 Sat 97 (98-99)
%/L of O2: 2 (2-4)
Weight (lbs) 149

I/Os: (05/20 07:00-05/21 07:00)

Net: -1,811 Intake: 1,769 Output: 3,580
#1 JP:: 5 Foley:: 750 IV Fluids (A):: 209 Ileostomy:: 2,225 PO:: 1,560 Stool Episodes:: 0 Void (ml):: 600

Electronically signed by Michael H. MD Ellis on 05/21/16 at 14:46

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Hayek, Hafez MD	DATE: 05/22/16 10:50	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 8

Patient narrative: no acute events overnight.
feeling good, breathing is much better.
on RA

REVIEW OF SYSTEMS

EXAM

Vitals: (05/21 10:50 - 05/22 10:50)
Temp 98.8 (97.9-98.8)
Pulse 79 (74-82)
Resp 16 (16-20)
BP 116/72 (107/69-132/83)
O2 Sat: 95 (93-100)
%/L of O2: 2

I/Os: (05/21 07:00-05/22 07:00)
Net: 930 Intake: 2,380 Output: 1,450
IV:: 270 IVPB:: 200 Ileostomy:: 400 PO:: 1,910 Void (ml):: 1,050

CONSTITUTIONAL:	Alert,
RESPIRATORY:	clear bil
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2.+lower extremity edema.
GASTROINTESTINAL:	Soft, nontender, nondistended. post op, ileostomy in place.
MUSCULOSKELETAL:	Neck is supple.
SKIN:	Warm and dry.
NEUROLOGICAL:	Awake and alert, oriented to person, place and time.

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/22/16 04:17)
Panel

16.0	11.4	302
	34.0	

RED BLOOD COUNT 3.92 L, MEAN CELL VOLUME 86.7 , MEAN CORPUSCULAR HEMOGLOBIN 29.2 , MEAN CORPUSCULAR HGB CONC 33.6 , RED CELL DISTRIBUTION WIDTH 13.5 , NEUT % 83.7 , LYMPH % 8.2 , MONO % 8.0 , EOS % 0.0 , BASO % 0.1 , NEUT # 13.4 H, LYMPH # 1.3 , MONO # 1 3 H, EOS # 0.0 , BASO # 0.0

HEMATOCRIT05/22/16 04:1734.0%
HEMOGLOBIN05/22/16 04:1711.4g/dL
PLATELET COUNT05/22/16 04:17302K/mm3
WBC05/22/16 04:1716.0K/mm3

MAG (05/22/16 04:17)
Panel
MAGNESIUM 2.5 H

PHOS (05/22/16 04:17)
Panel
PHOSPHOROUS 3.3

COMPREHENSIVE METABOLIC PANEL (05/22/16 04:17)
Panel
GLUCOSE,RANDOM 157 H, BUN 35 H, CREATININE 1.04 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 139 , POTASSIUM 3.1 L, CHLORIDE 98 , ANION GAP 9.0 , CO2 32 , CALCIUM 8.4 L, TOTAL PROTEIN 6.3 L, ALBUMIN 2.3 L, GLOBULIN 4.0 , BILIRUBIN,TOTAL 1.3 H, ALK PHOS/ALP 181 H, SGOT,AST 110 H, SGPT,ALT 268 H

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   - **A:** secondary to ALI and volume overload.
     improving with good diuresis
     resoleved, On RA now
   - **P:** continue ACT.
     IS/ acapella valve

2. **Perforated bowel**
   - **A:** s/p surgery with bowel resection and ileostomy
   - **P:** as per surgery

3. **Muscular deconditioning**
   P: PT/OT

4. **Hypotension**
   A: resolved

5. **Elevated LFTs**
   A: improving slowly
   P: repeat CMP in AM

Additional Comments:
will be available if needed
Electronically signed by Hafez MD Hayek on 05/22/16 at 10:52

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Budhoo, David MD	DATE: 05/22/16 17:48	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 8

Patient narrative: Patient in good spirits today. States his appetite is poor but is trying to keep up with his calorie intake

REVIEW OF SYSTEMS

EXAM

Vitals: (05/21 17:48 - 05/22 17:48)
Temp 98.8 (97.9-98.8)
Pulse 74 (74-82)
Resp 18 (16-18)
BP 118/73 (107/69-118/73)
O2 Sat: 94 (93-98)
%/L of O2: 0

I/Os: (05/21 07:00-05/22 07:00)
Net: 930 Intake: 2,380 Output: 1,450
IV:: 270 IVPB:: 200 Ileostomy:: 400 PO:: 1,910 Void (ml):: 1,050

CONSTITUTIONAL:	Alert, in minimal resp distress
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Breath sounds better today, good air expansion, occasional crackles
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. +1 pitting edema in lower extremities
GASTROINTESTINAL:	Abd soft and non-tender. RLQ ileostomy draining moderate amt
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake, oriented to person, place and time.

DATA

LAB RESULTS

COMPREHENSIVE METABOLIC PANEL (05/22/16 04:17)
Panel
GLUCOSE,RANDOM 157 H, BUN 35 H, CREATININE 1.04 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 139 , POTASSIUM 3.1 L, CHLORIDE 98 , ANION GAP 9.0 , CO2 32 , CALCIUM 8.4 L, TOTAL PROTEIN 6 3 L, ALBUMIN 2.3 L, GLOBULIN 4.0 , BILIRUBIN,TOTAL 1.3 H, ALK PHOS/ALP 181 H, SGOT,AST 110 H, SGPT,ALT 268 H

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/21/16 06:05)
Impression: Bilateral airspace opacities remain slightly improved
since prior study.

MEDICATIONS

CeFAZolin Sodium with/in Sodium Chloride 0.9% 1 GM Q8
Enoxaparin Sodium 40 MG Q24A
FLUoxetine HCl 20 MG Q24A
HYDROmorphONE Hydrochloride 1 MG Q4H (PRN)
MetroNIDAZOLE 500MG/NS 100ML 100 ML Q8
OxyCODONE HCl 5-10 MG Q4H (PRN)

ASSESSMENT/PLAN

1. **Hypoxemia**
   - A: Improving rapidly which goes gainst ARDS. Is now off oxygen.
   - P: On Duonebs. Appreciate pulmonary consult. CT chest showing air bronchograms and small pleural effusion on right. Patient clinically better today not requiring any oxygen

2. **Hypotension**
   - A: resolved. I/O better.
   - P: cont monitoring.

3. **Abdominal pain**
   - P: Pain better controlled on current regimen.

4. **Perforated bowel**
   - P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus.CT abdnot showing any leaks. Dr Ellis following this weeknend. For reversal in approx 3 months

5. **Hyperglycemia**
   P: Likely steroid induced. Steroids were stopped as this was not likely ARDS

6. **Depression**
   P: Better mood with prozac at 20mg po q daily

7. **Transaminitis**
   P: Possibly from IV difucan +/- Invanz. D/C Diflucan and switch Abx to Flagyl and Ancef 5/21. LFT's better today and will trend tomorrow.

BILLING

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have discussed the patient's condition with other members of the care team
- ☑ I have reviewed all medications for this patient.

Electronically signed by David MD Budhoo on 05/22/16 at 17:58

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Vuppala, Srinivas MD	DATE: 05/23/16 07:10	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 9

Patient narrative

CONSULT NOTE
Wife at bedside. More dyspneic working with PT today ambulating in hall and patient complains of more right sided chest pain with deep inspirations. Denies cough/productive cough. Tolerating po but not eating much. Abd pain fairly well controlled outside of dressing changes

REVIEW OF SYSTEMS

EXAM

Vitals: (05/22 07:10 - 05/23 07:10)

Temp 99.5 (98.1-99.5)
Pulse 91 (74-91)
Resp 18 (16-18)
BP 102/65 (102/65-118/73)
O2 Sat: 91 (91-98)
%/L of O2: 0

I/Os: (05/22 07:00-05/23 07:00)

Net: 770 Intake: 2,835 Output: 2,065
#1 JP:: 15 IV:: 525 Ileostomy:: 450 PO:: 2,310 Void (ml):: 1,600

CONSTITUTIONAL:	Alert, Ox4, NAD and breathing comfortably laying at 30 degrees
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Crackles bilateral lower lung fields. Good insp effort, no accessory muscle use noted at present and speaking in complete sentences
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. +1 pitting edema in lower extremities as before
GASTROINTESTINAL:	Abd soft and non-tender. RLQ ileostomy draining moderate amt. Wounds heavily bandaged and appear to be dry
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake, oriented to person, place and time.

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/23/16 05:05)
Panel

21.9	12.4	377
	37.8	

RED BLOOD COUNT 4.27 L, MEAN CELL VOLUME 88.5 , MEAN CORPUSCULAR HEMOGLOBIN 28.9 , MEAN CORPUSCULAR HGB CONC 32.7 , RED CELL DISTRIBUTION WIDTH 13.8 , NEUT % 87.0 , LYMPH % 8.5 , MONO % 4.2 , EOS % 0.1 , BASO % 0.2 , NEUT # 19.1 H, LYMPH # 1.9 , MONO # 0.9 H, EOS # 0.0 , BASO # 0.0
HEMATOCRIT05/23/16 05:0537.8%HEMOGLOBIN05/23/16 05:0512.4g/dLPLATELET COUNT05/23/16 05:05377K/mm3WBC05/23/16 05:0521.9K/mm3

COMPREHENSIVE METABOLIC PANEL (05/23/16 05:05)
Panel
GLUCOSE,RANDOM 130 H, BUN 24 H, CREATININE 0.86 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 135 L, POTASSIUM 3.5 , CHLORIDE 99 , ANION GAP 9.0 , CO2 27 , CALCIUM 7.7 L, TOTAL PROTEIN 5.4 L, ALBUMIN 2.0 L, GLOBULIN 3.4 , BILIRUBIN,TOTAL 1.4 H, ALK PHOS/ALP 165 H, SGOT,AST 63 H, SGPT,ALT 199 H

ARTERIAL BLOOD GAS (05/23/16 06:17)
Panel
TYPE ART , SITE L RAD , ALLEN'S TEST PASS , HAND DOMIENT RIGHT , SITE HELD 5 MINUTES YES , SITE RECHECK YES , ABG FIO2 0.21 , ABG PH 7.47 H, ABG PCO2 39.2 , ABG PO2 67.5 , ABG O2 SAT 94.6 L, Aa-gradient 36.7 H, CO O2 HB% 92.1 L, CARBOXYHEMOGLOBIN 2.0 H, METHEMOGLOBIN < 1.0 H, DEOXYHEMOGLOBIN 5.3 H, TOTAL HEMOGLOBIN 12.8 L, CO O2 CONTENT 16.65 H, BASE EXCESS 3.9 H, ABG HCO3 27.7 H, ABG TCO2 24.5 , ABG DELIVERY RA , ABG TEMP 37.0

TEST RESULTS

PORTABLE CHEST ONE VIEW * (05/21/16 06:05) -
OTHER
Bilateral airspace opacities remain slightly improved since prior study.

MEDICATIONS

CeFAZolin Sodium with/in Sodium Chloride 0.9% 1 GM Q8
Dakins Solution 0.125% USE BID FOR WOUND CARE BID
Enoxaparin Sodium 40 MG Q24A
FLUoxetine HCl 20 MG Q24A
MetroNIDAZOLE 500MG/NS 100ML 100 ML Q8
Pantoprazole Sodium 40 MG .HS
UNKNOWN 3 ML Q6HRT

ASSESSMENT/PLAN

1. **Hypoxemia**
   - A: Improved rapidly which goes gainst ARDS.
   - P: On Duonebs. Appreciate pulmonary consult. CT chest showing air bronchograms and small pleural effusion on right. Though more dyspneic CXR suggests more volume overloaded. Will diurese again today and monitor response. Low suspicion of PE but if chest pain or hypoxia worsen consider a PE study- much more likely volume overload with atelectasis vs. new pneumonia (increasing WBC). Already on broad spectrum abx but can consider adding Vanc if WBC continues to rise or becomes febrile.

2. **Hypotension**
   - A: resolved. I/O better.
   - P: cont monitoring esp with diuresis

3. **Abdominal pain**
   - P: Pain better controlled on current regimen.

4. **Perforated bowel**
   - P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Reversal planned in 3 months or so. Gen sx to manage but do not suspect a new intraperitoneal infection at this point

5. **Hyperglycemia**
   - P: Blood sugars better

6. **Depression**
   - P: Better mood with prozac at 20mg po q daily

7. **Transaminitis**
   - P: Possibly from IV difucan +/- Invanz. Improving

8. **Generalized weakness**
   - P: Cont PT- prefer home discharge with either home health versus outpatient rehab for now. Open to rehab if recommended by PT.

Level Of Decision Making:
High

Additional Comments:
Will follow along

Electronically signed by Srinivas MD Vuppala on 05/23/16 at 10:11

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/23/16 13:14	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 9

Patient narrative Still hurting, less SOB.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/22 13:14 - 05/23 13:14)
Temp 98.9 (98.8-99.5)
Pulse 93 (74-93)
Resp 16 (16-18)
BP 103/68 (102/65-118/73)
O2 Sat: 93 (91-98)
%/L of O2: 0

I/Os: (05/22 07:00-05/23 07:00)
Net: 770 Intake: 2,835 Output: 2,065
#1 JP:: 15 IV:: 525 Ileostomy:: 450 PO:: 2,310 Void (ml):: 1,600

GASTROINTESTINAL: Ostomy looks good, wound is packed

ASSESSMENT/PLAN

1. **Perforated bowel**
   - **A:** s/p resection and ileostomy, recovering slowly.
   - **P:** Continue abx and address medical issues.

Electronically signed by Gilbertas MD Rimkus on 05/23/16 at 13:17

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Vuppala, Srinivas MD	DATE: 05/24/16 07:22	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 10

Patient narrative: C/O "dry mouth" but ambulating more today. Wife at bedside. Eating some, no new c/o except that left sided chest pain is persistent.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/23 07:22 - 05/24 07:22)
Temp 98.5 (98.5-99.0)
Pulse 103 (90-103)
Resp 16 (16-20)
BP 109/73 (98/60-109/73)
O2 Sat: 98 (93-98)
%/L of O2: 0

I/Os: (05/23 07:00-05/24 07:00)
Net: -742 Intake: 2,360 Output: 3,102
#1 JP:: 27 IV:: 210 IVPB:: 400 Ileostomy:: 725 PO:: 1,750 Void (ml):: 2,350

CONSTITUTIONAL:	Appears uncomfortable sitting on sdie of the bed, Ox4, breathing not labored.
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Decreased BS and dullness to percussion LLL zone but clear otherwise, no accessory muscle use noted.
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. Less edema B LE;s
GASTROINTESTINAL:	Wound vac in place
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake, oriented to person, place and time.

DATA

LAB RESULTS

MAG (05/24/16 06:09)
Panel
MAGNESIUM 2.3

COMPREHENSIVE METABOLIC PANEL (05/24/16 06:09)
Panel
GLUCOSE,RANDOM 144 H, BUN 22 H, CREATININE 0.86 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 134 L, POTASSIUM 3.2 L, CHLORIDE 96 , ANION GAP 7.0 , CO2 31 , CALCIUM 8.0 L, TOTAL PROTEIN 5.9 L, ALBUMIN 2.0 L, GLOBULIN 3.9 , BILIRUBIN,TOTAL 1.4 H, ALK PHOS/ALP 146 H, SGOT,AST 29 , SGPT,ALT 126 H

CBC W/AUTO DIFF (05/24/16 06:09)
Panel

20.6	12.4 / 38.0	409

RED BLOOD COUNT 4.28 L, MEAN CELL VOLUME 88.9 , MEAN CORPUSCULAR HEMOGLOBIN 29.1 , MEAN CORPUSCULAR HGB CONC 32.7 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 84.3 , LYMPH % 9.9 , MONO % 5.0 , EOS % 0.6 , BASO % 0.2 , NEUT # 17.4 H, LYMPH # 2.0 , MONO # 1.0 H, EOS # 0.1 , BASO # 0.0
HEMATOCRIT05/24/16 06:0938.0%HEMOGLOBIN05/24/16 06:0912.4g/dLPLATELET COUNT05/24/16 06:09409K/mm3WBC05/24/16 06:0920.6K/mm3

MEDICATIONS

CeFAZolin Sodium with/in Sodium Chloride 0.9% 1 GM Q8
Dakins Solution 0.125% USE BID FOR WOUND CARE BID
Enoxaparin Sodium 40 MG Q24A
FLUoxetine HCl 20 MG Q24A
MetroNIDAZOLE 500MG/NS 100ML 100 ML Q8
Pantoprazole Sodium 40 MG .HS
UNKNOWN 3 ML Q6HRT

ASSESSMENT/PLAN

1. **Hypoxemia-resolved**
   - A: Improved rapidly which goes gainst ARDS.
   - P: Appreciate pulm recs. Low suspicion of PE as cause of his pain and more likely pleuritic. Still with no supplemental oxygen requirement. If pain worsens can consider repeat imaging but otherwise supportive care. Encoouraged increased activity

2. **Hypotension**
   P: Hold off any further diuresis- appears close to euvolemia.

3. **Perforated bowel**
   P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Reversal planned in 3 months or so. Gen sx to manage but still do not suspect a new intraperitoneal infection at this point

4. **Hyperglycemia**
   P: Stress induced- monitor

5. **Depression**
   P: Better mood with prozac at 20mg po q daily

6. **Transaminitis**
   P: Possibly from IV difucan +/- Invanz. Improving

7. **Generalized weakness**
   P: Cont PT- prefer home discharge with either home health versus outpatient rehab for now. Open to rehab if recommended by PT but not likely at this point.

Electronically signed by Srinivas MD Vuppala on 05/24/16 at 17:06

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/24/16 09:36	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 10

Patient narrative Feels better, still some SOB

REVIEW OF SYSTEMS

EXAM

Vitals: (05/23 09:36 - 05/24 09:36)
Temp 98.5 (98.5-99.0)
Pulse 103 (90-103)
Resp 16 (16-20)
BP 109/73 (98/60-109/73)
O2 Sat 93 (93-98)
%/L of O2: 0

I/Os: (05/23 07:00-05/24 07:00)
Net: -742 Intake: 2,360 Output: 3,102
#1 JP:: 27 IV:: 210 IVPB:: 400 Ileostomy:: 725 PO:: 1,750 Void (ml):: 2,350

SKIN: Wound is clean, ostomy with stool and gas

DATA

LAB RESULTS

COMPREHENSIVE METABOLIC PANEL (05/24/16 06:09)
Panel
GLUCOSE,RANDOM 144 H, BUN 22 H, CREATININE 0.86 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 134 L, POTASSIUM 3.2 L, CHLORIDE 96 , ANION GAP 7 0 , CO2 31 , CALCIUM 8.0 L, TOTAL PROTEIN 5.9 L, ALBUMIN 2.0 L, GLOBULIN 3.9 , BILIRUBIN,TOTAL 1.4 H, ALK PHOS/ALP 146 H, SGOT,AST 29 , SGPT,ALT 126 H

CBC W/AUTO DIFF (05/24/16 06:09)
Panel

20.6	12.4 / 38.0	409

RED BLOOD COUNT 4.28 L, MEAN CELL VOLUME 88.9 , MEAN CORPUSCULAR HEMOGLOBIN 29.1 , MEAN CORPUSCULAR HGB CONC 32 7 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 84.3 , LYMPH % 9.9 , MONO % 5.0 , EOS % 0.6 , BASO % 0.2 , NEUT # 17.4 H, LYMPH # 2.0 , MONO # 1.0 H, EOS # 0.1 , BASO # 0.0

HEMATOCRIT05/24/16 06:0938.0%
HEMOGLOBIN05/24/16 06:0912.4g/dL
PLATELET COUNT05/24/16 06:09409K/mm3
WBC05/24/16 06:0920.6K/mm3

ASSESSMENT/PLAN

1. **Perforated bowel**
   - A: s/p resection and ileostomy, improving slowly
   - P: Continue abx, apply wound vac.

Electronically signed by Gilbertas MD Rimkus on 05/24/16 at 09:39

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Hayek, Hafez MD	DATE: 05/24/16 10:44	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 10

Patient narrative — patient is complaining of subjective SOB and left side pain with deep inspiration. he remains on RA

REVIEW OF SYSTEMS

EXAM

Vitals: (05/23 10:44 - 05/24 10:44)
Temp 98.5 (98.5-99.0)
Pulse 106 (90-106)
Resp 16 (16-20)
BP 106/68 (98/60-109/73)
O2 Sat 93 (93-98)
%/L of O2: 0

I/Os: (05/23 07:00-05/24 07:00)
Net: -742 Intake: 2,360 Output: 3,102
#1 JP:: 27 IV:: 210 IVPB:: 400 Ileostomy:: 725 PO:: 1,750 Void (ml):: 2,350

CONSTITUTIONAL:	Alert, awake, NAD
RESPIRATORY:	clear bil
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2.+lower extremity edema.
GASTROINTESTINAL:	Soft, nontender, nondistended. post op, ileostomy in place.
MUSCULOSKELETAL:	Neck is supple.
SKIN:	Warm and dry.
NEUROLOGICAL:	Awake and alert, oriented to person, place and time.

DATA

LAB RESULTS

MAG (05/24/16 06:09)
Panel
MAGNESIUM 2.3

COMPREHENSIVE METABOLIC PANEL (05/24/16 06:09)
Panel
GLUCOSE,RANDOM 144 H, BUN 22 H, CREATININE 0.86 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 134 L, POTASSIUM 3.2 L, CHLORIDE 96 , ANION GAP 7.0 , CO2 31 , CALCIUM 8.0 L, TOTAL PROTEIN 5.9 L, ALBUMIN 2.0 L, GLOBULIN 3.9 , BILIRUBIN,TOTAL 1.4 H, ALK PHOS/ALP 146 H, SGOT,AST 29 , SGPT,ALT 126 H

CBC W/AUTO DIFF (05/24/16 06:09)
Panel

20.6	12.4 / 38.0	409

RED BLOOD COUNT 4.28 L, MEAN CELL VOLUME 88 9 , MEAN CORPUSCULAR HEMOGLOBIN 29.1 , MEAN CORPUSCULAR HGB CONC 32.7 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 84.3 , LYMPH % 9.9 , MONO % 5.0 , EOS % 0.6 , BASO % 0.2 , NEUT # 17.4 H, LYMPH # 2.0 , MONO # 1 0 H, EOS # 0.1 , BASO # 0.0

HEMATOCRIT05/24/16 06:0938.0%
HEMOGLOBIN05/24/16 06:0912.4g/dL
PLATELET COUNT05/24/16 06:09409K/mm3
WBC05/24/16 06:0920.6K/mm3

ARTERIAL BLOOD GAS (05/23/16 06:17)
Panel
TYPE ART , SITE L RAD , ALLEN'S TEST PASS , HAND DOMIENT RIGHT , SITE HELD 5 MINUTES YES , SITE RECHECK YES , ABG FIO2 0.21 , ABG PH 7.47 H, ABG PCO2 39.2 , ABG PO2 67.5 , ABG O2 SAT 94.6 L, Aa-gradient 36.7 H, CO O2 HB% 92.1 L, CARBOXYHEMOGLOBIN 2.0 H, METHEMOGLOBIN < 1.0 H, DEOXYHEMOGLOBIN 5.3 H, TOTAL HEMOGLOBIN 12.8 L, CO O2 CONTENT 16.65 H, BASE EXCESS 3.9 H, ABG HCO3 27.7 H, ABG TCO2 24.5 , ABG DELIVERY RA , ABG TEMP 37.0

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   - A: secondary to ALI and volume overload.
     improving with good diuresis
     Patient remains on RA now.
     he is afebrile and WBC trending down.
     he has been on lovenox for DVT prophylaxis and he is not tachycardic or tachypneic and his O2 sat is stable on RA.
   - P: continue ACT.
     IS/ acapella valve
2. **Perforated bowel**

5A4D43B46E10429588C8, KNIGHT, 627

A: s/p surgery with bowel resection and ileostomy
surgical wound infection

P: as per surgery
wound vac will be applied today

3. **Muscular deconditioning**

P: PT/OT

4. **Elevated LFTs**

A: improving

BILLING

Care Activities / Care Coordination:

- ☒ I have reviewed the history and repeated the key elements
- ☒ I have seen and examined this patient
- ☒ I have reviewed the progress in the clinical course since the last examination
- ☒ I have discussed the patient's condition with other members of the care team
- ☒ I have reviewed all medications for this patient.

Electronically signed by Hafez MD Hayek on 05/24/16 at 10:49

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Vuppala, Srinivas MD	DATE: 05/25/16 08:18	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 11

Patient narrative: Pleuritic pain improved as patient is asking for pain medication more regularly. increased activity level today.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/24 08:18 - 05/25 08:18)
Temp 98.1 (98.1-99.5)
Pulse 81 (81-106)
Resp 20 (16-20)
BP 95/63 (91/46-111/72)
O2 Sat: 93 (92-97)
%/L of O2: 0

I/Os: (05/24 07:00-05/25 07:00)
Net: -105 Intake: 2,830 Output: 2,935
#1 JP:: 35 IVPB:: 600 Ileostomy:: 1,400 PO Supplement:: 30 PO:: 2,200 Void (ml):: 1,500

CONSTITUTIONAL:	Much more comfortable up in recliner. Ox4
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Decreased BS LLL zone but better effort than yesterday and no crackles. No accessory muscle use today
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. Less edema B LE;s
GASTROINTESTINAL:	Wound vac in place
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake, oriented to person, place and time.

DATA

LAB RESULTS

COMPREHENSIVE METABOLIC PANEL (05/25/16 05:44)
Panel
GLUCOSE,RANDOM 124 H, BUN 17 , CREATININE 0.89 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 135 L, POTASSIUM 3.6 , CHLORIDE 95 , ANION GAP 6.0 L, CO2 34 H, CALCIUM 8.0 L, TOTAL PROTEIN 5.7 L, ALBUMIN 2.0 L, GLOBULIN 3.7 , BILIRUBIN,TOTAL 1.0 , ALK PHOS/ALP 137 H, SGOT,AST 29 , SGPT,ALT 89 H

CBC W/AUTO DIFF (05/25/16 05:44)
Panel

17.8	11.4 / 33.8	492

RED BLOOD COUNT 3.86 L, MEAN CELL VOLUME 87.6 , MEAN CORPUSCULAR HEMOGLOBIN 29.6 , MEAN CORPUSCULAR HGB CONC 33.8 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 83.1 , LYMPH % 9.6 , MONO % 5.4 , EOS % 1.5 , BASO % 0.4 , NEUT # 14.8 H, LYMPH # 1.7 , MONO # 1.0 H, EOS # 0.3 , BASO # 0.1
HEMATOCRIT05/25/16 05:4433.8%HEMOGLOBIN05/25/16 05:4411.4g/dLPLATELET COUNT05/25/16 05:44492K/mm3WBC05/25/16 05:4417.8K/mm3

PHOS (05/25/16 05:44)
Panel
PHOSPHOROUS 2.1 L

MAG (05/25/16 05:44)
Panel
MAGNESIUM 2.3

MEDICATIONS

CeFAZolin Sodium with/in Sodium Chloride 0.9% 1 GM Q8
Enoxaparin Sodium 40 MG Q24A
FLUoxetine HCl 20 MG Q24A
MetroNIDAZOLE 500MG/NS 100ML 100 ML Q8H
Pantoprazole Sodium 40 MG .HS
UNKNOWN 3 ML Q6HRT

ASSESSMENT/PLAN

1. **Hypoxemia-resolved**
   - **A:** Improved rapidly which goes gainst ARDS.
   - **P:** Pluerisy improved- encouraged continued regular use of narcotic until his pain begins to diminish. Monitor for any evidence of pnuemonia but none apparent at this time.

2. **Hypotension**
   P: BP remains stable- low BP may be his baseline as no orthostatic sx's with ambulating and with pain controlled.

3. **Perforated bowel**
   P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Reversal planned in 3 months or so. Gen sx to manage but still do not suspect a new intraperitoneal infection at this point

4. **Hyperglycemia**
   P: BS's normalized- if continues can D/C SSI

5. **Depression**
   P: Better mood with prozac at 20mg po q daily

6. **Transaminitis**
   P: Possibly from IV difucan +/- Invanz. Improved

7. **Generalized weakness**
   P: Cont PT- prefer home discharge with either home health versus outpatient rehab for now. Will follow but surgery may D/C early next week.

8. **Protein-calorie malnutrition, moderate**
   P: Dietary consult as likely third spacing fluid

Electronically signed by Srinivas MD Vuppala on 05/25/16 at 14:56

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Hayek, Hafez MD	DATE: 05/25/16 12:05	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 11

Patient narrative

no acute events overnight.
sitting in a chair. feels better today, breathing is better.
some discomfort with deep breath but better

REVIEW OF SYSTEMS

EXAM

Vitals: (05/24 12:05 - 05/25 12:05)

Temp 98.5 (98.1-99.5)
Pulse 93 (81-106)
Resp 20 (18-20)
BP 106/72 (91/46-111/72)
O2 Sat 93 (92-97)
%/L of O2: 0

I/Os: (05/24 07:00-05/25 07:00)

Net: -105 Intake: 2,830 Output: 2,935
#1 JP:: 35 IVPB:: 600 Ileostomy:: 1,400 PO Supplement:: 30 PO:: 2,200 Void (ml):: 1,500

CONSTITUTIONAL:	Alert, awake, NAD
RESPIRATORY:	clear bil
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2.+lower extremity edema.
GASTROINTESTINAL:	Soft, nontender, nondistended. post op, ileostomy in place.
MUSCULOSKELETAL:	Neck is supple.
SKIN:	Warm and dry.
NEUROLOGICAL:	Awake and alert, oriented to person, place and time.

DATA

LAB RESULTS

COMPREHENSIVE METABOLIC PANEL (05/25/16 05:44)
Panel
GLUCOSE,RANDOM 124 H, BUN 17 , CREATININE 0.89 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 135 L, POTASSIUM 3.6 , CHLORIDE 95 , ANION GAP 8.0 L, CO2 34 H, CALCIUM 8.0 L, TOTAL PROTEIN 5.7 L, ALBUMIN 2.0 L, GLOBULIN 3.7 , BILIRUBIN,TOTAL 1.0 , ALK PHOS/ALP 137 H, SGOT,AST 29 , SGPT,ALT 89 H

CBC W/AUTO DIFF (05/25/16 05:44)
Panel

17.8	11.4 / 33.8	492

RED BLOOD COUNT 3.86 L, MEAN CELL VOLUME 87.6 , MEAN CORPUSCULAR HEMOGLOBIN 29.6 , MEAN CORPUSCULAR HGB CONC 33.8 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 83.1 , LYMPH % 9.6 , MONO % 5.4 , EOS % 1.5 , BASO % 0.4 , NEUT # 14.8 H, LYMPH # 1.7 , MONO # 1.0 H, EOS # 0.3 , BASO # 0.1

HEMATOCRIT05/25/16 05:4433.8%
HEMOGLOBIN05/25/16 05:4411.4g/dL
PLATELET COUNT05/25/16 05:44492K/mm3
WBC05/25/16 05:4417.8K/mm3

PHOS (05/25/16 05:44)
Panel
PHOSPHOROUS 2.1 L

MAG (05/25/16 05:44)
Panel
MAGNESIUM 2.3

ASSESSMENT/PLAN

1. **Acute respiratory failure**
   - A: secondary to ALI and volume overload.
     improving with good diuresis
     Patient remains on RA now.
     he is afebrile and WBC trending down.
   - P: continue ACT.
     IS/ acapella valve

2. **Perforated bowel**
   - A: s/p surgery with bowel resection and ileostomy
     surgical wound infection

P: as per surgery
continue wound vac

3. **Muscular deconditioning**
P: PT/OT

4. **Elevated LFTs**
A: improving

Level Of Decision Making:
Moderate

BILLING

Care Activities / Care Coordination:

- ☑ I have reviewed the history and repeated the key elements
- ☑ I have seen and examined this patient
- ☑ I have reviewed the progress in the clinical course since the last examination
- ☑ I have reviewed all medications for this patient.

Electronically signed by Hafez MD Hayek on 05/25/16 at 12:08

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/25/16 12:59	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 11

Patient narrative Eating better, less SOB

REVIEW OF SYSTEMS

EXAM

Vitals: (05/24 12:59 - 05/25 12:59)
Temp 98.5 (98.1-99.5)
Pulse 93 (81-108)
Resp 20 (18-20)
BP 106/72 (91/46-111/72)
O2 Sat 93 (92-97)
%/L of O2: 0

I/Os: (05/24 07:00-05/25 07:00)
Net: -105 Intake: 2,830 Output: 2,935
#1 JP:: 35 IVPB:: 600 Ileostomy:: 1,400 PO Supplement:: 30 PO:: 2,200 Void (ml):: 1,500

GASTROINTESTINAL: Soft, tender, nondistended. No rebound or guarding. No hepatosplenomegaly. Bowel sounds present. Ostomy with stool and gas.

ASSESSMENT/PLAN

1. **Perforated bowel**
   - **A:** s/p resection and ileostomy, improvimg slowly.
   - **P:** Increase activity, continue IV abx.

Electronically signed by Gilbertas MD Rimkus on 05/25/16 at 13:01

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 05/26/16 09:48	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 12

Patient narrative Feel better, breathing better.

REVIEW OF SYSTEMS

EXAM

Vitals: (05/25 09:49 - 05/26 09:49)
Temp 98.3 (98.3-100.0)
Pulse 70 (67-105)
Resp 18 (18-20)
BP 109/60 (98/57-112/72)
O2 Sat: 99 (93-99)
%/L of O2: 0

I/Os: (05/25 07:00-05/26 07:00)
Net: 681 Intake: 2,971 Output: 2,290
#1 JP:: 15 Colostomy:: 700 IV:: 195 IVPB:: 150 Ileostomy:: 775 PO Supplement:: 30 PO:: 2,596 Void (ml):: 800

GASTROINTESTINAL: Soft, tender, nondistended. No rebound or guarding. No hepatosplenomegaly. Bowel sounds present. Ostomy with stool and gas.

DATA

LAB RESULTS

CBC W/AUTO DIFF (05/25/16 05:44)
Panel

17.8	11.4 / 33.8	492

RED BLOOD COUNT 3.86 L, MEAN CELL VOLUME 87.6 , MEAN CORPUSCULAR HEMOGLOBIN 29.6 , MEAN CORPUSCULAR HGB CONC 33.8 , RED CELL DISTRIBUTION WIDTH 13.3 , NEUT % 83.1 , LYMPH % 9.6 , MONO % 5.4 , EOS % 1.5 , BASO % 0.4 , NEUT # 14.8 H, LYMPH # 1.7 , MONO # 1.0 H, EOS # 0.3 , BASO # 0.1

HEMATOCRIT05/25/16 05:4433.8%
HEMOGLOBIN05/25/16 05:4411.4g/dL
PLATELET COUNT05/25/16 05:44492K/mm3
WBC05/25/16 05:4417.8K/mm3

COMPREHENSIVE METABOLIC PANEL (05/25/16 05:44)
Panel
GLUCOSE,RANDOM 124 H, BUN 17 , CREATININE 0.89 , GLOMERULAR FILTRATION RATE > 60 , SODIUM 135 L, POTASSIUM 3.6 , CHLORIDE 95 , ANION GAP 6.0 L, CO2 34 H, CALCIUM 8.0 L, TOTAL PROTEIN 5.7 L, ALBUMIN 2.0 L, GLOBULIN 3.7 , BILIRUBIN,TOTAL 1.0 , ALK PHOS/ALP 137 H, SGOT,AST 29 , SGPT,ALT 89 H

ASSESSMENT/PLAN

1. **Perforated bowel**
   - **A:** s/p resection and ileostomy, improving slowly.
   - **P:** Continue as is, home in the day or two, needs home wound vac.

Electronically signed by Gilbertas MD Rimkus on 05/26/16 at 09:51

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Mexas, Nicholas DO	DATE: 05/26/16 11:39	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 12

Patient narrative Awake and NAD

REVIEW OF SYSTEMS

RESPIRATORY:	Negative for dyspnea or wheeze. No cough.
CARDIOVASCULAR:	Negative for chest pain or palpitations. No extremity swelling.
SKIN:	Negative for lesions or rashes. No pruritus.
NEUROLOGICAL:	Negative for headache. No vertigo, no disturbance in balance or coordination. No weakness, numbness, or paresthesias.
PSYCHIATRIC:	Negative for mood disturbance or change in cognitive function.

EXAM

Vitals: (05/25 11:39 - 05/26 11:39)
Temp 99.2 (98.3-100.0)
Pulse 90 (67-105)
Resp 20 (18-20)
BP 103/86 (98/57-112/86)
O2 Sat: 95 (93-99)
%/L of O2: 0

I/Os: (05/25 07:00-05/26 07:00)
Net: 681 Intake: 2,971 Output: 2,290
#1 JP:: 15 Colostomy:: 700 IV:: 195 IVPB:: 150 Ileostomy:: 775 PO Supplement:: 30 PO:: 2,596 Void (ml):: 800

CONSTITUTIONAL:	Much more comfortable up in recliner. Ox4
EYES:	PERL. Sclerae nonicteric. Conjunctivae pink.
ENT:	Mucus membranes moist. Oropharynx without exanthema or exudates.
RESPIRATORY:	Decreased BS LLL zone but better effort than yesterday and no crackles. No accessory muscle use today
CARDIOVASCULAR:	Regular rate and rhythm, normal s1/s2. No extra heart sounds or murmurs. Less edema B LE;s
GASTROINTESTINAL:	Wound vac in place
SKIN:	Warm and dry. Normal turgor. No rashes or lesions.
NEUROLOGICAL:	Awake, oriented to person, place and time.

ASSESSMENT/PLAN

1. **Hypoxemia-resolved**
   - A: Improved rapidly which goes against ARDS.
   - P: no sign sof pna
2. **Hypotension**
   - P: BP remains stable-
3. **Perforated bowel**
   - P: s/p resection of small bowel and ileostomy. Patient is being followed by Dr. Rimkus. Reversal planned in 3 months or so.
4. **Depression**
   - P: prozac at 20mg po q daily
5. **DVT prophylaxis**
   - A: LMWH

Level Of Decision Making:
StraightForward/Low

Additional Comments:
STABLE FOR DC WHEN OK BY SURG

BILLING

Approximate minutes spent (direct patient care): 25 min

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Mexas, Nicholas DO	DATE: 05/26/16 11:39	SURE.SUR232.1.CNW

Care Activities / Care Coordination:

- ☒ I have seen and examined this patient
- ☒ I have discussed the patient's condition with other members of the care team
- ☒ I have reviewed all medications for this patient.

Electronically signed by Nicholas DO Mexas on 05/26/16 at 12:04

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Epstein, Aaron M., MD	DATE: 05/27/16 07:24	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 13

Patient narrative pt doing well. waiting wound vac to get approved and he can go home

REVIEW OF SYSTEMS

EXAM

Vitals: (05/26 07:25 - 05/27 07:25)
Temp 98.0 (98.0-100.2)
Pulse 81 (70-85)
Resp 18 (18-20)
BP 89/80 (89/52-112/86)
O2 Sat: 95 (92-99)
%/L of O2: 0

I/Os: (05/26 07:00-05/27 07:00) Net: -123 Intake: 1,932 Output: 2,055
#1 JP:: 5 Colostomy:: 600 IV:: 20 Ileostomy:: 350 PO Supplement:: 30 PO:: 1,882 Void (ml):: 1,100

GASTROINTESTINAL: stoma looks good and belly soft

ASSESSMENT/PLAN

1. **Perforated bowel**
   A: can go home once wound vac available

Electronically signed by Aaron M., MD Epstein on 05/27/16 at 07:26

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006912886
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Epstein, Aaron M., MD	DATE: 05/28/16 08:47	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 14

Patient narrative: pt doing well with po and ostomy but not quite safe to ambulate alone yet. will use omd here to get that better and plan for dc tomorrow if all goes well

REVIEW OF SYSTEMS

GASTROINTESTINAL: belly soft and wound vac looks good

EXAM

Vitals: (05/27 08:47 - 05/28 08:47)

Temp 98.7 (98.0-99.2)
Pulse 84 (84-94)
Resp 19 (18-19)
BP 116/64 (100/62-116/75)
O2 Sat: 94 (92-98)
%/L of O2: 0

I/Os: (05/27 07:00-05/28 07:00)

Net: 115 Intake: 3,780 Output: 3,665
#1 JP:: 55 IV:: 200 IVPB:: 750 Ileostomy:: 1,100 PO Supplement:: 30 PO:: 2,800 Void (ml):: 2,500 Wound Vac:: 10

ASSESSMENT/PLAN

1. **Perforated bowel**
   A: see above

Electronically signed by Aaron M., MD Epstein on 05/28/16 at 08:49

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Walker,Aljoeson MD
[redacted] Sex: M
Acct: V00006912886 Loc: SUR232 1
Exam Date: 05/23/2016 Status: ADM IN
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 71010

ADMITTING DX: INTESTINAL PERFORATION,PERITONITIS

EXAM#	TYPE/EXAM	RESULT
001436574	PORT/PORTABLE CHEST ONE VIEW	

Study: Portable Chest

Comparison: 5/21/2016

Indication: Midline chest pain extending leftward with shortness of breath

Portable view demonstrates abnormal alveolar density remaining in the left upper lobe. Airspace density right base. No signs of pleural fluid, left basilar atelectasis

Impression: Bilateral infiltrates remain. Please see the above.

Electronically Signed By: G. Scott Mencken

** REPORT SIGNED IN OTHER VENDOR SYSTEM 05/23/2016 **
Reported By: G. Scott Mencken M.D.

CC: Aljoeson Walker MD

Technologist: AMY BAKER, R.T.(R)
Transcribed Date/Time: 05/23/2016 (0807)
Transcriptionist: RALLEN
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RT ASSESSMENT 05/20/16 0715 SP

RESPIRATORY CARE PATIENT EVALUATION

RT ASSESSMENT TYPE: F/U ADULT
Date: 05/20/16 Time: 0716

PULMONARY HISTORY:
NONE
Smoking Hx 1
Pulmonary Disease
Home Oxygen, Home Tx, Severe/ Chronic w/Exacerbation

SURGICAL PATIENT:
No Surgeries
Non-Thoracic 1
Thoracic/Upper Abd
Thoracic Surgery w/Pulm Dis

ACTIVITY LEVEL:
Ambulatory
Amb w/Assistance 1
Non-Ambulatory
Parplegic/Quad

RESPIRATORY PATTERN:
Normal Breath Pattern (RR12-20)
Increased Resp Rate (RR20-25) 1
Dyspnea/Irreg Pattern/Use of Accessory Muscles/Severe
Severe Dyspnea/Use of Accessory muscles/Assist Ventilation (RR>30)

CHEST X-RAY:
Clear 0
Chronic Radiographic Changes
Infiltrates/Atelectasis/Pleural Effusion 2
Known Pulmonary Dis or CXR not available

AUSCULTATION:
Clear
Diminished 1
Rales
Wheezes/Rhonchi/Stridor

MENTAL STATUS:
Alert, Oriented, Cooperative 0
Disoriented, Follows Commands
Restrained/Obtunded/Uncooperative
Comatose

INSPECTION:
No Signs of Discomfort 0
Dyspnea/SOB Noted
Dyspnea, Pursed Lip Breathing, Accessory Muscle Use, Abd Breathing, Cyanosis, Jugular Vein Distention, Nasal Flaring, Retractions, or Tactile Fremitus

COUGH:
Strong, Spontaneous, NPC
Strong Productive
Weak Prod/Non Prod 2
No Spont Cough/Sx may be needed

Total Points: 9

TOTAL POINTS EVALUATION RESULTS Improved Status/Mod Risk

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Coded Allergies/Adverse Reactions

Name / Reaction	Category	Severity	Ver?	Date	Time	User
Allergies						
Penicillins (Penicillins) RASH AS A CHILD	Drug	Unknown	Y	05/15/16	1005	SO
Sulfa (Sulfonamide Antibiotics) (Sulfa (Sulfonamide Antibiotics)) RASH AS A CHILD	Drug	Unknown	Y	05/15/16	1005	SO

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Monogram Initials	Name	Nurse Type
SO SOWENS2	OWENS,SALLY	PHA
SP SPAITSEL	PAITSEL,SUSANNA	RRT

Respiratory Therapy Notes

Occurred Date	Time	by	Author	Recorded Date	Time	by
05/15/16	1220	MES	SANDERS,MICHELE E	05/15/16	1247	MES

Abnormal? N Confidential? N

EXTUBATED PT WITHOUT DIFFICULTY TO 2L NC

05/18/16	0557	JW2	WILSON,JESSIE	05/18/16	0557	JW2

Abnormal? N Confidential? N

PT ON BIPAP THROUGH NIGHT 12/6 WITH 15LPM BLEED IN.

05/18/16	1709	SE	ESTES,SUSAN	05/18/16	1711	SE

Abnormal? N Confidential? N

0805-ABG DONE
0820-PT SET UP ON HIGH FLOW:80% ON 40LPM.
0930-DECREASED OXYGEN TO 70% ON 40LPM.
1350-DECREASED OXYGEN TO 60% ON 40LPM.

05/19/16	0605	JW2	WILSON,JESSIE	05/19/16	0606	JW2

Abnormal? N Confidential? N

PT ON HIFLOW NC THROUGH NIGHT. BIPAP ON STANDBY.

05/20/16	0551	JW2	WILSON,JESSIE	05/20/16	0552	JW2

Abnormal? N Confidential? N

BIPAP ON STANDBY PT REMAINED ON HI FLOW NC THROUGH NIGHT.

05/20/16	1439	SP	PAITSEL,SUSANNA	05/20/16	1440	SP

Abnormal? N Confidential? N

PATIENT TOLERATED HIGH FLOW EARLY AM UNTIL 10AM AT 30% 02.
-CHANGED TO 4LPM WITH N/C 02
SATS 95-97% HR 90 RR 20. TOLERATING WELL.

05/21/16	0601	CG	GRAVES,CHARLENE	05/21/16	0602	CG

Abnormal? N Confidential? N

PT REMAINED STABLE WITH O2 @ 3L/M NC. SPO2 97%. HI- FLOW AND CPAP ON SB.

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Wound Care Note

Occurred Date	Time	by	Author	Recorded Date	Time	by
05/17/16	1531	KM	MANJARREZ,KRISTIE	05/17/16	1536	KM

Abnormal? N Confidential? N

CONSULTED ON PT FOR NEW ILEOSTOMY. LOOP ILESOTOMY S/P PERFORATION AFTER CAR ACCIDENT. SURGERY WAS THIS WEEKEND. R UPPER QUADRANT STOMA PINK, SLIGHTLY EDEMATOUS, MEASURES ABOUT 32 MM IN DIAMETER. 45 MM POUCHING SYSTEM IN PLACE, NO LEAKS NOTED. HAS BEEN ON SINCE SURGERY. DRAINING LARGE AMOUNTS GRAY/GREEN LIQUID EFFLUENT. PT ON ONLY CLEAR LIQUIDS AT THIS TIME. PT DROWSY FROM PAIN MEDS BUT INTERESTED IN LEARNING, LOOKING AT STOMA. SPOUSE, ELIZABETH, IN ROOM AND VERY INVOLVED IN CARE. REVIEWED GENERAL INFORMATION, CARE. DEMONSTRATED HOW TO USE MOLDABLE WAFER, HOW TO OPERATE CLAMP AND EMPTY POUCHING SYSTEM. BOTH ABLE TO RETURN DEMO. SETTING UP PT WITH CONVATEC CONCIERGE SERVICE AND WILL SET UP SUPPLIES WITH BYRUM HEALTHCARE. PT WILL PROBABLY NOT NEED HOME HEALTH SERVICES BUT DID DISCUSS THE POSSIBILITY. PLAN TO MEET ELIZABETH IN THE ROOM 0745 TOMORROW TO DO A POUCHING SYSTEM CHANGE. WILL REQUEST DIETICIAN TO TEACH ABOUT ILEOSTOMY DIET.

05/17/16	1600	KM	MANJARREZ,KRISTIE	05/18/16	1633	KM

Abnormal? N Confidential? N

DUE TO PT'S FREQUENT LIQUID EFFLUENT AND NEEDING FREQUENT NEARLY Q 1 HOUR EMPTYING OF POUCHING SYSTEM, PT'S NURSE KATIE AND I DECIDED TO SWITCH HIM TO A SYSTEM WITH A UROSTOMY POUCH TO ATTACH TO BEDSIDE DRAINAGE TO ALLOW HIM SOME TIME TO REST BETWEEN EMPTYING. REMOVED ENTIRE SYSTEM, PERISTOMAL SKIN INTACT, NO S/S IRRITATION. STOMA BRIGHT PINK, MOIST, PROTRUDING ABOUT 1 CM WITH EFFLUENT COMING FROM CENTER. SOME STAPLES/SUTURES VISIBLE. PT'S ABDOMEN TENDER. HE DID VISUALIZE THE STOMA AND ASK IF IT WAS NORMAL LOOKING. REASSURANCE PROVIDED. REAPPLIED 45 MM MOLDABLE DURAHESIVE WAFER WITH UROSTOMY POUCHING SYSTEM TO BEDSIDE DRAINAGE. TOLERATED WELL.

05/18/16	0800	KM	MANJARREZ,KRISTIE	05/18/16	1637	KM

Abnormal? N Confidential? N

MET PT'S SPOUSE AT BEDSIDE THIS AM. HE IS HAVING SOME DIFFICULTY BREATHING, NEEDING O2 MASK. ENC DEEP BREATHING, SPLINTING BELLY. DUE TO HAVING CHANGED APPLIANCE YESTERDAY EVENING WILL NOT REMOVE AT THIS TIME. NO EVIDENCE OF LEAKING. DOES HAVE SMALL BLISTER TO R GROIN, NURSE TO PUT SOME DRY GAUZE THERE TO KEEP SKIN DRY AND ABSORB EXCESS MOISTURE. STOMA VISIBLE THROUGH POUCH, REMAINS PINK, SHINY, PROTRUDES STILL ABOUT 1 CM. DRAINAGE GRAYISH BROWN, MOSTLY LIQUID INTO BEDSIDE DRAINAGE. PROVIDED MORE HANDOUTS FOR PATIENT. REVIEWED HOW TO USE STOMA BELT IF NEEDED ONCE PATIENT MORE MOBILE. REVIEWED HOW TO CARE FOR SKIN, HOW TO APPLY MOLDABLE WAFER. DISCUSSED DIFFERENT POUCHING SYSTEMS (2 VERSUS 1 PIECE) AND I AM ORDERING THEM THE 2 PIECE WITH SAMPLES OF THE ONE PIECE TO BE SENT TO THEM. UTILIZING BYRAM HEALTHCARE FOR THEIR SUPPLIES. ORDER SENT. COPY OF ORDER WITH REORDER NUMBERS PROVIDED TO SPOUSE.

05/20/16	1612	KM	MANJARREZ,KRISTIE	05/20/16	1630	KM

Abnormal? N Confidential? N

MET PT AND SPOUSE AT 3P IN HIS ROOM. PT UP IN CHAIR, VERY ALERT. INTERESTED IN LEARNING MORE ABOUT SELF CARE. HAS BEEN EATING MORE SOLID FOODS SO WILL SWITCH BACK TO DRAINABLE BAG AND STOP USING UROSTOMY BAG AS IT HAS GOTTEN CLOGGED. SPOUSE AND PT VERY ATTENTIVE AND ASKING QUESTIONS. WE PREPARED NEW POUCHING SYSTEM. PT SUCCESSFULLY APPLIED NEW CLAMP TO BAG. MOLDED WAFER WITH MY ASSISTANCE. WE REMOVED OLD SYSTEM - AREA VERY TENDER TO PATIENT. CLEANSED WITH WATER AND PATTED DRY. NOTED THERE HAD BEEN LEAKING UNDER WAFER FROM 6-8 O'CLOCK WITH SOME STINGING TO AREA. NO VISIBLE OPEN OR IRRITATED AREA. DEMONSTRATED USING SLIGHT DUSTING OF STOMA POWDER OVER THIS AREA, DUSTING OFF EXTRA AND USING STOMA PASTE ON WAFER TO MEET UP WITH THIS AREA. CONNECTED BAG TO WAFER AND APPLIED TO PT'S ABDOMEN. PT HAS MULTIPLE SKIN TEARS FROM TAPE. WE PLACED A DRY 2X2 TO DENUDED AREA BELOW STOMA UNDER THE WAFER TAPE. I APPLIED DUODERM ON ABDOMEN WHERE TAPE HAD CAUSED SKIN TRAUMA AND ELIZABETH AND

Occurred Date	Time	by	Author	Recorded Date	Time	by	Wound Care Note

05/20/16 1612 KM MANJARREZ,KRISTIE 05/20/16 1630 KM (continued)

I CHANGED HIS MIDLINE ABD WOUND DRESSING. STAPLE LINE WITH SOME AREAS GAPPED OPEN AND OTHERS MORE APPROXIMATED. MINIMAL RED DRAINAGE. NO ERYTHEMA, INDURATION, OR ODOR. DRY GAUZE OVER STAPLE LINE COVERED WITH ABD AND SECURED WITH TAPE TO DUODERM, NOT SKIN. DRAIN SPONGE AROUND JP DRAIN. EDUCATED PT ON REASON FOR DUODERM, THAT IT SHOULD NOT BE REMOVED BUT LEFT IN PLACE UNTIL IT COMES OFF ON IT'S OWN - IT IS TO PROTECT SKIN FROM ADHESIVES AND TAPE SHOULD BE PUT ON TOP OF IT. STATES UNDERSTANDING. I REPORTED ALL OF THIS OFF TO S. TALBOT, LPN.

05/23/16 1659 KM MANJARREZ,KRISTIE 05/23/16 1705 KM

Abnormal? N Confidential? N

PT'S SPOUSE REMOVED OLD OSTOMY POUCHING SYSTEM. SKIN A BIT RED AND TENDER - APPEARS TO BE RELATED TO ADHESIVES. MINIMAL LEAKING NOTED ON SKIN BARRIER AT AREA FROM 7-8 O'CLOCK. CLEANSED WITH WATER. CAVILON SKIN BARRIER APPLIED TO HELP WITH IRRITATION FROM ADHESIVE. NOTED AREA WHERE LEAKING OCCURED TO HAVE SMALL AMT MUCOCUTANEOUS SEPARATION WITH MUCOUS COMING OUT OF IT. DR. RIMKUS AWARE AND STATES THIS IS OK DUE TO THE DISTAL END OF THE LOOP ILEOSTOMY BEING PRESENT THERE. REASSURED PT AND SPOUSE THIS WAS OK. WE USED STOMAHESIVE PASTE OVER THIS AREA FOR ADDED PROTECTION AND ABSORPTION. SPOUSE SUCCESSFULLY MOLDED AND PLACED NEW POUCHING SYSTEM TO SKIN. THEY HAVE BEEN EMPTYING THE POUCHING SYSTEM THEMSELVES INDEPENDENTLY. WILL CHECK ON PT TOMORROW.

05/24/16 1530 KM MANJARREZ,KRISTIE 05/24/16 1531 KM

Abnormal? N Confidential? N

CHECKED ON PT AND SPOUSE. THE POUCHING SYSTEM SHE APPLIED YESTERDAY IS ON, NO LEAKS. PT AND SPOUSE TO CHANGE THE SYSTEM WITH MY GUIDANCE ON FRIDAY. WILL DROP IN TO CHECK ON THEM TOMORROW.

05/26/16 1619 KM MANJARREZ,KRISTIE 05/26/16 1620 KM

Abnormal? N Confidential? N

VISITED PT AND CHECKED POUCHING SYSTEM FOR LEAKS. NO LEAKS. TO BE CHANGED TOMORROW AFTERNOON BY PT AND SPOUSE. THEY ARE AWARE AND I WILL BE THERE IN THE AFTERNOON. PT'S NURSE NOTIFIED AS WELL.

05/27/16 1414 KM MANJARREZ,KRISTIE 05/27/16 1421 KM

Abnormal? N Confidential? N

PT'S SPOUSE PERFORMED POUCHING SYSTEM CHANGE TODAY, WAS ABLE TO TALK THROUGH STEPS. PT VERY ATTENTIVE DURING THIS AND WILL BE ABLE TO DO THIS INDEPENDENTLY - HAS IV IN R ARM IMPINGING HIS ABILITY TO ASSIST MUCH. SKIN INTACT, WNL AROUND STOMA. STOMA PINK, MOIST. PROTRUDES ABOUT 1/2". AREA BETWEEN 6-7 SEPARATED FROM SKIN AND WE EXPRESSED MUCOUS (THIS IS WHERE DR. RIMKUS SAID THE DISTAL END OF THE ILEUM IS AND SHOULD EXPECT THIS). INSTRUCTED PT AND SPOUSE TO BE SURE TO GENTLY RUB THIS AREA TO EXPEL MUCOUS DURING EACH BAG CHANGE. SHE APPLIED A SMALL AMT OF POWDER THERE AND USED CAVILON SPRAY. SMALL AMT OF STOMAHESIVE PAST TO WAFER THAT WILL LAY OVER THAT. PLACED NEW POUCHING SYSTEM ON INDEPENDENTLY. THEY HAVE MY CONTACT INFORMATION IF THEY HAVE ANY CONCERNS OR QUESTIONS.

Monogram	Initials	Name	Nurse Type
AW3	AWRIGHT3	WRIGHT,ANTHONY	RN
BG	BGORDON	GORDON,BRITTANY	RN
BL5	BLEWIS5	LEWIS,BETHANY	RN
BW	BPAUL	PAUL,BETSY	RN
CB4	CBARKER4	BARKER,CANDACE	RN
CG	CGRAVES	GRAVES,CHARLENE	CRT
JB	JBURLESON	BURLESON,GLORIA JEAN	RN
JW2	JWILSON2	WILSON,JESSIE	RRT
KK	KBELLAM	BELLAM,KATIE	RN
KM	KMANJARREZ	MANJARREZ,KRISTIE	RN
LF	LFARNAM1	FARNAM,LARISSA	RD
LF*	LFADRI	FADRI,LOURDES	RN
LH	LHARRIS2	HARRIS,LINDSEY	RD
MES	MSANDERS	SANDERS,MICHELE E	CRT
MG	MGODWIN	GODWIN,MELISSA	RN
MM	MMAPLES	MAPLES,MICHELE	RN
MW	MWILLIAMS	WILLIAMS,MARSHA	RN
NR2	NROBERTS2	ROBERTS,NATALIE	RN
PL2	PLESLIE2	LESLIE,PRISCILLA	RN
PS	PSKINNER2	SKINNER,PAMELA	RN
RM	RMESHREKI	MESHREKI,RAFIK	RN
SE	SESTES	ESTES,SUSAN	CRT
SG	SGUTKNECHT	GUTKNECHT,SHARON	RD
SH2	SHERRINGT2	HERRINGTON,SHERRY	RN
SP	SPAITSEL	PAITSEL,SUSANNA	RRT
SS4	SSARVIS4	SARVIS,SABRINA	RN
ST	STALBOT	TALBOT,SUSIE	LPN
TB	TBOSSE2	BOSSE,TRICIA	RN
TK2	TKOCH2	KOCH,THOMAS	RN
WC	WCHICKERIN	CHICKERING,WESLYN	LMSW

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

PATIENT: KNIGHT,DANIEL ERIC
REG DR: Rimkus, Gilbertas MD
ACCT #: V00006912886 LOC: SURE U#: M000175313
[redacted] ROOM: SUR232 REG: 05/15/16
DOB: 09/26/74 DIS: 05/29/16

**********CHEMISTRY**********

Date / Time	05/25/16 0544	05/24/16 0609	05/23/16 0505	05/22/16 0417	Reference	Units
GLU	124 H	144 H	130 H	157 H	(70-110)	mg/dL
BUN	17	22 H	24 H	35 H	(7-18)	mg/dl
CREA	0.89	0.86	0.86	1.04	(0.7-1.30)	mg/dl
ESTIMATED GFR	> 60(a)	> 60(a)	> 60(a)	> 60(a)		mL/mi
NA	135 L	134 L	135 L	139	(136-145)	mmol/
K	3.6	3.2 L	3.5	3.1 L	(3.5-5.1)	mmol/
CL	95	96	99	98	(93-108)	mmol/
ANION GAP	6.0 L	7.0	9.0	9.0	(7-16)	mmol/
CO2	34 H	31	27	32	(21-32)	mmol/
CA	8.0 L	8.0 L	7.7 L	8.4 L	(8.5-10.1)	mg/dl
TOT PROT	5.7 L	5.9 L	5.4 L	6.3 L	(6.4-8.2)	gm/dL
ALB	2.0 L	2.0 L	2.0 L	2.3 L	(3.4-5.0)	gm/dl
GLOB	3.7	3.9	3.4	4.0		gm/dL
BILI,TOT	1.0	1.4 H	1.4 H	1.3 H	(0.2-1.0)	mg/dL
ALP	137 H	146 H	165 H	181 H	(45-117)	U/L
SGOT,AST	29	29	63 H	110 H	(10-40)	U/L
SGPT,ALT	89 H	126 H	199 H	268 H	(16-61)	U/L
PHOS	2.1 L			3.3	(2.5-4.9)	mg/dL
MAG	2.3	2.3		2.5 H	(1.8-2.4)	mg/dl

Date / Time	---------05/21/16--------- 1016	0637	05/20/16 0559	05/19/16 0456	Reference	Units
GLU		156 H	196 H	114 H	(70-110)	mg/dL
BUN		43 H	29 H	24 H	(7-18)	mg/dl
CREA		1.20	1.13	1.13	(0.7-1.30)	mg/dl
ESTIMATED GFR		> 60(a)	> 60(a)	> 60(a)		mL/mi
NA		137	136	137	(136-145)	mmol/
K		3.2 L	3.1 L	3.3 L	(3.5-5.1)	mmol/
CL		96	95	95	(93-108)	mmol/
ANION GAP		11.0	9.0	8.0	(7-16)	mmol/
CO2		30	32	34 H	(21-32)	mmol/
CA		9.2	9.3	9.2	(8.5-10.1)	mg/dl
TOT PROT		7.2			(6.4-8.2)	gm/dL
ALB		2.5 L			(3.4-5.0)	gm/dl
GLOB		4.7				gm/dL

NOTES: (a) Reference: mL/min/1.73 sq.m
The eGFR result is normalized to a standard body surface area of (1.73 sq.m) using sex, age, and race based on a serum creatinine measurement.

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Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

**********CHEMISTRY**********

Date	05/21/16		05/20/16	05/19/16		
Time	1016	0637	0559	0456	Reference	Units
BILI,TOT		1.9 H			(0.2-1.0)	mg/dL
ALP		187 H			(45-117)	U/L
SGOT,AST		240 H			(10-40)	U/L
SGPT,ALT		317 H			(16-61)	U/L
PHOS		3.8			(2.5-4.9)	mg/dL
MAG		2.4		2.1	(1.8-2.4)	mg/dl
ACETAMIN	< 2.0(b) L				(10-30)	ug/ml

Date	05/18/16	05/17/16	05/16/16	05/15/16		
Time	0643	0418	0620	0459	Reference	Units
GLU	122 H	101	105	224 H	(70-110)	mg/dL
BUN	21 H	24 H	22 H	25 H	(7-18)	mg/dl
CREA	1.11	1.22	1.18	1.74 H	(0.7-1.30)	mg/dl
ESTIMATED GFR	> 60	> 60	> 60	46		mL/mi
NA	140	142	142	140	(136-145)	mmol/
K	3.6	3.9	4.3	3.9	(3.5-5.1)	mmol/
CL	102	106	109 H	106	(93-108)	mmol/
ANION GAP	8.0	10.0	8.0	12.0	(7-16)	mmol/
CO2	30	26	25	22	(21-32)	mmol/
CA	8.6	8.6	7.7 L	8.8	(8.5-10.1)	mg/dl
TOT PROT				6.6	(6.4-8.2)	gm/dL
ALB				2.9 L	(3.4-5.0)	gm/dl
GLOB				3.7		gm/dL
BILI,TOT				1.3 H	(0.2-1.0)	mg/dL
ALP				100	(45-117)	U/L
SGOT,AST				21	(10-40)	U/L
SGPT,ALT				72 H	(16-61)	U/L
LIPA				224	(73-393)	U/L

**********BEDSIDE GLUCOSE**********

Date	05/21/16			05/20/16		
Time	2030	1050	0539	2031	Reference	Units
GLU BED, NURSE	172 H	183 H	149 H	166 H	(79-125)	MG/DL

NOTES: (b) ACTMN TOXIC LEVELS: 4 HR: >150.0 UG/ML
12 HR: > 50.0 UG/ML

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RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

**********BEDSIDE GLUCOSE**********

Date	05/20/16		05/19/16			
Time	1556	1040	2039	1551	Reference	Units
GLU BED, NURSE	147 H	170 H	149 H	142 H	(79-125)	MG/DL

Date	05/19/16	05/18/16				
Time	1055	1548	1033	0440	Reference	Units
GLU BED, NURSE	132 H	117	108	111	(79-125)	MG/DL

Date	05/17/16					
Time	2003	1604	1034	0728	Reference	Units
GLU BED, NURSE	108	122	94	95	(79-125)	MG/DL

Date	05/16/16					
Time	2118	1629	1051	0607	Reference	Units
GLU BED, NURSE	85	81	86	100	(79-125)	MG/DL

Date	05/15/16					
Time	1729				Reference	Units
GLU BED, NURSE	109				(79-125)	MG/DL

**********HEMATOLOGY**********

Date	05/25/16	05/24/16	05/23/16	05/22/16		
Time	0544	0609	0505	0417	Reference	Units
WBC	17.8 H	20.6 H	21.9 H	16.0 H	(4.5-11.0)	K/mm3
RBC	3.86 L	4.28 L	4.27 L	3.92 L	(4.50-5.50)	M/mm3
HGB	11.4 L	12.4 L	12.4 L	11.4 L	(14.0-17.4)	g/dL
HCT	33.8 L	38.0 L	37.8 L	34.0 L	(45.0-52.0)	%
MCV	87.6	88.9	88.5	86.7	(80.0-100.0	fl
MCH	29.6	29.1	28.9	29.2	(28.0-34.0)	pg
MCHC	33.8	32.7	32.7	33.6	(32.0-36.0)	g/dl
RDW	13.3	13.3	13.8	13.5	(12.0-14.6)	%
PLT	492 H	409	377	302	(150-450)	K/mm3
NEUT%	83.1	84.3	87.0	83.7		%
LYMPH%	9.6	9.9	8.5	8.2		%
MONO%	5.4	5.0	4.2	8.0		%
EOS%	1.5	0.6	0.1	0.0		%
BASO%	0.4	0.2	0.2	0.1		%

5A4D43B46E10429588C8, KNIGHT, 649

Conway Hospital Laboratory
300 Singleton Ridge Road
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RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

**********HEMATOLOGY**********

Date / Time	05/25/16 0544	05/24/16 0609	05/23/16 0505	05/22/16 0417	Reference	Units
NEUT#	14.8 H	17.4 H	19.1 H	13.4 H	(1.8-7.7)	K/mm3
LYMPH #	1.7	2.0	1.9	1.3	(1.0-4.8)	K/mm3
MONO#	1.0 H	1.0 H	0.9 H	1.3 H	(0.1-0.8)	K/mm3
EOS#	0.3	0.1	0.0	0.0	(0.0-0.4)	K/mm3
BASO#	0.1	0.0	0.0	0.0	(0.0-0.2)	K/mm3

Date / Time	05/21/16 0637	05/20/16 0559	05/19/16 0456	05/18/16 0440	Reference	Units
WBC	17.3 H	13.7 H	9.8	4.7	(4.5-11.0)	K/mm3
RBC	4.10 L	3.95 L	3.93 L	3.53 L	(4.50-5.50)	M/mm3
HGB	12.1 L	11.9 L	11.8 L	10.6 L	(14.0-17.4)	g/dL
HCT	35.9 L	34.8 L	35.2 L	31.9 L	(45.0-52.0)	%
MCV	87.5	88.3	89.5	90.5	(80.0-100.0	fl
MCH	29.4	30.1	30.0	30.1	(28.0-34.0)	pg
MCHC	33.7	34.1	33.5	33.3	(32.0-36.0)	g/dl
RDW	13.9	13.6	14.0	13.9	(12.0-14.6)	%
PLT	293	235	222	230	(150-450)	K/mm3
NEUT%	87.3	90.1	83.8			%
LYMPH%	8.3	6.1	7.8			%
MONO%	4.2	3.6	4.6			%
EOS%	0.0	0.0	3.6			%
BASO%	0.2	0.2	0.2			%
NEUT#	15.1 H	12.4 H	8.2 H		(1.8-7.7)	K/mm3
LYMPH #	1.4	0.8 L	0.8 L		(1.0-4.8)	K/mm3
MONO#	0.7	0.5	0.5		(0.1-0.8)	K/mm3
EOS#	0.0	0.0	0.3		(0.0-0.4)	K/mm3
BASO#	0.0	0.0	0.0		(0.0-0.2)	K/mm3
NEUTRO				61		
BAND				12		
LYMPH				11		
MONO				4		
EOS				8		
ATYP LYMPH				4		
PLT MORPH				GIANT(c)	(NORMAL)	
PLT EST				NORMAL	(NORMAL)	
MORPHOLOGY				NORMAL		
ABS NEUTROPHIL				3.4	(1.8-7.7)	K/mm3
ABS LYMPH COUN				0.7 L	(1.0-4.8)	K/mm3
ABS MONO COUNT				0.2	(0.1-0.8)	K/mm3
ABS EOS COUNT				0.4	(0.0-0.4)	K/mm3

NOTES: (c) FEW GIANT PLATELETS NOTED

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

**********HEMATOLOGY**********

Date / Time	05/21/16 0637	05/20/16 0559	05/19/16 0456	05/18/16 0440	Reference	Units
ABS BASO COUNT				0.0	(0.0-0.2)	K/mm3

Date / Time	05/17/16 0417	05/16/16 0620	05/15/16 0459	Reference	Units
WBC	4.3 L	6.0	9.8	(4.5-11.0)	K/mm3
RBC	3.50 L	3.64 L	5.57 H	(4.50-5.50)	M/mm3
HGB	10.7 L	11.0 L	16.9	(14.0-17.4)	g/dL
HCT	31.6 L	32.6 L	50.4	(45.0-52.0)	%
MCV	90.1	89.8	90.5	(80.0-100.0	fl
MCH	30.5	30.1	30.3	(28.0-34.0)	pg
MCHC	33.8	33.6	33.5	(32.0-36.0)	g/dl
RDW	13.3	13.4	13.0	(12.0-14.6)	%
PLT	256	296(d)#	632 H	(150-450)	K/mm3
NEUT%		90.6			%
LYMPH%		5.4			%
MONO%		2.5			%
EOS%		1.4			%
BASO%		0.1			%
NEUT#		5.5		(1.8-7.7)	K/mm3
LYMPH #		0.3 L		(1.0-4.8)	K/mm3
MONO#		0.1		(0.1-0.8)	K/mm3
EOS#		0.1		(0.0-0.4)	K/mm3
BASO#		0.0		(0.0-0.2)	K/mm3
NEUTRO	69		77		
BAND	7		10		
LYMPH	13		4		
MONO	6		5		
EOS	1		1		
META	2				
ATYP LYMPH	2		3		
PLT MORPH	NORMAL		(e)	(NORMAL)	
PLT EST	NORMAL		INC	(NORMAL)	
MORPHOLOGY	(f)		NORMAL		
ABS NEUTROPHIL	3.4		8.5 H	(1.8-7.7)	K/mm3
ABS LYMPH COUN	0.7 L		0.7 L	(1.0-4.8)	K/mm3
ABS MONO COUNT	0.3		0.5	(0.1-0.8)	K/mm3
ABS EOS COUNT	0.0		0.1	(0.0-0.4)	K/mm3

NOTES: (d) PLATLETS APPEAR TO BE HIGHER IN NUMBER THAN INSTRUMENT COUNT OF 296 BUT STILL NORMAL IN NUMBER.
(e) GIANT, NORMAL
(f) HYPOCHROMIA 1+

5A4D43B46E10429588C8, KNIGHT, 651

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

**********HEMATOLOGY**********

Date / Time	05/17/16 0417	05/16/16 0620	05/15/16 0459	Reference	Units
ABS BASO COUNT	0.0		0.0	(0.0-0.2)	K/mm3

**********BLOOD GAS**********

Date / Time	05/23/16 0617	05/18/16 0803	Reference	Units
TYPE	ART	ART		
SITE	L RAD	R RAD		
ALLEN'S TEST	PASS	PASS		
HAND DOMIENT	RIGHT			
SITE HELD	YES	YES		
SITE RECHECK	YES	YES		
FIO2	0.21	0.50		%
ABG PH	7.47 H	7.40	(7.35-7.45)	Units
ABG PCO2	39.2	50.8(g) H	(33-49.9)	mmHG
ABG PO2	67.5	60.2(h) L	(65-90)	mmHG
ABG O2 SAT	94.6 L	91.7 L	(96-98)	%
AaDO2	36.7 H	239.8(i)*H	(5-15)	mmHg
CO O2 HB%	92.1 L	90.1 L	(94-97)	%
CARBOXYHGB	2.0 H	1.1	(0.5-1.5)	%
METHEMOGLOBIN	< 1.0 H	< 1.0 H	(0.0-0.8)	%
DEOXYHGB	5.3 H	8.1 H	(0-5)	%
TOTAL HGB	12.8 L	11.1 L	(14.0-17.8)	g/dl
CO O2 CONTENT	16.65 H	14.14	(12.0-15.0)	ml/dl
BASE EXCESS	3.9 H	4.8 H	(-2.0-2.0)	mmol/
ABG HCO3	27.7 H	30.6 H	(22-26)	mmol/
ABG TCO2	24.5	28.0 H	(23.0-27.0)	mmol/
DELIVERY	RA	VENT MASK		
ABG LITER FLOW		12.0		L
ABG TEMP	37.0	37.0		CENT

NOTES: (g) PANIC VALUE CALLED TO DR MANSOUR BY SESTES AT 0808
RESULT READ BACK
(h) PANIC VALUE CALLED TO DR MANSOUR BY SESTES AT 0808
RESULT READ BACK
(i) PANIC VALUE CALLED TO DR MANSOUR BY SESTES AT 0808
RESULT READ BACK

5A4D43B46E10429588C8, KNIGHT, 652

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 05/30/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006912886 (Continued)

COLLECTED: May 15, 2016 7:29am

> ABO/Rh TYPE	A POS	05/15/16 0809
> AB SCREEN	NEGATIVE	05/15/16 0809

CLINICAL PATHOLOGY CONSULTANTS, P. A.

PATHOLOGISTS
D. Mark Wilson, MD
Keels Allen, MD
Matthew Bernstein, MD

P.O. Box 1599
Conway, S.C. 29528

843 347-7144
FAX 843 347-7331

Surgical Pathology Report

NAME: KNIGHT,DANIEL ERIC [redacted]

UNIT NO: M000175313

ROOM NO: CC26
RACE: CA
Signed Out

PATH NO: S16-3243
STATUS: SOUT
ACCOUNT NO: V00006912886
REC'D DATE: 05/16/16
DATE OF SVC: 05/15/16
REGISTERING MD:
SUBMITTING MD: Rimkus, Gilbertas MD

SITE OF SPECIMEN :
portion of small bowel

FIXATION TIME :
Time specimen removed: 8:55, placed in formalin: 9:29. Initials: MC.

CLINICAL DIAGNOSIS :
Ruptured bowel.

GROSS EXAMINATION :
Specimen "A" is received in formalin and labeled with patient name, medical record # and additional labeling of "portion of small bowel". Specimen consists of a length of small bowel which measures 15 cm with a diameter of 3.1 cm. The length of bowel has been closed at either end with a surgical staple margin. There is no orientation provided grossly, 5.5 cm from one end of the small bowel there is an obvious area of rupture. This measures 2.5 x 2.5 cm and is surrounded by adherent blood clot as well as a prominent purulent exudate which clings to the bowel serosal surface. Otherwise, the serosal surface is tan-brown and vaguely granular but unremarkable. There is no evidence of any exudate other than in the immediate vicinity of the area of perforation. Specimen is then opened to reveal a tan-brown mucosal surface divided into the usual mucosal folds. There are no polyps, masses or areas of ulceration identified. In the area of perforation, there is an erythematous quality to the mucosa but no true areas of ulceration are identified other than in the perforation itself. Multiple representative sections are then submitted.
Cassette summary:

A1&A2. Surgical margins.
A3&A4. Sections through the area of perforation.
A5. Section of more normal-appearing small bowel.

KA/ls

MICROSCOPIC EXAMINATION :
Five slides are examined. Benign small bowel has areas of mucosal ulceration where there is inflamed granulation tissue. There are also degenerative changes in the muscle wall in the area of gross perforation. Peritoneal surfaces have acute inflammation. Some blood vessels contain thrombi.

CLINICAL PATHOLOGY CONSULTANTS, P. A.

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Conway, S.C. 29528

843 347-7144
FAX 843 347-7331

Surgical Pathology Report

NAME: KNIGHT,DANIEL ERIC [redacted]

UNIT NO: M000175313

ROOM NO: CC26
RACE: CA
Signed Out

PATH NO: S16-3243
STATUS: SOUT
ACCOUNT NO: V00006912886
DATE OF SVC: 05/15/16

REC'D DATE: 05/16/16
REGISTERING MD:
SUBMITTING MD: Rimkus, Gilbertas MD

DIAGNOSIS :

PORTION OF SMALL BOWEL: BENIGN SMALL BOWEL WITH PERFORATION AND ACUTE PERITONITIS.

DMW/ls

Signed <Electronically Signed By>
MARK WILSON, MD 05/17/16 1807

5A4D43B46E10429588C8, KNIGHT, 655

Conway Medical Center

Patient Choice Form for Post Hospital Home Health Agency or Home Medical Equipment/IV Therapy Suppliers

Medicare regulations require Conway Medical Center to advise you that you may choose to receive services from any Home Health agency or Durable Medical Equipment company listed on this form or any other agency or company. Conway Medical Center cannot necessarily endorse any non-Conway Medical Center agency or company, nor guarantee the availablity of their services. If you reside outside of our geographical area, we will assist in providing information on home care provider options specific to your area.

Your physician has recommended Home Health Services/Home Medical Equipment/IV Therapy for you at home to aid in your recovery. The following information will allow us to assist you in making sure that your post hospital needs are met at time of discharge.

Are you currently renting any medical equipment, such as a hospital bed, wheelchair, oxygen, etc., or being followed by a nurse in your home?

☐ Yes ☐ No

Do you prefer a particular home health agency/IV therapy supplier or medical equipment supplier? The following is a list of area home health agencies/IV therapy suppliers and medical equipment suppliers. Please place a check mark in the box next to the vendor or agency of your choice.

Home Health Agencies

☒ Amedisys

Conway

Ph: 347-5899 Fax: 347-5885

Myrtle Beach

Ph: 916-0931 Fax: 916-0985

Georgetown

Ph: 546-1730 Fax: 545-9260

☐ Gentiva

Ph: 448-7060 Fax: 448-3619

☐ InCare Home Health, Inc.

Conway

Ph: 347-6418 Fax: 347-6430

Myrtle Beach

Ph: 293-4614 Fax: 293-5030

North Myrtle Beach

Ph: 280-4148 Fax: 280-6978

☐ Liberty Home Care

Ph: 839-2273 Fax: 839-2277

Place original of this document on patient's char

Rimkus, Gilbertas MD
V00006912886
KNIGHT,DANIEL ERIC
M 41 09/26/74 SUR232
M000175313 05/15/16

5A4D43B46E10429588C8, KNIGHT, 656

☒ American Home Patient
(Conway Medical Center partnership)
Ph: 347-0711 Fax: 347-0833

☐ American Health Services
Ph: 357-1691 Fax: 357-8808

☐ APRIA Murrells Inlet
Ph: 357-3520 Fax: 844-511-1671

☐ Aynor Home Medical
Ph: 358-3520 Fax: 358-2524

☐ Coram (Charleston)
Ph: 744-4183 Fax: 743-2902

☐ Drucker Home IV Meds
(Georgetown County)
Ph: 354-9582 Fax: 354-6080

☐ Express Medical
Ph: 236-4271 Fax: 236-4270

☐ Family Care Medical
Ph: 756-6869 Fax: 756-6890

☐ First Choice Medical
Ph: 756-4300 Fax: 756-0811

☐ Incare Medical Equipment
Ph: 293-2122 Fax: 293-4009

☐ Liberty Medical
Ph: 448-8315 Fax: 448-8317

☐ Lincare
Ph: 445-9997 Fax: 445-9838

☐ Medi Home Infusion
Ph: 800-672-6334 Fax: 803-957-2541

☐ Infuscience
Ph: 843-553-7588 Fax: 877-893-7041

☐ Pharmacy Express
Ph: 665-2066 Fax: 665-5128

☐ PPSI
Ph: 665-4051 Fax: 665-4786
Fax: 665-1616

☐ Reliable Medical
Ph: 234-1249 Fax: 234-1318

☐ Resource Medical Group
Ph: 839-5101 Fax: 839-5103
Ph: 839-5102

☐ Responsive Solutions
Ph: 497-5433 Fax: 497-5432

☐ RPI Medical
Ph: 669-0000 Fax: 669-4729

☐ Other: _____

_____

By signing below, I acknowledge that my choice of home health agency/IV Therapy supplier or medical equipment supplier was made freely. I authorize the release of medical information to the above named agency to facilitate discharge arrangements.

5-24-16
Date

X Elizabeth Knight
Patient's Signature

David Knight
Patient's Name (please print)

5A4D43B46E10429588C8, KNIGHT, 657

UNIVERSAL MEDICATION FORM Conway Medical Center 843-347-7111 *GIVE THIS COPY TO THE PATIENT* **Patients: Fold this form and keep it in your wallet for easy access.**	Patient's Name: KNIGHT,DANIEL ERIC [redacted] MRI Number: M116454 Date Started: 05/29/16 Unit Number: M000175313

Emergency Contact/Phone Numbers:

IMMUNIZATION RECORD (Record the date/year of last does taken, if known)

Tetanus	Flu Vaccine NFS	
Pneumonia Vaccine	Hepatitis Vaccine	Other

Allergic To/Adverse Reaction:
Penicillins, Sulfa (Sulfonamide Antibiotics)

Medications: Include all prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginko). Include medications taken as needed (example nitroglycerin).

NAME OF MEDICATION/STRENGTH	DOSE/DIRECTIONS/NOTES Use patient friendly directions (Do not use medical abbreviations.)	LAST DOSE	DATE STOPPED	* RX	* PEI
OXYCODONE HCL 5 MG TABLET (OXYCODONE HCL)	5-10 MG ORAL EVERY 6 HOURS As Needed for PAIN	05/29/16 0548			
PROZAC* 20 MG CAP (FLUOXETINE HCL)	20 MG Oral 20 MG DAILY	05/29/16 0848			

Please consult your Physician or Primary Care Provider before taking any medication(s) not listed above.

*Rx (prescriptions) and *PEI (patient education information) given at time of discharge from hospital.

Reminders to patients:

1. Please fold this form and keep it in your wallet for easy access.
2. If you start to take any new over-the-counter medications or herbals, add these to your list so you will have a complete list.
3. Show this form each time you are asked which medications you take (doctor visits, diagnosic tests, emergency room, hospital, etc.) This will save you time. Continue to update the form.
4. Extra forms are available at many doctors' offices, pharmacies, and www.scha.org.

5A4D43B46E10429588C8, KNIGHT, 658

OUTPATIENT AND EMERGENCY DEPT. RECORD

CONWAY MEDICAL CENTER
CONWAY, S.C.

MEDICAL RECORDS COPY

Unit #	Patient	Admit Date and Time	Location/Room	Visit #
M000175313	KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY,SC 29527 (330)719-5830	04/27/16 1824	ER	V6905806

Discharge Date and Time	Previous Admission/Visit	PTP	MSV	F/C
	07/14	ER		MGD

Maiden Name | Patient SS# | Physician: CONWAY EMERGENCY GROUP

[redacted]

Admitting Diagnosis: MVA | Healthcare Power of Attorney | Living Will

Time	General Lab	Cardiac	Radiology	Time	Orders
	☐ Blood Culture___	CBC w/ AD	☐ PCXR___Views		☐ CR Monitor
	☐ BMP	CIP #1	☐ CXR___Views		☐ Pulse OX
	☐ BNP (CHF)	CMP	☐ C-spine Port Lat.		☐ Td 0.5ml IM
	☐ C. diff (A&B)	EKG T:_____	☐ C-spine w/Flex + Ex		
	☐ CBC no diff.	Magnesium	☐ C-spine		
	☐ CBC w/ AD	PT, PTT	☐ T-spine		
	☐ CBC MD	Troponin I	☐ L-spine		
	☐ CMP		☐ L Shoulder R		
	☐ D. Billirubn	☐ Trauma	☐ L Elbow R		
	☐ D. Dimer	ABG	☐ L Wrist R		
	☐ GC/Chlamydia/Wet Prep	Amylase	☐ L Hand R		
	☐ Hepatic Panel	Lipase	☐ L Finger R____		
	☐ LP C&S_____	CBC w/ AD	☐ L Hip/Pelvis R		
	☐ LP gram stain ____	CIP#1	☐ Pelvis		
	☐ LP Glucose _____	CMP	☐ L Knee R		
	☐ LP Protein _____	ETOH	☐ L Ankle R		
	☐ LP Cell Count ____	PT, PTT	☐ L tib/fib R		
	☐ NP Flu (A & B)	Type & Cross_____	☐ L Foot R		
	☐ NP RSV	Type & Screen	☐ Abdomen ____Views		
	☐ QYN HCG	Urine Drug Screen	☐ CT Abdomen w/o		
	☐ Stool Culture	UA	☐ CT Angio Pulm.		
	☐ Stool heme	Urine Drug Screen	☐ CT AP Renal		
	☐ Stool O&P	CT AP (trauma)	☐ CT AP w		
	☐ Stool WBC		☐ CT C-Spine		
	☐ Strep Screen		☐ CT Head w/o		
	☐ Type for Rh		☐ L US Leg R		
	☐ UA		☐ Transvag US		
	☐ UHCG (qual)		☐ Gall Bladder US		
	☐ Urine C&S				
	☐ Wound Culture___				

Diagnosis

Physician's Signature | Time | Discharge condition: ☐ Good ☐ Admitted

EPIC Inst | S | MEDS | Refer | Work/School Days

Other Instructions: ReSalvo 2 Record on Appeal 2017

Time to F/U:

Copy to Patient
☐ LAB
☐ EKG
☐ RAD

5A4D43B46E10429588C8, KNIGHT, 659

ADM-5172-FRM REV 3 10.27.15

CONWAY MEDICAL CENTER
CONWAY S.C.

Unit #	Patient	Admit Date and Time	Location/Room	Visit #
M000175313	KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY,SC 29527 (330)719-5830	04/27/16 1824	ER	V6905806
		Discharge Date and Time	Previous Admission/Visit 07/14	PTP ER / MSV / FIC MGD
Maiden Name	Patient SS#	Physician	CONWAY EMERGENCY GROUP	
Sex: M / Race: CA / Marital: M	[redacted] Religion: UNKNOWN	Patient Mother's Name	BETZ, ROSEMARIE	

CONWAY MEDICAL CENTER
CONSENT AND CONDITIONS OF ADMISSION AND GUARANTY

In consideration for the medical care to be provided to the patient by Conway Hospital, Inc. d/b/a Conway Medical Center ("The Hospital"), the undersigned patient, guarantor, and/or responsible party (individually and collectively hereinafter referred to as the "undersigned") hereby consent to the following conditions of treatment and admissions:

1) CONSENT FOR TREATMENT: The undersigned authorizes and consents to the admission of the patient and all medical care, treatment, services, examinations, tests and procedures, which may be performed during this hospitalization or outpatient treatment including but not limited to surgery, x-ray examination, laboratory tests, diagnostic procedures, and anesthesia, which a Physician, the Hospital, their employees, nurses, associates, assistants or assignee deem advisable to the patient. The undersigned further agrees that no guaranty has been made to the undersigned about the outcome of the care and treatment during this admission/service.

2) HOSPITAL AND PHYSICIAN: The undersigned agrees that some Physicians and the like which are providing medical care or services to the patient are not employees or agents of the Hospital or its subsidiaries, and the undersigned agrees that the Hospital is not responsible or liable for the acts or omissions of non-Hospital employees. Further, the undersigned agrees there will be a separate charge for professional services including the professional component of clinical laboratory tests, but understands that the Hospital may bill for some professional fees.

3) PAYMENT GUARANTEE: The undersigned agrees and guarantees to pay all Hospital charges to the Hospital in accordance with the regular rates and terms of the Hospital, and agrees to pay for any balance and all charges not covered by a third party payer. The Hospital files insurance as a courtesy and the undersigned is ultimately responsible for payment of the total incurred charges. The undersigned agrees that if this account is not paid timely, it may be turned over to a collection agency or attorney, and in such circumstances, the undersigned, shall be obligated to pay the amount due plus all costs of collection including reasonable attorneys fees. The undersigned agrees that overpayment collected on this account may be applied directly to any past delinquent account(s) of the patient. The undersigned patient, responsible party and guarantor, if any, hereby agrees that they are jointly and severally liable to pay the Hospital for any and all charges, any balance due and costs associated with this treatment and/or admission.

4) ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: The undersigned hereby assigns unto the Hospital any and all rights and benefits the undersigned patient or responsible party may have under any policy of insurance (hospitalization, major medical, automobile, workers compensation, or third party liability insurance), and further directs any such insurance company to make payment of benefits directly to the Hospital or its attorney. In the event that the undersigned is entitled to any insurance or benefits covering physician services, the undersigned hereby assigns said benefits to the physicians rendering care, treatment, or service to be applied to patient's and/or the undersigned's bill. If the patient's treatment is as a result of any accident and the patient has a claim against a third party, the Hospital has the option to pursue the automobile coverage or third party liability proceeds as a primary source of payment. If the Hospital exercises this option, the patient and/or responsible party agree to assign the proceeds of any settlement or recovery in the accident claim toward the payment of any outstanding Hospital charges. This authorization is irrevocable by the undersigned.

5) AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE BENEFITS: The undersigned patient and or responsible party authorizes the Hospital to contact the undersigned's insurance company and its agents, the undersigned's employer or other third party payer including the patient's spouse, if applicable, to verify insurance or hospital coverage, to discuss all medical and financial information pertaining to the admission/service that may be required in processing or collecting on this claim. The undersigned authorizes and acknowledges that all medical and financial records will be accessible to all health care providers participating in the patient's care or treatment and acknowledges that patient medical records at the Hospital are stored electronically and are made available through computer networks to Hospital personnel, physicians and those health care providers involved in the patient's care. The undersigned further authorizes the Hospital, its collection agency, or attorney to obtain and review, at any time, the credit report of the patient, guarantor, and/or responsible party.

6) CHAMPUS/CHAMPVA CERTIFICATION: The undersigned requests payment of authorized benefits to the patient or on patient's behalf for medical treatment and services from the Hospital including physician services, and authorizes any holder of medical information regarding the patient to release to CHAMPUS and its agents any information needed to determine these benefits or benefits for related services.

7) MEDICARE PATIENT CERTIFICATION: The undersigned certifies that information given by the undersigned in applying for payment under the Medicare Program is correct. The undersigned hereby authorizes any holder of medical or other information about the patient to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The undersigned authorizes the payment of the patient's benefits to the Hospital.

8) AUTHORIZATION TO CONTACT
I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

Patient _____ Patient's Agent/Guardian/Guarantor/Relationship _____ Date _____

Witness _____ Date _____

pt cannot sign

Amy Reaves RN

HIM-465-FRM REV 1 01.08.15	Conway Medical Center Conway, South Carolina	V00006905806 ER / KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY, SC 29527 [redacted] CONWAY EMERGENCY GROUP M000175313

Patient Acknowledgement Form

Instructions: The patient or the patient's representative must acknowledge in the spaces provided the receipt of information regarding the following regulatory requirements:

HOSPITAL INFECTIONS DISCLOSURE ACT:

☐ I have been informed that all hospital infections are submitted to DHEC through the Centers for Disease Control (CDC) and National Healthcare Safety Network (NHSN). Upon request I will be provided with the appropriate information related to this subject matter. (Form 4050)

LEWIS BLACKMAN ACT INFORMATION SHEET:

☐ I acknowledge that I have received an informational sheet regarding the Lewis Blackman Act.

HEARING IMPAIRMENT / LIMITED ENGLISH ASSISTANCE:

☐ I understand that if I and/or my companion (family member, significant other, friend, driver, etc.) need assistance communicating with CMC staff, CMC will provide assistance at no charge.

PATIENT RIGHTS AND RESPONSIBILITIES:

☐ I acknowledge that I have received a copy of the Patient Rights and Responsibilities.

_____ ____/____/____

Patient or Patient Representative Signature — Date

52DL 00421646

PREHOSPITAL PATIENT CARE REPORT

NAME: Eric Knight

[redacted] SEX: M CAD#

ADDRESS: 206 Ecum Secum Conway SC 29527

PHONE: 830 719 5830 [redacted]

PMHX: Ø

MEDS: Prozac

ALLERGIES: Pen, Sulfa

C/C: Pelvis pain, left leg pain

OTHER:

ABS (R) shin + knee (S) (R) Head.

R/T ABC tenderness pain.

Refused LSB

TREATMENT:

IV (L) FA NS

EKG/12 LEAD: NSR

O2: 2L NC BGL: 82 TEMP:

Ox 130/P 100

TIME	BP	HR	REG/IRR	RR	REG/IRR	SPO2	AVPU	PUPILS	GCS	RTS
N	130/82	84	(R)	14	(R)	(95)	(A)	(=)	(15)	(12)
A	130/88	88	↓	(18)	↓	↓	↓	↓	↓	↓
A	117/65	88	↓	↓	↓	↓	↓	↓	↓	↓
A	127/62	82	↓	↓						
A	118/74	88								

PRIMARY: [signature] SECONDARY: K Hardwick UNIT #: 25

ED-156-FRM
REV 9 06.17.15

Conway Medical Center

EMS ENCODE RECORD

KNIGHT,DANIEL ERIC
V00006905806
M000175313
[redacted]
04/27/16

Unit: _____ # TRAUMA ALERT: ☐ LEVEL I ☑ LEVEL II

ETA: 15 ROOM 12 TIME ALERT PAGED 1811

AGE: 41 SEX: ☑ Male ☐ Female CPR IN PROGRESS: ☐

CHIEF COMPLAINT:

☑ MVC ☐ Auto vs. Ped ☐ Motorcycle
☐ Drowning ☐ Burn ☐ Crush
☐ Fall ☐ GSW ☐ Stabbing

Other: Pelvic pain (L) leg pain

BP	HR	O_2	Pulse Ox	RR	FSBS	GCS / RTS	RYTHYM	Misc:
122/66	88			20	82			☐ LSB refused ☐ (+) LOC ☑ C Collar ☐ (-) LOC ☐ (+) anticoag /ASA ☐ (-) anticoag / ASA

EMS	Airway	IV	FLUIDS	Meds Given Enroute
		✓		

PAST MEDICAL HISTORY:

Orders from MD:

DIVERSION? ☐ YES ☐ NO IF YES, WHERE? Receiving MD Name

REASON FOR DIVERSION?

PRIORITY 1 (2) 3 4

Report given to: _____

AD
RN Signature

4/27/16
Date

1809
Time

THIS FORM IS TO BE PART OF MEDICAL RECORD

5A4D43B46E10429588C8, KNIGHT, 663

TRAUMA ALERT – LEVEL 1 ACTIVATION

Criteria:

1. Glasgow coma score <9 (related to an injury)
2. Systolic BP <90 (child <1yr <60-70; >1yr < (70 + 2x age in yrs.)
3. Sustained tachycardia >110 in adults
4. Respiratory rate <10 or >29 (<10 or >60) (infant <20 if one year or less) or respiratory distress
5. Penetrating injury to head, neck, torso, or extremities proximal to elbow or knee
6. Flail chest
7. Two or more proximal long bone fractures or any open long bone fracture
8. Single proximal long bone fracture due to MVC (to include ATV) or fall $\geq$ 10 feet in an adult over 55
9. Single long bone fracture with abnormal BP, other injury, amnesia or LOC in a child $\leq$ 10
10. Crushed, de-gloved, mangled or pulseless extremity or amputation proximal to wrist or ankle
11. Clinically apparent pelvic fracture
12. Open or depressed skull fracture
13. New onset of paralysis or suspicion of spinal cord injury
14. Burns: >15% of 2nd and/or 3rd degree TBSA, or circumferential burns to extremity, torso, hands, feet or large joint surfaces or inhalation burns
15. Electrical injuries: Direct lightning strikes or other high voltage exposure
16. Requiring active airway assistance s/p traumatic event
17. Requiring/needing blood products to maintain hemodynamic stability s/p traumatic event
18. Clinical Discretion
19. Strong consideration for activation is recommended for patients on anticoagulants

TRAUMA ALERT – LEVEL II ACTIVATION

Criteria:

1. Falls> 20 feet in adult (one story = 10 ft)
2. Falls> 10 feet or two to three times the height of the child
3. Intrusion> 12 inches occupant side
4. Intrusion> 18 inches any side
5. MVC> 45 MPH (to include ATV's)
6. MVC Roll Over/Partial Roll Over (to include ATV's)
7. Ejection (partial or complete)from automobile (to include ATV's)
8. Death in same passenger compartment
9. Vehicle telemetry data consistent with a high risk injury (e.g. Steering wheel deformity, starred windshield)
10. Pedestrian struck by vehicle, thrown, run over, or with impact >20 mph thrown or run over
11. Bicyclist thrown, run over, or with impact >20 mph
12. Motorcycle/MOPED crash >20 mph (to include ATV's)
13. Burns: 5-15% TBSA 2nd and/or 3rd degree TBSA that do not meet level I activation
14. Clinical Discretion
15. Strong consideration for activation is recommended for patient on anticoagulants

SPECIALTY CRITERIA:

1. Older adults:
   __ 55 and older. Risks of injury/death increases
   __ 65 and older. SBP<110 may represent shock
   __ Low impact mechanisms (e.g. ground level falls) may result in severe injury
2. Patients with bleeding disorders or are on anticoagulant medication (patients with head injury are at risk for rapid deterioration)
3. Children (less than 10)
4. Pregnancy >20 weeks
5. Seatbelt sign is associated with an increased likelihood of abdominal and intestinal injuries and mandates a heightened index of suspicion.

Acute alcohol intoxication and illicit drug use after a traumatic event have the potential to mask injuries. Therefore, a patient under the influence of alcohol or illicit drugs must be evaluated with a high suspicion for more serious injuries than may be apparent on the surface.

THIS FORM IS TO BE PART OF MEDICAL RECORD

5A4D43B46E10429588C8, KNIGHT, 664

Conway Medical Center

300 Singleton Ridge Road
Conway, SC 29526
843-347-8139

Discharge Instructions for: **Knight, Daniel Eric**

Arrival Date: **Wednesday, April 27, 2016**

Thank you for choosing **Conway Medical Center** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: DeSalvo, Matthew, MD

Diagnosis: Whiplash; Abrasion of Multiple Sites w/o Infection; Hand Abrasion; Other - MVC; Chest Contusion; Abdominal Wall Contusion

DISCHARGE INSTRUCTIONS	FORMS
Abrasions Whiplash Motor Vehicle Collision, Easy-to-Read Chest Contusion, Easy-to-Read	None
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Private Physician When: 2 - 3 days; Reason: Further diagnostic work-up, Recheck today's complaints	Flexeril Naprosyn Percocet
SPECIAL NOTES	
None	

I hereby acknowledge that I have received and understand the above instructions and prescriptions (if any).

X _____

Daniel Knight

MRN # M000175313

_____

ED Physician or Nurse

X-RAYS and LAB TESTS:
If you had x-rays today the results will be reviewed with you prior to your discharge. Let the doctor know before your discharge if you have a question. Some lab tests may not be complete prior to your discharge. That includes cultures. Ultimately it is your responsibility to obtain the results. You may have your provider obtain the results or you may obtain the results through CMC's medical record department. Please verify your current phone number prior to discharge at the checkout desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

FOLLOW UP INSTRUCTIONS

Private Physician
When: 2 - 3 days
Reason: Further diagnostic work-up, Recheck today's complaints

PRESCRIPTIONS

Flexeril 10 mg Oral Tablet — Printed
Take 1 tablet by ORAL route 3 times per day; Quantity: 15 tablet

Naprosyn 500 mg Oral Tablet — Printed
Take 1 tablet by ORAL route 2 times per day with food; Quantity: 30 tablet

Percocet 5-325 mg Oral Tablet — Printed
Take 1 to 2 tablet by ORAL route Every 8 hours as needed As needed; Quantity: 15 tablet

Encounter Summary

Name: Daniel Knight
[redacted]
Sex: Male
Race: Caucasian
Martial Status: Married

[redacted]
MRN: M000175313
Account#: V00006905806
Home phone: (330)719-5830
Work phone: (843)903-0257

Chief Complaint: Motor Vehicle Collision (MVC)
MOA: EMS
Acuity: Level 2

Arrival: 04/27/2016 18:23

Responsible Dept: Ortho

Care Complete Date 04/27/2016
Care Complete Time 19:51
Departure Date 04/27/2016
Departure Time 20:21

Special Handling:
Family Waiting: No
Bed H3

Assigned staff & roles

Name	Role	Specialty
DeSalvo, Matthew	Attending Physician	Emergency Medicine
Dew, Cathy		
McDowell, Chad	Primary Nurse	
Dow, Aileen	Primary Nurse	

Outcome: Discharge
Location: Home
Condition: Stable
Chief Complaint: Motor Vehicle Collision (MVC)
Diagnosis: Whiplash, Other - MVC, Hand Abrasion, Abrasion of Multiple Sites w/o Infection, Chest Contusion, Abdominal Wall Contusion
Prescriptions: Flexeril 10 mg Oral Tablet - take 1 tablet by ORAL route 3 times per day; 15 tablet, Naprosyn 500 mg Oral Tablet - take 1 tablet by ORAL route 2 times per day with food; 30 tablet, Percocet 5-325 mg Oral Tablet - take 1 to 2 tablet by ORAL route Every 8 hours as needed As needed; 15 tablet
Follow up:
Special Notes:
Attending Physician: DeSalvo
Mid Level Provider:
Orders: CBC W/ AUTO DIFF, CMP: CMP includes HEPAN, if HEPAN needed ORDER DBIL, LACTIC ACID, PT, PTT, TYPE & SCREEN, NC oxygen to keep sats >92%, ABDOMEN W/IV CONTRAST ONLY, Cervical Spine W/o Contrast *, CT CHEST WITH CONTRAST, CT HEAD W/O CONTRAST, PELVIS WITH IV CONTRAST ONLY, NS 0.9%, ABDOMEN AND PELVIS IV ONLY, SALINE LOCK, VS q 15min X 2, then q 30 min X 2, then hourly
Discharge Instruction: Disposition Documents, Discharge Summary Sheet, Abrasions, Whiplash, Motor Vehicle Collision, Easy-to-Read, Chest Contusion, Easy-to-Read

5A4D43B46E10429588C8, KNIGHT, 667

Name: Daniel Knight [redacted]

Arrival Date: 04/27/2016 **Time:** 18:23
Bed H3

MRN: M000175313
Account#: V00006905806
Private MD:

Presentation:

04/27 18:11 (18:41) OR notified at Date/Time April 27, 2016 at 18:11. (18:41) Nursing Supervisor/ED Management notified at: April 27, 2016 at 18:11 Arrived April 27, 2016 at 18:11. (18:41) Security service was not needed. Security notified at: April 27, 2016 at 18:11. cd1

18:23 (18:27) Presenting complaint: EMS states: ***states pt was hit head on then again an the side an trauma 2 called in field pt has c-collar an #18 in left hand pt restrained driver air bags deployment an windshield broken an traveling 50 - 55 miles an hour.*** (18:27) Mechanism of Injury: MVC. (18:27) Trauma event details: The patient did not lose consciousness. County: The injury occurred in Horry County, Injury occurred on a street or highway. Injury occurred April 27, 2016 Injury occurred at ***1700.*** (18:27) Trauma Alert Activation: Level II. Notified ***Dr DE Salvo in room.*** (18:27) Care prior to arrival: Saline lock initiated. ***c- collar.*** (18:27) Transition of care: patient was not received from another setting of care. kb6

18:23 (18:27) Method Of Arrival: EMS. kb6

18:23 (18:27) Acuity: Level 2. kb6

Trauma Activation: Level II			
Physician	**Name**	**Notified At**	**Arrived At**
Surgeon	N/A		
ED Physician	DR. DESALVO	2016/04/27 18:11	2016/04/27 18:21
Respiratory Therapy	JENNIFER	2016/04/27 18:11	2016/04/27 18:15
Lab	KAREN	2016/04/27 18:11	2016/04/27 18:11
Radiology	SARAH	2016/04/27 18:11	2016/04/27 18:12

Historical:

Allergies:

18:31 (18:32) SULFA (SULFONAMIDES); (18:32) PCN; kb6

19:44 (19:46) SULFA (SULFONAMIDES); (19:46) PCN; mjd

Home Meds:

18:31 (18:32) 1. . Prozac Weekly oral Unknown Unknown 20 mg daily kb6

19:44 (19:46) 1. . None mjd

PMHx:

18:31 (18:32) Anxiety; kb6

19:44 (19:46) NONE; mjd

PSHx:

18:31 (18:32) None; kb6

19:44 (19:46) NONE; mjd

Historical:

18:30 Code Status: Full code. kb6

18:31 (18:32) Medication Information obtained from: Patient. (18:32) Social history Smoking status: Patient denies tobacco use. No barriers to communication noted. (18:32) Immunization history: Last tetanus immunization: up to date. Pneumococcal vaccine is up to date. Flu vaccine is up to date. (18:32) Do you have an kb6

Screening:

18:31 (18:33) **Abuse screen:** kb6
Denies threats or abuse.
(18:33) **Nutritional screening:**
No deficits noted.
(18:33) **Tuberculosis screening:**
No symptoms or risk factors identified.
(18:33) **Exposure risk/Travel Screening:**
None identified.

Advanced Directive or Health Care Power of Attorney? No. (18:32) Family history: Not pertinent.

19:44 (19:46) Social history Smoking status: Patient denies tobacco use. (19:46) The history from nurses notes was reviewed and I agree with what is documented up to this point. mjd

Assessment:

18:23 (18:30) **Injury Description:** Abrasion sustained to nose rigr lower leg back of right for arm complains of right an left hip bellow the hip line. (18:30) **Pain:** Complains of pain in right iliac crest and left iliac crest. (18:30) **General:** Appears uncomfortable, well nourished, well groomed. (18:30) **General:** Behavior is appropriate for age, cooperative, pleasant. (18:30) **Neuro:** No deficits noted. Level of Consciousness is awake, Oriented to person, place, Grips are equal bilaterally Moves all extremities. Speech is normal. (18:30) **EENT:** No deficits noted. (18:30) **Cardiovascular:** No deficits noted. (18:30) **Respiratory:** No deficits noted. (18:30) **GI:** No deficits noted. (18:30) **GU:** No deficits noted. (18:30) **Derm:** Skin temperature is warm. (18:30) **Musculoskeletal:** Reports pain in hips lower belt line of pants. kb6

20:14 (20:16) **Reassessment:** No changes from previously documented assessment. Patient states feeling better. cm9

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
18:25 (19:32)	119 / 83	83	20		94% on R/A				ad2
18:29 (18:30)	127 / 79	84	18	97.7(TE)	97% on R/A	76.2 kg / 167.99 lbs (R)	5 ft. 3 in. (160.02 cm) (R)	5/10	va3
18:42 (19:32)	126 / 77	86	20		97% on R/A				ad2
18:50 (19:32)	126 / 78	87	20		99% on R/A				ad2
19:00 (19:32)	125 / 76	78	20		96% on R/A				ad2
19:12 (19:32)	133 / 70	81	20		96% on R/A				ad2
19:34 (19:35)	129 / 71	84	18		97% on R/A				cm9
20:04 (20:21)	128 / 70	82	18		97% on R/A			5/10	cm9

18:29 Body Mass Index 29.76 (76.20 kg, 160.02 cm) va3

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
18:30	spontaneous(4)	oriented(5)	obeys commands(6)		15	kb6
20:21	spontaneous(4)	oriented(5)	obeys commands(6)		15	cm9

Trauma Score (Adult):

Time	Eye Response	Verbal Response	Motor Response	Systolic BP	Repiratory Rate	Glasgow Score	Trauma Score	Staff
18:30	spontaneous(1)	oriented(1)	obeys commands(2)	> 89 mm Hg(4)	10 to 29 per min (4)	15	12	kb6

20:21	spontaneous(1)	oriented(1)	obeys commands(2)	> 89 mm Hg(4)	10 to 29 per min (4)	15	12	cm9

ED Course:

18:23 Patient arrived in ED.	kb6
18:23 Patient moved to .	kb6
18:23 Dow, Aileen RN is Primary Nurse.	kb6
18:23 Patient moved to ED12.	kb6
18:23 Patient visited by Barton, Kathy B RN.	kb6
18:25 DeSalvo, Matthew, MD is Attending Physician.	mjd
18:25 Patient visited by DeSalvo, Matthew, MD.	mjd
18:29 Patient visited by Baker, Crystal.	cb6
18:30 Patient visited by Albani, Vanessa, MST.	va3
18:30 Patient visited by Albani, Vanessa, MST.	va3
18:31 (18:33) Arm band placed on right wrist. Allergy Band placed on right wrist.	kb6
18:33 Patient visited by Barton, Kathy B RN.	kb6
18:33 Patient visited by Barton, Kathy B RN.	kb6
18:37 Patient visited by Dow, Aileen RN.	ad2
18:37 Patient has correct armband on for positive identification. Placed in gown. Bed in low position. Call light in reach. Side rails up X2. Cardiac monitor on with alarms activated. Pulse Ox Monitor on with alarms activated. NIBP on with alarms activated. Report received from ***EMS.***	ad2
18:43 Patient moved to CT.	cp1
18:50 (20:17) Maintain field IV. Dressing intact. Good blood return noted. Site clean & dry. Gauge & site: ***18 gauge in left wrist.***	cm9
18:50 (20:17) Discontinued lock intact, bleeding controlled, pressure dressing applied, No redness/swelling at site.	cm9
18:51 Cervical Spine W/o Contrast * Sent.	cp1
18:51 CT CHEST WITH CONTRAST Sent.	cp1
18:51 CT HEAD W/O CONTRAST Sent.	cp1
18:55 McDowell, Chad RN is Primary Nurse.	cm9
19:25 Patient moved to ED12.	ad2
19:32 Patient visited by Dow, Aileen RN.	ad2
19:35 Patient visited by McDowell, Chad RN.	cm9
20:07 Patient moved to H3.	tb6
20:13 (20:14) Trauma Interventions: NA, no interventions required. (20:14) Portable x-ray done. (20:14) Critical Care Time: One-on-one care X 45 minutes.	cm9

Dispensed Medications:

Time	Drug & Dose	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
18:33	NS 0.9% 1000 mL		IV	Bolus		left hand		kb6
20:16	Follow up: IV Status: Completed infusion							cm9

Intake:

Nurse's Notes Con't

Time	PO	IV	Tubes	Total	Staff
18:30	0.00ml			0.00ml	kb6

Output:

Time	Urine	Gastric	Stool	EBL	Drainage	Other	Total	Staff
18:30	0.00 ml						0.00ml	kb6

Outcome:

19:51 Discharge ordered by MD. mjd

20:13 Discharged to home ambulatory, with family. Condition: stable. Discharge instructions given to patient, Instructed on discharge instructions, medication usage, no drinking with medication, no driving heavy equipment, follow up and referral plans. Demonstrated understanding of instructions, medications, Prescriptions given : 3. cm9

20:17 (20:18) Discharge instructions given to patient, Instructed on discharge instructions, follow up and referral plans. no drinking with medication, no driving heavy equipment, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given X 3. cm9

20:21 Patient left the ED. cm9

Corrections:

19:00 ~~18:51 To radiology for ABDOMEN W/IV CONTRAST ONLY+CT.~~ ~~cp1~~ EDMS

19:17 ~~18:51 To radiology for PELVIS WITH IV CONTRAST ONLY+CT.~~ ~~cp1~~ EDMS

20:21 ~~20:04 BP 128 / 70; Pulse 82bpm; Resp 18bpm; Pulse Ox 97% RA;~~ ~~cm9~~ cm9

Medication	Prescribing Physician	Dose	Frequency	Last Dose	Physician Order Continue on Admission/Discharge?
Prozac Weekly oral Unknown		Unknown	20 mg daily		Y N
None					Y N

Signatures:

Pacheco, Cindy, RN	RN	cp1	Dew, Cathy, MST	MST	cd1
McDowell, Chad RN	RN	cm9	Dow, Aileen RN	RN	ad2
Billings, Tammy RN	RN	tb6	Barton, Kathy B RN	RN	kb6
DeSalvo, Matthew, MD	MD	mjd	Albani, Vanessa, MST	MST	va3
Baker, Crystal		cb6			

Name: Daniel Knight
[redacted]
Arrival Date: 04/27/2016 **Time:** 18:23
Bed H3

MRN: M000175313
Account#: V00006905806
Private MD:

HPI:

04/27 19:39 This 41 yrs old Caucasian Male presents to ED via EMS with complaints of **Motor Vehicle Collision (MVC)**. mjd

19:44 (19:45) The patient was a driver of a car. The patient was restrained by a lap belt, with a shoulder harness, and air bag was deployed. The vehicle was impacted on the and was traveling at high speed, The vehicle did not rollover, the patient was not ejected from the vehicle, the patient had to be extricated from vehicle, the patient was not ambulatory at the scene, the force of impact was high. (19:45) Onset: The symptoms/episode began/occurred suddenly, just prior to arrival, today. (19:45) Associated signs and symptoms: Pertinent positives: abdominal pain, chest pain, headache, Pertinent negatives: numbness, shortness of breath, weakness, Loss of consciousness: the patient experienced loss of consciousness, the patient was "dazed". (19:45) Severity of symptoms: At their worst the symptoms were moderate, in the emergency department the symptoms are unchanged. (19:45) The patient has not experienced similar symptoms in the past. (19:45) The patient has not recently seen a physician. mjd

Historical:

Allergies:

18:31 (18:32) SULFA (SULFONAMIDES); (18:32) PCN; kb6

19:44 (19:46) SULFA (SULFONAMIDES); (19:46) PCN; mjd

Home Meds:

18:31 (18:32) 1. . Prozac Weekly oral Unknown Unknown 20 mg daily kb6

19:44 (19:46) 1. . None mjd

PMHx:

18:31 (18:32) Anxiety; kb6

19:44 (19:46) NONE; mjd

PSHx:

18:31 (18:32) None; kb6

19:44 (19:46) NONE; mjd

Historical:

18:30 Code Status: Full code. kb6

18:31 (18:32) Medication Information obtained from: Patient. (18:32) Social history Smoking status: Patient denies tobacco use. No barriers to communication noted. (18:32) Immunization history: Last tetanus immunization: up to date. Pneumococcal vaccine is up to date. Flu vaccine is up to date. (18:32) Do you have an Advanced Directive or Health Care Power of Attorney? No. (18:32) Family history: Not pertinent. kb6

19:44 (19:46) Social history Smoking status: Patient denies tobacco use. (19:46) The history from nurses notes was reviewed and I agree with what is documented up to this point. mjd

ROS:

19:44 (19:46) **Constitutional:** Negative for fever, chills **ENT:** Negative for injury, pain, and discharge, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling. (19:46) **Back:** Negative for decreased range of motion, pain with movement. (19:46) **MS/extremity:** Negative for decreased range of motion, deformity. (19:46) **Skin:** Positive for abrasion(s), Negative for laceration(s). (19:46) **General:** Other as in HPI, (19:46) **General:** All other systems are negative, mjd

Exam:

19:44 (19:47) mjd

Constitutional: The patient appears in no acute distress, alert, awake, comfortable, non-diaphoretic, non-toxic, well developed, well hydrated, well groomed, well nourished. (19:47)

Eyes: Pupils: equal, round, and reactive to light and accomodation, Extraocular movements: intact throughout, Sclera: icterus, is not appreciated. (19:47)

Neck: C-spine: C-collar is removed, after CT scanning reveals no obvious unstable abnormality, vertebral tenderness, is not appreciated, muscle tenderness, that is mild, crepitus, is not appreciated. (19:47)
Respiratory: the patient does not display signs of respiratory distress, moderate respiratory distress is noted, Respirations: no acute changes, labored breathing, asymmetrical chest movement, Breath sounds: are normal. (19:47)
Back: pain, is absent, ROM is normal. (19:47)
Musculoskeletal/extremity: Extremities: all appear grossly normal, with no appreciated pain with palpation, ROM: intact in all extremities. (19:47)
Skin: injury, abrasion(s), very small abrasion noted. (19:47)
Neuro: Orientation: is normal, appropriate for stated age, Mentation: is normal, appropriate for stated age.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
18:25 (19:32)	119 / 83	83	20		94% on R/A				ad2
18:29 (18:30)	127 / 79	84	18	97.7(TE)	97% on R/A	76.2 kg / 167.99 lbs (R)	5 ft. 3 in. (160.02 cm) (R)	5/10	va3
18:42 (19:32)	126 / 77	86	20		97% on R/A				ad2
18:50 (19:32)	126 / 78	87	20		99% on R/A				ad2
19:00 (19:32)	125 / 76	78	20		96% on R/A				ad2
19:12 (19:32)	133 / 70	81	20		96% on R/A				ad2
19:34 (19:35)	129 / 71	84	18		97% on R/A				cm9
20:04 (20:21)	128 / 70	82	18		97% on R/A			5/10	cm9

18:29 Body Mass Index 29.76 (76.20 kg, 160.02 cm) va3

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
18:30	spontaneous(4)	oriented(5)	obeys commands(6)		15	kb6
20:21	spontaneous(4)	oriented(5)	obeys commands(6)		15	cm9

Trauma Score (Adult):

Time	Eye Response	Verbal Response	Motor Response	Systolic BP	Repiratory Rate	Glasgow Score	Trauma Score	Staff
18:30	spontaneous(1)	oriented(1)	obeys commands(2)	> 89 mm Hg(4)	10 to 29 per min (4)	15	12	kb6
20:21	spontaneous(1)	oriented(1)	obeys commands(2)	> 89 mm Hg(4)	10 to 29 per min (4)	15	12	cm9

MDM:

18:29 Patient medically screened. cb6
18:29 Financial registration complete. cb6
19:44 mjd
(19:48)
Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies, CT scan. (19:48)

Physician Documentation Con't.

Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up, to return to the emergency department if symptoms worsen or persist or if there are any questions or concerns that arise at home. (19:48)
Test interpretations performed by ED physician or midlevel provider: plain radiologic studies were reviewed, Lab studies, A CT scan was reviewed, comment(s), if any: the Ct scan was reviewed with radiology, it was normal. (19:48)
Response to treatment: the patient's symptoms have markedly improved after treatment. (19:48)
ED course: ***CLEARED FROM C-COLLAR*** I repeated my evaluation of this patient during the ED course.

Order	Status	Time	By	For
NC oxygen to keep sats >92%	Ordered	04/27/16 18:27	mjd	mjd
	Completed	04/27/16 18:33	Kathy B Barton	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
SALINE LOCK	Ordered	04/27/16 18:27	mjd	mjd
	Completed	04/27/16 18:33	Kathy B Barton	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
VS q 15min X 2, then q 30 min X 2, then hourly	Ordered	04/27/16 18:27	mjd	mjd
	Completed	04/27/16 18:33	Kathy B Barton	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
CBC W/ AUTO DIFF	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
CMP: CMP includes HEPAN, if HEPAN needed ORDER DBIL	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
LACTIC ACID	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
PT	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Physician Documentation Con't.

Order	Status	Time	By	For
PTT	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
TYPE & SCREEN	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:52	Matthew DeSalvo	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
ABDOMEN W/IV CONTRAST ONLY	Ordered	04/27/16 18:27	mjd	mjd
	Canceled	04/27/16 19:00	Dispatcher MedHost	
Notes: Bed Name: ED12	**Order Method:** Electronic			
Reason for Cancellation: 11820477				

Order	Status	Time	By	For
Cervical Spine W/o Contrast *	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes: Bed Name: ED12	**Order Method:** Electronic			

Order	Status	Time	By	For
CT CHEST WITH CONTRAST	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes: Bed Name: ED12	**Order Method:** Electronic			

Order	Status	Time	By	For
CT HEAD W/O CONTRAST	Ordered	04/27/16 18:27	mjd	mjd
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes: Bed Name: ED12	**Order Method:** Electronic			

Order	Status	Time	By	For
PELVIS WITH IV CONTRAST ONLY	Ordered	04/27/16 18:27	mjd	mjd
	Canceled	04/27/16 19:17	Dispatcher MedHost	
Notes: Bed Name: ED12	**Order Method:** Electronic			
Reason for Cancellation: DUPLICATE ORDER				

Order	Status	Time	By	For
NS 0.9% 1000 mL IV at Bolus once	Ordered	04/27/16 18:27	mjd	mjd
	Administered	04/27/16 18:33	kb6	
Notes:	**Order Method:** Electronic			

04/27/16 18:33	**Administered:** NS 0.9% 1000 mL	kb6
04/27/16 20:16	**Follow Up:** IV Status: Completed infusion	cm9

Order	Status	Time	By	For
ABDOMEN AND PELVIS IV ONLY	Ordered	04/27/16 19:04	EDMS	
	Reviewed	04/27/16 19:38	Matthew DeSalvo	
Notes:	**Order Method:**			
	Sign off: DeSalvo, Matthew, MD 04/27/16 19:39			

Order Signatures:

DeSalvo, Matthew, MD	MD	mjd	Conway Emergency Group
Dispatcher MedHost		EDMS	

Dispensed Medications:

Time	Drug & Dose	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
18:33	NS 0.9% 1000 mL		IV	Bolus		left hand		kb6
20:16	Follow up: IV Status: Completed infusion							cm9

Disposition:

19:44 (19:51) Disposition. mjd

Disposition:

04/27/16 19:51 Discharged to Home. Impression: Whiplash, Other - MVC, Hand Abrasion, Abrasion of Multiple Sites w/o Infection, Chest Contusion, Abdominal Wall Contusion.

- Condition is Stable.
- Discharge Instructions: Abrasions, Whiplash, Motor Vehicle Collision, Easy-to-Read, Chest Contusion, Easy-to-Read.
- Prescriptions for
  Flexeril 10 mg Oral Tablet
  - take 1 tablet by ORAL route 3 times per day; 15 tablet.
  Naprosyn 500 mg Oral Tablet
  - take 1 tablet by ORAL route 2 times per day with food; 30 tablet.
  Percocet 5
  - 325 mg Oral Tablet - take 1 to 2 tablet by ORAL route Every 8 hours as needed As needed; 15 tablet.
- Follow up: Private Physician; When: 2 - 3 days; Reason: Further diagnostic work-up, Recheck today's complaints.
- Problem is new.
- Symptoms have improved.

Signatures:

Dispatcher MedHost		EDMS	McDowell, Chad RN	RN	cm9
Barton, Kathy B RN	RN	kb6	DeSalvo, Matthew, MD	MD	mjd
Baker, Crystal		cb6			

Corrections:

19:00 ~~18:32 ABDOMEN W/IV CONTRAST ONLY+CT ordered.~~ ~~EDMS~~ EDMS

19:17 ~~18:32 PELVIS WITH IV CONTRAST ONLY+CT ordered.~~ ~~EDMS~~ EDMS

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 04/28/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006905806 LOC: ER U#: M000175313
REG DR: Desalvo, Matthew MD [redacted] ROOM: REG: 04/27/16
DOB: 09/26/74 DIS:

Specimen: 0427:C00217S Entered: 04/27/16-1828 Collected: 04/27/16-1834
Status: COMP Received: 04/27/16-1843
Tests: CMP
Sub Dr: Desalvo, Matthew MD
Comments: Specimen Comment: ED12

Test	Result	Flag	Reference
**********CHEMISTRY**********			
COMPREHENSIVE METABOLIC PANEL			
> GLUCOSE,RANDOM	135	*H*	70-110 mg/dL
> BUN	33	*H*	7-18 mg/dl
> CREATININE	1.27		0.7-1.30 mg/dl
> ESTIMATED GFR	> 60		mL/min
> SODIUM	137		136-145 mmol/L
> POTASSIUM	3.6		3.5-5.1 mmol/L
> CHLORIDE	104		93-108 mmol/l
> ANION GAP	6.0	*L*	7-16 mmol/L
> CARBON DIOXIDE	27		21-32 mmol/L
> CALCIUM	9.0		8.5-10.1 mg/dl
> TOTAL PROTEIN	7.6		6.4-8.2 gm/dL
> ALBUMIN	3.9		3.4-5.0 gm/dl
> GLOBULIN	3.7		gm/dL
> BILIRUBIN,TOTAL	0.3		0.2-1.0 mg/dL
> ALK PHOS	74		45-117 U/L
> SGOT,AST	92	*H*	10-40 U/L
> SGPT,ALT	114	*H*	16-61 U/L

** END OF REPORT **

5A4D43B46E10429588C8, KNIGHT, 677

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 04/28/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006905806 LOC: ER U#: M000175313
REG DR: Desalvo, Matthew MD [redacted] ROOM: REG: 04/27/16
DOB: 09/26/74 DIS:

Specimen: 0427:CG00050S Entered: 04/27/16-1828 Collected: 04/27/16-1834
Status: COMP Received: 04/27/16-1843
Tests: PROT, PTT
Sub Dr: Desalvo, Matthew MD
Comments: Specimen Comment: ED12

Test	Result	Flag	Reference
**********COAGULATION**********			
PROTHROMBIN TIME			
> PROTIME	14.4	*H*	9.4-12.5 SEC
> INR	1.38		
> APTT	27.4		25.0-36.0 SEC
	THERAPEUTIC RANGE FOR CONTINUOUS HEPARIN INFUSION:		
	49 - 93 SEC		

** END OF REPORT **

5A4D43B46E10429588C8, KNIGHT, 678

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 04/28/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006905806 LOC: ER U#: M000175313
REG DR: Desalvo, Matthew MD [redacted] ROOM: REG: 04/27/16
DOB: 09/26/74 DIS:

Specimen: 0427:CR00020S Entered: 04/27/16-1828 Collected: 04/27/16-1834
Status: COMP Received: 04/27/16-1843
Tests: LACTA
Sub Dr: Desalvo, Matthew MD
Comments: Specimen Comment: ED12

Test	Result	Flag	Reference
**********CHEMISTRY**********			
> LACTIC ACID	0.9		0.4-1.9 mmol/L

** END OF REPORT **

5A4D43B46E10429588C8, KNIGHT, 679

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 04/28/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC
REG DR: Desalvo, Matthew MD
ACCT #: V00006905806
[redacted]
LOC: ER
ROOM:
DOB: 09/26/74
U#: M000175313
REG: 04/27/16
DIS:

Specimen: 0427:H00135S Entered: 04/27/16-1828 Collected: 04/27/16-1834
Status: COMP Received: 04/27/16-1843
Tests: CBC W/AUTO DIFF, CBC W/AUTO DIFF
Sub Dr: Desalvo, Matthew MD
Comments: Specimen Comment: ED12

Test	Result	Flag	Reference
**********HEMATOLOGY**********			
CBC W/AUTO DIFF			
CBC A			
> WBC	9.4		4.5-11.0 K/mm3
> RBC	4.65		4.50-5.50 M/mm3
> HGB	14.5		14.0-17.4 g/dL
> HCT	41.9	L	45.0-52.0 %
> MCV	90.0		80.0-100.0 fl
> MCH	31.2		28.0-34.0 pg
> MCHC	34.7		32.0-36.0 g/dl
> RDW	12.8		12.0-14.6 %
> PLT	226		150-450 K/mm3
> NEUT %	69.1		%
> LYMPH %	22.3		%
> MONO %	6.1		%
> EOS %	1.8		%
> BASO %	0.7		%
> NEUT #	6.5		1.8-7.7 K/mm3
> LYMPH #	2.1		1.0-4.8 K/mm3
> MONO #	0.6		0.1-0.8 K/mm3
> EOS #	0.2		0.0-0.4 K/mm3
> BASO #	0.1		0.0-0.2 K/mm3

** END OF REPORT **

5A4D43B46E10429588C8, KNIGHT, 680

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 04/28/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006905806 LOC: ER U#: M000175313
REG DR: Desalvo, Matthew MD [redacted] ROOM: REG: 04/27/16
DOB: 09/26/74 DIS:

Specimen: 0427:BB00022S Entered: 1827 Collected: 1834
Status: COMP Recieved: 1843 Sub Dr: Desalvo, Matthew MD

Test: TYPE/SCREEN

Test	Result	Flag	Reference
ABO/RH TYPE			
> ABO/Rh TYPE	A POS		
> AB SCREEN	NEGATIVE		

** END OF REPORT **

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Desalvo, Matthew MD
[redacted] Sex: M
Acct: V00006905806 Loc: ER
Exam Date: 04/27/2016 Status: REG ER
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 74177

ADMITTING DX: MVA

EXAM#	TYPE/EXAM	RESULT
001429236	CT/ABDOMEN AND PELVIS IV ONLY	
001429238	CT/CHEST WITH CONTRAST	

CT chest with contrast 4/27/2016

History: Motor vehicle accident

Comparison: None

Technique: Axial CT images were obtained from the lung apices through the adrenal glands after intravenous contrast was administered. There was no immediate adverse reaction.

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable. 100 cc Optiray 320

Findings: The heart and great vessels are unremarkable without pericardial effusion. No evidence of mediastinal injury. No pathologic adenopathy. There is significant bilateral gynecomastia.

No airspace disease, effusion, or pneumothorax. The central airways are widely patent.

There are no acute bony abnormalities. Reconstructed images demonstrate no additional findings.

Impression:
1. No acute intrathoracic trauma.

CT abdomen and pelvis with contrast 4/27/2016

History: Motor vehicle accident

Comparison: None

Technique: Axial CT images were obtained from the lung bases through the pubic symphysis after intravenous contrast was administered. There was no immediate adverse reaction.

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Desalvo, Matthew MD
[redacted] Sex: M
Acct: V00006905806 Loc: ER
Exam Date: 04/27/2016 Status: REG ER
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 74177

ADMITTING DX: MVA

EXAM#	TYPE/EXAM	RESULT
001429236	CT/ABDOMEN AND PELVIS IV ONLY	
001429238	CT/CHEST WITH CONTRAST	

<Continued>

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable. 100 cc Optiray 320

Findings:
Abdomen: The liver, gallbladder, pancreas, spleen, adrenals, and kidneys enhance normally.

There is no free fluid, free gas, or lymphadenopathy within the upper abdomen. No bowel obstruction or ileus. A normal appendix is identified. There are no acute bony abnormalities. Reconstructed images demonstrate no additional findings.

Pelvis: There is trace pelvic free fluid. I do not see any free gas or lymphadenopathy. No bowel obstruction or ileus. The prostate is normal. The bladder is unremarkable. There are no acute fractures.

Impression:
1. Trace pelvic free fluid, nonspecific.
2. Otherwise unremarkable CT of the abdomen and pelvis.

Electronically Signed By: Michael Brown

** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/27/2016 **
Reported By: MICHAEL H. BROWN, MD

CC:

Technologist: GREG O'SULLIVAN, R.T.(R)
Transcribed Date/Time: 04/27/2016 (1930)
Transcriptionist: BROMI
Printed Date/Time: 04/27/2016 (1930)

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Desalvo, Matthew MD
[redacted] Sex: M
Acct: V00006905806 Loc: ER
Exam Date: 04/27/2016 Status: REG ER
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 72125

ADMITTING DX: MVA

EXAM#	TYPE/EXAM	RESULT
001429237	CT/CERVICAL SPINE WITHOUT CONT.	

CT cervical spine without contrast 4/27/2016

History: Motor vehicle accident

Comparison: None

Technique: Axial CT images were obtained through the cervical spine without contrast. Sagittal and coronal reconstructions were later performed.

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable.

Findings: The cervical vertebral bodies are in grossly normal anatomic alignment. There is prominent spondylosis at C5-6 and C6-7 with disc space narrowing and osteophyte formation. I do not see any acute displaced cervical spine fractures. Prevertebral soft tissues are unremarkable. Airway is widely patent, and visualized portions of the lung apices are clear.

Reconstructed images demonstrate no additional findings.

Impression:
1. Cervical spondylosis, no acute fracture.

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Desalvo, Matthew MD
[redacted] Sex: M
Acct: V00006905806 Loc: ER
Exam Date: 04/27/2016 Status: REG ER
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 72125

ADMITTING DX: MVA

EXAM#	TYPE/EXAM	RESULT
001429237	CT/CERVICAL SPINE WITHOUT CONT.	

<Continued>

Electronically Signed By: Michael Brown

** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/27/2016 **
Reported By: MICHAEL H. BROWN, MD

CC:

Technologist: GREG O'SULLIVAN, R.T.(R)
Transcribed Date/Time: 04/27/2016 (1926)
Transcriptionist: BROMI
Printed Date/Time: 04/27/2016 (1926)

CONWAY MEDICAL CENTER
PO BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526-0829
(843) 347-8132

Name: KNIGHT,DANIEL ERIC
Phys: Desalvo, Matthew MD
[redacted] Sex: M
Acct: V00006905806 Loc: ER
Exam Date: 04/27/2016 Status: REG ER
Radiology No: 00108009
Unit No: M000175313
Patient Phone: (330)719-5830
CPT4 Code: 70450

ADMITTING DX: MVA

EXAM#	TYPE/EXAM	RESULT
001429239	CT/HEAD WITHOUT CONTRAST	

CT head without contrast 4/27/2016

History: Motor vehicle accident

Comparison: None

Technique: CT images were obtained through the brain and posterior fossa without intravenous contrast.

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight based dosing when appropriate to reduce radiation dose to as low as reasonably achievable.

Findings: Unenhanced images of the brain demonstrate no acute infarct or hemorrhage. Lateral ventricles and midline structures are unremarkable. There are no acute extra-axial fluid collections. There is no mass effect. Mucosal thickening is seen within the maxillary sinuses. No acute bony abnormalities.

Impression:
1. No acute intracranial trauma.

Electronically Signed By: Michael Brown

** REPORT SIGNED IN OTHER VENDOR SYSTEM 04/27/2016 **
Reported By: MICHAEL H. BROWN, MD

CC:

Technologist: GREG O'SULLIVAN, R.T.(R)
Transcribed Date/Time: 04/27/2016 (1925)
Transcriptionist: BROMI
Printed Date/Time: 04/27/2016 (1925)

ADMISSION RE D CON C HOSPITAL AY, S.C. MEDICA :CORDS COPY

Unit #	Patient	Admit Date and Time	Location/Room	Visit #
M000175313	KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY,SC 29527 (330)719-5830	07/08/16 0537	SURE SUR232-1	V6933263
		Discharge Date and Time	Previous Admission/Visit	PTC: IN MSV: SU F/C: CO
Maiden Name	Patient SS #	Physician: Rimkus, Gilbertas MD		

[redacted]

Admitting Diagnosis	Healthcare Power of Attorney	Living Will
INC HERNIA ILEOSTOMY		

How Arrived	Date, Time, Place of Accident	LMD	Smoking Cessation Materials Provided	Proration
	07/07/16 DATE ONSET OF SYMPTO			

Surgeon		Consultant

Principal Diagnosis

Secondary Diagnosis

Complications

Operations

Hospital Infections

Results of Discharge	Recovered	Improved	Not Improved	Not Treated	In For Diagnosis	Expired

MTADN04

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

[redacted]
Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

CASE MANAGEMENT - Discharge Plan

D/C Date 07/10/16 DISCHARGE DISPOSITION: H DC Dispostion Status: N
PCP

SPECIFIC DISCHARGE DISPOSITION LOCATION:

SUB ACUTE REHAB	ALF	HOSPICE
HHS	ACUTE REHAB	
PSYCHIATRIC:	DSS	DME
LTAC	NH - LONG TERM CARE	DME - Ordered Equipment:
	CLTC	:

HANDOUTS GIVEN:

Community Clinics	Long Term Care	Home Care	Transportation
Resource Directory	Social Security	Rx Assist	
Substance Abuse	Homelessness	RCF	Advance Directives

Other:

~~~~~~REFERRALS WERE MADE FOR THE FOLLOWING AGENCIES:~~~~~~

ALF (Assisted Living Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

SNF (Skilled Nursing Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HOSPICE
TO FACILITY: Referral status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

ACUTE REHAB REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HHS (Home Health Services)
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
~~~~~~

CM DISCHARGE PLAN

[redacted]

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

TO AGENCY: Referral Status:

NH-LTC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

CLTC (Community Long Term Care) Referral Status:
DSS REFERRAL:
TO WHICH SERVICE: Referral Status:

DME REFERRAL:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:

PSYCHIATRIC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

TRANSITIONAL CARE:
Contact Date: 07/12/16
Contact Time: 1120

Follow up Appointment:
Physician: RIMGI Date: 07/12/16 Time: 1440
Physician: Date: Time:
Physician: Date: Time:

Follow up appointment scheduled prior to D/C. N
Follow up appointment scheduled post D/C. Y

New Primary Care Provider Established. N New Primary Care Provider:
Comments: PATIENT WAS DISCHARGE HOME WITH HIS WIFE.
PT STATES DOING OK HAS F/U WITH SURGERY TODAY DENIES ANY NEEDS OR CONCERNS @ PRESENT

615386661D8848E0B793, KNIGHT, 7

CM DISCHARGE PLAN

[redacted]

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

Occurred Date: 07/17/16 Occurred Time: 0706
Monogram: BTM Initials: BMCCORMICK Name: MCCORMICK,BRANDI T Nurse Type: LPN

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

[redacted]
Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

CASE MANAGEMENT - Discharge Plan

D/C Date 07/10/16 DISCHARGE DISPOSITION: H DC Dispostion Status: N
PCP

SPECIFIC DISCHARGE DISPOSITION LOCATION:

SUB ACUTE REHAB	ALF	HOSPICE
HHS	ACUTE REHAB	
PSYCHIATRIC:	DSS	DME
LTAC	NH - LONG TERM CARE	DME - Ordered Equipment:
	CLTC	:

HANDOUTS GIVEN:

Community Clinics	Long Term Care	Home Care	Transportation
Resource Directory	Social Security	Rx Assist	
Substance Abuse	Homelessness	RCF	Advance Directives

Other:

~~~~~~REFERRALS WERE MADE FOR THE FOLLOWING AGENCIES:~~~~~~

ALF (Assisted Living Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

SNF (Skilled Nursing Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HOSPICE
TO FACILITY: Referral status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

ACUTE REHAB REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HHS (Home Health Services)
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
~~~~~~

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

[redacted]
Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

TO AGENCY: Referral Status:

NH-LTC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

CLTC (Community Long Term Care) Referral Status:
DSS REFERRAL:
TO WHICH SERVICE: Referral Status:

DME REFERRAL:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:

PSYCHIATRIC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

TRANSITIONAL CARE: Follow up Appointment:
Contact Date: Physician: Date: Time:
Contact Time: Physician: Date: Time:
Physician: Date: Time:

Follow up appointment scheduled prior to D/C.
Follow up appointment scheduled post D/C.

New Primary Care Provider Established. New Primary Care Provider:
Comments: PATIENT WAS DISCHARGE HOME WITH HIS WIFE.

Occurred Date: 07/11/16 Occurred Time: 0712

615386661D8848E0B793, KNIGHT, 10

CM DISCHARGE PLAN

[redacted]

Patient: KNIGHT,DANIEL ERIC
Account #: V00006933263
Admit Date: 07/08/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

Monogram: JB Initials: JBURLESON Name: BURLESON,GLORIA JEAN Nurse Type: RN

ANS-281-F
REV 3 04.19.16

Conway Medical Center
Conway, South Carolina

V000069332
KNIGHT,DANIEL ERIC
[redacted]
Rimkus, Gilbertas MD
M000175313

Consent for Anesthesia Services

I Daniel Knight, acknowledge that I will have an operation, diagnostic/treatment procedure or planned vaginal delivery. I understand that anesthesia services may be needed/requested.

It has been explained to me that there are **risks** for any anesthesia planned and that no promises or guarantees can be made. Although rare, unexpected severe complications with anesthesia can occur including a remote possibility of *infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, or death.* With present anesthesia practices these complications are extremely rare and risk may vary with my general medical health. I understand these risks apply to all forms of anesthesia and that additional or specific risks have been identified below.

I understand that the type(s) of anesthesia checked below will be used for my procedure and that the planned anesthesia is determined by many factors including my physical condition, the type of procedure and the physician's preference as well as my own desire. I understand that the planned anesthesia may not succeed completely and another technique may have to be used.

☑ General Anesthesia ☐ TIVA	Expected Result	Total unconscious state, possible placement of a tube into the windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia
☐ Spinal or Epidural Analgesia/ Anesthesia ☐ With sedation ☐ Without sedation	Expected result	Temporary decrease or loss of feeling and/or movement to lower part of body
	Technique	Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal"
☐ Major/Minor Nerve Block ☐ With sedation	Expected result	Temporary loss of feeling and /or movement of a specific limb or area of the body
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ Intravenous Regional Anesthesia ☐ With sedation	Expected result	Temporary loss of feeling and/or movement of a limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels
☐ Monitored Anesthesia Care (with sedation)	Expected result	Reduced anxiety and pain, partial or total amnesia
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes producing a semi-conscious state
	Risks	An unconscious state, depressed breathing, injury to blood vessels
☐ Monitored Anesthesia Care (without sedation)	Expected result	Measurement of vital signs, availability of anesthesia provider for further intervention
	Technique	None
	Risks	Increased awareness, anxiety and/or discomfort

ANS-281-F
REV 3 04.18.16

Con Medical Cent
Conway, South Carolina

V0000693326
KNIGHT, DANIEL ERIC
[redacted]
Rimkus, Gilbertas MD
M000175313

Consent for Anesthesia Services

I consent to the anesthesia checked above and authorize that it be ad ministered by a member of Conway Anesthesia Associates and/or a member of Conway Hospital Anesthesia Professional Services. I consent to an appropriate, alternate type of anesthesia, if necessary.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

X [signature] 7/08/16 1233 _____

(Patient or authorized person) (Date) (Time) (Relationship if authorized person)

_____/_____/_____ Reason for authorized person signature

(Witness) (Date) (Time) ☐ Minor Patient

No witness required if patient signature obtained by provider ☐ Incapacitated patient (form 441 required)

An interpreter or other special assistance was used to assist patient in completing this form as follows:

☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient

☐ Other: (specify) _____ _____

(name of interpreter or service)

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the nature of the procedure(s), anticipated benefits, material risks, alternative therapies and the risks associated with the alternative of the procedure(s).

[signature] 7,08,16 1233

Signature of Physician Date Time

Transfusion Consent

I understand there are potential risks from blood transfusion including, but not limited to, transfusion reaction, hepatitis, and HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome).

I do _____ **or do not** _____ **give consent to the use of blood and/or blood products** as deemed necessary
Patient/ PR initials Patient/ PR initials

during this operation/procedure.

(Refusal requires completion and signature of form #28 "Refusal to Receive Blood Transfusion")

Patient acknowledgement of Anesthesia providers on day of service

I acknowledge that _____ or his/her privileged associate will provide my anesthesia.

_____ _____ _____ _____

(Patient or authorized person) (Date) (Time) (Relationship if authorized person)

615386661D8848E0B793, KNIGHT, 13

ADM-5172-FRM REV 4 09

Conway M · l Center

Conv SC

Unit#	Patient	Admit Date & Time	Location/Room	Visit#
M000175313	KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY,SC 29527 (330)719-5830		ODS	V6933263
		Discharge Date & Time	Previous Admission/Visit: 05/18 06/16 PTP SDC MSV F/C CO	
Maiden Name	Patient SS#		Physician: Rimkus, Gilbertas MD	
Sex: M / Race: CA / Marital: M / [redacted] gion: NONE			Patient Mother's Name: BETZ, ROSEMARIE	

CONWAY MEDICAL CENTER
CONSENT AND CONDITIONS OF ADMISSION AND GUARANTY

In consideration for the medical care to be provided to the patient by Conway Hospital, Inc. d/b/a Conway Medical Center ("The Hospital"), the undersigned patient guarantor, and/or responsible party (individually and collectively hereinafter referred to as the "undersigned") hereby consent to the following conditions of treatment and admissions:

1) CONSENT FOR TREATMENT: The undersigned authorizes and consents to the admission of the patient and all medical care, treatment, services, examinations, tests and procedures, which may be performed during this hospitalization or outpatient treatment including but not limited to surgery, x-ray examination, laboratory tests, diagnostic procedures, and anesthesia, which a Physician, the Hospital, their employees, nurses, associates, assistants or assignee deem advisable to the patient. The undersigned further agrees that no guaranty has been made to the undersigned about the outcome of the care and treatment during this admission/service.

2) HOSPITAL AND PHYSICIAN: The undersigned agrees that some Physicians and the like which are providing medical care or services to the patient are not employees or agents of the Hospital or its subsidiaries, and the undersigned agrees that the Hospital is not responsible or liable for the acts or omissions of non-Hospital employees. Further, the undersigned agrees there will be a separate charge for professional services including the professional component of clinical laboratory tests, but understands that the Hospital may bill for some professional fees.

3) PAYMENT GUARANTEE: The undersigned agrees and guarantees to pay all Hospital charges to the Hospital in accordance with the regular rates and terms of the Hospital, and agrees to pay for any balance and all charges not covered by a third party payer. The Hospital files insurance as a courtesy and the undersigned is ultimately responsible for payment of the total incurred charges. The undersigned agrees that if this account is not paid timely, it may be turned over to a collection agency or attorney, and in such circumstances, the undersigned, shall be obligated to pay the amount due plus all costs of collection including reasonable attorney fees. The undersigned agrees that overpayment collected on this account may be applied directly to any past delinquent account(s) of the patient. The undersigned patient, responsible party and guarantor, if any, hereby agrees that they are jointly and severally liable to pay the Hospital for any and all charges, any balance due and costs associated with this treatment and/or admission.

4) ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: The undersigned hereby assigns unto the Hospital any and all rights and benefits the undersigned patient or responsible party may have under any policy of insurance (hospitalization, major medical, automobile, workers compensation, or third party liability insurance), and further directs any such insurance company to make payment of benefits directly to the Hospital or its attorney. In the event that the undersigned is entitled to any insurance or benefits covering physician services, the undersigned hereby assigns said benefits to the physicians rendering care, treatment, or service to be applied to the patient's and/or the undersigned's bill. If the patient's treatment is as a result of any accident and the patient has a claim against a third party, the Hospital has the option to pursue the automobile coverage or third party liability proceeds as a primary source of payment. If the Hospital exercises this option, the patient and/or responsible party agree to assign the proceeds of any settlement or recovery in the accident claim toward the payment of any outstanding Hospital charges. This authorization is irrevocable by the undersigned.

5) AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE BENEFITS: The undersigned patient and or responsible party authorizes the Hospital to contact the undersigned's insurance company and its agents, the undersigned's employer or other party payer including the patient's spouse, if applicable, to verify insurance or hospital coverage, to discuss all medical and financial information pertaining to the admission/service that may be required in processing or collecting on this claim. The undersigned authorizes and acknowledges that all medical and financial records will be accessible to all health care providers participating in the patient's care or treatment and acknowledges that patient medical records at the Hospital are stored electronically and are made available through computer networks to Hospital personnel, physicians and those health care providers involved in the patient's care. The undersigned further authorizes the Hospital, its collection agency, or attorney to obtain and review, at any time, the credit report of the patient, guarantor, and/or responsible party.

6) CHAMPUS/CHAMPVA CERTIFICATION: The undersigned requests payment of authorized benefits to the patient or on patient's behalf for medical treatment and services from the Hospital including physician services, and authorizes any holder of medical information regarding the patient to release to CHAMPUS and its agents any information needed to determine these benefits or benefits for related services.

7) MEDICARE PATIENT CERTIFICATION: The undersigned certifies that information given by the undersigned in applying for payment under the Medicare Program is correct. The undersigned hereby authorizes any holder of medical or other information about the patient to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The undersigned authorizes the payment of the patient's benefits to the Hospital.

8) AUTHORIZATION TO CONTACT:
I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or email, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

[signature] , 7/8/16, 10:30
(Patient or authorized person) (Date) (Time)

(Relationship if authorized person)

[signature] 7/8/16 10:30
(Witness) (Date) (Time)

Reason for authorized person signature
☐ Minor Patient
☐ Incapacitated patient (form 441 required)

No witness required if patient signature obtained by provider

An interpreter or other special assistance was used to assist patient in completing this form as follows:
☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient
☐ Other: (specify) _____ (name of interpreter or service) _____

RSK-02-FI
Rev 4 04.12.16

Con Medical Ce
Conway, South Carolina

V0000693
ODS
KNIGHT,DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
[redacted]
Rimkus, Gilbertas MD
M000175313

Consent to Operation and Other Medical Services

I Daniel Knight (name of patient), hereby authorize Dr. G. Rimkus and any associates or assistants the doctor deems appropriate, to perform: Takedown of ileostomy and repair of incisional Hernia (Description of operation/procedure in laymen's language)

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s).

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infections, heart complications, blood clots, loss of or loss of use of body part, damage to teeth, other neurological injury or death.

I understand that during the course of the operation/procedure, unforeseen conditions may occur or be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I hereby authorize and request that the above-named physician and/or his associates, partners, assistants or designees perform such procedures as are necessary and desirable in the exercise of his/her professional judgment.

The doctor has explained to me the reasonable alternative(s) to the procedure(s).

I hereby authorize the doctor or hospital personnel to utilize, dispose of, or store for future testing (as ordered by your physician) removed tissues, parts or organs resulting from the procedure(s) authorized above.

I consent to any photographing or video recording of the procedure(s) that may be performed as may be necessary and appropriate for the procedure(s) and do permit such photographs/video.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining/providing important product information.

APPLIES TO DNR PATIENTS ONLY

I have an Advance Directive, Living Will, and/or Do Not Resuscitate Order

I choose to suspend my Advance Directive, Living Will, and/or Do Not Resuscitate Order during my procedure or recovery from anesthesia/sedation ☐ Yes ☐ No

If No, contact physician performing the procedure prior to completing the consent

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

x [signature] 7, 8, 16 1100
(Patient or authorized person) (Date) (Time)

(Relationship if authorized person)

Carrie Knight 7, 8, 16 1100
(Witness) (Date) (Time)

No witness required if patient signature obtained by provider

Reason for authorized person signature
☐ **Minor Patient**
☐ **Incapacitated patient (form 441 required)**

An interpreter or other special assistance was used to assist patient in completing this form as follows:
☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient
☐ Other: (specify) _____ _____ (name of interpreter or service)

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the nature of the procedure(s), anticipated benefits, material risks, alternative therapies and the risks associated with the alternative of the procedure(s).

[signature] 7, 8, 16 12:30pm
Signature of Physician Date Time

HIM-465-FRM
REV 1 01.08.15

Conway Medical Center
Conway, South Carolina

Patient Acknowledgement Form

0006933263
ODS
KNIGHT, DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
[redacted]
Rimkus, Gilbertas MD
M000175313

Instructions: The patient or the patient's representative must acknowledge in the spaces provided the receipt of information regarding the following regulatory requirements:

HOSPITAL INFECTIONS DISCLOSURE ACT:

☑ I have been informed that all hospital infections are submitted to DHEC through the Centers for Disease Control (CDC) and National Healthcare Safety Network (NHSN). Upon request I will be provided with the appropriate information related to this subject matter. (Form 4050)

LEWIS BLACKMAN ACT INFORMATION SHEET:

☑ I acknowledge that I have received an informational sheet regarding the Lewis Blackman Act.

HEARING IMPAIRMENT / LIMITED ENGLISH ASSISTANCE:

☑ I understand that if I and/or my companion (family member, significant other, friend, driver, etc.) need assistance communicating with CMC staff, CMC will provide assistance at no charge.

PATIENT RIGHTS AND RESPONSIBILITIES:

☑ I acknowledge that I have received a copy of the Patient Rights and Responsibilities.

Patient or Patient Representative Signature

7, 8, 16 10:30
Date

HIM-2515-FRM
REV 2 04.27.16

Conway Medical Center
Conway, South Carolina

V00006933263
KNIGHT,DANIEL ERIC
[redacted]
Rimkus, Gilbertas MD
M000175313

Adult Healthcare Consent Act

The "Adult Healthcare Consent Act" takes effect on January 1, 2014. S.117 amends the Adult Healthcare Consent Act to require a provider to include on the patient information form an opportunity for the patient to designate an individual with whom the provider may discuss the patient's medical condition and treatment.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

IF YES, WHOM?

Elizabeth Knight
Name of Individual

☑ Next of Kin **(See Admission Record)**

330-717-0532
Contact Number(s) (if available)

☐ Emergency Contact **(See Admission Record)**

IF NO,

☐ Patient Unable to Complete Form

☐ **I DO NOT WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL**

Important Right and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Health Information Management department at Conway Medical Center at any time. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting the Health Information Management department at Conway Medical Center.

[signature], 7-8-16, 10:30
(Patient or authorized person) **(Date)** **(Time)** **(Relationship if authorized person)**

[signature], 7/8/16, 10:30
(Witness) **(Date)** **(Time)**

No witness required if patient signature obtained by provider

Reason for authorized person signature
☐ **Minor Patient**
☐ **Incapacitated patient (form 441 required)**

An interpreter or other special assistance was used to assist patient in completing this form as follows:
☐ **Foreign Language (specify)** _____ ☐ **Sign Language** ☐ **Patient is blind, form read to patient**
☐ **Other: (specify)** _____ _____
(name of interpreter or service)

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006933263
Unit Number:	M000175313
Admit Date:	07/08/2016
Discharge Date:	07/10/2016
Dictating Physician:	Gilbertas Rimkus, MD

DISCHARGE SUMMARY

DISCHARGE DIAGNOSES:
1. History of small bowel perforation ileostomy.
2. Peristomal hernia.

HISTORY AND HOSPITAL COURSE:
Mr. Knight is a 41-year-old patient with history of a traumatic perforation of the terminal ileum and extensive fecal peritonitis. He underwent a small bowel resection at that time with an ileostomy. He healed up. He developed a peristomal hernia. He presented for a takedown of the ileostomy and repair of the peristomal hernia which was done 07/08/16.

He also underwent a resection of the ileostomy stump to facilitate anastomosis. Strattice mesh was used to repair the incisional hernia. He did very well postop. Starting passing gas and tolerated liquids. Sent home in stable condition by my partner on-call.

MEDICATIONS:
Vicodin for pain as needed.

FOLLOWUP:
In the office in 1 week.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
Rachel M. Collins, CNP
GR/4105596
DD: 07/11/2016 17:29
DT: 07/11/2016 17:39
LM File#: 201607110000018120
Job #: 4105596

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jul 28 2016 12:04PM

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK [redacted]

Date of Encounter: 07/06/2016 02:24 PM

History of Present Illness *(Jenny Johnson 07/06/2016 02:24 PM)*
The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. Here for reck.

Allergies *(Jenny Johnson; 07/06/2016 02:25 PM)*
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching
No Known Drug Allergies 06/01/2016

Past Medical History (Jenny Johnson; *07/06/2016 02:25 PM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~7 weeks s/p resection and ileostomy, healing slowly.

Social History *(Jenny Johnson; 07/06/2016 02:25 PM)*
No alcohol use
Caffeine use
Current work status: Occupation: ; student
Tobacco use: Former smoker, Remotely quit tobacco use

Medication History *(Jenny Johnson; 07/06/2016 02:25 PM)*
Percocet (5-325MG Tablet, 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active. (rx written and given to pt)
PROzac (20MG Capsule, 1 Oral Daily) Active.
OxyCODONE HCl (10MG Tablet, Oral AS directed) Active.
Naproxen (500MG Tablet, 1 Oral Daily) Active.
Medications Reconciled.

Past Surgical *(Jenny Johnson; 07/06/2016 02:25 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Jenny Johnson; 07/06/2016 02:24 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

This fax was sent with GFI FAXmaker fax server. For more information, visit http://www.gfi.com

Physical Exam *(GILBERTAS RIMKUS; 07/06/2016 02:43 PM)*
The physical exam findings are as follows:

General
General Appearance - Not in acute distress. **Build & Nutrition** - Well nourished and Well developed.

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing.

Head and Neck
Head - normocephalic, atraumatic with no lesions or palpable masses.
Neck
Global Assessment - normal.

ENMT
Global Assessment
Upon examination of the ears, nose, mouth and throat - unremarkable.

Chest and Lung Exam
Auscultation:
Breath sounds: - Clear Bilaterally.

Cardiovascular
Auscultation: Rhythm - Regular.

Abdomen
Palpation/ Percussion: Palpation and Percussion of the abdomen reveal - Soft, Non Tender and Nondistended.

Developed reducible parastomal hernia.

Rectal
Anorectal Exam: - Deferred.

Peripheral Vascular
Lower Extremity: Inspection - **Left** - atraumatic. No Ulcers or skin lesions. **Right** - atraumatic. No Ulcers or skin lesions.

Assessment & Plan *(GILBERTAS RIMKUS; 07/06/2016 02:45 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~9 weeks s/p resection and ileostomy, skin healed.
Today's Impression: Plan ileostomy takedown.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()

INCISIONAL HERNIA (K43.2)
Problem Story: As above.
Today's Impression: Repair with Biologic mesh at the same time.
Current Plans:

Future Procedures:
- 07/08/2016: ILEOSTOMY, TAKE-DOWN (44620) Routine one time ()

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Signed electronically by GILBERTAS RIMKUS

FORM 19 - ***HISTORY AND PHYSICAL UPDATE***

Check all that apply:

- [x] History and physical has been reviewed
- [x] Patient has been examined
- [x] I concur with content of this document
- [ ] The following changes are noted today:

See additional note.

Physician Signature 7/8/16 Date 12:45 pm Time

This fax was sent with GFI FAXmaker fax server. For more information, visit: http://www.gfi.com/faxmaker

NAME: KNIGHT,DANIEL ERIC ADMIT DATE: 07/08/16
UNIT #: M000175313 DISCHARGE DATE: 07/10/16
ACCT #: V00006933263 STATUS: DIS IN
CODED ALLERGIES Penicillins, Sulfa (Sulfonamide Antibiotics)
CODED ADRs None
UNCODED ALLERGIES Please update patient allergies
UNCODED ADRs None

ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16	START/ STOP	
Lidocaine HCl 1% 2 Ml (LIDOCAINE HYDROCHLORIDE 1% 2 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07206110	07/08/16	1050 Discontinue 1053 STK MED AO 1609 CWHITE7
Ofirmev 10 MG/ML 100 ML (Acetaminophen 1,000 MG/100 ML VIAL) UD XX .STK-MED/ONE Comments: CONCENTRATION: 10 MG/ML Administer IV over 15 minutes Do not give any other Acetaminophen containing products while on Ofirmev. MAX APAP/24 HRS IS 4 GRAMS RX #: 07206133	07/08/16	1106 Discontinue 1113 STK MED AO 1609 CWHITE7
INVanz (Ertapenem 1GM/Ns 50ML 1 GM/50 ML PREMIX) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07206134	07/08/16	1107 Discontinue 1113 STK MED AO 1609 CWHITE7
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07206135	07/08/16	1107 Discontinue 1113 STK MED AO 1610 CWHITE7
Bupivacaine HCl 30 Ml (Bupivacaine HCl 0.25% 30 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07206465	07/08/16	1421 Discontinue 1422 STK MED AO 1609 CWHITE7
EXPAREL Liposomal Suspension 1.3% (Bupivacaine Liposome 20 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07206466	07/08/16	1421 Discontinue 1422 STK MED AO 1609 CWHITE7

*** CONTINUED ON PAGE 2 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses #1 O: Provider Aware - Continue as ordered ALL: The use of Invanz SolR (ertapenem) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 9620762 RX #: 07206579	07/09/16 07/09/16	Enter 1439 PKPHAUSER EDIT 1509 HGASSAWAY Verified 1509 HGASSAWAY EDIT 1510 HGASSAWAY AO 1645 CWHITE7
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 125 MLS/HR IV .Q8H Comments: Number of Liters Continuous PK ID: 9620764 RX #: 07206565	07/08/16 08/07/16	Enter 1440 PKPHAUSER 1500 CWHITE7 at 1540 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 07/08/16-1543 by CWHITE7 EDIT 1506 HGASSAWAY Verified 1506 HGASSAWAY AO 1540 CWHITE7 2300 PGREEN2 at 2344 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 07/08/16-2344 by PGREEN2 0700 PGREEN2 at 0636 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 07/09/16-0636 by PGREEN2
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV .HS Comments: DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS Give if NPO PK ID: 9620774 RX #: 07206574	07/08/16 08/07/16	Enter 1445 PKPHAUSER EDIT 1508 HGASSAWAY Verified 1508 HGASSAWAY AO 1645 CWHITE7

*** CONTINUED ON PAGE 3 ***
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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP		
Protonix (Pantoprazole Sodium 40 MG/EACH TAB)	07/08/16	Enter 1446 PKPHAUSER	
40 MG OR BEDTIME	08/07/16	Verified 1508 HGASSAWAY	
Comments: DO NOT CRUSH		AO 1645 CWHITE7	
may give IV if NPO		2100 PGREEN2 at 2117 GAVE: 40 MG	
PK ID: 9620776		NDC/DIN: (SOURCE: eMAR)	
RX #: 07206575		6699306885	PAN40T - Pantoprazole Sodium 40 MG/EAC..
		FDOC 07/08/16-2119 by PGREEN2	

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Toradol (Ketorolac Tromethamine 15 MG/ML VIAL) 15 MG IV EVERY 6 HOURS Comments: X 48 hrs total # of days: 2 PK ID: 9620778 RX #: 07206570	07/08/16 07/10/16	Enter 1448 PKPHAUSER 1500 CWHITE7 at 1540 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 0409379301 KET15I - Ketorolac Tromethamine 15 MG/.. Pt C/O Pain: Y Pain Scale: 4 Time Med Given: 1540 Date: 07/08/16 Reassess: 1640 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/08/16-1543 by CWHITE7 EDIT 1507 HGASSAWAY Verified 1507 HGASSAWAY AO 1540 CWHITE7 1625 REASSESS by CWHITE7 at 1624 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2100 PGREEN2 at 2118 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 6332316101 KET15I - Ketorolac Tromethamine 15 MG/... Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2118 Date: 07/08/16 Reassess: 2218 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/08/16-2119 by PGREEN2 2203 REASSESS by PGREEN2 at 2200 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: EASILY AROUSED. 0245 REASSESS by PGREEN2 at 0245 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: EASILY AROUSED.

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
		0300 PGREEN2 at 0200 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 0409379301 KET15I - Ketorolac Tromethamine 15 MG/... Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0200 Date: 07/09/16 Reassess: 0300 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-0201 by PGREEN2
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR DAILY RX #: 07206544	07/09/16 08/08/16	Enter 1503 HGASSAWAY AO 1645 CWHITE7
DIPRIVAN (Propofol 10 MG/ML VIAL) 200 MG XX .STK-MED/ONE RX #: 07206863	07/08/16 07/08/16	1759 Discontinue 1759 STK MED Enter 1759 CGARDNER1 AO 2355 PGREEN2
Sublimaze (FentaNYL CITRATE 50 MCG/ML AMP) 100 MCG XX .STK-MED/ONE RX #: 07206864	07/08/16 07/08/16	1759 Discontinue 1759 STK MED Enter 1759 CGARDNER1 AO 2355 PGREEN2
VERSED (Midazolam HCl 1 MG/ML VIAL) 2 MG XX .STK-MED/ONE RX #: 07206865	07/08/16 07/08/16	1759 Discontinue 1759 STK MED Enter 1759 CGARDNER1 AO 2355 PGREEN2
Demerol Hydrochloride (Meperidine HCl 50 MG/ML VIAL) 50 MG XX .STK-MED/ONE RX #: 07206866	07/08/16 07/08/16	1759 Discontinue 1759 STK MED Enter 1759 CGARDNER1 AO 2355 PGREEN2
Quelicin* (Succinylcholine Chloride 20 MG/ML VIAL) 200 MG XX .STK-MED/ONE RX #: 07206942	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Zemuron* (Rocuronium Bromide 10 MG/ML VIAL) 50 MG XX .STK-MED/ONE RX #: 07206943	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Lidocaine HCl 5 Ml (Lidocaine 1% 50 MG/5 ML AMP) 50 MG XX .STK-MED/ONE RX #: 07206944	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Neostigmine Methylsulfate (Neostigmine Methylsu 1:1000 1 MG/ML DOSE) 1 MG XX .STK-MED/ONE RX #: 07206945	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Dexamethasone Sodium Phosphate (Dexamethasone Sodium Phosphate 20 MG/5 ML MDV) 20 MG XX .STK-MED/ONE RX #: 07206946	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Zofran (Ondansetron 2 MG/ML SDV) 4 MG XX .STK-MED/ONE RX #: 07206947	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Robinul (Glycopyrrolate 0.2 MG/ML VIAL) 0.4 MG XX .STK-MED/ONE RX #: 07206948	07/08/16 07/08/16	1824 Discontinue 1825 STK MED Enter 1825 CGARDNER1 AO 2355 PGREEN2
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) See Dose Ins. IV Q5M/PRN PRN Reason: PAIN Dose Ins: 0.5mg IV Q5M PRN up to 2mg in PACU only Comments: 0.5mg IV Q5M PRN up to 2mg in PACU only PK ID: 9619571 RX #: 07206387	07/08/16 07/08/16	Admin Criterion Entered 1328 PKPHAUSER Enter 1328 PKPHAUSER Admin Criterion Edit 1342 SOWENS2 EDIT 1342 SOWENS2 Verified 1342 SOWENS2 AO 1435 KVALIPOUR2 Discontinue 1630 SCHEDULER

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Zofran (Ondansetron 2 MG/ML SDV)	07/08/16	Enter 1331 PKPHAUSER
4 MG IV AS NEEDED/PRN	07/08/16	Verified 1342 SOWENS2
PRN Reason: NAUSEA		AO 1435 KVALIPOUR2
Comments: IN PACU ONLY		Discontinue 1635 SCHEDULER
PK ID: 9619575		
RX #: 07206388		

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620756 RX #: 07206569	07/08/16 07/18/16	Admin Criterion Entered 1435 PKPHAUSER Enter 1435 PKPHAUSER Admin Criterion Edit 1507 HGASSAWAY EDIT 1507 HGASSAWAY Verified 1507 HGASSAWAY AO 1644 CWHITE7 2118 PGREEN2 at 2118 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2118 Date: 07/08/16 Reassess: 2218 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/08/16-2119 by PGREEN2 DOSE changed from TAB to 1 TAB 2203 REASSESS by PGREEN2 at 2200 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: EASILY AROUSED. 0201 PGREEN2 at 0201 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0201 Date: 07/09/16 Reassess: 0301 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-0201 by PGREEN2 DOSE changed from TAB to 1 TAB 0246 REASSESS by PGREEN2 at 0245 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: EASILY AROUSED.

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Acephen (Acetaminophen 650 MG/EACH SUP) 650 MG RE EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620746 RX #: 07206566	07/08/16 08/07/16	Enter 1436 PKPHAUSER EDIT 1506 HGASSAWAY Verified 1506 HGASSAWAY AO 1644 CWHITE7
Ambien (Zolpidem Tartrate 10 MG TAB) 5 MG OR BEDTIME/PRN PRN Reason: INSOMNIA Comments: PK ID: 9620751 RX #: 07206578	07/08/16 07/18/16	Admin Criterion Entered 1437 PKPHAUSER Enter 1437 PKPHAUSER Verified 1509 HGASSAWAY AO 1644 CWHITE7
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 9620765 RX #: 07206571	07/08/16 08/07/16	Enter 1441 PKPHAUSER Verified 1507 HGASSAWAY AO 1644 CWHITE7

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ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. IV EVERY 2 HOURS/PRN PRN Reason: PAIN Dose Ins: 2-4 mg Comments: PK ID: 9620766 RX #: 07206572	07/08/16 07/18/16	Admin Criterion Entered 1442 PKPHAUSER Enter 1442 PKPHAUSER Admin Criterion Edit 1508 HGASSAWAY EDIT 1508 HGASSAWAY Verified 1508 HGASSAWAY AO 1644 CWHITE7 1719 CWHITE7 at 1719 GAVE: 4 MG NDC/DIN: (SOURCE: eMAR) 0409189101 MS4I - MorphINE Sulfate 4 MG/ML SYR Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1719 Date: 07/08/16 Reassess: 1819 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/08/16-1725 by CWHITE7 DOSE changed from MG to 4 MG 1804 REASSESS by CWHITE7 at 1804 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:
MYLICON-80 (Simethicone 80 MG/EACH TAB) 80 MG OR BEFORE MEALS AND BEDTIME/PRN PRN Reason: GAS/BLOATING Comments: PK ID: 9620767 RX #: 07206577	07/08/16 08/07/16	Enter 1443 PKPHAUSER EDIT 1508 HGASSAWAY Verified 1508 HGASSAWAY AO 1644 CWHITE7
PHENERGAN (Promethazine HCl 25 MG/ML AMP) 12.5 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: DILUTE WITH 10-20ML SALINE AND ADMINISTER OVER 10-15 MINUTES PK ID: 9620769 RX #: 07206576	07/08/16 08/07/16	Enter 1444 PKPHAUSER Verified 1508 HGASSAWAY AO 1644 CWHITE7

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NAME: KNIGHT,DANIEL ERIC UNIT #: M000175313 ACCT #: V00006933263

ADMINISTRATION PERIOD: 0730 07/08/16 to 0729 07/09/16 (Continued)	START/ STOP	
Tylenol (Acetaminophen 325 MG/EACH TAB) 650 MG OR EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620779 RX #: 07206567	07/08/16 08/07/16	Enter 1445 PKPHAUSER EDIT 1507 HGASSAWAY Verified 1507 HGASSAWAY AO 1644 CWHITE7
Zofran (Ondansetron 2 MG/ML SDV) 4 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: PK ID: 9620781 RX #: 07206573	07/08/16 08/07/16	Enter 1447 PKPHAUSER Verified 1508 HGASSAWAY AO 1645 CWHITE7

ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16	START/ STOP	
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses #1 O: Provider Aware - Continue as ordered ALL: The use of Invanz SolR (ertapenem) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 9620762 RX #: 07206579	07/09/16 07/09/16	1316 CWHITE7 at 1430 GAVE: 50 MLS RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 07/09/16-1435 by CWHITE7 Discontinue 1416 SCHEDULER
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 125 MLS/HR IV .Q8H Comments: Number of Liters Continuous PK ID: 9620764 RX #: 07206565	07/08/16 08/07/16	Discontinue Verified 1329 CPOSTON1 AO 1442 CWHITE7

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ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16 (Continued)	START/ STOP			
Protonix (Pantoprazole Sodium 40 MG/EACH TAB)	07/08/16	2100 MGODWIN at 2006 GAVE: 40 MG		
40 MG OR BEDTIME	08/07/16	NDC/DIN: (SOURCE: eMAR)		
Comments: DO NOT CRUSH		6699306885	PAN40T	- Pantoprazole Sodium 40 MG/EAC..
may give IV if NPO		FDOC 07/09/16-2007 by MGODWIN		
PK ID: 9620776				
RX #: 07206575				

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ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16 (Continued)	START/ STOP	
Toradol (Ketorolac Tromethamine 15 MG/ML VIAL) 15 MG IV EVERY 6 HOURS Comments: X 48 hrs total # of days: 2 PK ID: 9620778 RX #: 07206570	07/08/16 07/10/16	0900 CWHITE7 at 0933 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 2502170001 KET15I - Ketorolac Tromethamine 15 MG/.. Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0933 Date: 07/09/16 Reassess: 1033 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-0936 by CWHITE7 1018 REASSESS by CWHITE7 at 1017 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1500 CWHITE7 at 1435 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 6332316101 KET15I - Ketorolac Tromethamine 15 MG/... Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1435 Date: 07/09/16 Reassess: 1535 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-1435 by CWHITE7 1520 REASSESS by CWHITE7 at 1512 Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2051 REASSESS by MGODWIN at 2051 Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2100 MGODWIN at 2006 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 6332316101 KET15I - Ketorolac Tromethamine 15 MG/... Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2006

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ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16 (Continued)	START/ STOP	
		Date: 07/09/16 Reassess: 2106 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-2007 by MGODWIN 0300 MGODWIN at 0310 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 6332316101 KET15I - Ketorolac Tromethamine 15 MG/... Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0310 Date: 07/10/16 Reassess: 0410 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/10/16-0311 by MGODWIN 0355 REASSESS by MGODWIN at 0400 Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment:
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR DAILY RX #: 07206544	07/09/16 08/08/16	0900 CWHITE7 at 0933 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 6808460511 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 07/09/16-0936 by CWHITE7
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 50 MLS/HR IV .Q20H Comments: Number of Liters Continuous PK ID: 9632081 RX #: 07207824	07/09/16 08/08/16	Enter 1320 PKPHAUSER 1325 CWHITE7 at 1430 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 07/09/16-1435 by CWHITE7 EDIT 1329 CPOSTON1 Verified 1329 CPOSTON1 AO 1430 CWHITE7

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ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620756 RX #: 07206569	07/08/16 07/18/16	0933 CWHITE7 at 0933 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0933 Date: 07/09/16 Reassess: 1033 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-0936 by CWHITE7 DOSE changed from TAB to 2 TAB 1018 REASSESS by CWHITE7 at 1017 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1434 CWHITE7 at 1434 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1434 Date: 07/09/16 Reassess: 1534 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/09/16-1435 by CWHITE7 DOSE changed from TAB to 1 TAB 1519 REASSESS by CWHITE7 at 1512 Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2009 MGODWIN at 2009 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2009 Date: 07/09/16 Reassess: 2109 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS

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ADMINISTRATION PERIOD: 0730 07/09/16 to 0729 07/10/16 (Continued)	START/ STOP	
		FDOC 07/09/16-2009 by MGODWIN
		DOSE changed from TAB to 2 TAB
		2054 REASSESS by MGODWIN at 2051
		Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0311 MGODWIN at 0311 GAVE: 1 TAB
		NDC/DIN: (SOURCE: eMAR)
		0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0311
		Date: 07/10/16 Reassess: 0411
		Pain Location: ABDOMINAL
		Quality Of Pain: STABBING
		Onset of Pain: POST-OP
		Duration of Pain: CONTINUOUS
		FDOC 07/10/16-0311 by MGODWIN
		DOSE changed from TAB to 1 TAB
		0356 REASSESS by MGODWIN at 0400
		Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:

ADMINISTRATION PERIOD: 0730 07/10/16 to 0729 07/11/16	START/ STOP	
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL)	07/08/16	Discontinue 1448 DISCHARGE
40 MG IV .HS	08/07/16	
Comments: DILUTE VIAL WITH 10 ML OF NORMAL SALINE		
AND ADMINISTER SLOW IV PUSH OVER 2 MINS		
Give if NPO		
PK ID: 9620774		
RX #: 07206574		

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ADMINISTRATION PERIOD: 0730 07/10/16 to 0729 07/11/16 (Continued)	START/ STOP	
Protonix (Pantoprazole Sodium 40 MG/EACH TAB) 40 MG OR BEDTIME Comments: DO NOT CRUSH may give IV if NPO PK ID: 9620776 RX #: 07206575	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
Toradol (Ketorolac Tromethamine 15 MG/ML VIAL) 15 MG IV EVERY 6 HOURS Comments: X 48 hrs total # of days: 2 PK ID: 9620778 RX #: 07206570	07/08/16 07/10/16	0900 KCUSANO at 0827 GAVE: 15 MG NDC/DIN: (SOURCE: eMAR) 2502170001 KET15I - Ketorolac Tromethamine 15 MG/.. Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0827 Date: 07/10/16 Reassess: 0927 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/10/16-0827 by KCUSANO 0912 REASSESS by KCUSANO at 0927 Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: Discontinue 1448 DISCHARGE
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR DAILY RX #: 07206544	07/09/16 08/08/16	0900 KCUSANO at 0826 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 6808460511 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 07/10/16-0827 by KCUSANO Discontinue 1448 DISCHARGE
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 50 MLS/HR IV .Q20H Comments: Number of Liters Continuous PK ID: 9632081 RX #: 07207824	07/09/16 08/08/16	Discontinue Verified 0917 CPOSTON1 AO 0918 KCUSANO 0925 KCUSANO at 0827 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 07/10/16-0827 by KCUSANO

*** CONTINUED ON PAGE 18 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 07/10/16 to 0729 07/11/16 (Continued)	START/ STOP	
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) KVO IV .Q24H RX #: 07208547	07/10/16 08/09/16	AO 0918 KCUSANO Enter 0918 CPOSTON1 1000 KCUSANO at 0927 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 07/10/16-0927 by KCUSANO Discontinue 1448 DISCHARGE
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620756 RX #: 07206569	07/08/16 07/18/16	0830 KCUSANO at 0830 GAVE: 1 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0830 Date: 07/10/16 Reassess: 0930 Pain Location: ABDOMINAL Quality Of Pain: STABBING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 07/10/16-0831 by KCUSANO DOSE changed from TAB to 1 TAB 0915 REASSESS by KCUSANO at 0927 Pt Relieved Of Pain: YRe-assess Pain Scale:1 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: Discontinue 1448 DISCHARGE
Acephen (Acetaminophen 650 MG/EACH SUP) 650 MG RE EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620746 RX #: 07206566	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
Ambien (Zolpidem Tartrate 10 MG TAB) 5 MG OR BEDTIME/PRN PRN Reason: INSOMNIA Comments: PK ID: 9620751 RX #: 07206578	07/08/16 07/18/16	Discontinue 1448 DISCHARGE

*** CONTINUED ON PAGE 19 ***

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ADMINISTRATION PERIOD: 0730 07/10/16 to 0729 07/11/16 (Continued)	START/ STOP	
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 9620765 RX #: 07206571	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. IV EVERY 2 HOURS/PRN PRN Reason: PAIN Dose Ins: 2-4 mg Comments: PK ID: 9620766 RX #: 07206572	07/08/16 07/18/16	Discontinue 1448 DISCHARGE
MYLICON-80 (Simethicone 80 MG/EACH TAB) 80 MG OR BEFORE MEALS AND BEDTIME/PRN PRN Reason: GAS/BLOATING Comments: PK ID: 9620767 RX #: 07206577	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
PHENERGAN (Promethazine HCl 25 MG/ML AMP) 12.5 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: DILUTE WITH 10-20ML SALINE AND ADMINISTER OVER 10-15 MINUTES PK ID: 9620769 RX #: 07206576	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
Tylenol (Acetaminophen 325 MG/EACH TAB) 650 MG OR EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 9620779 RX #: 07206567	07/08/16 08/07/16	Discontinue 1448 DISCHARGE
Zofran (Ondansetron 2 MG/ML SDV) 4 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: PK ID: 9620781 RX #: 07206573	07/08/16 08/07/16	Discontinue 1448 DISCHARGE

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NAME: KNIGHT,DANIEL ERIC UNIT #: M000175313 ACCT #: V00006933263

ADMINISTRATION PERIOD:	START/ STOP	
0730 07/11/16 to 0729 07/12/16		

*** CONTINUED ON PAGE 21 ***
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ADMINISTRATION PERIOD:	START/ STOP	
0730 07/11/16 to 0729 07/12/16 (Continued)		

LEGENDS

ACTIVITY CODES
AO - Nursing Acknowledged Order
DC - Pharmacy Discontinue
ED - Pharmacy Edit or Verification
ENTER - Order Entry
FDOC - File Document
REASSESS - Nursing Reassessment

REASON CODES

SITE CODES

ELECTRONICALLY SIGNED BY

USER USER NAME/TYPE	USER USER NAME/TYPE	USER USER NAME/TYPE	USER USER NAME/TYPE
CWHITE7 - WHITE,CORAZON RN	KCUSANO - CUSANO,KIM RN	KVALIPOUR2 - VALIPOUR,KATIE RN	MGODWIN - GODWIN,MELISSA RN
PGREEN2 - GREEN,PAMELA RN			

OTHER USERS

USER USER NAME	USER USER NAME	USER USER NAME	USER USER NAME
CGARDNER1 - GARDNER,CAROLINE	CPOSTON1 - POSTON,CATHY	HGASSAWAY - GASSAWAY,HUGH	PKPHAUSER - PK PHARMACY USER
SOWENS2 - OWENS,SALLY			

COMBINED ALLERGY HISTORY

DATE	MODULE	USER	ALLERGY DETAILS	
05/15/16 1005	PHA	SOWENS2 - OWENS,SALLY	ADDED Penicillins OLD: NEW: Penicillins added.	by SOWENS2
			ADDED Sulfa (Sulfonamide Antibiotics) OLD: NEW: Sulfa (Sulfonamide Antibiotics) added.	by SOWENS2
05/15/16 1104	ADM	CANDERSON - ANDERSON,CYNTHIA	FILED TEXT: User filed without changing allergy record.	by CANDERSON
07/08/16 1113	OE	ACOTELLESE - COTELLESE,AMY	FILED TEXT: User filed without changing allergy record.	by ACOTELLESE
			FILED TEXT: User filed without changing allergy record.	by ACOTELLESE

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ADMINISTRATION PERIOD:	START/ STOP	
0730 07/11/16 to 0729 07/12/16 (Continued)		

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Units	From Change	Comment
Activity Date: 07/08/16 Time: 1525											
6680 Vital Signs							A	06,10,14,18,22,02		OE	
- Document	07/08/16	1525	TH2	07/08/16	1840	TH2					
Temperature: 97.6											
Temperature Source+: Oral											
Pulse: 85											
Pulse Source+: BRACHIAL											
Respirations: 16											
Blood Pressure: 108/68											
BP Location+:											
BP Position+: SUPINE											
Weight (lbs):											
(Oz):											
kg:											
Weight Source:											
O2 Sat: 92 Nursing Note:											
IPI: (Surgical Patients ONLY)											
Pt Out of Room: Patient Refused: Nurse Notified:											
Activity Date: 07/08/16 Time: 1553											
6680 Vital Signs							A	06,10,14,18,22,02		OE	
- Create	07/08/16	1553	TJ9	07/08/16	1553	TJ9					
Activity Date: 07/08/16 Time: 1612											
Patient Notes: Nursing Notes											
- Create	07/08/16	1612	CW7	07/08/16	1613	CW7					
Abnormal? N Confidential? N											
RECEIVED FROM PACU. AWAKE, ALERT, VITAL SIGNS STABLE. REVIEWED PLAN OF CARE. INSTRUCTED RE: USE OF CALL BELL AS NEEDED FOR ASSIST. CALL BELL WITHIN REACH. RIGHT FLANK OPSITE INTACT WITH SMALL AMOUNT OF DRAINAGE. TOLERATING SMALL AMOUNT OF CLEAR LIQUIDS.											
Note Type Description											
No Type None											
Activity Date: 07/08/16 Time: 1625											
6680 Vital Signs							A	06,10,14,18,22,02		OE	
- Document	07/08/16	1625	TH2	07/08/16	1840	TH2					
Temperature: 97.9											
Temperature Source+: Oral											
Pulse: 74											
Pulse Source+: BRACHIAL											
Respirations: 16											
Blood Pressure: 106/69											
BP Location+:											
BP Position+: SUPINE											
Weight (lbs):											

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Units	From Change	Comment
Activity Date: 07/08/16 Time: 1625 (continued)											
6680 Vital Signs (continued)											
(Oz):											
kg:											
Weight Source:											
O2 Sat: 95 Nursing Note:											
IPI: (Surgical Patients ONLY)											
Pt Out of Room: Patient Refused: Nurse Notified:											
Activity Date: 07/08/16 Time: 1653											
Problem: General Surgery							A				
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
Outcome: Respiratory Status: Ventilation							A				
Definition: Movement of air in and out of the lungs											
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
3140 Airway Management							A	QS			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
Outcome: Wound Healing: Primary Intention							A				
Definition: Extent of regeneration of cells and tissues following intentional closure											
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
3440 Incision Site Care							A	QS			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
6540 Infection Control							A				CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
Outcome: Fluid Balance							A				
Definition: Water balance in the intracellular and extracellular compartments of the body											
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
2080 Fluid/Electrolyte Management							A	PRN			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
Outcome: Post Operative Care							A				
Definition: Patient free of post operative complications											
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
1629 OSA ASSESSMENT							A	QS			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
6419 C-Diff Screening							A	11			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
6955 Anticoagulant Educ Materials Provided							A	QS			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					
6990 Post Operative Care - GOALS							A	08,20			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7					

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 07/08/16		**Time: 1653**								
6991	Post Operative Care - OUTCOMES						A	18,06		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
Problem: Standard Of Care							A			
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
Outcome: Standard Of Care							A			
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
0840	Positioning						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
10026	DISCHARGE PATIENT-Escorted						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1160	Nutritional Monitoring						A	18		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
150005	Intake/Output						A	06,18		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1663	IPC, TED, VFP Documentation						A	04,16		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750022	Neurological Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750023	Cardiovascular Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750024	Respiratory Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750026	Musculoskeletal Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750027	Gastrointestinal Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750028	Genitourinary Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
1750029	Integumentary Surveillance						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
275051	VTE Prophylaxis Orders Complete?						A	08,20		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
3592	TED/HEEL PROTECTORS/IPC Skin Assessment						A	04,16		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
525001	Medications, PRN						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
525002	IV THERAPY ASSESSMENT						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
525003	IV Site Check						A	06,18		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
5500	Off-Unit for Test/Procedure						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
5500010	Rounds Surveillance						A	06,18		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
5500011	Purposeful Rounding						A	Q2HODD		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6409	FALLS SCREEN - FOLLOW-UP						A	02,14		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 07/08/16		**Time: 1653**								
6650	SHIFT ASSESSMENT (Surveillance)						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6901	PATIENT LINEN CHANGE						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6902	PATIENT TURNED						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6903	PATIENT FED						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6904	PATIENT BED/CHAIR ALARM SET						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6905	PATIENT BATH						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6910	Last BM						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6911	Transfer/Nursing Report Record						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6922	Nursing Report (Hand Off)						A	07,19		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6923	Message (Hand Off)						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6944	Supplements/Tube Feedings						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6945	TIME OUT-Universal Protocol Beside Proc						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
6980	Vital Signs Manual Recheck						A	AD		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
7310	Admission Care						A	ONCE		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
7370	Discharge Planning Assessment						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
7371	Discharge Information for PATIENT						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
750006	PAIN ASSESSMENT						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
750011	Pain Assessment (Telemetry Unit)						A			CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
75015	Discharge Med Rec via RXM						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
7900	Flu Vaccination Received						A	PRN		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
800001	Education/Teaching Assessment						A	04,16		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
9610	Fall Risk Assessment/Interventions						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				
99	SEPSIS Documentation						A	QS		CP
- Create	07/08/16	1653	CW7	07/08/16	1653	CW7				

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 1654

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 07/08/16 1654 CW7 07/08/16 1655 CW7
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: NA
Goal: COUGH AND DEEP BREATHE
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: DVT PREVENTION
Outcome: VERBAL
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: CLEAR LIQ
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18
- Document 07/08/16 1654 CW7 07/08/16 1654 CW7
Diet Ordered: CLEAR LIQ
Meal:
% Diet Taken:

Oral Supplement:
PO Supplement: cc (Total Intake)

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 1654 (continued)

CP 1160 Nutritional Monitoring (continued)
Comment:
150005 Intake/Output A 06,18 CP
- Document 07/08/16 1654 CW7 07/08/16 1656 CW7
INTAKE
PO: 240 IV: 500 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 07/08/16 1654 CW7 07/08/16 1656 CW7
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

CP Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 07/08/16 1654 CW7 07/08/16 1656 CW7

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From Change
Activity Date: 07/08/16		Time: 1700							
5500011	Purposeful Rounding						A	Q2HODD	CP
- Document	07/08/16	1700	TH2	07/08/16	1831	TH2			

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/08/16 Time: 1725

6680 Vital Signs — A — 06,10,14,18,22,02 — OE
- Document 07/08/16 1725 TH2 07/08/16 1840 TH2

Temperature: 97.6
Temperature Source+: Oral
Pulse: 89
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 111/66
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/08/16 Time: 1743

5500010 Rounds Surveillance — A — 06,18 — CP
- Document 07/08/16 1743 CW7 07/08/16 1743 CW7

Activity Date: 07/08/16 Time: 1744

Patient Notes: Nursing Notes
- Create 07/08/16 1744 CW7 07/08/16 1745 CW7
Abnormal? N Confidential? N
MEDICATED FOR COMPLAINTS OF INCISIONAL PAIN. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From Change
Activity Date: 07/08/16		Time: 1825							
6680	Vital Signs						A	06,10,14,18,22,02	OE
- Document	07/08/16	1825	TH2	07/08/16	1840	TH2			

Temperature: 97.2
Temperature Source+: Oral
Pulse: 78
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 105/68
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/08/16 Time: 1900

5500011 Purposeful Rounding — A — Q2HODD — CP
- Document 07/08/16 1900 JL 07/08/16 2138 JL

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

6922 Nursing Report (Hand Off) — A — 07,19 — CP
- Document 07/08/16 1900 PG2 07/09/16 0000 PG2

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside:

To/From PAM G RN / CORA RN

Comment

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 1950

Patient Notes: Nursing Notes
- Create 07/08/16 1950 PG2 07/08/16 2351 PG2
Abnormal? N Confidential? N
RESTING IN BED, A&OX3. NAD NOTED. RESP EVEN & UNLABORED ON RA. NO NEEDS OR COMPLAINTS VERBALIZED. R ABD DRSG DRY/INTACT WITH BLOODY SHADOWING NOTED. SCDS ON & OPERATIONAL. CB IN REACH. ENCOURAGED TO CALL WITH NEEDS, VERBALIZED UNDERSTANDING.
Note Type Description
No Type None

Activity Date: 07/08/16 Time: 2000

3140 Airway Management A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0000 PG2
3440 Incision Site Care A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0000 PG2
1629 OSA ASSESSMENT A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0000 PG2
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0013 PG2
Anticoagulant Educ Material provided to Patient &/or Family? N
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 07/08/16 2000 PG2 07/09/16 0014 PG2
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X Q1H W/A

Patient demonstates technique for splinting incision: Y

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: CLEARS

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NA
Smoking Status: Never smoker Nursing Note:
0840 Positioning A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0000 PG2
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 07/08/16 2000 PG2 07/09/16 0016 PG2
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0016 PG2
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT HAND IV Site #3:
Site Appear #1: NO REDNESS NOTED Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: LR @ Fluid/Rate #3:
Date Insert/DC #1: 07/08/16 Date Insert/DC #3:
IV #1 Comment: WNL IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

525002 IV THERAPY ASSESSMENT (continued)

Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>
- Edit Results 07/08/16 2000 PG2 07/09/16 0018 PG2
Fluid/Rate #1: LR @ 125 ML/HR [LR @]

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0013 PG2

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:
Rt Reaction To Light+: Normal
Reactive
Size Left+:
Lt Reaction To Light+: Normal
Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Vision Impairment: GLASSES
Hearing Impairment: NONE
Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale N

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously:	Converses/Oriented:	Obeys Command:
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score:

Neuro Comment <Esc>: A&OX3. RESPONDS TO COMMANDS APPROPRIATELY.

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Comfort Measures Only NA
Chest Pain: If Yes, Document in Pain Assessment Intervention.
Heart Sounds+: S1,S2
Telemetry Pattern+:
Pulse Rhythm+: Regular
Heart Rate: Pacemaker: Defibrillator:
Dizziness/Syncope+: Palpitations:
JVD+:

Edema 1+: 1+ Edema 2+:
Loc 1+: Post Op Site Loc 2+: TED Hose: N
IPC: Y
Pitting: N Pitting: Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal Femoral Rt+:
Dorsalis Rt+: Normal Femoral Lt+:
Post Tib Lt+:
Post Tib Rt+: Cap Refill RUE+: Brisk
Carotid Rt+: Cap Refill LUE+: Brisk
Carotid Lt+: Cap Refill RLE+: Brisk
Brachial Rt+: Cap Refill LLE+: Brisk
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Cardio Comment <Esc>: DENIES CP OR PRESSURE

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.
Respirations: 18 O2 Sat: 100 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL
Resp Pattern+: WNL
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:

Breath Sounds
LUL+: Clear
LLL+: Clear
RUL+: Clear

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

RML+: Clear
RLL+: Clear
Lung Sounds: CLEAR
COPD Educational Video: Profile

Resp Comment <Esc>: NAD NOTED. RESP EVEN & UNLABORED.
Cyanosis: N
Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+:

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: PT REPORTS EE AMBULATES W/O DIFFICULTY. GAIT IS NOT ASSESSED AT THIS TIME.

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti:
Location/Size<Esc>:

Stage+:

Wound Site #1: RIGHT LOW ABD
Wound Appear #1+: DRAINAGE
Closure Type #1+:
Dressing Type #1: OPSITE
Dress Appear #1: DRY/INTACT W/SHADOWING

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains:

Skin Comment <Esc>: RIGHT ABDOMEN OPSITE DRSG DRY/INTACT WITH BLOODY SHADOWING NOTED, AREA AROUND DRSG IS SWOLLEN/PUFFY NO REDNESS OR FOUL ODOR NOTED. OLD MID ABD WELL

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

HEALED INCISION NOTED.
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment:	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited:	No Apparent Problem:
Rarely Moist:	No Limitations:	

Total Braden Score:

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
Constipation: N
Diarrhea: N
Last BM:
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool:

Rectal Tube:
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present:
Ostomy Appliance:

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: SOFT
ASYMMETRICAL

GI Comment <Esc>: NO GI COMPLAINTS VERBALIZED AT THIS TIME.

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Currently Menses:
LMP:
Urine Color+: Yellow
Prostate Problems:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder:
Suprapubic Catheter:
Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: PT REPORTS NO PROBLEMS VOIDING CYU TO URINAL.

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift: 4
Pain Location+:
Quality Of Pain+:
Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:
Onset/Duration:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: WILL MEDICATE FOR PAIN AS INDICATED, SEE EMAR.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: No Preference
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

EDUCATION/INTERVENTION: POC, PAIN MANAGEMENT, MEDS/SIDE EFFECTS, ACTIVITY, DIET, SAFETY, WOUND CARE

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0013 PG2
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0015 PG2

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NOT AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:

9610 Fall Risk Assessment/Interventions A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0016 PG2

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern

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Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 6

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED LOW/LOCKED. CB IN REACH. CALLS FOR ASSIST WHEN NEEDED.

Problem/Outcome/Intervention Description

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

Activity Date: 07/08/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 07/08/16 2000 PG2 07/09/16 0000 PG2
Temperature: 98.9
Temperature Source+: Oral
Pulse: 91
Respirations: 18
Blood Pressure: 94/59
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:

Activity Date: 07/08/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/08/16 2100 JL 07/08/16 2138 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/08/16 Time: 2120

Patient Notes: Nursing Notes
- Create 07/08/16 2120 PG2 07/08/16 2349 PG2
Abnormal? N Confidential? N
PT RESTING IN BED WITH NAD NOTED. RESP EVEN & UNLABORED. A&OX3. RIGHT ABD OPSITE DRY/INTACT WITH BLOODY SHADOWING NOTED. PT VOIDING TO URINAL WITHOUT ANY DIFFICULTY. INITIAL SHIFT ASSESSMENT COMPLETED, SEE PI. SCHEDULED MEDS & PRN PO PAIN MED GIVEN AS CHARTED, SEE EMAR. SHIFT GOALS SET. POC & SAFETY MEASURES DISCUSSED. CB IN REACH. WILL REASSESS WITHIN THE HOUR.
Note Type Description
No Type None

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From Change
Activity Date: 07/08/16		Time: 2149							
6680 Vital Signs							A	06,10,14,18,22,02	OE
- Document	07/08/16	2149	JL	07/08/16	2149	JL			

Temperature: 98.9
Temperature Source+: Oral
Pulse: 91
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 94/59
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 100 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/08/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/08/16 2300 JL 07/08/16 2303 JL

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/08/16 Time: 2345

Patient Notes: Nursing Notes
- Create 07/08/16 2345 PG2 07/08/16 2352 PG2
Abnormal? N Confidential? N
PT REPORTS HE HAS PASSED GAS MULTIPLE TIMES OVER THE LAST HOUR OR SO.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From Change
Activity Date: 07/08/16		Time: 2346							

Patient Notes: Nursing Notes
- Create 07/08/16 2346 PG2 07/08/16 2347 PG2
Abnormal? N Confidential? N
PT RESTING COMFORTABLY IN BED WITH NO COMPLAINTS OR NEEDS AT THIS TIME. NO CHANGE IN ABD DRSG SINCE INITIAL SHIFT ASSESSMENT. CB IN REACH. IVF INFUSING AS ORDERED. NO S/S OF INFILTRATION.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 0100 JL 07/09/16 0208 JL

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 0139

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 07/09/16 0139 PG2 07/09/16 0139 PG2

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0139 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthatics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

or dosage within the last 24 hrs

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0139 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 07/09/16 Time: 0200

6680 Vital Signs						A	06,10,14,18,22,02		OE
- Document	07/09/16	0200	JL	07/09/16	0208	JL			

Temperature: 98.3
Temperature Source+: Oral
Pulse: 81
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 96/59
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 100 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 0204

Patient Notes: Nursing Notes

- Create	07/09/16	0204	PG2	07/09/16	0205	PG2

Abnormal? N Confidential? N
MEDICATED WITH ONE PO VICODIN FOR COMPLAINTS OF 5/10 POSTOP PAIN. NO FURTHER NEEDS. IVF INFUSING FREELY AS ORDERED. CB IN REACH. WILL MONITOR & REASSESS WITHIN THE HOUR.

Note Type	Description
No Type	None

Activity Date: 07/09/16 Time: 0300

5500011 Purposeful Rounding						A	Q2HODD		CP
- Document	07/09/16	0300	LN8	07/09/16	0547	LN8			

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0300 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 0349

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 07/09/16 0349 PG2 07/09/16 0349 PG2
IPC: Y
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 07/09/16 0349 PG2 07/09/16 0349 PG2
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

800001 Education/Teaching Assessment A 04,16 CP
- Document 07/09/16 0349 PG2 07/09/16 0350 PG2
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0349 (continued)

800001 Education/Teaching Assessment (continued)
Care/Education Codes: ACTIVITY Material Codes: VERBAL
DC PLAN
DIET
DIS
ISU
MEDS
OTHER
PAIN
POC
SAFETY
TX
Comment: REINFORCE Comment:

EDUCATION/INTERVENTION: POC, PAIN MANAGEMENT, MEDS/SIDE EFFECTS, ACTIVITY, DIET, SAFETY, WOUND CARE, DC PLANNING, NUTRITION

Outcome: REINFORCE

Non-Surgical Open Wound: Date Began:

New Surgical Flap or Graft: Date of Surgery:

Activity Date: 07/09/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 0500 LW8 07/09/16 0547 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 07/09/16 0600 LW8 07/09/16 0624 LW8
Temperature: 97.7
Temperature Source+: Oral
Pulse: 70
Pulse Source+: BRACHIAL
Respirations: 18

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0600 (continued)

6680 Vital Signs (continued)
Blood Pressure: 102/66
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 98 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 0627

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 07/09/16 0627 PG2 07/09/16 0627 PG2
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X Q1H W/A
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT
Outcome: VERBAL
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: CLEARS
Outcome: VERBAL

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0627 (continued)

6991 Post Operative Care - OUTCOMES (continued)

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N
150005 Intake/Output A 06,18 CP
- Document 07/09/16 0627 PG2 07/09/16 0628 PG2
INTAKE
PO: 1000 IV: 1250 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: 4 NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
- Edit Results 07/09/16 0627 PG2 07/09/16 0638 PG2
Void (ml): 1800 []
Void Episodes: [4]
525003 IV Site Check A 06,18 CP
- Document 07/09/16 0627 PG2 07/09/16 0628 PG2
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0627 (continued)

525003 IV Site Check (continued)

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance A 06,18 CP
- Document 07/09/16 0627 PG2 07/09/16 0628 PG2

Activity Date: 07/09/16 Time: 0643

Patient Notes: Nursing Notes
- Create 07/09/16 0643 PG2 07/09/16 0646 PG2
Abnormal? N Confidential? N
NO CHANGES TO REPORT IN INITIAL SHIFT ASSESSMENT. RESTED WELL. MEDICATED WITH PRN PO PAIN MED X2 FOR POSTOP PAIN. PT REPORTS PASSING GAS MULTIPLE TIMES THIS SHIFT. + BOWEL SOUNDS X4. PT ASSESSED & SAFETY REINFORCED Q2H & PRN. CB IN REACH. SHIFT GOALS MET.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 0700

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 0700 EW 07/09/16 0808 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 0706

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 07/09/16 0706 CW7 07/09/16 1051 CW7
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From FROM P GREEN RN

Comment

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0709

Patient Notes: Nursing Notes
- Create 07/09/16 0709 CW7 07/09/16 1058 CW7
Abnormal? N Confidential? N
RECEIVED RESTING UPON ROUNDS IN NO APPARENT DISTRESS. REVIEWED PLAN OF CARE. REINFORCED TEACHING RE: USE OF CALL BELL AS NEEDED FOR ASSIST. CALL BELL WITHIN REACH. REPORTS INCISIONAL PAIN CONTROLLED AT THIS TIME BUT WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 0800

3140 Airway Management A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
3440 Incision Site Care A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
1629 OSA ASSESSMENT A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
Anticoagulant Educ Material provided to Patient &/or Family? NA
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS A 08,20 CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X Q1H W/A

Patient demonstates technique for splinting incision: Y

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: CLEARS

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N

0840	Positioning							A	QS	CP
- Document	07/09/16 0800 CW7	07/09/16 1052 CW7								
275051	VTE Prophylaxis Orders Complete?							A	08,20	CP
- Document	07/09/16 0800 CW7	07/09/16 1053 CW7								
VTE Prophylaxix Orders Complete? Y										
525002	IV THERAPY ASSESSMENT							A	QS	CP
- Document	07/09/16 0800 CW7	07/09/16 1053 CW7								

IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT HAND
Site Appear #1: NO REDNESS NOTED
Type of Cath #1: Protectiv
Cath Gauge #1: 20
Fluid/Rate #1: LR @ 125 ML/HR
Date Insert/DC #1: 07/08/16
IV #1 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1056 CW7

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:
Rt Reaction To Light+:
Size Left+:
Lt Reaction To Light+:

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Vision Impairment: GLASSES
Hearing Impairment: NONE

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry.

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: Sticker:
Comfort Measures Only NA
Chest Pain: If Yes, Document in Pain Assessment Intervention.
Heart Sounds+:
Telemetry Pattern+:
Pulse Rhythm+: Regular
Heart Rate: Pacemaker: Defibrillator:
Dizziness/Syncope+: Palpitations:
JVD+:

Edema 1+: 1+
Loc 1+: Post Op Site
Edema 2+:
Loc 2+:
TED Hose: N
IPC: Y
Pitting: N
Pitting:
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.
Respirations: 18 O2 Sat: 97 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL
Resp Pattern+: WNL
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:

Breath Sounds

LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Diminished

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Airway+: Patent
RLL+: Diminished
Airway Suctioned+:
Lung Sounds:
COPD Educational Video: NA
Profile
Resp Comment <Esc>:
Cyanosis: N
Pallor: Y

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+:

Transfer, Lift, or Ambulation equipment NI

Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti: N
Location/Size<Esc>:
Stage+:
Wound Site #1: RIGHT LOW ABD
Wound Appear #1+: DRAINAGE
Closure Type #1+:
Dressing Type #1: OPSITE
Dress Appear #1: DRY/INTACT W/SHADOWING
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: NONE

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally: 3
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea:
Emesis:
Constipation:
Diarrhea: N
Last BM:
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool:
Rectal Tube:
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present:
Ostomy Appliance:
Bowel Sounds
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Currently Menses:
LMP:
Urine Color+:
Character+:
Urine Odor+:
Prostate Problems:
Incontinent Bladder:
Suprapubic Catheter:
Dialysis
CAPD:

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING

**********PAIN ASSESSMENT**********

Pt C/O Pain: N
Acceptable Scale/Goal for EXCELLENT pain management this shift: 4
Pain Scale:
Pain Location+:
Patient Sleeping:
Quality Of Pain+:
Sleeping Resp:
Respiratory Quality:
Onset/Duration:
Respiratory Depth:
Pain Med Given<Esc>:
Time Med Given:
Date:
Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE
Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: No Preference
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

EDUCATION/INTERVENTION:
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800

7370 Discharge Planning Assessment A QS
- Document 07/09/16 0800 CW7 07/09/16 1053 CW7

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NOT AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:

CP 9610 Fall Risk Assessment/Interventions A QS
- Document 07/09/16 0800 CW7 07/09/16 1053 CW7

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

*****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 2

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800 (continued)

CP 9610 Fall Risk Assessment/Interventions (continued)

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB.
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 0800

99 SEPSIS Documentation — A QS — CP
- Document 07/09/16 0800 CW7 07/09/16 1052 CW7

Temperature: 97.7
Temperature Source+: Oral
Pulse: 80
Respirations: 22
Blood Pressure: 99/62
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:

Activity Date: 07/09/16 Time: 0932

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 07/09/16 0932 EW 07/09/16 0932 EW

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 1031

6680 Vital Signs — A 06,10,14,18,22,02 — OE
- Document 07/09/16 1031 EW 07/09/16 1032 EW

Temperature: 97.7
Temperature Source+: Oral
Pulse: 80
Pulse Source+: BRACHIAL
Respirations: 22
Blood Pressure: 99/62
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1031 (continued)

6680 Vital Signs (continued)
IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 1056

6419 C-Diff Screening — A 11 — CP
- Document 07/09/16 1056 CW7 07/09/16 1056 CW7

**Three loose,watery stools past 24hrs; no clinical reason: N (i.e. Laxatives use)

Activity Date: 07/09/16 Time: 1100

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 07/09/16 1100 EW 07/09/16 1207 EW

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 1300

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 07/09/16 1300 EW 07/09/16 1431 EW

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 1432

6680 Vital Signs — A 06,10,14,18,22,02 — OE
- Document 07/09/16 1432 EW 07/09/16 1442 EW

Temperature: 98.6
Temperature Source+: Oral
Pulse: 77

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1432 (continued)

6680 Vital Signs (continued)
Pulse Source+: BRACHIAL
Respirations: 24
Blood Pressure: 112/63
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 100 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 1442

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 07/09/16 1442 CW7 07/09/16 1442 CW7

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1442 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 07/09/16		Time: 1458								
6905 PATIENT BATH							A	PRN		CP
- Document	07/09/16	1458	EW	07/09/16	1459	EW				
Hygiene: Assisted								Date: 07/09/16		
Patient Refused (Bath):				Nurse Notified (Bath):						
Hygiene Comment: WIFE HELP WITH BATH.										
Activity Date: 07/09/16		Time: 1500								
5500011 Purposeful Rounding							A	Q2HODD		CP
- Document	07/09/16	1500	EW	07/09/16	1642	EW				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 07/09/16		Time: 1609								
1663 IPC, TED, VFP Documentation							A	04,16		CP
- Document	07/09/16	1609	CW7	07/09/16	1609	CW7				
IPC: Y										
TED Hose: N										
Venous Foot Pump: N										
3592 TED/HEEL PROTECTORS/IPC Skin Assessment							A	04,16		CP
- Document	07/09/16	1609	CW7	07/09/16	1610	CW7				
TED Hose - removed for skin assessment and reapplied. NA										
IPC - removed for skin assessment and reapplied. Y										
Heel Protectors - removed for skin assessment and reapplied. NA										
Comment:										
800001 Education/Teaching Assessment							A	04,16		CP
- Document	07/09/16	1609	CW7	07/09/16	1610	CW7				
Written Education Materials Provided.										
CHF EDUCATION: N										
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions.								Instructional video shown? Comment		
STROKE/TIA EDUCATION N Education Material Provided:								Educ Material Date:		

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 07/09/16		Time: 1609 (continued)								
800001 Education/Teaching Assessment (continued)										
Activation of Emerg Med System: Need for F/U after discharge:										
Medication prescribed at discharge: Risk factors for stroke:										
Warning signs & symptoms for stroke:										
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE										
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised										
Avoid major diet chges or notify Health Prof before changing										
Compliance Education: Importance of taking warfarin as instructed										
Important to monitor warfarin w/scheduled PT/INR blood draws										
Potential for Adverse Drug Reactions & Interactions:										
Don't take/DC any meds or OTC meds except thru Phys or Pharm										
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level										
Education Session Date: Follow-up Education:										
Care/Education Codes: ACTIVITY Material Codes: VERBAL										
DC PLAN										
DIET										
DIS										
ISU										
MEDS										
OTHER										
PAIN										
POC										
SAFETY										
TX										
Comment: REINFORCE Comment:										
EDUCATION/INTERVENTION: POC, PAIN MANAGEMENT, MEDS/SIDE EFFECTS, ACTIVITY, DIET, SAFETY, WOUND CARE, DC PLANNING, NUTRITION										CP
Outcome: REINFORCE										
Non-Surgical Open Wound: N Date Began:										
New Surgical Flap or Graft: N Date of Surgery:										
Activity Date: 07/09/16		Time: 1610								
6991 Post Operative Care - OUTCOMES							A	18,06		CP
- Document	07/09/16	1610	CW7	07/09/16	1611	CW7				
Post Operative Care - OUTCOMES										
Patient demonstrates use of Incentive Spirometer: Y										
Goal: 10X Q1H W/A										
Outcome: DEMON										

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1610 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT
Outcome: VERBAL
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: CLEARS
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 07/09/16 1610 CW7 07/09/16 1610 CW7
Diet Ordered: CLEAR LIQ
Meal: BREAKFAST, LUNCH
% Diet Taken: >75% (GOOD)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
150005 Intake/Output A 06,18 CP
- Document 07/09/16 1610 CW7 07/09/16 1611 CW7
INTAKE
PO: 960 IV: 1000 Blood: TPN: NG Irrigation:
TF Tube: IVPB: 100 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1610 (continued)

150005 Intake/Output (continued)
OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 07/09/16 1610 CW7 07/09/16 1611 CW7
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 07/09/16 1610 CW7 07/09/16 1611 CW7
Patient Notes: Nursing Notes
- Create 07/09/16 1610 CW7 07/09/16 1610 CW7
Abnormal? N Confidential? N
OOB TO CHAIR. WILL AMBULATE WHEN PATIENT READY.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 1700

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 1700 EW 07/09/16 1835 EW
Pain
Potty

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1700 (continued)

5500011 Purposeful Rounding (continued)
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/09/16 Time: 1751

Patient Notes: Nursing Notes
- Create 07/09/16 1751 CW7 07/09/16 1751 CW7
Abnormal? N Confidential? N
AMBULATING IN HALLWAY WITH MINIMAL ASSIST.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 1820

Patient Notes: Nursing Notes
- Create 07/09/16 1820 CW7 07/09/16 1821 CW7
Abnormal? N Confidential? N
TOLERATING FULL LIQUID DIET WELL. DENIES NAUSEA/VOMITING. REPORTS PASSING FLATUS. NO B.M. NOTED YET.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 1836

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 07/09/16 1836 EW 07/09/16 1839 EW
Temperature: 98.6
Temperature Source+: Oral
Pulse: 74
Pulse Source+: BRACHIAL
Respirations: 22
Blood Pressure: 112/67
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 1836 (continued)

6680 Vital Signs (continued)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 1900 SW6 07/10/16 0126 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 07/09/16 Time: 1915

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 07/09/16 1915 MG 07/09/16 1941 MG
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From MELISSA,RN/CORA,RN

Comment
Patient Notes: Nursing Notes
- Create 07/09/16 1915 MG 07/09/16 1940 MG
Abnormal? N Confidential? N
UP TO BATHROOM WITH ASSISTANCE OF WIFE. NO C/O AT PRESENT. CALL BELL IN REACH. WILL MONITOR.
Note Type Description
No Type None

Activity Date: 07/09/16 Time: 2011

3140 Airway Management A QS CP
- Document 07/09/16 2011 MG 07/09/16 2356 MG
3440 Incision Site Care A QS CP
- Document 07/09/16 2011 MG 07/09/16 2356 MG
1629 OSA ASSESSMENT A QS CP
- Document 07/09/16 2011 MG 07/09/16 2356 MG
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

1629 OSA ASSESSMENT (continued)
Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 07/09/16 2011 MG 07/10/16 0001 MG
Anticoagulant Educ Material provided to Patient &/or Family? NA
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS A 08,20 CP
- Document 07/09/16 2011 MG 07/10/16 0001 MG
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X Q1H W/A

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: Liquids

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N

0840 Positioning A QS CP
- Document 07/09/16 2011 MG 07/09/16 2356 MG

275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 07/09/16 2011 MG 07/10/16 0002 MG
VTE Prophylaxix Orders Complete? Y

525002 IV THERAPY ASSESSMENT A QS CP
- Document 07/09/16 2011 MG 07/10/16 0003 MG
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT FOREARM IV Site #3:
Site Appear #1: NO REDNESS NOTED Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: LR @ 50 ML/HR Fluid/Rate #3:
Date Insert/DC #1: Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 07/09/16 2011 MG 07/10/16 0000 MG
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:
Rt Reaction To Light+: Normal Reactive
Size Left+:
Lt Reaction To Light+: Normal Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative Site:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous Hearing Impairment: NONE

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Comfort Measures Only NA

Chest Pain: If Yes, Document in Pain Assessment Intervention.

Heart Sounds+:

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate: Pacemaker: Defibrillator:

Dizziness/Syncope+: Palpitations:

JVD+:

Edema 1+: 1+ Edema 2+:
Loc 1+: Post Op Site Loc 2+:
TED Hose: N
IPC: Y
Pitting: N Pitting: Venous Foot Pump: N

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Peripheral Pulses

Dorsalis Lt+: Normal	Femoral Rt+:
Dorsalis Rt+: Normal	Femoral Lt+:
Post Tib Lt+:	
Post Tib Rt+:	Cap Refill RUE+: Brisk
Carotid Rt+:	Cap Refill LUE+: Brisk
Carotid Lt+:	Cap Refill RLE+: Brisk
Brachial Rt+:	Cap Refill LLE+: Brisk
Brachial Lt+:	
Radial Rt+: Normal	
Radial Lt+: Normal	

Cardio Comment <Esc>:

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 22 O2 Sat: 100 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Breath Sounds

LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Diminished
RLL+: Diminished

Resp Pattern+: WNL
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Lung Sounds: CLEAR
COPD Educational Video: NA Profile

Resp Comment <Esc>: NAD NOTED. RESP EVEN & UNLABORED. Cyanosis: N
Pallor: Y

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+:

61538666 1D8848E0B793, KNIGHT, 68

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Transfer, Lift, or Ambulation equipment NI

Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: RIGHT LOW ABD
Wound Appear #1+: DRAINAGE
Closure Type #1+:
Dressing Type #1: OPSITE
Dress Appear #1: DRY/INTACT W/SHADOWING
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: NONE

Skin Comment <Esc>: RIGHT ABDOMEN OPSITE DRSG DRY/INTACT WITH BLOODY SHADOWING NOTED, AREA AROUND DRSG IS SWOLLEN/PUFFY NO REDNESS OR FOUL ODOR NOTED. OLD MID ABD WELL HEALED INCISION NOTED.

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally:	Adequate: 3
No Impairment:	Walks Frequently: 4	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 07/09/16
Emesis: N Diarrhea: N Stool Amount+: Large
Stool Color+: Brown
Stool Consistency+: Liquid
Incontinent Stool: N
Rectal Tube:
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present:
Ostomy Appliance:
GI Comment <Esc>:

Bowel Sounds
RUQ+: HYPERACTIVE
LUQ+: HYPERACTIVE
RLQ+: HYPERACTIVE
LLQ+: HYPERACTIVE
Abd Appearance+: SOFT

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Urine Color+: Yellow
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder:
Suprapubic Catheter:

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT pain management this shift: 4
Pain Scale: 5
Pain Location+:
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:

Patient Sleeping: N
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: 2009 Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Pain Comment<Esc>:
WILL MEDICATE FOR PAIN AS INDICATED, SEE EMAR.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: No Preference
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

EDUCATION/INTERVENTION: POC, PAIN MANAGEMENT, MEDS/SIDE EFFECTS, ACTIVITY, DIET, SAFETY, WOUND CARE, DC PLANNING, NUTRITION

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 07/09/16 2011 MG 07/10/16 0001 MG
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 07/09/16 2011 MG 07/10/16 0001 MG
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NOT AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

7370 Discharge Planning Assessment (continued)
[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:
9610 Fall Risk Assessment/Interventions A QS CP
- Document 07/09/16 2011 MG 07/10/16 0002 MG
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthatics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 5

*****Interventions*****
Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

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Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2011 (continued)

9610 Fall Risk Assessment/Interventions (continued)

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 07/09/16 2011 MG 07/09/16 2356 MG
Temperature: 98.6
Temperature Source+: Oral
Pulse: 74
Respirations: 22
Blood Pressure: 112/67
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:

Activity Date: 07/09/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 2100 SW6 07/10/16 0127 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

Problem/Outcome/Intervention Description

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

Activity Date: 07/09/16 Time: 2100 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 07/09/16 Time: 2200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 07/09/16 2200 SW6 07/10/16 0124 SW6
Temperature: 98.5
Temperature Source+: Oral
Pulse: 69
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 107/69
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 95
Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/09/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/09/16 2300 SW6 07/10/16 0129 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0100

5500011 Purposeful Rounding — A — Q2HODD
- Document 07/10/16 0100 SW6 07/10/16 0127 SW6

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 07/10/16 Time: 0200

6680 Vital Signs — A — 06,10,14,18,22,02 — OE
- Document 07/10/16 0200 SW6 07/10/16 0656 SW6

Temperature:
Temperature Source+:
Pulse:
Pulse Source+:
Respirations:
Blood Pressure:
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

6409 FALLS SCREEN - FOLLOW-UP — A — 02,14 — CP
- Document 07/10/16 0200 MG 07/10/16 0426 MG

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0200 (continued)

CP 6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 07/10/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/10/16 0300 SW6 07/10/16 0654 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 07/10/16 Time: 0426

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 07/10/16 0426 MG 07/10/16 0426 MG
IPC: Y
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 07/10/16 0426 MG 07/10/16 0426 MG
TED Hose - removed for skin assessment and reapplied. NA
IPC - removed for skin assessment and reapplied. Y
Heel Protectors - removed for skin assessment and reapplied. NA

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0426 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)
Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 07/10/16 0426 MG 07/10/16 0426 MG
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions.
Instructional video shown?
Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: ACTIVITY
DC PLAN
DIET
DIS
ISU
MEDS
OTHER
PAIN
POC
SAFETY
TX
Material Codes: VERBAL
Comment: REINFORCE
Comment:

EDUCATION/INTERVENTION: POC, PAIN MANAGEMENT, MEDS/SIDE EFFECTS, ACTIVITY, DIET, SAFETY, WOUND CARE, DC PLANNING, NUTRITION

Outcome: REINFORCE

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0500

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 07/10/16 0500 SW6 07/10/16 0654 SW6

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 07/10/16 Time: 0628

6991 Post Operative Care - OUTCOMES — A 18,06 — CP
- Document 07/10/16 0628 MG 07/10/16 0628 MG

Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X Q1H W/A
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT
Outcome: VERBAL
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: Liquids
Outcome: VERBAL

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0628 (continued)

6991 Post Operative Care - OUTCOMES (continued) — CP

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NA
Smoking Status: Never smoker Nursing Note: N

150005 Intake/Output — A 06,18 — CP
- Document 07/10/16 0628 MG 07/10/16 0629 MG

INTAKE
PO: 300 IV: 600 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 500 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: 2 Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

525003 IV Site Check — A 06,18 — CP
- Document 07/10/16 0628 MG 07/10/16 0629 MG

IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 07/10/16 Time: 0628										
5500010 Rounds Surveillance							A	06,18		CP
- Document	07/10/16	0628	MG	07/10/16	0629	MG				
Activity Date: 07/10/16 Time: 0629										
Patient Notes: Nursing Notes										
- Create	07/10/16	0629	MG	07/10/16	0631	MG				

Abnormal? N Confidential? N

RESTING IN BED WITH EYES CLOSED AT INTERVALS. REGULAR RISE AND FALL OF CHEST WALL NOTED. AROUSES EASILY TO VERBAL STIMULI. DRESSING TO ABD DRY AND INTACT. REFUSED SCDS THIS SHIFT. AMBULATING TO BATHROOM WITHOUT DIFFICULTY. NAD NOTED. IV FLUID INFUSING WITHOUT DIFFICULTY. SITE WITHOUT REDNESS OR EDEMA. CALL BELL IN REACH.

Note Type: No Type Description: None

Activity Date: 07/10/16 Time: 0637										
6680 Vital Signs							A	06,10,14,18,22,02		OE
- Document	07/10/16	0637	SW6	07/10/16	0640	SW6				

Temperature: 98.2
Temperature Source+: Oral
Pulse: 75
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 108/66
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/10/16 Time: 0700										
5500011 Purposeful Rounding							A	Q2HODD		CP
- Document	07/10/16	0700	EW	07/10/16	1003	EW				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Activity Date: 07/10/16 Time: 0700 (continued)										
5500011 Purposeful Rounding (continued)										

Comment:
<Esc>

Activity Date: 07/10/16 Time: 0730										
6922 Nursing Report (Hand Off)							A	07,19		CP
- Document	07/10/16	073D	KC	07/10/16	0939	KC				

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From MELISSA GODWIN RN

Comment

Activity Date: 07/10/16 Time: 0800										
3140 Airway Management							A	QS		CP
- Document	07/10/16	0800	KC	07/10/16	0942	KC				
3440 Incision Site Care							A	QS		CP
- Document	07/10/16	0800	KC	07/10/16	0942	KC				
1629 OSA ASSESSMENT							A	QS		CP
- Document	07/10/16	0800	KC	07/10/16	0942	KC				

OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided							A	QS		CP
- Document	07/10/16	0800	KC	07/10/16	0944	KC				

Anticoagulant Educ Material provided to Patient &/or Family? NA
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS							A	08,20		CP
- Document	07/10/16	0800	KC	07/10/16	0945	KC				

Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

6990 Post Operative Care - GOALS (continued)
Goal: 10X Q1H W/A

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: Liquids

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NA
Smoking Status: Never smoker Nursing Note:

0840 Positioning A QS CP
- Document 07/10/16 0800 KC 07/10/16 0942 KC

275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 07/10/16 0800 KC 07/10/16 0945 KC
VTE Prophylaxix Orders Complete? Y

525002 IV THERAPY ASSESSMENT A QS CP
- Document 07/10/16 0800 KC 07/10/16 0945 KC
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT FOREARM IV Site #3:
Site Appear #1: NO REDNESS NOTED Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: LR @30 Fluid/Rate #3:

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Date Insert/DC #1: 07/08/16 Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 07/10/16 0800 KC 07/10/16 0944 KC
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils ***Strength Of Extremities***
Size Right+: RUE+:
Rt Reaction To Light+: LUE+:
RLE+:
Size Left+: LLE+:
Lt Reaction To Light+:

Peripheral Sensory Deficit:

Behavior+: Site:

Speech/Cry+:

Vision Impairment:
Responsive To+: Hearing Impairment:

Mental Status:

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: If Yes, Document in Pain Assessment Intervention.

Heart Sounds+:

Telemetry Pattern+:

Pulse Rhythm+:

Heart Rate: Pacemaker: Defibrillator:

Dizziness/Syncope+: Palpitations:

JVD+:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal Femoral Rt+:
Dorsalis Rt+: Normal Femoral Lt+:
Post Tib Lt+:
Post Tib Rt+: Cap Refill RUE+: Brisk
Carotid Rt+: Cap Refill LUE+: Brisk
Carotid Lt+: Cap Refill RLE+: Brisk
Brachial Rt+: Cap Refill LLE+: Brisk
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Cardio Comment <Esc>:

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: O2 Sat: %/L of O2:
O2 Mode+: ***Breath Sounds***
RR Description+: LUL+:

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Resp Pattern+: LLL+:
Chest Expansions+:
Cough+: RUL+:
Sputum Amount+:
Sputum Consistency+: RML+:
Sputum Color+:
Airway+: RLL+:
Airway Suctioned+:

Lung Sounds: CLEAR
COPD Educational Video: Profile

Resp Comment <Esc>: Cyanosis:
Pallor:

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+:

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal Wound Site #1: RIGHT LOW ABD
Skin Temp+: Warm Wound Appear #1+: DRAINAGE
Skin To Touch+: Dry Closure Type #1+:
Skin Condition+: Warm & Dry Dressing Type #1: OPSITE
Dress Appear #1: DRY/INTACT W/SHADOWING

Turgor+: GOOD
Mucous Membranes+: Moist & Intact Wound Site #2:
Specialty Bed: Wound Appear #2+:
Decubiti: N Closure Type #2+:
Location/Size<Esc>: Dressing Type #2:
Dress Appear #2:

Stage+:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Tubes/Drains: NONE

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally:
Walks Frequently: 4

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited:
No Limitations: 4

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 22

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
Constipation: N
Diarrhea: N
Last BM: 07/09/16
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool:
Rectal Tube:
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present:
Ostomy Appliance:

Bowel Sounds
RUQ+: HYPERACTIVE
LUQ+: HYPERACTIVE
RLQ+: HYPERACTIVE
LLQ+: HYPERACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Does Patient have a Foley Catheter? N

Urine Color+:
Character+:
Urine Odor+:
Incontinent Bladder:
Suprapubic Catheter:
Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y
Pain Scale: 5
Acceptable Scale/Goal for EXCELLENT pain management this shift: 4
Pain Location+: ABDOMINAL
Quality Of Pain+: STABBING
Onset/Duration: POST OP
Pain Med Given<Esc>: SEE EMAR
Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******

Response to Treatment: STABLE

Type of Isolation: NONE
Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: No Preference
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

EDUCATION/INTERVENTION:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 07/10/16 0800 KC 07/10/16 0944 KC
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 07/10/16 0800 KC 07/10/16 0945 KC

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NOT AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:

9610 Fall Risk Assessment/Interventions A QS CP
- Document 07/10/16 0800 KC 07/10/16 0945 KC

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued) CP

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 4

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 07/10/16 0800 KC 07/10/16 0942 KC
Temperature: 98.2
Temperature Source+: Oral
Pulse: 75
Respirations: 18
Blood Pressure: 108/66
MAP:
Mental Status: Alert & Oriented
(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk
Physician Notified:
If NO, Reason:
Patient Notes: Nursing Notes
- Create 07/10/16 0800 KC 07/10/16 0948 KC
Abnormal? N Confidential? N
RECEIVED REPORT FROM PREVIOUS RN. PT LYING IN BED WATCHING TV. ALERT AND ORIENTED, ANSWERS QUESTIONS APPROP. RR REGULAR AND NONLABORED, ON ROOM AIR. SKIN WARM AND DRY, DRESSING IN PLACE TO RL ABDOMEN WITH SOME OLD DRAINAGE NOTED. ABDOMEN SOFT AND SURGICALLY TENDER. TOLERATING PO MEALS WITHOUT COMPLAINT. VOIDING CLEAR YELLOW URINE IN URINAL. BED IN LOCKED AND LOW POSITION, CALLBELL WITHIN REACH.
Note Type Description
No Type None

Activity Date: 07/10/16 Time: 0900

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/10/16 0900 EW 07/10/16 1005 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/10/16 Time: 1039

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 07/10/16 1039 EW 07/10/16 1039 EW
Temperature: 98.3

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1039 (continued)

6680 Vital Signs (continued)
Temperature Source+: Oral
Pulse: 90
Pulse Source+: BRACHIAL
Respirations: 22
Blood Pressure: 112/69
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat:
Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/10/16 Time: 1114

6419 C-Diff Screening A 11 CP
- Document 07/10/16 1114 KC 07/10/16 1114 KC
**Three loose,watery stools past 24hrs; no clinical reason: N
(i.e. Laxatives use)

Activity Date: 07/10/16 Time: 1147

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/10/16 1147 EW 07/10/16 1147 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
75015 Discharge Med Rec via RXM A PRN CP
- Document 07/10/16 1147 TG 07/10/16 1155 TG
Discharge Medication Link (RXM): Y

Activity Date: 07/10/16 Time: 1156

7371 Discharge Information for PATIENT A PRN CP
- Document 07/10/16 1156 TG 07/10/16 1158 TG
Discharge Diagnosis: HISTORY OF CREATION OF OSTOMY
Discharge Diagnosis Care Notes given to Patient: Y

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1156 (continued)

7371 Discharge Information for PATIENT (continued)
***COMMUNITY REFERRALS - Service Needed

Home Health? NONE Home Health Company:
Hospice? NONE Hospice Agency:
Facility? NONE Facility Name:
Equipment? NONE Equipment Needed:
Other:

Diet: REGULAR Dietary Supplements NONE
Comment:
***ACTIVITIES

No Restrictions: Up with walker Cane Crutches
Resume activities as tolerated: Up with assistance Fall Precautions
No driving for days. Other
No heavy lifting (No more than lbs for days.)
May return to work/school on Restrictions NO DRIVING WHILE TAKING NARCOTICS
Activities as per Dr instructions.
Follow-up Appointments

	Date:	Time:	With Whom:	Reason:	Patient/SO to Arrange:
1:	:	:	DR.RIMKUS	HOSPITAL F/U 347-7291 1 WEEK:	
2:	:	:		CALL FOR APPT MONDAY	:
3:	:	:		:	:

Follow up with as scheduled as needed

***WOUND CARE INSTRUCTIONS NA

Keep same dressing on until clinic appointment
Leave incision open to air Cover incision with gauze or transparent dressing
Keep wound/incision clean and dry
If Steri-strips loose, remove them Other

***MEDICATION INFORMATION

Universal Medication Form Given: Y New Prescriptions Given: Y

Patient verbalized understanding of Medications: Y

Patient/Family has been instructed to bring updated current
medication list when returning to Conway Medical Center: Y

Educ material given patient/significant other-all new meds Y

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1156 (continued)

7371 Discharge Information for PATIENT (continued)

Date Flu Vaccination Received: NFS

Patient states counseling was given and understood on the
risks associated with smoking and second hand smoke: Y Why Not?
<Esc>

***EDUCATION Written Education Materials Provided.

Patient provided with written discharge instruction booklet/ CHF Indicators:
pamphlet: HEART FAILURE CONTROL PLAN; includes activity, Instructional video shown?
diet, physician follow-up, medications, what to do if
symptoms worsen and weight monitoring instructions. Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:
***PAIN MANAGEMENT X

You may have some pain and discomfort from your procedure. A prescription for pain
may be given to you before you leave the hospital. If the doctor did not prescribe
medication for pain, you may take your non-prescription pain reliever.

Notify Physician for: If you feel that your pain is increasing, or is unrelieved,
Temperature over 101 for 24hrs Y Incision red, swollen, or warm Y
Foul odor from Wound or Drainage Y Wound red, swollen, or warm Y

Valuables taken from safe (if stored): N Contacts: N Sent W/Pt: N
Personal belongings taken: Y Glasses: N Sent W/Pt: N
Medications taken: (if stored) N Hearing Aide(s): N Sent W/Pt: N
Dependency/Mental Health Diagnosis: N Dentures: N Sent W/Pt: N
Prostheses: N Sent W/Pt: N

Patient Owned Med Equipment Details: NONE Taken home: N

ADDITIONAL GENERAL INSTRUCTIONS: CALL DR. IF TEMP OVER 101.5 FOR MORE THAN 24 HRS,
<Esc> NAUSEA/VOMITING UNRELIEVED OR PAIN UNRELIEVED.

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1156 (continued)

7371 Discharge Information for PATIENT (continued)

Instructions Given To: Patient: Y Significant Other: Relationship:

If limited English or hearing impaired, interpreter offered?
Interpreter:

Requested electronic discharge instructions. N
Electronic copy of discharge instructions given: N
Escorted By: STAFF
Via: WHEELCHAIR

I have received and understand the above instructions and
was given the opportunity to ask questions. Yes No

Discharge nurse: KIM C., RN

Patient/Responsible Person Signature & Relationship:

Activity Date: 07/10/16 Time: 1312

5500011 Purposeful Rounding A Q2HODD CP
- Document 07/10/16 1312 EW 07/10/16 1313 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 07/10/16 Time: 1320

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 07/10/16 1320 KC 07/10/16 1320 KC

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1320 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

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Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1320 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 07/10/16 Time: 1400

Patient Notes: Nursing Notes
- Create 07/10/16 1400 KC 07/10/16 1608 KC
Abnormal? N Confidential? N
REVIEWED DC INSTRUCTIONS WITH PT, STATES UNDERSTANDING AND IS IN AGREEMENT FOR DISCHARGE. HL DISCONTINUED.
Note Type Description
No Type None

Activity Date: 07/10/16 Time: 1430

10026 DISCHARGE PATIENT-Escorted A PRN CP
- Document 07/10/16 1430 KC 07/10/16 1608 KC
Escorted By: STAFF
Via: WHEELCHAIR

Activity Date: 07/10/16 Time: 1440

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 07/10/16 1440 EW 07/10/16 1455 EW
Temperature: 98.2
Temperature Source+: Oral
Pulse: 78
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 111/67
BP Location+:
BP Position+:
Weight (lbs):
(Oz):

Problem/Outcome/Intervention Description

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

Activity Date: 07/10/16 Time: 1440 (continued)

6680 Vital Signs (continued)
kg:
Weight Source:
O2 Sat: Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 07/10/16 Time: 1448

6680 Vital Signs D 06,10,14,18,22,02 OE
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A -> D
Problem: General Surgery D
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A -> D
Outcome: Respiratory Status: Ventilation D
Definition: Movement of air in and out of the lungs
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
3140 Airway Management D QS CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
Outcome: Wound Healing: Primary Intention D
Definition: Extent of regeneration of cells and tissues following intentional closure
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
3440 Incision Site Care D QS CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
6540 Infection Control D CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
Outcome: Fluid Balance D
Definition: Water balance in the intracellular and extracellular compartments of the body
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
2080 Fluid/Electrolyte Management D PRN CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
Outcome: Post Operative Care D
Definition: Patient free of post operative complications
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
1629 OSA ASSESSMENT D QS CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
6419 C-Diff Screening D 11 CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D
6955 Anticoagulant Educ Materials Provided D QS CP
- Ed Status 07/10/16 1448 his 07/10/16 1448 his A => D

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Documented Units	From Change
Activity Date: 07/10/16		**Time: 1448**								
6990	Post Operative Care - GOALS						D	08,20		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6991	Post Operative Care - OUTCOMES						D	18,06		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
Problem: Standard Of Care							D			
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
Outcome: Standard Of Care							D			
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
0840	Positioning						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
10026	DISCHARGE PATIENT-Escorted						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1160	Nutritional Monitoring						D	18		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
150005	Intake/Output						D	06,18		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1663	IPC, TED, VFP Documentation						D	04,16		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750022	Neurological Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750023	Cardiovascular Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750024	Respiratory Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750026	Musculoskeletal Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750027	Gastrointestinal Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750028	Genitourinary Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
1750029	Integumentary Surveillance						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
275051	VTE Prophylaxis Orders Complete?						D	08,20		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
3592	TED/HEEL PROTECTORS/IPC Skin Assessment						D	04,16		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
525001	Medications, PRN						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
525002	IV THERAPY ASSESSMENT						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
525003	IV Site Check						D	06,18		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
5500	Off-Unit for Test/Procedure						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
5500010	Rounds Surveillance						D	06,18		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
5500011	Purposeful Rounding						D	Q2HODD		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Documented Units	From Change
Activity Date: 07/10/16		**Time: 1448**								
6409	FALLS SCREEN - FOLLOW-UP						D	02,14		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6650	SHIFT ASSESSMENT (Surveillance)						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6901	PATIENT LINEN CHANGE						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6902	PATIENT TURNED						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6903	PATIENT FED						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6904	PATIENT BED/CHAIR ALARM SET						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6905	PATIENT BATH						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6910	Last BM						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6911	Transfer/Nursing Report Record						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6922	Nursing Report (Hand Off)						D	07,19		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6923	Message (Hand Off)						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6944	Supplements/Tube Feedings						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6945	TIME OUT-Universal Protocol Beside Proc						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
6980	Vital Signs Manual Recheck						D	AD		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
7310	Admission Care						D	ONCE		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
7370	Discharge Planning Assessment						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
7371	Discharge Information for PATIENT						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
750006	PAIN ASSESSMENT						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
750011	Pain Assessment (Telemetry Unit)						D			CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
75015	Discharge Med Rec via RXM						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
7900	Flu Vaccination Received						D	PRN		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
800001	Education/Teaching Assessment						D	04,16		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D
9610	Fall Risk Assessment/Interventions						D	QS		CP
- Ed Status	07/10/16 1448 his			07/10/16 1448 his						A => D

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Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 07/10/16	Time: 1448									
99	SEPSIS Documentation						D	QS		CP
- Ed Status	07/10/16	1448	his	07/10/16	1448	his				A => D
Activity Date: 07/11/16	Time: 0712									
7323	CASE MANAGEMENT - Discharge Plan						A	PRN		AS
- Create	07/11/16	0712	JB	07/11/16	0712	JB				
- Document	07/11/16	0712	JB	07/11/16	0712	JB				

CASE MANAGEMENT - Discharge Plan

D/C Date 07/10/16 DISCHARGE DISPOSITION: H DC Dispostion Status: N
PCP

SPECIFIC DISCHARGE DISPOSITION LOCATION:
SUB ACUTE REHAB ALF HOSPICE

HHS ACUTE REHAB

PSYCHIATRIC: DSS DME

LTAC NH - LONG TERM CARE DME - Ordered Equipment:

CLTC :

HANDOUTS GIVEN:
Community Clinics Long Term Care Home Care Transportation
Resource Directory Social Security Rx Assist
Substance Abuse Homelessness RCF Advance Directives
Other:

~~~~~~REFERRALS WERE MADE FOR THE FOLLOWING AGENCIES:~~~~~~

ALF (Assisted Living Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

SNF (Skilled Nursing Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HOSPICE
TO FACILITY: Referral status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

ACUTE REHAB REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 07/11/16	Time: 0712 (continued)									
7323	CASE MANAGEMENT - Discharge Plan (continued)									

TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
HHS (Home Health Services)
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:

NH-LTC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

CLTC (Community Long Term Care) Referral Status:
DSS REFERRAL:
TO WHICH SERVICE: Referral Status:

DME REFERRAL:

TO PROVIDER: Referral Status: Equipment ordered:
:
TO PROVIDER: Referral Status: Equipment ordered:
:
TO PROVIDER: Referral Status: Equipment ordered:
:
TO PROVIDER: Referral Status: Equipment ordered:

PSYCHIATRIC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

TRANSITIONAL CARE: Follow up Appointment:
Contact Date: Physician: Date: Time:
Contact Time: Physician: Date: Time:
Physician: Date: Time:

Follow up appointment scheduled prior to D/C.
Follow up appointment scheduled post D/C.

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Problem/Outcome/Intervention Description

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

Activity Date: 07/11/16 Time: 0712 (continued)

7323 CASE MANAGEMENT - Discharge Plan (continued)

New Primary Care Provider Established. New Primary Care Provider:
Comments: PATIENT WAS DISCHARGE HOME WITH HIS WIFE.

Activity Date: 07/11/16 Time: 0825

7323	CASE MANAGEMENT - Discharge Plan						D	PRN		AS
- Ed Status	07/11/16	0825	his	07/11/16	0825	his				A => D

Monogram	Initials	Name	Nurse Type
CW7	CWHITE7	WHITE,CORAZON	RN
EW	EWHEELER	WHEELER,EVA	NA
JB	JBURLESON	BURLESON,GLORIA JEAN	RN
JL	JLEWIS10	LEWIS,JORDON	US
KC	KCUSANO	CUSANO,KIM	RN
LW8	LWILLIAMS8	WILLIAMS,LASHIKA	NA
MG	MGODWIN	GODWIN,MELISSA	RN
PG2	PGREEN2	GREEN,PAMELA	RN
SW6	SWILLIAMS6	WILLIAMS,SHARON	NA
TG	TGRAINGER	GRAINGER,TONY	RN
TH2	THEMINGWA2	HEMINGWAY,THOMASINA	NA
TJ9	TJOHNSON9	JOHNSON,TINA	US
his		automatic by program	

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes

07/08/16 1612 CW7 WHITE,CORAZON 07/08/16 1613 CW7
Abnormal? N Confidential? N
RECEIVED FROM PACU. AWAKE, ALERT, VITAL SIGNS STABLE. REVIEWED PLAN OF CARE. INSTRUCTED RE: USE OF CALL BELL AS NEEDED FOR ASSIST. CALL BELL WITHIN REACH. RIGHT FLANK OPSITE INTACT WITH SMALL AMOUNT OF DRAINAGE. TOLERATING SMALL AMOUNT OF CLEAR LIQUIDS.

07/08/16 1744 CW7 WHITE,CORAZON 07/08/16 1745 CW7
Abnormal? N Confidential? N
MEDICATED FOR COMPLAINTS OF INCISIONAL PAIN. WILL CONTINUE TO MONITOR.

07/08/16 1950 PG2 GREEN,PAMELA 07/08/16 2351 PG2
Abnormal? N Confidential? N
RESTING IN BED, A&OX3. NAD NOTED. RESP EVEN & UNLABORED ON RA. NO NEEDS OR COMPLAINTS VERBALIZED. R ABD DRSG DRY/INTACT WITH BLOODY SHADOWING NOTED. SCDS ON & OPERATIONAL. CB IN REACH. ENCOURAGED TO CALL WITH NEEDS, VERBALIZED UNDERSTANDING.

07/08/16 2120 PG2 GREEN,PAMELA 07/08/16 2349 PG2
Abnormal? N Confidential? N
PT RESTING IN BED WITH NAD NOTED. RESP EVEN & UNLABORED. A&OX3. RIGHT ABD OPSITE DRY/INTACT WITH BLOODY SHADOWING NOTED. PT VOIDING TO URINAL WITHOUT ANY DIFFICULTY. INITIAL SHIFT ASSESSMENT COMPLETED, SEE PI. SCHEDULED MEDS & PRN PO PAIN MED GIVEN AS CHARTED, SEE EMAR. SHIFT GOALS SET. POC & SAFETY MEASURES DISCUSSED. CB IN REACH. WILL REASSESS WITHIN THE HOUR.

07/08/16 2345 PG2 GREEN,PAMELA 07/08/16 2352 PG2
Abnormal? N Confidential? N
PT REPORTS HE HAS PASSED GAS MULTIPLE TIMES OVER THE LAST HOUR OR SO.

07/08/16 2346 PG2 GREEN,PAMELA 07/08/16 2347 PG2
Abnormal? N Confidential? N
PT RESTING COMFORTABLY IN BED WITH NO COMPLAINTS OR NEEDS AT THIS TIME. NO CHANGE IN ABD DRSG SINCE INITIAL SHIFT ASSESSMENT. CB IN REACH. IVF INFUSING AS ORDERED. NO S/S OF INFILTRATION.

07/09/16 0204 PG2 GREEN,PAMELA 07/09/16 0205 PG2
Abnormal? N Confidential? N
MEDICATED WITH ONE PO VICODIN FOR COMPLAINTS OF 5/10 POSTOP PAIN. NO FURTHER NEEDS. IVF INFUSING FREELY AS ORDERED. CB IN REACH. WILL MONITOR & REASSESS WITHIN THE HOUR.

07/09/16 0643 PG2 GREEN,PAMELA 07/09/16 0646 PG2
Abnormal? N Confidential? N
NO CHANGES TO REPORT IN INITIAL SHIFT ASSESSMENT. RESTED WELL. MEDICATED WITH PRN PO PAIN MED X2 FOR POSTOP PAIN. PT REPORTS PASSING GAS MULTIPLE TIMES THIS SHIFT. + BOWEL SOUNDS X4. PT ASSESSED & SAFETY REINFORCED Q2H & PRN. CB IN REACH. SHIFT GOALS MET.

07/09/16 0709 CW7 WHITE,CORAZON 07/09/16 1058 CW7
Abnormal? N Confidential? N
RECEIVED RESTING UPON ROUNDS IN NO APPARENT DISTRESS. REVIEWED PLAN OF CARE. REINFORCED TEACHING RE: USE OF CALL BELL AS NEEDED FOR ASSIST. CALL BELL WITHIN REACH. REPORTS INCISIONAL PAIN CONTROLLED AT THIS TIME BUT WILL CONTINUE TO MONITOR.

07/09/16 1610 CW7 WHITE,CORAZON 07/09/16 1610 CW7
Abnormal? N Confidential? N
OOB TO CHAIR. WILL AMBULATE WHEN PATIENT READY.

07/09/16 1751 CW7 WHITE,CORAZON 07/09/16 1751 CW7
Abnormal? N Confidential? N
AMBULATING IN HALLWAY WITH MINIMAL ASSIST.

07/09/16 1820 CW7 WHITE,CORAZON 07/09/16 1821 CW7
Abnormal? N Confidential? N
TOLERATING FULL LIQUID DIET WELL. DENIES NAUSEA/VOMITING. REPORTS PASSING

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Occurred Date	Time	by	Author	Recorded Date	Time	by	Nursing Notes
07/09/16	1820	CW7	WHITE,CORAZON	07/09/16	1821	CW7	(continued)

FLATUS. NO B.M. NOTED YET.

07/09/16 1915 MG GODWIN,MELISSA 07/09/16 1940 MG
Abnormal? N Confidential? N
UP TO BATHROOM WITH ASSISTANCE OF WIFE. NO C/O AT PRESENT. CALL BELL IN REACH. WILL MONITOR.

07/10/16 0629 MG GODWIN,MELISSA 07/10/16 0631 MG
Abnormal? N Confidential? N
RESTING IN BED WITH EYES CLOSED AT INTERVALS. REGULAR RISE AND FALL OF CHEST WALL NOTED. AROUSES EASILY TO VERBAL STIMULI. DRESSING TO ABD DRY AND INTACT. REFUSED SCDS THIS SHIFT. AMBULATING TO BATHROOM WITHOUT DIFFICULTY. NAD NOTED. IV FLUID INFUSING WITHOUT DIFFICULTY. SITE WITHOUT REDNESS OR EDEMA. CALL BELL IN REACH.

07/10/16 0800 KC CUSANO,KIM 07/10/16 0948 KC
Abnormal? N Confidential? N
RECEIVED REPORT FROM PREVIOUS RN. PT LYING IN BED WATCHING TV. ALERT AND ORIENTED, ANSWERS QUESTIONS APPROP. RR REGULAR AND NONLABORED, ON ROOM AIR. SKIN WARM AND DRY, DRESSING IN PLACE TO RL ABDOMEN WITH SOME OLD DRAINAGE NOTED. ABDOMEN SOFT AND SURGICALLY TENDER. TOLERATING PO MEALS WITHOUT COMPLAINT. VOIDING CLEAR YELLOW URINE IN URINAL. BED IN LOCKED AND LOW POSITION, CALLBELL WITHIN REACH.

07/10/16 1400 KC CUSANO,KIM 07/10/16 1608 KC
Abnormal? N Confidential? N
REVIEWED DC INSTRUCTIONS WITH PT, STATES UNDERSTANDING AND IS IN AGREEMENT FOR DISCHARGE. HL DISCONTINUED.

Monogram Initials	Name	Nurse Type
CW7 CWHITE7	WHITE,CORAZON	RN
KC KCUSANO	CUSANO,KIM	RN
MG MGODWIN	GODWIN,MELISSA	RN
PG2 PGREEN2	GREEN,PAMELA	RN

07/10/16

Conway Medical Center
CONWAY, SC
Patient Discharge Instructions

V00006933263 KNIGHT,DANIEL ERIC

Discharge Diagnosis: HISTORY OF CREATION OF OSTOMY

Community Referrals - Services Needed

- ☐ Home Health — Company:
- ☐ Hospice — Agency:
- ☐ Facility — Name:
- ☐ Equipment — Needed:

Other:

Activities ☐ No Restrictions Up with ☐ Walker ☐ Cane ☐ Crutches

- ☐ Resume Activities as Tolerated
- ☐ No Driving for days.
- ☐ No Heavy Lifting > pounds for days.
- ☐ Other:
- ☐ Up with Assistance
- ☐ Fall Precautions
- ☐ Return to Work/School on

☒ Restrictions: NO DRIVING WHILE TAKING NARCOTICS

Activities as per instructions of Dr.

Diet: REGULAR Supplements: NONE

COMMENT:

Follow-Up Appointments

	DATE	TIME	WITH WHOM	REASON	PATIENT/SO TO ARRANGE
1.			DR.RIMKUS	HOSPITAL F/U 347-7291 1 WEEK	
2.				CALL FOR APPT MONDAY	
3.					

Follow up with scheduled appointment as needed with .

MEDICATION INFORMATION

☒ Universal Medication Form Given ☒ New Prescriptions Given

PAIN INFORMATION

You may have some pain and discomfort from your procedure. A prescription form may be given to you before you leave the hospital. If the doctor did not prescribe medication for pain, you may take your own non-prescription pain reliever.

Notify Physician for: If you feel that your pain is increasing, or unrelieved.

- ☒ Temperature over 101 for 24 hours
- ☒ Foul odor from Wound or Drainage
- ☒ Incision red, swollen, or warm
- ☒ Wound red, swollen, or warm

Additional General Instructions CALL DR. IF TEMP OVER 101.5 FOR MORE THAN 24 HRS, NAUSEA/VOMITING UNRELIEVED OR PAIN UNRELIEVED.

I have received and understand these instructions and the attached Discharge Education.
I was given the opportunity to ask questions.

Patient/Responsible Person Signature & Relationship: X Daniel Knight

615386661D8848E0B793, KNIGHT, 90

Discharge Education

If any other tests are needed after discharge, please be sure to call your doctor.

NOTIFY DOCTOR IF YOU HAVE

- Trouble breathing or symptoms that are worse
- Pain that is not relieved by your medicine
- Nausea/vomiting/diarrhea that lasts longer than 24 hours
- Signs of Infection: swelling,heat,redness,red streaks,pus formation or other trouble at surgical site
- Signs of heavy bleeding
- Fever greater than 100.4 degrees F

PATIENTS WITH HEART FAILURE

Daily Weights: Weigh every morning, after you urinate and before you eat, using the same scale. Keep a record of your weights. Call your doctor if you gain 2 pounds or more in one (1) day.
Symptoms: Call your doctor immediately or go to the nearest Emergency Room if you have: New or worse shortness of breath, Waking up short of breath, Abnormal bleeding, Increase weakness or fatigue, Swelling of your feet and hands, Chest pain or pressure, Stomach bloating, nausea/vomiting, A fast heart rate, Dizziness or fainting

Diet: Low salt diet. Eat foods and drink beverages that are low in salt. Limit fluids as suggested by your doctor.

PATIENTS WITH STROKES

Risk Factors: Overweight, Diabetes, Sedentary Lifestyle, Irregular Heart Beat, High Blood Pressure

Warning Signs & Symptoms of Stroke: CALL 911 IMMEDIATELY if new or worse: Sudden weakness or numbness on one side of the body, Loss of balance or dizziness, Severe headaches without known cause, Trouble seeing in one or both eyes, Sudden confusion, difficulty speaking or unable to understand

PATIENTS WITH BLOOD CLOTS

Coumadin (Warfarin): Coumadin is a medicine that helps reduce clots from forming and increases the risk of bleeding. It is important to take the medicine at the same time of the day and as told by your doctor. Blood work should be done as instructed. The lab test result is used by the doctor to check and change Coumadin levels as needed. The blood tests are named PT/INR levels. Do NOT miss your blood tests.

Follow up Visits: DO NOT miss follow up visits; always make another appointment if you have to cancel. Talk to your doctor if you have any changes in your diet or medicines, including over-the-counter medications, as these affect the PT/INR levels

Diet: Vitamin K in your diet may affect your response to Coumadin. You do not have to avoid foods high in Vitamin K, but it is very important to try to stay on a steady diet. Too much Vitamin K in your diet may decrease the effect of Coumadin

AVOID major changes in diet, the use of alcohol, and activities/sports that could result in injury

STOP SMOKING

Smoking is not safe for you or the health of those around you. If you or someone in your home smokes or uses other tobacco products, please try to quit. There is support to help you quit.
> Set a date to quit, or begin cutting down the number of cigarettes you smoke
> Line up support-family, friends, or support group.
> Avoid situations that make you want to smoke; ask others not to smoke around you
> Ask your doctor about medication that can help you quit

Please contact the American Heart Association National Center at 1-800-242-8721 or visit the website at http://www.americanheart.org.

ODS-113-F
REV 3 11.20.15

Conway ical Center
Conway South Carolina

V00006933263
ODS
KNIGHT,DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
CA [redacted]
Rimkus, Gilbertas MD
M000175313

ODSU
Day of Surgery
Nursing Admission Assessment

Date: 7/8/16 Arrival Time: 1100

Mode of Admission: ☑ Ambulatory ☐ W/C ☐ Ambulance ☐ Stretcher ☐ Per Adult arms

Arrival from: ☑ Home ☐ ED ☐ Nursing Home ☐ Dr. Office ☐ Other _____

Vital Signs: T 99.6 ☑ Oral ☐ Temporal ☐ Axillary ☐ Rectal
P 77 ☐ Regular ☐ Irregular
R 18 ☑ Easy ☐ Labored O2Sat% 100%
BP 113/76 Weight: _____

Name answers to: Eric

Authorized person: ☐ Not present -Call: Elizabeth

☑ NPO Since 7/8/16 0200 clear liq. ☐ Liquid Diet Prep NA

☑ ID Bracelet ☑ Allergy Bracelet

Allergies: ☐ NKA ☑ Reviewed

☑ IV Fluid ☐ Saline Lock

Fluid Type: ☑ LR ☐ NS ☐ D51-R ☐ D5W

Location (L) Hand

Cath # 20g Rate KVO

Inserted By C.F LVN

Attempted X 1

☑ Procedure Explained

☐ Bowel prep Incomplete NA

☐ Enema x _____ ☐ Fleets

☐ Home ☐ Hospital

Date _____ Time _____

Results: ☐ Good ☐ Fair ☐ Poor

Level of Consciousness:
☑ Alert ☐ Confused
☑ Oriented ☐ Anxious
☑ Calm ☐ Crying
☐ Disoriented ☐ Lethargic
☐ Unresponsive

Color:
☑ Pink ☐ Pale ☐ Flushed
☐ Ashen ☐ Cyanotic

Skin:
☑ Warm ☑ Dry
☐ Cold ☐ Clammy
☐ Hot ☐ Cool

Ted Hose: ☑ N/A
☐ Knee ☐ Thigh
☐ IPC: ☐ Foot ☐ Calf ☐ Thigh
☐ Unable to apply -see note -doctor notified

☑ Voided pre-op
☐ Foley ☐ Robnel By: _____
Urine return: ☐ Yellow ☐ Clear ☐ Amber ☐ Cloudy
Amount _____

Fall Risk: ☑ Low ☐ Moderate ☐ High

Personal Belongings

Medications:	☐ With Pt./Family	☐ Secured	☑ N/A
Money/Jewelry	☑ With Pt./Family	☐ Secured	☐ N/A
Hearing Aid	☐ With Pt./Family	☐ Secured	☑ n/a
Dentures	☐ With Pt./Family	☐ Secured	☑ n/a
Glasses/Contacts	☑ With Pt./Family	☐ Secured	☐ _____
Clothing	☑ With Pt./Family	☐ Secured	☐ PACU
Other	☐ With Pt./Family	☐ Secured	☐ N/A

CPAP ☐ Mask ☐ Machine ☐ Family ☐ PACU ☐ PACU
NA
CPAP Settings:

Orientation to Unit
☑ Activity Limits
☑ Visitors
☑ Bed Rails
☑ No Smoking Policy
☑ Nurse Call Light
☐ Other _____

Hair Removal:
☑ Not Required/Not Performed
☐ Patient performed hair removal
☐ Hair removal with clippers
Site: _____

Prep:
☑ N/A
☐ Chloraprep pre-op
☐ CHG Showers at home as directed
☐ CHG wipes used pre-op
☐ Other: _____

MRSA decolonization:
☐ Yes
☑ No

Skin Integrity
☑ WNL
☐ Decubitus _____
☐ Laceration
☐ Rash
☐ See Notes

Initial Pain Assessment ☑ No Pain
Location _____
Intensity (0-10)_____ ☐ New ☐ Chronic
Quality (sharp, stabbing) _____
Manner of expressing pain _____
What relieves pain? _____
What causes or increases the pain? _____
☑ Verbalizes understanding of pain scale

☐ Pulses: ☑ NA ☐ Doppler
☐ Left ☐ Right
☐ Pedal ☐ Pedal
☐ Post tibial ☐ Post tibial

☐ Fetal Heart Tones pre-op _____

☐ Head Circumference (under 2 yrs) _____

☐ Sentinel Node Injection _____

61538666 1D8848E0B793, KNIGHT, 92

ODS-113-F
REV 3 11.20.15

Conway cal Center
Conway South Carolina

...006933263
ODS
KNIGHT,DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
CA M
[redacted]
Rimkus, Gilbertas MD
M000175313

ODSU
Day of Surgery
Nursing Admission Assessment

Pre-op Unit Checklist

- [x] SBAR Form
- [ ] Blood Trans. Form
- [ ] Medicaid form (Sterilization)
- [x] H & P
- [x] Labs/tests on chart
- [ ] Isolation _____
- [x] OSA Screening
- [ ] C-Section Scheduling Form
- [x] Anesthesia Consent
- [x] Surgical Consent
- [x] Verbalizes understanding of procedure
- [x] Appropriate attire
- [x] Medications reconciled on admission
- [ ] Honan Balloon applied
- [x] Appropriate pre-op antibiotic for procedure
- [ ] Beta Blocker
  - [ ] Taken
  - [ ] Administered
  - [ ] Held -see notes

Pre-op Meds

Side Time	Medication	Mode/Site	Intl.	Rails
1126	Lidocaine 1% prior to IV		CF	
	Invanz 1 gr. IVPB hang in OR			
1132	Toradol 30mg IV	preop	CF	
1135	Tylenol 1 gr. IV	preop	CF	

Initials — Signature w/ Title

CF — Carrie Floyd RN

Any changes since pre admission appt. or any illness in past 48 hrs:
☐ Yes ☒ No

Have you had a blood transfusion since your pre admission appt?
☐ Yes ☒ No ☐ NA

Additional Nurses Notes Needed? ☐ Yes ☒ No

To:
☒ OR ☐ Radiology ☐ Other: _____

Carrie Floyd RN
Prepared for surgery by:

Form # 00004

Conway Medi Center
Conway South Carolina

INTERDISCIPLINARY SCREENING AND PATIENT/FAMILY EDUCATION RECORD

V0000 263
ODS
KNIGHT, DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
CA [redacted] PLAD
Rimkus, Gilbertas MD
M000175313,
master's

LEVEL OF EDUCATION: ☐ ELEMENTARY ☐ HIGH SCHOOL ☑ COLLEGE

READINESS TO LEARN: Poor = P Average = A Good = G	Patient	Other
Ability to Understand Verbal Instructions	G	
Ability to Understand Written Instructions	G	
Knowledge of Educational Needs / Treatment Plan	G	

Patient Safety Education	
Call bell explained	☑ Yes ☐ No
Activity Level/Fall Prevention	☑ Yes ☐ No
Medication Safety	☑ Yes ☐ No

NUTRITIONAL SCREEN If one or more apply, consult RD. (MD order not required for referral)

Poor Appetite (Greater than 3 days) ☐Y ☑N	Difficulty Chewing ☐Y ☑N	New Dialysis Patient ☐Y ☑N	OB Pt. With:
Frequent diarrhea ☐Y ☑N	Consistent swallowing problems ☐Y ☑N	New Onset D.M./ Gestational ☐Y ☑N	Age less than 18 yrs. ☐Y ☑N
Unplanned Weight Loss (Greater than 10 lbs. in 6 mos.) ☐Y ☑N	Decubitus Ulcer ☐Y ☑N	Cultural/religious/ ethnic food preference. ☐Y ☑N	Hyperemesis ☐Y ☑N
Persistent nausea/vomiting ☐Y ☑N	TF, TPN, Pureed diet ☐Y ☑N	Need Diet Instruction for a special diet. ☐Y ☑N	Breast Feeding ☐Y ☑N

Learning Preference: ☐ Written ☐ Verbal ☐ Video ☑ No Preference

SPECIFIC BARRIERS TO LEARNING:

Physical ☐Y ☑N	Sensory (Visual) ☐Y ☑N	Cultural _____ ☐Y ☑N
Reading ☐Y ☑N	Sensory (Auditory) ☐Y ☑N	Religious _____ ☐Y ☑N
Language ☐Y ☑N	Motivation _____ ☐Y ☑N	Cognitive _____ ☐Y ☑N
Age Related Issues ☐Y ☑N	Emotional _____ ☐Y ☑N	Financial Concerns ☐Y ☑N

Appropriate teaching for disease process utilized ☑ Yes ☐ No

Functional Screen		P.T. Consult Requested Yes	No
a. New onset decreased joint motion	a.		✓
b. Recent decline in mobility status	b.		✓
c. S/P Orthopedic surgery	c.		✓
d. Wounds requiring whirlpool	d.		

The patient must have potential for functional improvement.
☐ If 2 or more apply, request M.D. order for P.T. Consult
☐ PT order in place

SUSPECTED ABUSE/NEGLECT? ☐ YES ☑ NO | *IF YES, REFERRED TO CASE MANAGEMENT?* ☐ YES ☐ NO *INITIALS*

MOTIVATIONAL LEVELS

1. Eager to Learn 2. Interested (asks questions) 3. Extremely anxious 4. Difficulty listening, restless, poor attention span 5. Seems uninterested 6. Denies need for education 7. Uncooperative / resistant 8. Not applicable

CARE & EDUCATION CODES		DEPARTMENT CODES		MATERIAL CODES	OUTCOME
1. Disease/Condition	7. Prevention	1. Nursing	7. Physical Therapy	a. Written	a. Verbalizes, recalls understanding
2. Treatment/ Procedure	8. Food/Drug Interaction	2. Pharmacy	8. Chaplain	b. Verbal	b. Demonstrates ability
3. Pain	9. Discharge Planning	3. Case Management	9. Physician	c. Demonstration	c. Not met
4. Medication	10.Patient CareConference	4. Cardio-Respiratory	10.D/C Planning Committee	d. Closed Circuit TV	d. Not applicable
5. Diet	11. Other (specify)	5. Dietary	11 Other (specify)	e. Video	
6. Activity	12. Teaching Plan	6. Radiology		f. Conference	
				g. Teaching Plan	

MOTIVATIONAL LEVELS	CARE & ED CODES	DATE INITIATED	INITIALS	INTERVENTION	DEPT. CODES	MATERIAL CODES	OUTCOME CODES
2,6	1,3,9	7/31/16	CF	Oriented to unit & pain scale explained	1	B	A

Signature	Initials	Signature	Initials
		Carrie Floyd, RN	CF

White Copy to Patient Chart Yellow Copy to Registered Dietitian

Form 117 | Conway Medical Center
Conway, South Carolina

ODSU
INTERDISCIPLINARY PRE-SURGERY ASSESSMENT AND DISCHARGE PLANNING

V0000 263
ODS
KNIGHT, DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
CA [redacted] PLAD
Rimkus, Gilbertas MD
M000175313
(Patient Admission Label)

CHIEF COMPLAINTS / SYMPTOMS / DURATION

Intestinal Perforation c Ileostomy & Incisional hernia

SELF CARE NEEDS

Feeds Self ☒ Yes ☐ No
Bottle ☐ Yes ☒ No
Elimination ☐ Diaper ☒ Commode ☐ Potty Training
Bathing ☒ Self ☐ Assistance
Ambulation ☒ Self ☐ Assistance

SOCIAL WORK SERVICES CONTACTED: ☐ Yes ☒ No
DATE: _____ REGARDING: _____
NOTES:

SPECIAL CARE NEEDS: ☐ Yes ☒ No
PROCEDURES:

EQUIPMENT:

COMMUNITY SERVICES IN USE: Na
☐ Community Long Term Care ☐ Home Health
☐ Appropriate Agency (ies) ☐ Mercy Hospice
Notified
☐ Foster Care ☐ DSS Care Mgt. ☐ Other:

DISCHARGE PLANNING:
Expected Discharge Destination: Home

Expected Caregiver/s.o.: Elizabeth
☒ Able ☐ Unable ☐ Environmental Defects

STANDARDS OF CARE INITIATED: (RESOURCE)

COMMENTS:

PEDIATRIC PATIENTS - VACCINE SCHEDULE CURRENT? ☐ YES ☐ NO

PEDIATRIC PSYCHO / SOCIAL ASSESSMENT

* PCG = PRIMARY CARE GIVER

COMMENTS:

Any Social/Environmental factors contributing to this illness/ injury? (Actual or suspected)

☐ Lack of routine meds ☐ PCG Knowledge deficit
☐ Safety Issues ☐ Inadequate access to healthcare
☐ Allergens in home ☐ Non-compliance to prescribed healthcare measures
☐ Inadequate heat/air/utilities ☐ None identified

Homebound tutoring need anticipated? ☐ Yes ☐ No ☐ N/A
(Expected out of school 5 days or longer) ☐ Yes ☐ No ☐ N/A

Effect of the patient's condition on the PCG/Family, and the Effect of the PCG/Family and condition on the patient

☐ Yes ☐ No a. financial concerns
☐ Yes ☐ No b. Work School absence concern
☐ Yes ☐ No c. Sibling Care Needs
☐ Yes ☐ No d. PCG/Family demonstrates concern for and attempts to sooth the patient
☐ Yes ☐ No e. Patient seeks out PCG/Family and is comforted by their actions

The PCG/Family:

☐ Yes ☐ No Verbalizes expectation that patient will recover from illness/injury
☐ Yes ☐ No Voluntarily assists with patient history & assessment and initial treatment
☐ Yes ☐ No Verbalizes understanding of their role in patient's care while hospitalization and in preparation for patient's care after discharge.

Carrie Hoyle RN 7/8/16 1130
SIGNATURE OF RN COMPLETING ASSESSMENT | DATE | TIME

615386661D8848E0B793, KNIGHT, 95

Date: 07/08/2016
Operating Room #: Operating Room 3
Pre-Operative Diagnosis: ILEOSTOMY, INCISIONAL HERNIA W/ MESH
Post-Operative Diagnosis: SAME AS PRE-OP DX.
Procedure # 1: RESECTION OF SMALL BOWEL WITH ANASTOMOSIS, TAKEDOWN OF ILEOSTOMY, REPAIR OF PARASTOMAL HERNIA WITH BIOLOGICAL MESH

Admit Status: ADM IN
Patient In Room Time: 13:16
Procedure #1 Start Time: 13:42
Procedure #1 End Time: 14:27
Patient Out of Room: 14:39
Wound Class: Classification 2
Anesthesia Type: General
ASA Classification: ASA 2

Pre-Operative Checklist

NPO: Yes **Since:** midnight

Surgery Site Marked By: Surgeon

Patient Identified:
Verbal: Yes
Armband: Yes

Procedure Verified:
Verbal: Yes
Consent: Yes

Allergies: Yes
PCN, SULFUR

H and P on Chart: Yes
Blood Available: Not Applicable
Mental/Emotional Status:
Awake, Calm, Oriented

IV in Place Upon Arrival: Yes
IV Therapy Explained to Patient: N/A

See Anesthesia Records for Fluid and IV Site: Yes

PREOPERATIVE CHG SHOWER/BATH/CLEANSE

Evening Before Surgery	Morning of Surgery	Cleanse with CHG Wipe Prior to Arrival to Holding	Cleanse with CHG Wipe in Holding Area	N/A
Yes	Yes			

RN: Cynthia Marcus RN,CNOR

Transported to OR:

Time	Via	Rails Up?
	Stretcher	Yes

Pre Op Antibiotic Group:	Antibiotic	Start Time	Finish Time
	invanz 1 gram	13:16	13:31

Equipment/Patient/Site Verification

Time Out Taken in O.R. Per Policy: Yes
Correct Implants/Equipment Available: Yes
Position Verified: Yes
Patient Identified: Yes **Procedure Verified:** Yes
Consent Verifed: Yes
Xrays Reviewed: N/A

Site Verification

Sx Site Marked: No **Noted in H and P:** Yes **On the Consent:** Yes

Conway Medical Center

Operating Room Record

Account #: V00006933263
Name: KNIGHT, DANIEL E
[redacted]
Race:
Surgeon 1: RIMKUS, GILBERTAS MD
Surgeon 2:
MRN: M000175313 **Admit Date:** 07/08/2016

Personnel

Anesthesiologist:
Barbieri,Susan C.
CRNA:
Chet Homicki, CRNA
Circulator:
Cynthia Marcus RN,CNOR
Scrub:
Maria Lane, CST
Assistant:
Betty Wade, ORT

Ancillary Personnel

Position and Preparation

Position: Supine Position
Positioning Devices: Pillow
Location under head
Safety Straps: THIGHS ARMS
Protective Devices Intermittant Pneumatic Compressions
Location lower legs

Equipment

Cautery	Bipolar	Wetfield	Cut	Coag	Lot	Pad	Skin Intact
T0H17638E				30		right thigh	No

Counts

Counts	Scrub	Final Count	RN
Taken	Maria Lane, CST	Correct	Cynthia Marcus RN,CNOR

Care Plan

Nursing Diagnosis:
1. Anxiety/Fear
Lack of knowledge related to surgery
Nursing Intervention:
Warm blanket
Describe events. Allow questions.
Provide emotional support
Remain with patient during induction
Provide quiet atmosphere

Expected Outcome:
Verifies Procedures to be Performed

Outcome: Calm

Nursing Diagnosis:
3. Fluid/Electrolyte Excess or Deficit
(Actual or Potential)
Nursing Intervention:
Catheter: N/A

Expected Outcome:
Patient's fluid electrolyte balance maintained
Outcome:
Expected Outcome Met: Yes

Nursing Diagnosis:
2. Infection (Actual or Potential)
Nursing Intervention:
Assess any breaks in skin
Hair Removal:

Prep Solution: Chloraprep

Expected Outcome:
Patient is free from signs of infection
Outcome:
Skin Intact: Yes
Reaction: No

Nursing Diagnosis:
4. Injury, Potential For:
Foreign Body
Burn
Neuromuscular Trauma (related to positioning)
Hemorrhage
Falls/Trauma
Thrombo-emboli Formation
Impaired Skin Integrity

Expected Outcome:
Patient's Skin Integritiy Remains Intact
Patient is free from injury
Outcome:
Skin Condition: Clear
Equip. Tested/Functioning Properly: Yes

Medication(s) and Irrigation(s)

Intra-op Medications:

Time	Meds	Dose	Admin By	Route
	MARCAINE 0.25% PLAIN / EXPAREL 1.3% PLAIN EQUAL MIX	40 ML	DR RIMKUS	Local Injection

Irrigation: Normal Saline

For Hysteroscopies Only:

Irrigation Input: 0 **Irrigation Output:** 0

Dressing(s) and Cast

Dressing: Tegaderm
Airstrip

Pathology and Laboratory

Specimens: Yes
Specimen Verified w/MD: Yes
Type: a) small bowel
Frozen Section: No

Implants

Implants:

Implant#	Lot#	Site	Type
1	SP100315-060	incisonal hernia	strattice mesh 6 x 10 firm

Implant#	Cat#	Model#	Serial#
1	0610008		

Closing Notes

Message: Message Given
Time 13:44
Transferred via: Transferred by Roller
Discharged to: Post Anesthesia Recovery Unit

Addendum:

ODSU-112-FRM
REV 3 05.24.16

ODSU / ANESTHESIA
INTERDISCIPLINARY PRE-SURGERY ASSESSMENT FORM

PROPOSED PROCEDURE: Takedown of ileostomy & Incisional Hernia R.	[redacted]	TIME: 1115	SURGEON: Rimkus
	EVAL. DATE: 7/8/16		SURG.DATE: 7/8/16
PREOPERATIVE DIAGNOSIS: Incisional Hernia / Intestinal Perforation c Ileostomy			

V00006933263

KNIGHT, DANIEL ERIC
CA
[redacted]
Rimkus, Gilbertas MD
M000175313

BP	TEMP	PULSE	RR	WEIGHT	HEIGHT
113/76	99 F	77	18	140	5'3"

HEAD & NECK ☒ Neg. Hx.
NEUROMUSCULAR ☒ Neg. Hx.
PULMONARY ☒ Neg. Hx.
CARDIOVASCULAR ☒ Neg. Hx.

☐ Neck Stiffness
☐ Jaw Problems
☐ Dentures
☐ Bridges / Crowns
☐ Loose or chipped teeth
☐ _____

☐ Seizures
Last Seizure _____
☐ Stroke
☐ TIA
☐ Arthritis - Site (s) _____
☐ Fibromyalgia
☐ Multiple Sclerosis
☐ Myasthenia gravis

☐ Asthma ☐ Hemoptysis
☐ Sleep Apnea ☐ Chronic Cough
☐ Tuberculosis ☐ Pneumonia
☐ Night Sweats ☐ 02 dependent
☐ COPD
☐ Productive Cough / Recent Cold

CV Risk: ☐ Fhx ☐ HTN ☐ Lipids ☐ Obesity
☐ Heart Attack: When _____
☐ Chest Pain: Last Pain _____
☐ Irregular Heart Beat ☐ Pacemaker
☐ Heart Murmur ☐ Congenital Heart Defect
☐ Congestive Heart Failure
☐ Heart Valve _____
☐ CABG ☐ Cardiac Stents x_____

Tobacco use past 12 months? ☐ Yes ☒ No ☐ Smokes _____ pk/day _____ yrs. ☐ Former Smoker NO hx.
Patient given education on "Hazards of Smoking" form #449? ☐ Yes ☐ No ☐ Refused Patient verbalizes understanding ☐ Yes ☐ No

GASTROINTESTINAL ☒ Neg. Hx. **OTHER** ☒ Neg. Hx. Immunizations Current ☐ Yes ☐ No (If No, Specify)

☐ Cirrhosis
☐ Hepatitis / Yellow Jaundice
☐ Ulcers
☐ Recent Nausea & Vomiting
☐ Reflux/Hiatal Hernia
☐ IBS/Diverticulosis
☐ Unexplained Weight Loss

☐ Pregnancy:
Last menstrual period _____
☐ Sickle Cell (Dz or Trait)
☐ Hyperthyroid / Hypothyroid
☐ Prostate Problems
☐ Kidney Problems
Last Dialysis _____
☐ Bleeding Problems
☐ Anemia denies

☐ Diabetes Mellitus X_____
Insulin Dependant X_____
Diet Controlled X denies
Pill Controlled X_____
☐ Glaucoma
☐ Alcohol Use
Rarely _____ Daily _____
☐ Hearing Problems
☐ Malignant Hyperthermia

☐ Cancer: Site: _____ denies
☐ Radiation Therapy
☐ Chemotherapy
Comments: _____

ALLERGIES:
☒ Yes ☐ NKDA
☐ Unable to Explain
☐ Latex Allergy

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☒ No
INFORMED TO BRING COPY ☐ Yes ☒ No
WOULD YOU LIKE FURTHER INFORMATION? ☐ Yes ☒ No

Flu Vaccine this season (Sept-March) ☒ Yes ☐ No ☐ Refused prior to this visit ☐ Contraindication
Pneumonia Vaccine ☐ Yes ☒ No
If no, Education Material provided ☐ Yes ☐ No ☐ Refused
Referred to MD ☐ Yes ☐ No

NAME	REACTION	LIST PREVIOUS OPERATIONS AND ANESTHETICS
PCN	rash	• Small Bowel Resection c ileostomy (April 2016) due to MVA
Sulfa	rash	

CURRENT MEDICATIONS: ☐ Unable to Obtain ☒ See Med Sheet ☐ Patient instructed to bring medications to hospital

Drug (include Herbs, Vitamins, Supplements)	Dosage	Freq.	Drug (include Herbs, Vitamins, Supplements)	Dosage	Freq.

PRE-OP LABS / STUDIES

red: H&H Plt Cnt CBC K+ Cr Glu CMP/BMP EKG CXR Pt/PTT Type S/Cm ____
bld. Avail.=____ Auto ____
f Below: _____ UA ____ Urine C&S ____ Pregnancy _____ K+ 4.1 Glu 91 BUN 8
11 HGB 12.5 HCT 35.4 Plt ____ PT____ PTT ____ Other: _____

Rachael Collins, (Paul Richardson)

☐ Phone Interview
OPT Nurse/Date:
ODS Nurse/Date: CF 7/8/16
O.R. Circ. Nurse/Date: [signature] 7/8/16

Record on Appeal 1200
615386661D8848E0B793, KNIGHT, 100

ODSU-112-A-
REV 3 05.24.

ANESTHESIA ASSESSMENT

KNIGHT, DANIEL ERIC
V00006933263

Have you or any family member ever had a complication from anesthesia?

☑ Yes ☐ No If yes, describe _____

He Was a power lifter prior to MVA

☐ History of Malignant Hyperthermia
☐ Awareness under Anesthesia
☐ Family History of Neuromuscular Disease

PONV Risk Assessment

☐ History of PONV ☐ History of Motion Sickness ☐ Female ☑ Non Smoker
☑ Intended administration of opiates for post-op analgesia

HEAD & NECK

Dental Hygiene ☑ Good ☐ Poor ☐ Possible anterior larynx (retro gnathic)
Neck ROM ☑ Good ☐ Poor ☐ Airway Class (I) II III IV
Oral Opening ☑ Good ☐ Poor ☐ Severe Indigestion/ Reflux Only after meals _____ Anytime _____

PROPOSED ANESTHESIA ☑ Interdisciplinary Assessment reviewed **ASA PS**

☑ General	Monitors Discussed:	
☐ SAB/CLE/Block ☐ Block for post-op pain mgt	☐ A-Line	(1) 2 3 4 5 E
☐ GA if Block Fails	☐ CVL	NPO Past MN
☐ MAC	☐ P A Catheter	
☐ TIVA		

_____ 7/08/16 1230
Signature -Anesthesia Provider Date Time

☑ Monitors/Equip Check/ Calibrated/Alarms enabled
Patient Re-assessed ☑ No Change ☐ See Additional notes

Additional Notes:

_____ 7/8/16 1310
Signature -Anesthesia Provider Date Time

PQRS

Pt. Smoked today ☐ Yes ☑ No
☐ PONV 3 or more risk factors and general inhalation anesthesia: Received multi-modal therapy
☐ Perioperative Temperature Management: All cases 60 minutes or greater: Temperature documented 95.9 or above on Anesthesia Record
SBAR used on transfer to: ☐ PACU ☐ ICU Initials: _____ Date: _____ Time: _____

CONWAY MEDICAL CENTER

ANESTHESIA RECORD

Rimkus, Gilbertas
V00006933263
KNIGHT,DANIEL ERIC
M0000175313 07/08/16

ANTIBIOTIC: Ancef 1gm IV
START: 1314
SIGN: Christopher CRNA

PS I II III IV V E
Pre-Op Diagnosis Incisional Hernia s/p Enterocutaneous Perforations x 2 Ileostomy
Post-Op Diagnosis

All medications administered IV unless another route documented.

Allergies Pen. Sulfa
Date 7/8/16 OR No. 3 Page of
Procedure Small Bowel Resection Take Down Ileostomy + Repair Incisional Hernia w/ Mesh
Surgeon Rimkus

	START	STOP
Anesthesia	1314	1443
Procedure	1342	1427

PRE-PROCEDURE
- ☑ Identified ☑ ID Band ☐ Questioning
- ☑ Chart Reviewed ☑ Permit Signed
- ☑ NPO Since PM
- Pre-anesthetic State: ☑ Calm ☑ Awake ☐ Asleep ☐ Apprehensive ☐ Confused ☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY
- ☑ Anes. Machine # 3 Checked
- ☑ Safety Belt On ☐ Axillary Roll
- ☑ Armboard Restraints ☐ Arms Tucked
- ☑ Pressure points checked and padded
- Eye Care: ☐ Ointment ☐ Saline ☑ Taped ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT
- ☐ Steth: ☐ Precord ☐ Esoph ☐ Other
- ☐ Non-Invasive B/P ☐ Left ☑ Right
- ☑ Continuous EKG ☐ V Lead EKG
- ☑ Pulse Oximeter ☐ Oxygen Sensor
- ☑ End Tidal CO_2 ☐ Gas Analyzer
- ☑ Temp ☐ ☐ Nerve Stimulator
- ☑ Warming Blanket ☐ BIS ☐ Doppler
- ☑ Airway Humidifier ☐ Fluid Warmer
- ☐ NG / OG tube ☐ Foley Catheter
- ☐ Art. Line
- ☐ CVP
- ☐ PA Line
- ☑ IV(s) G 20
- ☐

ANESTHETIC TECHNIQUE
- General: ☐ Pre-Oxygenation ☐ I.T.A. ☐ MAC ☐ Rapid Sequence ☐ Cricoid pressure ☑ Intravenous ☐ Inhalation
- Regional: ☐ Spinal ☐ Epidural ☐ Brachial ☐ Bier ☐ Popliteal
- ☐ Position
- ☐ Prep ☐ Local
- ☐ Needle
- ☐ Drug(s)
- ☐ Dose ☐ Attempts x
- ☐ Dose ☐ Level
- ☐ Site ☐ See Remarks
- Block Time cut at ____ Agreed: ____

AIRWAY MANAGEMENT
- Intubation: ☑ Oral Tube size 7.5
- ☐ Stylet used ☐ Nasal ☐ GS
- ☐ Mac ☐ Direct ☐ RAE
- ☐ Fiber optic ☐ Blind ☐ Armored
- ☐ Blade 3 mg ☐ Laser
- ☑ Secured at 22 cm ☐ Endobronch.
- ☐ Attempts x ☐ $ETCO_2$ present
- ☐ Breath sounds ☐ ☐
- ☐ Uncuffed leaks at ____ cm H O
- ☑ Cuffed ☐ Min. occ. pres. ☐ Air ☐ NS
- Airway: ☑ Oral ☐ Nasal ☐ Difficult
- Circuit ☐ Circle ☐ NRB see Remarks
- ☐ Mask Case ☐ Nasal Cannula
- ☐ Via Tracheostomy ☐ LMA #

RECOVERY
- Location PACU Time 1437
- B/P 116/71 O_2 Sat 97
- P 83 R 16 T 97
- ☐ Awake ☐ Drowsy ☐ Somnolent ☐ Unarousable ☐ Delirious ☐ Unstable ☐ Intubated ☐ Ventilator ☐ Nasal Oxygen ☐ Mask Oxygen ☐ T-piece Oxygen ☐ Oro/nasal airway
- Report to: Kathleen

FLUID TOTALS
- Crystalloid 1500 EBL 450
- Blood 0 Urine 0

REMARKS
Monitors applied. Patient reassessed Chr

Neostigmine 5 mg - Glycopyrrolate 0.4 mg. IVP 1425

Tourniquet: Rt.____ Lt.____
Up ____ Down ____
Torr____ Total Time ____

TIME: 1315 30 - 1400 - 30 - 1500

							TOTALS
Oxygen (L/min)	3	3	3	3	4	4	
N2O ☐ Air (L/min)	1	1	1	1			
Sevo (%)	3	2	2-2	2-2	—	—	
Versed mg	2						2 mg
Fentanyl mcg	50	50					100 mcg
Sufenta mcg							mcg
Propofol mg	200						200 mg
Zemuron mg	50	10					mg
Anectine mg	100						100 mg
Lidocaine mg	40						40 mg
Ondanestron mg		4					4 mg
Toradol mg							mg
Decadron mg		8					8 mg
	Decadron						20 mg
IV Fluids	LR						
Urine (ml)							
EBL (ml)							
EKG	SR	SR	SR	SR	SR	SR	
%O_2 Inspired	100	60	65	65	100	100	
O_2 Saturation	100	100	100	100	100	100	
End Tidal CO_2	33	34	32	32	34	—	
Temp ☐ °C/°F	97	—	97	—	97	—	
Bis	90	90	30	38	45	60	
Train of Four							
Warming Blanket °C		43	—	43	43		

VITAL SIGNS

Baseline Values: T 98.4 Wt 113/96 B/P 117 P 78 SPO2 100%

Symbols: × Anesthesia; ⊙ Operation; v ^ BP Cuff Pressure; ÷ Arterial Line Pressure; ▲ Mean Arterial Pressure; ● Pulse; ○ Spont Resp; ∅ Assisted Resp; ⊗ Controlled Resp; T Tourniquet

VENT

Tidal Volume	600	600	600	600		
Resp. Rate	10	10	10	10	12-14	
Peak Pressure	24	24	24	24		
PEEP						
Symbols for Remarks						
Position	L	—	—	—		

I/we attest that I or my partner(s) are:
- ☑ Present for intubation
- ☑ Immediately available throughout
- ☑ Monitoring at frequent intervals
- ☑ Present for extubation if applicable

Anesthesia Provider Christopher CRNA

OR-2319-FRM
REV 2 01.08.16

Conway Medical Center
Conway, South Carolina

Surgical Safety Checklist

V00006
ODS
KNIGHT,
206 ECU
CONWAY,
CA
Rimkus,
M00017

Procedure: Closure of ileostomy & incisional hernia repair

Pre-Anesthesia Interview → Before procedure → End

ODSU/OR Holding Area

☑ NURSE REVIEWS CHART AND CONFIRMS
- Patient Identity
- Allergies
- Procedural & Anesthesia Informed Consent
- Procedure
- H & P
- Surgical schedule/ Physician Order/ Plan of Care

☐ PATIENT/PROCEDURE SPECIFIC
- Blood or Blood Products available
- Non-pregnant status confirmed

☑ SCIP MEASURES
- Pre Op Antibiotics
- DVT Prophylaxis
- Beta Blockers
  - ☑ N/A
  - ☐ Hold (see Nurse' notes)
  - ☐ Administered/taken as instructed

☐ SIDE/SITE MARKED

Carrie Hughes 1130 7/8/16
RN Signature Date/Time

Anesthesia ☐ Not Applicable

☑ PATIENT HAS CONFIRMED
- IDENTITY
- SITE
- PROCEDURE
- CONSENT
- ALLERGIES

☑ Pre Anesthesia Assessment

Anesthesia considerations

Difficult air way/aspiration risk
☑ Yes, and equipment/assistance available

Risk of > 500ml blood loss (7ml/kg ch children)
☑ Yes, adequate intravenous access and fluids planned

Risk of hypothermia
☐ Yes, warmer in place

☐ Dosimeters for those procedures requiring radiological imaging/guidance

Signature CRNA/MDA 7/8/16 Date/Time

Time Out

TEAM MEMBERS HAVE BEEN IDENTIFIED

☑ TEAM CONFIRMS
- PATIENT IDENTITY
- SIDE & SITE MARKED
- PROCEDURE
- CONSENT
- POSITION
- ALLERGIES

☐ NURSING TEAM CONFIRMS
- STERILITY
- EQUIPMENT ISSUES OR CONCERNS
- IMPLANTS AVAILABLE Yes

☐ ESSENTIAL IMAGING
- FILMS DISPLAYED
- DOSIMETER BADGES
- LEAD SHEILDING

N/A

☐ SCIP
- Antibiotic administered Yes
- DVT Prophylaxis Yes
- Beta Blockers
  - ☐ Given ☑ NA ☐ Held

☐ ANTICIPATED CRITICAL EVENTS
- PATIENT SPECIFIC CONCERNS
- SAFETY PRECAUTIONS
- FIRE RISK LEVEL IDENTIFIED

Deb

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Date

Team members present for Time Out: #1 Carrie / Lana / Wade / Dr Rimkus / Monica

Team members present for Time Out: #2 _____

OR-106-FRM REV 0 01.30.13	Conway Medical Center Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006933263 [redacted]
M000175313

Device/Product Implant Labels

Date of Service	Device Label
7/8/16	Strattice™ LOT SP100315-060 2017-09-30 REF 0610008 Size (cm) 6x10 Firm LifeCell Corp., One Millennium Way, Branchburg, NJ 08876 USA by Dr Rimkus incisional Hernia

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V000006933263
KNIGHT,DANIEL ERIC
[redacted] TEMP R
M000175313 07/08/16

Date: 7/8/16 Arrival Time _____

Arrival From: ☑ OR ☐ RAD ☐ Cardiac Cath Lab ☐ Other

Via: ☐ Bed ☐ Stretcher

Admission assessment: _____ RN

Report Rec'd: ☑ CRNA ☐ Anesthesiologist

BP 116/71 P 85 R 16 Temp 97.0 SaO2 97%

Surgical Procedure Sm. Bowel Resection ileostomy Closure

Anesthesia Type
☐ General ☐ Block _____ ☐ TIVA
☐ Spinal
☐ Epidural ☐ Other:

Condition on Arrival
☐ Satisfactory
☐ Serious
☐ Critical

Surgeon Rimkus
Anesthesiologist Barbieri
CRNA Hornevi

Allergies ☐ NKA Sulfa, PCN

Admission Assessment

LOC:	☐ Awake ☐ Alert	☐ Awakens w/stimulus ☐ Sleeping/Somnolent	☐ Stupor/unarousable ☐ Unconscious
Orientation	☐ Person ☐ Place	☐ Situation ☐ Time	☑ Unable to assess ☐ Appropriate for age
Skin	☐ Warm ☑ Dry	☐ Cool ☐ Cold	☐ Diaphoretic ☐ Shivering
Color	☐ Pink ☐ Pale ☐ Dusky	☐ Flushed ☐ Mottled ☐ Cyanotic	☐ Other:
Respirations	☑ Regular ☑ Unlabored ☐ Labored	☐ Quiet ☐ Deep ☐ Moderate	☐ Shallow ☐ Apneic ☐ Irregular ☐ Assisted
Airway Adjunct	☐ N/A ☐ Nasal	☑ Oral ☐ ETT	☐ Trach D/C at 1442
Breath Sounds	☐ Anterior ☐ Lateral ☐ Posterior	☑ Clear Bil ☐ Equal Bil ☐ Wheezes	Other:
O_2 Delivery	☐ N/C _____ Liters ☐ Blowby ☐ Venti-Mask ☐ Ambu ☐ Face Tent _____ % ☐ Face Mask _____ % ☐ T-Piece ☐ Room Air ☐ Vent Mode FIO2 _____ TV R Peep		
Cardiac Rhythm EKG	Rhythm: ☐ NSR ☐ Sinus Tach ☐ Sinus Brady ☐ A-fib ☐ Other: _____ Rate: ☐ Regular ☐ Irregular		
Invasive Lines:	☑ NA ☐ A-Line ☐ SWAN ☐ PICC		
Abdomen	☐ Round ☐ Flat	☐ Firm ☑ Soft	☐ Distended ☐ Other
Fundus: Lochia:	☑ NA ☐ Small	☐ Firm ☐ Moderate	☐ Boggy ☐ Heavy
Skin Integrity:	☑ Intact	☐ Other:	
IV Site(s)	☐ NA ☐ Patent	☐ No redness/edema ☐ See Notes Site	
IV Fluids	Type LR Amt 500 Site LH Rate KVO Type _____ Amt _____ Site _____ Rate _____ Type _____ Amt _____ Site _____ Rate _____		
Foley	☐ No ☐ Yes ☐ Secured		
Urine	☑ N/A ☐ Cloudy ☐ Clear ☐ Red	☐ Pale Yellow ☐ Yellow ☐ Amber ☐ See Notes	☐ Pink ☐ Sediment ☐ CBI
OP Site/Dsg	Site Lower Right ABD ☐ Dry ☑ Intact Site _____ ☐ Dry ☐ Intact		
Position:	☐ Supine ☑ HOB ↑ / ↓ ☐ FOB ↑ / ↓	☐ Leg ↑ R / L ☐ R / L Side	☐ Other:

Physician's Orders:

☑ NA **Extremity Check**

Time	Site	Pulse	Color	Cap Refill	Sensation

Pulse: 0 - Absent; 1+ Faint; 2+ Normal; 3+ Bounding
Color: N - Normal (pink); C - Cyanotic; P - Pale; O - Other
Sensation: (+) Yes; (-) No

☐ Spinal / Epidural — ☒ N/A
Movement lower extremities: ☐ Yes ☐ No
Level of sensation: _____ Time: _____
Level of sensation: _____ Time: _____

Dermatome	Spinal Nerve Level	Dermatome	Spinal Nerve Level
T4	Nipple line	T10	Umbilicus
T6	Xiphoid Process	T12	Hips
L-3	Knee	L4-5	Medial & Lateral aspect of calf
S1-2	Posterior Aspects of thigh dorsiflexion of foot		

Safety: ☑ SR ↑ ☐ Low Position ☑ Stretcher/bed wheels locked ☑ ID Band ☐ Safety Strap ☑ Nurse at bedside

615386661D8848E0B793, KNIGHT, 105

POST-ANESTHESIA CARE RECORD

Date/Time	Nursing Diagnosis	Expected Patient Outcome	Interventions	Outcomes
1437 7.8.16	1. Potential for impaired gas exchange related to anesthesia/ surgery.	1a. Patient will maintain patent airway while muscle relaxants are reversed. 1b. Cough and deep breathe on own. 1c. O_2 Sat. greater than 92% or pre-procedure level	- Oral / nasal airway PRN - Chin Thrust PRN - 98% Face Tent PRN - 40% T-Tube - Nasal O_2 at ____ L/M - Adm. and monitor side effects of reversal agents as ordered - Monitor O_2 sat per pulse oximeter - Maintain vent at ordered settings	☐ Room air ☐ Nasal Cannula at ____ L/M ☑ O_2 sat 92 % ☐ Ventilator
1437 7.8.16	2. Actual/potential altered tissue perfusion related to cardiopulmonary irregularities inadequate fluid volume (excess, deficit).	2a. Urine output minimum 30cc / hr. 2b. BP +/- 20% pre-op level. 2c. PAR score 10-12 2d. T96.8 F prior to discharge.	- Ambu, patient PRN - Monitor I & O q 1 hr - VS q 10 min and PRN - Ck dsg's q 15 min and PRN - Monitor IV's - Warming blankets to maintain temp - Adm. fluids, meds. as ordered, monitor side effects - Evaluate OR Record for fluid loss and replacement - Capillary refill at 15 mins	☑ MET ☐ Reassess
1437 7.8.16	3. Potential for injury related to Gen/Reg/Local anesthesia, impaired communication, pain med.	3a. No injury occurred. 3b. Non-ventilated patients able to verbalize prior to discharge.	- SR's up, wrist restraints for lines/vent. Bumper pads when indicated - Orient X 3 PRN - Monitor IV lines, drain tubing - Administer sedation as prescribed and indicated, monitor for side effects. - Monitor for bladder irrig.	☑ MET ☐ Reassess
1437 7.8.16	4. Actual/Potential acute pain and/or nausea and vomiting related to surgery, effects of anesthesia and individual response to surgery and/or anesthesia.	4a. Patient verbalizes pain/nausea/ vomiting is decreased prior to discharge.	- Administer pain and N&V med as ordered, monitor effects - Position for comfort - Monitor environment, adjust to patient request - Provide diversional therapy, talking, deep breathing, cool cloth, etc. - General hygiene as needed - Splint incision - Pain Management	☑ No Nausea ☑ Pain Level Monitored ☐ Reassess

PATIENT CARE INTERVENTIONS

Padding: ☐ N/A ☐ Arm Pads ☐ Headrest ☐ Heel Pads ☑ Pillow ☐ Bumper Pads ☐ Other: ____

Circulatory: ☐ N/A ☐ Ted Hose – Short/Long – R / L Leg ☐ CMS Cks repeated ☐ IPC ☐ Foot Pump

Thermal: ☐ N/A ☑ Blankets ☐ Warming Blanket

Respiratory: ☐ N/A ☐ Turn ☑ Cough ☑ Deep breath ☐ Suction

Mucus- ☐ Clear ☐ Cloudy ☐ Thick ☐ Bloodtinged ☐ Other: ____

Mucus Amount ☐ Scant ☐ Small ☐ Moderate ☐ Copious ☐ Other: ____

Tubes: ☐ N/A ☐ N/G to Suction ☐ Low ☐ Wall ☐ Clamped ☐ Intermittent ☐ Constant

Chest Tube: Location: ____

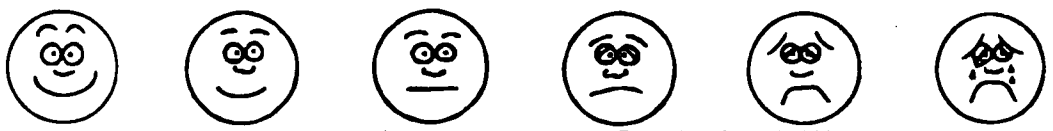
☐ Under H2O Seal ☐ Atrium ☐ Suction

Other: ☐ Cryotheraphy ☐ ICE:

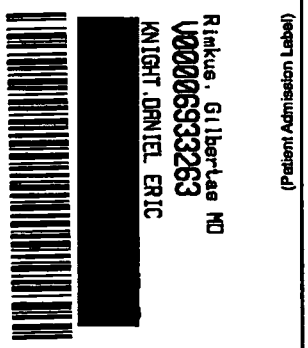
Comments: ____

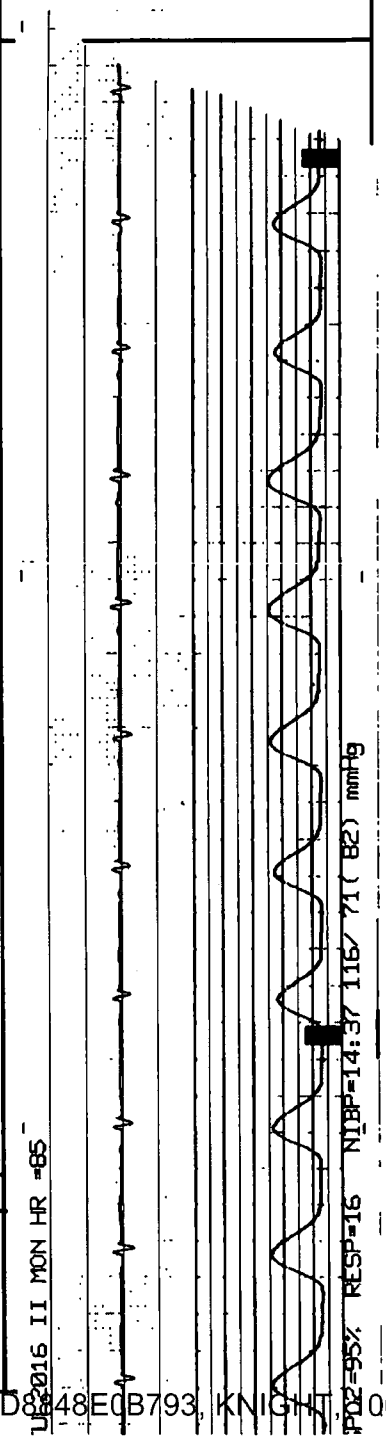
Pain Affect Faces Scale

None | Mild | Uncomfortable | Moderate | Severe | Worst Possible



615386661D848E0B793, KNIGHT, 06





Rimkus, Gilbertas MD
V00006933263
KNIGHT,DANIEL ERIC
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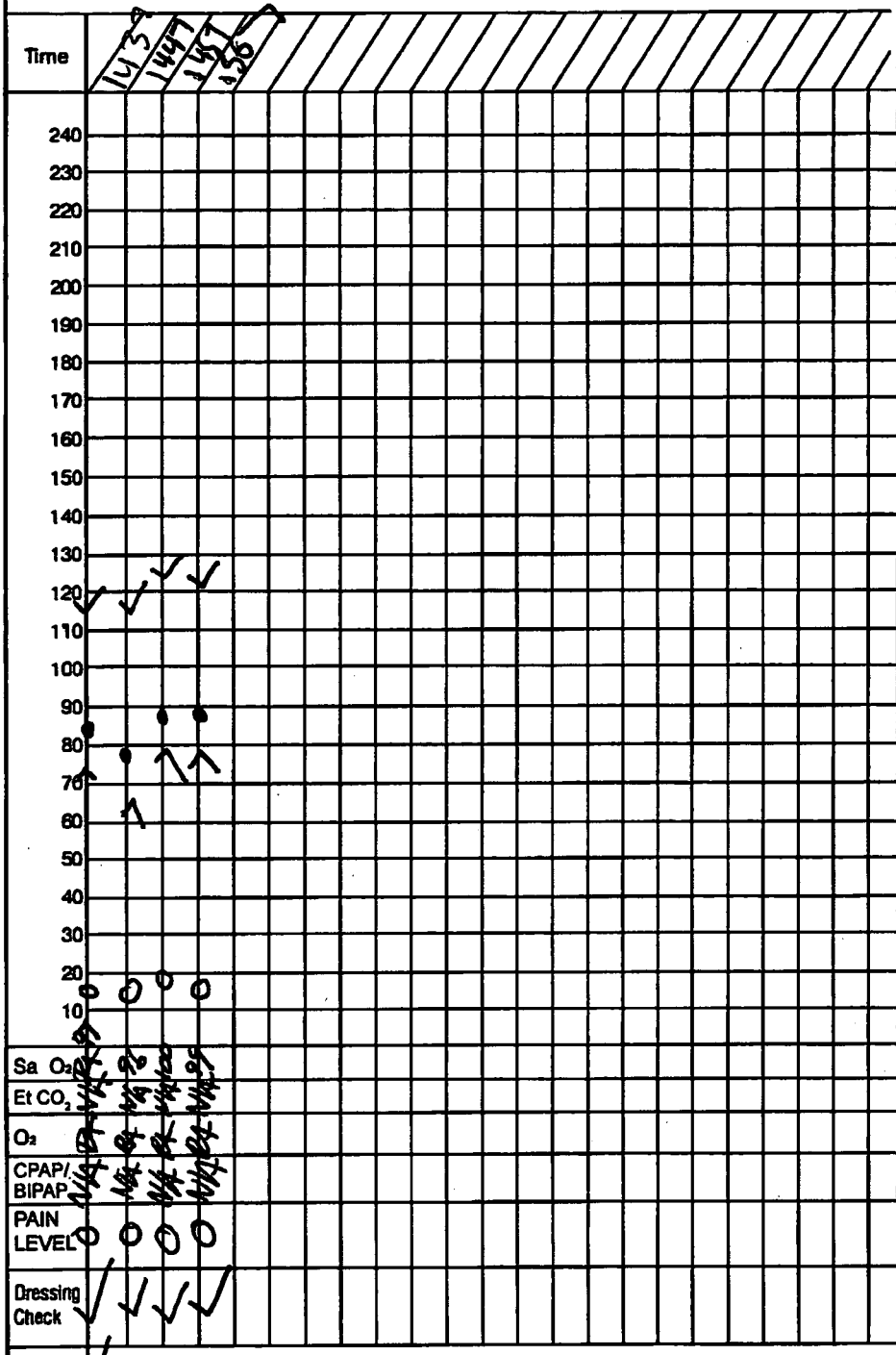
M0000175313 07/08/16

Pulse ● Resp. o Diastolic ∧ Systolic ∨ √ (WNL) * (see notes)



Drains ☐ N/A ☐ JP ☐ Hemovac
Output _____

Intake	OR	RR	Total	Output	OR	RR	Total
IV Fluid	1500	150	1650	EBL	√50	/	√50
Blood	/	/	/	Urine	/	/	/

Time	Pain Scale	Medication/Rationale	Route	Initial
1300	10	05mg dilaudid	IV	KV

☐ PCA pump as ordered

Labs

Test	Time	Results	Comment
Hgb			
Hct			
Bloodsugar			

Lab results to MD ☐ No ☐ Yes _____

POST-ANESTHETIC RECOVERY SCORE

	ADM.	30 min.	60 min.	DISCHARGE
Activity	0	2		2
Respiration	1	2		2
Circulation Systolic Pressure	2	2		2
Pulse	2	2		2
Consciousness	0	2		2
Color	2	2		2
Total	7	12		12

Post-Anesthetic Recovery Level

2 Able to move 4 extremities voluntarily or on command
1 Able to move 2 extremities voluntarily or on command
0 Able to move 0 extremities voluntarily or on command

2 Able to deep breath and cough freely
1 Dyspneic
0 Apneic

2 BP + 20% or preanesthetic level
1 BP + 20-50% or preanesthetic level
0 BP + 50% or preanesthetic level

2 Good volume, regular
1 Fair volume, occasional irregular beats
0 Poor volume, frequent irregular beats

2 Fully awake
1 Arousable
0 Not responding

2 Pink and normal
1 Pale or dusky
0 Cyanotic

Rimkus, Gilbertas MD
V00006933263
KNIGHT,DANIEL ERIC
[redacted] TEMP R
M000175313 07/08/16

Label)

DATE: 7.8.16
Time: 1505

Discharge Assessment

LOC:	☑ Awake ☐ Alert	☐ Awakens w/stimulus ☐ Sleeping	☐ Somnolent ☐ Unconscious
Orientation	☐ Person ☑ Place	☑ Situation ☐ Time	☐ Unable to assess ☐ Appropriate for age
Skin	☑ Warm ☐ Dry	☐ Cool ☐ Cold	☐ Diaphoretic ☐ Shivering
Color	☐ Pink ☐ Pale ☐ Dusky	☐ Flushed ☐ Mottled ☐ Cyanotic	☐ Other:
Respirations	☑ Regular ☑ Unlabored ☐ Labored	☐ Quiet ☐ Deep ☐ Moderate	☐ Shallow ☐ Irregular ☐ Assisted
O_2 Delivery	☐ N/C _____ Liters ☐ Venti-Mask ☐ Ambu ☑ Room Air ☐ Face Mask _____ % ☐ ETT		
Breath Sounds	☐ N/A ☑ Anterior ☐ Lateral ☐ Posterior	☑ Clear Bil ☐ Equal Bil	☐ Other:
Cardiac Rhythm EKG	Rhythm: ☑ NSR ☐ A-fib ☐ Sinus Tach ☐ Other: _____ ☐ Sinus Brady		
	Rate: ☑ Regular ☐ Irregular Rate: _____		
IV Site(s)	☐ NA ☑ Patent ☑ No Redness/Edema ☐ No Change		
IV Fluids	Type LR Amt 350 Site LH Rate KVO		
	Type _____ Amt _____ Site _____ Rate _____		
	Type _____ Amt _____ Site _____ Rate _____		
Abdomen	☐ Round ☐ Flat ☐ Firm ☑ Soft	☐ Distended ☐ Other _____	
Fundus: Lochia:	☑ NA ☐ Small ☐ Firm ☐ Moderate	☐ Boggy ☐ Heavy	
Foley	☑ No ☐ Yes ☐ Secured		
Urine	☑ N/A ☐ Cloudy ☐ Clear	☐ Pale Yellow ☐ Yellow ☐ Amber ☐ Red	☐ Pink ☐ Sediment ☐ CBI Other _____

☑ NA **Extremity Check**

Time	Site	Pulse	Color	Cap Refill	Sensation
		-			

OP Site/Dsg	Site Lower ⓡ ABD ☐ Dry ☑ Intact Site _____ ☐ Dry ☐ Intact
Drainage	Site LR ABD Amount Scant Char. Bloody Site _____ Amount _____ Char. _____ Site _____ Amount _____ Char. _____
Position:	☐ Supine ☐ HOB ↑/↓ ☐ FOB ↑/↓ ☐ Leg ↑ R/L ☐ R/L Side ☐ Other: ☐ FOB gatched 10° - 15°
Safety:	☑ SR ↑ BL ☑ Low Position ☐ Other ☑ Stretcher/bed wheels locked ☐ Safety Strap ☑ Nurse at bedside Temp 97.0
Pain Score	No 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Pain ☑ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Pain

Post Anesthesia Evaluation

Direct observation and PACU record review:
- ☐ Airway patent
- ☑ PONV controlled
- ☐ Patient conversant and appropriate
- ☑ Hydration adequate
- ☑ Vital signs stable for discharge
- ☐ Pain controlled

Anesthesia comments/complications/interventions:

Signature [signature] Date 7/8/16 Time 1515

- ☑ Medications reconciled
- ☐ Discharge Criteria Met
- ☑ Discharge per Anesthesiologist Protocol - Barbieri M.D.
- ☐ Message to family at 1500
- ☐ OSA Protocol Initiated

Discharge Assessment: KN RN

Report to: C White RN

Transfer
☐ W/C ☐ Bed ☑ Stretcher Room # 232

Transported by KN RN Time 1516
Received by: C White Time 1515
BP 108/68 P 85 R 16 Temp 97.1 SaO2 98%
IPI: _____

Kate Vidgen RN (KN)
Nurse Signature

_____ ( )
Nurse Signature

61538666ID8848E0B793, KNIGHT, 108

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006933263
Unit Number:	M000175313
Room #/Location:	TEMP ROOM2/SUR TEMP ROOM2 7
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

DATE OF PROCEDURE:
07/08/2016

PREOPERATIVE DIAGNOSIS:
1. Ileostomy.
2. Parastomal hernia.

POSTOPERATIVE DIAGNOSIS:
1. Ileostomy.
2. Parastomal hernia.

PROCEDURE:
1. Small-bowel resection and anastomosis.
2. Ileostomy closure.
3. Repair of stomal/ventral incisional hernia with biologic mesh.

SURGEON:
Gilbertas Rimkus, MD

ANESTHESIA:
General endotracheal.

ESTIMATED BLOOD LOSS:
As 50 mL.

DISPOSITION:
To recovery room in stable condition.

INDICATIONS:
Mr. Knight is a 41-year-old patient who is known to me for traumatic perforation of the terminal ileum with extensive cecal peritonitis. He underwent bowel resection at that time, washout of the abdomen, and ileostomy. He healed up. He presented now for ileostomy takedown. Meanwhile, he developed parastomal hernia which he is going to get repaired at the same time. I told him I would use biologic mesh given the contaminant environment at the ileostomy site.

OPERATIVE CONSENT:
Procedure was explained in detail to Mr. Knight. Potential risks of bleeding, infection, and anastomotic leak were explained. He understood procedure and risks and expressed written consent.

OPERATIVE TECHNIQUE:
Patient was positioned supine on the operative table. After induction of general endotracheal anesthesia, his abdomen was prepped and draped in usual sterile fashion. Prior to prepping, his ileostomy was oversewn with pursestring suture 2-0 silk suture. An elliptiform incision was made around the ileostomy site. Dissection was carried all the way into subcutaneous tissues along the ileostomy. I mobilized approximately 10 cm of ileum. Then I identified distal ileum which I had sewn to the fascia posteriorly. I dissected that one free and mobilized only about 7 cm of that. It would not give me any more slack. After mobilization, ileostomy stump appeared to be ischemic plus there was length mismatch between 2 limbs. Therefore, I resected approximately 3 cm of the ileum and submitted to pathology. Then, side-to-side anastomosis with GIA 75 stapler was created between 2 limbs of ileum. TA 60 stapler was used to close enterotomy defect. Anastomosis was reinforced with interrupted 3-0 silk stitches. There was hernia defect right next to ileostomy site. I closed the peritoneum and rectus muscles, and then I developed

OPERATIVE/PROCEDURE REPORT

plane over the rectus muscles to accommodate 6 x 10 cm Strattice mesh which was just slightly trimmed to fit nicely. Then I closed the anterior rectus sheath with looped #1 PDS stitch in transverse fashion, in this way giving best potential repair for this young and athletic man, given the contaminated environment. A total of 20 mL of 0.25% Marcaine and 20 mL of Exparel were injected around the incision. Skin was approximated with staples and packed with Telfa strips in between. Dressing was applied. The patient tolerated the procedure well, was transported to recovery room in stable condition.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
GR/4105400
DD: 07/08/2016 14:45
DT: 07/08/2016 15:27
LM File#: 201607080000013527
Job #: 4105400

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jul 11 2016 5:24PM

Daniel E Knight

ODS-320-8-FRM
REV 1 01.13.14

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006933263 [redacted]
M000175313

PHYSICIAN'S ORDERS
General/Vascular
One Day Surgery Unit

Another brand of drug identical in form and content may be dispensed unless checked. ☐	Drug Allergies: PCN - Sulfa
Admit Status	☐ Outpatient ☒ Inpatient 7/8/16
Additional order sets:	Surgical Consent: Takedown of ileostomy and repair of incisional hernia
Diagnosis	Intestinal Perforation w/ Ileostomy, Incisional Hernia
Vital Signs	☒ Vital Signs on arrival
Activity	
Diet	☒ NPO After midnight (or as instructed)
IV Access	☒ Initiate IV with LR at KVO (unless otherwise indicated by IV policy or physician) ☐ IV _____ at _____ ml/hr ☐ Saline Lock ☐ May use PICC line
Respiratory Care	☐ Oxygen at 2 liters via nasal cannula
Treatment/ Nursing	☐ No needle sticks or BP _____ arm ☐ Pre-op hair removal ☐ Scrub prep surgical area ☐ Foley catheter in OR
Labs	☒ **Labs/tests per anesthesia guidelines** (anesthesia cases only) ☐ CBC auto diff ☐ BMP ☐ BMP (AM of surgery) ☐ PSBS (AM of surgery) ☐ PT/PTT ☐ PT/PTT (AM of surgery) ☐ Urine ☐ Urine C & S ☐ Type and screen ☐ Type and Cross _____ units-packed red blood cells ☐ _____
Diagnostic Studies	☐ CXR (one view) _____ diagnosis ☐ EKG _____ diagnosis
Consults	

CF/ryd
7/8/16
1105

615386661D8848E0B793, KNIGHT, 111

ANS-382-FRM
REV 2 03.10.16

Conway Medical Center
Conway, South Carolina

PHYSICIAN'S ORDERS

Anesthesia Department Pre-Operative Orders

V00006933263
ODS
KNIGHT, DANIEL ERIC
206 ECUM CECUM DRIVE
CONWAY, SC 29527
[redacted]
Rimkus, Gilbertas MD
M000175313

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked. ☐	Drug Allergies
	☐ CBC auto diff ☐ BIVIP ☐ Type & Cross _____ unit(s) PRBC's	
	☐ CBC no diff ☐ BIVIP (AM of Surgery) ☐ Type & Screen	
	☐ H&H ☐ Digoxin level	
	☐ PT	
	☐ PTT	
	☐ CXR - one view	
	☐ EKG _____ (diagnosis)	
	☐ Diabetic Protocol (Form # 325)	
	☒ Pre op testing guidelines	
	☒ May use Lidocaine 1% for IV insertion	
	☒ 0.9% Normal Saline at KVO - 500 mL bag with micro drip (Dialysis or AV Fistula pt)	
	☐ D5W _____ Bolus	
	Pre Op Meds:	
	☐ Versed Syrup 0.25mg/kg (up to max dose 5mg): give _____ mg po on call to OR (anxiety) ☐ Versed Syrup 0.5mg/kg: give _____ mg po on call to OR (anxiety) ☐ Versed _____ mg IV on call to OR (anxiety)	
	☐ Scopolamine 1.5mg transdermal patch post auricular on arrival (remove after 24 hours) for nausea	
	☐ Alka Seltzer Gold 2 tablets in 30ml water po on call to OR (aspiration precautions)	
	☐ Pepcid 20 mg IV prior to surgery	
	☐ Reglan 10 mg IV prior to surgery	
	☐ Ofirmev 1000 mg IV now	
	☐ Morphine 4 mg IV now for pain	

Physician Signature [signature] **Date** 7,08,16 **Time** 1224

615386661D8848E0B793, KNIGHT, 112

Daniel E. Knight

ODS-320-B-FRM
REV 1 01.13.14

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC [redacted]
V00006933263
M000175313

PHYSICIAN'S ORDERS
General/Vascular
One Day Surgery Unit

Medication

Bowel Prep: (pre-op prescription/instructions by physician)
☐ Neomycin Sulfate + Erythromycin base
☐ Neomycin Sulfate + Metronidazole

ANTIBIOTICS: (Patient Weight: 140 lbs)

☒ **Give antibiotics within one hour prior to surgical incision**
☐ Ancef 1 gm IV if wt. less than (80 kg) **or**
Ancef 2 gm IV if wt. (80 kg) or greater

Colorectal:
☒ Invanz 1 gm IV
☐ Ancef 1 gm + Metronidazole 500 mg IV if wt. less than (80 kg) **or**
Ancef 2 gm + Metronidazole 500 mg IV if wt. (80 kg) or greater

Vascular/Pacemaker/PEG:
☐ Ancef 1 gm IV if wt. less than (80 kg) **or**
Ancef 2 gm IV if wt. (80 kg) or greater

Other: _____
(if other, document previous/current infection)

Beta Lactam Allergy:
☐ Vancomycin 1 gm IV if wt. less than (80 kg) or
Vancomycin 2 gm IV if wt. (80 kg) or greater (within 2 hrs of surgical incision)
☐ Clindamycin 600 mg + Gentamicin 2.5 mg/kg IV for weight less than 80 kg **or**
Clindamycin 900 mg + Gentamicin 2.5 mg/kg IV for weight greater than 80 kg **(colon/PEG)**
☐ Metronidazole 500 mg + Gentamicin 2.5 mg/kg IV **(colon)**
☐ Clindamycin 600 mg IV for weight less than 80 kg **or**
Clindamycin 900 mg IV for weight greater than 80 kg **(vascular/pacemaker)**

DVT prophylaxis
☐ IPC (outpatient)
☒ IPC (inpatient)
☐ TED hose ☐ Knee ☐ Thigh
☐ Enoxaparin 40 mg subcutaneously on arrival
☐ Enoxaparin 30 mg subcutaneously on arrival (if CRCl less than 30 ml/min or creatinine greater than 2 mg/dL)

Medications/Additional Orders:
☒ Toradol 30 mg IV pre-op
☒ Tylenol 1 gm IV pre-op
☐ Sentinel node injection at _____

CF Knight 7/8/16 1105

V.O. GR Hinkamp MD/ Maurice MD — 7/6/16 — 3pm
Physician Signature **Date** **Time**

615386661D8848E0B793, KNIGHT, 113

SURG-2228-MRFRM
REV 3 01.22.16

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC [redacted]
V00006933263
M000175313

Obstructive Sleep Apnea Assessment

Screening Assessment: Section I

Have you been diagnosed with sleep apnea? ☐ Yes ☒ No
Do you use a CPAP machine? ☐ Yes ☒ No
If yes, instruct patient to bring mask and tubing

☐ **If yes to being diagnosed with sleep apnea - initiate OSA protocol.**
☐ **If no, complete Section II**

Assessment completed by _____ Date/Time: _____/_____
Place behind Physician Orders tab in the Medical Record for physician review.

Screening Assessment: Section II

Recent opioid use (within 72 hours)? ☒ Yes ☐ No

List all Opioid Medication	Dose	Frequency	Route	How long has patient been taking?
Oxycodone	5mg	prn	po	Since May 15th

Have you been told that you Snore loudly on most nights? ☐ Yes ☒ No
Do you often feel Tired, fatigued, or sleepy during the daytime? ☐ Yes ☒ No
Has anyone Observed you stop breathing during your sleep? ☐ Yes ☒ No
Do you have or are you being treated for high blood Pressure or acid indigestion? ☐ Yes ☒ No
B. M. I. More than 35 kg/m2? ☐ Yes ☒ No (BMI=Weight in lbs X 703) ÷ (by height in inches X height in inches)
Age over 50 years old? ☐ Yes ☒ No
Gender: Male? ☒ Yes ☐ No
Neck circumference greater than 16" for female ☐ Yes ☒ No
Neck circumference greater than 17" for male ☐ Yes ☒ No

☒ 0-2 – **Low Risk** – No further action needed
☐ 3-5 – **Moderate Risk** – Anesthesia to assess patient for Capno 20 monitoring
☐ 6 or greater – **High Risk** – Initiate OSA Protocol

Carrie Floyd RN — 7/8/16 — 1105
Nurse Signature **Date** **Time**

Risk Category Actions

Low Risk	Known Controlled	High Risk for OSA
No further Action Needed	**Instruct patient to bring:** 1. **Tubing** 2. **Settings** 3. **Mask** ↓ **Initiate OSA Protocol**	**Anesthesia Interview** ↓ Proceed with Surgery No → Notify surgeon for further evaluation/testing Yes → Initiate OSA Protocol

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Post Anesthesia Care Orders (Form #363 - Rev 6 - 9/9/15) for inpatients.) - 07/08/16 13:27	
Other	
New: Discharge from PACU Discharge from PACU when discharge criteria met. **New:** Warming blanket May use warming blanket for hypothermia or comfort. **New:** O2 order O2 L/min:10 L Mode:Face Tent O2 Frequency:Continuous Maintain O2 Sat greater than or equal to:92 % O2 Sat Comment:May discharge with O2 at 2L via nasal cannula to keep SaO2 above 92%	
Medication	
New: Dilaudid Soln (hydromorphone (PF)) IV Q5Min X 4 doses PRN pain - 0.5mg IV Q5M PRN up to 2mg in PACU only **New:** Zofran Inj 4MG IV PRN X 1 doses PRN nausea - IN PACU ONLY	

PAC 4

Signed Electronically by SUSAN MD BARBIERI on 07/08/16 13:27

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

TC) 7/8/16 0553

Orders - 07/08/16 14:34	
The following orders are 'print-only.' Please take action: for each Order Type	
New: Reason(s) admission medically necessary for inpatient status: Major surgery and post op care	

7/8/16 1635

Signed Electronically by Gilbertas MD Rimkus on 07/08/16 14:34

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AIS - ASSOCIATES IN SURGERY - GENERAL SURGERY ADMISSION ORDERS (SURG-3330-REV 2-02.04.14)) - 07/08/16 14:34	
The following orders are 'print-only.' Please take action: for each Order Type	
New: Admit Location SURGICAL **New:** Admit Status Inpatient **New:** Dx Perforated bowel Parastomal hernia	
Lab	
New: CBC WITH AUTO DIFF in AM **New:** BMP in AM	
Diet	
New: CLEAR LIQUID DIET Dietary Supplements: Supplement Frequency: Fluid Restrictions: Special Modifications:	
Other	
New: Activity OOB to chair BID starting in AM **New:** Admit to: Rimkus, Gilbertas MD **New:** Wound Care Orders Dressing Orders:Reinforce dressing or change with sterile technique, clean with sterile saline. Frequency:PRN	
Medication	
New: Lactated Ringers IV Bag 1000 ML 125 MLS/HR Number of Liters: Continuous **New:** Hydrocodone-APAP 5 mg-325 mg Tab 1-2 TABS oral Q4H PRN pain **New:** Morphine Sulfate 2-4 mg IV Q2H PRN pain **New:** Tylenol Tab (acetaminophen) 650MG oral Q4H PRN fever > 101.5 **New:** Acetaminophen Rectal Supp 650MG rectal Q4H PRN fever > 101.5 **New:** Toradol Soln (ketorolac) 15MG IV Q6H X 2 days - X 48 hrs total **New:** Phenergan 12.5MG IV q3h PRN nausea **New:** Zofran Inj 4MG IV q3h PRN nausea **New:** Protonix (pantoprazole) TabEC 40MG oral qhs - may give IV if NPO **New:** Protonix (pantoprazole) 40MG IV .HS	

Signed Electronically by Gilbertas MD Rimkus on 07/08/16 14:34

7/8/16 1545 TCS 7/8/16 1548

Record on Appeal 1217

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (AIS - ASSOCIATES IN SURGERY - GENERAL SURGERY ADMISSION ORDERS (SURG-3330-REV 2-02.04.14)) - 07/08/16 14:34	
- Give if NPO **New:** Ambien Tab (zolpidem) 5MG oral HS PRN insomnia **New:** Maalox Plus Susp 30ML oral Q4H PRN indigestion - unless patient is NPO **New:** Mylicon-80 Chew (simethicone) 80MG oral ACHS PRN gas/bloating **New:** Invanz (ertapenem) 1GM IV Q24H X 1 doses - Please specify number of doses Allergy: The use of Invanz SolR (ertapenem) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins *Override Reason:* Provider Aware - Continue as ordered	

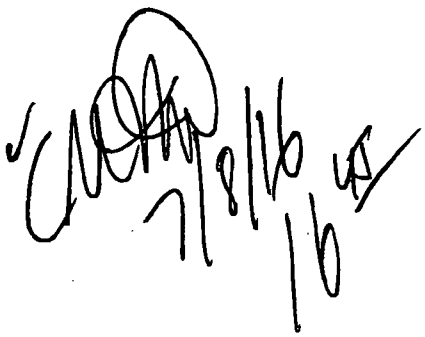
7/8/16 16:45

Signed Electronically by Gilbertas MD Rimkus on 07/08/16 14:34

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (VTE Prophylaxis Order Set (CCC-395-REV 1-03.13.14)) - 07/08/16 14:34	
Other	
New: Intermittent Pressure Devices Comment:Bilateral	



Signed Electronically by Gilbertas MD Rimkus on 07/08/16 14:34

KNIGHT, DANIEL E
[redacted]
Room: TEMP ROOM2
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders
Admission Medication Reconciliation

Home Medications

Percolone Tab (oxycodone) 5-10 MG oral Q6 PRN pain

PROzac capsule (fluoxetine) 20 MG oral 20 MG DAILY

Hospital Orders

Existing: Dilaudid Soln (hydromorphone (PF))
Dose:Dilaudid Soln 1 mg/mL (hydromorphone (PF)) 0.5mg IV Q5M PRN up to 2mg in PACU only IV Q5Min PRN pain

~~**New:** PROzac capsule (fluoxetine)~~
~~Dose: 20 MG oral 20 MG DAILY~~

✓ CM 7/8/16 1645

12° chart ✓ 7/8/16 1900

24° Chart ✓ 7/9/16 0420 P Green RN

Signed Electronically by Gilbertas MD Rimkus on 07/08/16 14:35

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 07/09/16 13:19	
Lab	
New: HEPATIC PANEL today @ 7/9@1447	
Medication	
DC due to change: **D/C** Lactated Ringers IV Bag 1000ML 125 MLS/HR RX Number: 07206565 **D/C** Number of Liters: Continuous **New:** Lactated Ringers IV Bag 1000 ML 50 MLS/HR Number of Liters: Continuous	

7/9/16 1530

24° chart 07/10/16 @ 0100AM. [illegible]

Signed Electronically by Michael H. MD Ellis on 07/09/16 13:19

-3315-FRM
REV 0 02.13.12

Conway Medical Center
Conway, South Carolina

Rimkus, Gilbertas MD
V000006933263
KNIGHT,DANIEL ERIC
[redacted] SUR232
M000175313 07/08/16

PHYSICIAN'S ORDERS

Date	Time	**Drug Allergies:**
7/9/16	1530	T.O. Dr. Ellis / [illegible]
		Full liquid diet
		Electronically Signed By: ELLIS,MICHAEL H., Jul 29 2016 6:02PM
		7/9/16 1530
		12° chart ✓ 7/9/16 1900
		24° chart 07/10/16 @ 0100 M. Godwin RN

Physician Signature ____/____/____ Date Time

DO NOT WRITE BELOW THIS LINE

FAX ALL ORDERS TO PHARMACY

615386661D8848E0B793, KNIGHT, 122

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders - 07/10/16 09:07	
Diet	
New: REGULAR DIET Dietary Supplements: Supplement Frequency: Fluid Restrictions: Special Modifications:	
Medication	
DC due to change: **D/C** Lactated Ringers IV Bag 1000ML 50 MLS/HR RX Number: 07207824 **D/C** Number of Liters: Continuous **New:** Lactated Ringers IV Bag 1000 ML KVO Number of Liters: Continuous	

Signed Electronically by Michael H. MD Ellis on 07/10/16 09:07

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders

Orders (Discharge Orders (REV 1 Form-340 5.13.16)) - 07/10/16 11:06	
The following orders are 'print-only.' Please take action: for each Order Type	
New: Dx History of creation of ostomy **New:** Prescriptions written and placed on chart	
Other	
New: Arrange Transportation via: FAMILY **New:** Discharge diet Regular **New:** Discharge order (340) **New:** Discharge patient to: Home **New:** Discontinue Lines Peripheral Line **New:** Follow up with Rimkus, Gilbertas MD in: 1 Week **New:** AMI Core Measure Did patient have an AMI during this hospitalization?: N **New:** Heart Failure Core Measure Did Patient have Heart failure this hospitalization?: N **New:** Stroke Core Measure Did the patient have a Stroke this hospitalization?: N **New:** VTE Core Measure Did this patient have a confirmed VTE and receive warfarin?: N	

7/8 @ 1142

Signed Electronically by Michael H. MD Ellis on 07/10/16 11:06

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders
Discharge Medication Reconciliation

Tony Corey
7/10/16 @ 1200

Pre-Admit/Hospital Medication

Percolone Tab (oxycodone) 5-10 MG oral Q6 PRN pain	
PROzac capsule (fluoxetine) 20 MG oral 20 MG DAILY	
~~Dc'd: Prozac cap (fluoxetine) 20MG oral DAILY~~	

Discharge Medication List

Percolone Tab (oxycodone)
Dose: 5-10 MG oral Q6 PRN pain

PROzac capsule (fluoxetine)
Dose: 20 MG oral 20 MG DAILY

✓ 7/10/16
1345

Stopped Hospital Medications

~~Dc'd: Acetaminophen Rectal Supp 650MG rectal Q4H PRN fever > 101.5~~	Stopped
~~Dc'd: Ambien Tab (zolpidem) 5MG oral HS PRN insomnia~~	Stopped
~~Dc'd: Hydrocodone-APAP 5 mg-325 mg Tab 1-2 TABS oral Q4H PRN pain~~	Stopped
~~Dc'd: Lactated Ringers IV Bag 1000ML KVO~~	Stopped
~~Dc'd: Maalox Plus Susp 30ML oral Q4H PRN indigestion~~	Stopped
~~Dc'd: Morphine Sulfate 2-4 mg IV Q2H PRN pain~~	Stopped
~~Dc'd: Mylicon-80 Chew (simethicone) 80MG oral AGHS PRN gas/bloating~~	Stopped
~~Dc'd: Phenergan 12.5MG IV Q3H PRN nausea~~	Stopped
~~Dc'd: Protonix (pantoprazole) TabEC 40MG oral HS~~	Stopped
~~Dc'd: Protonix (pantoprazole) 40MG IV .HS~~	Stopped
~~Dc'd: Toradol Soln (ketorolac) 15MG IV Q6H~~	Stopped
~~Dc'd: Tylenol Tab (acetaminophen) 650MG oral Q4H PRN fever > 101.5~~	Stopped

Signed Electronically by Michael H. MD Ellis on 07/10/16 11:06

KNIGHT, DANIEL E
[redacted]
Room: SUR232
V00006933263 M000175313
Allergies: Penicillins, Sulfa (Sulfonamide Antibiotics)

Conway Medical Center
Conway, SC
Physician's Orders
Discharge Medication Reconciliation

Stopped Hospital Medications

H	~~Dc'd: Zofran Inj 4MG IV Q3H PRN nausea~~	Stopped

Signed Electronically by Michael H. MD Ellis on 07/10/16 11:06

ODS-2225-FRM
REV 2 02.10.15

Conway Medical Center
Conway, South Carolina

Preoperative Testing Guidelines

KNIGHT,DANIEL ERIC
V00006933263 [redacted]
M000175313

Labs :	
Disease/Condition	
Minimal Blood Loss expected	No Labs
Moderate Blood Loss Expected	☐ CBC
High Blood loss expected	☐ CBC, CMP, Type and cross
History of Anemia	☐ Hgb, Hct
Diuretic Therapy	☐ BMP
Diabetes (not diet controlled or hypoglycemia)	☐ BMP, (FBS am. of surgery)
Renal Disease (dialysis patients only)	☐ CBC, (BMP am of surgery)
Liver Disease (diagnosed cirrhosis/hepatitis C)	☐ CBC, BMP, PT, PTT and Hepatic Panel
Digoxin/Lanoxin Therapy	☐ BMP, Digoxin Level
Bleeding History or Anti-coag therapy (Coumadin, Heparin)	☐ CBC (PT and PTT AM of surgery for regional anesthesia only)
Female of Childbearing age: Onset of menses to menopause	☐ Pregnancy Test (Urine) – day of surgery
Spinal Anesthesia (C-Section, Joint Replacement)	☐ CBC
Spine Surgery - ALIF	☐ CBC, Type and Screen
☐ CXR – 1 view – May use previous CXR if 6 mos. or less and no changes in condition / history.	☐ EKG – May use previous EKG if 6 mos or less and no change in condition /history
Disease/Condition	**Disease/Condition**
History of CHF, symptomatic	History of Angina/CAD
Thoracic related procedures	Previous Abnormal EKG
	Cardiovascular Surgery (or History of CV Surgery)
	Peripheral Circulatory Disorder 2nd to Diabetes
	Tachycardia, Murmurs, Palpitations, irregular pulse
	Hypertension

All testing based on patient history in accordance with guidelines established by the anesthesiologist. Additional tests must be ordered on a separate physician order sheet.

Moderate Blood loss procedures include:

TAH, TVH	Mastectomy
Colon resection	C-Section
Total Joints	TURP
ORIF hip	Carotid Endarterectomy
PLIF	Radical Neck
Other intra abdominal	Nephrectomy

High Blood Loss procedures include:

Insitu	Prostatectomy (Perineal)
Abdominal Aortic Aneurysm	
Aortic stent	
Aorto Bi Fem	
Thoracic Procedures	
Major abdominal (other)	

ASSOCIATES IN SURGERY, P.A.
GENERAL, THORACIC & VASCULAR SURGERY
2561 CYPRESS CIRCLE
CONWAY, SC 28526
(843) 347-7229
4367 RIVERWOOD DR., STE 210A
MYRTLE BEACH, SC 29576
(843) 839-1100
PAUL J. SASSER, M.D., FACS
DEA Reg. No. BS3182
GILBERTAS RIMKUS, M.D.
DEA REG. NO. BR7712263
MICHAEL H. ELLIS, M.D., FACS
DEA REG. NO. BE3387072
AARON M. [illegible], M.D., FACS
DEA REG. NO. BE4696716
NAME
ADDRESS
DATE
AGE
DR.
DR.
DISPENSE AS WRITTEN
SUBSTITUTION PERMITTED
BLUE BACKGROUND
REFLECTIVE WATERMARK

Daniel E Knight

ODS-320-B-FRM
REV 1 01.13.14

Conway Medical Center
Conway, South Carolina

PHYSICIAN'S ORDERS
General/Vascular
One Day Surgery Unit

Center Patient Admission Label Here

Another brand of drug identical in form and content may be dispensed unless checked. ☐

Drug Allergies: PCN - Sulfa

Admit Status	☐ Outpatient ☒ Inpatient 7/8/14
Additional order sets:	**Surgical Consent:** Takedown of ileostomy and repair of incisional hernia
Diagnosis	Intestinal Perforation w/ Ileostomy, Incisional Hernia
Vital Signs	☒ Vital Signs on arrival
Activity	
Diet	☒ NPO After midnight (or as instructed)
IV Access	☒ Initiate IV with LR at KVO (unless otherwise indicated by IV policy or physician) ☐ IV _____ at _____ ml/hr ☐ Saline Lock ☐ May use PICC line
Respiratory Care	☐ Oxygen at 2 liters via nasal cannula
Treatment/ Nursing	☐ No needle sticks or BP _____ arm ☐ Pre-op hair removal ☐ Scrub prep surgical area ☐ Foley catheter in OR
Labs	☒ **Labs/tests per anesthesia guidelines** (anesthesia cases only) ☐ CBC auto diff ☐ BMP ☐ BMP (AM of surgery) ☐ FSBS (AM of surgery) ☐ PT/PTT ☐ PT/PTT (AM of surgery) ☐ Urine ☐ Urine C & S ☐ Type and screen ☐ Type and Cross _____ units-packed red blood cells ☐ _____
Diagnostic Studies	☐ CXR (one view) _____diagnosis ☐ EKG _____diagnosis
Consults	

615386661D8848E0B793, KNIGHT, 129

Daniel E. Knight

ODS-320-B-FRM
REV 1 01.13.14

Conway Medical Center
Conway, South Carolina

PHYSICIAN'S ORDERS
General/Vascular
One Day Surgery Unit

Center Patient Admission Label Here

Medication

Bowel Prep: (pre-op prescription/instructions by physician)
☐ Neomycin Sulfate + Erythromycin base
☐ Neomycin Sulfate + Metronidazole

ANTIBIOTICS: **(Patient Weight:** 140 lb)

☒ **Give antibiotics within one hour prior to surgical incision**
☐ Ancef 1 gm IV if wt. less than (80 kg) **or**
Ancef 2 gm IV if wt. (80 kg) or greater

Colorectal:
☒ Invanz 1 gm IV
☐ Ancef 1 gm + Metronidazole 500 mg IV if wt. less than (80 kg) **or**
Ancef 2 gm + Metronidazole 500 mg IV if wt. (80 kg) or greater

Vascular/Pacemaker/PEG:
☐ Ancef 1 gm IV if wt. less than (80 kg) **or**
Ancef 2 gm IV if wt. (80 kg) or greater

Other: _____
(if other, document previous/current infection)

Beta Lactam Allergy:
☐ Vancomycin 1 gm IV if wt. less than (80 kg) **or**
Vancomycin 2 gm IV if wt. (80 kg) or greater (within 2 hrs of surgical incision)
☐ Clindamycin 600 mg + Gentamicin 2.5 mg/kg IV for weight less than 80 kg **or**
Clindamycin 900 mg + Gentamicin 2.5 mg/kg IV for weight greater than 80 kg **(colon/PEG)**
☐ Metronidazole 500 mg + Gentamicin 2.5 mg/kg IV **(colon)**
☐ Clindamycin 600 mg IV for weight less than 80 kg **or**
Clindamycin 900 mg IV for weight greater than 80 kg **(vascular/pacemaker)**

DVT prophylaxis
☐ IPC (outpatient)
☒ IPC (inpatient)
☐ TED hose ☐ Knee ☐ Thigh
☐ Enoxaparin 40 mg subcutaneously on arrival
☐ Enoxaparin 30 mg subcutaneously on arrival (if CRCl less than 30 ml/min or creatinine greater than 2 mg/dL)

Medications/Additional Orders:
☒ Toradol 30 mg IV pre-op
☒ Tylenol 1 gm IV pre-op
☐ Sentinel node injection at _____

V.O. G Rhinelow MD/ Mauris AW — 7/6/16 — 3PM
Physician Signature **Date** **Time**

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006933263
	[redacted]		MRN: M000175313
POST PROCEDURE NOTE	AUTHOR: Rimkus, Gilbertas MD	DATE: 07/08/16 13:19	SUR.TEMP ROOM2.7.CNW

SURGICAL PROCEDURE

Pre-Operative Diagnosis:	Ileostomy Parastomal hernia
Post-Operative Diagnosis:	Same
Indication(s):	As above
Surgical Procedure:	Small bowel resection and anastomosis Ileostomy closure Repair of incisional (parastomal)hernia with biologic mesh
Surgery Date:	07/08/16
Surgeon:	Rimkus, Gilbertas MD
Assistant:	Betty
Anesthesia:	GET
Blood Administered:	No
Estimated Blood Loss:	50 ml
Drain(s):	None
Specimen(s):	Small intestine
Complication(s):	None
Findings:	End of the ileostomy appeared ischemic after mobilization, had to be resected.
Grafts/Implants:	See Implant Sheet

Electronically signed by Gilbertas MD Rimkus on 07/08/16 at 14:33

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006933263
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Ellis, Michael H. MD	DATE: 07/09/16 13:19	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 2

Patient narrative POD#1 afebrile eating doing well

REVIEW OF SYSTEMS

EXAM

Vitals: (07/08 13:19 - 07/09 13:19)

Temp 97.7 (97.2-98.9)
Pulse 80 (70-91)
Resp 22 (16-22)
BP 99/62 (94/59-111/69)
O2 Sat: 97 (92-100)
%/L of O2: 0

I/Os: (07/08 07:00-07/09 07:00)

Net: 1,190 Intake: 2,990 Output: 1,800
IV:: 1,750 PO:: 1,240 Void (ml):: 1,800

Electronically signed by Michael H. MD Ellis on 07/09/16 at 13:20

Conway Medical Center	NAME: KNIGHT, DANIEL E.	SEX: Male	ACCOUNT #: V00006933263
	[redacted]		MRN: M000175313
PROGRESS NOTE	AUTHOR: Ellis, Michael H. MD	DATE: 07/10/16 09:06	SURE.SUR232.1.CNW

SUBJECTIVE

Hospital day 3

Patient narrative doing well will advance diet

REVIEW OF SYSTEMS

EXAM

Vitals: (07/09 09:06 - 07/10 09:06)
Temp 98.2 (97.7-98.6)
Pulse 75 (69-80)
Resp 18 (18-24)
BP 108/66 (99/62-112/69)
O2 Sat: 95 (95-100)
%/L of O2: 0

I/Os: (07/09 07:00-07/10 07:00)
Net: 2,460 Intake: 2,960 Output: 500
IV:: 1,600 IVPB:: 100 PO:: 1,260 Stool Episodes:: 2 Void (ml):: 500

CONSTITUTIONAL: Alert, in NAD.

RESPIRATORY: Lungs are clear to auscultation. Normal resonance to percussion. Normal respiratory effort.

Electronically signed by Michael H. MD Ellis on 07/10/16 at 09:07

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 07/11/16
RUN TIME: 0605

LOCATION
SURGERY EAST

PATIENT: KNIGHT,DANIEL ERIC
REG DR: Rimkus, Gilbertas MD
[redacted]
ACCT #: V00006933263 LOC: SURE U#: M000175313
ROOM: SUR232 REG: 07/08/16
DOB: 09/26/74 DIS: 07/10/16

**********CHEMISTRY**********

Date	07/9/16					
Time	1500	0507			Reference	Units
GLU		123 H			(70-110)	mg/dL
BUN		7			(7-18)	mg/dl
CREA		0.79			(0.7-1.30)	mg/dl
ESTIMATED GFR		> 60(a)				mL/mi
NA		142			(136-145)	mmol/
K		4.1			(3.5-5.1)	mmol/
CL		106			(93-108)	mmol/
ANION GAP		6.0 L			(7-16)	mmol/
CO2		30			(21-32)	mmol/
CA		8.8			(8.5-10.1)	mg/dl
TOT PROT	6.0 L				(6.4-8.2)	gm/dL
ALB	2.8 L				(3.4-5.0)	gm/dl
BILI,TOT	0.5				(0.2-1.0)	mg/dL
BILI,DIR	0.2				(0.0-0.2)	mg/dl
BILI,IND	0.3				(0.0-1.0)	mg/dL
ALP	113				(45-117)	U/L
SGOT,AST	33				(10-40)	U/L
SGPT,ALT	62 H				(16-61)	U/L

**********HEMATOLOGY**********

Date	07/9/16					
Time	0507				Reference	Units
WBC	14.0 H				(4.5-11.0)	K/mm3
RBC	4.14 L				(4.50-5.50)	M/mm3
HGB	12.1 L				(14.0-17.4)	g/dL
HCT	36.5 L				(45.0-52.0)	%
MCV	88.2				(80.0-100.0	fl
MCH	29.1				(28.0-34.0)	pg
MCHC	33.0				(32.0-36.0)	g/dl
RDW	14.8 H				(12.0-14.6)	%
PLT	220				(150-450)	K/mm3
NEUT%	88.6					%
LYMPH%	7.4					%
MONO%	3.5					%
EOS%	0.1					%

NOTES: (a) Reference: mL/min/1.73 sq.m
The eGFR result is normalized to a standard body surface area of (1.73 sq.m) using sex, age, and race based on a serum creatinine measurement.

Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
Summary Discharge Report - Do not Destroy

RUN DATE: 07/11/16
RUN TIME: 0605

LOCATION
SURGERY EAST

Patient: KNIGHT,DANIEL ERIC #V00006933263 (Continued)

**********HEMATOLOGY**********

	Date 07/9/16 Time 0507				Reference	Units
BASO%	0.4					%
NEUT#	12.4 H				(1.8-7.7)	K/mm3
LYMPH #	1.0				(1.0-4.8)	K/mm3
MONO#	0.5				(0.1-0.8)	K/mm3
EOS#	0.0				(0.0-0.4)	K/mm3
BASO#	0.1				(0.0-0.2)	K/mm3

CLINICAL PATHOLOGY CONSULTANTS, P. A.

PATHOLOGISTS
D. Mark Wilson, MD
Keels Allen, MD
Matthew Bernstein, MD

P.O. Box 1599
Conway, S.C. 29528

843 347-7144
FAX 843 347-7331

Surgical Pathology Report

NAME: KNIGHT,DANIEL ERIC [redacted]

UNIT NO: M000175313

ROOM NO: SUR232
RACE: CA
Signed Out

PATH NO: S16-4634
STATUS: SOUT
ACCOUNT NO: V00006933263
REC'D DATE: 07/08/16
DATE OF SVC: 07/08/16
REGISTERING MD:
SUBMITTING MD: Rimkus, Gilbertas MD

SITE OF SPECIMEN :
small bowel bx

FIXATION TIME :
Time specimen removed: 13:46, placed in formalin: 13:50. Initials: CM.

CLINICAL DIAGNOSIS :
Ileostomy, incisional hernia.

GROSS EXAMINATION :
The specimen consists of a small fragment of small bowel/ostomy tissue which has an open end and a stapled margin present. The specimen measures 3.5 x 3.0 x 2.7 cm. The specimen is opened to reveal normal ostomy-type, erythematous mucosa. Representative sections are submitted in one cassette.

MB/dm

MICROSCOPIC EXAMINATION :
Examination of the slide shows small bowel mucosa with villous architecture and increased chronic and active inflammation. Surface erosion is present along some areas. Chronic inflammation with lymphoid aggregates is seen throughout. No dysplastic features are identified.

DIAGNOSIS :
SMALL BOWEL, ILEOSTOMY TAKEDOWN:
BENIGN SMALL BOWEL CONSISTENT WITH ILEOSTOMY TAKEDOWN

MB/dap

Signed <Electronically Signed By>
Matthew Bernstein, MD 07/12/16 1430

UNIVERSAL MEDICATION FORM Conway Medical Center 843-347-7111 *GIVE THIS COPY TO THE PATIENT* **Patients: Fold this form and keep it in your wallet for easy access.**	Patient's Name: KNIGHT,DANIEL ERIC [redacted] MRI Number: M116454 Date Started: 07/10/16 Unit Number: M000175313

Emergency Contact/Phone Numbers:

IMMUNIZATION RECORD (Record the date/year of last does taken, if known)

Tetanus	Flu Vaccine NFS	
Pneumonia Vaccine	Hepatitis Vaccine	Other

Allergic To/Adverse Reaction:
Penicillins, Sulfa (Sulfonamide Antibiotics)

Medications: Include all prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginko). Include medications taken as needed (example nitroglycerin).

NAME OF MEDICATION/STRENGTH	DOSE/DIRECTIONS/NOTES Use patient friendly directions (Do not use medical abbreviations.)	LAST DOSE	DATE STOPPED	* RX	* PEI
OXYCODONE HCL 5 MG TABLET (OXYCODONE HCL)	5-10 MG Oral EVERY 6 HOURS	07/07/16 1830			
PROZAC* 20 MG CAP (FLUOXETINE HCL)	20 MG Oral 20 MG DAILY	07/10/16 0826			

Please consult your Physician or Primary Care Provider before taking any medication(s) not listed above.

*Rx (prescriptions) and *PEI (patient education information) given at time of discharge from hospital.

Reminders to patients:

1. Please fold this form and keep it in your wallet for easy access.
2. If you start to take any new over-the-counter medications or herbals, add these to your list so you will have a complete list.
3. Show this form each time you are asked which medications you take (doctor visits, diagnosic tests, emergency room, hospital, etc.) This will save you time. Continue to update the form.
4. Extra forms are available at many doctors' offices, pharmacies, and www.scha.org.

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Conway Hospital Laboratory
300 Singleton Ridge Road
Conway, South Carolina 29526
OUTPATIENT CUMULATIVE REPORT

RUN DATE: 06/21/16
RUN TIME: 0635

LOCATION

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006926648 LOC: LAB U#: M000175313
REG DR: Rimkus, Gilbertas MD [redacted] REG: 06/20/16
DIS:

Specimen: 0620:C00163R Entered: 06/20/16-1237 Collected: 06/20/16-1236
Status: COMP Received: 06/20/16-1236
Tests: HEPATIC PANEL
Sub Dr: Rimkus, Gilbertas MD

Test	Result	Flag	Reference
**********CHEMISTRY**********			
HEPATIC PANEL			
> TOTAL PROTEIN	8.2		6.4-8.2 gm/dL
> ALBUMIN	3.5		3.4-5.0 gm/dl
> BILIRUBIN,TOTAL	0.3		0.2-1.0 mg/dL
> BILIRUBIN,DIRECT	0.2		0.0-0.2 mg/dl
> BILIRUBIN,INDIRECT	0.1		0.0-1.0 mg/dL
> ALK PHOS	263	*H*	45-117 U/L
> SGOT,AST	32		10-40 U/L
> SGPT,ALT	123	*H*	16-61 U/L

** END OF REPORT **

615386661D8848E0B793, KNIGHT, 138

CPG Internal Medicine

Encounters and Procedures

Clinical Encounter Summaries

CONWAY HOSPITAL COMMUNITY SERVICES
Admin/CBO
300 Singleton Ridge Rd
CONWAY, SC 29526-1234
Phone: (843) 341-7111
Fax:

Encounter Summary - Progress Note
From Provider: RACHEL COLLINS, FNP
Date Printed: 06/24/2016

To Provider:

Patient	Knight, Daniel E (41 YR, M) #152915
DOB	09/26/1974

Patient Demographics:

Address	206 Ecum Secum Place Conway, SC 29527	**Home Phone**	(330) 719-5830
		Work Phone	(843) 733-3031

Encounter Notes:

Encounter Reason/Date	2 wk ago f/u 06/16/2016 - 02:00PM - CPG Carolina Internal Medicine
History of Present Illness	***General HPI** Reported by patient. Notes: Patient underwent abdominal surgery for perforation of small intestine and stomach by Dr. Rimkus. Patient had areas of small instestine removed with illestomy placed to lower right quadrant. Wound vac has been removed. Doing wet to dry dressing twice a day. Drainage minimal. Patient reports abdominal incision healing. Without fever. Patient has started walking 15-20 minutes a day outside. Patient denies chest pain or shortness of breath. Patient reports minimal abdominal pain. Patient also with elevated liver enzymes. Likely related to trauma and healing process.
Review of Systems	Patient reports no vomiting, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD; **Right LQ illestomy.** He reports **laceration (abdominal incision with wet to dry dressing intact)** but reports no abnormal mole, no jaundice, and no rashes. He reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, and no teeth problems. He reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. He reports no swollen glands, no bruising, and no excessive bleeding.
Vitals	

Pulse:	99 bpm regular 06/16/2016 02:01 pm	**RR:**	18 06/16/2016 02:01 pm	**Wt:**	138.6 lbs 06/16/2016 02:33 pm
BP:	99/56 sitting L arm 06/16/2016 02:06 pm 100/60 sitting L arm 06/16/2016 02:35 pm	**BMI:**	24.6 06/16/2016 02:33 pm	**Ht:**	5 ft 3 in 06/16/2016 02:01 pm
O2Sat:	97% Room Air at Rest 06/16/2016 02:01 pm				

Results/Interpretations	None recorded.
Physical Exam	Patient is a 41-year-old male. **Constitutional:** General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally. **ENMT:** Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no lesions on external nose, septal deviation, sinus tenderness, or nasal discharge and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged. **Neck:** Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. **Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted. **Cardiovascular:** Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout. **Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended; **midline abdominal incision.Wet to dry dressing intact. Illestomy to right LQ. Stoma pink. Good drainage, brown in color. Without redness or skin irritation around site.**. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable. **Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor.
Document Review	**Discussed the following orders:** • HEPATIC FUNCTION PANEL, SERUM - 06/16/16 **Discussed the following results:** • CMP, SERUM OR PLASMA - 06/08/16 Notes - Baseline kidney function. Liver improved except AST and ALT trending up. Recheck in 2 weeks. • CBC W/ AUTO DIFF - 06/08/16 Notes - WBC trended to normal range. Plt slight elevated, healing from trauma • Patient Portal - Family Medicine Health History Form - 06/16/16 • DISCHARGE SUMMARY - CONWAY MEDICAL CENTER (MED REC) - 05/29/16
Assessment and Plan	**1. Perforation of small intestine** - Established (stable) - Seen by Dr. Rimkus last week for drainage. Stopped wound vac and removed. Changed to wet to dry dressing BID. Taking minimal pain medication. Abdominal incision healing. Continue dressing instructions per Dr. Rimkus. K63.1: Perforation of intestine (nontraumatic) **2. Liver enzymes abnormal** - Established (stable) - Limit Tylenol intake. R94.5: Abnormal results of liver function studies • HEPATIC FUNCTION PANEL, SERUM **3. Malaise and fatigue** - Established (improving) R53.83: Other fatigue • FATIGUE: CARE INSTRUCTIONS Discussion **Patient Instructions** FOLLOW UP IN 1 MONTH **Discussion Notes** Above diagnoses discussed. Follow wound care instructions provided by Dr. Rimkus. Monitor for drainage, odor, and temperature. Continue with light exercise several times a day. Repeat lab work. Limit Tylenol intake and alcohol intake. Return to Office • Rachel Collins, FNP for Established Patient-15 at CPG Carolina Internal Medicine on 07/18/2016 at 02:00 PM

Patient Medical History:

Allergies List

Reviewed Allergies

- PENICILLINS
- SULFA (SULFONAMIDE ANTIBIOTICS)

Medications

Reviewed Medications

fluoxetine 20 mg capsule TAKE (1) CAPSULE BY MOUTH DAILY	09/29/15 renewed

Family History

Discussed Family History

Mother	- Heart disease
	- Chronic obstructive lung disease
	- Hypertensive disorder
Father	- Alcoholism
Sister	- Asthma
	- Obese

Past Medical History

Discussed Past Medical History
Depression: Y

Vaccine History

Vaccines not reviewed (last reviewed 11/17/2015)

Vaccine Type	Date	Amt.	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis										
Tdap	2013									
Tdap	01/01/13						01/01/01			
Influenza										
Influenza, intradermal, quadrivalent, preservative free	10/2015									
Influenza, intradermal, quadrivalent, preservative free	10/01/15						01/01/01			
Tetanus										
tetanus toxoid, adsorbed	06/01/14						01/01/01			

Electronically Signed by: RACHEL COLLINS, FNP, NP-C

Rachel Collins FNP

Encounter Date: 06/16/2016

CONWAY HOSPITAL COMMUNITY SERVICES
Admin/CBO
300 Singleton Ridge Rd
CONWAY, SC 29526-1234
Phone: (843) 341-7111
Fax:

From Provider: RACHEL COLLINS, FNP
Date Printed: 06/24/2016

To Provider:

Patient	Knight, Daniel E (41 YR, M) #152915
DOB	09/26/1974

Patient Demographics:

Address	206 Ecum Secum Place Conway, SC 29527	**Home Phone**	(330) 719-5830
		Work Phone	(843) 733-3031

Encounter Notes:

Encounter Reason/Date	transition of care: high (1 week) post hosp visit 06/03/2016 - 10:30AM - CPG Carolina Internal Medicine
History of Present Illness	**Transition Care Management** Reported by patient. Timing: date of discharge: **(05/29/16)**; date interactive contact was made: **(05/31/16)** Facility: discharged to home from facility type Inpatient Acute Care Hospital Current Caregivers: self; family member; Home Health services with Amedysis Non-Face-to-Face Services Performed: yes, please refer to patient case of date: Functional Status no difficulty following discharge instructions; taking medications as prescribed; following recommended activity level Follow Up scheduled yes; primary care provider, date: **(06/03/16)**; another provider-specialist, date: **(06/01/16 with Dr. Rimkus)** Notes: Patient underwent emergency surgery and admission to CMC on 05/15/16 after reporting to ER with severe abdominal pain, following a MVA 3 weeks prior. CT revealed gastric fluid and distention of bowels. Patient underwent abdominal surgery for perforation of small intestine and stomach by Dr. Rimkus. Patient had areas of small instestine removed with illestomy placed to lower right quadrant. Patient was admitted to ICU for further evaluation. After surgery patient became hypoxic and hypotensive. Patient received large amount of IV fluids. Then patient developed fluid overload in lungs and had to revceive lasix. Pulmonay was consulted. Patient was placed on fluid restriction and oxygen therapy. After a week, patient was transferred to surgical floor where patient remained for 1 more week. Patient lungs improved. Patient had wound vac placed to abdominal incision to help with helping. Also patient was taken off antibiotics and antifungal medication due to elevated liver enzymes. Patient stablized and was released home on 05/29/16 with Amedysis home health/wound care services. Patient denies chest pain or shortness of breath. Patient has been using incentive spirometer. Patient reports minial abdomainal pain, taking pain medication only twice a day and using NSAID therapy. Patient c/o fluid to left ear.
Review of Systems	Patient reports **weight loss (30 lbs) (since April 28, related to abdominal trauma)** but reports no fever, no night sweats, no significant weight gain, and no exercise intolerance. He reports no difficulty hearing and no ear pain; **fluid to left ear.** He reports **abdominal pain (improving. Right LQ illestomy)** but reports no vomiting, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports **laceration (abdominal incision with wound vac)** but reports no abnormal mole, no jaundice, and no rashes. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, and no teeth problems. He reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, and no suicidal thoughts. He reports no swollen glands, no bruising, and no excessive bleeding.
Vitals	

Pulse:	93 bpm regular 06/03/2016 10:34 am	**RR:**	18 06/03/2016 10:37 am	**T:**	98.4 F° 06/03/2016 10:34 am
Wt:	140 lbs 06/03/2016 10:34 am	**BP:**	90/60 sitting L arm 06/03/2016 10:37 am 98/60 sitting L arm 06/03/2016	**BMI:**	24.8 06/03/2016 10:34 am

			11:01 am		
Ht:	5 ft 3 in 06/03/2016 10:34 am	O2Sat:	97% Room Air at Rest 06/03/2016 10:34 am		

Results/Interpretations	None recorded.
Physical Exam	Patient is a 41-year-old male. **Constitutional:** General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD and **acutely ill**. Ambulation: ambulating normally. **ENMT:** Ears: no lesions on external ear, EACs clear, TM mobility normal, and **middle ear fluid (left TM)**. Nose: no lesions on external nose, septal deviation, sinus tenderness, or nasal discharge and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged. **Neck:** Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. **Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted. **Cardiovascular:** Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout. **Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended; **midline abdominal incision. Wound vac intact, with good seal and suction. Without redness or drainage from around incision site. Illestomy to right LQ. Stoma pink. Good drainage, yellow in color. Without redness or skin irritation around site.**. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable. **Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor.
Document Review	**Discussed the following orders:** • CMP, SERUM OR PLASMA - 06/03/16 • CBC W/ AUTO DIFF - 06/03/16 **Discussed the following results:** • Patient Portal - Family Medicine Health History Form - 06/03/16 • DISCHARGE NOTICE - 05/29/16 • HOSPITAL ADMISSION - 05/15/16
Assessment and Plan	**1. Perforation of small intestine** - Established (stable) - Wound vac changed by Amedysis home health nursing 3x per week. Had follow-up with Dr. Rimkus on 06/01/16, good healing. Next follow-up scheduled for 06/16/16. Following illestomy diet, avoiding nuts. Recommend chewable vitamin to help with healing and promote healthy tissue. Encouraged protein rich meals. Reversal planned for 3 months. Repeat labs to monitor WBC and liver enzymes. K63.1: Perforation of intestine (nontraumatic) • CBC W/ AUTO DIFF • CMP, SERUM OR PLASMA Fasting: Y **2. Hypoxemia** - Established (improving) - Resolved. Oxygen saturation 97% on room air. Continue use with incentive spironmeter. R09.02: Hypoxemia **3. Low blood pressure** - Established (stable) - Patient's BP runs 98-110/70-80 in office. Encouraged patient to keep increase of fluids and electrolytes to help with replacement lose through ostomy. I95.9: Hypotension, unspecified • LOW BLOOD PRESSURE: CARE INSTRUCTIONS **4. Depressive disorder** - Established (stable) - Patient in good spirits. Positive attitude with progession of healing. Good support at home and through work. F33.0: Major depressive disorder, recurrent, mild • LEARNING ABOUT MOOD DISORDERS **5. Allergic rhinitis** - New Problem (no further w/u) - With fluid to left TM. Use flonase daily. Recommend pressure blows. J30.9: Allergic rhinitis, unspecified

Discussion

Patient Instructions

FOLLOW UP IN 2 WEEKS

Discussion Notes

Above diagnoses discussed in detail with patient. Encouraged to keep follow-up appointments with Dr. Rimkus. Continue POC as prescribed by Dr. Rimkus.
Recommend chewable multiple vitamin to help with healing process.
Eat a well balanced diet. Avoid nuts, seeds, and foods high in fiber/folage.
Good handwashing techniques.
Patient to report to ER with any fever, drainage, foul odor, or increase in abdominal pain.
Recommend pressure blows and Flonase for fluid on TM.

Return to Office

- Rachel Collins, FNP for Established Patient-15 at CPG Carolina Internal Medicine on 06/16/2016 at 02:00 PM

Patient Medical History:

Allergies List

Reviewed Allergies	
PENICILLINS	
SULFA (SULFONAMIDE ANTIBIOTICS)	

Medications

Reviewed Medications	
fluoxetine 20 mg capsule TAKE (1) CAPSULE BY MOUTH DAILY	09/29/15 renewed
pantoprazole 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route for 30 days.	04/28/16 prescribed

Family History

Discussed Family History

Mother	- Heart disease
	- Chronic obstructive lung disease
	- Hypertensive disorder
Father	- Alcoholism
Sister	- Asthma
	- Obese

Past Medical History

Discussed Past Medical History
Depression: **Y**

Vaccine History

Vaccines not reviewed (last reviewed 11/17/2015)

Vaccine Type	Date	Amt.	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis										
Tdap	2013									
Tdap	01/01/13						01/01/01			
Influenza										
influenza, intradermal, quadrivalent, preservative free	10/2015									
influenza, intradermal, quadrivalent, preservative free	10/01/15						01/01/01			
Tetanus										
tetanus toxoid, adsorbed	06/01/14						01/01/01			

Electronically Signed by: RACHEL COLLINS, FNP-NP-C

EAF1FC36DF4940A69001, KNIGHT, 12

Rachel Collins FNP

Encounter Date: 06/03/2016

CONWAY HOSPITAL COMMUNITY SERVICES
Admin/CBO
300 Singleton Ridge Rd
CONWAY, SC 29526-1234
Phone: (843) 341-7111
Fax:

Encounter Summary - Progress Note
From Provider: RACHEL COLLINS, FNP
Date Printed: 06/24/2016

To Provider:

Patient	Knight, Daniel E (41 YR, M) #152915
DOB	09/26/1974

Patient Demographics:

Address	206 Ecum Secum Place Conway, SC 29527	**Home Phone**	(330) 719-5830
		Work Phone	(843) 733-3031

Encounter Notes:

Encounter Reason/Date	c/o was in a car wreck yesterday went to CMC ER. 04/28/2016 - 03:45PM - CPG Carolina Internal Medicine
History of Present Illness	**Emergency Department Follow-Up Record** Reported by patient. Discharge Information emergency department discharge date: (Please enter in format 'MM/DD/YYYY') **(4/27/16)** Notes: Patient was taken to ER last night after being in a head on collision. Patient has multiple abrasions to hands, arms, and knees. In ER, CT scan of head, chest, and abdomen/pelvis was performed. Without acute trauma internally. Patient given RX for pain medication, Naproxen, and Flexeril. Patient reports dark urine with light pink.
Review of Systems	Patient reports **hematuria** but reports no incontinence, no difficulty urinating, and no increased frequency. He reports **laceration (abrasions and bruising)** but reports no abnormal mole, no jaundice, and no rashes. He reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no vomiting, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. He reports no swollen glands, no bruising, and no excessive bleeding.
Vitals	04/28/2016 03:47 pm

Wt:	170 lbs	**BP:**	90/60	**BMI:**	30.1
Ht:	5 ft 3 in				

Results/Interpretations	URINALYSIS, DIPSTICK • Results: - **Glucose: 100 mg/dL** - **BIL: small**

	- **Ketones: trace** - **SG: 1.020** - **Blood: negative** - **pH: 6.0** - **Protein: 100 mg/dL** - **URO: 0.2** - **Nitrates: negative** - **Leukocytes: negative** - **Color: amber** - **Clarity: clear**
Physical Exam	Patient is a 41-year-old male. **Constitutional:** General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: **limited ambulation.** **Neck:** Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. **Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted. **Cardiovascular:** Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout. **Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable. **Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor. **Skin:** Inspection and palpation: no rash, lesions, ulcer, induration, nodules, jaundice, or abnormal nevi and good turgor; **bruising to hands, knees, and arms. With laceration to right hand and right knee.**. Nails: normal.
Document Review	**Discussed the following results:** • URINALYSIS, DIPSTICK - 04/28/16 Results: - Glucose: 100 mg/dL - BIL: small - Ketones: trace - SG: 1.020 - Blood: negative - pH: 6.0 - Protein: 100 mg/dL - URO: 0.2 - Nitrates: negative - Leukocytes: negative - Color: amber - Clarity: clear • Patient Portal - Family Medicine Health History Form - 04/28/16
Assessment and Plan	**1. Contusion of chest** - Self-Limited/Minor - Reflux medication given to provide GI protection while taking NSAID therapy and pain medication S20.20XD: Contusion of thorax, unspecified, subsequent encounter • CHEST CONTUSION: CARE INSTRUCTIONS • pantoprazole 40 mg tablet,delayed release - Take 1 tablet(s) every day by oral route for 30 days. Qty: 30 tablet(s) Refills: 0 Pharmacy: CONWAY MEDICAL **2. Contusion of abdominal wall** - Self-Limited/Minor S30.1XXD: Contusion of abdominal wall, subsequent encounter • URINALYSIS, DIPSTICK Discussion **Patient Instructions** FOLLOW UP IN 2 WEEKS **Discussion Notes** Above diagnoses discussed with patient. Patient encouraged to take pain medication as needed. Rest and avoid heavy lifting. Increase hydration. Make sure to keep bowels moving with pain medication. **Return to Office**

	Return to Office • Rachel Collins, FNP for Established Patient-15 at CPG Carolina Internal Medicine on 05/11/2016 at 09:45 AM

Patient Medical History:

Allergies List

Reviewed Allergies	
PENICILLINS	
SULFA (SULFONAMIDE ANTIBIOTICS)	

Medications

Reviewed Medications	
fluoxetine 20 mg capsule TAKE (1) CAPSULE BY MOUTH DAILY	09/29/15 renewed
pantoprazole 40 mg tablet,delayed release Take 1 tablet(s) every day by oral route for 30 days.	04/28/16 prescribed

Family History

Discussed Family History

Mother	- Heart disease
	- Chronic obstructive lung disease
	- Hypertensive disorder
Father	- Alcoholism
Sister	- Asthma
	- Obese

Past Medical History

Discussed Past Medical History
Depression: **Y**

Vaccine History

Vaccines not reviewed (last reviewed 11/17/2015)

Vaccine Type	Date	Amt.	Route	Site	Lot #	Mfr.	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis										
Tdap	2013									
Tdap	01/01/13						01/01/01			
Influenza										
influenza, intradermal, quadrivalent, preservative free	10/2015									
influenza, intradermal, quadrivalent, preservative free	10/01/15						01/01/01			
Tetanus										
tetanus toxoid, adsorbed	06/01/14						01/01/01			

Electronically Signed by: RACHEL COLLINS, FNP, NP-C

Rachel Collins FNP

Encounter Date: 04/28/2016

Imaging Results

PORTABLE CHEST ONE VIEW *

(#1482508, Final, 05/20/2016 7:54am)

41-year-old male shortness of breath, recent MVA. Lung injury.

Exam: Portable chest single view

Comparison: 5/19/2016.

Findings: Upright AP portable view of the chest shows cardiac silhouette and pulmonary vasculature to be stable. Alveolar density in the left upper lobe is improved. There is clearing of the right upper lobe density. New findings in the right infrahilar region. No pneumothorax.

Impression: Overall slight improvement to the bilateral alveolar densities. Some airspace disease remains.

Electronically Signed By: Russell Derrick

PORTABLE CHEST ONE VIEW *

(#1472513, Final, 05/19/2016 8:02am)

Exam: Portable chest dated May 19, 2016

Comparison: May 18, 2016

History: Short of breath for one month. Head on MVA on April 27.

Findings: AP portable chest radiograph was performed and compared to the prior study study. There is diffuse bilateral airspace disease which is worsening in the apices and improving in the bases. There may be small bilateral pleural effusions. Cardiac silhouette is within normal limits. The pulmonary vasculature is mostly obscured by the apical disease.

Impression:
1. Fluctuating areas of pulmonary consolidation. Findings could represent contusion, aspiration, or pneumonia among other noninfectious inflammatory diseases.

Electronically Signed By: Joshua Tew

Lab Results

HEPATIC FUNCTION PANEL, SERUM 06/21/2016 (#1671514, 06/20/2016)

06/21/2016 18:39 8433491008 CAROLINA INTERNAL ME PAGE 02/03

Run Date: 06/21/16 **Conway Medical Center Laboratory *LIVE*** PAGE 1
Run Time: 1641 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT,DANIEL ERIC ACCT #: VQ00006926648 LOC: LAB U#: M000175313
REQ DR: Rimkus, Gilbertas MD AGE/SX: 41/M ROOM: REG: 06/20/16
STATUS: REG REF DOB: 09/26/74 DIB:

Specimen: 0620:C00163R COMP Collected: 06/20/16-1236 Received: 06/20/16-1236
Subm DR: Rimkus, Gilbertas MD Verified Time: 06/20/16-1306

Test	Result	Flag	Reference	Site
**********	CHEMISTRY	**********		
HEPATIC PANEL				
TOT PROT	8.2		6.4-8.2 gm/dL	
ALB	3.5		3.4-5.0 gm/dl	
BILI,TOT	0.3		0.2-1.0 mg/dL	
BILI,DIR	0.2		0.0-0.2 mg/dl	
BILI,IND	0.1		0.0-1.0 mg/dL	
ALP	263	H	45-117 U/L	
SGOT,AST	32		10-40 U/L	
SGPT,ALT	123	H	16-61 U/L	

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** END OF REPORT **

CMP, SERUM OR PLASMA 06/09/2016 (#1594351, 06/08/2016)

06/09/2016 10:38 8433491008 CAROLINA INTERNAL ME PAGE 05/06

Run Date: 06/09/16 **Conway Medical Center Laboratory *LIVE*** PAGE 1
Run Time: 0844 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006922463 LOC: LAB U#: M000175313
REQ DR: Collins,Rachel M APRN AGE/SX: 41/M ROOM: REG: 06/09/16
STATUS: REG REF DOB: 09/26/74 DIS:

Specimen: 0608:CC0128R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collins,Rachel M APRN Verified Time: 06/08/16-1122

Test	Result	Flag	Reference	Site
**********CHEMISTRY**********				
CMP				
GLU	121	H	70-110 mg/dL	
BUN	8		7-18 mg/dl	
CREA	0.91		0.7-1.30 mg/dl	
ESTIMATED GFR	>60		mL/min	
	Reference: mL/min/1.73 sq.m			
	The eGFR result is normalised to a standard body surface area of (1.73 sq.m) using sex, age, and race based on a serum creatinine measurement.			
NA	136		136-145 mmol/L	
K	4.1		3.5-5.1 mmol/L	
CL	100		93-108 mmol/l	
ANION GAP	9.0		7-16 mmol/L	
CO2	27		21-32 mmol/L	
CA	9.4		8.5-10.1 mg/dl	
TOT PROT	8.1		6.4-8.2 gm/dL	
ALB	2.8	L	3.4-5.0 gm/dl	
GLOB	5.3		gm/dL	
BILI,TOT	0.4		0.2-1.0 mg/dL	
ALP	322	H	45-117 U/L	
SGOT/AST	62	H	10-40 U/L	
SGPT/ALT	304	H	16-61 U/L	

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** END OF REPORT **

CBC W/ AUTO DIFF 06/09/2016 (#1594348, 06/08/2016)

06/09/2016 10:38 8433491008 CAROLINA INTERNAL ME PAGE 02/05

Run Date: 06/09/16 **Conway Medical Center Laboratory *LIVE*** PAGE 1
Run Time: 0844 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006922463 LOC: LAB U#: M000175313
RBG DR: Collins,Rachel M APRN AGE/SX: 41/M ROOM: REG: 06/08/16
STATUS: REG REF DOB: 09/26/74 DIS:

Specimen: 0608:H00099R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collins,Rachel M APRN Verified Time: 06/08/16-1102

Test	Result	Flag	Reference	Site
**********HEMATOLOGY**********				
CBC W/AUTO DIFF				
CBC A				
WBC	8.9		4.5-11.0 K/mm3	
RBC	4.32	L	4.50-5.50 M/mm3	
HGB	12.5	L	14.0-17.4 g/dL	
HCT	38.4	L	45.0-52.0 %	
MCV	88.9		80.0-100.0 fl	
MCH	29.0		28.0-34.0 pg	
MCHC	32.7		32.0-36.0 g/dl	
RDW	14.1		12.0-14.6 %	
PLT	466	H	150-450 K/mm3	
NEUT%	71.5		%	
LYMPH%	18.4		%	
MONO%	6.5		%	
EOS%	2.7		%	
BASO%	0.9		%	
NEUT#	6.4		1.8-7.7 K/mm3	
LYMPH #	1.6		1.0-4.8 K/mm3	
MONO#	0.6		0.1-0.8 K/mm3	
EOS#	0.2		0.0-0.4 K/mm3	
BASO#	0.1		0.0-0.2 K/mm3	

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** END OF REPORT **

Report	Result	Ref. Range	Units		Status	Lab
Glucose	100 mg/dL					
BIL	small					
Ketones	trace					
SG	1.020					
Blood	negative					
pH	6.0					
Protein	100 mg/dL					
URO	0.2					
Nitrates	negative					
Leukocytes	negative					
Color	amber					
Clarity	clear					

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

Encounters and Procedures

Clinical Encounter Summaries

CONWAY HOSPITAL COMMUNITY SERVICES
Admin/CBO
300 Singleton Ridge Rd
CONWAY, SC 29526-1234
Phone: (843) 341-7111
Fax:

Encounter Summary - Progress Note
From Provider: RACHEL COLLINS, FNP
Date Printed: 08/16/2016

To Provider:

Patient	Knight, Daniel E (41yo, M) #152915
DOB	09/26/1974

Patient Demographics:

Address	206 Ecum Secum Place Conway, SC 29527	**Home Phone**	(330) 719-5830
		Work Phone	(843) 733-3031

Patient Medical History:

Allergies List

Reviewed Allergies	
PENICILLINS	
SULFA (SULFONAMIDE ANTIBIOTICS)	

Medications

Reviewed Medications	
Diflucan 100 mg tablet Take 1 tablet(s) every day by oral route for 6 days.	07/18/16 prescribed
Diflucan 200 mg tablet Take 1 tablet(s) every day by oral route for 1 day.	07/18/16 prescribed
fluoxetine 20 mg capsule TAKE (1) CAPSULE BY MOUTH DAILY	09/29/15 renewed

Family History

Discussed Family History

Mother	- Heart disease
	- Chronic obstructive lung disease
	- Hypertensive disorder
Father	- Alcoholism
Sister	- Asthma
	- Obese

Past Medical History

Discussed Past Medical History
Depression: Y

Vaccine History

Vaccines not reviewed (last reviewed 11/17/2015)

Vaccine Type	Date	Amt	Route	Site	Lot #	Mfr	Exp Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis										
Tdap	2013									

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

Tdap	01/01/13						01/01/01				
Influenza											
influenza, intradermal, quadrivalent, preservative free	10/2015										
influenza, intradermal, quadrivalent, preservative free	10/01/15						01/01/01				
Tetanus											
tetanus toxoid, adsorbed	06/01/14						01/01/01				

Encounter Notes:

Encounter Reason/Date	transition of care: moderate (2 week) 1 mo f/u , hosp f/u 07/18/2016 - 02:00PM - CPG Carolina Internal Medicine
History of Present Illness	**Transition Care Management** Reported by patient. Timing: date of discharge: 07/10/2016; date interactive contact was made: **07/11/2016)** Facility: discharged to home from facility type Inpatient Acute Care Hospital Current Caregivers: self; family member Non-Face-to-Face Services Performed: yes, please refer to patient case of date: Functional Status no difficulty following discharge instructions; taking medications as prescribed; following recommended activity level Follow Up scheduled yes; primary care provider, date: **(07/18/2016)** Notes: Patient admitted on 7/8/16 for reversal of stoma from bowel resection. Patient had also developed a peristomal hernia. Surgery was performed by Dr. Rimkus. Patient tolerated surgery well. Patient was able to eat solid food without vomiting or diarrhea. Patient was passing gas and had a bowel movement prior to discharge. Patient c/o thrush to mouth from prolonged antibiotic therapy. With bad breath and change in taste. Without pain.
Review of Systems	Patient reports **mouth ulcer** but reports no sore throat, no bleeding gums, no snoring, no dry mouth, and no teeth problems. He reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no vomiting, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. He reports no swollen glands, no bruising, and no excessive bleeding.

Vitals

Pulse:	72 bpm regular 07/18/2016 02:16 pm	**RR:**	18 07/18/2016 02:13 pm	**Wt:**	142 lbs 07/18/2016 02:13 pm
BP:	92/62 sitting L arm 07/18/2016 02:19 pm	**BMI:**	25.2 07/18/2016 03:17 pm	**Ht:**	5 ft 3 in 07/18/2016 03:17 pm

Results/Interpretations	None recorded
Physical Exam	Patient is a 41-year-old male. **Constitutional:** General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally. **ENMT:** Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition;**white patches to tongue**. **Neck:** Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. **Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted. **Cardiovascular:** Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

	gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout. **Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended; **healing surgical incision for stoma reversal.** Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable. **Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor.
Document Review	**Discussed the following orders:** • Diflucan 100 mg tablet - 07/18/16 • Diflucan 200 mg tablet - 07/18/16 **Discussed the following results:** • HEPATIC FUNCTION PANEL, SERUM - 06/20/16 • DISCHARGE SUMMARY - CONWAY MEDICAL CENTER (MED REC) - 07/10/16 • DISCHARGE SUMMARY - 07/10/16 • HOSPITAL ADMISSION - 07/08/16
Assessment and Plan	**1. Perforation of small intestine** - Established (improving) - Reversal performed. Without ostomy. Has moved bowels. Without change in appetite. Using Miralax as needed. Recommend probiotic twice a day. K63.1: Perforation of intestine (nontraumatic) **2. Hernia of abdominal cavity** - Established (improving) - Peristomal hernia, repaired. K46.9: Unspecified abdominal hernia without obstruction or gangrene **3. Candidiasis of mouth** - New Problem (no further w/u) - Change toothbrush within the next 48 hours. B37.0: Candidal stomatitis • CANDIDIASIS: CARE INSTRUCTIONS • Diflucan 200 mg tablet - Take 1 tablet(s) every day by oral route for 1 day. Qty: 1 tablet(s) Refills: 0 Pharmacy: CONWAY MEDICAL • Diflucan 100 mg tablet - Take 1 tablet(s) every day by oral route for 6 days. Qty: 6 tablet(s) Refills: 0 Pharmacy: CONWAY MEDICAL Discussion **Patient Instructions** FOLLOW UP IN 3 MONTHS **Discussion Notes** Discussed importance of following low fat, low cholesterol, low sodium diet Need to participate in regular exercise regimen, at least 3-4 times weekly, as tolerated. Start with low-resistance cardiovascular, walking. Continue current medications; no dose adjustments made today. Add diflucan for thrush. Monitor BP periodically or in presence of HA, dizziness, or blurry vision. Recommend probiotic twice a day for regulation of bowels. Recommend change toothbrush in 48 hours of taking thrush medication. Return to Office • Rachel Collins, FNP for Established Patient-15 at CPG Carolina Internal Medicine on 10/18/2016 at 03:00 PM

Electronically Signed by: RACHEL COLLINS, FNP, NP-C

Rachel Collins FNP

Encounter Date: 07/18/2016

Lab Results

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

Encounters and Procedures

Clinical Encounter Summaries

CONWAY HOSPITAL COMMUNITY SERVICES
Admin/CBO
300 Singleton Ridge Rd
CONWAY, SC 29526-1234
Phone: (843) 341-7111
Fax:

Encounter Summary - Progress Note
From Provider: RACHEL COLLINS, FNP
Date Printed: 04/04/2017

To Provider:

Patient	Knight, Daniel E (42yo, M) #152915
DOB	09/26/1974

Patient Demographics:

Address	206 Ecum Secum Place Conway, SC 29527	**Home Phone**	(330) 719-5830
		Work Phone	(843) 733-3031

Patient Medical History:

Allergies List

Reviewed Allergies

- **PENICILLINS**
- **SULFA (SULFONAMIDE ANTIBIOTICS)**

Medications

Reviewed Medications

FLUoxetine 20 mg capsule TAKE (1) CAPSULE BY MOUTH DAILY	09/29/15 renewed

Surgical History

Reviewed Surgical History
- Abdominal Surgery - 07/08/2016 - stoma reversal
- Abdominal Surgery - 05/15/2016 - small bowel resection with stoma

Past Medical History

Discussed Past Medical History
Depression: **Y**

Family History

Discussed Family History

Mother	- Heart disease
	- Chronic obstructive lung disease
	- Hypertensive disorder
Father	- Alcoholism
Sister	- Asthma
	- Obese

Vaccine History

Reviewed Vaccines

Vaccine Type	Date	Amt	Route	Site	Lot #	Mfr	Exp. Date	Date on VIS	VIS Given	Vaccinator
Diphtheria, Tetanus, Pertussis										
Tdap	2013									
Tdap	01/01/13						01/01/01			
Influenza										

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

influenza, injectable,quadrivalent, preservative free, pediatric	10/04/16										
influenza, intradermal, quadrivalent, preservative free	10/2015										
influenza, intradermal, quadrivalent, preservative free	10/01/15							01/01/01			
Tetanus											
tetanus toxoid, adsorbed	06/01/14							01/01/01			

Encounter Notes:

Encounter Reason/Date	3 month follow up 10/18/2016 - 03:00PM - CPG Carolina Internal Medicine
History of Present Illness	***General HPI** Reported by patient. Notes: Patient for routine follow-up since reversal of stoma in July. Patient is back at work. Patient is back in the gym. Without any pain or discomfort with working out. **Hyperlipidemia** Reported by patient. Type of hyperlipidemia: **hypercholesterolemia** Duration: **chronic** Control: usually well controlled; **unchanged** Compliance: compliant; compliant with diet; exercises Complications: no coronary artery disease; no peripheral artery disease; no cardiovascular disease
Review of Systems	Patient reports no fever, no night sweats, no significant weight gain, no significant weight loss, and no exercise intolerance. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, and no teeth problems. He reports no chest pain, no arm pain on exertion, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, and no known heart murmur. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no vomiting, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, and no tremor. He reports no swollen glands, no bruising, and no excessive bleeding.
Vitals	10/18/2016 03:15 pm

Pulse:	72 bpm regular	**RR:**	18	**Wt:**	163.8 lbs
BP:	98/68 sitting L arm	**BMI:**	29	**Ht:**	5 ft 3 in
O2Sat:	98% Room Air at Rest				

Results/Interpretations	None recorded
Physical Exam	Patient is a 42-year-old male. **Constitutional:** General Appearance: healthy-appearing, well-nourished, and well-developed. Level of Distress: NAD. Ambulation: ambulating normally. **ENMT:** Ears: no lesions on external ear, EACs clear, TMs clear, and TM mobility normal. Nose: no lesions on external nose, septal deviation, sinus tenderness, or nasal discharge and nares patent and nasal passages clear. Lips, Teeth, and Gums: no mouth or lip ulcers or bleeding gums and normal dentition. Oropharynx: no erythema or exudates and moist mucous membranes and tonsils not enlarged. **Neck:** Lymph Nodes: no cervical LAD, supraclavicular LAD, axillary LAD, or inguinal LAD. **Lungs:** Respiratory effort: no dyspnea. Percussion: no dullness, flatness, or hyperresonance. Auscultation: no wheezing, rales/crackles, or rhonchi and breath sounds normal, good air movement, and CTA except as noted.

KNIGHT, DANIEL E (id #152915, dob: 09/26/1974)

	Cardiovascular: Apical Impulse: not displaced. Heart Auscultation: normal S1 and S2; no murmurs, rubs, or gallops; and RRR. Neck vessels: no carotid bruits. Pulses including femoral / pedal: normal throughout. **Abdomen:** Bowel Sounds: normal. Inspection and Palpation: no tenderness, guarding, masses, rebound tenderness, or CVA tenderness and soft and non-distended. Liver: non-tender and no hepatomegaly. Spleen: non-tender and no splenomegaly. Hernia: none palpable. **Neurologic:** Gait and Station: normal gait and station. Cranial Nerves: grossly intact. Sensation: grossly intact. Reflexes: DTRs 2+ bilaterally throughout. Coordination and Cerebellum: no tremor.
Document Review	N/A
Assessment and Plan	**1. Hyperlipidemia** - Established (stable) E78.00: Pure hypercholesterolemia, unspecified • HIGH CHOLESTEROL: CARE INSTRUCTIONS **2. Hernia of abdominal cavity** - Established (improving) - resolved post surgery K46.9: Unspecified abdominal hernia without obstruction or gangrene **3. Perforation of small intestine** - Established (improving) - Reversal of stoma. Without complication. K63.1: Perforation of intestine (nontraumatic) Discussion **Patient Instructions** FOLLOW UP IN 6 MONTHS **Discussion Notes** Discussed importance of following low fat, low cholesterol, low sodium diet. Need to participate in regular exercise regimen, at least 3-4 times weekly, as tolerated. Continue current medications; no dose adjustments made today. Monitor BP periodically or in presence of HA, dizziness, or blurry vision. Return to Office • to see Rachel Collins, FNP for Established Patient-15 at CPG Carolina Internal Medicine on or around 04/18/2017

Electronically Signed by: RACHEL COLLINS, FNP, NP-C

Rachel Collins FNP

Encounter Date: 10/18/2016

Associates in Surgery

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

C 3856

OPERATIVE/PROCEDURE REPORT

DATE OF PROCEDURE:
05/15/2016

PREOPERATIVE DIAGNOSIS:
Perforated viscus, peritonitis.

POSTOPERATIVE DIAGNOSIS:
Perforation of terminal ileum, peritonitis.

PROCEDURE:
Resection of small intestine and ileostomy.

SURGEON:
Gilbertas Rimkus, MD

ANESTHESIA:
General endotracheal.

DISPOSITION:
To the recovery room, extubated, in fair condition.

INDICATIONS AND OPERATIVE CONSENT:
Please see my history and physical report.

OPERATIVE TECHNIQUE:
The patient was positioned supine on the operating room table. After induction of general endotracheal anesthesia the abdomen was prepped and draped in the usual sterile fashion. A middle laparotomy incision was made. The abdominal wall was opened in layers. A large amount of fluid with intestinal contents was in the abdomen. This was suctioned out. Upon exploration of the abdomen perforation in the terminal ileum was found with significant surrounding peritonitis and the intestine was resected and given the significance of contamination and peritonitis I decided to perform ileostomy. An opening in the right lower quadrant was created and the abdominal wall and I brought out both ends of the ileum one distal to the terminal ileum and the other proximal to the terminal ileum to facilitate take down of the ostomy in the future. The abdominal cavity was then irrigated with 2L of warm normal saline and after the irrigant was suctioned out the 10 mm JP drain was placed in the right lower quadrant where the contamination was the heaviest. It was brought out through the stab incision in the left lower quadrant and sewn in with 2-0 nylon stitch. After lap and instrument counts were confirmed correct, the midline fascia was closed with looped #1 PDS starting in each corner and tightening in the middle. The abdominal wound was irrigated again and a total of 10 mL of Exparel was injected to the wound for postop pain control. The skin was approximated loosely with staples and Telfa strips and cleaned and the double barrel ileostomy was matured with interrupted 4-0 Vicryl stitches. The ileostomy appliance was attached and initially it was thought the patient would be able to get extubated but we decided to leave him intubated due to persistent respiratory insufficiency. We will send the patient to the intensive care unit.

Gilbertas Rimkus, MD Date/Time

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

cc: Gilbertas Rimkus, MD
GR/4101507
DD: 05/15/2016 10:03
DT: 05/15/2016 10:30
LM File#: 20160515000035745
Job #: 4101507

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M0000175313
Admit Date:	05/15/2016
Room #/Location:	/ER
Dictating Physician:	Gilbertas Rimkus, MD

G3884

PREOPERATIVE HISTORY & PHYSICAL

REASON FOR ADMISSION:
Abdominal pain, abnormal CT abdomen.

HISTORY OF PRESENT ILLNESS:
Mr. Knight is a 41-year-old patient who was involved in a collision motor vehicle accident approximately 3 weeks ago. At that time he was seen in the ER and underwent extensive workup which included CT scan of the chest and abdomen and only trace pelvic fluid was found at that time which could clearly have been physiologic. The patient presented now with increasing abdominal pain over the last several days. Work up in the emergency room again included CT scan of the abdomen and pelvis which showed tremendously distended and thickened small bowel and intraperitoneal fluid, moderate amount, and small amount of peritoneal gas suggestive of bowel obstruction with possible perforation. The patient never had any previous abdominal surgeries. I was called and asked to see the patient urgently.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
SULFA, PENICILLIN.

MEDICATIONS:
Prozac.

SOCIAL HISTORY:
He does not smoke cigarettes and does not drink alcohol.

REVIEW OF SYSTEMS:
As per the ER physician's notes, reviewed with pertinent positives significant for abdominal pain getting worse the last couple of days.

PHYSICAL EXAMINATION:
VITAL SIGNS: Afebrile with heart rate of 110, blood pressure 95/60 after 2L of crystalloid.

GENERAL: A middle aged male in no distress.

HEENT: Unremarkable exam.

LUNGS: Decreased breath sounds at the bases bilaterally.

HEART: Tachycardic.

ABDOMEN: Distended. Tender diffusely with diffuse rebound tenderness.

EXTREMITIES: Atraumatic.

IMPRESSION:
A 41-year-old patient with peritonitis likely perforated viscus, possible ischemic intestine. He has been resuscitated with crystalloid and given broad spectrum IV antibiotics. We will take him to the operating

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	/ER
Dictating Physician:	Gilbertas Rimkus, MD

PREOPERATIVE HISTORY & PHYSICAL

room this morning for exploratory laparotomy and possible bowel resection and possible ostomy. I discussed this with the patient and told him of the potential risks of bleeding, infection and remote possibility of having a temporary ostomy. He understood the procedure and risks and expressed written consent.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
GR/4101506
DD: 05/15/2016 08:33
DT: 05/15/2016 08:44
LM File#: 201605150000035609
Job #: 4101506

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V0000912686
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC28 1
Dictating Physician:	Kenneth Santiago, MD

63658

CONSULTATION

DATE OF CONSULTATION:
05/15/2016

REFERRING PHYSICIAN:
Dr. Rimkus from Surgery.

REASON FOR CONSULTATION:
Hypertension after surgical procedure.

HISTORY OF PRESENT ILLNESS:
This is a 41-year-old male who has a history of a motor vehicle accident 2 weeks ago. Patient went to the emergency room under trauma for evaluation where he had a CAT scan of the head, chest, and abdomen without any problems. Patient was discharged home. During the last 3 weeks the patient had been having some discomfort on the abdominal area and not eating much and not drinking much fluid. Patient went back to the emergency room secondary to severe abdominal pain. He had a CT of the abdomen that showed apparent perforated viscus with ischemic bowel. Patient was brought into the operating room where he had a resection of small bowel and ileostomy secondary to perforated terminal ileum and peritonitis. Patient was placed on aggressive IV antibiotics and transferred to the ICU for close monitoring. The patient's blood pressure during the surgery was low and he required some albumin, and also lots of fluids. Patient was admitted to the ICU.

At this time the patient is having abdominal pain. Blood pressure in the 70s systolic but his MAP had been 68. He is lethargic but oriented x3.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
To SULFA and PENICILLIN.

MEDICATION:
Medication at this time includes ertapenem 1 g IV daily.
Fluconazole daily.
Hydromorphone 0.5 mg IV every 2 hours p.r.n. severe pain.
Morphine every 4 hours p.r.n. moderate pain.
Zofran p.r.n. nausea.
Pantoprazole 40 mg IV at bedtime.
Promethazine p.r.n. nausea.
Simethicone p.r.n. gas.

SOCIAL HISTORY:
No smoking or alcohol abuse. Patient lives at home.

FAMILY HISTORY:
Nobody else with abdominal pain or significant abdominal issues.

REVIEW OF SYSTEMS:

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

CONSULTATION

Difficult to obtain as the patient is lethargic post-surgery and uncomfortable. Patient has an ileostomy now. Positive for nausea. No vomiting. Positive for abdominal pain diffuse and not radiating anywhere. Pain started like cramping, episodes are severe, come and go. He denies any fevers or chills. No generalized weakness. No numbness or tingling. Patient is not hungry at this time. He has been having a poor p.o. intake in the last 2 weeks.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 72/51. Heart rate 130. Temperature 97.2. Respiration 18. O2 saturation 97% on 2 liters.

GENERAL: Patient is lethargic. No respiratory distress. Oriented x3.

HEENT: Moist oral mucosa. No oral thrush. White sclera bilaterally.

NECK: No masses. No JVD.

HEART: Regular rate. Tachycardic. No murmurs or gallops or rub.

LUNGS: Clear to auscultation bilaterally from the front. No wheezes.

ABDOMEN: Bowel sounds diminished. Diffuse mild tenderness. Ileostomy not draining anything at this time. Ileostomy bag in place.

EXTREMITIES: No cyanosis. No edema.

SKIN: Dry. No rash. No jaundice.

NEUROLOGIC EXAM: Cranial nerves II-XII grossly intact bilaterally. No focal sensory or motor deficits noticed. Head normocephalic. No signs of trauma or laceration.

LABORATORY DATA:
White blood cells 9.8. Hemoglobin 16.9. Hematocrit 50.4. Platelets 632. Lipase 224. Bands are 10%. Glucose 224. BUN 25. Creatinine 1.74. Sodium 140. Potassium 3.9. Chloride 106. Bicarb 22. Calcium 0.8. Albumin 2.9. T bili 1.3. Alk phos 100. AST 21. ALT 72.

IMPRESSION AND RECOMMENDATION:
1. Hypotension probably secondary to side effects from anesthetics and pain medication in combination with dehydration with hypovolemia. Patient has been having a poor p.o. intake lately. His urine is concentrated. He has a Foley catheter. His creatinine has bumped from his baseline 1.2 to 1.74.
   a. We will give 2 liters of Ringer's lactate boluses.
   b. Follow blood pressure closely in the ICU level.
   c. Adjust as needed.
   d. Patient will follow up blood pressure every 15 minutes.
   e. We consider if the patient would benefit from some Levophed if needed for his low blood pressure.
2. Abdominal pain.
   a. We will use some low-dose morphine at this time. Once the blood pressure is better we will restart maybe using the Dilaudid as ordered before.
3. Acute kidney injury, probably secondary to dehydration with hypoalbuminemia and the presence of abdominal peritonitis from perforated viscus. We will follow BUN and creatinine in the morning.

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CONWAY MEDICAL CENTER
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Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

CONSULTATION

His GFR at this time is 46. We will adjust medication to that GFR. We will hold the BUN and creatinine by the morning with aggressive hydration. Follow Ins and outs, too.

4. Patient is a FULL CODE.

Thank you for allowing me to participate in the care of this patient. We will follow the patient closely on a daily basis.

Kenneth Santiago, MD Date/Time

cc: Gilbertas Rimkus, MD
Kenneth Santiago, MD
KAS/3025600
DD: 05/15/2016 16:09
DT: 05/16/2016 00:12
LM File#: 20160516000036559
Job #: 3025600

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63858

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR, RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Conway Medical Center

Kim Litton (843) 347-8035 phone, (843) 347-8181 fax

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Elizabeth (First) Ashley (Middle) Knight (Last)

Name of family member for whom you will provide care: Daniel (First) Eric (Middle) Knight (Last)

Relationship of family member to you: Spouse

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

post surgical care, ileostomy care, ATC care post discharge - estimate 10 weeks due to another surgery needed 3 months from now - on and off time should be

Elizabeth Knight (Employee Signature) 5-17-16 (Date)

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Gilbert A. Rankin, MD 2361 Cypress Circle Conway, SC 29526

Type of practice / Medical specialty: Surgery

Telephone: (843) 347-7291 Fax: (843) 347-0139

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 5-15-16

Probable duration of condition: 6 weeks

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ✓Yes. If so, dates of admission: 5-15-16

Date(s) you treated the patient for condition: 5-15-16 thru present

Was medication, other than over-the-counter medication, prescribed? ___No ✓Yes

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ✓Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
✓No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓No ___Yes. If so, expected delivery date: ___

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

5-15-16 Surgery - Resection of small intestine and ileostomy.

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF CARE NEEDED. When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ✓Yes.

Estimate the beginning and ending dates for the period of incapacity: 5.15.16 – 6.27.16

During this time, will the patient need care? ___No ✓Yes.

Explain the care needed by the patient and why such care is medically necessary:

Patient will need assistance with activities of daily living, ostomy care, transportation for doctors visits

5. Will the patient require follow-up treatments, including any time for recovery? ___No ✓Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

as needed

Explain the care needed by the patient, and why such care is medically necessary:

as above #4

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____No ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date: 6-1-16

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If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Byram Healthcare

3010 Woodcreek Drive, Suite A
Downers Grove, IL 60515

Phone: 866-321-6923
Fax: 866-232-9726

To: GILBERTAS RIMKUS
Fax: 843-347-9309
From: DOCUMENT COLLECTIONS - Billing Department-SYSTEM USE
Subject: DANIEL E KNIGHT - RX: 8450034

Memo:

You recently submitted an RX but the following items are missing.
Please supply the missing information and resubmit the RX.
Thank You.

This document contains privileged and confidential information intended only for the use of the addressee(s) listed.
If you are not the intended recipient of this document, you are hereby notified that any dissemination or copying
of this document is strictly prohibited. If you have received this document in error, please notify us immediately by
telephone and return the original via the U.S. Postal Service, to:
Byram Healthcare 120 Bloomingdale Rd Ste 301, White Plains, NY 10605
Thank You

NOTE: PLEASE DO NOT WRITE ANY PERTINENT INFORMATION IN REGARDS TO YOUR PATIENT ON THIS COVER SHEET. IT WILL BE AUTO-DELETED BY OUR SYSTEM ONCE RETURNED.

Date: 06/01/16 Time: 10:20 PM EDT Pages Sent: 2

Byram Healthcare

BYRAM HEALTHCARE CENTERS, INC.
3010 WOODCREEK DRIVE SUITE A
DOWNERS GROVE, IL 60515
1-888-321-8923

B 4 5 0 0 3 4

REFERRED BY: CONWAY WOUND HEALING CENTER
06/01/16 22:20:53 34192352
TOLL FREE FAX: 1-888-232-9726

BY SIGNING THIS FORM I CONFIRM THE PHYSICIAN'S SIGNATURE CORRESPONDS TO THE NAME AND NPI LISTED BELOW AND THAT I AM PRESCRIBING THE ITEMS AND QUANTITIES LISTED BELOW

GILBERTAS RIMKUS 2361 CYPRESS CIR CONWAY SC 29526	BHC# 553573	DANIEL E KNIGHT 206 ECUM CECUM DRIVE CONWAY SC 29527 330-719-5830 Type: 6100

BENEFICIARY - FIRST NAME / LAST NAME	ID NUMBER	DOB
DANIEL E KNIGHT	14414969	09 26 1974
DIAGNOSIS	START DATE	
Z93.2 K63.1	06 01 16	

ITEMS PRESCRIBED	CODES	QTY PRESCRIBED	QTY CHANGES (IF NEEDED)	FORM NUMBER
SKIN BARRIER WIPES OR SWABS EA	A5120	25BX/Refill		
SKN BAR POWDER PER OZ	A4371	3OZ/Refill		
SKN BAR PECTIN BASED PASTE PER	A4406	4OZ/Refill		
SKN BAR W/ FLG SOL FLX ACD EXT	A4409	20EA/Refill		
PCH DRN FOR BAR W/ NONLKG FLG	A4425	20EA/Refill		

PLEASE GIVE MEDICAL JUSTIFICATION AS TO WHY THE ABOVE SUPPLIES ARE NECESSARY.
REFILL QUANTITIES AND AMOUNTS TO BE FILLED AS SPECIFIED

DURATION OF NEED (MONTHS/99 EQUALS LIFETIME)
12 unless otherwise noted

AUTHORIZING PHYSICIAN

PHYSICIAN'S NAME	NPI#	
GILBERTAS RIMKUS	1326126301	
ADDRESS (STREET NUMBER)	LICENSE#	
2361 CYPRESS CIR		
APT/SUITE		
CITY/STATE/ZIP		
CONWAY SC 29526		
TELEPHONE NUMBER	FAX NUMBER	
843-347-7291	843-347-9309	

SUPPLIER

SUPPLIER'S NAME	
BYRAM HEALTHCARE CENTERS	
ADDRESS (STREET NUMBER)	
3010 WOODCREEK DRIVE	
CITY/STATE/ZIP	
DOWNERS GROVE, IL 60515	
RX#	
Byram Rx #: 8450034	
TELEPHONE NUMBER	
800-248-4525	

PLEASE SIGN AND DATE BELOW:

PHYSICIAN'S SIGNATURE	DATE	PLEASE PRINT PHYSICIAN'S NAME
	6-8-16	Gilbertas Rimkus, MD

FOR RESIDENTS please provide attending physician's information:

NAME: _____ NPI #: 1326126301

* Maximum quantities/refills allowed unless otherwise noted.
* Please complete any attached forms

BYRAM-RX Rev 2.3 DFF

PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE

Please complete this form and bring it with you to your scheduled appointment.

If you are taking any medication please bring a list of your medications, your insurance card and a photo identification card.

Please arrive 15 minutes prior to your appointment.

PATIENT INFORMATION

Title ___ **Last Name** KNIGHT **First Name** DANIEL **Middle Initial** E

Street Address 266 ECUM SECUM DR **Apartment Number** ___

Mailing Address ___
(if different from street address)

Zip Code 29527 **City** CONWAY **State** SC **Home Phone** ___ **Cell Phone** 330-719-5830

Email Address: evicknight1@yahoo.com

Social Security Number [redacted] **Sex** M **Race** W

Marital Status []Single [](Married) []Divorced []Widowed []Separated **Primary Language** ENGLISH **Student** [] Full-time [] Part-time

Employment [] (Full-time) [] Part-time [] Unemployed [] Retired **Relationship to Insured** [](Self) [](Spouse) [] Child [] Other

Employer/School Name MCLEOD ORTHOPEDIC PHYSICAL THERAPY

Street Address ___ **Apartment Number** ___

Zip Code ___ **City** ___ **State** ___ **Business Phone** ___

INSURED/PARENT/LEGAL GUARDIAN (IF OTHER THAN PATIENT)

Title ___ **Last Name** Knight **First Name** Elizabeth **Middle Initial** A

Street Address Same **Apartment Number** ___

Mailing Address ___
(if different from street address)

Zip Code ___ **City** ___ **State** ___ **Home Phone** 330-717-0532

Social Security Number [redacted] **Sex** F **Race** C

Marital Status []Single [X]Married []Divorced []Widowed []Separated **Student** [] Full-time [] Part-time

Employment [X] Full-time [] Part-time [] Unemployed [] Retired **Relationship to Insured** [X] Self [] Spouse [] Child [] Other

Employer/School Name Conway medical Center

Street Address 300 Singleton Ridge **Apartment Number** ___

Zip Code 29526 **City** Conway **State** SC **Business Phone** 843-347-8120

[] **Associates in Surgery, PA**
2361 Cypress Circle
Conway, SC 29526
Across from the Emergency Room side of Conway Medical Center

[] **Associates in Surgery, PA**
Wachesaw Medical Park
4367 Riverwood Drive Suite 210
Murrells Inlet, SC 29576
Across from the main entrance of Waccamaw Community Hospital

843-347-7291

FORMS MUST BE COMPLETED PRIOR TO APPOINTMENT OR

RESCHEDULING MAY BE NECESSARY

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, Daniel Eric Knight consent to treatment by the physicians of Associates In Surgery, PA.
Please enter your name on this line

I understand that no guarantee will be made to the outcome of my care or treatment. I understand I may be prescribed medication during the course of my treatment that may make operating heavy equipment or driving a vehicle dangerous. I understand I am taking full responsibility for my own actions while I am under the influence of these medications. DEK
Please Initial

I understand that as part of my health care, Associates in Surgery, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity to include my insurance company. I understand I am personally responsible for all co-payment, co-insurance and deductibles due. I understand that if my account is delinquent all payments received may be applied to any past due amount I may owe Associates In Surgery, PA. Should collections actions be required to collect the balance on my account I assume full responsibility for all cost incurred. DEK
Please Initial

I consent to Associates in Surgery, PA utilizing telephone voice mail and answering machines for the purpose of leaving an appointment reminder or a message to include name and phone number to call.

I fully understand and accept / decline the terms of this consent.

Daniel Eric Knight
Patient's Signature

6/1/16
Date

Most medications prescribed by our physicians will be transmitted electronically. Please provide your pharmacy information below:

Conway Medical Center Outpatient Pharm 843 347-802
Pharmacy Name Phone Number

300 Singleton Ridge Conway SC 29526
Address City State

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

PLEASE COMPLETE BOTH SIDES OF THIS FORM, SIGN, DATE AND RETURN TO THE RECEPTIONIST. THEN FULLY COMPLETE THE NEXT PAGE WHICH IS YOUR MEDICAL HISTORY FORM.

Associates in Surgery, PA
Authorization for Release of Information – Compound Release

Name of Patient Daniel Eric Knight Date of Birth 9-26-74

Associates in Surgery, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of Information to be released.** Check each that can be given to person/entity on the left in the same section.
☑ Voice Mail	☐ Message to Return Staff Members call ☐ Appointment Reminders Only ☑ All of the Above
☑ Spouse or Partner (Please list Full Name) Elizabeth Ashley Knight	☐ Financial ☐ Medical ☑ Both
☐ All Others (Please list Full Name and Relationship) _____ _____	☐ Financial ☐ Medical ☐ Both
☑ EMERGENCY CONTACT ELIZABETH KNIGHT 850-717-0532 Please provide name and phone number.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Daniel Eric Knight Date 6/1/16

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

Associates in Surgery, PA
2361 Cypress Circle
Conway, SC 29526
Phone: 843-347-7291
Fax: 843-347-9309

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/01/2016 09:33 AM

History of Present Illness *(Connie Hucks 06/01/2016 09:44 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. WOUND VAC IN PLACE, REMOVED

Additional reason for visit:

Transition into care is described as the following:
The patient is transitioning into care from hospital (CMC) .

Allergies *(Connie Hucks; 06/01/2016 09:45 AM)*
No Known Drug Allergies 06/01/2016
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching

Past Medical History (Connie Hucks; *06/01/2016 09:45 AM)*
SPORTS HERNIA (S39.81XA)

Family History *(Connie Hucks; 06/01/2016 09:45 AM)*
Non-Contributory Family History

Social History *(Connie Hucks; 06/01/2016 09:45 AM)*
No alcohol use
Caffeine use
Tobacco use: Former smoker, Remotely quit tobacco use
Current work status: Occupation: ; student

Medication History *(Connie Hucks; 06/01/2016 09:46 AM)*
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/01/2016 09:47 AM)*
None - Status is Inactive (06/01/2016) (Marked as Inactive)
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Connie Hucks; 06/01/2016 09:44 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

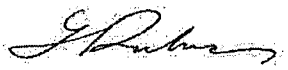
Vitals *(Connie Hucks; 06/01/2016 09:47 AM)*

06/01/2016 09:47 AM
Weight: 142 lb **Height:** 63 in
Body Surface Area: 1.69 m² **Body Mass Index:** 25.15 kg/m²
Temp.: 98.5 °F (Oral) **Pulse:** 50 (Regular)
BP: 128/78 Electronic (Sitting, Left Arm, Standard)

Physical Exam *(GILBERTAS RIMKUS; 06/01/2016 10:01 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing (Healing in secondary fassion with wound vac.).

Assessment & Plan *(GILBERTAS RIMKUS; 06/01/201610:03 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~3 wekks s/p resection and ileostomy.
Today's Impression: Doing well, healing nicely. F/u in 2 weeks.
Current Plans:



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/07/2016 02:27 PM

History of Present Illness *(Connie Hucks 06/07/2016 02:38 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. WOUND VAC IN PLACE WAS NOT REPLACED BY HH DUE TO DRAINAGE

Allergies *(Connie Hucks; 06/07/2016 02:38 PM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Connie Hucks; *06/07/2016 02:38 PM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~3 wekks s/p resection and ileostomy.

Social History *(Connie Hucks; 06/07/2016 02:38 PM)*
Tobacco use: Former smoker, Remotely quit tobacco use
No alcohol use
Caffeine use
Current work status: Occupation: ; student

Medication History *(Connie Hucks; 06/07/2016 02:38 PM)*
Medications Reconciled Specific dose unknown - Active - Hx Entry.
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/07/2016 02:38 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

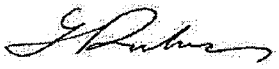
Review of Systems *(Connie Hucks; 06/07/2016 02:38 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Vitals *(Connie Hucks; 06/07/2016 02:32 PM)*
06/07/2016 02:32 PM
Temp.: 98.7 °F (Oral)

Physical Exam *(GILBERTAS RIMKUS; 06/07/2016 02:50 PM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing (In secondary fassion.).

Assessment & Plan *(GILBERTAS RIMKUS; 06/07/201602:51 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~5 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 1 week.
Current Plans:



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/07/2016 03:39 PM

History of Present Illness

Assessment & Plan *(Connie Hucks; 06/07/201603:40 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~5 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 1 week.
Current Plans:

- Started Percocet 5-325MG, 1-2 Tablet every six hours, as needed, #30, 06/07/2016, No Refill.

Signed electronically by Connie Hucks

Conway Physicians Group
Carolina Internal Medicine

Paul M. Richardson, Jr., M.D. FACP
Carol Ann Gardner, CFNP
Rachel M. Collins, CFNP
Jodi G. Pajaro, CFNP

2867-B Cypress Circle
Conway, SC 29526
843.349.1001
Fax 843.349.1008

FAX

Date 6/9/16 No. of pages 3

To Dr. Rimkus From Rachel Collins FNP

Fax 843-347-0139
843-347-9309 Phone 843-347-7291

Message:

Dr. Rimkus,

These are labs drawn 6/6/16 on D. Eric Knight (9/26/74). His WBC have trended down to normal. His kidney function is within normal limits. However his liver enzymes have trended back up. I am going to repeat them in two weeks but wanted you to be aware. If there is anything different that needs to be done, please let me know. (843-349-1007)

Thanks,
Rachel Collins FNP

CONFIDENTIAL:
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Run Date: 06/09/16 **Conway Medical Center Laboratory** *LIVE* PAGE 1
Run Time: 0843 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT, DANIEL ERIC ACCT #: VD0006922463 LOC: LAB U#: M00017531B
REG DR: Collins, Rachel M APRN AGE/SX: 41/M ROOM: REG: 06/09/16
STATUS: REG REF DOB: 09/26/74 DIS:

Specimen: 0608:C00128R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collin, Rachel M APRN Verified Time: 06/08/16-1122

Test	Result	Flag	Reference	Site
**********	**********CHEMISTRY**********			
CMP				
GLU	121	H	70-110 mg/dL	
BUN	8		7-18 mg/dl	
CREA	0.91		0.7-1.30 mg/dl	
ESTIMATED GFR	> 60		mL/min	
	Reference: mL/min/1.73 sq.m			
	The eGFR result is normalized to a standard body surface area of (1.73 sq.m) using sex, age, and race based on a serum creatinine measurement.			
NA	136		136-145 mmol/L	
K	4.1		3.5-5.1 mmol/L	
CL	100		98-108 mmol/l	
ANION GAP	9.0		7-16 mmol/L	
CO2	27		21-32 mmol/L	
CA	9.4		8.5-10.1 mg/dl	
TOT PROT	8.1		6.4-8.2 gm/dL	
ALB	2.8	L	3.4-5.0 gm/dl	
GLOB	5.3		gm/dL	
BILI,TOT	0.4		0.2-1.0 mg/dL	
ALP	322	H	45-117 U/L	
SGOT,AST	62	H	10-40 U/L	
SGPT,ALT	204	H	16-61 U/L	

	5/14/14	5/21/14	5/25/14
AST	21	240	29
ALT	72	317	89

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** END OF REPORT **

Run Date: 06/09/16 **Conway Medical Center Laboratory** *LIVE* PAGE 1
Run Time: 0844 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT,DANIEL ERIC ACCT #: V00006922463 LOC: LAB U#: M000175313
REG DR: Collins,Rachel M APRN AGE/SX: 41/M ROOM: REG: 06/08/16
STATUS: REG REF DOB: 09/26/74 DIS:

Specimen: 0608:H00099R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collins,Rachel M APRN Verified Time: 06/08/16-1102

Test	Result	Flag	Reference	Site
**********	**********HEMATOLOGY**********			
CBC W/AUTO DIFF				
CBC A				
WBC	8.9		4.5-11.0 K/mm3	
RBC	4.32	L	4.50-5.50 M/mm3	
HGB	12.5	L	14.0-17.4 g/dL	
HCT	38.4	L	45.0-52.0 %	
MCV	88.9		80.0-100.0 fl	
MCH	29.0		28.0-34.0 pg	
MCHC	32.7		32.0-36.0 g/dl	
RDW	14.1		12.0-14.6 %	
PLT	466	H	150-450 K/mm3	
NEUT%	71.5		%	
LYMPH%	18.4		%	
MONO%	6.5		%	
EOS%	2.7		%	
BASO%	0.9		%	
NEUT#	6.4		1.8-7.7 K/mm3	
LYMPH #	1.6		1.0-4.8 K/mm3	
MONO#	0.6		0.1-0.8 K/mm3	
EOS#	0.2		0.0-0.4 K/mm3	
BASO#	0.1		0.0-0.2 K/mm3	

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** END OF REPORT **

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/16/2016 08:23 AM

History of Present Illness *(Connie Hucks 06/16/2016 08:48 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. DOING WET TO DRY DRESSING

Allergies *(Connie Hucks; 06/16/2016 08:24 AM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Connie Hucks; *06/16/2016 08:24 AM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~5 weeks s/p resection and ileostomy, healing slowly.

Social History *(Connie Hucks; 06/16/2016 08:24 AM)*
Caffeine use
No alcohol use
Current work status: Occupation: ; student
Tobacco use: Former smoker, Remotely quit tobacco use

Medication History *(Connie Hucks; 06/16/2016 08:24 AM)*
Medications Reconciled.
Percocet (5-325MG Tablet, 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active. (rx written and given to pt)
PROzac (20MG Capsule, 1 Oral Daily) Active.
OxyCODONE HCl (10MG Tablet, Oral AS directed) Active.
Naproxen (500MG Tablet, 1 Oral Daily) Active.

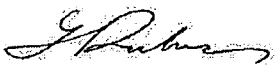
Past Surgical *(Connie Hucks; 06/16/2016 08:24 AM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Connie Hucks; 06/16/2016 08:24 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

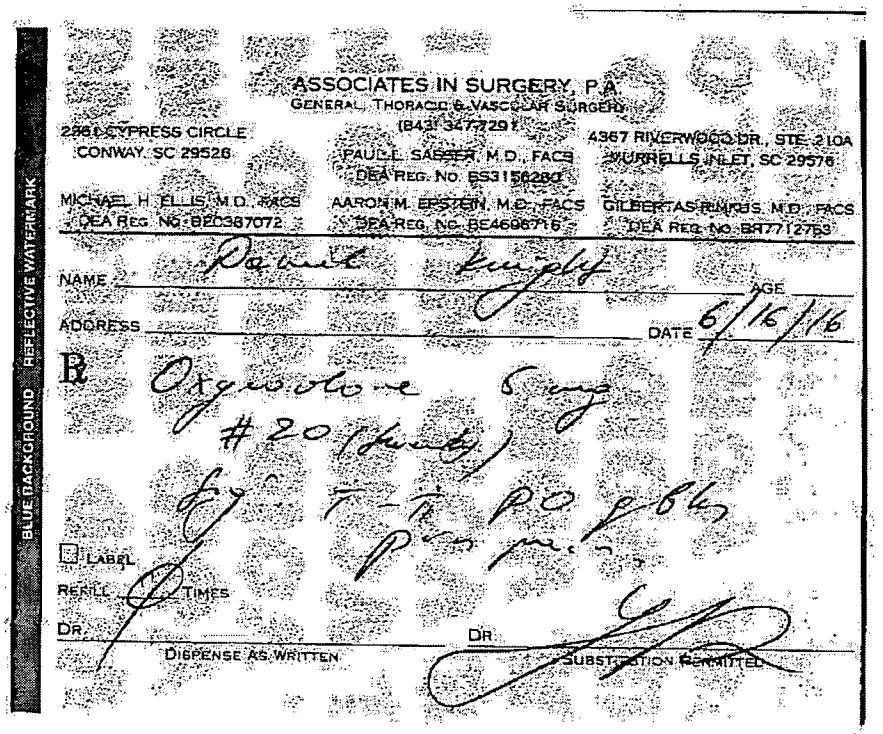
Physical Exam *(GILBERTAS RIMKUS; 06/16/2016 08:59 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing. Note: Healing in secondary fassion.

Assessment & Plan *(GILBERTAS RIMKUS; 06/16/201608:59 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~6 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 2 weeks.
Current Plans:



Signed electronically by GILBERTAS RIMKUS



ASSOCIATES IN SURGERY, P.A.
GENERAL, THORACIC & VASCULAR SURGERY
(843) 347-7291

2961 CYPRESS CIRCLE
CONWAY, SC 29526

4367 RIVERWOOD DR., STE. 210A
MURRELLS INLET, SC 29576

PAUL L. SASSER, M.D., FACS
DEA REG. NO. BS3156280

MICHAEL H. ELLIS, M.D., FACS
DEA REG. NO. BE0387072

AARON M. EPSTEIN, M.D., FACS
DEA REG. NO. BE4696716

GILBERT AS RUFUS, M.D., FACS
DEA REG. NO. BR7712783

BLUE BACKGROUND REFLECTIVE WATERMARK

NAME Patrick Quigley AGE

ADDRESS DATE 6/16/16

℞ Oxycodone 5 mg
#20 (twenty)
Sig: T-R PO q6h
Prn pain

☐ LABEL

REFILL 0 TIMES

DR [signature] DR

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V0000612886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

4 3856

OPERATIVE/PROCEDURE REPORT

DATE OF PROCEDURE:
05/15/2016

PREOPERATIVE DIAGNOSIS:
Perforated viscus, peritonitis.

POSTOPERATIVE DIAGNOSIS:
Perforation of terminal ileum, peritonitis.

PROCEDURE:
Resection of small intestine and ileostomy.

SURGEON:
Gilbertas Rimkus, MD

ANESTHESIA:
General endotracheal.

DISPOSITION:
To the recovery room, extubated, in fair condition.

INDICATIONS AND OPERATIVE CONSENT:
Please see my history and physical report.

OPERATIVE TECHNIQUE:
The patient was positioned supine on the operating room table. After induction of general endotracheal anesthesia the abdomen was prepped and draped in the usual sterile fashion. A middle laparotomy incision was made. The abdominal wall was opened in layers. A large amount of fluid with intestinal contents was in the abdomen. This was suctioned out. Upon exploration of the abdomen perforation in the terminal ileum was found with significant surrounding peritonitis and the intestine was resected and given the significance of contamination and peritonitis I decided to perform ileostomy. An opening in the right lower quadrant was created and the abdominal wall and I brought out both ends of the ileum one distal to the terminal ileum and the other proximal to the terminal ileum to facilitate take down of the ostomy in the future. The abdominal cavity was then irrigated with 2L of warm normal saline and after the irrigant was suctioned out the 10 mm JP drain was placed in the right lower quadrant where the contamination was the heaviest. It was brought out through the stab incision in the left lower quadrant and sewn in with 2-0 nylon stitch. After lap and instrument counts were confirmed correct, the midline fascia was closed with looped #1 PDS starting in each corner and tightening in the middle. The abdominal wound was irrigated again and a total of 10 mL of Exparel was injected to the wound for postop pain control. The skin was approximated loosely with staples and Telfa strips and cleaned and the double barrel ileostomy was matured with interrupted 4-0 Vicryl stitches. The ileostomy appliance was attached and initially it was thought the patient would be able to get extubated but we decided to leave him intubated due to persistent respiratory insufficiency. We will send the patient to the intensive care unit.

Gilbertas Rimkus, MD Date/Time

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29528

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

cc: Gilbertas Rimkus, MD
GR/4101507
DD: 05/15/2016 10:03
DT: 05/15/2016 10:30
LM File#: 20160515000035745
Job #: 4101507

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	/ER
Dictating Physician:	Gilbertas Rimkus, MD

G3584

PREOPERATIVE HISTORY & PHYSICAL

REASON FOR ADMISSION:
Abdominal pain, abnormal CT abdomen.

HISTORY OF PRESENT ILLNESS:
Mr. Knight is a 41-year-old patient who was involved in a collision motor vehicle accident approximately 3 weeks ago. At that time he was seen in the ER and underwent extensive workup which included CT scan of the chest and abdomen and only trace pelvic fluid was found at that time which could clearly have been physiologic. The patient presented now with increasing abdominal pain over the last several days. Work up in the emergency room again included CT scan of the abdomen and pelvis which showed tremendously distended and thickened small bowel and intraperitoneal fluid, moderate amount, and small amount of peritoneal gas suggestive of bowel obstruction with possible perforation. The patient never had any previous abdominal surgeries. I was called and asked to see the patient urgently.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
SULFA, PENICILLIN.

MEDICATIONS:
Prozac.

SOCIAL HISTORY:
He does not smoke cigarettes and does not drink alcohol.

REVIEW OF SYSTEMS:
As per the ER physician's notes, reviewed with pertinent positives significant for abdominal pain getting worse the last couple of days.

PHYSICAL EXAMINATION:
VITAL SIGNS: Afebrile with heart rate of 110, blood pressure 95/60 after 2L of crystalloid.

GENERAL: A middle aged male in no distress.

HEENT: Unremarkable exam.

LUNGS: Decreased breath sounds at the bases bilaterally.

HEART: Tachycardic.

ABDOMEN: Distended. Tender diffusely with diffuse rebound tenderness.

EXTREMITIES: Atraumatic.

IMPRESSION:
A 41-year-old patient with peritonitis likely perforated viscus, possible ischemic intestine. He has been resuscitated with crystalloid and given broad spectrum IV antibiotics. We will take him to the operating

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CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	/ER
Dictating Physician:	Gilbertas Rimkus, MD

PREOPERATIVE HISTORY & PHYSICAL

room this morning for exploratory laparotomy and possible bowel resection and possible ostomy. I discussed this with the patient and told him of the potential risks of bleeding, infection and remote possibility of having a temporary ostomy. He understood the procedure and risks and expressed written consent.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
GR/4101506
DD: 05/15/2016 08:33
DT: 05/15/2016 08:44
LM File#: 20160515000035609
Job #: 4101506

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

L3558

CONSULTATION

DATE OF CONSULTATION:
05/15/2016

REFERRING PHYSICIAN:
Dr. Rimkus from Surgery.

REASON FOR CONSULTATION:
Hypertension after surgical procedure.

HISTORY OF PRESENT ILLNESS:
This is a 41-year-old male who has a history of a motor vehicle accident 2 weeks ago. Patient went to the emergency room under trauma for evaluation where he had a CAT scan of the head, chest, and abdomen without any problems. Patient was discharged home. During the last 3 weeks the patient had been having some discomfort on the abdominal area and not eating much and not drinking much fluid. Patient went back to the emergency room secondary to severe abdominal pain. He had a CT of the abdomen that showed apparent perforated viscus with ischemic bowel. Patient was brought into the operating room where he had a resection of small bowel and ileostomy secondary to perforated terminal ileum and peritonitis. Patient was placed on aggressive IV antibiotics and transferred to the ICU for close monitoring. The patient's blood pressure during the surgery was low and he required some albumin, and also lots of fluids. Patient was admitted to the ICU.

At this time the patient is having abdominal pain. Blood pressure in the 70s systolic but his MAP had been 68. He is lethargic but oriented x3.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
To SULFA and PENICILLIN.

MEDICATION:
Medication at this time includes ertapenem 1 g IV daily.
Fluconazole daily.
Hydromorphone 0.5 mg IV every 2 hours p.r.n. severe pain.
Morphine every 4 hours p.r.n. moderate pain.
Zofran p.r.n. nausea.
Pantoprazole 40 mg IV at bedtime.
Promethazine p.r.n. nausea.
Simethicone p.r.n. gas.

SOCIAL HISTORY:
No smoking or alcohol abuse. Patient lives at home.

FAMILY HISTORY:
Nobody else with abdominal pain or significant abdominal issues.

REVIEW OF SYSTEMS:

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CONWAY MEDICAL CENTER
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CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

CONSULTATION

Difficult to obtain as the patient is lethargic post-surgery and uncomfortable. Patient has an ileostomy now. Positive for nausea. No vomiting. Positive for abdominal pain diffuse and not radiating anywhere. Pain started like cramping, episodes are severe, come and go. He denies any fevers or chills. No generalized weakness. No numbness or tingling. Patient is not hungry at this time. He has been having a poor p.o. intake in the last 2 weeks.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 72/51. Heart rate 130. Temperature 97.2. Respiration 18. O2 saturation 97% on 2 liters.

GENERAL: Patient is lethargic. No respiratory distress. Oriented x3.

HEENT: Moist oral mucosa. No oral thrush. White sclera bilaterally.

NECK: No masses. No JVD.

HEART: Regular rate. Tachycardic. No murmurs or gallops or rub.

LUNGS: Clear to auscultation bilaterally from the front. No wheezes.

ABDOMEN: Bowel sounds diminished. Diffuse mild tenderness. Ileostomy not draining anything at this time. Ileostomy bag in place.

EXTREMITIES: No cyanosis. No edema.

SKIN: Dry. No rash. No jaundice.

NEUROLOGIC EXAM: Cranial nerves II-XII grossly intact bilaterally. No focal sensory or motor deficits noticed. Head normocephalic. No signs of trauma or laceration.

LABORATORY DATA:
White blood cells 9.8. Hemoglobin 16.9. Hematocrit 50.4. Platelets 632. Lipase 224. Bands are 10%. Glucose 224. BUN 25. Creatinine 1.74. Sodium 140. Potassium 3.9. Chloride 106. Bicarb 22. Calcium 0.8. Albumin 2.9. T bili 1.3. Alk phos 100. AST 21. ALT 72.

IMPRESSION AND RECOMMENDATION:
1. Hypotension probably secondary to side effects from anesthetics and pain medication in combination with dehydration with hypovolemia. Patient has been having a poor p.o. intake lately. His urine is concentrated. He has a Foley catheter. His creatinine has bumped from his baseline 1.2 to 1.74.
   a. We will give 2 liters of Ringer's lactate boluses.
   b. Follow blood pressure closely in the ICU level.
   c. Adjust as needed.
   d. Patient will follow up blood pressure every 15 minutes.
   e. We consider if the patient would benefit from some Levophed if needed for his low blood pressure.
2. Abdominal pain.
   a. We will use some low-dose morphine at this time. Once the blood pressure is better we will restart maybe using the Dilaudid as ordered before.
3. Acute kidney injury, probably secondary to dehydration with hypoalbuminemia and the presence of abdominal peritonitis from perforated viscus. We will follow BUN and creatinine in the morning.

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CONWAY MEDICAL CENTER
P.O. BOX 829
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Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

CONSULTATION

His GFR at this time is 46. We will adjust medication to that GFR. We will hold the BUN and creatinine by the morning with aggressive hydration. Follow Ins and outs, too.

4. Patient is a FULL CODE.

Thank you for allowing me to participate in the care of this patient. We will follow the patient closely on a daily basis.

Kenneth Santiago, MD Date/Time

cc: Gilbertas Rimkus, MD
Kenneth Santiago, MD
KAS/3025600
DD: 05/15/2016 16:09
DT: 05/16/2016 00:12
LM File#: 201605160000036559
Job #: 3025600

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63858

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR, RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 5/31/2018

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Conway Medical Center

Kim Litton (843) 347-8035 phone, (843) 347-8181 fax

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Elizabeth (First) Ashley (Middle) Knight (Last)

Name of family member for whom you will provide care: Daniel (First) Eric (Middle) Knight (Last)

Relationship of family member to you: Spouse

If family member is your son or daughter, date of birth:

Describe care you will provide to your family member and estimate leave needed to provide care:

post surgical care, ileostomy care, ATC care post discharge - estimate 10 weeks due to another surgery needed 3 months from now - should be on and off time

Elizabeth Knight (Employee Signature) 5-17-16 (Date)

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Gilbert Raikes, MD 2321 Cypress Circle Conway, SC 29526

Type of practice / Medical specialty: Surgery

Telephone: (843) 347-7291 Fax: (843) 347-0139

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 5-15-16

Probable duration of condition: 6 weeks

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ✓Yes. If so, dates of admission: 5-15-16

Date(s) you treated the patient for condition: 5-15-16 thru present

Was medication, other than over-the-counter medication, prescribed? ___No ✓Yes

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ✓Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
✓No ___Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓No ___Yes. If so, expected delivery date: ___

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

5-15-16 Surgery - Resection of small intestine and ileostomy

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ✓Yes.

Estimate the beginning and ending dates for the period of incapacity: 5-15-16 – 6-27-16

During this time, will the patient need care? ___No ✓Yes.

Explain the care needed by the patient and why such care is medically necessary:

Patient will need assistance with activities of daily living, ostomy care, transportation for doctors visits

5. Will the patient require follow-up treatments, including any time for recovery? ___No ✓Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

QS needed

Explain the care needed by the patient, and why such care is medically necessary:

as above # 4

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ✓No ___Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

CONTINUED ON NEXT PAGE

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____No ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date: 6-1-16

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

63858

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REQUEST for AMERICANS with DISABILITIES ACT (ADA) ACCOMMODATION
MANAGER MUST COMPLETE SECTION II BEFORE TAKING TO PROVIDER

You have indicated that you may need an accommodation for a disability under the Americans with Disabilities Act. In order to determine whether your request can be granted, we need to gather some information from you, the healthcare provider who is treating you for your condition, and your manager. Please fill out Section I of this form and sign where indicated. You will also need to ensure that your manager completes Section II and your Healthcare provider completes Section III.

I. TO BE COMPLETED BY EMPLOYEE REQUESTING AN ACCOMMODATION:

Date 5/25/2016

Name Daniel Eric Knight

Leave ID: 445373699566

Employer Name: McLeod Health Services

Job Title Physical Therapy Assistant Employee ID 30829

Work Number 843.716.7731 Department Physical Therapy

Home Number 330.719.5830 City, State W: Loris, SC H: Conway, SC

Email address: eknighttrainer@gmail.com

Manager's Name Peter Winn Manager's Phone Number 843.716.7731

Directions

- The "Date of Diagnosis" requested below is the date of the original diagnosis.
- Do not provide the name of your diagnosed medical condition in Section I, as this information is not otherwise available to your manager.
- The "Limitations Due to Disability" below are the barriers that currently exist for you to perform your job tasks. Examples: hard of hearing or difficulty sitting for more than 30 minutes at a time.
- The "Accommodation Requested" below is the accommodation you are requesting. Your request will be a starting point in your discussion with your employer regarding what accommodation would remove the barriers to you being able to perform your job tasks. Below are some examples of what accommodations might include:
  - Unpaid leave
  - Adaptive equipment- for example, if the limitation is hard of hearing then the accommodation request may be for a telephone earpiece amplifier
  - Modified work schedule

Date of Diagnosis 5/15/16

Limitations Due to Disability:

What, if any, job function are you having difficulty performing?

Unable to lift, drive, bend, carry. Limited trunk mobility due to location of surgery, limiting ability to stand or walk for long periods of time.

1

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What, if any, employee benefit or privilege of employment, such as employer-provided training, are you having difficulty accessing?

Unable to receive Sovian computer training.

Please explain what limitations on your ability to perform your essential job functions you are currently experiencing due to your condition. Examples of possible limitations include difficulty hearing, difficulty sitting for more than 30 minutes at a time or difficulty walking more than 30 minutes.

Unable to lift even light weights to hand to patients. Unable to reach overhead or bend to assist patients. Unable to perform patient transfers. Unable to stand/walk for >15 minutes.

Accommodation Requested:

If known, please indicate the accommodation you are requesting. Examples of an accommodation may, depending on the circumstances, include, but are not limited to, modification of your work schedule, modified work tools or equipment, working from home, or a leave of absence.

Approval of leave of absence until MD clears me to return to work.

If you are not sure what accommodation is needed, please provide any suggestions about what options your employer can explore.

Treating Healthcare Provider

Name: Gilbertas Ponkus MD
Address: 2361 Lyons Crossing, Conway, SC 29526
Phone: 843 347-7291
Fax: 843 347-0139
Degree/Specialty/Type of Practice: MD / Surgery

MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize my employer, as well as its medical, ADA and/or vocational representative(s), including Cigna, to contact my healthcare provider to discuss the nature and extent of my condition for which I am seeking an accommodation necessary to perform the essential functions of my job. I also authorize the release of my medical records to the extent that they are relevant to my request for an accommodation to my employer, as well as its medical, ADA and/or vocational representative(s). I further authorize Cigna to release information related to any restrictions or limitations to my employer, as necessary to consider my request for a reasonable accommodation. This Authorization is valid for as long as I am seeking or receiving an accommodation from my employer unless I revoke it in writing by notifying: Cigna Leave Solutions – P.O. Box 16163 - Pittsburgh, PA 15242-0791.

Employee Signature [signature] Date 6/23/16

2

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II. TO BE COMPLETED BY MANAGER
(Must be completed prior to submission to the health care provider)

ESSENTIAL JOB FUNCTIONS: describe the physical work tasks (e.g., such as codes data, answers telephone, walking, pushing, etc.) and mental tasks (e.g., such as reading, observing, reasoning, etc.) and percent/frequency (i.e. duration, amount of time, whether it is continuous, etc.) of work activities. Use the employee's job description as a resource to determine essential job functions.
(For more information, see the Essential Functions Guidelines at the end of this form)

Essential Job Function	Physical/Mental Requirement	Percent/Frequency
1. Example: Telephonic outreach to customers	Example: Sit for 8 hours a day	Example: 100%
2		
3		
4		
5		
6		

Manager's Signature: _____ Date: _____

Essential Functions Guidelines

"Essential job functions" are the fundamental job duties of a position. The following describes factors to consider when identifying essential job functions under the Americans with Disabilities Act (ADA).

A work task is a distinct identifiable work activity that constitutes one of the necessary steps to perform a job. Identifying the necessary work tasks will enable you to identify the fundamental "requirements". Some work tasks examples include "codes data," "answers telephone" and "direct visitors to appropriate office."

In order to satisfactorily perform the job, the employee must complete the assigned work tasks, which require physical and/or mental activities. These physical and mental activities make up the job requirements and needs to be provided in Section II, Essential Job Functions of this Request for Americans with Disabilities Act Accommodation Form.

When stating the Job Requirements, describe the outcome of the job, not how it is performed.

A job requirement example would be a sack handler job requires the employee to pick up 50-pound sacks and carry them from the loading dock to storage. The essential function of the job is to move the sack from the loading dock to the storage area. This can be done through use of a dolly, hand truck or cart. The essential job function would be moving 50 pounds from the loading dock to the storage area.

When completing the job requirements on this form, consider the following:

- How tasks are accomplished (methods, techniques, tools or equipment that are used by a worker to complete the tasks).
- Physical movements such as pulling, pushing, lifting, carrying, kneeling, sitting, climbing, walking, hearing and seeing.
- Mental processes such as reasoning, thinking, remembering, reading and observing are also described.
- Degrees of physical effort and/or the complexity of mental processes involved in the work activities.
- The duration or total time involved in performing each work activity.
- The frequency with which work activities are performed.
- Whether employees actually required to perform the identified tasks or are they ancillary or "nice to have" tasks that could be eliminated or handled by others.

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REQUEST FOR DISABILITY ACCOMMODATION (ADA)

(Doctor's notes can be submitted, but do not replace information that is required to be recorded on the form.)

III. TO BE COMPLETED BY EMPLOYEE'S HEALTHCARE PROVIDER:

Your patient has requested an accommodation under the Americans with Disabilities Act (ADA). Under the ADA, an employee has a disability if he or she has a physical or mental impairment that substantially limits one or more major life activities or a record of such impairment. Please review the information provided by the patient/patient's manager above and answer each of the questions below. These questions are designed to provide information as to the existence of a disability, effective accommodation options, or both. The questions on this form should be answered solely with respect to the disability that is causing the patient/employee to have limitations that may require a reasonable accommodation.

A. Does the patient have a physical or mental impairment? ✓ Yes ☐ No

If yes, what is the nature of the impairment? Surgery - Laparotomy - Perforated intestine

B. Duration of Disability:

1. Is the individual's limitation(s) permanent? N/A
2. If not permanent, how long do you estimate the accommodation will be needed?

Start Date: 5-15-16 End Date: _____

C. Identify the major life activities which are substantially limited as compared to most people in the general population by the employee's physical or mental limitations. Examples of major life activities include, but are not limited to, normal cell growth; endocrine, neurological, or brain function; standing; lifting; and concentrating. Examples of possible limitations include, but are not limited to, difficulty hearing, difficulty sitting or difficulty walking.

all activities of daily living

D. What essential job function(s) is affected by the individual's disability, and to what degree is the individual's performance of the essential function(s) limited? *Refer to Section II above for list of the essential job functions.*

Essential Job Functions Affected	Degree of Limitation	Start Date of Limitation	End Date of Limitation
	Unable to work due to surgery		
	bowel resection and ileostomy		

E. What accommodations will allow the individual to perform each essential function affected by his/her disability? Please be specific. Examples of an accommodation may, depending on the circumstances, include, but are not limited to, modification of work schedule, modified work tools or equipment, working from home, a leave of absence. (Please note that the employer retains the discretion to determine whether an accommodation is reasonable).

4

Cigna

Please check what type of accommodation you are recommending for your patient:

☑ Leave of Absence

☐ Continuous
Start Date: 5-15-16 End Date: 8-15-16 (anticipated)

☐ Intermittent
Start date: / End Date:

Office Visits/Treatment:

Frequency: ____ times per week(s) / months (CIRCLE ONE)
Duration: as needed hours per day(s) ____ days per visit

Incapacity:

Frequency: ____ times per week(s) / months (CIRCLE ONE)
Duration: ____ hours per day(s) ____ days per episode

☐ Reduced Work Schedule
Start date: / End Date:
Hours per day ____ days per week ____

☐ Workplace Accommodation (accommodation will not involve leave as an accommodation, e.g. adaptive equipment, modified work schedule, etc.)

Please describe any suggested workplace accommodations that will help the employee perform their job or allow them to obtain equal access to a benefit or privilege of employment, such as employer-provided training:

None

Healthcare Provider Signature:

Phone: 843 347-7291 Date: 6-27-16

Please mail after Sections I, II, and III are complete to:

Cigna Leave Solutions
P.O. Box 16163
Pittsburgh, PA 15242-0791
Or Fax to: 866-931-5095 or
Email to FMLACertifications@Cigna.com

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Byram Healthcare

BYRAM HEALTHCARE CENTERS, INC.
3010 WOODCREEK DRIVE SUITE A
DOWNERS GROVE, IL 60515
1-888-321-8923

8450034

REFERRED BY: CONWAY WOUND HEALING CENTER
07/03/16 22:44:43 34192352
TOLL FREE FAX: 1-866-232-9726

BY SIGNING THIS FORM I CONFIRM THE PHYSICIAN'S SIGNATURE CORRESPONDS TO THE NAME AND NPI LISTED BELOW AND THAT I AM PRESCRIBING THE ITEMS AND QUANTITIES LISTED BELOW

GILBERTAS RIMKUS 2361 CYPRESS CIR CONWAY SC 29526	BHC#: 553573	DANIEL E KNIGHT 206 ECUM CECUM DRIVE CONWAY SC 29527 330-719-5830 Type: 8100

BENEFICIARY - FIRST NAME: DANIEL E KNIGHT — LAST NAME: [redacted]

DIAGNOSIS: Z93.2 K63.1 — DATE: 08 01 16

ITEMS PRESCRIBED	CODES	QTY PRESCRIBED	QTY CHANGES (IF NEEDED)	FORM NUMBER
SKIN BARRIER WIPES OR SWABS EA	A5120	25BX/Refill		
SKN BAR POWDER PER OZ	A4371	3OZ/Refill		
SKN BAR PECTIN BASED PASTE PER	A4408	4OZ/Refill		
SKN BAR W/ FLG SOL FLX ACD EXT	A4409	20EA/Refill		
PCH DRN FOR BAR W/ NONLKG FLG	A4425	20EA/Refill		

PLEASE GIVE MEDICAL JUSTIFICATION AS TO WHY THE ABOVE SUPPLIES ARE NECESSARY:
REFILL QUANTITIES AND AMOUNTS TO BE FILLED AS SPECIFIED

DURATION OF NEED (MONTHS/99 EQUALS LIFETIME):
12 unless otherwise noted

AUTHORIZING PHYSICIAN

PHYSICIAN'S NAME: GILBERTAS RIMKUS	NPI#: 1326126301	SUPPLIER'S NAME: BYRAM HEALTHCARE CENTERS
ADDRESS (STREET NUMBER): 2361 CYPRESS CIR	LICENSE#:	ADDRESS (STREET NUMBER): 3010 WOODCREEK DRIVE
APT/SUITE:		CITY/STATE/ZIP: DOWNERS GROVE, IL 60515
CITY/STATE/ZIP: CONWAY SC 29526		RX#: Byram Rx #: 8450034
TELEPHONE NUMBER: 843-347-7291	FAX NUMBER: 843-347-9309	TELEPHONE NUMBER: 800-248-4525

PLEASE SIGN AND DATE BELOW:

PHYSICIAN'S SIGNATURE:	DATE: 7/6/16	PLEASE PRINT PHYSICIAN'S NAME: GILBERTAS RIMKUS

FOR RESIDENTS please provide attending physician's information:

NAME: _____ NPI #: _____

* Maximum quantities/refills allowed unless otherwise noted.
* Please complete any attached forms

BYRAM RX Rev 2.3 DEF

Byram Healthcare

BYRAM HEALTHCARE CENTERS, INC.
3010 WOODCREEK DRIVE SUITE A
DOWNERS GROVE, IL 60515
1-866-321-8923

8450034

REFERRED BY: CONWAY WOUND HEALING CENTER
06/01/16 22:20:53 34192352
TOLL FREE FAX: 1-866-232-9726

INS: 18639

BY SIGNING THIS FORM I CONFIRM THE PHYSICIAN'S SIGNATURE CORRESPONDS TO THE NAME AND NPI LISTED BELOW AND THAT I AM PRESCRIBING THE ITEMS AND QUANTITIES LISTED BELOW

GILBERTAS RIMKUS 2361 CYPRESS CIR CONWAY SC 29526	BHC#: 553573	DANIEL E KNIGHT 206 ECUM CECUM DRIVE CONWAY SC 29527 330-719-5830 Type: 6100

BENEFICIARY - FIRST NAME: DANIEL E KNIGHT
LAST NAME: [redacted]

DIAGNOSIS: Z93.2 K63.1
START DATE: 06 01 16

ITEMS PRESCRIBED	CODES	QTY PRESCRIBED	QTY CHANGES (IF NEEDED)	FORM NUMBER
SKIN BARRIER WIPES OR SWABS EA	A5120	25BX/Refill		
SKN BAR POWDER PER OZ	A4371	3OZ/Refill		
SKN BAR PECTIN BASED PASTE PER	A4408	4OZ/Refill		
SKN BAR W/ FLG SOL FLX ACD EXT	A4409	20EA/Refill		
PCH DRN FOR BAR W/ NONLKG FLG	A4425	20EA/Refill		

PLEASE GIVE MEDICAL JUSTIFICATION AS TO WHY THE ABOVE SUPPLIES ARE NECESSARY:
REFILL QUANTITIES AND AMOUNTS TO BE FILLED AS SPECIFIED

DURATION OF NEED (MONTHS/99 EQUALS LIFETIME):
12 unless otherwise noted

AUTHORIZING PHYSICIAN

PHYSICIAN'S NAME: GILBERTAS RIMKUS	NPI#: 1326126301	
ADDRESS (STREET NUMBER): 2361 CYPRESS CIR	LICENSE #:	
APT/SUITE:		
CITY/STATE/ZIP: CONWAY SC 29526		
TELEPHONE NUMBER: 843-347-7291	FAX NUMBER: 843-347-9309	

SUPPLIER

SUPPLIER'S NAME: BYRAM HEALTHCARE CENTERS	
ADDRESS (STREET NUMBER): 3010 WOODCREEK DRIVE	
CITY/STATE/ZIP: DOWNERS GROVE, IL 60515	
RX#: Byram Rx #: 8450034	
TELEPHONE NUMBER: 800-248-4525	

PLEASE SIGN AND DATE BELOW:

PHYSICIAN'S SIGNATURE	DATE: 6-8-16	PLEASE PRINT PHYSICIAN'S NAME: Gilbertas Rimkus, MD

FOR RESIDENTS please provide attending physician's information:
NAME: _____ NPI #: 1326126301

* Maximum quantities/refills allowed unless otherwise noted.
* Please complete any attached forms

BYRAM-RX Rev 2.3 DFF

PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE

Please complete this form and bring it with you to your scheduled appointment.

If you are taking any medication please bring a list of your medications, your insurance card and a photo identification card.
Please arrive 15 minutes prior to your appointment.

PATIENT INFORMATION

Title ___ **Last Name** KNIGHT **First Name** DANIEL **Middle Initial** E

Street Address 200 ECUM SECUM DR **Apartment Number** ___

Mailing Address ___
(if different from street address)

Zip Code 29577 **City** CONWAY **State** SC **Home Phone** ___ **Cell Phone** 330-719-5830

Email Address: evicknight74@yahoo.com

Social Security Number 408-45-6569 **Birthday** 9/26/74 **Sex** M **Race** W

Marital Status []Single [](Married) []Divorced []Widowed []Separated **Primary Language** ENGLISH **Student** [] Full-time [] Part-time

Employment [] (Full-time) [] Part-time [] Unemployed [] Retired **Relationship to Insured** [](Self) [](Spouse) [] Child [] Other

Employer/School Name McLEOD ORTHOPEDIC PHYSICAL THERAPY

Street Address ___ **Apartment Number** ___

Zip Code ___ **City** ___ **State** ___ **Business Phone** ___

INSURED/PARENT/LEGAL GUARDIAN (IF OTHER THAN PATIENT)

Title ___ **Last Name** Knight **First Name** Elizabeth **Middle Initial** A

Street Address Same **Apartment Number** ___

Mailing Address ___
(if different from street address)

Zip Code ___ **City** ___ **State** ___ **Home Phone** 330-717-0532

Social Security Number 299-78-4240 **Birthday** 9-22-82 **Sex** F **Race** C

Marital Status []Single [X]Married []Divorced []Widowed []Separated **Student** [] Full-time [] Part-time

Employment [X] Full-time [] Part-time [] Unemployed [] Retired **Relationship to Insured** [X] Self [] Spouse [] Child [] Other

Employer/School Name Conway medical Center

Street Address 300 Singleton Ridge **Apartment Number** ___

Zip Code 29526 **City** Conway **State** SC **Business Phone** 843-347-8120

[] **Associates in Surgery, PA**
2361 Cypress Circle
Conway, SC 29526
Across from the Emergency Room
side of Conway Medical Center

[] **Associates in Surgery, PA**
Wachesaw Medical Park
4367 Riverwood Drive Suite 210
Murrells Inlet, SC 29576
Across from the main entrance of
Waccamaw Community Hospital

843-347-7291

FORMS MUST BE COMPLETED PRIOR TO APPOINTMENT OR

RESCHEDULING MAY BE NECESSARY

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, Daniel Eric Knight consent to treatment by the physicians of Associates In Surgery, PA.
Please enter your name on this line

I understand that no guarantee will be made to the outcome of my care or treatment. I understand I may be prescribed medication during the course of my treatment that may make operating heavy equipment or driving a vehicle dangerous. I understand I am taking full responsibility for my own actions while I am under the influence of these medications. DEK
Please Initial

I understand that as part of my health care, Associates in Surgery, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity to include my insurance company. I understand I am personally responsible for all co-payment, co-insurance and deductibles due. I understand that if my account is delinquent all payments received may be applied to any past due amount I may owe Associates In Surgery, PA. Should collections actions be required to collect the balance on my account I assume full responsibility for all cost incurred. DEK
Please Initial

I consent to Associates in Surgery, PA utilizing telephone voice mail and answering machines for the purpose of leaving an appointment reminder or a message to include name and phone number to call.

I fully understand and accept / decline the terms of this consent.

Daniel Knight — **Patient's Signature**

6/1/16 — **Date**

Most medications prescribed by our physicians will be transmitted electronically. Please provide your pharmacy information below:

Conway Medical Center Outpatient Pharm 843 347-802.
Pharmacy Name — Phone Number

300 Singleton Ridge Conway SC 29526
Address — City — State

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

PLEASE COMPLETE BOTH SIDES OF THIS FORM, SIGN, DATE AND RETURN TO THE RECEPTIONIST. THEN FULLY COMPLETE THE NEXT PAGE WHICH IS YOUR MEDICAL HISTORY FORM.

Associates in Surgery, PA
2361 Cypress Circle
Conway, SC 29526
Phone: 843-347-7291
Fax: 843-347-9309

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/01/2016 09:33 AM

History of Present Illness *(Connie Hucks 06/01/2016 09:44 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. WOUND VAC IN PLACE, REMOVED

Additional reason for visit:

Transition into care is described as the following:
The patient is transitioning into care from hospital (CMC) .

Allergies *(Connie Hucks; 06/01/2016 09:45 AM)*
No Known Drug Allergies 06/01/2016
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching

Past Medical History (Connie Hucks; *06/01/2016 09:45 AM)*
SPORTS HERNIA (S39.81XA)

Family History *(Connie Hucks; 06/01/2016 09:45 AM)*
Non-Contributory Family History

Social History *(Connie Hucks; 06/01/2016 09:45 AM)*
No alcohol use
Caffeine use
Tobacco use: Former smoker, Remotely quit tobacco use
Current work status: Occupation: ; student

Medication History *(Connie Hucks; 06/01/2016 09:46 AM)*
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/01/2016 09:47 AM)*
None - Status is Inactive (06/01/2016) (Marked as Inactive)
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Connie Hucks; 06/01/2016 09:44 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Vitals *(Connie Hucks; 06/01/2016 09:47 AM)*

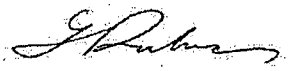
06/01/2016 09:47 AM
Weight: 142 lb **Height:** 63 in
Body Surface Area: 1.69 m² **Body Mass Index:** 25.15 kg/m²
Temp.: 98.5 °F (Oral) **Pulse:** 50 (Regular)
BP: 128/78 Electronic (Sitting, Left Arm, Standard)

Physical Exam *(GILBERTAS RIMKUS; 06/01/2016 10:01 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing (Healing in secondary fassion with wound vac.).

Assessment & Plan *(GILBERTAS RIMKUS; 06/01/2016 10:03 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~3 wekks s/p resection and ileostomy.
Today's Impression: Doing well, healing nicely. F/u in 2 weeks.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA
Authorization for Release of Information – Compound Release

Name of Patient Daniel Eric Knight Date of Birth 9-26-74

Associates in Surguery, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons..

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☑ Voice Mail	☐ Message to Return Staff Members call ☐ Appointment Reminders Only ☑ All of the Above
☑ Spouse or Partner (Please list Full Name) Elizabeth Ashley Knight	☐ Financial ☐ Medical ☑ Both
☐ All Others (Please list Full Name and Relationship) _____ _____	☐ Financial ☐ Medical ☐ Both
☑ EMERGENCY CONTACT ELIZABETH KNIGHT 330-717-0532 Please provide name and phone number.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Daniel Eric Knight Date 6/1/16

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised Oct 2014

6-29-16

KCI
An Acelity Company

Phone: 1-800-275-4524
Fax: 1-888-245-2295
Please – no fax coversheet

REQUEST FOR DISCHARGE ORDERS
RO#: 21397430

For your convenience, we have provided the information available to us from our records. Please review this information and make any necessary changes. *All changes must be initialed and dated by you.* PLEASE SIGN AND DATE THE DISCHARGE ORDERS. Stamp signature and dates are not allowed.

On behalf of KCI, thank you for your time and your continued support.

DISCHARGE ORDERS

Patient Name: DANIEL KNIGHT

DOB: 09/26/1974

Discharge Date: 06/07/2016

Reason for Discharge: Please select one option below

- ☐ Goal of Therapy Met
- ☐ Admission of Higher Level of Care (SNF, LTAC, Acute Care Hospital, etc)
- ☐ Surgical Wound Related Procedure (i.e. Closure, Flap, Graft, Debridement, etc)
- ☐ Other Reason: _____

I certify that the above named patient has been discharged off the V.A.C.® Therapy System.

Gilbertes Rukyaro
Prescriber Name

Prescriber Signature (No Stamps)

6/29/16
Date

Confidentiality Notice: This fax transmission is intended only for the use of the individual or entity named above and may contain information that is confidential, privileged and exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in this transmission is strictly prohibited. If you have received this transmission in error, please notify KCI by telephone at 1-800-275-4524. Thank you.

KCI
An Acelity Company

Phone: 1-800-275-4524
Fax: 1-888-245-2295
Please – no fax coversheet

REQUEST FOR DISCHARGE ORDERS

RO#: 21397430

For your convenience, we have provided the information available to us from our records. Please review this information and make any necessary changes. *All changes must be initialed and dated by you.* PLEASE SIGN AND DATE THE DISCHARGE ORDERS. Stamp signature and dates are not allowed.

On behalf of KCI, thank you for your time and your continued support.

DISCHARGE ORDERS

Patient Name: DANIEL KNIGHT

DOB: 09/26/1974

Discharge Date: 06/07/2016

Reason for Discharge: Please select one option below

- [x] Goal of Therapy Met
- [ ] Admission of Higher Level of Care (SNF, LTAC, Acute Care Hospital, etc)
- [ ] Surgical Wound Related Procedure (i.e. Closure, Flap, Graft, Debridement, etc)
- [ ] Other Reason: _____

I certify that the above named patient has been discharged off the **V.A.C.® Therapy System.**

Prescriber Name

Prescriber Signature (No Stamps) 6/22/16 2:15 pm
Date

Confidentiality Notice: This fax transmission is intended only for the use of the individual or entity named above and may contain information that is confidential, privileged and exempt from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in this transmission is strictly prohibited. If you have received this transmission in error, please notify KCI by telephone at 1-800-275-4524. Thank you.

6/22/16 (fax)

DSL#14-0624 US OCRX (Rev. 11/14)

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/07/2016 02:27 PM

History of Present Illness *(Connie Hucks 06/07/2016 02:38 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. WOUND VAC IN PLACE WAS NOT REPLACED BY HH DUE TO DRAINAGE

Allergies *(Connie Hucks; 06/07/2016 02:38 PM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Connie Hucks; *06/07/2016 02:38 PM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~3 wekks s/p resection and ileostomy.

Social History *(Connie Hucks; 06/07/2016 02:38 PM)*
Tobacco use: Former smoker, Remotely quit tobacco use
No alcohol use
Caffeine use
Current work status: Occupation: ; student

Medication History *(Connie Hucks; 06/07/2016 02:38 PM)*
Medications Reconciled Specific dose unknown - Active - Hx Entry.
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/07/2016 02:38 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Connie Hucks; 06/07/2016 02:38 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

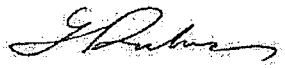
Vitals *(Connie Hucks; 06/07/2016 02:32 PM)*
06/07/2016 02:32 PM
Temp.: 98.7 °F (Oral)

Physical Exam *(GILBERTAS RIMKUS; 06/07/2016 02:50 PM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing (In secondary fassion.).

Assessment & Plan *(GILBERTAS RIMKUS; 06/07/201602:51 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~5 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 1 week.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/07/2016 03:39 PM

History of Present Illness

Assessment & Plan *(Connie Hucks; 06/07/201603:40 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~5 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 1 week.
Current Plans:

- Started Percocet 5-325MG, 1-2 Tablet every six hours, as needed, #30, 06/07/2016, No Refill.

Future Procedures:

- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()

Signed electronically by Connie Hucks

Conway Physicians Group
Carolina Internal Medicine

Paul M. Richardson, Jr., M.D. FACP
Carol Ann Gardner, CFNP
Rachel M. Collins, CFNP
Jodi G. Pajaro, CFNP

2367-B Cypress Circle
Conway, SC 29526
843.349.1001
Fax 843.349.1008

FAX

Date 6/9/16 No. of pages 3

To Dr. Rimkus From Rachel Collins FNP

Fax 843-347-0139
843-347-9309 Phone 843-347-7391

Message:

Dr. Rimkus,

These are labs drawn 6/8/16 on D. Eric Knight (9/26/74). His WBC have trended down to normal. His kidney function is within normal limits. However his liver enzymes have trended back up. I am going to repeat them in two weeks but wanted you to be aware. If there is anything different that needs to be done, please let me know. (843-349-1007)

Thanks,
Rachel Collins FNP

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Run Date: 06/09/16 **Conway Medical Center Laboratory** *LIVE* PAGE 1
Run Time: 0843 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT, DANIEL ERIC ACCT #: V0000692463 LOC: LAB U#: M0001275313
REG DR: Collins,Rachel M APRN AGE/SX: 41/M ROOM: REG: 06/08/16
STATUS: REG REF DOB: 09/26/74 DIS:

Specimen: 0608:C00128R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collin ,Rachel M APRN Verified Time: 06/08/16-1122

Test	Result	Flag	Reference	Site
**********	**********CHEMISTRY**********			
CMP				
GLU	121	H	70-110 mg/dL	
BUN	8		7-18 mg/dl	
CREA	0.91		0.7-1.30 mg/dl	
ESTIMATED GFR	> 60		mL/min	
	Reference: mL/min/1.73 sq.m			
	The eGFR result is normalized to a standard body surface area of (1.73 sq.m) using sex, age, and race based on a serum creatinine measurement			
NA	136		136-145 mmol/L	
K	4.1		3.5-5.1 mmol/L	
CL	100		98-108 mmol/l	
ANION GAP	9.0		7-16 mmol/L	
CO2	27		21-32 mmol/L	
CA	9.4		8.5-10.1 mg/dl	
TOT PROT	8.1		6.4-8.2 gm/dL	
ALB	2.8	L	3.4-5.0 gm/dl	
GLOB	5.3		gm/dL	
BILI,TOT	0.4		0.2-1.0 mg/dL	
ALP	322	H	45-117 U/L	
SGOT,AST	62	H	15-40 U/L	
SGPT,ALT	204	H	16-61 U/L	

5/14/16	5/21/16	5/25/16
AST 21	240	29
ALT 72	317	89

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** END OF REPORT **

Run Date: 06/09/16 **Conway Medical Center Laboratory** *LIVE* PAGE 1
Run Time: 0844 P.O. Box 829 300 Singleton Ridge Road Conway, SC 29528-0829

LABORATORY REPORT

PATIENT: KNIGHT,DANIEL ERIC
REQ DR: Collins,Rachel M APRN
ACCT #: V00006922463 LOC: LAB U#: M00017531J
AGE/SX: 41/M ROOM: REG: 06/08/16
STATUS: REG.REF DOB: 09/26/74 DIS:

Specimen: 0608-H00099R COMP Collected: 06/08/16-UNK Received: 06/08/16-1102
Subm DR: Collins,Rachel M APRN Verified Time: 06/08/16-1102

Test	Result	Flag	Reference	Site
**********	**********HEMATOLOGY**********			
CBC W/AUTO DIFF				
CBC A				
WBC	8.9		4.5-11.0 K/mm3	
RBC	4.32	L	4.50-5.50 M/mm3	
HGB	12.5	L	14.0-17.4 g/dL	
HCT	38.4	L	45.0-52.0 %	
MCV	88.9		80.0-100.0 fl	
MCH	29.0		28.0-34.0 pg	
MCHC	32.7		32.0-36.0 g/dL	
RDW	14.1		12.0-14.6 %	
PLT	466	H	150-450 K/mm3	
NEUT%	71.5		%	
LYMPH%	18.4		%	
MONO%	6.5		%	
EOS%	2.7		%	
BASO%	0.9		%	
NEUT#	6.4		1.8-7.7 K/mm3	
LYMPH #	1.6		1.0-4.8 K/mm3	
MONO#	0.6		0.1-0.8 K/mm3	
EOS#	0.2		0.0-0.4 K/mm3	
BASO#	0.1		0.0-0.2 K/mm3	

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** END OF REPORT **

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/16/2016 08:23 AM

History of Present Illness *(Connie Hucks 06/16/2016 08:48 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. DOING WET TO DRY DRESSING

Allergies *(Connie Hucks; 06/16/2016 08:24 AM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Connie Hucks; *06/16/2016 08:24 AM*)
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~5 weeks s/p resection and ileostomy, healing slowly.

Social History *(Connie Hucks; 06/16/2016 08:24 AM)*
Caffeine use
No alcohol use
Current work status: Occupation: ; student
Tobacco use: Former smoker, Remotely quit tobacco use

Medication History *(Connie Hucks; 06/16/2016 08:24 AM)*
Medications Reconciled Specific dose unknown - Active - Hx Entry.
Percocet (5-325MG Tablet 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active - Hx Entry. (rx written and given to pt)
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/16/2016 08:24 AM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

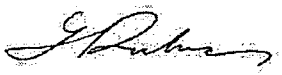
Review of Systems *(Connie Hucks; 06/16/2016 08:24 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Physical Exam *(GILBERTAS RIMKUS; 06/16/2016 08:59 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing. Note: Healing in secondary fassion.

Assessment & Plan *(GILBERTAS RIMKUS; 06/16/201608:59 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~6 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 2 weeks.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Page: 1 / 1
Patno: I1455456
Patient: KNIGHT, DANIEL
Location: 2222

Date: 06/30/2016

SUPPLEMENTAL ORDER

[msptorder/rpptord/3.0]

Amedisys Home Health of Conway
176 Waccamaw Medical Park Court

Conway, SC 29526-8965
(P) (843) 347-5899 (E) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL
206 ECU CECUM DR

CONWAY, SC 29527
DOB : 09/26/1974

[redacted]

ORDER 06/16/2016

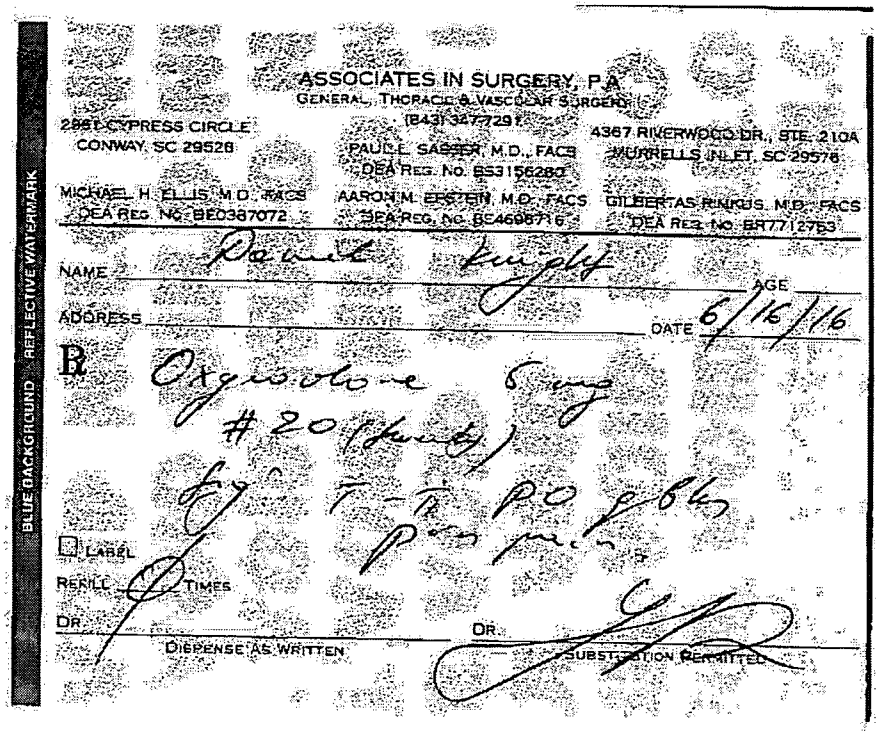
[06162016]
Effective 6/16/16, please discontinue wound vac to abdominal incision. Wound care to be performed as follows: Cleanse wound with normal saline or wound cleanser. Pat dry with 4x4 gauze. Apply wet to dry dressing with light packing. Dressing to be changed daily and as needed. SN to perform on regularly scheduled SN visit days. SN to instruct patient/caregiver to perform on non SN visit days.

TO Dr. Rimkus/Connie/Amy Allison, RN

Clinician Signature: AMY ALLISON RN Date: 06/16/2016

Physician Signature _____ Date 7/28/16

48672471



ASSOCIATES IN SURGERY, P.A.
GENERAL, THORACIC & VASCULAR SURGERY
(843) 347-7297

2961 CYPRESS CIRCLE
CONWAY, SC 29528

4367 RIVERWOOD DR., STE. 210A
MURRELLS INLET, SC 29576

PAUL L. SASSER, M.D., FACS
DEA REG. NO. BS3156280

MICHAEL H. ELLIS, M.D., FACS
DEA REG. NO. BE0387072

AARON M. ERSTEIN, M.D., FACS
DEA REG. NO. BE4696716

GILBERT AS RINKUS, M.D., FACS
DEA REG. NO. BR7712753

BLUE BACKGROUND REFLECTIVE WATERMARK

NAME Daniel Kupfer AGE

ADDRESS DATE 6/16/16

℞ Oxycodone 5 mg
#20 (twenty)
Sig: T-Th PO q6h
PRN pain

☐ LABEL

REFILL 0 TIMES

DR. DISPENSE AS WRITTEN

DR. SUBSTITUTION PERMITTED

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 06/22/2016 12:56 PM

History of Present Illness *(Connie Hucks 06/22/2016 12:57 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. CONCERNED THAT OPENING HAS CLOSED AND THERE MAY STILL BE A TRACK

Allergies *(Connie Hucks; 06/22/2016 12:57 PM)*
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching
No Known Drug Allergies 06/01/2016

Past Medical History (Connie Hucks; *06/22/2016 12:57 PM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~6 weeks s/p resection and ileostomy, healing slowly.

Social History *(Connie Hucks; 06/22/2016 12:57 PM)*
Tobacco use: Former smoker, Remotely quit tobacco use
Caffeine use
No alcohol use
Current work status: Occupation: ; student

Medication History *(Connie Hucks; 06/22/2016 12:57 PM)*
Medications Reconciled Specific dose unknown - Active - Hx Entry.
Percocet (5-325MG Tablet 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active - Hx Entry. (rx written and given to pt)
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Connie Hucks; 06/22/2016 12:57 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Connie Hucks; 06/22/2016 12:57 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Physical Exam *(GILBERTAS RIMKUS; 06/22/2016 01:20 PM)*
The physical exam findings are as follows:

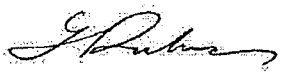
Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing.

Abdomen

Developed reducible parastomal hernia.

Assessment & Plan *(GILBERTAS RIMKUS; 06/22/201601:20 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~7 weeks s/p resection and ileostomy, healing slowly.
Today's Impression: Doing well. F/u in 2 weeks. Make plans for ostomy closure then.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 07/06/2016 02:24 PM

History of Present Illness *(Jenny Johnson 07/06/2016 02:24 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": S/P SMALL BOWEL RESECTION WITH ILEOSTOMY ON 05/15/2016. Here for reck.

Allergies *(Jenny Johnson; 07/06/2016 02:25 PM)*
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching
No Known Drug Allergies 06/01/2016

Past Medical History (Jenny Johnson; *07/06/2016 02:25 PM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~7 weeks s/p resection and ileostomy, healing slowly.

Social History *(Jenny Johnson; 07/06/2016 02:25 PM)*
No alcohol use
Caffeine use
Current work status: Occupation: ; student
Tobacco use: Former smoker, Remotely quit tobacco use

Medication History *(Jenny Johnson; 07/06/2016 02:25 PM)*
Percocet (5-325MG Tablet 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active - Hx Entry. (rx written and given to pt)
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.
Medications Reconciled Specific dose unknown - Active - Hx Entry.

Past Surgical *(Jenny Johnson; 07/06/2016 02:25 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Jenny Johnson; 07/06/2016 02:24 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Physical Exam *(GILBERTAS RIMKUS; 07/06/2016 02:43 PM)*
The physical exam findings are as follows:

General
General Appearance - Not in acute distress. **Build & Nutrition** - Well nourished and Well developed.

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing.

Head and Neck
Head - normocephalic, atraumatic with no lesions or palpable masses.
Neck
Global Assessment - normal.

ENMT
Global Assessment
Upon examination of the ears, nose, mouth and throat - unremarkable.

Chest and Lung Exam
Auscultation:
Breath sounds: - Clear Bilaterally.

Cardiovascular
Auscultation: Rhythm - Regular.

Abdomen
Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Soft, Non Tender and Nondistended.

Developed reducible parastomal hernia.

Rectal
Anorectal Exam: - Deferred.

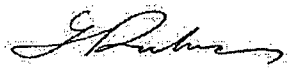
Peripheral Vascular
Lower Extremity: Inspection - **Left** - atraumatic. No Ulcers or skin lesions. **Right** - atraumatic. No Ulcers or skin lesions.

Assessment & Plan *(GILBERTAS RIMKUS; 07/06/201602:45 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: ~9 weeks s/p resection and ileostomy, skin healed.
Today's Impression: Plan ileostomy takedown.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()

INCISIONAL HERNIA (K43.2)
Problem Story: As above.
Today's Impression: Repair with Biologic mesh at the same time.
Current Plans:

Future Procedures:
- 07/08/2016: ILEOSTOMY, TAKE-DOWN (44620) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA

Patient: DANIEL E KNIGHT
Gender: Male
DOB: 09/26/1974
Home #: (330) 719-5830 Cell#: Work#:

[redacted]

44626

Permit For: TAKEDOWN OF ILEOSTOMY AND REPAIR OF ~~PARASTOMAL~~ HERNIA 44626
Incisional Incisional
Diagnosis: ILEOSTOMY, ~~PARASTOMAL~~ HERNIA

Hernia size ____ Reducible []yes [] no
Incarcerated []yes []no
Breast area ____
Allergies PCN, SULFA
Latex Allergy []yes [X]no

5 Strattice mesh

K63.1
K43.2

Admission Status:
[X] Inpatient Days 4 [] Outpatient

Anesthesia:
[] Local [] TIVA
[X] General [] Local w/IV Sedation
[]Spinal [] LMA
[] Preference of Anesthesiology Dept.

Orders:
[X] As needed per Anesthesia
[X] Invanz 1 gm IV within 1 hr. of incision
[] Ancef 1.0 gm IV within 1 hr. of incision
[] Gentamycin 80mg IVPB within 1 hr. of incison
[] ____ within 1 hr. of incision
[] Lovenox 40mg SQ within 2 hrs. of incision
[X] Tylenol 1gm IV preop
[X] Toradol 30mg IV preop
[] Ibuprofen 800mg IV preop
[] Saline lock
[] IV Fluid [] 0.9 NS []LR @ ____
LABS: [] Basic []Comprehensive [] H&H
[] CBC []PT [] APTT [] UA
[] Type & Cross ____ units PRBC's
[] UA PREG [] Liver Panel
[] EKG
[] CXR
[] Versed 8 mg po call to OR
[] Versed __mg IM on call to OR
[]SCD's
Hold [] Aspirin []Pletal
[] Plavix [] Coumadin
Others: ____

Insurance Carrier: PLANNED ADMINISTRATORS INC.
Group Number: NONE 800-652-3076
Plan Number: 14414969 Lisa
Michelle
Deductible $ ____
Deductible Remaining $ ____
Patient to Pay AIS $ ____
Auth # 161881559567C

4 days

Surgical Admission Orders

Surgeon: [] Ellis
[] Sasser
[] Epstein
[x] Rimkus

Special considerations:
[] Will need C-Arm to be available.
[] Will need PCU bed postoperatively.
[] Will need to be admitted ___ days prior to the surgery.
[] Will need bowel prep.
[] No needle sticks or blood pressure checks in the ____ upper extremity.
[] Consult Dr. ____
[] Will need mammographic needle localization for breast biospy.
[] Will need a frozen section.
[] Will need pulmonary function tests and ABG.
[] Will need assistance from
[] Dr. Ellis
[] Dr. Sasser
[] Dr. Epstein
[] Dr. Rimkus
[] whomever may be available
[] Will need endoscopy available

OR Schedule: 7/8/16 –
Date:

[] Have the patient consult with Kathy or Felicia

Others: ....

Language Preference
[X] English
[] Spanish
[] Other

PQRI

Perioperative Care: Timing of antibiotic Prophylaxis
[] 4047F Antibiotic Order Given
[] 1P Not ordered for medical reason
[] 8P Not ordered for unspecified reason

Perioperative Care: Selection of prophylactic Antibiotic
[] 4041F Selection of First or Second Generation Cephalosporin
[] 1P Not ordered for medical reason
[] 8P Not ordered for unspecified reason

Perioperative Care: Discontinuation of Prophylactic Antibiotic
[] 4049F Order given to Discontinue Antibiotic within 24 hrs
[] 1P Not ordered for medical reason
[] 8P Not ordered for unspecified reason

Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis
[] 4044F VTE prophylaxis ordered
[] 1P Not ordered for medical reason
[] 8P Not ordered for unspecified reason

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

63858

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006933263
Unit Number:	M000175313
Room #/Location:	TEMP ROOM2/SUR TEMP ROOM2 7
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

DATE OF PROCEDURE:
07/08/2016

PREOPERATIVE DIAGNOSIS:
1. Ileostomy.
2. Parastomal hernia.

POSTOPERATIVE DIAGNOSIS:
1. Ileostomy.
2. Parastomal hernia.

PROCEDURE:
1. Small bowel resection and anastomosis.
2. Ileostomy closure.
3. Repair of stomal/ventral incisional hernia with biologic mesh.

SURGEON:
Gilbertas Rimkus, MD

ANESTHESIA:
General endotracheal.

ESTIMATED BLOOD LOSS:
As 50 mL.

DISPOSITION:
To recovery room in stable condition.

INDICATIONS:
Mr. Knight is a 41-year-old patient who is known to me for traumatic perforation of the terminal ileum with extensive cecal peritonitis. He underwent bowel resection at that time, washout of the abdomen, and ileostomy. He healed up. He presented now for ileostomy takedown. Meanwhile, he developed parastomal hernia which he is going to get repaired at the same time. I told him I would use biologic mesh given the contaminant environment at the ileostomy site.

OPERATIVE CONSENT:
Procedure was explained in detail to Mr. Knight. Potential risks of bleeding, infection, and anastomotic leak were explained. He understood procedure and risks and expressed written consent.

OPERATIVE TECHNIQUE:
Patient was positioned supine on the operative table. After induction of general endotracheal anesthesia, his abdomen was prepped and draped in usual sterile fashion. Prior to prepping, his ileostomy was oversewn with pursestring suture 2-0 silk suture. An elliptiform incision was made around the ileostomy site. Dissection was carried all the way into subcutaneous tissues along the ileostomy. I mobilized approximately 10 cm of ileum. Then I identified distal ileum which I had sewn to the fascia posteriorly. I dissected that one free and mobilized only about 7 cm of that. It would not give me any more slack. After mobilization, ileostomy stump appeared to be ischemic plus there was length mismatch between 2 limbs. Therefore, I resected approximately 3 cm of the ileum and submitted to pathology. Then, side-to-side anastomosis with GIA 75 stapler was created between 2 limbs of ileum. TA 60 stapler was used to close enterotomy defect. Anastomosis was reinforced with interrupted 3-0 silk stitches. There was hernia defect right next to ileostomy site. I closed the peritoneum and rectus muscles, and then I developed

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CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006933263
Unit Number:	M000175313
Room #/Location:	TEMP ROOM2/SUR TEMP ROOM2 7
Dictating Physician:	Gilbertas Rimkus, MD

OPERATIVE/PROCEDURE REPORT

plane over the rectus muscles to accommodate 6 x 10 cm Strattice mesh which was just slightly trimmed to fit nicely. Then I closed the anterior rectus sheath with looped #1 PDS stitch in transverse fashion, in this way giving best potential repair for this young and athletic man, given the contaminated environment. A total of 20 mL of 0.25% Marcaine and 20 mL of Exparel were injected around the incision. Skin was approximated with staples and packed with Telfa strips in between. Dressing was applied. The patient tolerated the procedure well, was transported to recovery room in stable condition.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
GR/4105400
DD: 07/08/2016 14:45
DT: 07/08/2016 15:27
LM File#: 201607080000013527
Job #: 4105400

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CLINICAL PATHOLOGY CONSULTANTS, P. A.

PATHOLOGISTS
D. Mark Wilson, MD
Keele Allen, MD
Matthew Bernstein, MD

P.O. Box 1599
Conway, S.C. 29528

843 347-7144
FAX 843 347-7331

PATHOLOGY REPORT

NAME: KNIGHT,DANIEL ERIC
AGE/SEX:41/M
DOB: 09/26/74
PATH NO: S16-4624
STATUS: SOUT
UNIT NO: M000175313
ACCOUNT NO: V00006933263
REC'D DATE: 07/08/16
DATE OF SVC: 07/08/16
ROOM NO: SUR232
REGISTERING MD:
RACE: CA
SUBMITTING MD: Rimkus, Gilbertas MD
Signed Out

SITE OF SPECIMEN :
small bowel bx

FIXATION TIME :
Time specimen removed: 13:46, placed in formalin: 13:50. Initials: CM.

CLINICAL DIAGNOSIS :
Ileostomy, incisional hernia.

GROSS EXAMINATION :
The specimen consists of a small fragment of small bowel/ostomy tissue which has an open end and a stapled margin present. The specimen measures 3.5 x 3.0 x 2.7 cm. The specimen is opened to reveal normal ostomy-type, erythematous mucosa. Representative sections are submitted in one cassette.

MB/dm

MICROSCOPIC EXAMINATION :
Examination of the slide shows small bowel mucosa with villous architecture and increased chronic and active inflammation. Surface erosion is present along some areas. Chronic inflammation with lymphoid aggregates is seen throughout. No dysplastic features are identified.

DIAGNOSIS :
SMALL BOWEL, ILEOSTOMY TAKEDOWN:
BENIGN SMALL BOWEL CONSISTENT WITH ILEOSTOMY TAKEDOWN

MB/dap

Signed <Electronically Signed By>
Matthew Bernstein, MD 07/12/16 1430

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ADMISSION RECORD

CONWAY HOSPITAL
CONWAY, S.C.

MEDICAL RECORDS COPY

Unit #	Patient	Admit Date and Time	Location/Room	Visit #
M00017531	KNIGHT, DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY, SC 29527 (330)719-5830	07/08/16	ODB	V6933263
63858		Discharge Date and Time	Previous Admission/Visit 05/16 06/16	PTP SDC / MSV / FIC CO
Maiden Name	Patient SS #	Physician Rimkus, Gilbertas MD		

[redacted]

Surgeon | Consultant

Principal Diagnosis

Secondary Diagnosis

7/8/16 44120-58
44620-59
49560-51
+ 15777

Complications

Operations

Dr. Fleenor Verbal Consent

Hospital Infections

Results of Discharge	Recovered	Improved	Not Improved	Not Treated	In For Diagnosis	Expired

MTADINC4

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

63858

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006933263
Unit Number:	M000175313
Admit Date:	07/08/2016
Discharge Date:	07/10/2016
Dictating Physician:	Gilbertas Rimkus, MD

DISCHARGE SUMMARY

DISCHARGE DIAGNOSES:
1. History of small bowel perforation ileostomy.
2. Peristomal hernia.

HISTORY AND HOSPITAL COURSE:
Mr. Knight is a 41-year-old patient with history of a traumatic perforation of the terminal ileum and extensive fecal peritonitis. He underwent a small bowel resection at that time with an ileostomy. He healed up. He developed a peristomal hernia. He presented for a takedown of the ileostomy and repair of the peristomal hernia which was done 07/08/16.

He also underwent a resection of the ileostomy stump to facilitate anastomosis. Strattice mesh was used to repair the incisional hernia. He did very well postop. Starting passing gas and tolerated liquids. Sent home in stable condition by my partner on-call.

MEDICATIONS:
Vicodin for pain as needed.

FOLLOWUP:
In the office in 1 week.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
Rachel M. Collins, CNP
GR/4105596
DD: 07/11/2016 17:29
DT: 07/11/2016 17:39
LM File#: 201607110000018120
Job #: 4105596

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Associates in Surgery, PA
2361 Cypress Circle
Conway, SC 29526
Phone: 843-347-7291
Fax: 843-347-9309

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 07/06/2016 03:11 PM

History of Present Illness

Assessment & Plan *(Diane Lewis; 07/06/201603:19 PM)*

PERFORATION, INTESTINE (K63.1)
Problem Story: ~9 weeks s/p resection and ileostomy, skin healed.
Today's Impression: Plan ileostomy takedown.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()

INCISIONAL HERNIA (K43.2)
Problem Story: As above.
Today's Impression: Repair with Biologic mesh at the same time.
Current Plans:

Future Procedures:
- 07/08/2016: ILEOSTOMY, TAKE-DOWN (44620) Routine one time ()

Signed electronically by Diane Lewis

RSK-02-FRM
Rev 3 11.26.12

Conway Medical Center
Conway, South Carolina

Center Patient Admission Label Here

Consent to Operation and Other Medical Services

I, Daniel E Knight (name of patient), hereby authorize Dr. Rinkus and any associates or assistants the doctor deems appropriate, to perform: (Description of operation/procedure in laymen's language)

Takedown of Ileostomy and repair of parastomal hernia

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s).

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infections, heart complications, blood clots, loss of or loss of use of body part, damage to teeth, other neurological injury or death.

I understand that during the course of the operation/procedure, unforeseen conditions may occur or be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I hereby authorize and request that the above-named physician and/or his associates, partners, assistants or designees perform such procedures as are necessary and desirable in the exercise of his/her professional judgment.

The doctor has explained to me the reasonable alternative(s) to the procedure(s).

I hereby authorize the doctor or hospital personnel to utilize, dispose of, or store for future testing (as ordered by your physician) removed tissues, parts or organs resulting from the procedure(s) authorized above.

I consent to any photographing or video recording of the procedure(s) that may be performed as may be necessary and appropriate for the procedure(s) and do permit such photographs/video.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining/providing important product information.

APPLIES TO DNR PATIENTS ONLY

I have an Advance Directive, Living Will, and/or Do Not Resuscitate Order.

I choose to suspend my Advance Directive, Living Will, and/or Do Not Resuscitate Order during my procedure or recovery from anesthesia/sedation ☐ Yes ☐ No

If No, contact physician performing the procedure prior to completing the consent

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

Daniel E Knight 7/6/16 (Date) (Time) _____ (Relationship if authorized person)

(Patient or authorized person)

Diane Lewis RN 7/6/16 (Date) (Time) _____ Reason for signature (if other than patient)

(Witness)

No witness required if patient signature obtained by provider

An interpreter or other special assistance was used to assist patient in completing this form as follows:

☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient

☐ Other: (specify) _____ (name of interpreter or service)

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the nature of the procedure(s), anticipated benefits, material risks, alternative therapies and the risks associated with the alternative of the procedure(s).

_____ 7/6/16 _____

Signature of Physician **Date** **Time**

Page: 1 / 1
Patno: I1455456
Patient: KNIGHT, DANIEL
Location: 2222

Date: 07/08/2016

SUPPLEMENTAL ORDER [msptorder/rpptord/3.0]

Amedisys Home Health of Conway
176 Waccamaw Medical Park Court

Conway, SC 29526-8965
(P)(843) 347-5899 (F)(843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL
206 ECU CECUM DR

CONWAY, SC 29527
DOB : 09/26/1974
[redacted]

ORDER 07/07/2016

[07072016]
ORDER REASON:
DISCONTINUE WOUND CARE

ORDER:
EFFECTIVE 7/7/16
DISCONTINUE WOUND CARE
PER DR. RIMKUS/AMANDA SOLES LPN

Clinician Name: AMANDA SOLES LPN Date: 07/07/2016

Physician Signature _____ Date 7/29/16

48785062

Page: 1 / 1
Patno: I1455456
Patient: KNIGHT, DANIEL
Location: 2222

Date: 07/08/2016

SUPPLEMENTAL ORDER [meptorder/rpptord/3.0]

Amedisys Home Health of Conway
176 Waccamaw Medical Park Court

Conway, SC 29526-8965
(P) (843) 347-5899 (F) (843) 347-5885

PHYSICIAN

GILBERTAS RIMKUS
2361 CYPRESS CIRCLE

CONWAY, SC 29526-

PATIENT : I1455456

KNIGHT, DANIEL
206 ECU CECUM DR

CONWAY, SC 29527
DOB : 09/26/1974
[redacted]

ORDER 07/07/2016

[07072016]
ORDER REASON:
DISCONTINUE WOUND CARE

ORDER:
EFFECTIVE 7/7/16
DISCONTINUE WOUND CARE
PER DR. RIMKUS/AMANDA SOLES LPN

Clinician Name: AMANDA SOLES LPN Date: 07/07/2016

Physician Signature _____ Date 7/29/16

48785062

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 07/12/2016 02:40 PM

History of Present Illness *(Tracy Stone 07/12/2016 02:41 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": REVERSAL ILLEOSTOMY 7/8
DC'D CMC ON SAT 7/9

Allergies *(Tracy Stone; 07/12/2016 02:41 PM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Tracy Stone; *07/12/2016 02:41 PM)*
INCISIONAL HERNIA (K43.2) ; As above.
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; ~9 weeks s/p resection and ileostomy, skin healed.

Social History *(Tracy Stone; 07/12/2016 02:41 PM)*
Tobacco use: Former smoker, Remotely quit tobacco use
No alcohol use
Caffeine use
Current work status: Occupation: ; student

Medication History *(Tracy Stone; 07/12/2016 02:41 PM)*
Percocet (5-325MG Tablet 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active - Hx Entry. (rx written and given to pt)
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.

Past Surgical *(Tracy Stone; 07/12/2016 02:41 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Tracy Stone; 07/12/2016 02:41 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Vitals *(Tracy Stone; 07/12/2016 02:41 PM)*

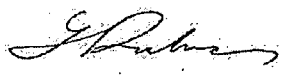
07/12/2016 02:41 PM
Weight: 142 lb **Height:** 63 in
Body Surface Area: 1.69 m² **Body Mass Index:** 25.15 kg/m²
Temp.: 98.8 ºF **Pulse:** 114 (Regular)
BP: 111/76 Manual (Sitting, Left Arm, Standard)

Physical Exam *(GILBERTAS RIMKUS; 07/12/2016 02:52 PM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing. **Incision** - Edges with gaps.

Assessment & Plan *(GILBERTAS RIMKUS; 07/12/201602:55 PM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: 5 days s/p ileostomy takedown. No c/o.
Today's Impression: Doing well, f/u in 1 week.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 07/26/2016 12:53 PM

History of Present Illness *(Jenny Johnson 07/26/2016 12:53 PM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": REVERSAL ILLEOSTOMY 7/8
DC'D CMC ON SAT 7/9 He is here for reck.

Subjective Transcription *(ELLIS, MICHAEL H; 7/28/2016 8:49:29 AM)*
He comes in and he has a couple little open areas in his wound ileostomy site closure. I think it is left open and just needs to fill in. I put a q-tip and there is no pus. It is just real small. He will do local wound care and come back to see Rimkus next week.

Allergies *(Jenny Johnson; 07/26/2016 12:54 PM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Jenny Johnson; *07/26/2016 12:54 PM)*
PERFORATION, INTESTINE (K63.1) ; 5 days s/p ileostomy takedown. No c/o.
INCISIONAL HERNIA (K43.2) ; As above.
SPORTS HERNIA (S39.81XA)

Social History *(Jenny Johnson; 07/26/2016 12:54 PM)*
Current work status: Occupation: ; student
Caffeine use
No alcohol use
Tobacco use: Former smoker; Remotely quit tobacco use

Medication History *(Jenny Johnson; 07/26/2016 12:54 PM)*
Percocet (5-325MG Tablet, 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active. (rx written and given to pt)
PROzac (20MG Capsule 1 Oral Daily) Active - Hx Entry.
OxyCODONE HCl (10MG Tablet Oral AS directed) Active - Hx Entry.
Naproxen (500MG Tablet 1 Oral Daily) Active - Hx Entry.
Medications Reconciled Specific dose unknown - Active - Hx Entry.

Past Surgical *(Jenny Johnson; 07/26/2016 12:54 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Jenny Johnson; 07/26/2016 12:54 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

M H Ellis M.D.

Signed electronically by MICHAEL H ELLIS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (41 years)

Date of Encounter: 08/02/2016 10:14 AM

History of Present Illness *(Tracy Stone 08/02/2016 10:15 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": hernia repair 3 weeks ago incision is opened at the right side end and drainage is green yellow thick but minimal pt c/o pain 4/10 it also has a bulge at the end of the side incision. smoothe edges

Allergies *(Tracy Stone; 08/02/2016 10:15 AM)*
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching
No Known Drug Allergies 06/01/2016

Past Medical History (Tracy Stone; *08/02/2016 10:15 AM)*
SPORTS HERNIA (S39.81XA)
PERFORATION, INTESTINE (K63.1) ; 5 days s/p ileostomy takedown. No c/o.
INCISIONAL HERNIA (K43.2) ; As above.

Social History *(Tracy Stone; 08/02/2016 10:15 AM)*
Tobacco use: Former smoker, Remotely quit tobacco use
Current work status: Occupation: ; student
Caffeine use
No alcohol use

Medication History *(Tracy Stone; 08/02/2016 10:16 AM)*
PROzac (20MG Capsule, 1 Oral Daily) Active.
OxyCODONE HCl (10MG Tablet, Oral AS directed) Active.
Naproxen (500MG Tablet, 1 Oral Daily) Active.
Medications Reconciled.

Past Surgical *(Tracy Stone; 08/02/2016 10:15 AM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Tracy Stone; 08/02/2016 10:15 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Vitals *(Tracy Stone; 08/02/2016 10:16 AM)*

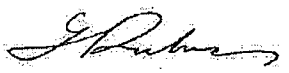
08/02/2016 10:16 AM
Weight: 142 lb **Height:** 63 in
Body Surface Area: 1.69 m² **Body Mass Index:** 25.15 kg/m²
Temp.: 99.1 °F **Pulse:** 82 (Regular)
BP: 113/72 Manual (Sitting, Left Arm, Standard)

Physical Exam *(GILBERTAS RIMKUS; 08/02/2016 10:45 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing. **Incision** - Edges with gaps.

Assessment & Plan *(GILBERTAS RIMKUS; 08/02/2016 10:48 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: 3 weeks s/p ileostomy takedown. Wound is not completely healed.
Today's Impression: Doing well, f/u in 2 weeks, not ready to return to work yet.
Current Plans:

Future Procedures:
- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()



Signed electronically by GILBERTAS RIMKUS

Associates in Surgery, PA - Office South
4367 Riverwood Dr, Suite 210
Murrells Inlet, SC 29576
Phone: 843-357-2680
Fax: 843-357-2682

DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (42 years)

Date of Encounter: 08/11/2016 09:55 AM

History of Present Illness *(Rhonda Mizelle 08/11/2016 09:58 AM)*

The patient is a 41 year old male presenting for a post-operative visit. Note for "Post-Operative": hernia repair 3 weeks ago incision is opened at the right side healed only very slight drainage noted at times.

Allergies *(Rhonda Mizelle; 08/11/2016 09:58 AM)*
Sulfa Drugs: Itching, Rash
Penicillins: Rash, Itching
No Known Drug Allergies 06/01/2016

Past Medical History (Rhonda Mizelle; *08/11/2016 09:58 AM)*
PERFORATION, INTESTINE (K63.1) ; 3 weeks s/p ileostomy takedown. Wound is not completely healed.
SPORTS HERNIA (S39.81XA)
INCISIONAL HERNIA (K43.2) ; As above.

Social History *(Rhonda Mizelle; 08/11/2016 09:58 AM)*
No alcohol use
Caffeine use
Current work status: Occupation: ; student
Tobacco use: Former smoker, Remotely quit tobacco use

Medication History *(Rhonda Mizelle; 08/11/2016 09:58 AM)*
Percocet (5-325MG Tablet, 1-2 Tablet Oral every six hours, as needed, Taken starting 06/07/2016) Active. (rx written and given to pt)
PROzac (20MG Capsule, 1 Oral Daily) Active.
OxyCODONE HCl (10MG Tablet, Oral AS directed) Active.
Naproxen (500MG Tablet, 1 Oral Daily) Active.
Medications Reconciled.

Past Surgical *(Rhonda Mizelle; 08/11/2016 09:58 AM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Rhonda Mizelle; 08/11/2016 09:58 AM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Physical Exam *(GILBERTAS RIMKUS; 08/11/2016 10:09 AM)*
The physical exam findings are as follows:

Integumentary
Problem #1: Assessment of Surgical Incision - consistent with normal anticipated wound healing. **Incision** - Dry and Intact.

Assessment & Plan *(GILBERTAS RIMKUS; 08/11/201610:10 AM)*
PERFORATION, INTESTINE (K63.1)
Problem Story: 5 weeks s/p ileostomy takedown. Wound is not completely healed.
Today's Impression: Doing well, f/u prn, released back to work.
Current Plans:

Future Procedures:

- 07/08/2016: INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine one time ()

Signed electronically by GILBERTAS RIMKUS

ASSOCIATES IN SURGERY, PA
843-347-7291 PHONE
843-347-0139 FAX

2361 Cypress Circle
Conway, SC 29526

Wachesaw Medical Center
4367 Riverwood Drive
Suite 210
Murrells Inlet, SC 29576

Disability Certificate

Date: 08/11/2016

Name:DANIEL E KNIGHT

To Whom it May Concern:
This is to certify that the above named pateint was under my professional care from 5-15-16 and was totally incapacitated during this time.
8-15-16
This is to further certify that the above named patient has now recovered sufficiently to be able to return to work or school on 8-15-16 .

Restrictions: none

Michael H. Ellis, M.D.
Paul L. Sasser, M.D.
Aaron M. Epstein, M.D.
******* Gilbertas Rimkus, M.D.

ASSOCIATES IN SURGERY, PA
843-347-7291 PHONE
843-347-0139 FAX

2361 Cypress Circle
Conway, SC 29526

Wachesaw Medical Center
4367 Riverwood Drive
Suite 210
Murrells Inlet, SC 29576

Disability Certificate

Date: 03/06/2017

Name:DANIEL E KNIGHT

To Whom it May Concern:
This is to certify that the above named pateint was under my professional care from 5-15-16 until 8-15-16 and was totally incapacitated during this time.

This is to further certify that the above named patient was given narcotics (Percocet) as part of his treatment.

Restrictions:

Michael H. Ellis, M.D.
Paul L. Sasser, M.D.
Aaron M. Epstein, M.D.
Gilbertas Rimkus, M.D.

[redacted]

ASSOCIATES IN SURGERY, PA
843-347-7291 PHONE
843-347-0139 FAX

2361 Cypress Circle
Conway, SC 29526

Waccamaw Medical Center
4367 Riverwood Drive
Suite 210
Murrells Inlet, SC 29576

Disability Certificate

Date: 03/06/2017

Name: DANIEL E KNIGHT

To Whom it May Concern;
This is to certify that the above named patient was under my professional care from 5-15-16 until 8-15-16 and was totally incapacitated during this time.

This is to further certify that the above named patient was given narcotics (Percocet) as part of his treatment.

Restrictions:

Michael H. Ellis, M.D.
Paul L. Sasser, M.D.
Aaron M. Epstein, M.D.
Gilbertas Rimkus, M.D.

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DANIEL E KNIGHT **Patient #:** 63858-DK **DOB:** 09/26/1974 (42 years)

Date of Encounter: 04/03/2017 02:52 PM

History of Present Illness *(Jennifer Norton 04/03/2017 03:02 PM)*

The patient is a 42 year old male who presents with abdominal swelling. Pt is here, noticed some bulging to mid abdominal area. States that he believes he has incisional hernis. is not painful but definitely able to feel the bulge when doing any ab work.

Allergies *(Jennifer Norton; 04/03/2017 03:02 PM)*
Penicillins: Rash, Itching
Sulfa Drugs: Itching, Rash
No Known Drug Allergies 06/01/2016

Past Medical History (Jennifer Norton; *04/03/2017 03:02 PM)*
PERFORATION, INTESTINE (K63.1) ; 5 weeks s/p ileostomy takedown. Wound is not completely healed.
SPORTS HERNIA (S39.81XA)
INCISIONAL HERNIA (K43.2) ; As above.

Social History *(Jennifer Norton; 04/03/2017 03:02 PM)*
Tobacco use: Former smoker, Remotely quit tobacco use
No alcohol use
Caffeine use
Current work status: Occupation: ; student

Past Surgical *(Jennifer Norton; 04/03/2017 03:02 PM)*
Colon Surgery (05/15/2016); SMALL BOWEL RESECTION WITH ILEOSTOMY

Review of Systems *(Jennifer Norton; 04/03/2017 03:02 PM)*
General: Not Present- Fever, Weight Gain and Weight Loss.
Skin: Not Present- Open wound.
HEENT: Present- Wears glasses/contact lenses. Not Present- Rhinitis and Hay Fever.
Respiratory: Not Present- Bloody sputum, Chronic Cough and Shortness of Breath.
Cardiovascular: Not Present- Swelling of Extremities, Calf Pain when walking, Foot pain at rest, Chest Pain and Irregular Heart Beat.
Gastrointestinal: Not Present- Abdominal Pain, Bloody Stool, Constipation, Diarrhea, Indigestion and Nausea.
Male Genitourinary: Not Present- Blood in Urine and Painful Urination.
Musculoskeletal: Not Present- Joint Pain and Joint Swelling.
Neurological: Not Present- Paralysis left and Paralysis right.
Psychiatric: Not Present- Memory Loss.
Endocrine: Not Present- Excessive Thirst.

Vitals *(Jennifer Norton; 04/03/2017 03:03 PM)*
04/03/2017 03:02 PM
Weight: 142 lb **Height:** 63 in
Body Surface Area: 1.69 m² **Body Mass Index:** 25.15 kg/m²
Temp.: 98.2 °F **Pulse:** 76 (Regular)
BP: 117/75 Manual (Sitting, Left Arm, Standard)

Physical Exam *(GILBERTAS RIMKUS; 04/03/2017 03:23 PM)*
The physical exam findings are as follows:

General
General Appearance - Not in acute distress. **Build & Nutrition** - Well nourished and Well developed.

Head and Neck
Head - normocephalic, atraumatic with no lesions or palpable masses.
Neck
Global Assessment - normal.

ENMT
Global Assessment
Upon examination of the ears, nose, mouth and throat - unremarkable.

Chest and Lung Exam
Auscultation:
Breath sounds: - Clear Bilaterally.

Cardiovascular
Auscultation: Rhythm - Regular.

Abdomen
Palpation/Percussion: Palpation and Percussion of the abdomen reveal - Soft, Non Tender and Nondistended.

Very large VIH, defect about 10 cm in transverse diameter.

Rectal
Anorectal Exam: - Deferred.

Peripheral Vascular
Lower Extremity: Inspection - **Left** - atraumatic. No Ulcers or skin lesions. **Right** - atraumatic. No Ulcers or skin lesions.

Assessment & Plan *(GILBERTAS RIMKUS; 04/03/201703:27 PM)*
INCISIONAL HERNIA (K43.2)
Problem Story: This time in the middline.
Today's Impression: Too large to approximate fascia, he will need repair with lap. musculocotaneous flaps (component separation).
Current Plans:

- FLAP, MYOCUTANEOUS, ABDOMINAL WALL (15734) Routine ()
- INCISIONAL HERNIA REPAIR WITH MESH (49568) Routine ()

Signed electronically by GILBERTAS RIMKUS