Progress Notes

ALEXIS,AARON (b) (6) May 09, 1979 (34)

*** WORK COPY ONLY *** Printed: Sep 17, 2013 11:13

Facility Date/Time Type of Note Author

WASHINGTON 08/28/2013 17:31 < EMERGENCY (b) (6)

Note Text

<< Interdisciplinary Note >>

LOCATION: EMERGENCY DEPARTMENT- VISIT DATE: AUG 28, 2013@17:30
LOCAL TITLE: EMERGENCY DEPARTMENT 10-10M INTAKE NOTE
STANDARD TITLE: EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 28, 2013@17:31 ENTRY DATE: AUG 28, 2013@17:31:49
AUTHOR: (b) (6) EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Date and time of arrival: Aug 28,2013@17:31
Age: 34
Sex: MALE
Mode of arrival: ambulatory

Patient's complaint (in patient's own words): Sleep apnea

Patient's Phone Number:
Homeless: No
Allergies: No Allergy Assessment

(Pls. see CPRS Vital Signs section for VS, height and weight).

/es/ (b) (6)
ADMIN OFFICER of the DAY
Signed: 08/28/2013 17:32

<< Interdisciplinary Note - Cont. >>

LOCAL TITLE: EMERGENCY DEPARTMENT RN TRIAGE NOTE
STANDARD TITLE: NURSING EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 28, 2013@18:56 STATUS: COMPLETED

RN TRIAGE NOTE:

Triage Date/Time: Aug 28,2013 @ 18:50 hrs; Sex:MALE Age:34 years old

Chief complaint (include date of onset): Patient presents to ER with c/o awakening each morning about 4:00 am like clockwork and he cannot figure out why this is happening.

<< Interdisciplinary Note >>
LOCATION: EMERGENCY DEPARTMENT- VISIT DATE: AUG 28, 2013@17:30
LOCAL TITLE: EMERGENCY DEPARTMENT 10-10M INTAKE NOTE
STANDARD TITLE: EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 28, 2013@17:31 ENTRY DATE: AUG 28, 2013@17:31:49
AUTHOR: (b) (6) EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Date and time of arrival: Aug 28,2013@17:31
Age: 34
Sex: MALE
Mode of arrival: ambulatory

Patient's complaint (in patient's own words): Sleep apnea

Patient's Phone Number:
Homeless: No
Allergies: No Allergy Assessment

(Pls. see CPRS Vital Signs section for VS, height and weight).

/es/ (b) (6)
ADMIN OFFICER of the DAY
Signed: 08/28/2013 17:32

<< Interdisciplinary Note - Cont. >>
LOCAL TITLE: EMERGENCY DEPARTMENT RN TRIAGE NOTE
STANDARD TITLE: NURSING EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 28, 2013@18:56 STATUS: COMPLETED

RN TRIAGE NOTE:

Triage Date/Time: Aug 28,2013 @ 18:50 hrs; Sex:MALE Age:34 years old

Chief complaint (include date of onset): Patient presents to ER with c/o awakening each morning about 4:00 am like clockwork and he cannot figure out why this is happening.

Mode of arrival:Ambulatory

Pain:0 (08/28/2013 18:54)
Pulse Ox:8/28/13 @ 1854 PULSE OXIMETRY: 100

EXAM (requires 6-11 elements):
General: NAD, alert and oriented x 3
HENT: normocephalic, atraumatic, normal external ear canal
Eyes: eomi, perrla,
no conjunctival injection, no scleral icterus.
Neck: supple, no meningismus, no ttp
Cardiac: RRR, no m/g/r,
Respiratory: lungs CTAB,
Abdomen: soft, + BS, no ttp.
Extremities: FROM,no edema, no calf pain
Skin: warm, well perfused.
no rash, vesicles, petechiae, purpura.
Neuro: no gross deficits.

Treatment and Plan: will d/c home on short course of trazodone and encourage pcp follow up with oragne clinic

Consultant called at:
Consultant arrived in Emergency Department at:

Follow-up/Referral:
Medication Reconciliation:
DISCHARGE INFORMATION:
Patient's condition: stable
Date and time of disposition: Aug 28,2013@19:35
Patient transferred/discharged to (pls. specify):

/es/ (b) (6)
PHYSICIAN ASSISTANT (FB)
Signed: 08/28/2013 19:52

/es/ (b) (6), MD
ATTENDING PHYSICIAN (FB)
Cosigned: 08/28/2013 20:37

08/28/2013 ADDENDUM STATUS: COMPLETED
I was present for evaluation and treatment and agree c above note. Pt presents requesting medication refill of trazodone for insomnia, currently taking same.

No new c/o. Unremarkable PE. Short course prescribed c plan for outpt primary care f/u for further mgmt.

/es/ (b) (6), MD
ATTENDING PHYSICIAN (FB)
Signed: 08/28/2013 20:38

Progress Notes

ALEXIS,AARON (b) (6) May 09, 1979 (34)

*** WORK COPY ONLY *** Printed: Sep 17, 2013 11:13

Facility	Date/Time	Type of Note	Author
PROVIDENCE	08/23/2013 17:37	ER BRIEF/PHY	(b) (6)

Note Text
LOCAL TITLE: ER BRIEF/PHYSICIAN (INPARENT)
STANDARD TITLE: EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 23, 2013@17:37 ENTRY DATE: AUG 23, 2013@17:37:13
AUTHOR: (b) (6) EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ALEXIS,AARON Aug 23,2013@17:37

Chief Complaint: insomnia

Brief focused history: 34 yrs old man presents with inability to go to sleep for more then 2-3 hrs for
about 3 weeks. He just cannot say asleep. He would wake up with around 1 or 2 am,
after 2-3 hours of sleep, startling and cannot go back to sleep. Denies drugs, cocaine, heroin, caffeine product, depression, anxiety, chest pain, sob, nightmares. He denies taking nap during the day. Denies SI or HI. He works in the defense department, no problem there.

Brief physical examination:

Lungs: CTA
Heart: RRR
Abd: normal
Ext: normal
Psy: normal

Most recent Vitals
HT:
WT:
T: 98.9 F [37.2 C] (08/23/2013 17:32)
P: 72 (08/23/2013 17:32)
R: 16 (08/23/2013 17:32)
BP: 123/81 (08/23/2013 17:32)

Progress Notes

ALEXIS,AARON (b) (6) May 09, 1979 (34)

*** WORK COPY ONLY *** Printed: Sep 17, 2013 11:13

Facility	Date/Time	Type of Note	Author
PROVIDENCE	08/23/2013 17:39	1010M NURSIN	(b) (6)

Note Text
LOCAL TITLE: 1010M NURSING INTAKE/EMERGENCY ROOM (IN CHILD) (T)
STANDARD TITLE: NURSING EMERGENCY DEPT TRIAGE NOTE
DATE OF NOTE: AUG 23, 2013@17:39 ENTRY DATE: AUG 23, 2013@17:39:47
AUTHOR: (b) (6) EXP COSIGNER:
URGENCY: STATUS: COMPLETED

ED NURSING NOTE

****
WANDERING PATIENT SCREENING (MANDATORY SCREEN)
****
1) At the time of this assessment, the patient appears to lack the cognitive ability to
make relevant decisions, had/has a cognitive disorder diagnosis, and has independent mobility?
No

2) Does the patient have a known history of elopement and appear to have independent mobility?
No

3) Does the patient have a court appointed legal guardian and appear to have independent mobility?
No

IF YES TO ANY OF ABOVE, IMPLEMENT WANDER GUARD

4) Was a Wander Guard applied? NA
If no specify:
****
THERAPEUTIC INTERVENTIONS AND OR PROCEDURES:
****
5:00pm pt placed in bed # 2
pt denies any illicit drugs or alcohol
denies si or hi
feels safe where he is staying
denies depression

nkda
5:10pm er md at bedside
6:00pm pt discharged at this time with his script for trazodone
pt to f/u with his pcp once he gets home in Texas- going home tomorrow

Community Acquired Pneumonia: No
If yes blood cultures obtained prior to first dose of Antibiotic?
Time # 1 Blood Culture Drawn
Time # 2 Blood Culture Drawn
Time Antibiotic given:
Infusion time for # 1 antibiotic
Infusion time for # 2 antibiotic

Acute MI/Acute Coronary Syndrome: No
If yes EKG within 10 minutes of Arrival?
Time EKG obtained:
Troponin drawn within 15 minutes of arrival?
ASA given within 10 minutes of arrival?

IV LINES: n/a
*IV site location(s):
*IV site appearance(s):
*Date of IV insertion:
*Date IV site/catheter needs to be changed:
*IV site issue(s) identified:
*If yes,select IV issue(s) identified:
Pain
Redness
Edema
Other:
*If IV issue(s) identified, specify action(s)taken:
Replaced line
If replaced specify date of insertion
If replaced specify date of anticipated needed change
Discontinued line
If line discontinued was catheter intact?
Other