History of Present Illness

Encounter Date & Time
10/11/20 13:59
Service: Rehab Medicine
Primary Care Physician
Pcp,Patient Reports No Local
Attending Physician
Bulkan,Phyllis N (PM)
Chief Complaint
Comprehensive inpatient rehabilitation secondary to major multiple fractures

Mall - 63/10

R Initials

Ht - 193 cm
wt - 78.5 kg
BMI - 20.

HPI
This is a 63 year old white male without any significant medical history who fell out of an SUV when he returned home from going out to a bar with his partner. He fell on to his left side which resulted in a left femur intertrochanteric fracture with subtrochanteric extension, left distal radius fracture, comminuted and left carpal tunnel syndrome. He underwent left femur antegrade intramedullary nailing by Dr. Wodicka on 9/25/20 and open reduction and internal fixation of the left distal radius, and open carpal tunnel release by Dr. Lovy on 9/25/20. He is NWB of the left upper extremity. He was noted to be anemic and received 2 units of packed red blood cells. Patient developed a cecal volvulus with a small bowel obstruction for which he underwent a right hemicolectomy by Dr Ron Arison on 10/4/20. He was initially NPO and received TPN but was since advanced to regular diet which he is tolerating well. He has participated in therapies and is minimal assistance/maximum assistance with bed mobility and transfers; Left PFRW 30 feet minimum assistance. Prior functional history, he was independent with ADL function and mobility. He is being admitted for comprehensive inpatient rehabilitation.

Review of Systems

Additional Comments
General: Denies fever or chills
HEENT: Denies headaches, dizziness, visual or hearing problems
Cardiovascular: Denies chest pain or palpitations
Pulmonary: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, abdominal pain or diarrhea
Genitourinary: Denies dysuria, frequent urination or urinary tract infections
Endocrine: Denies diabetes mellitus or thyroid dysfunction
Hematologic: Denies any bleeding problems or blood dyscrasias
Psychiatric: Denies depression or anxiety
Neurological: Denies strokes, TIA's or seizure disorder
Skin: Denies rash or skin breakdown

Past Medical History

Medications
Active Meds Reviewed: Yes

Allergies
Coded Allergies:
No Known Allergies (Unverified , 1/17/20)

Medical History
Medical History:

(1) Alcoholic intoxication
(2) Left wrist fracture
(3) Postoperative urinary retention
(4) Hyponatremia
(5) Acute blood loss anemia
(6) Postoperative ileus
(7) Volvulus of colon
(8) Cecal volvulus
(9) Femur fracture, left
(10) S/P right hemicolectomy

Social History

Smoking Status: Never Smoker
Alcohol Use: Socially
Additional Comments
Social history: lives with his partner

Family history; denies CAD or DM

Physical Exam

BP 155/74; PULSE 90; RR 20; TEMP 36.6
Weight in Kg

Physical Exam
GENERAL: Pleasant, no acute distress
EYES: Pupils equal and reactive to light, extra-ocular movements intact, sclera anicteric
EARS, NOSE & THROAT: Oropharynx with moist, pink mucous membranes and no lesions.
CARDIOVASCULAR: Regular rate and rhythm without significant murmur. No significant peripheral edema.
RESPIRATORY: Normal appearance and effort. Clear to auscultation bilaterally without focal areas of wheezing, *rales or rhonchi.*
GASTROINTESTINAL: Normal appearance. Soft, nontender with normal bowel sounds. Abdomen with intact *dressing*
MUSCULOSKELETAL: Left forearm cast intact; color, motion and sensitivity intact; Left femur incision healing.
SKIN: No rashes, eruptions or skin breakdown noted. Warm and dry.
NEUROLOGIC: Awake, alert and oriented to person, place, time and situation. 5/5 strength in flexion and extension in the right upper and lower extremities. Right upper extremity with 3/5; right lower extremity strength 4-/5
LYMPHATICS: No lymphedema.
PSYCHIATRIC: Normal mood and affect.

Plan

Assessment

Problem List:
(1) Femur fracture, left
Assessment & Plan: s/p left femur antegrade intramedullary nailing, s/p open reduction internal fixation of the left distal radius and open carpal tunnel release
full weight bearing left lower extremity; non weight bearing left upper extremity
admit for comprehensive inpatient rehabilitation to include physical therapy and occupational therapy
ELOS 14 - 16 DAYS
Prognosis good for continued gains

(2) Left wrist fracture
(3) Volvulus of colon
(4) Postoperative ileus
Assessment & Plan: s/p colon resection

(5) S/P right hemicolectomy
(6) Postoperative urinary retention
Assessment & Plan: now voiding spontaneously

(7) Alcoholic intoxication
(8) Acute blood loss anemia
Assessment & Plan: s/p 2 units of blood

BULKAN,PHYLLIS N (PM)

Oct 11, 2020 14:00

Report Dictated by: BULKAN, PHYLLIS N MD
Dictation Date: 10/11/20 1400

<Electronically signed by PHYLLIS N BULKAN MD>
Electronic Signature Date: 10/14/20 2153

Co-Signed:

cc:BULKAN,PHYLLIS N (PM);