

CASE 5

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Case 05

ALFRED STATE MEDICAL CENTER 100 MAIN ST. ALFRED, NY 14802 (607) 555-1234 HOSPITAL #: 000999				INPATIENT FACE SHEET			
PATIENT NAME AND ADDRESS				GENDER	RACE	MARITAL STATUS	PATIENT NO.
GIBBON, Andrew 22 Market Street Alfred, NY 14802				M	W	M	Case05
				DATE OF BIRTH		MAIDEN NAME	OCCUPATION
				08-19-YYYY		N/A	Retired
ADMISSION DATE	TIME	DISCHARGE DATE	TIME	LENGTH OF STAY		TELEPHONE NUMBER	
04-27-YYYY	13:00	04-29-YYYY	00:00	02 DAYS		(607) 555-4500	
GUARANTOR NAME AND ADDRESS				NEXT OF KIN NAME AND ADDRESS			
GIBBON, Andrew 22 Market Street Alfred, NY 14802				GIBBON, Cynthia 22 Market Street Alfred, NY 14802			
GUARANTOR TELEPHONE NO.		RELATIONSHIP TO PATIENT		NEXT OF KIN TELEPHONE NUMBER		RELATIONSHIP TO PATIENT	
(607) 555-4500		Self		(607) 555-4500		Wife	
ADMITTING PHYSICIAN		SERVICE		ADMIT TYPE		ROOM NUMBER/BED	
Alan Norris, MD		Medical		2		0362/02	
ATTENDING PHYSICIAN		ATTENDING PHYSICIAN UPIN		ADMITTING DIAGNOSIS			
Alan Norris, MD		100G02		Chest pain			
PRIMARY INSURER		POLICY AND GROUP NUMBER		SECONDARY INSURER		POLICY AND GROUP NUMBER	
Medicare							
DIAGNOSES AND PROCEDURES						ICD-9-CM	ICD-10-CM/PCS
PRINCIPAL DIAGNOSIS							
Unstable Angina						411.1	I20.0
SECONDARY DIAGNOSES							
Hypertension						401.9	I10
Status post myocardial infarction						412	I25.2
PRINCIPAL PROCEDURE							
SECONDARY PROCEDURES							
TOTAL CHARGES: \$ 4,855.65							
ACTIVITY: ☐ Bedrest ☒ Light ☐ Usual ☐ Unlimited ☐ Other:							
DIET: ☒ Regular ☐ Low Cholesterol ☐ Low Salt ☐ ADA ☐ Calorie							
FOLLOW-UP: ☐ Call for appointment ☐ Office appointment on Medications: Precardio, Lasidol, Vasotec, Inderal, Alend, Aspirin							
SPECIAL INSTRUCTIONS See Dr. Derby next week Do not take Dypaside until you see Dr. Derby.							
Signature of Attending Physician Alan Norris, MD							

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GIBBON, Andrew	Admission: 04-27-YYYY	CONSENT TO ADMISSION
Case 05	DOB: 08-19-YYYY	
Dr. Norris	ROOM: 0362	

I, Andrew Gibbon hereby consent to admission to the Alfred State Medical Center (ASMC) and I further consent to such routine hospital care, diagnostic procedures, and medical treatment that the medical and professional staff of ASMC may deem necessary or advisable. I authorize the use of medical information obtained about me as specified above and the disclosure of such information to my referring physician(s). This form has been fully explained to me, and I understand its contents. I further understand that no guarantees have been made to me as to the results of treatments or examinations done at the ASMC.

<u>Andrew Gibbon</u>	<u>April 27, YYYY</u>
Signature of Patient	Date
Signature of Parent/Legal Guardian for Minor	Date
Relationship to Minor	
<u>Andrew Wittenman</u>	<u>April 27, 9999</u>
WITNESS: Alfred State Medical Center Staff Member	Date

CONSENT TO RELEASE INFORMATION FOR REIMBURSEMENT PURPOSES

In order to permit reimbursement, upon request, the Alfred State Medical Center (ASMC) may disclose such treatment information pertaining to my hospitalization to any corporation, organization, or agent thereof, which is, or may be liable under contract to the ASMC or to me, or to any of my family members or other person, for payment of all or part of the ASMC's charges for services rendered to me (e.g., the patient's health insurance carrier). I understand that the purpose of any release of information is to facilitate reimbursement for services rendered. In addition, in the event that my health insurance program includes utilization review of services provided during this admission, I authorize ASMC to release information as is necessary to permit the review. This authorization will expire once the reimbursement for services rendered is complete.

<u>Andrew Gibbon</u>	<u>April 27, YYYY</u>
Signature of Patient	Date
Signature of Parent/Legal Guardian for Minor	Date
Relationship to Minor	
<u>Andrew Wittenman</u>	<u>April 27, 9999</u>
WITNESS: Alfred State Medical Center Staff Member	Date

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GIBBON, Andrew Case 05 Dr. Norris		Admission: 04-27-YYYY DOB: 08-19-YYYY ROOM: 0362		ADVANCE DIRECTIVE	
Your answers to the following questions will assist your Physician and the Hospital to respect your wishes regarding your medical care. This information will become a part of your medical record.					
		YES	NO	PATIENT'S INITIALS	
1.	Have you been provided with a copy of the information called "Patient Rights Regarding Health Care Decision?"	X		AG	
2.	Have you prepared a "Living Will?" If yes, please provide the Hospital with a copy for your medical record.		X	AG	
3.	Have you prepared a Durable Power of Attorney for Health Care? If yes, please provide the Hospital with a copy for your medical record.		X	AG	
4.	Have you provided this facility with an Advance Directive on a prior admission and is it still in effect? If yes, Admitting Office to contact Medical Records to obtain a copy for the medical record.		X	AG	
5.	Do you desire to execute a Living Will/Durable Power of Attorney? If yes, refer to in order: a. Physician b. Social Service c. Volunteer Service		X	AG	
HOSPITAL STAFF DIRECTIONS: Check when each step is completed.					
1.	✓ Verify the above questions where answered and actions taken where required.				
2.	✓ If the "Patient Rights" information was provided to someone other than the patient, state reason: _____				
		Name of Individual Receiving Information	Relationship to Patient		
3.	✓ If information was provided in a language other than English, specify language and method.				
4.	✓ Verify patient was advised on how to obtain additional information on Advance Directives.				
5.	✓ Verify the Patient/Family Member/Legal Representative was asked to provide the Hospital with a copy of the Advance Directive which will be retained in the medical record.				
File this form in the medical record, and give a copy to the patient.					
Name of Patient (Name of Individual giving information if different from Patient) <u>Andrew Gibbon</u>		Date <u>April 27, YYYY</u>			
Signature of Patient <u>Andrew Gibbon</u>		Date <u>April 27, YYYY</u>			
Signature of Hospital Representative		Date			
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GIBBON, Andrew Case 05 Dr. Norris	Admission: 04-27-YYYY DOB: 08-19-YYYY ROOM: 0362	HISTORY & PHYSICAL EXAM
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CHIEF COMPLAINT: 72 yr. old gentleman of Dr. K. Derby's who presents with chest pain.

HISTORY OF PRESENT ILLNESS: Mr. Gibbon is a very cheery sort of fellow. He is very pleasant. He looks as though he probably should be running some sort of hardware store commercial. He states that today while he was preparing breakfast, in the restroom he suffered some chest discomfort. He is a little bit vague as to where his chest really is. He felt it in his back, he felt it in his jaw. He took a couple of Nitroglycerin in sequence three minutes apart and felt better. Apparently this has been occurring a little more frequently recently. All these things are nebulous. If it wasn't for his wife I think he would deny everything. According to her he has been having more frequent episodes and has gained a fair amount of weight over the winter. He had been fairly active. His pastor who is with him and often serves as his spokesman, stated that he had hunted this past fall without having to take any Nitroglycerin. However he said the pace was quite controlled and he really didn't do very much in the way of heavy exercise. The patient has a history of an infarction in 1981. Underwent catheterization. Apparently no surgery was necessary. There is also some question about him having a lot of indigestion from time to time and it is not clear whether it is cardiac or GI. Because of his prior cardiac history, the progression of his chest pain, the uncertainty of its origin, he will be admitted for further evaluation and treatment.

PAST MEDICAL HISTORY: Is essentially that listed above.

MEDICATIONS: He is on Dyazide once a day, Isordil 10 mg. q.i.d. Vasotec 2.5 mg. daily, Aspirin one a day, Propranolol 40 mg. q.i.d.

ALLERGENS: Sulfia.

SOCIAL HISTORY & FAMILY HISTORY: The patient is married. Doesn't smoke, although he had in the past. Doesn't drink. There is no disease common in the family.

REVIEW OF SYSTEMS: Negative.

GENERAL: Reveals a very pleasant 72 yr. old gentleman.

VITAL SIGNS: Temperature of 97.6, pulse is 64, respirations 18, blood pressure 178/94.

HEAD: Normocephalic.

EYES: Eyes -sclera and conjunctiva normal. PERRL, EOM's intact. Fundi reveal arteriolar narrowing. ENT are unremarkable.

NECK: Supple. No thyromegaly. Carotids are 2 out of 4. No bruits, no jugular venous distention.

CHEST: Symmetrical. Clear to auscultation and percussion.

HEART: Regular rhythm without any particular murmurs or gallops.

ABDOMEN: Nontender. No organomegaly. Bowel sounds normal activity. No bruits or masses.

BACK: No CVA tenderness nor tenderness to percussion over the spinous processes.

GENTALIA: Normal male.

RECTAL: Good sphincter tones. Stool is hemoccult negative. Prostate is normal in size.

EXTREMITIES: No cyanosis, clubbing or edema. Pulses equal and full.

NEUROLOGIC: Is physiologic.

IMPRESSION: 1) Chest pain, etiology to be determined
2) Hypertension

PLAN: Outlined in the order sheet.

DD: 04-28-YYYY
DT: 04-30-YYYY

Alan Norris, MD
Alan Norris, MD

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GIBBON, Andrew	Admission: 04-27-YYYY	PROGRESS NOTES
Case 05	DOB: 08-19-YYYY	
Dr. Norris	ROOM: 0362	

Date	(Please skip one line between dates.)
4-27-YY	Chief Complaint: Unstable angina. Diagnosis: Unstable angina. Plan of Treatment: See orders. Discharge Plan: Home - No services needed.
	Alan Norris, MD
4/28/YY	Pt has had no pain overnight. Plan to get pt up and walking. Treadmill Thursday if no pain BG studies today.
	Alan Norris, MD
4/29/YY	Treadmill - pt not able to achieve goal. Shortness of breath.
	Alan Norris, MD

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GIBBON, Andrew		Admission: 04-27-YYYY	DOCTORS ORDERS
Case 05		DOB: 08-19-YYYY	
Dr. Norris		ROOM: 0362	
Date	Time	Physician's signature required for each order. (Please skip one line between dates.)	
4-27-YY	1330	TELEMETRY PROTOCOL	
		1 Saline lock, insert and flush every 24 hours and PRN	
		2 EKG with chest pain x 1	
		3 Oxygen 3 l/min. via nasal cannula PRN for chest pain	
		4 Chest Pain: NTG 0.4mg SL q 5 min x 3	
		5 Bradycardia: Atropine 0.5mg IV q 5 min to total of 2mg for symptomatic heart rate (Pulse less than 50 or 60 with decreased BP and/or PUC's)	
		6 PUC's: Lidocaine 50mg IV push Start drip 500cc D5W Lidocaine 2 gm @ 2mg/min (30cc/hr) for greater than 6 PUC's per min or 3 PUC's in a row	
		7 U-Tach: (If patient is hemodynamically stable) Lidocaine 50mg IV push Start drip 500cc D5W Lidocaine 2 gm @ 2mg/min (30cc/hr) (If unstable) Cardiovert at 50 watt seconds	
		8 U-fib: Immediately defibrillate at 200 watt seconds, if not converted. Immediately defibrillate at 300 watt seconds, if not converted. Immediately defibrillate at 360 watt seconds, if not converted. Start CPR Give Epinephrine (1:10,000) 1 mg IV push Give Lidocaine as per U-Tach protocol	
		9 Asystole/EMD: Begin CPR Epinephrine (1:10,000) 1mg IV push Atropine 1 mg IV push if no response with Epinephrine	
		10. Respiratory arrest Intubation with mechanical ventilation	
		11 Notify Physician for chest pain or arrhythmias requiring treatment	
		R AV TO Dr Norris/M Higgen, RN	
		Alon Norris MD	
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GIBBON, Andrew Case 05 Dr. Norris		Admission: 04-27-YYYY DOB: 08-19-YYYY Room: 0362		DOCTORS ORDERS	
Date	Time	Physician's signature required for each order. (Please skip one line between dates.)			
27 Apr YY	1340	Inderal 90 mg qid Procardia XL 60 mg q day Isordil 10 mg qid Vasotec 25 mg q day Schedule for stress test 4/28, 1230 if possible GB US R/D stones Reg diet Up in room Alan Norris MD			
27 Apr YY	1645	Reschedule for treadmill for 1230, 29 Apr YY. Hepatobiliary scan tomorrow Alan Norris MD			
29 Apr YY	0930	Ambulate in hall w/ok lbs Lyles SCGII in am Alan Norris MD			
29 Apr YY	1600	Inderal 20 mg po qid Lyles SCGII in am Alan Norris MD			

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GIBBON, Andrew		Admission: 04-27-YYYY	
Case 05		DOB: 08-19-YYYY	
Dr. Morris		ROOM: 0362	
SPECIMEN COLLECTED: 04-29-YYYY		SPECIMEN RECEIVED: 04-29-YYYY	
LABORATORY DATA			
TEST	RESULT	FLAG	REFERENCE
Glucose	97		70-110 mg/dl
BUN	12		8-25 mg/dl
Creatinine	1.0		0.9-1.4 mg/dl
Sodium	135	**L**	135-145 mmol/L
Potassium	4.2		3.6-5.0 mmol/L
Chloride	97	**L**	99-110 mmol/L
CO2	30		21-31 mmol/L
Calcium	9.3		8.8-10.5 mg/dl
WBC	4.7		4.5-11.0 thous/UL
RBC	5.80		5.2-5.4 mill/UL
HGB	17.0		11.7-16.1 g/dl
HCT	50.1		35.0-47.0 %
Platelets	102	**L**	140-400 thous/UL
Protime	11.4		11.0-13.0
PTT	21		< 32 seconds
End of Report			
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GIBBON, Andrew		Admission: 04-27-YYYY		LABORATORY DATA	
Case05		DOB: 08-19-YYYY			
Dr. Norris		ROOM: 0362			
SPECIMEN COLLECTED:		04-29-YYYY		SPECIMEN RECEIVED: 04-29-YYYY	
URINALYSIS					
URINE DIPSTICK					
COLOR	STRAW				
SP GRAVITY	1.010			1.001-1.030	
GLUCOSE	NEGATIVE			< 125 mg/dl	
BILIRUBIN	NEGATIVE			NEG	
KETONE	NEGATIVE			NEG mg/dl	
BLOOD	NEGATIVE			NEG	
PH	7.5			4.5-8.0	
PROTEIN	NEGATIVE			NEG mg/dl	
UROBILINOGEN	NORMAL			NORMAL-1.0 mg/dl	
NITRITES	NEGATIVE			NEG	
LEUKOCYTES	NEGATIVE			NEG	
WBC	RARE			0-5 /HPF	
RBC	---			0-5 /HPF	
EPI CELLS	RARE			/HPF	
BACTERIA	---			/HPF	
CASTS.	---			< 1 HYALINE/HPF	
End of Report					
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GIBBON, Andrew	Admission: 04-27-YYYY	NUCLEAR MEDICINE REPORT
Case 05	DOB: 08-19-YYYY	
Dr. Norris	ROOM: 0362	

Reason for Ultrasound (please initial): *n/o stones*

Date Requested:

Transport: ☒ Wheelchair ☐ Stretcher ☐ O₂ ☐ IV
☒ IP ☐ OP ☐ ER
☐ PRE OP ☐ OR/RR ☐ Portable

HEPATOBIILIARY SCAN: Following injection of isotope there is prompt demonstration of the liver, gallbladder, biliary system and small bowel. This would indicate no significant obstruction of either the cystic or the common duct.

CONCLUSION: Normal hepatobiliary scan.

ABDOMINAL ULTRASOUND: Multiple real time images show that the gallbladder is of normal size without evidence of any stones or wall thickening. Portions of the kidneys, spleen, pancreas and upper aorta are demonstrated and are unremarkable.

CONCLUSION: Normal ultrasound

DD: 04-28-YYYY
DT: 04-29-YYYY

D. Lane
D. Lane, M.D.

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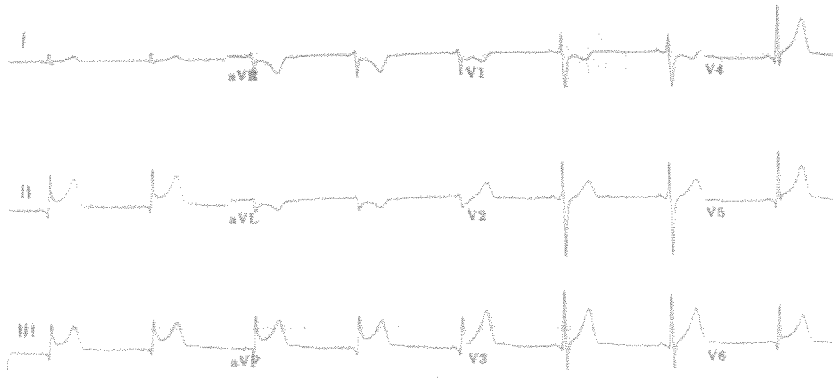
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GIBBON, Andrew		Admission: 04-27-YYYY	EKG REPORT
Case05		DOB: 08-19-YYYY	
Dr. Norris		ROOM: 0362	
	Date of EKG	04-27-YYYY	Time of EKG 11:42:03
Rate	61	Abnormal: Old inferior MI	
PR	158	non specific s-t-t changes	
QRSD	64	no old tracings for comparison	
QT	383	Clinical correlation needed.	
QTC	386		
-- Axis --			
P	1		
QRS	-27		
T	28		

Bella Kaplan, M.D.
Name of Physician



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GIBBON, Andrew		Admission: 04-27-YYYY		TREADMILL STRESS TEST	
Case 05		DOB: 08-19-YYYY			
Dr. Norris		ROOM: 0362			
Date of EKG: 04-29-YYYY		Time of EKG: 11:00			
Protocol	Manual	Time	6:45		
Age	72	Rate	116 BPM of Expected Max (197)		
Race	Caucasian	BP	150/95		
Sex	Male	Stage	1		
Ht	66 in	Speed	1.4		
Wt	160 lbs	Grade	14.0		
Opt	16	RPP	156		
Rate	72	METS	6.4		
BP	110/70	Inconclusive. Pt developed dyspnea probably due to Ischemia. No change on EKG to suggest ischemic disease. Bella Kaplan, M.D.			
Name of Physician					

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