

CASE 9

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Case 09

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
LUCK, Deborah L. 2399 Route 244 Alfred Station, NY 14802				F	W	M	Case09
				DATE OF BIRTH		MARSHEN NAME	OCCUPATION
				11-21-YYYY		Steinbeck	Teacher
ADMISSION DATE	TIME	DISCHARGE DATE	TIME	LENGTH OF STAY		TELEPHONE NUMBER	
05-01-YYYY	11:30	05-02-YYYY	11:50	01 DAYS		(607) 555-0909	
GUARANTOR NAME AND ADDRESS				NEXT OF KIN NAME AND ADDRESS			
LUCK, David 2399 Route 244 Alfred Station, NY 14802				LUCK, David 2399 Route 244 Alfred Station, NY 14802			
GUARANTOR TELEPHONE NO.		RELATIONSHIP TO PATIENT		NEXT OF KIN TELEPHONE NUMBER		RELATIONSHIP TO PATIENT	
(607) 555-0909		Husband		(607) 555-0909		Husband	
ADMITTING PHYSICIAN		SERVICE		ADMIT TYPE		ROOM NUMBER/BCD	
Ghann, MD Alan		Medical		2		0374/01	
ATTENDING PHYSICIAN		ATTENDING PHYSICIAN UPIN		ADMITTING DIAGNOSIS			
Ghann, MD Alan		100A90		Asthma			
PRIMARY INSURER		POLICY AND GROUP NUMBER		SECONDARY INSURER		POLICY AND GROUP NUMBER	
Empire Plan		556705250					
DIAGNOSES AND PROCEDURES						ICD-9-CM	ICD-10-CM/PCS
PRINCIPAL DIAGNOSIS							
Severe KAD						493.92	J45.901
SECONDARY DIAGNOSES							
w/ metabolic acidosis						276.2	E87.2
PRINCIPAL PROCEDURE							
SECONDARY PROCEDURES							
TOTAL CHARGES: \$ 1,955.95							
ACTIVITY: ☐ Bedrest ☐ Light ☐ Usual ☐ Unlimited ☐ Other:							
DIET: ☐ Regular ☐ Low Cholesterol ☐ Low Salt ☐ ADA ☐ Calorie							
FOLLOW-UP: ☐ Call for appointment ☐ Office appointment on _____ ☐ Other:							
SPECIAL INSTRUCTIONS:							
Signature of Attending Physician: Alan Ghann, MD							

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LUCK, Deborah L Case 09 Dr Ghann	Admission 05-01-YYYY DOB 11-21-YYYY ROOM 0374	CONSENT TO ADMISSION
I, <u>Deborah L. Luck</u> 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>Deborah L. Luck</u> Signature of Patient	<u>May 1, 2009</u> Date	
 Signature of Parent/Legal Guardian for Minor	 Date	
 Relationship to Minor		
<u>Andrea Wittenan</u> WITNESS: Alfred State Medical Center Staff Member	<u>May 1, 2009</u> 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>Deborah L. Luck</u> Signature of Patient	<u>May 1, 2009</u> Date	
 Signature of Parent/Legal Guardian for Minor	 Date	
 Relationship to Minor		
<u>Andrea Wittenan</u> WITNESS: Alfred State Medical Center Staff Member	<u>May 1, 2009</u> Date	
ALFRED STATE MEDICAL CENTER ■ 100 MAIN ST., ALFRED, NY 14802 ■ (607) 555-1234		

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LUCK, Deborah L. Case 09 Dr. Ghann	Admission: 05-01-YYYY DOB: 11-21-YYYY Room: 0374	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		DL
2. Have you prepared a "Living Will?" If yes, please provide the Hospital with a copy for your medical record.		X	DL
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	DL
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	DL
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	DL
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)			
Deborah L. Luck		May 1, 2009	
Signature of Patient		Date	
Andrea Wittenan		May 1, 2009	
Signature of Hospital Representative		Date	
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LUCK, Deborah L.	Admission 05-01-YYYY	HISTORY & PHYSICAL EXAM
Case 09	DOB 11-21-YYYY	
Dr. Ghann	ROOM 0374	

PAGE 1 OF 2

Mrs. Luck is a 37-year-old white female with past medical history significant for severe reactive airways disease who presents to the Emergency Room in respiratory distress. **CHIEF COMPLAINT:** Difficulty breathing progressive over the past two days.

HPI: Patient was in her usual state of health until approximately two days ago when she developed worsening of her asthma. She did not seek medical attention at that time and her symptoms progressed over the point where last night she was having difficulty sleeping. She was sitting on the edge of her bed most of the night in moderate respiratory distress. She presented to the ER this morning for evaluation and was found to be in moderately severe respiratory distress with impaired oxygenation. She is unable to give a meaningful history at this point because she is so dyspneic she cannot talk. However, she states she has not had fevers or chest pain. She has had a slight cough and she is not sure if this is due to bronchitis, infectious process or if this was due to her dyspnea. She has had a scant amount of sputum production over the past 12 hrs.

PAST HISTORY: Reactive airways disease as mentioned in the HPI. She has had one previous hospital admission. Status post C-section times two. Tonsillectomy, adenoidectomy. Cholecystectomy. Appendectomy. Right shoulder surgery. Bilateral tubal ligation.

MEDICATIONS: Proventil MDI p.r.n. Azmacort 2 puffs b.i.d. Prednisone courses are required from time to time. She is currently taking Advil for a toothache. **ALLERGIES:** Codeine, Penicillin

FAMILY HISTORY: Her father is alive with coronary artery disease post MI. Her mother is alive with diabetes mellitus, CAD, cerebrovascular disease. She has two female siblings who are alive and well with no identified health problems. There is no identified history of reactive airways disease or extrinsic asthma.

SOCIAL HISTORY: She lives with her husband and two children in Alfred Station, NY. Her children are ages 13 and 15. Habits include nonsmoking, minimal alcohol use. No excessive caffeine use. She denies excessive over the counter drug use.

ROS: LMP three weeks ago. She denies swallowing difficulties, chest pain, change in bowel habits. She has had no urinary symptoms of dysuria, frequency or urgency. She has had no joint pain, weight loss, weight gain, temperature intolerance. She performs breast self exam and has noted no new breast lesions. The remainder of the ROS is noncontributory except as mentioned in the HPI.

VITAL SIGNS: Upon presentation to the Emergency Room blood pressure was 180/120. Later repeated was 160/100. Temperature was 97.8 orally, pulse 140, respirations 40 initially. Slowed to 24 after a nebulizer treatment.

GENERAL: The patient is in moderate respiratory distress sitting on the hospital curt, alert and oriented and answers questions although she is severely dyspneic.

HEENT: Head atraumatic, normocephalic. TM's are grey bilaterally. PERRL at 2 mm. diameter. Sclera anicteric. Pharynx is moist with no lesions noted. **NECK:** Supple. There is no adenopathy.

CHEST: Reveals very poor air movement and marked expiratory wheezing throughout her entire lung field. There are no areas of decreased breath sounds. There are no crackles or rhonchi. **HEART:** Tachycardic, regular with no murmurs.

ABDOMEN: Soft, obese, nontender. No organomegaly.

BREASTS: Without masses, retractions, dimpling. There is no adenopathy.

PELVIC/RECTAL: Deferred due to patient discomfort. Will be performed during her hospital course.

Continued on next page.

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LUCK, Deborah L.	Admission 05-01-YYYY	HISTORY & PHYSICAL EXAM
Case 09	DOB 11-21-YYYY	
Dr. Ghann	ROOM 0374	
		PAGE 2 OF 2
EXTREMITIES: Without edema, cyanosis. They are warm to touch and well perfused. Good distal pulses are appreciated. NEUROLOGIC: Is nonfocal. She is alert and oriented. Has no motor or sensory deficits. Cranial nerves 2-12 are grossly intact. LAB DATA: White count 21,300, hgb. 14.8, platelets 369, segs 87, bands 4, lymphs 7. SUG H is pending. Initial blood gas on 15 liters nonrebreather face mask revealed pH of 7.286, PCO2 of 43.8, PO2 90.4, 94.6 saturated. Chest X-ray is pending at the time of this dictation. IMPRESSION/PLAN: 37-year-old white female with known reactive airways disease with an acute exacerbation probably due to an infectious process. Her white count is markedly elevated with a left shift, however she was given Epinephrine subcutaneously by Dr. Smith in the Emergency Room and this could have conceivably caused demargination of her white blood cells. She is however, breathing more comfortably on a 50% face mask at this time with oxygen saturations in the mid 90's. She is less tachypneic and she is breathing more comfortably. She is mentating well. We will load with IV Aminophyllin at 6 per kilo, ideal body weight, and follow with an infusion. Will check Theophylline level later tonight to be certain that we are avoiding toxicity. Frequent hand held nebulizer treatments, IV steroids. The rest of the regimen can be discerned from the admission orders. DD: 05-01-YYYY DT: 05-03-YYYY		
		Alan Ghann, MD
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LUCK, Deborah L		Admission: 05-01-YYYY		PROGRESS NOTES	
Case 09		DOB: 11-21-YYYY			
Dr. Ghann		ROOM: 0374			
Date	(Please skip one line between dates.)				
05-01	Chief Complaint: Respiratory distress.				
	Diagnosis: Severe RAO w/ metabolic acidosis.				
	Plan of Treatment: IV steroids, HHH txs, IV Aminophylline, O2 sat.				
05-01	3 pm Pt. seen improved. No distress. Alan Ghann, MD				
05-01	Late entry				
1400	Tx given HHA w/ 0.5 ml Pseudoephedrine via mask w/ pt. tolerating well BS ↓ w/ 4+ exp. Wheeze				
	P 130 R 28. No cough. O2 on a 50% Vent. R. Ross, CRP				
05-01	Tx given as above BS ↓ w/ harsh exp. Wheeze P 130 R 22 HPC O2 on a 50% Vent.				
1530	R. Ross, CRP				
05-01	Tx given as above BS ↓ w/ faint 4+ exp. Wheeze P 120 R 22 Harsh HPC O2 on a 50% Vent. mod				
1615	R. Ross, CRP				
05-01	HHH 0.5 ml Albuterol/nss. HR 121 RR 20. BS diminished w/ occasional exp. wheeze. Sa O ₂ 98% on 2L.				
1900	E. Blossom, RRT				
05-01	HHH 0.5 ml Albuterol/nss. HR 120 RR 24. BS - occasional rhonchi. No wheezes. Sa O ₂ 95% on 25% - ↓ to 30% VM.				
2230	E. Blossom, RRT				
05-02	HHH as above. HR 96 RR 20. BS - occasional exp. wheeze. Tight NPC. O ₂ on 28% Sa O ₂ on 30% VM 95.				
0150	E. Blossom, RRT				
05-02	HHH as above w/ 5 ml Albuterol/nss via mask BS diminished exp. wheeze. less on HHA 112 RR 20				
0450	P 130 R 28. No cough. Sa O ₂ 94% on 28% O2 on 28% vent mod Δ to 2L nasal cannula R. Ross, CRP				
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LUCK, Deborah L		Admission 05-01-YYYY	PROGRESS NOTES
Case 09		DOB: 11-21-YYYY	
Dr Ghann		ROOM 0374	
Date	(Please skip one line between dates.)		
05-02	R's given NPO n/03 at 11:00 AM / am via nasol n/03 at 1:00 PM. F ₂ ↓ n/resp. discharge F 1111 R 20		
05-02	Heard NPO 02 on a 2L NPO R. Room 0374		
05-02	S: Breathing much better. Admission about discharge today.		
	O: Afebrile, VS, O2 sat on 2L = 95%		
	CHLST - good air intake. No wheeze.		
	COM - RRR. No murmur.		
	ABD - soft.		
	A: Severe RAD, prompt resolution. Patient insists on discharge today.		
	P: Taper IV meds to pm. Check sat. Possible disch. later.		
		Alien Ghann, MD	
05-02	T's given as above. B ₂ ↓ since NPO		
11-10	F 120 R 20. O2 sat is 94 on 2L NPO		
		R Room 0374	

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LUCK, Deborah L. Case 09 Dr. Ghann		Admission 05-01-YYYY DOB: 11-21-YYYY ROOM: 0374		DOCTORS ORDERS
Date	Time	Physician's signature required for each order. (Please skip one line between dates.)		
05-01		Admit: Ghann MD		
		Di: Severe Asthma w/ resp distress		
		Vs Q2 x 24 ^h then Q4 ^h		
		Allerg: PCN ☒ Codeine		
		Diet - regular		
		IVF: D5 NS @ 125 cc/hr.		
		O2 15 L NRBFA - mean to face mask if SATs > 92%		
		STOP ILS; sputum C @ 3 if not obtained in 40		
		Lytes in ARA UA w/ c @ 2		
		MEDS: Albuterol HFA 0.5 cc am 2cc NS Q3 ^h @ Q4 ^h PRN		
		Salmeterol 125 mcg IV Q6 ^h ATC		
		Ancef 1 gm IV Q8 pending sputum results		
		Aminophylline 40 mg/hr IV Pharmacist to determine safe rate		
		Tylenol 650 mg po Q4 ^h PRN		
		Theophylline level @ 27:00 - call if < 10 or > 20.		
		O2 SATs - continuous x 8 hrs - alarms @ 92%, then Q treatment		
		Thank you		
		Alan Ghann, MD		
5/1	1515	↓ IVF to 75 cc/hr while Aminophylline is infusing. SC6 II results to chart please.		
		Alan Ghann, MD		

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LUCK, Deborah L		Admission 05-01-YYYY	
Case09		DOB 11-21-YYYY	
Dr Ghann		ROOM 0374	
SPECIMEN COLLECTED:		SPECIMEN RECEIVED:	
05-01-YYYY		05-01-YYYY	
LABORATORY DATA			
TEST	RESULT	FLAG	REFERENCE
SCG2, LYTES, BUN PANEL			
Glucose	162		70-110 mg/dl
Creatinine	0.8		0.6-1.0 mg/dl
Sodium	143		136-147 MEQ/L
Potassium	4.9		3.7-5.1 MEQ/L
Chloride	104		98-108 MEQ/L
TOTAL CO2	24		24-32 MEQ/L
Calcium	9.9		8.8-10.5 mg/dl
WBC	21.3	**H**	4.5-11.0 thous/UL
RBC	5.21		5.2-5.4 mill/UL
HGB	14.8		11.7-16.1 g/dl
HCT	45.2		35.0-47.0 %
MCV	86.8		85-99 fL
MCH	32.7		32-37
Platelets	369		140-400 thous/UL
End of Report			
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LUCK, Deborah L		Admission 05-01-YYYY	
Case09		DOB 11-21-YYYY	
Dr Ghann		ROOM 0374	
LABORATORY DATA			
SPECIMEN COLLECTED:		05-01-YYYY	SPECIMEN RECEIVED: 05-01-YYYY
TEST	RESULT	FLAG	REFERENCE
URINALYSIS			
DIPSTICK ONLY			
COLOR	CLOUDY YELLOW		
SP GRAVITY	1.025		≤ 1.030
GLUCOSE	110		≤ 125 mg/dl
BILIRUBIN	NEG		≤ 0.8 mg/dl
KETONE	TRACE		≤ 10 mg/dl
BLOOD	11	**H**	0.06 mg/dl hgb
PH	5.0		5-8.0
PROTEIN	TRACE		≤ 30 mg/dl
UROBILINOGEN	NORMAL		≤ 1 mg/dl
NITRITES	POS		NEG
LEUKOCYTE	NEG		≤ 15 WBC/hpf
EPITH	5-10		
W.B.C.	5-10		≤ 5/hpf
R.B.C.	RARE		≤ 5/hpf
BACT.	4f		1+ (≤ 20/hpf)
End of Report			
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LUCK, Deborah L.		Admission: 05-01-YYYY	
Case 09		DOB: 11-21-YYYY	
Dr. Ghann		ROOM: 0374	
LABORATORY DATA			
SPECIMEN COLLECTED: 05-01-YYYY		SPECIMEN RECEIVED: 05-01-YYYY	
TEST	RESULT	FLAG	REFERENCE
Urea Nitrogen	8		7-18 mg/dl
Alkaline Phosphatase	176	**H**	50-136 U/L
GLUCOSE	162	**H**	70-110 mg/dl
SGOT	19		15-37 U/L
Lactic Dehydrogenase	182		100-190 U/L
Phosphorus	2.7		2.5-4.9 mg/dl
Total Bilirubin	0.3		0.0-1.1 mg/dl
Total Protein	7.5		6.4-8.2 g/dl
Albumin	4.2		3.4-5.0 g/dl
Uric Acid	3.0		2.6-5.6 mg/dl
Cholesterol	186		≤ 200mg/dl
End of Report			
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LUCK, Deborah L.		Admission: 05-01-YYYY		LABORATORY DATA	
Case#9		DOB: 11-21-YYYY			
Dr. Ghann		ROOM: 0374			
SPECIMEN COLLECTED:		05-02-YYYY		SPECIMEN RECEIVED: 05-02-YYYY	
TEST	RESULT	FLAG	REFERENCE		
ELECTROLYTES PANEL					
Sodium	139		136-147 MEQ/L		
Potassium	3.9		3.7-5.1 MEQ/L		
Chloride	106		98-108 MEQ/L		
TOTAL CO2	20		24-32 MEQ/L		
End of Report					
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LUCK, Deborah L	Admission: 05-01-YYYY		
Case09	DOB: 11-21-YYYY	LABORATORY DATA	
Dr. Ghann	ROOM: 0374		
SPECIMEN COLLECTED:	05-01-YYYY	SPECIMEN RECEIVED:	05-01-YYYY
Theophylline Level			
TEST	RESULT	FLAG	REFERENCE
Theophylline	9.3	**L**	10.0-20.0 UG/ML
End of Report			
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LUCK, Deborah L	Admission: 05-01-YYYY	LABORATORY DATA
Case#09	DOB 11-21-YYY	
Dr Ghann	ROOM 0374	
SPECIMEN COLLECTED:	05-01-YYYY	SPECIMEN RECEIVED: 05-01-YYYY
TEST: Urine Culture		
2+ gram negative rod		
1. cc $\geq$ 100,000		
E. coli		
End of Report		
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Case 09 * 251

LUCK, Deborah L	Admission: 05-01-YYYY	
Case 09	DOB: 11-21-YYYY	
Dr. Ghann	ROOM: 0374	RADIOMETRY
SPECIMEN COLLECTED: 05-01-YYYY	SPECIMEN RECEIVED: 05-01-YYYY	

TEST	RESULT
BLOOD GAS VALUES	
pH	7.286
pCO ₂	43.8 mmHg
pO ₂	90.4 mmHg
TEMPERATURE CORRECTED VALUES	
pH (98.6°)	7.286
pCO ₂ (98.6°)	43.8 mmHg
pO ₂ (98.6°)	90.4 mmHg
ACID BASE STATUS	
HCO ₃ c	20.2 mmol/L
ABEc	-5.9 mmol/L
BLOOD OXIMETRY VALUES	
tHb	14.4 g/dL
O ₂ Hb	94.6%
COHb	0.2%
MetHb	0.6%
End of Report	

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