ED Provider Notes by Nayak, Hemant R, MD at 03/12/18 1824

Author: Nayak, Hemant R, MD | Service: (none) | Author Type: Physician
Filed: 03/12/18 2200 | Date of Service: 03/12/18 1824 | Status: Signed
Editor: Nayak, Hemant R, MD (Physician)

ISSAQUAH EMERGENCY DEPARTMENT

Patient Name: Omana Thankamma
Medical Record Number: 1003965862
Visit Date/time: 3/12/2018 5:42 PM
Mode of Arrival:Ambulance
Accompanied by: EMS Personnel
Primary Care Provider: No primary care provider on file.

History Obtained From: Information obtained from: police, social work, patient's son

BRIEF ED ASSESSMENT & TREATMENT SUMMARY

CHIEF COMPLAINT

Chief Complaint
Patient presents with

- ALLEGED DOMESTIC VIOLENCE

ED PHYSICIAN ASSESSMENT AND CLINICAL SUMMARY

Omana Thankamma is a 76 y.o. female who apparently is brought in after a complaint of possible neglect or inappropriate care. Apparently a neighbor was concerned when a caregiver approached them to ask a question and called the police. When they investigated they were concerned that care was not appropriate, caregiver might have been intoxicated, caregiver was not licensed and didn't seem to know how to care for the patient.

On arrival here the patient is contracted and largely nonverbal (I did witness her saying a few words to her son later). This is apparently her baseline. Her skin is generally very well cared for and there are no signs of trauma or neglect. There is a small area of skin breakdown in the perineum where the foley catheter seems to have broken through the skin.

I have spoken to the son who has arrived in the department and he seems to be quite caring and well-informed in regards to her care.

As risk management states we have no grounds to hold the patient at this time and she seems medically at her baseline, she will be discharged to follow up with her doctor pending investigation

FINAL DIAGNOSIS

		ICD-10-CM	ICD-9-CM
1.	**Dehydration**	**E86.0**	**276.51**
2.	Vascular dementia without behavioral disturbance	F01.50	290.40

DISCHARGE MEDICATIONS

New Prescriptions

No medications on file

FOLLOW-UP CARE

Issaquah Emergency Department
751 Ne Blakely Drive
Issaquah Washington 98029-6201
425-394-0610

As needed

DISPOSITION

Omana Thankamma is discharged to home well appearing and well hydrated in stable condition. Discharge diagnosis, instructions and plan were discussed and understood. The patient /family understood to return immediately to the emergency department if the symptoms worsen or if they have any additional concerns.

EXTENDED ED RECORD

HISTORY OF PRESENT ILLNESS (complete)

Omana Thankamma is a 76 y.o. female who apparently is brought in after a complaint of possible neglect or inappropriate care. Apparently a neighbor was concerned when a caregiver approached them to ask a question and called the police. When they investigated they were concerned that care was not appropriate, caregiver might have been intoxicated, caregiver was not licensed and didn't seem to know how to care for the patient.

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ED Records (continued)

ED Provider Notes by Nayak, Hemant R, MD at 03/12/18 1824 (continued)

REVIEW OF SYSTEMS

Patient unable to answer

Other pertinent items as noted in the HPI
All other systems reviewed and are negative

PAST MEDICAL HISTORY

Reviewed and

Past Medical History:

Diagnosis	Date
• Diabetes mellitus (HCC)	
• High blood pressure	
• Mental health problem	

There are no active problems to display for this patient.

PAST SURGICAL HISTORY

Reviewed and

Past Surgical History:

Procedure	Laterality	Date
• CARDIAC SURG PROCEDURE UNLIST		

SOCIAL HISTORY

Social History

Substance Use Topics

- Smoking status: Unknown If Ever Smoked
- Smokeless tobacco: Never Used
- Alcohol use No

No other significant social issues identified by me.

FAMILY HISTORY

No family history on file.
Family history reviewed by me.

CURRENT MEDICATIONS

Previous Medications

No medications on file

ALLERGIES

Allergies not on file

ED Records (continued)

ED Provider Notes by Nayak, Hemant R, MD at 03/12/18 1824 (continued)

VITAL SIGNS

Patient Vitals for the past 24 hrs:

	Temp	BP	Heart Rate	Pulse Rate	Resp	SpO2
03/12/18 2050	-	124/73	-	82 bpm	14	97 %
03/12/18 2000	-	131/62	-	78 bpm	14	98 %
03/12/18 1930	-	126/70	88	-	14	98 %
03/12/18 1741	36.4 °C (97.6 °F)	115/72	-	77 bpm	15	100 %

PHYSICAL EXAM

General Appearance: elderly, contracted, nonverbal
Head: Atraumatic, normocephalic, normal facies
Ears: external ears normal,
Eyes: PERRL, EOM's intact, no drainage, no erythema
Nose: nares normal, mucosa normal, no drainage or sinus tenderness
Throat: oropharynx normal, mucous membranes dry, teeth and gums unremarkable
Neck: neck supple, no adenopathy, no meningismus
Lungs: Clear to auscultation, equal breath sounds, no wheezing or crackles, good air movement, no respiratory distress
Heart: Regular rate and rhythm. No murmurs or noted abnormal heart sounds
Abdomen: Benign and soft. G tube in place
Neuro: alert and oriented, conversant, no focal deficits noted
Extremities: Extremities atraumatic, warm, without cyanosis or edema.
Psych: Normal, appropriate interactions
Lymphatic: no significant adenopathy
Skin: Normal, warm and dry without rash or jaundice - area of skin breakdown at the perineum where the foley catheter appears to have been against the skin

DATA GATHERING

The patient was seen and evaluated by myself.
I reviewed the nurses notes and flow sheets.
Prior EMR records reviewed in EPIC as available and clinically relevant.

ED LABS AND STUDIES

Results for orders placed or performed during the hospital encounter of 03/12/18 (from the past 24 hour(s))
POCT GROUP CHEM 8+ (HGB,HCT,BMP-ICA)
Collection Time: 03/12/18 6:05 PM

Result	Value	Ref Range
SODIUM-POCT	140	138 - 146 mmol/L

ED Records (continued)

ED Provider Notes by Nayak, Hemant R, MD at 03/12/18 1824 (continued)

POTASSIUM-POCT	4.3	3.5 - 4.9 mmol/L
CHLORIDE-POCT	102	98 - 109 mmol/L
TOTAL CO2-POCT	28	24 - 29 mmol/L
ANION GAP-POCT	15	10 - 20 mmol/L
BUN-POCT	27 (H)	8 - 26 mg/dL
CREAT-POCT	0.6	0.6 - 1.3 mg/dL
GLUCOSE-POCT	190 (H)	70 - 105 mg/dL
CALCIUM,ION (MMOL/L)-POCT	1.30	1.12 - 1.32 mmol/L
HEMOGLOBIN-POCT	12.9	12.0 - 17.0 g/dL
HEMATOCRIT-POCT	38	38 - 51 %PCV

CBC WITH DIFF (ABS-%)

Collection Time: 03/12/18 6:34 PM

Result	Value	Ref Range
WBC	9.2	3.4 - 10.8 th/mm3
RBC	4.30	3.77 - 5.28 mil/mm3
HGB	11.9	11.1 - 15.9 g/dL
HCT	39.2	34.0 - 46.6 %
MCV	91	79 - 97 fL
MCH	27.7	26.6 - 33.0 pg
MCHC	30.4 (L)	31.5 - 35.7 g/dL
RDW	14.1	12.3 - 15.4 %
PLATELET CT	347	150 - 379 x10E3/uL
POLYS-AUTO	5.83	1.4 - 7.0 th/mm3
LYMPHS	2.39	0.7 - 3.1 th/mm3
MONOS	0.74	0.1 - 0.9 th/mm3
EOSINOPHILS	0.18	0.0 - 0.4 th/mm3
BASOPHILS	0.00	0.0 - 0.2 th/mm3
POLYS-AUTO,%	64	Not Established %
LYMPHS,%	26	Not Established %
MONOS,%	8	Not Established %
EOSINOPHIL %	2	Not Established %
BASOPHILS,%	0	Not Established %
IMMATURE GRANULOCYTES	1	See Notes %
IMMATURE GRAN ABSOLUTE VALUE	0.05	See Notes th/mm3

HEPATIC FUNCTION PANEL

Collection Time: 03/12/18 6:34 PM

Result	Value	Ref Range
PROTEIN,TOTAL	7.6	6.0 - 8.5 g/dL
ALBUMIN, S	3.6	3.5 - 4.8 g/dL
BILIRUBIN,TOTAL	<0.2	0.1 - 1.2 mg/dL
BILIRUBIN,DIR	<0.2	0 - 0.4 mg/dL
ALT (GPT)	12	0 - 32 U/L
AST(GOT)	11	0 - 40 U/L
ALK PTASE	71	39 - 117 U/L

LACTATE POCT

Collection Time: 03/12/18 6:39 PM

Result	Value	Ref Range

ED Records (continued)

ED Provider Notes by Nayak, Hemant R, MD at 03/12/18 1824 (continued)

SPECIMEN TYPE-POCT	VEN	
LACTATE-POCT	0.86 (L)	0.90 - 1.70 mmol/L

URINALYSIS WITH CULTURE IF INDICATED

Collection Time: 03/12/18 7:45 PM

Result	Value	Ref Range
COLOR	Yellow	Yellow
APPEARANCE	SL CLDY	Clear
SPEC GRAV	1.020	1.005 - 1.030
BILIRUBIN	Negative	Negative
KETONES	Negative	Negative
GLUCOSE	Negative	Negative
PROTEIN	Negative	Negative/Trace
HEMOGLOBIN	Negative	Negative
PH	8.0 (H)	5.0 - 7.5
UROBILINOGEN	0.2	0.2 - 1.0 mg/dL
NITRITE	Negative	Negative
LEUK ESTERASE	2+ (A)	Negative
RBC	0-2	0 - 2 /hpf
WBC	11-30 (A)	0 - 5 /hpf
BACTERIA	Many	None-Few seen(<10) /hpf
EPITHELIAL CELLS, NON RENAL	0-10	0 - 10 /hpf
CRYSTALS	Present	See Notes
CRYSTAL TYPE	MIXED	See Notes
CULTURE INDICATED?	Yes (A)	See Notes

Urine Multistix

The above studies were interpreted by me contemporaneously in the emergency department.

Labs were reviewed

Radiology studies ordered and interpreted by radiology include

CT HEAD WITHOUT CONTRAST

Final Result

ED Records (continued)

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1. No intracranial hemorrhage, midline shift or hydrocephalus.
2. Findings compatible with remote chronic right MCA distribution infarct with encephalomalacia in the right frontal, right parietal, right insular and anterior right temporal lobe with Wallerian degeneration. Areas of calcification within the subcortical right frontal lobe likely within sites of previous remote hemorrhages.
Clinical correlation suggested.

Dictated by: DANIEL SUSANTO
Dictated: 3/12/2018 7:25 PM
Job: 3244538

EMERGENCY DEPARTMENT COURSE/INTERVENTIONS

Medications administered in the Emergency Department include: IVNS 500 cc

MEDICAL DECISION MAKING

Diagnoses considered include neglect or abuse, CVA/TIA, metabolic abnormality, sepsis, infection, hypokalemia, dehydration, malnutrition, neuropathy or pinched nerve, MI/cardiac ischemia, hypoxia, head injury/bleed, and acute spinal insult.

PROCEDURES IN THE EMERGENCY DEPARTMENT

Please see top of note for assessment, diagnosis and disposition.

Hemant Nayak MD
3/12/2018
18:27

END OF REPORT