

Patient Name: [REDACTED]  
MRN: [REDACTED]  
Encounter: [REDACTED]

Admit Date: 9/28/2020  
Discharge Date: 9/30/2020

### Discharge Summary

Document Type: Discharge Summary  
Service Date/Time: 9/30/2020 19:04 EDT  
Result Status: Auth (Verified)  
Document Subject: Discharge Summary  
Perform Information: [REDACTED] MD (9/30/2020 19:05 EDT)  
Sign Information: [REDACTED] MD (9/30/2020 20:27 EDT)

**Dates of Service**  
9/28/2020-9/30/2020

#### Admission Information

Patient is a 47-year-old female with a history of gastric bypass and GI bleed in the past came to the ER complaining of severe abdominal pain started yesterday associate with nausea and vomiting. She denies any associated fever or chills. No diarrhea. She describes the pain as sharp and diffuse 8-9 out of 10 and it is constant. She denies any dysuria or hematuria. She denies any vaginal discharge. Patient had CT of the abdomen done that showed development of moderate to large ascites, dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum. Patient also had elevated lipase and a low potassium level. She also had ultrasound of the right upper quadrant that showed pneumobilia. So patient is admitted for further treatment and evaluation of pancreatitis and possible obstruction of the biliary portion of the gastric bypass and for further treatment and evaluation of other medical problems.

#### Hospital Course

This is 47 year old female with PMH as above who was admitted with an abdominal pain, suspected and acute pancreatitis. Was placed on interavenous fluids, Zosyn. GI and Surgery were consulted. Was hypertensive and received Hydralazine in ED. Ultrasound showed pneumobilia. Patient became hypotensive and hypothermic and received fluid bolus. Core rescue was called and patient was transferred to CCU. Blood cultures were obtained. Was evaluated by surgery and bowel obstruction was suspected. Underwent under an urgent exploratory laparotomy, lysis of adhesions, small bowel resection including Rouex-en-Y and distal bowel resection, gastrostomy tube placement in remnant stomach. Patient was found to have large portion of the bowel necrotic and developed multiorgan failure after procedure. Developed respiratory failure, circulatory, renal failure. We adjusted antibiotics to Fluconazole and continued Zosyn. ID was consulted. Patient developed DIC and we continued blood transfusion, cryoprecipitate and plasma transfusion per protocol. We continued fluid resuscitation. Renal function become worse. Nephrology was consulted and patient was started on CRRT. Patient developed hypotensive shock and was placed on maximum doses of Levophed and Vasopressin. Remained hypothermic. We monitored hemoglobin very closely and followed DIC. Patient received multiple RBC transfusion, cryoprecipitate. Was not able to tolerate CRRT due to hypotensive shock. Patient developed worsening of encephalopathy and we noticed dilated pupils and absent corneal reflexes. Head CT was ordered. Surgery reevaluated patient and was considering surgical intervention after head CT. Patient developed asystole and code blue was called. ICU team followed ACLS protocol but patient expired from multiorgan failure at 149 PM.

Significant Findings

#### \* Final Report \*

ABD [REDACTED]  
[REDACTED]  
[REDACTED] Sep 28 2020 11:02P  
\*\*\*FINAL RESULT\*\*\*

PROCEDURE: SCT 4412 ABD PEL CT WO IV WO PO CON

PROCEDURE: ABD PEL CT WO IV WO PO CON

CLINICAL INDICATION:

Abdominal pain generalized abdominal pain

COMPARISON:

02/06/2020

TECHNIQUE: 2.5 mm collimation was utilized to image from the lung bases to the symphysis pubis without administration of IV contrast. Oral contrast not given. Sagittal and coronal reconstructions were also reviewed.

Patient Name: [REDACTED]

MRN: [REDACTED]

[REDACTED]

[REDACTED] [REDACTED]  
Discharge Date: 9/30/2020

## Discharge Summary

Radiation dose reduction techniques used for this exam include: Iterative Reconstruction Technique and/or adjustments of the mA/kV according to patient size. DICOM images are available.

### DISCUSSION:

#### Lungs/pleura:

Lung bases are clear without pleural effusions.

#### Liver/spleen:

The liver has a grossly normal noncontrast CT appearance. The spleen is nonenlarged. Patient status post gastric bypass no biliary pancreatic portion of the gastric bypass remains markedly dilated with segmental thickening of the proximal jejunum. There is a moderate intra-abdominal and pelvic amount of ascites.

#### Adrenals:

The adrenal glands are unremarkable.

#### Pancreaticobiliary:

Pancreas has a grossly normal noncontrast CT appearance. Gallbladder surgically removed.

#### Genitourinary:

4 mm nonobstructing left renal calyceal calculi present. Bladder collapsed limiting evaluation.

#### Lymph nodes:

No enlarged abdominal or pelvic nodes are present.

#### Bowel:

There continues to be diffuse dilated appearance to the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum .

#### Osseous structures:

There are no osseous destructive lesions.

### IMPRESSION:

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology

Signed Electronically [REDACTED] - 9/28/2020 11:07 PM

### Procedures and Treatment Provided

#### Preoperative Diagnosis

Small bowel obstruction

Ischemic bowel

History of open gastric bypass

#### Postoperative Diagnosis

Small bowel obstruction caused by adhesive band

Necrotic biliopancreatic limb

Necrotic distal small bowel

#### Operative Procedure Performed:

Exploratory laparotomy

Lysis of adhesions

Small bowel resection including Roux-en-Y (biliary pancreatic limb including Roux-en-Y)

Distal small bowel resection

Gastrostomy tube placement in remnant stomach

## Discharge Summary

### Surgeon(s)

Consults  
Surgery, Neurology, IVR  
Physical Exam

Vitals & Measurements

**HR:** 116 (Monitored) **RR:** 22 **RR:** 30 (Total) **BP:** 68/18 **BP:** 114/88 (Line) **SpO2:** 38% **WT:** 81.0 kg (Measured)  
patient was examined earlier on rounds. Please refer to my physical exam.

### Discharge Medications

Home

cloNIDine 0.3 mg oral tablet, 0.3 mg= 1 tabs, Oral, TID  
diazepam 10 mg oral tablet, 10 mg= 1 tabs, Oral, Every 6 hr, PRN  
IBU 800 mg oral tablet, 800 mg= 1 tabs, Oral, Every 8 hrs, PRN

### Discharge Diagnoses and Plan

- 1. Acute respiratory failure** (J96.00: Acute respiratory failure, unspecified whether with hypoxia or hypercapnia)  
was on full AC support
- 2. Severe sepsis** (R65.20: Severe sepsis without septic shock)  
due to necrotic bowel. On Zosyn and Diflucan
- 3. DIC (disseminated intravascular coagulation)** (D69: Disseminated intravascular coagulation [defibrination syndrome])  
received multiple RBC, FFP, cryoprecipitate
- 4. Lactic acidosis** (E87.2: Acidosis)  
due to SBO
- 5. SBO (small bowel obstruction)** (K56.609: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction)  
s/p resection
- 6. Acute blood loss anemia** (D62: Acute posthemorrhagic anemia)  
received multiple RBC, cryoprecipitate transfusion
- 7. H/O gastric bypass** (Z98.84: Bariatric surgery status)  
s/p surgical resection
- 8. Pneumobilia** (K83.8: Other specified diseases of biliary tract)  
on IV Zosyn and Diflucan
- 9. Acute hypokalemia** (Hypokalemia)  
replaced
- 10. Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)
- 11. Acute hyperglycemia** (R73.9: Hyperglycemia, unspecified)  
was on SSI
- 12. Ascites** (R18.8: Other ascites)  
was seen by IVR but was not candidate for intervention due to hypotensive shock
- 13. Benign HTN** (I10: Essential (primary) hypertension)  
was in hypotensive shock
- 14. Acute metabolic encephalopathy** (G93.41: Metabolic encephalopathy)  
worsened

**Palliative care encounter** (Z51.5: Encounter for palliative care)

Orders:

CBC with Diff (BHSF), Blood, Routine, 10/01/20 5:00:00 EDT, Once  
Renal Function Panel, Blood, Routine, 10/01/20 5:00:00 EDT, Once

### Patient Discharge Condition

Expired.

### Discharge Disposition

Patient is expired.

Time Spent

I spent 45 minutes on discharge process.

Discharge Date: 9/30/2020

**Emergency Documentation**

Document Type:	ED Triage Note
Service Date/Time:	9/28/2020 20:58 EDT
Result Status:	Auth (Verified)
Document Subject:	ED Triage Part 2 - Adult
Perform Information:	[REDACTED] RN (9/28/2020 20:58 EDT)
Sign Information:	[REDACTED] RN (9/28/2020 20:58 EDT)

**ED Triage Part 2 - Adult Entered On: 09/28/2020 20:59 EDT**  
**Performed On: 09/28/2020 20:58 EDT** [REDACTED]

**General Assessment**

*Document Falls Risk* : Falls Assessment  
*Document Social History* : Open social history documentation  
*Behavioral Health Concern* : Launch  
*Domestic Concerns* : None  
*Document Human Trafficking Screening* : Open Human Trafficking [REDACTED] - 09/28/2020 20:58 EDT

**DGP GENERIC CODE**

*You/household traveled in last 30 days?* : No  
*Fever* : No  
*Diarrhea* : No  
*Headache* : No  
*Photophobia* : No  
*Illness With Generalized Rash* : No  
*New or Worsening Cough* : No  
*Recent Exposure to Communicable Disease* : No  
*History of MDRO* : No  
*History of CRE* : No  
*Immunocompromised* : No

*Preferred Language* : English [REDACTED] - 09/28/2020 20:58 EDT  
[REDACTED] - 09/28/2020 20:58 EDT  
(As Of: 09/28/2020 20:59:00 EDT)

**Problems(Active)**

Anxiety (SNOMED CT :BgCTWgDjf6PNMBadCwsLDQ )  
*Name of Problem:* Anxiety ; *Recorder:* [REDACTED]  
*Jesus;* *Confirmation:* Confirmed ; *Classification:* Medical ;  
*Code:* BgCTWgDjf6PNMBadCwsLDQ ; *Contributor System:* PowerChart ; *Last Updated:* 05/19/2018 20:08 EDT ; *Life Cycle Date:* 05/19/18 ; *Life Cycle Status:* Active ; *Vocabulary:* SNOMED CT

Benign HTN (SNOMED CT :AZEGxwEmL07HeYbhwKgAAg )  
*Name of Problem:* Benign HTN ; *Recorder:* [REDACTED]  
*MD;* *Confirmation:* Confirmed ; *Classification:* Medical ;  
*Code:* AZEGxwEmL07HeYbhwKgAAg ; *Contributor System:* PowerChart ; *Last Updated:* 05/20/2018 10: 11 EDT ; *Life Cycle Date:* 05/20/18 ; *Life Cycle Status:* Active ; *Vocabulary:* SNOMED CT

**Emergency Documentation**

Diagnoses(Active)

Abdominal pain  
*Date:* 09/28/2020 ; *Diagnosis Type:* Reason For Visit ;  
*Confirmation:* Complaint of ; *Clinical Dx:* Abdominal pain ;  
*Classification:* Medical ; *Clinical Service:* Emergency  
medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:*  
4858AFEB-7C01-4A67-B4F5-9B3A35EA1FC8

Diarrhea  
*Date:* 09/28/2020 ; *Diagnosis Type:* Reason For Visit ;  
*Confirmation:* Complaint of ; *Clinical Dx:* Diarrhea ;  
*Classification:* Medical ; *Clinical Service:* Emergency  
medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:*  
8D82A80D-24DB-4E0E-99CE-8A341D8BFEEE

Nausea  
*Date:* 09/28/2020 ; *Diagnosis Type:* Reason For Visit ;  
*Confirmation:* Complaint of ; *Clinical Dx:* Nausea ;  
*Classification:* Medical ; *Clinical Service:* Emergency  
medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:*  
A110D0D0-N1fC10-4waeg

Vomiting  
*Date:* 09/28/2020 ; *Diagnosis Type:* Reason For Visit ;  
*Confirmation:* Complaint of ; *Clinical Dx:* Vomiting ;  
*Classification:* Medical ; *Clinical Service:* Emergency  
medicine ; *Code:* PNED ; *Probability:* 0 ; *Diagnosis Code:*  
A9FB7B2F-63E4-4BAA-8832-6D1C58823B2D

**Social History**

Social History

(As Of: 09/28/2020 20:59:00 EDT)

Tobacco:

Never smoker (Last Updated: 06/08/2018 03:18:26 EDT by  
Tobacco Use: Never (less than 100  
in lifetime). (Last Updated: 02/05/2020 02:50:24 EST by  
RN) Tobacco Use: Never (less than 100 in  
lifetime). (Last Updated: 09/28/2020 20:58:49 EDT by  
RN)

Alcohol:

Denies use )

Substance Use:

Denies ( )

**CSSRS Screen**

- 1. Have you wished you were dead or wished you could go to sleep and not wake up? (ref) : Past month, no
- 2. Have you actually had any thoughts of killing yourself? (ref) : Past month, no
- 6a. Have you ever done anything, started to do anything, or prepared to do anything to end your life? (ref) : Past month, no

Discharge Date: 9/30/2020

**Emergency Documentation**

[REDACTED] - 09/28/2020 20:58 EDT

**Human Trafficking Screening**

Does the nurse observe any of the following Human Trafficking signs? : No

[REDACTED] 09/28/2020 20:58 EDT

Document Type: ED Triage Note  
Service Date/Time: 9/28/20 20:55 EDT  
Result Status: Auth (Verified)  
Document Subject: ED Triage Part 1 - Adult  
Perform Information: [REDACTED] (9/28/2020 20:55 EDT)  
Sign Information: [REDACTED] (9/28/2020 20:55 EDT)

**ED Triage Part 1 - Adult Entered On: 09/28/2020 20:58 EDT**  
**Performed On: 09/28/2020 20:55 EDT by [REDACTED]**

**ED Triage Part 1 - [REDACTED]**

Chief Complaint : Abdominal pain , Nausea, Vomiting and diarrhea  
Onset Date/Time : 09/28/2020 20:56 EDT  
Lynx Mode of Arrival : Private vehicle  
History Obtained From : Patient  
Arrived from : Home  
You/household traveled in last 30 days? : No  
ED Open Pain Scale : Numeric  
Temperature Oral : 36.5 Deg C(Converted to: 97.7 Deg F)  
Systolic Blood Pressure : 108 mmHg  
Diastolic Blood Pressure : 89 mmHg  
Peripheral Pulse Rate : 130 bpm (>HHI)  
Respiratory Rate : 18 br/min  
SpO2 : 98 %  
Oxygen Therapy : Room air  
ED Allergies/Med Hx Section : Document Assessment  
Suspected sources of Infection : Document sources  
Actual Weight : 69.1 kg(Converted to: 152 lb 5 oz)  
Height/Length Measured : 152.4 cm(Converted to: 5 ft 0 in)  
Body Mass Index Measured : 29.75 kg/m2

[REDACTED] 09/28/2020 20:55 EDT

**DCP GENERIC CODE**

Tracking Acuity : 3 - Urgent  
Tracking Group : ED SM Tracking Group

[REDACTED] - 09/28/2020 20:55 EDT  
(As Of: 09/28/2020 20:58:36 EDT)

**Problems(Active)**

Anxiety (SNOMED CT :BgCTWgDjf6PNMBadCwsLDQ)  
Name of Problem: Anxiety ; Recorder: [REDACTED]  
Confirmation: Confirmed ; Classification: Medical ;  
Code: BgCTWgDjf6PNMBadCwsLDQ ; Contributor System:  
PowerChart ; Last Updated: 05/19/2018 20:08 EDT ; Life Cycle

Discharge Date: 9/30/2020

**Emergency Documentation**

Date: 05/19/18 ; Life Cycle Status: Active ; Vocabulary: SNOMED CT

Benign HTN (SNOMED CT :AZEGxwEmL07HeYbhwKgAAg )

Name of Problem: Benign HTN ; Recorder: Patricoff, Tracey C MD; Confirmation: Confirmed ; Classification: Medical ; Code: AZEGxwEmL07HeYbhwKgAAg ; Contributor System: PowerChart ; Last Updated: 05/20/2018 10:11 EDT ; Life Cycle Date: 05/20/18 ; Life Cycle Status: Active ; Vocabulary: SNOMED CT

Diagnoses(Active)  
Abdominal pain

Date: 09/28/2020 ; Diagnosis Type: Reason For Visit ; Confirmation: Complaint of ; Clinical Dx: Abdominal pain ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: PNED ; Probability: 0 ; Diagnosis Code: 4858AFEB-7C01-4A67-B4F5-9B3A35EA1FC8

Diarrhea

Date: 09/28/2020 ; Diagnosis Type: Reason For Visit ; Confirmation: Complaint of ; Clinical Dx: Diarrhea ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: PNED ; Probability: 0 ; Diagnosis Code: 8D82A80D-24DB-4E0E-99CE-8A341D8BFEEE

Nausea

Date: 09/28/2020 ; Diagnosis Type: Reason For Visit ; Confirmation: Complaint of ; Clinical Dx: Nausea ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: PNED ; Probability: 0 ; Diagnosis Code: AH9DQD9cNvfGoOn4waeg

Vomiting

Date: 09/28/2020 ; Diagnosis Type: Reason For Visit ; Confirmation: Complaint of ; Clinical Dx: Vomiting ; Classification: Medical ; Clinical Service: Emergency medicine ; Code: PNED ; Probability: 0 ; Diagnosis Code: A9FB7B2F-63E4-4BAA-8832-6D1C58823B2D

**ED Triage Allergies/Meds**

(As Of: 09/28/2020 20:58:36 EDT)

Allergies (Active)  
morphine

Estimated Onset Date: Unspecified ; Created By: RN; Reaction Status: Active ; Category: Drug ; Substance: morphine ; Type: Allergy ; Severity: Unknown ; Updated By: ; Reviewed Date: 09/28/2020 20:57 EDT

**Medication List**

(As Of: 09/28/2020 20:58:36 EDT)

Home Meds  
cloNIDine

: cloNIDine ; Status: Documented ; Ordered As Mnemonic: cloNIDine 0.1 mg oral tablet ; Simple Display Line: 1 tabs, Oral, TID ; Ordering Provider: ; Catalog Code: cloNIDine ; Order Dt/Tm: 02/05/2020 02:34:56

Discharge Date: 9/30/2020

### Emergency Documentation

ibuprofen : ibuprofen ; Status: Documented ; Ordered As Mnemonic: IBU 800 mg oral tablet ; Simple Display Line: 1 tabs, Oral, Every 8 hrs, PRN: pain, moderate (scale 4-6), 0 Refill(s) ; Ordering Provider: [REDACTED] ; Catalog Code: ibuprofen ; Order Dt/Tm: 02/05/2020 02:34:56

amLODIPine : amLODIPine ; Status: Documented ; Ordered As Mnemonic: amLODIPine 5 mg oral tablet ; Simple Display Line: 1 tabs, Oral, Daily, 0 Refill(s) ; Ordering Provider: [REDACTED] MD ; Catalog Code: amLODIPine ; Order Dt/Tm: 02/05/2020 02:34:56

diazePAM : diazePAM ; Status: Documented ; Ordered As Mnemonic: diazePAM 10 mg oral tablet ; Simple Display Line: 1 tabs, Oral, Every 6 hr, PRN: as needed for anxiety ; Ordering Provider: [REDACTED] MD ; Catalog Code: diazePAM ; Order Dt/Tm: 02/05/2020 02:34:56

#### Suspected Source of Infection

Patient displays signs or symptoms of infection : Yes

[REDACTED] - 09/28/2020 20:55 EDT

#### Numeric

Numeric Pain Score (0-10) : 10

Primary Pain Location : Abdomen

Primary Pain Time Pattern : Constant

[REDACTED] - 09/28/2020 20:55 EDT

Document Type:

Service Date/Time:

Result Status:

Document Subject:

Perform Information:

Sign Information:

ED Note Physician

9/28/2020 21 :05 EDT

Auth (Verified)

Abdominal Pain ED

[REDACTED] (9/28/2020 21 :11 EDT)

[REDACTED] (9/29/2020 05:16 EDT)

#### Abdominal Pain ED

[REDACTED] Age: 47 years Sex: Female DOB: 07/23/73

Associated Diagnoses: Acute pancreatitis; Acute pancreatitis

Author: [REDACTED]

## **Emergency Documentation**

### **Basic Information**

**Time seen:** Date & time 09/28/20 21:06:00.

**History source:** Patient.

**Arrival mode:** Private vehicle.

**History limitation:** None.

**Additional information:** Chief Complaint from Nursing Triage Note : Chief Complaint  
09/28/20 20:55 EDT Chief Complaint Abdominal pain , Nausea, Vomiting and diarrhea .

### **History of Present Illness**

The patient presents with abdominal pain. The onset was started today. The course/duration of symptoms is constant and worsening. The character of symptoms is sharp. The degree at onset was moderate. The Location of pain at onset was diffuse and abdominal. The degree at present is moderate. The Location of pain at present is diffuse and abdominal.

Radiating pain: none. The exacerbating factor is none. The relieving factor is none. Therapy today: none. Risk factors consist of diabetes mellitus and history of bypass surgery. Associated symptoms: nausea, vomiting, diarrhea, denies chest pain, denies back pain, denies shortness of breath, denies fever, denies chills, denies headache and denies dizziness.

Additional history:

47 y.o F with an active history of [REDACTED] surgery on 2013, having had GI bleed back in February as per records, presents to the ED c.o diffuse abdominal pain started today with associated nausea, vomiting, and diarrhea. As per records, patient had a suddenly drop of her hemoglobin level, had blood transfusion done along with angiogram, but it was unable to determine the source of bleeding at that time. While on evaluation, patient stated complaint of chest pain as well; denies any fever, chills, and denies any other symptoms or complains..

### **Review of Systems**

**Constitutional symptoms:** No fever, no chills, no sweats, no weakness.

**Skin symptoms:** No rash,

**Eye symptoms:** Vision unchanged.

**ENMT symptoms:** No ear pain, no nasal congestion.

**Respiratory symptoms:** No shortness of breath, no cough.

**Cardiovascular symptoms:** Chest pain.

**Gastrointestinal symptoms:** Abdominal pain, nausea, vomiting, diarrhea.

**Genitourinary symptoms:** No dysuria,

**Musculoskeletal symptoms:** No back pain,

**Neurologic symptoms:** No headache, no dizziness, no altered level of consciousness, no numbness, no tingling, no weakness.

**Psychiatric symptoms:** No anxiety,

**Additional review of systems information:** All other systems reviewed and otherwise negative, All systems reviewed as documented in chart.

1

### **Health Status**

#### **Allergies:**

Allergic Reactions (All)

Unknown

Morphine- No reactions were documented.

Canceled/Inactive Reactions (All)

No Known Allergies.

**Medications:** (Selected)

Documentation

Documented Medications

*Documented*

IBU 800 mg oral tablet: 1 tabs, Oral, Every 8 hrs, PRN: pain, moderate (scale 4-6), 0 Refill(s)  
amLODIPine 5 mg oral tablet: 1 tabs, Oral, Daily, 0 Refill(s)  
cloNIDine 0.1 mg oral tablet: 1 tabs, Oral, TID  
diazepam 10 mg oral tablet: 1 tabs, Oral, Every 6 hr, PRN: as needed for anxiety.

**Past Medical/ Family/ Social History**

**Medical history:**

Active

Anxiety (BgCTWgDjf6PNMBadCwsLDQ)  
Benign HTN (AZEGxwEmL07HeYbhwKgAAg)

Resolved

GI bleed (AZEGxwEmL07HeYMqwKgAAg): Resolved..

**Surgical history:**

Enteros wwo w b includ ileum 44376 (EN) on 02/07/20 at 46 Years.

Comments:

02/07/20 17:30 EST - [REDACTED] RN

auto-populated from documented surgical case

Gastric bypass (2819423013).

Laparoscopic adjustable gastric banding (2532982016)..

**Family history:**

Hypertension

Father

Grandmother (P)

**Social history: Social & Psychosocial Habits**

**Alcohol**

05/19/2018 **Use:** Denies use

**Substance Use**

05/19/2018 **Use:** Denies

**Tobacco**

06/08/2018 **Use:** Never smoker

02/05/2020 **Use:** Never (less than 100 in l

09/28/2020 **Use:** Never (less than 100 in l .

**Physical Examination**

**Vital Signs**

Vital Signs

09/28/20 20:55 EDT

Temperature Oral

36.5 Deg C

**Peripheral Pulse Rate**

**130 bpm >HHI**

Respiratory Rate

18 br/min

Systolic Blood Pressure

108 mmHg

Diastolic Blood Pressure

89 mmHg

**Emergency Documentation**

Measurements

09/28/20 20:55 EDT	Height/Length Measured	152.4 cm
	Body Mass Index Measured	29.75 kg/m2
	Weight Measured	69.1 kg

SpO2

09/28/20 20:55 EDT SpO2 98 % .

**General:** Alert, no acute distress.

**Skin:** Warm, dry, pink, intact.

**Head:** Normocephalic.

**Neck:** Supple.

**Eye:** Normal conjunctiva.

**Ears, nose, mouth and throat:** Oral mucosa moist.

**Cardiovascular:** Regular rate and rhythm, No murmur, Normal peripheral perfusion, No edema.

**Respiratory:** Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion.

**Chest wall:** No tenderness, No deformity.

**Back:** Normal range of motion, no cva tenderness.

**Musculoskeletal:** Normal ROM, no swelling.

**Gastrointestinal:** tenderness in all four quadrants, mild guarding, no rebound.

**Neurologic:** oriented to person, place, time, and situation, No focal neurological deficit observed, normal speech observed.

**Psychiatric:** Cooperative.

**Medical Decision Making**

**Documents reviewed:** Emergency department nurses' notes.

**Orders** Launch Order Profile (Selected)

Inpatient Orders

*Ordered*

L: 1,000 mL, IV Bolus, Once

RUQ US:

*Ordered (Dispatched)*

Calcium (Total):

Lipid Panel:

Urinalysis with Reflex Culture:

*Completed*

.Estimated Glomerular Filtration Rate:

Abd Pel CT WO IV WO PO Con:

Basic Metabolic Panel - BMP:

Benadryl: 25 mg, IV Piggyback, Once

CBC with Diff:

HYDROmorphone: 0.5 mg, IV Piggyback, Once, PRN: pain

HYDROmorphone: 1 mg, IV Piggyback, Once

Hepatic Function Panel:

LR bolus: 1,000 mL, 1000 mL/hr, IV Bolus, Once

Lipase Level:

Pregnancy Test-Blood(Qual):

Scan:

Troponin-I:

Type and Screen: .

**Emergency Documentation**

**Electrocardiogram:** Time 09/28/20 21:04:00, rate 121, The Rhythm is sinus tachycardia. , Interpretation by Emergency Physician left ventricular hypertrophy with strain.

<b>Results 9/28/2020:</b>	Lab View	Hemoglobin	13.2 g/dL
		Hematocrit	42.1 %
		WBC	5.65 K/uL
		Platelet Count	247 K/uL
		RBC	4.38 M/uL
		MCV	96.1 fL
		MCH	30.1 pg
		<b>MCHC</b>	<b>31.4 g/dL LOW</b>
		RDW CV	13.6 %
		<b>RDW SD</b>	<b>48.5 fL HI</b>
		MPV	11.2 fL
		Differential Type	Auto
		Differential Type	Auto
		<b>% Neutrophils</b>	<b>83.2 % HI</b>
		Immature Granulocytes	0.2 %
		<b>% Lymphocytes</b>	<b>13.5 % LOW</b>
		<b>% Monocytes</b>	<b>2.7 % LOW</b>
		%Eosinophils	0.0 %
		% Basophils	0.4 %
		Absolute Neutrophils	4.71 K/uL
		Absolute Lymphocytes	0.76 K/uL
		<b>Absolute Monocytes</b>	<b>0.15 K/uL LOW</b>
		Absolute Eosinophils	0.00 K/uL
		Absolute Basophils	0.02 K/uL
		Absolute Immature Granulocytes	0.01 K/uL
		NRBCs	0.00 /100 WBC
		Abs NRBCs	0.00 K/uL
		RBC Morphology	Reviewed
		Sodium on Blood	144 mmol/L
		<b>Potassium on Blood</b>	<b>2.8 mmol/L LOW</b>
		<b>Chloride on Blood</b>	<b>113 mmol/L HI</b>
		<b>CO2 on Blood</b>	<b>19 mmol/L LOW</b>
		Anion Gap	12
		<b>Glucose on Blood</b>	<b>210 mg/dL HI</b>
		Creatinine on Blood	0.98 mg/dL
		<b>BUN on Blood</b>	<b>23 mg/dL HI</b>
		<b>BUN/Creatinine Ratio</b>	<b>23.5 ratio HI</b>
		eGFR (CKD-EPI) if Africn Am	80 mL/min/1.73 m2 NA
		eGFR (CKD-EPI) NonAfricn Am	69 mL/min/1.73 m2 NA
		Calcium (Total)	8.8 mg/dL
		Total Protein on Blood	6.4 g/dL
		<b>Albumin on Blood</b>	<b>3.1 g/dL LOW</b>
		Globulin	3.3 g/dL
		<b>A/G Ratio</b>	<b>0.9 ratio LOW</b>
		ALT (SGPT) on Blood	22 U/L
		<b>AST (SGOT) on Blood</b>	<b>42 U/L HI</b>
		AST/ALT Ratio	1.9 ratio NA

**Emergency Documentation**

Alkaline Phosphatase on Blood	75 U/L
Total Bilirubin on Blood	0.5 mg/dL
Bilirubin (Direct)	0.2 mg/dL
Bilirubin, Indirect	0.3 mg/dL
Troponin I (Quant)	<0.02 ng/mL
<b>Lipase Level</b>	<b>2,771 U/L HI</b>
Est. CrCl-CG-Adult (drug dosing only)	62.21 mL/min
Pregnancy Test-Blood(Qual)	Negative
ABORH	B POS
Antibody Screen	Negative

**Radiology results:** Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00

ORDERED BY: [REDACTED]

READ BY: [REDACTED] ON: Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

Patient Name: [REDACTED] 3/1973

PROCEDURE: SCT 4412 ABD PEL CT WO IV WO PO CON

Acc #: [REDACTED]

PROCEDURE: ABD PEL CT WO IV WO PO CON

CLINICAL INDICATION:

Abdominal pain generalized abdominal pain

COMPARISON:

02/06/2020

TECHNIQUE: 2.5 mm collimation was utilized to image from the lung bases to the symphysis pubis without administration of IV contrast. Oral contrast not given. Sagittal and coronal reconstructions were also reviewed.

Radiation dose reduction techniques used for this exam include: Iterative Reconstruction Technique and/or adjustments of the mA/kV according to patient size. DICOM images are available.

DISCUSSION:

Lungs/pleura:

Lung bases are clear without pleural effusions.

Liver/spleen:

The liver has a grossly normal noncontrast CT appearance. The spleen is nonenlarged. Patient status post gastric bypass no biliary pancreatic portion of the gastric bypass remains markedly dilated with segmental thickening of the proximal jejunum. There is a moderate intra-abdominal and pelvic amount of ascites.

Adrenals:

The adrenal glands are unremarkable.

Pancreaticobiliary:

Pancreas has a grossly normal noncontrast CT appearance. Gallbladder surgically removed.

Genitourinary:

4 mm nonobstructing left renal calyceal calculi present. Bladder collapsed limiting evaluation.

Lymph nodes:

No enlarged abdominal or pelvic nodes are present.

Bowel:

There continues to be diffuse dilated appearance to the biliary

**Emergency Documentation**

pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum .

Osseous structures:

There are no osseous destructive lesions.

IMPRESSION:

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By: [REDACTED] - 039321 - 9/28/2020 11:07 PM

READ BY: [REDACTED] Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

**Reexamination/ Reevaluation**

Time: 09/28/20 21:06:00 . Vital signs

Basic Oxygen Information  
09/28/20 20:55 EDT

Oxygen Therapy  
SpO2

Room air  
98 %

Notes: patient seen and evaluated at this time.

Time: 09/28/20 23:04:00 .

Vital signs

Basic Oxygen Information  
09/28/20 21:30 EDT

Oxygen Therapy  
SpO2

Room air  
98 %

09/28/20 20:55 EDT

Oxygen Therapy  
SpO2

Room air  
98 %

Notes: patient with acute pancreatitis will be admitted for further evaluation and treatment.

Time: 09/28/20 23:56:00 .

Vital signs

Basic Oxygen Information  
09/28/20 21:30 EDT

Oxygen Therapy  
SpO2

Room air  
98 %

Notes: Case discussed with [REDACTED] ; will admit.

**Impression and Plan**

**Diagnosis**

Acute pancreatitis Discharge, Medical)

**Plan**

**Condition:** Guarded.

**Disposition:** Admit: Time 09/28/20 23:56:00, to Inpatient Unit, [REDACTED] MD.

**Counseled:** Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.

Discharge Date: 9/30/2020

**Emergency Documentation**

Document Type: ED Disposition Documentation-Text  
Service Date/Time: 9/29/2020 01:23 EDT  
Result Status: Auth (Verified)  
Document Subject: Disposition Documentation  
Perform Information: (9/29/2020 01:23 EDT)  
Sign Information: (9/29/2020 01:23 EDT)

**Disposition Documentation Entered On: 09/29/2020 1:24 EDT**  
**Performed On: 09/29/2020 1:23 EDT by**

**Disposition Documentation**

*Patient Condition-Disposition* : Satisfactory  
*ED Procedural Sedation* : No  
*ED Restraint/Seclusion* : No  
*ED Vital Sign documentation* : Open vital signs documentation  
*ED Open Pain Scale* : Nu  
*ED Depart* : Admitted to this hospital as inpatient  
*Patient or Family member was educated* : No  
*ED Admission Documentation* : Open admission documentation

- 09/29/2020 1:23 EDT

**Vitals/Ht/Wt**

*Actual Weight* : 69.1 kg(Converted to: 152 lb 5 oz)  
*Height/Length Measured* : 152.4 cm(Converted to: 5 ft 0 in, 60.00 in)  
*Body Mass Index Measured* : 29.75 kg/m2

RN - 09/29/2020 1:23 EDT

**Admission**

*Report given to* :  
*Report Given DT/TM* : 09/29/2020 00:33 EDT  
*ID Band on and Verified* : Yes  
*Allergy Band on and Verified* : Yes  
*Lines Traced* : Yes  
*Orders Reviewed* : Yes  
*Mode of Transport* : Stretcher  
*Intrahospital Transport Equipment* : Cardiac monitor/defibrillator  
*Accompanied by (ED Admit)* : Other: RN

RN - 09/29/2020 1:23 EDT

**Numeric**

*Numeric Pain Score (0-10)* : 9  
*Numeric Rating With Activity* : 9

RN - 09/29/2020 1:23 EDT

Discharge Date: 9/30/2020

## History and Physical Reports

Document Type: History and Physical  
Service Date/Time: 9/29/2020 01:18 EDT  
Result Status: Modified  
Document Subject: Admission H&P  
Perform Information:

MD (9/29/2020 02:36 EDT)

### Addendum by [REDACTED] MD on September 29, 2020 05:14:07 EDT

Patient also received multiple antihypertensive agents in the ER. That is also a possibility for her persistent hypertension at this time. Continue with IV fluids. Hold all the blood pressure medications for now.

Electronically Signed on 09/29/2020 05:14

[REDACTED] MD

### Addendum by [REDACTED] MD on September 29, 2020 04:53:06 EDT

Code rescue was called because patient was having hypo-tension and hypothermia. She is also getting more confused. CT of the abdomen also showed ascites in the abdomen and the pelvic area. She was given normal saline bolus and her blood pressure went up to low 100s and it dropped back again in the 80s. Patient is awake alert but confused. Also she was hypothermic. Suspect she may be having occult internal bleeding. Obtain a stat CBC and a type and cross 2 units for now. Transfer her to IMCU for close observation.

The other differential is sepsis. Patient is already started on Zosyn empirically. Obtain blood cultures x2 UA urine cultures. If the blood pressure does not improve she may need pressors. Monitor her status closely at this time.

Electronically Signed on 09/29/2020 04:56

[REDACTED] MD

### Chief Complaint [REDACTED]

Abdominal pain, Nausea, Vomiting and diarrhea

### History of Present Illness

Patient is a 47-year-old female with a history of gastric bypass and GI bleed in the past came to the ER complaining of severe abdominal pain started yesterday associate with nausea and vomiting. She denies any associated fever or chills. No diarrhea. She describes the pain as sharp and diffuse 8-9 out of 10 and it is constant. She denies any dysuria or hematuria. She denies any vaginal discharge. Patient had CT of the abdomen done that showed development of moderate to large ascites, dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum. Patient also had elevated lipase and a low potassium level. She also had ultrasound of the right upper quadrant that showed pneumobilia. So patient is admitted for further treatment and evaluation of pancreatitis and possible obstruction of the biliary portion of the gastric bypass and for further treatment and evaluation of other medical problems.

### Review of Systems

Constitutional: [No unexplained weight gain or loss, fevers, chills, fatigue]  
Eye: [No recent visual problems]  
ENMT: [No ear pain, nasal congestion, sore throat]  
Respiratory: [No shortness of breath, cough]  
Cardiovascular: [No chest pain, palpitations, leg edema]  
Gastrointestinal: [+ nausea, vomiting, no diarrhea]

### Problem List/Past Medical History

#### Ongoing

Acute pancreatitis  
Anxiety  
Benign HTN

#### Historical

GI bleed

### Procedure/Surgical History

- Enteroscopy w/w b incl ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

### Home Medications

#### Home Medications (3) Active

cloNIDine 0.3 mg oral tablet 0.3 mg = 1 tabs,  
Oral, TID  
diazepam 10 mg oral tablet 10 mg = 1 tabs,  
PRN, Oral, Every 6 hr  
IBU 800 mg oral tablet 800 mg = 1 tabs,  
PRN, Oral, Every 8 hrs

## History and Physical Reports

Genitourinary: [No dysuria, h+ematuria]  
 Hema/Lymph: [Negative for bruising tendency, swollen lymph glands]  
 Endocrine: [Negative for excessive thirst or urination, heat or cold intolerance]  
 Musculoskeletal: [No back pain, joint pain, muscle pain]  
 Integumentary: [No rash, itching, abrasions]  
 Neurologic: [No history of fainting, memory loss, numbness]  
 Psychiatric: [No anxiety, depression]  
 Allergic/Immun: [No nasal allergies, itchy/red eyes, enlarged lymph nodes]

### Allergies

morphine

### Social History

#### Alcohol

Denies use, 05/19/2018

#### Substance Use

Denies, 05/19/2018

#### Tobacco

Tobacco Use: Never (less than 100 in lifetime)., 09/28/2020

Tobacco Use: Never (less than 100 in lifetime)., 02/05/2020

Never smoker, 06/08/2018

### Family History

Hypertension: Father and Grandmother (P).

### Physical Exam

#### Vitals & Measurements

T: 36.6 °C (Oral) HR: 130 (Peripheral) RR: 112 (Monitored) BP: 127/88

SpO2: 95% HT: 152.4 cm WT: 69.1 kg (Measured) BMI: 29.75

General: [Alert, well nourished, no acute distress]

Eye: [Pupils equal, EOMI, normal conjunctiva, no scleral icterus]

ENMT: [Normocephalic, normal hearing, ears/nose inspection non-revealing, moist oral mucosa, no sinus tenderness]

Neck: [Supple, non-tender, trachea midline, no thyroid enlargement or tenderness]

Respiratory: [Normal respiratory effort, clear to auscultation]

Cardiovascular: [Regular rate, normal heart sounds, no peripheral edema]

Gastrointestinal: [Soft, diffuse tender, non-distended, normal bowel sounds, no masses, no hepatomegaly]

Musculoskeletal: [No digital clubbing or cyanosis, Gait Normal]

Skin: [Skin is warm, no rashes or lesions]

Neurologic: [Cranial Nerves grossly intact, DTR intact, Sensation to touch intact]

Psychiatric: [Good judgment and insight, Oriented X3, appropriate mood and affect]

### Lab Results (Most Recent 36 hrs)

Hemoglobin: 13.2 g/dL (09/28/20 22:05:00)

Hematocrit: 42.1 % (09/28/20 22:05:00)

WBC: 5.65 K/uL (09/28/20 22:05:00) Platelet

Count: 247 K/uL (09/28/20 22:05:00) Sodium

on Blood: 144 mmol/L (09/28/20 22:05:00)

Potassium on Blood: 2.8 mmol/L Low (09/28/20 22:05:00)

Chloride on Blood: 113 mmol/L High (09/28/20 22:05:00)

CO2 on Blood: 19 mmol/L Low (09/28/20 22:05:00)

Anion Gap: 12 (09/28/20 22:05:00)

Glucose on Blood: 210 mg/dL High (09/28/20 22:05:00)

Creatinine on Blood: 0.98 mg/dL (09/28/20 22:05:00)

BUN on Blood: 23 mg/dL High (09/28/20 22:05:00)

Calcium (Total): 8.8 mg/dL (09/28/20 22:05:00)

Total Protein on Blood: 6.4 g/dL (09/28/20 22:05:00)

Albumin on Blood: 3.1 g/dL Low (09/28/20 22:05:00)

Globulin: 3.3 g/dL (09/28/19 22:05:00)

ALT (SGPT) on Blood: 22 U/L (09/28/20 22:05:00)

AST (SGOT) on Blood: 42 U/L High (09/28/20 22:05:00)

AST/ALT Ratio: 1.9 ratio (09/28/20 22:05:00)

Alkaline Phosphatase on Blood: 75 U/L (09/28/20 22:05:00)

Total Bilirubin on Blood: 0.5 mg/dL (09/28/20 22:05:00)

Bilirubin (Direct): 0.2 mg/dL (09/28/20 22:05:00)

### Clinical Images

#### **ABD PEL CT WO IV WO PO CON**

ORDERED BY: [REDACTED], M.D.

READ BY: [REDACTED] ON: Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

[1] IMPRESSION: [REDACTED]

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By: Dr. [REDACTED] - 039321 - 9/28/2020 11:07 PM

[2]

### Assessment/Plan

**1. Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)

The reason for it is unclear at this time. Started on IV fluid, pain control and monitor lipase. Consult general surgery and gastroenterology

**2. Pneumobilia** (K83.8: Other specified diseases of biliary tract)

Ultrasound showed pneumobilia this may be due to the bypass anatomy. But cannot rule out infectious cause. Start over her on empiric Zosyn

**3. Hypokalemia** (E87.6: Hypokalemia)

Supplement potassium chloride as needed

**4. Hyperglycemia** (R73.9: Hyperglycemia, unspecified)

No prior history of diabetes, start on sliding scale insulin and check hemoglobin A1c and monitor blood sugar

History and Physical Reports

5. Benign HTN (I10: Essential (primary) hypertension)

Uncontrolled, start on IV hydralazine as needed for now and start back on the oral medication once able to tolerate oral diet

6. Anxiety (F41.9: Anxiety disorder, unspecified)

Continue Valium as needed

Discussed with patient non-opioid alternatives for pain treatment. Discussed the advantages and disadvantages of the use of non-opioid alternatives. Patient provided non-opioid alternative educational pamphlet. Non-opioid alternatives considered were Tylenol and NSAID which are not effective at this time. She does not require us contact PCP at this time.

Orders:

- Tylenol, 650 mg, Oral, Tab, Every 6 hr, PRN pain, moderate (scale 4-6), Start Date/Time 09/29/20 1:39:00 EDT
Dextrose 50% in Water intravenous solution, 25 mL, IV Push, Injectable, As Directed, PRN other (see comment), Start Date/Time 09/29/20 3:25:00 EDT
Dextrose 50% in Water intravenous solution, 25 mL, IV Push, Injectable, As Directed, PRN other (see comment), Start Date/Time 09/29/20 3:25:00 EDT
diazepam, 10 mg, Oral, Tab, Every 6 hr, PRN anxiety, Start Date/Time 09/28/20 23:56:00 EDT
Colace, 100 mg, Oral, Cap, BID, Start Date/Time 09/29/20 1:39:00 EDT
Lovenox Post-op, 09/29/20 0:15:00 EDT, 40 Other (specify in special instructions) mg, SubCutaneous, Injectable, Every 24 hr, Bleeding Precautions, Start Date/Time 09/29/20 1:39:00 EDT
Pepcid, 20 mg, IV Push, Injectable, BID, Start Date/Time 09/29/20 1:39:00 EDT
glucagon, 1 mg, IntraMuscular, Injectable, As Directed, PRN other (see comment), Start Date/Time 09/29/20 3:25:00 EDT
glucose, 15 g, Oral, Gel, As Directed, PRN other (see comment), Start Date/Time 09/29/20 3:25:00 EDT
hydrALAZINE, 10 mg, IV Push, Injectable, Every 4 hrs, PRN other (see comment), Start Date/Time 09/29/20 2:22:00 EDT
Dilaudid, 0.5 mg, IV Push, Injectable, Every 3 hrs, PRN pain, severe (scale 7-10), Start Date/Time 09/29/20 1:21:00 EDT
HumaLOG Regimen 1 Mild, 1. MILD Correction Regimen, SubCutaneous, Form: Injectable, Before meals and HS, Start Date/Time: 09/29/20 7:30:00 EDT
lactulose, 20 g =, Oral, Solution, Every 6 hr, PRN constipation, Start Date/Time 09/29/20 1:39:00 EDT
morphine, 2 mg, IV Push, Injectable, Every 4 hr, PRN pain, severe (scale 7-10), Start Date/Time 09/29/20 0:00:00 EDT
Zofran, 4 mg, IV Push, Injectable, Every 6 hr, PRN nausea/vomiting, Start Date/Time 09/29/20 1:39:00 EDT
Zosyn, 3.375 g, IV Piggyback, Injectable, Every 8 hrs, Abdominal infection, Other, Administer over: 30 minutes, Order Duration: 7 days, Start Date/Time 09/29/20 5:00:00 EDT, Stop Date: 10/06/20 4:59:00 EDT, Rate: 100, Bag Volume (mL): 50
potassium chloride 20 mEq/100 mL intravenous solution, 10 mEq, IV Piggyback, Injectable, Every 1 hrs, Administer over: 1 hr(s), Order Duration: 2 doses, Start Date/Time 09/29/20 2:00:00 EDT, Stop Date: 09/29/19 3:59:00 EDT, Rate: 100, Bag Volume (mL): 100
Restoril, 7.5 mg, Oral, Cap, Daily at bedtime, PRN insomnia, Start Date/Time 09/29/20 0:00:00 EDT
Ambulate, 09/29/20 1:39:00 EDT, TID

Bilirubin, Indirect: 0.3 mg/dL (09/28/20 22:05:00)
Troponin I (Quant): <0.02 (09/28/20 22:05:00)
Color - UR: Yellow (09/28/20 23:46:00)
Appearance-Ur: Clear (09/28/20 23:46:00)
Glucose - Urine: Negative Hem (09/28/20 23:46:00)
Bilirubin - UR: Negative Hem (09/28/20 23:46:00)
Acetone (Ketones)-Urine: 15 Abnormal (09/28/20 23:46:00)
Specific Gravity: >=1.030 (09/28/20 23:46:00)
Blood: Negative Hem (09/28/20 23:46:00)
PH in Urine: 5.5 (09/28/20 23:46:00) Protein, UR SCR: 100 Abnormal (09/28/20 23:46:00)
Urobilinogen: 0.2 (09/28/20 23:46:00) Nitrite: Negative Hem (09/28/20 23:46:00)
Leukocyte Esterase: Negative Hem (09/28/20 23:46:00)
WBCs - UR: 0 (09/28/20 23:46:00)
RBCs - UR: 0 (09/28/20 23:46:00)
Squamous Epithelial Cells: 5 (09/28/20 23:46:00)
Bacteria: Few Ser Abnormal (09/28/20 23:46:00)

Diagnostics Results (Last 48 hrs)

Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00

IMPRESSION:

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By:

039321 - 9/28/2020 11:07 PM

READ BY: ON: Sep 28 2020 11:02P
\*\*\*FINAL RESULT\*\*\*

Ruq US

**History and Physical Reports**

Basic Metabolic Panel - BMP, Blood, AM Draw (Inpatient Only), 09/30/20 3:30:00 EDT, Once  
 Bleeding Precaution  
 Cardiac Tele Category II - 48 hours, 09/29/20 1:39:00 EDT, SBP > 160 < 90 , HR > 110 < 50, 10/01/20 1:38:00 EDT  
 CBC with Diff (BHSF), Blood, AM Draw (Inpatient Only), 09/30/20 3:30:00 EDT, Once  
 Communication Order, 09/29/20 1:39:00 EDT, Constant order, See Comment  
 Communication Order, 09/29/20 1:39:00 EDT, Constant order, See Comment  
 Communication Order, 09/29/20 1:39:00 EDT, Constant order, See Comment  
 Communication Order, 09/29/20 2:25:00 EDT, 4 oz. of clear glucose-containing liquid (juice or regular soda pop) for Glucose less than 70 mg/dL.  
 Communication Order, 09/29/20 1:39:00 EDT, Constant order, See Comment  
 Communication Order, 09/29/20 1:39:00 EDT, Constant order, See Comment  
 Consult to Gastroenterology, Routine, Consult Reason: pancreatitis, MD  
 Consult to Interventional Radiology, 09/29/20 2:22:00 EDT, Routine, paracentesis, send for culture and cytology  
 Consult to Surgery, Routine, Consult Reason: gastric by pass with pancreatitis, MD  
 Hemoglobin A1c - Glycosylated, Blood, InLAB, 09/29/20 2:25:00 EDT, Once, Do not perform if a level is available in patient's chart within 90 days from admission  
 Intake and Output, 09/29/20 1:39:00 EDT, every 4 hr  
 IVR Non-Vascular - Drainage, Paracentesis, 09/29/20 2:21:00 EDT, Routine, Abdominal pain  
 Notify Provider, 09/29/20 1:39:00 EDT, Constant order, Pauses lasting more than 3 seconds or that are symptomatic. Any sustained supraventricular tachycardia (SVT) that is hemodynamically unstable or symptomatic, or with a HR equal to or greater than 130 bpm.  
 Notify Provider, 09/29/20 1:39:00 EDT, Constant order, Any Ventricular arrhythmia that is symptomatic or that lasts more than 5 seconds. Atrial Fibrillation with a sustained ventricular rate equal or greater than 130 bpm.  
 Notify Treating Provider, 09/29/20 2:25:00 EDT, Constant order, for medication adjustments for BG levels higher than 180 mg/dL for 2 consecutive readings or for any BG lower than 70 mg/dL higher than 400 mg/dL and complete critical value report for any value less than 60 mg...  
 Notify Treating Provider (Vital Signs), 09/29/20 1:39:00 EDT, SBP greater than 180 mmHg, SBP less than 100 mmHg, Mean AP less than 65 mmHg, HR greater than 100 beats/min, HR less than 50 beats/min, RR greater than 30 breaths/min, RR less than 10 breaths/min, O2 Requirements Change in Delive...  
 Notify Treating Provider (Vital Signs), 09/29/20 1:39:00 EDT, SBP greater than 180 mmHg, SBP less than 100 mmHg, Mean AP less than 65 mmHg, HR greater than 100 beats/min, HR less than 50 beats/min, RR greater than 30 breaths/min, RR less than 10 breaths/min, O2 Requirements Change in Delive...  
 NPO, 09/29/20 1:39:00 EDT, No Exceptions  
 Order and Draw, 09/29/20 2:25:00 EDT, If results are unexpected or outside the limits of the meter, obtain STAT Lab glucose.  
 Peripheral IV, 09/29/20 1:39:00 EDT, unless already in place  
 POCT Glucose-Monitor, 09/29/20 2:25:00 EDT, Before meals and HS, 15-30 minutes  
 PSO Admit to Inpatient, 09/28/20 23:56:00 EDT, to Telemetry (Order Required), for Acute pancreatitis, Attending: Anticipated  
 Disposition: Home, Anticipated LOS: 2 Midnights or More, This certifies that inpatient hospital services are needed...  
 Saline lock with routine flush, 09/29/20 1:39:00 EDT, Stop date 09/29/20 1:39:00 EDT  
 Up ad Lib  
 Up with Assistance  
 Vital Signs, 09/29/20 1:39:00 EDT, every 4 hr

09/29/20 00:22:00

IMPRESSION:

1. Moderate to large ascites
2. Pneumobilia

Signed Electronically By: Dr. 151662 - 9/29/2020 1:23 AM

READ BY: : Sep 29 2020 12:43A

\*\*\*FINAL RESULT\*\*\*

Discharge Date: 9/30/2020

**History and Physical Reports**

[1] ABD PEL CT WO IV WO PO CON; [REDACTED] MD 09/28/2020 22:55 EDT  
[2] ABD PEL CT WO IV WO PO CON; [REDACTED] MD 09/28/2020 22:55 EDT

Electronically Signed on 09/29/2020 02:36

[REDACTED] MD

**Consultation Notes**

Document Type: Critical Care Consultation  
 Service Date/Time: 9/29/2020 06:19 EDT  
 Result Status: Auth (Verified)  
 Document Subject: Critical Care Consult Note  
 Perform Information: [REDACTED] MD (9/29/2020 06:43 EDT)  
 Sign Information: [REDACTED] MD (9/29/2020 06:43 EDT)

**Chief Complaint**

Abd pain  
 Abdominal pain , Nausea, Vomiting and diarrhea

**Referring Physician**

Dr. [REDACTED]

**Reason for Consultation**

Sepsis

**HPI**

47F with h/o mult abd surgeries including gastric bypass presents 9/28/19 to hospital with abd pain, N/V, and diarrhea. Initially, pt was noted to be hypertensive and she received Vasotec and Lopresolol. [REDACTED] as found to have elevated lipase in the ED. She then underwent RUQ U/S and CT abd/pelv. U/S showed evidence of pneumobilia and ascites and dilatation of the pancreaticobiliary portion of the gastric bypass. Pt was dosed with Zosyn, given 2L LR, and admitted to 2 Tower. Several hours later, Code Rescue was called for hypotension, tachycardia, AMS. Lactate was noted to be 8.0. Pt was bolused another liter of fluid and transferred to ICU. On my arrival, pt is somewhat confused and a poor historian. She complains of abd pain.

**Physical Exam**

Vitals & Measurements

T: 33.8 °C (Oral) T: 34.6 °C (Temporal Artery) TMIN: 33.8 °C (Oral) TMAX: 34.6 °C (Temporal Artery) [REDACTED] 30 (Peripheral) HR: 60 (Monitored) RR: 18 BP: 80/50  
 SpO2: 98% HT: 152.4 cm WT: 69.1 kg (Measured) BMI: 29.75  
 GEN: disoriented, awake  
 HEENT: PERRL; no scleral icterus; EOMI; No facial deformities  
 NECK: trachea midline; normal ROM  
 CV: tachycardic  
 PULM: CTA B  
 GI: abd distended and diffusely tender  
 M/S: moves all ext x 4; no deformities  
 NEURO: AA+Ox1; no neuro deficits; cranial nerves intact  
 PSY: disoriented  
 SKIN: normal temperature, moisture, color

**Assessment/Plan**

- SBO (small bowel obstruction)** (K56.609: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction)
- H/O gastric bypass** (Z98.84: Bariatric surgery status)
- Severe sepsis** (R65.20: Severe sepsis without septic shock)
- Pneumobilia** (K83.8: Other specified diseases of biliary tract)
- Lactic acidosis** (E87.2: Acidosis)
- Acute hypokalemia** (E87.6: Hypokalemia)
- Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)
- Acute hyperglycemia** (R73.9: Hyperglycemia, unspecified)

**Problem List/Past Medical History**

Ongoing

- Acute pancreatitis
- Anxiety
- Benign HTN

Historical

- GI bleed

**Procedure/Surgical History**

- Enterostomy w w b includ ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

**Medications**

**Medications (17) Active**

Scheduled: (7)  
**docusate sodium (Colace) 100 mg capsule** 100 mg 1 cap, Oral, BID  
**enoxaparin (Lovenox) 40 mg/0.4 mL syringe** 40 mg 0.4 mL, SubCutaneous, Every 24 hr  
**famotidine (Pepcid) PF 20 mg/2 mL vial** 20 mg 2 mL, IV Push, BID  
**insulin lispro (HumaLOG) 100 units/mL (3 mL vial)** 1. MILD Correction Regimen, SubCutaneous, Before meals and HS  
**Lactated Ringers Injection intravenous solution** 1,000 mL, IV Bolus, Once  
**piperacillin/tazobactam/D5W** 3.375 g 50 mL, IV Piggyback, Every 8 hrs  
**sodium chloride 0.9%** 1,000 mL/L, IV Bolus, Once  
 Continuous: (2)  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% with KCl 20 mEq/L 1,000 mL** 1,000 mL, IV Continuous, 150 mL/hr  
 PRN: (8)  
**acetaminophen (Tylenol) 325 mg tablet** 650 mg 2 tabs, Oral, Every 6 hr  
**dextrose 50% syringe 50 mL** 12.5 g 25 mL, IV Push, As Directed  
**dextrose 50% syringe 50 mL** 25 g 50 mL, IV Push, As Directed  
**glucagon recombinant 1 mg vial** 1 mg,

9/30/2020

## Consultation Notes

**9. Ascites** (R18.8: Other ascites)

**10. Benign HTN** (I10: Essential (primary) hypertension)

**11. Anxiety** (F41.9: Anxiety disorder, unspecified)

### PLAN:

- 1) Discussed with [REDACTED] Surgery --> they will evaluate pt.
- 2) Cont IVF resuscitation.
- 3) Cont abx.
- 4) SCD's.

### Time Spent/Critical Care Statement:

Critical care time: 45 min

IntraMuscular, As Directed

**glucose 40% 15 g gel** 15 g 1 EA, Oral, As Directed

**HYDROmorphone (Dilaudid) 0.5 mg/0.5 mL syringe** 0.5 mg 0.5 mL, IV Push, Every 3 hrs

**lactulose 10 g/15 mL oral soln 30 mL UD** 20 g 30 mL, Oral, Every 6 hr

**ondansetron 4 mg/2 mL injectable** 4 mg 2 mL, IV Push, Every 6 hr

### Allergies

morphine

### Social History

#### Alcohol

Denies use, 05/19/2018

#### Substance Use

Denies, 05/19/2018

#### Tobacco

Tobacco Use: Never (less than 100 in lifetime), 09/28/2020

Tobacco Use: Never (less than 100 in lifetime), 02/05/2020

Never smoker, 06/08/2018

### Family History

Hypertension: Father and Grandmother (P).

### Lab Results

Hemoglobin: 13.8 g/dL (09/29/20 04:52:00)

Hematocrit: **46.3 %** High (09/29/20 04:52:00)

WBC: 3.69 K/uL (09/29/20 04:52:00) Platelet

Count: 281 K/uL (09/29/20 04:52:00) Sodium

on Blood: 144 mmol/L (09/28/20 22:05:00)

Potassium on Blood: **2.8 mmol/L** Low (09/28/20 22:05:00)

Chloride on Blood: **113 mmol/L** High (09/28/20 22:05:00)

CO2 on Blood: **19 mmol/L** Low (09/28/19 22:05:00)

Anion Gap: 12 (09/28/20 22:05:00)

Glucose on Blood: **210 mg/dL** High (09/28/20 22:05:00)

Creatinine on Blood: 0.98 mg/dL (09/28/20 22:05:00)

BUN on Blood: **23 mg/dL** High (09/28/20 22:05:00)

Calcium (Total): **8.4 mg/dL** Low (09/29/20 02:20:00)

Total Protein on Blood: 6.4 g/dL (09/28/20 22:05:00)

Albumin on Blood: **3.1 g/dL** Low (09/28/20 22:05:00)

Globulin: 3.3 g/dL (09/28/20 22:05:00)

ALT (SGPT) on Blood: 22 U/L (09/28/20

Discharge Date: 9/30/2020

**Consultation Notes**

22:05:00  
AST (SGOT) on Blood: 42 U/L High (09/28/20 22:05:00)  
AST/ALT Ratio: 1.9 ratio (09/28/20 22:05:00)  
Alkaline Phosphatase on Blood: 75 U/L (09/28/20 22:05:00)  
Total Bilirubin on Blood: 0.5 mg/dL (09/28/20 22:05:00)  
Bilirubin (Direct): 0.2 mg/dL (09/28/20 22:05:00)  
Bilirubin, Indirect: 0.3 mg/dL (09/28/20 22:05:00)  
Lactic Acid (Lactate): 8 mmol/L Critical (09/29/20 04:52:00)  
Troponin I (Quant): <0.02 (09/28/20 22:05:00)  
Cholesterol Level: 174 mg/dL (09/29/20 02:20:00)  
Triglycerides: 64 mg/dL (09/29/20 02:20:00)  
HDL Cholesterol: 73 mg/dL High (09/29/20 02:20:00)  
Cholesterol/HDL Ratio: 2.4 ratio (09/29/20 02:20:00)  
LDL: 88 mg/dL (09/29/20 02:20:00) Glucose Point of Care: 126 mg/dL (09/29/20 04:18:00)  
Color - UR: Yellow (09/28/20 23:46:00)  
Appearance-Ur: Clear (09/28/20 23:46:00)  
Glucose - Urine: Negative Hem (09/28/20 23:46:00)  
Bilirubin - UR: Negative Hem (09/28/20 23:46:00)  
Acetone (Ketones)-Urine: 15 Abnormal (09/28/20 23:46:00)  
Specific Gravity: >=1.030 (09/28/20 23:46:00)  
Blood: Negative Hem (09/28/20 23:46:00)  
PH in Urine: 5.5 (09/28/20 23:46:00) Protein, UR SCR: 100 Abnormal (09/28/20 23:46:00)  
Urobilinogen: 0.2 (09/28/20 23:46:00) Nitrite: Negative Hem (09/28/20 23:46:00)  
Leukocyte Esterase: Negative Hem (09/28/19 23:46:00)  
WBCs - UR: 0 (09/28/20 23:46:00)  
RBCs - UR: 0 (09/28/20 23:46:00)  
Squamous Epithelial Cells: 5 (09/28/20 23:46:00)  
Bacteria: Few Ser Abnormal (09/28/20 23:46:00)

**Diagnostic Results**

Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00

IMPRESSION:

Discharge Date: 9/30/2020

**Consultation Notes**

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology  
Signed Electronically By: [REDACTED]  
[REDACTED] 039321 - 9/28/2020 11:07 PM

READ BY: [REDACTED] ON: Sep 28 2020 11:02P  
\*\*\*FINAL RESULT\*\*\*

Rug US

09/29/20 00:22:00

IMPRESSION:

- 1. Moderate to large ascites
- 2. Pneumobilia

Signed Electronically By: Dr. [REDACTED]  
151662 - 9/29/2020 1:23 AM

READ BY: [REDACTED]: Sep 29 2020 12:43A  
\*\*\*FINAL RESULT\*\*\*

Electronically Signed on 09/29/2020 06:43

[REDACTED] MD

Document Type: Infectious Disease Consultation  
Service Date/Time: 9/30/2020 06:41 EDT  
Result Status: Auth (Verified)  
Document Subject: Infectious Disease Consult Note  
Perform Information: [REDACTED] MD (9/30/2020 06:50 EDT)  
Sign Information: [REDACTED] MD (9/30/2020 07:02 EDT)

**Chief Complaint**

Abdominal pain , Nausea, Vomiting and diarrhea

**Referring Physician**

[REDACTED] MD.

**Problem List/Past Medical History**

Ongoing

- Acute pancreatitis
- Anxiety
- Benign HTN

## Consultation Notes

### Reason for Consultation

Sepsis/septic shock.

### HPI

Information is obtained from chart review, relatives are not present. Patient is a 47-year-old African-American female, with a history of gastric bypass in 2013, and also placement of a laparoscopic band in February 2020. She came to the hospital with a history of severe abdominal pain which status a day prior to admission associated nausea and vomiting. No fevers or chills. The pain was sharp apparently very intense. On admission she had a CT scan of the abdomen and pelvis which show evidence of moderate to large ascites, marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal ileum. She had a partial obstruction. On admission 9/28/2020 she had a white count of 5.6 IMA globin 13.2 platelet count of 247,000. Her BUN was 23 with a creatinine of 0.9. Blood sugar of 210. Had a sodium of 144 and a potassium of 2.8 initially. Next day her PT was 33.3 and a PTT is 70.4 with an INR of 3.3. She developed progressive anemia to hemoglobin of 6.8. And her white cell count of 1.5. Platelet count dropped 210,000. She has remained leukopenic with anemia and thrombocytopenic. Last white cell count today 1.1 with 63% neutrophils for an absolute neutrophil count of 730. Platelet count 2 35,000. Her PT is 26.4 with a PTT of 657.5 and INR of 2.4. Creatinine is 1.9 with a BUN of 23. Her potassium of 3.8, and sodium of 144 her blood sugar [REDACTED] ion test yesterday which showed an albumin of 1.5 ALT of 977 and an AST of 2139. Alkaline phosphatase 67 with bilirubin 1.5. Patient [REDACTED] Friday 9/29/2020 exploratory laparotomy with lysis of adhesions, small bowel resection including a Roux-en-Y (biliary pancreatic limb including Roux-en-Y) distal small bowel resection and gastrostomy tube placement. She had a small bowel obstruction caused by adhesive band, necrotic biliopancreatic limb, necrotic distal small bowel. Intraoperative cultures were taken Gram stain shows no WBCs no organisms. Patient is presently intubated on mechanical ventilation with an FiO2 of 70% and a PEEP of 10. She is on CRRT. And receiving norepinephrine at 60 mcg and vasopressin at 0.03. She was started on piperacillin tazobactam and fluconazole. She has persistent with low hemoglobin which suggest bleeding. And has received at least 4 units of fresh frozen plasma. Platelet 1 unit, 10 units of cryo [REDACTED] and packed RBCs. An infectious disease consultation was requested.

### Epidemiologic Review

Unable to obtain. Relatives are not present.

### ROS

All other systems reviewed and negative except as noted in the HPI

### Physical Exam

#### Vitals & Measurements

**T:** 35 °C (Axillary) **HR:** 91 (Monitored) **RR:** 17 **RR:** 30 (Total) **BP:** 79/46

**BP:** 102/84 (Line) **SpO2:** 98% **HT:** 152.4 cm **WT:** 81.0 kg (Measured)

General: Intubated.

HEENT: Pupils are dilated and nonreactive, orotracheal/orogastric tube in place. Left IJ dialysis catheter. Right IJ line.

Cardio: Regular rate and rhythm, no murmurs, gallops or rubs tachycardia.

Respiratory: Decreased breath sounds bilaterally.

Abdomen: Soft, distended, dressing in place. Dry. Gastrostomy tube connected to a bag. JP in place with bloody fluid.

Extremities: No clubbing, cyanosis or edema

Neuro: Intubated.

Skin: No rashes

### Historical

GI bleed

### Procedure/Surgical History

- Laparotomy Exploratory Lvl 4 (09/29/2020)
- Enteros wwo w b includ ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

### Medications

#### Medications (25) Active

Scheduled: (5)

**1. Pharmacy Consult:** Maximally concentrate all IV drips, N/A, As Directed  
**fluconazole/NaCl 0.9% 400 mg 200 mL**, IV Piggyback, Daily  
**insulin lispro (HumaLOG) 100 units/mL (3 mL vial)** 1. MILD Correction Regimen, SubCutaneous, Before meals and HS  
**pantoprazole 40 mg vial** 40 mg, IV Push, BID  
**piperacillin/tazobactam/D5W 3.375 g 50 mL**, IV Piggyback, Every 8 hrs  
 Continuous: (12)  
**dextrose 10% 1,000 mL** 1,000 mL, IV Continuous, 50 mL/hr  
**norEPINEPHrine 32 mg [2 mcg/min] + dextrose 5% 218 mL** 218 mL, IV Continuous, 0.94 mL/hr  
**propofol 1,000 mg [5 mcg/kg/min] + Premix 100 mL** 100 mL, IV Continuous, 2.11 mL/hr  
**sodium bicarbonate 8.4% 150 mEq + dextrose 5% 850 mL** 850 mL, IV Continuous, 300 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**vasopressin 20 units [0.03 unit/min] + sodium chloride 0.9% 250 mL** 250 mL, IV Continuous, 22.5 mL/hr  
 PRN: (8)

**Consultation Notes**

**Assessment/Plan**

1. Acute abdomen, status post exploratory laparotomy, With lysis of adhesions distal small bowel resection, gastrostomy tube placement. Small bowel resection including Roux-en-Y biliary pancreatic limb closed. Intraoperative cultures taken. Patient on piperacillin tazobactam and fluconazole.
2. Shock, on pressors. Norepinephrine and vasopressin. hemorrhagic shock/septic. Receiving transfusion support.
3. Disseminated intravascular coagulation.
4. Lactic acidosis.
5. Fixed and dilated pupils, anoxic encephalopathy?.
6. Acute kidney injury.
7. Multisystem organ failure.
8. GI bleed.

**Plan.**

1. Continue mechanical ventilation.
2. Follow blood cultures.
3. Follow intraoperative cultures.
4. Continue antibiotics will adjust. Start meropenem and micafungin.
5. EEG. Neurology consult.
6. Continue pressors.
7. CRRT.
8. Transfusions.
9. We will follow this patient with you.

Discussed with intensivist.

Thank you for the consult.

- albumin human 5%** 12.5 g 250 mL, IV Piggyback, Every 4 hr
- dextrose 50% syringe 50 mL** 12.5 g 25 mL, IV Push, As Directed
- dextrose 50% syringe 50 mL** 25 g 50 mL, IV Push, As Directed
- glucagon recombinant 1 mg vial** 1 mg, IntraMuscular, As Directed
- glucose 40% 15 g gel** 15 g 1 EA, Oral, As Directed
- HYDROMORPHONE (Dilaudid) 0.5 mg/0.5 mL syringe** 0.5 mg 0.5 mL, IV Push, Every 6 hr while awake
- magnesium sulfate/NaCl 0.9%** 2 g 50 mL, IV Piggyback, As Directed
- ondansetron 4 mg/2 mL injectable** 4 mg 2 mL, IV Push, Every 4 hr

**Allergies**

morphine (Headache, Itching, Watering Eyes)

**Social History**

Alcohol

Denies use, 05/19/2018

Substance Use

Denies, 05/19/2018

Tobacco

Tobacco Use: Never (less than 100 in lifetime), 09/28/2020

Tobacco Use: Never (less than 100 in lifetime), 02/05/2020

Never smoker, 06/08/2018

**Family History**

Hypertension: Father and Grandmother (P).

**Lab Results**

**Most Recent/Last 36 Hours** Hemoglobin: **6.6 g/dL** Critical (09/30/20 03:06:00)  
 Hematocrit: **21 %** Low (09/30/20 03:06:00)  
 WBC: **1.16 K/uL** Low (09/30/20 03:06:00)  
 Platelet Count: **35 K/uL** Low (09/30/20 03:06:00)  
 PT - INR (Prothrombin Time): **26.4 seconds** High (09/30/20 03:06:00)  
 International Normalized Ratio: **2.4** High (09/30/20 03:06:00)  
 PTT (Partial Thromb Time): **57.5 seconds** High (09/30/20 03:06:00)  
 Sodium on Blood: 144 mmol/L (09/30/20 03:06:00)  
 Potassium on Blood: 3.8 mmol/L (09/30/20 03:06:00)  
 Chloride on Blood: **108 mmol/L** High (09/30/20 03:06:00)  
 CO2 on Blood: **15 mmol/L** Low (09/30/20 03:06:00)

Discharge Date: 9/30/2020

### Consultation Notes

03:06:00  
Anion Gap: 21 High (09/30/20 03:06:00)  
Glucose on Blood: 256 mg/dL High (09/30/20 03:06:00)  
Creatinine on Blood: 1.9 mg/dL High (09/30/20 03:06:00)  
BUN on Blood: 23 mg/dL High (09/30/20 03:06:00)  
BUN/Creatinine Ratio: 12.1 ratio (09/30/20 03:06:00)  
Calcium (Total): 6.5 mg/dL Low (09/30/20 03:06:00)  
Phosphorus Level: 7.5 mg/dL High (09/30/20 03:06:00)  
Total Protein on Blood: 3 g/dL Low (09/29/20 21:25:00)  
Albumin on Blood: 1.7 g/dL Low (09/30/20 03:06:00)  
Globulin: 1.5 g/dL Low (09/29/20 21:25:00)  
ALT (SGPT) on Blood: 977 U/L High (09/29/20 21:25:00)  
AST (SGOT) on Blood: 2139 U/L High (09/29/20 21:25:00)  
AST/ALT Ratio: 2.2 ratio (09/29/20 21:25:00)  
Alkaline Phosphatase on Blood: 67 U/L (09/29/20 21:25:00)  
Total Bilirubin on Blood: 1.5 mg/dL (09/29/20 21:25:00)  
Bilirubin (Direct): 0.2 mg/dL (09/28/20 22:05:00)  
Bilirubin, Indirect: 0.3 mg/dL (09/28/20 22:05:00)  
Lactic Acid (Lactate): 8 mmol/L Critical (09/29/20 04:52:00)  
Procalcitonin (PCT): 24.83 ng/mL Critical (09/29/20 04:52:00)  
Color - UR: Yellow (09/28/20 23:46:00)  
Appearance-Ur: Clear (09/28/20 23:46:00)  
Glucose - Urine: Negative Hem (09/28/20 23:46:00)  
Bilirubin - UR: Negative Hem (09/28/20 23:46:00)  
Acetone (Ketones)-Urine: 15 Abnormal (09/28/20 23:46:00)  
Specific Gravity: >=1.030 (09/28/20 23:46:00)  
Blood: Negative Hem (09/28/20 23:46:00) PH in Urine: 5.5 (09/28/20 23:46:00) Protein, UR SCR: 100 Abnormal (09/28/20 23:46:00) Urobilinogen: 0.2 (09/28/20 23:46:00) Nitrite: Negative Hem (09/28/20 23:46:00) Leukocyte Esterase: Negative Hem (09/28/20 23:46:00)  
WBCs - UR: 0 (09/28/20 23:46:00)

Discharge Date: 9/30/2020

**Consultation Notes**

RBCs - UR: 0 (09/28/20 23:46:00)  
Squamous Epithelial Cells: 5 (09/28/20 23:46:00)  
Bacteria: Few Ser Abnormal (09/28/20 23:46:00)

**Diagnostic Results**  
Chest Single View XR

09/29/20 19:43:00

**IMPRESSION:**

Interval placement of a left-sided jugular central line with tip in good position. No pneumothorax.

Signed Electronically By: Dr. [REDACTED]  
[REDACTED] 038398 - 9/29/2020  
8:00 PM

READ BY: [REDACTED]  
ON: Sep 29 2020 7:59P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Chest Single View XR

09/29/20 14:30:00

**IMPRESSION:**

New right internal jugular central venous catheter in good position.

Signed Electronically By: Dr. [REDACTED]  
- 133777 - 9/29/2020 2:48 PM

[REDACTED] ON: Sep 29  
2020 2:47P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Chest Single View XR

09/29/20 12:34:00

**IMPRESSION:**

1. Appropriately positioned lines and tubes.
2. Bilateral hypoventilatory changes are present.

Signed Electronically By: [REDACTED]  
[REDACTED] - 173195 - 9/29/2020  
12:47 PM

READ BY: [REDACTED]  
ON: Sep 29 2020 12:45P

Discharge Date: 9/30/2020

Consultation Notes

\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00

IMPRESSION:

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended.

Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By: Dr. [REDACTED]

PM

READ BY: [REDACTED] ON: Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Rug US

09/29/20 00:22:00

IMPRESSION:

- 1. Moderate to large ascites
2. Pneumobilia

Signed Electronically By: Dr. [REDACTED] 151662 - 9/29/2020 1:23 AM

READ BY: [REDACTED] ON: Sep 29 2020 12:43A

\*\*\*FINAL RESULT\*\*\*

Electronically Signed on 09/30/2020 07:02

[REDACTED] MD

Discharge Date: 9/30/2020

### Consultation Notes

Document Type: MCVI/IVR Consultation  
Service Date/Time: 9/30/2020 10:28 EDT  
Result Status: Auth (Verified)  
Document Subject: Free Text Note  
Perform Information: [REDACTED] 9/30/2020 10:29 EDT  
Sign Information: [REDACTED] (10/1/2020 16:12 EDT); ,  
[REDACTED] (9/30/2020 10:29 EDT)

Received consult for paracentesis however read critical care note of poor prognosis and patient maxed out on pressors at this time. Therefore no plan for paracentesis.

Electronically Signed on 09/30/2020 10:29

[REDACTED] APRN

Electronically Signed on 10/01/2020 16:12

[REDACTED] MD

Document Type: [REDACTED] Nephrologist Consultation  
Service Date/Time: 9/29/2020 20:13 EDT  
Result Status: Auth (Verified) Nephrology  
Document Subject: Consult Note  
Perform Information: [REDACTED] MD (9/29/2020 20:14 EDT)  
Sign Information: [REDACTED] MD (9/29/2020 20:14 EDT)

#### Chief Complaint

Abdominal pain , Nausea, Vomiting and diarrhea

#### HPI

Nephrology consult requested for evaluation and electrolyte disturbances.

Patient is a 47-year-old female with a history of hypertension gastric bypass history of gastrointestinal bleeding according to the family at bedside patient was diagnosed with a mild form of lupus unclear if the patient was ever told she had lupus nephritis?

Patient presented to the ER complaining of severe abdominal pain with nausea vomiting according to the chart pain was sharp and diffuse 10 out of 10 CT scan of the abdomen showed moderate to large ascites dilation of biliary pancreatic portion and gastric bypass segmental thickening of the jejunum elevated lipase patient was taken to the OR for ex lap she had high suspicion for an ischemic bowel.

This morning the patient underwent a exploratory laparotomy lysis of adhesions small bowel resection biliary pancreatic limb including Roux-en-Y distal small bowel resection gas trauma need to place an remanent stomach. Patient had a necrotic biliopancreatic limb necrotic distal small bowel.

Patient is currently intubated and sedated unable to provide any information she is in multisystem organ failure on multiple vasopressors. Case discussed with the ICU team and the family. Decision was made to start the patient on continuous renal replacement therapy.

#### Problem List/Past Medical History

##### Ongoing

- Acute pancreatitis
- Anxiety
- Benign HTN

##### Historical

- GI bleed

#### Procedure/Surgical History

- Laparotomy Exploratory Lvl 4 (09/29/2020)
- Enteros wwo w b includ ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

#### Medications

##### Inpatient

albumin human 5% intravenous solution, 12.5 g= 250 mL, IV Piggyback, Every 4 hr, PRN

Consult to Pharmacy, Maximally concentrate all IV drips, N/A, As Directed

D10W 1,000 mL, 1000 mL, IV Continuous

**Consultation Notes**

**Postoperative day #0**

**preoperative Diagnosis**

Small bowel obstruction  
Ischemic bowel  
History of open gastric bypass

**Postoperative Diagnosis**

Small bowel obstruction caused by adhesive band  
Necrotic biliopancreatic limb  
Necrotic distal small bowel

**Operative Procedure Performed:**

Exploratory laparotomy  
Lysis of adhesions  
Small bowel resection including Roux-en-Y (biliary pancreatic limb including Roux-en-Y)  
Distal small bowel resection  
Gastrostomy tube placement in remnant stomach

**Surgeon(s)**

FACS, FASMBS [1]

**ROS**

Intubated and sedated unable

**Physical Exam**

Vitals & Measurements

**T:** 35 °C (Axillary) **T:** 34.9 °C (Oral) **T:** 34.6 °C (Temporal Artery) **TMIN:** 34.6 °C (Temporal Artery) **TMAX:** 35 °C (Axillary) **HR:** 130 (Peripheral) **HR:** 98 (Monitored)  
**RR:** 30 **RR:** 30 (Total) **BP:** 74/25 **BP:** 116/39 (Line) **SpO2:** 98% **HT:** 152.4 cm  
**WT:** 70.4 kg (Measured) **BMI:** 30.31

**GENERAL:**

Intubated and Sedated

**VOLUME STATUS:**

+ Hypervolemia

**LUNGS:**

Bilateral Coarse BS, Decrease BS at Bilateral Bases

**HEART:**

S1 S2 no pericardial rub

**ABDOMEN:**

+BS, soft , non-distended, non-tender

**EXTREMITY:**

+ peripheral edema

**NEURO:**

Intubated and Sedated

Database, labs and inpatient medication list were reviewed in detail in the electronic medical record.

**Assessment/Plan**

- 1. Acute respiratory failure** (J96.00: Acute respiratory failure, unspecified whether with hypoxia or hypercapnia)
- 2. Severe sepsis** (R65.20: Severe sepsis without septic shock)
- 3. DIC (disseminated intravascular coagulation)** (D65: Disseminated intravascular coagulation [defibrination syndrome])
- 4. Lactic acidosis** (E87.2: Acidosis)
- 5. SBO (small bowel obstruction)** (K56.609: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction)
- 6. Acute blood loss anemia** (D62: Acute posthemorrhagic anemia)

dextrose 5% in water drip 850 mL + sodium bicarbonate 8.4% IV solution 150 mEq  
Dextrose 50% in Water intravenous solution, 12.5 g= 25 mL, IV Push, As Directed, PRN  
Dextrose 50% in Water intravenous solution, 25 g= 50 mL, IV Push, As Directed, PRN  
Dilaudid, 0.5 mg= 0.5 mL, IV Push, Every 6 hr while awake, PRN  
flucanazole, 400 mg= 200 mL, IV Piggyback, Daily  
glucagon, 1 mg, IntraMuscular, As Directed, PRN  
glucose, 15 g= 1 EA, Oral, As Directed, PRN  
HumaLOG Regimen 1 Mild, 1. MILD Correction Regimen, SubCutaneous, Before meals and HS  
lactated ringer's bolus, 1000 mL, IV Bolus, Once  
magnesium sulfate, 2 g= 50 mL, IV Piggyback, As Directed, PRN  
norEPINEPHrine IV additive 32 mg [2 mcg/min] + dextrose 5% in water Drip. 250 mL  
propofol IV additive 1,000 mg [5 mcg/kg/min] + Premix: 100 mL  
Protonix, 40 mg, IV Push, BID  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Zofran, 4 mg= 2 mL, IV Push, Every 4 hr, PRN  
Zosyn, 3.375 g= 50 mL, IV Piggyback, Every 8 hrs

Home

cloNIDine 0.3 mg oral tablet, 0.3 mg= 1 tabs, Oral, TID  
diazepam 10 mg oral tablet, 10 mg= 1 tabs, Oral, Every 6 hr, PRN  
IBU 800 mg oral tablet, 800 mg= 1 tabs, Oral, Every 8 hrs, PRN

**Allergies**

morphine (Headache, Itching, Watering Eyes)

**Social History**

Alcohol

Denies use, 05/19/2018

Substance Use

Denies, 05/19/2018

Tobacco

**Consultation Notes**

- 7. **H/O gastric bypass** (Z98.84: Bariatric surgery status)
- 8. **Pneumobilia** (K83.8: Other specified diseases of biliary tract)
- 9. **Acute hypokalemia** (E87.6: Hypokalemia)
- 10. **Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)
- 11. **Acute hyperglycemia** (R73.9: Hyperglycemia, unspecified)
- 12. **Ascites** (R18.8: Other ascites)
- 13. **Benign HTN** (I10: Essential (primary) hypertension)
- 14. **Acute metabolic encephalopathy** (G93.41: Metabolic encephalopathy)

**Orders:**

Consult to Pharmacy, Maximally concentrate all IV drips  
 magnesium sulfate, 2 g, IV Piggyback, Soln-IV, As Directed, PRN other (see comment),  
 Administer over: 4 hr(s), Start Date/Time 09/29/19 20:42:00 EDT, Bag Volume (mL): 50  
 norEPINEPHrine IV additive 32 mg [2 mcg/min] + dextrose 5% in water Drip. 250 mL, IV  
 Continuous, 250 mL Order Rate: 0.94 mL/hr Starting Rate: 2 mcg/min Max Rate: 200  
 mcg/min Titrate Instructions: Start at 2 mcg/min, titrate up to 10 mcg every 5 minutes to  
 max of 200 mcg/min. MAP Greater Than 65, Order Weight: 70.4 kg Start Date/Tim...  
 CBC-BHSF, Blood, Routine, 09/29/20 19:42:00 EDT, Every 6 hrs, for 3, days  
 Communication Order, 09/29/20 19:42:00 EDT, Constant order, Prime Dialysis filter with  
 1 Liter of Normal Saline  
 Communication Order, 09/29/20 19:42:00 EDT, If potassium is less than 3.5 use 4 K+  
 bath and notify MD. If potassium is 3.5 to 4.0 use a 2 K+ bath. If potassium level is 4.6 to  
 5 use 2 K+ bath. If potassium level is 5.1 to 5.5 use a 2 K+ bath  
 Communication Order, 09/29/20 19:42:00 EDT, Change dialysis filter and circuit at least  
 every 48 hours and notify department to disinfect and acid wash dialysis machine every  
 48 hours  
 Communication Order, 09/29/20 19:42:00 EDT, Keep IV fluids to a minimum  
 CRRT Dialysis, 09/29/20 19:42:00 EDT, CVVHD, NxStage Dialyzer, Dialysate Potassium  
 4 mEq/L, Dialysate Sodium 140 mEq/L, Dialysate Calcium 2.5 mEq, Dialysate  
 Bicarbonate 35 mEq, Prime with Normal Saline, Blood Flow Rate 250 mL/min, Dialysate  
 Flow Rate 600 mL/hr, Even...  
 Magnesium Level, Blood, Routine, 09/29/20 19:42:00 EDT, Every 6 hrs, for 3, days Notify  
 Treating Provider Laboratory Results, 09/29/20 19:42:00 EDT, K greater than 5.5, K less  
 than 3.5  
 Notify Treating Provider Laboratory Results, 09/29/20 19:42:00 EDT, K greater than 5.5,  
 K less than 3.5  
 Renal Function Panel, Blood, Routine, 09/29/20 19:42:00 EDT, Every 6 hrs, for 3, days  
 Weigh Patient, 09/29/20 19:42:00 EDT, Every 24 hrs, and record  
 Weigh Patient, 09/29/20 19:42:00 EDT, Stop date 09/29/20 19:42:00 EDT, Prior to  
 beginning of CRRT Treatment and record on nursing flow-sheet

**NEPHROLOGY ASSESSMENT:**

Acute kidney injury likely due to acute tubular necrosis from the septic shock

Severe metabolic acidosis and acidemia from renal failure and lactic acidosis from the  
 bowel ischemia should improve with initiation of continuous renal replacement therapy.

Dehydration hypovolemic shock hypernatremia

Hypoglycemia

Hypocalcemia

Hyperphosphatemia

Tobacco Use: Never (less than 100 in  
 lifetime)., 09/28/2020  
 Tobacco Use: Never (less than 100 in  
 lifetime)., 02/05/2020  
 Never smoker, 06/08/2018

**Family History**

Hypertension: Father and Grandmother (P).

**Labs Results**

Sodium on Blood: <b>152</b> mmol/L High (09/29/20 12:15:00)	Sodium on Blood: 144 mmol/L (09/28/20 22:05:00)
Potassium on Blood: <b>2.8</b> mmol/L Low (09/28/20 22:05:00)	Potassium on Blood: <b>2.8</b> mmol/L Low (09/28/20 22:05:00)
Chloride on Blood: <b>121</b> mmol/L High (09/29/20 12:15:00)	Chloride on Blood: <b>113</b> mmol/L High (09/28/20 22:05:00)
CO2 on Blood: <b>17</b> mmol/L Low (09/29/20 12:15:00)	CO2 on Blood: <b>19</b> mmol/L Low (09/28/20 22:05:00)
Anion Gap: 14 (09/29/20 12:15:00)	Anion Gap: 12 (09/28/20 22:05:00)
Glucose on Blood: <b>11</b> mg/dL Critical (09/29/20 12:15:00)	Glucose on Blood: <b>210</b> mg/dL High (09/28/20 22:05:00)
Creatinine on Blood: <b>1.4</b> mg/dL High (09/29/20 12:15:00)	Creatinine on Blood: 0.98 mg/dL (09/28/20 22:05:00)
BUN on Blood: <b>25</b> mg/ dL High (09/29/20 12:15:00)	BUN on Blood: <b>23</b> mg/ dL High (09/28/20 22:05:00)
BUN/Creatinine Ratio: 17.9 ratio (09/29/20 12:15:00)	BUN/Creatinine Ratio: <b>23.5</b> ratio High (09/28/20 22:05:00)
Calcium (Total): <b>6.6</b> mg/dL Low (09/29/20 12:15:00)	Hemoglobin: <b>9.8</b> g/dL Low (09/29/20 14:37:00)
Phosphorus Level: <b>6.4</b> mg/dL High (09/29/20 12:15:00)	Hematocrit: <b>30.5</b> % Low (09/29/20 14:37:00)
Total Protein on Blood: <b>2.3</b> g/dL Low (09/29/20 12:15:00)	WBC: <b>1.56</b> K/uL Low (09/29/20 14:37:00)
Albumin on Blood: <b>1.2</b> g/dL Low (09/29/20 12:15:00)	Platelet Count: <b>106</b> K/ uL Low (09/29/20 14:37:00)
ALT (SGPT) on Blood: <b>558</b> U/L High (09/29/20 12:15:00)	PT - INR (Prothrombin Time): <b>33.3</b> seconds High (09/29/20 12:15:00)

**Consultation Notes**

Acute pancreatitis

Shock liver

**Postoperative day #0**

**preoperative Diagnosis**

Small bowel obstruction  
Ischemic bowel  
History of open gastric bypass

**Postoperative Diagnosis**

Small bowel obstruction caused by adhesive band  
Necrotic biliopancreatic limb  
Necrotic distal small bowel

**Operative Procedure Performed:**

Exploratory laparotomy  
Lysis of adhesions  
Small bowel resection including Roux-en-Y (biliary pancreatic limb including Roux-en-Y)  
Distal small bowel resection  
Gastrostomy tube placement in remnant stomach

**Surgeon(s)**

[REDACTED] FACS, FRCMBS [1]

**RECOMMENDATIONS:**

Start the patient on continuous renal replacement therapy

Dose all medications for estimated GFR in the patient I will be on CVVHD the antibiotics will need to be adjusted as per pharmacy

Case discussed with [REDACTED] and ICU team in detail all questions were answered to the best of my ability.

AST (SGOT) on International  
Blood: **1205 U/L** High Normalized  
(09/29/20 12:15:00) Ratio: **3.3** High  
AST/ALT Ratio: 2.2 PTT (Partial Thromb  
ratio (09/29/20 Time): **70.4**  
12:15:00) **seconds** High  
(09/29/20 12:15:00)

Alkaline Phosphatase  
on Blood: 63 U/L  
(09/29/20 12:15:00)

Total Bilirubin on  
Blood: 0.8 mg/dL  
(09/29/20 12:15:00)  
Bilirubin (Direct): 0.2  
mg/dL (09/28/20  
22:05:00)

Bilirubin, Indirect: 0.3  
mg/dL (09/28/20  
22:05:00)

Lipase Level: **2771 U/**  
**L** High (09/28/20  
22:05:00)

Magnesium Level: **1.4**  
**mg/dL** Low (09/29/20  
12:15:00)

Color - UR: Yellow  
(09/28/20 23:46:00)

Appearance-Ur: Clear  
(09/28/20 23:46:00)

Glucose - Urine:  
Negative Hem  
(09/28/20 23:46:00)

Bilirubin - UR:  
Negative Hem  
(09/28/20 23:46:00)

Acetone  
(Ketones)-Urine: 15  
Abnormal (09/28/20  
23:46:00)

Specific Gravity:  
>=1.030 (09/28/20  
23:46:00)

Blood: Negative Hem  
(09/28/20 23:46:00)

PH in Urine: 5.5  
(09/28/20 23:46:00)

Protein, UR SCR: 100  
Abnormal (09/28/20  
23:46:00)

Urobilinogen: 0.2  
(09/28/20 23:46:00)

Nitrite: Negative Hem  
(09/28/20 23:46:00)

Discharge Date: 9/30/2020

Consultation Notes

Leukocyte Esterase:  
Negative Hem  
(09/28/20 23:46:00)  
WBCs - UR: 0  
(09/28/20 23:46:00)  
RBCs - UR: 0  
(09/28/20 23:46:00)  
Squamous Epithelial  
Cells: 5 (09/28/20  
23:46:00)  
Bacteria: Few Seen  
Abnormal (09/28/20  
23:46:00)

[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] 038398 - 9/29/2020  
8:00 PM

READ BY: [REDACTED]  
ON: Sep 29 2020 7:59P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Chest Single View XR

09/29/20 14:30:00

IMPRESSION:

New right internal jugular central venous  
catheter in good position.

Signed Electronically By: Dr. [REDACTED]  
- 133777 - 9/29/2020 2:48 PM

READ BY: [REDACTED] ON: Sep 29  
2020 2:47P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Chest Single View XR

09/29/20 12:34:00

IMPRESSION:

- 1. Appropriately positioned lines and tubes.
- 2. Bilateral hypoventilatory changes are present.

Discharge Date: 9/30/2020

Consultation Notes

Signed Electronically By: [REDACTED]  
[REDACTED] 173195 - 9/29/2020  
12:47 PM

READ [REDACTED]  
ON: Sep 29 2020 12:45P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Abd\_Pel\_CT\_wo\_IV\_wo\_PO\_Con

09/28/20 22:55:00

IMPRESSION:

Interval development of moderate  
intra-abdominal and pelvic ascites with  
persistent diffuse marked dilatation of the  
biliary pancreatic portion of  
the gastric bypass with segmental thickening  
of the proximal jejunum  
further surgical evaluation recommended.  
Partial obstruction not  
excluded, this of uncertain etiology

Signed Electronically By: [REDACTED]  
[REDACTED] 039321 - 9/28/2020 11:07  
PM

READ BY: [REDACTED] ON: Sep 28  
2020 11:02P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Rug\_US

09/29/20 00:22:00

IMPRESSION:

- 1. Moderate to large ascites
- 2. Pneumobilia

Signed Electronically By: Dr. [REDACTED] -  
151662 - 9/29/2020 1:23 AM

READ BY: [REDACTED] ON: Sep 29 2020  
12:43A  
\*\*\*FINAL RESULT\*\*\*

[1] Operative report [REDACTED] MD; [REDACTED] MD 09/29/2020 10:58 EDT

Electronically Signed on 09/29/2020 20:14



## Consultation Notes

### Assessment/Plan

- 1. Acute respiratory failure** (J96.00: Acute respiratory failure, unspecified whether with hypoxia or hypercapnia)
- 2. Severe sepsis** (R65.20: Severe sepsis without septic shock)
- 3. DIC (disseminated intravascular coagulation)** (D65: Disseminated intravascular coagulation [defibrination syndrome])
- 4. Lactic acidosis** (E87.2: Acidosis)
- 5. SBO (small bowel obstruction)** (K56.609: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction)
- 6. Acute blood loss anemia** (D62: Acute posthemorrhagic anemia)
- 7. H/O gastric bypass** (Z98.84: Bariatric surgery status)
- 8. Pneumobilia** (K83.8: Other specified diseases of biliary tract)
- 9. Acute hypokalemia** (E87.6: Hypokalemia)
- 10. Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)
- 11. Acute hyperglycemia** (R73.9: Hyperglycemia, unspecified)
- 12. Ascites** (R18.8: Other ascites)
- 13. Benign HTN** (I10: Essential (primary) hypertension)
- 14. Acute metabolic encephalopathy** (G93.41: Metabolic encephalopathy)

The patient was evaluated for possible brain death today. However, she has significant hypotension (52/15), hypothermia (33.3 C), and anemia (Hgb 6.6). These abnormalities make the clinical determination of brain death inappropriate. I cannot conclude based on my examination today that the patient is indeed brain dead, though her prognosis may be poor. Further assessments and recommendations regarding brain death must wait until the patient is warm with normal vitals and correction of metabolic abnormalities. As such, any emergent medical or surgical treatments should be undertaken by the primary team and consultants as deemed necessary and medically appropriate.

I have reviewed all available labs, imaging, and diagnostics.

**Palliative care encounter** (Z51.5: Encounter for palliative care)

Thank you for inviting us to care for this patient. Please do not hesitate to contact us with any further questions or concerns, [REDACTED]

Time Spent/Data Reviewed:

More than 50% of the time was spent in face-to-face counseling, record review, and coordination of care.

norEPINEPHrine IV additive 32 mg [2 mcg/min] + dextrose 5% in water Drip. 218 mL  
propofol IV additive 1,000 mg [5 mcg/kg/min] + Premix: 100 mL  
Protonix, 40 mg, IV Push, BID  
sodium bicarbonate 8.4% IV solution 150 mEq + dextrose 5% in water drip 850 mL  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
vasopressin IV additive 20 units [0.03 unit/min] + sodium chloride 0.9% drip 250 mL  
Zofran, 4 mg= 2 mL, IV Push, Every 4 hr, PRN

### Home

cloNIDine 0.3 mg oral tablet, 0.3 mg= 1 tabs, Oral, TID  
diazepam 10 mg oral tablet, 10 mg= 1 tabs, Oral, Every 6 hr, PRN  
IBU 800 mg oral tablet, 800 mg= 1 tabs, Oral, Every 8 hrs, PRN

### Allergies

morphine (Headache, Itching, Watering Eyes)

### Social History

#### Alcohol

Denies use, 05/19/2018

#### Substance Use

Denies, 05/19/2018

#### Tobacco

Tobacco Use: Never (less than 100 in lifetime)., 09/28/2020

Tobacco Use: Never (less than 100 in lifetime)., 02/05/2020

Never smoker, 06/08/2018

### Family History

Hypertension: Father and Grandmother (P).

### Lab Results

RP-Source: Arterial (09/30/20 04:34:00)

Sodium-RP: 138.5 mmol/L (09/30/20 04:34:00)

Chloride-RP: 105 mmol/L (09/30/20 04:34:00)

[REDACTED]

[REDACTED]

**Consultation Notes**

Potassium-RP: 4.01 mmol/L (09/30/20 04:34:00)  
Glucose-RP: 312 mg/dL High (09/30/20 04:34:00)  
RP-Calcium Ionized: 0.73 mmol/L Low (09/30/20 04:34:00)  
Lactic Acid-Respiratory: 12.45 mmol/L Critical (09/30/20 04:34:00)  
pH - BG: 7.225 Critical (09/30/20 04:34:00)  
Rp-pCO2: 30.2 mmHg Low (09/30/20 04:34:00)  
PO2: 180.1 mmHg High (09/30/20 04:34:00)  
HCO3: 12.2 mmol/L Low (09/30/20 04:34:00)  
RP-Base Excess, BE: -14.1 mmol/L (09/30/19 04:34:00)  
RP-O2 SAT (est) %: 98.3 % (09/30/20 04:34:00)  
RP-02HB(Meas)%: 97.6 % (09/30/20 04:34:00)  
THB: 5.8 g/dL Critical (09/30/20 04:34:00)  
RP-COHB: 0.4 % (09/30/20 04:34:00)  
RP-METHB: 0.3 % (09/30/20 04:34:00) RP-FIO2: 70 % (09/30/19 04:34:00)  
RP - Mode: Ventilator-AC (09/30/20 04:34:00)  
RP-Resp Rate: 30 (09/30/20 04:34:00)  
RP-Tidal Vol: 350 mL (09/30/20 04:34:00)  
RP-PEEP: 10 (09/30/19 04:34:00)  
Draw Site- Respiratory: A Line (09/30/20 04:34:00)  
Allen Test- Respiratory: NA (09/30/20 04:34:00)  
Lidocaine Given?- Respiratory: No (09/30/20 04:34:00)  
Hemoglobin: 5.4 g/dL Critical (09/30/20 11:45:00)  
Hematocrit: 18.5 % Critical (09/30/20 11:45:00)  
WBC: 2.08 K/uL Low (09/30/20 11:45:00)  
Platelet Count: 35 K/uL Low (09/30/20 11:45:00)  
PT - INR (Prothrombin Time): 26.4 seconds High (09/30/20 03:06:00)  
International Normalized Ratio: 2.4 High (09/30/20 03:06:00)  
PTT (Partial Thromb Time): 57.5 seconds High (09/30/20 03:06:00)  
Sodium on Blood: 141 mmol/L (09/30/20 11:45:00)  
Potassium on Blood: 5.2 mmol/L High (09/30/20 11:45:00)  
Chloride on Blood: 97 mmol/L Low (09/30/20 11:45:00)  
CO2 on Blood: 10 mmol/L Low (09/30/20 11:45:00)

[REDACTED]

[REDACTED]

[REDACTED]

**Consultation Notes**

Anion Gap: 34 High (09/30/20 11:45:00)  
Glucose on Blood: 543 mg/dL Critical (09/30/20 11:45:00)  
Creatinine on Blood: 2.3 mg/dL High (09/30/20 11:45:00)  
BUN on Blood: 21 mg/dL High (09/30/20 11:45:00)  
Calcium (Total): 6.6 mg/dL Low (09/30/20 11:45:00)  
Phosphorus Level: 8.9 mg/dL High (09/30/20 11:45:00)  
Total Protein on Blood: 3 g/dL Low (09/29/20 21:25:00)  
Albumin on Blood: 1.3 g/dL Low (09/30/20 11:45:00)  
Globulin: 1.5 g/dL Low (09/29/20 21:25:00)  
ALT (SGPT) on Blood: 977 U/L High (09/29/20 21:25:00)  
AST (SGOT) on Blood: 2139 U/L High (09/29/20 21:25:00)  
AST/ALT Ratio: 2.2 ratio (09/29/20 21:25:00)  
Alkaline Phosphatase on Blood: 67 U/L (09/29/20 21:25:00)  
Total Bilirubin on Blood: 1.5 mg/dL (09/29/20 21:25:00)  
Glucose Point of Care: 477 mg/dL Critical (09/30/20 11:57:00)

**Diagnostics Results**  
Chest Single View XR

09/29/20 19:43:00

IMPRESSION:

Interval placement of a left-sided jugular central line with tip in good position. No pneumothorax.

Signed Electronically By: [REDACTED]

[REDACTED] - 038398 - 9/29/2020

8:00 PM

READ BY: [REDACTED]

ON: Sep 29 2020 7:59P

\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Chest Single View XR

09/29/20 14:30:00

IMPRESSION:

New right internal jugular central venous catheter in good position.

Signed Electronically By: Dr. [REDACTED]

- 133777 - 9/29/2020 2:48 PM

[REDACTED]

[REDACTED]

**Consultation Notes**

READ [REDACTED] ON: Sep 29  
2020 2:47P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Chest Single View XR

09/29/20 12:34:00  
IMPRESSION:  
1. Appropriately positioned lines and tubes.  
2. Bilateral hypoventilatory changes are present.  
Signed Electronically By: [REDACTED]  
[REDACTED] - 173195 - 9/29/2020  
12:47 PM

READ [REDACTED]  
ON: Sep 29 2020 12:45P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00  
IMPRESSION:  
Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology  
Signed Electronically By: Dr. [REDACTED]  
[REDACTED] 039321 - 9/28/2020 11:07 PM

READ [REDACTED] ON: Sep 28  
2020 11:02P  
\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*  
Rug US

09/29/20 00:22:00  
IMPRESSION:  
1. Moderate to large ascites  
2. Pneumobilia

[REDACTED]

[REDACTED]

**Consultation Notes**

Signed Electronically By: [REDACTED]  
151662 - 9/29/2020 1:23 AM

READ [REDACTED] ON: Sep 29 2020  
12:43A  
\*\*\*FINAL RESULT\*\*\*

**Cardiovascular Results**  
EKG Standard

09/28/20 21:04:00  
[REDACTED].D.

\*\*\*\*\*  
EKG Standard

09/28/20 21:04:00  
SINUS TACHYCARDIA WITH SHORT PR  
INTERVAL  
LEFT VENTRICULAR HYPERTROPHY AND  
ST-T CHANGE  
LEFT ATRIAL ABNORMALITY  
ABNORMAL ECG

Electronically Signed on 09/30/2020 17:45

[REDACTED] A MD

Document Type:	[REDACTED]	Surgery Consultation
Service Date/Time:	[REDACTED]	9/29/2020 08:11 EDT
Result Status:		Auth (Verified)
Document Subject:		Free Text Note
Perform Information:		[REDACTED] R MD (9/29/2020 08:12 EDT)
Sign Information:		[REDACTED] R MD (9/29/2020 08:12 EDT)

Patient seen and examined. Full consult note to follow. In brief, this is a 46-year-old woman with hx open RNYGB with probable bowel obstruction from an internal hernia - patient has lactic acidosis in the setting of a rigid abdomen. High suspicion for ischemic bowel requiring emergent exploration. Lipase elevation may be secondary to significant distention of the biliopancreatic limb. Given patient's past surgical history we will proceed with emergent exploratory laparotomy, possible bowel resection, possible ostomy, possible open abdomen.

Electronically Signed on 09/29/2020 08:12

[REDACTED] R MD

**Consultation Notes**

Document Type: Surgery Consultation  
 Service Date/Time: 9/29/2020 07:46 EDT  
 Result Status: Auth (Verified)  
 Document Subject: Consult Note  
 Perform Information: [REDACTED] (9/29/2020 08:11 EDT)  
 Sign Information: [REDACTED] (9/29/2020 20:06 EDT); [REDACTED] (9/29/2020 09:17 EDT)

**Chief Complaint**

Abdominal pain , Nausea, Vomiting and diarrhea

**Referring Physician**

[REDACTED], MD

**Reason for Consultation**

Abdominal pain, elevated lactate

**HPI**

Mrs. [REDACTED] is a 47-year-old woman with history of an abdominoplasty, open cholecystectomy, morbid obesity status post laparoscopic adjustable gastric band placement. Per her husband, [REDACTED] and she regained weight. She then underwent a open gastric bypass operation either in 2003 or 2013.

Patient presents to the ED on Friday with a 2-week history of no bowel movements followed by worsening abdominal pain and vomiting. In the emergency department she was found to have a normal white blood cell count and an elevated lipase. She was hypertensive and was given Lopressor. Overnight patient became tachycardic with altered mental status and her blood pressure had decreased to 80s over 40s. CT scan was obtained which showed significantly dilated biliopancreatic limb with a moderate amount of ascites with pneumobilia. Lactate was checked and was elevated at 8.0. Her white blood cell count was normal.

**ROS**

Constitutional: No acute distress  
 Eye: No recent visual problems  
 ENMT: No ear pain, nasal congestion, sore throat  
 Respiratory: No shortness of breath, cough  
 Cardiovascular: No chest pain, palpitations, leg edema  
 Gastrointestinal: No nausea, vomiting, diarrhea  
 Genitourinary: No dysuria, hematuria  
 Hema/Lymph: Negative for bruising tendency, swollen lymph glands  
 Endocrine: Negative for excessive thirst or urination, heat or cold intolerance  
 Musculoskeletal: No back pain, joint pain, muscle pain  
 Integumentary: No rash, itching, abrasions  
 Neurologic: No history of fainting, memory loss, numbness  
 Psychiatric: No anxiety, depression  
 Allergic/Immun: No nasal allergies, itchy/red eyes, enlarged lymph nodes

**Physical Exam**

Vitals & Measurements

T: 34.9 °C (Oral) T: 34.6 °C (Temporal Artery) **TMIN:** 34.6 °C (Temporal Artery)  
**TMAX:** 34.9 °C (Oral) **HR:** 130 (Peripheral) **HR:** 96 (Monitored) **RR:** 25 **BP:** 102/60  
**SpO2:** 98% **HT:** 152.4 cm **WT:** 70.4 kg (Measured) **BMI:** 29.75  
 General: Confused, in moderate acute distress  
 Respiratory : Normal respiratory effort, clear to auscultation  
 Cardiovascular: Tachycardic, regular no murmur or pedal edema

**Problem List/Past Medical History**

Ongoing

- Acute pancreatitis
- Anxiety
- Benign HTN

Historical

- GI bleed

**Procedure/Surgical History**

- Enteros wwo w b includ ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

**Medications**

Inpatient

- Colace, 100 mg= 1 cap, Oral, BID
- Dextrose 50% in Water intravenous solution, 12.5 g= 25 mL, IV Push, As Directed, PRN
- Dextrose 50% in Water intravenous solution, 25 g= 50 mL, IV Push, As Directed, PRN
- Dilaudid, 0.5 mg= 0.5 mL, IV Push, Every 3 hrs, PRN
- glucagon, 1 mg, IntraMuscular, As Directed, PRN
- glucose, 15 g= 1 EA, Oral, As Directed, PRN
- HumaLOG Regimen 1 Mild, 1. MILD Correction Regimen, SubCutaneous, Before meals and HS
- lactulose, 20 g= 30 mL, Oral, Every 6 hr, PRN
- morphine, 2 mg, IV Push, Every 4 hr, PRN
- NS (Sodium Chloride 0.9%) 1,000 mL, 1000 mL, IV Continuous
- Pepcid, 20 mg= 2 mL, IV Push, BID
- Restoril, 7.5 mg= 1 cap, Oral, Daily at bedtime, PRN
- Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback
- Sodium Chloride 0.9% with KCl 20 mEq/L intravenous solution 1,000 mL, 1000 mL, IV Continuous

## Consultation Notes

Gastrointestinal: Rigid abdomen with diffuse peritonitis. Healed Kocher incision, open midline incision, left lower quadrant incision (previous port placement), transverse pelvic incision from prior abdominoplasty

Musculoskeletal: No digital clubbing or cyanosis, Gait Normal

Skin: Skin is warm, no rashes or lesions

### Clinical Images

None

### Assessment/Plan

**1. SBO (small bowel obstruction)** (K56.609: Unspecified intestinal obstruction, unspecified as to partial versus complete obstruction)

47 year-old woman with probable bowel obstruction with elevated lactate and rigid abdomen. High suspicion for ischemic bowel requiring emergent exploration. Lipase elevation may be secondary to significant distention of the biliopancreatic limb. This may all be secondary to an internal hernia. Given patient's past surgical history we will proceed with emergent exploratory laparotomy, possible bowel resection, possible ostomy, possible open abdomen.

Likely the patient has obstruction of the biliopancreatic limb causing a backflow into the biliary tree as well as into the pancreas and obviously elevating the pancreatic enzymes.

Since the patient had previous open cholecystectomy, open LAP-BAND, open gastric bypass plans are made for open laparotomy, lysis of adhesions possible bowel resection and any other indicated procedures.

There is been discussed in detail with the husband.

I, [REDACTED] personally saw the patient., performed the history and physical examination. I initiated the course of treatment/diagnosis and directly supervised the services. This note accurately reflects work and decisions made by me.

**2. H/O gastric bypass** (Z98.84: Bariatric surgery status)

Status post conversion to gastric bypass after failed laparoscopic gastric band placement

**3. Severe sepsis** (R65.20: Severe sepsis [REDACTED] shock)

Improving with antibiotics and IV fluid resuscitation

**4. Pneumobilia** (K83.8: Other specified diseases of biliary tract)

Concern for bowel ischemia given this finding on CT scan

**5. Lactic acidosis** (E87.2: Acidosis)

Concern for bowel ischemia, continue to trend and aggressively rehydrate.

**7. Acute pancreatitis** (K85.90: Acute pancreatitis without necrosis or infection, unspecified)

Lipase elevation is likely secondary to distention of the biliopancreatic limb versus primary pancreatitis

**9. Ascites** (R18.8: Other ascites)

Likely secondary to bowel ischemia

Orders:

Witness Surgical Consent, 09/29/20 7:28:00 EDT, Exploratory laparotomy, possible bowel resection, possible ostomy, possible open abdomen

Tylenol, 650 mg= 2 tabs, Oral, Every 6 hr, PRN

Zofran, 4 mg= 2 mL, IV Push, Every 6 hr, PRN

Zosyn, 3.375 g= 50 mL, IV Piggyback, Every 8 hrs

### Home

cloNIDine 0.3 mg oral tablet, 0.3 mg= 1 tabs, Oral, TID

diazepam 10 mg oral tablet, 10 mg= 1 tabs, Oral, Every 6 hr, PRN

IBU 800 mg oral tablet, 800 mg= 1 tabs, Oral, Every 8 hrs, PRN

### Allergies

morphine (Headache, Itching, Watering Eyes)

### Social History

#### Alcohol

Denies use, 05/19/2018

#### Substance Use

Denies, 05/19/2018

#### Tobacco

Tobacco Use: Never (less than 100 in lifetime)., 09/28/2020

Tobacco Use: Never (less than 100 in lifetime)., 02/05/2020

Never smoker, 06/08/2018

### Family History

Hypertension: Father and Grandmother (P).

### Lab Results

Hemoglobin: 13.8 g/dL (09/29/20 04:52:00)

Hematocrit: **46.3 %** High (09/29/20 04:52:00)

WBC: 3.69 K/uL (09/29/20 04:52:00) Platelet

Count: 281 K/uL (09/29/20 04:52:00) Sodium

on Blood: 144 mmol/L (09/28/20 22:05:00)

Potassium on Blood: **2.8 mmol/L** Low (09/28/20 22:05:00)

Chloride on Blood: **113 mmol/L** High (09/28/20 22:05:00)

CO2 on Blood: **19 mmol/L** Low (09/28/20 22:05:00)

Anion Gap: 12 (09/28/20 22:05:00)

Glucose on Blood: **210 mg/dL** High (09/28/20 22:05:00)

Creatinine on Blood: 0.98 mg/dL (09/28/20 22:05:00)

BUN on Blood: **23 mg/dL** High (09/28/20 22:05:00)

Calcium (Total): **8.4 mg/dL** Low (09/29/20 02:20:00)

Total Protein on Blood: 6.4 g/dL (09/28/20 22:05:00)

Albumin on Blood: **3.1 g/dL** Low (09/28/20

Patient Name:  
MRN:  
Encounter:

Admit Date: **9/28/2020**  
Discharge Date: **9/30/2020**

### Consultation Notes

22:05:00  
Globulin: 3.3 g/dL (09/28/20 22:05:00)  
ALT (SGPT) on Blood: 22 U/L (09/28/20 22:05:00)  
AST (SGOT) on Blood: **42 U/L** High (09/28/20 22:05:00)  
AST/ALT Ratio: 1.9 ratio (09/28/20 22:05:00)  
Alkaline Phosphatase on Blood: 75 U/L (09/28/20 22:05:00)  
Total Bilirubin on Blood: 0.5 mg/dL (09/28/20 22:05:00)  
Bilirubin (Direct): 0.2 mg/dL (09/28/20 22:05:00)  
Bilirubin, Indirect: 0.3 mg/dL (09/28/20 22:05:00)  
Lactic Acid (Lactate): **8 mmol/L** Critical (09/29/20 04:52:00)  
Troponin I (Quant): <0.02 (09/28/20 22:05:00)  
Cholesterol Level: 174 mg/dL (09/29/20 02:20:00)  
Triglycerides: 64 mg/dL (09/29/20 02:20:00)  
HDL Cholesterol: **73 mg/dL** High (09/29/20 02:20:00)  
Cholesterol/HDL Ratio: 2.4 ratio (09/29/20 02:20:00)  
LDL: 88 mg/dL (09/29/20 02:20:00) Glucose Point of Care: **<10** Critical (09/29/20 07:44:00)  
Color - UR: Yellow (09/28/20 23:46:00)  
Appearance-Ur: Clear (09/28/20 23:46:00)  
Glucose - Urine: Negative Hem (09/28/20 23:46:00)  
Bilirubin - UR: Negative Hem (09/28/20 23:46:00)  
Acetone (Ketones)-Urine: 15 Abnormal (09/28/20 23:46:00)  
Specific Gravity: >=1.030 (09/28/20 23:46:00)  
Blood: Negative Hem (09/28/20 23:46:00)  
PH in Urine: 5.5 (09/28/20 23:46:00) Protein, UR SCR: 100 Abnormal (09/28/20 23:46:00)  
Urobilinogen: 0.2 (09/28/20 23:46:00) Nitrite: Negative Hem (09/28/20 23:46:00)  
Leukocyte Esterase: Negative Hem (09/28/20 23:46:00)  
WBCs - UR: 0 (09/28/20 23:46:00)  
RBCs - UR: 0 (09/28/20 23:46:00)  
Squamous Epithelial Cells: 5 (09/28/20 23:46:00)  
Bacteria: Few Ser Abnormal (09/28/20 23:46:00)

**Pathology**  
**Most Recent/Last 24 Hours**

Patient Name:  
MRN:  
Encounter:

Admit Date: 9/28/2020  
Discharge Date: 9/30/2020

**Consultation Notes**

**Diagnostics Results**

Abd Pel CT wo IV wo PO Con

09/28/20 22:55:00

**IMPRESSION:**

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended.

Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By: Dr. [REDACTED]

[REDACTED] 039321 - 9/28/2020 11:07 PM

READ BY: [REDACTED] ON: Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

\*\*\*\*\*

Rug US

09/29/20 00:22:00

**IMPRESSION:**

- 1. Moderate to large ascites
- 2. Pneumobilia

Signed Electronically By: Dr. [REDACTED]  
151662 - 9/29/2020 1:23 AM

READ BY: [REDACTED] ON: Sep 29 2020 12:43A

\*\*\*FINAL RESULT\*\*\*

Electronically Signed on 09/29/2020 20:06

[REDACTED] M

Electronically Signed on 09/29/2020 09:17

[REDACTED] MD

[REDACTED]  
[REDACTED]  
[REDACTED] : 9/30/2020

**Multidisciplinary Progress Notes**

Document Type: Case Manager Progress Note  
Service Date/Time: 10/1/2020 08:19 EDT  
Result Status: Auth (Verified)  
Document Subject: DISCHARGE  
Perform Information: [REDACTED] (10/1/2020 08:19 EDT)  
Sign Information: [REDACTED] (10/1/2020 08:19 EDT)

PT EXPIRED ON 9/30/20 AT 13:49. D/C DISPOSITION COMPLETED.

Electronically Signed on 10/01/2020 08:19

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Document Type: Case Manager Progress Note  
Service Date/Time: 9/30/2020 12:51 EDT  
Result Status: Auth (Verified)  
Document Subject: Assessment  
Perform Information: [REDACTED] in (9/30/2020 12:53 EDT)  
Sign Information: [REDACTED] n (9/30/2020 12:53 EDT)

SW unable to complete assessment at this time. Pt is incapacitated to make medical decisions at this time. Observed pts family at bedside and in distress about pts current condition. SW introduced self and role and provided contact information. SW to continue to follow.

Electronically Signed on 09/30/2020 12:53

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Document Type: Interdisciplinary Rounding Summary Note  
Service Date/Time: 9/30/2020 10:12 EDT  
Result Status: Auth (Verified)  
Document Subject: Interdisciplinary Rounding Documentation  
Perform Information: [REDACTED] E RN (9/30/2020 10:12 EDT)  
Sign Information: [REDACTED] E RN (9/30/2020 10:12 EDT)

**Patient&#047;Family&#047;Caregiver Concerns:**

**Interdisciplinary Concerns:**

**Goals&#047;Plans for Today:**

consult neurology to evaluate for brain death, EEG ordered; transfuse 2 units PRBC & 1unit PLT, ID started patient on merrem and micafungin today, CRRT, paracentesis, palliative care consult.

**Barriers to Discharge&#047;Discharge Needs:**

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Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

Document Type: Interdisciplinary Rounding Summary Note  
Service Date/Time: 9/30/2020 10:12 EDT  
Result Status: Auth (Verified)  
Document Subject: Interdisciplinary Round Attendance  
Perform Information: [REDACTED] E RN (9/30/2020 10:12 EDT)  
Sign Information: [REDACTED] E RN (9/30/2020 10:12 EDT)

**Interdisciplinary Round Attendance Entered On: 09/30/2020 10:12 EDT**  
**Performed On: 09/30/2020 10:12 EDT [REDACTED] RN**

**Interdisciplinary Round Attendance**

*Interdisciplinary Rounding Attendance :* Social Worker, Physician, Nurse, Nursing Leader, Pharmacist, Dietician, Respiratory Therapist, Palliative care

*Addl Team Member Present Team Conference :* UR RN

[REDACTED] RN - 09/30/2020 10:12 EDT

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 13:35 EDT  
Result Status: Auth (Verified)  
Document Subject: code at this time.  
Perform Information: [REDACTED] K RN (9/30/2020 15:00 EDT)  
Sign Information: [REDACTED] K RN (9/30/2020 15:00 EDT)

patient noted, no pulse initially, for confirming with doppler checked the carotid pulse, which was very feeble, then within seconds patient became brady and asystole., called code, see code sheet for detailed documentation.

Electronically Signed on 09/30/2020 15:00

[REDACTED] K RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 10:45 EDT  
Result Status: Auth (Verified)  
Document Subject: [REDACTED] at bedside.  
Perform Information: [REDACTED] RN (9/30/2020 10:47 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 10:47 EDT)

Dr [REDACTED] explained everything to the family, as per the healthsurrogate, patients husband, wants everything to be done.

Electronically Signed on 09/30/2020 10:47

[REDACTED] RN

Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 10:33 EDT  
Result Status: Auth (Verified)  
Document Subject: [REDACTED] discussed with Neurology  
Perform Information: [REDACTED] (9/30/2020 10:37 EDT) RN  
Sign Information: [REDACTED] (9/30/2020 10:37 EDT)

Neurology consult placed by Dr. [REDACTED] a just spoken to him, made aware about the consult as well as the situation what is going on with the patient.,He said he will come and evaluate the patient soon.

Electronically Signed on 09/30/2020 10:37  
[REDACTED]

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 08:00 EDT  
Result Status: Auth (Verified)  
Document Subject: [REDACTED] Initial assessment note  
Perform Information: [REDACTED] RN (9/30/2020 10:44 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 10:44 EDT)

Received the patient from Night shift RN, patient was on CRRT, due to low BP, unable to continue the CRRT, D/C the HD [REDACTED] made aware about the situation as well as the dialysis unit also.  
Dr [REDACTED] is informed, he ordered to increase the levophed and vasopressors to titrate to maximum dose now, which is done.

levo at 200 mics, and vasopressin at 0.04.

Patient is in comatose state now. no response, no gag or corneal reflex, pupils are fully dilated and fixed..

All consults including the primary M made aware about the situations.

Skin condition unable to assess fully, patient is so critical to turn.

Due to the critical situation of the patient , even unable to transfer the patient to do any CT scan or MRI of the Brain. .

Electronically Signed on 09/30/2020 10:44  
[REDACTED]

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 05:35 EDT  
Result Status: Auth (Verified)  
Document Subject: chest xray  
Perform Information: [REDACTED] RN (9/30/2020 19:23 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 19:23 EDT)

Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

dr. [REDACTED] cancelled morning chest xray " stated that the patient is to critical to move at this time. 'information passed on to the day shift nurse.

unable to turn the patient q2 due to the patient being unstable. information passed on to the day shift nurse.

Electronically Signed on 09/30/2020 19:23

[REDACTED] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 05:12 EDT  
Result Status: Auth (Verified)  
Document Subject: dr.tavangari  
Perform Information: [REDACTED] e RN (9/30/2020 05:15 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 05:15 EDT)

dr. [REDACTED] called back and i explained in detail the patient current condition, dr. [REDACTED] verbalize understanding and stated that he wants me to transfer him to d [REDACTED] call was transfered.

Electronically Signed on 09/30/2020 05:15

[REDACTED] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 04:43 EDT  
Result Status: Auth (Verified)  
Document Subject: abg  
Perform Information: [REDACTED] RN (9/30/2020 04:44 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 04:44 EDT)

dr. [REDACTED] called back with the patient abg results and informed me due to the hgb being 5 to give the patient a pack of plaletes and to call surgery to notify them of the drop in hgb.

Electronically Signed on 09/30/2020 04:44

[REDACTED] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/30/2020 04:22 EDT  
Result Status: Auth (Verified)  
Document Subject: fixed pupils  
Perform Information: [REDACTED] RN (9/30/2020 04:24 EDT)  
Sign Information: [REDACTED] RN (9/30/2020 04:24 EDT)

**Multidisciplinary Progress Notes**

dr.johri called due to the fact that at this time for 0400 assessment the patient pupils look fixed. d. informed me to order an abg for now and a chest xray for the morning. continue to monitor the patient. infuse blood over 1 hr each pack.

Electronically Signed on 09/30/2020 04:24

RN

Document Type:	Nursing Narrative Note
Service Date/Time:	9/30/2020 03:48 EDT
Result Status:	Auth (Verified)
Document Subject:	
Perform Information:	At RN (9/30/2020 03:53 EDT)
Sign Information:	RN (9/30/2020 03:53 EDT)

dr. called in regards to the patient fluid volume status ( the sbar method was use to update the doctor on the patient status.) dr. is aware that i am unable to remove fluid and or keep the patient in a zero balance, primarily because the patient is requiring high doses of pressors. dr. stated thank you for the call and no new changes at this time.

Electronically Signed on 09/30/2020

RN

Document Type:	Nursing Narrative Note
Service Date/Time:	9/30/2020 02:17 EDT
Result Status:	Auth (Verified) decrease
Document Subject:	drainage output
Perform Information:	e RN (9/30/2020 02:35 EDT)
Sign Information:	e RN (9/30/2020 02:35 EDT)

Dr. a service called in regards to the patient output has decrease from her abdominal and her jp site. Dr. CALLED BACK AND I INFORMED HIM OF THE DECREASE IN DRAINAGE HE TOLD ME NO NEW ORDERS AT THIS TIME AND TO CALL HIM BACK IF THE DRAINAGE IN THE JP TURNS TO the same bile like color thats in the foley cath thats connected to the abdomen. i verbalize understanding. Dr. is also area that the patient is on 60 mcg of levo double concentration. no new orders at this time.

Electronically Signed on 09/30/2020 02:35

RN

Document Type:	Nursing Narrative Note
Service Date/Time:	9/30/2020 00:14 EDT
Result Status:	Auth (Verified)
Document Subject:	abg
Perform Information:	RN (9/30/2020 00:14 EDT)
Sign Information:	RN (9/30/2020 00:14 EDT)

Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

dr. [redacted] aware of abg nothing new at this time.

Electronically Signed on 09/30/2020 00:14

[redacted] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 22:20 EDT  
Result Status: Auth (Verified)  
Document Subject: cuff and aline  
Perform Information: [redacted] RN (9/29/2020 22:21 EDT)  
Sign Information: [redacted] RN (9/29/2020 22:21 EDT)

[redacted] is aware that the patient bloodure cuff and aline are not correlating at all. per dr. [redacted] follow and titrate medications based off the aline pressure.

Electronically Signed on 09/29/2020 22:21

[redacted] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 21:50 EDT  
Result Status: Auth (Verified)  
Document Subject: DR. [redacted]  
Perform Information: [redacted] RN (9/29/2020 21:51 EDT)  
Sign Information: [redacted] RN (9/29/2020 21:51 EDT)

Dr. [redacted] called at 20:52 in regards to the patient blood pressure dropping while on 50 mcg of levo,

Electronically Signed on 09/29/2020 21:51

[redacted] RN

Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 09:00 EDT  
Result Status: Auth (Verified)  
Document Subject: morning rounds- surgery  
Perform Information: [REDACTED] RN (9/29/2020 09:41 EDT)  
Sign Information: [REDACTED] RN (9/29/2020 09:41 EDT)

patient to be transported to OR now, consents reviewed and signed with husband. physicians at bedside. 2 units of blood on call to OR and ready. fluids and monitor to be transported with patient, hypoglycemia resolved prior to transfer. orders and history reviewed with OR nurse.

Electronically Signed on 09/29/2020 09:41

[REDACTED] RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 04:19 EDT  
Result Status: [REDACTED] Auth (Verified)  
Document Subject: [REDACTED]  
Perform Information: [REDACTED] 9/29/2020 07:59 EDT) a  
Sign Information: [REDACTED] (9/29/2020 07:59 EDT)

pt become confused. bp 80/50, 85%, hr 106, RR20. . Code Rescue was called

Electronically Signed on 09/29/2020 07:59

[REDACTED] RN

Document Type: [REDACTED] Nursing Narrative Note  
Service Date/Time: 9/29/2020 03:40 EDT  
Result Status: Auth (Verified)  
Document Subject: [REDACTED]  
Perform Information: [REDACTED] RN (9/29/2020 07:54 EDT)  
Sign Information: [REDACTED] RN (9/29/2020 07:54 EDT)

pt remains cold and diaphoretic. temp 34.6, bp 95/32 o2 98%. MD was made aware. more blankets were given at this time and room temperature was increased. no additional orders given at this time. continue to monitor

Electronically Signed on 09/29/2020 07:54

Sanchez, Maria M RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 03:33 EDT  
Result Status: Auth (Verified)  
Document Subject: [REDACTED]  
Perform Information: [REDACTED] RN (9/29/2020 07:42 EDT)  
Sign Information: [REDACTED] RN (9/29/2020 07:42 EDT)

Discharge Date: 9/30/2020

### Multidisciplinary Progress Notes

pt remains cold and diaphoretic. current temp 34.3. MD was made aware. no orders were given at this time. continue to monitor and reassess temp.

Electronically Signed on 09/29/2020 07:42

M RN

Document Type: Nursing Narrative Note  
Service Date/Time: 9/29/2020 02:08 EDT  
Result Status: Auth (Verified)  
Document Subject:  
Perform Information: [REDACTED] RN (9/29/2020 07:40 EDT)  
Sign Information: [REDACTED] RN (9/29/2020 07:40 EDT)

pt is cold and diaphoretic. BP 127/88, temp 34.5, o2 95%, HR 112. pt stated she is in extreme pain. warm blankets were given to pt at this time. called MD and made aware of pt current conditions. orders for additional dose of 0.5mg of Dilaudid was given as well as to continue to monitor Temp. will reassess temp and call MD with results.

Electronically Signed on 09/29/2020 07:40

RN

Document Type: Nutrition Note  
Service Date/Time: 9/30/2020 12:30 EDT  
Result Status: Auth (Verified)  
Document Subject: Nutrition Note  
Perform Information: [REDACTED] (9/30/2020 13:24 EDT)  
Sign Information: [REDACTED] (9/30/2020 14:04 EDT)

#### Nutrition Risk Level

Nutrition screen MST score of 2

#### Assessment and Monitoring

47 year old female S/P E-Lap Small bowel resection, lysis of adhesions, gastrostomy tube placement. Intubated. Unresponsive per MD notes. HX: gastric Bypass, gastric band, GI Bleed, HTN. Intubated. Chart reviewed. Medical status noted per discussion during rounds. Wt noted, increased. Lab: increased Bun/creatinine. Renal following Hyperglycemia/insulin. Skin: Mottled, cold, dry per RN assessment.

#### Nutrition Diagnosis

Problem #1 - IDNT Diagnosis: Inadequate energy intake (09/30/20 12:53:00)

Problem #1 - IDNT Inadequate Energy Intake: Other: related to disease state (09/30/20 12:53:00)

Problem #1 - IDNT As Evidenced by: patient NPO (09/30/20 12:53:00)

#### Nutrition Goals

Meet 80% or more of needs - Nutrition Goal Status: Active (09/30/20 12:53:00)

#### Admitting Diagnosis

No qualifying data available.

#### Problem List/Past Medical History

##### Ongoing

Acute pancreatitis  
Anxiety  
Benign HTN

##### Historical

GI bleed

#### Procedure/Surgical History

- Laparotomy Exploratory Lvl 4 (09/29/2020)
- Enteros wwo w b includ ileum 44376 (EN) (02/07/2020)
- Gastric bypass
- Laparoscopic adjustable gastric banding

#### Social History

##### Alcohol

Denies use, 05/19/2018

Substance Use Denies, 05/19/2018

Tobacco

Discharge Date: 9/30/2020

## Multidisciplinary Progress Notes

### Nutrition Calorie Count

No qualifying data available.

### Nutrition Interventions/Education

Monitor patient progress.

Followup based on status change/clinical judgment.

### Estimated Needs

(Based on 50kg)

Calories:1250-1500 ( 25-30 kcal/kg)

Protein:60 grams ( 1.2 grams/kg as tolerated)

Fluid: per MD

### Anthropometrics

Height/Length Measured: 152.4 cm (09/29/20 07:53:00)

Actual Weight: 81 kg (09/29/20 21:40:00)

9/28 69.1kg

BMI 29.75 with 69.1kg

DBW +10%: 50kg

Tobacco Use: Never (less than 100 in lifetime)., 09/28/2020

Tobacco Use: Never (less than 100 in lifetime)., 02/05/2020

Never smoker, 06/08/2018

### Family History

Hypertension: Father and Grandmother (P).

### Diet Order

NPO - Ordered

-- 09/29/20 1:39:00 EDT, No Exceptions

### Allergies

morphine (Headache, Itching, Watering Eyes)

### Lab Results

Creatinine on Blood: 1.9 mg/dL High (09/30/20 03:06:00)

Phosphorus Level: 7.5 mg/dL High (09/30/20 03:06:00)

Magnesium Level: 2.1 mg/dL (09/30/20 03:06:00)

WBC: 2.08 K/uL Low (09/30/20 11:45:00)

MCV: 96.4 fL (09/30/20 11:45:00)

Hematocrit: 18.5 % Critical (09/30/20 11:45:00)

Hemoglobin: 5.4 g/dL Critical (09/30/20 11:45:00)

### Medications

#### Inpatient

albumin human 5% intravenous solution, 12.5 g= 250 mL, IV Piggyback, Every 4 hr, PRN

Consult to Pharmacy, Maximally concentrate all IV drips, N/A, As Directed

D10W 1,000 mL, 1000 mL, IV Continuous

Dextrose 50% in Water intravenous solution, 12.5 g= 25 mL, IV Push, As Directed, PRN

Dextrose 50% in Water intravenous solution, 25 g= 50 mL, IV Push, As Directed, PRN

Dilaudid, 0.5 mg= 0.5 mL, IV Push, Every 6 hr while awake, PRN

glucagon, 1 mg, IntraMuscular, As Directed, PRN

glucose, 15 g= 1 EA, Oral, As Directed, PRN

HumaLOG Regimen 1 Mild, 1. MILD Correction Regimen, SubCutaneous, Before meals and HS

magnesium sulfate, 2 g= 50 mL, IV Piggyback, As Directed, PRN

meropenem, 1000 mg= 50 mL, IV Piggyback, Every 12 hrs

micafungin

norEPINEPHrine IV additive 32 mg [2 mcg/min] + dextrose 5% in water Drip. 218 mL

propofol IV additive 1,000 mg [5 mcg/kg/min] + Premix: 100 mL

Protonix, 40 mg, IV Push, BID

sodium bicarbonate 8.4% IV solution 150 mEq + dextrose 5% in water drip 850 mL

Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback

Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback

Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback

Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback

Discharge Date: 9/30/2020

**Multidisciplinary Progress Notes**

Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
Sodium Chloride 0.9% intravenous solution 250 mL, 250 mL, IV Piggyback  
vasopressin IV additive 20 units [0.03 unit/min] + sodium chloride 0.9% drip 250 mL  
Zofran, 4 mg= 2 mL, IV Push, Every 4 hr, PRN

Electronically Signed on 09/30/2020 14:04

RD

Document Type: Respiratory Therapy Progress Note  
Service Date/Time: 9/29/2020 20:07 EDT  
Result Status: Auth (Verified)  
Document Subject: ASSESSMENT  
Perform Information: (9/29/2020 20:09 EDT)  
Sign Information: (9/29/2020 20:09 EDT)

PATIENT RECEIVED ON AC MODE NO SIGN OF RESPIRATORY DISTRESS NOTED AT THIS MOMENT ,BBS ,ETT SECURED AMBU BAG AT BED SIDE ALARMS VERIFIED

Electronically Signed on 09/29/2020 20:09

Document Type: Respiratory Therapy Progress Note  
Service Date/Time: 9/29/2020 12:03 EDT  
Result Status: Auth (Verified)  
Document Subject: admission of patient  
Perform Information: (9/29/2020 18:29 EDT)  
Sign Information: RT (9/29/2020 18:29 EDT)

pt received from O.R ALREADY intubated via ambu with O2. PLACED ON ABOVE SETTING. DR [REDACTED] AT BEDSIDE. PT VERY UNSTABLE. L RADIAL ALINE IN PLACED ATTACHED TO MONITOR GOOD WAVEFORM. PT PERIPHERALS VRY COLD. SAT PROBES ON SEVERAL AREAS. UNABLE TO GET CONSTANT SAT READINGS. CHEST XRAY ANF ABGS PENDING.

Electronically Signed on 09/29/2020 18:29

RT

**Therapeutic Notes**

\*\*\* Clinical Documentation Content on Following Page \*\*\*

CROSSMATCH TRANSFUSION SLIP

Patient: ~~Smith~~, [REDACTED]

Patient ABO/Rh: ~~B POS~~

MR#: ~~970183~~

Product number: ~~W036819465259~~

DOB: ~~07/23/1973~~

Product ABO/Rh: ~~B POS~~

Product type: ~~Red Blood Cells Leukoreduced~~

EBID: ~~451787~~

Product expiration: ~~10/30/2020 23:59~~

Product Volume: 376 mL

Physician: [REDACTED]

Crossmatch Interp: Compatible

Location: [REDACTED]

Crossmatch tech: [REDACTED]

Accession: 002-19-271-0803

Crossmatch date/time: 09/30/2020 04:00

LEUKOREduced:       IRRADIATED:       CMV NEG:       HGB & NEG:   
 AUTOLOGOUS:       DIRECTED:       HLA TYPED:       BGA DEFICIENT:

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

TRANSFUSIONIST	TIME STARTED
[REDACTED]	
TRANSFUSIONIST	TIME ENDED

Issue Time: 0640  
Transfuse within 4 hours

[REDACTED]

[REDACTED]

RECEIVED AS IS

COMPONENT TRANSFUSION SLIP

Patient: [REDACTED]

Patient ABO/Rh: B POS

MRN: 978183

Product number: W239619031301

DOB: 07/23/1973

Product ABO/Rh: B POS

Product type: Thawed Pooled Cryoprecipitate 5 Units Open

Product expiration: 09/30/2020 09:19

BBID: T451787

Product Volume: 114 mL

Location: [REDACTED]

Prepared by: [REDACTED]

Prepared date/time: 09/30/2020 05:21

LEUKOREduced: \_\_\_\_\_ IRRADIATED: \_\_\_\_\_ CMV NEG: \_\_\_\_\_ RGS S NEG: \_\_\_\_\_  
ANTHODOGUS: \_\_\_\_\_ DIRECTED: \_\_\_\_\_ HLA TYPED: \_\_\_\_\_ IGA DEFICIENT: \_\_\_\_\_

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME STARTED

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME ENDED

Issue Time: \_\_\_\_\_  
Transfuse within 4 hours

[REDACTED]  
RECEIVED AS IS

COMPONENT TRANSFUSION SLIP

Patient:



Patient ABO/Rh: B POS

MRN: 978183

Product number: W036919730160

DOB: 07/23/1973

Product ABO/Rh: O POS

Product type: Apheresis Platelets Leukoreduced Irr

Product expiration: 10/01/2020 23:59

BBID: T451787

Product Volume: 216 mL

Location:



Prepared by:



Prepared date/time: 09/30/2020 04:48

LEUKOREDUCE:   
AUTOLOGOUS:

IRRADIATED:   
DIRECTED:

CMV NEG:   
HLA TYPED:

HGB S NEG:   
IGA DEFICIENT:

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBAND AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

\_\_\_\_\_  
TRANSFUSIONIST

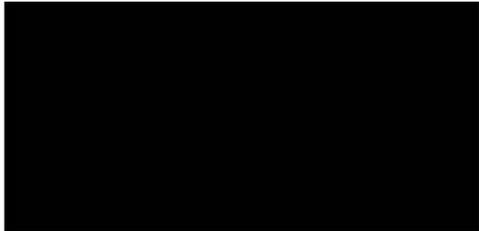
\_\_\_\_\_  
TIME STARTED

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME ENDED

Issue Time: 0514  
Transfuse within 4 hours



RECEIVED AS IS

COMPONENT TRANSFUSION SLIP

RECEIVED AS IS

Patient: [REDACTED]

Patient ABO/Rh: B POS

978183

Product number: W036819298603

DOB: 07/23/1973

Product ABO/Rh: B POS

Product type: Thawed Plasma

BBID: T451787

Product expiration: 10/04/2020 23:59

Location: [REDACTED]

Product Volume: 345 mL

Prepared by:

Prepared date/time: 09/29/2020 23:23

LEUKOREduced: \_\_\_\_\_  
AUTOLOGOUS: \_\_\_\_\_

IRRADIATED: \_\_\_\_\_  
DIRECTED: \_\_\_\_\_

CMV NEG: \_\_\_\_\_  
HLA TYPED: \_\_\_\_\_

HGB S NEG: \_\_\_\_\_  
IGA DEFICIENT: \_\_\_\_\_

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME STARTED

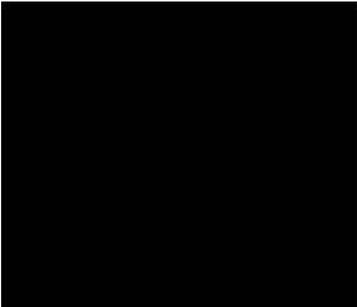
\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME ENDED

Time: 23:26

Transfuse within 4 hours



RECEIVED AS IS

COMPONENT TRANSFUSION SLIP

Patient: [REDACTED]

Patient ABO/Rh: B POS

IN: 978183

Product number: W036819145967

DOB: 07/23/1973

Product ABO/Rh: B POS

Product type: Thawed Plasma

BBID: T451787

Product expiration: 10/05/2020 23:59

Product Volume: 357 mL

Location: [REDACTED]

Prepared by: [REDACTED]

Prepared date/time: 09/30/2020 01:36

LEUKOREduced:       IRRADIATED:       CIV NBC:       MCB S BEC:   
 AUTOLOGOUS:       DIRECTED:       RLA TYPED:       MCA DEFICIENT:

COMMENT: \_\_\_\_\_

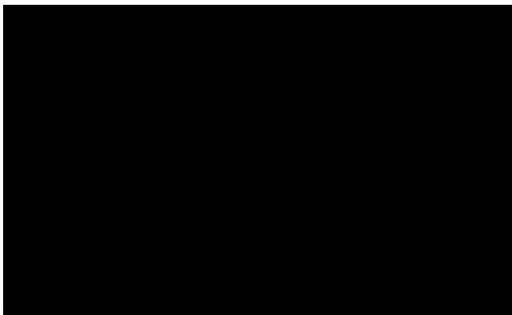
BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

\_\_\_\_\_  
 TRANSFUSIONIST      TIME STARTED

\_\_\_\_\_  
 WITNESS

\_\_\_\_\_  
 TRANSFUSIONIST      TIME ENDED

Issue Time: 0210  
 transfuse within 4 hours



COMPONENT TRANSFUSION SLIP

RECEIVED AS IS

Patient: [Redacted]

Patient ABO/Rh: B POS

MRN: 978163

Product number: W036819227792

DOB: 07/23/1973

Product ABO/Rh: B POS

Product type: Thawed Plasma

BBID: T451787

Product expiration: 10/05/20 23:59

Product Volume: 339 mL

Location: [Redacted]

Prepared by: [Redacted]

Prepared date/time: 09/30/2020 01:36

LEUKOREduced:	_____	IRRADIATED:	_____	CMV NEG:	_____	HGB & NEG:	_____
AUTOLOGOUS:	_____	DIRECTED:	_____	HLA TYPED:	_____	IGA DEFICIENT:	_____

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, BOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE ORDER UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

_____ TRANSFUSIONIST	_____ TIME STARTED
_____ WITNESS	
_____ TRANSFUSIONIST	_____ TIME ENDED

Issue Time: 0348  
Use within 4 hours

COMPONENT TRANSFUSION SLIP **RECEIVED AS IS**

Patient: 

Patient ABO/Rh: B POS

MRN: 978183

Product number: W239619031302



Product ABO/Rh: B POS

DOB: 07/23/1973

Product type: Thawed Pooled Cryoprecipitate 5 Units Open

Product expiration: 09/30/2020 09:19

BBID: T451787

Product Volume: 117 mL

Location: 

Prepared by: 

Prepared date/time: 09/30/2020 05:21

LEUKOREduced: <input type="checkbox"/>	IRRADIATED: <input type="checkbox"/>	CMV NEG: <input type="checkbox"/>	HGB S NEG: <input type="checkbox"/>
AUTOLOGOUS: <input type="checkbox"/>	DIRECTED: <input type="checkbox"/>	HLA TYPED: <input type="checkbox"/>	IGA DEFICIENT: <input type="checkbox"/>

CONVERT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

\_\_\_\_\_  
TRANSFUSIONIST

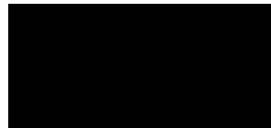
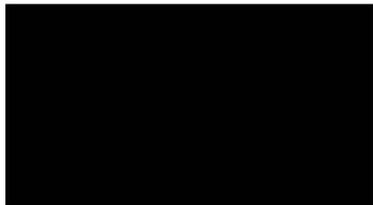
\_\_\_\_\_  
TIME STARTED

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
TRANSFUSIONIST

\_\_\_\_\_  
TIME ENDED

Issue time: \_\_\_\_\_  
Transfuse within 4 hours



COMPONENT TRANSFUSION SLIP

RECEIVED AS IS



Patient ABO/Rh: B POS

978183

Product number: W036819306216

Product ABO/Rh: B NEG

DOB: 07/23/1973

Product type: Thawed Plasma

Product expiration: 10/04/2020 23:59

BRID: T451787

Product volume: 200 ml

Location:



Prepared by:



Prepared date/time: 09/29/2020 23:23

LEUKOREduced:   
AUTOLOGOUS:

IRRADIATED:   
DIRECTED:

CMV NEG:   
HLA TYPED:

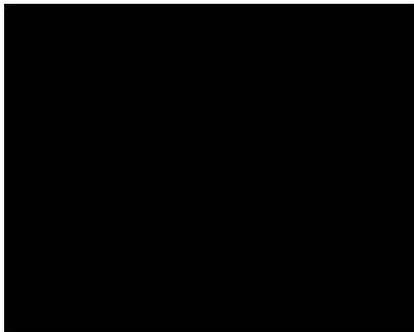
HGB S NEG:   
IGA DEFICIENT:

COMMENT: \_\_\_\_\_

BEFORE STARTING TRANSFUSION, I CERTIFY THAT I HAVE IDENTIFIED THE RECIPIENT BY INSPECTION OF THE WRISTBANDS AND THAT THE NAME, DOB AND MED RECORD NUMBER ARE THE SAME AS ON THIS FORM. I FURTHER CERTIFY THAT THE DONOR UNIT LABEL HAS THE SAME UNIT NUMBER, ABO GROUP, AND RH AS STATED ON THIS FORM.

_____ TRANSFUSIONIST	_____ TIME STARTED
_____ WITNESS	
_____ TRANSFUSIONIST	_____ TIME ISSUED

me: 0055  
re within 4 hours



Discharge Date: 9/30/2020

***CPR Forms***

**\*\*\* Clinical Documentation Content on Following Page \*\*\***

\* Auth (Verified) \*

Time	(check as indicated)			ABC						(check or enter value as indicated)							Defibrillation	Medication	Notes			
	BVM Bag/mask	Chest compression	Invasive Airway	Capnography	Spontaneous Pulse	Blood Pressure	Spontaneous Respirations	Sinus	SVT	V. Fib	V. Tach	PEA	Asystole	Other	Joules	Name, Dose & Route						
1335	✓	✓	✓																			
1337	✓	✓	✓	10																		
1340	✓	✓	✓	15																		
1341																						
1342	✓	✓	✓	13																		
1343	✓	✓	✓	13																		
1344																						
1346	✓	✓	✓	10																		
1347																						
1349	✓	✓	✓	12																		
1350																						

Sheet # \_\_\_\_\_ of \_\_\_\_\_

**SCITATION REPORT**

Page 2 of 2

SMH 1553 Rev. 10/14  
05500S1553



\* Auth (Verified) \*

SURG: [REDACTED] SURG: [REDACTED] ANESTHESIOLOGIST: [REDACTED] MD ANESTHESIA TYPE: General ASA Class: III	DOB: 04/23/1973 AGE: 46 years Gender: Female PRE-EXISTING CONDITIONS: BOWEL OBSTRUCTION PRE-EXISTING CONDITIONS: "Acute pancreatitis" NPO:	Height: 152.4cm Weight: 70.4kg Allergies: morphine
---	---	--

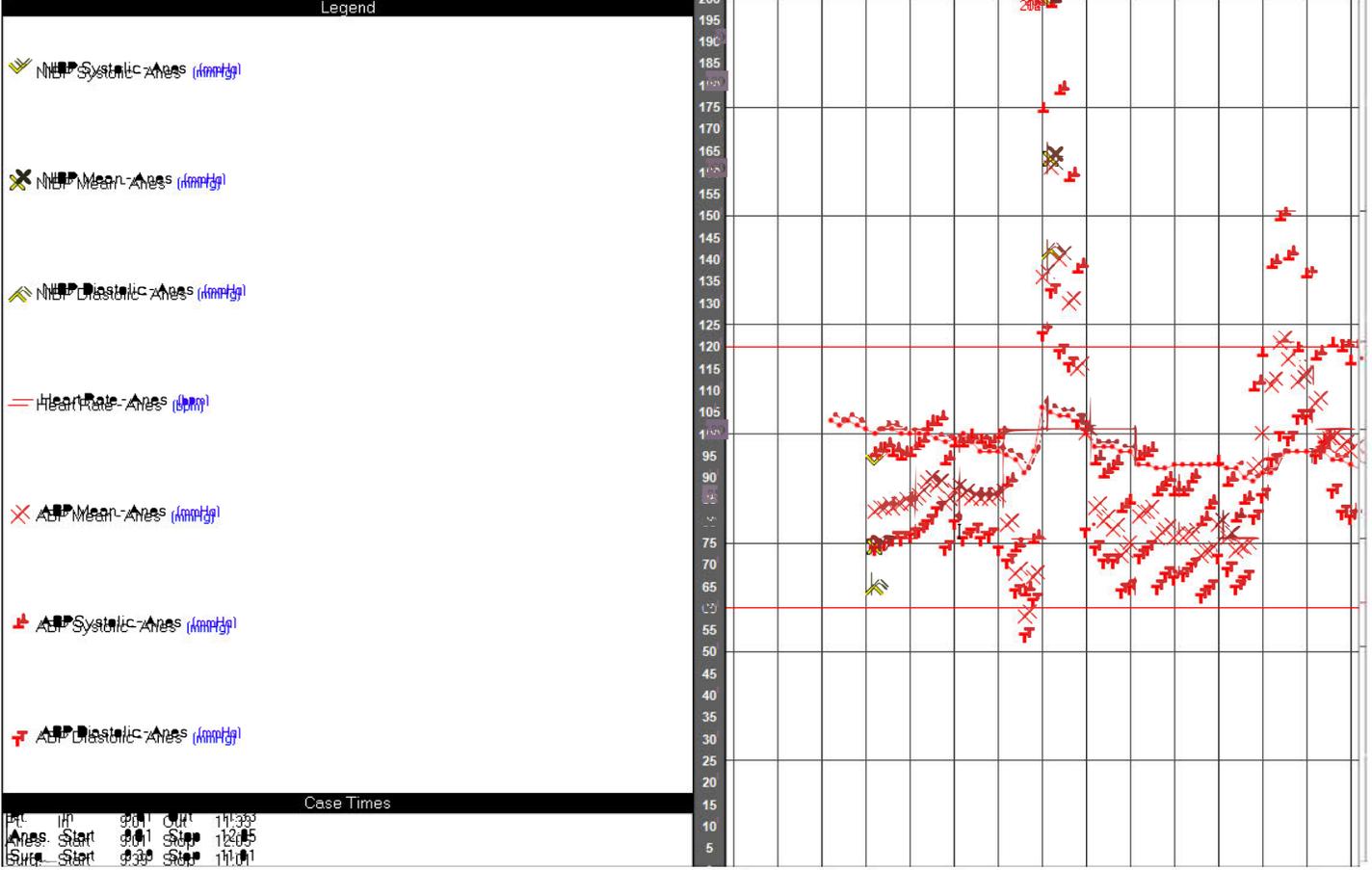
Time	09:29:2019	9:15	9:30	9:45	10:00
<b>Medications</b>					
Propofol 200 mg/mL 10 mL	10 mg		10 mg		
Propofol 200 mg/mL 10 mL	10 mg		10 mg		
Propofol 200 mg/mL 10 mL	4 mg			2 mg	
Propofol 200 mg/mL 10 mL	5 mg				
Propofol 200 mg/mL 10 mL	40 mg		20 mg		
Propofol 200 mg/mL 10 mL	29.55 mg				
Propofol 200 mg/mL 10 mL	80 mg		20 mg	10 mg	10 mg
Propofol 200 mg/mL 10 mL	100 mg		100 mg		
Propofol 200 mg/mL 10 mL	8 mg		8 mg		
Propofol 200 mg/mL 10 mL	8 mg			8 mg	
Sevoflurane 8% 50 mL	125 mL			50 mL	20 mL

Time	09:29:2019	9:15	9:30	9:45	10:00
<b>Gases</b>					
O2 Flow	100%	100%	100%	100%	97%
FiO2	0.21	0.21	0.21	0.21	0.21
PEEP	0	0	0	0	0

Time	09:29:2019	9:15	9:30	9:45	10:00
<b>Intake</b>					
Left Anes Circuit	1400 mL				
Right Anes Circuit	1000 mL				
Right Anes Circuit	500 mL				

Time	09:29:2019	9:15	9:30	9:45	10:00
<b>Output</b>					
Urine	5 mL				
Stomach	100 mL				

Time	09:29:2019	9:15	9:30	9:45	10:00
<b>Monitors</b>					
SpO2	99%	99%	99%	99%	99%
ET CO2	35	35	35	35	35
Temp	36.5	36.5	36.5	36.5	36.5
MAP	70	70	70	70	70
HR	100	100	100	100	100
PEEP	0	0	0	0	0



Patient Name:  
Date of Birth:

\* Auth (Verified) \*

Finalized: 09/29/2020 2:05  
Page 2 of 4

978183  
SMOP-2020-7381  
Laboratory Explanatory Lvl 4

OPR: SMORINTR06  
Surgery Date: 09/29/2020 0:20  
Surgeon: [REDACTED] MD  
Anesthesiologist: [REDACTED] MD  
Anesthesia Type: General  
ASA Class: 4E

DOB: 07/23/1973  
AGE: 46 years  
Gender: Female  
Pre-Op Diagnosis: BOWEL OBSTRUCTION  
Reason for Admit: "Acute pancreatitis"  
NPO:

Height: 152.4 cm  
Weight: 70.4 kg  
Allergies: morphine

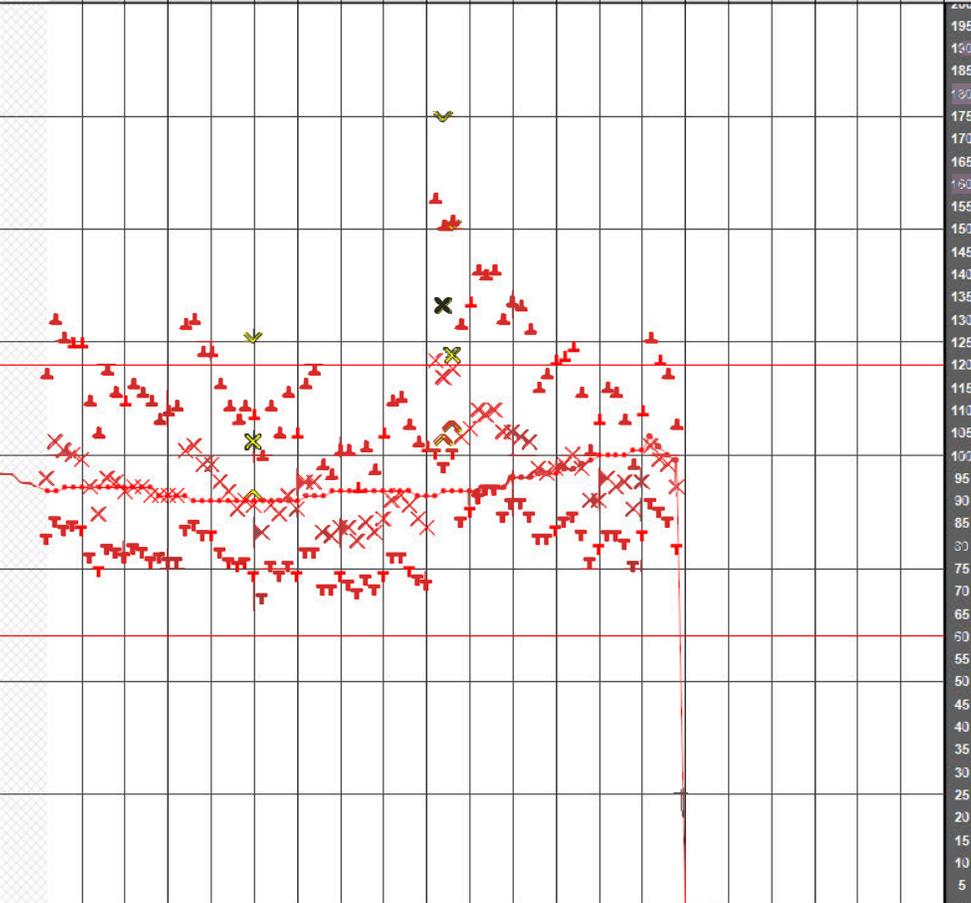
	10:30	10:45	11:00	11:15	11:30	11:45	09/29/2020
<b>Medications</b>							
		5 mg	2 mg				
		100 mcg	100 mcg				
		0.25 mg/kg/hr	0.25 mg/kg/hr				
		200 mg					
<b>Gases</b>							
	4	4	4	4	4	4	4
	96	96	96	96	96	96	96
	0	0	0	0	0	0	0
	0.9	1	1	0.9	0.8	0.8	0.6
	0.6	0.6	0.6	0.6	0.4	0.4	0.3
<b>Intake</b>							
	628.00 ml (qtz)		175 ml (qtz)				
	628.00 ml (qtz)		175 ml (qtz)				
<b>Output</b>							
			5				
			100				
<b>Monitors</b>							
	31	30	32	32	31	27	25
	35.2	35.2	35.2	35.5	35.5		
	41						
	696	694	693	689	611	556	677
	18	18	7	9	9	9	7
	29	29	31	31	29	29	32
	4	4	4	4	4	4	4

Personnel

Provider: [REDACTED] 8:58- 12:01

Supervisor: [REDACTED] 8:58- 12:01

Signed By: [REDACTED] 12:03 09/29/2020



Actions

09/25/2013

8:58 Anesthesia Pre-Op Start  
 8:59 Pre-Op Checklist  
 Patient Identified: Yes  
 Vent Machine Checked: Yes  
 Nitrous Oxide/O2 Supply Checked: Yes  
 Suction Available and Checked: Yes  
 O2 Analysis Checked: Yes  
 Monitoring Devices Checked: Yes  
 Airway Maint Equip Available: Yes  
 Scavenging System Checked: Yes  
 Emergency Drugs Available: Yes  
 9:00 Anesthesia Pre-Op Stop  
 9:01 Patient In Room  
 Anesthesia Start  
 9:03 Anesthesia Pause  
 Patient ID: Yes  
 Anesthesia Plan: Yes  
 Surgical Procedure: Yes  
 Surgical Site: Yes  
 9:13 Arterial Line  
 Art Line Start Time: Art Line Start Time: 09/25/2013 9:13  
 Site: Anterior Iliac  
 Procedure Location: OR  
 Side: Left  
 Site: Radial  
 Seldinger Technique: Yes  
 Allen Test: Normal  
 Sterile Technique: Cap and Mask  
 Sterile Technique: Hand Hygiene and Sterile Glove  
 Sterile Technique: Sterile Drapes  
 Skin Preparation: Chlorhexidine  
 Guidance: Ultrasound Guided  
 Dressing/Fixation: Suture  
 Dressing/Fixation: Taped  
 Dressing/Fixation: Transparent Occlusive  
 Inserted by: By - Laukas, Andrew MD  
 Art Line Procedure: Procedure - ARTERIAL LINE INSERTION 39920  
 Art Line Stop Time: Art Line Stop Time: 09/25/2013 9:13  
 Pre-Anes & Eval Performed: Yes  
 Anes Plan Described: Yes  
 Present at Induction: Yes  
 Immediate Avail at All Times: Yes  
 Pre Induction Assessment  
 Patient ID Verified: Yes  
 Pt Reval'd Prior to Induction: Yes  
 Proceed W/ Planned Anesthesia: Yes  
 9:35 Induction of Anesthesia  
 Type of Induction: Intravenous  
 Type of Induction: Rapid Sequence with Cricoid Pressure  
 Face Mask Size: Adult Face Mask  
 Preoxygenation w/ High Flow O2: Yes  
 Eyes Protected by: Taped  
 Eyes Protected by: Manually Closed  
 Endotracheal Intubation  
 In-Situ: No  
 100% Pre-Oxygenate: Yes  
 Laryngoscope Type: Macintosh  
 Laryngoscope Type: 3  
 Laryngoscopic Grade: 1 (Full View of Glottis)  
 Route: Oral  
 Endotracheal Tube Type: Standard  
 Endotracheal Tube Size: 7.5  
 Cuffed: Yes  
 Leak: None  
 Position Confirmed: CO2  
 Position Confirmed: Chest Expansion  
 Position Confirmed: Auscultation  
 Breath Sounds: Breath Sounds Equal Bilaterally  
 Etc @ Teeth/Gums: cm - 22  
 ET Tube Secured: Taped  
 Atraumatic: Yes  
 Difficult Intubation: No  
 Difficult Intubation Procedure: N/A  
 Freetext Note  
 Note: Note - all standard monitors applied, unable to obtain SaO2 reading after multiple attempts. patient unstable proceeded to induce and intubate. Abg drawn immediately following induction.  
 9:38 Patient Positioning  
 Position: 1  
 Body Position: Supine

Legs: Neutral  
 Right Arm: Extended less than 90 degrees with palms up  
 Right Arm: Pressure Point Padded  
 Left Arm: Extended less than 90 degrees with palms up  
 Left Arm: Pressure Point Padded  
 Head Supported By: Pillow  
 Neck: Neutral  
 Patient Positional: With Surgeon  
 Patient Positional: With Nurse  
 9:39 Surgery Start  
 9:41 Prophylactic Antibiotic \*  
 Given in: OR Prior to Incision  
 Reason Not Given: Ongoing Treatment  
 Temperature Management  
 Temperature Probe: Esophageal  
 Warming/Cooling Devices: Forced Air Warming  
 Location: Upper Body  
 10:15 NG and/or OG Tube Placemen  
 In-Situ: No  
 Tube Type: Salem Sump  
 Gauge: 16 Fr  
 Route: Nasal  
 Side (Nares): Right  
 Suctioned Applied: Intermittent  
 Tube Left in Place: Surgeon request  
 Tube Removal: At Termination of Surgery  
 10:48 Postop Documentation  
 Surgical Procedure: Procedure #1 - e lap. lyses of adhesion  
 Surgical Procedure: Procedure #2 - roux n y  
 Surgical Procedure: Procedure #3 - small bowel resection  
 Surgical Procedure: Procedure #4 - gastrectomy  
 ICD10 Postop Diagnosis: Diagnosis #1 - bowel necrosis  
 ICD10 Postop Diagnosis: Diagnosis #2  
 ICD10 Postop Diagnosis: Diagnosis #3  
 11:01 Surgery Stop  
 11:32 Transport  
 O2 Delivery Device: ETT  
 O2 Delivery Device: Ambu Bag  
 O2 Flow: L/min - 15  
 Hemodynamically Stable: Yes  
 Monitors for Transport: EKG  
 Monitors for Transport: Arterial Line  
 Monitors for Transport: Pulse Oximeter  
 Transported To: PACU  
 Report Given To: RN  
 Report Given To: ICU Physician  
 Vital Signs: Temperature (C) - 35  
 Vital Signs: Respiratory Rate - 18  
 Vital Signs: Systolic Blood Pressure (mmHg) - 102  
 Vital Signs: Diastolic Blood Pressure (mmHg) - 57  
 Vital Signs: Heart Rate (BPM) - 106  
 Vital Signs: Oxygen Saturation (%) - 98  
 Vent Settings: FiO2 (%) - 100  
 Post-Op Status: Guarded  
 11:33 Patient Out Room  
 12:05 Postop Handoff  
 Location: ICU  
 Transferred Via: Bed  
 Transfer Monitor: Arterial Line  
 Transfer Monitor: EKG  
 Transfer Monitor: Pulse Oximeter  
 Vital Signs: Temp - 35  
 Vital Signs: Heart Rate - 106  
 Vital Signs: Respiratory Rate - 16  
 Vital Signs: SpO2% - 98  
 Vital Signs: Systolic Blood Pressure - 102  
 Vital Signs: Diastolic Blood Pressure - 57  
 Intubated: No  
 Ventilated: No  
 Ventilated: Breathes Spontaneously  
 LOC: Awake  
 Airway: Patent  
 Hand Off to: RN  
 Hand Off to: Full Report Given, No Anesthetic Complication  
 Situation: Described the Patient's Current Status  
 Background: Provided an Overview of Relevant Assessment: Communicated the Patient's Current Condition  
 Recommendation: Recommended a Plan to Meet the Patient's Needs  
 Anesthesia Stop

\* Auth (Verified) \*

08/09/2012 12:05  
12:05 @pegie04 61 4

978183  
SMOR-2019-7381  
Laparotomy Exploratory Lvl 4

Comments

Medication Comments

**norEPINEPHrine (Levophed) 16 mg/D5W 250 mL Drip (Scanning Only) - 2155 mcg @ 9:37**  
Comment: continued by ICU staff

Monitor Comments

**SPO2 - Anes - 83 @ 11:05**  
poor signal

Action Comments

**Prophylactic Antibiotic @ 9:41**  
Zosyn infusing prior to OR

Discharge Date: 9/30/2020

## Anesthesia Records

Document Type: PreAnesthesia Note  
Service Date/Time: 9/29/2020 08:01 EDT  
Result Status: Auth (Verified)  
Document Subject: Pre anesthesia Evaluation  
Perform Information: [REDACTED] (9/29/2020 08:24 EDT)  
Sign Information: [REDACTED] w MD (9/29/2020 08:24 EDT)

### Pre anesthesia Evaluation

Patient: [REDACTED] MRN: 978183 FIN: 905814081  
Age: 47 years Sex: Female DOB: 07/23/73  
Associated Diagnoses: None  
Author: [REDACTED]

### History of Present Illness

Diagnosis  
**Abdominal pain**  
**Acute hyperglycemia**  
**Acute hypokalemia**  
**Acute pancreatitis**  
**Anxiety**  
**Ascites**  
**Benign HTN**  
**Diarrhea**  
**H/O gastric bypass**  
**Lactic acidosis**  
**Nausea**  
**Pneumobilia**  
**SBO (small bowel obstruction)**  
**Severe sepsis**  
**Vomiting.**

### Preoperative Information

#### VS/Measurements

##### Vital Signs

09/29/20 07:00 EDT	Heart Rate Monitored	96 bpm	
	<b>Respiratory Rate</b>	<b>25 br/min HI</b>	(Modified)
	Systolic Blood Pressure	102 mmHg	
	Diastolic Blood Pressure	60 mmHg	
	Mean Arterial Pressure, Cuff	74 mmHg	
09/29/20 06:45 EDT	Heart Rate Monitored	98 bpm	
	Respiratory Rate	18 br/min	
	Systolic Blood Pressure	112 mmHg	
	Diastolic Blood Pressure	59 mmHg	
	Mean Arterial Pressure, Cuff	75 mmHg	
09/29/20 06:30 EDT	Heart Rate Monitored	100 bpm	
	<b>Respiratory Rate</b>	<b>28 br/min HI</b>	
	Systolic Blood Pressure	106 mmHg	
	Diastolic Blood Pressure	82 mmHg	
	Mean Arterial Pressure, Cuff	91 mmHg	
09/29/20 06:15 EDT	<b>Heart Rate Monitored</b>	<b>105 bpm HI</b>	
	<b>Respiratory Rate</b>	<b>26 br/min HI</b>	
	Systolic Blood Pressure	96 mmHg	
	Diastolic Blood Pressure	85 mmHg	
	Mean Arterial Pressure, Cuff	91 mmHg	

Discharge Date: 9/30/2020

### Anesthesia Records

09/29/20 06:00 EDT	<b>Heart Rate Monitored</b>	<b>108 bpm HI</b>
	<b>Respiratory Rate</b>	<b>26 br/min HI</b>
	<b>Systolic Blood Pressure</b>	<b>78 mmHg &lt;LLOW</b>
	Diastolic Blood Pressure	53 mmHg
	<b>Mean Arterial Pressure, Cuff</b>	<b>62 mmHg LOW</b>
09/29/20 05:45 EDT	<b>Heart Rate Monitored</b>	<b>103 bpm HI</b>
	Respiratory Rate	14 br/min
	<b>Systolic Blood Pressure</b>	<b>79 mmHg &lt;LLOW</b>
	Diastolic Blood Pressure	66 mmHg
	Mean Arterial Pressure, Cuff	72 mmHg
09/29/20 05:30 EDT	Heart Rate Monitored	99 bpm
	<b>Respiratory Rate</b>	<b>34 br/min &gt;HHI</b>
09/29/20 05:15 EDT	<b>Heart Rate Monitored</b>	<b>102 bpm HI</b>
	<b>Respiratory Rate</b>	<b>34 br/min &gt;HHI</b>
	Systolic Blood Pressure	100 mmHg
	Diastolic Blood Pressure	71 mmHg
	Mean Arterial Pressure, Cuff	95 mmHg
09/29/20 04:10 EDT	<b>Temperature Oral</b>	<b>34.9 Deg C &lt;LLOW</b>
	<b>Systolic Blood Pressure</b>	<b>80 mmHg &lt;LLOW</b>
	Diastolic Blood Pressure	50 mmHg
09/29/20 04:05 EDT	<b>Temperature Oral</b>	<b>33.8 Deg C &lt;LLOW</b>
	<b>Systolic Blood Pressure</b>	<b>75 mmHg &lt;LLOW</b>
	Diastolic Blood Pressure	38 mmHg
09/29/20 03:40 EDT	<b>Temperature Temporal Artery</b>	<b>34.6 Deg C &lt;LLOW</b>
	Heart Rate Monitored	60 bpm
	Systolic Blood Pressure	95 mmHg
	Diastolic Blood Pressure	32 mmHg
	<b>Mean Arterial Pressure, Cuff</b>	<b>48 mmHg &lt;LLOW</b>
09/29/20 03:33 EDT	<b>Temperature Oral</b>	<b>34.3 Deg C &lt;LLOW</b>
09/29/20 02:28 EDT	Respiratory Rate	18 br/min
09/29/20 02:05 EDT	Respiratory Rate	18 br/min
	Blood Pressure Location	Left arm
	Temperature Route	Oral
	Blood Pressure Position	Lying down
09/29/19 02:01 EDT	Respiratory Rate	18 br/min
09/29/19 02:00 EDT	<b>Heart Rate Monitored</b>	<b>112 bpm HI</b>
	Systolic Blood Pressure	127 mmHg
	Diastolic Blood Pressure	88 mmHg
	Mean Arterial Pressure, Cuff	96 mmHg
09/29/20 02:00 EDT	<b>Temperature Oral</b>	<b>34.5 Deg C &lt;LLOW</b>
09/29/20 01:31 EDT	Respiratory Rate	20 br/min
09/29/20 01:13 EDT	Temperature Oral	36.6 Deg C
	<b>Heart Rate Monitored</b>	<b>105 bpm HI</b>
	<b>Respiratory Rate</b>	<b>21 br/min HI</b>
	Systolic Blood Pressure	140 mmHg
	<b>Diastolic Blood Pressure</b>	<b>95 mmHg HI</b>
09/29/20 00:33 EDT	Temperature Oral	36.5 Deg C
	<b>Heart Rate Monitored</b>	<b>104 bpm HI</b>
	Respiratory Rate	19 br/min
	<b>Systolic Blood Pressure</b>	<b>174 mmHg HI</b>
	<b>Diastolic Blood Pressure</b>	<b>97 mmHg HI</b>
09/28/20 23:58 EDT	<b>Heart Rate Monitored</b>	<b>123 bpm &gt;HHI</b>
	Respiratory Rate	20 br/min
	<b>Systolic Blood Pressure</b>	<b>171 mmHg HI</b>
	Diastolic Blood Pressure	89 mmHg
09/28/20 22:30 EDT	<b>Heart Rate Monitored</b>	<b>129 bpm &gt;HHI</b>

Discharge Date: 9/30/2020

### Anesthesia Records

	<b>Respiratory Rate</b>	24 br/min HI	
	<b>Systolic Blood Pressure</b>	178 mmHg HI	
	<b>Diastolic Blood Pressure</b>	94 mmHg HI	
09/28/20 22:01 EDT	<b>Respiratory Rate</b>	21 br/min HI	
09/28/20 21:30 EDT	<b>Heart Rate Monitored</b>	114 bpm HI	
	<b>Respiratory Rate</b>	22 br/min HI	
	<b>Systolic Blood Pressure</b>	162 mmHg HI	(Modified)
	<b>Diastolic Blood Pressure</b>	93 mmHg HI	
09/28/20 20:55 EDT	Temperature Oral	36.5 Deg C	
	<b>Peripheral Pulse Rate</b>	130 bpm >HHI	
	Respiratory Rate	18 br/min	
	Systolic Blood Pressure	108 mmHg	
	Diastolic Blood Pressure	89 mmHg	

, Measurements from flowsheet : Measurements

09/29/20 07:53 EDT	Height/Length Measured	152.4 cm
	Ideal Body Weight Calculated	45.5 kg
09/29/20 06:23 EDT	Height/Length Measured	152.4 cm
	Ideal Body Weight Calculated	45.5 kg
	BSA Estimated	1.73 m2
	Weight Measured	70.4 kg
09/29/20 05:30 EDT	Height/Length Measured	152.4 cm
	Body Mass Index Measured	30.31 kg/m2
	Weight Measured	70.4 kg
09/29/20 01:39 EDT	Height/Length Measured	152.4 cm
	BSA Measured	1.66 m2
	BSA Measured	1.66 m2
	BSA Estimated	1.71 m2
	Body Mass Index Measured	29.75 kg/m2
	Weight Measured	69.1 kg
09/29/20 01:23 EDT	Height/Length Measured	152.4 cm
	Body Mass Index Measured	29.75 kg/m2
	Weight Measured	69.1 kg
09/28/20 20:55 EDT	Height/Length Measured	152.4 cm
	Body Mass Index Measured	29.75 kg/m2
	Weight Measured	69.1 kg

#### Health Status

##### Allergies:

Nonallergic Reactions (All)

Unknown

Morphine- Itching, watering eyes and headache.

Canceled/Inactive Reactions (All)

No Known Allergies

##### Current medications: (Selected)

Inpatient Medications

Ordered

Colace: 100 mg, Oral, BID

Dextrose 50% in Water intravenous solution: 12.5 g, IV Push, As Directed, PRN: other (see comment)

Dextrose 50% in Water intravenous solution: 25 g, IV Push, As Directed, PRN: other (see comment)

Dilaudid: 0.5 mg, IV Push, Every 3 hrs, PRN: pain, severe (scale 7-10)

HumaLOG Regimen 1 Mild: 1. MILD Correction Regimen, SubCutaneous, Before meals and HS

NS (Sodium Chloride 0.9%) 1,000 mL: 150 mL/hr, IV Continuous, Stop: 10/29/20 8:04:00 EDT

Pepcid: 20 mg, IV Push, BID

Sodium Chloride 0.9% intravenous solution 250 mL: 10 mL/hr, IV Piggyback, Stop: 09/30/20 6:48:00 EDT

**Anesthesia Records**

Sodium Chloride 0.9% with KCl 20 mEq/L intravenous solution 1,000 mL: 150 mL/hr, IV Continuous, Stop: 10/29/20

6:10:00 EDT

Tylenol: 650 mg, Oral, Every 6 hr, PRN: pain, moderate (scale 4-6)  
 Zofran: 4 mg, IV Push, Every 6 hr, PRN: nausea/vomiting  
 Zosyn: 3.375 g = 50 mL, 100 mL/hr, IV Piggyback, Every 8 hrs  
 glucagon: 1 mg, IntraMuscular, As Directed, PRN: other (see comment)  
 glucose: 15 g, Oral, As Directed, PRN: other (see comment)  
 lactated ringer's bolus: 1,000 mL, 1000 mL/hr, IV Bolus, Once  
 Futurectulose: 20 g, Oral, Every 6 hr, PRN: constipation  
 Restoril: 7.5 mg, Oral, Daily at bedtime, PRN: insomnia  
 morphine: 2 mg, IV Push, Every 4 hr, PRN: pain, severe (scale 7-10)

Documented Medications

*Documented*

IBU 800 mg oral tablet: 1 tabs, Oral, Every 8 hrs, PRN: pain, moderate (scale 4-6), 0 Refill(s)  
 cloNIDine 0.3 mg oral tablet: 1 tabs, Oral, TID  
 diazePAM 10 mg oral tablet: 1 tabs, Oral, Every 6 hr, PRN: as needed for anxiety,

**Medications (16) Active**

Scheduled: (5)

**docusate sodium (Colace) 100 mg capsule** 100 mg 1 cap, Oral, BID  
**famotidine (Pepcid) PF 20 mg/2 mL vial** 20 mg 2 mL, IV Push, BID  
**insulin lispro (HumaLOG) 100 units/mL (3 mL vial)** 1. MILD Correction Regimen, SubCutaneous, Before meals and HS  
**lactated ringers** 1,000 mL, IV Bolus, Once  
**piperacillin/tazobactam/D5W** 3.375 g 50 mL, IV Piggyback, Every 8 hrs  
 Continuous: (3)  
**sodium chloride 0.9% 1,000 mL** 1,000 mL, IV Continuous, 150 mL/hr  
**sodium chloride 0.9% 250 mL** 250 mL, IV Piggyback, 10 mL/hr  
**sodium chloride 0.9% with KCl 20 mEq/L 1,000 mL** 1,000 mL, IV Continuous, 150 mL/hr  
 PRN: (8)  
**acetaminophen (Tylenol) 325 mg tablet** 650 mg 2 tabs, Oral, Every 6 hr  
**dextrose 50% syringe 50 mL** 12.5 g 25 mL, IV Push, As Directed  
**dextrose 50% syringe 50 mL** 25 g 50 mL, IV Push, As Directed  
**glucagon recombinant 1 mg vial** 1 mg, IntraMuscular, As Directed  
**glucose 40% 15 g gel** 15 g 1 EA, Oral, As Directed  
**HYDRomorphone (Dilaudid) 0.5 mg/0.5 mL syringe** 0.5 mg 0.5 mL, IV Push, Every 3 hrs  
**lactulose 10 g/15 mL oral soln 30 mL UD** 20 g 30 mL, Oral, Every 6 hr  
**ondansetron 4 mg/2 mL injectable** 4 mg 2 mL, IV Push, Every 6 hr

**Review of Systems**

**Problem list:**

All Problems

Acute pancreatitis / 303630010 / Confirmed  
 Anxiety / BgCTWgDjf6PNMBadCwsLDQ / Confirmed  
 Benign HTN / AZEGxwEmL07HeYbhwKgAAg / Confirmed,

**Active Problems (3)**

**Acute pancreatitis**  
**Anxiety**  
**Benign HTN .**

**Physical Examination**

**Pain assessment:** Pain Assessment  
 09/29/20 05:30 EDT

Pain Management Goal	2
Pain Present	Yes actual or suspected pain
Numeric Pain Score (0-10)	10
Total Numeric Pain Score	10
Preferred Pain Tool v2	Numeric

**Anesthesia Records**

	Numeric Pain Score with Activity	10
	Pasero Opioid Induced Sedation Scale	2=Slightly drowsy, easily aroused
	Pain comment	Patient states she stil has pain worst ain og her life. Intensivist notified, she has received a total of 2mg of dilaudid
09/29/20 04:10 EDT	Pain Present	No actual or suspected pain
09/29/20 04:05 EDT	Pain Present	No actual or suspected pain
09/29/20 03:33 EDT	Pain Present	No actual or suspected pain
09/29/20 02:28 EDT	Pain Present	Yes actual or suspected pain
09/29/20 02:01 EDT	Pain Management Goal	2
	Numeric Pain Score (0-10)	6
	Numeric Rating With Activity	7
	Primary Pain Aggravating Factors	None
	Primary Pain Alleviating Factors	Deep breathing, Medications, Repositioning
	Primary Pain Location	Abdomen
	Primary Pain Time Pattern	Intermittent
	Primary Pain Onset	Continuous
	Primary Pain Quality	Aching
	Pasero Opioid Induced Sedation Scale	1=Awake and alert
	Pasero Opioid Induced Sedation Score	1
09/29/20 01:39 EDT	Pain Management Goal	2
	Pain Present	Yes actual or suspected pain
	Numeric Pain Score (0-10)	6
	Total Numeric Pain Score	6
	Preferred Pain Tool v2	Numeric
	Primary Pain Aggravating Factors	Movement, Palpation
	Primary Pain Alleviating Factors	Deep breathing, Medications, Repositioning
	Numeric Pain Score with Activity	8
	Primary Pain Location	Abdomen
	Primary Pain Time Pattern	Constant
	Primary Pain Onset	Continuous
	Primary Pain Quality	Aching
	Pasero Opioid Induced Sedation Scale	1=Awake and alert
	Pasero Opioid Induced Sedation Score	1
	Nonpharmacological Therapy	Positioning, Relaxation techniques, Rest, Lights dimmed
	Pain comment	pt received pain mediation at 0131
09/29/20 01:23 EDT	Numeric Pain Score (0-10)	9
	Numeric Rating With Activity	9
09/28/20 22:30 EDT	Pain Management Goal	0
	Pain Present	Yes actual or suspected pain
	Numeric Pain Score (0-10)	9
	Total Numeric Pain Score	9
	Preferred Pain Tool v2	Numeric
	Numeric Pain Score with Activity	9
	Pasero Opioid Induced Sedation Scale	1=Awake and alert
	Pasero Opioid Induced Sedation Score	1
	Pain comment	Patient has no had any pain relief at this time, Dr. B█n made aware, no new orders.
09/28/20 22:00 EDT	Pain Management Goal	0
	Pain Present	Yes actual or suspected pain
	Numeric Pain Score (0-10)	9
	Total Numeric Pain Score	9

Discharge Date: 9/30/2020

### Anesthesia Records

09/28/20 20:55 EDT

Preferred Pain Tool v2	Numeric
Numeric Pain Score with Activity	9
Pasero Opioid Induced Sedation Scale	1=Awake and alert
Pasero Opioid Induced Sedation Score	1
Pain comment	Patient is still in pain at this time despit medication. Dr. [REDACTED], new orders.
Pain Management Goal	0
Pain Present	Yes actual or suspected pain
Numeric Pain Score (0-10)	10
Total Numeric Pain Score	10
Preferred Pain Tool v2	Numeric
Primary Pain Aggravating Factors	None
Primary Pain Alleviating Factors	None
Numeric Pain Score with Activity	10
Primary Pain Location	Abdomen
Primary Pain Time Pattern	Constant
Primary Pain Onset	Continuous
Primary Pain Quality	Aching, Discomfort, Tenderness
Pasero Opioid Induced Sedation Scale	1=Awake and alert
Pasero Opioid Induced Sedation Score	1
Pain comment	Patient states that she started having generalized abdominal pain since this AM and started getting worse. Patient has been vomiting all day. As per patient she has a GI appt on Monday for endoscopy but was unable to wait for appt. Patient is not nauseous

#### Histories

##### Family History:

Hypertension  
Father  
Grandmother (P)

##### Procedure history:

Enteros wwo w b includ ileum 44376 (EN) on 02/07/20 at 46 Years.

##### Comments:

02/07/20 17:30 EST - [REDACTED] G RN  
auto-populated from documented surgical case

Gastric bypass (2819423013).

Laparoscopic adjustable gastric banding (2532982016).

##### Social History

##### Social & Psychosocial Habits

##### Alcohol

05/19/2018 **Use:** Denies use

##### Substance Use

05/19/2018 **Use:** Denies

##### Tobacco

**Anesthesia Records**

06/08/2018 **Use:** Never smoker

02/05/2020 **Use:** Never (less than 100 in l

09/28/2020 **Use:** Never (less than 100 in l.

**Review / Management**

**Results review:**

**Labs** (Last four charted values)

<b>WBC</b>	3.69	(SEP 29)	5.65	(SEP 28)	, Lab results	
	09/29/20 07:53 EDT				Est. CrCl-CG-Adult (drug dosing only)	62.80 mL/min
	09/29/20 07:48 EDT				<b>Glucose Point of Care</b>	<b>22 mg/dL CRIT</b>
					<b>Point Of Care Note</b>	<b>CallReadBackRN</b>
	09/29/20 07:44 EDT				<b>Glucose Point of Care</b>	<b>&lt;10 mg/dL CRIT</b>
					<b>Point Of Care Note</b>	<b>Repeated Test</b>
	09/29/20 06:23 EDT				Est. CrCl-CG-Adult (drug dosing only)	62.80 mL/min
	09/29/20 05:30 EDT				Est. CrCl-CG-Adult (drug dosing only)	62.80 mL/min
	09/29/20 04:52 EDT				Hemoglobin	13.8 g/dL
					<b>Hematocrit</b>	<b>46.3 % HI</b>
					WBC	3.69 K/uL
					Platelet Count	281 K/uL
					RBC	4.55 M/uL
					<b>MCV</b>	<b>101.8 fL HI</b>
					MCH	30.3 pg
					<b>MCHC</b>	<b>29.8 g/dL LOW</b>
					RDW CV	13.8 %
					<b>RDW SD</b>	<b>52.3 fL HI</b>
					MPV	11.0 fL
					NRBCs	0.00 /100 WBC
					Abs NRBCs	0.00 K/uL
					<b>Lactic Acid (Lactate)</b>	<b>8.0 mmol/L CRIT</b>
					<b>Procalcitonin (PCT)</b>	<b>24.83 ng/mL CRIT</b>
	09/29/20 04:49 EDT				RBC Product Ready	Done
	09/29/20 04:18 EDT				Glucose Point of Care	126 mg/dL
	09/29/20 02:20 EDT				<b>Calcium (Total)</b>	<b>8.4 mg/dL LOW</b>
					Cholesterol Level	174 mg/dL
					Trig	64 mg/dL
					<b>HDL Cholesterol</b>	<b>73 mg/dL HI</b>
					Cholesterol/HDL Ratio	2.4 ratio
					LDL	88 mg/dL
	09/29/20 01:39 EDT				Est. CrCl-CG-Adult (drug dosing only)	62.21 mL/min
	09/29/20 01:23 EDT				Est. CrCl-CG-Adult (drug dosing only)	62.21 mL/min
	09/28/20 23:46 EDT				Color - UR	Yellow
					Appearance-Ur	Clear
					Glucose - Urine	Negative
					Bilirubin - UR	Negative
					<b>Acetone (Ketones)-Urine</b>	<b>15</b>
					Specific Gravity	>=1.030
					Blood	Negative
					PH in Urine	5.5
					<b>Protein, UR SCR</b>	<b>100</b>
					Urobilinogen	0.2
					Nitrite	Negative
					Leukocyte Esterase	Negative
					<b>WBCs - UR</b>	<b>0 /HPF</b>

**Anesthesia Records**

09/28/20 22:05 EDT

<b>RBCs - UR</b>	<b>0 /HPF</b>
<b>Squamous Epithelial Cells</b>	<b>5 /HPF</b>
<b>Bacteria</b>	<b>Few /HPF</b>
Hemoglobin	13.2 g/dL
Hematocrit	42.1 %
WBC	5.65 K/uL
Platelet Count	247 K/uL
RBC	4.38 M/uL
MCV	96.1 fL
MCH	30.1 pg
<b>MCHC</b>	<b>31.4 g/dL LOW</b>
RDW CV	13.6 %
<b>RDW SD</b>	<b>48.5 fL HI</b>
MPV	11.2 fL
<b>Differential Type</b>	<b>Auto</b>
<b>Differential Type</b>	<b>Auto</b>
<b>% Neutrophils</b>	<b>83.2 % HI</b>
% Immature Granulocytes	0.2 %
<b>% Lymphocytes</b>	<b>13.5 % LOW</b>
<b>% Monocytes</b>	<b>2.7 % LOW</b>
% Eosinophils	0.0 %
% Basophils	0.4 %
Absolute Neutrophils	4.71 K/uL
Absolute Lymphocytes	0.76 K/uL
<b>Absolute Monocytes</b>	<b>0.15 K/uL LOW</b>
Absolute Eosinophils	0.00 K/uL
Absolute Basophils	0.02 K/uL
Absolute Immature Granulocytes	0.01 K/uL
NRBCs	0.00 /100 WBC
Abs NRBCs	0.00 K/uL
<b>RBC Morphology</b>	<b>Reviewed</b>
Sodium on Blood	144 mmol/L
<b>Potassium on Blood</b>	<b>2.8 mmol/L LOW</b>
<b>Chloride on Blood</b>	<b>113 mmol/L HI</b>
<b>CO2 on Blood</b>	<b>19 mmol/L LOW</b>
Anion Gap	12
<b>Glucose on Blood</b>	<b>210 mg/dL HI</b>
Creatinine on Blood	0.98 mg/dL
<b>BUN on Blood</b>	<b>23 mg/dL HI</b>
<b>BUN/Creatinine Ratio</b>	<b>23.5 ratio HI</b>
<b>eGFR (CKD-EPI) if Africn Am</b>	<b>80 mL/min/1.73 m2 NA</b>
<b>eGFR (CKD-EPI) NonAfricn Am</b>	<b>69 mL/min/1.73 m2 NA</b>
Calcium (Total)	8.8 mg/dL
Total Protein on Blood	6.4 g/dL
<b>Albumin on Blood</b>	<b>3.1 g/dL LOW</b>
Globulin	3.3 g/dL
<b>A/G Ratio</b>	<b>0.9 ratio LOW</b>
ALT (SGPT) on Blood	22 U/L
<b>AST (SGOT) on Blood</b>	<b>42 U/L HI</b>
<b>AST/ALT Ratio</b>	<b>1.9 ratio NA</b>
Alkaline Phosphatase on Blood	75 U/L
Total Bilirubin on Blood	0.5 mg/dL
Bilirubin (Direct)	0.2 mg/dL
Bilirubin, Indirect	0.3 mg/dL
Troponin I (Quant)	<0.02 ng/mL
<b>Lipase Lvl</b>	<b>2,771 U/L HI</b>

[Redacted]

**Anesthesia Records**

Est. CrCl-CG-Adult (drug dosing only) 62.21 mL/min  
Pregnancy Test-Blood(Qual) Negative  
ABORH B POS  
Antibody Screen Negative  
Crossmatch - IS Compatible  
Crossmatch - IS Compatible

**Assessment and Plan**

**American Society of Anesthesiologists(ASA) physical status classification:** Class IV, E.

**Anesthetic Preoperative Plan**

Anesthetic technique: General anesthesia.

Notes: ASA 4 E for GETA

Pt is s/p gastric bypass (a few years ago) presents to the hospital with hard/tender abdomen and one week of vomiting. Pt was admitted to the floor early this morning hypertensive. Pt administered dilaudid and vasotec after which BP was very low and pt was transferred to the ICU. When seen this morning, BP: 109 systolic after receiving 4 liters of LR. Pt with foley- no urine output over past several hours. Pt is confused, husband at bedside. BS 20 this morning- Pt being administered D50. Pt is hypothermic, hypokalemic.

PMH: HTN, no Hx of CAD

PSH: gastric bypass sx, adbominoplasty - no anesth comps

ALL: morphine

Airway: MP2

NPO: >8Hrs.

Electronically Signed on 09/29/2020 08:24

[Redacted] MD

Document Type: PostAnesthesia Note  
Service Date/Time: 9/29/2020 21:33 EDT  
Result Status: [Redacted] Auth (Verified)  
Document Subject: Post Anesthesia Evaluation Note  
Perform Information: [Redacted] MD (9/29/2020 21:35 EDT)  
Sign Information: [Redacted] MD (9/29/2020 21:35 EDT)

**Post Anesthesia Evaluation Note**

Patient: [Redacted] MRN: 978183 FIN: 905814081  
Age: 47 years Sex: Female DOB: 07/23/73  
Associated Diagnoses: None  
Author: [Redacted] P MD

**Assessment**

**Post Anesthesia Assesment**

Vitals: Temperature Axillary: 35 Deg C Low (09/29/20 08:00:00)  
Temperature Oral: 34.9 Deg C Critical (09/29/20 04:10:00)  
Temperature Temporal Artery: 34.6 Deg C Critical (09/29/20 03:40:00)  
Heart Rate Monitored: 98 bpm (09/29/20 20:02:00)  
Respiratory Rate: 30 br/min High (09/29/20 20:02:00)  
Systolic Blood Pressure: 74 mmHg Critical (09/29/20 14:15:00)  
Diastolic Blood Pressure: 25 mmHg (09/29/20 14:15:00)  
SpO2: 98 % (09/29/20 08:41:00).

Discharge Date: 9/30/2020

### Anesthesia Records

Mental status: Sedated in SICU.  
Respiratory function: Airway Patent remained intubated postoperatively as discussed with surgical team, ETT secured in place.  
Followed by intensivist.  
Pain: unable to assess, pt sedated.  
Nausea status: see nursing med documentation.  
Hydration: euvolemic.  
Recovery: Anesthesia continued sedation postoperatively.  
Notes: No apparent anesthetic problems.

Electronically Signed on 09/29/2020 21:35

MD

### Perioperative Record

Document Type: Main OR IntraOperative Record  
Service Date/Time: 9/29/2020 11:01 EDT Modified  
Result Status: SMOR IntraOp Record  
Document Subject:  
Perform Information: (10/2/2020 14:32 EDT); RN  
(9/29/2020 18:43 EDT); RN (9/29/2020 11:48 EDT)

### SMOR IntraOp Record

#### SMOR IntraOp Record Summary

Primary Physician:   
Case Number: SMOR-2020-7381  
Finalized Date/Time: 10/02/19 14:32:20  
Pt. Name:   
D.O.B./Sex: 07/23/1973 Female  
Med Rec #: 978183  
Physician:   
Financial #: 905814081  
Pt. Type: I  
Room/Bed: SICU/05  
Admit/Disch: 09/28/20 20:53:00  
-09/30/20 17:07:14  
Institution:

#### SMOR - Case Attendance

	Entry 1	Entry 2	Entry 3
Case Attendee		MD	
CRNA	el MD		
Role Performed	Surgeon/Proceduralist - Primary	Anesthesiologist of Record	CRNA
Time In	09/29/20 09:01:00	09/29/20 09:01:00	09/29/20 09:01:00
Time Out	09/29/20 10:57:00	09/29/20 11:33:00	09/29/20 11:33:00

Patient Name:  
MRN:  
Encounter:

Admit Date: 9/28/2020  
Discharge Date: 9/30/2020

### Perioperative Record

<b>Procedure</b> Exploratory Lvl 4 Vendors A - F Vendors G - O Vendors P - Z Vendor Rep/Other Personnel Last Modified By:	Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN 10/02/20 14:31:58	Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN 10/02/20 14:31:58	Laparotomy Lvl 4, Gastrostomy [REDACTED] RN 10/02/20 14:31:58
<b>Case Attendee</b> Role Performed Time In Time Out Procedure Exploratory Lvl 4 Vendors A - F Vendors G - O Vendors P - Z Vendor Rep/Other Personnel Last Modified By:	<b>Entry 4</b> [REDACTED] Surgical Assistant 09/29/20 09:01:00 09/29/20 11:33:00 Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN 10/02/20 14:31:58	<b>Entry 5</b> [REDACTED] RN Circulator 09/29/20 09:01:00 09/29/20 11:33:00 Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN 10/02/20 14:31:58	<b>Entry 6</b> [REDACTED] RN Circulator 09/29/20 09:01:00 09/29/20 11:33:00 Laparotomy Lvl 4, Gastrostomy [REDACTED] RN 10/02/20 14:31:58
<b>Case Attendee</b> Role Performed Time In Time Out Procedure Exploratory Lvl 4 Vendors A - F Vendors G - O Vendors P - Z Vendor Rep/Other Personnel Last Modified By:	<b>Entry 7</b> XXXXXXXXXXXXXXXXXXXX Scrub Personnel 09/29/20 09:01:00 09/29/20 11:33:00 Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN 10/02/19 14:31:58	<b>Entry 8</b> XXXXXXXXXXXXXXXXXXXX MD Fellow 09/29/20 09:01:00 09/29/20 11:33:00 Laparotomy Exploratory Lvl 4, Gastrostomy Lvl 4 [REDACTED] RN [REDACTED]/19 14:31:58	

#### SMOR - Case Attendance Audit

10/02/19 14:31:58	Owner: ROS30480	Modifier: ROS30480
1	<*> Procedure	Laparotomy Exploratory Lvl 4
2	<*> Procedure	Laparotomy Exploratory Lvl 4
3	<*> Procedure	Laparotomy Exploratory Lvl 4
4	<*> Procedure	Laparotomy Exploratory Lvl 4
5	<*> Procedure	Laparotomy Exploratory Lvl 4
6	<*> Procedure	Laparotomy Exploratory Lvl 4
7	<*> Procedure	Laparotomy Exploratory Lvl 4
8	<*> Procedure	Laparotomy Exploratory Lvl 4
09/29/19 11:33:27	Owner: ROS30480	Modifier: ROS30480
1	<*> Procedure	Laparotomy Exploratory Lvl 4
2	<+> Time Out	
2	<*> Procedure	Laparotomy Exploratory Lvl 4
3	<+> Time Out	
3	<*> Procedure	Laparotomy Exploratory Lvl 4
4	<+> Time Out	
4	<*> Procedure	Laparotomy Exploratory Lvl 4

Patient Name:

MRN:

Encounter:

Admit Date: 9/28/2020

Discharge Date: 9/30/2020

**Perioperative Record**

5 <+> Time Out  
5 <\*> Procedure Laparotomy Exploratory Lvl 4  
6 <+> Time Out  
6 <\*> Procedure Laparotomy Exploratory Lvl 4  
7 <+> Time Out  
7 <\*> Procedure Laparotomy Exploratory Lvl 4  
8 <+> Time Out  
8 <\*> Procedure Laparotomy Exploratory Lvl 4  
**09/29/20 10:58:42 Owner: ROS30480 Modifier: ROS30480**  
1 <\*> Time Out 09/29/20 09:36:00  
1 <\*> Procedure Laparotomy Exploratory Lvl 4  
**09/29/20 10:04:03 Owner: ROS30480 Modifier: ROS30480**  
1 <+> Time Out  
1 <\*> Procedure Laparotomy Exploratory Lvl 4  
**09/29/20 09:24:42 Owner: ROS30480 Modifier: ROS30480**  
<+> 8 Case Attendee  
<+> 8 Role Performed  
<+> 8 Time In  
<+> 8 Procedure  
**09/29/20 09:20:33 Owner: ROS30480 Modifier: ROS30480**  
1 <+> Time In  
1 <\*> Procedure Laparotomy Exploratory Lvl 4  
<+> 2 Case Attendee  
<+> 2 Role Performed  
<+> 2 Time In  
<+> 2 Procedure  
<+> 3 Case Attendee  
<+> 3 Role Performed  
<+> 3 Time In  
<+> 3 Procedure  
<+> 4 Case Attendee  
<+> 4 Role Performed  
<+> 4 Time In  
<+> 4 Procedure  
<+> 5 Case Attendee  
<+> 5 Role Performed  
<+> 5 Time In  
<+> 5 Procedure  
<+> 6 Case Attendee  
<+> 6 Role Performed  
<+> 6 Time In  
<+> 6 Procedure  
<+> 7 Case Attendee  
<+> 7 Role Performed  
<+> 7 Time In  
<+> 7 Procedure

**SMOR - Case Times**

**Entry 1**  
Pt In Room Time 09/29/20 09:01:00 Surgery / Procedure 09/29/20 09:39:00  
Surgery / Procedure 09/29/20 11:01:00 Start Time  
Stop Time Pt. Out Room Time 09/29/20 11:33:00  
Last Modified By: [REDACTED]  
09/29/20 11:33:26

**SMOR - Case Times Audit**

09/29/20 11:33:26 Owner: ROS30480 Modifier: ROS30480  
<+> 1 Pt. Out Room Time  
09/29/20 11:01:30 Owner: ROS30480 Modifier: ROS30480  
<+> 1 Surgery / Procedure Stop Time

Patient Name:

MRN:

Encounter:

Admit Date: 9/28/2020

Discharge Date: 9/30/2020

### Perioperative Record

09/29/20 09:51:31 Owner: ROS30480 Modifier: ROS30480  
<+> 1 Surgery / Procedure Start Time

#### SMOR - General Case Data

**Pre-Care Text:**

A.350.1 Classifies surgical wound  
Entry 1

**Case Information**

OR	SMOR INTR 06	Specialty	General Surgery (SN)
ASA Class	4E	Case Level	Level 4
Wound Class	1-Clean	Case Level Verified	Yes
Wound Class Verified	Yes		
Preop Diagnosis	BOWEL OBSTRUCTION	Postop Same As Preop	Yes
Postop Diagnosis	BOWEL OBSTRUCTION		
Last Modified By:	[REDACTED] RN		
	09/29/20 09:20:51		

**Post-Care Text:**

0.760 Patient receives consistent and comparable care regardless of the setting

#### SMOR - Surgical Procedures

**Pre-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality Im.150 Develops individualized plan of care

	Entry 1	Entry 2
<b>Procedure Description</b>		
Procedure	Laparotomy Exploratory Lvl 4	Gastrostomy Lvl 4
<b>Modifiers</b>		
Additional Procedure Detail	LYSIS OF ADHESIONS, SMALL BOWEL RESECTION, ROUX-EN-Y	LYSIS OF ADHESIONS, SMALL BOWEL RESECTION, ROUX-EN-Y
<b>Primary Procedure</b>	Yes	No
Primary	[REDACTED]	[REDACTED] MD
<b>Start</b>	09/29/20 09:39:00	09/29/20 09:39:00
<b>Stop</b>	09/29/20 11:01:00	09/29/20 11:01:00
<b>Anesthesia Type</b>	General	General
<b>Surgical Service</b>	General Surgery (SN)	General Surgery (SN)
<b>Wound Class</b>	1-Clean	1-Clean
<b>Last Modified By:</b>	[REDACTED] RN 09/29/20 11:33:29	[REDACTED] RN 10/02/20 14:31:53

**Post-Care Text:**

0.730 The patient's care is consistent with the individualized perioperative plan of care

#### SMOR - Surgical Procedures Audit

10/02/20 14:31:53	Owner: ROS30480	Modifier: ROS30480
<+> 2	Procedure	
<+> 2	Primary Procedure	
<+> 2	Primary Surgeon/Proceduralist	
<+> 2	Surgical Service	
<+> 2	Start	
<+> 2	Stop	
<+> 2	Wound Class	
<+> 2	Anesthesia Type	
<+> 2	Additional Procedure Detail	
09/29/20 11:33:29	Owner: ROS30480	Modifier: ROS30480
<+> 1	Stop	
09/29/20 10:16:53	Owner: ROS30480	Modifier: ROS30480

Discharge Date: 9/30/2020

**Perioperative Record**

1 <\*> Procedure Laparotomy Exploratory Lvl 4  
1 <\*> Additional Procedure Detail LYSIS OF ADHESIONS, SMALL BOWEL RESECTION ,ROUX-EN-Y  
09/29/19 10:04:36 Owner: ROS30480 Modifier: ROS30480  
1 <\*> Procedure Laparotomy Exploratory Lvl 4  
1 <+> Start  
1 <\*> Additional Procedure Detail

**SMOR - Counts Verification**

**Pre-Care Text:**

A.20 Verifies operative procedure, sugical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

	Entry 1	Entry 2	Entry 3
Count Type	Initial Count	Closing 1 Count	Final Count
Procedure	Laparotomy Exploratory	Laparotomy Exploratory	Laparotomy Exploratory
Count Participants	Lvl 4 [REDACTED] RN, [REDACTED]	Lvl 4 [REDACTED] RN, [REDACTED]	Lvl 4 [REDACTED]
Count Status	Initial	Correct	Correct
Items Counted	Instruments, Sponges, Sponges,	Instruments, Sponges,	Instruments,
Last Modified By:	[REDACTED] 09/29/20 09:23:26	[REDACTED] 09/29/20 10:59:06	[REDACTED] RN 09/29/20 10:59:06

**Post-Care Text:**

E.50 Evaluates results of the surgical count 0.20 Patient is free from unintended retained foreign objects

**SMOR - Counts Verification Audit**

09/29/20 10:59:06 Owner: ROS30480 Modifier: ROS30480  
<+> 2 Count Type  
<+> 2 Count Participants  
<+> 2 Count Status  
<+> 2 Items Counted  
<+> 2 Procedure  
<+> 3 Count Type  
<+> 3 Count Participants  
<+> 3 Count Status  
<+> 3 Items Counted  
<+> 3 Procedure

**SMOR - Cultures and Specimens**

**Pre-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality Im.320 Manages culture specimen collection  
Im.330 Manages specimen handling and disposition

	Entry 1	Entry 2	Entry 3
Type	Culture	Specimen	Specimen
Culture/Specimen #	1. PERITONEAL FLUID	A. SMALL BOWEL RESECTION ROUX-EN-Y	B. DISTAL SMALL BOWEL
Description			
Date/Time	09/29/20 10:04:00	09/29/20 10:04:00	09/29/20 10:04:00
Tests Requested (specimens)	Culture	Tissue in formalin	Tissue in formalin
Disposition	To Microbiology	Specimen Room	Specimen Room
Disposition Comment			
Transported By			
Culture Type			

Discharge Date: 9/30/2020

Perioperative Record

Last Modified By: [redacted] 09/29/20 10:04:57 [redacted] 09/29/20 11:31:23 [redacted] 09/29/20 11:31:23

Post-Care Text: E.40 Evaluates correct processes have been performed for specimen handling and disposition 0.40 Patient's specimen(s) is managed in the appropriate manner

SMOR - Cultures and Specimens Audit

09/29/20 11:31:23 Owner: ROS30480 Modifier: ROS30480
<+> 2 Tests Requested (specimens)
<+> 2 Disposition
<+> 2 Date/Time
<+> 2 Type
<+> 2 Culture/Specimen #
<+> 3 Tests Requested (specimens)
<+> 3 Disposition
<+> 3 Date/Time
<+> 3 Type
<+> 3 Culture/Specimen #

SMOR - Dressing/Packing

Pre-Care Text: A.350 Assesses susceptibility for infection Im.250 Administers care to invasive devices Im.290 Administer care to wound sites Im.300 Implements aseptic technique

Table with 4 columns: Procedure, Entry 1, Entry 2, Entry 3. Rows include Dressing/Packing/Immobilization Items, Site, Site Details, Additional Dressing Details, and Dressed By.

Post-Care Text: E.320 Evaluate factors associated with increased risk for postoperative infection at the completion of the procedure 0.200 Patient's wound perfusion is consistent with or improved from baseline levels 0. Patient is free from signs and symptoms of infection

SMOR - Dressing/Packing Audit

09/29/20 11:22:01 Owner: ROS30480 Modifier: ROS30480
1 <\*> Procedure Laparotomy Exploratory Lvl 4
1 <+> Dressing/Packing/Immobilization Items
<+> 2 Site
<+> 2 Procedure
<+> 2 Dressing/Packing/Immobilization Items
<+> 2 Dressed By
<+> 3 Site

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**Perioperative Record**

<+> 3 Procedure  
<+> 3 Dressing/Packing/Immobilization  
Items  
<+> Dressed By  
09/29/20 09:24:53 Owner: ROS30480 Modifier: ROS30480  
1 <\*> Procedure Laparotomy Exploratory Lvl 4  
1 <+> Dressed By

**SMOR - Medications**

**Pre-Care Text:**

A.10 Confirms patient identity A.30 Verifies allergies Im.220 Administers prescribed medications  
Im.220.2 Administers prescribed antibiotic therapy as ordered

**Entry 1**

Non-anesthesia  
Intraoperative  
medications ordered  
and documented per  
policy?

Yes  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:26:10

**Post-Care Text:**

E.20 Evaluates response to medications O.130 Patient receives appropriately administered medication(s)

**SMOR - Patient Care Devices**

**Pre-Care Text:**

A.200 Assesses risk for normothermia regulation A.40 Verifies presence of prosthetics or corrective  
devices  
Im.280 Implements thermoregulation measures Im.60 Uses supplies and equipment within safe parameters

**Entry 1**

**Entry 2**

**Entry 3**

Equipment Type  
Serial Number  
Flexible Endoscope  
Sterilization/HLD  
Cycle Number:  
Equipment Setting  
Comment

SMOR CAUTERY BOVIE  
VALLEYLAB  
1G  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:28:59

SMOR CAUTERY  
ENSEAL/HARMONIC  
SB52147  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:28:59

SMOR PUMP FLOWTRON  
SB89657  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:28:59

**Entry 4**

Equipment Type  
Serial Number  
Flexible Endoscope  
Sterilization/HLD  
Cycle Number:  
Equipment Setting  
Comment

SMOR WARMER BAIRHUGGER  
SB61598  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:28:59

**Post-Care Text:**

E.10 Evaluates signs and symptoms of physical injury to skin and tissue O.60 Patient is free from signs  
and symptoms of injury caused by extraneous objects

**SMOR - Patient Positioning**

**Pre-Care Text:**

A.240 Assesses baseline skin condition A.280 Identifies baseline musculoskeletal status A.280.1  
Identifies

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physical alterations that require additional precautions for procedure-specific positioning A.510.8
Maintains patient's dignity and privacy Im.120 Implements protective measures to prevent skin/tissue injury due
to mechanical sources Im.40 Positions the patient Im.80 Applies safety devices

Entry 1
Procedure Laparotomy Exploratory Body Position Supine
Left Arm Position Extended on padded arm Right Arm Position Extended on padded
arm board at <90 degrees
Left Leg Position Extended Right Leg Position Extended
Feet Uncrossed? Yes Pressure Points Checked Yes
Positioning Device Arm Boards, Arm Strap, Positioned By MD,
Foam Pad, Head
Positioner, Standard OR
Table, Safety Strap, -May
Pillow R

Last Modified By: RN
09/29/20 09:29:52

Post-Care Text:
E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.290 Evaluates
musculoskeletal status 0.80 Patient is free from signs and symptoms of injury related to positioning 0.120 the patient
is free from signs and symptoms of injury related to transfer/transport 0.250 Patient's musculoskeletal status
is maintained at or improved from baseline levels

SMOR - Safety Checklist 1) Sign In

Pre-Care Text:
A.10 Confirms patient identity A.20 Verifies operative procedure, surgical site, and laterality A.20.1
Verifies consent for planned procedure A.30 Verifies allergies

Entry 1
Chart Review NPO Status, Labwork, H Blood Ordered T&S
& P, Pre-Op Checklist,
Pre-Op Skin Assessment,
Surgical Consent,
Anesthesia Consent,
Other Consent
Mental / Emotional Sedated Patient identity, Status Yes
site, procedure,
consent confirmed
Secondary ID Yes Site Marked Yes
bracelet placed on
patient
Procedure/Surgery Yes If the patient has Consent Confirmed Yes
a known allergy, is
the allergy band in
place?
Hair Removal No Limitations Mobility
Completed in Preop
Comfort Level Pain free, Patient Warm Special Equipment/ Yes
Implants / Medical
Devices Available
Patient ID Yes Does patient have No

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**Perioperative Record**

confirmed on X-rays  
and Scanned images

metal in body?

Patient asked "Do  
you have any other  
removable  
items...i.e.

Discharge Plan

PACU I

jewelry/contacts/den  
tures/hearing aids?

Completed Date/Time 09/29/20 09:00:00

Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:31:02

**Post-Care Text:**

E.30 Evaluates verification process for correct patient, site, side, and level surgery

**SMOR - Safety Checklist 3) Sign Out**

**Pre-Care Text:**

Im.330 Manages specimen handling and disposition

**Entry 1**

Nurse verbally  
verifies with  
surgeon and team  
the name of the  
procedure(s)  
recorded

Yes

Nurse verbally  
verifies with  
surgeon and team  
that instrument,  
sponge, and needle  
counts are correct  
(or N/A)

Yes

Nurse verbally  
verifies with  
surgeon and team  
how specimen is  
labeled (including  
patient name)

Yes

Nurse verbally  
verifies with  
surgeon and team  
any equipment  
problems to be  
addressed

Yes

Surgeon,  
anesthesia, nurse  
review key concerns  
for recovery and  
management of  
patient

Yes

Sign Out Time

09/29/20 10:56:00

Last Modified By: \_\_\_\_\_ RN  
09/29/20 10:58:46

**Post-Care Text:**

is performed on the correct site, side, and level 0.50 patient's current status is communicated throughout  
the continuum of care 0.40 Patient's specimen(s) is managed in the appropriate manner

**SMOR - Safety Checklist 3) Sign Out Audit**

09/29/20 10:58:46

Owner: ROS30480

Modifier: ROS30480

<+> 1 Sign Out Time

**SMOR - Skin Assessment**

**Pre-Care Text:**

injury due to mechanical sources Im.240 Assesses baseline skin condition Im.120 Implements protective measures to prevent skin or tissue  
to thermal sources Im.280.1 Implements protective measures to prevent skin or tissue injury due  
thermal sources Im.360 Monitors for signs and symptoms of infection

**Entry 1**

**Entry 2**

Skin assessment done Prior to Procedure

Post procedure

Skin Integrity Intact

Intact

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**Perioperative Record**

Skin Abnormality No No  
Surgeon Notified n/a n/a  
Abnormality Location  
Abnormality Type  
Color  
Abnormality Comment  
Last Modified By: \_\_\_\_\_ RN \_\_\_\_\_ RN  
09/29/20 09:31:30 09/29/20 09:31:30

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.270 Evaluate tissue perfusion  
0.60 Patient is free from signs and symptoms of injury caused by extraneous objects 0.210 Patient's tissue perfusion is consistent with or improved from baseline levels

**SMOR - Skin Prep**

**Pre-Care Text:**

A.30 Verifies allergies A.20 Verifies procedure, surgical site, and laterality A.510.8 Maintains patient's dignity and privacy Im.270 Performs Skin Preparation Im.270.1 Implements protective measures to prevent skin and tissue injury due to chemical sources A.300.1 Protects from cross-contamination

**Entry 1**

**Skin Prep**

Prep Agents (Im.270) Chloraprep Prep By \_\_\_\_\_ E  
RN  
Prep Area (Im.270) Nipple to pubis Prep Area Details Bilateral  
Skin Prep Agent Dry Yes  
Without Pooling  
Hair Removal  
Hair Removal Methods No hair removal performed in OR  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:31:44

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.100 Patient is free from signs and symptoms of chemical injury 0.740 The patient's right to privacy is maintained

**SMOR - Irrigation**

**Pre-Care Text:**

A.280 Verifies allergies A.310 Identifies factors associated with an increased risk for hemorrhage or fluid and electrolyte imbalance Im.210 Administers prescribed solutions A.280.1 Implements protective measures to prevent skin or tissue injury due to thermal sources

**Entry 1**

Irrigant 0.9% Normal Saline Irrigant Volume In 2000 mL  
Irrigant Volume Out 2000 mL  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:26:06

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.10 Patient is free from signs and symptoms of injury due to thermal sources 0.100 Patient is free from signs and symptoms of chemical injury

**SMOR - Delays**

**Entry 1**

Delay Reason No Delays Duration 0.00 minutes  
Last Modified By: \_\_\_\_\_ RN

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Perioperative Record

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SMOR - Transport

Entry 1
Patient Status Intubated Patient LOC Unresponsive
Patient IV Access Yes Oxygen in Use? Yes
Patent
Airway Device Endotracheal tube Post-op Destination ICU
Via Bed Transport and Care Information Reported to Receiving Nurse? Siderails Up? Yes
Monitors? Ambu-Bag, Cardiac/Transport Monitor, Oxygen Saturation Monitor
Transported By Anesthesia Provider, Nurse, MSA
Last Modified By: 09/29/20 18:43:17 RN

SMOR - Transport Audit

09/29/20 18:43:17 Owner: ROS30480 Modifier: ROS30480
1 <\*> Via Stretcher
1 <\*> Post-op Destination PACU
1 <\*> Airway Device Oxygen Mask
1 <+> Patient Status
1 <+> Monitors?
1 <+> Patient LOC
1 <\*> Transported By Anesthesia Provider, Nurse

SMOR - Cautery

Pre-Care Text:

A.240 Assesses baseline skin condition A280.1 Identifies baseline musculoskeletal status Im.50 Implements protective measures to prevent injury due to electrical sources Im.60 Uses supplies and equipment within safe parameters Im.80 Applies safety devices

Entry 1

ESU Type Electrosurgical Unit Identification Number 1G
Grounding Pad Details
Grounding Pad Needed? Yes Verified By XXXXXXXX RN
Grounding Pad Site Thigh Grounding Pad Site Detail Left
Grounding Pad Lot Number 83470219X Within Expiration Date? Yes
ESU Settings
Cut Setting 40 Coag Setting 40
Last Modified By: 09/29/20 09:22:56 RN

Post-Care Text:

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.10 Patient is free from signs and symptoms of injury related to thermal sources 0.70 Patient is free from signs and symptoms of electrical injury

SMOR - Catheters, Drains and Tubes

Discharge Date: 9/30/2020

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Pre-Care Text:

A.310 Identifies factors associated with an increased risk for hemorrhage or fluid and electrolyte imbalance

Im.250 Administers care to invasive device sites

Table with 4 columns: Device Description, Entry 1, Entry 2, Entry 3. Rows include Device Type, Location, Balloon Inflation Amount, Location Detail, Is this a urinary catheter?, Urine Color/Characteristics, Present on Arrival?, Inserted By, Time In, DC'd at End of Case?, DC'd By, Time Out, Drainage Details, Drainage?, Drainage Type, Drainage System, Color, Odor, Amount, Consistency, Amount Drained in mL, Last Modified By.

Post-Care Text:

E.340 Evaluates tubes and drains are intact and functioning as planned 0.60 Patient is free from signs and symptoms of injury caused by extraneous objects

SMOR - Catheters, Drains and Tubes Audit

Table with 3 columns: Date/Time, Owner, Modifier. Rows list audit items with counts, such as Device Type, Device Description, Location, Drainage System, Present on Arrival, etc.

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**Perioperative Record**

- <+> 2 Device Description
- <+> 2 Location
- <+> 2 Drainage System
- <+> 2 Present on Arrival?
- <+> 2 Inserted By
- <+> 2 DC'd at End of Case?
- <+> 2 Drainage Type
- <+> 2 Consistency
- <+> 2 Amount
- <+> 2 Color
- <+> 2 Odor
- <+> 2 Drainage?
- <+> 2 Time In
- <+> 2 Is this a urinary catheter?

**SMOR - Communication**

**Pre-Care Text:**

A.520 Identifies barriers to communication (Patient and Family Communications) A.20 Verifies operative procedure, surgical site, and laterality (Hand-off Communications) Im.500 Provides status reports to family members Im.150 Develops individualized plan of care

**Entry 1**

<b>Communication</b>	Phone call	<b>Communication By</b>	_____ RN
<b>Date and Time</b>	09/29/20 10:05:00	<b>Comments</b>	FAMILY UPDATED REGARDING START OF SURGERY

**Last Modified By:** \_\_\_\_\_ RN  
09/29/20 10:05:57

**Post-Care Text:**

E.520 Evaluates psychosocial response to plan of care O.500 Patient or designated support person demonstrates knowledge of the expected psychosocial responses to the procedure E.800 Ensures continuity of care O.50 Patient's current status is communicated throughout the continuum of care

**SMOR - Communication Audit**

09/29/20 10:05:57      **Owner:** ROS30480      **Modifier:** ROS30480  
<+> 1      Date and Time

**SMOR - PNDS Outcomes**

**Entry 1**

<b>Outcome Met:</b>	Yes	<b>Outcome Met:</b>	Yes
Patient is free from injury related to surgical positioning or physical hazards from procedure as evidenced by no signs/symptoms of injury to the patient		Patient is free from unintended retained foreign objects	
<b>Outcome Met:</b> All medication and solutions both on and off the sterile field will be properly identified and labeled	Yes	<b>Outcome Met:</b> Patient is free from injury	Yes
<b>Outcome Met:</b>	Yes	<b>Outcome Met:</b>	Yes

Discharge Date: 9/30/2020

### Perioperative Record

Patient's skin integrity is maintained as evidenced by no signs/symptoms of impaired skin integrity

Patient tolerated surgical procedure with no apparent breaks in sterile technique as evidenced by no signs/symptoms of wound infection

Last Modified By: \_\_\_\_\_  
09/29/20 09:29:56

#### SMOR - Fire Risk Assessment

##### Entry 1

##### Fire Risk

##### Assessment Score

Is the surgical or incision site above the Xiphoid Ignition source (ESU, Laser or Fiberoptic Light Source) present

No (0 pt)

Oxygen administered by face mask or nasal cannula

No (0 pt)

##### Plan and Intervention

Low Risk (1-2)

Standard fire safety precautions in place, Let prep dry for at least 3 mins, Protect heat sources (i.e. cautery holder), Employ standard draping procedures

When electrocautery (ESU) is used with an open oxygen delivery system

Stop supplemental oxygen at least 1 min before & during cautery use, Use wet, rather than dry sponges, Keep sterile water or saline solution available for fire suppression, Keep a syringe full of saline solution available (Oral/Dental cavities), Protect heat sources, Use the lowest possible electrocautery setting

Last Modified By: \_\_\_\_\_ RN  
09/29/20 09:25:00

#### SMOR - Safety Checklist 2) Time Out

##### Entry 1

Procedure(s) Laparotomy Exploratory Lvl 4

Time Out led by Physician or by Yes

Entire surgical team involved Yes

Physician designee Correct patient: Using two approved identifiers Yes

Consent form accurately completed and signed Yes

Agreement on the procedure to be performed Yes

Agreement on the Yes

Direct Yes

Patient Name: \_\_\_\_\_  
MRN: 978183  
Encounter: 905814081

Admit Date: 9/28/2020  
Discharge Date: 9/30/2020

### Perioperative Record

correct site

visualization of  
the site marking  
after prepping and  
draping

Sterile indicators verified Yes  
Is essential imaging displayed? Yes

Emergent procedure No  
Antibiotic prophylaxis given prior to incision according to guidelines Yes

Time Out Time 09/29/20 09:38:00  
Last Modified By: \_\_\_\_\_ RN  
09/29/20 10:05:40

#### SMOR - Safety Checklist 2) Time Out Audit

09/29/20 10:05:40 Owner: ROS30480  
1 <\*> Procedure(s)  
1 <+> Time Out Time

Modifier: ROS30480  
Laparotomy Exploratory Lvl 4

#### Case Comments

<None>

Finalized By: \_\_\_\_\_

#### Document Signatures

Signed By:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Unfinalized History

Date/Time	Username	Reason for Unfinalizing	Freetext Reason for Unfinalizing
09/29/20 18:42	ROS30480	Correct Documentation	
10/02/20 14:31	ROS30480	Correct Documentation	

### Operative Notes and Reports

Document Type: Operative Report  
Service Date/Time: 9/29/2020 20:42 EDT  
Result Status: Auth (Verified)  
Document Subject: temporary dialysis placement  
Perform Information: \_\_\_\_\_ MD (9/29/2020 20:47 EDT)  
Sign Information: \_\_\_\_\_ MD (9/29/2020 20:47 EDT)

#### Procedure Note

temporary dialysis catheter placement

time out 9/29/20 1800

consent obtained by husband

Discharge Date: 9/30/2020

### Operative Notes and Reports

attempted right femoral dialysis catheter. Was able to place guidewire into vein and imaged with ultrasound. Was able to dilate easily however unable to advance the catheter. Procedure was then aborted and pressure was applied to insertion site. Hemostasis achieved. Dressing with gauze applied.

EBL 10cc

Electronically Signed on 09/29/2020 20:47

MD

Document Type:	Operative Report
Service Date/Time:	9/29/2020 14:06 EDT
Result Status:	Auth (Verified)
Document Subject:	Central line placement
Perform Information:	MD (9/29/2020 14:07 EDT)
Sign Information:	MD (9/29/2020 14:07 EDT)

Central Line procedure note

Procedure: Central venous catheter insertion

Description of Procedure:

Central venous catheter inserted into right internal Jugular vein for assessment of intravascular volume drug and/or fluid administration under ultrasound guidance. Sterile procedures employed-hand hygiene prior to donning gloves, gown, mask, barrier kit, full barrier drape; Local anesthetic administered; Seldinger technique used; No introducer inserted; Blood flow good; CXR pending; Type of skin prep Chlorhexidine; No apparent complications. Estimated blood loss was negligible. Ultrasound images of the guidewire in the vein were recorded and uploaded to the system.

Time-Out Process: 9/29/2020 1311; Time-Out performed, Verified patient identification, Verified procedure, Verified site/side - marked, Verified correct patient position, Special equipment/implants available, Medications/allergies/relevant history reviewed

I performed this myself. This procedure was performed independently of the time included in today's admission/progress note (s)

Electronically Signed on 09/29/2020 14:07

MD

Document Type:	Operative Report
Service Date/Time:	9/29/2020 10:58 EDT
Result Status:	Auth (Verified)
Document Subject:	Operative report MD
Perform Information:	MD (9/29/2020 11:08 EDT)
Sign Information:	MD (9/29/2020 11:08 EDT)

#### **Preoperative Diagnosis**

Small bowel obstruction  
Ischemic bowel  
History of open gastric bypass

#### **Postoperative Diagnosis**

Small bowel obstruction caused by adhesive band

Discharge Date: 9/30/2020

## Operative Notes and Reports

Necrotic biliopancreatic limb  
Necrotic distal small bowel

### **Operative Procedure Performed:**

Exploratory laparotomy  
Lysis of adhesions  
Small bowel resection including Roux-en-Y (biliary pancreatic limb including Roux-en-Y)  
Distal small bowel resection  
Gastrostomy tube placement in remnant stomach

### **Surgeon(s)**

\_\_\_\_\_ FACS, FASMBS

### **Assistant**

\_\_\_\_\_ MD

### **Estimated Blood Loss**

100 mL's

### **Findings**

Necrotic biliopancreatic limb and Roux-en-Y anastomosis caused by an adhesive band  
Small segment necrotic small bowel and distal small bowel  
Distended and ischemic gastric remnant

### **Specimen(s)**

Cultures of peritoneal ascites  
Biliary pancreatic limb small bowel with Roux-en-Y anastomosis  
Distal small bowel

### **Type of Anesthesia**

General

### **Urine Output**

Per anesthesia

### **Drains**

15 French Blake left at the ligament of Treitz/duodenal stump  
Gastrostomy tube in the remnant/excluded portion of stomach

### **Packing**

None

### **Implants**

None

### **Complications**

None

### **Surgeon Participation Attestation** (insert autotext **.surgeryAttestation**, if applies, and describe participation)

\_\_\_\_\_ MD, FACS, FASMBS was present and an active participant throughout the key or critical components of the operation.

### **Operative Procedure Technique:**

The abdomen was prepped and draped usual fashion. A timeout was performed by the nursing staff. A midline incision was made. There was noted to be a black-colored ascites in the abdomen. Cultures were obtained and sent for culture evaluation.

A lysis of adhesions was performed due to the previous open gastric bypass there was lysis of adhesions needed to free up both the right and left abdominal wall. At this point the abdomen was suctioned in its entirety. At the area of necrotic small bowel was localized which was the proximal biliary pancreatic limb. There was an adhesive band that was cut releasing the necrotic small bowel. At this point continued evaluation revealed that there was some necrotic small bowel all the way to the ligament of Treitz. Therefore a this was followed distally to the Roux-en-Y. The Roux-en-Y is found to be necrotic as well. At this point the anastomosis of the Roux-en-Y was

**Operative Notes and Reports**

taken down with Echelon 60 blue x3 to take down all 3 limbs of the Roux-en-Y including the alimentary limb, the biliopancreatic limb as well as the common channel. The LigaSure was taken to take the mesentery towards the biliopancreatic limb all the way to the ligament of Treitz. This was taken all the way to the ligament of Treitz until the small bowel was found to be adequate. Therefore an Echelon 60 blue was taken to resect the ligament of Treitz and transect the small bowel. Since the patient at this point was hypotensive on pressors and decision was made to not reconstruct at the ligament of Treitz due to this tedious anastomosis at high risk.

At this point the alimentary limb in the continuity of the small bowel was read the created. The alimentary limb was a retrocolic alimentary limb and it was reconnected checking the mesentery to ensure he was the same small bowel and was reconnected to the area of the distal common channel in a side-to-side functional end-to-end fashion using a Echelon 60 blue x2 to create the enterotomy and then a 6 the balloon to close the enterotomy. The mesenteric defect was closed with 3-0 Vicryl sutures.

The distal small bowel was followed all the way to the common channel and all the way down to the terminal ileum and cecum. There was a small segment of 10 cm of necrotic bowel distally. This was resected with an Echelon 60 blue proximally and distally. The mesenteric was taken with the LigaSure device. The anastomosis was created in a side-to-side functional end-to-end fashion with a Echelon 60 blue x2 and closed with an Echelon 60 blue x1. The mesenteric event was closed with 3-0 Vicryl suture. At this point the abdomen is really inspected. There was no other abnormalities noted. It was irrigated multiple liters of irrigation.

In order to decompress the remnant stomach and the duodenal/ligament of Treitz stump that was left stapled a the remnant stomach was evaluated. The alimentary limb was found above the colon. It was separated from the transverse colon using careful Bovie dissection. The remnant stomach was encountered it was massively distended. There was some ischemic patches on the remnant stomach. Decision was made to not resected read remnant stomach at this point since the patient continued on pressors and this bowel was ischemic and may recover after the pressure and tension of the remnant stomach was released. At this point a gastrotomy was performed by placing a 20 French Foley through the anterior abdominal wall. A pursestring of 3-0 Vicryl was placed in the remedied/excluded stomach. The gastrotomy was placed and the stomach was suctioned. The Foley was placed in it and the balloon was instilled with 10 mL's of sterile water. The pursestring was tied. The remnant stomach was sutured to the anterior abdominal wall with 3-0 Vicryl sutures interrupted fashion fastening the remnant stomach to the anterior abdominal wall at the gastrotomy site. The gastrostomy tube was sutured to skin with 2-0 nylon. At this point the abdomen was irrigated copiously again. All needle sponge and instrument counts were correct. The midline fascia was approximated #1 looped PDS in a running fashion and tied. The skin was left open with a Kerlix gauze.

At this point the patient planned was to return to the operating room in 24 to 48 hours if the patient's condition failed to improve or worsen with the concern of further ischemic bowel or ischemic remnant stomach/excluded stomach.

**The plan is that patient would return to the operating room in 1 week - 2 weeks depending on the clinical status of the patient to reconstruct the Roux-en-Y gastric bypass. The patient was left in discontinuity due to the difficulty of reconstructing the Roux-en-Y with this duodenum/ligament of Treitz. And due to the patient's overall clinical status.**

It was discussed with the patient husband via phone the exact operative findings and the time of surgery and with the regard the possibility of return to the operating a 24-48 hours if the patient's clinical status worsened and the absolute need to return to the operating room in 1 to 2 weeks to complete the reconstruction of the Roux-en-Y. All questions were answered and he wishes to proceed.

Patient is transferred to the intensive care unit in critical condition..

Electronically Signed on 09/29/2020 11:08

MD

\* Auth (Verified) \*

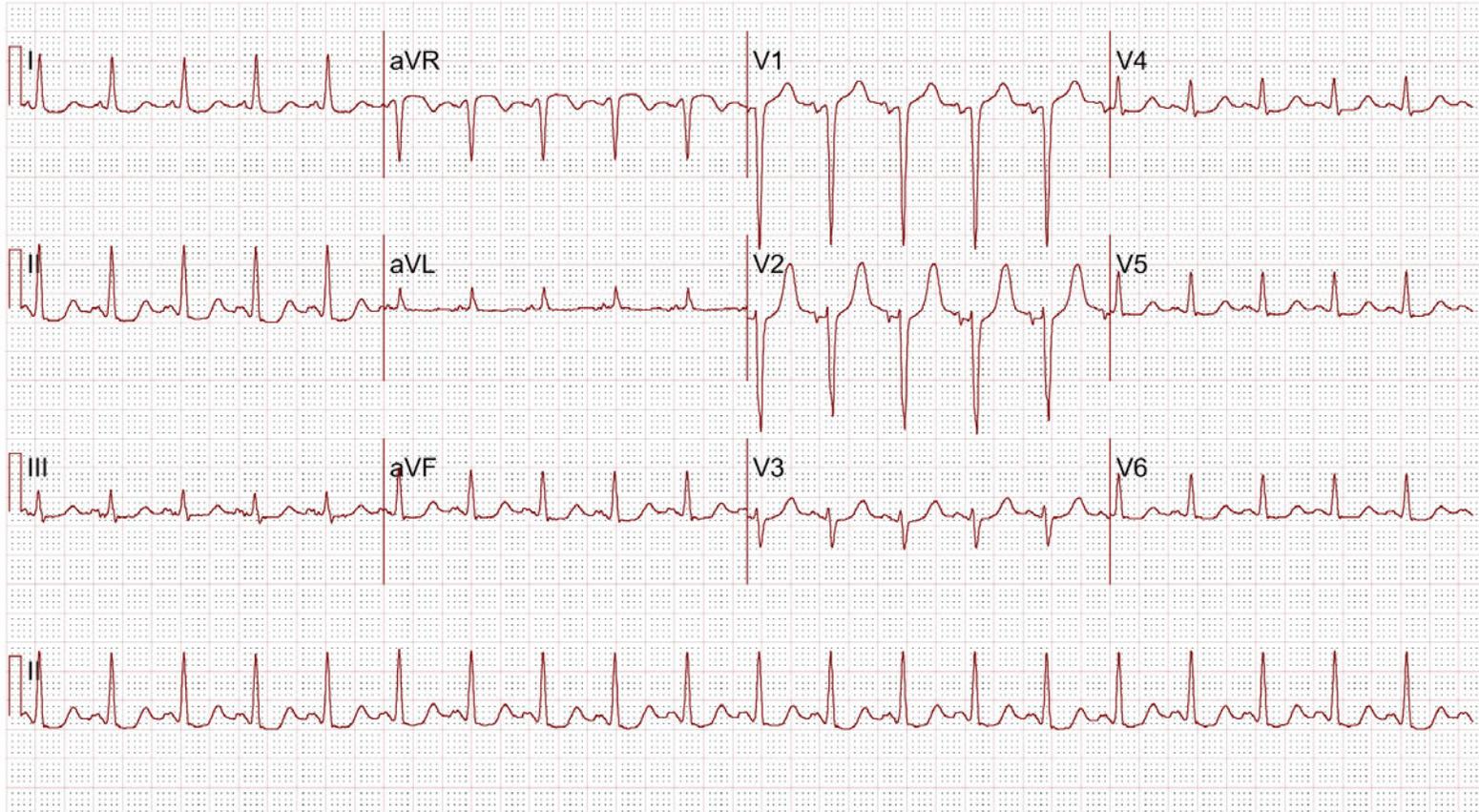
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 ID: [REDACTED]  
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 RN#: 905814081  
 DOB: Age 7.153 years Race: Unknown  
 Age: 46 years Sex: Female  
 Facility: SMH  
 Tech: 22971 Room: CC0501  
 Meds: No Medication  
 Coll: [REDACTED]  
 Etc: [REDACTED]  
 Cmt: [REDACTED]  
 Dept: EMRate: Time 12104535thimamad  
 Qr/28/10 Speeds GTime 102D. On/Adv  
 25 mm/s 25 mm/s Limb Lead Gain: 10.0 mm/mV

Heart rate: 121  
 RR: 495  
 Durations: [REDACTED]  
 P: 105  
 QRS: 85  
 Intervals: [REDACTED]  
 PR: 113  
 QT: 327  
 QTc: 433  
 QRS: [REDACTED]  
 P: 47  
 QRS: 44  
 T: 64

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
 LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE  
 LEFT AXIAL ABNORMALITY  
 ABNORMAL ECG

Confirmed By: [REDACTED], M.D.

Chest Lead Gain: 10.0 mm/mV Filter(s): Notch 60 Hz Antiflick 40 Hz Stable Off



\*20190928210435.12633\*

ECG Printed 10/30/2008 08:39:36  
 CONFIRM

Transcribed By JU [REDACTED] . D. 10/30/2008 08:37:20  
 ECG V2.1.2.0 115440278550 QRS=(Hodge)

Page 1 of 11

\* Auth (Verified) \*

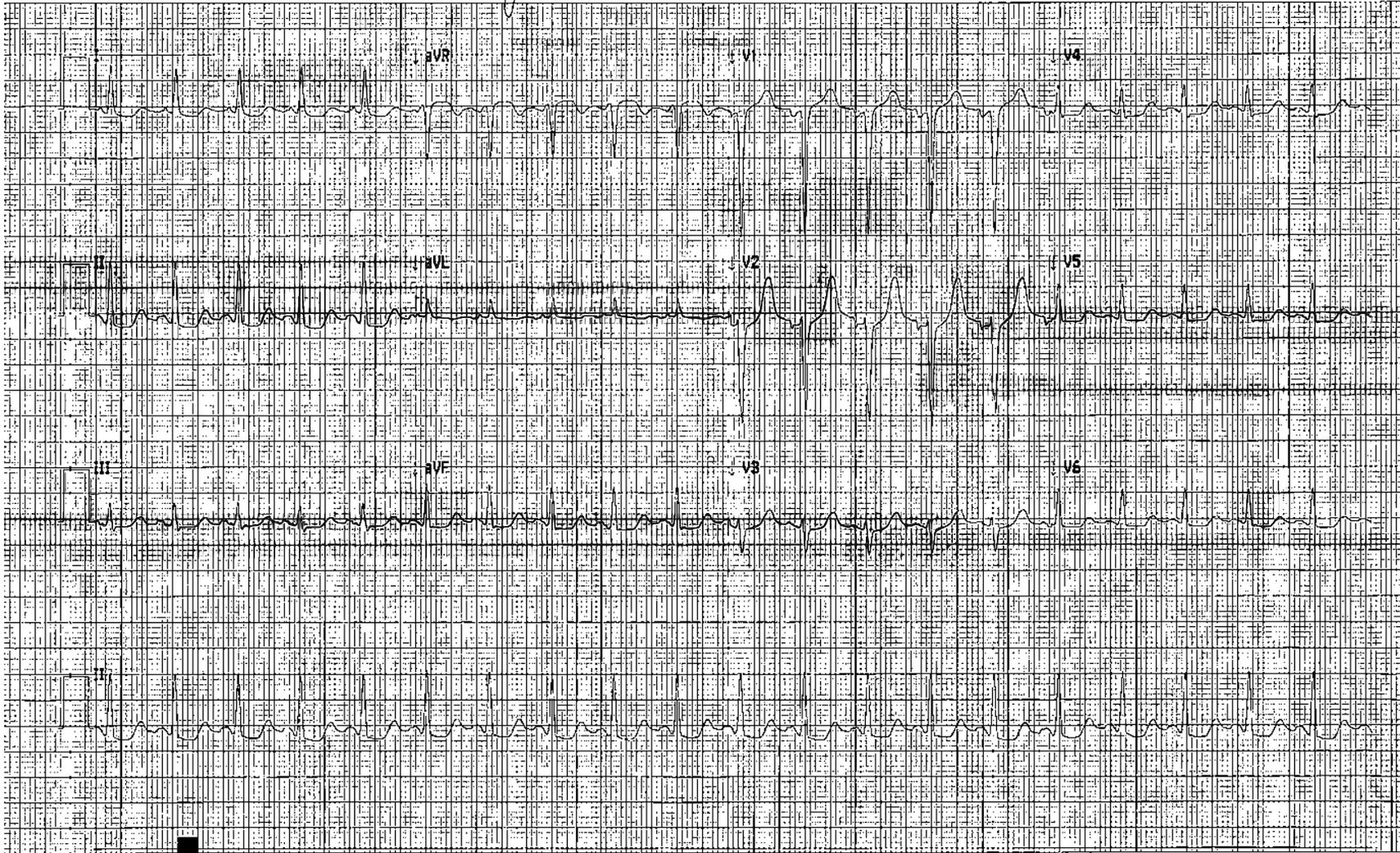
Tech: 22971  
 Dept: ED  
 EIN:   
 DOB: 23-Jul-1973 Age: 47ygr  
 Sex: Female Race:   
 P.Reg#: Rm:1  
 Order Phys:   
 Cmt:

28-Sep-2020 21:04:35  
 Vent rate 121 BPM  
 PR int 113 ms  
 QRS dur 85 ms  
 QT/QTc 327/399 ms  
 P-R-T axes 47 44 64

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
 LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE (VOLTAGE CRITERIA PLUS ST/T  
 ABNORMALITY)  
 ABNORMAL ECG  
 UNCONFIRMED REPORT

✓

2106 js



1161100278550

South Miami

65369085Part 80 Version 2120 Sequence 812673 25mm/c 10mm/mV 0.05-40 Hz

Discharge Date: 9/30/2020

**EKG-Stress**

Document Type: EKG Standard  
Service Date/Time: 9/28/2020 21:04 EDT  
Result Status: Auth (Verified)  
Document Subject: EKG Standard  
Perform Information:  
Sign Information:

**ECG IMAGE LOCATION**

<http://ddmsecgw2/PyramisUI/Edit.aspx?Provider=Pyramis&EndEdit=login.aspx?Logout=EXIT&User=CARD&Password=password&TestType=Any&Status=Any&Inst=0&LockMRN=000000978183&ReqID=3780564977> HNAM URL

**Physician Interpreter**

\_\_\_\_\_ M.D.

**Interpretation Text**

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE  
LEFT ATRIAL ABNORMALITY  
ABNORMAL ECG

---

\* Auth (Verified) \*

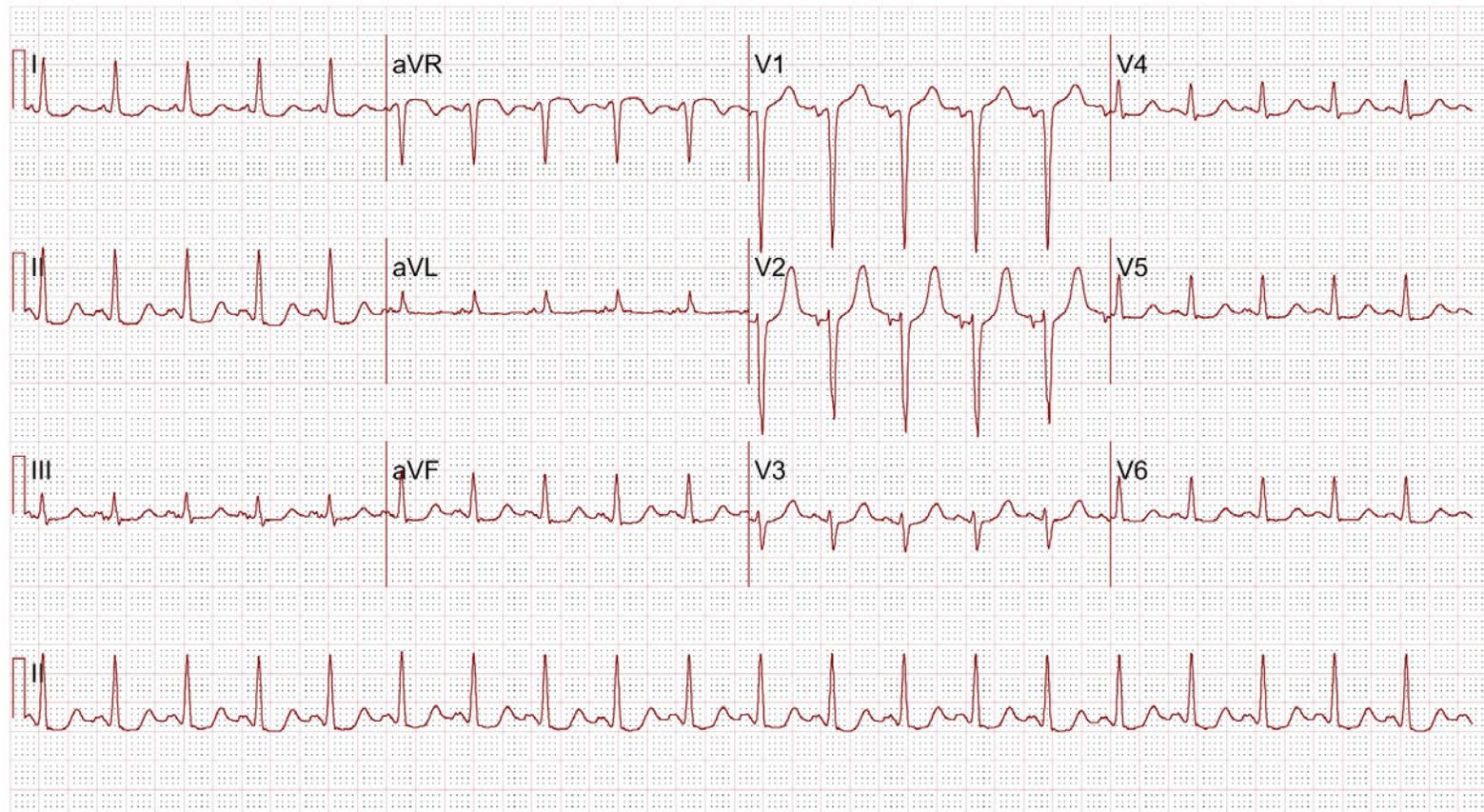
Name: [REDACTED], S [REDACTED]  
ID : [REDACTED]  
Req#: 3780564977  
FIN#: 9068810881  
DOB: 07/22/1977 Age: Race: Unknown  
46 years Sex : Female  
Facility: SMH  
Tech: 22971 Room: CC0501  
Medl: No Medication  
Ccll:  
Phys: [REDACTED]  
Cmnt:  
Dept: EBM Date: Inst: South Miami  
9/28/2019 08:19 Time: 21210435  
25 mm/s Gain: 1.0 mV/mV1.0 mm/mV

Vent rate: 121  
RR : 495  
-- Durations --  
P : 105  
QRS: 85  
-- Intervals --  
PR : 113  
QT : 327  
QTcH: 433  
QTd:  
-- Axes --  
P : 47  
QRS: 44  
T : 64

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE  
LEFT ATRIAL ABNORMALITY  
ABNORMAL ECG

Confirmed By: [REDACTED], M.D.

Chest Lead Gain: 10.0 mm/mV Filters(s): Notch 60 Hz Artifact 40 Hz Stable Off



\*20190928210435.12633\*

ECG Printed 09/28/2019 08:19:35 Transcribed By: [REDACTED] M.D. 09/28/2019 08:37:20  
CONFIRM ELI38 V2.1.2.0 115440278550 QTcH=(Hodges)



Discharge Date: 9/30/2020

**Pathology Report**

Accession:  
002-SP-19-0008789

Collected Date/Time:  
9/29/2020 10:47 EDT

Received Date/Time:  
9/30/2020 10:48 EDT

Pathologist:  
\_\_\_\_\_r MD

**Surgical Pathology Report**

**DIAGNOSIS:**

**A. Small bowel resection, Roux-en-Y:**

Small bowel with ischemic necrosis and serosal adhesions.

**B. Distal small bowel:**

Sections of benign small bowel with ischemic changes.

NNN/pj

\_\_\_\_\_, MD  
(Electronically signed by)  
Verified: 10/01/2020

**CLINICAL INFORMATION:**

Procedure: Exploratory laparotomy  
Pre-Operative Diagnosis: Bowel obstruction  
Post-Operative Diagnosis: Same

**SPECIMEN SOURCE:**

- A. Small bowel resection, Roux-en-Y
- B. Distal small bowel

**GROSS DESCRIPTION:**

A. Small bowel, resection: A 46 x 4 x 4 cm discolored and necrotic-appearing portion of small bowel that is adherent to a 7.5 x 3 x 3 cm portion of discolored bowel. These are connected to what appears to be adhesion bands. Bowel contents of blood. The folds on the wall are intensely hemorrhagic and discolored. No mass is seen. Representative sections are submitted in 6 blocks; 1-4 contains section of the necrotic-appearing bowel; 5-6 contain the adherent portion of bowel.

B. Distal small bowel: A 5.5 x 3 x 2 cm segment of bowel. Both margins are stapled. The specimen is mildly congested. Representative sections are submitted in 4 blocks.

NNN/ab

Discharge Date: 9/30/2020

**Surgical Pathology Report**

Accession:  
002-SP-19-0008789

Collected Date/Time:  
9/29/2020 10:47 EDT

Received Date/Time:  
9/30/2020 10:48 EDT

Pathologist:  
\_\_\_\_\_ far MD

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Sections of benign small bowel with ischemic changes.

NNN/pj

\_\_\_\_\_  
(Electronically signed by)

Verified: 10/01/2020

**CLINICAL INFORMATION:**

Procedure: Exploratory laparotomy

Pre-Operative Diagnosis: Bowel obstruction

Post-Operative Diagnosis: Same

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A. Small bowel resection, Roux-en-Y

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A. Small bowel, resection: A 46 x 4 x 4 cm discolored and necrotic-appearing portion of small bowel that is adherent to a 7.5 x 3 x 3 cm portion of discolored bowel. These are connected to what appears to be adhesion bands. Bowel contents of blood. The folds on the wall are intensely hemorrhagic and discolored. No mass is seen. Representative sections are submitted in 6 blocks; 1-4 contains section of the necrotic-appearing bowel; 5-6 contain the adherent portion of bowel.

B. Distal small bowel: A 5.5 x 3 x 2 cm segment of bowel. Both margins are stapled. The specimen is mildly congested. Representative sections are submitted in 4 blocks.

NNN/ab

Discharge Date: 9/30/2020

**Critical Results**

Collected Date	9/30/2020	9/30/2020		
Collected Time	12:35 EDT	03:34 EDT		
Procedure			Units	Reference Range
Critical result reported	h/h, 5.4 and 18.5	hgb 6.6 hct 21.0		
Result Received By	[REDACTED] RN	[REDACTED] RN		
Reporting Department	lab	lab		
Critical result reported by	[REDACTED] TN	[REDACTED] le		
Date/Time Reported	9/30/2020 12:35 EDT	9/30/2020 03:35 EDT		
Care provider called	Yes	Yes		
Critical result provider name	[REDACTED] MD	[REDACTED] MD		
1st Call Date/time	9/30/2020 12:35 EDT	-		
Actions to be taken	-	Orders received		
Critical result comment	See Below <sup>T2</sup>	See Below <sup>T3</sup>		

Textual Results

- T2: 9/30/2020 12:35 EDT (Critical result comment)  
orders recieved to transfuse 2 units prbc
- T3: 9/30/2020 03:34 E [REDACTED]  
transfuse two prbc after 4 dose of plasma is completed.

Collected Date	9/29/2020	9/29/2020		
Collected Time	13:29 EDT	12:41 EDT		
Procedure			Units	Reference Range
Critical result reported	blood glucose 11	hemoglobni 6.8		
Point of care	No	No		
Result Received By	[REDACTED]	[REDACTED]		
Critical result reported by	[REDACTED]	[REDACTED]		
Date/Time Reported	9/29/2020 13:29 EDT	9/29/2020 12:41 EDT		
Care provider called	Yes	Yes		
Critical result provider name	[REDACTED] R MD	[REDACTED] R MD		
1st Call Date/time	9/29/2020 13:29 EDT	9/29/2020 12:41 EDT		
Callback received from	[REDACTED] R MD	[REDACTED] R MD		
Callback date/time	9/29/2020 13:29 EDT	9/29/2020 12:41 EDT		
Actions to be taken	Orders received	Orders received		
Critical result comment	See Below <sup>T4</sup>	See Below <sup>T5</sup>		

Textual Results

- T4: 9/29/2020 13:29 EDT (Critical result comment)  
MD at bedside. Blood glucose was already addressed and corrected
- T5: 9/29/2020 12:41 EDT (Critical result comment)  
MD at bedside. Orders placed for blood

Collected Date	9/29/2020	9/29/2020		
Collected Time	07:48 EDT	05:47 EDT		
Procedure			Units	Reference Range
Critical result reported	See Below <sup>T1</sup>	procal 24.83		
Point of care	Yes	-		
Result Received By	-	[REDACTED]		

Discharge Date: 9/30/2020

**Critical Results**

Collected Date	9/29/2020	9/29/2020		
Collected Time	07:48 EDT	05:47 EDT		
Procedure			Units	Reference Range
Reporting Department	-	lab		
Critical result reported by	[REDACTED] RN	[REDACTED]		
Date/Time Reported	9/29/2020 07:48 EDT	9/29/2020 05:47 EDT		
Care provider called	Yes	Yes		
Critical result provider name	[REDACTED] R MD	[REDACTED] MD		
Actions to be taken	Orders received	-		
Critical result comment	See Below <sup>T6</sup>	See Below <sup>T7</sup>		

Textual Results

- T1: 9/29/2020 07:48 EDT (Critical result reported)  
blood glucose 22 after repeat test
- T6: 9/29/2020 07:48 EDT (Critical result comment)  
give a second amp of dextrose and 2 liters of LR
- T7: 9/29/2020 05:47 EDT (Critical result comment)  
Dr. XXXX called about both results of Lactate and ProCalcitonin, on his way to see the patient

Collected Date	9/29/2020			
Collected Time	05:35 EDT			
Procedure		Units	Reference Range	
Critical result reported	lactic acid 8.0			
Result Received By	[REDACTED]			
Reporting Department	Lab			
Critical result reported by	[REDACTED]			
	9/29/2020 05:35 EDT			
Critical result provider name	[REDACTED] MD			
Critical result comment	On his way to see the patient			

**Blood Gases**

Collected Date	9/30/2020	9/30/2020		
Collected Time	04:34 EDT	00:06 EDT		
Procedure			Units	Reference Range
RP-Source	Arterial	Arterial		
Sodium-RP	138.5	139.2	mmol/L	[135.0-145.0]
Chloride-RP	105	112 <sup>H</sup>	mmol/L	[98-107]
Potassium-RP	4.01	4.10	mmol/L	[3.50-5.10]
Glucose-RP	312 <sup>H</sup>	199 <sup>H</sup>	mg/dL	[70-126]
RP-Calcium Ionized	0.73 <sup>L</sup>	0.89 <sup>L</sup>	mmol/L	[1.18-1.30]
Lactic Acid-Respiratory	12.45 <sup>C f4</sup>	8.70 <sup>C f5</sup>	mmol/L	[0.50-2.20]
pH -BG	7.225 <sup>C f4</sup>	7.173 <sup>C f5</sup>		[7.350-7.450]
Rp-pCO2	30.2 <sup>L</sup>	39.8	mmHg	[35.0-45.0]
PO2	180.1 <sup>H</sup>	150.1 <sup>H</sup>	mmHg	[80.0-100.0]
HCO3	12.2 <sup>L</sup>	14.3 <sup>L</sup>	mmol/L	[22.0-26.0]
RP-Base Excess,BE	-14.1	-13.2	mmol/L	

**Blood Gases**

Collected Date	9/30/2020	9/30/2020		
Collected Time	04:34 EDT	00:06 EDT		
Procedure			Units	Reference Range
RP-O2 SAT (est) %	98.3	97.8	%	[92.0-99.0]
RP-02HB(Meas)%	97.6	97.3	%	[92.0-99.0]
THB	<b>5.8</b> <sup>c f4</sup>	<b>8.6</b> <sup>L</sup>	g/dL	[12.0-18.0]
RP-COHB	0.4	0.3	%	[0.0-3.0]
RP-METHB	0.3	0.2	%	[0.0-1.5]
RP-FIO2	70.0	70.0	%	
RP -Mode	Ventilator-AC <sup>f9</sup>	Ventilator-AC <sup>f10</sup>		
RP-Resp Rate	30.0	30.0		
RP-Tidal Vol	350.0	350.0	mL	
RP-PEEP	10.0	10.0		
Draw Site-Respiratory	A Line	A Line		
Allen Test-Respiratory	NA	NA		
Lidocaine Given?-Respiratory	No	No		

Result Comments

- f4: Lactic Acid-Respiratory, pH - BG, THB  
md [redacted] notified by [redacted] RRT at 9/30/2020 4:37:17 AM
- f5: Lactic Acid-Respiratory, pH - BG  
MD [redacted] notified by [redacted] RRT at 9/30/2020 12:10:07 AM
- f9: RP - Mode  
called in accordance with sepsis protocol to md [redacted]
- f10: RP - Mode  
CALLED IN ACCORDANCE WITH SEPSIS PROTOCOL TO MD JOHRI

Collected Date	9/29/2020	9/29/2020		
Collected Time	21:04 EDT	16:49 EDT		
Procedure			Units	Reference Range
RP-Source	Arterial	Arterial		
Sodium-RP	141.5	144.7	mmol/L	[135.0-145.0]
Chloride-RP	<b>115</b> <sup>H</sup>	<b>115</b> <sup>H</sup>	mmol/L	[98-107]
Potassium-RP	4.91	3.87	mmol/L	[3.50-5.10]
Glucose-RP	101	<b>53</b> <sup>c f11</sup>	mg/dL	[70-126]
RP-Calcium Ionized	<b>1.06</b> <sup>L</sup>	<b>1.12</b> <sup>L</sup>	mmol/L	[1.18-1.30]
Lactic Acid-Respiratory	<b>6.29</b> <sup>c f6</sup>	<b>4.37</b> <sup>c f11</sup>	mmol/L	[0.50-2.20]
pH -BG	<b>7.197</b> <sup>c f6</sup>	<b>7.145</b> <sup>c f11</sup>		[7.350-7.450]
Rp-pCO2	<b>33.4</b> <sup>L</sup>	43.2	mmHg	[35.0-45.0]
PO2	<b>305.6</b> <sup>H</sup>	<b>154.5</b> <sup>H</sup>	mmHg	[80.0-100.0]
HCO3	<b>12.7</b> <sup>L</sup>	<b>14.5</b> <sup>L</sup>	mmol/L	[22.0-26.0]
RP-Base Excess, BE	-14.3	-13.8	mmol/L	
RP-O2 SAT (est) %	98.6	98.1	%	[92.0-99.0]
RP-02HB(Meas)%	98.2	97.7	%	[92.0-99.0]
THB	<b>10.1</b> <sup>L</sup>	<b>11.4</b> <sup>L</sup>	g/dL	[12.0-18.0]
RP-COHB	0.2	0.3	%	[0.0-3.0]
RP-METHB	0.2	0.1	%	[0.0-1.5]
RP-FIO2	70.0	80.0	%	

**Blood Gases**

Collected Date	9/29/2020	9/29/2020		
Collected Time	21:04 EDT	16:49 EDT		
Procedure			Units	Reference Range
RP -Mode	Ventilator-AC <sup>f11</sup>	Ventilator-AC/VC+ <sup>f11</sup>		
RP-Resp Rate	30.0	30.0		
RP-Tidal Vol	350.0	350.0	mL	
RP-PEEP	10.0	10.0		
Draw Site-Respiratory	A Line	A Line		
Allen Test-Respiratory	NA	NA		
Lidocaine Given?-Respiratory	No	No		

Result Comments

- f1: Glucose-RP, Lactic Acid-Respiratory, pH - BG, RP - Mode  
DR [redacted] notified by [redacted] I trrt at 9/29/2020 4:51:48 PM
- f6: Lactic Acid-Respiratory, pH - BG  
md [redacted] notified by [redacted] r rrt at 9/29/2020 9:10:41 PM
- f11: RP - Mode  
called accordance with [redacted] protocol to [redacted] at 2111 on 9/29/20

Collected Date	9/29/2020	9/29/2020		
Collected Time	14:43 EDT	12:17 EDT		
Procedure			Units	Reference Range
RP-Source	Arterial	Arterial		
Sodium-RP	<b>145.9<sup>H</sup></b>	144.8	mmol/L	[135.0-145.0]
Chloride-RP	<b>118<sup>H</sup></b>	<b>117<sup>H</sup></b>	mmol/L	[98-107]
Potassium-RP	3.55	3.56	mmol/L	[3.50-5.10]
Glucose-RP	<b>48<sup>C f2</sup></b>	**NOT VALUED**	mg/dL	[70-126]
RP-Calcium Ionized	<b>1.04<sup>L</sup></b>	<b>1.10<sup>L</sup></b>	mmol/L	[1.18-1.30]
Lactic Acid-Respiratory	<b>6.20<sup>C f2</sup></b>	<b>6.02<sup>C f7</sup></b>	mmol/L	[0.50-2.20]
pH -BG	<b>7.047<sup>C f2</sup></b>	<b>7.026<sup>C f7</sup></b>		[7.350-7.450]
Rp-pCO2	<b>56.8<sup>H</sup></b>	<b>61.1<sup>C f7</sup></b>	mmHg	[35.0-45.0]
PO2	<b>143.4<sup>H</sup></b>	<b>43.5<sup>C f7</sup></b>	mmHg	[80.0-100.0]
HCO3	<b>15.3<sup>L</sup></b>	<b>15.6<sup>L</sup></b>	mmol/L	[22.0-26.0]
RP-Base Excess, BE	-15.0	-14.4	mmol/L	
RP-O2 SAT (est) %	97.6	<b>74.0<sup>C f7</sup></b>	%	[92.0-99.0]
RP-O2HB(Meas)%	96.9	<b>73.3<sup>C f7</sup></b>	%	[92.0-99.0]
THB	<b>10.7<sup>L</sup></b>	<b>7.7<sup>L</sup></b>	g/dL	[12.0-18.0]
RP-COHB	0.3	0.3	%	[0.0-3.0]
RP-METHB	0.4	0.6	%	[0.0-1.5]
RP-FIO2	100.0	80.0	%	
RP -Mode	Ventilator-AC/VC+ <sup>f2</sup>	Ventilator-AC/VC+ <sup>f7</sup>		
RP-Resp Rate	26.0	18.0		
RP-Tidal Vol	350.0	350.0	mL	
RP-PEEP	10.0	5.0		
Draw Site-Respiratory	A Line	A Line		
Allen Test-Respiratory	NA	NA		
Lidocaine Given?-Respiratory	No	No		

**Blood Gases**

Result Comments

f2: Glucose-RP, Lactic Acid-Respiratory, pH - BG, RP - Mode  
 DR [REDACTED] notified by [REDACTED] at 9/29/2020 2:48:57 PM

f7: Lactic Acid-Respiratory, pH - BG, PO2, RP-02HB(Meas)%, RP - Mode, RP-O2 SAT (est) %, Rp-pCO2  
 DR [REDACTED] notified by [REDACTED] at 9/29/2020 12:25:53 PM

Procedure	Collected Date Collected Time	9/29/2020 10:24 EDT	9/29/2020 09:53 EDT	Units	Reference Range
RP-Source		Arterial	Arterial		
Sodium-RP		143.1	141.5	mmol/L	[135.0-145.0]
Chloride-RP		116 <sup>H</sup>	116 <sup>H</sup>	mmol/L	[98-107]
Potassium-RP		3.59	4.01	mmol/L	[3.50-5.10]
Glucose-RP		53 <sup>C f3</sup>	74	mg/dL	[70-126]
RP-Calcium Ionized		1.03 <sup>L</sup>	1.40 <sup>H</sup>	mmol/L	[1.18-1.30]
Lactic Acid-Respiratory		5.70 <sup>C f3</sup>	5.64 <sup>C c1 f8</sup>	mmol/L	[0.50-2.20]
pH -BG		7.116 <sup>C f3</sup>	6.834 <sup>C c2 f8</sup>		[7.350-7.450]
Rp-pCO2		[REDACTED]	7 <sup>C c3 f8</sup>	mmHg	[35.0-45.0]
PO2		387.1 <sup>H</sup>	60.9 <sup>L</sup>	mmHg	[80.0-100.0]
HCO3		13.9 <sup>L</sup>	10.6 <sup>L</sup>	mmol/L	[22.0-26.0]
RP-Base Excess,BE		-14.6	-23.1	mmol/L	
RP-O2 SAT (est) %		98.8	81.2 <sup>L</sup>	%	[92.0-99.0]
RP-02HB(Meas)%		97.8	80.3 <sup>L</sup>	%	[92.0-99.0]
THB		8.9 <sup>L</sup>	10.7 <sup>L</sup>	g/dL	[12.0-18.0]
RP-COHB		0.6	0.6	%	[0.0-3.0]
RP-METHB		0.4	0.5	%	[0.0-1.5]
RP -Mode		AC <sup>f12</sup>	Ventilator-AC <sup>f13</sup>		
Draw Site-Respira [REDACTED]		A Line	A Line		
Allen Test-Respiratory		NA	NA		
Lidocaine Given?-Respiratory		No	No		

Corrected Results

c1: Lactic Acid-Respiratory  
 Result comment added on 9/29/2020 09:53 EDT by SYSTEM, SYSTEM Cerner

c2: pH - BG  
 Result comment added on 9/29/2020 09:53 EDT by SYSTEM, SYSTEM Cerner

c3: Rp-pCO2  
 Result comment added on 9/29/2020 09:53 EDT by SYSTEM, SYSTEM Cerner

Result Comments

f3: Glucose-RP, Lactic Acid-Respiratory, pH - BG  
 DR [REDACTED], [REDACTED] notified by [REDACTED] RRT at 9/29/2020 10:28:37 AM

f8: Lactic Acid-Respiratory, pH - BG, Rp-pCO2  
 DR [REDACTED] notified by [REDACTED] at 9/29/2020 9:55:00 AM

f12: RP - Mode  
 ALL C/VALUES GIVEN TO DR. XXXX including lact.

f13: RP - Mode  
 ALLVALUES GIVEN TO M/D FIO2 100%. PT ON VENT PER MD.

**Chemistry**

**Routine Chemistry**

Procedure	Collected Date	9/30/2020	9/30/2020	9/29/2020	Units	Reference Range
	Collected Time	11:45 EDT	03:06 EDT	21:25 EDT		
Sodium on Blood		141	144	152 <sup>H</sup>	mmol/L	[136-145]
Potassium on Blood		5.2 <sup>H</sup>	3.8	4.3	mmol/L	[3.5-5.1]
Chloride on Blood		97 <sup>L</sup>	108 <sup>H</sup>	117 <sup>H</sup>	mmol/L	[98-107]
CO2 on Blood		10 <sup>L</sup>	15 <sup>L</sup>	20 <sup>L</sup>	mmol/L	[21-32]
Anion Gap		34 <sup>H</sup>	21 <sup>H</sup>	15		[2-15]
Glucose on Blood		543 <sup>C c4 f15,16</sup>	256 <sup>H</sup>	106	mg/dL	[70-126]
Creatinine on Blood		2.30 <sup>H</sup>	1.90 <sup>H</sup>	1.90 <sup>H</sup>	mg/dL	[0.60-1.30]
BUN on Blood		21 <sup>H</sup>	23 <sup>H</sup>	28 <sup>H</sup>	mg/dL	[7-18]
BUN/Creatinine Ratio		9.1 <sup>L</sup>	12.1	14.7	ratio	[12.0-20.0]
eGFR (CKD-EPI) if Africn Am		29 <sup>f18 i1</sup>	36 <sup>f18 i1</sup>	36 <sup>f18 i1</sup>	mL/min/1.73 m2	
eGFR (CKD-EPI) NonAfricn Am		25 <sup>f18 i1</sup>	31 <sup>f18 i1</sup>	31 <sup>f18 i1</sup>	mL/min/1.73 m2	
Calcium (Total)		6.6 <sup>L i2</sup>	6.5 <sup>L i2</sup>	7.4 <sup>L i2</sup>	mg/dL	[8.5-10.1]
Phosphorus Level		8.9 <sup>H</sup>	7.5 <sup>H</sup>	7.9 <sup>H</sup>	mg/dL	[2.5-4.9]
Total Protein on Blood		-	-	3.0 <sup>L</sup>	g/dL	[6.4-8.2]
Albumin on Blood		1.3 <sup>L</sup>	1.7 <sup>L</sup>	1.5 <sup>L</sup>	g/dL	[3.4-5.0]
Globulin		-	-	1.5 <sup>L</sup>	g/dL	[2.3-3.9]
A/G Ratio		-	-	1.0 <sup>L</sup>	ratio	[1.1-2.5]
ALT (SGPT) on Blood		-	-	977 <sup>H</sup>	U/L	[16-65]
AST (SGOT) on Blood		-	-	2139 <sup>H</sup>	U/L	[8-37]
AST/ALT Ratio		-	-	2.2	ratio	
Alkaline Phosphatase on Blood		-	-	67	U/L	[50-136]
Total Bilirubin on Blood		-	-	1.5	mg/dL	[0.2-2.0]
Magnesium Level		2.1 <sup>i5</sup>	2.1 <sup>i5</sup>	2.1 <sup>i5</sup>	mg/dL	[1.8-2.4]

**Corrected Results**

c4: Glucose on Blood  
 Result comment added on 10/1/2020 08:20 EDT by [REDACTED] M TN  
 Result comment added on 9/30/2020 13:31 EDT by SYSTEM, SYSTEM Cerner

**Result Comments**

f15: Glucose on Blood  
 CRITICAL.CALL

f16: Glucose on Blood  
 Called to and read back by: PATIENT EXPIRED RN [REDACTED] NOTIFIED 9/30/2020

f18: eGFR (CKD-EPI) if Africn Am, eGFR (CKD-EPI) NonAfricn Am  
 Note: The estimated glomerular filtration rate (eGFR) is calculated using the CKD-EPI 2009 formula. It is important to note that all estimates of GFR based on serum creatinine will be less accurate for patients at the extremes of muscle mass (including frail elderly, critically ill or cancer patients), those with unusual diets and those with conditions associated with reduced secretion or extra-renal elimination of creatinine. This calculation is not accurate for patients <18 years old. Confirmatory tests with exogenous measured GFR or creatinine clearance should be performed for people whom estimates based on serum creatinine alone may be inaccurate.

**Chemistry**

**Routine Chemistry**

Procedure	Collected Date	9/29/2020	9/29/2020	9/29/2020	Units	Reference Range
	Collected Time	12:15 EDT	04:52 EDT	02:28 EDT		
Sodium on Blood		152 <sup>H</sup>	-	-	mmol/L	[136-145]
Potassium on Blood		3.8 <sup>f14</sup>	-	-	mmol/L	[3.5-5.1]
Chloride on Blood		121 <sup>H</sup>	-	-	mmol/L	[98-107]
CO2 on Blood		17 <sup>L</sup>	-	-	mmol/L	[21-32]
Anion Gap		14	-	-		[2-15]
Glucose on Blood		11 <sup>C f17</sup>	-	-	mg/dL	[70-126]
Creatinine on Blood		1.40 <sup>H</sup>	-	-	mg/dL	[0.60-1.30]
BUN on Blood		25 <sup>H</sup>	-	-	mg/dL	[7-18]
BUN/Creatinine Ratio		17.9	-	-	ratio	[12.0-20.0]
eGFR (CKD-EPI) if Africn Am		52 <sup>f18 i1</sup>	-	-	mL/min/1.73 m2	
eGFR (CKD-EPI) NonAfricn Am		45 <sup>f18 i1</sup>	-	-	mL/min/1.73 m2	
Calcium (Total)		6.6 <sup>L i2</sup>	-	-	mg/dL	[8.5-10.1]
Phosphorus Level		6.4 <sup>H</sup>	-	-	mg/dL	[2.5-4.9]
Total Protein on Blood		2.3 <sup>L</sup>	-	-	g/dL	[6.4-8.2]
Albumin on Blood		1.2 <sup>L</sup>	-	-	g/dL	[3.4-5.0]
Globulin		1.1 <sup>L</sup>	-	-	g/dL	[2.3-3.9]
A/G Ratio		1.1	-	-	ratio	[1.1-2.5]
ALT (SGPT) on Blood		558 <sup>H</sup>	-	-	U/L	[16-65]
AST (SGOT) on Blood		1205 <sup>H</sup>	-	-	U/L	[8-37]
AST/ALT Ratio		2.2	-	-	ratio	
Alkaline Phosphatase on Blood		63	-	-	U/L	[50-136]
Total Bilirubin on Blood		0.8	-	-	mg/dL	[0.2-2.0]
Lactic Acid (Lactate)		-	8.0 <sup>C f19</sup>	-	mmol/L	[0.5-2.2]
Procalcitonin (PCT)		-	24.83 <sup>C f20 i3</sup>	-	ng/mL	[0.00-0.09]
Magnesium Level		1.4 <sup>L i5</sup>	-	-	mg/dL	[1.8-2.4]
Hemoglobin A1C (Glycosylated)		-	-	6.0 <sup>H i6</sup>	%	[4.8-5.6]
Est.Average Glucose		-	-	126	mg/dL	[70-126]

**Result Comments**

f14: Potassium on Blood  
Hemolysis 2+, result could be falsely increased

f17: Glucose on Blood  
CRITICAL.CALL&XA&CRITICAL RESULT CALLED TO AND READ BACK BY [REDACTED] R.N  
RECHECKED SPECIMEN FOR GLUCOSE , 29SEP2020 1338 NURSES EXPECTING THESE RESULTS,  
PATIENT TREATED, GLUCOMETER DID NOT GIVE RESULTS.

f18: eGFR (CKD-EPI) if Africn Am, eGFR (CKD-EPI) NonAfricn Am  
Note: The estimated glomerular filtration rate (eGFR) is calculated using the CKD-EPI 2009 formula. It is important to note that all estimates of GFR based on serum creatinine will be less accurate for patients at the extremes of muscle mass (including frail elderly, critically ill or cancer patients), those with unusual diets and those with conditions associated with reduced secretion or extra-renal elimination of creatinine. This calculation is not accurate for patients <18 years old. Confirmatory tests with exogenous measured GFR or creatinine clearance should be performed for people whom estimates based on serum creatinine alone may be inaccurate.

**Chemistry**

**Routine Chemistry**

Result Comments

- f19: Lactic Acid (Lactate)  
 CRITICAL.CALL&XA&CRITICAL RESULT CALLED TO AND READ BACK BY [REDACTED].car04220,  
 29SEP2020 0551
- f20: Procalcitonin (PCT)  
 Called to and read back by: [REDACTED] RN 09/29/2020 05:48:12 EDT

Procedure	Collected Date Collected Time	9/29/2020 02:20 EDT	9/28/2020 22:05 EDT	Units	Reference Range
Sodium on Blood	-	-	144	mmol/L	[136-145]
Potassium on Blood	-	-	2.8 <sup>L</sup>	mmol/L	[3.5-5.1]
Chloride on Blood	-	-	113 <sup>H</sup>	mmol/L	[98-107]
CO2 on Blood	-	-	19 <sup>L</sup>	mmol/L	[21-32]
Anion Gap	-	-	12		[2-15]
Glucose on Blood	-	-	10 <sup>H</sup>	mg/dL	[70-126]
Creatinine on Blood	-	-	0.98	mg/dL	[0.60-1.30]
BUN on Blood	-	-	23 <sup>H</sup>	mg/dL	[7-18]
BUN/Creatinine Ratio	-	-	23.5 <sup>H</sup>	ratio	[12.0-20.0]
eGFR (CKD-EPI) if Africn Am	-	-	80 <sup>f18 i1</sup>	mL/min/1.73 m2	
eGFR (CKD-EPI) NonAfricn Am	-	-	69 <sup>f18 i1</sup>	mL/min/1.73 m2	
Calcium (Total)	8.4 <sup>L i2</sup>	-	8.8 <sup>i2</sup>	mg/dL	[8.5-10.1]
Total Protein on Blood	-	-	6.4	g/dL	[6.4-8.2]
Albumin on Blood	-	-	3.1 <sup>L</sup>	g/dL	[3.4-5.0]
Globulin	-	-	3.3	g/dL	[2.3-3.9]
A/G Ratio	-	-	0.9 <sup>L</sup>	ratio	[1.1-2.5]
ALT (SGPT) on Blood	-	-	22	U/L	[16-65]
AST (SGOT) on Blood	-	-	42 <sup>H</sup>	U/L	[8-37]
AST/ALT Ratio	-	-	1.9	ratio	
Alkaline Phosphatase on Blood	-	-	75	U/L	[50-136]
Total Bilirubin on Blood	-	-	0.5	mg/dL	[0.2-2.0]
Bilirubin (Direct)	-	-	0.2	mg/dL	[0.0-0.2]
Bilirubin,Indirect	-	-	0.3	mg/dL	[0.3-1.9]
Troponin I (Quant)	-	-	<0.02 <sup>i4</sup>	ng/mL	[0.00-0.05]
Lipase Level	-	-	2771 <sup>H</sup>	U/L	[73-393]

Result Comments

- f18: eGFR (CKD-EPI) if Africn Am, eGFR (CKD-EPI) NonAfricn Am  
 Note: The estimated glomerular filtration rate (eGFR) is calculated using the CKD-EPI 2009 formula. It is important to note that all estimates of GFR based on serum creatinine will be less accurate for patients at the extremes of muscle mass (including frail elderly, critically ill or cancer patients), those with unusual diets and those with conditions associated with reduced secretion or extra-renal elimination of creatinine. This calculation is not accurate for patients <18 years old. Confirmatory tests with exogenous measured GFR or creatinine clearance should be performed for people whom estimates based on serum creatinine alone may be inaccurate.

**Chemistry**

**Routine Chemistry**

Interpretive Data

i1: eGFR (CKD-EPI) if Africn Am, eGFR (CKD-EPI) NonAfricn Am

**Stages of Chronic Kidney Disease**

Stage 1 Kidney damage with normal kidney function

GFR=90 or >, 90-100% of kidney function

Stage 2: Kidney damage with mild loss of kidney function

GFR=60 to 89, 89-60% of kidney function

Stage 3a: Mild to moderate loss of kidney function

GFR=45 to 59, 59 to 45% of kidney function

Stage 3b: Moderate to severe loss of kidney function

GFR=30 to 44, 44-30% of kidney function

Stage 4: Severe loss of kidney function

GFR=15 to 29, 29-15% of kidney function

Stage 5: Kidney failure

GFR= <15, less than 15% of kidney function

i2: Calcium (Total)

Reference Range for premature infants: 0.2-1.16 mg/dL

i3: Procalcitonin (PCT)

Interpretive Comment:

<0.50 ng/mL: low risk for sepsis; local bacterial infection possible

>=0.50 to <2.00 ng/mL: sepsis is possible; other conditions possible

>=2.00 to <10.00 ng/mL: sepsis likely

>=10.00 ng/mL: severe bacterial sepsis or septic shock probable

i4: Troponin I (cardiac)

Interpretive Comments:

Negative: <0.05 ng/mL

Indeterminate: 0.06-0.50 ng/mL

Suggests AMI: >0.50 ng/mL

Correlation with clinical findings and ECG changes is recommended.

i5: Magnesium Level

Therapeutic Range (Pregnant Females): 5.0-8.0 mg/dL

i6: Hemoglobin A1C (Glycosylated)

Interpretive Comment:

Increased risk for diabetes 5.7% to 6.4%

Diabetes >= 6.5%

Glycemic control for adults with diabetes <7.0%

**Chemistry**

**Lipids and CV Risk**

Collected Date	9/29/2020		
Collected Time	02:20 EDT		
Procedure		Units	Reference Range
Cholesterol Level	174 <sup>i7</sup>	mg/dL	[0-199]
Triglycerides	64 <sup>i8</sup>	mg/dL	[0-149]
HDL Cholesterol	73 <sup>H i9</sup>	mg/dL	[40-60]
Cholesterol/HDL Ratio	2.4	ratio	[0.0-4.4]
LDL	88 <sup>i10</sup>	mg/dL	[0-129]

Interpretive Data

i7: Cholesterol Level  
Interpretive Comment

Desirable <200 mg/dL

Borderline High 200-239 mg/dL

High >=240 mg/dL

i8: Triglycerides

Interpretive Comment:

Borderline High 150-199 mg/dL

High Triglycerides 200-499 mg/dL

Very High Triglycerides >=500 mg/dL

i9: HDL Cholesterol

Interpretive Comment:

Favorable >55 mg/dL

CHD Risk Indicator <35 mg/dL

i10: LDL

Interpretive Comment:

Above Optimal 100-129 mg/dL

Borderline High 130-159 mg/dL

High 160-189 mg/dL

Very High >=190 mg/dL

**Hormones**

Collected Date	9/28/2020		
Collected Time	22:05 EDT		
Procedure		Units	Reference Range
Pregnancy Test-Blood(Qual)	Negative		[Negative]

Discharge Date: 9/30/2020

### Chemistry

**POC**

Collected Date	9/30/2020	9/29/2020	9/29/2020	9/29/2020		
Collected Time	11:57 EDT	22:16 EDT	12:46 EDT	08:05 EDT		
Procedure					Units	Reference Range
Glucose Point of Care	<b>477<sup>c</sup></b>	72	108	<b>143<sup>H</sup></b>	mg/dL	[70-126]

Collected Date	9/29/2020	9/29/2020	9/29/2020		
Collected Time	07:48 EDT	07:44 EDT	04:18 EDT		
Procedure				Units	Reference Range
Glucose Point of Care	<b>22<sup>c</sup></b>	<b>&lt;10<sup>c</sup></b>	126	mg/dL	[70-126]
Point Of Care Note	CallReadBackRN	Repeated Test	-		

### Coagulation

Collected Date	9/30/2020	9/29/2020	9/29/2020	9/29/2020		
Collected Time	[REDACTED] EDT	[REDACTED] EDT	20:33 EDT	12:15 EDT		
Procedure					Units	Reference Range
PT -INR (Prothrombin Time)	<b>26.4<sup>H</sup></b>	<b>27.7<sup>H</sup></b>	<b>24.1<sup>H</sup></b>	<b>33.3<sup>H</sup></b>	seconds	[11.1-15.5]
International Normalized Ratio	<b>2.4<sup>H</sup> i11</b>	<b>2.6<sup>H</sup> i11</b>	<b>2.2<sup>H</sup> i11</b>	<b>3.3<sup>H</sup> i11</b>		[0.8-1.2]
PTT (Partial Thromb Time)	<b>57.5<sup>H</sup></b>	<b>52.4<sup>H</sup></b>	<b>50.9<sup>H</sup></b>	<b>70.4<sup>H</sup></b>	seconds	[21.8-39.0]
Fibrinogen Level	<b>169<sup>L</sup></b>	-	238	<b>101<sup>L</sup></b>	mg/dL	[232-497]

**Interpretive Data**

i11: International Normalized Ratio  
 Interpretive Comment:  
 2.0 - 3.0 Therapeutic  
 2.5 - 3.5 [REDACTED] ical Heart Valve

### Hematology

**Blood Count**

Collected Date	9/30/2020	9/30/2020	9/30/2020		
Collected Time	11:45 EDT	03:06 EDT	03:06 EDT		
Procedure				Units	Reference Range
Hemoglobin	<b>5.4<sup>C</sup> f21</b>	-	<b>6.6<sup>C</sup> f22</b>	g/dL	[12.0-15.0]
Hematocrit	<b>18.5<sup>C</sup> f21</b>	-	<b>21.0<sup>L</sup></b>	%	[35.0-45.0]
WBC	<b>2.08<sup>L</sup></b>	-	<b>1.16<sup>L</sup></b>	K/uL	[3.40-11.00]
Platelet Count	<b>35<sup>L</sup></b>	-	<b>35<sup>L</sup></b>	K/uL	[130-360]
RBC	<b>1.92<sup>L</sup></b>	-	<b>2.25<sup>L</sup></b>	M/uL	[3.80-5.20]
MCV	96.4	-	93.3	fL	[80.0-100.0]
MCH	28.1	-	29.3	pg	[26.0-35.0]
MCHC	<b>29.2<sup>L</sup></b>	-	<b>31.4<sup>L</sup></b>	g/dL	[32.0-36.0]
RDW CV	<b>19.5<sup>H</sup></b>	-	<b>19.0<sup>H</sup></b>	%	[11.5-14.5]
RDW SD	<b>69.2<sup>H</sup></b>	-	<b>64.3<sup>H</sup></b>	fL	[36.4-46.3]

Discharge Date: 9/30/2020

## Hematology

### Blood Count

Procedure	Collected Date	9/30/2020	9/30/2020	9/30/2020	Units	Reference Range
	Collected Time	11:45 EDT	03:06 EDT	03:06 EDT		
MPV		11.1	-	12.1	fL	[7.7-13.2]
Differential Type		-	Auto	Auto		
% Neutrophils		-	-	63.0	%	[40.0-70.0]
% Immature Granulocytes		-	-	1.7 <sup>H#2</sup>	%	[0.0-0.4]
% Lymphocytes		-	-	29.3	%	[17.0-45.0]
% Monocytes		-	-	4.3	%	[3.0-12.0]
% Eosinophils		-	-	1.7	%	[0.0-7.0]
% Basophils		-	-	0.0	%	[0.0-1.0]
Absolute Neutrophils		-	-	0.73 <sup>L</sup>	K/uL	[1.10-8.00]
Absolute Lymphocytes		-	-	0.34 <sup>L</sup>	K/uL	[0.60-3.10]
Absolute Monocytes		-	-	0.05 <sup>L</sup>	K/uL	[0.44-1.00]
Absolute Eosinophils		-	-	0.02	K/uL	[0.00-0.36]
Absolute Basophils		-	-	0.00	K/uL	[0.00-0.08]
Absolute Immature		-	-	0.02	K/uL	[0.00-0.09]
NRBCs		13.50 <sup>H</sup>	-	6.90 <sup>H</sup>	/100 WBC	[0.00-0.00]
Abs NRBCs		0.28 <sup>H</sup>	-	0.08 <sup>H</sup>	K/uL	[0.00-0.01]
RBC Morphology		Reviewed	Reviewed	-		
Anisocytosis		Present @	-	-		[None Seen]
Burr Cells		Present @	Present @	-		[None Seen]
Hypochromia		Present @	-	-		[None Seen]
Ovalocytes		-	Present @	-		[None Seen]
Schistocytes		-	Few @	-		[None Seen]
Platelet Estimate		Decreased @	Decreased @	-	K/uL	[Adequate]

### Result Comments

f21: Hematocrit, Hemoglobin

This result has been called to RN [REDACTED] by [REDACTED] on 09 30 2020 at 1222, and has been read back.

f22: Hemoglobin

This result has been called to [REDACTED] RN by [REDACTED] on 09 30 2020 at 0336, and has been read back.

Procedure	Collected Date	9/29/2020	9/29/2020	9/29/2020	Units	Reference Range
	Collected Time	21:25 EDT	20:33 EDT	14:37 EDT		
Hemoglobin		8.4 <sup>L</sup>	9.9 <sup>L</sup>	9.8 <sup>L</sup>	g/dL	[12.0-15.0]
Hematocrit		26.3 <sup>L</sup>	30.8 <sup>L</sup>	30.5 <sup>L</sup>	%	[35.0-45.0]
WBC		1.43 <sup>L</sup>	1.56 <sup>L</sup>	1.56 <sup>L</sup>	K/uL	[3.40-11.00]
Platelet Count		81 <sup>L</sup>	87 <sup>L</sup>	106 <sup>L</sup>	K/uL	[130-360]
RBC		2.90 <sup>L</sup>	3.35 <sup>L</sup>	3.27 <sup>L</sup>	M/uL	[3.80-5.20]
MCV		90.7	91.9	93.3	fL	[80.0-100.0]
MCH		29.0	29.6	30.0	pg	[26.0-35.0]
MCHC		31.9 <sup>L</sup>	32.1	32.1	g/dL	[32.0-36.0]

Discharge Date: 9/30/2020

## Hematology

### Blood Count

Procedure	Collected Date	9/29/2020	9/29/2020	9/29/2020	Units	Reference Range
	Collected Time	21:25 EDT	20:33 EDT	14:37 EDT		
RDW CV		18.4 <sup>H</sup>	18.4 <sup>H</sup>	17.7 <sup>H</sup>	%	[11.5-14.5]
RDW SD		60.4 <sup>H</sup>	61.2 <sup>H</sup>	60.6 <sup>H</sup>	fL	[36.4-46.3]
MPV		12.1	11.2	11.6	fL	[7.7-13.2]
NRBCs		8.40 <sup>H</sup>	5.80 <sup>H</sup>	2.60 <sup>H</sup>	/100 WBC	[0.00-0.00]
Abs NRBCs		0.12 <sup>H</sup>	0.09 <sup>H</sup>	0.04 <sup>H</sup>	K/uL	[0.00-0.01]
RBC Morphology		-	Reviewed	Reviewed		
Anisocytosis		-	Present <sup>@</sup>	-		[None Seen]
Platelet Clumps		-	Present <sup>@</sup>	Present <sup>@</sup>		[None Seen]
Large Platelets		-	Present <sup>@</sup>	Present <sup>@</sup>		[None Seen]
Platelet Estimate		-	Decreased <sup>@</sup>	Decreased <sup>@</sup>	K/uL	[Adequate]

Procedure	Collected Date	9/29/2020	9/29/2020	Units	Reference Range
	Collected Time	12:15 EDT	04:52 EDT		
Hemoglobin		6.8 <sup>C f23</sup>	13.8	g/dL	[12.0-15.0]
Hematocrit		22.5 <sup>L</sup>	46.3 <sup>H</sup>	%	[35.0-45.0]
WBC		1.55 <sup>L</sup>	3.69	K/uL	[3.40-11.00]
Platelet Count		110 <sup>L</sup>	281	K/uL	[130-360]
RBC		2.22 <sup>L</sup>	4.55	M/uL	[3.80-5.20]
MCV		101.4 <sup>H</sup>	101.8 <sup>H</sup>	fL	[80.0-100.0]
MCH		30.6	30.3	pg	[26.0-35.0]
MCHC		30.2 <sup>L</sup>	29.8 <sup>L</sup>	g/dL	[32.0-36.0]
RDW CV		13.8	13.8	%	[11.5-14.5]
RDW SD		51.3 <sup>H</sup>	52.3 <sup>H</sup>	fL	[36.4-46.3]
MPV		10.7	11.0	fL	[7.7-13.2]
NRBCs		1.30 <sup>H</sup>	0.00	/100 WBC	[0.00-0.00]
Abs NRBCs		0.02 <sup>H</sup>	0.00	K/uL	[0.00-0.01]
RBC Morphology		Reviewed	-		
Crenated RBC's		Present <sup>@</sup>	-		[None Seen]
Platelet Clumps		#P SMALL PLATELET CLUMP SEEN	-		
Giant Platelets		Present <sup>@</sup>	-		[None Seen]
Large Platelets		Present <sup>@</sup>	-		[None Seen]
Platelet Estimate		Decreased <sup>@</sup>	-	K/uL	[Adequate]
Blood Smear Interpretation		See Below <sup>T8</sup>	-		

### Textual Results

T8: 9/29/2020 12:15 EDT (Blood Smear Interpretation)  
 Reviewed and concur.  
 .D.

**Hematology**

**Blood Count**

Result Comments

f23: Hemoglobin

This result has been called to [REDACTED] RN by [REDACTED] on 09 29 2020 at 1247, and has been read back.

Procedure	Collected Date Collected Time	9/28/2020 22:05 EDT	9/28/2020 22:05 EDT	Units	Reference Range
Hemoglobin	-	-	13.2	g/dL	[12.0-15.0]
Hematocrit	-	-	42.1	%	[35.0-45.0]
WBC	-	-	5.65	K/uL	[3.40-11.00]
Platelet Count	-	-	247	K/uL	[130-360]
RBC	-	-	4.38	M/uL	[3.80-5.20]
MCV	-	-	96.1	fL	[80.0-100.0]
MCH	-	-	30.1	pg	[26.0-35.0]
MCHC	-	-	1.4 <sup>L</sup>	g/dL	[32.0-36.0]
RDW CV	-	-	13.6	%	[11.5-14.5]
RDW SD	-	-	48.5 <sup>H</sup>	fL	[36.4-46.3]
MPV	-	-	11.2	fL	[7.7-13.2]
Differential Type	Auto	Auto			
% Neutrophils	-	-	83.2 <sup>H</sup>	%	[40.0-70.0]
% Immature Granulocytes	-	-	0.2 <sup>i12</sup>	%	[0.0-0.4]
% Lymphocytes	-	-	13.5 <sup>L</sup>	%	[17.0-45.0]
% Monocytes	-	-	2.7 <sup>L</sup>	%	[3.0-12.0]
% Eosinophils	-	-	0.0	%	[0.0-7.0]
% Basophils	-	-	0.4	%	[0.0-1.0]
Absolute Neutrophils	-	-	4.71	K/uL	[1.10-8.00]
Absolute Lymphocytes	-	-	0.76	K/uL	[0.60-3.10]
Absolute Monocytes	-	-	0.15 <sup>L</sup>	K/uL	[0.44-1.00]
Absolute Eosinophils	-	-	0.00	K/uL	[0.00-0.36]
Absolute Basophils	-	-	0.02	K/uL	[0.00-0.08]
Absolute Immature Granulocytes	-	-	0.01	K/uL	[0.00-0.09]
NRBCs	-	-	0.00	/100 WBC	[0.00-0.00]
Abs NRBCs	-	-	0.00	K/uL	[0.00-0.01]
RBC Morphology	Reviewed	-	-		

Interpretive Data

i12: % Immature Granulocytes

Metamyelocytes, Myelocytes, and Promyelocytes only

**Urine & Feces**

**Urinalysis**

Collected Date	9/28/2020		
Collected Time	23:46 EDT		
Procedure		Units	Reference Range
Color -UR	Yellow		[Yellow]
Appearance-UR	Clear		[Clear]
Glucose -Urine	Negative		[Negative]
Bilirubin -UR	Negative		[Negative]
Acetone (Ketones)-Urine	<b>15</b> @		[Negative]
Specific Gravity	>=1.030 <sup>i13</sup>		[1.005-1.030]
Blood	Negative		[Negative]
PH in Urine	5.5		[5.0-8.0]
Protein,UR SCR	<b>100</b> @		[Negative]
Urobilinogen	0.2		[0.0-1.0]
Nitrite	Negative		[Negative]
Leukocyte Esterase	Negative <sup>i14</sup>		[Negative]
WBCs -UR	0	/HPF	[0-2]
RBCs -UR	0	/HPF	[0-2]
Squamous Epithelial Cells	5	/HPF	[0-2]
Bacteria	<b>Few</b> @	/HPF	[None Seen]

**Interpretive Data**

- i13: Specific Gravity  
Highly buffered alkaline urines may cause low specific gravity readings relative to other methods. Elevated specific gravity readings may be obtained in the presence of moderate quantities (100-750 mg/dL) of protein.
- i14: Leukocyte Esterase  
A Culture is not reflexed on this test, please order manually if needed.

Discharge Date: 9/30/2020

**Microbiology**

Procedure: Culture & Gram-Surgical      Accession: 002-19-272-0328  
Source: Surgical  
Body Site: Peritoneum      Collected Date/Time: 9/29/2020 09:50 EDT

Final Report

Light Growth *Escherichia coli*  
Light Growth *Klebsiella pneumoniae ssp pneumoniae*

Anaerobic Culture Report

No Anaerobes Isolated

\*\*\*SUSCEPTIBILITY RESULTS\*\*\*

Escherichia coli		
Antibiotic	MIC Dilutn	MIC Interp
Cefepime	<=1	Susceptible
Ceftriaxone	<=1	Susceptible
Ciprofloxacin	>=4	Resistant
Gentamicin	<=1	Susceptible
Levofloxacin	>=8	Resistant
Meropenem	<=0.25	Susceptible
Piperacillin/Tazobactam	<=4	Susceptible
Trimethoprim/Sulfa	<=20	Susceptible

Klebsiella pneumoniae ssp pneumoniae		
Antibiotic	MIC Dilutn	MIC Interp
Cefepime	<=1	Susceptible
Ceftriaxone	<=1	Susceptible
Ciprofloxacin	<=0.25	Susceptible
Gentamicin	<=1	Susceptible
Levofloxacin	<=0.12	Susceptible
Meropenem	<=0.25	Susceptible
Piperacillin/Tazobactam	<=4	Susceptible
Trimethoprim/Sulfa	<=20	Susceptible

Procedure: Culture, Blood-Peripheral      Accession: 002-19-272-0186  
Source: Blood  
Body Site: Blood,Peripheral      Collected Date/Time: 9/29/2020 04:52 EDT

Final Report

No Growth in 5 Days

Procedure: Culture, Urine      Accession: 002-19-272-0054  
Source: Urine, Clean Catch  
Body Site:      Collected Date/Time: 9/28/2020 23:54 EDT

Final Report

>100,000 CFU/ml *Klebsiella pneumoniae*  
10,000 - 50,000 CFU/ml *Escherichia coli*

**Microbiology**

\*\*\*SUSCEPTIBILITY RESULTS\*\*\*

Antibiotic	MIC Dilutn	MIC Interp
Klebsiella pneumoniae		
Amoxicillin/Clavulanate	<=2	Susceptible
Ampicillin	>=32	Resistant
Cefazolin	<=4	Susceptible
Cefepime	<=1	Susceptible
Ceftriaxone	<=1	Susceptible
Ciprofloxacin	<=0.25	Susceptible
Gentamicin	<=1	Susceptible
Levofloxacin	<=0.12	Susceptible
Meropenem	<=0.25	Susceptible
Nitrofurantoin	64	Intermediate
Piperacillin/Tazobactam	<=4	Susceptible
Tetracycline	<=1	Susceptible
Trimethoprim/Sulfa	<=20	Susceptible

Antibiotic	MIC Dilutn	MIC Interp
[REDACTED]chia coli		
Amoxicillin/Clavulanate	8	Susceptible
Ampicillin	>=32	Resistant
Cefazolin	<=4	Susceptible
Cefepime	<=1	Susceptible
Ceftriaxone	<=1	Susceptible
Ciprofloxacin	>=4	Resistant
Gentamicin	<=1	Susceptible
Levofloxacin	>=8	Resistant
Meropenem	<=0.25	Susceptible
Nitrofurantoin	<=16	Susceptible
Piperacillin/Tazobactam	<=4	Susceptible
Tetracycline	<=1	Susceptible
Trimethoprim/Sulfa	>=320	Resistant

██████████ : 905814081

Discharge Date: 9/30/2020

**Crossmatch Summary**

Collected Date/Time	Crossmatch Result	ABO/Rh Display	Product Display	Product Attribute Display	Product Number
9/28/2020 22:05 EDT	Compatible	B POS	E0382 RBC CP2D AS3 500 LR	Leukoreduced	W036819759833
9/28/2020 22:05 EDT	Compatible	B POS	E0382 RBC CP2D AS3 500 LR	Leukoreduced	W036819465259
9/28/2020 22:05 EDT	Compatible	O POS	E4532 Aph RBC ACDA AS1 LR 1	Apheresis;1st container; Leukoreduced	W036819718254
9/28/2020 22:05 EDT	Compatible	O POS	E4533 Aph RBC ACDA AS1 LR 2	Apheresis;2nd container; Leukoreduced	W036819717119
9/28/2020 22:05 EDT	Compatible	B POS	E0382 RBC CP2D AS3 500 LR	CMV-; Leukoreduced	W036819738190
9/28/2020 22:05 EDT	Compatible	B POS	E0382 RBC CP2D AS3 500 LR	Leukoreduced	W036819739994

**Transfusion Medicine**

**Transfusion Services**

Collected Date	9/30/2020	9/30/2020	9/30/2020	9/29/2020	9/29/2020	9/29/2020	9/29/2020
Collected Time	05:01 EDT	04:45 EDT	03:43 EDT	22:37 EDT	14:54 EDT	09:05 EDT	04:49 EDT
Procedure							
RBC Product Ready	-	-	Done	-	-	Done	Done
FFP Product Ready	-	-	-	Done <sup>f24</sup>	-	Done	-
Cryo Product Ready	Done <sup>f25</sup>	-	-	-	Done	-	-
Platelet Product Ready	-	Done <sup>f26</sup>	-	-	-	-	-

**Result Comments**

- f24: FFP Product Ready  
09/30/2020 1:48 ██████████  
2 ffps already given
- f25: Cryo Product Ready  
09/30/2020 5:25 ██████████  
spoke with Miracle at 0519
- f26: Platelet Product Ready  
09/30/2020 4:52 ██████████  
2 prbc and 1 plt available, spoke with ██████████, RN

Collected Date	9/28/2020
Collected Time	22:05 EDT
Procedure	
ABORH	B POS
Antibody Screen	Negative

Discharge Date: 9/30/2020

**Transfusion Summary**

Product Status	Transfused Date/Time	ABO/Rh Display	Product Number	Product Display
Transfused	9/30/2020 14:09 EDT	O POS	W036819718254	E4532 Aph RBC ACDA AS1 LR 1
Transfused	9/30/2020 13:22 EDT	O POS	W036819717119	E4533 Aph RBC ACDA AS1 LR 2
Transfused	9/30/2020 08:58 EDT	B POS	W036819759833	E0382 RBC CP2D AS3 500 LR
Transfused	9/30/2020 07:10 EDT	B POS	W036819465259	E0382 RBC CP2D AS3 500 LR
Transfused	9/30/2020 06:16 EDT	B POS	W239619031302	E7827 Thawed Pooled Cryo 5 Units Open
Transfused	9/30/2020 06:16 EDT	B POS	W239619031301	E7827 Thawed Pooled Cryo 5 Units Open
Transfused	9/30/2020 05:44 EDT	O POS	W036819730160	E3056 Aph Plt ACDA LR Irr 1
Transfused	9/30/2020 04:19 EDT	B POS	W036819227792	E2737 Thawed Plasma CP2D <24h
Transfused	9/30/2020 [REDACTED]	B POS	W036819145967	E2737 Thawed Plasma CP2D <24h
Transfused	9/30/2020 01:25 EDT	B NEG	W036819306216	E2737 Thawed Plasma CP2D <24h
Transfused	9/29/2020 23:56 EDT	B POS	W036819298603	E2737 Thawed Plasma CP2D <24h
Transfused	9/29/2020 17:02 EDT	B POS	W239619014338	E7826 Thawed Pooled Cryo 10 Units Open
Transfused	9/29/2020 15:49 EDT	B POS	W036819095564 A0	E2284 Thawed Aph Dv Plasma ACDA <24h
Transfused	9/29/2020 14:15 EDT	B POS	W036819077584	E0797 Thawed FFP CP2D
Transfused	9/29/2020 13:33 EDT	B POS	W036819739994	E0382 RBC CP2D AS3 500 LR
Transfused	9/29/2020 13:33 EDT	B POS	W036819738190	E0382 RBC CP2D AS3 500 LR

Discharge Date: 9/30/2020

**Cardiology Reports**

Document Type: EKG Standard  
Service Date/Time: 9/28/2020 21:04 EDT  
Result Status: Auth (Verified)  
Document Subject: EKG Standard  
Perform Information:  
Sign Information:

**ECG IMAGE LOCATION**

<http://ddmsecgw2/PyramisUI/Edit.aspx?Provider=Pyramis&EndEdit=login.aspx?Logout=EXIT&User=CARD&Password=password&TestType=Any&Status=Any&Inst=0&LockMRN=000000978183&ReqID=3780564977> HNAM URL

**Physician Interpreter**

[REDACTED], M.D.

**Interpretation Text**

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE  
LEFT ATRIAL ABNORMALITY  
ABNORMAL ECG [REDACTED]

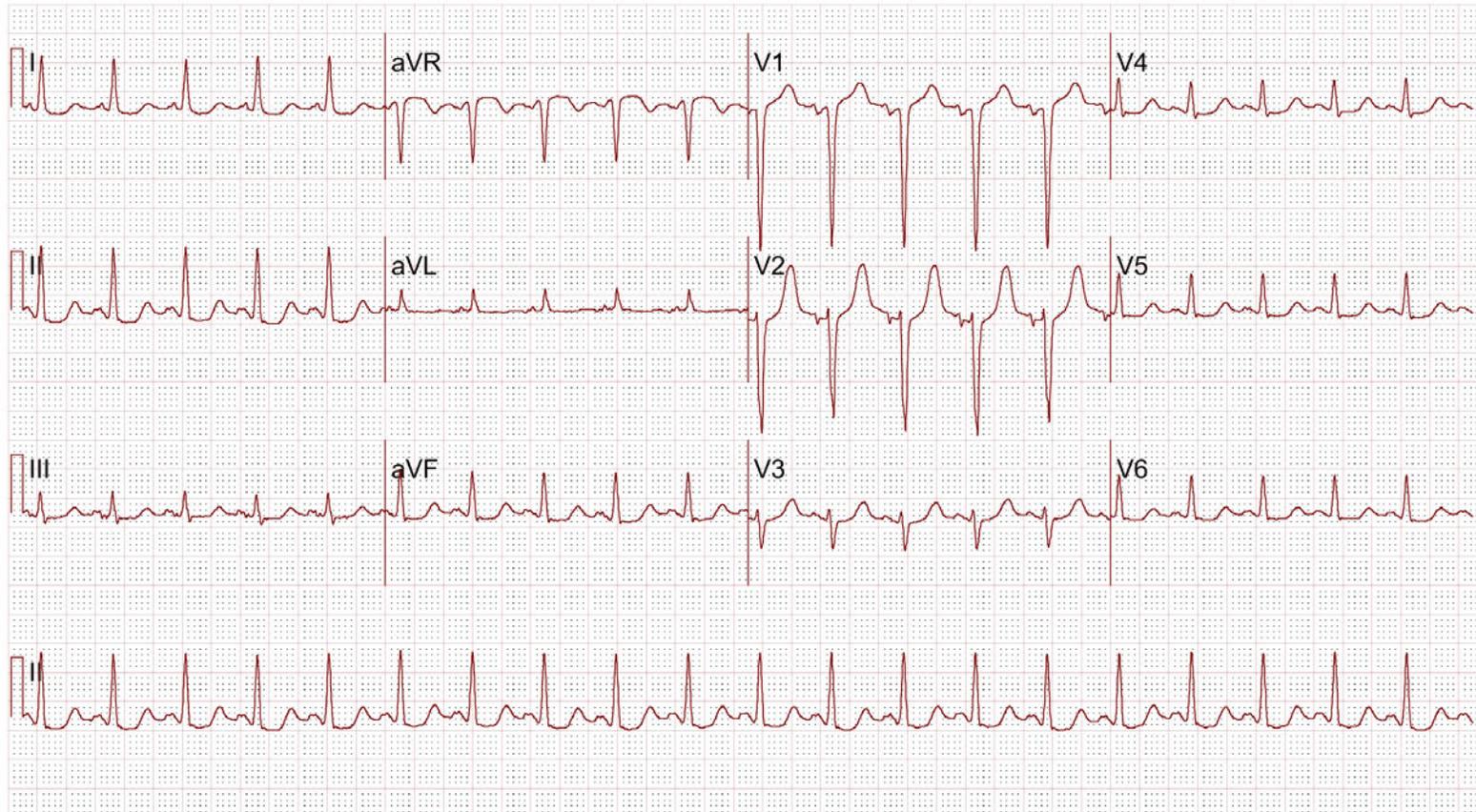
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[REDACTED]

[REDACTED]

\* Auth (Verified) \*

Name: [REDACTED], S [REDACTED]	Vent rate: 121	SINUS TACHYCARDIA WITH SHORT PR INTERVAL
ID: [REDACTED]	RR: 495	LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE
Req#: 3780564977	--Durations--	LEFT ATRIAL ABNORMALITY
FIN#: 905814081	P: 105	ABNORMAL ECG
DOB: 07/23/73	QRS: 85	
Age: 47 years	--Intervals--	
Race: Unknown	PR: 113	
Sex: Female	QT: 327	
Facility: SMH	QTcH: 433	
Tech: 22971	QTd:	
Room: CC0501	--Axes--	
Medl: No Medication	P: 47	
Cml:	QRS: 44	Confirmed By: [REDACTED], M.D.
Phys: [REDACTED]	T: 64	
Cmnt:		
Dept: EMBR	Inst: South Miami	
Date: 09/28/2019	Time: 21.04.35	
Speed: 25 mm/s	Limb Lead Gain: 10.0 mm/mV	Chest Lead Gain: 10.0 mm/mV
		Filters(s): Notch 60 Hz Artifact 40 Hz Stable Off



\*20190928210435.12633\*

ECG Printed 09/28/2019 08:37:36 Transcribed By: [REDACTED], MDD.09/28/2019 08:37:20  
CONFIRM ELI38 V2.1.2.0 115440278550 QTcH=(Hodges)

\* Auth (Verified) \*

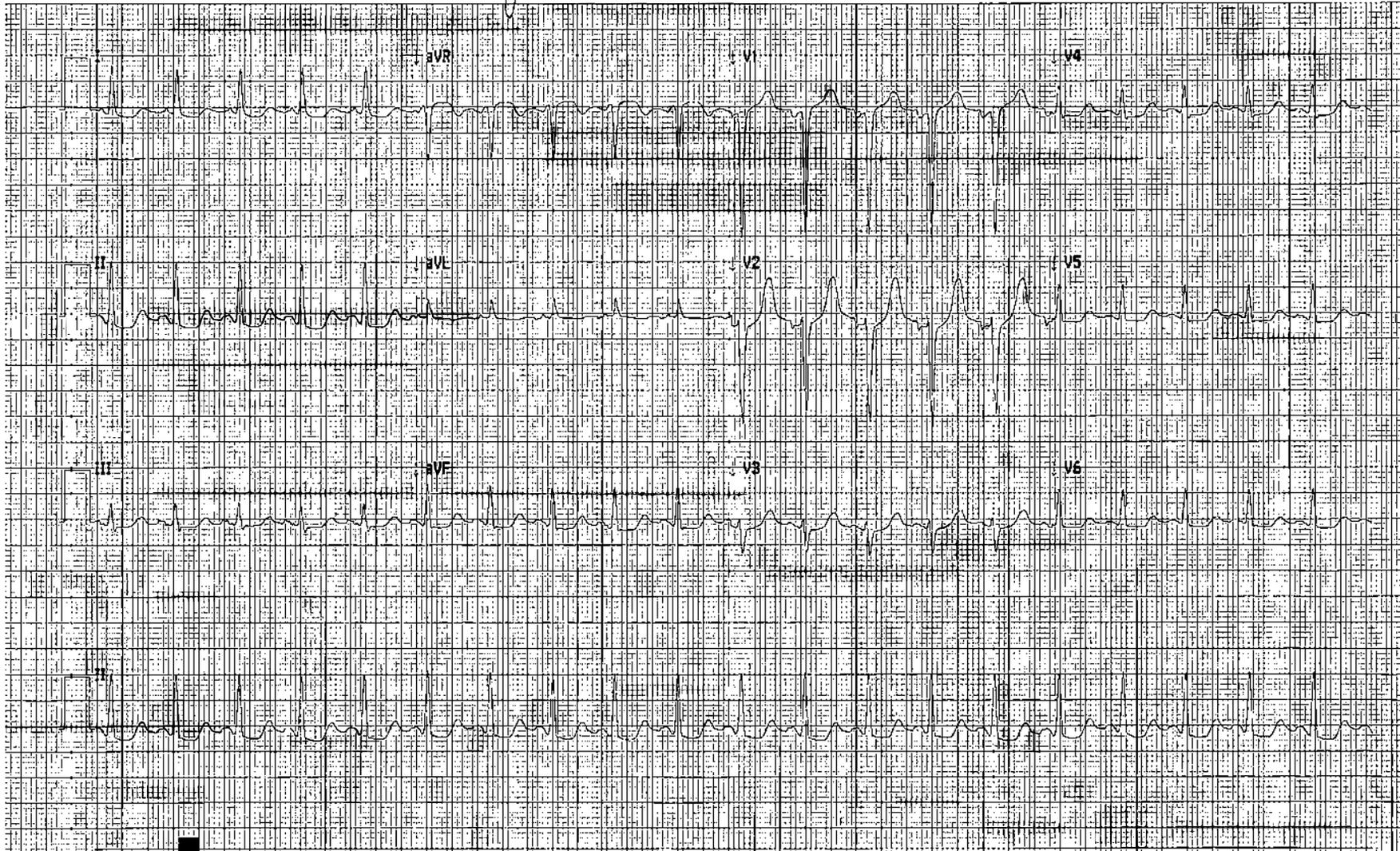
██████████  
Tech: 22971  
EIN: ██████████  
DOB: 23-Jul-1973 Dept: ED  
Sex: Female Age: 46yr  
Race: RACE  
P.Req#: Rm:1  
Order Phys:  
Cmt:

28-Sep-2020 21:04:35  
Vent rate 121 BPM  
PR int 113 ms  
QRS dur 85 ms  
QT/QTc 327/399 ms  
P-R-T axes 47 44 64

SINUS TACHYCARDIA WITH SHORT PR INTERVAL  
LEFT VENTRICULAR HYPERTROPHY AND ST-T CHANGE (VOLTAGE CRITERIA PLUS ST/T  
ABNORMALITY)  
ABNORMAL ECG  
UNCONFIRMED REPORT

✓

2106 js



Discharge Date: 9/30/2020

## Radiology Results

Document Type: Abd Pel CT wo IV wo PO Con  
Service Date/Time: 9/28/2020 22:55 EDT  
Result Status: Auth (Verified)  
Document Subject: ABD PEL CT WO IV WO PO CON  
Perform Information: (9/28/2020 23:07 EDT)  
Sign Information:

### ABD PEL CT WO IV WO PO CON

[http://BHSF00AP1/integrations/iseemr/iseite\\_emr.aspx?patient\\_id=3332159&accession\\_number=24306635](http://BHSF00AP1/integrations/iseemr/iseite_emr.aspx?patient_id=3332159&accession_number=24306635) HNAM URL

### ABD PEL CT WO IV WO PO CON

ORDERED BY:   
ON: Sep 28 2020 11:02P  
\*\*\*FINAL RESULT\*\*\*

Patient Name: E DOB:07/23/1973  
PROCEDURE: SCT 4412 ABD PEL CT WO IV WO PO CON  
Acc #: 24306635  
PROCEDURE: ABD PEL C  
CLINICAL INDICATION:  
Abdominal pain general abdominal pain  
COMPARISON:  
02/06/2020

TECHNIQUE: 2.5 mm collimation was utilized to image from the lung bases to the symphysis pubis without administration of IV contrast. Oral contrast not given. Sagittal and coronal reconstructions were also reviewed.

Radiation dose reduction techniques used for this exam include: Iterative Reconstruction Technique and/or adjustments of the mA/kV according to patient size. DICOM files are available.

#### DISCUSSION:

##### Lungs/pleura:

Lung bases are clear without pleural effusions.

##### Liver/spleen:

The liver has a grossly normal noncontrast CT appearance. The spleen is nonenlarged. Patient status post gastric bypass no biliary pancreatic portion of the gastric bypass remains markedly dilated with segmental thickening of the proximal jejunum. There is a moderate intra-abdominal and pelvic amount of ascites.

##### Adrenals:

The adrenal glands are unremarkable.

##### Pancreaticobiliary:

Pancreas has a grossly normal noncontrast CT appearance. Gallbladder surgically removed.

##### Genitourinary:

4 mm nonobstructing left renal calyceal calculi present. Bladder collapsed limiting evaluation.

##### Lymph nodes:

No enlarged abdominal or pelvic nodes are present.

##### Bowel:

Discharge Date: 9/30/2020

**Radiology Results**

There continues to be diffuse dilated appearance to the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum .

Osseous structures:

There are no osseous destructive lesions.

IMPRESSION:

Interval development of moderate intra-abdominal and pelvic ascites with persistent diffuse marked dilatation of the biliary pancreatic portion of the gastric bypass with segmental thickening of the proximal jejunum further surgical evaluation recommended. Partial obstruction not excluded, this of uncertain etiology

Signed Electronically By: [REDACTED] - 039321 - 9/28/2020 11:07 PM

READ [REDACTED] ON: Sep 28 2020 11:02P

\*\*\*FINAL RESULT\*\*\*

Document Type:

Service Date/Time:

Result Status:

Document Subject:

Perform Information:

Sign Information:

Chest Single View XR

9/29/2020 19:43 EDT

Auth (Verified)

CHEST SINGLE VIEW XR

[REDACTED] (9/29/2020 20:00 EDT)

**CHEST SINGLE VIEW XR**

[http://BHSF00AP1/integrations/isiteemr/isite\\_emr.aspx?patient\\_id=3332159&accession\\_number=24308309](http://BHSF00AP1/integrations/isiteemr/isite_emr.aspx?patient_id=3332159&accession_number=24308309) HNAM URL

**CHEST SINGLE VIEW XR**

ORDERED BY: [REDACTED]

READ BY: [REDACTED] ON: Sep 29 2020 7:59P

\*\*\*FINAL RESULT\*\*\*

Patient Name: [REDACTED] DOB:07/23/1973

PROCEDURE: SXR 7101 CHEST SINGLE VIEW XR

Acc #: 24308309

PROCEDURE: CHEST SINGLE VIEW XR

CLINICAL INDICATION:

dialysis catheter placement RESPIRATORY DISTRESS FOR FOLLOWUP

COMPARISON:

None.

TECHNIQUE:

Single view chest radiography.

DISCUSSION:

Left-sided IJ dialysis catheter with tip in SVC. No pneumothorax.

Otherwise support lines unchanged in position. No development of a pneumothorax. There is no interval change in pulmonary appearance. Heart and mediastinal structures are grossly unchanged.

Discharge Date: 9/30/2020

## Radiology Results

### IMPRESSION:

Interval placement of a left-sided jugular central line with tip in good position. No pneumothorax.

Signed Electronically By: Dr. [REDACTED] - 038398 - 9/29/2020 8:00 PM

READ BY: [REDACTED] ON: Sep 29 2020 7:59P

\*\*\*FINAL RESULT\*\*\*

Document Type:	Chest Single View XR
Service Date/Time:	9/29/2020 14:30 EDT
Result Status:	Auth (Verified)
Document Subject:	CHEST SINGLE VIEW XR
Perform Information:	[REDACTED] MD (9/29/2020 14:48 EDT)
Sign Information:	[REDACTED]

### CHEST SINGLE VIEW XR

[http://BHSF00AP1/integrations/siteemr/site\\_emr.aspx?patient\\_id=3332159&accession\\_number=24307670](http://BHSF00AP1/integrations/siteemr/site_emr.aspx?patient_id=3332159&accession_number=24307670) HNAM URL

### CHEST SINGLE VIEW XR

ORDERED BY: [REDACTED], M.D.

READ BY: [REDACTED] ON: Sep 29 2020 2:47P

\*\*\*FINAL RESULT\*\*\*

Patient Name: [REDACTED] DOB:07/23/1973  
PROCEDURE: SXR 7101 CHEST SINGLE VIEW XR  
Acc #: 24307670 [REDACTED]

PROCEDURE: CHEST SINGLE VIEW XR

#### CLINICAL INDICATION:

central line catheter

#### COMPARISON:

Chest x-ray 09/29/2020

#### TECHNIQUE:

AP view chest radiography.

#### DISCUSSION:

There is a new right internal jugular central venous catheter with tip in the SVC. An endotracheal tube is present with tip approximately 3.5 cm above the carina. An enteric tube is present with tip in the stomach. Low lung volumes noted. No focal consolidation. Cardiac silhouette is unremarkable.

#### IMPRESSION:

New right internal jugular central venous catheter in good position.

Signed Electronically By: Dr. [REDACTED] - 133777 - 9/29/2020 2:48 PM

Discharge Date: 9/30/2020

**Radiology Results**

READ BY: [REDACTED] ON: Sep 29 2020 2:47P

\*\*\*FINAL RESULT\*\*\*

Document Type: Chest Single View XR  
Service Date/Time: 9/29/2020 12:34 EDT  
Result Status: Auth (Verified)  
Document Subject: CHEST SINGLE VIEW XR  
Perform Information: [REDACTED] MD (9/29/2020 12:47 EDT)  
Sign Information:

**CHEST SINGLE VIEW XR**

[http://BHSF00AP1/integrations/isiteemr/bsite\\_emr.aspx?patient\\_id=3332159&accession\\_number=24307474](http://BHSF00AP1/integrations/isiteemr/bsite_emr.aspx?patient_id=3332159&accession_number=24307474) HNAM URL

**CHEST SINGLE VIEW XR**

ORDERED BY: [REDACTED], M.D.

READ BY: [REDACTED] ON: Sep 29 2020 12:45P

\*\*\*FINAL RESULT\*\*\*

Patient Name: [REDACTED] DOB:07/23/1973  
PROCEDURE: SXR CHEST SINGLE VIEW XR  
Acc #: 24307474

PROCEDURE:  
CHEST SINGLE VIEW XR

CLINICAL INDICATION:  
Acute respiratory failure

COMPARISON:  
02/05/2020

TECHNIQUE:  
Frontal chest radio [REDACTED]

DISCUSSION:  
There is left basilar subsegmental atelectasis. Bilateral hypoventilatory changes.

Endotracheal tube terminates 2.4 cm above the carina. Enteric tube extends into the stomach.

No substantial pleural effusion or pneumothorax.  
The cardiomeastinal silhouette is unremarkable.

Osseous structures are stable.

IMPRESSION:  
1. Appropriately positioned lines and tubes.  
2. Bilateral hypoventilatory changes are present.

Signed Electronically By: XXXXXXXXXXXXXXXXXXXX - 173195 - 9/29/2020  
12:47 PM

READ BY: [REDACTED] ON: Sep 29 2020 12:45P

\*\*\*FINAL RESULT\*\*\*

Discharge Date: 9/30/2020

## Radiology Results

Document Type: Ruq US  
Service Date/Time: 9/29/2020 00:22 EDT  
Result Status: Auth (Verified)  
Document Subject: RUQ US  
Perform Information: (9/29/2020 01:23 EDT)  
Sign Information:

### RUQ US

[http://BHSF00AP1/integrations/isisiteemr/isisite\\_emr.aspx?patient\\_id=3332159&accession\\_number=24306634](http://BHSF00AP1/integrations/isisiteemr/isisite_emr.aspx?patient_id=3332159&accession_number=24306634) HNAM URL

### RUQ US

ORDERED BY: [REDACTED]  
READ BY: [REDACTED] ON: Sep 29 2020 12:43A  
\*\*\*FINAL RESULT\*\*\*

Patient Name: [REDACTED] DOB:07/23/1973  
PROCEDURE: SUS 4005 RUQ US  
Acc #: 24306634  
PROCEDURE: RUQ US [REDACTED]  
CLINICAL INDICATION: Right upper quadrant pain.  
COMPARISON: No relevant prior examination available for comparison.  
TECHNIQUE: Right upper quadrant ultrasound. Grayscale and color Doppler images of the right upper quadrant  
DISCUSSION:  
LIVER:  
measures 13.5 cm In craniocaudal dimension  
Liver is heterogeneous .  
No focal lesions on the provided images  
There is no liver surface nodularity on high frequency images.  
Limited color doppl [REDACTED] onstrates hepatapedal flow in the main portal vein.  
GALLBLADDER: Status post cholecystectomy. Sonographic Murphy sign is reported to be negative  
No biliary dilation. Common bile duct diameter is 1.0 cm  
PANCREAS: No abnormality of the visualized portion.  
RIGHT KIDNEY: Anatomic location, normal size and contour. Normal parenchymal thickness and echogenicity. No solid masses. No hydroureteronephrosis. Craniocaudal dimension is 9.3 cm  
ASCITES: There is moderate to large amount ascites  
IMPRESSION:  
1. Moderate to large ascites  
2. Pneumobilia  
Signed Electronically By: [REDACTED] - 151662 - 9/29/2020 1:23 AM

READ BY: [REDACTED] I ON: Sep 29 2020 12:43A  
\*\*\*FINAL RESULT\*\*\*