Result date: 20 January 2014 17:07 EST
Result status: Auth (Verified)

* Final Report *

ED Triage Entered On: 01/20/2014 17:09 EST
Performed On: 01/20/2014 17:07 EST by [redacted]

Assessment I
Chief Complaint : Reporting diarrhea x 1 week. Hypotension. Reports dehydration.
IV Field Start : No
Affect/Behavior : Appropriate
Pain Scale Type : 0-10 Pain scale
Primary Pain Intensity : 0
Allergies Reviewed : Yes
Oxygen Therapy : Room air
Temperature Oral : 97.7 DegF(Converted to: 36.5 DegC)
Peripheral Pulse Rate : 102 bpm (HI)
Respiratory Rate : 20 br/min
Systolic Blood Pressure : 92 mmHg
Diastolic Blood Pressure : 53 mmHg (LOW)
SpO2 : 96 %
Dosing Weight : [redacted]
(R) Patient Weight : Stated
Height : [redacted]

[redacted]

Assessment II
Pregnancy Status : N/A
Fall Risk Order Detail : No
Preferred Language to Discuss Healthcare : English
ED Suspected Infection : No

[redacted]

ESI
Requires immediate life-saving interventions? : No
ESI High Risk, Altered LOC, Distressed : No
How many different resources are needed? : Many
ESI vital sign alert : No
ESI recommended level : 3
ESI clinical agreement : Yes

[redacted]

<u>DCP GENERIC CODE</u>
Tracking Specialty : Main ED
Tracking Acuity : 3
Tracking Group : ED Tracking Group

[redacted]

Allergy

(As Of: 01/20/2014 17:09:50 EST)

<u>Allergies (Active)</u>
NKA *Estimated Onset Date:* Unspecified ; *Created By:* [redacted] [redacted] *Reaction Status:* Active ; *Category:* Drug ; *Substance:* NKA ; *Type:* Allergy ; *Updated By:* [redacted] [redacted] *Reviewed Date:* 12/30/2013 21:03 EST

Result date: 20 January 2014 19:40 EST
Result status: Auth (Verified)

Abdominal Complaint

Patient [redacted]
Age: **70 years** Sex: **Female** DOB: [redacted]
Author: [redacted]
Attachments: **None**

Basic Information

Time seen: Date & time 01/20/2014 19:01:00.
History source: Patient.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.
01/20/2014 17:07 EST Chief Complaint Reporting diarrhea x 1 week. Hypotension. Reports dehydration.

History of Present Illness

The patient presents with Patient presents to the emergency department with over 1 week of diarrhea. . Patient was seen 3 days ago with essentially negative workup, instructed to adhere to a clear liquid diet at that time. Pain has not worsened- however, she took her blood pressure measuring and 89 / 50 at home and came to the ED. denies any vomiting over the past 3 days, no fevers or chills. She does report when questioned about antibiotic usage that she was taking an antibiotic (is not sure which noe) for suspected small region of cellulitis on the face, ended course approximately 10 days ago. . Associated symptoms: denies chest pain, denies shortness of breath, denies fever and denies chills.

Review of Systems

Constitutional symptoms: No fever or no chills.
Skin symptoms: No jaundice or no rash.
Eye symptoms: Vision unchanged.
Respiratory symptoms: No shortness of breath.
Cardiovascular symptoms: No chest pain.
Genitourinary symptoms: No dysuria.
Musculoskeletal symptoms: No back pain.
Neurologic symptoms: No headache.
Hematologic/Lymphatic symptoms: Bleeding tendency negative.

Health Status

Allergies: .
Allergic Reactions (All)
NKA
Medications.

Past Medical/ Family/ Social History

Problem list: .
All Problems
Syncope / 406440010 / Confirmed
Inactive: HTN - Hypertension / 2164904016
Inactive: Hypercholesterolemia / 23283015
Surgical history: .
No active procedure history items have been selected or recorded.
Family history: .
No family history items have been selected or recorded.
Social history: Alcohol use: Denies, Tobacco use: Denies.

Physical Examination

Vital Signs
Vital Signs.

01/20/2014 19:21 EST	Peripheral Pulse Rate	86 bpm
	Respiratory Rate	20 br/min
	Systolic Blood Pressure	109 mmHg
	Diastolic Blood Pressure	66 mmHg
	SpO2	98 %

01/20/2014 17:07 EST Temperature Oral 97.7 DegF
Peripheral Pulse Rate 102 bpm HI
Respiratory Rate 20 br/min
Systolic Blood Pressure 92 mmHg
Diastolic Blood Pressure 53 mmHg LOW
SpO2 96 %

Per nurse's notes.

General: Alert and no acute distress.
Skin: Warm and dry.
Head: Normocephalic and atraumatic.
Neck: Supple and trachea midline.
Eye: Pupils are equal, round and reactive to light and normal conjunctiva.
Cardiovascular: Regular rate and rhythm and No murmur.
Respiratory: Lungs are clear to auscultation and respirations are non-labored.
Gastrointestinal: Soft, Nontender and Non distended.
Back: Nontender and Normal range of motion.
Musculoskeletal: Normal ROM, normal strength and no swelling.
Neurological: Alert and oriented to person, place, time, and situation and No focal neurological deficit observed.
Lymphatics: No lymphadenopathy.
Psychiatric: Normal judgment.

Medical Decision Making

Differential Diagnosis: Abdominal pain, Cdiff, Gastroenteritis, Crohn's dx.

Rationale: Given patient's history of recent antibiotic usage before diarrhea, and suspicious for Clostridium difficile. Her white count is not consistent with typical C. difficile- however given I have suspicion for occult C. difficile, I will obtain sample from initiate treatment of Flagyl. I contacted GI associates for patient to be seen within the next 2 days. Patient is very given stool sample to quest for analysis. Given her 2 L of IV fluid in emergency department, Rx for Flagyl, patient states that she's feeling much better, has not had diarrhea while in emergency department. Patient admits that she has not appeared to clear liquid diet as instructed during last visit. I've gone over strict diet instructions for the next few days including clear liquids only. .

Reexamination/ Reevaluation

Course: improving, I left message for [redacted] office for patient to be seen within next 2 days for full re-eval and assessment of stool sample.

Impression and Plan

Diagnosis

Diarrhea

Plan

Condition: Improved.
Disposition: Discharged: to home.
Prescriptions: Launch prescriptions.
Pharmacy:
Flagyl 500 mg oral tablet (Prescribe): 500 mg = 1 tab, Oral, q8hr, X 7 day(s), # 21 tab, 0 Refill(s)
Patient was given the following educational materials: DIARRHEA, Unk Cause (Adult) Report Pendg, DIARRHEA, Unk Cause (Adult) Report Pendg.
Follow up with: [redacted].
Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Patient indicated understanding of instructions.