Result date: 23 January 2014 9:29 EST
Result status: Auth (Verified)

* Final Report *

ED Triage Entered On: 01/23/2014 9:32 EST
Performed On: 01/23/2014 9:29 EST by [redacted]

Assessment I
Chief Complaint : pt with c/o nausea and vomiting diarrhea feeling very weak on going since thursday
IV Field Start : No
Affect/Behavior : Calm, Cooperative
Pain Scale Type : 0-10 Pain scale
Primary Pain Intensity : 0
Allergies Reviewed : Yes
Oxygen Therapy : Room air
Temperature Oral : 96 DegF(Converted to: 35.6 DegC) (LOW)
Peripheral Pulse Rate : 130 bpm (>HHI)
Respiratory Rate : 20 br/min
Systolic Blood Pressure : 80 mmHg (LOW)
Diastolic Blood Pressure : 46 mmHg (<LLOW)
SpO2 : 99 %
Dosing Weight : 78 kg(Converted to: 171 lb 15 oz, 171.961 lb)
(R) Patient Weight : Stated
Height : 63 inch(Converted to: 5 ft 3 inch, 160.02 cm, 5.25 ft)

[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 : Yes
ESI recommended level : 2
ESI clinical agreement : Yes

[redacted]

DCP GENERIC CODE
Tracking Specialty : Main ED
Tracking Acuity : 2
Tracking Group : ED Tracking Group

[redacted]

Allergy

(As Of: 01/23/2014 09:32:14 EST)

Allergies (Active)
NKA — *Estimated Onset Date:* Unspecified ; *Created By:* [redacted] ; *Reaction Status:* Active ; *Category:* Drug ; *Substance:* NKA ; *Type:* Allergy ; *Updated By:* [redacted] ; *Reviewed Date:* 01/20/2014 19:41 EST

Result date: 23 January 2014 10:08 EST
Result status: Auth (Verified)

Abdominal Complaint

Patient [redacted] [redacted]
Age: **70 years** Sex: **Female** DOB: [redacted]
Author: [redacted]
Attachments: **None**
Associated Diagnosis: Dehydration; Hypokalemia

Basic Information

Time seen: Date & time 01/23/2014 09:56:00.

Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.

01/23/2014 9:29 EST Chief Complaint pt with c/o nausea and vomiting diarrhea feeling very weak on going since thursday

History of Present Illness

the patient presents emergency room with complaints of continued diarrhea now associated with vomiting this morning. Patient was seen by me 3 days ago and has seen one time in between and has also been seeing a gastroenterologist office yesterday for evaluation of continued diarrhea. According to the patient C. difficile as well as celiac disease have been ruled out. She continues to have watery diarrhea associated with some mild epigastric pain did note some vomiting today. She denies any fevers or chills and is not taking any current antibiotics.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.
Skin symptoms: No rash, no petechiae or no lesion.
Eye symptoms: Vision unchanged.
ENMT symptoms: No ear pain, no sore throat or no nasal congestion.
Respiratory symptoms: No shortness of breath or no cough.
Cardiovascular symptoms: No chest pain or no syncope.
Genitourinary symptoms: No dysuria or no hematuria.
Musculoskeletal symptoms: No Muscle pain or no Joint pain.
Neurologic symptoms: No headache, no dizziness or no weakness.
Psychiatric symptoms: No anxiety or no depression.
Endocrine symptoms: No polyuria or no polydipsia.
Hematologic/Lymphatic symptoms: Bleeding tendency negative.

Health Status

Allergies: .

Allergic Reactions (All)

NKA

Medications: (Selected).

Inpatient Medications

Ordered

NSS Bolus 500 mL: 500ml bolus x1 wide open, IV, NOW, 01/23/14 10:03:00 EST

Prescriptions

Prescribed

Flagyl 500 mg oral tablet: 500 mg = 1 tab, Oral, q8hr, X 7 day(s), # 21 tab, 0 Refill(s)

Documented Medications

Documented

Benicar: 20 mg, Oral, Tablet, qDay, 0 Refill(s)
Lipitor 20 mg oral tablet: 20 mg, 1 tab, PO, qHS, 0, 0
atropine-diphenoxylate: PRN as needed for loose stool, Refill(s) 0
hydrochlorothiazide: 12.5 mg, Oral, Capsule, qDay, 0 Refill(s)

Past Medical/ Family/ Social History

Problem list: .

All Problems

Syncope / 406440010 / Confirmed
Inactive: HTN - Hypertension / 2164904016
Inactive: Hypercholesterolemia / 23283015

Surgical history: Negative.

Family history: Not significant, .

No family history items have been selected or recorded.
Social history: Alcohol use: Denies, Tobacco use: Denies, Drug use: Denies.

Physical Examination

Vital Signs
Vital Signs.

01/23/2014 10:07 EST Peripheral Pulse Rate 98 bpm
Respiratory Rate 18 br/min
Systolic Blood Pressure 78 mmHg <LLOW
Diastolic Blood Pressure 62 mmHg
Mean Arterial Pressure 67.333 mmHg
SpO2 96 %

01/23/2014 9:58 EST Peripheral Pulse Rate 96 bpm
Respiratory Rate 18 br/min
Systolic Blood Pressure 76 mmHg <LLOW
Diastolic Blood Pressure 54 mmHg LOW
SpO2 96 %

01/23/2014 9:43 EST **Peripheral Pulse Rate 104 bpm HI**
Respiratory Rate 18 br/min
Systolic Blood Pressure 90 mmHg
Diastolic Blood Pressure 64 mmHg
Mean Arterial Pressure 72.667 mmHg
SpO2 98 %

01/23/2014 9:29 EST **Temperature Oral 96 DegF LOW**
Peripheral Pulse Rate 130 bpm >HHI
Respiratory Rate 20 br/min
Systolic Blood Pressure 80 mmHg LOW
Diastolic Blood Pressure 46 mmHg <LLOW
SpO2 99 %

General: Moderate distress.
Skin: Warm and dry.
Head: Normocephalic.
Neck: Supple, trachea midline and no JVD.
Eye: Pupils are equal, round and reactive to light and extraocular movements are intact.
Ears, nose, mouth and throat: Tympanic membranes clear and oral mucosa moist.
Cardiovascular: Regular rate and rhythm, No murmur and No edema.
Respiratory: Lungs are clear to auscultation.
Gastrointestinal: Soft and mild tenderness in epigastric area without rebound.
Musculoskeletal: Normal ROM, no tenderness, no swelling and no deformity.
Neurological: Alert and oriented to person, place, time, and situation, CN II-XII intact, normal sensory observed and normal motor observed.
Lymphatics: No lymphadenopathy.
Psychiatric: Cooperative and appropriate mood & affect.

Medical Decision Making
Differential Diagnosis: Abdominal pain, electrolyte imbalance, colitis.
Documents reviewed: Emergency department nurses' notes, emergency department records, prior records.
Cardiac monitor: Rate 100, Sinus Tachycardia.
Electrocardiogram: Rate 101, sinus tachycardia with poor R-wave progression and nonspecific ST-T changes unchanged from previous.
Results review: Lab results : Lab View.

01/23/2014 11:44 EST Order(s) to be added
If unable to add, redraw? No
Lab action Added labs

01/23/2014 10:04 EST **WBC 16.5 thous/mm3 HI**
RBC 4.78 mill/mm3
HGB 14.9 g/dL
HCT 43.8 %
MCV 91.7 fL

MCH	**31.3 pg HI**
MCHC	34.1 g/dL
RDW	12.6 %
Platelet	397 thous/mm3
MPV	7.5 fL
Gran %	**90.8 % HI**
Lymph %	**4.9 % LOW**
Mono %	4.0 %
Eos %	0.1 %
Baso %	0.2 %
Gran #	**15.0 thous/mm3 HI**
Lymph #	**0.8 thous/mm3 LOW**
Mono #	0.7 thous/mm3
Eos #	0.0 thous/mm3
Baso #	0.0 thous/mm3
Segs	61 %
Bands	**32 % HI**
Lymphocyte	**5 % LOW**
Monocyte	2 %
Platelet Estimate	Normal
RBC Morphology	Normal
Sodium Level	143 mmol/L
Potassium Level	**2.6 mmol/L CRIT**
Chloride	107 mmol/L
CO2	24 mmol/L
Anion Gap	12 mmol/L
Glucose Level	**153 mg/dL HI**
BUN	12 mg/dL
Creatinine	**1.21 mg/dL HI**
eGFR	**44 mL/min LOW**
eGFR Afri-Amer	**53 mL/min LOW**
Calcium Level	9.0 mg/dL
Magnesium	**1.4 mg/dL LOW**
Phosphorus	3.8 mg/dL
Total Protein	6.1 g/dL
Albumin Level	3.6 g/dL
Bili Total	0.5 mg/dL
ALT	**53 IntUnit/L HI**
AST	32 IntUnit/L
Alk Phos	67 IntUnit/L
Lipase Level	231 IntUnit/L

01/23/2014 10:03 EST Lactic Acid 1.8 mmol/L

Radiology results: CT shows GB sludge but no sign of colitis.

Notes: The patient was evaluated immediately upon arrival and was noted with hypotension whcih responded to fluid boluses. GI wsa consulted and recommended admission for continued workup. The CT scan showed GB sludge which may be the cause of her epigastric pain but would not explain the continued diarrhea. There was no sign of colitis. , The patient was also noted with hypokalemia which was corrected with oral and iv potassium.

Reexamination/ Reevaluation

Course: improving.

Assessment: exam improved.

Procedure

Critical care note

Total time: 30-74 minutes spent engaged in work directly related to patient care and/ or available for direct patient care.

Critical condition(s) addressed for impending deterioration include: cardiovascular, metabolic.

Associated risk factors: shock.
Management: Interpretation blood pressure, Interventions hemodynamic management, Alternate history family.

Impression and Plan

Diagnosis

Dehydration - Present On Admission
Hypokalemia - Present On Admission

Plan

Condition: Guarded.
Disposition: Admit: to Inpatient Unit.