

Flowsheet Print Request

Patient: HOPKINS, STEPHEN A

MRN: 001188330

Date Range: 09/04/2018 12:21 PDT - 09/06/2018 12:21 PDT

Printed by: Aboyan, Tamara

Printed on: 09/05/2018 12:22 PDT

Medications		09/04/2018 12:30 PDT	09/04/2018 12:41 PDT	09/04/2018 12:59 PDT	09/04/2018 13:30 PDT	09/04/2018 13:59 PDT	09/04/2018 14:00 PDT
 norepinephrine IV Additive 8 mg [2 mcg/min] D5W 500 mL 500 mL, IV, Rate = 7.5 mL/hr, Start date 09/04/18 14:46:00 PDT, Routine, Patient Weight: 70 kg Titrate to maintain SBP > 100 or MAP > 65 mm H...							
Administration Information							
norepinephrine							
Dextrose 5% in Water							
Premix Volume							
 Oxepa Tube Feed 1,000 mL 1,000 mL, NG-tube, Rate = 40 mL/hr, Start date 09/05/18 12:00:00 PDT, Patient Weight: 70 kg, mL/hr. Titration Goal = 40 mL/hr							
Administration Information							
Oxepa							
 propofol 1000 mg / 100 mL 1,000 mg [5 mcg/...] Premix Volume 100 mL 100 mL, Titrated, IV, Sedation, Rate = 2.1 mL/hr, Titrate to RASS score: -2, Start date 09/04/18 13:20:00 PDT, Patient Weight: 70 kg Concentration = 10 mg/mL **Hospital IV Ti							
Administration Information							
propofol					Begin Bag 1C		Rate Change
Premix Volume					5 mcg/kg/mi		10 mcg/kg/n
 Sodium Chloride 0.9% 1,000 mL 1,000 mL, IV, Rate = 10 mL/hr, Start date 09/04/18 13:32:00 PDT, Patient Weight: 70 kg, Special Instructions: To run with insulin infusion. To run with insulin infusion.							
Administration Information							
Sodium Chloride 0.9%							
Discontinued Scheduled							
 albuterol (albuterol 2.5 mg/3 mL (0.083%) in... 2.5 mg = 3 mL, HH Neb, Q6hr Awake, Drug Form: Inhaled Solution, Routine, Start Date/Time: 09/04/18 7:00:00 PDT							
albuterol							
 ALPRAZolam (Xanax) 0.125 mg = 0.5 tab(s), Oral, NOW, Drug Form: Tab, Routine, Start Date/Time: 09/04/18 12:00:00 PDT, Stop Date/Time: 09/04/18 12:00:00 PDT							
ALPRAZolam							

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Medications		09/04/2018 14:30 PDT	09/04/2018 14:45 PDT	09/04/2018 14:50 PDT	09/04/2018 14:59 PDT	09/04/2018 15:00 PDT	09/04/2018 15:14 PDT
Scheduled							
 aspirin (aspirin 81 mg oral enteric coated tabl... 81 mg = 1 tab(s), Oral, Daily, Drug Form: Tab EC, Routine, Start Date/Time: 09/04/18 9:00:00 PDT							
aspirin							
Temperature F							
Temperature C							
Temperature Method							
Pain Score							
Pain Score Method							
atorvastatin 40 mg = 1 tab(s), Oral, Q Bedtime, Drug Form: Tab, Routine, Start Date/Time: 09/04/18 6:18:00 PDT							
atorvastatin							
clopidogrel 75 mg = 1 tab(s), Oral, Daily, Drug Form: Tab, Routine, Start Date/Time: 09/05/18 9:00:00 PDT							
clopidogrel							
 insulin glargine (Lantus) 16 Unit(s) = 0.16 mL, Subcut, BID, Drug Form: Inj Susp, STAT, Start Date/Time: 09/05/18 12:04:00 PDT Hold for BG < 120							
insulin glargine							
Gluc by Nursing							
 insulin regular (insulin regular sliding scale) 2-12 Unit(s), Subcut, Q4hr, Drug Form: Inj Soln, Routine, Start Date/Time: 09/05/18 13:00:00 PDT << Sliding Scale Comments >> 150 - 199 2 Uni...							
insulin regular							
Gluc by Nursing							
pantoprazole (Protonix IV) 40 mg = 1 vial(s), IV Push, Q24H-int, Drug Form: Injection, Routine, Start Date/Time: 09/04/18 13:00:00 PDT							
pantoprazole							
ranolazine (Ranexa) 500 mg = 1 tab(s), Oral, BID, Drug Form: Tab ER, Routine, Start Date/Time: 09/04/18 11:42:00 PDT, CAD							
ranolazine							

Document Type: History & Physical
*Date - Date of Service: September 04, 2018 05:10 PDT
Document Status: Auth (Verified)
Document Title: History & Physical
Author: DERHARTUNIAN MD, GAREN on September 04, 2018 08:06 PDT
Authenticated By: DERHARTUNIAN MD, GAREN on September 04, 2018 11:56 PDT
Encounter info: 695806372, USC VHH, Inpatient, 09/04/2018 -
Contributor system: USC_EMDATF

* Final Report *

09/04

History & Physical

DATE OF ADMISSION: 09/04/2018

Patient Name: HOPKINS, STEPHEN
Medical Record #: 1188330
Date of Birth: 11/22/1960

CHIEF COMPLAINT: Shortness of breath.

HISTORY OF PRESENT ILLNESS: A 57-year-old male with a past medical history of CAD status post CABG, end-stage renal disease on dialysis who had his last session yesterday, type 2 diabetes and recent admission for CHF and NSTEMI, presents back with worsening shortness of breath. The patient states that he was doing well yesterday. Went to dialysis yesterday. Afterward at night started having severe shortness of breath. Denies chest pain or palpitations. He states that he feels much better with medications and on BiPAP now. The family is at bedside. Denies any fever, shakes or chills. Denies any nausea or vomiting.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

REVIEW OF SYSTEMS: Denies fever, shakes or chills. Admits to weakness. Denies change in vision. Denies change in hearing. Denies chest pain. Admits to shortness of breath. Denies cough. Denies palpitations. Denies abdominal pain, nausea, vomiting, diarrhea. Denies any edema. Denies any rash.

CURRENT MEDICATIONS: Aspirin 81 mg daily, Lipitor 40 mg daily, Coreg 25 mg daily, Sensipar 30 mg daily, Humalog mix 75/25 20 units in the morning with insulin sliding scale, and Renagel 800 mg daily.

PAST MEDICAL HISTORY: CAD status post CABG, end-stage renal disease on dialysis, diabetes.

Printed by: 
Printed on: 9/5/2018 12:32 PDT

SOCIAL HISTORY: Lives with his mother, former smoker. Denies alcohol.

PAST SURGICAL HISTORY: Cataract extraction, CABG, AV fistula on left arm.

PHYSICAL EXAMINATION:

GENERAL: Awake, alert, oriented x3, in moderate distress.

HEENT: Pupils equal, round, reactive to light. Extraocular muscles intact.

NECK: Supple.

LUNGS: Have diffuse rales.

HEART: Tachycardic.

ABDOMEN: Soft, nontender, nondistended with positive bowel sounds.

EXTREMITIES: He has a left AV fistula with positive _____ murmur. There is no edema.

NEUROLOGIC: His strength is equal throughout.

ASSESSMENT AND PLAN: A 57-year-old male with a history as above who presents with acute shortness of breath.

1. Acute hypoxemic respiratory failure secondary to decompensated heart failure.
2. Cardio, Dr. Joe Lee, will consult.
 - a. Troponin is mildly elevated. We will trend.
 - b. Continue with diuresis.
 - c. Nephrology consult for both end-stage renal disease and for ultrafiltration as possible.
 - d. Previous admission. The patient had a nuclear stress test that showed a small zone of anteroapical stress-induced ischemia superimposed on a moderately sized chronic apical infarct. We will discuss these findings with cardiology again as last time it was recommended for patient to undergo medical management; however, given multiple admissions, may benefit from cardiac catheterization.
3. Diabetes.
 - a. Insulin regimen for now.
4. Prophylaxis.
 - a. Given the fact that patient is in acute decompensated heart failure, we will treat _____.

GD/tr

D: 09/04/2018 8:06:37 AM PST

T: 09/04/2018 8:21:20 AM PST

J#: 177981792

Signature Line

Printed by: 
Printed on: 9/5/2018 12:32 PDT

PAST MEDICAL HISTORY:

1. Coronary artery disease status post CABG x3 in 2015.
2. End-stage renal disease on hemodialysis.
3. Hypertension.
4. Diabetes mellitus type 2 with CKD.

PAST SURGICAL HISTORY:

1. Status post cataract extraction with intraocular implants, both eyes.
2. Status post CABG x3.
3. Status post AV fistula left arm status post repair.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: The patient lives with his mother. He quit smoking in 2013. He does not drink.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: As above.

PHYSICAL EXAMINATION:

GENERAL: Middle-aged male in no acute distress.

VITAL SIGNS: Blood pressure 160/83, pulse 76 per minute, respirations 16, temperature 36.4 degrees centigrade.

HEENT AND NECK: No icterus. No pallor. Pupils are equal and reactive. Extraocular movements intact. Pseudophakia present bilaterally. Oral cavity within normal limits. Trachea midline.

No lymphadenopathy. No goiter. No JVD. No carotid bruit. Neck is supple.

LUNGS: _____ rales present bilaterally.

HEART: S1, S2 present. No S3 or gallop. Surgical scar from CABG present over midline.

ABDOMEN: Soft, nontender. No hepatosplenomegaly. No mass. Bowel sounds are present.

EXTREMITIES: No pedal edema. No clubbing. No cyanosis.

NEUROLOGIC: No focal neurological deficit.

LABORATORY DATA: WBC 10.6, hemoglobin 13.8, hematocrit 41.0, platelet count 158. Sodium 139, potassium 4.5, chloride 98, bicarb 25, calcium 9.5, BUN 64, creatinine 59.5, albumin 4.0, bilirubin 1.0, alkaline phosphatase 91, ALT 21, AST 18, glucose _____, Total protein 7.5. Troponin 0.050.

ASSESSMENT:

1. Recurrent nausea and vomiting.
2. End-stage renal disease on hemodialysis.
3. Hypertension, uncontrolled.
4. Coronary artery disease status post coronary artery bypass graft x3.
5. Diabetes mellitus type 2 with chronic kidney disease.
6. Hypertension.

7. Hearing loss.

PLAN:

1. The patient is admitted to telemetry.
2. Renal diet.
3. Accu-Chek a.c. and at bedtime and sliding scale insulin per protocol.
4. Continue Humalog 75/25 at 20 units subcutaneous q.a.m. and 12 units q.p.m.
5. Zofran 4 mg IV push q. 6 hourly p.r.n. nausea and vomiting.
6. Pantoprazole 40 mg p.o. daily.
7. Renal consult for hemodialysis.
8. Continue Lipitor 40 mg p.o. daily.
9. DVT prophylaxis.

DSG/bc

D: 08/24/2018 6:50:22 PM PST

T: 08/24/2018 7:07:03 PM PST

J#: 177482679

Signature Line

Electronically Signed On 08/28/18 01:57 AM PDT

DEVINDER GANDHI

SOCIAL HISTORY: Lives with his mother, former smoker. Denies alcohol.

PAST SURGICAL HISTORY: Cataract extraction, CABG, AV fistula on left arm.

PHYSICAL EXAMINATION:

GENERAL: Awake, alert, oriented x3, in moderate distress.

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GD/tr

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Signature Line

Printed by: Aboyan, Tamara
Printed on: 9/5/2018 12:32 PDT

Page 2 of 3
(Continued)

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Contributor system: USC_EMDATF

*** Final Report ***

History & Physical

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Medical Record #: 1188330
Date of Birth: 11/22/1960

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PAST MEDICAL HISTORY: CAD status post CABG, end-stage renal disease on dialysis, diabetes.

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MRN: 001188330

Date Range: 09/04/2018 12:43 PDT - 09/06/2018 12:43 PDT

Printed by: Aboyan, Tamara
Printed on: 09/05/2018 12:43 PDT

Lab View	09/05/2018 05:00 PDT
Blood Gases Result	
Sample Type	ARTERIAL
Draw Site	RBRACH
☐ FiO2%	80.0
☐ pH	7.370
☐ pCO2	42.0
☐ pO2	222.0 H
☐ HCO3	24.3
☐ Base Excess	-1.0
☐ O2 Sat Art	0.0
☐ O2 Sat	98.0
☐ Met Hgb	1.9
☐ tHb	11.4
☐ O2Hb	94.8 L
☐ COHb	1.5
☐ DeoxyHgb	1.9 L
Blood Gas Modalities	
ALLENS TEST	
Oxygen Device	
Mode Vent	AC
☐ Mechanical Tidal Volume	500
☐ Mechanical Rate	20.0
CBC	
☐ WBC	21.2 H
☐ RBC	3.56 L
☐ Hgb	11.5 L
☐ Hct	34.3 L
☐ MCV	96.3 H
☐ MCH	32.3
☐ MCHC	33.5
☐ RDW	14.2
☐ Platelet Count	164
☐ MPV	10.2
Automated Differential	
☐ Neutrophil Rel	84.8 H
☐ Lymphocyte Rel	7.8 L
☐ Monocyte Rel	6.5
☐ Eosinophil Rel	0.5
☐ Basophil Rel	0.4
☐ Neutrophil Abs	18.0 H
☐ Lymphocyte Abs	1.7
☐ Monocyte Abs	1.4
☐ Eosinophil Abs	0.1
☐ Basophil Abs	0.1
Manual Differential	
☐ Segs Rel Man	87 H
☐ Lymphocyte Rel Man	9 L
☐ Monocyte Rel Man	4
Plt Estimate	NORMAL
Morphology	
RBC Morph	NORMAL
Coagulation Studies	
☐ PTT	

Flowsheet Print Request

Patient: HOPKINS, STEPHEN A
MRN: 001188330

Date Range: 09/04/2018 12:43 PDT - 09/06/2018 12:43 PDT

Printed by: Aboyan, Tamara
Printed on: 09/05/2018 12:43 PDT

Lab View		09/05/2018 05:00 PDT
Chemistries		
☐ Sodium Lvl		137
☐ Potassium Lvl		5.3 H
☐ Chloride Lvl		96 L
☐ CO2		25
☐ Calcium Lvl		9.2
☐ BUN		53 H
☐ Creatinine Lvl		7.3 H
☐ eGFR Non African American		7.77 L
☐ Albumin Lvl		3.7
☐ Bili Total		1.9 H
☐ Alk Phos		72
☐ ALT		71
☐ AST		491 H
☐ Glucose Random		152 H
☐ Magnesium Lvl		2.6 H
☐ Phosphate		6.2 H
☐ Total Protein		7.0
Cardiac Studies		
☐ Troponin I		219.000 C
Point of Care Tests		
☐ Glucose POC		

Plan of Care Summary[Collapse All](#) [Help](#)**HOPKINS, STEPHEN A** Male 57 Years DOB: 11/22/1960 MRN: 001188330 FIN: 695806372 Isolation: VisitReason: **SOB - BIBA RESC 74**

This page is not a complete source of visit information.

Plan of Care (5)

Selected visit

☒ Display Met Outcomes[Collapse All](#)

▶ Discharge Planning Care Plan ALL (In Process)

0 of 2 met 0%

▲ Fall Risk Care Plan ALL (In Process)

☒ Display Met Outcomes0 of 3 met 0%

Name	Last Evaluation	Documented Variance Reason	Documented Variance Action
Patient will be free from falls and injuries related to falls throughout hospital stay	--	--	--
Patient/caregiver will demonstrate fall prevention behaviors throughout hospital stay	--	--	--
Patient/caregiver will verbalize fall risk factors throughout hospital stay	--	--	--

▲ Knowledge Deficit Care Plan ALL (In Process)

☒ Display Met Outcomes0 of 4 met 0%

Name	Last Evaluation	Documented Variance Reason	Documented Variance Action
Patient/caregiver will demonstrate a motivation and willingness to learn throughout hospital stay	--	--	--
Patient/caregiver will participate in	--	--	--

the learning
process
throughout
hospital stay

Patient/caregiver -- -- --
will perform teach
back method of
desired skills
throughout
hospital stay

Patient/caregiver -- -- --
will verbalize
understanding of
disease process,
causes, and
symptoms during
stay

▲ Respiratory Management Care Plan ALL (In Process)

☒ Display Met Outcomes

7 of 7  100%
met

Name	Last Evaluation	Documented Variance Reason	Documented Variance Action
Maintain/re-establish effective ventilation via assistive device throughout hospital stay	Progressing within 120 mins	--	--
The patient will maintain/improve an effective respiratory pattern throughout hospital stay	Progressing within 120 mins	--	--
The patient will maintain/improve ventilation & adequate oxygenation of tissues during hospital stay	Progressing within 120 mins	--	--
The patient will maintain/improve ventilation &	Progressing within 120 mins	--	--

adequate
oxygenation of
tissues during
hospital stay

The patient will
reestablish
independent
respirations
within their
normal range
during hospital
stay

Progressing
within 120 mins

--

--

The
patient/caregiver
will participate in
treatment
regimen
throughout
hospital stay

Progressing
within 120 mins

--

--

The
patient/caregiver
will verbalize an
understanding of
treatment
regimen during
hospital stay

Progressing
within 120 mins

--

--

▲ Skin Integrity Management Care Plan ALL (In Process)



Display Met Outcomes

0 of 5 met

0%

Name	Last Evaluation	Documented Variance Reason	Documented Variance Action
The patient will demonstrate promotion of integumentary healing throughout hospital stay	--	--	--
The patient will maintain and/or improve skin integrity throughout hospital stay	--	--	--
The patient will participate in	--	--	--

prevention of skin
integrity
complications
throughout
hospital stay

The patient will
verbalize
understanding of
preventive
measures to
protect skin
during hospital
stay

--

--

--

The
patient/caregiver
will participate in
preventive
measures/treatme
nt program
during hospital
stay

--

--

--