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Bar #3845

June 13, 2022

Burke Rehabilitation Hospital
785 Mamaroneck Avenue
White Plains, NY 10605-2523

RE: My Client: Todd Tilley
[redacted]: 6/06/1961

Dear Burke Rehabilitation Hospital:

Enclosed is a medical release so that I might receive a copy of only narrative medical records of treatment since January 2022, not including lab reports.

Thank you for your prompt attention.

Very truly yours,

Robert A. Levine

RAL/sgf
Enclosures
C: Todd Tilley

Fax:

AUTHORITY TO RELEASE MEDICAL AND/OR HOSPITAL RECORDS

To Doctor/Hospital: Burke Rehab Hospital

Address: 785 Mamaroneck Ave. White Plains, NY 10605-2525

In Re: Patient: Todd Tilley Date of Birth: [redacted]

Address: 15 Reservoir Rd. S. Paris, ME 04281

You are hereby authorized to furnish and release to my Attorney, Robert A. Levine, 17 South Street, Portland, Maine 04101, telephone number, (207) 871-0036, all information and records he requests concerning findings, treatment rendered and opinions as to my condition. Please do not disclose information to insurance adjusters or other persons without written authority from me. All prior authorizations are hereby canceled and I waive any privilege I have to my said Attorney. The foregoing authority shall continue in force until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. This release expires 18 months after the date of signing.

****

I respectfully request the following be provided:

- ___ Entire medical file
- ___ Itemized bill for services rendered to patient
- X Medical Reports narrative reports only
- ___ Complete Hospital Records
- ___ Emergency Room Records
- ___ Prognosis
- ___ Laboratory Reports
- ___ X-ray Reports
- ___ Reports of Surgical Procedure
- ___ Hospital Admission & Discharge (summary only)
- ___ Psychiatric/Psychological Reports/Evaluations
- ___ Treatment Plans
- ___ Consultations

X I DO ___ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without my specific consent.

X I DO ___ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

___ I DO X I DO NOT wish to review such information prior to its release. Review must be supervised.

X I DO ___ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

Dated: 5/16/22

X Todd A. Tilley
(Patient or adult with authority to act for minor)

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1961, Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Henry H Chen, MD
Resident
Physical Medicine and Rehabilitation
Date of Service: 1/28/2022 1:45 PM
Creation Time: 1/28/2022 1:45 PM

H&P
Attested Addendum

Attestation signed by Sharon Bushi, MD at 1/31/2022 10:11 PM

Patient seen and agree with documentation as below. Patient is an excellent acute rehabilitation candidate for management of sequelae of L temporal parietal IPH.

Traumatic Brain Injury Rehabilitation History and Physical

Admission Date: 1/28/2022

Current Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis [I63.30]

Impairment Group:

Stroke: 01.4 No Paresis

Date of Onset of Impairment:
01/12/22

Comorbid Conditions: Other: HLD, HTN

Referring Hospital: Cornell Hospital

Translator Used: No

Chief Complaint: The patient is seen today for evaluation and management of difficulties with ambulation and activities of daily living, cognitive impairments, as well as the medical problems secondary to Cerebral infarction due to cerebral venous thrombosis.

HPI
History was taken from the patient and chart review as the patient was unable to comprehend fully.

Mr. Tilley is a 60 yo left handed male who presented to outside hospital in Maine on 1/12 with dense mixed aphasia. There he was diagnosed with L temporal parietal intraparenchymal hemorrhage with subarachnoid blood. His course was c/b elopement according to patient's dtr Kristen (a pediatric ICU RN in NYC). The patient thought he was being D/C'ed and walked out - police located him, returned to hospital. , D/C'ed on antihypertensive regimen. Dtr- kristen brought him to Cornell on 1/17 for Further workup. While at Cornell the workup was done and he was found to have hemorrhagic venous infarct 2/2 L straight/transverse venous sinus thrombosis. He was placed on apixaban 5 BID. His course was complicated by intermittent electrographic seizures and continued on keppra 1.5 BID. Hypercoagulability workup was done, but factor V leiden, factor II mutation, JAK2, V617F mutation pending. Protein C, Protein S, APLS, AT3 were negative.

Patient was seen and examined by the bedside. He says that his speech has improved significantly from 2 weeks ago. He says he is hopeful that his speech will return to what it was before and that he would like it to flow better. He is thankful for his girlfriend gail and his daughter who is an RN. He was previously building houses in Maine and was planning on building one in New Hampshire and would like to return to doing that when he is better. Otherwise the patient has no concerns.

No past medical history on file.

No past surgical history on file.

Social History

Socioeconomic History

• Marital status:	Single
Spouse name:	Not on file
• Number of children:	Not on file
• Years of education:	Not on file
• Highest education level:	Not on file

No family history on file.

Not on File

Medications

Premorbid Functional Status:

Prior Level of Function: independent in ADL

Living Situation: The patient lives girlfriend in Maine in a house with 4 stairs to enter.

Access: One-level

Current Functional Status:

Bed Mobility: Supervision
Sitting Balance:Good (-)
Transfers: Supervision
Ambulation:

- Device: No device
- Distance: 20 Feet
- Level of Assistance: Contact guard
- Weight Bearing Status: Weight bearing as tolerated

Review of Systems
Constitutional: Negative for activity change.
Respiratory: Negative for chest tightness and shortness of breath.
Gastrointestinal: Negative for abdominal pain.
Genitourinary: Negative for difficulty urinating.
Musculoskeletal: Negative for arthralgias.
Skin: Negative for wound.
Neurological: Negative for weakness and headaches.
Psychiatric/Behavioral: Negative for agitation and confusion.

There were no vitals filed for this visit.

Physical Exam
Constitutional: He is oriented to person, place, and time.
Well developed, well nourished, in no acute distress.
Skin: Intact without rash.
Eyes:No ptosis, conjunctivae clear, sclerae anicteric, PERRL, EOMI.
HENT:
Head:

Normocephalic, atraumatic. External canals normal, TMs normal,hearing grossly normal .
Pulmonary/Chest:
Clear to auscultation; no crackles, rhonchi, or wheezing.
Cardiovascular: Regular rate and rhythm with no murmurs, rubs or gallops.
Abdominal: Normal bowel sounds, soft, non-tender and non-distended.
Neurological: He is oriented to person, place, and time. He has normal strength.
Reflex Scores:
Tricep reflexes are 2+ on the right side and 2+ on the left side.
Bicep reflexes are 2+ on the right side and 2+ on the left side.
Brachioradialis reflexes are 2+ on the right side and 2+ on the left side.
Patellar reflexes are 2+ on the right side and 2+ on the left side.

Achilles reflexes are 2+ on the right side and 2+ on the left side.Alert & oriented X 3
Psychiatric: Alert and cooperative, normal mood and affect, normal attention span and concentration.

Neurologic Exam

Mental Status
Oriented to person, place, and time.
Registration of memory: Recalls none of the objects, unclear if this is related to comprehension of the task or purely memory Follows 2 step commands.
Attention: normal.
Level of consciousness: alert
Knowledge: good.
Able to name object. Able to read. Able to repeat. Able to write. Abnormal comprehension.

Cranial Nerves
Cranial nerves II through XII intact.

Motor Exam
Muscle bulk: normal

Strength
Strength 5/5 throughout.

Sensory Exam
Light touch normal.

Gait, Coordination, and Reflexes

Tremor
Resting tremor: absent

Reflexes
Right brachioradialis: 2+
Left brachioradialis: 2+
Right biceps: 2+
Left biceps: 2+
Right triceps: 2+
Left triceps: 2+
Right patellar: 2+
Left patellar: 2+
Right achilles: 2+
Left achilles: 2+
Right grip: 2+
Left grip: 2+

Breast: Not indicated.

Pap Smear: Not indicated

Labs
Labs in chart were reviewed.

Imaging
No results found.

Relevant Neurological Studies:
1/21 VEEG:
1) Continuous left fronto-temporal focal slowing indicative of focal cerebral lesion in this region.
2) Left fronto-temporal intermittent rhythmic delta activity (T IRDA) and occasional left lateralized rhythmic delta activity (l-RDA) indicative of focal cerebral dysfunction within this region and underlying epileptogenicity.
3) One electrographic/subclinical seizure as described above with onset in the left temporal Region.

Diagnostic angiogram : There is a 2-3 mm inferiorly projecting aneurysm in the posterior supraclinoid portion of the right internal carotid artery near the origin of the posterior communicating artery.
The left transverse sinus, left sigmoid sinus, and left internal jugular vein do not opacify..
Otherwise, diagnostic cerebral angiogram with no other evidence of aneurysms, arteriovenous malformations or fistulas, hemodynamically significant stenosis, or vasculitis.

1/17 CT Head: There is an evolving left temporoparietal intraparenchymal hematoma dissecting into the adj acent subarachnoid space, measuring 3. 9 x 2 .7 x 2 .2 cm (series 3, image 35) , not substantially changed from prior, however slightly increased in size from more remote CT head January 12, 2022 . There is persistent confluent surrounding hypoattenuation consistent with edema . There is increased conspicuity of subtle loss of gray—white differentiation in the anterolateral left temporal lobe. There is unchanged mass effect and mild compression on the atrium of the left lateral ventricle. There is unchanged 2 mm of rightward midline shift. There is prominence of the left vein of Labbe .
The ventricles and sulci are normal in size and configuration. There is no new hemorrhage . There is no hydrocephalus or downward hernia t ion.
No suspicious osseous lesion identified, The visualized portions of the paranasal sinuses and mastoid air cells are unremarkable.

CT Head/neck: 1. Long segment left transverse/sigmoid sinus dural venous thrombosis extending into the left jugular bulb, jugular vein, and vein of Labbe
2. No substantial change in size and mass effect of left temporoparietal hemorrhagic venous infarction. Unchanged 2mm rightward midline shift. 3, no hemodynamically significant stenosis in the intracranial or cervical arterial vasculature.

1/19 CT Head: No significant interval change in left temporal intraparenchymal hemorrhage and surrounding edema consistent with known hemorrhagic venous infarction with stable mass effect on the left lateral ventricle.Dural venous sinus thrombosis involving the left transverse and sigmoid sinuses is better seen on recent CT venogram.

1/21 CT head: Interval decrease in size of hematoma associated with the patient' s left temporal hemorrhagic venous infarction. Interval decrease in attenuation of the left transverse and sigmoid sinuses probably reflecting improved thrombosis .

Assessment:
60 year old male iagnosed with L temporal parietal intraparenchymal hemorrhage with subarachnoid hemorrhage 2/2 L straight/transverse venous sinus thrombosis. Hospital course

was complicated by seizures and now on Keppra. Hypercoagulability workup at OSH has been negative so far.

Plan:

Rehabilitation:
- Patient appropriate for comprehensive acute inpatient physical therapy, occupational therapy, and speech therapy for at least 3 hours per day, 5 days per week.
- Patient requires 24-hour rehabilitation nursing care and supervision by rehabilitation physician.
- Therapeutic recreation consult as indicated
- Neuropsychology assessment as indicated

Acquired Brain Injury:
#L parietal/temporal ICH + SAH 2/2 dural sinus thrombosis
#Mixed receptive and fluent expressive aphasia
#Left Temporal Lobe Seizure
~ EEG w L frontotemporal T IRD and occasional I-RDA
~ protein C, protein S, APLS, AT3 negative
- Comprehensive physical therapy, occupational therapy and speech therapy.
- Continue seizure prophylaxis with Keppra 1500 mg every 12 hours.
- Continue Apixaban 5 mg BID

Behavioral Dysregulation:

- Monitor for agitation, impulsivity, and impaired awareness
- Agitated Behavior Scale Score
- Maintain low-stimulation environment

Psych/Mood:
- Monitor for anxiety, depression, hallucinations.
- Consider neuropsychology consultation.
- Consider neuropsychiatry consultation.

Sleep/Wake Cycle Dysregulation:
- Monitor sleep patterns.

Fall Prevention Measures:
- Maintain fall precautions.
- CareView monitoring

Cardiovascular:
#HTN
#HLD
- Monitor vital signs q8h
- Continue Lisinopril 20 mg daily
- Continue Carvedilol 3.125 mg BID
- Continue Atorvastatin 80 mg QHS

Pulmonary:
- Monitor vitals q8h
- Incentive spirometry

GI:

- Assess for continence.
- Daily bowel assessment
- Bowel regimen with colace, senna and PRN medications
- Continue GI ppx with Famotidine

GU:
- Admission urine studies are pending
- Assess for Incontinence. Bladder scans with PVRs every 6 hours and intermittent catheterization for volumes > 350 mLs for at least 24 hours

Diet:
- No documented dysphagia. Continue regular solids.
- Nutritional consultation.
- Aspiration precautions.

Skin:
- Consider wound care team consultation to evaluate and prvided recommendations.
- Institute pressure relief measures per nursing protocol.
- Staples or sutures present: No.

VTE prophylaxis
- Obtain doppler ultrasound to rule out active DVTYs
- Continue prophylaxis with Apixaban 5 mg every 12 hours.

Follow-up Providers:
1. Rehabilitation Physician: Dr. Bushi
2. Neurology/Neurosurgery: no name given, but number provided for scheduling of follow up appointment 212-746-2323
3. PCP: No primary care provider on file.

Expected Length of Stay: 2-3 weeks

Anticipated Disposition: TBD

Code Status: Full Code
I have discussed the patient's code status with the patient.

Next of Kin of HCP: Kristen Merritt (347)-740-5315

I have reviewed the patient's preadmission data; agree with the patient's presentation at the time of my examination. The patient condition is sufficiently stable to allow active participation in an intensive inpatient rehabilitation program. Given the patient's complex condition, rehabilitation services would not be safely and effectively provided at a lower level of care. We will initiate a comprehensive interdisciplinary program with OT, PT and SLP, 24-hour rehabilitation nursing, and social work. The patient progress, rehabilitation goals and discharge plans will be evaluated at the physician led multidisciplinary team meetings weekly. The patient will receive an ongoing face to face visits by a rehabilitation physician at least 3 times per week throughout the rehabilitation stay to assess the patient's both medically and functionally, as well as to modify the course of treatments needed to maximize the patient's capacity to benefit from the rehabilitation process.

Cosigned by: Sharon Bushi, MD at 1/31/2022 10:11 PM

Electronically Signed by Sharon Bushi, MD on 1/31/2022 10:11 PM

Admission (Discharged) on 1/28/2022 *Note shared with patient*

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
[redacted], Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Libby Rice, OT Occupational Therapist Occupational Therapy	Initial Assessments Signed	Date of Service: 1/29/2022 8:30 AM Creation Time: 1/29/2022 9:23 AM

INPATIENT OCCUPATIONAL THERAPY INITIAL EVALUATION

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis
Patient Identifiers: Verification of patient name, Verification of birth date

SUBJECTIVE

Patient Subjective Report: "I'm doing healthy thank god"
Patient Goals for Therapy: "I want to focus, to really get my sentences"
Pain Scale
Pain information: Pt denied pain throughout session
Additional Documentation: Pain Scale: Numbers Pre/Post-Treatment (Group)
Pain Scale: Numbers Pre/Post-Treatment
Pretreatment Pain Rating: 0/10 - no pain
Posttreatment Pain Rating: 0/10 - no pain

Previous Level of Function
Previous Level of Function: Pt reports he was previously independent in all tasks and working building houses prior to admission. Difficult to determine additional information about prior level of function secondary to communication deficits.
ADLs: Independent
IADLs: Independent
DME Owned: unable to determine secondary to communication deficits, will follow up with family as needed

Living Environment
Home Accessibility: Difficult to assess secondary to communication deficits, will follow up as needed

OBJECTIVE

General Observations/Findings: Pt greeted supine in bed, agreeable to therapy. Pt appears fairly reliable with basic questions, however noted with difficulty responding to complex or out of context questions.

BP: 119/73
Pulse: 64
SpO2: 98 %

FUNCTIONAL PERFORMANCE
Without Intervention

Oral Hygiene
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Oral hygiene: 4
Upper Body Dressing
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Upper body dressing: 4
Lower Body Dressing
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Lower body dressing: 4
Putting On/Taking Off Footwear
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Putting on/taking off footwear: 4
Roll Left and Right
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Roll left and right: 4
Sit to Lying
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Sit to lying: 4
Lying to Sitting on Side of Bed
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Lying to sitting on side of bed: 4
Sit to Stand
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Sit to stand: 4
Chair/Bed-to-Chair Transfer
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Chair/bed-to-chair transfer: 4
Toilet Transfer
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Toilet transfer: 4
Car Transfer
Assistance Needed: Supervision or touching assistance
Comment: supervisio
CARE Score: Car transfer: 4

With Intervention

Bed/Mat Mobility
The following activities were performed on: Bed
Bed/Mat Mobility : All Positional Changes
All Positional Changes: Supervised
Cueing Required: none

Self Care - Comments
Comments: Pt demonstrates good initiation, sequencing, and completion of basic self care

Upper Body Dressing
Upper Body Dressing: Shirt
Shirt: Supervision/Set-Up
Position Level: Edge of bed
Cueing Required: none

Lower Body Dressing
Lower Body Dressing: Pants, Socks, Shoes
Pants: Supervision/Set-Up
Socks: Supervision/Set-Up
Shoes: Supervision/Set-Up
Position Level: Edge of bed
Cueing Required: 1 cue for sitting while donning pants

Grooming
Grooming: Oral Care, Washing Face, Washing Hands, Shaving
Oral Care: Supervision/Set-Up
Washing Face: Supervision/Set-Up
Washing Hands: Supervision/Set-Up
Shaving: Supervision/Set-Up
Position Level: Standing
Cueing Required: none
Additional Details Regarding Grooming: Pt spontaneously initiated all tasks, retreived items from sink area and used appropriately

Functional Transfers
Functional Transfers: Bed Chair Transfer, Toilet Transfer, Tub Shower Transfer, Car Transfer

Bed to Chair/Wheelchair Transfer
Method of Transfer: Ambulatory Transfer
Surface: Wheelchair
Level of Assistance: Supervision
Cueing Required: none
Ambulatory Device(s) Used: No Assistive Device

Toilet Transfer
Method of Transfer: Ambulatory Transfer
Toilet Height: Standard Toilet
Level of Assistance: Supervision
Cueing Required: none
Ambulatory Device(s) Used: No Assistive Device

Tub/Shower Transfer
Tub/Shower Transfer: simulated

Method of Transfer: Ambulatory Transfer
Tub or Shower: Shower
DME: Shower Chair
Level of Assistance: Supervision
Cueing Required: 1 cue for technique
Ambulatory Device(s) Used: No Assistive Device

Car Transfer
Car Transfer: simulated
Method of Transfer: Ambulatory Transfer
Level of Assistance: Supervision
Cueing Required: 1 cue for technique
Ambulatory Device(s) Used: No Assistive Device
Wheelchair Seating and Positioning
Type of Wheelchair: Manual wheelchair
Wheelchair Dimensions: Wide (20"), Standard (19" STF)
Type of Cushion Provided: Single Density Foam (Standard)
Accessories or Positional Devices Provided: Front tippers, Seatbelt, Chair alarm
Patients Response to Seating Intrervention(s): Pt reports comfort in wheelchair

Wheelchair Mobility/Management
Comments: Not a focus of evaluation
Wheelchair Mobility (Basic): Unable to self-propel

Sitting Balance
Sitting Balance: Good static and dynamic
Standing Balance
Standing Balance: Good static and dynamic

Upper Extremity Observations
General Observations/Screen: Bilateral upper extremities (BUE) appear within functional limits for range of motion and strength. Pt incorporates into all taks without difficulty.

Cognitive Observations
Awareness/Insight into Deficits: Emergent awareness
Safety/Judgement: No instances of decreased safety awareness were observed during this task
General Observations: Pt alert and oriented x4, requiring increased time/cues for word finding during orientation questions. Pt appears to have some deficits in communication, both receptive and expressive, however demonstrates good insight into these deficits. Pt benefits from short answer, yes/no, and contextual questions, as well as occasional gestures to improve understanding and commuication.

Visual And Visual Perceptual Observations
General Observations: Pt denies blurred or double vision and has corrective lenses present in hospital that he wears at all times. Pt able to visualize items in L/R visual fields including call bell and grooming materials.

Behavioral Observations
Behavioral Observations: No concerning behaviors observed
Second Staff Member Required for Behavior and Safety Concerns?: No

Education
Audience Receiving Education: Patient
Mode of Education: Explanation, Demonstration

Limitations to understanding and/or application: Comprehension/Expression limitations
Focus of Education: Home/hospital/community recommendations
Home/Facility/Community Recommendations: Use of call bell, Fall prevention, Home safety
Response to Education: Verbal understanding, Needs practice/reinforcement

ASSESSMENT

Patient currently presents with primary impairments of: Decreased Functional Endurance, Decreased Functional Strength, Decreased Balance, Executive function Deficits, Language Impairments. These impairments impact independence and safety in the following functional activities: Basic Activities of Daily Living, Ambulation, Self Care, Bed Mobility, Transfers, Instrumental Activities of Daily Living, Community Re-entry, Return to Work, Return to Driving, Return to Leisure, Cognitive-communicative skills for functional ADL's / IADL's.These impairments and functional limitations have the potential to restrict patient's participation in the life roles of Self-caretaker, Homemaker, Active family member, Employee, Participant in social activities, Participant in leisure activites. Patient requires continued skilled inpatient occupational therapy services to address the above noted deficits to maximize safety and minimize burden of care.

BARRIERS TO DISCHARGE:
Supervision needed for basic activities of daily living, Cognitive deficits impacting function and/or safety, Durable Medical Equipment needs

PLAN

Treatment Interventions: Therapeutic Exercise, Therapeutic Activity, Cognitive Skills, Community/Work Reintegration, Self Care Management
Intensity/Frequency: 60 minutes 5-6 days per week

ADDITIONAL EVALUATION AND TREATMENT NEEDS

Caregiver Training, Education and Exercise Program, Adaptive Equipment, Return to Driving Information

GOALS

ST Goal 1: Pt will identify safe/unsafe situations with 100% accuracy with no more than min cues.
ST Goal 2: Pt will verbalize appropriate response to emergency situations with 100% accuracy and no more than min cues
ST Goal 3: Pt will perform financial management activity with supervision and mod cues.
ST Goal 4: Pt will verbally identify all grooming supplies with 100% accuracy and min cues.

LT Goal 1: Pt will perform all positional changes on standard bed with modified independence
LT Goal 2: Pt will perform upper and lower body dressing with modified independence.
LT Goal 3: Pt will perform grooming in standing with modified indepedence
LT Goal 4: Pt will perform ambulatory transfers to bed, chair, and toilet with modified independence.
LT Goal 5: Pt will perform homemaking activities with supervisio
LT Goal 6: Pt will perform simulated community mobility task with supervision
LT Goal 7: Pt will perform HEP independently
LT Goal 8: Pt and family will participate in caregiver training, as needed, to facilitate safe discharge.

CARE Score Goal: Oral hygiene
Assistance Needed: Independent
CARE Score Goal: Oral hygiene: 6
CARE Score Goal: Roll left/right
Assistance Needed: Independent
CARE Score Goal: Roll left and right: 6

Electronically Signed by Libby Rice, OT on 1/29/2022 9:25 AM

Admission (Discharged) on 1/28/2022

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1961, Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Megan Raniolo, CCC-SLP	Initial Assessments	Date of Service: 1/29/2022 11:30 AM
Speech Language Pathologist	Signed	Creation Time: 1/29/2022 1:59 PM
Specialty: Speech Pathology		

INPATIENT SPEECH-LANGUAGE PATHOLOGY INITIAL EVALUATION

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis
Patient Identifiers: Verification of patient name, Verification of birth date

Language & Interpreter: not needed

SUBJECTIVE

Previous Level of Function: Patient reports being independen PTA.
Patient Subjective Report: "hi there"
Patient Goals for Therapy: "I want to focus um you know words and sentences."

Pain Scale
Pain information: Patient reports no pain.
Additional Documentation: Pain Scale: Numbers Pre/Post-Treatment (Group)
Pain Scale: Numbers Pre/Post-Treatment
Pretreatment Pain Rating: 0/10 - no pain
Posttreatment Pain Rating: 0/10 - no pain

OBJECTIVE

General Observations
General Observations/Findings: Patient alert t/o this evaluation. During formalized testing, patient asked for frequent repetition of stimuli vs. informal conversation patient asked for no repetitions for clarification. Patient reported, "it's these things I just can't see your lips so you know um how can I get it." SLP increased vocal volume and reduced rate of speech, however, patient continues to blame PPE (mask) for difficulty understanding stimuli. Patient began to get frustrated and SLP provided education about aphasia/CVA. Patient denied that's why he was having trouble and perseverated on PPE. SLP continued formalized testing, however, focused on verbal expression vs. auditory comprehension. At this time suspect auditory comprehension deficits at the complex level.

Behavioral Observations

Behavioral Observations: Anxious (easily frustrated)
Second Staff Member Required for Behavior and Safety Concerns?: No

Communication Assessment

Language: Informally and formally assessed.

Auditory Comprehension: Assessed
Simple Yes/No Questions: WFL
1-Step Commands: WFL
Object Identification: WFL
Auditory Comprehension Details: Patient asked for frequent repetition of stimuli in structured tasks. Suspect auditory comprehension deficits at a complex level.

Reading Comprehension: Not Assessed

Verbal Expression: Assessed
Sentence Completion: Impaired
Confrontational Naming: Impaired
Conversational Speech: Impaired
Verbal Expression Details: Suspect patient was a nonfluent aphasic due to overt word finding deficits, however, no emerged into a fluent aphasic.

Written Expression: Not Assessed

Motor Speech Assessment

Dysarthria
Dysarthria: Not present

Apraxia
Apraxia: Not present

Voice Assessment

Perceptual Observations
Vocal Quality: WFL

Cognitive Assessment

Arousal/Alertness
Arousal/Alertness: Alert

Attention
Sustained: Impaired

Memory
Memory: Not Assessed

has her shoes. I feel stupid I cant figure it out. A lot going on and a lot of activity. They are happy and a lot of stuff going on."

Auditory Verbal Comprehension
Yes/No Questions Score (out of 60): 48

Repetition

Naming and Word Finding
Object Naming (out of 60): 51
Word Fluency (out of 20): 12

SWALLOWING
Current Nutritional Route: PO
Solids: Regular Consistency
Liquids: Thin Liquids
Swallow Function Details: Patient was seen for a swallowing screen with regular solids and thin liquids. Patient demonstrated no overt s/s of aspiration/penetration and/or oropharyngeal dysphagia. Full swallow evaluation not warranted. Change in status notify SLP.

ASSESSMENT

Clinical Diagnosis: suspect mild-moderate fluent aphasia

Patient currently presents with primary impairments of: Language Impairments Across All Domains. These impairments impact independence and safety in the following functional activities: Language skills for functional ADL's / IADL's. These impairments and functional limitations have the potential to restrict patient's participation in the life roles of Self-caretaker, Homemaker, Active family member, Employee, Participant in social activities, Participant in leisure activites. Patient requires continued skilled inpatient speech- language pathology services to address the above noted deficits to maximize function and safety while minimizing burden of care.

BARRIERS TO DISCHARGE
Language deficits

PLAN

Treatment Plan: Therapy Is Recommended (Initial or Change in Previously Established Duration/Frequency)
Treatment Interventions: Speech Therapy Treatment

Intensity/Frequency: 60 minutes 5-6 days per week

Additional Treatment Needs: continue further formal/informal assessment of language skills, including readng and writing

Short Term Goals
ST Goal 1: Patient will complete semi-complex word finding tasks with 90% accuracy given min-mod cues.

ST Goal 2: Patient will complete complex auditory comprehension tasks with 85% accuracy given min-mod cues.

Long Term Goals

LT Goal: Patient will improve language skills for completion of functional ADLs

Electronically Signed by Megan Raniolo, CCC-SLP on 1/29/2022 2:04 PM

Admission (Discharged) on 1/28/2022

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1961 Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Catherine L. Curtis, PT	Initial Assessments	Date of Service: 1/29/2022 2:30 PM
Physical Therapist	Addendum	Creation Time: 1/29/2022 8:43 PM
Physical Therapy		

INPATIENT PHYSICAL THERAPY INITIAL EVALUATION

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis
Patient Identifiers: Verification of patient name, Verification of medical record

SUBJECTIVE

Patient Subjective Report: "Oh hi"
Patient Goals for Therapy: "I want to focus, to really get a good program going"
Previous Level of Function: Pt reports he was previously independent in all tasks and working building houses prior to admission. Pt has supportive girlfriend in Maine and dauthter in tristate area. Pt reports home has one level with 4 steps to access deck and enter home

Pain Scale: Numbers Pre/Post-Treatment
Pretreatment Pain Rating: 0/10 - no pain
Posttreatment Pain Rating: 0/10 - no pain

OBJECTIVE

General Observations/Findings: Pt received in bed in NAD and agreeable to PT session

Cognitive Observations
General Observations: Pt alert and oriented x4, requiring increased time/cues for word finding. Pt with difficulty following 1 and 2 step commands requiring repetition
Safety/Judgement: No instances of decreased safety awareness were observed during this task
Impact of Cognitive Impairments on Participation: Moderate
Participation Limited By: Preseveration

Behavioral Observations: No concerning behaviors observed
Second Staff Member Required for Behavior and Safety Concerns?: No

Comments: at rest
Patient Position: Sitting

BP: 125/81
Pulse: 79
SpO2: 97 %

Comments: post session
Patient Position: Sitting
BP: 109/79
Pulse: 85
SpO2: 100%

FUNCTIONAL PERFORMANCE
Without Intervention
Walk 10 Feet
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 10 feet: 4
Walk 50 Feet with Two Turns
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 50 feet with two turns: 4
Walk 150 Feet
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 150 feet: 4
Walking 10 Feet on Uneven Surfaces
Comment: access to uneven surface not readily available
Reason if not Attempted: Not attempted due to environmental limitations
CARE Score: Walking 10 feet on uneven surfaces: 10
1 Step (Curb)
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG - 6" curb
CARE Score: 1 step (curb): 4
4 Steps
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG with unilat railing step-over-step
CARE Score: 4 steps: 4
12 Steps
Comment: requires therapeutic intervention
Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: 12 steps: 88
Picking Up Object
Assistance Needed: Supervision or touching assistance
CARE Score: Picking up object: 4
Wheel 50 Feet with Two Turns
Comment: Not attempted due to cognitive and communication limitations
Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: Wheel 50 feet with two turns: 88
Wheel 150 Feet
Comment: Not attempted due to cognitive and communication limitations

Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: Wheel 150 feet: 88

With Intervention

Bed/Mat Mobility : Type of Positional Changes
Type of Positional Changes: Supine to sit, Sit to supine
Supine to Sit: Supervision
Sit to Supine: Supervision
Devices Used: Bed Rails, Head of Bed Elevated
Cueing Required: none

Bed to Chair/Wheelchair Transfer
Method of Transfer: Ambulatory Transfer
Surface: Wheelchair
Level of Assistance: Supervision
Cueing Required: none
Ambulatory Device(s) Used: No Assistive Device

Gait Level of Assistance: Contact Guard Assistance
Weight Bearing (Gait Training): weight-bearing as tolerated
Ambulatory Device(s) Used: No Assistive Device
Gait Distance (Feet): 150
Gait Analysis Pattern: 2-point gait
Gait Analysis Deviations: decreased cadence, decreased velocity of limb motion, decreased step length, decreased push off
Gait Analysis Impairments: impaired balance, decreased strength, impaired motor control
Cueing Required: none

Stairs/Curb/Ramp
Stairs/Curb/Ramp: Stairs, Curb
Stairs
Number of Stairs: 4
Step Height: 6 inch
Stair Railings: ascending, descending
Ambulatory Device(s) Used: No Assistive Device
Performance on Stairs Pattern Analysis: reciprocal
Level of Assistance: Contact Guard Assistance
Cueing Required: pacing
Curb
Curb Height: 6 inch
Ambulatory Device(s) Used: No Assistive Device
Level of Assistance: Contact Guard Assistance

Sitting Balance
Static Supported Sitting: Supervision
Static Unsupported Sitting: Supervision
Dynamic Supported Sitting: Supervision
Dynamic Unsupported Sitting: Supervision
Standing Balance
Static Supported Standing: Supervision
Static Unsupported Standing: Contact Guard
Dynamic Supported Standing: Contact Guard

Dynamic Unsupported Standing: Contact Guard

Orthotic/Bracing/Prosthetic
Orthotic/Bracing: none

ROM
Comments: Bilat LEs WNL

Sensation
Sensation: Assessed
Sensation Type: Light Touch, Proprioception
Light Touch
Left Lower Extremity: Intact
Right Lower Extremity: Intact
Proprioception
Proprioception: Left Lower Extremity, Right Lower Extremity
Left Lower Extremity
Left Hallux: Intact
Right Lower Extremity
Right Hallux: Intact

Skin
Bilateral Lower Extremity: C/D/I
Edema
Comment: none

Tone
Comments: bilat LEs WNL

Strength
MMT: Hip, Knee, Ankle
Hip
Right Hip Flexion: Full ROM against gravity, almost full resistance
Left Hip Flexion: Full ROM against gravity, almost full resistance
Knee
Right Knee Extension: Full ROM against gravity, almost full resistance
Left Knee Extension: Full ROM against gravity, almost full resistance
Ankle
Right Ankle Dorsiflexion: Full ROM against gravity, almost full resistance
Left Ankle Dorsiflexion: Full ROM against gravity, almost full resistance

Therapeutic Exercise: NuStep: L2 LE's only x 10 min

Education
Audience Receiving Education: Patient
Mode of Education: Explanation
Education Provided: benefits of exercise and healing and recovery process
Response to Education: Verbal understanding, Needs practice/reinforcement

Post session Pt assisted back into bed. All needs met and safety measures in place. Pt instructed on use of call bell and verbalized understanding and that he would comply

ASSESSMENT

Patient currently presents with primary impairments of: Decreased Functional Endurance, Decreased Balance, Upright Tolerance, Cognitive Impairments, Decreased Safety Awareness, Language Impairments. These impairments impact independence and safety in the following functional activities: Basic Activities of Daily Living, Self Care, Ambulation, Stair Negotiation, Curb Negotiation, Bed Mobility, Transfers, Wheelchair Mobility, Standing Tolerance, Sitting Tolerance, Return to Work, Return to Leisure.These impairments and functional limitations have the potential to restrictpatient's participation in the life roles of Self-caretaker, Caretaker, Homemaker, Active family member, Participant in social activities, Participant in leisure activites, Employee. Patient requires continued skilled inpatient physical therapy services to address the above noted deficits to maximize safety and minimize burden of care.

BARRIERS TO DISCHARGE:
Supervision needed for functional mobility, Physical assistance needed for functional mobility

PLAN

Treatment Interventions: Therapeutic Exercise, Therapeutic Activity, Gait Training, Cold / Hot Pack, Neuromuscular Re-education, Manual Therapy
Intensity/Frequency: 60 minutes 5-6 days per week

ADDITIONAL EVALUATION AND TREATMENT NEEDS

GOALS
ST Goal 1: AMBULATION: Pt will amb 40' without AD in room with distant supervision
ST Goal 2: AMBULATION: Pt will amb 260' without AD with CG on level indoor surface
ST Goal 3: STAIRS: Pt will ascend/descend 12 - 7" steps without AD with railing and CG
ST Goal 4: CURB: Pt will ascend/descend 6" curb without AD and supervision
ST Goal 5: AMBULATORY TRANSFER: Pt will perform ambulatory transfers to bed, standard chair with arms and w/c without AD with distant supervision
ST Goal 6: HEP: Pt will perform HEP with supervision

LT Goal 1: AMBULATION: Pt will amb 40' without AD independently in household
LT Goal 2: AMBULATION: Pt will amb 260' without AD with supervision on level indoor surface
LT Goal 3: STAIRS: Pt will ascend/descend 12 - 7" steps without AD with railing and supervision
LT Goal 4: CURB: Pt will ascend/descend 6" curb without AD and supervision
LT Goal 5: AMBULATORY TRANSFER: Pt will perform ambulatory transfers to bed, standard chair with arms and w/c without AD independently
LT Goal 6: HEP: Pt will perform HEP independently
LT Goal 7: CAREGIVER TRAINING: Pt's caregiver will be independent in assisting Pt with amb, stairs and curb

CARE Score Goal: Wheel 50 Feet with two turns
Assistance Needed: Supervision or touching assistance
CARE Score Goal: Wheel 50 feet with two turns: 4
CARE Score Goal: Wheel 150 feet
Assistance Needed: Supervision or touching assistance
CARE Score Goal: Wheel 150 feet: 4

Electronically Signed by Catherine L. Curtis, PT on 1/29/2022 8:47 PM

Admission (Discharged) on 1/28/2022

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1961, Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Sara Klusky, PT Physical Therapist Physical Therapy	Discharge Note Signed	Date of Service: 2/10/2022 8:05 AM Creation Time: 2/10/2022 8:05 AM

INPATIENT PHYSICAL THERAPY DISCHARGE EVALUATION

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis
Patient Identifiers: Verification of patient name, Verification of birth date

Language & Interpreter: English speaking, no interpreter required

SUBJECTIVE

"I knew it was you"

Pain Scale
Is pain limiting functional tasks?: No
Pain Scale: Numbers Pre/Post-Treatment
Pretreatment Pain Rating: 0/10 - no pain
Posttreatment Pain Rating: 0/10 - no pain

OBJECTIVE

General Observations/Findings: Patient greeted in room seen seated in chair at start of session, patient agreeable to therapy. Patient ambulated to/from therapy with supervision from therapist

Cognitive Observations
General Observations: Patient alert and oriented. Patient presents with communciation impairments, but is able to follow all commands and make all needs known
Safety/Judgement: No instances of decreased safety awareness were observed during this task

Behavioral Observations: No concerning behaviors observed
Second Staff Member Required for Behavior and Safety Concerns?: No

Walk 10 Feet
Assistance Needed: Independent
Comment: no assistive device

CARE Score: Walk 10 feet: 6
Walk 50 Feet with Two Turns
Assistance Needed: Independent
Comment: no assistive device
CARE Score: Walk 50 feet with two turns: 6
Walk 150 Feet
Assistance Needed: Independent
Comment: no assistive device
CARE Score: Walk 150 feet: 6
Walking 10 Feet on Uneven Surfaces
Assistance Needed: Independent
Comment: no assistive device
CARE Score: Walking 10 feet on uneven surfaces: 6
1 Step (Curb)
Assistance Needed: Independent
Comment: no assistive device
CARE Score: 1 step (curb): 6
4 Steps
Assistance Needed: Independent
Comment: no handrails
CARE Score: 4 steps: 6
12 Steps
Assistance Needed: Independent
Comment: no handrails
CARE Score: 12 steps: 6
Picking Up Object
Assistance Needed: Independent
CARE Score: Picking up object: 6

The following activities were performed on: Mat
Bed/Mat Mobility : All Positional Changes
All Positional Changes: Modified Independent
Cueing Required: no cues required

Functional Transfers
Functional Transfers: Ambulatory transfers with modified independence and no assistive device
Sit to/from Stand Transfer
Sit-to-Stand Transfer: Modified Independent
Stand-to-Sit Transfer: Modified Independent
Surface: Wheelchair
Ambulatory Device(s) Used: No Assistive Device

Gait Level of Assistance: Modified Independent
Weight Bearing (Gait Training): weight-bearing as tolerated
Ambulatory Device(s) Used: No Assistive Device
Gait Distance (Feet): 150ft
Gait Analysis Pattern: swing-through gait
Ambulation Performed With Orthotics/Prosthesis: none
Gait Training : Patient performs longer community distances (room to therapy gym) with supervision for safety

Outdoor Ambulation Distance: community distances
Outdor Ambulation Surface: Uneven Surfaces, Sidewalks
Ambulatory Device(s) Used: No Assistive Device

Level of Assistance: Supervision
Ambulation Performed With Orthotics/Prosthesis: none

Stairs
Number of Stairs: 42
Step Height: 7 inch
Stair Railings: (none)
Ambulatory Device(s) Used: No Assistive Device
Perfomance on Stairs Pattern Analysis: reciprocal
Level of Assistance: Modified Independent
Cueing Required: no verbal cues required

Curb
Curb Height: 8 inch
Ambulatory Device(s) Used: No Assistive Device
Level of Assistance: Modified Independent
Cueing Required: no cues required

Ramp
Ramp Negotiation: indoor ramp
Ambulatory Device(s) Used: No Assistive Device
Level of Assistance: Modified Independent
Cueing Required: no cues required

ROM
Comments: All bilateral lower extrmeity passive range of motion within functional limits

Hip
Right Hip Flexion: Full ROM against gravity, almost full resistance
Left Hip Flexion: Normal, maximal resistance
Knee
Right Knee Extension: Normal, maximal resistance
Left Knee Extension: Normal, maximal resistance
Ankle
Right Ankle Dorsiflexion: Normal, maximal resistance
Left Ankle Dorsiflexion: Normal, maximal resistance

Light Touch
Bilateral Lower Extremity: Intact

Proprioception
Left Lower Extremity
Left Hallux: Intact
Right Lower Extremity
Right Hallux: Intact

Skin
Left Lower Extremity: Clean, dry and intact
Right Lower Extremity: Callous at medial aspect of great toe
Edema
Comment: no edema at bilateral feet and ankles

Tone

Comments: No abnormal tone noted throughout bilateral lower extremity passive range of motion
Left Clonus: absent
Right Clonus: absent

Deep Tendon Reflexes Assessed?: No

Sitting Balance
Static Unsupported Sitting: Independent
Dynamic Unsupported Sitting: Independent
Standing Balance
Static Unsupported Standing: Independent
Dynamic Unsupported Standing: Independent

Education
Audience Receiving Education: Patient
Mode of Education: Explanation
Communication: Verbal expression status and strategies
Home/Facility/Community Recommendations: Home safety, Anticipated level of assistance needed at discharge, Return to leisure/life roles, Accessibility in the community, Community re-entry
Precautions and Medical Considerations: Healing and recovery process, Recognizing signs and symptoms of stroke
Response to Education: Verbal understanding, Applied knowledge

10 Meter Walk Test

Details

Assistive Device	No Assistive Device
Bracing	none
Level of Physical Assistance	6 - Modified independence

Comfortable Walking Speed

Self-Selected Velocity: Trial 1	5.72 seconds
Self-Selected Velocity: Trial 2	5.47 seconds
Self-Selected Velocity: Average Time	5.6 seconds
Self-Selected Gait Speed	1.07 meters/second

Fast Walking Speed

Fast Velocity: Trial 1	3.94 seconds
Fast Velocity: Trial 2	4 seconds
Fast Velocity: Average Time	3.97 seconds
Fast Gait Speed	1.51 meters/second

Functional Gait Assessment:	
Dimension	Score

Gait Level Surface	3-Normal
Change In Gait Speed	3-Normal
Gait with Horizontal Head Turns	3-Normal
Gait with Vertical Head Turns	3-Normal
Gait and Pivot Turn	3-Normal
Step Over Obstacle	3-Normal
Gait with Narrow Base of Support	3-Normal
Gait with Eyes Closed	3-Normal
Ambulating Backwards	3-Normal
Steps	3-Normal
Total Score	30

ASSESSMENT

Patient tolerated session well
No adverse reactions

DISCHARGE SUMMARY

Patient is a 60 y.o. year old male with a diagnosis of Cerebral infarction due to cerebral venous thrombosis who received skilled Physical Therapy in the inpatient rehabilitation department. The patient has made improvements in the following areas: Self Care, Bed Mobility, Transfers, Ambulation, Stair Negotiation, Curb Negotiation, Activity tolerance. Therapy services recommended at discharge Outpatient Physical Therapy.

Continue Therapy Services to Address the Following:: Executive Function Deficits, Cognitive Impairments, Language Impairments, Verbal Expression Deficit
These Impairments Limit the Following Functional Activities : Basic Activities of Daily Living, Community Re-entry, Instrumental Activities of Daily Living, Return to Work, Return to Driving, Language Skills for ADLs/IADLs, Responding to Questions Accurately
The following life roles may be impacted: Self-caretaker, Homemaker, Active family member, Employee, Participant in social activities, Participant in leisure activites

Patient has made good progress in physical therapy during his stay and his presenting close to baseline physically. Patient is modified independent indoors without assistive device and supervision for community mobility. Patient continues to present with language impairments, however, is able to make needs known and follow instructions

GOALS

LT Goal 1: AMBULATION: Patient will ambulate 50' without AD independently for household mobility Met
LT Goal 2: AMBULATION: Patient will ambulate community distances with supervision Met
LT Goal 3: STAIRS: Patient will ascend/descend 21 - 7" steps without AD modified independence for safety considerations Met
LT Goal 4: CURB: Patient will ascend/descend indoor 6" curb without AD and modified independence for safety considerations Met

LT Goal 5: AMBULATORY TRANSFER: Patientt will perform ambulatory transfers to bed, standard chair with arms and w/c without AD independently Met
LT Goal 6: HEP: Patient will perform HEP independently Met

PLAN

Discharge Recommendations

Patient Related Instructions: Continue with prescribed home exercise program

Caregiver Training: Yes, Education provided via phone/video during patient's stay
Occupational therapist performed caregiver training over the phone with patient's daughter for supervision recommendations for community negotiation and safety recommendations

Supervision/Support Recommendations: Supervision for community mobility, Supervision for IADLs, Supervision for all communication tasks
Recommendations Discussed With: Patient, Family Member

Is Patient Being Discharged on Supplemental Oxygen?: No

Durable Medical Equipment (DME)
Final DME Recommendation(s) Upon Discharge: None required

Bracing
Bracing Recommendation: None required

Electronically Signed by Sara Klusky, PT on 2/10/2022 3:30 PM

Admission (Discharged) on 1/28/2022

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

BRH TWO WEST
785 MAMARONECK AVE
WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1962, Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Jasal Patel, MD
Resident
Physical Medicine and Rehabilitation
Date of Service: 2/11/2022 9:10 AM
Creation Time: 2/10/2022 12:42 PM

Discharge Summary
Attested

Attestation signed by Erika L Trovato, MD at 2/11/2022 9:41 AM

The patient is stable for discharge home today with family. All questions answered at bedside. Patient agreeable with plan.

Inpatient Discharge Summary

Admission Date: 1/28/22
Discharge Date: 02/11/2022
Current Treating Diagnosis: Cerebral infarction due to cerebral venous thrombosis [I63.30]

History of Present Illness:

Mr. Tilley is a 60 yo left handed male who presented to outside hospital in Maine on 1/12 with dense mixed aphasia. There he was diagnosed with L temporal parietal intraparenchymal hemorrhage with subarachnoid blood. His course was c/b elopement according to patient's dtr Kristen (a pediatric ICU RN in NYC). The patient thought he was being D/C'ed and walked out - police located him, returned to hospital. , D/C'ed on antihypertensive regimen. Dtr- kristen brought him to Cornell on 1/17 for Further workup. While at Cornell the workup was done and he was found to have hemorrhagic venous infarct 2/2 L straight/transverse venous sinus thrombosis. He was placed on apixaban 5 BID. His course was complicated by intermittent electrographic seizures and continued on keppra 1.5 BID. Hypercoagulability workup was done with Protein C, Protein S, APLS, AT3 were negative.

He was previously building houses in Maine and was planning on building one in New Hampshire and would like to return to doing that when he is better. Otherwise the patient has no concerns.

Past Medical History:

Past Medical History:

Diagnosis	Date
• Cerebral infarction	
• HLD (hyperlipidemia)	
• Hypertension	
• SAH (subarachnoid hemorrhage)	

Allergies:
No Known Allergies

Rehabilitation Hospital Course:
The patient participated in multidisciplinary therapy programs. Baseline blood, urine tests, and an EKG were performed. Patient received rehabilitative nursing care throughout hospital course. In addition, social work/case management services were provided. The patient's progress was discussed at the multidisciplinary team conference with the discharge plan made according to the rehabilitation goals.

Prior to admission to Burke Rehabilitation the patient was started on antihypertensive medications. During his stay the patient was found to have persistently low blood pressures, and thus his blood pressure medications were discontinued.

Acute Rehab Plan at Time of Discharge:

#L parietal/temporal ICH + SAH 2/2 dural sinus thrombosis
#Mixed receptive and fluent expressive aphasia
#Left Temporal Lobe Seizure
~ EEG w L frontotemporal T IRD and occasional I-RDA
~ protein C, protein S, APLS, AT3 negative
- Comprehensive physical therapy, occupational therapy and speech therapy.
- Continue seizure prophylaxis with Keppra 1500 mg every 12 hours.
- Continue Apixaban 5 mg BID

Cardiovascular:
#HTN, currently Hypotensive, resolved
#HLD
- Monitor vital signs q8h
- Discontinue Lisinopril 20 mg daily
- Discontinue Carvedilol 3.125 mg BID
- Continue Atorvastatin 40 mg QHS

Diet:
- No documented dysphagia. Continue regular solids.

VTE prophylaxis
- Doppler ultrasound to rule out active DVTYs was negative on 1/31

- Continue prophylaxis with Apixaban 5 mg every 12 hours.

Follow-up Providers:

1. Rehabiliation Physician: Dr. Bushi
2. Neurology/Neurosurgery: no name given, but number provided for scheduling of follow up appointment 212-746-2323

Consults: None

Pertinent Test Results:

No results for input(s): WBC, HGB, HCT, PLT in the last 72 hours.
No results for input(s): NA, K, CL, CO2, BUN, CREATININE, GLU in the last 72 hours.

Lab Results

Component	Value	Date
CALCIUM	8.9	02/07/2022

Lab Results

Component	Value	Date
AST	21	02/07/2022
ALT	23	02/07/2022
ALKPHOS	93	02/07/2022
BILIDIR	0.2 (H)	02/07/2022
ALBUMIN	4.4	02/07/2022

Patient's Condition at Discharge: Stable

Physical Exam

Vitals:

	02/09/22 1624	02/09/22 1950	02/10/22 0601	02/10/22 0740
BP:	126/84	135/87	96/69	100/78
BP Location:				
Patient Position:				
BP Method:				
Pulse:	73	74	77	75
Resp:				
Temp:	97.9 °F (36.6 °C)	98.1 °F (36.7 °C)	98 °F (36.7 °C)	97.9 °F (36.6 °C)
TempSrc:	Oral	Oral	Oral	Oral
SpO2:	97%	95%	96%	96%
Height:				
Weight:				
BMI (Calculated):				

Constitutional: Alert, well-appearing, and in no distress.
HEENT: MMM, anicteric
Resp: Non-labored breathing on room air
CV: RRR

Abd: soft, non-distended
Skin: skin intact without rash or open wounds
Psych: normal affect
Neuro:
- A&Ox3. 3-word repetition and recall intact. Appropriate in conversation. Word finding difficulty
- CNs grossly intact
- MMT of UE: 5/5 throughout all major muscle groups.
- MMT of LE: 5/5 throughout all major muscle groups.
- Sensation: intact to light touch.
- MSRs: 2+ in BL biceps/BR. 2+ in BL quads/gastroc-soleus.
- Hoffman: negative BL
- Babinski: down-going BL
- Cerebellar: intact

ADL/Motor Function or Discharge Functional Status

Eating
Assistance Needed: Setup or clean-up assistance
CARE Score: Eating: 5

Oral Hygiene
Assistance Needed: Independent
Comment: mod I
CARE Score: Oral hygiene: 6

Toileting Hygiene
Assistance Needed: Supervision or touching assistance
CARE Score: Toileting hygiene: 4

Shower/Bathe Self
Assistance Needed: Partial/moderate assistance
CARE Score: Shower/bathe self: 3

Upper Body Dressing
Assistance Needed: Independent
Comment: mod I
CARE Score: Upper body dressing: 6

Lower Body Dressing
Assistance Needed: Independent
Comment: mod I
CARE Score: Lower body dressing: 6

Putting On/Taking Off Footwear
Assistance Needed: Independent
Comment: mod I
CARE Score: Putting on/taking off footwear: 6

Roll Left and Right
Assistance Needed: Independent
Comment: mod I
CARE Score: Roll left and right: 6

Sit to Lying

Assistance Needed: Independent
Comment: mod I
CARE Score: Sit to lying: 6

Lying to Sitting on Side of Bed
Assistance Needed: Independent
Comment: mod I
CARE Score: Lying to sitting on side of bed: 6

Sit to Stand
Assistance Needed: Independent
Comment: mod I
CARE Score: Sit to stand: 6

Chair/Bed-to-Chair Transfer
Assistance Needed: Independent
Comment: mod I
CARE Score: Chair/bed-to-chair transfer: 6

Toilet Transfer
Assistance Needed: Independent
Comment: mod I
CARE Score: Toilet transfer: 6

Car Transfer
Assistance Needed: Supervision or touching assistance
Comment: supervision
CARE Score: Car transfer: 4

Walk 10 Feet
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 10 feet: 4

Walk 50 Feet with Two Turns
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 50 feet with two turns: 4

Walk 150 Feet
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG
CARE Score: Walk 150 feet: 4

Walking 10 Feet on Uneven Surfaces
Comment: access to uneven surface not readily available
Reason if not Attempted: Not attempted due to environmental limitations
CARE Score: Walking 10 feet on uneven surfaces: 10

1 Step (Curb)
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG - 6" curb
CARE Score: 1 step (curb): 4

4 Steps
Assistance Needed: Supervision or touching assistance
Comment: without AD with CG with unilat railing step-over-step
CARE Score: 4 steps: 4

12 Steps
Comment: requires therapeutic intervention
Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: 12 steps: 88

Picking Up Object
Assistance Needed: Supervision or touching assistance
CARE Score: Picking up object: 4

Ambulation/Wheelchair
Does the patient use a Wheelchair/Scooter?: Yes

Wheel 50 Feet with Two Turns
Comment: Not attempted due to cognitive and communication limitations
Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: Wheel 50 feet with two turns: 88

Wheel 150 Feet
Comment: Not attempted due to cognitive and communication limitations
Reason if not Attempted: Not attempted due to medical condition or safety concerns
CARE Score: Wheel 150 feet: 88

Cognitive and Behavioral Function or Discharge Functional Status

Discharge Medications:

Medication List

START taking these medications
apixaban 5 mg Tab tablet
Commonly known as: ELIQUIS
Take 1 tablet (5 mg total) by mouth 2 (two) times a day
Start taking on: **February 11, 2022**

---

atorvastatin 40 mg tablet
Commonly known as: LIPITOR
Take 1 tablet (40 mg total) by mouth nightly
Start taking on: **February 11, 2022**

---

levETIRAcetam 750 mg tablet
Commonly known as: KEPPRA
Take 2 tablets (1,500 mg total) by mouth 2 (two) times a day
Start taking on: **February 11, 2022**

Where to Get Your Medications

These medications were sent to RITE AID-196 EAST HARTSDALE A - HARTSDALE, NY - 196 EAST HARTSDALE AVENUE
Phone: 914-725-8890

196 EAST HARTSDALE AVENUE, HARTSDALE NY 10530-3505

- apixaban 5 mg Tab tablet
- atorvastatin 40 mg tablet
- levETIRAcetam 750 mg tablet

Discharge Disposition:
Home

Discharge Instructions: (disregard if transferred to another institution)
1. See your private physician within one week of leaving Burke.
2. Take medications listed on the attached medication instruction sheet.
3. See attached rehabilitation clinic appointment date.
4. Neurology/Neurosurgery: no name given, but number provided for scheduling of follow up appointment 212-746-2323
5. Follow up with Dr. Bushi (Burke Rehabilitation) on 3/18/2022 at 12PM

Test Results Pending at Discharge: None

For any further information, please do not hesitate to contact us at Burke Rehabilitation Hospital at (914) 597-2500.

Cosigned by: Erika L Trovato, MD at 2/11/2022 9:41 AM

Electronically Signed by Erika L Trovato, MD on 2/11/2022 9:41 AM

Admission (Discharged) on 1/28/2022 *Note shared with patient*