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

Dora Granato, CCC-SLP
Speech Language Pathologist
Speech Language Pathology

Discharge Note
Signed

Date of Service: 2/10/2022 4:30 PM
Creation Time: 2/10/2022 3:14 PM

INPATIENT SPEECH-LANGUAGE PATHOLOGY DISCHARGE EVALUATION

Primary SLP provided discharge impressions.

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

Language & Interpreter: n/a

SUBJECTIVE

Patient Subjective Report: "Ready to go home"

Pain Scale
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 greeted in room seen seated in chair at start of session, patient agreeable to therapy.

Behavioral Observations
Behavioral Observations: No concerning behaviors observed

OUTCOME MEASURES/ASSESSMENTS
The **Western Aphasia Battery (WAB)** is a diagnostic tool used to assess the linguistic skills and main nonlinguistic skills of adults with aphasia. This provides information for the diagnosis of the type of aphasia and identifies the location of the lesion causing aphasia.

Spontaneous Speech:

Picture Description:
"A picnic. A guy. Uh a young boy who has a kite and a dog. A girl with a sand cat. Sandcastle. Shove and a pail. Guy in the back. A radio and a picnic basket and probably some wine it looks like being a book a book. It's a small house and you also got a tan. Uh a tree. A sailboat is in the uh someone somebody is yelling for somebody. Waving to them. A tree back in the sailboat. A coast. A coast. Um uh the eh flag stuff. A fail. No flag. A smaller house it seems. I don't see any um birds. But we got some um uh the guy that is um reading a book has his um (pointing) um no slippers but uh what these. Have a hard time remembering this. A dog is there. A boy. A dog. Following the guy doing the kite. I'm assuming it's a family here. Um maybe maybe not. A lot going on. Everybody is kind of. I dont see that. The fish is keeping out of the uh uh water here. The guy got his um uh cut Im sorry the fish is out of the water and um uh he got his yupp. He is in the warf. The car In the drive. Driveway rather. Again I'll repeat that. The pail and the little shelf. Shovel. The girl is doing a sandle castle. A lot going on here. I feel stupid on these little geese things. I know what they are but can't get it. He got bare feet. Everything I cant say who house it is maybe it's them but um right every is pretty close. A lot going on here. Got some wine and rape radio cant see any food but they are happy. Girl is happy boy is happy. The blanket they are happy and they seem fun. The dog is happily um uh trying uh he is actually behind the fellow. Not much I can say about the house. You got two um uh windows a two um one one door and uh a also a stone um another door with a f um uh a car in front of door and maybe a lot of the um um uh the big tree in front of the house and tree got plenty of leaves may june july some nice um um stuff going on pretty much bushes behind and behind on the other ssss um the sailboat 470 number behind that is the bushes I don't think clouds bushes and what not and um some wind can't really swing in the bushes or bushing um some grass and roise? And some bushes in the house. A lot going on. I could probably um got to say that's a tough one. Other then that I know it's his because she has her shoes and he has this and she 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

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

MCLA
Factual Reading task "Destination Unknown" not for standardized measures 16/20

Discharge Testing:
The **Assessment of Language-Related Functional Activities (ALFA)** assesses a person's ability to perform 10 language-related functional tasks. It is designed to answer the question, "Despite this person's impairment, is he or she able to integrate skills adequately to perform selected functional daily activities?"

Skills	Performance	Functional Impairment
Solving Daily Math Problems	Number Correct: 10/10	1: high probability of independent functioning on this task

Ages >65 years

1	8-10	7-10	8-10	6-10	7-10	8-10	8-10	8-10	8-10	14-20
2	6-7	5-6	6-7	4-5	5-6	6-7	6-7	6-7	6-7	11-13

3	0-5	0-4	0-5	0-3	0-4	0-5	0-5	0-5	0-5	0-10

Boston Naming Test - Second Edition (BNT-2)
Administered to evaluate confrontation naming of nouns.
The BNT-2 is a standardized assessment tool.

BNT Long Form

	Most Recent Value
BNT - Summary of Scores	
Number of spontaneously given correct responses (out of 60)	52

BNT Norms for Adults

Age Group	*Education Mean*	*Education SD*	*BNT Score Mean*	*BNT Score SD*
18-39	*15.1*	*2.3*	*55.8*	*3.8*
40-49	*15.1*	*2.5*	*56.8*	*3.0*
50-59	*13.5*	*2.1*	*55.2*	*4.0*
60-69	*13.2*	*2.3*	*53.3*	*4.6*
70-79	*13.9*	*3.0*	*48.9*	*6.3*

Key: SD=standard deviation

ASSESSMENT

Response to Treatment: Patient tolerated session well

DISCHARGE SUMMARY
Patient is a 60 y.o. year old male with a diagnosis of CVA who received skilled Speech Language Pathology therapy in the inpatient rehabilitation department to address at least mild fluent aphasia . The patient has made improvements in the following areas: Language Skills for ADLs/IADL's, Reading, Writing, Expressing Wants and Needs, Cognitive-Communicative Skills for ADL's/IADL's. Patient benefits from Note taking, writing template for simplification of information, simple instrusction /simple language , reduce distractions and cues for task/topic discontinuation to maximize function.
Therapy services recommended at discharge Home Speech Therapy, Outpatient Speech Therapy.

Continued therapy services to address the following: Cognitive Impairments, Verbal Expression Deficit, Auditory Comprehension Deficit, Written Expression Deficit
These impairments limit 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
The following life roles may be impacted: Self-caretaker, Caretaker, Homemaker, Active family member, Participant in social activities, Participant in leisure activites, Employee

Discharge Impressions: Patient presents with a mild fluent aphasia. Verbal expression is marked with phonemic and semantic paraphasias, may talk and write excessively with occasional word finding. Sentences may be complete but may be irrelevant to the task at hand or perseverative. Patient benefits from verbal and written feedback to promote awareness.

Patient benefits from simple language and written /spoken examples for comprehension and carryover. To simplify written expression, patient benefits from a written template including instructions and bullet points for limitations. Patient has a binder for carryover information. Patient will require supervision for all complex IADLs and assistance/support for communication. SLP created medication chart provided by MD. Team created a Do's and Don'ts list. Recommended a Life Alert Emergency Device in the home/community setting.

GOALS- goals ongoing

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.

ST Goal 3: Patient will complete functional reading comprehension and written expression tasks with 80% accuracy given min-mod cues to reduce distracibility, and comprehension

ST Goal 4: Patient will completed simple /functional executive function tasks with 80% accuracy with mod-max cues for slow rate, double checking work, and insight/awareness

Long Term Goals

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

PLAN

Discharge Recommendations: Home Speech Therapy, Outpatient Speech Therapy

Patient Related Instructions: Continue use of external aides to assist with function, recall, and/or improved communication., Continue with use of language and/or motor speech strategies to increase expressive and comprehension skills., Continue with cognitive-communicative retraining exercises and compensatory strategies to maximize function.

Therapeutic devices recommended: Burke Binder

Caregiver Training provided:

Supervision/Support Recommendations:

24/7 direct supervision

Diet Recommendations

Current Nutritional Route: PO

Solids: Regular Consistency

Liquids: Thin Liquids

Electronically Signed by Dora Granato, CCC-SLP on 2/10/2022 4:34 PM

Admission (Discharged) on 1/28/2022

Executive Function
Executive Function: Not Assessed

Awareness/Insight
Awareness/Insight into Deficits: Emergent awareness
Safety/Judgement: Could not assess as no instances of decreased safety awareness were observed during this session.

Pragmatic Skills
Pragmatic Skills : Turn taking deficits

Patient Education
Education
Audience Receiving Education: Patient
Mode of Education: Explanation
Limitations to understanding and/or application: Comprehension/Expression limitations
Focus of Education: Communication
Communication: Auditory comprehension status and strategies
Response to Education: Verbal understanding, Difficulties understanding or retaining information

OUTCOME MEASURES/ASSESSMENTS
The **Western Aphasia Battery (WAB)** is a diagnostic tool used to assess the linguistic skills and main nonlinguistic skills of adults with aphasia. This provides information for the diagnosis of the type of aphasia and identifies the location of the lesion causing aphasia.

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WHITE PLAINS NY 10605-2523

Tilley, Todd
MRN: 09568808, DOB: 6/6/1963, Sex: M
Admission: 1/28/2022, Discharge: 2/11/2022

Tilley, Todd

MRN: 09568808

Libby Rice, OT	Discharge Note	Date of Service: 2/10/2022 3:45 PM
Occupational Therapist	Signed	Creation Time: 2/10/2022 3:41 PM
Occupational Therapy		

INPATIENT OCCUPATIONAL THERAPY DISCHARGE EVALUATION

This note reflects a charting discharge.

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis

SUBJECTIVE

This note reflects a charting discharge.

OBJECTIVE

This note reflects a charting discharge.

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

Bed/Mat Mobility
The following activities were performed on: Bed
Bed/Mat Mobility : All Positional Changes
All Positional Changes: Modified Independent

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

Upper Body Dressing
Upper Body Dressing: Shirt
Shirt: Modified Independent
Position Level: Edge of bed

Lower Body Dressing
Lower Body Dressing: Pants, Socks, Shoes
Pants: Modified Independent
Socks: Modified Independent
Shoes: Modified Independent
Position Level: Edge of bed

Grooming
Grooming: Oral Care, Washing Face, Washing Hands, Shaving
Oral Care: Modified Independent
Washing Face: Modified Independent
Washing Hands: Modified Independent
Shaving: Modified Independent
Position Level: Standing
Cueing Required: none

Toileting
Toileting: Pt performs all aspects of toileting with modified independence

General Self-Care Performance
General Self-Care Performance Summary: Pt modified independent with all basic self care, caregiver education on being present in the home, but not needing to provide direct supervision

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: Standard Chair without Armrests
Level of Assistance: Modified Independent
Ambulatory Device(s) Used: No Assistive Device

Toilet Transfer
Method of Transfer: Ambulatory Transfer
Toilet Height: Standard Toilet
Level of Assistance: Modified Independent
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

IADLs
Comments: Focus of IADLs has been on cognitive and communication task demands. Pt able to perform physical aspects of IADLs without difficulty, but requires supervision and/or assistance for cognitive components

Medication Management
Medication Management: (requires supervision)

Financial Management
Financial Management: (requires supervision)

Complex Meal Prep
Comment: Preparation of hot meal with multiple components
Position Level: Standing
Level of Assistance: Supervision
Cueing Required: min for problem solving/item retrieval

Homemaking

Homemaking: Pt performs most homemaking tasks with supervision and good safety awareness

Community Skills
Community Skills - Comments: Pt performs long distance community mobility without a device with no adverse symptoms
Community Skills: Simulated
Position Level: Standing
Level of Assistance: Supervision
Cueing Required: none, pt demonstrated good topographical orientation aand wayfinding

Wheelchair Seating and Positioning
Comments: Pt will not require use of wheelchair upon discharge
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: Seatbelt
Patients Response to Seating Intrervention(s): Pt reports comfort in wheelchair

Wheelchair Mobility/Management
Comments: From elevator to therapy gym and back
Wheelchair Mobility (Basic): Able to self propel with limitations, supervision or assistance
Patient Self Propels: With bilateral lower extremities
Parts Management: Cues for consistent brake management

Upper Extremity Observations
General Observations/Screen: Bilateral upper extremities appear functional across all domains. Pt performs UE theraband HEP with modified independence

Cognitive Observations
Awareness/Insight into Deficits: Emergent awareness
Safety/Judgement: No instances of decreased safety awareness were observed during this task
Pt alert and oriented x4. Pt demonstrates good intact basic initiation, sequencing, problem solving, and safety awareness during familiar tasks. Pt able to retrieve information appropriately from a variety of written/printed sources, however demonstrates some deficits in comprehension and higher level problem solving and executive functioning. Pt benefits from strategy use for word finding and clarification when presented with verbal information to ensure comprehension. Interventions have focused on organizational strategies for task breakdown and prioritization. Pt able to use strategies with cues, but requires assistance for reinforcement and will benefit from supervision during complex IADLs and cognitive tasks upon discharge. Caregiver aware and in agreement.

Visual And Visual Perceptual Observations
General Observations: No significant visual changes, vision appears functional and pt wears corrective lenses at all times

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

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

Limitations to understanding and/or application: Cognitive limitations, Comprehension/Expression limitations
Focus of Education: Cognition, Home/hospital/community recommendations, Communication
Cognition: Importance of self-monitoring and self-awareness in improving cognitive skills, Cognitive skills limitations and impact on function and/or safety, Cognitive skills improvement and/or compensation strategies, Use of external aides to assist with recall, Executive functioning skills required for IADLs, Level of supervision and/or support recommended due to cognitive skills limitations
Communication: Verbal expression status and strategies
Home/Facility/Community Recommendations: Home safety, Anticipated level of assistance needed at discharge, Community re-entry, Accessibility in the community, Return to leisure/life roles, Return to work/school, Emergency preparedness
Response to Education: Demonstrated skill(s), Verbal understanding

ASSESSMENT

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 Occupational Therapy in the inpatient rehabilitation department. The patient has made improvements in the following areas: Self Care, Bed Mobility, Transfers, Ambulation, Language Skills for ADLs/IADL's, Instrumental Activities of Daily Living, Cognitive-Communicative Skills for ADL's/IADL's. Therapy services recommended at discharge Home Occupational Therapy.

Continue Therapy Services to Address the Following:: Decreased Functional Strength, Cognitive Impairments, Executive Function Deficits
These Impairments Limit the Following Functional Activities : Basic Activities of Daily Living, Self Care, Ambulation, Transfers, Instrumental Activities of Daily Living, Community Re-entry, Return to Work, Return to Driving, Return to Leisure, Cognitive-Communicative Skills for Functional ADLs/IADLs
The following life roles may be impacted: Self-caretaker, Homemaker, Active family member, Participant in social activities, Participant in leisure activites

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

LT Goal 1: Pt will perform all positional changes on standard bed with modified independence. MET
LT Goal 2: Pt will perform upper and lower body dressing with modified independence. MET
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LT Goal 4: Pt will perform ambulatory transfers to bed, chair, and toilet with modified independence. MET
LT Goal 5: Pt will perform homemaking activities with supervision. MET

LT Goal 6: Pt will perform simulated community mobility task with supervision. MET
LT Goal 7: Pt will perform HEP independently. MET
LT Goal 8: Pt and family will participate in caregiver training, as needed, to facilitate safe discharge. MET

PLAN

Discharge Recommendations

Patient Related Instructions: Patient Related Instructions: Continue with prescribed exercise program

Caregiver Training: Caregiver Training Provided: Yes, Education provided via phone/video during patient's stay Pt's daughter, Kristen, educated on d/c recommendations via phone on 2/10/22. Recommendations include mod I for activities in the home with additional support/supervision present elsewhere in the home. Direct supervision for medication/financial management, communication tasks, community mobility, and use of equipment/electronics. Mod I for leisure activities and other light homemaking.

Supervision/Support Recommendations: Supervision/Support Recommended Post Discharge: Supervision for community mobility, Supervision for IADLs, Supervision for all communication tasks
Patient, Family Member

Is Patient Being Discharged on Supplemental Oxygen?: No

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

Electronically Signed by Libby Rice, OT on 2/10/2022 3:48 PM

Admission (Discharged) on 1/28/2022

*******AUTO**MIXED ADC 300
812 9 MB 2.491
ROBERT A LEVINE
ROBERT LEVINE
17 SOUTH ST
PORTLAND, ME 04101-3914

000812

52pgs

*005200812K0 *

ATTENTION

Confidential Information enclosed.
To be viewed by authorized persons only.

If you have questions regarding any information you have requested, please call the phone number on the enclosed invoice.

To Whom It Concern:

CIOX has provided to you protected health information that may contain information that falls under the 42 C.F.R. Part 2. The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publically available information, or through verification of such identification by another person unless further disclosure is expressly permitted by written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see 42 CFR §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR §§ 2.112(c)(5) and 2.65.

If the enclosed record pertains to HIV/AIDs, it has been disclosed to you from records whose confidentiality is protected by federal and perhaps, state law, which prohibits you from making any further disclosure of such information without the specific consent of the person to whom such information pertains or as otherwise permitted by state law. A general authorization for this release of health or other information is not sufficient for this purpose.

If the information requested is from a facility located within the Washington State area then this information will fall under the RCW 70.02.300 which states that this information has been disclosed to you from records who confidentiality may be protected by state law. State law prohibits you from making any further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of this protected information is not sufficient for this purpose.

293790793

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P.O. Box 409740
Atlanta, Georgia 30384-9740
Fed Tax ID 58 - 2659941
1-800-367-1500

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Date: [redacted]
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Requested By: ROBERT A LEVINE
Patient Name: TILLEY TODD
DOB : [redacted]

Description	Quantity	Unit Price	Amount
Basic Fee			0.00
Retrieval Fee			0.00
Per Page Copy (Paper) 1	48	0.75	36.00
Shipping			2.60
Subtotal			38.60
Sales Tax			0.00
Invoice Total			38.60
Balance Due			38.60

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BURKE
Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

785 Mamaroneck Ave White Plains, NY 10605
(914) 597-2500

TO: 207-871-8070
Company:
Fax:
Phone:

Number of pages: 3
(Including cover sheet)

Date: 5/24/22

FROM: Carla
Fax: 914-597-2760
Phone: 914-597-2285

NOTES:

RE: Todd Tilley REF# 3845

DOB: 6/6/1961

BURKE Rehabilitation Hospital
MEMBER OF MONTEFIORE HEALTH SYSTEM

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WHITE PLAINS NY
10605-2523

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

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
- Cerebral infarction
- HLD (hyperlipidemia)
- Hypertension
- SAH (subarachnoid hemorrhage)

Date

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. Rehabilitation 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 (Current) 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: —

Tilley, Todd

[redacted]

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
Cosign Needed Addendum

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 (I-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. Rehabiliation 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.

Electronically Signed by Henry H Chen, MD on 1/28/2022 8:47 PM

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

ID: 09568808 28-Jan-2022 21:30:21 Burke rehab

60yea~
Male

Vent. rate 71 bpm
PR interval 168 ms
QRS duration 94 ms
QT/QTc 378/410 ms
P-R-T axes 42 19 14

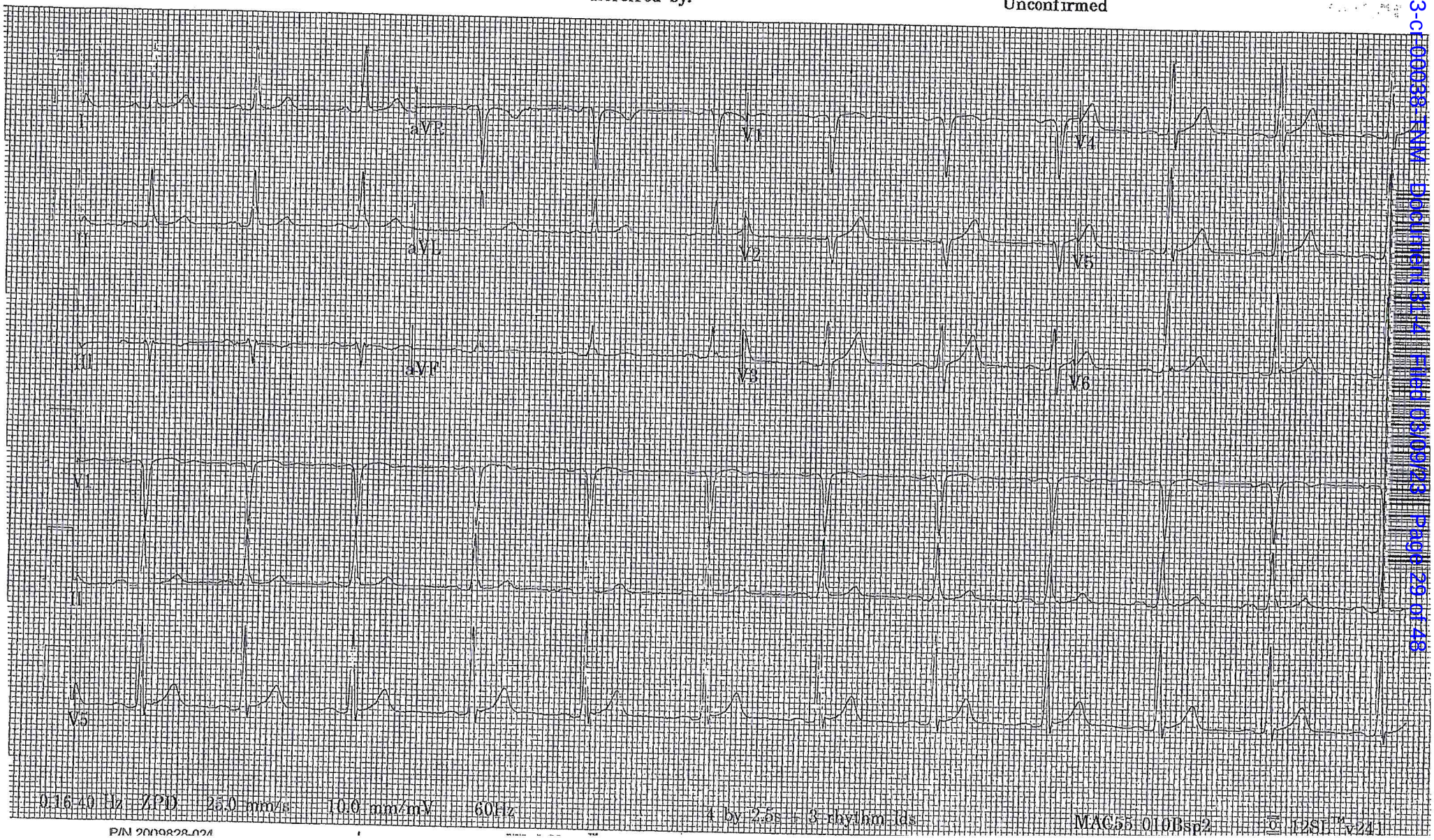
Norm~~l~~ sinus rhythm
Nor~~m~~al ECG

Loc: 7014

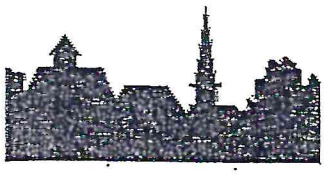
Technician:
Test ind:

Referred by:

Order no.: 12807186~
Unconfirmed



P/N 2009828-024



Western Maine Primary Care

MaineHealth

FAMILY MEDICINE WELCOMES YOU!

Family Medicine is here to help you maintain and improve the health of you and your family. Our team includes Physicians, Nurse Practitioners, Registered Nurses, Medical Assistants, LCSW's, Health Guide and office personnel.

Please fill out the enclosed new patient paperwork and return it to the office at 8 Pikes Hill, Norway Maine, 04268. Once we receive your new patient paperwork, we will contact you with an appointment.

Please Note until you have successfully completed an initial appointment with a provider within our practice you are not officially under the care of our facility. We advise that until your scheduled appointment here, that you keep your current PCP to address any prescription refills or acute needs that may arise until your scheduled appointment date and time. We make every attempt to schedule within a reasonable timeframe. If the appointment you are given will not meet your healthcare needs, please discuss with us at the time of scheduling.

What to expect at your visits:

- Please arrive 20 minutes earlier than your scheduled appointment time.
- Please bring a photo ID and your insurance card, and a friendly staff member will help you.
- Please plan to pay your co-pay at the time of your visit.
- You may receive bills from Stephens Memorial Hospital, which you or your insurance company will be responsible to pay, such as laboratory, pathology, or other services related to your office visit. You may also receive bills from other physicians such as radiologist for x-ray readings, or a pathologist for reading biopsies or pap smears.

Services offered at Family Medicine:

- Primary Care for all patients, birth to geriatric.
- Osteopathic Manipulative Treatment (OMT)
- Integrative Medicine
- Addiction Services
- Behavioral Health Counseling

Office Appointments and Hours:

- We schedule appointments Monday through Thursday from 7:30AM to 6:30PM and 7:30AM to 5:30PM on Fridays. Our phones are answered until 5:00 PM each day.
- In the event of a snow storm, please call our office if you have an appointment for the day, as we do occasionally close for the safety of our patients and staff. **The office number is 744-6444 and press option #1 for Family Medicine.**

Emergency and After Hours Care:

We recognize that there may be times when you or a member of your family may be sick and need to talk with the physician after hours. When this occurs, you should do the following:

- Call Stephens Memorial Hospital at 743-5933. The hospital will contact the on-call family practice physician, who will return your call.
- If at any time you have a medical emergency such as severe breathing problems, seizures, chest pain or decreased levels of consciousness, please call an ambulance and go immediately to the nearest Emergency Room (ER).
- We encourage you **not** to use the ER for mild illnesses such as ear infection, mild coughs and slight fever.

Medical Forms and Prescriptions once you have had your initial appointment with our practice:

- For prescription refills, please allow at **least three days** for the prescription to arrive at the pharmacy.
- The **MyChart** patient portal is a great way to request refills of medications, without having to call the office! Staff can assist you in signing up for this portal.
- Please allow a 5 day turnaround time, depending on the provider's schedules, for completion of forms: camps, sports or insurance/disability.

Missed Appointments: are concerning to us because we lose the opportunity to care for you or your family member and we also lose the opportunity to offer that appointment to another person in need. If your initial appointment is missed, please note that this may not be rescheduled.

Transferring Care: We feel it is important for you to know that when a patient transfers out of the practice they may not be able to return to the practice, depending on their reason for leaving.

Western Maine Primary Care
MaineHealth

Dear Prospective New Patient,

Welcome to Western Maine Primary Care Family Medicine! We are excited you are joining our practice and look forward to partnering with you to meet your preventive care and health care needs!

We are committed to providing you with exceptional care for all of your health concerns. We feel it is important to inform you that if you have a condition causing you to have chronic pain, our primary goal will be to help manage your pain by offering options other than opioid medications. There are proven treatment alternatives such as physical therapy, weight management, stress management, anti-inflammatory medications, and exercise that may help your pain and offer you an improved quality of life that is free from potentially harmful medications. Referral to pain management or other specialists may be another possibility. Western Maine Primary Care Family Medicine doctors and nurse practitioners will work with you to find the safest and most effective way to manage your pain before considering opioid medication.

If you are currently on an opioid pain medication, please know that our providers will help to coordinate other treatment options to effectively reduce or eliminate opioid medication and opioids will not be prescribed on your first office visit.

We encourage you to discuss any questions or concerns with us.
In good health!

Western Maine Primary Care Family Medicine

12/28/17 - lam

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: —

Tilley, Todd

[redacted]

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 (Current) 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: —

Tilley, Todd

MRN: 09568808

Libby Gross, OT
Occupational Therapist
Occupational Therapy

Discharge Note
Signed

Date of Service: 2/10/2022 3:45 PM
Creation Time: 2/10/2022 3:41 PM

INPATIENT OCCUPATIONAL THERAPY DISCHARGE EVALUATION

This note reflects a charting discharge.

Medical Diagnosis: Cerebral infarction due to cerebral venous thrombosis

SUBJECTIVE

This note reflects a charting discharge.

OBJECTIVE

This note reflects a charting discharge.

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

Bed/Mat Mobility
The following activities were performed on: Bed
Bed/Mat Mobility : All Positional Changes
All Positional Changes: Modified Independent

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

Upper Body Dressing
Upper Body Dressing: Shirt
Shirt: Modified Independent
Position Level: Edge of bed

Lower Body Dressing
Lower Body Dressing: Pants, Socks, Shoes
Pants: Modified Independent
Socks: Modified Independent
Shoes: Modified Independent
Position Level: Edge of bed

Grooming
Grooming: Oral Care, Washing Face, Washing Hands, Shaving
Oral Care: Modified Independent
Washing Face: Modified Independent
Washing Hands: Modified Independent
Shaving: Modified Independent
Position Level: Standing
Cueing Required: none

Toileting
Toileting: Pt performs all aspects of toileting with modified independence
General Self-Care Performance

General Self-Care Performance Summary: Pt modified independent with all basic self care, caregiver education on being present in the home, but not needing to provide direct supervision

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: Standard Chair without Armrests
Level of Assistance: Modified Independent
Ambulatory Device(s) Used: No Assistive Device

Toilet Transfer
Method of Transfer: Ambulatory Transfer
Toilet Height: Standard Toilet
Level of Assistance: Modified Independent
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

IADLs
Comments: Focus of IADLs has been on cognitive and communication task demands. Pt able to perform physical aspects of IADLs without difficulty, but requires supervision and/or assistance for cognitive components

Medication Management
Medication Management: (requires supervision)

Financial Management
Financial Management: (requires supervision)

Complex Meal Prep
Comment: Preparation of hot meal with multiple components
Position Level: Standing
Level of Assistance: Supervision
Cueing Required: min for problem solving/item retrieval

Homemaking
Homemaking: Pt performs most homemaking tasks with supervision and good safety awareness

Community Skills
Community Skills - Comments: Pt performs long distance community mobility without a device with no adverse symptoms
Community Skills: Simulated
Position Level: Standing
Level of Assistance: Supervision
Cueing Required: none, pt demonstrated good topographical orientation aand wayfinding

Wheelchair Seating and Positioning
Comments: Pt will not require use of wheelchair upon discharge
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: Seatbelt
Patients Response to Seating Intrervention(s): Pt reports comfort in wheelchair

Wheelchair Mobility/Management
Comments: From elevator to therapy gym and back
Wheelchair Mobility (Basic): Able to self propel with limitations, supervision or assistance
Patient Self Propels: With bilateral lower extremities
Parts Management: Cues for consistent brake management

Upper Extremity Observations
General Observations/Screen: Bilateral upper extremities appear functional across all domains. Pt performs UE theraband HEP with modified independence

Cognitive Observations
Awareness/Insight into Deficits: Emergent awareness
Safety/Judgement: No instances of decreased safety awareness were observed during this task Pt alert and oriented x4. Pt demonstrates good intact basic initiation, sequencing, problem solving, and safety awareness during familiar tasks. Pt able to retrieve information appropriately from a variety of written/printed sources, however demonstrates some deficits in comprehension and higher level problem solving and executive functioning. Pt benefits from strategy use for word finding and clarification when presented with verbal information to ensure comprehension. Interventions have focused on organizational strategies for task breakdown and prioritization. Pt able to use strategies with cues, but requires assistance for reinforcement and will benefit from supervision during complex IADLs and cognitive tasks upon discharge. Caregiver aware and in agreement.

Visual And Visual Perceptual Observations
General Observations: No significant visual changes, vision appears functional and pt wears corrective lenses at all times

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

Education
Audience Receiving Education: Patient, Family member
Mode of Education: Explanation, Demonstration
Limitations to understanding and/or application: Cognitive limitations, Comprehension/Expression limitations
Focus of Education: Cognition, Home/hospital/community recommendations, Communication

Cognition: Importance of self-monitoring and self-awareness in improving cognitive skills, Cognitive skills limitations and impact on function and/or safety, Cognitive skills improvement and/or compensation strategies, Use of external aides to assist with recall, Executive functioning skills required for IADLs, Level of supervision and/or support recommended due to cognitive skills limitations
Communication: Verbal expression status and strategies
Home/Facility/Community Recommendations: Home safety, Anticipated level of assistance needed at discharge, Community re-entry, Accessibility in the community, Return to leisure/life roles, Return to work/school, Emergency preparedness
Response to Education: Demonstrated skill(s), Verbal understanding

ASSESSMENT

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 Occupational Therapy in the inpatient rehabilitation department. The patient has made improvements in the following areas: Self Care, Bed Mobility, Transfers, Ambulation, Language Skills for ADLs/IADL's, Instrumental Activities of Daily Living, Cognitive-Communicative Skills for ADL's/IADL's. Therapy services recommended at discharge Home Occupational Therapy.

Continue Therapy Services to Address the Following:: Decreased Functional Strength, Cognitive Impairments, Executive Function Deficits
These Impairments Limit the Following Functional Activities : Basic Activities of Daily Living, Self Care, Ambulation, Transfers, Instrumental Activities of Daily Living, Community Re-entry, Return to Work, Return to Driving, Return to Leisure, Cognitive-Communicative Skills for Functional ADLs/IADLs
The following life roles may be impacted: Self-caretaker, Homemaker, Active family member, Participant in social activities, Participant in leisure activites

GOALS

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

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

PLAN

Discharge Recommendations

Patient Related Instructions: Patient Related Instructions: Continue with prescribed exercise program

Caregiver Training: Caregiver Training Provided: Yes, Education provided via phone/video during patient's stay Pt's daughter, Kristen, educated on d/c recommendations via phone on 2/10/22. Recommendations include mod I for activities in the home with additional support/supervision present elsewhere in the home. Direct supervision for medication/financial management, communication tasks, community mobility, and use of equipment/electronics. Mod I for leisure activities and other light homemaking.

Supervision/Support Recommendations: Supervision/Support Recommended Post Discharge: Supervision for community mobility, Supervision for IADLs, Supervision for all communication tasks
Patient, Family Member

Is Patient Being Discharged on Supplemental Oxygen?: No

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

Electronically Signed by Libby Gross, OT on 2/10/2022 3:48 PM

Admission (Current) on 1/28/2022

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

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

Tilley, Todd

[redacted]

Dora Granato, CCC-SLP
Speech Language Pathologist
Speech Language Pathology

Discharge Note
Signed

Date of Service: 2/10/2022 4:30 PM
Creation Time: 2/10/2022 3:14 PM

INPATIENT SPEECH-LANGUAGE PATHOLOGY DISCHARGE EVALUATION

Primary SLP provided discharge impressions.

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

Language & Interpreter: n/a

SUBJECTIVE

Patient Subjective Report: "Ready to go home"

Pain Scale
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 greeted in room seen seated in chair at start of session, patient agreeable to therapy.

Behavioral Observations
Behavioral Observations: No concerning behaviors observed

OUTCOME MEASURES/ASSESSMENTS
The **Western Aphasia Battery (WAB)** is a diagnostic tool used to assess the linguistic skills and main nonlinguistic skills of adults with aphasia. This provides information for the diagnosis of the type of aphasia and identifies the location of the lesion causing aphasia.

Spontaneous Speech:
Picture Description:

"A picnic. A guy. Uh a young boy who has a kite and a dog. A girl with a sand cal. Sandcastle. Shove and a pail. Guy in the back. A radio and a picnic basket and probably some wine it looks like being a book a book. It's a small house and you also got a tan. Uh a tree. A sailboat is in the uh someone somebody is yelling for somebody. Waving to them. A tree back in the sailboat. A coast. A coast. Um uh the eh flag stuff. A fail. No flag. A smaller house it seems. I don't see any um birds. But we got some um uh the guy that is um reading a book has his um (pointing) um no slippers but uh what these. Have a hard time remembering this. A dog is there. A boy. A dog. Following the guy doing the kite. I'm assuming it's a family here. Um maybe maybe not. A lot going on. Everybody is kind of. I dont see that. The fish is keeping out of the uh uh water here. The guy got his um uh cut Im sorry the fish is out of the water and um uh he got his yupp. He is in the warf. The car In the drive. Driveway rather. Again I'll repeat that. The pail and the little shelf. Shovel. The girl is doing a sandle castle. A lot going on here. I feel stupid on these little geese things. I know what they are but can't get it. He got bare feet. Everything I cant say who house it is maybe it's them but um right every is pretty close. A lot going on here. Got some wine and rape radio cant see any food but they are happy. Girl is happy boy is happy. The blanket they are happy and they seem fun. The dog is happily um uh trying uh he is actually behind the fellow. Not much I can say about the house. You got two um uh windows a two um one one door and uh a also a stone um another door with a f um uh a car in front of door and maybe a lot of the um um uh the big tree in front of the house and tree got plenty of leaves may june july some nice um um stuff going on pretty much bushes behind and behind on the other ssss um the sailboat 470 number behind that is the bushes I don't think clouds bushes and what not and um some wind can't really swing in the bushes or bushing um some grass and roise? And some bushes in the house. A lot going on. I could probably um got to say that's a tough one. Other then that I know it's his because she has her shoes and he has this and she 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

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

MCLA
Factual Reading task "Destination Unknown" not for standardized measures 16/20

Discharge Testing:
The **Assessment of Language-Related Functional Activities (ALFA)** assesses a person's ability to perform 10 language-related functional tasks. It is designed to answer the question, "Despite this person's impairment, is he or she able to integrate skills adequately to perform selected functional daily activities?"

Skills	Performance	Functional Impairment
Solving Daily Math Problems	Number Correct: 10/10	1: high probability of independent functioning on this task

Ages >65 years

1	8-10	7-10	8-10	6-10	7-10	8-10	8-10	8-10	8-10	14-20
2	6-7	5-6	6-7	4-5	5-6	6-7	6-7	6-7	6-7	11-13
3	0-5	0-4	0-5	0-3	0-4	0-5	0-5	0-5	0-5	0-10

Boston Naming Test - Second Edition (BNT-2)
Administered to evaluate confrontation naming of nouns.
The BNT-2 is a standardized assessment tool.

BNT Long Form

	Most Recent Value
BNT - Summary of Scores	
Number of spontaneously given correct responses (out of 60)	52

BNT Norms for Adults

Age Group	Education Mean	Education SD	BNT Score Mean	BNT Score SD
18-39	15.1	2.3	55.8	3.8
40-49	15.1	2.5	56.8	3.0
50-59	13.5	2.1	55.2	4.0
60-69	**13.2**	**2.3**	**53.3**	**4.6**
70-79	13.9	3.0	48.9	6.3

Key: SD=standard deviation

ASSESSMENT

Response to Treatment: Patient tolerated session well

DISCHARGE SUMMARY
Patient is a 60 y.o. year old male with a diagnosis of CVA who received skilled Speech Language Pathology therapy in the inpatient rehabilitation department to address at least mild fluent aphasia . The patient has made improvements in the following areas: Language Skills for ADLs/IADL's, Reading, Writing, Expressing Wants and Needs, Cognitive-Communicative Skills for ADL's/IADL's . Patient benefits from Note taking, writing template for simplification of information, simple instrusction /simple language , reduce distractions and cues for task/topic discontinuation to maximize function.
Therapy services recommended at discharge Home Speech Therapy, Outpatient Speech Therapy.

Continued therapy services to address the following: Cognitive Impairments, Verbal Expression Deficit, Auditory Comprehension Deficit, Written Expression Deficit
These impairments limit 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
The following life roles may be impacted: Self-caretaker, Caretaker, Homemaker, Active family member, Participant in social activities, Participant in leisure activites, Employee

Discharge Impressions: Patient presents with a mild fluent aphasia. Verbal expression is marked with phonemic and semantic paraphasias, may talk and write excessively with occasional word finding. Sentences may be complete but may be irrelevant to the task at hand or perseverative. Patient benefits from verbal and written feedback to promote awareness. Patient benefits from simple language and written /spoken examples for comprehension and carryover. To simplify written expression, patient benefits from a written template including instructions and bullet points for limitations. Patient has a binder for carryover information. Patient will require supervision for all complex IADLs and assistance/support for communication. SLP created

medication chart provided by MD. Team created a Do's and Don'ts list. Recommended a Life Alert Emergancy Device in the home/community setting.

GOALS- goals ongoing

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.

ST Goal 3: Patient will complete functional reading comprehension and written expression tasks with 80% accuracy given min-mod cues to reduce distracibility, and comprehension

ST Goal 4: Patient will completed simple /functional executive function tasks with 80% accuracy with mod-max cues for slow rate, double checking work, and insight/awareness

Long Term Goals

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

PLAN

Discharge Recommendations: Home Speech Therapy, Outpatient Speech Therapy

Patient Related Instructions: Continue use of external aides to assist with function, recall, and/or improved communication., Continue with use of language and/or motor speech strategies to increase expressive and comprehension skills., Continue with cognitive-communicative retraining exercises and compensatory strategies to maximize function.

Therapeutic devices recommended: Burke Binder

Caregiver Training provided:

Supervision/Support Recommendations:
24/7 direct supervision

Diet Recommendations
Current Nutritional Route: PO
Solids: Regular Consistency
Liquids: Thin Liquids

Electronically Signed by Dora Granato, CCC-SLP on 2/10/2022 4:34 PM

Admission (Current) on 1/28/2022