03/01/2022 - SLP Treatment in WMHS Speech Therapy

Visit Information

Admission Information

Arrival Date/Time:		Admit Date/Time:	03/01/2022 1000	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Clinic/physician Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	MAINEHEALTH	Unit:	WMHS Speech Therapy
Admit Provider:		Attending Provider:	System, Provider Not In	Referring Provider:	System, Provider Not In

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
03/01/2022 2359	Home Or Self Care	None	None	WMHS Speech Therapy

Treatment Team

Provider	Service	Role	Specialty	From	To
System, Provider Not In	—	Attending Provider	—	02/24/22 1058	—

Medication List

Medication List

This visit has been closed. A record of the med list at the time of the visit is not available.

Clinical Notes

Ancillary Note

Nalipinski, Paige M, CCC-SLP at 3/1/2022 1000

Physical Rehabilitation
193 Main Street, Norway, ME 04268
Phone (207) 744-6160
Fax (207) 743-1577

Speech Pathology OUTPATIENT Daily Note 3/1/2022

Client: **Todd S. Tilley [redacted]**

Patient seen for individual treatment session.

Authorized Visits: 4 out of 12
End Date: 3/31/22

S: Todd arrived to today's appointment on time, unaccompanied. He was present and participated for the duration of the session.

O/A: Functional therapy was the focus today:

Treatment area(s):
verbal expression, language organization, auditory comprehension, reading comprehension and written expression

Short tem objectives:
Goal 1: The patient will manipulate the communication environment by adhering to the following strategies:

- Controlling the Communication Environment- **GOAL ONGOING.**
  - Reduce/eliminate distractions
  - Watch the speaker
- Setting the stage for the interaction
  - Ask for the topic of the message so you can use context cues to help you
- Prompting the Speaker
  - Signal when you have not understood-**GOAL ONGOING.** *Continues to monitor his comprehension, though still misses meaning without recognition approx 3x/session.*
    - Ask for repetition or rephrasing of the message
    - Ask, "say it slower next time"
    - Repeat the part of the message you have understood to aid the flow of the conversation

Goal 2: The patient will learn and apply strategies to facilitate comprehension in conversation.

- Patient will signal or tell partner when unfamiliar with a word, or unsure of its meaning. Partner will respond by rephrasing, repeating, or using an alternative way of communicating the concept. **GOAL ONGOING.** *During conversation and exercises, Mr. Tilley stopped clinician to get clarification demonstrating increased insight as to when his understanding breaks down.*
  - *Exercise determining meaning of written inferential questions (Harry is laid off from his study job. Jane is working as a substitute teacher. Who is working? Harry or Jane?)- 85% correct.*
- Patient will ask for repetition or clarification, and repeat information back to partner to ensure accurate comprehension.**GOAL ONGOING.** *Completed exercise to discriminate between sentence meaning (/I put ion my right shoe last./ vs. /I put on my left shoe first./). Successfully determined meaning 80% of the time.*

Noted to have morphological errors specific to suffixes (confusing use of exciting vs. Excited).

Goal 3: The patient will learn and apply strategies to facilitate expression in conversation.

- Patient will respond to a comment or question in conversation by using any modality/strategy including the following:
  - Provide a response to expand nuanced vocabulary use. **GOAL ONGOING.** *Provided 2 words to describe situation presented (Coming out of living alone in a cave for a year: "overwhelmed and scared".)*
  - Write a word, short phrase, or sentence.**GOAL ONGOING.**

Goal 4: Continue to monitor cognitive status and provide strategies to monitor his performance on tasks.

Home Program work completed: yes. Completed worksheets targeting synonyms (20/24), antonyms (22/24)
Patient/Family/Caregiver Education completed in the session:yes. Reviewed suffix use and importance of using correct form.
Learner(s): Patient
Method: verbal explanation and demonstration
Response: Patient demonstrated understanding

P: **Follow up plan:**
Recommend continue treatment 2x/week for 12 sessions.
Increase to target language skills.
Homework assigned for auditory comprehension, word finding and written expression.

Next session:

03/01/2022 - SLP Treatment in WMHS Speech Therapy (continued)

Clinical Notes (continued)

3/3/22

Paige Nalipinski, MA, CCC, SLP
Speech Pathology

Charge: Speech Therapy 92507
Time:45 minutes

Electronically signed by Nalipinski, Paige M, CCC-SLP at 03/01/22 1124

02/24/2022 - SLP Treatment in WMHS Speech Therapy

Visit Information

Admission Information

Arrival Date/Time:		Admit Date/Time:	02/24/2022 1058	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Clinic/physician Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	MAINEHEALTH	Unit:	WMHS Speech Therapy
Admit Provider:		Attending Provider:	System, Provider Not In	Referring Provider:	System, Provider Not In

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
02/24/2022 2359	Home Or Self Care	None	None	WMHS Speech Therapy

Treatment Team

Provider	Service	Role	Specialty	From	To
System, Provider Not In	—	Attending Provider	—	02/24/22 1058	—

Medication List

Medication List

This visit has been closed. A record of the med list at the time of the visit is not available.

Clinical Notes

Ancillary Note

Nalipinski, Paige M, CCC-SLP at 2/24/2022 1100

Physical Rehabilitation
193 Main Street, Norway, ME 04268
Phone (207) 744-6160
Fax (207) 743-1577

Speech Pathology OUTPATIENT Daily Note 2/24/2022

Client: **Todd S. Tilley** [redacted]

Patient seen for individual treatment session.

Authorized Visits: 3 out of 12
End Date: 3/31/22

S: Todd arrived to today's appointment on time, unaccompanied. He was present and participated for the duration of the session, though did need to leave early due to meeting at bank.

O/A: Functional therapy was the focus today:

Treatment area(s):
verbal expression, language organization, auditory comprehension, reading comprehension and written expression

Short tem objectives:
Goal 1: The patient will manipulate the communication environment by adhering to the following strategies:

- Controlling the Communication Environment- **GOAL ONGOING.**
  - Reduce/eliminate distractions
  - Watch the speaker
- Setting the stage for the interaction
  - Ask for the topic of the message so you can use context cues to help you
- Prompting the Speaker
  - Signal when you have not understood-**GOAL ONGOING.** *Continues to monitor his comprehension, though still misses meaning without recognition approx 3x/session.*
    - Ask for repetition or rephrasing of the message
    - Ask, "say it slower next time"
    - Repeat the part of the message you have understood to aid the flow of the conversation

Goal 2: The patient will learn and apply strategies to facilitate comprehension in conversation.

- Patient will signal or tell partner when unfamiliar with a word, or unsure of its meaning. Partner will respond by rephrasing, repeating, or using an alternative way of communicating the concept. **GOAL ONGOING.**
- Patient will ask for repetition or clarification, and repeat information back to partner to ensure accurate comprehension.**GOAL ONGOING.** *Asked before/after questions to target comprehension of nuanced language. 25/30 correct. Pt aware of his difficulty in comprehension in 2/5 errors.*
- Partner will provide cues such as a gesture, written words, drawing, and use of pictures or real objects.

Goal 3: The patient will learn and apply strategies to facilitate expression in conversation.

- Patient will respond to a comment or question in conversation by using any modality/strategy including the following:
  - Provide a response to expand nuanced vocabulary use. **GOAL INITIATED.**
    -Provided synonyms 21/22 times. Difficulty with delicious.
    -Provided antonyms 20/22 times. Difficulty with rested and nicest.
  - Write a word, short phrase, or sentence.**GOAL ONGOING.**

  Noted to have several semantic (arms/eyes) and phonemic (abable/ability) paraphasias in the context of spontaneous conversation, of which he was not aware.

Goal 4: Continue to monitor cognitive status and provide strategies to monitor his performance on tasks.

Home Program work completed: yes. Completed worksheets targeting synonyms (24/24), list generation (provided more than 5 requested per topic and found it easy), and following written directions (7/8). Noted to make spelling errors on generative naming task (camyon/canyon and Battfield/Battlefield).
Patient/Family/Caregiver Education completed in the session:yes. Discussed types of paraphasias noted in conversation. Reviewed word finding strategies and importance of monitoring his own output.
Learner(s): Patient
Method: verbal explanation.
Response: Patient demonstrated understanding

P: **Follow up plan:**
Recommend continue treatment 2x/week for 12 sessions.
Increase to target language skills.
Homework assigned for auditory comprehension, word finding and reading comp.

Next session:

Clinical Notes (continued)

3/1/22

Paige Nalipinski, MA, CCC, SLP
Speech Pathology

Charge: Speech Therapy 92507
Time: 35 minutes

Electronically signed by Nalipinski, Paige M, CCC-SLP at 02/24/22 1213

02/22/2022 - SLP Treatment in WMHS Speech Therapy

Visit Information

Admission Information

Arrival Date/Time:		Admit Date/Time:	02/22/2022 1057	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Clinic/physician Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	MAINEHEALTH	Unit:	WMHS Speech Therapy
Admit Provider:		Attending Provider:	System, Provider Not In	Referring Provider:	System, Provider Not In

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
02/22/2022 2359	Home Or Self Care	None	None	WMHS Speech Therapy

Treatment Team

Provider	Service	Role	Specialty	From	To
System, Provider Not In	—	Attending Provider	—	02/22/22 1057	—

Medication List

Medication List

This visit has been closed. A record of the med list at the time of the visit is not available.

Clinical Notes

Ancillary Note

Nalipinski, Paige M, CCC-SLP at 2/22/2022 1100

Stephens Memorial Hospital
MaineHealth

Physical Rehabilitation
193 Main Street, Norway, ME 04268
Phone (207) 744-6160
Fax (207) 743-1577

Speech Pathology OUTPATIENT Daily Note 2/22/2022

Client: **Todd S. Tilley (6/6/1961)**

Patient seen for individual treatment session.

Authorized Visits: 2 out of 12
End Date: 3/31/22

S: Todd arrived to today's appointment on time, unaccompanied. Hewas present and participated for the duration of the session.

O/A: Functional therapy was the focus today:

Treatment area(s):
verbal expression, language organization, auditory comprehension, reading comprehension and written expression

Short tem objectives:
Goal 1: The patient will manipulate the communication environment by adhering to the following strategies:

- Controlling the Communication Environment- **GOAL INITIATED.** *discussed factors that impact communication success. He specifically pointed out that even before his stroke he was aware of how much face masks have impacted his ability to understand the nuances of communicative partner's intent.*
  - Reduce/eliminate distractions
  - Watch the speaker
- Setting the stage for the interaction
  - Ask for the topic of the message so you can use context cues to help you
- Prompting the Speaker
  - Signal when you have not understood-**GOAL INITIATED.** *He is practicing recognizing when his comprehension has broken down and how to communicate this to the speaker.*
    - Ask for repetition or rephrasing of the message
    - Ask, "say it slower next time"
    - Repeat the part of the message you have understood to aid the flow of the conversation

Goal 2: The patient will learn and apply strategies to facilitate comprehension in conversation.

- Patient will signal or tell partner when unfamiliar with a word, or unsure of its meaning. Partner will respond by rephrasing, repeating, or using an alternative way of communicating the concept.**GOAL INITIATED.**
- Patient will ask for repetition or clarification, and repeat information back to partner to ensure accurate comprehension.**GOAL INITIATED.**
- Partner will provide cues such as a gesture, written words, drawing, and use of pictures or real objects.

Goal 3: The patient will learn and apply strategies to facilitate expression in conversation.

- Patient will respond to a comment or question in conversation by using any modality/strategy including the following:
  - Select a response from multiple-choice options given by the partner
  - Write a word, short phrase, or sentence.**GOAL INITIATED.** *Wrote sentences to describe Norman Rockwell painting. Produced 4 sentences and left out functors x1 and possessive apostrophe x2. Sentences were not very descriptive focusing only on the centerpiece of a very detailed painting that had lots of content to write about. Discussed the importance of writing being functional but also descriptive. He did recognized and successfully correct errors.*
  - *SAMPLE provided: The truck drivers are trying to move the dog. Everyones attention at the action. The dog's owner was right closely attentive too. Everyone is waiting for the driver to get the dog.*

Goal 4: Continue to monitor cognitive status and provide strategies to monitor his performance on tasks.

Home Program work completed: no: today was first treatment session.

Patient/Family/Caregiver Education completed in the session:yes. Discussed word finding strategies, importance of monitoring own output and letting comm partner know when comm breakdown has occurred.
Learner(s): Patient
Method: verbal explanation.
Response: Patient demonstrated understanding

P: **Follow up plan:**
Recommend continue treatment 2x/week for 12 sessions.
Increase to target language skills.
Homework assigned for auditory comprehension, word finding and reading comp.

Clinical Notes (continued)

Next session:
2/24/22

Paige Nalipinski, MA, CCC, SLP
Speech Pathology

Charge: Speech Therapy 92507
Time: 45 minutes

Electronically signed by Nalipinski, Paige M, CCC-SLP at 02/22/22 1215

02/15/2022 - SLP Initial Evaluation in WMHS Speech Therapy

Visit Information

Admission Information

Arrival Date/Time:		Admit Date/Time:	02/15/2022 1256	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Clinic/physician Referral	Admit Category:	
Means of Arrival:		Primary Service:		Secondary Service:	N/A
Transfer Source:		Service Area:	MAINEHEALTH	Unit:	WMHS Speech Therapy
Admit Provider:		Attending Provider:	Nalipinski, Paige M, CCC-SLP	Referring Provider:	Nalipinski, Paige M, CCC-SLP

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
02/15/2022 2359	Home Or Self Care	None	None	WMHS Speech Therapy

Treatment Team

Provider	Service	Role	Specialty	From	To
Nalipinski, Paige M, CCC-SLP	—	Attending Provider	Speech Pathology	02/15/22 1256	—

Medication List

Medication List

This visit has been closed. A record of the med list at the time of the visit is not available.

Clinical Notes

Progress Notes

Nalipinski, Paige M, CCC-SLP at 2/15/2022 1300

Physical Rehabilitation
159 Main Street, Norway, ME 04268
Phone (207) 744-6160
Fax (207) 743-1577

Speech–Language Pathology Initial Evaluation

Name: Todd S. Tilley
Age: 60 y.o.
[redacted]
Referring Provider: Sean Callender, MD
Primary Care Provider: No primary care provider on file.

Date of evaluation: 2/15/2022
Evaluator:Paige M Nalipinski, CCC-SLP

History
Historical information was compiled for this report from the patient's accessible medical records and from the interview conducted at the Stephen's Memorial Hospital Department of Physical Rehab Speech Pathology office on 02/15/22.

Mr. Tilley is a 60 y.o. male who was evaluated today due to an aphasia from a stroke in January. He is referred for this evaluation by Dr. Callender.

Clinical Notes (continued)

In the week prior to January 11, 2022, Mr. Tilley developed an intermittent headache with some visual changes. Two days prior to his January 11, 2022 admission his headache localized to the left side of his head. Early in the morning of January 12 the patient's sister noticed that he was speaking in full sentences but without any comprehensible output. He reportedly did not recognize her and could not follow any commands. There are some reports (girlfriend and daughter) that he may have been experiencing word finding difficulties for several weeks prior to his admission. He was brought to Stephen's Memorial emergency department on 1/12/2022 where a head CT revealed a left temporal intraparenchymal hemorrhage with extension into the overlying subarachnoid spaces with mass-effect and left-to-right midline shift. CTA head and neck did not reveal any vascular abnormalities.

He did not have any upper or lower extremity weakness but was assessed by speech pathology and diagnosed with global aphasia. He was found to have poor auditory comprehension, severely impaired confrontational naming and though he could copy written words, he was unable to read them aloud. He did not respond well to phonemic or semantic cueing for any language tasks presented. At the time of discharge he continued to have severe aphasia, though with more appropriate phrases interspersed in his expressive language. Mr. Tilley was discharged to his daughter's care on 1/16/2022 and traveled to Burke Rehab in White Plains, New York. He received speech therapy 5+ times per week and on discharge from Burke on 2/11/22, had made improvements in the following areas: Language skills for ADLs, reading, writing, expressing wants and needs, and cognitive communicative skills for ADLs. He continued to present with a mild fluent aphasia marked by phonemic and semantic paraphasias. He was occasionally verbose, with a relevant and perseverative comments. He did benefit from verbal and written feedback to increase his awareness. Continued speech therapy was recommended targeting understanding for complex auditory comprehension, word finding tasks and high-level functional reading and written expression. It was also suggested that more functional executive functioning skills continue to be addressed especially with regard to strategies such as slowing his rate, double checking his work and increasing overall awareness.

Past Medical History:
He has Intracranial hemorrhage (CMS-HCC); Elevated BP without diagnosis of hypertension; Delirium; and Hypertension on their problem list.

Ambulatory Problems

Diagnosis	Date Noted
• Intracranial hemorrhage (CMS-HCC)	01/12/2022
• Elevated BP without diagnosis of hypertension	01/12/2022
• Delirium	01/15/2022
H/O alcohol abuse	
• Hypertension	

Hearing and vision: Patient wears glasses and with them in place had no difficulty with visual acuity for pictures or written word. Hearing appeared to be adequate for interactions and is quiet testing environment.

Social history: Mr. Tilley has a home in Waterford, Maine, and reports that he lives there and with a friend in South Paris. Prior to his stroke he was working for a security company mostly doing flag details at construction sites along the road. He is currently looking into retirement.

Behavioral observations

Mr. Tilley presents as a amiable and kind individual. He was on time and unaccompanied for his evaluation. Mr. Tilley was pleasant and cooperative with all tasks, as well as attentive to the material presented. He endorsed decreased confidence with verbal communication skills as a result of his new aphasia. He appeared aware of his deficits and he consistently attempted to correct errors.
Considering the above-mentioned observations of this clinician and the favorable testing environment, the results of the evaluation are considered reliable, valid, and representative of Mr. Tilley's current cognitive and language abilities.

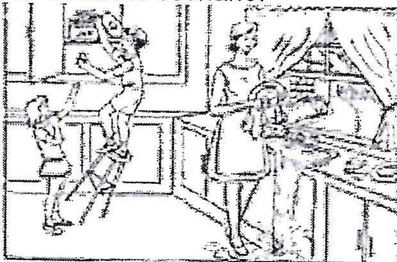
IMPRESSIONS

Mr. Tilley is a lovely 60-year-old gentleman who presents with a mild to moderate mixed expressive and receptive

aphasia. His informal interactions his deficits appear quite mild with rare pauses for word finding, but testing does reveal more significant impairments that will impact understanding of complex information (such as medical information, directions, etc.), his ability to accurately provide detailed information (relating medications to healthcare providers, answering questions regarding finances, etc.). He has made tremendous gains since his stroke, but does require ongoing intervention to increase both expressive and receptive language, as well as increase his awareness of deficits and their impact on executive functioning.

He was initially presented with the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), but due to his impaired language, performance was limited. Specifically he was unable to participate in the *List Learning* and *Story Memory* subtests that require accurate auditory comprehension for encoding. He was able to complete subtests related to visual-spatial and constructional skills and scored at the 63rd percentile. On the language subtest (specifically *Picture Naming* and *Semantic Fluency*) he scored at the 19th percentile. Similarly his attention was noted to be in the borderline low to below average range at 21%.

Mr. Tilley was then administered the complete Boston Diagnostic Aphasia Exam (BDAE) in order to gather a complete picture of his current level of functioning. Expressive language was generally functional. He was able to describe pictures and retell stories with enough accuracy and word choice and syntax to allow a communication partner to understand his overall message, though specific details may be lost on the listener. In the following example he is describing the Cookie Theft picture below and without the visual representation, a listener would have trouble picturing the accurate scenario:



Mom was cleaning the dishes with the sink that is not even closed... It is opened out into the sink. I mean into the floor. And the kids.... While she is distracted looking outside and her son is sneaking some cookies. Her daughter... His sister... And he is getting ready to tip-topple over stove-or as we say as a kid.... Off with the stool.

He had minimal difficulty with confrontational naming even for special categories including letters, numbers, colors and actions. Repetition broke down at the sentence level where he appeared to have difficulty with recall of syntactic elements. Both responsive and generative naming were mildly impaired with semantic paraphasias as most common error type (mending/knitting, wax/matches).

Auditory comprehension was functional as long as he had adequate time and access to repetition. Without these, he had significant difficulty with increased length and complexity. For example, when allowed repetition of the following command, "Tap each shoulder twice with 2 fingers, keeping your eyes shut.", he performed without error, but after only one presentation, he became completely overwhelmed and was unable to complete any of the task. For complex ideational material, he performed similarly. He accurately answered yes/no questions about story read aloud to him where syntax was straightforward, but when presented with the paragraph of the same length, where syntax and semantics were significantly more challenging, he became completely overwhelmed. When the clinician had finished reading the story he simply said "that is a lot", and reported that he had not been able to comprehend any of it. Syntactic processing assessment revealed that he could follow complex commands as long as the word order was expected, but when word order was shifted (agent and action switched as in "touching the pencil with the scissors") he had difficulty figuring out intended message. He was aware of his struggle and was noted to have excellent insight into when his comprehension broke down.

Reading comprehension was highly functional. He had no difficulty with lexical decision-making nor derivational and grammatical morphology (recogntizing meaning in word endings and conjugations like vacate vs. vacant, sicken vs.

sickly), and oral reading was intact even for semantic paralexia prone words (detest, conquer). Reading comprehension for sentences and paragraphs did breakdown when material was lengthy and complex. He did benefit from re-reading.

Written expression revealed well-formed and fully legible handwriting with strong spelling skills, even for uncommon irregular words such as /yacht/ and /colonel/. His narrative writing sample revealed strong mechanics and written vocabulary access, but he did have some issues with syntax and adequacy of content. The reader is able to glean the general concept he is trying to communicate, but the specifics are lacking. When asked to write a short paragraph about his favorite place, he wrote the following:

I enjoy on the top of Algonquin, NY. I hike there with my daughter because we like the hike. Top is the ultimate so we can show our goal.

As demonstrated in his performance outlined above, Mr. Tilley continues to present with language deficits that leave him performing significantly below his baseline. Although he is largely functional for day-to-day tasks, he should continue to be supervised when understanding of written and spoken material is crucial such as when getting information about medical or financial information. He is an excellent candidate for ongoing speech therapy given his progress to date, his motivation and his insight.

Recommendations
Based on Mr. Tilley's performance during this evaluation, as well as his concerns about managing day-to-day communication responsibilities, aphasia therapy is recommended. A certified speech-language pathologist who has knowledge and practice with aphasia and language hierarchy's should conduct the therapy sessions which will focus on practical compensatory strategies for word finding deficits as well as restorative treatment for language impairment.

It is recommended that Mr. Tilley be seen one to two times per week for 6 weeks initially. Further treatment may be recommended based on the patient's progress with therapy.

Prognosis
Prognosis for further improvement in both receptive and expressive language as well as executive functioning is excellent given his progress to date, his high degree of insight into areas of impairment and his family support.

Patient Education
Mr. Tilley participated in education regarding the role of the speech-language pathologist in language rehabilitation. Speech-language pathologist have a specialty training treating language deficits due to neurologic impairment.

General treatment plan

Goal 1: The patient will manipulate the communication environment by adhering to the following strategies:
- Controlling the Communication Environment
  - Reduce/eliminate distractions
  - Watch the speaker
- Setting the stage for the interaction
  - Ask for the topic of the message so you can use context cues to help you
- Prompting the Speaker
  - Signal when you have not understood
    - Ask for repetition or rephrasing of the message
    - Ask, "say it slower next time"
    - Repeat the part of the message you have understood to aid the flow of the conversation

Goal 2: The patient will learn and apply strategies to facilitate comprehension in conversation.
- Patient will signal or tell partner when unfamiliar with a word, or unsure of its meaning. Partner will respond by rephrasing, repeating, or using an alternative way of communicating the concept.

- Patient will ask for repetition or clarification, and repeat information back to partner to ensure accurate comprehension.
- Partner will use straightforward and direct language (i.e. minimal use of figurative expressions and round-about ways of saying something.)
- Partner will provide brief chunks of information at a time.
- Partner will provide cues such as a gesture, written words, drawing, and use of pictures or real objects.

Goal 3: The patient will learn and apply strategies to facilitate expression in conversation.

- Patient will respond to a comment or question in conversation by using any modality/strategy including the following:
  - Select a response from multiple-choice options given by the partner
  - Write a word, short phrase, or sentence
  - Draw an object, place, and person
  - Point to a picture in a communication book or page
  - Provide a gesture
  - Use body language or facial expression
  -

Goal 4: Continue to monitor cognitive status and provide strategies to monitor his performance on tasks.

It was a pleasure to meet with Mr. Tilley. I would be happy to clarify and/or elaborate on any of the information contained in the report. Please do not hesitate to contact me at 207-744-6106.

Paige Nalipinski, MA, CCC,SLP
Speech Language Pathologist

Charge: Language Evaluation 92523
Time: 90 minutes

Electronically signed by Nalipinski, Paige M, CCC-SLP at 02/16/22 0931

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit

Visit Information

Admission Information

Arrival Date/Time:	01/12/2022 0849	Admit Date/Time:	01/12/2022 0853	IP Adm. Date/Time:	01/12/2022 1606
Admission Type:	Emergency	Point of Origin:	Non Healthcare Facility Point Of Origin	Admit Category:	
Means of Arrival:	Car	Primary Service:	Hospitalist	Secondary Service:	N/A
Transfer Source:		Service Area:	MAINEHEALTH	Unit:	WMHS Med Surg Unit
Admit Provider:	Deblock, Heidi, MD	Attending Provider:	Weems, Patricia, MD	Referring Provider:	

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
01/16/2022 1121	Home Or Self Care	Home	None	WMHS Med Surg Unit

Treatment Team

Provider	Service	Role	Specialty	From	To
Deblock, Heidi, MD	Internal Medicine	Admitting Provider	Internal Medicine	—	—
Callender, G Sean, MD	Internal Medicine	Attending Provider	Family Medicine	01/13/22 0653	01/16/22 1121
Deblock, Heidi, MD	Internal Medicine	Attending Provider	Internal Medicine	01/12/22 1611	01/13/22 0653
Weems, Patricia, MD	Emergency	Attending Provider	Emergency Medicine	01/12/22 0858	01/12/22 1611
Campbell, Jeffrey F, CNA	—	Certified Nursing Assistant	—	01/16/22 0725	—
Hill, Carla J, RN	—	Registered Nurse	Nursing	01/16/22 0709	—
Callina, Tovah, RN	Case Manager	Case Manager	Care Management	01/16/22 0633	01/16/22 1115
Piper, Jill, RN	—	Registered Nurse	Nursing	01/15/22 2309	01/16/22 0737
Ring, Michael J, CNA	—	Certified Nursing Assistant	—	01/15/22 2300	01/16/22 0745
Gordon, Kimberly, CNA	—	Certified Nursing Assistant	Nursing	01/15/22 1559	01/15/22 2356
Campbell, Jeffrey F, CNA	—	Certified Nursing Assistant	—	01/15/22 0717	01/15/22 1532
Mains, Allison, RN	—	Registered Nurse	Nursing	01/15/22 0659	01/15/22 1945
Poirier, Joni M, CNA	—	Certified Nursing Assistant	—	01/15/22 0322	01/15/22 0548
Piper, Jill, RN	—	Registered Nurse	Nursing	01/15/22 0318	01/15/22 0714
Chappel, Maya, CNA	—	Certified Nursing Assistant	Nursing	01/15/22 0057	01/15/22 0330
Verrill, Roland H, CNA	—	Certified Nursing Assistant	Nursing	01/14/22 2014	01/14/22 2333
Neujahr, Lauren, LCSW	—	Social Worker	—	01/14/22 1547	—
Berube, Samantha, RN	—	Registered Nurse	Nursing	01/14/22 1510	01/14/22 2224
Topper, Douglas R, SLP	Speech Language Pathology	Speech Language Pathologist	Speech Pathology	01/14/22 0822	—
Michaud, Caroline, RN	—	Registered Nurse	Nursing	01/14/22 0726	01/14/22 1534
Lancaster, Alexandra, RN	—	Registered Nurse	Nursing	01/14/22 0723	01/14/22 1714
Proctor, Esther, RN	Case Manager	Case Manager	Care Management	01/14/22 0629	01/14/22 1604
Withey, Sondra G, RN	—	Registered Nurse	Nursing	01/13/22 2016	01/14/22 0312
Douglass, Lori A, RN	—	Registered Nurse	Nursing	01/13/22 1910	01/14/22 0730
Raymond, Henry H, RN	—	Certified Nursing Assistant	Nursing	01/13/22 0743	01/14/22 1714
Callina, Tovah, RN	Case Manager	Case Manager	Care Management	01/13/22 0639	01/13/22 1615
Douglass, Lori A, RN	—	Registered Nurse	Nursing	01/12/22 2006	01/13/22 0730
Gallinari, Samantha, RN	—	Registered Nurse	Nursing	01/12/22 1855	01/12/22 1924
Godwin, Vanessa,	—	Registered Nurse	Nursing	01/12/22 1328	01/12/22 1829

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

Treatment Team (continued)

Provider	Service	Role	Specialty	From	To
RN					
Bickford, Stacey, RN	—	Registered Nurse	—	01/12/22 0939	01/12/22 1343

Medication List

Medication List

This report is for documentation purposes only. The patient should not follow medication instructions within. For accurate instructions regarding medications, the patient should instead consult their physician or after visit summary.

Prior To Admission

None

Discharge Medication List

acetaminophen 325 MG Tab

Instructions: Take 3 Tablets (975 mg total) every 6 hours as needed by mouth for Pain or Fever
Authorized by: Callender, G Sean, MD — Ordered on: 1/15/2022
Start date: 1/15/2022 — Quantity: 120 Tablet
Refill: No refills remaining

carvedilol 3.125 MG Tab

Instructions: Take 1 Tablet (3.125 mg total) 2 times daily (with meals) by mouth
Authorized by: Callender, G Sean, MD — Ordered on: 1/15/2022
Start date: 1/15/2022 — Quantity: 60 Tablet
Refill: No refills remaining

lisinopril 20 MG Tab

Instructions: Take 1 Tablet (20 mg total) daily by mouth
Authorized by: Callender, G Sean, MD — Ordered on: 1/15/2022
Start date: 1/16/2022 — Quantity: 30 Tablet
Refill: No refills remaining

Stopped in Visit

None

ED Provider Note

ED Provider Notes by Weems, Patricia, MD at 1/12/2022 0913

History

Chief Complaint
Patient presents with
- Headache
- Confusion

HPI
60-year-old male with no significant past medical history who presents with a headache and confusion. His sister gives history as the patient is unable. She states that he has had a left-sided headache for 2 days. His last known well was 3 AM when his partner reported that he started "not making sense". He has been trying to speak in

sentences that are not making sense to his sister or his partner. He also does not know who his sister is. He is not following commands. No history of similar. The patient is unable to provide any history.

No past medical history on file.

No past surgical history on file.

No family history on file.

Social History

Tobacco Use
- Smoking status: Never Smoker

Substance Use Topics
- Alcohol use: No
- Drug use: No

Review of Systems
Unable to perform ROS: Mental status change

Physical Exam
BP 148/90 | Pulse 96 | Temp 36.2 °C (97.2 °F) (Oral) | Resp 16 | Wt 116 kg (255 lb 12.8 oz) | SpO2 97%

Physical Exam
Vitals and nursing note reviewed.
Constitutional:
 Appearance: He is well-developed. He is not diaphoretic.
HENT:
 Head: Normocephalic and atraumatic.
 Mouth/Throat:
 Pharynx: No oropharyngeal exudate.
Eyes:
 Conjunctiva/sclera: Conjunctivae normal.
 Pupils: Pupils are equal, round, and reactive to light.
Cardiovascular:
 Rate and Rhythm: Normal rate and regular rhythm.
 Heart sounds: Normal heart sounds. No murmur heard.
No friction rub. No gallop.
Pulmonary:
 Effort: Pulmonary effort is normal. No respiratory distress.
 Breath sounds: Normal breath sounds. No wheezing.
Chest:
 Chest wall: No tenderness.
Abdominal:
 General: Bowel sounds are normal. There is no distension.
 Palpations: Abdomen is soft.
 Tenderness: There is no abdominal tenderness. There is no guarding or rebound.
Musculoskeletal:
 General: Normal range of motion.
 Cervical back: Normal range of motion and neck supple.
Lymphadenopathy:

Cervical: No cervical adenopathy.

Skin:

General: Skin is warm and dry.

Findings: No erythema or rash.

Neurological:

Mental Status: He is alert.

Comments: **Sitting in bed, alert. When asked orientation questions, he gives answers that do not make any sense. He will not follow any commands. Unable to test visual acuity because he does not understand when to answer yes. Unable to perform finger-to-nose because he does not understand commands. He will grab both of my hands with seemingly equal strength and hold both of his arms up in the air, though not to command, just doing the act. Same with both of the legs. He does not have a facial droop. Very aphasic. Not dysarthric.**

MDM (ED Course and Disposition)

Pertinent diagnostic study results include:
EKG: Reviewed
Sinus, regular, rate 90, normal intervals, no ST elevation or depression.
Labs: Reviewed
Labs Reviewed
CBC + DIFFERENTIAL
COMPREHENSIVE METABOLIC PANEL
URINALYSIS REFLEX SEDIMENT + CULTURE
DRUGS OF ABUSE SCREEN UR
ETHANOL LEVEL
INR
PARTIAL THROMBOPLASTIN TIME

Diagnostic Imaging: Reviewed
CT Head WO Contrast
Final Result

CTA Head and Neck (Results Pending)
IMPRESSION:
Acute intraparenchymal hemorrhage within the left temporal lobe with extension into the overlying subarachnoid spaces. There is associated vasogenic edema with mass effect upon the adjacent cerebral sulci and minimal 1-2 mm left-to-right midline shift.

IMPRESSION:

The intracranial and cervical vasculature is widely patent. No flow-limiting stenosis or occlusion. No evidence of aneurysm.

This is a 60 y.o. male who presents with aphasia. His last known well was 3 AM, so 6 hours ago so he is not within the window for tPA. My concern is for either an occlusive stroke, intracranial bleed as he is having a headache and is very hypertensive, or a new mass with edema or bleed. I am less concerned for infectious process. He is afebrile with no infectious symptoms. I am less concerned for any sort of ingestion we will check this. From a neuro standpoint, he

ED Provider Note (continued)

does not have any obvious deficits other than the severe aphasia, both expressive and receptive. I am unable to test visual acuity, finger-to-nose due to his inability to follow commands. We have ordered a CT head, CTA head and neck, labs, EKG. Disposition pending what ever we find on his imaging.

CT head shows an acute left temporal bleed. Minimal shift. Started on nicardipine. Spoke with neurosurgery and neuro critical care at Maine Medical Center. They are happy to accept him but they have no beds at this time. They recommended systolic blood pressure less than 140. We will also get the CT angio.

Update:
Patient developed a severe headache so repeat head ct done early. No change. Given hydromorphone for pain which helped. Currently sleeping. Blood pressure is lowering so we have titrated down and now stopped nicardipine. Will continue ot monitor.

Update:
No beds at MMC tonight. The patient is still doing well. Blood pressure is down and he remains off nicardipine. Will admit to our ICU until bed opens up at MMC.

Diagnosis:
Encounter Diagnoses

Name	Primary?
• Intracranial hemorrhage (CMS-HCC)	Yes
• Hypertension, unspecified type	

Critical Care Time: Total critical care time excluding procedures but involving direct care at the bedside, review of labs testing, images, other testing, and discussion with consultants was 35 minutes.

Weems, Patricia, MD
01/12/22 1118

Weems, Patricia, MD
01/12/22 1514

Weems, Patricia, MD
01/12/22 1621

Electronically signed by Weems, Patricia, MD at 01/12/22 1621

ED Notes

ED Triage Notes by Sawyer, Derica D, RN at 1/12/2022 0856

Patient here with sister. Woke up this morning around 0300 and was talking to his partner with word scramble. Patient has had left sided headache x2 days. Patient alert and disoriented.

Electronically signed by Sawyer, Derica D, RN at 01/12/22 0857

ED Notes by Bickford, Stacey, RN at 1/12/2022 1054

Speech is clear but word salad. Is following directions better than on arrival.

Electronically signed by Bickford, Stacey, RN at 01/12/22 1055

ED Care Timeline

Patient Care Timeline (1/12/2022 08:49 to 1/12/2022 18:29)

1/12/2022	Event	Details	User
08:49	**Patient arrived in ED**		Hunt, Christine M
08:49:53	**Emergency encounter created**		Hunt, Christine M
08:50:18	**Arrival Complaint**	Confusion/Headache	
08:53:11	**ED Roomed**	To room ED5	Sawyer, Derica D, RN
08:53:11	**Patient roomed in ED**		Sawyer, Derica D, RN
08:55	**Arrival Documentation**	**Triage Start** Triage Start: Start **Language Assistant** Interpreter: N/A **Prehospital Treatment** Prehospital Treatment: No	Sawyer, Derica D, RN
08:55:59	**Triage Start**		Sawyer, Derica D, RN
08:55:59	**Triage Started**		Sawyer, Derica D, RN
08:56	**Travel/Exposure Screening**	**Travel/Exposure** Have you experienced any of the following symptoms in the past 48 hours? [Select all that apply]: New headache If you are recovering from COVID, has it been 10 days since symptoms first appeared or you tested positive? : No Are you awaiting the results of a COVID-19 test?: No Have you traveled outside the United States in the past month? : No **Other flowsheet entries** To the best of your knowledge, in the last 10 days have you been in close physical contact with anyone who has confirmed or suspected COVID-19 infection? : No	Sawyer, Derica D, RN
08:56:21	**Chief Complaints Updated**	**Confusion** **Headache**	Sawyer, Derica D, RN
08:56:25	**ED Triage Notes**	Patient here with sister. Woke up this morning around 0300 and was talking to his partner with word scramble. Patient has had left sided headache x2 days. Patient alert and disoriented.	Sawyer, Derica D, RN
08:57	**Acuity/Destination**	**Acuity/Destination** Patient Acuity: 2 Triage Complete: Triage complete	Sawyer, Derica D, RN
08:57:27	**Allergies Reviewed - Review Complete**		Sawyer, Derica D, RN

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
08:57:40	Home Medications Reviewed		Sawyer, Derica D, RN
08:57:44	Triage Completed		Sawyer, Derica D, RN
08:58	Vitals Reassessment	**Vitals Assessment** Restart Vitals Timer: Yes	Sawyer, Derica D, RN
08:58	Vital Signs	**Vital Signs** Restart Vitals Timer: Yes Heart Rate: 103 HR Source: AutoBP machine BP: **200/129** ! BP Method: Automatic Patient Position: Sitting Respirations: 18 SpO2: 100 % **Oxygen Therapy** O2 Device: None (Room Air)	Sawyer, Derica D, RN
08:58	Custom Formula Data	**Other flowsheet entries** MAP (calculated): 153 mmHg	Sawyer, Derica D, RN
08:58:18	Assign Attending	Weems, Patricia, MD assigned as Attending	Weems, Patricia, MD
08:58:18	Assign Physician		Weems, Patricia, MD
08:58:25	Provider First Contact	ED First Provider Evaluation Documented	Weems, Patricia, MD
09:00	Sepsis/DI Scores	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2	Epic, User
09:00:15	Orders Placed	CBC + Differential ; CMP ; EKG 12 lead - STAT ; Urinalysis Reflex Sediment + Culture ; Drugs of Abuse Screen, Ur ; ETOH Level ; INR ; PTT ; CT Head WO Contrast ; CTA Head and Neck	Weems, Patricia, MD
09:00:18	Lab Ordered	PARTIAL THROMBOPLASTIN TIME, INR, ETHANOL LEVEL, DRUGS OF ABUSE SCREEN UR, URINALYSIS REFLEX SEDIMENT + CULTURE, COMPREHENSIVE METABOLIC PANEL, CBC + DIFFERENTIAL	Weems, Patricia, MD
09:00:18	CT Ordered	CT ANGIOGRAM HEAD NECK, CT HEAD WO CONTRAST	Weems, Patricia, MD
09:00:18	Imaging Exam Ordered		Weems, Patricia, MD
09:00:18	Imaging Exam Ordered		Weems, Patricia, MD
09:00:18	EKG Ordered	EKG 12-LEAD	Weems, Patricia, MD
09:03	Registrar for Patient	**Registrar for Patient** Registrar Name: Donna	Johnson, Donna
09:05:35	Peripheral IV 01/12/22 20 G Right Antecubital Assessment	Phlebitis Scale: 0 PIV line status: Flushed; Locked Infiltration Scale: 0	Sawyer, Derica D, RN
09:06:35	Fall Risk/BMAT	**Fall Risk Assessment** Fall Risk Factors : Impaired cognition **Bedside Mobility Assessment Tool** BMAT Mobility Level: Level 3	Sawyer, Derica D, RN
09:06:43	Orders Placed	ED Fall Precautions	Weems, Patricia, MD

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

09:06:46	**Orders Acknowledged**	New - ED Fall Precautions	Sawyer, Derica D, RN
09:06:47	**Orders Acknowledged**	New - CTA Head and Neck	Sawyer, Derica D, RN
09:06:48	**Orders Acknowledged**	New - CT Head WO Contrast	Sawyer, Derica D, RN
09:06:48	**Ready for Imaging**	**Patient Ready for Imaging** Patient Ready for CT: Yes	Sawyer, Derica D, RN
09:06:51	**Pt Ready for CT**		Sawyer, Derica D, RN
09:09:52	**Orders Acknowledged**	New - ETOH Level	Sawyer, Derica D, RN
09:09:53	**Orders Acknowledged**	New - INR	Sawyer, Derica D, RN
09:09:54	**Orders Acknowledged**	New - PTT	Sawyer, Derica D, RN
09:09:55	**Orders Acknowledged**	New - CBC + Differential ; CMP	Sawyer, Derica D, RN
09:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2	Epic, User
09:20:20	**Imaging Exam Started**	CT Head WO Contrast	Corthell, Emily T, RTR
09:20:26	**Imaging Exam Started**	CTA Head and Neck	Corthell, Emily T, RTR
09:20:55	**EKG Final Result**	EKG 12 lead - STAT	Edi, Rad Results In
09:20:55	**MH ED EKG TIMER COMPLETE**		Edi, Rad Results In
09:21	**Anthropometrics**	**Anthropometrics** Weight Change: 0	Sawyer, Derica D, RN
09:21	**Vital Signs**	**Vital Signs** Restart Vitals Timer: Yes **Height and Weight** Weight: 116 kg (255 lb 12.8 oz) Weight Source: Stretcher scale	Sawyer, Derica D, RN
09:21	**Custom Formula Data**	**Vitals** Weight Change since Birth (gms): 0 gms Weight Change since prev. wt (gms): 0 gms **Other flowsheet entries** Weight Change (lbs) vs. Initial: 255.8 Weight Change (lbs) vs. Prior: 255.8 Weight Change (lbs) vs. Day of Surgery: 255.8 Weight Change Since Birth (%): 0 % Change In Weight Since Admission (kg): 0 kg Weight: 116.03 kg	Sawyer, Derica D, RN
09:21:08	**Orders Acknowledged**	New - EKG 12 lead - STAT	Hodson, Kevin M, RN
09:21:10	**EKG Final Result**	EKG 12 lead - STAT - [96692695]	Weems, Patricia, MD
09:21:10	**New Orders: EKG 12 lead - STAT Completed**	EKG 12 lead - STAT	Hodson, Kevin M, RN
09:21:34	**Orders Placed**	POC Bedside Glucose Test	Weems, Patricia, MD
09:21:35	**Lab Ordered**	INPATIENT POC BEDSIDE GLUCOSE TEST	Weems, Patricia, MD

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
09:22:02	**Orders Acknowledged**	New - POC Bedside Glucose Test	Sawyer, Derica D, RN
09:22:04	**Orders Completed**	POC Bedside Glucose Test	Sawyer, Derica D, RN
09:22:04	**POC Bedside Glucose Test Task Completed**	POC Bedside Glucose Test	Sawyer, Derica D, RN
09:22:05	**EKG**	**EKG** Physician Notified: Yes Physician Name: Dr. Weems	Sawyer, Derica D, RN
09:22:12	**Neurological**	**Neurological** Neuro (WDL): Exceptions to WDL Neuro Symptoms: Headache History of LOC?: No Level of Consciousness: Alert Orientation Level: Disoriented to situation; Disoriented to place Cognition: Poor attention/concentration; Unable to follow commands Speech: Expressive aphasia LUE Motor Strength: Normal strength/movement against gravity and resistance RUE Motor Strength: Normal strength/movement against gravity and resistance LLE Motor Strength: Normal strength/movement against gravity and resistance RLE Motor Strength: Normal strength/movement against gravity and resistance	Sawyer, Derica D, RN
09:23	**Vital Signs**	**Vital Signs** Restart Vitals Timer: Yes Temperature : 36.2 °C (97.2 °F) Temp Source: Oral	Sawyer, Derica D, RN
09:23	**Custom Formula Data**	**Relevant Labs and Vitals** Temp (in Celsius): 36.2	Sawyer, Derica D, RN
09:25:05	**Glucose, Point of Care Resulted**	Collected: **1/12/2022 09:24** Last updated: **1/12/2022 09:25** Status: **Final result** Glucose, POC: **94 mg/dL** [Ref Range: 70 - 99]	Edi, Lab In Hlseven
09:25:07	**Lab Ordered**	GLUCOSE, POINT OF CARE	Edi, Lab In Hlseven
09:25:07	**Lab Resulted**	(Final result) GLUCOSE, POINT OF CARE	Edi, Lab In Hlseven
09:28:21	**Registration Completed**		Johnson, Donna
09:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2.5	Epic, User

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

09:31:41	**CBC + Differential Resulted**	**Abnormal Result** Collected: **1/12/2022 09:10** Last updated: **1/12/2022 09:31** Status: **Final result** Leukocytes: **11.4 thou/uL** ^ [Ref Range: 4.2 - 9.9] Erythrocytes: **4.90 mil/uL** [Ref Range: 4.08 - 5.74] Hemoglobin: **16.2 g/dL** [Ref Range: 13.0 - 17.4] Hematocrit: **47.1 %** [Ref Range: 38.0 - 50.0] Mean Corpuscular Volume: **96.1 fL** [Ref Range: 82.0 - 100.0] Mean Corpuscular Hemoglobin: **33.1 pg** [Ref Range: 27.0 - 34.0] Mean Corpuscular Hemoglobin Conc: **34.4 g/dL** [Ref Range: 32.0 - 36.0] Platelet Count: **238 thou/uL** [Ref Range: 140 - 440] Mean Platelet Volume: **11.2 fL** [Ref Range: 8.6 - 12.7] Erythrocyte Distribution Width SD: **44.8 fL** [Ref Range: 37.0 - 48.0] Erythrocyte Distribution Width CV: **12.6 %** [Ref Range: 12.0 - 14.6] Neutrophils Percent: **86 %** ^ [Ref Range: 47 - 80] Lymphocytes Percent: **8 %** ˅ [Ref Range: 14 - 46] Monocytes Percent: **5 %** [Ref Range: 5 - 13] Eosinophils Percent: **0 %** [Ref Range: 0 - 5] Basophils Percent: **1 %** [Ref Range: 0 - 2] Immature Granulocytes Percent: **1 %** [Ref Range: <1] Neutrophils Absolute: **9.78 thou/uL** ^ [Ref Range: 2.40 - 7.60] Lymphocytes Absolute: **0.90 thou/uL** ˅ [Ref Range: 1.00 - 3.30] Monocytes Absolute: **0.51 thou/uL** [Ref Range: 0.25 - 0.90] Eosinophils Absolute: **0.05 thou/uL** [Ref Range: 0.00 - 0.40] Basophils Absolute: **0.06 thou/uL** [Ref Range: 0.00 - 0.12] Immature Granulocytes Absolute: **0.06 thou/uL** ^ [Ref Range: 0.00 - 0.05]	Edi, Lab In Hlseven
09:31:44	**Lab Resulted**	(Final result) CBC + DIFFERENTIAL	Edi, Lab In Hlseven
09:33:11	**Orders Placed**	labetalol injection 10 mg	Weems, Patricia, MD
09:33:25	**Imaging Exam Ended**	CT Head WO Contrast	Corthell, Emily T, RTR
09:37:15	**Orders Discontinued**	labetalol injection 10 mg	Weems, Patricia, MD
09:38:40	**Orders Placed**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL)	Deblock, Heidi, MD
09:39:03	**Orders Placed**	Initiate One Call	Callender, G Sean, MD
09:39:40	**Assign Nurse**	Bickford, Stacey, RN assigned as Registered Nurse	Bickford, Stacey, RN
09:40	**Peripheral IV 01/12/22 18 G Left Antecubital Placed**	Removal Date/Time: 01/15/22 1626 Placement Date/Time: 01/12/22 0940 Size Gauge: 18 G Orientation: Left Location: Antecubital Site Prep: Chlorhexidine scrub Inserted by: Derica, RN Insertion attempts: 1 Removal Reason: Leaking	Bickford, Stacey, RN
09:40:27	**Peripheral IV 01/12/22 18 G Left Antecubital Assessment**	Phlebitis Scale: 0 PIV line status: Locked; Flushed Infiltration Scale: 0	Bickford, Stacey, RN
09:41:09	**Orders Acknowledged**	New - Urinalysis Reflex Sediment + Culture ; Drugs of Abuse Screen, Ur ; labetalol injection 10 mg ; niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) ; Initiate One Call ; Discontinued - labetalol injection 10 mg	Bickford, Stacey, RN
09:43:42	**CT Head WO Contrast Resulted**	Collected: **1/12/2022 09:15** Last updated: **1/12/2022 09:43** Status: **Final result**	Edi, Rad Results In
09:43:46	**Imaging Final Result**	CT Head WO Contrast	Edi, Rad Results In
09:43:46	**CT Final Result**	(Final result) CT HEAD WO CONTRAST	Edi, Rad Results In

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

09:44:42	**INR Resulted**	Collected: **1/12/2022 09:10** Last updated: **1/12/2022 09:44** Status: **Final result** INR: **0.9** [Ref Range: 0.9 - 1.2] Comment INR: **see below** (Recommended therapeutic ranges for oral anticoagulant: STANDARD THERAPY: 2.0 - 3.0 HIGH DOSE THERAPY: 2.5 - 3.5 FFP is rarely indicated in a bleeding patient, or as prophylaxis prior to surgery/invasive procedure, if the INR is <= 1.7.)	Edi, Lab In Hlseven
09:44:44	**Lab Resulted**	(Final result) INR	Edi, Lab In Hlseven
09:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2.6	Epic, User
09:47:19	**PTT Resulted**	Collected: **1/12/2022 09:10** Last updated: **1/12/2022 09:47** Status: **Final result** Partial Thromboplastin Time: **31 sec** [Ref Range: 26 - 34] (Therapeutic Reference Range: Low Intensity Heparin Therapy: 55 - 75 Seconds High Intensity Heparin Therapy: 65 - 100 Seconds Refer to appropate Heparin nomogram for dosing.)	Edi, Lab In Hlseven
09:47:23	**Lab Resulted**	(Final result) PARTIAL THROMBOPLASTIN TIME	Edi, Lab In Hlseven
09:48	**Medication New Bag**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **5 mg/hr** ; Rate: **25 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **0945** ; Comment: **147/90**	Bickford, Stacey, RN
09:54:41	**BEFAST Stroke Screening**	**BEFAST Stroke Screening** BEFAST Stroke Screening WDL?: Exceptions to WDL Speech: Difficulty speaking; Difficulty understanding speech Last Known Well Date: 01/11/22 Last Known Well Time: 0755	Bickford, Stacey, RN
09:54:41	**CMP Resulted**	**Abnormal Result** Collected: **1/12/2022 09:10** Last updated: **1/12/2022 09:54** Status: **Final result** Sodium: **140 mEq/L** [Ref Range: 133 - 145] Potassium: **4.2 mEq/L** [Ref Range: 3.3 - 5.3] Chloride: **103 mEq/L** [Ref Range: 96 - 108] Carbon Dioxide: **25 mEq/L** [Ref Range: 21 - 30] Anion Gap: **12 mEq/L** [Ref Range: 7 - 16] Blood Urea Nitrogen: **18 mg/dL** [Ref Range: 6 - 19] Creatinine: **1.07 mg/dL** [Ref Range: 0.50 - 1.30] BUN Creatinine Ratio: **16.8** Glucose: **120 mg/dL ^** [Ref Range: 70 - 99] Protein: **8.3 g/dL** [Ref Range: 5.9 - 8.4] Albumin: **5.0 g/dL** [Ref Range: 3.2 - 5.2] Globulin: **3.3 g/dL** [Ref Range: 2.0 - 3.5] Albumin/Globulin Ratio: **1.5** Bilirubin: **0.4 mg/dL** [Ref Range: 0.0 - 1.0] Calcium: **9.2 mg/dL** [Ref Range: 8.6 - 10.4] Alkaline Phosphatase: **116 U/L** [Ref Range: 39 - 117] AST: **52 U/L ^** [Ref Range: 0 - 37] ALT: **81 U/L ^** [Ref Range: 0 - 40] EGFR (MDRD): **>60** [Ref Range: >60] (-- eGFR UNITS OF MEASURE -- mL/min/1.73m(2)) Comment EGFR: **SEE BELOW** (This test has multiple limitations. Please see www.NorDx.org.)	Edi, Lab In Hlseven
09:54:41	**ETOH Level Resulted**	Collected: **1/12/2022 09:10** Last updated: **1/12/2022 09:54** Status: **Final result** Ethanol Level: **LESS THAN 10 mg/dL** [Ref Range: 0 - 10] (LIMIT OF DETECTION = 10 mg/dL. This report is intended for use in clinical monitoring and management of patients only.)	Edi, Lab In Hlseven
09:54:44	**Lab Resulted**	(Final result) COMPREHENSIVE METABOLIC PANEL	Edi, Lab In Hlseven
09:54:44	**Lab Resulted**	(Final result) ETHANOL LEVEL	Edi, Lab In Hlseven

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
09:55:19	**Neurological**	**Neurological** Neuro (WDL): Exceptions to WDL Neuro Symptoms: Other (Comment) (confusion, speech/word salad) History of LOC?: No Level of Consciousness: Alert; Responds to Voice Orientation Level: Disoriented X4 Speech: Inappropriate words; Delayed responses	Bickford, Stacey, RN
09:57:12	**Vital Signs Simple**	**Vital Signs** BP: **155/101** !	Bickford, Stacey, RN
09:57:12	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 119 mmHg	Bickford, Stacey, RN
10:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2.4	Epic, User
10:00	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
10:00	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 117 mmHg	Bickford, Stacey, RN
10:00	**Device Vitals**	**Device Data** Heart Rate: 93 (Device Time: 09:59:39) Respirations: 14 (Device Time: 09:59:39) SpO2: 95 % (Device Time: 09:59:39) BP: **153/99** ! (Device Time: 10:00:00) Oximeter Pulse: 90 (Device Time: 09:59:39)	Bickford, Stacey, RN
10:08:49	**Orders Modified**	Order Modified - niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) (Comment: Order Modified)	Weems, Patricia, MD
10:10	**Medication Rate/Dose Change**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **7.5 mg/hr** ; Rate: **37.5 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1010** ; Comment: **153/99**	Bickford, Stacey, RN
10:14:43	**Orders Acknowledged**	Modified - niCARdipine 40 mg in 200 mL NS (0.2 mg/mL)	Bickford, Stacey, RN
10:14:50	**Imaging Exam Started**	CTA Head and Neck	Corthell, Emily T, RTR
10:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 2.4	Epic, User
10:15	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
10:15	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 109 mmHg	Bickford, Stacey, RN
10:15	**Device Vitals**	**Device Data** Heart Rate: 96 (Device Time: 10:14:38) Respirations: 16 (Device Time: 10:14:38) SpO2: 97 % (Device Time: 10:14:38) BP: 148/90 (Device Time: 10:15:00) Oximeter Pulse: 97 (Device Time: 10:14:38)	Bickford, Stacey, RN
10:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 3.4	Epic, User
10:36:03	**Imaging Exam Ended**	CTA Head and Neck	Wiggin, Aaron

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

10:37	**Medication Rate/Dose Change**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **10 mg/hr** ; Rate: **50 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1037** ; Comment: **161 82**	Bickford, Stacey, RN
10:37:19	**Vital Signs Simple**	**Vital Signs** BP: 161/82	Bickford, Stacey, RN
10:37:19	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 108 mmHg	Bickford, Stacey, RN
10:43	**Print Lab Req / Collect Drugs of Abuse Screen, Ur Completed**	Drugs of Abuse Screen, Ur - Type: **Urine**	Bickford, Stacey, RN
10:43	**Print Lab Req / Collect Urinalysis Reflex Sediment + Culture Completed**	Urinalysis Reflex Sediment + Culture - Type: **Urine**	Bickford, Stacey, RN
10:43	**Specimens Collected**	Urinalysis Reflex Sediment + Culture - ID: **V31205223:7** Type: **Urine** Drugs of Abuse Screen, Ur - ID: **V31205223:8** Type: **Urine**	Bickford, Stacey, RN
10:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 3.4	Epic, User
10:45	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
10:45	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 108 mmHg	Bickford, Stacey, RN
10:45	**Device Vitals**	**Device Data** Heart Rate: 106 (Device Time: 10:44:38) Respirations: 19 (Device Time: 10:44:38) SpO2: 96 % (Device Time: 10:44:38) BP: 147/88 (Device Time: 10:45:00) Oximeter Pulse: 105 (Device Time: 10:44:38)	Bickford, Stacey, RN
10:52	**Medication Rate/Dose Change**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **12.5 mg/hr** ; Rate: **62.5 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1052** ; Comment: **147/88**	Bickford, Stacey, RN
10:54:39	**ED Notes**	Speech is clear but word salad. Is following directions better than on arrival.	Bickford, Stacey, RN
10:55:18	**CTA Head and Neck Resulted**	Collected: **1/12/2022 10:15** Last updated: **1/12/2022 10:55** Status: **Final result**	Edi, Rad Results In
10:55:26	**Imaging Final Result**	CTA Head and Neck	Edi, Rad Results In
10:55:26	**CT Final Result**	(Final result) CT ANGIOGRAM HEAD NECK	Edi, Rad Results In
10:55:27	**Intake/Output**	**Urine Output** Urine Output (mL): 150 mL	Bickford, Stacey, RN
11:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 3.4	Epic, User
11:00	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
11:00	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 103 mmHg	Bickford, Stacey, RN
11:00	**Device Vitals**	**Device Data** Heart Rate: 110 (Device Time: 10:59:37) Respirations: 14 (Device Time: 10:59:37) SpO2: 96 % (Device Time: 10:59:37) BP: 146/82 (Device Time: 11:00:00) Oximeter Pulse: 110 (Device Time: 10:59:37)	Bickford, Stacey, RN
11:11	**Medication Rate/Dose Change**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **15 mg/hr** ; Rate: **75 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1111**	Bickford, Stacey, RN
11:11:43	**Urinalysis Reflex Sediment + Culture Resulted**	Collected: **1/12/2022 10:43** Last updated: **1/12/2022 11:11** Status: **Final result** Color Ur: **YELLOW** Appearance UR: **CLEAR** Specific Gravity UR: **1.025** [Ref Range: 1.005 - 1.030] Leukocyte Esterase Ur: **NEGATIVE** [Ref Range: NEGATIVE] Nitrite Ur: **NEGATIVE** [Ref Range: NEGATIVE] pH Ur: **5.0** [Ref Range: 5.0 - 8.0] Protein UR: **NEGATIVE mg/dL** [Ref Range: NEGATIVE] Glucose UR QL: **NEGATIVE mg/dL** [Ref Range: NEGATIVE] Ketones Ur Ql: **NEGATIVE** [Ref Range: NEGATIVE] Urobilinogen Ur: **NORMAL mg/dL** [Ref Range: NORMAL] Hemoglobin, UR: **NEGATIVE Ery/uL** [Ref Range: NEGATIVE] Urine Sediment: **NOT PERFORMED** Urine Culture Comment: **NOT INDICATED**	Edi, Lab In Hlseven
11:11:45	**Lab Resulted**	(Final result) URINALYSIS REFLEX SEDIMENT + CULTURE	Edi, Lab In Hlseven
11:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 3.4	Epic, User
11:15	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
11:15	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 110 mmHg	Bickford, Stacey, RN
11:15	**Device Vitals**	**Device Data** Heart Rate: 111 (Device Time: 11:14:37) Respirations: 21 (Device Time: 11:14:37) SpO2: 93 % (Device Time: 11:14:37) BP: 163/84 (Device Time: 11:15:00) Oximeter Pulse: 112 (Device Time: 11:14:37)	Bickford, Stacey, RN
11:17:24	**Intake/Output**	**Urine Output** Urine Output (mL): 300 mL	Sawyer, Derica D, RN
11:18:23	**ED Provider Notes**	Note originally filed at this time	Weems, Patricia, MD
11:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
11:30:50	**Orders Placed**	CT Head WO Contrast	Weems, Patricia, MD
11:30:53	**CT Ordered**	CT HEAD WO CONTRAST	Weems, Patricia, MD
11:30:53	**Imaging Exam Ordered**		Weems, Patricia, MD
11:30:53	**Imaging Exam Ordered**		Weems, Patricia, MD

ED Care Timeline (continued)

11:36:49	**Drugs of Abuse Screen, Ur Resulted**	**Abnormal Result** Collected: **1/12/2022 10:43** Last updated: **1/12/2022 11:36** Status: **Final result** THC Screen Ur: **DETECTED** ! (LOD: 50 ng/mL) Phencyclidine Screen UR: **NOT DETECTED** (LOD: 25 ng/mL) Cocaine Metabolite Screen UR: **NOT DETECTED** (LOD: 150 ng/mL) Methamphetamine Screen: **NOT DETECTED** (LOD: 500 ng/mL) Opiate Screen UR: **NOT DETECTED** (LOD: 100 ng/mL) Amphetamine Screen Ur: **NOT DETECTED** (LOD: 500 ng/mL) Benzodiazepine Screen UR: **NOT DETECTED** (LOD: 150 ng/mL) Tricyclic Antidepressants Ur: **NOT DETECTED** (LOD: 300 ng/mL) Methadone Screen UR: **NOT DETECTED** (LOD: 200 ng/mL) BarbitURates Screen UR: **NOT DETECTED** (LOD: 200 ng/mL) Oxycodone Screen UR: **NOT DETECTED** (LOD: 100 ng/mL) Propoxyphene Screen UR: **NOT DETECTED** (LOD: 300 ng/mL) Buprenorphine Screen UR: **NOT DETECTED** (LOD: 10 ng/mL) SPECIFIC GRAVITY UR, POC: **1.025** [Ref Range: 1.003 - 1.035] pH UR Tox: **5.0** [Ref Range: 4.5 - 9.0] Comment Toxicology: **see below** (Test results are unconfirmed unless otherwise indicated. This report is intended for clinical monitoring and management of patients. It is not intended for non-medical use such as employment or forensic testing. LOD= Limit of detection For help with interpretation please call: 877-323-0045)	Edi, Lab In Hlseven
11:36:50	**Lab Resulted**	(Final result) DRUGS OF ABUSE SCREEN UR	Edi, Lab In Hlseven
11:38:57	**Orders Acknowledged**	New - CT Head WO Contrast	Bickford, Stacey, RN
11:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
11:45	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
11:45	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 117 mmHg	Bickford, Stacey, RN
11:45	**Device Vitals**	○ **Device Data** Heart Rate: 110 (Device Time: 11:44:36) Respirations: 17 (Device Time: 11:44:36) SpO2: 96 % (Device Time: 11:44:36) BP: **156/98** ! (Device Time: 11:45:00) Oximeter Pulse: 111 (Device Time: 11:44:36)	Bickford, Stacey, RN
12:00	**Predictive Model Scores**	**Fall Risk Model Score** Fall Risk Model Score: 2.3	Epic, User
12:01	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
12:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
12:15	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Bickford, Stacey, RN
12:15	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 102 mmHg	Bickford, Stacey, RN

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
12:15	Device Vitals	**Device Data** Heart Rate: 99 (Device Time: 12:14:36) Respirations: 19 (Device Time: 12:14:36) SpO2: 92 % (Device Time: 12:14:36) BP: 141/83 (Device Time: 12:15:00) Oximeter Pulse: 96 (Device Time: 12:14:36)	Bickford, Stacey, RN
12:30	Sepsis/DI Scores	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
12:30	Vitals Reassessment	**Vitals Assessment** Restart Vitals Timer: Yes	Sawyer, Derica D, RN
12:30	Custom Formula Data	**Other flowsheet entries** MAP (calculated): 103 mmHg	Sawyer, Derica D, RN
12:30	Device Vitals	**Device Data** Heart Rate: 100 (Device Time: 12:29:35) Respirations: 21 (Device Time: 12:29:35) SpO2: 95 % (Device Time: 12:29:35) BP: 142/84 (Device Time: 12:30:00) Oximeter Pulse: 101 (Device Time: 12:29:35)	Sawyer, Derica D, RN
12:45	Sepsis/DI Scores	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 5	Epic, User
12:45	Vitals Reassessment	**Vitals Assessment** Restart Vitals Timer: Yes	Sawyer, Derica D, RN
12:45	Custom Formula Data	**Other flowsheet entries** MAP (calculated): 102 mmHg	Sawyer, Derica D, RN
12:45	Device Vitals	**Device Data** Heart Rate: 91 (Device Time: 12:44:35) Respirations: 21 (Device Time: 12:44:35) SpO2: 93 % (Device Time: 12:44:35) BP: 143/82 (Device Time: 12:45:00) Oximeter Pulse: 95 (Device Time: 12:44:35)	Sawyer, Derica D, RN
12:45:56	Hourly Rounding	**Hourly Rounding** Hourly Rounding Performed: Patient not disturbed - resting with eyes closed **Safety** Bed In Lowest Position: Yes ED stretcher side rail(s) up: Yes ED stretcher number of side rails up: Two Side Rails Call bell/light at bedside: explained use: Yes **Communication** Updated patient/family on plan of care: Yes	Bickford, Stacey, RN
13:00	Sepsis/DI Scores	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.8	Epic, User
13:01:36	Orders Placed	acetaminophen tablet 650 mg	Weems, Patricia, MD
13:15	Sepsis/DI Scores	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.8	Epic, User
13:16:14	Orders Acknowledged	New - acetaminophen tablet 650 mg	Godwin, Vanessa, RN
13:17	Medication Given	acetaminophen tablet 650 mg - Dose: **650 mg** ; Route: **Oral** ; Scheduled Time: **1315**	Godwin, Vanessa, RN

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

13:17	**Data**	**Other flowsheet entries** **Wong-Baker Pain Rating: Hurts whole lot **Pain Scale Used: Faces (Wong Baker)	Godwin, Vanessa, RN
13:19	**Medication New Bag**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **15 mg/hr** ; Rate: **75** mL/hr ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1319**	Godwin, Vanessa, RN
13:28:40	**Assign Nurse**	Godwin, Vanessa, RN assigned as Registered Nurse	Godwin, Vanessa, RN
13:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.8	Epic, User
13:30	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
13:30	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 99 mmHg	Godwin, Vanessa, RN
13:30	**Device Vitals**	**Device Data** Heart Rate: 102 (Device Time: 13:29:33) Respirations: 18 (Device Time: 13:29:33) SpO2: 99 % (Device Time: 13:29:33) BP: 131/83 (Device Time: 13:30:00) Oximeter Pulse: 100 (Device Time: 13:29:33)	Godwin, Vanessa, RN
13:33:59	**Imaging Exam Started**	CT Head WO Contrast	Corthell, Emily T, RTR
13:43:29	**Remove Nurse**	Bickford, Stacey, RN removed as Registered Nurse	Bickford, Stacey, RN
13:43:36	**Intake/Output**	**Urine Output** Urine Output (mL): 200 mL	Godwin, Vanessa, RN
13:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.8	Epic, User
13:48:58	**Imaging Exam Ended**	CT Head WO Contrast	Wiggin, Aaron
13:51:25	**Orders Placed**	HYDROmorphone PF injection 0.5 mg	Weems, Patricia, MD
13:51:44	**Orders Acknowledged**	New - HYDROmorphone PF injection 0.5 mg	Godwin, Vanessa, RN
14:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
14:00	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
14:00	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 96 mmHg	Godwin, Vanessa, RN
14:00	**Device Vitals**	**Device Data** Heart Rate: 94 (Device Time: 13:59:33) Respirations: 22 (Device Time: 13:59:33) SpO2: 93 % (Device Time: 13:59:33) BP: 132/78 (Device Time: 14:00:00) Oximeter Pulse: 101 (Device Time: 13:59:33)	Godwin, Vanessa, RN
14:01:30	**CT Head WO Contrast Resulted**	Collected: **1/12/2022 13:35** Last updated: **1/12/2022 14:01** Status: **Final result**	Edi, Rad Results In
14:01:35	**Imaging Final Result**	CT Head WO Contrast	Edi, Rad Results In

ED Care Timeline (continued)

Time	Event	Details	User
14:01:35	**CT Final Result**	(Final result) CT HEAD WO CONTRAST	Edi, Rad Results In
14:08	**Medication Given**	HYDROmorphone PF injection 0.5 mg - Dose: **0.5 mg** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 20 G Right Antecubital** ; Scheduled Time: **1400**	Godwin, Vanessa, RN
14:08	**Data**	**Other flowsheet entries** **Pain Scale Used: Faces (Wong Baker)	Godwin, Vanessa, RN
14:09	**Device Vitals**	**Device Data** SpO2: **88 %** ! (Patient placed on 2L o2) (Device Time: 14:08:33)	Godwin, Vanessa, RN
14:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
14:15	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
14:15	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 91 mmHg	Godwin, Vanessa, RN
14:15	**Device Vitals**	**Device Data** Heart Rate: 100 (Device Time: 14:14:32) Respirations: 20 (Device Time: 14:14:32) SpO2: 92 % (Device Time: 14:14:32) BP: 126/73 (Device Time: 14:15:00) Oximeter Pulse: 96 (Device Time: 14:14:32)	Godwin, Vanessa, RN
14:19:21	**Orders Placed**	Oxygen - Protocol	Callender, G Sean, MD
14:19:39	**Orders Acknowledged**	New - Oxygen - Protocol	Godwin, Vanessa, RN
14:30	**Medication Rate/Dose Change**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **10 mg/hr** ; Rate: **50 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1430**	Godwin, Vanessa, RN
14:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
14:30	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
14:30	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 89 mmHg	Godwin, Vanessa, RN
14:30	**Device Vitals**	**Device Data** Heart Rate: 100 (Device Time: 14:29:32) Respirations: 19 (Device Time: 14:29:32) SpO2: 94 % (Device Time: 14:29:32) BP: 128/69 (Device Time: 14:30:00) Oximeter Pulse: 100 (Device Time: 14:29:32)	Godwin, Vanessa, RN
14:31:47	**Pain Assessment**	**Pain Re-assessment** Complete Pain Alert: Yes **Pain 1** **Patient Currently in Pain: Resting, eyes closed (Current respiration rate required) (22)	Godwin, Vanessa, RN
14:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

14:45	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
14:45	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 90 mmHg	Godwin, Vanessa, RN
14:45	**Device Vitals**	**Device Data** Heart Rate: 103 (Device Time: 14:44:32) Respirations: 24 (Device Time: 14:44:32) SpO2: 96 % (Device Time: 14:44:32) BP: 121/74 (Device Time: 14:45:00) Oximeter Pulse: 102 (Device Time: 14:44:32)	Godwin, Vanessa, RN
14:52	**Medication New Bag**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Dose: **7.5 mg/hr** ; Rate: **37.5 mL/hr** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1452**	Godwin, Vanessa, RN
15:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
15:00	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
15:00	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 88 mmHg	Godwin, Vanessa, RN
15:00	**Device Vitals**	**Device Data** Heart Rate: 95 (Device Time: 14:59:31) Respirations: 28 (Device Time: 14:59:31) SpO2: 97 % (Device Time: 14:59:31) BP: 115/75 (Device Time: 15:00:00) Oximeter Pulse: 99 (Device Time: 14:59:31)	Godwin, Vanessa, RN
15:08	**Medication Stopped**	niCARdipine 40 mg in 200 mL NS (0.2 mg/mL) - Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital** ; Scheduled Time: **1508** ; Comment: **Per MD**	Godwin, Vanessa, RN
15:14:52	**ED Provider Notes Addendum**	Addendum filed at this time	Weems, Patricia, MD
15:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
15:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
15:30	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
15:30	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 96 mmHg	Godwin, Vanessa, RN
15:30	**Device Vitals**	**Device Data** Heart Rate: 99 (Device Time: 15:29:30) Respirations: 20 (Device Time: 15:29:30) SpO2: 96 % (Device Time: 15:29:30) BP: 126/81 (Device Time: 15:30:00) Oximeter Pulse: 96 (Device Time: 15:29:30)	Godwin, Vanessa, RN
15:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
15:45	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
15:45	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 96 mmHg	Godwin, Vanessa, RN
15:45	**Device Vitals**	**Device Data** Heart Rate: 95 (Device Time: 15:45:30) Respirations: 20 (Device Time: 15:45:30) SpO2: 96 % (Device Time: 15:45:30) BP: 122/83 (Device Time: 15:45:00) Oximeter Pulse: 98 (Device Time: 15:45:30)	Godwin, Vanessa, RN
16:00	**Predictive Model Scores**	**Fall Risk Model Score** Fall Risk Model Score: 5.1	Epic, User
16:00	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
16:00	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 99 mmHg	Godwin, Vanessa, RN
16:00	**Device Vitals**	**Device Data** Heart Rate: 98 (Device Time: 16:00:30) Respirations: 21 (Device Time: 16:00:30) SpO2: 98 % (Device Time: 16:00:30) BP: 126/86 (Device Time: 16:00:00) Oximeter Pulse: 96 (Device Time: 16:00:30)	Godwin, Vanessa, RN
16:01	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7	Epic, User
16:02:52	**Lab Ordered**	HEMOGLOBIN A1C	Weems, Patricia, MD
16:02:52	**Orders Placed**	Hemoglobin A1C	Weems, Patricia, MD
16:02:59	**Admit Disposition Selected**	ED Disposition set to Admitted	Weems, Patricia, MD
16:02:59	**Disposition Selected**		Weems, Patricia, MD
16:06	**Patient class changed**		Deblock, Heidi, MD
16:06:33	**Orders Placed**	Rapid PCR SARS-COV-2 ; Administrative COVID-19 Testing Ordered	Weems, Patricia, MD
16:06:33	**Lab Ordered**	RAPID PCR SARS-COV-2	Godwin, Vanessa, RN
16:10:29	**Orders Acknowledged**	New - Hemoglobin A1C ; Rapid PCR SARS-COV-2 ; Administrative COVID-19 Testing Ordered	Godwin, Vanessa, RN
16:11	**Print Lab Req / Collect Rapid PCR SARS-COV-2 Completed**	Rapid PCR SARS-COV-2 - Type: **Swab**	Godwin, Vanessa, RN
16:11:19	**Admit Disposition Selected**	ED Disposition set to Admitted	Deblock, Heidi, MD
16:11:19	**Disposition Selected**		Deblock, Heidi, MD
16:11:19	**Orders Placed**	Admit to: Inpatient Acute Care ; Medical Necessity 96 Hours Attestation	Deblock, Heidi, MD
16:11:19	**Orders Placed**	Full code	Callender, G Sean, MD

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

Time	Event	Details	User
16:11:25	**Team Member Assigned**	Deblock, Heidi, MD assigned as Admitting	Deblock, Heidi, MD
16:11:25	**Assign Attending**	Deblock, Heidi, MD assigned as Attending	Deblock, Heidi, MD
16:11:25	**Assign Physician**		Deblock, Heidi, MD
16:11:26	**Bed Requested**	Requested: Internal Medicine	Deblock, Heidi, MD
16:11:27	**Bed Request Ready to Plan**	Ready to Plan: Internal Medicine	Deblock, Heidi, MD
16:11:27	**Bed Requested**	Admit to: Inpatient Acute Care - [245049770]	Deblock, Heidi, MD
16:11:27	**Admission Order Placed**	Admit to: Inpatient Acute Care - [245049770]	Deblock, Heidi, MD
16:11:27	**Orders Completed**	Admit to: Inpatient Acute Care ; Medical Necessity 96 Hours Attestation	Deblock, Heidi, MD
16:13:17	**Orders Acknowledged**	New - Admit to: Inpatient Acute Care ; Medical Necessity 96 Hours Attestation ; Full code	Godwin, Vanessa, RN
16:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7 Deterioration Index Score: 39.8	Epic, User
16:21:49	**ED Provider Notes Addendum**	Addendum filed at this time	Weems, Patricia, MD
16:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.7 Deterioration Index Score: 32.7	Epic, User
16:34	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
16:34	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 93 mmHg	Godwin, Vanessa, RN
16:34	**Device Vitals**	**Device Data** Heart Rate: 101 (Device Time: 16:34:29) Respirations: 22 (Device Time: 16:34:29) SpO2: 98 % (Device Time: 16:34:29) BP: 122/78 (Device Time: 16:34:08) Oximeter Pulse: 102 (Device Time: 16:34:29)	Godwin, Vanessa, RN
16:34:54	**IP Bed Assigned**		Carter, Jonathan, RN
16:34:54	**Bed Assigned**	Assigned: WMHS ICU - SCU101/SCU101	Carter, Jonathan, RN
16:34:54	**Hospital bed ready**	Bed Ready: WMHS ICU - SCU101/SCU101	Carter, Jonathan, RN
16:40:32	**Orders Placed**	HYDROmorphone PF injection 0.2 mg	Callender, G Sean, MD
16:41:15	**Orders Acknowledged**	New - HYDROmorphone PF injection 0.2 mg	Godwin, Vanessa, RN
16:43:36	**Hemoglobin A1C Resulted**	Collected: **1/12/2022 16:19** Last updated: **1/12/2022 16:43** Status: **Final result** Hemoglobin A1C: **5.3 %** [Ref Range: 4.5 - 5.7] (Falsely low percent A1c may be seen with abnormal hemoglobin variants or shortened erythrocyte survival (such as hemolysis, blood loss and pregnancy).) Average Plasma Glucose: **105 mg/dL** [Ref Range: 82 - 117]	Edi, Lab In Hlseven
16:43:37	**Lab Resulted**	(Final result) HEMOGLOBIN A1C	Edi, Lab In Hlseven

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

16:45	**Medication Given**	HYDROmorphone PF injection 0.2 mg - Dose: **0.2 mg** ; Route: **Intravenous** ; Line: **Peripheral IV 01/12/22 18 G Left Antecubital**	Godwin, Vanessa, RN
16:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 34.3	Epic, User
16:45	**Data**	**Other flowsheet entries** **Wong-Baker Pain Rating: Hurts whole lot **Pain Scale Used: Faces (Wong Baker) Pasero Opioid-Induced SEDATION Scale (POSS): Awake and alert **Pain 1** **Patient Currently in Pain: Yes	Godwin, Vanessa, RN
16:46:44	**History Reviewed**	Sections Reviewed: Medical	Macaulay, Christina M, PA
16:46:49	**History Reviewed**	Sections Reviewed: Surgical	Macaulay, Christina M, PA
16:47:46	**History Reviewed**	Sections Reviewed: Alcohol, Drug Use, Tobacco	Macaulay, Christina M, PA
16:51:23	**Rapid PCR SARS-COV-2 Resulted**	Collected: **1/12/2022 16:11** Last updated: **1/12/2022 16:51** Status: **Final result** COVID-19 Rapid PCR: **NOT DETECTED** [Ref Range: NOT DETECTED] (This SARS-CoV-2 Nucleic acid test for use on the cobas® Liat® System is an automated real-time RT-PCR assay intended for the rapid in vitro qualitative detection of SARS-CoV-2 virus RNA. This test has not been FDA cleared or approved in the United States; is only for use under the Food and Drug Administration's Emergency Use Authorization. Negative results must be combined with clinical observations, patient history, and/or epidemiological information. Negative results do not preclude SARS-CoV-2 infection and should not be used as the sole basis for diagnosis, treatment or other patient management decisions.)	Edi, Lab In Hlseven
16:51:24	**Lab Resulted**	(Final result) RAPID PCR SARS-COV-2	Edi, Lab In Hlseven
16:58	**Vitals Reassessment**	**Vitals Assessment** Restart Vitals Timer: Yes	Godwin, Vanessa, RN
16:58	**Custom Formula Data**	**Other flowsheet entries** MAP (calculated): 100 mmHg	Godwin, Vanessa, RN
16:58	**Device Vitals**	**Device Data** Heart Rate: 93 (Device Time: 16:58:28) Respirations: 20 (Device Time: 16:58:28) SpO2: 97 % (Device Time: 16:58:28) BP: 129/86 (Device Time: 16:58:00) Oximeter Pulse: 94 (Device Time: 16:58:28)	Godwin, Vanessa, RN
17:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6	Epic, User
17:01	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Deterioration Index Score: 34.3	Epic, User
17:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

17:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User
17:45	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User
18:00	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User
18:11	**Care Handoff**	**Care Handoff** Report Given to: Receiving unit (Sam, RN) Notification Method: Face to face report given	Godwin, Vanessa, RN
18:15	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User
18:27	**Vital Signs Complex**	**Vitals** Temperature : 37.1 °C (98.7 °F) Temp Source: Oral Heart Rate: 106 Oximeter Pulse: 99 HR Source: Monitor BP: **144/92** ! MAP (calculated): 109 mmHg BP Location: Right Arm BP Method: Automatic Patient Position: Semi-Fowlers Head of bed elevated: HOB 30 **Oxygen Therapy** SpO2: 92 % O2 Device: None (Room Air) **Pain 1** **Patient Currently in Pain: Yes Pain At Rest/With Activity: At rest Pasero Opioid-Induced SEDATION Scale (POSS): Awake and alert **Pain Scale Used: Faces (Wong Baker) **Wong-Baker Pain Rating: Hurts whole lot Pain Location: Head Pain Orientation: Left **Pain Type: Acute disease process	Gallinari, Samantha, RN
18:27	**Custom Formula Data**	**Relevant Labs and Vitals** Temp (in Celsius): 37.1	Gallinari, Samantha, RN
18:29	**Patient admitted**	To department WMHS SPECIAL CARE UNIT	Gallinari, Samantha, RN
18:29:53	**SOC Sent to PCP**		Gallinari, Samantha, RN
18:29:53	**Patient admitted**		Gallinari, Samantha, RN
18:29:54	**Charting Complete**		Weems, Patricia, MD
18:29:54	**Charting Complete**		Bickford, Stacey, RN
18:30	**Sepsis/DI Scores**	**Sepsis/Deterioration Model Scores** Sepsis Model Score: 4.6 Deterioration Index Score: 30.8	Epic, User

01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

ED Care Timeline (continued)

18:30:14	**Orders Placed**	Potential palliative needs screen - negative ; Diet NPO ; Reason for no VTE prophylaxis at admission ; NaCl 0.9% infusion ; Neuro checks	Deblock, Heidi, MD
18:30:14	**Orders Placed**	Oxygen Administration ; POC Bedside Glucose Test ; Vital signs ; Notify provider of vital signs - standard parameters ; Bed rest ; Positioning - Head of bed ; Saline lock IV ; ondansetron injection 4 mg	Callender, G Sean, MD
18:30:20	**Orders Completed**	Potential palliative needs screen - negative ; Reason for no VTE prophylaxis at admission	Gallinari, Samantha, RN

H&P Notes

H&P by Huitt, Perri, DO at 1/12/2022 1620

Hospital Medicine

Admission History and Physical

Patient Name:	Todd S. Tilley
Date of Birth:	[redacted]
Age/Gender:	60 y.o. male
Medical Record Number:	[redacted]
Date of Admission:	1/12/2022

Reason for Hospitalization: Intracranial hemorrhage (CMS-HCC)
Primary Care Physician: No primary care provider on file.

CHIEF COMPLAINT:
Chief Complaint
Patient presents with
- Headache
- Confusion

HISTORY OF PRESENT ILLNESS
Todd S. Tilley is a 60 y.o. male with no known past medical history present with confusion and difficulty speaking.

Pre-hospital course: History was obtained from the sister as the patient was unable to provide any history. According to sister patient developed an intermittent headache the week prior to admission with some associated vision changes (unable to characterize changes). In the two days prior to admission headache became constant and localized to the left side of his head. Around 3AM morning of admission patient began "not making sense". He was able to speak in full sentences however the sentences did not make any sense. He did not know how his sister was and he was unable to follow commands. Sister denied any knowledge of fevers, chills, abdominal pain, diarrhea, constipation. He is not vaccinated for COVID. He does not have a PCP and does not have good follow up with the health care system.

First Vitals: Temperature : 36.2 °C (97.2 °F) (01/12/22 0923), Pulse: 103 (01/12/22 0858), Respirations: 18 (01/12/22 0858), BP: **(!) 200/129** (01/12/22 0858), SpO2: 100 % (01/12/22 0858), O2 Device: None (Room Air) (01/12/22 0858)

ED course notable for initial significant hypertension with SBP of 200. He had mild elevation of AST and ALT at 52 and 81 respectively. Etoh level was negative. Mild leukocytosis of 11.4. CT head notable for intracranial hemorrhage of the left temporal lobe with resulting mass effect. This was discussed with MMC neurosurgery and neuro critical care who accepted patient in transfer however no beds were currently available. In the meantime they suggested starting patient on nicardipine drip with goal SBP <140. While in ED patient had a recurrent headache and repeat head imaging was obtained which was unchanged from prior imaging.

At the time of my evaluation the patient had been medicated for his headache with Dilaudid. Appear to be more comfortable but having fluctuating neurological exam. Patient attempting to follow commands but having significant confusion and difficulty with simple commands. Per discussion with ED RN, patient had expressive aphasia but had had improving ability to follow commands while in the emergency department.

PAST MEDICAL HISTORY

Past Medical History:

Diagnosis	Date
• H/O alcohol abuse *per sister - currently only occasional alcohol use - 1/12/2022*	

MEDICATIONS

Home Medication List reviewed and is reliable

Prior to Admission Medications

Prescriptions	Last Dose	Taking?
cyclobenzaprine 10 MG TABS Sig: Take 1 Tab (10 mg total) by mouth 3 times daily as needed for Muscle spasms	Unknown	No
naproxen 500 MG TABS Sig: Take 1 Tab (500 mg total) by mouth 2 times daily	Unknown	No

Facility-Administered Medications: None

ALLERGIES

Patient has no known allergies.

SURGICAL HISTORY

No past surgical history on file.

FAMILY HISTORY

Negative, parents or siblings, for any contributing risk factors.

Family History

Problem	Relation	Name	Age of Onset
• Heart Attack	Father		
• Stroke	Father		
• Dementia	Father		
• Stroke	Mother		

SOCIAL HISTORY

Social History

Socioeconomic History

• Marital status:	Divorced
Spouse name:	Not on file
• Number of children:	Not on file

H&P Notes (continued)

- Years of education: Not on file
- Highest education level: Not on file

Occupational History
- Not on file

Tobacco Use
- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance and Sexual Activity
- Alcohol use: Yes
  Comment: socially
- Drug use: Yes
  Types: Marijuana
- Sexual activity: Not on file

Other Topics Concern
- Not on file

Social History Narrative

Per sister who history was obtained from due to patient's mentation on admission 1/12/2022: Previously incarcerated for 18 years but released >5 years ago. May have had a previous issue with street drugs but not aware of any IV drug use history. Also may have had a history of alcohol abuse but has significantly decreased his alcohol intake and only drinks socially now.

Social Determinants of Health

Financial Resource Strain: Not on file
Food Insecurity: Not on file
Transportation Needs: Not on file
Physical Activity: Not on file
Stress: Not on file
Social Connections: Not on file
Intimate Partner Violence: Not on file

REVIEW OF SYSTEMS:

Unable to be obtained due to patient's mentation at time of admission.

PHYSICAL EXAM

BP 133/79 (Patient Position: Semi-Fowlers) | Pulse 103 | Temp 37.1 °C (98.7 °F) (Oral) | Resp 17 | Wt 116 kg (255 lb 12.8 oz) | SpO2 92%
General: Awake, alert, oriented. No distress. Well-appearing.
Eyes: No scleral icterus. No conjunctival injection or pallor. No lid lag
HENT: Mucous membranes moist. No oral lesions. Normocephalic, atraumatic.
Neck: No lymphadenopathy or masses. No nuchal rigidity.
Cardiovascular: Regular rhythm, normal rate. No murmurs, clicks, or rubs. 2+ pulses. No JVD.
Pulm: No accessory muscle use. Clear to auscultation bilaterally with good air entry.
GI: Non-distended. Normoactive bowel sounds. Soft, non-tender. No guarding, rebound or rigidity. No hepatosplenomegaly.
GU: No costovertebral angle tenderness, urethra not catheterized
Musculoskeletal: Full painless range of motion. No joint swelling or erythema.
Neurological: Cranial nerves II-XII grossly intact, difficulty following commands but face is symmetrical and when able to follow commands appears to be equal. Word salad. Appears to have both expressive and receptive aphasia.

Ability to follow commands appears to be waxing and waning.
Skin: No rashes or lesions. No peripheral edema.
Psych: Unable to evaluate due to his intracranial hemorrhage. Not agitated. Wants to follow commands but having difficulty understanding commands.

Labs: Reviewed and are as follows:

Recent Labs

	01/12/22 0910
NA	140
K	4.2
CREATININE	1.07
BUN	18
CL	103
CO2	25
ANIONGAP	12
GLUCOSE	**120***
CALCIUM	9.2

Recent Labs

	01/12/22 0910
WBC	**11.4***
HGB	16.2
HCT	47.1
PLAT	238

No results for input(s): TROPONINT, CKTOTAL, CKMB in the last 72 hours.

Lab Results

Component	Value	Date
INR	0.9	01/12/2022

Lab Results

Component	Value	Date
PTT	31	01/12/2022

Microbiology:
Rapid covid PCR negative

Imaging: Independently reviewed by me and are significant for:
CT ANGIOGRAM HEAD NECK
IMPRESSION:
The intracranial and cervical vasculature is widely patent. No flow-limiting stenosis or occlusion. No evidence of aneurysm.

CT HEAD WO CONTRAST
IMPRESSION:
Acute intraparenchymal hemorrhage within the left temporal lobe with extension into the overlying subarachnoid spaces. There is associated vasogenic edema with mass effect upon the adjacent cerebral sulci and minimal 1-2 mm left-to-right midline shift.

CT HEAD WO CONTRAST
IMPRESSION:
No significant interval change in the size of the left temporal lobe/subarachnoid hemorrhage.

ECG:
Sinus rhythm, heart rate 94 bpm, QTc 426, LVH

ASSESSMENT AND PLAN

Pt is a 60 y.o. male with no significant past medical history presents with intracranial hemorrhage. Family unaware of any trauma previous to headache or intracranial hemorrhage.

*** Intracranial hemorrhage (CMS-HCC)**
Assessment & Plan
According to sister patient had two days of left-sided headache. Morning of admission patient awoke with significant expressive aphasia and could not recognize his sister. Work up in ED notable for CT head with acute intraparenchymal hemorrhage within the left temporal lobe with extension into the overlying subarachnoid spaces with associated vasogenic edema with mass effect upon the adjacent cerebral sulci and minimal 1-2 mm left-to-right midline shift. CTA head and neck without any vascular abnormalities. MMC neuro critical care was consulted who accepted patient in transfer however no bed was immediately available. In the meantime they have suggested BP control with nicardipine with goal SBP < 140. While waiting of bed in emergency patient again developed severe headache so head was re-imaged and was stable from 4 hours later.

-Admit to SCU for close monitoring
-Q1 hour neuro checks
-Repeat imaging for any neurological changes
-BP control with nicardipine drip
-Awaiting transfer to MMC neuro critical care

Elevated BP without diagnosis of hypertension
Assessment & Plan
Upon arrival in the emergency department patient's blood pressure was noted to be 200/129. EKG shows findings consistent with LVH which may indicate longstanding history of hypertension that is untreated. Patient's sister is unaware of any current medications or health issues. Patient does not currently follow with a PCP.

Blood pressure goals with acute intracranial hemorrhage is systolic of 120-140 x 24 hrs.
Postacute phase will decide on appropriate antihypertensive therapy.

Global Issues
F/E/N - Diet NPO
Prophylaxis - Contraindicated due to intracranial bleed
Home medication reconciliation complete?: completed with sister. Patient is not on any regular medications to her knowledge
Code status - Full Code
Family communication - Spoke with sister and daughter.

Disposition - admit inpatient

COVID-19 Immunization History

No immunizations on file.

Discussed COVID Vaccination during the hospitalization and patient is not vaccinated.

Diagnostic Certainty Review Complete

I spent a total of 70 minutes in patient care today and a total of 45 minutes in Coordination of care regarding intracranial hemorrhage.

Perri M Huitt, DO
1/12/2022
8:01 PM
Pg# 741-3714

Electronically signed by Huitt, Perri, DO at 01/12/22 2002

Discharge Summary Note

Discharge Summary by Callender, G Sean, MD at 1/16/2022 0938

Stephen's Memorial Hospital
Hospitalist Service

Discharge Summary

Patient Name:	Todd S. Tilley
Date of Birth:	[redacted]
Age/Gender:	60 y.o. male
Medical Record Number:	[redacted]
PCP:	No primary care provider on file.

ADMISSION DATE: 1/12/2022

DISCHARGE DATE: 1/16/2022

ATTENDING PHYSICIAN: Callender, G Sean, MD

PRECAUTION ALERT: No drug-resistant organisms identified

PRINCIPAL DIAGNOSIS:
Intracranial hemorrhage (CMS-HCC)

OTHER DIAGNOSES:

Active Hospital Problems

Diagnosis

- Intracranial hemorrhage (CMS-HCC)
- Delirium
- Elevated BP without diagnosis of hypertension

Resolved Hospital Problems

No resolved problems to display.

OPERATIONS/PROCEDURES:

None

CONSULTANTS (providers and services):

Speech, PT, OT

CONDITION ON DISCHARGE:

Code Status: Full

Day of Discharge:
BP 117/84 (Patient Position: Sitting) | Pulse 74 | Temp 36.3 °C (97.3 °F) (Oral) | Resp 18 | Wt 116 kg (255 lb 12.8 oz) | SpO2 100%
Weight 116 kg (255 lb 12.8 oz)
Alert, seems to recognize this provider, seems aware he is in the hospital. Accepting of direction and help.
He requires several demonstrations, but can follow commands if shown what is desired. Normal face, equal strength and coordination. Normal gait and balance.

Functional status:
moderate receptive and expressive aphasias

ALLERGIES:

No Known Allergies

MEDICATIONS:

Current Discharge Medication List

START taking these medications

	Details
acetaminophen 325 MG Tab	Take 3 Tablets (975 mg total) every 6 hours as needed by mouth for Pain or Fever *Qty:* 120 Tablet, *Refills:* 0
carvedilol 3.125 MG Tab	Take 1 Tablet (3.125 mg total) 2 times daily (with meals) by mouth *Qty:* 60 Tablet, *Refills:* 0

lisinopril 20 MG Tab	Take 1 Tablet (20 mg total) daily by mouth *Qty:* 30 Tablet, *Refills:* 0

REASON FOR ADMISSION:
60 y/o male without regular medical care. Girlfriend told pt's daughter that he had been having HA and possibly some word-finding difficulty for weeks. Morning of admission patient awoke with significant expressive aphasia and could not recognize his sister.

HOSPITAL COURSE:
*** Intracranial hemorrhage (CMS-HCC)**
CT head showed L temporal intraparenchymal hemorrhage with extension into the overlying subarachnoid spaces, causing associated vasogenic edema with mass effect andl 1-2 mm left-to-right midline shift.
CTA head and neck without any vascular abnormalities.
MMC neuro critical care initially accepted patient in transfer however no bed was immediately available. BP control with nicardipine with goal SBP < 140 recommended.
While waiting of bed in emergency patient again developed severe headache so head was re-imaged and was stable from 4 hours later. 3rd head CT overnight into 1/13 done for possible mental status change was also stable.
Morning of 1/13 neuro critical care attending felt pt no longer met criteria for transfer to ICU at MMC, and recommended that he have an MRI with contrast looking for stroke and/or other issues amenable to intervention.

MRI brain with contrast showed only the blood--no ischemia, no vascular abnormalities
Moved to oral BP meds 1/13
PT/OT/speech with no concerns other than his expressive and receptive aphasias.

Elevated BP without diagnosis of hypertension
Upon arrival in the emergency department patient's blood pressure was noted to be 200/129. EKG shows findings consistent with LVH which may indicate longstanding history of hypertension that is untreated. Patient's sister is unaware of any current medications or health issues. Patient does not currently follow with a PCP.

Blood pressure goals with acute intracranial hemorrhage is systolic of 120-140 x 24 hrs.
Started lisinopril, carvedilol

Delirium
Pt's girlfriend readily agreed to take him back morning of 1/15, but needed some time to re-open the house that he had built (no water, girlfriend had moved in with her daughter). Pt was very anxious to leave, and was agreeable to having Kristin come to pick him up and take him home to Gail.
Immediately after being told that his daughter was coming to pick him up, he was grateful, thanked us for our care, shook hands and sat down to wait, however a few minutes later, Housekeeping watched him walk out the SCU entrance into the parking lot. The housekeeper called after him but he kept walking away, and was not visible when other staff came out to look for him.
Daughter arrived shortly after pt walked out. She stated that this behavior was not surprising to her at all, and that she had been shocked that he had stayed as long as he did. Daughter stated that pt is wanted by law enforcement, and that this may have been driving his anxiety about leaving.
Medications sent to Walgreens for daughter to pick up.
Pt found at home in Waterboro--a friend saw him walking outside the highschool and picked him up. Pt had called Gail

prior to eloping.
In morning pt was frequently able to get complete and appropriate phrases out, and was clearly able to communicate to staff (and to Gail) his preferences. Family had pt brought back to hospital as they felt he was altered. Upon arrival, pt was no longer able to get any meaningful phrases out, nor was he able to make his wishes known, though he understood quickly when family wanted him to keep quiet.
Gail had initially agreed to let him come home, but with increasing impulsivity and confusion, he would need someone with him 24/7. Gail states she is unable to do this, and neither his daughter nor his brother are willing.
Agreed that pt was confused, and with no safe discharge plan, agreed to keep pt here until family could figure out a better plan. Ultimate plan is to get him to North Carolina to live with his daughter.

Daughter called this morning and asked for discharged. She has made arrangements to get him to North Carolina. Recommended against flying for the next two weeks at least.

Morning of 1/16, pt is calm, cooperative, cheerful. He is sitting in a chair with notes spread out in front of him, on the phone with Gail trying to make plans for his property and belongings. Similar to yesterday afternoon, he will have some words/phrases that seem appropriate, but most are nonsensical.

LAST LABS:
CBC with Differential:
Recent Labs

	01/15/22 0646
WBC	7.3
RBC	4.59
HGB	15.2
HCT	41.7
PLAT	222
MCV	90.8
MCH	33.1
MCHC	**36.5***
RDWCV	12.1
RDWSD	39.9

and BMP:
Recent Labs

	01/15/22 0646
NA	134
K	3.7
CL	99
CO2	23
BUN	17
CREATININE	0.98
BUNCR	17.3
CALCIUM	8.9
GLUCOSE	**108***
ANIONGAP	12