COVID-19 TESTING THIS ADMISSION:
COVID-19 Test Results:
Lab Results

Component	Value	Date
CVDR	NOT DETECTED	01/12/2022

SIGNIFICANT IMAGING:
CT head:

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.

CTA head/neck:
The intracranial and cervical vasculature is widely patent. No flow-limiting stenosis or occlusion. No evidence of aneurysm.

MR brain w and w/o contrast:
Essentially unchanged into proximal hemorrhage within the left temporal/parietal lobe with extension into the overlying subarachnoid spaces. No abnormal enhancement or evidence of acute ischemia.

PENDING LAB TESTS and STUDIES:
Unresulted Labs (From admission, onward)

None

DISPOSITION:
Home with services

PATIENT DISCHARGE INSTRUCTIONS and FOLLOW-UP APPOINTMENTS:
Last Diet Order: Diet regular

PROVIDER TO PROVIDER COMMUNICATION:
Note: This section is a brief summary of major care plan changes and items necessitating follow-up after discharge. Please refer to documentation above for complete details of patient's course and final discharge medication list.

I personally spent over 30 minutes on direct patient care, counseling and coordination of the discharge plan on the day of discharge.

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

Discharge Summary Note (continued)

Electronically signed by Callender, G Sean, MD at 01/16/22 0947

Clinical Notes

Ancillary Note

Topper, Douglas R, SLP at 1/13/2022 1348

SLP Diet Consistency Recommendation
Liquids: Thins (IDDS-0)
Solids: Solids, Easy to Chew (IDDSI-7)
Oral Medications: Regular with liquids

Clinical Swallow Evaluation (CSE) Summary
Todd presented with normal swallow function but with symptoms of receptive/expressive aphasia. Oral Exam: Todd was unable to follow spoken command but could imitate gesture. Facial and tongue symmetrical. Lips, jaw, and tongue strength, speed, and ROM were WNL. Oral control of bolus was WNL during 3ozH2o swallow screening which he passed. Mastication speed was reduced due edentulous state, has upper dentures. Oral transport of bolus appeared well time with intimation of pharyngeal swallow. Laryngeal elevation was observed suggesting adequate laryngeal vestibular closure and reduced risk of laryngeal penetration/aspiration. Todd was able to feed himself. Significant difficulty understanding oral commands suggested receptive language difficulty with Ideational apraxia and diminished expressive language. Further aphasia assessment appears warranted.

Electronically signed by Topper, Douglas R, SLP at 01/13/22 1409
Electronically signed by Callender, G Sean, MD at 01/13/22 1459

Callina, Tovah, RN at 1/13/2022 1514

	01/13/22 1500
Patient Assessment	
Review Category	Initial
Patient Class	Acute
Patient Origin	Non Healthcare Facility Point of Origin
Discharge Plan	
Post Discharge Level of Care	*(TBD)*
Anticipated Discharge Needs	Other

Admit Note/Today's Plan/ Patient Discharge Goals and Plan:
Pt presented to the ED with confusion and a headache. Pt woke at 3 am not making sense and was unable to follow commands. BP was elevated to 200/129. Head CT showed intercranial hemorrhage of the left temporal lobe with

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

Clinical Notes (continued)

mass effect. Neurosurgery consulted, nicardipine drip recommended. Dilaudid IV ordered for headache. BP improved with drip, later discontinued. MRI of the brain confirmed head CT result.

Pt comes from home, unclear if he lives with anyone. Sister Tammy and daughter Kristen were updated by Dr.Callender. CM spoke with both Tammy and Kristen, who shared concern that pt doesn't have insurance, and they also were requesting to complete an advance directive for HPOA. CM explained that to complete an advance directive, the pt has to participate and currently pt is not able to do so. Tammy and Kristen also requested access to pts chart via my chart, and again CM explained that the pt would need to be involved in that process. CM notified coverage case manager Libby that family would like assistance with a me care application.

Electronically signed by Callina, Tovah, RN at 01/13/22 1538

Topper, Douglas R, SLP at 1/14/2022 0905

Speech Pathology Bedside Clinical Swallow Evaluation (CSE)

Client: Tilly, Todd S.
Referred by: Callender, G Sean, MD
Diagnosis: Intracranial hemorrhage (CMS-HCC

RECOMMENDATIONS: no further Tx or evaluation of dysphagia
Liquids: Thins (IDDS-0)
Solids: Solids, Easy to Chew (IDDSI-7)
Oral Medications: Regular with liquids

CLINICAL HISTORY: "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. 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....While waiting of bed in emergency patient again developed severe headache so head was re-imaged and was stable from 4 hours later.... 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". (Callender, G Sean, MD at 01/13/22)

ER DIAGNOSES:

Active Hospital Problems
Diagnosis
- Hypertension, unspecified type

SOCIAL:

Clinical Notes (continued)

BEHAVIOR: Alter and cooperative

HEARING/ VISION: Unknown

ORAL MOTOR AND PO Intake Trials:. Oral Exam: Todd was unable to follow spoken command but could imitate gesture. Facial and tongue symmetrical. Lips, jaw, and tongue strength, speed, and ROM were WNL. CN:V-XII appeared intact(Pt poor self reporting). Oral control of bolus was WNL during 3ozH2o swallow screening which he passed. Mastication speed was reduced due edentulous state, has upper dentures. Oral transport of bolus appeared well time with intimation of pharyngeal swallow. Laryngeal elevation was observed suggesting adequate laryngeal vestibular closure and reduced risk of laryngeal penetration/aspiration. Todd was able to feed himself. Significant difficulty understanding oral commands suggested receptive language difficulty with Ideational apraxia and diminished expressive language. Further aphasia assessment appears warranted.

SPEECH: Did not present with dysarthria

IMPRESSIONS: Todd presented with normal swallow function but with symptoms of receptive/expressive aphasia

Recommendations: No further Tx or evaluation of dysphagia.

PLAN: Further evaluation of cognitive/linguistic deficits.

Douglas Topper SLP/CCC
Speech Pathology

Charge: Swallow Evaluation 92610
Time: 47 minutes

Electronically signed by Topper, Douglas R, SLP at 01/14/22 0912

Proctor, Esther, RN at 1/14/2022 1346

	01/14/22 0700
Patient Assessment	
Review Category	Continued Stay
Patient Class	Acute
Hospital Level of Care	Reviewed Insurance Coverage;Adult
Patient Origin	Non Healthcare Facility Point of Origin
Living Status Pre-Admission	Significant Other
Support Systems	Family members
Discharge Risk	Chronically Ill
Discharge Plan	
Post Discharge	*(TBD)*

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

Clinical Notes (continued)

Level of Care	
Anticipated Discharge Needs	*(TBD)*
Type of Discharge Plan	*(TBD)*
Discharge Plan Reviewed with	Patient;Family;Provider
Discharge pharmacy:	Walgreens
Public Health Emergency Waiver	
Discharge to medically necessary Skilled Nursing Facility without the 3 midnights to maintain bed access in order to manage the Public Health emergency in Maine and nationally.	N/A

Continues with expressive aphasia, ? Receptive aphasia. Motions to confirm headache, tylenol. Continues on IV hydration. ST continues to work with patient--communication assessment today. PT/OT evals pending

DC plan: ? Need for acute rehab. Mainecare application submitted today.

TC to Daughter Kristen (with patient's Sister: Tammy also on call) with LCSW Lauren.
Reviewed patient status and evals today. Communication is a challenge at this time. They would be interested in acute rehab for patient, aware that Covid vaccination status may be a deterrant. The final discharge plan they are looking at is for patient to go to his daughter's home in North Carolina. CM to verbally connect with acute rehab today re: patient and will update family early next week.

2pm: CM rec'd a call from Erika Henderson who reports she is the daughter of patient's significant other: Gail. They are aware patient is in the hospital and checking on patient status. Encouraged to contact patient's family for updates

Electronically signed by Proctor, Esther, RN at 01/14/22 1425

Topper, Douglas R, SLP at 1/14/2022 1429

Speech Pathology Aphasia Assessment

Client:Tilley. Todd S, 6/6/1961

Referred by: Callender, G Sean MD
Diagnosis: Global Aphasia Without Hemiparesis (GAWH), (anomia/alexia)
169.120 Aphasia

RECOMMENDATIONS:
Continued Aphasia evaluation and SL- Language and Cognitive Tx
Consideration of neuropsychological testing after 3 weeks recovery

CLINICAL HISTORY: "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. CT head showed L temporal intraparenchymal hemorrhage with extension into the overlying subarachnoid spaces, causing associated vasogenic edema with mass effect and 1-2 mm left-to-right midline shift.
CTA head and neck without any vascular abnormalities..... 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." (Callender, G Sean MD).

ER DIAGNOSES:

Active Hospital Problems
Diagnosis
- Intracranial hemorrhage (CMS-HCC)
- Elevated BP without diagnosis of hypertension

BEHAVIOR: Todd was cooperative and concerned about his current difficulty communicating.

HEARING/ VISION: Unknown

IMPRESSION: Todd presented with Global Aphasia Without Hemiparesis (GAWH), 169.120 Aphasia. Sequela of L temporal intraparenchymal and lesion constellation of subarachnoid hemorrhage (SAH) resulted in poor auditory comprehension limiting this initial evaluation by preventing him from preforming the visual and language portions of Cognitive Linguistic Quick Test (CLQT) cognitive domains. On the Naming subtest, Todd was unable to generate forced naming of pictured objects or read the written word for target object names. He was able to copy the written word, but could not read them aloud or respond to sound or sematic cueing for naming. This suggested that Todd is experiencing severe anomia (word-recall deficit) and alexia (inability to read letters and words).Given left temporal/parietal lobe with left parietal in conceptual processing of object names, Todd may also be experiencing difficulty for retrieval of learnt facts involved in conceptual decisions of object naming. Todd attempted to use gesture for communication things and objects within discourse exchange.

Characteristic of GAWH, although Todd exhibited minimal speech dysfluency, he exhibited marked comprehension impairment, no repetition, and severe naming deficits. This classified him within the least severe GAWH Level-3 with a prognosis of "variable language resolution. but generally characterized by increased narrative fluency, improving auditory comprehension, with inconsistent change in repetition and naming." (Jeurol Neurosurg Psychiatry 1999, 66 pg. 367-8). This suggest SP Tx may be tailored toward spoken discourse and sematic field generation. L-side infarctions are important risk factors in cognitive dysfunction after SAH .....associate with poor performance in global mental status (GMS) (Stroke 1 Jan 2002, pg 200-2009) suggesting the neurocognitive deficit evaluation and Tx may be of benefit to Todd with computer assisted program such as Brain HQ and Elevate under Tx guidance of an SLP.
: .

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

Clinical Notes (continued)

Language Sample from:
"Cookie Thief" language stimulation test : Todd, "um....the um..the um...the um..I don't know how to...she's...she's" .
Spontaneous discourse: : Todd, "my dad um, my dad um", " Something that I ....read, that I read um...my....uh....uh.....uh " clinician cueing, " Is it something your want to wear?", Todd, " ya uh.....I really don't even know."

Douglas Topper SLP/CCC
Speech Pathology

Charge: Aphasia Evaluation 55 min's

Electronically signed by Topper, Douglas R, SLP at 01/15/22 1633
Electronically signed by Callender, G Sean, MD at 01/15/22 1715

Neujahr, Lauren, LCSW at 1/14/2022 1525

High-Risk Screen

	01/14/22 1512
Patient Information	
Primary Caregiver	Self
Support Systems	Spouse/significant other;Family members
Community Care Manager & Mainecare Caseworker Contact Information	
Does the patient have a Community Care Manager, Mainecare Caseworker or Mental Health Support?	No
Values / Beliefs	
Does the patient have cultural request during hospitalization ?	Unknown
Does the patient have spiritual request during hospitalization ?	Unknown
Financial Information	
Income Source	Employed
Insurance Information	Primary

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

Clinical Notes (continued)

Decision Making Capacity	
Patients Level of Capacity/Decision Making Capacity	*(Provider is assessing.)*
Assessment	
Living Status Pre-Admission	Significant Other
Housing Arrangement	House (not own house)
Patient's Discharge Goals/Preferences	Other (comment) *(To be determined.)*
Interventions	
Patient's Pre-Hospital Community Resource	Patient has no community resources in place (prior to hospitalization)
Community Resource Referrals/Information Provided	Other (Comment) *(Potential for acute rehab referral.)*
Financial Resources	Other (Comment) *(Medical outreach case manager involved and submitted MaineCare application.)*
Psychosocial Interventions	Support
Patient/Family has good understanding of Plan of Care?	Yes

Patient meets criteria for a high-risk screen due to potentially complicated discharge. Patient has limited known past medical history; he does not have a PCP. Patient was admitted 1/12/2022 for intracranial hemorrhage.

Patient is noted to have expressive aphasia and was in the process of completing a speech pathology aphasia assessment when social worker attempted to make contact.

Social worker and RN case manager made phone contact with patient's daughter Kristin who has been the primary family contact. She wanted to share that patient's significant other Gail informed the family that patient could not return to her home upon discharge "if he isn't fully functional". It is unclear how long patient has lived with Gail.

Kristin shared that patient has lived a fairly marginalized life. He was incarcerated for a period of time and has lived with his adult children at different periods of his life. Patient has 3 daughters. The eldest is described as estranged, the middle daughter Grace lives in North Carolina, and Kristin is the youngest daughter and lives in North Carolina. Patient has a supportive sister who lives locally (Tammy) and a supportive brother (Dave) who has financially

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

Clinical Notes (continued)

supported the patient in the past.

Family is concerned that patient is essentially homeless. Patient's daughter has agreed for patient to live with her in North Carolina if needed. Family would arrange transportation for him. They are uncertain if patient would be amenable to this plan but they don't foresee another option if patient isn't permitted to return to Gail's home. Furthermore, the family expressed concerns that patient doesn't have running water and they would like to see him in a more supportive environment.

Patient was employed as a security guard prior to admission. The family has collaborated with medical outreach case manager to complete and submit a MaineCare application. Family would be supportive of patient going to acute rehab if he meets criteria and is accepted at a facility. They also reasonably understand that he may be discharged to the community with outpatient follow up.

Patient has been sleeping for much of the day and not available to participate in discharge planning at this time. Social worker will continue to follow.

Electronically signed by Neujahr, Lauren, LCSW at 01/14/22 1547

Phinney, Sharon J, PT at 1/15/2022 1038

PT eval received. Patient demonstrates independent mobility with good balance, no device. He can be independently ambulating in room.

He does have expressive aphasia and perseverates on topics even after staff acknowledges what he is trying to say. When walking in hall he could not relocate his room when I told him which room number he was. Pt is clearly indicating he wants to go home. Treatment team is aware and physician is contacting family.

Recommend outpatient speech therapy if patient is discharged.

Electronically signed by Phinney, Sharon J, PT at 01/15/22 1042

Mills, Yvonne M, RN at 1/15/2022 1614

	01/15/22 1300
Patient Assessment	
Review Category	Continued Stay
Discharge Plan	
Post Discharge Level of Care	*(TBD)*
Anticipated Discharge Needs	*(TBD)*
Discharge Plan Reviewed with	Patient;Family;Provider

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

Clinical Notes (continued)

Patient insists he wants to be discharged today. He asked Dr. Callender to contact Gail in regards to taking him home today. Gail was contacted and agreed to come get him. I called and spoke with Kristin who was upset about him going home. I asked her to come to the hospital so we could discuss further discharge plans. She agreed. While this patient was anxiously waiting to leave, he got dressed and walked out the back door. A housekeeper tried to stop him from leaving. He refused to stay, nursing was then notified. A code Green was called; Law Enforcement, Pace and staff looking for this patient. Family was contacted regarding the situation.
2:00- Family called and stated the patient was found, he had received a ride to Waterford. Patient returned to the hospital for further discharge planning. Dr. Callender, this writer, and family discussed the best plan for this patient.. Todd will stay here one more night until his daughter can drive him safely to North Carolina tomorrow morning to live with his oldest daughter.

Electronically signed by Mills, Yvonne M, RN at 01/15/22 1641

Callina, Tovah, RN at 1/16/2022 0938

Admit Note/Today's Plan/ Patient Discharge Goals and Plan:

CM received a call from pts daughter Kristin. She would like to come pick pt up at 11 am to take him to North Carolina. She requested copies of pts head imaging and medical records- disks will be provided for imaging, CM directed Kristin to contact the medical records dept on Tuesday regarding process for obtaining pts records. Kristin was agreeable to this.

Electronically signed by Callina, Tovah, RN at 01/16/22 0946

Assessment & Plan Note

Callender, G Sean, MD at 1/12/2022 1618

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.
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

Electronically signed by Callender, G Sean, MD at 01/15/22 1727

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

Clinical Notes (continued)

Callender, G Sean, MD at 1/12/2022 1958

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

Electronically signed by Callender, G Sean, MD at 01/15/22 1716

Callender, G Sean, MD at 1/15/2022 1727

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 now 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.

Electronically signed by Callender, G Sean, MD at 01/15/22 1727

Pharmacy Med History Note

Staples, Paula J, CPhT at 1/13/2022 1239

Pharmacy Medication History Note

Name: Todd S. Tilley
DOB [redacted]
Sex: male
Patient Location: [redacted]

Admit date: 1/12/2022 8:53 AM

Medication Interview Source: Family Member was interviewed

Medication History Source: Community Pharmacy, Surescripts, Healthinfonet, Family, and PMP

Medication History Reliability: Reliable

Medication history completed prior to admission orders:
Medication History/ reconciliation completed within 24 hours of admission.

Reporting Below

This note has been completed by a pharmacy intern or pharmacy technician on the Med Transitions Service. This note should not be considered as final until a pharmacist has cosigned it.

Additional Medication Information (recent medication changes, prn use, adherence/access issues)

Current Medication List/Sig/Informant/Taking
None

Number of Meds Reviewed (# pta meds) list):2
Clinically significant changes: 2

Meds added:

Meds removed:2
- Cyclobenzaprine 10 mg tablet by mouth 3 times daily as needed for muscle spasms. (ED 4/18/2017)
- Naproxen 500 mg tabs Take 1 tab by mouth 2 times daily. (ED 4/18/2017)

Meds changed/replaced:None changed

Sister (Tammy) & daughter (Kristen) interviewed via phone as they were together.
No known allergies verified at this time.
Tammy & Kristen both agreed that the patient does not take any maintenance prescription medications.
PMP accessed with no entries found for this patient.

Medication comments documented by: Paula J Staples, CPhT 1/13/2022 at 12:32 PM
Contact number 207-744-6109

Primary Pharmacy:

WALGREENS DRUG STORE #11416 - NORWAY, ME - 53 PARIS ST AT SWC OF FAIR & PARIS
53 PARIS ST
NORWAY ME 04268-5631
Phone: 207-744-0712 Fax: 207-744-0718

Attestation with edits by Powers, Madeleine, PharmD at 01/13/22 1411

I have reviewed and attest that a good-faith effort has been performed in obtaining an accurate Medication History for this patient. The Prior To Admission (PTA) Medications have been updated to reflect any changes discovered. Any clinically significant discrepancies with any inpatient medications have been discussed with the provider.

Electronically signed by Powers, Madeleine, PharmD at 01/13/22 1411
Electronically signed by Powers, Madeleine, PharmD at 01/13/22 1411

Progress Notes

Callender, G Sean, MD at 1/13/2022 1512

Todd S. Tilley
1/13/2022

Hospital Day: 2
Chief Complaint/Reason for Visit: CVA

Assessment/Plan:

*** Intracranial hemorrhage (CMS-HCC)**

Assessment & Plan

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.
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
Move to oral BP tx if pt passes swallow test
PT/OT
Plan for rehab

Elevated BP without diagnosis of hypertension

Assessment & Plan

Clinical Notes (continued)

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.
Start lisinopril, carvedilol

Subjective/24 hour events:
No distress this morning, but SLP felt he was having some HA.
Spoke with sister and daughter--both of them are in agreement that daughter Kristin speak for him for now. They state that his girlfriend does not want him to come back, and they are fearful that people from his current circle of friends might try to take advantage of him.

Scheduled Medications:

• carvedilol	6.25 mg	Oral	BID with meals
• lisinopril	20 mg	Oral	Daily

Objective:
Constitutional:
BP (!) 158/97 | Pulse 85 | Temp 37.3 °C (99.1 °F) (Axillary) | Resp 18 | Wt 116 kg (255 lb 12.8 oz) | SpO2 98%
Temp (24hrs), Avg:36.9 °C (98.4 °F), Min:36.3 °C (97.3 °F), Max:37.3 °C (99.1 °F)

Wt Readings from Last 3 Encounters:
01/12/22 116 kg (255 lb 12.8 oz)

Intake/Output Summary (Last 24 hours) at 1/13/2022 1537
Last data filed at 1/13/2022 1500

	Gross per 24 hour
Intake	600 ml
Output	1400 ml
Net	**-800 ml**

BP Min: 112/57 Max: 184/99
Pulse Avg: 90.5 Min: 74 Max: 109
Resp Avg: 19.3 Min: 13 Max: 28
Appearance: well.

Psych: Awake, alert.
CV: Regular rhythm, normal rate. No murmurs. 2+ pulses. No edema.
Respiratory/Chest: Clear to auscultation, good aeration. No accessory muscle use.
Musculoskeletal: Moving all four extremities spontaneously. No joint swelling or erythema.
Neurological: Word salad, but otherwise no focal deficits. Moving arms and legs equally and easily. Does not understand commands, but sits up and moves easily.
Skin: Good turgor. No rashes or lesions.

IMAGING:
MRI brain with contrast:
Again identified is an intraparenchymal hemorrhage within the left temporal/parietal lobe. Hemorrhage also extends into the overlying subarachnoid spaces/sylvian fissure. The hemorrhage is essentially stable in size compared to the prior CTs. There is
surrounding vasogenic edema with mild effacement of the left lateral ventricle. Minimal 1-2 mm left to right midline shift is stable.

No enhancing lesions identified. No restricted diffusion on the DWI imaging to suggest acute ischemia.

Satisfactory flow-voids are demonstrated within the distal vertebral, basilar, internal carotid arteries into the circle of Willis and proximal cerebral arteries. Satisfactory flow-voids are also demonstrated within the dural venous sinuses.

Visualized orbits and mastoid air cells are normal.

Visualized paranasal sinuses are also normal in appearance.

There is no evidence of a destructive calvarial lesion.

I spent a over 35 minutes in patient care today, over half in coordination of care.

G Sean Callender, MD

Electronically signed by Callender, G Sean, MD at 01/13/22 1537

Callender, G Sean, MD at 1/14/2022 1159

Todd S. Tilley
1/14/2022

Hospital Day: 3
Chief Complaint/Reason for Visit: cva

Assessment/Plan:
*** Intracranial hemorrhage (CMS-HCC)**
Assessment & Plan
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.
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.
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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

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.
Start lisinopril, carvedilol

Subjective/24 hour events:
Much more alert, active, moving easily. Occasionally placing head in hands.

Scheduled Medications:

• carvedilol	6.25 mg	Oral	BID with meals
• lisinopril	20 mg	Oral	Daily

Objective:
Constitutional:
BP 117/83 (Patient Position: Sitting) | Pulse 72 | Temp 37.1 °C (98.8 °F) (Oral) | Resp 20 | Wt 116 kg (255 lb 12.8 oz) | SpO2 96%
Temp (24hrs), Avg:36.8 °C (98.2 °F), Min:36.5 °C (97.7 °F), Max:37.3 °C (99.1 °F)

Wt Readings from Last 3 Encounters:
01/12/22 116 kg (255 lb 12.8 oz)

Intake/Output Summary (Last 24 hours) at 1/14/2022 1159
Last data filed at 1/14/2022 0600

	Gross per 24 hour
Intake	1980 ml
Output	1025 ml
Net	**955 ml**

BP Min: 96/61 Max: 184/99
Pulse Avg: 73.1 Min: 66 Max: 85

Resp Avg: 18.8 Min: 15 Max: 24
Appearance: well

Psych: Awake, alert, oriented. Cannot understand speech.
CV: Regular rhythm, normal rate. No murmurs. 2+ pulses. No edema.
Respiratory/Chest: Clear to auscultation, good aeration. No accessory muscle use.
Musculoskeletal: Moving all four extremities spontaneously. No joint swelling or erythema.
Neurological: No focal deficits other than receptive and expressive aphasia. Moving arms and legs equally and easily. Can follow commands if demonstrated.
Skin: Good turgor. No rashes or lesions.

IMAGING:
MR brain:
Essentially unchanged into proximal hemorrhage within the left temporal/parietal lobe with extension into the overlying subarachnoid spaces. No abnormal enhancement or evidence of acute ischemia.

G Sean Callender, MD

Electronically signed by Callender, G Sean, MD at 01/14/22 1207

Callender, G Sean, MD at 1/15/2022 1724

Todd S. Tilley
1/15/2022

Hospital Day: 4
Chief Complaint/Reason for Visit: Delirium

Assessment/Plan:
*** Intracranial hemorrhage (CMS-HCC)**
Assessment & Plan
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.
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

Delirium

Assessment & Plan

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 now 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.

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.
Started lisinopril, carvedilol

Subjective/24 hour events:

Much more alert, active, moving easily. Occasionally placing head in hands.

Scheduled Medications:

• carvedilol	3.125 mg	Oral	BID with meals
• lisinopril	20 mg	Oral	Daily

Objective:

Constitutional:

BP 148/80 (Patient Position: Semi-Fowlers) | Pulse 81 | Temp 36.7 °C (98.1 °F) (Oral) | Resp 16 | Wt 116 kg (255 lb 12.8 oz) | SpO2 98%

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

Clinical Notes (continued)

Temp (24hrs), Avg:37 °C (98.6 °F), Min:36.6 °C (97.9 °F), Max:37.3 °C (99.1 °F)

Wt Readings from Last 3 Encounters:
01/12/22 116 kg (255 lb 12.8 oz)

Intake/Output Summary (Last 24 hours) at 1/15/2022 1727
Last data filed at 1/15/2022 1018

	Gross per 24 hour
Intake	480 ml
Output	400 ml
Net	**80 ml**

BP Min: 102/66 Max: 148/80
Pulse Avg: 70.4 Min: 66 Max: 81
Resp Avg: 16.3 Min: 16 Max: 18
Appearance: well

Psych: Awake, alert, oriented. Able to understand some questions and answer clearly in the morning. spontaneously. No joint swelling or erythema.
Neurological: No focal deficits. Moving arms and legs equally and easily.

LABS: Reviewed. See Flowsheet.

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:

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

Clinical Notes (continued)

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

I spent over 90 minutes minutes in patient care today well over half of that in coordination of care.

G Sean Callender, MD

Electronically signed by Callender, G Sean, MD at 01/15/22 1728

Subjective & Objective

Callender, G Sean, MD at 1/13/2022 1459

Much more alert, active, moving easily. Occasionally placing head in hands.

Electronically signed by Callender, G Sean, MD at 01/14/22 1158

Imaging

Imaging

CT Head WO Contrast (Final result)

Electronically signed by: **Weems, Patricia, MD on 01/12/22 0900** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Weems, Patricia, MD 01/12/22 0900
Authorized by: Weems, Patricia, MD
Frequency: STAT Once 01/12/22 0859 - 1 occurrence
Quantity: 1
Indications of use: Neuro deficit, acute, stroke suspected
Ordering provider: Weems, Patricia, MD
Ordering mode: Standard
Class: WESTRAD
Lab status: Final result
Indications comment: aphasic, concern for bleed vs stroke, LKW 3am
Instance released by: Weems, Patricia, MD (auto-released) 1/12/2022 9:00 AM

Questionnaire

Question	Answer
Hx of Diabetes, Renal Insuf, Multiple Myeloma?	Unknown
Post Imaging Patient Instruction?	Send Patient Back to Clinic/Floor

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

Imaging (continued)

End Exam Questions

	Answer	Comment
Was this exam performed on a stroke protocol patient?	No	
Was Contrast used for this study?	No	
Lot Number		
Expiration Date		
Reviewed medications?	No	
Comments:		
Was the patient shielded?	Yes	

CT Head WO Contrast — Resulted: 01/12/22 0943, Result status: Final result

Ordering provider: Weems, Patricia, MD 01/12/22 0900
Resulted by: Baril, Robert, DO
Performed: 01/12/22 0920 - 01/12/22 0933
Resulting lab: MH RADIOLOGY
Order status: Completed
Filed by: Edi, Rad Results In 01/12/22 0943
Accession number: 44964306

Narrative:
EXAM: CT HEAD WO CONTRAST

INDICATION: Neuro deficit, acute, stroke suspected. aphasic, concern for bleed vs stroke, LKW 3am

COMPARISON: None.

TECHNIQUE: 2.5 mm contiguous multiplanar MDCT of the brain is obtained without intravenous contrast administration.

FINDINGS:

BRAIN: Acute intraparenchymal hemorrhage within the left temporal lobe with extension into the overlying subarachnoid spaces. There is associated vasogenic edema. The hemorrhage is difficult to measure given that it is in multiple planes, largest portion measuring approximately 4.7 x 3.1 x 2.1 cm. Mild mass effect upon the adjacent cerebral sulci and left lateral ventricle. Minimal 1-2 mm left to right midline shift.

Ventricles are normal in size and configuration.

The paranasal sinuses are clear. Mastoid air cells are clear. No evidence of destructive calvarial lesion.

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.

The above findings were discussed with Dr. Weems at 9:40 AM on 1/12/2022.

WORKSTATION: DRBRADHOME
Home read site:RBG

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1/12/2022 9:41 AM Robert Baril, DO

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
26 - Unknown	MH RADIOLOGY	Unknown	Unknown	10/26/11 1109 - Present

Signed

Electronically signed by Baril, Robert, DO on 1/12/22 at 0943 EST

CTA Head and Neck (Final result)

Electronically signed by: **Weems, Patricia, MD on 01/12/22 0900** — Status: **Completed**

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

Imaging (continued)

This order may be acted on in another encounter.
Ordering user: Weems, Patricia, MD 01/12/22 0900
Authorized by: Weems, Patricia, MD
Frequency: STAT Once 01/12/22 0900 - 1 occurrence
Quantity: 1
Indications of use: Stroke/TIA, assess intracranial arteries, Stroke/TIA, assess extracranial arteries

Ordering provider: Weems, Patricia, MD
Ordering mode: Standard
Class: WESTRAD
Lab status: Final result
Instance released by: Weems, Patricia, MD (auto-released) 1/12/2022 9:00 AM

Questionnaire

Question	Answer
CTA Head Neck Indication?	Non Thrombolytic Candidate
Indication Signs/Symptoms (No Rule Out)	outside of window (6hrs out)
Hx of Diabetes, Renal Insuf, Multiple Myeloma?	No
Post Imaging Patient Instruction?	Send Patient Back to Clinic/Floor

Scan on 1/12/2022 1034 by Wiggin, Aaron: CT CONTRAST CONSENT/SCREENING FORM (below)

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

Imaging (continued)

Stephens Memorial Hospital
Main Health

(5)

Nonionic Intravenous Contrast Consent/ Screening Form

Date: 1.12.2022 MRN: E2955416 Physician: Weems

Patient Name: Tilley, Todd Date of Birth: 6.6.61
Exam Ordered: Head / H+N CTA

Your doctor has ordered an x-ray or Cat Scan. As part of your test, you may need to have a contrast agent called Nonionic Contrast that is injected into a vein. Nonionic Contrast is used to help define normal and abnormal areas.

While most patients have no allergic reactions from the Nonionic injection, allergic reaction may occur. The most common reactions include nausea, vomiting, hives and injection site symptoms. Other reactions include shortness of breath, swelling, chest pain and difficulty breathing. In very rare cases, life-threatening reactions, including death have occurred. **It is important that you tell the technologist right away if you have any of these symptoms.**

I have read and understand the above information. I have been given the chance to ask questions about the x-ray contrast test and risks. I [illegible] consent for the contrast procedure.

Exp: 29 SEP 2024
Lot: 15664561
OMNIPAQUE 350 mgI/mL

IV Contrast Material:

Omnipaque 350 per Radiology Protocol (80 ml) IV @ (B) AC (20 g) INJ@ 1023 @ 4.0 mL/sec

Patient Risk Assessment for IV Contrast Injection

1. Diabetes: Metformin (Glucophage), Advandamet, Metaglip and Glucovance etc.	Yes	No
2. Allergies (please list)	Yes	No
3. Does the patient have any history of allergic reactions during injecting of IV contrast?	Yes	No
4. Asthma	Yes	No
5. Renal Disease (if yes, please obtain serum creatinine)	Yes	No
6. Multiple Myeloma	Yes	No
7. Pregnant (If yes, gestational age)	Yes	No
8. Previous Surgeries i.e.: (Cholecystectomy, Appendectomy, Hysterectomy)?	Yes	No
9. Any medical problems that we should know about? Explain:	Yes	No

Headache / Confusion

Not waiting on labs per Dr. Weems

Date: 1/12/22 BUN 15 Creatinine 1.07 eGFR >60 Age: 60 Wt: 255lbs

Verbal Consent
Patient Signature

Emily T. [signature]
Witness Signature

Date 1/12/2022

Date

SMH Form # 5503 (05/12/20-njw)

End Exam Questions

	Answer	Comment
Was this exam performed on a stroke protocol patient?	No	
Was Contrast used for this study?	Yes	
Lot Number	15664561	
Expiration Date	9/29/2024	
Reviewed medications?	No	

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

Imaging (continued)

Comments:
Was the patient shielded? Yes

CTA Head and Neck Resulted: 01/12/22 1055, Result status: Final result

Ordering provider: Weems, Patricia, MD 01/12/22 0900
Resulted by: Baril, Robert, DO
Performed: 01/12/22 1014 - 01/12/22 1035
Resulting lab: MH RADIOLOGY
Order status: Completed
Filed by: Edi, Rad Results In 01/12/22 1055
Accession numbe[redacted]

Narrative:
EXAM: CT ANGIOGRAM HEAD NECK

INDICATION: outside of window (6hrs out), stroke.

COMPARISON: CT dated 1/12/2022

TECHNIQUE: 2.5 mm contiguous multiplanar MDCT of the head and neck is obtained during the intravenous contrast administration of 80 mL of Omnipaque 350. MIP reconstructed images were created and reviewed.

FINDINGS:

HEAD

INTERNAL CAROTID ARTERIES: No acute findings. Intracranial ICA are patent with no significant stenosis. No occlusion. No aneurysm.

ANTERIOR CEREBRAL ARTERIES: No significant stenosis. No occlusion. No aneurysm.

MIDDLE CEREBRAL ARTERIES: No significant stenosis. No occlusion. No aneurysm.

POSTERIOR CEREBRAL ARTERIES: No significant stenosis. No occlusion. No aneurysm.

BASILAR ARTERY: No significant stenosis. No occlusion. No aneurysm.

VERTEBRAL ARTERIES:No significant stenosis. No occlusion. No aneurysm.

BRAIN: See prior noncontrast CT head report.

NECK

COMMON CAROTID ARTERIES: Appears unremarkable.

INTERNAL CAROTID ARTERIES: Appears unremarkable.

EXTERNAL CAROTID ARTERIES: Appears unremarkable.

VERTEBRAL ARTERIES: The vertebral arteries are patent bilaterally. The left vertebral artery is dominant.

OTHER VASCULATURE: Appears unremarkable.

BONES / JOINTS: No acute fracture. No dislocation.

SOFT TISSUES: Appear unremarkable.

CAROTID STENOSIS REFERENCE USING NASCET CRITERIA:
% ICA stenosis = (1 - narrowest ICA diameter/diameter of distal cervical ICA) x 100.
Mild - <50% stenosis.
Moderate - 50-69% stenosis.
Severe - 70-94% stenosis.
Near occlusion - 95-99% stenosis.
Occluded - 100% stenosis.

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

Imaging (continued)

IMPRESSION:

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

WORKSTATION: DRBRADHOME
Home read site:RBG

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1/12/2022 10:53 AM Robert Baril, DO

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
26 - Unknown	MH RADIOLOGY	Unknown	Unknown	10/26/11 1109 - Present

Signed

Electronically signed by Baril, Robert, DO on 1/12/22 at 1055 EST

CT Head WO Contrast (Final result)

Electronically signed by: **Weems, Patricia, MD on 01/12/22 1130** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Weems, Patricia, MD 01/12/22 1130
Authorized by: Weems, Patricia, MD
Frequency: Timed Once 01/12/22 1600 - 1 occurrence
Quantity: 1
Indications comment: Nsgy/neuro crit care requested repeat at 16:00 assessing for evolvement
Ordering provider: Weems, Patricia, MD
Ordering mode: Standard
Class: WESTRAD
Lab status: Final result
Instance released by: Weems, Patricia, MD (auto-released) 1/12/2022 11:30 AM

Questionnaire

Question	Answer
Hx of Diabetes, Renal Insuf, Multiple Myeloma?	Unknown
Post Imaging Patient Instruction?	Send Patient Back to Clinic/Floor

End Exam Questions

	Answer	Comment
Was this exam performed on a stroke protocol patient?	No	
Was Contrast used for this study?	No	
Lot Number		
Expiration Date		
Reviewed medications?	No	
Comments:		
Was the patient shielded?	Yes	

CT Head WO Contrast Resulted: 01/12/22 1401, Result status: Final result

Ordering provider: Weems, Patricia, MD 01/12/22 1130
Resulted by: Baril, Robert, DO
Performed: 01/12/22 1333 - 01/12/22 1348
Resulting lab: MH RADIOLOGY
Order status: Completed
Filed by: Edi, Rad Results In 01/12/22 1401
Accession number: 44965784

Narrative:
EXAM: CT HEAD WO CONTRAST

INDICATION: Nsgy/neuro crit care requested repeat at 16:00 assessing for evolvement

COMPARISON: 1/12/2022

TECHNIQUE: 2.5 mm contiguous multiplanar MDCT of the brain is obtained without intravenous contrast administration.

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

Imaging (continued)

FINDINGS:

BRAIN: The intraparenchymal hemorrhage within the left temporal lobe extending into the overlying subarachnoid spaces is not significantly changed in size when compared to the prior exam. There is persistent vasogenic edema with mild mass effect upon the
adjacent cerebral sulci. Minimal if any left to right midline shift is unchanged.

There is residual IV contrast in the vessels.

VENTRICLES: Mild effacement of the left lateral ventricle is unchanged.

BONES: Appears unremarkable. No acute fracture.

SINUSES: Unremarkable as visualized. No acute sinusitis.

MASTOID AIR CELLS: Unremarkable as visualized. No mastoid effusion..

IMPRESSION:

No significant interval change in the size of the left temporal lobe/subarachnoid hemorrhage.

WORKSTATION: DRBRADHOME
Home read site:RBG

* * THIS IS AN ELECTRONICALLY VERIFIED REPORT CREATED USING VOICE RECOGNITION * *
1/12/2022 1:59 PM Robert Baril, DO

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
26 - Unknown	MH RADIOLOGY	Unknown	Unknown	10/26/11 1109 - Present

Signed

Electronically signed by Baril, Robert, DO on 1/12/22 at 1401 EST

CT Head WO Contrast (Final result)

Electronically signed by: **Huitt, Perri, DO on 01/12/22 1923** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Huitt, Perri, DO 01/12/22 1923
Authorized by: Huitt, Perri, DO
Frequency: Routine Once 01/12/22 1923 - 1 occurrence
Quantity: 1
Indications of use: Cerebral hemorrhage suspected
Ordering provider: Huitt, Perri, DO
Ordering mode: Standard
Class: WESTRAD
Lab status: Final result
Indications comment: changing neuro exam, eval for changing intracranial hemorrhage
Instance released by: Huitt, Perri, DO (auto-released) 1/12/2022 7:23 PM

Questionnaire

Question	Answer
Hx of Diabetes, Renal Insuf, Multiple Myeloma?	No
Post Imaging Patient Instruction?	Send Patient Back to Clinic/Floor

Scan on 1/12/2022 1957 by Annance, Sarah Ann, RTR: VRAD PRELIM RESULT (below)

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

Imaging (continued)

vRad TWapp13 1/12/2022 6:53:57 PM PAGE 1/002 Fax Server

vRad

Stephens Memorial Hospital - ME
Preliminary Radiology Report

24/7/365 assistance Call: 866.941.5895 Online chat: https://access.vrad.com

Patient Name: TILLEY, TODD
Institution Name: STEPHE NS MEMORIAL HOSPITAL - ME NORWAY, ME 04268
Study Type: CT HEAD WO
Ordered As: CT HEAD WO
Date of Dictation: 12 Jan 2022 EST
Date of Exam: 12 Jan 2022 EST
Patient ID: E2955416
Patient Location: Unknown
Account #:
Accession: [redacted]
Account Number:
Patient DOB: [redacted]
Caretaker:
Referring Physician: HUTT, PERRI
This interpretation is based upon the receipt of 276 images.

PROCEDURE INFORMATION:
Exam: CT Head Without Contrast
Exam date and time: 1/12/2022 7:34 PM
Age: 60 years old
Clinical indication: Condition or disease; Headache and other: Known bleed; Patient HX: Cerebral hemorrhage suspected; Changing neuro exam, eval for changing intracranial hemorrhage

TECHNIQUE:
Imaging protocol: Computed tomography of the head without contrast.
Other technique: STROKE PROTOCOL was implemented.

COMPARISON:
CT HEAD WO CONTRAST (NE) 1/12/2022 1:40 PM

FINDINGS:
Brain: Again identified is a intraparenchymal cerebral hemorrhage involving the left-sided temporal lobe and parietal lobe which appears similar in size compared to the prior examination. Additional areas of increased density are also present along the sylvian fissure consistent with subarachnoid extension. This finding is also unchanged. Mild edema is present throughout the left temporal lobe. Mild midline shift to the right side is present currently measuring at 1-2 mm which is unchanged. No new areas of hemorrhage are seen. The approximate size of the hemorrhage is 5.2 x 2.8 cm.
Cerebral ventricles: No ventriculomegaly.
Paranasal sinuses: Visualized sinuses are unremarkable. No fluid levels.
Mastoid air cells: Visualized mastoid air cells are well aerated.
Bones/joints: Unremarkable. No acute fracture.
Soft tissues: Unremarkable.

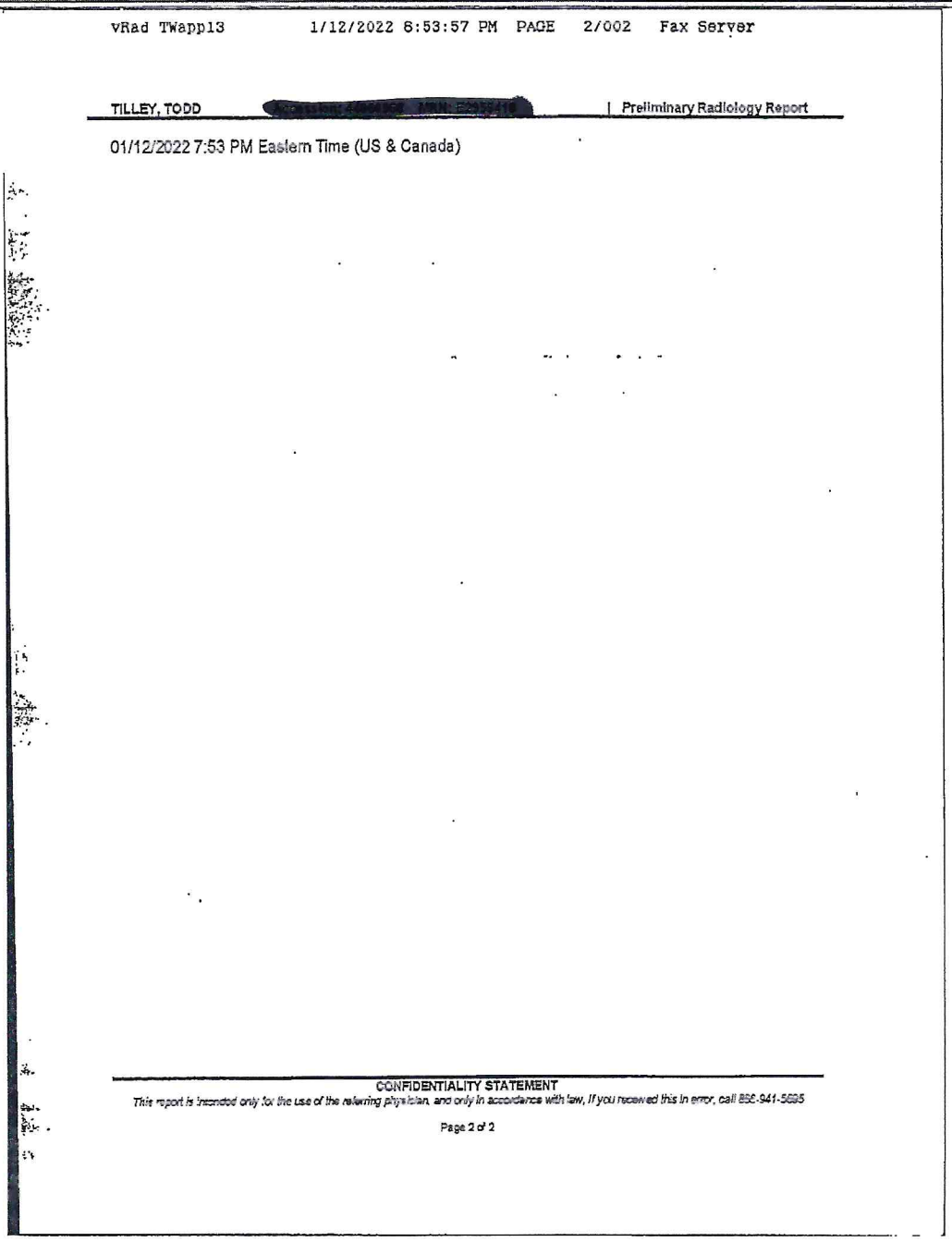
IMPRESSION:
Stable intracranial cerebral hemorrhage.
ASSESSMENT:
ASPECTS (Alberta Stroke Program Early CT Score) is 10

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Molina, Carlos, MD

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

Imaging (continued)



vRad TWapp13 1/12/2022 6:53:57 PM PAGE 2/002 Fax Server

TILLEY, TODD [redacted] | Preliminary Radiology Report

01/12/2022 7:53 PM Eastern Time (US & Canada)

CONFIDENTIALITY STATEMENT

This report is intended only for the use of the referring physician, and only in accordance with law. If you received this in error, call 866-941-5695

Page 2 of 2

End Exam Questions

	Answer	Comment
Was this exam performed on a stroke protocol patient?	No	
Was Contrast used for this study?	No	
Lot Number		
Expiration Date		
Reviewed medications?	No	

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

Imaging (continued)

Comments:
Was the patient shielded? No

CT Head WO Contrast Resulted: 01/13/22 0755, Result status: Final result

Ordering provider: Huitt, Perri, DO 01/12/22 1923
Resulted by: Baril, Robert, DO
Performed: 01/12/22 1932 - 01/12/22 1945
Resulting lab: MH RADIOLOGY
Order status: Completed
Filed by: Edi, Rad Results In 01/13/22 0756
[redacted]

Narrative:
EXAM: CT HEAD WO CONTRAST

INDICATION: Cerebral hemorrhage suspected. changing neuro exam, eval for changing intracranial hemorrhage

COMPARISON: 1/12/2022

TECHNIQUE: 2.5 mm contiguous multiplanar MDCT of the brain is obtained without intravenous contrast administration.

FINDINGS:

BRAIN: Again demonstrated is an intraparenchymal hemorrhage within the left temporal/parietal lobe which is similar in size compared to the most recent exam, measuring approximately 5.0 x 2.8 cm. Again seen is extension of the hemorrhage into the overlying subarachnoid space. Mild vasogenic edema with minimal midline shift to the right measuring 1-2 mm.

VENTRICLES: Effacement of the left lateral ventricle is unchanged. No hydrocephalus.

BONES: Appears unremarkable. No acute fracture.

SINUSES: Unremarkable as visualized. No acute sinusitis.

MASTOID AIR CELLS: Unremarkable as visualized. No mastoid effusion..

IMPRESSION:

Stable intraparenchymal hemorrhage within the left temporal/parietal lobe.

Findings concordant with the preliminary radiology report.

WORKSTATION: DRBRADHOME
Home read site:RBG

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1/13/2022 7:53 AM Robert Baril, DO

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
26 - Unknown	MH RADIOLOGY	Unknown	Unknown	10/26/11 1109 - Present

Signed

Electronically signed by Baril, Robert, DO on 1/13/22 at 0755 EST

MR Brain W WO Contrast (Final result)

Electronically signed by: **Callender, G Sean, MD on 01/13/22 1209** Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Callender, G Sean, MD 01/13/22 1209
Authorized by: Callender, G Sean, MD
Frequency: Routine Once 01/13/22 1210 - 1 occurrence
Quantity: 1
Indications of use: Stroke, follow up
Ordering provider: Callender, G Sean, MD
Ordering mode: Standard
Class: WESTRAD
Lab status: Final result
Instance released by: Callender, G Sean, MD (auto-released) 1/13/2022 12:09 PM

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

Imaging (continued)

Questionnaire

Question	Answer
Hx of Diabetes, Renal Insuf?	No
Post Imaging Patient Instruction?	Send Patient Back to Clinic/Floor

Screening Form

General Information

Patient Name: Tilley, Todd S.
Date of Birth: 6/6/1961
Legal Sex: Male

MRN: E2955416
Mobile: 207-461-0780

Procedure	Ordering Provider	Authorizing Provider	Appointment Information
MR BRAIN W WO CONTRAST	Callender, G Sean, MD 207-743-5933	Callender, G Sean, MD 207-743-5933	1/13/2022 1:20 PM WMHS MAIN MR WMHS MR IMAGING

Screening Form Questions

	Answer	Comment
Please enter your name and date after you have verified the patient's identity (name and DOB):	Henry Raymond 1/13/21	
Height?	6feet	
Weight? Please indicate in lbs.	255	
Cardiac pacemaker?	No	
Implanted cardiac defibrillator?	No	
Have you ever been injured by a metal object or foreign body (bullet, BB, shrapnel)?	No	
If yes, please describe injury:		
Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings or other metal objects)?	No	
If yes, is there previous clearance by imaging after date of injury (check FYI)?		
If no, are facial xrays scheduled?		
Do you have a history of renal failure or renal insuffiency?	No	
Are you diabetic? If yes, a GFR must be calculated to determine your risk of receiving contrast.	No	
Have you ever had a surgical operation or procedure of any kind, including cardiac catheterization, or an angiogram?	No	
If yes, list all prior surgeries and approximate dates:		
Any type of electronic or mechanical implant?	No	
Type:		
Any implanted items such as pins, rods, screws, nails, plates, wires, spinal fixation device or any other implanted item?	No	
Type:		
Aneursym clip?	No	
Clip Location? If brain follow guidelines.		
Neurostimulators or biostimulators?	No	
Any type of internal electrodes or wires?	No	
Cochlear implant or any type of ear implant?	No	
If yes, please describe:		
External or implanted drug pump (eg. insulin, baclofen, chemotherapy, pain medicine)	No	
If yes, can it be disconnected?		

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

Imaging (continued)

At MMC, if Flolan pump, coordinate with the nursing coverage with R7, ext 2708		
Artificial heart valve?	No	
Make and model of heart valve:		
Any type of coil, filter or stent?	No	
Date inserted and manufacturer:		
Any identifying information (model, name, lot):		
Penile implant?	No	
Make, model and lot:		
Artificial eyes?	No	
Make, model and lot:		
Eyelid implant or spring?	No	
Make, model and lot:		
Permanent retainer, palate expander or herbst appliance?	No	
List appliance:		
Do you have any external fixation devices or halo vest?	No	
Shunt?	No	
Manufacturer and model:		
Any body piercing? If yes, follow guidelines.	No	
Location:		
Medication patch?	None	
If other, please indicate:		
Tattoo?	None	
If yes, please indicate:		
Who provided the answers for the Screening Form?	Other	Sister
If other than patient, enter name and phone number:	Tammy Laidlaw 890-4779	
Technologist: Did you supply earplugs or headphones during the MRI examination? Patients may find noise levels unacceptable and the noise levels may affect hearing wihtout protection.	Yes	
Technologist: jewelry removed (e.g. necklace,pins,rings)?	None Present	
Technologist: hairpins, bobby pins, barrettes, clips, wigs, etc. removed?	None Present	
Technologist: Dentures, false teeth and/or partial dental plates removed?	None Present	
Technologist: Hearing aids removed?	None Present	
Technologist: Eyeglasses removed?	None Present	
Technologist: Watches, pagers, cell phones or cards with magnetic strips (e.g. credit, bank, gift cards) removed?	None Present	
Technologist: Body piercings removed? Follow screening guidelines.	None Present	
Technologist: Clothing with metal fasteners, zippers, etc. removed? Use gown if necessary.	None Present	
Technologist: If patient has been transported on stretcher, have you rolled patient and checked sheets and blankets for any metallic objects?	None Found	

Proceed with Exam

Proceed?	User	Time
Proceed	Tracy,Susan	01/13/2022 01:17 PM EST

Shared Electronic Health Record

MRI Screening Questionnaire

3 0 0 0 6 3

General Information

Patient Name: Tilley, Todd S.
[redacted]
Legal Sex: Male

Procedure	Ordering Provider	Authorizing Provider	Appointment Information
MR BRAIN W WO CONTRAST	Callender, G Sean, MD 207-743-5933	Callender, G Sean, MD 207-743-5933	1/13/2022 1:20 PM WMHS MAIN MR WMHS MR IMAGING

Patient Signature _____ Date _____ MRI Technologist Signature _____ Date _____

Scan on 1/13/2022 1339 by Clark, Douglas, RTR(M): Contrast consent (below)

Stephens Memorial Hospital
MaineHealth

MRI Contrast Consent Form

Patient Name Tilley, Todd

Your doctor has ordered a Magnetic Resonance Imaging Test (MRI). As part of your MRI test, you may need to have a contrast agent called Gadolinium injected into a vein. Gadolinium is used to help define normal and abnormal areas.

While most patients have no unusual reactions from the Gadolinium injection, a few risks are involved. The most common reactions include headache, nausea, vomiting, dizziness and injection site symptoms. Reactions that are more rare include rash, hives, tissue swelling, chest pain, and trouble breathing. In very rare cases, life-threatening reactions, including death have occurred. It is **important that you tell the technologist right away if you have any of these symptoms.**

I have read and understand the above reactions. I have been given the chance to ask questions about the MRI test and any risks. I give my consent for the contrast procedure.

Verbal — Patient Signature — 1/13/22 — Date

Witness Signature — 1/13/22 — Date

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

Imaging (continued)

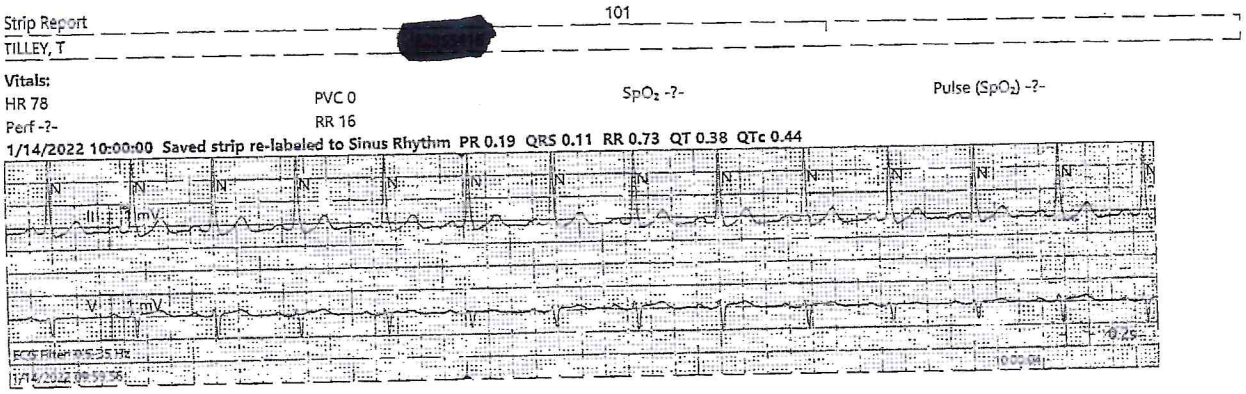
Cardiology

Cardiac Services

TELEMETRY (SCAN) (Final result)

Electronically signed by: **Edi, Scans on 01/12/22 0000**
Ordering user: Edi, Scans 01/12/22 0000
Authorized by: Scanprovider, Unknown
Frequency: -
Lab status: Final result
Status: **Completed**
Ordering provider: Scanprovider, Unknown
Ordering mode: Standard
Quantity: 1

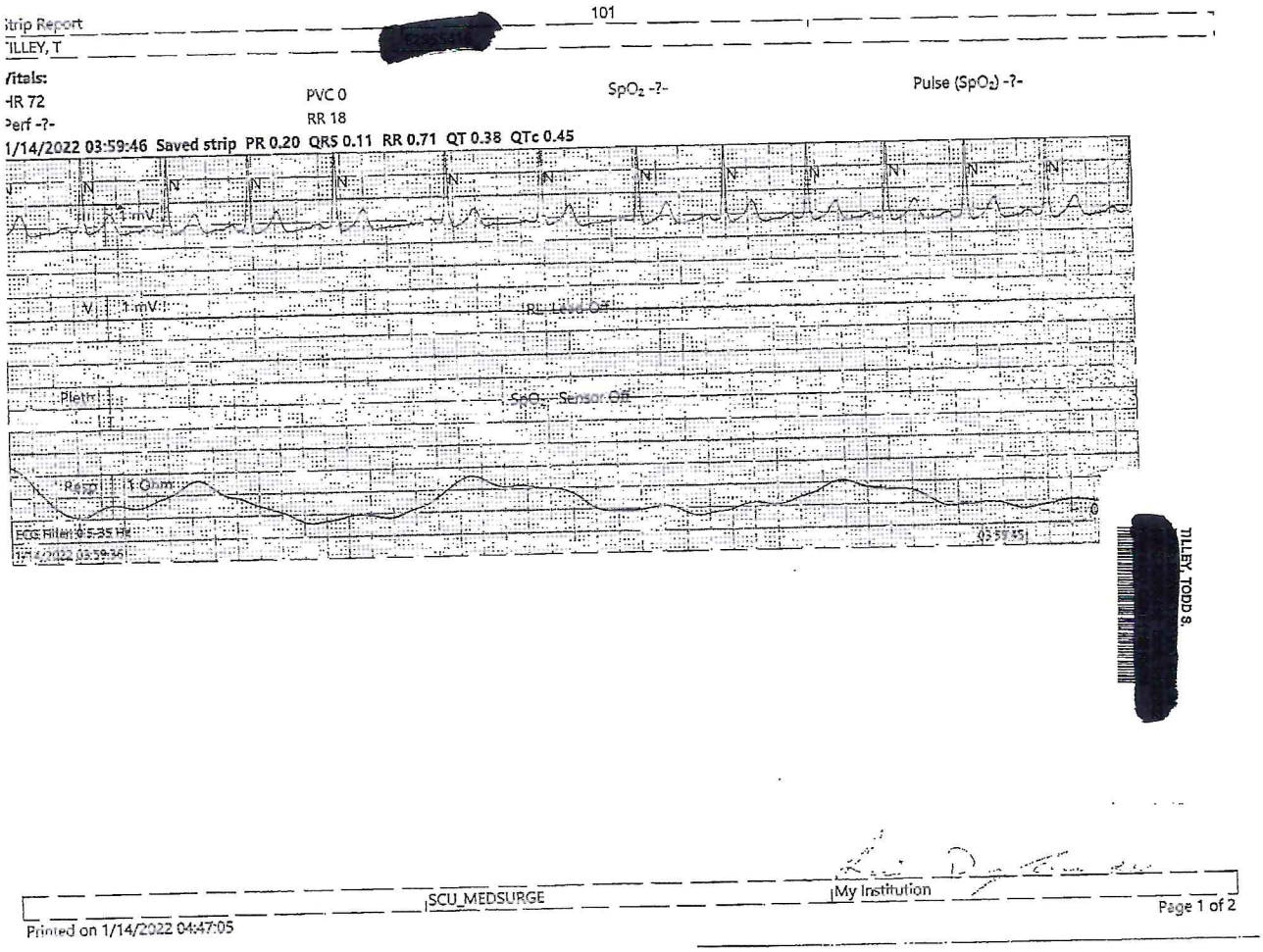
Scan on 1/18/2022 0815 (below)



Caroline Michaud, RN SCU_MEDSURGE My Institution
Printed on 1/14/2022 10:25:57

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

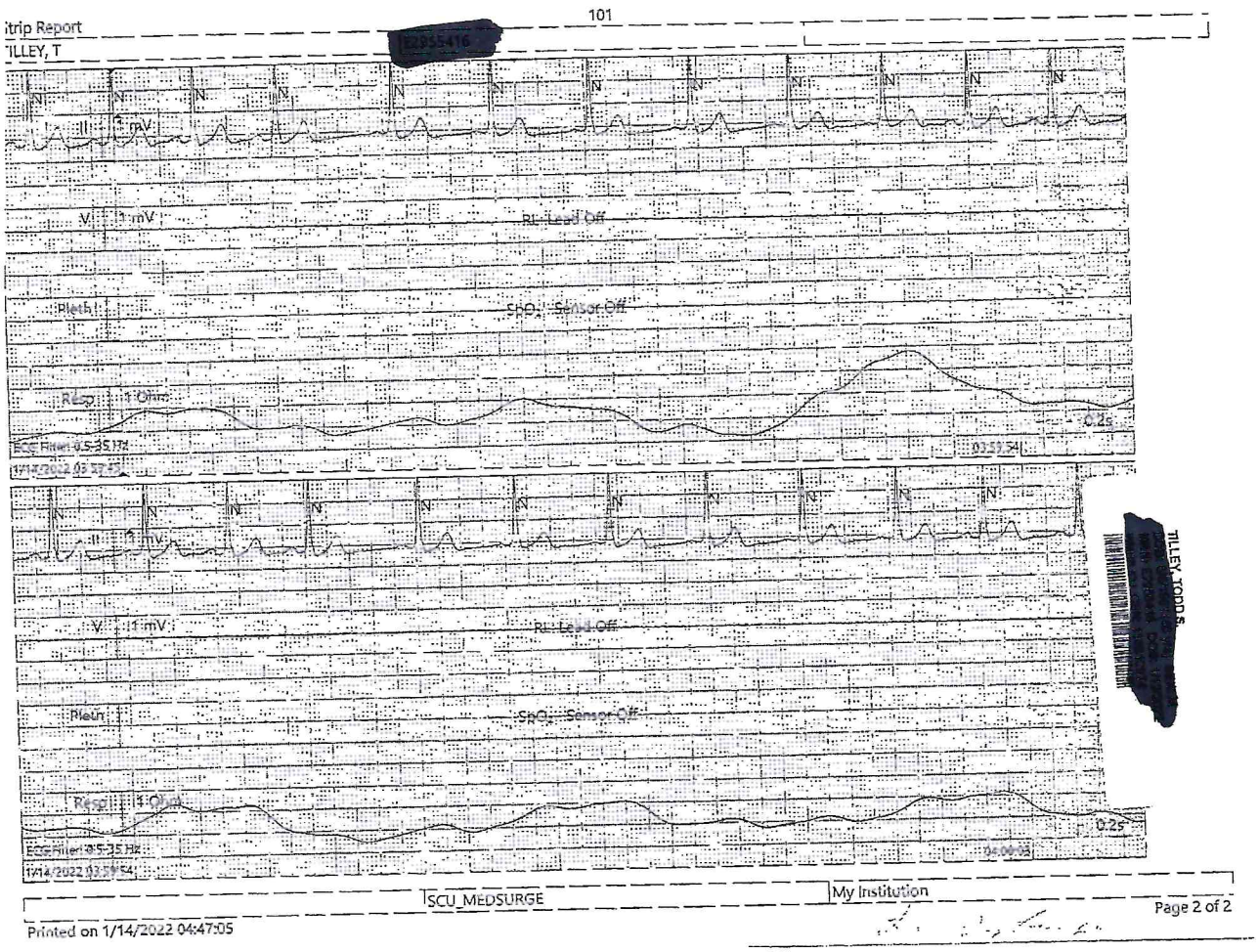
Cardiology (continued)



Tilley, Todd S.
[redacted] Sex: M
Adm: 1/12/2022, D/C: 1/16/2022

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

Cardiology (continued)



Tilley, Todd S.
[redacted] Sex: M
Adm: 1/12/2022, D/C: 1/16/2022

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

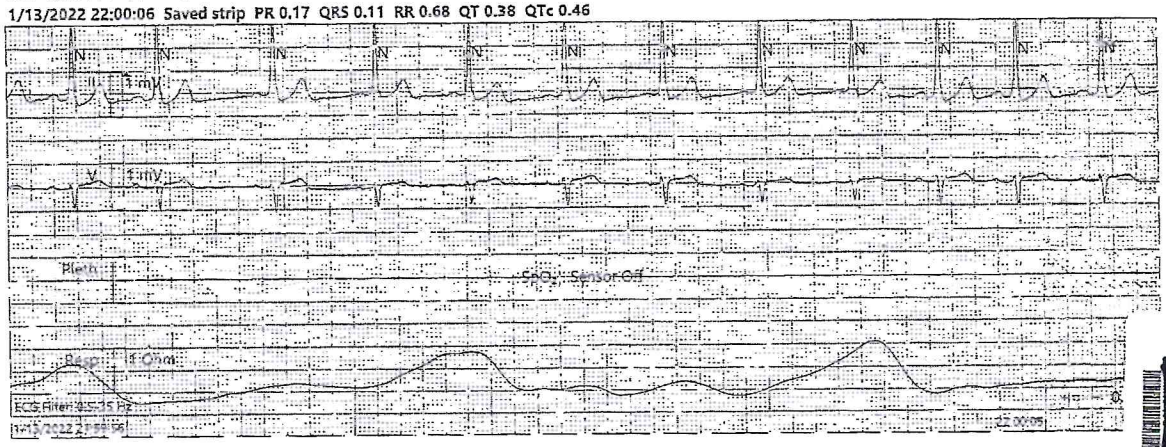
Cardiology (continued)

Strip Report 101
TILLEY, T [redacted]

Vitals:

HR 75 PVC 0 SpO_2 -?- Pulse (SpO_2) -?-
Perf -?- RR 21
NBP 161/91 (111) (22:00) Pulse (NBP) 70 (22:00)

1/13/2022 22:00:06 Saved strip PR 0.17 QRS 0.11 RR 0.68 QT 0.38 QTc 0.46



TILLEY, TODD S. [redacted]

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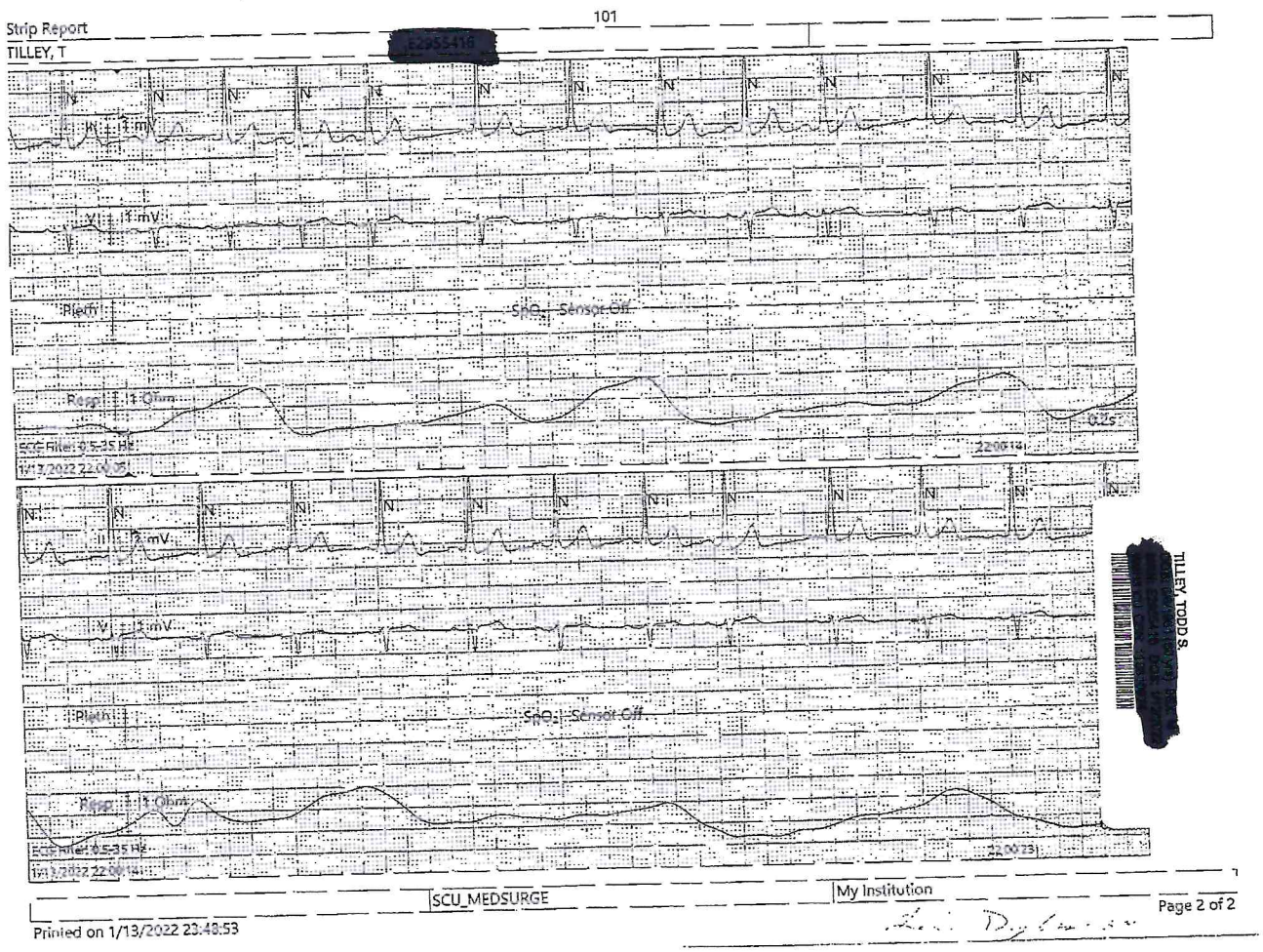
Printed on 1/13/2022 23:48:53

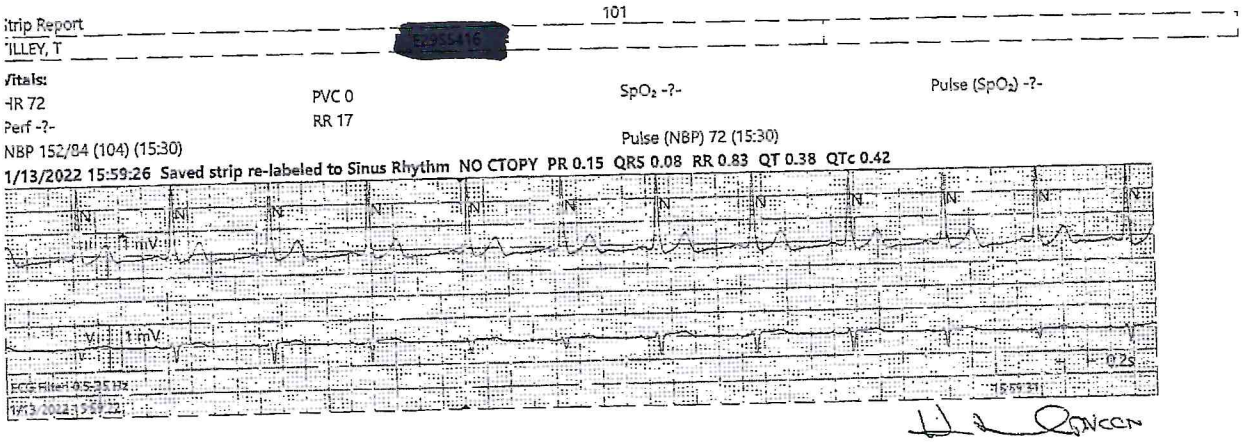
01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

Cardiology (continued)



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

Cardiology (continued)



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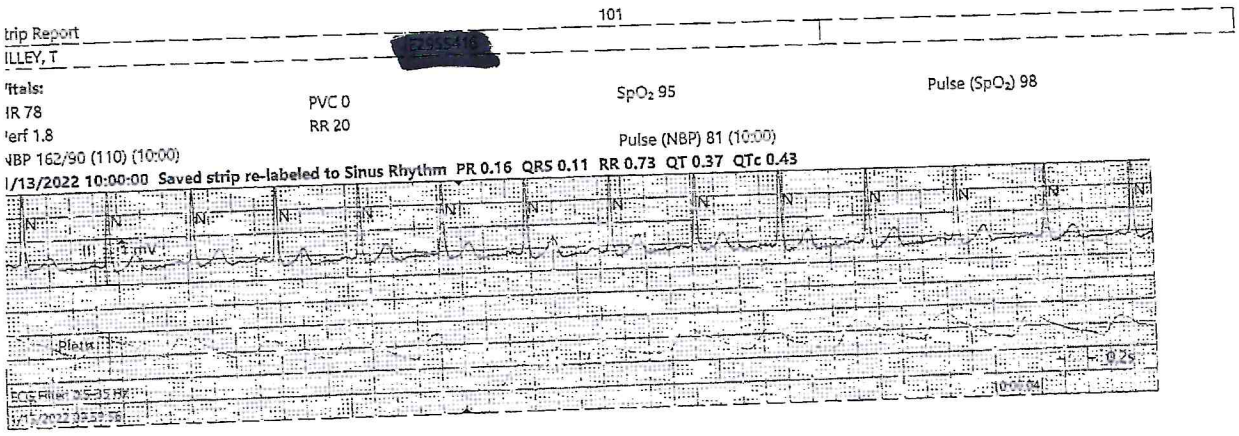
Printed on 1/13/2022 16:55:46

Tilley, Todd S.
MRN: [redacted], DOB: [redacted] Sex: M
Adm: 1/12/2022, D/C: 1/16/2022

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

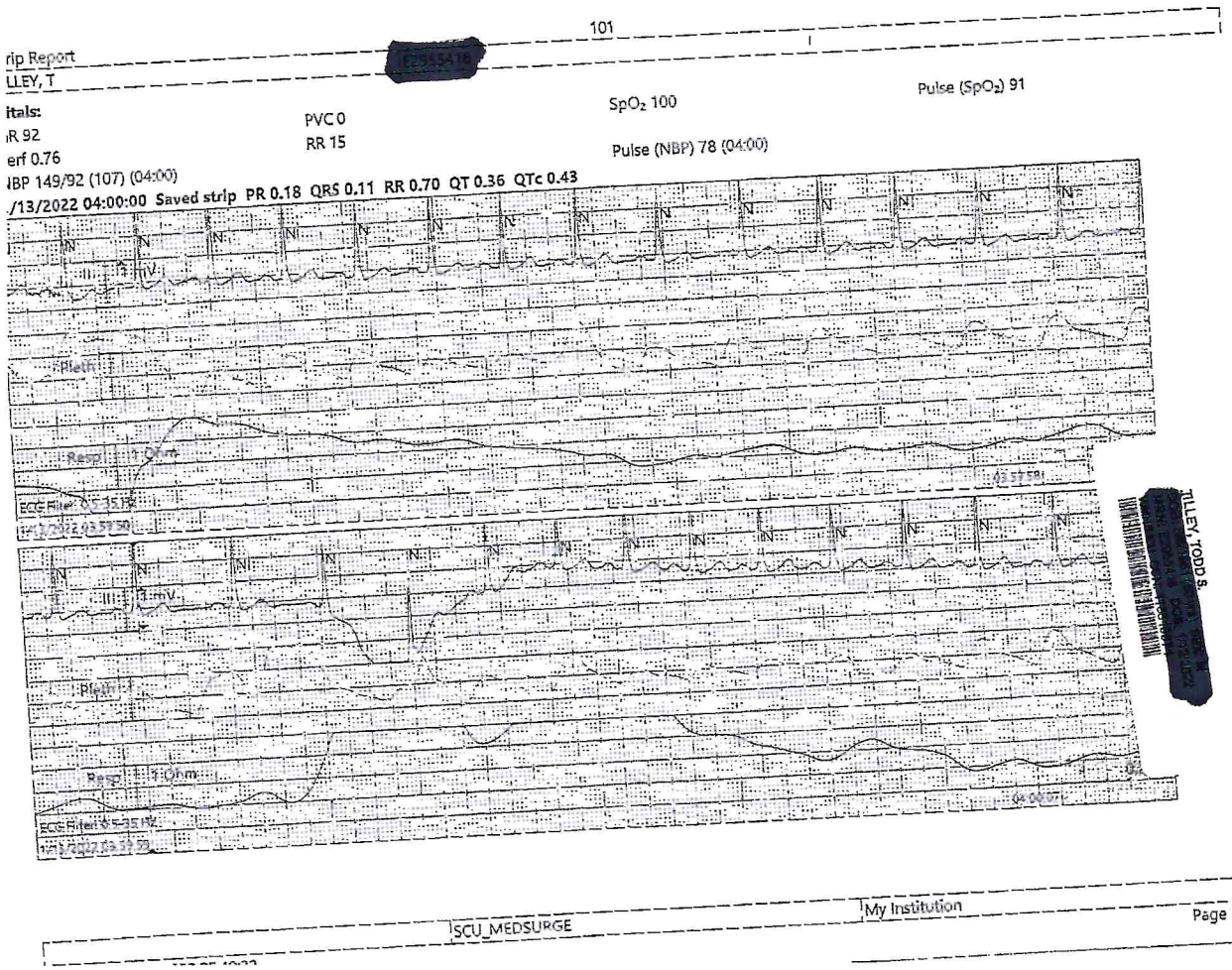
Cardiology (continued)



[redacted] SCU_MEDSURGE My Institution Page 1 of 1
Printed on 1/13/2022 10:11:29

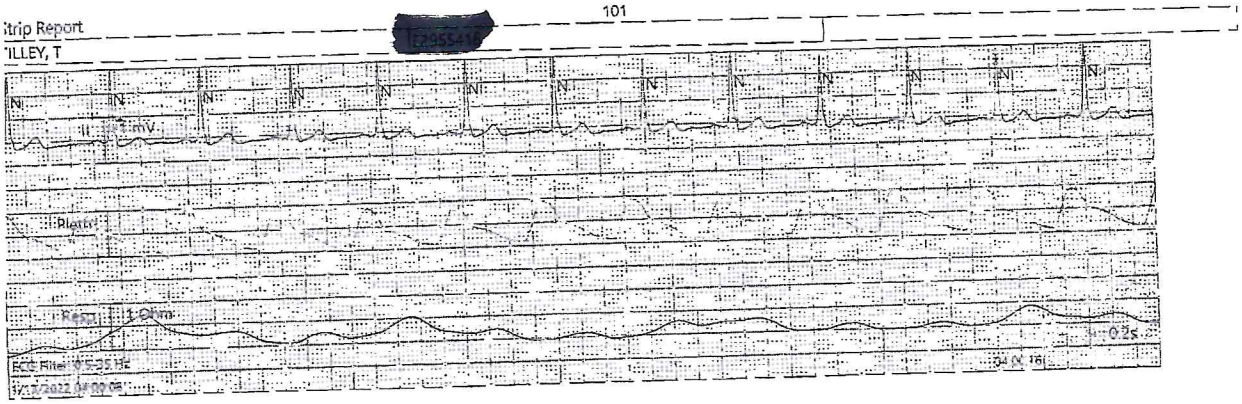
01/12/2022 - ED to Hosp-Admission (Discharged) in WMHS Med Surg Unit (continued)

Cardiology (continued)



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

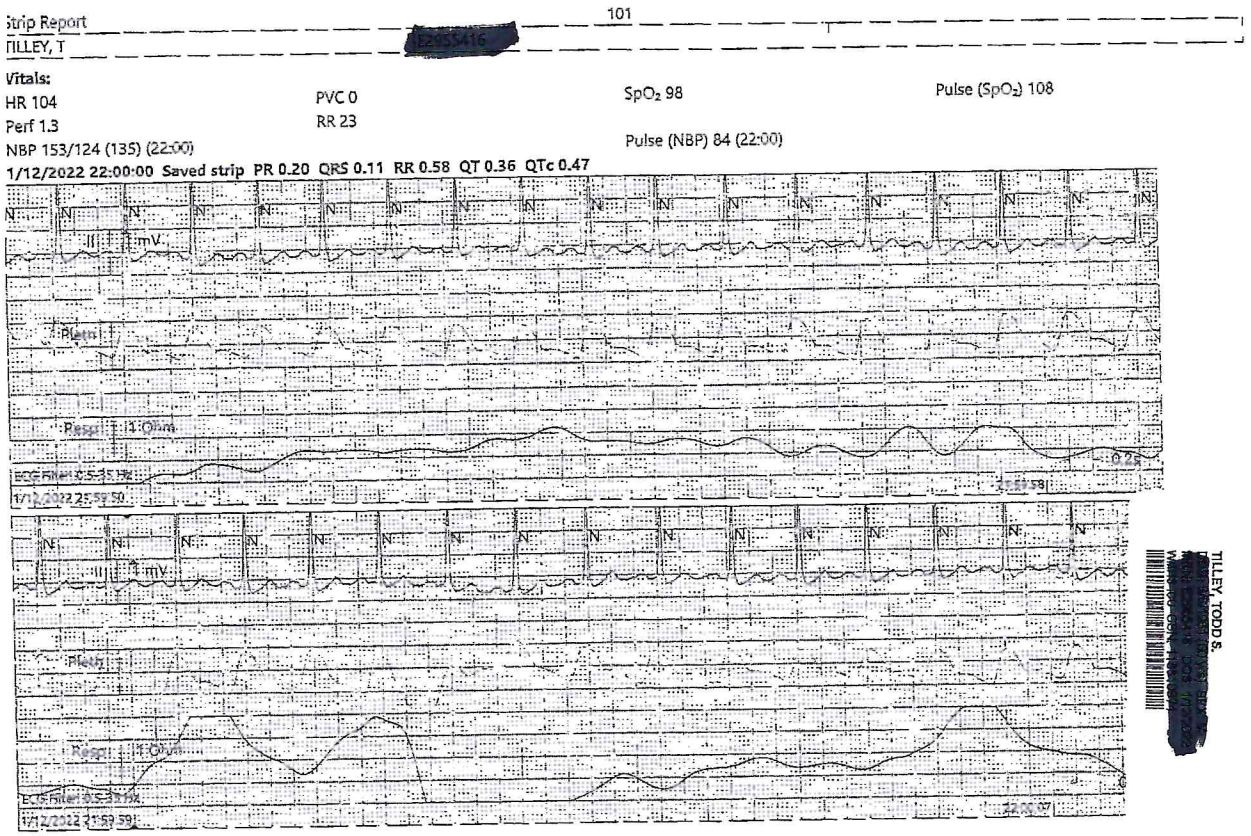
Cardiology (continued)



Tilley, Todd S.
MRN: [redacted], DOB: 6/6/1961 Sex: M
Adm: 1/12/2022, D/C: 1/16/2022

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

Cardiology (continued)



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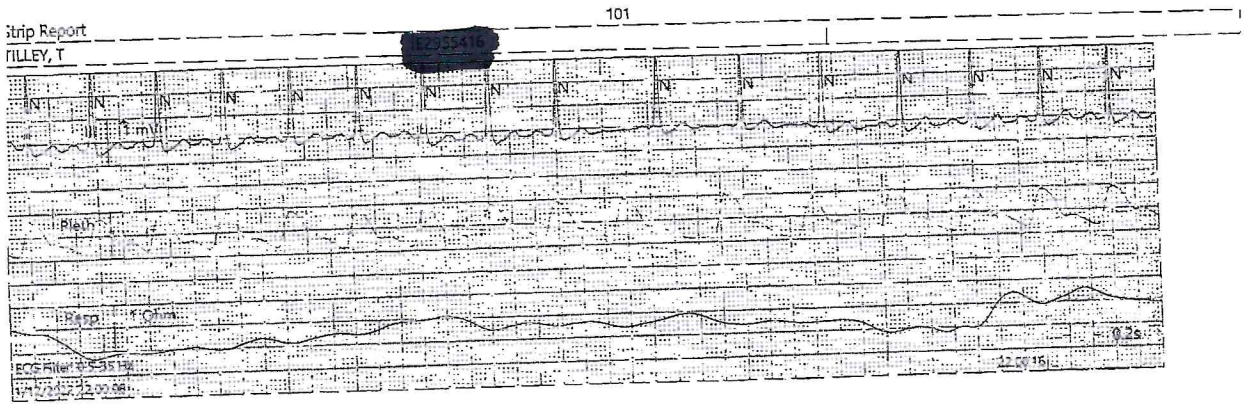
Printed on 1/12/2022 22:16:17

Tilley, Todd S.
[redacted] Sex: M
Adm: 1/12/2022, D/C: 1/16/2022

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

Cardiology (continued)



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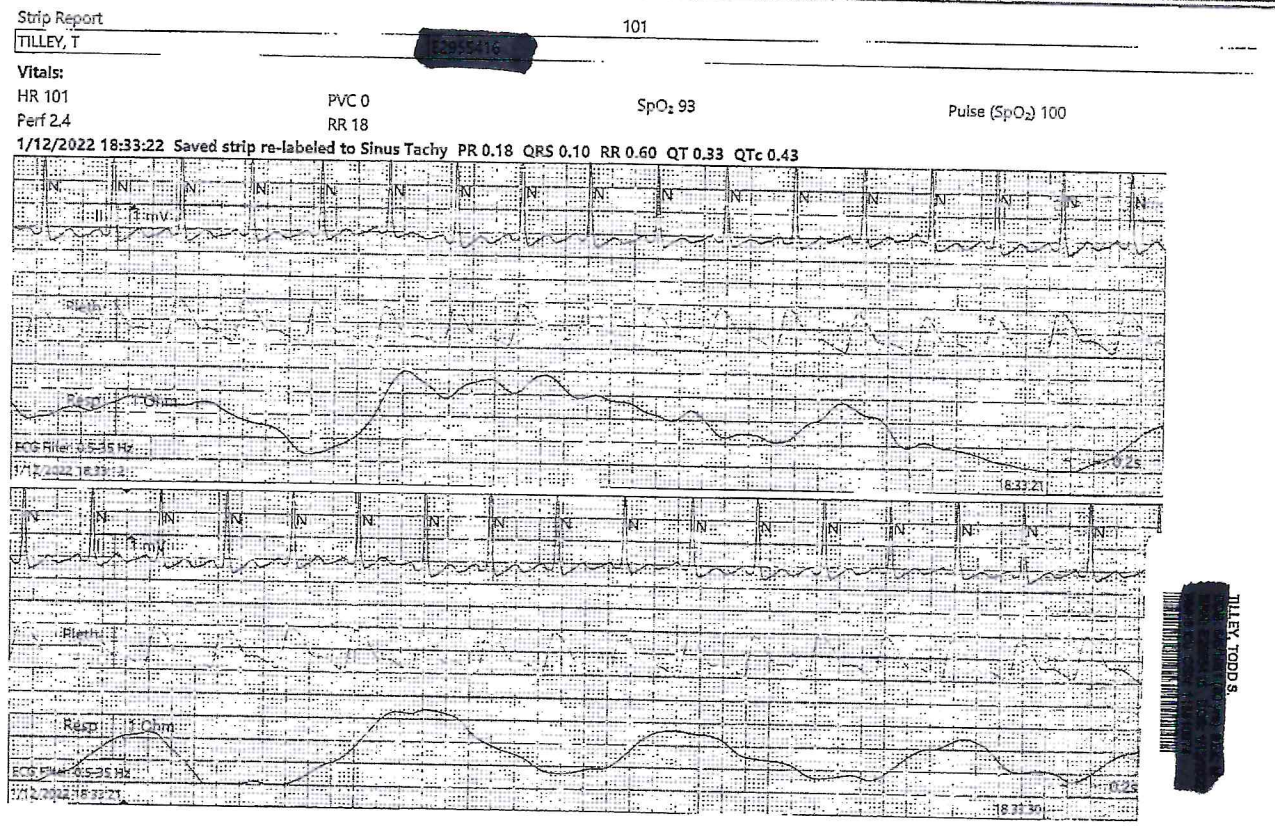
Printed on 1/12/2022 22:16:17

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

Cardiology (continued)



SCU_MEDSURGE My Institution

Printed on 1/12/2022 19:06:22

TELEMETRY (SCAN)

Resulted: 01/12/22 0000, Result status: Final result

Ordering provider: Scanprovider, Unknown 01/12/22 0000
Order status: Completed
Filed by: Edi, Scans 01/18/22 0815

ECG

EKG 12 lead - STAT (Final result)

Electronically signed by: **Weems, Patricia, MD on 01/12/22 0900**
Status: **Completed**
Ordering user: Weems, Patricia, MD 01/12/22 0900
Ordering provider: Weems, Patricia, MD
Authorized by: Weems, Patricia, MD
Ordering mode: Standard
Frequency: STAT Once 01/12/22 0859 - 1 occurrence
Class: Hospital Performed
Quantity: 1
Lab status: Final result
Instance released by: Weems, Patricia, MD (auto-released) 1/12/2022 9:00 AM

Questionnaire

Question	Answer
Indications:	Screening for cardiovascular condition - Z13.6
What time was the EKG completed?	9:21 AM

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

Cardiology (continued)

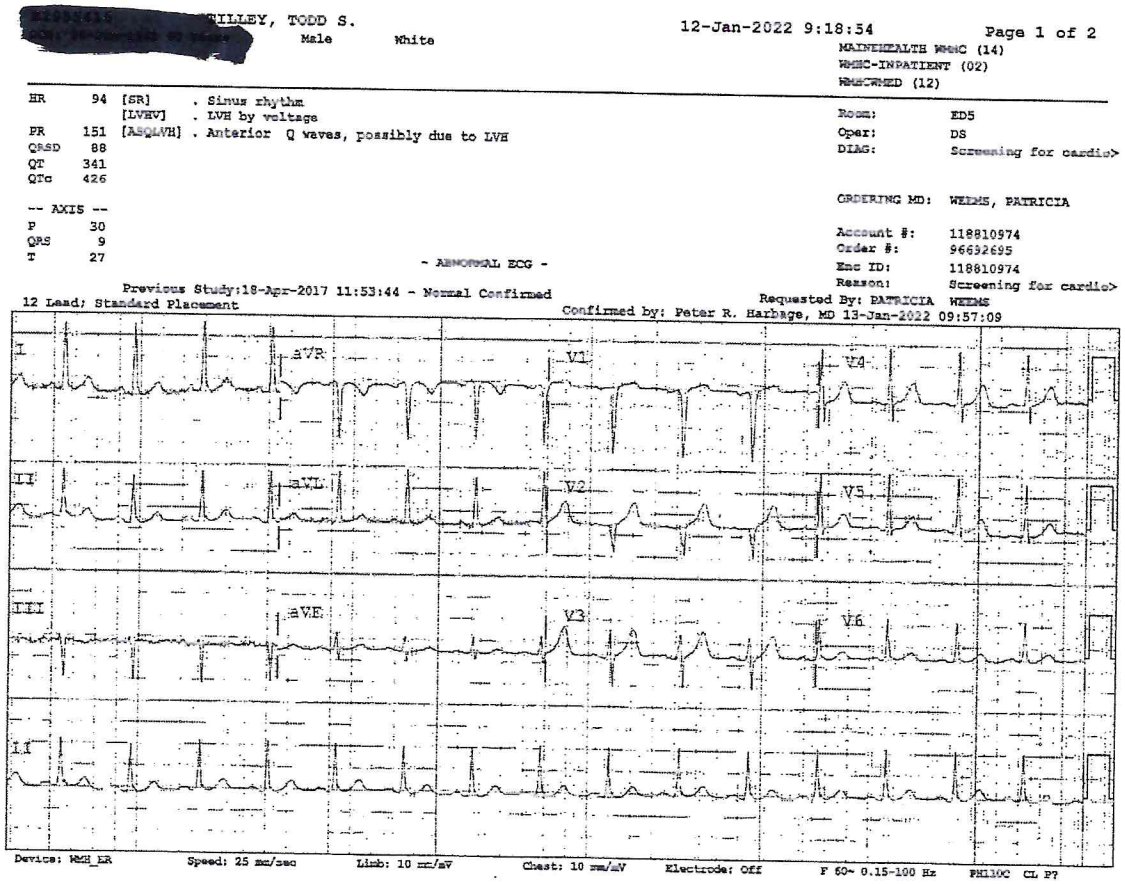
EKG 12 lead - STAT

Resulted: 01/13/22 0957, Result status: Final result

Ordering provider: Weems, Patricia, MD 01/12/22 0900
Resulted by: Harbage, Peter R, MD
[redacted]
Impression:
Sinus rhythm LVH by voltage Anterior Q waves, possibly due to LVH

Order status: Completed
Filed by: Edi, Rad Results In 01/13/22 0957
Resulting lab: TRACEMASTER VUE

View Image (below)



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

Cardiology (continued)

E2955416 TILLEY, TODD S. 12-Jan-2022 09:18:54 Page 2 of 2

Patient ID	[redacted]
Name	TILLEY, TODD S.
Age/Date of Birth	[redacted]
Gender	Male
Race	White
Height	
Weight	
BP	
Rx	
Dx	
SX	
HX	
DRG	
Requested By	PATRICIA WEEMS
Oper	DS
Reason	Screening for cardiovascular con
Enc ID	118810974
Order #	96692695
DIAG	Screening for cardiovascular con
COMMENT	
PRIORITY	
ORDERING MD	WEEMS, PATRICIA
Institution	MAINEHEALTH WMMC (14)
Facility	WMMC-INPATIENT (02)
Department	WMMCWMED (12)
Room	ED5
Device ID	WMH_ER
Priority	Stat

Device: WMH_ER Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV Electrode: Off F 60- 0.15-100 Hz PH110C CL P?

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
27 - TraceMaster V	TRACEMASTER VUE	Unknown	Unknown	11/23/11 0956 - Present

Signed

Electronically signed by Harbage, Peter R, MD on 1/13/22 at 0957 EST

**********End of Document**********