T98'
HR 85-109
RR 14-30
BP 104/62 - 157/93 SaO2 99-100%

Anesthetic Pre-Assessment / History & Physical (H&P)

If right hand ☐ is checked, the system is negative on history and physical examination

Proposed Operation: TRACHEOSTOMY

CNS:
CHRONIC BENZO USE
CHRONIC PAIN
TOXIC ENCEPHALOPATHY — 11/19 ?
NON RESPONSIVE ☐

Genitourinary:
Ø ☐

Head, Neck, Airway: LARVAE SEEN DURING ORAL CARE ON 11/30.
MAL I II III IV ☐

Gastrointestinal:
TF STOPPED 9AM
HAS NG → Emergency
NO RESIDUAL
NG TO SUCTION @ 9AM - NOTHING OUTPUT ☐
NG TO SUCTION IN OR - NOTHING OUTPUT

Pulmonary:
LEFT UPPER LOBE 11/13 - EXTUBATED F PROCEDURE
TX TO STEPDOWN 11/16
INTUBATED OVERNIGHT 11/16 ; EXTUBATED 11/23
REINTUBATED 11/24
ARDS
HEATHCARE - ASSOCIATED PNEUMONIA
Lungs: ↓ THROUGHOUT ☐

Circulatory:
ATROPONINS → ↑ASYSTOLIC ARREST LIKELY PEA ON 11/25/15
ECHO 11/25/15 : EF 60-65%
NO RWMA NO OBVIOUS VALVE ☐
COR
PVCs - OCC. No M/O/G. ABNL - LIMITED STUDY.

Endocrine, Orthopedic, Others:
Ø ☐

Previous Surgeries:
LEFT UPPER LOBE 11/13/15 ☐

Medications:

NORVASC	GUAIFENESIN	REGLAN
DULCOLAX	HEPARIN Q12	MICAFUNGIN
BUSPAR	HYDRALAZINE	SINGULAIR
PERIDEX	INSULIN LISPRO	BACTROBAN
CYMBALTA	DUONEB	OMEPRAZOLE
GABAPENTIN	MERO PENEM	FLORASTOR
	SOLUMEDROL Q12	VANCOMYCIN
		SENNA

DILANTIN D/C'D
HOLD

Labs: 12/1/15 12/1 CA 7.2
CXR: 22 | 12.7 / 39 | 217 — 140 | 108 | 22 / 4.1 | 25 | 0.4 — 143
EKG:
STRESS:
ECHO:
CATH:
ABG: 7.45/32/105/22 ON 30%

Allergies: BACLOFEN
HYDROMORPHONE

Height: 5'8"
Weight 134 #

ASA: 4E — Emergency 2/2 maggots / WBC
Plan: GEN

R/B Discussed and Questions Answered ☐

Date: 12/1/15
Time: 1425

Signature:

Orange Park Medical Center

Anesthetic Pre-Assessment - History & Physical (H&P)

Patient Information / Label

MOONEYHAM, DOROTHY

ANES

PC.0034A; Rev. 12/24/2013

DOB: MR#

11/16/2015 07:34 AM

Problem/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Directions / Documented Units	From Change

Activity Date: 12/01/15 Time: 0730

635111 Vital Signs Monitor Link + A MO
- Document 12/01/15 0730 MK 12/01/15 0758 MK
Pulse: 109
Respirations: 21
Blood Pressure: 132/71
MAP: 95
02 Sats % 99

Activity Date: 12/01/15 Time: 0731

635142 Teaching + A RT: PRN PS
- Document 12/01/15 0731 MJB 12/01/15 0732 MJB
Learner: PATIENT
Readiness to Learn: COOPERATIVE
Teaching Method: VERBAL
Subjects Reviewed & Understood by Learner: EMERGENCY/CALL SYSTEM
02: OXYGEN THERAPY
Cmt: VENTED PATIENT. ORAL CARE DONE. SUCTION. HME CHANGED
Composite of Cmt's entered:
<<<- Patient Education Comment ->>>
VENTED PATIENT. ORAL CARE DONE. SUCTION. HME CHANGED
Patient or caregiver provided written education addressing activation of
Patient/caregiver provided written education addressing need for
Patient/caregiver provided written education addressing all medications
Patient/caregiver provided written education addressing risk
Patient/caregiver provided written education addressing warning
635143 Plan of Care + A .END OF SHIFT CP
- Document 12/01/15 0731 MJB 12/01/15 0732 MJB
Problem 1: NEUROLOGICAL
Goal 1: MENTATION WILL RETURN TO BASE LINE. Pt will remain safe during visit
Problem 2: RESPIRATORY
Goal 2: Cont to wean vent as tolerated. SBT AS TOLERATED TO EXTUBATE
Problem 3: CARDIAC
Goal 3: Stable rate and rhythm: hemodynamically stable: HR will remain 70-110.
Problem 4: CIRCULATORY
Goal 4: Improved circulation: skin warm,pulses palpable,decreased BLE edema.
Problem 5: HIGH RISK: INFECTION
Goal 5: Pt will be free of infection.
Problem 6: INTEGUMENTARY
Goal 6: Skin intact w/o breakdown. Wounds healing.
Problem 7: HIGH RISK: SKIN BREAKDOWN
Goal 7: Skin intact w/o breakdown.Review Interventions on Skin Risk Assessm
Problem 8: MUSCULOSKELETAL
Goal 8: ROM,muscle strength returns to baseline by D/C. Pt walks TID.
Problem 9: PROTOCOL: ABCDE Protocol
Goal 9: Complete SAT safety screening as evidenced by no active seizures. n
Problem 10: PSYCHOSOCIAL
Goal 10: Demonstrates effective,realistic coping skills.Support system available.

Problem/Goal/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Directions / Documented Units	From Change

Activity Date: 12/01/15 Time: 0731 (continued)

635143 Plan of Care + (continued)
Problem 11: PAIN
Goal 11: Pain will be remain <4 on 11/19
Problem 12: DISCHARGE PLANNING
Goal 12: Discharged to appropriate care setting based on pt/family input & eval.
Problem 13: GASTROINTESTINAL
Goal 13: Return to baseline bowel function. PT will have a BM on 11/19
Problem 14: GENITOURINARY
Goal 14: Return to baseline urinary function, have >30cc/hr output
Problem 15: EENT
Goal 15: Inflammation,drainage,edema controlled. Adapts to deficits.
Problem 16: HIGH RISK: FALLS
Goal 16: Pt will be free from falls during this admission.
- Expected progress is being made toward respiratory therapy related goals.

Activity Date: 12/01/15 Time: 0800

635111 Vital Signs Monitor Link + A MO
Document 12/01/15 0800 JNS 12/01/15 0920 JNS
Pulse: 96
Respirations: 14
Blood Pressure: 101/63
MAP: 76
02 Sats % 99
615185 Focused Care: CCU + A CP
- Document 12/01/15 0800 JNS 12/01/15 0920 JNS
Position: LEFT SIDE
HOB: 30 DEGREES
Heels Elevated: Y
=======INCENTIVE SPIROMETER=======
% of rotation
hours (chart prior day)
Rectal Tube: N
Peri Care Completed: Y
Document Activity: N
Last page
See next page
635105 Shift Assessment/Reassessment + A CP
Document 12/01/15 0800 JNS 12/01/15 0917 JNS
| N
Neurological Assessment WDP: N
Cmt: PT ETT TO VENT. NO SEDATION INFUSING.
RESPONSIVE TO NOXIOUS STIMULI
EENT Assessment WDP: N
Cmt: NOTED MAGGOTS COMING FROM ORAL CAVITY
WHEN PATIENT ORALLY SUCTIONED. DR.
BEACHER AND DR. BATES AWARE. NO
VERBAL ORDERS TAKEN

Weight		

General appearance: unresponsive throughout positioning and pelvic exam, did open eyes later but did not seem to be a direct response to stimuli
HEENT: moist mucosal membranes
Neck: no JVD
Cardiovascular: normal heart sounds
Respiratory: symmetric expansion
Abdomen: non-tender, soft, no distention, no guarding
Genitourinary: no external labial lesions or edema, vagina is nml, no pessary present. normal vaginal d/c thin white nonodorous small quantity, no pelvic masses or adnexal fullness
Extremities: pvd changes, b/l arms w/ weeping edema
Considered stroke alert: no
Skin: on skin of inner left thigh is a wiggling worm? approx 5-7mm long w/ a tiny black appendage at the tip, seemed to almost have implanted into skin although when removed, skin beneath it appeared completely nml. body and bed inspected w/ no other organisms seen

Results
Findings/Data:
Laboratory Tests

	12/03 0536
Blood Gas	
Specimen Type	ARTERIAL
Puncture Site	Right Radial
Patient Temperature (degree C)	36.5
pH (7.350 - 7.450)	7.452H
pCO2 (35.0 - 45.0 mmHg)	32.8L
pO2 (80.0 - 105.0 mmHg)	119.0H
O2 Saturation (95 - 100 %)	99
ABG HCO3 (23.0 - 28.0 meq/L)	23.0
ABG Base Excess (-3 to 3 mmol/L)	-1.0
ABG FiO2 (%)	30
PEEP (cmH2O)	5
Pressure Support Vent (cmH2O)	10
Allen Test	Positive
Respiration Rate (/MIN)	21
Barometric Pressure (mmHg)	765.0