

Centegra Hospital-McHenry

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06  
**Centegra Health System**  
**EMERGENCY PHYSICIAN RECORD**  
**Upper Extremity Injury (4)**

B117900323  
 DULBERG, PAUL R  
 M 41Y 03/19/1970  
 06/28/2011  
 0000109381

DATE: 6/28/11 TIME: 1457 ☐ on arrival  
 ROOM: 18 EMS Arrival ☐  
 EMS treatments ordered \_\_\_\_\_  
 HISTORIAN: patient spouse paramedics  
 HX / EXAM LIMITED BY: \_\_\_\_\_

**HPI**

**chief complaint:** Injury to: right / left  
 hand wrist forearm elbow arm  
 shoulder collar-bone area

**duration / occurred:**  
 just prior to arrival  
 today \_\_\_\_\_  
 yesterday \_\_\_\_\_  
 \_\_\_\_\_ days ago

**where:**  
 home school  
 neighbor's park  
 work street

**severity of pain:**  
 mild moderate severe  
 worse / persistent since \_\_\_\_\_  
 pain intermittent / lasting \_\_\_\_\_

**context:** fall blow incised crushed burn

**associated symptoms:** tingling / numbness distally

**ROS**

suspected FB (skin lac) \_\_\_\_\_  
 loss feeling / power arms / legs \_\_\_\_\_  
 headache / neck pain \_\_\_\_\_  
 double vision / hearing loss \_\_\_\_\_  
 nausea / vomiting \_\_\_\_\_

trouble breathing / chest pain \_\_\_\_\_  
 loss of bladder function \_\_\_\_\_  
 recent fever / illness \_\_\_\_\_  
 other injuries \_\_\_\_\_  
☐ all systems neg except as marked

**SOCIAL HX** smoker + drug use / abuse \_\_\_\_\_  
 recent ETOH \_\_\_\_\_ lives alone \_\_\_\_\_  
 lives at home \_\_\_\_\_ lives in nursing home \_\_\_\_\_

**FAMILY HX** negative

**PAST HX** negative R / L HANDED prior injury \_\_\_\_\_  
 diabetes Type 1 / Type 2 diet / oral / insulin \_\_\_\_\_  
 HTN heart disease DIABETES TYPE 2  
 Mads- none see nurses note  
 Allergies- AKDA see nurses note

☒ Nursing Assessment Reviewed ☒ Vitals Reviewed ☐ Tetanus Immun. UTD

**PHYSICAL EXAM**

**GENERAL APPEARANCE** collar (PTA / In ED) / backboard  
 no acute distress mild/moderate/severe distress  
 alert \_\_\_\_\_  
 anxious \_\_\_\_\_

**EXTREMITIES**

**HAND**

nmI inspection see diagram  
non-tender tenderness soft-tissue / bony  
 swelling / ecchymosis  
 deformity

**WRIST**

nmI inspection see diagram  
non-tender tenderness soft-tissue / bony  
nmI ROM\* tenderness in anatomical snuff box  
 wrist pain on axial thumb load  
 swelling / ecchymosis  
 limited ROM  
 deformity

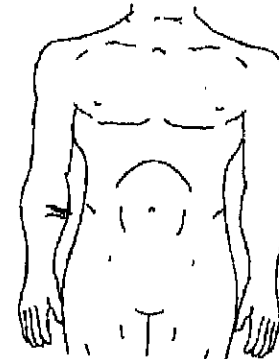
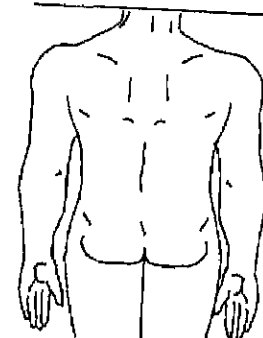
**FOREARM / ELBOW**

nmI inspection  
non-tender  
nmI ROM\*

**ARM / SHOULDER**

nmI inspection  
non-tender  
nmI ROM\*

see diagram  
 tenderness soft-tissue / bony  
 swelling / ecchymosis  
 limited ROM  
 deformity  
see diagram  
 tenderness soft-tissue / bony  
 swelling / ecchymosis  
 limited ROM  
 deformity



T=Tenderness PIT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion  
 L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound  
 (0=without 1=mild 2=moderate 3=severe)  
 Example: T0 = Tenderness on palpation (severe)

**NEURO / VASC / TENDON**

sensation intact sensory / motor deficit  
motor intact  
no vascular  
compromise  
tendon function normal  
 pallor / cool skin / abnml cap refill  
 pulse deficit radial ulnar  
 deficit in tendon function

\*3EDTSN\* / Rev. 08 / 07



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**SKIN**

warm, dry

diaphoretic / cool / cyanotic

**HEAD / ENT**

nm inspection

pharynx nml

**NECK / BACK**

nm inspection

non-tender

**RESPIRATORY**

chest non-tender

breath snds nml

**CVS**

heart sounds nml

**GI (ABDOMEN)**

non-tender

no organomegaly

nml bowel snds\*

tenderness

swelling / ecchymosis

tenderness

swelling / ecchymosis

tenderness

swelling / ecchymosis / abrasions

crepitus / subcutaneous emphysema

decreased breath sounds

wheezes / rales / rhonchi

tachycardia / bradycardia

tenderness / guarding

**PROCEDURES**

**Wound Description / Repair**

length 2 1/2 in location RIGHT ARM Biceps

linear irregular flap stellate

superficial subcut muscle through-and-through

contused tissue contaminated minimally / moderately / heavily

clean with

distal NVT: neuro & vascular status intact no tendon injury

anesthesia: local LET / tetracaine / adrenaline / cocaine 15 ml.

marcaine 0.25% 0.5% lidoc 1% 2% epi / bicarb digital / metacarpal block

moderate sedation required; see attached 23d template

prep: SURCLEAS TOOTH

Betadine / scrub 16 MAC debrided

irrigated / washed w/ saline minimal / mod. / \*extensive

wound explored minimal / mod. / \*extensive

foreign material removed undetermined

partially completely minimal / mod. / \*extensive

minimal / mod. / \*extensive wound margins revised

no foreign body identified multiple flaps aligned

repair: Wound closed with: wound adhesive / steri-strips

SKIN: # 11 4-0 nylon / crolex / staples

interrupted running simple mattress (h/v)

\*SUBCUT: # 3 4-0 (vicryl / chromic)

interrupted running simple mattress (h/v)

OTHER: # -0 material

interrupted running simple mattress (h/v)

\*may indicate intermediate repair \*may indicate complex repair

splint Vekro OCL / Ortho-glass / Plaster Aluminum-foam

Valar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Collies

applied by ED Physician / Orthopedist / Tech

examined post splint application NY intact alignment good

deformity reduced no compartment syndrome

sling

nursemaid's elbow reduced with supination

foreign body removed with forceps with incision

closed reduction finger traps traction

Underline indicates organ system

\* equivalent or minimum required for organ system exam

Upper Extremity Injury - 06

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**XRAYs**

☐ Interp. by me ☐ Reviewed by me ☐ Discd w/ radiologist

**R / L hand wrist forearm elbow humerus shoulder**

normal / NAD

☒ no fracture

nm alignment

no foreign body

DJD

dislocation

soft-tissue swelling

positive anterior fat-pad sign

positive posterior fat-pad sign

foreign body

fracture non-displaced displaced

transverse oblique comminuted angulated

Impacted torus

Other study:

☐ See separate report

**PROGRESS**

Time

unchanged

improved

re-examined

initial fracture care provided: follow-up on

Rx given

referred to / discussed with Dr.

will see patient in ED / hospital / office in days

**CLINICAL IMPRESSION**

Contusion R / L shoulder forearm wrist

Hematoma arm elbow hand

Sprain / Strain

Dislocation

Laceration

Fracture R / L radius distal / shaft / proximal

ulna distal / shaft / proximal / ulnar styloid

humerus distal / shaft / proximal / supracondylar

Colles fracture stabilized / restorative

**DISPOSITION:**

Time

☐ transferred

☒ home

☐ admitted

☐ expired

CONDITION:

☐ AMA

☒ good

☐ fair

☐ poor

☐ critical

☒ improved

☐ stable

☐ unchanged

**ATTENDING NOTE:**

Resident / PA / NP's history reviewed, patient interviewed and examined.

Briefly, pertinent HPI is:

My personal exam of patient reveals:

Assessment and plan reviewed with resident / midlevel. Lab and ancillary studies show:

I confirm the diagnosis of:

Care plan reviewed. Patient will need:

Please see resident / midlevel note for details.

Physician Signature Autof RTI # 9025

turned care over at

Physician Signature RTI #

assumed care at

☐ Template Complete ☐ Additional T-Sheet

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## EMERGENCY ADMISSION ASSESSMENT

TIME TRIAGED: 1450  
TIME TO TREATMENT AREA: 1455  
ED BED# 18  
EXPRESS BED#  
ESI: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5  
Primary Physician: Sek  
Height: 5'9" Weight: 165# GCS: 15 RTS: 12 BP: 130/75 R 14 97.4 SPO<sub>2</sub> 97 Time of Injury: 9-10  
Room air ☐ O<sub>2</sub> Pain Level: 9-10

BROUGHT BY:  
☐ Self ☐ Relative  
☐ Police ☒ Friend  
☐ Other  
Ambulance:

MODE OF ARRIVAL  
☒ SWC  
☐ Stretcher  
☐ Carried  
☐ Walked

TREATMENT PTA  
☐ Ice ☐ Elevate  
☐ O<sub>2</sub>  
☐ IV  
☐ Med:

☒ Patient Band applied  
☐ Hand Off Communication  
Band applied  
☐ Security watch

Chief complaint/reason for visit: States chainsaw vs Rt arm  
15 min ago at home, no feeling, lightheaded

CURRENT MEDS <input checked="" type="checkbox"/> Denies	Triage RN	ALLERGIES <input checked="" type="checkbox"/> NKA	REACTION
		Medications:	
		4703	
		Food:	
		Other: <input type="checkbox"/> Latex <input type="checkbox"/> Dye	

Meds reviewed by: \_\_\_\_\_  
Language barrier ☐ Yes Interpreter Name/ATT Number: \_\_\_\_\_  
Do you feel safe at home? ☒ Yes ☐ No Is there anyone in your life that threatens, intimidates or harms you in any way? ☐ Yes ☒ No  
Crisis/Social Worker ☐ Notified: \_\_\_\_\_ ☐ Here: \_\_\_\_\_ ☐ DNR Resources called: \_\_\_\_\_ Time: \_\_\_\_\_

Past Medical History <input type="checkbox"/> None	Yes	Yes	Yes	Yes	Yes
<input type="checkbox"/> Autoimmune	<input type="checkbox"/> Dementia/ Alzheimer's	<input type="checkbox"/> Headaches/ migraines	<input type="checkbox"/> Pressure Ulcer	<input type="checkbox"/> Infectious diseases	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Head inj past 3 months	<input type="checkbox"/> Recent exposure	<input type="checkbox"/> MRSA	
<input type="checkbox"/> Back problems	<input type="checkbox"/> GI Problems	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Reproductive problems	<input type="checkbox"/> VRE	
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> GU Problems	<input type="checkbox"/> MusculoSkeletal problems	<input type="checkbox"/> Respiratory problems	<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neuro problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Measles	
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> HEENT problems	<input type="checkbox"/> PsychoSocial problems	<input type="checkbox"/> Skin problems	<input type="checkbox"/> Shingles	
<input type="checkbox"/> CHF	<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Vision problems	<input type="checkbox"/> Strep Throat	
<input type="checkbox"/> LMP: _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Pregnant	<input type="checkbox"/> No <input type="checkbox"/> Unsure	Grava _____ Para _____ Ab _____ FHT _____			
Expanded/surgical history: Lt arm surg					
Implanted medical device: <input type="checkbox"/> Pacemaker <input type="checkbox"/> IV access <input type="checkbox"/> Eye <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> AICD <input type="checkbox"/> Other: _____					
TB History	<input type="checkbox"/> None Ever had a positive TB test? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Self-history of TB <input type="checkbox"/> Family history of TB <input type="checkbox"/> Cough <input type="checkbox"/> Fever <input type="checkbox"/> Bloody sputum <input type="checkbox"/> Weight loss <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Recent international travel <input type="checkbox"/> Denies signs & symptoms				
Vaccine	<input type="checkbox"/> Flu <input type="checkbox"/> Tetanus <input type="checkbox"/> N/A <input checked="" type="checkbox"/> Up to date <input type="checkbox"/> >5 years <input type="checkbox"/> Unsure Pediatric immunization <input type="checkbox"/> Up to date <input type="checkbox"/> No <input type="checkbox"/> Unsure				

EDN10000-00 07/08 10/08 03/09 12/09 03/10  
\*JEDRN\*

EMERGENCY ADMISSION ASSESSMENT  
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# ADMISSION ASSESSMENT

Do you currently have pain? ☒ Yes <sup>9-10</sup> (1-10) ☐ No If yes, is it ☐ Chronic ☐ New Onset  
Type of pain: ☐ Burning ☐ Dull Pressure ☐ Cramping ☐ Heavy ☐ Sharp ☐ Achy  
☐ Other: \_\_\_\_\_

Pain Scale used: ☐ Wong Baker ☐ FLACC ☐ Numeric

ALCOHOL INTAKE: ☒ Never ☐ Occasionally ☐ DAILY

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ Last Drink: \_\_\_\_\_

STREET/REC DRUGS: ☒ Never ☐ Occasionally ☐ DAILY

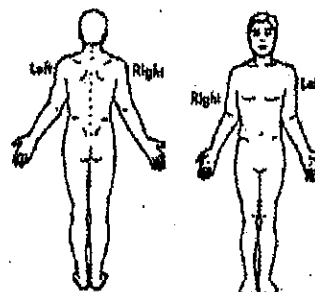
Type: \_\_\_\_\_ Amount: \_\_\_\_\_ Last Used: \_\_\_\_\_

TOBACCO HISTORY: ☐ Never ☐ Occasionally ☒ DAILY

Type: 1 PKT Amount: \_\_\_\_\_ Date Quit: \_\_\_\_\_

Mark drawing with number:

1. Abrasion
2. Amputation
3. Avulsion
4. Bleeding
5. Burn
6. Bruise
7. Deformity
8. Fracture
9. GSW
10. Hematoma
11. Laceration
12. Pain
13. Slab wound
14. Foreign body
15. Pressure ulcer
16. Leg ulcer



Neurological ☐ NA  
LOC ☐ Yes ☐ No  
☒ Conscious ☐ Unconscious  
☒ Alert ☒ Oriented X <sup>3</sup>  
☐ Crying ☐ Lethargic ☐ MAE  
☐ Slurred speech  
☐ Irritable  
☐ Combative  
Pupils ☐ NA ☒ PERL R L  
Reactive ☐ ☐  
Sluggish ☐ ☐  
Fixed ☐ ☐  
Nonreactive ☐ ☐  
Pupil size  
AVPU ☐ A ☐ V ☐ P ☐ U  
GCS: \_\_\_\_\_

Cardiac/Circulatory: ☐ NA  
☐ Pink ☐ Warm ☐ Dry ☐ Cool  
☐ Hot ☐ Flushed ☐ Diaphoretic  
☐ Dusky ☐ Ashen ☐ Jaundice  
☐ Pale ☐ Clammy ☐ Cyanotic  
RADIAL PULSES R L  
Present ☒ ☒  
Absent ☐ ☐  
PEDAL Present: ☒ ☒  
Absent ☐ ☐  
Cap Refill ☐ <2Sec ☐ >2 Sec  
Ankle edema ☐ Yes ☒ No  
Monitor: \_\_\_\_\_

Lung Sounds ☐ NA R L  
Clear ☒ ☒  
Rales ☐ ☐  
Wheezing ☐ ☐  
Rhonchi ☐ ☐  
Diminished ☐ ☐  
Absent ☐ ☐

EENT: ☐ NA ☒ Denies  
VISUAL ACUITY ☐ NA  
L: \_\_\_\_\_ R: \_\_\_\_\_  
☐ Correction ☐ No Correction  
Ear Drainage: ☐ Yes ☐ No

Describe: \_\_\_\_\_  
Epistaxis: ☐ NA R L  
Controlled ☐ ☐  
Uncontrolled ☐ ☐  
THROAT:  
☐ Diff. swallowing  
☐ Diff. speaking  
☐ Drooling

GI/Abdominal: ☐ NA ☐ Denies  
☐ Soft ☐ Distended ☐ Firm  
☒ Nontender ☐ Tender  
Bowel sounds: ☐ Present ☐ Absent  
☐ Hypoactive ☐ Hyperactive  
Last BM: \_\_\_\_\_  
☐ Diarrhea x \_\_\_\_\_ Denies  
☐ Vomiting x \_\_\_\_\_ Denies  
☐ Nausea ☐ Yes ☒ No  
Last oral intake: \_\_\_\_\_  
Comments: \_\_\_\_\_

Genito-Urinary: ☐ NA ☒ Denies  
URINARY ☐ NA  
☐ Frequency ☐ Pain  
☐ Hematuria ☐ Incontinent  
☐ Unable to void ☐ CLUD  
VAGINAL/PENILE ☐ NA  
☐ Discharge ☐ Bleeding  
Character: \_\_\_\_\_  
Amount: \_\_\_\_\_

## FALL RISK ASSESSMENT

☐ Medically unsafe to be independently mobile  
☐ Unaware or forgetful of physical limitations  
☐ Recent history of falls

ANY POSITIVE ANSWER INDICATES ENHANCED FALL RISK ☐ No risks noted

1455 Pt accompanied to ED by co-worker for "laceration" by chainsaw to (R) forearm. Pt cut to xray (1505). Pt added in ERT (1800) Dr Ford att (1500) Pt medicated as ordered (1600) Wound irrigated and cleaned. Dr Ford for suturing (1713) Dr instructions to pt. All questions addressed. Pt verbalized understanding.

Associate Signature/Initials: W. D. D.

Associate Signature/Initials: \_\_\_\_\_

EMERGENCY ADMISSION ASSESSMENT

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## ADMISSION ASSESSMENT

Lab	MD/DO Order Time MD/DO Initials	Lab	MD/DO Order Time MD/DO Initials	Lab	MD/DO Order Time MD/DO Initials	Medical Imaging	MD/DO Order Time MD/DO Initials
<input type="checkbox"/> ABG		<input type="checkbox"/> PTT		<input type="checkbox"/> wound culture		<input type="checkbox"/> T Spine	
<input type="checkbox"/> Amylase		<input type="checkbox"/> RSV		<input type="checkbox"/>		<input type="checkbox"/> LS Spine	
<input type="checkbox"/> Blood Culture		<input type="checkbox"/> Salicylate				<input type="checkbox"/> Ultrasound-	
<input type="checkbox"/> BMP		<input type="checkbox"/> Sputum culture				<input type="checkbox"/> CT Scan-Brain	
<input type="checkbox"/> BNP		<input type="checkbox"/> Strep				<input type="checkbox"/> CT Scan-C Spine	
<input type="checkbox"/> CBC w/diff		<input type="checkbox"/> Trichomonas				<input type="checkbox"/> CT Scan-Chest	
<input type="checkbox"/> CMPL		<input type="checkbox"/> Troponin <input type="checkbox"/> POC		<b>Other/Miscellaneous</b>		<input type="checkbox"/> CT Scan-Chest PE	
<input type="checkbox"/> D. Dimer		<input type="checkbox"/> Tylenol		<input type="checkbox"/> O <sub>2</sub>		<input type="checkbox"/> CT Scan-Abd/Pelvis	
<input type="checkbox"/> Digoxin Level		<input type="checkbox"/> Type & screen		<input type="checkbox"/> EKG Time Acquired		<input type="checkbox"/> MRI	
<input type="checkbox"/> ETOH		<input type="checkbox"/> Type & cross		Time Read		<input type="checkbox"/> FAST Scan	
<input type="checkbox"/> GC/Chlamydia		of units		<input type="checkbox"/> EKG Time Acquired		<input type="checkbox"/> ED Preg Ltd US	
<input type="checkbox"/> Hepatic Panel		<input type="checkbox"/> UA		Time Read		<input type="checkbox"/> ED Preg follow up US	
<input type="checkbox"/> HCG Qualitative		<input type="checkbox"/> UA/Reflex culture		<b>Medical Imaging</b>		<input type="checkbox"/> ED Pelvis Ltd US	
<input type="checkbox"/> HCG Quantitative		<input type="checkbox"/> Urine Culture		<input type="checkbox"/> Chest PA/Lat		<input type="checkbox"/> ED Abd Aorta US	
<input type="checkbox"/> Influenza Screen		<input type="checkbox"/> Urine Drug Screen		<input type="checkbox"/> Chest Port		<input type="checkbox"/> ED Doppler pelvis	
<input type="checkbox"/> Lipase		<input type="checkbox"/> Urine HCG		<input type="checkbox"/> C-Spine		<input type="checkbox"/> ED Venous Duplex Ext	
<input type="checkbox"/> MRSA		<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> POC		<input type="checkbox"/> X-Table		<input type="checkbox"/> ED Trauma trans echo	
<input type="checkbox"/> PT		<input type="checkbox"/> Urine Dip <input type="checkbox"/> POC		<input type="checkbox"/> Pelvis		<input type="checkbox"/> ED Trauma abd ltd	
		<input type="checkbox"/> Wet prep					

MD/DO Order Time & Initials	ORB	Start Time	Stop Time	IV Solution & Amount	Warm Y/N	Additives	Site	Cath Size	Rate	Amt Infused	Initials

Pt Height: 5'09" Pt Weight: 165 Allergies: NKDA

MD/DO Order Time & Initials	ORB	Time Given	Stop Time	Pain Scale	Medication/Order	Dosage	Route	Site	Initials	Time	Effects	Pain Scale	Initials
<u>MD/DO</u>		<u>15:00</u>		<u>10</u>	<u>NORCO</u>	<u>10mg</u>	<u>PO</u>		<u>MD/DO</u>		<u>15:00</u>	<u>4</u>	<u>MD/DO</u>
<u>MD/DO</u>		<u>15:00</u>			<u>Hydrocodone 5mg/acetaminophen 650mg</u>	<u>2 tabs</u>	<u>PO</u>		<u>MD/DO</u>		<u>15:00</u>		<u>MD/DO</u>

☐ Td 0.5mL ☐ Tdap 0.5mL ☐ TT 0.5mL

Time: \_\_\_\_\_ Site: \_\_\_\_\_ RN: \_\_\_\_\_ Lot# \_\_\_\_\_ Exp \_\_\_\_\_ Mfr \_\_\_\_\_  
☐ Nursing Assessment and Medication Reconciliation Reviewed  
☐ Vitals Reviewed \_\_\_\_\_

Tech: \_\_\_\_\_ Initials: \_\_\_\_\_ Tech: \_\_\_\_\_ Initials: \_\_\_\_\_  
 RN: \_\_\_\_\_ Initials: \_\_\_\_\_ Physician: \_\_\_\_\_ Initials: \_\_\_\_\_  
 RN: MD/DO Initials: MD/DO Physician: MD/DO Initials: MD/DO

Rev 04/04/11

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Time	Blood pressure	Pulse	Resp	Temp	SpO2	O2	GCS E/V/M	Monitor	Intake	Output
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
							/ / /			
Orthostatic Lying:		Sitting:		Standing:						

## Treatments/Procedures:

☐ O<sub>2</sub> Therapy: \_\_\_\_\_ ☐ Intubated \_\_\_\_\_ ☐ Respiratory treatment: \_\_\_\_\_ Neb Tx: \_\_\_\_\_ ☐ Cont Pulse Ox \_\_\_\_\_  
☐ Chest tube: \_\_\_\_\_ ☐ Time Out: \_\_\_\_\_ ☐ Eye irrigation: \_\_\_\_\_ ☐ Ear irrigation: \_\_\_\_\_  
☐ NG tube # \_\_\_\_\_ @ \_\_\_\_\_ Character: \_\_\_\_\_ ☐ Gastric lavage: \_\_\_\_\_  
☐ Lumbar puncture: \_\_\_\_\_ ☐ Time Out: \_\_\_\_\_ ☐ See neuro assessment sheet  
☐ Pelvic exam: \_\_\_\_\_ Straight Cath/CUD @ \_\_\_\_\_ ☐ Bladder scan Amount: \_\_\_\_\_  
☐ Blood Glucose value: \_\_\_\_\_ Time: \_\_\_\_\_ By: \_\_\_\_\_ ☐ Continuous Cardiac Monitoring  
 Normal Values Age 60 or more (80-99 mg/dl), 13-60 yr. (75-99), 1 mo.-13 yr. (60-99) Critical Value less than 40 or more than 400  
 Normal Value: Age newborn to 1d (40-60 mg/dl) 1d-1 Mo. (50-99) Critical Value less than 40 or more than 200

☒ Wound Care: \_\_\_\_\_ ☐ Dressing: \_\_\_\_\_ ☐ Ortho Care: \_\_\_\_\_ ☐ Crutches \_\_\_\_\_  
☒ Irrigation: 1 Liter NS ☐ Antibiotic \_\_\_\_\_ ☐ Ice Time: \_\_\_\_\_ ☐ Cast \_\_\_\_\_ ☐ Patient's own crutches \_\_\_\_\_  
☐ Spak: \_\_\_\_\_ ☐ Adaptic \_\_\_\_\_ ☐ Elevate Time: \_\_\_\_\_ ☐ Sling \_\_\_\_\_ ☐ Crutch walking instr/ret demo \_\_\_\_\_  
☒ Antiseptic Wash \_\_\_\_\_ ☐ 4X4 \_\_\_\_\_ ☐ Splint: \_\_\_\_\_ ☐ Tubi Grip \_\_\_\_\_ ☐ Velcro Splint: \_\_\_\_\_  
☐ Other: \_\_\_\_\_ ☐ Kling \_\_\_\_\_ ☐ Knee immobilizer: \_\_\_\_\_ ☐ Posterior mold: \_\_\_\_\_  
☐ Tube gauze \_\_\_\_\_ ☐ Shoulder immobilizer \_\_\_\_\_ ☐ Location: \_\_\_\_\_  
☐ Steristrip \_\_\_\_\_ ☐ Ace Wrap \_\_\_\_\_ ☐ Width: \_\_\_\_\_  
 Isolation Type: \_\_\_\_\_ ☐ Burn dressing \_\_\_\_\_ ☐ SMV's after immobilization \_\_\_\_\_ ☐ Length: \_\_\_\_\_

DISPOSITION: ☒ Home ☐ Jail ☐ Nursing home/ECC  
☐ Other facility: \_\_\_\_\_ ☐ Expired ☐ AMA  
 Mode: ☐ W/C ☒ Walk ☐ Carry ☐ Ambulance: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

LEFT WITH: ☐ Self ☐ Family ☒ Friend ☐ Police  
☒ Discharge Instructions given-expresses understanding  
☒ Discharge Pain Level: 4 (0-10) GCS: 5 RTS: \_\_\_\_\_  
☒ Discharge by: [Signature] @ 1713

Discharge Vital Signs:

Discharge Summary:

RN: [Signature]

Tech: [Signature]

☐ Inpatient ☐ Observation ☐ Surgical  
☐ Mode: \_\_\_\_\_ Time: \_\_\_\_\_ Accompanied by: \_\_\_\_\_  
☐ ER hold from \_\_\_\_\_ to \_\_\_\_\_  
☐ To unit/room # \_\_\_\_\_  
☐ No old chart ☐ Old chart in ED ☐ Chart to floor  
☐ Discharge Pain Level: \_\_\_\_\_ (0-10)  
 GCS: \_\_\_\_\_ RTS: \_\_\_\_\_

Skin Integrity Intact ☐ Yes ☐ No (see documentation)

EMERGENCY ADMISSION ASSESSMENT

Page 4 of 4

Northern Illinois Medical Center

NIMC Radiology

Patient Name: DULBERG, PAUL R

Account Number: B1117900323

Northern Illinois Medical Center

06/28/2011

10135 RIGHT FOREARM 2139703

HISTORY:

Chain saw versus forearm, forearm laceration.

IMPRESSION:

Right forearm films demonstrate no fracture or radiopaque foreign body. There is deep soft tissue laceration along the ventral surface of the mid forearm.

FINDINGS:

This exam consists of two views of the right forearm which demonstrate deep laceration on the ventral aspect of the mid forearm as best visualized on the lateral view. No fracture or radiopaque foreign body is identified.

cc:

Apiwat W. Ford, D.O.

Donald R Kennard, M.D.

Frank Sek, M.D.

Electronically Authenticated

Donald R Kennard, M.D. 06/28/2011 18:18

815-759-4683

D 06/28/2011

T 06/28/2011 5:19 P / LBA

Northern Illinois Medical Center

NIMC Radiology

## RESTRICTIONS / RELEASE FORM



**Northern Illinois Medical Center**  
**Emergency Department**  
**4201 Medical Center Drive**  
**McHenry, Illinois 60050**  
**(815) 344-5000**



**Memorial Medical Center**  
**3701 Doty Rd.**  
**Woodstock, Illinois 60098**  
**(815) 334-3900**

PATIENT NAME Paul Dulberg DATE 6/28/2011

PHYSICIAN SIGNATURE [Signature]

1117900323  
 DULBERG, PAUL R  
 M 41Y 03/19/1970  
 06/28/2011 B 0000109381

- ☐ May return to ☐ work ☐ school ☐ gym without restriction.
- ☒ May not return to ☒ work ☐ school ☐ gym for 2 day(s).

☐ May return to school with the following restrictions:

- ☐ Gym/Sports restrictions are \_\_\_\_\_ for \_\_\_\_\_ day(s).
- ☐ Must take prescription medication for \_\_\_\_\_ day(s).

☐ May return to work with the following restrictions:

- ☐ No lifting greater than \_\_\_\_\_ lbs. for \_\_\_\_\_ day(s).
- ☐ Machinery/Driving restriction while on medication that can cause drowsiness.
- ☐ No continuous ☐ standing ☐ sitting for \_\_\_\_\_ day(s).
- ☐ Must keep \_\_\_\_\_ elevated for \_\_\_\_\_ day(s).
- ☐ Sedentary work only for \_\_\_\_\_ day(s).
- ☐ Must use crutches for \_\_\_\_\_ day(s).
- ☐ No overhead work for \_\_\_\_\_ day(s).
- ☐ No bending or twisting for \_\_\_\_\_ day(s).
- ☐ Must wear immobilizer for \_\_\_\_\_ day(s).
- ☐ No climbing on ladder or stairs for \_\_\_\_\_ day(s).
- ☐ Other \_\_\_\_\_

<input type="checkbox"/> LIMITED WORK WITH	
<input type="checkbox"/> NO WORK WITH	
<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Hand	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Arm
<input type="checkbox"/> Foot	<input type="checkbox"/> Foot
<input type="checkbox"/> Leg	<input type="checkbox"/> Leg
For _____ Days	

☐ See your physician in \_\_\_\_\_ days for reevaluation.

All patients are referred to their personal physicians or a doctor on the staff of this hospital. Release from restriction must be obtained from that doctor and not the Emergency Department.

I (or responsible person) have/has received and understand(s) the instructions to follow as noted above.

Patient signature (or responsible person): Paul Dulberg

ED 102 NIMC/MHC

**EMCARE, INC**

MEDICAL RECORDS COPY



Centegra Northern Illinois Medical Center  
4201 Medical Center Drive  
McHenry, IL 60050  
(815) 344-5000

Patient: PAUL DULBERG, Med. Rec. #: B0000109381, Visit #:  
B1117900323, Date: 06/28/2011 Time: 17:02

#### Home Care Instructions

**IMPORTANT:** We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. You were treated today by: Ford, Aplat W..

After your visit to our Emergency Department, you may receive a survey in the mail. We want to be sure we have given you very good care and we ask that you please fill out the survey and return it in the mail.

After you leave, please follow the instructions below.

#### This Information Is About Your Follow Up Care

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.

Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

#### This Information Is About Your Illness and Diagnosis

##### **WOUND CARE (with stitches)**

Your wound was closed with stitches. These are small threads that keep the skin closed to help it heal. You have 3 internal and 11 external stitches. These should be removed in 10 days.

##### **At home, please follow these Instructions:**

- Wash your hands before touching the dressing or wound.
- Keep the wound clean and dry.
- After 2 days, wash the wound gently with warm water and soap. Pat it dry.
- Put a light dressing on it if it rubs or there is drainage.

##### **Call your doctor if:**

- you have redness, pain, or swelling in the area of your stitches.
- your wound drains pus.
- your stitches come out before your wound is healed.
- you have any new or bothersome symptoms.

#### This is Information About Your New Medications - Start taking as prescribed.

**HYDROCODONE and ACETAMINOPHEN** (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamilcal, Norco, Zydona, Anexsia, Anolor, Bancap HC)

Take this medicine by mouth with food in the following dose: one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

This is a mixture of medicines (hydrocodone and acetaminophen) used to relieve moderate to severe pain. This medicine may be used for other reasons, as prescribed by your doctor.

##### **Side effects may include:**

- sleepiness or dizziness
- upset stomach, nausea or vomiting
- constipation

Other side effects may occur, but are not as common. Allergy would show up as: rash or itching, facial or throat swelling, wheezing or shortness of breath. This medicine can be habit forming if used for a long period of time.

##### **Follow these instructions:**

- Never take more of this medicine than prescribed. Too much acetaminophen in your body can cause liver damage.
- Read the labels of non-prescription medicines before taking them. Many contain acetaminophen. To avoid an overdose, do not take any other medicines that contain acetaminophen.
- Talk to your doctor or pharmacist before taking medicines for sleep, colds or allergies. Severe drowsiness may occur.
- Do not share this medicine with others as this medicine is a controlled-substance. Sharing this medicine with others is against the law.
- To avoid constipation while taking this medicine:
  - Drink plenty of liquids. Try to drink 8 to 10 eight-ounce glasses of water or juice each day.
  - Include extra fiber in your diet.
  - Exercise daily.
- Watch for signs of dependence:
  - feeling that you "cannot live without this medicine".
  - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery until you know how this medicine affects you.
- Store this medicine away from heat, moisture or direct light.
- If you are taking this on a regular schedule and you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and return to your regular schedule. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

##### **Call your doctor if you have:**

- any sign of dependence or allergy.
- Increased pain not helped by the pain medicine.
- slow, weak breathing.
- seizures.
- slow or irregular heart beat.
- a yellow-color to your skin or eyes, or dark urine.
- stomach pain.
- unusual or extreme tiredness.
- any new or severe symptoms.

#### CEFADROXIL (Duricef)

Take this medicine until gone in the following dose: 500 mg by mouth 2 times a day for 5 days.

Centegra Northern Illinois Medical Center  
4201 Medical Center Drive  
McHenry, IL 60050  
(815) 344-5000

Cefadroxil is an antibiotic used to treat infections caused by bacteria. Antibiotics kill bacteria or prevent them from growing inside your body. This medicine may be used for other reasons, as prescribed by your doctor.

**Side effects may include:**

- diarrhea
- upset stomach, nausea or vomiting
- headache

Other side effects may occur, but are not as common. An upset stomach is not a sign of allergy. Allergy would show up as rash or itching, facial or throat swelling, wheezing or shortness of breath.

**Follow these instructions:**

- Space your medicine doses evenly throughout the day. This medicine works best if there is a constant amount in your blood.
- Take this medicine with food to avoid an upset stomach.
- Swallow the capsule and tablet form of this medicine whole with a full 8-ounce glass of water.
- For diabetics, this medicine can cause false test results when testing your urine for sugar. Talk with your doctor if you have questions.
- Store the tablet or capsule form of this medicine away from heat, moisture or direct light.
- Store the liquid form of this medicine in the refrigerator. Shake the liquid well before each use.
- If you miss a dose, take it as soon as possible. If it is almost time for your next dose, skip the missed dose. Do not double the doses.
- Talk with your doctor before taking any other medicines (including vitamins and herbals) as you may require additional monitoring.

**Call your doctor if you have:**

- any sign of allergy.
- no improvement after you've taken all the medicine.
- a seizure.
- any sign of a new infection (fever, general aches, chills, or unusual tiredness or weakness).
- ongoing nausea, vomiting or stomach pain.
- white patches in your mouth.
- women: itching in or change in discharge from your vagina.
- inflammation (pain and swelling) in your intestine during treatment or up to weeks after you've finished this medicine:
  - ongoing diarrhea
  - stomach pain or cramping
  - blood or mucus in your bowel movements
- any new or bothersome symptoms.

**SMOKING CESSATION**

Smoking is the nation's leading preventable cause of death. It significantly increases the risk of coronary heart disease, stroke and cancer. In fact, more than half of all smoking related deaths in America each year are from heart disease, stroke, or other cardiovascular diseases. The good news is, that one year after quitting, the risk of heart disease is cut in half. After five to fifteen smoke-free years, the risk is that of a person who never smoked!

If you or someone you love is interested in quitting, consider joining our "Freedom From Smoking" classes for adults. Centegra Health System and the McHenry County Department of Health have partnered together to bring you an effective program that will help you quit smoking. Call 877-CENTEGRA, (877-236-8347) for more information regarding this program. To speak with a counselor immediately, call the Illinois Tobacco line at 1-866-QUIT-YES.

**PAIN MANAGEMENT AFTER DISCHARGE:**

A person may feel less pain just by being in familiar surroundings. Here are some frequently asked questions about your pain management:

- What can I do to help my pain management? A person's level of relaxation and their environment can affect their pain. If you are tired, overstimulated (too many visitors) are anxious about your diagnosis, or a past experience with a hospitalization, your pain perception may be impacted and your tolerance decreased. Ask questions, and inform us about any problems or concerns that you may have, re: pain. Partner with your health team for your best pain management.
- What if the medication is not working? Tell your health-care provider; physician, home health nurse, etc. You may need a different dose or type of medication.
- What if I feel I'm not getting enough pain control? Talk to your physician or home health nurse about it. Together you may be able to develop a plan to prevent or ease your pain. Depending on the cause of your pain, your health-care provider may suggest exercise, use of heat/cold, massage, repositioning, immobilization of the affected part, or distraction such as music or rest.
- There are other methods of pain management. Let your health-care provider assist you in finding the best one for you.

Weight management is one step to help maintain a healthy lifestyle. For certain medical problems, such as congestive heart failure, weight should be monitored daily.

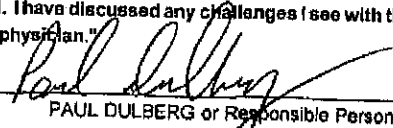
**YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY.**

Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed.

If you have problems that we have not discussed, or your problem changes or gets worse, Call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department immediately.

Centegra Health System is very concerned about your safety and well being. As part of our efforts to always provide very good care, any medications you received during this visit were reconciled with medication you are currently taking. This reconciliation was based on the information you or your representative provided regarding your current medications and allergies.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."

  
PAUL DULBERG or Responsible Person

PAUL DULBERG or Responsible Person has received this information and tells me that all questions have been answered.

  
RN Staff Signature

**Centegra Northern Illinois Medical Center**  
**4201 Medical Center Drive**  
**McHenry, IL 60050**  
**(815) 344-5000**

PAUL DULBERG was discharged on 06/28/2011 at 17:06 from the hospital. The following is a summary of the discharge instructions given to PAUL before discharge:

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**This Information Is About Your Follow Up Care**

---

Call as soon as possible to make an appointment to see your doctor in 10 days for suture removal. You can reach your doctor by calling their clinic phone number.  
Please return to the Emergency Department in 10 days for suture removal if you would prefer to have the sutures removed in the ER. We do recommend that you follow-up with your Primary Care Physician but you can return to the ER for removal of your stitches if you choose..

---

**This Information Is About Your Illness and Diagnosis**

---

**WOUND CARE** (with stitches)

---

**This is Information About Your New Medications - Start taking as prescribed.**

---

**HYDROCODONE and ACETAMINOPHEN** (Vicodin, Vicodin ES, Lortab, Lortab elixir, Zamcet, Norco, Zydone, Anexsia, Anolor, Bancap HC)  
one 10mg/325mg tablet every 4 to 6 hours if needed for pain. Do not take more than as directed per day (24 hours).

**CEFADROXIL** (Duricef)

500 mg by mouth 2 times a day for 5 days.

1. How are you and/or your family doing today?
2. Is your pain/or symptoms better today?
3. Did you understand your discharge instructions?
4. Are you following up with a Doctor?

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**Patient Name, PAUL R**

**Account Number, B1117900323**

**Centegra Northern Illinois Medical Center**  
**4201 Medical Center Drive**  
**McHenry, IL 60050**  
**(815) 344-5000**

5. Comments:

Signature of nurse making phone call; \_\_\_\_\_  
Date: \_\_\_\_\_ Time: \_\_\_\_\_

FORM GOES TO MEDICAL RECORDS

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**Patient Name, PAUL R**  
**Account Number, B1117900323**

**-EMERGENCY DEPARTMENT-**  
(Please fill out card completely and print clearly.)

Time: \_\_\_\_\_

Patient's Legal Name: Welter Kaithyn D  
Last name, First name, Middle Initial

Patient's Birth Date: 11/28/00  
Month / Day / Year

Patient's S.S.#: \_\_\_\_\_

Patient's Home Phone #: (85) 245-3629

Patient is: ☐ Male ☒ Female

Reason for visit to EMERGENCY ROOM (Chief Complaint):  
wrist / thumb