CENTEGRA Health System

DISCHARGE DATE | TIME

ACCOUNT NO.	ADMISSION DATE/TIME	BY	STATION ROOM	ACC	SERVICE	TYPE	AT	AS	UNIT NO/MEDICAL RECORD NO
B11179-00323	06/28/11 0246pm	MXC	EDB -		EMD	EDB	1	1	B0000109381

SEX	RC	MS	BIRTHDATE	SOC SEC NO	CLERGY	AD	OD	INJURY	FIN CLASS
M	3	S	03/19/70 41Y	323-76-4001		N		AT WORK	L LIAB-MVA/M

PATIENT

PATIENT NAME AND ADDRESS
ENGLISH
DULBERG,PAUL R
4606 HAYDEN CT (847)497-4250
CELL#
MCHENRY IL 60051-7918 *MCHENRY CNTY, IL

PREVIOUS NAME

GUARANTOR

GUARANTOR NAME AND ADDRESS
DULBERG,PAUL R
4606 HAYDEN CT (847)497-4250
SELF
MCHENRY IL 60051-7918 CELL#
SOC SEC NO 323-76-4001 PHI CONTACT: Y

EMERGENCY CONTACT/RELATIVE 1
DULBERG,HERBERT (847)497-4250
4606 HAYDEN CT *FATHER
MCHENRY IL 60051-7918
SOC SEC NO PHI CONTACT: Y

EMERGENCY CONTACT 2
DULBERG,BARBARA (847)497-4250
4606 HAYDEN CT *MOTHER
MCHENRY IL 60051-7918
PHI CONTACT: Y

EMPLOYER

PATIENT EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

GUARANTOR EMPLOYER
SHARP PRINTING
4606 HAYDEN CT (847)497-4250
SELF EMP
MCHENRY IL 60050

RELATIVE 1 EMPLOYER

PATIENT ALTERNATE ADDRESS

INSURANCE

INSURANCE 1
PAUL DULBERG/ACCIDENT 1 601067
4606 HAYDEN CT
JOHNSBURG IL 60051 DOB: 03/19/70
ACCIDENT DULBERG,PAUL R
99999 999999999
(847)497-4250

INSURANCE 2
DOB:

INSURANCE 3
DOB:

INSURANCE 4
DOB:

MISC

DIAGNOSIS/COMPLAINT
ER

COMMENT

ATTENDING PHYSICIAN
FORD,APIWAT W

ADMITTING PHYSICIAN
FORD,APIWAT W

PRIMARY CARE PHYSICIAN
SEK,FRANK

ADDITIONAL PHYSICIAN

STN:ERA

PRINCIPAL DIAGNOSIS

COMPLICATIONS AND COMORBIDITIES

PRINCIPAL PROCEDURE & DATE

OTHER PROCEDURES & DATE

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I CERTIFY THAT THE NARRATIVE DESCRIPTIONS OF THE PRINCIPAL AND SECONDARY DIAGNOSES & THE MAJOR PROCEDURES PERFORMED ARE ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ M D DATE _____

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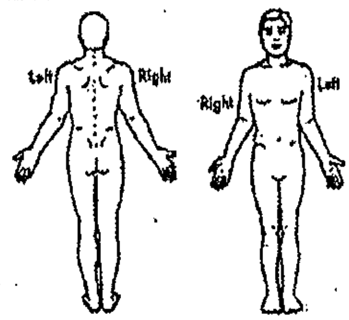
ADMISSION ASSESSMENT

Do you currently have pain? ☒ Yes 9-10 (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 pk/d 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. Stab wound
14. Foreign body
15. Pressure ulcer
16. Leg ulcer



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

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

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: ______

Respiratory ☒ NA
☐ Distress ☐ None ☐ Mild
☐ Moderate ☐ Severe
☐ Stridor ☐ Nasal Flaring
☐ Retractions
☐ Productive cough: ______
☐ Unproductive cough

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 ☐ CUD
VAGINAL/PENILE ☐ NA
☐ Discharge ☐ Bleeding
Character: ______
Amount: ______

(1455) Pt accompanied to ED by co-worker for c/o laceration by chainsaw to (R) forearm. Pt out to xray. (1505) Pt back in ER#18 Dr Ford at bedside (1522) Pt medicated as ordered (1530) Wound irrigated and cleaned. Dr Ford for suturing. (1713) D/C instructions to pt. All questions addressed Pt verbalized understanding.

Associate Signature/Initials: [signature] 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 Initial	Lab	MD/DO Order Time MD/DO Initial	Medical Imaging	MD/DO Order Time MD/DO Initial
☐ ABG		☐ PTT		☐ wound culture		☐ T Spine	
☐ Amylase		☐ RSV		☐		☐ LS Spine	
☐ Blood Culture		☐ Salicylate				☐ Ultrasound-	
☐ BMP		☐ Sputum culture				☐ CT Scan-Brain	
☐ BNP		☐ Strep				☐ CT Scan-C Spine	
☐ CBC w/diff		☐ *Trichimonas*				☐ CT Scan-Chest	
☐ CMPL		☐ Troponin ☐ POC		**Other/Miscellaneous**		☐ CT Scan-Chest PE	
☐ D. Dimer		☐ Tylenol		☐ O_2		☐ CT Scan-Abd/Pelvis	
☐ Digoxin Level		☐ Type & screen		☐ EKG Time Acquired		☐ MRI	
☐ ETOH		☐ Type & cross		Time Read		☐ FAST Scan	
☐ GC/Chlamydia		of units		☐ EKG Time Acquired		☐ ED Preg Ltd US	
☐ Hepatic Panel		☐ UA		Time Read		☐ ED Preg follow up US	
☐ HCG Qualitative		☐ UA/Reflex culture		**Medical Imaging**		☐ ED Pelvis Ltd US	
☐ HCG Quantitative		☐ Urine Culture		☐ Chest PA/Lat		☐ ED Abd Aorta US	
☐ Influenza Screen		☐ Urine Drug Screen		☐ Chest Port		☐ ED Doppler pelvis	
☐ Lipase		☐ Urine HCG ☐ Pos ☐ Neg ☐ POC		☐ C-Spine		☐ ED Venous Duplx Ext	
☐ MRSA		☐ Urine Dip ☐ POC		☐ X-Table		☐ ED Trauma trans echo	
☐ PT		☐ Wet prep		☐ Pelvis		☐ ED Trauma abd ltd	

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

☐ Td 0.5mL ☐ Tdap 0.5mL ☐ TT 0.5mL Time:___ Site:___ RN: ___ Lot# _____ Exp___ Mfr _____ ☐ VIS Given

☐ Nursing Assessment and Medication Reconciliation Reviewed
☐ Vitals Reviewed _____

Tech: _____ Initials: _____ Tech: _____ Initials: _____
RN: _____ Initials: _____ Physician: _____ Initials: _____
RN: _____ Initials: _____ Physician: _____ Initials: _____

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EMERGENCY ADMISSION ASSESSMENT

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

Treatments/Procedures:

☐ O_2 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
☐ Soak: ___ ☐ 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: 15 RTS: ___
☒ Discharge by: WTDO610 @ 1713
Discharge Vital Signs:
Discharge Summary
RN: WTDO610 Initials: WTD
Tech: Rebecca Rotis Initials: RROIB

☐ 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)
RN: ___ Initials: ___

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EMERGENCY PHYSICIAN RECORD
Upper Extremity Injury (4)

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 +
recent ETOH —
lives at home +
drug use / abuse —
lives alone
lives in nursing home

FAMILY HX (negative)

PAST HX ✓ negative R / L HANDED prior injury
diabetes Type I Type 2 diet / oral / insulin
HTN heart disease DEGENERATIVE DISC
Meds- (none) / see nurses note
Allergies- (NKDA) / see nurses note

☑ Nursing Assessment Reviewed ☑ Vitals Reviewed ☐ Tetanus immun. UTD

PHYSICAL EXAM

GENERAL APPEARANCE c-collar (PTA / in ED) / backboard
__no acute distress
✓ alert
__mild (moderate) / severe distress
__anxious

EXTREMITIES

HAND
✓ nml inspection
✓ non-tender

__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__deformity

WRIST
✓ nml inspection
✓ non-tender
✓ nml ROM*

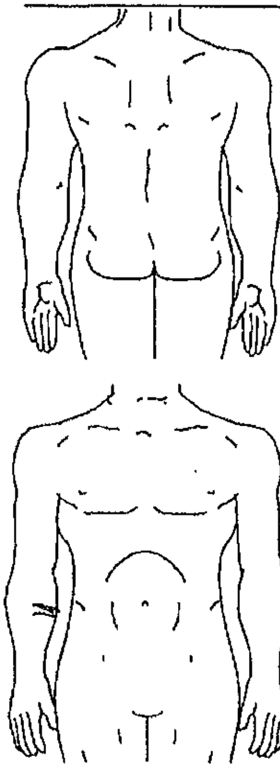
__see diagram
__tenderness soft-tissue / bony
__tenderness in anatomical snuff box
__wrist pain on axial thumb load
__swelling / ecchymosis
__limited ROM
__deformity

FOREARM / ELBOW
__nml inspection
__non-tender
✓ nml ROM*

✓ see diagram 6cm LACERATION (R) FOREARM BELLY
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity

ARM / SHOULDER
✓ nml inspection
✓ non-tender
✓ nml ROM*

__see diagram
__tenderness soft-tissue / bony
__swelling / ecchymosis
__limited ROM
__deformity



T=Tenderness PtT=Point Tenderness S=Swelling E=Ecchymosis B=Burn C=Contusion
L=Laceration A=Abrasion M=Muscle spasm PW=Puncture Wound
(Ø= without m=mild mod=moderate s=severe)
Example- Ts = Tenderness on palpation (severe)

NEURO / VASC / TENDON
✓ sensation intact
✓ motor intact
✓ no vascular compromise
✓ tendon function normal

__sensory / motor deficit
__pallor / cool skin / abnml cap refill
__pulse deficit radial ulnar
__deficit in tendon function

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SKIN — __diaphoretic / cool / cyanotic
__warm, dry

HEAD / ENT — __tenderness / __swelling / ecchymosis
__nml inspection
__pharynx nml

NECK / BACK — __tenderness / __swelling / ecchymosis
__nml inspection
__non-tender

RESPIRATORY — __tenderness / __swelling / ecchymosis / abrasions / __crepitus / subcutaneous emphysema / __decreased breath sounds / __wheezes / rales / rhonchi
__chest non-tender
__breath snds nml

CVS — __tachycardia / bradycardia
__heart sounds nml

GI (ABDOMEN) — __tenderness / guarding
__non-tender
__no organomegaly
__nml bowel snds*

XRAYS ☐ Interp. by me ☐ Reviewed by me ☐ Discad w/ radiologist
R / L *hand wrist forearm elbow humerus shoulder*
__normal / NAD
__no fracture
__nml 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

PROCEDURES

Wound Description / Repair
length 8cm location R FOREARM Bicep
linear irregular flap stellate
superficial *subcut muscle through-and-through
contused tissue lip laceration
clean contaminated minimally / moderately / *heavily
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: SOURCLENS TOPAZ
Betadine / scrub
irrigated / washed w/ saline 1L NSS debrided
*minimal / mod. / *extensive* — *minimal / mod. / *extensive*
wound explored — undermined
foreign material removed — *minimal / mod. / *extensive*
partially completely — *wound margins revised*
*minimal / mod. / *extensive* — multiple flaps aligned
no foreign body identified

repair: Wound closed with: wound adhesive / steri-strips
SKIN- # 11 interrupted 4-0 running nylon / prolene / staples simple mattress (h / v)
*SUBCUT-# 3 interrupted 4-0 running vicryl / chromic simple mattress (h / v)
OTHER- # interrupted -0 running material simple mattress (h / v)
*may indicate intermediate repair *may indicate complex repair

splint Velcro OCL / Ortho-glass / Plaster Aluminum-foam
Volar Thumb spica Ulnar Wrist Sugar-Tong Cock-up Colles
applied by ED Physician / Orthopedist / Tech
examined post splint application NV 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

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

Fall *Alleged Assault*

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- ☐ transferred ☑ home ☐ admitted ☐ expired
Time ____ ☐ AMA
CONDITION- ☐ good ☑ fair ☐ poor ☐ critical ☑ improved
☐ stable ☐ unchanged

RESIDENT / PA / NP SIGNATURE

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 — RTI # 9025 — turned care over at
Physician Signature — RTI # — assumed care at
☐ Template Complete ☐ Additional T-Sheet

Underline indicates organ system
* equivalent or minimum required for organ system exam

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