10

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

MLS: 55223
DD: Mon Jul 09 17:36:30 2012 EST
DT: Tue Jul 10 02:03:22 2012 EST
JN: 51418590

DSC OPERATIVE REPORT

DATE OF OPERATION: 07/09/2012

PREOPERATIVE DIAGNOSES:
1. Right cubital tunnel syndrome.
2. Right ulnar nerve injury at the forearm.

POSTOPERATIVE DIAGNOSES:
1. Right cubital tunnel syndrome.
2. Right ulnar nerve injury at the forearm.

PROCEDURES:
1. Right cubital tunnel release.
2. Right ulnar neurolysis at the forearm.

SURGEON: Scott Sagerman, MD.

ASSISTANT: Sam Biafora, MD.

ANESTHESIA: Regional block.

COMPLICATIONS: None.

TOURNIQUET TIME: 1 hour.

FINDINGS: The right cubital tunnel showed thickening of the cubital tunnel ligament with scarring of the ulnar nerve to the floor of the cubital tunnel and local constriction. The nerve also appeared constricted at the flexor pronator aponeurosis at the distal aspect of the cubital tunnel. Also, a thick arcade of Struthers was present proximal to the cubital tunnel, though the ulnar nerve was not visibly constricted at this level.

The right forearm, the site of the previous chainsaw laceration revealed extension to the subcutaneous tissue and fascia overlying the flexor carpi ulnaris muscle. A piece of retained absorbable suture material was present. The muscle fibers were in intact. The ulnar nerve was intact beneath the muscle belly. There was no visible scarring around the ulnar nerve at this level.

DESCRIPTION OF PROCEDURE: Informed consent was obtained from the patient. Prophylactic IV antibiotic was given. He received medical clearance from his primary care physician. Regional block anesthetic was administered by the

DSC OPERATIVE REPORT, continued

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

anesthesiologist in the right upper extremity. The right arm was prepped and draped sterilely. A sterile tourniquet was applied to the right upper arm, and it was elevated following exsanguination of the limb.

A longitudinal incision was made over the posteromedial aspect of the right elbow centered at the cubital tunnel. Under loupe magnification, the subcutaneous tissue was dissected. Superficial veins were ligated with bipolar cautery. A branch of the medial antebrachial cutaneous nerve was identified. This was gently retracted safely and protected. The fascia was incised proximal to the cubital tunnel, and the ulnar nerve was visualized. The cubital tunnel ligament was divided and completely released. The flexor pronator aponeurosis was also incised and released, and the nerve was dissected distally into the musculature where motor branches were identified. The release was then carried proximally, and the arcade of Struthers was divided and completely released. The ulnar nerve was inspected. The nerve was mobilized from adhesions with gentle blunt dissection. Nerve gliding was checked and found to be satisfactory. The ulnar nerve was stable at the cubital tunnel. The field was irrigated with antibiotic solution. The subcutaneous tissue was reapproximated with buried Vicryl sutures, and the skin edges were reapproximated with nylon sutures.

Attention was then directed to the forearm scar. A longitudinal incision was made over the ulnar aspect of the mid forearm centered at the site of the scar. Under loupe magnification, the subcutaneous tissue was dissected. The fascia was visualized. Superficial vein was ligated with bipolar cautery. The dermis was elevated off of the scarred fascia with blunt dissection. The retained suture material was removed. The muscle fibers were visualized and found to be in continuity. The ulnar nerve was exposed in the interval between the flexor digitorum and flexor carpi ulnaris muscle bellies. The nerve was dissected proximal and distal from the region of the laceration. The nerve was completely intact at this level with no visible scarring or adhesions. The field was irrigated with antibiotic solution. The subcutaneous tissue was reapproximated with buried Vicryl sutures, and the skin edges were reapproximated with nylon sutures.

A sterile bulky gauze dressing was applied. The tourniquet was deflated. Circulation returned to the right arm
with normal capillary refill distally. The patient was transported to recovery in stable condition. He tolerated the procedure well. There were no complications. An arm sling was applied for protection.

DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
DSC OPERATIVE REPORT Page 2 of 2
cc: Sam Biafora, MD

DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
DSC OPERATIVE REPORT Page 2 of 2
cc: Sam Biafora, MD

Authenticated and Edited by Scott Sagerman MD On 7/10/12 11:58:39 AM

TYPE OF BILL	DATE OF BILL	DATE OF PREV. BILL

CYCLE 07/13/12
OUT:

NORTHWEST COMMUNITY HOSPITAL
800 W CENTRAL
ARLINGTON HTS, IL 60005-2349
847 618-4747
FEI # 362340313

HOSP. NO.

BIRTH-DATE 03/19/70 424

S	G	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		DULBERG, PAUL	71265382	M	42	07/09/12		

GUARANTOR NAME AND ADDRESS
PAUL R DULBERG
4606 HAYDEN COURT
MCHENRY IL 60051

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	SELFPAY		00000

SAGERMAN, SCOTT D MD

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT $

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
07/09	001 NEUROLYSIS		1559.00					1559.00
07/09	001 ULNAR NERVE REPAIR		3817.00					3817.00
07/09	001 BLOCK,SUPRACLAVICULAR		479.00					479.00
07/09	001 US ECHO GUIDE FOR BIO		511.00					511.00
BALANCE FORWARD			0.00					
SUMMARY OF CURRENT CHARGES								
	OPERATING ROOM		5855.00					5855.00
	IMAGING/X-RAY		511.00					511.00
SUB-TOTAL OF CURR. CHARGES			6366.00					6366.00

THIS IS THE ONLY ITEMIZED BILL YOU WILL RECEIVE. PLEASE RETAIN FOR YOUR RECORDS. WE ARE BILLING THE INSURANCE THAT IS LISTED ABOVE. IF SELF PAY IS LISTED, AND YOU DO HAVE INSURANCE, PLEASE CALL 847-618-4747.

PATIENT NUMBER
71265382

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNTS SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

6366.00

PAY THIS AMOUNT 6366.00

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HTS, IL

001

NWC DAY SURGERY CENTER
675 W KIRCHOFF
ARLINGTON HT IL 600052349
8476184747

NORTHWEST COMMUNITY HOSP
PO BOX 95865
CHICAGO IL 6069

3a PAT CNTL # 71265382
b. MED REC. # 0001307925
4 TYPE OF BILL 0831

5 FED. TAX NO 363540436
6 STATEMENT COVERS PERIOD FROM 070912 THROUGH 070912
7

PATIENT NAME: DULBERG ,PAUL
9 PATIENT ADDRESS: 4606 HAYDEN COURT, MCHENRY, IL 60051

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
03191970	M	070912	12	3	1		01			

31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 CODE OCCURRENCE SPAN FROM THROUGH | 36 CODE OCCURRENCE SPAN FROM THROUGH | 37

38
AUTO OWNERS INS
6000 TALLGATE
SUIT D
ELGIN IL 60123

39 CODE VALUE CODES AMOUNT | 40 CODE VALUE CODES AMOUNT | 41 CODE VALUE CODES AMOUNT

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0402	ULTRASOUND	76942	070912	1	511 00		
0490	AMBUL SURG	64718RT	070912	1	5855 00		
0001	PAGE 01 OF 01	CREATION DATE	071712	TOTALS	6366 00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
AUTO OWNERS INS		Y	Y		

56 NPI 1194782342
57 OTHER PRV ID

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO
DULBERG ,PAUL	18	CLM#13-2775-11		

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

67 3542 9552

68

69 ADMIT DX 3542 | 70 PATIENT REASON DX 3542 | 71 PPS CODE | 72 ECI E9289 | 73

74 PRINCIPAL PROCEDURE CODE 0449 DATE 070912
a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75
c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 1841383031 QUAL 1G F54646
LAST SAGERMAN FIRST SCOTT
77 OPERATING NPI 1841383031 QUAL 1G F54646
LAST SAGERMAN FIRST SCOTT
78 OTHER NPI QUAL
LAST FIRST
79 OTHER NPI QUAL
LAST FIRST

80 REMARKS
PT - G SVC - DSC FC - P

81 CC a B3 261QA1903X
b
c
d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

07/09/2012 12:02

NORTHWEST COMMUNITY HOSPITAL / DAY SURGERY CENTER

PATIENT FACE SHEET

PATIENT NUMBER	ADM. DATE	ADM. TIME	NRS ST	ROOM/BD	FCL	TP/SVC	REG BY	CLN CD	MEDICAL RECORD NO.
71265382	07/09/12	12:02			S	G / DSC	RBAGG	DSC	0001307925

PATIENT

PATIENT NAME AND ADDRESS	S.S. NUMBER	AGE	DATE OF BIRTH	SEX	RACE	M/S	PATIENT STATUS
DULBERG ,PAUL R 4606 HAYDEN COURT MCHENRY IL 60051-	XXX-XX-XXXX	42	03/19/1970	M	1	S	OA
	PHONE: 847/497-4250	RELIGION: NOP					CNTRY CD
CASE MGR	COMPLAINT/DX: RIGHT ULNAR NEURITIS						
	NCMG(Y)/Elec Ord(Q):						

EMPLOYER

NONE
7777 WINN ROAD
SPRING GROVE IL 60081-
WORK PHONE 999/999-9999

SUBSCRIBER

DULBERG ,PAUL
4606 HAYDEN COURT
MCHENRY , IL 60051-
HOME PHONE 847/497-4250

EMERGENCY CONTACT

PRIMARY
DULBERG ,BARB
HOME PHONE 847/497-4250
WORK PHONE / EXT
RELATIONSHIP: ADULT CHIL

SECONDARY
HOME PHONE / -
WORK PHONE / - EXT
RELATIONSHIP

INSURANCE

Ins 1: S99 SELFPAY
Pol #: 00000 Type:
DULBERG
4606 HAYDEN COURT
MCHENRY , IL 60050-
Sub1: DULBERG ,PAUL
Phn #:847/497-4250
Grp #:00000
SELF
COB: 1
Vfy: Y

Ins 2:
Pol #: Type:
Sub2:
Phn #:/ -
Grp #:
COB:
Vfy:

Ins 3:
Pol #: Type:
Sub3:
Phn #:/ -
Grp #:
COB:
Vfy:

EPISODE INFO

ATTENDING PHYSICIAN: 009628 SAGERMAN, SCOTT D MD ORH
PHYSICIAN GROUP: 628 HAND SURGERY ASSOC S.C.
ADMITTING PHYSICIAN: 009628 SAGERMAN, SCOTT D MD ORH
REF/FAMILY PHYSICIAN: / -
PRIMARY CARE PHYSICIAN: / -
LAST EPISODE ACTIVITY DATE: 06/11/12

Outpatient Coding Summary

Patient Name		Sex	Birth Date	Age	MR Number	Account Number
DULBERG, PAUL R		**Male**	**03/19/1970**	**42**	**0001307925**	**71265382**
Admit Date	Discharge Date	LOS	Financial Class		Disposition	
07/09/12 12:02 PM	**07/09/12 12:02 PM**	**1**	**Self Pay**			
Attending Physician		Coder			Patient Type	
SAGERMAN, SCOTT D MD		**Litty Vincent**			**O/P Day Surgery Center (DSC)**	

Reason for visit
3542 Lesion of ulnar nerve
Secondary Diagnosis
9552 Injury to ulnar nerve E9289 Unspecified environmental and accidental causes

Procedures	Provider	Date
0449 Peripheral nerve/ganglion decompression/lysis of adhesion	SAGERMAN, SCOTT D MD	07/09/12

CPT Procedures and Modifiers	Provider	Date
64718 -RT Neuroplasty and/or transposition; ulnar nerve at elb	SAGERMAN, SCOTT D MD	07/09/12

APC	CPT	APC Text	APC Weight	APC Pct	APC Reimb	CMS Reimb
00220	64718	00220 Level I Nerve Procedures	18.88	1.00	1344.01	1075.21

APC Total Reimbursement	APC Total Weight	Total CMS Reimbursement
1344.01	**18.88**	**1075.21**

Bill Type	Claim Type	Claim Disposition	Condition Code
131	**Single day proc**	**No edits on claim**	**None of the above**

nch Northwest Community Hospital

Outpatient Coding Summary

Patient Name		Sex	Birth Date	Age	MR Number	Account Number
DULBERG, PAUL R		**Male**	**03/19/1970**	**42**	**0001307925**	**71265382**
Admit Date	Discharge Date	LOS	Financial Class		Disposition	
07/09/12 12:02 PM	**07/09/12 12:02 PM**	**1**	**Self Pay**			
Attending Physician		Coder			Patient Type	
SAGERMAN, SCOTT D MD		**Litty Vincent**			**O/P Day Surgery Center (DSC)**	

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Bill Type	Claim Type	Claim Disposition	Condition Code
131	**Single day proc**	**No edits on claim**	**None of the above**

nch Northwest Community Hospital

AUTHORIZATION FOR PERIPHERAL NERVE BLOCK PLACEMENT

A peripheral nerve block has been chosen by both your surgeon and anesthesiologist as a way to manage your pain after surgery. The following information outlines the type of block that has been indicated for your procedure. Your anesthesiologist, who is specially trained in performing this procedure, and is an independent practitioner and not an employee of Northwest Community Healthcare, will be placing the nerve block.

Though peripheral nerve blocks have a good safety record, all the listed blocks below have possible adverse effects of incomplete block, infection, bleeding, hematoma formation, adverse drug reaction, local anesthetic systemic toxicity, damage to nerve and/or surrounding structures. The duration of block may vary between patients and some motor and sensory deficits may last longer then expected.

Right
___ **Brachial Plexus block**
This is performed to reduce post operative pain in the upper extremity. Possible specific adverse effects include but are not limited to dryness or numbness of the throat/facial region, hoarseness of the voice, redness of the eye, drooping of the eye lid, shortness of breath and rarely collapsed lung.

___ **Femoral, Sciatic, Popliteal nerve block(s)**
This is performed to reduce post operative pain in the lower extremity. This block(s) will reduce your sensation and muscle strength in your leg. You will be required to have a leg splint on at all times when standing or walking until full feeling and muscle strength has returned, otherwise a potential injury due to fall may occur.

___ **Lumbar Plexus block**
This is performed to reduce post operative pain in the hip and lower extremity. Possible specific adverse effects include but are not limited to hematoma of the retroperitoneal space, spread of local Anesthetic to epidural/subarachnoid space, hypotension, possible injury due to fall.

___ **Transversus Abdominis Plane Block (TAP block)**
This is performed to reduce post operative pain in the abdominal area. Possible adverse effects include inadvertent needle puncture of the peritoneal space or abdominal viscera, bowel hematoma.

Other regional nerve blocks: _____

_____

With your signature, you have acknowledged that you have been informed of risks and benefits as well as expected outcomes for the post operative nerve block chosen for you. You are also confirming that you have read and fully understand the content of this authorization.

Patient Signature Paul Dulberg Date and Time 7/6/12 10:1

Witness Signature _____ Date and Time 7/6/12 12:

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

NCH Item # 56917

Northwest Community Hospital
Arlington Heights, IL 60005

14675CONSN

AUTHORIZATION FOR PERIPHERAL NERVE BLOCK PLACEMENT

Form # 001.175-07/11-1-PS

1. I hereby authorize Sagerman

M.D. and whomever he may designate as physician, assistants, to administer such medical treatment, including blood transfusions, as he deems necessary and/or to perform upon Paul Dulberg (State Name of Patient) the following procedure: Right ulnar nerve decompression and transposition, neurolysis at forearm

(State Nature of Procedure(s) to be Performed)

and if any unforeseen condition arises in the course of the procedure calling, in his judgment, for procedures in addition to, or different from, those now contemplated, I further request and authorize him to do whatever he deems advisable.

2. My physician has explained the nature and purpose of the procedure, or blood transfusion, possible alternative methods of treatment, the risks involved, and the possibility of complications. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

3. I consent to the administration of anesthesia and/or sedation to be applied by or under the direction of a qualified physician, and to the use of such anesthetics as he may deem advisable, and that the risks and benefits of anesthesia have been explained to me, with the exception of:

(A Blank Space or the Word "None" Indicates No Exceptions)

4. I consent to the disposal by authorities of Northwest Community Hospital of any tissues or parts which may be removed.

5. I consent to and authorize the photographing or televising of such operations and/or procedures, including appropriate portions of my body for medical, scientific or educational purposes, provided my identity is not revealed by the picture or by descriptive text accompanying them.

6. I consent to and authorize students in the health care professions and appropriate non-medical persons to be present during the above procedure.

7. The above physician, the anesthesiologist, if applicable, their assistants, and their physician groups are not employees or agents of the hospital, but are independent practitioners.

8. I certify that I have read and fully understand the entire contents of this authorization in proof of which I affix my signature below.

(WITNESS) X (SIGNATURE OF PATIENT)

NOTE: If patient is a Minor or incompetent to give consent, complete the following:

(WITNESS) (SIGNATURE OF PERSON AUTHORIZED TO CONSENT FOR PATIENT)

(WITNESS) (RELATION TO PATIENT)

7/9/12 1230
(DATE/TIME)

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

NCH Item # 1143 (front)

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

2 4 6 0 1 C O N S N

AUTHORIZATION FOR SURGICAL TREATMENT OR DIAGNOSTIC OR MINOR PROCEDURES

Form No. 001.011-03/10-1-SD

1. Por medio de este documento autorizo al Doctor _____

_____

y a quien él señale como médico, y asistentes, para que administren tratamiento médico, lo cual incluye transfusiones de sangre, si lo estima necesario, y /o practicar en _____ el siguiente procedimiento:

(Indique nombre del paciente)

_____

_____

_____

(Indique la naturaleza del procedimiento o procedimientos a ser practicado(s))

y, si surgiere alguna situación imprevista en el transcurso del procedimiento mencionado, yo pido y también le autorizo para que, a su criterio, aplique otros procedimientos que no hayan sido aquí considerados; y que proceda con lo que estime aconsejable.

2. Mi médico me ha explicado la naturaleza y el propósito del procedimiento, o transfusión de sangre, los métodos alternativos posibles del tratamiento, los riesgos que implica y la posibilidad de complicaciones. Declaro que ni garantía ni seguridad ha sido expresada acerca de los resultados que puedan ser obtenidos.

3. Consiento en que la administración de anestesia y/o sedación sea aplicada por o bajo la supervisión de un médico calificado, y que el uso de tales anestésicos será según el lo estime aconsejable, con la excepción de:

_____

(Un espacio en blanco o la palabra "ninguna" indica que no hay excepciones)

4. Consiento en que las autoridades de Northwest Community Hospital dispongan de los tejidos o partes que hayan sido removidos.

5. Consiento y autorizo la toma de fotografías y las grabaciones televisivas de tales operaciones y/o procedimientos, lo cual incluye porciones apropiadas de my cuerpo con fines médicos, científicos o educacionales, siempre que mi identidad no sea revelada en las fotografías o en el texto que acompaña a éstas.

6. Consiento y autorizo que estudiantes de la profesión del cuidado de la salud, así como personal no-médico calificado, puedan estar presentes durante el procedimiento arriba mencionado.

7. El médico arriba mencionado, el anestesiólogo, si es aplicable, sus asistentes y su grupo médico no son empleados ni agentes del hospital, pero son personal médico independiente.

8. Certifico que he leído y que comprendo completamente todo el contenido de esta autorización y, como prueba estampo mi firma aquí.

_____ _____

(TESTIGO) (FIRMA DEL PACIENTE)

Si el paciente es menor de edad o está incapacitado para dar su consentimiento, complete la siguiente información:

_____ _____

(TESTIGO) (FIRMA DE LA PERSONA AUTORIZADA PARA DAR CONSENTIMIENTO POR EL PACIENTE)

_____ _____

(TESTIGO) (RELACION CON EL PACIENTE)

_____

(FECHA/HORA)

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

AUTORIZACIÓN PARA PROCEDIMIENTOS E DIAGNÓSTICO, TERAPÉUTICOS Ó QUIRÚRGICOS
AUTHORIZATION FOR SURGICAL TREATMENT OR DIAGNOSTIC OR MINOR PROCEDURES (SPANISH)
Form No. 001.011-03/10-1-SD

NCH Item # 1143 (backer)

DAY SURGERY CENTER PATIENTS

☒ I received the Day Surgery Center brochure by mail outlining my Patient Rights and Advance Directive options.

☐ I have received a copy of the Patient Rights and Responsibilities.

SHARING CONSENT

- To comply with the Federal Privacy rules, we request that a spokesperson be identified by the patient to be the primary contact to receive updates about the patient's condition. An alternate spokesperson(s) may be selected in case the primary spokesperson is not available. It is a requirement that both primary and alternate spokespersons have the patient's permission to receive protected health information as it relates to his/her care.
- Information requests via the telephone will be given only to an identified spokesperson on this written document.

Physician may share information about my procedure with the following individuals:

Name	Relationship	*(Cell Phone Number)*
Barb	mom	

☐ ***Do not share routine information regarding my procedure***

Responsible adult that will drive me home: _____

☐ Same as above

☐ *My driver plans to stay in the immediate area (waiting room)- **Pager number*** 42

☐ *My driver will pick me up when ready:* _____
Name and phone number for driver

☐ *Adult who will stay with me at home for 24 hours:* _____

Notes: _____

Patient/Guardian Signature: Paul Dulberg Date: _____

BLOCK

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

2-

14629CONSN

SHARING PATIENT INFORMATION FORM

NCH Item # 57533

Form # 001.170-09/11-1-SD

UNIVERSAL CONSENT

LANGUAGE SERVICES [PL] (please initial)
I understand that I have the right to a free interpreter.

[X] English Speaking - No Interpreter Necessary.

[ ] I accept the interpreting services provided by the hospital.

Language Requested: _____ Name of Interpreter: _____

[ ] I refuse the interpreting services. [ ] I request a friend or family member to interpret.

Refusal Signature: _____

[ ] Form read to patient by: _____

CONSENT FOR TREATMENT [PL] (please initial)
I hereby consent to the administration and performance of all tests and treatments by members of the medical staff and personnel at Northwest Community Hospital, Northwest Community Day Surgery Center, and/or Northwest Community Medical Group ("NCH") which in the judgment of the physicians may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. I authorize NCH to request and receive information, including my medical record, from my treating physician(s) or agents.

DISCLOSURE STATEMENT [PL] (please initial)
My care will be managed by physicians who are not employed by or acting as agents of NCH but have privileges at these facilities. My physician may decide to call in consultants who are also not employed by or agents of NCH and who practice in other specialties to provide care to me. To provide specialized services such as emergency medicine, radiology, radiation oncology, pathology and anesthesiology, NCH has entered into agreements with independent physician groups. The members of these groups are not employees or agents of NCH. My care may be managed by allied health professionals such as nurse anesthetists, physician assistants, advanced practice nurses and nurse midwives who are not employees or agents of NCH. I understand that NCH does not exercise any control or authority over any physician's professional or allied health professional's judgment, diagnosis or treatment decisions. I understand that my treating physicians may not participate in the same insurance plans as NCH, and that I will receive a separate bill for these physician services.

RELEASE OF RESPONSIBILITY FOR VALUABLES [PL] (please initial)
I acknowledge that NCH **WILL NOT** be liable for any loss or theft of any personal property of mine, other than that which is deposited in the hospital safe, whether such loss or theft is caused by any patient, visitor, guest, agent or employee of NCH. I hereby release and exonerate NCH from any loss or theft of my personal property.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF RECORDS [PLD] (please initial)
I currently maintain insurance coverage which will reimburse the charges from NCH, my treating physicians, and any ambulance transport for medical care provided to me. In consideration of those services, I hereby assign, transfer and convey to NCH, my treating physicians, and any ambulance providers all of my rights, title and interest in my medical insurance for medical expense reimbursement, including, but not limited to adding dependent eligibility, and to have a policy continued or issued in accordance with the terms and benefits under any insurance policy continued or issued.

I hereby authorize the NCH and any physician or other healthcare provider who may treat me to release, for the purpose of billing and collecting, any and all pertinent information contained in my medical records, including HIV, to one another and/or their billing agents, and third party payors responsible for payment of patient charges including but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.

PAYMENT GUARANTEE [PLD] (please initial)
I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided by NCH and/or my treating physicians, whether as an inpatient or outpatient, unless I qualify for financial assistance or charity care. If my medical insurance coverage is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered by the Assignment of Insurance Benefits, I will be fully responsible for payment of the balance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES [PLD] (please initial)
I acknowledge that I have received NCH's Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by NCH and informs me of my rights with respect to my protected health information. For more information, please contact the Patient Advocate Office at 847.618.4390.

RECEIPT OF CHARITY CARE/FINANCIAL ASSISTANCE BROCHURE [PLD] (please initial)
I acknowledge that I have received the NCH Charity Care/Financial Assistance brochure. For more information, please contact a Financial Counselor at 847.618.4542.

Upon signing this consent, I acknowledge that I have read and understand the foregoing and accept its terms.

Patient Signature Paul Dulberg Date 7/9/12

If Patient under 18 years Parent or Guardian Signature _____ Date _____

If Patient unable to sign-Legal Representative _____

Relationship to Patient and reason Patient unable to sign _____

Date of Service _____

NCH Employee Witness Signature [illegible] Date _____

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

UNIVERSAL CONSENT

LANGUAGE SERVICES [initials] (please initial)
I understand that I have the right to a free interpreter.

☒ English Speaking - No Interpreter Necessary.

☐ I accept the interpreting services provided by the hospital.

Language Requested: _____ Name of Interpreter: _____

☐ I refuse the interpreting services. ☐ I request a friend or family member to interpret.

Refusal Signature: _____

☐ Form read to patient by: _____

CONSENT FOR TREATMENT [initials] (please initial)
I hereby consent to the administration and performance of all tests and treatments by members of the medical staff and personnel at Northwest Community Hospital, Northwest Community Day Surgery Center, and/or Northwest Community Medical Group ("NCH") which in the judgment of the physicians may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. I authorize NCH to request and receive information, including my medical record, from my treating physician(s) or agents.

DISCLOSURE STATEMENT [initials] (please initial)
My care will be managed by physicians who are not employed by or acting as agents of NCH but have privileges at these facilities. My physician may decide to call in consultants who are also not employed by or agents of NCH and who practice in other specialties to provide care to me. To provide specialized services such as emergency medicine, radiology, radiation oncology, pathology and anesthesiology, NCH has entered into agreements with independent physician groups. The members of these groups are not employees or agents of NCH. My care may be managed by allied health professionals such as nurse anesthetists, physician assistants, advanced practice nurses and nurse midwives who are not employees or agents of NCH. I understand that NCH does not exercise any control or authority over any physician's professional or allied health professional's judgment, diagnosis or treatment decisions. I understand that my treating physicians may not participate in the same insurance plans as NCH, and that I will receive a separate bill for these physician services.

RELEASE OF RESPONSIBILITY FOR VALUABLES [initials] (please initial)
I acknowledge that NCH **WILL NOT** be liable for any loss or theft of any personal property of mine, other than that which is deposited in the hospital safe, whether such loss or theft is caused by any patient, visitor, guest, agent or employee of NCH. I hereby release and exonerate NCH from any loss or theft of my personal property.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF RECORDS [PD] (please initial)
I currently maintain insurance coverage which will reimburse the charges from NCH, my treating physicians, and any ambulance transport for medical care provided to me. In consideration of those services, I hereby assign, transfer and convey to NCH, my treating physicians, and any ambulance providers all of my rights, title and interest in my medical insurance for medical expense reimbursement, including, but not limited to adding dependent eligibility, and to have a policy continued or issued in accordance with the terms and benefits under any insurance policy continued or issued.

I hereby authorize the NCH and any physician or other healthcare provider who may treat me to release, for the purpose of billing and collecting, any and all pertinent information contained in my medical records, including HIV, to one another and/or their billing agents, and third party payors responsible for payment of patient charges including but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.

PAYMENT GUARANTEE [PD] (please initial)
I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided by NCH and/or my treating physicians, whether as an inpatient or outpatient, unless I qualify for financial assistance or charity care. If my medical insurance coverage is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered by the Assignment of Insurance Benefits, I will be fully responsible for payment of the balance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES [PD] (please initial)
I acknowledge that I have received NCH's Notice of Privacy Practices. I understand that the notice describes the uses and disclosures of my protected health information by NCH and informs me of my rights with respect to my protected health information. For more information, please contact the Patient Advocate Office at 847.618.4390.

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Upon signing this consent, I acknowledge that I have read and understand the foregoing and accept its terms.

Patient Signature [Paul Dulberg] Date 7/9/12

If Patient under 18 years Parent or Guardian Signature _____ Date _____

If Patient unable to sign-Legal Representative _____

Relationship to Patient and reason Patient unable to sign _____

Date of Service _____

NCH Employee Witness Signature [RBaop] Date _____

DAY SURGERY CENTER PATIENTS

☒ I received the Day Surgery Center brochure by mail outlining my Patient Rights and Advance Directive options.

☐ I have received a copy of the Patient Rights and Responsibilities.

SHARING CONSENT

- To comply with the Federal Privacy rules, we request that a spokesperson be identified by the patient to be the primary contact to receive updates about the patient's condition. An alternate spokesperson(s) may be selected in case the primary spokesperson is not available. It is a requirement that both primary and alternate spokespersons have the patient's permission to receive protected health information as it relates to his/her care.
- Information requests via the telephone will be given only to an identified spokesperson on this written document.

Physician may share information about my procedure with the following individuals:

Barb — mom

Name / Relationship / *(Cell Phone Number)*

Name / Relationship / *(Cell Phone Number)*

☐ ***Do not share routine information regarding my procedure***

Responsible adult that will drive me home: _____

☐ Same as above

☐ *My driver plans to stay in the immediate area (waiting room)-* ***Pager number*** 42

☐ *My driver will pick me up when ready:* _____
Name and phone number for driver

☐ *Adult who will stay with me at home for 24 hours:* _____

Notes: _____

Patient/Guardian Signature: X [signature] Date: _____

BLOCK

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

2-

146290CONSN

SHARING PATIENT INFORMATION FORM

NCH Item # 57533

Form # 001.170-09/11-1-SD

Key Points to observe after hospital discharge:

1) Begin to take your oral pain medication when you start to have feeling in your operative limb. This will provide more effective pain relief than if you wait until the block wears off completely.

2) Start taking your home medications as directed by your family physician or surgeon.

3) You may notice a slight temperature difference between your "blocked" limb versus your other limbs. This is not unusual and is a normal occurrence for this type of anesthesia.

Upper Limb (Arm)

1) The nerve block will wear off in about 6 - 24 hours. Until then, your arm and shoulder area will be numb and weak. DO NOT lift or carry objects.

2) Limit your activities until full feeling and strength have returned to avoid injury due to altered sensation.

3) If given an arm sling, wear sling until you have feeling and muscle strength to control your arm or your surgeon tells you to remove it. This also is to prevent injury.

Lower Limb (Leg)

1) The nerve block will wear off in about 6 - 24 hours. Until then, your leg will be numb and weak. DO NOT try to bear weight on your leg or you might fall! When given a brace, wear it at all times that you are up and about, until your surgeon tells you otherwise.

2) Limit your activities until full feeling and muscle strength have returned to avoid injury due to altered sensation.

3) Use assistive devices such as crutches or a walker as ordered by your physician.

If you have redness or swelling at the injection site, metallic taste in your mouth, facial numbness or tingling, slurred speech, restlessness, or any question that is of concern please call the 847.618.7200 immediately and ask to talk to an anesthesiologist.

Patient/Patient Rep Signature

Nurse Signature 7/9/12 Date and Time 540

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Arlington Heights, IL 60005

14054DISR

Regional Anesthesia/ Single Block Injection
Discharge Instruction Sheet

NCH Item # 56906

Form # 005.789-12/11-1-PS

Original – Chart

Photocopy – Patient

You are urged to carefully follow these instructions. Following anesthesia you may experience lightheadedness, dizziness, and sleepiness.

YOU MUST HAVE A RESPONSIBLE ADULT TO TAKE YOU HOME AND STAY WITH YOU FOR THE FIRST 24 HOURS.

ACTIVITY:

☒ The first 24 hours after surgery/procedure
- ☒ NO operating of power/heavy equipment.
- ☒ NO driving a motor vehicle.
- ☒ NO activities that require judgment decisions.
- ☒ NO work or school.

☒ REST at home. Limited activity as tolerated. No heavy lifting.
☒ No weight bearing. ☐ Weight bearing as tolerated with crutches/walker/surgical shoe as discussed.
☒ Keep operative site elevated. (R) arm
☐ Fall prevention discussed.
☐ May shower on _____
☐ May return to work on _____

DIET:

☐ Clear liquids for 24 hours, then advance to soft diet then regular diet.
☒ Resume normal diet ☒ as tolerated ☐ after _____
☒ Do not drink alcoholic beverages including beer or wine for 24 hours.

MEDICATIONS: Norco

Pain medication containing codeine or other narcotics may produce some loss of judgment and/or coordination. If you are taking such medication, please adhere to the following instructions:
☒ Do not drive a motor vehicle; operate power tools or machinery while taking this medication.
☒ Do not drink alcoholic beverages (including beer and wine) while taking pain medication.
☒ Medication reconciliation sheet discussed and given to patient.

IMPORTANT: Call your physician promptly for the following:

☒ Signs of infection at operative area(s) and/or IV site: fever >101 or chills, pus or foul smelling drainage, redness or swelling at site, severe pain.
☒ Any abnormal bleeding ☒ Heart palpitations ☒ New or unusual pain
☒ Persistent nausea and vomiting ☒ Rash
☒ If your extremity looks pale or blue, becomes swollen, or you feel a change in sensation.

If you are unable to contact your physician/surgeon and feel that your symptoms require a physician's attention, call or go directly to the nearest emergency department or call 911.

GYNECOLOGY / UROLOGY

☐ Avoid sexual intercourse as instructed by your physician for _____
☐ No tampons, no douching, and no tub baths or swimming as instructed by your physician for _____
☐ You may expect some vaginal bleeding, some abdominal cramping, and lower back pain.
☒ If unable to urinate within 6-8 hours after discharge, go to the Emergency Room.

FOLLOW UP:

☐ Call for an appointment to see Dr SAGERMAN in/on 7/12
☐ With Dr _____ as follows _____

Call 911 or go directly to the nearest emergency department for the following:

• difficulty breathing • chest pain • inability to remain alert.

ADDITIONAL INSTRUCTIONS

keep dressing dry, elevate (R) arm, sling x24 o

I have received and understand the above instructions:

Patient Signature _____ Nurse Signature _____ RN Date 7/9/12

Guardian/Adult with Patient Signature Scott Dulberg Date 7/9/12

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

140100ISR

PATIENT DISCHARGE INSTRUCTIONS
for Diagnostic, Therapeutic or Surgical Procedures

DATE: _____ **TIME:** _____

HISTORY AND PHYSICAL:
This patient was examined, and "no change" has occurred in the patient's condition since the history and physical was completed.

Physician Signature _____ **M.D. / D.O.**

Interval Changes:

Physician Signature _____ **M.D. / D.O.**

DULBERG ,PAUL R
71265382 M 42 07/09/12
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SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

100037 H P

HISTORY AND PHYSICAL UPDATE NOTE

NCH Item # 46027

Form # 005.739-01/12-1-SD

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

MLS: 95331
DD: Mon Jul 09 11:20:41 2012 EST
DT: Mon Jul 09 11:35:47 2012 EST
JN: 51400438

PREOPERATIVE HISTORY AND PHYSICAL

DATE OF ADMISSION: 07/09/2012 12:00 AM

CHIEF COMPLAINT/DETAILS OF PRESENT ILLNESS: The patient is a 42-year-old male being admitted for elective surgery for right ulnar nerve injury.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: left ulnar nerve decompression - SS

FAMILY HISTORY: n/c - SS

ALLERGIES: None.

MEDICATIONS : Naproxen, tramadol and fluoxetine

SOCIAL HISTORY: Smoking history positive.

REVIEW OF SYSTEMS: Negative.

PHYSICAL EXAMINATION:
HEART AND LUNGS: Normal.
EXTREMITIES: The right elbow shows positive Tinel signs at the cubital tunnel with satisfactory range of motion. Scar is noted at the ulnar aspect of the midforearm from prior chainsaw accident with local sensitivity and tenderness. He indicates numbness in his ring and small fingers with gripping activities.

DIAGNOSTIC DATA : X-rays of the right forearm from June 20, 2011, are negative. The MRI of the right forearm from February of 2012 was unremarkable.

IMPRESSION: Right ulnar neuritis at the cubital tunnel and partial ulnar nerve injury right forearm.

PLAN: Right ulnar nerve decompression, possible transposition and neurolysis at the forearm. The surgery is scheduled under regional block anesthetic in day surgery. The patient understands the risks and benefits of surgery and the chance of complications, and he requests to proceed.

DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
PREOPERATIVE HISTORY AND PHYSICAL Page 1 of 2
cc:

SS - Sagerman MD, Scott Tue Jul 31 12:24:16 CDT 2012

SS - Sagerman MD, Scott Fri Aug 24 13:15:32 CDT 2012

PREOPERATIVE HISTORY AND PHYSICAL, continued

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
PREOPERATIVE HISTORY AND PHYSICAL Page 2 of 2
cc:

Authenticated by Scott Sagerman MD On 07/10/2012 11:58:23 AM

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

MLS: 95331
DD: Mon Jul 09 11:20:41 2012 EST
DT: Mon Jul 09 11:35:47 2012 EST
JN: 51400438

PREOPERATIVE HISTORY AND PHYSICAL

DATE OF ADMISSION: 07/09/2012 12:00 AM

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PAST SURGICAL HISTORY:

FAMILY HISTORY:

ALLERGIES: None.

MEDICATIONS : Naproxen, tramadol and fluoxetine

SOCIAL HISTORY: Smoking history positive.

REVIEW OF SYSTEMS: Negative.

PHYSICAL EXAMINATION:
HEART AND LUNGS: Normal.
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DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
PREOPERATIVE HISTORY AND PHYSICAL Page 1 of 2
cc:

PREOPERATIVE HISTORY AND PHYSICAL, continued

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

DULBERG, PAUL
071265382
0001307925
Room#:
Scott D Sagerman, MD
PREOPERATIVE HISTORY AND PHYSICAL Page 2 of 2
cc:

Authenticated by Scott Sagerman MD On 07/10/2012 11:58:23 AM

DATE: 7/9/12 TIME: ______

EXPECTED PATIENT OUTCOMES

Patient/significant other verbalizes understanding of planned procedure.
- ☑ Surgical consent signed
- ☑ Compliance with verbal or written instructions
- ☑ States in own words understanding of pre-procedure teaching

*Patient demonstrates or verbalizes an acceptable level of coping with anxiety.
- ☐ States in own words anxiety level
- ☐ States in own words coping needs
- ☑ Demeanor appropriate to situation

*(one or more of above)

Patient exhibits evidence of being prepared for the procedure in a safe and supportive environment.
- ☐ Complies with activity restrictions
- ☑ Ready for procedure

IMMEDIATE PRE-PROCEDURE PATIENT ASSESSMENT

☑ ID bracelet on ☐ ALLERGIES denies
☐ allergy bracelet on

Scaled Weight: 76.1 kg Height 5'9" Last menses N/A
Vital Signs: T 98.1 ☐ oral ☐ axillary ☐ tympanic ☑ temporal
P 66 Resp 18 BP 102/63 SaO_2 100%
NPO since 1700 7/8/12 Last Void 1220

Check For Following and/or Remove:

Present		Removed
☐	make up/nail polish	☐
☐	jewelry/piercing/ring	☐
☐	dentures/partials	☐
☐	glasses/contact lenses	☐
☐	wig	☐
☐	hearing aid (right/left)	☐

☐ other ______
Given to ______

Impairments:
- ☐ none
- ☐ hearing (right / left)
- ☐ mobility ☐ vision
- ☐ speech ☐ language
- ☐ prosthesis ______

Implants: ☐ none ☐ pacemaker ☐ joint replaced ☐ ICD ☐ other ______

☑ Surgical side/site verified with patient/family/guardian.
Surgical site location right hand RN initials [initials]

IV: Time: 1318 Solution: SL Gauge: 20g Site: Lt hand Rate: TKO By: [signature]

IV: Time: ______ Solution: ______ Gauge: ______ Site: ______ Rate: ______ By: ______

Preps: ☐ enema ☐ foley catheter ☐ other ______
☐ anti-embolism stockings ☐ SCD (☐ OR aware)
☐ Hair clipped: time ______ location ______ by ______
☐ Skin Prep: time ______ location ______ by ______
Type ______

Instructions: ☑ stay in bed, on cart or in (chair) ☐ side rails up
☐ crutch / cane walking ☑ deep breathing, coughing, leg exercises
☐ PCA ☐ Incentive Spirometry ☑ pain scale ☐ CPM
☐ Other ______

Outpatients: ☐ NA
☑ Confirm ride home, Name mom
Phone # if not present ______
☑ Confirm adult supervision at home, Name mom

Signature: [signature] RN

CHART REVIEW

☐ Old Records ______ ☑ Consent completed [initials]
☐ H&P complete ______ ☐ Advanced directives NO

Underline Test Ordered - Check Box & Initial Results On Chart:

☐ Basic Metabolic	☐ Pregnancy Test
☐ CBC / with Diff	☐ Blood Glucose denies
☐ Comp. Metabolic	☐ U/A
☐ Micro Rhogam	☐ Urine Culture
☐ PT/PTT	☐ CXR
☐ Coagulation Profile	☐ EKG
☐ HIV	☐ Other

Abnormal Labs	Anes. notified	M.D. notified	Comments	Init

Blood Orders:
☐ Type and screen ______ Directed donor blood available ___
☐ Type and crossmatch ______ Autologous blood available ___
Number of units ordered ______

Nurses Notes: 7/9/12 - 1310 [illegible] Pre OK'd at pol Allergies [illegible]

Locker #5

Initials	Signature	Date

Teaching Audience ☑ Patient ☐ Family/Significant Other ☑ Phone Interview ☐ In Person

Purpose: To educate the patient in preparation for their procedure.

Expected Outcomes

I	The patient will verbalize the planned procedure.
II	The patient will arrive on day of surgery safely prepared for procedure and anesthesia.
III	The patient will be aware that discharge instructions will be given to them and their family or significant other upon discharge.

Individual Needs Assessment

Patient		Family/Significant Other	
☐ Language	☐ Vision	☐ Language	☐ Vision
☐ Hearing	☑ Physical Limitations	☐ Hearing	☐ Physical Limitations
☐ Cognitive	☐ None	☐ Cognitive	☑ None

☐ Comment _____

Readiness to learn is evidenced by:

☐ Asking questions ☐ Verbalization of treatment plan ☐ Focusing attention

Patient preference for learning:

☐ Demonstration ☐ Printed material
☑ Verbal Instruction/discussion ☐ Return demonstration
☐ Video (if available) ☐ Other _____

Teaching Plan and Material

	Discussed	Provided		Discussed	Provided
DSC Brochure	☐	☐	Pre Operative Instructions	☐	☐
Pre Operative Booklet	☐	☐	Pain Management	☐	☐
Advance Directives	☐	☐	Herbal/Dietary Supplement	☐	☐
☐ Carelink			Peripheral Nerve Block	☐	☐
☐ Complete on ADM			Crutch Walking	☐	☐
☑ Not Interested			Smoking Cessation	☐	☐

☐ Other _____

RN Signature: _____ Date/Time 6/26/12

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

NCH Item # 64479

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

154 16 P I O P

PRE-SURGICAL TEACHING NEEDS ASSESSMENT

Form # 005.867-08/10-1-SD

Northwest Community Hospital
800 W. Central Rd.
Arlington Heights, IL, 60005
☐ **847.618.7258** ☐ **847.618.7255**
Entrance # 2
North Elevator to 2nd Floor

Date of Procedure_____

On_____between 2:00-7:00PM

Call **847.618.7244** for arrival time

Northwest Community Day Surgery Center
675 W. Kirchoff Rd.
Arlington Heights, IL, 60005
847.618.7080
Entrance # 3

PS mom Angie Dulberg, Paul 1:30

Monday

Date of Procedure	7/9	7/9	
Time of Procedure	1:30	200	
Time of Arrival	1:30	1200	

☑ Beginning at midnight prior to surgery, do not eat or drink anything, including water, candy, mints, or gum.

☑ No solid food after midnight before surgery.

☐ Clear liquids until _____ and then nothing by mouth after that time.

☑ Continue to take all of your routine medications up until the night before surgery. Check with your physician regarding taking any blood thinning medications like Aspirin, NSAIDS (Motrin®, Advil®, Aleve®), Coumadin®, Plavix®, or Herbal supplements/Vitamins.

☑ If not allergic, you may take the following acceptable pain medications (e.g. Tylenol®, Acetaminophen, Vicodin®, etc.)

_____

☑ On the day of surgery, take the following inhalers and/or medications with a small sip of water_____

_____

☑ No alcoholic beverages and no smoking 24 hours before and after surgery.

☑ Bathe/shower day of surgery. Leave off makeup, contact lenses, nail/toe polish, and all jewelry including wedding bands/body piercings. Wear loose, comfortable clothes. Leave all valuables at home.

directions to DSC given

☑ Bring on the day of surgery if applicable:

☑ Photo ID & Insurance Card ☐ Medications/inhalers ☐ Glasses with Case
☐ Crutches/Walker ☐ CPAP machine ☐ Hearing Aids ☐ Physician Orders
☐ Toiletries, robe, and slippers if desired ☐ Laboratory/X-ray results/ECG
☐ Advance Directives/Living Will/ Power of Attorney for Healthcare
☐ Other: _____

☑ Report any signs of illness/infection/respiratory symptoms to your surgeon. You may need to reschedule your surgery.

☑ Name of responsible adult to drive you home after the procedure Ramart

☑ Name of responsible adult to stay with you overnight after your procedure Ramart

Patient/Significant Other Signature_____ Date_____

RN Signature Shanalan Scott Date/Time 6/26/12

☑ Phone Interview

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Arlington Heights, IL 60005

15401PIOP

PRE-OPERATIVE INSTRUCTIONS

NCH Item # 26675

Form # 005.033-08/10-2-SD

White Copy (Chart) Yellow (Patient)

DATE: 7/9/12 | SURGEON: Sagerman, [illegible] | ALLERGIES: NKDA

NOTES: [illegible]

DIAGNOSIS PER SURGEON: Right ulnar neuritis

14:12-14:14
[illegible]
Right supraclavicular block
Versed 2mg, Fentanyl 50mcg,
20cc 0.5% bupivacaine [illegible]

TIME 14:30 | 15:00 | 16:00 | 17:00

ANESTHETIC AGENTS
O2 (L/M) Nasal cannula 4 — 4 — 4
N2O (L/M)

PROPOFOL (mcg/kg/min) 140 — 120 — 80 — 65
KETOROLAC
VERSED (mg) 2
FENTANYL (mcg) 50

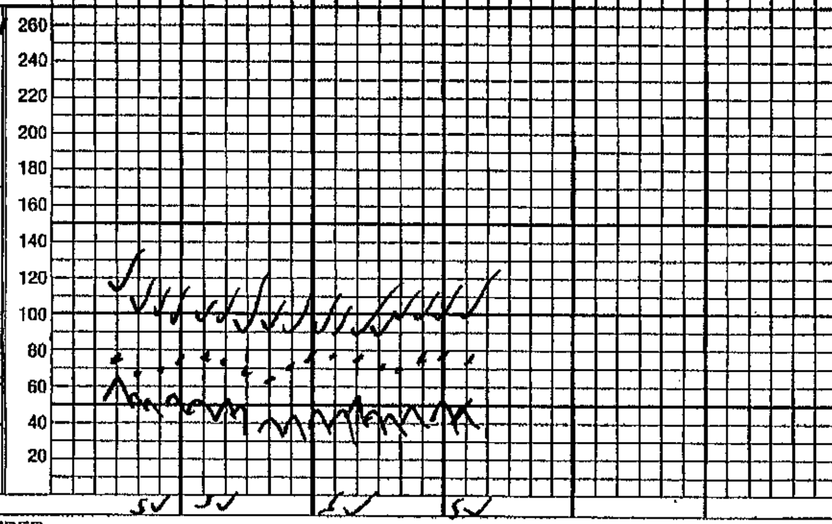
MONITOR
☑ EKG 52 / 52 / 52 / 52
☑ PULSE OX / SpO2% 99 / 99 / 98 / 98
☐ FiO2
☐ CAPNOGR / EtCO2
☐ PC STETH
☐ TEMP
☐ BIS
☐ TOURNIQUET
☐ NERVE STIM.

PREOPERATIVE:
WT: 76 kg HT: 5'9"
B/P: 102/63
P: 66
AIRWAY: 1
PHYSICAL STATUS: 2

SUPPORTIVE DIAGNOSIS: Smoker, OSA

PREOP. MEDS

☑ PATIENT ASSESSMENT/CHART CHECKED
☑ ANESTH. MACHINE SAFETY CHECK
☐ NASAL CANNULA



FOOTNOTES NUMBER

POSITION: Supine

I.V. SITE: (L) [illegible] | FLUIDS: 800

TECHNIQUE: ☐ GA ☐ MAC ☑ REGIONAL (TYPE: Supraclavicular block)

OPERATION: Right ulnar nerve decompression neurolysis at forearm

Anesthesiologist PRINT NAME: [illegible] | SIGNATURE: [signature]

INDUCTION
☐ MASK INDXN
☐ PREOXYGEN/ DENITROGENATION
☐ RAPID SEQUENCE
☐ CRICOID PRESS.
☐ MASK POS PRESSURE VENT

(marked N/A)

INTUBATION
☐ DIRECT LARYNGOSCOPY
MAC MILLER, MIS NO. ___
GRADE: CORDS ARYTENOIDS EPIGLOTTIS PALATE
☐ ENDOTRACHEAL TUBE ___
☐ ORAL ☐ NASAL ☐ CUFF
AIR LEAKS AT ___ cmH2O
☐ BILAT BREATH SOUNDS
___ cm
AT ___
☐ SCCA ☐ OTHER: ___
☐ EYECARE: LACRILUBE, TAPE, OPTIGARD
☐ PRESSURE POINTS CHECKED & PADDED

FLUID TOTALS
CRYSTALLOID: 900
BLOOD:
COLLOID:
EBL:
URINE:
OTHER:

EXTUBATION (marked N/A)
☐ FOLLOWS COMMANDS
☐ SWALLOWS
☐ SUSTAINED TET, PRESENT (50 Hz5s)
☐ PHARYNX SUCTIONED
☐ SPON RESPIRATIONS, RATE ___
☐ EtCO2
☐ REVERSAL ___ mg(+) ___ mg
☐ NALOXONE
☐ HEAD LIFT > 5 SEC.
☑ PATENT TO PACU WITH ANESTHESIA MD
☑ REPORT GIVEN TO PACU RN

MONITORS
TYPE LOCATION
☐ A-LINE
☐ CVP
☐ S-GANZ
☐ TEE
☐ OTHER
(marked N/A)

STATUS PACU:
☑ AWARE ☑ STABLE
☐ DROWSY ☐ UNSTABLE
☐ SOMNOLENT ☐ INTUBATED
☐ UNAROUSABLE ☐ VENTILATED
☑ NASAL 02 3 L/M
☐ MASK 02 ___ %
☐ T-PIECE 02 ___ %
TEMP. 96.4
SPO2: 95 | R: 16
P: 67 | B/P: 96/47

POST-OP PAIN BLOCK
☐ EPIDURAL
☐ OTHER

ANESTHESIA STARTED 14:47
OPERATION STARTED 15:04
OPERATION ENDED 16:08
ANESTHESIA ENDED 16:20

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

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Day Surgery Center
Arlington Heights, IL 60005

21502ANE

ANESTHESIA RECORD

Item # 01038

Form # 005.095 - 05/04 - 2 - S&D

NOTES

DULBERG ,PAUL R
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ANESTHESIA PRE-OPERATIVE HEALTH HISTORY ASSESSMENT & PHYSICAL EXAM

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
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NCH Item # 32132

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

41501ANE

ANESTHESIA PRE-OPERATIVE HEALTH HISTORY ASSESSMENT AND PHYSICAL EXAM
Form # 002.018-02/11-1-SD

Please Print:
Patient's full name: Paul (first) middle initial R Dulberg (last) Date: 6/26/12.

Age: 42 Sex: ☒ Male ☐ Female Stated height: 5'10" Stated weight: 160 lbs. BMI 24.4

Home phone: ( ) Work phone: ( ) BMI - DOS - 24.8

Primary care physician: Dr. Sorch Phone #:

Specialist: Phone #:

ALLERGIES: ☒ None ☐ Yes (Include food & latex, list; if yes, describe reaction).

MEDICAL / HEALTH HISTORY given by Patient obtained by CMA ☐ In person ☒ Phone

		NO	YES			NO	YES			NO	YES
1.	Heart attack/disease	☒	☐	14.	Tuberculosis	☒	☐	28.	Cancer	☒	☐
2.	Chest pain/pressure	☒	☐	15.	Cold in last 2 weeks	☒	☐	29.	Blood Clots/disorders	☒	☐
3.	Irregular heart beat/palpitations	☒	☐	16.	Acid reflux/hiatal hernia	☒	☐	30.	Bruises easily	☒	☐
4.	Mitral Valve Prolapse	☒	☐	17.	Hepatitis/jaundice	☒	☐	31.	Arthritis DJD neck	☐	☒
5.	High Blood Pressure	☒	☐	18.	Liver disease/cirrhosis	☒	☐	32.	Neck/back pain	☐	☒
6.	Pacemaker/AICD	☒	☐	19.	Kidney disease/dialysis	☒	☐	33.	Glaucoma	☒	☐
7.	Shortness of breath	☒	☐	20.	Peripheral vascular/arterial disease	☒	☐	34.	Infectious Disease (C-Diff, HIV, MRSA, VRE)	☒	☐
8.	Able to climb 1 flight of stairs	☐	☒	21.	Stroke	☒	☐				
9.	Able to walk 2 city blocks	☐	☒	22.	Seizures	☒	☐	35.	Malignant Hyperthermia		
10.	Asthma/wheezing	☒	☐	23.	Motion Sickness	☒	☐		Self Family	☒	☐
11.	COPD (emphysema/bronchitis)	☒	☐	24.	Parkinson's disease	☒	☐	36.	Any Anesthesia complications		
12.	Other lung Disease	☒	☐	25.	Multiple Sclerosis	☒	☐		Self Family	☒	☐
13.	Sleep Apnea	☒	☐	26.	Diabetes	☒	☐	37.	Other Illness/injury	☒	☒
				27.	Thyroid	☐	☐				

Comments:
(31) June 2011, was involved in a chainsaw accident involving the right arm.

Previous surgery and previous anesthesia: ☐ None

	SURGERY TYPE	DATE OF SURGERY	TYPE OF ANESTHESIA	ANESTHESIA PROBLEMS
(32)	Left Ulnar Nerve Transposition	10yrs ago	Gen.	Nausea
2.				
3.				
4.				
5.				
6.				
7.				

Aspirin; NSAIDS (Motrin/Advil), Coumadin, Plavix, Other blood thinners? ☒ No ☐ Yes Last taken: Naproxen - Last Tuesday

Steroid use in the last 6 months? ☒ No ☐ Yes

Do you smoke? ☐ No ☒ Yes # packs/day? 1 ppd # years smoked: 20yrs Date quit?

Do you drink alcoholic beverages? ☒ No ☐ Yes How much every day/week?

Do you use recreational drugs? ☒ No ☐ Yes How much every day/week?

Females: could you be pregnant? ☐ No ☐ Yes Date of last menstrual period:

Did you donate blood for surgery? ☐ No ☐ Yes Number of units

Patient/Guardian Signature: X Paul Dulberg Date: 7/9/12

Admitting RN Signature: Date: 7/9/12

PRE-OPERATIVE HEALTH HISTORY

DULBERG ,PAUL R
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PRE-OPERATIVE HEALTH HISTORY

NCH Item # 32132

Form #002.018-02/11-1-SD

PHYSICAL EXAM: PAT Vitals: T _____ P _____ RR _____ BP _____ SAO2 _____

Airway

DENTAL WORK:
- Loose Caps
- Partials
- Dentures

ASSESSMENT:

	Female	Male
Underweight	<19	<20
Acceptable	19-25	20-25
Overweight	25-30	25-30
Obese	30-40	30-40
Morbidly Obese	>40	>40

ASA CLASS: I (II) III IV V E

PREOPERATIVE ORDERS:

- ☑ NPO past midnight

MEDICATIONS
- ☑ IV: LR 1000 cc TKO
- ☐ Reglan 10mg po OCOR
- ☑ Pepcid 20mg po OCOR
- ☑ Valium 5 mg po OCOR
- ☐ Versed _____ mg po OCOR
- ☐ Home med:

TEST	REASON/DX
☐ ECG	
☐ CXR	
☐ CBC	
☐ Metabolic Panel, Basic	
☐ Metabolic Panel, Comprehensive	
☐ Hepatic Function Panel	
☐ Coagulation Profile	
☐ PT	
☐ PTT	
☐ Pregnancy Test serum/urine	
☐ Other	

PLAN:
- ☑ Physician reviewed health history
- ☑ Risks discussed
- ☐ Patient accepts anesthesia plan
- ☐ Anesthesia options discussed
- ☐ Common complications discussed

Physician Signature: Date: Time:

Day of surgery, Patient seen and record reviewed. **Physician Signature:** Date: 7/9/12 Time: 14:01

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ANESTHESIA ASSESSMENT & PHYSICAL EXAM
COMPLETED BY ANESTHESIOLOGIST ONLY

NCH Item # 32132

Form #002.018-02/11-1-S&D

ANESTHESIA ASSESSMENT & PHYSICAL EXAM

MEDICATIONS (Daily, Over the Counter, Herbal, Vitamins, Dietary Supplements)

NAME	DOSE	ROUTE	FREQUENCY	LAST DOSE TAKEN
Advance Directives ☐ Yes ☐ Bring copy day of surgery ☐ Carelink Validated ☐ No ☐ Form mailed/to be given day of surgery ☐ Not interested				

ADDITIONAL COMMENTS	
DATE / TIME	

Post Anesthesia Evaluation Note for Outpatients

- ☐ Blood Pressure and pulse returned to baseline
- ☐ Cardiovascular function/hydration status stable
- ☐ Respiratory function stable; airway patient; O2 saturation returned to baseline
- ☐ Temperature returned to baseline
- ☐ Mental status recovered; patient participates in evaluation
- ☐ Nausea and vomiting control satisfactory
- ☐ Pain control satisfactory

Post Anesthesia Evaluation Note for Inpatients

Cardiopulmonary status returned to baseline:	☐ yes	☐ no	(explain below)
Level of consciousness returned to baseline:	☐ yes	☐ no	(explain below)
Complications occuring during post-anesthesia recovery:	☐ yes	☐ no	(explain below)
Mental status recovered; patient participates in evaluation:	☐ yes	☐ no	(explain below)
Anesthetic follow-up care and/or observations:	☐ yes	☐ no	(explain below)

Notes: _____

Physician Signature _____ Date 9/9/12 Time 10:22

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ANESTHESIA ASSESSMENT

Date: 7-9-12 Room Number: 1 Allergies: None

Report received from L. BURNS at 1318

Check Identity: ☒ Band ☒ Consent Anxiety Level: ☒ Mild ☐ Moderate ☐ Severe

Position Verified: (Y)
Correct Patient: (Y)
Agreement Procedure (Y)
Correct Site / Side (Y)
Correct Implants Y (N/A)
Antibiotics Given Y (N/A)

TYPE OF BLOCK: ☒ Right ☐ Left ☒ Single ☐ Continuous

☐ Interscalene ☒ Supraclavicular ☐ Infraclavicular ☐ Axillary ☐ Femoral ☐ Sciatic ☐ Lumbar plexus ☐ Popliteal ☐ tap
☐ Other

PLANNED SURGICAL PROCEDURE: Right Ulnar Nerve Decompression and Transposition, Neurolysis at Forearm

PROCEDURAL TEAM (name, title, relief time)	Initials
Anesthesiologist: S. SINGH ~~MD~~ DO.	SS
Nurse: M. ZIEGLER RN	MZ
Nurse:	

PATIENT MAINTAINED IN A SAFE AND SUPPORTIVE ENVIRONMENT
- ✓ Proper body alignment for self and procedure maintained
- ✓ Provide quiet environment
- ✓ Explain procedure and reassure patient
- ✓ Skin integrity maintained
- ✓ Siderails elevated
- ✓ Patient is free from extraneous objects

PATIENT POSITION:
☒ Supine ☐ Right/Left Lateral ☐ Prone ☐ Sitting ☒ Other Blanket Roll behind Right Shoulder

SKIN PREPARATION:
☐ Betadine ☒ Chloraprep ☐ Other ________ by SS O_2 per Nasal Cannula at 3 L/min

EQUIPMENT
☒ Stimuplex ☒ Ultrasound ☐ Other

VITAL SIGNS:

TIME	B/P	HR	Rhythm	O_2 SAT%	RESPIRATORY RATE	RESPIRATORY DEPTH	LOC	COLOR	MEDICATIONS TYPE	DOSE	ROUTE	PATIENT RESPONSE
Prep	102/63	66	—	100%	18	R	A	2				C
1320	116/69	54	NSR	99%	16	R	A	2	~~VERSED~~	~~2mg~~	~~IV~~	C
1402	117/67	52	NSR	96	16	R	A	2	FENTANYL	50mcg	IV	C
1411	103/62	56	NSR	96	14	R	S	2	—			C
1421	103/50	66	NSR	98	12	R	S	2	—			C
1431	110/58	68	NSR	98	13	R	S	2	—			C
1441	112/56	66	NSR	99	14	R	S	2	—			C

KEY: Color: 2=Pink 1=Changes in skin condition (pale, jaundice, flushed) 0=Cyanotic, Dusky, Extreme pallor
RESP Depth: R=Regular I=Irregular S=Shallow L=Labored
LOC: A=Awake S=Sleepy NR=Not Responding
PATIENT: A=Anxious/apprehensive C=Calm/Comfortable CO=Combative G=Grimacing M=Moaning R=Restless ST=States Pain

NARRATIVE: Pt tolerated procedure well, safety precautions given to pt. (R) arm padded c̄ bath blankets. Mother updated - not present in lobby - update given to [illegible]. Pt sleeping, easily arousable. Mom updated in lobby MZ. ~~Dr. Sagerman [illegible]~~ prior to OR MZ

Time Patient in room 1318 Procedure start 1402 Procedure end 1414 DRESSINGS: ☐ Bandaid ☐ Tegaderm ☒ None ☐ Other

Time Patient Tranferred to: 1442 OR room 7 Condition: Stable /Report given to: N. Martini by MZ

ANESTHESIOLOGIST'S SIGNATURE [signature]

RN Initials	Signature	RN Initials	Signature
MZ	MZiegler		

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11510ANE

REGIONAL BLOCK PROCEDURE
PRE AND POST PROCEDURE ASSESSMENT/PLAN OF CARE

Do you have known Sleep Apnea?

☐ Yes (complete section A only) ☑ No (complete sections B only)

A. Diagnosed Sleep Apnea

1. Do you have a CPAP machine? ☐ Yes ☐ No
2. Do you know your pressure settings? ☐ Yes _____ ☐ No
3. Who supplies your equipment? _____
4. How many hours/night do you wear your CPAP? _____

Patients with a CPAP machine should bring the unit for use during hospital stay.

B. Screening:

Do you snore?	☐ Yes	☑ No
Are you excessively tired during the day?	☐ Yes	☑ No
Have you been told you stop breathing during sleep?	☐ Yes	☑ No
Do you have a history of hypertension?	☐ Yes	☑ No
Do you wake during the night feeling breathless?	☐ Yes	☑ No

Comments: _____

To be completed by NCH Staff

C. Results Calculation of BMI = 24.4

A positive screening for sleep disordered breathing is one or more of the following:

1. A "YES" response in section A
2. A "YES" response to 3 or more of the screening questions
3. BMI > 35 and "YES" response to one additional screening question

PLEASE CIRCLE THE FINAL RESULT: (Negative) Positive

Results of this screening are not diagnostic. Formal evaluation is required for diagnosis.

Notify physician of positive screening or history of sleep apnea.

RN Signature: Lilian Ann Date: 6/26/12

☐ See Preoperative Health History Assessment and Exam for additional orders/comments.

Reviewing Physician Signature: _____ Date: 6/26/12

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71265382 M 42 07/09/12
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Arlington Heights, IL 60005

1 1 5 0 8 A N E

OBSTRUCTIVE SLEEP APNEA SCREENING

NCH Item # 53718

Form # 005.761-08/09-1-PS

Allergies: NKA **Date:** 07-09-12

Pre-Operative RN confirms
- ☑ ID Band w/2 identifiers ☑ Procedural Consent
- ☑ Site Marked/☐ NA ☑ Preanesthesia assessment
- ☑ NPO Status ☑ H & P ☐ DNR ☒ NA
- ☐ Diagnostic test results; ☑ NA
- ☐ Type/Screen ☑ NA ☐ Blood available ____ units; ☒ NA
- ☑ Equipment/Implant avail; ☐ NA ☐ Isolation ☒ NA
- ☑ Pre-op antibiotic ordered ☐ NA
- ☐ VTE Prophylaxis order ☒ NA

Level of Consciousness: ☑ Responsive ☐ Non Responsive
Anxiety Level: ☑ Mild ☐ Moderate ☐ Severe
Skin Condition: ☑ Intact ☐ Other ____
Report From M. Zieglen at 1140
Transferred to OR per ☐ Cart ☑ Bed ☐ Chair
☐ Ambulated ☐ Carried By ____

Pre-Induction RN/Anesthesia discuss
- ☑ Confirm patient identity, and signed consent
- ☑ Allergies ☐ Latex Precautions ☑ NA
- ☑ Difficult airway/Aspiration risk/Preparation confirmed

RN Confirm
VTE prophylaxis
- ☑ NA
- ☐ SCD/Ted Hose/PlexiPulse Left/Right Knee/Thigh
- ☑ Medication given

RN/Scrub Confirm
- ☑ Chemical Indicators Verified

Pre-Incision Team reviews:
- ☑ Team Introductions
- ☑ Allergies
- ☑ Anticipated blood loss ☐ NA
  Blood products available ____ units
- ☑ Plan of Care discussed
- ☐ Imaging Displayed ☒ NA
- ☑ Skin prep dry per manufacturer's guideline

Other ____

	Time Out #1 at 1502	Time Out #2 at ____
Correct Patient	☑ Yes	☐ Yes
Correct Procedure	☑ Yes	☐ Yes
Correct Site	☑ Yes	☐ Yes
Site/Side Marked	☑ Yes ☐ NA	☐ Yes ☐ NA
Implants available	☑ Yes ☐ NA	☐ Yes ☐ NA
Position verified	☑ Yes	☐ Yes
Antibiotic given	☑ Yes ☐ NA	☐ Yes ☐ NA
Redose ordered	☐ Yes ☐ NA	☐ Yes ☐ NA

Preoperative diagnosis: Right ulnar neuritis at the cubital tunnel and distal ulnar nerve entrapment right forearm
Operative Procedure 1: Right ulnar nerve release with neurolysis at forearm
Start ____ Stop ____
Operative Procedure 2: ☐ NA ____
Start ____ Stop ____
Post operative diagnosis: ☐ Same as preoperative

OR Number	Anesthesia (Circle) General Mac Local Consed Regional (Type) Block	☑ Scheduled ☐ Add-On ☐ Emergency	Acuity # 3 ASA# 2
1			

OR In 1443	Case Start 1504	Family Notified	Family Notified
OR Out 1613	Case Stop 1608	Family Notified	Family Notified

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5

3126710RR

OPERATING ROOM RECORD AND PLAN OF CARE
PAGE 1 OF 3

NCH Item # 25901 White - Chart Yellow - Journal Form # 005.017-12/11-2-SD

Date:

	initial		initial	in	out	in	out
Surgeon 1 DR. S. SAGERMAN MD		Circulator 1 S. MAGFIRA RN					
Surgeon 2 DR BRAFORA MD		Circulator 2 A. BELTON RN					
Assistant		Circulator relief					
Assistant		Scrub 1 V. LAWRY RN					
Anesthesiologist 1 DR. SINGH		Scrub 2					
Anesthesiologist 2		Scrub relief					
Perfusionist/Cell Saver		Other					
Other		Other					

Surgical Position: ☒ Supine ☐ Prone ☐ Jackknife ☐ Sitting ☐ Lithotomy ☐ Lateral ☐ Right ☐ Left

☒ Arm Secured on Armboard ☒ Right ☒ Left | ☐ Arm at Secured Side ☐ Right ☐ Left | ☐ Fluroscopy ☐ Fluroscan ☐ X-Ray ☐ Patient shielded location _____

Check all those that apply

- ☐ Andrews Frame
- ☐ Arthroscopy leg holder Left/Right
- ☐ Axillary Roll Left/Right
- ☐ Beach chair positioner _____
- ☐ Bean Bag
- ☐ Elbow Pads Left/Right
- ☐ Fracture Table
- ☐ Hand table
- ☐ Head butler
- ☐ Head support _____
- ☐ Heel Pads Left/Right
- ☐ Jackson Table
- ☐ Kidney Rest
- ☐ Lateral Arm Holder Left/Right
- ☐ Lateral positioner _____
- ☐ Mayfield Head Holder
- ☐ Montreal Positioner
- ☐ Pillows
- ☐ Positioning Rolls
- ☐ Sandbags
- ☐ Shoulder Holder Left/Right
  - ☐ Type _____
- ☐ Spreader bars
- ☐ Stirrups (Circle)
  - Padded Fins Candycane
- ☐ Wilson Frame

Warming/Cooling Interventions

Forced Air Warming
☐ Upper ☐ Lower Setting
☐ Blanketrol Setting _____
☒ Warm Blankets

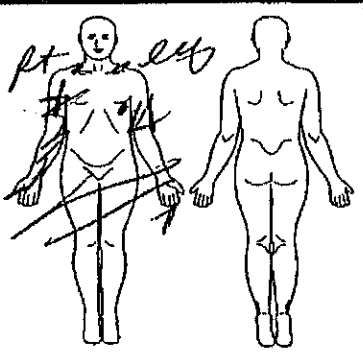
Comments: _____

Skin Preparation
☐ Betadine: ____ 10% ____ 5%
☐ Other: _____
☒ CHG ☐ Chloroprep ☐ Duraprep
By: A.B

Hair Removal:
☐ None ☒ Clipper by DR. S. SAGERMAN MD

Item Locations

BP Cuff △
Safety Strap =
ESU Pad ☐
Monitor Leads ○
Tourniquet +
Pulse Oximeter ←
Prep ////
Reddened R
Bruise B
Decubiti D



ESU No 9841 Type Bovie
Bipolar 15 Medo
Coag _____
☐ Standard ☐ Spray
Cut _____
☐ Blend ☐ Pure

ESU No _____ Type _____
Bipolar _____
Coag _____
☐ Standard ☐ Spray
Cut _____
☐ Blend ☐ Pure

Tourniquet ☒ Padded Cuff Applied By: DR S. Sagerman
8801 Inflated @ 1503 Deflated @ 1625 Pressure 250
_____ Inflated @ _____ Deflated @ _____ Pressure _____
_____ Inflated @ _____ Deflated @ _____ Pressure _____

☐ Laser Protocol Followed, Joules _____
Laser Type _____ Time _____

Additional equipment:
Type _____ Unit No _____
Setting(s) _____

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OPERATING ROOM RECORD AND PLAN OF CARE

Medications	Dose	Route	Time	Administered By	Verified: Initials

Irrigation Type	Amount	Warmed	
1000 ml 9% NaCL WITH		Y or ☒N	
50,000 BACITRACIN		Y or No	
Scrub Relief Meds Verified: Initials			

Blood Products Given ☒ No ☐ Yes (See Transfusion record)	☐ Pathology (See Tissue Record) ☒NA
Cultures	☐ Implant (See Implant Record) ☒NA
A	Drains
B	Drains
C	Urinary Catheter: Type ______ Size______ By ______
D	Amount Color Source Time
	☐ Indwelling ☐ Voided prior to OR ☐ Discontinued at ______

Initial Count By: SM VL	First By: SM VL	Relief By: ______	Final By: SM VL
SPONGE: ☒ Completed ☐ NA	Correct: ☒Y ☐ N ☐ NA	Correct: ☐ Y ☐ N ☐ NA	Correct: ☒Y ☐ N ☐ NA
ITEM: ☒ Completed ☐ NA	Correct: ☒Y ☐ N ☐ NA	Correct: ☐ Y ☐ N ☐ NA	Correct: ☒Y ☐ N ☐ NA
INSTRUMENT: ☐ Completed ☐ NA	Correct: ☐ Y ☐ N ☒NA	Correct: ☐ Y ☐ N ☐ NA	Correct: ☐ Y ☐ N ☒NA

☐ UNRESOLVED COUNT X-RAY TAKEN ☐ YES ☐ NO SURGEON NOTIFIED ☐ YES RESULTS:______ PER:______

DRESSING ☐ NONE ☒ SOFT ☐ PRESSURE ☐ CAST ☐ SPLINT ☐ IMMOBILIZER ☐ BINDER LOCATION: RT ARM
PACKING: ☐ NONE ☐ LOCATION SIGN ☐ TYPE ______

Post-Procedure **Team review:**
☒ Procedure(s) Confirmed ☒ Wound Class confirmed (I) II III IV
☐ Specimen(s) identified and labeled Number of Specimens Ø ______ ☐ NA
Outcomes: ☒ Patient maintained in a safe and supportive environment
☒ Aseptic technique maintained
☒ Skin integrity maintained
☒ Body alignment maintained
☐ Concerns for recovery discussed
Transferred to: Acute Report Given to: E. BRAWENDER R.N. by DR. SINGH MD
Notes ______

☐ See additional progress note ☐ NA

RN Signature(s): A. Martin R Date: 07/09/12

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OPERATING ROOM RECORD
AND PLAN OF CARE
PAGE 3 OF 3

Check or fill in appropriate areas/blanks. Write NA if not appropriate.

TO BE COMPLETED BY DISCHARGE RN

Date of surgery 7/9/12 Phone Number 8479971450 Alternate number ___/___/___ Admitted to ___

☒ Verify phone number(s) and permission: to call patient and/or leave message, representative Mom - Barb

Procedure right ulnar nerve decompression + transposition + possible neurolysis

Anesthesiologist/Radiologist Black Singh

At time of Discharge
☐ Nausea/vomiting
☐ Able to urinate
☐ Other ___

Block time 1400

Anesthesia(circle one) General (MAC) Spinal Epidural Conscious Sedation Local Regional Nerve Block: Single Continuous

Attempt to Call

1st 7/10/12 Date 1640 Time — Spoke with ☒ Patient ☐ Patient representative as identified above ☐ Left Message ☐ Unable to Contact

2nd ___/___/___ Date ___ Time — Spoke with ☐ Patient ☐ Patient representative as identified above ☐ Left Message ☐ Unable to Contact

4th Day (CPNB) ___/___/___ Date ___ Time — Spoke with ☐ Patient ☐ Patient representative as identified above ☐ Left Message ☐ Unable to Contact

PATIENT OUTCOMES

Pain Scale 0-None 1-3.Minimal 4-7 Moderate 8-10 Severe

Pain level at 3

IV/Surgical Site condition WNL	Yes	No	NA
Tolerating Diet	Yes	No	NA
Urinating as usual	Yes	No	NA
Minimal bleeding	Yes	No	NA
Taking prescription meds as directed	Yes	No	NA

Questions or concerns regarding Post-Operative Care and Activity ___

Instructions/Narrative
Stitch block worked great. Dsn + wear KJ until this AM

Physician notified of any issues Yes No NA
Who notified/Action taken ___

Perineural Local Anesthethetic

Alternate pain relief ☐ po meds ☐ IV meds

Site redness or swelling noted Yes No
☐ Site covered/dressing

Any unusual symptoms/problems Yes No
Date ___ Comment ___

Date ___ ☐ No Change
Comment ___

We would appreciate feedback on your surgical experience. If you receive a survey in the mail, we hope that you will take a moment to complete it.
Any comments/suggestions:

Reminded/Advised to contact Physician:
☒ Any problems ☒ Follow-up appt: 7-11-12

RN Signature [signature] Date 7-10-12

DULBERG ,PAUL R.
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

14501PACU

PATIENT POST-OPERATIVE PHONE ASSESSMENT

NCH Item # 25014

Form # 005.021-03/12-1-SD

DATE / TIME	POST-OPERATIVE OUTCOME OF PROCEDURE NOTE	DATE / TIME	PRE-OPERATIVE ORDERS:
7/9 2012	SURGEON: Sagerman		
	ASSISTANT: Bifano		
			7/9/12 (1615)
	PREOPERATIVE DIAGNOSIS: Right cubital tunnel syndrome, ulnar nerve injury forearm		☒ STATUS OUTPATIENT:
			DISPOSITION: (select one)
			☒ Discharge when criteria met with Post-Op Instructions
			☐ To Phase III Recovery for _____ hours
			Discharge when criteria met with Post-Op Instructions
	POSTOPERATIVE DIAGNOSIS: Same		
			Discharge Instructions:
			Diet: Regular
			Medications:
	PROCEDURE PERFORMED: Right cubital tunnel release, hemolysis ulnar nerve forearm		DOCUMENT ON MEDICATION RECONCILIATION FORM
			Incision Care: Keep dry
	FINDING / COMPLICATIONS: N/A (none)		Activity: Ulnar @ arm sling x 24°
			Follow-up: Office 7/12/12
	SPECIMENS REMOVED: None		
			Other:
	ESTIMATED BLOOD LOSS: none		Disposition/condition on discharge: stable
	Physician Signature:		Physician Signature:

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NCH ITEM # 5365

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

10503PRGN

OUTPATIENT PHYSICIAN POST OPERATIVE ORDERS / DISCHARGE NOTE

Form # 002.011-02/09-1-PS

Directions: Check boxes to indicate a choice and select all those that apply.

ALLERGIES: NKA

GENERAL MEDICAL ORDERS

☐ Bypass Phase I Recovery

OXYGEN THERAPY:
☐ Nasal Cannula at 2-6 liters per minute ☐ Wean to room air as tolerated ☐ High humidity face tent _____FIO2
☐ Pulse Oximetery: Wean patient to lower FiO2 of ____% as long as SPO2 is greater than _____ for 15min
☐ Continue Oxygen overnight per _____at _____liters.
☐ Ventilator: TV_____FIO2_____% Rate:_____PS:_____PEEP:_____
☐ Other_____

PAIN MANAGEMENT:
Nurses: Give the analgesic medication(s) below in the order specified until the patient's pain score is an acceptable level to the pt.

Treatment Order
1 2 3 4 ☐ Fentanyl_____ mcg IV every_____minutes PRN up to a total of _____mcg.
1 2 3 4 ☐ Morphine 1 mg IV every 5 minutes PRN pain up to total of 10 mg.
1 2 3 4 ☐ Hydromorphone (Dilaudid) 0.2 mg IV every 5 minutes PRN pain up to 6 mg.
1 2 3 4 ☐ Meperidine (Demerol) 25 mg IV every 5 minutes PRN pain up to a total 100 mg.
1 2 3 4 ☐ Other_____
☐ Acetaminophen (Ofirmev) 1000 mg IV x 1 PRN pain; infuse over 15 minutes IVPB
☐ Ketorolac (Toradol)_____mg IV x 1 dose
☐ Hydrocodone/Acetaminophen (Norco) 5/325mg po x 1 PRN pain

ANTIEMETICS:
Treatment Order
1 2 3 4 ☐ Ondansetron (Zofran) 4 mg IV x 1 PRN nausea
1 2 3 4 ☐ Metoclopramide (Reglan) 10 mg IV x 1 PRN nausea
1 2 3 4 ☐ Prochlorperazine (Compazine) 10 mg IV x 1 PRN nausea
1 2 3 4 ☐ Ondansetron (Zofran) ODT 4 mg place on the tongue x 1 PRN nausea
1 2 3 4 ☐ Dexamethasone (Decadron) 10mg IV x 1 PRN for nausea
☐ Other_____

OTHER MEDICATIONS:
☐ Meperidine 12.5 mg IV x 1 time as needed for shivering
☐ _____ ☐ _____

IV FLUIDS:
☐ LR ☐ D5LR ☐ NS ☐ Other_____Infuse at _____ml/hour
☐ Give _____ ml bolus x1 for SBP lower than _____.
☐ Give _____ ml bolus x 1 for low urine output less than < _____.

STAT LABORATORY:
☐ CBC (Without Diff) ☐ Metabolic Panel, Basic ☐ ABG ☐ POC blood glucose ☐ Cardiac Markers
☐ Other_____

RADIOLOGY:
☐ PA Chest X-Ray Reason: _____ ☐ Other_____

CARDIAC DIAGNOSTICS:
☐ 12 Lead ECG Reason:_____ ☐ Central Telemetry ☐ Other_____

GENERAL MEDICAL ORDERS:
☐ Warming blanket for temperature less than < _____.
☐ Discharge to inpatient unit when PACU discharge criteria are met.
☐ Discharge to: ☐ Phase II ☐ Home when discharge criteria are met.
☐ Provide Perineural Nerve Block discharge Instructions sheet.
☐ Provide Obstructive Sleep Apnea Discharge Instructions.
☐ Other_____

Physician Signature: _____ Date: 7/9/12 Time: 15:02 7/9/12 1620

DULBERG ,PAUL R
71265382 M 42 07/09/12
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Northwest Community Hospital
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1040700RD

POST ANESTHESIA CARE
PREPRINTED ORDERS

NCH Item # E34391

Form # 003.107-02/12-1-E

Peripheral Nerve Block (PNB) Procedure Note

Allergies None known

Reason for Block: ☑ Primary Anesthesia Type
☐ Post-op Pain Management ☑ Surgeon Request

Block start time 1430 Block end time 1441

Blocks performed:	Left	Right	Single	Continuous
☐ Interscalene	☐	☐	☐	☐
☑ Supraclavicular	☐	☑	☑	☐
☐ Infraclavicular	☐	☐	☐	☐
☐ Axillary	☐	☐	☐	☐
☐ Lumbar Plexus	☐	☐	☐	☐
☐ Sciatic	☐	☐	☐	☐
☐ Femoral	☐	☐	☐	☐
☐ Popliteal	☐	☐	☐	☐
☐ tap	☐	☐	☐	☐

☐ Other _____

Ultrasound guided: ☑ Yes ☐ No

Position:
☑ Supine ☐ Lateral Left ☐ Right ☐
☐ Prone ☐ Other _____

Prep:
☑ Chlora-prep ☐ Other _____

Skin infiltration 1% Lidocaine 1 mls

Needle type: Nerve Response @:
☐ Touhy _____ Gauge _____ mA
☐ Stimuplex _____ Gauge _____ mA
☑ Other Arrow 2.1 sure

Catheter (if applicable):
☐ Stimucath ☐ Perifix ☐ Other _____

Test dose: 1.5% Lidocaine with Epinephrine 5 mls
☑ Yes ☐ No

Secured on the skin @ _____ cm

Medication(s):		With Epinephrine		Volume (ml):
☑ Bupivacaine	0.1 %	☐ Yes	☐ No	32
☐ Ropivacaine	____ %	☐ Yes	☐ No	
☐ Mepivacaine	____ %	☐ Yes	☐ No	
☐ Xylocaine	____ %	☐ Yes	☐ No	
☐ Clonidine	____ mcg			
☐ Other				

Narrative: After negative aspiration, medications injected in 5ml increments.

Complications: ☑ No ☐ Yes (please explain)

Note: _____

CPNB Administration Orders Post-Operatively

Pump continuous Peripheral Nerve Block

Fill with _____ ml of _____ %
☐ Bupivacaine
☐ Ropivacaine
☐ Mepivacaine
☐ Other _____

Rate _____ ml/H

Bolus _____ ml

Interval _____ min

Initiated @ _____ (time)

1. Nursing to instruct patient on use of the pain pump.
2. Place post block peripheral caution sign at patient bed.
3. If lightheadedness, oversedation, tinnitus, metallic taste in the mouth or circumoral numbness occurs, stop the infusion and notify anesthesiologist immediately.
4. If redness, swelling, fever, purulent drainage occurs at the catheter site, immediately notify anesthesiologist on call.
5. Maintain integrity of dressing. Reinforce if needed. If leakage occurs at the catheter site, reinforce with gauze and tape.
6. For breakthrough pain, call primary anesthesiologist, if not available, notify on-call anesthesiologist.
7. For pump discontinuation consult surgeon.
8. Adjuvant pain meds: _____

Anesthesiologist Signature

7/9/12 Date 1416 Time

DULBERG ,PAUL R
71265382 M 42 07/09/12
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SAGERMAN, SCOTT D MD

NCH Item # E52182

Northwest Community Hospital
Arlington Heights, IL 60005

1110470RD

Procedural Note/Orders for Continuous Peripheral Nerve Block Infusion (CPNB)

Form No. 003.282-04/11-1-E

☒ Day Surgery
Fax: 847.618.7068

☐ Main OR
Fax: 847.618.7259

☐ Labor & Delivery
Fax: 847.618.8409

Admission Status: ☐ Inpatient ☒ Outpatient

Patient Name: DULBERG, PAUL DOB: 3/19/70 Medicare: ☐ yes ☒ no

Surgeon: Scott Sagerman, M.D. Doctor responsible for H&P:

Reason / Dx for Surgery: Right Elbow Neuritis

Surgery Date: 7/9/12 Allergies: None

DIRECTIONS: Check boxes indicate a choice. Select those that apply.

TESTING:

	Reason/Dx		Reason/Dx
☐ Basic Metabolic		☐ Pregnancy - Serum	
☐ CBC / with Diff		☐ Pregnancy - Urine	
☐ Comprehensive Metabolic		☐ Type & Cross	X ____ units
☐ Micro Rhogam		☐ Type & Screen	
☐ Potassium		☐ U/A	
☐ PT		☐ U/A (with reflex)	
☐ PTT		☐ EKG	
☐ Other:		☐ CXR	

DIET: ☐ NPO after midnight
☐ Per anesthesia order / guidelines.
☐ Other:

PATIENT EDUCATION PRE-OP:
☐ Continuous Peripheral Nerve Block ☐ PCA Pump
☐ Epidural ☐ Single Injection Block

(3 pgs)

TREATMENTS:
☐ Surgical Site Hair Removal Location:
☐ Incentive Spirometry – Instruct Pre op
☐ Enema ☐ Fleets ☐ Other:
☐ Other:

Muted 7/9/12 JW

VTE PROPHYLAXIS - Mechanical:
☐ Graduated Compression Stockings (TEDS) ☐ Knee ☐ Thigh
☐ Intermittent Pneumatic Compression ☐ Knee (SCD) ☐ Thigh(SCD) ☐ Foot (Plexipulse)

MEDICATIONS: Antibiotic – order on page 2
☐ IV (Non-anesthesia patients):
☐ Other:
Patient on Dialysis ☐ Yes ☐ No
Seated Weight:

CONSENT:
Obtain Procedural Consent for: Right Ulnar Nerve decompression & transposition ? Neurolysis at forearm

Procedure including Risks, Benefits, Common Complications and Alternatives have been discussed with patient / guardian.

Physician Signature: Date: 6/29/12 Time:

Northwest Community Hospital
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Arlington Heights, IL 60005

3042700RD

DULBERG ,PAUL R
71265382 M 42 07/09/12
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SAGERMAN, SCOTT D MD

NCH Item # L

PRE-SURGICAL TESTING / PRE-OPERATIVE ORDERS
Form# 003.121-02/12-1-SD

Patient name: Dulberg, Paul

Initial and repeat dose and times per "Perioperative Prophylactic Antibiotic Policy"

☐ **MD aware of PCN allergy - ok to give antibiotics as ordered below**

Nature of Operation	Preoperative Antibiotic Regimen IVPB X 1 dose OCOR	Alternative Regimen for pt with Beta lactam allergy IVPB X 1 dose OCOR
Colon Surgery - adult pt	☐ cefoxitin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg ☐ ampicillin / sulbactam 3 gm ☐ cefazolin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg AND metronidazole 500 mg	☐ clindamycin 900 mg AND gentamicin 1.5 mg / kg ☐ clindamycin 900 mg AND ciprofloxacin 400 mg ☐ clindamycin 900 mg AND levofloxacin 500 mg ☐ clindamycin 900 mg AND aztreonam 2 gm ☐ metronidazole 500 mg AND gentamicin 1.5 mg / kg ☐ metronidazole 500 mg AND ciprofloxacin 400 mg ☐ metronidazole 500 mg AND levofloxacin 500 mg
Hysterectomy - adult pt	☐ cefazolin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg ☐ cefoxitin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg ☐ ampicillin / sulbactam 3 gm	☐ clindamycin 900 mg AND gentamicin 1.5 mg / kg ☐ clindamycin 900 mg AND ciprofloxacin 400 mg ☐ clindamycin 900 mg AND levofloxacin 500 mg ☐ metronidazole 500 mg AND gentamicin 1.5 mg / kg ☐ metronidazole 500 mg AND ciprofloxacin 400 mg ☐ metronidazole 500 mg AND levofloxacin 500 mg For hysterectomy WITH colon procedure ☐ clindamycin 900 mg AND aztreonam 2 gm
CABG - adult pt **Cardiac** - adult pt **Vascular** - adult pt **Orthopedic** - adult pt Hip arthroplasty Knee arthroplasty	☐ cefazolin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg ☐ vancomycin (MRSA risk) 1 gm for pt < 80 kg 1.5 gm for pt ≥ 80kg	☐ vancomycin 1 gm for pt < 80 kg 1.5 gm for pt ≥ 80kg ☐ clindamycin 900 mg
Other Procedures adult pt For procedures not listed above, consult published guidelines for current procedure - specific antibiotic recommendations	Common Regimens: ☐ cefazolin 1 gm for pt < 80 kg 2 gm for pt ≥ 80 kg ☐ vancomycin (MRSA risk) 1 gm for pt < 80 kg 1.5 gm for pt ≥ 80kg	Common Regimens: ☐ vancomycin 1 gm for pt < 80 kg 1.5 gm for pt ≥ 80kg ☐ clindamycin 900 mg
Pediatric Procedures consult published guidelines for current procedure - specific antibiotic recommendations	Common Regimens: ☐ cefazolin 25 mg / kg* for pt <40 kg 1 gm for pt 40 - 80 kg 2 gm for pt ≥ 80 kg *dose rounded to the nearest 50 mg ☐ cefoxitin 30 mg / kg* for pt <30 kg 1 gm for pt 30 - 80 kg 2 gm for pt ≥ 80 kg *dose rounded to the nearest 50 mg	Common Regimens: ☐ clindamycin 10 mg / kg * for pt < 80 kg *dose rounded to the nearest 50 mg 800 mg for pt ≥ 80 kg ☐ vancomycin 20 mg / kg * for pt < 50 kg *dose rounded to the nearest 50 mg 1 gm for pt 50 - 80 kg 1.5 gm for pt ≥ 80kg

Other antibiotic(s) _____

Physician signature _____ Date 6/29/12 Time _____

Northwest Community Hospital
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DULBERG ,PAUL R
71265382 M 42 07/09/12
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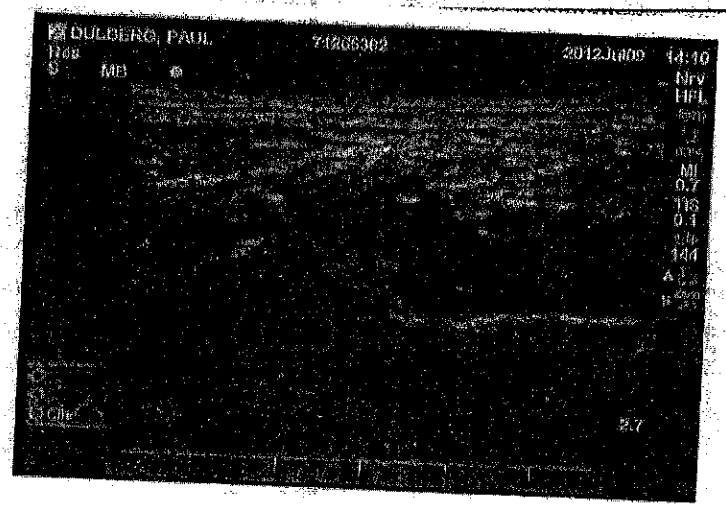
NCH Item SAGERMAN, SCOTT D MD

PRE-SURGICAL TESTING / PRE-OPERATIVE ORDERS

Form# 003.121-02/12-1-SD

DATE	TIME	NOTES



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SAGERMAN, SCOTT D MD

Northwest Community Hospital
Arlington Heights, IL 60005

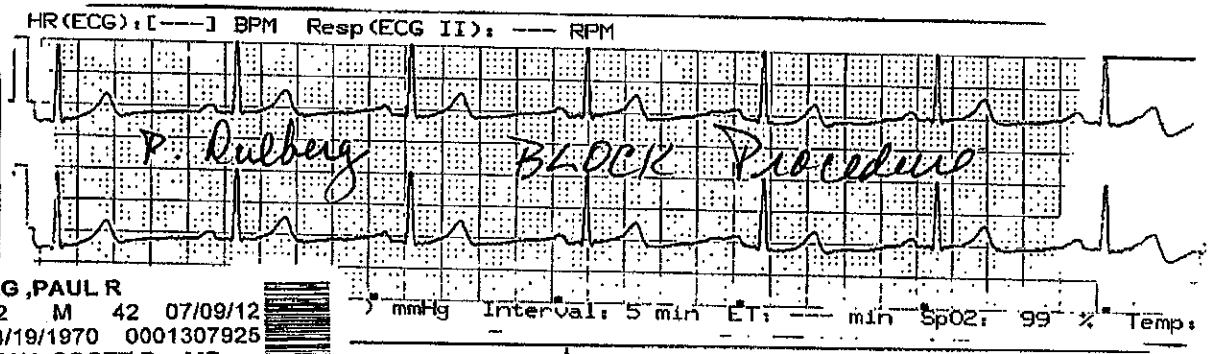
1100031

Scanned Radiology Reports

PATIENT

DATE:

PR:
QRS
QT
R-R
RATE
INTERPRETATION



SIGNATURE

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

(Post 3rd report on this line)

PR:
QRS
QT
R-R
RATE
INTERPRETATION

SIGNATURE

(Post 2nd report on this line)

PR:
QRS
QT
R-R
RATE
INTERPRETATION

SIGNATURE

(Post 1st report on this line)

PR:
QRS
QT
R-R
RATE
INTERPRETATION

SIGNATURE

DULBERG ,PAUL R
71265382 M 42 07/09/12
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SAGERMAN, SCOTT D MD

NCH Item #973

Northwest Community Hospital
Arlington Heights, IL 60005

12000EKG

ELECTROCARDIOGRAM TRACINGS

Form # 005.673-10/04-1-S&D

PROCEDURE: R ulnar nerve release with neurolysis at forearm.

ALLERGIES: NKDA

MEDICAL HISTORY: SMOKER

SURGEON: SAGERMAN ANESTHESIOLOGIST: SEIKET

ANESTHESIA (CIRCLE ONE) GENERAL REGIONAL MAC SPINAL EPIDURAL LOCAL

LEGEND

L = LOW, M = MED., H = HIGH, ✓ = PRESENT, / = NOT APPLICABLE, A = ADMISSION, D = DISCHARGE, * = SEE NURSES NOTES, A = ART. LINE, V = LINE, X = HEART RATE, O = RESPIRATIONS, I = BLOOD PRESS.

PULSES: +1 = FLEETING, +2 = WEAK, +3 = NORMAL, +4 = FULL & BOUNDING

G = GRAVITY, C = CLEAR, I = INTERMITTENT, CL = CLOUDY, Y = YELLOW, BL = BLOODY, BC = BLOOD CLOTS, B = BILE, SS = SEROSANGUINOUS, FB = FRANK BLOOD

AIRWAY	A	D
NONE	✓	
ORAL / NASAL		
CHIN / JAW SUPP		
ENDOTRACHEAL ORAL / NASAL cm @ LIP		
TIME OUT		

RT Method	FIO2	ON	OFF
NASAL CANNULA	3L	✓	1650
MASK			
FACE TENT			
T-PIECE			

REFLEXES	Time
COUGH	1637
SWALLOW	
LIFT HEAD	
ENCOURAGED TO COUGH/ DEEP BREATHE q 10	

LUNG SND	A	D
BILAT CLEAR	✓	

COLOR	A	D
PINK	✓	
PALE		
JAUNDICED		
DUSKY		

BED Position	Time
FLAT	
HOB ↑ 30°	17
HOB ↑ 45°	1645

DRESSING	A	PH I D	PH II D
SITE: RUE	✓	✓	✓
DRY/INTACT	✓	✓	✓
REINFORCED / CHANGED			
EXTREMITY ELEVATED	✓	✓	✓
ICE			

VENTILATOR

Time	FIO2	Rate	Tidal Vol	PEEP	Press. Supp.

RESTRAINTS TIME ON TIME OFF

DRAINS	Size / Mode	Drng Characteristics	A	PH I D	PH II D
FOLEY					
NG POSITION VERIFIED BY AIR BOLUS					
J-P / HEMOVAC					
CONSTAVAC					
CHEST TUBE					
OTHER					

EQUIPMENT	A	PH I D	PH II D
SCD'S / TEDS			
ELECTRICOOL			
PLEXIPULSE			
SLING / IMMOB	SITE		
TRACTION	SITE		
OTHER	SITE		

PAR SCORE II

	A	D
SURGICAL BLEEDING (2) Minimal does not require dsg change (1) Moderate up to two dsg changes (0) Severe more than three dsg changes	2	2
NAUSEA / VOMITING (2) Minimal / absence of N & V (1) N & V controlled by meds (0) Uncontrolled N & V	2	2
PAIN (2) 0-2 No Pain / Mild (1) 3-6 Discomforting / Distressing (0) 7-10 Horrible / Excruciating	1	1
AMBULATION (2) Steady gait, No dizziness or meets preoperative level (1) Ambulate with Assistance (0) Unable to Ambulate	1	2
PHASE II TOTAL:	6	7

PATIENT OUTCOMES POST-PROCEDURE

- ☑ PATIENT WILL EXHIBIT PATENT AIRWAY AND GAS EXCHANGE
- ☐ PATIENT WILL DEMONSTRATE REFLEXES & LEVEL OF CONSCIOUSNESS APPROP FOR PROCEDURE
- ☑ PATIENT WILL EXHIBIT STABLE HEMODYNAMIC PARAMETERS
- ☑ PATIENT WILL EXHIBIT FLUID BALANCE WITHIN NORMAL LIMITS FOR SELF AND PROCEDURE
- ☑ PATIENT MAINTAINS BODY TEMPERATURE WITHIN PARAMETERS FOR SELF AND PROCEDURE
- ☐ PATIENT COMMUNICATES THAT DISCOMFORT IS MINIMAL OR TOLERABLE

PATIENT/SO COMMUNICATES UNDERSTANDING OF POST PROCEDURE CARE.

- ☒ VERBALIZES UNDERSTANDING OF INSTRUCTIONS
- ☒ RETURN DEMONSTRATION OF CARE IF APPROPRIATE
- ☐ DISCHARGE INSTRUCTIONS SIGNED

EXTREMITY CIRC. CHK.	RUE A	RUE PH I D	RUE PH II D	LUE A	LUE PH I D	LUE PH II D	RLE A	RLE PH I D	RLE PH II D	LLE A	LLE PH I D	LLE PH II D
TEMPERATURE	WM	WM	WM									
COLOR	PK	PK	PK									
PULSE	+	+	+									
CAPILL. REFILL	+	+	+									
SENSATION	+	Ø	NUMB									
MOBILITY	+	Ø										

PAR SCORE I

		A	15"	D
CONSCIOUSNESS	(2) AWAKE, FOLLOWS COMMANDS (1) SLEEPY, AROUSABLE (0) NOT RESPONDING, ASLEEP	1	1	2
CIRCULATION	(2) B.P. ± 20mm OF PREANESTHETIC LEVEL (1) ± 20-50mm OF PREANESTHETIC LEVEL (0) ± 50mm OF PREANESTHETIC LEVEL	2	2	2
RESPIRATION	(2) COUGH / DEEP BREATH / CRY (1) DYSPNEA / SHALLOW / AIRWAY (0) APNEA / MECHANICAL VENTILATION	1	1	2
PAIN	(2) 0-2 NO PAIN / MILD (1) 3-6 DISCOMFORTING / DISTRESSING (0) 7-10 HORRIBLE / EXCRUCIATING	2	2	2
O_2 SATURATION	(2) MAINTAINS O_2 SAT >92% ON ROOM AIR (1) NEEDS O_2 INHALATION TO MAINTAIN O_2 SAT. > 90% (0) O_2 SAT. < 90% EVEN WITH O_2 SUPPLEMENTATION	1	1	2
ACTIVITY	(2) 4 EXTREMITIES OR AS PRE-OP (1) 2 EXTREMITIES (0) NO MOVEMENT OF EXTREMITIES	1	1	2
Temperature must be within 2° of preop temperature		✓	✓	✓
	PHASE I TOTAL:	12	10	14

INTAKE / OUTPUT

INTAKE		OUTPUT	
OR / IV / BLOOD	900	OR / URINE / EBL	
ORAL	200	URINE / VOIDED	
IV	100	DRAINS	
BLOOD	200	EMESIS	
TOTAL	1400	TOTAL	0

PAR SCORE I	A	15"	D
NAUSEA / VOMITING (2) Minimal / absence of N & V (1) N & V controlled by meds (0) Uncontrolled N & V	2	2	2

DATE: 7/9/12

Init.	SIGNATURE	Init.	SIGNATURE

PHASE I	5	ARRIVAL 1614	DISCHARGE 1711	PACU GUIDELINES OF CARE FOLLOWED
PHASE II	15	ARRIVAL 1711	DISCHARGE 1812	
TRANSFERRED TO		TRANSFERRED BY	REPORT GIVEN TO	

☐ O2 ☐ EKG ☐ RN

NCH Item # 25904

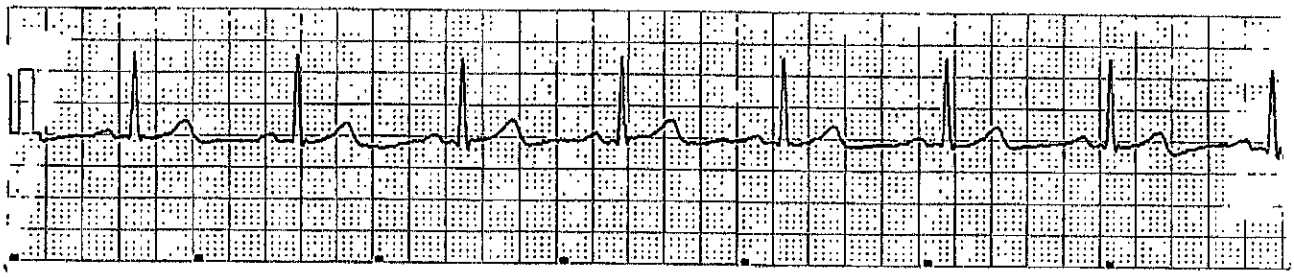
Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

406199RP

POSTANESTHESIA FLOWSHEET

DULBERG, PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

01 - 1 - S & D



TIME	A	15	30	45	60	1700	
PATIENT TEMP	96.4					96.8	96.8
WARMING METHOD	UB	UB					
RHYTHM STRIP	SR	SR	SR	SR	SR	SB	
PULSE OXIMETRY	96	97	99	99	98	98	100

220
200
180
160
140
120
100
80
60
40
20

R/A

Phase 2

HR	96	PP	PP	PP	PP	PP	MD

Init.	SIGNATURE	Init.	SIGNATURE
MD		UB	
		PP	P Patane RN

DATE 7/9/12

Northwest Community Hospital
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DULBERG ,PAUL R
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POSTANESTHESIA FLOWSHEET
PLAN OF CARE 2

TIME	MEDICATIONS	DOSE	RTE	LOCATION OF PAIN	PAIN SCALE	INITIALS OF NURSE
A	~~~~~~~~~~			RUE	0/10	[illegible]

TIME	IV SOLN / IVPB MEDS	IV SITE PATENT	A		PRN D	PRN D	INIT
A	LR (L)	La	900		0		[illegible]
1653	LR #2	LH	1000	900			

☐ Updated Patient Family Representative

TIME	EPIDURAL	DOSE	RTE	AMT A	AMT D	INITIALS OF NURSE

Character of pain _____

☐ Insertion Site Clean & Dry ☐ No Aspirate from Catheter 1900 IV CATH D/C'd AND INTACT X

PCA	DOSE mg	CONT. mg	LOCKOUT mins	4 HOUR LOCKOUT mg.

PT TEACHING W/ RETURN DEMO OF PCA BUTTON ☐ AMOUNT USED

A-LINE ○ GOOD WAVE A D

PA CATH GOOD WAVE A D

NURSE'S NOTES

TIME	SIDE RAILS UP AT ALL TIMES
A	Report from Dr Sengupta, pt sleepy, 97% 3L NC
	VS stable
1637	Opens eyes to name, returns to sleep immediately. VSS O2 on
1652	Pain ✓ denies, + nausea denies. VSS. O2 off.
1708	Dr Sagerman in to see pt. Questions addressed.
1711	Upright in chair. VSS. To phase II #15 in stable cond.
1715	Received in phase 2, VSS, tolerating clear liquids Family @ bedside.
1750	Discharge instructions reviewed with patient and mother, verbalized understanding
1812	Discharged home escorted to car without difficulty

Init.	SIGNATURE	Init.	
MK		BP	B Bodewes RN
		PP	P. Peters RN

DATE 8/9/12

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

POSTANESTHESIA FLOWSHEET
PLAN OF CARE 3

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

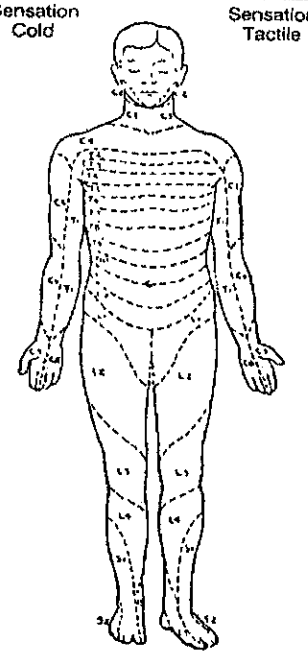
TIME													INITIALS OF NURSE

TIME	NURSE'S NOTES	INITIALS OF NURSE

CIRCLE ONE: Spinal Epidural
BLOCKS Femoral Caudal Scalene
Other

Sensation Cold

Sensation Tactile



☐ PROM q 30 minutes

Init.	SIGNATURE	Init.	SIGNATURE

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

DATE 7/9/12

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

POSTANESTHESIA FLOWSHEET
PLAN OF CARE 4

INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE

LACTATED RINGERS RATE: ~~TKO~~ 100 cc/hr	IV 1000 ML X 1 RN: DATE: 7/10/12	1345 dg		
VALIUM 5 MG (DIAZEPAM) ON CALL TO OR	PO X 1 RN: DATE: 7/10/12	1210 dg 7/10/12		
PEPCID (FAMOTIDINE) ON CALL TO OR	PO 20 MG X 1 RN: DATE: 7/10/12	1210 dg HOLD for BLOCK		
REGLAN (METOCLOPRAMIDE) ON CALL TO OR	PO 10 MG X 1 RN: DATE:			
TYLENOL TABLET ____ MG (ACETAMINOPHEN) ON CALL TO OR	PO X 1 RN: DATE:			
ANCEF ____ GM (CEFAZOLIN) D5W 100 ML INFUSE OVER 30 MINUTES	IV PREOP X 1 RN: DATE:			
VANCOMYCIN ____ MG (VANCOCIN) D5W 250 ML INFUSE OVER 1 HOUR	IV PREOP X 1 RN: DATE:			
CLINDAMYCIN ____ MG (CLEOCIN) D5W 100 ML INFUSE OVER 30 MINUTES	IV PREOP X 1 RN: DATE:			
MEFOXIN ____ GM (CEFOXITIN) D5W 100 ML INFUSE OVER 30 MINUTES	IV PREOP X 1 RN: DATE:			
AMPLICILLIN ____ GM (AMPLICILLIN) NS 100 ML INFUSE OVER 30 MINUTES	IV PREOP X 1 RN: DATE:			
GENTAMICIN ____ MG (GARAMYCIN) NS 100 ML INFUSE OVER ____ MINUTES	IV PREOP X 1 RN: DATE:			
LEVAQUIN ____ MG (LEVOFLOXACIN) IN D5W ____ ML INFUSE OVER ____ MINUTES	IV PREOP X 1 RN: DATE:			

Administration Period: 07:01 7/10/12 (date) to 07:00 _____ (date) **07:01 – 15:00** **15:01 – 23:00** **23:01 – 7:00**

Allergies: NKA

PATIENT ID DOB:
MED REC NO: AGE:
ADMITTED:
PHYSICIAN:
DX:

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

NCH Item # 62496

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

30917MAR

DSC MEDICATION ADMINISTRATION RECORD

Form # 005.850-04/10-1-SD

INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE	INIT.	SIGNATURE

NORMAL SALINE RATE: TKO	IV 500 ML X 1 RN: _____ DATE: _____			
ZOFRAN (ONDANSETRON) ON CALL TO OR	PO 8 MG X 1 RN: _____ DATE: _____			
VERSED_____ MG (MIDAZOLAM) ON CALL TO OR	PO SYRUP X 1 RN: _____ DATE: _____			
TYLENOL LIQUID_____ MG (ACETAMINOPHEN) ON CALL TO OR	PO X 1 RN: _____ DATE: _____			
ALBUTEROL 8 GM INHALER (VENTOLIN HFA) ON CALL TO OR	2 PUFFS X 1 RN: _____ DATE: _____			
SCOPOLAMINE 1.5 MG (TRANSDERM-SCOP) ON CALL TO OR	PATCH X 1 SITE APPLIED: _____ RN: _____ DATE: _____			
SOLUCORTEF _____ MG (HYDROCORTISONE) ON CALL TO OR	IV PREOP X 1 RN: _____ DATE: _____			

Administration Period: 07:01_____(date) to 07:00 _____(date) **07:01 – 15:00** **15:01 – 23:00** **23:01 – 7:00**

Allergies:

PATIENT ID DOB:
MED REC NO: AGE:
ADMITTED:
PHYSICIAN:
DX:

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

NCH Item # 62496

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

DSC MEDICATION ADMINISTRATION RECORD

Form # 005.850-04/10-1-SD

1100034

Medication Reconcile Record

DULBERG, PAUL R.
NCH-A - DSC
MD: Sagerman, Scott D., MD
Acct: 71265382 MRN: 0001307925
Discharge Date:
Requested Date:07/09/2012 16:33
Page 1 of 1

Allergy History

Allergen	Onset Date	Primary Reaction	Severity
No Known Allergies			

Patient Medication Reconciliation

Medication	Dose	Route	Freq	Last Taken	Next Dose Due	Start Date	Stop Date
Neurontin Oral *Generic: gabapentin*	900 mg Tablet	Oral	2 times per day	07/08/2012			
Norco Oral *Generic: hydrocodone-acetaminophen*	7.5-352 mg	Oral	Every 6 hours as needed				
Comment: for severe pain							
cyclobenzaprine 10 mg Tab *Generic:*	1 Tablet	Oral	As Needed	06/08/2012			
naproxen Oral *Generic: naproxen*	500 mg Tablet	Oral	2 times per day	07/06/2012			
tramadol 50 mg Tab *Generic:*	1 Tablet	Oral	As Needed	06/16/2012			
Comment: not for months							

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

To the best of our knowledge, this is a list of the medications you are taking as of this date. Questions regarding these medications should be directed to the prescribing physician.

Nurse Signature: _____ Date: 7/9/12

Patient Signature: Barb Dulberg Date: 7/9/12

This report indicates medications to be taken/given following discharge. Do not take any additional medications unless you check with your Physician. Please take this report with you when you visit your Physician and other Healthcare Providers.

DULBERG, PAUL R. Opt Out:
NCH-A - DSC
Discharge Med Reconciliation Orders
From: 07/08/2012 12:49 To: 07/09/2012 12:49
Rm-Bed: Admit Dt: 07/09/2012 12:02
Age: 42 yr Gender: M MD: Sagerman, Scott D., MD
DOB: 03/19/1970 Acct: 71265382
MRN: 0001307925
Requested: 07/09/2012 12:49 (LB57) Page 1 of 2

Allergy History

No Known Allergies

Active Medications

Drug Name	Dose	Route	Frequency	Last Taken	Comments:	Continue	Discontinue	M.D. Initials	Start Date
cyclobenzaprine 10 mg Tab	1 Tablet	Oral	As Needed	06/08/2012	Strength: 10 mg	☑	☐	☐	☐
gabapentin(Neurontin Oral)	900 mg Tablet	Oral	2 times per day	07/08/2012		☑	☐	☐	☐
hydrocodone-acetaminophen 10-650 mg Tab	0.5-1 Tablet Tablet	Oral	As Needed	03/01/2012	Special Instructions: not for months Strength: 10-650 mg	☑	☐	☐	☐
naproxen(naproxen Oral)	500 mg Tablet	Oral	2 times per day	07/06/2012		☑	☐	☐	☐
tramadol 50 mg Tab	1 Tablet	Oral	As Needed	06/16/2012	Special Instructions: not for months Strength: 50 mg	☑	☐	☐	☐

NO DATA FOUND FOR MODULE: 3. Active Inpatient Medications

New Medication Orders

Drug Name	Dose	Route	Frequency
Norco	1 tab/325	PO	1-2 tabs 4-6 hrs prn

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

FORM: 1100042

DULBERG, PAUL R. Opt Out:
NCH-A - DSC
Discharge Med Reconciliation Orders
From: 07/08/2012 12:49 To: 07/09/2012 12:49
Rm-Bed: Admit Dt: 07/09/2012 12:02
Age: 42 yr Gender: M MD: Sagerman, Scott D., MD
DOB: 03/19/1970 Acct: 71265382
MRN: 0001307925
Requested: 07/09/2012 12:49 (LB57) Page 2 of 2

Signatures:
Any medication changes (ie, dose, route, frequency) needs to be written in the New Medication Order Section.

Physician: _____ Date: 7/9/12 Time: 1430
Physician: _____ Date: _____ Time: _____
Physician: _____ Date: _____ Time: _____
Nurse: _____ Date: _____ Time: _____
Nurse: _____ Date: 7/9/12 Time: 1630

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

FORM: 1100042

DULBERG, PAUL R. Opt Out:
NCH-A
nch_hhsadmhx
Rm-Bed: Admit Dt: 07/09/2012 12:02
Age: 42 yr Gender: M MD: Sagerman, Scott D., MD
DOB: 03/19/1970 Acct: 71265382
MRN: 0001307925
Requested: 07/11/2012 22:01
Page 1 of 4

Admission History Assessment

Observables

Template: Admission History

Category: Arrival Date/Time				
Observable Name	Observation	Chart Time	Perform Time	Confirm Time
Arrival Date/Time	07/09/2012 12:14	07/09/2012 12:48 BURNS, LYNDA, RN	07/09/2012 12:46 BURNS, LYNDA, RN	
Category: Tobacco Use				
Observable Name	Observation	Chart Time	Perform Time	Confirm Time
Have you smoked within the last 30 days?	yes	06/26/2012 12:00 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN
Smoking status	current every day smoker	06/26/2012 12:00 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN
Category: Advance Directives				
Observable Name	Observation	Chart Time	Perform Time	Confirm Time
Advance directives	no	06/26/2012 12:00 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN	06/26/2012 11:59 MANALANSAN, LORENA, RN

Medication Detail

Description	Dose	Route	Freq/ Rate	Form	Strength
Active - Unknown					
Neurontin Oral (gabapentin Oral) PRN: No AKA: Indication: Type: Info Source: Spec Instr: Comments: Entered: 06/26/2012 11:43 Manalansan, Lorena , RN Confirmed: 07/09/2012 16:32 Balawender, Edyta , RN Modified: 07/09/2012 16:32 Balawender, Edyta , RN	900 mg	Oral	2 times per day	Tablet	

Medication Detail (continued)

Description	Dose	Route	Freq/ Rate	Form	Strength
Active - Unknown					
Norco Oral (hydrocodone- acetaminophen Oral) PRN: No AKA: Indication: Type: Info Source: Spec Instr: for severe pain Comments: Entered: 07/09/2012 16:33 Balawender, Edyta , RN Confirmed: 07/09/2012 16:33 Balawender, Edyta , RN Modified: 07/09/2012 16:33 Balawender, Edyta , RN	7.5-352 mg	Oral	Every 6 hours as needed		
cyclobenzaprine 10 mg Tab (cyclobenzaprine 10 mg Tab) PRN: Yes AKA: Indication: Type: Info Source: Spec Instr: Comments: Entered: 06/26/2012 11:45 Manalansan, Lorena , RN Confirmed: 07/09/2012 16:32 Balawender, Edyta , RN Modified: 07/09/2012 16:32 Balawender, Edyta , RN	1	Oral	As Needed	Tablet	10 mg
naproxen Oral (naproxen Oral) PRN: No AKA: Indication: Type: Info Source: Spec Instr: Comments: Entered: 06/26/2012 11:42 Manalansan, Lorena , RN Confirmed: 07/09/2012 16:32 Balawender, Edyta , RN Modified: 07/09/2012 16:32 Balawender, Edyta , RN	500 mg	Oral	2 times per day	Tablet	
tramadol 50 mg Tab (tramadol 50 mg Tab) PRN: No AKA: Indication: Type: Info Source: Spec Instr: not for months Comments: Entered: 06/26/2012 11:45 Manalansan, Lorena , RN Confirmed: 07/09/2012 16:32 Balawender, Edyta , RN Modified: 07/09/2012 16:32 Balawender, Edyta , RN	1	Oral	As Needed	Tablet	50 mg

Medication Detail (continued)

Description	Dose	Route	Freq/ Rate	Form	Strength
Discontinued - Unknown					
hydrocodone- acetaminophen 10- 650 mg Tab (hydrocodone- acetaminophen 10- 650 mg Tab) PRN: No AKA: Indication: Type: Info Source: Spec Instr: not for months Comments: Entered: 06/26/2012 11:47 Manalansan, Lorena , RN Confirmed: 07/09/2012 16:32 Balawender, Edyta , RN Modified: 07/09/2012 16:32 Balawender, Edyta , RN	0.5-1 Tablet	Oral	As Needed	Tablet	10-650 mg
Inactive- ERROR - Unknown					
Bayer Aspirin Oral (aspirin Oral) PRN: No AKA: Indication: Type: Info Source: Spec Instr: Comments: Entered: 06/26/2012 11:49 Manalansan, Lorena , RN Confirmed: 07/09/2012 12:46 Burns, Lynda , RN Modified: 07/09/2012 12:46 Burns, Lynda , RN		Oral	As Needed	Tablet	250 mg

Problem Detail

Description (Snomed code)	Chronicity	Additional Info
Active - Medical		
Neuritis (84299009) (Right)[1] ICD: 729.2 Problem Priority: Problem Onset: Current Occurrence: Comment: right ulna Entered: 06/26/2012 11:59 Manalansan, Lorena , RN Last Confirmed: 07/09/2012 12:46 Burns, Lynda , RN Last Modified: 07/09/2012 12:46 Burns, Lynda , RN		

Allergy Detail

Allergen	Reaction	Severity	Sensitivity Type

DULBERG, PAUL R. Opt Out:
NCH-A
nch_hhsadmhx
Rm-Bed: Admit Dt: 07/09/2012 12:02
Age: 42 yr Gender: M MD: Sagerman, Scott D., MD
DOB: 03/19/1970 Acct: 71265382
MRN: 0001307925
Requested: 07/11/2012 22:01
Page 4 of 4

Allergy Detail (continued)

Allergen	Reaction	Severity	Sensitivity Type
Active			
[NS] ***No Known Allergies***			
Onset Date:			
Reported By:			
Rel. to Patient:			
Comments:			
Entered: 07/09/2012 12:44 Burns, Lynda , RN			
Confirmed: 07/09/2012 00:00 Staffid, Auto			
Verified: 07/09/2012 00:00 Staffid, Auto			

NO DATA FOUND FOR MODULE: 5. Immunization Details

CURRENT LIVING SITUATION / SUPPORT SERVICES

Occupation has been on has not been working. Disabled.

- ☐ Lives Alone
- ☐ Home Health Agency
- ☐ Foster Care
- ☐ Other
- ☐ With Spouse / S.O.
- ☐ Assisted
- ☐ Hospice
- ☐ With Family Parents.
- ☐ Retirement Comm.
- ☐ Nursing Home

Facility:

Cultural/Religious Practices ☒ None List:

Primary Language Spoken: English Support System

Recent Stressors (Major Loss/Changes) ☐ None List:

FUNCTIONAL SCREEN

Y = Yes
N = No
I = Independent
A = Assisted
D = Dependent
U = Unknown

FUNCTIONAL LEVEL PRIOR TO ILLNESS	FUNCTIONAL LEVEL ON ADMISSION	IS THERAPY APPROPRIATE?	
I	I		Ambulation (PT)
I	I		Transfers (PT)
I	I		Toileting (OT)
I	I		Hygiene (OT)
I	I		Dressing (OT)
I	I		Feeding (OT)
I	I		Swallowing (ST)
I	I		Communication (CT)

☐ Therapy not appropriate upcoming surgery is within: 24 hours

FALL RISK ASSESSMENT (Check All That Apply)

- ☐ Previous Fall (in past 6 months)
- ☐ Mobility Problem
- ☐ Confusion
- ☐ Incontinent
- ☐ Hearing / Visual Impairment
- ☐ Meds That Put Patient at Risk of Falling
- ☐ Communication Barrier
- ☐ CNS Impairment
- ☒ None of Above

PRESSURE ULCER RISK ASSESMENT

Braden Scale tool attatched

Braden Scale Score ➤

CHECK IF PRESENT ON ADMISSION

EQUIPMENT/PROSTHESES USED (Check All That Apply)

- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Dentures Full U L / Partial U L
- ☐ Glasses
- ☐ Contact Lenses
- ☐ Artificial Eye R L
- ☐ Hearing Aid R L
- ☒ OTHER: NONE

NUTRITION SCREEN Circle numbers that apply to patient; total the points.

	Points		Points
Dx. of malnutrition	5	Nausea/vomiting/diarrhea > 3 days	2
Inadequate po intake/dehydration	3	Difficulty chewing/swallowing	3
Surgical patient > 65 yrs. old	2	Decubitis ulcer/non-healing wound	5
Appears emaciated/morbidly obese	4	Trauma/sepsis	3
Special diet/diet schedule	1	Unintentional 10 lb. gain/loss in 1 month	3
Pregnant/lactating (non-OB admission)	3		
Braden scale ≤ 12	5	**Total Points**	0

Risk Level: Low (1-4) / Moderate (5-7) / High > 7 **Risk total 5 or greater must be referred by documentation on physician orders for order to NFS.**

RN Signature Date 6/29/12 7/9/12

DULBERG ,PAUL R
71265382 M 42 07/09/12
DOB 03/19/1970 0001307925
SAGERMAN, SCOTT D MD

Northwest Community Hospital
Northwest Community Day Surgery Center
Arlington Heights, IL 60005

22903NUR

NURSING ADMISSION ASSESSMENT

NCH Item No. 25668

Form # 005.014-02/04-1-S&D