

Discharge Summary

* Final Report *

ROY, MICHAEL F - E000181886

Result type: Discharge Summary
Result date: July 22, 2024 11:07 CDT
Result status: Auth (Verified)
Result title: BH Discharge Summary
Performed by: Rasheed (HPS), Khalid, MD on July 22, 2024 11:08 CDT
Verified by: Rasheed (HPS), Khalid, MD on July 22, 2024 13:56 CDT
Encounter info: E2420200212, Baptist East, East Inpatient, 7/20/2024 - 7/22/2024

* Final Report *

BH Discharge Summary

Patient: **ROY, MICHAEL F** MRN: **E000181886** FIN: **E2420200212**
Age: **78 years** Sex: **Male** DOB: **4/23/1946**
Associated Diagnoses: **None**
Author: **Rasheed (HPS), Khalid, MD**

Discharge Information

Discharge Summary Information:

Admit Date/Time: **07/20/2024 22:31**

, Discharged 7/22/2024.

Consulting physician:

Consulting Physicians: **Lorenzo-Bueltel, Donna L MD**

Procedure

Operations and Procedures

None Found

Physical Examination

VS/Measurements

Vitals - Last 24 Hours

<u>Vital Sign</u>	<u>Latest</u>	<u>Latest Dt/Tm</u>	<u>Min</u>	<u>Min Dt/Tm</u>	<u>Max</u>	<u>Max Dt/Tm</u>
Temp	97.8	07-22-2024 11:12	98	07-21-2024 16:27	98.2	07-21-2024 19:33
Heart Rate	70	07-22-2024 11:12	67	07-21-2024 16:27	71	07-21-2024 19:33
Resp Rate	16	07-22-2024 11:12	17	07-21-2024 16:27	18	07-22-2024 03:27
SBP	188	07-22-2024 11:12	134	07-21-2024 16:27	188	07-22-2024 11:12
DBP	94	07-22-2024 11:12	73	07-21-2024 16:27	94	07-22-2024 11:12
SpO2	96	07-22-2024 11:12	95	07-21-2024 16:27	96	07-22-2024 11:12

Printed by: Dotson, Phyllis E
Printed on: 7/29/2024 9:56 CDT

7/29/24
Reviewed
J. Dotson, MD

Discharge Summary

ROY, MICHAEL F - E000181886

* Final Report *

General: Alert and oriented, No acute distress comfortable on bed**Eye:** Pupils are equal, round and reactive to light.**HENT:** Normocephalic.**Neck:** Supple, Non-tender.**Respiratory:** Lungs are clear to auscultation, Respirations are non-labored.**Cardiovascular:** Normal rate, Regular rhythm, No murmur, No gallop.**Gastrointestinal:** Soft, Non-tender, Non-distended, Normal bowel sounds.**Integumentary:** NO EDEMA**Psychiatric:** Cooperative, Appropriate mood and affect.**Results Review****Laboratory results****Labs** (Last four charted values)

WBC	5.5	(JUL 21)	8.6	(JUL 20)
Hgb	13.3	(JUL 21)	14.0	(JUL 20)
Hct	L 39.6	(JUL 21)	41.3	(JUL 20)
Plt	201	(JUL 21)	208	(JUL 20)
Na	141	(JUL 21)	140	(JUL 20)
K	3.8	(JUL 21)	4.4	(JUL 20)
CO2	25	(JUL 21)	24	(JUL 20)
Cl	H 110	(JUL 21)	108	(JUL 20)
Cr	1.29	(JUL 21)	1.25	(JUL 20)
BUN	H 26	(JUL 21)	H 25	(JUL 20)
Glucose	95	(JUL 20)		
Glucose Random	93	(JUL 21)	93	(JUL 20)
Mg	2.4	(JUL 21)		
Phos	4.2	(JUL 21)		
Ca	8.6	(JUL 21)	9.0	(JUL 20)
PT	10.5	(JUL 20)		
INR	0.97	(JUL 20)		
PTT	27	(JUL 20)		

Cardiac Labs**BNP (Cross Visit)/D-Dimer/Troponin Lab Results**

Assay	Result	Date/Time
HS Troponin	3.91 ng/L	07/20/24 14:45
Chol	195 mg/dL	07/21/24 04:49
HDL	41 mg/dL	07/21/24 04:49
LDL	124 mg/dL H	07/21/24 04:49

Radiology results**All Radiology Reports (this visit) - Range: 07/20/2024 22:31 - 07/22/2024 13:51**

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Discharge Summary

* Final Report *

ROY, MICHAEL F - E000181886

Reports Found: 3

MR Brain MRI w/o contrast Exam Dt/Tm: 07/21/2024 11:11

IMPRESSION: Normal MRI brain. Workstation: SPACS-READ05-PC Job ID: 204884

CT Angio Brain w/ + w/o Exam Dt/Tm: 07/20/2024 16:07

IMPRESSION: 1. No acute intracranial findings. 2. Normal CTA of the brain and neck. Workstation: PWPRMTDOCFL1B Job ID: 204632

DX Chest Portable Exam Dt/Tm: 07/20/2024 15:24

IMPRESSION: No active disease. Workstation: PWPMGMTEL109 Job ID: 204630

Pending Results

Pending Diagnostics ST

Anti-Cardiolipin	Ordered: 07/20/2024 22:51	Status: Report Pending
Factor V Leiden 81241	Ordered: 07/20/2024 22:51	Status: Report Pending
Lupus Anticoagulant	Ordered: 07/20/2024 22:51	Status: Report Pending
Protein C	Ordered: 07/20/2024 22:51	Status: Report Pending
Protein S Activity	Ordered: 07/20/2024 22:51	Status: Report Pending
Protein S Antigen	Ordered: 07/20/2024 22:51	Status: Report Pending
Protein S Antigen Free	Ordered: 07/20/2024 22:51	Status: Report Pending
Prothrombin Gene Mutation 81240	Ordered: 07/20/2024 22:51	Status: Report Pending
ANA	Ordered: 07/20/2024 22:51	Status: Report Pending
Anti-Cardiolipin	Ordered: 07/22/2024 11:22	Status: Report Pending
Factor V Leiden 81241	Ordered: 07/22/2024 11:22	Status: Report Pending
Lupus Anticoagulant	Ordered: 07/22/2024 11:22	Status: Report Pending
Protein C	Ordered: 07/22/2024 11:22	Status: Report Pending
Prothrombin Gene Mutation 81240	Ordered: 07/22/2024 11:22	Status: Report Pending
Protein S Activity	Ordered: 07/22/2024 11:22	Status: Report Pending
B2 Glycoproteins 1 Ab, G, A, M	Ordered: 07/22/2024 11:22	Status: Report Pending

Hospital Course

Hypertensive encephalopathy

Hypertensive urgency

Impaired transient memory

Mild renal insufficiency

History of? Factor V Leyden deficiency

History of DVT in past

Discharge summary

78-year-old very pleasant male who came to the hospital because of progressive confusion and transient memory loss. He was brought to the hospital. Imaging studies of the brain is unremarkable. He has recently moved from Mobile to Montgomery. He has not seen any doctor here. According to him and his wife he was diagnosed with DVT in the past and was supposed to take Eliquis which she stopped a few years ago on his own. He states he is family has been diagnosed

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Printed on: 7/29/2024 9:56 CDT

Page 3 of 5

Discharge Summary

* Final Report *

ROY, MICHAEL F - E000181886

with factor V Leyden deficiency. And was being told that he might need Eliquis forever. However he stopped it himself. At this point is not clear. I am discharging him on aspirin and Eliquis. I have discussed case with hematology who will see him as an outpatient. I have ordered coagulation studies which hematologist can follow as an outpatient. I have discussed risk benefits of anticoagulation

Discharge Plan**Discharge Summary Plan**

Condition at Discharge: improved.

Follow-up: Mohammad Irfan; Amy Cooper Within 1 month FOR Mitral regurgitation.; Susmitha Nimmagadda; PCP No.

Discharge Medications**Discharge Prescriptions****1. amlODIPine (Norvasc 10 mg oral tablet)****Dose:** 10 mg / 1 Tab **Route:** PO **Freq:** DAILY **Refills:** 0**2. apixaban (apixaban 5 mg oral tablet)****Dose:** 5 mg / 1 Tab **Route:** PO **Freq:** Twice Daily **Refills:** 0**3. atorvastatin (Lipitor 40 mg oral tablet)****Dose:** 40 mg / 1 Tab **Route:** PO **Freq:** Bedtime **Refills:** 0**Home Medications****1. ascorbic acid (Vitamin C)****2. aspirin (aspirin)****Dose:** 81 mg **Route:** PO **Freq:** DAILY**3. calcium-vitamin D (calcium (as carbonate and lactate)-vitamin D 200 mg-6.25 mcg oral tablet)****Dose:** 1 Tab **Route:** Chewed **Freq:** DAILY**4. cyanocobalamin (Vitamin B-12)****5. ergocaliferol (Vitamin D2)****6. ginger (ginger)****7. multivitamin with minerals (Alive Men's Complete Multivitamin oral tablet)**

Discharge Summary
* Final Report *

ROY, MICHAEL F - E000181886

8. pyridoxine (Vitamin B6)

9. turmeric (Turmeric)

Professional Services

Time spent: Time spent 35 minutes.
FACE TO FACE TIME

Signature Line

(Electronically Signed On 07.22.24 13:56 CDT)

Rasheed (HPS), Khalid, MD

Completed Action List:

- * Perform by Rasheed (HPS), Khalid, MD on July 22, 2024 11:08 CDT
- * Modify by Rasheed (HPS), Khalid, MD on July 22, 2024 13:56 CDT
- * Sign by Rasheed (HPS), Khalid, MD on July 22, 2024 13:56 CDT
- * VERIFY by Rasheed (HPS), Khalid, MD on July 22, 2024 13:56 CDT

History and Physical

* Final Report *

ROY, MICHAEL F - E000181886

Result type: History and Physical
Result date: July 20, 2024 22:38 CDT
Result status: Auth (Verified)
Result title: Admit H&P
Performed by: Muneer (HPS), Kashiff M, MD on July 20, 2024 22:49 CDT
Verified by: Muneer (HPS), Kashiff M, MD on July 20, 2024 22:49 CDT
Encounter info: E2420200212, Baptist East, East Inpatient, 7/20/2024 - 7/22/2024

* Final Report *

Admit H&P

Patient: **ROY, MICHAEL F** **MRN: E000181886** **FIN: E2420200212**
Age: **78 years** Sex: **Male** DOB: **4/23/1946**
Associated Diagnoses: **None**
Author: **Muneer (HPS), Kashiff M, MD**

Basic Information

Admission Date/Time:

Admit Date/Time: **07/20/2024 22:38**

Primary Care Physician: No PCP.

Specialist(s):

Consulting Physicians: **Lorenzo-Bueltel, Donna L MD**

Chief Complaint

Concern for TIA

History of Present Illness

This is a 78-year-old Caucasian male with past medical history listed below presents to the ER due to concerns of a TIA/CVA. According to the patient and his wife at bedside, patient did some window cleaning the morning, around noon he came back in the house, patient's wife noticed that he was confused and seemed lost. She tried to ask him and he was not able to answer her questions. She went to shower came back patient was on the bed but still seemed confused and did not seem right. Therefore she brought him to the ER at Baptist East. He was seen and evaluated, teleneurology was consulted who evaluated the patient and recommended admitting the patient for further workup for stroke versus TIA. Patient has a history of factor V Leyden and his family members also have a history of this as well. He was on Eliquis previously but has stopped taking it a while ago, he does snore but unsure if he has any episodes of apnea. At this time, patient and wife state that he is feeling much better, back to his baseline, however they are waiting to follow their recommendations from teleneurology and stay in the hospital to get complete workup performed. At this time, patient denies any chest pain, shortness of breath, dizziness, diaphoresis, blurred vision, nausea, vomiting. No other acute complaints at this time.

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Page 1 of 6

History and Physical
* Final Report *

ROY, MICHAEL F - E000181886

Histories

Problem list:

Factor V Leyden

Procedure history: Procedure history (ST)

Cholecystectomy

Cyst removal from back

Skin cancer removal from face

Social History

Social and Psychosocial Habits

Alcohol

07/20/2024 Alcohol Use No

Substance Abuse

07/20/2024 Drug Use No

Tobacco

07/20/2024 Tobacco Use: Never (less than 100 in 1

Non-Smoking Literature Non-smoker, Non-smoker

Family History:

Factor V Leiden in family.

Health Status

Allergies:

Allergies (1) Active

codeine

Reaction

None Documented

Home medications:

Patient used to be on medication aspirin, Eliquis, statin. However he stopped taking all his medications.

Review of Systems

All other systems reviewed and found to be negative.

Physical Examination

Intake and Output

Intake and Output Summary

beg date: 07/19 07:00

end date: 07/20 06:59

24 Hour

Input: 0.00 ml

Output: 0.00 ml

Balance: 0.00 ml

Stool Count: 0

Urine Count: 0

History and Physical

* Final Report *

ROY, MICHAEL F - E000181886

Emesis Count: 0

VS/Measurements

Vitals - Last 24 Hours

<u>Vital Sign</u>	<u>Latest</u>	<u>Latest Dt/Tm</u>	<u>Min</u>	<u>Min Dt/Tm</u>	<u>Max</u>	<u>Max Dt/Tm</u>
Temp	98.0	07-20-2024 17:00	97.7	07-20-2024 13:41	98.0	07-20-2024 17:00
Heart Rate	64	07-20-2024 20:00	70	07-20-2024 13:41	71	07-20-2024 14:30
Resp Rate	20	07-20-2024 20:00	18	07-20-2024 14:30	20	07-20-2024 20:00
SBP	141	07-20-2024 20:00	183	07-20-2024 13:41	188	07-20-2024 15:30
DBP	94	07-20-2024 20:00	94	07-20-2024 13:41	112	07-20-2024 15:30
SpO2	95	07-20-2024 20:00	96	07-20-2024 13:41	97	07-20-2024 19:00

General: No acute distress.**Eye:** Pupils are equal, round and reactive to light, Extraocular movements are intact.**HENT:** Normocephalic.**Neck:** Supple, No jugular venous distention.**Respiratory:** Lungs are clear to auscultation, Respirations are non-labored.**Cardiovascular:** Normal rate, Regular rhythm, No murmur, No edema.**Gastrointestinal:** Soft, Non-tender, Non-distended, Normal bowel sounds.**Musculoskeletal:** Normal range of motion.**Integumentary:** Warm, Dry.**Neurologic:** Alert, Oriented, No focal deficits.**Psychiatric:** Cooperative, Appropriate mood and affect.

Results Review

Laboratory Results Today's Lab Results : LABORATORY

7/20/2024 14:53 CDT

U Color	Yellow
U Appear	Clear
U Spec Grav Auto	1.009
U pH	5.5
U Protein	NEGATIVE
U Gluc	NEGATIVE
U Ketones	NEGATIVE
U Occult Blood	NEGATIVE
Ur Leuk est	NEGATIVE
Ur Nitrite	NEGATIVE
U Urobilinogen	0.2 E.U./dL E.U./dL
U Bili	NEGATIVE
U Amph Scrn	NEG
U Barb Scrn	NEG
U Benzodia Scrn	NEG
U Cocaine Scrn	NEG
U Opiate Scrn	NEG
U Cannab Scrn	NEG
U EXTC Scrn	NEG
U Oxycodone Scrn	NEG
U Fentanyl Scrn	NEG
WBC	8.6 X10-3/uL

7/20/2024 14:45 CDT

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History and Physical
* Final Report *

ROY, MICHAEL F - E000181886

RBC	4.48 X 10⁻⁶/uL LOW
Hemoglobin	14.0 gm/dl
Hematocrit	41.3 %
MCV	92 FL
MCH	31 pg
MCHC	34 gm/dl
Platelet Count	208 X10 ⁻³ /uL
RDW	12.3 %
Neutro Auto	74 %
Lymph Auto	17 % LOW
Mono Auto	7 %
Eos Auto	1 %
Basophil Auto	1 %
Immature Gran Auto	0.6 %
Neutro Abs	6.4 X10 ⁻³ /uL
Lymph Abs	1.4 X10 ⁻³ /uL
Mono Abs	0.6 X10 ⁻³ /uL
Eos Abs	0.1 X10 ⁻³ /uL
Basophil Abs	0.0 X10 ⁻³ /uL
Immature Gran Abs	0.0 X10 ⁻³ /uL
NRBC	0.0 /100 WBC
NRBC Abs	0.0 X10 ⁻³ /uL
Gluc	93 mg/dL
BUN	25 mg/dL HI
Creat	1.25 mg/dL
eGFR CKD-EPI	59 mL/min/1.73m2 LOW
eCrCl	47 mL/min
Sodium Ivl	140 mmol/L
Potassium Ivl	4.4 mmol/L
Chloride	108 mmol/L
CO2	24 mmol/L
Anion Gap	10
Calcium	9.0 mg/dL
Total Protein	7.2 gm/dl
Albumin	3.9 gm/dl
Alk Phos	61 unit/L
ALT	21 unit/L
AST	11 unit/L
Bili Total	0.6 mg/dL
HS Troponin	3.91 ng/L
Glucose POC	95 mg/dL

7/20/2024 13:48 CDT

Radiology results

Radiology Results (ST)

Radiology Reports (Last 24 Hours) - Range: 07/19/2024 07:00 - 07/20/2024 22:38

Reports Found: 2

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Printed on: 7/29/2024 9:56 CDT

Page 4 of 6

History and Physical

* Final Report *

ROY, MICHAEL F - E000181886

Angio Brain w/ + w/o Exam Dt/Tm: 07/20/2024 16:07

FINDINGS: CT brain: Cortical sulcal pattern, basilar cisterns, and ventricles are within normal limits. Gray-white matter differentiation is preserved. No acute intracranial hemorrhage, mass effect, midline shift, or herniation. Posterior fossa grossly unremarkable. Calvarium is intact. Visualized paranasal sinuses and mastoid air cells are predominantly clear. **CTA OF THE NECK:** Aortic arch and great vessel origins are normal. Left common carotid reveals no stenosis (0% narrowing). Left internal carotid reveals no stenosis (0% narrowing). Right common carotid artery reveals no stenosis (0% narrowing). Right internal carotid artery reveals no stenosis (0% narrowing). Vertebral arteries are unremarkable. Cervical spine and soft tissues of the neck show no significant abnormality. **CTA OF THE BRAIN:** Intracranial internal carotid arteries are normal. Middle cerebral arteries are unremarkable. Anterior cerebral arteries are normal. Vertebrobasilar circulation and posterior cerebral arteries are normal. No aneurysms.

IMPRESSION: 1. No acute intracranial findings. 2. Normal CTA of the brain and neck. Workstation: PWPRMTDOCFL1B Job ID: 204632

Chest Portable Exam Dt/Tm: 07/20/2024 15:24

FINDINGS: The mediastinal and cardiac silhouettes are normal. The lungs are clear. No acute bony abnormality.

IMPRESSION: No active disease. Workstation: PWPMGMTTEL109 Job ID: 204630

EKG

Sinus rhythm, normal axis, heart rate 63, no acute ST elevation or depression of significance noted at this time.

Documents reviewed: Prior documents, ED Notes

Impression and Plan

Concern for CVA/TIA
Impaired transient memory
Mild renal insufficiency
History of factor V Leiden
DVT and GI prophylaxis
CODE STATUS, full code
Next of kin: Wife: Barbara Roy. 251-327-7973.

Plan:

Patient presents with concern for CVA/TIA. We will admit the patient, get the workup done. Allow permissive hypertension at this time. She has a history of factor V Leyden, used to be on Eliquis, has not taken it in a while. He also snores. Could be due to atrial fibrillation as well. Will keep him on telemetry, get MRI/MRA/cardiac echo. Get workup for coagulopathy. As recommended by neuro will start on aspirin and Plavix. Will also keep him on Eliquis given his history of factor V Leyden. Counsel on medication compliance. Check labs. Continue statin as well. Continue to monitor, augment/escalate/optimize care as appropriate.

Total time taken for this H&P is at least 35 minutes.

Signature Line

Printed by: Dotson, Phyllis E
Printed on: 7/29/2024 9:56 CDT

History and Physical
* Final Report *

ROY, MICHAEL F - E000181886

(Electronically Signed On 07.20.24 22:49 CDT)

Muneer (HPS), Kashiff M, MD

D: 07.20.24 22:49 CDT

Completed Action List:

- * Perform by Muneer (HPS), Kashiff M, MD on July 20, 2024 22:49 CDT
- * Sign by Muneer (HPS), Kashiff M, MD on July 20, 2024 22:49 CDT
- * VERIFY by Muneer (HPS), Kashiff M, MD on July 20, 2024 22:49 CDT

Consultation
* Final Report *

ROY, MICHAEL F - E000181886

Result type: Consultation
Result date: July 20, 2024 16:18 CDT
Result status: Auth (Verified)
Result title: Teleneurology Note
Performed by: Lorenzo-Bueltel, Donna L, MD on July 20, 2024 16:28 CDT
Verified by: Lorenzo-Bueltel, Donna L, MD on July 20, 2024 18:10 CDT
Encounter info: E2420200212, Baptist East, East Inpatient, 7/20/2024 - 7/22/2024

* Final Report *

Chief Complaint

stroke

Reason for Consultation

stroke

History of Present Illness

Pt is a 78 y/o LHM who went to bed at 2200 on 7/19/2024 in his usual state of health. The pt was found today at 1200, standing in his bedroom with confusion. The symptoms lasted about 3 hours. The pt was brought to the ED for an evaluation. The pt recalls having tingling in his bilateral fingertips which also resolved. The pt denies any diplopia, speech difficulty, dysphagia, weakness, gait imbalance, falling, syncope, headache, dizziness, vertigo, fever, nausea, vomiting, chest pain, SOB, incontinence or tongue bite. Pt had discontinued AC for DVT on his own about 2 years ago with possible Factor v Leiden.

Review of Systems

as per HPI

Physical Exam

Vitals and Measurements

T: 97.7 °F (Oral) **HR:** 59 (Monitored) **RR:** 18 **BP:** 177/100 **SpO2:** 97%**WT:** 79 kg (Dosing)

General - WNWD, NAD. MS - alert and oriented x 3. Normal speech. CNs - EOMI. VF full to throat. Facial muscles without weakness. Facial sensation is normal. Hearing intact. Tongue protruded midline. Motor - antigravity in all extremities. Sensory - intact light touch in extremities. Mvmt - NRAMS. No tremor. Gait - deferred. MSR - unable to assess via telemedicine.

NIHSS score 0. No thrombolytic- outside of window, low NIHSS score.

Assessment/Plan

TIA

Secondary stroke prevention - Continue ASA, add Plavix 75 mg po q daily. Work up - MRI brain, echo with bubble study. Labs - A1c, Lipid panel, Factor V Leiden. If LDL >70, recommend medium dose statin. Goals - LDL <70, A1c <7. Monitor pt on telemetry for cardiac arrhythmia and if AF is present, pt may need DOAC. PT/OT/ST to evaluate and treat. BP should be treated PRN >220/110, unless end organ damage or other clinical scenario needs it lowered. Permissive HTN is for 24 hours after TIA/stroke and lowering to normotension should be by 10-15%/day. Stroke education for pt and/or caregiver. Please call for any questions/concerns or if new information becomes available.

Teleneurology evaluation was performed using a HIPAA compliant A/V platform occurring synchronously between our separate locations. Pt permission was

Problem List/Past Medical History

Ongoing

No qualifying data

Medications

Inpatient

No active inpatient medications

Home

No active home medications

Allergies

codeine

Social History

Alcohol

Alcohol Use: No.

Substance Abuse

Drug Use: No.

Tobacco

Former tobacco use.

Family History

non-contributory

Diagnostic Results

CTH - no acute changes.

CTA head/neck - no LVO.

Consultation

* Final Report *

ROY, MICHAEL F - E000181886

obtained.

Recommendation and assessment was discussed with Dr Folashade.

Signature Line

(Electronically Signed On 07.20.24 18:10 CDT)

Lorenzo-Buelstel, Donna L, MD

D: 07.20.24 16:28 CDT

Completed Action List:

- * Perform by Lorenzo-Buelstel, Donna L, MD on July 20, 2024 16:28 CDT
- * Modify by Lorenzo-Buelstel, Donna L, MD on July 20, 2024 18:10 CDT
- * Sign by Lorenzo-Buelstel, Donna L, MD on July 20, 2024 18:10 CDT Requested by Lorenzo-Buelstel, Donna L, MD on July 20, 2024 16:28 CDT
- * VERIFY by Lorenzo-Buelstel, Donna L, MD on July 20, 2024 18:10 CDT

Emergency Room Report

* Final Report *

ROY, MICHAEL F - E000181886

Result type: Emergency Room Report
Result date: July 20, 2024 15:00 CDT
Result status: Auth (Verified)
Result title: Altered Mental Status *ED
Performed by: Folashade, Caroline O, MD on July 20, 2024 15:22 CDT
Verified by: Folashade, Caroline O, MD on July 21, 2024 0:11 CDT
Encounter info: E2420200212, Baptist East, East Inpatient, 7/20/2024 - 7/22/2024

* Final Report *

Altered Mental Status *ED

Patient: **ROY, MICHAEL F** MRN: **E000181886** FIN: **E2420200212**
Age: **78 years** Sex: **Male** DOB: **4/23/1946**
Associated Diagnoses: **Brain TIA; Acute memory impairment**
Author: **Folashade, Caroline O, MD**

Basic Information

Time seen: Date and time 7/20/2024 15:00:00.

History source: Patient, significant other.

Arrival mode:

Automobile from Home or Work

Additional information: ED Chief Complaint

7/20/2024 13:41 CDT ED Chief Complaint pt to the ED with c/o memory loss since appx 1200. stroke scale negative .

History of Present Illness

The patient presents with confusion. The onset was 3 hours ago. The course/duration of symptoms is resolved: lasted 3 hour(s). The character of symptoms is confused. The degree at onset was moderate. The degree at present is none. Baseline status: alert and oriented X 4.

The exacerbating factor is none. The relieving factor is none. Risk factors consist of none. Prior episodes: none.

Therapy today: none. Associated symptoms: none. Additional history: none. Patient is a 78-year-old male history of factor V Leiden deficiency previous DVT of his right lower extremity presenting today with episode of confusion. Patient's wife states she noted around 12 noon patient was standing in the bedroom looking confused states he was trying to figure out things. Patient wife stated his speech was slow and he had difficulty remembering events which had happened within the last week. Patient's wife states he did not have any facial droop denies any weakness. As of time of my evaluation patient seems to be at his baseline neurological exam alert and oriented x 4. Patient denies history of headache denies any history of head trauma denies any other symptoms..

Review of Systems

Constitutional symptoms: Negative except as documented in HPI, no fever, no chills, no weakness, no decreased activity.

Skin symptoms: Negative except as documented in HPI.

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Emergency Room Report
* Final Report *

ROY, MICHAEL F - E000181886

Eye symptoms: Vision unchanged.

ENMT symptoms: Negative except as documented in HPI.

Respiratory symptoms: No shortness of breath, no orthopnea, no cough.

Cardiovascular symptoms: No chest pain, no palpitations, no syncope, no diaphoresis.

Gastrointestinal symptoms: No nausea,

Genitourinary symptoms: Negative except as documented in HPI.

Musculoskeletal symptoms: Negative except as documented in HPI.

Neurologic symptoms: Negative except as documented in HPI.

Psychiatric symptoms: Negative except as documented in HPI.

Endocrine symptoms: Negative except as documented in HPI.

Allergy/immunologic symptoms: Negative except as documented in HPI.

Additional review of systems information: All other systems reviewed and otherwise negative.

Health Status

Allergies:

codeine

Allergic Reactions (Selected)

Moderate

Codeine- No reactions were documented..

Medications:

No qualifying data available

Immunizations:

Last Tetanus: Unknown

No Immunizations UDT Information Found For This Visit

Past Medical/ Family/ Social History

Medical history: Active problems

No qualifying data available.

, Nurses note reviewed.

Surgical history:

No qualifying data available.

No active procedure history items have been selected or recorded., Nurses note reviewed.

Family history:

No qualifying data available.

No family history items have been selected or recorded., Nurses note reviewed.

Social history:

Alcohol

Details: Alcohol Use: No.

Substance Abuse

Details: Drug Use: No.

Tobacco

Details: Tobacco Use: Never (less than 100 in lifetime). Non-Smoking Literature: Non-smoker.
, Nurses note reviewed.

Emergency Room Report
* Final Report *

ROY, MICHAEL F - E000181886

Physical Examination

Vital Signs

Triage Vital Signs (First Results)

Label	Result	Date / Time
Respiratory Rate	20 br/min	07/20/2024 13:41
Blood Pressure, Systolic (Monitored)	183 mmHg	07/20/2024 13:41
Blood Pressure, Diastolic (Monitored)	94 mmHg H	07/20/2024 13:41
Blood Pressure, Mean (Monitored)	133 mmHg	07/20/2024 14:30
Temperature, Oral	97.7 DegF	07/20/2024 13:41
SpO2 96 %	07/20/2024 13:41	
Heart Rate, Monitored	70 bpm	07/20/2024 13:41

General: Alert, no acute distress.

Glasgow coma scale: Eye response: 4 / 4, verbal response: 5 / 5, motor response: 6 / 6, Total score: Total score: 15.

Neurological: No focal neurological deficit observed, normal sensory observed, normal speech observed, normal coordination observed, normal and symmetrical reflexes, Level of consciousness: Appropriate for age, Cranial nerves II - XII: Intact, Motor strength: Equal bilaterally.

Skin: Warm, dry.

Head: Normocephalic, atraumatic.

Neck: Supple, trachea midline, no tenderness, no JVD.

Eye: Pupils are equal, round and reactive to light, extraocular movements are intact, normal conjunctiva, vision grossly normal.

Ears, nose, mouth and throat: Tympanic membranes clear, oral mucosa moist, no pharyngeal erythema or exudate.

Cardiovascular: Regular rate and rhythm, No murmur, Normal peripheral perfusion.

Respiratory: Lungs are clear to auscultation, respirations are non-labored, Symmetrical chest wall expansion.

Chest wall: No tenderness, No deformity.

Back: Nontender, Normal range of motion, Normal alignment, no step-offs.

Musculoskeletal: Normal ROM, normal strength, no tenderness, no swelling.

Gastrointestinal: Soft, Nontender, Normal bowel sounds.

Genitourinary: No tenderness, normal external genitalia.

Psychiatric: Cooperative, appropriate mood and affect, normal judgment.

Medical Decision Making

Differential Diagnosis: Confusion, dementia, cerebral vascular accident, transient ischemic attack, hypoglycemia, urinary tract infection, pneumonia, drug abuse, dehydration, electrolyte imbalance.

Rationale: Patient with no significant past medical history of heart problems factor V Leiden deficiency presenting today with an acute episode of confusion which wife states had lasted about 3 hours earlier today. Patient's neurological examination is normal at this time. Will obtain lab work CT angiogram of the head and neck neurology consult will be placed..

Electrocardiogram: Time 7/20/2024 14:41:00, rate 63, normal sinus rhythm, No ST-T changes, no ectopy, normal PR and QRS intervals.

Results review:

ED Lab Results

Emergency Room Report

* Final Report *

ROY, MICHAEL F - E000181886

Assay Result	Date/Time	
Hematology		
WBC	8.6 X10-3/uL	07/20/24 15:07
RBC4.48 X 10-6/uL L	07/20/24 15:07	
Hemoglobin	14.0 gm/dl	07/20/24 15:07
Hematocrit	41.3 %	07/20/24 15:07
MCV	92 FL	07/20/24 15:07
MCH	31 pg	07/20/24 15:07
MCHC	34 gm/dl	07/20/24 15:07
Platelet Count	208 X10-3/uL	07/20/24 15:07
RDW	12.3 %	07/20/24 15:07
Automated Differential		
Neutro Auto	74 %	07/20/24 15:07
Lymph Auto	17 % L	07/20/24 15:07
Mono Auto	7 %	07/20/24 15:07
Eos Auto	1 %	07/20/24 15:07
Basophil Auto	1 %	07/20/24 15:07
Immature Gran Auto	0.6 %	07/20/24 15:07
Neutro Abs	6.4 X10-3/uL	07/20/24 15:07
Lymph Abs	1.4 X10-3/uL	07/20/24 15:07
Mono Abs	0.6 X10-3/uL	07/20/24 15:07
Eos Abs	0.1 X10-3/uL	07/20/24 15:07
Basophil Abs	0.0 X10-3/uL	07/20/24 15:07
Immature Gran Abs	0.0 X10-3/uL	07/20/24 15:07
NRBC	0.0 /100 WBC	07/20/24 15:07
NRBC Abs	0.0 X10-3/uL	07/20/24 15:07
Coagulation		
PT 10.5 Sec	07/20/24 23:15	
INR 0.97	07/20/24 23:15	
PTT27 Sec	07/20/24 23:20	
Fibrinogen	374 mg/dL	07/20/24 23:20
Urinalysis		
U Color	Yellow	07/20/24 15:01
U Appear	Clear	07/20/24 15:01
U Spec Grav Auto	1.009	07/20/24 15:01
U pH	5.5	07/20/24 15:01
U Protein	NEGATIVE	07/20/24 15:01
U Gluc	NEGATIVE	07/20/24 15:01
U Ketones	NEGATIVE	07/20/24 15:01
U Occult Blood	NEGATIVE	07/20/24 15:01
Ur Leuk est	NEGATIVE	07/20/24 15:01
Ur Nitrite	NEGATIVE	07/20/24 15:01
U Urobilinogen	0.2 E.U./dL E.U./dL	07/20/24 15:01
U Bili	NEGATIVE	07/20/24 15:01
Chemistry		
Chemistry Tests		
Gluc	93 mg/dL	07/20/24 15:29
BUN25 mg/dL H	07/20/24 15:29	

Emergency Room Report

* Final Report *

ROY, MICHAEL F - E000181886

Creat	1.25 mg/dL	07/20/24 15:29
eGFR CKD-EPI	59 mL/min/1.73m2 L	07/20/24 15:29
eCrCl	47 mL/min	07/20/24 15:29
Sodium lvl	140 mmol/L	07/20/24 15:11
Potassium lvl	4.4 mmol/L	07/20/24 15:11
Chloride	108 mmol/L	07/20/24 15:11
CO2	24 mmol/L	07/20/24 15:29
Anion Gap	10	07/20/24 15:29
Calcium	9.0 mg/dL	07/20/24 15:29
Total Protein	7.2 gm/dl	07/20/24 15:29
Albumin	3.9 gm/dl	07/20/24 15:29
Alk Phos	61 unit/L	07/20/24 15:29
ALT 21 unit/L	07/20/24 15:29	
AST	11 unit/L	07/20/24 15:29
Bili Total	0.6 mg/dL	07/20/24 15:29
Cardiac Panel		
HS Troponin	3.91 ng/L	07/20/24 15:29
Drugs of Abuse		
U Amph Scrn	NEG	07/20/24 15:32
U Barb Scrn	NEG	07/20/24 15:32
U Benzodia Scrn	NEG	07/20/24 15:32
U Cocaine Scrn	NEG	07/20/24 15:32
U Opiate Scrn	NEG	07/20/24 15:32
U Cannab Scrn	NEG	07/20/24 15:32
U EXTC Scrn	NEG	07/20/24 15:32
U Oxycodone Scrn	NEG	07/20/24 15:32
U Fentanyl Scrn	NEG	07/20/24 15:32
Point of Care		
Glucose POC	95 mg/dL	07/20/24 14:00

Radiology results: Radiology results (ST)**Radiology Reports (Last 24 Hours) - Range: 07/20/2024 07:00 - 07/21/2024 00:08**

Reports Found: 2

Angio Brain w/ + w/o Exam Dt/Tm: 07/20/2024 16:07

FINDINGS:CT brain:Cortical sulcal pattern, basilar cisterns, and ventricles are within normal limits. Gray-white matter differentiation is preserved. No acute intracranial hemorrhage, mass effect, midline shift, or herniation. Posterior fossa grossly unremarkable. Calvarium is intact. Visualized paranasal sinuses and mastoid air cells are predominantly clear. CTA OF THE NECK: Aortic arch and great vessel origins are normal. Left common carotid reveals no stenosis (0% narrowing). Left internal carotid reveals no stenosis (0% narrowing). Right common carotid artery reveals no stenosis (0% narrowing). Right internal carotid artery reveals no stenosis (0% narrowing). Vertebral arteries are unremarkable. Cervical spine and soft tissues of the neck show no significant abnormality. CTA OF THE BRAIN: Intracranial internal carotid arteries are normal. Middle cerebral arteries are unremarkable. Anterior cerebral arteries are normal. Vertebrobasilar circulation and posterior cerebral arteries are normal. No aneurysms.

IMPRESSION: 1. No acute intracranial findings. 2. Normal CTA of the brain and neck. Workstation: PWPRMTDOCFL1BJob ID: 204632

Emergency Room Report
* Final Report *

ROY, MICHAEL F - E000181886

Chest Portable Exam Dt/Tm: 07/20/2024 15:24

FINDINGS: The mediastinal and cardiac silhouettes are normal. The lungs are clear. No acute bony abnormality.

IMPRESSION: No active disease. Workstation: PWPMGMTTEL109 Job ID: 204630

Reexamination/ Reevaluation

Time: 7/20/2024 20:40:00 .

Course: well controlled.

Notes: Patient was evaluated by neurology consult recommend admission to inpatient service to complete stroke workup patient to be given aspirin and Plavix..

Impression and Plan

Diagnosis

Brain TIA (ICD10-CM G45.9, Discharge, Medical)

Acute memory impairment (ICD10-CM R41.3, Discharge, Medical)

Calls-Consults

- 7/20/2024 20:40:00 , Muneer (HPS), Kashiff M, MD, Consult for admission.

Plan

Condition: Stable.

Disposition: Admit: Time 7/20/2024 20:40:00, Muneer (HPS), Kashiff M, MD.

Certified medical emergency: Yes.

Counseled: Patient, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions.

Signature Line

(Electronically Signed On 07.21.24 00:11 CDT)

Folashade, Caroline O, MD

Completed Action List:

- * Perform by Folashade, Caroline O, MD on July 20, 2024 15:22 CDT
- * Modify by Folashade, Caroline O, MD on July 21, 2024 0:11 CDT
- * Sign by Folashade, Caroline O, MD on July 21, 2024 0:11 CDT

Printed by: Dotson, Phyllis E
Printed on: 7/29/2024 9:57 CDT

Emergency Room Report
* Final Report *

ROY, MICHAEL F - E000181886

* VERIFY by Folashade, Caroline O, MD on July 21, 2024 0:11 CDT