Chief Complaint: Difficulty breathing

Encounter Type: Initial

Acuity: D Blue

NO DICTATION FOUND

CHART:

Physicians caring for patient:
MD
Diagnosis
Dyspnea
Disposition
Provider documentation to be completed on HMED.

Disposition - Discharge from ED: home . Condition: stable . The patient is to follow up with his or her private physician , as planned . Recheck immediately for new or worsening symptoms. . Aftercare: Chest pain
Private Physician(s)

Chief Complaint

Chief complaint/quote: pt states she delivered 5 days, she had a c section, was doing fine then began having a feeling of not getting enough air in, no CP, she is relaxed and breathing easy, worse when she is standing or laying down

History of Present Illness

HPI text: the patient is an 18 year-old female who is status post cesarean section. Her C-section was on Tuesday this week. She went home on Friday and has been doing well. Today, she had onset of shortness or breath. She complains of shallow breathing and increased work of breathing. The symptoms seem somewhat positional and are worse when she lies down flat.
The patient denies any fevers, chills, vomiting or diarrhea.
The patient does not have any significant past medical history including any prior history of pulmonary embolism or other respiratory problems.
This is her first baby and she is not breast-feeding.

Review of Systems

Review of systems is as indicated in the HPI. All other systems were reviewed and were negative.

Medications

Home medications: Patient not currently taking any medications.

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Panic disorder Ventricular-septal defect
Caesarean section

Patient has not been diagnosed with antibiotic resistant infection.

Vaccinations are up to date.

Social History

Tobacco use: (-)

VITAL SIGNS

Initials/Date/Time	Temp(C)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2 Sat	O2 Del	Pain Sc
SRS 5/18/2008 16:56	37.1	O	90	17				98	.R/A	0
SRS 5/18/2008 16:58					91	48	S			
R1E 5/18/2008 18:08			80	19	124	74	L	100	3 L	0

Physical Exam

GENERAL: anxious appearing; moderate distress

HEAD: normocephalic; atraumatic

EYES: sclera clear; extra-ocular muscle movement intact; pupils are equal,
round and reactive to light; conjunctiva pink, moist, without exudates

OROPHARYNX: oral mucosa moist and pink; no tonsillar swelling or exudate

NECK: supple without meningismus; no cervical adenopathy; no tenderness to
palpation

PULMONARY: lungs clear to auscultation bilaterally; no retractions; no
wheezes; no rales; no ronchi

CARDIOVASCULAR: heart with regular rate and rhythm; no murmurs; no
gallops; no rubs; strong peripheral pulses; no peripheral edema

GASTROINTESTINAL: abdomen soft; appropriate postoperative tenderness with
no signs of postoperative infection; no guarding or rebound tenderness;
normal bowel sounds; no abdominal distension; no masses or
hepatosplenomegaly

GENITOURINARY: no suprapubic tenderness; no costovertebral angle
tenderness to percussion

MUSC/SKEL: no focal bony tenderness; no apparent deformity; no soft tissue
swelling or tenderness to extremities

BACK: no midline spine tenderness; no peri-spinal muscle tenderness or

spasm

NEURO: normal mental status; alert and awake; no focal motor or sensory deficits

SKIN: warm, dry; normal turgor; no rash; no petechia or purpura

RESULTS

Lab

CBC/Auto Diff; Specimen: blood ; Location: Not applicable MD
Result 5/18/2008 17:46

CBC/Auto Diff; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
NEUTROPHIL %		70	%	40-76	F
LYMPHOCYTE %	L	21	%	23-45	F
MONOCYTE %		5	%	1.0-10.0	F
EOSINOPHIL %		3	%	0.0-3.0	F
BASOPHIL %		1	%	0.0-1.0	F
NEUTROPHIL #		7.6	K/UL	1.90-10.10	F
LYMPHOCYTE #		2.3	K/UL	1.10-5.80	F
MONOCYTE #		0.6	K/UL	0.20-0.80	F
EOSINOPHIL #		0.3	K/UL	0.00-0.50	F
BASOPHIL #		0.1	K/UL	0.00-0.10	F

Reviewed By: MD 5/18/2008 18:11
Result 5/18/2008 17:46

CBC/Auto Diff; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
WBC COUNT		10.9	K/UL	4.5-12.5	F
RBC COUNT		3.55	MIL/UL	3.50-5.50	F
HEMOGLOBIN	L	10.8	G/DL	12.0-15.0	F
HEMATOCRIT	L	31.3	%	36.0-48.0	F
MCV		88.0	FL	79.0-98.0	F
MCH		30.4	PG	25.0-35.0	F
MCHC		34.5	%	31.0-37.0	F
RDW-CV		13.1	FL	11.0-16.0	F
PLATELET COUNT	H	459	K/UL	130-350	F
MPV	L	6.4	FL	7-10	F

Reviewed By: MD 5/18/2008 18:11

Basic Metabolic Panel; Specimen: blood ; Location: Not applicable MD
Result 5/18/2008 17:55

Basic Metabolic Panel; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
SODIUM		140	MMOL/L	135-148	F
POTASSIUM		3.6	MMOL/L	3.5-5.5	F
CHLORIDE		104	MMOL/L	95-108	F
TOTAL CO2		26.4	MMOL/L	21.0-32.0	F
GLUCOSE	H	97	MG/DL	60-95	F
BUN		9	MG/DL	7-25	F
CREATININE		0.7	MG/DL	0.6-1.0	F

GFR Estimated	>60		>60	F
GFR Estimated	UNITS = ML/MIN/1.73m2		>60	
GFR Estimated	If patient is African-American, multiply result by 1.21.		>60	
CALCIUM	9.2	MG/DL	8.7-10.5	F

Reviewed By: MD 5/18/2008 18:11

PT-APTT; Specimen: blood ; Location: Not applicable MD
Result 5/18/2008 17:55

PT-APTT; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
PROTHROMBIN TIME		9.5	SEC	9.1-11.9	F
INR		0.88		0.82-1.18	F
INR		RECOMMENDED REFERENCE RANGES VENOUS THROMBOEMBOLISM: 2.0-3.0 MECHANICAL		0.82-1.18	
INR		HEART VALVES-ARTERIAL EMBOLISM: 2.5-3.5			
APTT		28.0	SEC	21.0-33.8	F
APTT		APTT THERAPEUTIC RANGE: 60.0-95.0	SEC	21.0-33.8	

Reviewed By: MD 5/18/2008 18:11

Radiology

CT; Pulmonary CT Angio w/WO/IV Contrast; Modifier: None; Indications: chest pain J Thomas Ahlquist, MD
Result 5/18/2008 17:51

CT; Pulmonary CT Angio w/WO/IV Contrast; Modifier: None; Indications: chest pain
*** PRELIMINARY REPORT ***

DATE: 05/18/2008
CT PULMONARY ANGIOGRAM

CLINICAL DATA: Chest pain.

COMPARISON EXAM: None.

PROCEDURE: Images were obtained from the thoracic inlet through the diaphragm following contrast administration. Thin-section multiplanar reformations were then performed.

FINDINGS: No acute thrombopulmonary embolism is present. Vascular structures of the mediastinum are normal. No hilar or mediastinal adenopathy. The heart is of normal size. No pericardial effusion. The lungs are clear Visualized portions of the liver, spleen, pancreas, gallbladder, adrenals, and kidneys are normal on this unenhanced study.

CONCLUSION: No acute thrombopulmonary embolism.
Findings discussed with Dr. on 05/18/08 at 6:02 p.m.
Preliminary Report
M.D.
Boise Radiology Group
T: DLZ
d: May 18 2008 6:01P t: May 18 2008 7:32P
Document #2560708 Job # 02321
CC: MD

Read by:.

Procedures

12 lead EKG per order ; shown to: MD Old EKG unavailabl
HS 05/18/08 17:58

Old EKG unavailable
R1E 05/18/08 18:11

Medications Administered

IV's: Insert heparin lock IV MD 5/18/2008 17:22

Given: Yes RN 5/18/2008 17:30

IV's: Insert heparin lock IV MD 5/18/2008 17:22

Given: Yes RN 5/18/2008 17:30

Progress Notes

Medical Decision-Making

The patient's prior medical records were reviewed.

INITIAL ASSESSMENT AND PLAN:
After a complete history and physical examination, I discussed the presenting signs and symptoms with the patient. We have discussed the differential diagnosis including acute pulmonary embolism, congestive heart failure and pneumonia. I reviewed the need for further emergency department evaluation. The treatment plan including the medications and ancillary studies that will be ordered. I have answered all of the patient's questions regarding the workup and plan.
ECG: Normal sinus rhythm, normal axis of deviation, non specific ST-T wave changes were noted, no ectopy, normal intervals and heart rate normal.

Medical Decision-making:
CT pulmonary angiogram negative for pneumonia, pulmonary more failure. The patient was reassured.
At the time of discharge, I discussed the discharge plan and reviewed to the ED visit with the patient. I discussed the diagnosis and have answered all of the patient's questions. The patient will follow up as indicated in the discharge instructions. I have emphasized the need to read and follow the Micromedics discharge instruction sheets.
If the patient is not improving, is worse in any way, or has any new concerns or symptoms that develop after discharge and prior to being seen

in follow-up, the patient is instructed to be rechecked immediately in the emergency department.

Patient Discussion

Test results were discussed with the patient and/or the patient's family.

The diagnosis was discussed with the patient and/or the patient's family.

The treatment plan, as specified under disposition documentation, was discussed with the patient and/or the patient's family. The patient and/or the patient's family have expressed understanding and comprehension of the plan.

Resident Supervision

Signatures: