

Chief Complaint: Fall

Encounter Type: Initial

Acuity: D Blue

NO DICTATION FOUND

CHART:

Physicians caring for patient:

MD

Diagnosis

Fracture - right femoral neck, closed

Disposition

Provider documentation to be completed on HMED.

Disposition - Admit: Admit the patient to St. Luke's Regional Medical

Center Med/Surg . Patient condition: stable. . Admission type:
Inpatient.

. Admitting diagnosis: Hip Fracture . Admitting Physician is:
Private Physician(s)

INTERNIST

INTERNAL MEDICINE

Chief Complaint

Chief complaint/quote: had GLF this morning. states lost balance while going into the bathroom. denies hitting head, denies head, neck, back pain. denies LOC

History of Present Illness

General Template

CC: GLF, Right hip pain

ONSET: This am, just prior to arrival

TIME COURSE: This is an 89 yo female who presents to the ED with complaints of right hip pain after falling this am while walking to the bathroom. Pt reports that she was using her quad-cane and "lost her balance." Upon falling to the left, Pt reports that she over corrected herself, falling onto her right side. She denies any dizziness, lightheadedness or syncope causing her fall. She reports that her pain is localized to her right hip only and that she sustained no other injuries.

SEVERITY: Severe with any movement of right hip.

TREATMENT AT HOME: EMS was called by the patient's home health care nurse and Pt was transferred to the ED for evaluation.

ASSOCIATED POSITIVE SYMPTOMS: Pt reports right hip pain.

PERTINENT NEGATIVE SYMPTOMS: Pt denies any head injury, LOC, neck pain,

back pain, right shoulder pain, right elbow pain, right wrist pain, right knee pain, loss of sensation distal to right hip, or any other concerning symptoms/injuries.

RELEVANT UNDERLYING MEDICAL CONDITIONS: Pt reports Hx of right sided weakness/paralysis secondary to stroke in 1999.

Review of Systems

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

Medications

Home medications: Aspirin EC PO 81 mg every day
Norvasc PO 10 mg BID
Metoprolol Tartrate PO 100 mg BID
Avapro PO 300 mg every day
Zanaflex oral 6 mg at bedtime
Citracal PO 250 mg +D every day
Vitamin E PO 400 unit(s) every day
Vitamin C PO 500 mg every day
Vitamin B-12 PO SL every day
theragra-M advanced Formula every day

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Hypertension Stroke Appendectomy
Patient has not been diagnosed with antibiotic resistant infection.

Social History

Tobacco use: (-)

Alcohol use: (-)

Living arrangement: Pt lives at home with a home health nurse.

Family History

There is no significant family history of any medical condition pertinent to the patient's current presentation

VITAL SIGNS

Initials/Date/Time	Temp (C)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2	O2
DelPain									
								Sat	
Sc									
MRD 5/7/2008 06:39	36.1	O	87	18	127	60	S	94	.R/A 8
RR2 5/7/2008 07:04			66	18	134	54	S	100	3 L
LM 5/7/2008 08:09			67	18	131	53	S	100	3 L
CB 5/7/2008 08:39			72	14	126	54	S	97	3 L
LM 5/7/2008 09:52			71	16	143	53	S	100	3 L
CFK 5/7/2008 10:09			71	18	132	53	S	100	3 L

Physical Exam

GENERAL: well nourished appearing; no distress

HEAD: normocephalic; atraumatic

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

OROPHARYNX: oral mucosa dry and pink; tonsillar pillars without erythema; no tonsillar swelling; no exudate

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

PULMONARY: lungs with good air movement bilaterally; no retractions; breath sounds normal; no wheezes; no rales; no rhonchi; no increased work of breathing

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

GASTROINTESTINAL: abdomen soft; no tenderness to palpation; no guarding; no rebound tenderness; normal bowel sounds; no abdominal distension; no masses or pulsatile masses; no hepatosplenomegaly

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

BACK: no midline spine tenderness;

NEURO: alert and awake; normal mental status; normal orientation; mild right lower facial droop; slightly slurred speech; right sided weakness; these are all chronic findings secondary to her CVA; strength 5/5 left upper and lower extremity

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

MUSC/SKEL: right hip tenderness; severe pain in the right hip with any range of motion of the right lower extremity; right lower extremity held in external rotation; pelvis stable to anterior and lateral compression; no other focal bony tenderness; no apparent deformity; no soft tissue swelling or other tenderness to extremities

RESULTS

Lab

CBC/Auto Diff; Specimen: blood ; Location: Not applicable
Result 5/7/2008 07:23

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

Test	Flag	Value	Units	Ref. Range	Status
NEUTROPHIL	% H	79	%	40-76	F
LYMPHOCYTE	% L	15	%	24-44	F

MONOCYTE %	5	%	1.0-10.0	F
EOSINOPHIL %	1	%	0.0-3.0	F
BASOPHIL %	0	%	0.0-1.0	F
NEUTROPHIL #	H 11.2	K/UL	1.90-8.80	F
LYMPHOCYTE #	2.2	K/UL	1.00-4.80	F
MONOCYTE #	0.7	K/UL	0.10-0.80	F
EOSINOPHIL #	0.2	K/UL	0.00-0.50	F
BASOPHIL #	0.0	K/UL	0.00-0.10	F

Reviewed By: MD 5/7/2008 07:26
 Result 5/7/2008 07:23

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

Test	Flag	Value	Units	Ref. Range	Status
WBC COUNT	H	14.3	K/UL	4.5-11.0	F
RBC COUNT		4.16	MIL/UL	3.50-5.50	F
HEMOGLOBIN		13.7	G/DL	12.0-15.0	F
HEMATOCRIT		39.7	%	36.0-48.0	F
MCV		95.3	FL	79.0-98.0	F
MCH		33.0	PG	25.0-35.0	F
MCHC		34.6	%	31.0-37.0	F
RDW-CV		12.0	FL	11.0-16.0	F
PLATELET COUNT	H	365	K/UL	130-350	F
MPV	L	6.9	FL	7-10	F

Reviewed By: MD 5/7/2008 07:26

Basic Metabolic Panel; Specimen: blood ; Location: Not applicable
 Result 5/7/2008 07:19

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

Test	Flag	Value	Units	Ref. Range	Status
SODIUM	L	133	MMOL/L	135-148	F
POTASSIUM		3.7	MMOL/L	3.5-5.5	F
CHLORIDE		99	MMOL/L	95-108	F
TOTAL CO2		25.2	MMOL/L	21.0-32.0	F
GLUCOSE	H	127	MG/DL	60-95	F
BUN		19	MG/DL	7-25	F
CREATININE		1.0	MG/DL	0.6-1.0	F
GFR Estimated L		55		>60	F
GFR Estimated L		UNITS = ML/MIN/1.73m2		>60	
GFR Estimated L		If patient is African-American, multiply result by 1.21.		>60	
CALCIUM		8.9	MG/DL	8.7-10.5	F

Reviewed By: MD 5/7/2008 07:26
 PT-APTT
 Result 5/7/2008 09:05

PT-APTT

Test	Flag	Value	Units	Ref. Range	Status
PROTHROMBIN TIME		10.4	SEC	9.1-11.9	F
INR		0.98		0.82-1.18	F
INR		RECOMMENDED REFERENCE		0.82-1.18	

RANGES VENOUS

THROMBOEMBOLISM: 2.0-3.0

MECHANICAL

INR

HEART VALVES-ARTERIAL

EMBOLISM: 2.5-3.5

APTT

21.8

SEC

21.0-33.8

F

APTT

APTT THERAPEUTIC RANGE:

SEC

21.0-33.8

60.0-95.0

Reviewed By: MD 5/7/2008 15:21
Radiology

XRAY; Hip 2 Views XRay; Modifier: Right; Indications: pain
Result 5/7/2008 07:29

XRAY; Hip 2 Views XRay; Modifier: Right; Indications: pain
*** PRELIMINARY REPORT ***

DATE: 05/07/2008
HIP TWO-VIEW MINIMUM

CLINICAL DATA: An 89-year-old had a ground-level fall this morning
after
losing balance.

FINDINGS: Marked osteopenic changes are present. Fracture deformity
of
the right femoral neck is evident with high riding position of the
remainder of the right femur. There appears to be anterior and
slightly
lateral apex angulation as the fracture line appears to cross the
caudal
aspect of the right femoral neck.

CONCLUSION: Right femoral neck fracture. Marked osteopenic changes.
Preliminary Report

M.D.

Boise Radiology Group

T: VLL

d: May 7 2008 7:41A t: May 7 2008 8:18A

Document #2550729 Job # 18754

CC: MATTHEW P. HULQUIST, MD

Read by:

Reviewed By: MD 5/7/2008 08:26

PORT X RAY; Chest AP only; Modifier: None; Indications: dyspnea
Result 5/7/2008 08:51

PORT X RAY; Chest AP only; Modifier: None; Indications: dyspnea
*** PRELIMINARY REPORT ***

DATE: 05/07/2008
AP PORTABLE SUPINE CHEST AT 0848 HOURS

CLINICAL DATA: Ground-level fall with hip fracture and dyspnea.

COMPARISON EXAMS: No comparisons are available currently.

FINDINGS: The lungs appear clear and show normal volumes. There is
no pleural effusion or pneumothorax. The heart size is normal. Diffuse
osteopenia is noted. The vascularity is probably normal for supine
technique.

CONCLUSION: No acute cardiopulmonary abnormality is identified.

Preliminary Report

M.D.

Boise Radiology Group

T: TJC

d: May 7 2008 8:58A t: May 7 2008 9:14A

Document #2550842 Job # 18846

CC: MD

Read by:

Reviewed By: MD 5/7/2008 15:21

Procedures

12 lead EKG per order ; shown to: MD Old EKG unavailable

RR2 05/07/08 06:50

Medications Administered

Titrated meds: Morphine sulfate IV 2-10mg IV prn, max dose 10mg MD
5/7/2008 06:49

Given: Yes 4mg IV. Infused over Slow IVP RN 5/7/2008 06:55
Moderate relief RN 5/7/2008 07:06

Given: Yes 2 mg IV. Infused over Slow IVP RN 5/7/2008 07:1

Given: Yes 2 mg IV RN 5/7/2008 11:01

Titrated meds: Zofran IV 4-8mg IV prn, max dose 8mg MD 5/7/2008 06:49

Given: Yes 4mg IV. Infused over Slow IVP RN 5/7/2008 06:54

IV's: Insert heparin lock IV SCRIB 5/7/2008 06:49

Given: Yes RN 5/7/2008 06:55

: Valium Intravenous 2.5mg IV over 2 min Matthew MD
5/7/2008 08:32

Given: Yes 2.5mg IV IVP. Infused over Slow IVP RN
5/7/2008 08:39

Progress Notes

Consults

Consultant: Call placed to:,"ORTHOPEDIC SURGERY KE
05/07/08 08:36

Notes:

Dr. Poole is in surgery all day.

Consultant: Call received from:,"ORTHOPEdic SURGERY KE
05/07/08 08:37

Consultant: Call placed and received from:,"INTERNAL
MEDICINE KE 05/07/08 08:43

Consultant: Call placed and received from:,"ORTHOPEdic
SURGERY KE 05/07/08 08:50

Medical Decision-Making

INITIAL ASSESSMENT AND PLAN:

primary concern for right hip fracture versus dislocation. X-ray
pending.

Basic labs and EKG done for likely preoperative purposes.

ECG: sinus rhythm with first-degree AV block, rate 78, left axis
deviation, left bundle branch block, QRS duration 138 ms, otherwise
unremarkable.

Medical Decision-making:

after right femoral neck fracture was identified on x-ray, the case
was

discussed with Dr. as well as Dr.. Dr. agreed to admit the patient
primarily with consulting. Transition orders written by me.

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: