

12/11/2007
8:50

EDIMS Medical Center
632 Mt Pleasant Ave
Livingston, New Jersey 07039
(973)555-2100

Page : 1

Physician Notes

Patient Name : FORSTATER, ALAN Date of Service : 12/11/2007 ED Physician : Giles
Date of Birth : 12/11/1953 Age : 54 YRS Sex : M Chart # : PMD :

TX:=====

TRIAGE NOTES:

Pt c/o abd pain for 2 days. States having rectal bleedin starting this AM with nausea and dizziness. Also states has felt feverish. Abd tender in LLQ. Denies vomiting.

ALLERGIES (Reaction): PENICILLIN (Rash)

Latex/Rubber: NO, Allergy bracelet applied: Yes

MEDICATIONS: Metoprolol, ASA, Zantac, cholesterol

VITAL SIGNS: Pulse: 130 Resp: 27 Weight: 68 Kg BP: 110/50 Pulse ox: 96%

======(TX) End

PRESENTING PROBLEM: Rectal bleeding

Initial considerations based on the presenting problem include but are not limited to: Diverticulosis, tumor, hemorrhoids, peptic ulcer, bleeding disorder.

HISTORY OF PRESENT ILLNESS: ALAN FORSTATER is a 54 -year-old Male who reports onset of 2 days of abdominal pain, nausea and felt dizzy this am. Pt reports arising from bed and nearly passed out. Reports he has been having bloody diarrhea after a trip to New Orleans 2 weeks ago. rectal bleeding associated with lower abdominal pain. Otherwise: (-) syncope, (-) chest pain. Has no history of GI bleeding.

PMD: None

REVIEW OF SYSTEMS: Other than the symptoms associated with the present events, the following is reported with regard to recent health:

General: (-) fever. HENT: (-) congestion. Respiratory: (-) cough. Cardiovascular: (-) chest pain. GI: (-) prior abdominal pain. GU: (-) urinary complaints. Musculoskeletal: (-) other aches or pains. Endocrine: (-) prior generalized weakness. Neurological: (-) localized weakness. Psychiatric: (-) emotional stress.

PAST MEDICAL HISTORY: (-) DM, (-) HTN, (-) asthma, (-) COPD, (+) previous MI, (+) Emphysema.

FAMILY HISTORY: (+) MI

SOCIAL HISTORY: (+) smoking, (+) occ ETOH.

MEDICATIONS: Per nurse's note, reviewed by me

ALLERGIES: Per nurse's note, reviewed by me PCN

PHYSICAL EXAMINATION:

GENERALIZED APPEARANCE: Patient is alert, awake and in moderate painful distress.

VITAL SIGNS: Per nurse's note, reviewed by me 150/97, hr 130, rr 27, T103.7

SKIN: Warm, dry; (-) cyanosis, (-) petechiae.

EYES: (-) conjunctival pallor, (-) scleral icterus.

ENMT: Mucous membranes moist.

NECK: (-) tenderness, (-) stiffness, (-) lymphadenopathy.

CHEST AND RESPIRATORY: (-) rales, (-) rhonchi, (-) wheezes; breath sounds equal bilaterally.

HEART AND CARDIOVASCULAR: (-) irregularity; (-) murmur, (-) gallop.

ABDOMEN AND GI: Soft; (-) distention, (+) LLQ tenderness, (-) rebound, (-) guarding, (-) palpable masses.

RECTAL: (-) mass, (-) tenderness melena; stool Hemoccult positive with Performance Monitor as control.

EXTREMITIES: (-) deformity, (-) edema.

NEURO AND PSYCH: Mental status as above; (-) focal findings.

DIAGNOSTICS: pulse ox 96%Ra

hgb inr 1, cbc 12.5 hgb 7, hct 21,

chem 12 normal

CT abd & pelvis: diverticulitis and abscess no free air, no appendicitis.

EKG: sinus tach right axis, (-) ischemic changes

EMERGENCY DEPARTMENT COURSE AND TREATMENT: Previous medical records requested. Intravenous access established. Fluid resuscitation initiated. Hemodynamic status monitored. NG tube negative for blood.

PLAN: Situation discussed with admitting physician. Patient to be admitted to OR.

FORSTATER, ALAN

MD Seen : 8:36

Medrec #:

Chart #:

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8:50

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Page : 2

Physician Notes

Patient Name : FORSTATER, ALAN

Date of Service : 12/11/2007

ED Physician : Giles

Date of Birth : 12/11/1953

Age : 54 YRS

Sex : M

Chart # :

PMD :

Condition :

Diagnosis : ACUTE GASTROINTESTINAL BLEEDING.

CPT Codes : 10005 10094 10091

Physician : Robert Giles M.D

PA :

Resident :

Emergency Department Orders Summary

Date of Service: 12/11/2007 ED Physician: Giles PMD:

Patient Name: FORSTATER, ALAN DOB: 12/11/1953 Age: 54 YRS Sex: Male MRN#: Chart #:

Weight: 68 Kg Height: Allergies: ALLERGIES(Reaction):PENICILLIN(Rash); Latex/Rubber: NO, Allergy bracelet applied: Yes

Time Issued	Electronically Issued By	Order	Comments	Justification	Origin of Order	Recv'd By:	Order Completed By:	Order Canceled By:	Unable to Complete	Unable to Complete Reason	Scheduled For
12/11/2007 08:33	Robert Giles	EKG		tachycardia			RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	IV 0.9% NS, 1000 mL bolus 1000									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	IV 0.9% NS, 1000 mL at 150 mL per hour									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	Place in Observation Status and Perform Initial Observation Assessment									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	CBC and Differential					RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	Comprehensive Metabolic Panel					RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	Lipase					RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	CT Abdomen (liver/spleen) With Oral Contrast Only		abdominal pain			RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	CT Pelvis with Oral Contrast Only		abdominal pain			RG @ 08:44				12/11/2007 08:33

Emergency Department Orders Summary

Date of Service: 12/11/2007 ED Physician: Giles PMD:

Patient Name: FORSTATER, ALAN DOB: 12/11/1953 Age: 54 YRS Sex: Male MRN#: Chart #:
 Weight: 68 Kg Height:

Allergies: ALLERGIES(Reaction):PENICILLIN(Rash); Latex/Rubber: NO; Allergy bracelet applied: Yes

Time Issued	Electronically Issued By	Order	Comments	Justification	Origin of Order	Recv'd By:	Order Completed By:	Order Canceled By:	Unable to Complete	Unable to Complete Reason	Scheduled For
12/11/2007 08:33	Robert Giles	Start IV Line									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	Pulse Ox on RA									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	NPO									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	NG tube									12/11/2007 08:33
12/11/2007 08:33	Robert Giles	Type and Screen					RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	PTT		gi bleeding			RG @ 08:44				12/11/2007 08:33
12/11/2007 08:33	Robert Giles	PT/INR		gi bleeding			RG @ 08:44				12/11/2007 08:33
12/11/2007 08:34	Robert Giles	O2 - 2 liters per min via Nasal Cannula									12/11/2007 08:34
12/11/2007 08:35	Robert Giles	Morphine 4 mg IV - Intravenous									12/11/2007 08:35

DEPARTMENT OF EMERGENCY MEDICINE
ASSESSMENT SHEET ADULT

Patient Name: **FORSTATER, ALAN**

Date of Birth: **12/11/1953**

Medical Record #:

Chart #:

Date of Service: **12/11/2007 08:27**

ADDRESSOGRAPH / LABEL

Glasgow Coma Scale/Level of Consciousness: Best Motor Response: 6-Obeys Simple Commands, Best Verbal Response: 5-Oriented, Best Eye Opening: 4-Spontaneously. Total Score is 15.
Orientation: x 4. Pupils: N/A.
Respiratory: Airway: Patent.
Respirations: Spontaneous, Unlabored.
Breath Sounds: Wheezing: R, L.
Chest Expansion: Symmetrical.
Cough: No.
Cardiovascular: Rhythm: Sinus Tachycardia. Pacemaker: No.
Chest Pain: No, JVD: No, Edema: No.
Pulses: Strong, Equal.
Capillary Refill: Less than 4 sec.
Color: WNL. Mucous Membranes: Pink, Moist.
Musculoskeletal: Gait: Steady
Back Pain

Integumentary: Skin Temp: Dry, Warm.
Skin Integrity: Intact.
Gastrointestinal: Nausea X 2 Days, Diarrhea X 2 Days
Blood In Stool.
Abdomen: Soft, Tender
Pain: Yes-LLQ.
Bowel Sounds: Present x 4.
GU: Burning/Pain on Urination.
GYN: N/A
Pain Scale: Pain Rating at Present Time: 08:44 #: 6/10 Location: LLQ
Safety: Siderails up/brakes on/bed low, Call bell within reach.
Social/Discharge Planning: Patient does not live alone, has relative, has help at home, does not have medical equipment, does not need social service.
Barriers to Learning: No Barriers.
Patient at risk for falls or injury: No
Nurse Signature: Robert Giles, MD, Time: 12/11/07 08:43

DEPARTMENT OF EMERGENCY MEDICINE
NURSING ASSESSMENT & PROGRESS NOTES

Patient Name: **FORSTATER, ALAN**
 Date of Birth: **12/11/1953**
 Medical Record #:
 Chart #:
 Date of Service: **12/11/2007, 08:27**

ADDRESSOGRAPH / LABEL

Time	Vitals (q 2-4 hrs or prn)	Notes	Init.	Time Edited (E) Deleted (D) Reverted (R)
12/11/2007 08:32		Possible Abuse/Violence/Neglect identified?: No	SZ	
12/11/2007 08:44		CBC and Differential drawn at 08:44	RG	
12/11/2007 08:44		Comprehensive Metabolic Panel drawn at 08:44	RG	
12/11/2007 08:44		Lipase drawn at 08:44	RG	
12/11/2007 08:44		Type and Screen drawn at 08:44	RG	
12/11/2007 08:44		PTT drawn at 08:44	RG	
12/11/2007 08:44		PT/INR drawn at 08:44	RG	
12/11/2007 08:44		ECG Done by: SZ at 08:44 ECG Int. By: Dr. Giles at 08:44	RG	
12/11/2007 08:44		To CT for CT Abdomen (liver/spleen) With Oral Contrast Only by RG at 08:44	RG	
12/11/2007 08:44		To CT for CT Pelvis with Oral Contrast Only by RG at 08:44	RG	

DEPARTMENT OF EMERGENCY MEDICINE
TRIAGE/ASSESSMENT FORM ADULT

Patient Name: FORSTATER, ALAN

Date of Birth: 12/11/1953

Medical Record #:

Chart #:

Date of Service: 12/11/2007,08:27

ADDRESSOGRAPH / LABEL

Name: ALAN FORSTATER Sex: Male DOB: 12/11/1953 Age: 54YRS
Arrival Date: 12/11/2007, Arrival Time: 8:27
ARRIVAL: Ambulatory
Triage Time: 12/11/2007 8:27
Person Providing Info: self and wife
Chief Complaint: ABD PAIN
Weight: 68 Kg
Pain Scale: 6/10
Vital Signs: Pulse: 130, Respiration: 27, Blood Pressure: 110/50, SO2: 96% on Room Air , Init.SZ
MEDICATIONS: Metoprolol; ASA; Zantac; cholesterol
Triage Medications: None
MEDICAL HX/SURGICAL HX: Emphysema, MI, Other: Eczema, Appendicitis

ETOH: Yes, Description: beer/day
Smoking: Yes, Description: cig
Recreational Drugs: No
Possible Abuse/Violence/Neglect identified? No

ALLERGIES (Reaction): PENICILLIN (Rash)
Latex/Rubber: NO, Allergy bracelet applied: Yes

VACCINES UP TO DATE: Tetanus: Unknown; Pneumococcal: Unknown; Influenza: Unknown
EXPOSED TO ANY COMMUNICABLE DISEASES: None

Assessment: Pt c/o abd pain for 2 days. States having rectal bleedin starting this AM with nausea and dizziness. Also states has felt feverish.
Abd tender in LLQ. Denies vomiting..
Nurse Signature: Steven Zurlo, RN
Nursing Actions at Triage: None
Acuity Level: Level 2
Triage Disposition: Main ED
Advance Directives: No
Nurse Signature: Steven Zurlo, RN

EMERGENCY CARE PROVIDERS:
Init.: RG Signature: Giles, Robert (MD)
Init.: SZ Signature: Zurlo, Steven (RN)