

# Emergency Department Clinical Chart

J #:  
Episode No:  
Name: ALN, A  
D.O.B.:  
Age: 51 yrs  
Sex: Male  
OHIP #:

Triage Date / Time: 8th DEC 2008 12:07 PM  
Complaint: ABDOMINAL PAIN  
Presenting Problem: ABDOMINAL PAIN  
PAIN (ACUTE)- MOD (4-7/10) | VITAL SIGNS - UPPER/LOWER LIMITS OF NML  
Diagnosis: SEPTIC SHOCK  
Alerts/Allergies:

## Medications:

### CLINICAL NOTES

DOCTOR HISTORY commenced at 12:09.8 DEC 2008 by DOCTOR DOCTOR

- GI ABDOMINAL PAIN: CC/HPI  
COMPLAINT: [ABDOMINAL PAIN](#) (Note: [bloody diarrhea](#))
- GI ABDOMINAL PAIN: SYMPTOMS /SIGNS  
CONST: Note: [weakness](#)  
CV / RESP: [no chest pain](#), [SOB](#)  
GI: [Constipation](#) (Note: [bowels don't move](#))
- GI ABDOMINAL PAIN: OTHER HX  
RECENT HOSPITALIZATIONS: [yes, different problem](#) (Note: [gastro 2 days ago needed IV fluid](#))

DOCTOR EXAM commenced at 12:12.8 DEC 2008 by DOCTOR DOCTOR

- GI ABDOMINAL PAIN: CONSTITUTIONAL  
APPEARANCE: [alert, looks sick](#)  
DISTRESS: [moderate](#)  
VITAL SIGNS: [tachycardic](#)
- GI ABDOMINAL PAIN: HEAD / NECK  
EYES: [NML](#), [PERL](#)
- GI ABDOMINAL PAIN: ABDOMEN  
PALPATION: [tender \( left, lower abdomen\)](#)  
BOWEL SOUNDS: [Increased](#)  
RECTAL EXAM: [mass](#) (Note: [left](#))  
STOOL: [Hem +](#)
- GI ABDOMINAL PAIN: CNS  
SPEECH: [NML](#)  
MOTOR FX: [NML](#)  
REFLEXES: [NML](#)

DOCTOR REASSESS commenced at 12:26.8 DEC 2008 by DOCTOR DOCTOR

- GI ABDOMINAL PAIN: RECORD REVIEW / CONSULTS / FAMILY  
DISCUSSIONS: [with family](#) (Note: [WIFE CALLED 1:30](#))  
OLD RECORDS: [Ordered](#)  
FIRST CONSULT / CALL: [ICU](#)

# Emergency Department Clinical Chart

J #:

Name: ALN, A

CONSULTANT PROVIDING: [immediate care](#)

- GI ABDOMINAL PAIN: REASSESS DETAILS  
RESPIRATORY DISTRESS: [getting worse](#)

## ORDERS

### MEDICATIONS:

- DOPAMINE IV x 5 micrograms, IV completed at [12:40,8 DEC 2008](#) by DOCTOR DOCTOR

### PROCEDURES/INVESTIGATIONS:

- CBC PLUS DIFFERENTIAL RESULTS, HGB: 7, HCT: 21, WBC COUNT: 26.5 completed at [12:18,8 DEC 2008](#) by DOCTOR DOCTOR
- LIVER FUNCTION TEST RESULTS, SUMMARY: NORMAL completed at [12:19,8 DEC 2008](#) by DOCTOR DOCTOR
- LYLES, GLU, BUN, CREAT RESULTS, SUMMARY: NORMAL completed at [12:19,8 DEC 2008](#) by DOCTOR DOCTOR
- CT ABDOMEN, CONTRA INDICATION TO CONTRAST: NO, VIEW: NO CONTRAST completed at [12:20,8 DEC 2008](#) by DOCTOR DOCTOR
- CT ABDOMEN RESULT, SUMMARY: no free fluid, no appendicitis, diverticulitis (Note: ischemic bowel loops descending colon with diverticular abscess) completed at [12:20,8 DEC 2008](#) by DOCTOR DOCTOR
- NG TUBE INSERTION, ROUTE: Nasal (Note: no blood) completed at [12:21,8 DEC 2008](#) by DOCTOR DOCTOR
- EKG - 12 LEAD RESULT, RATE: 132, RHYTHM: Atrial fib, AXIS: Rt deviation, ST MORPHOLOGY: NML completed at [12:22,8 DEC 2008](#) by DOCTOR DOCTOR
- INR RESULT, : 1, SUMMARY: NML completed at [12:24,8 DEC 2008](#) by DOCTOR DOCTOR
- AIRWAY INTUBATION, INDICATION: Resp failure, INTUBATION: Standard, TUBE PLACEMENT CONFIRMATION: confirmed with end tidal CO2 completed at [12:28,8 DEC 2008](#) by DOCTOR DOCTOR
- ARTERIAL BLOOD GAS RESULT, pO2 (mmHg): 90, pCO2 (mmHg): 22, pH: 7.14, COMMENT: acute hypoxia completed at [12:35,8 DEC 2008](#) by DOCTOR DOCTOR

## VITALS

12:07,8 DEC 2008: T: [38.0 °C](#) TLOC: [3](#) P: [120 /min](#) RR: [27 /min](#) BP/S: [90 mmHg](#) BP/D: [60 mmHg](#) SaO2: [88 %](#) by NURSE NURSE

## FLUIDS

<EMPTY>

## DISCHARGE

PRIMARY DIAGNOSIS: [SEPTIC SHOCK](#)

SECONDARY DIAGNOSIS: [PNEUMONIA, NOS,ACUTE RESPIRATORY DISTRESS SYNDROME](#)

DESTINATION: [INPATIENT UNIT](#)

## PROJECTS

<EMPTY>